

Reducing Health Disparities in California's Public Health Care Systems

In California, health disparities are well-documented and often linked to race, ethnicity, language, sexual orientation, and gender identity, among other socio-economic factors. California's 21 public health care systems serve a diverse, low-income patient population who are at greater risk for health disparities and poor health outcomes. Now, for the first time, through the Public Hospital Redesign and Incentive Medi-Cal (PRIME) program, all of California's public health care systems statewide are taking a standardized approach to identify and reduce disparities in health care.

Through PRIME, public health care systems are required to improve the collection and stratification of detailed Race, Ethnicity, and Language (REAL) data and collect Sexual Orientation and Gender Identity (SOGI) data. For REAL data, public health care systems must also identify a disparity, implement an intervention to reduce the disparity, and demonstrate year-over-year improvement throughout the five-year PRIME program.

Data Collection

Over the past three years, public health care systems have made significant advancements in their ability to collect detailed REAL data (See Figure 1). PRIME helped advance data collection efforts so that public health care systems could better identify the diversity of their patients and provide more tailored care.

By the end of program year three, public health care systems collected detailed REAL data for more than 638,000 patients - an additional 345,000 patients since program year one.

Figure 1. REAL Data Collection (Years 1-3)*

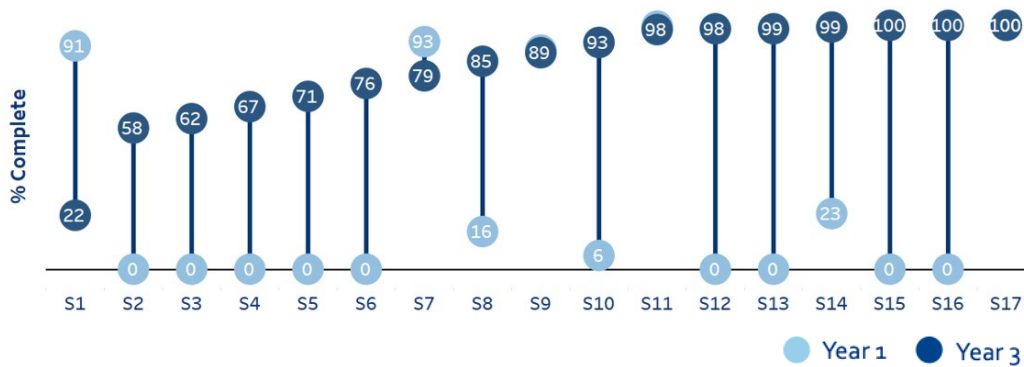


Figure 2. SOGI Data Collection (Years 2-3)*



*Data shows rates for public health care systems participating as individual PRIME entities (e.g. S1 = System 1).

Disparities Reduction Projects



Blood Pressure Control



Colorectal Cancer Screening



Diabetes Care



Heart Disease



Tobacco Screening and Cessation

California, like many states, is in the early stages of SOGI data collection (See Figure 2). In the first year, public health care systems laid the ground work for collecting SOGI data. By the end of program year three, public health care systems collected SOGI data on nearly 279,000 patients.

By testing out data collection methods, workflows, and staff trainings, public health care systems are leading the way in establishing best practices for the collection of SOGI data.

Highlights: Public Health Care Systems' Disparities Reduction Projects

PRIME Performance



13 out of 17 public health care systems met their annual improvement target for their disparities reduction projects in year three

Contra Costa



Piloted group medical visits for African Americans co-led by African American Health Conductors

Natividad



Increased access to colorectal cancer screening for English speakers by streamlining workflows, sharing quality improvement data, and launching a new referral module

Riverside



Conducted focus groups with Latinxs on diabetes management to inform the development of a health education diabetes program

Santa Clara



Used the EHR to better track and identify Latinxs in need of diabetes testing and follow-up, increased offering of group classes and visits, and produced community resources for clinics

UC Irvine Health



Integrated data collection and sharing across the EHR and streamlined workflows to increase colorectal screening rates for Latinx patients

Kern



Launched a culturally-tailored campaign for Spanish-speaking patients with heart disease about the benefits of taking aspirin

San Francisco



Implemented "food pharmacies" in primary care, conducted nurse chronic care office visits, and developed tailored tools and trainings for African Americans

Ventura



Expanded hours for targeted hypertension clinic for Latinxs and developed reports for proactive scheduling of patient appointments

UCLA Health



Educated primary care physicians on blood pressure control for African Americans and provided individual physician-level disparities targets

Alameda



Embedded a chronic care team at primary care sites for African Americans and launched group visits and phone encounters

Los Angeles



Increased utilization of home-based test kits for colorectal cancer screening for African Americans and trained providers to better understand cultural barriers

San Joaquin



Leveraged a community-based health coach to conduct outreach and education for African Americans with high blood pressure

San Mateo



Partnered with African Americans with high blood pressure to understand barriers to attending office visits and managing blood pressure

UCSD Health



Integrated EHR data and developed clinical workflows to capture social determinants, health literacy, and tobacco cessation opportunities for African Americans

Arrowhead



Developed new data registries to identify and outreach to Latinx males in need of colorectal cancer screening

Key Themes from Disparities Reduction Projects

- Incorporating equity into strategic goals and priorities
- Training staff to provide culturally responsive care
- Involving patients in care delivery design
- Using data to drive performance improvement for disparities reduction
- Partnering with community leaders and organizations

UC Davis Health



Used a team-based approach to conduct individual outreach to African Americans to identify barriers and facilitate better clinical care

UCSF Health



Developed a blood pressure home monitoring program for African Americans, provided culturally-tailored resources and a voucher for pill boxes to support medication adherence