Clinical Safety & Effectiveness
Cohort # 22
Team 8
Data for Effective Equity ACTION-PLANS

UT Health San Antonio
Center for Patient Safety & Health Policy

THE UNIVERSITY OF TEXAS MD ANDERSON CANCER CENTER
Making Cancer History®

Educating for Quality Improvement & Patient Safety

D.E.F.E.A.T (DATA FOR EFFECTIVE EQUITY ACTION-PLANS) DISPARITIES PROJECT

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THE TEAM

Primary team

- Michelle Ogunwole, MD Internal Medicine Chief Resident Quality and Safety (CS&E participant)
- Ventrice Shillingford-Cole, CSE Course Facilitator
- Inez Cruz, PhD, LMSW Department of Family Medicine
- Linda McFarlin, Practice Manager, MARC Primary Care Center
- Martha Gonzales, Director of MAS Department

Consultants:

- Carlos Jaen MD PhD, Chair, Department of Family Medicine
- Jan Patterson MD, Associate Dean for Quality & Lifelong Learning
- Kenyatta Lee MD, Chief Quality Officer UT Medicine
- Timothy Barker MD, Senior Director, Medical Information for UT Medicine
- Amelie Ramirez DrPh, Director and Professor, Institute for Health Promotion Research
- David Sell, Director of Business Intelligence and Data Analytics
- Chiquita Collins PhD, Vice Dean of Inclusion and Diversity, Long School of Medicine
- Laura Manuel, Senior Software engineer, Clinical Informatics Research Division
- Gorden Whiting, Clinical Data and Workflow Analyst
- Oralia Balzaldua PharmD, Professor, Department of Family Medicine

Sponsoring Department:

- Patricia Wathen, MD, Internal Medicine Program Director
- David Dooley, MD, ACOS for Education at ALMVA

BACKGROUND

HEALTH DISPARITIES

DIFFERENCES IN HEALTH OUTCOMES BETWEEN GROUPS

Health Disparities exist by:

- Race/ethnicity
- Gender
- Education
- Income
- Geographic location
- Sexual orientation
- Disability

To reduce disparities in care across patient groups, health care organizations must first understand **where disparities exist, the magnitude of the disparities and why these disparities are occurring within their patient population.**

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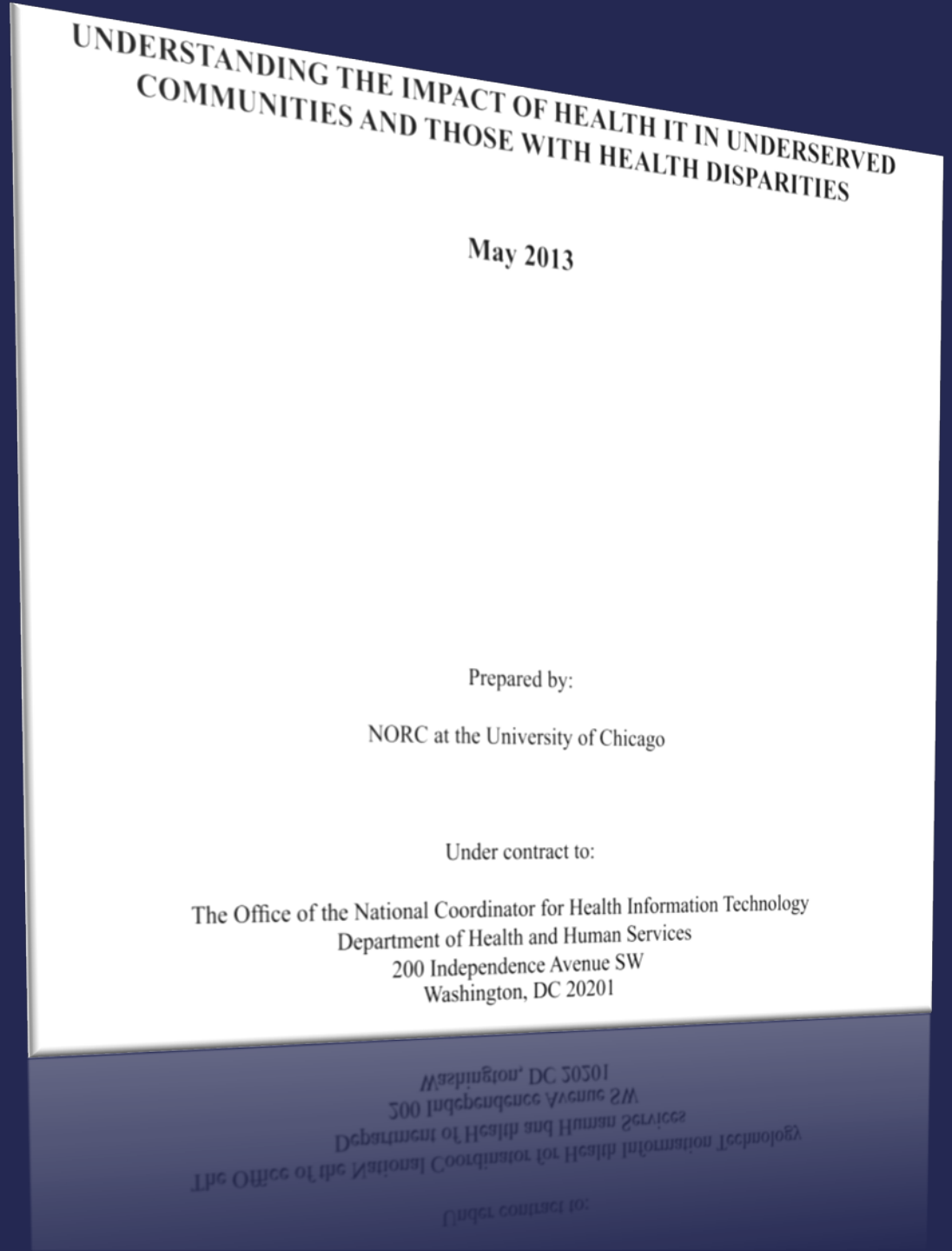
UNDERSTANDING THE IMPACT OF HEALTH IT IN UNDERSERVED COMMUNITIES AND THOSE WITH HEALTH DISPARITIES

May 2013

Prepared by:

NORC at the University of Chicago

Under contract to:

The Office of the National Coordinator for Health Information Technology
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Overview of Key Findings

Health IT has Potential to Impact the Health of Populations Experiencing Health Disparities

Health IT can enable effective redesign of health care systems to advance elements of the "three part aim:" improving the patient experience of care (e.g., quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care.[10] Under some circumstances, health IT used for chronic disease management can yield population health benefits. Underserved populations often have higher rates of cancer, asthma, obesity, behavioral health disorders, and other chronic diseases. Data also show that these populations are more likely to exhibit signs of poor management of chronic disease.

Applying health IT tools like ….EHRs, and EHR-based clinical decision support (CDS) can enhance patient engagement, improve patient safety, and reduce adverse events.

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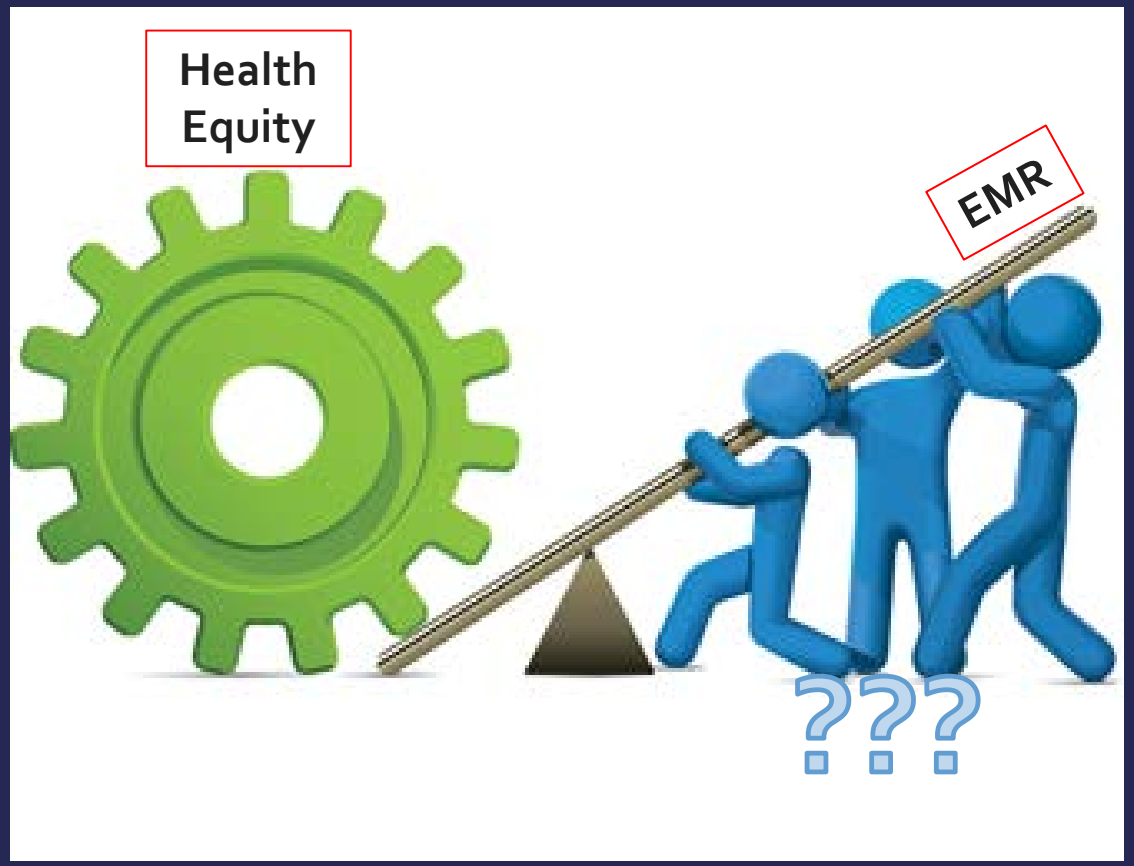

