Session Objectives

Objective 1: Describe 3 strategies for addressing social determinants of health

Objective 2: Highlight two organizations who were successful in implementing these strategies

Agenda

Welcome
Disparities and Equity in the Time of Healthcare Transformation
Collection of Social Determinants of Health Data
Screening for Social Determinants of Health at St. Christopher’s Hospital for Children
Health Equity: Addressing Social Determinants of Health

Group Breakouts

Outline

• High-Value, Transformation and Equity

• Key Drivers

• Lessons from the Field

High-Value in A Time of Healthcare Transformation

Value-based purchasing and health care reform will alter the way health care is delivered and financed; quality not quantity…

• Increasing Access: Assuring appropriate utilization
  – Linking to the PCMH, decreasing ED use & avoidable hospitalizations

• Improving Quality: Providing the best care
  – Importance of Wellness, Population Management

• Controlling Cost: Focusing on the Pressure Points
  – Importance of hot spotting and preventing readmissions, avoiding medical errors, and improving patient experience
  – Banding together and risk-sharing through ACO’s
Increasing Diversity

Health care organizations need to prepare staff to work with patients and colleagues from diverse cultural backgrounds.

Current and Projected Population of the United States, 1998-2030

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>1998</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>70%</td>
<td>60%</td>
</tr>
<tr>
<td>Black</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Asian Hispanic</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>Native American</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Other non-Hispanic</td>
<td>5%</td>
<td>5%</td>
</tr>
</tbody>
</table>


Diabetes-Related Death Rate, 2012

Deaths per 100,000 population

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>22.8</td>
</tr>
<tr>
<td>Black</td>
<td>50.1</td>
</tr>
<tr>
<td>Hispanic</td>
<td>33.8</td>
</tr>
<tr>
<td>Native American</td>
<td>50.3</td>
</tr>
<tr>
<td>Asian/PI</td>
<td>18.4</td>
</tr>
</tbody>
</table>

What causes these Racial/Ethnic Disparities in Health?

- **Social Determinants**
- **Access to Care**
- **Health Care?**

Racial and Ethnic Disparities in Health Care

A High-Value Target

Racial/Ethnic disparities found across a wide range of health care settings, disease areas, and clinical services, even when various confounders (SES, insurance) controlled for.

Many sources contribute to disparities—no one suspect, no one solution

- Navigation
- Communication
- Stereotyping
- Mistrust

Variations in care and quality, inefficiencies, costly care and poor outcomes are the epitome of low-value.

Linking Disparities to Quality and Safety and the Pressure Points

- **Safe**
  - Minorities have more medical errors with greater clinical consequences
- **Effective**
  - Minorities received less evidence-based care (diabetes)
- **Patient-centered**
  - Minorities less likely to provide truly informed consent; some poorer patient experience
- **Timely**
  - Minorities more likely to wait for same procedure (transplant)
- **Efficient**
  - Minorities experience more test ordering in ED due to poor communication
- **Equitable**
  - No variation in outcomes
- **Also**
  - Minorities have more CHF readmissions and avoidable hospitalizations

IOM’s Unequal Treatment

[www.nap.edu](http://www.nap.edu)

Recommendations

- Increase awareness of existence of disparities
- Address systems of care
  - Support race/ethnicity data collection, quality improvement, evidence-based guidelines, multidisciplinary teams, community outreach
  - Improve workforce diversity
  - Facilitate interpretation services
- Provider education
  - Health Disparities, Cultural Competence, Clinical Decisionmaking
- Patient education (navigation, activation)
- Research
  - Promising strategies, Barriers to eliminating disparities
Preparing for the Future

- Addressing variations in quality—such as racial/ethnic disparities in health care—will be essential going forward if we are to achieve equity, high-performance and high-value.
- This is not just about equity for equity’s sake—cost is key—as equity connects to all areas of quality:
  - Population Management
  - Transitions of Care and Readmissions
  - Appropriate Utilization and Avoidable Hospitalizations
  - Patient Safety
  - Patient Experience
- Healthcare organizations ignore this at their own peril...action will separate winners from losers...

