Planning for Diversity: BeatPain Utah

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David W. Wetter, PhD
Disparities in Pain Prevalence and Management

From 1999 to 2016, the rate of opioid mortality increased 4.5 times faster in rural versus metro communities.

Persons residing in low-income communities have a 63% higher odds of receiving a prescription opioid for a new back pain diagnosis.

Use of self-management and nonpharmacologic pain treatments are lower in rural versus non-rural settings, lower for persons of Hispanic/Latino ethnicity.
Disparities in Pain Prevalence and Management

Age-Adjusted Prevalence of High Impact Chronic Pain

FROM: (Dahlhamer J et al, MWMR Morb Mortal Weekly Rep, 2018)
Share of the Population Identifying Outside Non-Hispanic White

The U.S. Population is 1.8x more racially/ethnically diverse than Utah

Utah ranks as the 34th most racially/ethnically diverse state in the nation

San Juan County ........ 55.7%
West Valley City .......... 54.0%
Ogden City ............. 39.5%
Salt Lake City .......... 36.4%
Salt Lake County ....... 30.0%

Note: This is sample-based survey data. Source: U.S. Census Bureau, American Community Survey Ranking Tables. Calculations by Kem C. Gardner Policy Institute.
Utah ranks 13th for percent Hispanic/Latino

Utah ranks 5th for percent Native Hawaiian/Other Pacific Islander

Utah ranks 13th for percent American Indian/Alaskan Native

Figure 1. Share of Utah Population by Race and Ethnicity, 2015–2019

Source: U.S. Census Bureau, 2019 5-Year American Community Survey Estimates
Frontier Counties
(Fewer than 7 people per square mile)
Purpose: Serve as a research infrastructure and bridge between scientists and community organizations (e.g., health care, government, education, nonprofits, faith based, social services, tribal) throughout Utah and the Mountain West. Utilize strategic focused partnering for community engagement and sustainability.

Mission: Bring communities and researchers together to create long-term solutions to prevent cancer, chronic and infectious disease, and improve health among underserved populations.

Vision: Equity in cancer and chronic disease incidence, morbidity, and mortality in Utah/Mountain West.

Major Research Foci:
- Health inequities
- Implementation and dissemination of evidence-based interventions
- Behavioral interventions
- Low socioeconomic status, racial/ethnic minority, rural/frontier

Training Mission
- Train scientists/researchers to address health inequities and social justice
Strategic, Focused Partnering for Community Engagement and Sustainability

Partnership Categories

• **Network Partner**: Maintain contact for information sharing, dissemination, recruitment.

• **Development Partner**: Developing relationship toward potential projects/proposals; communicate on shared priorities and opportunities.

• **Research Partner**: Long-term, formal partnership for research projects or programs; shared decision-making.
Racially/Ethnically Diverse
- 49% Hispanic/Latino Ethnicity
- 9% American Indian/Alaska Native

Low Socioeconomic Status
- 66% < Federal Poverty Level
- 49% Uninsured

Rural/Frontier (28 Clinics in Total)
- 10 clinics in frontier counties (<6 people per square mile)
- 18 clinics in rural counties (6-100 people per square mile)
Research Partnership

Association for Utah Community Health (AUCH)
Utah Department of Health (UDOH)
Utah Community Health Centers (CHCs)
Center for HOPE/University of Utah/Huntsman Cancer Institute

• Funded Grants
  • QuitSMART Utah (PCORI Pragmatic Trial) $9.5M
  • HRSA Health Information Technology (AUCH leads)
  • Colorectal Cancer Screening (CDC) ~$3.5M
  • BeatPain Utah (NINR) ~$3M
  • RADxU COVID-19 (NCATS) ~$5M
  • HPV Vaccination (ACS) ~$900K

• Pending Grants
  • RADxUP COVID-19 Schools (NIH)
  • Social Determinants of Health/Obesity (NIH)

• Planned Grant Submissions
  • RADxUP COVID-19 Phase II (NIH)
  • Low Dose CT Screening for Lung Cancer (NIH)
  • Adolescent Vaping (NIH)
Community – Engaged Dissemination and Implementation Research

Key Partners
- Academic Research Center
- Primary Care Association
- Community Health Centers
- State Department of Health

Key Partnership Characteristics
- Shared Goals
- Mutual Respect of Expertise
- Shared Resources and Data

Key Engagement Activities
- Patient and Study Advisory Committees
- Clinical Workflow Analyses and Usability Assessments
- Adaptation to Implementation Strategies

