CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

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ADVANCING INTEGRATED HEALTHCARE

2024 Improving Demographic Data Collection in Primary Care to Address Health Disparities Quality Improvement Initiative

Wrap-up Learning Collaborative | December 18th, 2024

Care Transformation Collaborative of RI

Agenda

ADVANCING INTEGRATED HEALTHCARE

Item	Presenter	Time
Welcome	Yolanda Bowes	7:30-7:35 AM
Southcoast Health Stratification Presentation	Katelyn Ferreira	7:35-8:10 AM
Project Updates & Program Overview	Nijah Mangual / Yolanda Bowes	8:10-815 AM
Data Trendlines for Performance	Yolanda Bowes	8:15 – 8:20 AM
Pre & Post Best Practice Assessment Results	Sue Dettling	8:20 – 8:30 AM
Staff Survey Review	Kerri Costa	8:30 – 8:45 AM
Questions/Discussion	Susanne	8:45 – 9:00 AM

Thank you to our funders

United Healthcare

RHODE ISLAND FOUNDATION

Meet our Speaker

Katelyn Ferreira, Southcoast Health

Katelyn Ferreira is the Health Equity Program Manager at Southcoast Health, where she works with care teams and communities to address disparities and promote health access. Katelyn also serves as the co-chair of More Pride Southcoast, an LGBTQ+ Employee Resource Group. Her career has included managing research teams as well as providing direct service to individuals and families impacted by incarceration and involvement with child welfare systems. She is passionate about bridging science, policy, and practice. Katelyn lives in Pawtucket, Rhode Island. She enjoys traveling, camping, crafting, and reading, and is happiest near the ocean.

Katelyn received an MPH from the Harvard T.H. Chan School of Public Health, where she focused on Social Drivers of Health and Disparities and completed a concentration in Women, Gender, and Health. Prior to that, she earned a Bachelor of Arts in Psychology from the University of Massachusetts Amherst. Katelyn is also a proud alumna of the Fulbright Program, through which she spent a year living and working in Malaysian Borneo.

Southcoast Health

Southcoast Cares About My Diabetes:

A Community Collaboration to Advance Equity in Diabetes Management

CTC-RI Demographic Data Collection Quality Improvement Wrap Up Meeting

December 18, 2024

Lauren Melby Nieder, MBA, MPP
Vice President of Population Health

Katelyn Ferreira, MPH
Health Equity Program Manager

More than medicine.

Intro to Southcoast Health

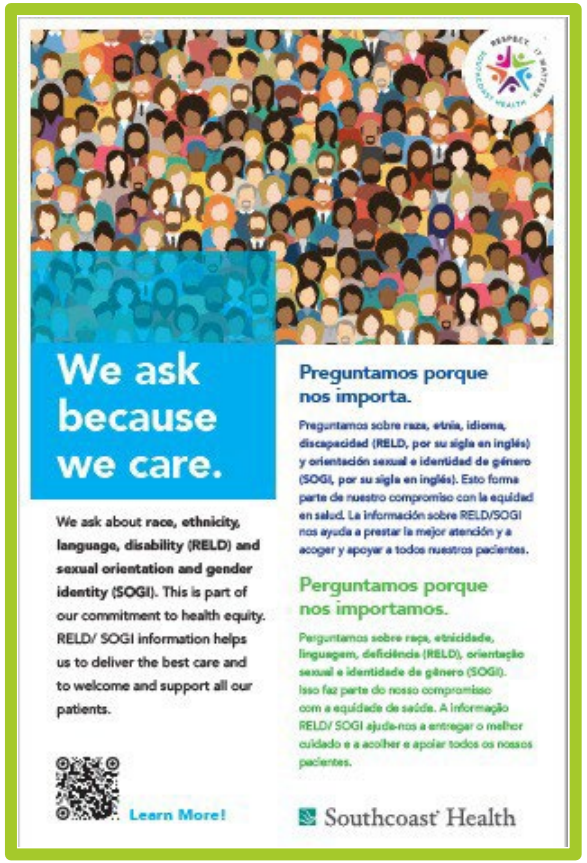
Community-based health system in Massachusetts and Rhode Island

+ Southcoast Hospitals Group (3 hospitals)
+ Southcoast Physicians Group
  + primary care
  + specialty care
  + cancer centers
  + urgent care
+ Southcoast Health at Home
+ Acute inpatient rehabilitation

Health Equity at Southcoast Health

We advance health equity at Southcoast Health by:

1. **Asking** our patients about their race, ethnicity, language, disability, sexual orientation, and gender identity (RELDSOGI) information.
2. **Analyzing** that information to identify disparities.
3. **Acting** to address health disparities through programs like Southcoast Cares About My Diabetes.
4. **Tailoring** care to meet patient needs (e.g., interpreter services, disability-related accommodations).
5. **Screening** patients for Health-Related Social Needs and collaborating with community partners to address them.
6. **Ensuring** that our teams reflect the diversity of our communities, and that we understand how our patients' lives and circumstances impact their care.



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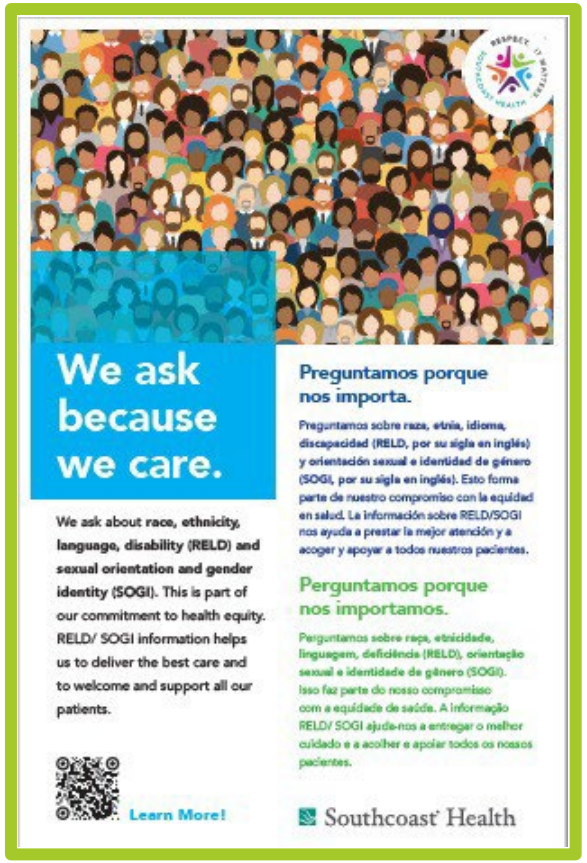


RELDSOGI Data Collection at Southcoast Health

- We have been collecting **race** and **ethnicity** data historically (and made changes in August 2023).
- We began collecting **sexual orientation** and **gender identity** data since August 2022, and we made minor changes in July 2024.
- We began collecting self-reported **disability** data in December 2023.
- Many groups of personnel across the system—e.g., registration, MAs, PARs, service center, providers—are currently collecting this data.
  - Also available in **MyChart**

Southcoast Cares About My Diabetes: Project Overview

Grant info

- Participation in **BCBSMA/IHI's** "Equity Action Community" → awarded $1.7M to address disparities
- **Period:** January 2023 – June 2024
- **Project team:** Southcoast staff from a variety of disciplines, including CHWs, nurses, pharmacists, primary care, endocrinology
- **Partnerships:** Boys & Girls Club, YMCA South Coast

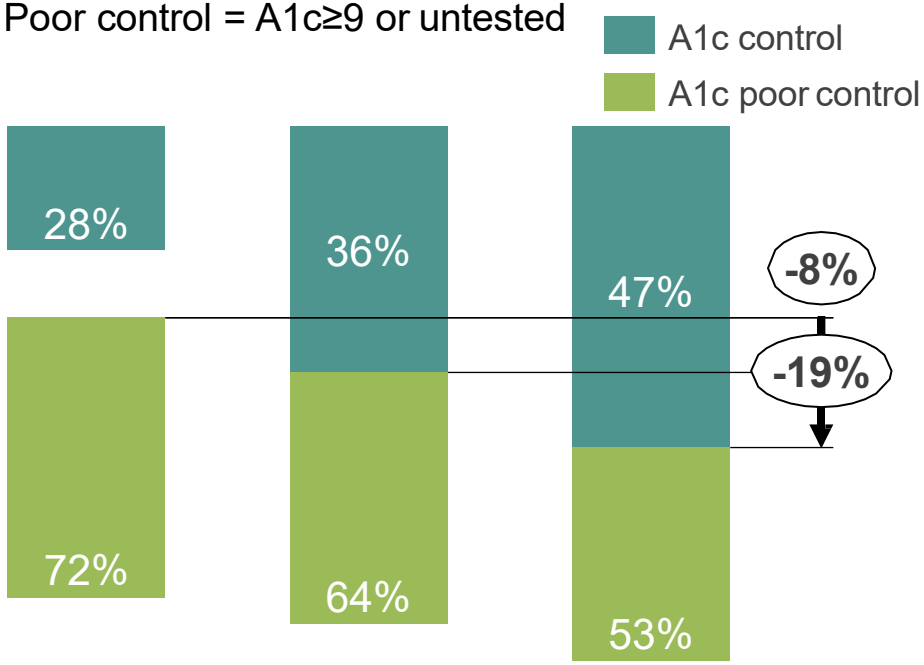
Aims

- Reduce **disparities** in diabetes management and outcomes for our most at risk populations
- Provide a **holistic approach to diabetes management**
- Improve culturally competent race, ethnicity, and language **(REaL)** data collection in Epic

Southcoast Cares About My Diabetes: The Problem

A1c control among patients with diabetes

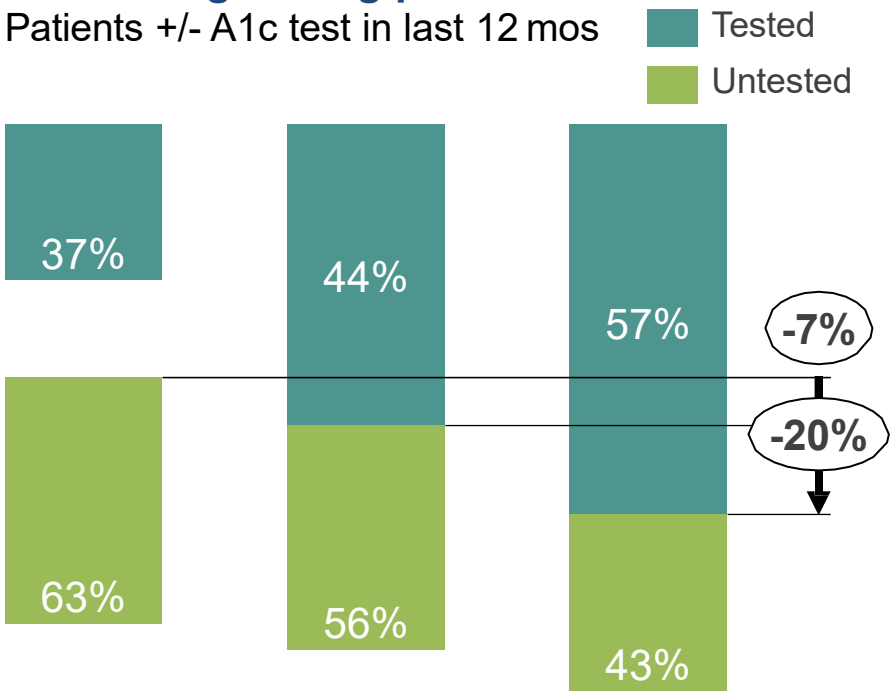
Poor control = A1c≥9 or untested



Hispanic or Latino/a/x/e | Black/ African American (non-Hispanic) | White (non-Hispanic)

