UNMC ID ECHO Project to Reduce COVID-19 Health Disparities Through Quality Improvement

Welcome to Session 6

Housekeeping Reminders

➢ Discussion makes sessions work best!
➢ Please stay muted unless you are speaking
➢ We love to see your face!
➢ Sessions will be recorded and available upon request
➢ Attendance is taken by filling the survey in the chat

➢ Reminder: Project ECHO collects registration, participation, questions and answers, chat comments, and poll responses for some ECHO programs. Your individual data will be kept confidential. This data may be used for reports, maps, communications, surveys, quality assurance, evaluation, research, and to create new initiatives.

Subject Matter Experts

Infectious Diseases Team

- M. Salman Ashraf, MBBS
- Erica Stohs, MD, MPH
- Anum Abbas, MD
- Kelly Cawcutt, MD, MS

Quality Improvement Team

- Jeff Wetherhold, QI Consultant
- Gale Etherton, MD
- Mahliqha Qasimyar, MD

Health Equity & Cultural Sensitivity Team

- Nada Fadul, MD
- Mahelet Kebede, HE & CS Consultant
- Shirley Delair, MD
- Jasmine Marcelin, MD
- Andrea Jones, MD
- Precious Davis, Case Manager
- Samantha Jones, Program Manager

*Ardis Reed, State QIN/QIO Representative

CE Disclosures

UNMC ID Health Equity and Quality Improvement ECHO Project

Topics: IPC Risk Assessments and Different Forms of Racism (i.e.. structural, medical, interpersonal, etc.)

Free Live ECHO Project
January 19, 2022
CID 53866

TARGET AUDIENCE

This live activity is intended for physicians, APPs, nurses, social workers, case managers, and anyone else interested in learning about health equity in underserved populations.

ACTIVITY DESCRIPTION

Achieving health equity, addressing COVID-19 disparities, and improving the health of all Nebraskans using a quality improvement approach are the goals for our newly launched educational initiative. This COVID-19-focused health equity and quality improvement educational series will use the ECHO model for training healthcare workers.

The course is being offered through the University of Nebraska Medical Center (UNMC) infectious diseases (ID) ECHO program and is funded by the Nebraska Department of Health and Human Services (DHHS) via a CDC grant.

EDUCATIONAL OBJECTIVES

At the conclusion of this live activity, the participants should be better able to:

- Characterize the principles of effective risk assessment for COVID-19.
- Apply these principles to facility risk assessment in order to identify areas for intervention and improvement.
- Demonstrate how structural racism impacts health care.
- Differentiate between the different forms of racism (i.e., structural; systemic; interpersonal; etc.).

REQUIREMENTS FOR SUCCESSFUL COMPLETION

In order to receive continuing education credit/credits, you must:

1. Participate in the live activity via ZOOM. Your attendance will be tracked by the course facilitator.
2. Complete the overall evaluation
   a. Instructions on how to access the overall evaluation will be provided on a quarterly basis.
   b. Continuing education credits will be issued for activities you attended.

For questions regarding evaluation and attendance, please contact Nuha Mirghani, MD, MBA, HCM at nmirghani@unmc.edu

ACCREDITED CONTINUING EDUCATION

In support of improving patient care, University of Nebraska Medical Center is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

PHYSICIANS/PHYSICIAN ASSISTANTS

The University of Nebraska Medical Center designates this live activity for a maximum of 1.5 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

NURSES/NURSE PRACTITIONERS

The University of Nebraska Medical Center designates this activity for 1.5 ANCC contact hour(s). Nurses should only claim credit for the actual time spent participating in the activity.

ACCREDITED CONTINUING EDUCATION

As a Jointly Accredited Organization, University of Nebraska Medical Center is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. University of Nebraska Medical Center maintains responsibility for this course. Social workers completing this live activity receive 1.5 interactive continuing education credits.
Social work level of content: Basic

This program has been pre-approved by The Commission for Case Manager Certification to provide continuing education credit to CCM® board certified case managers.
The course is approved for 1.5 CE contact hour(s).
Activity code: I00049130 Approval Number: 210004495

To claim these CEs, log into your CCMC Dashboard at www.ccmcertification.org.

DISCLOSURE INFORMATION

As a jointly accredited provider, the University of Nebraska Medical Center (UNMC) ensures accuracy, balance, objectivity, independence, and scientific rigor in its educational activities and is committed to protecting learners from promotion, marketing, and commercial bias. Faculty (authors, presenters, speakers) are encouraged to provide a balanced view of therapeutic options by utilizing either generic names or other options available when utilizing trade names to ensure impartiality.

All faculty, planners, and others in a position to control continuing education content participating in a UNMC accredited activity are required to disclose all financial relationships with ineligible companies. As defined by the Standards for Integrity and Independence in Accredited Continuing Education, ineligible companies are organizations whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients. The accredited provider is responsible for mitigating relevant financial relationships in accredited continuing education. Disclosure of these commitments and/or relationships is included in these activity materials so that participants may formulate their own judgments in interpreting its content and evaluating its recommendations.
This activity may include presentations in which faculty may discuss off-label and/or investigational use of pharmaceuticals or instruments not yet FDA-approved. Participants should note that the use of products outside currently FDA-approved labeling should be considered experimental and are advised to consult current prescribing information for FDA-approved indications.

All materials are included with the permission of the faculty. The opinions expressed are those of the faculty and are not to be construed as those of UNMC.

