Achiving Equity: Readmissions and Real World Lessons

Sunday, December 4, 2016
1:00 – 4:30pm

Session Objectives

- Provide an overview of the key issues and strategies related to readmissions for racial and ethnically diverse patients
- Identify 7 strategies hospitals can take to reduce readmissions in diverse populations
- Discuss a successful case study that incorporates these strategies
# Agenda

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<td>Disparities and Equity in the Time of Healthcare Transformation</td>
<td>Disparities Solutions Center Aswita Tan-McGrory, MBA, MSPH</td>
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<td>Overview of the Guide to Preventing Readmissions for Diverse Populations among Racially and Ethnically Diverse Medicare Beneficiaries</td>
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<td>Readmissions for COPD in African Americans</td>
<td>Novant Health Larry Weems II, MD</td>
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<td>Not-for-Profit Super Regional Integrated Healthcare System: Readmission for Pneumonia in African-Americans</td>
<td>South Carolina Hospital Association Rick Foster, MD</td>
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<td>A Collective Commitment to Health and Social Equity</td>
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**Group Discussion (25 min)**

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# Improving Quality and Achieving Equity

**Delivering Value in a Time of Healthcare Transformation**

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

- 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 Resident Population of the United States, 1998-2030

Diabetes-Related Death Rate, 2012
Deaths per 100,000 population

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
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…

Our Vision:
The Disparities Leadership Program

- To arm health care leaders with rich understanding of the causes of disparities and the vision to implement solutions and transform their organization to one delivering high-value care.

- To help leaders create strategic plans and projects to advance their work in reducing disparities in a customized way, with practical benefits tailored to every organization.

- To align the goals of health equity with health care reform and other strategic imperatives designed to improve value.
CMS Guide to Preventing Readmissions Among Racially and Ethnically Diverse Medicare Beneficiaries

Aswita Tan-McGrory, MBA, MSPH
Deputy Director,
The Disparities Solutions Center
Massachusetts General Hospital
IHI Learning Lab
December 4, 2016

Guide to Preventing Readmissions among Racially & Ethnically Diverse Medicare Beneficiaries
Alignment with CMS Quality Strategy

Goal 1 • Make care safer by reducing harm caused in the delivery of care.
Goal 2 • Strengthen persons & their families as partners in their care.
Goal 3 • Promote effective communication & coordination of care.
Goal 4 • Promote effective prevention & treatment of chronic disease.
Goal 5 • Work with communities to promote best practices of healthy living.
Goal 6 • Make care affordable.

Why this 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.


Contents

- **Background** on readmissions and racial and ethnic minorities
- **Overview of key issues** and strategies related to readmissions for diverse populations
- **High level recommendations** for addressing readmissions for diverse populations
- **Case studies** that illustrate how organizations are addressing avoidable readmissions for vulnerable populations in hospital and home-based settings

### Readmission Rates

- **CHF**
  - Higher readmission rates for African American patients
  - Among Medicare beneficiaries higher readmission rates for Hispanic patients
  - Higher risk of readmission for foreign born patients w/LEP
- **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.
Key Issues for Racially and Ethnically Diverse Patients

Several factors contribute to disparities in readmission rates for racially and ethnically diverse Medicare beneficiaries including:

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

**Recommendation #1:**

Create a strong radar that collects key patient demographic data including race, ethnicity, language, education, social determinants and disability.

- This data can be **collected at registration, updated routinely and used in predictive modeling** for “hot spotting”. The goal is to develop a better understanding of what underlies readmission rates.
- In the absence of standardized data collection systems, information can be gathered in the short-term via **chart review, focus groups, structured interviews, and through the use of multicultural advisory boards and/or patient/family councils.**
Recommendation #2:

**Identify the Root Causes** by determining patients, populations, and characteristics that are linked to readmissions.

− Once root causes are identified, a process can be initiated that focuses on addressing barriers and developing the systems to prevent them.

− Performance measurement and monitoring makes the data meaningful and useful.

− Systems innovations and improvement become the natural outgrowth of a strong radar that picks up clear root causes.

Recommendation #3:

**Start from the start** by developing preemptive efforts to prevent readmissions that span the duration of pre-admission to post-discharge.

