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

- 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

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.

Betancourt JR, Tan-McGrory A, Kenst KS. Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries. Prepared by the Disparities Solutions Center, Mongan Institute for Health Policy at Massachusetts General Hospital. Baltimore, MD: Centers for Medicare & Medicaid Services Office of Minority Health; September 2015.

Patient-Level Factors Predicting Hospital Readmission

- Socioeconomic Status
- Race and Ethnicity
- Disability Status
- Limited English Proficiency
- Low Health Literacy

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

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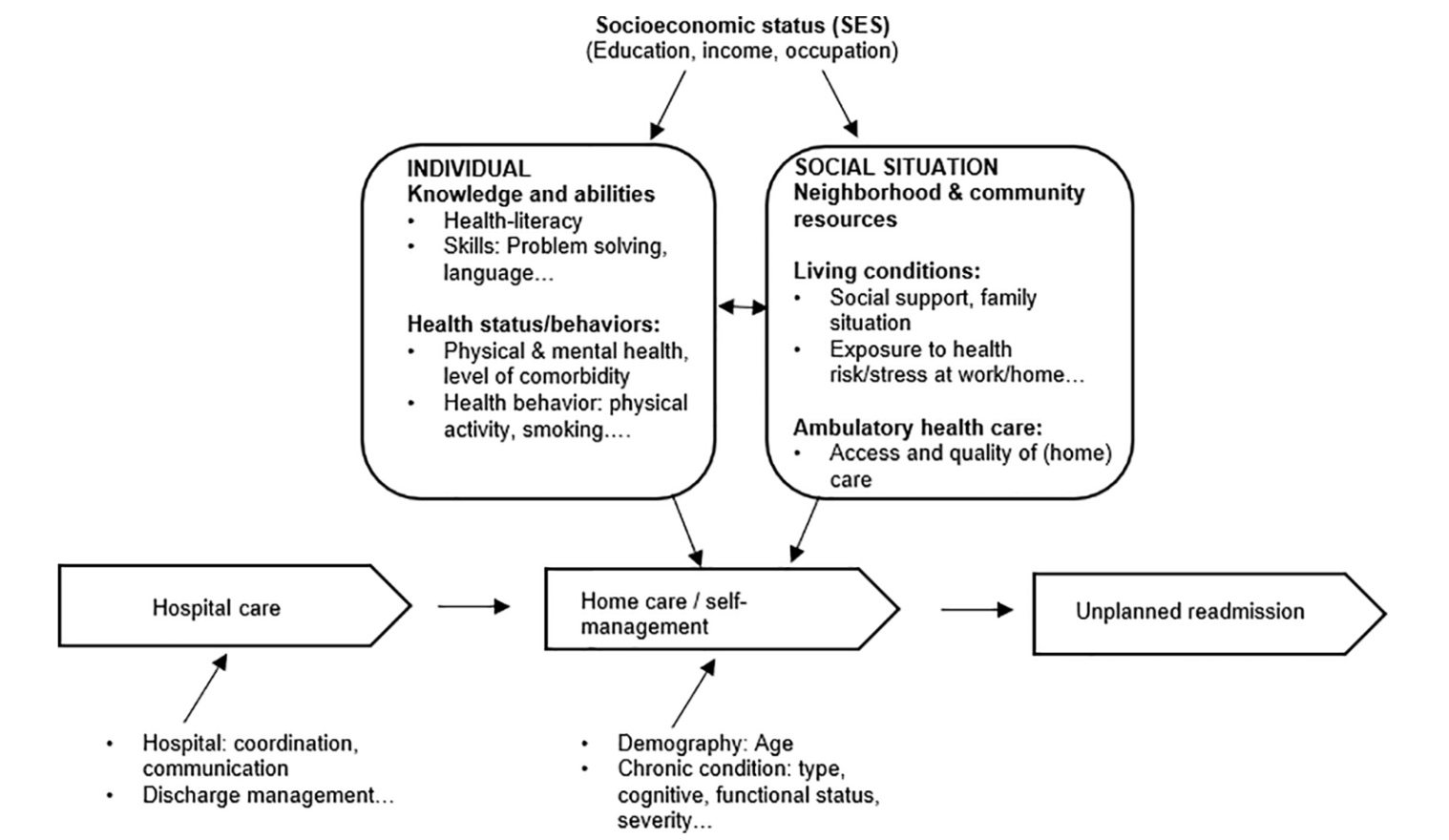
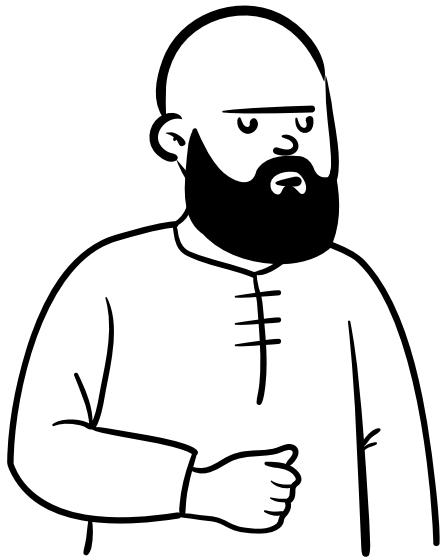
Social and Contextual Factors and Readmissions



