Exploring Equity Through a Readmissions Reduction Collaborative

Presented By: Cate Harmon, Erin Aklestad & Debbie Lowenthal

Reverse Site Visit 2023

July 20th 2023

Alaska Flex Team

Cate Harmon
Flex Coordinator, Alaska Department of Health

Debbie Lowenthal
Alaska Hospital & Healthcare Association

Erin Aklested
Mountain Pacific Quality Health

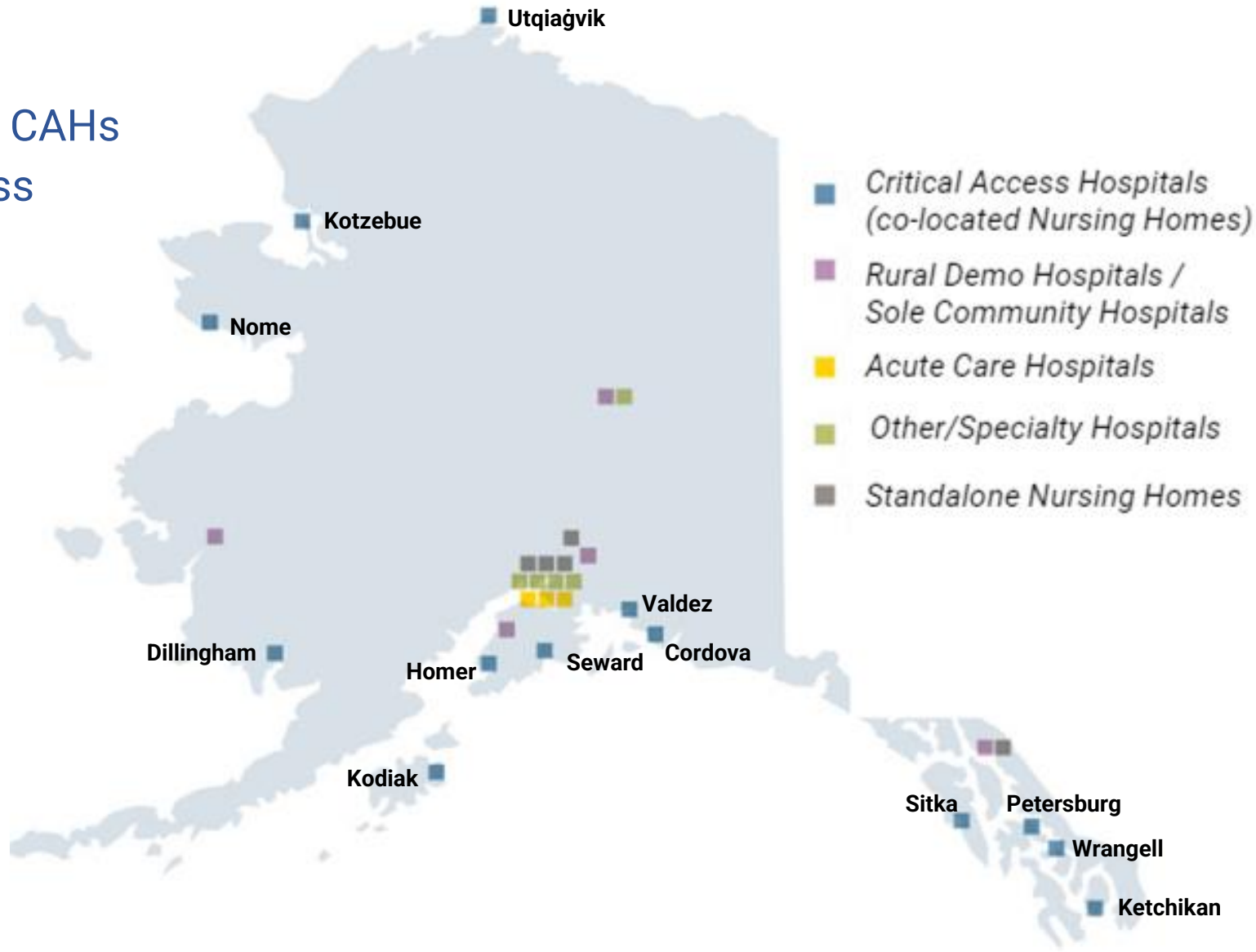
Alaska Facts

en.wikipedia.org

- Largest State by size
- Third least populated
- Alaska Native/Indigenous population is 15%, most of any State
- Highest concentration of veterans per capita
- Most communities are not on the road system

Alaska Hospitals and Nursing Homes

Only 3 of the 13 CAHs have road access



Thirteen Alaska Critical Access Hospitals

Tribal

- SEARHC Mt. Edgecumbe Hospital (Sitka)
- Kanakanak Hospital (Dillingham)
- Maniilaq Health Center (Kotzebue)
- Norton Sound Regional Hospital (Nome)
- Samuel Simmonds Memorial Hospital (Utqiagvik/Barrow)
- Wrangell Medical Center/SEARHC