A1c testing among patients with diabetes

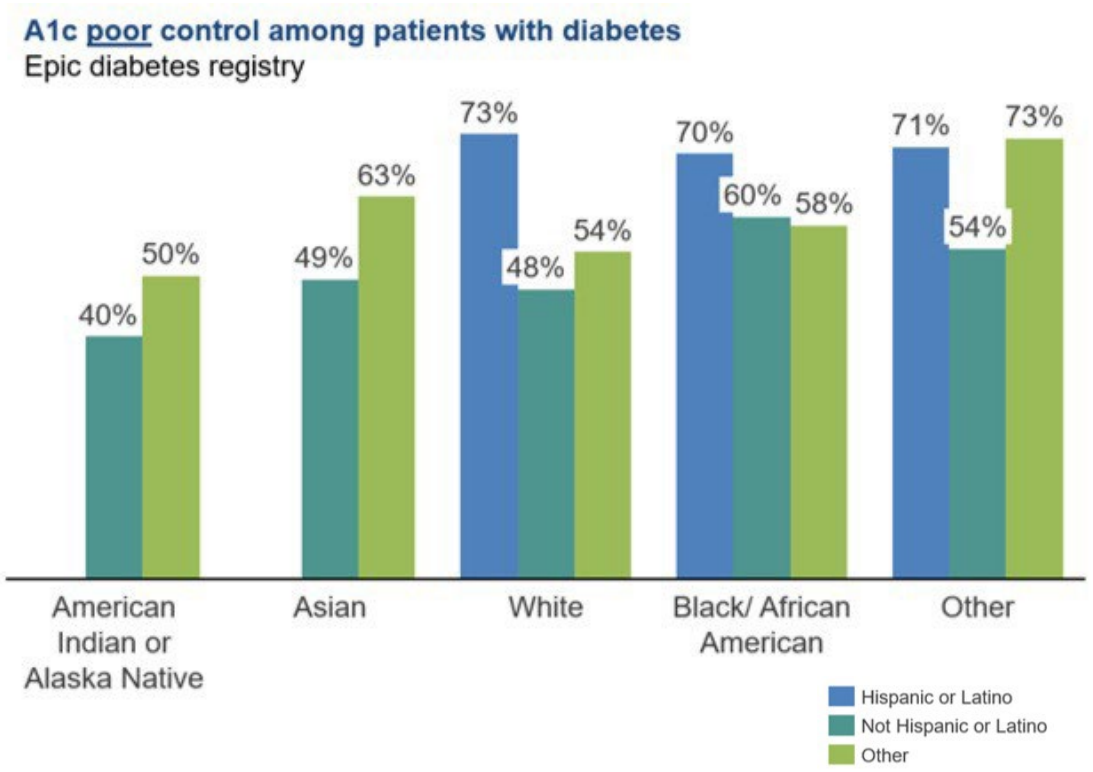
Patients +/- A1c test in last 12 mos

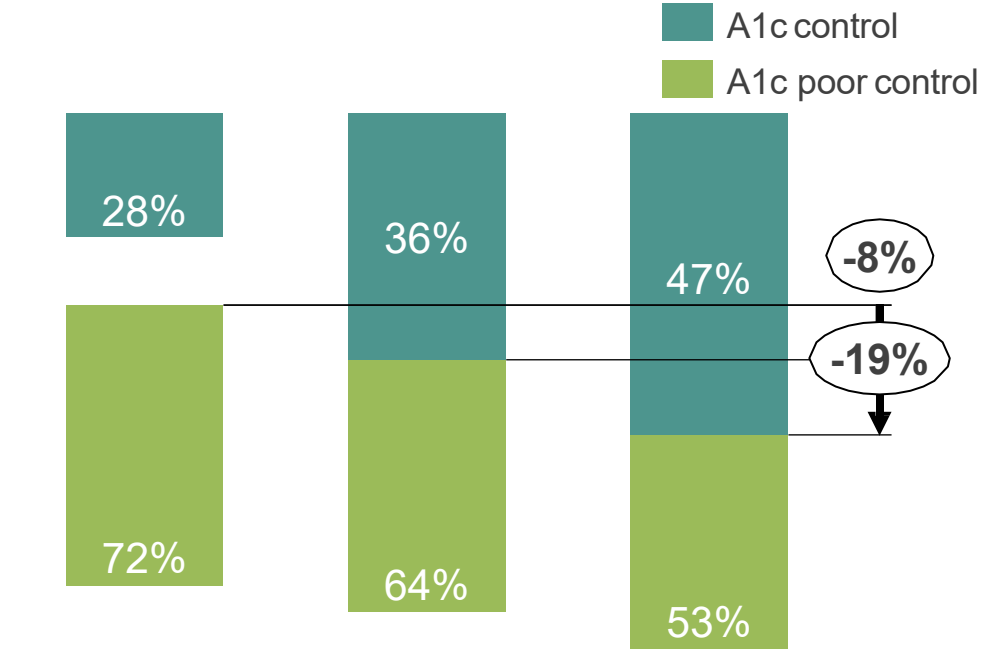


Hispanic or Latino/a/x/e | Black/ African American (non-Hispanic) | White (non-Hispanic)

Southcoast Health

Lessons in Displaying and Sharing Stratified Data





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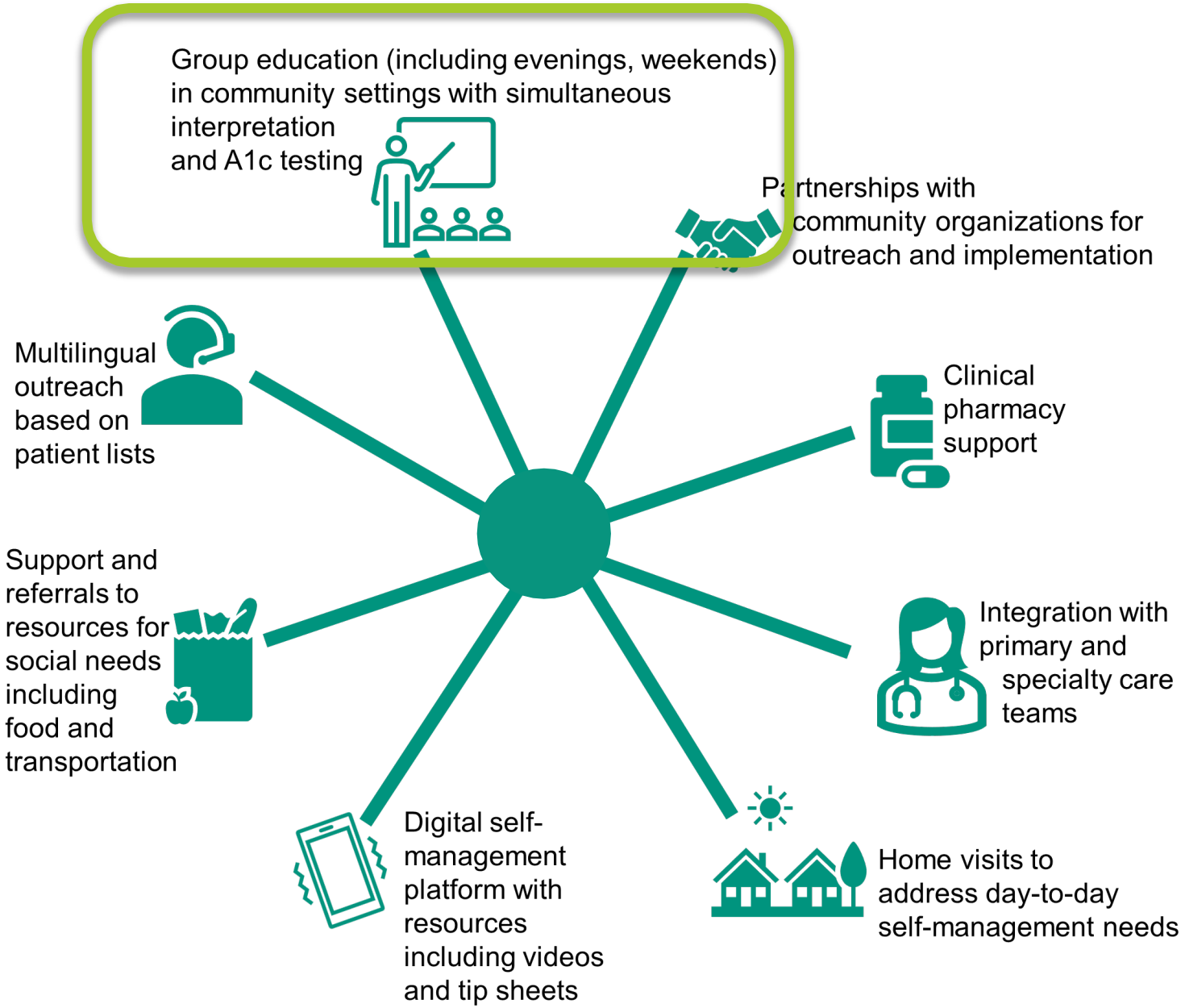
Intervention Components

Intervention Components



Intervention Components

Group education (including evenings, weekends) in community settings with simultaneous interpretation and A1c testing

Partnerships with community organizations for outreach and implementation

Diabetes Education Groups

Roles:

+ CDCES
+ Pharmacy
+ Community Health & Wellness

Logistics:

- In locations with highest numbers of patients in groups experiencing disparities
- Patient preference for both location and time of day (Weekend mornings, weekday evenings)
- Transportation support

Clinical pharmacy

including videos and tip sheets

Southcoast Health

Intervention Components

Group education (including evenings, weekends) in community settings with simultaneous interpretation and A1c testing

Partnerships with community organizations for outreach and implementation

Multilingual outreach based on patient lists

Clinical pharmacy support

Support and referrals to

Integration with primary and specialty care teams

Digital self-management platform with resources including videos and tip sheets

Home visits to address day-to-day self-management needs

Southcoast Health

Intervention Components

Group education (including evenings, weekends) in community settings with simultaneous interpretation and A1c testing

Multilingual outreach based on patient lists

Support and referrals to resources for social needs including food and transportation

English, Spanish, & Portuguese

Digital self-management platform with resources including videos and tip sheets

Home visits to address day-to-day self-management needs

Southcoast Health

Project Outcomes

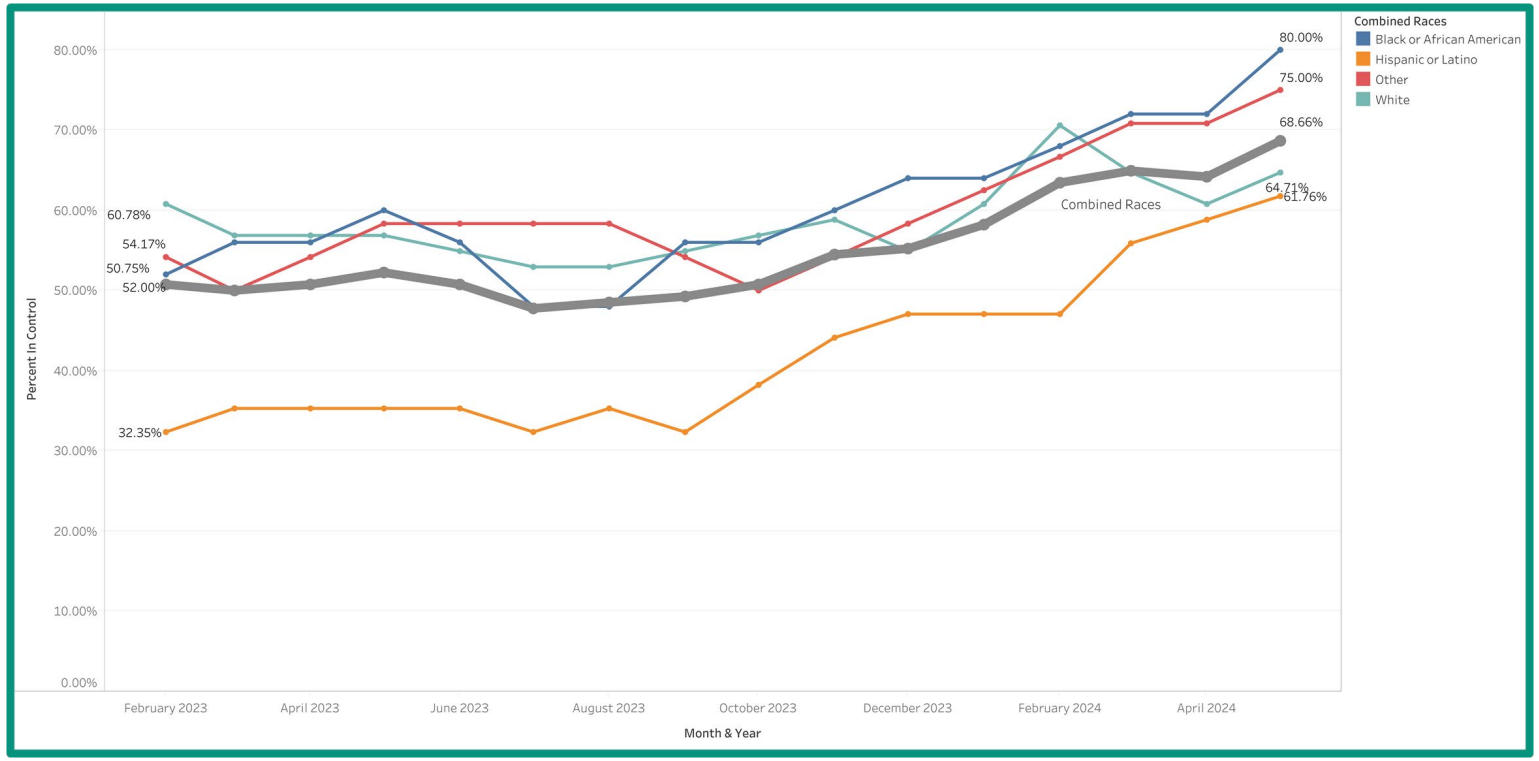
805 patients received outreach

147 patients were engaged

"Very informative concerning label reading and way the pancreas operates."

