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

Welcome to Session 28

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
➢ All the session presentation are available on our website

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

Subject Matter Experts

Infectious Diseases Team

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

Quality Improvement Team

- Jeff Wetherhold, QI Consultant
- Gale Etherton, MD
- Mahliqha Qasimyar, MD

Health Equity & Cultural Sensitivity Team

- Nada Fadul, MD
- Mahelet Kebede, HE & CS Consultant
- Shirley Delair, MD
- Jasmine Marcelin, MD
- Andrea Jones, MD
- Precious Davis, EdD
- Samantha Jones, Program Manager
- Dan Cramer, NP

UNMC ID Health Equity and Quality Improvement ECHO Project

Topics:
HE: Leveraging Clinical/Public Health Data to Eliminate Health Disparities (part 2/2)
QI Recap: Q & A

Free Live ECHO Project
December 21, 2022
CID 57617

TARGET AUDIENCE

This accredited continuing education 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:
- Identify strategies to eliminate health disparities.
- Outline the implementation steps for one strategy to eliminate health disparities.
- Discuss how to apply the content from QI sessions to project implementation.

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

JOINTLY ACCREDITED PROVIDER™
INTERPROFESSIONAL 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 Credit(s)™*. 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 hour(s). 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. Regulatory boards are the final authority on courses accepted for continuing education credit. Social workers completing this course receive 1.5 general continuing education credits. Social work level of content: **Advanced**

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 hour(s).
Activity code: I00053207   Approval Number: 220004054
To claim these CEs, log into your CCMC Dashboard at www.ccmcertification.org.

DISCLOSURE DECLARATION

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
- Michael Griffin, MPH
- Mahelet Kebede, MPH*
- Mahliqha Qasimyar, MD
- Jeff Wetherhold, M. Ed*

*Faculty and Planning Committee member

Disclosures

PLANNING COMMITEE

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

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
- Nada Fadul, MD
- Samantha Jones, CSW
- Nuha Mirghani, MD, MBA, HCM
- Renee Paulin, MSN, RN, CWOCN
- Bailey Wrenn, MA

POLL

Midpoint Evaluation

Health Equity Competencies

Describing the social determinants of health that may impact an individual's access to healthcare — 2.22 (+49%)

Tracking and identifying needs that may arise when implementing COVID-19 prevention and control efforts for marginalized communities — 2.11 (+59%)

Describing the historical context that may lead certain communities of color and rural communities to have varying acceptance rates of recommendations made by healthcare providers (e.g., COVID-19 vaccination) — 1.97 (+50%)

Implementing a COVID-19 prevention and control effort that is focused on health equity — 1.92 (+47%)

Establishing a process to routinely engage community stakeholders in my workplace's COVID-19 efforts, including those experiencing health inequities — 1.78 (+48%)

Not at all confident — Extremely confident

■ Preassessment ■ Midpoint

Participant Interviews

- 30-45 minutes each

- Focused on how you hope to apply what you are learning to your work

- Helps us improve program content

Schedule an interview:
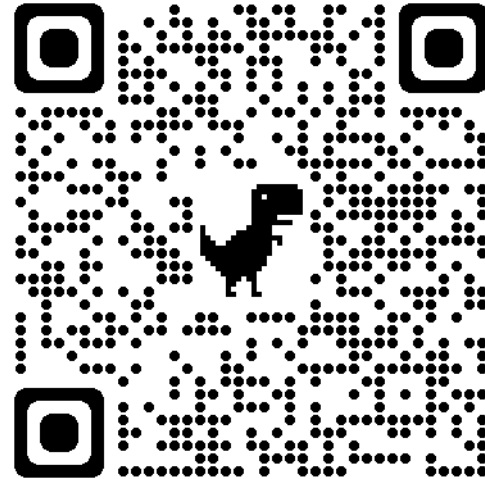
Health Equity: Leveraging Clinical/Public Health Data to Eliminate Health Disparities (Part 2/2)

Presenter: Michael Griffin

UNMC College of Public Health | Center for Reducing
Health Disparities

Objectives

1. Identify strategies to eliminate health disparities

2. Outline the implementation steps for one strategy to eliminate health disparities

About Me

- From Omaha, Nebraska
- B.S. In Sociology
- Masters in Health Policy from Emory
- *Community Health Programs Manager* at the CRHD

  - Community-Based Participatory Research (CBPR)
  - Program Management, Community Engagement

Discussion: How Do We Build Trust?

- Interpersonally?
- Institutionally?

Leveraging Data into Action

- Establish a community-wide behavioral change to prevent increased disparities by leveraging culturally-informed data.

- Use culturally-driven ways of distributing information to educate and promote healthy behaviors.

Key Terms

Culture

- Groups have more than disparities
- Cultural practices are existing systems to promote mass participation, and trust between community and health/governmental systems
  - Cultural landmarks
    - Churches as COVID vaccine clinics
    - Beauty Shops in the Civil Rights Movement

Discussion: What are Other Cultural Landmarks That We Can Use with Program Implementation?

