Blue Cross Blue Shield of Illinois Health Equity Pilot Program Year 2

UI Health | UIC

Introduction

The University of Illinois Health & Hospital System and the University of Illinois College of Medicine are committed to improving health disparities through clinical services, education, and research. Part of our mission as an enterprise is to improve the health and wellbeing of the communities we serve.

As an extension of UI Health's participation in the BCBSIL's Hospital Quality Program, beginning in 2021, UI Health received grant funding from Blue Cross Blue Shield of Illinois (BCBSIL) to expand our efforts to improve diversity among healthcare providers and to reduce the health disparities disproportionally experienced by communities of colors leading to poor health outcomes. The funding aligns with our UI Health commitment to pursuing health equity and reducing health disparities for patients.

The HEPP Program has allowed us to advance and spearhead innovation in addressing health inequities. We are developing models of care that are transformative, preventative, and restorative for all our patients.

We present highlights from our Year 2 participation In the BCBS Health Equity Pilot Program.

Gloria Elam, MD
Heather Prendergast, MD
Co-leads HEPP

UI Health at a Glance
YEAR 2 Summary Data

UI Health Patient Demographics

UI HEALTH PATIENTS BY RACE (207,422 PATIENTS WITH ENCOUNTER IN PAST YEAR)	
Black or African American	39%
Other	30%
White	22%
Asian	6%
Unknown	3%
American Indian or Alaska Native	Less than 1%
Unreported / Decline to Answer	Less than 1%
Native Hawaiian	Less than 1%
Other Pacific Islander	Less than 1%

UI HEALTH PATIENTS BY ETHNICITY (207,422 PATIENTS WITH ENCOUNTER IN PAST YEAR)	
Not Hispanic, Latino/a, or Spanish Origin	65%
Hispanic, Latino/a, or Spanish Origin	27%
Unknown	6%
Decline to Answer	2%

UI HEALTH PATIENTS BY SEX (207,422 PATIENTS WITH ENCOUNTER IN PAST YEAR)	
Female	57%
Male	43%
Nonbinary	Less than 1%
X	Less than 1%

UI HEALTH PATIENTS BY PRIMARY LANGUAGE (207,422 PATIENTS WITH ENCOUNTER IN PAST YEAR)	
English	84%
Spanish	11%
Other	5%
(Arabic, Burmese, Cantonese, Chinese, Estonian, French, Hungarian, Korean, Mandarin, Nepali, Persian, Polish, Portuguese, Sign Language, Ukrainian, Urdu)	

UI HEALTH PATIENTS BY GENDER IDENTITY (207,422 PATIENTS WITH ENCOUNTER IN PAST YEAR)	
Female	21%
Male	12%
Gender Non-Conforming / Gender Non-binary	Less than 1%
Transgender Female	Less than 1%
Transgender Male	Less than 1%
Genderqueer	Less than 1%
Not recorded	66%

UI HEALTH PATIENTS BY SEXUAL ORIENTATION (207,422 PATIENTS WITH ENCOUNTER IN PAST YEAR)	
Heterosexual	19%
Bisexual	Less than 1%
Pansexual	Less than 1%
Asexual	Less than 1%
Gay	Less than 1%
Lesbian	Less than 1%
Not recorded	79%

BCBS Managed Care Patients

BCBS MANAGED CARE PATIENTS BY RACE (9,545 PATIENTS)	
Black or African American	39%
Other	31%
White	19%
Asian	8%
Unknown	2%
American Indian or Alaska Native	Less than 1%
Unreported / Decline to Answer	Less than 1%
Native Hawaiian	Less than 1%
Other Pacific Islander	Less than 1%

BCBS MANAGED CARE PATIENTS BY SEX (9,545 PATIENTS)	
Not Hispanic, Latino/a, or Spanish Origin	65%
Hispanic, Latino/a, or Spanish Origin	35%
Unknown	Less than 1%

BCBS MANAGED CARE PATIENTS BY SEX (9,545 PATIENTS)	
Female	60%
Male	40%
Nonbinary	Less than 1%
X	Less than 1%

BCBS MANAGED CARE PATIENTS BY PRIMARY LANGUAGE (9,545 PATIENTS)	
English	95%
Spanish	4%
Other	1%
(Arabic, Burmese, Cantonese, Chinese, Estonian, French, Hungarian, Korean, Mandarin, Nepali, Persian, Polish, Portuguese, Sign Language, Ukrainian, Urdu)	

BCBS MANAGED CARE PATIENTS BY GENDER IDENTITY (9,545 PATIENTS)	
Female	35%
Male	17%
Gender Non-Conforming / Gender Non-binary	Less than 1%
Not recorded	47%

BCBS MANAGED CARE PATIENTS BY SEXUAL ORIENTATION (9,545 PATIENTS)	
Heterosexual	19%
Bisexual	1%
Not recorded	80%

WHAT WE'RE DOING
Increasing access and care coordination

Care Connect
The "Care Connect" model addresses disparities by blending efforts and interventions of three (3) UI Health teams1, to deliver the right care at the right time via targeted screening, a persistent "caseload" model that ensures patients who most need coordination and advocacy continue to be followed across contexts, education, tools, coaching, and community-based referrals, to fit each patient's unique needs.

Care Connect is tailored to the acuity of different populations and employs community health workers and healthcare professionals with consistent, standardized training in system navigation and access to system and community-based resources, health equity, social determinants of health, trauma-informed care, and motivational Interviewing techniques with an empowerment perspective for address real barriers or gaps in care.

Impact for Year 2
Outpatient visits, on average, remained stable during program engagement (3.04 in 6 months prior vs. 3.10 during the program episode, but increased to 4.64 in the 6 months post engagement). ED and inpatient visits remained stable for the moderate and lower risk populations, but for the high-risk population, where a higher volume of ED visit could be eligibility criteria, average ED visits decreased from 1.47 to 0.17 when comparing the 6 months prior to post. A similar trend shows for inpatient visits which decreased from 1.16 to 0.17 for the high-risk population.

Collaboration
Three (3), discrete care coordination and patient engagement entities at UI Health collaborated extensively on the blended model, which allowed all staff to function as a seamless care unit, flexible and adaptable to a broad scope of care needs, plans, and barriers, but a clearly defined scope, persistent and consistent in the pilot contexts, something other staff can anticipate available. This further allowed Care Connect to better target interventions to needs and patient care preferences, then receive support scoped to their level of care, rather than a "one size fits all" approach. Patients with SDOH or basic appointment scheduling related needs are supported through Community Health Workers from CHECK and OCEAN-HP, patients with higher level medical coordination and high-risk needs are coordinated through UI Health Care Coordination, and patients with behavioral health needs are coordinated through the CHECK Behavioral Health team. This integration allows for more cost-effective care coordination while ensuring everyone can operate "at the top of their license".