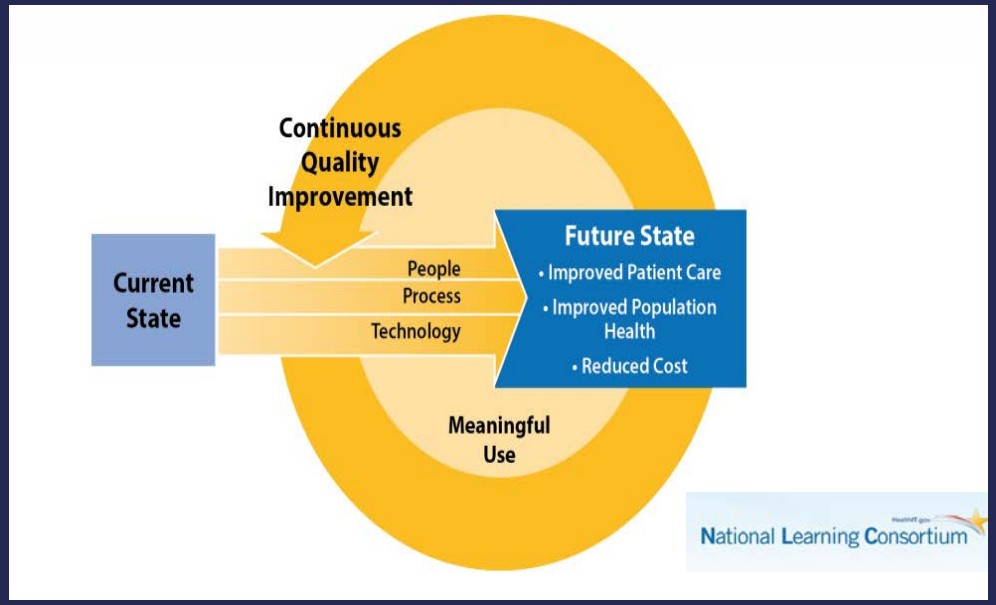

EMR Equity Checklist to evaluate and improve data collection for Health Disparities

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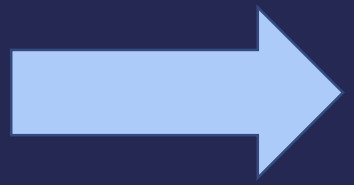
EVOLUTION OF AIM STATEMENT

Global Aim:

Use the EMR to identify disparities in quality of care to inform institutional priorities



Improve the health information elements needed to inform leadership and set institutional priorities/action plans about health disparities for patient in the MARC primary care clinic

In order for Health IT to function at a level that can inform our leadership about health disparities, the following elements have to be met:

❑ Standardization of Data collection

- ❑ Data must be reported by patient
- ❑ Collected in a culturally sensitive manner
- ❑ Complete
- ❑ Accurate

❑ Mandate to report and act on health disparities data

- ❑ Stratification of data to evaluate the presence of health disparities
- ❑ Mechanism to report findings to senior leadership and create action plans that addresss the identified disparities

❑ Inclusion of 'metrics that matter':

Social determinants of health systematically captured

- ❑ Race/Ethnicity
- ❑ Primary language
- ❑ Health Literacy
- ❑ Education level (surrogate for SES)
- ❑ Employment
- ❑ Financial resource strain
- ❑ Stress
- ❑ Depression
- ❑ Physical activity
- ❑ Tobacco use and exposure
- ❑ ETOH use
- ❑ Abuse of other substances
- ❑ Social connections and social isolation
- ❑ Exposure to violence: intimate partner violence
- ❑ Neighborhood and community compositional characteristics

DESCRIPTION OF CURRENT SYSTEM

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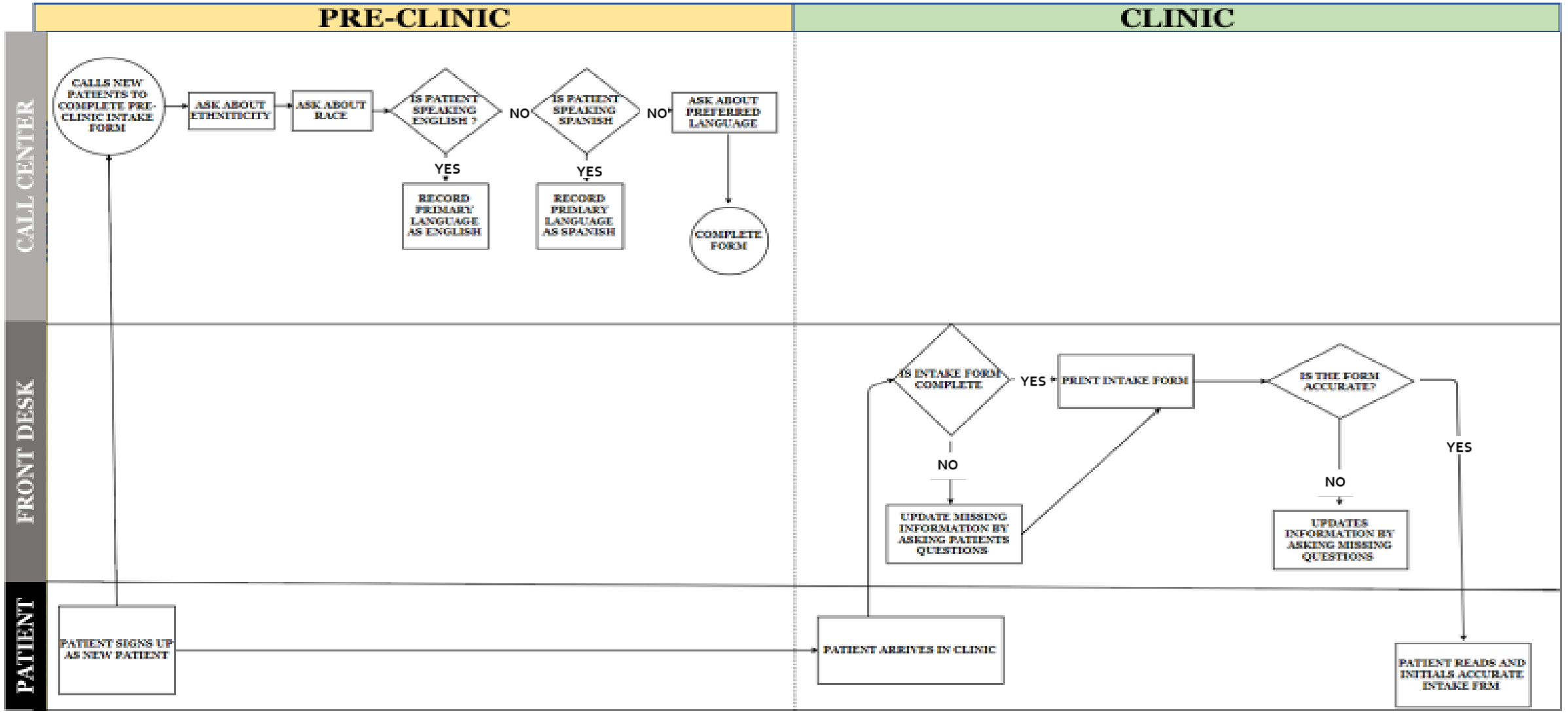

PROCESS MAP MARC PRIMARY CARE CENTER

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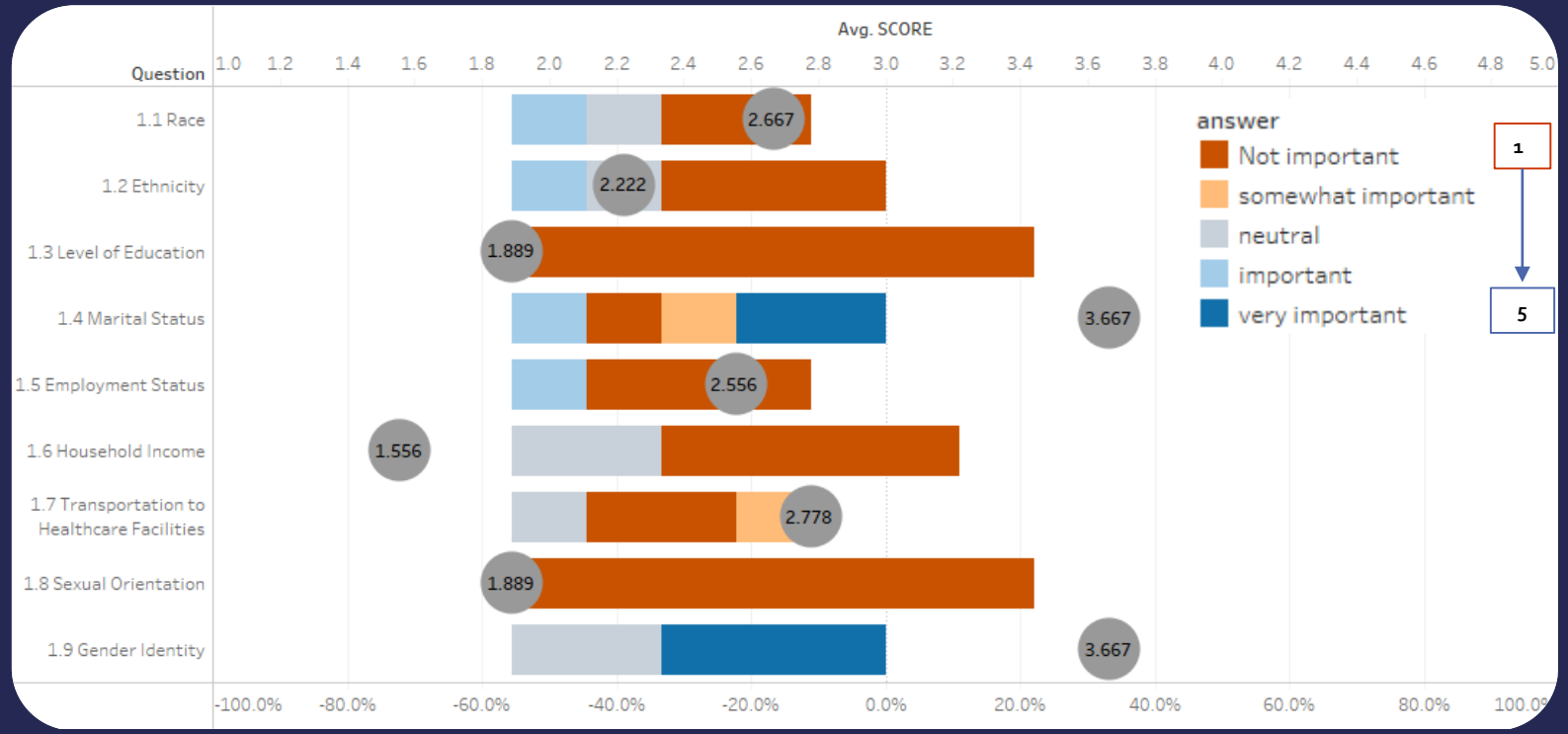
BARRIERS FROM THE FRONT LINE WORKERS

No one has a set way/script for asking Race, Ethnicity, or Language (REAL) intake questions.