System

- PeaceHealth Ketchikan Medical Center
- Providence Valdez Medical Center
- Providence Kodiak Island Medical Center
- Providence Seward Medical Center

Community

- Petersburg Medical Center
- Cordova Community Medical Center
- South Peninsula Hospital (Homer)

Air miles from Anchorage

Utqiagvik (Barrow) -500 miles

Kodiak Island – 250 miles

Petersburg Medical Center – 650 miles

Capital of Alaska - Juneau

Rural Travel

Weather-Related Events

FLEX QI Project - Year 1 Reducing Readmissions

Bartlett Regional Hospital
QUALITY in Community Healthcare

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

Providence Alaska Medical Center

Critical Access Hospitals

SEARHC
healthy is here.

South Peninsula Hospital

Providence Valdez Medical Center

Providence Seward Medical Center

Providence Kodiak Island Medical Center

Year 1 Focus & Goals

Year 1 Project Focus: Readmissions

- Alaska had over 600 unplanned 30 day readmissions in 2021 with a rate of 12.81 per 1000 discharges

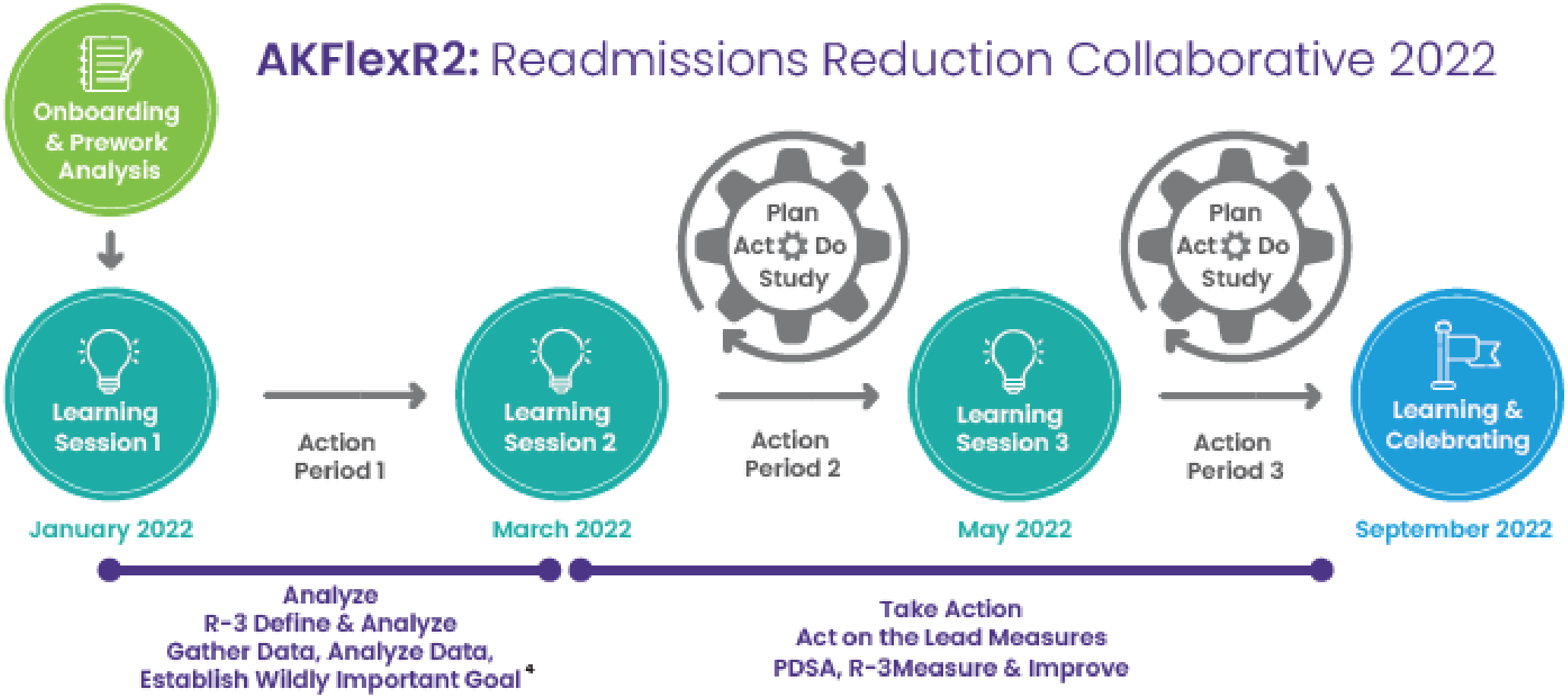
Year 1 Project Goals:

- Recruit two hospitals in Alaska to engage in a readmission reduction collaborative by December 31, 2021

- Reduce the average Alaska CAH Medicare readmission rate by 3% for participating hospitals by the end of 2022

