hospitals in pursuit of excellence
Accelerating Performance Improvement

HPOE *Live!*

2016 Webinar Series

The presentation will begin shortly.

DSC Web Seminar Series in Partnership with
the Hospitals in Pursuit of Excellence (HPOE) of the American Hospital Association

Going Beyond REaL Data Collection: Collecting Social Determinants of Health

Tuesday, February 23rd, 2016

12:00PM – 1:00PM ET
11:00 AM – 12:00 PM CT
9:00 AM – 10:00 AM PT

THE DISPARITIES SOLUTIONS CENTER
One Goal – High Quality Care for All

Going Beyond REaL Data Collection: Collecting Social Determinants of Health

Moderator

Lenny López, MD, MDiv, MPH, Chief of Hospital Medicine, University of California San Francisco - SFVA and Senior Faculty, the Disparities Solutions Center at Massachusetts General Hospital

Presenters:

Kirsten Bibbins-Domingo, PhD, MD, MAS, Director, UCSF Center for Vulnerable Populations at San Francisco General Hospital

Aswita Tan-McGrory, MBA, MSPH, Deputy Director, The Disparities Solutions Center at Massachusetts General Hospital

THE DISPARITIES SOLUTIONS CENTER

One Goal – High Quality Care for All

Kirsten Bibbins-Domingo, PhD, MD, MAS

Kirsten Bibbins-Domingo, PhD, MD, MAS is the Lee Goldman, MD Endowed Chair in Medicine and Professor of Medicine and of Epidemiology and Biostatistics. She directs the UCSF Center for Vulnerable Populations at San Francisco General Hospital, a research center focused on discovery, innovation, policy and advocacy, and community engagement for populations at risk for poor health and inadequate healthcare. She is a Board Member of UCSF's Clinical and Translational Science Institute (CTSI) and Director of the CTSI Clinical and Translational Science Training (CTST) Programs. Dr. Bibbins-Domingo is a general internist at San Francisco General Hospital and a cardiovascular epidemiologist with expertise in cardiovascular disease, diabetes, and chronic kidney disease, as well as the development of chronic disease in young adults. Her work focuses on racial, ethnic and income differences in manifestations of chronic disease and effective clinical, public health, and policy interventions aimed at prevention. She has been a member of the US Preventive Services Task Force (USPSTF) since 2010 and is currently co-Vice Chair of the USPSTF. She is a member of the American Society for Clinical Investigation and the National Academy of Medicine.

Aswita Tan-McGrory, MBA, MSPH

In her role as Deputy Director at the Disparities Solutions Center, Aswita Tan-McGrory is a key member of the senior management team and supervises the broad portfolio of projects and administration of the Center. These include a collaboration with Center of Quality and Safety at MGH to develop the Annual Report on Equity in Healthcare Quality to analyze key quality measures stratified by race, ethnicity, and language; the Boston Public Health Commission on developing and implementing a city-wide disparities dashboard; and the Pediatric Health Equity Collaborative to develop recommendations on collecting race, ethnicity and language from pediatric patients. Ms. Tan-McGrory also oversees the Disparities Leadership Program, an executive-level leadership program on how to address disparities. In addition, she works closely with the Director to chart the DSC's future growth and strategic response to an ever-increasing demand for the Center's services.

Her interests are in providing equitable care to underserved populations and she has over 19 years of professional experience in the areas of disparities, maternal/child health, elder homelessness, and HIV testing and counseling. She received her Master of Business Administration from Babson College and her Master of Science in Public Health, with a concentration in tropical medicine and parasitology, from Tulane University School of Public Health and Tropical Medicine. Ms. Tan-McGrory is a Returned Peace Corps Volunteer where she spent 2 years in rural Nigeria, West Africa, on water sanitation and Guinea Worm Eradication projects.

Capturing Socioeconomic Status in Electronic Health Records

Kirsten Bibbins-Domingo, PhD, MD, MAS
Lee Goldman, MD Endowed Chair in Medicine
Professor of Medicine and Epidemiology and Biostatistics
University of California, San Francisco

Disclosures

- Nothing to disclose

CAPTURING SOCIAL & BEHAVIORAL DOMAINS & MEASURES IN ELECTRONIC HEALTH RECORDS

An Institute of Medicine Committee on Recommended Social & Behavioral Domains & Measures for Electronic Health Records (EHRs)

BOARD ON POPULATION HEALTH AND PUBLIC HEALTH PRACTICE

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

COMMITTEE MEMBERS

NANCY E. ADLER, PH.D. *(Co-Chair)*
University of California, San Francisco

WILLIAM W. STEAD, M.D. *(Co-Chair)*
Vanderbilt University

KIRSTEN BIBBINS-DOMINGO, PH.D., M.D.
University of California, San Francisco

PATRICIA F. BRENNAN, R.N., PH.D.
University of Wisconsin-Madison

ANA V. DIEZ-ROUX, M.D., PH.D., M.P.H.
Drexel University School of Public Health

CHRISTOPHER B. FORREST, M.D., PH.D.
University of Pennsylvania and Children's Hospital of Philadelphia

JAMES S. HOUSE, PH.D.
University of Michigan

GEORGE HRIPCSAK, M.D., M.S.
Columbia University

MITCHELL H. KATZ, M.D.
Department of Health, County of Los Angeles

ERIC B. LARSON, M.D., M.P.H., M.A.C.P.
Group Health Research Institute

KAREN MATTHEWS, PH.D.
University of Pittsburgh School of Medicine

DAVID A. ROSS, SC.D.
Public Health Informatics Institute
The Task Force for Global Health

DAVID R. WILLIAMS, PH.D., M.P.H.
Harvard School of Public Health

Study Fellow

DEIDRA CREWS, M.D., Sc.M., FASN
IOM Gilbert S. Omenn Anniversary Fellow
Johns Hopkins University School of Medicine

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

SPONSORS:

The National Institutes of Health

Blue Shield of California Foundation

California HealthCare Foundation

Centers for Disease Control and Prevention

Centers for Medicare & Medicaid Services

The Department of Veterans Affairs

The Lisa and John Pritzker Family Fund

Robert Wood Johnson Foundation

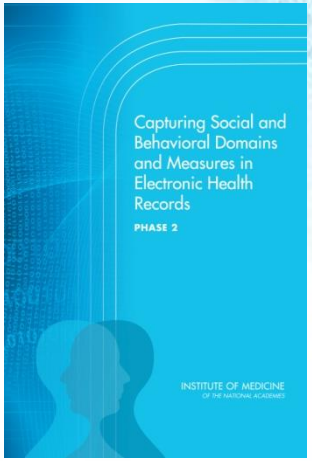
Substance Abuse and Mental Health Services Administration

COMMITTEE CHARGE

THE COMMITTEE WAS ASKED TO:

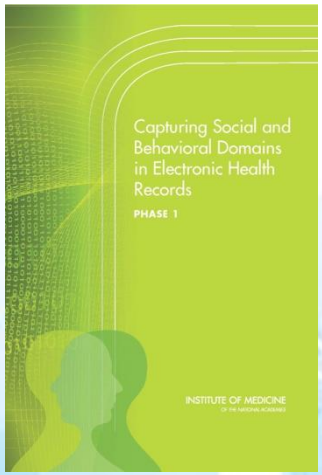
- Identify domains for consideration for Stage 3 meaningful use;
- Determine criteria for selection;
- Identify domains and measures for inclusion in all EHRs;
- Consider implications of incorporating recommended measures into all EHRs; and
- Identify Issues in linking other data systems.

