Achieving Health Equity through Research, Implementation, Media, and Policy Efforts

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- HRSA
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- Merck Foundation
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- Robert Wood Johnson Foundation
Outline

- Describe a roadmap for reducing disparities in health care
- Tell story of my personal pathway to these lessons
  - Career development pearls
  - Lessons for implementing change
- Outline implications for future efforts to reduce disparities
Agenda

- 2 stories
- Roadmap to Reduce Disparities
- Backtrack – my story to the roadmap
- Media, partnerships, and policy
- Take home points
Finding Answers

- A national program supported by the Robert Wood Johnson Foundation with direction provided by the University of Chicago.
Goals of Finding Answers

- Grant funds to evaluate solutions to reduce racial/ethnic health care disparities.
- Conduct systematic reviews of disparities interventions
- Disseminate results and provide technical assistance to address disparities in care.
Dissemination & Translation

- Provide information about what works—and what doesn’t
- Create resources and toolkits

Now that we’ve revealed racial disparities in health care, we can work to eliminate them.

Those who research racial disparities in health care understand how big the problem is. Please join us in working to find real solutions.

Visit www.SolvingDisparities.org for information on racial disparities in health care and how you can receive funding to help improve health care for all.
33 Interventions
A Roadmap and Best Practices for Organizations to Reduce Racial and Ethnic Disparities in Health Care


www.solvingdisparities.org
Roadmap for Reducing Racial and Ethnic Disparities in Care

1) Recognize disparities and commit
2) Implement QI infrastructure and process
3) Make equity an integral part of quality
4) Design intervention(s)
5) Implement, evaluate, and adjust intervention(s)
6) Sustain intervention(s)

Chin MH et al. JGIM 2012; 27:992-1000
Roadmap for Reducing Racial and Ethnic Disparities in Care

#1 Recognize disparities and commit to reducing them

Examine Your Performance Data Stratified by Race, Ethnicity, Language, and SES

- Individual and organizational readiness to change
Get training for your staff to work effectively with diverse populations

**SGIM Goals for Health Disparities Courses**

- Existence of disparities, etiologies, solutions
- Mistrust, subconscious bias, stereotyping
- Communication, trust building
- Commitment to reduce disparities

Univ. of Chicago Course

- Self-insight exercises
- Field trips & Chicago history
- Group disparities project
- Reflective essays and discussion
- Individual patient care (e.g. interpreters) and policy (e.g. Medicare)

Vela et al. JGIM 2008; 23:1028-1032; Vela et al. JGIM 2010;25 Suppl 2:S82-85
Does It Work?

- Disparity data interventions helpful but not sufficient
- Knowledge/attitude interventions helpful but not sufficient
  - Sequist TD et al. Ann Intern Med 2010
- RWJF Aligning Forces For Quality
  - Data show us the problem, now what?
Roadmap Step 2

- Implement basic quality improvement structure and process
  - Quality culture
  - Quality improvement team
  - Goal setting and measuring
  - Local champion
  - Leadership support
Roadmap Step 3

- Make equity an integral component of quality improvement efforts
# IOM Model of Quality

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<th>Components of Quality Care</th>
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**A National Program of the Robert Wood Johnson Foundation at the University of Chicago**
Roadmap Step 4

- Design intervention(s)
  - Determine root causes
  - Consider 6 levels of influence
  - Review literature
  - Learn from peers
  - Consider specific interventions
Roadmap Step 4

- **Design intervention(s)**
  - Determine root causes
    - Process mapping
    - Talk to target population, not just proxies
      - Minority providers may not be proxies for the target population
Conceptual Model

Financing / Regulation / Accreditation

Community

Person

Health Care Organization

Provider

Patient

Access

Process

Outcomes

Chin MH & Goldmann D. JAMA 2011
Example Research Questions

6 Levels of Influence

Pediatric Asthma

- **Policy**: How can policy and resource allocation promote clean air, reduced exposure to second-hand smoke, and a non-allergenic housing environment for children?
6 Levels of Influence

- **Health Care Delivery Entity**: How can emergency department visits and readmissions be reduced by enhanced primary care access?
  - Extended hours
  - Same-day appointments
  - Open access scheduling
6 Levels of Influence

- **Microsystem**: How can office-based care teams collaborate with community health workers to support home-based asthma management?