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.

Let's Meet LT…

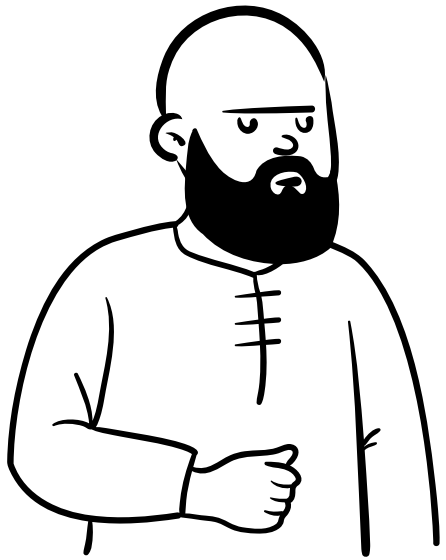


- 72-year-old male with Congestive Heart Failure (CHF) and history of hypertension and diabetes
- First language is Spanish; he can speak and read English
- He lives alone; his wife died this year, and she was his primary support and cooked food to manage his CHF.
- Admitted with shortness of breath, 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!

Let's Focus In…



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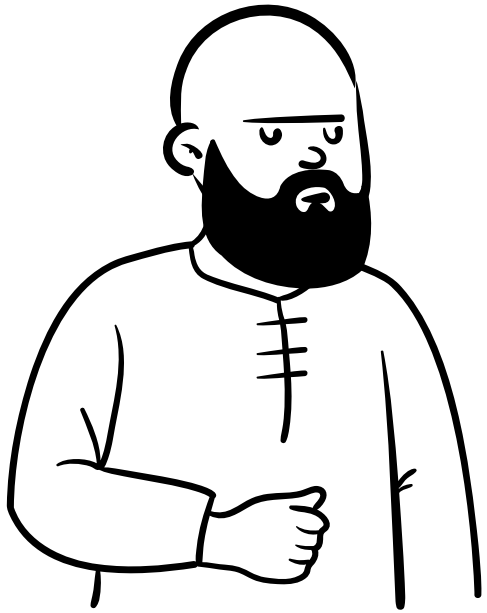
Factors that Contributed to LT's Readmission

