Healthy communities leave no one behind. In 2011, we continued our work to open the doors to high-quality health care for vulnerable individuals and families. We focused on those who lacked access to vital services due to barriers to private health care coverage, the limited capacity of safety net programs, or the persistence of racial, ethnic, and other disparities in health and health care.

Through our care and coverage programs, we built partnerships with public and private organizations to fill gaps in access and meet the unique health care needs of local communities. Our safety net partnerships strengthened the capacity of existing institutions, with evidence-based knowledge and practice, to meet the growing needs of underserved populations.

We learned much from our partners while sharing our own clinical innovations in the quest to eliminate health disparities and promote diversity throughout the nation’s health care enterprise. And with an eye to the future, we invested in scholarships and training for safety net clinicians and tomorrow’s health care workforce.
CARE AND COVERAGE

Though the nation showed promising signs of emerging from the depths of the economic crisis in 2011, the relief was scarcely evident to the unemployed, underemployed, and uninsured, whose numbers remained at stubbornly high levels. The persistence of a weak job market and the ongoing loss of employment-based health coverage undermined the physical, financial, emotional, and social health of individuals, families, and communities across the economic spectrum. More than 5.7 million Americans under the age of 65 were added to the already swollen ranks of the uninsured between 2007, when the recession began, and 2010. And the rate of loss continued through much of 2011. These trends, combined with sharp declines in real median household income and continuing threats to the nation’s public and nonprofit safety nets, left millions of Americans slipping into poverty and struggling to obtain the basic necessities of life, including healthy food, housing, and access to health care.

In 2011 and throughout the four long years of the nation’s economic struggle, we sustained our commitment to make high-quality, affordable health care available to our members and our communities, especially the most vulnerable among us. For thousands of low-income individuals and families unable to afford private coverage or to qualify for public health care programs, our care and coverage programs provided access to vital, high-quality health care services that would otherwise have been unavailable.
Membership in our care and coverage programs increased in 2011 to 547,842.

Responding to Regional Needs with Charitable Health Coverage

Without exception, every region and every community served by Kaiser Permanente has witnessed the hardships of the recession. But the impacts have not been uniform, and the promising signs of recovery have been brighter in some regions than in others. Because of the uneven nature of the crisis, no single approach to care and coverage assistance makes sense. That’s why our 12 Charitable Health Coverage programs are regionally based and designed to respond to the specific circumstances of each community.

In California, we responded to the state’s persistently high unemployment, which remained above 11 percent through most of 2011, by increasing membership in the Kaiser Permanente Child Health Plan. The plan, which operates in both our Northern and Southern California Regions, serves children up to 19 years old from families earning under 300 percent of the federal poverty level. Families pay premiums of either $8 or $15 per month per child, depending on their income, and most copayments are $5 a visit. The plan covered more than 80,000 children in California in 2011.

In Ohio, we expanded the Kaiser Permanente Transition Plan dramatically. Since 2009, the number of people enrolled has tripled. The plan covers adults and families with household incomes of less than 250 percent of the federal poverty level. It provides a much-needed safety net for single adults who often do not qualify for Medicaid under the current guidelines, and it allows dependents up to age 28 to be included on a parent’s plan. The Transition Plan offers a robust benefits package, including coverage for prescription drugs, for a premium of $20 or $40 per month.

In Hawaii, in the early days of the recession, we responded to a local need for coverage among low-income young adults with a new Bridge Program. The program continues today and provides the full benefits of Kaiser Permanente coverage to individuals ages 19 to 26 for up to two years. In 2011, we followed up this effort by sponsoring Hawaii’s first-ever health needs assessment, prepared in collaboration with numerous community partners. The assessment compiles up-to-date information on the needs of the state’s vulnerable populations and the resources available to meet those needs. This invaluable data will help guide future outreach and intervention efforts by Kaiser Permanente and local health agencies to assist populations in need.
Last December Seth and Jessica Gilley had the kind of month that only the parents of young children can fully appreciate. Their 3-year-old son, Jaxson, and 4-month-old son, Mattix, took turns suffering from a stomach virus, and then each spent time battling an ear infection.

