

Wednesday, July 31, 2024

1:00pm - 3:00pm

MetroHealth Brooklyn Heights Campus or via Zoom

Health Equity & Diversity Committee

Regular Meeting

HEALTH EQUITY & DIVERSITY COMMITTEE

DATE: Wednesday July 31, 2024

TIME: 1:00 pm - 3:00 pm

PLACE: Zoom:

https://us02web.zoom.us/j/83728485171

AGENDA

I. Approval of Minutes

Committee Meeting Minutes of March 27, 2024

II. Introduction/Opening Remarks – M. Dee

III. Information Items

- 1. Health Equity Strategy Retreat Recap and MH Health Equity Steering Committee Launch *Dr. Merugu*
- 2. Health Equity Performance Update
 - a. Lown Institute 2024 Rankings K. Chagin
 - b. Health Quality Update with Health Equity Data Dr. Golob
- 3. Health Equity Centers of Excellence Dr. Modlin
- 4. Joint Commission and NCQA Health Equity Accreditation Dr. Modlin
- 5. Medical Diversity & Inclusion Initiatives Dr. Moreland

HEALTH EQUITY & DIVERSITY COMMITTEE REGULAR MEETING

Wednesday, March 27, 2024 1:00pm – 2:00pm via Zoom

Meeting Minutes

Present: Inajo Davis-Chappell-R, John Corlett-R, Maureen Dee-R, John Moss-R,

Vanessa Whiting-R ¹

Staff: Airica Steed, Ed.D.-R, Ifeolorunbode Adebambo, M.D.-R, Christine

Alexander, M.D.-R, Arlene Anderson-R, Bridget Barrett-R, Jim Bicak-R, Robert (Doug) Bruce, Kevin Chagin-R, Nabil Chehade, M.D.-R, John Chae, M.D.-R, Karen Cook-R, Justin Gallo-R, Joseph Golob, M.D.-R, Olusegun Ishmael, M.D.-R, Kimberly Green-R, Derrick Hollings-R, Ryan Johnson-R, Melissa Kline-R, Charles Modlin, M.D.-R, Tamiyka Rose-R, Dalph Watson-R

Guest: Ms. Bridget Barrett-R, Ms. Jasmine Boutros-I, Ms. Shannon Boutros-I, Ms.

Suzanne Boutros-R, Ms. Tess Boutros-R, Ms. Gail Long -I, Mr. Dalton Perry-

R, Ms. Sabrina Roberts-I

Ms. Whiting called the meeting to order at 1:01 pm, in accordance with Section 339.02(K) of the Ohio Revised Code.

(The minutes are written in a format conforming to the printed meeting agenda for the convenience of correlation, recognizing that some of the items were discussed out of sequence.)

I. Approval of Minutes

The minutes of the December 20, 2023, Committee meeting were approved as presented.

II. Information Items

A. Opening Comments

Ms. Whiting expressed excitement to start the Health Equity Committee's work which will focus on creating a national model to eradicate health disparities and ensure quality healthcare access for everyone, regardless of zip code or demographics.

¹ I-In-person, R-Remote



B. Introduction of New Health Equity Team Members

Dr. Modlin introduced two new members of the Health Equity team, LaShon Carson and Michele Davis-Ishmael.

Ms. Carson is a 20-year veteran project manager who has worked on creating Employee Business Resource Groups (EBRGs) and facilitating implicit bias training and cultural competency education for MetroHealth caregivers. She is currently a Master of Public Health student at Baldwin Wallace University and will graduate with her MPH degree this May.

Michele Davis-Ishmael joined the team as the Executive Director of Health Equity and Community Engagement, working with Dr. Golob's teams to achieve Joint Commission health equity accreditation. Ms. Davis-Ishmael has a MBA in healthcare management is a Registered Nurse.

C. Review of Enterprise Health Equity Strategy

Dr. Chehade introduced Dr. Srinivas Merugu, the incoming SVP and President for the Institute for H.O.P.E. (the "Institute") and discussed the Institute's strategy for improving health outcomes of underrepresented populations, particularly in the Glenville neighborhood.

The Institute will be the cornerstone for achieving MetroHealth's health equity strategy by integrating health equity into the center of everything they do. This will include working with clinical practices to identify specific care gaps and developing plans to not only close these gaps, but to also measure, monitor, and improve processes that address these disparities.

Dr. Steed challenged the Institute to become a global model in addressing and eradicating health inequities and discussion focused on making it a priority to align efforts with businesses, private and public partnerships, faith-based organizations, government, and schools.

Dr. Steed also challenged the organization to build a Health Equity Information Center, which is already in development. It was noted that Ryan Johnson and Kevin Chagin have significantly contributed to this work over the past four years, emphasizing that this work is iterative and will continue to evolve as new data becomes available, new partnerships are formed, and expanded geographic areas are connected. The Center will act as a hub for all available information to support the health equity goals of the Institute.



The Committee discussed the overarching goal to outline a bold vision for health equity and demonstrate how MetroHealth is working towards eradicating healthcare disparities through the Center using a purposeful, data-driven approach.

Furthermore, it was discussed that the focus on Social Determinants of Health (SDOH) remains crucial, as more than 80% of the impact on health equity lies beyond the walls of the hospital system. The Committee noted that fundraising support from both public and private funding sources will be required to achieve the desired impact and highlighted ambitious goals of the Health Equity Cleve Fund.

D. Health Equity Marketing Overview

Ms. Barrett and Dr. Modlin discussed the marketing strategies and interventions at MetroHealth's fairs and wellness clinics. MetroHealth is committed to addressing healthcare disparities and increasing trust in the nation by ensuring access to care, enhancing it with wraparound services like transportation and social services. Further, the People-First Culture at MetroHealth emphasizes combining clinical excellence with a commitment to equity, ensuring every innovation and treatment is developed with people's needs at the forefront.

The Institute is focusing on scaling initiatives through the Health Equity Cleve Fund, including investing in community health workers and establishing community advisory councils. MetroHealth is partnering with local small businesses, often minority-owned, to offer door-to-door services, mirroring a white-glove service model. The Cleve Fund is currently in its soft launch phase, with a fundraising event scheduled for September 2024.

Dr. Modlin discussed health and wellness interventions, including the Men's Health Fair, which will mark its 20th anniversary on April 27th. Further, MetroHealth has introduced Multicultural Health Equity Centers of Excellence within every clinical department across the organization to promote health equity.

E. Update on Joint Commission and CMS Health Equity Accreditation

Dr. Golob and Dr. Chehade discussed the Joint Commission CMS Health Equity accreditation, which has evolved significantly to become a national patient safety goal. MetroHealth meets and exceeds these standards, including designating a hospital leader for Health Equity activities, gathering SDOH data, identifying disparities using data, having a written plan to address disparities, and regularly educating hospital leaders and staff about Health Equity.



The accreditation standards highlight MetroHealth's early stages of Health Equity on a national scale and its prioritization of initiatives.

The Joint Commission introduced the Healthcare Equity Certification program in July 2023, and MetroHealth is actively pursuing this certification. The effort will involve all teams, including the accreditation office, as health equity needs to be integrated into daily operations. The goal is to establish MetroHealth as the gold standard in health equity.

With no further questions from the Board members in attendance, the meeting was adjourned at approximately 2:02 pm.

NEXT MEETING: Wednesday, July 31, 2024 – 1:00pm - 3:00pm

MetroHealth Brooklyn Hts. Campus and via Zoom

THE METROHEALTH SYSTEM

Vanessa Whiting, Chairperson





Health Equity Strategy Retreat

July 17, 2024



"Of all the forms of inequality, injustice in health is the most shocking and the most inhuman because it often results in physical death."

Agenda



8:30 AM- Light Breakfast

9:00 AM- Ice-Breaker

9:10 AM- Mission Alignment & Call to Action

Dr. Steed

9:20 AM- Goals and Objectives for Today's Meeting

Dr. Merugu

9:25 AM- Defining Health Equity

Dr. Merugu

9:30 AM- Overviews of Existing Health Equity Strategies & Linkages to System Priorities and Health Equity Accreditation

Dr. Modlin, Romona Brazile, Will Dube, Bridget Barrett, Dr. Golob

10:20 AM- Break

10:30 AM- Group Discussion & Break-Outs

11:00 AM- Working towards a Community-Centered Health Equity Strategy

Dr. Merugu, Community Engagement team

Health Equity and Diversity Steering Committee

Purpose (Draft – to be discussed, finalized and adopted)

The Health Equity and Diversity Steering Committee will provide oversight and direction on how community–centered health equity practices are integrated into organizational decisions and operations.



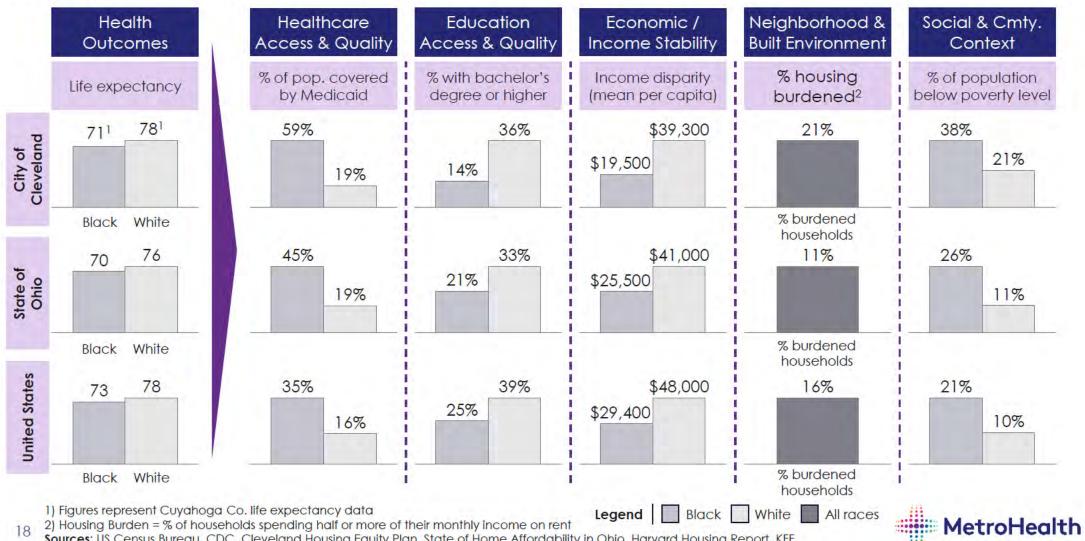
Health Equity and Diversity Steering Committee - Representation

- Provider Enterprise
- Nursing
- Finance
- Quality
- Operations
- Data
- Government Relations
- Foundation

- Ethics/Compliance
- Community Engagement
- Community Development
- HR
- Research
- Communications
- Marketing
- Strategy

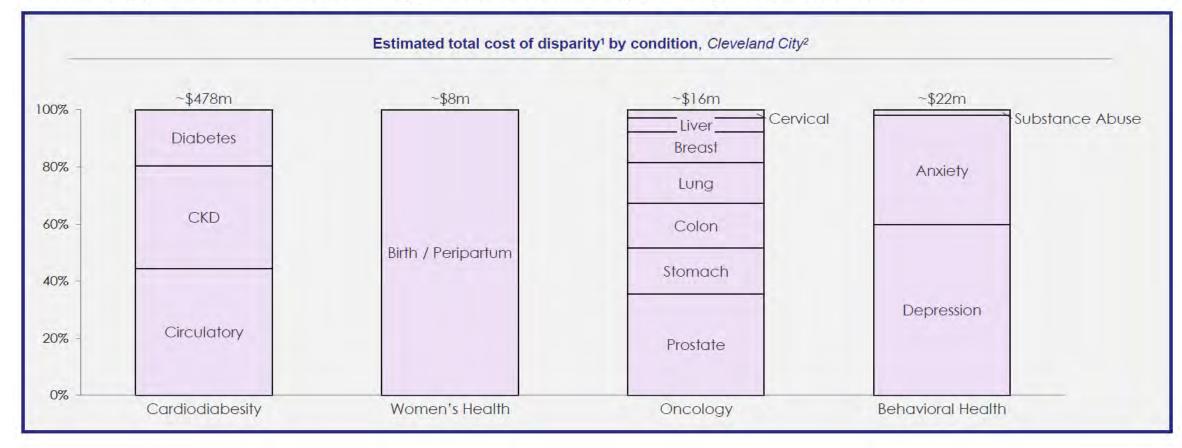


Cleveland health outcomes and socioeconomic indicators differ from Ohio averages in a significant way