TIMELINE



PHASE 2

PHASE 1



CRITERIA
PHASE 1

1 STRENGTH	3 RELIABLE & VALID MEASURES	5 SENSITIVITY
2 USEFULNESS	4 FEASIBILITY	6 ACCESSIBILITY

USEFULNESS

INDIVIDUAL

POPULATION HEALTH

RESEARCH

CANDIDATE DOMAINS

SOCIODEMOGRAPHIC DOMAINS
Sexual orientation
Race/ethnicity
Country of origin/U.S. born or non-U.S. born
Education
Employment
Financial resource strain
(Food and housing insecurity)

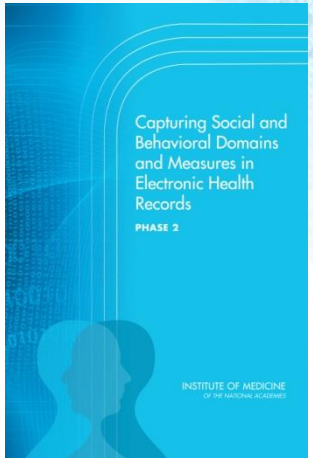
PSYCHOLOGICAL DOMAINS
Health literacy
Stress
Negative mood and affect
(Depression, anxiety)
Psychological assets
(Conscientiousness, patient engagement/ activation, optimism, self-efficacy)

BEHAVIORAL DOMAINS
Dietary patterns
Physical activity
Tobacco use and exposure
Alcohol use

INDIVIDUAL-LEVEL SOCIAL RELATIONSHIPS & LIVING CONDITIONS
Social connections and social isolation
Exposure to violence

