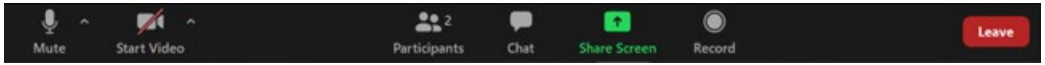
Health Equity Now! Workgroup, Session 4

Tuesday, May 23, 2023

Introduction

Temi Olafunmiloye, BS

Manager, Health Equity



a. To ask questions, click on the **Chat** icon. At the end of the presentation, you will also be able to unmute to ask a question verbally.

b. You may adjust your audio by clicking the caret next to the **Mute** icon.

c. Resources from today's session will be shared after the call.

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Welcome to Learning Session 4!

Session 4 Objectives:

- Addressing disparities in readmissions
  - Assessing the landscape by collecting critical data
  - Learning to identify root causes & promote early intervention

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Sessions will be held at 12pm EST on these dates:

Learning Sessions	February 21	March 21	April 18	May 23	June 20	July 18
HEH Sessions	March 7	April 4	May 2	June 6	June 27	August 1

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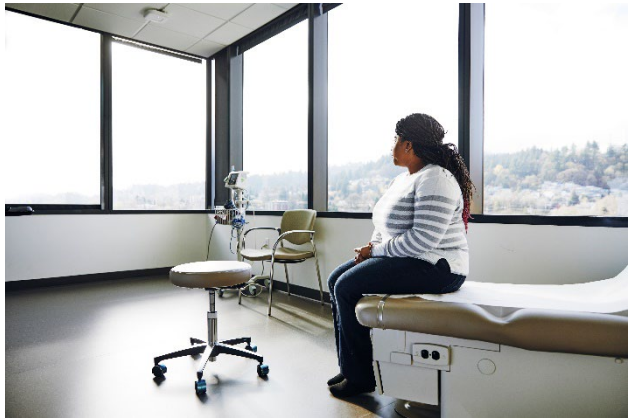
Disparities in Readmissions

- Black patients have higher readmissions rate in comparison to white patients for CHF, AMI, Pneumonia, COPD, and THA/TKA[1]
    - Black patients and Asian patients experienced higher rates of 7-day readmission than patients who identified as white[2]
- Hospitals with higher proportions of Black patients have higher readmission rates[1]
- Non-English-speaking patients have a higher odds of readmissions, with Latino and Chinese patients experiencing the highest risk[3]

Factors Affecting Readmissions

- Race/ethnicity is a factor associated with 30-day readmissions, with Black patients having a significant association[4]
- Patients in high-poverty neighborhoods are 24% more likely to be readmitted[5]
- Social support is also considered a factor, with married patients at reduced risk of readmission than unmarried patients[5]



Importance of Focus

- **Reducing Avoidable Costs**: Hospitalizations account for almost one-third of the total $2 trillion spent on health care. A substantial portion of these are rehospitalizations soon after the patient's previous stay. These are costly, potentially harmful, and often avoidable
- **Reducing Harm**: marginalized populations are more at risk for harm

