SOCIAL DETERMINANTS OF HEALTH FORUM
EXPLORING MEDICATION ACCESS & QUALITY
November 14 -15 • Alexandria, VA

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How Do We Measure a State of Equitable Opportunity?

Philip M. Alberti, PhD
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Pharmacy Quality Alliance
November 15th, 2018

Association of American Medical Colleges

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How (and Why) Do We Measure (and Incent & Train for) a State of Equitable Opportunity?

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Measure

Incent

Aspire

Train

Measure

What are We Measuring?

- **Health Disparity/Inequity** – A measurable, systematic, and avoidable difference in ***health*** between groups, stemming from differences in levels of social advantage/disadvantage.

- **Healthcare Disparity/Inequity** – A measurable, systematic, and avoidable difference in ***healthcare access, utilization, quality, and outcomes*** between groups, stemming from differences in levels of social advantage/disadvantage.

****Inequities exist for Populations not Persons****

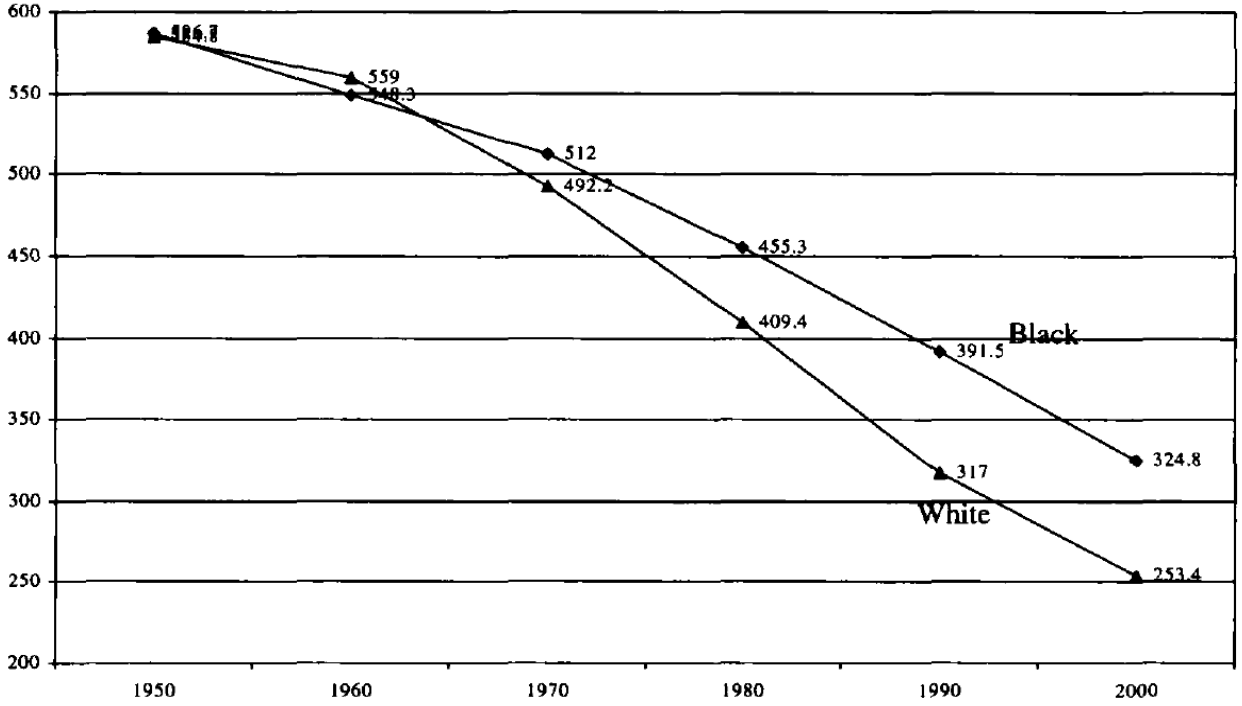
Insurance ≠ Access

Access ≠ Utilization

Utilization ≠ Quality

Quality ≠ Equity

FIGURE 4. Heart Disease—Age-adjusted Death Rates per 100,000, 1950–2000 by Race



National Center for Health Statistics—Health United States 2006

How Do We Currently Measure?