Inpatient Visits

Outpatient visits (mean)
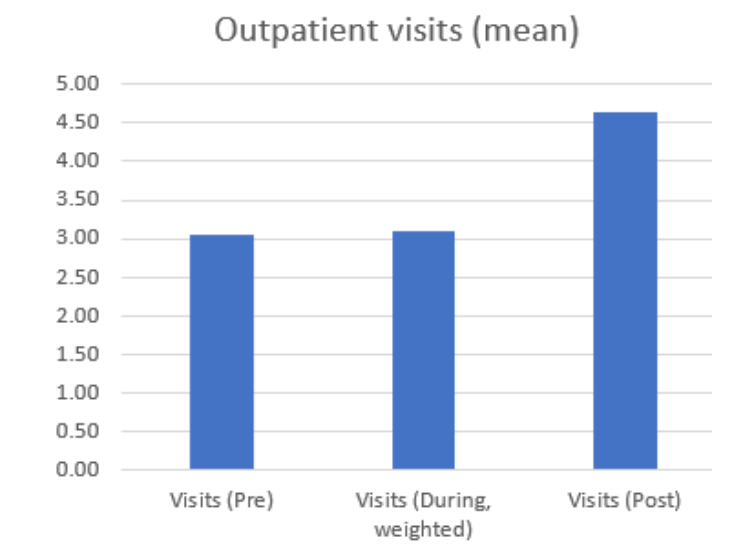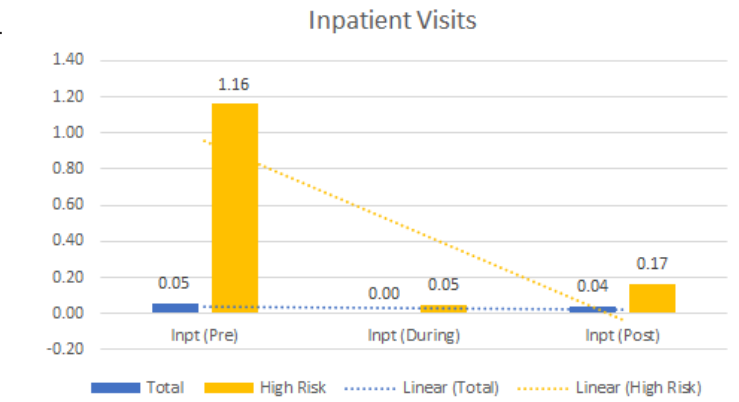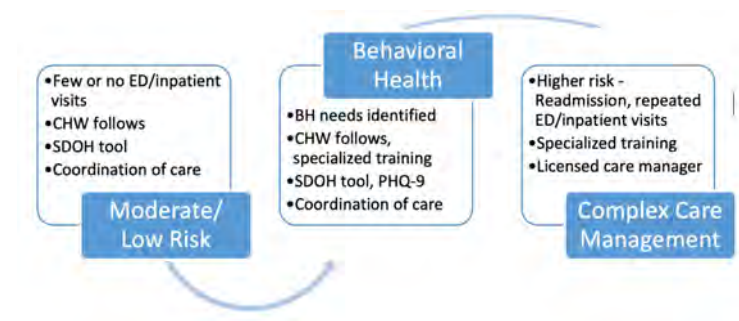
Measure	Total
Patients contacted	424
Encounters	2,959
Patients per staff	35
Encounters per staff	247
Staff	12

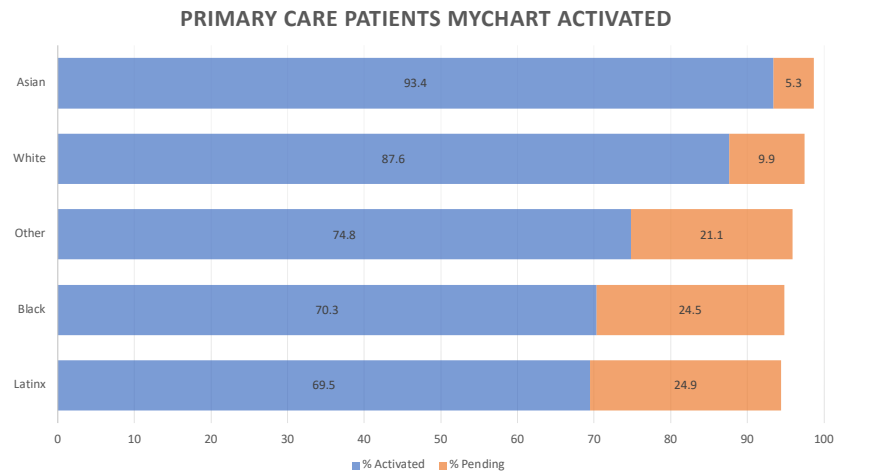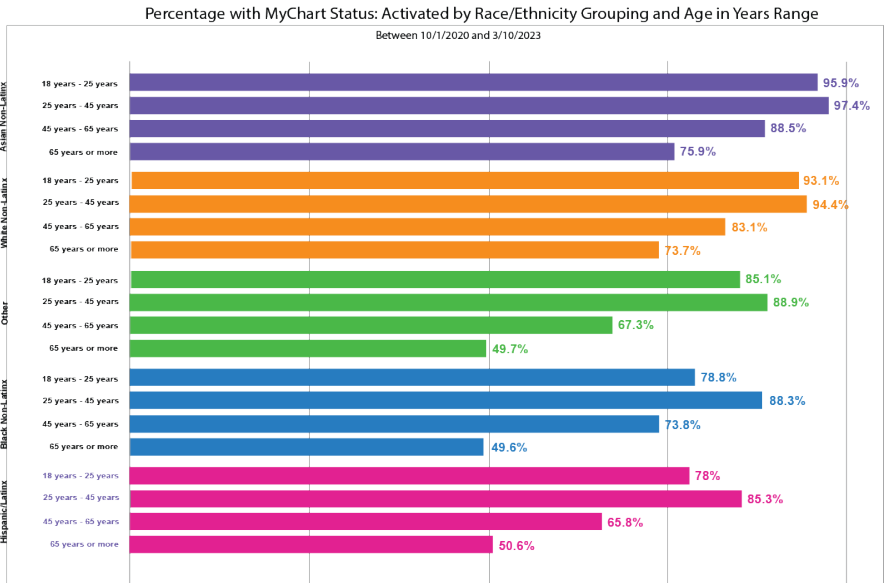### Identifying Disparities with MyChart In Primary Care
Medicine is becoming increasingly digital and patients who have access to and expertise in digital health tools will naturally be able to see the benefit of these changes. The existing disparity in MyChart sign-up and use in our minority patients will make it more difficult to equitably distribute innovations and care opportunities that arise from digital health initiatives.

Digital Health Hub
Supported by the HEPP pilot program, the Digital Health Hub project addresses the existing disparity in MyChart sign-up and use among our minority patients. The goal is to enhance care opportunities that arise from digital health initiatives. The Digital Health Hub can help to narrow the modifiable differences in the our patient engagement and care. Scheduling appointments, managing medications, communicating with primary care team and even understanding your health status is much easier using tools like MyChart.

Dedicated Digital Health Hubs are set up in clinic waiting areas to help patients sign up for MyChart.

Percentage with MyChart Status: Activated by Race/Ethnicity Grouping and Age in Years Range
Between 10/1/2020 and 3/10/2023

PRIMARY CARE PATIENTS MYCHART ACTIVATED

SDOH Screening Tool

We have launched a streamlined social determinants of health (SDOH) screening tool for our inpatient population. UI Health uses Epic for our patients' electronic health records. The SDOH screening tool asks about 5 domains, 4 of which are already included in Epic's standard SDOH screening. The 5 domains are Interpersonal Safety, Food Insecurity, Housing Instability, Transportation Problems, and Utility Difficulties. The Utility Difficulties domain will be released by Epic in 2023.

Our SDOH Screening Tool has been added to the Nursing Admissions Navigator, allowing us to screen patients as part of the stand inpatient admissions process. The tool has a 6-month standard cadence, allowing us to rescreen patients twice per year and reduce the likelihood of screening fatigue by both patients and staff. At the same time, the screening tool can be asked more frequently if appropriate for a particular patient or inpatient setting.

The goal of the SDOH screening tool is to provide an avenue for us to better understand our patients' needs related to the 5 identified domains. If a patient screens positive on any domain, the tool automatically notifies social work (for interpersonal safety and utility difficulties) and/or Care Coordination (for

food insecurity, housing instability, or transportation problems), allowing us to provide those patients with resources in short order. In addition to the near immediate follow up, the aggregate data the tool collects will help UI Health identify the scope and magnitude of social determinants of health experienced by our patients. This data will be used to inform the next priority areas for our department to address.

Training includes system navigation and access, health equity conceptually and practically, the impact of adverse SDOH on persons in environment, identification of and referral to both system- and community-based resources to address needs, trauma-informed care, and Motivational Interviewing techniques, to address real barriers or gaps in care with an empowerment perspective.

