

# Addressing Health Disparities in Readmissions

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# Introductions

- Nurse with a public health background
- Serve as a health equity SME
- Experience in quality improvement and measurement across settings



Share your **name**,  
**title**, **organization**,  
and response to  
what you're looking  
forward to in the  
Spring.

# Objectives

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- Understand the context around disparities in readmissions
- Learn about strategies that can help mitigate disparities
- Learn about resources that can be used in quality improvement activities
- Connect the dots in terms of how key strategies can advance health equity and reduce readmissions



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# Readmissions Overview

While not all readmissions are entirely preventable, it is widely understood that a portion of unplanned readmissions can be prevented by addressing a **series of barriers** patients face prior to, during, and after admission and discharge.

Annually, about \$17 billion in Medicare program spending is for readmissions that could be classified as **potentially avoidable**.

Minorities and other vulnerable populations are more likely to be readmitted.



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# Patient-Level Factors Predicting Hospital Readmission

Socioeconomic  
Status

Race and  
Ethnicity

Disability  
Status

Limited  
English  
Proficiency

Low Health  
Literacy



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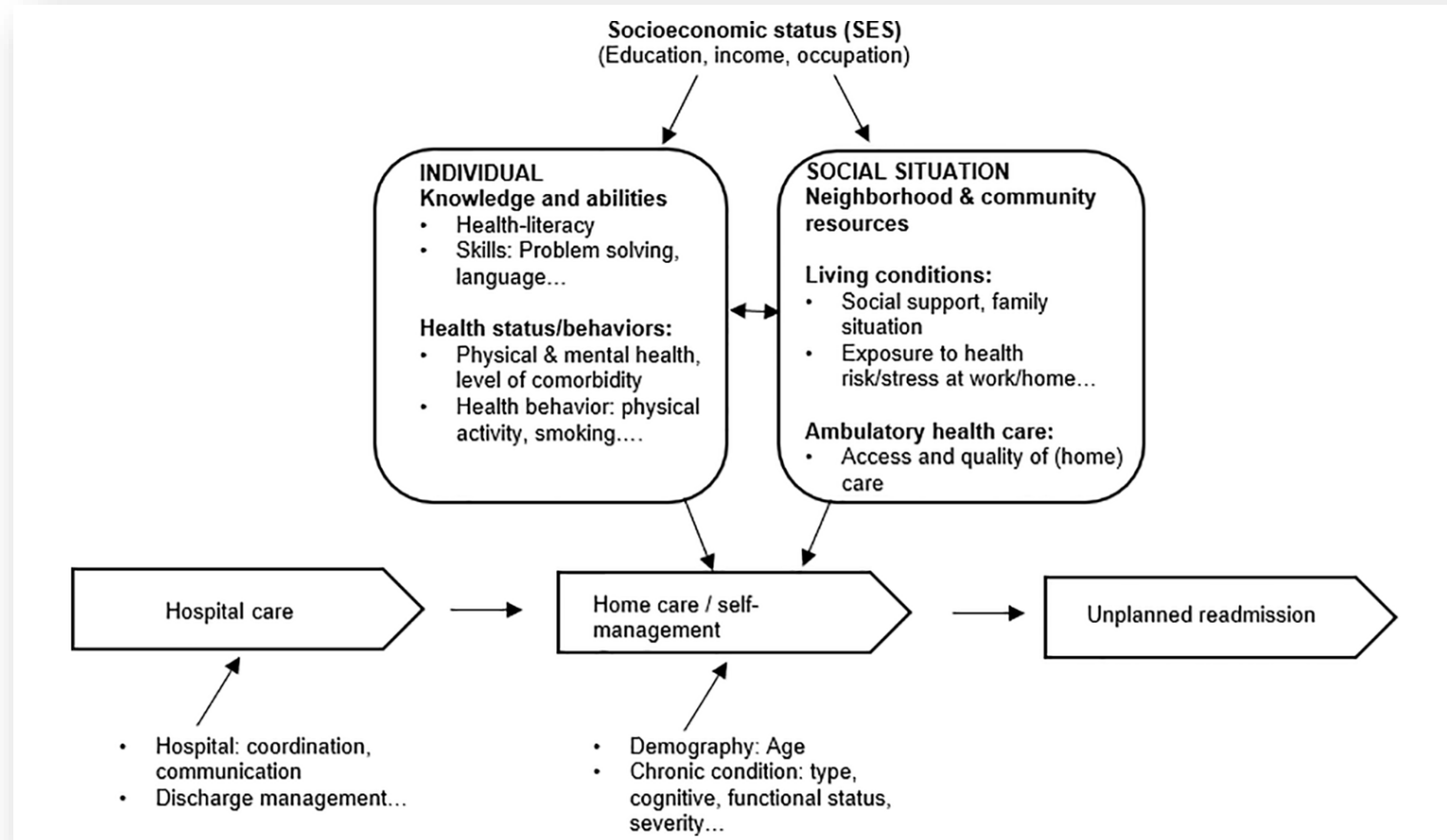
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# Key Issues for Racially and Ethnically Diverse Patients

