RACISM-FOCUSED CRITICAL METHODOLOGIES

- ✓ *How should public health practitioners rethink racism-focused population health measures?*

- ✓ *How should researchers & analyst realign methods to measure isms?*

- ✓ *How should leaders and executives engage data dashboards with a lens of equity?*

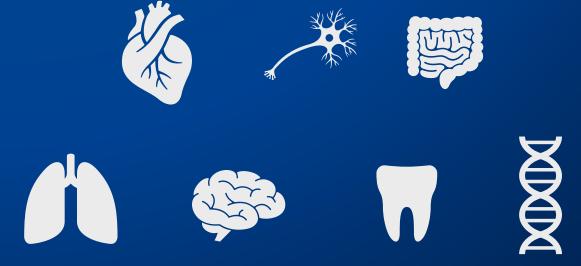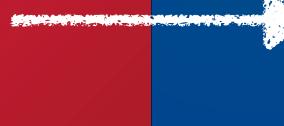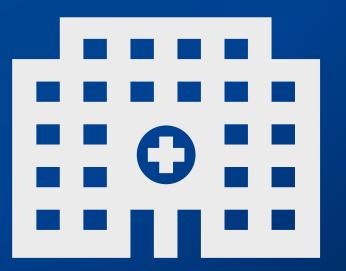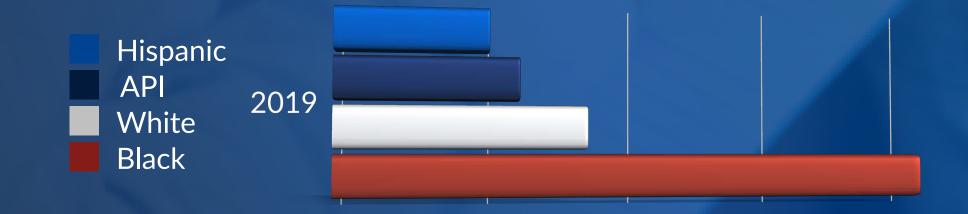# PLACING RACISM UNDER THE MICROSCOPE.

PHYSIOLOGICAL

SOCIOLOGICAL

PUBLIC HEALTH

MEDICINE

WHO IS IN CHARGE?

IN HINDSIGHT, RACIAL HEALTH DISPARITIES ARE 2020—LITERALLY

Does **Race** Matter?

THE CONSEQUENCES OF HEALTH INJUSTICE

Americans Living With at Least One Chronic — **5** OUT OF 10

Americans Living With Two or More Chronic Diseases — **3** OUT OF 10

US Diabetes Mortality by Race and Gender from 1980-2009

- White Women
- White Men
- Black Women
- Black Men

180.0
135.0
90.0
45.0
0.0

1980 1983 1986 1989 1992 1995 1998 2001 2004 2007

Source: Division of Vital Statistics (data from the National Vital Statistics System) and Division of Health Interview Statistics (data from the National Health Interview Survey). Per 100,000

40%

Rural America represents 14% of US population but **40% higher preventable hospitalization** rate than urban residences

23%

Higher Mortality Rate Compared to Urban

ACCESS TO SPECIALISTS

Accounted for 55% of rural-urban difference in preventable hospitalizations and 40% difference in mortality

- Hispanic
- API
- White
- Black

2019

US Asthma Mortality Rate (per Million) by Race and Ethnicity

Source. WONDER Online Database. United States Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute
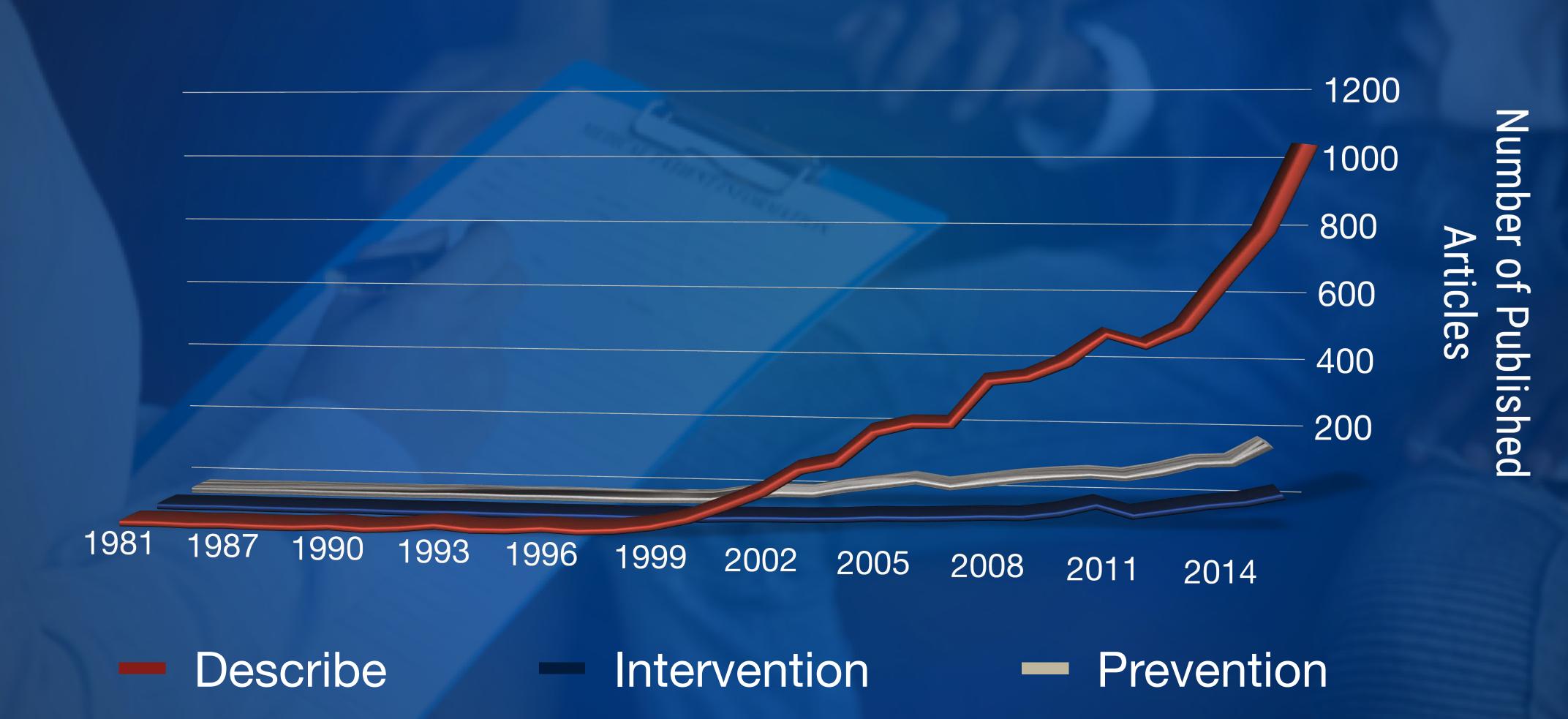
NUMBER OF PUBLISHED ARTICLES ON PUBMED USING THE KEYWORDS "RACIAL HEALTH DISPARITIES," AND INTERVENTION OR PREVENTION

Does **Racism** Matter?
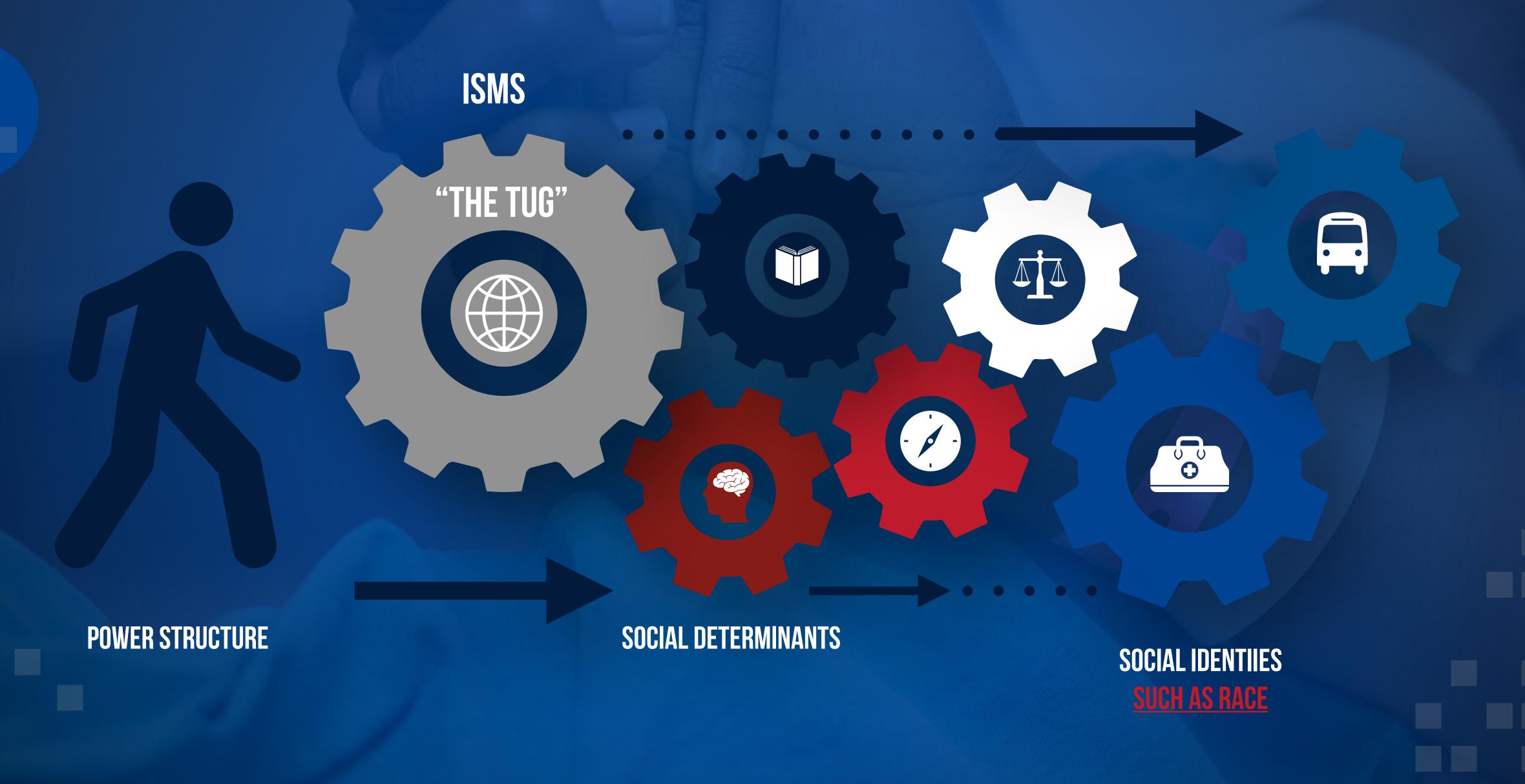
POWER

PERCEPTION

PERFORMANCE

PROPOGATION

4 P'S OF RACISM

THE MULTIPLICATIVE EXPOSURE TO INEQUITY

MILITARY

Roughly 82% of Black Veterans experienced racism while serving

WORK

61% of minorities experienced or witnessed racism at work

HOME

Nearly 80% of Black Americans experienced racism as an adult

HOSPITAL

1 in 4 minorities experience racism while seeking medical care
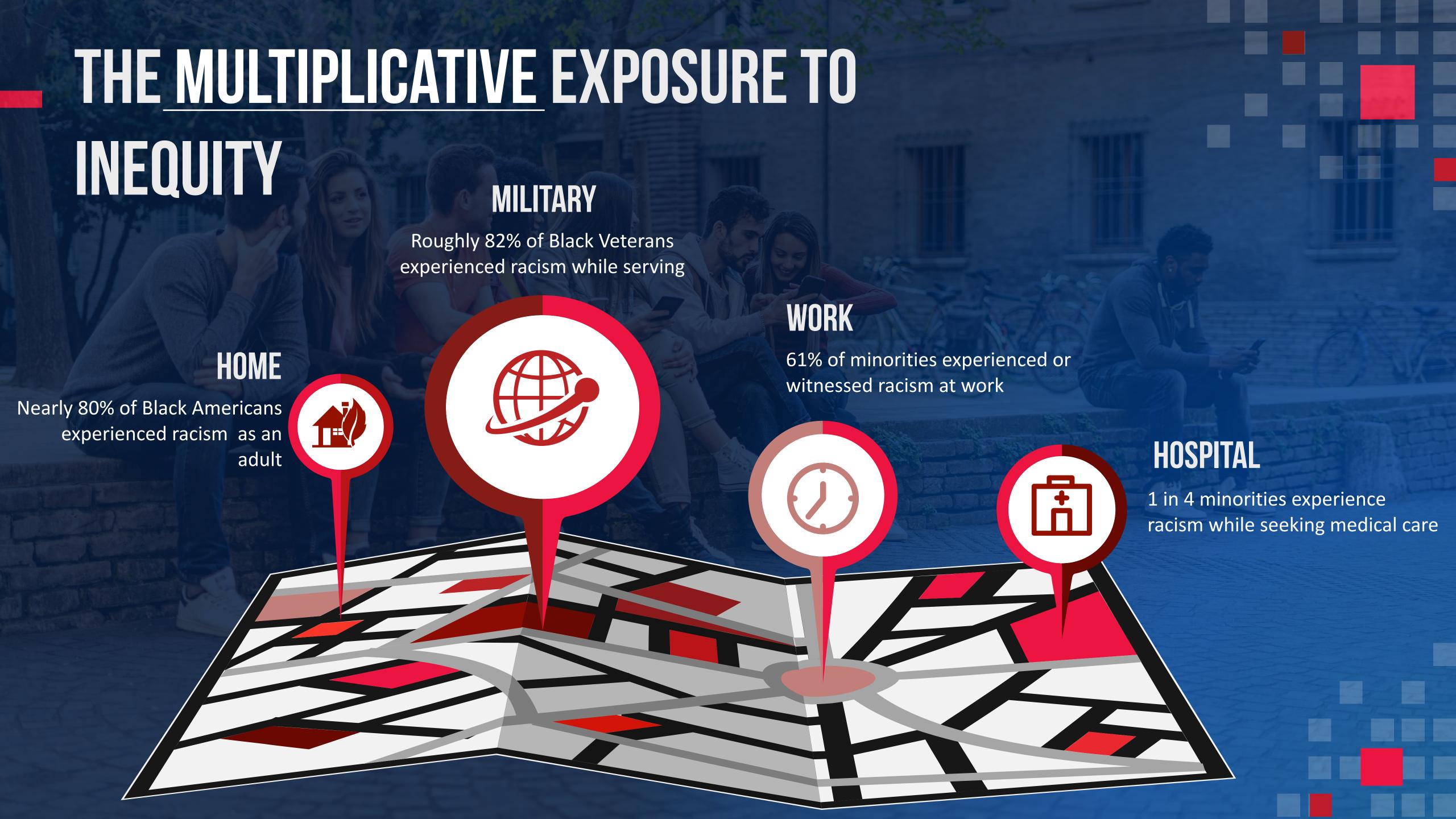
THE HOUSE THAT RACISM BUILT