Sources: US Census Bureau, CDC, Cleveland Housing Equity Plan, State of Home Affordability in Ohio, Harvard Housina Report, KFF

Estimated total cost of health disparities across Cleveland surpass \$500 million annually, with Cardiodiabesity as the most costly of disparate outcomes



^{1.} The total cost of disparity is estimated under the basis of improving the performance of race/ethnicity minorities (e.g., Black, Hispanic, AIAN, AAPI) to the non-White Hispanic performance against key health measures; the resulting value is then multiplied by the average incremental cost for the bad outcome (e.g., pre-term birth costs ~\$51k more than a term birth inclusive of medical and non-medical costs)

^{2.}The makeup of Cleveland City's population base by race/ethnicity, age, and gender was used to estimate total cost of disparity based on US
19 Census Bureau data (2022)



Another small step



Applications

Departments

Information

Policy & Reference

Medical Staff



Institute for H.O.P.E. Helps Bridge Gaps in Cleveland's Digital Literacy Through New Position

7/22/2024



MetroHealth is proud to partner with DigitalC to co-host a Digital Navigator role at the health system as part of the City of Cleveland's initiative to provide affordable and accessible internet connectivity to residents. The program aims to drastically improve Cleveland residents' connectivity by helping community members find low-cost internet and technology as well as providing digital literacy courses and support.

Shartina Caver joined MetroHealth's Institute for H.O.P.E.² as the program's Digital Navigator in February 2024 and has helped Cleveland residents through programming at the Opportunity Center at Buckeye Health Center. Each week, she hosts several classes using Northstar's Digital Literacy curriculum and serves as a general resource about technology for the community.

This program is a response to the large digital divide in Cleveland. In 2019, Cleveland was ranked the worst-connected big city in the United States, spurring legislators and local leaders into action. The city ultimately awarded DigitalC a \$20 million contract to expand broadband wireless networks in Cleveland and educational programs about digital literacy. The initial funding for the Digital Navigator position was provided through this partnership.



Review of 2024 Lown Institute Social Responsibility Rankings



July 31, 2024

Current Ranking

2024 Social Responsibility Score

Social Responsibility



Reflects the performance across health equity, value and outcomes.

NATIONAL 53 of 2758 (Duke is #1)

STATE 2 of 106 (UH Elyria is #1)

2023 Social Responsibility Score

Social Responsibility



Reflects the performance across health equity, value and outcomes.

NATIONAL 325 of 3637

STATE 13 of 132

Lown Institute

What is the Lown Institute?

An independent think tank that advocates for equity within healthcare.

"Doing what is best for people by identifying and promoting healthcare systems who care for those most in need."

Highlight healthcare systems and providers who are addressing **equity within care, accountability, low-value care and human connection** by:

- Conducting Research
- Lead conversations
- o Rank healthcare systems who are the most socially responsible

Lown Institute Ranking

Since inception, they have evaluated over 4,000 healthcare systems with publicly available information ranging from 2019 to 2023

Performance measured across:

Equity

Commitment to equity, inclusion, and community Health

Pay Equity

Ratio of executive compensation to worker wages

Community Benefit

Measures the hospital's investment within the community

Inclusivity

Extent to which patients being served are demographically similar based on Income, Race and Education

Value

Avoidance of use of low-value services and cost efficiency

Avoiding Overuse

Avoidance of inappropriate tests/procedures

Cost Efficiency

Risk-adjusted clinical outcomes over cost per patients adjusted for local cost of living and labor cost at 30 days and 90 days

Outcomes

Performance as it relates to patients' health and experience of care

Clinical Outcomes

Measure patient mortality during hospital stay and readmission rates

Patient Safety
Measures patient safety through established indicators on the CMS Care Compare website

Patient Satisfaction

Measures patient satisfaction from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)



2023 vs. 2024 Rankings

2023 MetroHealth had a grade of:

A

National Ranking: 325 of 3637

Ohio Ranking: 13 of 132

For <u>2024</u> MetroHealth had a grade of:



1 National Ranking: 53 of 2758

† Ohio Ranking: 2 of 106

What has Changed in the Methodology?

- Created separate rankings for short-term acute care and critical access hospitals Note: MetroHealth is ranked as an acute care hospital, not a hospital system.
- Shifted weighting of the index to place a **higher emphasis on Equity and less on Outcomes**.
- The ratio of CEO pay to average worker pay

Previously - Worker pay was based on nonmedical HCRIS wage categories.

Now - CEO hourly pay is compared to the **housekeeping average hourly wage** to better reflect the

lowest paid workers.



2024 Domain Rankings

Equity

Pay Equity



National Ranking: **2417** of 2780

Ohio Ranking:

94 of 106

National Ranking: **90** of 2752

Community Benefit

Ohio Ranking:

Equity



National Ranking: 250 of 2616

Ohio Ranking:

6 of 105

Value

Avoiding Overuse



National Ranking:

Ohio Ranking:

1 of 105

Cost Efficiency



A

National Ranking: 302 of 2768

Ohio Ranking: **13** of 106

Outcomes

Improved Domains

Clinical Outcomes



National Ranking: 935 of 2784

Ohio Ranking:

28 of 2593

60 of 106

Patient Safety



National Ranking: 1560 of 2173

Ohio Ranking:

59 of 82

Patient Satisfaction



National Ranking: 1484 of 2717

Ohio Ranking:

76 of 135



Appendix



Change in Patient Safety

Outcomes

Reflect performance as it relates to patients' health and experience of care

Patient Safety

Use indicators from the CMS Care Compare website for hospitalizations

CMS composite measure (PSI-90) that hat has 10 separate indicators for patient safety as well as 5 hospital acquired infection (HAI) measures from July 2019- March 2022

2024 Scoring

NATIONAL

1560 of 2173

STATE

59 of 82

Central line-associated bloodstream infections (CLABSI)

Catheter-associated urinary tract infections (CAUTI)

Surgical site infection: Major colon surgery

Methicillin-resistant Staphylococcus aureus (MRSA)

Clostridioides difficile (C. diff)

PSI 90: CMS patient safety and adverse events composite











2023 Scoring



NATIONAL

1969 of 2255

STATE

80 of 90

Central line-associated bloodstream infections (CLABSI)

Catheter-associated urinary tract infections (CAUTI)

Surgical site infection: Major colon surgery

Methicillin-resistant Staphylococcus aureus (MRSA)

Clostridioides difficile (C. diff)

PSI 90: CMS patient safety and adverse events composite















Outcomes

Reflect performance as it relates to patients' health and experience of care

Patient Satisfaction

uses the annual Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey to give a rating of patient experience across 10 factors from July 2021 to March 2022

2024 Scoring

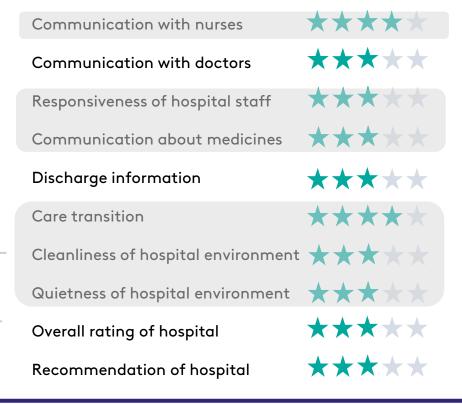


NATIONAL

1484 of 2717

STATE

76 of 135



2023 Scoring



NATIONAL **2631** of 3379

STATE

120 of 135

Communication with nurses Communication with doctors Responsiveness of hospital staff Communication about medicines Discharge information Care transition Cleanliness of hospital environment Quietness of hospital environment Overall rating of hospital **** Recommendation of hospital



Important Note for Each Metric

Important Call-Outs:

- Measurement of health equity is only a small part of the social responsibility ranking.
- The information that goes into each of the metrics are historical and some incorporate a range of information.

Date Range for Data Sources by each Category within the Metric

Metric	2024 Methodology	2023 Methodology
Pay Equity	2021	2020
Community Benefit	2021	2020
Inclusivity	2021-2022	2021
Avoiding Overuse	2019-2022	2019-2021
Cost Efficiency	2020-2022	2019-2021
Clinical Outcomes	2019-2022	2019-2021
Patient Safety	July 2020-March 2023	July 2019-March 2022
Patient Satisfaction	April 2022-March 2023	July 2012-March 2022

• All information comes from public sources and if not available the metric is omitted from the overall ranking.

MetroHealth does not have information available in Community Benefit

Other information is based on CMS measurements only



There are 3 categories for measurements

Equity

Reflects commitment to equity, inclusion, and community Health

Pay Equity

Ratio of executive compensation to worker wages

Community Benefit

Measures the extent of hospital investment in

- 1) financial assistance as a share of total expense
- 2) community investment as a share of total expense
- 3) Medicaid revenue as share of net patient revenue

Inclusivity

Extent to which patients being served are demographically similar based on Income, Race and Education

Value

Reflects the avoidance of use of low-value services and cost efficiency

Avoiding Overuse

Avoidance of inappropriate tests/procedures

- Knee arthroscopy
- Carotid endarterectomy
- · Carotid artery imaging for fainting
- EEG for headache
- EEG for fainting
- Colonoscopy screening
- Inferior vena cava filters
- Spinal fusion and/or laminectomies
- Coronary artery stenting
- Renal artery stenting
- Head imaging for fainting
- Vertebroplasty

Cost Efficiency

Risk-adjusted clinical outcomes over cost per patients adjusted for local cost of living and labor cost at 30 days and 90 days

Outcomes

Reflect performance as it relates to patients' health and experience of care

Clinical Outcome

Measure patient mortality during hospital stay and at 30- and 90-days after discharge and readmission rates at 7- and 30-days

Patient Safety

Measures patient safety through established indicators on the CMS Care Compare website

Patient Satisfaction

Measures patient satisfaction from the CMS Care Compare which looks at 10 factors from the annual Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)



Rang of data

Date Range for Data Sources by each Category within the Metric

Metric	2024 Methodology	2023 Methodology	Same Data Sources Used
Pay Equity	2021	2020	Yes
Community Benefit	2021	2020	Yes
Inclusivity	2021-2022	2021	Yes
Avoiding Overuse	2019-2022	2019-2021	Yes
Cost Efficiency	2020-2022	2019-2021	Yes
Clinical Outcomes	2019-2022	2019-2021	Yes
Patient Safety	July 2020-March 2023	July 2019-March 2022	Yes
Patient Satisfaction	April 2022-March 2023	July 2012-March 2022	Yes

Notable Methodology Changes:

- Lown created separate rankings for short-term acute care and critical access hospitals to ensure that ranks
 and grades are relative to a peer group. Note: MetroHealth is ranked as an acute care hospital, not a hospital
 system.
- The Equity category has more weight (30% to 40%), and the Outcome category weight has decreased (40% to 30%) this year, which improves our ranking position.
- Pay Equity: The ratio of CEO pay to average worker pay
 - <u>Previously</u> Worker pay was based on nonmedical HCRIS wage categories.
 - Now CEO hourly pay is compared to the housekeeping average hourly wage to better reflect the lowest paid workers.

Equity

Reflects commitment to equity, inclusion, and community Health

Pay Equity

Ratio of CEO compensation over the average lower wage staff pay, such as janitorial staff, kitchen staff, and medical records personnel (anyone with specialized degrees were removed i.e. nurses and physicians).