Equity and Action Challenges and Possibilities

- Getting Disparities/Diversity on Leadership Agenda
  - Leaders are swamped, anxious, full of uncertainty, and may be swimming in the red
  - Need to “connect the dots” for leaders on link between disparities, equity, quality, and value
  - Constant focus on connection to pressure points
- Data Collection and Monitoring
  - Few collect data and monitor equity
  - Monitoring performance, and targeting services accordingly will be the essential foundation for population health, safety, patient/member experience
  - Identifying disparities can lead to “high-value” targets

Equity and Action Challenges and Possibilities

- Developing Interventions—Equity
  - Chronic, complex, costly conditions will be managed through interprofessional, well-trained care teams focused on population health (the 20/80 rule)
    - IT, Care coordination and training necessary
    - Emergence of coaches, navigators, and reemergence of community health workers
    - Utilizations, Wellness, Care Management, Transitions
  - One size won’t fit all; need focus to impact utilization, patient experience and patient safety
    - Cross-cultural communication and Interpretation
    - Health literacy
    - Patient engagement and Shared decisionmaking
  - Need to make case that will lead to better care for all patients

The New Era of Health Equity

Moving to Access and Accountability

- Value is real...MACRA is here, but we’re still living in two worlds
- Attention turns to social determinants and Population Health 2.0
- Mapping, duals, super-utilizers now a priority to address cost
- HIT and disruptors changing game
- Energy on diversity/inclusion, implicit bias, stereotyping
- Risk Adjustment???
- AHA #123, CMS Equity Strategy

Organizational Change Management For Health Equity: Perspectives From The 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 strat’s for identifying/addressing disparities
  - Leadership skills to implement and transform organizations
- Assist individuals and organizations to:
  - Create a strategic plan to address disparities, or
  - Advance or improve an ongoing project, and
  - Be prepared to meet new standards from the JC, NCQA, and PPACA
The Importance of Organizational Change Management for Health Equity

- Know who to involve
  - Establish a powerful guiding coalition
  - Involve both leadership and middle management
  - Develop cross collaborations
- Shape Organizational Culture
  - Disparities efforts anchored to current culture, or equity as part of quality

Study Data & Methods

- 2007 – 2017 ten cohorts but excluded current one
- 9 years of survey data
- 115 organizations
- Excluded those that were not hospitals, health plans, community health centers
- Final survey results of 97 unique organizations from 2007 – 2016
- 22 organizations of the 97 sent an additional team resulting in a total of 119 team/surveys

The Importance of Organizational Change Management for Health Equity

- Engage Your Organization and Your Audience
  - Align with key stakeholders and share vision early and often
  - Continuous engagement through creation of short term wins such as awards, dissemination, benchmarking work or publications
  - Senior leadership models new behavior - e.g. Chiefs request data by R/E

The Importance of Organizational Change Management for Health Equity

- Create Urgency, Vision, and Make the Rational and Emotional Case
  - Leadership buy-in & Benchmarking with external orgs creates urgency
  - Rocket pitch as a way to clarify your vision
  - Combining data with a personal story
  - Communication strategy, branding & marketing

The Importance of Organizational Change Management for Health Equity

- Harness the Power of a Collaborative Network
  - Develop strategic leadership skills
    - Anticipate changing environment
    - Promote a culture of learning
    - Challenge assumptions and encourage divergent points of view.
Collecting Social Determinants of Health Data

Aswita Tan-McGrory, MBA, MSPH
Deputy Director,
The Disparities Solutions Center
Massachusetts General Hospital
December 9, 2018

Follow us on Twitter: @MGHdisparities, @atanmcgrory
Like us on Facebook: www.facebook.com/disparitiessolutionscenter

What are Social Determinants of Health?


Race and Economic Opportunity in the US


Guide to Preventing Readmissions among Racially & Ethnically Diverse Medicare Beneficiaries

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.

