

Health Equity in Action: Successfully Reducing Readmissions in Vulnerable Populations



Monthly HQIC Health Equity Office Hours

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Rosa leads Alliant Health Solution's health equity strategic portfolio and embeds health equity in the core of Alliant's work. Rosa has 10+ years of experience in public health advisory for premier agencies, including the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), and the Food and Drug Administration (FDA). She holds a master's of public health in health policy and management from Emory University.

Guest Presenter: Genie Hamilton, Crisp Regional Health Services



Genie G. Hamilton, PT, DPT, MBA-
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Director of Quality

Crisp Regional Health Services

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Genie is a doctor of physical therapy by trade with 12 years of clinical and leadership experience in acute care, long term care, and home health care. Throughout her career, Genie developed a passion for healthcare quality and administration. That passion drove her to continue her education and receive her Master's of Business Administration with a concentration in Healthcare Administration (MBA-HCAD) as well as becoming a Certified Professional in Healthcare Quality (CPHQ). Genie returned to her hometown hospital as the director of quality for Crisp Regional Health Services in Cordele, GA and has been in the role for a little over a year. In her role, she also functions as the associate chair for the renewed Patient and Family Advisory Council for Quality and Safety. Genie enjoys the fulfillment of leading the organization in continuous performance improvement and is dedicated to providing the highest quality of care to the communities they serve.

Crisp Regional

- Located in Cordele, GA
- Established 1952
- 76-bed hospital, 2 LTC facilities, Home Health, Hospice, Retirement Villa, Physician Practices, Rural Health Clinics, Dialysis Center, Retail Pharmacy
- Over 850 employees
- Level 3 Trauma Center
- Level 3 Emergency Cardiac Care Center
- **Mission:** To provide appropriate, quality care and assistance in maintaining good health to all who need our services as near to their home as possible





The Community We Serve

Target opportunities for diverse populations

- Unemployment rate over 2 times higher than state average
- About 29% of the population is living in poverty, which is double the state average
- 1 in 5 households are experiencing food insecurity and/or housing insecurity

Readmission Taskforce

MEMBERS

- Quality director
- Executive sponsor
- Nursing directors
- Ancillary staff leaders (RT, pharmacy, case management director)
- Other hospital staff (dietician, case manager, social workers)
- Physician practices, LTC, home health, hospice/palliative care

PURPOSE

- Meet once a month
- Review readmission data and trends
- Collaborate and integrate resources organization wide
- Multiple action items/PI initiatives
- Report back progress to the taskforce