Social and Behavioral Domains and Measures.

Domain	Measure*	Frequency
Race or ethnic group†	1. What is your race? 2. Are you of Hispanic, Latino, or Spanish origin?	At entry
Education	1. What is the highest level of school you have completed? 2. What is the highest degree you earned?	At entry
Financial-resource strain	How hard is it for you to pay for the very basics like food, housing, medical care, and heat?	Screen and follo
Stress	Stress means a situation in which a person feels tense, restless, nervous, or anxious, or is unable to sleep at night because his or her mind is troubled all the time. Do you feel this kind of stress these days?	Screen and follo
Depression	Over the past 2 weeks, how often have you been bothered by 1. Little interest or pleasure in doing things? 2. Feeling down, depressed, or hopeless?	Screen and follo
Physical activity	1. On average, how many days per week do you engage in moderate to strenuous exercise (like walking fast, running, jogging, dancing, swimming, biking, or other activities that cause a light or heavy sweat)? 2. On average, how many minutes do you engage in exercise at this level?	Screen and follo
Tobacco use†	1. Have you smoked at least 100 cigarettes in your entire life? If yes: 2. Do you now smoke cigarettes every day, some days, or not at all?	Screen and follo
Alcohol use†		
Social connection or isolation		
Intimate-partner violence		
Residential address†		
Census-tract median income		

Essential Social Need Domains

Representing the most common social needs impacting the health of patients are based on findings from IOM, CMS, and Health Leads' two decades of exp social needs programs. We recommend all healthcare systems include these tool for social determinants of health.

SOCIAL NEED DOMAIN	EXAM
Food Insecurity	Limited or uncertain access to adequate &
Housing Instability	Homelessness, unsafe housing quality, inal housing disruptions, eviction
Utility Needs	Difficulty paying utility bills, shut off notices, discounted phone
Financial Resource Strain[2]	Public cash benefits, charity emergency funds, financial literacy, medication under-use due to cost, benefit denial
Transportation	Difficulty accessing/affording transportation (medical or public)
Exposure To Violence[3]	Intimate partner violence, elder abuse, community violence
Socio-Demographic Information	Race & ethnicity, educational attainment, family income level, immigration status, languages spoken

Box 1 | Accountable Health Communities
Core Health-Related Social Needs Screening Questions

Underlined answer options indicate positive responses for the associated health-related social need. A value greater than 10 when the numerical values for answers to questions 7-10 are summed indicates a positive screen for interpersonal safety.

Housing Instability

1. What is your housing situation today?
   - ☐ I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
   - ☐ I have housing today, but I am worried about losing housing in the future.
   - ☐ I have housing

2. Think about the place you live. Do you have problems with any of the following? (check all that apply)
   - ☐ Bug infestation
   - ☐ Mold
   - ☐ Lead paint
   - ☐ Inadequate heat
   - ☐ Oven or stove not working
   - ☐ No or not working smoke detectors
   - ☐ Water leaks
   - ☐ None of the above

Food Insecurity

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

+ 1000

MLP legal needs screening tool available for download

WEDNESDAY, OCTOBER 14, 2015

To treat the health-harming social conditions that stand in the way of good health, health care organizations must first be able to detect these prob- ming civil legal needs in a clinical setting?

o support from edical-legal ds. We then de- and health cen-

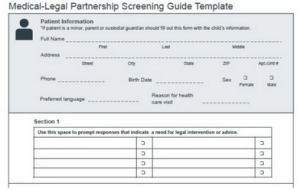
orization tools; issues and ect questions

er measure its

ership to cus- g and the population it serves, but that is based on well-tested, consistent questions ucation and employment, legal status and personal stability (the I-HELP issues where s.)