Key Terms

Mass Participation

- Familiarity is key for buy-in to intervention
- Mass participation encourages collective efficacy, which is pivotal for maintaining a behavioral change
- Don't reinvent the wheel
    - Community basketball event with the Nebraska AIDS Project
- Data highlights that after natural disaster, community bands together more closely
    - Could be used to increase participation post-covid

National Association for the Advancement of Colored People's (NAACP) Original Exec. Branch

….Notice anything?
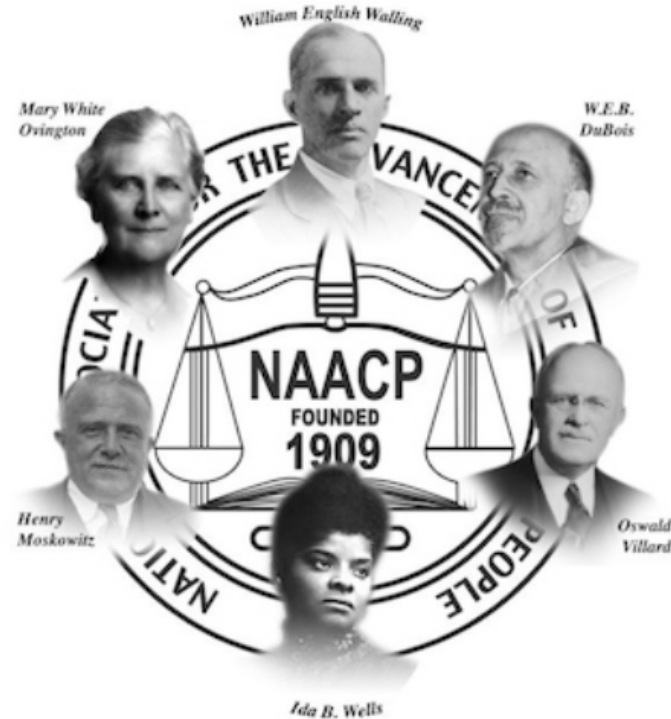
Southern Christian Leadership Conference (S.C.L.C)

….Notice anything?

Implementation Process

- Establishing trust is a pre-implementation trust
  - Not just understand, but have some level of relationship with community
  - Establish relationship with community members to build partnership

- Art's role as an existing system for health information dissemination

Case Studies

- "Strange Fruit" and anti-lynching legislation
- "What's Going on" and environmental sciences
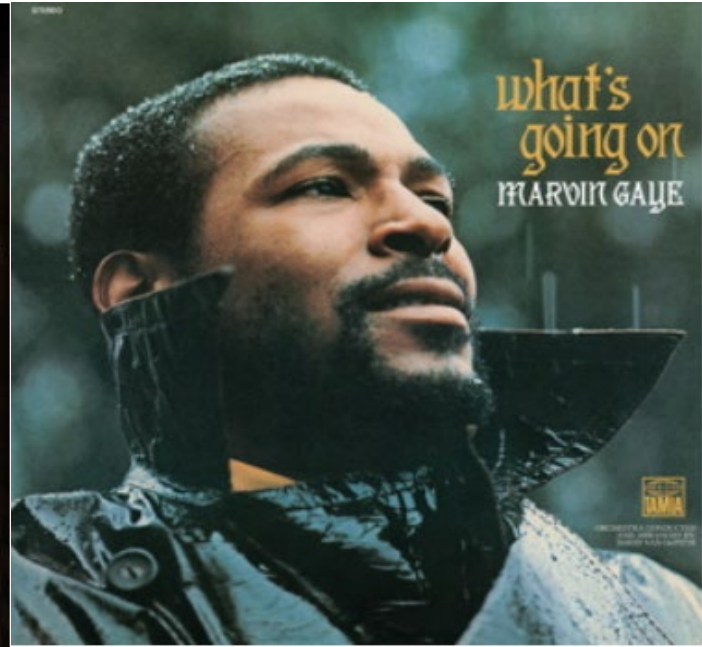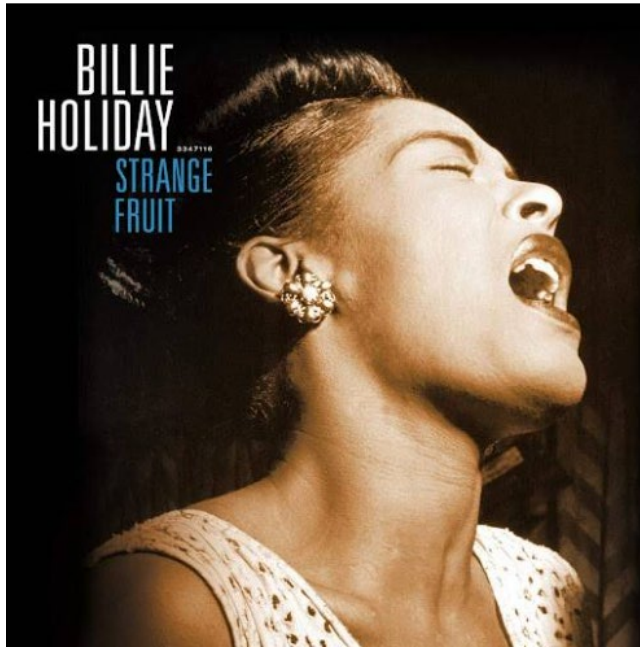
"Strange Fruit"

- Recorded in 1939
  - Anti-lynching legislation was actively ignored
  - The true horrors was contained in the South
  - Anti-lynching bill was finally passed…in 2022.

