Using Health Equity Data to Stratify QI Performance Measures

Addressing Disparities in Care and Outcomes

Thursday, April 18, 2024

PBGH California Quality Collaborative

Today's Objectives

By the end of today's presentation, we will have…

- **Discussed** guidance on using health equity data to stratify QI performance measures.
- **Illustrated** how health equity data can inform the design of QI strategies and interventions to reduce inequities in care and outcomes.
- **Heard from** Community Medical Centers on their approach and experience collecting health equity data.

Reflecting on your quality improvement strategies

Thinking of your quality improvement strategies across your organization…

How often does your organization review quality improvement data stratified by patient demographics (e.g., race, ethnicity, language, gender, socioeconomic status) to identify and address health inequities?

A. Regularly (monthly or quarterly)
B. Occasionally (annually or biannually)
C. Rarely
D. Never

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Stratifying QI Performance Measures & Health Equity Data

CQC's QI Strategies and Interventions to Reduce Inequities

Model for Improvement*

What are we trying to accomplish?

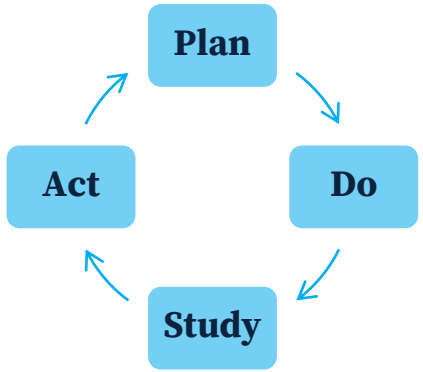
- For which community members?
- Experiencing what disparities?

How will we know change is an improvement?

- Are disparities being addressed?
- Do changes impact other aspects of care?

What changes can we make that will result in improvement?

- Do all benefit from the change equitably?
- Are there unintended consequences?



QI Strategies to Reduce Inequities

- Equity focused AIMs
- Data stratification
- Root Cause Analysis

Patient Input to Design Interventions

* Adapted from:

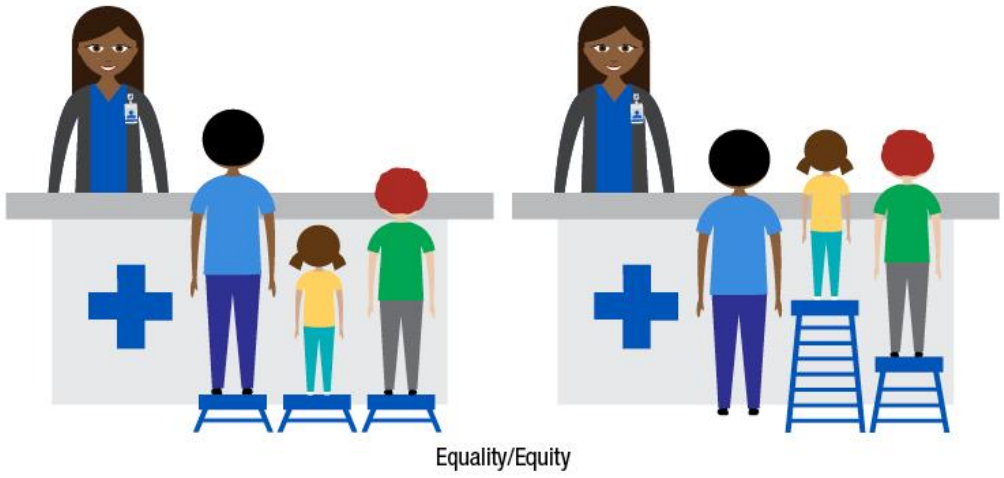
- Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance (2nd Edition). San Francisco: Jossey-Bass Publishers; 2009.
- Richie J. Rubio, Ph.D, San Francisco Department of Public Health CIN presentation, 2021

Critical Importance of Collecting Health Equity Data

- Health equity is a complex topic that looks beyond the clinical room and acknowledges that not all people, or all communities, are starting from the same place due to historic and current systems of oppression.

- REaLD, SOGI and other demographic data are some of the many essential data points that can help us identify disparities across access, cost, and quality of care.