REIMAGINED FROM DAVID WILLIAMS AND COLLEAGUES

Source: Jenkins, Hue Process the Quantitative Measurement of Racism in Medicine (forthcoming)

INSTITUTIONAL RACISM
Illigetimate biological and ideological methodologies

| Structures | Policies | Practices | Norms |

ACCESS

SOCIOECONOMIC EFFECTS
Education, employment, income, poverty

BIOLOGIC AGING

HEALTH & HEALTHCARE EFFECTS
Allostatic load, Environmental toxins, Medical decisions

Biological dysregulation

Vascular (e.g. heart rate, blood pressure, contracted blood vessels)

BIOLOGIC AGING
Weathering Effect

Biochemical Changes (e.g. increased cortisol, phosphorous, white blood cells)

Respiratory (e.g. constricted airways, reduced oxygen)

Maladaptive coping behaviors

PYSCHOSOCIAL STRESS

QUALITY OF LIFE CONSEQUENCES
Policing, Retail experiences, Lack of Representation, Media Bias

PYSCHOSOCIAL STRESS

BIOLOGIC AGING

PERSONALLY MEDIATED RACISM
Discriminatory acts perpetrated by one person to another
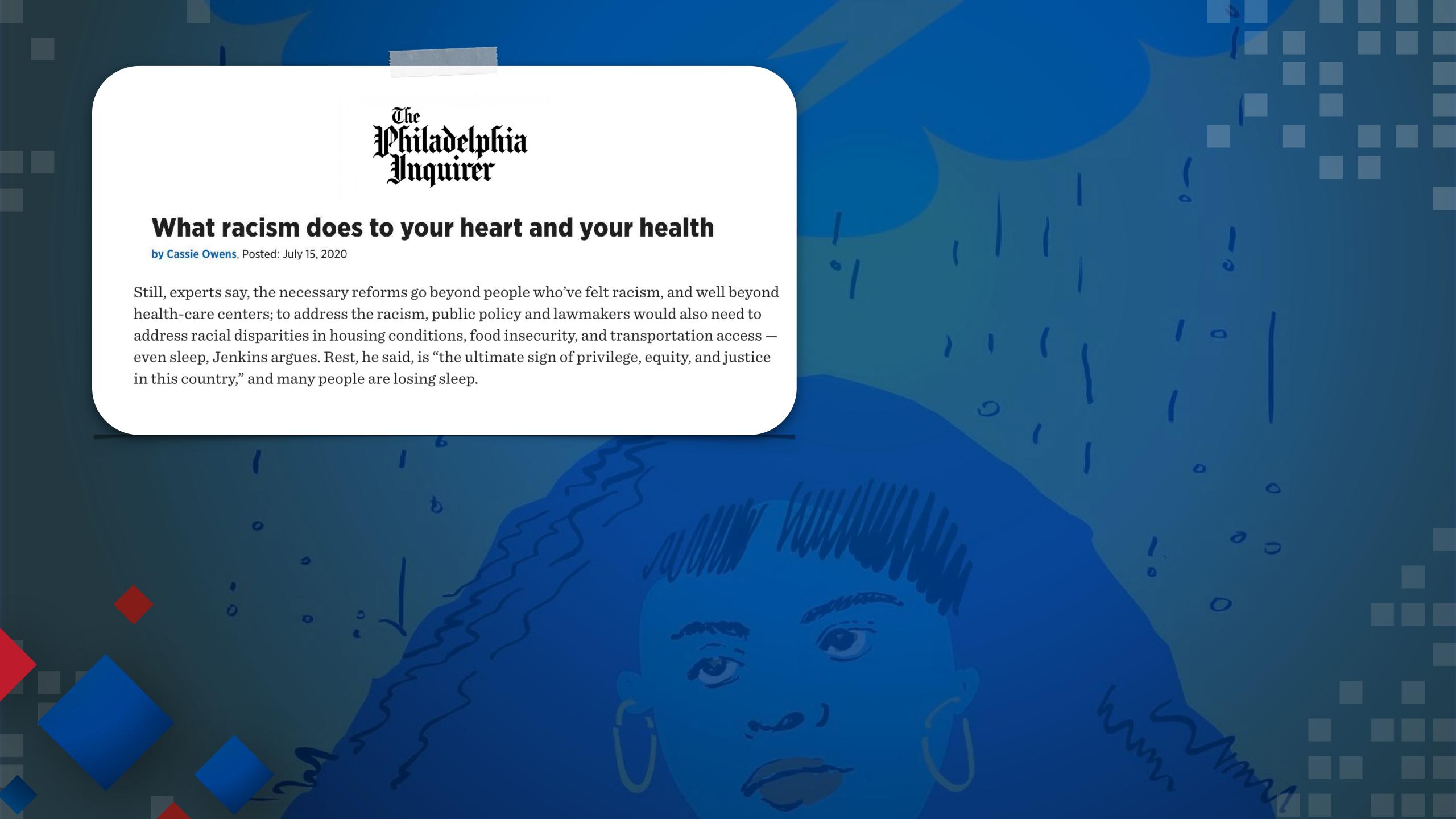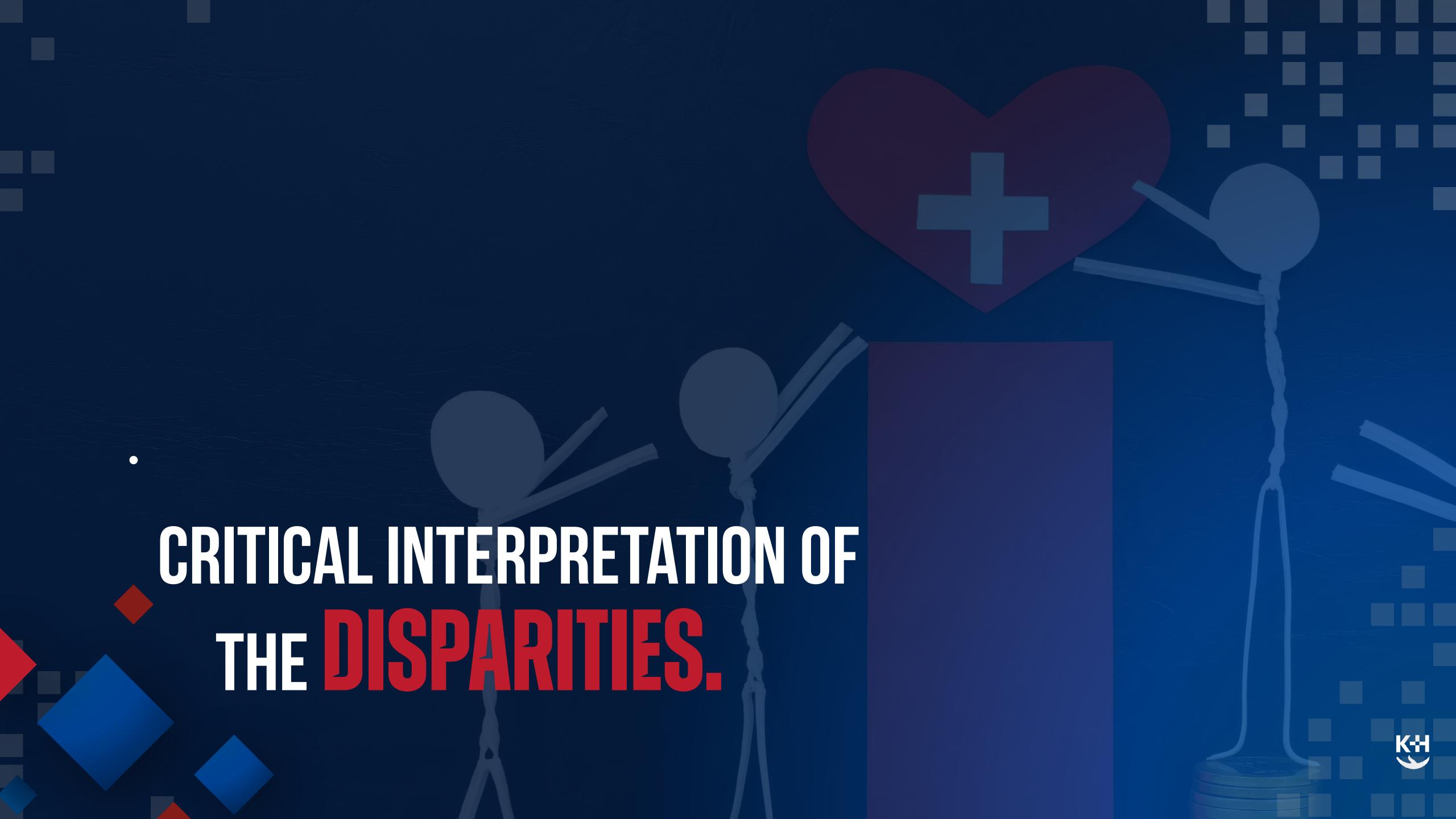
CULTURAL RACISM
Creation, acceptance, and promotion of stereotypes and stigma

K+H

The Philadelphia Inquirer

What racism does to your heart and your health

by Cassie Owens, Posted: July 15, 2020

Still, experts say, the necessary reforms go beyond people who've felt racism, and well beyond health-care centers; to address the racism, public policy and lawmakers would also need to address racial disparities in housing conditions, food insecurity, and transportation access — even sleep, Jenkins argues. Rest, he said, is "the ultimate sign of privilege, equity, and justice in this country," and many people are losing sleep.

CRITICAL INTERPRETATION OF THE **DISPARITIES.**

LEVERAGING
DATA ECOSYSTEMS TO
IMPROVE HEALTH & HEALTHCARE DISPARITIES.

TOWARDS A RACISM-FOCUSED TRAUMA INFORMED CARE APPROACH | **LEVERAGING PATIENT DATA ECOSYSTEMS**

Personal **Lived Environment** **Work**

DATA ECOSYSTEMS

Physical Health

Mental Health

Health Behavior

EQUITY

EQUITY

Accountability

Affordability

Allyship

Awareness

Acceptability

Accommodation

Availability

Accessibility

EQUITY

$$\frac{Allyship}{EQUITY}$$

WHAT ARE ALGORITHMS

UNDERSTANDING

IMPROVE & STANDARDIZE DECISIONS MADE IN HEALTHCARE DELIVERY

- Most insurance companies and health systems have **care management programs** that provide extra resources to high-need patients at risk of poor outcomes.

RESOURCES
Uses risk of a health or healthcare event to route resources

HEALTHCARE
Guides clinicians from genetic testing to predicting a patient's prognosis

BIOFEEDBACK
Improves the relationship between decision making and biofeedback devices
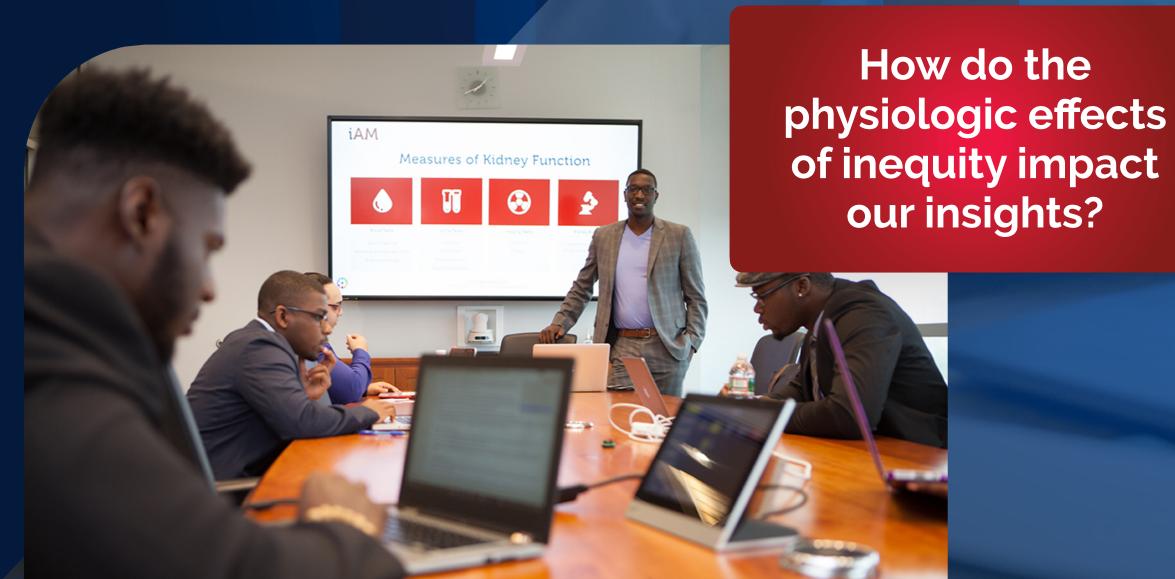
PARTNERSHIP PUSHES PROGRESS.

RACISM IN ALGORITHMS

IMPROVING RACIAL EQUITY IN THE VETERANS HEALTH ADMINISTRATION CARE ASSESSMENT NEEDS RISK SCORE

Ravi Parikh, Kristin Linn, Jiali Yan, Matthew Maciejewski, Kevin Ahmaad Jenkins, Deborah Cousins, Amol Navathe

SCAN ME!