For all Care Connect patients, 315 SDOH tools were completed, which indicates at least cursory engagement, and 176 PCP appointments were scheduled during the Episode range.

Building Sustainability

Through various teams, we are focusing the improvement of health care disparities in the following areas: Hypertension, Diabetes, and Cancer Screenings. These areas were selected to align with existing Blue Cross Blue Shield of Illinois(BCBSIL) Quality Initiatives (QI) Performance Measures.

BLUE CROSS BLUE SHIELD OF ILLINOIS(BCBSIL) QUALITY INITIATIVES (QI) PERFORMANCE MEASURES

QI Fund Project	Measurement Period	Performance Benchmark	2021 Results	2022 Performance
Controlling high blood pressure	01/01/2022-09/30/2022	60%	61.04%	62.00%
Prenatal and Postpartum	10/08/2019-10/07/2020	55%	91.00%	90.98%
Comprehensive Diabetes Control	01/01/2022-11/30/2022	45%	57.38%	58.00%
Colorectal Cancer Screening	01/01/2022-08/31/2022	45%	59.87%	58.40%
Cervical Cancer Screening	01/01/2022-07/31/2022	60%	68.94%	70.85%
Breast Cancer Screening*	01/01/2021-12/31/2022	60%	76.05%	65.96%

NEW NURSE-DRIVEN SDOH SCREENING WORKFLOW FOR NEW INPATIENTS
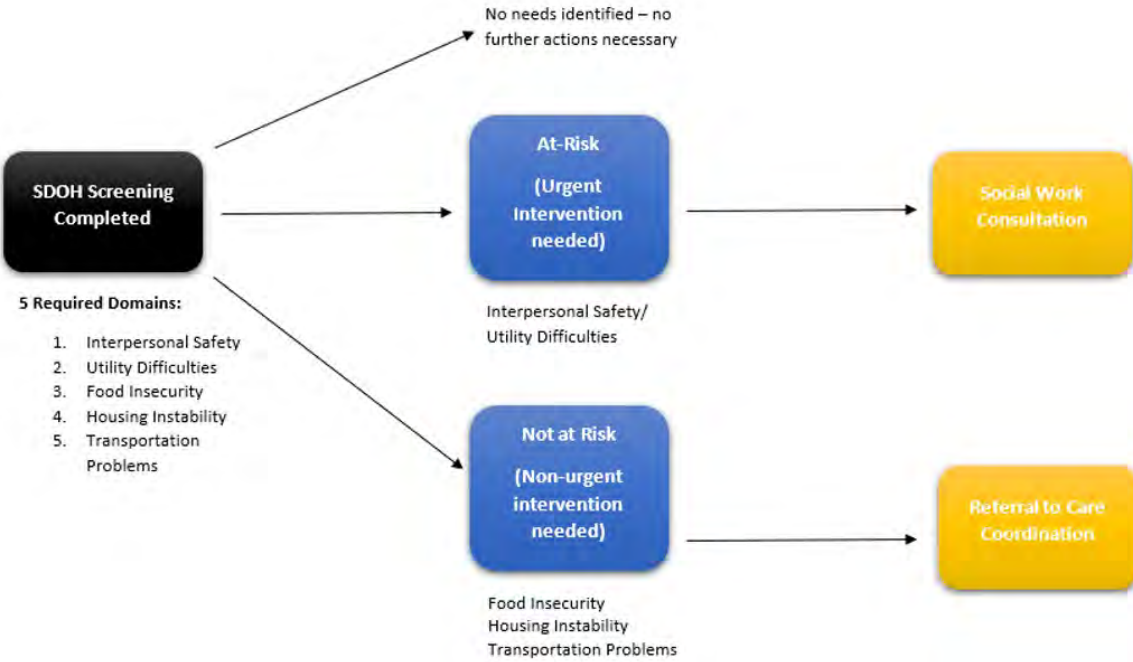
Addressing Health Disparities

COVID-19 Outcomes

The COVID-19 pandemic continued to disproportionately affected communities of color across the United States and particularly here in the City of Chicago.

COVID-19 TESTING BY RACE

White	32%
Black or African American	25%
Other	18%
Asian	14%
Unknown	6%
American Indian or Alaska Native	Less than 1%
Decline to Answer	Less than 1%
Native Hawaiian	Less than 1%
Other Pacific Islander	Less than 1%
Not Documented	5%

COVID-19 POSITIVE RESULTS BY RACE

Black or African American	34%
Other	27%
White	17%
Asian	5%
Unknown	5%
American Indian or Alaska Native	Less than 1%
Decline to Answer	Less than 1%
Native Hawaiian	Less than 1%
Other Pacific Islander	Less than 1%
Not Documented	12%

COVID-19 VACCINE ADMINISTERED BY RACE

White	42%
Other	18%
Asian	16%
Black or African American	16%
Unknown	6%
Decline to Answer	2%
American Indian or Alaska Native	Less than 1%
Native Hawaiian	Less than 1%
Other Pacific Islander	Less than 1%
Not Documented	Less than 1%

COVID-19 TESTING BY ETHNICITY

Not Hispanic, Latino/a, or Spanish Origin	65%
Hispanic, Latino/a, or Spanish Origin	18%
Unknown	6%
Decline to Answer	2%
Not Documented	9%

COVID-19 POSITIVE RESULTS BY ETHNICITY

Not Hispanic, Latino/a, or Spanish Origin	53%
Hispanic, Latino/a, or Spanish Origin	27%
Unknown	5%
Decline to Answer	2%
Not Documented	13%

UI Health COVID+ Outreach Project

Summary Data
- 8,000+ Outreach Encounters
- Over 80% of Black/Latinx patients
- Over 40% of patients without previous primary care at UI Health
- Utilized 300+ personnel (Students + Clinicians + Hospital Staff)

WHERE DO PATIENTS GO FOR PRIMARY CARE?

May 2020 – June 2021

July 2021 – Current
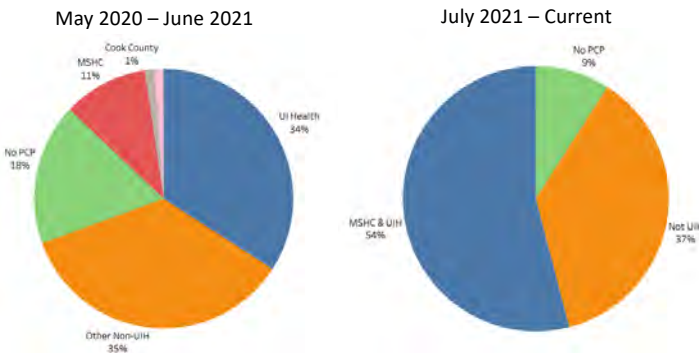
Patient Outcomes
- Readmissions for patients contacted through this project 10.5% —> 5%
- 300+ patients with escalations
- Clinical Decompensation
- Poor understanding of diagnosis
- Need for COVID-related social services
- Medication needs (Pharmacy Locator)
- Facilitated home oxygen education
- New PCP provided
- Direct contact with PGM
- Direct access to Pilsen or MSHC clinics
- Hospital Staff)

COVID-19 VACCINE ADMINISTERED BY ETHNICITY

Not Hispanic, Latino/a, or Spanish Origin	68%
Hispanic, Latino/a, or Spanish Origin	20%
Unknown	6%
Decline to Answer	3%
Not Documented	3%

Patient Registries

EHR-based specialty registries were created for Diabetes, Hypertension and Selected Cancer Screenings in order to capture relevant disease-specific demographic and outcome information.

Hypertension Registry

UI Health patients with Hypertension with >1 patient encounter for FY2022.

