**QI Award Grant for COPPHI Initiative:**

**Improving the DPH Data Infrastructure for Race/Ethnicity and Other Demographic Data**

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**AIM Statement**

**Section 1: Problem Description, Boundary, and Team Composition**

 Describe the problem or opportunity to be addressed:

Only two of the 49 DPH databases identified are in compliance with the DPH Policy on Collecting Sociodemographic Data (a.k.a. the DPH data collection policy). The 2identified are:

Med-IT – Breast cancer/Wise Women Program (contact is Susan Yurasevecz)

GPRS (gram-positive rod) – Infectious disease (contacts are Jessica Brockmeyer, Paul Gacek)

 This process is important to work on now because of:

A renewed focus on improving population health that looks at health equity as a major contributing factor. To do this, it is necessary to enhance our state-wide data infrastructure for documenting, addressing, and reporting health disparities so that data is standardized and complete.

 Team Sponsor: Margaret Hynes

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 Team Members & Area of Expertise:

Margaret Hynes DPH lead for Health Equity; Subject matter expert (SME) on the DPH data collection policy

Lloyd Mueller SME on Birth data

Ava Nepaul SME on the DPH data collection policy

Jane Purtill SME for Vital Records - Birth Records

Jen Filippone SME for Health Care Provider Licensure Database

Vanessa Kapral SME for Information Technology

Susan Logan SME Performance Management/QI

 The QI opportunity starts with identifying the two appropriate databases to improve. This was done by discussion between the team sponsor and data experts and narrowing down the potential candidates for improvement. They were specifically looking for databases that inform other databases through linkages, were large, timely, and within DPH and the QI team’s control to change with assistance from the IT vendor(s). The opportunity ends with making them compliant with the DPH data collection policy and having a quality improvement plan in place to enhance compliance for the other 47 databases.

**Section 2: Internal and External Benefit and Cost Description**

 This opportunity has the following estimated potential benefits internally and to the external community:

1. **Internal:**  Tangible Benefits

* + - * Availability of standardized race, ethnicity, gender, and age data
			* Comparability across databases (caveat: some will be self-reported and others reported by program and administrative staff)
			* Increase DPH ability to monitor equity and identify health disparities.
			* Increase DPH ability to develop and target appropriate interventions

 Intangible Benefits

* Better positioned to access DHHS grants

2. **External:** Tangible Benefits

* Accessible on a statewide basis to DPH partners
* Comparability to national and other external databases using the OMB standards

 Intangible Benefits

* + - Provide more meaningful data to DPH external partners
		- Increase satisfaction of that other state agencies/programs that use the data

 The cost of this project is estimated to be: $ 5,000 and is composed of the following categories:

* IT vendors - $3,990
* Supplies - $750
* Meetings - $250
* Staff time (in kind) - $5,250

NOTES: Actual cost to bring 2 databases in compliance may depend on

* database(s) chosen for the project
* if other agencies sending us the data need to make changes to their data collection forms/processes.

**Section 3: Current State Performance and Desired Future State**

 Describe the current state of the problem or opportunity and its current performance (baseline data):

 Two of 49 DPH databases are currently in full compliance.

 Describe the ideal future state:

Five (3 additional) of 49 DPH databases are in full compliance by November 30, 2012. A written plan is in place to improve the other databases so that they are in compliance. Funding is available for compliance.

Driving forces:

1. Affordable Care Act
2. Agency Strategic Mapping Process which identified health equity and improving the data infrastructure as priorities
3. Need for comparable data on race and ethnicity, gender and age
4. Improve customer satisfaction
5. Time/ effort savings

Restraining forces:

1. Cost
2. Lack of financial incentives ( e.g. federal grant does not require it and will not provide additional funding needed to make changes)
3. Complexity (make one change or add to a number of changes that need to be made; marketing)
4. Staff time/ labor intensive
5. Lack of buy-in
6. Lack of awareness
7. Silo culture

 **Section 4: Improvement Description**

**This effort should improve the current state by:**

Improvement goals to be achieved:

1. The number of compliant databases will increase from two to five. Thus, the ability to report on race, ethnicity, gender, and age in a standardized way will be improved and expected to more than double from the baseline.
2. A quality improvement plan will be in place that delineates how the remaining databases will be revised so that they will be in full compliance with the DPH Policy on Collecting Sociodemographic Data by November 30, 2012.
3. Customer satisfaction is a desired outcome of this QI project and needs further team discussion on how this can be measured. One possibility is a baseline survey and follow-up survey(s) targeted at internal and/or external customers immediately after the two additional databases are in compliance (and, if possible, a few months after the QI plan has been put into effect and many more databases are fully compliant).

The timing of these improvements:

1. Every 3 months, the measures below will be assessed (July 1, 2012; October 1, 2012; and November 30, 2012 (end of project period).

NOTE: The timing of the improvements depends on the database(s) being updated. Each database will have its own particular issue that is out of compliance. Some are quick fixes, some may cost money or need to be addressed over the long term.

We will measure improvements by:

1. Reviewing the changes to the database and tracking how many changes are made, doing quality assurance checks to ascertain that the DPH data collection policy standards are met, and calculating the percent of databases in full compliance.
2. Monitoring the progress of the database revision plan and determining if the planned revisions took place within a certain to-be specified timeframe. A percent revised database metric can be calculated on a weekly/monthly basis until all databases that are able to be revised (cost- and effort-wise) are updated. It is yet to be determined who will develop the revision plan, but will most likely be the members of the QI project team.

**Section 5: Internal and External Customer Identification:**

 For the following customers/clients (*customers, staff or those affected by the process under improvement)*

Internal

1. DPH data users (epidemiologists, program staff)
2. Affirmative action office (AAO)

External

1. LHDs
2. General public
3. Researchers
4. Other state agencies
5. Genealogists
6. Professional organizations looking at workforce issues
7. Physicians (for the CIRTS)