DIFFERENCES IN PREDICTIONS OF BLACK & WHITE VETERANS

Objective: Examine the CAN Care Assessment Needs (CAN) score for racial unfairness.

Population: Our population consisted of 791,438 (18.3%) Blacks and 540,877 (81.7%) Whites.

Design: A cross-sectional cohort of Veterans who were alive and had at least one outpatient primary care encounter during 2016, based on a VA national repository of administrative claims and electronic health data containing inpatient, outpatient, laboratory, procedure, and pharmacy encounters

Key Findings:

- Black Veterans were younger (median age 59 vs. 67)
- More likely to suffer from PTSD (30.9% vs. 22.4%)
- Less likely to be unmarried (58.8% vs. 42.9%)

CAN scores were **lower** for Blacks than Whites (mean [SD] 41.8 [28.2] vs 52.2 [28.1])

Appeared more **unfair** for Blacks than Whites (FNR 35.3% vs. 26.5%, meaning CAN **under-predicted** death for Blacks versus Whites)

RACE, RACISM, & STRESS

Perspectives on Racism in Health Care Among Black Veterans With Chronic Kidney Disease

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Original Investigation | Diversity, Equity, and Inclusion

Perspectives on Racism in Health Care Among Black Veterans With Chronic Kidney Disease

Kevin A. Jenkins, PhD; Shimrit Keddem, PhD; Selamawite B. Bekele, BA; Karisa E. Augustine, BA; Judith A. Long, MD

Abstract

IMPORTANCE The burden of chronic kidney disease (CKD) and end-stage kidney disease falls disproportionately on Black individuals in the US, with Black veterans experiencing substantial consequences, and only a portion of the disparities in health conditions and health care can be explained by nonbiological factors. Among Black individuals, racism is likely one of those factors, suggesting the need to examine the consequences of racism and the resulting social structures that establish and perpetuate these racial disparities.

OBJECTIVE To investigate the health care experiences of Black veterans with CKD and identify and explore the racial discrimination encountered by this vulnerable population.

DESIGN, SETTING, AND PARTICIPANTS This qualitative study used semistructured interview guides to investigate the health care experiences of 36 Black veterans with CKD who received care at the Corporal Michael Crescenz Veterans Affairs Medical Center in Philadelphia, Pennsylvania, from October 2018 to September 2019. Interview transcripts were analyzed using applied thematic analysis.

RESULTS Among 36 Black veterans with CKD who characterized racism in the context of their care at a Veterans Affairs medical center, the mean (SD) age was 66.0 (7.8) years; 35 participants (97.2%) were male, 1 participant (2.8%) was female, and 19 participants (52.8%) were married. The mean (SD) duration of military service was 8.0 (7.0) years. Overall, 15 participants (41.7%) were not dependent on dialysis, and hypertension was the most common comorbidity (9 participants [25.0%]). Veterans described the ways in which racism produced emotional and physical stress, including psychological symptoms (eg, anger and hurt) and physiological symptoms (eg, headaches). Veterans described a strong sense of distrust in the health care system coupled with a need to be hypervigilant during clinical encounters. When encountering racism, veterans described bottling up their feelings, which sometimes led to maladaptive behavior (eg, substance use). Veterans also described individual and collective positive strategies (eg, faith) for coping with the stress of racism.

CONCLUSIONS AND RELEVANCE In this study, Black veterans with CKD experienced racism in the clinical setting that produced physical and emotional stress and a strong sense of distrust in the health care system. These findings highlight an important opportunity for education and training of health care professionals in the implementation of trauma-informed approaches to care as a means of addressing race-based stress and trauma.

Key Points
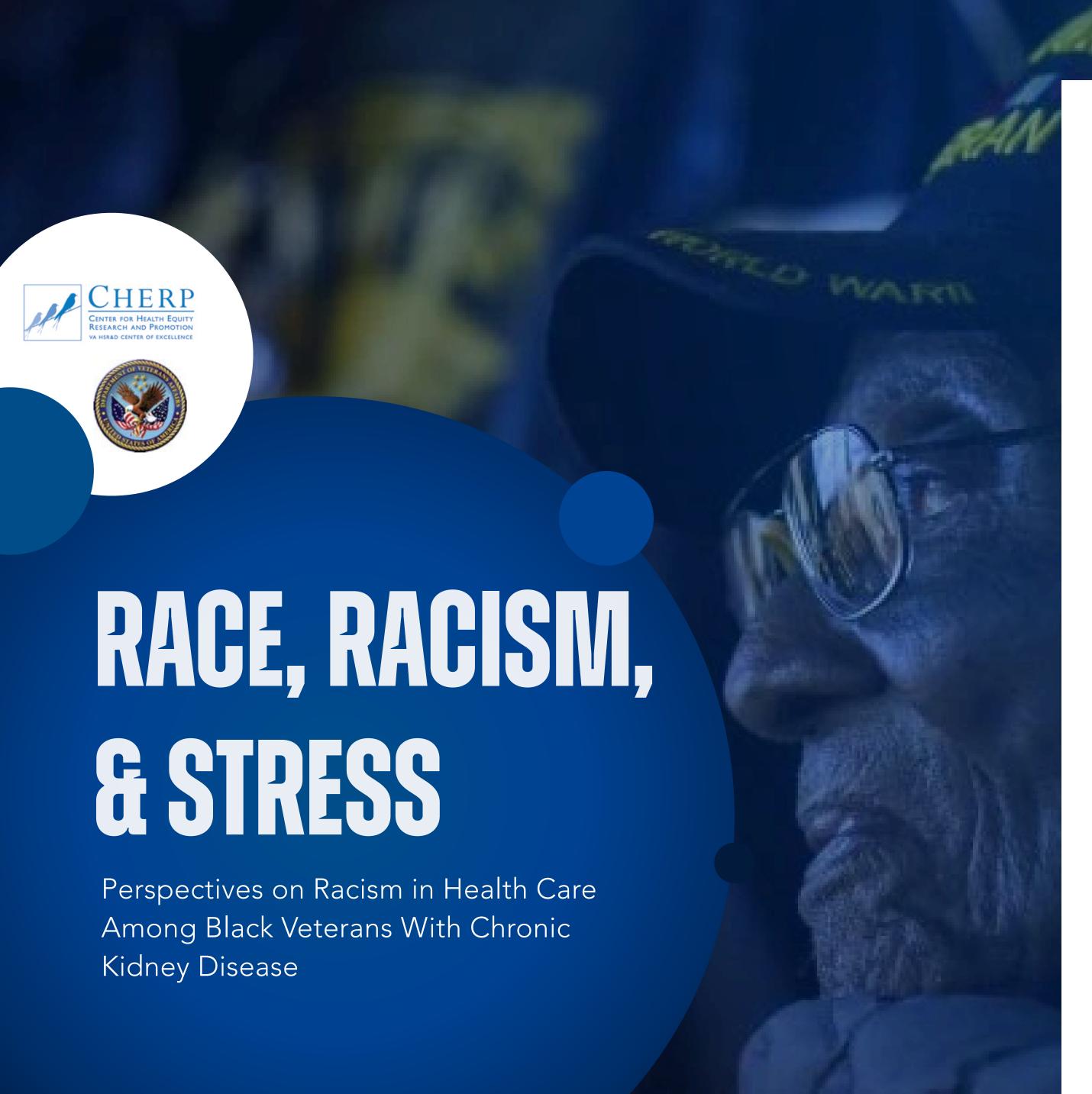
Question How do Black veterans with chronic kidney disease describe their experiences of racism in the health care setting?

Findings In this qualitative study of 36 Black veterans with chronic kidney disease, participants described feeling angry and resentful and experiencing stress as a result of encounters with racism; some veterans also expressed a strong sense of distrust in the health care system coupled with a need to be hypervigilant during clinical encounters. When encountering racism, veterans described using both negative and positive coping strategies.

Meaning These findings highlight an important opportunity for educating and training health care professionals in the implementation of trauma-informed approaches to care as a means of addressing race-based stress and trauma.

+ **Invited Commentary**

Author affiliations and article information are listed at the end of this article.

LEVERAGING DATA ECOSYSTEMS

1 STRESS

Association of racism with emotional and physical stress

2 DISTRUST

Strong sense of distrust in the health care system coupled with a need to be hypervigilant

3 BOTTLED FEELINGS

Bottling up of feelings, which sometimes led to maladaptive behavior,

4 COPING STRATEGIES

individual and collective positive strategies for coping with racism

Table. Participant Demographic Characteristics

Characteristic	Partiicpants, No. (N=36)
Age, mean (SD) y	66.0 (7.8)
Duration of Military Service (SD), y	8.0 (7.0)
Sex assigned at birth	
Female	1 (2.8)
Male	35 (97.2)
Marital Status	
Single	12 (33.3)
Married	19 (52.8)
Divorced	4 (11.1)
Widowed	1 (2.8)
CKD Classification	
Non-dialysis-dependent (stages 3-4)	15 (41.7)
Dialysis-dependent (stage 5)	10 (27.8)
Posttransplant (stage 5)	11 (30.6)
Immediate family member with CKD	10 (27.8)
Chronic conditions	
Diabetes	8 (22.2)
High blood pressure (hypertension)	9 (25.0)
Heart disease	3 (8.3)
HIV/AIDS	2 (5.6)
Agent Orange exposure	2 (5.6)
Stroke	1 (2.8)

THEMES OF OUR STUDY

Perspectives on Racism in Health Care Among Black Veterans With Chronic Kidney Disease

EQUITIZING YOUR DATA?

DASHBOARD INTERPRETATION

Interpret insights that speak most to:
- The Organization
- The People
- The Experience
- Choose Your Subgroups with reason and not only for reporting

RELATE RISK BEHAVIORS TO THE ENVIRONMENT

- Evaluating insights without environmental, societal, and cultural context devalues the use of rich data

CONNECT CLINICAL BIOMARKERS TO SDOH

- Think critically about how dashboards speak to the people
- Smallest numerical differences can matter statistically (Chi2 & T Test)

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EQUITABLE MEASUREMENT

THE WEATHERING EFFECT

BIOLOGICAL VS. CHRONOLOGICAL AGE

Researchers note that a positive **Weathering Effect** value indicates that a person's biological age is older than their chronological age.

BIOLOGIC AGING

represents an untimely "wear and tear" or cumulative degeneration of physiologic function due to environmental exposures.

CHRONOLOGIC AGE

signifies the sequence of typical loss of biologic function associated with one's number of years of life.

Access code implementing a method for calculating biological age based off of the paper "Modeling the Rate of Senescence: Can Estimated Biological Age Predict Mortality More Accurately Than Chronological Age?" By Morgan Levine at the QR code of link below.

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CLINICAL BIOMARKERS

- **Biologic Aging Inputs** breaks down different vital signs and lab-based biomarkers of inequity to watch as key outcomes to help predict mortality, disease progression and Heath Services Research allocation.

Biological Aging Inputs
Vital signs
BMI
Weight variability
Heart rate
Respiratory rate
Laboratory
Albumin
Blood Urea Nitrogen
Lymphocytes/White Blood Cells
Red blood cells
Sodium
C-Reactive Protein
a1c

SOCIAL DETERMINANTS OF HEALTH

- **Social Determinants of Health Variables** help predict hospitalizations, Emergency Department visits and resource allocations. All are key outcomes essential to hospital management and organization, but not as effective for health outcomes.

SDOH Variables
Patient Facing
Complaints
Total number of complaints
Patient complaints by division
Nature of complaints (e.g. racial/ethnic groups
Contact information changes in a year
Provider Facing
Missed appointments by provider
Requests for provider changes
Employee attrition by division

K+H

VA Author Manuscript

VA Author Manuscript

VA Author Manuscript

Racial/Ethnic Differences in 30-Day Mortality for Heart Failure and Pneumonia in the Veterans Health Administration Using Claims-based, Clinical, and Social Risk-adjustment Variables

Gabriella C. Silva, PhD[*], Lan Jiang, MS[†], Roee Gutman, PhD[*], Wen-Chih Wu, MD[†], Vincent Mor, PhD[†,‡], Michael J. Fine, MD, MSc[§,‖], Nancy R. Kressin, PhD[¶,#], Amal N. Trivedi, MD, MPH[†,‡]

[*]Department of Biostatistics, Brown University School of Public Health;

[†]Providence VA Medical Center, Brown University School of Public Health, Providence, RI;

[‡]Department of Health Services, Policy and Practice, Brown University School of Public Health, Providence, RI;

[§]Center for Health Equity Research and Promotion, VA Pittsburgh Healthcare System;

[‖]Division of General Internal Medicine, School of Medicine, University of Pittsburgh Medical Center, Pittsburgh, PA;

[¶]Center for Healthcare Organization and Implementation Research, VA Boston Healthcare System;

[#]School of Medicine, Boston University, Boston, MA.

Abstract

Background: Prior studies have identified lower mortality in Black Veterans compared with White Veterans after hospitalization for common medical conditions, but these studies adjusted for comorbid conditions identified in administrative claims.

Objectives: The objectives of this study were to compare mortality for non-Hispanic White (hereafter, "White"), non-Hispanic Black (hereafter, "Black"), and Hispanic Veterans hospitalized for heart failure (HF) and pneumonia and determine whether observed mortality differences varied according to whether claims-based comorbid conditions and/or clinical variables were included in risk-adjustment models.

Research Design: This was an observational study.

Subjects: The study cohort included 143,520 admissions for HF and 127,782 admissions for pneumonia for Veterans hospitalized in 132 Veterans Health Administration (VA) Medical Centers between January 2009 and September 2015.

Correspondence to: Gabriella C. Silva, PhD, 121 South Main Street, Providence, RI 02903. gabriella_silva@brown.edu.

