Bringing the Focus to Complex Care

Understanding and Addressing Health Equity as a Driver for Readmissions
January 19, 2023

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Please chat in…

- Who is on the webinar with us today?
- What organization you are with?
- Where are you located? and
- Your role within your organization.

Overview

- Health disparities & readmissions
- Accurate patient sociodemographic data
- Cultural and linguistic competency
- Open forum

Learning Objectives for this Session

- Explain how complex health and healthcare disparities contribute to excessive emergency room utilization, readmissions, and longer hospital stays;
- Recognize how accurate patient demographic data is foundational to identifying and addressing disparities, and ways to improve your organization's data collection capabilities;
- Describe how culturally and linguistically appropriate services (CLAS) help advance health equity, improve quality, and eliminate disparities.

Introducing Speaker

Laura Benzel, MS, BS, CSSGB

Project Director at Qlarant and supports the IPRO Quality Innovation Network – Quality Improvement Organization (QIN-QIO) as a health equity lead across 11 states (NY, NJ, OH, MD, DE, and the 6 New England states) and the District of Columbia.

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Understanding and Addressing Health Equity as a Driver for Readmissions

Laura Benzel, MS, BS, CSSGB

Health Equity Lead

IPRO QIN-QIO

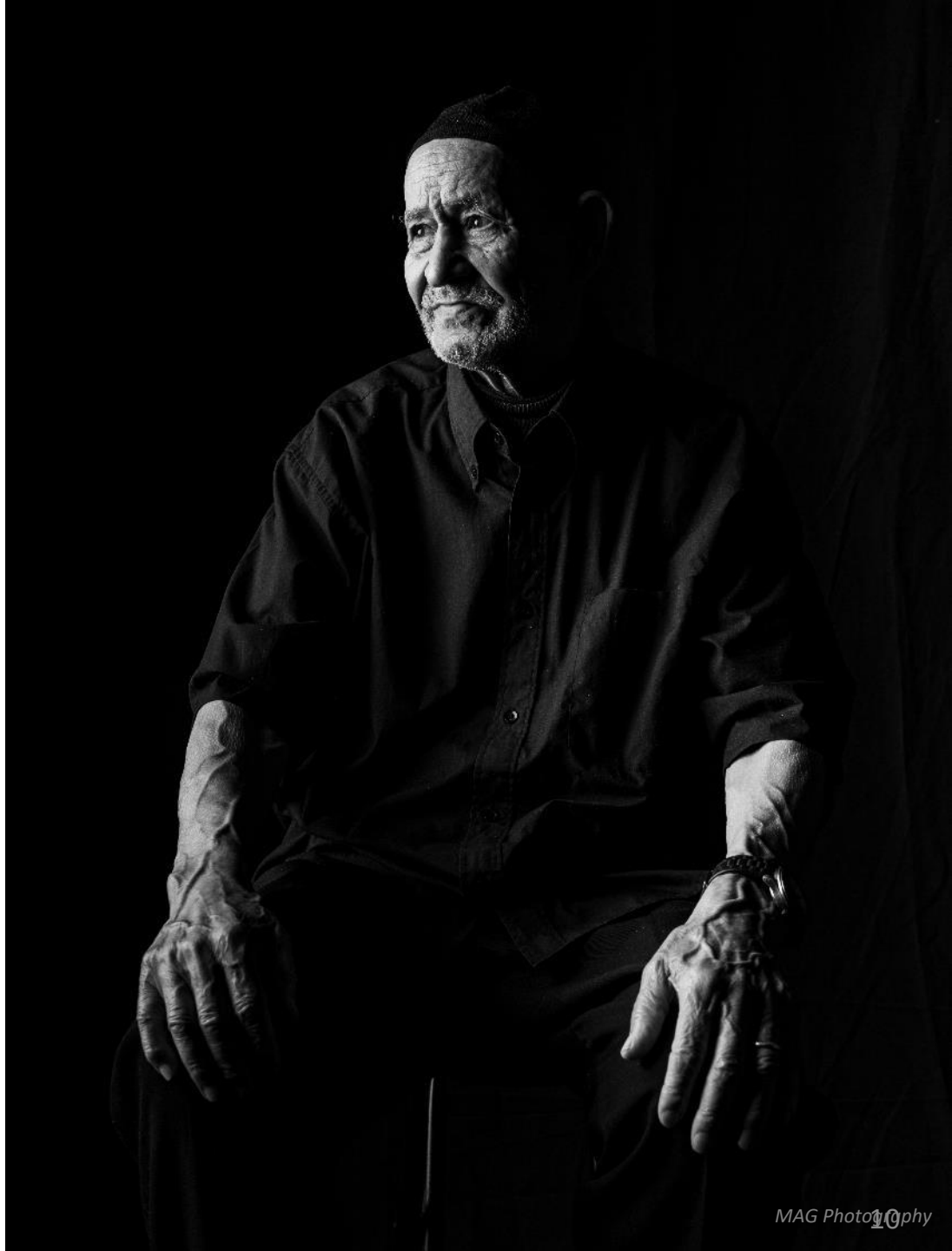
January 19, 2023

CMS Office of Minority Health, CMS Framework for Health Equity 2022-2023
https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf

Aligning Quality Goals

Remember Our Patient

- 65-year-old male
- History of alcohol use disorder, depression, atrial fibrillation, and heart failure
- Admitted with HF exacerbation
- Hospital course complicated by alcohol withdrawal and afib with RVR
- 6 different ED visits and hospital admissions in past year
- Marginally housed, food access barriers



How Disparities Contribute to Readmissions

> While not all readmissions are entirely preventable, it is widely understood that a portion of unplanned readmissions could be prevented by addressing a series of barriers patients face prior to, during, and after admission and discharge.

- **CMS Office of Minority Health**

Guide to Reducing Disparities in Readmissions

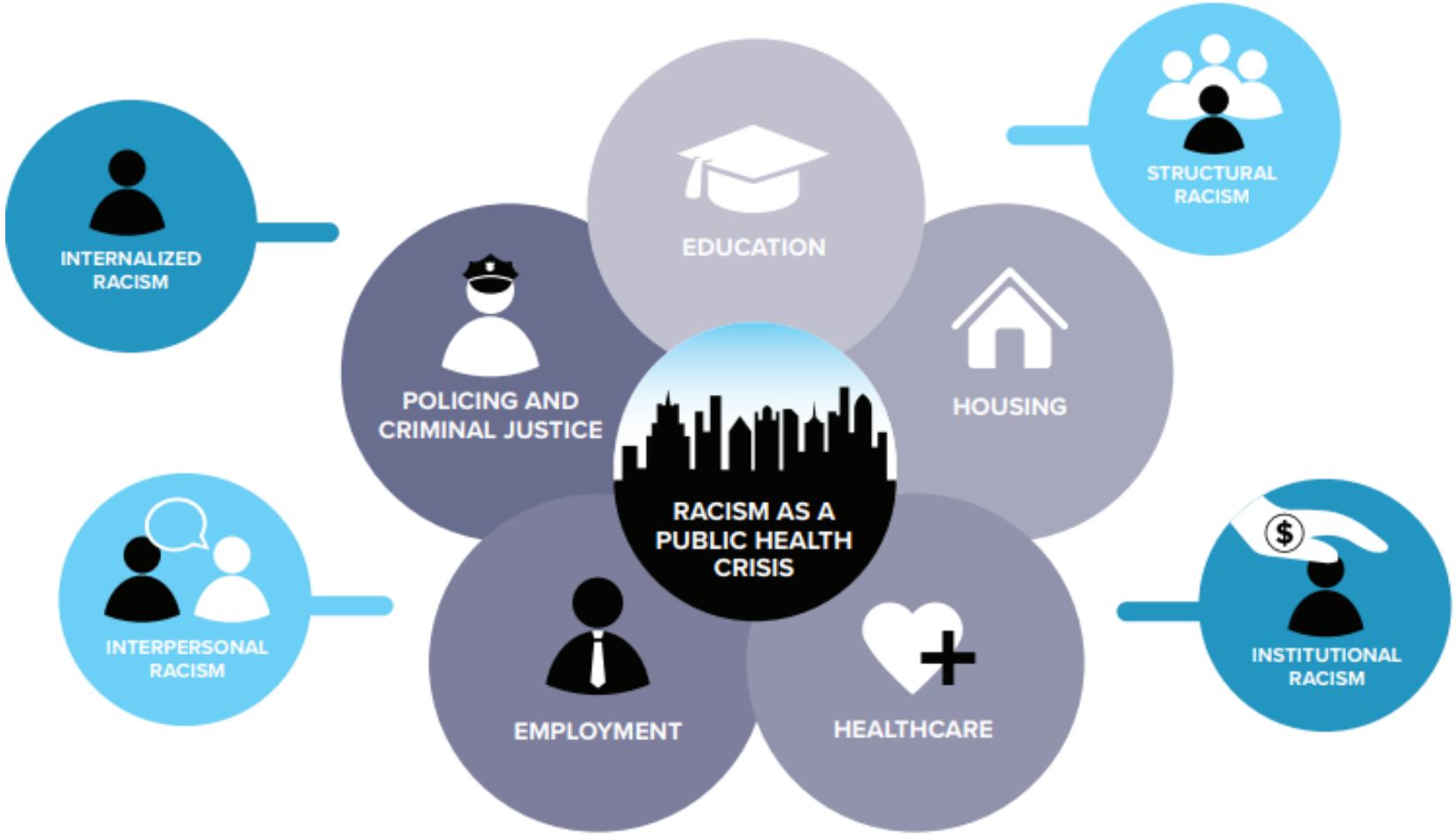
Centers for Medicare & Medicaid Services. 2018. A Guide to Reducing Disparities in Readmissions. https://www.cms.gov/about-cms/agency-information/omh/downloads/omh_readmissions_guide.pdf

