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Why Health and Health Care Disparities Matter - Transcript from Live Session

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Knitasha: Hi, good morning. This is Knitasha Washington and thank you to Quality Insights for welcoming me as a guest speaker today. Our topic is, Why Health and Health Care Disparities Matter. And really today, I'm going to talk to you more so from a person and family engagement standpoint. If we can go to the next slide, please?

Knitasha: Just a little bit about myself, I have been working in the healthcare space for more than 20 years now. Most of my work has been as a performance improvement consultant. I've worked with hospitals across the country as well as practices, helping to transform their organizations. I've worked directly with clinicians as well as with policymakers, and individuals from various, representing various agencies, in terms of really working to move our country really towards improvements in both health equity but also in patient safety. I also do have a research background and so, I also try to focus on building evidence in these spaces as well. Next slide, please.

Knitasha: When we talk about, you know, health disparities, what context, what framing are we really coming from? I guess the real, and for this, the real piece of that I'm trying to underscore is the real effect that health disparities have on our health systems. You know, health disparities cost our nation more than $300 billion annually. Readmissions, which is an issue that a number of our organizations deal with, whether you are on the acute care side or you're on the ambulatory side, costs our organizations an excess of $26 billion and $17 billion of that is avoidable.

Knitasha: And so, you know, this whole notion of helping individuals or organizations understand not only disparities but the impact of disparities, to me, that business case is really justified when you look at, you know, the dollar amounts we're talking about. Much of this is related to, you know, race, ethnicity, and we're going to spend some time talking about social determinants, but, so socioeconomic disparities as well, in our health service delivery systems and how it impacts our health service delivery system. Next slide, please.

Knitasha: You know, given some real practical examples, right, of what that looks like. When I talk about the, you know, $306 billion annually, that disparities cost us, what does that mean, right? What does that look like on the local level? What does that look like in real life? Well, one thing that we know, you know, when it comes to readmissions, minority ratio, individuals that come from minority populations are more likely to be admitted

within 30 days of discharge. I'm going to actually share some real data, also national statistics, and then statistics of a specific health network that I've worked with, that will be proof in the pudding behind that bullet point.

Knitasha: You know, it is safe to say that we do see more readmissions among a vulnerable population than not. Also, when we look at, there's 2014 data that was released on our national quality report that shows the rate of inpatient sepsis was worse for patients with Medicaid or not insurance, then it was for patients with private insurance. Again, when we began to look at financial class, right? Or dollars, or income, as a social determinate, we see disparities in those numbers as well.

Knitasha: And then, when we look at some of the other patients, safety measures, that are also within that quality and safety report, The National Quality and Safety Report, we see that blacks and Hispanics have received worse care than white, for more than 20% of the patient's safety measures. If you go to look at that report, which also looks at disparities nationally, you will also see, you know, that we can underscore the business case there as well, in terms of disparities that we see and we look at patients' safety measures nationally. Next slide, please.

Knitasha: You know, why is race important? Why is ethnicity important? Why is this topic, you know, piece important? We treat all patients the same, is commonly, you know, what I've heard in this work over the years. I'll make the preface in saying this, is that when we think about patient-centered care, patient-centeredness, which is something that we all are striving for within health services delivery, whether you're on the acute care side or the ambulatory side.

Knitasha: We know that personal and family engagement or patient family engagement, is certainly one of those transformational elements that organizations across the country have seen, you know, the value in implementing. In other words, in working closely with patients, there has been improvements that organizations have seen, in terms of, you know, being able to improve outcomes through shared decision making, through patient activation. I'm going to talk a little bit about some of those concepts later.

Knitasha: Ultimately, at the end of the day, if we're going to improve things, we got to know who we're talking about. This particular slide, the reason why I like it so much, is that it always really brings good context to our individuality, right? We talk about patients, one patient doesn't equal all patients. That, you know, we're all individuals. At the end of the day, all of these things that you see on this slide, do impact or can influence our health outcomes or our health decision making.

