The presentation will begin shortly.

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Aligning Diversity and Inclusion, Community Engagement, Business Operations and Population Health Efforts to Achieve Equity

December 13, 2017

Speakers:

- Laura Vail, Director of the Office of Inclusion and Health Equity, Cone Health
- Nora Jones, Executive Director, Partnership Project
- Dr. Samuel Cykert, Professor of Medicine, Division of General Internal Medicine and Clinical Epidemiology, University of North Carolina at Chapel Hill-Chapel Hill
- Moderator: Cynthia Washington, Interim President and CEO, Institute for Diversity and Health Equity, American Hospital Association

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Institute for Diversity and Health Equity

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Starting The Conversation

Poll # 1

❖ Do you track race specific data at your health system/organization?
- Yes
- No
- Unsure
- Not applicable

Starting The Conversation

Poll # 2

❖ Do you use that data to improve health outcomes?

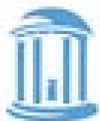
- Yes
- No
- Unsure
- Not applicable

Office of Inclusion and Health Equity

Laura Vail, Director, Office of Inclusion and Health Equity

Nora Jones, MA, Executive Director, The Partnership Project & President, Sisters Network Greensboro

Sam Cykert, MD, Professor of Medicine, Division of General Medicine and Director of the Program on Health and Clinical Informatics, UNC School of Medicine



UNC
CENTER FOR HEALTH PROMOTION AND DISEASE PREVENTION

Equity of Care

INSTITUTE FOR DIVERSITY
in Health Management
An affiliate of the American Hospital Association

Cone Health was proud to be an honoree for the 2017 Equity of Care Award, and we acknowledge that we could not do this work without our community partners.

CONE HEALTH
The Network for Exceptional Care

Institute for Diversity and Health Equity

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#123forEquity Campaign

Take the Pledge

About the Pledge

We must work together to eliminate racial and ethnic (and other) health and health care disparities.

- Increase the collection and use of race, ethnicity, language preference and other socio-demographic data
- Increasing cultural competency (cultural humility) training
- Increasing Diversity in leadership and governance
- Improve and strengthen community partnerships

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The Network for Exceptional Care

Creating Scorecards: Using the Data to Improve Care

- Metrics
  - REaL data collection: we needed to develop training for registration staff
  - HR/Strategic Plan metric to track diverse hires at the director level and above, tie to incentive compensation
  - Establish metric for Board of Trustees diversity
- Other Metrics to consider
  - Patient Experience stratified by race, ethnicity and language
  - Health outcomes and Quality data stratified using REaL data
  - The collection of sexual orientation and gender identity to track disparities

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The Network for Exceptional Care

Internal Trainings

- Unconscious Bias Training for all Executive Directors, Vice Presidents, Senior Vice Presidents and Executive Leaders.

  - Face to face classes & online modules through a partnership with an external vendor
  - In FY 18, this work will be offered to Directors with a plan to cascade to all employees by end of FY 2019

- Sensitivity/Diversity Training for all employees about collecting gender identity and sexual orientation in the medical record.

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Poll # 3

- Does your health system/organization offer training on implicit bias or structural racism?
  - Yes
  - No
  - Unsure
  - Not Applicable

Language Services

10% of Alamance County's population speaks Spanish

120 languages are spoken in Guilford County

Cone Health uses a hybrid services to serve our Limited English Proficiency patients:

- in-person interpreters
- over-the-phone interpretation services
- Video Remote Interpreters