- **Provider**: How can providers perform culturally appropriate motivational interviewing to promote self-management?
6 Levels of Influence

- **Patient/Family:** How can parents safely use email or text messaging to receive real-time advice on handling severe asthma exacerbations?

- **Community:** How can school-based programs promote early recognition and management of asthma in student athletes?
Roadmap Step 4 (Cont.)

- Evidence-based strategies
  - Multifactorial attacking different levers
  - Culturally tailored QI
  - Team-based care
  - Families and non-health partners
  - Patient navigators
  - Interactive skills-based training
Roadmap Step 5

- Implement, evaluate, and adjust intervention(s)
Consolidated Framework for Implementation Research

- Intervention (relative advantage)
- Outer (external incentives)
- Inner (culture)
- Individuals (beliefs)
- Process (plan, execute, evaluate)

Behavior Change Theory

- Beliefs and knowledge
  - Why innovations are good
- Social norms
  - It’s the culture / QI collaboratives
- Environmental factors
  - Incentives
- Self-efficacy
  - Coaching / QI collaboratives
Motivation

- **Intrinsic**
  - Professionalism
  - Doing the right thing

- **Extrinsic**
  - Financial
  - Other rewards

- **RWJF Reducing Health Care Disparities Through Payment and Delivery System Reform**

A National Program of the Robert Wood Johnson Foundation at the University of Chicago
Roadmap Step 6

- **Sustain intervention(s)**
  - Institutionalization
    - Culture, incentives, integrate into daily operations
  - Societal Business Case
    - Direct medical costs - $229 billion 2003-2006
    - Indirect costs - $1 trillion 2003-2006
    - Healthy national workforce – US Census Bureau
      - 2050 – Hispanic 30%, Black 13%, Asian 8%
Roadmap Step 6

- Sustain intervention(s)
  - Business Case – Align policy incentives
    - Global payments – Accountable care organizations (ACOs), bundled payments
    - Population health
    - Pay-for-performance - disparities
    - Link community & health care system - CDC, HHS
    - Community needs assessment for non-profit hospitals
## Payment and Care Types

### Payment Type
- Fee for service
- Capitation
- Bundled payment
- Blended approach

### Care Type
- Prevention
- Acute care
  - Outpatient
  - Inpatient
- Chronic care
- End of life

Wells Shoemaker, MD, October 2014
Summary Points

- Prioritize reducing disparities
  - Leadership matters
- Look at your own data
  - Sunlight is a great sanitizer and motivator
- Tailor your care delivery solutions
- Align financial incentives to reduce disparities
- Address the spectrum
My GIM Story –
4 Critical Decisions
Quality Improvement Implementation and Disparities

The Case of the Health Disparities Collaboratives

Marshall H. Chin, MD, MPH*†‡

Quality improvement implementation is challenging under the best of circumstances, and efforts to reduce racial and socioeconomic disparities in health care with quality improvement (QI) techniques have additional barriers to hurdle. Many minority patients and patients of lower socioeconomic status receive their care in settings that have limited resources. In addition, vulnerable populations have a variety of economic, educational, and social difficulties that make it harder for them to improve the self-management of chronic illnesses. Although equity is 1 of the 6 fundamental domains of the Institute of Medicine’s definition of quality,¹ it has generally received less attention compared with other elements, such as effectiveness.² Moreover, in the health disparities field,³ most of the existing literature documents disparities, but a much smaller body of work seeks to develop and evaluate interventions to reduce these disparities.⁴

Community health centers (HCs) are vanguard providers of health care for vulnerable populations,⁵６ serving 20 million Americans in 1200 centers.⁶ Forty percent of HC patients are uninsured, 26% have Medicaid coverage, even though they are eligible for Medicare.⁷

Background: The Health Disparities Collaboratives (HDCs), a quality improvement (QI) collaborative incorporating rapid QI, a chronic care model, and learning sessions, have been implemented in over 900 community health centers across the country.

Objectives: To determine the HDC’s effect on clinical processes and outcomes, their financial impact, and factors important for successful implementation.

Research Design: Systematic review of the literature.