Knitasha: Whether it's gender, whether its physical disability, whether it's religion, whether it's my education, or my native language that I speak, at the end of the day, all of these things do have the capacity to influence our health outcomes. And so, for this reason, it is important to begin to understand who we're talking about it so that we can better improve outcomes for all people. Next slide, please.

Knitasha: Here's a little bit of data that I referenced earlier. If you remember one of the bullets I talked about in the earlier slide, spoke to readmissions data and how we see a disparity among minority populations, as it relates to readmissions. This data was, this actually slide, was pulled together in partnership with myself, working with AHRQ, so the agency for healthcare research, quality, and research. AHRQ pulled this slide together and essentially stratified our national readmissions data.

Knitasha: It's a 30-day all-cause readmission rates for hospitals. They stratified that by looking at hospitals that had minority populations, so those patients that fit into the racial-ethnic minority population, those hospitals that had a percentage greater than 16% verses those that are less than 16%. And so, those are less than 16% is what you see highlighted there in the blue. And then, the ones with higher minority populations are those that is represented there in the red.

Knitasha: You can clearly see the disparity that is consistent over years, between ethnic minorities that are readmitted and those that are, you know, from organizations that have lower percentages of ethnic minorities. If you go to the next slide, I'll show you the same data. One of the things that I commonly do with many of the health systems that I work with, is asked them to repeat the same exercise with their own date, just to kind of test and see, you know, what they actually have going on within their system.

Knitasha: What you see here is the Vizient network, which is a network that I've worked with over the years. Represented in this chart is more than 200 hospitals. This is within their specific network and these are 200 hospitals. As you can see, they aggregated, meaning all ethnic minorities, you can clearly see a disparity among African American, so red is that very top line there, you can clearly see the disparity between, let's see, black race and white, which is there. Green, you can clearly see the disparities there in the aggregate.

Knitasha: Again, if we put together or if we look in the aggregates, we see that black population, or the African American population, is really driving, you know, that average up because many of the other races are actually below white, but again, you still disparities irrespective across the board. And so, one of the things that you'll want to potentially look at is stratifying your data by race and ethnicity, if you have not, just to see if there are particular populations that you might want to take a special look at. In this particular network, it was the African American population and really understanding, you know, what's going on there as it relates to readmissions. Next slide, please.

Knitasha: When we think about what are some of the causes, you know, what causes those disparities? What are some of the, you know, things that might influence that? The most populations are often the most at risk for admissions and medical errors because of miscommunication and mistrust. I was just having this conversation on yesterday as a part of another exercise. We had a lot of patients who basically had said that they wanted, initially, to participate in a program, and then after going back to them six months later, many of them did not want to participate in the same program.

Knitasha: One has to ask them, you know, the question, why is that? And trust is certainly an influencer among populations. For those organizations that are represented here today,

those practices, you know, that are represented here today, having a mechanism for community engagement that aligns with your person and family engagement strategies is really critical for engaging minority populations or vulnerable populations, period. Whether we're looking at children, or we're looking at a person with disabilities, we're looking at veterans, you name the vulnerable populations, you know, really having a strategy for making some connectivity with that community engagement piece, along with your person and family engagement component, is really critical.

Knitasha: And then, the miscommunication piece is certainly, we know a factor. If you think about the earlier slide that I showed, you know, that demonstrated the iceberg of culture, two of those indicators that influence miscommunication, certainly is language. Whether or not you have patients and you're actually speaking to them in their preferred language, or their native language, or communicating with them in their preferred, or native language, or even had a mechanism for doing so.

Knitasha: Education is another influencer in terms of my ability to be able to communicate. Remember, it's not just, you know, the words that we say, it's also the interpretation, you know, of what is being said. And so, that miscommunication piece, certainly, also, is influenced by the education piece. So, some barriers, implicit bias, culture and language differences. I talked about the communication barrier, certainly health literacy, and then a lack of resources to care. Next slide please.

