Incorporating Equity into PDSAs: Linking Quality and Equity in QI Projects

Presenters:
Melanie Ridley, HANC-NCCN QI Consultant

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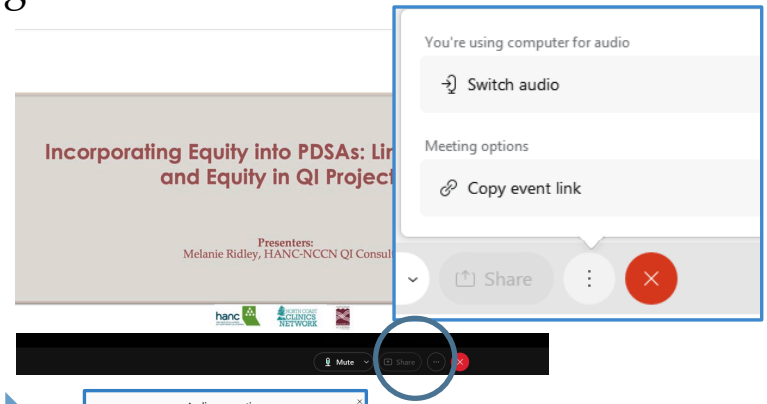

Figure 1

Figure 2

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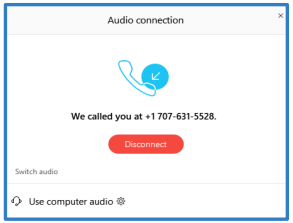

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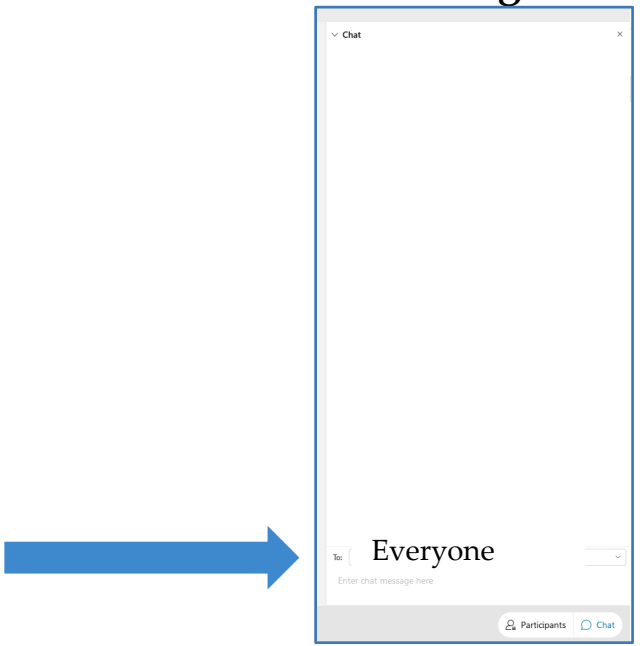
Figure 1



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Learning Objectives

- Understand the imperative of focusing a learning health system on equity
- Identify actions to take as part of PDSA improvement projects to address equity
- Explore selecting and monitoring QI measures with an equity lens

Before We Begin - Question for You?

How knowledgeable are you on the topic of incorporating health equity in QI projects?

- Extremely knowledgeable
- Very knowledgeable
- Somewhat knowledgeable
- Not so knowledgeable
- Not at all knowledgeable