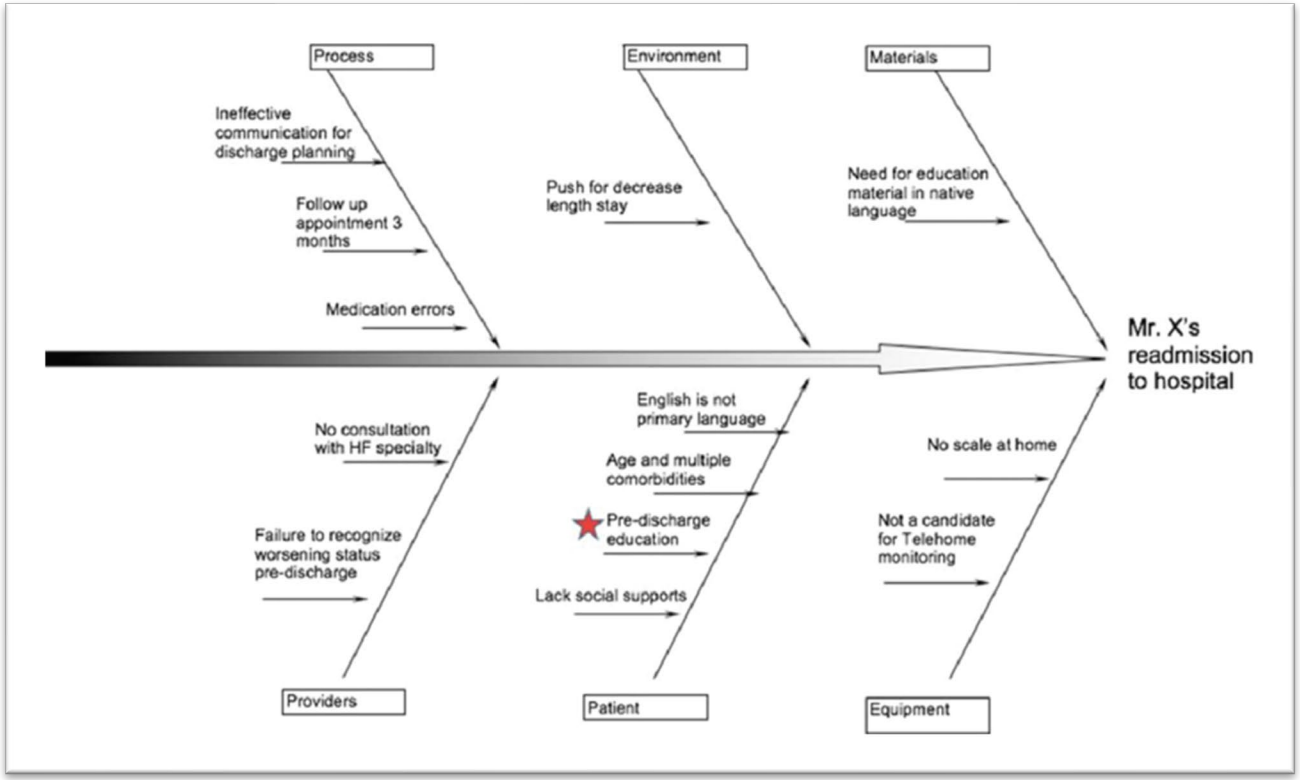


- Medication side-effects
- Lack of social support
- Dietary imbalance
- Missed PCP follow-up

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



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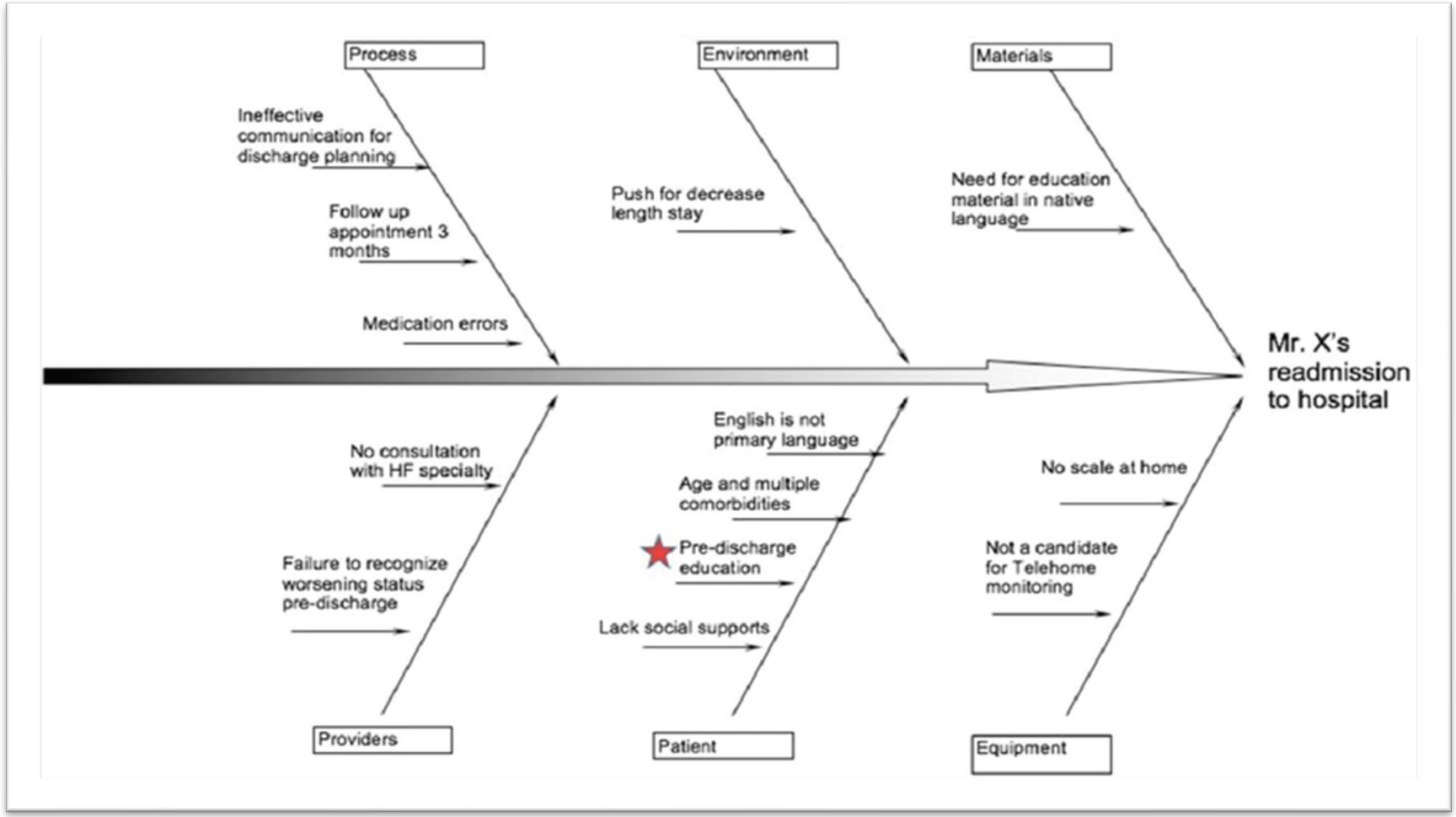
Strategies to Close the Readmission Gap, Continued