Results: The HDCs improve clinical processes of care over short-term period of 1 to 2 years, and clinical processes and outcomes over longer period of 2 to 4 years. Most participants perceive that the HDCs are successful and worth the effort. Analysis of the Diabetes Collaborative reveals that it is societally cost-effective, with an incremental cost-effectiveness ratio of $33,386 per quality-adjusted life year, but that consistent revenue streams for the initiative do not exist. Common barriers to improvement include lack of resources, time, and staff burnout. Highest ranked priorities for more funding are money for direct patient services, data entry, and staff time for QI. Other common requests for more assistance are help with patient
[Chin’s study seeks] “to build a bridge between 2 important worlds of endeavor: the world of study and assessment of the effectiveness of medical practices, and the world of action to put that knowledge to work on behalf of patients.”

- Don Berwick Med Care 2007
Finding Answers: Disparities Research for Change

IMPROVING DIABETES CARE AND OUTCOMES ON THE SOUTH SIDE OF CHICAGO

www.SouthSideDiabetes.org

A National Program of the Robert Wood Johnson Foundation at the University of Chicago
Health Disparities in Chicago

- African-American South Side of Chicago
  - Nearly 1 out of 5 people have diabetes
  - 5x rate of leg amputation
South Side of Chicago

- **Challenges:**
  - Poverty
  - Social challenges
  - Food deserts
  - Unsafe recreation
  - Mistrust of healthcare
  - Weakened hospital safety net

- **Strengths**
  - Historical social, political and cultural traditions
  - Community resources and institutions
  - Healthcare institutions

*Finding Answers: Disparities Research for Change*

*A National Program of the Robert Wood Johnson Foundation at the University of Chicago*
Early Lessons From An Initiative On Chicago’s South Side To Reduce Disparities In Diabetes Care And Outcomes

ABSTRACT Interventions to improve health outcomes among patients with diabetes, especially racial or ethnic minorities, must address the multiple factors that make this disease so pernicious. We describe an intervention on the South Side of Chicago—a largely low-income, African American community—that integrates the strengths of health systems, patients, and communities to reduce disparities in diabetes care and outcomes. We report preliminary findings, such as improved diabetes care and diabetes control, and we discuss lessons learned to date. Our initiative neatly aligns with, and can inform the implementation of, the accountable care organization—a delivery system reform in which groups of providers take responsibility for improving the health of a defined population.

Racial and ethnic disparities in diabetes care and outcomes arise from multiple causes. These include differential access to high-quality health care, healthy food, and opportunities for safe recreation; cultural traditions regarding cooking; beliefs about disease and self-management; and socioeconomic status. Consequently, the solution must be multifactorial. Improving patients’ knowledge and increasing their motivation to make healthy lifestyle changes will have minimal impact if their limited access to healthy food and physical activity is not simultaneously addressed.

To date, few interventions have taken a multifaceted approach to improving outcomes among and practice are encouraging greater interaction and collaboration among health care providers and communities. One driver of this collaboration is the creation of accountable care organizations, as authorized under the Affordable Care Act of 2010. Accountable care organizations are likely to have financial incentives to take responsibility for broad health care outcomes and costs for a defined population. Thus, accountable care organizations are potentially motivated to prioritize evidence-based prevention strategies that build on community resources and create a continuum of care from community settings to health care systems.

Racial or ethnic minorities are disproportionately represented among high-risk patients with complex medical conditions. Thus, accountable...
Improving Diabetes Care and Outcomes on Chicago’s South Side

- Geographic areas
- Community + Healthcare systems
- Quality improvement + Disparities
Project Goals

- **Short-term goals:**
  - Improve access to care, quality, and outcomes

- **Long-term goals:**
  - Strengthen partnerships - Community and University of Chicago
  - Empower communities to address diabetes
  - Be sustainable
Finding Answers: Disparities Research for Change

A National Program of the Robert Wood Johnson Foundation at the University of Chicago
Quality Improvement

- QI teams/collaborative
- One-on-one coaching
Provider Workshops

- Provider communication training
  - Cultural competency
  - Behavioral change
  - Motivational Interviewing
  - Shared decision-making
Culturally tailoring patient education and communication skills training to empower African-Americans with diabetes.