UI HEALTH HYPERTENSION PATIENTS BY RACE (59,096 PATIENTS WITH ENCOUNTER IN PAST YEAR)

Black or African American	49%
Other	24%
White	21%
Asian	3%
Unknown	3%
American Indian or Alaska Native	Less than 1%
Unreported / Decline to Answer	Less than 1%
Native Hawaiian	Less than 1%
Other Pacific Islander	Less than 1%

UI HEALTH HYPERTENSION PATIENTS BY ETHNICITY (59,096 PATIENTS WITH ENCOUNTER IN PAST YEAR)

Not Hispanic, Latino/a, or Spanish Origin	72%
Hispanic, Latino/a, or Spanish Origin	22%
Unknown	4%
Decline to Answer	2%

UI HEALTH HYPERTENSION PATIENTS BY PRIMARY LANGUAGE (59,096 PATIENTS WITH ENCOUNTER IN PAST YEAR)

English	84%
Spanish	12%
Other	4%
(Arabic, Burmese, Cantonese, Chinese, Estonian, French, Hungarian, Korean, Mandarin, Nepali, Persian, Polish, Portuguese, Sign Language, Ukrainian, Urdu)	

UI HEALTH HYPERTENSION PATIENTS BY SEX (59,096 PATIENTS WITH ENCOUNTER IN PAST YEAR)

Female	57%
Male	43%
Nonbinary	Less than 1%
X	Less than 1%

Diabetes Registry

UI Health patients with Diabetes with >1 patient encounter for FY2022.

UI HEALTH DIABETES PATIENTS BY RACE (28,292 PATIENTS WITH ENCOUNTER IN PAST YEAR)

Black or African American	44%
Other	31%
White	18%
Asian	4%
Unknown	3%
American Indian or Alaska Native	Less than 1%
Unreported / Decline to Answer	Less than 1%
Native Hawaiian	Less than 1%
Other Pacific Islander	Less than 1%

UI HEALTH DIABETES PATIENTS BY ETHNICITY (28,292 PATIENTS WITH ENCOUNTER IN PAST YEAR)

Not Hispanic, Latino/a, or Spanish Origin	64%
Hispanic, Latino/a, or Spanish Origin	30%
Unknown	4%
Decline to Answer	2%

UI HEALTH DIABETES PATIENTS BY PRIMARY LANGUAGE (28,292 PATIENTS WITH ENCOUNTER IN PAST YEAR)

English	79%
Spanish	17%
Other	4%
(Arabic, Burmese, Cantonese, Chinese, Estonian, French, Hungarian, Korean, Mandarin, Nepali, Persian, Polish, Portuguese, Sign Language, Ukrainian, Urdu)	

UI HEALTH DIABETES PATIENTS BY SEX (28,292 PATIENTS WITH ENCOUNTER IN PAST YEAR)

Female	56%
Male	44%

Outcomes

Across both our Hypertension and Diabetes registries, we saw improvements in both the respective measures of blood pressures controlled and A1C <8 across race and ethnicity.

HYPERTENSION CONTROLLED

Race/Ethnicity	Year 1 Baseline			Year 2 Baseline		
	Number of patients	BP Controlled (<140/90)	Percent Controlled	Number of patients	BP Controlled (<140/90)	Percent Controlled
Black or Hispanic	27,195	15,365	56.5%	38,908	23,393	60.1%
Not Black or Hispanic	6,893	3,892	56.5%	10,021	6,185	61.7%
Total	34,088	19,257	56.5%	48,929	29,578	60.5%

DIABETES CONTROLLED

Race/Ethnicity	Year 1 Baseline			Year 2 Baseline		
	Number of patients	A1C<8	Percent Controlled	Number of patients	A1C<8	Percent Controlled
Black or Hispanic	10,595	5,872	55.4%	14,146	9,027	63.8%
Not Black or Hispanic	2,160	1,212	56.1%	2,681	1,676	62.5%
Total	12,755	7,074	55.5%	16,827	10,703	63.6%

Addressing Health Disparities (cont)

Hypertension

In 2021, supported by the HEPP pilot program a visual, easy-to-understand hypertension action plan available in English and Spanish was developed with input from UI Health patients and primary care providers. The plan was piloted and subsequently revised and refined based on feedback.

Pilot Outcomes

Hypertensive patients were recruited to the pilot study based on their last non-hospital reading in Epic. For the results, we compare an average of up to 4 of a patient's last non-hospital Epic readings taken within the last 12 months prior to study enrollment with an average of up to 3 of their most recent self-reported readings taken on different days at least a month after enrollment and 1 non-hospital reading in Epic if available. Overall, systolic blood pressure readings have reduced in a majority of the 23 patients in the study pilot.

"…Sometimes you need good people that they wake you up or make you realize what you're doing is like a suicide path… This study you're making opened my eyes …" Patient

"Before [my involvement in this study, I would often hear] 'do this and that' but now I'm more aware of actual changes I can make, and things I can do everyday to help my blood pressure." Patient

Figure: The change in systolic blood pressure measurement from pre- to post-pilot. (N=26 as one patient was missing post-pilot measurements).

For systolic blood pressure, compared to patients' baseline starting BPs, the Action Plan Pilot resulted in a mean reduction of 9.5 mmHg (Mean difference=-9.5; 95% CI: -15.3 to -3.8) (p=0.0021, n=26). For diastolic blood pressure, the mean difference was -0.4. However, this difference was not statistically significant (p=0.29, n=26).

Diabetes

Diabetes screening

BPA ordered for those that met eligibility criteria. Not all eligible will have a lab, e.g., no labs drawn, LWBS, other reasons. Of those with abnormal HbA1c approximately 75% are prediabetes and 25% diabetes.

ED BPA Screening Results From 02/2021 to 01/2023
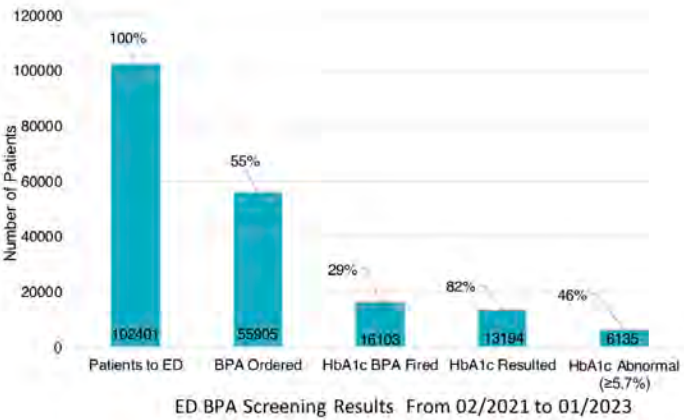
02/13/2023 NBC Chicago: UI Health ER Study Finds High Prevalence of Diabetes

Addressing Health Disparities (cont)

Cancer

Cancer Screening*

A focus of the health equity pilot program is increasing the percentage of cancer screenings among our patient population. We know that disparities in early detection of cancer lead to increased cancer diagnoses at an advanced stage which substantially contributes to the disproportionate burden of cancer-related deaths in racial and ethnic minorities and other medically underserved populations

For the upcoming year, we work to expand screening opportunities directly into communities through extended partnership with the UI Cancer Center

Outpatient Quality Measures

In FY2022, UI Health launched the Quality and Safety Transformation (QST) Program. For FY23,the QST established 11 True North Metrics which includes PSI 90. Sepsis and transformative change is underway.

Sepsis: Severe Sepsis and Septic Shock Management Bundle

Sepsis confirmed cases with BPA compliance 2021 49.75%
Sepsis confirmed cases with BPA compliance 2022 50.50%

PSI 90: Patient Safety and Adverse Events Composite

2021 1.86
2022 1.658

APPROPRIATE CERVICAL CANCER SCREENING

	Year 2 Report		
Race/Ethnicity	Number of Patients	Screened	Percent Screened
Black or Hispanic	44,444	27,069	60.9%
Not Black or Hispanic	13,503	6,612	49%
Total	57,947	33,681	58.1%

MAMMOGRAM SCREENING

	Year 2 Report		
Race/Ethnicity	Number of Patients	Screened	Percent Screened
Black or Hispanic	13,405	7,760	57.9%
Not Black or Hispanic	3,188	1,501	47.1%
Total	16,593	9,261	55.8%

FY23 True North Metrics FY23 True North Metrics will utilize 3i/Epic infrastructure, along with the QST infrastructure, as their foundation for improved supporting processes.

