Training /CoP Call
Disparities National Coordinating Center

Part 1: Training on Leadership
Allen Herman, DNCC
Becky Roberson, IHQ

Part 2: CoP Call
Maria Triantis, DNCC
Thaer Baroud, DNCC

February 12, 2013
2:00 PM ET
Call Norms:

- All lines will be muted during the call.
- We will begin Q & A after the training portion of today’s call.
- Please submit questions via the WebEx chat box or press 14 and the monitor will call on you.
- We are recording this call, and will post slides, recording, and transcript on [www.healthcarecommunities.org](http://www.healthcarecommunities.org).
- Evaluation: Please fill out our evaluation at the end of today’s call. Questions will also be sent via listserve.
Agenda

Part 1: Training
• Module 1: Broadening and Strengthening Leadership to Address Health Disparities at All Levels

Part 2: CoP Call
• The DNCC’s Centralized Information Management Environment
• Data Dissemination Plan
Part I: Broadening and Strengthening Leadership to Address Health Disparities at All Levels

Allen Herman, MD, ChB, PhD
Disparities Subject Matter Expert
Disparities National Coordinating Center

Becky Roberson,
Senior Vice President
Information and Quality Healthcare, Mississippi
Module 1: Awareness
   Goal: Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations

Module 2: Leadership
   Goal: Strengthen and broaden leadership for addressing health disparities at all levels

Module 3: Data, Research, and Evaluation
   Goal: Improve data availability, coordination, utilization, and diffusion of research and evaluation outcomes

Module 4: Health System and Life Experience
   Goal: Improve health and healthcare outcomes for racial, ethnic, and underserved populations

Module 5: Cultural and Linguistic Competency
   Goal: Improve cultural and linguistic competency and the diversity of the health related workforce
Module 2 “Leadership” will cover how to:

1. **Identify community, organizational, and beneficiary leadership** to build capacity at all levels to promote solutions for health equity.

2. **Solicit community input** on the acquisition and distribution of resources necessary to reduce disparities.

3. **Invest in the beneficiary population** to prepare them to be leaders in health disparity reduction initiatives.
Module 2: Leadership
Broaden and strengthen leadership for addressing health disparities at all levels
QIOs can serve as **catalysts** for change. We can:

- Spread awareness of the impact of health disparities
- Motivate others to take an active role in overturning the status quo
- Build healthy and active partnerships between providers, patients, and communities
- Empower communities to develop their own solutions
- Create opportunities for patients and beneficiaries to become active agents of change
Sub-Competency 1

Be able to identify community, organizational, and beneficiary leadership to build capacity at all levels to promote solutions for health equity.
Components of Collaborative Leadership

- Coalition Building
- Collaboration
- Community Development
- Leadership Empowerment
Steps for Collaborative Leadership

1. Identify established institutional leaders at all levels of the healthcare system:
   a. Individuals who are respected and who have knowledge of the healthcare system
   b. Individuals who can expand or restrict access to potential partners in the healthcare system
2. Convert established institutional leaders into pathfinders or champions for change:
   a. Share the vision and goals of the health equity initiative
   b. Integrate their ideas and proposals into your initiative
   c. Identify ongoing projects within their organizations and find common ground with the projects
   d. Identify a specific roles for them within the health disparity initiative
An Example of Efficacy

Mississippi Health First
A Collaborative Effort Targeted at Improving Health Outcomes Among Persons with Diabetes
Mississippi Health First

• A collaborative effort to improve health outcomes among persons with diabetes in the state of Mississippi

• Used group-based diabetes self-management education (DSME) as the intervention

• Collaborated with federal, state, and private sector partners

• Worked with Medicare, Medicaid, and Dual Eligible beneficiaries from private primary care providers, federally qualified health centers (FQHCs), and the Indian Health Service

• Focused on African Americans, rural whites, and the Mississippi Band of Choctaw Indians with type 2 diabetes mellitus
Building Capacity: Mississippi Health First

- American Association of Diabetes Educators (AADE)
- American Diabetes Association (ADA)
- Administration on Aging (AoA)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare and Medicaid Services (CMS)
- Health Resources and Services Administration (HRSA)
- Housing and Urban Development (HUD)
- National Academy for State Health Policy (NASHP)
- National Institutes of Health (NIH)
- Office of Minority Health, DHHS (OMH)
Becky Roberson
Senior Vice President
Information and Health Quality
Mississippi QIO
How did you go about identifying leaders and building partnerships with organizations and community members?
Polling Question

What types of organizations have you collaborated with in your past or current work?