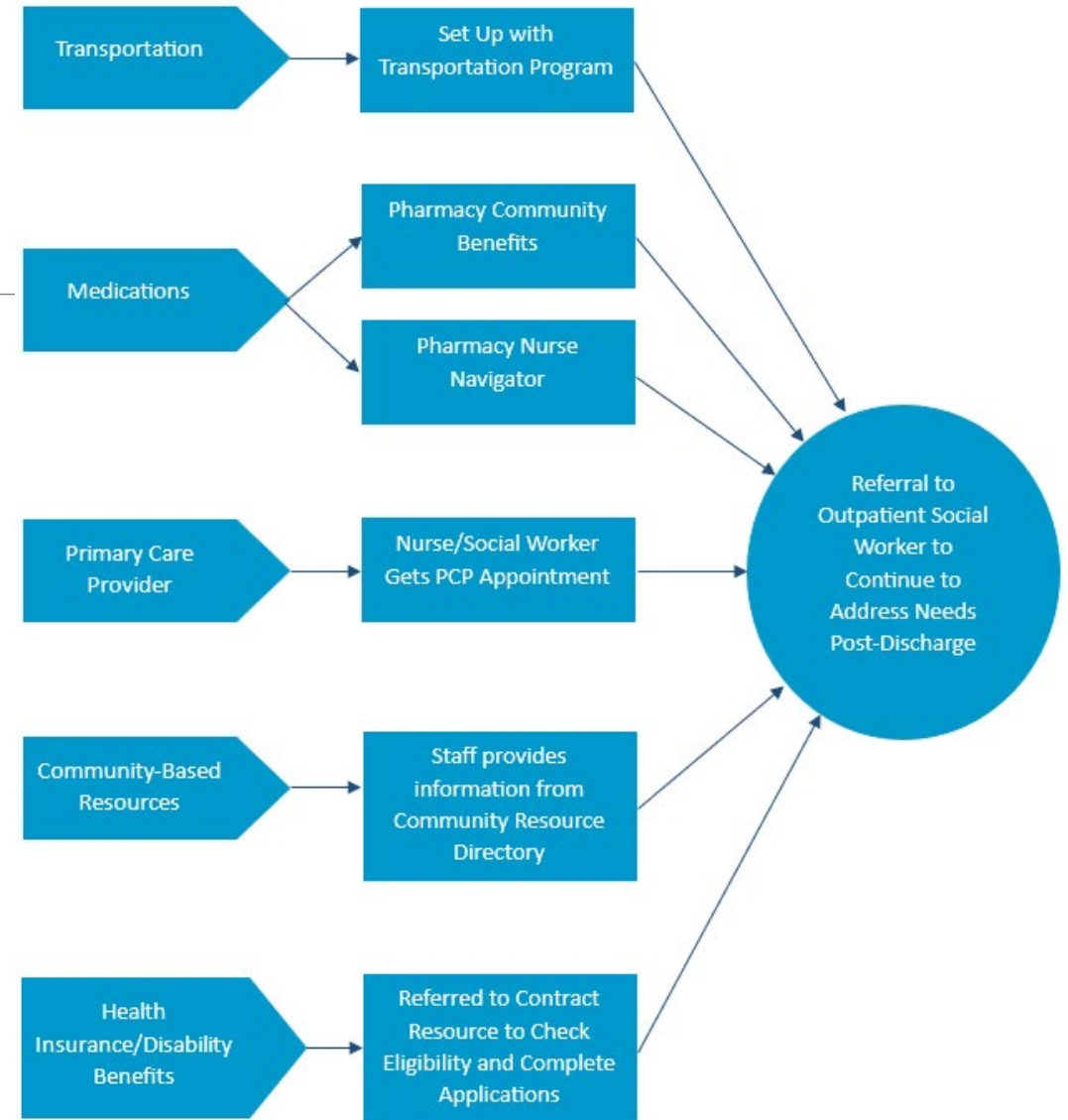
Project Goals

- Utilize resources to reduce the risk of readmissions for vulnerable population
 - Readmission Interviews
 - Paramedicine Program
 - Identify Health Related Social Needs
- New screening tool built into HER
- Ensure we have effective resources in place to address healthcare disparities and ensure the resources are integrated throughout our organization



Target Areas

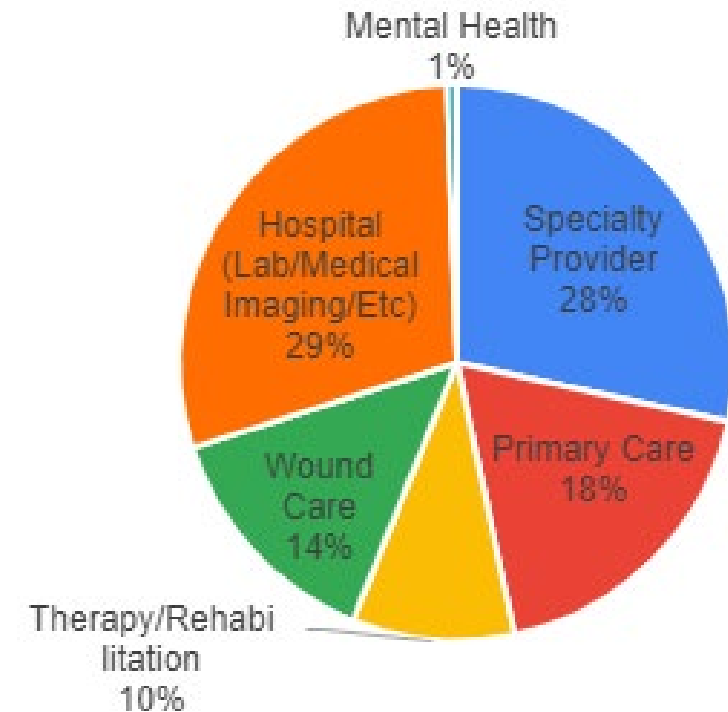
- Transportation
- Culturally competent patient education
- Obtaining medications
- Linkage to primary care
- Connection to community-based resources
- Obtaining health insurance/disability resources
- Outpatient Social Worker



