Disparities Leadership Program: Implementing Strategies to Address Disparities

Sunday, December 8th, 2013
1:00-4:30 pm

Session Objectives

- Recognize the root causes for disparities in quality of care.
- Describe the approaches taken by healthcare organizations to identify and address racial and ethnic disparities.
- Discuss the challenges, successes, and next steps in addressing health care disparities.
The Disparities Leadership Program: Implementing Strategies to Address Disparities in Health Care

Joseph R. Betancourt, M.D., M.P.H.
Director, The Disparities Solutions Center
Senior Scientist, Mongan Institute for Health Policy
Assistant Professor of Medicine, Harvard Medical School

Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>1:00-1:15 pm</td>
<td>Introductions</td>
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<tr>
<td>1:15-2:15 pm</td>
<td>Welcome and brief summary on the field of disparities and the Disparities Leadership Program</td>
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<tr>
<td>2:15-2:30 pm</td>
<td>Break</td>
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<tr>
<td>2:30-2:45 pm</td>
<td>Overview of the Disparities Leadership Program</td>
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<tr>
<td>2:45-3:15 pm</td>
<td>Key Lessons Learned &amp; Discussion Alumni</td>
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<tr>
<td>3:15-3:45 pm</td>
<td>University of New Mexico Hospitals Kristina Sanchez</td>
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<tr>
<td>3:45-4:15 pm</td>
<td>Manchester Community Health Center Kris McCracken</td>
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<tr>
<td>4:15-4:30 pm</td>
<td>Wrap up and Closing Dr. Joseph Betancourt</td>
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Improving Quality and Achieving Equity in a Time of Healthcare Transformation
The Pursuit of High-Value Health Care

Joseph R. Betancourt, M.D., M.P.H.
Director, The Disparities Solutions Center
Senior Scientist, Mongan Institute for Health Policy
Director for Multicultural Education, Massachusetts General Hospital
Associate Professor of Medicine, Harvard Medical School

Outline

◆ High-Value, Transformation and Equity

◆ Key Drivers

◆ Lessons from the Field
High-Value, Transformation and Equity

High-Value in A Time of Healthcare Transformation
Value-based purchasing and health care reform will alter the way health care is delivered and financed

◆ Increasing access: Assuring appropriate utilization
  – Decreasing ED use, linkage to primary care

◆ Paying for quality: ACO’s and PCMH’s
  – Importance of Wellness, Population Management, Preventing ACS

◆ Controlling cost: Transitions, safety and patient experience
  – Importance of hot spotting, preventing readmissions, avoiding medical errors, and improving patient satisfaction
Increased Diversity

Health care organizations need to prepare staff to work with patients and colleagues from diverse cultural backgrounds.

Current and Projected Resident Population of the United States, 1998-2030

Diabetes-Related Death Rate, 2012

Deaths per 100,000 population

<table>
<thead>
<tr>
<th>Group</th>
<th>1998 Death Rate</th>
<th>2000 Death Rate</th>
<th>2012 Death Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>22.8</td>
<td>25.1</td>
<td>50.1</td>
</tr>
<tr>
<td>Black</td>
<td>33.6</td>
<td>37.7</td>
<td>50.3</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>11.7</td>
<td>14.9</td>
<td>18.4</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>7.6</td>
<td>10.5</td>
<td></td>
</tr>
<tr>
<td>Asian/PI</td>
<td>12.8</td>
<td>15.7</td>
<td></td>
</tr>
</tbody>
</table>
What causes these Racial/Ethnic Disparities in Health?

- Social Determinants
- Access to Care
- Health Care?

