# A Closer Look at Health Disparities in Clinical Care: Social Determinants

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Health Care Homes Learning Days

APRIL 9-10, 2019

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## OBJECTIVES

1. Understand how to collect social determinants of health data and identify how social determinants lead to health care disparities and impact patient access to care.

2. Describe strategies for analyzing social determinants of health and use data analysis methods to formulate action steps to reduce disparities and achieve optimal care.

## CHARACHTERISTICS

- Large Minnesota FQHC
- Over 37,000 unduplicated patients seen annually
- 40% remain uninsured
- Large percentage of non-English speakers
- Large percentage of low health literacy
- Scores on quality measures are below our goals.

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# QUALITY MEASURES BY MN MEDICAL GROUP 2017

## Optimal Diabetes Care (Medical Group

| Medical Group Name (Δ = Endocrinology) | Rate (Actual) | Lower Bound of 95% CI | Upper Bound of 95% CI | N |
|---|---|---|---|---|
| STATEWIDE AVERAGE | 44.8% | 44.6% | 44.9% | 295,049 |
| Meeker Memorial Clinic | 77.1% | 63.5% | 86.7% | 48 |
| Richard Schoewe MD LLC | 69.6% | 55.2% | 80.9% | 46 |
| Christopher J Wenner MD PA | 64.9% | 48.8% | 78.2% | 37 |
| Richfield Medical Group | 57.6% | 52.3% | 62.8% | 340 |
| Burnsville Family Physicians | 54.9% | 49.7% | 60.1% | 344 |
| Stillwater Medical Group | 54.4% | 52.5% | 56.2% | 2,870 |
| Fairview Health Services | 54.0% | 53.4% | 54.7% | 21,464 |
| Entira Family Clinics | 52.8% | 51.6% | 54.1% | 5,913 |
| Park Nicollet Health Services | 50.9% | 50.2% | 51.5% | 21,572 |
| HealthPartners Clinics | 49.7% | 49.0% | 50.5% | 17,930 |
| Allina Health Clinics | 48.9% | 48.4% | 49.4% | 41,241 |
| Dawson Clinic | [illegible] | [illegible] | [illegible] | [illegible] |
| Community University Health Care Center | 31.0% | 27.5% | 34.7% | 639 |
| Riverwood Healthcare Center | 30.1% | 27.1% | 33.3% | 840 |
| Sleepy Eye Medical Center | 30.1% | 24.9% | 36.0% | 259 |
| Raiter Clinic, LTD - IHN | 30.1% | 27.3% | 33.1% | 947 |
| Northfield Hospital + Clinics | 29.6% | 26.0% | 33.4% | 588 |
| Hennepin County Medical Center (HCMC) Clinics | 29.0% | 28.0% | 30.1% | 7,061 |
| Advanced Medical Clinic | 28.6% | 18.9% | 40.7% | 63 |
| Synergy Family Physicians, P.A | 28.3% | 18.5% | 40.8% | 60 |
| United Family Medicine | 27.9% | 25.4% | 30.4% | 1,224 |
| Kittson Memorial Clinic | 26.3% | 20.6% | 33.0% | 190 |
| Duluth Family Medicine Clinic | 26.3% | 22.1% | 31.0% | 373 |
| Neighborhood Healthsource | 25.3% | 21.6% | 29.4% | 470 |
| Lake Superior Community Health Center | 24.6% | 19.7% | 30.3% | 252 |
| North Valley Health Center | 24.4% | 17.8% | 32.6% | 127 |
| Williams Integracare Clinic | 24.0% | 18.1% | 31.0% | 167 |
| NorthPoint Health & Wellness Center | 23.2% | 21.1% | 25.4% | 1,523 |
| Indian Health Board of Minneapolis | 21.8% | 17.4% | 26.9% | 289 |
| Native American Community Clinic | 21.5% | 17.8% | 25.8% | 395 |
| West Side Community Health Services | 21.2% | 19.6% | 22.9% | 2,386 |
| Lakewood Health Center Clinic | 19.1% | 13.9% | 25.6% | 173 |
| Cedar Riverside People's Center | 18.7% | 15.6% | 22.2% | 541 |
| Axis Medical Center | 18.1% | 14.2% | 22.7% | 310 |
| Mille Lacs Health System | 18.0% | 15.1% | 21.2% | 612 |
| Parkview Medical Clinic - Minnesota Healthcare Network | 17.2% | 12.8% | 22.6% | 227 |
| Scandia Clinic | 13.3% | 9.1% | 19.0% | 181 |
| Open Cities Health Center | 11.9% | 9.9% | 14.3% | 813 |
| Open Door Health Center | 9.8% | 6.7% | 14.1% | 255 |

