

Loma Linda University Medical Center

Health's Equity Plan Supplemental Document

Measure	Stratification	Reference Group	Reference Rate	Rate Ratio
All-Cause Unplanned 30-Day Hospital Readmission Rate, MHD	Race/Ethnicity	White	7.6	2.4
HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Expected Payor	Private	4	1.9
HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Expected Payor	Private	4	1.9
All-Cause Unplanned 30-Day Hospital Readmission Rate, No Behavioral Health Disorders	Expected Payor	Private	3.7	1.8
AHRQ PSI Death Rate among Surgical Inpatients	Expected Payor	Medicaid	206.9	1.8
All-Cause Unplanned 30-Day Hospital Readmission Rate, SUD	Age	35 to 49	6.9	1.7
AHRQ PSI Death Rate among Surgical Inpatients	Expected Payor	Medicaid	206.9	1.6
All-Cause Unplanned 30-Day Hospital Readmission Rate, SUD	Race/Ethnicity	White	7.1	1.6
All-Cause Unplanned 30-Day Hospital Readmission Rate, MHD	Expected Payor	Private	5.8	1.6
All-Cause Unplanned 30-Day Hospital Readmission Rate, MHD	Race/Ethnicity	White	7.6	1.6

Loma Linda University Medical Center-Action Plan

Rank	Disparity Description	Plan for Action
1	Measure: All-Cause Unplanned 30-Day Readmission (MHD)	1. Data Validation & Deeper Analysis: Stratify readmission data by race/ethnicity, conduct chart reviews for Black/African American patients, and identify workflow or clinical practice

	<p>Stratification: Race/Ethnicity Group: Black or African American vs White Disparity Ratio: 2.4</p>	<p>gaps.</p> <p>2. Root Cause Analysis: Engage frontline staff to assess documentation, intervention timeliness, and barriers (e.g., communication, health literacy).</p> <p>3. Targeted Interventions: Develop culturally tailored discharge protocols, embed interpreter services, and enhance patient education.</p> <p>4. PDSA Cycles: Pilot interventions in high-disparity units, monitor 30-/60-/90-day readmission rates.</p> <p>5. Monitoring: Use Health Care Equity Dashboard for real-time tracking; adjust interventions as needed.</p> <p>6. Leadership Oversight: Report progress to Health Care Equity Committee.</p>
2	<p>Measure: HCAI All-Cause Unplanned 30-Day Readmission Rate Stratification: Expected Payor Group: Medicare vs Private Disparity Ratio: 1.8</p>	<p>1. Cohort Identification: Use EHR/ADT feeds to flag Medicare patients at high risk for readmission.</p> <p>2. Alerts: Notify care teams when Medicare patients are discharged to ensure enhanced follow-up.</p> <p>3. Care Plan Integration: Standardize post-discharge follow-up and care navigation for Medicare cohort.</p> <p>4. Retrospective Review: Monthly analysis of readmission rates by payor; identify gaps in care transitions.</p> <p>5. RCA: Investigate if gaps stem from missed handoffs, provider shortages, or documentation lags.</p> <p>6. Trend Monitoring: Track readmission rates and follow-up completion weekly/monthly.</p>
3	<p>Measure: HCAI All-Cause Unplanned 30-Day Readmission Rate Stratification: Expected Payor Group: Medicaid vs Private Disparity Ratio: 1.9</p>	<p>1. Patient Prioritization: Collaborate with the care coordination team to identify patients who may be at higher risk (e.g., those with Medicaid coverage and significant social needs). Use available data sources and staff insights to help recognize these individuals.</p> <p>2. Alerts: Establish processes for communicating with care coordinators and relevant staff when high-risk patients are identified, so they can provide additional support and navigation as needed.</p> <p>3. Care Plan: Work with care coordinators and navigators to ensure that high-risk patients receive appropriate follow-up and support. This may include developing templates or checklists for follow-up actions, even if automated systems are not available.</p> <p>4. Retrospective Review: Analyze readmission and follow-up rates by payor through Healthcare Equity Dashboard quarterly.</p> <p>5. RCA: Examine provider counseling, documentation, and implicit bias or other relevant categories to identify patterns</p>