---

Readmission Rates

- **CHF**
  - Higher readmission rates for African American patients
  - Among Medicare beneficiaries higher readmission rates for Hispanic patients
- **AMI**
  - Higher readmission rates for African American patients
  - Among Medicare beneficiaries higher readmission rates for Hispanic patients
- **Pneumonia**
  - Higher readmission rates for African American patients
- **COPD**
  - Among Medicare beneficiaries higher readmission rates for African American patients
- **THA/TKA**
  - Among Medicare beneficiaries higher readmission rates for African American patients

---

Race and Ethnicity

- **Race** – group or groups with whom a patient identifies
  - A category of humankind that shares certain distinctive physical traits*
  - Examples: Asian, Black, White, etc.
- **Ethnicity** – background, heritage, culture, ancestry. May also include country where the patient was born
  - “Being a member of a specified ethnic group”*
  - Examples: Haitian, Vietnamese, Brazilian, etc.

*Source: Merriam Webster Dictionary

---

Recommendation #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.

- Patients’ ability to engage in their care is influenced by their clinical, physical, and emotional status; the support system available to them; and their capacity to overcome the social obstacles present in their lives and environment.
- Assuring that patients have the social supports they need to manage their condition is critical and can be addressed by social workers and community health workers.

---

Office of Management & Budget (OMB) Categories

- **Race:**
  - American Indian or Alaska Native
  - Asian
  - Black or African American
  - Native Hawaiian or Other Pacific Islander
  - White
- **Ethnicity:**
  - Hispanic or Latino
  - Not Hispanic or Latino
By 2020, the child population is projected to have more children of color make up the majority of the population.


The Newly Insured Population: ~50% Minority

What will the newly insured look like?
The newly insured compared to the currently insured are:

- Race
  - Non-Hispanic
  - White
  - black
  - Hispanic
- Health status
  - Excellent
  - Very good
  - Good
  - Fair
  - Poor
- Marital status
  - Married
  - Single
- Language
  - Spoken English
  - Limited English Proficiency (LEP)
- Educational attainment
  - Less than high school
  - High school graduate
  - Some college
  - College degree
- Employment status
  - Full-time
  - Part-time
  - Unemployed
  - Self-employed

How to Address Patient Concerns

- A patient asks, "Why do you want this information?"
  - Identify health differences
  - Data will be reported by groups
- A patient asks, "Who will see this information?"
  - HIPAA
  - Will not be shared with immigration or government agency
  - Registration personnel, providers, quality improvement personnel
- A patient asks, "What do you mean by race and/or ethnicity?"
  - Provide definition
  - Patient can have more than one answer, use free text
- A patient says, "I think that the answers are obvious."
  - Explain regardless of how obvious, you are required to ask the questions and record responses.
- What other questions have you heard in your practice?

Key Strategies for Success

- Train your registrars, front-line staff
  - Job aids, scripts, videos, role-playing, provide time to address concerns
- Inform your patient of the why, who and what
  - Why are you collecting the data
  - Who will see the data
  - What will you do with the data
- Do periodic quality checks on your data collection
  - Secret shopper
  - Follow up w/patients to confirm race/ethnicity/language
  - Observation
- Monitor and report on your data
  - Disparities Dashboard
  - Develop interventions
- Report back to front line staff, registrars, etc about results.
  - Keeping them informed and up to date is key.

Race/Ethnicity/Language Data Process Map

1. Staff in this area will collect demographic information.

2. Registration access points:
   - Emergency Department
   - Patient Service Center (via phone; only communicates with patient if insurance status changes)
   - Admitting Services (inpatient/on floor)
   - Affiliated community health centers (have own registers; who are trained by Admitting Services)
   - Patient Gateway (2/3 of patients are on PC)

3. Data points will be registration source (see updated and create new registration)

4. Note: numbers correspond to questions on

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

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.

A Patient and Family Data Collection Framework for Identifying Disparities in Pediatrics: Results from the Pediatric Health Equity Collaborative

When Collecting SDH DATA...

