
2024 VIZIENT CONNECTIONS SUMMIT
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REFLECTION
REFLECT | ADAPT | EVOLVE

Learning Objectives

- Identify current organizational performance and opportunities in relation to the Diversity, Health Equity and Inclusion Maturity Model.
- Discuss the identification and reporting of disparities, including interventions to decrease readmissions in behavioral health patients.
- Examine how to assess for structural bias in population health risk models.
- Describe how mentorship/sponsorship programs and dedicated resources focused on innovation and strategic action can improve organizational culture.

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Brownsyne Tucker Edmonds, MD, MPH, MS, speaker for this educational activity, is a Research Funding Recipient for Novartis and Cook Medical.

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Equity and Outcomes: How Mature is Your Organization and What Does It Mean for Your Patients?

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Health equity and clinical outcomes correlation

Working hypothesis:
Members that commit to workplace culture and care delivery focused on diversity, health equity and inclusion have better patient outcomes.

Vizient Diversity, Health Equity and Inclusion Maturity Model

- Identify key characteristics and commonalities among the best performing organizations in the nation to inform a maturity model
- Benchmark member maturity to identify areas of opportunity and alignment
- Correlate culture/operations to patient outcomes to establish best practices
- Increase the speed of improvement through Vizient member networks and analytics
- Lead by example—using the evidence-based correlation and maturity model, Vizient can adopt, publish and encourage a point of view on the most effective ways to address health equity.

Maturity levels

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Survey domains	Maturity Levels			
	Comply & Activate	**Address**	**Align**	**Anchor**
Governance and Leadership	Organizations must comply with many laws, regulations and accrediting body standards related to these domains which are not comprehensively listed here. Organizations expend significant effort to activate DHEI strategies through preliminary investigation, coalition building and developing capabilities.	This early work goes above and beyond compliance requirements and utilizes data to create a vision and build a foundation for DHEI as a way of doing business.	Maturity builds through internal and external collaboration with shared goals, engraining DHEI in the organization's culture and decision making.	The highest level of maturity focuses on structural- and systemic-level influences. In close partnership with the community, the organization leverages its power as an economic engine to drive sustainable change and mitigate upstream inequities.
Quality, Analytics and Outcomes				
Culturally Responsive Care				
Workforce Diversity Development				
Community Wellbeing and Partnerships				

Maturity model domain focus

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1	Governance and leadership	• Board and leadership commitment to health equity (HE) and diversity and inclusion (DEI) • Executive-level responsibilities, goals and performance related to HE and DEI	• Board demographics • Partnerships to support structural equity
2	Quality, analytics and outcomes	• Social needs, Race, Ethnicity and Language and Sexual Orientation Gender Identity data collection • Disparities in quality and safety outcomes • Equitable access	• Impact on social needs and influence on public health
3	Culturally responsive care	• Stratification of patient complaints and action plans to address • Culturally and linguistically appropriate services delivery	• Trauma-informed care delivery methodology • Stratification of HCAHPS results • Patient activation education and assessments

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Maturity model domain focus

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4	Workforce diversity development	• Employee resource groups • Employee recruitment • Employee interview and interview slates	• Evaluation of workforce data to ensure equity in representation • Employee training and workforce learning and growth • DEI goals
5	Community wellbeing and partnerships	• Community health needs assessments and alignment with quality goals • Community coalition and shared goals	• Expectations of community partners

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Benchmarking survey goals

Project focus:

Diversity, health equity and inclusion (DHEI) continues to be an area of investment and improvement for many hospitals. This initiative is an opportunity for Vizient PI Programs and Member Networks providers to participate in a survey that will identify the current state of their organization's operational strategy and identify areas in need of development.

The Holistic Approach to Health Equity Benchmarking Survey aims to:

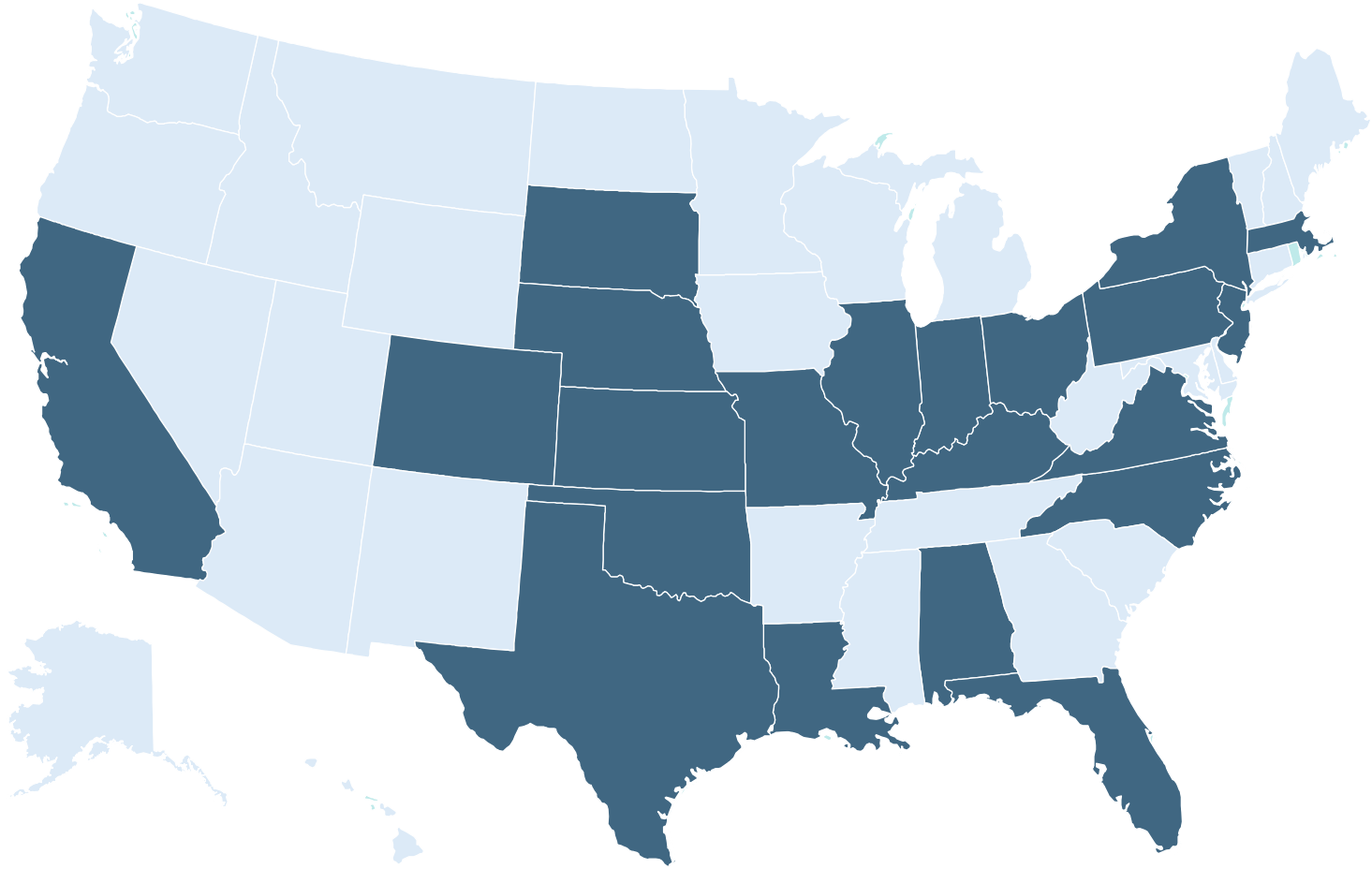
- **Evaluate** organizational alignment to the diversity, health equity and inclusion maturity model
- **Identify** focal areas where opportunity for development exists
- **Network** with each other to share some successful strategies and learn from others' experiences in pursuing leading practice performance
- **Provide** compelling data to drive improvement initiatives in an ongoing process

Benchmarking survey participants by state

87 hospitals representing 21 states

*Participants are denoted by the darker blue

- 44% Academic Medical Centers
- 15% Large Community hospitals
- 41% Medium/Small/Rural hospitals



Benchmarking survey – 49 questions total*

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Survey domains (number of questions)	Maturity Levels			
	Comply & Activate	**Address**	**Align**	**Anchor**
Governance and Leadership (11)	Organizations must comply with many laws, regulations and accrediting body standards related to these domains which are not comprehensively listed here. Organizations expend significant effort to activate DHEI strategies through preliminary investigation, coalition building and developing capabilities.	This early work goes above and beyond compliance requirements and utilizes data to create a vision and build a foundation for DHEI as a way of doing business.	Maturity builds through internal and external collaboration with shared goals, engraining DHEI in the organization's culture and decision making.	The highest level of maturity focuses on structural- and systemic-level influences. In close partnership with the community, the organization leverages its power as an economic engine to drive sustainable change and mitigate upstream inequities.
Quality, Analytics and Outcomes (8)				
Culturally Responsive Care (7)				
Workforce Diversity Development (11)				
Community Wellbeing and Partnerships (6)				

*Includes demographic questions

Benchmarking survey aggregate-level responses by domain and maturity level

Domain	Activate	Address	Align	Anchor
Governance and leadership	0%	13%	46%	41%
Quality, analytics and outcomes	0%	20%	72%	8%
Culturally responsive care	13%	20%	40%	28%
Workforce diversity development	8%	22%	51%	20%
Community wellbeing and partnerships	11%	18%	53%	17%
Overall	**0%**	**17%**	**72%**	**10%**

Survey findings with notable disparities

Governance and leadership

Maturity level	Evaluate each statement about your executive goals and performance. Select the statement that best represents your current state.	Percent of respondents
Activate	The organization has begun preliminary investigation, exploration or discussions about executive-level goals and performance related to DEI and/or HE.	
Address	DEI or HE goals are tied to executive performance and/or compensation.	
Align	DEI and HE goals are tied to executive performance and/or compensation.	
Anchor	DEI and HE goals are tied to both executive performance and compensation.	
	None of these statements represent the current state at my organization.	

Governance and leadership

Maturity level	Evaluate each statement about your executive goals and performance. Select the statement that best represents your current state.	Percent of respondents
Activate	The organization has begun preliminary investigation, exploration or discussions about executive-level goals and performance related to DEI and/or HE.	33%
Address	DEI or HE goals are tied to executive performance and/or compensation.	10%
Align	DEI and HE goals are tied to executive performance and/or compensation.	6%
Anchor	DEI and HE goals are tied to both executive performance and compensation.	15%
	None of these statements represent the current state at my organization.	36%

69% Activate or Not Applicable

Key insights from anchor hospitals
Governance and leadership

- Let data drive decision making. Build goals with intentionality.
- Strategic direction should be linked to the organization's board score card and enterprise metrics. Build out cascading goals that can pinpoint department-level improvement opportunities.
- Accountability is key! Regular check-ins on KPIs are required.
- Collaboration among stakeholders, to include patient experience and community benefit.
- Utilize a Health Equity Bundle that includes collaborative goals informed by the Office of Health Equity and linked to patient experience, community benefit, etc.
- Moved from collecting, to stratifying, to measuring, to improving in a systematic and organic way over several years and have included HE and DEI metrics in our compensation and strategic plan for several cycles.
- The board expanded formally in 2021 to include Equity under the subcommittee of Quality and Safety.
- We have a clear accountability process and report regularly on HE and DEI initiatives to our senior executive and the board.

Quality, analytics and outcomes

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Maturity level	Evaluate each statement about your identified disparities. Select the statement that best represents your current state.	Percent of respondents
Activate	The organization has begun preliminary investigation, exploration or discussions on analyzing quality and safety outcomes to identify disparities.	
Address	The organization addresses identified disparities in one quality and safety outcome.	
Align	The organization addresses identified disparities in multiple quality and safety outcomes.	
Anchor	The organization annually demonstrates progress in closing disparity gaps in one or more quality and safety outcomes.	
	None of these statements represent the current state at my organization.	

REFLECTION

Quality, analytics and outcomes

Maturity level	Evaluate each statement about your identified disparities. Select the statement that best represents your current state.	Percent of respondents
Activate	The organization has begun preliminary investigation, exploration or discussions on analyzing quality and safety outcomes to identify disparities.	23%
Address	The organization addresses identified disparities in one quality and safety outcome.	15%
Align	The organization addresses identified disparities in multiple quality and safety outcomes.	36%
Anchor	The organization annually demonstrates progress in closing disparity gaps in one or more quality and safety outcomes.	25%
	None of these statements represent the current state at my organization.	1%

24% Activate or Not Applicable

Key insights from anchor hospitals
Quality, analytics and outcomes

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- Shared urgency created from requirements set forth by accrediting bodies established the need to select and maintain one, manageable focus area for improvement. Prioritizing one area/outcome allowed for concentrated efforts towards closing disparity gaps.
- Use existing, standard reporting solutions to stratify key quality metrics by demographics as a method to identify and prioritize opportunities. I.e., project selection was driven by data.
- Engage patients and caregivers throughout project planning, initiating and executing to ensure the voice of customer is incorporated into the strategy.
- Established an Equity Domain Oversight Committee composed of Inpatient and Ambulatory Leaders. Meet monthly with an annual report out to the Board and active engagement with clinical teams to support and highlight their equity work.
- Initially focused on creating data infrastructure, stratified equity measures, evaluated validity and integrate with internal dashboards.
- Build organizational capacity by educating data collectors so they understand the importance of demographic data collection and how data impacts patient care. Promote patient self-reporting.
- Hired a director of DEI to focus on our team members and community which supports the overall culture of equity awareness.

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Culturally responsive care

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Maturity level	Evaluate each statement about your use of Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey results. Select the statement that best represents your current state.	Percent of respondents
Activate	The organization has begun preliminary investigation, exploration or discussions on the need to review HCAHPS survey results for DEI and HE improvement opportunities.	
Address	The organization stratifies HCAHPS survey results by populations or other demographical data to support DEI and HE improvement.	
Align	The organization stratifies HCAHPS survey results by populations or other demographical data and creates population-specific action plan(s) to address DEI and HE gaps.	
Anchor	The organization annually achieves one or more population-specific HCAHPS action plan goals.	
	None of these statements represent the current state at my organization.	

REFLECTION

Culturally responsive care

Maturity level	Evaluate each statement about your use of Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey results. Select the statement that best represents your current state.	Percent of respondents
Activate	The organization has begun preliminary investigation, exploration or discussions on the need to review HCAHPS survey results for DEI and HE improvement opportunities.	27%
Address	The organization stratifies HCAHPS survey results by populations or other demographical data to support DEI and HE improvement.	39%
Align	The organization stratifies HCAHPS survey results by populations or other demographical data and creates population-specific action plan(s) to address DEI and HE gaps.	21%
Anchor	The organization annually achieves one or more population-specific HCAHPS action plan goals.	5%
	None of these statements represent the current state at my organization.	8%

36% Activate or Not Applicable

Key insights from anchor hospitals
Culturally responsive care

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Physician Partnership: Physician communication was identified as a key driver of the global Rate the Hospital metric. Educated providers on best practices such as demonstrating compassion and patient/family communication, and the impact on quality, safety and outcomes. Also created a pilot program through which the hospital medical team could give patients a PFAC-informed info card to help them understand their role and build a connection and trust with the provider.

Interdisciplinary approach: evaluated which units had the greatest impact on scores and ways to support. Created interdisciplinary teams, consisting of Nursing, Patient Experience, Pharmacy, EVS, Care Coordination and others, who spent time talking with patients and families and team members to develop ways to improve. Units met as a group, which allowed them to learn from each other. Action plans with timelines were reviewed weekly to maintain momentum.

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Workforce diversity development

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Maturity level	Evaluate each statement about your employee advancement pathways. Select the statement that best represents your current state.	Percent of respondents
Activate	The organization has begun preliminary investigation, exploration or discussions on incorporating strategies for historically underrepresented groups in employee advancement programs.	
Address	The organization declares a commitment to supporting employee advancement specific to historically underrepresented groups.	
Align	The organization's employee advancement pathways include strategies for historically underrepresented groups.	
Anchor	The organization demonstrates effectiveness of employee advancement pathways that include strategies for historically underrepresented groups.	
	None of these statements represent the current state at my organization.	

REFLECTION

Workforce diversity development

Maturity level	Evaluate each statement about your employee advancement pathways. Select the statement that best represents your current state.	Percent of respondents
Activate	The organization has begun preliminary investigation, exploration or discussions on incorporating strategies for historically underrepresented groups in employee advancement programs.	34%
Address	The organization declares a commitment to supporting employee advancement specific to historically underrepresented groups.	28%
Align	The organization's employee advancement pathways include strategies for historically underrepresented groups.	17%
Anchor	The organization demonstrates effectiveness of employee advancement pathways that include strategies for historically underrepresented groups.	6%
	None of these statements represent the current state at my organization.	15%

49% Activate or Not Applicable

Key insights from anchor hospitals
Workforce diversity development

- Developed an 8-week diversity in leadership program designed for front-line team members focusing on DEI strategies and opportunities that provide career growth.
- Created a platform focused on fostering growth and innovation with access to professional development classes, leadership initiatives, education assistance programs, career growth pathways and external training programs.
- Partner with local Historically Black Colleges and Universities to provide student mentorship and expand learning and career opportunities.
- Introduce high school seniors to entry-level positions and provide opportunities to develop real world skills such as resume building and interview preparation.
- Intentionally created a program designed from the start to support employees who are members of underrepresented groups as they pursue career growth and step into leadership roles.
- The program includes opportunities for participants to be mentored by more senior leaders who are themselves members of underrepresented groups, providing a safe space to ask questions and share insights on how to grow your career as a member of an underrepresented group.
- This program also requires participants to be nominated by their supervisor rather than self-selecting into the program, thereby ensuring their leader is invested in the employee's career growth.

Community wellbeing and partnerships

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Maturity level	Evaluate each statement about your expectations of community partners. Select the statement that best represents your current state.	Percent of respondents
Activate	The organization has begun preliminary investigation, exploration or discussions about taking the commitment to DEI and HE into consideration when partnering with community-based businesses.	
Address	The organization considers a community partner's vision for DEI and HE when creating a contract.	
Align	The organization requires that contract language with community partners includes a shared commitment to non-discrimination and pursuit of health equity.	
Anchor	The organization establishes tracking and analysis of referrals-to-care continuity partners, segmented by diversity dimension, to ensure equity in services delivered.	
	None of these statements represent the current state at my organization.	

Community wellbeing and partnerships

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Maturity level	Evaluate each statement about your expectations of community partners. Select the statement that best represents your current state.	Percent of respondents
Activate	The organization has begun preliminary investigation, exploration or discussions about taking the commitment to DEI and HE into consideration when partnering with community-based businesses.	21%
Address	The organization considers a community partner's vision for DEI and HE when creating a contract.	16%
Align	The organization requires that contract language with community partners includes a shared commitment to non-discrimination and pursuit of health equity.	21%
Anchor	The organization establishes tracking and analysis of referrals-to-care continuity partners, segmented by diversity dimension, to ensure equity in services delivered.	13%
	None of these statements represent the current state at my organization.	29%

50% Activate or Not Applicable

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Key insights from anchor hospitals
Community wellbeing and partnerships

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- Formed a strategic partnership with 14 local charity clinics and FQHCs with two-way data sharing to track efficacy. The program uses in-hospital liaisons to screen and vet potential partners who qualify, and then counsels the patients on the importance of primary care and follow up care after discharge.
- A warm referral is made to the clinic that best fits the patient's needs, and any wrap around services are identified such as co-pay assistance and transportation. Analyze primary care and follow up appointment show rates and the number of days between ED visit/discharge and appointments.
- Track readmissions data on the patients to understand longer-term outcomes and identify improvement opportunities in our operations or within the partnership.
- Demographic data on these patients such as race/ethnicity, insurance status, age, and zip code, are evaluated on an annual basis.
- When we enter into formal agreements with CBOs, whether they are funded by us or not, we require regular reporting inclusive of demographics (race, gender, insurance type, age at a minimum) and referral management to monitor outcomes as well as diversity dimensions, etc.

Lessons Learned

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- DHEI journeys look different at every organization. Developing a level of maturity takes time and concerted effort.
- DHEI must be integrated into all areas of the business and not a standalone topic or check-the-box exercise.
- Data must drive improvement – we're getting there! Data, analytics and outcomes domain had highest percentage of respondents in "align" and fewest in "anchor" vs. other domains.

Key Takeaways

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- Collaboration with leaders across the organization is key to DHEI maturity (e.g., C-suite, human resources, data/analytics, information technology, population health, community benefits, etc.).
- Double down on data! Review data regularly, stratify where appropriate, look for gaps and measure improvement.
- Set quantifiable goals in each DHEI domain and hold all employees accountable for achieving.

Questions?

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This educational session is enabled through the generous support of the Vizient Member Networks program.

REFLECTION

Developing a Health Equity Quality Index

Brownsyne Tucker Edmonds, MD, MPH, MS
VP, Chief Health Equity Officer
Indiana University Health

REFLECTION

Office of Health Equity Research and Engagement (HERE) Strategic Pillars

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Address, impact and make lasting change in the societal, institutional and interpersonal health inequities across Indiana.

3 **strategic pillars** will support equitable levels of **Access, Experience & Outcomes of Care** for the diverse patients and communities that IU Health serves.

- **Data**: Monitoring & Transparency
- **Rigor**: Research & Evidence-based Interventions
- **Engagement**: Community & Stakeholder

REFLECTION

Office of Health Equity Research and Engagement (HERE)
Strategic Pillars

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Address, impact and make lasting change in the societal, institutional and interpersonal health inequities across Indiana.

3

System Health Equity Priority Areas will guide our programs, policies and systems in addressing health inequities across the lifecourse for our communities.

- **Cardiovascular**
- **Maternal/Infant**
- **Behavioral Health**

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2023 Watch Metric: Health Equity Quality Index

Monitors Progress on Closing Disparity (Gaps) in 3 Quality Measures

Equity Metric	Gap
Black/White Uncontrolled HTN	11%
Black/White Severe OB Complications (CMS)	.47%
Black/White Childhood Immunizations	21%

Gap Closure	Score
Gap INCREASE	0 (Circuit Breaker)
No change	1
1-10% Decrease	2
11-20% Decrease	3
21-30% Decrease	4
31%+ Decrease	5

Internal Indiana University Health data

Health Equity Performance Improvement Council (HEPIC)

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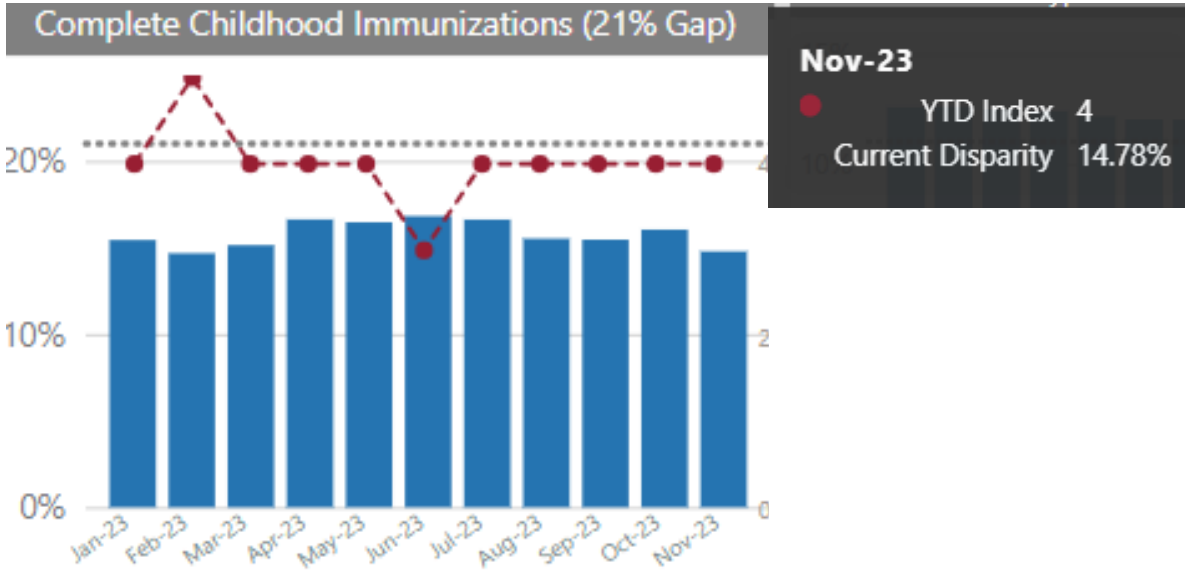
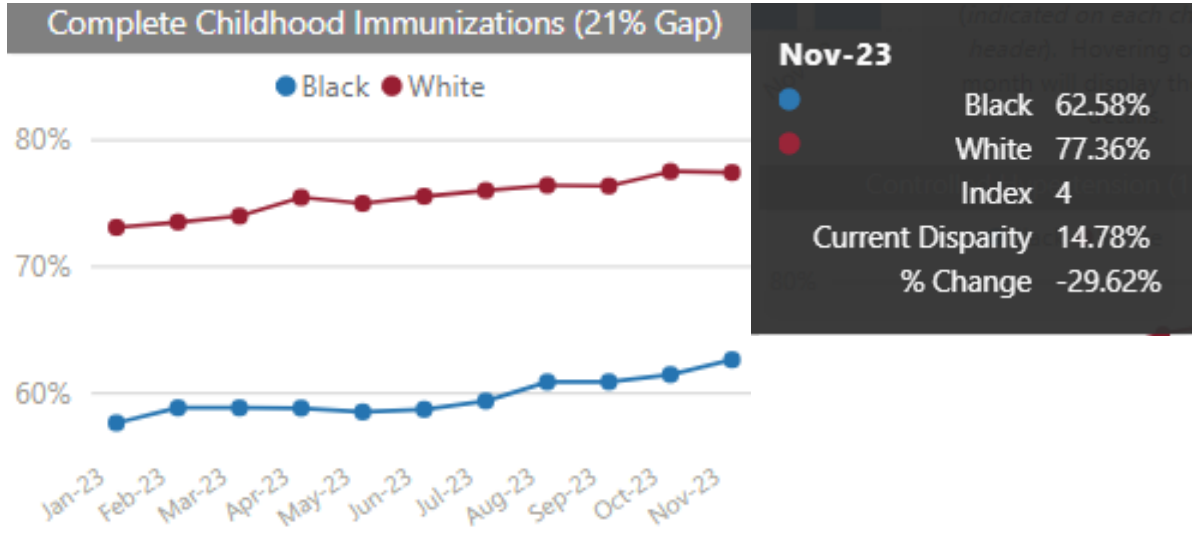
- Responsible for the oversight of developing and executing The Joint Commission's newly required Health Equity Plans and performance improvement initiatives, organized around the system's new Health Equity Quality Index

  - Chief Medical Officers (Inpatient)
  - Chief Physician Executives (Ambulatory)
  - Regional Health Equity Medical Directors
  - Departmental Vice Chairs for Health Equity

Complete Childhood Immunizations (21%)

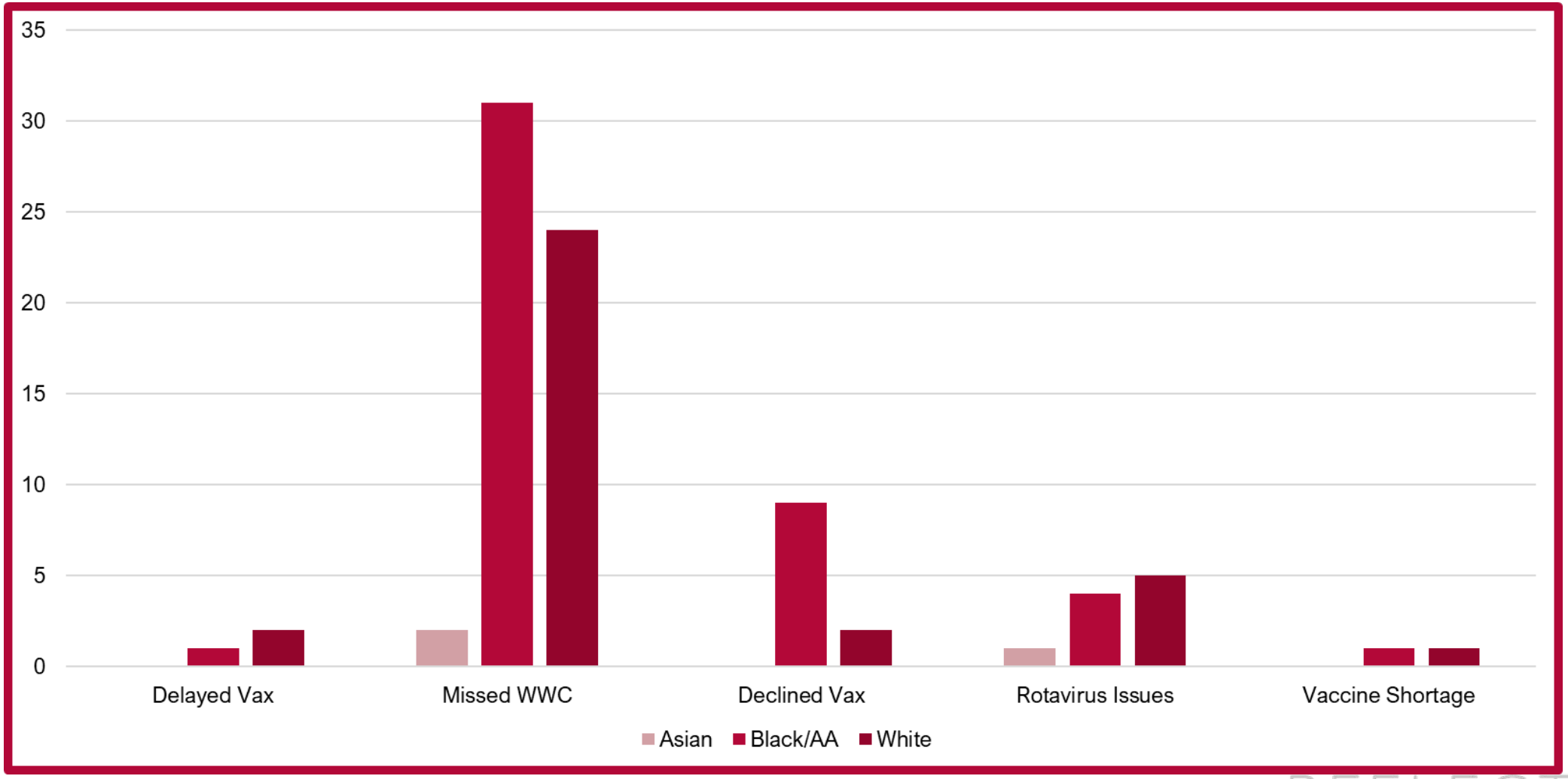
- ~30% gap closure from baseline (Oct. 2022)
- Disparity performed below baseline for most of the year (Index score=4), but we did not see month-over-month improvement in the measure
  - Patient Navigator efforts focused on rotavirus take at least a year to impact the metric