ABSTRACT

New translational strategies are needed to improve diabetes outcomes among low-income African-Americans. Our goal was to develop/pilot test a patient intervention combining culturally tailored diabetes education with shared decision-making training. This was an observational cohort study. Surveys and clinical data were collected at baseline, program completion, and 3 and 6 months. There were 21 participants; the mean age was 61 years. Eighty-six percent of participants attended >70% of classes. There were improvements in diabetes self-efficacy, self-care behaviors (i.e., following a “healthful eating plan” (mean score at baseline 3.4 vs. 5.2 at program’s end; p=0.002), self-glucose monitoring (mean score at baseline 4.3 vs. 6.2 at program’s end; p=0.04), and foot care (mean score at baseline 4.3 vs. 6.0 at program’s end; p=0.001), hemoglobin A1c (8.24 at baseline vs. 7.33 at 3-month follow-up, p=0.02), and HDL cholesterol (51.2 at baseline vs. 61.8 at 6-month follow-up, p=0.01). Combining tailored education with shared decision-making may be a promising strategy for empowering low-income African-Americans and improving health outcomes.

Implications

Research: Culturally-tailored diabetes empowerment programs can improve self-efficacy, behaviors, and clinical outcomes among African-Americans. However, more work is needed to identify effective strategies to enhance shared decision-making among this population. Our findings may have relevance for other racial/ethnic minorities and vulnerable populations with diabetes health disparities, and this research should be extended to other populations (e.g., Hispanics) to assess its feasibility and potential effectiveness.

Practice: African-Americans with diabetes often want to be more active in their diabetes care, both in self-care activities and in shared decision-making (SDM). While dynamic classroom instruction may be sufficient to change self-care behaviors, patients may likely need encouragement and support from their health care providers in order to enhance SDM within clinical encounters.

Policy: Sustaining behavioral change and ultimately reducing diabetes disparities among African-Americans will require continued efforts.
Cultural Tailoring in the Diabetes Empowerment Program

- Storytelling and testifying
- Group goal setting
- Family/social network included
- Modify traditional diets
- Community resources
- “Who Wants to Have a Say in Their Health Care?” game
- Shared Decision-Making video

- Text message reminders re: diabetes self-management
- HbA1c 7.9% -> 7.2%
- Cost savings 8.8%
Community Partnerships

- **Regular Source of Care**
  - Urban Health Initiative
  - Over 4,000 pts connected to primary care providers

- **Public Education**
  - Television, Radio, Print
  - Community health venues
  - Center for Community Health & Vitality
Community Partnerships

- KLEO Community Family Life Center
- Chicago Food Depository
- Save-A-Lot Grocery Store
- Walgreens
- Chicago Park District
- Farmer’s Markets
Prescriptions for Food and Exercise

- Chicago Park District
- Walgreens
- Chicago Food Depository
- 61st Street Farmer’s Market
Integrating Patient Education and Community Partnerships
Take action and do something.
Be inclusive. Be open to different partners and collaborations.
Gain skills in working with media and utilize local public relations staff.
Understand historical, policy, and economic contexts.
Do not be afraid to create an action oriented integrated healthcare – community project.
Media, Partnerships, Policy
Chicago Health Disparities Persist But Can Be Stopped

Peek, Choucair, Chin

The Dartmouth Atlas of Health Care reported recently that blacks with diabetes in Chicago had 1.7 times the rate of limb amputations than whites with diabetes (3.4 per 1,000 vs. 2.0 per 1,000).

Losing a leg from diabetes isn’t a given, nor are racial differences in this health outcome. We know how to prevent diabetes-related complications such as limb amputations, blindness, and kidney failure. Controlling blood sugar, blood pressure and cholesterol can significantly reduce the risk of complications and improve quality of life.

The problem is that lifestyle changes to control diabetes (e.g., healthy eating, regular physical activity, taking medications, and regular visits to the doctor) are often a challenge, particularly in low-income minority communities where resources are limited.

People with diabetes are supposed to do 150 minutes of physical activity every week and eat vegetables as 50 percent of their meals. Concerns about crime have driven many indoors, and food deserts make purchasing fresh produce difficult.
End health-care disparities

The U.S. has been good at documenting gaps, poor at delivering solutions.