“We were at Kaiser Permanente in Santa Rosa twice a week,” Jessica said. “With the kids being so sick, it was miserable. But it helped knowing that going to the doctor wasn’t going to be such a financial burden.”

Just days before the boys became ill, the Gilleys got word that Jaxson and Mattix had been approved for coverage through the Kaiser Permanente Child Health Plan. For a decade this plan has provided comprehensive health care coverage for uninsured children in California who don’t qualify for public programs such as Medi-Cal (the state’s Medicaid program) and Healthy Families (the state’s Children’s Health Insurance Program).

The Gilley boys were two of 51,611 children covered by the Child Health Plan in Northern California last year. Membership grew 5 percent from 2010 to 2011. That’s about 2,700 more children who received coverage last year.

Many families covered by the plan are still feeling the effects of a sluggish economy, according to Kelly Paschal-Hunter, manager of the Child Health Plan. “We see a lot of people who’ve lost jobs, or households where only one parent is working,” she said. “We also see situations where employers are no longer offering health coverage for dependent children.”

That’s the case with the Gilley family. Seth works full time as a cabinetmaker, and Jessica stays home with the kids. He has Kaiser Permanente coverage through his employer, but he couldn’t afford coverage for his wife and children.

“I’m the one who stresses out about the money,” Seth said. “Not having to worry about my children and their health care … There are no words to relate how relieved I am.”

For the Gilleys, the Child Health Plan offers an added bonus. “The boys have Dr. Mark Sloan as their pediatrician in Santa Rosa, and he was my pediatrician when I was a kid,” Jessica said. “It was important to me to stay at Kaiser Permanente because we trust Dr. Sloan. He’s like family to us.”
MEETING INCREASED DEMAND FOR MEDICAL FINANCIAL ASSISTANCE

For growing numbers of patients struggling to pay out-of-pocket medical expenses, our Medical Financial Assistance Program has been a vital resource. The program is open to members and nonmembers who meet financial guidelines based on household size and income, and who have exhausted all means of private or public health care coverage. In 2011, more than 165,000 people applied for assistance — up 6 percent from 2010. The approval rate also increased, to 80 percent, enabling 133,013 people to receive financial assistance.

CONNECTING PEOPLE IN NEED TO COMMUNITY SERVICES

Most of the individuals and families who apply for membership in our Charitable Health Coverage programs also struggle to cope with an array of nonmedical needs that often impact or even compete with their health care needs. Something as common as a lack of access to transportation can be a serious barrier to keeping a doctor’s appointment. And for families who struggle to put food on the table, even paying the bus fare can create conflicting priorities with their basic health care needs.

Yet in many underserved communities there are public or nonprofit programs that provide subsidized services, such as food stamps or home heating assistance, that target barriers to people pursuing healthy, productive lives. The problem isn’t always a lack of availability of these community resources; it’s that people aren’t aware of their eligibility for them.

That’s where we plan to make an impact as we move toward a broader vision of the delivery of health care services to vulnerable populations. In 2011, we invested in developing a way to use the screening process for our care and coverage programs to provide referrals to nonmedical community resources that can contribute to a person’s total health. As a result of this investment, we will be piloting an electronic screening process in Northern California in 2012. Those who apply for our Charitable Health Coverage programs in the Fresno area will also be screened for their eligibility for nonmedical community services.

CARE AND COVERAGE PROGRAMS SERVING LOW-INCOME FAMILIES AND INDIVIDUALS

Medicaid
A federal and state program that provides health care coverage for low-income children and their parents, as well as pregnant women, the disabled, and the elderly.

Children’s Health Insurance Program (CHIP)
A federal and state program that covers children up to 19 years of age with household incomes higher than those in Medicaid, but whose parents can’t afford private insurance.

Kaiser Permanente Charitable Health Coverage Programs
These programs are designed by Kaiser Permanente regions to offer highly subsidized insurance coverage to low-income individuals and families who do not qualify for Medicaid or CHIP. These programs are unique to Kaiser Permanente, offering subsidized members the same access to high-quality care as nonsubsidized members.