CLINICAL BIOMARKERS

Table 1. Characteristics
Clinical Variables
Systolic Blood Pressure (mm Hg)
Diastolic blood pressure (mm Hg)
Heart rate
Respiratory rate
Blood urea nitrogen (mg/dL)
Creatinine (mg/dL)
Potassium (mEq/L)
Hematocrit (%)
B-type natriuretic peptide (pg/mL)
Body Mass index (kg/m^2)
Left ventricular ejection fraction (%)
Sodium (mEq/L)

Silva GC, Jiang L, Gutman R, Wu WC, Mor V, Fine MJ, Kressin NR, Trivedi AN. Racial/Ethnic Differences in 30-Day Mortality for Heart Failure and Pneumonia in the Veterans Health Administration Using Claims-based, Clinical, and Social Risk-adjustment Variables. Med Care. 2021 Dec 1;59(12):1082-1089. doi: 10.1097/MLR.0000000000001650. PMID: 34779794; PMCID: PMC8652730.

LOOK UP TO
EQUITY.

KEVIN AHMAAD JENKINS, PHD

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@kjanswers

www.kjanswers.com

MEASURING THE UNSEEN
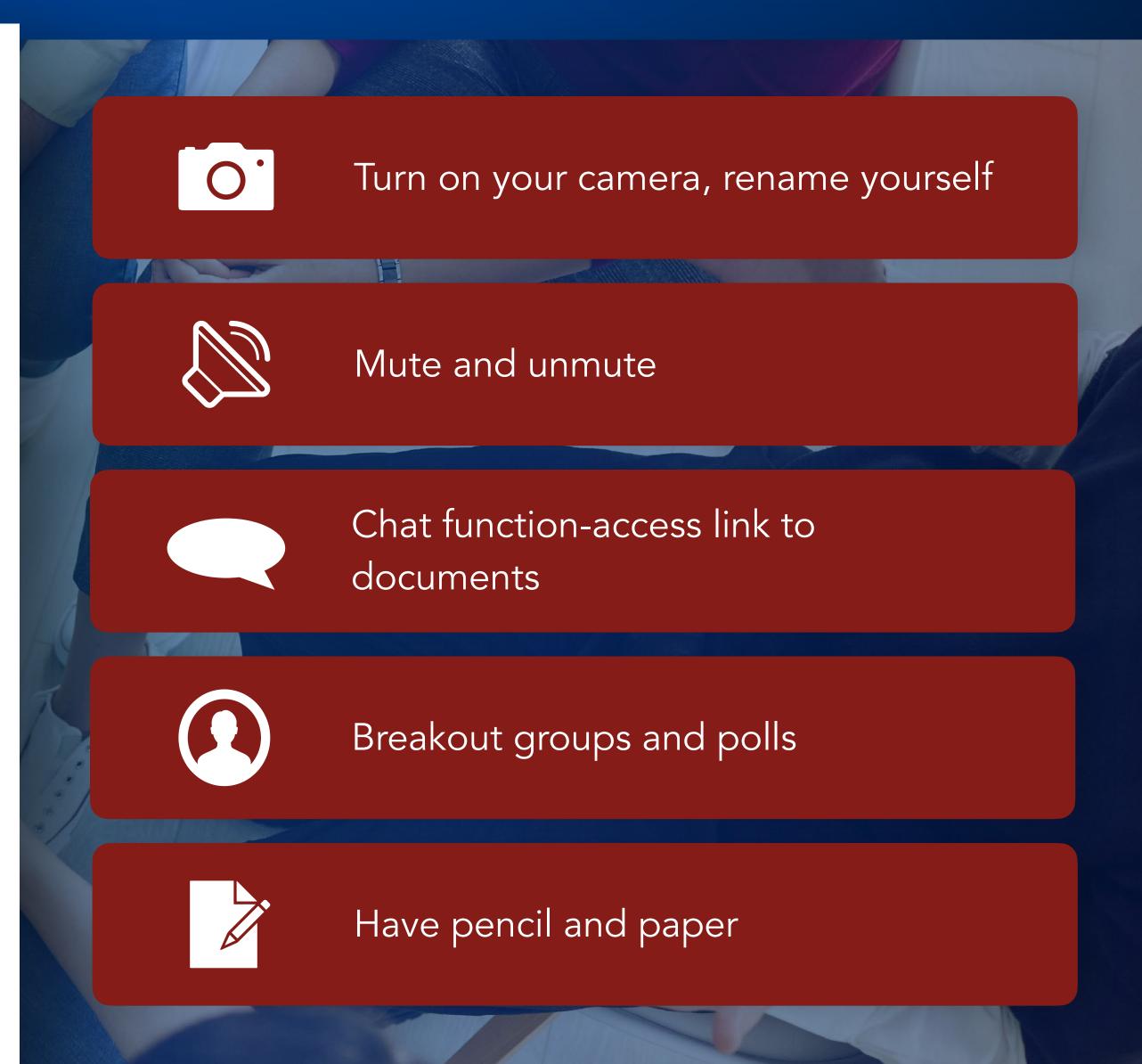
Interactive Breakout Session

Each Group Assigned A Case Study

CASE STUDIES

1.0

Rural Communities

Evaluate with your group a case study addressing lack of healthcare access to a rural population.

2.0

Urban Communities

Evaluate with your group a case study addressing lack of healthcare access to a urban population.

3.0

Health Equity Dashboards

Evaluate with your group how leaders measured and evaluated data to best serve their communities.

7As

In each group:
1. Identify two ways access is fractured.

7As

In each group:
2. Workshop three opportunities to expand access.

In each group:
3. Identify your inputs and metrics for desired outcome.

Share group work on virtual white board

FIND YOUR CASE STUDY

Case studies vary in topic, but all address health inequity relating to rural communities, urban communities, and health equity dashboards.

Scan me to find your case study!

https://bit.ly/mhacasestudy

7As

IDENTIFY TWO WAYS ACCESS IS FRACTURED

Which of the 7 As of Access were restricted to create this disparate outcome?

7As

WORKSHOP THREE OPPORTUNITIES TO EXPAND ACCESS

How can the 7As of Access be expanded to prevent more inequitable outcomes?

IDENTIFY INPUTS AND METRICS

What inputs and metrics are needed to activate on the intervention?

Group 1

https://bit.ly/mhagroup1

Group 2

https://bit.ly/mhagroup2

Group 3

https://bit.ly/mhagroup3

Scan me!

Share group work on our Virtual White Board!

https://bit.ly/mhahealthequity

Scan me!

Share group work on our Virtual White Board!

https://bit.ly/mhahealthequity

Scan me!

Access your group's case study!

https://bit.ly/mhahealthequity

Case Study 1:

Rural Communities

How can we expand access to address the concerns of rural hospital systems, patients, and communities?

Physician Burnout - Dr. Belcher

Physicians suffer from one of the highest burnout rates among professionals. In rural West Virginia, a shortage of healthcare professionals has exponentiated this problem.

Dr. Kimberly Belcher had spent eight years as a family physician in Clay County, West Virginia. Working with patients like Zane Wilkinson, Dr. Belcher excelled in providing suffering patients with proper diagnoses of their rare conditions. In Clay County, patients suffer from some of the nation's highest rates of poor health outcomes, including the highest prevalence of obesity, coronary disease, and diabetes. Clay County residents also have the nation's lowest life expectancy, the fourth-highest poverty rate, and the second-highest prevalence of depression. As one of only two family doctors in the county, Dr. Belcher took on a workload far beyond that of most practicing healthcare professionals. Her work expanded beyond just the office, as she frequently visited patients in their homes to provide comfortable care, organized local food drives, and administered Suboxone to treat opioid addiction in her community.

On April 17, 2021, Dr. Belcher's heart broke. At a chess tournament with her son, Belcher began to experience severe chest pains and was admitted into the emergency room, where her blood pressure was read to be dangerously high. It was revealed that Belcher was suffering from a rare disease called takotsubo cardiomyopathy, which forces the tip of the heart's left ventricle to stretch. This condition has been coined "broken heart syndrome", and is most frequently diagnosed in elderly women and those who have recently experienced extreme emotional stress. Dr. Belcher was able to recover in the hospital, but her condition revealed to her the effects of extreme stress caused by burnout. In a blog post written following her recovery, Dr. Belcher wrote, "No one put me in this position. I applied to medical school, I sought a job in rural primary care and I poured my identity into it. Takotsubo's is typically caused by severe accuse stress, something traumatic and abrupt. Mine was just from going to work every day."

Case Study 2:

Urban Communities

How can we expand access to address the concerns of urban hospital systems, patients, and communities?

KONQUERED

CASE STUDY
Urban Communities

MICHIGAN HEALTH EQUITY SUMMIT
November 3, 2022

Closure of Atlanta Medical Center

In Georgia, the closure of the Atlanta Medical Center has restricted access to healthcare for community members and has caused rapid overcrowding in neighboring facilities. The closure of the Atlanta facility has caused patients experiencing already limited access to further healthcare obstacles in acquiring treatment, with many Atlanta residents relying on this center for its geographical convenience. Without a reliable hospital within close proximity, transportation barriers will leave thousands of Atlanta citizens unable to receive necessary healthcare services as they were once able to do.

Following the closure, Democratic candidate for Georgia's agricultural commissioner, Nakita Hemmingway, visited the neighboring Grady Memorial Hospital. On this visit, she explains, "What I experienced yesterday was a scene from any post-apocalyptic or zombie movie you have ever seen." The effects of overcrowding were immediately evident, with gurneys haphazardly lining hallways and long lines of patients waiting to receive care. Beyond overcrowding, access barriers for Atlanta's underserved communities will continue to compound as patients struggle to access the next closest hospital.

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Column Headers
Accommodation | Availability | Accessibility | Awareness | Acceptability | Affordability | Accountability

Row Labels
Rural Health | Urban Health | Health Equity Dashboards

Notes (top area)

The utilization of technology seems the only way to bridge the gap in providing quality care of rural populations. However the technology has to be made available and accessible to thos patients.

lack of first responders ems ambualnce

accessibility of resources in rural communities negatively affects health and treatments

Rural Health row

employers working with their staff during illness

Need to prioritize all health centers, not just urban and provide back-up measures for natural disasters, i.e. diesel-powered generators.

The lack of healthcare access in rural areas is unfortunately getting worse & more Dr. & others scenarios are on the horizon.

Few local doctors, high workload & burnout for rural docs/ healthcare professionals

Closure of major hospital resulting in overcrowding at neighboring facilities

self choice- not to access due to pay/ covering

lack of transportaion

Rual 1.4 lack of accessability to vaccine and lack of bes

awareness of burnout and the negative consequensces

The impact of daily trauma that may not neccessarily be our own howver we internalize to our own health detriment.

Community memebers not consulted prior to closing

Teams have no bandwidth

affordability of care; those uninsured, or underinsured

Rural residents in need of critical care having to be airlifted to receive treatment. not affordable for most.

medicaid gap

standardizing and streamlining methods of data collection

Which metrics needs to be collected? Must be oversight for this

Stock up on diesal fuel during the off season for rural health centers when demand is low.

Driving hours for appointments is both unrealistic and unsafe for many consumers.

what processes are in place to identify low cost/ low income patients?

Does not seem like the community had much notice to prepare for the closure.

no one should be laid off for being sick, and no one should die from treatable illness because of lack of insurance.

Rual 1.4 Accepting vaccine restrictions

resources and insurance considerations

set-up telemidicine clinic with tertiary care facility to servicew rural population

Urban Health row

Utilize community health workers and community paramedics to reach patients where they are.

virtual triage booths at libraries where patients can access telehealth

community nurse triage phone lines to direct people to appropriate levels of care and services

decrease load in hospital of non-essential services to handled increased. virtual visits-infrastructure. pop up locations in economically disadvantaged locations provide computer for virtual caremseevices.

Closure of major hospital restricted access

sure of major TL hospital created compunding access issues by straining other organizations

Mobilr health clinic to provide community access with preventatice services, non urgent care, lab and x-ray. Consider launching last track ER.

Create awareness of when to go to Urgent Care vs ER. Ensure it is health literate.

No formal plan in place to transition care of those that used the now closed facility to ensure continuity of care

general lack of awareness of community need/ health

can other community hospitals expand to take in the loss? Can the local community discuss? churchs? faith based communications, social media, health and human services from the city, city boards, politicians. Lobbyists need to be involved which would include the state organization. Involving industry, pharma companies.

acceptable standards of data methods

Ensure community access points are reflective or members of population.

Communication to nethborhood surrounding closed hospital regarding opportunities.

apply emtala to prioritized non wmergent services and swt up locarions to provide thiose services

iinvest reaources into increased access for preventative services to decrease the load on hospitals and acute care centers

the associated costs of having to travel for medical care

who is keeping the hospital accountable for providing quality care?

create strategic imperative and equity goals as required component of leadership compensation.

make it associated incentives/

Health Equity Dashboards row

Remove barrier of medicaid copay @ urgent cares. ER does not have copay for Medicaid.

transportation lost - are they using Aunt Bertha? united way 211, partnering with other community hospitals, philanthropic organizations, analysis of why the hospital failed and closed - 6 sigma to find at which point it broke down

lack of resources to manage data

Hospital to home and treat in place concepts to treat patients at home using local partners/EMS

Focus on locally accessible clinics and other points of healthcare and prevention.

--Lack of access to the data collection tools and personel to do it.

loss of access from closing hospital

public health campaign around created pop up locations for triage and virtual visits d

Are the patients aware of their risk score & the strategies in place to minimize adverse outcomes?

South Dakota case study: What is the process for enrolling patients in financial assistance program? is it a non-profit hospital that is required to report community benefit? One west Michigan hospital has staff doing outreach to patients listed as "bad debt" to determine whether they can be enrolled in the charity care program and taken out of collections?

incentivize staff to attend educational opportunuties. beyond just their hourly wage. .

Find a good way to go to people, instead of expecting them to come to us.

availability of care to the community for healthcare needs

Think about the patients needs that would equip them to be successful (transportation, work schedules)

Include SDoH in the CAN score

-How to best communicate with consumer, could be improved.

