

SINAI-GRACE HOSPITAL

Addressing Disparities in Cardiac Care Among African American Populations

Project goal: To improve cardiovascular care for the African American population; to develop effective, replicable, quality-improvement strategies, models and resources; to utilize those strategies and models in clinical areas outside of cardiac care.

Reason for project: To effectively address gaps in the delivery of cardiovascular care to African American patients.

Sustained accomplishments: Maintained equality in the provision of evidenced based quality core measures to all patients regardless of race/ethnicity.

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Organization: Sinai-Grace Hospital

Program: Addressing Disparities in Cardiac Care Among African American Populations

Location: Detroit, MI

Summary:

The Health Resources and Services Administration have designated over half of Detroit as “medically underserved.” Eighty-nine percent of the population has at least one chronic illness and 39 percent report having three or more chronic illnesses. Sinai-Grace Hospital is the only major medical facility for the population in Northwest Detroit and also serves as the area’s trauma center. Sinai-Grace Hospital participated in the Robert Wood Johnson Foundation’s *Expecting Success* project to help identify what improvements could be made to continue to provide high quality care to this population and to also show others in similar situations that providing high quality care is attainable.

NOTE: Some programs are in the initial stages of data collection and reporting, while others are small in scope and have not yet established benchmarks. Where there is data available, it is provided in the questions and answers below.

Q&A:

1. **Why did Sinai-Grace decide to participate in Robert Wood Johnson Foundation’s *Expecting Success* program? Had the organization identified improving cardiac care among minority patients as a quality goal prior to participation? If yes, how (i.e., quality reporting data, outcomes measures, HCAHPS, other data)?**

Older, African Americans in Detroit are dying at dramatically higher rates than their counterparts who live in other parts of Michigan. A recent study conducted by Wayne State University found thousands of older African Americans in Sinai-Grace’s primary and secondary service areas are living in communities with excess mortality rates well over 3.00, when compared to non-urban Whites.

Sinai-Grace Hospital (SGH) had made substantial investments to improve quality of care and patient safety for African Americans. Clinical and management staff was trained, new technology was purchased and utilized, data collection and information technology was improved and expanded, and systems were streamlined. While proud of these accomplishments, SGH was not satisfied. There was a desire to develop new systems and identify opportunities for improvement, which provided the basis for involvement with the *Expecting Success* program.

2. **How did the organization create interventions that addressed gaps in cardiac care and implement them?**

With regard to inpatient practices, the collection of race/ethnicity/language data shifted to direct questioning of the patient as opposed to observation by registration staff. Additionally, the reading level of the patient population was evaluated and materials were adjusted to a 4th - 6th grade reading level. SGH also worked with input from patients to create a recipe book that showed the target patient population healthier ways to prepare their favorite meals.

The marketing department, in conjunction with the Division of Cardiology, developed a program entitled People’s Medical College. This program is an educational program where

patients, their families and the community at large are invited to educational sessions with physicians. In addition, with assistance from various chefs from area restaurants, cooking lessons are provided.

For ambulatory practices, SGH conducted an evaluation of its care and outcomes comparing a multidisciplinary congestive heart failure clinic concept with a physician office-style setting. Results showed that the multidisciplinary approach provided a greater propensity for patients to receive evidence-based care with minimal delays in adjustment, leading to better outcomes (including less exacerbation, less visits to the Emergency Department (ED) or admissions into the hospital). However, in both settings there were high no-show and compliance rates. Through a combined effort of sending a multidisciplinary professional group (nurse, pharmacist, social worker) into the community, creating educational programs, patient advisory groups and providing transportation for patients to come to the hospital, improved outcomes were achieved—most notably related to visits to the ED and readmissions to the hospital within 15 and 30 days post-initial discharge.

3. Did you incorporate this program into the organization's broader quality improvement goals?

Yes, SGH has taken lessons learned from the focus on chronic heart failure and acute myocardial infarction through *Expecting Success* and broadened the scope to community-acquired pneumonia, stroke and the surgical care improvement prevention program. In particular, SGH has taken the concept of ideal or perfect care and applied those principles to other quality improvement and process improvement initiatives throughout the hospital.

4. What was the initial time frame from conception to operational implementation of the program?

It took approximately one year for everyone to be engaged in the goal SGH was trying to achieve. Initially, everyone felt that high quality care was provided without disparities. While SGH did not have significant disparities in care provided to minorities, data evaluation demonstrated there were needs among its African American population that were not being addressed. Most of these were related to socioeconomic needs (i.e. insurance coverage, literacy, diet preferences, transportation, etc.).