Disparities in Health Care 2002

Racial/Ethnic disparities found across a wide range of health care settings, disease areas, and clinical services, even when various confounders (SES, insurance) controlled for. Many sources contribute to disparities—no one suspect, no one solution
- Provider-Patient Communication
- Stereotyping
- Mistrust
What we have learned…

◆ Disparities in Quality
  1. Less communication sensitive, less prevalent
     ♦ Beta blocker post MI, ACE with CHF
  2. More communication sensitive, more prevalent
     ♦ Flushot, Pneumovax, Tobacco Cessation
  3. Inpatient less prevalent than outpatient, especially when susceptible to social determinants (more navigation of complex systems, more challenges)
     ♦ Asthma, Diabetes, Colon Cancer Screening
  4. Organizations that are under-resourced, and minority serving, may have overall lower quality
     ♦ Related to infrastructure

Key Drivers
### The Newly Insured Population

Approximately 50% Minority

**What will the newly insured look like?**

The newly insured compared to the currently insured are...

<table>
<thead>
<tr>
<th>Race</th>
<th>Health status</th>
<th>Marital status</th>
<th>Language</th>
<th>Educational attainment</th>
<th>Employment status</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>... less likely to be white</td>
<td>75%</td>
<td>92%</td>
<td>69%</td>
<td>42%</td>
</tr>
<tr>
<td>Excellent/Very good/Good</td>
<td>... less likely to rank self excellent/very good/good</td>
<td>79%</td>
<td>52%</td>
<td>88%</td>
<td>59%</td>
</tr>
<tr>
<td>Single</td>
<td>... more likely to be single</td>
<td>29%</td>
<td>37%</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>English</td>
<td>... less likely to speak English</td>
<td>88%</td>
<td>29%</td>
<td>69%</td>
<td></td>
</tr>
<tr>
<td>College degree or higher</td>
<td>... less likely to have a college degree</td>
<td>14%</td>
<td>37%</td>
<td>42%</td>
<td></td>
</tr>
<tr>
<td>Employed full-time</td>
<td>... less likely to have full-time employment</td>
<td>42%</td>
<td>59%</td>
<td>59%</td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**
- Minority have more medical errors with greater clinical consequences
- Effective – Minorities received less evidence-based care (diabetes)
- Patient-centered – Minorities less likely to provide truly informed consent; some have lower satisfaction
- Timely – Minorities more likely to wait for same procedure (transplant)
- Efficient – Minorities experience more test ordering in ED due to poor communication
- Equitable – No variation in outcomes
- Also – Minorities have more CHF readmissions, ACS admissions, and longer LOS

*Source: PwC HR analysis for year 2013, Current Population Survey, Medical Expenditure Panel Survey and OEO

[12/2/2013]
Accreditation, Quality Measures, and HC Reform

- Joint Commission: Disparities/Cultural competence Standards
- National Quality Forum: Disparities and Cultural Competence Quality Measures, developing disparities measures, incorporating into MAP
- AHA Call to Action: REaL Data, Governance, Cultural Competency Training
- Health Care Reform has multiple provisions addressing disparities

Cost of Disparities

- Between 2003 and 2006, the combined direct and indirect cost of health disparities in the United States was $1.24 trillion (in 2008 inflation-adjusted dollars).
IOM's Unequal Treatment
www.nap.edu
Recommendations

- Increase awareness of existence of disparities
- Address systems of care
  - Support race/ethnicity data collection, quality improvement, evidence-based guidelines, multidisciplinary teams, community outreach
  - Improve workforce diversity
  - Facilitate interpretation services
- Provider education
  - Health Disparities, Cultural Competence, Clinical Decisionmaking
- Patient education (navigation, activation)
- Research
  - Promising strategies, Barriers to eliminating disparities

Break
2:15-2:30 pm
Our Vision:  
The Disparities Leadership Program  

• To arm health care leaders with rich understanding of the causes of disparities and the vision to implement solutions and transform their organization to one delivering high-value care.

• To help leaders create or shape strategic plans already in progress to advance their work in reducing disparities in a customized way

• To align the goals of health equity with health care reform and other strategic imperatives designed to improve value.