Bottom notes

Urban 2.2
1. triage cases for quicker in & out of less urgent cases 2. outdoor for clinic 3. popup clinics 4. telemedicine 5. partnership with community organisations for clinics or transportation

Urban 2.2 Metrics 1. wait times 2. Identify areas that people are coming from to identify places for satelite or popup clinic

Urban 2.2 closure of hospital increase travel distance and time required

Rual 1.4 1.Problem solve ways around vaccine restrictions 2. Open additional beds to care for sick children 3. Why are other hospitals closing down
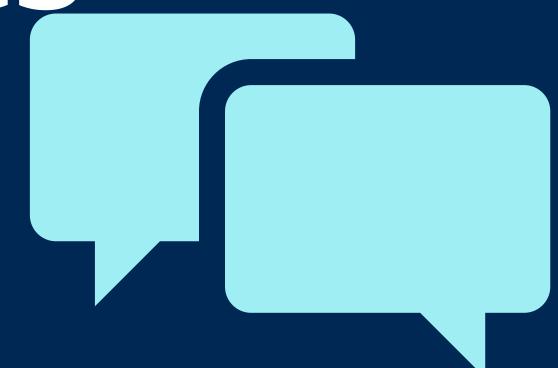
Corewell Health South

Corey Smith, PhD, Director, Health Equity Evaluation

Samantha Fell, MS, Director, Clinical Integration & Quality Improvement

Lynn Todman PhD, VP Health Equity & Community Partnerships

NOVEMBER 2022

Disclosures

Lynn Todman, Corey Smith, and Samantha Fell declare they have no conflict of interest

Strategic Framework: Three levels of intervention

Through diverse and strategic partnerships, we will address:

Individual-level social needs

Community-level social determinants

Society-level structural determinants of health equity

Healthcare Systems

with the goal of eliminating health inequities in the communities we serve.

3 System-wide Priorities

Corewell Health

1

Foundational Building Blocks for Health Equity

- Pledges
- Strategy, Business Development, Integrated Analytics
- Improve data collection processes
- Education
- Governance
- Partnerships

2

Heart Health

3

Maternal-Infant Health

Targeted Health Outcomes

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8 Core Features of the Health Equity Strategy at Corewell Health

1. Make health equity a **strategic priority**

2. Create internal **structures & processes** to support health equity

3. Invest in **community programing**, including addressing the social determinants of health

4. Address **institutional racism** and other forms of discrimination (DEI)
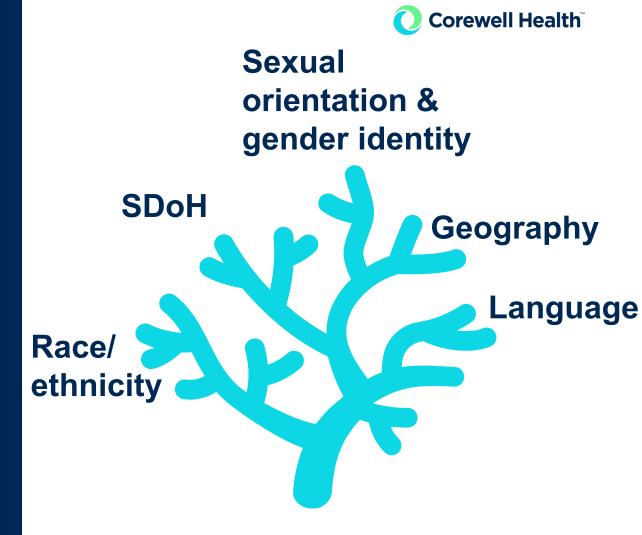
5. Establish strategic **partnerships**

6. **Provide education** to internal and external stakeholders

7. Conduct **research & evaluation**

8. Create and implement **resource development** strategy

6

Data helps us to identify inequities in our communities and amongst our patients so we can act…

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Patients
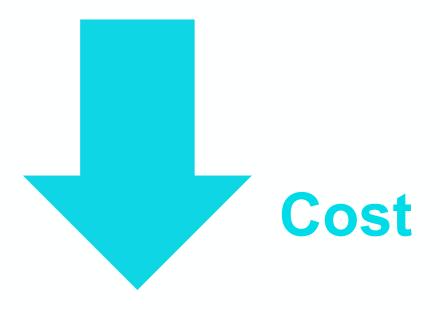
Value

"Health outcomes achieved per dollar spent"
- Michael Porter, Harvard Business School

Quality

Cost

Lakeland Institute for Value & Equity

MISSION
Improve health, instill humanity and inspire hope.

VISION
A future where health is simple, affordable, equitable and exceptional.

VALUES
Compassion. Collaboration. Clarity. Curiosity. Courage.

Purpose: Support collaboration among Lakeland teams to advance two mutually supportive BHSH system goals:

1. Improve Health and Health Equity
2. Improve Health Care Quality, Value and Outcomes.

LIVE will:

1. Create an evidence base of promising practices
2. Coordinate existing and emerging health equity and value initiatives across the division
3. Serve as a source of guidance and counsel
4. Help ensure divisional alignment with the broader health equity and value goals of BHSH.

LIVE Projects

Integrating Health Equity into Continuing Care Services

Equity Impact Assessment

Improving Data Infrastructure

Capacity Building & Guidance Notes

A Glimpse into the Issue

Race - EPIC vs. Self-Reported   Time Period: Nov '17 to Apr '18   SPECTRUM HEALTH — Patient Experience Advanced Analytics

Race	EPIC	Self-Reported
American Indian or Alaska Native	52	109
Asian, Hawaiian Native or Other Pacific Islander	313	342
African American	863	816
Hispanic/Latino	494	-
Multiracial	304	558
Other	191	724
White	41,869	41,537

Approximately 3.6% of the 44,086 patients surveyed during this time period were reported incorrectly in EPIC.

Of the non-White patients, 52.4% were reported incorrectly in EPIC.

Note: Self-Reported Hispanic patients are listed under Other.

Race – EPIC vs. Self-Reported   Time Period: Oct '20 to Mar '21   Spectrum Health

Race	Epic	Self-Reported
American Indian or AlaskaNative	44	112
Asian, Hawaiian Native or Other Pacific Islander	132	168
AfricanAmerican	454	491
Other	785	318
White	19248	19574

Approximately 4.5% of the 20,663 patients surveyed during this time period were reported incorrectly in EPIC.

Of the non-White patients, 55.8% were reported incorrectly in EPIC.

Note: Hispanic is not listed as a Race.

Project Overview

- Location: Spectrum Health Lakeland, Emergency Department, St. Joseph Campus

- Target Population: 18 years of age and older

- Purpose: Enhance data collection infrastructure related to REaL, SOGI, and SDOH to improve analytic capabilities and ability to identify & address disparities

- Defining Success: Accurate collection of REAL, SOGI, and SDOH data in 75% of patient health records

- Our Why: Startling difference in life expectancy and death rates for certain census tracks in Berrien county

Review of the Results: REaL

≤ 97%

Percentage of patients discharged from the emergency department who had **race** documented in Epic

≤ 99%

Percentage of patients discharged from the emergency department who had an **ethnicity** documented in Epic

≤ 99%

Percentage of patients discharged from the emergency department who had a **language** preference documented in Epic
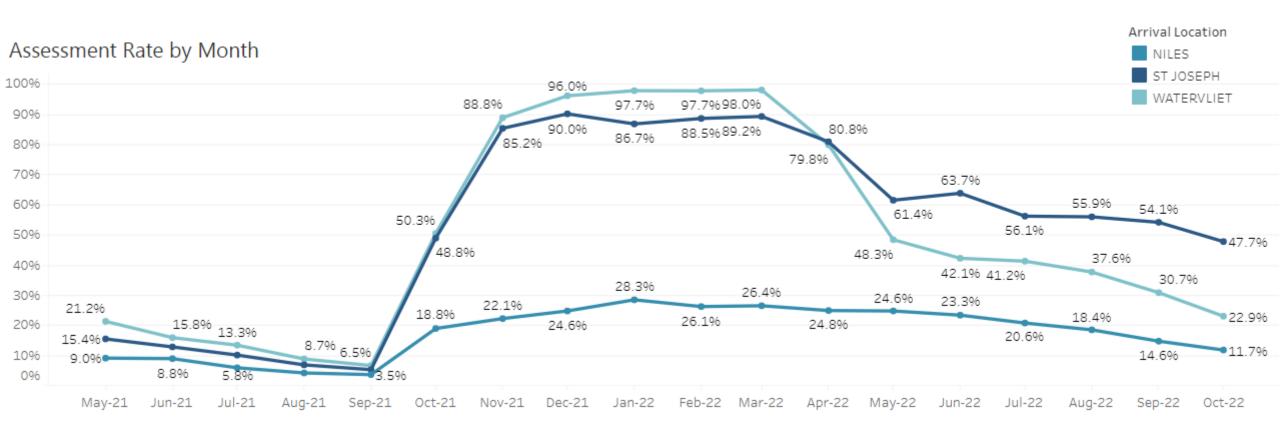
Auditing the Accuracy

82% accuracy

Observer: _____ Date: _____

REaL Data Quality Tracer

AIDET – Explanation "We want to make sure that all our patients receive the best care possible. We utilize your racial and ethnic information to ensure you are able to understand and receive the highest quality of care available.	Yes	No	Comments
Provided rationale as to why they are asking demographic and communication questions			
Race/Ethnicity			
Asked: "Are you of Hispanic, Latino, or Spanish origin"			
Language			
Asked: "How well do speak English?"			
Asked: "Would you like an interpreter?"			
Asked: "Do you speak a language other than English?" *Note: If yes, asked "what is this language?"*			
Asked: "What language do you feel most comfortable speaking with your doctor or nurse?"			
Asked: "In which language would you feel most comfortable reading medical or health care instructions?"			

Review of the Results: SDoH

Successes & Challenges

Successes

- Multi-stakeholder team allowed for deeper insights and better context

- Roll out of SDoH questions

- New relationships and connections

Challenges

- Significant need to train staff before SOGI roll-out

- Not always clear understanding amongst clinical teams around certain workflow changes

- Time-intensive methodology for monitoring REaL accuracy

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Lessons Learned

- It's harder than it looks…

- Context matters (political and units)

- Sensitivity around the subject matter (SDoH & SOGI)

- COVID

- Staff burnout/shortages

The Next Phase - SOGI

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- Building on what we learned in Phase 1 of our SOGI journey
- Focusing on primary care
- Activity at all levels of the system

SOGI Phase Plan

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Planning Oct - Dec 2022

Scope out work at all levels
Choose sites
Determine what success looks like

**Monitoring/Doing Phase II
July 2023 – Dec 2023**

Review how phase I went
Update plans as necessary
Roll out to next cohort

Kick off change management process
Begin practice level training
Initiate provider level training
Complete all levels of certification

Doing Jan – June 2023

Address any opportunities
Operationalize SOGI
Ensure dashboard monitoring and action

**Monitoring – Phase II
Jan 2024**

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Imperative for Health Equity to be focus of Quality, Safety, & Experience

Understanding Social Determinants of Health

*"**Social determinants of health**," defined by the World Health Organization as "the conditions in which people are born, grow, live, work, and age."*

Food Security

Housing Stability

Transportation

Health Care Access & Quality

Education & Literacy

Employment & Living Wage

Community & Social Networks

The Need for Equitable Evaluation

eef PRACTICE PARTNER

Corewell Health South engages in the practice of the Equitable Evaluation Framework™ (EEF), which seeks to **reimagine the purpose and practice of evaluation** by seeding and growing a field to advance equity and expand notions of validity, objectivity, rigor, and embrace complexity.

Dean-Coffey, Jara. "Equitable Evaluation Framework™." 2017. Equitable Evaluation Initiative. https://www.equitableeval.org/framework.

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The Need for Equitable Evaluation

eef PRACTICE PARTNER

Evaluation and evaluative work should be in service of equity

Evaluation work should be designed and implemented with the values underlying equity work

Evaluative work can and should answer critical questions

Dean-Coffey, Jara. "Equitable Evaluation Framework™." 2017. Equitable Evaluation Initiative. https://www.equitableeval.org/framework.

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Corewell Health is committed to ensuring all key measures include the elements of equity analysis.

Corewell Health Actions

Integrate Health Equity & Social Determinants of Health information with the ability to stratify and analyze

Develop a One Epic Ecosystem by 2023/24

Evolving Regulatory & Payors Evaluating Health Equity

Centers for Medicare and Medicaid Services

The Joint Commission

Leapfrog

US News and World Report (USNWR)

BCBS/BCN

Priority Health

New Standards to Address Health Disparities from Joint Commission: Leadership Chapter

- The hospital **designates** an individual to lead activities to reduce health care disparities for the hospital's patients.

- The hospital **assesses** the patient's health-related social needs and provides information about community resources and support services.

- The hospital **identifies** health care disparities in its patient population by stratifying quality and safety data using sociodemographic characteristics of hospital patients.

- The hospital **develops** a written action plan to address at least one healthcare disparity.

- The hospital **acts** when it does not achieve the sustained goals of improvement.

- The hospital **informs** key stakeholders, leaders and staff of progress being made to address disparities annually.

New CMS IPPS Finalized Rules for SDoH

Measure #1: Hospital Commitment to Health Equity

- Structural measure that assesses hospital commitment to health equity using a suite of equity-focused organizational competencies aimed at achieving health equity for racial and ethnic minority groups, people with disabilities, members of the LGBTQ+ community, individuals with limited English proficiency, rural populations, religious minorities and people facing socioeconomic challenges.