- Mostly anecdotal data on social determinants of health: on socioeconomic factors that could be affecting health, health disparities, health care inequities, and health inequities.
- SDOH Data Collection
  - Registration collected age, race, ethnicity, gender, some housing
  - Inadequate data collection on SDOH, such as insecurities around housing, legal, food, stress, medications, and transportation
- Patient experiences in clinical care indicated that these insecurities impact patient’s ability to access care, receive care, and improve health
- No clinic mechanism to collect SDOH data
- No ability to align SDOH data with quality measures, or patient’s problem list, or resources needed.

## Goals:

1. Create a strategy to identify social determinants of health (SDOH) that could be affecting clinical care at West Side.

2. Evaluate connections between SDOH and clinical care, particularly measures of preventive care and chronic diseases.

3. Implement practice changes to improve health equity, particularly for preventive care and chronic diseases.

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## SMALL GROUP DISCUSSION: INTRODUCTIONS

- Introduce yourself, your work place and your role

- State whether your clinic has yet:
  a. Discussed using an SDOH tool
  b. Decided on an SDOH tool
  c. Implemented SDOH tool, started collecting data
  d. Analyzed data
  e. Reviewed data
  f. Chosen projects based on data
  g. All of these
  h. None of these
  i. Other

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## HEALTH DISPARITIES AND HEALTH EQUITY AS PRIORITIES

- Disparities Leadership Program, Harvard University
  - Challenged us as an organization to evaluate our own progress in cultural humility strategic change
  - Followed the Kotter Model
  - Developed processes to collect data, evaluate data, and report data through an organization-wide Equity and Inclusion Dashboard

- Also, ongoing organizational change in order to reduce health disparities and improve health equity
  - Equity and Inclusion Council
  - Align results with strategic goals
  - Clinic wide trainings on cultural humility and biases

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# KOTTER MODEL

## SMALL GROUP DISCUSSION: PROCESS

- What has motivated you/ your clinic to measure SDOH?
- What tools did you consider using or decide to use?
- What has helped you be successful?
- What challenges have you met?
- How could the Kotter Model help you?

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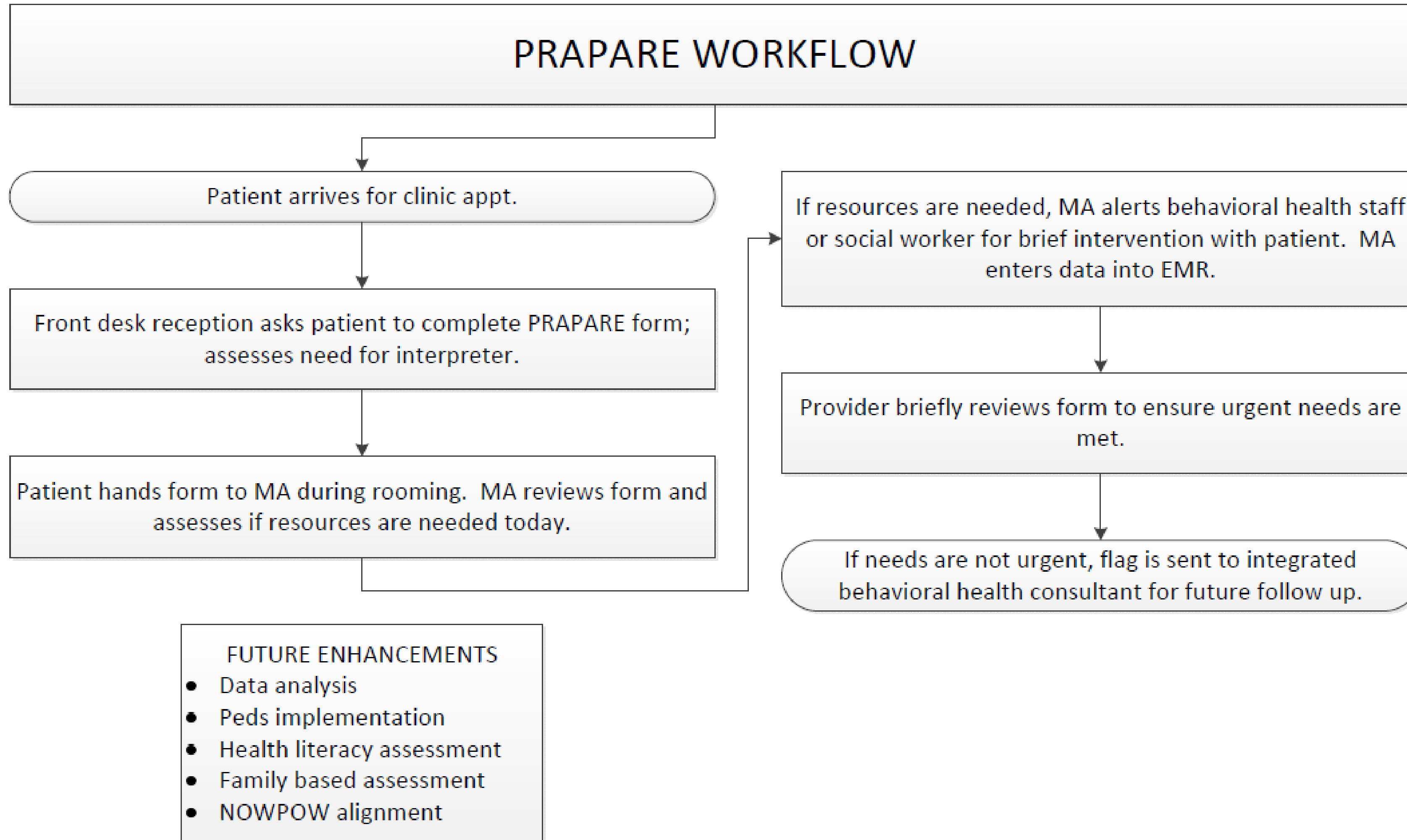
# PRAPARE TOOL