Disparities Leadership Program Objectives  
At the conclusion, participants will be able to:

• Articulate the ways in which equity is linked to healthcare transformation, health care reform, value-based purchasing, accreditation and quality measurement.

• Identify ways to secure buy-in from leadership

• Identify techniques and technology for race and ethnicity data collection and disparities/equity performance measurement.

• Describe interventions to reduce disparities (readmission, avoidable hospitalizations, improving patient safety & experience, population management)

• Identify ways to message the issue of equity both internally and externally

• Describe a concrete step that their organization will take towards improving quality, addressing disparities and achieving equity.
Curriculum

- Two day kick off meeting in Boston in May
- Three web-based collaborative group calls
- Three team technical assistant calls
- Two web seminars on topics relevant to the DLP
- Two day meeting in CA in February

Disparities Leadership Program Alumni

- Disparities Leadership Program has trained:
  - 211 participants
  - 98 organizations
    - 47 hospitals
    - 21 health plans
    - 20 community health centers
    - 1 hospital trade organization
    - 1 federal government agency
    - 1 city government agency
    - 7 professional organizations
DLP participants hail from 29 states, the Commonwealth of Puerto Rico, and Switzerland.

Knowledge of Key Content Areas – Most Change

- How to create a shared vision
- How to develop a sense of urgency
- How to design and develop interventions to address disparities
- How to develop and implement a communication strategy to address disparities
- How to develop tools to identify racial/ethnic disparities in health care (disparities dashboards, registries, reports)

Before the DLP
- Extensive
- Moderate
- Minimal
- None

After the DLP
- Extensive
- Moderate
- Minimal
- None

Note: The chart represents the items with the greatest difference in average.
Note: This question is based on a 1-4 scale (None, Minimal, Moderate, Extensive).
Share of Participants Citing “Extensive” Knowledge

How to create a shared vision
Root causes for racial/ethnic disparities in healthcare
How to communicate your vision repeatedly
Identifying and evaluating related resources, including journal and web based
How to secure leadership buy-in to address disparities
How to collect race/ethnicity data
How to establish a sense of urgency
How to design and develop interventions to address disparities
Considering and examining major national health issues from the...
How to empower others to act on the vision
How to plan for and create short term wins
How to developing and integrating a strategic plan to address disparities

Note: This question is based on a 1-4 scale (None, Minimal, Moderate, Extensive).

Share of respondents reporting ‘extensive’ knowledge BEFORE participating in the DLP
Additional share of respondents reporting ‘extensive knowledge’ AFTER participating in the DLP

Share of Participants Citing “Extensive” Knowledge

How to develop tools to identify racial/ethnic disparities in healthcare
(disparities dashboards, registries, reports)
How to develop and implement a communication strategy to address disparities
Assessing and understanding the health status of populations and factors influencing the use of health services
How to reinforce the change
How to form a powerful guiding coalition
Utilizing methods of assessment, quality assurance, and improvement
How to institutionalize new approaches
Research on racial/ethnic disparities in healthcare
Negotiating and managing conflict
How to make health systems responsive to the needs of diverse populations

Note: This question is based on a 1-4 scale (None, Minimal, Moderate, Extensive).
DLP Effects on Leadership and Career Development

Note: This question is based on a 1-5 scale (from "not at all", or 1, to "a great deal", or 5).

Preparedness to Lead Before and After the DLP

Note: This question is based on a 1-4 scale (not prepared, or 1, somewhat prepared, or 2, moderately prepared, or 3, very prepared, or 4).
In health care reform, the ‘meaningful use requirement’ includes collecting patient demographic data, for example on language and race. We met the requirement this summer because of the project I started at DLP. If we didn’t meet it, we would have lost millions of ‘meaningful use’ dollars.”

