Hospital Performance Metrics

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Objectives

After finishing this course, the reader will be able to:

1. Differentiate between the different calculations for length of stay (LOS)
2. Discuss how LOS can impact the quality of the healthcare process
3. Describe how hospital financial performance is impacted by readmissions
4. Explain how HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) surveys can improve patient care
5. Recognize how implicit bias may impact healthcare
Background

• The goals of healthcare institutions are to:
  1. Improve performance which, in turn, will improve patient outcomes
  2. Improve quality of care and patient safety
  3. Lower costs for patients and the healthcare institution

• By tracking outcomes and performance metrics and then comparing results with their peers, healthcare institutions are better able to determine the efficacy of their efforts.

• **Benchmarking** is a method of setting goals that are used to monitor clinical performance and improve operations management.
Why do hospital performance metrics matter?

**Performance metrics are navigation tools for a hospital or healthcare institution**

- The data collected through following performance metrics provides valuable information
- This data provides the hospital the ability to identify strengths, weaknesses, and/or opportunities (drivers)
- The hospital can, in turn, improve performance by addressing the identified drivers

**Performance metrics enable a hospital or healthcare institution to reach its institutional goals**

- Institutional goals ensure that the organization remains connected with the outside environment
- Hospitals are faced with social, political, cultural, and economic challenges that must be addressed
- Monitoring performance metrics allows the hospital to implement strategies to address these challenges
What is CMS?

CMS = Centers for Medicare & Medicaid Services

Medicare – A federal insurance system for a specific population including:

- Individuals 65 and older
- Individuals under 65 with certain disabilities
- Individuals with end-stage renal disease regardless of age

CMS is responsible for:

- Improving health outcomes
- Expanding insurance coverage
- Increasing health equity
Why is CMS important to hospital performance metrics?

Healthcare systems are now reimbursed by insurance companies for value rather than volume or number of services – value-based care.

CMS helps to provide quality metric data to set standards for value-based healthcare.

CMS analyzes performance data and identifies trends in healthcare metrics.

CMS can then reimburse hospitals based on quality of care rather than fee for service.

This model creates incentives for healthcare systems to improve value and quality of services.
What is a diagnosis-related group (DRG)?

- Different diagnoses are classified as either medical or surgical DRGs.
- Classified by CMS with related weights assigned to each ICD (International Classification of Diseases) diagnosis.
- Payment or reimbursement to a hospital or healthcare institution is a lump sum based on the DRG at the time of discharge.
- Diagnosis, age, sex, comorbidities, procedures, and discharge status are considerations in calculations of DRG.
- DRG weight represents the expected use of resources to care for similar cases.
- Classifications and weights are readjusted yearly to reflect changes in treatment patterns and technology.
- DRGs can be further classified by associated complication and comorbidity (CC) or major complication and comorbidity (MCC).
- Because DRGs are fixed payments, hospitals are incentivized to decrease LOS.
Performance metric

Length of stay (LOS)
Length of stay - LOS

- **Length of stay (LOS)** is the amount of time (measured in days) that a patient spends in a hospital, from the time of admission to the time of discharge.
- LOS is one of the biggest indicators for hospital efficiency.
- The flow and efficiency of hospital processes are collectively known as **throughput**.
- LOS is affected by different variables including, but not limited to:
  - Diagnosis
  - Severity of illness
  - Surgical intervention
  - Hospital demographics
  - Provider-to-patient ratios
  - Organization of care
  - Medical decision making
  - Delays in care
  - Difficulties in discharge planning
LOS findings (based on 2018 study)

36.4 MILLION INPATIENT STAYS

AVERAGE LOS OF 5 ½ DAYS
Different calculations for length of stay

- Arithmetic mean length of stay (AMLOS)
- Geometric mean length of stay (GMLOS)
- Length of stay O/E or length of stay index (LOSI)
• Arithmetic mean length of stay

• Also known as average length of stay (ALOS)

• Calculated by averaging the number of inpatient days for a given timeframe

• Tracked by hospitals as a measure of efficiency of the system or throughput

• Can be tracked based on a particular DRG

• AMLOS per DRG is compared to CMS predicted GMLOS for the same DRG to measure performance
GMLOS

