



# HPOE *Live!* Webinar Series 2014

**The presentation  
will begin shortly.**



INSTITUTE FOR DIVERSITY  
in Health Management

An affiliate of the American Hospital Association



Symposium for Leaders  
in Healthcare Quality

A forum of the  
American Hospital Association

*HPOE Live Webinar Series 2014*

# Making Data Meaningful: Monitoring Performance in Quality and Equity

Tuesday, October 14, 2014

3:30-4:30 pm ET

2:30-3:30 pm CT

12:30-1:30 pm PT



THE DISPARITIES  
SOLUTIONS CENTER

*One Goal - High Quality Care for All*

# Presenters



**Joseph R. Betancourt, MD, MPH**  
Director  
Disparities Solutions Center  
Massachusetts General Hospital



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



**Laura Archbold, RN, MBA**  
Vice President, Operations  
Unified Clinical Organization  
CHE Trinity Health

# Joseph R. Betancourt, MD, MPH



Dr. Betancourt directs the Disparities Solutions Center, which works with healthcare organizations to improve quality of care, address racial and ethnic disparities, and achieve equity. He is Director of Multicultural Education for Massachusetts General Hospital (MGH), and an expert in cross-cultural care and communication. Dr. Betancourt is also a co-founder of Quality Interactions, Inc., an industry-leading company that has created and deployed a portfolio of e-learning programs in the area of cross-cultural care and communication to over 125,000 health care professionals across the country.

Dr. Betancourt served on several Institute of Medicine committees, including those that produced *Unequal Treatment: Confronting Racial/Ethnic Disparities in Health Care* and *Guidance for a National Health Care Disparities Report*. He also actively serves as an advisor to the government, healthcare systems, as well as the public and private sector on strategies to improve quality of care and eliminate disparities. He is a practicing internist, co-chairs the MGH Committee on Racial and Ethnic Disparities, and sits on the Boston Board of Health. Dr. Betancourt is on the Boards of Trinity CHE, a large, national healthcare system, as well as Neighborhood Health Plan, based in Boston. He practices Internal Medicine at the MGH Internal Medicine Associates.

# 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.

# Laura Archbold, RN, MBA



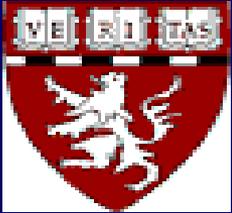
A healthcare leader with over 30 years of experience, Laura combines her clinical and operational expertise to lead the day-to-day operations of the UCO, stewarding resources, managing the budget, and improving processes. As a certified nurse expert in the operating room, she used her 25-plus years of experience as an operating room nurse to effectively lead Lean Six Sigma projects regarding surgeon preference cards, the accuracy of surgical instrumentation, the reduction of surgical cancellations, and the redesign of a surgical preparation center. Laura has conducted Process Excellence training and supported organizational assessments and projects across Trinity Health, including such projects as length of stay reduction, best practice patient designation, medication reconciliation, and OB workflow documentation. Laura also has been responsible for hospital operating performance, advising Trinity organizations on methodologies and strategies to improve quality and financial margins. Part of her operational performance work included in the merger and acquisitions of new hospitals into the Trinity Health system. Laura currently volunteers at the Hope Clinic, a free clinic for the underserved, and serves on their strategic planning committee.



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*One Goal - High Quality Care for All*

# Making Data Meaningful: *Monitoring Performance in Quality and Equity*



Joseph R. Betancourt, M.D., M.P.H.

Director, The Disparities Solutions Center

Senior Scientist, Mongan Institute for Health Policy

Director for Multicultural Education, Massachusetts General Hospital

Associate Professor of Medicine, Harvard Medical School



# Outline

- ◆ High-Value, Transformation and Equity
- ◆ History of the Massachusetts General Hospital's (MGH) Disparities Dashboard
- ◆ Where to Start and Lessons Learned at MGH
- ◆ The Disparities Leadership Program
- ◆ Monitoring and Reporting at CHE Trinity Health

# High-Value in A Time of Healthcare Transformation

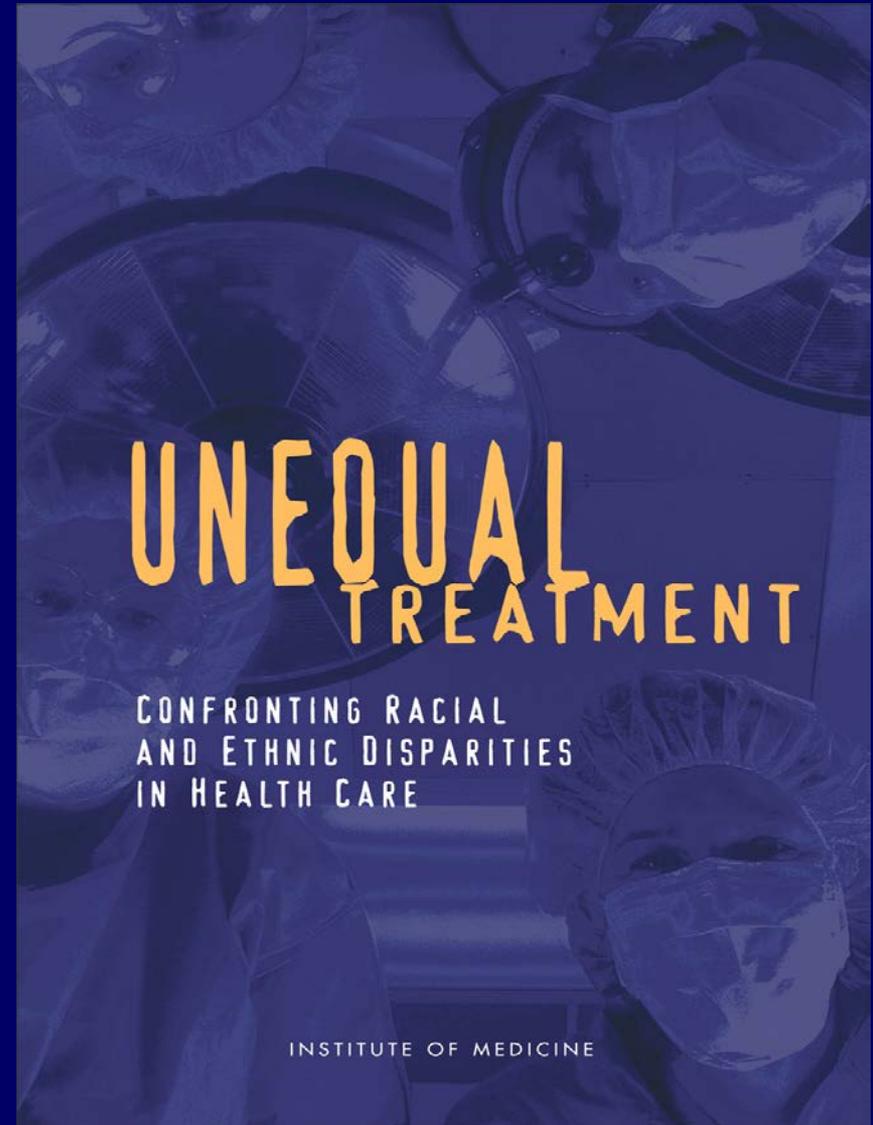
Value-based purchasing and health care reform will alter the way health care is delivered and financed; *quality* not quantity...

