![DNCC - Disparities National Coordinating Center]

Proceedings: Driving Down Disparities

Disparities National Coordinating Center
Virtual Conference:

Innovations in Health Care Delivery,
Communications and Technology
April 8, 2014

Summary of the Virtual Conference

Innovations in Health Care Delivery, Communication and Technology

Virtual Conference

April 8, 2014 12-4PM EST

Summary:

The Disparities National Coordinating Center (DNCC) held a virtual conference on Tuesday, April 8, 2014 to inspire QIOs with innovations in technology, communications and care delivery that will be applicable to their future disparities work. Over 200 participants joined the conference to learn about new techniques in healthcare delivery; gain understanding of how technology, effective communication and policies can impact health disparities and explore innovative ways to apply these tools to their work

Background on the DNCC and QIOs:

By law, the mission of the QIO program is to improve the effectiveness, efficiency, economy and quality of services delivered to Medicare beneficiaries. The QIOs are key mechanisms by which the Centers for Medicare & Medicaid Services (CMS) improve the quality of care for over 50 million Medicare beneficiaries, including the growing number of racial and ethnic minorities and those from underserved populations. CMS contracts with 53 organizations representing every state, as well as the District of Columbia, the U.S. Virgin Islands and Puerto Rico. In September 2012, CMS named Delmarva Foundation for Medical Care as the Disparities National Coordinating Center (DNCC). The role of the DNCC is to support QIOs' efforts to reduce health disparities among underserved Medicare populations. This Virtual Conference is one of many trainings and conferences held monthly for all of the 53 QIOs.

DNCC Speaker Biographies

Edo Banach, J.D., Senior Advisor in the Medicare-Medicaid Coordination Office; Acting Director, Demonstrations, Models and Analytics Group-Medicare-Medicaid Coordination Office

Edo Banach is the Senior Advisor in the Medicare-Medicaid Coordination Office, and Acting Director of the Demonstrations, Models and Analytics Group. He previously was Associate General Counsel at the Visiting Nurse Service of New York. Prior to that, Edo Banach was the Medicare Rights Center's General Counsel. Edo also practiced health law at the firm of Latham & Watkins and clerked for U.S. Judge John T. Nixon of the Federal District Court for the Middle District of Tennessee. Prior to attending law school, Edo worked for the New York City Department of Homeless Services and Mayor's Office of Operations. Mr. Banach holds a B.A. from Binghamton University and a J.D. from the University of Pennsylvania Law School.

Clement Bezold, Ph.D., Chairman and Senior Futurist, Institute for Alternative Futures

Dr. Bezold is a Chairman and Senior Futurist at the Institute for Alternative Futures (IAF), which he and others founded in 1977 to encourage "Anticipatory Democracy." Trained as a political scientist, he has been a major developer of foresight techniques, applying futures research and strategic planning methods in both the public and private sectors. Health futures is among Dr. Bezold's specialties and he has done futures work with the American Cancer Society, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the National Institutes of Health, and the World Health Organization. He has also worked with many health professional associations, including those for physicians (the American Medical Association, American College of Surgeons, American Osteopathic Association, and American Association of Naturopathic Physicians); state medical societies; and specialty societies in aging, hospice, and palliative care. He leads IAF's health equity efforts – believing that health equity is the next civil rights movement. Recent futures projects he has lead include Chiropractic 2025, Community Health Centers Leveraging the Social Determinants of Health, Primary Care 2025, Public Health 2030, and Vulnerability 2030.

Jeffrey Brenner, M.D., Executive Director, The Camden Coalition of Health Providers

Dr. Jeffrey Brenner, MD is a family physician that has worked in Camden, NJ for the past fifteen years. Dr. Brenner owned and operated a solo-practice, urban family medicine office that provided full-spectrum family health services to a largely Hispanic, Medicaid population including delivering babies, caring for children and adults, and doing home visits. Recognizing the need for a new way for hospitals, providers, and community residents to collaborate he founded and has served as the Executive Director of the Camden Coalition of Healthcare Providers since 2003. Through the Camden Coalition, local stakeholders are working to build an integrated, health delivery model to provide better care for Camden City residents. Dr. Brenner's work was profiled by the writer and surgeon Dr. Atul Gawande in an article in The New Yorker entitled "The Hot Spotters" (1/24/11) and in an episode of PBS Frontline (7/27/11). In 2013 he received a MacArthur award. Dr. Brenner is also the Medical Director of the Urban Health Institute, a dedicated business unit built at the Cooper Health System focused on improving care of the underserved. Using modern business techniques, they are redesigning long-standing clinical care models to deliver better care at lower costs.

Naturopathic Physicians); state medical societies; and specialty societies in aging, hospice, and palliative care. He leads IAF's health equity efforts – believing that health equity is the next civil rights movement. Recent futures projects he has lead include Chiropractic 2025, Community Health Centers Leveraging the Social Determinants of Health, Primary Care 2025, Public Health 2030, and Vulnerability 2030.

Sandy Hilfiker, M.A., Principal, Director of User Centered Design, CommunicateHealth Inc.

Sandy is a Principal at CommunicateHealth and a leading expert in the design and development of consumer health websites and e-health tools for users with limited health literacy skills and limited experience on the web. She is a passionate advocate for user-centered design, with over a decade of experience in health communication and usability research. Sandy is also a seasoned contract and project manager with experience coordinating large federal communications contracts, both as a contractor and as a federal employee.