- PRAPARE: A NACHC tool to collect SDOH data. We adjusted questions to align with our patients and our clinic and added a question if urgent needs were identified
- General information: Migrant work, veteran status, household info, family income, education
- Resources: Challenges with food, utilities, child care, transportation, clothing, phone, legal services, or medicines
- Social and emotional health: Stress, social support, stress, corrections, access to care, paying for care
- Safety: Physical, emotional, domestic concerns
- Health literacy
- Do you want to meet with a social worker today?

- Reviewed NACHC best practices for implementation of data collection tool
  - Option A:  Interview individual patients (assessment model)
  - Option B:  Form completed at time of registration (data collection model)
  - Option C:  Hybrid of above two options
- Designed workflow for Option B
- Ensured that tool fit with EMR entry format
- Registration staff gave to patients to complete
- MAs entered into EMR.


PRAPARE WORKFLOW
Patient arrives for clinic appt.
Front desk reception asks patient to complete PRAPARE form; assesses need for interpreter.
Patient hands form to MA during rooming. MA reviews form and assesses if resources are needed today.
If resources are needed, MA alerts behavioral health staff or social worker for brief intervention with patient. MA enters data into EMR.
Provider briefly reviews form to ensure urgent needs are met.
If needs are not urgent, flag is sent to integrated behavioral health consultant for future follow up.
FUTURE ENHANCEMENTS
Data analysis
Peds implementation
Health literacy assessment
Family based assessment
NOWPOW alignment

## SMALL GROUP DISCUSSION: PRAPARE TOOL

- Look at PRAPARE tool.
- How might the PRAPARE tool help your/ your clinic?
- What changes might you have to do?

# OVERALL INFORMATION COLLECTED

- We have given to adult populations at largest clinical sites only
- 2,411 people have completed forms
- We are aligning SDOH data with quality of care measures
- We are starting to analyze the data to inform practices for preventive care and chronic disease management.