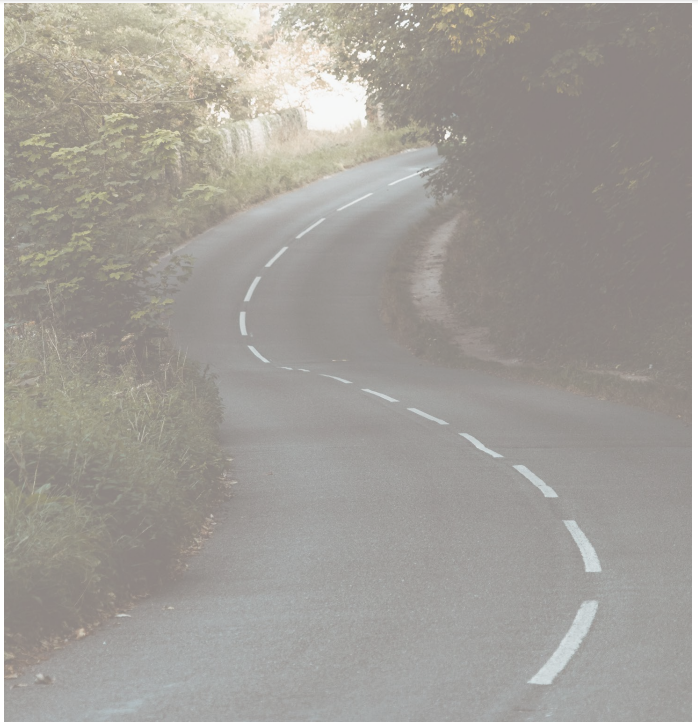
Recap of April 2023 Equity in QI Webinar

- National program supported by the Robert Wood Johnson Foundation
- Identifying and implementing strategies to reduce and eliminate disparities in health and health care
- Aligning payment reform and quality improvement efforts
- Created *Roadmap to Advancing Health Equity*
- Leading a learning collaborative of 7 states

https://advancinghealthequity.org/

Roadmap for a Health Equity Approach

- Identify a health equity focus
- Diagnose root causes with an equity lens
- Prioritize root causes
- Design care delivery transformation



Bringing Equity into Quality Improvement

UCSF Center for Health Professions recommendations to address equity in quality (2012):

- Disparities remain a common marker of poor health system performance
- Improvements in equity cannot be made without high quality race, ethnicity, and language data (REAL) data
- Quality improvement may not benefit all populations equally
- Interventions to improve health equity must be tailored to overcome barriers and meet the needs of populations experiencing unequal care.
- All organizations have the ability to start small, identify goals for improvement, and track performance in reducing disparities
- Reforms provide opportunities to advance equity through initiatives to achieve meaningful use, accountable care, and patient-centered services.

> *"...it's now part of the meaningful use requirements for health information technology [which] means that we are going to see hospitals and physicians and then everyone that's affiliated with them begin to have [REAL] data and potentially... use it."*
>
> —Roundtable participant

Source: https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/6.1%20Part%201%20_Equity%20into%20QI.pdf

Addressing Racism to Improve Quality in Healthcare

"the legacy of racism is baked into our institutions, our thinking, and our policies"

~Alan Weil, the editor-and-chief of Health Affairs

Source: https://www.healthaffairs.org/racism-and-health

Creating a Learning Health System

Health Systems are learning when…

"…They acquire the ability to continuously, routinely, and efficiently study and improve themselves."

Five Observable Characteristics of Learning Health Systems:

1. Circumstances, actions, and outcomes are available as data
2. Knowledge generated is immediately available
3. Improvement is continuous due to ongoing learning
4. A socio-technical infrastructure that makes this routine
5. Activities are embraced within a professional culture of practice

Source: Friedman et al. The science of learning health systems: Foundations for a new journal. Learn Health Sys 2017. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6516721/pdf/LRH2-1-e10020.pdf

Learning Health Systems with an Equity Focus

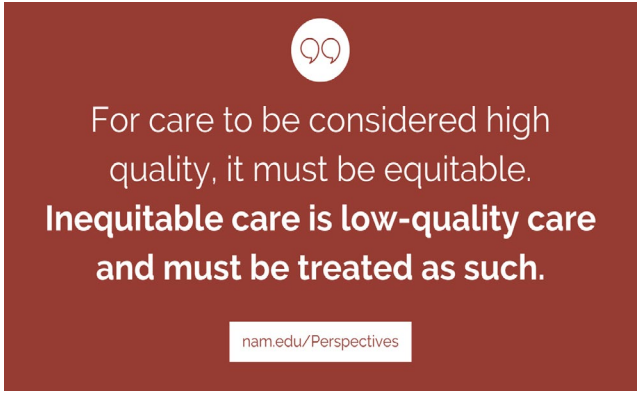
Learning Health Systems offer a response to current evidence challenges:

- Slow, expensive evidence generation
- We don't have the answers yet for how to produce the best outcomes for different populations
- We must harness learning and evidence generation within health care practices

National Academy of Medicine

An Equity Agenda for the Field of Health Care Quality Improvement

- Embed an equity lens into all quality and safety improvement activities.
- Create an equity dashboard and embed equity into quality dashboards to ensure that equity data are presented to health system leaders.
- Ensure that leadership commitment, resources, and infrastructure are adequate / sustained.
- Ensure diverse leadership at all levels.
- Empower and equip quality officers within health care systems to take on this work.
- Improve the quality of data collected on race and ethnicity (as well as other variables).
- Routinely stratify and report data by race and ethnicity in order to identify the greatest opportunities for improvement, set goals, and direct resources there.
- Normalize a culturally affirming approach to care.
- Update patient experience measures to include experience of bias and/or discrimination.
- Engage patients and communities as partners in improvement efforts.



Source: https://nam.edu/an-equity-agenda-for-the-field-of-health-care-quality-improvement/

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Learning Health Systems and Equity

"Every system is perfectly designed to get the results it gets."
~ W. Edwards Deming

"To **disassemble systems that have produced inequities**, reimagine and create ones that **produce equity**, and overcome the inertia of the status quo along the way, learning health systems need to **transform the people and processes through which the improvement work itself is done**.

To achieve and sustain equity, learning health systems need not only embed equity-centric measurement across their learning and improvement work but also measure the ways in which they do their own internal learning and improvement work."

Source: https://onlinelibrary.wiley.com/doi/full/10.1002/lrh2.10279

A Toolkit to Advance Racial Health Equity in Primary Care Improvement

"Racial health equity can be viewed as both an outcome and a process requiring continuous learning and improvement."

Purpose of the toolkit: To integrate racial health equity into care improvement efforts in primary care settings.

Two foundational beliefs:

- Primary care cannot improve the health of patient populations without simultaneously advancing health equity.
- Health equity, including racial health equity, is core to high-quality primary care. High-quality care is equitable care.

Link: https://www.chcf.org/wp-content/uploads/2022/07/ToolkitRacialEquityPrimaryCareImprovement.pdf

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Building an Anti-racist Healthcare System

Anti-racist practice is an active process of naming and confronting racism by changing systems, organizational structures, policies, and attitudes so that power is redistributed and shared equitably.

- Implicit bias training is insufficient.
- Anti-racist efforts to advance racial health equity must therefore address the social, economic, political, legal, educational, and health care systems that maintain structural racism.

" The reality is, even if we could reliably reduce individual-level bias, various forms of institutional racism embedded in health care (and other organizations) would likely make these improvements hard to maintain."

Source: https://www.chcf.org/wp-content/uploads/2022/07/ToolkitRacialEquityPrimaryCareImprovement.pdf

A Toolkit to Advance Racial Health Equity in Primary Care Improvement

Key Drivers

- Shared foundational understanding of racism and racial health equity
- Shared norms and commitment to becoming a multicultural, anti-racist organization
- Organized teams that include people who belong to historically marginalized communities
- Data collection and reporting systems for race, ethnicity, and language (REAL)
- Ability to prioritize and stratify measures by REAL data
- Ability to analyze and identify root causes of identified racial health inequities
- Ability to co-design equity-focused improvement efforts that address root causes
- Dashboards and systems to monitor and guide racial equity-focused improvement efforts
- Ability to inform and accelerate equity-focused institutional and community transformation