Kaiser Permanente Medical Financial Assistance Program
This program helps those who are uninsured receive care for episodic illnesses at Kaiser Permanente, and also offers assistance to those who are insured but cannot afford the out-of-pocket costs of care.
“The roots of all goodness lie in the soil of appreciation for goodness.”

DALAI LAMA
For us, it is not enough just to increase access to care for the underserved. We must also make sure they get the same high-quality care we give to all Kaiser Permanente members. This is especially relevant for the relatively small proportion of Medicaid patients whose multiple or high-risk conditions account for a large share of medical services. Finding better models of care for these patients is essential to controlling costs and improving the quality of care for all high-need, high-cost patients — not only those in our own programs but also the millions in other publically financed programs across the country. These patients, like all our members, deserve care that enables them to live the most productive and healthy lives possible.

In our drive to improve the quality of care for the poorest and sickest among us, we continued to partner with the Center for Health Care Strategies (CHCS) in 2011. This highly regarded Medicaid policy organization works with partners across the nation to test new approaches for high-need, high-cost Medicaid patients. Since 2008, we’ve been working with CHCS on Medicaid Learning Initiative, aimed at improving the service and care we provide to our high-need Medicaid members. In 2011, we continued our targeted care interventions with these members and evaluated the outcomes to identify and share opportunities for improvement. The following Medicaid Learning Initiative interventions were so successful that they have the potential to become new models of care for all of our high-need Medicaid patients.

**Northwest Region**

The New Member Navigator program in our Northwest Region uses a dedicated staff person to serve as a “navigator” to assist new members in accessing health care services. The navigator helps members choose a primary care physician and understand how to make appointments, transfer prescriptions, and get mental health and dental services in the community. This program helps new members take full advantage of Kaiser Permanente services to improve their health and productivity as quickly as possible. The program is already in full effect for all our Medicaid and Charitable Health Coverage members in the Northwest, due to its demonstrated ability to significantly increase primary care visits and decrease emergency department visits and hospitalizations.

**Northern California Region**

Medi-Cal is California’s Medicaid program. Our Medi-Cal Care Coordination program addresses the needs of high-risk Medi-Cal patients in our Northern California Region through four teams of care coordinators. Each team consists of a registered nurse, psychiatric social worker, and two care coordination assistants who are licensed vocational nurses. Key goals of the program include reducing emergency department visits and hospital stays by meeting these members’ medical needs in more convenient, effective, and efficient ways. To date, the care coordinators have conducted more than 70,000 interventions, including clinic visits, home visits, and telephone interactions, and the results continue to be remarkable. As the program enters its fifth year, emergency department visits are down 20 percent and hospitalizations have been reduced by 15 percent, when compared to a matched comparison group.
### Charitable Health Coverage Spending

<table>
<thead>
<tr>
<th>Year</th>
<th>Spending in Millions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>$98.2</td>
</tr>
<tr>
<td>2006</td>
<td>$120.1</td>
</tr>
<tr>
<td>2007</td>
<td>$165.6</td>
</tr>
<tr>
<td>2008</td>
<td>$220.7</td>
</tr>
<tr>
<td>2009</td>
<td>$260.3</td>
</tr>
<tr>
<td>2010</td>
<td>$268.6</td>
</tr>
<tr>
<td>2011</td>
<td>$250.8</td>
</tr>
</tbody>
</table>

### Charitable Health Coverage Membership

<table>
<thead>
<tr>
<th>Year</th>
<th>Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>51,070</td>
</tr>
<tr>
<td>2006</td>
<td>72,012</td>
</tr>
<tr>
<td>2007</td>
<td>89,877</td>
</tr>
<tr>
<td>2008</td>
<td>104,127</td>
</tr>
<tr>
<td>2009</td>
<td>113,184</td>
</tr>
<tr>
<td>2010</td>
<td>105,809</td>
</tr>
<tr>
<td>2011</td>
<td>101,614</td>
</tr>
</tbody>
</table>
### 2011 CHARITABLE HEALTH COVERAGE PROGRAMS

