UNMC[SM]

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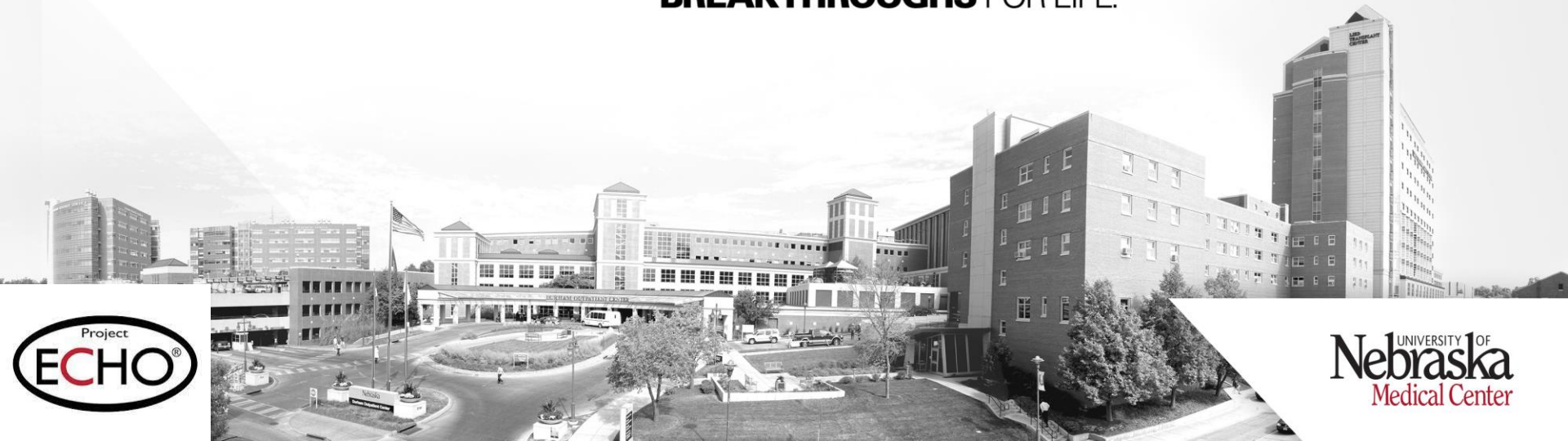

Project ECHO®

University of Nebraska Medical Center

UNMC ID ECHO Project to Reduce COVID-19 Health Disparities Through Quality Improvement

Welcome to Session 1

Project Funded by Nebraska DHHS through a CDC grant

Housekeeping Reminders

- Discussion makes sessions work best!
- Please stay muted unless you are speaking
- We love to see your face!
- Sessions will be recorded and available upon request
- Attendance is taken by filling the survey in the chat

- Reminder: Project ECHO collects registration, participation, questions and answers, chat comments, and poll responses for some ECHO programs. Your individual data will be kept confidential. These data may be used for reports, maps, communications, surveys, quality assurance, evaluation, research, and to form new initiatives.

Subject Matter Experts

Infectious Diseases Team

- M. Salman Ashraf, MBBS
- Nada Fadul, MD
- Erica Stohs, MD, MPH
- Anum Abbas, MD
- Kelly Cawcutt, MD, MS

Quality Improvement Team

- Jeff Wetherhold, QI Consultant
- Gale Etherton, MD
- Mahliqha Qasimyar, MD
- Ardis Reed, State QIN/QIO Representative

Health Equity & Cultural Sensitivity Team

- Mahelet Kebede, HE & CS Consultant
- Shirley Delair, MD
- Jasmine Marcelin, MD
- Precious Davis, Case Manager
- Andrea Jones, MD
- Samantha Jones, Program Manager

Project Overview

COVID-19 Response/Infection Control/Long COVID Module

Health Equity Module

Quality Improvement Module

Cultural Sensitivity Module

UNMC ID Health Equity and Quality Improvement Project ECHO Objectives

By the end of the UNMC ID ECHO Project, participants will be able to:

- Explain the relationship of principles of health equity, cultural sensitivity, infection prevention and control, and quality management.
- Develop the skill set to address COVID-19-related health disparities and provide quality healthcare with a culturally sensitive, equity-minded approach.
- Implement a quality improvement project that addresses a need at the facility level related to health disparity or cultural sensitivity.

CE Disclosures

Project ECHO®

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UNMC ID Health Equity and Quality Improvement ECHO Project

Topics: Introduction to Health Equity and Quality Improvement

Free Live ECHO Project
November 3, 2021
CID 53866

TARGET AUDIENCE

This live activity is intended for physicians, APPs, nurses, social workers, case managers, and anyone else interested in learning about health equity in underserved populations.

ACTIVITY DESCRIPTION

Achieving health equity, addressing COVID-19 disparities, and improving the health of all Nebraskans using a quality improvement approach are the goals for our newly launched educational initiative. This COVID-19-focused health equity and quality improvement educational series will use the ECHO model for training healthcare workers.

The course is being offered through the University of Nebraska Medical Center (UNMC) infectious diseases (ID) ECHO program and is funded by the Nebraska Department of Health and Human Services (DHHS) via a CDC grant.