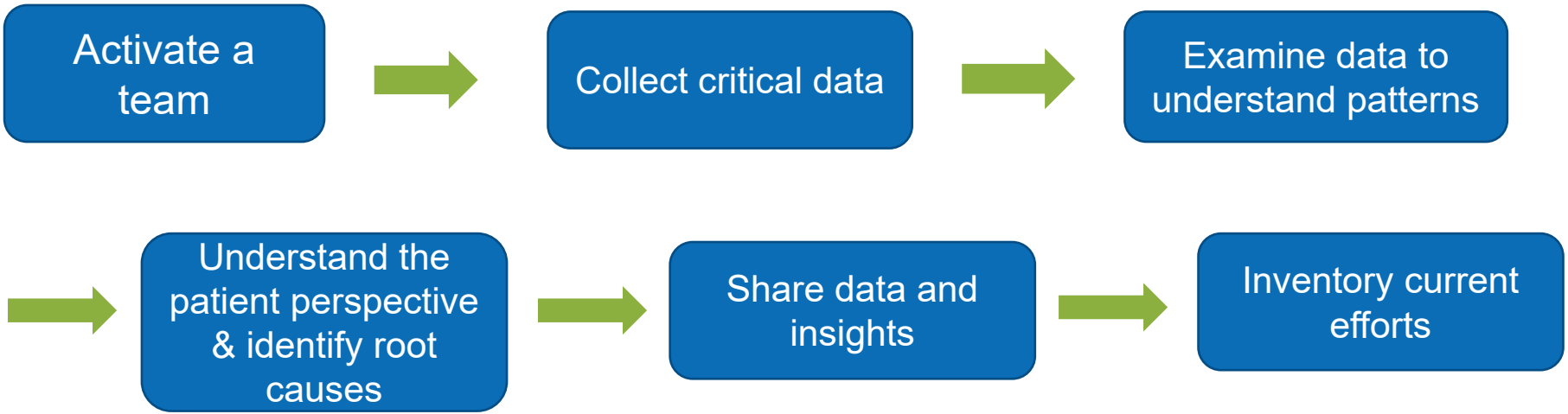
Poll Question

Are you currently aware of disparities in readmissions at your organization? Please select all that apply.

a) Yes, disparities in race/ethnicity
b) Yes, disparities in gender
c) Yes, disparities among dual-eligibles
d) Yes, disparities in disability
e) No, not to my knowledge

Disparities in Readmissions

Framework for Getting Started



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Activating a Team

- Success requires a multidisciplinary team with clear leadership and roles
- Focus will be on the redesign of care transitions and/or assuring best practices are for transition processes
- Teams may include quality and safety leaders, doctors, nurses, social workers, and professional medical interpreters
    - May also include mental health providers, substance abuse services, CHWs, and navigators

Disparities in Readmissions

Collecting Critical Data

- Collecting data on:
  - Who is readmitted;
  - For what condition;
  - From what location;
  - Due to what factors;
  - And at what cost
- Data types:
  - Race/ethnicity
  - Language
  - Education
  - Social Drivers of Health
  - Disability
  - Linkage to Primary Care/Usual Source of Care

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Disparities in Readmissions

Collecting Critical Data

- Information can be gathered through:
  - Registration and used to do predictive modeling
  - Chart review
  - Focus groups
  - Structured interviews
  - Multicultural advisory boards and/or patient/family councils

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Disparities in Readmissions

Examine the Data

- Aim to understand current readmission patterns and pathways for action
- What demographic groups are experiencing the highest readmissions?
- What are the top discharge diagnoses leading to the most readmissions? What is surprising?
- Does it make sense to focus on a limited set of discharge diagnoses? Why or why not?

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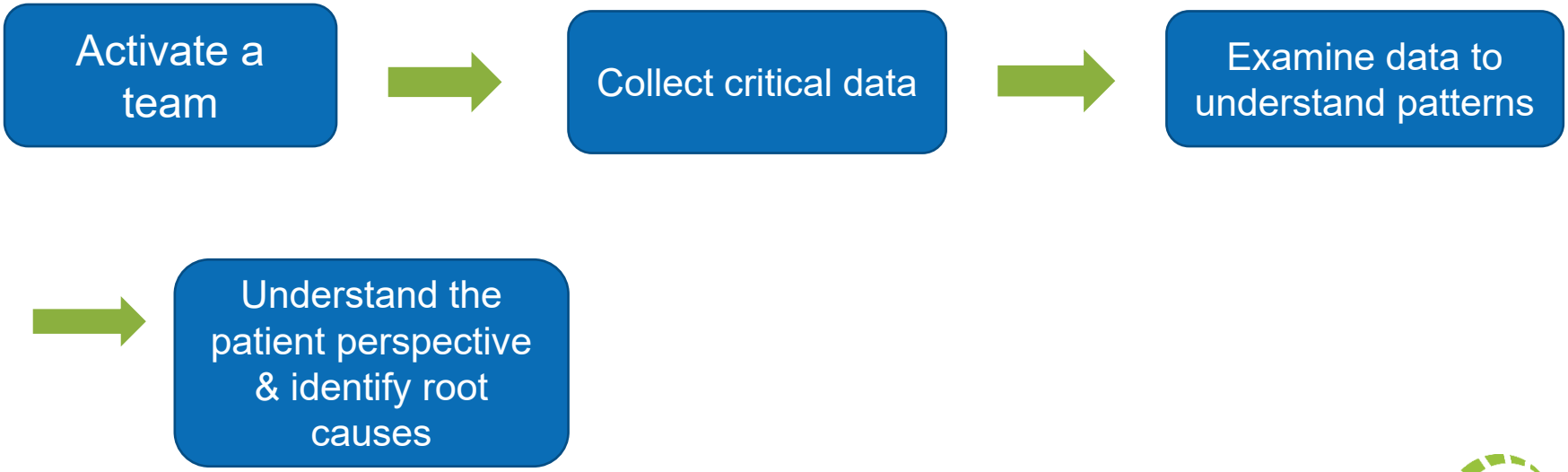
Disparities in Readmissions