They don't know what to say when patients get upset or ask "why are you asking me these questions?"

PERSPECTIVES ON COLLECTING DEMOGRAPHIC INFORMATION



How important is collecting data about each of the following items as a part of patient EMR?

- "I really don't see why race/ethnicity is so important to ask each patient? To me we are open to see anyone so why does this matter? We are not going to turn away service pending what a person is."
- "I don't believe level of education should be a required question that needs to be asked. Patients are coming to us for health care not for a job."

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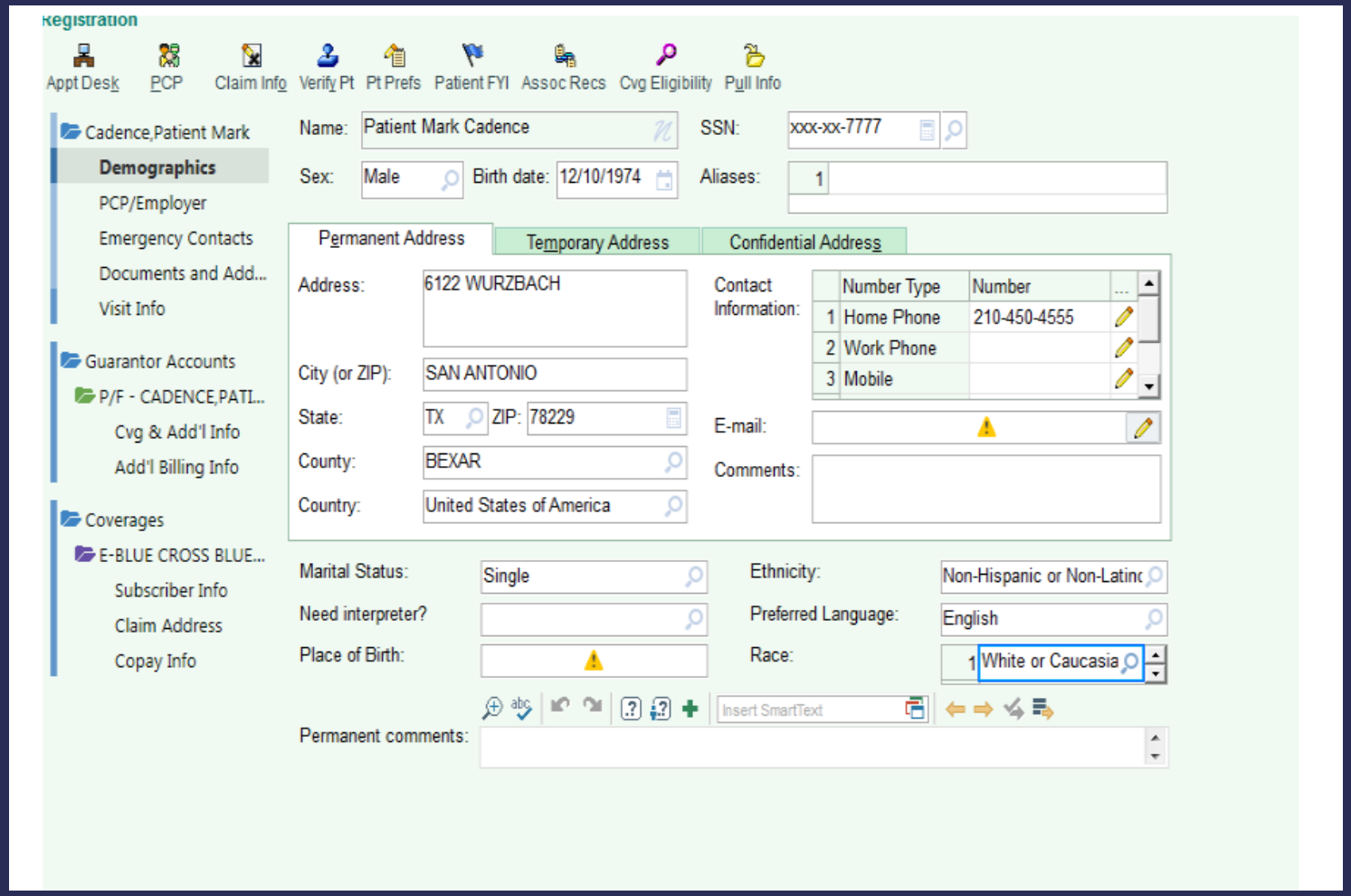
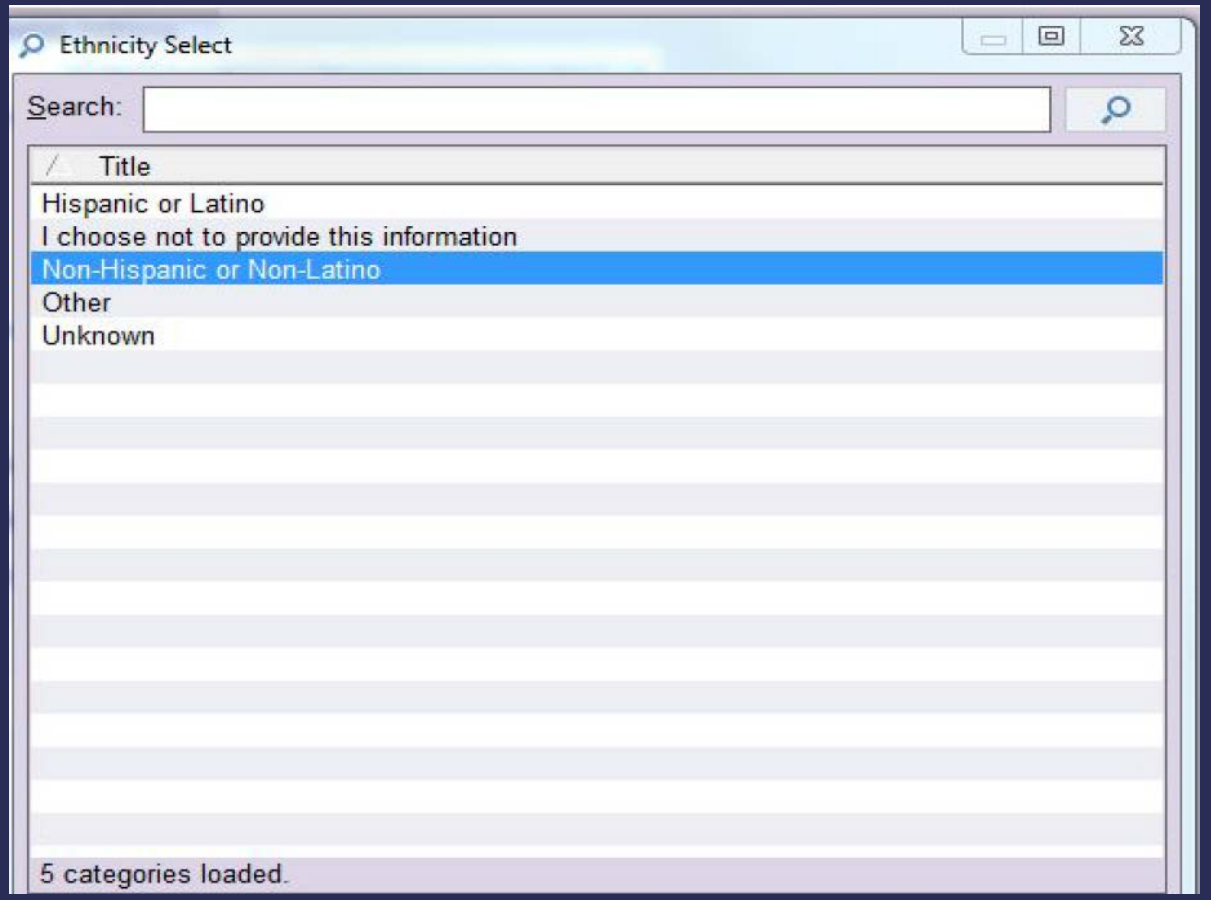
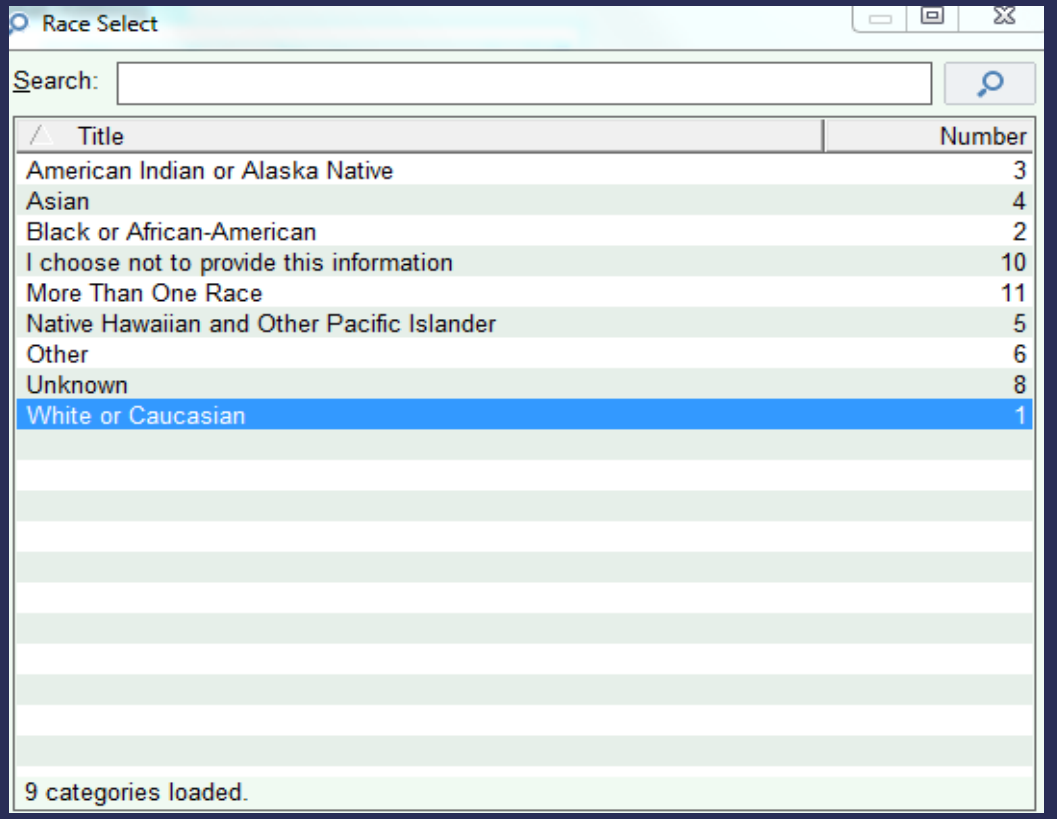
EPIC EMR