Internal Indiana University Health data

Missed Rotavirus Visits



Internal Indiana University Health data

Riley PCC Navigator Pilot

Goal: patient access to 2,4,6-month WC visits and complete vaccine schedule by 7 months and 30 days

1 2-month-old B/AA patient

- Added to Riley PCC Patient Navigator Tracker

2 Patient Navigator

- Review first/newborn progress note, last progress note, and social work notes prior to outreach
- Outreach to patient prior to 2-month WC visit – confirmation of appointment and offer transportation arrangement if needed

3 Outreach

- Patient makes 2-month WC appointment
- Patient does not make 2-month WC appointment

4 Follow Up/Referrals

Patient Navigator documentation in Cerner
- Appointment complete
- 4 – month appointment scheduled

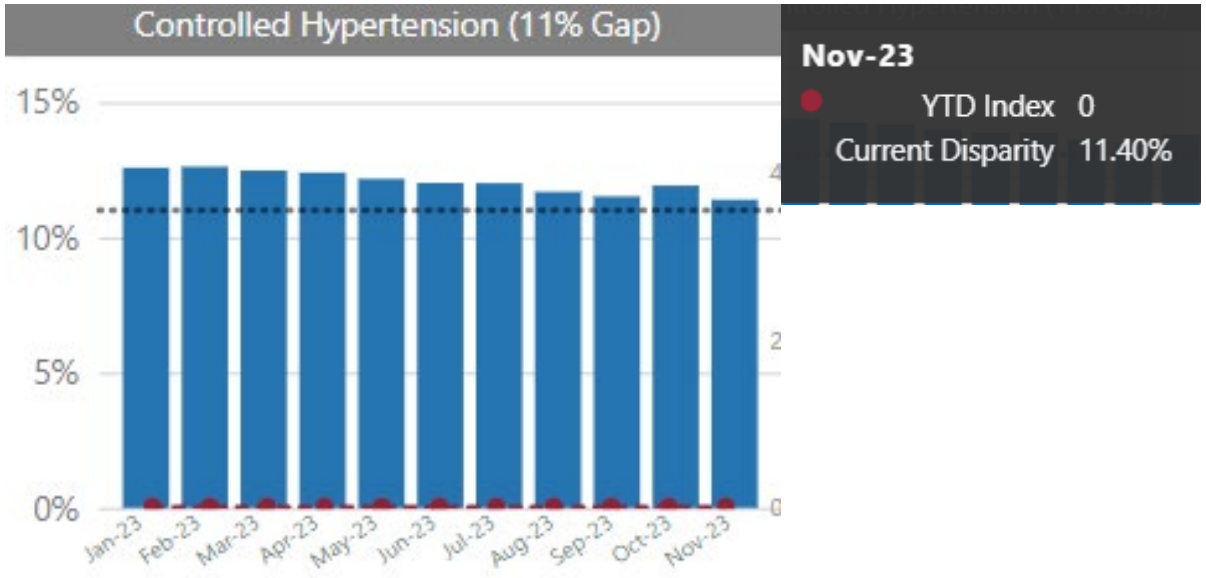
Continuous Outreach
- Ahead of 4 and 6 – month appointments

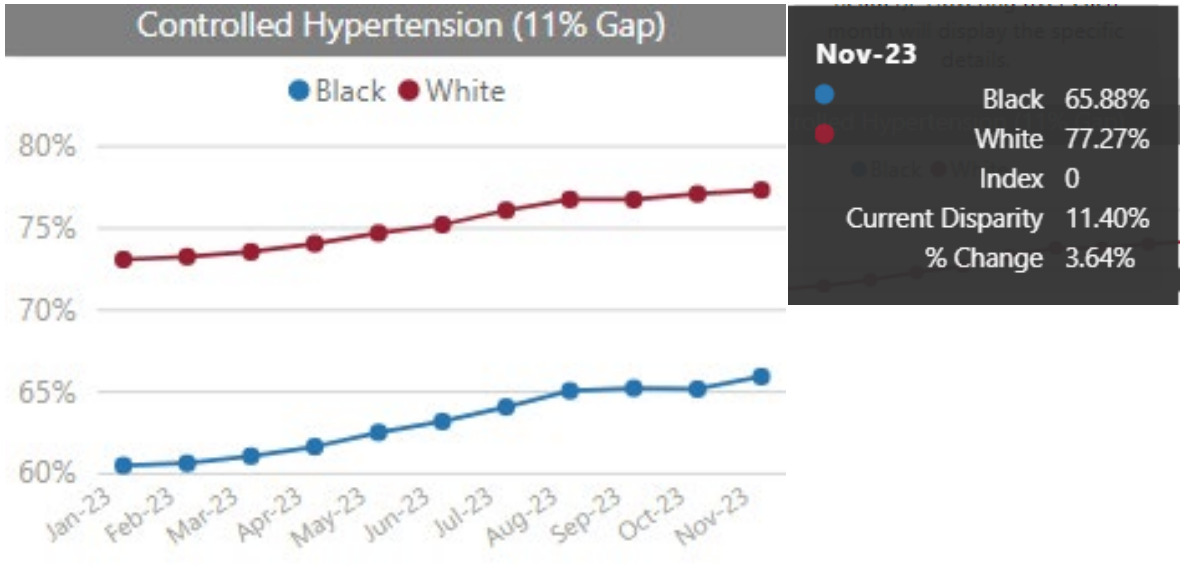
MA message Patient Navigator in Cerner
- New appointment scheduled within 7 days of original appointment
- Outreach to patient to address barriers to appointment i.e., arrange transportation or referral to social worker for additional needs

Continuous Outreach
- Ahead of 4 and 6 – month appointments

Controlled Hypertension Disparity Gap (11%)

- Steady decline in gap from Jan to Sept 2023
- Proposed to incorporate HTN Disparity into the Ambulatory Quality Index for incentivization on the Promise Dashboard in 2024. Board approved October 2023.
- Despite failing to close the gap, Black patients' HTN control rates improved **10% faster month-over-month than the System** through 2023 resulting in overall rates **improving by 5 percentage points**





Internal Indiana University Health data

CHECK-IT – Remote Patient Monitoring

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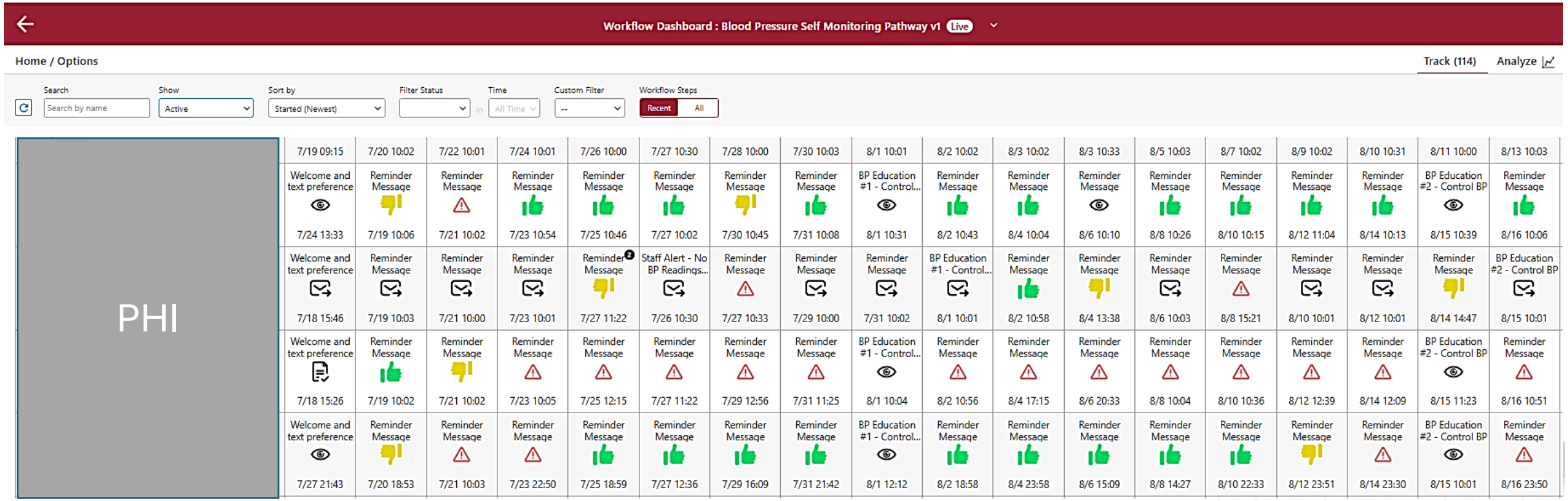
Clinic CHWs imbedded in 3 iHEART clinics enroll patients with BP >140/90 for ongoing support and review their BP submissions to: 1) follow-up on severely elevated readings, 2) refer for virtual pharmacy management, 3) identify and overcome SDOH barriers contributing to their high BP readings.

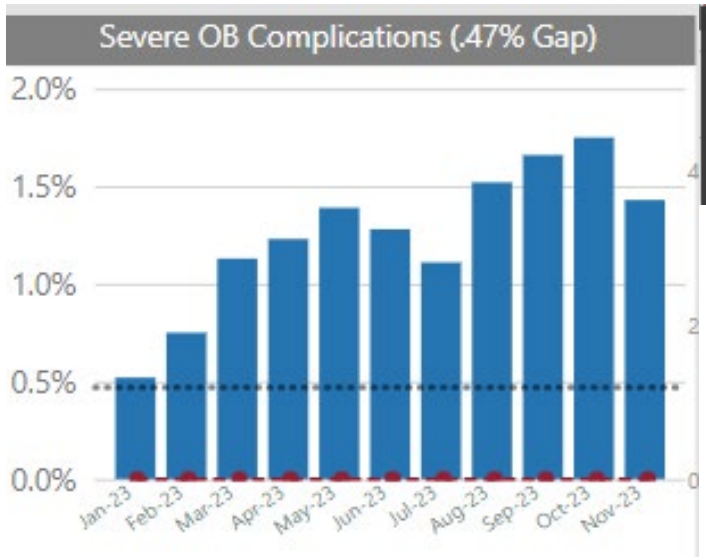
In the first 6 months, 489 enrolled and, **on average reduced their SBP by 6mmHG**. Over the 4-month program, **57% of participant's converted to met from unmet.**

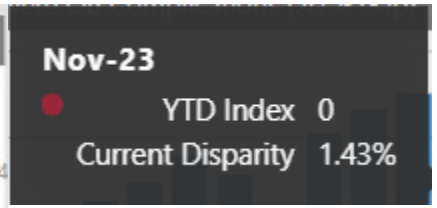


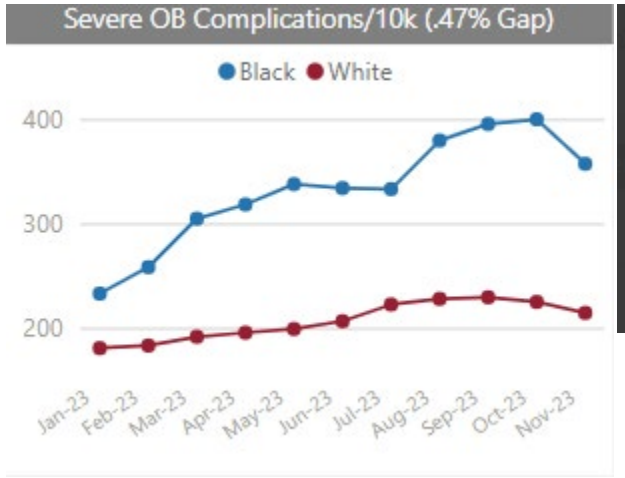
Internal Indiana University Health data

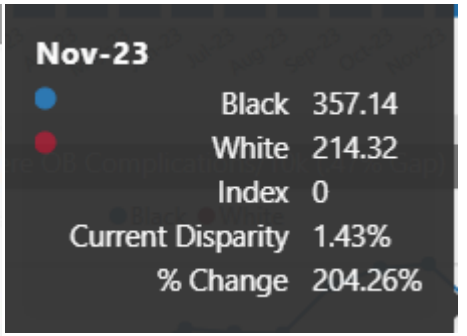
Severe Obstetric Complications (.47%)

- Reset of this measure in May revealed largest, and GROWING, Blk/Wht disparity
- Ended the year with more than a doubling in the size of the gap
- 4/5 Top SOBC dx related to hemorrhage management (i.e. BPT, ARF, DIC, hysterectomy)
- DMAIC work with Operational Excellence to ID largest drivers of SOBC disparity>>BPTs at Riley among Black women undergoing unscheduled primary cesareans
- Working with HEPIC, the OB Gyn Clinical Effectiveness Council, and regional quality and safety teams to drive gap closure with anemia and pp hemorrhage management overhaul



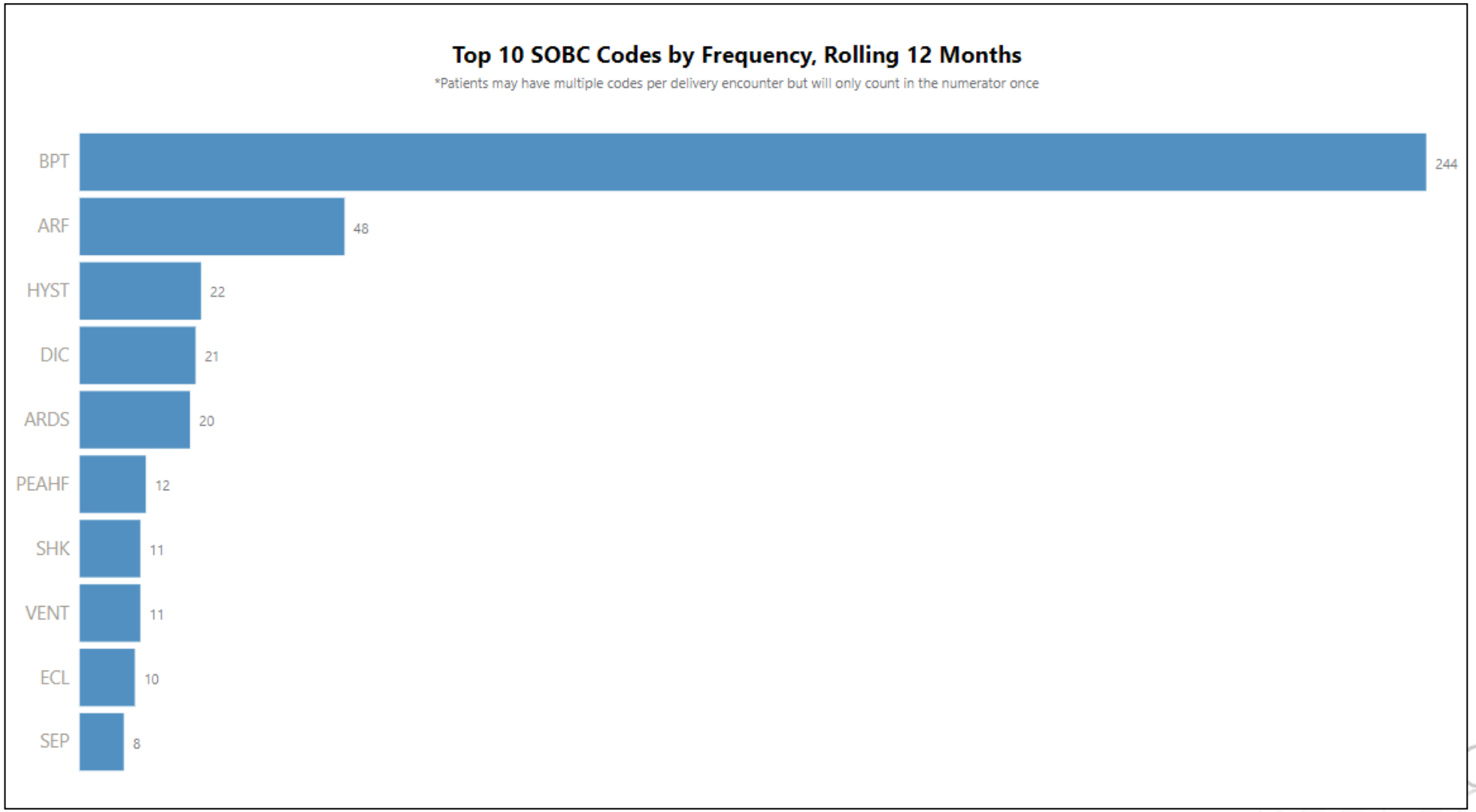






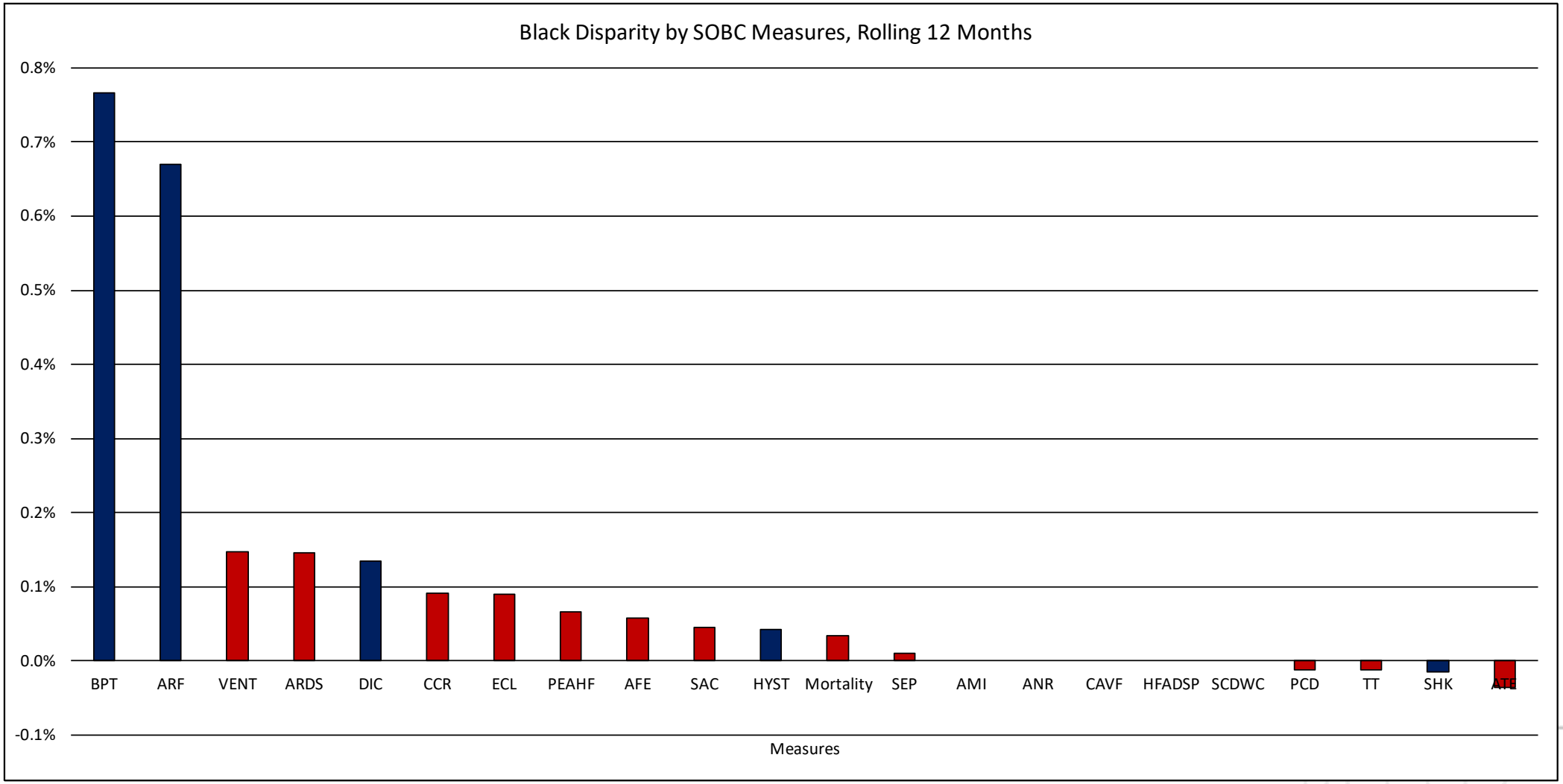
Internal Indiana University Health data

Top SOBC Dx's: Hemorrhage-related



Internal Indiana University Health data

Largest SOBC Disparity: Transfusion & Acute Renal Failure



*Blue bars represent measures that could be impacted by hemorrhage management

Internal Indiana University Health data

Estimated Blood Loss (EBL)

Black patients in our had a higher average EBL than white patients and patients overall

Race	Average EBL	Count of Patients
Black or African American	465	5370
white	400	26027
Grand Total	426	31397

Internal Indiana University Health data

Medication Administration Record (MAR)

Black patients in our denominator were also less likely to receive thrombogenic agents during their delivery encounter than white patients

Medication	Pearls Race	Numerator	Denominator	%Received	%Diff
Methergine	Black or African American	115	3507	3.3%	2.6%
	White	1106	18857	5.9%	
Misoprostol	Black or African American	1233	3507	35.2%	5.8%
	White	7720	18857	40.9%	
Packed red blood cells	Black or African American	53	3507	1.5%	0.3%
	White	339	18857	1.8%	
Platelets	Black or African American	88	3507	2.5%	-0.8%
	White	322	18857	1.7%	
Toradol	Black or African American	112	3507	3.2%	-0.8%
	White	450	18857	2.4%	
Tranexamic acid	Black or African American	124	3507	3.5%	2.8%
	White	1201	18857	6.4%	

Indiana University Health

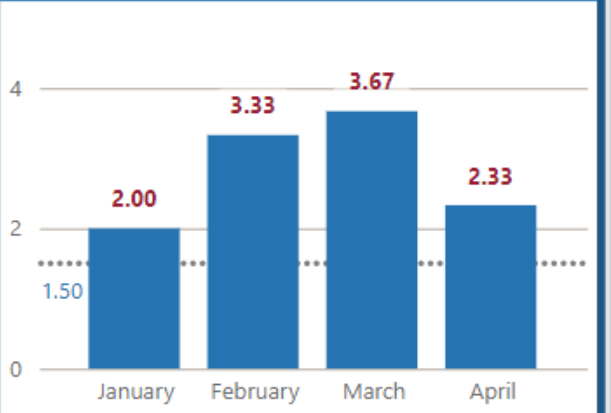
Watch Metric | Health Equity Quality Index

Adult Academic Health Center | Indy Suburban Region | Northeast Region | South Central Region | West Central Region

East Central Region | IUHP | Riley Hospital for Children | System

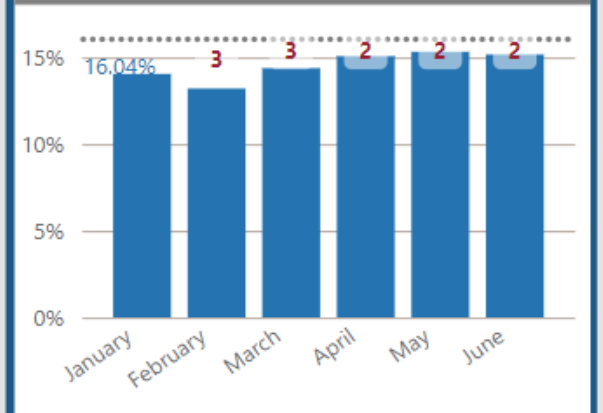
Health Equity Quality Index

Monthly avg delayed to include 30 Day Readmit



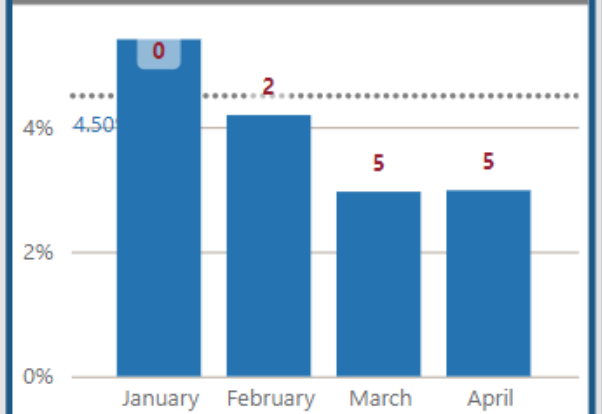
Complete Childhood Immunizations

Gap View



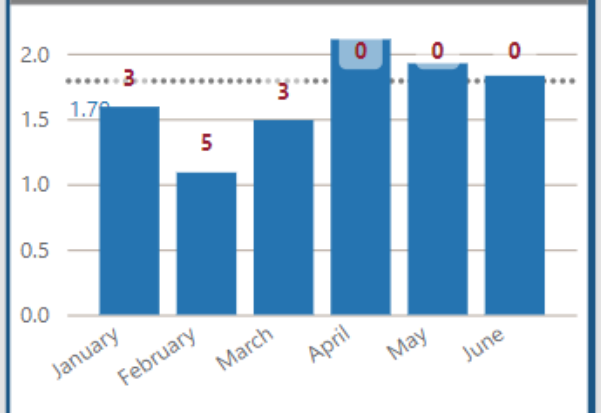
30 Day Readmission

Gap View

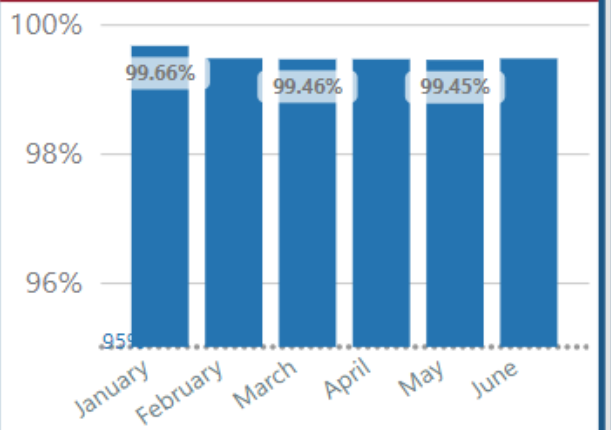


Severe OB Complications

Gap View



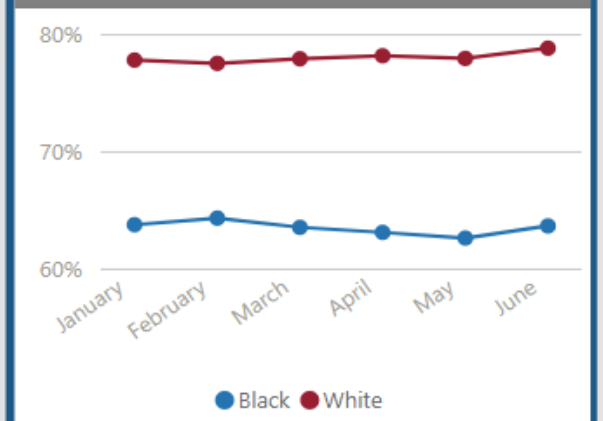
REaL Data Capture (All Fields)



Internal Indiana University Health data

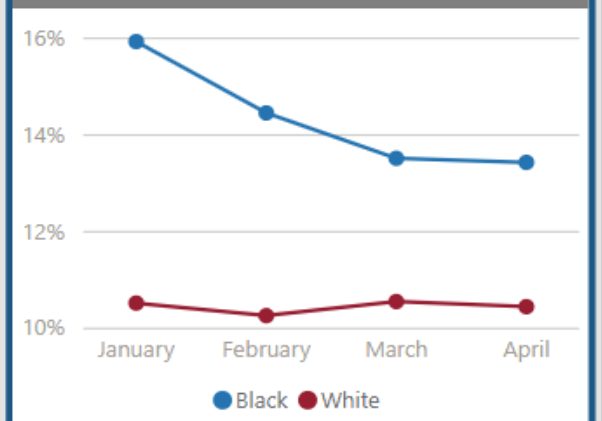
Complete Childhood Immunizations

Performance View



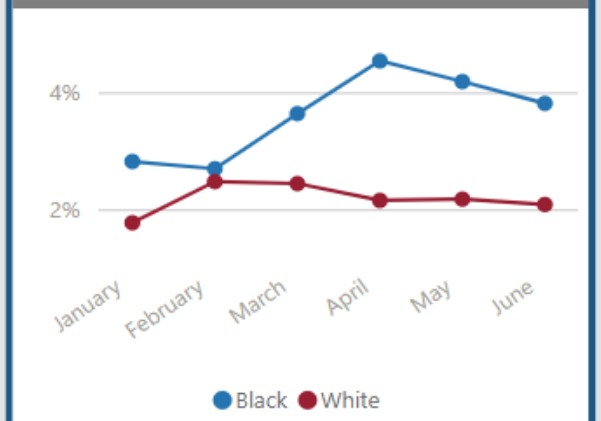
30 Day Readmission

Performance View



Severe OB Complications

Performance View



Lessons Learned

vizient.

- IU Health initiated this work by enhancing the quality of REaL data through a “Why We Ask: We Ask Because We Care” campaign in 2022. This internal and community-facing initiative improved REaL data capture from 82% to 93% over 2 years. **Reliable data is critical before progressing toward influencing incentives with disparity metrics.**
- **Capacity building is also key**. The HEPIC serves to designate ownership and oversight for performance improvement efforts needed to address identified disparities in care.
- Although guidance and performance expectations were developed centrally, **the implementation of the work must be carried out in a decentralized and differentiated manner**. Our team advocates for this differentiation while aligning the efforts around the HEQI, positioned as the system’s North Star.
- **It’s challenging to chase a moving target.** We have done exceptional work improving black patient HTN control performance but disparity persists because we continue to fail to outpace the progress of our white patient population.

REFLECTION

Key Takeaways

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- Disaggregated data analysis are needed to identify drivers of disparity.
- Advancing health equity requires that we ‘grade’ ourselves based on the poorest-performing segments of our patient populations.
- Incentivizing equitable outcomes at a system-level brings these concepts into focus; elevates these conversation to leadership; and aligns resource allocation around improving inequitable performance

REFLECTION

Questions?

vizient.

Contact:

Brownsyne Tucker Edmonds, MD, MPH, MS, btuckeredmon@iuhealth.org

This educational session is enabled through the generous support of the Vizient Member Networks program.