Framework for Getting Started



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Disparities in Readmissions

Readmissions Review

1. Identify patients in the hospital who have been readmitted
2. Ask the patients/caregivers if they are willing to have a 5- to 10-minute discussion about their recent hospitalizations
3. Capture patient/caregiver responses
4. Analyze responses for new insight regarding “why” patients returned to the hospital soon after being discharged

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Readmissions Interview

1. Why were you hospitalized earlier this month?
2. When you left the hospital:
    1. How did you feel? Where did you go?
    2. Were you able to get your medications?
    3. Did you need help taking care of yourself?
3. Tell me about the time between the day you left the hospital and the day you returned:
    1. When did you start not feeling well?
    2. Did you call anyone?
    3. Did you try and manage symptoms yourself
4. Is there anything we could have done to help you after your first admission?

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Disparities in Readmissions

Readmissions Interview Example

Patient Description	Readmission Interview Findings
24-year-old, dual-eligible female with HIV/AIDS, hospitalized 8 times and visited the ER twice in the last year. First hospitalized for pneumonia; readmitted 8 days later for pneumonia.	When asked how the hospital can help her and others prepare to leave the hospital, she said, "Make all appointments before I leave the hospital." **Key finding: Needed assistance navigating the health care system.**
46-year-old Spanish-speaking-only female on Medicaid with breast cancer. Hospitalized 6 times and visited the ER 3 times in the past year.	Patient received instruction in English, and her 12-year-old daughter was asked to translate. Patient had poor understanding of prescription instructions. **Key finding: No use of interpreter services; lack of teach-back to confirm understanding and clarify.**

Disparities in Readmissions

Identifying Root Causes

- Determine patients, populations, and characteristics that are linked to readmissions
- Systems innovations and improvement become the natural outgrowth of a strong radar that picks up clear root causes.

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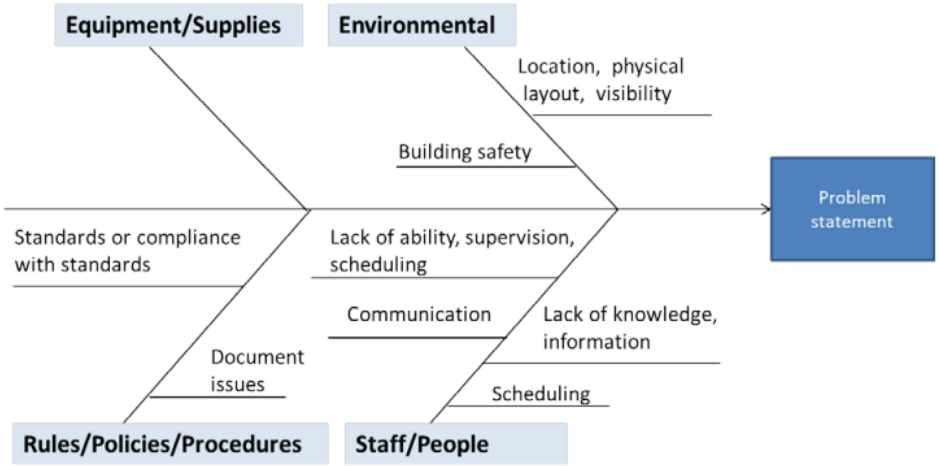
Disparities in Readmissions