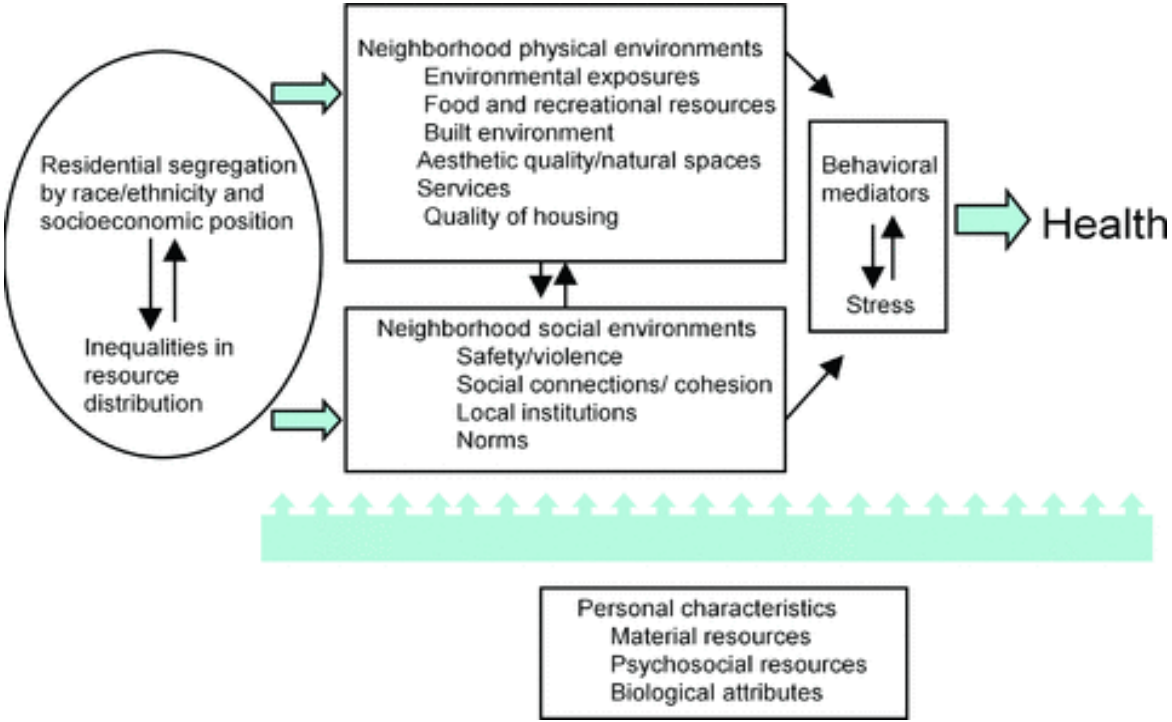
National Center for Medical Legal Partnership

Medical-Legal Partnership Screening Guide Template



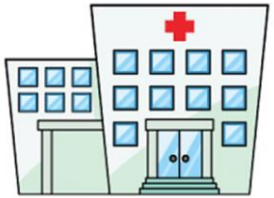
1. Available for use now
2. Available for use now for some outcomes, but research needed for improved, future use
3. Not sufficiently available now; research needed for improved, future use
4. Research needed to better understand relationship with health care outcomes and on how to best collect data

Neighborhoods and Health



Neighborhoods and health, Volume: 1186, Issue: 1, Pages: 125-145, First published: 16 February 2010, DOI: (10.1111/j.1749-6632.2009.05333.x)

Why Do We Measure?



NY 14

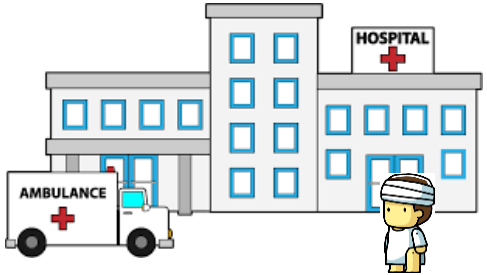
- Total Population: 652,681
- Median Household Income: $79,385
- Below Poverty Line: 9.9%
- Households with Single Mothers: 2.6%
- Households on Food Stamps: 14,977 (2%)
- B.A. degree: 35.8%
- Number of gyms: 91
- Heating complaints: 7,963
- Residential noise complaints: 4,684
- Smoking prevalence (M/F): 16%/14%
- Obesity prevalence (M/F): 28%/25%
- Rec. physical activity (M/F): 61%/56%