<table>
<thead>
<tr>
<th>REGION</th>
<th>PROGRAM ELIGIBILITY GUIDELINES</th>
</tr>
</thead>
</table>
| Northern California and        | **Steps Plan**  
| Southern California            | Members under 300 percent FPL* whose coverage has been terminated in the past six months  
|                                | **Child Health Plan**  
|                                | Children under 19 years of age who are under 300 percent FPL |
| Colorado                       | **Steps Plan**  
|                                | Adults and families under 300 percent FPL; targets adults under 35 who are enrolled in community colleges |
| Georgia                        | **Bridge Program**  
|                                | Adults and families at or below 300 percent FPL; targets adults in training for allied health professions |
| Hawaii                         | **Bridge Program**  
|                                | Individuals 19 to 26 years of age under 250 percent FPL |
| Mid-Atlantic States            | **Bridge Program**  
|                                | Adults and families at or below 300 percent FPL  
|                                | **Medical Care for Children Partnership**  
|                                | In collaboration with county initiatives, Kaiser Permanente provides a medical home for children up to 18 years of age who are at or below 250 percent FPL |
| Northwest                      | **Transitions**  
|                                | Adults and families under 250 percent FPL in targeted community colleges  
|                                | **Child Health**  
|                                | K-12th graders and their siblings ages 3 to 6 years who are under 250 percent FPL in targeted low-income schools |
| Ohio                           | **Transition Plan**  
|                                | Adults and families under 250 percent FPL |

*The federal poverty level (FPL) is determined each year by the United States Census Bureau, based on family size and income. The FPL for a family of four in 2011 was an annual household income of approximately $22,150.*
Our communities are our ultimate safety nets.

SAFETY NET PARTNERSHIPS

One way to describe the state of the nation’s health care safety net institutions in 2011 may be the Chinese term weiji, which is often said to encompass the contradictory meanings of threat and opportunity.

The threat was palpable in the continuing spike in demand for safety net services that in many communities overwhelmed the shrinking public resources available to meet the need. At the same time, these public hospitals, community health clinics, and other safety net institutions have had to grapple with new, reform-driven demands. They need to reinvent themselves into more integrated, patient-centric, technology-enabled providers of choice, rather than providers of last resort, in anticipation of future increases in Medicaid patients and other newly insured individuals. That challenge, of course, also represents an unprecedented opportunity, not only for safety net providers and their patients, but for every community and every American.

At Kaiser Permanente, we believe a transformed and strengthened health care safety net is essential to the building of healthy, empowered communities. And these communities are the ultimate source of the social and environmental strengths that support our vision of total health. Supporting our safety net partners to meet the tough challenges of the present and to realize the opportunities that lie just around the corner is a major stream of the work we’re engaged in every day.

Part of that effort is served through our grants to 381 community-based safety net partners who work on the front lines to promote healthy behaviors, improve access to primary and preventive care, and reduce health disparities. That investment totaled $24.6 million in 2011 and served more than 8.7 million people. But the more engaging work comes in our efforts to expand those partnerships and to leverage our investments through technical assistance and the sharing of Kaiser Permanente’s evidence-based clinical innovations and health information technology. We also provide critical financial support for the training of tomorrow’s safety net physicians, nurses, and allied health workers.

Following are a few examples of the many ways we’re working with our safety net partners to help ensure they have the resources they need to fulfill their essential role in making total health a reality throughout our communities.

REACHING OUT TO SCHOOLS TO GROW TOMORROW’S HEALTHY COMMUNITIES

Nothing is more basic to the future of our communities than the health and well-being of our children. Yet, in many low-income communities, access to the health care they need for successful learning and growing is in short supply. That’s why we’re directing a growing portion of our youth-targeted investments at public schools because that’s where we can reach the most kids.