Sara Minsky, M.P.H., Assistant Director, Viswanath Lab, Center for Community-Based Research
Dana-Farber Cancer Institute

Sara completed a BA in Economics at Emmanuel College and an MPH at Boston University. She has
been working in the Center for Community Based Research at Dana-Farber Cancer Institute (DFCI)
for the past seven years managing study operations for several community-based participatory
research projects. Prior to joining DFCI, Sara worked at Boston University School of Public Health, in
the Social and Behavioral Sciences Department, managing randomized controlled trials that
examined residual effects of alcohol on occupational and academic performance, and effectiveness of
condom promotion interventions on STI reduction.

Madeleine Shea, Ph.D., Vice President of Population Health; Director, DNCC,
Delmarva Foundation for Medical Care

Maddy Shea is a leader in population health improvement with expertise in disparities
analytics, community development, health policy, and program evaluation. Over the past
two decades, she has served as a public health leader in Maryland with responsibility for
population health improvement planning, chronic disease prevention and management,
infectious disease and environmental health. She holds degrees in economics, management and
public policy. In her role as Vice President for Delmarva Foundation's new Population Health Center,
Maddy leads the DNCC's strategies and partnerships to reduce disparities among Medicare
beneficiaries.

Gisele Sorenson, R.N., M.S.N., NAH Director, Telehealth, Care Beyond Walls and
Wires

Gisele (Gigi) Sorenson, a graduate of Northern Illinois University with Master of Science in
Nursing, is Director of Telehealth for Northern Arizona Healthcare; parent organization
comprised of Flagstaff Medical Center, Verde Valley Medical Center (VVMC) and VVMC
Sedona Campus. Ms. Sorenson previously held Clinical and Administrative leadership
roles in Cardiology, with expertise in interventional cardiology and open heart surgery
program development. As Telehealth Director, Ms. Sorenson is responsible for the
inception of the program, strategic planning, and global operational responsibilities with NAH acting
as both hub and spoke site with work in remote monitoring, outpatient and inpatient care delivery
model development, and transitions planning using telemedicine. Extensive partnership work on
clinical telemedicine delivery has occurred with healthcare facilities of all scope and sizes across
northern Arizona. She is actively involved in the American Telemedicine Association being current
Vice Chair of the Business & Finance SIG and a member of the Arizona Telemedicine Council.

AGENDA

Introductory Remarks by:
Madeleine Shea, Ph.D., Vice President of Population Health; Director for the Disparities National Coordinating Center

"Hot Spots" – A New Care Delivery Model presented by:
Jeffrey Brenner, M.D., Executive Director for the Camden Coalition for Health Providers

The Future of Primary Care presented by:
Clement Bezold, Ph.D., Chairman and Senior Futurist, Institute for Alternative Futures

Addressing Disparities: Innovations in Coordinated Medicare/Medicaid Initiatives presented by:
Edo Banach, Senior Advisor, Medicare-Medicaid Coordination Office; Acting Director, Models, Demonstrations and Analysis Group, Medicaid Coordination Office

Innovations in User Centered Design: Improving Research Among Underserved Populations presented by:
Sandy Hilfiker, M.A. Principal, Director of User Centered Design, CommunicateHealth Inc.

QIO Discussion facilitated by:
Amy Steinmann, M.S., Manager, CRISP NCC, VHQC
Amelia Williams, Ph.D., Communications Coordinator & Medical Editor, CRISP NCC

Project IMPACT: Mobilizing Community Based Organizations to Address Health Disparities presented by:
Sara Minsky, M.P.H., Assistant Director, Center for Community-Bassed Research, Dana Farber Cancer Institute

Innovative Technology Applications in Healthcare presented by:
Gigi Sorenson, R.N., M.S.N., NAH Director, Telehealth, Care Beyond Walls and Wires

QIO Discussion facilitated by:
Catherine Price, M.S. Ed, Project Manager, Care Transitions, Health Services Advisory Group, Inc.

Closing Remarks by:
Madeleine Shea, Ph.D.

Introductory Remarks:

Dr. Madeleine Shea provided the following overview of the work being done by the DNCC. For the past eighteen months the DNCC has been developing and shared national and state data to drive down Medicare disparities, in adverse drug reactions, healthcare acquired infections, nursing home quality and chronic disease.

The DNCC has led monthly trainings, published three regular newsletters and managed two websites to drive solutions to Medicare disparities.

Disparities related to race, ethnicity, poverty, age, gender, disabilities and geography were studied. The DNCC has been impressed by the work of the QIOs in improving healthcare while lowering healthcare costs and obtaining better outcomes.

The DNCC's goal for this Virtual Conference was to challenge participants to identify, adapt and continuously improve innovative approaches to reduce disparities in health resources, services and outcomes.

Presentation #1:

Jeffrey Brenner, M.D., The Camden Coalition of Health Providers: Healthcare Hotspotting: Innovative Approaches to Caring for Superutilizers

Dr. Brenner began with thought provoking statements about the state of healthcare and its current framework. He described population health as an emerging field that does not yet exist because it lacks a clear definition and framework. Care management was dubbed a meaningless word that may apply to many existing models. "Hotspotting," in which he describes as using data in real time to locate, identify and target outliers who represent failures in service delivery is the focus of his work. The Camden Coalition of Health Providers uses billing data from three major hospitals, including more than 500,000 records from 98,000 patients to stimulate better health targeting. The Camden Coalition data showed that 50% of the population used the Emergency Room or inpatient services in one year and $108,000,000, mostly public money is spent each year in the Camden area to re-hospitalize patients. When breaking down the costs, it was found that 1% of the patients account for 30% of the costs; 13% of patients for 80% of the costs and 20% of patients for 90% of the costs. The value of focused data analysis is less about getting answers and more about asking better questions.

Dr. Brenner shared that systems have a hard time responding to 'superutilizers,' more commonly known as outliers; patients who return to the hospital excessively. Biostatisticians and epidemiologists stick to descriptive data because the long, nonlinear streams of information mess up data analytic models and are often ignored. Focusing solely on outliers reveals much more about the properties of an underlying problem in any system.