• Hospital leadership
• Providers
• FQHCs
• Faith-based organizations
• Health departments
• Community centers
• Senior centers
Sub-Competency 2

Be able to improve coordination, collaboration, and opportunities for soliciting community input on the acquisition and distribution of resources necessary to reduce disparities
1. Once leaders have been identified, build multiple ties and channels of communications with the collaborative leadership group

2. Develop a common understanding of the vision and goals of the initiative

3. Jointly define key metrics throughout the process of the intervention, in order to build confidence
<table>
<thead>
<tr>
<th>Activity</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants Trained</td>
<td>1,379</td>
</tr>
<tr>
<td>Physician Practices Sites Recruited</td>
<td>120</td>
</tr>
<tr>
<td>Primary Care Practitioners in Practices</td>
<td>173</td>
</tr>
<tr>
<td>Participant Support Persons</td>
<td>85</td>
</tr>
<tr>
<td>Level 3 Diabetes Educators**</td>
<td>65</td>
</tr>
<tr>
<td>Community Health Workers</td>
<td>40</td>
</tr>
</tbody>
</table>

** Based on the AADE® Definition
Process of Collaborative Leadership

- Prioritize and Focus Efforts
- Communicate
- Build Confidence
- Recruit Partners
- Implement
- Monitor and Sanction
- Build and Sustain Trust
- Reevaluate
How did the goals of the project evolve as you took into account input from the community about how to structure the project and allocate resources?
Sub-Competency 3

Invest in the beneficiary population to prepare them to be leaders in health disparity reduction initiatives
Beneficiaries as Leaders

• Beneficiaries can serve as community resources and referral agents
• Beneficiaries can be health counselors
• Beneficiaries can serve as health advocates and navigators
• Beneficiaries can serve as health educators and facilitators
Did patients or beneficiaries take on leadership roles? How was this accomplished and what were the results?
Examples of Beneficiaries as Leaders

Beneficiaries:

• Volunteered for a health disparity reduction initiative in senior centers
• Managed stakeholder meetings in two rural communities
• Co-hosted healthy cooking shows and hands-on nutritional experiences
• Became critical resources in understanding the urban/rural, white/black communities
• Identified faith communities and other resources
Polling Question

My organization involves beneficiaries as:

• Advisors
• Board members
• Focus group participants
• Community health workers
• Other (please specify in the chat box)
• Beneficiaries do not currently take an active leadership role in our work.
Q & A

Press 14 to enter the queue to ask a question.
Action Items

Post-Training Review/Office Hours

• February 20th, 2:00 ET

• This is an opportunity for further discussion of disparities issues with fellow QIOs

• Prior to the call, please think about:
  – Past, current, and future disparities efforts in your state
  – Ways to involve beneficiaries and community members as leaders
  – Challenges and lessons learned
Part II: The DNCC’s Centralized Information Management Environment

Maria Triantis, RN, MBA
Project Director, Disparities National Coordinating Center

Thaer Baroud, BSN, MHSA, MA
Senior Analyst/Scientist, Disparities National Coordinating Center
Topics to Discuss Today

• DNCC update and plan for going forward
• Health disparity assessment/environmental scan
• Data management and analysis plan
DNCC is here to support you!

• Supports all QIOs’ 10th SOW efforts to reduce health and health care disparities
• Provides targeted support for two SIPs:
  • Everyone with Diabetes Counts (EDC): NY, WV, TX
  • Disparities and Cardiac Health (DACH): AK, CA, MI
• Support we offer:
  • Training and education
  • Learning and sharing opportunities
  • Technical assistance and disparities subject matter expertise
  • Knowledge transfer and resources
  • Analytics, measurement, and reporting
Centralized Information Management Environment

- Ensure ready access to information that will help QIOs, CMS, providers/partners in health disparities reduction

Four-pronged approach:

- Knowledge transfer/communication tools and strategies
- Data management and analysis*
- Assessment and environmental scan*
- 11SOW exploratory measures

*Focus of today and the coming months!
First Quarter Focus: Knowledge Exchange & Making Connections

Knowledge Transfer/Communication Tools & Strategies

- www.healthcarecommunities.org
- Monthly training/CoP sessions: 2nd Tuesday of every month
- Post-Training Review/Office Hours: 3rd Wednesday of every month
- E-mail communication tools: e-News; The WORD
- One-on-one assistance is just a phone call away!
- Toolkits, resource library, publications and reports
- Coming soon: April is Minority Health Month!

EDC and DACH Connections

- Monthly work groups
- Toolkit development (EDC)
- Data management plan (EDC)
DNCC Communication & Tools
Second Quarter: Data!

- DNCC is charged with conducting an assessment and environmental scan on disparities work in the 10SOW
- Health disparities are noted in the 10SOW: C.9, C.10
- Purpose:
  - Catalog QIO HD work, interventions, data sources, and community work
  - Capture and summarize best practices/lessons learned
  - Identify opportunities for a Disparities LAN or other support
  - Help inform future work
- Due: March 8, 2013
Section I: General health disparity activities/efforts

- Awareness of health disparity work in your community
- Understand your state’s profile
- Data sources utilized
- Challenges or needed resources to address health disparities
- Recommendations to CMS on 11th SOW

Section II: What 10SOW AIMS are you addressing?