Several factors contribute to disparities and readmission rates for racially and ethnically diverse patients, including:

- Low linkage to primary care/usual source of care
- Language barriers/access to interpreter services
- Lack of understanding
- Lack of culturally competent patient education
- Health-related social needs not addressed

# Social and Contextual Factors and Readmissions



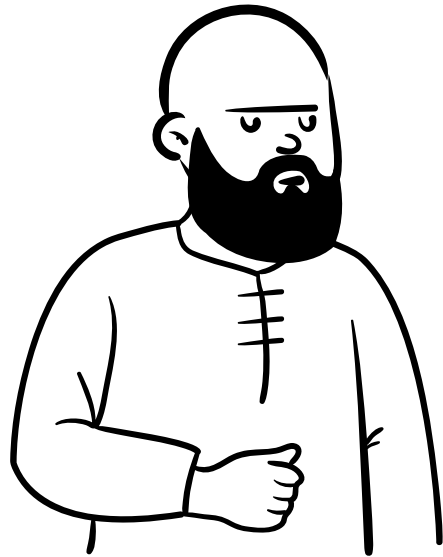
Zumbrunn, Andrea, et al. "Social disparities in unplanned 30-day readmission rates after hospital discharge in patients with chronic health conditions: A retrospective cohort study using patient level hospital administrative data linked to the population census in Switzerland." *Plos one* 17.9 (2022): e0273342.



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# Let's Meet LT...



- 72-year-old male with Congestive Heart Failure (CHF) and history of hypertension and diabetes
- First language is Spanish; he can speak and read English
- He lives alone; his wife died this year, and she was his primary support and cooked food to manage his CHF.
- Admitted with shortness of breath, fatigue, swollen legs; treated with diuretics, ACE inhibitors, and beta-blockers; discharged after 7 days with a follow-up appointment scheduled; discharged with education and self-care strategies
  - He used to measure his weight, but could not find his scale
  - He was feeling nauseous and skipped a few doses of his medications
  - He missed his follow-up appointment with his PCP
- Readmitted after 3 weeks with weight gain, shortness of breath, and edema; chest X-ray confirms worsening CHF



# What Factors Contributed to LT's Readmission?



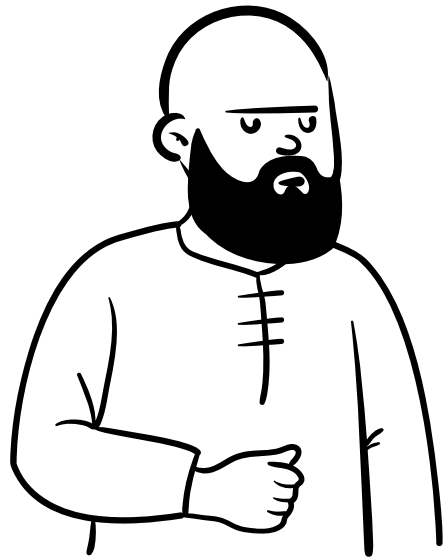
**Chime in via Chat!**



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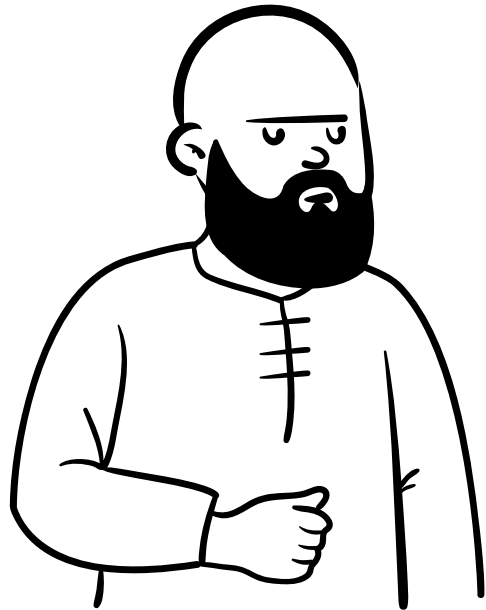
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# Let's Focus In...