NEIGHBORHOODS & COMMUNITIES
Compositional characteristics

TIMELINE
PHASE 2



PHASE 2

PHASE 1

- Review of domain measures
- Selection of parsimonious panel

CRITERIA
PHASE 2

1 STRENGTH

2 USEFULNESS

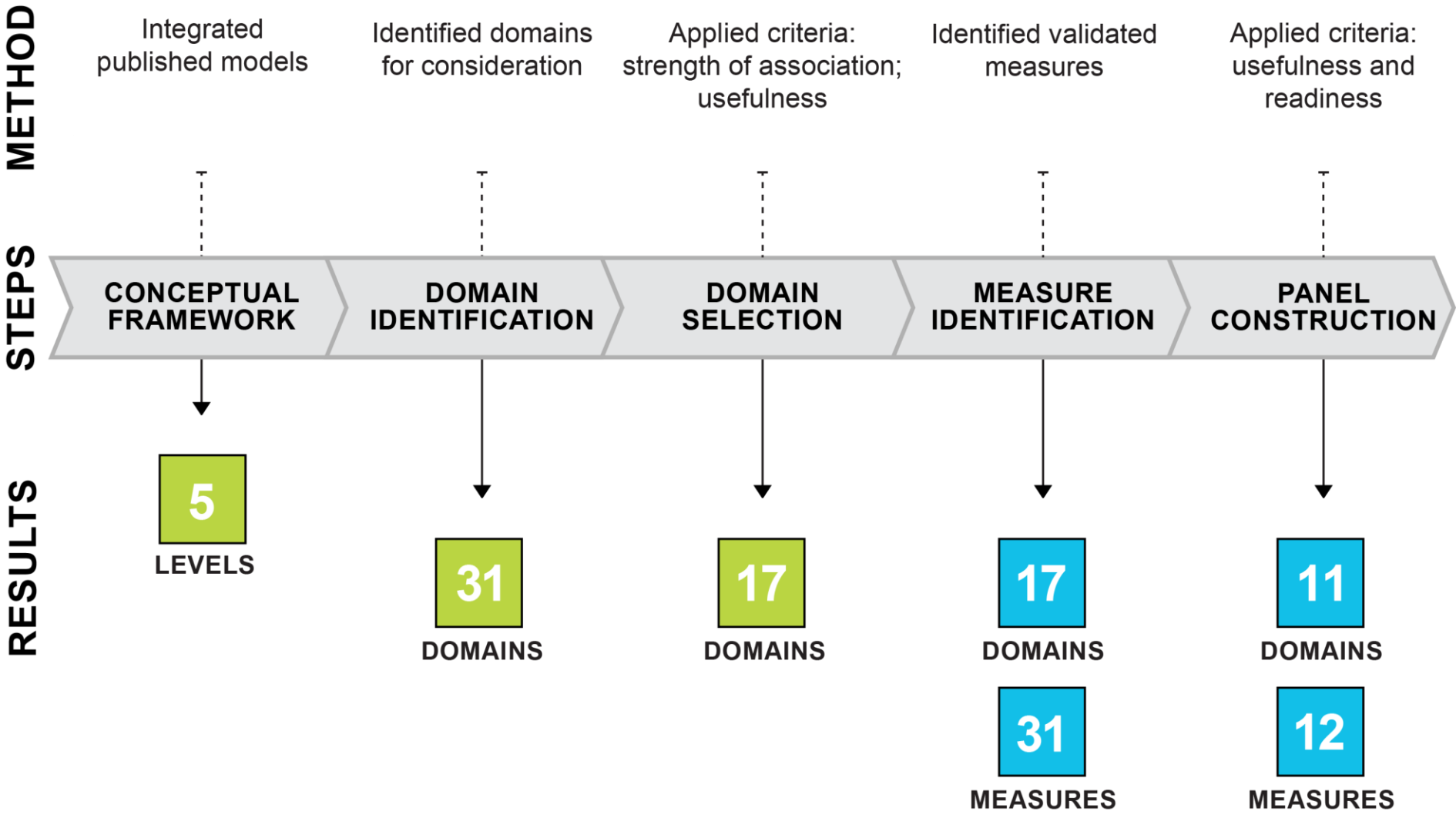
3 RELIABLE & VALID MEASURES

4 FEASIBILITY

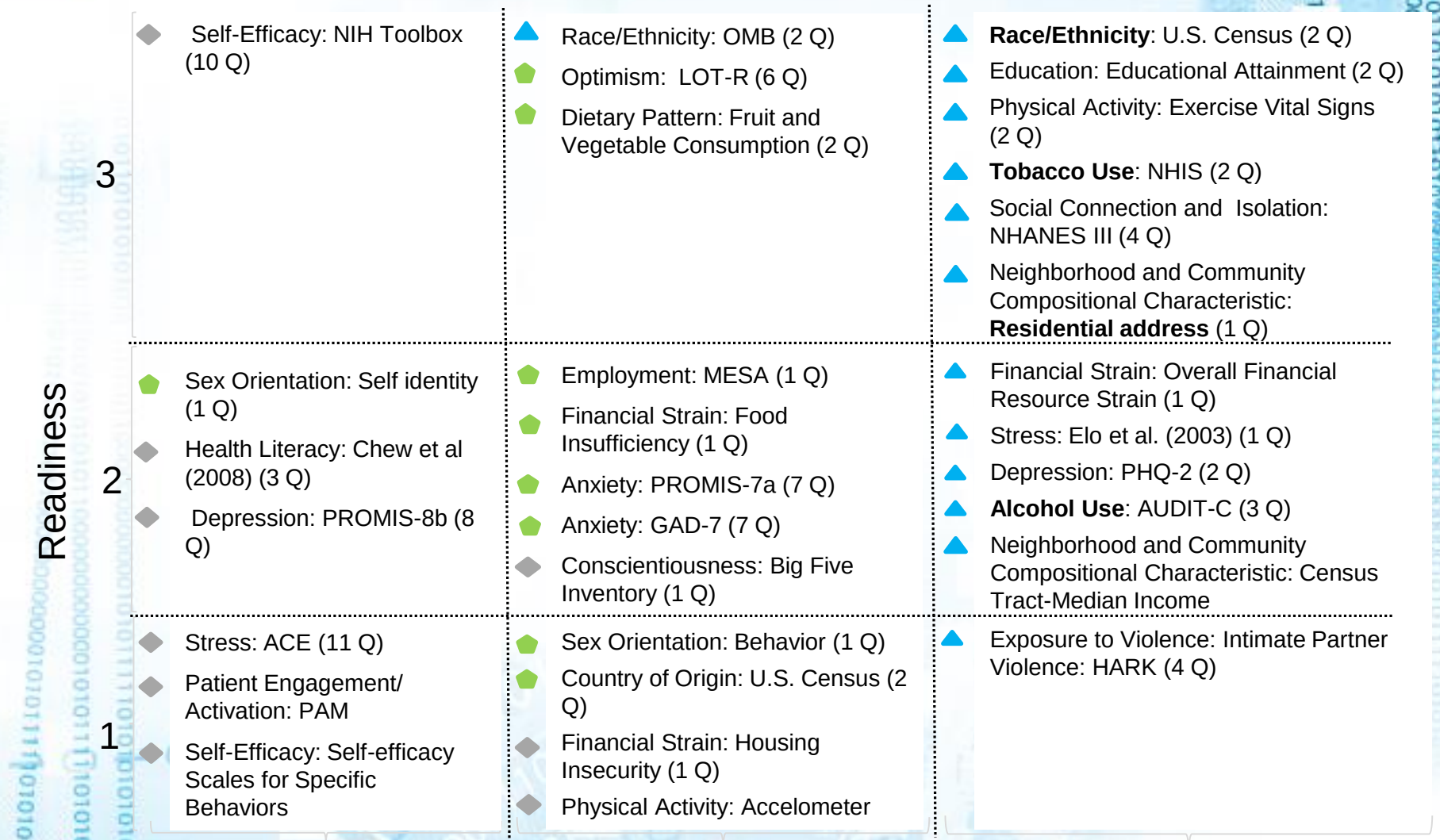
5 SENSITIVITY

6 ACCESSIBILITY

PROCESS


METHOD
STEPS
RESULTS
Integrated published models
Identified domains for consideration
Applied criteria: strength of association; usefulness
Identified validated measures
Applied criteria: usefulness and readiness
CONCEPTUAL FRAMEWORK
DOMAIN IDENTIFICATION
DOMAIN SELECTION
MEASURE IDENTIFICATION
PANEL CONSTRUCTION
5
LEVELS
31
DOMAINS
17
DOMAINS
17
DOMAINS
31
MEASURES
11
DOMAINS
12
MEASURES

STANDARD DOMAIN MEASURES



NOTE: Bolded items are domains that are already frequently collected.

CORE DOMAINS & MEASURES

WITH SUGGESTED FREQUENCY OF ASSESSMENT

DOMAIN/MEASURE	MEASURE	FREQUENCY
Alcohol Use	3 questions	Screen and follow up
Race and Ethnicity	2 questions	At entry
Residential Address	1 question (geocoded)	Verify every visit
Tobacco Use	2 questions	Screen and follow up
Census Tract-Median Income	1 question (geocoded)	Update on address change
Depression	2 questions	Screen and follow up
Education	2 questions	At entry
Financial Resource Strain	1 question	Screen and follow up
Intimate Partner Violence	4 questions	Screen and follow up
Physical Activity	2 questions	Screen and follow up
Social Connections & Social Isolation	4 questions	Screen and follow up
Stress	1 question	Screen and follow up

NOTE: Domains/Measures are listed in alphabetical order; domains/measures in the shaded area are currently frequently collected in clinical settings; domains/measures not in the shaded area are additional items not routinely collected in clinical settings.

FINDING

5-1

Four social and behavioral domains of health are already frequently collected in clinical settings. The value of this information would be increased if standard measures were used in capturing these data.

RECOMMENDATION

5-1

The Office of the National Coordinator for Health Information Technology and the Centers for Medicare & Medicaid Services should include in the certification and meaningful use regulations the standard measures recommended by this committee for four social and behavioral domains that are already regularly collected: race/ethnicity, tobacco use, alcohol use, and residential address.

FINDING

5-2

The addition of selected social and behavioral domains, together with the four domains that are already routinely collected, constitute a coherent panel that will provide valuable information on which to base problem identification, clinical diagnoses, treatment, outcomes assessment, and population health measurement.

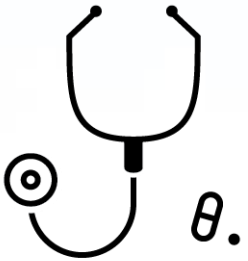
RECOMMENDATION

5-2

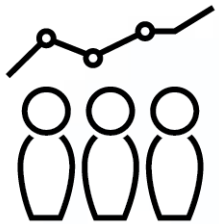
The Office of the National Coordinator for Health Information Technology and the Centers for Medicare & Medicaid Services should include in the certification and meaningful use regulations addition of standard measures recommended by this committee for eight social and behavioral domains: educational attainment, financial resource strain, stress, depression, physical activity, social isolation, intimate partner violence (for women of reproductive age), and neighborhood median-household income.

BENEFITS

Benefits of including recommended measures in all EHRs include:



MORE EFFECTIVE TREATMENT



MORE EFFECTIVE POPULATION MANAGEMENT

DISCOVERY OF LINKAGES

FINDING and Recommendation

7-1

Standardized data collection and measurement are critical to facilitate use and exchange of information on social and behavioral determinants of health. Most of these data elements are experienced by an individual and are thus collected by self-report. Currently, EHR vendors and product developers lack harmonized standards to capture such domains and measures.

7-1

The Office of the National Coordinator for Health Information Technology's electronic health record certification process should be expanded to include appraisal of a vendor or product's ability to acquire, store, transmit, and download self-reported data germane to the social and behavioral determinants of health.

FINDING and Recommendation

7-2

The addition of social and behavioral data to EHRs will enable novel research. The impact of this research is likely to be greater if guided by federal prioritization activities.

7-2

The Office of the Director of the National Institutes of Health (NIH) should develop a plan for advancing research using social and behavioral determinants of health collected in electronic health records. The Office of Behavioral and Social Science Research should coordinate this plan, ensuring input across the many NIH institutes and centers.