–Public and Private Hospital Executive

Post DLP Collaborations

• Transforming Healthcare: Intersection with Health Equity (Minneapolis)
• DLP Pediatric Working Group (Nashville)
• DLP Alumni meeting (Santa Monica)
• The Healthcare Quality and Equity Action Forum (Boston)
For More Information Contact:

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Deputy Director
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www.mghdisparitiessolutions.org

Lessons from the Field
Quality and Disparities

- R/E Data Collection, Registries, Dashboards, QI, Carrots/Sticks

1. Gather the Data
REaL Data Collection

- Collect REaL and Education data of all patients
  - Piloted different versions
    - Gets key info
    - Doesn’t confuse patients
    - Can be done in a timely fashion
  - Registrar Training
    - Preamble
    - FAQ’s
  - PR Poster Campaign
  - QA and Registrar Feedback
    - “Secret Santa”
    - Presentation on impact
- Net-Net: It can be done, is being done, no need to reinvent the wheel
2. Make the Data Useful

MGH Disparities Dashboard Executive Summary

- **Green Light:** Areas where care is equitable
  - National Hospital Quality Measures
  - HEDIS Outpatient Measures (Main Campus)
  - Pain Mgmt in the ED

- **Yellow Light:** National disparities, areas to be explored
  - Mental Health, Renal Transplantation
  - All cause and ACS Admissions (so far no disparities)
  - CHF Readmissions (so far no disparities)
  - Patient Experience (H-CAHPS shows subgroup variation)

- **Red Light:** Disparities found, action being taken
  - Diabetes at community health centers
    - Chelsea (Latino), Revere (Cambodian) Diabetes Project
  - Colonoscopy screening rates
    - Chelsea CRC Navigator Program (Latinos)
3. Educate Providers and Staff
   Link to Transitions, Safety, Patient Experience

- Quality Interactions Cross-Cultural Training offered as option as part of MGPO QI Incentive; case-based, evidence-based, interactive e-learning program which allows learners to develop a skill set to provide quality to patients of diverse cultural backgrounds; has been used to train 125,000 health care professionals nationwide
- 987 doctors completed at mgh; more than 88% said program increased awareness of issues, would improve care they provide to patients, and would recommend to colleagues; average pretest score 51%, posttest score 83%
- Trained 1500 frontline staff with Healthcare Professional Version

![Quality Interactions](http://www.qualityinteractions.org/)

4. Engage, Empower and Activate Patients

Patient Activation Poster Campaign

In 2011, MGH launched a poster campaign modeled after the national Speak Up campaign developed by the Joint Commission and Centers for Medicare and Medicaid Services in 2002.

The Speak Up campaign urges patients to take a role in improving quality and preventing medical errors by becoming active, involved, and informed participants of the health care team.

![Patient Cases](http://www.qualityinteractions.org/)

![HABLE!](http://www.massachusettsgeneral.org/)

[Available at: http://www.qualityinteractions.org/](http://www.qualityinteractions.org/)

[1](http://www.qualityinteractions.org/)

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5. Develop Culturally Competent Interventions
Diabetes Disease Management Program

A quality improvement / disparities reduction program with 3 primary components:

- **Telephone outreach** to increase rate of HbA1c testing
- **Individual coaching** to address patients’ needs and concerns regarding diabetes self-management to improve HbA1c
- **Group education** meeting ADA requirements

*Also focus on link between mental health, chronic disease management, and prevention*

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**Diabetes Control Improving for All:**
Gap between Whites and Latinos Closing

<table>
<thead>
<tr>
<th>Year</th>
<th>% of Patients with Poorly Controlled Diabetes (HbA1c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>37%</td>
</tr>
<tr>
<td>2008</td>
<td>34%</td>
</tr>
<tr>
<td>2009</td>
<td>29%</td>
</tr>
</tbody>
</table>

* Chelsea Diabetes Management Program began in first quarter of 2007; in 2008 received Diabetes Coalition of MA Programs of Excellence Award*
6. Navigate to Access and Wellness