EDUCATIONAL OBJECTIVES

At the conclusion of this live activity, the participants should be better able to:

- Define health equity.
- Describe the difference between equity and equality.
- Describe how quality improvement will be integrated into the curriculum for this program.
- Characterize the historical origins of quality improvement in healthcare and other industries.

REQUIREMENTS FOR SUCCESSFUL COMPLETION

In order to receive continuing education credit/credits, you must:

1. Participate in the live activity via ZOOM. Your attendance will be tracked by the course facilitator.
2. Complete the overall evaluation
    a. Instructions on how to access the overall evaluation will be provided on a quarterly basis.
    b. Continuing education credits will be issued for activities you attended.

For questions regarding evaluation and attendance, please contact Nuha Mirghani, MD, MBA, HCM at nmirghani@unmc.edu

ACCREDITED CONTINUING EDUCATION

In support of improving patient care, University of Nebraska Medical Center is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

PHYSICIANS/PHYSICIAN ASSISTANTS

The University of Nebraska Medical Center designates this live activity for a maximum of 1.5 *AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

NURSES/NURSE PRACTITIONERS

The University of Nebraska Medical Center designates this activity for 1.5 ANCC contact hours. Nurses should only claim credit for the actual time spent participating in the activity.

ACCREDITED CONTINUING EDUCATION

As a Jointly Accredited Organization, University of Nebraska Medical Center is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. University of Nebraska Medical Center maintains responsibility for this course. Social workers completing this live activity receive 1.5 interactive continuing education credits.

Social work level of content: Basic.

This program has been pre-approved by The Commission for Case Manager Certification to provide continuing education credit to CCM® board certified case managers. The course is approved for 1.5 CE contact hours.

Activity code: I00048226 Approval Number: 210003593

To claim these CEs, log into your CCMC Dashboard at www.ccmcertification.org.

DISCLOSURE INFORMATION

As a jointly accredited provider, the University of Nebraska Medical Center (UNMC) ensures accuracy, balance, objectivity, independence, and scientific rigor in its educational activities and is committed to protecting learners from promotion, marketing, and commercial bias. Faculty (authors, presenters, speakers) are encouraged to provide a balanced view of therapeutic options by utilizing either generic names or other options available when utilizing trade names to ensure impartiality.

All faculty, planners, and others in a position to control continuing education content participating in a UNMC accredited activity are required to disclose all financial relationships with ineligible companies. As defined by the Standards for Integrity and Independence in Accredited Continuing Education, ineligible companies are organizations whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients. The accredited provider is responsible for mitigating relevant financial relationships in accredited continuing education. Disclosure of these commitments and/or relationships is included in these activity materials so that participants may formulate their own judgments in interpreting its content and evaluating its recommendations.
This activity may include presentations in which faculty may discuss off-label and/or investigational use of pharmaceuticals or instruments not yet FDA-approved. Participants should note that the use of products outside currently FDA-approved labeling should be considered experimental and are advised to consult current prescribing information for FDA-approved indications.

All materials are included with the permission of the faculty. The opinions expressed are those of the faculty and are not to be construed as those of UNMC.

Disclosures

The accredited provider has mitigated and is disclosing identified relevant financial relationships for the following faculty, planners, and others in control of content prior to assuming their roles:

FACULTY

The below faculty have nothing to disclose:

- Gale Etherton, MD, FACP
- Mahelet Kebede, MPH*
- Jasmine Marcelin, MD
- Mahliqha Qasimyar, MD, FACP
- Jeff Wetherhold, M.Ed*

**Indicates on the planning committee*

Disclosures

PLANNING COMMITTEE

M. Salman Ashraf, MBBS
Merck & Co, Inc: Industry funded research/investigator

Nada Fadul, MD
ViiV Healthcare: Advisory Committee/Board

Erica Stohs, MD, MPH
ReViral Ltd.: Industry funded research/investigator

The below planning committee members have nothing to disclose:

- Valeta Creason-Wahl, HMCC
- Precious Davis, MSN, BSN, RN
- Samantha Jones, CSW
- Nuha Mirghani, MD, MBA, HCM
- Renee Paulin, MSN, RN, CWOCN
- Bailey Wrenn, MA

Session 1 Objectives

1. Define health equity.
2. Describe the difference between equity and equality.
3. Describe how quality improvement will be integrated into the curriculum for this program.
4. Characterize the historical origins of quality improvement in healthcare and other industries.

www.unmc.edu/cce

Current State of COVID-19 in Nebraska

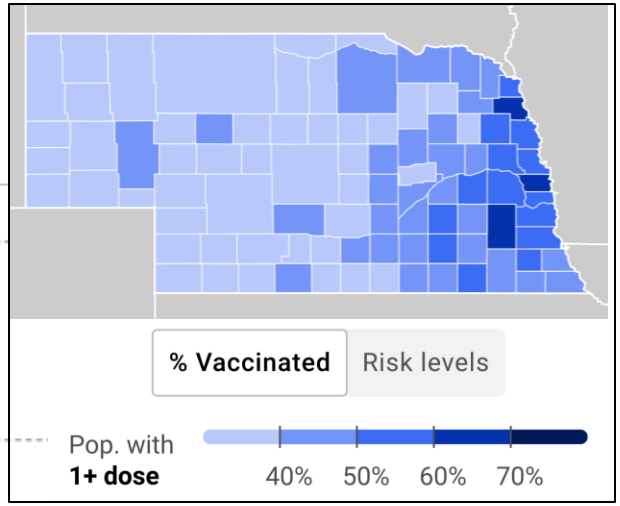
Nebraska Statistics

Cases

DAILY NEW CASES
• 29.6 PER 100K

INFECTION RATE
• 1.03

POSITIVE TEST RATE
• 12.8%



Over the last week, Nebraska has averaged 573 new confirmed cases per day (**29.6** for every 100,000 residents). About this data