REFLECTION

Breaking Barriers: Stanford's Quest for Healthcare Equity

Bilwa Buchake, MPH
Director, Quality Analytics, Stanford Health Care

Dr. Alice Yan, PhD
Director, Health Equity Research, Stanford Health Care

Outline

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Who We Are &
Who We Serve

Health Disparities
Analysis

Current Actions &
Next Steps

REFLECTION

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Stanford Health Care – Who We Are

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Founded in 1959

Not For Profit

645 Licensed Beds

Academic Medical Center

Highly ranked

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Stanford Health Care – Operational Plan

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$$V = \left[\frac{Q + S}{C}\right] \times E$$

Stanford Health Care's Value Equation

Value equals quality plus service divided by cost, amplified by the engagement of our employees

QUALITY, SAFETY & HEALTH EQUITY (Q)

PATIENT EXPERIENCE (S)

ENGAGEMENT AND WELLNESS (E)

FINANCIAL STRENGTH (C)

REFLECTION

Health Equity as a Strategic Priority

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SEP 2021

- Health Equity formally added to FY22 Operational Plan

MAR 2022

- Health Equity Council kick-off with focus on: Strategy & Culture, Governance & Alignment, and Community

SEP 2022

- Joyce Sackey, MD, FACP joined Stanford Medicine as the inaugural Chief Equity, Diversity, and Inclusion Officer (CEDIO)
- Operational goal to develop Health Disparities Report

JAN 2023

- Work underway to create inaugural Health Disparities Report

APR 2023

- Development of Stanford Medicine Inclusive Excellence and Health Equity Strategic Plan

JUL 2023

- Launched search for Chief Health Equity Officers at SHC and SMCH
- Inaugural Health Disparities Report completed

AUG/ SEP 2024

- Chief Health Equity Officers for SHC and SMCH started

REFLECTION

FY23 Operational Plan: Health Equity Goals

01 | **Annual Health Equity Report:**

Identify disparities in quality and safety outcomes based on patients' demographic variables.

02 | **Equitable Access to Research/Clinical Trials:**

Perform baseline assessment of inclusion practices related to underserved populations/patients enrolled in clinical trials.

Nguyen Family

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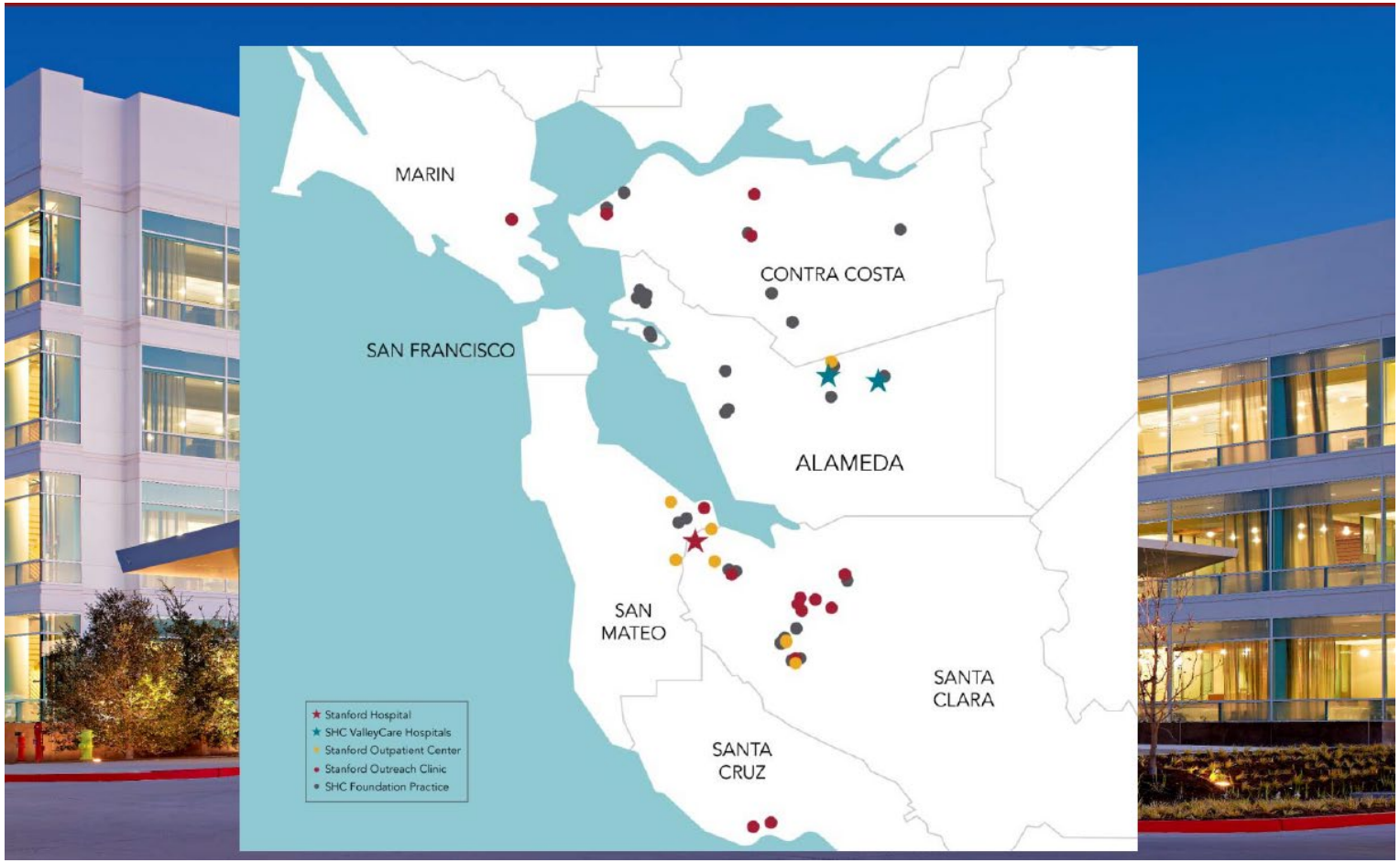
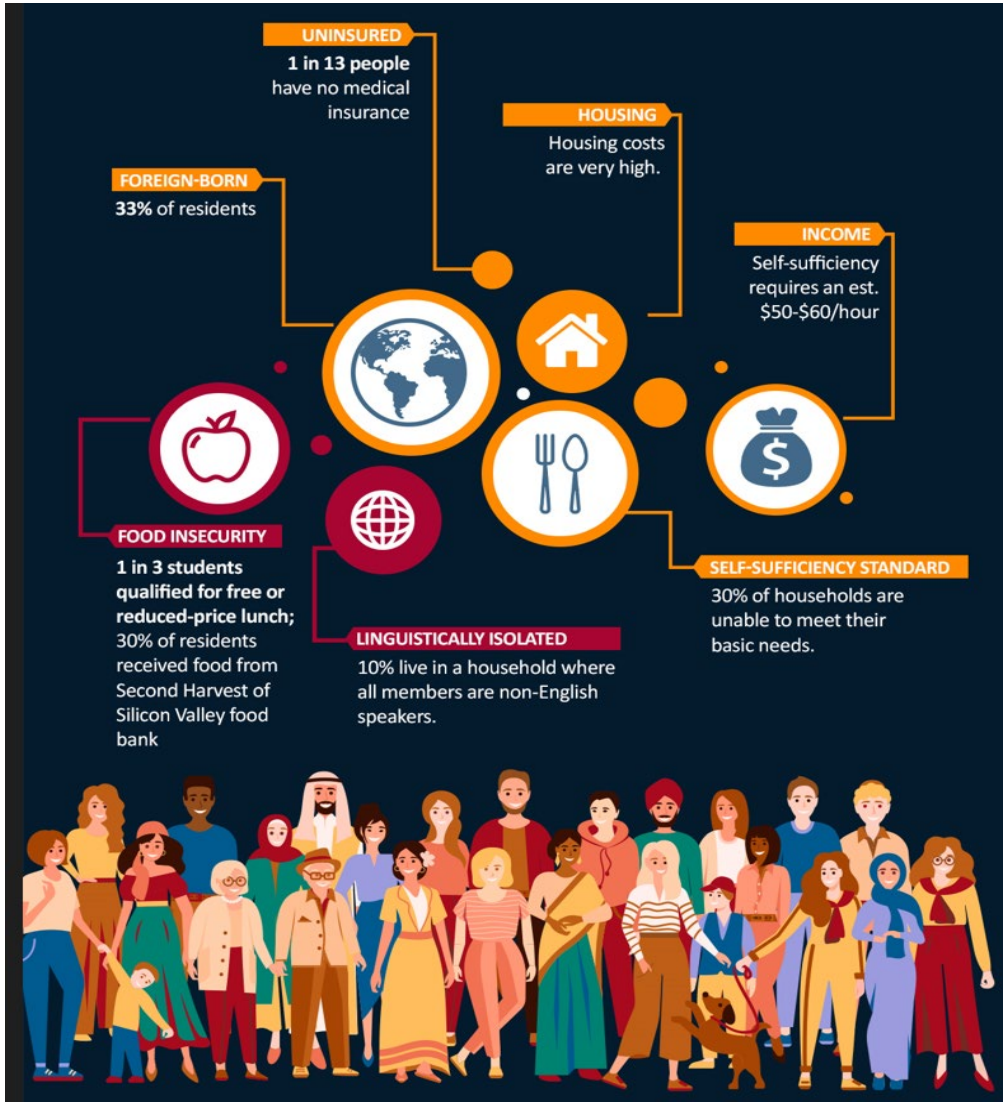
Stanford Health Care – Who We Serve



Stanford Health Care's Main Campus is located **40 miles south of San Francisco** and 20 miles north of San Jose. Our community represents **21 counties within 5 regions**.

Data source: Stanford Health Care Community Partnership Program, FY 2021 Community Impact Report.

Stanford Health Care – Who We Serve



Data source: Stanford Health Care Community Partnership Program, FY 2021 Community Impact Report.

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Inaugural Health Disparities Report

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Health Disparities Report: Goals

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Primary Aim: To identify potential sociodemographic disparities in quality and safety outcomes within Stanford Health Care's patient population.

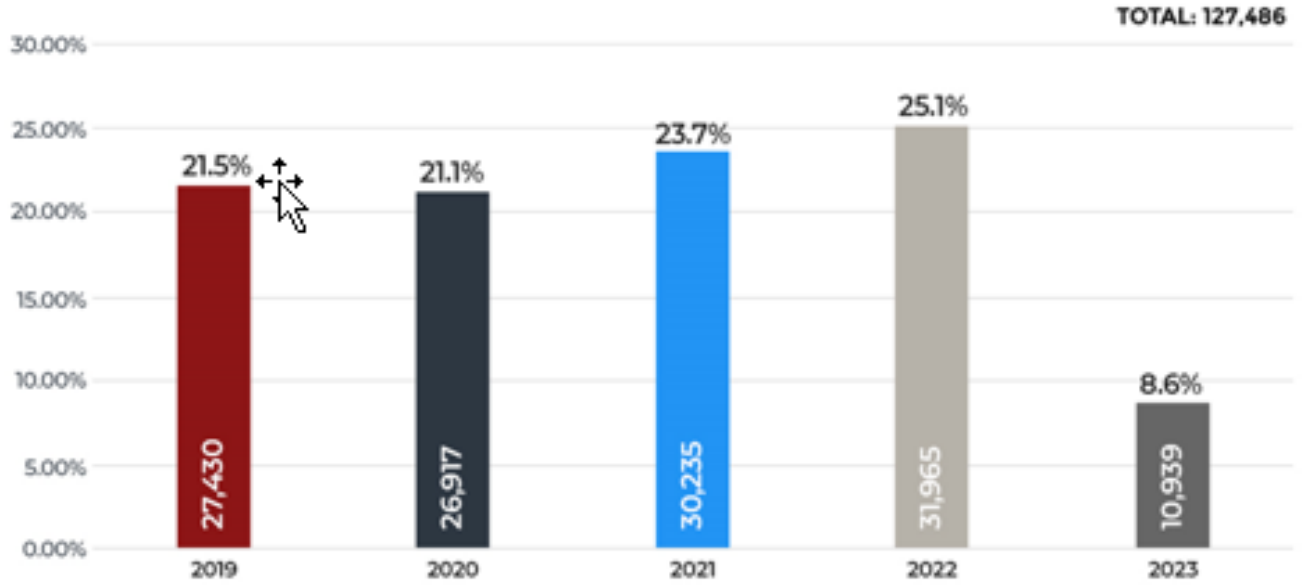
For our inpatient population, the report investigates three key domains: Mortality, Effectiveness, and Safety & High Reliability, using 2019 -2023 EMR.

For ambulatory population, the report examines three preventive measures: Hypertension control , Clinical depression screening , and Hemoglobin A1c control.

REFLECTION

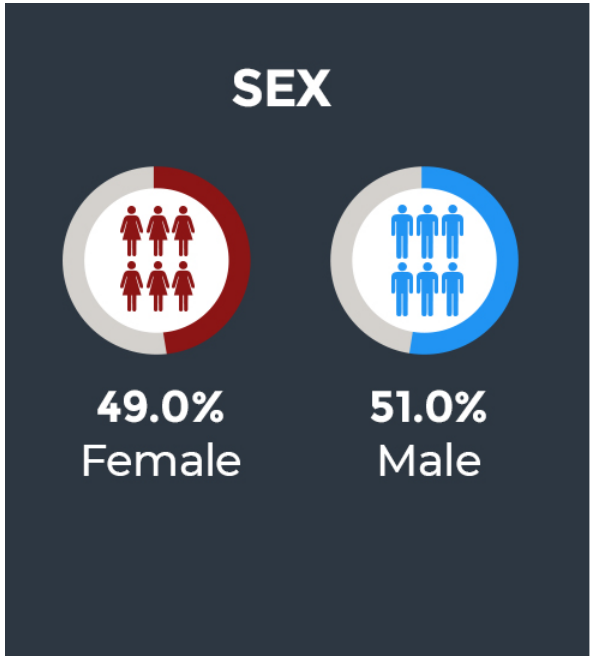
Findings Overview: Demographics

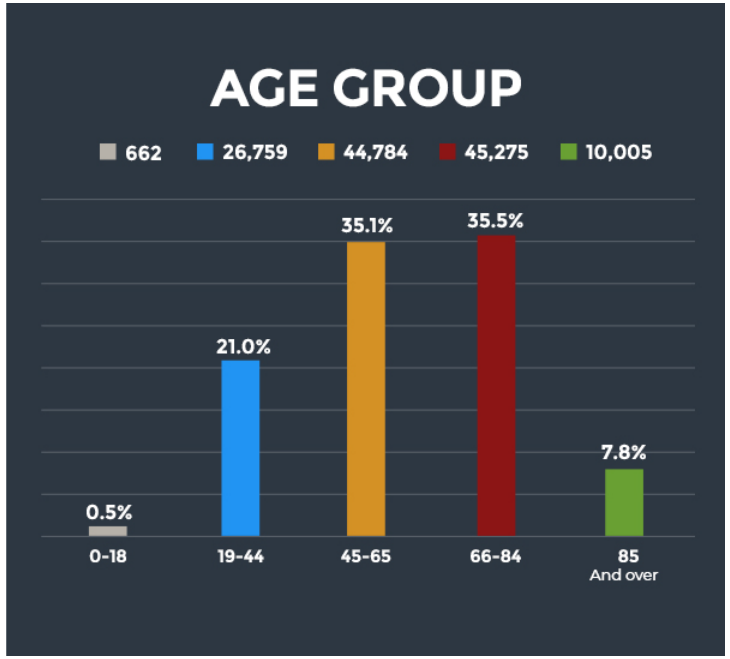
Findings Overview: Patient Demographics

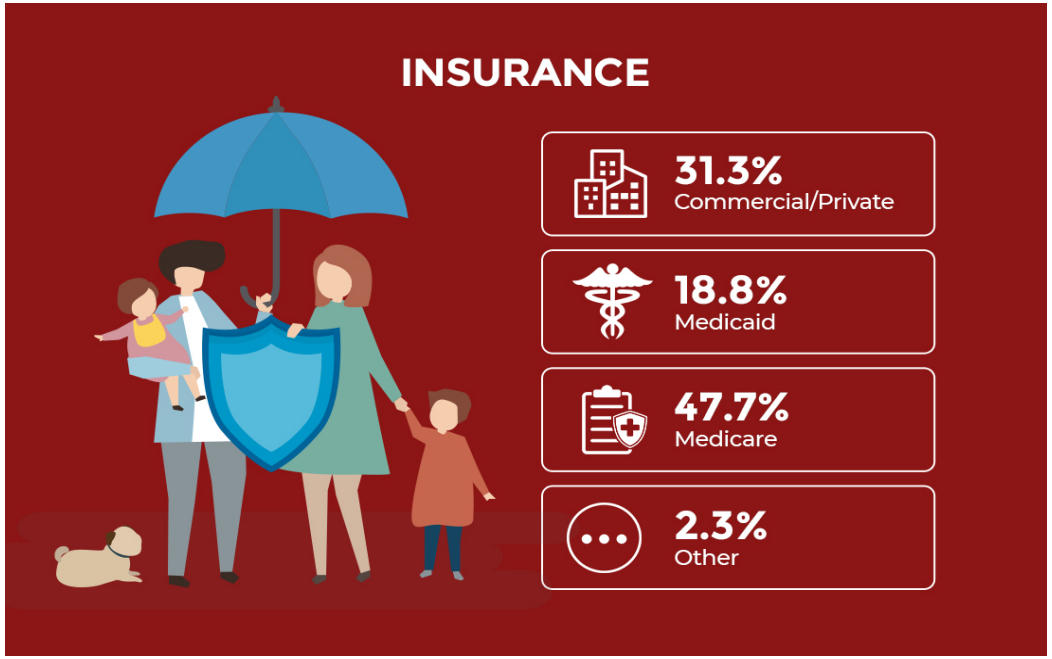


Stanford Health Care Internal Data

Findings Overview: Patient Demographics

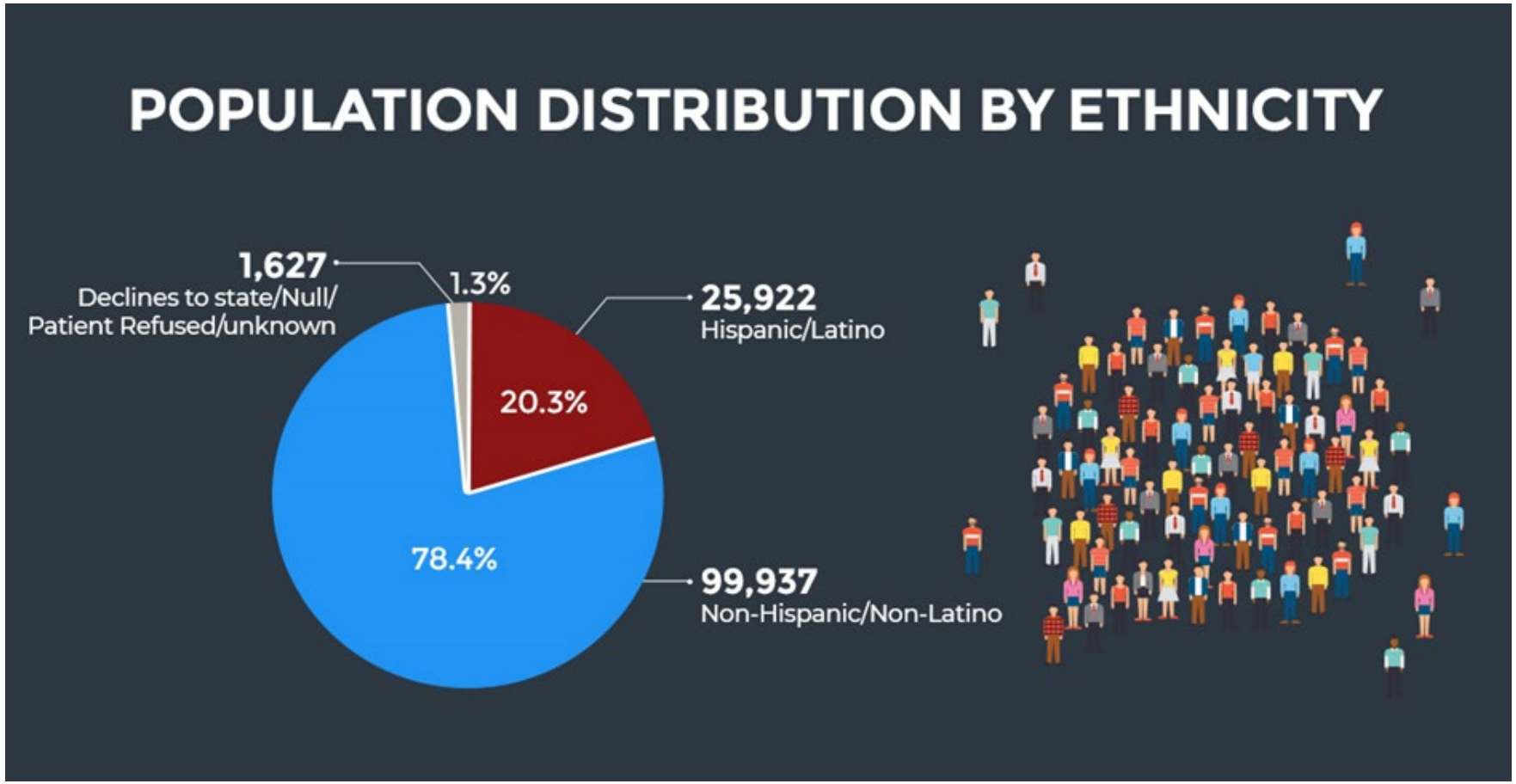






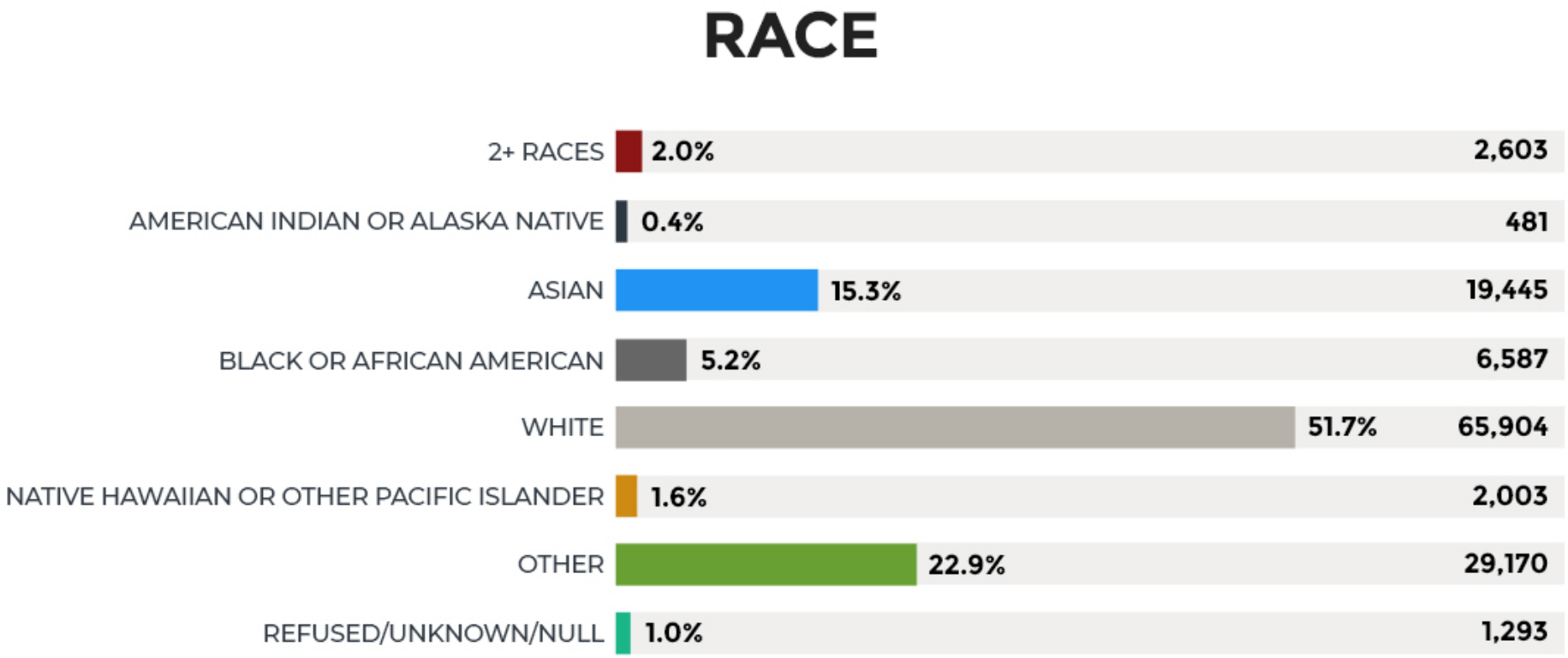
Stanford Health Care Internal Data

Findings Overview: Patient Demographics

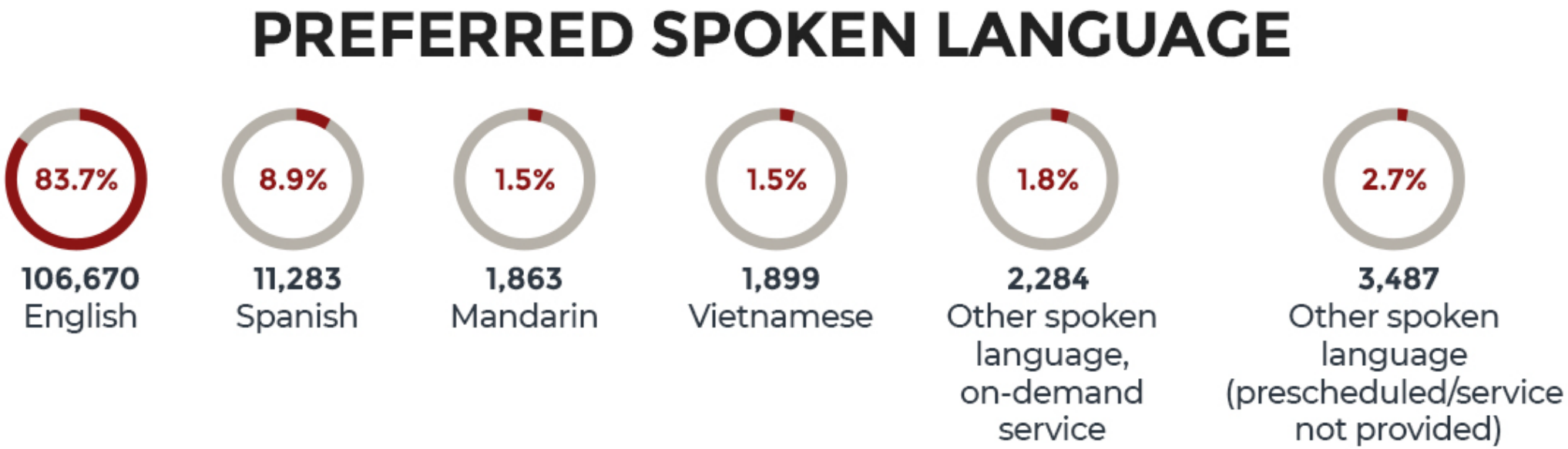


Stanford Health Care Internal Data

Findings Overview: Patient Demographics



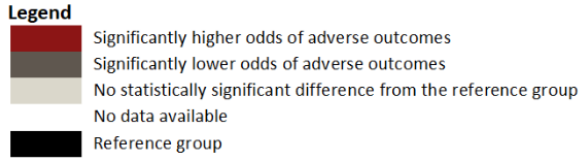
Findings Overview: Patient Demographics



Stanford Health Care Internal Data

Findings Overview: Results

Results from Multivariate Analysis



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LOS: Length of Stay; **Readmission**: 30-day Readmission; **CAUTI:** catheter-associated urinary tract Infection; **CLABSI**: central line-associated bloodstream infection; **COCDIFF**: community-acquired clostridium difficile Infection; **HOCDIFF**: hospital-associated clostridium difficile Infection

	LOS	Readmissions	Mortality	CAUTI	CLABSI	HOCDIFF	COCDIFF	Hypertension Control	Screen for Depression	Hemoglobin A1c Control
Race										
2+ races										
American Indian or Alaska Native										
Asian										
Black or African American										
White										
Native Hawaiian or Other Pacific Islander										
Other*										
Refused/Unknown/Null										
Ethnicity										
Hispanic/Latino										
Non-Hispanic/Non-Latino										
Declines to state/Null/Patient Refused/unknown										
Preferred spoken language										
English										
Spanish										
Mandarin										
Vietnamese										
Other spoken language, on-demand service										
Other spoken language, prescheduled/no service										
Insurance										
Commercial/private										
Medicaid										
Medicare										
Other										

ECTION

Stanford Health Care Internal Data

Results Summary

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- **Black or African American Patients** (compared to White patients) have a statistically significant
  - Higher mortality risk.
  - Increased likelihood of 30-day readmissions.
  - Longer hospital stays.
  - Lower likelihood of achieving optimal hypertension and Hemoglobin A1c levels.
- **Asian Patients** (compared to White patients) have a statistically significant
  - Higher mortality risk.
  - Higher risk of 30-day readmissions.
  - Higher likelihood of contracting hospital-associated clostridium difficile infections.
- **Hispanic/Latinx Patients** (compared to non-Hispanic patients) have a statistically significant
  - Higher risk of 30-day readmissions.
  - Longer hospital stays.
  - Increased odds of central line-associated bloodstream infections.
  - Lower likelihood of achieving optimal Hemoglobin A1c levels.

REFLECTION

Results Summary

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•**Vietnamese-speaking Patients (**compared to the patients whose preferred language is English) have a statistically significant

- Increased odds of 30-day readmissions.
- Higher risk of developing catheter-associated urinary tract infections.

•**Patients with Languages Not Supported by Immediate On-Demand Services (**compared to the patients whose preferred language is English) have a statistically significant

- Higher mortality risk.
- Lower likelihood of receiving clinical depression screening.