- Geometric mean length of stay
- Calculations provided by Centers for Medicare & Medicaid Services (CMS) for benchmarking and calculating reimbursement
- Gives a predicted LOS for inpatients based on provider documentation of diagnosis and comorbidities that projects what the DRG will be
- This calculates the weighted payment to the hospital based on DRG at the time of inpatient discharge
- Each DRG will be assigned a specific GMLOS yearly
- The goal is to keep the actual LOS (AMLOS) at or below CMS predicted GMLOS in order to collect appropriate reimbursement
- The difference between the AMLOS and CMS predicted GMLOS is called a length of stay variance
• Observed LOS/expected LOS

• Also called length of stay index (LOSI)

• A LOS O/E of 1.00 is when the actual LOS is exactly aligned with the expected LOS

• A LOS O/E less than 1.00 is a discharge that occurs earlier than expected

• A LOS O/E more than 1.00 is a discharge that occurs later than expected
Length of stay “outliers”

- Outliers are data points in a data set that are significantly lower or higher than the closest data point
- Outliers occur rarely and are considered outside of the norm
- Outliers are typically excluded from data because they can impact and skew data disproportionately
- Outliers will affect the mean if kept in the data summary
- These cases can consume a disproportionate amount of hospital resources
- Outliers usually have barriers to discharge that occur outside of the need for hospitalization, such as post-discharge disposition issues
- Outlier cases can benefit from focused interventions to improve quality of care and improve hospital throughput
### How can LOS impact the healthcare process?

<table>
<thead>
<tr>
<th>Increased LOS</th>
<th>Decreased LOS</th>
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<tbody>
<tr>
<td>• Associated with a higher mortality rate</td>
<td>• Lower risk of infection</td>
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<tr>
<td>• Increased rate of opportunistic infections</td>
<td>• Lower risk of medication side effects</td>
</tr>
<tr>
<td>• Higher risk of medication side effects</td>
<td>• Higher quality of treatment</td>
</tr>
<tr>
<td>• Higher risk of inpatient complications</td>
<td>• Reduced medical fees</td>
</tr>
<tr>
<td>• Higher medical fees for patient and society</td>
<td>• Better hospital bed turnover rate</td>
</tr>
<tr>
<td>• Usually results in less hospital profit</td>
<td>• Increased hospital profit</td>
</tr>
<tr>
<td>• Decreased efficiency in hospital bed turnover rate</td>
<td>• Lower overall social costs</td>
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<td></td>
<td>• Better patient satisfaction</td>
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Best practices to reduce LOS

• Through improved clinical care
  • Clinical care pathways
  • Early ambulation/mobility initiatives

• Through logistical practices
  • Assessment of high-risk populations
  • Frequent medication assessments
  • Early involvement of case management
  • Hospitalist and telehealth services
  • Early discharge planning
  • Discharging patient to home location

• Through workforce interventions
  • Interdisciplinary or multidisciplinary care team meetings and rounding
  • Innovative staffing models
Clinical care pathways

Clinical care pathways are clinical interventions that are evidenced-based and developed for best outcomes and quality improvement.

Clinical care pathways can be DRG specific, such as order sets or algorithms.

Education for staff and patients can be developed based on clinical care pathways.

Clinical care pathways can even be implemented after discharge, such as discharge phone calls.
Early ambulation/mobility programs

- Hospital initiatives aimed at ambulating or mobilizing patients as soon as it is deemed safe
  - Unless contraindicated, ambulation or mobilization should occur throughout entire hospital stay
- If patient is unable to ambulate, mobility should be the focus
  - Get patients into a chair or sit patient up in bed if ambulation is not possible

- Prevent debilitation through muscle tone loss
- Reduce prevalence of pressure ulcers
- Reduce the risk of blood clots
- Reduce adverse event occurrences
## Assessment of high-risk populations

- **Interdisciplinary or multidisciplinary approached assessment**

- **Assessment of patients at high-risk for prolonged length of stay**
  - Those with socioeconomic risk factors, such as the underinsured or uninsured
  - Medically complex patients, such as those who are frail or have multiple comorbidities
  - Geriatric assessment
  - Utilization of tertiary, quaternary, or safety-net care facilities