◆ Focus on Primary Care Linkage in ED & Community

◆ CRC Navigator Program
  – Initiated 2005
  – Use of registry to identify individuals, by race/ethnicity, who haven’t been screened for colon cancer
  – Navigator contacts patient (phone or live)
  – Determine key issues, assist in process
    ◆ Education
    ◆ Exploration of cultural perspectives
    ◆ Logistical issues (transportation, chaperone)
  – GI Suite facilitates time/spaces issues

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**CRC Screening Over Time**

![Graph showing CRC screening completion over time for Chelsea Patients by race/ethnicity](chart.png)

- **Chelsea Patients**
- **Graph**
- **CRC Screening Completion (%)**: 25%, 35%, 45%, 55%, 65%, 75%
Preparing for the Future

- Addressing variations in quality—such as racial/ethnic disparities in health care—will be essential going forward if we are achieve equity and high-value.

- This is not just about equity for equity’s sake—ethics and cost are key—as equity connects to all areas of quality:
  - Population Management
  - Transitions of Care and Readmissions
  - Appropriate Utilization and Avoidable Hospitalizations
  - Patient Safety
  - Patient Experience

- Hospitals ignore this at their own peril…action will separate winners from losers…

Thank You

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www.mghdisparitiessolutions.org

www.qualityinteractions.org
CREATING A METHODOLOGY FOR IDENTIFYING UNDERLYING CAUSES OF DISPARITIES AT UNM HOSPITALS

Kristina Sanchez, MBA
Executive Director of Ambulatory Business Operations

Misty Salaz, MPA
Manager of Diversity, Equity and Inclusion (DEI)

UNM Hospitals (UNMH)

- Located in Albuquerque, NM
- 629 beds
- Only public and only teaching hospital in New Mexico
- Only Level 1 Trauma Center and 24/7 Pediatric ER in NM
- Multi-facility
- 500,000 Outpatient Visits Annually
- 83,000 ED Visits Annually
- Part of UNM Health System
About our Patients

- Majority-Minority State
- Population Spread Out - Geographic Isolation
- Poverty and Access
- Our Role as a Safety Net Public Hospital

**Inpatient Discharges 2013**

**UNMH Payer Mix**

UNMH Office of Diversity, Equity and Inclusion (DEI)

Mission:

- The UNMH Office of Diversity, Equity and Inclusion leads the effort to make sure that every UNMH patient receives the safest, most effective, most sensitive medical care possible, regardless of the patient’s race, ethnicity, or any other group identity.
- This is done through data collection and analysis, community collaboration, intercultural competence training, education and process improvement.
- 3 DLP Alumni in Advisory Roles – connected through UNM Health Sciences Center Office of Diversity and UNM Sandoval Regional MC
Health Literacy at UNMH

- Taskforce formed in 2008
- Health Literacy Specialist hired in 2012
- Health literacy and clear communication can improve:
  - Patient Safety
  - Patient Satisfaction
  - Quality of Care
  - Health Outcomes
  - Cost Savings
  - Accreditation Compliance
  - Evidence-Based Best Practice

DLP Project Description

- FY14: Develop a framework for addressing disparities
- FY15: Explore & apply successful intervention strategies for our Native American patient population
DEI Scorecard

DLP Project
Work Plan Goals

• What do we hope to achieve in FY2014?
  • Explore our Native American diabetes population and underlying drivers of the disparity we see in our data
  • Survey Native American patients on attitudes about diabetes and begin to identify trends
  • Identify Best Practices for the Native American population relating to diabetes

• For FY2015
  • Identify an MPH student or resident to help in research
  • Develop interventions targeted at improving trends
  • Implement, and Study effects of interventions
Where are we now?