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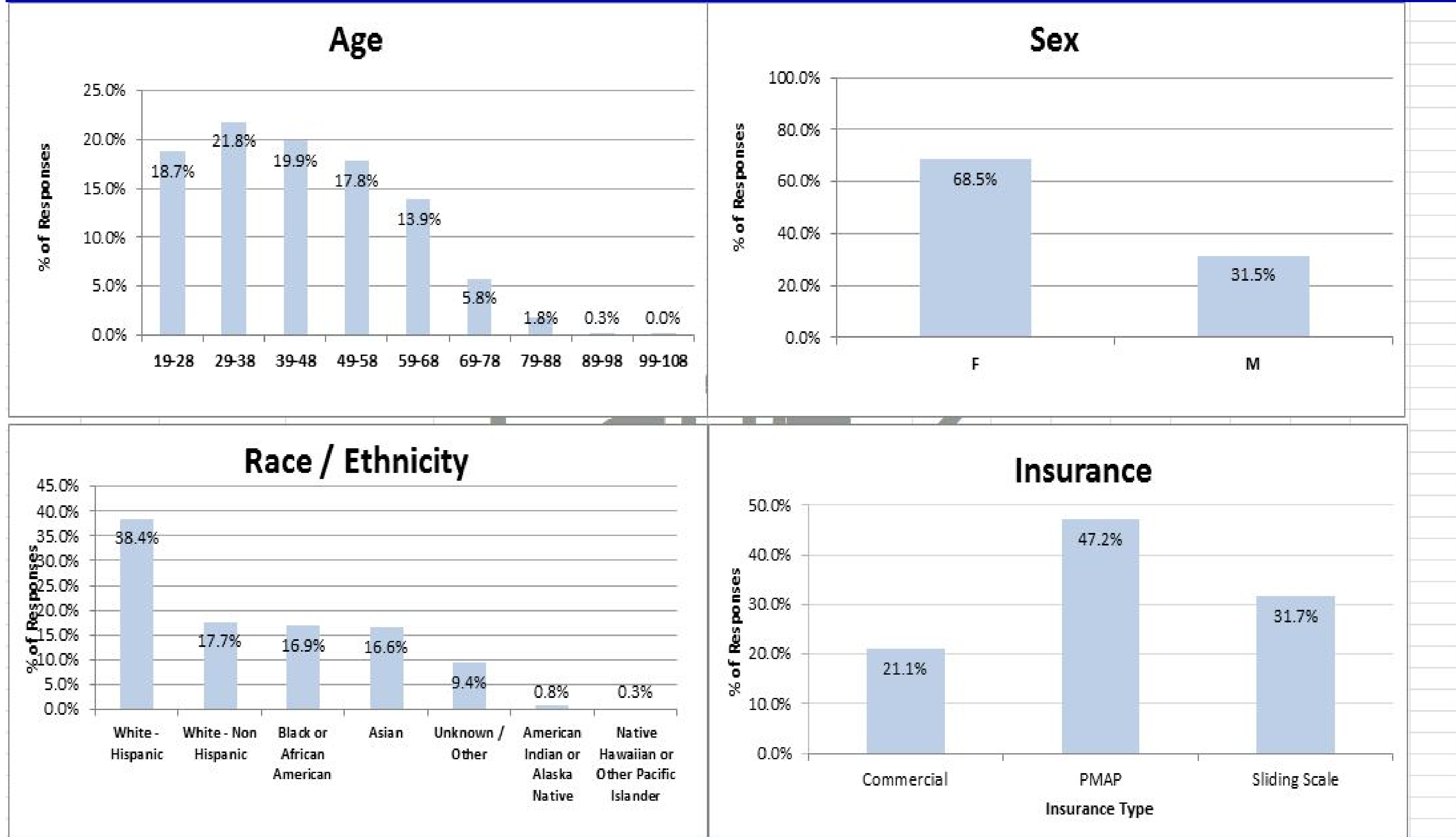
# OVERALL INFORMATION: AGE, GENDER, RACE/ETHNICITY FOR PRAPARE