- The collection of some health equity data (REaL) is becoming a requirement for many federal and state grants/quality programs.



What is Health Equity Data?

Health equity data (quantitative and qualitative) is the collection and analysis of various demographic, socioeconomic, and health-related data to **identify** and **address health disparities** and **inequities.**

- Race, Ethnicity, Language and Disability (REaLD) Sexual Orientation and Gender Identity (SOGI), other demographic characteristics
- Socioeconomic Factors (e.g., income, education level, employment status, housing)
- Social determinants of health (SDOH): community level factors like transportation and food security
- Health Outcomes and Utilization (e.g., clinical outcomes, utilization, patient experiences stratified)

Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9311469/

Data to inform QI

Understand	• How does the current system perform?
Predict	• What interventions might improve the performance of the current system?
Evaluate	• Did our interventions result in improvement? For all populations?
Monitor	• Are our improvements sustained over time?
Engage	• Are we considering what is important for others to know?

Stratification to Identify Disparities

Stratification

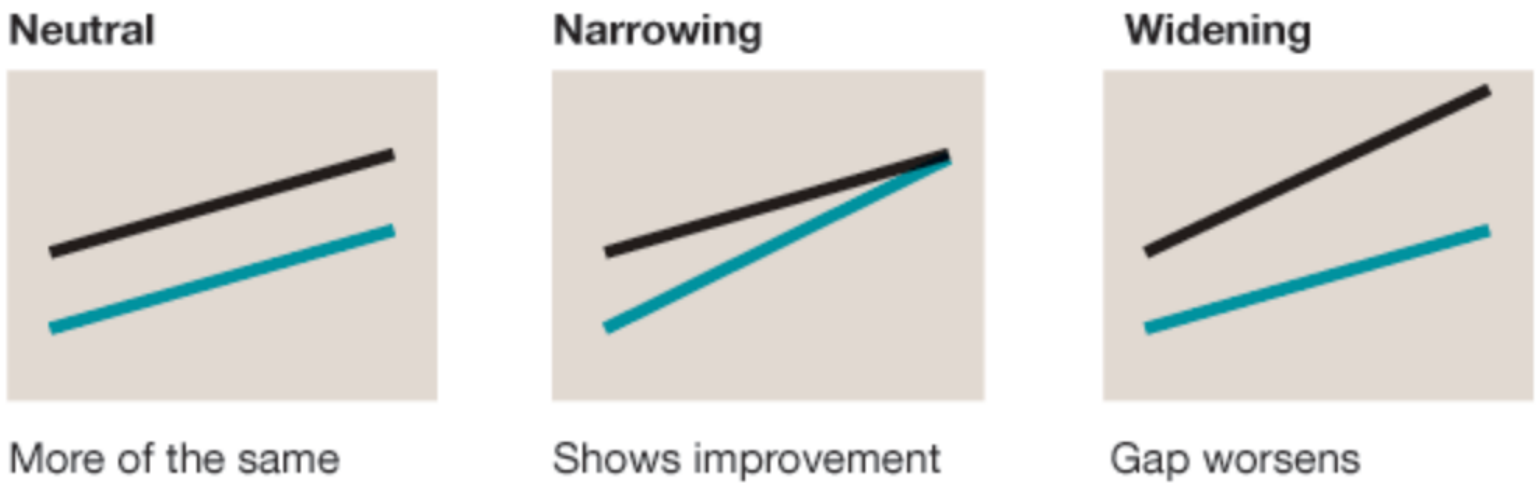
- Sorts data, people and objects into distinct groups or layers
- Used in combination with other data analysis tools
- Separates data so that patterns are clearly visible

Why Stratify Data?