FINDING

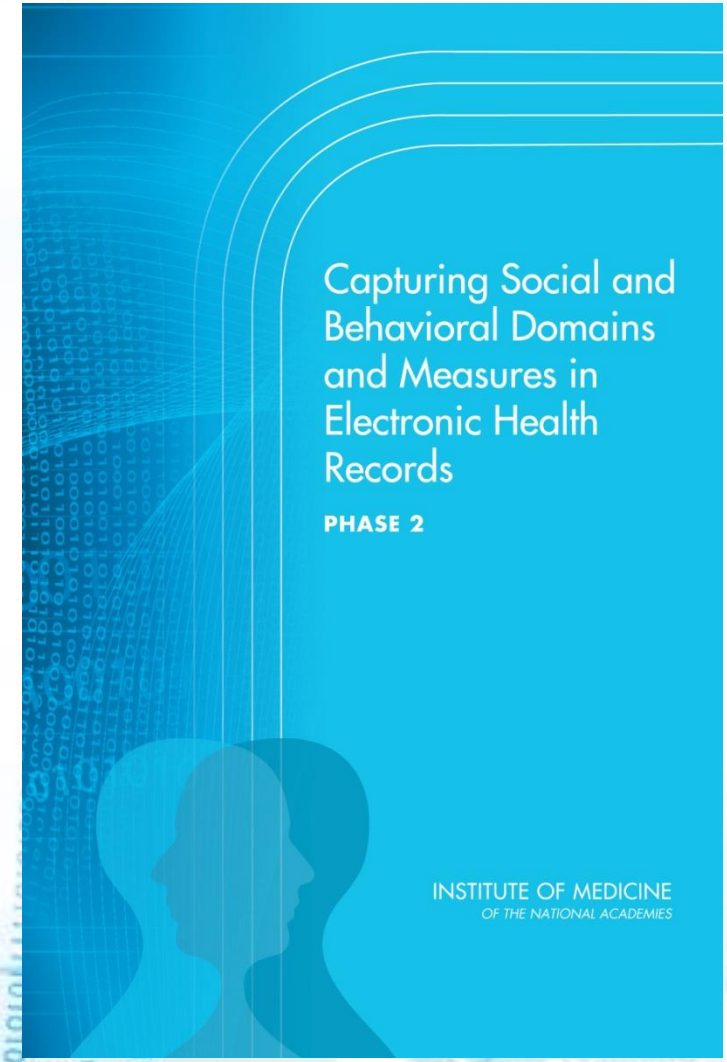
7-3

Advances in research in the coming years will likely provide new evidence of the usefulness and feasibility of collecting social and behavioral data beyond that which is now collected or which is recommended for addition by this committee. In addition, discoveries of interventions and treatments that address the social and behavioral determinants and their impact on health may point to the need for adding new domains and measures. There is no current process for making such judgments.

RECOMMENDATION

7-3

The Secretary of Health and Human Services should convene a task force within the next three years, and as needed thereafter, to review advances in the measurement of social and behavioral determinants of health and make recommendations for new standards and data elements for inclusion in electronic health records. Task force members should include representatives from the Office of the National Coordinator for Health Information Technology, the Center for Medicare and Medicaid Innovation, the Agency for Healthcare Research and Quality, the Patient-Centered Outcomes Research Institute, the National Institutes for Health, and research experts in social and behavioral science.



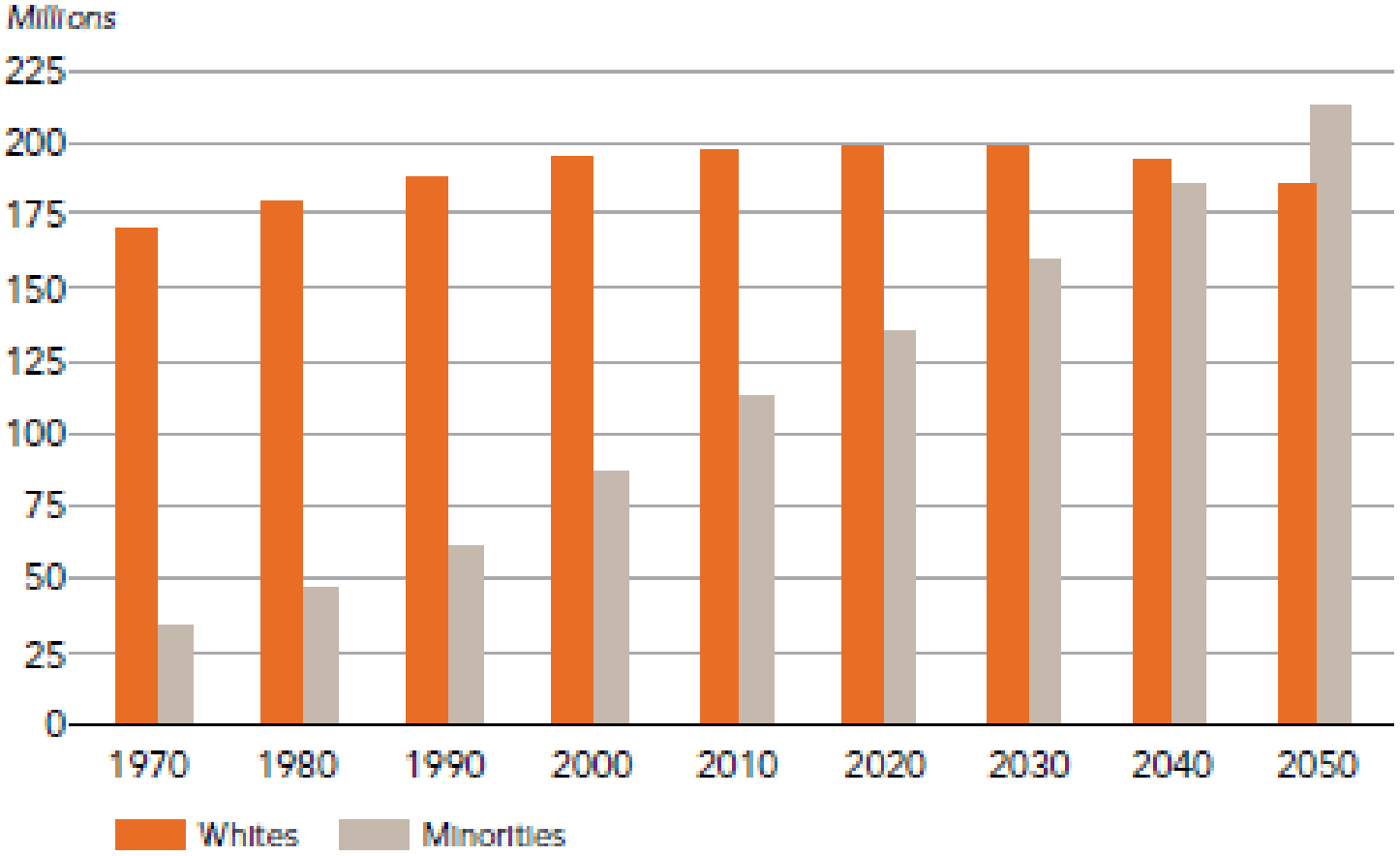
THE FULL REPORT IS NOW AVAILABLE FOR FREE DOWNLOAD AT: iom.edu/ehrdomains2

Also summarized in
Adler NE, Stead WW. N Engl J Med 2015;372:698-701.

Implementation of Data Collection of Social Determinants of Health

Aswita Tan-McGrory, MBA, MSPH
Deputy Director
The Disparities Solutions Center at Massachusetts General Hospital

U.S. White and Minority Populations, 1970–2050



Source: U.S. censuses and Census Bureau projections, various years.