Share

https://covidactnow.org/us/nebraska-ne/?s=24951410

Nebraska Statistics

Week	Daily New Cases/ 100K	Infection Rate	Positive Test Rate	ICU Capacity Used	Vaccinated 1+
11/01/21	29.6	1.03	12.8%	80%	61%

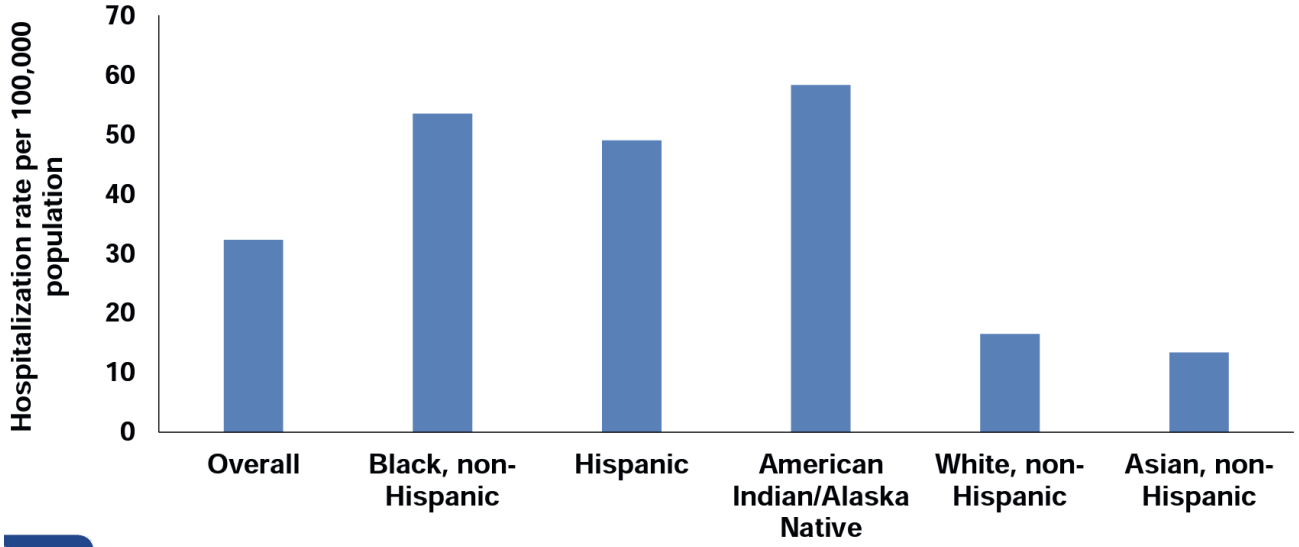
https://covidactnow.org/us/nebraska-ne/?s=24951410

COVID-19 Vaccine Updates

- **COVID-19 Vaccination in Children Aged 5-11 years authorized**
  - Pfizer, 2-part vaccination spaced 21 days

Cumulative COVID-19-Associated Hospitalization Rates by Race and Ethnicity among Children 5-11 Years of Age — COVID-NET, March 1, 2020–October 23, 2021

ge Group



Children 5-11 years are making up a greater proportion of total cases:
10.6% of cases the week of October 10, 2021

https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covid-net/purpose-methods.html, Data are preliminary and subject to change

COVID-19 Vaccine Updates - Boosters

mRNA Vaccine (Pfizer or Moderna ½ dose) Boosters

- Eligible for a booster shot at **6 months** or more after their initial series:
  - 65 years and older
  - Age 18+ who live in long-term care settings
  - Age 18+ who have underlying medical conditions
  - Age 18+ who work or live in high-risk settings
    - *Examples:* First responders (**healthcare workers**, firefighters, police, congregate care staff), education staff (teachers, support staff, daycare), food and agriculture, manufacturing, corrections, USPS, public transit, & grocery store workers