W

when I was a medical student in San Francisco in the 1980s, I did most rotations at county and VA hospitals. Most patients were poor, and many were from racial and ethnic minority groups.

One day, two teenage Asian American boys were wheeled into the trauma emergency room, already dead. They had been slashed in the neck, victims of gang violence. These boys were not much younger than I was, and I realized all too clearly that it could have been me on that stretcher.

Most of my patients now are African Americans from Chicago’s South Side.

I see patients with diabetes who have had legs amputated because their sugar, blood pressure, and cholesterol are poorly controlled. I see patients with asthma who bounce back to the emergency department because they are not using their inhalers correctly.

I see patients with heart failure readmitted to the hospital because their inpatient and outpatient doctors didn’t talk to one another. My reaction is not “but for the grace of God,” but “Why aren’t we doing better?”

Our country has been good at documenting disparities in care, but poor at delivering solutions. The Affordable Care Act takes a crucial step forward by covering millions of people who would otherwise go uninsured, but access to care is not enough. Access to effective care is the real goal.

United disparities reduction with quality improvement for all. Do not marginalize efforts to reduce disparities. Instead, health-care organizations should say: “Let’s address all of our patients’ needs.”

The language or making follow-up phone calls. Technology can help make needed connections more convenient.

Health staff at the University of Pennsylvania, for example, have successfully treated African Americans with high blood pressure using an interactive computer program that shows patients the connection between controlling their high blood pressure and reducing their risk of heart disease. This effort was supplemented with a program in which patients from the same community, with well-controlled blood pressure, made monthly phone calls to peers who were having trouble with their blood pressure. They offered tips and linked them to resources in the community.

This team approach is among the many we have seen during the last seven years in 33 disparity-reduction projects in urban and rural settings across the country.

Patients have a key role in ensuring they get high-quality care. We know that patients who speak up and actively participate in care decisions with their doctors do not fully at the table when decisions are made.

Since 2005, our team has reviewed hundreds of studies, funded researchers who test innovative solutions, and given technical help to groups to reduce disparities. From this, we developed a “Roadmap” that shows providers and patients how high-quality care for all patients can be achieved:

1. Show health providers their own clinical performance-breaking down the data by patient race, ethnicity, and language. Providers are motivated to address disparities when they see concrete examples in their practices.

2. Unite disparities reduction with quality improvement for all. Do not marginalize efforts to reduce disparities. Instead, health-care organizations should say: “Let’s address all of our patients’ needs.”

3. Implement proven interventions with families and communities working.

4. Create financial incentives for preventive care and attention to social determinants of health, and disincentives for costly hospitalizations and procedures. For example, Accountable Care Organizations (ACOs) are responsible for caring for a population of patients within a defined region, while meeting clinical performance standards.

One of the smartest things these ACOs can do is to partner with local groups to help their patients live a healthy lifestyle.

We have seen this work on the South Side of Chicago, where we link clinics with groups that provide healthy eating options for patients who live in “food deserts” without regular access to fresh produce.

Reducing racial and ethnic disparities in health care does not rely on chance or faith. Financial incentives are starting to align, but long-term solutions are local and require everyone to say that disparities in health outcomes are unacceptable. Together, we can do better.

— Marshall Chin is a general internist and the Richard Familo Family Professor of Medicine at the University of Chicago. He is director of the Robert Wood Johnson National Program of the Robert Wood Johnson Foundation at the University of Chicago.

Children’s Health

Our blog about their health issues

www.philly.com/kidshealth

6 ways to readjust to early school mornings

For many families, the return to school means the end of unscheduled days. It’s a return to the morning routines of getting up, getting dressed and eating breakfast, brushing teeth, and getting to the bus or school on time with all the stuff a student needs.

Here are ways to help. Some are obvious, but it also helps to review:

1. Start the night before. Get the clothes laid out and make sure everything is packed for school. It will save time in the morning and keep the children off electronic media at a critical time. Set an expectation that you will have a great morning the next day, that they will see their friends, that this is a change but a good change.

2. Light up their room in the a.m. Light does help start the body’s daytime cycle of waking. Open the shades and/or turn some lights on just before it is time to get up.