- Have 100% of participating hospitals develop robust readmissions data, analyze readmission rates by provider category, and become familiar with the ASPIRE framework

Project Design & Methods



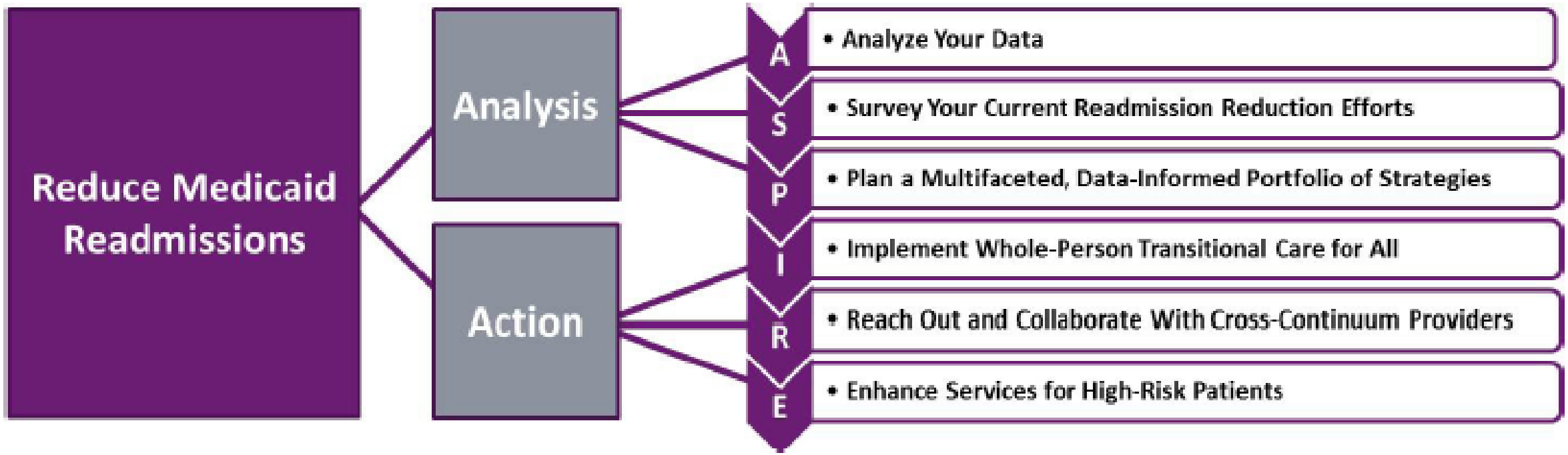
Action Period Supports: Coaching, Webinars, Team Reports, Peer Learning, Online Resource Center, Listserv, Data Support

Health Literacy Training & Work Session

1. **Initial training and intro to health literacy**
2. **In-person work session**
   - Prevalence of low literacy and implications for health
   - Methods for clear verbal, written and web-based communications

   Small group breakout sessions
   - Creating handouts
   - Explaining to a patient or the public in plain language
   - Making your facility more health literacy friendly