- **Performed at all stages of patient care, at least daily**

- **Include all specialties in discussion for optimal patient outcomes**

- **Planning for most appropriate next site of care**

- **Discussion of available resources to ensure seamless discharge**
Frequent medication assessments

<table>
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<tr>
<th>Review</th>
<th>Target</th>
<th>Assess</th>
<th>Educate</th>
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| Review patient’s home medications on admission and discharge  
  • Utilize electronic entry systems | Target high-risk medications  
  • Anticoagulants  
  • Antibiotics  
  • Medications with known adverse effects | Assess patient’s medications daily throughout patient stay  
  • Employ tools developed to support clinical decisions  
  • Include pharmacist-led consultation into multidisciplinary care team | Educate patient and encourage feedback throughout patient stay  
  • Upon any changes to medication regimen  
  • At time of discharge |
Early involvement of case management

- Case managers are trained to implement various strategies to address the needs of the patient and discuss with various members of the care team.

- Medication review
- Family conferences
- Education
- Home assessment
- Discharge needs and referrals
- Appropriate next site of care
Hospitalist and telehealth

Hospitalist services

- Hospitalist staffing programs focus on more efficient inpatient care
- Includes assessment of hospitalist performance and quality of care
- Performance metrics are monitored for trends and opportunities

Telehealth services

- Use technology such as telephone, video conferencing, and teleradiology
- Links hospital care team to outside services and specialized clinicians
Early discharge planning

- Assessment of patient’s potential needs at discharge
- Discussion of safe discharge plan with patient and care team
- Schedule follow-up as soon as possible after discharge with primary care provider
- Discharge phone call to patient within 24 hours of discharge
- Arranging outpatient needs such as DME, outpatient therapy, or home oxygen
- Referring patient for home healthcare visits or placement at skilled nursing facility
- Giving patient information about on-call or outpatient services
Interdisciplinary or multidisciplinary care team meetings and rounding

<table>
<thead>
<tr>
<th>Coordination of care comprised of a team of health providers including, but not limited to:</th>
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<tbody>
<tr>
<td>• Nursing</td>
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<td>• Case management</td>
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<tr>
<td>• Physicians, including specialists</td>
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<tr>
<td>• Pharmacy</td>
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</table>

| Interdisciplinary or multidisciplinary meetings and rounds for efficient communication to patient and care team |

| Innovative communication strategies including education to patient |

| Delegation of tasks recommended by care team |
Innovative staffing models

- Specialist nurse and advanced practice nurse role creation to address the current physician shortage
- Addition of unregistered nursing support staff, such as nursing assistants, nurse extenders, and healthcare assistants to optimize spread of nursing staff amongst patients

Staffing of nursing personnel can directly affect the quality of care and overall patient outcomes.

Nursing shortage and complexity of patients have made innovation of staffing models necessary.
Performance metric

Readmissions
Readmissions

- Patients with unplanned inpatient hospital admission within 1 to 30 days from discharge post-index hospital stay
  - Index hospitalization – the initial hospitalization to which the readmission is attributed
- Readmissions are typically associated with poor outcomes
- Readmissions increase healthcare costs due to unnecessary utilization of resources
- Annual cost of readmissions in the US is about $17.4 billion yearly
- 20% of Medicare members readmit within 30 days of discharge
- An additional 34% of patients readmit within 90 days
Hospital Readmissions Reduction Program (HRRP)

- Implemented by CMS to reduce readmission costs and improve outcomes
- Part of the Affordable Care Act
- Aimed at 6 conditions that greatly impacted readmission rates
  - CHF (congestive heart failure)
  - Pneumonia
  - AMI (acute myocardial infarction)
  - COPD (chronic obstructive pulmonary disease)
  - TKA/THA (total knee arthroplasty/total hip arthroplasty)
  - Coronary artery bypass graft (CABG) surgery
- Consists of penalties for readmission rates above target, and incentives for readmission rates below target
Things that can impact readmissions

• Discharge disposition (level of care after hospital discharge)
  • Home discharge without home healthcare services
  • Home with home healthcare services
  • Placement at post-acute facility
  • Left against medical advice (AMA)

