





TIPQC

Tennessee Initiative for
Perinatal Quality Care



Using Data to Understand Health Disparities & SDOH

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Immediate Past Maternal Medical Director



Unless specifically measured, disparities in health and healthcare can go unnoticed even as providers, health plans, and healthcare organizations seek to improve care.



Stratifying quality data by patient race, ethnicity, language, and other demographic variables such as age, sex, health literacy, sexual orientation, gender identity, socio-economic status, and geography is an important tool for uncovering and responding to healthcare disparities.



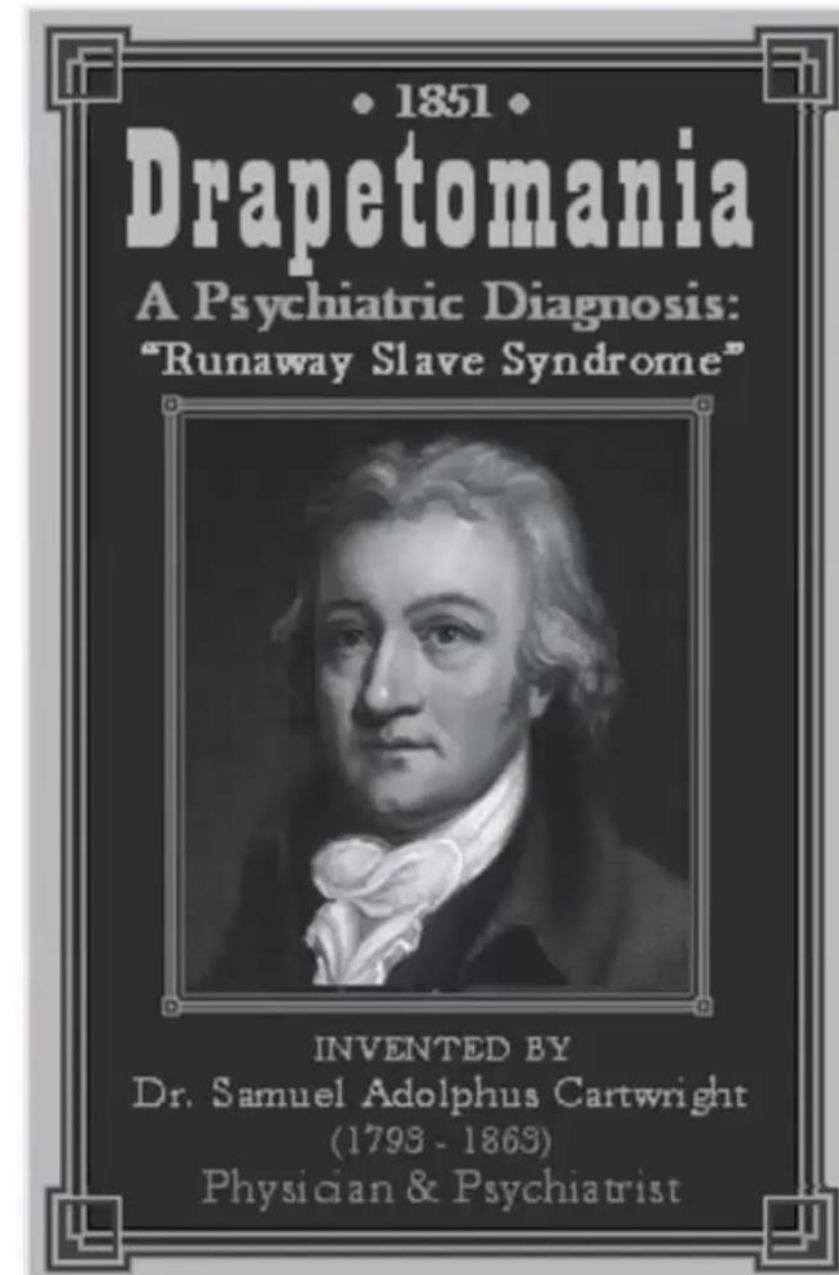
WHAT WE KNOW...