Registration
Appt Desk
PCP
Claim Info
Verify Pt
Pt Prefs
Patient FYI
Assoc Recs
Cvg Eligibility
Pull Info
Cadence,Patient Mark
Demographics
PCP/Employer
Emergency Contacts
Documents and Add...
Visit Info
Guarantor Accounts
P/F - CADENCE,PATI...
Cvg & Add'l Info
Add'l Billing Info
Coverages
E-BLUE CROSS BLUE...
Subscriber Info
Claim Address
Copay Info
Name: Patient Mark Cadence
SSN: xxx-xx-7777
Sex: Male
Birth date: 12/10/1974
Aliases: 1
Permanent Address
Temporary Address
Confidential Address
Address: 6122 WURZBACH
City (or ZIP): SAN ANTONIO
State: TX
ZIP: 78229
County: BEXAR
Country: United States of America
Contact Information:
Number Type
Number
1 Home Phone 210-450-4555
2 Work Phone
3 Mobile
E-mail:
Comments:
Marital Status: Single
Need interpreter?
Place of Birth:
Ethnicity: Non-Hispanic or Non-Latinc
Preferred Language: English
Race: 1 White or Caucasia
Insert SmartText
Permanent comments:

EPIC EMR


Ethnicity Select
Search:
Title
Hispanic or Latino
I choose not to provide this information
Non-Hispanic or Non-Latino
Other
Unknown
5 categories loaded.


Race Select
Search:
Title
Number
American Indian or Alaska Native 3
Asian 4
Black or African-American 2
I choose not to provide this information 10
More Than One Race 11
Native Hawaiian and Other Pacific Islander 5
Other 6
Unknown 8
White or Caucasian 1
9 categories loaded.

DATA QUERY: COMPLETENESS

Data source: i2b2

- An open-source data warehouse developed by the NIH-funded National Center for Biomedical Computing at Partners HealthCare System in Boston.
- Allowed access to de-identified EMR data.

Ran query: Not recorded for race+ ethnicity+ language at all MARC PCC (IM, FM, Geriatrics)

Numerator:
empty records(406)

Denominator :
unique patients (37,325)

1.08%
incomplete

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DATA QUERY: ACCURACY

Random Audits

Hello,

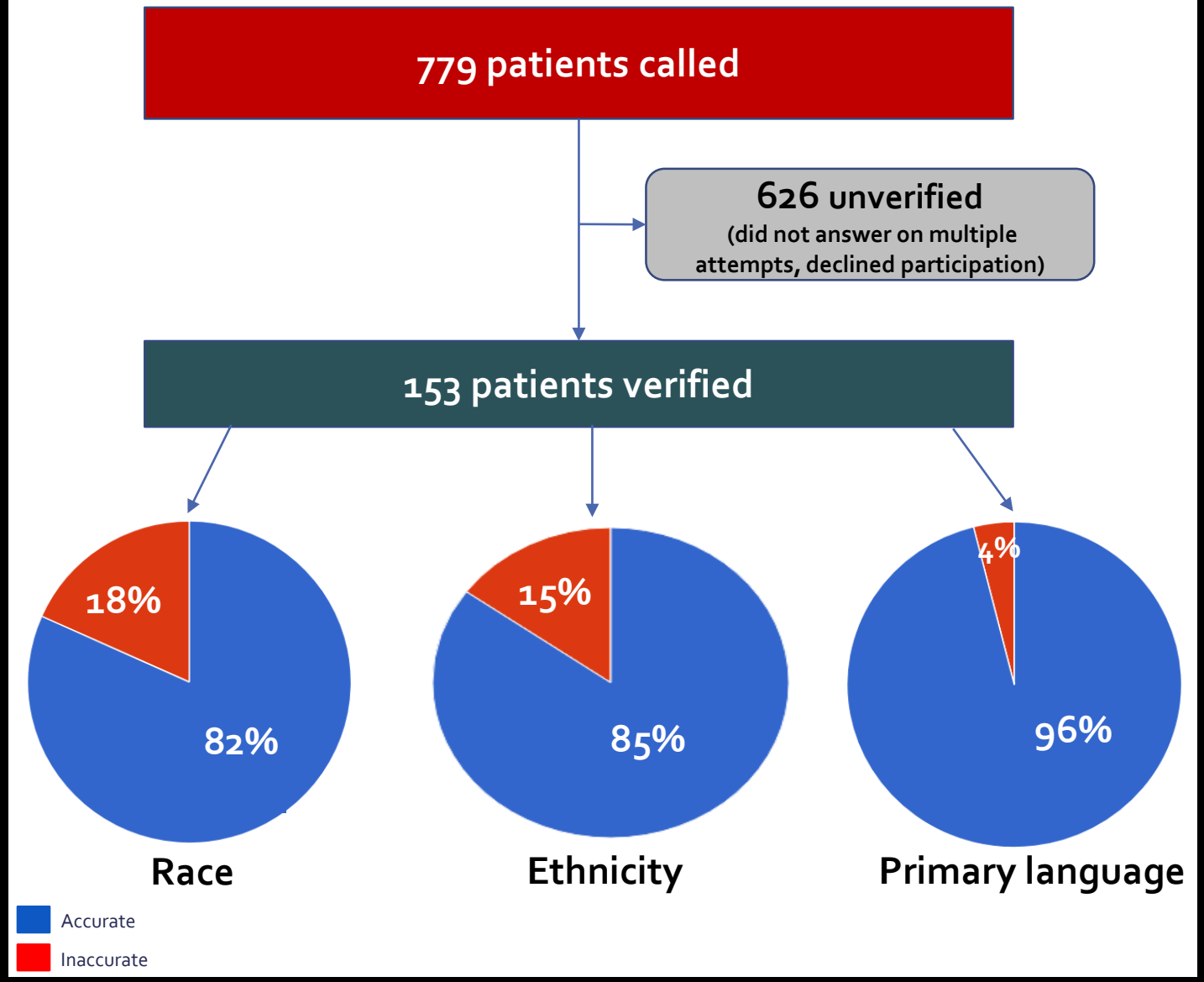
My name is _____, I am _____(position) at UT health. I am calling you because you have been identified as a UT health patient who receives care at the MARC. We are working to ensure that the data we collect in the electronic medical record is as accurate as possible.

Participation is completely voluntary, however with your permission, we're going to ask you some questions about yourself such as: your name, your age, your address, your education level, your gender, your race, and your ethnicity.

We'll keep this information confidential and will update it in your medical record. This information will not be used for immigration purposes or reported to the authorities. The only people who see this information will be members of your care team and others who are authorized to see your medical record. I will provide you with my name and contact information at the end of this call should you have any questions

This should take less than 5 minutes.

Would you like to proceed?



In order for Health Information Technology to function at a level that can inform our leadership about health disparities, the following elements have to be met:

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❑ Must be a requirement to report and act on health disparities data

- ❑ Stratification of data to evaluate the presence of health disparities
- ❑ Mechanism to report findings to leadership and create action plans that addresss the identified disparities

****Baseline 10/21 being met****

❑ Must include 'metrics that matter':

Social determinants of health systematically captured

- ☑ Primary language
- ☑ Race/Ethnicity
- ❑ Health Literacy
- ❑ Education level (surrogate for SES)
- ☑ Employment
- ❑ Financial resource strain
- ❑ Stress
- ☑ Depression
- ☑ Physical activity
- ☑ Tobacco use and exposure
- ☑ ETOH use
- ❑ Abuse of other substances
- ❑ Social connections and social isolation
- ❑ Exposure to violence: intimate partner violence
- ❑ Neighborhood and community compositional characteristics

REVISED AIM

To increase the health information elements needed to inform leadership about health disparities for patients in the MARC Primary care clinics

Phase 1: increase elements from 10/21 elements to 11/21 elements [targeting standardization] by May 15th, 2018.

Phase 2: increase elements from 11/21 to 21/21 elements [targeting social determinants and mandate to report and act] by January 1,2019.