Scent of magnolias, sweet
and fresh
Then the sudden smell of
burning flesh

"The Ecology"

- From "What's Going On"
    - Released in 1971, a year after EPA was created
    - Evidence-based information on environmental disparities
        - Sold nearly 2 million copies
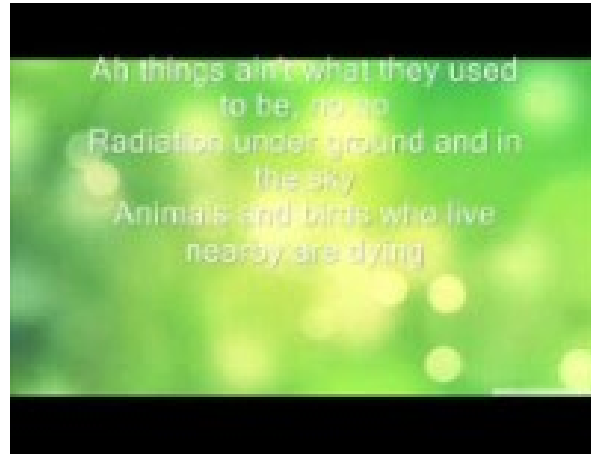
How Do These Principles Apply to COVID?

- COVID vaccine clinics
- Diversify approaches to dispersing health education to communities.

    - Leveraging existing systems

    - Culturally-informed program implementation

What We're Doing at the Center?

- Weigh and Win Weight Loss Program
  - Establishing program adaptations through consistent meetings with community members as architect of program structure .

- Gen X Program
  - Established program structure through feedback and evaluations work from partnering community members

In Conclusion

- Establishing trust, and acquiring mass participation are necessary ingredients to long-term behavioral change
- Art is a viable resource to distribute scientific information
    - What are other sources of distributing scientific information?
- Thank you!!

Objective

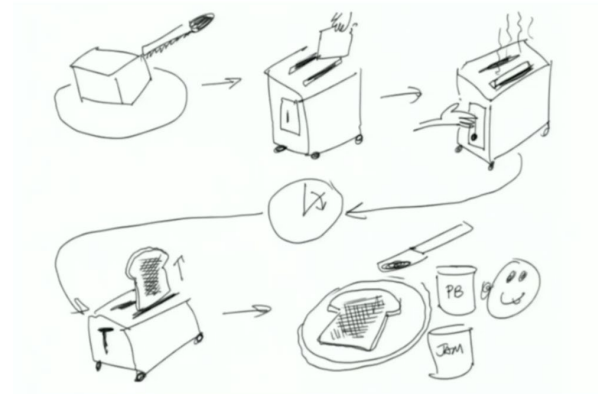Discuss how to apply content from QI sessions to project implementation

Our QI Roadmap

1. Define a problem statement

2. Map the process

3. Generate a fishbone diagram

4. Identify root cause(s)

5. Apply potential solutions to the hierarchy of actions and impact/effort matrix
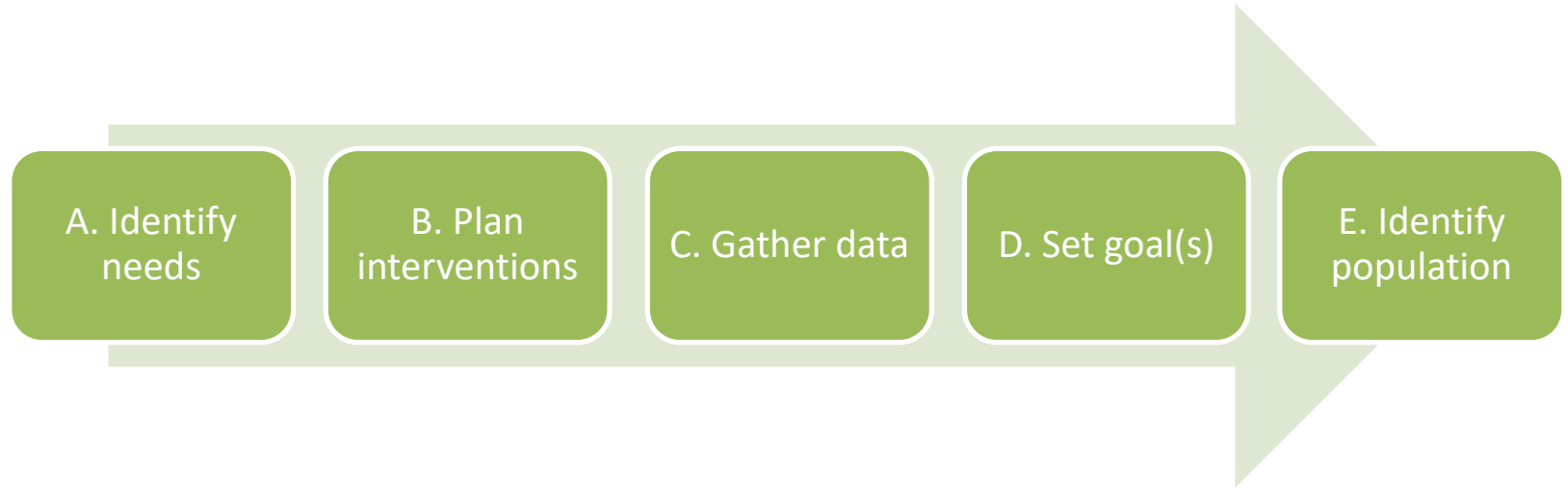
6. Define a SMART aim statement