Medicare Beneficiary Readmissions

- About 1 in 5 Medicare beneficiaries are readmitted within 30 days of discharge
- Annually, about **$17 billion** in Medicare program spending is for readmissions that could be classified as potentially **avoidable**

Zhao P, Yoo I, Naqvi SH. Early Prediction of Unplanned 30-Day Hospital Readmission: Model Development and Retrospective Data Analysis. JMIR Med Inform. 2021 Mar 23;9(3):e16306. doi: 10.2196/16306.

Racism & Discrimination in our Health Care System



Yearby R, Lewis CN, Gilbert KL, Banks K. 2020. Racism is a Public Health Crisis: Here's How To Respond. Data for Progress. Accessed January 5, 2023 at https://www.filesforprogress.org/memos/racism-is-a-public-health-crisis.pdf.

Patient-Level Factors Predicting Hospital Readmission

- Socioeconomic Status
- Race and Ethnicity
- Disability Status
- Limited English Proficiency
- Low Health Literacy

Centers for Medicare & Medicaid Services. 2018. A Guide to Reducing Disparities in Readmissions. https://www.cms.gov/about-cms/agency-information/omh/downloads/omh_readmissions_guide.pdf

Condition-Specific Disparities in Hospital Readmission

Congestive Heart Failure (CHF)	• Higher readmission rates for Black, Hispanic, and foreign-born patients with low English proficiency (LEP)
Acute Myocardial Infarction (AMI)	• Higher readmission rates for Black and Hispanic patients
Pneumonia	• Higher readmission rate for Black patients
Chronic Obstructive Pulmonary Disease (COPD)	• Higher readmission rate for Black patients
Total Hip/Knee Arthroplasty (THA/TKA)	• Higher readmission rate for Black patients

Centers for Medicare & Medicaid Services. 2018. A Guide to Reducing Disparities in Readmissions. https://www.cms.gov/about-cms/agency-information/omh/downloads/omh_readmissions_guide.pdf