- Identifies distinct groups within the data
  - Clinic sites
  - Provider
  - Teams
  - Health Equity
    - Patient demographics (e.g., age, Race, Ethnicity and/or Language)
    - Social Determinants of Health (e.g., access, quality, economic stability)
- Highlights health inequities and factors that drive them

Using QI Data to Address Inequities

- Ensure you are monitoring any new **gaps in quality** between patients of focus and general popualtion



Source: Solving Disparities

How Health Equity Data Helps Reduce Disparities

Identify disparities	Design targeted interventions	Monitor progress	Align with policy priorities	Enhance research and evidence
Disaggregating data reveals disparities that may be masked by aggregated data	Understanding specific health needs and barriers faced by marginalized populations enables the creation of tailored, equity-focused interventions and programs to address root causes of disparities	Ongoing collection and analysis of health equity data allows healthcare delivery systems track the impact of their efforts to reduce disparities and advance health equity	Federal and state initiatives, such as **Equity and Practice Transformation (EPT) Payment Program** are emphasizing the importance of collecting and using health equity data and this alignment helps healthcare organizations access resources and support for equity-focused work	Comprehensive health equity data can improve generalizability and applicability of clinical research by ensuring diverse representation

Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863701/
https://health.gov/healthypeople/priority-areas/health-equity-healthy-people-2030

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Health Equity Data Informs QI Strategies

How CQC is supporting efforts to address disparities

Statewide System Alignment

Advanced Primary Care

- Shared definition to strengthen primary care in the state (attributes & measures)

Public Purchasers

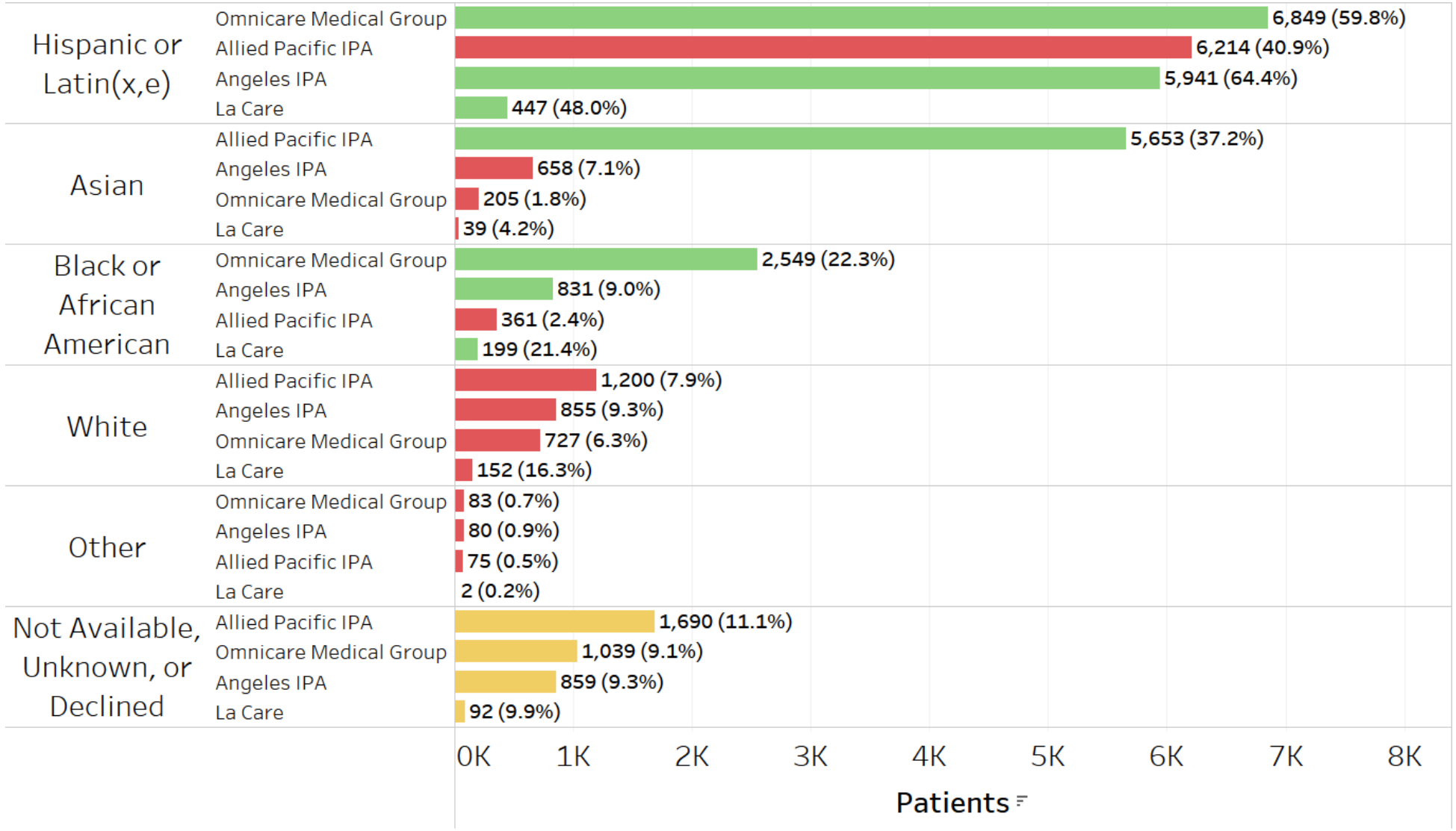
- Covered California, CalPERs and DMHC defined a common core of measures (represent 46% of CA)
- Requirements to stratify measures by race and ethnicity