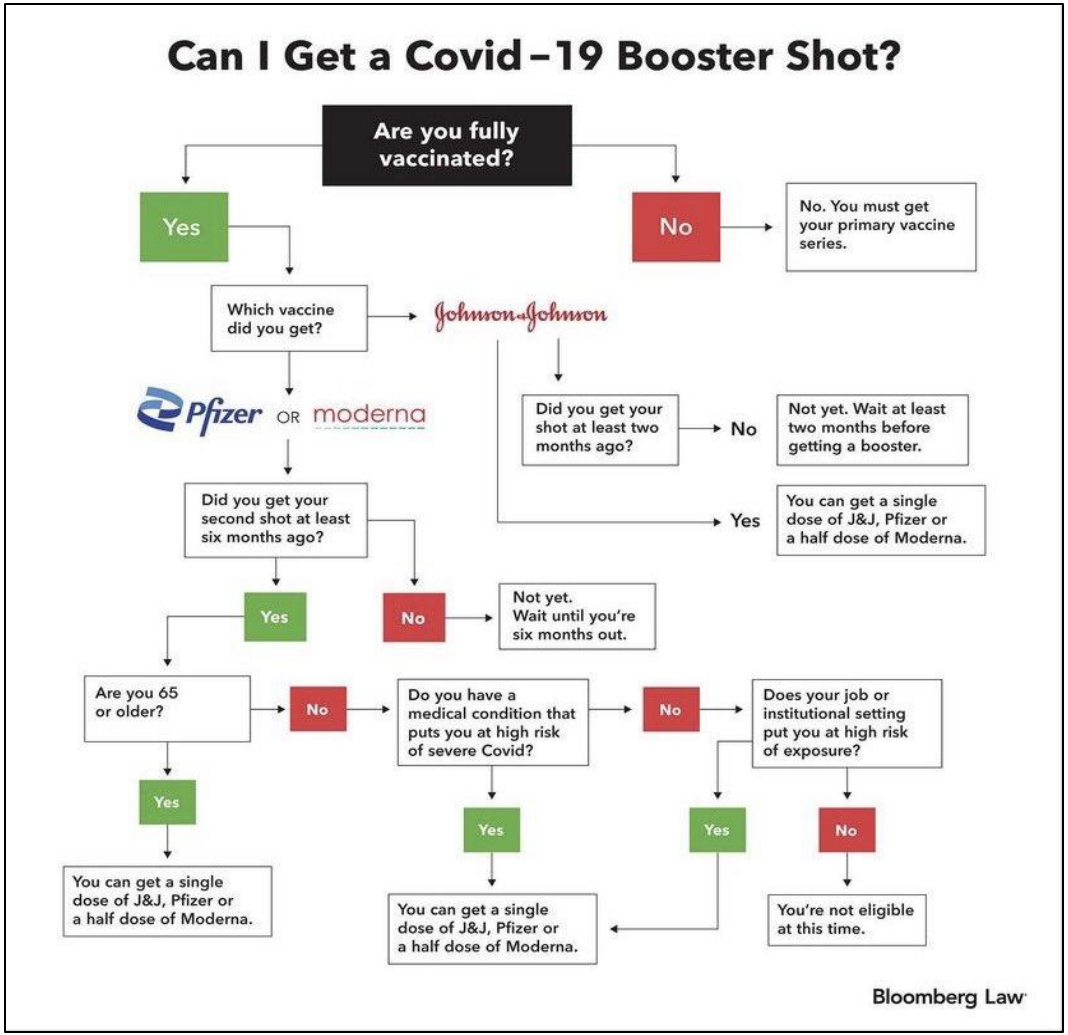
Janssen (Johnson & Johnson) Boosters

- Eligible for a booster at least **2 months** after single-dose regimen: 18 years and older

"Mix & Match" Boosters: Individuals may choose which booster they receive based on eligibility criteria of the original series

https://www.cdc.gov/media/releases/2021/p1021-covid-booster.html

COVID-19 Vaccine Booster Algorithm



https://news.bloomberglaw.com/pharma-and-life-sciences/can-i-get-a-covid-19-booster-shot-heres-how-to-decide