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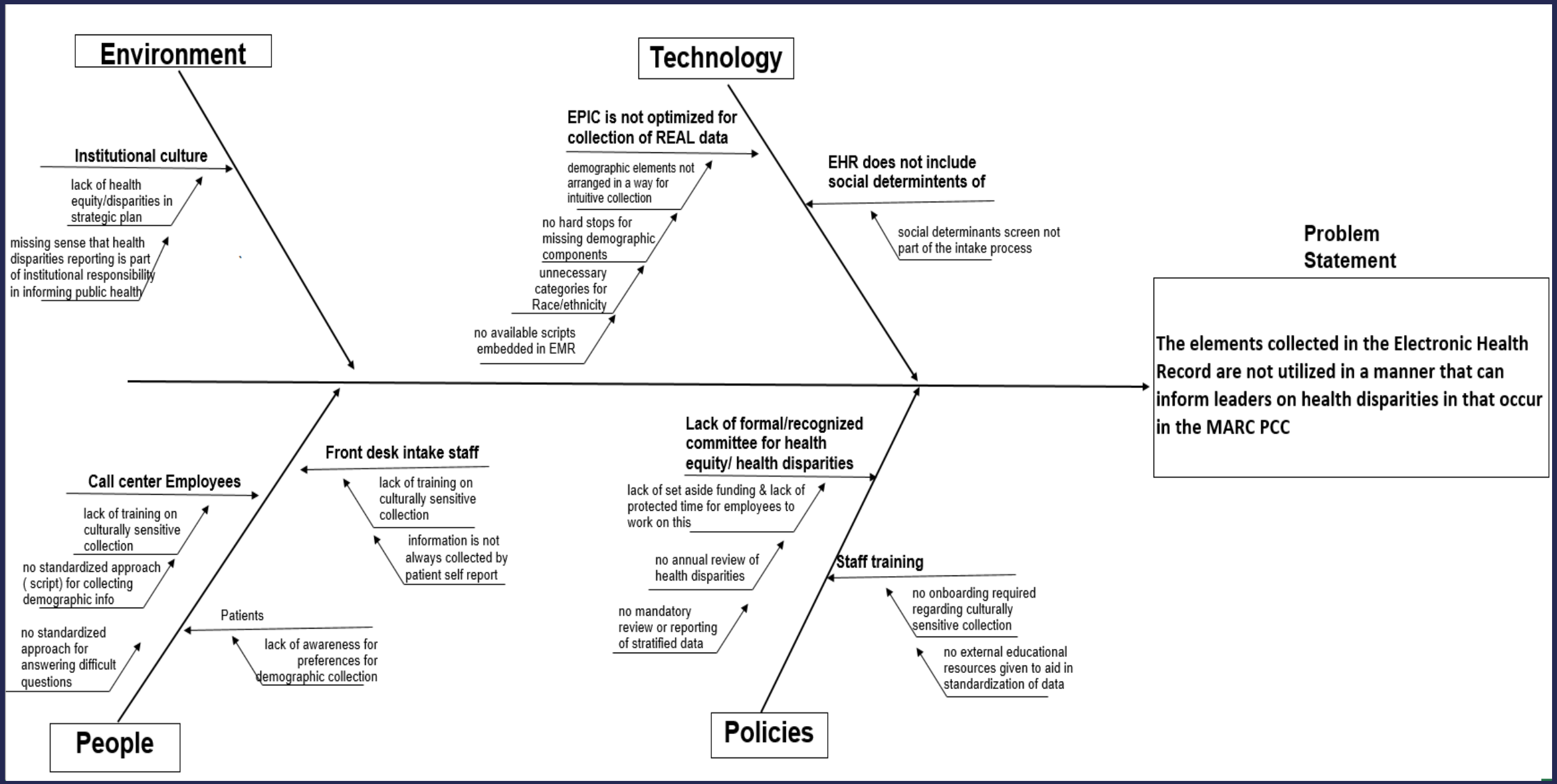

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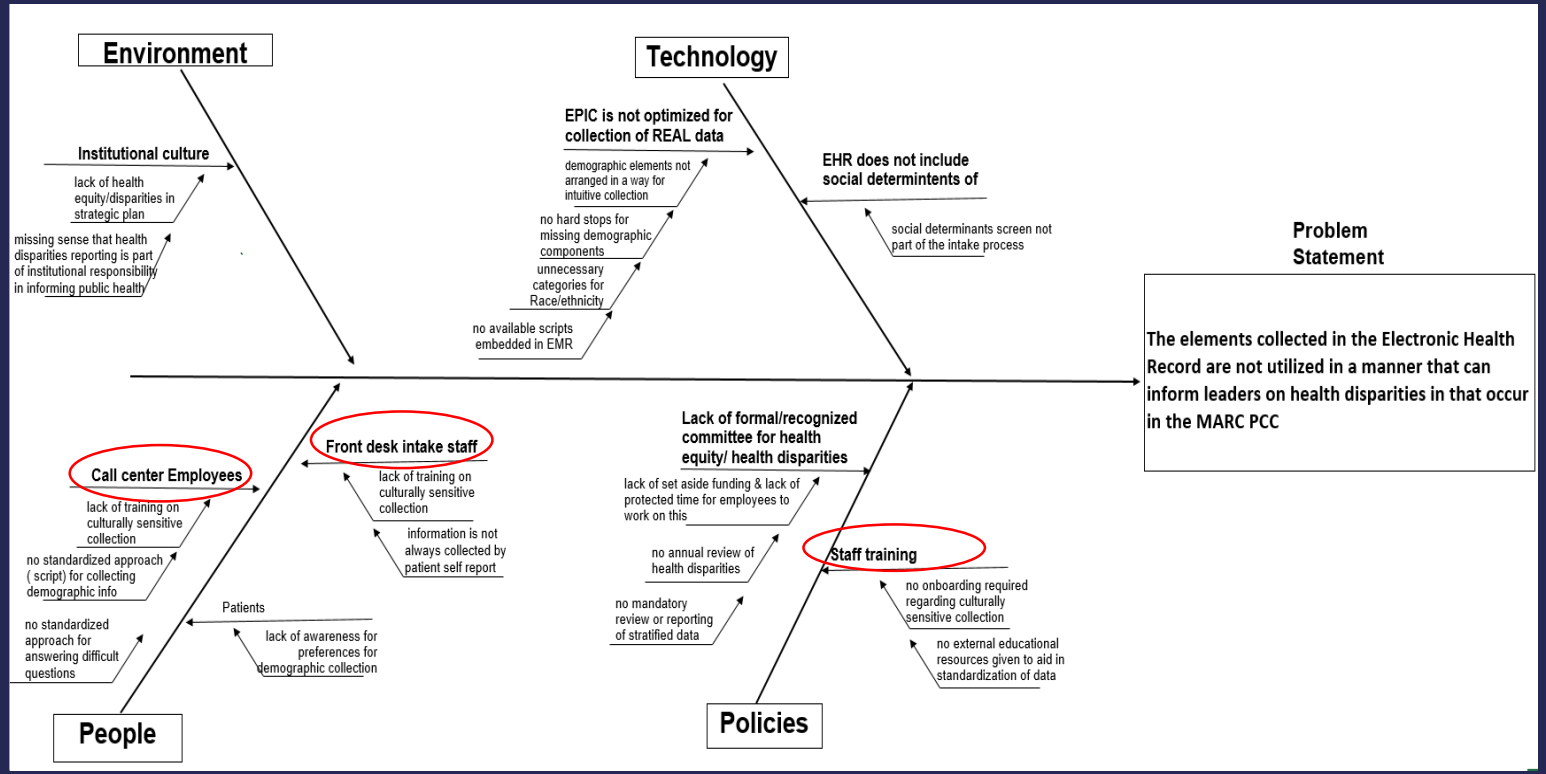
PLANNING AND DOING: SUMMARY AND RECOMMENDATIONS

PHASE 1

(COMPLETION DATE: MAY 15, 2018)

FINDING #1

Staff feel that they would benefit from additional training to help standardize the process for data collection.

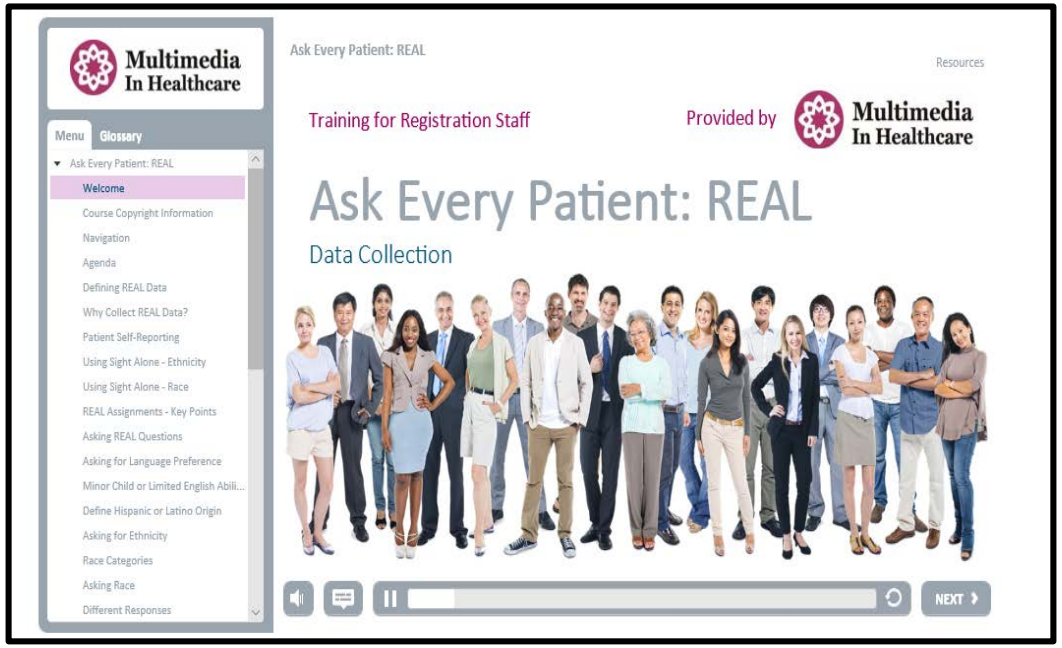


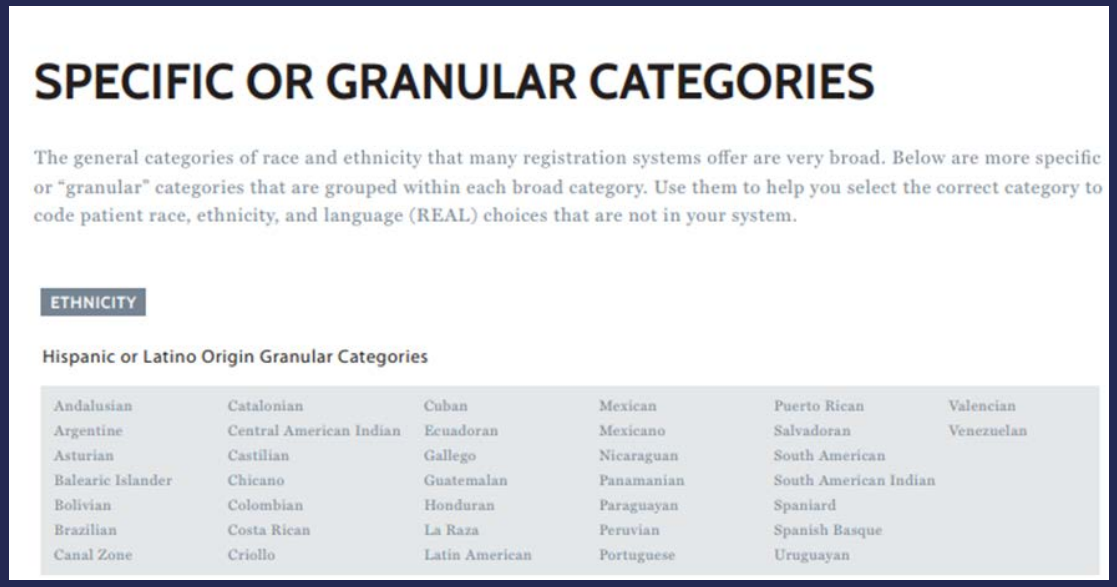
RECOMMENDATION #1

The training course *Ask Every Patient: REAL (Race, Ethnicity and Language)* should be required for all administrative staff that participate in patient registration.