• Look at the capacity of your EHR
• Identify & prioritize 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

Thank You

Aswita Tan-McGrory, MBA, MSPH
Deputy Director,
The Disparities Solutions Center
Massachusetts General Hospital
atanmcgrory@partners.org

Follow us on Twitter: @MIGHdisparities, @atanmgregory
Like us on Facebook: www.facebook.com/disparitiesolutionscenter
Health Equity: Addressing Social Determinants of Health

December 9, 2018

Johanna Martinez, MD, MS
GME Director of Diversity and Health Equity

Adopted IHI’s Equity Framework

- Make health equity a strategic priority
- Develop structure and processes to support health equity work
- Specific strategies to address the social determinants of health
- Increase diversity and inclusion across the organization
- Develop partnerships with community organizations

Northwell Health Service Area* Demographics - Diversity Defined...

Northwell Health: Serving 8 million people with 23 hospitals, 60K employees

Factors in Health Disparities

Equity Strategy
1. Clinical Transformation
2. Education and Awareness
3. Community Partnerships

Northwell Health major components
Clinical Transformation

1. Social Determinants of Health Screening Program

2. Medical Legal Partnership

Social Determinants of Health Program

- Universal social determinants of health screening
  - (housing, utilities, financial, employment, immigration status, insurance, public benefits)

- Pediatrics -> Internal Med -> System-wide SDH screening process

- Over 2000 families screened to date, 45% have screened positive

- Care managers, navigators, Medicaid Health Home

- Referral and follow-up services

Screening Form (1/2)

Life & Wellness Screen

Today’s Date: ___________

To provide you with the best care possible, we would like to learn more about you and your household.

Patient Name: ___________________________ Phone: ________________________

Patient Date of Birth: ____________________ Address: __________________________

Do you have any children who are living in your household or taking care of another child? __________

Do you have any adult family members who live in your household? __________

Do you live in a multi-family household? __________

Do you receive any public assistance or benefits? __________

Do you have any pets in your household? __________

Do you have any other health or social issues that are important to share? __________

Screening Form (2/2)

C保证 your family is safe, we would like to learn more about your household.

Do you have any children who are living in your household or taking care of another child? __________

Do you have any adult family members who live in your household? __________

Do you live in a multi-family household? __________

Do you receive any public assistance or benefits? __________

Do you have any pets in your household? __________

Do you have any other health or social issues that are important to share? __________

Summary of Follow-Up Process & Patient Calls

<table>
<thead>
<tr>
<th>TYPE OF CALL</th>
<th>TIMEFRAME (AFTER SCREEN)</th>
<th>PURPOSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intake</td>
<td>3-5 days</td>
<td>Reviews indicated needs</td>
</tr>
<tr>
<td>Referral Call</td>
<td>Within 14 days</td>
<td>Provides appropriate resources</td>
</tr>
<tr>
<td>1st Follow Up</td>
<td>Within 30 days</td>
<td>Status update</td>
</tr>
<tr>
<td>2nd Follow Up &amp; Additional F/U's</td>
<td>Within 6 weeks</td>
<td>Status update</td>
</tr>
<tr>
<td>Final Follow Up/Completion</td>
<td>Within 12 weeks</td>
<td>Patient feedback &amp; Close out</td>
</tr>
</tbody>
</table>

Navigator Training

Week long

- Motivational Interviewing
- Managing Difficult Patient Encounters
- Crisis Management
- 111
- Public Benefits
- Care Coordination
- Cultural Competence
- Social Determinants of Health
- Trauma Informed Care

Care Managers [shadow] Role Plays

Courses

- Cultural competence
- Social determinants
- Home care
- Trauma informed care

What questions would you ask?
Maurice A. Deane School of Law at Hofstra University forms first medical-legal partnership with Northwell Health

To Date:
- Screened over 2,000 unique families
- Screening Rate (# of screens given out / # of eligible pts. in clinic): 88%
- Screen Completion Rate (# of completed screens / # of screens given out): 75%
- Screen positive (SDH) rate: 50%
- Screen positive (HHLN) rate: 10%
- Social needs: dental/health insurance
- Legal needs: immigration

MLP Deliversables
- Training of staff and providers
- Patient-legal care
- Clinical-legal care
- Policy

Equity Strategy
1. Clinical Transformation
2. Education and Awareness
3. Community Partnerships