The Camden study is the exploration of such outliers. The data showed the top ten diagnoses in the emergency room were primarily made up of problems that could be treated in primary care. In the United States, most Emergency Room visits are from insured patients who could not get an appointment with their primary care physicians.

To illustrate hotspotting, Dr. Brenner provided a geographic slide of the Camden area. However, he noted that geographic mapping does not mean anything if you are not prepared to implement changes to management structures in response to the data.. Focus must be on the unit of accountability and how to create an accountable management system. To do this, there is a need to push the authority down to accountable managers to let them access data and make decisions according to it. Make the level of authority the same as the level of responsibility.

There is a growing need to focus on the sickest and most complicated patients who require a different construct of data driven, service delivery models and much deeper segmentations instead of linear stratifications. The return on investment for delivering community health service/education to patients who are mildly sick/generally well is at least ten, twenty, thirty years from now. Although it may be morally and ethically important, it is deemed almost entirely useless in the federal/state budget projections.

Knowing that, the Camden project shifted its model and began looking at "outliers." An example of healthcare dollars not being spent wisely is this situation in which, a patient required six hospitalizations in a six month period costing approximately $60,000. For that amount, two community workers could have been hired to assist multiple patients.

The diagram below illustrates patient centered care coordination (PCCC). Currently, doctors are not trained to work in teams and there is no collaborative framework/operational models to support team approaches to care. If everyone in the PCCC did the right thing, they would all go out of business and like the return on investment mentioned earlier, we are about twenty years away from solving this problem.
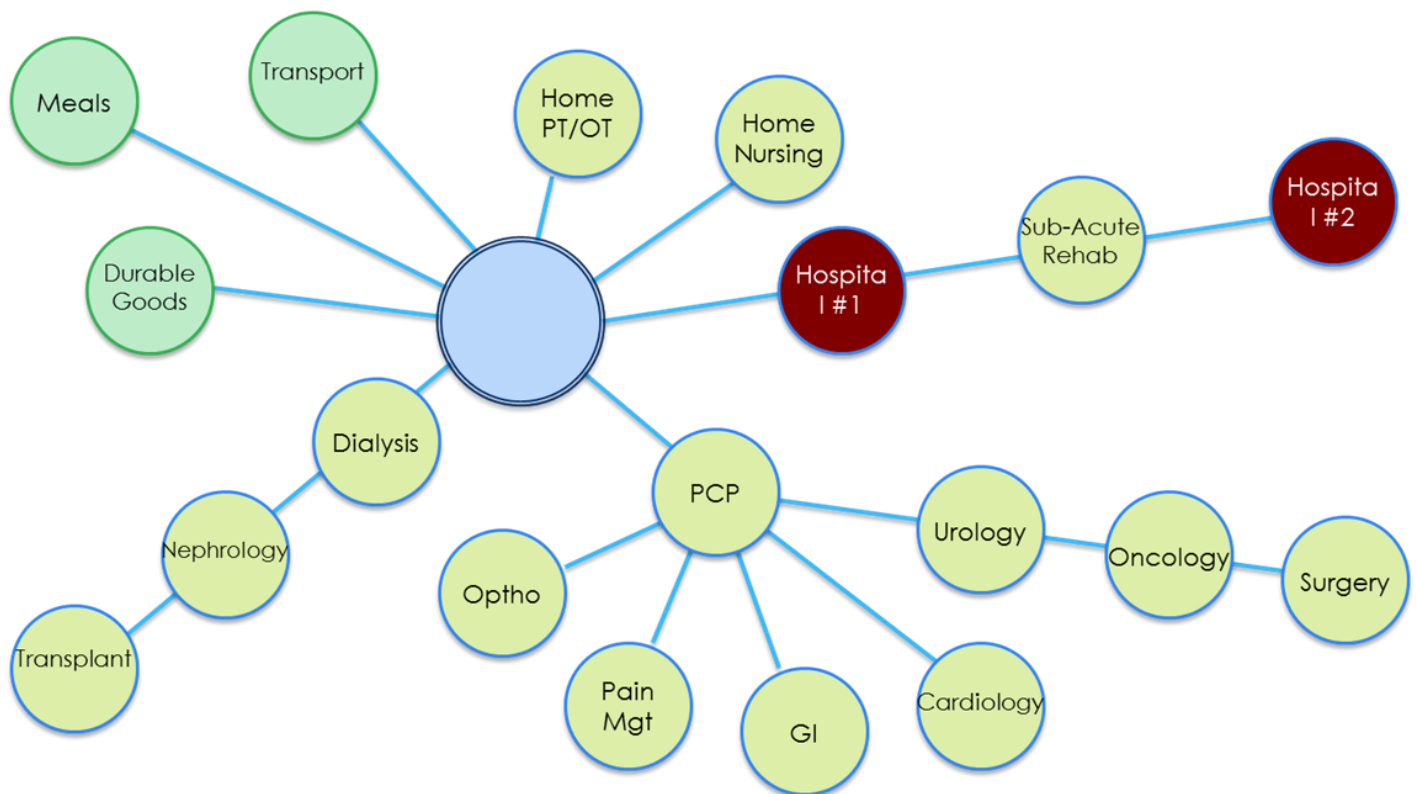
Conclusion:

There is a huge amount of the work that can be shifted but it requires new training, delegation and operational models and can be very difficult to scale. To work around those issues, the Camden project uses a health information exchange which is updated every day to target, triage and implement care plans for patients from their bedside. Subsequently, a 90 day work flow is developed with home visits, professional accompaniment, and help with navigating benefits and applications.