Root Cause Analysis

- Assists in identifying underlying factors or causes of an adverse event
- Fishbone diagrams help in brainstorming possible causes of a problem and sorting ideas into useful categories



How to Use the Fishbone Tool for Root Cause Analysis | cms.gov

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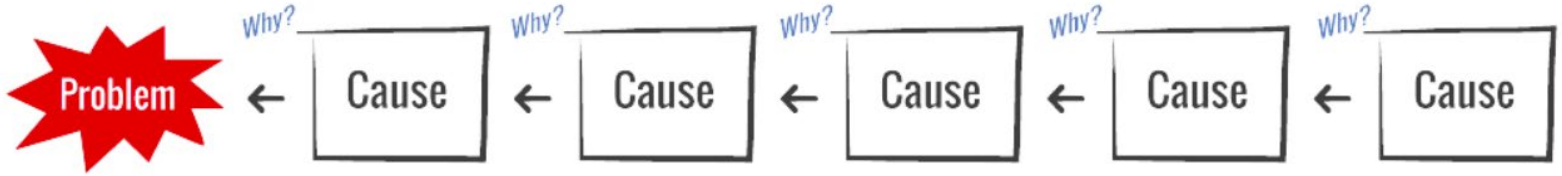
Disparities in Readmissions

Cause Mapping

- Connects individual cause-and-effect relationships to reveal the system of causes within an issue, can be basic or very detailed depending on the issue



Cause Mapping® Method | ThinkReliability, Root Cause Analysis

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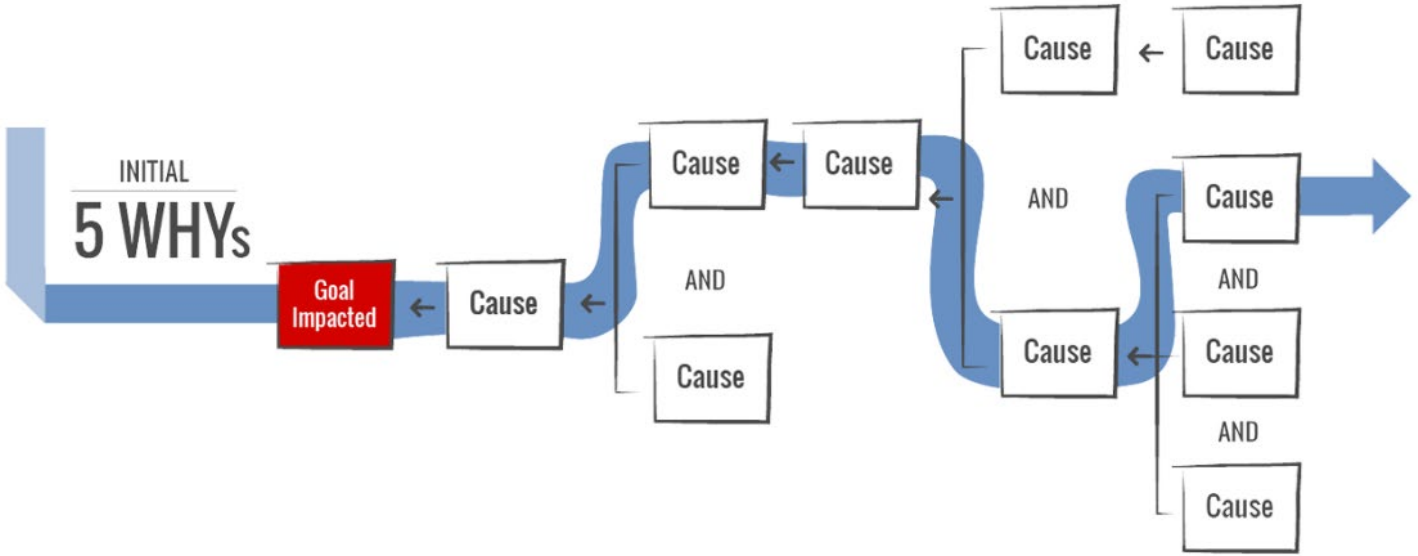
Disparities in Readmissions