Introduction to Health Equity

Objectives

1. Define health equity.
2. Describe the difference between equity and equality.

Poll Question

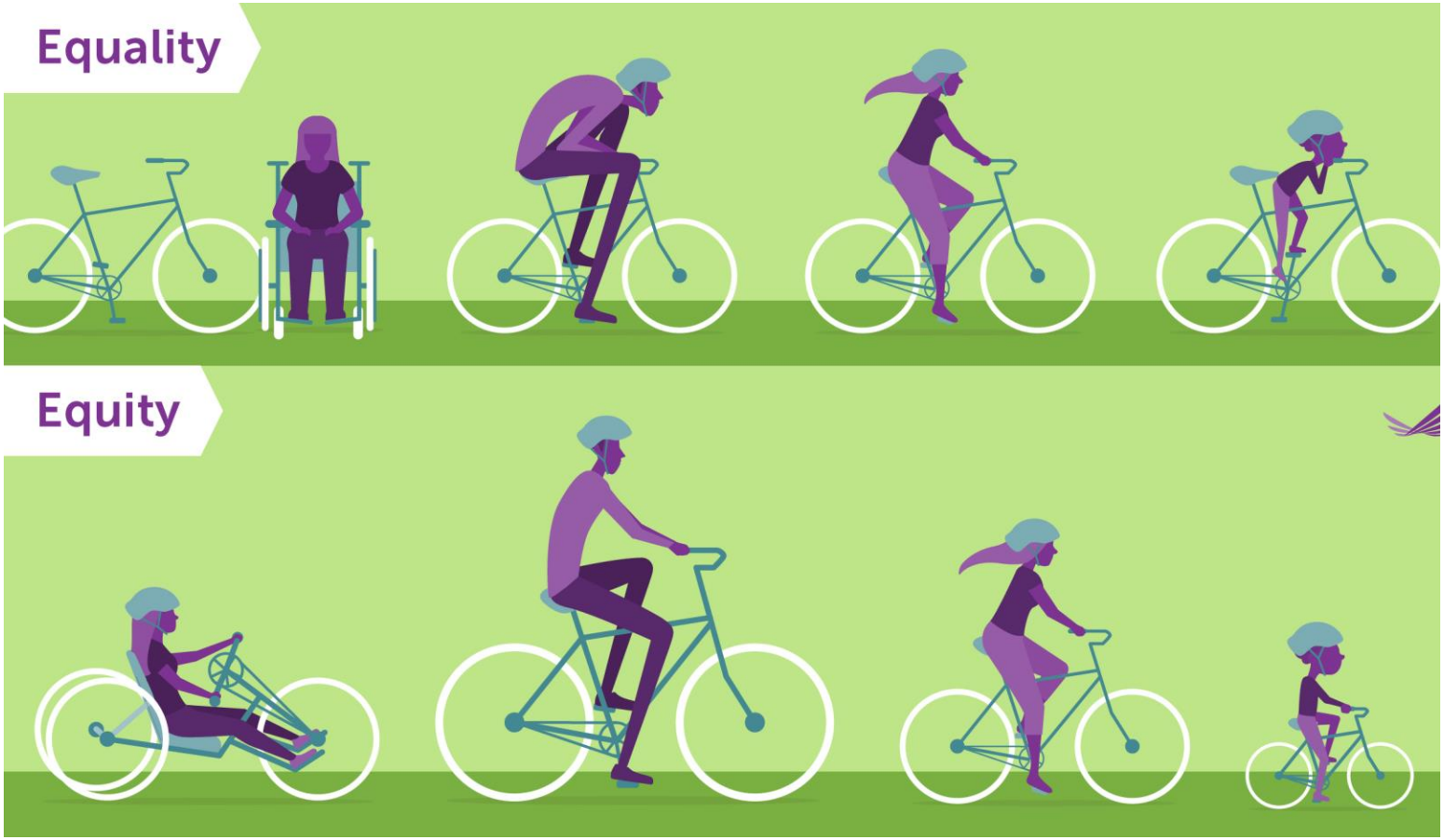
Definitions

Health Equity

"Health equity means that everyone has a fair and just opportunity to be as healthy as possible.

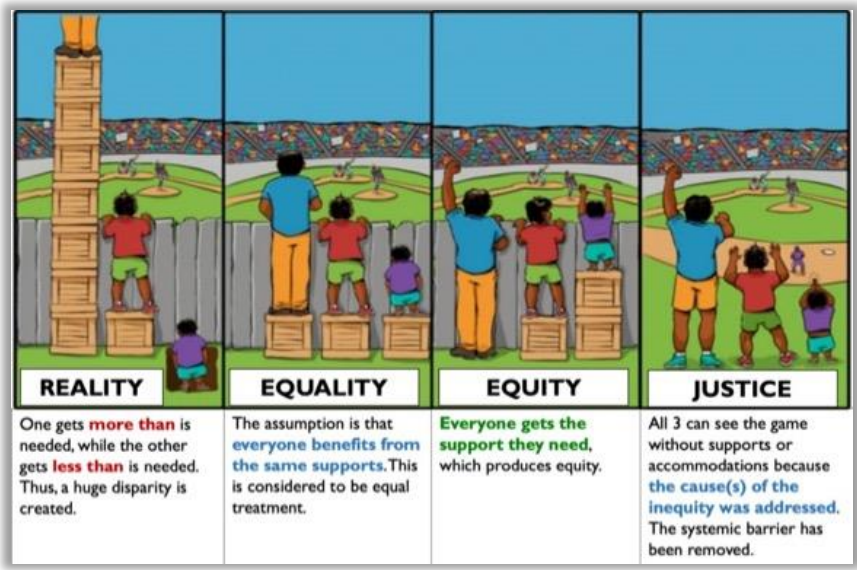
This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."

– Robert Wood Johnson Foundation


Equality
Equity

AAMC DEI Competencies
Domain II: Equity

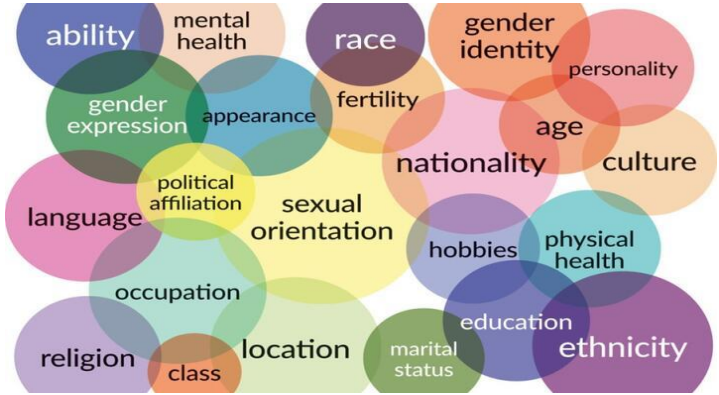
- Equity is the fair treatment, access, opportunity, and **advancement for all people.**
- Striving to **identify and eliminate barriers** that have prevented the full participation of some groups and allowed unfair advantage to other groups.
- Improving equity involves increasing justice and fairness within the procedures and processes of institutions or systems, as well as in their **distribution of resources.**
- Tackling equity issues requires an understanding of the **root causes of outcome disparities** within our society.