• Number and severity of chronic conditions that the patient has
  • More complex chronic conditions can result in increased readmissions
Home discharge without home healthcare services

- Home discharges are associated with the lowest readmission rate of all discharge dispositions
- Case management can interview the patient to ensure that adequate family or home support is present
- Outpatient therapies can be arranged for those patients discharged home without home healthcare services
### Home healthcare services offered

- Assistance with activities of daily living (ADLs)
- Transfer training (such as transferring from wheelchair to bed)
- Medication assistance
- Medical equipment (such as Oxygen)
- Palliative/comfort care
Placement at post-acute facility

Patients that are discharged from the hospital to be admitted into a different medical facility with a lower level of care

- Inpatient rehabilitation
- Skilled nursing facility
- Inpatient palliative care facility

The elderly are at higher risk for needing skilled nursing, either home health or skilled facility based

Risk factors for the need for post-acute care include, but are not limited to:

- Decreased mobility or increased debilitation from hospitalization
- Social factors such as homelessness
- Limited social or family support
Left against medical advice (AMA)

Those patients who left the hospital against the advice of their medical provider.

This group of patients were shown to have the highest readmission rate of all discharge dispositions.
Ways to avoid inpatient readmission

• Change in triage patterns:
  • Treat and release patients from emergency departments
    • Use of outpatient or ambulatory services in place of admission to healthcare facility
  • Observe and treat patients in observation units (observation stays do not count toward a readmission)

• Change in communication:
  • “Warm-handoff” – the term used to describe the communication between healthcare providers within the hospital setting and post-acute care providers that will be continuing care for patient after discharge
  • Better communication and education to patient about medications and caring for themselves after discharge
Best practices to prevent readmission

• Pre-discharge interventions:
  • Identification of high-risk patient populations using data analytics to predict likelihood of readmission
  • Improvements in quality of care based on findings
  • Identification of local social issues
    • Lack of public transportation system
    • Lack of resources for food and housing
  • Medication reconciliation
  • Discharge protocols to address high readmission risks

• Post-discharge interventions:
  • Better care transitions and more appropriate discharge disposition
  • Follow-up with primary care provider, ideally within a week
  • Arrange for appropriate follow-up resources and support services to reinforce education to patient about disease process and management
Various approaches to readmission reduction

- Care coordination throughout the continuum of care
- Patient education about disease process and management, medication, and importance of follow-up care
- Development of local and community initiatives to reduce readmissions
- Interdisciplinary teams/rounds
- Monitoring and trending readmission rates
- Post-acute services
Care coordination throughout the continuum of care

Proven to reduce readmission rate

Starts in Emergency Department and continues through post-acute services

Education of nurses and doctors in all affected departments of the hospital and post-acute facilities

Inpatient education:
- To include available ambulatory and outpatient services available
- Education of pre-discharge interventions to inpatient healthcare providers

Outpatient education:
- To include options available that don’t include sending patient back to the hospital after discharge
- Education of post-discharge interventions to post-acute healthcare providers
**Patient education**

Lack of education to patient about disease process and management is a driving factor for readmissions

Patients should be given a good understanding of condition, treatments, and symptom management in order to increase compliance

<table>
<thead>
<tr>
<th>Education should include:</th>
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<tr>
<td>Importance of following up with primary care provider</td>
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Addressing social factors plays a significant role in reducing readmissions.

Social factors that can influence readmissions include:
- Hunger/food insecurity
- Poverty
- Homelessness
- Lack of transportation

Partner with community resources to provide patients with basic needs:
- Meals on Wheels
- Food banks
- Salvation Army
- Public transport systems
### Interdisciplinary teams/rounds

Care team includes many disciplines who all give input on patient condition, care, and anticipated needs to prevent readmissions:

- Case management
- Social worker
- Pharmacy
- Nursing
- Therapies
- Nutrition
- Spiritual care
- Healthcare provider

Helps to increase communication amongst team members who are caring for the patient:

Team members can focus efforts on providing resources and education to the patient about disease management.
Monitoring and trending readmission rates

- Monitoring readmission rates and trends are key in readmission prevention
- Utilize baselines and benchmarks to work toward goal
- Look at readmission trends by provider and/or DRG
Patients who have access to more post-acute services have lower chances of readmission.

