Advancing Health Equity

Mollie O’Brien, MA
September 2017
The filters on this sheet are divided into two groups to allow you to compare patient populations. Filters you make on other sheets do not carry over to this sheet.

**Filter:** Choose filters from the "A" side (blue/left), then choose filters from the "B" side (red/right) to compare patients from different measures, months, clinics, etc.

**Analyze:** To create a meaningful analysis, make sure that only one filter differs between A and B.

**Export:** To export the charts, take a screenshot using Windows' Snipping Tool, and be sure to include the Selected A and B Filters boxes for reference.

### A Filters: Clear All
- **Measure and Date Filters**
  - **Measure:**
    - Colorectal Cancer Screening
  - **Month Year:**
    - Jan 2015
    - Mar 2015
    - May 2015

- **Location Filters**
  - **Clinic Group:** Allina Health Clinic
  - **Region:**
  - **Local:**
  - **Revenue Location:**

- **Provider Filters**
  - **Provider:**
  - **Provider Type:**
  - **Provider Specialty:**

- **Patient Coverage Filters**
  - **Financial Class:**
  - **Payer:**
  - **Benefit Plan:**
  - **Next Generation ACO:**
  - **BluePrint ACO:**
  - **Allina IHP ACO:**
  - **Courage Kenny IHP:**

- **Patient Demographics**
  - **Age:**
  - **Age Range:**
  - **Sex:**
  - **Race Category:** White
  - **Combined Race Category:** White
  - **Ethnic Group Category:** Not Hispanic/Not Latino
  - **Language Major Category:** English
  - **Country of Origin:**
  - **Zip Code:**
  - **American Indian or Alaska Native:** N
  - **Asian:** N
  - **Black or African American:** N
  - **Native Hawaiian or Other Pacific Islander:** N
  - **White:** N
  - **Comparison Population:**
  - **General Disparity Population:**

### B Filters: Clear All
- **Measure and Date Filters**
  - **Measure:** Colorectal Cancer Screening
  - **Month Year:**
    - Jan 2015
    - Mar 2015

- **Location Filters**
  - **Clinic Group:** Allina Health Clinic
  - **Region:**
  - **Local:**
  - **Revenue Location:**

- **Provider Filters**
  - **Provider:**
  - **Provider Type:**
  - **Provider Specialty:**

- **Patient Coverage Filters**
  - **Financial Class:**
  - **Payer:**
  - **Benefit Plan:**
  - **Next Generation ACO:**
  - **BluePrint ACO:**
  - **Allina IHP ACO:**
  - **Courage Kenny IHP:**

- **Patient Demographics**
  - **Age:**
  - **Age Range:**
  - **Sex:**
  - **Race Category:** Black or African American
  - **Combined Race Category:** Black or African American
  - **Ethnic Group Category:**
  - **Language Major Category:**
  - **Country of Origin:**
  - **Zip Code:**
  - **American Indian or Alaska Native:** N
  - **Asian:** N
  - **Black or African American:** N
  - **Native Hawaiian or Other Pacific Islander:** N
  - **White:** N
  - **Comparison Population:**
  - **General Disparity Population:**

**Optimal Care Percentage Trended (n=unique patients for all selected months)**

![Optimal Care Percentage Trended Chart](image-url)
Ambulatory Quality

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Measure and Date Filters
- Colorectal Cancer Screening
- Allina Health Clinic
- Arabic, Hmong, Russian, Somali, Spanish
- 2015, 2016, 2017

Location Filters
- Clinic Group: Allina Health Clinic
- Year: 2015, 2016, 2017

Provider Filters
- Provider
- Provider Type
- Provider Specialty

Patient Coverage Filters
- Financial Class
- Payor
- Benefit Plan
- Next Generation ACO
- BluePrint ACO
- Allina IHP ACO
- Courage Kenny IHP

Patient Demographics
- Age
- Age Range
- Sex
- Race Category
- Combined Race Category
- Ethnic Group Category
- Language Major Category
- Country of Origin
- Zip Code
- American Indian or Native Hawaiian or Alaska Native
- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Comparison Population
- General Disparity Population

Optimal Care Percentage Trended (n=unique patients for all selected months)

A Filters (n=189,169)
B Filters (n=2,309)
What Causes Disparities?