Disclosures

The accredited provider has mitigated and is disclosing identified relevant financial relationships for the following faculty, planners, and others in control of content prior to assuming their roles:

FACULTY

M. Salman Ashraf, MBBS*
Merck & Co, Inc: Industry funded research/investigator

The below faculty have nothing to disclose:

- Shirley Delair, MD, MPH
- Mahelet Kebede, MPH*

*Indicates on the planning committee

Disclosures

PLANNING COMMITTEE

Nada Fadul, MD
ViiV Healthcare: Advisory Committee/Board

Erica Stohs, MD, MPH
ReViral Ltd.: Industry funded research/investigator

The below planning committee members have nothing to disclose:

- Valeta Creason-Wahl, HMCC
- Precious Davis, MSN, BSN, RN
- Samantha Jones, CSW
- Nuha Mirghani, MD, MBA, HCM
- Renee Paulin, MSN, RN, CWOCN
- Jeff Wetherhold, M.Ed
- Bailey Wrenn, MA

COVID-19 Updates

https://www.nytimes.com/interactive/2021/us/covid-cases.html

Nebraska Statistics

Week	Daily New Cases/ 100K	Infection Rate	Positive Test Rate	Number of Hospitalizations	ICU Capacity Used	*Vaccinated 1+
11/01/21	29.6	1.03	12.8%	413	80%	61%
11/15/21	44.0	1.15	14.8%	455	86%	62%
12/1/21	38.1	0.94	17.6%	545	80%	64%
12/15/21	47.4	1.01	16.2%	637	85%	65%
1/5/22	89.7	1.30	25.1%	532	84%	66.7%
1/19/22	209.6	1.33	35.4%	643	82%	67%

*Percent of the entire state population vaccinated, regardless of eligibility/age.

NE COVID-19 Updates

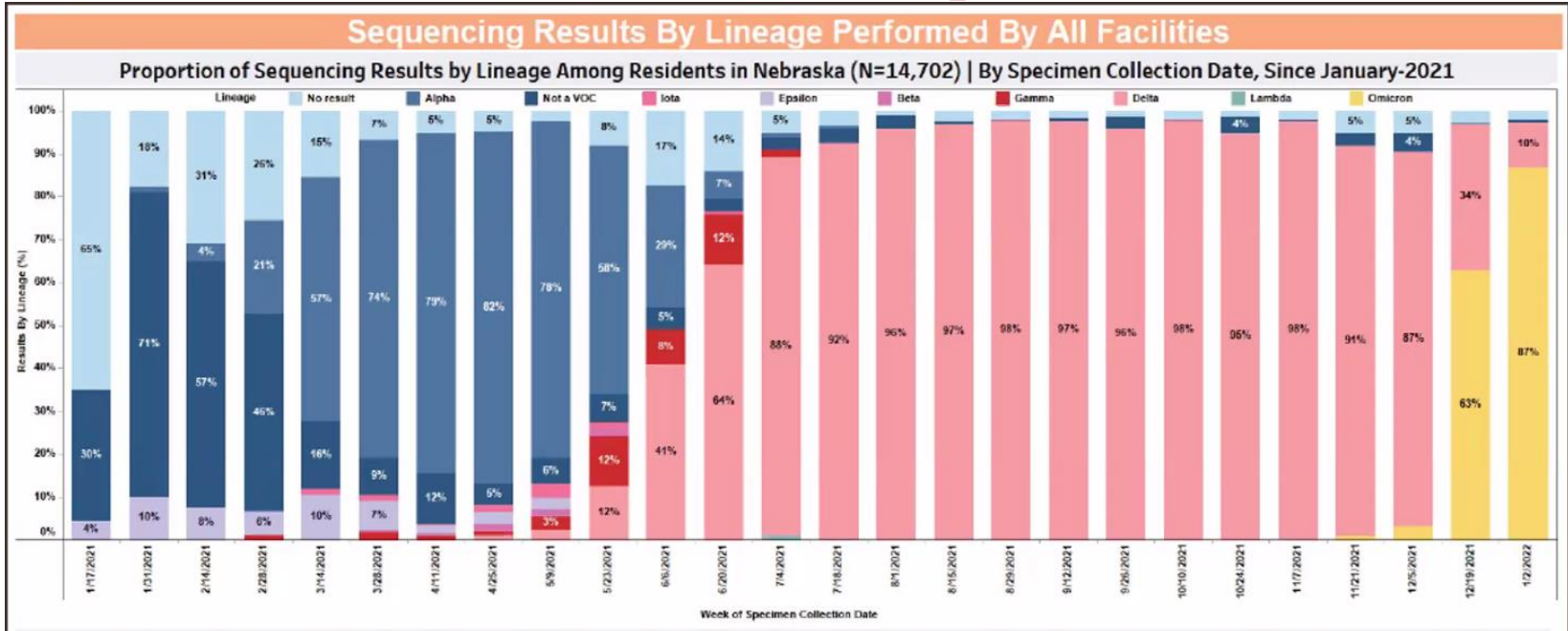- Average 68 new COVID pts hospitalized each day
- 15% of hospitalized patients are COVID+
- 24% of hospitalized COVID patients are in ICU
- 29% of ICU patients are COVID, 47% of ICU patients are on a vent
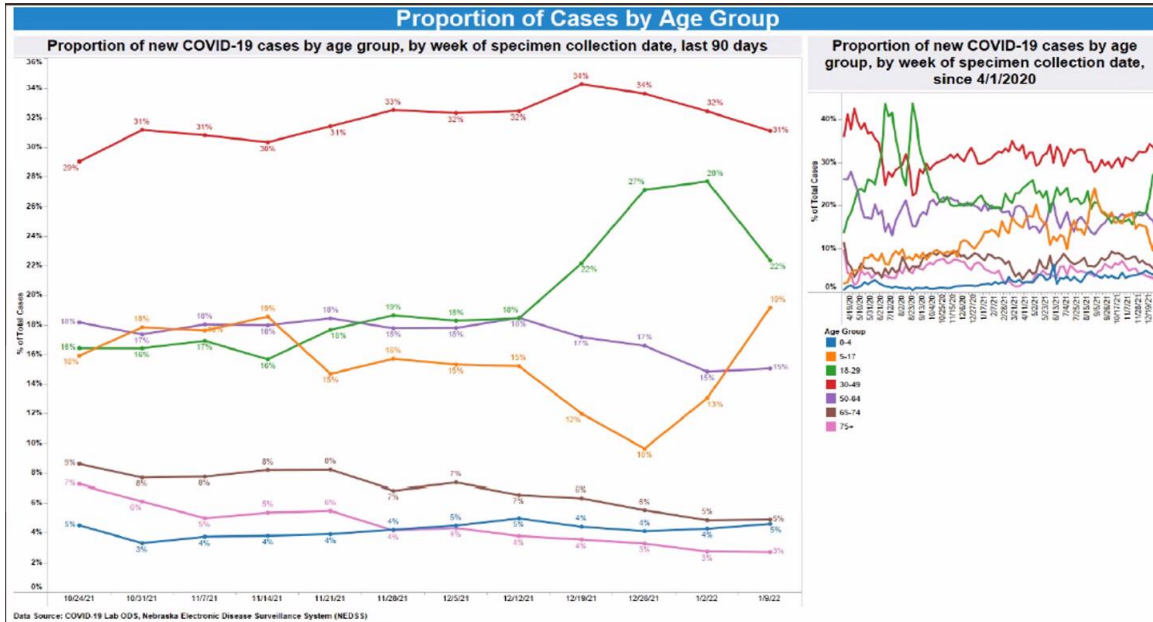
COVID-19 Updates