In 2011, we expanded our already substantial support for school-based health clinics in Oakland, California, with a $7.5 million investment in the Oakland Unified School District. The funding will assist in the operations of 10 school-based health clinics, some of them brand new, and also go toward the district’s African American Male Achievement project, which seeks to address inequities facing African-American male students.
Northwest Region Supports Total Health Through Oral Health

Finding ways to keep bright and healthy smiles on children’s faces comes naturally for our Northwest Region, where Kaiser Permanente provides dental services as a member benefit. But we understand that coverage for dental services can be a rarity in many of our communities, especially in low-income and rural areas where many families depend on local community and school-based health clinics for care. That’s why the Kaiser Permanente Northwest Oral Health Initiative invested more than $1.2 million in 2011 in 10 community-based programs that provide prevention, advocacy, care, and education aimed at long-term dental health and disease prevention.

Typical of the programs we’re supporting is the Virginia Garcia Memorial Health Center, which provides bilingual primary care services in two rural Oregon counties with large populations of migrant and seasonal farmworkers. Virginia Garcia will use its grant to send a dental hygienist and student dental assistants to do weekly cleanings and apply sealants at two rural schools serving several thousand children. Once a quarter, dentists and dental students will visit the schools with a mobile dental clinic to do restorative work, such as filling cavities and treating abscesses.

The clinics all provide medical, mental health, and health education services for students and their families at no cost and in a familiar environment. Services, including physicals, first aid, prescriptions, immunizations, screenings for sexually transmitted infections, pregnancy tests, and ongoing care for conditions like asthma and diabetes, are provided by the Native American Health Center, a nonprofit clinic that serves patients regardless of tribal or ethnic identity, and the East Bay Agency for Children, which provides mental health services for students experiencing emotional and behavioral difficulties. Most of the health clinics also stock a supply of snacks and juices to hand out to students who come in complaining of hunger. The clinics have also built relationships with community food banks and can connect students and families to those agencies when needed.

Spreading Healthy Smiles with “Take and Give”

Oral disease affects children in the United States more than any other chronic infectious disease, according to the Centers for Disease Control and Prevention. Over the last 25 years, oral disease has become increasingly prevalent among poor and minority children.

In 2011, we found a novel way to support school-based clinics around the nation in delivering oral health care by linking it directly to a health and wellness program for our own physicians and employees. To encourage participation in a voluntary workforce health initiative, we offered to donate $50 to a charitable cause for every Kaiser Permanente employee who took an online total health assessment. The assessment produces a personalized plan that can help improve the participant’s health.

The response was fast and impressive. More than 22,500 people participated in this Take and Give campaign, resulting in more than $1.2 million in charitable contributions to two organizations working to promote better health in underserved populations. Half of the total went to the Wholesome Wave organization, which manages successful fresh food incentive programs for low-income consumers in 25 states. And the remainder went to the National Assembly on School-Based Health Care, which is using the funds to enhance the capacity of 20 school-based primary care clinics to deliver preventive oral health services to low-income children, many of whom have never seen a dentist before.
KEEPING THE BEAT WITH THE MILLION HEARTS INITIATIVE

Americans suffer more than 2 million heart attacks and strokes each year, making cardiovascular disease the leading cause of death in the United States. Imagine the benefits if we could prevent half of those heart attacks and strokes.

We believe we can, and so does the U.S. Department of Health and Human Services. In 2011, they began recruiting health care organizations and others to share strategies for achieving that goal within five years. We eagerly took part in their Million Hearts initiative to share our life-saving cardiovascular care programs already underway in safety net clinics across the United States.

For five years, we’ve been reaching out to our community safety net partners to share our ALL/PHASE initiative, which is based on Kaiser Permanente research and practice showing that a simple bundle of low-cost medications, in combination with a beta-blocker and healthy lifestyle changes, reduces heart attacks and strokes by 50 to 60 percent for at-risk populations, like people with diabetes. The ALL program consists of aspirin, lisinopril, and lipid-lowering medication, and in Northern California the additional PHASE program (Preventing Heart Attacks Everyday) includes the beta-blocker and emphasizes lifestyle changes.