Telehealth services are a newer option in readmission prevention.

Addressing issues such as follow-up care and available outpatient resources can prevent readmission.

Holistic treatment of the patient can help prevent readmission.
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
Background

• Modern value-based healthcare centers around the patient, not just clinical outcomes
• Healthcare providers must strive to provide a positive patient experience
• CMS requires healthcare institutions that treat Medicare populations to use HCAHPS surveys
• HCAHPS survey reports are displayed and reported publicly
• Healthcare institutions’ reimbursements are directly tied to survey results
What is the HCAHPS survey?

- Standardized national survey comprised of 21 questions
- Survey to find patient’s satisfaction and perspectives of hospital care
- Results are reported publicly
- Can be used to compare to hospitals nationwide, statewide, or locally
- Provider-specific data available for trending by healthcare provider

What is the purpose of the HCAHPS survey?

- Survey data is used to gain objective data for comparisons of hospitals that is meaningful to consumers
- Creates incentives for hospitals and healthcare providers to improve quality of care
- Transparency of care quality to the public for increased accountability in healthcare
**HCAHPS - What subjects are included in the survey?**

<table>
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<th>Subjects</th>
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<tr>
<td>Communication with providers – doctors and nurses</td>
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<tr>
<td>Responsiveness of staff</td>
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<tr>
<td>Medication communication</td>
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<tr>
<td>Information about discharge</td>
</tr>
<tr>
<td>Transitions of care information</td>
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<tr>
<td>Hospital environment cleanliness</td>
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<tr>
<td>Overall hospital rating</td>
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<tr>
<td>Recommendation of hospital</td>
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HCAHPS - How is the survey administered?

- Random sampling of patients 48 hours to 6 weeks after discharge from hospital
- Includes Medical, Surgical, or Maternity Care inpatient adults
- Administered to patients regardless of insurance payor or lack of
- CMS-approved survey vendor will conduct survey
- Conducted by mail, telephone, mixed mail and telephone, or active interactive voice response (IVR)
- Multiple patient contact attempts must be made through any of the above modes
- Surveys must be administered during each month of the year
- Some hospitals may be required to meet a minimum number of surveys
Criteria to participate in HCAHPS survey

1. 18 years old and above at time of admission to hospital
2. Patient has spent at least one night in hospital in inpatient status
3. MS-DRG or diagnosis is not psychiatric in nature
4. Discharged from hospital alive
Implications of the HCAHPS survey

High Score
• Patient is overall satisfied with care received
• Patient feels that communication with care team was effective
• Patient understands treatment plan in hospital and discharge instructions
• Patient feels that the facility was clean
• Patient would recommend this hospital to others

Low Score
• Patient is not satisfied with some or all of the care that they received
• Patient did not understand instructions or treatment plan
• Patient does not feel that communication with or among care team was effective
Best practices to increase patient satisfaction in nurse and physician domains

- Good provider communication with patient
- Provider continuity
- Setting expectations with patient regarding care
- Involving patient in decision making regarding care
- Ensuring that patient has good understanding of instructions, medications, plan of care, and discharge plan
- Utilizing words that most patients will comprehend when communicating with patients
Case mix index (CMI)
Case mix index is a representation of the relative weight assigned for each DRG based on documentation.

CMI is calculated by dividing the sum of the DRG weights for discharges by the number of discharges.

A CMI greater than 1.00 indicates an assumed case mixed complexity.
CMI is based on:

- Severity of illness
- Difficulty of treatment
- Patient prognosis
- Intervention needed
- Intensity of resource
Implications of CMI

• The CMI value is also an important gauge of hospital performance and clinical documentation
• Higher CMI values indicate that a hospital is treating bigger volumes of complex patients that require more resources
• Higher CMI results in increased revenue for hospital due to increased reimbursement rates
Factors that impact CMI

- Accurate coding
- Specific documentation of complications and comorbidities, and major complications and comorbidities (CCs and MCCs)
- Increased volumes of DRGs with higher weights (usually major surgeries)
- Changes to relative MS-DRG weights that occur yearly
# Best practices to maintain and increase CMI

<table>
<thead>
<tr>
<th>Monitoring, trending, and benchmarking CMI</th>
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<tr>
<td>Implementation and use of clinical documentation improvement (CDI) programs to capture maximum reimbursement through appropriate documentation</td>
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<tr>
<td>Close communication with CDI specialists to capture necessary documentation</td>
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<tr>
<td>Education of changes to CDI processes</td>
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<tr>
<td>Auditing charts of discharged patients to find opportunities for improvement</td>
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</table>
Reflective Question

At your facility, what performance improvements have been made as a result of data collected through performance metrics?