Questions and Answers:

Question 1:

How were you able to get protected health information? The data collection began twelve years ago and went through IRB review. The entire process is posted on The Camden Coalition website. Click HERE to view. The Camden coalition has also developed business associate agreements with 25 hospitals to collect data and is working on an open source toolkit which will be available on the website in the near future.

Question 2:

Do you feel like programs like NCQA's Medical Home Accreditation are effective? In his opinion, NCQA certifications are doing damage to population health. The initial concepts developed by primary care should have been researched for an extended period to figure out what was being done in the real world and then a body of information could emerge on change management focusing on better care delivery at lower costs. We need to modernize primary care and figure out what the model of the future will look like. Dr. Brenner referenced the Nuka system of healthcare in Alaska, a flat team based model, which he considers about 15 years ahead of other primary care systems.

Presentation #2:

Dr. Clement Bezold – Chairman and Senior Futurist for the Institute for Alternative Futures: <u>Primary Care Futures: Quality, Care and Equity</u>

In Dr. Bezold's opening remarks, he introduced the following key points:

- Our definitions of primary care quality are evolving rapidly
- Health equity is part of a larger trend and represents the next civil rights movement
- QIOs ensure and accelerate quality
- This is an intensely uncertain, challenging and opportunity filled time for health care

Quality relates to a range of futures and primary care scenarios. Futures is defined as considering what might happen (plausible) based on trends and scenarios and what we *want* to happen (preferred) based on an aspirations model and vision.

As health care systems shift, scenarios are alternative stories about the future. They explore major pathways and are used to understand change, clarify assumptions, track trends and develop vision. Scenarios consider likelihoods and possibilities and aid in understanding and creating the future. In the center of the drawing below, Dr. Bezold illustrates different scenarios. Given the current trends, we should ask, what is the most likely future? What can go wrong? What are the challenges? In addition, we should look at visionary and surprisingly successful possibilities as well.
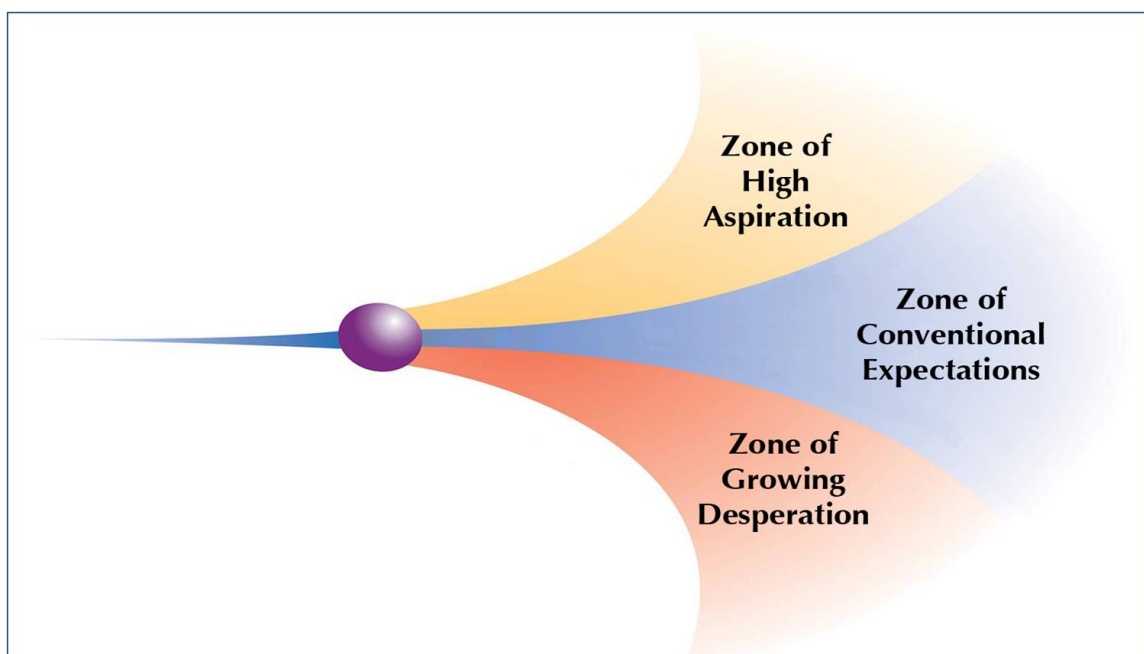
Summary of the Virtual Conference

Dr. Bezold also spoke of disruptive innovations which can be business innovations (quality, PCMH to CCHH, bundled payments, medical tourism, transparency of costs, retail clinics) and/or new business technologies (personalized medicine and care, electronic medical records, digital coach/navigators, care in virtual space). Healthcare quality is evolving as seen in the Institute of Healthcare Improvement's Triple Aim or more robustly, in the Institute of Medicine's Six Aims. The Triple Aim targets population health, experience of care and per capita costs. Don Berwick, one of the originators of the Triple Aim has added a fourth target, love and kindness.

Healthcare represents about 10-25% of what determines our health. Behavior, access to care and environment are also are major factors. You cannot change health without focusing on social determinants. The audience was asked to imagine a care system that works for all, in which everyone has access to effective, lower cost primary care that is personalized, anticipatory, available anywhere based on evidence-based protocols and includes a digital health coach. Quality has evolved from the patient center medical home (PCMH) to the community centered health home (CCHH) which has stronger community awareness. In this model the primary care team expands to include physicians, nurse practitioners, physician assistants, chiropractors, physical therapists, (5-20% of primary care issues are related to spine, muscular, skeletal issues) social workers, pharmacists, dentists, and community health workers. The PCMH includes health care personnel and teams all practicing at the top of their licenses. It also includes community health care workers going into homes supported by digital coaches.