Actions to Address Health Disparities

FY24-25 Operational Health Equity Goals

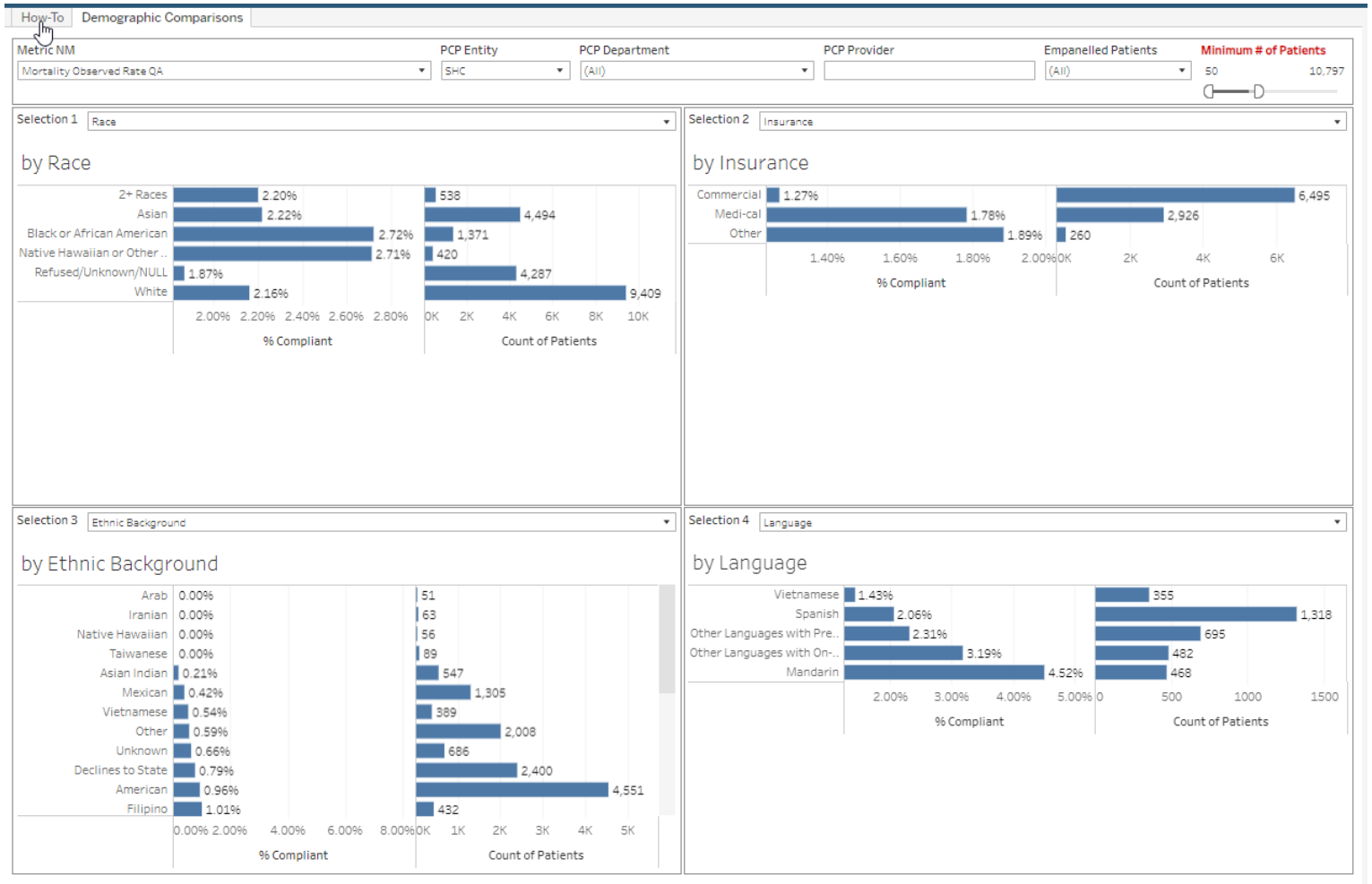
01 | Annual Health Equity Report:

Continue disparity analysis and digitize access to disparity data

02 | Health Equity Accreditation:

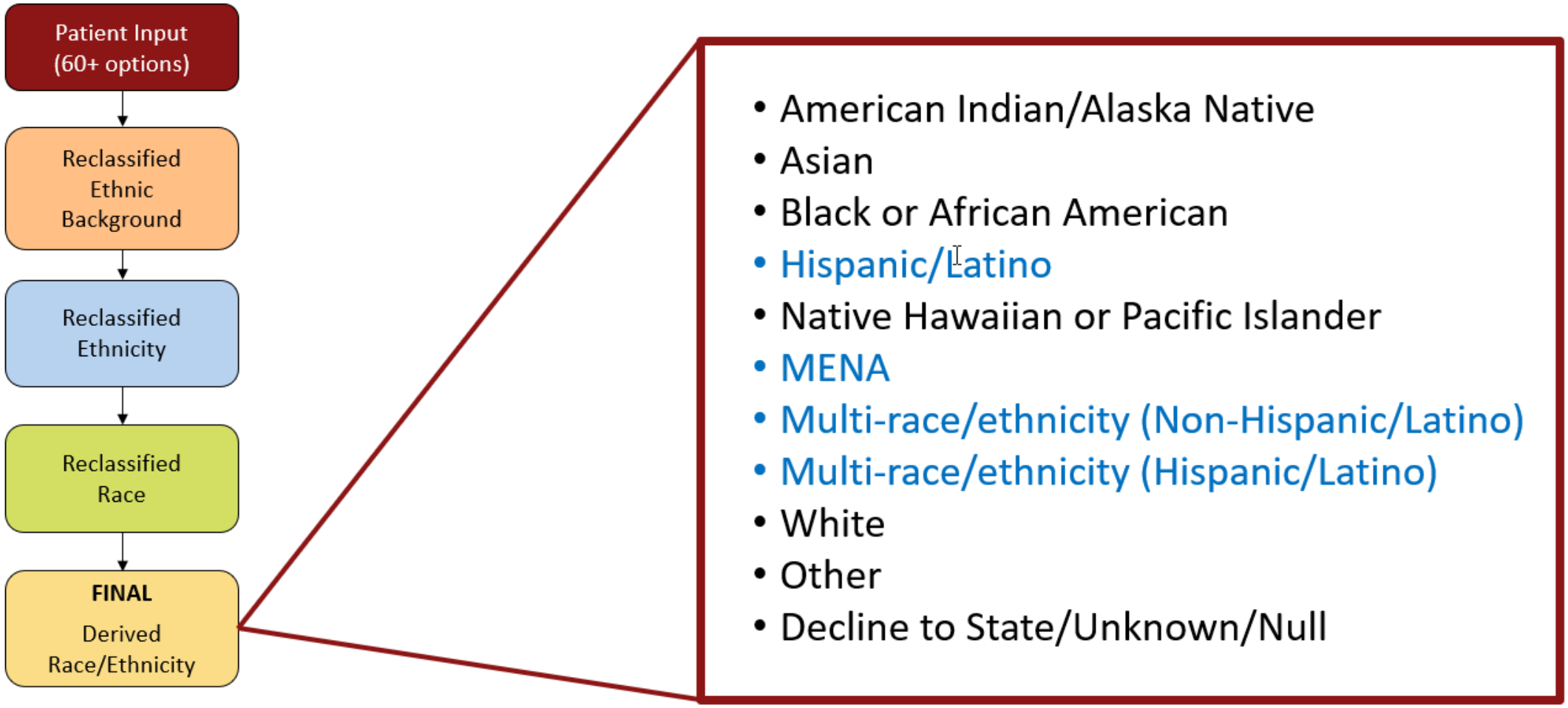
Achieve nationally recognized Health Equity Certification

Health Disparities Dashboard



- Releasing September 2024
- Digital, interactive version of the Health Disparities Repot
- Allows for comparison of up to four demographic factors
- Statistically significant disparity identification
- Broad range of inpatient and ambulatory metrics

Derived Race and Ethnicity Framework



Preparing for TJC's Healthcare Equity Certification

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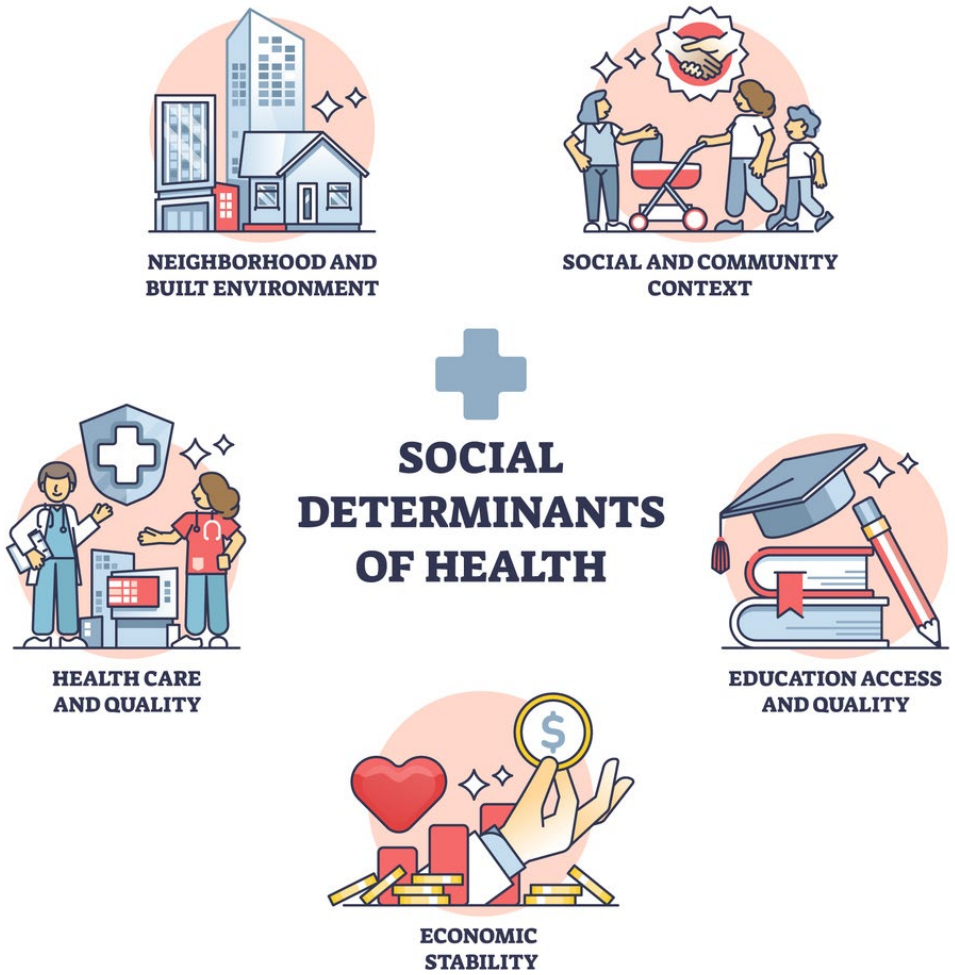
- Emphasizes structures and processes to reduce healthcare disparities
- Promotes diversity, equity, and inclusion for staff
- Five key domains:
  - Leadership
  - Collaboration
  - Data collection
  - Provision of care
  - Performance improvement

REFLECTION

Screening for Social Needs



Systematically identify and assist with the health-related social needs of patients that may be barriers to good health.

Comprehensive Clinical Interpreter Services

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- Available in 200+ languages and American Sign Language (ASL)
- On-demand (24/7) and prescheduled services
- Service Modalities:
  - In-person
  - By phone: VOAIT
  - Video Medical Interpretation (VMI)
    - Jabber VMI
    - Zoom VMI
    - Vidyox

REFLECTION

Lessons Learned

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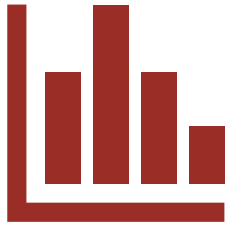

Data Quality

Data Governance

Collaboration

REFLECTION

Key Takeaways

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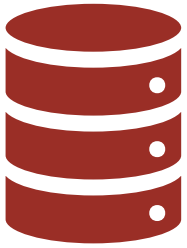
Guiding Framework



Data Integration

Intervention Design

REFLECTION

Questions?

Stanford MEDICINE | Health Care

vizient.

Contact:

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Alice Yan, AliceYan@stanfordhealthcare.org

This educational session is enabled through the generous support of the Vizient Member Networks program.

REFLECTION

vizient.

Reducing Readmission and Improving Health Outcomes through an Evidence-based Approach

Presenters: **Dr. Victor Carrillo**, PhD, MPA, MBA, *Senior Vice President & Associate Chief Quality Officer*, HMH
Dr. Jenny Bernard, DNP, MSN, RN-BC, AGNP-BC, *Network Director of Community Health Quality and QIP-NJ*, HMH

Co-authors:
Jazmin Cascante, MSN, RN, APN-BC, *Clinical Lead Manager,* HMH
Carmen Luna, MBA, *Data Quality & Operations Manager,* HMH
Nida Ali, MHA, *Project Manager,* HMH
Dr. Themba Nyirenda, Ph.D, *Research Biostatistician*, HMH
Dr. Chinwe Ogedegbe, MD, MPH, MBA, FACEP, *Professor and Academic Vice Chair of Emergency Medicine*, HMH
Dr. Aimee Gabuya, DNP, RN, CEN, PMH-BC, *Research Nurse Coordinator*

REFLECTION

Unveiling Key Terms……..

1. **Mental Health:** A state of mind characterized by emotional, psychological, and social well-being, measured by:
   - Good behavioral adjustment
   - Freedom from anxiety and disabling symptoms
   - Establishment of healthy relationships
   - Ability to cope with life's demands and stresses
2. **Behavioral Health (BH):** Is a broad term referring to substance use and mental health disorders
3. **Serious Mental Illness (SMI):** The presence of mental, behavioral, or emotional disorder(s) resulting that interferes with or limits one or more major life activities
4. **Substance Use Disorder (SUD):** A treatable mental disorder that affects a person's brain and behavior, leading to the inability to control the use of substances like recreational drugs, alcohol, or medications

Disparities in Healthcare

Social Determinants of Health (SDoH)

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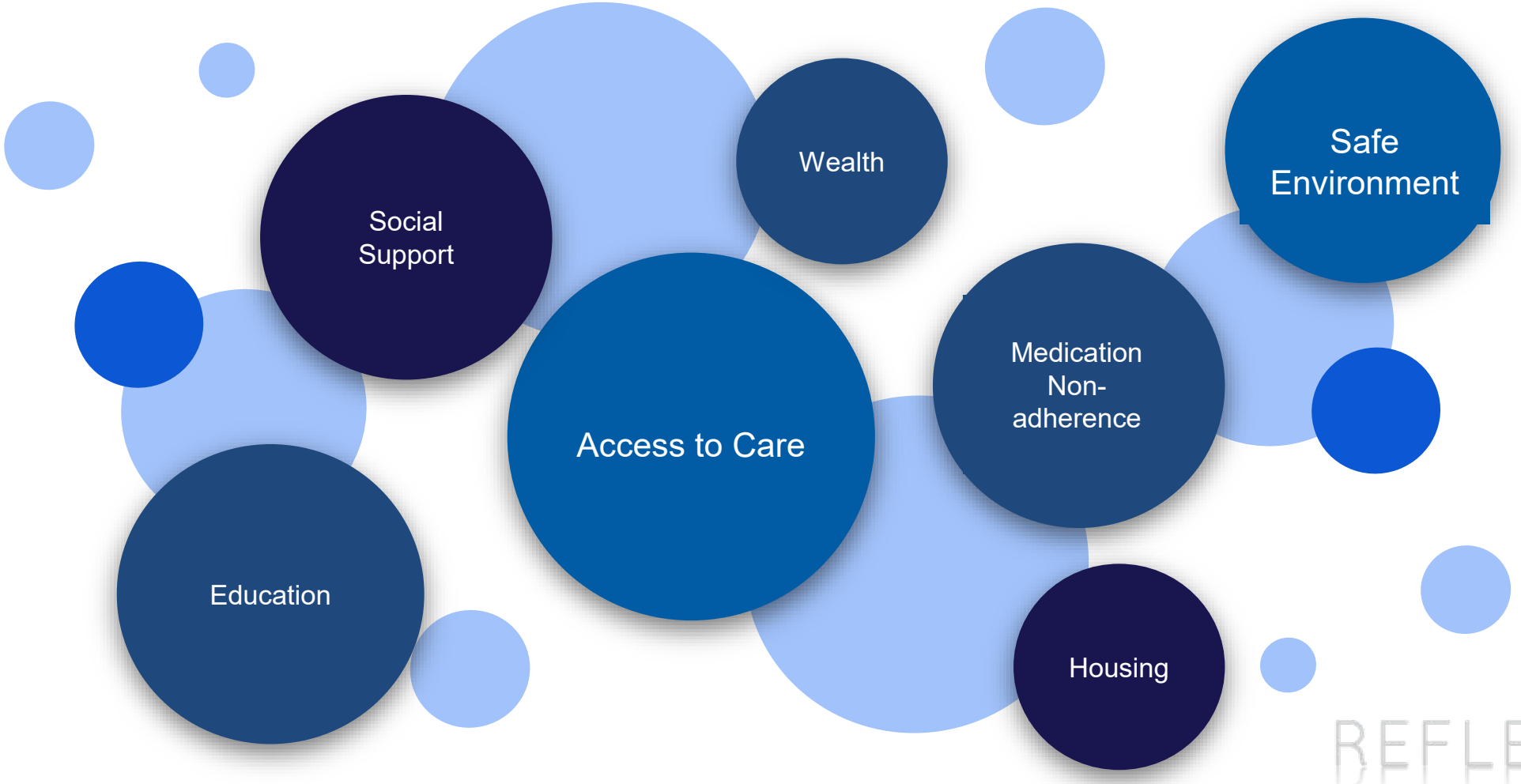

REFLECTION

Impact on the Healthcare System

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Hospital Readmissions

- U.S. News and World Report Rankings
- Star rating
- HRRP penalty
- Hospital Acquired Conditions (HAC) penalty

$$Financial impact$$

REFLECTION

SUD and MI

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Substance Use Disorder

15.35% Substance Use Disorder

6.82% Illicit Drug Use Disorder

10.96% Alcohol Use Disorder

93.5% Received no treatment

Adult Access to Care

93.5% Received no treatment

Mental Illness

21 % Any Mental Illness (AMI)

(50 million Americans)

5.44% Severe Mental Illness (SMI)

Adult Access to Care

54.7% of adults with a mental illness received no treatment

(Over 28 million individuals experiencing a mental illness are untreated)

REFLECTION

Mental Health America (MHA) 2023 Survey Data collection in 2020

Severe Mental Illness

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Access to Care:

- 42% Could not afford treatment

-10.8% Uninsured

Hispanic adults with SMI:

-Were least likely to have health insurance

-19% were not covered by insurance

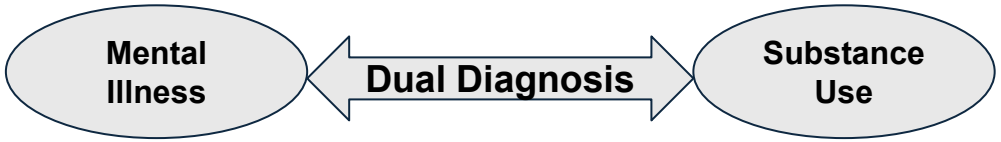
-22.87% of adults who reported experiencing 14 or more mentally unhealthy days each month were not able to see a doctor due to costs

REFLECTION

Co-Occurrence

Mental Illness and Substance Use

- Opioid disorder- 64% of individuals with opioid disorder has a co-occurrence of mental illness
- Individuals with mental illness are more likely to experience SUD



Only one fourth of adults with co-occurrence received treatment for both conditions

THE AMERICAN JOURNAL OF DRUG AND ALCOHOL ABUSE 2021, VOL. 47, NO. 3, 280–304
https://doi.org/10.1080/00952990.2021.1887202

Financial Impact - Substance Use Disorder

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Substance Use Disorder - Financial Impact

- 2017 - $1.07 T
- 2018 - $1.04 T
- 2019 - $0.99 T
- 2020 - $1.47 T

Fatal overdose cases*

- 2020- 69,061
- 2021- 80,926

**Substance use disorder in the United States increased during the pandemic, which led to the highest numbers of fatal overdoses*

REFLECTION

https://www.jec.senate.gov/public/_cache/files/67bced7f-4232-40ea-9263-f033d280c567/jec-cost-of-opioids-issue-brief.pdf

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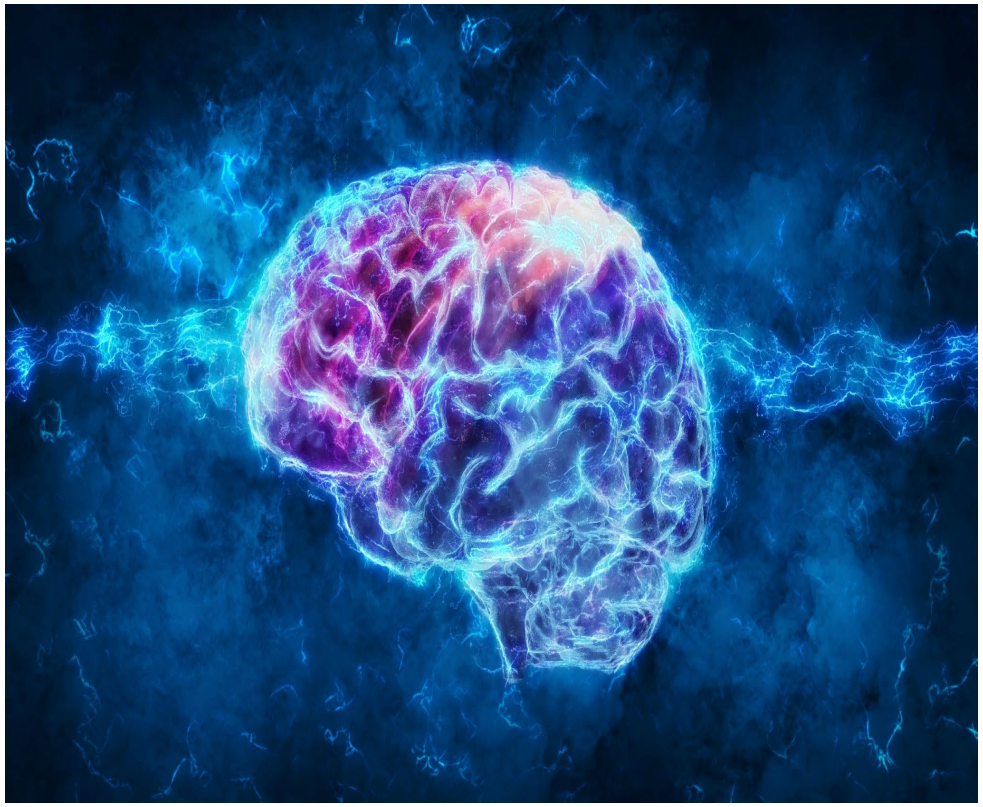
How does this issue impact the human brain?

REFLECTION

The Brain

- Trauma impacts the structure and function of the brain
  - Prefrontal cortex
  - Amygdala
  - Hippocampus
- Outcome:
  - Poor coping mechanisms
  - Emotional pain
  - Physical Symptoms

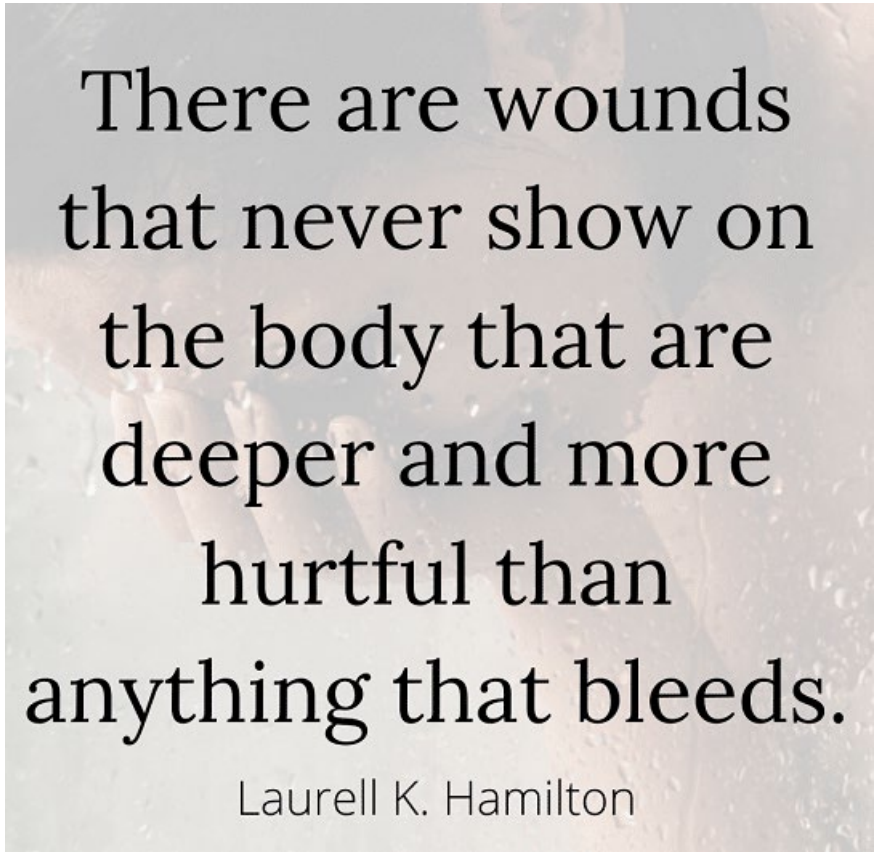


What does Trauma have to do with it…

- New Jersey
  - In 2020, **2 out of every 3** law enforcement use of force with a civilian involves individuals with mental illness or substance use disorder
  - There is an increased burden on the law enforcement
  - Law enforcement are often not equipped with resources and knowledge to address these issues

70% of adults in the USA experience at least one type of traumatic event in their lives (SAMHSA).

90% patients with SMI experience trauma (SAMHSA)



BEHAVIORAL HEALTH INITIATIVES. New Jersey Office of Attorney General. (2023b, July 13).
Jankowski, A., & Hamblen, J. (2022, October 6). PTSD: National Center for PTSD. U. S. Department of Veterans Affairs.
National Council for Behavioral Health. (n.d.). How to Manage Trauma.

Chronic Disease

- Cardiovascular disease
- Liver disease
- Respiratory disease
- Infectious disease
- Sleep disorders
- Nutritional deficiencies
- Diabetes
- Obesity
- Kidney Disease

Who is at risk?

Vulnerable Populations

Racial Disparities

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1970s to 1990s	1990s to 2010	2011 to Present
The use of heroin increased Mortality rates increase in the Black communities Reports of law enforcement use of force was higher in Black and minority individuals	Misuse of prescribed opioid analgesics increased Overdose in White Americans increased Prescribers: less likely to prescribed opioid to Black patients, restrict refills, etc.	The use of synthetic opioids- Fentanyl Increase mortality rate on all racial groups COVID-19 2020: mortality rate among Black and minorities disproportionately increased

REFLECTION

Becker WC, Starrels JL, Heo M, et al. Racial differences in primary care opioid risk reduction strategies. The Annals of Family Medicine. 2011; 9(3): 219-225.

Race and Ethnicity

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Race

Race: A category of individuals identified as inferior or superior on the basis of real or assumed physical characteristic such as skin color, hair texture, eye shape etc.

Race has been used to determine social class and status

Is it biological?
No trait or gene has been identified

Ethnicity

Ethnicity: A group of people with common nationality, linguistic characteristics or cultural traditions

Sharing a cultural heritage has more variability than race

Set of socially constructed traits

No set of common physical characteristics

REFLECTION

Understanding Bias

Bias:

- A shortcut that helps you process information
- To be biased is to hold or act in a way that favors or disfavors one individual or group over another
    - **Implicit Bias:** unconscious
    - **Explicit Bias:** conscious

"there is a positive relationship between level of implicit bias and lower quality of care"
FitzGerald & Hurst

All humans have bias!!!

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What did we do?

REFLECTION

The First Thirty Program

Quality Improvement Program (QIP-NJ)

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Definition:

- QIP- NJ is a five-year program to improve quality of life in underserved communities
- The NJ Department of Health (DOH) established and implemented the QIP- NJ program, approved by the Centers for Medicare and Medicaid Services
- HMH currently has nine hospitals that qualify for the QIP-NJ program

Quality Measures include:

- Improvement in maternal care processes
- Reductions in maternal morbidity
- Enhancements in connections to behavioral health services
- Decline in potentially preventable utilization for BH population

THE FIRST THIRTY
QIP-NJ at HMH

NJ Health

REFLECTION

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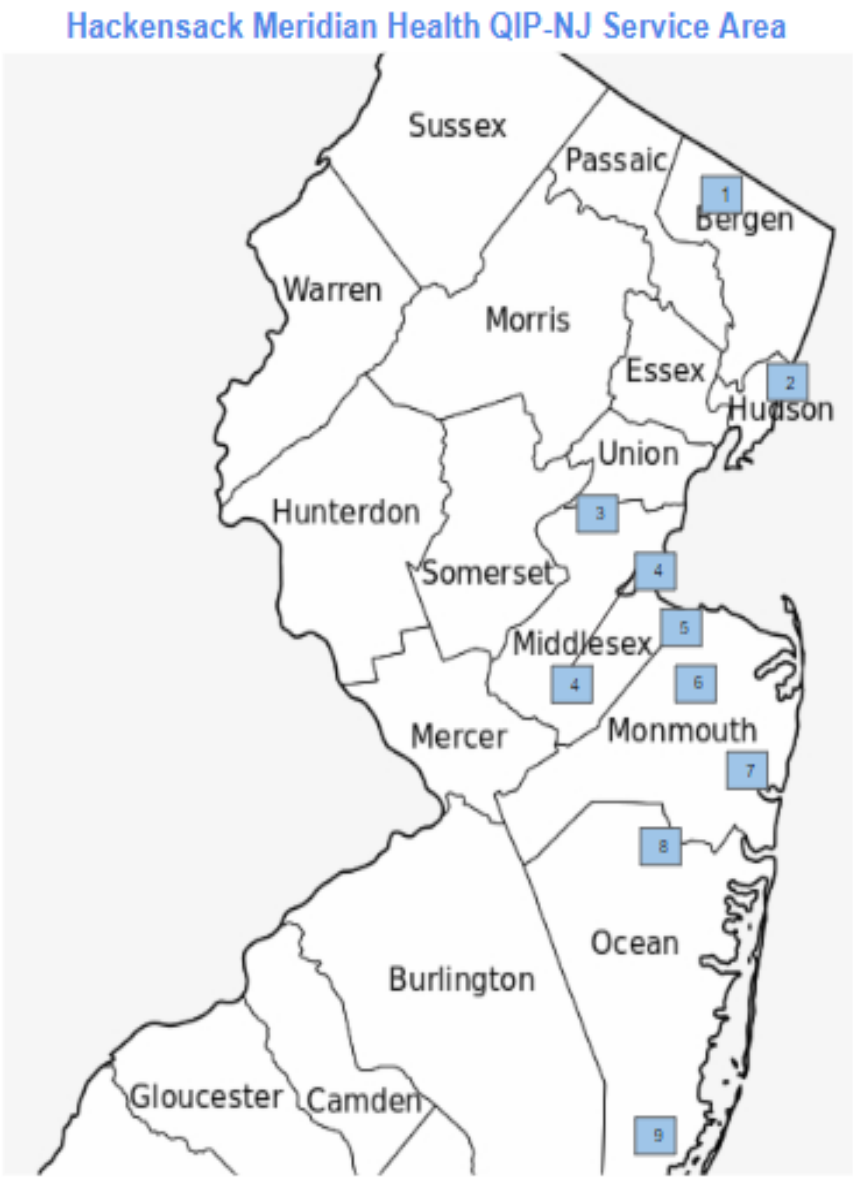
HMH Catchment Area

- Established in 6 counties comprising of Bergen, Hudson, Middlesex, Monmouth, Ocean, and Union

- Divided into 3 regions:
  - Northern Region - HUMC, PMC
  - Central Region - JFK, RBMC & OBMC, BMC
  - Southern Region - RMC, JSUMC, OUMC, SOMC

Hackensack Meridian Health Hospitals QIP-NJ

1 - Hackensack University Medical Center (HUMC)
2 - Palisades Medical Center (PMC)
3 - John F. Kennedy University Medical Center (JFK)
4 - Raritan Bay Medical Centers (Both RBMC & OBMC)
5 - Bayshore Medical Center (BMC)
6 - Riverview Medical Center (RMC)
7 - Jersey Shore Medical Center (JSUMC)
8 - Ocean University Medical Center (OUMC)
9 - Southern Ocean Medical Center (SOMC)