Problem Statement

- A concise and focused description of the issue that needs to be addressed by the problem-solving team

- Describes what is wrong without offering theories about cause(s) or solutions(s)

    - Examples: "wrong drug given," "wrong line inserted"

- Delineates the difference between current state and ideal state in measurable/observable terms

    - Example: "10x dose of high-risk medication almost injected"
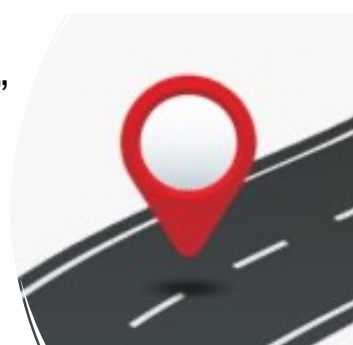
Exercise: Improving a Problem Statement

We are unable to meet the COVID needs of our minority population.

How could this problem statement be improved?

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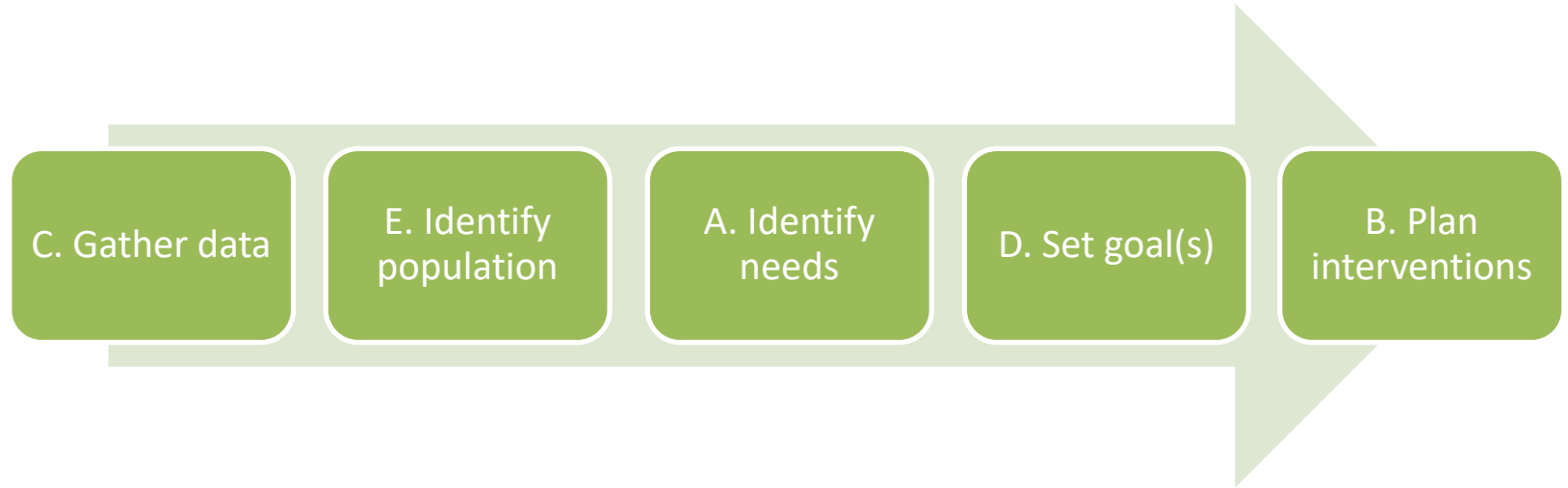
6. Define a SMART aim statement

Process Mapping

- Visual representation of all the steps involved in a workflow for any activity

- Shows the inputs, actions and outputs of a process in a clear, step-by-step fashion

Exercise: Sequencing a Process

A. Identify needs

B. Plan interventions

C. Gather data

D. Set goal(s)

E. Identify population

Sequenced Process Map

C. Gather data

E. Identify population

A. Identify needs

D. Set goal(s)

B. Plan interventions

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Fishbone Diagram

- Head: Problem statement

- Ribs: The standard categories of Root Causes with both primary and secondary causes
  - Primary cause: Leads directly to the outcome
  - Secondary cause: Leads to primary cause, but does not directly lead to the end effect

- Each industry has different buckets that are standardized for grouping the causes
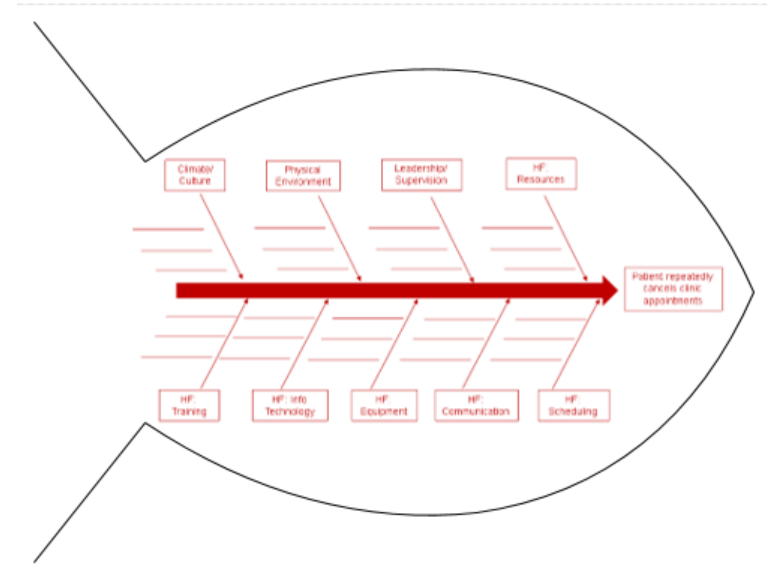
Exercise: Change Ideas

Healthcare Access & Quality

Neighborhood & Built Environment

Social & Community Context

Improve uptake of COVID vaccine boosters for our African American population.