Lessons Learned
- Importance of Bridging Capacity
- Leverage Partnership Expertise to Overcome Challenges
- Include Diverse Perspectives to Advance Health Equity

Schlechter, C. R. et al. Application of Community – Engaged Dissemination and Implementation Research to Improve Health Equity. (under review)
Partnership Characteristics

- **Shared Goals**
  - All of our research projects have been driven by the priorities of our community partners

- **Mutual Respect of Expertise**
  - Patient and Study Advisory Committees
  - Primary Care Association team member from AUCH embedded at the Center for HOPE

- **Shared Resources and Data**
  - All projects include bidirectional communication with respect to patient data (e.g., immunization registry)
  - Utah Department of Health has shifted funding and provided resources/data to create synergy with the funded research projects (e.g., providing tobacco cessation medications for uninsured; identifying COVID hotspots to target)
  - Projects have provided funding to AUCH to tie together Utah’s 13 CHCs via a Population Health Management tool
Designing for Sustainability

• **Health Information Technology as a Foundation**
  • Work with CHC EHRs and EHR vendors to create solutions that can be immediately disseminated and implemented by other users of those EHRs
  • Population Health Management tools to tie CHC systems together to enable identification of patient cohorts and “campaigns” (e.g., texting) to address patient needs

• **Community Health Workers/Health Educators/Patient Navigators**
  • Many CHCs have Community Health Workers on staff
  • Association for Utah Community Health has Community Health Workers on staff

• **Utilize Existing Evidence-Based Interventions (EBIs)/Resources**
  • Linkages for primary prevention utilize existing EBIs (e.g., Tobacco Quitlines, Diabetes Prevention Programs)
  • Linkages for screening/testing/vaccination collaborate with state programs (e.g., colorectal, breast and cervical, COVID, HPV)
SUMMARY

• Consider the different categories of partnerships
• Research opportunities arise from the priorities of community partners
• Mutual respect for expertise and bidirectional communication
• Designing for sustainability from the outset
Grand Rounds Diversity Workshop Series

Session 1: Planning for Diversity:
Stakeholder Engagement and Site Selection to Maximize Diversity

Gloria Coronado, Distinguished Investigator
Amanda Petrik, Sr. Research Associate
Presentation Agenda

STOP CRC Pragmatic Study in Community Health Centers

Stakeholder Engagement

Patient Engagement

Organizational Engagement
Pragmatic Implementation
Research determines the best approach for the population.
Stakeholder engagement supports pragmatic research

- Builds partnerships based on mutual respect
- Grounds the research in the contributions of community organizations, advocates, stakeholders
- Conducts research that gives policy-makers and implementers access to detailed data to guide the design and delivery of care/services
- Leverages local knowledge -- informed by advisory group
- Produce results that are meaningful
- Shares results that are tailored to population subgroups, in a non-technical way, without oversimplification
CRC Screening Disparities

Colorectal Cancer Screening

- Hispanic
- Am Ind
- Asian/ PI
- Black

BRFSS 2018
The STOP CRC pilot was more effective in the Hispanic population.

FIT Completion, STOP CRC Pilot Study

- Hispanic
- Non-Hispanic White
Stakeholder engagement is critical.

<table>
<thead>
<tr>
<th>Clinic</th>
<th>N Patients aged 50-74</th>
<th>% Hispanic aged 50-74</th>
<th>% aged 50-74 who obtained FIT or FOBT</th>
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<tbody>
<tr>
<td>#1</td>
<td>898</td>
<td>73</td>
<td>3.7</td>
</tr>
<tr>
<td>#2</td>
<td>1562</td>
<td>52</td>
<td>3.9</td>
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<td>#3</td>
<td>1495</td>
<td>31</td>
<td>5.2</td>
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<tr>
<td>#4</td>
<td>1235</td>
<td>38</td>
<td>7.6</td>
</tr>
</tbody>
</table>
Stakeholder engagement leads to trust.

- Leadership Engagement
- Patient Council Engagement
Patient and clinical engagement creates sustainability.
Patient feedback improved patient facing materials.
Stellar Examples!
Stellar Examples!
Stellar Examples!
Stellar Examples!

Funding provided by the Centers for Disease Control and Prevention (Award Number U48 DK105488) and the Kaiser Permanente Fund for Excellence.

Adapted with permission from: scalesmenstru.org. Credit: C. Tan, M. Saechit.
Stellar Examples!