THE TRUST IS BROKEN

History of Bias Beliefs About Race and Medicine

March 17, 1851 at the Louisiana Medical Association, Dr. Samuel Cartwright's committee report, "A Report on the Diseases and Physical Peculiarities of the Negro Race"



Black People:

- Have Smaller Brains
- Immune to Pain
- Needed to be Enslaved and Chastised because of Biological Differences

Bias Beliefs about Race and Pain



Dr. Marion Sims invented the speculum and the surgical procedure to repair vesicovaginal fistulas.

He performed thirty surgeries on a slave woman named Anarcha over approximately five years, finally successfully treating her vesicovaginal fistula with silver sutures.

In accord with the scientific racism of the time, she and the other slave women, Betsy and Lucy, were viewed as “medical super bodies” who could tolerate surgery without anesthesia.

Bias Beliefs about Race and Pain

Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites

[Kelly M. Hoffman](#)^{a,1} [Sophie Trawalter](#)^a [Jordan R. Axt](#)^a and [M. Norman Oliver](#)^{b,c}

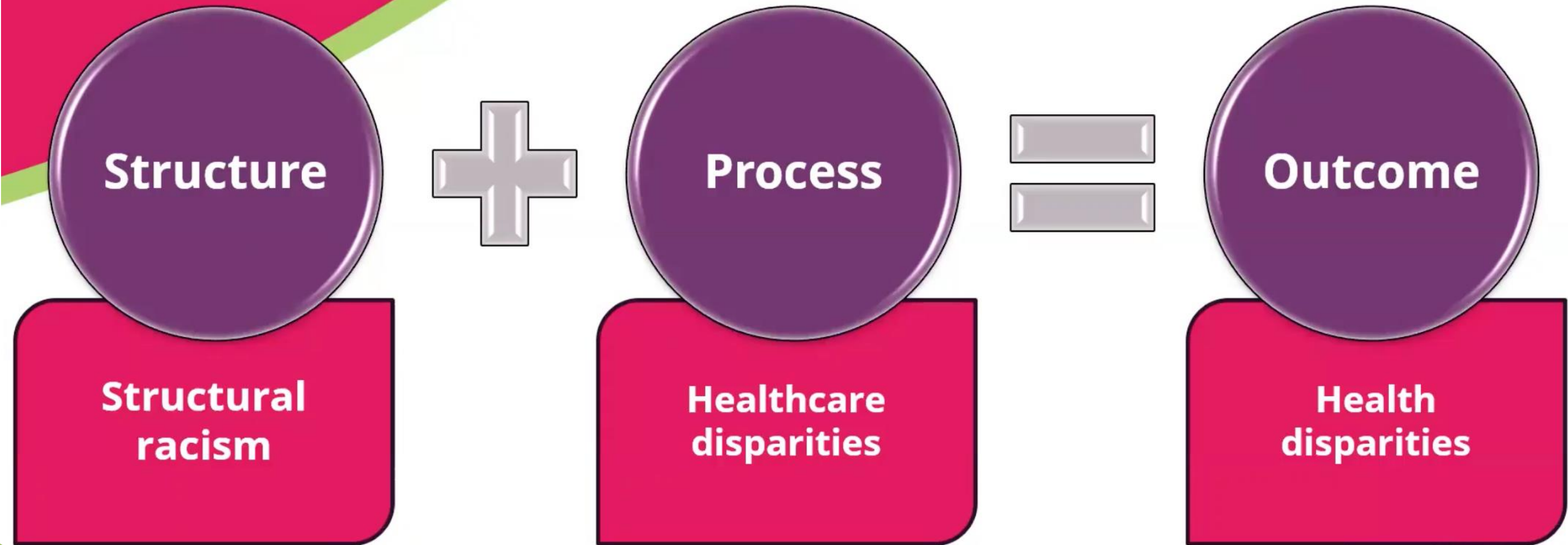
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- In a study of 222 **white medical students and residents**, about **50% believed Black people were biologically different than white people**, including having nerve endings that are less sensitive than whites and having thicker skin than whites