- 72-year-old male with Congestive Heart Failure (CHF) and history of hypertension and diabetes
- **First language is Spanish**; he can speak and read English.
- He **lives alone; his wife died** this year, and she was his **primary support** and **cooked food to manage his CHF**
- Admitted with shortness of breath, fatigue, swollen legs; treated with diuretics, ACE inhibitors, and beta-blockers; discharged after 7 days with a follow-up appointment scheduled; discharged with education and self-care strategies
  - He used to measure his weight but **could not find his scale**
  - He was **feeling nauseous** and skipped a few doses of his medications
  - **He missed his follow-up appointment** with his PCP.
- Readmitted after 3 weeks with weight gain, shortness of breath, and edema; chest X-ray confirms worsening CHF

# Factors that Contributed to LT's Readmission



Medication side-effects

Lack of social support

Dietary imbalance

Missed PCP follow-up

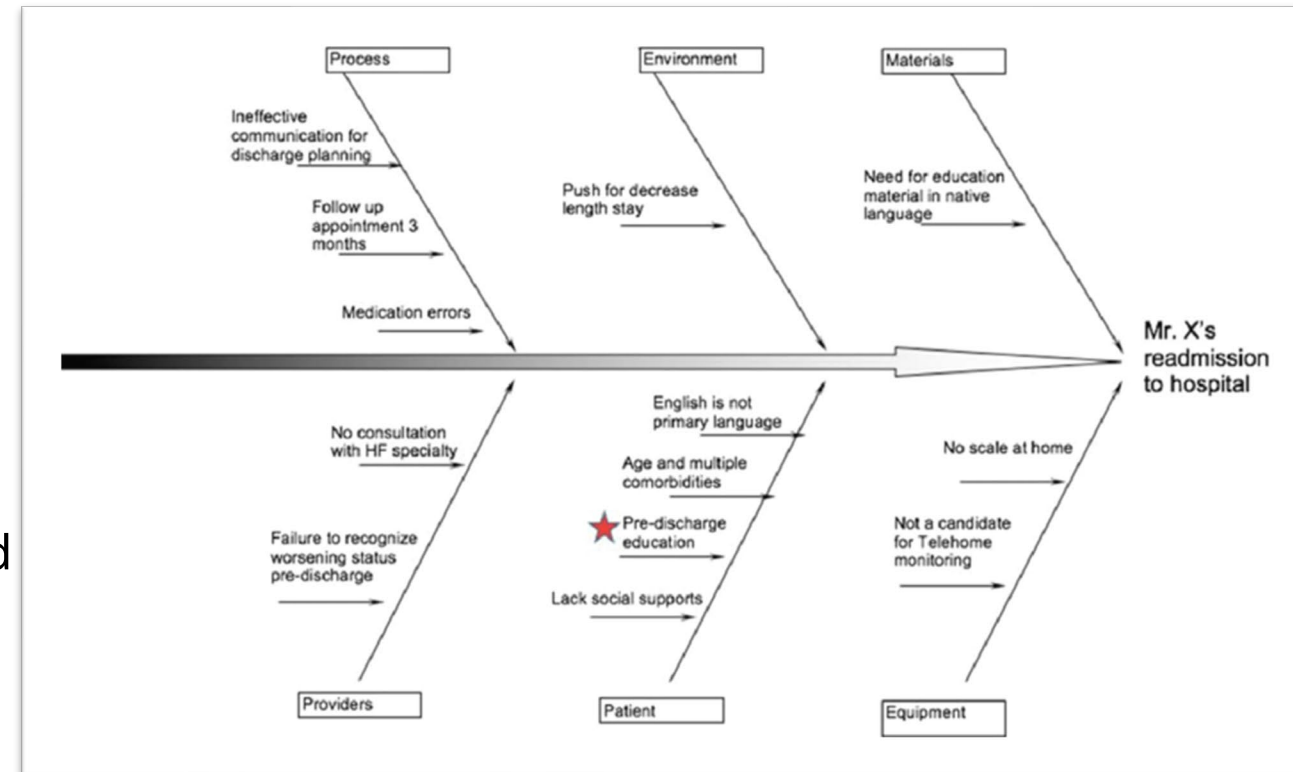
# Strategies to Close the Readmission Gap