Education and Awareness
- Workforce Training
- Health Equity Curriculum
- GME Annual Educational Retreat-SDH
- Train-the-trainer sessions

Health Equity Curricular Inventory
SDH Retreat
Over 100 participants
Over 30 individual programs
90% committed to a curricular change
At 3 months 25% had made a formal change

TBL Session Outline
Increase in Knowledge/Skill

Community Health Track
ENHANCE: Engaging in Health Advocacy through Neighborhood Collaboratives & Education

Residency Programs
- Family Medicine
- Internal Medicine
- Pediatrics
- SIUH site

Skills
- Population health
- Social determinants of health
- Community engagement

Collaboration
- GNYHA
- CCNY
- INN

Focus on Food and Housing
Housing
- Affordability
- Substandard
- Overcrowding
- Homeless

To date:
Community Educational Campaign - Housing and Voting
Queens and Nassau County
Working on Policies for LI
Meet with local stakeholders - Housing Authority, Courts

With our CBOs
1. Structured SDH screen at CBO
2. Grant budget sharing
3. Placed SW, Care coordinators at their sites
4. Bidirectional referrals
5. Lawyers joining team

Equity Strategy
1. Clinical Transformation
2. Education and Awareness
3. Community Partnerships
Workforce Diversity and Inclusion
1. Established selection and recruitment strategies
2. Resident and Fellow Forum
3. Worked on pipeline
   • LMSA National Meeting
   • SOM NERA program
   • Queens College
4. Learning climate survey
5. Benchmarks and Metrics

Diversity Metrics and Outcomes
- Keep track of your numbers
- URMs applicants applied
- URMs applicants invited
- URMs applicants interviewed
- URMs applicants ranked
- URMs applicants ranked to match
- URMs applicants that matched to program

Highlights:
- Since 2016, over 50% increase in URMs in several programs
  - Family Medicine 20%-86%
  - Internal Medicine 8%-16%
  - Pediatrics 9%-18%
  - Psychiatry 8%-17%

A Strategic Focus on Workforce Diversity
Strategic initiatives focused on diversity and inclusion throughout the entire employee life cycle
1. Development & Selection
2. Employee Value Proposition (EVP)
3. Talent & Engagement
4. Promotion, Empowerment & Retention
Selection and Recruitment Strategies

- Updated mission statements to include diversity
- Target HBUC and Schools in Puerto Rico
- Training on structured interviewing
- Diverse selection committee
- Holistic review
- Diversity Second Look
- Post-match survey

**Screening for Social Determinants of Health at St. Christopher’s Hospital for Children**

Hans Kersten, MD
Professor of Pediatrics
Drexel University College of Medicine
St. Christopher’s Hospital for Children

**Inspiration:**

- Philadelphia
  - 39% of children in Philadelphia live below federal poverty line ¹
  - one of the poorest major cities in the U.S. ²
- U.S. Congressional District 1
  - 40.6% of the population has experienced food insecurity (FI)
  - Families lack access to nutritious and healthy foods.
ST. CHRISTOPHER’S HOSPITAL FOR CHILDREN (SCHC)

- SCHC has been a leader in pediatric care since 1875
- SCHC is a 189-bed tertiary care medical center
- St. Chris’ mission is to provide quality pediatric services in a caring, progressive environment.
- The Center for the Urban Child (CUC) at St. Chris, opened in 2014, to create a community-focused setting on the hospital campus designed to help children break from cycles of violence, food insecurity, and childhood illness.
- 85% patients have Medicaid insurance
- 40% Hispanic 40% Black
- CUC serves 25,000 patients

HUNGER-FREE HEALTH CENTER MODEL

- **Screen** – FI and other determinants of health
- **Provide** families resources
- **Educate** faculty, staff and community
- **Advocate** for patients/families
- **Care** - children/families with FI

Screen, Provide, Educate, Advocate, Care

- Over 30,000 screens have been completed since 2013
- In 2017, 1651 (25%) families self-reported at least one unmet need