- CLABSI (Central Line-associated Bloodstream Infection)
- Hospital-onset C. Difficile Infection
- Surgical-site Infection: Colon, Hysterectomy
- PSI 90: Patient Safety & Adverse Events Composite
- Postoperative Respiratory Failure Rate
- Perioperative PE or DVT Rate
- Postoperative Sepsis Rate
- Retained Foreign Objects (RFO)
- Communication with Nurses
- Communication about Discharge
- Care Transition

Four CMS Inpatient & Outpatient Quality Measures were selected for quantitative and qualitative analysis of performance. We report here preliminary data on OP-18 Median Time from ED Arrival to ED Departure for Discharged ED Patients; OP-32 Facility 7-Day Risk Standardized Hospital Visit Rate after Outpatient Colonoscopy; and OP-35 Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy.

OP-18 Median Time from ED Arrival to ED Departure for Discharged ED Patients

OP-18 MEDIAN TIME FROM ED ARRIVAL TO ED DEPARTURE FOR DISCHARGED ED PATIENTS BY SEX

		Median Time (minutes)
Female	56%	308
Male	44%	284
Nonbinary	Less than 1%	320

OP-18 MEDIAN TIME FROM ED ARRIVAL TO ED DEPARTURE FOR DISCHARGED ED PATIENTS BY ETHNICITY

		Median Time (minutes)
Not Hispanic, Latino/a, or Spanish Origin	67%	298
Hispanic, Latino/a, or Spanish Origin	31%	295
Unknown	1%	256
Decline to Answer	1%	322

OP-18 MEDIAN TIME FROM ED ARRIVAL TO ED DEPARTURE FOR DISCHARGED ED PATIENTS BY RACE

		Median Time (minutes)
Black or African American	54%	298
Other	31%	295
White	11%	312
Asian	4%	275
Unknown	Less than 1%	254
American Indian or Alaska Native	Less than 1%	327
Unreported / Decline to Answer	Less than 1%	262
Native Hawaiian	Less than 1%	242
Other Pacific Islander	Less than 1%	245

OP-18 MEDIAN TIME FROM ED ARRIVAL TO ED DEPARTURE FOR DISCHARGED ED PATIENTS BY PRIMARY LANGUAGE

		Median Time (minutes)
English	87%	293
Spanish	10%	338
Other (Arabic, Burmese, Cantonese, Chinese, Estonian, French, Hungarian, Korean, Mandarin, Nepali, Persian, Polish, Portuguese, Sign Language, Ukrainian, Urdu)	3%	329

OP-22 Left Without Being Seen

OP-22 LEFT WITHOUT BEING SEEN BY SEX

UI Health Overall Left Without Being Seen 3.5%	
Female	55%
Male	45%

OP-22 LEFT WITHOUT BEING SEEN BY ETHNICITY

UI Health Overall Left Without Being Seen 3.5%	
Not Hispanic, Latino/a, or Spanish Origin	72%
Hispanic, Latino/a, or Spanish Origin	24%
Unknown	3%
Decline to Answer	1%

OP-22 LEFT WITHOUT BEING SEEN BY RACE

UI Health Overall Left Without Being Seen 3.5%	
Black or African American	60%
Other	23%
White	11%
Asian	2%
Unknown	2%
American Indian or Alaska Native	Less than 1%
Unreported / Decline to Answer	Less than 1%
Native Hawaiian	Less than 1%
Other Pacific Islander	Less than 1%

OP-22 LEFT WITHOUT BEING SEEN BY PRIMARY LANGUAGE

UI Health Overall Left Without Being Seen 3.5%	
English	90%
Spanish	6%
Other (Arabic, Burmese, Cantonese, Chinese, Estonian, French, Hungarian, Korean, Mandarin, Nepali, Persian, Polish, Portuguese, Sign Language, Ukrainian, Urdu)	4%

OP-32 Facility 7-Day Risk Standardized Hospital Visit Rate after Outpatient Colonoscopy

OP-32 FACILITY 7-DAY RISK STANDARDIZED HOSPITAL VISIT RATE AFTER OUTPATIENT COLONOSCOPY BY SEX	
Female	53%
Male	47%

OP-32 FACILITY 7-DAY RISK-STANDARDIZED HOSPITAL VISIT RATE AFTER OUTPATIENT COLONOSCOPY BY ETHNICITY	
Not Hispanic, Latino/a, or Spanish Origin	77%
Hispanic, Latino/a, or Spanish Origin	23%

| OP-32 FACILITY 7-DAY RISK-STANDARDIZED HOSPITAL VISIT RATE AFTER OUTPATIENT COLONOSCOPY BY RACE	
Black or African American	50%
Other	22%
White	21%
Asian	6%
Unknown	Less than 1%

OP-32 FACILITY 7-DAY RISK-STANDARDIZED HOSPITAL VISIT RATE AFTER OUTPATIENT COLONOSCOPY BY PRIMARY LANGUAGE	
English	84%
Spanish	15%
Other (Arabic, Burmese, Cantonese, Chinese, Estonian, French, Hungarian, Korean, Mandarin, Nepali, Persian, Polish, Portuguese, Sign Language, Ukrainian, Urdu)	1%

Preliminary Outcomes and Demographics

Our data shows no change in median time for ED departure based on patient Ethnicity.

Our data shows no change in Left Emergency Department Without Being Seen based on patient Sex.

Our data shows no change in Hospital Visit Rate after Outpatient Colonoscopy based on patient Sex.

Our data shows no change in Hospital Visit Rate after Outpatient Colonoscopy based on patient ethnicity.
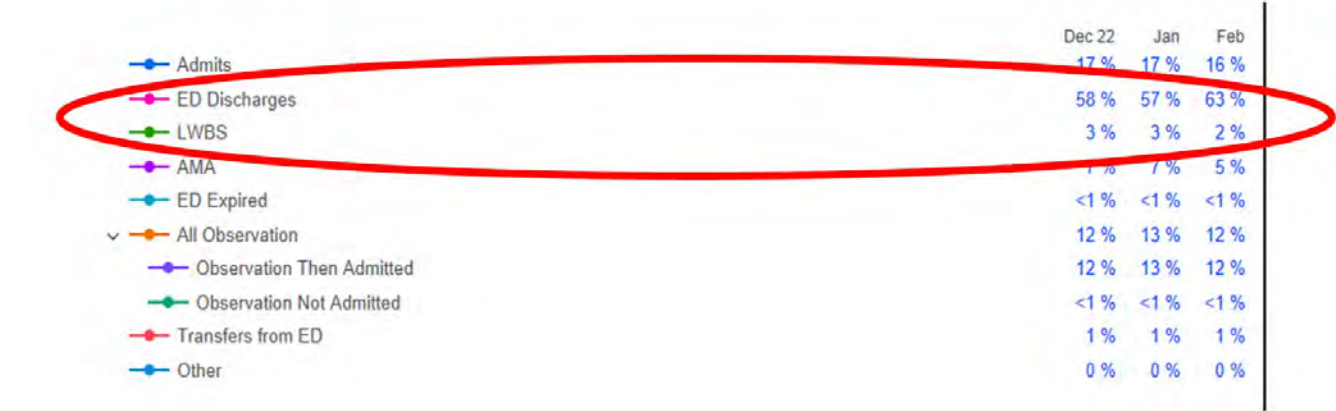
OP-35 Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy

OP-35 ADMISSIONS AND ED VISITS FOR PATIENTS RECEIVING OUTPATIENT CHEMOTHERAPY BY SEX	
Female	53%
Male	55%

OP-35 ADMISSIONS AND ED VISITS FOR PATIENTS RECEIVING OUTPATIENT CHEMOTHERAPY BY ETHNICITY	
Not Hispanic, Latino/a, or Spanish Origin	73%
Hispanic, Latino/a, or Spanish Origin	26%

OP-35 ADMISSIONS AND ED VISITS FOR PATIENTS RECEIVING OUTPATIENT CHEMOTHERAPY BY RACE	
Black or African American	47%
White	34%
Asian	8%
Other	8%
Unknown	2%
American Indian or Alaska Native	Less than 1%

OP-35 ADMISSIONS AND ED VISITS FOR PATIENTS RECEIVING OUTPATIENT CHEMOTHERAPY BY PRIMARY LANGUAGE	
English	83%
Spanish	15%
Other (Arabic, Burmese, Cantonese, Chinese, Estonian, French, Hungarian, Korean, Mandarin, Nepali, Persian, Polish, Portuguese, Sign Language, Ukrainian, Urdu)	2%

OP-22 & OP-18 Outcomes

Our data shows an increase in Hospital Visit Rate after Outpatient Colonoscopy for patient Primary Language of Spanish.