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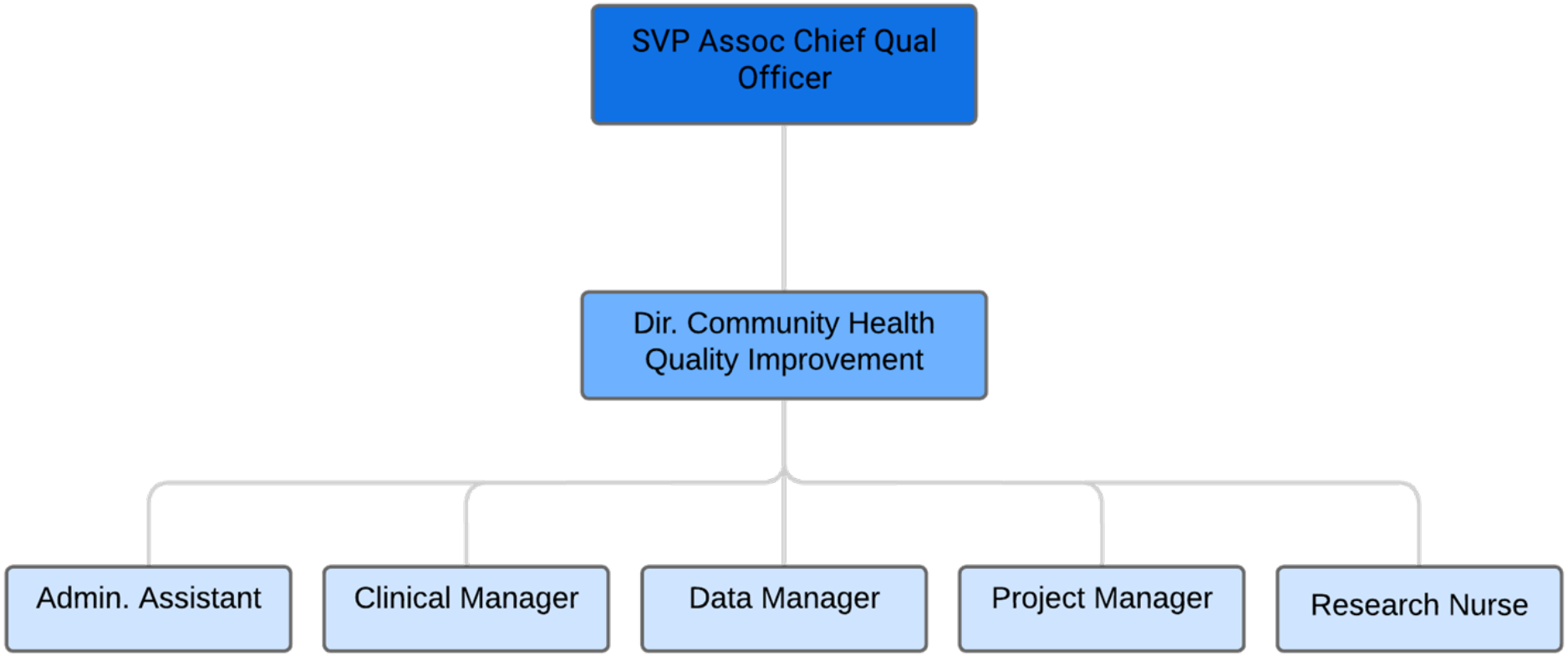
HMH First Thirty Staffing Model



HMH First Thirty Staffing Model

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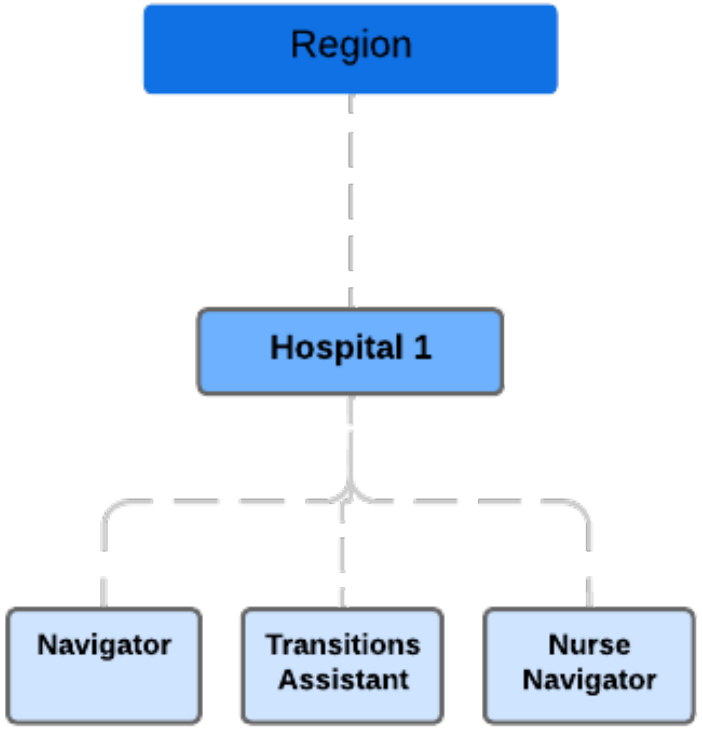
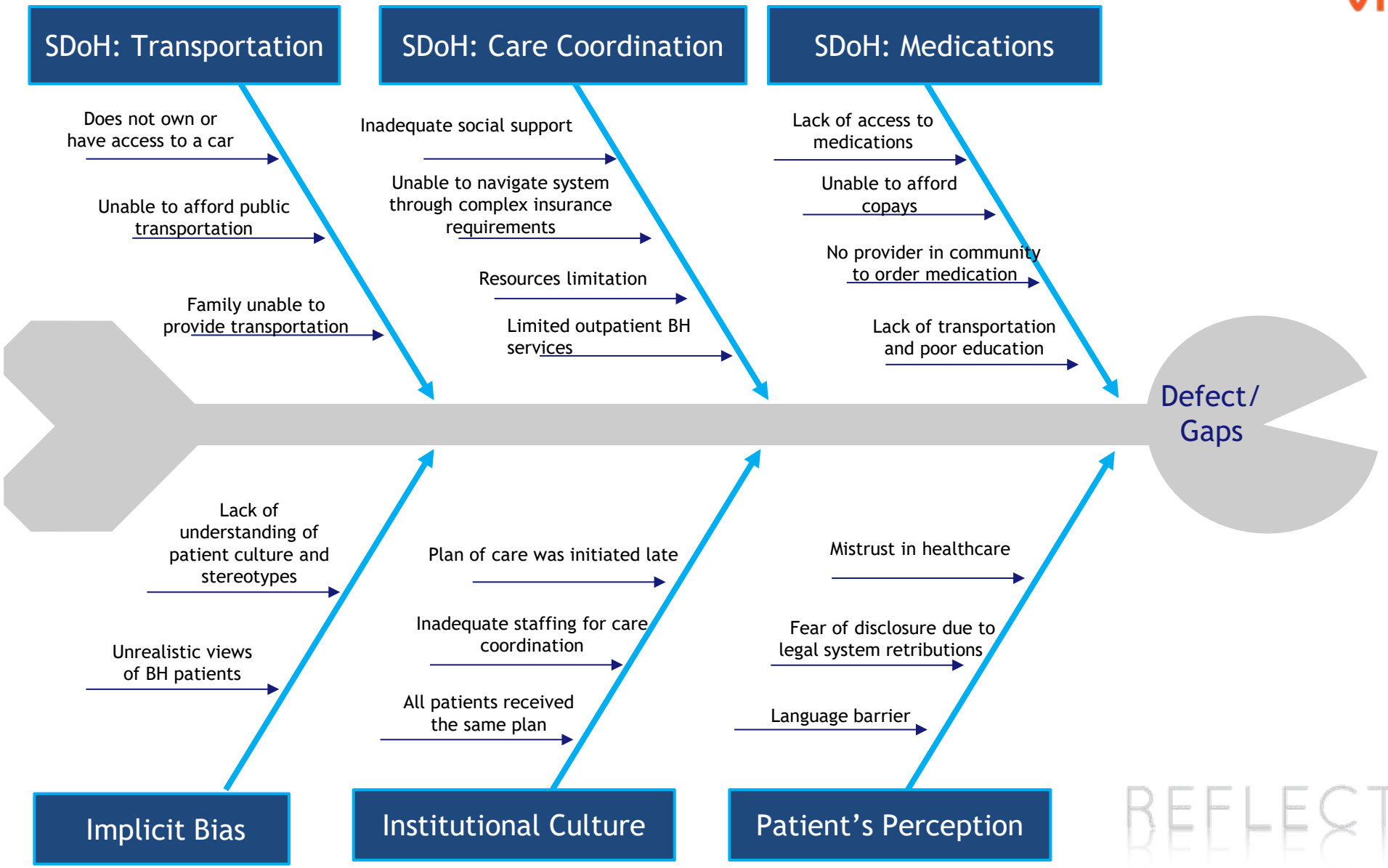
Local Sites



- Three Regions
- 10 hospitals
- Team
  - RN/NAV - Nurse Navigator
  - Transitions Assistant

REFLECTION

Fishbone Diagram



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First Thirty Team Training

- First Thirty Program Overview
  - General HMH orientation
  - Program overview and metrics
  - Data collection
  - Post-discharge follow up process

- EHR Training
  - Specific flowsheets
  - Templates and documentation

- Regional/Site Specific Orientation
  - Orientation/Tour
  - Patient population
  - Face-to-Face enrollment

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Communication Skills

Terms to Avoid:

- Abuse/abuser
- Addict/former addict
- Alcoholic
- Bad Influence
- Junkie
- Clean
- Dirty
- Slip
- Lapse
- Relapse

Why?

- Person-first language helps to focus on the person and not their disorder. While they may have a history of substance use, it is not their only identity.
- The change shows that a person “has” a problem, rather than “is” the problem.
- The terms avoid eliciting negative associations, punitive attitudes, and individual blame.

U.S. Department of Health and Human Services. (2022, July 25). Your words matter – language showing compassion and care for women, infants, families, and communities impacted by Substance Use Disorder. National Institutes of Health. Retrieved from https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-language-showing-compassion-care-women-infants-families-communities-impacted-substance-use-disorder.

Additional Training

HMH FIRST THIRTY CRISIS - DE-ESCALATION TRAINING

- Therapeutic communication
- Suicide prevention
- De-escalation
- Hands on safety training

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The First Thirty - Enrollment Process

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In-patient	Day of Discharge	At home

• Patient identification
• Needs assessment
• Risk stratification
• Formulate plan of care
	• Referral process
	• Care coordination
	• Transportation assessment
	• Patient education & provide wellness package
		• Risk stratified follow-up calls
		• Mitigate barriers to care
		• Additional needs
		  • Additional appointments
		  • Transportation

First Thirty: 5 Key Interventions

1. Care Coordination
2. Medications
3. Discharge phone calls
4. SDoH

   Transportation, Food Insecurity, Social Isolation, Domestic Violence, & Human Trafficking
5. Wellness Package

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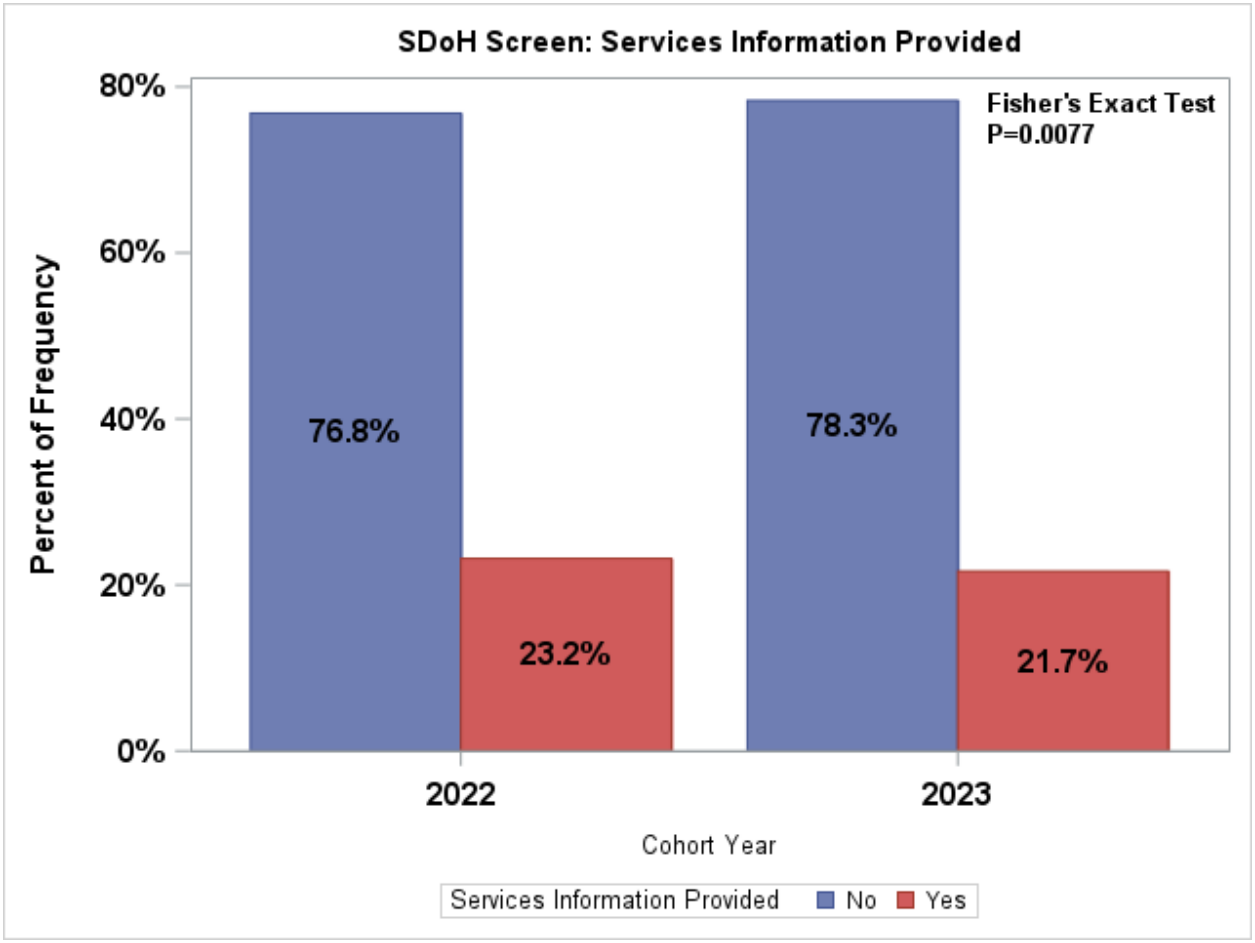
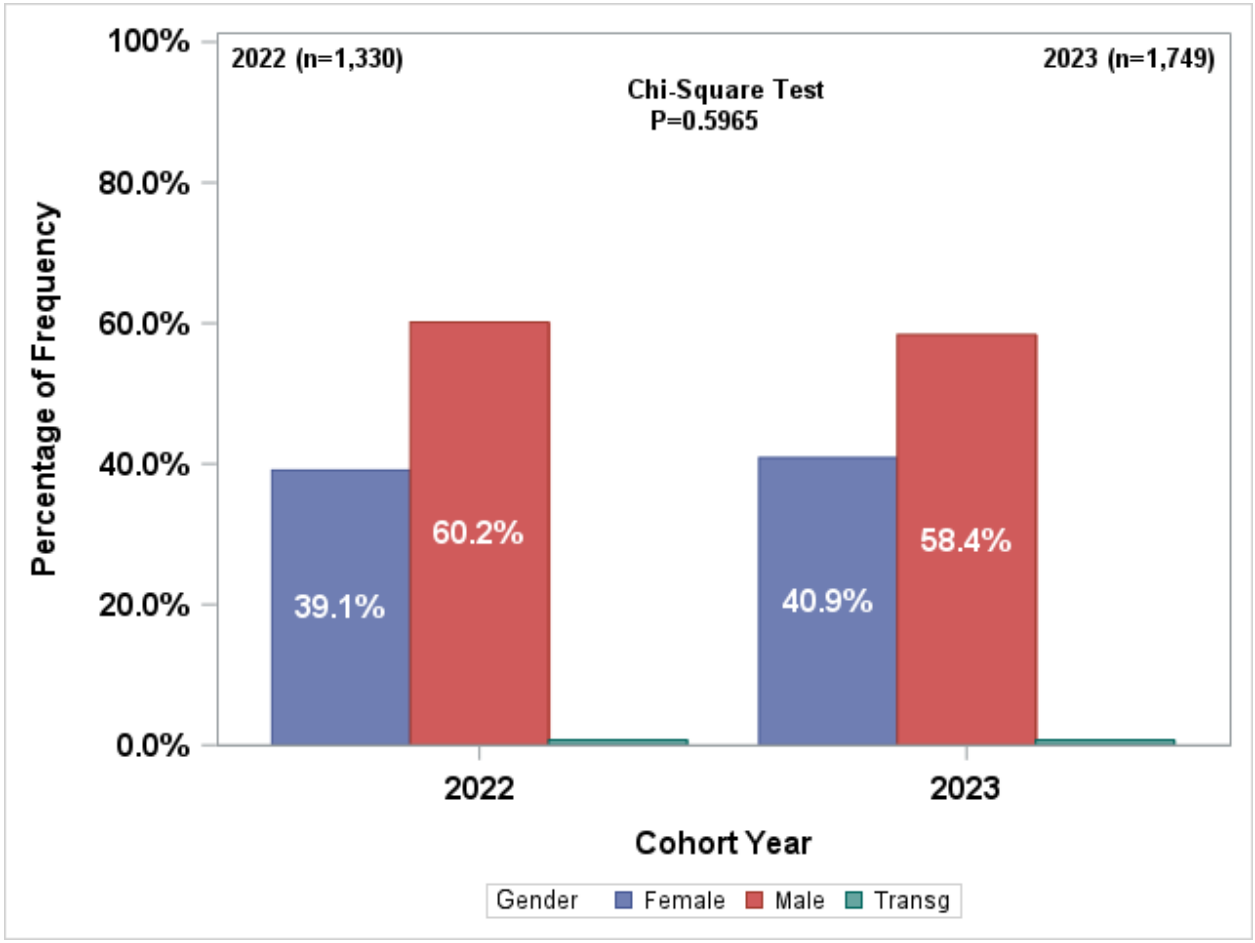
How did we know it worked?

REFLECTION

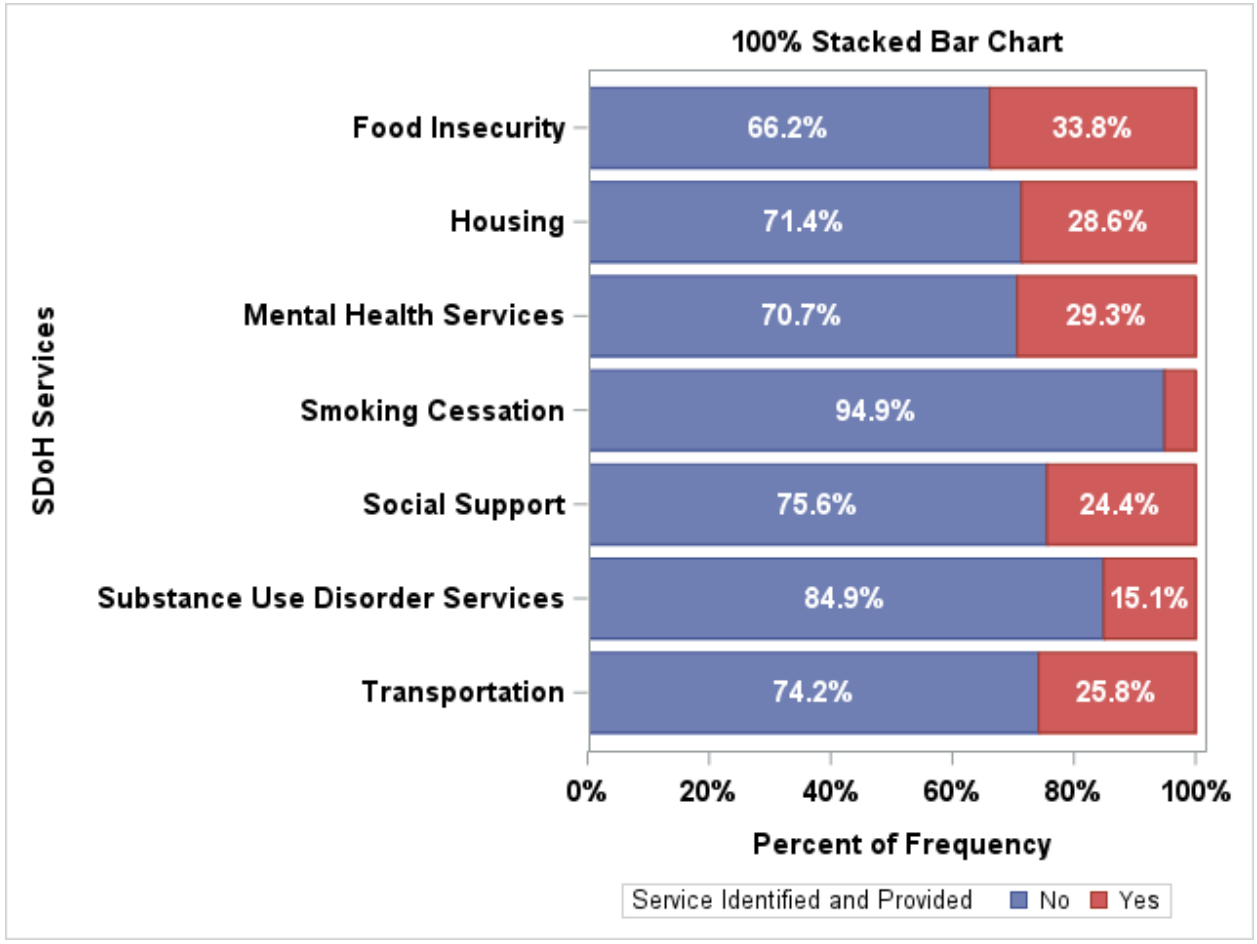
Tabular Comparisons: Services Information Provided



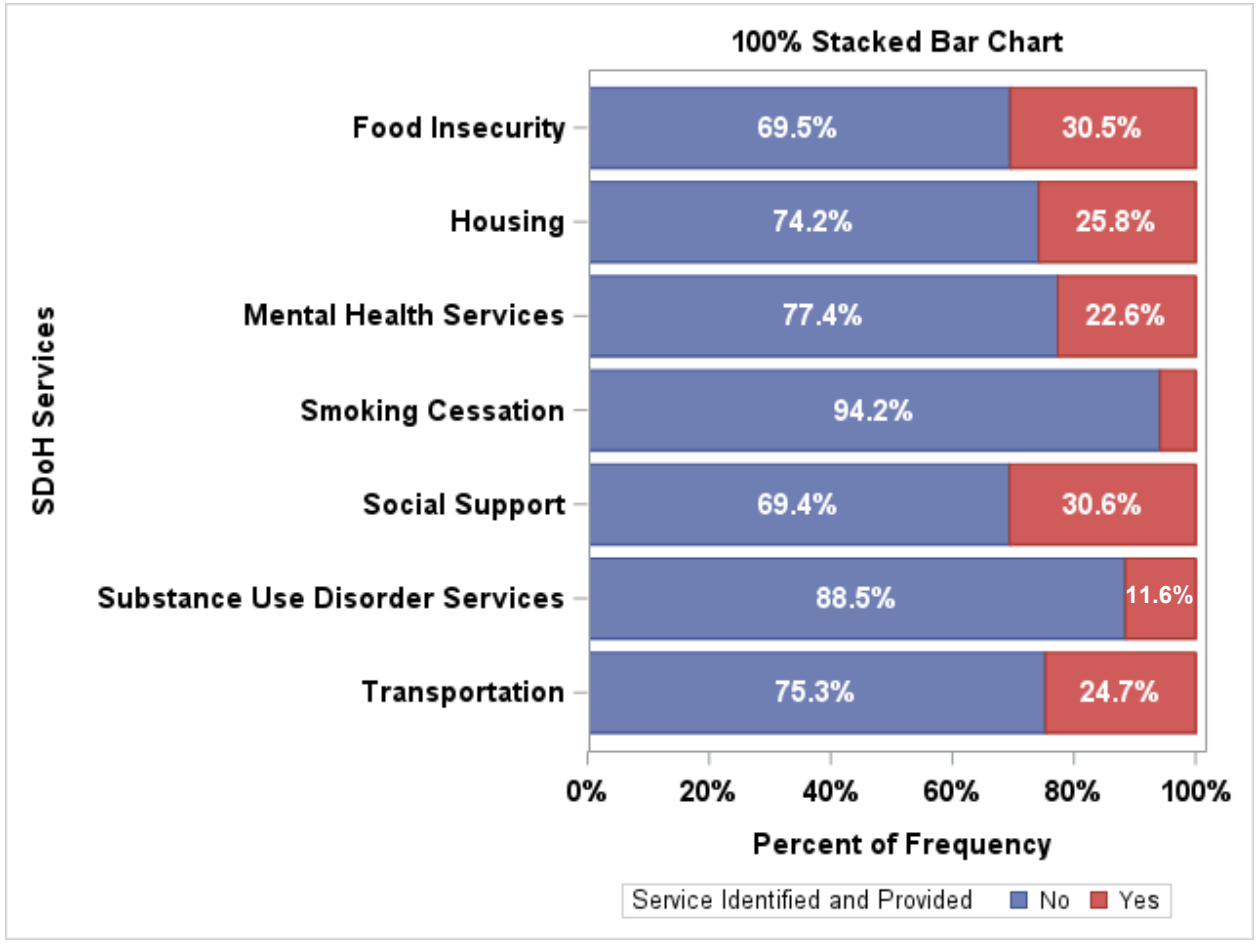


Internal Hackensack Meridian Health data

SDoH Key Factors



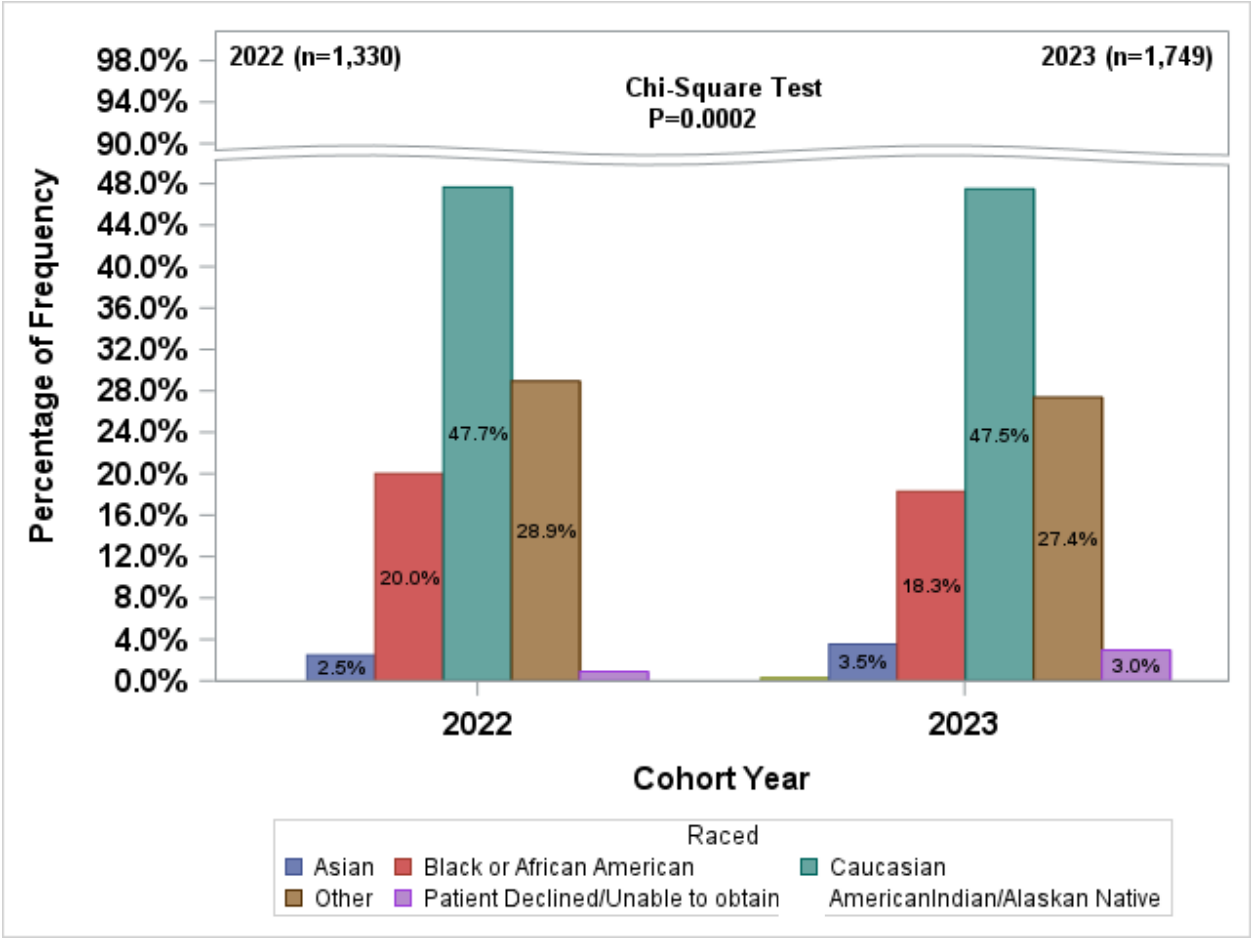
Cohort Year: 2022 (n=1,330)