− Create systems that:
  - Assess risk prior to admission
  - Address these factors in a planned way at admission and throughout hospitalization

− These efforts are important for vulnerable minority populations where complexity may require more time for providers to effectively communicate and address patients’ needs.
Recommendation #4:

**Deploy a team** that is multi-disciplinary and includes allied health professionals as well as “non-traditional” team members such as health coaches, navigators, and community health workers.

- Either create a specific team or have teams that already charged with this work focus their efforts on assuring these approaches are incorporated into the transitions process.
- Investing in these resources, derived from the communities-at-risk, will be essential.

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.
Recommendation #6:

Develop **culturally competent** strategies for addressing **communication-sensitive, high-risk scenarios** such as medication reconciliation and discharge instructions.

- Communication in "high-risk scenarios" includes elements that are foundational to preventing readmissions. These scenarios rely on effective patient provider communication to avoid harm caused by communication problems or barriers.

- Deploying the necessary set of resources to address these factors in a culturally, linguistically, and educationally appropriate way is a key element of strategy to prevent readmissions in minority populations.

Recommendation #7:

Foster **community partnerships** to promote **continuity of care**.

- These partnerships will help facilitate the transition of patients back into the community by leveraging partners to ensure continuity of care for patients following hospitalization.

- Community partners are also sometimes equipped to address non-medical factors that could lead to readmissions such as behavioral, health literacy, and cultural issues.
Health Connections
An Interdisciplinary Approach to Improved Care Coordination for Vulnerable Patients

Background

According to the US Census, four neighborhoods near Jewish Hospital have families in poverty up to six times the community norm with higher death rates from heart disease, cancer and diabetes.

They used a “hot spotting” method to map the home addresses of “super-users” of care (defined for their study as having four or more inpatient, outpatient, or ED visits resulting in an admission).
Criteria

- Top 5% in charges among inpatient, outpatient and ED cases - identify target zipcodes
- Lace Index Score of 11 or higher
- Medicare, Medicaid or self-pay
- Live in one of the neighborhoods of concern

The Program

- Employs a multidisciplinary team working in the homes of recently discharged, high-risk patients from low-income neighborhoods to help them better manage their medical conditions and prevent readmission, while addressing barriers to good health
- Patient is in the program for 90 days.
- Health Connections Initiative is based on the model developed by Camden Coalition of Healthcare Providers
- The team works with the patient to set goals for health improvement, to identify any barriers to good health, and to work together to overcome them.
- Home visits focus on medical and social-support service delivery, with the ultimate goal of promoting self-management and transitioning the participant to a medical home.
Key Components

- Identified root causes with risk modeling (neighborhood, payer sources, LACE tool)
- Start from the start – team works with patients for 90 days on assessing and addressing risk of readmissions
- Deploy a team - Lead RN, LPN, SW, CHW, dietician and interpreter
- Consider systems, social support and social determinants – address participants needs holistically with home visits
- Focus attention on community, coordination and continuity - connect w/comm based resources

Results

- From November 2013 through February 2015 readmission rates decreased significantly by 17%, from 29.7% to 12.8%
- Participants saw dramatic improvements in rates of depression, confidence in their ability to manage their health and connection to the medical home.
Annual Report on Equity in Health Care Quality

• Since 2006 MGH has released the Annual Report on Equity in Health Care Quality (formerly the Disparities Dashboard)

• In 2013, MGH received the AAMC Learning Health System Challenge Award for our efforts to reduce disparities through data collection & quality improvement

• In July of 2014, MGH will receive AHA’s inaugural Equity of Care Award. The AHA Equity of Care Award was created to recognize outstanding efforts among hospitals and care systems to advance equity of care to all patients, and to spread lessons learned and progress toward achieving health equity.
Contents of AREHQ

- Demographic Profile of MGH patients
- New Areas of Exploration: Readmission
- Improvement Initiatives: Patients with Limited English Proficiency
- Department-Level Measures
  - OB (new in 2013)
  - Pediatrics (new in 2013)
- Includes all previously reported measures
  - National Hospital Quality Measures (NHQM)
  - Physician/Practice linkage data
  - Healthcare Effectiveness & Data Information Set (HEDIS)
  - Patient Experience (HCAHPS & CG-CAHPS)

MGH Patient Population: Language

- The proportion of patients with limited English proficiency seen as MGH is not representative of the catchment area population.