NY 16

- Total Population: 693,819
- Median Household Income: $23,073
- Below Poverty Line: 39.2%
- Households with Single Mothers: 22.6%
- Households on Food Stamps: 83,973 (12%)
- B.A. degree: 7.4%
- Number of gyms: 15
- Heating complaints: 45,748
- Residential noise complaints: 17,890
- Smoking prevalence (M/F): 24%/17%
- Obesity prevalence (M/F): 33%/42%
- Rec. physical activity (M/F): 47%/40%

Thought Experiment

NY 14



NY 16

Sociodemographic Status-Adjustment for Value Based Purchasing

Conceptual Model

Transportation

Neighborhood Deprivation

Education

Income

Social Support

Food Access

Racism

Crime

Empirical Model

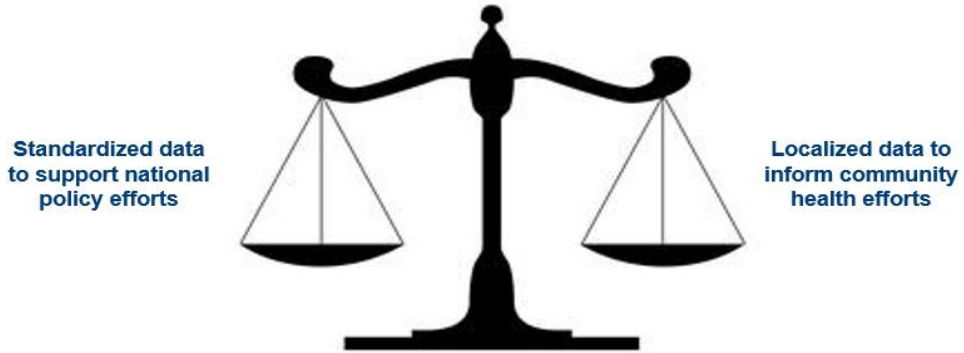
Dual Eligibility

Black Race

No Adjustment

Research Questions:
What, How, and Why Do We Measure?

- What variables – at both patient and community levels – do we need?
- What's the right workflow(s)?
- How to *use* those data in a clinical setting?