## 1. Collect and Analyze Data

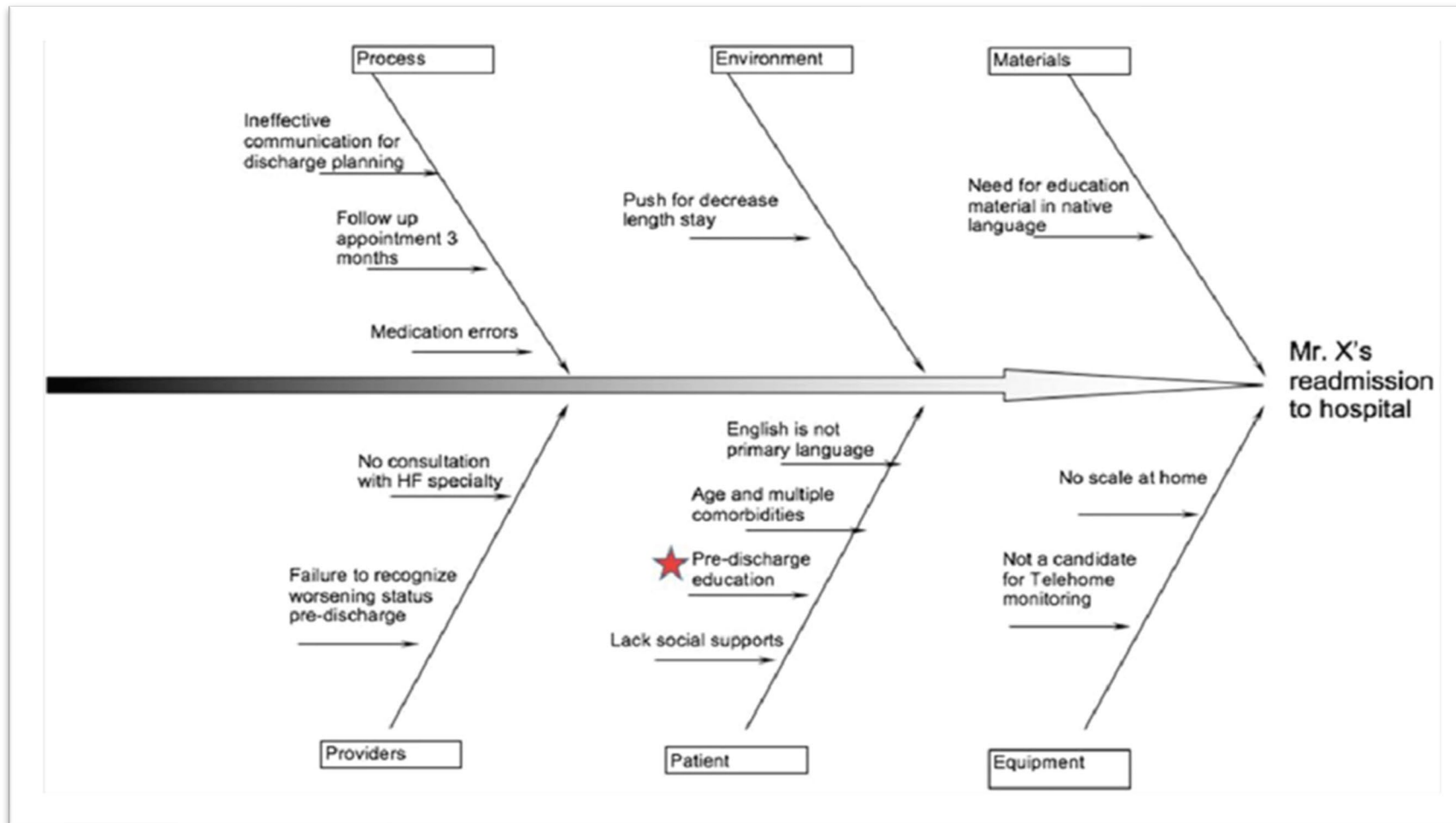
- ✓ race/ethnicity
- ✓ preferred language
- ✓ social needs
- ✓ disability status

## 2. Identify Root Causes

- Use quality improvement strategies and tools to understand barriers and develop systems to address them



# Strategies to Close the Readmission Gap, Continued



Example of a fishbone diagram to identify the root causes of a readmission (Moayed et al., 2017).

# Strategies to Close the Readmission Gap, Continued

## 3. Begin Early

- Use a series of preemptive efforts that span the duration from pre-admission to post-discharge

## 4. Deploy a Team

- Consider non-traditional partners like community health workers, navigators, and/or health coaches