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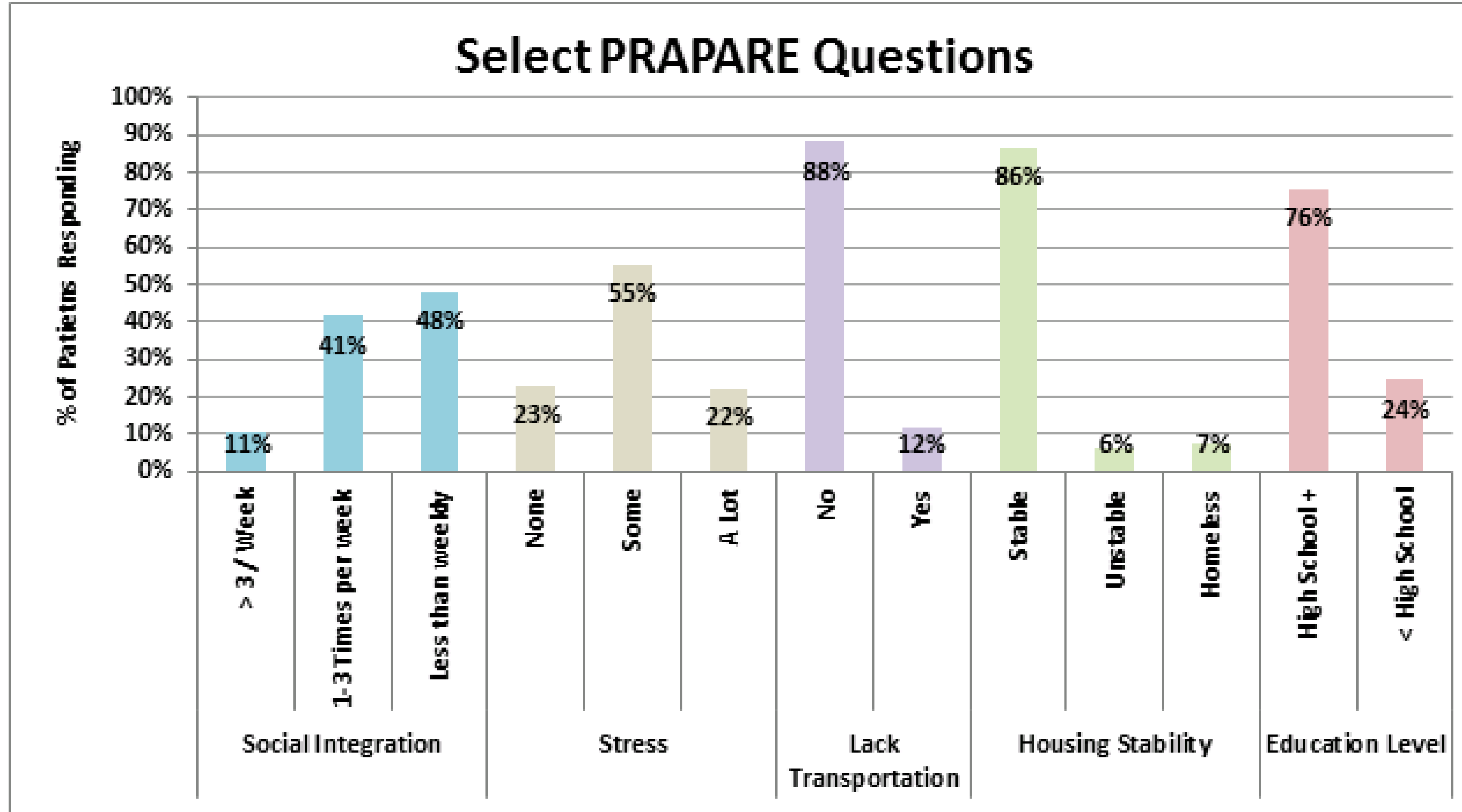
# OVERALL INFORMATION



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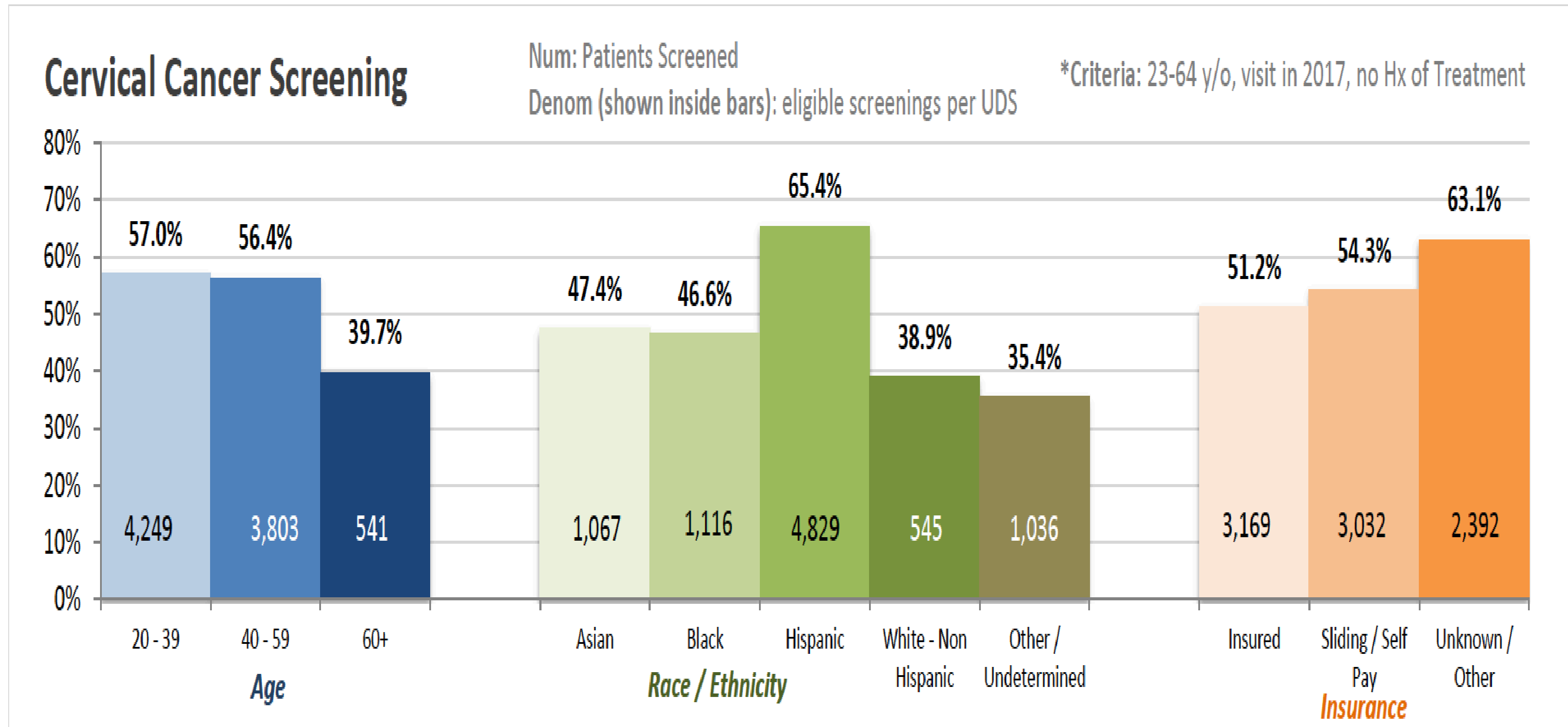
# PREVENTION EXAMPLE: CERVICAL CANCER SCREENING



