

4. Equity Plan: What actions are planned to address the Top 10 disparities identified in the data, including population impact, measurable objectives, and specific timeframe.

Tri-City Healthcare District (TCHD) is committed to addressing the unique factors and intervention opportunities for each of the ten disparities identified in the hospital's 2024 summary report. Below is a detailed, evidence-based strategy for each group, ensuring targeted, equitable action for the populations most affected.

Multiracial and/or Multiethnic, Black, African American, Hispanic or Latino Readmission

- **Action Taken:**

All TCHD staff undergo annual training on cultural competence and cultural humility. The computer-based trainings address implicit bias, health equity, age-appropriate care, and education on the needs of transgender, gender-diverse, and intersex individuals, as well as communication across the lifespan.

TCHD staff screen all patients for limited English proficiency and provide multiple types of translation services, including audio, and video translation.

TCHD is also committed to increasing diversity within the workforce and actively recruits and retains a diverse staff. Recently, TCHD contracted with an agency that provides foreign-educated registered nurses to help increase workforce diversity.

In an effort to improve cultural responsiveness, TCHD staff utilize multiple platforms to provide evidence-based printed education for patients in their native languages, ensuring materials are accessible and culturally relevant.

TCHD partners with various community organizations that serve underserved communities. This includes Vista Community Clinic, North County Health Services, and other community-based programs.

Within the past year, TCHD leadership developed a diverse, multiracial, and interdisciplinary committee to address health equity and improve health outcomes for the community the TCHD serves. This committee includes physicians, nurses, social workers, and data analysts.

- **Future Equity Focus:**

For the next year, TCHD plans to include community members in our health equity committee. This expanded committee will enhance community engagement and ensure lived experiences inform our strategies. The committee members analyze health data by social determinants of health and identify goals to address disparities. For example, this past year, committee members have been working on improving diabetic care for Hispanic/Latinx patients by enhancing bilingual education and strengthening partnerships with community organizations.

Self-Pay Patients (Readmission Rate Ratio 1.6)

- **Action Taken:**

Social Services inform patients about various payment options available, such as applying for Medicaid and accessing other financial resources. Patient's social needs are assessed to identify and address barriers to care, including transportation, healthcare coverage, food insecurity, and other social needs.

Patients are also linked to community clinics, such as Vista Community Clinic, to establish primary care services and support follow-up care.

TCHD has a financial assistance program that screens self-pay patients for insurance enrollment eligibility and provides financial counseling.

As a community hospital, TCHD offers financial assistance (charity care) for eligible patients who cannot pay for medically necessary services. Assistance may include full or partial discounts based on demonstrated financial hardship or high medical expenses. The TCHD also posts information on the hospital website to assist patients with bill payment options.

TCHD offers free transportation for patients who demonstrate need. This includes transportation to behavioral health services, wound care, cardiac rehab, primary care, and other essential services.

- **Equity Future Focus:**

TCHD plans to expand transportation services and reduce barriers that impact access to treatment. TCHD recently secured a grant to hire an additional driver, which will enhance our ability to provide timely and reliable transportation for patients in need.

White Patients (Readmission Rate Ratio 1.4)

- **Action Taken:**

TCHD tracks readmissions related to acute myocardial infarction (AMI), stroke, heart failure, pneumonia, and chronic obstructive pulmonary disease (COPD). Several initiatives have been implemented to help identify and reduce specific readmissions. For example, staff in the Pulmonary Rehab department proactively connect with patients to provide tailored education on their diagnosis and disease management. They assess whether patients are candidates for outpatient pulmonary rehab and facilitate referrals.

Similar protocols are applied across other diagnoses to ensure early identification of patient needs, delivery of condition-specific education, and linkage to appropriate outpatient services. These efforts aim to reduce readmissions by improving continuity of care and empowering patients with knowledge and resources.

- **Equity Future Focus:**

TCHD plans to continue tracking readmission rates and implementing universal improvement strategies across all demographic groups. This includes enhancing care coordination, expanding patient education, and strengthening outpatient follow-up systems to ensure equitable outcomes.

Age 50–64 (Readmission Rate Ratio 1.2) and Age 65+ (Readmission Rate Ratio 1.2)

- **Action Taken:**

To help reduce readmissions, TCHD staff provide ongoing, individualized patient education tailored to each individual's healthcare needs. Direct patient care includes a standardized process for medication reconciliation, medication education, and clear, accessible post-discharge instructions.