Cause Mapping



Cause Mapping® Method | ThinkReliability, Root Cause Analysis

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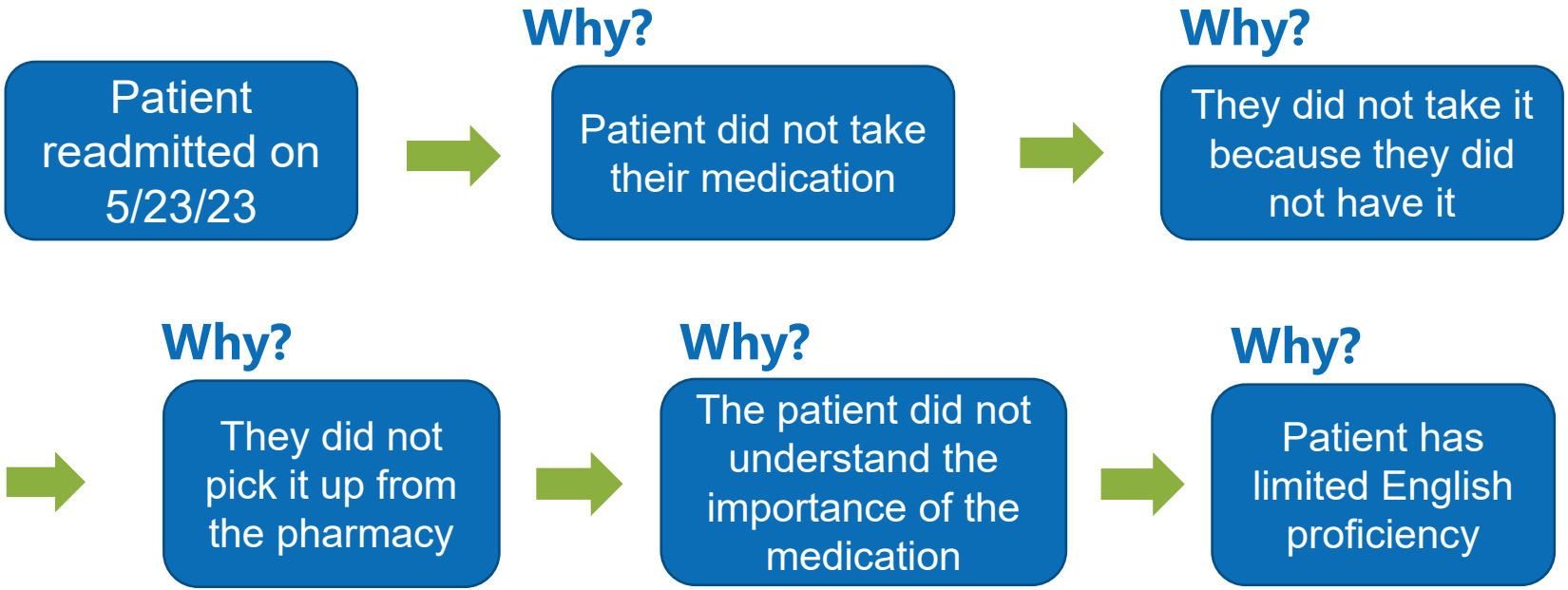
Root Cause Analysis



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Disparities in Readmissions

Identifying Root Causes

- **Discharge and care transitions**: less likely to follow up with primary care or specialist
- **Low linkage to Primary Care/Usual Source of Care**: less likely to be linked
- **Language barriers and access to interpreter services**: leads to lower rates of follow up and use of preventive services, med adherence and understanding instructions
- **Low Health Literacy**: leads to limited knowledge, non-adherence, poor management of meds