- ◆ 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

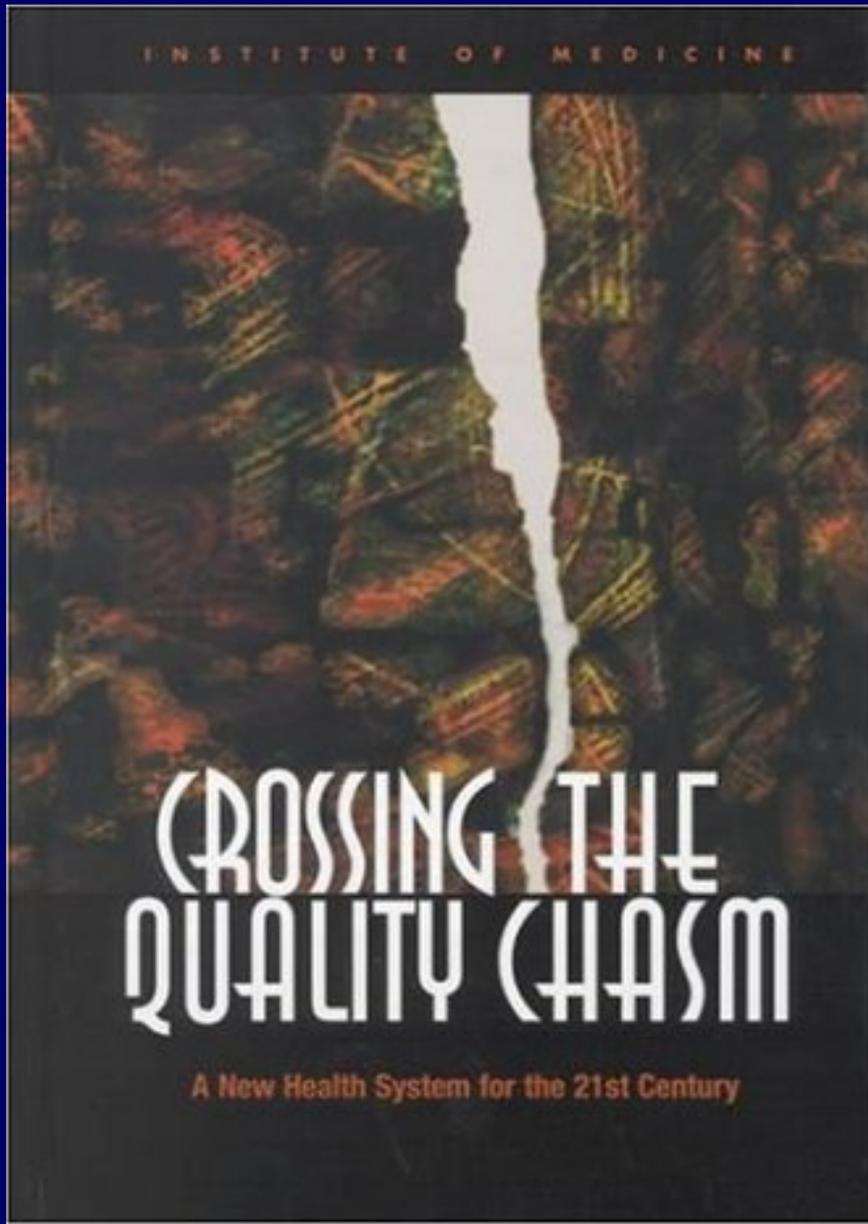
## Disparities in Health Care 2002

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*



# 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*

## 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

# MGH Equity and Disparities

## *Disparities Committee 2003*

### Underlying Principle

- ◆ While data specific to disparities at MGH important, not necessary to begin to take action given IOM Report documented issue nationally

### Charge

- ◆ **Identify** and **address** disparities in health and health care wherever they may exist at MGH
  - Subcommittees: Quality, Patient Experience, Education/Awareness
  - Present plan and results to Board, Executive Council and hospital leadership re

### Build on Strong Foundation

- ◆ Diversity/Recruitment/Retention/Promotion at all levels, including Governance, Leadership, Physicians, Nursing, HR, GME
- ◆ Fortify efforts in racial/ethnic data collection, add new elements

*Association of American Medical Colleges Learning Challenge Award, 2013*

*American Hospital Association Equity of Care Award, 2014*

# Initial Disparities Dashboard

- ◆ Welcome and Purpose
  - Definition of Disparities
    - ◆ Focus on disparities in care
  - Purpose of Dashboard
    - ◆ Annual Report
    - ◆ Embedded into Q and S Reporting
  - Data and Measurement
    - ◆ How race/ethnicity data collected
      - Process, categories
    - ◆ Data Sources
      - IDX, PATCOM, TSI, H-CAHPS survey data, medical record review (Core/NHQM)
- ◆ Snapshot of diversity of MGH patients
  - Who they are and where they are seen

# Initial Disparities Dashboard

## ◆ Measures

- Clinical quality indicators
  - ◆ Inpatient: National Hospital Core Measures
    - AMI, CHF, CAP, SCIP
  - ◆ Outpatient: HEDIS Measures
    - Mammogram, Pap, CRC Screening
    - Diabetes, Coronary Artery Disease
- Physician, Practice Linkage
- Patient Experiences with Care
  - ◆ Press-Ganey Inpatient satisfaction by r/e
  - ◆ Results of Quality Rounds
  - ◆ Results of Minority Survey
- Communication with LEP patients

# Disparities Dashboard Evolution

- ◆ H-CAHPS stratified by race/ethnicity
- ◆ All-cause and ACS Admission by race/ethnicity
- ◆ CHF Readmissions by race/ethnicity
- ◆ Sentinel Measures
  - Pain Management in the ED
- ◆ New Measures
  - Pediatric Asthma Treatment
  - OB Measures (GrB Strep)
- ◆ Greater focus on disparities by LEP
  - Outline of new initiatives including interpreter rounds, quality and safety rounds, and patient safety training (interpreters, providers)
- ◆ *Now: Annual Report on Equity and Healthcare Quality*

# MGH Annual Report

## ANNUAL REPORT ON EQUITY IN HEALTH CARE QUALITY 2013

### Massachusetts General Hospital Committee on Racial and Ethnic Disparities

Joseph R. Betancourt, MD, MPH

Joan Quinlan, MPA

Aswita Tan-McGrory, MBA, MSPH

Karey S. Kenst, MPH

### MGH/MGPO Center for Quality and Safety

Elizabeth A. Mort, MD, MPH

Taruna R. Banerjee, MPH

Robert J. Malin, MHA

For Internal MGH/MGPO Use Only



### Green Light: Care is equitable

- ◆ National Hospital Quality Measures
- ◆ HEDIS Outpatient Measures (MGH)
- ◆ Pain Mgmt in the ED

### Yellow Light: Areas being explored

- ◆ Mental Health, Renal Transplantation
- ◆ All cause and ACS Admissions (so far no disparities)
- ◆ CHF Readmissions (so far no disparities)
- ◆ Patient Experience (H-CAHPS shows subgroup variation)
- ◆ Pediatrics (Asthma), Ob (GrB Strep)

### Red Light: Disparities, Action Taken

- ◆ Diabetes at CHC's
  - Chelsea (Latino), Revere (Cambodian) Diabetes Project
- ◆ Colonoscopy screening rates
  - Chelsea CRC Navigator Program



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- » [Delivering the Right Care](#)
- » [Keeping Patients Safe](#)
- » [Listening to Patients](#)
- » [Providing Equitable Care](#)