Education Access & Quality

Economic Stability

Our QI Roadmap

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Cause Analysis
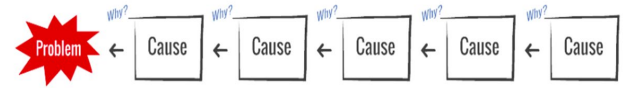
- You have defined the problem, mapped out the process, brainstormed many potential causes to that problem and picked out steps in the process that are not reliable

- The next step is to narrow down the potential causes
    - Bigger problems (higher risk) may need in depth review of potential causes using formal root cause analysis technique
    - Smaller problems may only need quick study of the potential causes as is done using Plan-Do-Study-Act technique
    - Both techniques address the answer to WHY?

Exercise: 5 Whys

Problem Statement: COVID vaccine booster uptake for our African American population is low.

Why is that?

Public transportation to get to clinic is unreliable
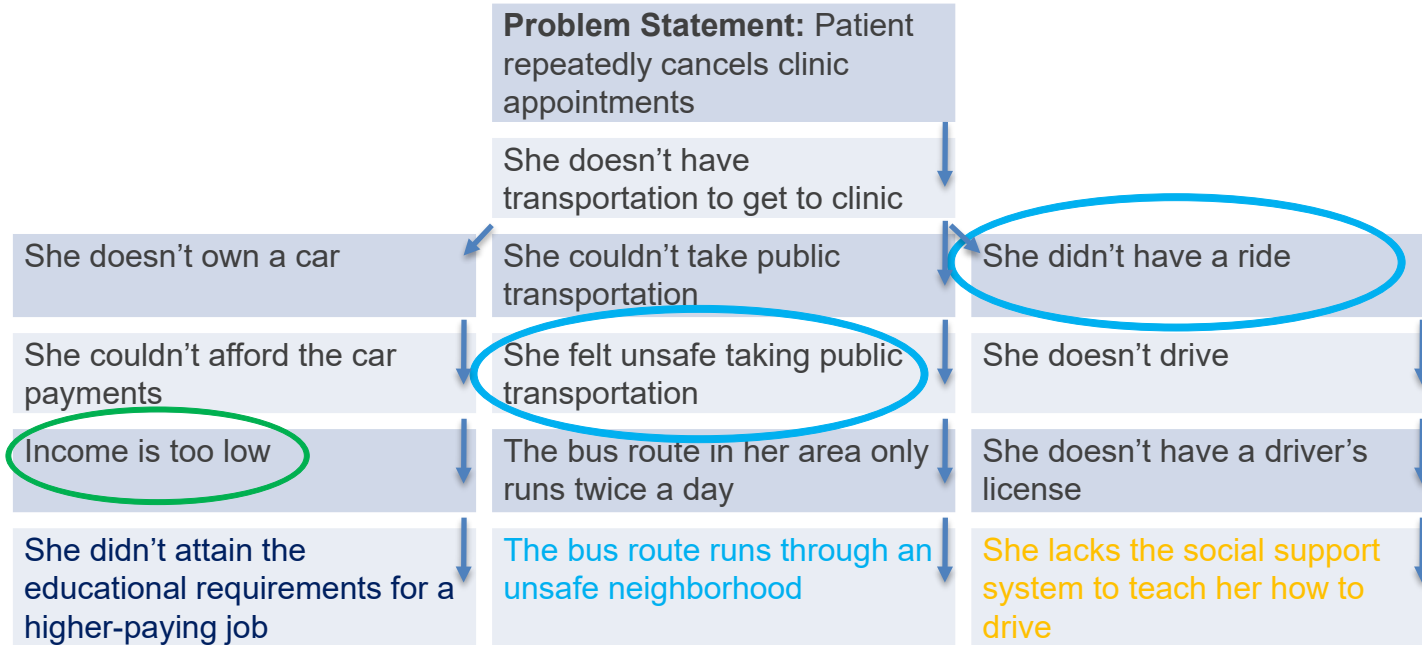
Why is that?

Why is that?

Why is that?

Why is that?