Donabedian Model for Quality of Care



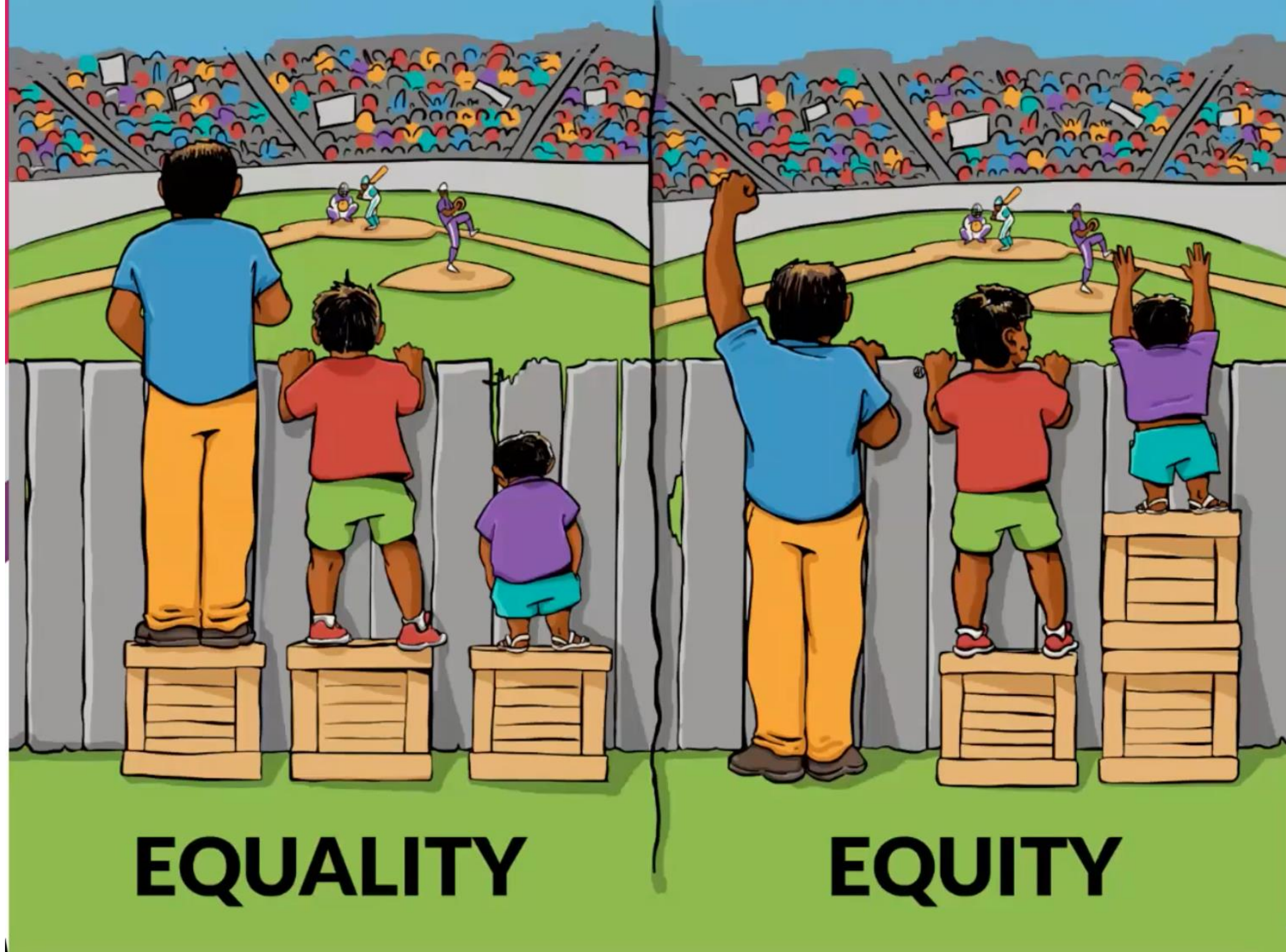
Donabedian Model for Quality of Care





**You cannot have quality
without equity!**

**Health disparities are the
health outcome measure of
progress toward health equity**

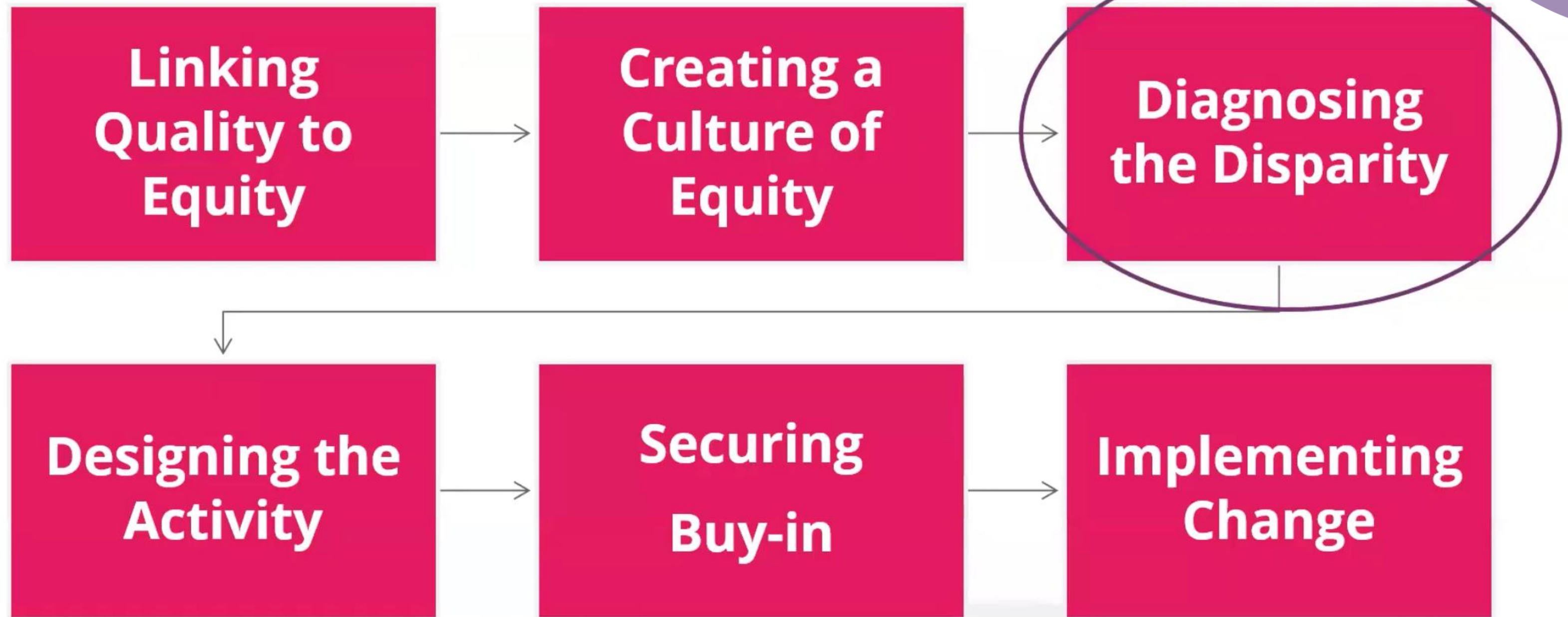


EQUALITY

EQUITY

Ref "Interaction Institute for Social Change" Artist: Angus Maguire

The Roadmap to Reduce Disparities






**HOW CAN WE USE DATA
TO DEMONSTRATE
DISPARITIES IN CARE?**



Using stratified quality data strategically allows healthcare organizations to:

1. Discover and prioritize differences in care, outcomes, and/or experiences across patient groups
 2. Plan Equity-Focused Care Transformations and Measure Impact.
 3. Tell the story of how patients experience health care
- 

Using Data to Discover and Prioritize Health and Healthcare Disparities

- To reduce disparities across patient groups, healthcare organizations must first understand:
 - Where disparities exist
 - Magnitude of the disparities
 - Why disparities are occurring within their patient population
- Examining disparities allows organizations to:
 - Understand differences in how patients experience care
 - Improve care processes to ensure appropriate care for all patients

Using Data to Discover and Prioritize Health and Healthcare Disparities

STRATEGIC COMPARISONS

- Identify how a chosen quality measure is distributed within each demographic group (rather than how the measure is distributed across the whole population)
- Compare the distribution in one group against the distribution in another
- Benchmarking current data against historical data from within your organization or against comparison data from other organizations