CEO compensation was collected from

- For-profit/publicly-traded hospitals: Security and Exchange Commission's Edgar database
- Public/non-Federal hospitals: available public records data
- Nonprofit hospitals: IRS 990 filings 2020

Worker compensation was collected from CMS Cost Report Information System (HCRIS)

2024 Scoring



NATIONAL	2417 of 2780
STATE	Q4 of 106



2023 Scoring



NATIONAL	3081 of 3923
STATE	127 of 140

Star Rating





Equity

Reflects commitment to equity, inclusion, and community Health

Community Benefit

Financial Assistance – Provide free or discounted care provided to patients eligible for assistance based on their income as a share of total hospital expenses from Centers for Medicare and Medicaid's Hospital Cost Reports (HCRIS) for 2020

Community Investment - measured hospital spending on community investment, as a share of total functional expenses, using Fiscal Year Ending 2020 or the most recent year available of Internal Revenue Service (IRS) Forms 990 Schedule H and include

Medicaid Revenue – measures net Medicaid revenue as a proportion of net patient revenue using HCRIS data for 2020.

2024 Scoring



 NATIONAL
 90 of 2752

 STATE
 2 of 106

Star Rating

Financial assistance

Community investment

Medicaid revenue share

DATA UNAVAILABLE



2022 Scoring



NATIONAL **258** of 3680

STATE **6** of 135

Star Rating

Financial assistance

Community investment

Medicaid revenue share

DATA UNAVAILABLE



Equity

Reflects commitment to equity, inclusion, and community Health

Inclusivity

Measures the degree to which a hospital's patient population reflects the demographics of its community area.

Information is pulled from inpatient admissions recorded in the Medicare Provider Analysis and Review (MEDPAR) and US Census in 2021.

2024 Scoring



NATIONAL	250 of 2616
STATE	6 of 105

Star Rating

Financial assistance

Community investment

Medicaid revenue share



2023 Scoring



NATIONAL	243 of 3533
STATE	6 of 136

Star Rating

Financial assistance

Community investment

Medicaid revenue share









Value

Reflects the avoidance of use of low-value services and cost efficiency

Avoiding Overuse

Includes rates of overuse of 12 low-value medical services for particular conditions

data is collected from Medicare claims FFS inpatient and outpatient claims from 2019 through 2021

2024 Scoring



NATIONAL **28** of 2593

STATE 1 of 105 Knee arthroscopy
Carotid endarterectomy
Carotid artery imaging for fainting
EEG for headache
EEG for fainting
Colonoscopy screening
Inferior vena cava filters
Spinal fusion and/or laminectomies
Coronary artery stenting
Renal artery stenting
Head imaging for fainting

Vertebroplasty



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Spinal fusion and/or laminectomies
Coronary artery stenting
Renal artery stenting
Head imaging for fainting
Vertebroplasty



Value

Reflects the avoidance of use of low-value services and cost efficiency

Cost Efficiency

Measures mortality outcomes over the cost of care as a mortality cost ratio at 30- and 90-days after a hospitalization.

Data is from the standardized Medicare FFS payments for patients hospitalized in 2019 to 2021

2024 Scoring



NATIONAL	302 of 2768
STATE	13 of 106

Star Rating

Cost efficiency at 30-days

Cost efficiency at 90-days



2023 Scoring



NATIONAL	1021 of 3637
STATE	57 of 132

Star Rating

Cost efficiency at 30-days

Cost efficiency at 90-days





Outcomes

Reflect performance as it relates to patients' health and experience of care

Clinical Outcomes

Measured as Mortality rates (In-hospital mortality, 30-day mortality, and 90-day mortality) and readmission rates (7- and 30-days)

Data is from from the Medicare inpatient FFS claims files for years 2019 through 2021 as well as from Medicare Advantage inpatient encounter files for 2019 and 2020.

2024 Scoring



NATIONAL	935 of 2784
STATE	60 of 106

Star Ratina

	star itating
In-hospital mortality	****
30-day mortality	****
90-day mortality	****
7-day readmission	****
30-day readmission	****
7-day unplanned admt.	****

2023 Scoring

1180 of 3685



NATIONAL

STATE	75 of 132
	Star Rating
In-hospital mortality	****
30-day mortality	****
90-day mortality	****
7-day readmission	****
30-day readmission	****



Outcomes

Reflect performance as it relates to patients' health and experience of care

Patient Safety

Use indicators from the CMS Care Compare website for hospitalizations

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2024 Scoring



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2023 Scoring



NATIONAL

1969 of 2255

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80 of 90

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Outcomes

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Patient Satisfaction

uses the annual Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey to give a rating of patient experience across 10 factors from July 2021 to March 2022

2024 Scoring



NATIONAL

1484 of 2717

STATE

76 of 135

Communication with nurses

Communication with doctors

Responsiveness of hospital staff

Communication about medicines

Discharge information

Care transition

Cleanliness of hospital environment $\star\star\star\star$

Quietness of hospital environment

Overall rating of hospital

Recommendation of hospital

**** 2023 ****

Scoring



NATIONAL

2631 of 3379

STATE

120 of 135

Communication with nurses

Communication with doctors

Communication about medicines

Care transition

Cleanliness of hospital environment ***

Quietness of hospital environment

Overall rating of hospital

Recommendation of hospital

Responsiveness of hospital staff

Discharge information















Quality Health Equity Data

Joseph F. Golob Jr. MD

EVP – Chief Quality and Safety Officer

MetroHealth True North

CMS
Hospital
Compare 5star Hospital

Leapfrog Grade "A"

Top Place to Work

Eliminate Healthcare Disparities a voice and is listened to

Every patient we touch will receive equitable, safe, high quality, patient centered care to afford them the ultimate patient experience

Every employee is working collaboratively toward True North

Financial Health Top Performer in Patient Experience

Overcome workforce crisis

Win the
Malcolm
Baldrige
National
Quality Award

Ambulatory CMS Metrics January-June 2024

Metric	All Patients	Black	White	Hispanic	Epic Percentile Benchmark
Hemoglobin A1C (measure of diabetes glucose control) - Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement (<i>Lower is better</i>)	28%	29%	27%	28%	68 th percentile
<u>Cervical Cancer Screening</u> - Percentage of women 21-64 years of age who were screened for cervical cancer	68%	74%	64%	67%	94 th percentile
Breast Cancer Screening - Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer in the 27 months	77%	80%	74%	79%	97 th percentile
<u>Colorectal Cancer Screening</u> - Percentage of adults 46-75 years of age who had appropriate screening for colorectal cancer	62%	64%	61%	65%	73 rd percentile







Ambulatory CMS Metrics January-June 2024

Metric	All Patients	Black	White	Hispanic	Epic Percentile Benchmark	
<u>Diabetic Eye Care</u> - Percentage of patients 18-75 years of age with diabetes and an active diagnosis of retinopathy in any part of the measurement period who had a retinal or dilated eye exam by an eye care professional	47%	50%	43%	46%	86 th percentile	∑
Controlling High Blood Pressure - Percentage of patients 18-85 years of age who have a diagnosis of hypertension and whose most recent blood pressure was adequately controlled (<140/90 mmHg) during the measurement period	73%	72%	74%	79%	69 th percentile	$\overline{\mathbf{v}}$
<u>Depression Screening and Follow Up</u> – Percentage of patient 12 and older who receive an ageappropriate depression screen and if positive a follow up plan is documented	64%	70%	60%	64%	79 th percentile	



≥5% difference from system performance or between groups

Inpatient CMS Metrics - Readmissions Rolling 12 Months – May 2023-Apr 2024

Readmissions					Gend	er	Race		
Measure (Medicare FFS)	2023 Target %- Benchmark Vizient	2023 Baseline	Rolling 12 Month Rate % (May 2023- Apr 2024)	Variance from Benchmark	R12	Male % Readmitted- R12 (Total Eligible)	African American/Black % Readmitted- R12 (Total Eligible)	White % Readmitted- R12 (Total Eligible)	
CMS COPD Rate	15.25%	13.51%	16.54%	-1.29%	14.81% (81)	19.23% (52)	15.56% (45)	17.50% (80)	
CMS AMI Rate	9.46%	19.05%	12.20%	-2.74%	14.29% (21)	10.00% (20)	0.00% (8)	14.29% (28)	
CMS Heart Failure Rate	14.61%	16.56%	17.80%	-3.19%	16.75% (191)	19.18% (146)	13.99% (143)	20.83% (168)	
CMS Pneumonia Rate	11.02%	14.86%	17.46%	-6.44%	18.81% (101)	15.91% (88)	17.02% (47)	18.46% (130)	
CMS Hip/Knee Rate	5.26%	0.00%	0.00%	5.26%	0.00% (8)	0.00% (6)	0.00% (2)	0.00% (12)	
CMS CABG Rate	5.71%	0.00%	0.00%	5.71%	0.00% (3)	0.00% (6)	0.00% (1)	0.0% (8)	
CMS Hospital Wide Rate	10.71%	10.76%	11.56%	-0.85%	11.33% (2,048)	11.84% (1,620)	12.39% (1,041)	10.97% (2,397)	

Inpatient CMS Metrics - Mortality Rolling 12 Months – May 2023-Apr 2024

Mortalities						Ge	Gender		e
Measure (Medicare FFS)	2023 Target Benchmark- 50th (O/E-Vizient)	2023 Baseline O/E	Rolling 12 months O/E (Jun 23-May 24)	Variance from Benchmark	Monthly O/E (May 2024)	Female O/E Ratio- Deaths- R12 (Total Eligible)	Male O/E Ratio- Deaths- R12 (Total Eligible)	African American/Black O/E Ratio- Deaths- R12 (Total Eligible)	White O/E Ratio- Deaths-R12 (Total Eligible)
						0.76	0.37	0.00	0.67
CMS COPD Mortality	0.65	0.24	0.56	0.09	3.24	(85)	(54)	(44)	(87)
						4.03	3.46	3.22	5.84
CMS AMI Mortality	0.91	2.92	3.72	-2.81	0.00	(26)	(27)	(13)	(34)
CMS Heart Failure						0.64	1.36	0.70	1.07
Mortality	0.85	0.86	0.95	-0.10	1.93	(195)	(147)	(140)	(170)
CMS Pneumonia						0.62	1.03	0.83	0.96
Mortality	0.72	1.06	0.87	-0.15	0.00	(104)	(104)	(50)	(146)
						0.32	2.22	1.27	1.29
CMS Stroke Mortality	0.71	1.57	1.19	-0.48	0.00	(53)	(54)	(41)	(53)
						0.00	0.00	0.00	0.00
CMS CABG Mortality	0.00	0.00	0.00	0.00	0.00	(2)	(6)	(1)	(7)

Patient Experience (HCAHPS) – 2024 through May

						Ger	nder	Ra	ice
	Target - Benchmark NRC 55th Percentile	2023 Baseline	Recent Month Performance (May 2024)	YTD Performance	YTD Performance Variance from Benchmark	Female YTD Performance	Male YTD Performance		White YTD Performance
Measure						(# Eligible)	(# Eligible)	(# Eligible)	(# Eligible)
HCAHPS - Communication with Nurses	92.10%	91.50%	91.30%	91.30%	-0.80%	91.50% (264)	90.90% (179)	89.50% (91)	91.70% (319)
HCAHPS - Communication with Doctors	91.90%	90.40%	92.80%	91.70%	-0.20%	91.90% (261)	91.50% (179)	91.20% (92)	91.60% (315)
HCAHPS - Responsiveness of Staff	85.40%	83.60%	83.70%	83.00%	-2.40%	83.60% (249)	82.00% (158)	81.80% (88)	83.30% (289)
HCAHPS - Communication about Meds	77.50%	75.80%	77.80%	77.40%	-0.10%	76.80% (172)	78.20% (114)	78.30% (53)	76.70% (212)
HCAHPS - Discharge Information	87.70%	84.80%	83.50%	85.80%	-1.90%	86.20% (246)	85.20% (166)	82.80% (87)	86.30% (296)
HCAHPS - Care Transitions	82.00%	81.00%	76.50%	79.50%	-2.50%	80.10% (260)	78.50% (177)	77.30% (90)	79.90% (315)
HCAHPS - Cleanliness of Hospital	87.20%	86.50%	86.60%	86.00%	-1.20%	80.10% (285)	89.90% (202)	83.20% (99)	86.30% (350)
HCAHPS - Quietness of Hospital	83.80%	83.10%	81.00%	82.40%	-1.40%	80.10% (277)	80.10% (196)	87.70% (95)	81% (342)
HCAHPS - Hospital Rating	89.30%	88.40%	86.40%	88.00%	-1.30%	80.10% (262)	88.10% (179)	88.70% (93)	87.30% (315)
HCAHPS - Recommend the hospital	88.80%	86.90%	86.30%	87.70%	-1.10%	80.10% (260)	88.60% (178)	84.80% (92)	88.30% (313)