"I needed to see that Diabetes will win unless I continue to do better. It is necessary to hear other folks' stories… Teaching was done honestly with compassion. I want to do better because I start to feel better… The notebook about Diabetes is so easy to understand. Making it very clear."

% of participants with A1c <9 (vs ≥9 or untested) among engaged participants

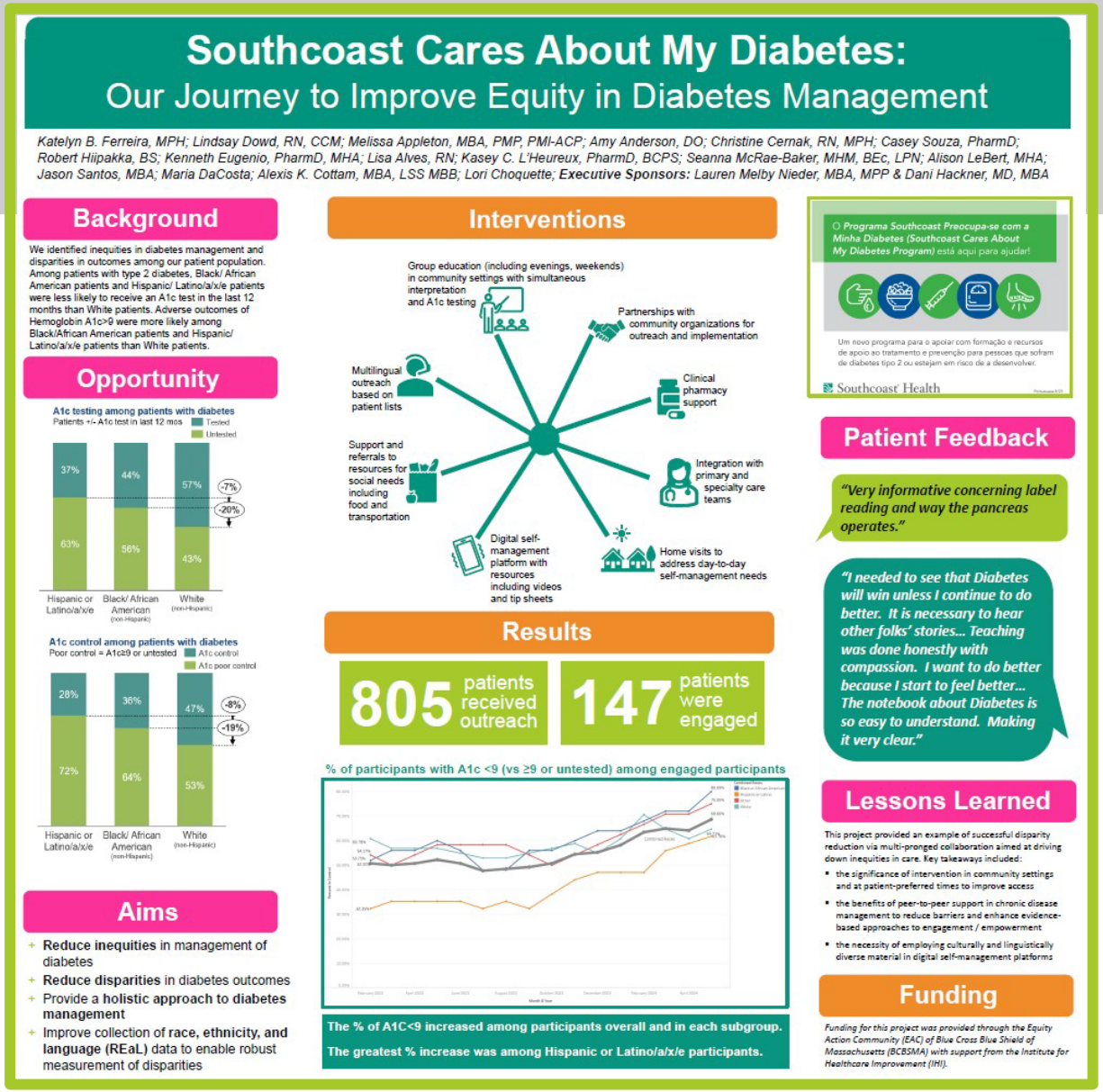


The % of A1C<9 increased among participants overall and in each subgroup.

The greatest % increase was among Hispanic or Latino/a/x/e participants.

Dissemination

We have prioritized peer-to-peer sharing of this work through BCBSMA's Equity Action Community and other venues (e.g., IHI Forum Dec 9-11).



Southcoast Cares About My Diabetes:
Our Journey to Improve Equity in Diabetes Management

Katelyn B. Ferreira, MPH; Lindsay Dowd, RN, CCM; Melissa Appleton, MBA, PMP, PMI-ACP; Amy Anderson, DO; Christine Cernak, RN, MPH; Casey Souza, PharmD; Robert Hiipakka, BS; Kenneth Eugenio, PharmD, MHA; Lisa Alves, RN; Kasey C. L'Heureux, PharmD, BCPS; Seanna McRae-Baker, MHM, BEc, LPN; Alison LeBert, MHA; Jason Santos, MBA; Maria DaCosta; Alexis K. Cottam, MBA, LSS MBB; Lori Choquette; ***Executive Sponsors:*** *Lauren Melby Nieder, MBA, MPP & Dani Hackner, MD, MBA*

Background

We identified inequities in diabetes management and disparities in outcomes among our patient population. Among patients with type 2 diabetes, Black/ African American patients and Hispanic/ Latino/a/x/e patients were less likely to receive an A1c test in the last 12 months than White patients. Adverse outcomes of Hemoglobin A1c>9 were more likely among Black/African American patients and Hispanic/ Latino/a/x/e patients than White patients.

Opportunity

A1c testing among patients with diabetes
Patients +/- A1c test in last 12 mos — Tested / Untested

A1c control among patients with diabetes
Poor control = A1c≥9 or untested — A1c control / A1c poor control

Aims

- **Reduce inequities** in management of diabetes
- **Reduce disparities** in diabetes outcomes
- Provide a **holistic approach to diabetes management**
- Improve collection of **race, ethnicity, and language (REaL)** data to enable robust measurement of disparities

Interventions

Results

805 patients received outreach

147 patients were engaged

% of participants with A1c <9 (vs ≥9 or untested) among engaged participants

The % of A1C<9 increased among participants overall and in each subgroup.

The greatest % increase was among Hispanic or Latino/a/x/e participants.

Patient Feedback

"Very informative concerning label reading and way the pancreas operates."

"I needed to see that Diabetes will win unless I continue to do better. It is necessary to hear other folks' stories... Teaching was done honestly with compassion. I want to do better because I start to feel better... The notebook about Diabetes is so easy to understand. Making it very clear."

Lessons Learned

This project provided an example of successful disparity reduction via multi-pronged collaboration aimed at driving down inequities in care. Key takeaways included:

- the significance of intervention in community settings and at patient-preferred times to improve access
- the benefits of peer-to-peer support in chronic disease management to reduce barriers and enhance evidence-based approaches to engagement / empowerment
- the necessity of employing culturally and linguistically diverse material in digital self-management platforms

Funding

Funding for this project was provided through the Equity Action Community (EAC) of Blue Cross Blue Shield of Massachusetts (BCBSMA) with support from the Institute for Healthcare Improvement (IHI).

Institute *for* Healthcare Improvement

Southcoast Health

Ongoing work and Continued Impact

+ Incorporating lessons learned into ongoing operations

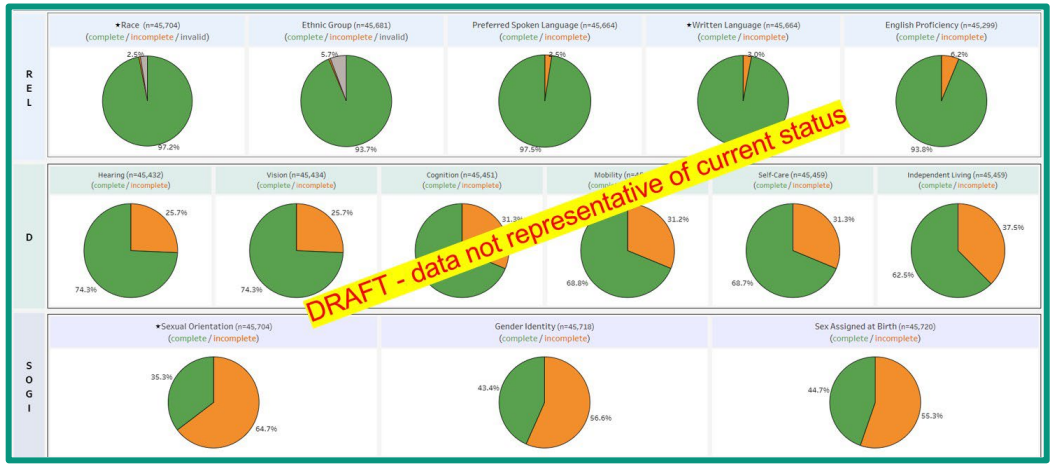
+ Integrating newly created, community-tailored Care Companion content

+ Spread and standardization across healthcare system

+ Continuous improvement of RELDSOGI data collection

+ Monitoring performance across patient population

Populations: patients in primary care, patients in value-based contracts



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Ongoing work and Continued Impact

PRESIDENT'S AWARD for EXCELLENCE

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Lessons Learned

This project represented a new frontier in equity-focused clinical quality improvement intervention for Southcoast.

Our system will carry forward learnings regarding:

- data / dashboarding & stratification
- cross-team collaboration, cross-training, and co-education
- patient-centered intervention design

+ QUESTIONS

+ APPENDIX

Resource Hub

southcoast.sharepoint.com/sites/HealthEquity

+

Key Definitions

What is health equity? Health equity is achieved when everyone can attain their **full potential** for health and well-being. (WHO)

What is a health disparity? Health disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations (CDC). A **healthcare disparity** is a difference between population groups in the way they access, experience, and receive health care. Factors that influence health care disparities include social, economic, environmental, and other disadvantages. (NIH)

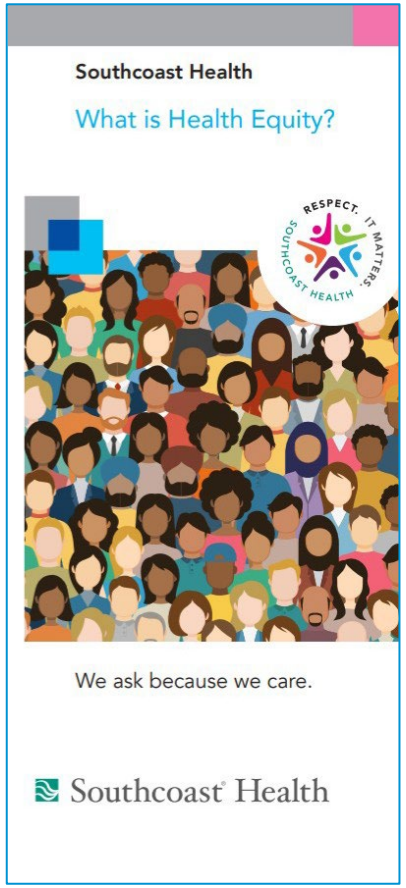
What is a social driver of health? These are the nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age. (CDC) Social determinants of health (SDoH) and Health-Related Social Needs (HRSN) are similar terms that are sometimes used interchangeably.