7 opportunities for improvement addressed by this toolkit

Figure 2: Roadmap: Seven Opportunities on the Road to Improvement

Source: https://www.chcf.org/wp-content/uploads/2022/07/ToolkitRacialEquityPrimaryCareImprovement.pdf

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How Health Equity is Defined at FQHCs

A mixed methods study of FQHCs from the Massachusetts League of Community Health Centers (2023)

- Focusing on underserved populations
- Equitable access to healthcare
- Providing person-centered healthcare
- Identifying and understanding root causes of inequities
- Opportunities for health and wellness

Source: https://academic.oup.com/tbm/advance-article/doi/10.1093/tbm/ibad046/7237815

"Health equity in the way that we address it in my work is **looking at the root causes** of why there are such **differences in health outcomes and health concerns among populations**. Whatever separating demographics you're looking at, there are always differences. And often that has to do with things that are more systemic, environmental, things like that are commonly not viewed as health or health indicators"

"It's primarily about having **opportunities for health and wellness for the community**. For instance, in the community, and really meeting our patients where they're at and meeting their needs. We had this **traditional thought before that it was primarily about access**, and if you make it available, that was good enough. And we've learned over the years that's really not good enough and that **access doesn't equal equity**."

How to Include Health Equity in QI

"… a call for healthcare to play a more active role in building community power where people facing similar inequities act together to hold policy makers and institutions accountable for equitable outcomes."

- Set improvement targets
- Tailor and/or adapt patient outreach and engagement strategies
- Interpreter services
- Community health workers
- Transportation
- Community resources

"We'll share [data] with our clinical groups, and then it's about what other strategies for us to outreach or engage patients. So it's looking at best practices, learning from other sites how they do things, or just tweaking a little bit of what we do already. So doing different test [PDSA] cycles, meaning it's almost like oversampling; we just **over-outreach in the different groups that are a little behind**, and then from there you **gather some sort of qualitative information, like why are people declining** and then tweak and/or tailor further."

Source: https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2022.00540

Organizing Teams for Equity-Focused QI

- Leverage quality and performance improvement programs to embed and advance racial health equity
- Include patients, families, and community members with lived experience on the team
- Set clear roles, responsibilities, and expectations for all team members
- Develop an equity-focused team charter

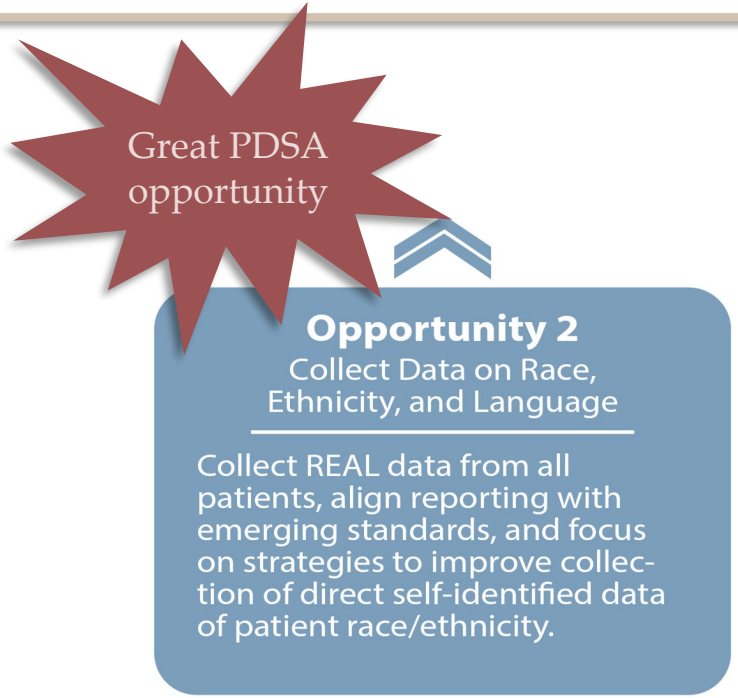
Reflections on these? How are you addressing these in your QI?