Local Practice Transformation

Equity and Quality at Independent Practices in LA County (EQuIP-LA)

- Supporting 31 primary care practices across Los Angeles
- Advancing the equitable delivery of care provided to over 40,000 Medi-Cal enrollees of color

EQuIP-LA IPA Patient Demographics (Enrolled Practices)



***The Other category includes Alaskan or Native American, Hawaiian or Pacific Islander, and other**

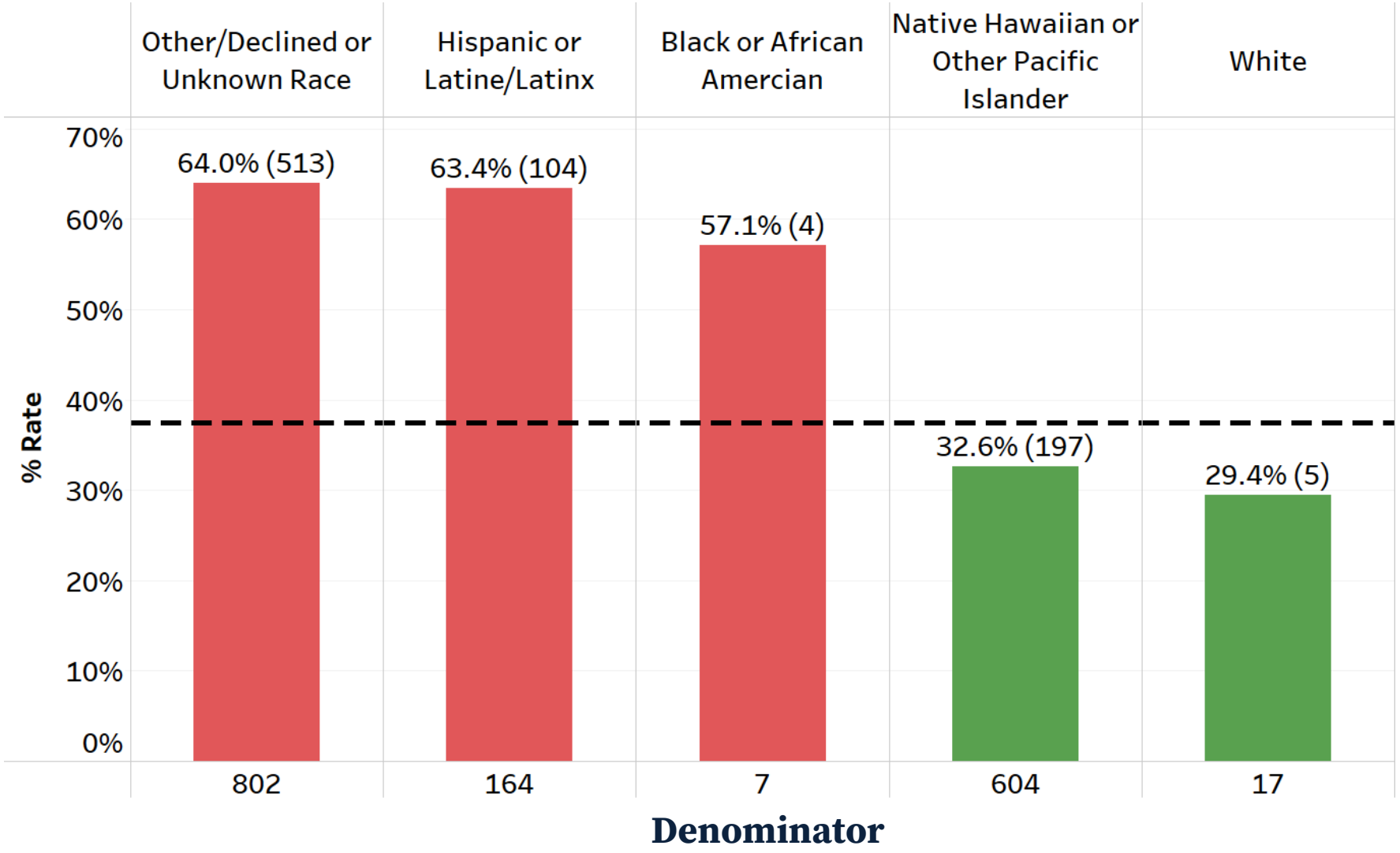
Comparison with LA County % Pop.	
	Higher than the LA County % Pop.
	Lower than the LA County % Pop.
	LA County % Pop. Not Available