Sequencing Results By Lineage Performed By All Facilities

Proportion of Sequencing Results by Lineage Among Residents in Nebraska (N=14,702) | By Specimen Collection Date, Since January-2021
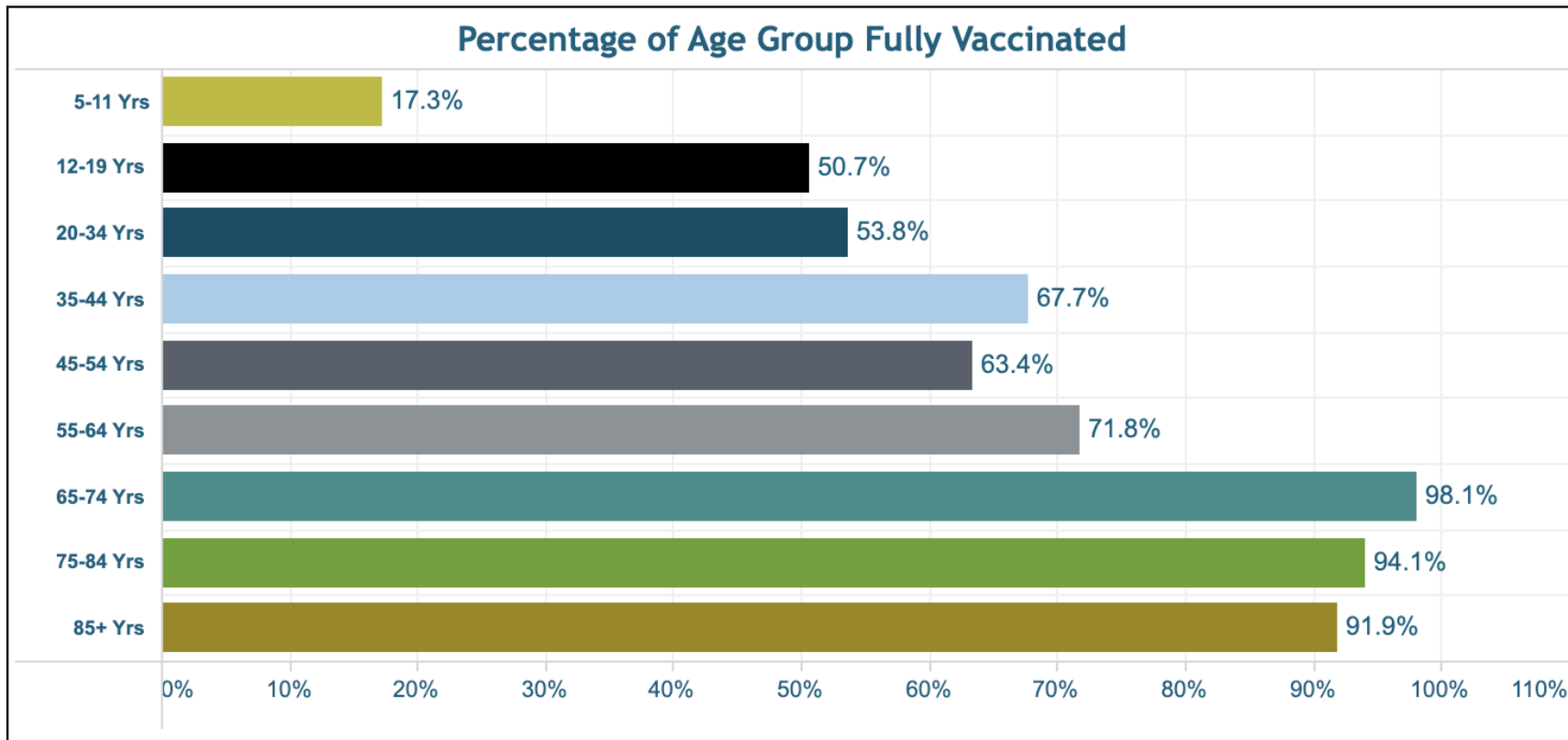
- Sequenced isolates throughout the state reflected 87% omicron variant
- Highest testing rates the state has seen. Average tests per day: 18,777

NE COVID-19 Vaccinations

NE DHHS: 66% of Nebraskans are fully vaccinated (excludes booster).

Percentage of Age Group Fully Vaccinated

Age Group	Percentage
5-11 Yrs	17.3%
12-19 Yrs	50.7%
20-34 Yrs	53.8%
35-44 Yrs	67.7%
45-54 Yrs	63.4%
55-64 Yrs	71.8%
65-74 Yrs	98.1%
75-84 Yrs	94.1%
85+ Yrs	91.9%