Transportation

- One of the largest barriers in our community
 - 14% of our community has no motor vehicle
- Early 2023 began a congressionally funded nonemergent transportation service for medical care
 - Labs
 - Medical Imaging
 - Primary Care
 - Specialty Care
- 2 vans transporting patients free of charge
 - Ambulatory and wheelchair dependent
- Provided 636 round trip rides in the first 6 months of the program

Transportation Program Destinations



Culturally Competent Patient Education

Large population of Spanish speaking residents

- 14% growth in our community from 2015 to 2020
- Additional 11% increase projected for 2020 to 2025

Professional medical interpretation services

Written instructions in English/Spanish

Electronic Patient Education System

- Electronic Patient Education System
 - Educational videos
 - Specific to diagnosis, risk factors or treatment
 - Can be sent to cell phones for at home viewing
 - Whiteboard
 - Care team information (provider, nurse, patient care tech and case manager)
 - Plans/goals for the day
 - Diet
 - Allergies
 - Emergency contact name



Obtaining Medications

Identified inability to afford medication

- IDT rounds

Pharmacy community benefits program

- 30-day supply of medications upon discharge at no charge
- Provided medications for 98 patients/413 filled prescriptions over a 12-month period



Obtaining Medications

Pharmacy Nurse Navigator

- Advocates for underinsured and uninsured
- Copay assistance programs
- Available grant funds
- Medication replacements
- Assists patients and their families with application process

In 1 year, assisted over 50 patients in medication affordability, copay assistance, grant funds, replacement meds and free meds.

Linkage to Primary Care

Primary Care follow up within 14 days of discharge

Uninsured are less likely to have a PCP

Identify patients without a PCP and set them up with one upon discharge

- Social workers and nurses work together to identify and link patients with a provider

Link to providers with sliding scale pay programs and reduced cash rates for self pay patients



Community Based Resources

Determined a lack of awareness of community programs

- Food and housing
- Mental health
- Support for families and children

Community Council Family Connection

- Compiles an annual resource directory of all available community resources
- Obtained and distributed to key stakeholders within the organization
- Now available in house at all patient care units and case management, home care agencies, physician practices and community paramedics

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Health Insurance and Disability Benefits

Uninsured patients may be eligible for state and/or federal programs

Patients do not know they are eligible/overwhelmed by the process

CRHS partners with a consulting agency that can assist patients in obtaining insurance and disability benefits

- Works with families to determine if the patient meets criteria
- Assists with all paperwork and throughout the submission process if patient is eligible



Outpatient Social Worker

Established in February 2023

Focuses on follow up for patients after they discharge from the hospital

Focuses on community outreach activities

- Meets with church leaders and elected officials
- Provides marketing materials around the community
- Presents at various community agencies and civic clubs

Referrals are made by hospital staff for any inpatients needing social support

Follows patients after they return to the community

- Pharmacy Nurse Navigator
- Pharmacy community benefits program
- Transportation program
- In need of a PCP

Can meet with patient while still in the hospital to establish a relationship

Outpatient Social Worker

Within the first 6 months, has assisted over 70 patients in obtaining support services:

- Transportation
- Establish PCP
- Assistance applications
- Obtaining medications