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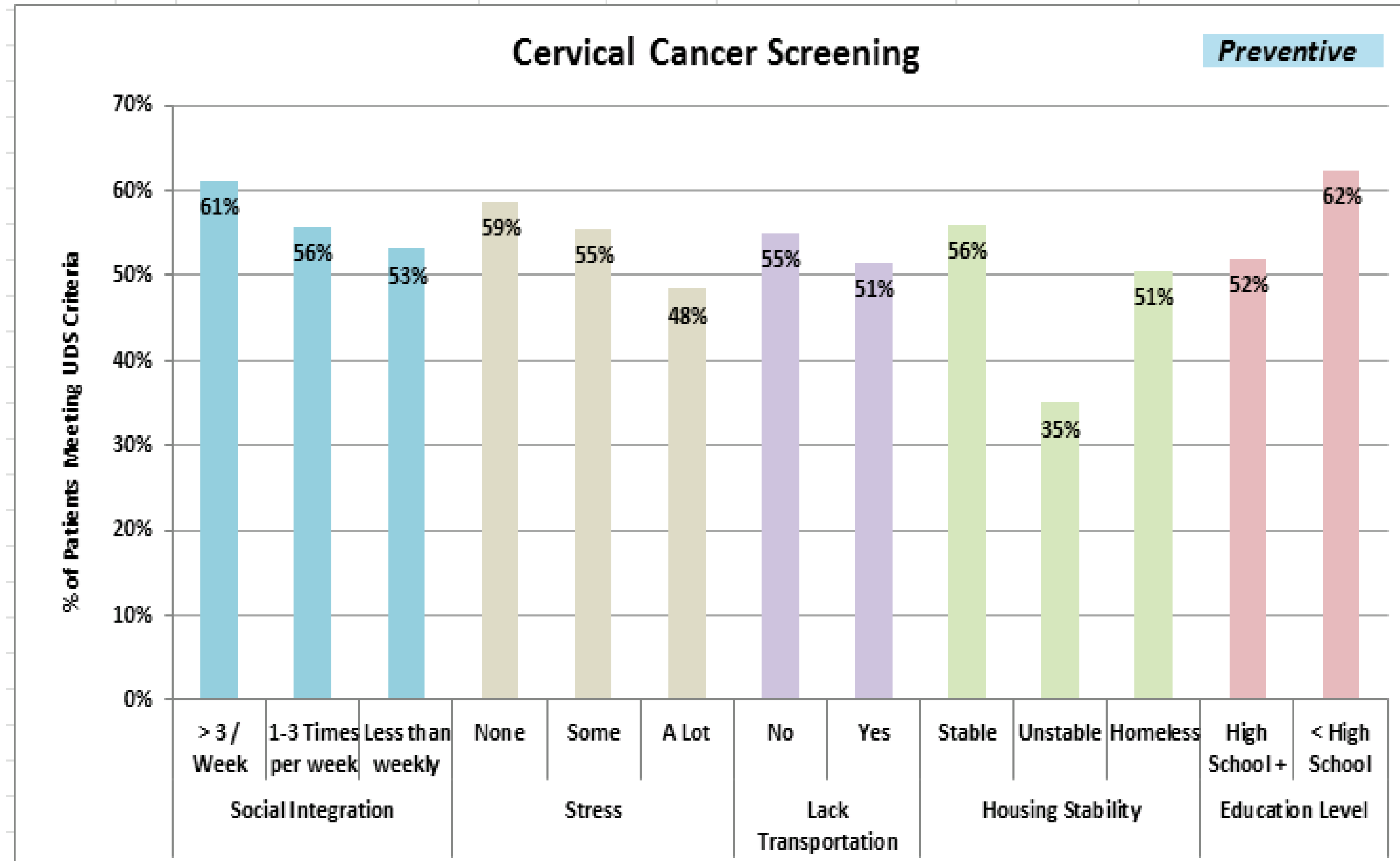