**Key:**

- Equal care by race
- Unequal care by race
- Not applicable
- Click on this icon to read an Improvement Story related to this measure

[Home](#) > [Performance Reports](#) > [Providing Equitable Care](#)

Text Size: [A](#) | [A](#) | [A](#)

## Providing Equitable Care

At MGH, we are committed to making sure that all patients, regardless of race, ethnicity, and primary language spoken, receive proper care. When we looked at rates of compliance with guidelines for heart attack, heart failure and pneumonia, we found no statistical differences in compliance rates by race at MGH for these populations of patients. The population we serve at MGH is reflective of the population of the state of Massachusetts. [Read about one of MGH's programs to ensure equal healthcare for all.](#)

Higher values are better performance

Measures	Comparison Group		Equity of Care
	Race: White	Race: Non-white	
<b>Heart Attack</b>			
Aspirin at Arrival	99%	100%	
Aspirin at Discharge	100%	100%	
Beta Blocker at Arrival	99%	97%	
Beta Blocker at Discharge	100%	100%	
ACE-I/ARB at Discharge (AMI)	84%	83%	
Time to Primary PCI of Less Than or Equal to 90 Minutes	73%	89%	
Smoking Counseling (AMI)	94%	98%	
<b>Heart Failure</b>			
ACE-I/ARB at Discharge (HF)	82%	86%	
Discharge Instructions (HF)	63%	65%	
LVF Assessment	99%	99%	
Smoking Counseling (HF)	78%	85%	
<b>Pneumonia</b>			
Pneumovax Vaccination	60%	52%	
Oxygenation Assessment	100%	100%	
Antibiotics within 6 hours	72%	70%	
Timing of Blood Cultures	84%	82%	
Selection of Antibiotics	86%	84%	
Smoking Counseling (PN)	56%	50%	

### INSTITUTIONAL PRIORITIES CY 2009

National Hospital Quality Measures

Select Safety Metrics

Healthcare Associated Infections

Safety Reporting

Patient Experience

High Performance Medicine

Pay for Performance

Efficiency & Throughput

Other Reports

Partners Quality Dashboard

**Disparities Dashboard**

[Home](#) > [Improvement Stories](#) > [Story Detail](#)

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## Improvement Stories

### Ensuring Equal Healthcare for All: Chelsea Diabetes Disparities Program working to reduce differences in care

Why do disparities in diabetes care matter?

Robust scientific research has demonstrated that diabetes disproportionately affects minorities in the United States. Nationwide, diabetes affects 11.2% of African Americans and 9% of Latinos, compared to 7.2% of whites. Studies have also shown that Latinos are 33% less likely than whites to receive standard care for diabetes, including blood pressure and cholesterol control. In a study at the MGH Chelsea Health Care Center, which serves the hospital's largest Latino community, about one-third of Latino diabetics had not had their HbA1c level—a measure of blood sugar control—tested in the last nine months. Moreover nearly twice as many Spanish-speaking Latinos (41%) had poor diabetes control, compared to English-speaking whites (23%).