ASPIRE Method



https://www.ahrq.gov/patient-safety/settings/hospital/resource/guide/index.html

Results

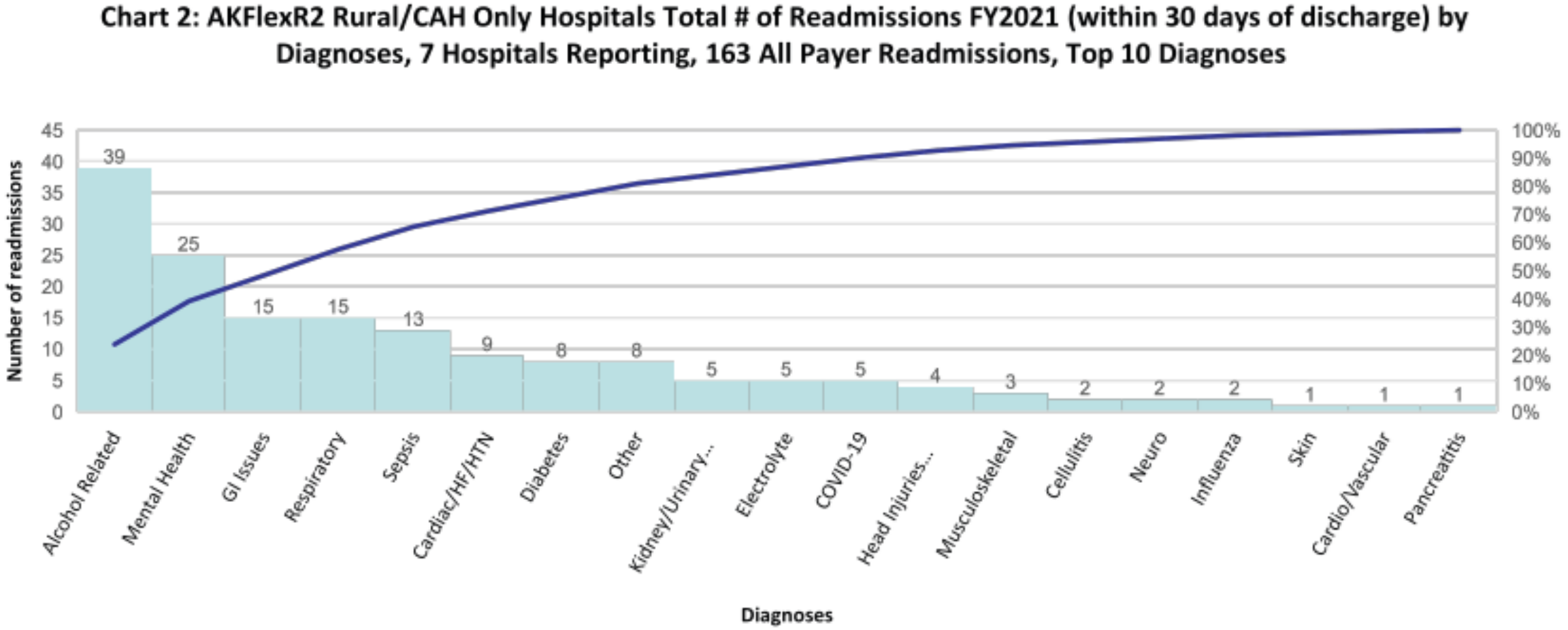
Table 2: Hospital Engagement & Outcomes

2022 FLEXR2 Hospital Engagement & Outcomes	Count & %
Hospitals participating in the collaborative	10
Critical access hospitals participating	7
Completed tool 1 - data analysis	100%
Hospitals received coaching calls with Dr. Boutwell	50%
% that received technical assistance	90%
Hospitals completing health literacy training	100%
Hospitals that completed posters	90%
Developed ideas for QI projects	90%
Hospitals that completed the project	90%
Hospitals that create culturally competent discharge instructions	In progress

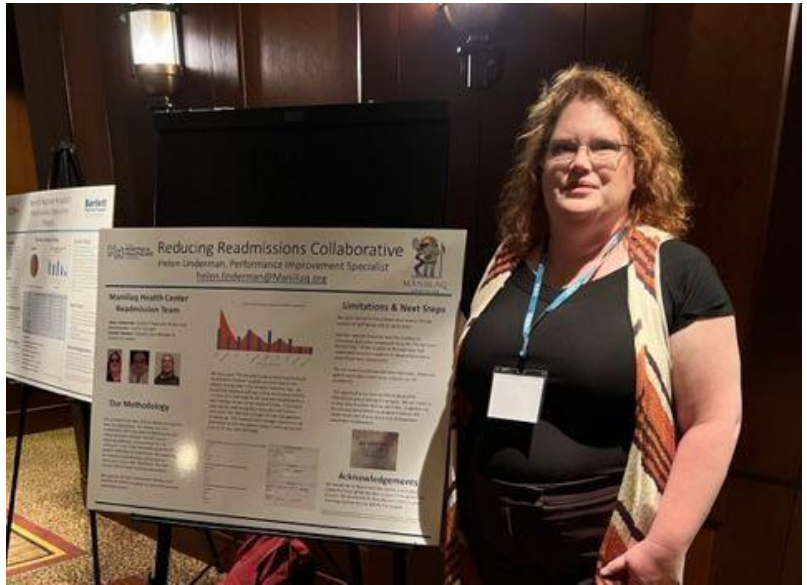
Goal	Rate Achieved	Change	% Achieved
Goal: Reduce Alaska Medicare Readmissions rate by one point from 12.81 to 11.81 (baseline Q1 & Q2 2021 as compared to 1/1/2022 - 8/30/2022)	11.41	↓ 1.40	11%
Goal: Reduce Medicare Readmissions CAHs by 3% from 14.25 to 11.25 (baseline Q1 & Q2 2021 as compared to 1/1/2022 - 8/30/2022)	8.31	↓ 5.94	42%

Source: Telligen CDS Data All State Org, All Project Org, 12/8/2022 & 2/1/2023

Results (continued)



Poster Presentations - September 2022



ASPIRE & Readmissions

Lessons Learned

Barriers

- **Timeframe was too short, need another year to continue the work**
- Using Medicare only data for outcomes
- **Limitations to extract social drivers of health data**
- Few readmits, low census, skewed readmission rates
- **Minimal community options at discharge, no home health services**

Benefits

- Hospitals worked collaboratively in a supportive environment with peers
- Data driven interventions
- Identified resources to address and improve patient outcomes
- Readmission awareness, recognition of high ED utilizers and multi-visit patients
- Alcohol as a contributing factor in readmissions - Alcohol Education Pilot Project with Recover Alaska

Patient-Focused Alcohol Education Pilot Project

- Alcohol-related diagnoses accounted for 24% of all readmissions
- Alcohol and mental health diagnoses combined equated to 47% of readmissions
- A patient focused alcohol education resource kit was developed and is being piloted in four facilities that were part of the collaborative
- The main message: We can all Drink Less and Live More!