3. Make sure they’re up. If you need to prompt, shake, or hover to get your child out of bed, don’t leave the house until you see they’re actually up.

4. Write out a schedule. You may have to put on paper items such as “out of bed by 6:45,” “breakfast by 7,” “back upstairs by dress by 7:20,” “leave by 7:30.” Post it on the refrigerator or on their bulletin board. This is a blueprint to guide a groggy brain.

5. Refuel them. Don’t skip breakfast; this will cause problems by 10 a.m. Cereal and milk, a banana and whole-grain toast, a sandwich, even a piece of fruit and whole-grain cereal in a mug, hectic but for the bus stop, it’s all good.

6. Getting back to an early morning routine is a hard change. So praise them for getting ready in time. They’ll be more likely to be ready in the future.

— By W. Douglas Tyman, chief psychologist with Nemours Health and associate professor of pediatrics at Jefferson Medical College.
How to Achieve Health Equity

Marshall H. Chin, M.D., M.P.H.

Two studies in this issue of the Journal indicate that differences in how we deliver care to patients in various racial or ethnic groups have narrowed nationally, but health outcomes remain worse for blacks than for whites. Trivedi et al. studied hospitalizations of patients for acute myocardial infarction, heart failure, and pneumonia from 2005 through 2010. They found that racial or ethnic differences decreased for processes of care (i.e., what clinicians do for patients), such as evidence-based prescribing of medications and the administration of flu shots. In contrast, Ayanian et al. discovered that black enrollees in Medicare Advantage health plans had worse outcomes (i.e., the actual health result) than did whites on control of blood pressure, cholesterol, and glucose, except in the West.

These divergent findings illustrate that years to ensure that they take their medications, consume healthful diets, and are physically active. The best care spans outpatient care, inpatient care, and self-care and is tailored to the needs of each patient. Clinicians must help patients manage their health while patients are outside the clinic and living in the community — which is most of the time. Bottom-line outcomes such as hospital readmissions, for which rates are higher for blacks, are harder to improve and ultimately more important than the improvement of process measures such as echocardiography for patients with heart failure. Eliminating disparities requires truly patient-centered care — that is, individualized care by clinicians who appreciate that patients’ beliefs, behaviors, social and economic challenges, and environments influence their health outcomes.

Dartmouth Atlas

- Report shows disparities in U.S. diabetes prevention, amputation
- By Kathryn Doyle, NEW YORK (Reuters Health)
- “These are entirely preventable, this shouldn’t happen,” Chin told Reuters Health by phone.
- “There are very specific ways that we need to understand each individual patient situation, their particular set of family and neighborhood factors,” Chin said.
- Just recording and tracking the racial disparities may make a difference, he said. “Almost all clinicians and organizations want to do the right thing, but if they don’t believe there’s a problem they won’t do anything,” Chin said.
Talk Circuit
Twitter Chats – AMA - Teaching Medical Students about Disparities
Twitter Partners

- HHS Office of Minority Health
- National Council of La Raza
- AHRQ
- America’s Essential Hospitals
- APA
- AAMC
- ADA
- AHA
- Community Commons
- AMA
- AADE
RWJF Conf. Stakeholders

- AAFP
- AAP
- AcademyHealth
- AHA
- AHIP
- AHRQ
- AMA
- AMGA
- APHA
- BCBS
- CMS
- IOM
- MGMA
- NACHC
- NHMA
- NQF
- OMH
- PCORI
Collaborators

- CMS Innovations Center
- AAMC
- HRSA
- NACHC
NQF – Risk Adjustment and Socioeconomic Status – Helen Burstin

“The report has catalyzed a much needed, thoughtful, national conversation.”

-Debra Ness, President of the National Partnership for Women and Families
How to Achieve Health Equity

- Look at your data
- Talk to your patients and tailor care
- Align the incentives
  - Population health
  - Incentivize reducing disparities
- Assist the safety net

Leadership Matters

- Changing attitudes and behaviors of individuals, organizations, and policymakers
- Emotional (heart) + technical (head)
- Intrinsic and extrinsic motivation
- Keep developing skills
- Work on multiple levels
- Different types of partners