Measure #2 : Screening for Social Drivers of Health

- Assesses whether a hospital implements screening of all patients that are 18 years or older at time of admission for health-related social needs (HRSNs). Including food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

- **Voluntary Reporting** beginning CY 2023, and mandatory in CY 2024 reporting period/FY 2026 payment determination

Measure #3: Screen Positive Rate for Social Drivers of Health Measure

- Structural measure that provides information on the percent of patients admitted for an inpatient hospital stay and who are 18 years or older on the date of admission, were screened for an HRSN, and who screen positive for one or more of the following five HRSNs: Food insecurity, housing instability, transportation needs, utility difficulties, or interpersonal safety

- **Voluntary Reporting** beginning CY 2023, and mandatory in CY 2024 reporting period/FY 2026 payment determination
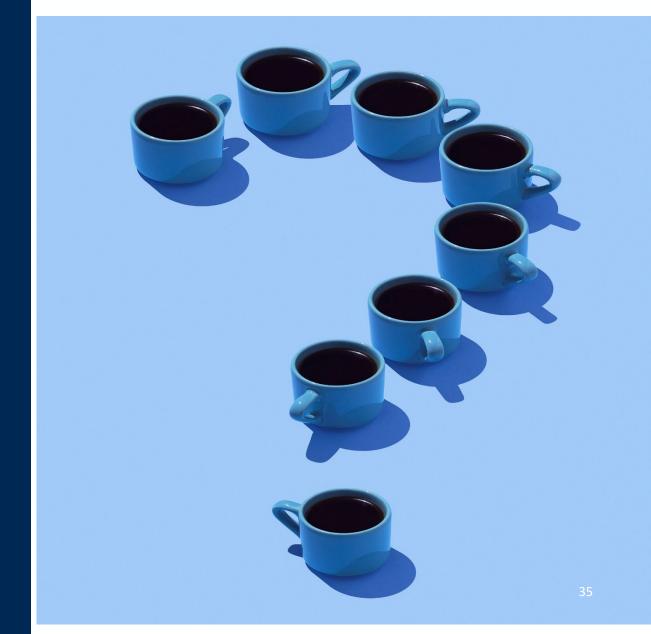
Addressing Joint Commission and CMS New Rules/Standards

- System level
  - Socialize new standards
  - Alignment across regions for tracking/responding
- Corewell Health South
  - Addition to LIVE project updates
  - Dashboard creation
  - Monthly updates

Questions?

EQUITY AT BRONSON HEALTHCARE

November 3, 2022

Abby Leonard, MSN, RN, CPHQ
System Health Equity of Care Performance Improvement
Christy Moore, MBA, SPHR
System Manager Patient Experience Analytics

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Disclosures

Abby Leonard and Christy Moore declare they have no conflict of interest

Objectives

Build on the lessons learned shared from Corewell Health - South

Provide actionable tools for Healthcare systems to apply equity principles to support data collection, data validation and implementation processes

Provide a framework for health systems to understand the implications of expanding sex and gender in quality, safety and operations

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Bronson Healthcare

- **Regional, not-for-profit health system**
- **Locally owned and governed**
- **Serving southwest Michigan since 1900**
- **8,600 employees**
- **1,500 medical staff**
- **Over 100 patient care sites**
- **4 hospitals: Battle Creek, Kalamazoo, Paw Paw and South Haven**
- **796 licensed beds**

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Bronson Equity Framework

Together, create an environment, mindset, policies and interventions that empowers people to have full and equal access to opportunities to lead healthy lives

Governance & Leadership	Social Demographic Data	Community Partnership	Intercultural Competency
Goal: Increase the diversity of leadership and governance to support, assist, and advocate for employees, patients, and families	**Goal:** Increase the collection, reporting and analysis of social demographic data to prioritize and determine interventions	**Goal:** Build and strengthen community relationships and partnerships to advance health equity	**Goal:** Improve our knowledge, skills and attitudes to meet the social, cultural and linguistic needs of our employees, patients and families
• Implement policies, practices and tools that explicitly address inequities • Create a current and future mix of candidates that are reflective of the communities we serve	• Systematically collect social demographics data including race, ethnicity, language (REaL), sexual orientation and gender identity (SOGI) and social determinants of health (SDoH) • Use social demographic data and research to assess, identify, and prioritize opportunities to reduce inequities	• Engage in multi-sector collaborations to expand capacity to impact equity outcomes • Provide health care support and education to advance the health of our communities • Formalize relationships with community groups for ongoing collaboration	• Provide intercultural competency training and educational tools and programs • Ensure safe, equitable communication and language services for people with limited English proficiency (LEP) and disabilities

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Together, cre... ...s and interventions that empowers people ...ortunities to lead healthy lives

Governance & Leadership

Goal: Increase the diversit... leadership and governanc... support, assist, and advoca... employees, patients, and fa...

- Implement policies, pra... and tools that explicitly address inequities

- Create a current and fut... mix of candidates that a... reflective of the communities we serve

Social Demographic Data

Goal: Increase the collection, reporting and analysis of social demographic data to prioritize and determine interventions

- Systematically collect social demographics data including race, ethnicity, language (REaL), sexual orientation and gender identity (SOGI) and social determinants of health (SDoH)

- Use social demographic data and research to assess, identify, and prioritize opportunities to reduce inequities

Community Partnership

Goal: Build and strengthen community relationships and partnerships to advance health equity

- Engage in multi-sector collaborations to expand capacity to impact equity outcomes

- Provide health care support and education to advance the health of our communities

- Formalize relationships with community groups for ongoing collaboration

Intercultural Competency

Goal: Improve our knowledge, skills and attitudes to meet the social, cultural and linguistic needs of our employees, patients and families

- Provide intercultural competency training and educational tools and programs

- Ensure safe, equitable communication and language services for people with limited English proficiency (LEP) and disabilities

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Capturing accurate Race, Ethnicity and Language (REaL) in order to uncover disparities

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REaL Timeline

2015/2016
Blanks/Unknowns= 16%
Accuracy= 15-20% errors
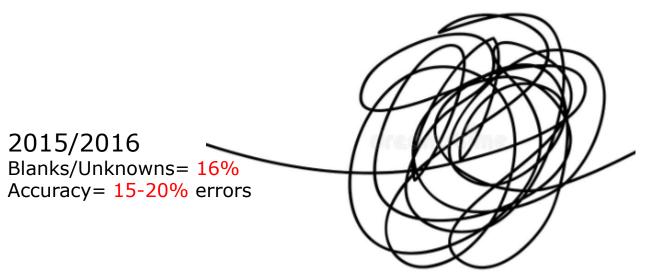
2022
Blanks/Unknowns= <3%
Accuracy= <1% errors

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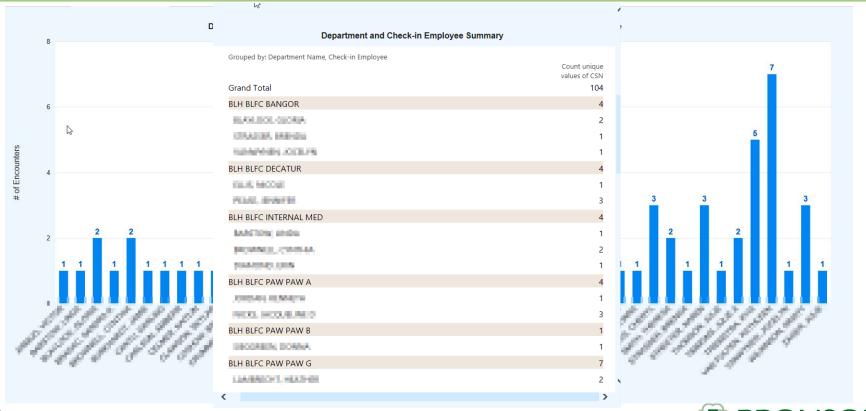
Dept	Include/ Not include	Comments/Barriers	Baseline 2021			
			# of patients with Unknown or patient refuse Race field but also has a race	# of patients with a REaL unknown/ blank	Total # of Patients	% of patients with a REaL unknown/ blank
			0	0	0	N/A
			0	1	1	100.0%
			1	1	1	100.0%
		Exposure account when doing blood	374	379	393	96.4%
			0	8	10	80.0%
			2	2	3	66.7%
			0	31	53	58.5%
			0	1	2	50.0%
			8	7	15	46.7%
			0	4	9	44.4%
		Assigned beds to patients for	29	306	804	38.1%
			1	5	14	35.7%
			8	7	20	35.0%
			2	3	9	33.3%
		transcribing a referral, paper order, not	446	1085	3839	28.3%
			284	329	1254	26.2%
			0	1	4	25.0%
		Lab drop off, no patient is present	95	118	494	23.9%
			0	3	13	23.1%
		Lab drop off, no patient is present	3050	3782	17006	22.2%
			0	2	9	22.2%
			307	324	1469	22.1%
		Images being read by provider, no	36	122	581	21.0%
			5	15	72	20.8%

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Leader Accountability Report

Department and Check-in Employee Summary

Grouped by: Department Name, Check-in Employee

	Count unique values of CSN
Grand Total	104
BLH BLFC BANGOR	**4**
[redacted]	2
[redacted]	1
[redacted]	1
BLH BLFC DECATUR	**4**
[redacted]	1
[redacted]	3
BLH BLFC INTERNAL MED	**4**
[redacted]	1
[redacted]	2
[redacted]	1
BLH BLFC PAW PAW A	**4**
[redacted]	1
[redacted]	3
BLH BLFC PAW PAW B	**1**
[redacted]	1
BLH BLFC PAW PAW G	**7**
[redacted]	2

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System Likelihood to Recommend Peer Group Rank by Race

System Likelihood to Recommend By Survey Type
All PG Database Peer Group Rank
Visit/Discharge Dates Oct '20– Sep '21, as of Jan 17, 2022

	White/Caucasian	Black/African American	Multiracial	Asian	American Indian or Alaska Native	Native Hawaiian or Other Pacific Islander	Not listed*
Medical Practice	63	34	34	19	22	N/A	41
Outpatient Services	47	13	10	4	19	80	16
Emergency	52	18	15	55	19	N/A	
Inpatient	78	33	28	59		N/A	
Urgent/Fast Care	87	95		N/A	N/A	N/A	96
Surgery	49	21	16	N/A	N/A	N/A	38

Rank < 50th%ile
Rank > 50th%ile

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Home Health racial demographic information not available due to CMS regulations
Oncology and OP Rehab not included in breakdown due to n sizes
*Not listed includes "Other", "Patient Refused", "Something Else" and "Unknown"

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Demographic Analysis: Sexual Orientation

Surveys Received Between 7/1/2021 and 12/31/21

"Were you treated with dignity and respect?"			
Sexual Orientation*	**N Size**	**"Yes"**	**"No"**
Bisexual	249	94.78%	5.22%
Choose not to disclose	583	96.9_%	3.09%
Don't know	_43	97.67%	2.33%
Lesbian or Gay	_34	96.11%	3.89%
Not listed	56	91.07%	8.93%
Straight (not lesbian or gay)	17,314	98.78%	1.22%
*Choices based on Epic demographic fields			

SAMPLE

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Understanding sex and gender in Healthcare to provide Safe, Equitable and Quality care to <u>all</u> Patients

Sex and Gender Data Timeline

2018 – First workgroup formed focused on implementation of sexual orientation and gender identity

2020 – Passive go-live allowing documentation at the request of the patient and self-report in MyChart (pandemic interruption)

2021 – Joined MHA/MPHI Equity Collaborative to enable us to dig deeper into the impact of this work

2022 – Phased implementation of active collection of expanded sex and gender information in ambulatory locations (system go-live will be December 2022)

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Sex & Gender Documentation: Bronson System Encounter (visit) Data

EHR Field	Documentation (%)	Choose not to disclose (%)
Gender Identity	53.2	1.3
Sexual Orientation	48.4	4.1
Sex Assigned at Birth	48.7	1.1

Timeframe: Jan 1, 2022 – Oct 14, 2022

Non-Binary Legal Sex: 176 patient encounters

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U.S. LGBTQ+ Prevalence

- **7-20%** identify as part of the **LGBTQ+** community

- **1.6 million**, 13+, identify as **transgender**

- **1.2 million** identify as **non-binary**

Consider this:
- 10% of people are left-handed
- 2% of people have green eyes

https://www.hrc.org/press-releases/we-are-here-lgbtq-adult-population-in-united-states-reaches-at-least-20-million-according-to-human-rights-campaign-foundation-report

https://news.gallup.com/poll/389792/lgbt-identification-ticks-up.aspx?utm_source=twitter&utm_term=gallupnews&utm_content=9d68a961-575f-4953-ae94-fa5461533941&utm_campaign=gallup_news

https://williamsinstitute.law.ucla.edu/press/lgbtq-nonbinary-press-release/

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Discrimination in Healthcare

Over 56% of LGBTQ+ people report experiencing some form of discrimination when seeking healthcare

- Refusal to provide care
- Questions related to transgender/non-binary identity, not related to reason for visit
- Physical exams not related to reason for visit
- Denigrating or harmful use of language

The majority of transgender patients report having to educate their healthcare provider on foundational transgender health topics.

https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf

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We have ALWAYS incorporated sex and gender including sexual orientation and gender identity into the healthcare experience and care plan for our patients

In the past, we assumed that a person's sexual orientation and gender identity were heterosexual and cisgender, unless told otherwise
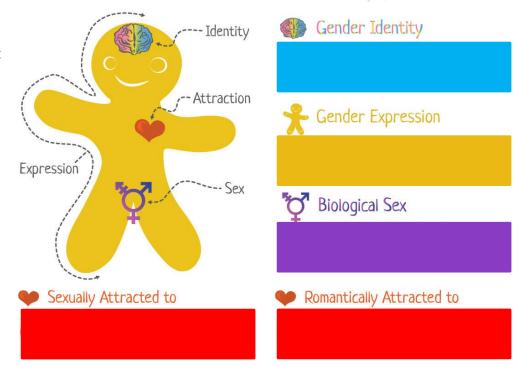
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The Genderbread Person v3.3 by it's pronounced METROsexual.com

Identity

Attraction

Expression

Sex

Gender Identity

Gender Expression

Biological Sex

Sexually Attracted to

Romantically Attracted to

Legal Sex:
the gender recognized at the state or federal level that is displayed on legal documents such as state issued IDs and birth certificates

Sexual Orientation:
a person's innate romantic, emotional, and/or sexual attraction toward others

Gender Identity:
a person's internal sense of being female, male, a combination of both, or neither

Gender Expression:
a person's outward expression of their gender identity; gender expression norms vary significantly across cultures

Biological (Assigned) Sex:
the sex an individual is assigned at birth, usually by a clinician based on external reproductive organs

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Legal Sex Vs. Biological Sex Vs. Sex Assigned at Birth

Legal Sex (Legal/administrative gender)	Sex Assigned at Birth (External anatomy at birth)	Gender* (Innate sense of self)
F = female	Female, Male, Unknown, Intersex	Cisgender Female Transgender Female
M = male	Female, Male, Unknown, Intersex	Cisgender Male Transgender Female
X = non-binary	Female, Male, Unknown, Intersex	Non-binary Gender Queer/Fluid Agender