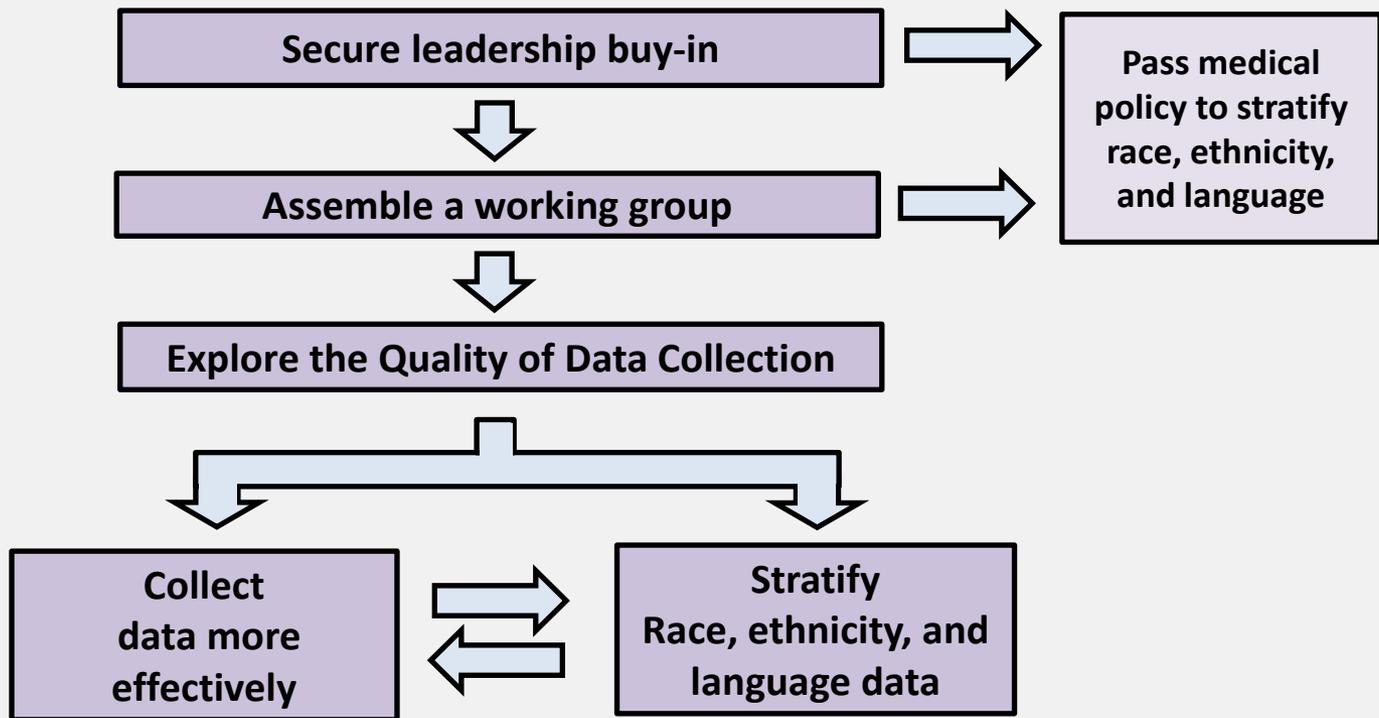


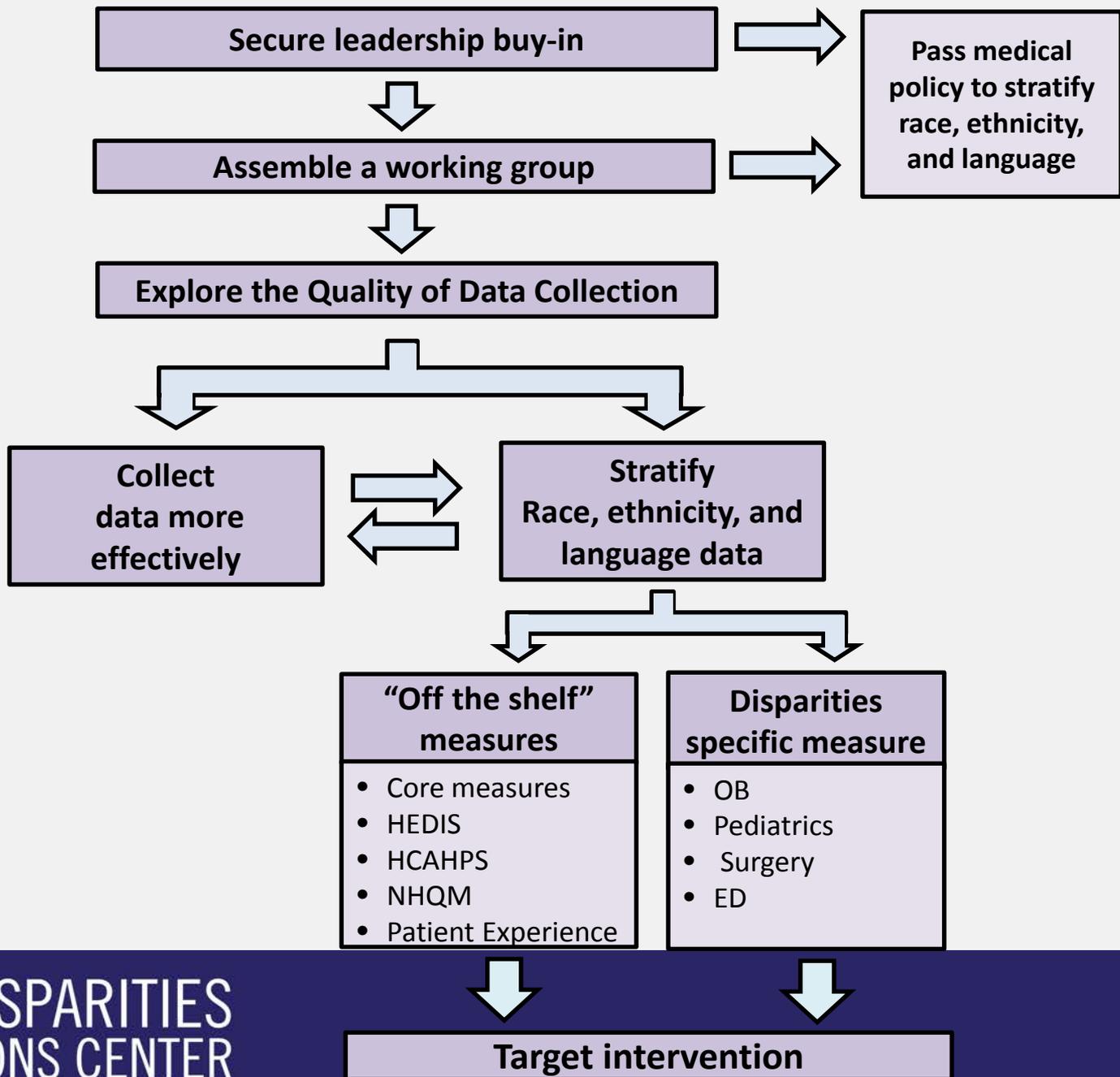
# Where Do I Start?



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# What Are Disparities Specific Measures?

- Care with high degree of discretion (pain management)
- Communication sensitive services (discharge instructions)
- Social determinant-dependent measures (SES, education, environment as barriers to self-management of CHF or Diabetes)
- Outcome and communication-sensitive process measures (flu shot)

# Department of Pediatrics

## Pediatric Asthma Composite Measure (ages 5-17), 2012-2013

	Race		Primary Language	
	White	Other	English	Other
<b>Total flu vaccine received between Aug. 1-Dec. 31, 2012 or declined due to allergy or refusal</b>	(%) (N=)	(%) (N=)	(%) (N=)	(%) (N=)
<b>Use of appropriate medication for people with asthma</b>	(%) (N=)	(%) (N=)	(%) (N=)	(%) (N=)
<b>Total Asthma Action Plan documented in patient's medical record***</b>	(%) (N=)	(%) (N=)	(%) (N=)	(%) (N=)



# Department of Obstetrics

## MassHealth Maternity Measures

Maternity Measures	Race				Primary Language			
	White		Other		English		Other	
	N	%	N	%	N	%	N	%
<b>Intrapartum antibiotic prophylaxis for GBS</b>								
2008 Q1 – 2010 Q4								
2009 Q1 – 2011 Q4								
2010 Q1 – 2012 Q4								
2011 Q1 – 2013 Q4								
<b>Timing of antibiotic for cesarean section</b>								
2010 Q1 – 2012 Q4								
2011 Q1 – 2013 Q4								
<b>Selection of antibiotic for cesarean section</b>								
2010 Q1 – 2012 Q4								
2011 Q1 – 2013 Q4								
<b>Elective Delivery <math>\geq</math> 37 and &lt;39 Weeks Delivery</b>								
2011Q3 – 2013 Q4								

# A Brief Word About Interventions

- Consider your resources and capacity when developing your dashboard
- Data will drive interventions and inform leadership
- The low-hanging fruit versus the ideal intervention
- Ownership is key - ideally these would be deployed by your Quality and Safety department, or by a specific department (OB, peds)

# Lessons Learned

- **Assume disparities exist**, the dashboard will monitor and allow for action
- **Engage key stakeholders** early on and continue during the process
- **Clinicians are key** in interpreting data and determining if you are looking at the right source/denominator
- Don't underestimate **the role of your EHR**

# Lessons Learned

- **It's complicated** - Examining disparities-specific measures at the department level is a more complex process than stratifying existing, “off the shelf” measures (HEDIS, NHQM, H-CAHPS)
- **It's an iterative process** to develop the measure and to define the population
- **Transparency is key** – leverage reporting back to C-suite, department chairs, or specific departments involved in getting the data (admitting) and include a brief overview of disparities for your audience

# Future Areas to Explore

- Disability
- Collecting data on social determinants of health (health literacy, food insecurity, homelessness etc.)
- Pediatric Health Equity Collaborative
- Understanding the perspective of patients, health care providers & registrars on collecting sexual orientation & gender identity in a hospital setting

# Resources

- NQF Healthcare Disparities Measurement  
[http://www2.massgeneral.org/disparitiessolutions/z\\_files/Disparities%20Commissioned%20Paper.pdf](http://www2.massgeneral.org/disparitiessolutions/z_files/Disparities%20Commissioned%20Paper.pdf)
- AHRQ's National Healthcare Disparities and Quality Report  
<http://www.ahrq.gov/research/findings/nhqrdr/nhdr13/2013nhdr.pdf>