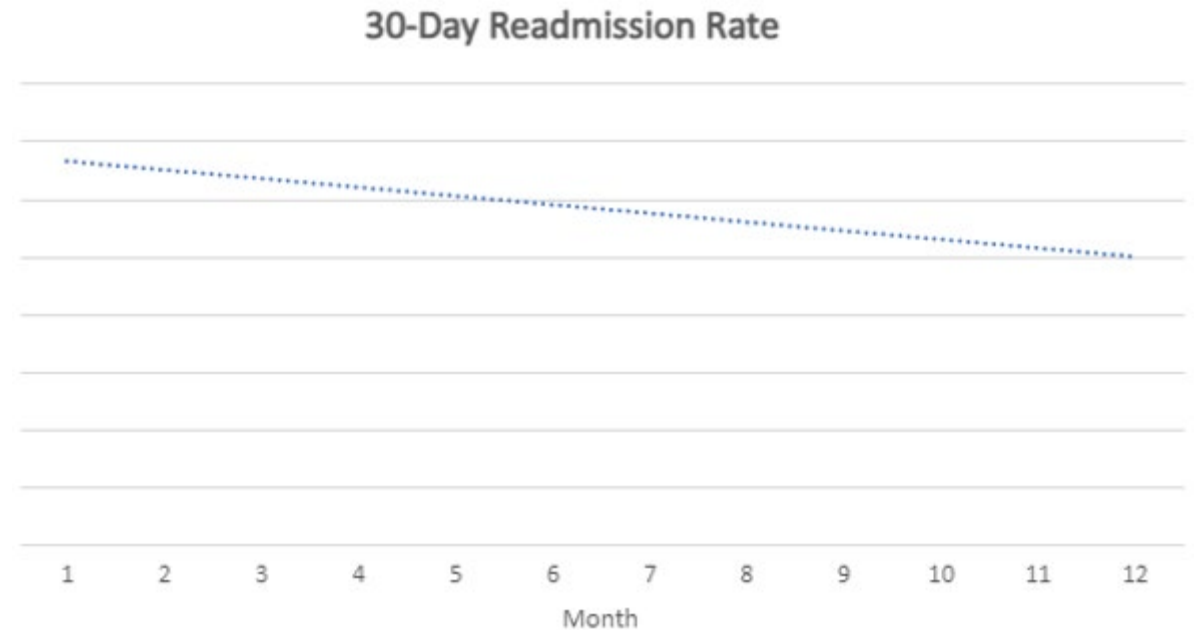


Data Analysis/Results

Readmissions

- 3% linear reduction over 12 months
- 31% reduction in self-pay readmissions compared to the previous 12 months

Monitor outreach of various initiatives and programs to capture impact on the community and patients



Additional Data Points

Stratify data further

- Age
- Race
- Gender
- Insurance provider

Data to be stratified

- Readmissions
- Patients enrolled in transport services
- Patients referred to outpatient social worker
- Patients who receive pharmacy community benefits
- Patients who are referred to the Pharmacy Nurse Navigator



Data Collection Methods

CHALLENGES

Data collection is manual

- Working with IT and EHR support to create more standard reports

Readmission data is internal only

- Cannot track patients who initially admitted here and readmit at another facility and vice versa

OPPORTUNITIES

New Care Optics tool through the GHA SHIP Grant

- Will track all readmissions, including those who readmit at a different facility
- Automated and will take significant manual data burden off the Quality Department

Conclusion

Cohesive approach to targeting readmissions

Organization wide use of available resources

Readmission Taskforce

- Key stakeholders collaborate on integration and execution of processes
- Ensure consistent, systematic approach to address health disparities
- Review data and recognize our impact
- Identify further opportunities to improve

Q&A/Wrap Up

**Please type questions
and comments in chat.**



Asked and Answered (from Registration)

1. How are hospitals creating their own reports on SDOH?

Some hospitals manually track Social Determinants of Health (SDOH) data using tools like Excel during the collection process and then maximize them to create reports with the numerator and denominator for tracking each inpatient monthly admission. They roll that report up to an annual report. I only advise this as temporary option if you are a CAH or smaller (under 20 inpatient admits monthly).

In contrast, others have partnered with their EHR vendors to create reports and adopted interoperable systems to integrate these reports into their EHR.

Do any other hospitals have tips they want to share on this?

Asked and Answered (from Registration)

2. I need guidance on completing the SOGI portion of our data tracking.

The specs manual for the hospital inpatient quality measures include the new SOGI definition under “*section 1 – data dictionary*”. This section in the manual exists to outline the changes to the new SOGI fields, but it’s not mandating the collection of SOGI data. The mandatory measures are listed under the highlighted *section 10* and nothing in that section mandates SOGI data collection. It is my understanding from this specs manual that CMS is trying to have hospitals be on one accord about how they collect this kind of information. They essentially took the original sex data element and adapted it to be able to capture additional information to help evaluate health equity. So, hospitals who are asking SOGI questions need to adapt their existing language to this defined terminology within their EHRs in order to be inclusive to the populations included in the definition.

Here is the screenshot from the specs manual for how to include this SOGI question in your data collection.

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Select all that apply:

- 1 Male
- 2 Assigned/Designated Male at Birth
- 3 Female
- 4 Assigned/Designated Female at Birth
- 5 LGBTQ
- 6 Unknown

Notes for Abstraction

Change to:

- Select any of the values that are applicable. The data element and values encompass both the patient’s current gender identity and one assigned at birth.
- Consider the sex to be unable to be determined and select “Unknown” if the patient refuses to provide their sexual orientation and/or gender identity. If “Unknown” is selected, then no other value should be selected.