• Conducted a survey

• Diving deeper into data for this population
  – Seeking IRB approval

• Compare/Contrast within these populations
  – good control vs. out of control (look for characteristics and trends unique to each group)

Next Steps for This Year

• Analyze results of the data dive

• Sort Into two groups

• Identify characteristics unique to each group

• Identify Best Practices for the Native American population through tribal community resources

• Identify potential focus groups
Next Steps for FY15

- Continue Work Plan
- Partner for Best Practices
- Pull in Student Researcher
- Focus Group Feedback
- Develop cultural competence curriculum
- Begin training, other interventions

Unintended Benefits of Project

Benefits
- Survey yielded feedback from broader Native American population
- Project Expansion
- Learning the IRB process
- Scorecard re-formatting with DLP expertise
- Mentor Guidance
Foreseeable Challenges and Solutions

Challenges
- Timelines
- Finding time to meet with provider leaders
- Our own lack of expertise
- Lack of published information

Possible Solutions
- Anticipate changes
- Incorporate disparity work into organization initiatives
- Identify experts
- Identify additional resources
- Conduct research at planned community outreach events

Key Lessons
- Anticipate timeline changes
- Identify expert mentors
- Start the IRB process EARLY!
- Identify additional resources
- Data should be your driver
Critical Success Factors

1. Connections are Crucial
2. Clinician Sponsor is Essential
3. Flexibility, Openness

Questions?
Manchester Community Health Center
“CHW Pilot Project”
Dr. Gavin Muir, CMO
Kris McCracken, President/CEO

Demographics ...
- FQHC in NH’s largest city, 20 years of operation, 2 sites
- PRIMARY SERVICE AREA: Manchester + 9 surrounding towns
- TOTAL # ACTIVE PATIENTS: 11,000
- PERCENTAGE of PATIENTS w/FOREIGN LANG PRIMARY: 45%
- LANGUAGES SPOKEN IN SERVICE AREA: 70+
- LANGUAGES SPOKEN at MCHC: 60+
- PERCENTAGE of DIVERSE STAFF/BILINGUAL: 50%
- PRIMARY LANGUAGES OF PATIENT POPULATION: Spanish, Nepali, Arabic, Bosnian, Russian, Mandarin/Cantonese, Vietnamese, Portuguese, French, Albanian, many African Languages (Specifically from Sudan, Liberia, Somalia, Kenya, Rwanda and Nigeria)
- NUMBER of EMPLOYEES: 83 FTE’s

About MCHC
Endowment Project Description

MCHC is the recipient of a three year grant from the Endowment for Health. The goal of this grant is to create a Center of Excellence for Culturally Effective Care and our DLP-associated work encompasses the first phase of this project: implementation of a CHW (Community Health Worker) Intervention within our Patient Centered Medical Home model. This grant has the following aims:

- Center of Excellence for Culturally Effective Care
  - CHW Intervention Model & Cost Effectiveness Study
  - Immersion Training of Students in a Culturally Effective Organization
  - Cultural Effectiveness Training for All Staff, Students and Volunteers
  - Recruitment & Retention of a Diverse Workforce
  - Collection of REaL Data & Analysis of Quality data for Health Disparities
  - Integrated Policies & Procedures that Embed Health Equity Practices Across the Facility

**Patient Centered Medical Home:**

- **4 chronic disease states.**
  - Diabetes
  - Hypertension
  - Pediatric obesity
  - HIGH RISK: Any of the three listed above and coexistence of mental health diagnoses.

**Populations of Focus:**

- Spanish and Arabic speaking patients from PCMH groups who are not reaching clinical outcome goals

**Control Groups:**

- All other patients

**Intervention:**

- Assigned CHW from their communities.
Social Determinants of Health

Restricting Factors within SDOH

1. The Social Gradient - "Life expectancy is shorter and most diseases are more common further down the social ladder in each society."

2. Stress - "Stressful circumstances, making people feel worried, anxious and unable to cope, are damaging to health and may lead to premature death."

3. Early life - "A good start in life means supporting mothers and young children: the health impact of early development and education lasts a lifetime."