Nebraska COVID-19 Vaccinations
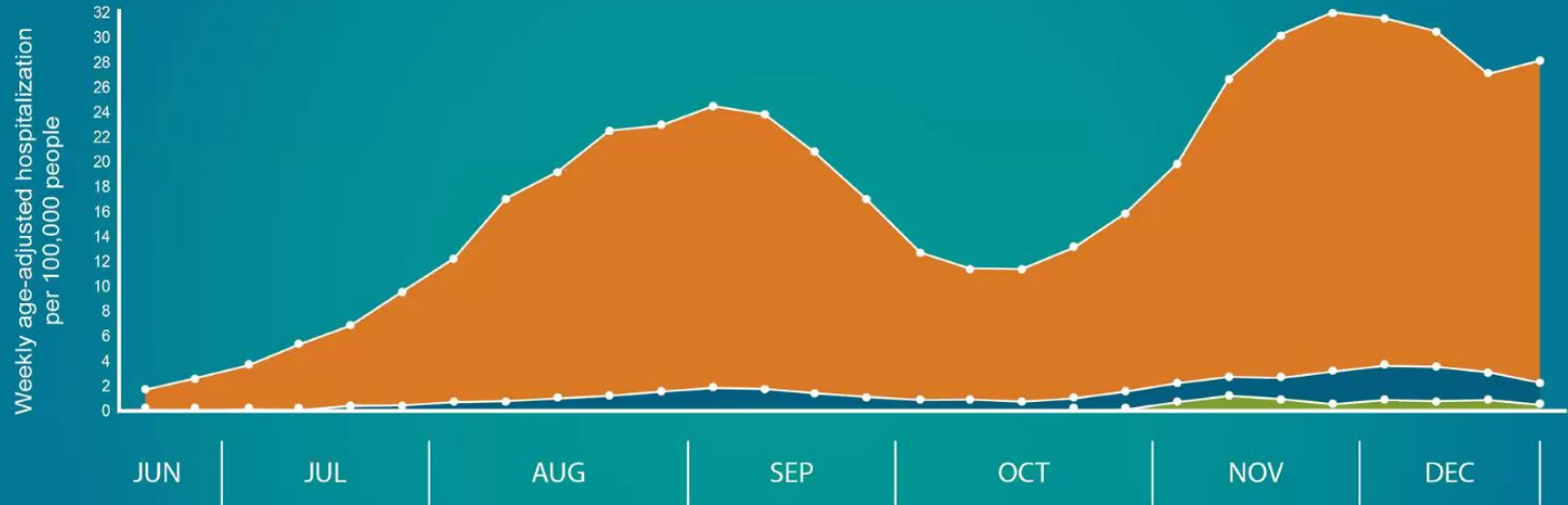
Poll Results

Case Study

You work in an outpatient infusion center that is seeing an increase in its CLABSI rate. A colleague on the CLABSI committee has noticed that the most recent few cases occurred in non-English speaking patients. This individual has proposed that the center reconsider criteria for placing central lines in these patients.

1. What assumptions were made here?
2. How might these assumptions provide an opportunity for structural racism to influence actions?
3. What strategies could you employ to manage this?

Infection Prevention & Control- Risk Assessment

Presenter: Dr. M. Salman Ashraf

Objectives

1. Characterize the principles of effective risk assessment for CoVID-19.

2. Apply these principles to risk assessment in your facility to identify areas for intervention and improvement.

Infection Control Risk Assessment

- A facility risk assessment is conducted by identifying and reviewing potential risk factors for infection related to the care, treatment, and services provided and to the environment of care in a specific healthcare setting.

- Goal – Development of Infection Surveillance, Prevention and Control Plan

Risk Assessment for Infection Surveillance, Prevention and Control Programs in Ambulatory Healthcare Settings

Explanation of Risk Assessment Tool and the Template for a Risk Assessment Report

This Risk Assessment tool, beginning on page 6, can be used to conduct a facility risk assessment for acquiring and transmitting infections in a variety of ambulatory healthcare settings. The results of the risk assessment can then be reported using the accompanying template for a Risk Assessment Report (beginning on page 3). **The findings of the risk assessment should be used to provide information about where an organization should focus its infection surveillance, prevention and control activities.**

[APIC Risk Assessment Tool](#)

Risk Assessment Process

- Convening a multidisciplinary team

- Identifying potential risk factors in various areas (e.g community, procedures performed, current infection control procedure compliance, etc.)

- Assessing and weighing each risk factor on its impact, probability and current level of organization preparedness

- Developing an annual plan based on the assessment (usually prioritizing the highest risk factors)

Understanding Population Characteristics for Risk Assessment and Infection Surveillance

- What types of patients do we serve?

- What are the most common diagnoses?

- What are our most frequently performed surgical or other invasive procedures?

- Which services or treatments are used most frequently?

- Are there services or treatments that increase risk of infection for the patient?

- What types of patients increase liability and/or costs for the organization?

- Does the organization's strategic plan focus on particular groups of patients?

- What types of health concerns exist in the community, region, or regulatory environment?

- Which patients are at increased risk for infection or other important outcome?

- Are there specific patient groups with certain disadvantages that increase the risk of infection ?

Lee TB et al. Am J infect Control 2007 Sep; 35(7):427-40

Data Needed for Risk Assessment

Basic organization-specific and community-level data are usually needed to perform risk assessment. Sources for the data may include:

- Medical records
- Financial services
- Information services
- Quality/ utilization management/ Previous infection control reports
- Surgical database
- Administrative/management reports
- Risk management
- Public health reports
- Community agencies
- Occupational/employee health
- Human resources records
- Marketing reports
- Social determinants of health

Lee TB et al. Am J infect Control 2007 Sep; 35(7):427-40

Examples of Broad Categories for Infection Control Risk Assessment

- Community and populations served
- Potential for specific infection
- Treatment and care practices
- Instrument and medical device cleaning, disinfection and handling
- Environment of care
- Emergency management
- Others identified by the organization

Scoring Potential Risk Factors

Risk Factors are generally scored (e.g. high, medium, low or none) during the assessment based on the following:

- Probability of the event/condition occurring

- Potential impact (clinical, operational and/or financial)
    - Risk level of failure (life threatening, permanent harm, temporary harm)
    - Potential change in care (e.g leading to change in level of care, or major or minor change in care plan)