What is RELDSOGI data? RELDSOGI (sometimes stylized RELD/SOGI or RELD and SOGI) stands for Race, Ethnicity, Language, Disability, Sexual Orientation and Gender Identity. You might also see the abbreviation REaL, which stands for Race, Ethnicity, and Language (a subset of RELDSOGI data).

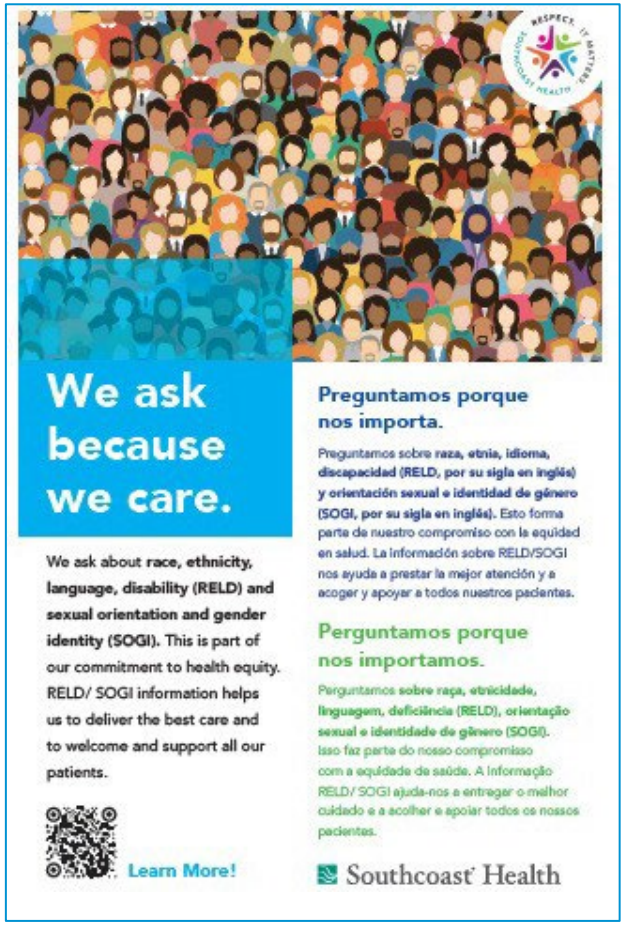
+ Tip sheets
+ Trainings
+ Laminates
+ Tri-folds
+ Posters
+ More!

Example Materials from Health Equity Intranet Site

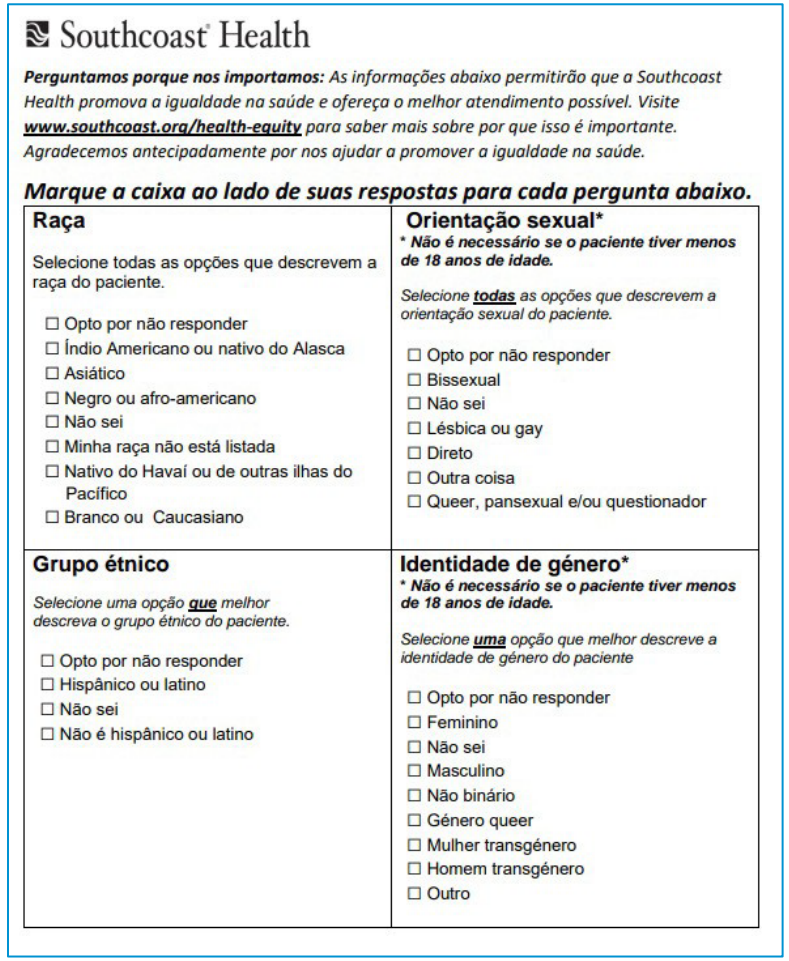
Patient Brochure



Poster



Laminates for data collection



Southcoast Health

Perguntamos porque nos importamos: *As informações abaixo permitirão que a Southcoast Health promova a igualdade na saúde e ofereça o melhor atendimento possível. Visite* ***www.southcoast.org/health-equity*** *para saber mais sobre por que isso é importante. Agradecemos antecipadamente por nos ajudar a promover a igualdade na saúde.*

Marque a caixa ao lado de suas respostas para cada pergunta abaixo.

Raça

Selecione todas as opções que descrevem a raça do paciente.

- ☐ Opto por não responder
- ☐ Índio Americano ou nativo do Alasca
- ☐ Asiático
- ☐ Negro ou afro-americano
- ☐ Não sei
- ☐ Minha raça não está listada
- ☐ Nativo do Havaí ou de outras ilhas do Pacífico
- ☐ Branco ou Caucasiano

Orientação sexual*

**** Não é necessário se o paciente tiver menos de 18 anos de idade.***

Selecione ***todas*** *as opções que descrevem a orientação sexual do paciente.*

- ☐ Opto por não responder
- ☐ Bissexual
- ☐ Não sei
- ☐ Lésbica ou gay
- ☐ Direto
- ☐ Outra coisa
- ☐ Queer, pansexual e/ou questionador

Grupo étnico

Selecione uma opção ***que*** *melhor descreva o grupo étnico do paciente.*

- ☐ Opto por não responder
- ☐ Hispânico ou latino
- ☐ Não sei
- ☐ Não é hispânico ou latino

Identidade de género*

**** Não é necessário se o paciente tiver menos de 18 anos de idade.***

Selecione ***uma*** *opção que melhor descreve a identidade de género do paciente*

- ☐ Opto por não responder
- ☐ Feminino
- ☐ Não sei
- ☐ Masculino
- ☐ Não binário
- ☐ Género queer
- ☐ Mulher transgénero
- ☐ Homem transgénero
- ☐ Outro

+ THANK YOU!

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Project Updates

Care Transformation Collaborative of RI

Project Updates

Milestone Document

January 8, 2024

- All Practices: Program Evaluation Due

https://www.surveymonkey.com/r/DD_QI_Eval

CTC-RI Demographic Data Collection Quality Improvement Initiative - Milestones Summary*
April 2024 - December 2024

Goal: To support primary care practices (pediatric, family medicine and adult medicine) in their efforts to participate in a data driven quality improvement initiative to measure and improve their capture and reporting of accurate and complete demographic data information, which is a foundational step towards reducing health disparities.

*4--9-24 version		
	Important Dates	Notes/Links
Required Meetings		
3 Learning Collaborative Meetings: 1. Kickoff Meeting (90 minutes) 2. Mid-point Meeting (90 minutes) 3. Wrap-up meeting (90 minutes) 8 Monthly Meetings with Practice Facilitator (PF)	1. April 25, 2024 - 7:30 – 9:00 2. September 18, 2024 - 7:30 – 9:00 3. December 18, 2024 - 7:30 – 9:00 Practice Facilitation Meetings to be scheduled monthly with individual practices. May – December2024	All meetings will be virtual; Zoom invitations for Learning Collaborative Meetings will be sent out by CTC In person, Zoom or Go to Meeting invitations for Practice Facilitation Meetings will be sent by Practice Facilitator Sue Dettling or Kerri Costa
Resources Resource Guide MB Announces New Agency Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity OMB Publishes Revisions to Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity		
Assessments		
New Practices: Baseline Needs Assessment: 1. Practice Needs Assessment – Survey Monkey 2. Patient Survey – Survey Monkey & Word Docs 3. Staff Survey – Survey Monkey 4. Walk Around Tool – Word Doc	Start March 20, 2024 Due April 19, 2024	Link to Baseline Needs Assessment Checklist which includes Survey Monkey and Word Doc links
New Practices: Baseline Needs Assessment Information Session	March 26, 2024, 12:00 – 1:00 p.m.	Zoom Link: https://ctc-ri.zoom.us/j/83893659099?pwd=Y29nT0ZLcFFXd09CWGkxZkZ6dUxhZz09
New Practices: Baseline Needs Assessment Information Session	March 27, 2024, 7:30 – 8:30 a.m.	Zoom Link: https://ctc-ri.zoom.us/j/83893659099?pwd=Y29nT0ZLcFFXd09CWGkxZkZ6dUxhZz09
Continuation Practices: Complete Learning Collaborative Best Practice Pre-Assessment (Providing Updates from Pilot Baseline Practice Needs Assessment)	Due April 12, 2024	Demographic Data QI Best Practice Pre-Assessment
New Practices: Submit Attestation for reading Pilot reports and webinar Power Point presentations	Due June 28, 2024	Link to Attestation Document

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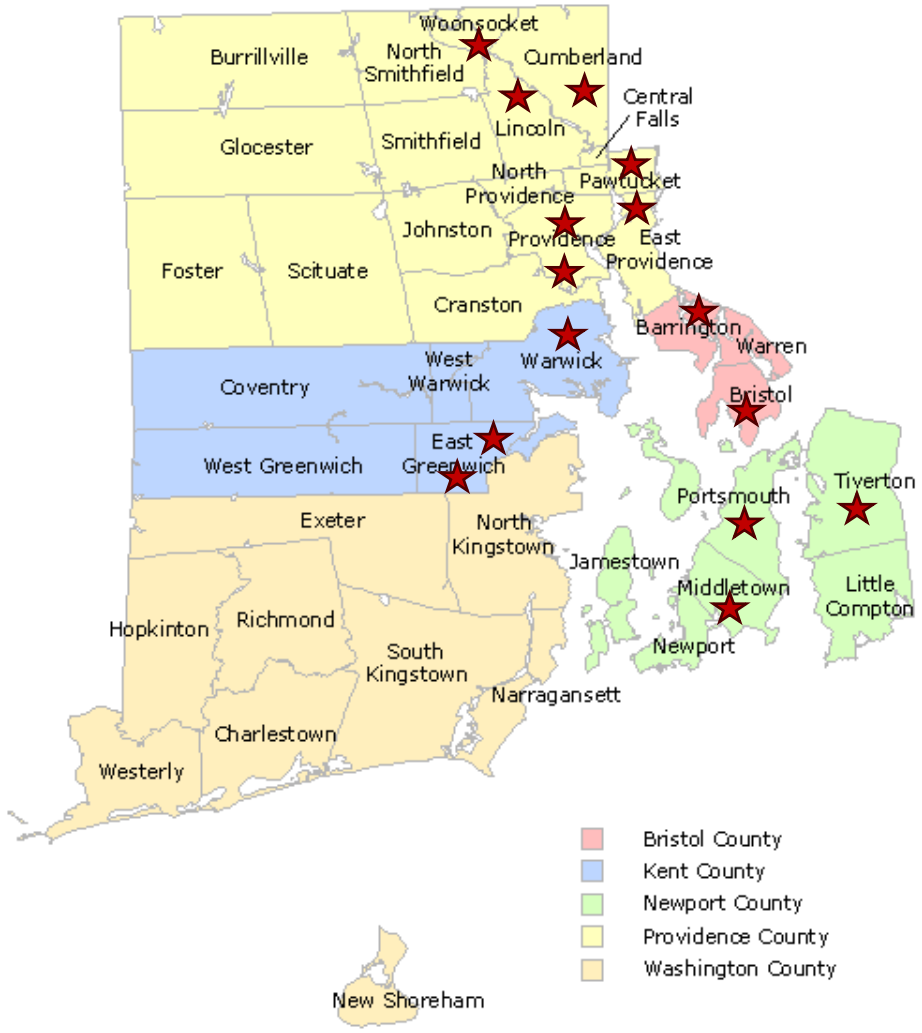
Project Overview

ADVANCING INTEGRATED HEALTHCARE

Goal: Support practice quality improvement teams to identify and implement plans to improve the completeness of their patient demographic data, and a second practice-selected improvement as steps to improving health equity.

