## Project Description / Purpose

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| **Project Name:** | Data Analysis to Determine Health Inequities |
| **Clinic:** | Copa Health (Partners In Recovery and Marc Community Resources) |
| **Process:** | Examine all data feeds and analyze information by race, ethnicity and other DEI factors |
| **TIP 2.0 Process Milestone:** | *HE 6A and HE 6B* |
| **Project Description / Purpose** | |
| Project: Implement a new evaluation process for stratifying quality incentive measures using EHR data to identify health disparities.  The project will represent a joint effort by the Population Health, Information Technology, and Integrated Health Solutions Departments to examine all the data we receive and collect including HEDIS Measures, Value Based Care Measures, diagnoses, attendance rates, adherence to medication, medication categories, follow up after hospitalization, medical and behavioral hospitalizations, emergency room usage, access to care, etc. The data will be examined by identified demographic data to determine if there are any health inequities. | |

## Project Overview

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| **Problem Summary:** | Analyzing quality measures to address health equity involves a systematic approach to identify, evaluate, and improve health outcomes across different population groups. To fully engage in this process, there is a need to comprehensively understand and utilize the data that the organization has available. While we have a robust number of health data elements, we have not analyzed the data with respect to health equity. |
| **Desired Outcome(s):** | Through our data analysis we will be able to determine if there are inequities in any of the varied populations that we serve. Specifically, the desired outcome is to systematically identify and quantify health disparities across different demographic groups, including racial, ethnic, socioeconomic, and geographic groups. This could subsequently lead to improved health outcomes for all populations served, equitable access to our services, data-driven decision making, and continuous quality improvement. |
| **Benefits:** | We will be able to identify and address any inequities that we discover, enhancing our Population Health initiatives and activities. Immediate benefits include compliance with the TIP 2.0 Health Equity Milestone and the ability to identify specific interventions that align with data. Long term benefits include increased quality of care by addressing gaps and disparities identified through quality measures. |

## Timeline

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|  | **Description of Task and Completion Dates** |
| **Task 1** | We will identify all data sources that we receive or collect in our electronic medical record by 6/1/2024. |
| **Task 2** | We will identify additional data sources that would potentially be useful in examining health equity by 6/15/2024. |
| **Task 3** | We will match our demographic data to our sources to examine differences in performance on the various measures by 7/31/2024. |
| **Task 4** | Based on our findings we will choose activities to reduce disparities in the outcomes we believe that we can impact and create an action plan by 9/1/2024. |
| **Task 5** | We will continue to track progress on our activities and will add new activities as we identify them by 1/1/2025. |

\* Add new rows as needed.

## Project Scope

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| **In Scope Project Objectives** |
| * To identify and address health inequities in the population we serve. * To identify additional data sources where we can better track our outcomes and more accurately stratify risk. * To select specific quality measures related to health outcomes, access to care, and preventive services that are pertinent to health equity. * To quantify any identified health disparities. |
| **Out of Scope Project Objectives or Activities** |
| * Identifying or utilizing any additional data sources in which costs are associated with use of the data. * Implementing large-scale structural changes or activities that are outside the scope of analyzing and addressing quality measures. |

## Project Team

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| **Team Lead:** | Jacqueline Webster/ Michael Franczak | **Project Champion:** | Latrice Hickman |
| **Process Owner:** | Jacqueline Webster | **Process Manager:** | Michael Franczak |

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| **Stakeholders** | | | |
| **Stakeholder** | **Title** | **Department** | **Organization** |
| Latrice Hickman | Chief Risk and Compliance Officer | Risk and Compliance | Copa Health |
| Dan Hixon | Chief Information and Digital Officer | Information Technology | Copa Health |
| Michaela Statt | Vice President | Integrated Health Solutions | Copa Health |

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| **Project Team Members** | |
| **Name** | **Team Role** |
| Jacqueline Webster | Director, Population Health (population health expert) |
| Michael Franczak | Director, Population Health (population health expert) |
| Ashok Kumar | Sr. Director of Systems & Data Engineering (IT expert) |
| Aaron Scrignar | Data Analyst (IT expert) |
| Bob Leeper | Data Analyst (IT expert) |
| Tim Owen | Sr. EHR Manager (IT expert) |
| Maria Cholley | Sr. Director, Outpatient Services (integrated care expert) |
| Derrick Baker | Director of Risk & Compliance (compliance expert) |

## Signatures

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| **Process Owner** |  |
| **Project Champion** | Graphical user interface, application  Description automatically generated |
| **Team Leader** |  |