Since 2008, we’ve worked with the Community Clinics Health Network in San Diego to bring ALL to thousands of patients with diabetes and other risks of heart disease in 16 community clinics, which operate 100 sites in San Diego, Imperial, and Riverside counties. Our $1 million investment in 2011 will enable the clinics to expand the program to additional sites by covering the costs of implementation and training.

Having proven the successful transferability of the program, we’ve been supporting the spread of the ALL/PHASE initiative to a growing number of community clinics and hospitals serving tens of thousands of uninsured, low-income patients. In Northern California, our continuing investments and technical assistance in ALL/PHASE dissemination enabled 16 additional clinics and public hospitals, including San Francisco General Hospital, to implement the programs in 2011. And in our Mid-Atlantic States Region, we’re introducing ALL/PHASE at the Community Clinic, Inc., of Rockville, Maryland, which serves uninsured and underinsured residents at seven locations in two counties.
Making a Difference with Community Health Ambassadors

In our Mid-Atlantic States Region, we scaled up a pilot program that places Kaiser Permanente nurse practitioners and physician assistants in full-time roles at several community health clinics. The Kaiser Permanente Community Ambassadors Program placed 35 clinicians at 15 local clinics in Maryland, Virginia, and Washington, D.C., in 2011. The program is designed to cultivate the exchange of best practices and to identify, implement, and evaluate health outcomes in targeted areas of clinical focus. Those areas include reducing risk of heart disease, decreasing infant mortality through increased prenatal care, and improving rates of childhood immunization. The aim of the program is to create long-term collaborations between Kaiser Permanente and the clinics, and to serve vulnerable populations while making measurable improvements in overall community health.

Teaching Empathetic Care in Colorado

We launched a new initiative in 2011 in Colorado to help personalize and enrich the quality of care and service experienced by low-income patients, whether they seek care at a Kaiser Permanente facility or at a safety net clinic. Our Colorado Care Equity Project is unique in that it focuses on helping clinicians understand some of the barriers and tough realities faced by low-income individuals in need of health care services. For example, a person with diabetes might encounter conflicting priorities like deciding between paying the rent or paying for diabetes medication. To the extent that the physicians and nurses who care for low-income patients can see the world through their eyes, the care and service they provide is likely to be more empathetic, personalized, effective, and caring.

To promote a deeper level of clinician understanding and identification with low-income patients, the project offers participants a series of experiential workshops that address common biases, share real-life stories of families in poverty, and engage participants in a simulated experience of living with limited financial resources. To underline the lessons, the Kaiser Permanente Educational Theatre Program of Colorado has mounted a moving production called Loose Change. It dramatizes the real-life stories of the 15 percent of the U.S. population that is living in poverty.

In the first six months of the program, more than 100 community health care providers in the Colorado Springs area participated in the trainings and theater production, including faculty and students from the Beth-El College of Nursing & Health Sciences at the University of Colorado, Colorado Springs. The program is accredited for continuing medical education and will be provided in other Colorado areas to meet requests by colleges and safety net clinics to help prepare nursing and allied health graduates to serve in safety net clinics with genuine cultural awareness, knowledge, and humility.
“I want to show how strong I am from my roots.”

EDWARD JAMES OLMOS
Promoting Health Equity

“A nation free of disparities in health and health care.” That bold goal expresses the vision behind the HHS Action Plan to Reduce Racial and Ethnic Health Disparities published by the U.S. Department of Health and Human Services in April 2011. And it aligns exactly with our high-priority focus on health equity and the need for broad cultural diversity throughout the health care enterprise.

The HHS plan provided a first-ever national road map for moving aggressively toward a future in which members of all racial and ethnic minorities and other underserved populations have the opportunity to live healthy lives. At Kaiser Permanente, we are pursuing this goal from multiple directions and at an accelerating pace, driven by the understanding that whenever any group or community is left behind on the road to health, we all suffer.