- April – December 2024
- Best Practice Assessment
- Staff and Patient Surveys
- Practice Facilitation Support
- Plan Do Study Act/Adjust (PDSA)
  - Improve REL Completeness
  - One Practice Selected Measure
- Build on learning from demographic data pilot

Participating Practices



Returning Demo Pilot Practices

- Concilio Pediatrics - Lincoln
- University Internal Medicine – Pawtucket
- Your Health – East Greenwich

New Practices

- Barrington Pediatrics - Barrington
- Chad Lamendola, MD, Inc – East Greenwich
- Chad Nevola, MD, Ltd - Providence
- Clinica Esperanza/Hope Clinic - Providence
- Medical Associates of RI, Inc - Bristol
- Middletown Family Practice - Middletown
- Northeast Internal Medicine - Pawtucket
- NRI Pediatrics, PC - Cumberland
- Ocean Medical Practice, Inc - Woonsocket
- Pilgrim Park Physicians - Warwick
- Portsmouth Family Practice - Portsmouth
- Tiverton Family Medicine - Tiverton

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ADVANCING INTEGRATED HEALTHCARE

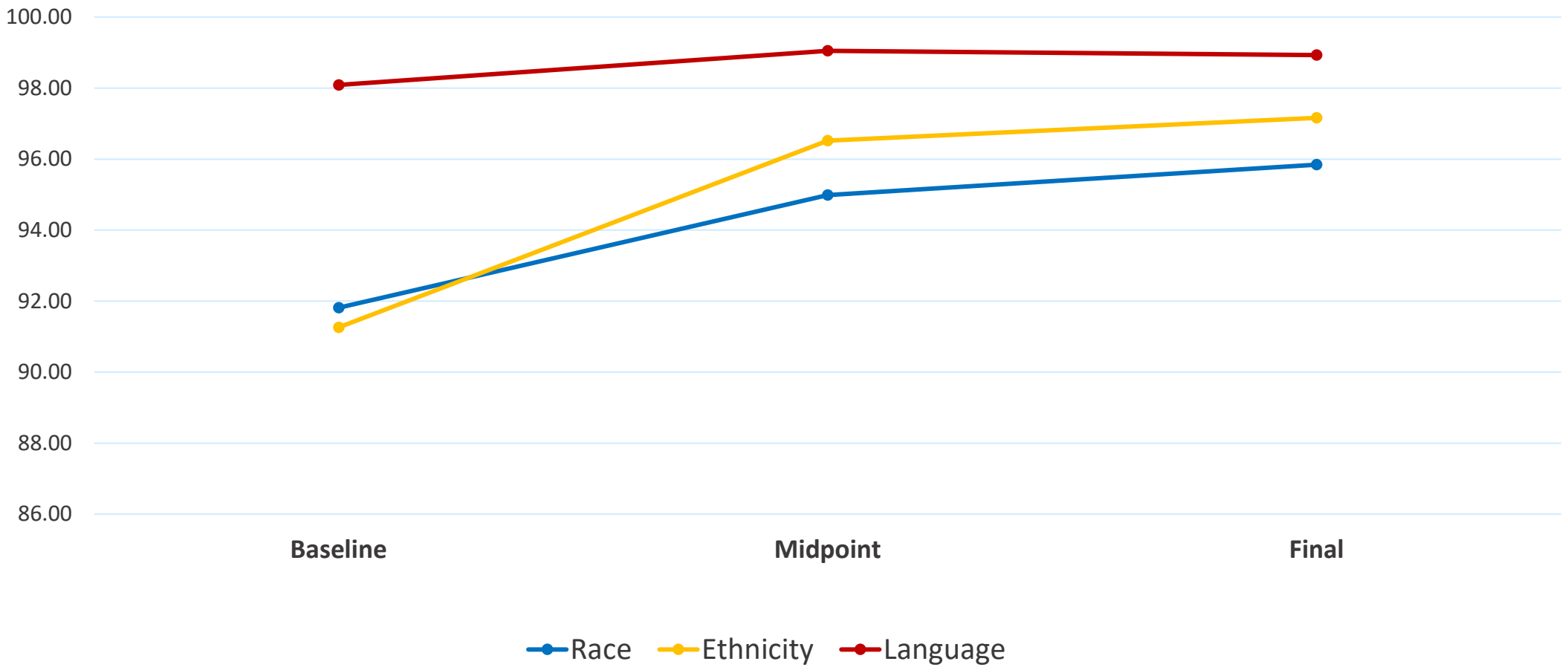
Demographic Data Quality Improvement

REL and SOGI Data Trends

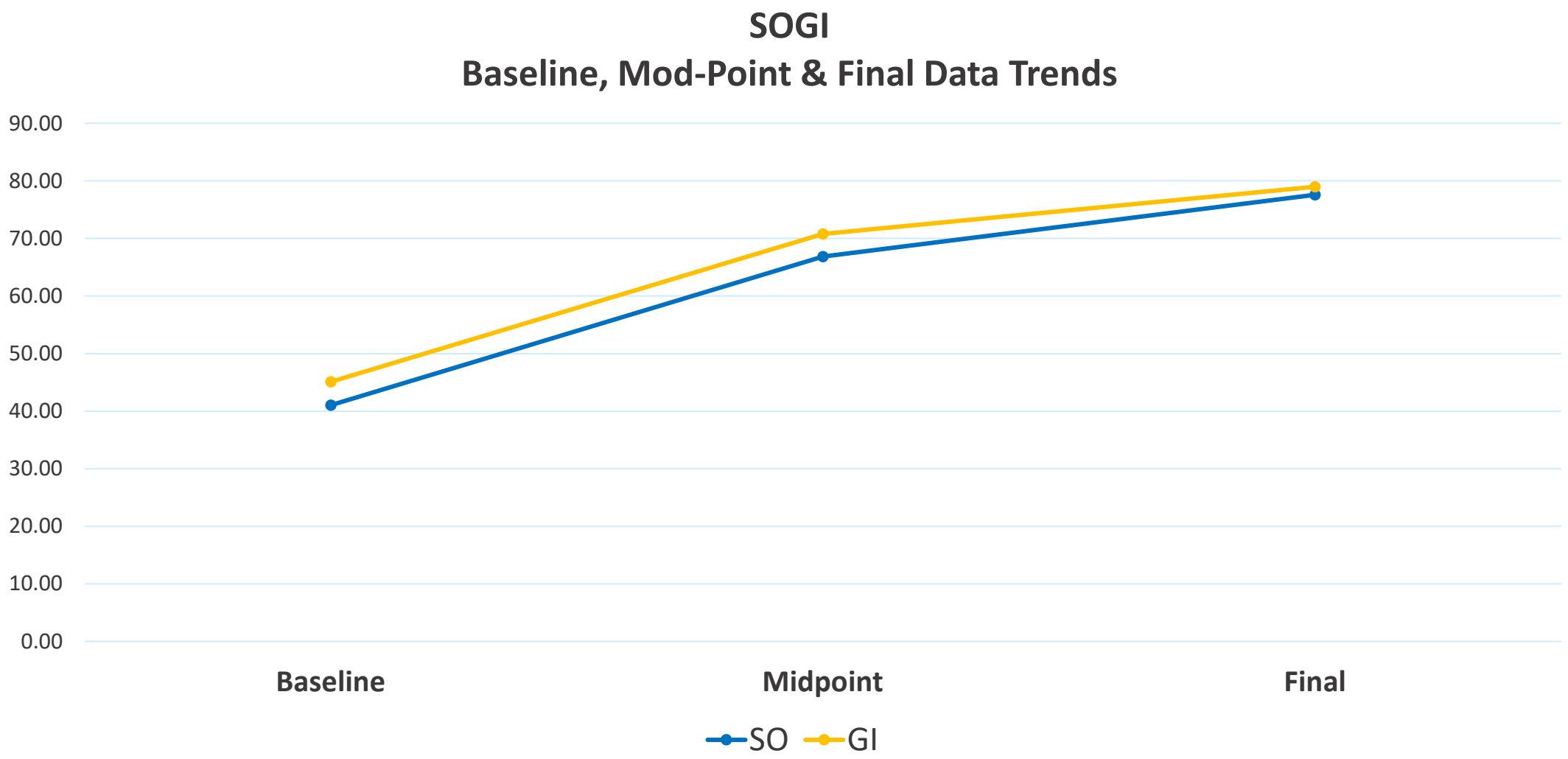
Care Transformation Collaborative of RI

Race, Ethnicity and Language

Race, Ethnicity and Language Baseline, Mid-Point & Final Data



Sexual Orientation & Gender Identity



How did you do it?

- Staff Training
  - SOGI
  - Best Practices
  - Tools and Scripting
- Patient Education
  - Why We Ask
- Changing workflows to increase privacy
  - Providers asking SOGI in exam room
  - Using laminated forms at check in
  - Promoting the patient portal to update information

Resurvey Staff to Assess Improvement

Create or Update Policies

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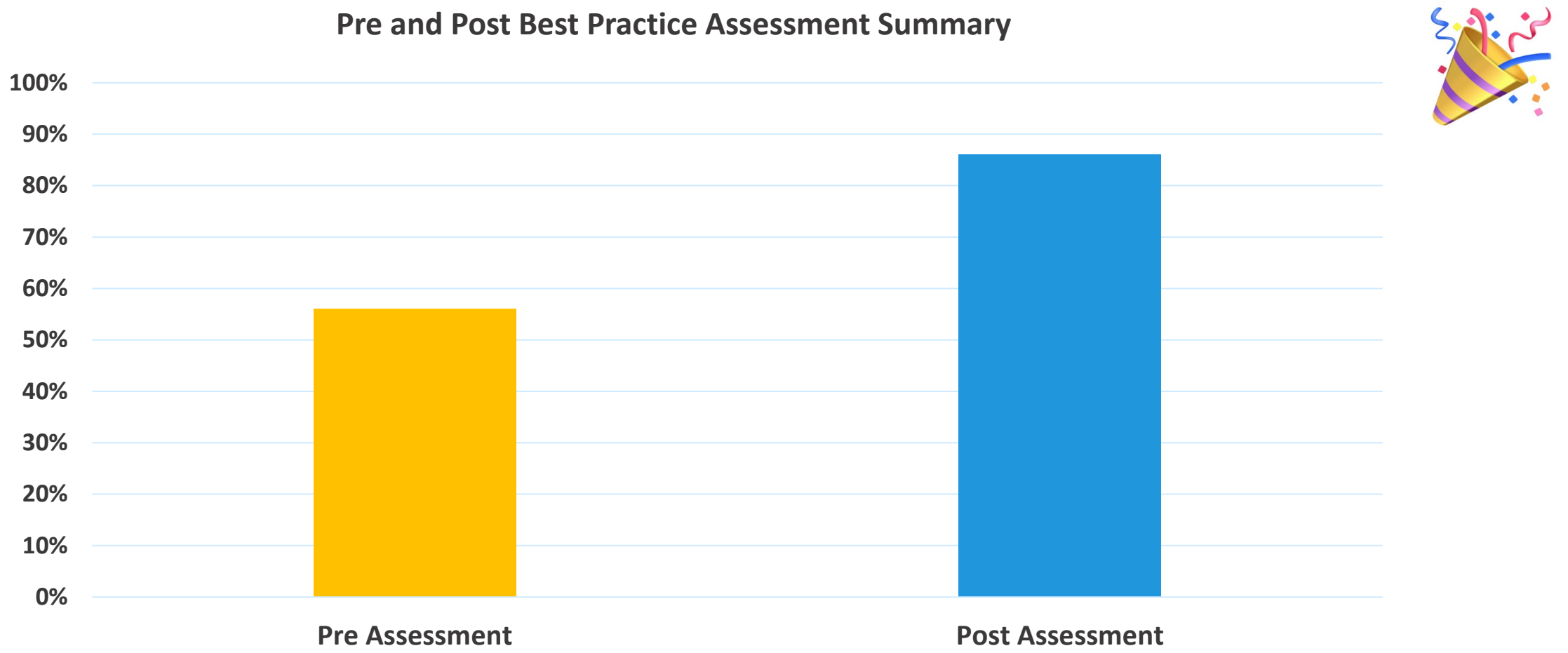
ADVANCING INTEGRATED HEALTHCARE