EQuIP-LA IPA Outcome Measures

- The EQuIP-LA measures are pre-defined outcome measures that were selected during the design of the initiative

Measure	Measure Type	Improvement Notation	Medi-Cal Managed Care Accountability Set MY2023
Diabetes: HbA1c Poor Control (>9%)	Outcome	Lower Rate	X
Controlling High Blood Pressure	Outcome	Higher Rate	X
Colorectal Cancer Screening	Outcome	Higher Rate	X

Diabetes HbA1c Poor Control (>9%) Program's Baseline



Managed Medi-Cal State Average (37.5%)

Performing lower than the Managed Medi-Cal State Average

Performing higher than the Managed Medi-Cal State Average

Note: A lower rate indicates better performance for this measure

Community Medical Centers

Alyssa Arismendi-Alvarez, MPH, CPHQ, Director of Quality Improvement.

Invite You To An Open Dialogue

1. What insights do you or your organization have on the collection of REaL Data that have helped excel your health equity improvement efforts?

2. How can Quality Improvement teams effectively engage and partner with diverse stakeholders (e.g., providers, community-based organizations, patients, policymakers, etc.) to ensure that equity-focused measures are culturally appropriate, address the unique needs of different populations, and promote trust and buy-in from the communities they serve?

In Closing,

Actionable Next Steps

Conduct a Comprehensive Health Equity Data Assessment
Understand your current availability of health equity data within your organization

1. Does your existing data support disparity interventions?
2. Do you need to embark on additional data collection?

Continuously Monitor and Evaluate Progress

Establish specific goals that address an identified disparity and regularly utilize stratified data to monitor progress

Establish Partnerships and Collaborations

Identify approaches to incorporate direct input from patient/families/community into the design, implementation and evolution of your disparities reduction efforts

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CQC Supporting Your Disparities Reduction Efforts

California Quality Collaborative (CQC):

https://www.pbgh.org/program/california-quality-collaborative/

Sign up for the CQC Newsletter:

https://www.pbgh.org/cqc-newsletter-sign-up-page/

To learn more about CQC's technical assistance support, reach out to cqcinfo@pbgh.org

Our Thanks

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Appendix

Equity Focused Aim Statements

Specific	Measurable	Ambitious	Relevant	Time-Bound	Inclusive	Equitable
S	M	A	R	T	I	E

Original AIM Statement	Updated AIM Statement	Equity-focused AIM Statement
Seaside Clinic will improve depression screening rates for all patients.	By December 31, 2025, Seaside Clinic will decrease (by 80%) the gap between patients who have been screened by a PHQ-9 or PHQ-2, while improving depression screening rates for all patients (to 60%).	By December 31, 2025, Seaside Clinic will decrease (by 80%) the gap between (Hispanic and Non-Hispanic White) patients between the ages of 20 -50 years who have been screened by a PHQ-9 or PHQ-2, while improving depression screening rates for all patients (to 60%).
No **SMARTIE** Characteristics	**SMART** Characteristics	**SMARTIE** Characteristics

Cause and Effect (Fishbone) Diagram Template