Despite much progress in recent years, the barriers to real equity in health care and health outcomes remain daunting. Minorities and uninsured, low-income individuals in America still trail well behind the insured population in many health outcome measures and in access to preventive and other levels of care. And they hold unenviable leads in rates of acute and chronic diseases, such as diabetes, heart disease, cancer, asthma, and other conditions. Overcoming these barriers requires multipronged, population-based strategies that transform health care delivery, transcend public-private boundaries, expand access to quality care, invest in prevention and wellness, promote a diverse and culturally competent health care workforce, and support community empowerment wherever it is lacking. We are traveling down every one of these roads.

Tracking Race / Ethnicity Data Against Quality Measures

HEDIS®, or the Healthcare Effectiveness Data and Information Set, was developed by the National Committee for Quality Assurance to measure and compare the performance of America’s health plans. Since late 2009, we’ve been tracking 16 HEDIS measures for effectiveness of care among our members in six race/ethnicity categories. The measures we track include prevention and screening, cardiovascular care, and diabetes care. We regularly combine all this data into a measure for each race/ethnicity category on our quality and service dashboard, as a way to keep our progress against disparities front and center.

This is possible thanks to innovative tools like Kaiser Permanente HealthConnect®, our electronic health record system, and our Geographically Enriched Member Socio-demographics datamart, or GEMS, a collection of reported and imputed data on our members’ racial, ethnic, geographic, linguistic, and socioeconomic characteristics. Fully 65 percent of our members have self-reported their data. By linking this information with care quality and utilization data, we’re increasingly able to measure the scope of existing health disparities among our members, as well as improve our understanding of the causes of those disparities and our progress in reducing them.

HEDIS® is a registered trademark of the National Committee for Quality Assurance.
TARGETING HYPERTENSION AND COLORECTAL CANCER

In October 2011, senior Kaiser Permanente national and regional leaders in quality and diversity gathered for the organization’s first Equity Summit, charged with setting specific targets to reduce health care disparities across all Kaiser Permanente regions. They came away with an ambitious plan calling for each region to focus on one or both of the following goals:

1 | to reduce the gap between African-American members and white members in the control of hypertension by 25 percent in 2012 and 2013, and

2 | to reduce the gap between Hispanic members and white members in the rate of colorectal cancer screening by 25 percent in 2012 and 2013 — and to close that gap within five years, while becoming the best in the nation for colorectal cancer screening for all populations.

Closing the gap in hypertension control for African-Americans will entail a variety of initiatives, including data gathering, population segmentation, and dissemination of successful practices. Community outreach and engagement through innovative communication campaigns will also come into play, along with family-based interventions. The colorectal cancer screening campaign among Hispanic members will involve piloting and customizing effective practices, including tracking subpopulations, convening focus groups with patients, and reaching out through multimedia channels.

TAKING ON THE HIV CHALLENGE

Since the HIV epidemic emerged 30 years ago, we’ve treated more than 60,000 HIV patients and reduced disparities among our current HIV population of more than 20,000 people. Our work has met or exceeded the objectives of the National HIV/AIDS Strategy developed by the White House Office of National AIDS Policy — and our achievements have been notable.

☐ Our HIV mortality rates are half the national average.

☐ There are no disparities among our black and Latino HIV-positive patients for mortality and medication rates, compared to a 15 percent higher rate for mortality and a lower rate for access to medication nationally.

☐ 89 percent of our HIV-positive patients are in HIV-specific care within 90 days of their HIV test results, compared to just 50 percent within one year nationally.

☐ 69 percent of our HIV-positive patients have maximal viral control, compared to just 19 to 35 percent nationally.
During 2011, we assembled a toolkit of the clinical best practices, educational materials, and health information technology resources that went into achieving these numbers. Our plan was to offer the toolkit to other health care providers as part of a challenge announced at the Care Innovations Summit hosted by the Center for Medicare & Medicaid Innovation in early 2012. Our message: Improve health equity for people living with HIV by increasing their access to effective treatment.

HIV is still an epidemic in the United States, with 56,000 people becoming infected each year and more than 1.1 million Americans living with HIV. Yet one in five people with HIV don’t know they are infected.