Our data shows no change in ED Visit or Admission After Receiving Outpatient Chemotherapy based on patient Race.

	Dec 22	Jan	Feb
Admits	17 %	17 %	16 %
ED Discharges	58 %	57 %	63 %
LWBS	3 %	3 %	2 %
AMA	7 %	7 %	5 %
ED Expired	<1 %	<1 %	<1 %
All Observation	12 %	13 %	12 %
Observation Then Admitted	12 %	13 %	12 %
Observation Not Admitted	<1 %	<1 %	<1 %
Transfers from ED	1 %	1 %	1 %
Other	0 %	0 %	0 %

ED Physician in Triage (PIT) Pilot

In order to address Left Without Being Seen (LWBS) and Time to ED Discharge, a pilot program was initiated in the Emergency Department. The Physician in Triage model has been previously shown to improve patient throughput.

Arrival to Discharge — Pit vs No Pit

371 / 331

Adjusted for Pit hours

Arrival to Discharge — Pit vs No Pit

409 / 357

T- value = 1.5931
P-Value = 0.113

Total number of discharges

	Number of Discharges	Number of Days	Average
Pit Doctor Present	1224	23	53.21
No Pit Doctor	725	13	55.769

Total number of LWBS

	Number of Discharges	Number of Days	Average
Pit Doctor Present	343	23	14.91
No Pit Doctor	310	13	25.833

For total LWBS:

No Pit Doc: 61+100=161

With Pit Doc: 61+14+86 = 161

Normalized per number of shift:

No PIT Doc: 161/13 = 12.3/shift

PIT Doc: 161/23 = 7/shift

	Average	St.Dev
Pit Doctor Present	14.91	15.48
No Pit Doctor	25.833	13.26
T Value	2.2336	
P-Value	0.0322	

Telehealth Utilization

Providing health equity through telehealth means making changes in digital literacy, technology, and analytics to ensure that all our patients are able to utilize the telehealth platform.

TELEHEALTH UTILIZATION BY SEX

Female	62%
Male	38%
Nonbinary	Less than 1%
X	Less than 1%

TELEHEALTH UTILIZATION BY ETHNICITY

Not Hispanic, Latino/a, or Spanish Origin	70%
Hispanic, Latino/a, or Spanish Origin	25%
Unknown	3%
Decline to Answer	2%

TELEHEALTH UTILIZATION BY RACE

Black or African American	45%
Other	25%
White	23%
Asian	4%
Unknown	3%
American Indian or Alaska Native	Less than 1%
Unreported/Declined to Answer	Less than 1%
Native Hawaiian	Less than 1%
Other Pacific Islander	Less than 1%

TELEHEALTH UTILIZATION BY PRIMARY LANGUAGE

English	90%
Spanish	8%
Other (Arabic, Burmese, Cantonese, Chinese, Estonian, French, Hungarian, Korean, Mandarin, Nepali, Persian, Polish, Portuguese, Sign Language, Ukrainian, Urdu	2%

TELEHEALTH UTILIZATION AND PATIENT SATISFACTION BY RACE/ ETHNICITY

Questions	Very Poor %	Very Poor n	Poor %	Poor n	Fair %	Fair n	Good %	Good n	Very Good %	Very Good n
Overall	1.72	2	0.00	0	1.72	2	4.31	5	92.24	107
Access Overall	0.00	0	0.00	0	3.85	1	3.85	1	92.31	24
Ease of scheduling appointments	0.00	0	0.00	0	0.00	0	7.69	1	92.31	12
Ease of contacting	0.00	0	0.00	0	7.69	1	0.00	0	92.31	12

IT ENC_TYPE: 'Unknown' - Received Date: 1/1/2022 - 12/31/2022

Questions	Very Poor %	Very Poor n	Poor %	Poor n	Fair %	Fair n	Good %	Good n	Very Good %	Very Good n
Overall	3.28	2	6.56	4	1.64	1	1.64	1	86.89	53
Access Overall	0.00	0	14.29	2	0.00	0	0.00	0	85.71	12
Ease of scheduling appointments	0.00	0	14.29	1	0.00	0	0.00	0	85.71	6
Ease of contacting	0.00	0	14.29	1	0.00	0	0.00	0	85.71	6

IT ENC_TYPE: 'Not Hispanic Latino/a or Spanish origin' - Received Date: 1/1/2022 - 12/31/2022

Questions	Very Poor %	Very Poor n	Poor %	Poor n	Fair %	Fair n	Good %	Good n	Very Good %	Very Good n	Total n
Overall	3.72	136	2.68	98	6.17	226	17.65	646	69.78	2554	3660
Access Overall	4.75	39	2.68	22	7.06	58	21.07	173	64.43	529	821
Ease of scheduling appointments	4.37	18	1.70	7	5.58	23	22.09	91	66.26	273	412
Ease of contacting	5.13	21	3.67	15	8.56	35	20.05	82	62.59	256	409

IT ENC_TYPE: 'Hispanic Latino/a or Spanish origin' - Received Date: 1/1/2022 - 12/31/2022

Questions	Very Poor %	Very Poor n	Poor %	Poor n	Fair %	Fair n	Good %	Good n	Very Good %	Very Good n	Total n
Overall	2.43	19	3.32	26	5.63	44	23.79	186	64.83	507	782
Access Overall	2.92	5	6.43	11	8.77	15	23.98	41	57.89	99	171
Ease of scheduling appointments	2.30	2	4.60	4	10.34	9	22.99	20	59.77	52	87
Ease of contacting	3.57	3	8.33	7	7.14	6	25.00	21	55.95	47	84