FLEX QI Project - Year 2 Health Equity

Bristol Bay Area Health Corporation

Providence Seward Medical Center

Bartlett Regional Hospital

QUALITY in Community Healthcare

Providence Valdez Medical Center

Providence Kodiak Island Medical Center

South Peninsula Hospital

MANIILAQ ASSOCIATION

FAIRBANKS MEMORIAL HOSPITAL

PeaceHealth

Why focus on health equity for Year 2?

- Health equity and social drivers of health play a *major* role in readmissions and health outcomes generally
- In year one facilities weren't always able to assess readmissions by age, ethnicity, and language preference "REAL" data
- Support facilities to incorporate health equity and a social driver of health lens into readmission data
- Allow facilities to determine if there are certain populations of people at higher risk
- Visibility will allow the collaborative to work together to address inequities

Health Equity and Quality Reporting

Joint Commission

6 new Elements of Performance focused on reducing health disparities

CMS Inpatient Quality Reporting

3 new measures: Hospital Commitment to Health Equity, Screening for Social Drivers of Health, Screen Positive for Social Drivers of Health

MBQIP

Proposed health equity measures to align with CMS IQRs

c

Health Equity

"Everyone has the opportunity to attain their highest level of health." – American Public Health Association

Health Disparities

A measure of progress

Social Drivers of Health

A strategy to advance health equity

Credit to: NORC Walsh Center, https://www.norc.org/content/norc-org/us/en/about/departments/walsh-center-rural-health.html

Cynosure Health, "Hospital Equity, The Big Picture" May 2023

Health Equity- the Hospital's Role

- Improving the health of community members?
- Increasing access to community services?
- Advocating for change?
- Addressing gaps as identified by patient feedback and improving systems to address those gaps?
- Partnering with other organizations to meet unmet needs?

Health Equity Data Collection Considerations

Staff availability and systems to collect, analyze, and use data

- The right people – local context is important
- The right training – scripting and sensitivity with patients
- The right tools – EHR, tablet, paper tool, post-discharge call or all of the above

Availability of community resources and capacity to support patients who are referred

- Tracking databases are emerging
- Availability of resources varies

Data collection & documentation… determining a disparity is complex

Source: 10/27/2022 Cynosure Health webinar chat question: What is the greatest challenge you face in setting up SDOH screening?

Year 2 Focus & Goals

Project Focus:

Implementation of health equity with a focus on readmissions

Project Goals:

- Increase the collection and use of race, ethnicity and language preference (REaL) data
- Increase cultural competency training
- Increase diversity at the leadership and governance levels

Project Design and Method

- Secure Hospital Participation
- In Person Project Kick-Off
  - Dr. Anthony Iton provided an inspirational introduction to health equity
- Building Foundational Knowledge
  - HSAG Quickinars- 13 quick health equity webinars designed for adult learning
- Virtual Hospital Learning Sessions
  - Cynosure learning series
- Collaborative Meetings
  - To share best practices, resources, provide support
- Website
  - Hosting all collaborative resources

Secure Hospital Participation

Invitation to Participate - list of goals, activities, timeline, commitment & scholarship info

Conducted a call for all hospitals to learn about the project, invited quality teams

- Follow-up to those that were part of the first year QI project/readmissions collaborative
- Six of the ten decided to continue (five CAHs, one medium)

Letters about the project emailed to all quality leads that hadn't been part of the first year

- Follow-up phone calls/personal emails to other hospitals
- Seven hospitals interested (five CAHs, one medium, one large)

Of the thirteen hospitals interested

10 CAHs (4 Tribal)

2 medium-sized facilities, PPS

1 large PPS (Tribal)

In-Person Project Kick-Off

Learning Session: “What is a hospital’s role in health equity?” with subject matter expert Dr. Anthony Iton, California Endowment

Round Table Discussion

Where is your facility at in their health equity journey?

Alaska's hospitals reported:

- Advocating for policy makers to change reimbursement models
- Instituting culturally appropriate interventions for Alaska Native staff and patients
- Educating traveling staff on local culture
- Advocating for change to background check laws so that people can work and care for people in their own communities
- Working with school nurses to coordinate care for children

Building Foundational Knowledge

HSAG Health Equity Quickinars & Toolkits

- 1. Health Equity, Hospitals, and CMS Reporting
- 2. Engaging Leadership in Health Equity
- 3. Health Equity as a Strategic Priority
- 4. Collecting and Validating REaL Data
- 5. Social Determinants and Social Drivers of Health
- 6. Screening for Social Drivers
- 7. Culturally Competent Data Training
- 8. Analysis and Stratification of Health Equity Data
- 9. Health Equity Interventions
- 10. Best Practices in Health Equity Interventions
- 11. Community Paramedicine
- 12. Identifying Community Health Disparities
- 13. Community Engagement—Health Equity