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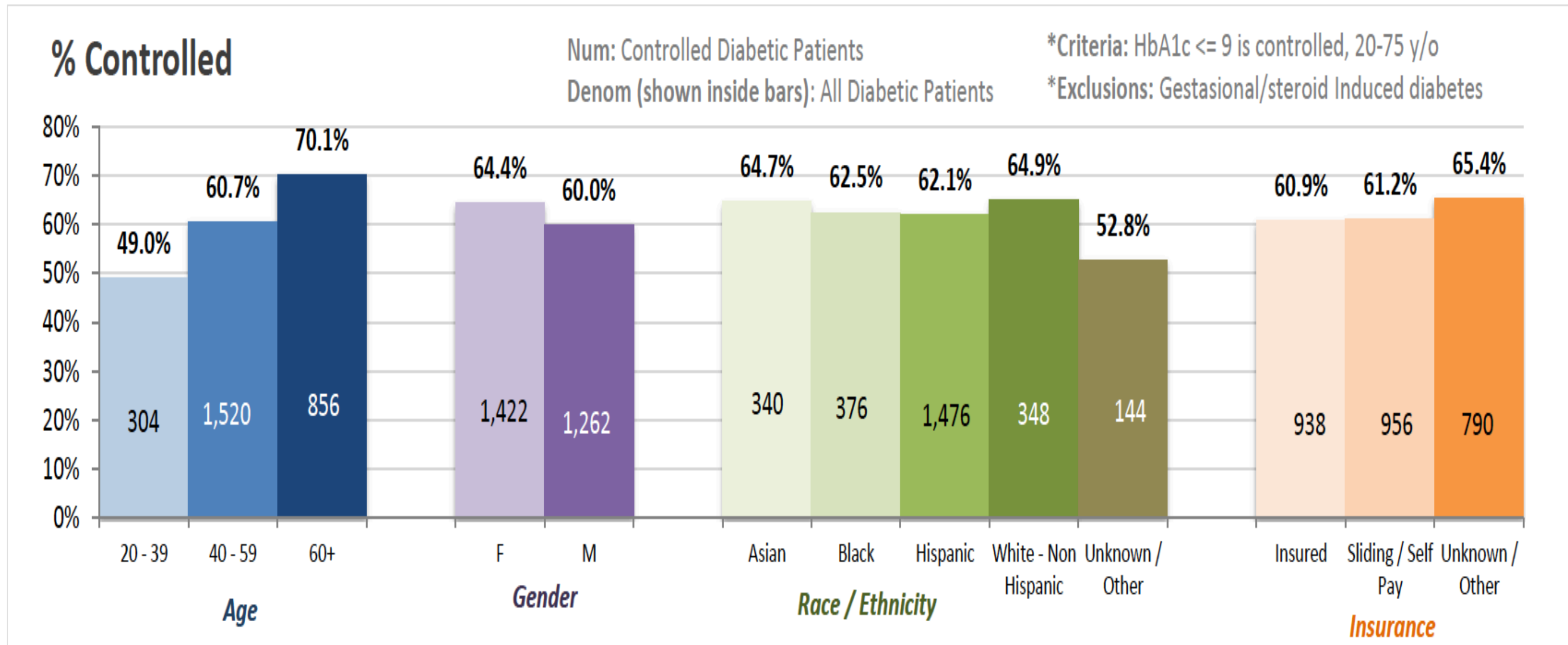
# CHRONIC DISEASE EXAMPLE: DIABETES MELLITUS