Asked and Answered (from Registration) Continued....

2. I need guidance on completing the SOGI portion of our data tracking.

CDC created this type of questionnaire version that the patient fills out themselves:

<https://www.cdc.gov/hiv/clinicians/transforming-health/health-care-providers/collecting-sexual-orientation.html>

If you desire, you can adapt this document and be sure to change the response options to what is in the specs manual (on the slide prior) because the CDC response options are different.

Sexual Orientation

Do you think of yourself as:

- Straight or heterosexual
- Lesbian or gay
- Bisexual
- Queer, pansexual, and/or questioning
- Something else; please specify: _____
- Don't know
- Decline to answer

Gender Identity

Do you think of yourself as:

- Male
- Female
- Transgender man/trans man
- Transgender woman/trans woman
- Genderqueer/gender nonconforming neither exclusively male nor female
- Additional gender category (or other); please specify: _____
- Decline to answer

What sex was originally listed on your birth certificate?

- Male
- Female
- Decline to answer

Join Us for Monthly Hospital Health Equity Office Hours



February - August 2024 Registration:
https://bit.ly/AHS_HealthEquityOfficeHour_Registration



SCAN ME



HQIC
Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES
EQUALITY IMPROVEMENT & INNOVATION GROUP

JOIN OUR UPCOMING WEBINAR EVENT

ALLIANT HQIC
Health Equity Office Hours
Tues, Jan. 16 from 3-4:00 p.m. ET & Every
3rd Thursday from 3-4:00 p.m. ET from
February through August 2024 via ZOOM

[01.16.24_TO3_HQIC Health Equity Office Hours](#)
[02.15.24_TO3_HQIC Health Equity Office Hours](#)
[03.21.24_TO3_HQIC Health Equity Office Hours](#)
[04.18.24_TO3_HQIC Health Equity Office Hours](#)

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[08.15.24_TO3_HQIC Health Equity Office Hours](#)

CLICK ON TITLES TO REGISTER

OVERVIEW:
Interested in networking with peers and learning about the health equity regulatory requirements and best ways to implement at your hospital? Join our subject matter experts from Alliant Health Solutions and Tift Regional Medical Center (GA) for monthly interactive office hours.

Office hours are participant driven and with minimum slide presentations. Discussions will focus on the six health equity planning and action steps as well as other questions from the hospitals, e.g., CEO engagement.

Step 1: Identify your health equity champion and team, including leadership

Step 2: Solidify a process for collection of REA, a SDCA and embed it into EHR

Step 3: Identify and analyze your REA, a SDCA data by quality measure

Step 4: Utilize your data to identify and address 1-3 priority populations impacting health disparities

Step 5: Develop concrete health equity goals with short and long-term action steps to address your identified disparities

Step 6: Develop community partnerships that focus on reducing your identified disparities

Six Steps to Hospital Health Equity Action Planning

Office hours will be held the 3rd Thursday of the month from 3-4:00 p.m. ET. Please register to attend.

Jan. 16, 2024 • Feb. 15, 2024 • Mar. 21, 2024 • Apr. 18, 2024
May 16, 2024 • Jun. 20, 2024 • Jul. 18, 2024 • Aug. 15, 2024

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FEATURED SPEAKERS:



ROSA ABRAHA, MPH
Health Equity Lead
Alliant Health Solutions



LEANN PRITCHETT, MSN, RN, CPHQ
System Director of Quality and Safety
Tift Regional Medical Center

AUDIENCE:
Health equity team leaders, quality and patient safety professionals, clinical social workers, community and population health professionals, clinical team members, leadership

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Alliant Health Solutions HQIC Health Equity Office Hour Materials

What can we help you find?

Upcoming Events

Presentation
Materials
Found Here

HQIC Office Hours

Health Equity Office Hours | 1.16.24



Office Hours - Infection Prevention Chats |
1.24.24



Health Equity Office Hours | 2.15.24



Health Equity Office Hours | 3.21.24



Health Equity Office Hours | 4.18.24



[SHOW MORE](#)

HQIC LAN Events

HQIC LAN - Workplace Violence Prevention:
Best Practices for Safer Care | 1.23.24



[SHOW MORE](#)

HQIC Community of Practice Calls (COP) Events

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Questions?



Email us at HospitalQuality@allianthealth.org
or call us at 678-527-3681.

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Thank you for joining us!
How did we do today?

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