# Disparities Leadership Program Goals

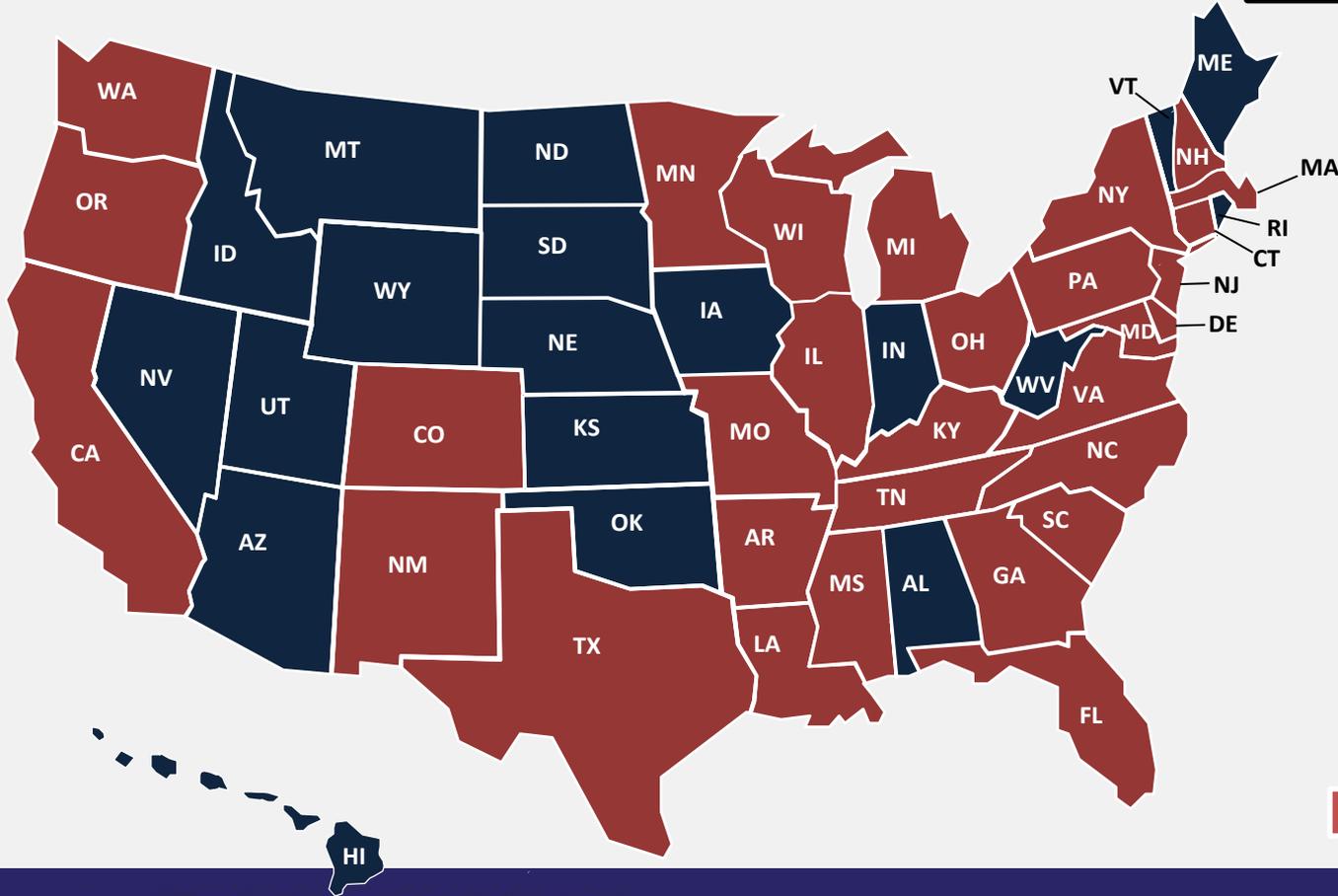
- Develop cadre of leaders in health care equipped with:
  - Knowledge of disparities, root causes, research-to-date
  - Cutting-edge QI strat's for identifying/addressing disparities
  - Leadership skills to implement and transform organizations
- Assist individuals and organizations to:
  - Create 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
- Presented by faculty with extensive experience:
  - Health Plan, Hospitals, Health Centers, Public Health, Private Sector
  - Real-world expertise and implementation
- Alumni network for sharing and expedited learning

# DLP Organizations

30 states

Commonwealth of Puerto Rico

Canada, Switzerland



 **DLP Participants**



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TRINITY  HEALTH  
Livonia, Michigan

 CATHOLIC HEALTH EAST

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# CHE TH Data Philosophy and Approaches

**Laura Archbold**  
**Shannon Porenta**



# CHE TH Plan alignment with 2009 IOM Report on REaL Data



REaL = Race, Ethnicity and Language

# Which clinical cohort? Rationale? Metric?

## Maternal

- Female
- Age range narrowed
- Specific condition
- Probabilities of comorbidities in population – smaller
- Evidence based confounders around metric – less complex

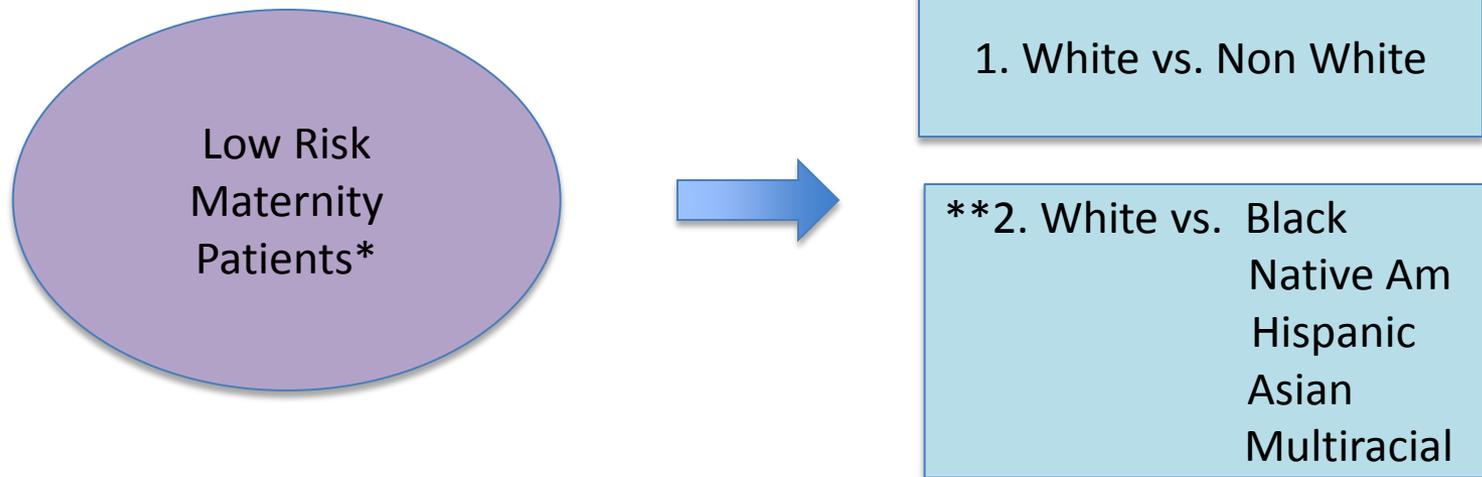
## Sepsis

- Male and female
- Age range wide
- Variable conditions
- Probabilities of comorbidities in population - larger
- Evidence based confounders around metric – more complex



# Cesarean Section Rates: System Level Analysis

1: Determine if the risk of C-section among low risk deliveries is different for non-whites compared to whites at the CHE Trinity Health system level.



\*Low Risk = full term, singleton pregnancy, and vertex presentation

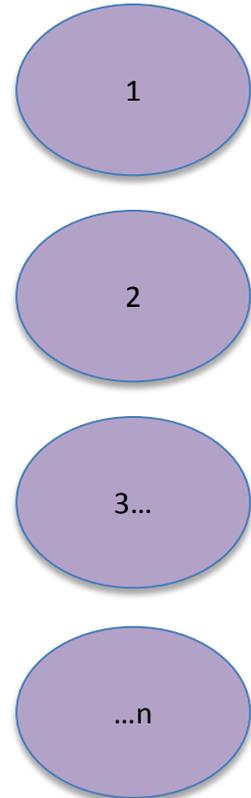
(Defined by HP 2020 (MICH-7.1 and MICH7.2)

\*\*OMB defined race categories

# Cesarean Section Rates: Hospital Level Analysis

2: Determine if the risk of C-section is different for non-whites compared to whites at the hospital level.