Knitasha: Person and family engagement, how does that really help us as it relates to, you know, these vulnerable populations that we are talking about? I'll start with saying, listening to the voices that are unheard. When working with your organizations or looking in your organizations to really begin strategies around how to better activate patients, how to better engage patients, how to work with patients in these specialty populations, one thing that you might want to consider, who are the voices that are commonly not heard?

Knitasha: I can give you some examples here. In one organization that I worked with and I asked this question to them, they said it was their teen moms. And so, voices unheard is a very local issue. Being able to answer that question, you know, really is dependent upon who you have around the table and that level of transparency also, and how welcomed individuals are in terms of bringing other voices or having that diversity at the table.

Knitasha: Diversity and inclusion within your person and family engagement or how you engage your patients is critical. Mostly, because when we talk about person and family engagement, really what we're attempting to do is to better understand the values, beliefs, and preferences so that we can better shape decision making. I'm going to talk a little bit about shared decision making, but again, what are the preferences of your patient, your patient profile, you know, that you're seeing today? What are the preferences as it relates to access to care? Do we even know what the barriers are?

Knitasha: For example, if transportation is one of the barriers for your patients to your practice, right? Then what are their preferences in terms of getting to your practice? Are their preferences for public transportation? Are their preference is that they would actually prefer to have your practice contract or utilize Uber to do transports, which many

practices are doing today. Would they prefer the actual, you know, private transportation services?

Knitasha: Again, what are barriers, number one? What are the issues that we have? You know, that are influencing the outcome. Number two, what are the values, beliefs, and preferences of our patient profile that's going to help us make better decisions? And then, the last point that I'll make here. When we did a diversity profile of patient, family engagement council, or patient, family, advisory councils across the country, what we found was that only 39% of hospitals, PFACs, actually have a diverse representation of their community.

Knitasha: Basically, what that tells us is that we have a huge opportunity to make certain that we're bringing a diverse profile of individuals into our practices or into a hospital setting to engage, and to be a part of our transformation process. Next slide, please. Shared decision making. I talked a little bit about values, beliefs, and preferences. I talked about vulnerable populations. Now, you know, essentially, what understanding all of that gets us to better treatment options and then tailored decisions that are made in alignment with those personal preferences.

Knitasha: Again, those characteristics that influence, you know, could be a disease. There's a patient population that we work with that is the HIV-AIDS population and so really understanding the disease stigma. And then, what are their preferences to access to care? What are their preferences as it relates to the sharing of information, things of that nature? Again, we must ... well, first, we got to understand what the issues are. What are the barriers, right?

Knitasha: And then, number two, we have to understand who we're talking about? So, what does my patient population really look like? So, when we talk about vulnerable populations, what are those descriptors that you put around that? And then, number three, by engaging them, how am I better learning how to understand, you know, treatment options that are in alignment with their personal preferences, as well as partnering with them so that we improve our operations and or our organization to meet those needs. Next slide, please.

Knitasha: Patient goals is another piece. We talked about values and preferences, but often times, you know, we don't have enough conversation with our patients to really understand what goals they are even attempting to accomplish. A good example of that, I was talking with a patient who said, "You know, I just really wanted to be in a circumstance where I could attend my son's wedding. We needed to make certain that we were setting up my chemo treatments in a way that allow me to meet that goal in August."

Knitasha: Making certain that we do understand the goals of our patients, as well. Not only their values, and beliefs, and their preferences, but what are some of their individual goals, right? And then, we do know that also things such as social determinants, and you know, spiritual background, or the spiritual preferences, also influence a shared decision making as well. Next slide, please.

Knitasha: In shared decision making, again, this is not about having a conversation, but it's really about the co-creation of health care decisions. It goes along with my example that I used about, you know, the patient that wanted to make certain that they attended their son's wedding, but was, you know, scheduling to go through chemo. How are we working, you know, really to co-create health decisions, so that there is value being bought back on both ends?

Knitasha: Not that we are giving treatments plans, or not that we are designing our organizational infrastructures, only to bring back values of those constituents that we see as stakeholders, meaning, our practice administrators, you know, physicians, other clinicians. But, that we're also doing that in partnership with patients. What that really does is it does help to build trust. I do believe that you also have to work to build trust before even getting to some of this.