Patient Experience (Real Time) – 2024 through May

						Gen	der	Ra	ice
	Target - Benchmark	2023	Recent Month Performance	YTD	YTD Performance	Female	Male	African American	White
	NRC 55th Percentile	Baseline	(May 2024)	Performance	Variance from Benchmark	YTD Performance	YTD Performance	YTD Performand e	YTD Performanc e
Measure						(# Eligible)	(# Eligible)	(# Eligible)	(# Eligible)
Real Time - Rate ED	64.50%	58.50%	60.20%	61.20%	-3.30%	80.10% (2226)	60.50% (1506)	58.00% (1677)	63.80% (2010)
Real Time - Good Communication Between Docs and Nurses ED	64.70%	56.30%	58.40%	58.50%	-6.20%	80.10% (2181)	59.10% (1545)	57.10% (1730)	60.40% (2041)
Real Time -Would Recommend Office	94.20%	89.00%	92.40%	92.10%	-2.10%	80.10% (24276)	92.60% (13762)	90.70% (13855)	93.20% (20738)
Real Time - Routine Appointment When Wanted	95.30%	88.10%	91.70%	91.70%	-3.60%	80.10% (9169)	92.40% (5348)	91.90% (5535)	91.80% (7649)

Thank you!



Multicultural Health Equity Centers of Excellence

Charles Modlin, MD, MBA

VP Chief Health Equity Officer, Staff Urologist

Michele Davis-Ishmael, RN, MBA

Executive Director, Health Equity & Community Engagement

LaShon Carson, MPH

Coordinator, Health Equity Programs



2023 System Strategy

The Multicultural Center Model supports all of our system goals

- Increased number of patients resulting in increased revenue
- Better patient outcomes and decrease in health disparities
- Promotes MH commitment to being an inclusive healthcare system
- Promotes opportunities to explore innovative, cutting-edge technology and therapies

Financial Health

Our services and ventures will grow and generate positive revenue.

Our clinical and system services will be efficient and cost effective.

We will ensure we are optimizing all revenue sources.

Our health care model will meet the current and future needs of all of our communities.

All of our communities will have a seat at the table so medicine is done with them and not to them.

We will eliminate health care disparities, zero out the death gap and improve the lives of all members of our community.

We will strategically collaborate and partner with others to improve and expand health care delivery.

We will widen our front door to ensure all of our communities have access to the services and care needed.

We will test, shape and scale our services to expand our ability to improve health

In collaboration with industry, leverage our cutting-edge research to provide patients with the latest technologies and medical discoveries while furthering strategic growth for our institution.

Culture & Diversity

MetroHealth will be a workplace of choice and embrace a "people-first" culture.

Our workforce will represent the communities we serve.

We will improve the health and wealth of all of our communities.

Patients, providers and caregivers will be respected, valued and heard.

Quality & Service

Our patients will be provided the highest quality of care in a safe and healthy environment.

We will advocate for our patients and ensure they understand their care options and have a say in their care experience.

We will maintain our position as a nationally recognized academic medical center, developing a workforce that can meet the current and future needs of our community

& Research

Increase the scale and impact of MetroHealth's spin-off entities to enhance the impact of our services, improve quality of care and enhance revenue generation.

Our research will be recognized as a national leader for translating discoveries into applications that can improve the health of all of our communities.

We will align the work of our research institutes with our clinical and system services.



Clinical Transformation, Health Equity & Community Impact

Our health care model will meet the current and future needs of all of our communities.

All of our communities will have a seat at the table so medicine is done with them and not to them.

We will eliminate health care disparities, zero out the death gap and improve the lives of all members of our community.

We will strategically collaborate and partner with others to improve and expand health care delivery.

Multicultural Health Equity Centers of Excellence

- What are the Multicultural Health Equity Centers?
 - Innovative & Substantive Health System-Wide Approach to Addressing and Eradicating Health Disparities
 - Health inequities exists in every arena of clinical medicine
 - Multicausality: SDOH; Hereditary/Genetic; Provider/Health Systems/Policies/Patient
 - Examples of Health Disparities across spectrum of medicine

Common Health Disparities in African Americans

- **Hypertension:** 45% incidence (40% greater incidence)
- Diabetes: 13% AA over 20 have diabetes; 1.7x Whites
- **Heart Disease:** 30% > death than whites
- Stroke: AAs 50% > stroke; Black men 70% > stroke death
- **Kidney Disease:** 4-6x > incidence
- Cancers: 44% > death than whites
- Prostate Cancer 2x incidence 2x death rates compared to whites

US Life Expectancy by Race & Gender

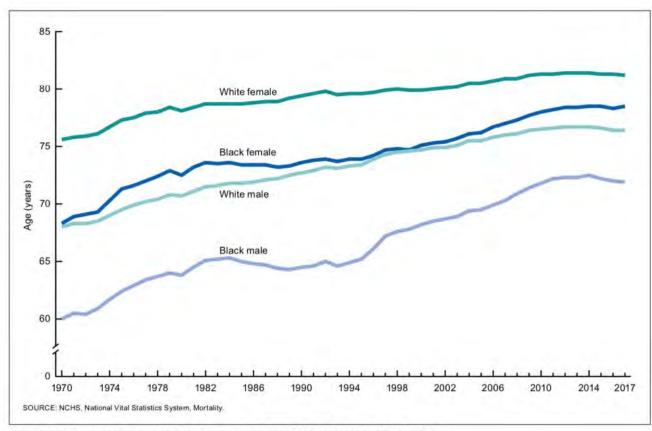
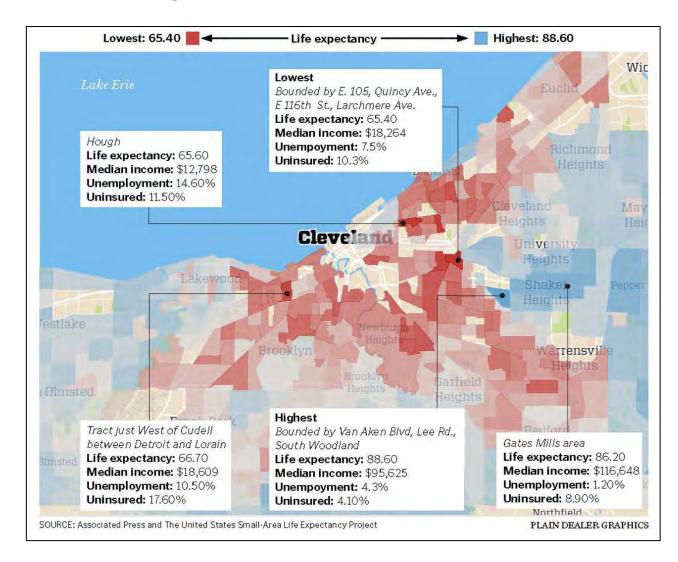


Figure 1. Life expectancy at birth, by race and sex: United States, 1970-2017

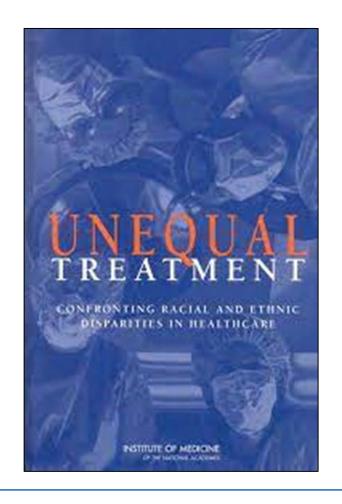
Where you live determines how long you live



Why Healthcare Disparities?

- Multifactorial
 - Patient, Provider, System/Systemic Factors
 - Culture/ Culture Competency/ Communication
 - Education/ Health Literacy
 - Historical Factors/ Distrust/ Racism/ Stereotyping/ Biases
 - Socio-Economic Determinants of Health
 - Lack of health insurance
 - Lack of Access
 - Environment/ Nutrition/Behaviors
 - Lack of Diverse Healthcare Workforce
 - Genetics/ Biologic/ Diff. Response to Medications
 - Lack of Minority Patients in Research Trials
 - Sub-specialization in Medicine & Lack of Awareness of Disparities

CHRONIC <u>UNFAIR</u> AND <u>UNEQUAL</u> TREATMENT





Dying For Basic Care

- More than 886,000 deaths could have been prevented 1991 to 2000 if Blacks had received same care as whites, American Journal of Public Health.
- Study estimates technological improvements in medicine -- including better drugs, devices and procedures -- averted only 176,633 deaths during the same period.
- "Five times as many lives can be saved by correcting the disparities [in care between whites and blacks] than in developing new treatments,"

Multicultural Health Equity Centers of Excellence

Mission: Elimination of Health Disparities

Vision: Improving the health of our patients and communities

Goals:

- Development of Clinicians Focused on Elimination of Health Disparities in respective disciplines
- Strategic Community Outreach, Health Education, Facilitated Patient Access (working with KPMG re: clinic visit types)
- Providing welcoming environment
- Listening and Learning, Responding to Patient/Community Needs (Leader Listening Affinity Group Rounding)
- Earning trust and respect of our patients and exceeding patient expectations
- Higher levels of engagement with our patients
- Learning, Incorporating, Teaching, Researching best practices of health equity medicine
 Advancing latest technologies and therapies for all

Goals of Multicultural Health Equity Centers

Community Impact and Health System Impact

- Increasing preventive care in our communities
- Increases patient satisfaction and outcomes
- Enhanced research opportunities
- Enhanced provider and caregiver recruitment opportunities
- Enhanced philanthropy, grants
- Enhanced community/stakeholder partnerships
- Enhanced training pipelines

Multicultural Health Equity Centers of Excellence

Department	Clinical Center Lead
Anesthesiology	Dr. Bushra Abdul Aleem
Bariatrics/Weight Management	Dr. Sergio Bardero, Amelia Dorsey, Pamela Olszko, Kerry Stougis
Behavioral Health	Dr. Tiffani Monford Dent
Cancer Care Research	Koretia Williams, Research Project Specialist
Cardiology	Dr. Kathleen Quealy
Chronic Pain	
Dental	Dr. Victoria Barany-Nunez, Bridgetta Haller
Dermatology	Dr. David Crowe
Endocrinology	*Dr. Daniela Pirela Araque Clinical requirement tied to Visa
Family Medicine	Dr. Bode Adebambo, Dr Moreland
Gastroenterology	Dr. Adrian Lindsey
Gender Affirming Sexual Health	Dr. Mishra
General Internal Medicine	Jayne Barr
Geriatrics	Fassil Gemechu; Lorella Luezas-Shamakian; Jennifer Hudak; James Campbell

Department	Clinical Center Lead
GYN/ONC	Dr. Kimberly Resnick, Dr.Moreland (in patient)
Hematology/Oncology	Dr. Carvall Nguyen
Infectious Disease	Melissa Jenkins
Medicine/Pediatrics	Aparna Roy, MD, Candis Platt-Houston, MD
Nephrology	Dr. Nagaraju Sarabu, APP Doreen Papajcik, PA Jeffrey Weaver, Brittany Grimaldi
Neurology	Dr. Ardelt
Nutrition	Patricia McClain
Obstetrics/Gynecology	Dr. Moreland
Oncologic Surgery/Cancer Center	Dr. Rakhshanda Raham
Ophthalmology	Dr. Seidel & Mrs. Kelly
Oral Health	Dr. Victoria Barny Nunez
Orthopedics	Dr. Jon Wilber, Dr. Adrienne Lee, Dr. Blaine Todd Bafus, Dr. Jon Belding; Dr. Chris Matson
Otolaryngology including Audiology	Brigitta Haller
Palliative Care	Beth McLaughlin