Demographic Data Quality Improvement

Pre and Post Best Practice Assessments

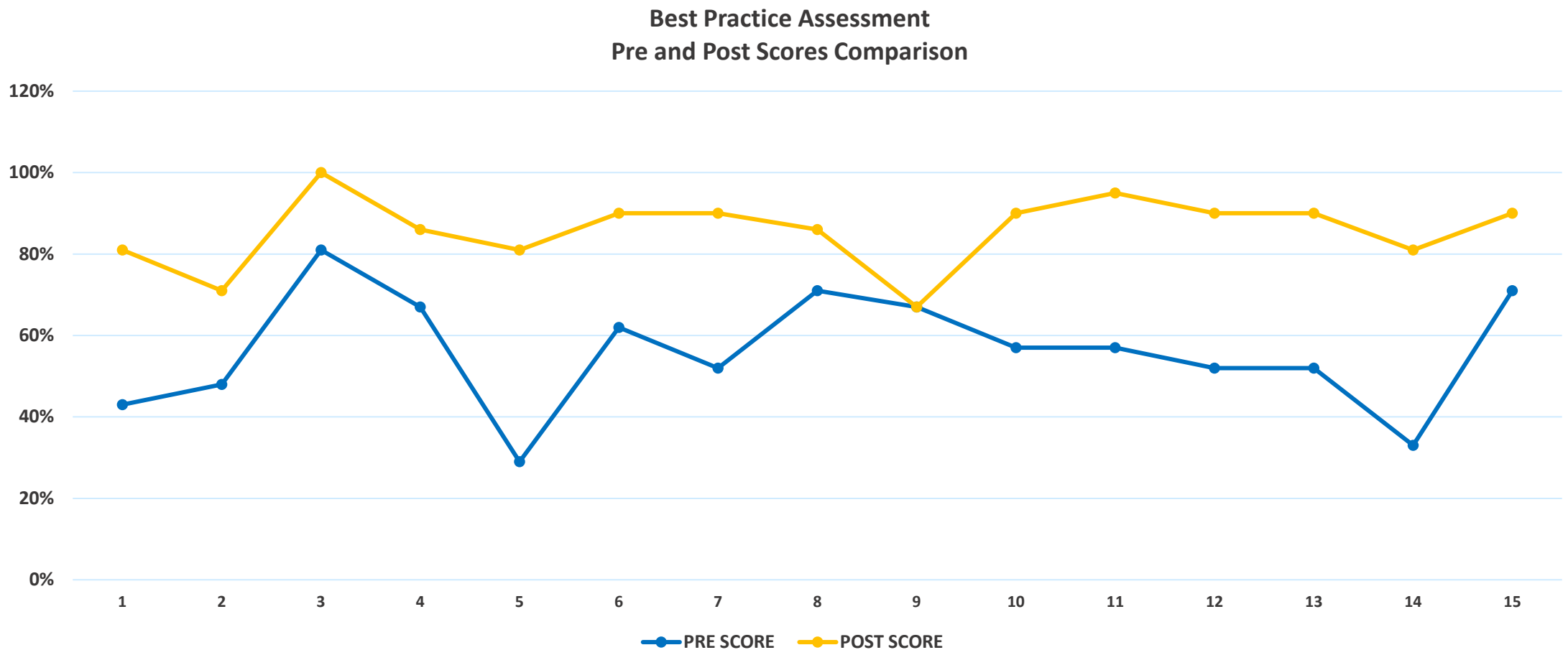
Care Transformation Collaborative of RI

Pre/Post Best Practice Assessment Summary



[View Pre Post Assessment Survey Monkey PDF]

Best Practice Pre/Post Trends



Best Practices with 100% adoption

- Patients are allowed to use multiple selections
- Processes and systems support patients who decline
- Ability to ensure patient privacy
- Patient education is provided
- Staff is trained on internal processes
- Staff has time needed
- Staff education is provided
- Clear accountability has been established
- Regular measurement of completeness and accuracy
- EHR is configured to support race/ethnicity mapping and eliminate free text input

Opportunities for Continued Improvement

- Collect data at a more granular level based on local community population needs with proactive mapping to aggregated standards
- EMR prompts staff to update demographic data at predefined frequency
- Use other technology to capture demographic data from patients, for example pre-registration on a portal, kiosk, or texting system

Best Practice Discussion

- What did your practice learn from the best practice assessment?
- What did you find valuable about the process?

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ADVANCING INTEGRATED HEALTHCARE

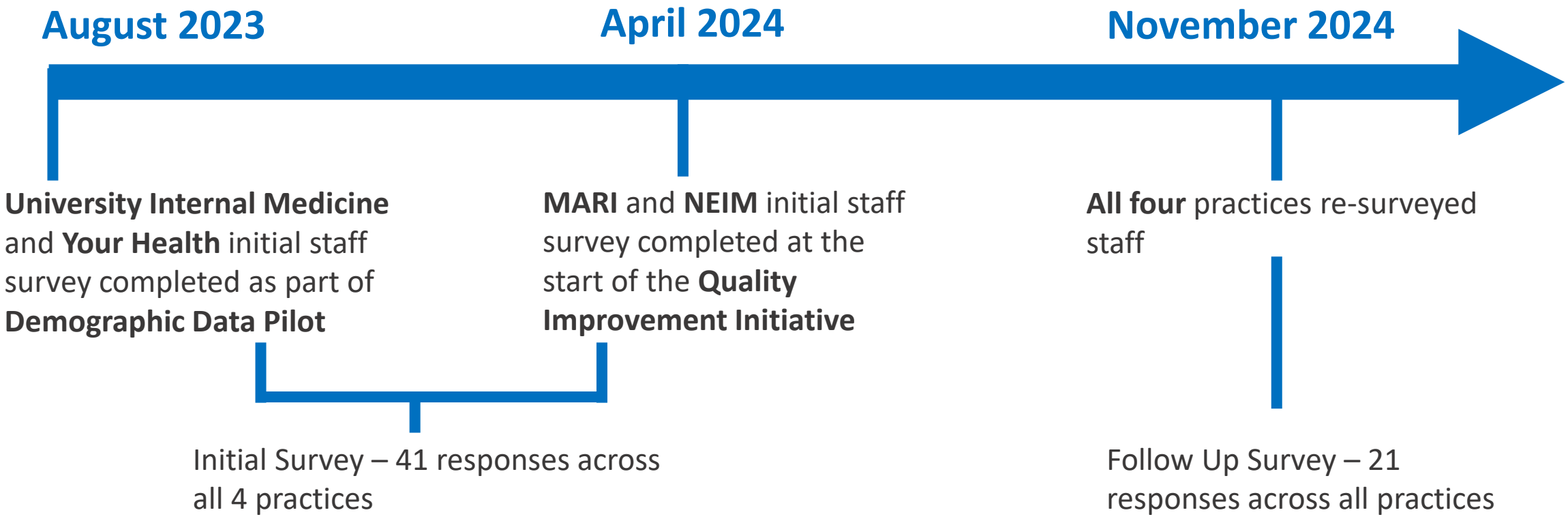
Demographic Data Quality Improvement Staff Survey Comparison

Medical Associates of RI, Northeast Internal Medicine,

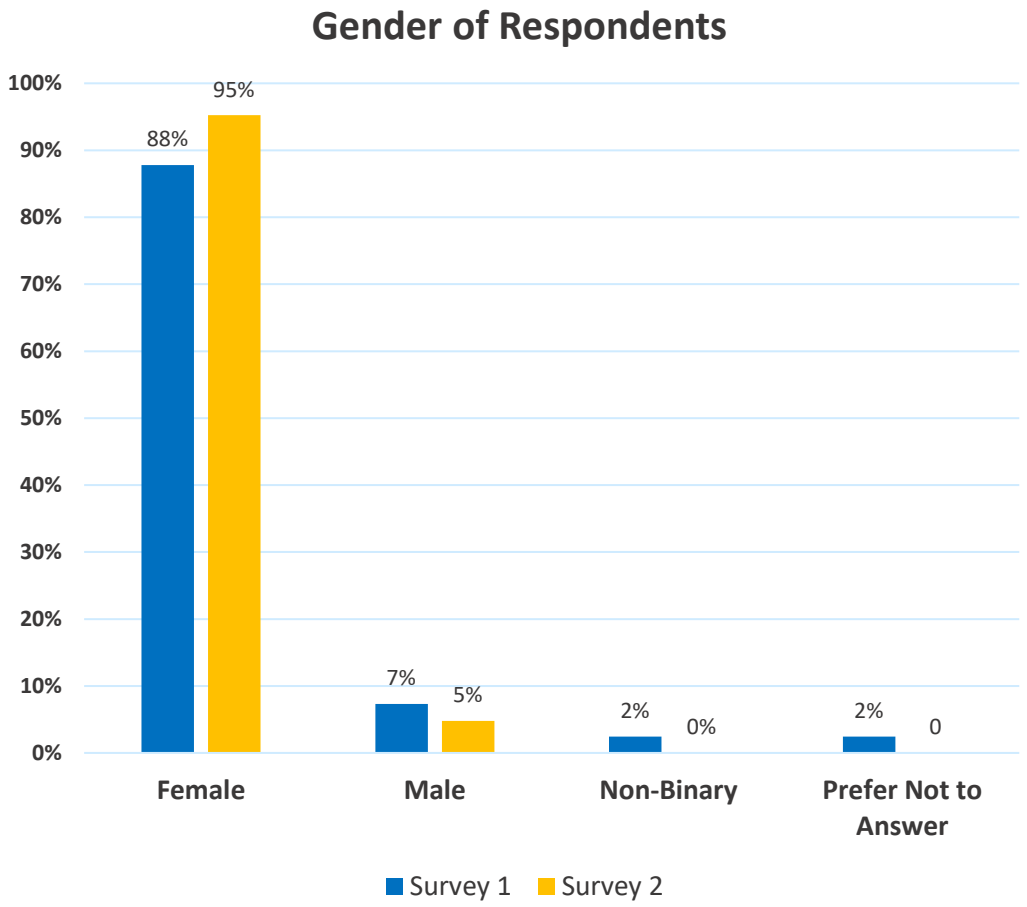
University Internal Medicine, Your Health