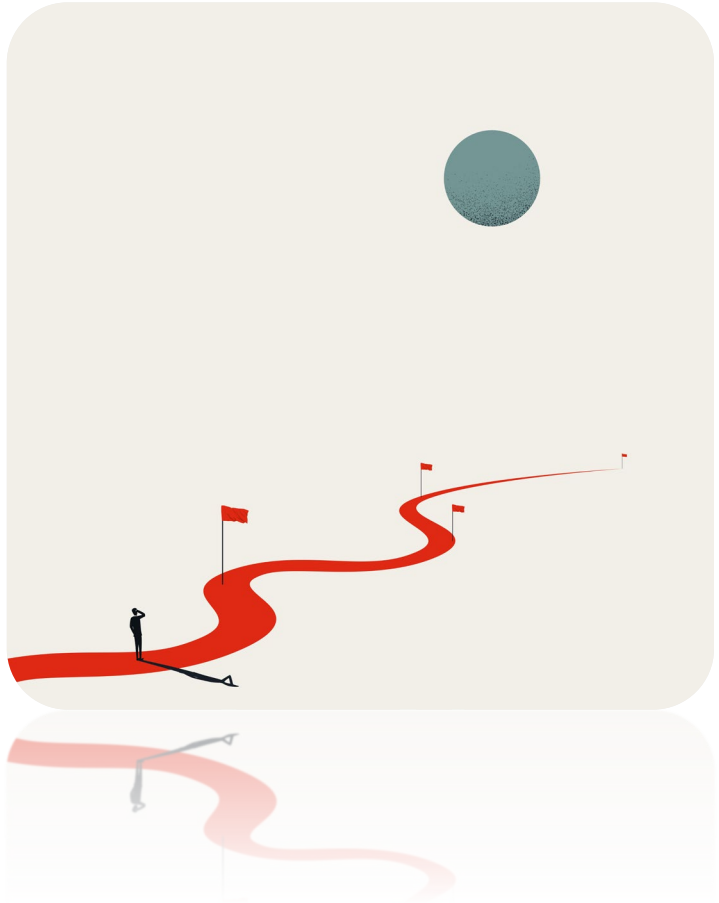


Example of a fishbone diagram to identify the root causes of a readmission (Moayedi et al., 2017).