Multicultural Health Equity Centers of Excellence

Department	Clinical Center Lead
Pediatrics	Aparna Roy, MD, Candis Platt-Houston, MD
Pharmacy	Dr. Ryan Mezinger, Curtis Warren
Physical Medicine & Rehab Plastic Surgery	Dr. Richard Wilson, Dr. Antwon Morton Aparna Roy, MD, Candis Platt-Houston, MD
Pulmonary	Dr. John Thornton, Dr. John Carter
Radiation Oncology	Roger Ove
Red Carpet	Dr. Nicholas Dreher
Rheumatology	Eli Weinberger, MD
Sickle Cell	Dr. Grace Onimoe; Dr. Tonjeh Bah
Social Work	Patricia Kachmyers
Surgery/ General Surgery	Dr. Morton, Rebecca Dykes
Vascular Surgery	Dr. Persky, Dr. Garietta Falls
Wound	Dr. Rowe
-	

Waiting on Center Lead Identification

Department	Clinical Center Lead
Epilepsy	

No Centers

Department	Clinical Center Lead
Pathology	
Radiology	
Emergency Medicine	

Other

Department	Clinical Center Lead
Preadmissions	
Research	
Hospital Medicine	
Depatment of Nursing	
Risk Clinic	

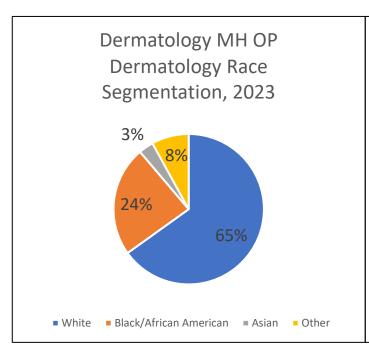


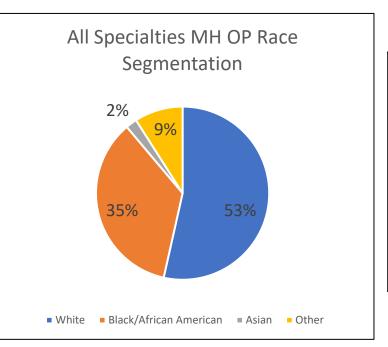
Multicultural Dermatology Center (MDC): Origins

David Crowe, MD
Chair, Department of Dermatology
MetroHealth Systems

Outpatient Dermatology versus All Specialties – Race Distribution

- Dermatology volumes are predominantly White (just under two-thirds) for both MH versus more mixed racial segmentation across all specialties.
- MH dermatology volumes in Black/African American cohort remain flat in 2023 versus 2021. The percentage of Black/African American patients receiving OP Dermatology visits is lower (24%) than it is for our All Specialties OP services as a whole.
- MH dermatology vs All Specialties: underperform in the Black/African American and "Other" cohorts and overperform in the White and Asian cohorts.





	MH Deri	matology	MH All Specialties		
OP	2021	2023	2021	2023	
White	64.6%	65.1%	52.4%	53.3%	
Black/African American	23.7%	23.7%	36.4%	35.2%	
Asian	3.0%	3.2%	2.1%	2.1%	
Other*	9.0%	8.0%	10.0%	9.0%	

Data Source: *Other includes American Indian, HI/PI, Mixed Races and Other per Sg2 segmentation. **OHA for MH derm. race distribution as race not broken out in Sg2 market SL data, MH EPIC.

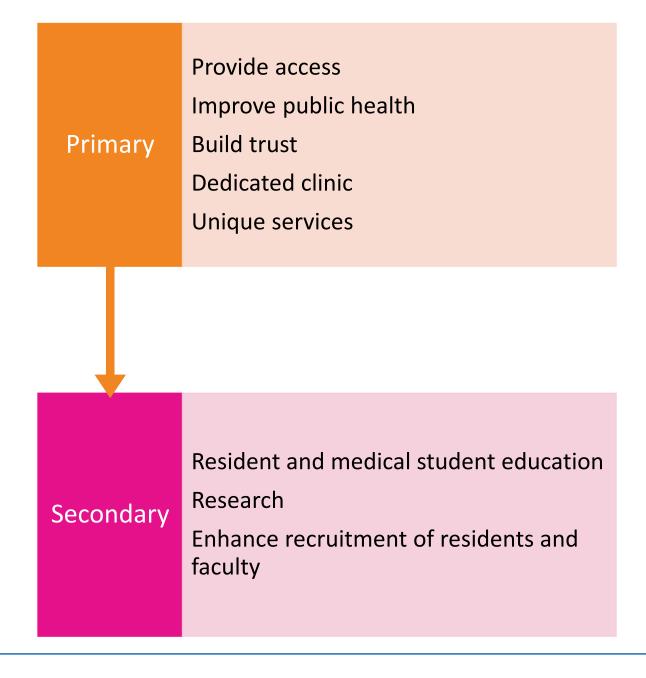
African American Cuyahoga population Estimates in next 5 –years (2023 to 2028)

- ➤ The growth estimates for the Africa American Population are relatively varied depending on are within Cuyahoga.
- MH Parma and MH Middleburg Heights are in areas with largest estimated Africa American population growth into 2028.
- ➤ MH Brunswick and Westlake are in 2nd highest growth areas.
- ➤ MH Main, Cle Hts and Beachwood areas are expected to see declines in African American population.

Data Source: Sg2



Goals





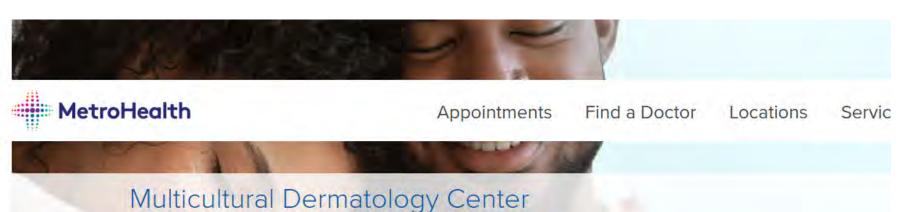
Marketing Business Case and Creative Brief

• Requester name: David Crowe, MD

• Date: 12/2/22

• Project title: Multicultural Dermatology Clinic

- Introduction: The MetroHealth System is piloting the launch of several multicultural service line clinics, starting with urology and dermatology. The following marketing business brief is to support the launch of a new Multicultural Dermatology Clinic.
- Executive Summary and Program Description: The Multicultural Dermatology Clinic is dedicated to meeting the unique dermatologic health needs for people with skin of color. This new clinic leverages a specialized team of providers who have experience and training in caring for skin and hair conditions in people of various skin tones.



Specializes in treating skin and hair conditions for people of color.

To make an appointment call 216-778-3376 (DERM).

Dermatology

Cosmetic Services

Multicultural Dermatology Center

SkinIO Advanced Skin Imaging and Mole-Mapping

Snapshot Skin Cancer Screening

Multicultural Dermatology Center

Our Multicultural Dermatology Center specializes in treating skin and hair conditions that main color. We understand the psychological impact of these conditions and will tailor treatment as skin type. This holistic approach may include vitamin supplementation, prescription medicatio for underlying health conditions that can influence the hair and skin.

Our providers are trained and skilled to treat the following skin conditions that primarily affect darker skin tones:

- Keloids
- · Skin Discoloration / Hyperpigmentation
- Melasma
- Hair loss / Alopecia

- Hidradenitis Supperativa
- Vitiligo
- Nail Unit Melanoma
- Lupus involving the Skin

To schedule an appointment, call 216-778-3376 (DERM) or request an appointment online.

Multicultural Dermatology Center Appointment Request

Please complete the form below. By pressing Submit you give MetroHealth permission to contact you.

One of our MetroHealth dermatology team members will follow up with you in 2-3 business days to schedule an appointment with one of our providers.

First Name*		
Last Name*		
Email*		
Appointments	Find a Doctor	Locations
Birthday		
mm/dd/yyyy		::
Zip Code		
Preferred Follow-Up Method*		
		~
Preferred Time Of Day For Phone	Call Follow-Up	
		~
How Did You Hear About Our Cen	iter?*	~
Tell us about your skin problem		
Please verify your request*		
I'm not a robot	reCAPTCHA Privacy - Terms	

Dermatology

Cosmetic Services



Multicultural Dermatology Center

SkinIO Advanced Skin Imaging and Mole-Mapping

Snapshot Skin Cancer Screening

Multicultural Dermatology Center

Our Multicultural Dermatology Center specializes in treating skin and hair conditions that mainly affect people of color. We understand the psychological impact of these conditions and will tailor treatment approaches to your skin type. This holistic approach may include vitamin supplementation, prescription medications, or assessment for underlying health conditions that can influence the hair and skin.

Our providers are trained and skilled to treat the following skin conditions that primarily affect people with darker skin tones:

- Keloids
- Skin Discoloration / Hyperpigmentation
- Melasma
- · Hair loss / Alopecia
- Hidradenitis

- Suppurativa
- Vitiligo
- Nail Unit Melanoma
- Lupus involving the Skin

To schedule an appointment, call 216-778-3376 (DERM).

Our Doctors/Medical Providers

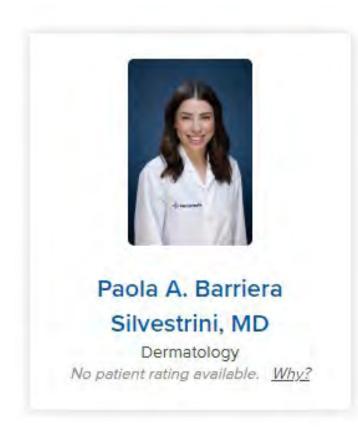


David R. Crowe, MD

Department Chair of Dermatology

Dermatology

MDC Providers





MDC Patient Features (subset of 80 patients)

Majority seen at Cleveland Heights and Main Campus

Avg age 50

75% identified as female

97% identified as African-American

80% presented with inflammatory skin disease (psoriasis, lichen planus, dermatitis, acne, hidradenitis)

Procedural Care for Hidradenitis

Intralesional triamcinolone

Performing regularlyGenerally contraindicated

Incision and drainage

Unroofing and marsupialization

Practice gap

• Full excision (+/- grafting)

Plastic surgery territory

MetroHealth Announces Opening of Minority Men's Health Institute







Cleveland, OH, September 15, 2022

The MetroHealth System is proud to announce the opening of the MetroHealth Minority Men's Health Institute, under the leadership of Charles Modlin, MD, MBA, Director of Health Equity & Medical Director of the Office of Equity, Inclusion & Diversity.

The Minority Men's Health Institute welcomes all men, regardless of race, ethnicity or demographics. However, the mission of the Minority Men's Health Institute is to address the numerous health disparities that disproportionately afflict and burden men of color and contribute to the higher incidence of chronic disease rates and lower life expectancies in men of color compared to other populations.

The Minority Men's Health Institute will be housed within the MetroHealth Division of Urology and function in partnership with the MetroHealth Division of Medicine and additional subspecialty areas, as well as with the MetroHealth Institute for H.O.P.E., the Office of Patient Experience, Office of Equity, Inclusion & Diversity, the Department of Population Health and others.

"We know men of color have higher incidences and death rates from prostate, colon and lung cancer, prostate disease, heart and kidney disease, hypertension, diabetes, HIV, stroke and mental health conditions, among others," Dr. Modlin said. "Many of these conditions can be prevented, treated, controlled and/or cured if diagnosed in early stages."

Biological and hereditary factors, along with many social determinants of health, including poverty, lack of access to quality care, education levels, cultural and health behaviors, lack of preventative health screenings and other factors contribute to many of the health disparities observed in men of color and that especially afflict African-American males.