- Name disparities identified within the AIM
- Intervention, strategy, rationale
- Partnerships and collaborations
- Best practices, lessons learned, barriers/challenges
Disparities Data Development & Dissemination Plan

Alignment of Disparity Measures with QIO Program’s 10th SOW
Data Plan Going Forward

• Reducing health and health care disparities is a key element in the Triple Aim and is interwoven throughout the 10SOW

• QIOs have been working on reducing and eliminating disparities since the 4th SOW and continue to do today

• The DNCC will facilitate those efforts by providing data that identifies disparities and help QIOs find effective interventions, look for affinity groups, and connect people doing similar work
Purpose

• The DNCC’s SOW states that we will “analyze data & create reports related to progress, achievements, results, and recommended practices associated with the reduction of racial and ethnic health care disparities in the 10SOW”

• As noted for QIOs in the 10SOW as specified in C.10.2.B.5.d

• There are limitations of current data sources to produce measure reports on disparities.

• Some QIOs use alternative data sources but no standard methods are available.

• DNCC is working on solutions from available data sources to support the QIO community.
Current & Upcoming Focus

Improving Individual Patient Care (IIPC) Aim

• **Adverse Drug Events (ADEs)**
  • Claims-based analysis
    • Expected release date: March 2013

• **Healthcare-Associated Infections (HAIs)**
  • Central Line-Associated Blood Stream Infection (CLABSI)
  • Catheter-Associated Urinary Tract Infection (CAUTI)
  • C. Difficile Infection (CDI)
    • Expected release date: May 2013
Improving Individual Patient Care (IIPC) Aim

Healthcare-Associated Conditions (HACs)
  • Pressure Ulcers
  • Physical Restraints
    o Acquisition of National MDS 3.0 data in progress

Improving Health for Populations & Communities (IHPC) Aim

National Behavioral Risk Factor Surveillance System (BRFSS)
  • Cardiovascular disease and stroke risk factor
  • Self-reported prevalence
    o Continue to identify external data sources
Sample ADE Reports

### Table 1: Adverse Drug Events by Category
**STATE 01/01/2010-12/31/2011**

<table>
<thead>
<tr>
<th>Type and Class of Adverse Drug Events (ADEs)†</th>
<th>Admissions with at Least 1 ADE</th>
<th>Total ADEs</th>
</tr>
</thead>
<tbody>
<tr>
<td>All ADEs</td>
<td>53,064</td>
<td>56,666</td>
</tr>
<tr>
<td>Adverse effects of other agents</td>
<td>7,988</td>
<td>8,195</td>
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<tr>
<td>Adverse effects of hormones and synthetic substitutes</td>
<td>8,107</td>
<td>8,442</td>
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<tr>
<td>Adverse effects of agents primarily affecting blood constituents</td>
<td>6,869</td>
<td>7,338</td>
</tr>
<tr>
<td>Adverse effects of chemotherapeutic agents</td>
<td>2,284</td>
<td>2,426</td>
</tr>
<tr>
<td>Adverse effects of antitubercular agents</td>
<td>1,680</td>
<td>1,747</td>
</tr>
<tr>
<td>Adverse effects of anti-infective agents</td>
<td>1,793</td>
<td>1,861</td>
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<tr>
<td>Adverse effects of anti-infective antimonials</td>
<td>1,632</td>
<td>1,704</td>
</tr>
</tbody>
</table>

### Table 2: Adverse Drug Events by Hospital
**STATE 01/01/2011-12/31/2011**

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Total Admissions</th>
<th>Total Adverse Drug Events (ADEs)†</th>
<th>ADEs per 1,000 Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>All STATE Facilities</td>
<td>634,570</td>
<td>56,331</td>
<td>88.8</td>
</tr>
<tr>
<td>HOSPITAL 1</td>
<td>41,596</td>
<td>3,708</td>
<td>89.1</td>
</tr>
<tr>
<td>HOSPITAL 2</td>
<td>16,259</td>
<td>2,653</td>
<td>163.2</td>
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<tr>
<td>HOSPITAL 3</td>
<td>20,075</td>
<td>2,430</td>
<td>121.0</td>
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<tr>
<td>HOSPITAL 4</td>
<td>20,538</td>
<td>2,340</td>
<td>113.9</td>
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<tr>
<td>HOSPITAL 5</td>
<td>21,357</td>
<td>2,171</td>
<td>101.7</td>
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### Table 3: Adverse Drug Events by Beneficiary Sex
**STATE 01/01/2011-12/31/2011**