Moayedi Y, Schofield T, Etchells E, Silver SA, Kobulnik J, McQuillan R, Bell C, Linghorne M, Ross HJ. Closing the Care Gap: A Primer on Quality Improvement for Heart Failure Clinicians. Circ Heart Fail. 2017 May;10(5):e003722. doi: 10.1161/CIRCHEARTFAILURE.116.003722. PMID: 28490429.

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



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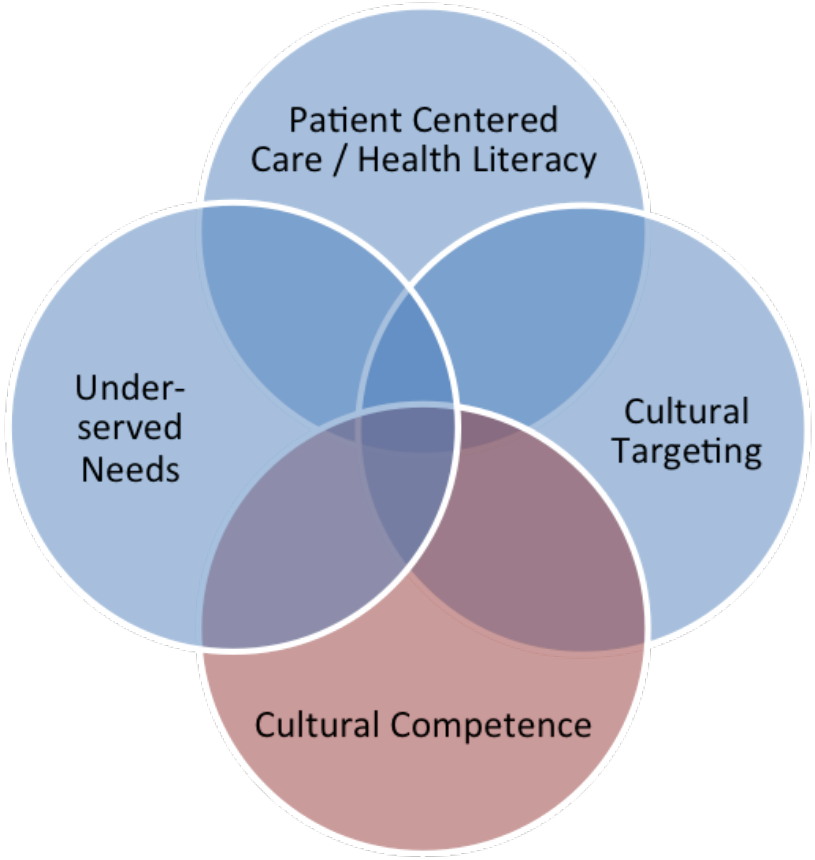
Strategies to Close the Readmission Gap, Continued

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



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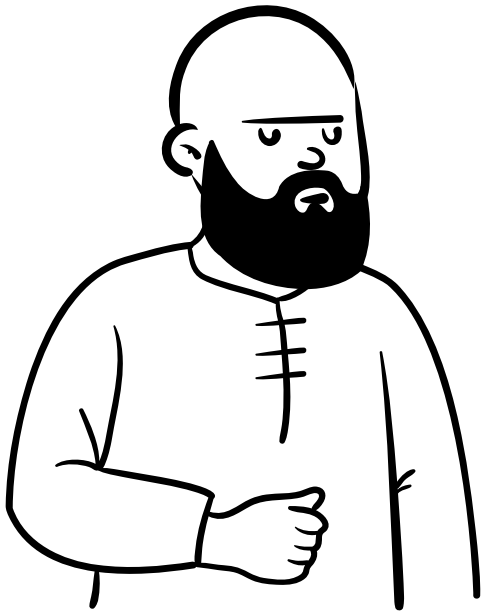
LT's New Discharge Plan



Medication adherence	Social support	Diet	Follow-up
• 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	• Connect to local CHF support program • Discuss family support nearby and coping skills given his wife's recent death	• Discuss current meals and identify options based on food preferences • Refer to registered dietician to review food options	• 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

AHA, Heart Failure Tools and Resources, https://www.heart.org/en/health-topics/heart-failure/heart-failure-tools-resources

The Project RED Toolkit

A Research Group at
Boston University Medical Center

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BU
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.