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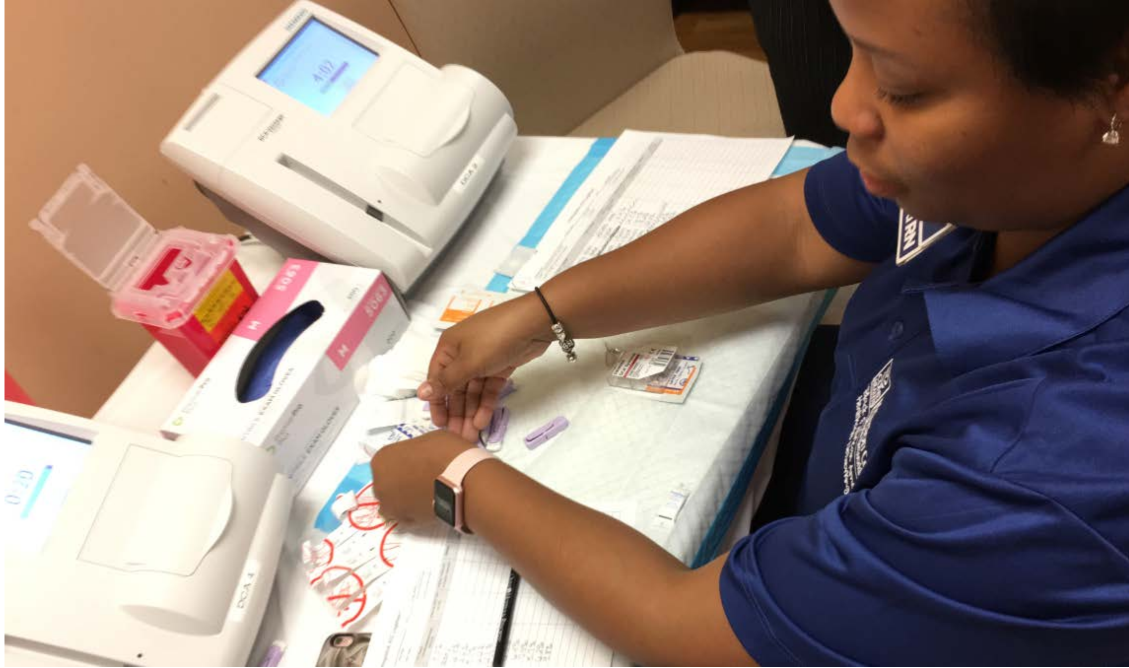
Black and African American Health Network Group



BAHNG was recognized by the American Hospital Association in 2017 in Case Studies.

BAHNG has given me the opportunity to participate in one of the best community-based volunteer groups within the Cone Health System. BAHNG is designed to improve the quality of life for community residents. Being involved is truly rewarding. ~ Cynthia Cobb, Member

Women Inspiring Women Employee Network Group

Women's Symposium 2017

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LGBT Employee Network Group

Cone Health received an award for at Greensboro's Pride event last month for our longstanding commitment to Pride and LGBT care.

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VetNet Employee Network Group

Wreaths Across America

Serving homeless veterans in our community

Caregivers Employee Network Group

Purpose:
Provide support for Cone Health employees who are caring for loved ones with emotional, physical and cognitive needs.

Employee Resource Fair

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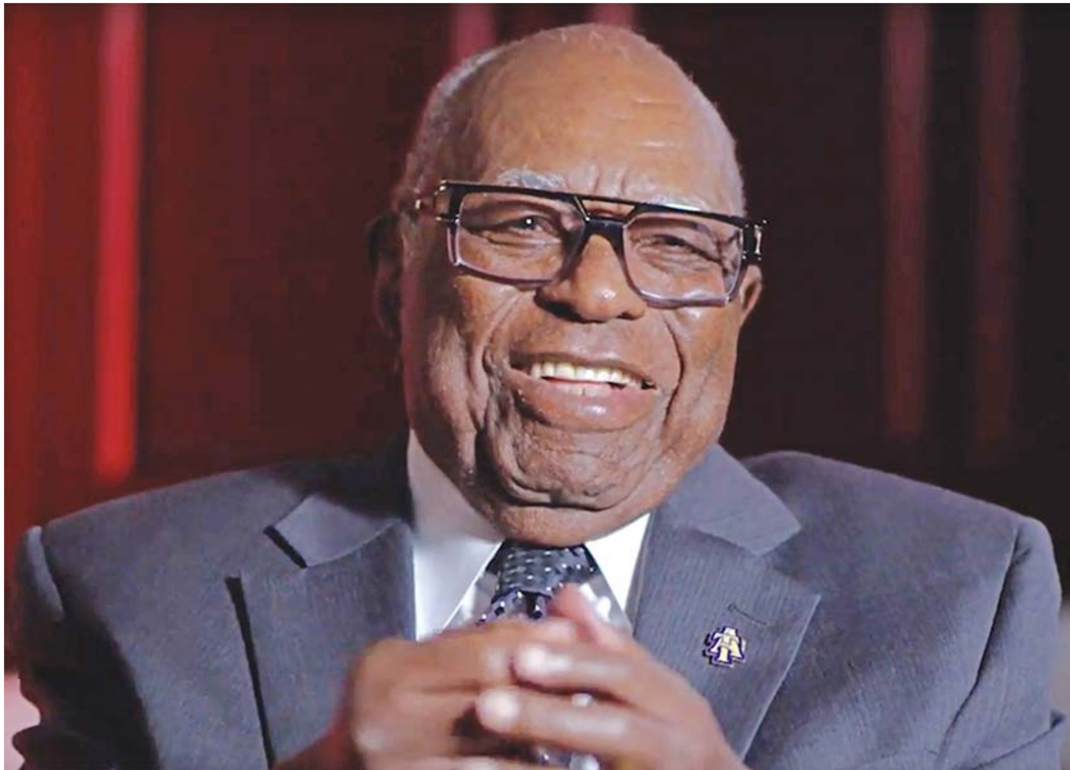
Understanding a History of Racism and Taking Steps to Undo-Racism