Source: Frey, William. *Diversity Explosion,* Brookings Institute: 2014

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Guide to Preventing Readmissions among Racially & Ethnically Diverse Medicare Beneficiaries

MGH 1811

THE DISPARITIES SOLUTIONS CENTER
One Goal – High Quality Care for All

In collaboration with

NORC at the UNIVERSITY of CHICAGO

"Working to Achieve Health Equity"

Why the Guide Was Developed

The Guide was developed as part of the *CMS Equity Plan for Improving Quality in Medicare* and positions CMS to support key stakeholders with strategies to address avoidable readmissions for diverse populations.

- **Reduce Waste/Unnecessary Cost:** Medicare spending on potentially preventable readmissions was estimated at $12 billion for patients readmitted within 30 days of discharge in 2005.[1]

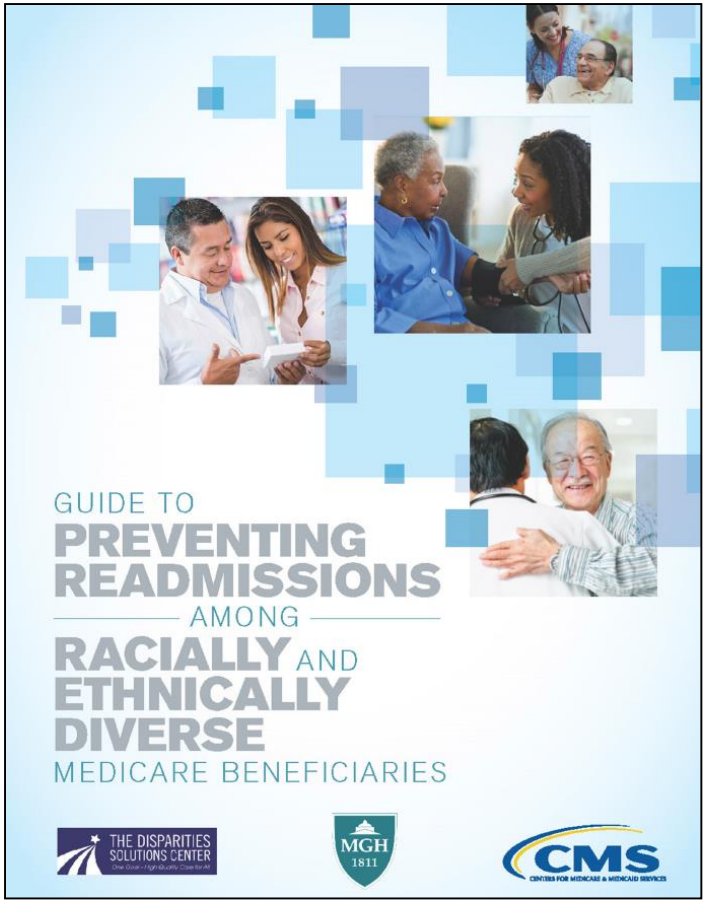
- **Address Diverse Populations:** Racial and ethnic minority populations are more likely than their white counterparts to be readmitted within 30 days of discharge. [2]

- **Support Hospital Organizations:** The Guide provides concise, actionable guidance for addressing avoidable readmissions for minority populations.

1. Report to Congress: Promoting greater efficiency in Medicare. Washington, DC: Medicare Payment Advisory Commission. http://www.medpac.gov/documents/reports/Jun07_EntireReport.pdf. Published 2007. Accessed December 21, 2015.
2. Joynt KE, Orav EJ, Jha AK. Thirty-day readmission rates for Medicare beneficiaries by race and site of care. *JAMA. Feb 16 2011;305(7):675-681.*

Contents

- **Background** on readmissions and racial and ethnic minorities
- **Overview of key issues** and strategies related to readmissions for diverse populations
- **High level recommendations** for addressing readmissions for diverse populations
- **Case studies** that illustrate how organizations are addressing avoidable readmissions for vulnerable populations in hospital and home-based settings



Key Recommendations for Preventing Readmissions Addressed in the Guide

1. **Create a strong radar** that collects key patient demographic data, including race, ethnicity, language, education, social determinants, disability, and linkage to primary care/usual source of care.

2. **Identify the root causes** by determining patients, populations, and characteristics that are linked to readmissions.

3. **Start from the start** by developing preemptive efforts to prevent readmissions that span the duration of pre-admission to post-discharge.

4. **Deploy a team** that is multi-disciplinary and includes allied health professional as well as “non-traditional” team members such as health coaches, navigators, and community health workers.

Key Recommendations (Cont.)

5. Create **systems that are responsive** to the needs of diverse populations and address the **social determinants** that put them at risk of bouncing back.

6. Develop **culturally competent** strategies for addressing **communication-sensitive, high-risk scenarios** such as medication reconciliation and discharge instructions.

7. Foster **community partnerships** to promote **continuity of care**.

The Disparities Leadership Program

The
Disparities Leadership Program

Empowering Leaders.
Getting to Solutions.

Important Dates:

Intent to Apply Due
Friday, November 20, 2015

Application Due
Friday, January 29, 2016

Notification of Acceptance
Friday, March 25, 2016

This program is jointly sponsored by the National Committee for Quality Assurance (NCQA) and supported by Joint Commission Resources, Inc. (JCR), an affiliate of The Joint Commission.

Continuing Education Credit:
CME/CEU credits will be provided through NCQA

To learn more
about the Disparities Leadership Program or for more information on tuition and available partial scholarships, please visit our website at

http://www2.massgeneral.org/disparitiessolutions/dlprogram.html

Or contact
Aswita Tan-McGrory, MBA, MSPH
Deputy Director
The Disparities Solutions Center
Massachusetts General Hospital

(617) 643 – 2916 (direct line)
(617) 724 – 7658 (main line)
atanmcgrory@partners.org

MASSACHUSETTS GENERAL HOSPITAL
THE DISPARITIES SOLUTIONS CENTER

DLP
DISPARITIES LEADERSHIP PROGRAM

Disparities Leadership Program Goals

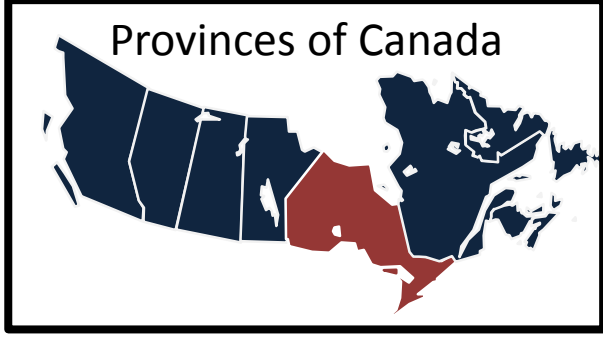
- Develop cadre of leaders in health care equipped with:
  - Knowledge of disparities, root causes, research-to-date
  - Cutting-edge QI strategies for identifying/addressing disparities
  - Leadership skills to implement and transform organizations