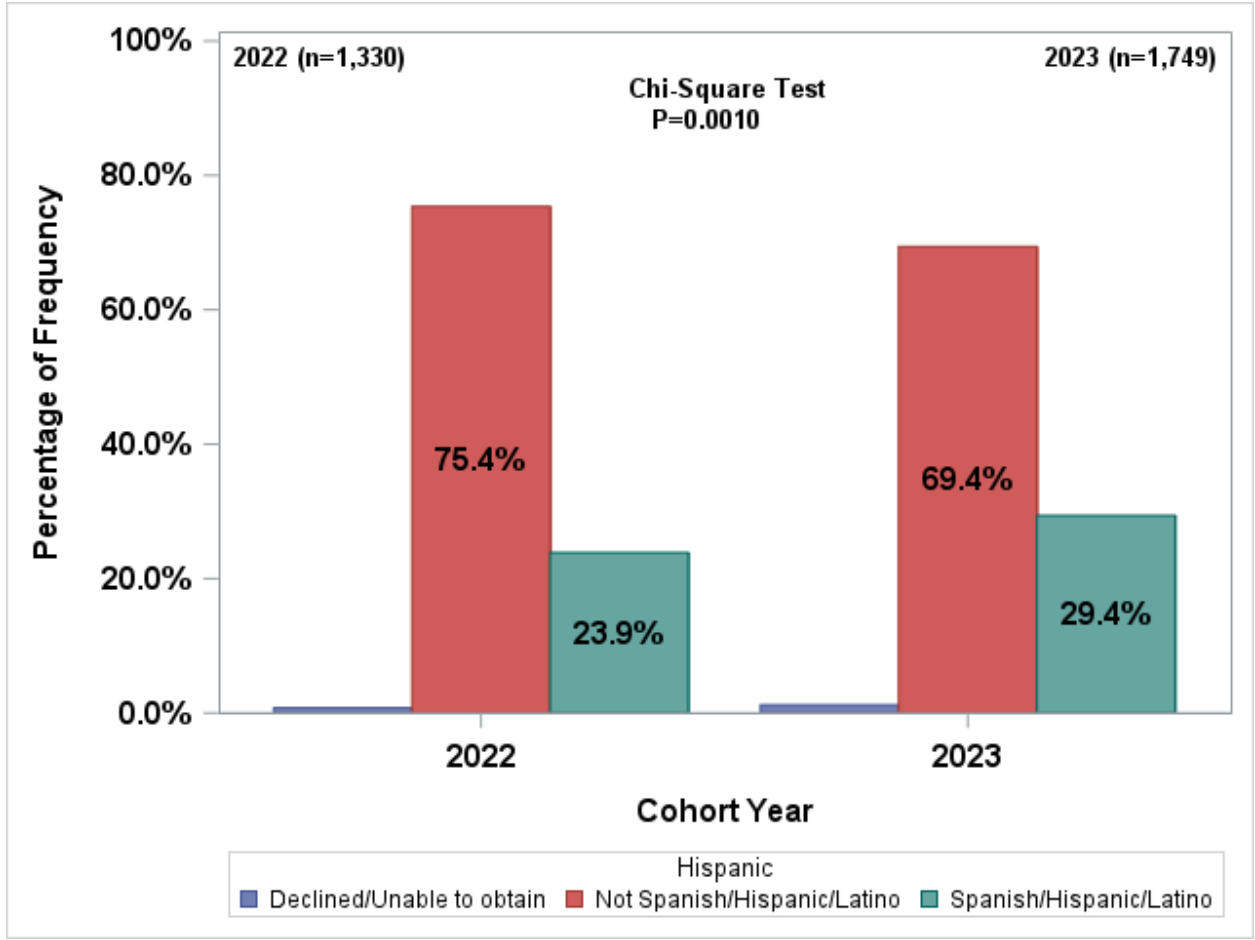


Cohort Year: 2023 (n=1,749)

Internal Hackensack Meridian Health data

Race and Ethnicity





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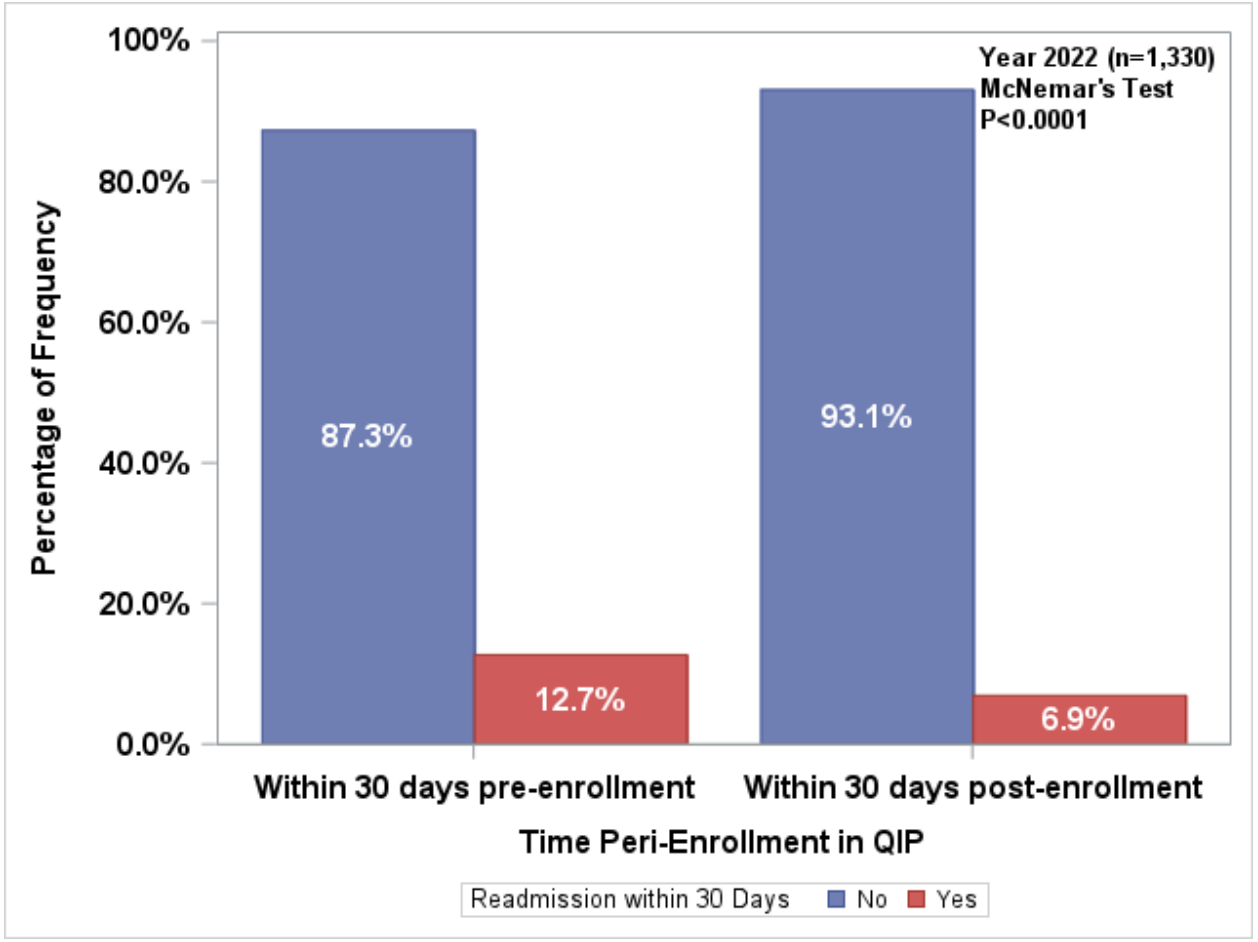
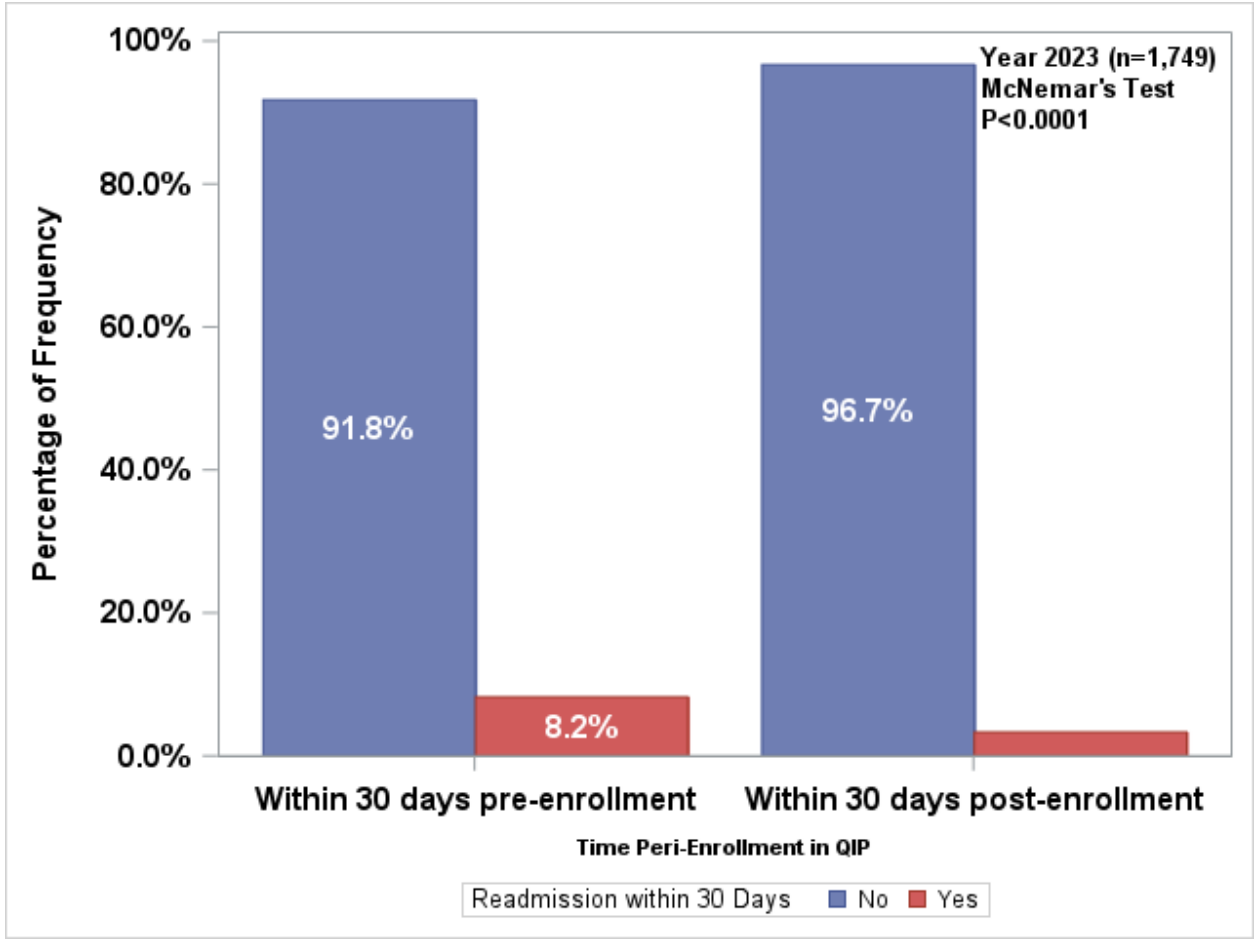
Readmission Rate: Peri-Enrollment





Internal Hackensack Meridian Health data

First Thirty Patient Video

Consent was obtained from patient to share publicly

https://www.youtube.com/watch?v=UKs8vnH_9N0

Video duration: 2:33 min

Name: M.J.

This story highlights:

- Human Connection
- SUD
- Recovery resources
- Medicaid services
- Employment resources
- Transportation

THE FIRST THIRTY
QIP-NJ at HMH

Hackensack Meridian *Health*
KEEP GETTING BETTER

Lessons Learned

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- Building strong relationships with community organizations is crucial for providing patients with the support they need after discharge.
- Cultural competency is essential for ensuring that the program is accessible and effective for all patients.
- Employ effective interpersonal communication among clinical and corporate teams to identify social determinants of health barriers for improving long-term patient outcomes.

REFLECTION

Takeaways and Sustainability

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- Ensure transition of care program goals align with organizational goals
- Engaging leadership and including key stakeholders is key
- Ensure coordination and communication between all care providers, patients & caregivers
- Develop and strengthen community partnerships
- Collect and share metrics/data with stakeholders and at internal and external meetings
- Use this model to expand transitions of care to other diagnoses and populations

REFLECTION

Patient Resources

- The National Center for PTSD: https://www.ptsd.va.gov/
- The National Sexual Assault Hotline: 1-800-656-HOPE
- The National Domestic Violence Hotline: 1-800-799-SAFE
- The Crisis Text Line: Text HOME to 741741
- Division of the Deaf and Hard of Hearing

  609-588-2648 – Office

  DDHH.communications2@dhs.state.nj.us

- The National Institute on Drug Abuse (NIDA): https://www.drugabuse.gov/
- The Substance Abuse and Mental Health Services Administration (SAMHSA): https://www.samhsa.gov/
- The National Alliance on Mental Illness (NAMI): https://www.nami.org/

Questions?

Hackensack Meridian Health

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Jenny Bernard, qipcorp@hmhn.org

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REFLECTION

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UC DAVIS HEALTH

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Applying an Equity-Centered Framework to Assess Bias in Population Health Risk Models

- **Reshma Gupta MD, MSHPM**, Chief of Population Health and Accountable Care
- **Matthew Crase**, Lead Data Informatics Specialist, Population Health & Accountable Care

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Background

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- Population health programs across the country use risk models to proactively offer limited resources (e.g. care management) to patients with complex health needs.

- Most health system do not evaluate risk models for bias and may be reproducing societal disparities if risk models under-predict among certain populations resulting in certain patients receiving less outreach.

- To mitigate, health systems need strategies to assess for structure bias, they need to proactively investigate:
  - Underrepresentation of certain patient populations
  - Lack of understanding of historical context of the outcome selected
  - Lack of formal evaluation and on-going monitoring of risk model performance and bias

REFLECTION

Background

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Patient population and metrics for original model development

- Cohort (UCD population health patient registry ~120K patients): patients with 1 primary care visit within the last two years + patients in accountable care programs even without a primary care visit within the last two years
- Model build based on 1/1/2019 data; look back to 1/1/2018; built on training data: 4K patients, 2 test sets: 20K patients each
- Input measures for model build:

Ambulatory Engagement/Patient Activation	Chronic Conditions	Demographic	Labs and Tests	Medication	Prior Utilization	Social Determinants	Final Outcome
Ambulatory Engagement 6 and 12 months	Chronic Condition Warehouse of Conditions (70 total)	Primary Care Dept, Clinic Attribution	Complexity by Labs	Various Medications	Hospitalization	Area Deprivation Index (ADI), State and	Future Predictable/ Preventable Hospitalizations or ED Visits
Ambulatory Engagement missing, missing appts and orders	Advanced Illness (Cancer, Dementia, HF, CKD)	Race/ ethnicity, HPI, Age/Gender/ Language/etc.	Complexity by imaging	High Dose Opioids	ED	Future will have patient reported domains	
	Tobacco Use	Health Plan	BMI		Ambulatory, primary and specialty care		
	Fall Risk		Blood Pressure		Surgery	**Total Measures: 215**	

Internal UC Davis Health Data

We Explored Potential Bias to Guide Health System Bias-Mitigation Efforts

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- Question: Does the association between the predicted probability and actual use of Emergency Department or hospital use over a 12-month period vary systematically by characteristics for which we have data (e.g., race/ ethnicity, Health Places Index (HPI), gender)?

- Subgroups evaluated:
  - Race/ ethnicity: White, Black, Native American/ Native Alaskan, Asian American/ Pacific Islander, Mixed, Hispanic/Latinx and other
  - HPI quartiles
  - Gender: female, male, other gender minorities

REFLECTION

The Framework

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Apply an Anti-racism lens to proactively identify and address bias and race-based assumptions from the start.	•Biases can be mitigated if meaningful health equity goals are prioritized at project inception. The team created a charter prioritizing health inequity across all initiative phases that could implement across primary care clinics uniformly. •The team prioritized examining systems-related root causes (e.g. missing data, outcome prevalence, healthcare access, trust) rather than attributing causes to patient race routinely throughout model development (aka race-based assumptions).
Meaningfully engage partners that have insights into the perspectives and experiences of the impacted communities.	•There was early recognition that patient care decisions would not be dictated by the predictive model alone but rather final decisions were made by human clinical judgement. •The team elicited patient feedback to understand perspectives about the consequences of using the model. They also partnered with health equity researchers, community leaders, and/or DEI offices throughout the project.
Review the history of health system interactions with locally underserved communities.	• Identify which groups are historically and/ or locally underserved by the health system. • Review known literature on disparities experienced by these groups. • Put in place safeguards including methods for assessing these inequities.
Disaggregate and assess the baseline data for training model across racial, cultural, and socioeconomic demographics.	• The team assessed baseline data for the availability and quality of data overall and disaggregated by race-ethnicity, gender, and HPI categories. • Improve workflows and data collection to mitigate lack of representation of data to include in training model.

REFLECTION

The Framework

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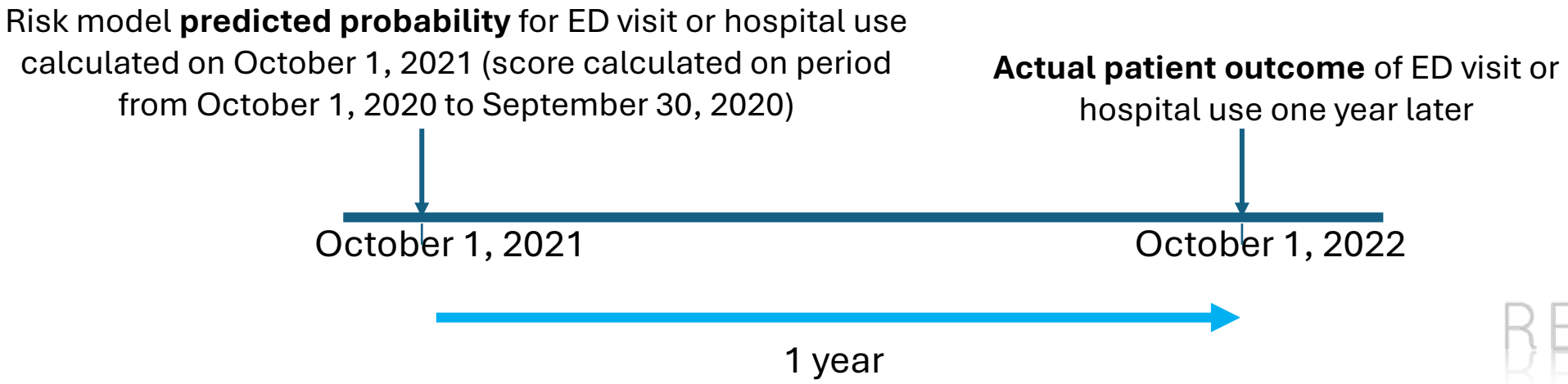
Select technical features with hypothesized causal relationships to the desired outcome, include race and social determinants particularly given racism's pervasive yet often unrecognized influence on outcomes.	• The team reviewed each candidate model feature and patterns of missing data within patient groups. • Discussion points considered how use of differentially missing data may result in underrepresentation of patient groups and choice of metrics.
Evaluate predictive models for differential performance among groups or exclusion of patients when models are used to mitigate bias.	• Carefully consider which performance metrics are most important clinically. • The team evaluated calibration and discrimination to identify differential performance of the model across groups at different levels of predicted risk to help identify where the model had increased risk of bias.
Utilize Culturally and Linguistically Appropriate Services (CLAS), cultural humility, and trustworthiness strategies to inform intervention design and implementation.	• Focus improvement strategies and trainings on addressing bias arising from patient, care team, institutional, and structural factors rather than patient factors alone. • Make information available for patients and communities about when the predictive model is used in their care and how the model performs for their sociodemographic group.
Institute inclusive and equitable continuous improvement. Sustained efforts are often needed to address health inequities.	• Focus on formal evaluation for bias, continuous monitoring, and formal oversight for model drift considering that over time the patient group may change
Address underlying structural inequities through advocacy, education, and anchor strategies.	• Assess the potential for and how the process can help make changes within the organization to eliminate institutional and structural racism. • The team identified a fairness and outreach process to guide operational decision-making for the identified mitigation strategies.

REFLECTION

Methods: Study Population, Timeframe, and Outcomes

- Cohort (UCD population health patient registry): collection of patients where UCDH is accountable for their primary care and therefore ambulatory quality outcomes
- 10/1/2021 look back to 10/1/2020; outcomes in 10/1/2022
  - allowed for post-Covid analysis
- Independent variables: race/ ethnicity (updated), HPI, gender
- Dependent variables: Unplanned hospitalization (e.g. not birth, transplant) or ED visit



Methods: Analysis

- Risk model provides a **predicted probability** of hospital or ED assigned to each patient
  - Resulting probability score ranging from 0 - 100% for at least one hospitalization or ED visit over the next 12 months
- Performed logistic regression between the predicted probability (i.e. risk score) and the outcome (i.e. actual hospitalization or ED visit)
- Sensitivity analysis: Analyses for hospitalization and ED visit as separate outcomes
- Assessed interaction effect of covariates (race/ethnicity, HPI, gender)

Results: Study Population Characteristics (n=114,311)

	Full data set (N = **114311**)	ED visit prevalence[1] (N = 2525)	Hospitalization prevalence[1] (N = 5271)
Age (years), mean (SD)	43.4 (24.0)	-	-
Gender			
Female	63345 (55.4%)	1491 (2.4%)	3192 (5.0%)
Male	50966 (44.6%)	1035 (2.0%)	2079 (4.1%)
Race/Ethnicity			
White / Caucasian	68061 (59.5%)	1367 (2%)	2989 (4.4%)
AIAN[2]	415 (0.4%)	8 (1.9%)	25 (6%)
Black	6207 (5.4%)	322 (5.2%)	550 (8.9%)
Multi-Racial	4180 (3.7%)	96 (2.3%)	182 (4.4%)
AAPI[2]	15172 (13.3%)	243 (1.6%)	546 (3.6%)
Hispanic	15806 (13.8%)	393 (2.5%)	773 (4.9%)
Other	4470 (3.9%)	97 (2.2%)	206 (4.6%)
HPI[3] Quartiles			
HPI 0-25% (-1.995 - -.024)	28675 (25.1%)	1051 (3.7%)	1984 (6.9%)
HPI 25%-50% (-.024 - -.266)	28677 (25.1%)	599 (2.1%)	1344 (4.7%)
HPI 50%-75% (-.266 - .535)	28541 (25%)	475 (1.7%)	1097 (3.8%)
HPI 75%-100% (.535 – 1.411)	28418 (24.9%)	401 (1.4%)	846 (3%)

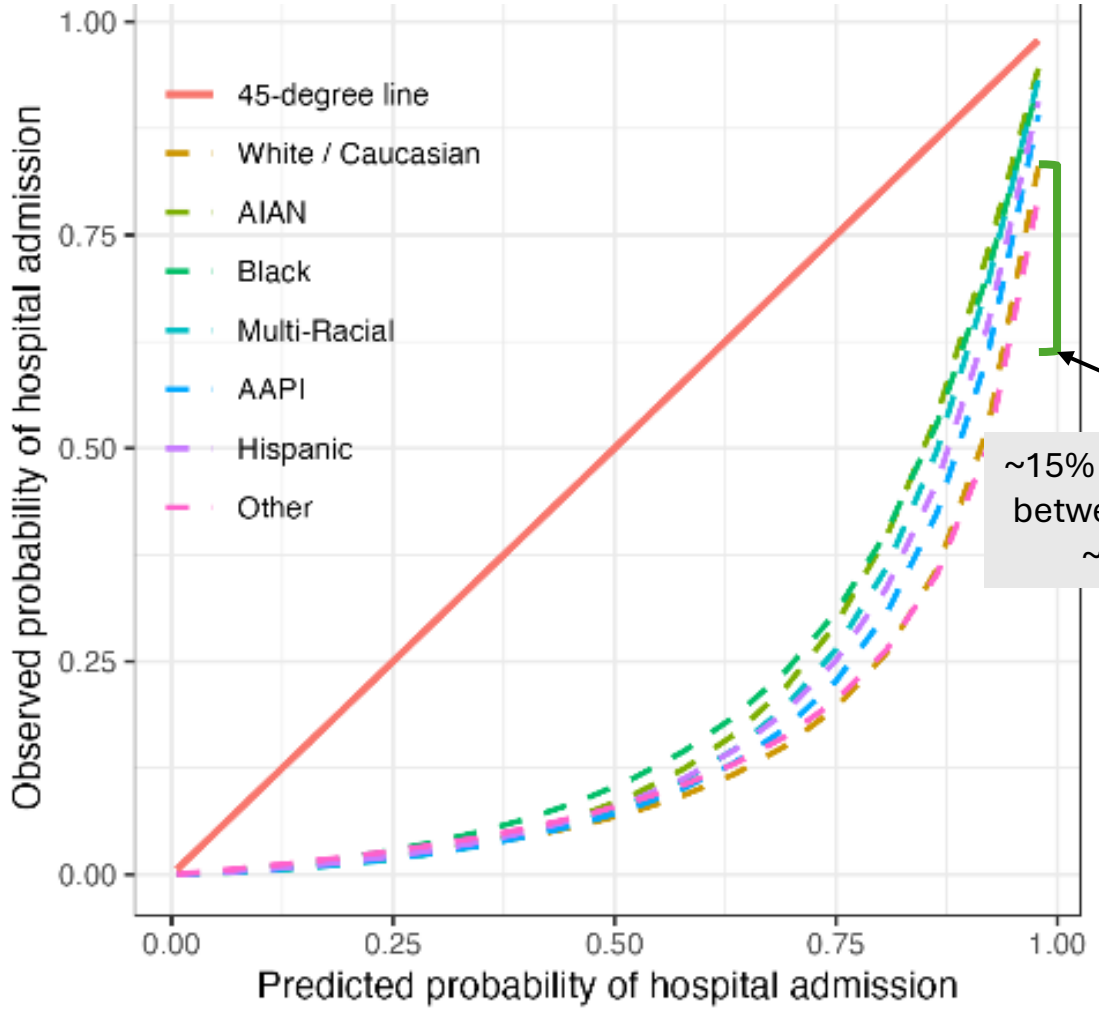
[1] Counts and percentages are prevalences of ED visits or hospitalizations for each group. For example, 1367 (2%) white/Caucasians had an ED visit.

[2] AIAN = American Indian or Alaskan Native; AAPI = Asian American or Pacific Islander

[3] HPI = Healthy Places Index (healthier community conditions have higher HPIs)

Results: Hospitalizations by Race and Ethnicity

The model may be underestimating hospitalization risk for AAPI, multi-race, Black and Hispanic patients

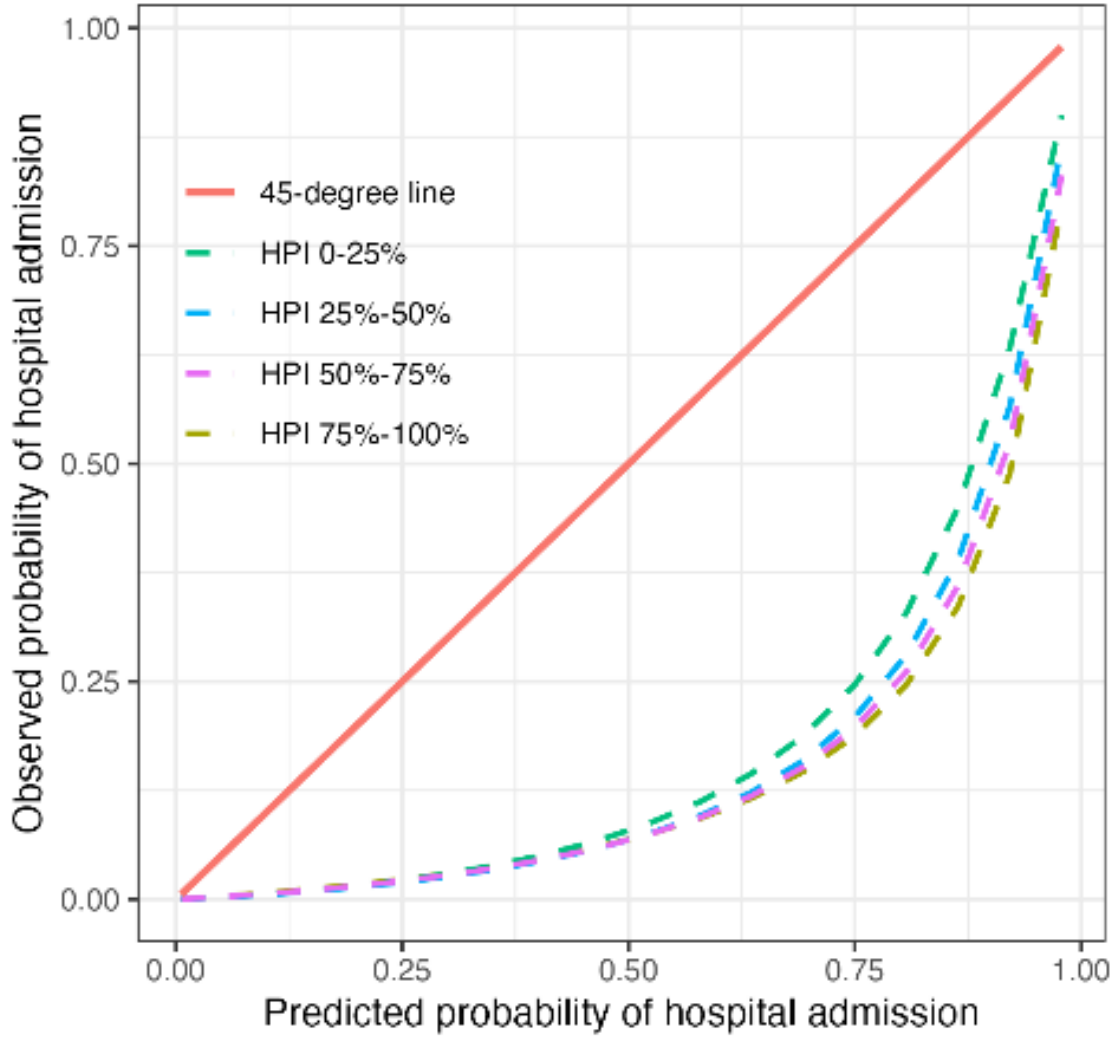


~15% difference in actual use between White and Black for ~85% predicted use

Legend:
AIAN = American Indian, Alaska Native
AAPI = Asian, Native Hawaiian, or Other Pacific Islander