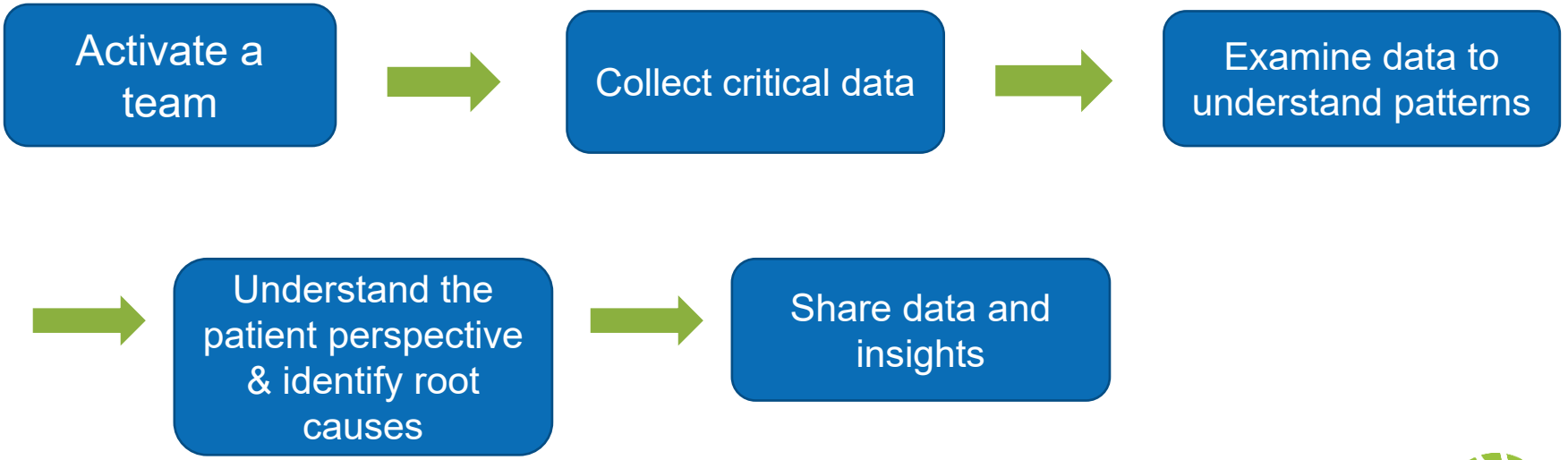
Disparities in Readmissions

Identifying Root Causes

- **Lack of culturally competent patient education**: cultural beliefs influence health behaviors, perceptions of care and interpretation of med info/advice
- **Social Drivers of Health**: socioeconomic, education, environment, social & community context
- **Mental Health**: disproportionally impacts minorities, impacts follow up and self-care
- **Co-Morbidities**: minorities have multiple co-morbidities, need for treating full spectrum

Disparities in Readmissions

6-Step Framework



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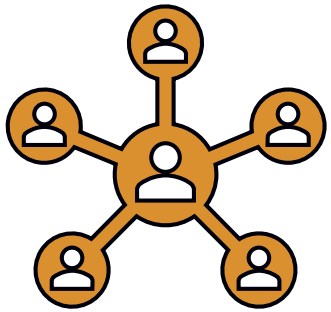
Share Data and Insights

- Ensure that data is shared with leaders, clinicians, staff, and stakeholders
  - Executive team
  - Quality department
  - Hospital medicine/internal medicine
  - Emergency medicine
  - Psychiatry
  - Nursing
  - Case management
  - Social work
  - Patient and family advisory committee



Disparities in Readmissions

Tracking Data

- To develop improvements, track and trend:
  - High utilizer status
  - Readmissions source
  - Unmet needs
  - Patient's readmissions within 7 days and/or 30 days

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Disparities in Readmissions

Tracking Data

- Automated flags if:
  - patient was discharged <30 days ago
  - if the patient has had more than three hospitalizations this year
- Manual flag (as by patient registration) for the above
- Tool-based or manual tracking of high-risk patients for 30(+) days post-discharge
- Encounter notification for when patients present to ED or are discharged from hospital

Disparities in Readmissions

Creating a Dashboard

- Outcomes for hospital-wide all-cause 30-day readmission rates
- 30-day readmission rates by race/ethnicity and gender
- Other high-risk patients (e.g., medically complex, behavioral health)
- Number and type of cross-continuum partners engaged
- Number of readmissions reviews conducted; % of all readmissions that makes up
- Number of patients receiving transitional care services; % of total