This training should be given both at intake and as an annual refresher.

Additionally, the resources that support the course should be readily available to staff members.





SPECIFIC OR GRANULAR CATEGORIES

The general categories of race and ethnicity that many registration systems offer are very broad. Below are more specific or "granular" categories that are grouped within each broad category. Use them to help you select the correct category to code patient race, ethnicity, and language (REAL) choices that are not in your system.

ETHNICITY

Hispanic or Latino Origin Granular Categories

Andalusian	Catalonian	Cuban	Mexican	Puerto Rican	Valencian
Argentine	Central American Indian	Ecuadoran	Mexicano	Salvadoran	Venezuelan
Asturian	Castilian	Gallego	Nicaraguan	South American	
Balearic Islander	Chicano	Guatemalan	Panamanian	South American Indian	
Bolivian	Colombian	Honduran	Paraguayan	Spaniard	
Brazilian	Costa Rican	La Raza	Peruvian	Spanish Basque	
Canal Zone	Criollo	Latin American	Portuguese	Uruguayan	

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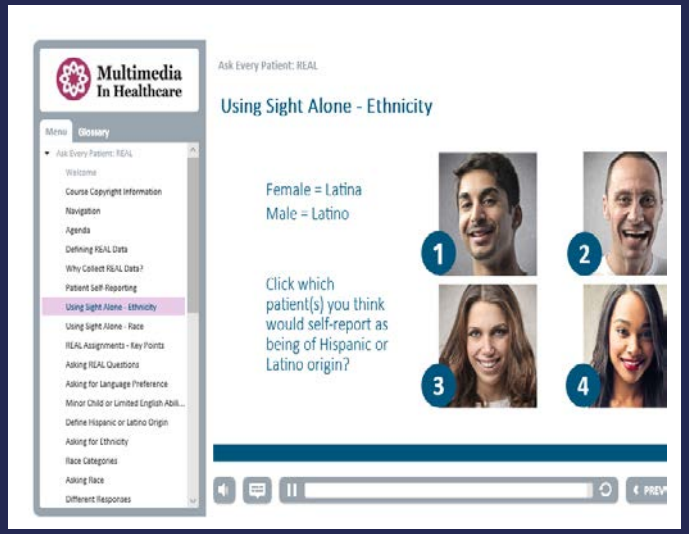
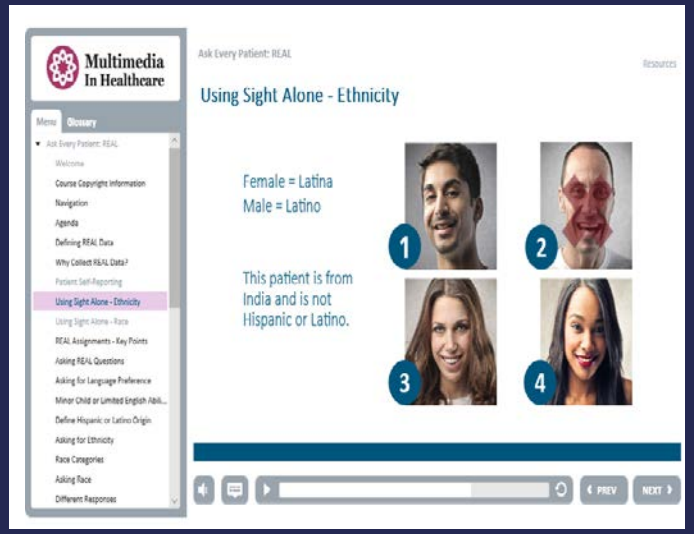
MULTIMEDIA IN HEALTH

Ask Every patient REAL

DEMO AND FEEDBACK FROM STAFF TRAINING



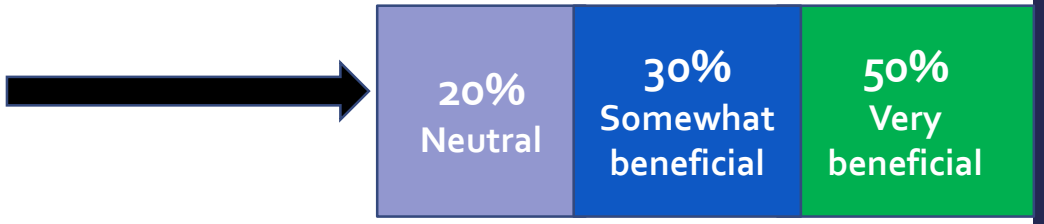


On a scale of 1-5 How helpful was this course?

1. Very helpful
2. Somewhat helpful
3. Neutral
4. Not very helpful
5. Not at all helpful

On a scale of 1-5 How beneficial do you think it would for all patient intake staff to take this course?

1. Very beneficial
2. Somewhat beneficial
3 Neutral
4. Not very beneficial
5. Not at all beneficial



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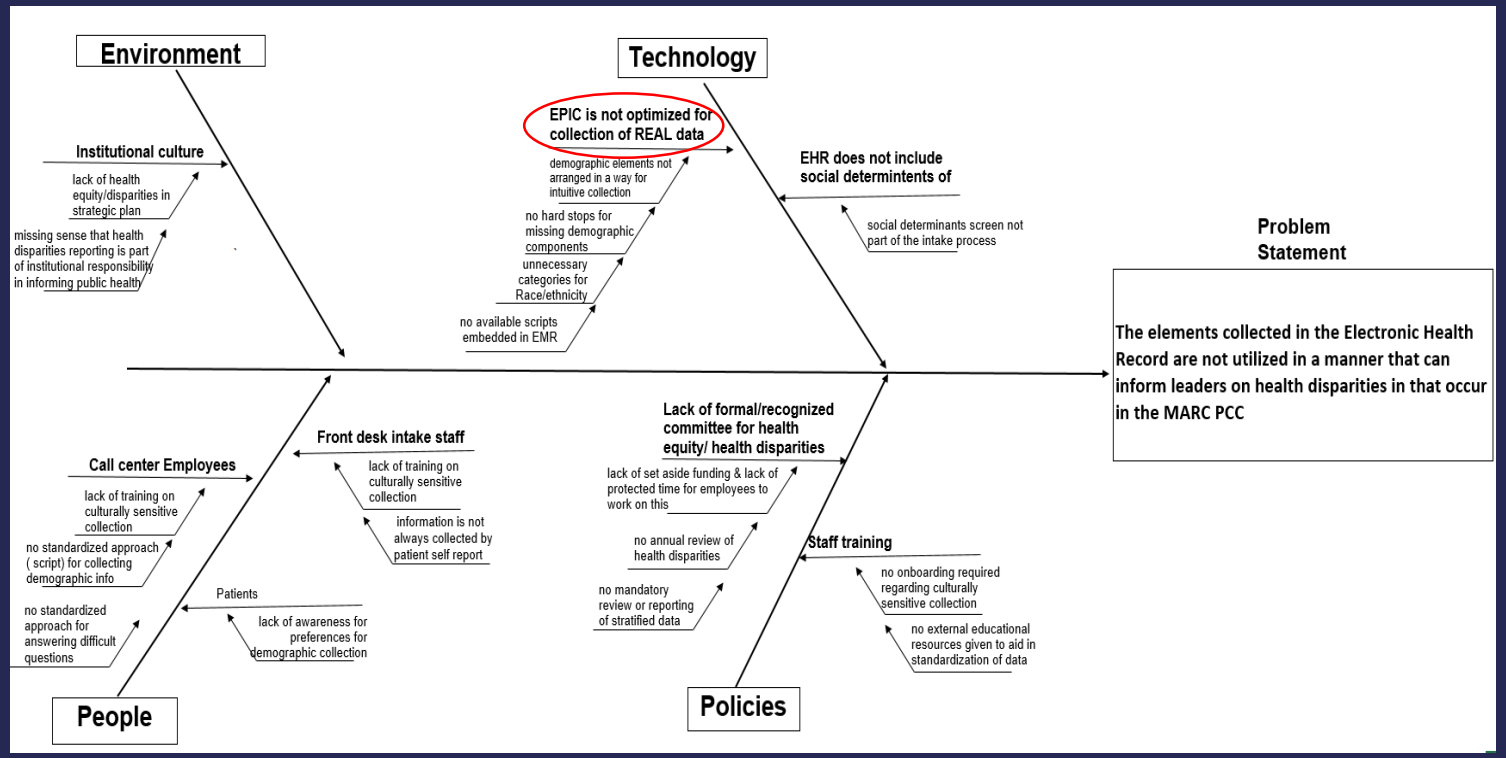
FINDING #2

Epic is not optimized for collection of REAL data



RECOMMENDATION # 2

Modify EPIC to enhance the collection of REAL data

2.1 Rearrange the categories in EPIC to facilitate intuitive collection of responses

2.2 Input EMR hard stops for incomplete REAL fields

2.3 Change and eliminate unnecessary categories in the RACE/ETHNICITY fields

2.4 Include scripted prompts in Epic

In order for Health Information Technology to function at a level that can inform our leadership about health disparities, the following elements have to be met:

*

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  - ☑ Complete
  - ☑ Accurate

****Post 1st PDSA 10/21→11/21 and improved standardization of data collection****

PHASE 2

(COMPLETION DATE: JANUARY 1, 2019)