Incent

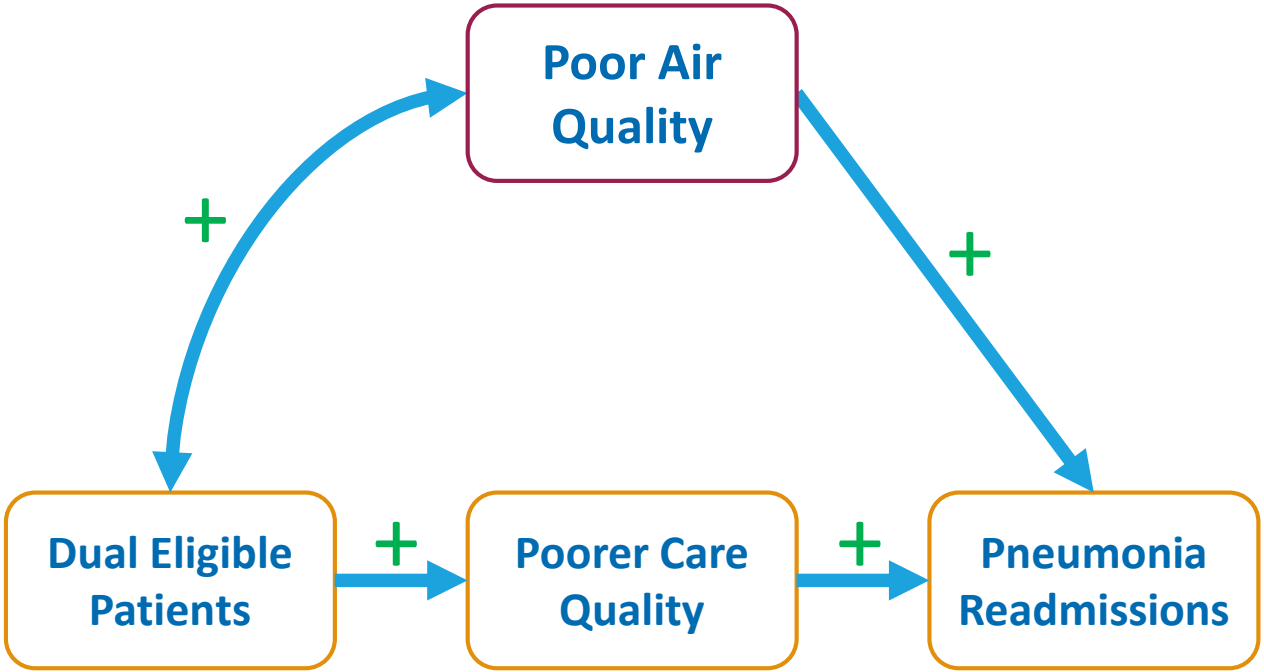
Table 1: Summary of Your Hospital's Performance on **Both Disparity Methods (Within-Hospital Disparity Method and Dual Eligible Outcome Method)** Applied to the Hospital-Level 30-Day Risk-Standardized Pneumonia Readmission Measure and Summary of Your Hospital's Performance on the Hospital-Level 30-Day Risk-Standardized Pneumonia Readmission Measure as Currently Implemented in the Hospital Inpatient Quality Reporting Program (For Reference Only)
Social Risk Factor: Medicare and Medicaid Dual Eligibility

[redacted]

Hospital Discharge Period: July 1, 2014 through June 30, 2017

Performance Information	**Within-Hospital Disparity Method**	**Dual Eligible Outcome Method**	**Pneumonia Readmission Measure**
Your Hospital's Comparative Performance	No Difference between Dual and Non-Dual	No Different than the National Rate for Dual	No Different than the National Rate
Overall Risk-Standardized Readmission Rate (RSRR) at Your Hospital	*	*	17.22%
Your Hospital's Absolute Rate Difference for Dual Eligible and Non-Dual Eligible Patients (Within-Hospital Disparity Method) [a]	[redacted]	*	*
Your Hospital's RSRR for Dual Eligible Patients (Dual Eligible Outcome Method) [b]	*	[redacted]	*
National RSRR for Dual Eligible Patients	*	18.95%	*
Total Number of Pneumonia Readmission Dual Eligible Patients at Your Hospital	92	92	*

Confounded!



What are We Incentivizing?

- Raise awareness?
- “Close the gap!”
  - How? What is the intervention for “Dual Eligibility?
  - How? We might not be comparing the same Dual Eligible populations!
  - Self-referent? Sub-strata?

Aspire

Long Term Goal

Health Equity – A state where everyone has the opportunity to attain his or her full health potential and no one is disadvantaged because of their social position or other socially derived circumstance.

How do you measure an equitable state?

What are the behaviors of a healthcare system that is the best partner it can be in a "health opportunity-promoting" system?