- Organization's preparedness

APIC Risk Assessment Tool

Example of Risk Assessment Tool for a LTCF

EVENT	PROBABILITY OF OCCURRENCE (How likely is this to occur)[1]				RISK LEVEL OF FAILURE (What would be the most likely)[2]				POTENTIAL CHANGE IN CARE (Will treatment/care be needed for resident/staff)[3]				PREPAREDNESS (Are processes in place and can they work)[4]			YEAR: _____ RISK LEVEL Add rankings (score of 8 or >are considered highest priority for improvement efforts)
Score	High	Med	Low	None	Life Threatening	Permanent Harm	Temp Harm	None	High	Med	Low	None	Poor	Fair	Good	
	3	2	1	0	3	2	1	0	3	2	1	0	3	2	1	
Healthcare personnel																
Lack of compliance with influenza immunization																
Lack of notification or employee with illness/disease																
Non-compliance with annual TB screening																
Non compliance with mandatory education																
Resident/Family																
Lack of TB screening for resident at time of admission																
Lack of compliance with influenza immunization																
Lack of compliance with pneumococcal vaccine																
Lack of resident compliance with personal hygiene																
Lack of family compliance with facility policies																
Inadequate resident/family education																
Environment																
Inadequate cleaning and disinfection of resident room																
Use of non-approved products for environmental cleaning																
Inadequate cleaning/disinfection of resident common areas																
Inadequate cleaning of areas with visible contamination																
Medical Devices, Supplies and Equipment																
Improper storage of medical supplies and equipment																
Improper use, cleaning/disinfection of blood																

https://spice.unc.edu/resources/template-risk-

Using Risk Assessment to Develop Infection Surveillance, Prevention and Control Plan

- Prioritize higher risk conditions for further focus on program development

- Develop a goal for reducing the risk of infection associated with each of the higher risk conditions (e.g improving hand hygiene compliance)

- Include measurable objectives for each goal (e.g. achieve >90% hand hygiene compliance by mid year and >95% by the end of the year)

- Put in place specific strategies (how, what, who, when, where) to achieve the objectives (Don't forget to assign responsibilities)

- Implement a process to monitor progress periodically and adjust strategy as needed

RISK EVENT/ CONDITION	GOAL	OBJECTIVE (measurable, includes timeframe for completion)	STRATEGIES	IMPLEMENTATION	
				Respon-sible Person(s)	Method for Evaluating Effectiveness

APIC Risk Assessment Tool

Frequency of Infection Control Risk Assessments

At least annually

and

Anytime circumstances change or significant changes occur.

- New services
- New programs
- Response to external events
- New risk identified and there may be a need to reprioritize.
- Change in regulations

All Construction Activities Requires An Infection Control Assessment Too

- Perform infection control risk assessment prior to all construction activities using standard assessment tools

- Infection control precautions and mitigation strategies will depend on the type of construction project and patient risk group that may be impacted from that construction project

- Regularly round in the area to ensure compliance with infection control recommendations (use a checklist to monitor)

https://www.ashe.org/icra2

ASHE

Infection Control Risk Assessment 2.0
Matrix of Precautions for Construction, Renovation and Operations

Step One:
Using Table 1, identify the Construction Project Activity Type (A-D).

Table 1 - Construction Project Activity Type:

Type A	**Inspection and non-invasive activities.** Includes but is not limited to: • Removal of ceiling tile for visual inspection-limited to 1 tile per 50 square feet with limited exposure time. • Limited building system maintenance (e.g., pneumatic tube station, HVAC system, fire suppression system, electrical and carpentry work to include painting without sanding) that does not create dust or debris. • Clean plumbing activity limited in nature.
Type B	**Small-scale, short duration activities that create minimal dust and debris.** Includes but is not limited to: • Work conducted above the ceiling (e.g., prolonged inspection or repair of firewalls and barriers, installation of conduit and/or cabling, and access to mechanical and/or electrical chase spaces). • Fan shutdown/startup. • Installation of electrical devices or new flooring that produces minimal dust and debris. • The removal of drywall where minimal dust and debris is created. • Controlled sanding activities (e.g., wet or dry sanding) that produce minimal dust and debris.
Type C	**Large-scale, longer duration activities that create a moderate amount of dust and debris.** Includes but is not limited to: • Removal of preexisting floor covering, walls, casework or other building components. • New drywall placement. • Renovation work in a single room. • Nonexisting cable pathway or invasive electrical work above ceilings. • The removal of drywall where a moderate amount of dust and debris is created. • Dry sanding where a moderate amount of dust and debris is created. • Work creating significant vibration and/or noise. • Any activity that cannot be completed in a single work shift.
Type D	**Major demolition and construction activities.** Includes but is not limited to: • Removal or replacement of building system component(s). • Removal/installation of drywall partitions. • Invasive large-scale new building construction. • Renovation work in two or more rooms.

Objectives

1. Define race and racism.

2. Differentiate between different forms of racism (structural; systemic; interpersonal; individual).

3. Demonstrate how structural racism impacts health care.

Reflection

Enter your response to the question into the chat box.

How would you define race?

How would you define racism?