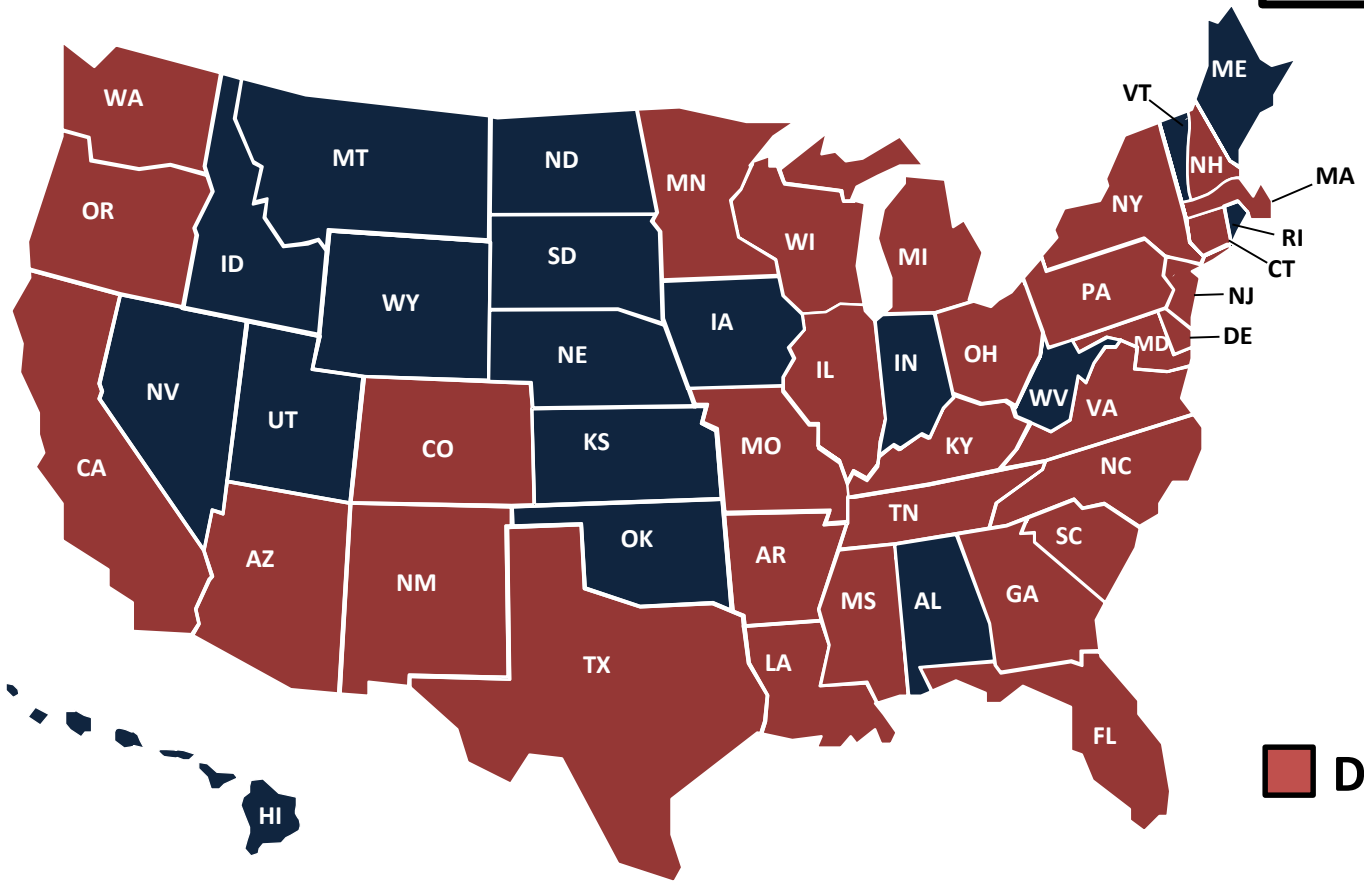
Disparities Leadership Program Alumni

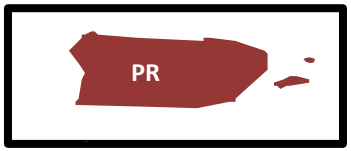
- 312 participants
- 142 organizations
  - 77 hospitals
  - 31 health plans
  - 21 community health centers
  - 8 professional organizations
  - 1 pharmaceutical company
  - 1 school of medicine
  - 1 hospital trade organization
  - 1 federal government agency
  - 1 city government agency

DLP Organizations

31 states
Commonwealth of Puerto Rico
Canada, Switzerland







DLP Participants

THE DISPARITIES SOLUTIONS CENTER

One Goal – High Quality Care for All

Challenges of Implementation

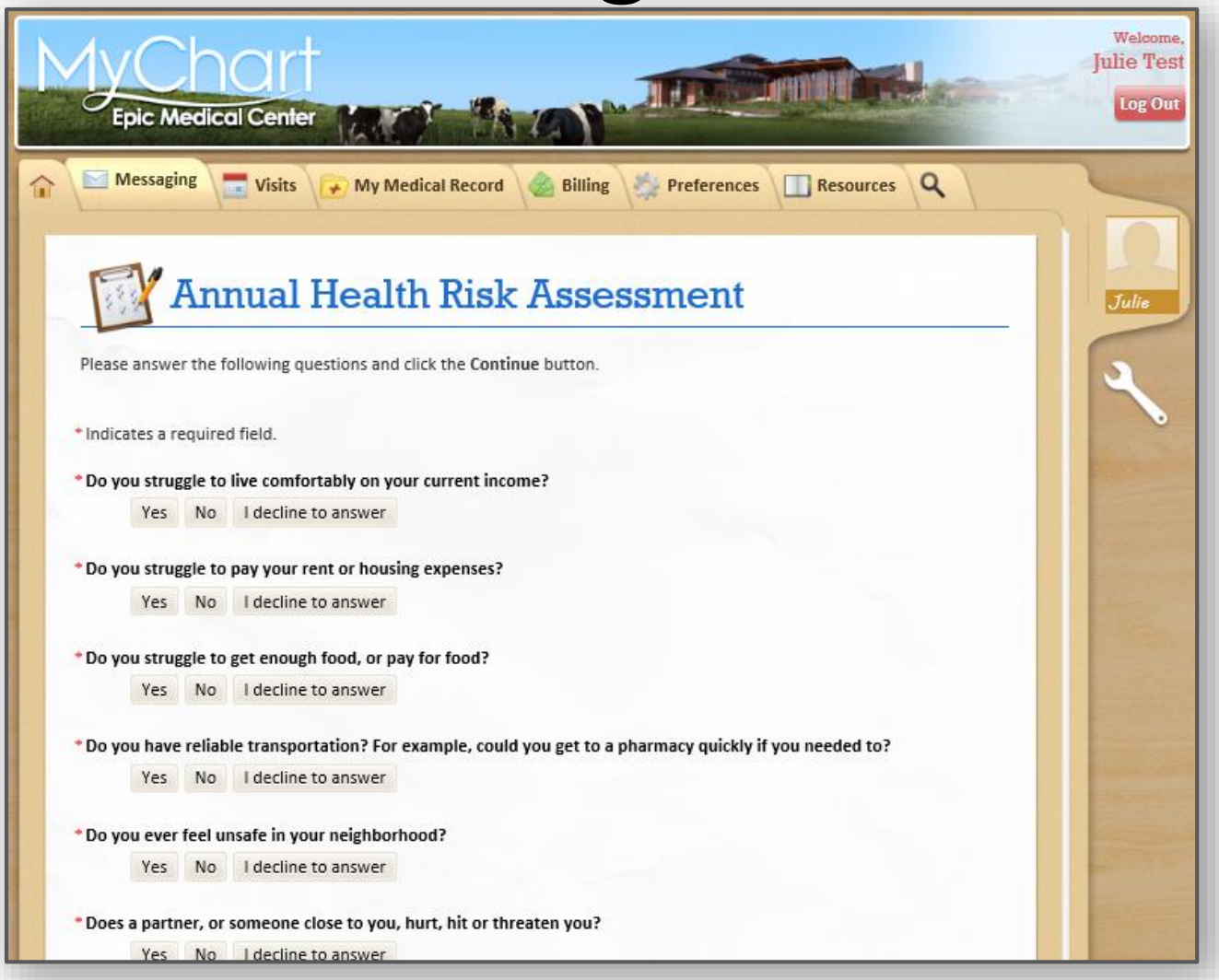
- Who will collect?
- Who will access this information?
- Training?
- What domains to use?
- What is the capacity of the electronic health record?