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Community Engagement

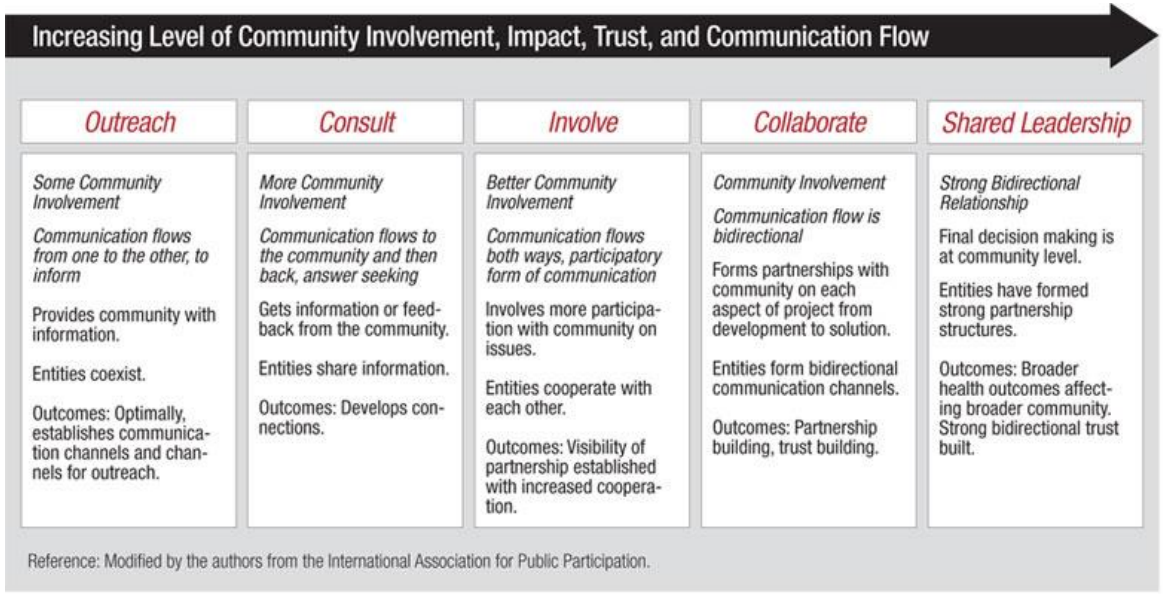

Figure 1.1. Community Engagement Continuum

Centers for Disease Control and Prevention. Principles of community engagement (2nd ed.) Atlanta (GA): CDC/ATSDR Committee on Community Engagement; 2011, pg.22.

Patient Engagement

Patient-Focused Drug Development: Collecting Comprehensive and Representative Input

Guidance for Industry, Food and Drug Administration Staff, and Other Stakeholders

DRAFT GUIDANCE

This guidance document is being distributed for comment purposes only.

Equitable Opportunity Includes…

HEALTHCARE

- Accessibility
- Language Services
- Lack of bias
- Data
- Consideration of social context in care planning