CCHH is the next step, putting primary providers to work with community partners to collect socio-economic & community conditions, aggregate health and safety data and review trends, identify priorities and strategies and coordinate activities, act as community health advocates, mobilize patient populations, strengthen partnerships with local health care organizations, and establish model organizational practices.

Personalized care will include genomics and biomonitoring, epigenetics and zipcodemics; personalized definitions of normal and diseased (where your results are based on your baseline and not the national average); massive data on treatments and the analysis of the side effects, in addition to the results for personalized prescriptions for individuals. Electronic medical records, expert support of providers, digital health coaches, personalized vital signs, digital health agents, gaming and social networks were also discussed as potential aides.

The four scenarios in the **Primary Care 2025**, an Institute for Alternative Futures/National Association of Community Health Centers project supported by a grant from the Kresge Foundation are as follows:

- **Many Needs, Many Models** scenario - The expansion of patient centered medical homes which is a core definition of quality for primary care. With some shortages of primary care physicians, all team members will practice at the top of their license with prevention being an integral part. In this scenario, we double the percent of Americans using integrated systems to 40% by 2025. It is anticipated that employers will drop insurance and members will be placed in health insurance exchanges with significant disparities remaining in access and quality.
- **Lost Decade, Lost Health** scenario – Physician revenue declines, there is a shortage of primary care providers and health care reform doesn't go through but the need for it increases; however, those with access will receive great care with advanced technology; many rely on unreliable online advances, many more uninsured.
- **Primary Care That Works for All** scenario – PCMH evolves to CCHH. Triple AIM becomes increasingly significant in population health. Health reform moves forward in this model with 85% of Americans using integrated systems with an expanded team of providers. Ten percent use concierge fee-for-service and 5 % uninsured using community health centers and ERs. CCHH will address local, social and economic foundations for equitable health, creating healthy communities. Proactive electronic records with virtual access, digital health coaching, advanced knowledge technologies and community mapping allowed for identification and remediation of hotspots of ill health.
- **I Am My Own Medical Home** scenario - Advanced technologies will allow self-care through high deductable insurance. 40% using consumer directed health plans (self-care management); 40% using integrated systems; 10% using concierge fee-for-service and 10% uninsured using community health centers and ERs.

The following chart shows the application of the aforementioned scenarios as it relates to knowledge technology and decision support:

	#1 Many Needs, Many Models	#2 Lost Decade, Lost Health	#3 Primary Care that Works for All	#4 "I am my medical home"
Knowledge tech / decision support	• Biomonitoring integrated to EMR & care protocols --consumer PHR & integration EMR • Health Avatars, digital coaches • New vital signs & community health measures	• EMR's are not interoperable • little consumer uptake (due to both cost and relevance) • New vital signs, biomonitoring, most effective avatars, available for the affluent	• Interoperable EMRs that include genetic, epigenetic, biomic, community and other factors • Health avatars support individual and community health	• Interoperable EMRs that include genetic, epigenetic, biomic, community and other factors • Health avatars support individual and community health • quality standards for avatars, both sold and given for free

Conclusion:

The meaning of high quality healthcare is evolving. It is important to know the range of likely futures, particularly in primary care but even more important to know and still pursue a vision and preferred future.

Questions and Answers:

Question 1:

What impact will the Affordable Care Act have on the four scenarios? The exchanges were built into all scenarios and the effect would depend on how well it is implemented. A well implemented exchange system is seen in scenario three.

Question 2:

Can you give any examples of the scenarios that are currently active? In the Primary Care 2025 report, (which you can view HERE) the Nuka Healthcare System is listed as an example.

Question 3:

Can you comment on the most effective method for changing behavior for the better? There are two pieces to this. One is the increasing use of behavioral reminders. The second is to make the healthy choice the easy choice. Social media will play a greater role in behavioral change in the future. This aspect will be discussed in Primary Care 2030 which is scheduled for release in May 2014.

Presentation #3:

Edo Banach – Senior Advisor, Acting Director for Models, Demonstrations and Analysis Group – Medicare – Medicaid Coordination Office; Centers for Medicare & Medicaid Services: <u>Addressing Disparities: Innovation in Coordinated Medicare/Medicaid Initiatives</u>

Mr. Banach launched into his presentation citing that most dual eligibles have a difficult time navigating and coordinating all the complexities of Medicare and Medicaid services. Section 2602 of the Affordable Care Act created by the Medicare-Medicaid Coordination Office (MMCO) strives to improve quality, reduce costs, improve the beneficiary experience through coordination and eliminate financial misalignments that lead to poor quality and cost shifting. Current initiatives of the MMCO include 1) Initiative to Reduce Avoidable Hospitalizations, 2) Financial Alignment Demonstration and 3) Program of All-Inclusive Care for the Elderly (PACE) Initiatives.

The Initiative to Reduce Avoidable Hospitalizations is set to reduce preventable hospitalizations among residents of nursing facilities. Organizations in six states are partnering with 144 nursing facilities. Each organization will have on-site staff to partner with the existing nursing facility staff to provide preventative services as well as improve assessments and management of medical conditions.

In 2011, CMS announced new models to integrate the service delivery and financing of the Medicare and Medicaid programs through a federal-state demonstration to better serve the population. The Capitated Model and the Managed Fee for Service Model have a common goal to increase access to quality and integrate programs for the 9 million Medicare-Medicaid enrollees. Both are contracts and agreements between the state and CMS to provide comprehensive, coordinated care in a more cost-effective way and reduce costs in both Medicaid and Medicare respectively. This collaboration will create a more seamless system by focusing on person-centered models, developing an easier system to navigate, ensuring access, establishing accountability for outcomes, requiring robust networks to evaluate data on access outcomes and beneficiary experience. Nine states have approved capitated demonstrations, two have approved a managed fee for service demonstration and one state has approved an alternative model.