“People with HIV need to get into treatment because quality HIV treatment prevents others from getting infected,” said Michael Horberg, MD, director of HIV/AIDS for Kaiser Permanente, executive director of research for the Mid-Atlantic Permanente Medical Group, and a member of the Presidential Advisory Council on HIV/AIDS. “Patients on effective therapy and better case management are living longer and more productive lives. However, quality HIV treatment requires effort.”

The toolkit offered as part of the Kaiser Permanente HIV Challenge includes education for both the provider and patient, quality improvement programs that measure gaps in care, and testing, prevention, and treatment guidelines. It also includes guidance for setting up multidisciplinary care team models that emphasize patient-centered, team-based health care delivery, also known as a medical home, so HIV specialists, care managers, clinical pharmacists, and providers can work together.

**NURTURING TOMORROW’S SAFETY NET LEADERSHIP**

Safety net institutions are not only coping with unprecedented demands for services, but at the same time they are having to prepare for potential changes in health care coverage and financing as well as the size and nature of the uninsured population. The need for innovative leaders well trained in system transformation issues and performance improvement has never been greater.

Since 2004, we’ve been providing scholarships to hundreds of safety net leaders to attend the highly regarded quality improvement conferences and seminars conducted by the Institute for Healthcare Improvement (IHI), a not-for-profit organization focused on motivating change and innovation in health care. In 2011, we provided 225 such scholarships to safety net professionals, and among them was the 1,000th safety net scholar to participate in an IHI course since the beginning of the Kaiser Permanente IHI endowment.

We also announced the founding of a new Kaiser Permanente Safety Net Fellowship program at IHI. Each year the fellowship will enable an individual to spend a full year in immersion training at the IHI headquarters in Cambridge, Massachusetts, including a seven-week summer program at the Harvard School of Public Health.
The first recipient is Margo Maida, director of delivery system reform for the Santa Clara Valley Health & Hospital System in California, and a leading advocate for the county’s health care safety net for more than 18 years. Beginning in June 2012, she will spend a year on site at ihi, working alongside up to six other fellows and the ihi team of quality improvement experts before returning to the Santa Clara Valley to continue being a leader for change.

In California, we are in our third year of our support for two academic programs: the Kaiser Permanente Center for Health Equity at the University of California, Los Angeles, and the Kaiser Permanente Public Health Scholars Program at the University of California, Berkeley, School of Public Health. Both programs focus on attracting and training new talent for safety net and public health leadership and the work of eliminating health disparities.

We are also continuing our support for an innovative program at the ucla david geffen school of medicine that helps foreign-trained physicians, mostly from Mexico and Latin America, who are committed to practicing in underserved communities get licensed in the United States.

Sharing Our Qualified Bilingual Staff Model
A decade ago, our National Diversity Department developed the Qualified Bilingual Staff Model as an innovative approach to communicating effectively with our increasingly diverse membership. It involved recruiting and training thousands of our own bilingual employees to act as qualified interpreters for non-English-speaking members as a way to provide high-quality, equitable care. Now we’re sharing this award-winning program with other health care providers and offering a 40-hour train-the-trainer course. Last year, we partnered with Adventist HealthCare in Maryland and the Maryland Hospital Association to replicate the training course for health systems throughout the state and in Virginia, Colorado, and Georgia.

Uncovering e-Health Disparities
Health information technologies have proven to be valuable tools for improving health care quality, and they may play an important role in reducing health disparities. But work underway at Kaiser Permanente since 2011 suggests some caution: If the benefits of these technologies are available primarily to people who have the access, skills, support, and incentives to use them, these tools could inadvertently increase existing health disparities. These unequal factors are known as e-health disparities.

Analysts from the Kaiser Permanente Institute for Health Policy joined with the Agency for Healthcare Research and Quality and amia, an association for informatics professionals, to sponsor a two-day roundtable called “HIT’s Impact on Health Disparities: Will It Help or Harm?” Participants addressed the impact of health information technology (HIT) on health care and health disparities. A synthesis of that meeting and additional research is expected to be published in 2012.
Whatever the outcome for health care reform, we must be prepared to meet the ongoing needs of our communities.