## 5. Address Diverse Needs

- Respond to the needs of diverse populations



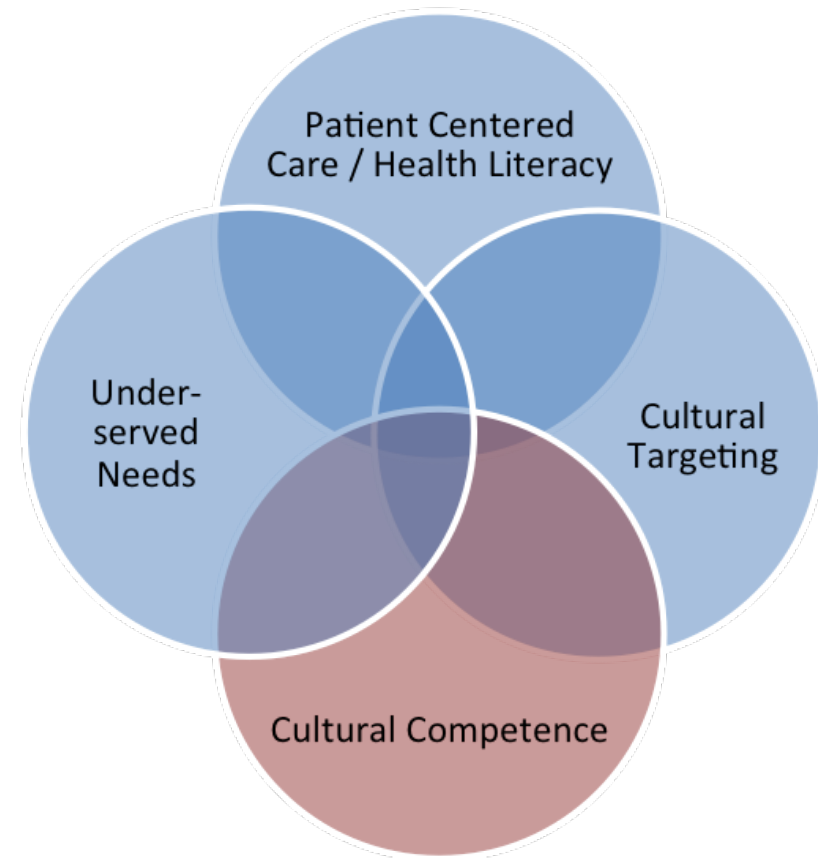
# Strategies to Close the Readmission Gap, Continued

## 6. Focus on Culturally Competent Communication

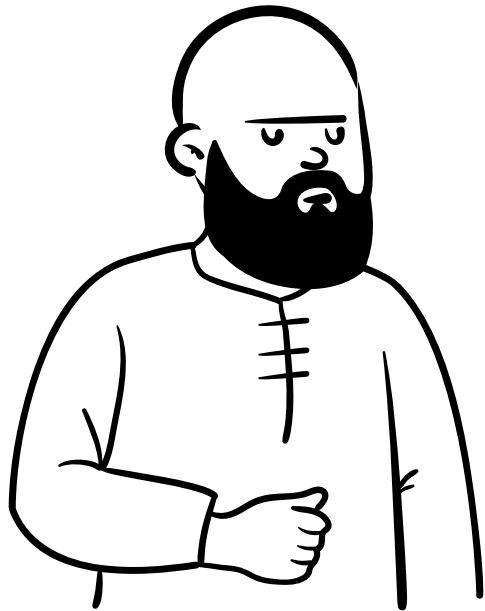
- Ensure patients' ability to understand their diagnosis, the care they received, and their discharge instructions

## 7. Foster Community Partnerships to Promote Continuity of Care

- Create a system to follow-up and promote continuity of care to the next setting



# LT's New Discharge Plan



## Medication adherence

- Review of medications and adjust to address nausea
- Provide and review educational materials in preferred language, with teach back
- Provide a scale to help with weight monitoring

## Social support

- Connect to local CHF support program
- Discuss family support nearby and coping skills given his wife's recent death

## Diet

- Discuss current meals and identify options based on food preferences
- Refer to registered dietician to review food options

## Follow-up

- Schedule PCP visit, request a reminder, and call back to follow-up
- Provide home health visit for adherence follow-up support



# LT's Tools to Manage his CHF

**American Heart Association**

## Plan de autochequeo para el control de la insuficiencia cardiaca

**¡Excelente! ¡Siga así, muy bien!**

- ✓ No presenta falta de aire al respirar o empeoramiento de la misma
- ✓ Su nivel de actividad física es normal
- ✓ No tiene nueva hinchazón, sus pies y piernas se ven normales
- ✓ Control del peso estable. Peso:
- ✓ No hay señales de dolor en el pecho

**¡ESTUPENDO! CONTINUE:**

- Revisando su peso
- Tomando sus medicamentos siguiendo las indicaciones de su médico
- Una dieta baja en sodio
- Citas de seguimiento

**¡Preste atención! ¡Tenga cuidado!**

- ⚠ Tos seca
- ⚠ Su falta de aire al respirar empeora con la actividad física
- ⚠ Mayor hinchazón de sus piernas, pies y tobillos
- ⚠ Aumento súbito de peso de más de 2-3 lb en aproximadamente un día (o 5 libras en una semana)
- ⚠ Malestar o hinchazón en el abdomen
- ⚠ Dificultad para dormir

**¡REVISE! Sus síntomas pueden indicar:**

- La necesidad de ponerse en contacto con su médico o proveedor
- La necesidad de un cambio en sus medicamentos