Sources of Community Data

SOURCES OF COMMUNITY DATA	PRIMARY VALUE
Regional newspapers, neighborhood newsletters, public bulletin boards (in libraries, community centers) and culturally-specific news media	Identify local priorities and current events among minority communities
Digital storytelling archives or photo voice projects(often run by community-based organizations or public health campaigns)	Hear first-hand accounts of community needs (potential causes of disparities), particularly among more vulnerable populations
Meetings with local business leaders, cultural or religious figures, social services directors, school superintendents, consumer advocacy groups, and neighborhood coalition patients	Promote equity efforts among diverse stakeholders, gain buy-in for future interventions, and access resources such as additional data or other kinds of data
Community needs assessments and health improvement plans, developed by local authorities for public health accreditation or regional planning efforts	Identify community priority issues that could affect your clinical data (e.g., the prevalence of disease, environmental hazards, and behavioral risk factors like smoking rates) Collaborate with public health entities that can help support and spread effective interventions

Prioritizing Healthcare Disparities

National Quality Forum (NQF) criteria to help select meaningful measures that focus on health equity and health disparities:

- Prevalence:
 - How prevalent is the disease or condition (targeted by the quality measure) in the disparate population?
- Size of Disparity:
 - How large is the gap in quality, access, and/or health outcome between the disparate population and the group with the highest quality for that measure?

Prioritizing Healthcare Disparities

National Quality Forum (NQF) criteria to help select meaningful measures that focus on health equity and health disparities:

- Strength of Evidence:
 - How strong is the evidence linking improvement in performance on the measure to improved outcomes in the disparate population?
- Ease and feasibility of improvement (actionable):
 - Is the measure actionable (e.g. by providers, clinicians, health plans, etc.) among the disparate population?

Defining Goals for Improvement and Tracking Appropriate Measures

- **Intervention process measures** evaluate whether the care transformation was successfully implemented as planned.
- **Health process measures** refer to what is done to a patient.
 - Ideally evidence-based measures that have been demonstrated to improve patient outcomes.
 - Improve faster than outcome measures since they focus on one part of care rather than on the constellation of factors that influence outcome measures
- **Outcome measures** refer to the actual results for the patient.

Intervention Process Measure Example

HEALTH PRIORITY	INTERVENTION	EXAMPLE INTERVENTION PROCESS MEASURE
Hard-to-reach patients with chronic health conditions were not being properly engaged leading to gaps in care, high utilization of preventable emergency department visits and hospitalizations, and low-quality outcomes	<ul style="list-style-type: none">▪ The health plan implemented a community health worker program to target hard-to-reach patients.▪ Established an automated review and analysis of patient claims data to capture when a patient visited a provider different from their PCP or ED.▪ Patients were flagged based on analyses and followed-up with phone calls, targeted education, and referrals to resources to address high-risk and treatable conditions.▪ Staff also attended cultural competency training.	<ul style="list-style-type: none">▪ Number of patients identified within claims data▪ Number of staff who attended cultural competency training▪ Number of patients engaged and connected to their PCP.▪ Barriers to care documented in EHR▪ Number of providers engaged

Defining Goals in Terms of:

- The same population before and after the intervention
 - Ex: 10 percent increase in screening rates
- A comparison to another group
 - Ex: Equal rates between Hispanic/Latino patients and Asian-American patients
- A comparison to a benchmark outside of the organization
 - Ex: 80 percent of the national rate for this measure

Develop a Process for Reviewing Data

- Determine how often to review data over the course of the intervention to monitor outcomes and adjust processes
- Regularly review to ensure that an efforts are not creating or worsening disparities.
- Regularly review data to adjust their intervention processes
 - Consider “pilot testing”
- Account for lags in data availability that will impact timelines

Telling the Patient's Story

By sharing results within and outside of the organization, the team can:

- Receive feedback and ideas for ways to improve health equity efforts
- Celebrate progress (including “quick wins”) in order to maintain momentum
- Understand why results came out as they did
- Create a culture of transparency with patients and communities of goals and improvements

Telling the Patient's Story

By sharing results within and outside of the organization, the team can:

- Lay the groundwork at the end for future partnerships
- Encourage action from people not previously involved
- Maintain health equity as a top priority by linking clear, compelling results to other high-priority programs in the organization (e.g., patient safety or care management).