Knitasha: What I mean by that is that often times we see where vulnerable populations within our community, need to be engaged on some level to begin to even actively build relationships with them that start to build trust. You know, how am I going to even have a conversation with you and I'm not really in the knowledge or understanding of, you know, what your issues are, this perspective that you see. And so, building that level of trust, in particular, working within the community to build that level of trust is critically important.

Knitasha: And then, one other piece that I'll underscore here is, yielding joy in practice. There's not one organization that we have worked with, from a transformation standpoint that has not seen the value that going through these efforts, actually does yield joy in practice. Meaning that you know, those clinicians, those practitioners that are working in our environment, you know, are much happier in working with their patients. Number one, because the relational component of it is improved. We now are in relationship with our patients, right? We have an understanding of them.

Knitasha: And then also, you know, it poses a lot of efficiency and greater effectiveness in the work that we do. You know, there's everything from stories about making decisions about which types of drugs to take. So, co-creating that decision platform, where there's a cost saving, right, for the patient. I didn't recognize, you know, that there were other options that would have saved me money, right? And then, being able to reap the value of not only having that but the value that it builds in trust with your patients. The values that it brings back in terms of reduce cost, on both sides, et cetera.

Knitasha: Really, this work is not just about, you know, partnering with patients, you know, for the sake of partnering with patients, it's also, you know, what we get back as a benefit in being able to do that. Next slide, please. Shared decision making is obviously a key component in this work that we do. It certainly does activate patients. I want to go to the next slide and give you a couple of examples of that work. There's decision-aids. I want to show you really quickly. AHRQ has some decision-aid tools. There's actually quite a few decision-aid tools that are out here that will help you. And not only the education process, but also you know, really practicing what shared decision making looks like in practice.

Knitasha: Engaging family and caregivers. I'm underscoring caregivers here because often times what we do is, we talk a lot about, you know, having the conversation with the patient, but in many instances, it's those caregivers that we also need to be having a conversation with. In particular, as it relates to things like readmissions, you know, are we even having a conversation with the family to understand or are we inviting the family into the conversation to better understand why readmission may have recurred. And so, engaging family and caregivers is also very important in this piece as well. Next slide, please.

Knitasha: Here's just come components for you to think about. This is the part of the transforming clinical practice initiative. This is for those of you who are aware of CMSs, TCPI program. These are six different areas that we're actually tracking or that we're looking for improvement within that network. The inclusion of the patient voice within the patient operations that really goes to how are you pulling patients from your practice into, perhaps, a patient and family advisory council? Or, some structure that operates similar to an advisory council, where you're hearing the voice of the patient and where patients are authentically invited to engage in the process of quality improvement.

Knitasha: The use of e-technology to engage patients and families. Here, there are a lot of organizations that have rolled out practice portals. So, they rolled out portals within their practices for the sharing of information. Often times, number one, we're not educating patients, really on the use of that. And then, number two, we're not doing the due diligence on the back end to make certain that information is adequately being posted so that utilization increases.

Knitasha: And so, think about those are opportunities to further engage and then how are you using that platform also in regular visits? When a patient comes in for an office visit, how is the use of that technology being incorporated? How is the use of that technology in the information that it provides being incorporated into those visits? Measurement of patient health literacy, again, there's literally a piece that is listed with AHRQ for those of you who are not aware of it, I would invite you to go to their website to pull that down.

Knitasha: Basically, here are tools that will help to educate on practicing or improving health literacy within the practice setting. Shared decision making, I talked a lot about that. Also, the assessment of patient readiness to be activated. We do know that, you know, there are different levels of readiness as it relates to patients. Certainly, we want to see all patients move toward self-management. So, whether it's diabetes self-management, or any other chronic conditions, you know really working with them to number one, be able to measure where they are today, but then number two, to measure their progress over time, as you continue to work with them and engage with them using these techniques.