**Alerta médica. ¡Esté atento!**

- ⚠ Tos seca y frecuente
- ⚠ Dificultad para respirar en reposo
- ⚠ Aumento de las molestias o hinchazón en la parte inferior del cuerpo
- ⚠ Aumento súbito de peso de más de 2-3 lb en aproximadamente un día (o 5 libras en una semana)
- ⚠ Aparición de síntomas de mareo, confusión, tristeza o depresión
- ⚠ Pérdida de apetito
- ⚠ Aumento de dificultad para dormir; no puede descansar en posición horizontal

**¡ADVERTENCIA! Necesita ser evaluado de forma inmediato.** Llame a su médico o al **911**

[heart.org/HF](http://heart.org/HF)

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**American Heart Association**

## 10 maneras de mejorar tu salud cardíaca

- 1 Equilibra las calorías que comes con actividad física.
- 2 Busca una variedad de frutas y verduras.
- 3 Elige productos integrales.
- 4 Incluye fuentes de proteínas saludables, principalmente plantas y mariscos.
- 5 Usa aceites líquidos que no sean de plantas tropicales.
- 6 Elige alimentos mínimamente procesados.
- 7 Evita productos con azúcares añadidos.
- 8 Reduce la sal.
- 9 Limita el consumo de alcohol.
- 10 ¡Haz todo esto dondequiera que comas!

**¿Quieres informarte más? Go to [www.heart.org/eatsmart](http://www.heart.org/eatsmart)**

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Estilo de vida + Reducción de riesgos

## CAMBIOS EN EL ESTILO DE VIDA

### La aplicación HF Helper™ ayuda a los pacientes en casa

Desde la American Heart Association, nos complace lanzar HF Helper, una aplicación de autogestión que permite a los pacientes con insuficiencia cardiaca controlar y convivir mejor con su enfermedad.

La nueva aplicación HF Helper permite a los usuarios:

- Realizar un seguimiento de los síntomas, los medicamentos y otras métricas de salud.
- Compartir información de salud con su médico en tiempo real.
- Conectarse con otras personas que tienen insuficiencia cardiaca.

Con estas funciones, HF Helper es una herramienta destinada a que los pacientes gocen de una mejor calidad de vida.

**HF Helper**

Disponible para descargar a partir de febrero del 2022.

Visite [heart.org/HF](http://heart.org/HF).

Haga un seguimiento de su estado de ánimo  
 Haga un seguimiento de sus síntomas  
 Haga un seguimiento de su medicación  
 Haga un seguimiento de su nivel de energía  
 Conéctese con otras personas  
 Invite al equipo de atención médica

Puede consultar otras hojas informativas que lo ayudarán a tomar decisiones más saludables con el fin de reducir los riesgos, tratar la enfermedad o cuidar a un ser querido. Visite [heart.org/answersbyheart](http://heart.org/answersbyheart) para obtener información adicional.

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# The Project RED Toolkit



A Research Group at  
Boston University Medical Center



Boston University School of Medicine

Funded by the Agency for Healthcare Research and Quality, National Heart, Lung and Blood Institute, the Blue Cross Blue Shield Foundation, and the Patient-Centered Outcomes Research Institute

- The Re-Engineered Discharge consists of 12 mutually reinforcing actions that the hospital takes during and after the hospital stay to ensure a smooth and effective transition at discharge.
- [Tool 4](#) in the toolkit includes specific guidance on culturally and linguistically appropriate delivery of the RED to diverse populations.

# Components of the Re-Engineered Discharge Process

1. Ascertain need for an obtain language assistance.
2. Make appointment for follow-up care (e.g., medical appointments, post-discharge tests or labs).
3. Plan for the follow-up of results from tests or labs that are pending at discharge.
4. Organize post-discharge outpatient services and medical equipment.
5. Identify the correct medicines and a plan for the patient to obtain them.
6. Reconcile the discharge plan with national guidelines.
7. Teach a written discharge plan the patient can understand.
8. Educate the patient about his or her diagnosis and medicines.
9. Review with the patient what to do if a problem arises.
10. Assess the degree of the patient's understanding of the discharge plan.
11. Expedite transmission of the discharge summary to clinicians accepting care of the patient.
12. Provide telephone reinforcement of the discharge plan.