Re-Engineered Discharge (RED) Toolkit. U.S Department of Health and Human Services Agency for Healthcare Research and Quality. https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html.

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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.

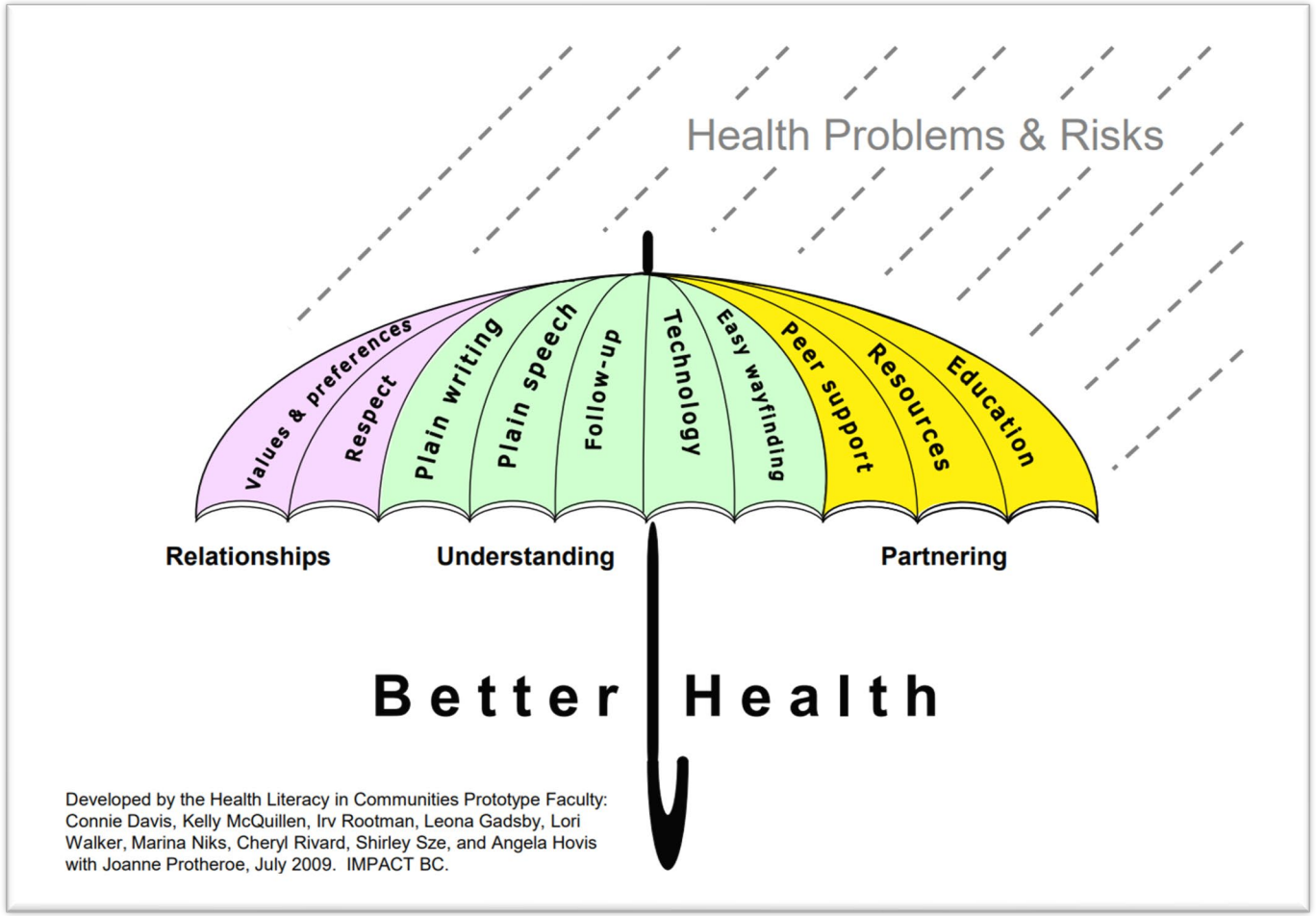
*As listed in the AHRQ *Re-Engineered Discharge (RED) Toolkit*. http://www.ahrq.gov/professionals/systems/hospital/red/toolkit/

https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html, accessed 10/25/22.