Knitasha: And then, last but certainly not least, a support for medication use or medication management. Again, these are ... I would ask that if any of you are on the healthcare communities to also go onto health communities to look up the TCIP PEF components and there are a number of different resources that are available. I'm just going to show you a couple of links if you can go to the next slide. As it relates to shared decision

making, those links, those hyperlinks, I believe this presentation was sent out to everyone. Those hyperlinks are actual decision aids or education tools that we have highlighted as a part of this education process.

Knitasha: I would invite you to go and take a look at those, and incorporate those into the work that you're doing within your practice. Especially, what we are looking at within the TCPI community, so again, this is around practice transformation, is whether or not the organization or practice is supporting shared decision making by training, and ensuring their clinical teams integrate patient goals, preferences, concerns, so on and so forth, into their decision making process. Again, it's really about that engagement piece. Also, that motivational interviewing component is also very important and critical here. And then, there's some links that will take you to tools that will help you with that as well. Next slide, please.

Knitasha: Now, this is the AHRQ tool that I talked about or at least one of the other AHRQ tools that I talked about. It's the shared approach workshop curriculum, which is also online. If you go to the next slide, this next slide actually breaks down the components of that. Seek your patient's participation. Remember, it's that engagement piece. Help your patient explore and compare treatment options, assessing your patient's values and preferences, reaching a decision with your patient, and evaluating your patient's decision.

Knitasha: Again, if you have not seen this, it's a great quick reference tool that you can go onto the site, that's also noted here, within this webinar, for additional learning, and actual integration in your practice education with your clinical teams and your physicians. Next slide, please. PFE and equity, remember, one patient isn't all patients. Really understanding equity in terms of what are subpopulations look like and how we can partner with them to co-create or co-design more equitable systems.

Knitasha: That means, you know, we have to have a more diverse profile of individuals at the table, really helping us to guide our decision making and really helping us to understand what their barriers are. Again, I'll say this, under scoring, it's a very local issue. In other words, when I'm working Iowa and really understanding what's going on with their rural population, that's very different from what we might see in terms of health equity issues and working with partners in the city of Chicago, right? And so, understanding these issues from a very local standpoint is critical, which is the reason why I would recommend and again, underscore the connection between your community engagement strategies and your person and family engagement strategy. Next slide.

Knitasha: As we prepare to close, one of the things that, you know, I want to bring back to the surface is, first of all, it is very important to engage patients in your practice transformation efforts. Whether you are in a private practice, a small private practice, a large, you know, multi-specialty practice, at the end of the day, having patients at the table to help us really examine and understand what the issues are, and how we can improve these things, is very important. That's number one.

Knitasha: But also, having a diverse profile of those patients around the table, so that we better understand these barriers from different lenses, right? Different people see things

differently and they impact the lives of people differently. You know, those of your suburban residents, or suburban patients, might be very different from those that are in urban, the urban communities or urban environments. And really making certain that we have that diverse profile around the table to represent the voices of the patient, it's critical.

Knitasha: You have to be very intentional about this work. What I mean by that is that we can't assume. You saw the picture of me earlier, you can't look at the picture and assume that as a checkbox, that represents certain populations. The real best practice is for you to really have people self-identify and also you are being very intentional about that. In other words, how we're collecting data to really support what languages we need to have around the table, right. In some populations, I have seen where, you know, Polish is really the more dominant language in the particular community around a clinic that we were working with. Whereas, they had someone, you know, that they had selected that spoke Hispanic.

Knitasha: Again, at the end of the day, we want to make certain that we understand “the who” that needs to be around the table and having data to support that. Intentionality is critical. If there's any tools, any additional tools that you might want to see, in terms of collecting social determinant's data, in terms of collecting race-ethnicity data, so a patient profile data, in terms of best practice of engaging patients, and how to bring them into the practice setting, or now to bring them into your acute care setting, to engage in a PFAC, all of those things are tools that I can certainly assist you with. Here is my contact information. Please feel free to email me and thank you so much for joining today's webinar.

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