Data Messaging for Different Stakeholder Groups

STAKEHOLDER	LIKELY CONCERN	ADDRESSING THE CONCERN
Leadership	Return on investment	Present data on potential positive financial impact, or flattening of spending trend. Highlight how the initiative satisfies a contractual requirement.
Providers	Office visit efficiency	Describe patients' cultural background as information that, like family history, helps determine the best course of action with the patient. Give examples of how culturally tailored approaches enhance patient engagement and satisfaction, reducing redundancy or disconnect in visits and outreach.
Front-Line Staff	Clinic flow	Be honest about potential temporary impact but not how changes will ultimately improve flow (for example, reduce patient confusion). Solicit input for improvement.
Patients	How the clinic will use equity data (e.g. Privacy) Health status	Ensure the patient that data are used to ensure everyone is getting high quality care and that all data will remain confidential.
Community	Access to health care services and general wellness in the community	Emphasize project outcomes that benefit the community and include community partners in developing strategies to reduce disparities.
Everyone	Patient outcomes	Explain health equity efforts and how activity should affect outcomes.

Using Data to Support Sustainability

- Health equity data used to track disparities helps maintain a focus on the importance of reducing disparities and providing equitable care among competing priorities.
- Using health equity data helps identify how factors that drive disparities (e.g., systemic racism, bias) also drive overall quality.
- Health equity data can help demonstrate success to external entities, such as the Center for Medicaid & Medicare Services and charitable foundations.

Key Issues Identified with Use of Health Equity Data

- Reliable collection of ***self-reported*** race and ethnicity data → Impacts both local and state data.
- Variation in use of stratified AIM data at the LOCAL levels by teams.
- Learning from the patient voice ***and*** Acting on what is learned.

Best Practices that Support Self-Reported Demographic Data

- Script for registration staff to ask about demographics
- Explanation of need for demographics on surveys
- Ask language preferences first
- Annual competency training for registration staff
- Ask every patient at least annually
- Use of OMB minimum race and ethnicity standards
- Granular race and ethnicity categories based on your population
- Clinical team reviews demographics with patient

Self-Reported Patient Demographics

Outcomes data, stratified by REaL (Race, Ethnicity and Language) data is a cornerstone of improvement in healthcare equity. The first step for use of such data is a strategy to collect accurate self-reported patient demographics. There are well-documented practices and resources that can support this work.



Measurement

The recommended measure to monitor your progress is the % of missing patient demographics. This includes the categories of missing, unknown and declined to answer.

Best Practices: Categories to Collect

- Race and Ethnicity Minimum Categories defined by Office of Management & Budget
- Race and ethnicity should be separate categories
- Language categories should be determined by those most requested by interpretive services
- Order of categories is important: language, ethnicity, then race
- Granular race and ethnicity categories should be added to reflect the diversity of your population



Best Practices: Data Collection

- Competency training at orientation and annually for registration and clinical staff
- Training Resource: What is REaL?
- Collect data at point of registration
- Require a response for REaL data entry before registration can be completed
- Validate data by asking every patient, every time or at least annually

Best Practices: Asking the Questions:

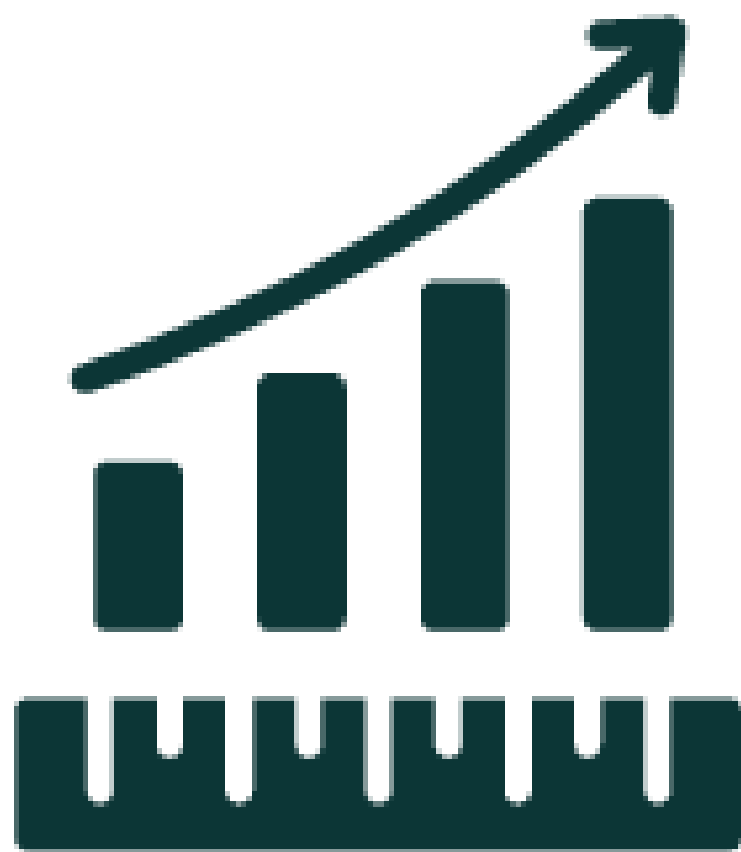
- Electronic or paper surveys should have an explanation included. Following is an example:
 - “Research has shown that a person’s health and their risk for certain medical problems may be influenced by many factors, including their race and ethnicity. The more we know about our patients, the better care we can provide! Please let us know if you have questions.”
- Scripts are a helpful tool for registration and clinical staff. Following is an example to test and adapt for your comfort and in your words:
 - “I’m going to ask about your background. These questions will allow you to tell us more about you and your family. We ask these questions of everyone so we can provide the best experience for every patient and family.”
 - “What language do you usually speak at home?”
 - “Thank you, and what ethnic background do you identify with? Do you identify as Hispanic or Latino?”
 - “Thank you, and finally, what racial group do you identify with?”



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Potential Barriers with Use of Stratified Data (at the local level) for Improvement

- Lagging data
- Data is not displayed as stratified by race and ethnicity
- Difficulty of extracting data from HER
- Access to software for data analysis and display
- Limit data review to measures that impact accreditation and reimbursement
- Team does not have time to review
- Scheduling team meetings is difficult
- Meeting attendance
- Large number of metrics
- Not all team has access to stratified data