Cone Health CEO, Terry Akin, apologized to Dr. Alvin Bount
September 2016

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The Network for Exceptional Care

https://www.youtube.com/watch?v=9Fm4B72vbyE

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ACCURE: A System-Based Intervention To Address Disparities in Treatment of Early Stage Lung and Breast Cancer

Funded by National Cancer Institute - 5 R01 CA150980-04

Nora Jones, MA, Executive Director, The Partnership Project, and President, Sisters Network Greensboro

Samuel Cykert, MD, Professor of Medicine, Division of General Medicine and Director of the Program on Health and Clinical Informatics, UNC School of Medicine

U.S. Statistics per 100,000 Population

	Incidence	Mortality
Breast Cancer		
- AA women	121	33
- White women	121	22
Lung Cancer		
- AA men	78	66
- White men	68	56

Silber et al. JAMA 2013;310:389

- Compare 7,375 Black women > 65 years old to 3 sets of matched White controls (N = 7,375)

- 5-yr survival: White patients 68.8%
  Black patients 55.9%

- Received Rx: White patients 91.8%
  Black patients 87.4%

- Anthracyclines or taxols: W 5.0%, B 3.7%
- Other RX with BCS: W 92.7% B 91.8%

Hershman et al. (J Clin Oncol 2005;23:6639)

- 472 patients started adjuvant chemo:

  - White patients: 23% finished < 75% of cycles

  - Black patients: 31% finished < 75% of cycles

  - The 25% reduced completion for Black women was strongly associated with worse survival

Bach et Al. Racial Differences In The Treatment Of Early Stage Lung Cancer. (N Engl J Med 1999;341:1198).

Race	Lung Cancer Surgery	5-year survival
Caucasian	77%*	34%*
African-American	64%	26%

$^*p < 0.001$

44 excess deaths per **1000 lung cancer cases** due to decisions against surgery!

Prospective Cohort Study

Cykert, Dilworth-Anderson, McGuire et al.

Factors associated with decisions to undergo surgery among patients with newly diagnosed early stage lung cancer.

JAMA 2010; 303:2368-2376.

4 Month Surgery Rates

- Tissue confirmed only (N = 339)

White	75%*
African-American	63%

*p = .03

Factors Contributing To Treatment Disparities

- Uneven interpretation of comorbid illnesses (implicit / unintended bias)
- Poor perceptions of communication
- Non-medical beliefs (air exposure, prayer alone can cure)
- Lack of a regular source of care

THE BEGINNING

Greensboro Health Disparities Collaborative

- Partnership Project recruited researchers from the UNC School of Public Health to secure a planning grant from Moses Cone-Wesley Long Community Health Foundation.
- GHDC formed in 2003.

Greensboro Health Disparities Collaborative

Our mission is to establish structures and processes that respond to, empower, and facilitate communities in defining and resolving issues related to disparities in health.

CBPR approach

- Recognizes the unique strengths each partner brings
- A collaborative and co-learning process
- Equitably involves all partners in the research process
  - Grant-writing
  - Participant recruitment
  - Data collection
  - Data analysis
  - Data interpretation & dissemination

GHDC's Anti-Racism Framework

- **Racism** = Race Prejudice + Social and Institutional Power
- **Institutional racism** is a process of oppression, unconscious or not, functioning as a system of structuring opportunity and assigning value based on race, that unfairly disadvantages some, unfairly advantages others, and undermines the potential of the whole society.
- Racial inequity occurs in all systems. Racial inequity in one system will affect another system.
- SES alone does not explain racial inequity.
- System level inequities cannot be explained by a few "bad apples."

Accountability for Cancer Care through Undoing Racism and Equity (ACCURE)

Funded by National Cancer Institute - 5 R01 CA150980-04

University of North Carolina at Chapel Hill

- Eugenia Eng, *Principal Investigator*
- Sam Cykert, *Principal Investigator*
- Christina Yongue, *Project Manager*
- Alexandra Lightfoot, *Process Evaluator*
- Cleo Samuel, *Co-I, Diversity Fellow*
- Ziya Gizlice, *Biostatistician,*
- Brian Cass, *IT Specialist*
- Katrina Ellis, *Post-Doc*
- Kristin Black, *Research Assistant*
- Jada Walker*, Project Manager*
- Fatima Guerrab, *Research Assistant*

The Partnership Project and **Sisters Network**
(Greensboro)