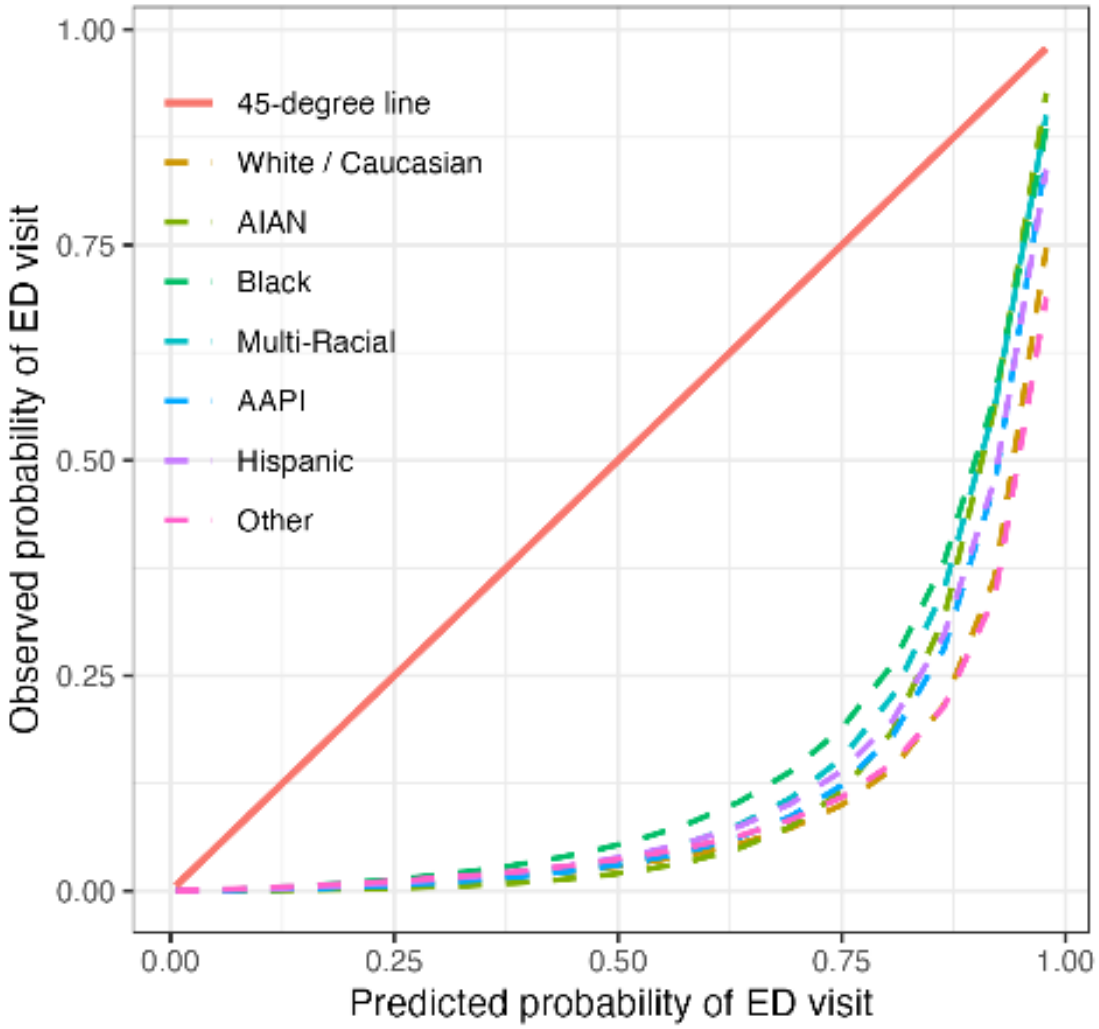
Results: Hospitalizations by Healthy Places Index (HPI)

The model may be underestimating risk of hospitalizations for the lowest HPI quartile (0-25%)



Results: ED visits by Race and Ethnicity

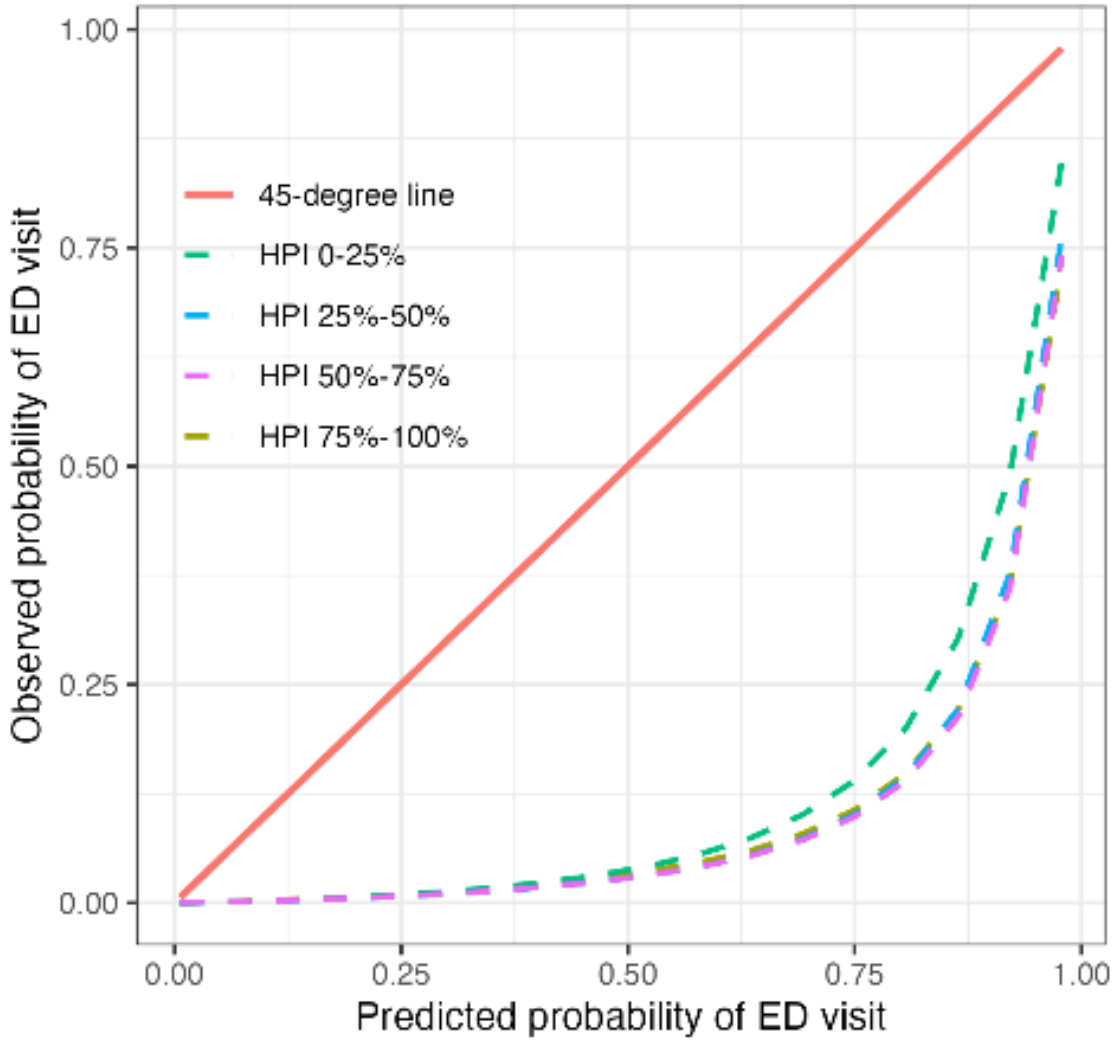
The model may be underestimating ED visit risk for AAPI and multi-race patients



Legend:
AIAN = American Indian, Alaska Native
AAPI = Asian, Native Hawaiian, or Other Pacific Islander

Results: ED visits by Healthy Places Index (HPI)

No statistically significant differences among HPI quartiles, but there is suggestion of underestimation of ED visit risk for lowest quartile (0-25%)



- There were no significant differences of predicted risk for ED visits or hospitalizations for all languages when compared to English
- There were no significant differences of predicted risk for ED visits or hospitalizations between females and males
- Similar findings found over two timeframes

New Mitigation Strategies

- Data collection standardization to better capture data for patients with patterns of systematic missing data,
- Education for teams involved in outreach to better understand limitations of the tool and incorporate cultural humility when communicating, and
- Adjustment of the threshold for patient outreach to a level that reduced potential bias among some groups (e.g. using an 85% vs 60% threshold).

Key Takeaways

- Our risk model may be under-estimating hospitalization probabilities for smaller populations (AAPI, multi-race, Black and Hispanic) defined by race/ ethnicity and the lowest HPI quartile and
- ED probabilities for AAPI and multi-race patients whose predicted outcome probability is high (e.g. >=85%).
- Vital to evaluate for bias in population risk model to avoid creating inequities

Key Takeaways

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Strengths

- Evaluation led by health system leadership for system-wide implementation
- Creation of model and evaluation was a collaborative process: Population Health, Quality, Operations, IT, Biostatistics, Diversity,-Equity-Inclusion, and Clinic leadership
- Used internally developed anti-bias equity tool for risk model development and deployment
  - Interdisciplinary team to develop and evaluate model
  - Feature and outcome selection
  - Technical approaches to reduce risk of bias
  - Care team engagement, training for deployment, and continuous evaluation
- Incorporated claims data
- Evaluated over two timeframes, showed replicability

REFLECTION

Lessons Learned

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- Even more work is needed to optimize predictive model use in practical application within health systems. This evaluation is limited by generalizability and health system structural barriers.
- BE-FAIR does not address generative artificial intelligence models for which model development and evaluation standards are still in their infancy.
- Known health system structural barriers for minority groups in accessing care or providing data may be factors in underestimating and overestimating outcomes.
- Data can guide mitigation methods including choosing different thresholds for outreach to achieve a more equitable model performance across patient populations (e.g. >=60% threshold to conduct outreach)
- In the future:
  - Re-launch risk model across the health system using new outreach thresholds for specific populations.
  - Develop a novel Anti-bias Framework to Risk Model Development including social and technical mitigation strategies
  - Explore systemically biased practiced in raw data collection

REFLECTION

Questions?

Contact:

Reshma Gupta MD, regupta@ucdavis.edu

This educational session is enabled through the generous support of the Vizient Member Networks program.

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

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Culture Change: Driving Inclusive Excellence Through Mentorship and Sponsorship

Franklin Owusu, MBA, MPA, FACHE
Administrator, Hospital Operations

Tracey Boggs, MBA
Leadership and Organizational Effectiveness Consultant

The Ohio State University Wexner Medical Center, Columbus, OH

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Agenda

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- Introduction
- OSUWMC Structure
- Mentorship vs Sponsorship
- Inclusive Excellence
  - Buckeye Diversity Summer Internship Program
  - Inclusive Excellence Leadership Program
  - OSUWMC Mentorship Program
- Importance of Inclusive Excellence Programs
- Outcomes
- Lessons Learned
- Key Takeaways
- Questions

REFLECTION


Introduction

Introduction

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About OSUWMC

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Facts and figures

Nationally ranked academic medical center

On the campus of one of the nation's largest public universities

Ranked for **31 consecutive years** by *U.S. News & World Report "Best Hospitals"*

Magnet recognition from the American Nurses Credentialing Center

1,404 staffed beds

24,507 employees

60,713 patient admissions (FY23)

2,745 faculty researchers

3.4M outpatient visits (FY23)

225,000 telehealth visits

20 research centers and institutes

Internal The Ohio State University Wexner Medical Center data

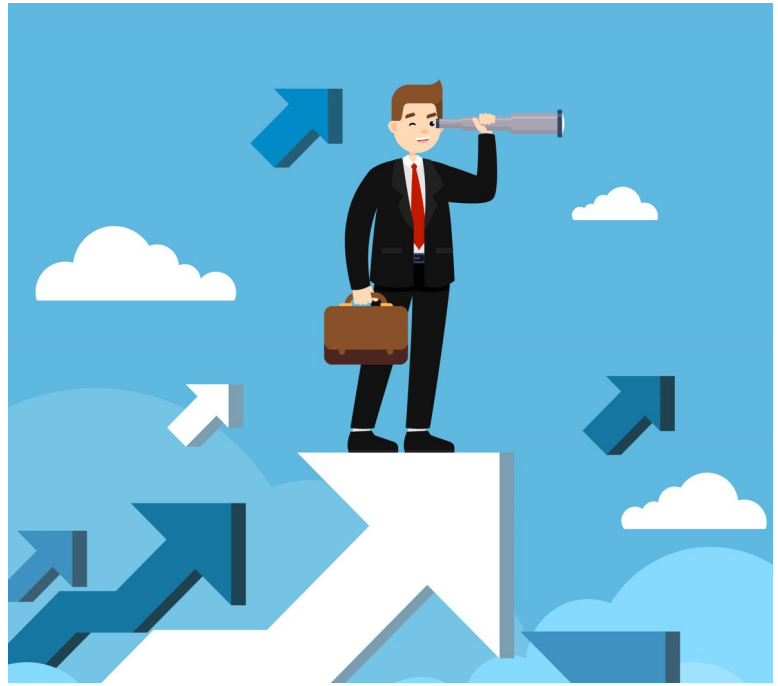

Mentorship vs Sponsorship

Mentorship

- **Mentorship** is a key to success
  - Mentorship is like having a lawyer in your back pocket to provide guidance/advice
- **Role**: A mentor provides guidance, advice, and support for personal and professional growth.
- **Focus**: It's about gaining knowledge, learning from their experience, and receiving feedback.
- **Long-Term**: Mentorship involves regular check-ins and ongoing support.
- **Foundation**: Building trust is essential before the relationship can evolve.
- **Advancement**: While it contributes to growth, it's not directly tied to career advancement.

Sponsorship

- **Sponsorship** is a key to growth
  - Sponsorship is the lawyer representing you in court
- **Role**: A sponsor actively advocates for you.
- **Advancement**: Sponsors promote your skills, endorse you, and provide access to opportunities.
- **Visibility**: They use their platform to help you build connections.
- **Impact**: Sponsorship directly influences career progression.




Inclusive Excellence:
Buckeye Diversity Summer Internship Program
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Inclusive Excellence: Buckeye Diversity Summer Internship Program

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Purpose:

To build upon The Ohio State University Wexner Medical Center's commitment to diversity and inclusion, both exposing the six interns to the breadth and depth of a career in the health care industry and helping to build a pipeline of high-potential and diverse candidates for roles at the Ohio State Wexner Medical Center and beyond.

Target Audience:

Undergraduate rising seniors from The Ohio State University, Historically Black Colleges and Universities (HBCUs), minority-serving institutions and other four-year universities who seek to support the mission of our program.

Qualifications:

- Undergraduate rising
- Minimum 3.0 GPA
- Studying Business, Healthcare, Public Health, Psychology or other health care related majors
- Experience with Microsoft Office Suite
- Available 38 hours per week

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BDSI Structure

Mentoring and shadowing:

- Six Interns Paired with OSUWMC Hospital Executive Directors and Senior Leaders
- Lunch meet and greets with OSUWMC senior leaders
- Shadow and tour opportunities in emergency department, operating room, perioperative services, new UH inpatient tower and more

Practical Experience:

- Involved in many high-level projects and training opportunities across the health system:
  - Human Resources
  - Operations
  - Ambulatory Services
  - Diversity Council
  - Volunteer Services
  - And more
- Final presentation in front of leadership

Professional Development Workshops and Engagement:

- CliftonStrengths for Students assessment
- Presentation Skills
- Resume Building
- Personal Brand
- Networking and Social Capital
- Team building activities
- Volunteer Opportunities (Pelotonia, Special Olympics, etc.)
- Internship dinner with interns, mentors and other invited guests

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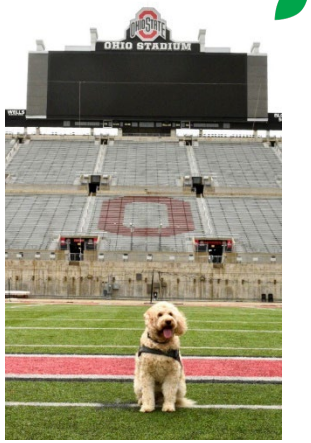
BDSI Projects

Buckeye Paws



Volunteer

Besa
BE THE GOOD

Special Olympics

Shadowing

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Emergency Department

Operating Room

DEI Poster and Surveys

Laboratory DEI Survey

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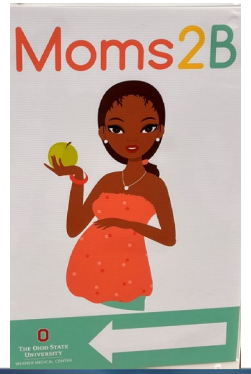
He belongs
She belongs
They belong
I belong

Genius Bar for New Tower

Marketing Brochures

Moms2B- social justice initiative



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Inclusive Excellence:
Inclusive Excellence Leadership Development Program
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Inclusive Excellence Leadership Program

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Purpose:

- To foster The Ohio State University Wexner Medical Center's (OSUWMC) shared value of inclusiveness, building a pipeline of potential leaders that reflect the patients that we serve, through exposure to the breadth and depth of healthcare leadership career pathways.
- The program is designed to promote learning, networking, and career development with support from preceptors and senior leaders.

Program Structure:

- 4 Candidates paired with a senior leader as a preceptor who will provide one-on-one guidance for the duration of the program
- Participate in leadership meetings, councils, and department specific forums and huddle
- Placement in a strategic and/or meaningful project(s) in an area outside of current responsibility
- Enrollment in two leadership development programs/workshops
- Networking opportunities with various directors and senior leaders
- Lunch & learns with hospital senior leaders
- Exposure to strategy and operations, network across clinical and operations teams, and professional development opportunities.

Professional Development Workshops and Engagement:

- CliftonStrengths for Students assessment
- Presentation Skills
- Resume Building
- Personal Brand
- Networking and Social Capital
- Team building activities

Manager, Rehab Services

Patient Experience Analyst

Operations Manager, Environmental Services

Assistant Nurse Manager, Emergency Services

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Inclusive Excellence:
OSUWMC Mentorship Program
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Inclusive Excellence: Staff Mentorship

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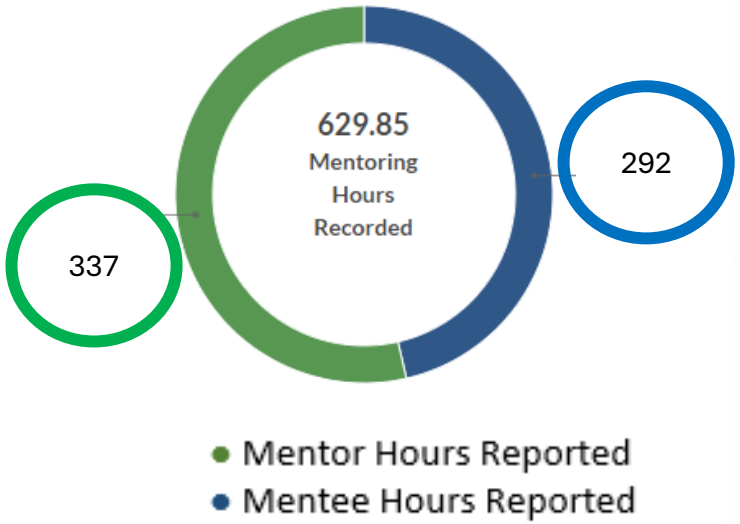
Diversity, Equity and Inclusion MENTORSHIP Program

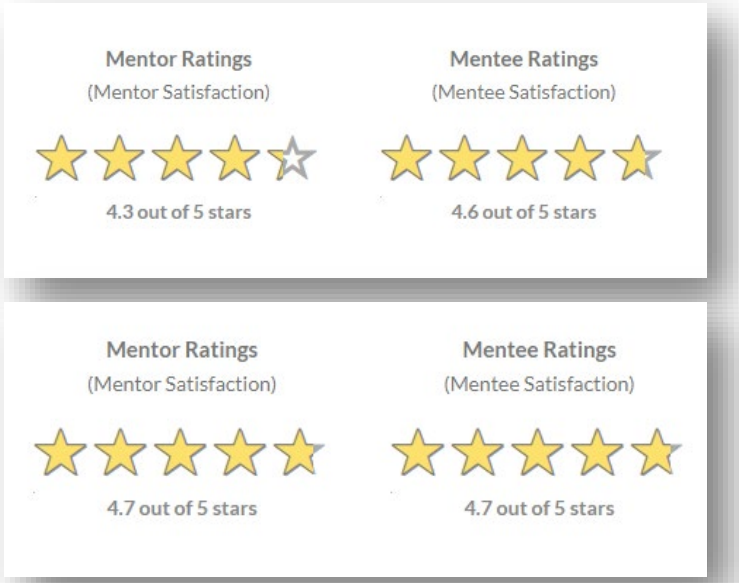
Personalized and role or vision-specific mentoring support for staff to support the advancement of underrepresented minority communities to enhance talent pipeline and advancement into leadership

- 140+ people enrolled in pilot phase
- 59 mentoring pairs
- Nearly 630 hours spent on mentoring over six months
- Program and relationship satisfaction 4+ stars

Mentorship Hours



Surveys



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Importance of Inclusive Excellence
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Key Statistics

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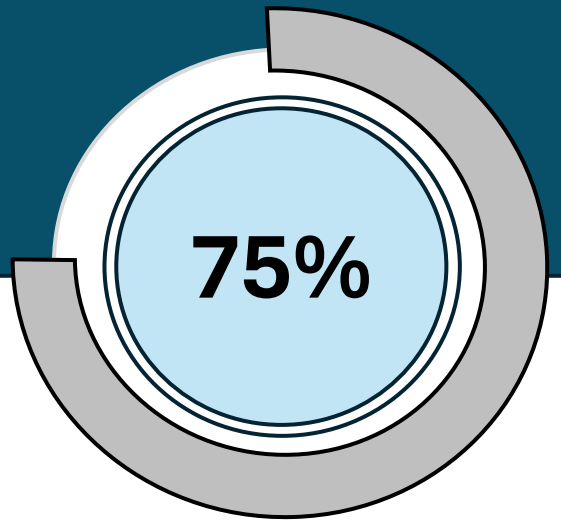
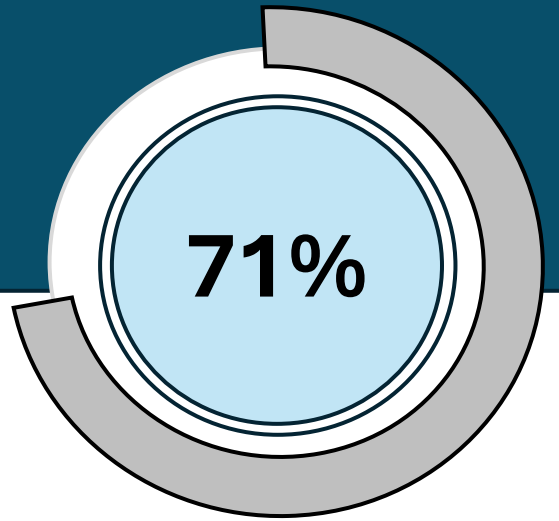
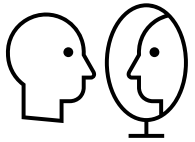


Executives Credit Mentoring for Their Success



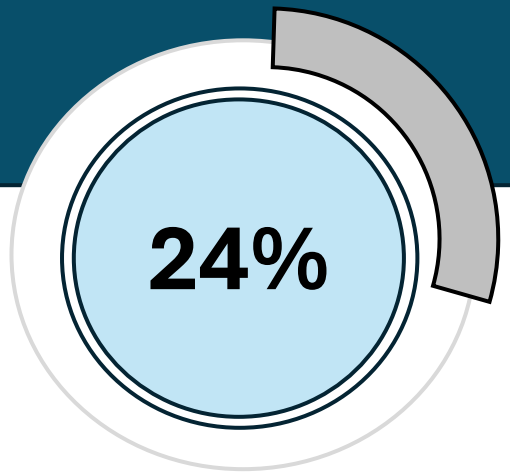


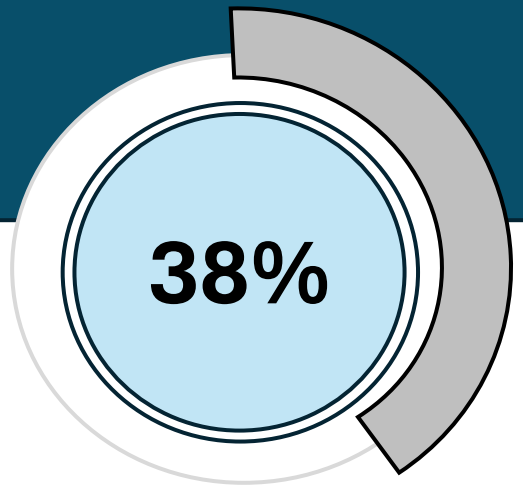
Executives Choose to Mentor Employees Who Are of Their Same Gender or Race

Harvard Business Review

REFLECTION

Key Outcomes





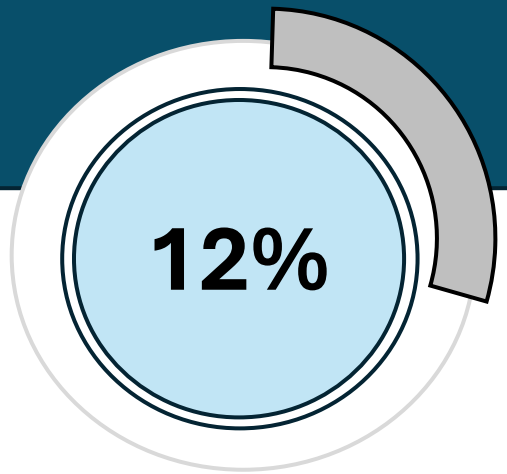
Mentoring Programs
Boost minority representation at the management level

Mentoring Programs Dramatically
Improve Promotion & Retention Rates For Minorities & Women

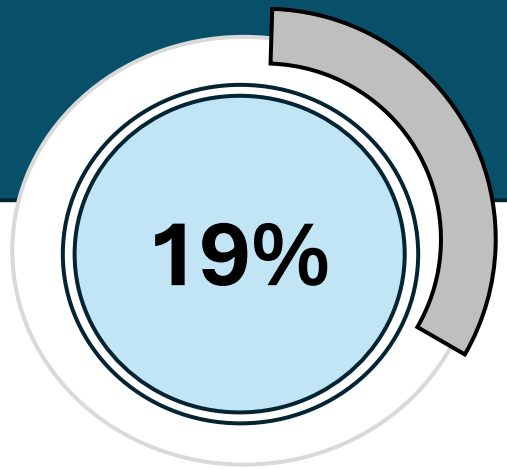
Forbes

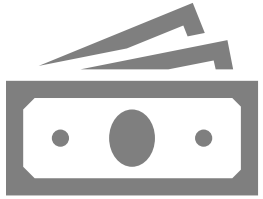
Key Outcomes

Diverse workforce



higher employee productivity





higher revenues

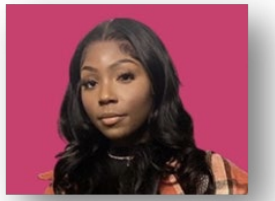
Forbes
Vervoe (n.d.).The Most Significant Economic Benefits of Diversity That Will Set Your Business Apart. Retrieved 7.15.24, from https://vervoe.com/economic-benefits-of-diversity/

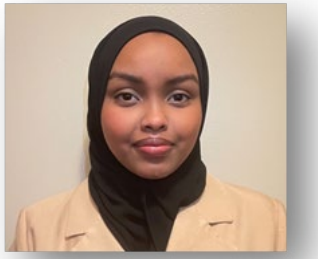

Outcomes

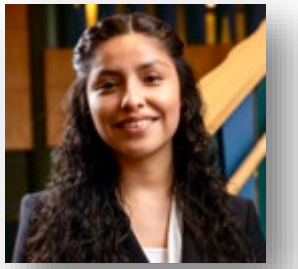
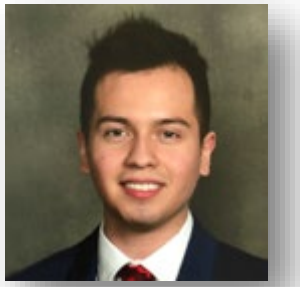
2022 & 2023 Cohort









Graduate School

Full time Job offers

100% Graduation Rate

Direct Hires

Doctorate Programs

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BDSI Participant Feedback

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"The shadowing opportunities and the connections made with everyone we came in contact with, especially the executives." ***– Intern, 2022 cohort***

"I loved how open everyone was to helping and/or connecting us to others. The many opportunities that were given to us (lunch & learns, meet & greets, shadowing, etc.)." ***– Intern, 2023 cohort***

"The most satisfying part about this internship was being able to gain knowledge about different roles in healthcare through shadowing as well as being able to build up our skills through the career readiness sessions." ***– Intern, 2023 cohort***

"They offered candid, fresh approaches and asked pertinent questions to the task at hand. I was impressed because their work was as good, if not better, than established workers. They were, in my opinion, the cream of the crop." ***- Project preceptor, 2023***

Inclusive Excellence: Staff Mentorship- Outcomes and Feedback

Expansion of pilot to ALL Staff mentoring program with nearly 400 participants
43% of participants affiliated with one or more employee resource groups

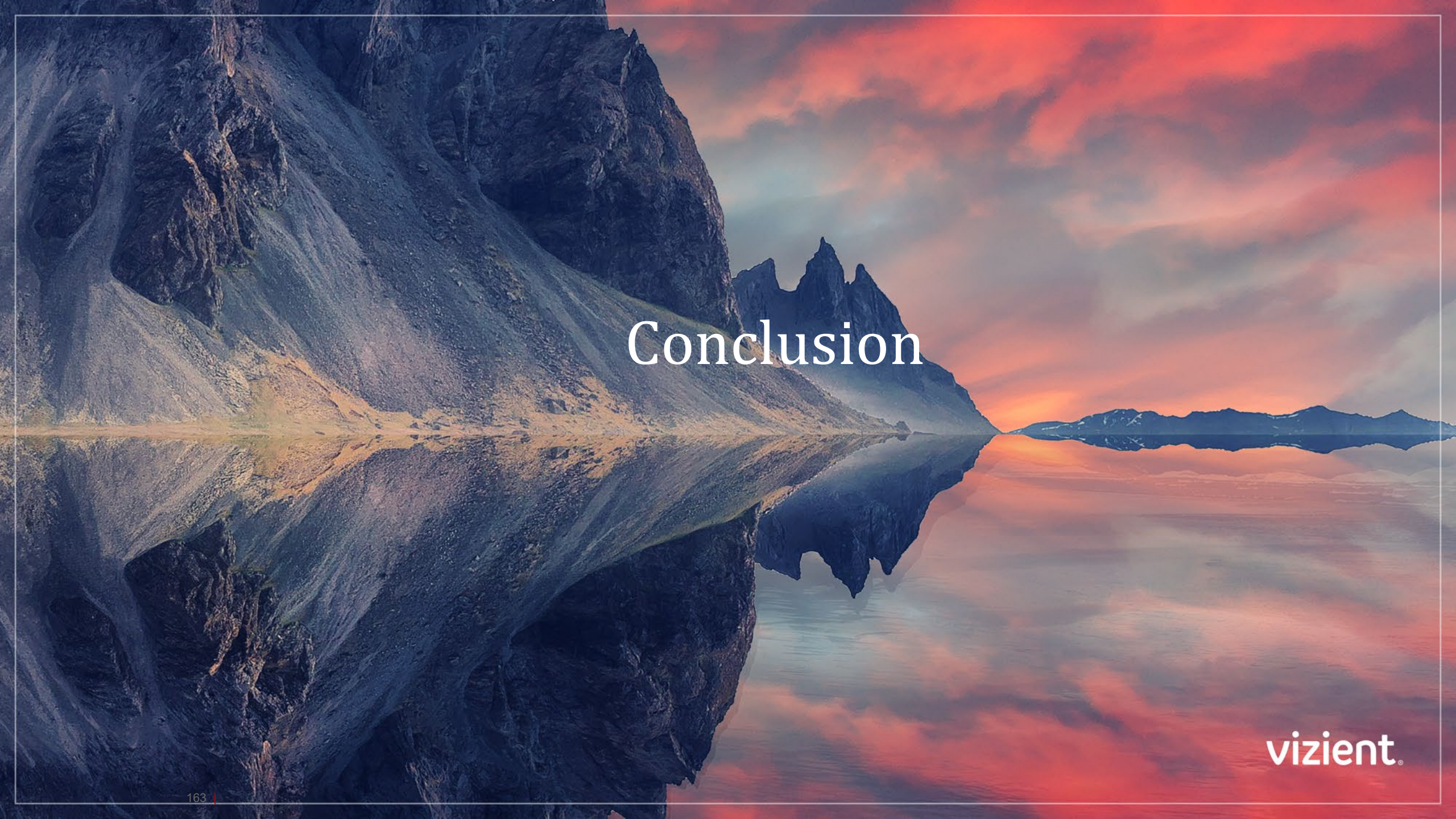
SPONSORSHIP *"I had a fantastic experience with the DEI Mentoring Program. I would like to give kudos to my mentor…**from mentorship to sponsorship**…**lifetime connection**. Thank you!"* ***– Mentee***

GUIDANCE AND EXPOSURE *"My mentor has been a great match for my needs! It's been very helpful to hear her career journey and how she got "unstuck." She is a wonderful and understanding listener that has **provided valuable advice**. I'm excited to continue to develop this relationship!"* ***- Mentee***

INCLUSIVE LEADERSHIP SKILLS *"I've learned the importance of **establishing a safe space for conversations about DEIB** and how to effectively to do that with each individual. For these conversations to be successful, it requires an **intention to learn and challenge your own biases/practices** as well as a willingness to partner with others in new ways."* ***– Mentor***

CAREER ADVANCEMENT *"I believe I was able to help [mentee] with her career goals and this resulted in her **moving into a new leadership position** at The James Cancer Hospital during the mentorship period. Very exciting to see her take this step. I'm sure she will be very successful!"* ***- Mentor***

REFLECTION


Conclusion

Lessons Learned

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- Not everyone recognizes the value of diversity and inclusion (i.e., SB83, Political environment, etc.,)
- Leaders must intentionally champion inclusion
- It takes a village: Organizational support is key
- Interns should hit the ground running
  - Provide and align projects ahead of start dates

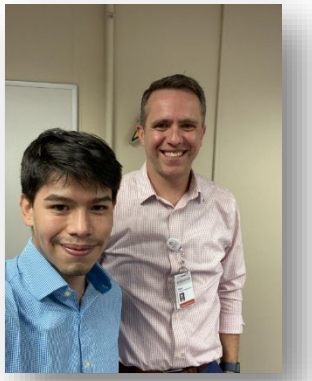
REFLECTION

Key Takeaways

- All it takes is one idea, take the risk
- Embed inclusion in systems, processes, policies, and day-to-day operations.
- Representation matters. Ensure diverse voices are represented at all levels of the organization.
- Grow the organization to be inclusive through intentional pipelines and hiring
- Research shows students who take part in paid internships receive:
  - More Job offers and higher salaries*

* 2022 Student Survey, National Association of Colleges and Employers

Thank You



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Questions?