## UDS Diabetes



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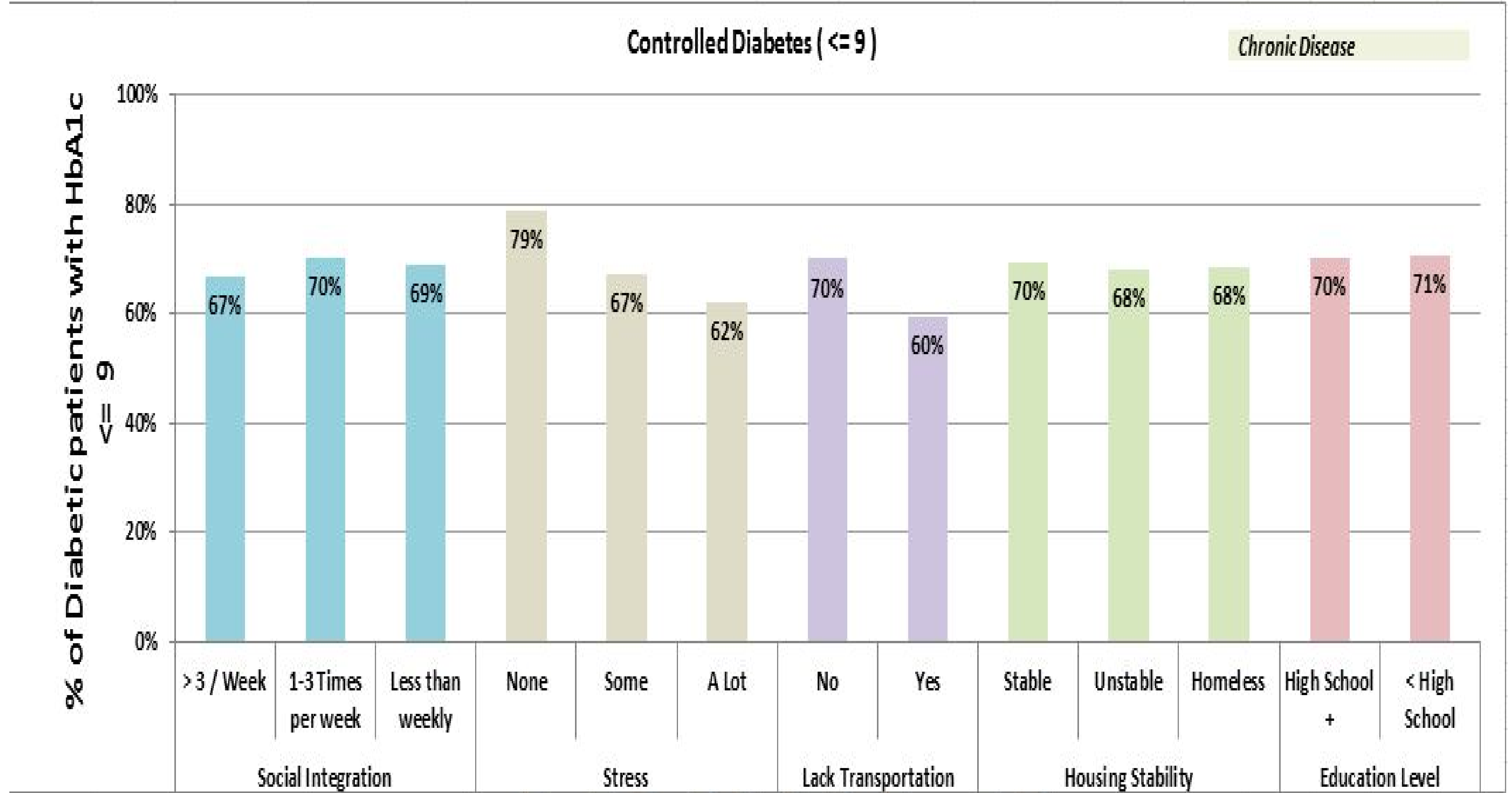

## NEXT STEPS

- #1 Expand data collection:
  Collect data for all populations at all sites
  - School based clinics
  - Homeless clinics
  - Pediatrics

- #2 Identify resources to respond to needs:
  Implement NOWPOW and align with resource data

- #3 Evaluate results to identify clinical interventions
  Will support clinical processes in clinical care redesign

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## SMALL GROUP DISCUSSION: APPLICATION

- How might this type of data and analysis help you and your clinic to improve quality care, address health disparities and move towards health equity?

- Create a draft plan:
  1. Kotter Model
  2. Tool choice and adjustment
  3. Implementation
  4. Data analysis

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# QUESTIONS?