Health Outcomes
- Length of Life (50%)
- Quality of Life (50%)

Health Factors
- Health Behaviors (30%)
- Clinical Care (20%)
- Social & Economic Factors (40%)
- Physical Environment (10%)

Policies & Programs
- Tobacco Use
- Diet & Exercise
- Alcohol & Drug Use
- Sexual Activity
- Access to Care
- Quality of Care
- Education
- Employment
- Income
- Family & Social Support
- Community Safety
- Air & Water Quality
- Housing & Transit

County Health Rankings model © 2014 UWPHI
What Causes Disparities?

Figure 3

PATIENT PRESENTS TO THE HEALTH CARE SYSTEM

Challenges navigating the health care system

Barriers to communication and rapport

Lack of follow-through with provider recommendations

Biases in clinical decision-making

DISPARITIES IN HEALTH CARE

Source: Improving quality and Achieving Equity: A Guide for Hospital Leaders. The Disparities Solutions Center, Institute for Health Policy, Massachusetts General Hospital
What Causes Disparities?

Black Hospital Patients Given Cold Shoulder In Disturbing New Study

Doctors used very different body language when interacting with black and white actors who portrayed dying patients.

By David Freeman

Original Investigation
Racial Disparities in Pain Management of Children With Appendicitis in Emergency Departments

Monika K. Goyal, MD, MSCE; Nathan Kuppermann, MD, MPH; Sean D. Cleary, PhD, MPH; Stephen J. Teach, MD, MPH; James M. Chamberlain, MD

Importance Racial disparities in use of analgesia in emergency departments have been previously documented. Further work to understand the causes of these disparities must be undertaken, which can then help inform the development of interventions to reduce and eradicate racial disparities in health care provision.

Vol. 51 No. 1 January 2016  Journal of Pain and Symptom Management

Original Article
Differences in Physicians’ Verbal and Nonverbal Communication With Black and White Patients at the End of Life

Andrea M. Elliott, MD, Stewart C. Alexander, PhD, Craig A. Mescher, MD, Deepika Mohan, MD, MPH, and Amber E. Bamato, MD, MPH, MS

Department of Medicine (A.M.E., C.A.M., A.E.B.); Department of Critical Care Medicine (D.M.), and Center for Research on Health Care (A.E.B.) University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania; and Department of Consumer Sciences (S.C.A.), College of Health and Human Science, Purdue University, West Lafayette, Indiana, USA
What is Health Equity?

• “Health equity means that everyone has a **fair and just opportunity** to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.”

• “reducing and ultimately **eliminating disparities in health and its determinants** that adversely affect excluded or marginalized groups.”

  – RWJF, 2017
Identify Disparities

Data creates the case.

Understand Root Causes

Story creates the cause.

Close the Gap

People create the change.
First they came for the Socialists, and I did not speak out—
Because I was not a Socialist.

Then they came for the Trade Unionists, and I did not speak out—
Because I was not a Trade Unionist.

Then they came for the Jews, and I did not speak out—
Because I was not a Jew.

Then they came for me—and there was no one left to speak for me.

- Martin Niemöller (1892-1984) on display in the Permanent Exhibition of the United States Holocaust Memorial Museum. Niemöller was a Lutheran minister and early Nazi supporter who was later imprisoned for opposing Hitler’s regime.
Identify Disparities

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Close the Gap

People create the change.
REAL Data

Race
Country of Origin
Language
Ethnicity
Barriers to Collecting/Sharing Demographic Data

• Per Allina Survey of Registrants
  – Lack of a private setting
  – Offended patients
  – Lack of knowledge: why is this needed?
  – Confusion between race and ethnicity
  – Registration process is long

• Per MDH Survey of Patients
  – Privacy concern: don’t connect my name with this information (de-identification)
  – How will the socio-demographic information be used?
  – Who will have access to it?
  – When should it be collected? Split response: 39% at check in, 40% in exam room
Current state: An incomplete picture...

- housing instability
- gender identity
- culture
- values & beliefs
- sexual orientation
- financial resource strain
- food insecurity
- environment
- social connectedness
Ambulatory Quality

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Optimal Care Percentage Trended (n=unique patients for all selected months)
Disparities

- **Primary Care**
  - diabetes, hypertension, asthma, pediatric immunizations, depression screening, cancer screening, no show-rates, Primary Care Physician (PCP) assignment.

- **Obstetric Care**
  - breastfeeding, transfusion, post-partum hemorrhage, pre-term delivery, fetal loss.

- **Mental Health**
  - depression screening, depression claims, outpatient follow-up.

- **Emergency Care**
  - ED use, wait times, use of restraints/seclusions.