Virtual Hospital Learning Sessions

- Cynosure Health - experts to lead educational and coaching sessions with facilities
- Experience working with rural hospitals in other states on health equity and can bring that to the table
- Recent “Storming Sessions” on Social Drivers of Health
- Six webinar sessions to address health equity and readmissions
- Individual coaching sessions

Cynosure Learning Sessions Timeline

June

Building Trust to Strengthen SDOH Data Collection

August

Deep Dive on Data Collection Plans and Practices

September

Identifying Disparities and Basic Interpretation

Fall TBD

Deep Dive on Challenges and Lessons from Initial Analyses

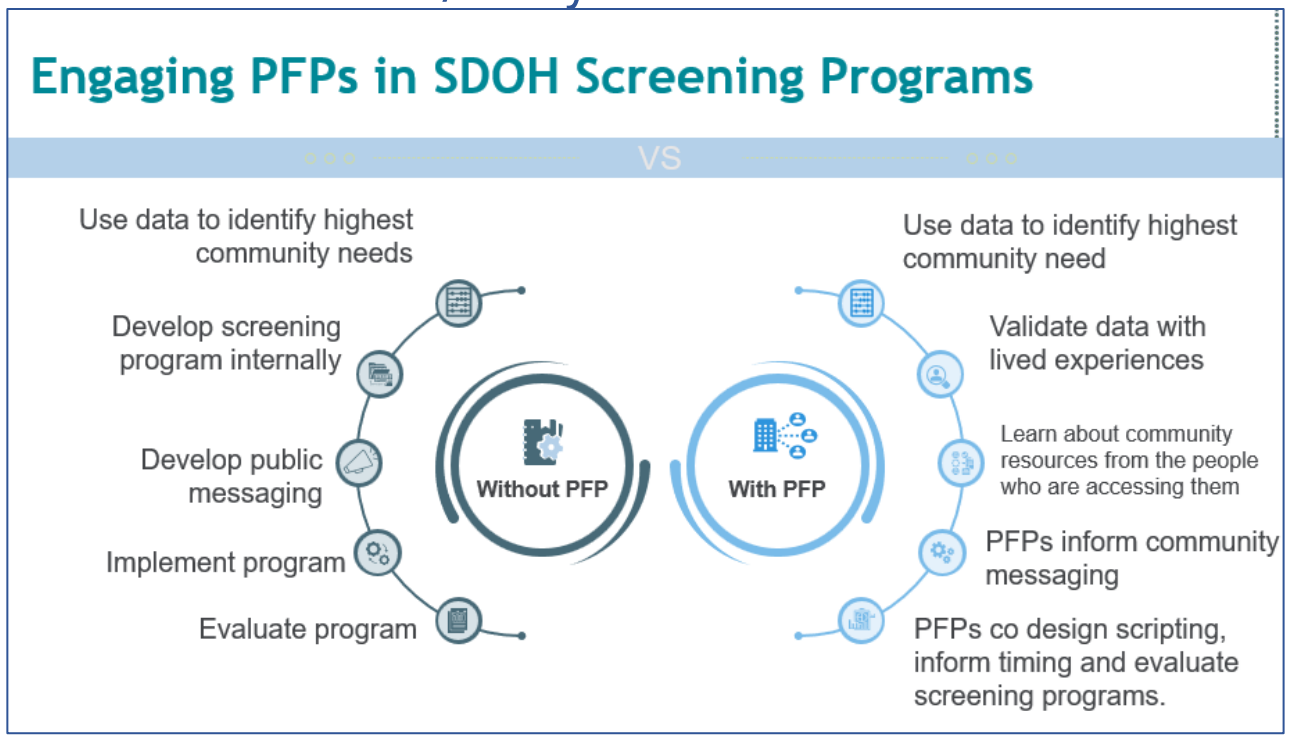
Fall TBD

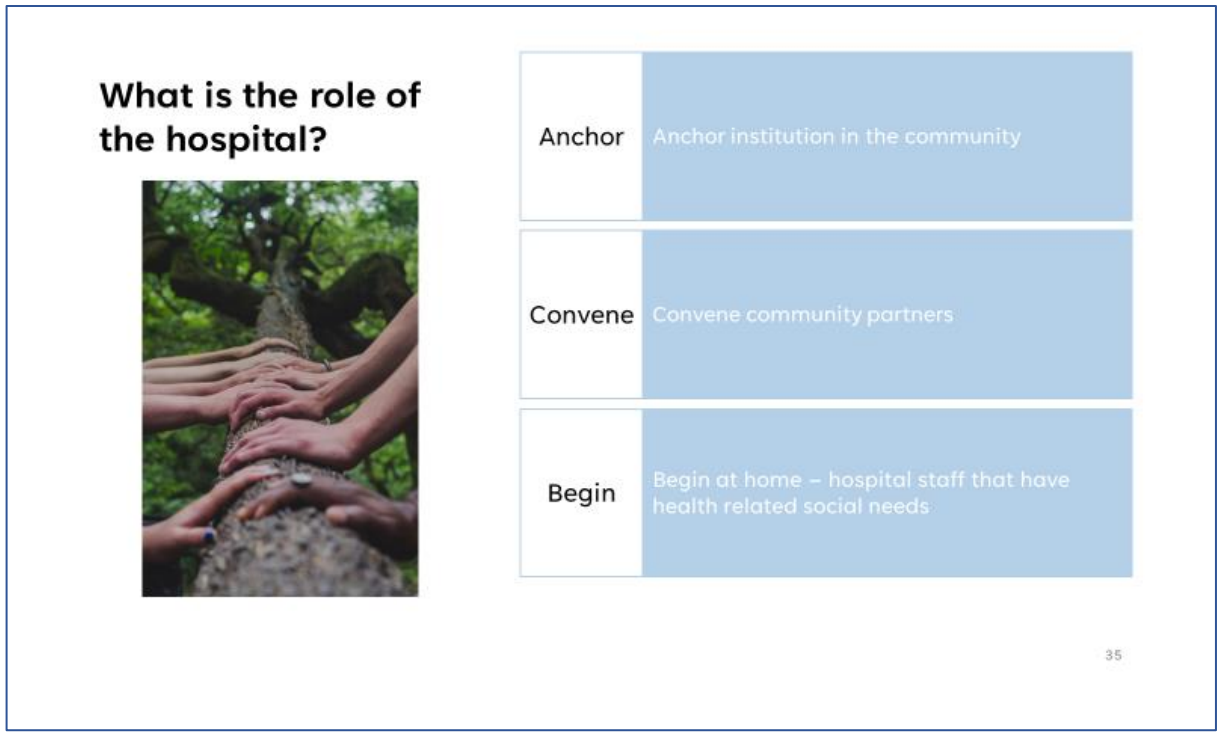
Getting to Action

Cynosure Learning Sessions

Learning Session #1 – Hospital Equity the "Big Picture"

Review Hospital area level vulnerability analysis and mapping tools, Intro CMS equity data collection/analysis





Cynosure Learning Sessions (once more)

Learning Session #2 – Building Trust to Strengthen SDOH Data Collection

Deep dive into the why, how, what, when and who of interviewing for SDOH and demographics with an emphasis on building trust