Definitions

Health Disparities

"A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on the following…"



IOM's report *Unequal treatment*: healthcare disparities

- Minority Americans are less likely than whites to get many effective medical and surgical services across a variety of clinical settings:
  - Inferior pain treatment
  - Lower rates of revascularization procedures for acute MI
  - Fewer prescriptions for beta-blockers after MI
  - Less timely administration of antibiotics for pneumonia
  - Less optimal care for diabetes
  - Fewer prescriptions for inhalers in children with asthma
  - Fewer cancer screening tests
  - Among others…

Smedley BD et al. Institute of Medicine; 2003.

Example: Health Disparities

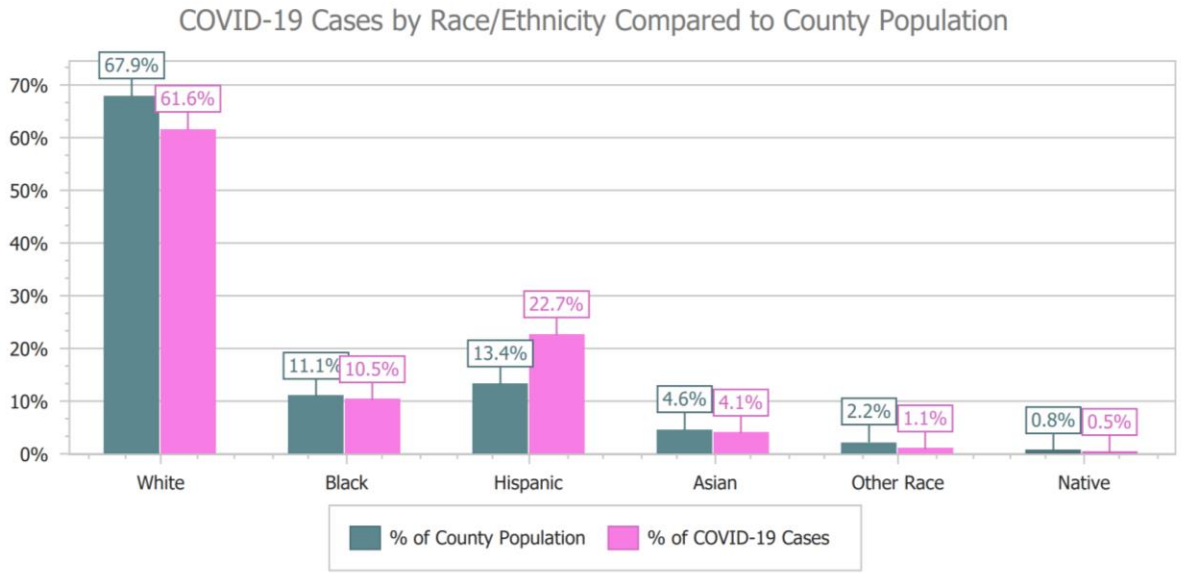
DOUGLAS COUNTY Health Department
Healthy. Vibrant. Everyone. Everywhere.