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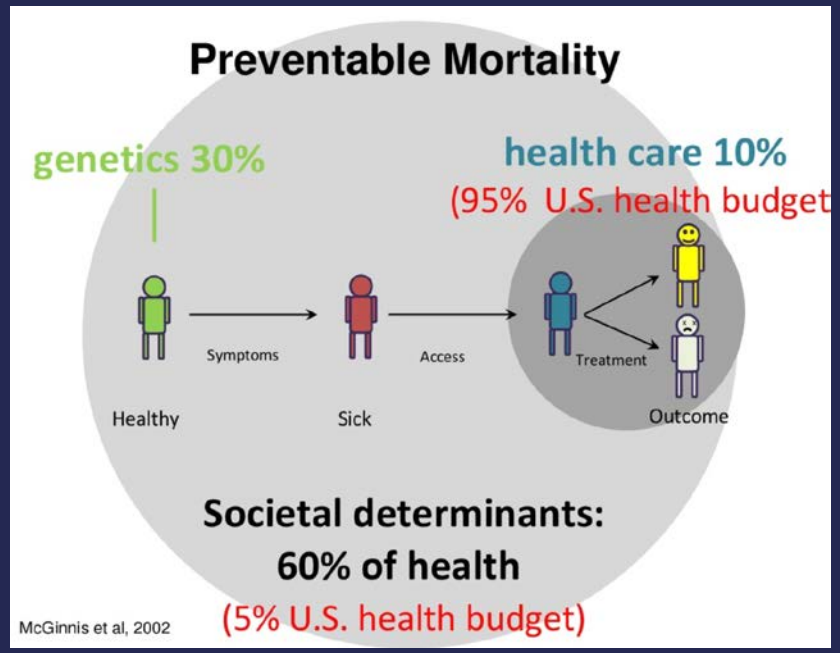
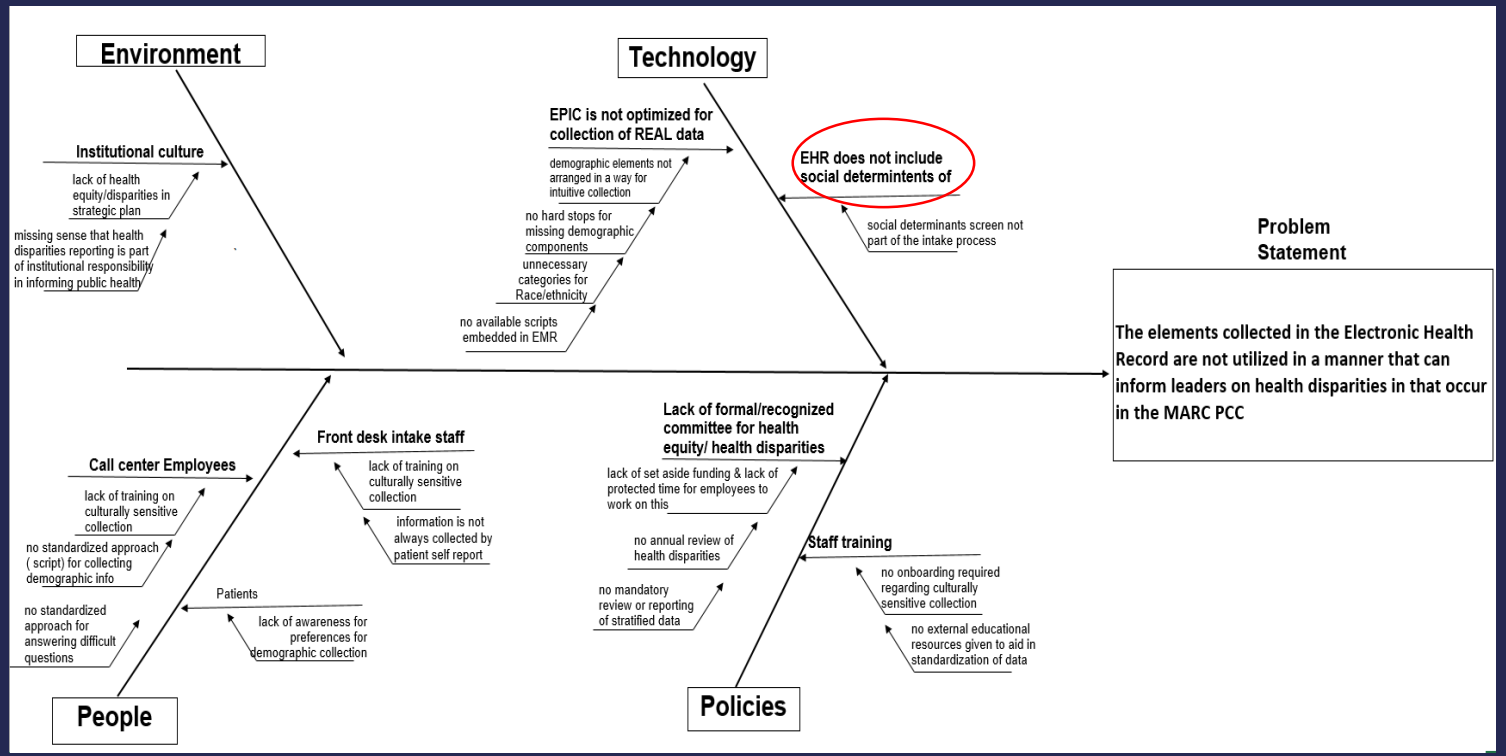
FINDING #3

Social determinants of health are largely absent from the EMR





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In order for Health Information Technology to function at a level that can inform our leadership about health disparities, the following elements have to be met:

❑ Inclusion of 'metrics that matter':

Social determinants of health systematically captured

- ☑ Race/Ethnicity
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- ❑ Abuse of other substances
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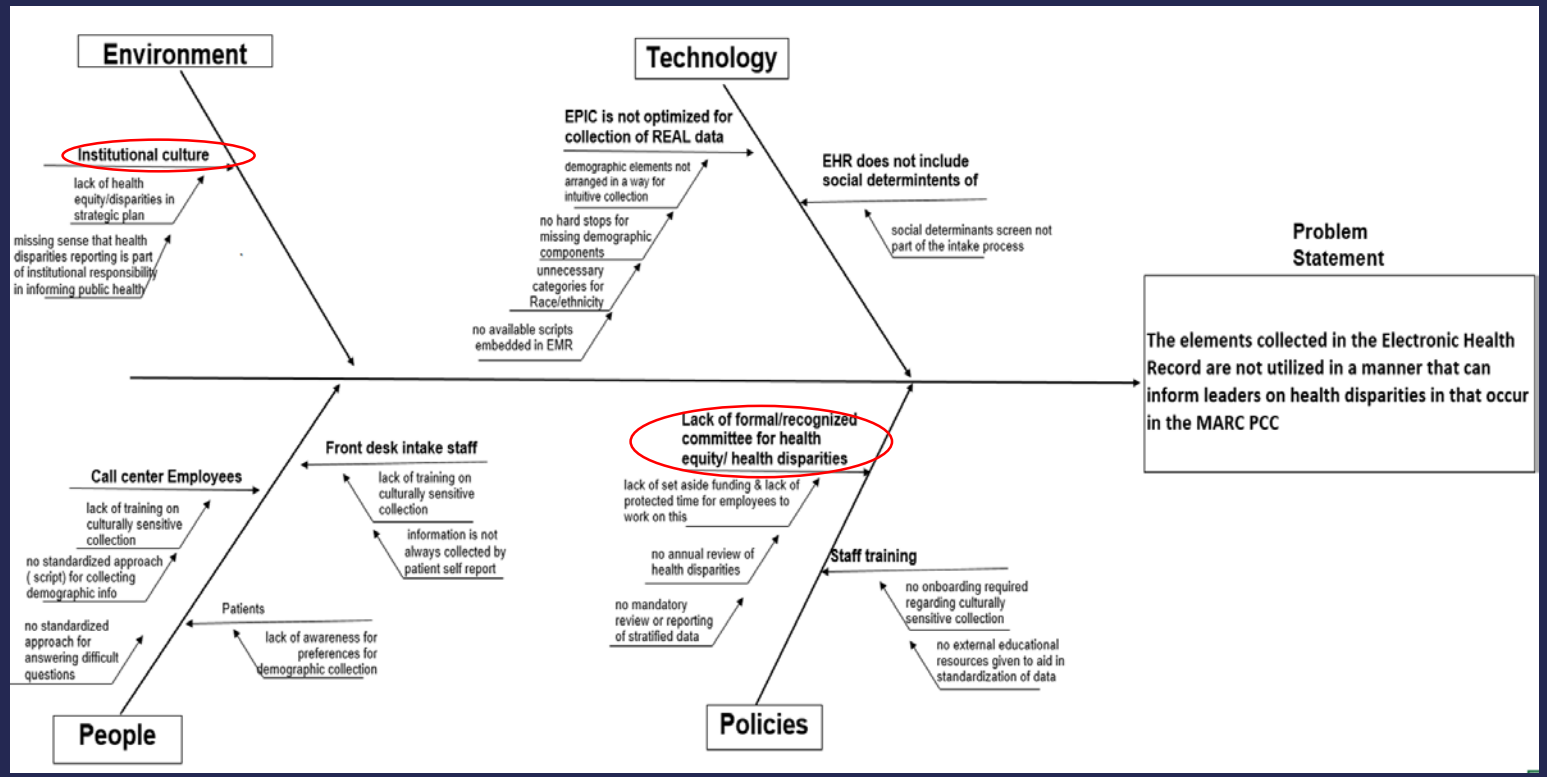
- ❑ Exposure to violence: intimate partner violence
- ❑ Neighborhood and community compositional characteristics

Remaining list to be included in new Epic 2019 update

FINDING #4

To advance the work of this project, turning data into actionable and sustainable results there has to be a significant investment by leadership.

Investment in time, resources, and a meaningful recognition of the importance of this work at an institutional level.



RECOMMENDATION #4

Resource allocation to support the formation and sustainment of a

Taskforce on Health Equity:

- Funding
- Protected time (FTE's)
- Outside consultants

Enforce Monitoring and Reporting

Delegate the creation of teams to meet the needs of vulnerable patients experiencing disparities (as identified in data)

In order for Health Information Technology to function at a level that can inform our leadership about health disparities, the following elements have to be met:

- ❑ Mandate to report and act on health disparities data
  - ❑ Stratification of data to evaluate the presence of health disparities
  - ❑ Mechanism to report findings to senior leadership and create action plans that addresss the identified disparities

LESSONS LEARNED AND FUTURE DIRECTIONS

LESSONS LEARNED

- Multidisciplinary team is critical
- Social determinants of health should be tailored to patient population
- Think about value added for stakeholders
- Be prepared to be creative to find resources