Screen, Provide, Educate, Advocate, Care

Ambulatory Pediatric SDH Screening Process

- Partnership between the Legal Clinic for the Disabled (LCD) and SCHC
- Started in 2011 in the Ambulatory Pediatrics practice
- Expanded to the Center for Children with Special Health Care Needs (2013) and the Asthma Clinic (2015), CSHCN (2017), and Newborn Clinic (2017)
Income supplements:
- Helped apply for SNAP, TANF and Medicaid
  - Assistance with a valuated return of $116,000

Immigration:
- Referred 16 families for free confidential
  - Consultations

Public utilities:
- Standardized medical certification protocol to prevent shut-offs

SSI benefits:
- Assisted 6 families with SSI benefit applications
- Reduced SSI overpayment by $800.00 for one family

Public utilities:
- Standardized medical certification protocol to prevent shut-offs

Family Engagement
- 15 families
- Verbally administered
- English only
- Results
  - 80% comfortable completing
  - 27% concerns not addressed
  - 80% provider did not seem to care
Do you feel that factors outside of the medical care we provide at St. Chris (what goes on in families, home, school, and environment) have an impact on our patients’ health and their overall well-being?

Newborn Clinic

Collaborative to Advance Social Health Integration (CASHI)

By October 2019, St. Chris will integrate social health into primary care such that:

- 75% of ambulatory visits are screened for SDH
- 75% of families with a positive SDH screen (in ambulatory and newborn) are provided with resources/services
- 50% of ambulatory SDH screens are captured in the EHR
- follow-up with families who received resources (in ambulatory and newborn) improves by 20%

Evolution of screener

Adaptation of screening tools

Swot Analysis

Strengths
- Provider-driven – got it started
- MFR involvement from start
- Screen for many SDH
- FI and IPV embedded in EHR
- Staff buy-in
- Expansion to other clinics
- SW and CHW teams
- Creates "conversation"
- Expands ways to help families

Weaknesses
- Provider-driven
- Passionate few
- Nebulous administrative support
- Difficult to capture actions for + screens
- Low-visibility in clinical space
- Complex array of needs for + screens
- Inconsistent workflow and provider abilities

Opportunities
- CASHI involvement
- PCMH SDH requirement
- BHEE involvement
- Career rollout
- AAP panel on SDH
- Like-minded mission-based owner

Threats
- Lack of effective scalable community referral system
- Volatile healthcare environment
- Dehumanize provider-patient relationship
- Year-to-year funding
Next steps

- Continued improvements with CASHI
- Expansion to other clinics
- Transition to Cerner
- More practice-based efforts
- Commitment for hospital-wide community referral system

Conclusions

- Healthcare centers can successfully screen and address for SDH
- Healthcare centers need to adapt screening for community needs
- QA and QI methods can be used to improve processes
- Need to focus on follow-up to measure success at a patient and system level

Group Breakout Activity and Report Out
3:55-4:25 pm

Racial & Ethnic Disparities in Health Care

- Health system level factors (systems)
- Care process variables (providers)
- Patient level variables (patient)
Racial & Ethnic Disparities in Health Care

Health system level factors (systems)
These include issues related to the complexity of the health care system and how it may be poorly adapted to and disproportionately difficult to navigate for patients of color or those with limited-English proficiency.

Racial & Ethnic Disparities in Health Care

Care process variables (providers)
These include issues related to health care providers, including stereotyping, the impact of race/ethnicity on clinical decision-making, and clinical uncertainty due to poor communication.

Racial & Ethnic Disparities in Health Care

Patient level variables (patient)
These include patient’s mistrust, poor adherence to treatment, and delays in seeking care.

Discussion

• In groups at your tables discuss what Health System level change would help address social determinants of health? (at your organization)
• 10 minutes
• Report back to the larger group

Health system level factors (systems)
These include issues related to the complexity of the health care system and how it may be poorly adapted to and disproportionately difficult to navigate for patients of color or those with limited-English proficiency.

For More Information About
The Disparities Leadership Program

www.mghdisparitiessolutions.org

Contact: Aswita Tan-McGrory, MBA, MSPH
Deputy Director
atanmcgrory@partners.org
617-643-2916