Readmissions

Reducing preventable hospital readmissions is a priority and will be a part of our Quality and Safety Transformation. For FY 2022 , UI Health saw a 1.1% decrease in our Readmissions rate.
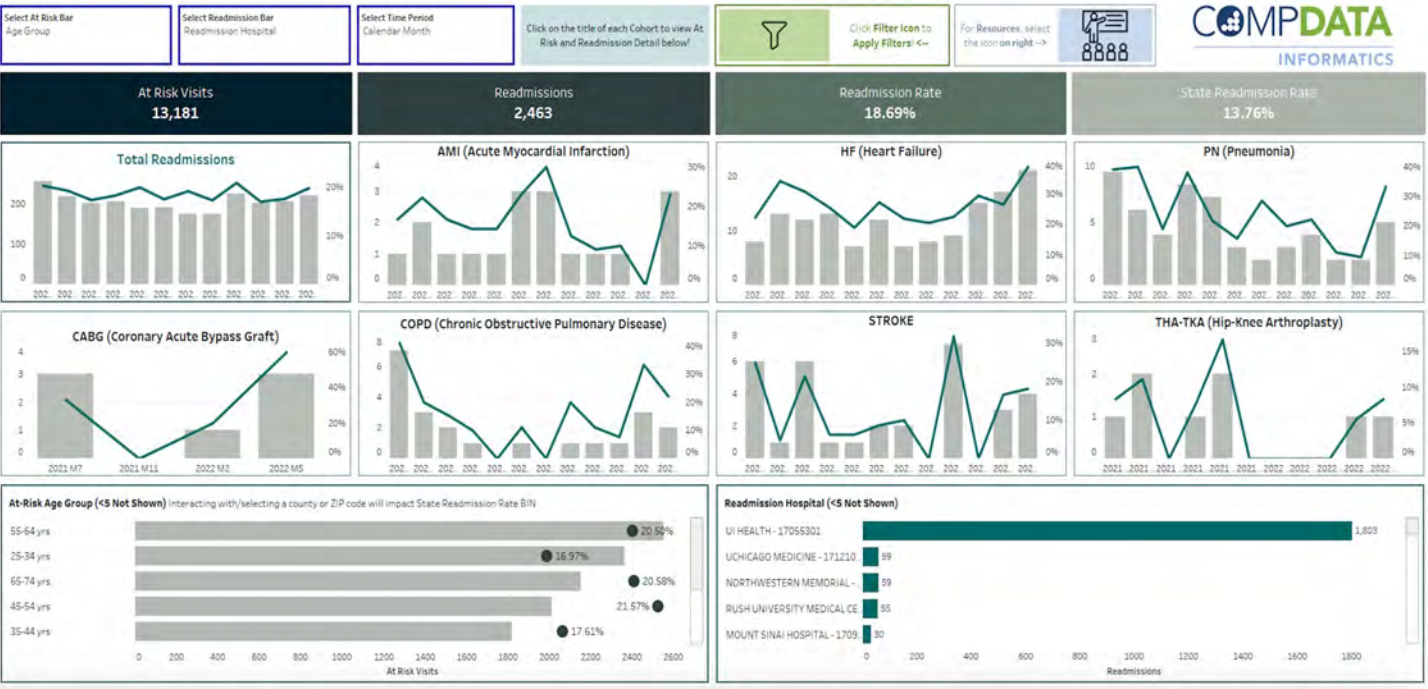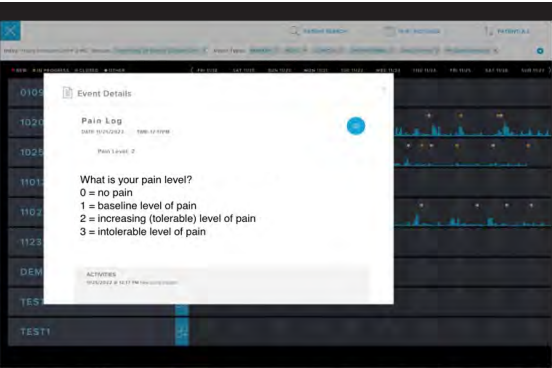

2021: 19.82 (IHA Compdata)

Ed Sickle Cell Pilot (to decrease Readmissions and Acute Hospitalizations)
A Partnership with BCBS, PhysIQ and the HEPP Pilot Program

Example of clinical alerts from the patients portal. Elevated Heart Rate is depicted here. N = 30 enrolled. Preliminary data on 5 patients

Daily Point Measurement as viewed from the portal (available every morning at 8am).

REDUCTION OF EMERGENCY DEPARTMENT VISITS

Patient #	ED visits 12 mos prior	ED visits during 1 mo monitoring
1	2	0
2	39	3
3	1	0
4	0	0
5	3	1

REDUCTION OF HOSPITAL ADMISSIONS + OBSERVATION STAYS

Patient #	Obs prior 12 mos	Admit pri- or 12 mos	Obs during 1 mo monitor	Admit during 1 mo monitor
1	1	8	0	0
2	35	15	3	0
3	0	2	0	0
4	0	1	0	0
5	37	2	4	0

Maternal Hemorrhage & Maternal Hypertension*

*Quantitative and qualitative analysis of performance managing maternal hypertension and maternal hemorrhage, including identification of racial/ethnic disparities.

In order to avoid the sequelae of postpartum hypertension – eclampsia, cardiomyopathy, cerebrovascular accidents and contributing to the ongoing health disparity surrounding maternal hypertension in women of color, the PostpartumHypertensive Initiative was launched. Patients with any hypertensive condition on medication receive a blood pressure monitor issued at discharge. The patients are scheduled for a virtual blood pressure check at the Center for Women's Health within 72 hours of discharge. Thus connecting patients to timely triage and quick access to care. Patient receive education regarding the warning signs and symptoms and the positive impact of well controlled blood pressures in the peripartum period as well as how to perform self monitoring of their blood pressures.

Health Equity Pilot Program

In Spring 2022, the HEPP program sponsored a Health Equity Call for Proposals with the option to participate in the Inaugural Health Equity Shark Tank of Quality. There were over 40 proposals received and 10 proposals were selected for funding.

Year	Hypertension Readmits OB
2020	2.66%
2021	2.66%
2022	1.99%

Pilot underway to distribute BP cuffs to post-partum women w/education.

HEPP HEALTH EQUITY & QUALITY PROPOSAL AWARDEES
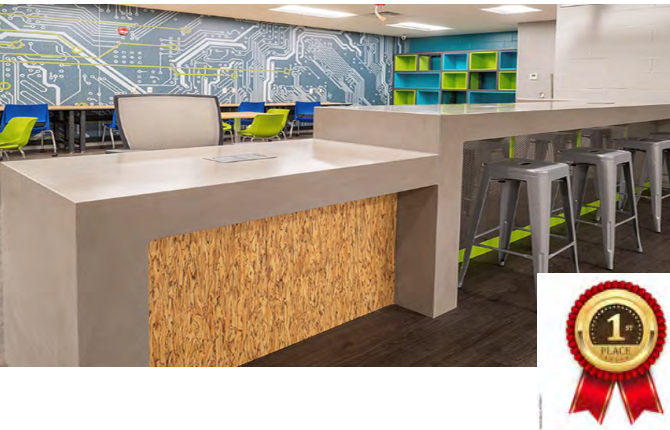
Proposal	Awardees
Colorectal Surgery Patient Nutrition	Gerald Gantt/ Mary Niewinski
Educational Tools to Increase Mobility to Reduce VTE	John Quigley/ Coleen Smith
Improving Healthcare Experience for Patients with Limited English Proficiency	Tochukwu Ndukwe /Paul Chan
Health Literacy in Urology	Daniel Moreira/ Kelly Banks-Enorense
Language & Educational Barriers for Perioperative Materials	Mark Gonzalez / Benjamin Goldberg
Operating Room Safety & Communication	Aarti Raghavan/ Shirley Belocura
Patient Health Technology Literacy	Bhrandon Harris/ Kunal Patel
Pressure Injury Risk Assessment/ Objective detection of skin concerns	Clive Horrocks
Antepartum Patient Satisfaction, postpartum depression	Gaby Fuchs/ Jessica George
Maximizing Patient Independence through use of equipment	Nexhip Cuca/Joseph Mendoza

Addressing Disparities with a Digital Health Hub

Identifying Disparities with MyChart in Primary Care

PRIMARY CARE PATIENTS MYCHART ACTIVATED

	% Activated	% Pending
Asian	93.4	5.3
White	87.6	9.9
Other	74.6	21.1
Black	70.3	24.5
Latinx	69.5	24.9
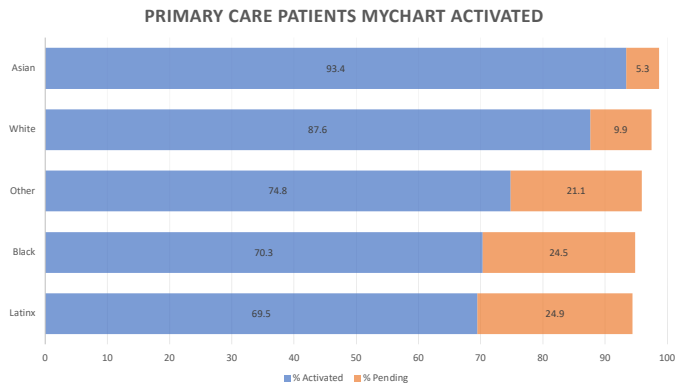
Projects Supported with HEPP Funding