FIT Instructions

1. Check
2. Write

3. Pee and Flush
4. Prepare

5. Poop

6. Collect

7. Flush
8. Drop off or Mail

DATE OF BIRTH
YOUR NAME

30/05/2024

Funding provided by the Ontario Ministry of Health and Long-Term Care
Adapted by Cancer Care Ontario with permission from BCNDR (Generosity Grant Number 146948) and the UCLA Health Outcomes Study & Evaluation (UHSE) - Research Program
Adapt the project to address barriers.
Organizational Engagement Strategies

ADVISORY BOARD

PLAN-DO-STUDY-ACT CYCLES
STOP CRC Advisory Board identified need for policy changes

- 14-member board comprised of
  - Health center leaders
  - Patient advocates
  - Legislators
  - Community organizations leader

- Meeting schedule
  - Annual full-day in-person meeting
  - Monthly, then quarterly meetings

- Advisory board continues to meet
Advisory board paved the way to policy changes

Incentives metric for coordinated care organization – 2013 - 2019 (~90% of Medicaid

Oregon passed legislation to make a screening colonoscopy remain a screening

Oregon passed legislation to eliminate out-of-pocket costs for follow-up colonoscopy
### Addition: Colorectal Cancer Screening

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage of patients 50 to 75 years of age who had appropriate screening for colorectal cancer.</th>
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</thead>
<tbody>
<tr>
<td>Measure steward</td>
<td>National Committee for Quality Assurance (NCQA)</td>
</tr>
<tr>
<td>NQF number (if endorsed)</td>
<td>0034</td>
</tr>
<tr>
<td>Measure type</td>
<td>Process</td>
</tr>
<tr>
<td>Recommended to replace current measure?</td>
<td>No</td>
</tr>
<tr>
<td>Data collection method</td>
<td>Administrative, hybrid, and HEDIS® Electronic Clinical Data Systems (ECDS). (Note: ECDS includes data from administrative claims, electronic health records, case management systems, and health information exchange clinical registries. NCQA has proposed transitioning this measure to ECDS only reporting starting measurement year 2024 and is currently assessing public comment regarding this proposal.)</td>
</tr>
<tr>
<td>Denominator</td>
<td>Members 51 to 75 years of age as of December 31 of the measurement year.</td>
</tr>
</tbody>
</table>
| Numerator | Members with one or more screenings for colorectal cancer. Any of the following meet criteria:  
  - Fecal occult blood test (FOBT) during the measurement year. For administrative data, assume the required number of samples were returned, regardless of FOBT type.  
  - Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.  
  - Colonoscopy during the measurement year or the nine years prior to the measurement year.  
  - Computed tomography (CT) colonography during the measurement year or the four years prior to the measurement year.  
  - Fecal immunochemical DNA (FIT-DNA) test during the measurement year or the two years prior to the measurement year. |
Plan–Do–Study–Act

engaged health centers to address challenges

1. Plan
   • Plan the intervention

2. Do
   • Try the intervention on a small scale

3. Study
   • Study the results

4. Act
   • Refine the intervention
Partnered with a Quality Improvement facilitator, trained in PDSA approach.

Met with the leadership teams of each health center (n = 8).

- Reviewed PDSA approach
- Shared EMR screening rates and provider survey data

PDSA plan (due within 1 month)

PDSA results (due 3 – 6 months later)

All sites presented findings at Advisory Board meeting.
One health center used a PDSA to test FIT reminders

- 2,722 patients identified in 4 clinics and mailed a FIT kit;
- 2232 patients randomized to one of several reminders

Coronado et al. 2017
Success of reminders for a mailed FIT program

FIT return rates among patients who prefer Spanish versus English

Source: Sea Mar Community Health Center

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Reactions to PDSA used in research

Providers and clinic staff had favorable reactions

“But the [PDSA] process itself, we kind of do that organically already without calling it a PDSA. So now it’s nice to have a form and a template that we can work by so that we can get feedback ... and come up with questions like ‘What about if we did this?’ or ‘Who’s going to do that?’ So it’s good to have that template to work from.”

— Quality Improvement Manager
Lessons learned

In STOP CRC, we selected our most diverse clinic for the pilot phase.

We refined our materials using clinic and patient feedback; these materials are being used by KP and dozens of other health systems.

We assembled an advisory board that addressed policy barriers, this provided data for national policy changes.

We guided health centers to conduct Plan-Do-Study-Act Cycles, this allowed up to understand implementation barriers.

Building partnerships take time; staff turnover is a key challenge.
Resources

www.MailedFIT.org

Mailed FIT - Resources to Optimize Colorectal Cancer Screening

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