← Root Cause

Project ECHO®

Example: 5 Whys

Problem Statement: Patient repeatedly cancels clinic appointments

She doesn't have transportation to get to clinic

She doesn't own a car	She couldn't take public transportation	She didn't have a ride
She couldn't afford the car payments	She felt unsafe taking public transportation	She doesn't drive
Income is too low	The bus route in her area only runs twice a day	She doesn't have a driver's license
She didn't attain the educational requirements for a higher-paying job	The bus route runs through an unsafe neighborhood	She lacks the social support system to teach her how to drive

Root Causes

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Hierarchy of Actions

Strong • Likely to eliminate or greatly reduce the probability of an event. It uses *physical plant/architectural* or *systemic fixes* with application of human factors principles.
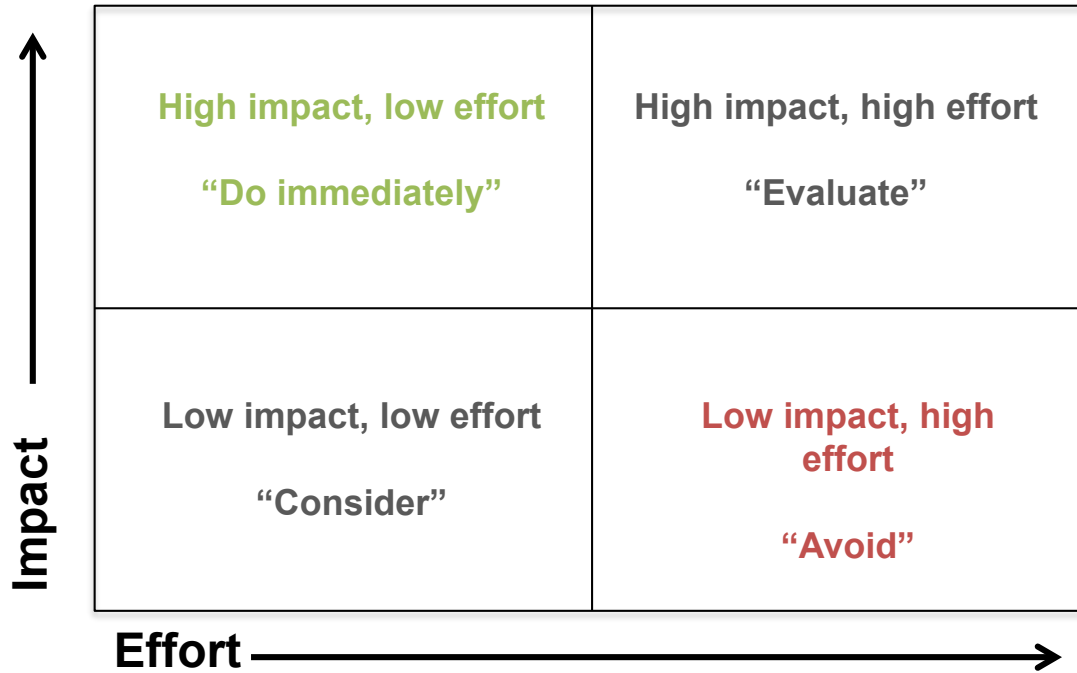
Intermediate • Likely to control the root cause or vulnerability. It employs human factors principles, but it also relies upon individual action such as a *checklist* or *cognitive aid*.

Weak • Less likely to be effective by itself. It relies on *policies*, *procedures*, and *individual action.*

Impact Effort Matrix

Problem statement: COVID vaccine booster uptake for our African American population is low because of unreliable transportation.

High impact, low effort **"Do immediately"**	High impact, high effort "Evaluate"
Low impact, low effort "Consider"	**Low impact, high effort** **"Avoid"**

Impact ↑

Effort →

Exercise: Impact/Effort

Problem statement: COVID vaccine booster uptake for our African American population is low because of unreliable transportation.

Impact

Effort

Example: Impact/Effort

High impact, low effort ✓

- Coordinate with transportation benefits offered through patients' insurance

High impact, high effort

- Implement a clinic-specific patient transport service
- Offer alternative appointment times
- Provide transportation vouchers

Low impact, low effort

- EMR reminder for scheduler to check with patients about transportation access
- Incorporate transportation questions into screening during reminder calls
- Check with patients to see if they have a drivers' license

Low impact, high effort 🚫

- Put an organizational policy in place requiring clinicians to ask about transportation
- Change bus route to front door pickup

Impact

Effort

Project ECHO®

Our QI Roadmap

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6. Define a SMART aim statement

Aim Statement

- An aim statement is a written, measurable, time sensitive statement of the expected results of a system redesign/quality improvement project

- The aim can change as needed to flex with information obtained during project

- Leadership and frontline staff must agree on this to be successful

Exercise: SMART Aim

Proposed Fix that is Highest Impact, Lowest Effort:

Coordinate with transportation benefits offered through patients' insurance

How would you make this a SMART aim statement?

Discussion

Discussion

Where and when does strong engagement already exist in the community you are trying to reach?

Consider how you might use a different and culturally-driven pathway for communicating information on healthy behaviors. Think beyond health care to consider:

- Locations
- Events
- Community leaders
- Media

Nebraska COVID-19 Statistics

WEEKLY NEW REPORTED CASES

● **182.5** PER 100K

WEEKLY COVID ADMISSIONS

● **10.8** PER 100K

PATIENTS W/ COVID

● **6.2%** OF ALL BEDS

Higher

Lower

200

182.5

Mar | May | Jul | Sep | Nov | Jan'21 | Mar | May | Jul | Sep | Nov | Jan'22 | Mar | May | Jul | Sep | Nov | Jan'2