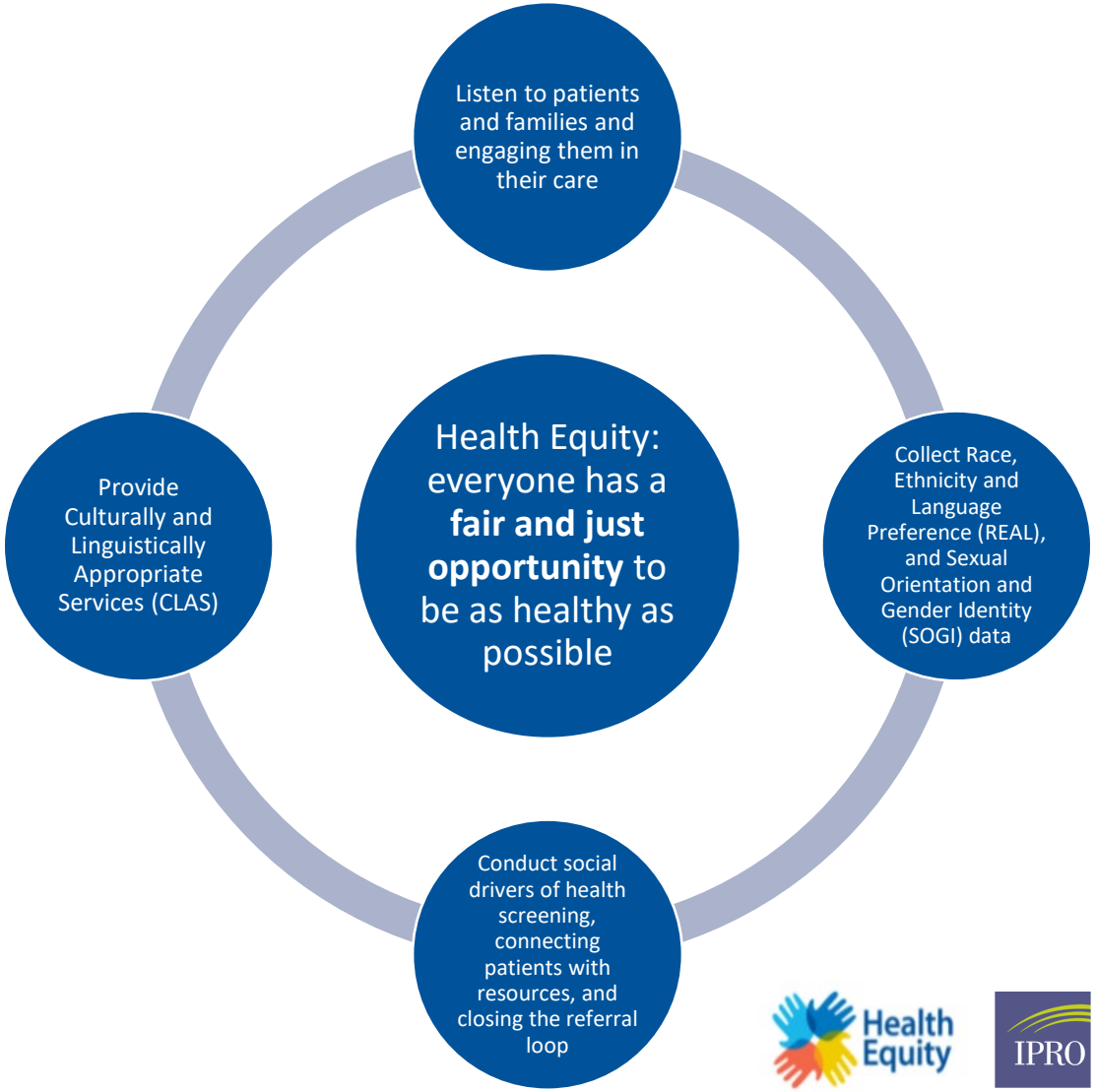
Key Features of the Re-Engineered Discharge Process

- 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.

Looking at the Full Picture



Connecting the Pieces



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Concepts in Action

- ✓ 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

Resources

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- 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

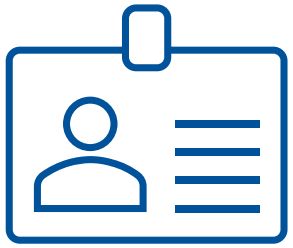
AHA

- 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

Thank you!