Inventory Current Efforts

- What readmissions efforts are currently happening within the hospital? (e.g., query clinical leaders, service lines, clinical departments, nursing, case management)
- Inventory disparities-specific services
- Analyze current transitional care processes
- Assess leadership commitment to reducing disparities in readmissions

Hospital Inventory Tool

Administrative Activities/Assets
☑ Specified readmission reduction aim
☑ Executive/board-level support and champion/team
☑ Readmission data analysis
☑ Monthly readmission rate tracking
☑ Readmissions case review and root cause analyses

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Hospital Inventory Tool

Health Information Technology Assets
☑ Readmission flag
☑ Automated ID of patients who are high risk
☑ Automated consults for patients who are high risk
☑ Automated notification of admission sent to primary care provider
☑ Electronic workflow prompts to support multistep transitional care

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Hospital Inventory Tool

Transitional Care Delivery
☑ Assess whole-person or other clinical readmission risk
☑ Providing culturally competent education and discharge planning
☑ Use teach-back to improve patient understanding of information
☑ Schedule follow-up appointment prior to discharge
☑ Conduct post-discharge follow-up calls

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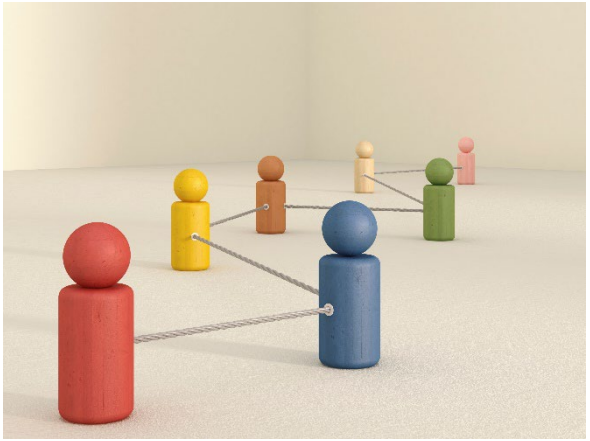
Inventory Efforts Beyond the Hospital

- Consider current partners that may be relevant to your populations
  - Community-based care management
  - Support services
  - Transitional housing



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Disparities in Readmissions

Analyze Current Discharge Processes

- Does the discharge process vary by department, service line, or floor/unit?
- Is there a lack of detailed understanding of the extent to which those actions occur consistently for all patients?
- Is “care transitions” included in the electronic health record (EHR) for tracking and analysis?
- Is any system in place for performance feedback and continual improvement?

Disparities in Readmissions

Analyze with Equity Lens

- Are any populations being left out?
- What's the process for ensuring patients have access to interpreters during discharge planning?
- How do you engage the patient and family in the discharge processes?

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Disparities in Readmissions

Building Interventions

- Develop preventative efforts that range from pre-admission to post-discharge
- Systems should aim to assess risk prior to admission and address those factors during admission
- Focus on:
    - Systemically addressing social drivers
    - Cultural competency
    - Building community partnerships

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Disparities in Readmissions

Systemically Respond to Social Drivers

- Reducing disparities in readmissions requires:
    1. Systems responsive to the needs of diverse populations and
    2. Addressing the social drivers that put them at continued risk for readmissions
- Navigators can provide support in linking patients to community resources
- Ensuring patients have social support

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Culturally Competent Communication

- Goals is for patients to understand:
  - Their diagnosis and its implications for care
  - Care choices (e.g., what requires attention)
  - Discharge instructions (e.g., what signs and symptoms trigger a return visit, when to return for follow-up, and how to take medications)
- Low health literacy, mistrust, or language barriers can influence a patient's understanding

Culturally Competent Communication

- Successful communication requires ensuring patients' understanding and ability to act on the instructions provided
- Utilize interpreters at discharge, write discharge instructions at low literacy levels and in various languages
- Train staff on team communication, interpreter use, and cultural competency

Disparities in Readmissions

Foster Community Partnerships

- Community partnerships promote the continuity of care by facilitating patients' transition back to the community
- Community partners are equipped to address non-medical factors such as behavioral, health literacy, and cultural issues
- Promote collaboration with primary care providers

