Health Disparities

Abstract C-A3-02A

Demographic Data Collection on Racial, Ethnic, and Language Preference Information

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Tell me everything about yourself: who you are, where you are from, what languages are you most comfortable in. In 2004, the Kaiser Permanente Partnership Group approved a program-wide policy on the collection of race, ethnicity, and language preference data. Meaningful, authentic, and accurate information is essential to the provision of quality and equitable health care. Health disparities among racial and ethnic minorities continue to be persistent and pervasive. Heightening this complexity is increasing immigration from countries and territories outside of the United States. In 2005, there were over 35 million foreign-born persons in the United States; and our regions rank among the top states with the highest foreign-born populations. A critical barrier to both patient-centered care as well as culturally and linguistically competent care is the frequent lack of patient data. Systematic collection and analysis of demographic data would inform opportunities to improve health care at various levels of service, from provider-patient interaction to system-wide institutional change. Standardized data collection would enhance our care delivery model; improving our ability to eliminate health disparities/inequities as well as attend to the different needs of our various populations. Come explore innovative data collection activities, the challenges and lessons learned in these processes, as well as opportunities for data utilization.

Abstract C-A3-03B

Cardiometabolic Risk and Healthcare Utilization for Hispanic and Non-Hispanic Female Health Plan Members

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Objectives: Cardiometabolic risk (CMR) is the overall risk of developing diabetes and/or cardiovascular disease due to a cluster of modifiable risk factors. CMR has been defined in a variety of ways, but all definitions include some combination of abdominal obesity, hypertension, hyperglycemia, and dyslipidemia. This retrospective study was conducted to (1) determine the prevalence of these CMR factors among female health plan members, identifying differences by ethnicity status (Hispanic vs non-Hispanic); and (2) quantify differences in 2-year healthcare utilization between cohorts of individuals with CMR versus controls without CMR. **Methods:** The study consisted of 2578 female members (27.6% Hispanic) of a southwestern US HMO who had a bone mineral density test during 2003-2004. This population was selected since these patients had, in addition to their bone scan results, a measure of height and weight, allowing us to calculate BMI. The following risk factors were used to define CMR: obesity (BMI >27 kg/m²), high triglycerides (>150 mg/dL), low HDL cholesterol (<50 mg/dL), high blood pressure (systolic >130 mm Hg or diastolic >85 mm Hg), and high fasting glucose (>100 mg/dL). **Results:** Results showed that Hispanic females had significantly higher prevalence rates of CMR compared to non-Hispanic females (65.8% vs 52.3%, respectively, $P<0.001$). Patients with CMR factors were more likely than controls to have at least one hospitalization ($P<0.05$). Outpatient visit rates and total costs were higher than controls, particularly for those patients with a diabetes diagnosis. Patients with obesity and diabetes and patients with obesity, diabetes, and dyslipidemia averaged approximately 34 visits vs approximately 22 visits for their respective controls ($P<0.01$). Total costs were about \$11,500 for those cases with diabetes vs \$5,500 for controls. Total costs for all CMR cases were about \$7,000 vs \$5,500 for controls. **Conclusions:** Higher rates of CMR among female Hispanics compared to female non-Hispanics are consistent with earlier studies. The higher utilization for those with CMR suggests the need for health maintenance organizations to identify and monitor health

plan members with CMR. Future research should explore cultural diversity as it relates to CMR, including differences between Hispanics and non-Hispanics in access to care and disease management programs.

Obesity

Abstract C-A4-01

Incidence of Overweight and Obesity Among Child, Adolescent, and Adult Enrollees of a Managed Care Organization

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Background: While the prevalence of adult obesity and pediatric overweight (OW) is well known, incident obesity/OW is minimally described in the literature. We estimated 1-year incidence rates of adult obesity and pediatric OW among enrollees of a group-model managed care organization. We also examined demographic, clinical, and socioeconomic correlates of incident obesity/OW. **Methods:** Enrollee-level data, including enrollment history and demographics, height and weight measurements and chronic disease history, were linked with US Census data based on residential address and geocoded to the census block group. Among enrollees with more than one BMI in a year, the average of BMIs was used for ascertaining adult obesity and the last BMI was used for ascertaining pediatric OW. Separate analyses were conducted for adult (18-74 years) and pediatric (2-17 years) enrollees. Associations of incident obesity/OW with enrollee and area-based residential characteristics were assessed using bivariate statistics. **Results:** In 2006, 37.0% of adult enrollees ($n=155,887$) were obese. Among adult enrollees not obese in 2006 with BMI measured again in 2007 ($n=67,200$), 5.8% became obese by 2007. Incident obesity was associated with age (6.6% for 30-39 years, 3.4% for ≥ 70 years; $P<0.01$) and pre-existing diabetes (7.8%, $P<0.01$) and hypertension (6.7%, $P<0.01$). Incident obesity was higher among adults living in areas with higher percentage of black residents ($P<0.01$), adults with a high school education or less ($P<0.01$), and lower median household income ($P=0.02$). In 2006, 33.7% of child and adolescent enrollees ($n=29,995$) were OW. Among children and adolescents not OW in 2006 with BMI measured again in 2007 ($n=10,743$), 9.2% became OW by 2007. Incident OW was associated with age (11.4% for 2-9 years, 6.3% for 13-17 years; $P<0.01$), male gender (9.7%, $P=0.04$), and pre-existing diabetes (25.0%, $P=0.01$). Incident OW was higher among children and adolescents living in areas with higher percentage of black residents ($P=0.01$), adults with a high school education or less ($P=0.01$), and lower median household income ($P<0.01$). **Conclusions:** Rates of incident obesity among adults and OW among children and adolescents will be compared to similarly calculated rates for metabolic syndrome conditions. Findings inform the need to target lifestyle intervention recruitment to specific subsets of enrollees at risk of becoming obese or OW.

Abstract C-A4-03

BMI, Health Behaviors and Utilization of Preventive Services in the California Men's Health Study

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Background: Two-thirds of U.S. adults are overweight or obese. Obesity is a major risk factor for cardiovascular disease, type II diabetes, and certain cancers including prostate and colorectal. While overweight and obesity are associated with increased morbidity, mortality and health care costs, their association with health behaviors and use of preventive health services is unclear. **Methods:** We examined lifestyle and screening exams in the past 5 years by categories of body mass index (BMI) in the California Men's Health Study ($n=84,170$). The cohort includes Kaiser Permanente members 45-69 years of age in 2003-2004 with nearly 40% belonging to a minority racial/