COVID-19 Daily Summary Report

Douglas County, Nebraska

DCGIS

Report Created: 10/22/2021 2:16 PM



Source: Case investigation data, US Census 2020 estimates

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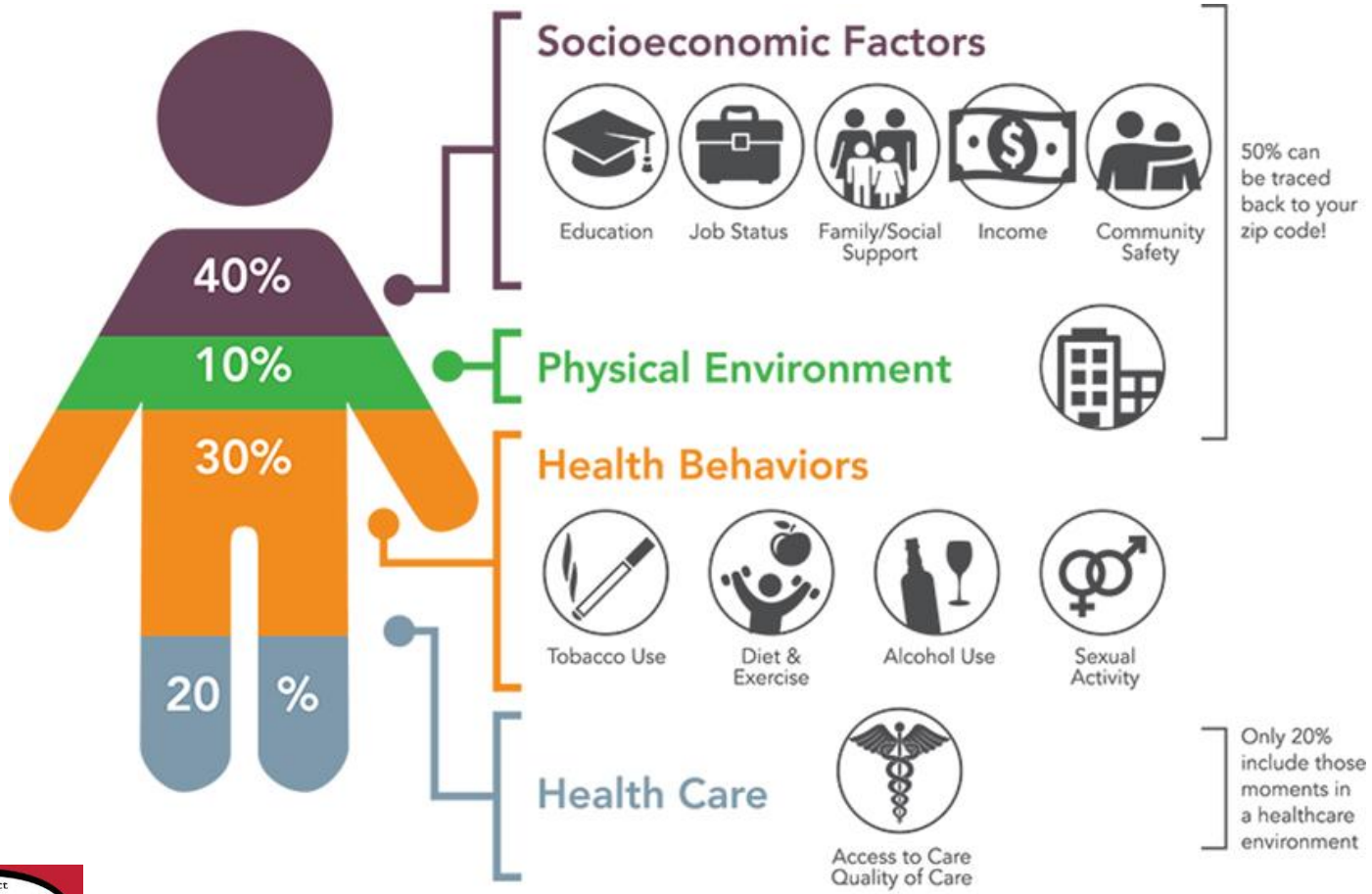
Poll Question



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

COVID-19 is a Health Equity Issue: Key Drivers of Disease Inequities

COVID-19 Inequities

Many social, political and environmental factors• affect community health and contribute to adverse health outcomes, social inequities, and health inequities. The COVID-19 pandemic has further exacerbated existing inequities, with many people suffering from chronic illnesses and other conditions that increase their risk to severe illness. In addition, the lack of investment in addressing barriers to healthy and productive lives in marginalized communities leads to many other health and social consequences. Below are examples of some key interdependent drivers of disease inequities. A multi-sectoral approach is needed to reduce the impact of COVID-19 and other health issues among marginalized, vulnerable, and underserved communities.

Discriminatory Policies

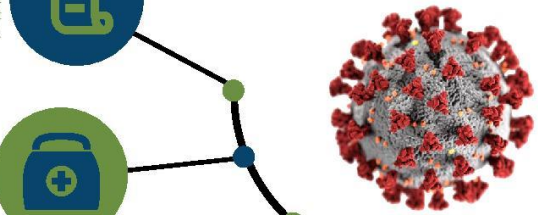
Policies impacting healthcare, education, finance, criminal justice, and other formative systems which should serve to protect communities can lead to stress as well as act as barriers towards proper healthcare[1].

Limited Access to Essential Services and Resources

Barriers towards health insurance, childcare, sick leave, paid leave, or access to PPE, among others, make some demographics more prone to COVID-19 inequities[2].

History of Racism & Social Discrimination

Systemic racism and other forms of social discrimination (e.g., xenophobia, gender discrimination, bias against the LGBTQI+ community) have contributed to discriminatory policies, limited investment in community well-being, lack of access to quality healthcare, and a poor sense of trust between communities and health and social systems[1, 3].



Poverty

For many people living in poverty, health is one of many priorities. Too many commitments, such as multiple jobs or concerns with access to food and shelter, make issues such as preventative health seem less urgent[9].

Overcrowded Living Conditions

Many groups live in overcrowded conditions such as: multi-generational homes or nursing homes, prisons, homeless shelters, or other kinds of group "homes." This can make it difficult to social distance and increase the risk for COVID-19. Of great importance are factors such as unemployment which can lead to homelessness, and therefore increased vulnerability to COVID-19[1, 4].

Chronic Stress

Continued stress can impact physical health, inducing conditions such as heart disease or high blood pressure, which could lead to COVID-19 complications[5].

Low Health Literacy & Misinformation

Many people from ethnically and racially diverse communities as well as people of low SES didn't have the opportunity to develop skills to identify credible news sources, which has been shown to correlate with low health statuses[6].

Mistrust

Insufficient community engagement, combined with misinformation or a lack of consistent information as well as a history of discrimination, causes many marginalized communities to lack trust towards health and social services[7, 8].