*The genders listed above are not inclusive of all genders, always reflect the terms used by the individual to label their gender

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- **Barriers to payor coverage** of sex dependent services impacting access to care and cost to the patient

- **Automated algorithms/logic** within the EHR that utilize sex information to guide clinical decision making (BPAs, health maintenance prompts)

- **Pathology**: lab reference ranges that utilize sex information to differentiate normal parameters

- **Diagnostics**: Diagnostic procedures that utilize sex information to inform the diagnosis (e.g. Pulmonary Function Test, Pediatric EKGs, Ultrasounds)

- **Quality & Safety data** that reports out or stratifies by sex (or uses the term gender to mean sex)

- **Managed care programs data** – often linked to payor reimbursement or provider compensation/incentives

- **Interoperability** between primary EHR and other software programs used across the continuum of care

- **Legal name vs. Chosen Name Use**: patient facing documents vs. legal vs. operational documents (developed decision making algorithm to support IT analysts)

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Sex and Gender in Healthcare

Sex and Gender information necessary for <u>respectful patient interactions</u>:	Sex and Gender information necessary for <u>clinical decision making</u>:	Sex and Gender information necessary for <u>billing and legal requirements</u>:
- Chosen name - Pronouns - Gender Identity - Relevant social/familial relationships *Use the person's chosen name at all times <u>except</u> when the person's legal name is necessary for safety, legal or billing purposes. **Legal name and DOB must be confirmed using 2 identifiers per policy**. E.g. consents, med administration, prescriptions, procedures, etc. Refer to System Nursing G-01 Patient Identification Policy and Patient Care Safety Guideline.*	- Sex Assigned at Birth - Organ inventory *(based on clinical situation)* - Gender affirming medical therapies *(based on clinical situation)* - Sexual Orientation *(based on clinical situation)*	- Legal sex - Legal name *As listed on state or federal ID* *(While called 'legal sex', this is actually a reflection of the person's legal gender, as it is based on the person's gender identity not on their biological sex. A third legal sex/gender marker is now available at both the state and federal level).* *Payor considerations: Sex assigned at birth may be necessary to support payor coverage of sex dependent services.*

How to decide what roles see what information? Simply follow standard HIPPA practices. The information available is limited to the information needed for that person to do their job.

24   * A patient's overall plan of care and healthcare experience should incorporate all of these components

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Overwhelmed Yet?

- It's a lot to take in. Give yourself grace.
- It's a big change with potential for heightened emotions.
- It's the right thing to do. The right thing is rarely easy.
- This empowers your system to provide higher quality care for everyone.
- This promotes patient safety and empowers your system to chase zero harm.
- **It can be done** successfully when we:
  - Act with intentionality
  - Remain flexible but resolute
  - Avoid shame/blame
  - Apply equity implementation principles
  - Focus on our shared goals, vision and mission
  - Support each other

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Examining Sex and Gender Across the System

Step 1
- Distinct definitions and use of the terms sex and gender
- Foundational understanding of sex and gender in health and well-being
- Foundational understanding of the components within each domain, sex and gender (sex assigned at birth, legal sex, gender identity, sexual orientation, etc.)

Step 2
- Examine interoperability of sex and gender related fields across clinical software platforms, databases and billing programs
- Deep dive into understanding when sex and gender are used across the system: patient experience, clinical decision making, legal/billing/regulatory
- Ask the question "What information is actually needed for this situation/workflow/process?"
- Determine appropriate use of sex and gender information including the underlying components
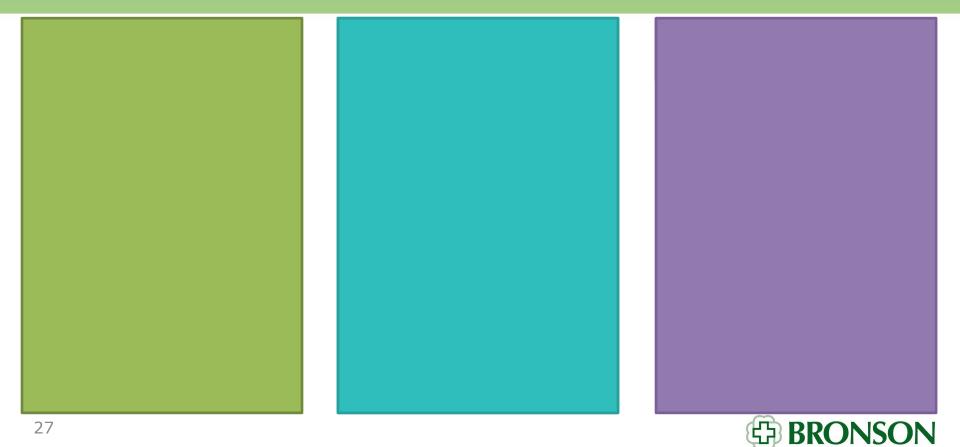
Step 3
- Adapt the electronic health record to optimize workflows and documentation and improve visibility of chosen name and pronouns
- Work with vendors to optimize interoperability between systems
- Adapt standard work to ensure the appropriate sex and/or gender information is utilized to meet the operational and patient care need
- Incorporate relevant sex and gender information into patient interactions using inclusive language principles (e.g. Scripting for staff, consent forms, patient letters, and after visit summary)

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Standardize Language, Study & Adjust (PDSA), and Communicate

- Standardize how you define and use equity and sociodemographic terms in patient care, administrative operations and quality improvement

- Examine how sex and gender impact systems and processes

- **There is no 'perfect' timing, prepare your system to respond**

- Implement robust multi-modal internal and external communication and intercultural development plans

- Establish ongoing processes that include staff and patient feedback to check & adjust both during and after implementation

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Key Take-Away

Consistent Messaging and Responsiveness

- There is no 'magic' wording that will eliminate all negative responses from patients and employees, <u>consistency and education are key</u>

- Workplace violence and harassment is <u>not</u> acceptable, regardless of the reason or sensitivity of the topic, patient behavior expectations and follow up remain the same

- Key messaging considerations:

  - Everyone has a sexual orientation and gender identity and they are part of the bigger domains of sex and gender
  - Our current systems and processes were built based on assumptions, these changes remove those assumptions and enable safe patient care tailored to the needs of the individual
  - There is no universal set of rules for gender, gender varies across cultures
  - No culture is better than another, inclusion and belonging is for everyone
  - Use clear, distinct definitions for race, ethnicity, sex and gender and how are they are relevant to a person's health
  - Acknowledge the external social and political climate, it does impact this work
  - Focus on shared values of exceptional patient care for everyone (bring it back the your mission and vision)

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Bronson's Model for
Improvement (PDSA)

- Use what we learned from validating REaL data to ensure confidence and reliability in the sex and gender data collected

- "Why We Ask" video series for patients

- Annual Workday learning module for all employees and contracted providers that shares the why and best practices for patient interactions

- Expanded training and education opportunities for internal teams – building upon what was covered in the required learning module

- Ongoing PDSA cycle for identifying and addressing gaps and needs unknown prior to system go-live

- Begin stratifying our quality metrics using REaL (already begun) and Sex and Gender data to uncover and address disparities in patient care

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Do the best you can until you know better.

Then when you know better, do better.

~ Maya Angelou

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APPENDIX

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REaL Implementation

Defining the Problem & Planning

- 2015/16: Assess the data
  - Self-report v EPIC
  - REaL fields with blanks and unknowns

Go and See; education

Evaluated Race and Ethnicity fields

Goals aligned to Strategic Plan and Health Equity PI

Equitable Implementation

2021: reestablished inclusive work team including front-line supervisors

Input and control for go-live dates and work flow details

Accountability tools for leaders

Continually check and adjust

Future

- Other/Something Else/Not Listed
  - What to call it and why is it being used so much?

- Consistent reporting for multi-ethnic

- Language field: focus on updating "unknown" and improve accuracy

- Capture disability status

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Overall "Blanks and Unknowns":

- Collaboration population of focus (OB): 0%

- System: 2.3%

Accuracy of Race field improved to <1% discrepancy from 15-20% in 2017

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Bronson OB SOGI & REaL Data Scorecard

	2021	January	February	March	April	May	June	July	August	September
Denominator: Birthing parents who delivered at BMH	4799	186	171	229	20_		223	219	225	219
Numerator #1:	4797	186	171	229			223	219	225	219
Birthing parents who delivered at BMH with answers for all 3 REaL questions	100.0%	100.0%							100.0%	100.0%
Numerator #2:	21	1	1						0	1
Birthing parents who delivered at BMH with a blank or "Unknown" in any of the 3 REaL questions	0.4%	0.5%	0.6%					0.0%	0.0%	0.5%
Numerator #3:	2644	137	121	176			9	179	185	187
Birthing parents who delivered at BMH with answers for both SOGI questions	55.1%	73.7%	70.8%	76.9%		%		81.7%	82.2%	85.4%
Numerator #4:	322	12	11	1_				4	13	4
Birthing parents who delivered at BMH with an answer for GI and no answer for SO	6.7%	6.5%	6.4%	5_		2.4%		1.8%	5.8%	1.8%
Numerator #5:	45	2	0		1	1		2	0	0
Birthing parents who delivered at BMH with an answer for SO and no answer for GI	0.9%	1.1%	0.0%	_%	0.5%	0.5%	0.0%	0.9%	0.0%	0.0%

REaL: 100% SOGI: 85.4%

Population of focus: Birthing parents, 18+, vaginal delivery, Bronson Methodist Hospital

Data Collection Goal: >75% have Race Ethnicity & Language (REaL), Sexual Orientation & Gender Identity (SOGI) and Social Determinants of Health (SDoH) documented

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Project Goals: Collect all 3 data sets (REaL, SOGI, SDoH) at multiple points of care on >75% of all patients served within target population by the end of the two-year period (December 2022)

Population of Focus: L&D discharges, 18+, vaginal deliveries (exclusions: C-sections; <18 yrs.)

Care Continuum Scope: Collaborative system process for screening and follow up across the perinatal experience

Perinatal experience: All interactions between the birthing parents/family and the healthcare system related to maternal and fetal health monitoring/management and support, from first perinatal visit to 6 weeks post delivery

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Resources Bronson has utilized on our Equity Journey

AHA Health Equity Snapshot: A Toolkit for Action
AHA Connecting the Dots: Value and Health Equity
AHA Institute for Diversity and Health Equity (IFDHE): Health Equity Resource Series – Diversity and Inclusion in Leadership and Governance
AHA Institute for Diversity and Health Equity (IFDHE): Health Equity Resource Series – Training and the Culture of Learning
AHA Institute for Diversity and Health Equity (IFDHE): Health Equity Transformation Model: Literature Overview
American Heart Association Call to Action: Structural Racism as a Fundamental Driver of Health Disparities
American Heart Association: Cardiovascular Health in LGBTQ Adults - Minority Stress Model
AMA Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity
CMS Strategic Plan Pillar: Health Equity
IHI The Quintuple Aim for Healthcare Improvement
IHI Whole System Quality: A Unified Approach to Building Responsive, Resilient Health Care Systems
IHI Equity and Quality: Improving Healthcare Delivery Requires Both
IHI Achieving Health Equity: A Guide for Healthcare Organizations
MHA Eliminating Disparities to Advance Health Equity and Improve Quality
National Academies of Medicine: An Equity Agenda for the Field of Healthcare Quality Improvement
National LGBTQIA+ Health Education Center
Human Rights Campaign: Health Equality Index
Intersex Society of North America
World Professional Association for Transgender Health
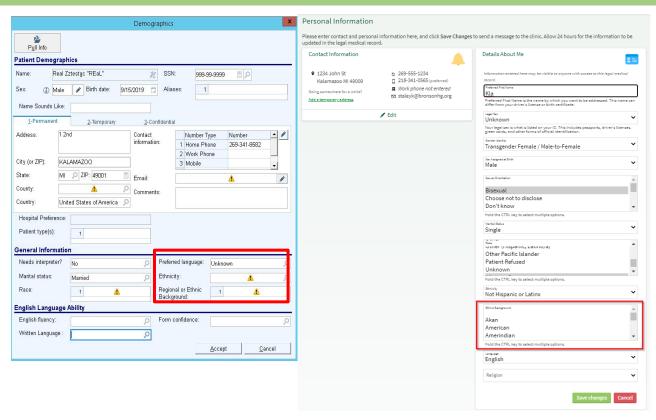American Academy of Pediatrics: LGBTQ+ Health & Wellness
The Trevor Project

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Updated June 29, 2022

Percentage of Patients that had at least one blank REaL Demographic Field

	2019	2020	2021	Goal	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	YTD*
Total Patients					162,264	149,934	161,112	154,463	158,164								277,814
ALL SYSTEM LOCATIONS	6.5%	6.1%	5.4%	3.00%	2.4%	2.1%	2.2%	2.2%	1.9%								3.0%
BRONSON METHODIST HOSPITAL	7.0%	6.5%	6.1%	3%	2.7%	2.4%	2.5%	2.5%	2.1%								3.5%
BRONSON BATTLE CREEK	4.8%	4.8%	3.8%	3%	1.5%	1.3%	1.3%	1.2%	1.3%								1.8%
BRONSON LAKEVIEW HOSPITAL	3.0%	3.3%	3.0%	3%	1.3%	2.0%	1.8%	1.5%	1.0%								1.5%
BRONSON SOUTH HAVEN HOSPITAL	8.6%	7.7%	5.5%	3%	2.7%	1.0%	1.2%	1.4%	1.8%								2.7%

Number of Patients that had an Unknown or Patient Refused Race field with an actual race

	2019	2020	2021	Goal	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	YTD*
ALL SYSTEM LOCATIONS	1065	1096	10635		1,973	1,635	1,815	1,688	1,532								4,400
BRONSON METHODIST HOSPITAL	837	845	8309		1,633	1,409	1,563	1,441	1,261								3,699
BRONSON BATTLE CREEK	133	145	1434		201	122	66	56	168								421
BRONSON LAKEVIEW HOSPITAL	41	53	326		61	61	37	34	45								125
BRONSON SOUTH HAVEN HOSPITAL	54	53	566		78	43	149	157	58								155