FUTURE DIRECTIONS

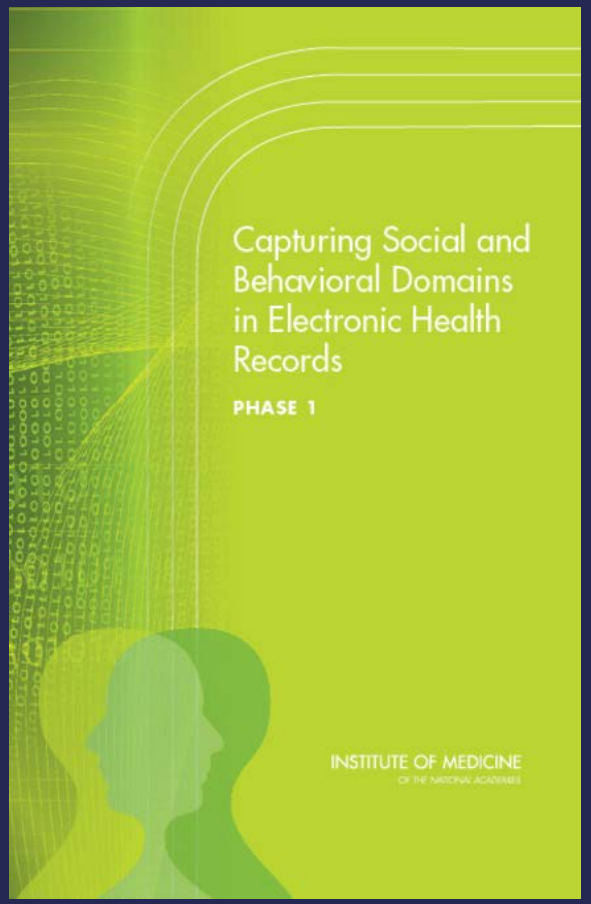
- Patient Family Advisory Council to tailor social needs screen
- Find funding mechanisms
- Recruit Health Equity Taskforce

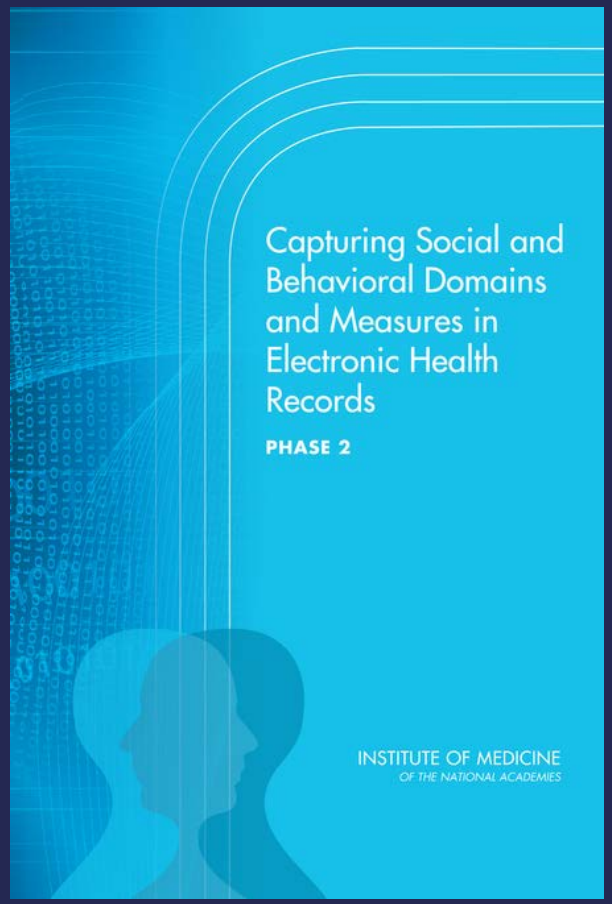
QUESTIONS?

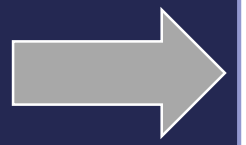
THE END

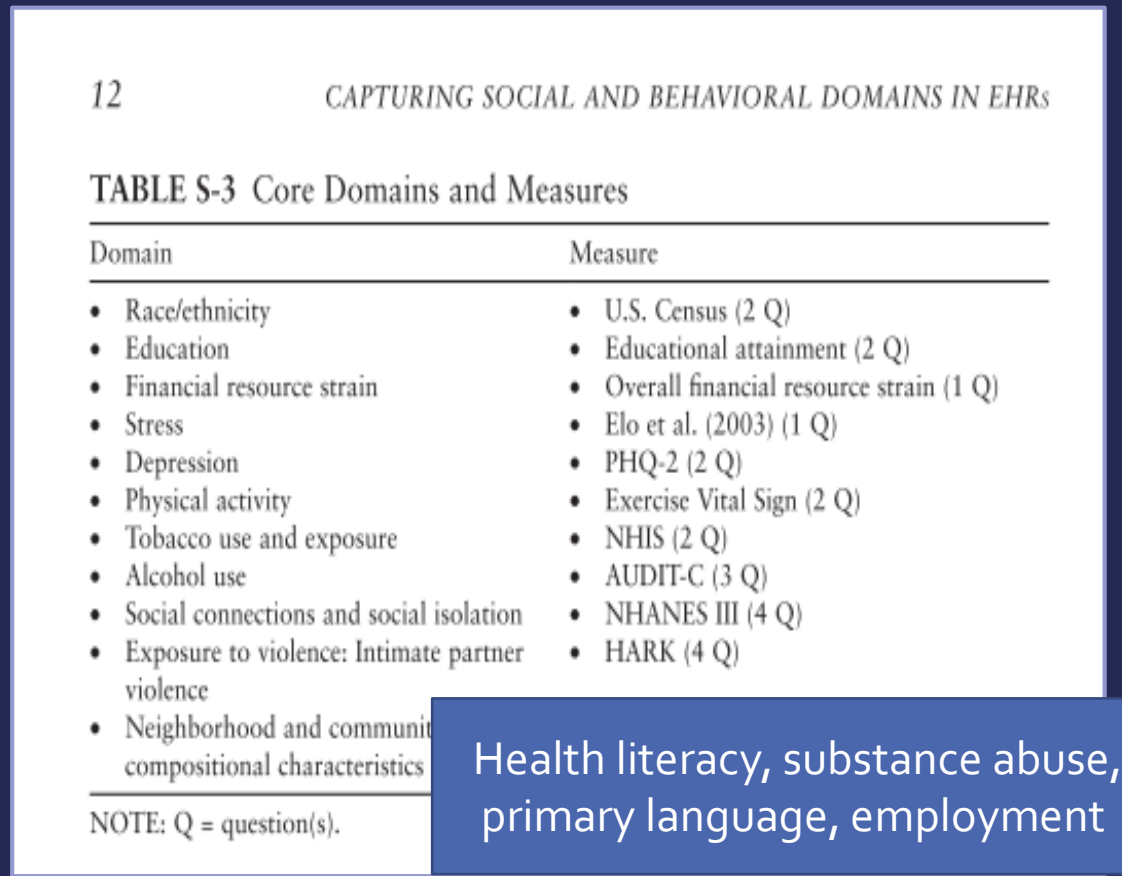
RECOMMENDATION # 3

- In EPIC, add an additional tab for social determinants of health, and make this screen part of the intake process.









12 CAPTURING SOCIAL AND BEHAVIORAL DOMAINS IN EHRs

TABLE S-3 Core Domains and Measures

Domain	Measure
• Race/ethnicity	• U.S. Census (2 Q)
• Education	• Educational attainment (2 Q)
• Financial resource strain	• Overall financial resource strain (1 Q)
• Stress	• Elo et al. (2003) (1 Q)
• Depression	• PHQ-2 (2 Q)
• Physical activity	• Exercise Vital Sign (2 Q)
• Tobacco use and exposure	• NHIS (2 Q)
• Alcohol use	• AUDIT-C (3 Q)
• Social connections and social isolation	• NHANES III (4 Q)
• Exposure to violence: Intimate partner violence	• HARK (4 Q)
• Neighborhood and communit compositional characteristics	

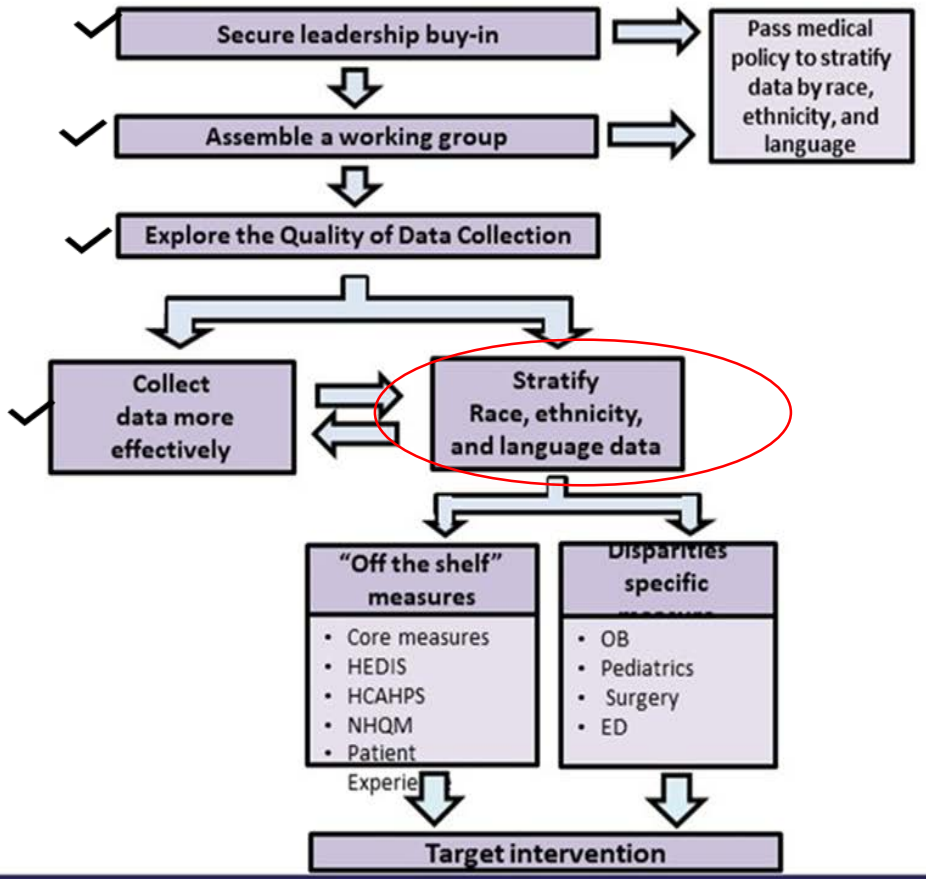
NOTE: Q = question(s).

Health literacy, substance abuse, primary language, employment

RETURN ON INVESTMENT

POSSIBLE VALUE ADDED FOR STAKE HOLDERS INCLUDES

- DSRIP/ACO
- Improving documentation of social determinants and billing for these factors helps to capture the complexity of our population and improves reimbursement



THE DISPARITIES SOLUTIONS CENTER

One Goal - High Quality Care for All

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