American Cancer Society data demonstrates that up to 1 in 4 Black men will get prostate cancer in their lifetime, compared to a 1 in 8 chance for White men and the death rate for prostate cancer in Black men is twice that in White men. The American Urological Association recommends Black men start screening for prostate cancer at the age of 40. If diagnosed in early stages, cure rates of prostate cancer in Black men is equivalent to that seen in White men.

Kidney Health Equity System of Excellence Change Initiative Implementation Plan A3 Report

Establishing a Sense of Urgency

	Threat	Opportunity
Short Term	 High unrecognized CKD Low urine albumin testing Low evidence-based therapy 	Build clinical decision support in EMR for timely diagnosis of CKD and urine albumin testing Educate PCPs on diagnosis and evidence-based therapies
Long Term	Loss of revenue because kidney health is a quality metric Lost finances due to high utilization Lost lives due to preventable cardiac deaths	Savings from timely diagnosis of CKD Savings from decreased rates of utilization Saved lives from preventing cardiac deaths

Creating the Guiding Coalition

Stakeholder (Name or Group)	Strongly Supportive	Supportive	Neutral	Against	Strongly Against	Issues/ Concerns	Influence Strategy
Pop Health	Х					Onboard	Regularly involve
PCPs			Х			Extra work	Incentivize
Specialists			Х			Resistance	Support
Pharmacists		х				Lack of knowledge	Educate/collaborate
Community		Х				Lack of expertise	Educate/collaborate
Patients			х			Cost/safety	Support/educate

Developing a Vision and Strategy

- Be a top health system for kidney health equity
- CKD is a common and burdensome problem to patients, health systems, and payers because of high costs, morbidity, and death, and fraught with inequities. New interventions can decrease this burden if implemented at high rates. I believe we can be a top health system for kidney health equity by implementing evidence-based therapies to 80% because we serve underserved populations. If all disciplines, including specialists, and pharmacy, work together, we can achieve this goal.

Communicating the Change Vision

Group	Key Message	Delivery Mechanism (email/ phone/ etc)	Frequency
Pop Health	Improved value	In person	Weekly
PCPs	Improved savings and quality	Group meetings, emails	Quarterly
Nephrologists	Less burden and improved quality	Group meetings, emails	Quarterly
Pharmacists	Recognition and quality	Group meetings, emails	Quarterly
Community	Patient and provider awareness	Conference, in-person	Semi-annual
Patients	Improved health and equity	In-person	Office visits

Empowering Broad-Based Action

	In Frame		Out of Frame		
1.	Awareness of evidence-based interventions	1.	Diverse locations, staffing, and processes of PCP offices		
2.	Availability of clinical practice guideline	2.	Data scientists ability to capture data from EMR for timely reporting		
3.	Risk based referral to nephrology	3.	Limited nephrology workforce		
4.	Educate PCPs on timely diagnosis of CKD	4.	Multiple demands on PCPs for patient management		
5.	Pharmacist assistance for prescription	5.	High costs for new medications		
	and monitoring of specialty medications	6.	Need for multiple specialists for care of CKD patients		
		7.	Social determinants of health adversely affecting CKD patients		

Generating Short-Term Wins

What (Action Items)	Who (Owner)	Measurement	When (Completion Date)
Educate PCPs	Kidney health equity team	Diagnosis rates	12/31/2024
Dashboard	Pop health team	Quality metrics by SDoH	12/31/2024
Pharmacy assist	N Sarabu	SGLT2i rates	Ongoing
Scholarly publication	N Sarabu	Publication in a peer-reviewed journal	12/31/2024

Consolidating Gains and Producing More Change

Stage	Rating (0-100)	Stage	Rating (0-100)
Urgency	70%	Empower Action	40%
Guiding Coalition	70%	Short-Term Wins	30%
Vision	60%	Consolidate Gains	20%
Communication	50%	Culture	20%

Anchoring New Approaches in Culture

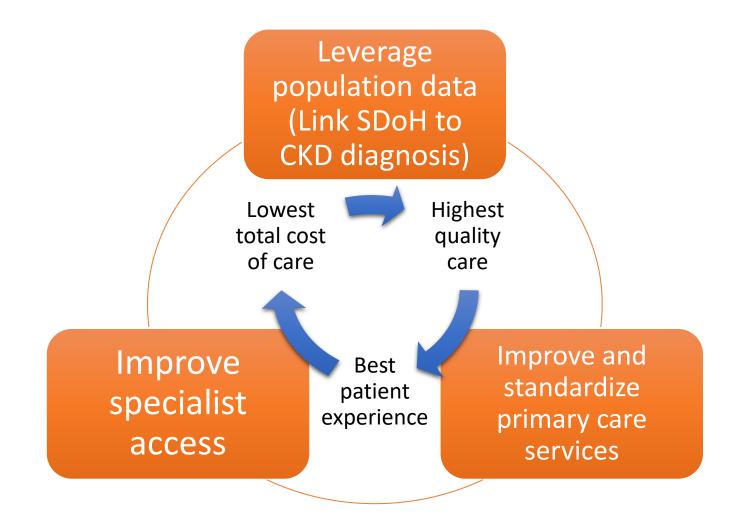
Structure	Impact (L/M/H)	Structure	Impact (L/M/H)
Staffing	М	Communication	М
EE Development	L	Org Structure	Н
Perf. Measures	L	IS	Н
EE Recognition	L	Resources	Н

Recommendations/ Action Items

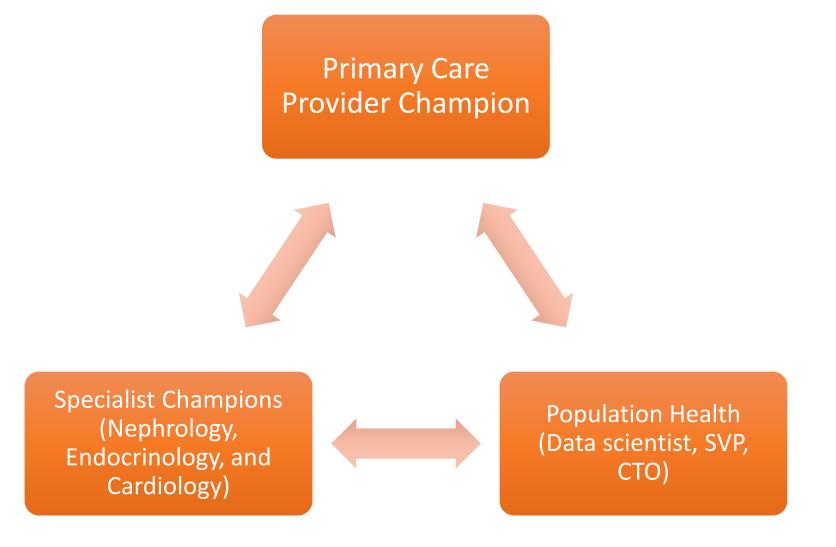
- Communicate why this is needed to stakeholders
- Weekly meetings of the core team
- Communicating vision to multiple stakeholders, multiple times, through multiple channels
- Ongoing monitoring of the performance of providers, reduction in utilization, and costs of CKD
- Establish EMR clinical decision support for providers

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Kidney Health Equity Center of Excellence (SOE)



SOE Construct: Guiding Coalition



Within MH Interventions

- Kidney Health Equity Summit
 - Half to One-day CME event for all providers at MH
- Pilot Qualitative Study to Understand Patient Perspectives on "No Shows" in Nephrology Clinic
- EMR alerts recommending evidence-based therapies to be sent to PCPs by specialists
- Create a dashboard of Kidney Health Equity Quality Metrics (note that
 if we increase overall performance at MH, since we serve
 underserved population, we are improving equity in the community)
- Pre-Transplant optimization

Beyond MH Interventions

- Increase awareness of diabetes, hypertension, and kidney disease in schools
- Increase awareness in the community with the use of community health workers
- Collaborate with non-profit organizations such as Kidney Foundation of Ohio and National Kidney Foundation to organize programs based on kidney health equity



The Why



Increasing U.S. Diversity

Increased
Health
Disparities
Populations



Common Health Disparities in African Americans

- **Hypertension:** 45% incidence (40% greater incidence)
- Diabetes: 13% AA over 20 have diabetes; 1.7x Whites
- **Heart Disease:** 30% > death than whites
- Stroke: Aas 50% > stroke; Black men 70% > stroke death
- **Kidney Disease:** 4-6x > incidence
- Cancers: 44% > death than whites
- Prostate Cancer 2x incidence 2x death rates compared to whites

Common Health Disparities in African Americans

- HTN—AA adults less likely to have HTN controlled
- AA women 60% greater incidence HTN than non-Hispanic white women
- Blacks less likely to receive certain invasive cardiovascular diagnostic and treatment procedures than whites
- Lung Cancer—black men are 11% more likely to be diagnosed with lung cancer, and 9.8% more black men die from lung cancer
- Kidney Cancer (CDC)—black men most likely to get kidney and renal pelvic cancer
- Colorectal Cancer-black men 24% more likely to get colorectal cancer than white men; 47% more likely to die from it.
- Colorectal Cancer-black women risks 19% and 34% respectively.
- Oral Cancer—AA men at one of the groups at highest risks and many don't know it.
- Thyroid Cancer—less common in blacks; but AA poorer survival than whites—related to disease characteristics (higher rates of anaplastic thyroid cancer and larger tumors at presentation)



Advanced

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Editorial

> Hepatol Commun. 2022 Jan;6(1):8-11. doi: 10.1002/hep4.1771. Epub 2021 Sep 23.

Liver Cancer Has a Distinctive Profile in Black Patients: Current Screening Guidelines May Be Inadequate

Adam C Winters ¹, Tali Shaltiel ², Umut Sarpel ², Andrea D Branch ³

Affiliations + expand

PMID: 34558225 PMCID: PMC8710783 DOI: 10.1002/hep4.1771

Press Release

Current Liver
Cancer Screenings
May Leave African
Americans at
Greater Risk

Mount Sinai Study Finds Cancer Disparities Persist in African Americans





Advanced

Save

Email

> Glob Qual Nurs Res. 2020 Jun 3;7:2333393620925793. doi: 10.1177/2333393620925793. eCollection 2020 Jan-Dec.

"Bearing the Pain": The Experience of Aging African Americans With Osteoarthritis Pain

Staja Q Booker ¹, Toni Tripp-Reimer ², Keela A Herr ²

Affiliations + expand

PMID: 32548212 PMCID: PMC7271276 DOI: 10.1177/2333393620925793

Free PMC article

Proc Natl Acad Sci U S A. 2016 Apr 19; 113(16): 4296-4301.

Published online 2016 Apr 4. doi: 10.1073/pnas.1516047113

PMCID: PMC4843483

PMID: 27044069

Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites

Kelly M. Hoffman, a,1 Sophie Trawalter, Jordan R. Axt, a and M. Norman Oliverb,c

Author information Copyright and License information Disclaimer

Podiatric Conditions and Care

- Among those aged 45 or older, African Americans have 3x the rate of corns and flat feet.
- With obesity removed as a factor, bunions and hammertoes are 2x prevalent in blacks as whites

Latinos were 31% less likely to receive colonoscopies than Whites (95% CI, 7%–55%). Among individuals 40–49 y old, African Americans were 71% less likely to have had a colonoscopy than Whites (95% CI, 13%–96%). Feb 28, 2015

https://www.ncbi.nlm.nih.gov > pmc

Racial and Ethnic Disparities in Colonoscopic Examination of ...

Comparative Study

Persisting Racial
Disparities in Colonoscopy
Screening of Persons with
a Family History of
Colorectal Cancer

Meng-Han Tsai et al. J Racial Etnn Health Disparities. 2018 Aug. Recommended colon cancer screening for African American men

African American men are statistically at a higher risk for colon cancer than other groups. When should Black men get a screening? Here's what you need to know.