Training

THE DISPARITIES SOLUTIONS CENTER

One Goal – High Quality Care for All

Training Cont.

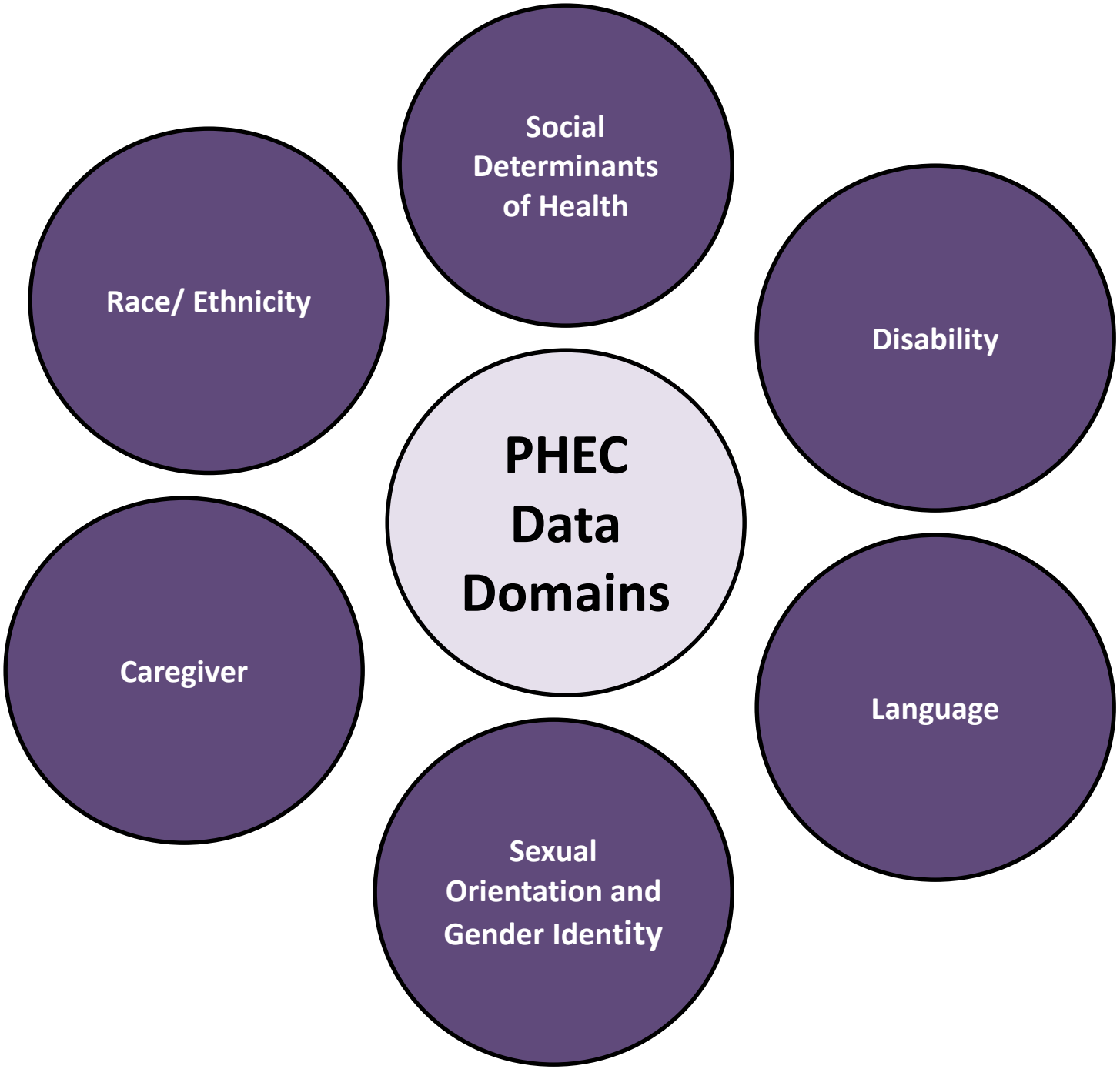


Challenges of Implementation

- Who will collect?
- Who will access this information?
- Training?
- What domains to use?
- What is the capacity of the electronic health record?
- Are resources and services available?
- Pediatrics?

Pediatric Health Equity Collaborative

The Pediatric Health Equity Collaborative (PHEC) is comprised of 11 organizations working together with the goals of establishing best practices, lessons learned, and recommendations for the field with regard to race, ethnicity, language, and other demographic data collection in pediatric care settings.


Social Determinants of Health
Race/ Ethnicity
Disability
PHEC Data Domains
Caregiver
Language
Sexual Orientation and Gender Identity

Caregiver

Language Domain	Patient	Caregiver 1	Caregiver 2
Preferred Spoken Language	English	English	Spanish
Preferred Written Language	English	Spanish	Spanish

In Summary

- Look at the capacity of your EHR
- Identify priority 3 measures and start with that
- Identify ahead of time how you will use the data (measure and report)
- Think about resources but don't let it be the limiting factor
- Pilot, pilot, pilot
- Training is key, including providers
- Address patient privacy concerns
- Check your assumptions

hospitals in pursuit of excellence

HPOE Live!

2016 Webinar Series

Please click the link below to take our webinar evaluation. The evaluation will open in a new tab in your default browser.

https://www.surveymonkey.com/r/hpoe-webinar-02-23-16

Question and Answer Period

You can submit questions by typing them in the chat box at the lower left hand corner of your screen and hitting "submit question."

Audience Q&A

Moderator

Lenny López, MD, MDiv, MPH, Chief of Hospital Medicine, University of California San Francisco - SFVA and Senior Faculty, the Disparities Solutions Center at Massachusetts General Hospital

Presenters:

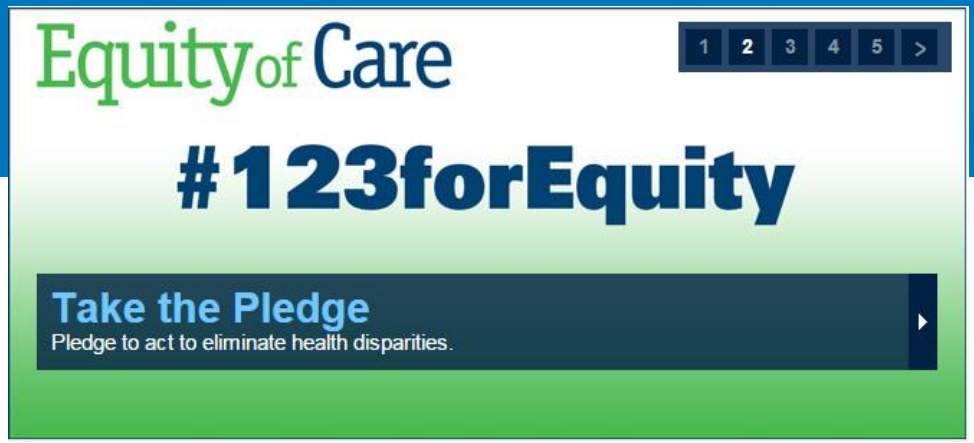
Kirsten Bibbins-Domingo, PhD, MD, MAS, Director, UCSF Center for Vulnerable Populations at San Francisco General Hospital

Aswita Tan-McGrory, MBA, MSPH, Deputy Director, The Disparities Solutions Center at Massachusetts General Hospital

Thank you for your participation!

www.mghdisparitiessolutions.org

www.HPOE.org



#123forEquity Pledge to Act

TAKE THE PLEDGE - Pledge to achieve the three areas of the Call to Action within the next 12 months.