\*As listed in the AHRQ *Re-Engineered Discharge (RED) Toolkit*. <http://www.ahrq.gov/professionals/systems/hospital/red/toolkit/>

# Key Features of the Re-Engineered Discharge Process

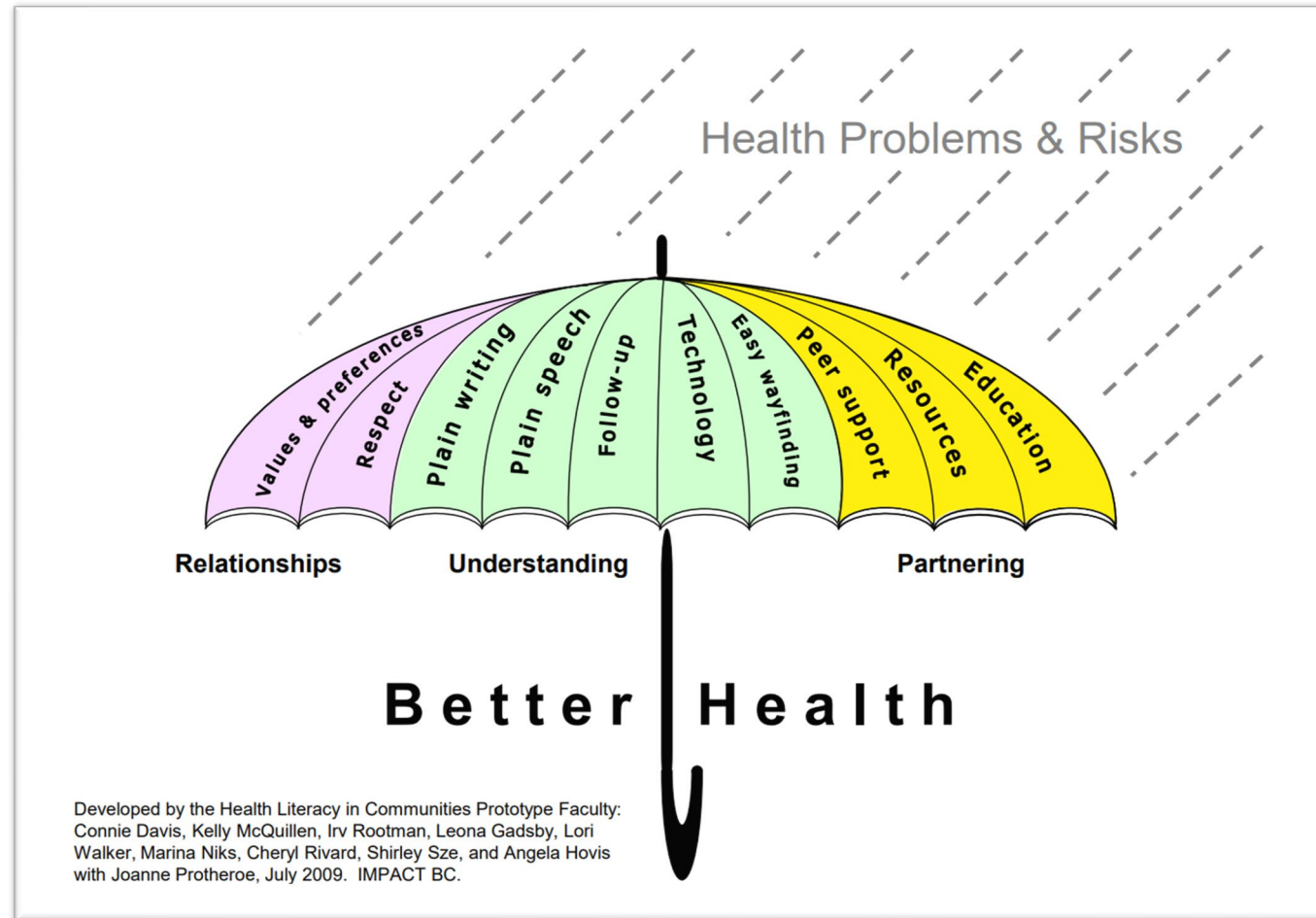
- Dedicated transition care personnel (Nurse Discharge Advocates) work directly with the patient and their caregivers to ensure a smooth transition for patients.
- Patient-centered discharge instructions (After Hospital Care Plan) is provided to the patient and their PCP on the day of discharge.
- A discharge advocate may be used to explain the discharge instructions, answer patient and caregiver questions, and test understanding of key information.
- Patients receive a follow-up call from a clinical pharmacist 2-4 days following discharge to reinforce the plan, review all medications, and address any problems.