		<p>and areas for improvement.</p> <p>6. Trend Monitoring: Track outcomes and intervention effectiveness.</p>
4	<p>Measure: All-Cause Unplanned 30-Day Readmission (No Behavioral Health Disorders) Stratification: Expected Payor Group: Medicare vs Private Disparity Ratio: 1.8</p>	<p>1. Collaborate with care coordination to identify Medicare patients at higher risk for readmission.</p> <p>2. Enhance discharge planning and post-discharge support for Medicare patients (e.g., follow-up calls, appointment scheduling, patient education).</p> <p>3. Review readmission rates and follow-up completion monthly by payor group.</p> <p>4. Conduct root cause analysis for readmissions to identify process gaps.</p> <p>5. Develop and pilot targeted interventions; monitor effectiveness and adjust as needed.</p>
5	<p>Measure: AHRQ PSI Death Rate among Surgical Inpatients Stratification: Expected Payor Group: Medicare vs Medicaid Disparity Ratio: 1.8</p>	<p>1. Safety Event Analysis: Stratify PSI death rates by payor, conduct RCA for Medicare and Medicaid groups. Work with relevant teams to review safety event data and identify high-risk patient groups by payor.</p> <p>2. Care Plan Integration: Establish processes to identify, communicate about, and support patients who may be at higher risk, ensuring staff are aware and able to respond appropriately.</p> <p>4. Retrospective Review: Quarterly analysis of PSI events by payor.</p> <p>5. Trend Monitoring: Track safety event rates and intervention impact.</p>
6	<p>Measure: All-Cause Unplanned 30-Day Readmission (SUD) Stratification: Age Group: 65 and Older vs 35 to 49 Disparity Ratio: 1.7</p>	<p>1. Patient Identification & Collaboration: Work with care teams and the age-friendly workgroup to identify older patients with substance use disorder who may be at higher risk.</p> <p>2. Communication & Support: Establish broad processes for communicating about and supporting these patients, leveraging expertise and resources from the age-friendly workgroup.</p> <p>3. Care Plan Integration: Collaborate to develop and implement age-appropriate follow-up and monitoring strategies for high-risk groups.</p> <p>4. Retrospective Review: Regularly review readmission rates and outcomes by age group, involving the age-friendly workgroup in analysis and planning.</p> <p>5. Team Analysis: Use multidisciplinary discussions, including input from the age-friendly workgroup, to identify barriers and gaps.</p>

		<p>6. Trend Monitoring: Track trends and adjust support strategies as needed, ensuring ongoing engagement with the age-friendly workgroup.</p>
7	<p>Measure: AHRQ PSI Death Rate among Surgical Inpatients Stratification: Expected Payor Group: Private vs Medicaid Disparity Ratio: 1.6</p>	<p>1. Safety Event Review: Work with relevant teams to review safety event data and identify patients at higher risk by payor.</p> <p>2. Communication: Establish general processes to communicate about and support these patients.</p> <p>3. Monitoring Protocols: Integrate enhanced monitoring protocols for patients at increased risk.</p> <p>4. Retrospective Review: Regularly review safety event rates and outcomes by payor group.</p> <p>5. Team Analysis: Conduct team-based analysis to identify barriers and process gaps.</p> <p>6. Trend Monitoring: Track trends and adjust strategies as needed.</p>
8	<p>Measure: All-Cause Unplanned 30-Day Readmission (SUD) Stratification: Race/Ethnicity Group: Hispanic or Latino vs White Disparity Ratio: 1.6</p>	<p>1. Patient Identification & Engagement: The Health Care Equity Taskforce will work with care teams to identify patients from specific racial/ethnic groups who may be at higher risk for readmission.</p> <p>2. Communication & Outreach: Establish culturally responsive communication and support processes, leveraging input from the Taskforce and relevant community partners.</p> <p>3. Care Plan Integration: Collaborate to develop and implement tailored follow-up and monitoring strategies that address cultural and linguistic needs.</p> <p>4. Retrospective Review: The Taskforce will regularly review readmission rates and outcomes by race/ethnicity, sharing findings with stakeholders.</p> <p>5. Multidisciplinary Analysis: Facilitate team discussions, including the Taskforce and frontline staff, to identify barriers and opportunities for improvement.</p> <p>6. Trend Monitoring & Reporting: Track trends and intervention effectiveness, with the Taskforce overseeing ongoing evaluation and adjustment of strategies</p>
9	<p>Measure: All-Cause Unplanned 30-Day Readmission (MHD) Stratification: Expected Payor Group: Medicaid vs Private Disparity Ratio: 1.6</p>	<p>1. Patient Identification & Collaboration: The Health Care Equity Taskforce will coordinate with care management to identify Medicaid patients at higher risk for readmission.</p> <p>2. Communication & Support: Develop inclusive processes for communicating about and supporting these patients, ensuring equity-focused practices.</p> <p>3. Care Plan Integration: Work with the Taskforce to implement enhanced follow-up and navigation for Medicaid</p>

		<p>patients.</p> <p>4. Retrospective Review: The Taskforce will lead regular reviews of readmission rates and outcomes by payor group.</p> <p>5. Team-Based Analysis: Use multidisciplinary input, including the Taskforce, to identify barriers and gaps in care.</p> <p>6. Trend Monitoring & Continuous Improvement: Monitor trends and adjust strategies, with the Taskforce guiding ongoing improvement efforts</p>
10	<p>Measure: All-Cause Unplanned 30-Day Readmission (MHD) Stratification: Race/Ethnicity Group: Hispanic or Latino vs White Disparity Ratio: 1.6</p>	<p>1. Patient Identification & Equity Focus: The Health Care Equity Taskforce will partner with care teams to identify and prioritize patients from specific racial/ethnic groups at higher risk.</p> <p>2. Communication & Community Engagement: Establish culturally appropriate communication and support, involving the Taskforce and, where possible, community organizations.</p> <p>3. Care Plan Integration: Collaborate to ensure care plans reflect the unique needs of these groups, with input from the Taskforce.</p> <p>4. Retrospective Review: The Taskforce will oversee regular analysis of readmission rates and outcomes by race/ethnicity.</p> <p>5. Collaborative Analysis: Facilitate broad team discussions, led by the Taskforce, to uncover barriers and inform solutions.</p> <p>6. Trend Monitoring & Accountability: Track outcomes and intervention impact, with the Taskforce responsible for reporting and ongoing strategy refinement for the next 6-24 months.</p>