- Nora Jones, *Executive Director / President SN*
- Jennifer Schaal, *Board Member, Telephone Interview Manager*
- Belinda Sledge*, Accountant*

Cone Health System (Greensboro)

- Skip Hislop, *VP for Oncology Services*
- Matthew Manning, *Oncologist, Physician Champion*
- Gus Magrinat, *Oncologist, Physician Champion*
- Beth Smith, *Nurse Navigator*
- Jeff Wilson, *IT Specialist*

- **University of Pittsburgh Medical Center**
- Linda Robertson, *School of Medicine*
- Dwight Heron, *Oncologist, Physician Champion*
- Steve Evans, *Oncologist, Physician Champion*
- Karen Foley, *Nurse Navigator*
- Michael Davis, *IT Specialist*

Study Design

- A 5-year study to examine the effect of a multifaceted intervention on disparities in treatment completion for Black patients with stages 1 and 2 lung and breast cancer compared to similar White patients.
  - based on anti-racism principles and community participation
  - longitudinal study design

- Our study was a pragmatic trial as assessed by the PRECIS-2 definition
  - community based
  - broad enrollment criteria,
  - treated by usual care providers in a typical cancer care setting
  - study tools and personnel that could easily fit routine clinic workflows.

Who Was Eligible for ACCURE?

- All Breast and Lung Cancer patients with Stage 1 and 2 disease, aged 18 – 85 years
- Exclusions: pregnant, non-English speaking, cognitive impairment

Interventions

(1) A real time warning system derived from electronic health records (EHRs)

- **missed appointments**
- **anticipated milestones in care not achieved**

(2) Feedback to clinical teams regarding completion of cancer treatment according to race

(3) Health equity education and training (HEET) covering concepts such as implicit bias and institutional racism

(4) The ACCURE navigator (AN) who was specially trained in particular barriers and beliefs that limit care for African-Americans and participated in anti-racism training

Analysis

- Retrospective control group 2007-2012

- Concurrent control group (for secular trends) 2014-2015

- Within intervention group navigator comparison

Analysis

- Primary Outcome = "**Treatment Complete**"

  - Definitions

  1) Lung Cancer

     a. Surgery or completed stereotactic radiation

     b. If chemo started then at least 3 completed cycles received

  2) Breast Cancer

     a. Surgery must be done

     b. If breast conserving surgery, radiation must be started and

     c. If chemo started, chemo must be complete (at least 4 completed cycles)

ACCURE Findings for Treatment Completion

Cohort	White	African-American
Baseline Control*	87.3	79.8
Intervention Group	89.5	88.4
Concurrent Control*	90.1	83.1

*statistically significant racial difference $p<0.05$

Table. Results from Multivariate Logistic Regression of Treatment Completions Including All Race-Group Combinations.

Variable	Beta	Odds Ratio (95% Confidence Interval)	p-Value
Age	0.004	1.00 (0.99, 1.01)	0.15
Charlson Score (> 1 vs. < or =1)	-0.12	0.89 (0.79, 1.0)	0.06
Median Zip Code Income	0.003	1.00 (1.0, 1.01)3	0.15
Marital Status **Not Married vs. Married**	-0.22	0.80 (0.71, 0.90)	<0.001
Private Insurance **No vs. Yes**	-0.29	0.75 (0.65, 0.86)	<.0001
Site	-0.74	0.48 (0.42, 0.54)	<0.001
Race and Study Group			
Black-Retrospective*	-0.24	*0.79 (0.65, 0.96)*	0.02
Black-Intervention*	0.48	1.6 (0.90, 2.9)	0.11
Black-Concurrent†	-0.37	*0.69 (0.49, 0.96)*	0.03
White-Intervention*	0.50	*1.6 (1.03, 2.7)*	0.04
Black-Intervention†	0.08	1.1 (0.59, 2.0) **NS**	0.80
Black-Intervention**	-0.02	0.98 (0.46, 2.1) **NS**	0.95

*White retrospective cohort is the referent group.

†White concurrent cohort is the referent group.

**White intervention cohort is the referent group

Conclusions

- The ACCURE Intervention worked to improve treatment completion for all and mitigate Black-White cancer treatment disparities

Possible Future Directions

- Other cancers and stages likely can improve with similar interventions and it may work for other ethnic groups
- Applying interventions to chronic disease care might also be effective

Recommendations for Enhancing Racial Equity In Quality of Care and Research

- Partner with **the community, including cancer survivors,** to give feedback on designing effective interventions

- Partner with an organization experienced in using **anti-racism principles** and community/institutional organizing **systems-change methods**

- Consider applying these principles to other disparity scenarios

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