5. What were the results of the program? How did your organization assess outcomes?

The results of the program were amazing. SGH improved core measure scores across the board for congestive heart failure (CHF) and acute myocardial infarction (AMI). A sustained process was implemented to gather race, ethnicity and primary language information. By identifying root causes of the challenges and barriers SGH was facing, long-term solutions and remedies could be developed and implemented. This new way of looking at processes and thinking helped SGH propel its quality of care in all areas of the hospital.

6. How has the data been used? What data would you recommend other organizations track?

Every month this data is provided to the medical and nursing community as well as other ancillary groups for review, with detailed process improvement discussions at the Leadership Process Improvement Committee, led by a Vice President for Medical Affairs. It is also presented to the hospital's Board of Trustees. SGH has begun looking at other pieces of information besides the CMS core measures or identified quality performance improvement targets and plans to include more drilled down data necessary for improvements (i.e., measuring time from patient arrival at door-to-table in radiology for CAT Scan as a component of turnaround time for stroke patients).

SGH also includes HCAHPS and Press Ganey numbers for various pieces, such as admission results for initial ED throughput metrics and discharge results for its evaluation of discharge order to depart metric as well as overall length of stay and re-admission data for specific patients, particularly the "frequent flyers."

7. Was there key data you felt drove the adaptation of interventions or the measurement of success?

The key measure wasn't necessarily looking at the data to reduce disparity in care, but rather working on improvement strategies to obtain perfect care. By looking at measures in this way, clinicians began to see that although 95 percent sounds good, it's not good enough.

Many physicians and other clinicians continue to have a hard time grasping this concept so SGH has moved away from the numbers and graphs. Data is shown in terms of colors. Blue = perfect care, yellow = within an initially acceptable range and red = not acceptable.

Using this system, an acceptable range can be 96-99 percent and anything less than 95 percent is considered unacceptable. This method of dashboard reporting is being implemented for all quality initiatives, not just the core measures. It also takes out any issues with disparities, whether it be race, ethnicity, language or insurance status.

8. Did your organization track similar data before participating in the program?

Prior to *Expecting Success*, information was not tracked with this level of detail. Core measure data was available, but was not shared with everyone nor was it used to the extent it currently is for process improvement.

9. Are there aspects of the program that you feel could be replicated by other health care organizations?

Implementing a process for gathering accurate race, ethnicity and language information is not difficult, and is something every hospital should begin doing if they do not already. Using this information to show organizations what, if any, disparities in care exist is an important step to determine how to proceed.

If there is disparity, it is important to drill down to determine why that may be. Is it because of a language barrier between patients and staff? Is there a cultural barrier? Identify these root causes and bring them to the forefront. Instead of simply working to bridge the gap of disparity, work on achieving perfect care: 100 percent of care to 100 percent of patients, 100 percent of the time.

10. Has there been a sustained improvement since your participation in *Expecting Success*?

SGH has sustained several components from the original implementation of *Expecting Success*; most notably, the process by which problems and root causes are identified.

Have the numbers waxed and waned? Yes, however, a sense of discipline has been built that allows staff to objectively identify the root causes of the occurrence and work as a team to address and correct them.

11. What challenges or obstacles had to be overcome?

Being a teaching institution, SGH has the ongoing challenge of residents coming and going. Additionally, the economy in Michigan has worsened and people find themselves unable to care for themselves as they have in the past. Socioeconomic problems have continued to worsen rather than improve, despite the increased community involvement the hospital has made. As a result, patients coming through the doors are sicker.

An additional challenge is the constant competing priorities. Staff must focus on a variety of different projects and needs at the same time forcing them to prioritize to their best ability. As an example, SGH has been implementing an electronic medical record (EMR) system that has gone through many changes, at times making the work of documentation more difficult than providing the care itself. This is in addition to other, equally demanding projects.

This prioritization challenge led SGH to adopt the Lean Six Sigma approach to process improvement. Variables and competing priorities will always exist, SGH needed to learn how to consistently adapt and move forward.

12. Were other stakeholders (i.e., community groups) involved?

A Health Advisory Board was created with membership of community leaders to guide quality proposals. Additional support came from the Northwest Detroit community, including area block groups, church leaders and even business leaders interested in improving the quality of care in the area. Everyone's priority was ensuring that though there was a disparate population, that didn't translate into disparate health care.

13. What advice would you give others wanting to improve care in similar ways?

Change is difficult and requires dedication and discipline. It also requires collaboration and great leadership. To improve quality, one cannot look exclusively to the quality departments and expect high results. One must look to the front-line professionals who are at the bedside. An institutional leader who is passionate about quality is needed. Without this passion, the organization will settle for less than perfect care.