National History Museum

Race

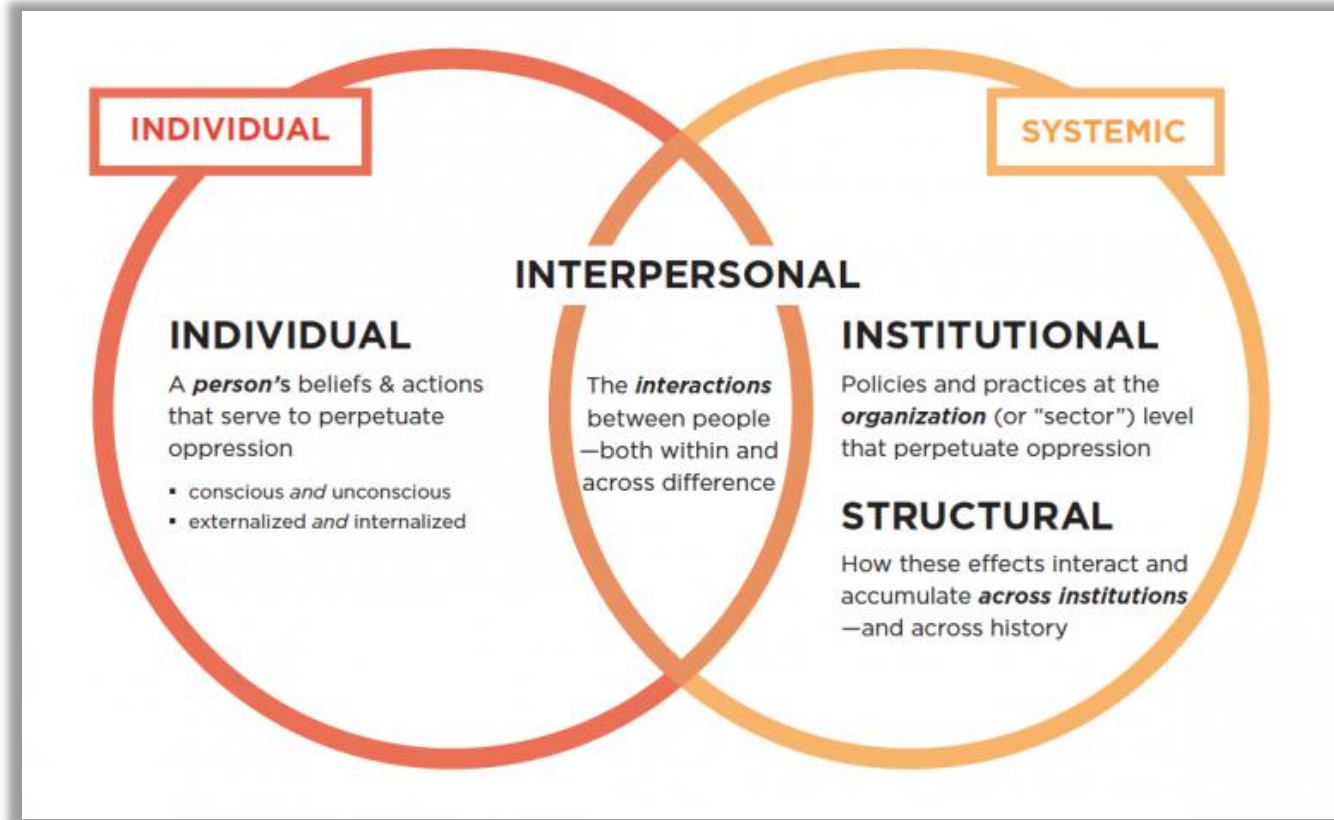❖ Sociopolitical construct
❖ No biological basis

Racism

"System of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call "**race**"), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources."

Camara Phyllis Jones, MD, MPH, PhD

Forms of Racism

INDIVIDUAL

SYSTEMIC

INTERPERSONAL

INDIVIDUAL

A *person's* beliefs & actions that serve to perpetuate oppression

- conscious *and* unconscious
- externalized *and* internalized

The *interactions* between people —both within and across difference

INSTITUTIONAL

Policies and practices at the *organization* (or "sector") level that perpetuate oppression

STRUCTURAL

How these effects interact and accumulate *across institutions* —and across history

Systemic Racism

In many ways "systemic racism" and "structural racism" are synonymous. If there is a difference between the terms, it can be said to exist in the fact that a <u>structural</u> racism analysis pays more attention to the historical, cultural and social psychological aspects of our currently racialized society.

**While <u>systemic</u> focuses more on the ongoing inequalities maintained in our racialized society.**

Structural Racism

A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity.

It identifies dimensions of our history and culture that have allowed privileges associated with "whiteness" and disadvantages associated with "color" to endure and adapt over time.
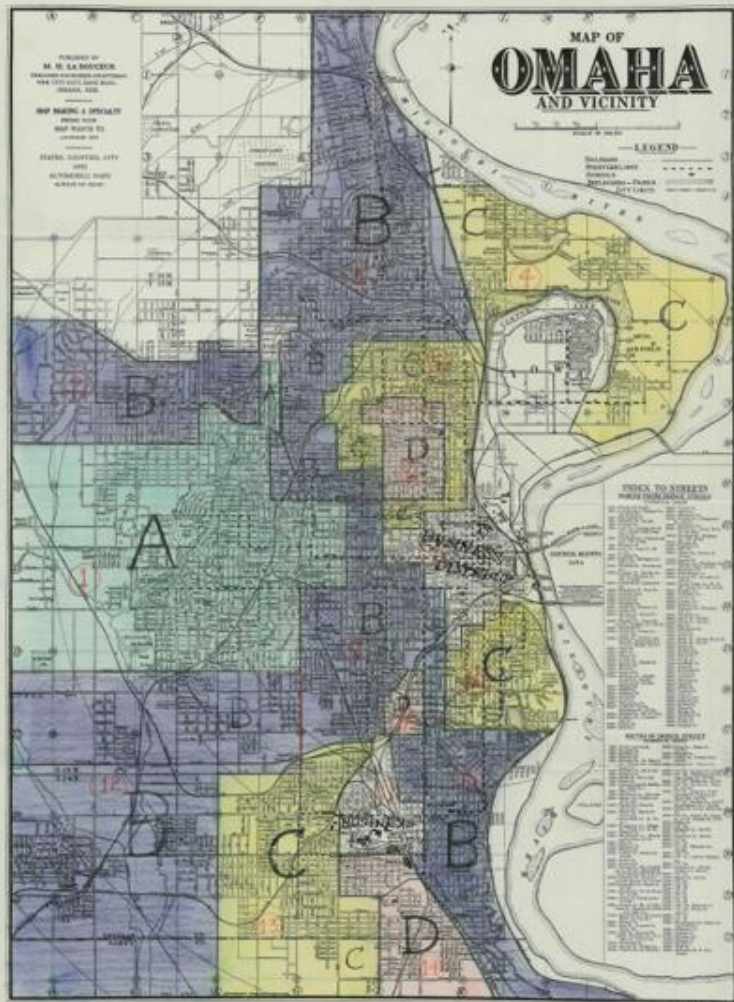
Structural Racism - Redlining
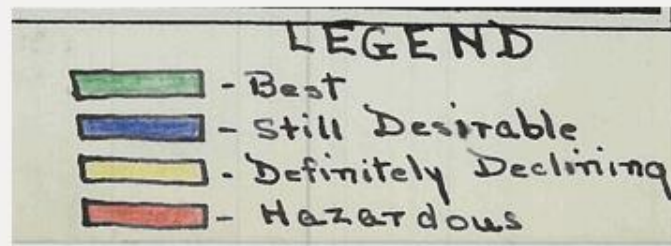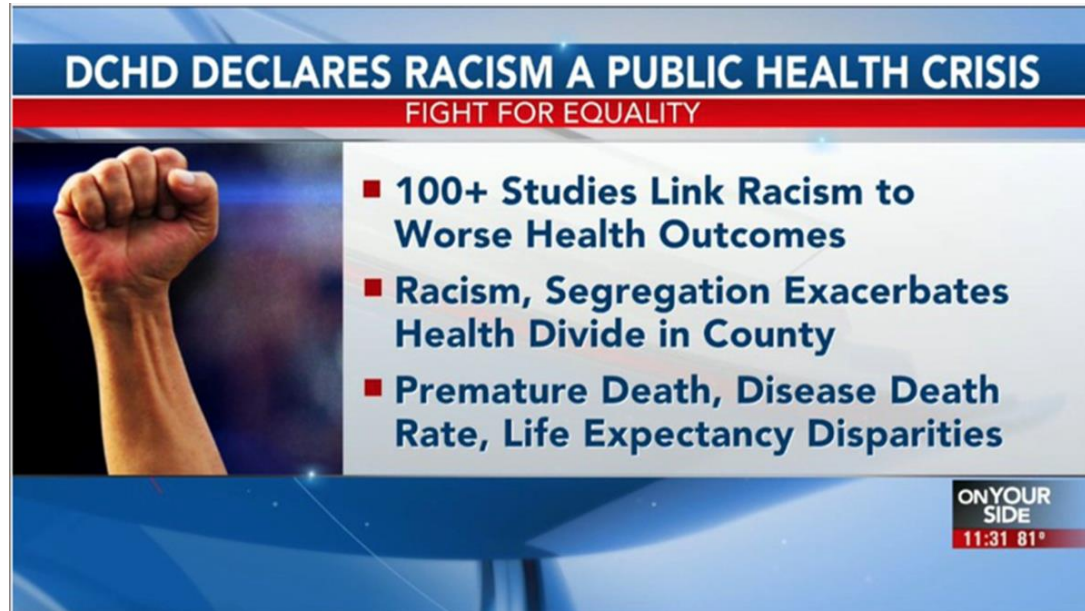
Systemic Racism