References

• CMS. (2021). HCAHPS: Patients’ Perspectives of Care Survey. Retrieved from HCAHPS: Patients’ Perspectives of Care Survey | CMS


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References


The following slides address the California BON regulation that, beginning January 2023, all continuing education providers shall ensure compliance with the requirement that continuing education courses contain curriculum that includes the understanding of implicit bias.
Implicit Bias  |  How does it affect healthcare?
Why does implicit bias matter?

Implicit attitudes are thoughts and feelings that often exist outside of conscious awareness, and thus are difficult to consciously acknowledge and control. (Hall et al., 2015)

Implicit (subconscious) bias refers to the attitudes or stereotypes that affect our understanding, actions and decisions in an unconscious manner. These biases, which encompass both favorable and unfavorable assessments, are activated involuntarily and without an individual’s awareness or intentional control. (The Joint Commission, 2016)
Why does implicit bias matter?

Implicit biases affect behavior through a two-phase process: biases are activated in the presence of a member of a social group and then are applied so that they affect the individual’s behavior related to that group member. In the healthcare context, for instance, implicit biases may be activated when a provider is interacting with an African American patient, particularly under conditions that tax her cognitive capacity (e.g., stress, time-pressure, fatigue, competing demands), and can then influence how she communicates with and makes decisions about her patient. (Burgess et al, 2017)
Why does implicit bias matter?

Implicit (unconscious) biases can create gaps between good intentions and good outcomes in the health care field. (The Ohio State University, 2020)

Based on the available evidence, physicians and nurses manifest implicit biases to a similar degree as the general population. The following characteristics are at issue: race/ethnicity, gender, socio-economic status (SES), age, mental illness, weight, having AIDS, brain injured patients perceived to have contributed to their injury, intravenous drug users, disability, and social circumstances. (FitzGerald & Hurst, 2017)
Why does implicit bias matter?

The implicit biases of concern to health care professionals are those that operate to the disadvantage of those who are already vulnerable. Examples include minority ethnic populations, immigrants, the poor, low health-literacy individuals, sexual minorities, children, women, the elderly, the mentally ill, the overweight, and the disabled. However, anyone may be rendered vulnerable given a certain context. (FitzGerald & Hurst, 2017)
Why does implicit bias matter?

Implicit biases among health care providers are associated with the following negative effects on patient care:

- inadequate patient assessments
- inappropriate diagnoses and treatment decisions
- less time involved in patient care
- patient discharges with insufficient follow-up
Why does implicit bias matter?

The terms "health care disparities" and "health care inequities" refer to the poorer health outcomes observed in minority and other vulnerable patient groups compared with those observed in majority or dominant patient populations. Disparate patient outcomes are associated with age, sex, religion, socioeconomic status, sexual orientation, gender identification, disability, and stigmatized diagnoses (for example, HIV, obesity, mental illness, and substance abuse). (Narayan, 2019)
Why does implicit bias matter?

Implicit bias isn’t limited to race. The Implicit Association Test (IAT) measures attitudes and beliefs that people may be unwilling or unable to report.

For example, when the IAT was administered at an obesity conference, participants implicitly associated obese people with negative cultural stereotypes, such as “bad, stupid, lazy and worthless.”

Implicit gender bias among physicians also may unknowingly sway treatment decisions.
Why does implicit bias matter?

Women are three times less likely than men to receive knee arthroplasty when clinically appropriate. One of the stereotypical reasons for this inequity and underuse problem is that men are viewed as being more stoic and more inclined to participate in strenuous or rigorous activity.

(The Joint Commission, 2016)
Why does implicit bias matter?

