

KP Evidence-Based Medicine in the Community

By Winston F Wong, MD, MS

A family practitioner who has been the clinical director for a facility providing primary care to a rural community that includes hundreds of individuals who are HIV sero-positive. An internist who develops outreach programs for migrant farm workers with diabetes. A physician who works with a medically uninsured African-American population in Georgia, a population suffering a disproportionate prevalence of obesity and diabetes. These are just a few of the backgrounds of sponsored guests at the Care Management Institute (CMI)/ *Permanente Journal*-sponsored conference on "Evidence-based Medicine" (EBM), which took place in December 2004, in Costa Mesa, California. Seventeen "community-based" physicians from around the country were nominated for sponsorship by Kaiser Permanente's (KP) Community Benefit Program.

The effort was the most recent and visible display of how KP is working to expand our understanding and implementation of EBM. By actively inviting and supporting the participation of clinical experts working outside of KP, we are seeking to foment opportunities to bring into our Program the lessons and expertise of physicians who work with some of the most challenging populations in our country—populations that represent an ever-increasing segment of our membership, and ones that we are committed to serving.

"We project that most of our membership growth in the next few years

will be among small businesses and thousands of new members will be enrolling in our so-called "new products," plans that have low-cost premiums with higher deductibles. We need to learn the challenges of providing population care management, using EBM, to populations that are increasingly diverse not only in terms of culture and language, but also in terms of social background and financial means," comments Paul Wallace, MD, Executive Director of CMI.

"The number of uninsured in the United States continues to climb every year. Forty-four million Americans are uninsured, and when they fall ill, or suffer from chronic disease, they turn to institutions that are publicly or community funded: public hospitals, emergency departments, federally supported community health centers, or free-standing clinics—our "safety net." The problem is that as the number of working poor who are medically uninsured continues to climb, the resources and financial support given to public hospitals and clinics to do their job continue to come up short. It's counter-cyclical," stresses Ray Baxter, PhD, Senior Vice President, Community Benefit, KP.

Herein lies a convergence: a realization that *real* population management, applying EBM to care for *all* our members, and thus, providing them with the quality and value that Permanente medicine represents, compels us to work closely with providers who are at the frontlines of working with populations *already* facing challenging choices

and decisions. Safety net providers, who care for a disproportionate number of the poor and underserved, largely minority, population are logical partners because they have often achieved optimal clinical outcomes by integrating culturally diverse views of health and patient/clinician decision-making that takes in account the limited resources of individuals.

Bringing physicians from the safety net into a setting with Permanente clinicians sets the framework for common language and objectives that further illuminates the impact of EBM to improve the health of entire communities, and not just membership-defined populations. In an increasingly mobile and transient workforce, today's KP member might be tomorrow's uninsured patient using a community health center, and vice-versa. Issues and approaches in applying evidence-based practices might not be so institutionally defined as we might expect.

In fact, KP already provides care to a sizeable number of members who would normally encounter barriers to mainstream care. For example, in 2003, KP served over 225,000 members who were enrolled under Medicaid, State Child Health Insurance Plans (SCHIP), and dues subsidy programs. An additional 30,000 to 50,000 patients were served through charity care and nonmember Medicaid programs. As our membership diversifies and grows, so will

KP is working to expand our understanding and implementation of EBM.

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Special Feature

our need to encompass multiple approaches to evidence-based care management.

Evidence suggests that shared decision-making is critical for patients to make meaningful changes in their self management of diabetes and other chronic diseases. At KP, we seek to work with members to

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cultivate interactions so that patients can work with their doctors to make optimal choices. But what do we do when our patients are difficult to reach because of transience, family, or job obligations? And what if they relate to their disease in ways different than their provider does?

At one rural Hawaii community health center serving a medically uninsured population, emphasis is placed on literally bringing care to the patient. "After plenty of frustration and experience, we found that some patients just won't return for a class or appointment scheduled some time in the future. So, we decided that if patients wouldn't come to us, we'd go to them—at home or on the beach—to provide the education and support to facilitate improved health," comments Sheila Beckham RD, MPH, of the Waianae Coast Comprehensive Health Center, in Oahu.

Anne Peters, MD, Director of the University of Southern California Clinical Diabetes program, agrees, "Our patients are mostly Spanish-speaking and functionally illiterate. They're also among the working poor, so if they miss work it's a significant hardship. We built our own area in the clinic and devel-

oped care protocols so that within two hours patients can have everything they need in what previously took three-to-four visits." After an intensive six-month program, mean HgbA1c scores decreased from 10.3% to 8.2%, and lipid-lowering agent use increased from 37% to a remarkable 82%.

Alex Moy, MD, a family physician with the Los Angeles County Department of Health Services, further observes the importance of understanding the cultural components of shared decision-making, "We know there are patients who rely on the use of traditional healing practices for treating their chronic illness; what we don't know is the evidence or lack of evidence for these practices. Part of our evidence-based approach to understanding self management has to factor this in."

Evidence suggests that KP's influence on medical costs in the regions where it has significant "market" presence extends far beyond its membership, eg, health care premiums in Northern California are generally \$1000 less than in other parts of the country, largely due to the presence of KP. Similarly, might not KP be able to influence the overall quality and promulgation of EBM in the communities it serves?

Indeed, in certain geographic regions where KP operates, more than 85% of adults are provided medical care by either KP or the "safety net," which provides a powerful impetus to construct approaches to population care management that are high quality and evidence driven. What stakes are involved when an institution such as KP works closely to promulgate evidence-based practices for a community?

"I firmly believe that when it's all over and done with, it'll be only KP and the community health centers that will be left standing. That's why it's so important for us to work together," predicts Dan White, MD, of the Marin Community Health Center in California.

Indeed, the guiding principles of community providers, namely clinician-driven priorities based upon the overall improvement of a community's health and an emphasis on prevention, are values that are part of the fabric and history of Permanente Medicine. Community health centers and KP also share a common history of being initially marginalized and disdained by the medical establishment.

KP's Community Benefit and CMI both realize the importance of continuing to "give back" to the community, with one of the assets being KP's experience in developing successful practices to manage populations to healthier outcomes. But there is also the realization that in an increasingly complex health care delivery system, one that is simultaneously spiraling to crisis and relying on interdependencies, that "benefit" is not unilateral, and that seeking shared approaches and practices in medical delivery ultimately render healthier populations—a benefit to the entire system and nation.

Thus, the presence of physicians and colleagues from community-based settings at Permanente conferences and meetings should become less of an oddity and more of a logical extension to how Permanente seeks to create value for our members, and build healthier communities for all. ♦