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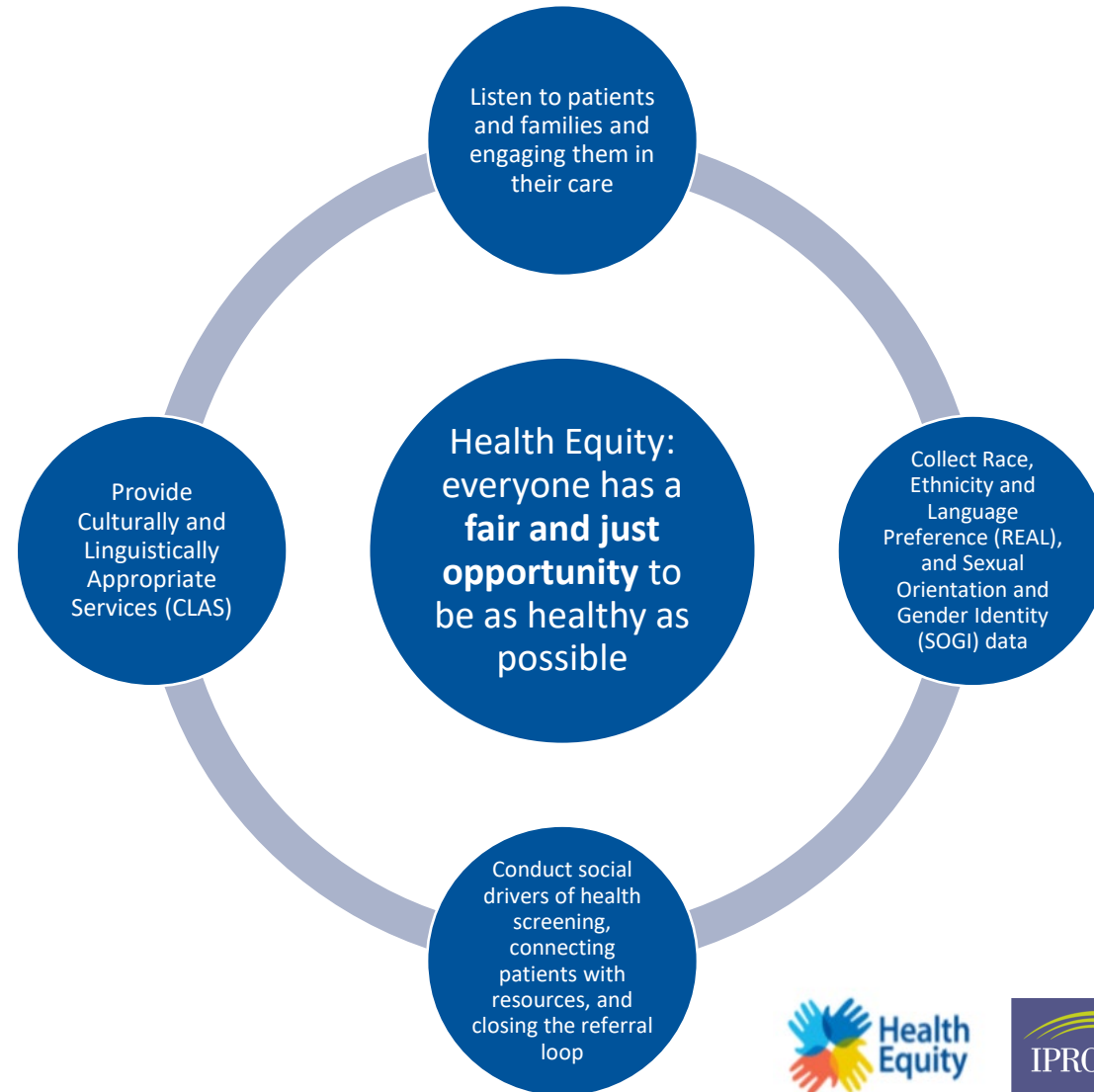
# Looking at the Full Picture



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# Connecting the Pieces



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# Concepts in Action

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- ✓ Collect standardized data and use it to understand the root causes leading to disparities in readmissions
- ✓ Plan for preemptive efforts spanning from pre-admission through
- ✓ Identify patient-specific needs and preferences and tailor patient education
- ✓ Leverage non-traditional partners, resources, and technology
- ✓ Connect with community-based organizations and provide continuity with outpatient providers



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# Resources

## I PRO

- [Improving Care Transitions: A Guide to Tools & Resources for Providers and Patients](#)
- [Preadmissions Planning Checklist \(English\)](#)
- [Preadmissions Planning Checklist \(Spanish\)](#)
- [IHI STAAR Root Cause Analysis Tool](#)

## AHRQ

- [Project RED \(Re-Engineered Discharge\)](#)

## CMS

- [Guide to Reducing Disparities in Readmissions](#)

## AHA

- [Equity of Care: A Toolkit for Eliminating Health Care Disparities](#)

## Journal Articles

- [Factors Associated with Disparities in Hospital Readmission Rates Among US Adults Dually Eligible for Medicare and Medicaid](#)
- [A Machine Learning Model for Predicting, Diagnosing, and Mitigating Health Disparities in Hospital Readmission](#)





# Contact Information

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# Q&A

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# Thank you!

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