% of MGH Patients by Language Compared with Catchment Area (CY 2014)

![Graph showing language distribution]
New Area of Exploration: Readmissions

Readmission Findings
• No differences in overall readmission rates between racial and ethnic minority groups and white patients or between patients with English as their primary language and patients speaking other languages
• Statistically higher readmission rates for:
  – Patients with limited English proficiency age 65 or older compared to their English-speaking counterparts (16.1% vs. 13.9%)
  – Asian patients with limited English proficiency compared to Asian patients with English as their primary language (13.2% vs. 8.7%)
Readmissions: Next Steps

• Further study is needed to understand the causes of higher readmission rates among Asian patients with limited English proficiency

• Chinese, Vietnamese, and Khmer-speaking patients account for the majority of Asian patients who were readmitted in the timeframe studied

• The DSC and CQS will conduct a chart review and qualitative interview study with patients, caregivers, and providers to explore the causes of readmissions in this population and identify improvement opportunities

In Summary

• Racial and ethnic disparities in health care persist and are a clear sign of inequality in quality and low-value healthcare.

• Root causes for these disparities are complex, but there is a well-developed set of evidence-based approaches to address them.

• Being inattentive to the root causes of disparities adversely impacts efficiency and the bottom line.
Disparities Leadership Program Objectives

At the conclusion, participants will be able to:

• Articulate the ways in which equity is linked to healthcare transformation, health care reform, value-based purchasing, accreditation and quality measurement

• Identify strategies to secure buy-in by having health care leaders better understand these links and become invested in addressing them.

• List techniques and technology for race and ethnicity data collection and disparities/equity performance measurement.

• Identify interventions to reduce disparities in health care with a particular focus on preventing readmissions and avoidable hospitalizations, improving patient safety and experience, and deploying culturally competent population management initiatives.

• Identify ways to message the issue of equity both internally and externally.

• Describe a concrete step that their organization will take towards improving quality, addressing disparities and achieving equity

Curriculum

• Two day kick off meeting in Boston in May

• Three web-based collaborative group calls

• Three team technical assistance calls

• Two web seminars on topics relevant to the DLP

• Two day meeting in CA in February
Disparities Leadership Program Alumni

- 350 participants
- 160 organizations
  - 86 hospitals
  - 36 health plans
  - 21 community health centers
  - 8 professional organizations
  - 2 hospital trade organizations
  - 1 school of medicine
  - 1 dental benefits administrator
  - 1 federal government agency
  - 1 state government agency
  - 1 city government agency
  - 2 others

DLP Organizations
31 states
Commonwealth of Puerto Rico
Canada, Switzerland
Health Equity at Palmetto Health

Vince Ford
Chief Community Health Services
Palmetto Health
Columbia, South Carolina

• The largest and most comprehensive integrated health care system in the South Carolina Midlands region.
• More than 12,000 team members/volunteers and more than 1,000 physicians provide care to patients throughout our healthcare system, which includes:
  - Palmetto Health Baptist
  - Palmetto Health Baptist Parkridge
  - Palmetto Health Children’s Hospital
  - Palmetto Health Heart Hospital
  - Palmetto Health Richland
  - Palmetto Health Tuomey

• Palmetto Health Vision: To be remembered by each patient as providing the care and compassion we want for our families and ourselves.

PALMETTO HEALTH
Problem Statement:
African-American men and women with COPD are more likely to be readmitted to the acute care setting within 30 days of prior discharge than White men and women.

Target population:
African-American men and women diagnosed with COPD.

Caucasians compared to Non Caucasians with COPD
- 15.8% Caucasians
- 20.0% Non Caucasians

• October 2015-February 2016
Workout Basics

Bring together the people who know the issues.

Develop creative solutions.

Decide on the solutions.

Empower people to carry them out. ☑

Follow-up rigidly to ensure that the solutions are implemented.