Hospital Assignment – Develop/refine your plan and practices for data collection

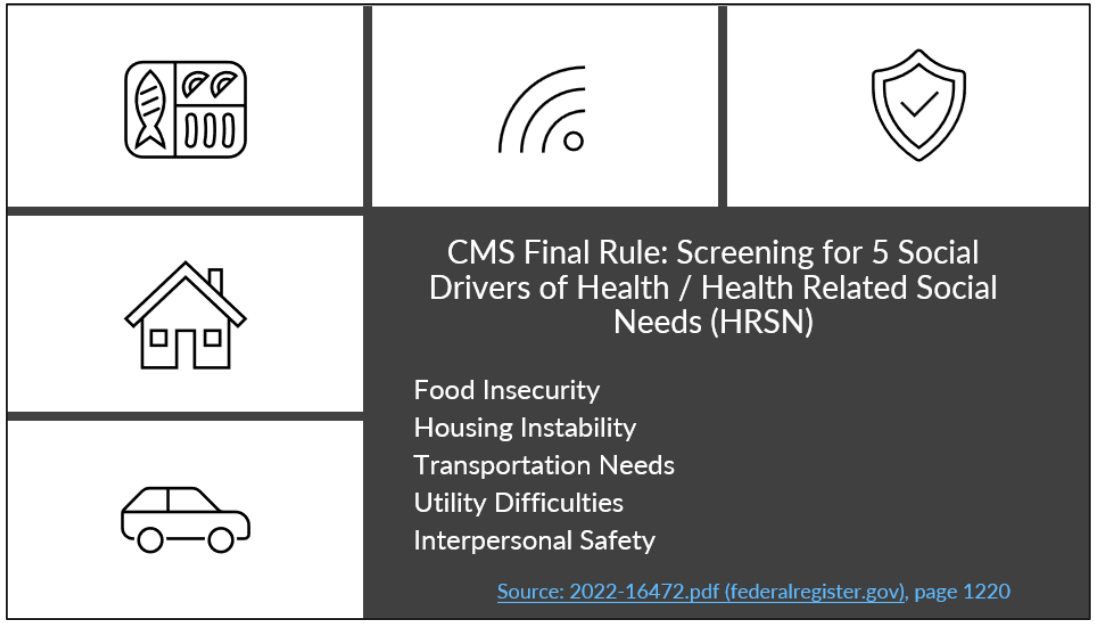
Getting Started

Actions

- **Set a vision** – what does success look like?
- **Convene stakeholders** – nursing, quality, case managers/social workers, IT, population health, education/marketing, patient family partners
- **Identify existing resources**

Resources

- Existing screening tools- SIREN
- Your Electronic Medical Record (EMR) capabilities
- Existing partnerships and organizations with whom you have not yet partnered
- Perspectives and ideas from patient family partners who have experienced SDOH screening



Cynosure Learning Sessions (continued)

Learning Session #3 – Group discussion/deep dive on data collection plans and practices

Learning Session #4 – Identifying Disparities and Basic Interpretation

How to use the demographic and SDOH info and analyze quality measures for disparities. The use of Z-codes to augment the analysis

Hospital Assignment – discover the IT capabilities of your EMR and attempt an easy analysis to identify a potential disparity (readmissions?)