TAKE ACTION – Implement strategies that are reflected in your strategic plan and supported by your board and leadership. Provide quarterly updates on progress to AHA and your board in order to track progress nationally.

TELL OTHERS – Achieve the goals and be recognized. Tell your story and share your learnings with others in conference calls and other educational venues including social media to accelerate progress collectively.

American Hospital Association

#123forEquity Pledge to Act

to Eliminate Health Care Disparities

I, _____ on behalf of

Name, Title

_____, _____

Organization Name **City / State**

pledge my commitment toward the achievement of the Call to Action goals, as outlined below.

☐ I pledge to addressing the following areas in the next **12 months**. Below is a suggested timeline for addressing each area, but it can be modified based on your needs:

- By the end of month one (from the date of your start), choose a quality measure to stratify by race, ethnicity or language preference or other sociodemographic variables (such as income, disability status, veteran status, sexual orientation and gender, or other) that are important to your community's health. Quality measures to stratify could include readmissions or other core measures.
- By the end of month three, determine if a health care disparity exists in this quality measure. If yes, design a plan to address this gap.
- By the end of month six, provide cultural competency training for all staff or develop a plan to ensure your staff receives cultural competency training.
- By the end of month nine, have a dialogue with your board and leadership team on how you reflect the community you serve, and what actions can be taken to address any gaps if the board and leadership do not reflect the community you serve.

Contact: _____

Email: _____

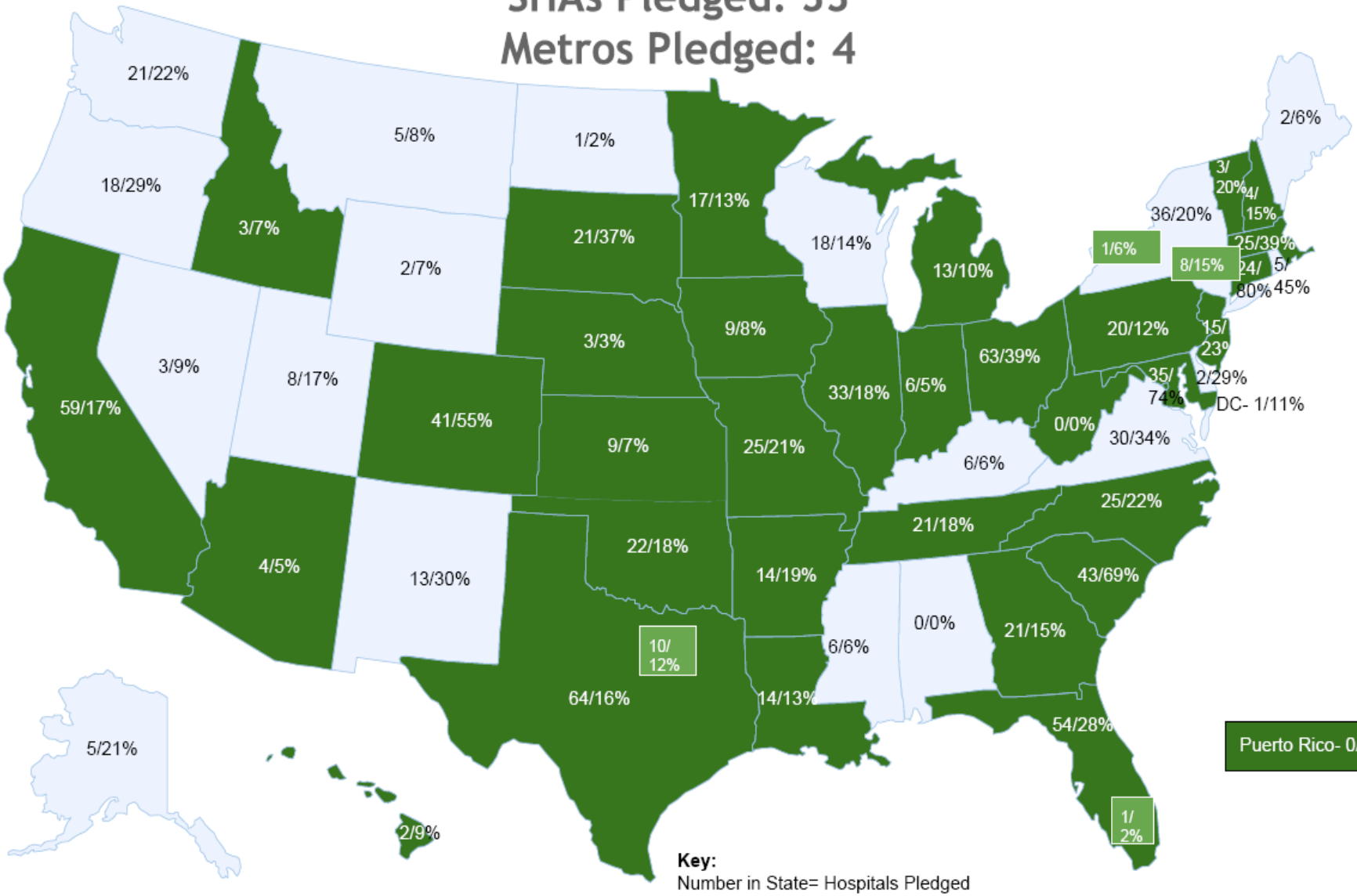
Phone Number: _____

Date: _____

INSTITUTE FOR DIVERSITY
in Health Management
An affiliate of the American Hospital Association

#123forEquity Pledge to Act
Hospitals Pledged: 894
SHAs Pledged: 33
Metros Pledged: 4

American Hospital Association



Key:
Number in State= Hospitals Pledged
Percentage in State= % of All Hospitals in State Pledged
Dark Green= State Hospital Association Pledged
Light Green= Metropolitan Hospital Association Pledged

www.equityofcare.org

Data from 2/19/16

hospitals in pursuit of excellence

HPOE

Social Media Presence

Follow us on Twitter

@HRETtweets

#hpoe

hospitals in pursuit of excellence

HPOE Live!

2016 Webinar Series

Upcoming HPOE Live! Webinars

- March 8, 2016
  - Combating the Opioid Crisis: Massachusetts' Path to Action
- April 20, 2016
  - Collaboration is Key: Addressing Hunger as a Health Issue

For more information go to www.hpoe.org