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PROCESS IMPROVEMENT

<table>
<thead>
<tr>
<th>Implemented Action Items</th>
<th>Patient Outcomes</th>
<th>Caregiver Outcome</th>
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</thead>
<tbody>
<tr>
<td>Designed interview tool to identify what the patient felt led to being readmitted.</td>
<td>Identified needs are shared to unit case manager for transitional service referrals</td>
<td>Interviewer asks to interview the patients primary caregiver to identify support needs and connected to case manager</td>
</tr>
<tr>
<td>Hired COPD Navigator</td>
<td>Interviewer reports needs to unit social worker and COPD Navigator.</td>
<td>Collect contact information from the primary caregiver. COPD Navigator communicates with caregivers as standard practice.</td>
</tr>
<tr>
<td>Developed a readmission alert system to identify readmitted patients for COPD Navigator</td>
<td>Referrals for DME, address socio-determinants (air conditioners and fans, food resources, medication needs)</td>
<td>Ask what type of support would help them care for their loved one</td>
</tr>
<tr>
<td>Hired Community Coordinators to do interviews</td>
<td>Participate in community coalition to better coordinate clinical and social services for patients</td>
<td>Large print documents, home visits from ACT, getting care giver connected with PCP</td>
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</tbody>
</table>
Change Management Techniques + Coordinated Efforts to Improve Outcomes = Reduction and Equity in COPD Readmissions

### Reduction in COPD Readmissions Objectives:

**SAMPLE PATIENT/CAREGIVER FORM**

<table>
<thead>
<tr>
<th>Campus</th>
<th>G</th>
<th>R</th>
<th>Zip Code</th>
<th>Interviewee</th>
<th>Current PCP</th>
<th>Readmit Reason (Patient)</th>
</tr>
</thead>
<tbody>
<tr>
<td>B M W</td>
<td></td>
<td></td>
<td>29073</td>
<td>Patient &amp; Family * caregiver not present (wife)</td>
<td>Dr. Eddie Williams</td>
<td>Felt bad but believes he waited too long to seek help</td>
</tr>
<tr>
<td>R F AA</td>
<td></td>
<td></td>
<td>29204</td>
<td>Waverly Family Practice (Eau Claire)</td>
<td></td>
<td>No Transportation for F/U, Too many prescriptions, Housing Issues (only one cooling unit in living room/bedroom hot), Needed better family support, Quality of Food, Availability of Food, Waited too long to seek help - did not want to return to hospital</td>
</tr>
<tr>
<td>B M W</td>
<td></td>
<td></td>
<td>29209</td>
<td>Patient /Caregiver (daughter)</td>
<td>Dr. McCain (South Hampton Practice)</td>
<td>Could not afford medication (copay/out of pocket cost)</td>
</tr>
<tr>
<td>B M W</td>
<td></td>
<td></td>
<td></td>
<td>Patient</td>
<td>None</td>
<td>No transportation for F/U, Couldn’t afford medications, No Housing, Needed better family support</td>
</tr>
<tr>
<td>R M AA</td>
<td></td>
<td></td>
<td>29203</td>
<td>Patient</td>
<td>Dr. Knight (Eau Claire)</td>
<td>Could not afford medicine, Too many prescriptions, Could not afford copay/out of pocket costs, Availability of Food, Unable to reach PCP/specialist, Waited too long to seek help - did not want to return to hospital</td>
</tr>
</tbody>
</table>

NOTES: PROCESS: ADD COMMENT SECTION AFTER EACH QUESTION FOR MORE INFO
THANK YOU!

Vince Ford, Chief Community Health Services
Palmetto Health
(803) 296-2158
Break (15 min)
2:45-3:00 pm

Novant Health
Not-for-profit super regional integrated healthcare system

Readmission for Pneumonia in African-Americans

Larry Weems II, MD
Background

- **Identified disparity**
  - African American patients have a higher readmission rate for pneumonia than our other populations of patients

- **Scope**
  - Condition – community acquired pneumonia
  - Readmission using CMS methodology
  - Data Timeframe:
    - July 1, 2014 – June 30, 2015 (original data)
    - January 1, 2016 – June 30, 2016 (updated data)

Goal and milestones

**Goal:**

- **Decrease avoidable readmissions while improving the patient experience and ensuring quality outcomes**

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Timeline</th>
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<tbody>
<tr>
<td>Design plan to address the disparity by understanding the “why”</td>
<td>May – July 2016</td>
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<tr>
<td>Design plan to ensure team members receive cultural competency training</td>
<td>July – October 2016</td>
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<tr>
<td>Implement plan to eliminate disparity</td>
<td>July 2016 – March 2017</td>
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Components, Key Activities, and Outputs