People of color face disparities in terms of morbidity, mortality, and health status. Black, Hispanic, and Indigenous Americans have higher infant mortality rates than White and Asian Americans. The premature death rate from heart disease and stroke is highest among Black Americans. Race and ethnicity are not the only demographic factors associated with disparity in health outcomes. Women are more likely to experience delayed diagnosis of heart disease compared to men, as well as inferior heart attack treatment. Sometimes, these disparities intersect, as in the case of childbirth, where the United States is one of the few countries experiencing a rise in the maternal mortality rate, and Black women are nearly four times as likely to die during childbirth as are White women. (Whitmer, 2020)
Why does implicit bias matter?

Healthcare providers in a certain geographic area may equate certain races and ethnicities with specific health beliefs and behaviors (e.g., “these patients” engage in risky behaviors, or “those patients” tend to be noncompliant) that are more associated with the social environment (like poverty) than a patient’s racial/ethnic background or cultural traditions. (Stanford University, 2020)
How does implicit bias develop?

The ability to distinguish friend from foe helped early humans survive, and the ability to quickly and automatically categorize people is a fundamental quality of the human mind. Categories give order to life, and every day, we group other people into categories based on social and other characteristics.

This is the foundation of stereotypes, prejudice and, ultimately, discrimination.

Social scientists believe children begin to acquire prejudices and stereotypes as toddlers.
How does implicit bias develop?

Once learned, stereotypes and prejudices resist change, even when evidence fails to support them or points to the contrary.

People will embrace anecdotes that reinforce their biases, but disregard experience that contradicts them. The statement "Some of my best friends are ____" captures this tendency to allow some exceptions without changing our bias. (Learning for Justice, 2022)
How does implicit bias develop?

Scientific research has demonstrated that biases thought to be absent or extinguished remain as "mental residue" in most of us. Studies show people can be consciously committed to egalitarianism, and deliberately work to behave without prejudice, yet still possess hidden negative prejudices or stereotypes.

A growing number of studies show a link between hidden biases and actual behavior. In other words, hidden biases can reveal themselves in action, especially when a person's efforts to control behavior consciously flags under stress, distraction, relaxation or competition. (Learning for Justice, 2022)
How does implicit bias develop?

Research has frequently focused on the amygdala, a structure in the medial temporal lobes. The amygdala receives direct input from all sensory organs, enabling it to respond rapidly to immediate threats in advance of more elaborative cognitive processing. It plays a central role in arousal, attentiveness and triggering the flight-or-fight response, reacting to social threats in exactly the same way it reacts to physical ones. Unconscious bias, then, is the immediate, reflexive, defensive reaction to the “other.” (Korn Ferry Institute, 2022)
How do I recognize implicit biases?

One way to discover implicit biases is to pay attention to gut feelings. Nurses can ask themselves if they anticipate unpleasant experiences when caring for any particular group of patients, or if any particular group of patients makes them feel uncomfortable, anxious, or fearful.

Such feelings may indicate implicit bias and prompt self-reflection. Thoughtfully reflecting on the meaning and origin of such feelings and whether they influence the quality of relationships with patients can help nurses acknowledge and control previously unrecognized biases. (Narayan, 2019)
How do I recognize implicit biases?

Take one or more of the free Implicit Association Tests (IATs) available at Project Implicit (https://implicit.harvard.edu/implicit/education.html). Developed by Harvard, there are 14 instruments for measuring some of the most prevalent biases—those related to race, ethnicity, skin color, religion, age, gender, overweight or obesity, sexual orientation, or disability.

Learning about potential biases can enable people to employ strategies to reduce them or mitigate their effects on future interactions. The IATs are reliable and valid research instruments, and should not be used to diagnose bias but rather as educational tools.
How do I recognize implicit biases?

Implicit bias is different from prejudice. Implicit bias means we have the instinctive tendency to evaluate other groups against the norms of our own groups. Prejudice, on the other hand, means that one feels consciously and overtly that some groups are inferior, an attitude that can be used to justify discriminatory actions. (Narayan, 2019)
But I really don’t think I’m biased

There’s a reason it’s called unconscious bias.