Opportunity 1
Organize Teams

Form and revise improvement teams dedicated to incorporating racial health equity in care improvement workflows.

Collect Patient Data to Support Health Equity

- Align ethnicity data categories with minimum standards
- Provide patients with the option of self-identifying
- Allow patients to "Select all that apply" and "Choose not to respond"
- Collect more granular data to reflect California's racial, ethnic, and linguistic diversity
- Validate your current REAL data



Resource: AHA Disparities Toolkit - scripts for how to speak with patients about collecting this data. https://ifdhe.aha.org/aha-disparities-toolkit

Measure Differences by REAL Data

- Choose at least five measures to disaggregate and stratify by REAL data
- Select meaningful, "disparities-sensitive" measures
- Identify additional measures to stratify based on clinical needs and strategic priorities informed by key stakeholders
- Identify how a chosen performance measure is distributed within each demographic group and compare one group against another (i.e., How big is the "gap" in quality between groups?)

Measures for REAL:
» Colorectal Cancer Screening
» Adolescent Well Care Visits
» Controlling High Blood Pressure
» Prenatal and Postpartum Care
» HbA1c Control for Patients with Diabetes
» Well Child Visits 0-15 months

Opportunity 3
Identify Measures to Stratify by REAL Data

Choose performance measures to disaggregate and stratify using REAL data, including clinical performance and patient experience measures.

Equity Measurement Approach in PDSA Improvement Projects

Asking questions as part of planning an improvement project that will help frame an equity focus.

- Planning Phase: Do preventive screening rates, treatment recommendations, or other measures of the quality of our patient care differ by race, ethnicity, and/or language?
- Identifying Root Causes: What factors may be contributing to these differences?
- Selecting an Intervention: Is the change to be tested based on evidence of the relationships between the social risk factor and outcome?

Resource: Racial and Health Equity: Concrete STEPS for Health Systems https://edhub.ama-assn.org/steps-forward/module/2788862
Resource: ASPE Developing Health Equity Measures https://aspe.hhs.gov/sites/default/files/private/pdf/265566/developing-health-equity-measures.pdf

Case Study: Colorectal Cancer Screening and SDOH

Four community health centers participated in a research project to test a colorectal cancer screening through PDSA. The test paired CRC and SDOH screening targeting age-eligible (50–75 years old) average-risk adults. Goal was providing fecal immunochemical test (FIT) screening paired with screening for SDoH.

- Outreach to eligible patients (could be linked to a visit or done by phone);
- Education on the indications for, benefits of, and ways to overcome barriers to cancer screening;
- Education on FIT and recommendations to offer other CRC screening based on patient preference;
- SDoH screening.
- Narrowed the registry list:
  - Patients who had completed FIT before but not in the past year;
  - English-speaking patients from racial groups with lower than average CRC screening rates; and
  - Patients scheduled for upcoming visits.
- Reviewed gaps in the outreach list and returned FIT kits for the paired screening intervention by race/ethnicity, gender, age, and language.

Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9530430/

Case Study: Pediatric Diabetes PDSA

- To identify and define an equity gap, extracted data from clinical registry. Saw significant variation in measures like HbA1c, ED visits, and admission for diabetic ketoacidosis (DKA) by both race and neighborhood poverty.
- SMART aim: Reduction of ED visits among a cohort of children with T1D living in high poverty, high minority population neighborhoods.
- PDSA began with 20 patients:
  - Community Health Worker (CHW) support between medical visits
  - SDOH and environmental factors assessment (used CareMaps)
  - Innovation fund to address key SDOH barriers (e.g. transportation, food)

Source: https://onlinelibrary.wiley.com/doi/full/10.1002/lrh2.10279

Equity Focused QI Approach May Begin with a Health Equity Analysis

When looking at your issue of focus for QI work, you may begin by:

- Researching existing health disparities within your community or patient population
- Stratifying quality data to see how performance on measures differs by patient sub-groups
- Explore how health equity challenges may be causing or exacerbating poor outcomes (e.g. readmissions), no-shows, or poor patient experience survey results

Source: https://healthcare.rti.org/insights/wheres-your-health-equity-fulcrum-part-2

What Health Disparities or Inequities Exist Among Patients?