https://covidactnow.org/us/nebraska-ne/?s=44133160
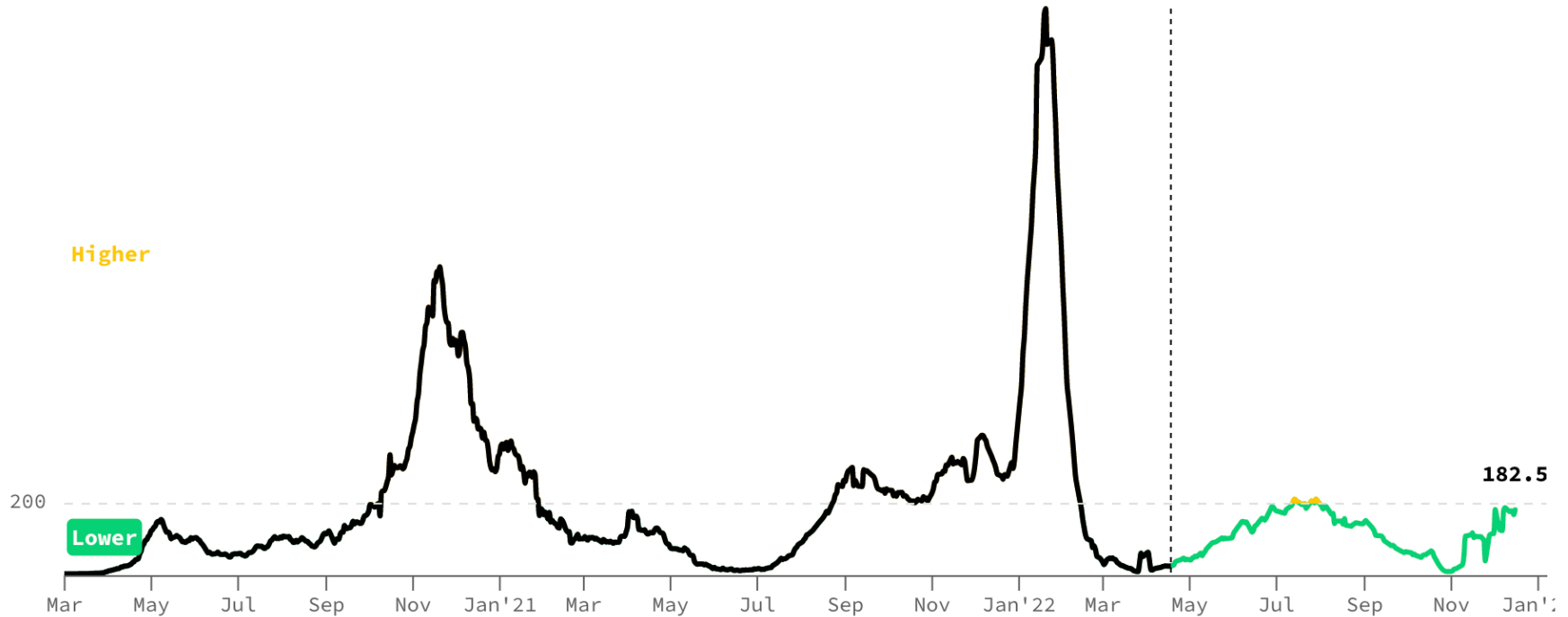
Nebraska COVID-19 Statistics

Test positivity rate

Mar. 2020   Dec. 2022

Hospitalized

Mar. 2020   Dec. 2022

Deaths

Mar. 2020   Dec. 2022
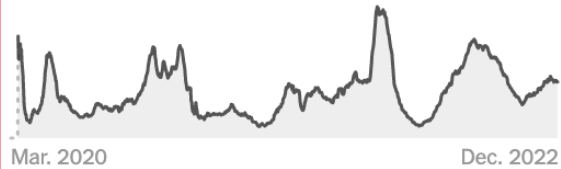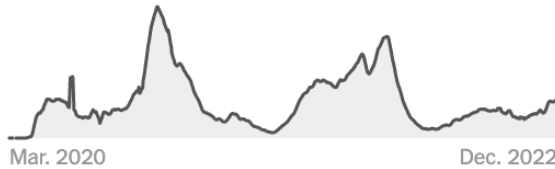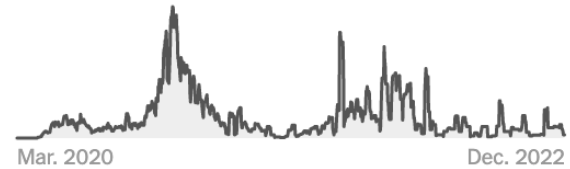
	DAILY AVG. ON DEC. 18	PER 100,000	14-DAY CHANGE
Cases	504	26	Flat
Test positivity	16%	—	−6%
Hospitalized	300	16	+7%
In I.C.U.s	32	2	+17%
Deaths	<1	<1	−71%

https://www.nytimes.com/interactive/2021/us/nebraska-covid-cases.html

Nebraska COVID-19 Statistics

Week	Weekly Cases*	Weekly Admits*	COVID-19 Hospitalizations	% COVID Hospitalizations
10/5/22	63.3	6.3	175	3.4%
10/19/22	54.3	4.4	160	3.1%
11/2/22	61.6	6.0	177	3.9%
11/16/22	100.3	8.2	203	4.9%
12/7/22	126.2	15	290	6.4%
12/21/22	182.5	11	300	6.2%