Story by: Sara Thompson on

November 23, 2022

Disparate Access to Kidney Transplantation

African-Americans Still More Likely
Than Caucasian-Americans to Receive
Kidney Transplants from Deceased,
Rather than Living Donors

Those who get living donor kidneys fare better



Common Health Disparities in Racial/Ethnic Minority Children

300x Incidence in Asthma in AA adolescents Higher rates of Type 2DM, HTN, Obesity

Common Health Disparities in Racial/Ethnic Minority Children

300x Incidence in Asthma in AA adolescents

Higher rates of Type 2DM, HTN, Obesity

Mental Health Inequities in AA Children

Toxic stress and children's outcomes

African American children growing up poor are at greater risk of disrupted physiological functioning and depressed academic achievement

Report • By Leila Morsy and Richard Rothstein • May 1, 2019

Download DDE

Home // Racial Equity and Health Policy // Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address...

Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them

Latoya Hill 🍑 , Samantha Artiga 😏 , and Usha Ranji

Published: Nov 01, 2022

AA women 3x and AlAN women 2.5x higher pregnancy related mortality than white women



The influence of patient race on the use of diagnostic imaging in United States emergency departments; data from the National Hospital Ambulatory Medical Care survey

Andrew B. Ross, Vivek Kalia, [...], and Geng Li

Results

Using the weighted data, an average of 131,558,553 patient encounters were included each year for the 11year study period. Imaging was used at 46% of all visits although this varied significantly by patient race and ethnicity with white patients receiving medical imaging at 49% of visits and non-white patients at 41% of visits (p < 0.001). This effect persisted in the controlled regression model and across all imaging modalities with the exception of ultrasound. Other factors with a significant influence on imaging use included patient age, gender, insurance status, number of comorbidities, hospital setting (urban vs Review > J Racial Ethn Health Disparities. 2018 Jun;5(3):563-569.

doi: 10.1007/s40615-017-0400-y. Epub 2017 Jul 17.

Cultural Biases in Current Medical Practices with a Specific Attention to Orthopedic Surgery: a Review

Gracia Etienne ¹, Todd P Pierce ², Anton Khlopas ³, Morad Chughtai ³, Carlos J Lavernia ⁴, Teva Y Vogelstein ³, Craig M Thomas ⁵, Charles S Modlin ⁶, Michael A Mont ⁷

Affiliations + expand

PMID: 28718058 DOI: 10.1007/s40615-017-0400-y

11 Common African **American Skin Conditions**

October 24, 2018









How Glaucoma Affects Different **Ethnic Groups**

Yvonne Ou, MD

University of California, San Francisco, **UCSF Medical Center**

Expert Advice

Published on: August 18, 2021





FACTSHEET

MARCH 2020 alzimpact.org

Race, Ethnicity, and Alzheimer's

Although the rate of Alzheimer's and other dementias in African Americans and Hispanics is higher than in whites, they are *less likely* than whites to have a diagnosis of the condition.

- While African Americans are about two times more likely than whites to have Alzheimer's and other dementias, they are only 34% more likely to have a diagnosis.
- Hispanics are about one and one-half times more likely than whites to have Alzheimer's and other dementias, but they are only 18% more likely to be diagnosed.

In general, whites appear to respond better to β-blockers and angiotensin-converting enzyme inhibitors whereas blacks appear to respond better to diuretics and calcium channel blockers.

https://www.ahajournals.org > full

Overlap Between Whites and Blacks in

Differential Approach to Rx CHF

What is BiDil used for?

BiDil is approved for use with other heart medicines to treat heart failure in black patients to improve survival, improve heart failure symptoms, and help patients stay out of the hospital





Advanced

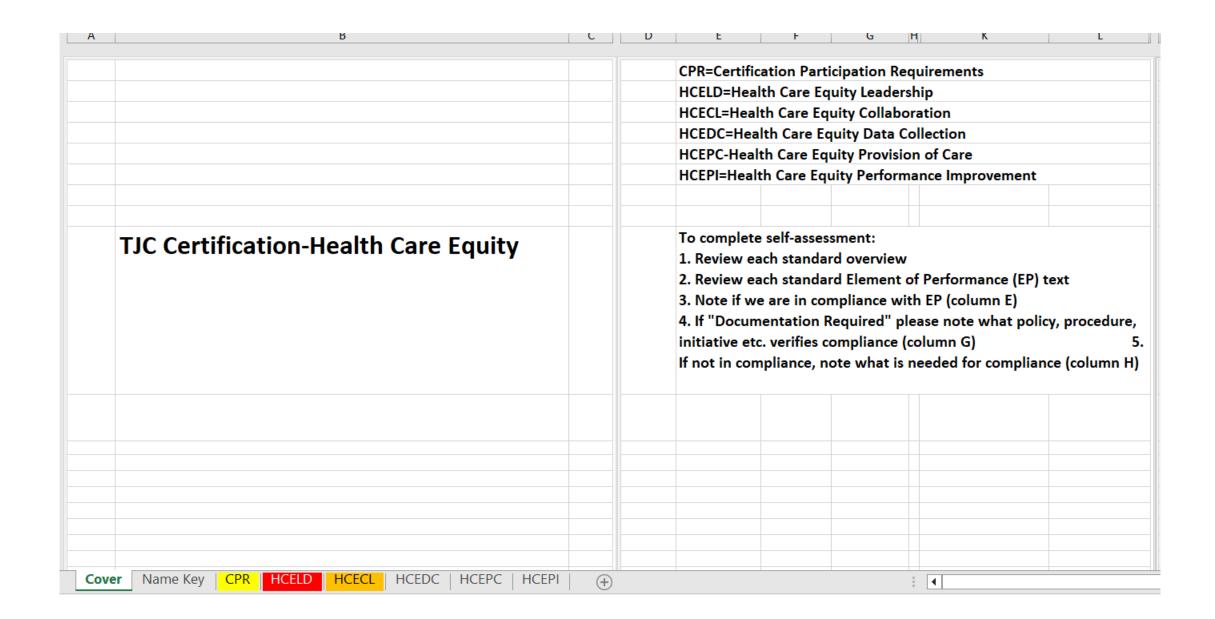
Comparative Study

Association Between
African American Race and
Clinical Outcomes in Men
Treated for Low-Risk
Prostate Cancer With
Active Surveillance

Rishi Deka et al. JAMA. 2020.

Clinical recommendations on who should be screened for lung cancer are based largely on how long a person smoked and the number of cigarettes they smoked. But current recommendations may need to be reviewed when it comes to African Americans who smoke, a new study suggests.

In the study, only about one-third of African American smokers diagnosed with lung cancer over a 12-year period would have met the criteria for annual lung cancer screening with low-dose



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4	Α	В	С	D					
1	KEY:								
2	RC: Robynn Cox-Stroke Accred								
3	KC: Karen Cook - I4HOPE								
4	MM: Michelle Mencke and Albert Ferreira -Language Services								
5	JL: Jennifer Lastic - Patient Experience								
6	MD: Margarita Diaz - DEI/HR								
7	KC: Kelly Connelly - Accreditation								
8									
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Standard	Standard Text	EP		In compliance with standard? Y or N	Documentation Required?	Compliance Verification Documents	What is needed for compliance?
CPR .01	The organization allows The Joint Commission to review the results of external evaluations from publicly recognized bodies.	1	When requested, the organization provides The Joint Commission with all official records and reports of licensing, examining, reviewing, or planning bodies.		Yes		RC- Kelly Connelly hadocuments
CPR .02	The organization reports any changes in the information provided in the application for certification and any changes made between reviews.	1	The organization notifies The Joint Commission in writing within 30 days of a change in ownership, control, location, capacity, or services offered. Note: When the organization changes ownership, control, location, capacity, or services offered, it may be necessary for The Joint Commission to review the organization again. If the organization does not provide written notification to The Joint Commission within 30 days of these changes, the organization could lose its certification.		Yes		RC- Kelly Connelly re leadership changes t
CPR .03	The organization permits the performance of a review at The Joint Commission's discretion.	1	The organization permits the performance of a review at The Joint Commission's discretion.		No		1st time certification you will receive 30 d advance notice. All subsequent reviews receive 7 business d advance notice.
CPR .04	The organization uses performance measures relevant to the services provided and populations served.	1	A minimum of 4 performance measures must be identified by the disease-specific care program.		Yes		RC- Stroke has 30 standardardized performance metric to Joint Commission monthly.
CPR .04	The organization uses performance measures relevant to Cover Name Key CPR HCELD HCECL HCEDC	2	The organization collects performance measure data related to		Yes		

CPR .04	The organization uses performance measures relevant to the services provided and populations served.	2	The organization collects performance measure data related to health care equity; analyzes the data internally; and generates run charts, control charts, or other performance improvement tools that show monthly data points for use in performance improvement activities.	Yes	
CPR .06	The organization notifies the public it serves about how to contact its organization management and The Joint Commission to report concerns about patient safety and quality of care. Note: Methods of notice may include, but are not limited to, distribution of information about The Joint	1	The organization informs the public it serves about how to contact its management to report concerns about patient safety and quality of care.	No	RC- Information is a on the MH website a inpatinet admission
CPR .06	The organization notifies the public it serves about how to contact its organization management and The Joint Commission to report concerns about patient safety and quality of care. Note: Methods of notice may include, but are not limited to, distribution of information about The Joint Commission, including contact information in published materials such as brochures and/or posting this information on the organization's website.	2	The organization informs the public it serves about how to contact The Joint Commission to report concerns about patient safety and quality of care.	No	RC- Information is an on the MH website a inpatinet admission
CPR .07	The organization provides accurate information throughout the certification process.	1	The organization provides accurate information throughout the certification process. (See also CPR 12, EP 1) Note 1: Information may be received in the following ways: - Provided verbally - Obtained through direct observation by, or in an interview or any other type of communication with, a Joint Commission employee - Derived from documents supplied by the organization to The Joint Commission	No	RC- Stroke account e gives Stroke list of documents to uploa Commission website application or CMIP submission prior to 1 survey. Example of documents: evidence

	-		-	 	-	
CPR .08	The organization accurately represents its certification status and the facilities and services to which Joint Commission certification applies.	2	The organization does not engage in any false or misleading advertising about its certification award.	No		
CPR .09	Applicants and certified organizations do not use Joint Commission employees to provide certification-related consulting services.	1	The organization does not use Joint Commission employees to provide any certification-related consulting services.	No		
CPR .10	The organization accepts the presence of Joint Commission reviewer management staff or a Board of Commissioners member in the role of observer of an on-site review.	1	The organization allows Joint Commission reviewer management staff or a member of the Board of Commissioners to observe the onsite review. Note 1: The observer will not participate in the on-site review process, including the scoring of standards compliance. Reviewer management staff will only participate in the review process if he or she feels it is necessary to bring any potential findings or observations to the attention of the reviewer and the organization. Note 2: The organization will not incur any additional fees because an observer(s) is present.	No		
CPR .11	Any individual who provides care, treatment, and services can report concerns about safety or the quality of care to The Joint Commission without retaliatory action from the organization.	1	The organization educates its staff and other individuals who provide care, treatment, and services that concerns about the safety or quality of care provided in the organization may be reported to The Joint Commission.	No		
CPR .12	The organization submits information to The Joint Commission as required. (Rationale for CPR 12) The cornerstone of TJC's certification process is the emphasis on a continuous process. As such, in order to realize the full benefit of a more continuous certification process, certified organizations will be required to have regular interactions with TJC	1	The organization meets all requirements for timely submission of data and information to The Joint Commission. (See also CPR 7, EP 1) Note: If information in an organization's electronic application for certification (E-App) leads to inaccuracies in the appropriate length of the review and a longer review is required, the organization will incur the additional costs of the longer review. In addition, if there is evidence that the organization has intentionally falsified the information submitted to The Joint Commission, the Information	No		

		l	applicanie.			I
CPR .13	CPR .13 The organization is truthful and accurate when describing		The organization adheres to The Joint Commission's published		No	
	information in its Quality Report to the public.		guidelines for how it describes information in its Quality Report.			
CPR .14	The organization is compliant with applicable federal laws,	1	The organization is compliant with applicable federal laws, including		No	
	including Medicare Conditions of Participation, and the		Medicare Conditions of Participation, and the requirements found in			
	requirements found in Appendix A		Appendix A			
CPR .15	The organization provides care, treatment, services, and	1	The organization provides care, treatment, services, and an		No	
	an environment that pose no risk of an "Immediate Threat		environment that pose no risk of an "Immediate Threat to Health or			
	to Health or Safety."		Safety."			
	Contributors: Kelly Connelly (Accreditation), F	Roby	nn Cox (Stroke Accreditation), Jen Lastic (Patient Expe	rience)		
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MEDICAL DIVERSITY AND INCLUSION

Connie Moreland, M.D., Mm Sc, FACOC METRO HEALTH SYSTEM CLEVELAND, OHIO

VP of Medical Diversity & Inclusion

VP of Medical Diversity & Inclusion

The MetroHealth System (MHS) and Case Western Reserve University (CWRU) School of Medicine seeks a dynamic and respected leader to be the next VP of Medical Diversity and Inclusion. The VP of Medical Diversity and Inclusion will work to increase the diversity of the MetroHealth Systems provider community, including advanced practice providers, faculty and house staff.