Public School Locations

- ❑ Purple district most likely to receive a loan from a bank
- ❑ Blue section second most likely
- ❑ Yellow districts third most likely
- ❑ Red district least likely ⋯ lenders often discouraged from offering loans
- ❑ **Green dots – public school locations**

https://storymaps.arcgis.com/stories/c465257aee4b4dacb6f7d189d0eaff6a
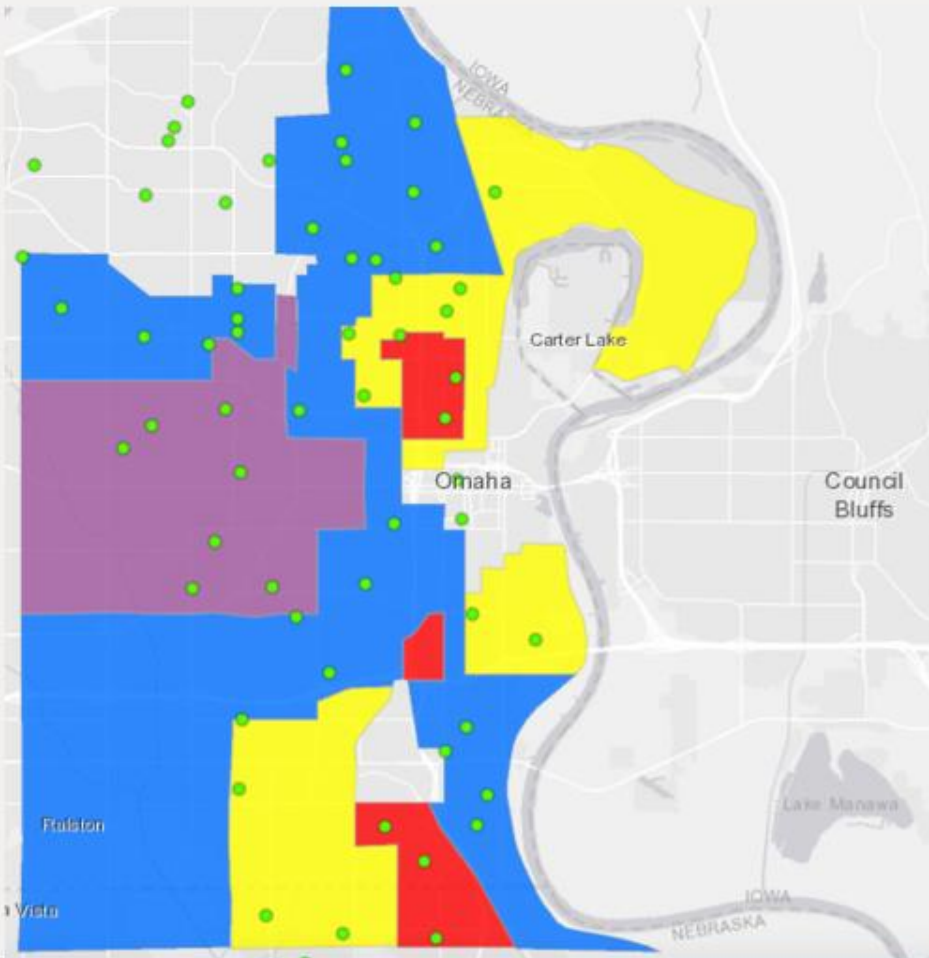
Institutional Racism

Definition

Policies and practices within and across institutions that, intentionally or not, produce outcomes that chronically favor, or put a racial group at a disadvantage.