Cynosure Learning Sessions (final)

Learning Session #5 – Group discussion/deep dive on challenges and lessons from initial analyses; preliminary priorities

Learning Session #6 – Getting Into Action

Expanding your resources to meet Health Related Social Needs (HRSN) and Identifying Community Based Organizations (CBOs)

Hospital Assignment – Explore expanding/deepening local community relationships

Website for Collaboration

ALASKA HOSPITAL & HEALTHCARE ASSOCIATION 70 YEARS

ABOUT AHHA | ADVOCACY & POLICY | TRAINING & EDUCATION | RESOURCES & PROGRAMS

QUICK LINKS:
Collaborative Meetings
Resources
Group Chat

ALASKA FLEX READMISSION REDUCTION COLLABORATIVE 2023

AHHA, with the State of Alaska Flex Team, has launched a readmission reduction collaborative based upon the ASPIRE model, "Designing and Delivering Whole-Person Transitional Care," a framework developed by Dr. Amy Boutwell for the Agency for Healthcare Research and Quality (AHRQ). The collaborative will meet monthly from March through December 2023. New for the second year of the collaborative, we will focus on Health Equity and Social Drivers of Health.

PARTICIPATING FACILITIES

Bartlett Regional Hospital Quality In Community Healthcare
South Peninsula Hospital
MANILAQ ASSOCIATION
Providence Seward Medical Center
Providence Valdez Medical Center
Providence Kodiak Island Medical Center

Download a list of teams and contact information for the Collaborative participants.

2023 Highlights
Learning forums highlighting best practices
Hospital engagement meetings, peer learning
Networking opportunities, both virtual and in-person

2023 LEARNING SESSIONS & COLLABORATIVE MEETING SCHEDULE

GOALS

- **Increase the Collection and use of Race, Ethnicity and Language Preference (REAL) Data**
- **Increase Cultural Competency Training**
- **Increase Diversity at the Leadership and Governance Levels**

August Meeting Date TBD

- Assignment for Facilities - Complete one PDSA cycle for screening SDOH to be shared
- Recording of HSAG HQIC Quality Series: 4. Quality Improvement Models - watch the first eight minutes for PDSA Information (enter email to get download)
- PDSA Worksheet
- A-3
- A-3 with definition and resources for each section

June 2023
Learning Session
Link for June 22 Webinar with Cynosure
Passcode: **qzU6#Z3d**

May 2023
Learning Session 2: May 23, Webinar with Cynosure Health
Link for May 23 Webinar with Cynosure
Passcode: **c0eE$+$G**

Next Steps

- Summer Hospitals are working on their PDSA of a health equity screening a few patients
- Continually update website with new tools and experience hospital have with screening
- Coaching with Cynosure and Flex Team
- Offering assistance with data analysis to facilities who were in the first year readmission collaborative to review progress
- Teams eligible to submit for a scholarship to attend the IHI National Patient Safety Congress in 2024 and share their journey to advance health equity
- Return to RSV to share results and lessons learned!

References & Acknowledgements

1. McIlvennan, Colleen K et al. “Hospital readmissions reduction program.” Circulation vol. 131,20 (2015): 1796-803. doi:10.1161/CIRCULATIONAHA.114.010270

1. Designing and Delivering Whole-Person Transitional Care. Content last reviewed June 2017. Agency for Healthcare Research and Quality, Rockville, MD. Accessed 11/20/2021. https://www.ahrq.gov/patient-safety/settings/hospital/resource/guide/index.html

1. IHI Breakthrough series College. Institute for Healthcare Improvement. Accessed 11/30/2021. http://www.ihi.org/education/InPersonTraining/breakthrough-series-college/Pages/default.aspx1

1. McChesney, C., Covey, S., Huling J. The 4 disciplines of execution: Achieving your wildly important goals Washington D.C.: Free Press; 2012:35

1. OHDIN,

Special Thanks:
Dr. Amy Boutwell MD, MPP – Collaborative Healthcare Strategies
Dr. Barry Weiss MD - Southwest Center for Medical Education
Dr. Anthony Iton
Lynn Van Vactor, MAS, CPHQ
Sara Platt , RECOVER Alaska
Cynosure Health
Alaska hospitals and their teams