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<thead>
<tr>
<th>Components</th>
<th>Key Activities</th>
<th>Outputs</th>
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<tbody>
<tr>
<td>Organizing for Success</td>
<td>• Analytics and Informatics</td>
<td>• Monthly meetings established</td>
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<td></td>
<td>• Care Connections</td>
<td>• Goals and milestones determined</td>
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<td></td>
<td>• Readmission committee leaders</td>
<td></td>
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<td></td>
<td>• Diversity and Inclusion</td>
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<tr>
<td>Assessment and Data Collection</td>
<td>• Analyzed readmission data by race and ethnicity to identify disparity</td>
<td>• Identified focus areas</td>
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<tr>
<td></td>
<td>• Care Connections contact rates</td>
<td></td>
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<tr>
<td></td>
<td>• Chart Reviews</td>
<td></td>
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<tr>
<td></td>
<td>• Patient Interviews</td>
<td></td>
</tr>
<tr>
<td>Design</td>
<td>• Discharge</td>
<td>• Workstreams formed</td>
</tr>
<tr>
<td></td>
<td>• Care Connections and Home Visits</td>
<td>• Draft of design plan</td>
</tr>
<tr>
<td></td>
<td>• Access to Healthcare</td>
<td></td>
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<tr>
<td></td>
<td>• Electronic Health Record Improvement</td>
<td></td>
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<tr>
<td></td>
<td>• Awareness</td>
<td></td>
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<tr>
<td>Final Check-In</td>
<td>• Team report out to executive sponsor and readmission leaders for approval on design</td>
<td>• Approved final design plans</td>
</tr>
<tr>
<td>Implementation</td>
<td>• Workstream leaders organize for success on implementation and recurring updates</td>
<td>• Design plans executed</td>
</tr>
<tr>
<td>Monitor Progress</td>
<td>• Workstream leaders track implementation and complete status updates</td>
<td>• Updates to D&amp;I, Readmissions Committee, and Healthcare Disparities Workgroup</td>
</tr>
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Understanding our data

- **Chart Reviews**
  - Comparison between index patients and readmitted patients within 30 days
  - Timeframe April 1, 2015 – December 31, 2015
  - Findings:
    - Lack of support person
    - Less Case Management visits upon discharge
    - Co-morbidities
    - Mortality:
      - System-wide PN Medicare patients – 1.5% Mortality

Combined Comorbidities

Mortality
Understanding our patients

- **Patient Interviews (readmitted chart review patients via phone)**
  - Findings:
    - Difficulty making contact
    - Discharge instructions were unclear
    - Unsure about medications
    - Transportation limited; patients had to get medications when they had someone available to take them

Successes/Challenges

**Successes:**
- Identified focus areas from the chart audits and patient interviews
- Transitional care/bridge concept
- Data rich organization

**Challenges:**
- New at segmenting and having targeted interventions based off of REaL data
- Discharge process
- Home care coordination
- Access to care
- Electronic health record:
  - Identifying PN patients
  - Inconsistencies with documentation
- Team member cultural competency training
Lessons Learned

Critical success factors:
- Executive leadership support
- Appropriate subject matter experts on team
- Existing readmissions committee work
- Strong team committed to the work

What we would do differently:
- Engage case management sooner
- Reporting – engage organization on disparity and progress of project
- Engage primary care team
- Utilize work streams to arrive at interventions sooner

Anticipated successes to achieve – Acute Plan of Care

General
- Develop a repeatable model that can be used in identifying and eliminating healthcare disparities
- Establish hospital and community resource partnerships
- Utilize Transcultural Health Managers
- Deploying a risk score for unplanned readmissions
- Developed BOOST-based interdisciplinary tool (in build phase)

Discharge
- Create a reporting process for readmissions to be identified and seen by case management
- Schedule follow up visits within the facility
- Increase contact rate with patients by providing 24/7/365 to Care Connections
- Hospitalists team to have focused efforts on improving patient experience within the transition of care domain
- Medications in hand at time of discharge – “Ready for Home”
Anticipated successes to achieve - Post-Acute Plan of Care

**Home Care**
- Leverage the risk of unplanned readmit tool to guide the care team in the utilization of home and community health services
- Pilot community health worker home visit program

**Access to Care**
- Expansion and growth of Transitional Care Services
- Piloting transportation vouchers

Questions?
A collective commitment to health and social equity

The Alliance for a Healthier South Carolina

Mission:
Coordinating action on shared goals to improve the health of ALL people in South Carolina.
Our Common Agenda for Health Improvement

FOR ALL PEOPLE IN SC
Everyone with the same probability of obtaining the best health status, independent of gender, race, sexual orientation, neighborhood, disability, ethnicity, education attainment or socioeconomic status.