The PACE intiative is a current program using a patient centered approach that provides coordinated and seamless care for the elderly. A PACE pilot program for younger disabled is being considered for the 2015 budget.

Conclusion:

The new demonstrations include readiness review, implementation, monitoring and evaluation. Mr. Banach challenged QIOs to hold the government, health plans and providers accountable for outcomes.

Questions and Answers:

Question 1:

Could you discuss expected outcomes for the capitated model and are they uniform or different for each state? Some things will be uniform across all states such as stabilized costs. State demonstrations may target different populations.

Question 2:

Are there any projects targeting racial/ethnic minorities? The short answer is no but the status quo does not work well for a number of people so all of the work has to focus on disparities, especially in the Medicare population.

Question 3:

Are out of state Medicaid payment issues being addressed? That cannot be guaranteed but the contracts with health plans stipulate that they cover urgent and emergent care anywhere.

Question 4:

How is your office addressing network adequacy? Because there are a lot of providers who are not always willing to take Medicare/Medicaid patients, the Medicare-Medicaid Coordination Office requires health plans to have adequate providers to participate and move toward uniformity in networks.

Presentation #4:

Sandy Hilfiker, M.A., Principal, Director of User Centered Design, CommunicateHealth Inc.: Innovations in User Centered Design to Increase Health Literacy

In Ms. Hilfiker's experience, health information that is engaging and easy to use will hold a user's attention. The User Centered Design (UCD) involves end users (the audience) in the design and development of a product, message or campaign. The UDC process includes research with the user audience, developing a prototype, testing, tweaking and re-testing. By involving users, target audiences will be empowered and invested in your product and time will not be wasted developing materials and products that nobody will utilize.

Research shows that it takes fifteen seconds to grab a user's attention to your website and web pages with clear value will hold their attention longer. Therefore, designs must be usable (technical issues), useful (the information and content meets the need), appropriate (cultural appropriateness and literacy) and appealing (attractiveness) to the audience.

Literacy is a key consideration. About 9 in 10 Americans have limited health literacy skills and 50% have limited literacy skills in general as illustrated in the drawing below. We need to make sure we are accommodating all of the population we are trying to reach. Designing for people with lower literacy does not necessarily turn off those with higher skills.

Do I need to worry about health literacy?

About 9 in 10 Americans have limited health literacy skills.

Limited Literacy

Limited Health Literacy
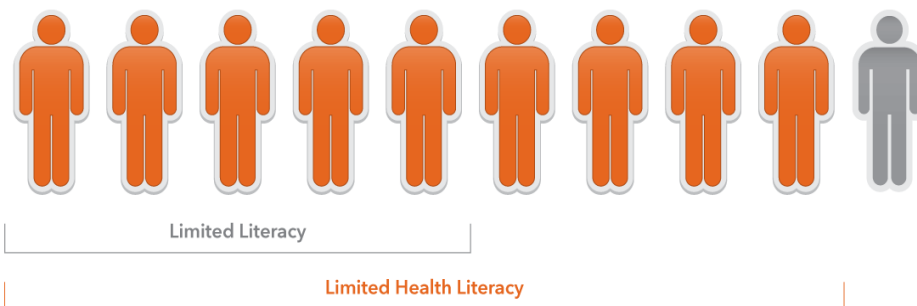
Some techniques to learn more about your audience include: interviews, focus groups, surveys and the following methods:

- Collaging is a sample method in which participants create a collage that represents the characteristics they would like to see in a new website or product. This provides insight into users' needs not normally revealed in interviews and focus groups.
- Tree testing is an online tool that helps organize content. It is a technique for evaluating how easy it is for people to locate information within a material or website structure.
- Card sorting allows people to make piles of similar information with a description label that will form the organizational structure.
- Click testing is an online tool that will reveal which part(s) of a product is usable. It gathers quick feedback on wireframes or mock-ups of webpage design. It provides a heat map of where participants expect to find certain information and aides in gathering feedback on specific label and visual design elements.

Ms. Hilfiker commented that usability testing helps participants explore a website or application in a natural way through real-life scenarios. It allows people to think aloud, provides realistic results, and exposes unexpected usability issues. This method with five participants will reveal 85% of usability problems.

Ms. Hilfiker shared the top ten tips to involve participants with limited health literacy: partner with community organizations to recruit special populations, screen for participants with limited health literacy using proxy measures, develop screeners, consent forms, and moderator's guides in plain language, limit the use of Likert-style questions, use cash incentives when possible, screen for participants with limited technology use, limit the number of tasks, pre-test your protocol with at least one participant with limited literacy skills, choose a moderator with experience conducting research with limited literacy participants, and conduct testing sessions in a setting that is familiar and accessible to participants.

Conclusion:

Ms. Hilfiker reiterated that 75% of adults have looked online for health or medical information, 60% of adults have searched for health information online and searching for health information is one of top three most popular online activities.

Questions and Answers:

Question 1:

Why should Likert-style questions be avoided? If there are a lot of questions at the end of a survey, interview or focus group, it can be overwhelming and the data collected may not be accurate.

Question 2:

Are there any consequences of a CMS contractor providing financial incentives to beneficiaries? As a government contractor, User Centered Design, Communicate Health Inc. incentivizes all the time but there must be clearance from the Office of Management and Budget. One caveat is that federal and state employees are usually not permitted to take incentives.