Where can you look to explore such questions?

Community Health Needs Assessment (CHNA) reports

eReports: Preventive care reports with Race/Ethnicity filter or Race / Ethnicity by measure

County Health Rankings & Roadmaps: https://www.countyhealthrankings.org/

Social Vulnerability Index: https://www.atsdr.cdc.gov/placeandhealth/svi/index.html

Health Landscape: https://healthlandscape.org/

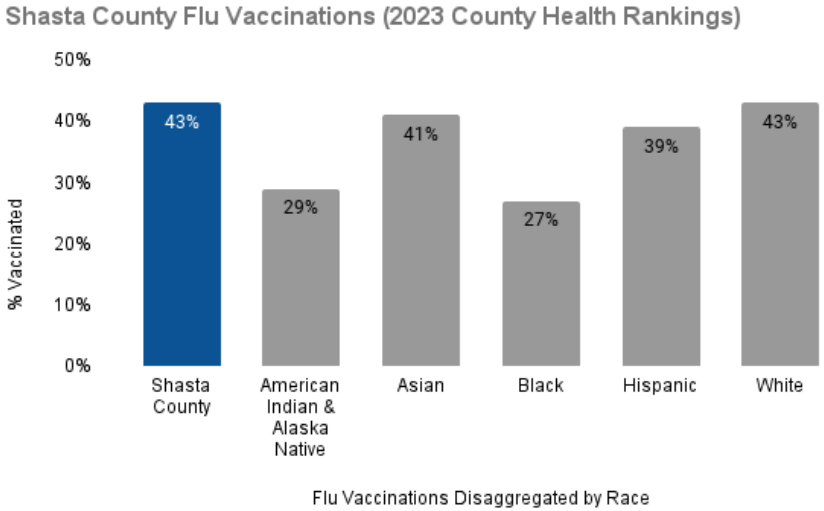
Community Commons: https://www.communitycommons.org/

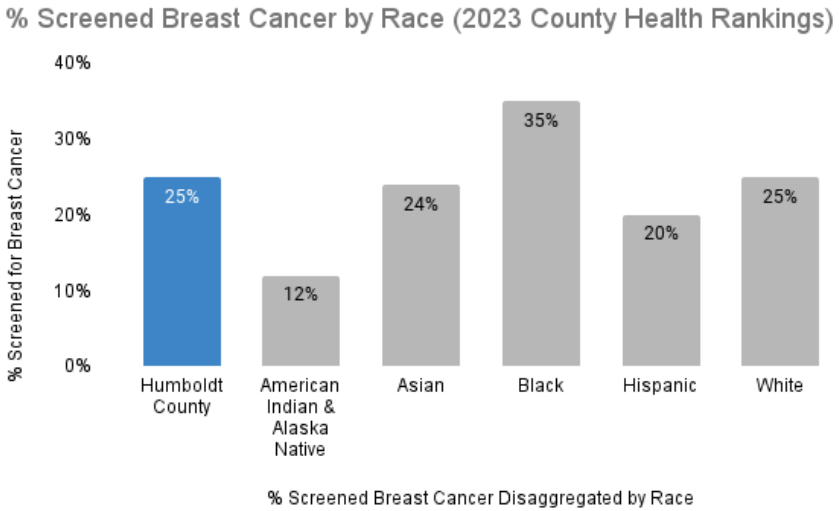
Health Equity Tracker: https://healthequitytracker.org/

Mapping Medicare Disparities: https://data.cms.gov/tools/mapping-medicare-disparities-by-population