HEALTH DISPARITIES

AI-Driven Diabetic Retinopathy Screening

Management of Pediatric Overweight & Obesity

ACCESS TO CARE

Access to Bariatric Surgery in Minorities

Demographic and Social Factors Impacting Access to Surgical Care

Access to Care and Hypertension Management - SDOH

CANCER SCREENING

Lung Cancer Screening, Diagnosis, and Treatment

Racial/Ethnic Disparities in Cervical Cancer Screening

Highlights: Physician-Focused Initiatives

The UI College of Medicine has for over 40 years committed to recruiting, retaining and graduating a diverse student body through its Urban Health Programs. Initially conceived in the College of Medicine, the Urban Health Programs now exist in each of our health science colleges, our undergraduate campus and in our early outreach program for students elementary through high school. These programs expose and prepare students for careers in health. UI COM ranks at the top of the list of schools graduating more Black and Hispanic/LatinX students outside of the Historically Black Colleges and Universities (HBCU) and the Hispanic Serving Institutions (HSI).

Our holistic review of medical school applications no longer focuses solely on grades and scores, but now focuses on the whole student, their life experiences, and their previous and planned contributions to improving the health of their patients and communities. This concept has now been entrenched in the medical student admission process and over the past two years, we have started to implement similar practices into the residency recruitment process. We have diversified our medical students, resident, and fellowship cohorts in a dramatic fashion with the emphasis on opening opportunities by broadening our outreach.
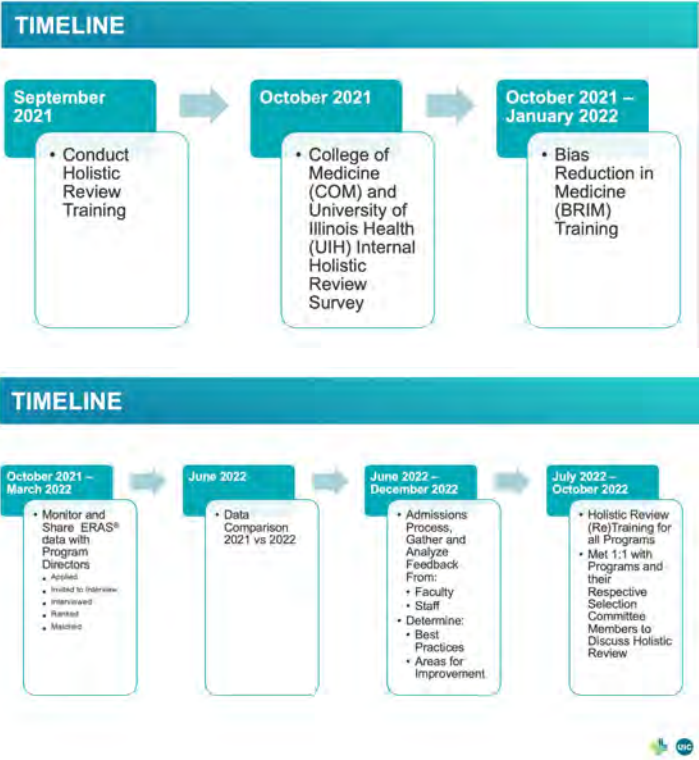
Bias Reduction in Medicine (BRiM) Program
- Completed 50 workshops
- A total of 636 attended the workshops (Chicago: 252, Peoria: 253, Rockford: 104, UI Hosp: 25, Urbana: 2)
- Trained 14 new facilitators
- Expansion to Cancer Center in Fall 2023

TIMELINE

September 2021
- Conduct Holistic Review Training

October 2021
- College of Medicine (COM) and University of Illinois Health (UIH) Internal Holistic Review Survey

October 2021 – January 2022
- Bias Reduction in Medicine (BRIM) Training

TIMELINE

October 2021 – March 2022
- Monitor and Share ERAS® data with Program Directors
  - Applied
  - Invited to Interview
  - Interviewed
  - Ranked
  - Matched

June 2022
- Data Comparison 2021 vs 2022

June 2022 – December 2022
- Admissions Process, Gather and Analyze Feedback From:
  - Faculty
  - Staff
  - Determine:
    - Best Practices
    - Areas for Improvement

July 2022 – October 2022
- Holistic Review (Re)Training for all Programs
- Met 1:1 with Programs and their Respective Selection Committee Members to Discuss Holistic Review

Year 2 Provider Summary Data

MEDICAL STUDENTS BY RACE / ETHNICITY

Medical Student Year	Asian	Black / African American	Hispanic	International	Multi-Race	Unknown	White
1 (185)	26%	16%	19%	2%	7%	8%	21%
2 (209)	23%	16%	19%	6%	6%	5%	24%
3 (152)	29%	14%	14%	3%	7%	2%	31%
4 (227)	30%	8%	14%	1%	6%	0%	38%

RESIDENTS AND FELLOWS BY RACE / ETHNICITY

	Asian	Black / African American	Hispanic	International	Multi-Race	Unknown	White
Fellows (144)	36%	10%	6%	7%	2%	2%	37%
Residents (930)	30%	8%	8%	2%	3%	3%	47%

Outcomes/Lessons Learned

The graph depicts the initiatives and progress to close the diversity gap between graduate medical education and the population data for our Primary Service Area that was reflected in our 2019 Community Assessment of Needs Report. The center of the ring represent what we are doing to close the gap. The inner ring was our AY2021-2022 Race and Ethnic group, the middle ring represents are AY2022-2023 Matched Race and Ethnic Group, and the Outer Ring represents the race and ethnic group of our primary service area.

We are doing this through:
- BRIM (Bias Reduction in Medicine) training
- Holistic Review
- AAMC Experiences-Attributes-Metrics Model: Association of American Medical College's methodology of Holistic Review.

Holistic review involves widening the lens through which we view applicants, recognizing and valuing the different dimensions that shape each individual. Similar to the hospital's mission of recognizing and respecting diversity in our patient population and our UI Health family. Positive impact to cultural competency – food choices, health choices, traditional family roles vs extended family roles, religious viewpoints.

Exceeded Goals

We have an increase to 41% of the entering student body being comprised of underrepresented minorities in medicine (URiM), and an increase of multiracial (33%), Hispanic/LatinX (40%), and Black (150%) residents entering our training programs this year.

	AY2021	AY2022	Δ
African American	6%	15%	9%
Hispanic/Latinx	10%	14%	4%
Multiracial	3%	4%	1%
Sum	**19%**	**33%**	**14%**

Graduate Medical Education
- 150% Increase in African-American/Black Residents and Fellows from Academic Year 2021-2022 to 2022-2023 (Matched)
- 40% Increase in Hispanic/Latinx Residents and Fellows from Academic Year 2021-2022 to 2022-2023 (Matched)
- 33% Increase in Multiracial Residents and Fellows from Academic Year 2021-2022 to 2022-2023 (Matched)

2022 CLINICAL FACULTY BY RACE / ETHNICITY

Rank	Asian	Black / African American	Hispanic	International	Multi-Race	Unknown	White
Professor (120)	26%	4%	4%	1%	0%	3%	62%
Associate Professor (147)	26%	5%	10%	0%	1%	3%	54%
Assistant Professor (312)	30%	7%	9%	6%	2%	2%	45%
Instructor (10)	10%	0%	10%	0%	0%	0%	80%

Change from 2021 to 2022
- 9% increase in Hispanic Faculty
- 1% increase in Professor rank for AA faculty