Number of Patients that had at least one blank REaL Demographic Field

	2019	2020	2021	Goal	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	YTD*
ALL SYSTEM LOCATIONS	20,698	23,785	21,004		3,890	3,111	3,576	3,361	3,015								8,459
BRONSON METHODIST HOSPITAL	16,211	18,256	16,618		3,194	2,630	3,026	2,832	2,510								7,098
BRONSON BATTLE CREEK	2,317	3,113	2,489		356	146	156	137	283								744
BRONSON LAKEVIEW HOSPITAL	654	917	901		166	118	115	87	114								303
BRONSON SOUTH HAVEN HOSPITAL	1,510	1,497	996		174	217	279	305	108								314

Total Number of Patients

	2019	2020	2021	Goal	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	YTD*
ALL SYSTEM LOCATIONS	318,897	391,526	386,509		162,264	149,934	161,112	154,463	158,164								277,814
BRONSON METHODIST HOSPITAL	231,018	279,353	271,798		119,701	111,279	120,169	115,295	118,203								203,950
BRONSON BATTLE CREEK	48,109	64,714	66,231		23,497	11,440	11,903	11,433	21,896								41,941
BRONSON LAKEVIEW HOSPITAL	22,135	28,008	30,289		12,584	6,037	6,482	5,993	11,948								20,425
BRONSON SOUTH HAVEN HOSPITAL	17,559	19,447	18,191		6,482	21,178	22,558	21,742	6,117								11,498

*YTD is not a sum of all months as it takes out the duplicates from month to month. It is the true YTD of unique patients

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Expanding Ethnicity Field

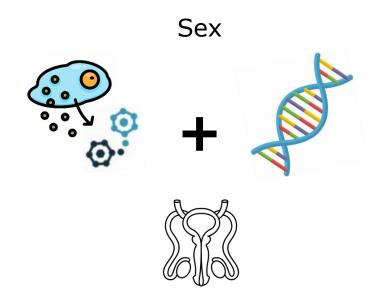
No new values in "Ethnicity" field
- Update Latino/a to Latinx

Add "Regional or Ethnic Background" field
- All options are new and based on Bronson specific language volume and/or research
- Not required field
- This field does not impact
- Enables the hospital to learn from the patient what is most meaningful to them in how they identify their ethnicity

Sex and Gender: What is the difference?

Sex

Gender

Combination of chromosomes, production of and response to hormones, and anatomy

A culture-dependent term that links societal norms, behaviors and expectations with specific sexes. Gender varies across cultures

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Legal Sex is really <u>legal gender</u>, it is the social and administrative information reflecting a person's gender identity and used to identify the person in formal contexts
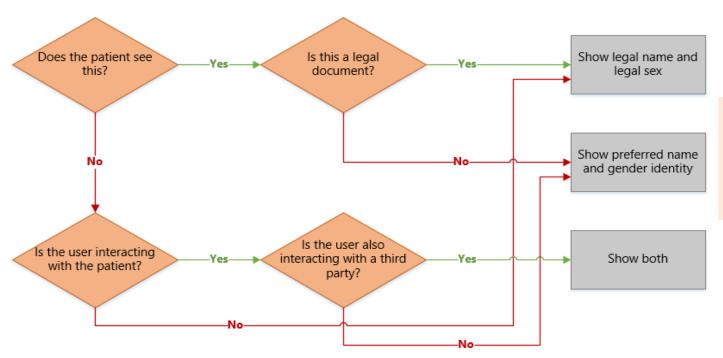
Biological Sex reflects the full pathophysiology of the individual (chromosomes, hormones & anatomy) but for most people the complete picture is assumed or unknown

Sex Assigned at Birth (external anatomy) is not the complete picture of person's biological sex but it is the best information available, at this time, to drive clinical decision making

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Note: The use of the term 'preferred name' is no longer considered an inclusive language best practice. The term 'Chosen name' is considered best practice, at this time.

Third party is defined as a person, program or software that functions in a supportive or care coordination capacity. This includes handoff of care between primary care teams and clinical support services. This also includes software systems and programs outside of primary EHR.

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Sex and Gender Standard Work: 18+

Role	Information Documented/Reviewed
Registration/Central Scheduling/Front desk personnel *Sex and Gender information should NOT be asked at registration. Exception: legal information and chosen name*	At the time of scheduling/registration: ○ Chosen Name ○ Legal Name ○ Legal Sex
Clinical Staff: RN/MA/LPN	When 'rooming' the patient (ambulatory) or during nursing admission assessment (inpatient): ○ Chosen Name ○ Legal Name ○ Pronouns ○ Sex Assigned at Birth ○ Legal Sex (Legal Gender) ○ Gender Identity ○ Sexual Orientation
Clinician: MD/DO/NP/PA/APP	○ Use the patient's sex and gender to determine individualized best practice, as applicable ○ Document organ inventory information ○ Document gender affirming steps/therapies, as applicable ○ Provide patient education on sex and gender in healthcare, when applicable.

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Sex and Gender Standard Work: 13-17 years old

Role	Information Documented/Reviewed
Registration/Central Scheduling/Front desk personnel *Sex and Gender information should NOT be asked at registration. Exception: legal information and chosen name*	At the time of scheduling/registration: ○ Chosen Name ○ Legal Name ○ Legal Sex (Legal Gender)
Clinical Staff: RN/MA/LPN	When 'rooming' the patient (ambulatory) or during nursing admission assessment (inpatient): confirm below information ○ Chosen Name ○ Legal Name ○ Utilize known information for respectful interactions
Clinician: MD/DO/NP/PA/APP/PhD *For safety and privacy considerations of adolescents, sex and gender information should only be documented with the consent of the adolescent. Engage Risk Management and Compliance teams to ensure Cures Act compliance and patient safety risk mitigation.*	**Provider (MD/DO/NP/PA/APP/PhD) driven conversation and documentation process**: ○ Chosen name (confirm) ○ Pronouns used ○ Gender Identity ○ Sex Assigned at Birth ○ Sexual Orientation, based on clinical situation ○ Use the patient's sex and gender to determine individualized best practice, as applicable ○ Document organ inventory information ○ Document gender affirming steps/therapies, as applicable ○ Provide patient education on sex and gender in healthcare, when applicable.

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Patient Experience Data

What have we learned from the pilot?

"Were you treated with dignity and respect?"

Treated with Dignity and Respect (Appendix, 9-10):
BMG= 98.8% "yes"
ED=   93.2% "yes"
N size= 42,154

Top Option Selected (Appendix, 11):
✓ Disability
✓ Age

Race (Appendix, 14-15):
non-white patients have higher percentage of not feeling respected

Age (Appendix, 16):
18-34 year old patients report feelings of less respect and dignity

SOGI (Appendix, 12-13):
Sexual Orientation
Patients identifying as "Something Else/Other" report the highest percentage of "no"
Gender Identity
Non-binary patients answered "no" 11% compared to Male patients answering "no" <1%

Comments (Appendix, 18-21):
• pain
• waiting
• dismissive/lack of empathy
• privacy and confidentiality

Note:
Data from Press Ganey (PG) Patient Surveys from visits Oct 20-Sep 21, unless noted
N sizes vary between demographics, but all valid statistical sample
Demographics from EPIC fields
Sexual Orientation & Gender Identity(SOGI): nearly one-third patients have these fields populated

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Multimodal approach:

- Computer-based learning modules

- Knowledge Sharing Documents

- Presentations to executives, leaders and clinicians

- Presentations at performance improvement committee meetings

- Lunch 'n Learn sessions with front line staff

- Equity Newsletter (with raffle prizes for engagement)

- Trusted external resources shared internally: National LGBTQIA+ Health Education Center

- Scripting documents (general and scenario/dept specific)

- System Intercultural Competency plan: 5 part program for staff
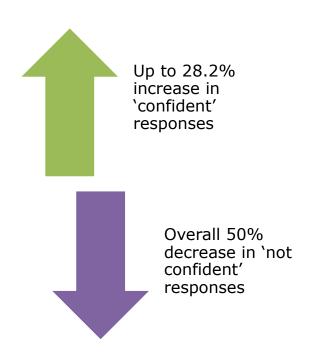
REaL Data Collection

SOGI Data Collection

Language Services

Equity of Care

Implicit Bias

Sex and Gender

Race and Ethnicity

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Assess Learning

Pre/Post survey paired with the required SOGI data collection module to assess effectiveness of learning by measuring level of confidence across 6 learning objectives:

- Workday learning module focuses on culturally humble data collection practices for sexual orientation and gender identity and LGBTQ+ population disparities

- Data was captured on a Likert scale using the following dimensions: Not at all confident, Not so confident, Somewhat confident, Very confident, and Extremely confident.

- Learning assessment showed positive results: overall 1.9% - 28.2% increase in level of confidence; 50% decrease in *Not at all confident* and *Not so confident* responses

- Post survey open-ended feedback was consistently appreciative and eager for more learning

Up to 28.2% increase in 'confident' responses

Overall 50% decrease in 'not confident' responses

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Thank you!

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Hospital Inpatient Quality Reporting Program

Laura Appel, Executive Vice President, Government Relations & Public Policy, Michigan Health & Hospital Association

Monica Trevino, Director, Center for Social Enterprise, MPHI

Funded by:

3 New Equity-Focused Measures

To address health care disparities in hospital inpatient care and beyond, CMS is adopting three health equity-focused measures in the IQR Program.

1. Screening for Social Drivers of Health

2. Screen Positive Rate for Social Drivers of Health

3. Hospital Commitment to Health Equity

Specifications: https://qualitynet.cms.gov/inpatient/iqr/resources

Screening for Social Drivers of Health

Finalized: CY2023 Reporting Period   Reporting Mechanism: Hospital Quality Reporting (HQR) System

Description: Whether a hospital implements screening for all patients that are 18 years or older at time of admission.

Measure Numerator: The numerator consists of the number of patients admitted to an inpatient hospital stay who are 18 years or older on the date of admission and are screened for one or all of the HRNS during their hospital stay.

Measure Denominator: The denominator consists of the number of patients who are admitted to a hospital inpatient stay and who are 18 years or older on the date of admission.

Health Related Social Needs:

- **Food**
- **Housing**
- **Transportation**
- **Utilities**
- **Interpersonal Violence**

Screen Positive Rate for Social Drivers of Health

Description: percent of patients admitted for an inpatient hospital stay and who are 18 years or older on the date of admission, were screened for an HSRN, and who screen positive for one or more of the five HRSNs.

Measure Numerator: Number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, who were screened for an HSRN, and who screen positive for having a need in one or more of the following five HRSNs (calculated separately)

Measure Denominator: Number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission and are screened for an HSRN

Health Related Social Needs:

- **Food**
- **Housing**
- **Transportation**
- **Utilities**
- **Interpersonal Violence**

Hospital Commitment to Health Equity

Finalized: CY2023 Reporting Period   **Reporting Mechanism: QualityNet Portal**

 This structural measure assesses hospital commitment to health equity using a suite of equity-focused organizational competencies aimed at achieving health equity for these populations:

- Racial and ethnic minority groups
- People with disabilities
- Members of the lesbian, gay, bisexual, transgender and queer (LGBTQ+) community

- Individuals with limited English proficiency
- Rural populations
- Religious minorities
- People living near or below poverty level

Hospital Commitment to Health Equity

Finalized: CY2023 Reporting Period   **Reporting Mechanism: QualityNet Portal**

This measure includes five attestation-based questions, each representing a separate domain of commitment. Hospitals receive one point for each domain to which they attest "yes," stating they are meeting the required competencies.

Domain 1: Equity is a strategic priority

Domain 2: Data Collection

Domain 3: Data Analysis

Domain 4: Quality Improvement

Domain 5: Leadership Engagement

Hospital Commitment to Health Equity

Domain 1: Equity is a Strategic Priority
Hospital commitment to reducing healthcare disparities is strengthened when equity is a key organizational priority. Please attest that your hospital has a strategic plan for advancing healthcare equity and that it includes all of the following elements. Select all that apply (note: attestation of all elements is required in order to qualify for the measure numerator):

Our hospital strategic plan:

A.   Identifies priority populations who currently experience health disparities.
B.   Identifies healthcare equity goals and discrete action steps to achieving these goals.
C.   Outlines specific resources which have been dedicated to achieving our equity goals.
D. Describes our approach for engaging key stakeholders, such as community-based organizations.

Hospital Commitment to Health Equity

Domain 2: Data Collection
Collecting valid and reliable demographic and social determinant of health data on patients served in a hospital is an important step in identifying and eliminating health disparities. Please attest that your hospital engages in the following activities. Select all that apply (note: attestation of all elements is required in order to qualify for the measure numerator):

Our hospital:
A. Collects demographic information, including self-reported race and ethnicity, and/or social determinant of health information on the majority of our patients.
B. Has training for staff in culturally sensitive collection of demographic and/or social determinant of health information.
C. Inputs demographic and/or social determinant of health information
D. collected from patients into structured, interoperable data elements using a certified EHR technology.

Hospital Commitment to Health Equity

Domain 3: Data Analysis

Effective data analysis can provide insights into which factors contribute to health disparities and how to respond. Please attest that your hospital engages in the following activities. Select all that apply (note: attestation of all elements is required in order to qualify for the measure numerator):

A. Our hospital stratifies key performance indicators by demographic and/or social determinants of health variables to identify equity gaps and includes this information on hospital performance dashboards.

Hospital Commitment to Health Equity

Domain 4: Quality Improvement

Health disparities are evidence that high quality care has not been delivered equally to all patients. Engagement in quality improvement activities can improve quality of care for all patients. Select all that apply (note: attestation of all elements is required in order to qualify for the measure numerator):

A. Our hospital participates in local, regional, or national quality improvement activities focused on reducing health disparities.

Hospital Commitment to Health Equity

Domain 5: Leadership Engagement

Leaders and staff can improve their capacity to address disparities by demonstrating routine and thorough attention to equity and setting an organizational culture of equity. Please attest that your hospital engages in the following activities. Select all that apply (note: attestation of all elements is required in order to qualify for the measure numerator):

A. Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews our strategic plan for achieving health equity.
B. Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews key performance indicators stratified by demographic and/or social factors.

Questions?