4. Social exclusion - "Life is short where its quality is poor. By causing hardship and resentment, poverty, social exclusion and discrimination cost lives."

5. Work - "Stress in the workplace increases the risk of disease. People who have more control over their work have better health."


7. Social Support - "Friendship, good social relations and strong supportive networks improve health at home, at work and in the community."

8. Addition - "Drug use is both a response to social breakdown and an important factor in worsening the resulting inequalities in health."

9. Food - "A good diet and adequate food supply are central for promoting health and well-being. A shortage of food and lack of variety cause malnutrition and deficiency diseases."

10. Transport - "Healthy transport means less driving and more walking and cycling, backed up by better public transport. Cycling, walking and the use of public transport promote health in four ways. They provide exercise, reduce fatal accidents, increase social contact and reduce air pollution."

www.who.int/healthpromotion/foundations/determinants/en
**Work Plan Goals & Timeline**

What do we hope to achieve:

- **Work Plan Goal 1**: Enhance the reporting capability of the existing shared EMR to strate data by race, ethnicity and language.
- **Work Plan Goal 2**: Analyze the new REaL data sets for disparities.
- **Work Plan Goal 3**: Develop programming and systems including a Community Health Worker pilot project to address the identified disparities.

**Timeline:**
August 2013: Training DLP, Create job descriptions, Finalize funding, Begin recruiting
September 2013: Design and begin testing of new REaL data sets
November 2013: Site visits, Positions recruited, Initial staff training completed
December 2013: Begin analysis of REaL data sets as well as PCMH/Availity and other MCO data reports available
February 2014: Completing implementation of evidence-based practices to improve identified disparities
May 2014: Wrap up and presentation of interval REaL data

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**Progress**

Progress to Date:

- Largest grant fund requested received, one small match received, one more needed
- Working with IT on REaL data collection tools
- Have received several studies on successful CHW implementation
- Site visit completed for program in Worcester, MA that is much further ahead
- Job Descriptions complete, Health Equity Coordinator and CHW’s hired
- Identified a training program for CHW’s in NH and possible funding source, training begins in early December
Challenges:
- Accurate REaL data collection via existing EMR and PM system
- Funding to support CHW’s – partially completed
- Identifying best practice tools for CHW’s to utilize in screening/assessment of patients
- Delineating clear pre- and post-intervention outcomes and methods to gather those metrics in:
  - Patient Engagement
  - Provider & Staff Engagement
  - Clinical Outcomes
  - Cost/Utilization Analyses

Next Steps:
- Choose Patient Engagement Measurement Tool
- Develop/Choose Assessment Tools for CHW’s
- Map Pathways for integration of CHW’s into PCMH Team
- Train Staff
- Identify Patient Panels
- Pre-Intervention Data Analysis
- Begin Intervention
- Measure progress, UR data, Quality Outcomes
- Post-Intervention Analysis
- Summary
We started with too many of the components at once and used the DLP process to narrow down to a one-year plan. The resources in the program are very valuable and the expertise and knowledge in the network are key. You don’t have to start from scratch—much work has already been done. Figure out what you hope to have as the deliverable and WORK BACKWARDS. Make sure you can tell the story afterward— if you can’t define it, you can’t replicate it. How will you utilize PDSA’s to rapidly cycle through and tweak your model? Who are your topic matter experts that can you use to ask the difficult questions BEFORE you start so you can anticipate potential pitfalls?

**Evolution & Lessons Learned (So far!)**

- **Take Away Messages…**
  - PARTNER, PARTNER, PARTNER— Reach out to topic matter experts and learn from the work they’ve done
  - WHERE ARE YOU GOING???? Develop your GOAL and work backwards
  - HOW DID YOU GET THERE? Document your process/progress so you can share with others
  - WHERE IS YOUR PROOF? Start with the data you will need to show when you are done
For More Information the Disparities Leadership Program

www.mghdisparitiessolutions.org

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