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Contact:

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Tracey Boggs, MBA: tracey.boggs@osumc.edu

This educational session is enabled through the generous support of the Vizient Member Networks program.

REFLECTION

Journey to Equity: Program Management Transforms Ideas into Innovative Implementations

Wendy Parisi, MS
Senior Director
Health Equity Program Support Office
University of Rochester Medical Center

Jherell Drain, BA
Senior Communications Specialist
Health Equity Program Support Office
University of Rochester Medical Center

REFLECTION

What's the University of Rochester Medical Center?

- Integrated academic medical center based in Rochester, NY
- Part of UR Medicine healthcare system, comprising:
  - 6 hospitals throughout Finger Lakes/Southern Tier
  - 7 emergency departments
  - More than 1,000 specialists

Photo Credit: URMC

UR Medicine by the Numbers

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- 1,391 licensed beds
- 68,410 inpatient discharges
- 222,077 emergency department visits
- 144,045 urgent care visits
- 44,356 ambulatory surgeries

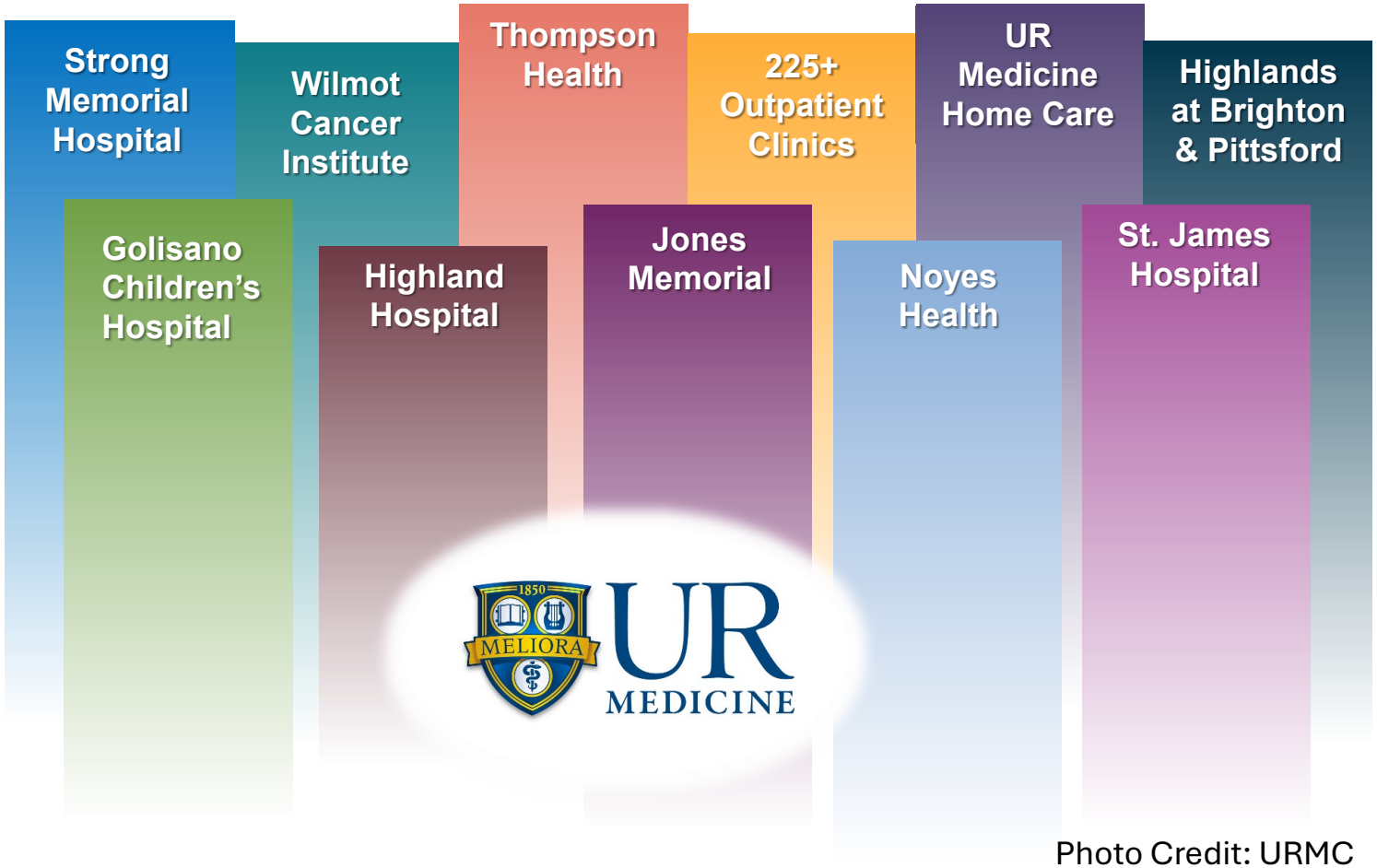

Photo Credit: URMC

REFLECTION

Internal University of Rochester Medical Center data

Commitment to Health Equity

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URMC aspires to make every person feel safe, welcome, and supported at all times; to **be a place where everyone**, regardless of identity or challenges they face, **is lifted up to become their best and healthiest selves**…

URMC Equity & Anti-Racism Action Plan: FY2021 to FY2025

REFLECTION

Why Engage in Equitable Health Care?

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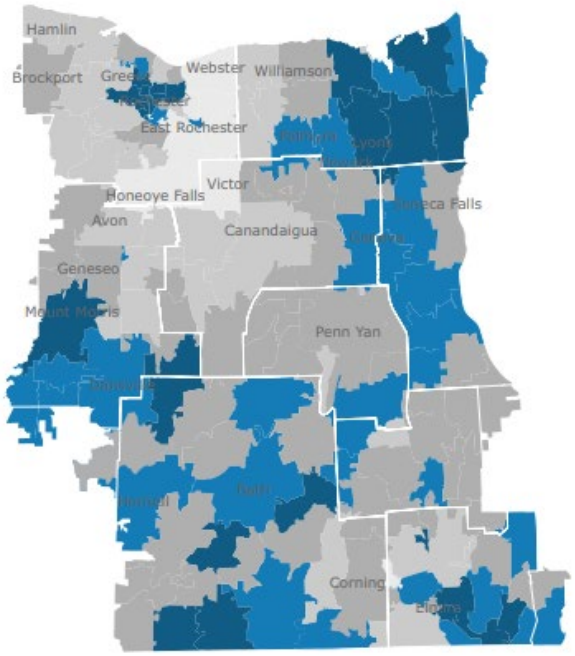
Low Income Areas Typically Have the Highest Premature Mortality Rates

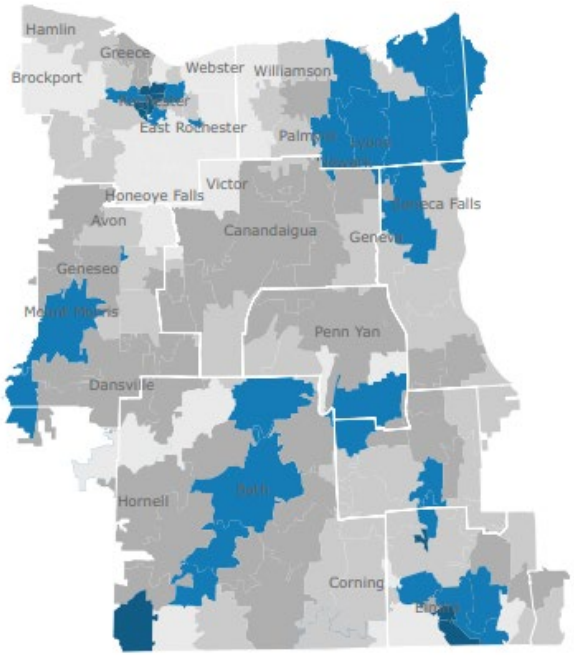
Areas with Low Socioeconomic Status in Blue[‡]



SES 1 SES 2 SES 3 SES 4 SES 5

Source: American Community Survey; ZIP code level analysis by Common Ground Health

Areas with High Rates of Years of Potential Life Lost in Blue[†]



More than 150% of region avg | 121-150% of region avg | 101-120% of region avg | 81-100% of region avg | Up to 80% of region avg

Source: NYSDOH Vital Statistics 2006-2015; ZIP code level analysis by Common Ground Health

"Of all the forms of inequality, **injustice in health is the most shocking and the most inhuman** because it often results in physical death."

- Martin Luther King Jr.

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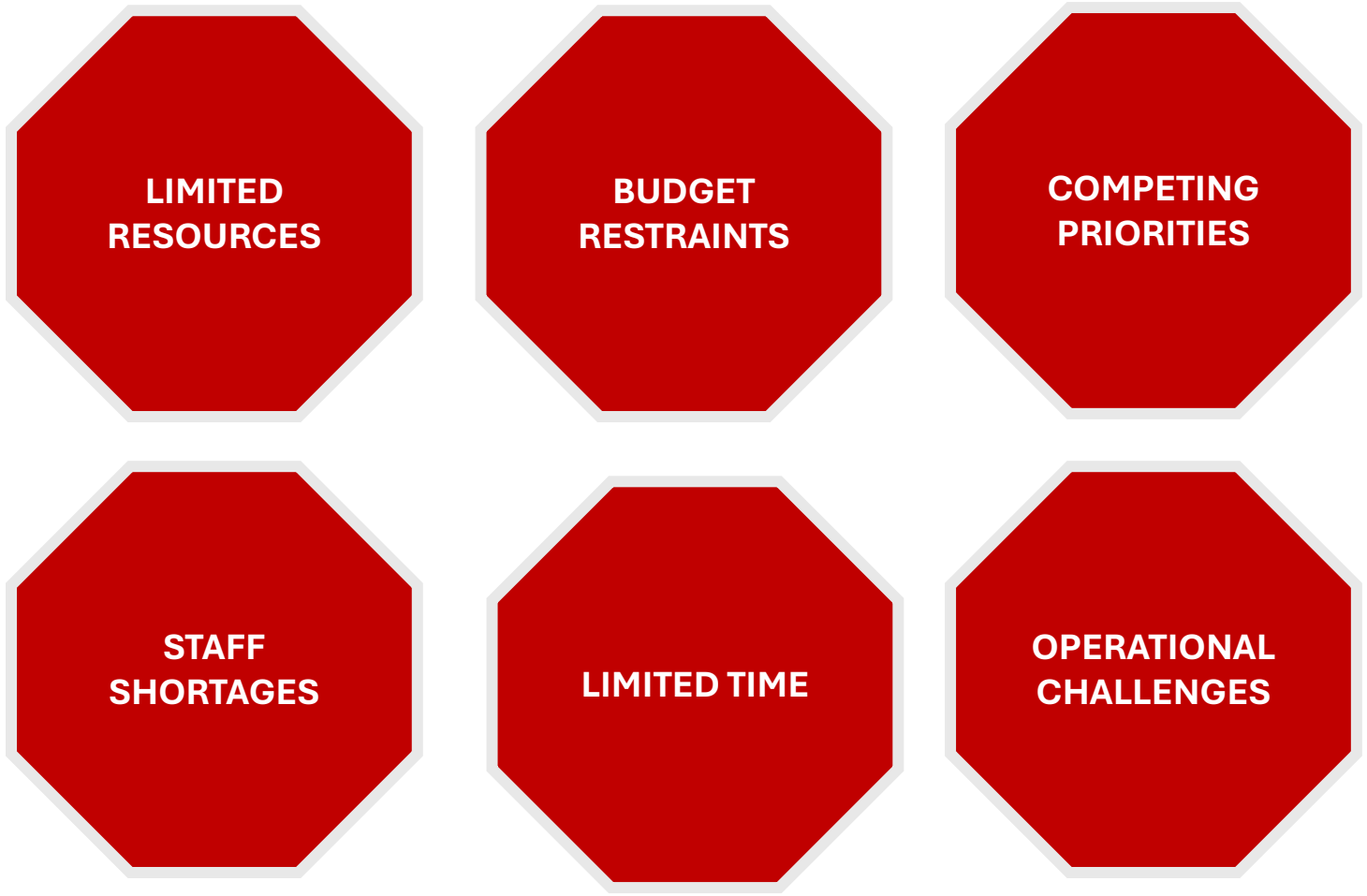
Internal Barriers

Passionate clinical staff and teams often face barriers that stand in the way of bringing their health equity ideas and goals to fruition



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Intervention

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- Journey to equity requires equipping our clinical teams with resources and partners to help **transform ideas into operations**

- Specific resources include:
  - Program & project management
  - Informatics
  - Information systems/technology
  - Communication
  - Stakeholder & leadership engagement

An embedded model to leverage these resources is key!

REFLECTION

How HEPSO Helps

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Health Equity Program Support Office (HEPSO) created at URMC to:

- **Support** the 2015 CMS 1115 Waiver (NYS Delivery System Reform Incentive Payment [DSRIP] Program) rollout
- **Engage** patients & providers in efforts to reduce ED utilization, increase use of behavioral health services within primary care, etc.
- **Champion** equity-driven implementations across clinical enterprise with embedded resources

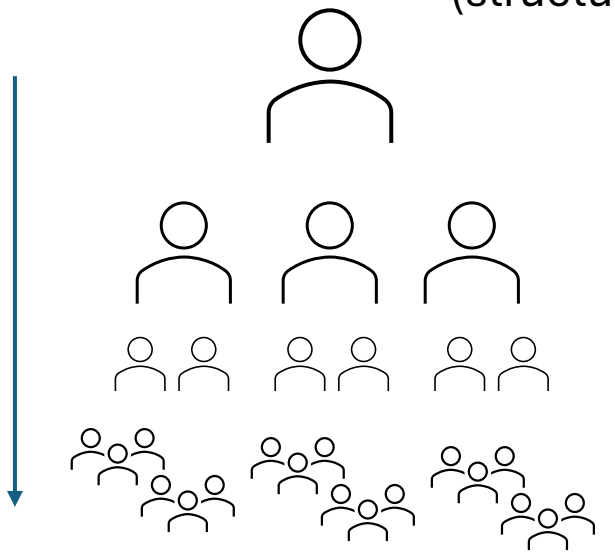
REFLECTION

In Other Words

We help our clinical colleagues navigate a lot of this ↓

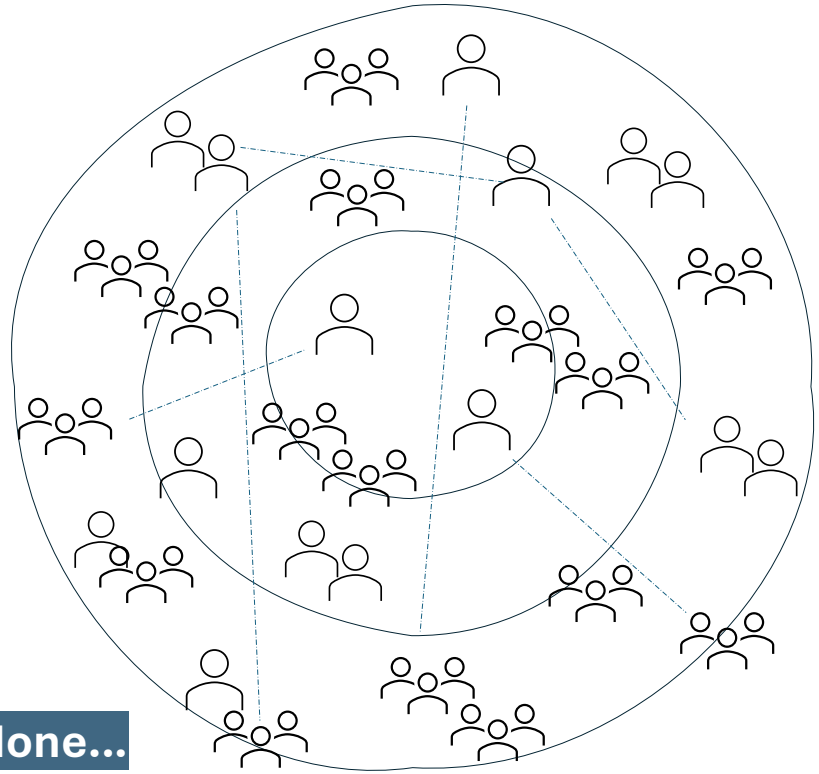
How we think work gets done…

(structures)



How work actually gets done…

(teams)



Example 1: Health-Related Social Needs Screening

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How can we optimize our electronic health record to better identify and address health inequities?

HEALTH EQUITY & ANTI-RACISM TECHNOLOGY PROGRAM

Program workstreams:

- Health-Related Social Needs (HRSN)
- Demographics
- Internal Connections Management
- External Connections Management

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HRSN: We Ask Because We Care

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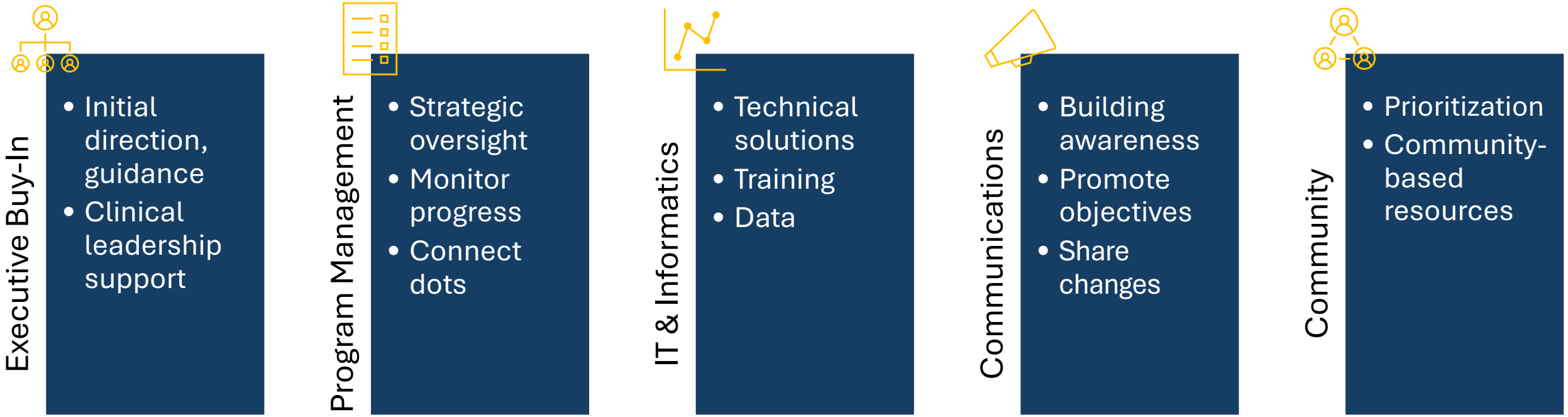
Photo Credit: Getty

Good health is rooted in where we live, how easily we can get around, and what we eat. **Because we care about our patients**, talking about these areas of their lives is important and makes sure we're **working together to help patients live and feel their best.**

REFLECTION

HRSN: Many Hands Make…

"Light" Work!



HRSN: 2023 Milestones

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247,000+
Pediatric and adult patients screened

200,000+
completed eCheck-in screenings

Staff eLearning launched

Utilities domain implemented

Improved data availability

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Example 2: UR Medicine Food Pantry

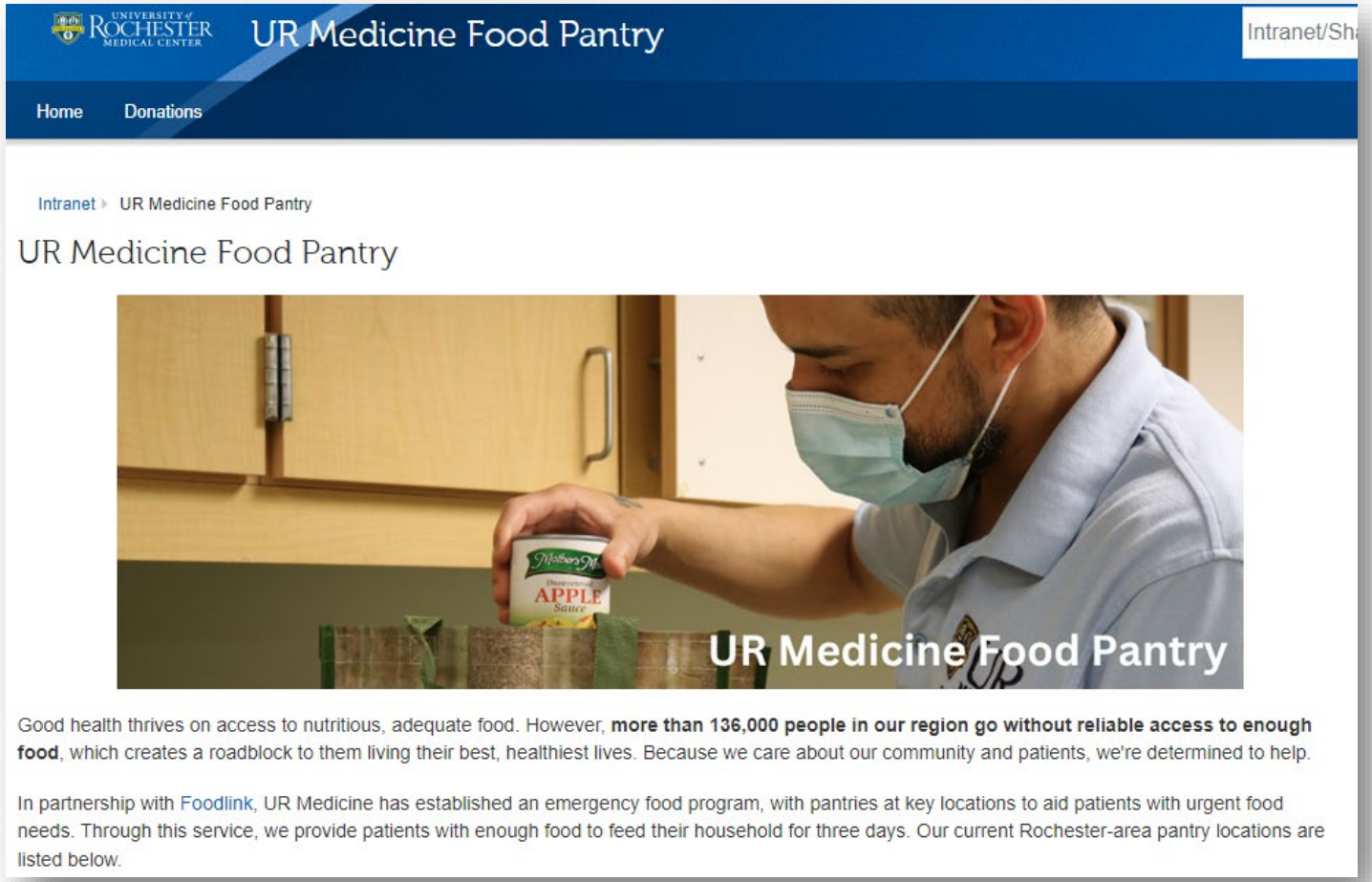
How can we help provide emergency food assistance to patients within our clinics?

UR Medicine Food Pantry

Photo Credit: URMC

URM Food Pantry: How it Works

- Referral-based emergency food pantry located in Patient Discharge
- Serving main URMC campus & 9 offsite locations
- Patients with positive screening for food insecurity can be referred in the EHR



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URM Food Pantry: Dot Connecting

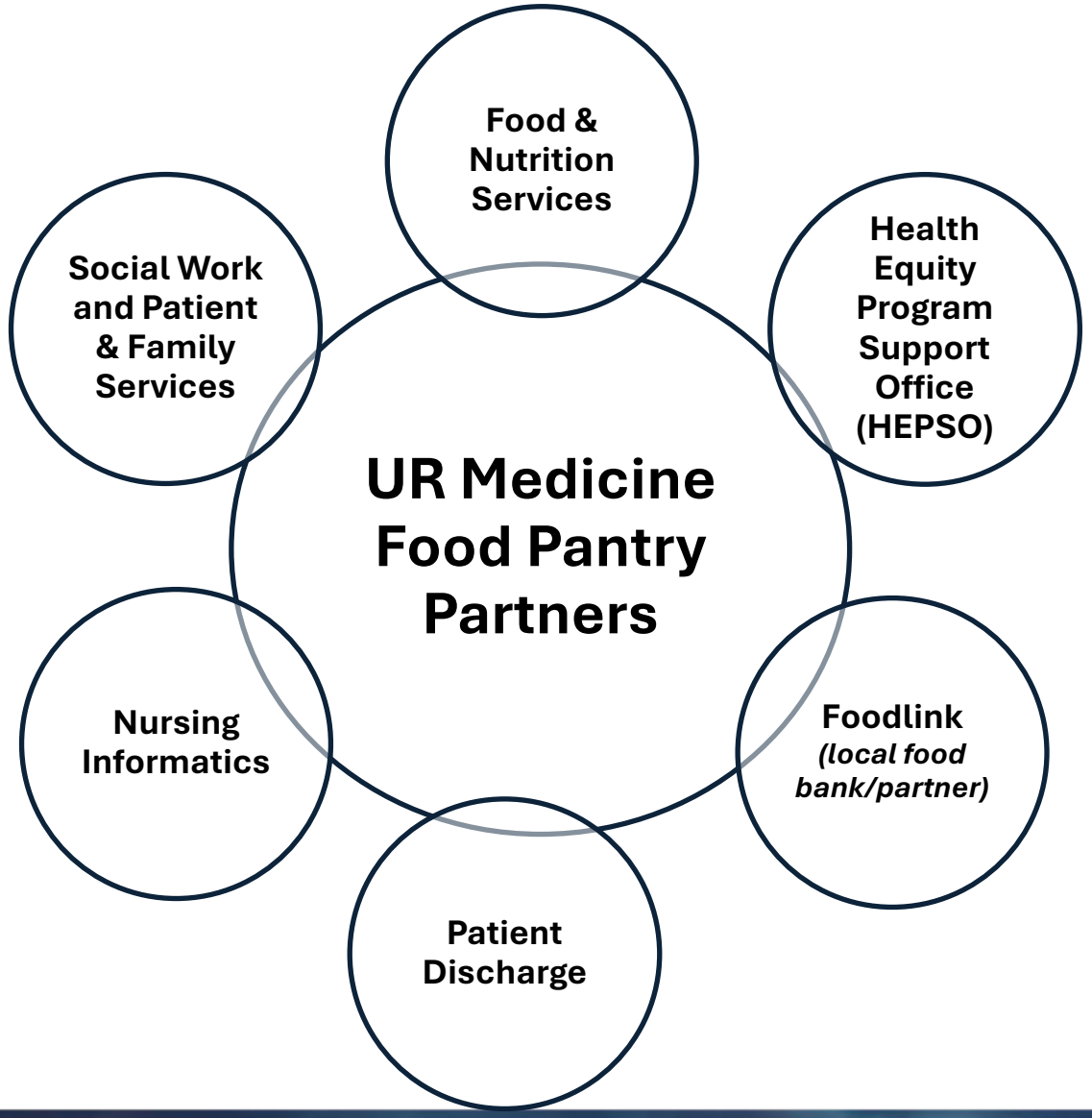

Photo Credit: URMC

URM Food Pantry: 2023 Milestones

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1,735
referrals across pantry network

1,389
pantry visits across pantry network

28
department-led food drives

225
referring clinicians

REFLECTION

Leader / Staff Feedback

"HEPSO's **collective expertise** and experience in program management, engaging our community partners, and supporting our clinical faculty and staff makes the team an **invaluable asset in our ongoing quest towards fostering equitable health care**."

- Kathy Parrinello, President & CEO, Strong Memorial Hospital

"The HRSN initiative brings to light the importance of treating each patient and family with individualized care that assures their needs are being met beyond the care given here at the hospital. **This initiative keeps us on the path of being 'ever better.'"**

- Colleen Nowacki, Nurse Manager, Highland Hospital

Lessons Learned

vizient.

What we've found to be paramount to success:

- Embedded model (centralized/ dedicated resources)
- Institutional knowledge (familiarity with how things work)
- Support early on from leaders, providers & administrators

Journey Essentials — Key Takeaways

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- **Secure Buy-in:** Leverage innovation-minded leaders early
- **Integrate:** Identity key players and start connecting dots
- **Balance:** Consider both efficacy & effectiveness

REFLECTION

Questions?

Let's Connect!

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