## Individual Hospitals

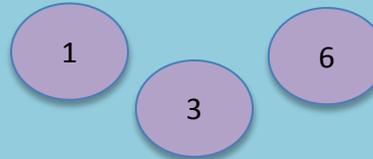


- %Black
- %Hispanic
- %Asian
- %Native Am
- %Multiracial

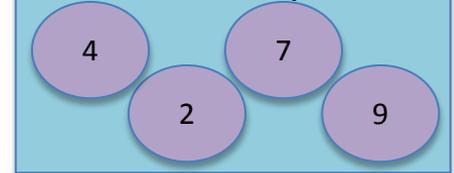
1. Determine % of each race at each hospital.
2. Rank and identify hospitals in the top quartile of non-white race.
3. Define cohorts of hospitals for analysis.



### White vs. Black



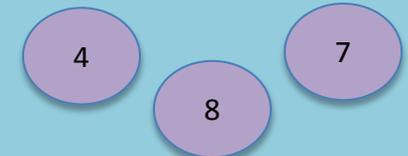
### White vs. Hispanic



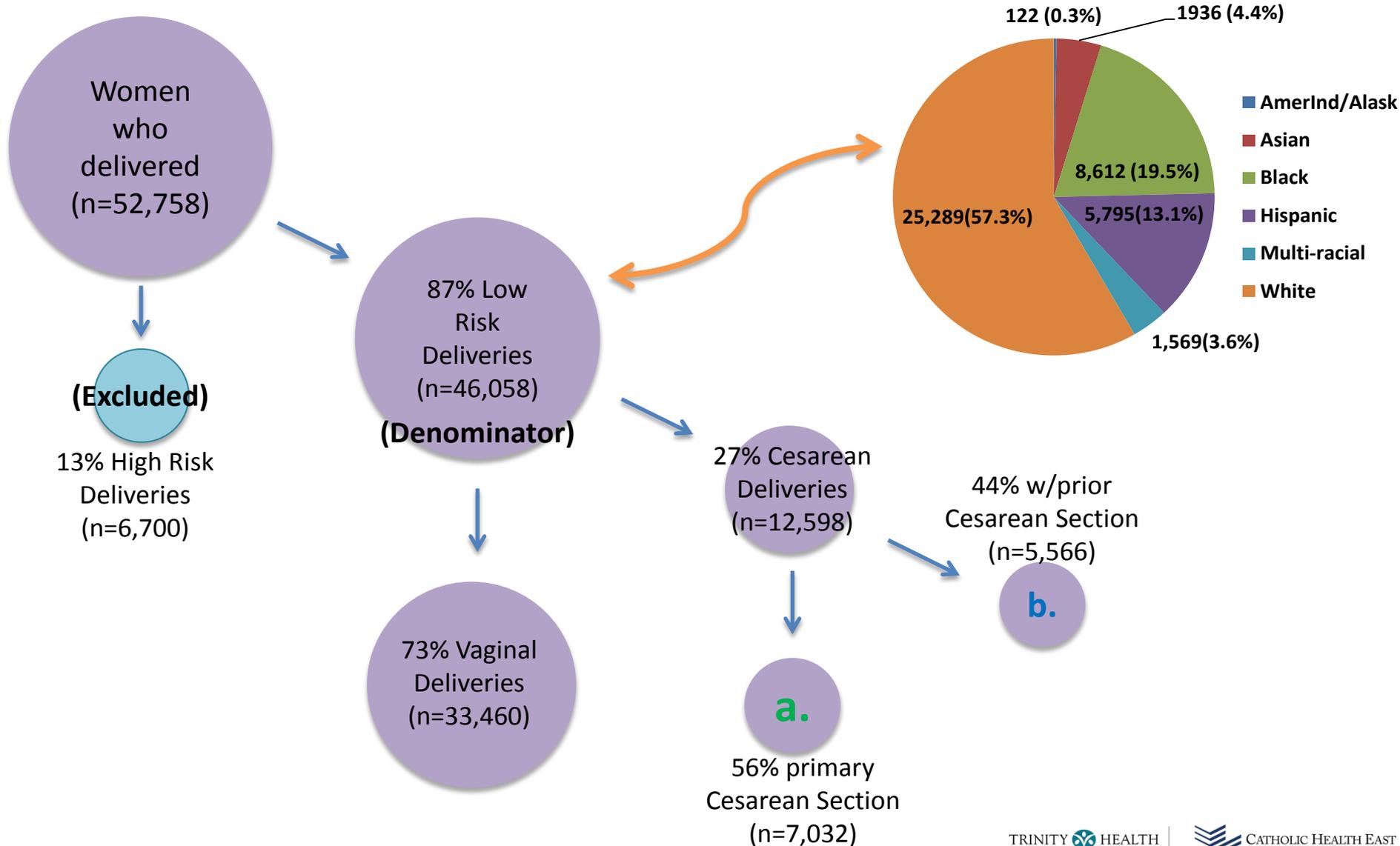
### White vs. Asian



### White vs. Multi-racial



# Cesarean Section Rates (CY 2013) Population



# Proportion of C-Sections within each race

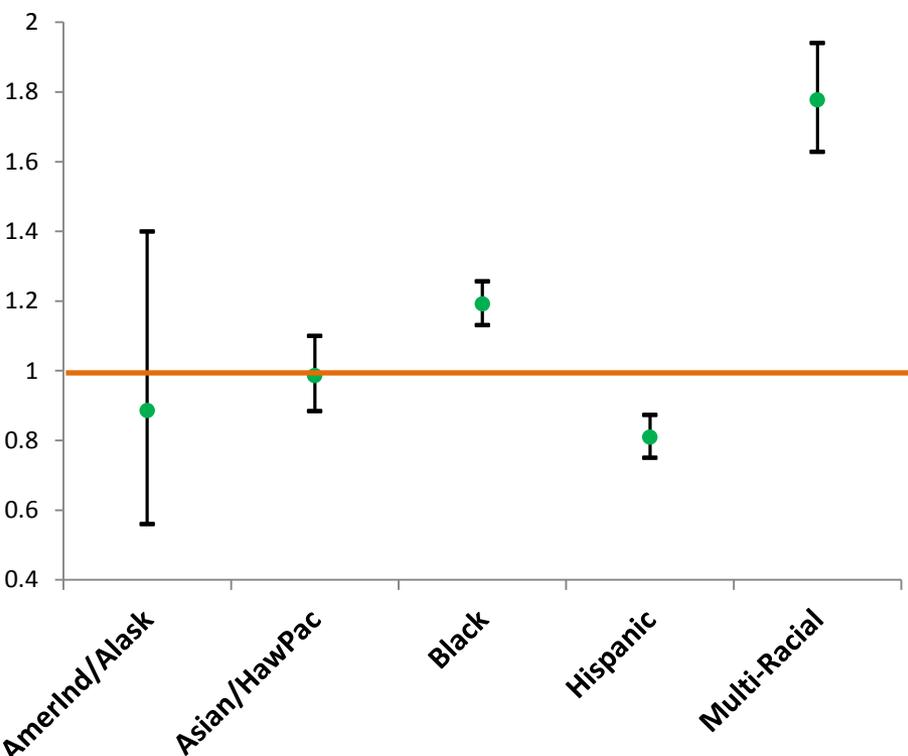
	Primary C-section	Prior C-Section
<b>AmerInd/Alask</b>	16 (13.1%)	13 (10.7%)
<b>Asian</b>	297 (15.3%)	234 (12.1%)
<b>Black</b>	1,646 (19.1%)	1,196 (13.9%)
<b>Hispanic</b>	700 (12.1%)	859 (14.8%)
<b>Multi</b>	413 (26.3%)	113 (7.2%)
<b>White</b>	3,828 (15.1%)	3,057 (12.1%)

# 1. System Level Analysis

a.