1) CDC, 2020
2) Pew Research Center, 2020
3) Health Affairs, 2020
4) NY Times, 2020
5) NIMH, 2020
6) Harvard, 2020
7) L.C. Cooper and D.C. Crews, 2020
8) J. Jaiswal, C. LoSchiavo, and D. C. Perlman, 2020
9) CDC, 2020

https://www.healthequityinitiative.org/

HEI Health Equity Initiative
JOIN THE MOVEMENT

Case Example

50-year-old woman presented to ER with generalized bone pain. She had been seen in the ER multiple times over the last 2 decades for the same complaint. In handoff, the resident describes her as a "frequent flier" and says, "she's here for pain medication again," before rolling their eyes.

False ideas about pain

"Black people's nerve endings are less sensitive than white people's."
"Black people's skin is thicker than white people's."
"Black people's blood coagulates more quickly than white people's."

40% of first- and second-year medical students endorsed the belief that "black people's skin is thicker than white people's".

A meta-analysis of 20 years of studies covering many sources of pain in numerous settings found that black/African American patients were 22% less likely than white patients to receive any pain medication.

Leads to worrisome treatment disparities and unnecessary suffering.

In the 2016 study, for example, trainees who believed that black people are not as sensitive to pain as white people were less likely to treat black people's pain appropriately.

Introduction:

Quality Improvement in our ECHO

Agenda for This Section

1. Define QI in relation to healthcare
2. Characterize QI's historical origins
3. Describe how QI will be integrated into this program

What does QI mean to you?

Type the first word that comes to mind in the chat

What does QI mean to us?

“The best possible care"

- Optimizing the likelihood of desired health outcomes
  - Was the care delivered as good as it could be?
  - What improvement(s) would lead to better care?

Click to add text

- Systemic and continuous actions that lead to measurable improvements

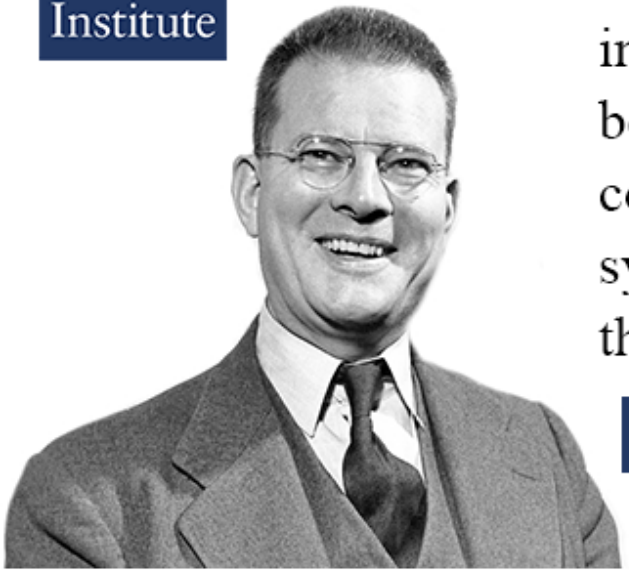
When did QI principles originate?

- QI in healthcare has its origins in manufacturing
- In order to understand key concepts and tools for QI, it is helpful to understand their origins

A Historical Timeline of QI

Craft Guilds	1911: Frederick Taylor	1931: Walter Shewhart	1955: Edward Deming	1966: Avedis Donabedian	1980s: Lean	1980s: Six-Sigma
• Each individual item custom built for each individual need • Lots of variation • Quality control maintained personally	• *The Principles of Scientific Management* • Every process should be scientifically studied, timed and standardized to maximum efficiency and profit	• Each step in the process creates data • Statistical analysis of the data needed to continuously improve the process and increase efficiency • Statistical Process Control Theory • PDSA Cycle	• Applied Shewhart's theories of manufacturing processes to business • Front line workers need to be involved in improving the process • Improving quality would reduce expenses, increase productivity and market share • Process Management must be innovative and willing to change	• *Evaluating the Quality of Medical Care* • Who provides care and where (structure); how care is provided (process); and the consequences of care (outcomes) are all needed to measure quality	• Toyota's operations focused on reducing waste	• Motorola's operations focused on reducing variability

The W. Edwards Deming Institute



Management of a system requires knowledge of the interrelationships between all of the components within the system and of everybody that works in it.

W. Edwards Deming

source: quotes.deming.org/10221

Project ECHO

Discussion

Is the practice of medicine a craft?

Discussion

In your organization:

How often are front line workers solicited for input to improve processes?

Why is QI important to you?

- Helps you to provide high value clinical care to all your patients
- Addresses the whole system of healthcare delivery, understanding that the healthcare system is inherently a complex system
- Facilitates compliance to performance mandates imposed by regulatory agencies (JC, CMS)

How is QI integrated in this ECHO?

We will use case-based, interactive sessions to:

- Define the problem
- Identify areas for improvement
- Explicitly state goals
- Identify measures of progress
- Create improvements
- Build upon successes
- Sustain reliable processes over time

Discussion & Wrap-Up

1. You will receive today's presentation, in addition to a one-page key-takeaways document and next session's agenda through email.
2. Next session will be on ***Cultural Sensitivity - Foundational Awareness***, and ***Basic Infection Prevention & Control Infrastructure*****.**
3. If you'd like to share a case with us, kindly send it by Monday, November 15th.
4. Please complete the pre-assessment survey if you haven't done so already.

By Session 2

Who Else Should Be Here from Your Team in Nebraska?

Thank You