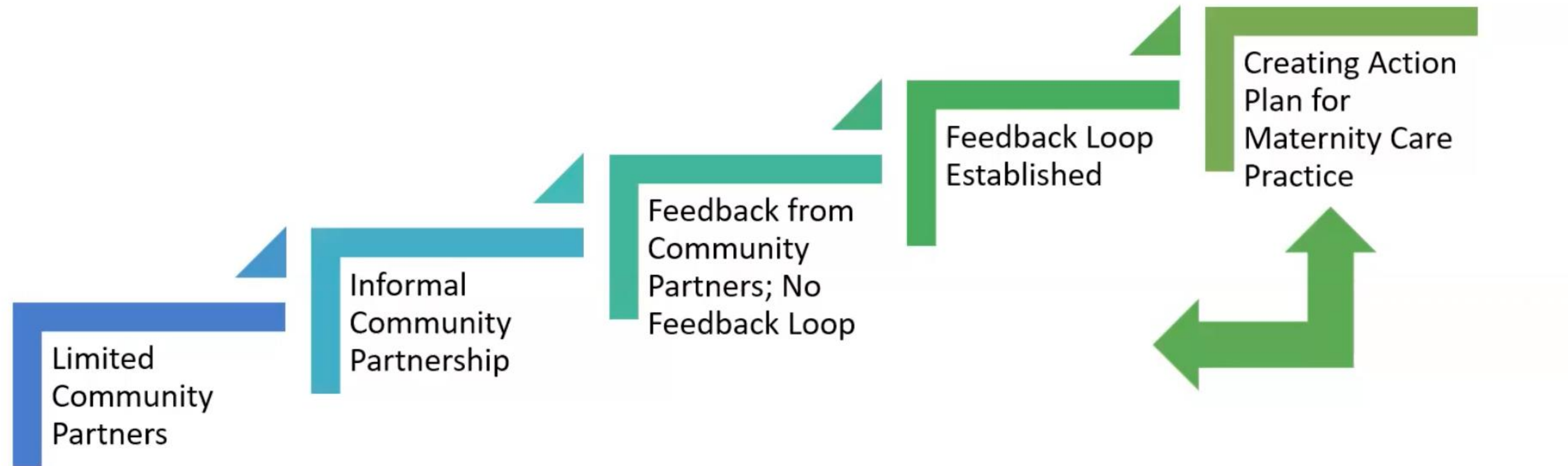


**BEYOND THE PATIENT
SATISFACTION SURVEY...**

**THE IMPORTANCE OF THE PATIENT
VOICE IN QUALITATIVE DATA**



Where is your team on this continuum?



Finding a safe space to give feedback AND Joint Commission highlights development of action plan to address identified issues

Finding a safe space to give feedback

The Importance of Amplifying All Voices



References

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A Word on Diversity, Equity, and Inclusion...

WHY DIVERSITY, EQUITY AND INCLUSION?



**The right
thing to do**



**Better place to
work**



**Improves care
and service**

PROMEDICA DEI TRANSFORMATION 2025: STRATEGIC FRAMEWORK

VISION

ProMedica will be among the most inclusive and equitable healthcare organizations in America.

STRATEGIC PILLARS

WORKPLACE

HEALTHCARE

COMMUNITY

STRATEGIC OBJECTIVES

INCLUSIVE TALENT PROCESSES

Create an inclusive, engaged, high performance workplace culture where all talent has a fair and equitable opportunity to contribute and grow.

INCLUSIVE CARE + SERVICE

Be responsive to the diverse needs and expectations of everyone we care for and serve. Eliminate unfair or avoidable disparities in care and health outcomes.

INCLUSIVE COMMUNITY

Utilize our community presence to build stronger and healthier communities that are more inclusive and increase access to opportunity.

STRATEGIC ALIGNMENT



**Better place to
work**



**Improves care +
service**



Healthier communities

HEALTH EQUITY AT PROMEDICA

Our Mission is to improve the health and well-being of people.

Health equity at ProMedica means:

- Making sure people have the opportunity to achieve their optimal health
- Being responsive to the diverse needs and expectations of everyone we care for and serve
- Eliminating any unfair and avoidable differences in healthcare treatment and outcomes among populations we care for and serve
- Addressing the social determinants of health

Building an approach:

- Listening to the voice of the customer
- Using data to guide improvement
- Learning and education to support improvement
- Community partnerships that build engagement and trust

HEALTH EQUITY AT PROMEDICA



Voice of the Customer + Community Partnerships

- LGBTQ+ patient & family advisory council
- Ohio hospitals committed to confronting racism, County Getting to 1 Coalition



Data + Improvement

- Alliance for Innovation on maternal health
- American Hospital Association – health equity assessment pilot
- CDC – cardiovascular health equity indicators pilot
- Diversity scorecards
- Human Rights Campaign
- Social Determinants of Health Screening Data + Interventions
- REaL & SOGI Data (race, ethnicity and language / sexual orientation and gender identity)
- Safety, quality, experience – filter data by race/ethnicity



Inclusion Learning & Education

- Racial equity & racial determinants of health
- Implicit bias – maternal health equity (March of Dimes)
- LGBTQ+, veterans, disabilities – workplace & health care

MATERNAL HEALTH EQUITY AT PROMEDICA



Voice of the Customer + Community Partnerships

- Patient experience data
- Community listening sessions



Data + Improvement

- Alliance for Innovation on maternal health (AIM)
- Safety, quality, experience – filter data by race/ethnicity
- OPQC – Compassionate, Respectful & Equitable Care
- Northwest Ohio Pathways Hub



Inclusion Learning & Education

- Implicit bias – maternal health equity (March of Dimes)