Relative Risk of having a primary C-section Delivery by Race/Ethnicity

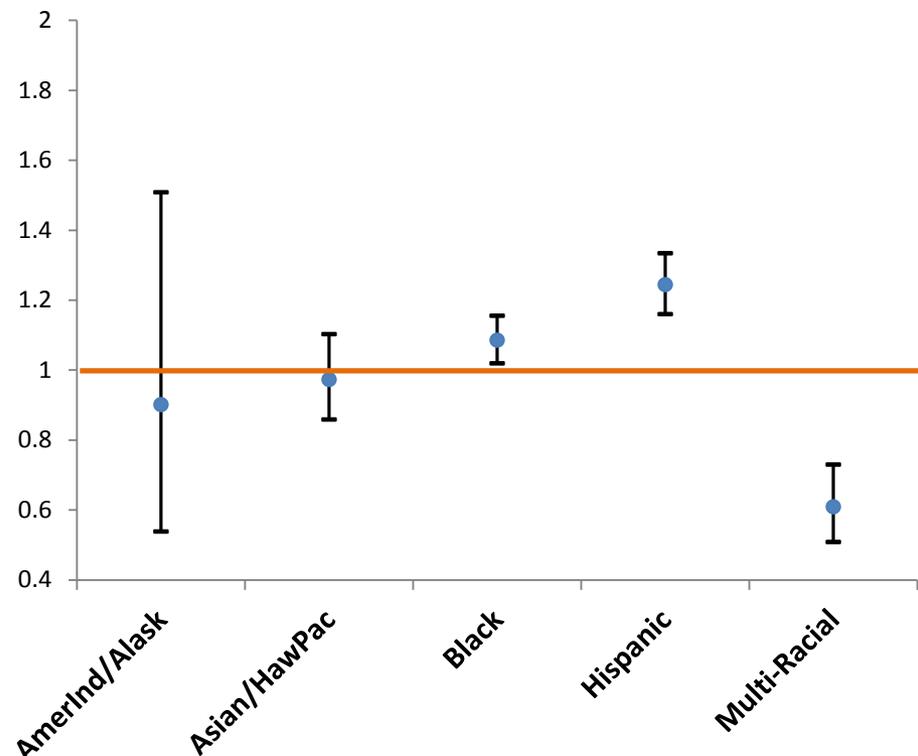
(Reference = White)



b.

Relative Risk of having a C-section Delivery with a prior C-section by Race/Ethnicity

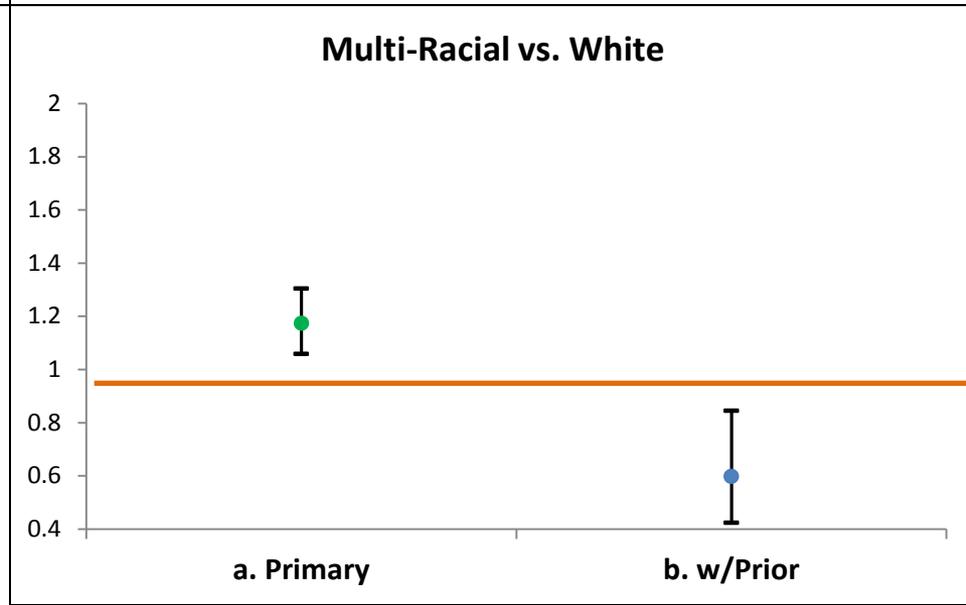
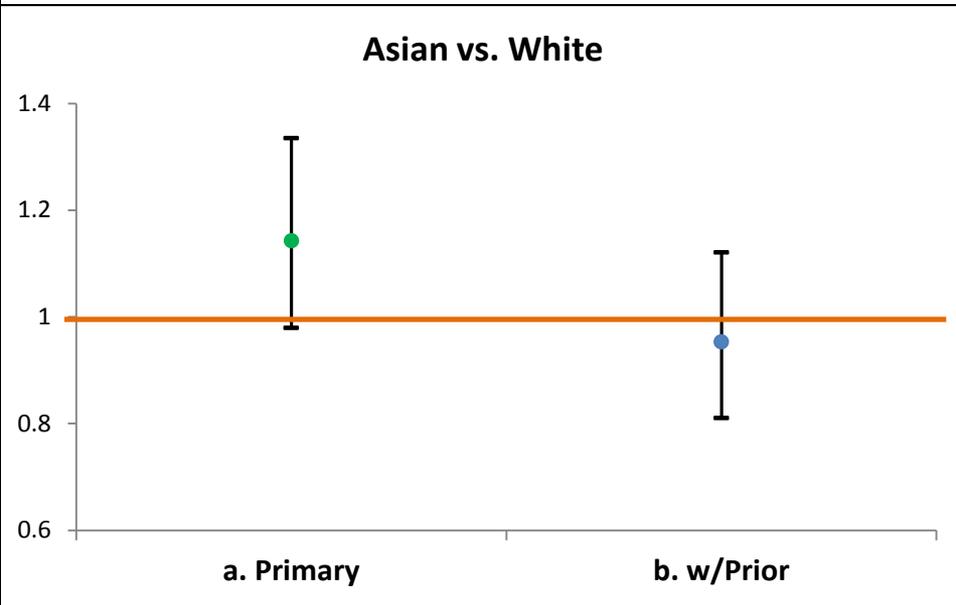
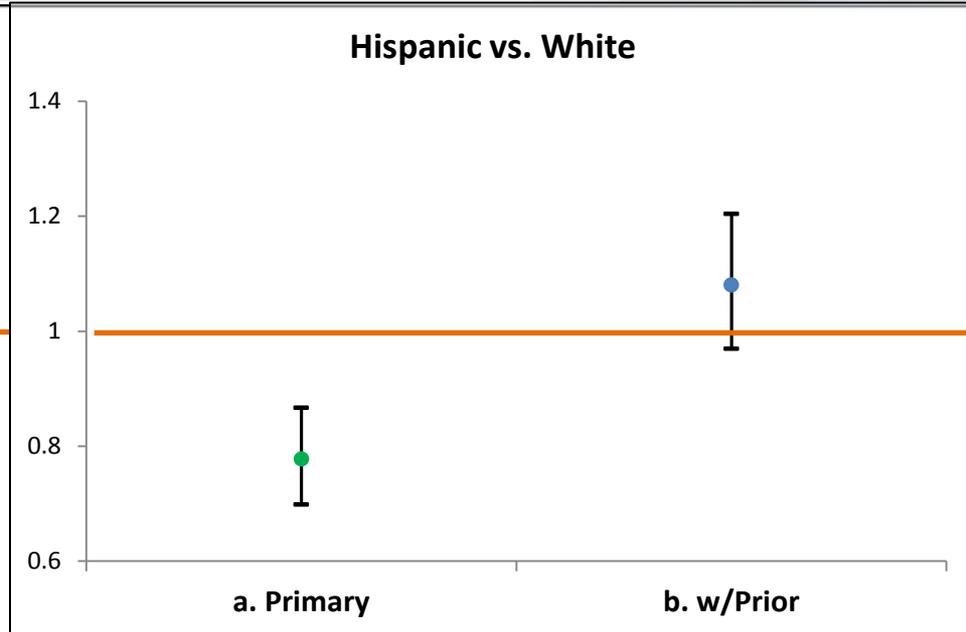
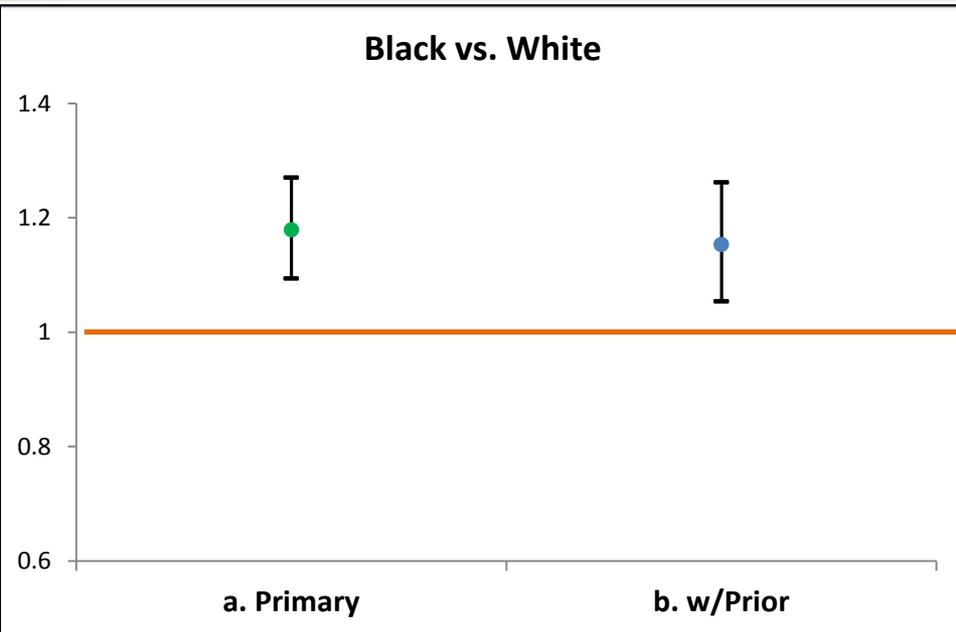
(Reference = White)