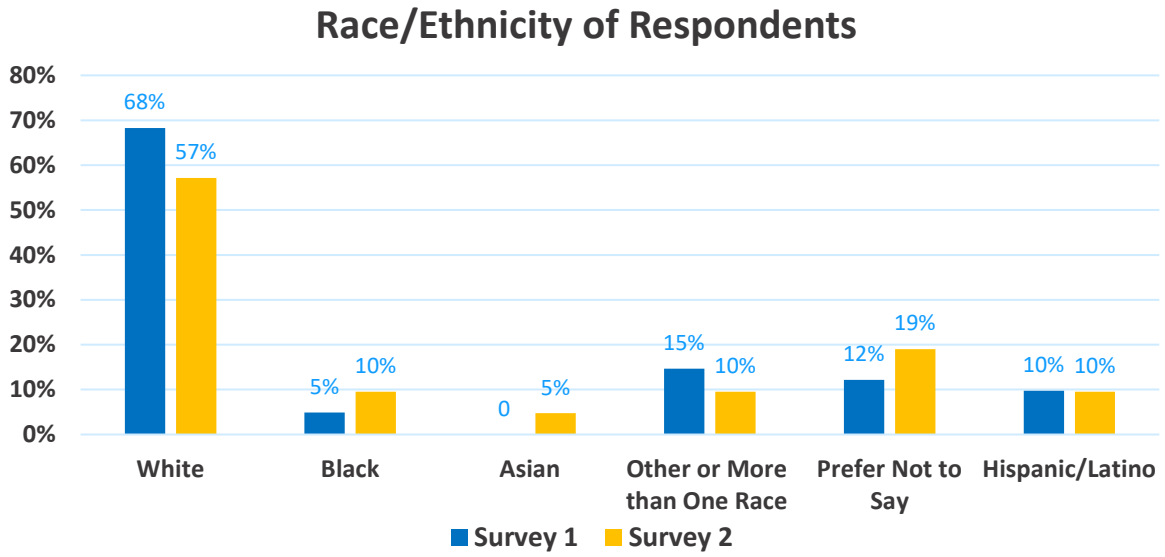
Care Transformation Collaborative of RI

Staff Survey: Process and Timelines

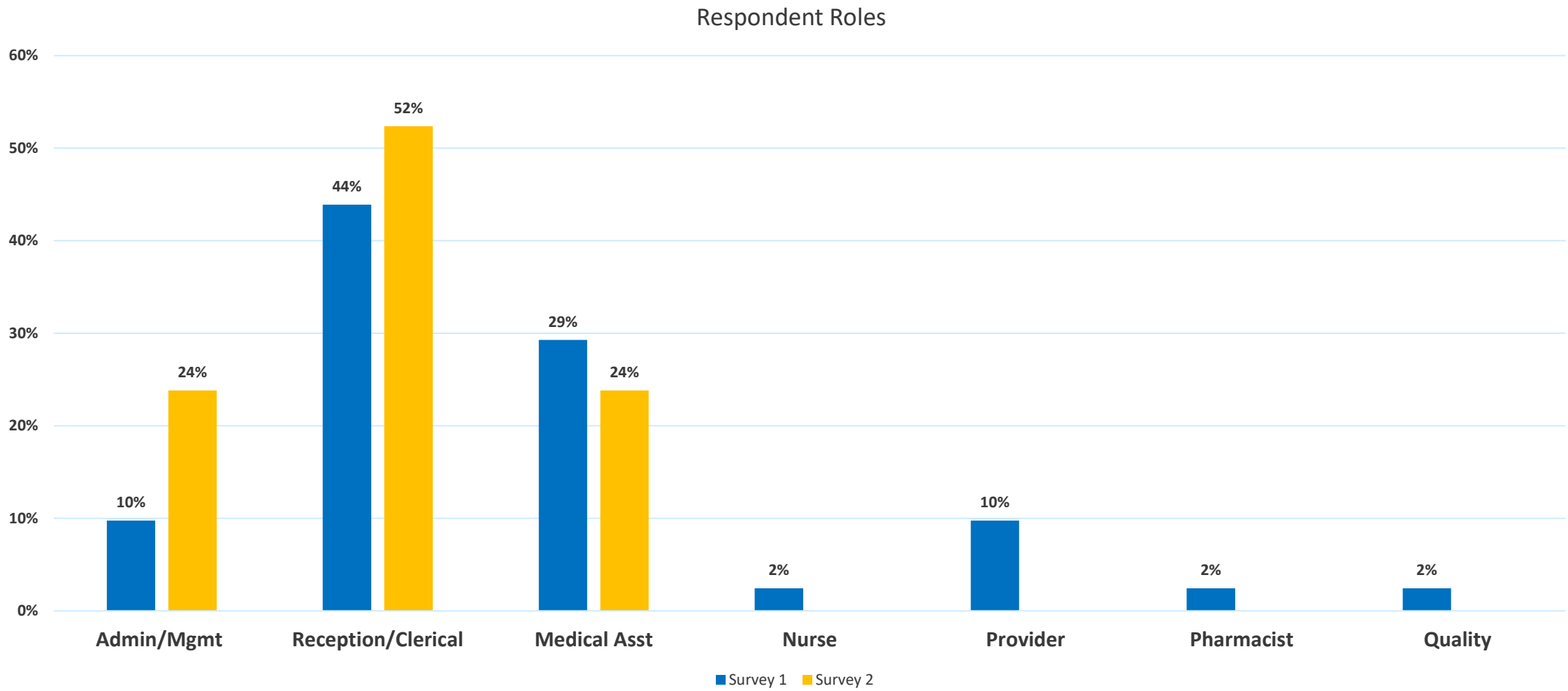


Staff Survey Respondent Demographics





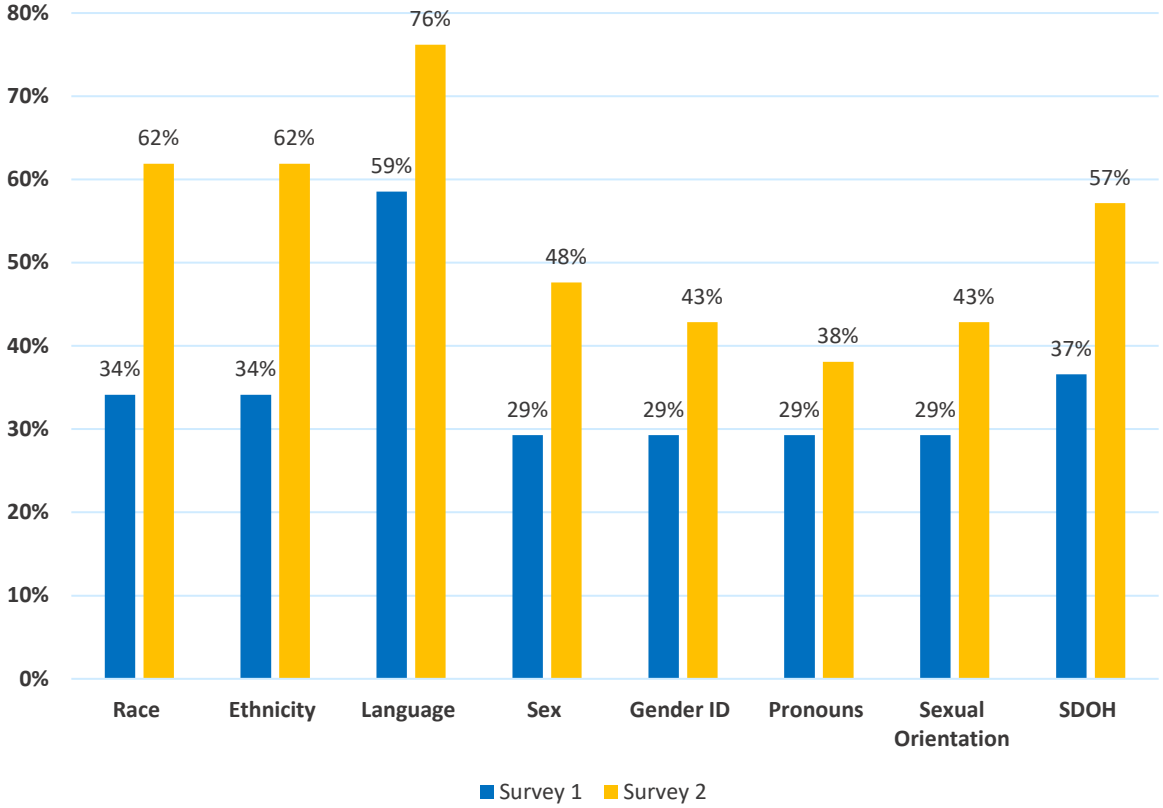
Staff Survey Respondent Roles



Key Comparisons – Comfort & Confidence

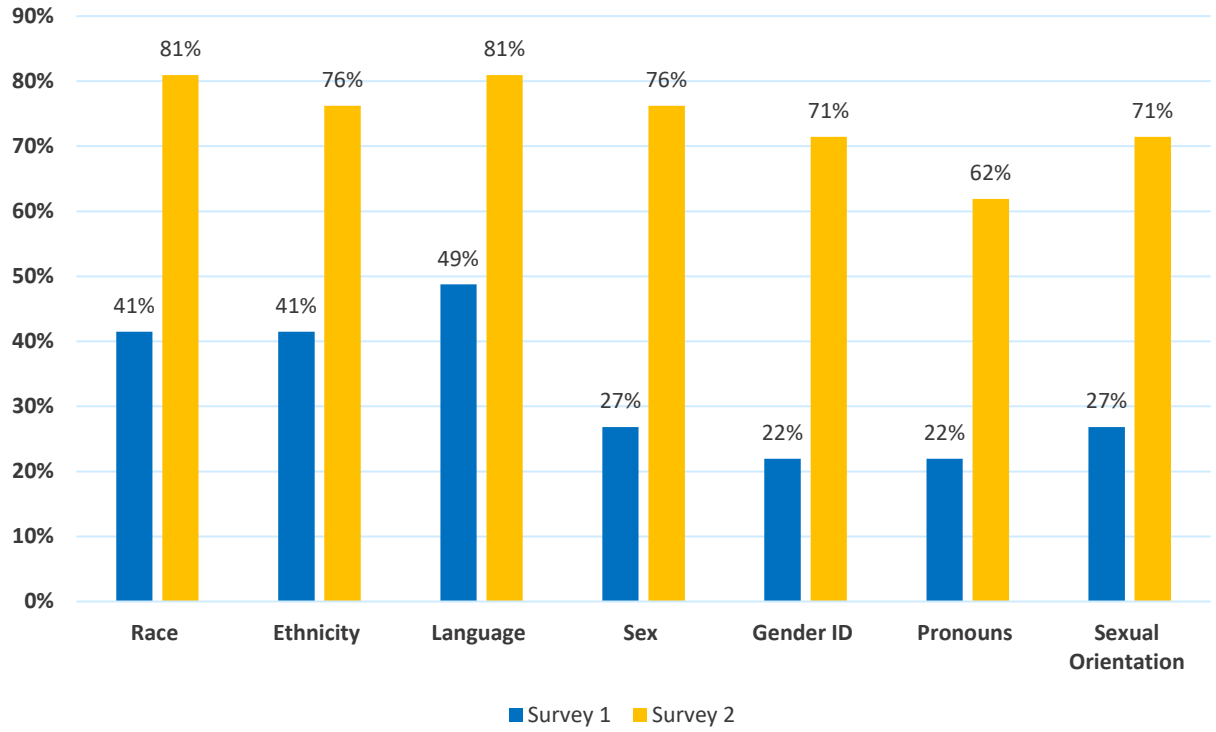
How comfortable do you feel collecting the following demographic information from patients?