TCHD staff screen for health literacy and provide education that aligns with the patient's learning style and comprehension level. Caregivers are actively included in the education process to support post-discharge care and improve adherence to treatment plans.

TCHD requires all staff to complete annual training in age-specific care and effective communication across the lifespan. This training ensures staff are equipped to meet the unique physical, emotional, and cognitive needs of older adult patients.

- **Equity Future Focus:**

Future focus includes continued improvement in the clarity and effectiveness of discharge instructions and aftercare follow-up. TCHD staff are implementing structured, regular cross-disciplinary meetings to monitor readmission patterns and adjust care strategies based on age-related needs.

Additionally, the health equity committee plans to prioritize the development of post-discharge education classes and support groups tailored to older adults, aimed at reducing readmissions and promoting long-term wellness.

Medicaid Patients (Readmission Rate Ratio 1.2)

- **Action Taken:**

TCHD partners with community clinics that serve Medicaid beneficiaries, including Vista Community Clinic and North County Health Services. Patients who do not have a primary care provider are connected to appropriate services to support continuity of care following hospital discharge.

To facilitate smooth care transitions, TCHD staff communicate directly with community providers by sending both treatment and discharge summaries. This ensures that patients receive timely and informed follow-up care.

TCHD staff hold regular meetings with community providers to identify patient needs and collaboratively address any challenges. These meetings foster shared accountability and problem-solving across care settings.

Regular meetings are also conducted with Medicaid health plans to identify trends and address patient needs. For example, TCHD staff work closely with Medicaid plans to improve care transitions, streamline referrals, and enhance coordination for Medicaid beneficiaries.

Equity Future Focus:

TCHD plans to continue strengthening connections with community-based primary care providers and maintaining regular collaborative meetings to identify and address patient needs. Future efforts will focus on enhancing care coordination, improving data sharing, and expanding access to wraparound services for Medicaid patients.

Males (No Behavioral Health Diagnosis, Readmission Rate Ratio 1.2)

Action Taken:

Patients who exhibit behavioral health symptoms are provided with referrals to address any behavioral health needs. Addressing these needs is critical to improving adherence to medical treatment and overall health outcomes.

Patients referred to case management receive a comprehensive biopsychosocial screening to identify social determinants of health and barriers to treatment. This may include referrals for behavioral health services and connections to community resources that address unmet needs.

All staff receive annual training on effective communication across the lifespan and age-appropriate care. Additionally, they complete annual training focused on transgender, gender-diverse, and intersex patient education to ensure inclusive and respectful care.

All patients are universally screened for psychosocial history, mental health concerns, and suicidal ideation. Those identified as at risk are evaluated by psychiatric liaisons and provided with appropriate services to address behavioral health needs. This holistic approach supports both physical and mental well-being.

- **Equity Future Focus:**

TCHD plans to continue tracking readmission rates and implementing strategies for universal improvement across all demographic groups. This includes enhancing care coordination, expanding patient education, and strengthening outpatient follow-up systems to ensure equitable outcomes.

Females (Pneumonia Mortality Rate Ratio 1.2)

- **Action Taken:**

TCHD physicians utilize point-of-care tests and imaging to confirm pneumonia diagnoses quickly and guide timely, targeted treatment plans. This approach helps reduce delays in care and improves clinical outcomes.

TCHD nursing staff screen patients for influenza (flu) upon admission. Nurses provide education and actively encourage eligible patients to receive recommended vaccinations, emphasizing their role in preventing respiratory infections and complications.

TCHD provides on-site flu vaccines to eligible patients prior to discharge, helping to reduce future risk and improve community health.

In addition, discharge planning includes education on symptom monitoring, medication adherence, and when to seek follow-up care, with special attention to older female patients who may be at higher risk for complications.

- **Equity Future Focus:**

TCHD staff plan to conduct patient interviews to identify and resolve barriers unique to women, such as caregiving responsibilities, delayed care-seeking, and access to preventive services.

TCHD staff plan to review pneumonia mortality data disaggregated by gender and age to identify trends and develop targeted interventions to reduce mortality rates. This includes exploring enhanced post-discharge support, improved access to outpatient care, and tailored education for female patients.