Presentation #5:

Sara Minsky, M.P.H. Assistant Director, Center for Community-Based Research Dana Farber Cancer Institute: <u>Project IMPACT: Mobilizing Community Based Organizations to Address Health Disparities</u>

Ms. Minsky began the presentation by presenting this question to the audience: Can Communities change public agenda and political will to address the complex problems of health disparities? Project IMPACT builds community capacity to change the public agenda through local media coverage to ensure sustainability. The project builds on community assets rather than focusing on deficits and differences which is common in disparities research. The media tends to emphasize individual behaviors as the major driver in health outcomes as opposed to disparities; a significant determinant which largely explains why people are so uninformed.

Project IMPACT is one of five cancer related projects at the Lung Cancer Disparities Center at Harvard School of Public Health funded by the National Cancer Institute. It is Community-Based Participatory Research (CBPR) with a community partners advisory committee comprised of community leaders from city government, community organizations, the Department of Public Health and study investigators. The project is in its fourth year and remains focused on understanding and addressing the joint impact of socioeconomic status, racial and ethnic disparities along the cancer continuum. Guided by CBPR approaches, the principles of social justice and actions as key elements are heavily employed. These approaches elucidate the complex drivers of health and allow the communication findings, which are more amenable to translation, to be crafted into practical solutions.
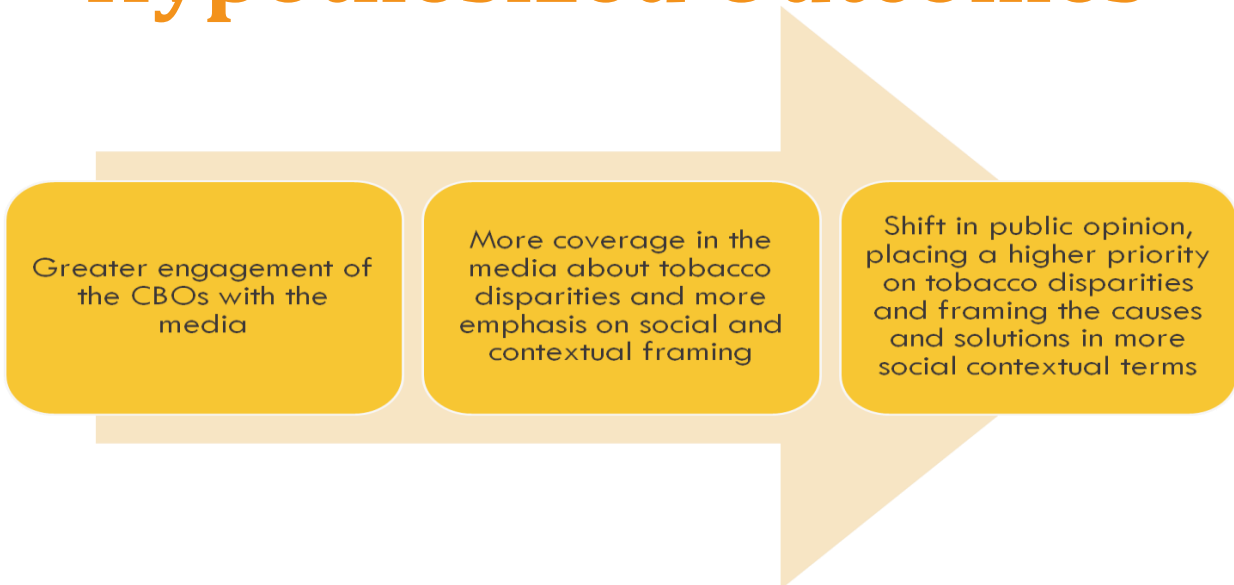
Project IMPACT has three aims:

- Aim 1: Public Agenda Assessment – Examine the public agenda about health disparities including tobacco disparities. This was assessed in the media environment, public opinion, and community leadership interviews.
- Aim 2: Intervention Development – Using findings from the Public Agenda Assessment to design a model to influence the public agenda on health disparities with specific attention to tobacco disparities including the development of a media training program and a toolkit for journalists. An objective of the intervention aim was to foster media relationships. In doing so, the community can educate editors and the media can then educate the public.

- Aim 3: Intervention will be used to train community-based organizations (CBOs) that work with underserved populations, on how to work with local media to advance their agenda around health disparities focusing on socioeconomic status and race/ethnicity.

Following the explanation of each aim, Ms. Minsky described how hypothesized outcomes can create a shift in public opinion and subsequently place a higher priority on tobacco disparities. This would then frame the causes and solutions in more socially contextual terms. The flowchart below illustrates the process from start to finish.

Hypothesized Outcomes

Greater engagement of the CBOs with the media

More coverage in the media about tobacco disparities and more emphasis on social and contextual framing

Shift in public opinion, placing a higher priority on tobacco disparities and framing the causes and solutions in more social contextual terms

The findings from the public agenda assessment illustrated that individual responsibility is the dominant frame for understanding cancer prevalence in Lawrence, MA. The results highlighted missed opportunities by the media to examine health disparities, which are often ignored by media outlets. Local media shows little to no coverage of health inequalities. Healthcare stories are typically limited to healthcare reform, fundraisers for cancer and other common diseases and heroic tales of people who have battled against illnesses.

Project IMPACT is providing five workshops from 2013-2014 to help CBOs understand how to work with the media on stories about health disparities. The intervention components include the workshops previously mentioned, interactive in-class exercises, a training manual, a wiki providing additional resources and continuing networking and alumni events.

Conclusion:

The workshops were evaluated pre, post and six months after the final workshop. All participants agreed/somewhat agreed that the workshop helped them to understand that where people live, work and play has an important effect on health, participants also learned strategies for communicating about health inequalities and for interacting with the media. Participants have since used social media, written press releases, developed communication plans and more. There will be a final workshop and in depth interviews with high and low utilizers of the workshop components to learn about their barriers and facilitators to using these skills. There is also a plan to package highlights of the workshop to share with the community.