It’s because hard-wired biases operate at a level that is beneath our conscious awareness. Even if we sincerely believe we’re being fair and objective, stereotypes may still be influencing our opinions - without us being aware of it. (Stanford University, 2020)

We may consciously reject negative images and ideas associated with disadvantaged groups (and may belong to these groups ourselves), but we have all been immersed in cultures where these groups are constantly depicted in stereotyped and pejorative [derogatory] ways. (FitzGerald & Hurst, 2017)
Challenges in reducing implicit biases

Some types of interventions focus more on declarative knowledge – what you know – than on procedural knowledge – knowing how to do something.

Understanding implicit bias as a score on the IAT also may engender the view of implicit bias as a fixed trait that one can do little about.

Issues of race and racism are emotionally fraught and politically charged. The idea that healthcare providers may contribute to racial disparities may contradict their core beliefs and values, including beliefs that they treat everyone equally and that racial inequality is a thing of the past. (Burgess, 2017)
How to reduce implicit bias

1. **Stereotype replacement** — Recognizing that a response is based on stereotype and consciously adjusting the response

2. **Counter-stereotypic imaging** — Imagining the individual as the opposite of the stereotype.

3. **Individuation** — Seeing the person as an individual rather than a stereotype (e.g., learning about their personal history and the context that brought them to the doctor’s office or health center)

4. **Perspective taking** — “Putting yourself in the other person’s shoes”
How to reduce implicit bias

5. **Increasing opportunities for contact with individuals from different groups** — Expanding your network of friends and colleagues or attending events where people of other racial and ethnic groups, gender identities, sexual orientation, and other groups may be present.

6. **Partnership building** — Reframing the interaction with the patient as one between collaborating equals, rather than between a high-status person and a low-status person.
How to reduce implicit bias

7. **Emotional regulation** — People who have good emotional regulation skills and who experience positive emotion during clinical encounters may be less likely to view patients in terms of their individual attributes, and to use more inclusive social categories. It’s easier to empathize with others when people view themselves as being part of a larger group. (The Joint Commission, 2016).

8. **Mindfulness** — A “mode of awareness” that can be enacted in different situations, including those which are emotionally challenging (Burgess, 2017).
How to reduce implicit bias

9. **Habit replacement** — Implicit bias is like a habit that can be broken through a combination of awareness of implicit bias, concern about the effects of that bias, and the application of strategies to reduce bias. (Devine et al, 2012)

10. **Take care of yourself** — Protect your mental resources. Do things to protect your mental energy, such as getting sufficient sleep, finding ways to reduce stress and taking mental breaks throughout the day to refocus on being present with your patients. (van Ryn, 2016)

The Institute for Healthcare Improvement (2017)
How to reduce implicit bias

The Institute for Healthcare Improvement (2017) also offers practical tips to combat implicit bias in healthcare, drawn from the book Seeing Patients: Unconscious Bias in Health Care, by Dr. Augustus White.

• Have a basic understanding of the cultures your patients come from.
• Don’t stereotype your patients; individuate them.
• Understand and respect the tremendous power of unconscious bias.
• Recognize situations that magnify stereotyping and bias.
How to reduce implicit bias

The Institute for Healthcare Improvement (2017) also offers practical tips to combat implicit bias in healthcare, drawn from the book Seeing Patients: Unconscious Bias in Health Care, by Dr. Augustus White.

• Know the National Culturally and Linguistically Appropriate Services (CLAS) Standards. (Available at https://thinkculturalhealth.hhs.gov/clas/standards)

• Do a “Teach Back.” Teach Back is a method to confirm patient understanding of health care instructions that is associated with improved adherence, quality, and patient safety.

• Assiduously practice evidence-based medicine.
Recommended viewing

Institute for Healthcare Improvement. (2020)

• How Does Implicit Bias Affect Health Care?
  http://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Anurag-Gupta-How-Does-Implicit-Bias-Affect-Health-Care.aspx

• What Are the Harms of Not Addressing Bias in Health Care?
Recommended viewing

Institute for Healthcare Improvement. (2020)

• What Is Bias, and What Can Medical Professionals Do to Address It?  

• Why Shouldn’t Providers Judge Patients’ Choices?  
  http://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Nia-Zalamea-Why-Shouldnt-Providers-Judge-Patients-Choices.aspx
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References


References


Thank You
Hospital Performance Metrics
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