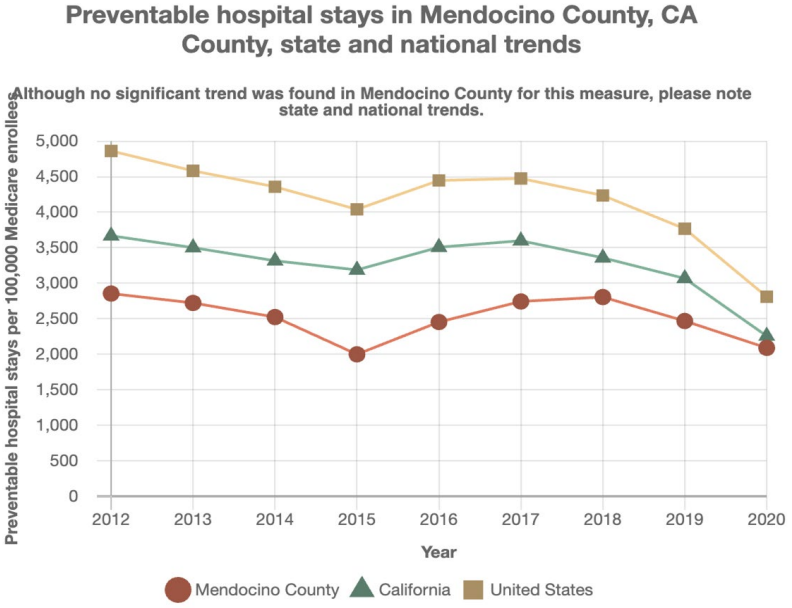
California Health Information Survey: https://ask.chis.ucla.edu/ask/SitePages/AskChisLogin.aspx

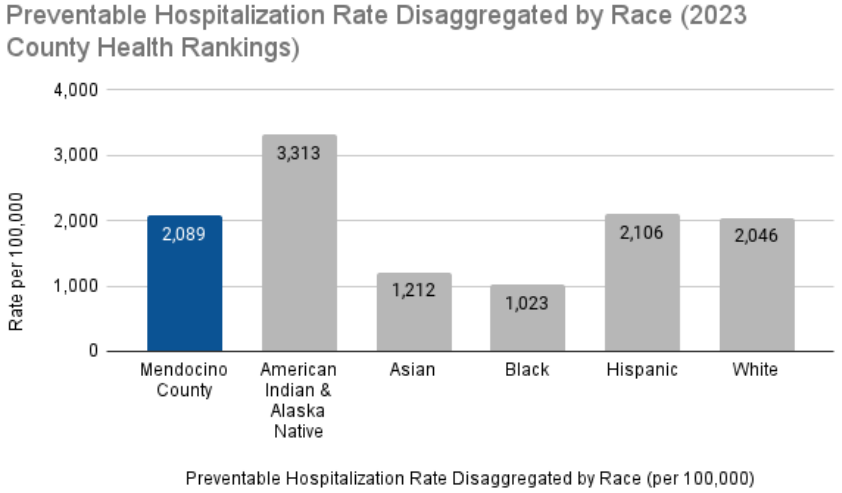
Identifying Health Disparities





Finding Differences in Improvement by Population





Where to Begin? Equity in PDSA Projects

Focus on a specific population with a health disparity

Monitor impact of improvement on patient populations

Source: https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/6.1%20Part%201%20_Equity%20into%20QI.pdf

As We Wrap Up - Questions for You?

Overall, how satisfied are you with this session in equity in QI?

- Very satisfied
- Satisfied
- Neither satisfied nor dissatisfied
- Dissatisfied
- Very dissatisfied

How confident are you that you will be able to apply information from this session on equity in QI at your organization?

- Extremely confident
- Very confident
- Somewhat confident
- Not so confident
- Not at all confident

The information presented increased my knowledge of the subject matter.

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

Questions & Answers

Thank you!

Webinar Evaluation Link: Insert Link here and in chat

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