- **Hospital Care**
  - potentially avoidable hospitalizations for diabetes, CHF, asthma, COPD, pneumonia and depression, readmissions, high-tech imaging claims.

- **Pharmacy Utilization**
Identify Disparities

Data creates the case.

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Story creates the cause.

Close the Gap

People create the change.
Eliminating Racial Disparities in Colorectal Cancer in the Real World: It Took a Village

Stephen S. Grubbs, Delaware Cancer Consortium, Dover; and Helen F. Graham Cancer Center, Newark, DE
Blasa N. Polite, The University of Chicago, Chicago, IL
John Carney Jr, US House of Representatives, Washington, DC
William Bowser, Delaware Cancer Consortium, Dover, DE
Jill Rogers, Delaware Division of Public Health, Dover, DE
Nora Katurakes, Delaware Cancer Consortium, Dover, DE
Paula Hass, Delaware Cancer Consortium, Dover, DE
Electra D. Paskett, College of Medicine and Comprehensive Cancer Center, Indiana University

Program to Improve Colorectal Cancer Screening in a Low-Income, Racially Diverse Population: A Randomized Controlled Trial

Muriel Jean-Jacques, MD, MA
Erin O. Kaltke, MPH
John L. Gillis, PhD
Gabriela Goffia, MS
Elizabeth R. Ryan, EID

METHODS
All adults aged 50 to 80 years who did not have documentation of being up to date with colorectal cancer screening as of December 31, 2009, and who had had at least 2 visits to the community health center in the prior 18 months were randomized to the outreach intervention or usual care. Patients in the outreach group were mailed a colorectal cancer fact sheet and FOBT kit. Patients in the usual care group could be referred for screening during usual clinic visits. The primary outcome was completion of colorectal cancer screening (by FOBT, sigmoidoscopy, or colonoscopy) 4 months after initiation of the outreach protocol. Outcome measures were compared using the Fisher exact test.

RESULTS
Analyses were based on 104 patients assigned to the outreach intervention and 98 patients assigned to usual care. In all, 30% of patients in the outreach group completed colorectal cancer screening during the study period, compared with 5% of patients in the usual care group (P < .001). Nearly all of the screening were by FOBT. The groups did not differ significantly with respect to the percentage of patients making a clinician visit or the percentage for whom a clinician placed an order for a screening test.
Insights from Staff Interpreters

• May be perceived as “shameful” or “sexual”
• Offensive billboards
• May not understand pain medication will reduce discomfort (pain medication may not have been available in home country in previous medical procedures)
• Prep may be seen as a medication
• Concept of “screening” may be unfamiliar. Use “preventing cancer” or “finding cancer”
• Basic needs such as food, housing, bills may take priority
• May not know preventative screening is covered by insurance
• If life expectancy is lower in home country, elders may feel ‘prevention’ is irrelevant
• May be unaware of alternatives to colonoscopy (stool test)
• May feel uncomfortable with opposite sex providers and interpreters
• May believe cancer is God’s will – should not intervene or prevent
• Women may defer decisions to the males in their life (spouse/brother/father)
Identify Disparities

Data creates the case.

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Close the Gap

People create the change.
CRCS Goal

• Improve colon cancer screening rates for minority populations & reduce disparity gap.

• Achieve 2017 Measures of Caring Scorecard Goal = 76.8 % screened by years end.

• As of July 18, 6895/9821 (70.2%) have been screened. To achieve goal, 648 more patients must be screened.
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### Patient Demographics
- **Race Category:** White
- **Ethnic Group Category:** Not Hispanic/Not Latino
- **Language Major Category:** English
- **Country of Origin:**
- **American Indian or Alaska Native:** N
- **Asian:** N
- **Black or African American:** N
- **Native Hawaiian or Other Pacific Islander:** N
- **White:** 27
- **Comparison Population:** N
- **General Disparity:** Y

### Measure and Date Filters
- **Measure:** Colorectal Cancer Screening
- **Month Year:**
- **Year:**

### Provider Filters
- **Provider:**
- **Provider Type:**
- **Provider Specialty:**

### Patient Coverage Filters
- **Financial Class:**
- **Payer:**
- **Benefit Plan:**
- **Next Generation ACO:**
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### Location Filters
- **Clinic Group:** Allina Health Clinic
- **Region:**
- **Locale:**
- **Revenue Location:**

### Measure and Date Filters
- **Measure:**
- **Month Year:**
- **Year:**

### B Filters:
- **Clinic Group:** Allina Health Clinic
- **Language Major:** Russian
- **Category:**
- **Year:** 2015, 2016, 2017
- **Measure:** Colorectal Cancer Screening