Among low risk deliveries, significant disparities in the rates of cesarean sections are seen in Blacks, Hispanics, and Multi-Racial patients compared to White patients.

- Above reference line = ↑ increased risk
- Below reference line = ↓ decreased risk
- Crosses reference line = no significant difference in risk

# 2. Race Cohort Analysis



# Next Steps - Data

## Current Analysis within cohorts naturally leads to...

- Questions of which hospitals are in the cohort?
- Conclusions that each hospital has same magnitude, and direction of disparity if they are in the analysis cohort (not always true)

## Solution: Deeper Dive....

- Analysis to assess disparities within each hospital
- Multilevel model: helps to account for lack of power, and probable clustering effect of hospitals within the CHE Trinity Health System

# CHE TH Approach to resolving Disparities

## Specific Problem

1. Identify clinical initiative
2. Analyze data
3. Identify potential disparity
4. Inform leadership
5. Investigate locally – what is/are root cause(s)?
6. Design solution collaboratively
7. Implement

## Overall Program

1. Intentional strategic alignment
2. System Office/Local Departments aligned
  1. Community Benefit Ministry
  2. Diversity and Inclusion
  3. Mission
  4. Unified Clinical Organization
3. Equity Council
4. Dashboard – future looking

# Appendix: Accountability Plan

## System level action:

### *Unified Clinical Organization*

- Analyze populations to manage health equity
- Analyze clinical improvement initiatives against REaL and any appropriate data; design clinical interventions to mitigate any noted disparities, inclusive of collaborative interventions
- Communicate findings to System Office Leadership/CEOs/Clinically Integrated Networks
- Monitor disparities data at system level

### *Diversity and Inclusion*

- Develop resources, i.e., cultural competency tools, education regarding cultural bias, to support improvements
- Identify, design, and develop resources that would support the RHM specific needs

### *Community Benefit Ministry*

- Develop systematic and replicable programs to improve social determinants of care

### *Mission*

- Develop systematic and replicable programs to address spiritual needs in the community

### *Equity Council*

- Promote inclusion into strategic work of organization
- Visibility for equity, disparities resolution, and lessons learned
- Dashboard

## Local level action:

Partner with System Office to achieve Clinical Quality and Patient Safety goals

Identify root cause(s) for disparities: social determinants, access, healthcare bias

- Clinical Issues
  - Resource work through existing clinical collaboratives
  - Implement clinical interventions identified
- Social Determinants
  - Partner with community resources within Clinically Integrated Networks to address social determinants
  - Partner with community resources to promote disparities education
- Mission
  - Partner with local clergy/churches to support spiritual and clinical wellness
- Diversity and Inclusion
  - Provide education regarding root causes of disparities
  - Coordinate work via existing Equity teams
- Communicate/resource work through existing Clinically Integrated Networks
- Utilize site Process Excellence practitioners

Share resolution plan with System Office Equity Council and other RHMs/Clinically Integrated Networks

# Symposium for Leaders in Healthcare Quality

**MISSION:** SLHQ is a community of health care professionals whose work is focused on performance improvement in support of the Institute for Medicine (IOM) aims of providing care that is safe, timely, effective, efficient, equitable and patient centered.

## MEMBER BENEFITS:

### Education

- Online resource library
- Bi-monthly webinars
- Regular updates on the latest advances in quality and patient safety via LISTSERV, Twitter, website updates, SLHQ News Now

### Professional Development

- Annual meeting: Quality & Patient Safety Roadmap
- Discount to HF/AHA Leadership Summit
- Discount to Health Forum Rural Conference

### Collaboration

- Best practice exchange through LISTSERVs and social media
- Searchable member directory
- Networking events at quality and patient safety conferences across the country

# Learn More

## Upcoming Webinar for SLHQ Members:

Integrating Equity and Quality: Implementing Improvement Projects to Address Health Care Disparities

November 4, 2014 | 11:00 – 12:00 AM CT

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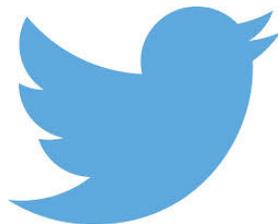
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