S1 N=41
S2 N=21

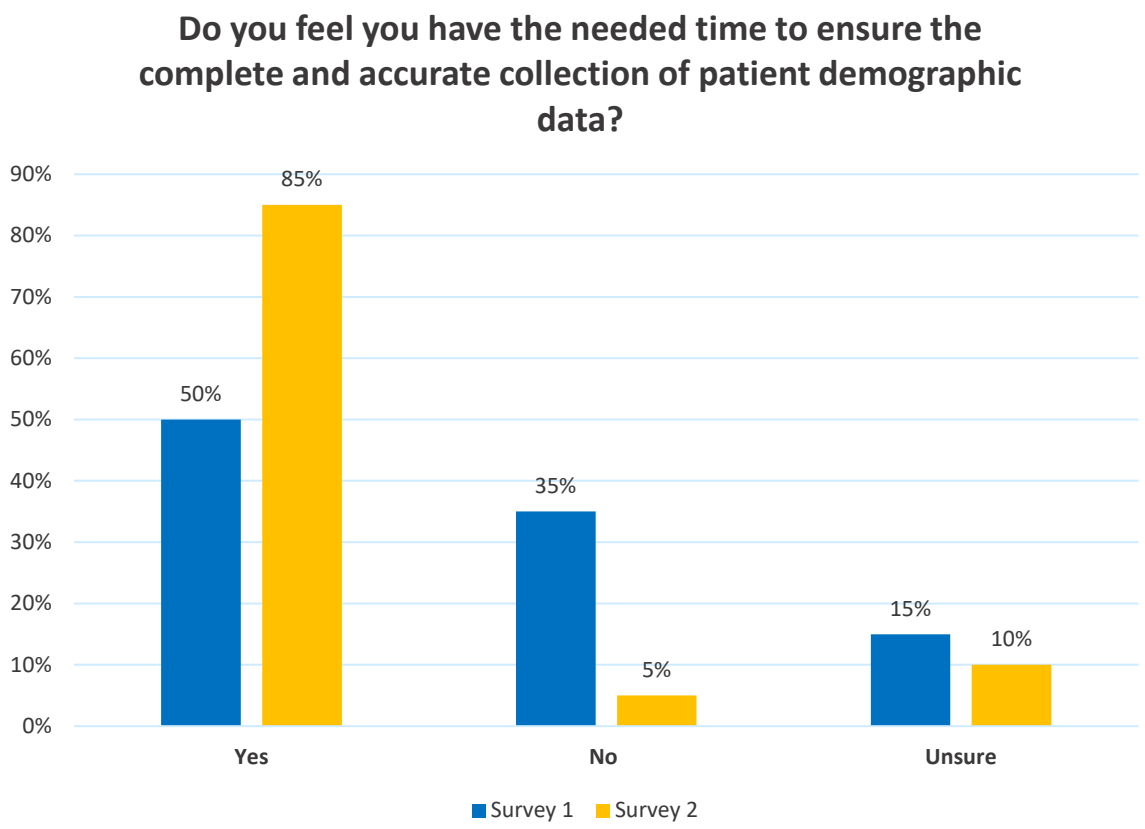


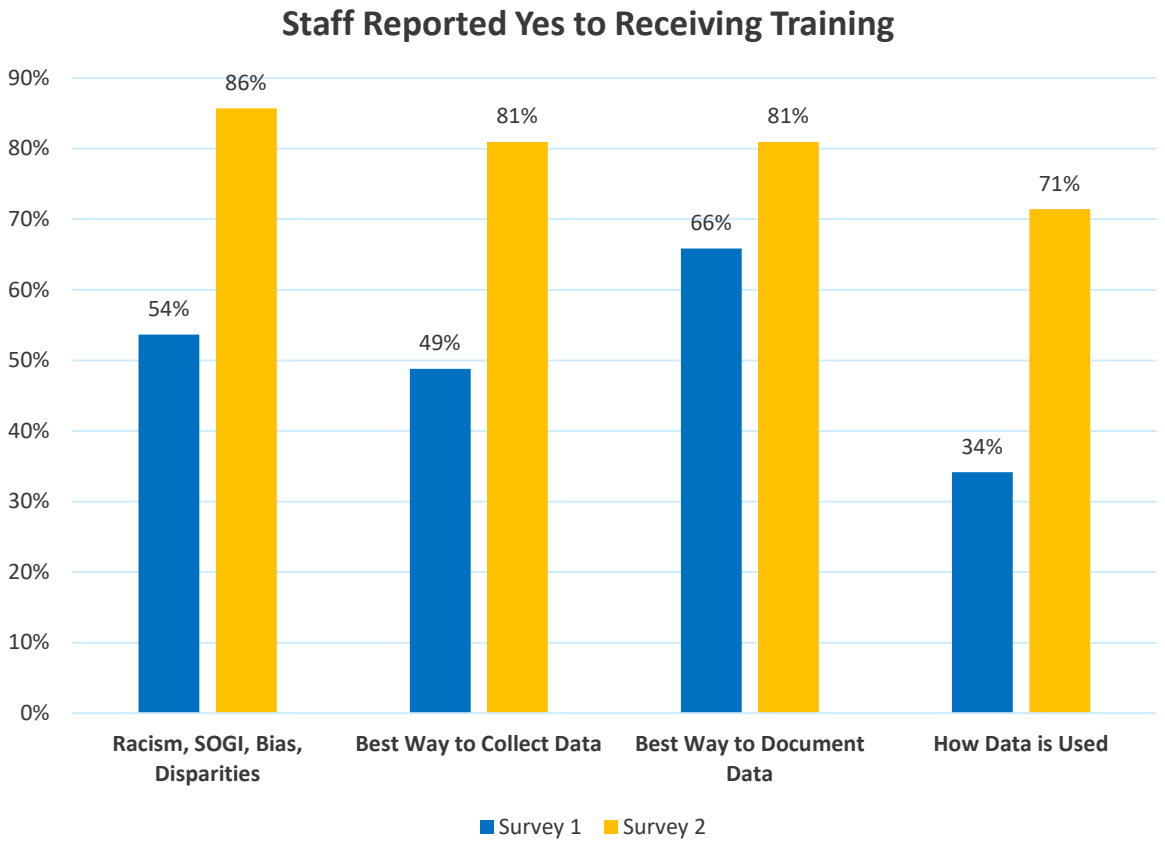
How confident are you about the quality of the following demographic information in your practice's EHR?

S1 N=41
S2 N=21

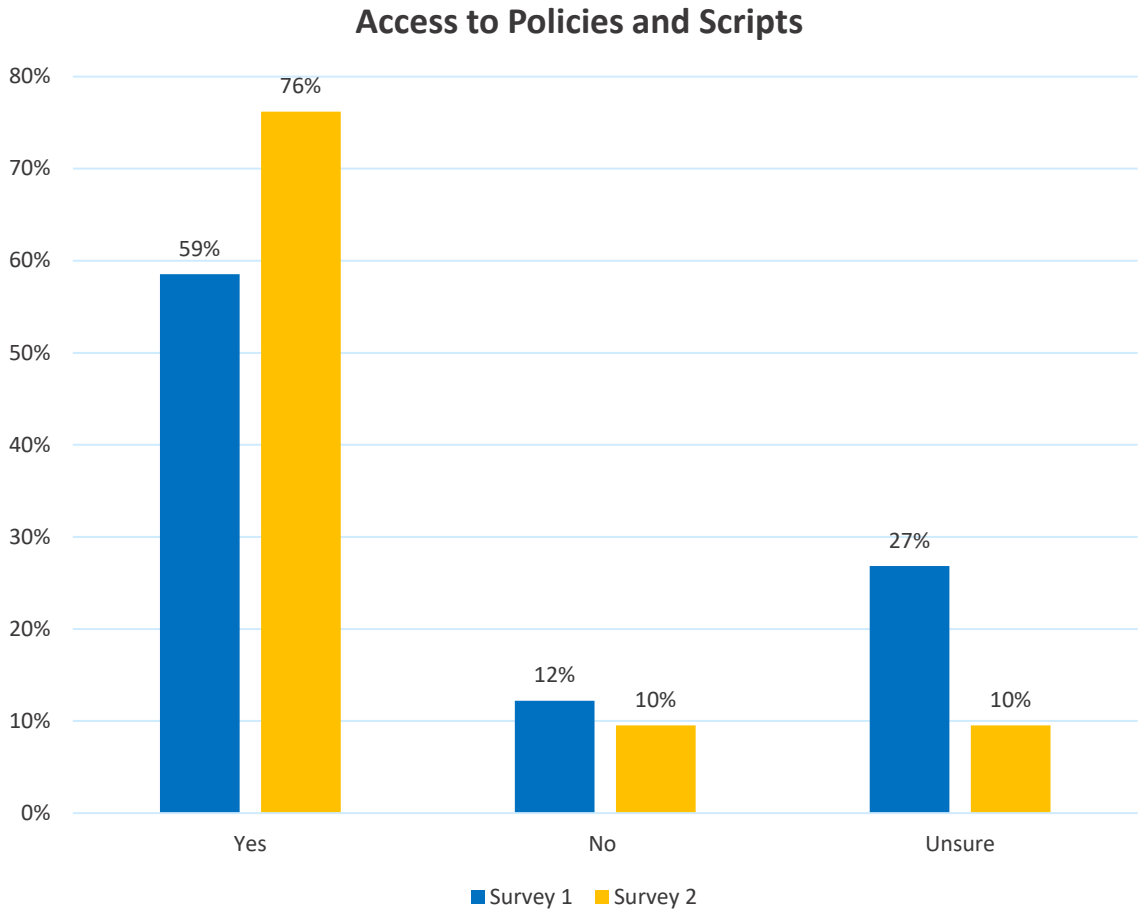


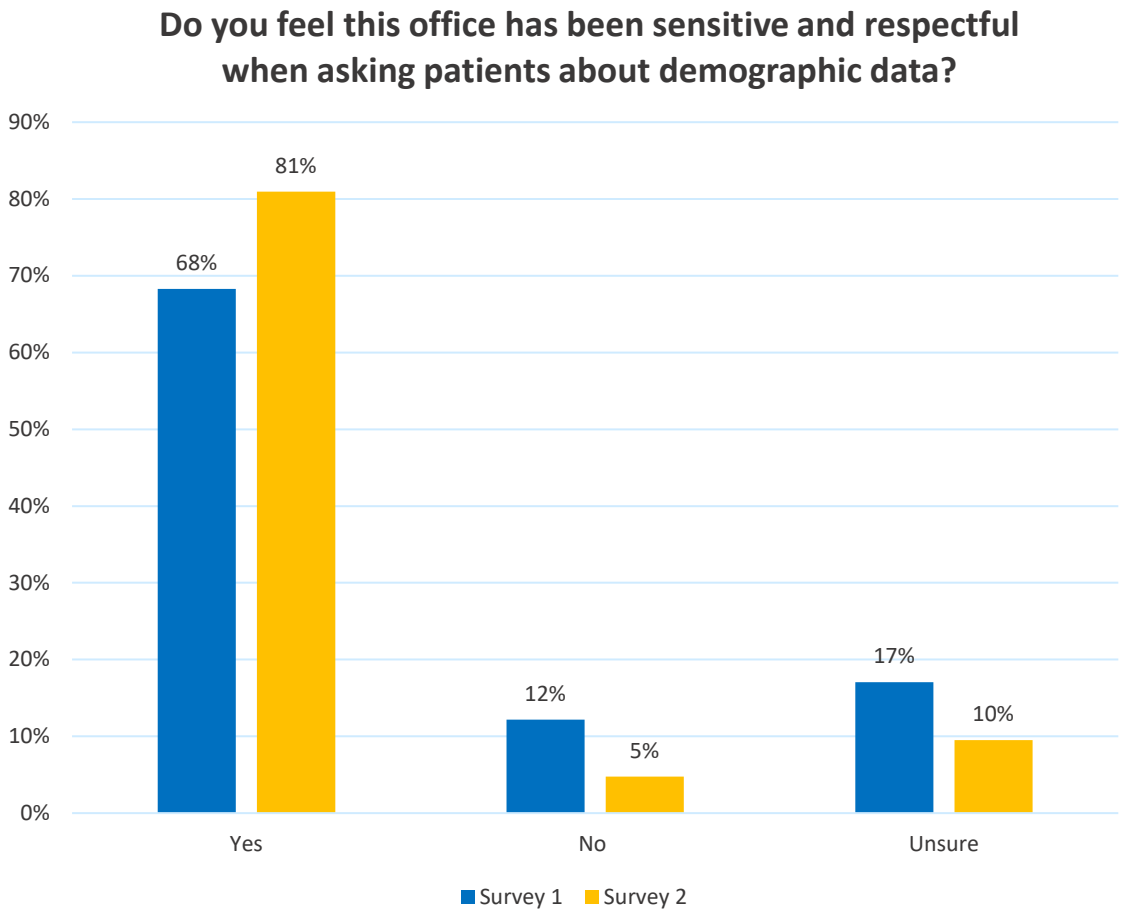
Key Comparisons – Time & Training





Key Comparisons – Policies/Scripts & Sensitivity





Have you experienced challenges related to patient ability or willingness to share their demographic information?

First Survey – 15/41 Yes, Please Explain

Second Survey – 9/21 Yes, Please Explain

Have you encountered challenges related to your comfort asking patients about demographic information?

First Survey – 9/41 Yes, Please Explain

Second Survey – 6/21 Yes, Please Explain

Staff Survey Discussion

- What did your practice learn?
- How did your practice address issues?

Discussion

- What did you learn today?
- How do you intend to use improved demographic data to improve health equity?

Next Steps and Opportunities

- **Reminder: January 8, 2024**
  - All Practices: Program Evaluation Due: https://www.surveymonkey.com/r/DD_QI_Eval
- **Pre & Post Best Practice reports to be distributed to each individual practice**
- **Practice PDSA final data to be sent by Practice Facilitators**

- **New Opportunity April 2025**:

  Implementing Improvements in Collection and Use of Patient Demographic Data in Primary Care Funded by United Healthcare

- **Screened for Developmental Delay, Now What? ECHO® –** Register by Dec 13, 2024 - **Six sessions Jan 2025 – July 2025** aimed at enhancing capacity to deliver patient- and family-centered care for children aged 0-5 with neurodevelopmental challenges, including care coordination and resource linkage.
- **Call for Applications**: 2025 Community Health Worker (CHW) or Medical Assistant Asthma Training Program Read Call for Applications **Application Deadline**: Jan 17, 2025

Thank you, from your Project Team

Susanne Campbell, RN, MS, PCMH CCE
Senior Program Administrator
Scampbell@ctc-ri.org

Yolanda Bowes
Project Manager
Ybowes@ctc-ri.org

Nijah Mangual, BA
Program Coordinator
Nmangual@ctc-ri.org

Sue Dettling, BS, PCMH CCE
Program Manager & Practice Facilitator
Sdettling@ctc-ri.org

Kerri Costa, MBA, CMHP
Practice Facilitator
k12costa@outlook.com

THANK YOU

Debra Hurwitz, MBA, BSN, RN
dhurwitz@ctc-ri.org