### Optimal Care Percentage Trended (n=unique patients for all selected months)

![Graph showing Optimal Care Percentage Trended over time](image-url)

- **A Filters:** n=169,169
- **B Filters:** n=578
Targeted Community Outreach
Somali CRCS Video

https://youtu.be/_NnAnQhR5qU
CRCS Campaign

**Patient-Level Intervention**
- IFOBT Home Test Kits
- Translated Instructions and FAQs
- Personal Phone Calls
- Reinforcement from Care Guides

**Community-Level Intervention**
- Newspaper
- Facebook
- Social Media & Employee Volunteerism Campaign
- Public Access TV
- Radio Call-In
- Allinahealth.org
- In-Person (e.g. faith communities, barber shops, social hubs)

Diversity Reports to Clinic Managers
Culturally-Tailored Messaging from Clinicians
Key Goals

• Increase screening rates by:
  - Providing case for early detection
  - Providing options/choices
  - Addressing real/perceived barriers; alleviating fears
  - Motivating/compelling action

• Evaluate efficacy and results of campaign and contribute to state/national knowledge & best practice via ACS
Key Resource

- National Colorectal Cancer Center Roundtable’s “2017 Communications Guidebook: Recommended Messaging to Reach the Unscreened”

- Includes:
  - Market research
  - Methods for reaching unscreened
  - Tested messaging
  - Templates
Did you know getting screened for colorectal cancer can prevent at least 60% of deaths caused by colorectal cancer? Learn more about your screening options: [http://bit.ly/2heOZv1](http://bit.ly/2heOZv1)

Colon Cancer: Early screening may help you avoid it

Screening to look for colorectal cancer screening doesn't have to be inconvenient, scary, embarrassing, painful or expensive.

[ALLINAHEALTH.ORG](http://www.allinahealth.org)
Employee Volunteerism & Be Fit Programs

What's new in 2017?
In response to participants’ feedback, the Be Fit screening is now an optional part of the 2017 Well-being Program!
Once you’ve completed the online well-being assessment, YOU get to choose how you want to earn points toward your well-being rewards. You’ll have dozens of options personalized to you based on your well-being assessment results, interests and location. Engage in activities that will not only help you enhance your well-being, but also earn you valuable rewards along the way.

What are the rewards for 2017?
The rewards for 2017 include:
• up to $780 in 2018 Be Fit premium credits
• up to $150 in Amazon gift cards
• and entry into drawings for cash prizes.

Browse Rewards to learn which rewards you are eligible to earn, what steps you must take to qualify and how to monitor your progress throughout the year.
Eliminate Targeted Disparities

**Identify Disparities**
- Collect Demographic Data (e.g. Race, Ethnicity, Language)
- Stratify Clinical Quality Outcomes to Identify & Prioritize Disparities

**Understand Root Causes**
- Consult National Literature & Best Practices
- Conduct Chart Reviews
- "Unpack" Disparities & Co-Create Solutions through Authentic Cultural Community Engagement

**Eliminate Targeted Disparities**
- Healthcare-Community Integrated Solutions
  - Implement Test of Change (e.g. Innovation, AATP, QI)
  - Implement Scorecard Goal

*People create the change.*
Health Equity
2017 Strategic Initiatives

STRENGTHEN
Customer Care & Experience

Innovate our care model
1. Primary care team foundation (*Bent*)
2. Frail elderly care model (*Bache-Wiig*)
3. Close clinical disparity gaps (*Sielaff*)
Diversity
Equity-Focused Quality Improvement
Cultural Competency
Diversity
Inclusion

Opportunity Area

Social Determinants of Health
Equity-Focused Quality Improvement
Cultural Competency
Diversity
Inclusion

Overarching Goal
Assess and address non-medical health-related social needs and the underlying social/economic determinants of health
Identify and address disparities in clinical quality outcomes
Address whole person care dimensions of culture, language, sexual orientation, gender identity, ability and SES
Build a diverse work environment and governance that reflects the communities we serve
Cultivate an inclusive culture where all are welcome, all are heard, all are valued and all are contributing to their fullest potential to advance the common good

Outcome Measures

Initiatives

1. 2. 3.
1. 2. 3.
1. 2. 3.
1. 2. 3.
1. 2. 3.
1. 2. 3.

Organizational Construct (and/or Advisory Council)
to support alignment and accountability of goals, strategy, initiative and outcomes across owners