DCHD DECLARES RACISM A PUBLIC HEALTH CRISIS
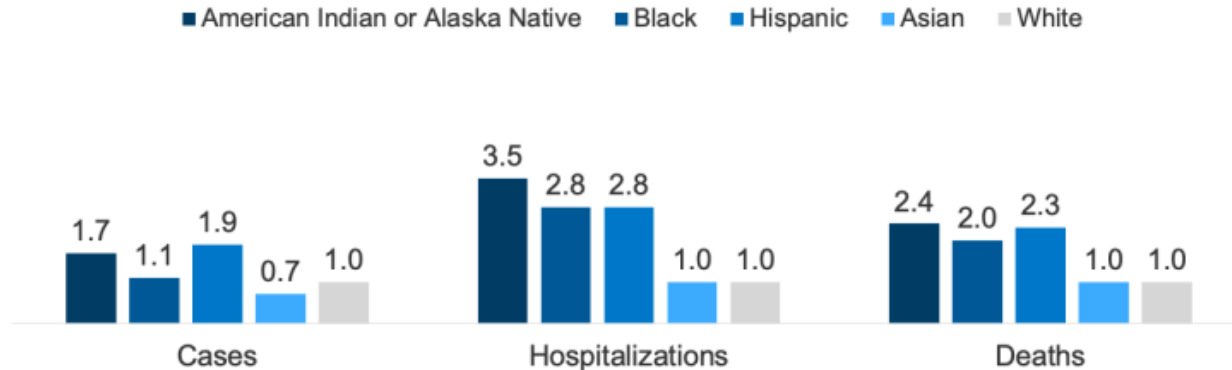FIGHT FOR EQUALITY

- 100+ Studies Link Racism to Worse Health Outcomes
- Racism, Segregation Exacerbates Health Divide in County
- Premature Death, Disease Death Rate, Life Expectancy Disparities

ON YOUR SIDE
11:31 81°

COVID-19 Example

Figure 2

Risk of Infection, Hospitalization, and Death compared to White People in the United States, Adjusted for Age

■ American Indian or Alaska Native   ■ Black   ■ Hispanic   ■ Asian   ▪ White

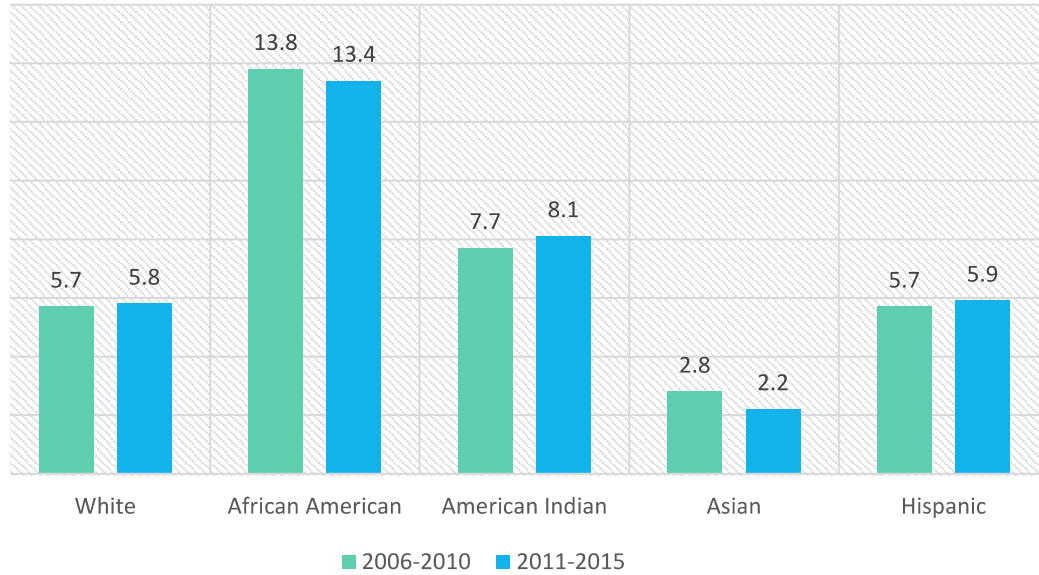|	Cases	Hospitalizations	Deaths
American Indian or Alaska Native	1.7	3.5	2.4
Black	1.1	2.8	2.0
Hispanic	1.9	2.8	2.3
Asian	0.7	1.0	1.0
White	1.0	1.0	1.0

NOTE: Persons of Hispanic origin may be of any race but are categorized as Hispanic; other groups are non-Hispanic.

SOURCE: CDC, Risk for COIVD-19 Infection, Hospitalization, and Death by Race/Ethnicity, https://cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html, accessed October 6, 2021.

KFF

Infant Mortality

Source: Nebraska DHHS Vital Statistics, Birth Certificates, 2001 – 2015

Interpersonal Racism

Definition

Racist assumptions, beliefs, or behaviors that are exemplified (intentionally or unintentionally) through an interaction with Black, Indigenous, or other people of color.

Individual Racism

Definition

An individual's assumptions, beliefs, or behaviors that oppress Black, Indigenous, or other people of color intentionally or unintentionally.

Individual racism is learned from broader societal history, culture, and processes and is supported and reinforced by systemic racism.

Reflection

In what ways do race or racism effect a patient's risk for the following?

→ **Insert responses into the chat box.**

- Infant mortality
- Hospitalization with COVID-19
- Deciding the priority group for the roll out of COVID-19 vaccines

Case Study

Case Study

You work in an outpatient infusion center that is seeing an increase in its CLABSI rate. A colleague on the CLABSI committee has noticed that the most recent few cases occurred in non-English speaking patients. This individual has proposed that the center reconsider criteria for placing central lines in these patients.

1. What assumptions were made here?
2. How might these assumptions provide an opportunity for structural racism to influence actions?
3. What strategies could you employ to manage this?

POLL

Wrap-Up

1. You will receive today's presentation, in addition to a one-page key-takeaways document and next session's agenda through email.

2. Next session will be on February 2nd on *"Cultural Practices - Behaviors (3/3) and Quality Improvement Root Causes (1/6): What is the problem you are trying to solve?"*.

3. If you'd like to share a case with us, kindly send it by Monday, January 31st.

Poll Results