Nebraska COVID-19 Statistics
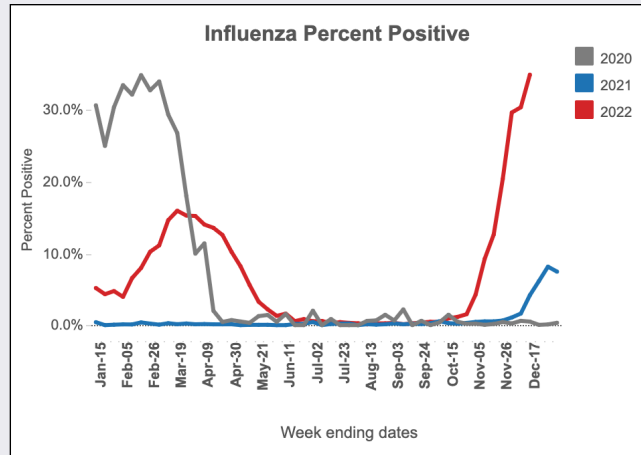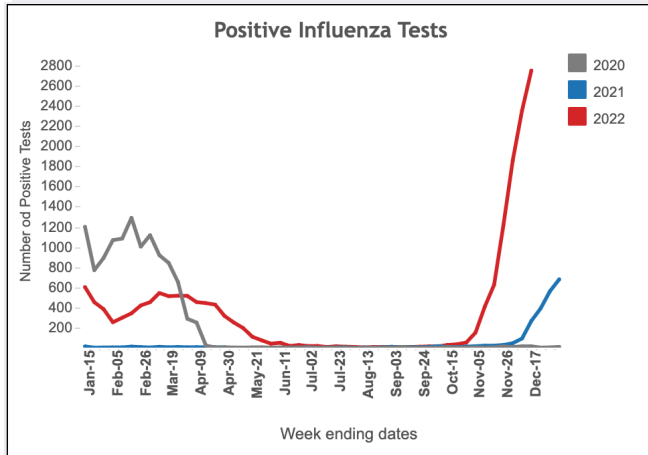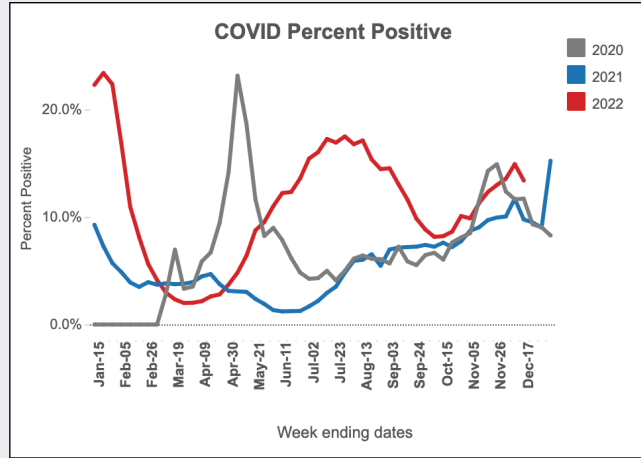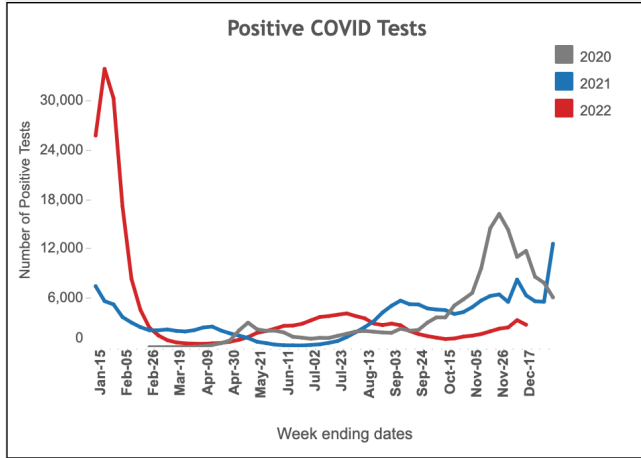
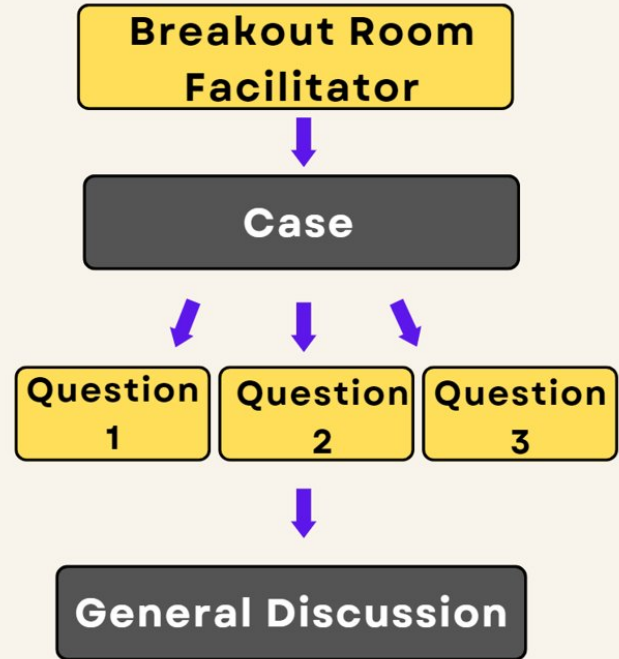https://atlas-dhhs.ne.gov/Atlas/Respiratory_Illness

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 **January 4th** on:

➢ Cultural Sensitivity: ***Gender Expression and Identity***

Session Flow

Poll Results

Happy Holidays