HEALTH

- Multisector Partnerships & Collaborations
- Trust
- CHNA processes & use

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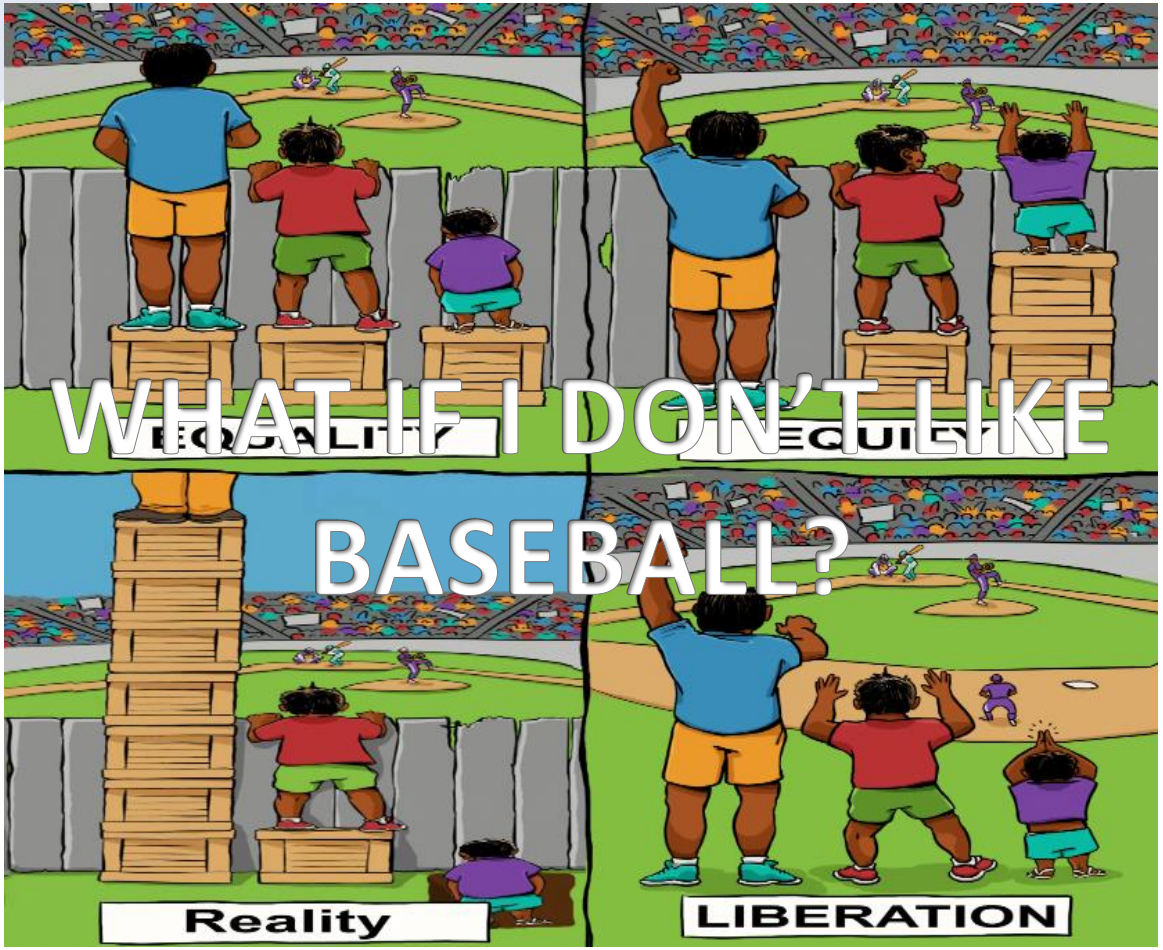
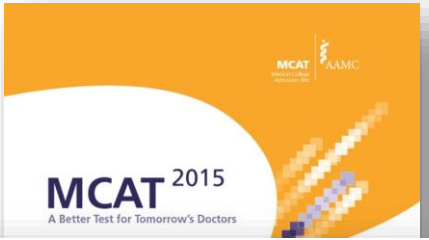
WHAT IF I DON'T LIKE BASEBALL?



Long Term Goal

Health Equity – A state where everyone has the opportunity to attain his or her full health potential and no one is disadvantaged **because of their social position or other socially derived circumstance**.

Train



DRAFT - - FOR INFORMAL REVIEW ONLY - - August 9, 2018

Health Equity in QIPS

Health equity is the attainment of the highest level of health for all people. This requires the application of a quality improvement lens to the provision of equitable and safe care.

Entering Residency (Recent Medical School Graduate)	**Entering Practice (Recent Residency Graduate)** *All of Prior Competencies +*	**Experienced Faculty Physician (3-5 Years Post Residency)** *All of Prior Competencies +*
Health and health care equity in practice		
Demonstrates knowledge of population and community health needs and disparities. HM-SBP2	Participates in changing and adapting practice to provide for the needs of specific populations. HM-SBP2	Role models the use of/referral to local resources to effectively meet the needs of patients and patient populations with social risk factors.
Demonstrates knowledge of local resources available to patients and patient populations with social risk factors.		
Collects data regarding social determinants of health during history taking.	Describes how social determinants of health impact quality of care for patients experiencing disparities in healthcare quality.	Tailors care plans around patient-specific social needs.

AAMC Health Equity Research and Policy

- Monthly Updates and Just-in-Time Alerts
  - www.aamc.org/healthequity
- Exemplary AAMC Member HER Activity
  - Snapshots, Virtual Site Visits
- Community Engagement Toolkits
- ROCChe
  - SDS data collection in EHRs
  - Health Impact Assessments to inform national advocacy efforts

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