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In Summary & Next Session

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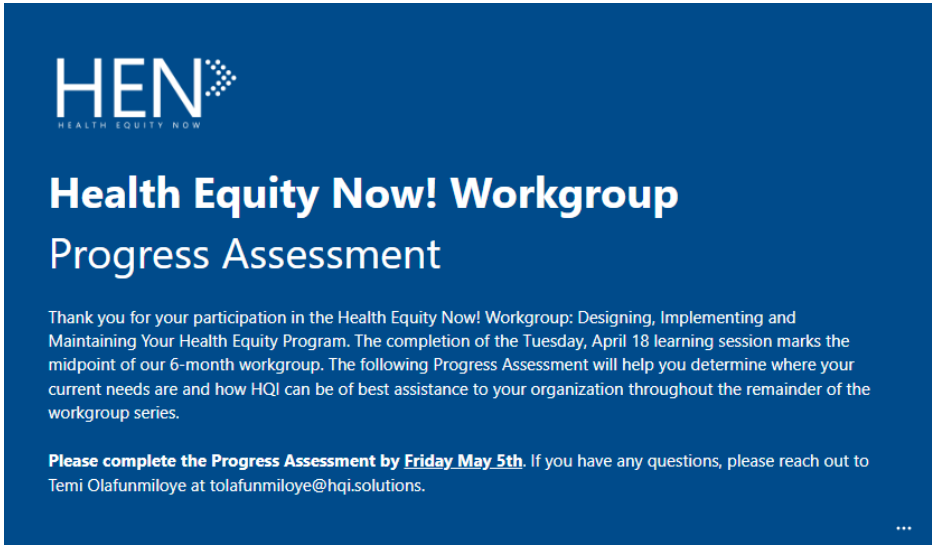
Looking Ahead

For Discussion:

- Progress Assessments
- What readmissions disparities, if any, persist at your organization?
- What tools and processes are you using for discharge planning?



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Resources

1. Guide to Disparities in Readmissions
2. Readmissions Review Tool
3. Cause Mapping Tool

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References

1. Guide to Reducing Disparities in Readmissions
2. Rambachan A, Abe-Jones Y, Fernandez A, Shahram Y. Racial Disparities in 7-Day Readmissions from an Adult Hospital Medicine Service. J Racial Ethn Health Disparities. 2022 Aug;9(4):1500-1505. doi: 10.1007/s40615-021-01088-3. Epub 2021 Jun 28. PMID: 34181237; PMCID: PMC9249686.
3. Karliner LS, Kim SE, Meltzer DO, Auerbach AD. Influence of language barriers on outcomes of hospital care for general medicine inpatients. J Hosp Med. 2010 May-Jun;5(5):276-82. doi: 10.1002/jhm.658. PMID: 20533573.
4. Allaudeen N, Vidyarthi A, Maselli J, Auerbach A. Redefining readmission risk factors for general medicine patients. J Hosp Med. 2011 Feb;6(2):54-60. doi: 10.1002/jhm.805. Epub 2010 Oct 12. PMID: 20945293.
5. Hu J, Gonsahn MD, Nerenz DR. Socioeconomic status and readmissions: evidence from an urban teaching hospital. Health Aff (Millwood). 2014 May;33(5):778-85. doi: 10.1377/hlthaff.2013.0816. PMID: 24799574.

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Recorded Sessions

Learning Session 1, February 21

- Webinar: https://youtu.be/NLVlb6vQwFs
- Slides: https://hqin.org/resource/health-equity-now-workgroup-session-1-slides/

Learning Session 2, March 21

- Webinar: https://youtu.be/OQ9kYVwnk70
- Slides: https://hqin.org/resource/health-equity-now-workgroup-session-2-slides/

Learning Session 3, April 18

- Webinar & Slides: https://hqin.org/resource/health-equity-now-workgroup-session-3-slides/

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Contact Information

Temi Olafunmiloye

Manager, Health Equity

804.287.0298

tolafunmiloye@hqi.solutions

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