Questions and Answers:

Question 1:

Can you describe the participants of the training? The majority of the participants are female, college educated professionals providing programming in the city of Lawrence working as grant writers or in the communication departments of hospitals.

Question 2:

What made you choose the media? The Community-Based Research Dana Farber Cancer Institute was trying to address the public agenda and previously the media had not done a good job of exposing health and heath disparities with their platform and tremendous community influence.

Presentation #6:

Gigi Sorenson, **R.N., M.S.N.,** NAH, Director of Telehealth Care Beyond Walls and Wires: Innovative Technology Applications In Healthcare

The Flagstaff Medical Center (FMC) is located in northern Arizona and serves an area of approximately 62,000 square miles. FMC is a Level I trauma center and the regional referral center for Northern Arizona. At any one time, 30% of all inpatients are from Native American reservations in the area. The population density of the area served is 12-15 people per square mile. Due to the geographic spread, FMC needed to look beyond in-hospital patient care and also at care transitions to ensure the patients are discharged to a safe place.

The strategy for healthcare delivery should always come before strategizing about use of technology. FMC defined telehealth needs and identified partners and the tools needed to improve health services. It was important to consider the needs and concerns of patients and families as well as providers since telehealth devices can be considered invasive based on cultural beliefs. Other considerations included cultural sensitivity, use of a help center for technology and compatibility tools for wireless devices (certain places on the reservation do not allow GPS tracking). One size does not fit all, and there must be multiple tools in place to reach the maximum amount of patients.

Certain things to consider when selecting technology include: privacy and security needs, integration into existing technology, connectivity compatibility, ability to expand, ease of use, cost and ease of installation.

The following is a list of the technology currently available:

- Carts [Picture 1]
- Remote monitoring tools
    - Weight scale
    - Blood pressure cuff
    - Pulse oximeter
    - Transmission pod
- Software connections
- Mobile phones

Picture 1

The aforementioned technologies can be used in the ways listed below:

- Pre-hospital care assessment which is particularly helpful for trauma patients
- Patient education
- Acute care specialty consultation
- Provider to Provider consultation
- Transitional care
- Chronic Care

Ms. Sorenson told the story of an elderly Navaho gentleman who lived without running water and electricity two hours from the hospital. He had been hospitalized eight times and had five emergency room visits one year prior to being enrolled in the Care Beyond Walls and Wires program. Although he was unfamiliar with the technology provided, his daughter was very willing to work with the program to keep her father in a better state of health in his own home. Following his enrollment and up until the time of his death, he did not have any emergency room visits and was hospitalized only once. The video of this powerful and moving story can be viewed HERE.

Wireless Monitoring Saving Lives

Conclusion:

Health care agencies cannot solely rely on technology. There must also be a trusting personal relationship between the patient and the health care provider.

Questions and Answers facilitated by *Amy Steinman & Amelia Williams*:

Question 1:
What do you see as the biggest barriers in hard to reach populations? The most important thing is the "willingness to try." Healthcare agencies and professionals need to engage the community, start small and expect to tweak the program.

Question 2:
Have you had any security issues? Telehealth is very careful to only use FDA approved devices that have passed all the security channels and to date have had no incidents.

Question 3:
How are providers billing for telehealth? Most providers billed with E&M codes with modifiers and more codes are coming out in the future.

Question 4:
Which partner was the most difficult to engage? Initially physicians, who feared being inundated with patient data. The program took this into consideration and individualized the data for each physician as to how they wanted it presented and in what time intervals.

Question 5:
What do you monitor as follow-up and outcomes? The minimum follow-up is 31 days post hospitalization but they frequently follow a patient for a year. In terms of outcomes they have seen a 67%-72% reduction in patient medical costs, a 50% reduction in hospital admissions and an increase in patient and provider satisfaction.

Closing Remarks:

Dr. Shea thanked the audience for their attendance at this stimulating conference where a variety of innovations to increase health equity were discussed. She noted Dr. Brenner's story about the failures of the Camden Coalition and his urging that organizations examine why they have failed in the past. He also emphasized the value of focusing analysis and improvement efforts on the tails of the bell curve. Collectively, all the presenters created visions for a brighter healthcare trajectory and outlined steps toward optimal care. Continuing, Dr. Shea recognized CMS' efforts to reduce misalignments between public and private health payers and providers. Now that programmatic and financial incentive realignment is actively happening, the prospects for the care of dual eligibles, who are often disabled and most vulnerable, may be improving.

Dr. Shea ended with a note of hope around the promise of telemedicine to provide access to some of the great care that is available now but that is unequally distributed. She challenged the audience to take these thoughts with them as they consider what to do differently over the next five years and to remember that the future is closer than we think.

Social Media Presence

The Virtual Conference was shared on Twitter, one of the most popular social media outlets in the country. Amy Steinmann, the Manager for CRISP NCC tweeted on behalf of the QIOs (@QIOProgram) and moderated the Twitter chat for the duration of the conference. Given that the fastest growing demographic on Twitter is the 55-64 year age bracket, #DriveDownDisparities, the hashtag created for the conference has the potential to reach the targeted population. Over the course of the four hours, there were 172 tweets sent out from eighteen account holders who actively participated in the discussion. Those eighteen influencers were calculated to make 139,372 impressions to their followers and social networks altogether.

Many of the tweets were direct quotes from our presenters and live tweets from DNCC staff. There was much agreement that healthcare systems lacked and desperately needed cultural competency and more examination on re-hospitalization situations. The growing social interest supports all of the speakers who agree that technology can break down some of the barriers between physicians and patients. To view the entire Twitter transcript, please click HERE.

To view the full presentations and slides or to listen to the recording please click HERE.