<table>
<thead>
<tr>
<th>Sex</th>
<th>Total Admissions</th>
<th>Total Adverse Drug Events (ADEs)†</th>
<th>ADEs per 1,000 Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>634,570</td>
<td>56,331</td>
<td>88.8</td>
</tr>
<tr>
<td>Females</td>
<td>355,212</td>
<td>32,810</td>
<td>92.4</td>
</tr>
<tr>
<td>Total</td>
<td>279,358</td>
<td>23,522</td>
<td>84.2</td>
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</tbody>
</table>
### Table 3: Adverse Drug Events by Beneficiary Sex*

<table>
<thead>
<tr>
<th>Sex</th>
<th>Total Admissions</th>
<th>Total Adverse Drug Events (ADEs)†</th>
<th>ADEs per 1,000 Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Beneficiaries</td>
<td>634,570</td>
<td>56,331</td>
<td>88.8</td>
</tr>
<tr>
<td>Female</td>
<td>355,212</td>
<td>32,810</td>
<td>92.4</td>
</tr>
<tr>
<td>Male</td>
<td>279,358</td>
<td>23,522</td>
<td>84.2</td>
</tr>
</tbody>
</table>

### Table 4: Adverse Drug Events by Beneficiary Race/Ethnicity*

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Total Admissions</th>
<th>Total Adverse Drug Events (ADEs)†</th>
<th>ADEs per 1,000 Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Race/Ethnicities</td>
<td>634,570</td>
<td>56,331</td>
<td>88.8</td>
</tr>
<tr>
<td>White</td>
<td>554,765</td>
<td>49,970</td>
<td>90.5</td>
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<tr>
<td>Black</td>
<td>69,991</td>
<td>5,452</td>
<td>75.8</td>
</tr>
<tr>
<td>Unknown or Other Race/Ethnicity</td>
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<tr>
<td>American Indian/Alaska Native</td>
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<td></td>
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<tr>
<td>Asian or Pacific Islander</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Hispanic or Latino</td>
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</table>

### Table 5: Adverse Drug Events by Beneficiary Age Group*

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total Admissions</th>
<th>Total Adverse Drug Events (ADEs)†</th>
<th>ADEs per 1,000 Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Ages</td>
<td>634,570</td>
<td>56,331</td>
<td>88.8</td>
</tr>
<tr>
<td>(1) &lt;65 Yrs</td>
<td>150,858</td>
<td>13,065</td>
<td>86.8</td>
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<tr>
<td>(2) 65 - 69</td>
<td>92,432</td>
<td>6,629</td>
<td>93.4</td>
</tr>
<tr>
<td>(3) 70 - 74</td>
<td>93,889</td>
<td>8,876</td>
<td>94.5</td>
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<tr>
<td>(4) 75 - 79</td>
<td>81,735</td>
<td>8,521</td>
<td>92.0</td>
</tr>
<tr>
<td>(5) 80 - 84</td>
<td>89,735</td>
<td>7,956</td>
<td>88.7</td>
</tr>
<tr>
<td>(6) 85+</td>
<td>115,911</td>
<td>9,252</td>
<td>79.8</td>
</tr>
</tbody>
</table>
Press 14 to enter the queue to ask a question.
Next Steps

Evaluation

- Evaluation: Please fill out our evaluation at the end of today’s call. Questions will also be sent via listserv.

Post-Training Review/Office Hours

- February 20th, 2:00 ET

Slides, recording, and transcript will be posted online.

- [www.healthcarecommunities.org](http://www.healthcarecommunities.org)

Assessment and Environmental Scan

- Due: March 8th, 2013
Next Steps

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- Prior to the call, please think about:
  - Past, current, and future disparities efforts in your state
  - Ways to involve beneficiaries and community members as leaders
  - Challenges and lessons learned
- Questions on:
  - Assessment and environment scan
  - Data Plan
Join the DNCC Community

To Join the DNCC Listserv:

• Log onto the SDPS system.
• Open Internet Explorer. Your default homepage should be qionet.sdps.org.
• At the top of the page, you should see a tab labeled “Listserve.” Click “Listserve.”
• Enter your user information at the top of the page and scroll down to “Disparities”. Join “Discussion” and “Notify”.
• Click “Subscribe”.

To Join DNCC Healthcare Communities:

• Log onto www.healthcarecommunities.org
• Sign in, or create an account.
• Scroll over the “Communities” tab, scroll down to “Available Communities” and select “QIO 10TH SOW”.
• Scroll down to DNCC and select “Join DNCC”.

Quality Improvement Organizations
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DNCC
Disparities National Coordinating Center
Thank you for participating in today’s webinar.

At the close of the presentation, you will automatically be directed to an evaluation screen.