AT A LOWER PER-CAPITA COST
Reduce the per-person cost of healthcare in the state when accounting for all public and private healthcare expenditures.

CALL TO ACTION FOR HEALTH EQUITY

DATA DRIVEN INTERVENTIONS
We can use data to discover which groups of people may need extra support from our organization and partners.

CULTURAL COMPETENCE & RESPONSIVENESS
We can assess and train ourselves to have more empathetic relationships with people of different backgrounds.

COMMUNITY ENGAGEMENT
We can partner with communities to increase the impact of health improvement interventions.

INCLUSIVE DECISION MAKING
We can invest in maximizing opportunity for diverse groups of the population to be included at all levels of decision making.
Our equity metrics

Early success of the Call to Action

• Over 60 launching partners including 40 hospitals
• Webinar series sharing how South Carolina champions are improving health equity in SC: HealthierSC.org/Webinars
  • Cross-cultural communication
  • How to include an equity lens in recruitment
  • Training community members to serve on boards
  • How to stratify data for health equity in publicly available sources
  • How to meaningfully engage community members
  • How to include an equity lens in decision making
  • Impact of implicit bias and micro-aggressions on health disparities
• 7 Case studies about how to decrease disparities due to race, income, and behavioral health co-morbidity at HealthierSC.org/Resources
• Created list of South Carolina peer mentors willing to help others in the process of improving health equity: HealthierSC.org/priorities/health-equity/
SC Hospital Association is responding to the challenge

- Over 40 health system CEOs committing to the Health Equity call to action
- All SC health systems provided with a baseline equity-based readmission disparity gap profile

Collaboration for Care Journey

- Goal: Improve coordination of care for patients with chronic conditions and their families, and reduce unnecessary readmissions
- Over 450 organizations statewide (hospitals, home health, SNF, hospice, pharmacy)
- Aligned with the Hospital Engagement Network and our Quality Improvement Organization
- How we help the hospitals and their community partners:
  - Identify and track how care transitions work is accomplished internally and provide trended comparative readmission datasets
  - Provide a learning collaborative w/ active education and information sharing on best practices
  - Convene/connect hospitals with their community partnerships
59 out of 64 hospitals are engaged with care transitions

All Payor Readmission Rates by Diagnosis
Racial Readmission Disparity Gap

**OVERALL: 11.31%**
522,910 Discharges • 59,217 Readmissions

**WHITE: 10.95%**
338,800 Discharges • 37,703 Readmissions

**BLACK: 12.88%**
184,100 Discharges • 21,514 Readmissions

**S.C. BLACK READMISSION RATE IS 18% HIGHER THAN THE WHITE READMISSION RATE.**

Grey Sloan Memorial Health System
Your hospital is being compared to 14 other hospitals with more than 100,000 discharges

**30-day Readmission Rate by race to any SC hospital**

<table>
<thead>
<tr>
<th></th>
<th>Overall</th>
<th>White</th>
<th>Black</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharges</td>
<td>525,613</td>
<td>340,767</td>
<td>158,593</td>
</tr>
<tr>
<td>Readmissions</td>
<td>48,593</td>
<td>29,911</td>
<td>17,136</td>
</tr>
</tbody>
</table>

**Overall Readmission Rate** 9.25%

**White Readmission Rate** 8.78%

**Black Readmission Rate** 10.81%

1. Stratify the data
Grey Sloan Memorial Health System
Your hospital is being compared to 14 other hospitals with more than 100,000 discharges

Racial Disparity Gap
Your hospital’s Black readmission rate is 23% higher than your White readmission rate.

Potential Overall Readmission Rate if racial disparity gap is closed
If your hospital eliminated the racial disparity, your overall readmission rate would decrease by 7% to:

Overall Readmission Rate
8.63%

Best Worst

You would avoid 3215 readmissions among your Black patients
And you would move your Overall Readmission Rate from Orange to Yellow in the comparative dashboard

HealthierSC.org
Questions?

For More Information About
The Disparities Leadership Program

www.mghdisparitiessolutions.org

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617-643-2916
Please turn in evaluations to Aswita Tan-McGrory.

Thank you!