Among the Vice President's duties and responsibilities include:

- Assist MetroHealth System in achieving greater diversity in MetroHealt Systems's provider community, residency programs, and advanced practice providers.
- Employ mechanisms to broaden the participation of all current and future healthcare providers with an aim to recruit, retain and mentor under-represented minorities in medicine (URMiM). To that aim, participate in the recruitment of new house staff to the MHS GME programs.
- Identify and create tools around Diversity, Equity and Inclusion topics to help increase cultural awareness within the MetroHealth System's provider community.
- Promote DEI programming and encourage submission of proposals to MetroHealth System's education programs (medical students, nursing students, residents, fellows and advanced practice providers) that align with this mission

VP of Medical Diversity & Inclusion (cont'd)

Collaborate with student training program and clerkship leadership to enhance the diversity of these training opportunities.

- Encourage open dialogue and discussion that fosters inclusivity and a safe learning community.
- Participate in the strategic planning process of increasing provider diversity.
- Collaborate in proposals to increase diversity in the MetroHealth System.
- Develop the guidelines and tools to advance the MetroHealth System standard of DEI within the provider community.
- Be a resource for diversity and inclusion for the MetroHealth System provider community. Generate proposals for programs, sessions, and meetings that address DEI within the provider community.

Qualifications of the successful candidate include:

- MD or DO with an active Ohio license or ability to obtain an Ohio license
- Eligible for CWRU faculty appointment at Assistant Professor level or higher
- Experience and interest in diversity, equity and inclusion in medical education
- Experience with GME
- Have excellent verbal and written communications skill

WHERE ARE WE?

WHERE DO WE WANT TO GO?

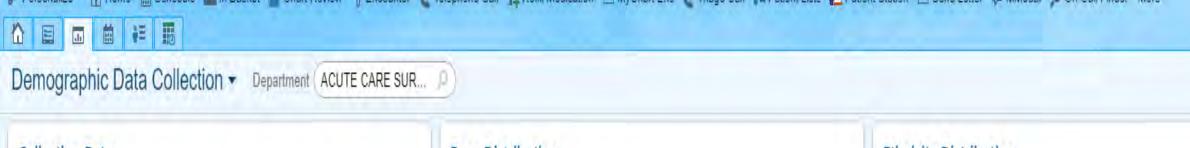
WHY?

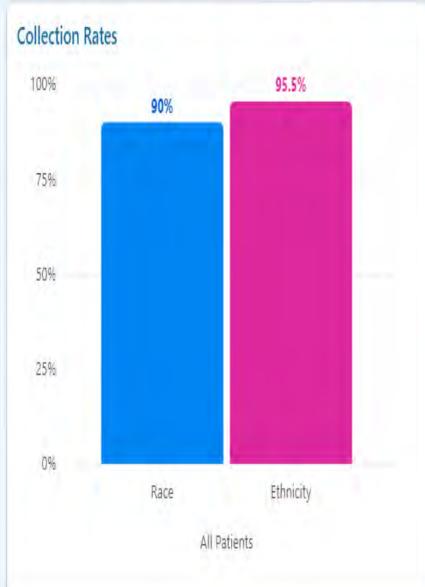
Eradicate

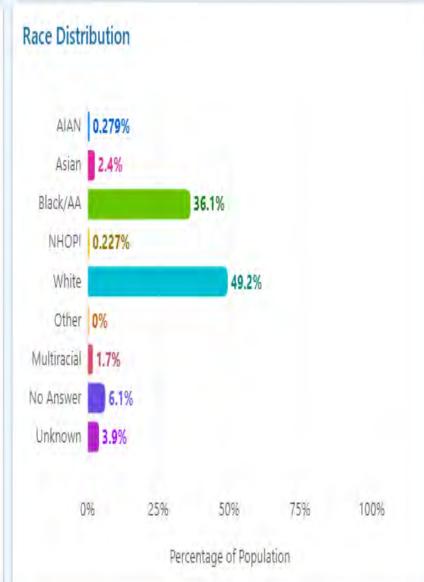
Healthcare Disparities

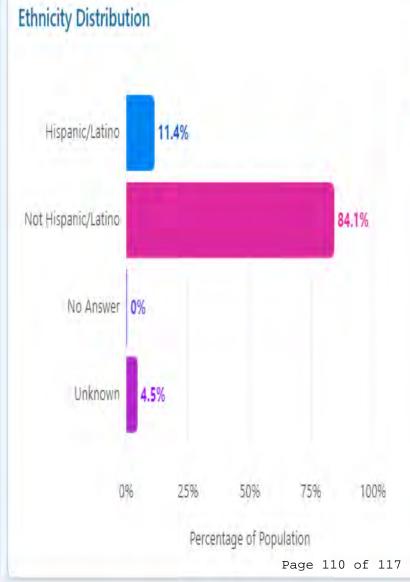
Outcomes are improved

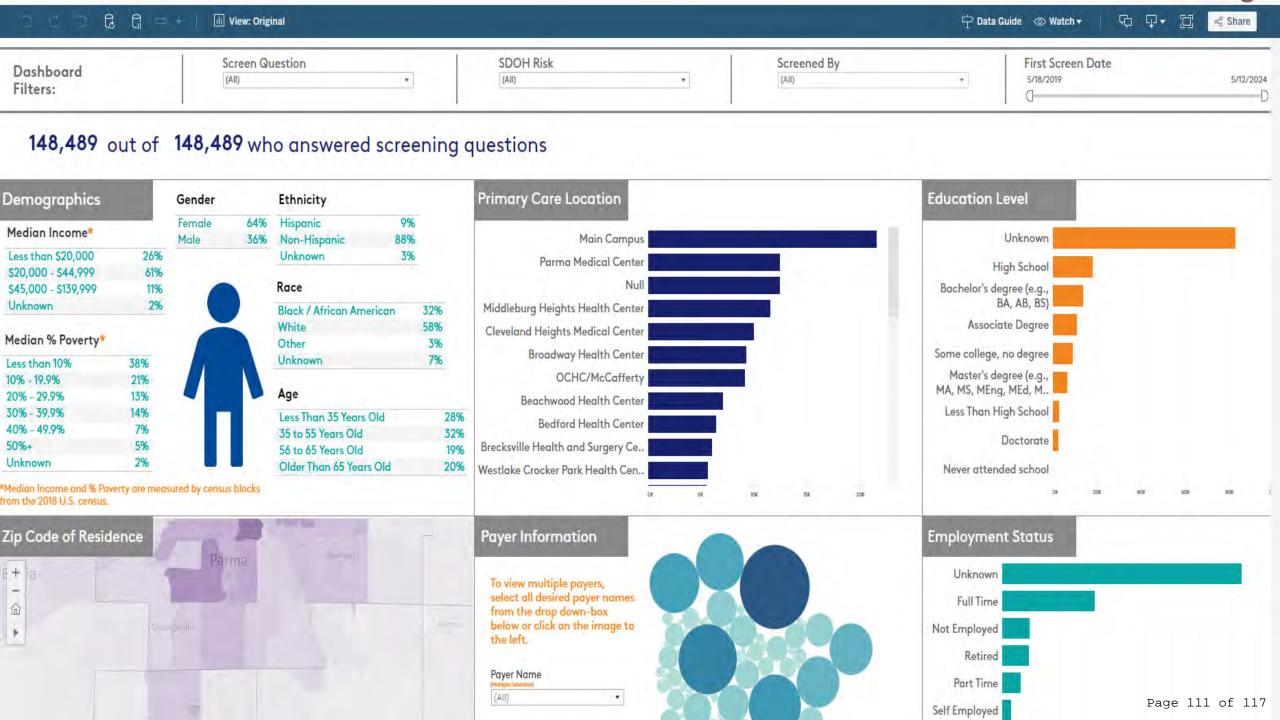
>Diversity medical providers



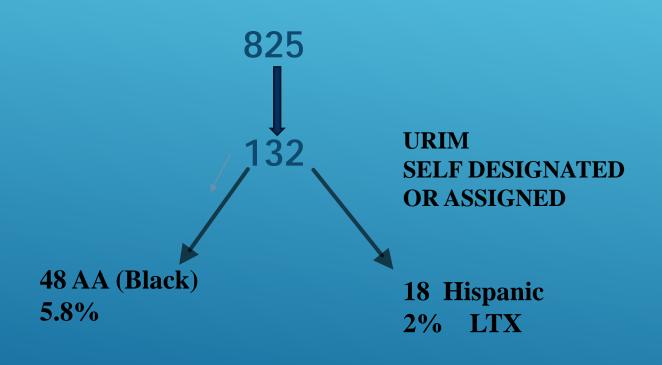




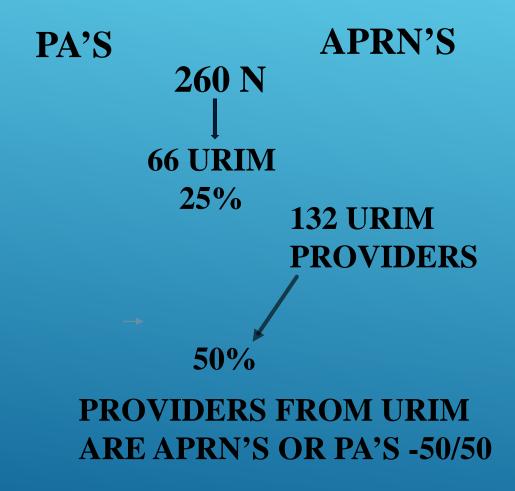




METRO HEALTH SYSTEM PHYSICIANS (MD DO DDS PHD)



METRO HEALTH SYSTEM ADVANCED PRACTICE PROVIDERS



DEPARTMENT (LTX / AA)

OB / GYN **OBESITY MEDICINE SURGERY PEDIATRICS** MED / PEDS **FAMILY MEDICINE PSYCHIATRY HOSPITAL MEDICINE** INTERNAL MEDICINE **DENTAL MEDICINE**

SPECIALTY DEPARTMENT (LTX / AA)

HEMATOLOGY ONCOLOGY	UROLOGY
NEUROSURGERY	VASCULAR SURGERY
NEPHROLOGY 1	PEDIATRIC ENDOCRINOLOGIST
CARDIOLOGY	GASTROENTEROLOGY
RADIOLOGY	GERIATRIC MEDICINE
ADULT GERONTOLOGY	REHAB PSYCHOLOGY
	VIRTUAL MEDICINE 1
	<u> </u>

CHALLENGES

"Buy = n VS Commitment"

"Foster a greater sense of community and inclusivity among all providers"

Diversity Beyond Race and Ethnicity – language, age, ability and experience

RESOURCES ARE NEEDED TO DO THIS WORK

FUNDING

Team

Everyone

Education

Training

Research

Will

Commitment