Health Equity

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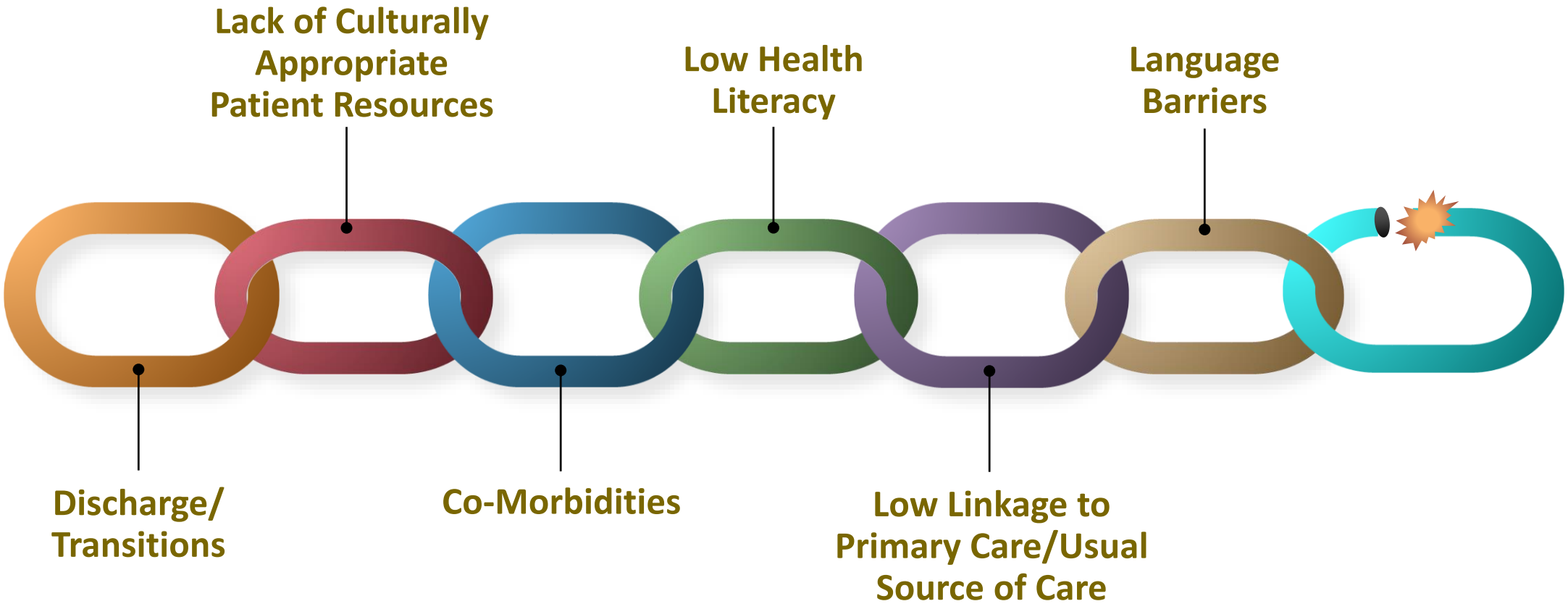
Key Issues for Racially and Ethnically Diverse Patients



Closing the Readmissions Gap

Strategies to Close the Readmission Gap

1. Create a Strong Radar

- Collect patient sociodemographic data:
  - race/ethnicity
  - preferred language
  - educational level
  - health related social needs (e.g., social support, food insecurity, transportation barriers)
  - disability status
  - linkage to primary care/usual source of care

2. Identify Root Causes

- Use performance measurement and monitoring to understand barriers to equitable care

https://www.hrmssolutions.com/resources/blog/dashboards-to-visualize-your-organizations-hr-health/

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Patient Demographic Data Collection

Collecting patient demographic data can improve quality of care by helping:

- Identify and address gaps in care
- Measure and evaluate the impact of health equity interventions
- Assess whether care is culturally and linguistically appropriate
- Provide insights on patients' lived experiences based on multiple dimensions

Health Equity Organizational Assessment (HEOA)

Data Collection	Hospital uses a self-reporting methodology to collect demographic data from the patient and/or caregiver.
Data Collection Training	Hospital provides workforce training regarding the collection of self-reported patient demographic data.
Data Validation	Hospital verifies the accuracy and completeness of patient self-reported demographic data.
Data Stratification	Hospital stratifies patient safety, quality and/or outcome measures using patient demographic data.
Communicate Findings	Hospital uses a reporting mechanism (e.g., equity dashboard) to communicate outcomes for various patient populations.
Addressing Resolve Gaps in Care	Hospital implements interventions to resolve difference in patient outcomes.
Organizational Infrastructure & Culture	Hospital has organizational culture and infrastructure to support the delivery of care that is equitable for all patient populations.

Strategies to Close the Readmission Gap, con't.

3. Start from the Start

- Use a series of preemptive efforts that span the duration from pre-admission to post-discharge for all patients.

4. Deploy a Team

- Consider including non-traditional partners like community health workers, navigators, and/or health coaches.

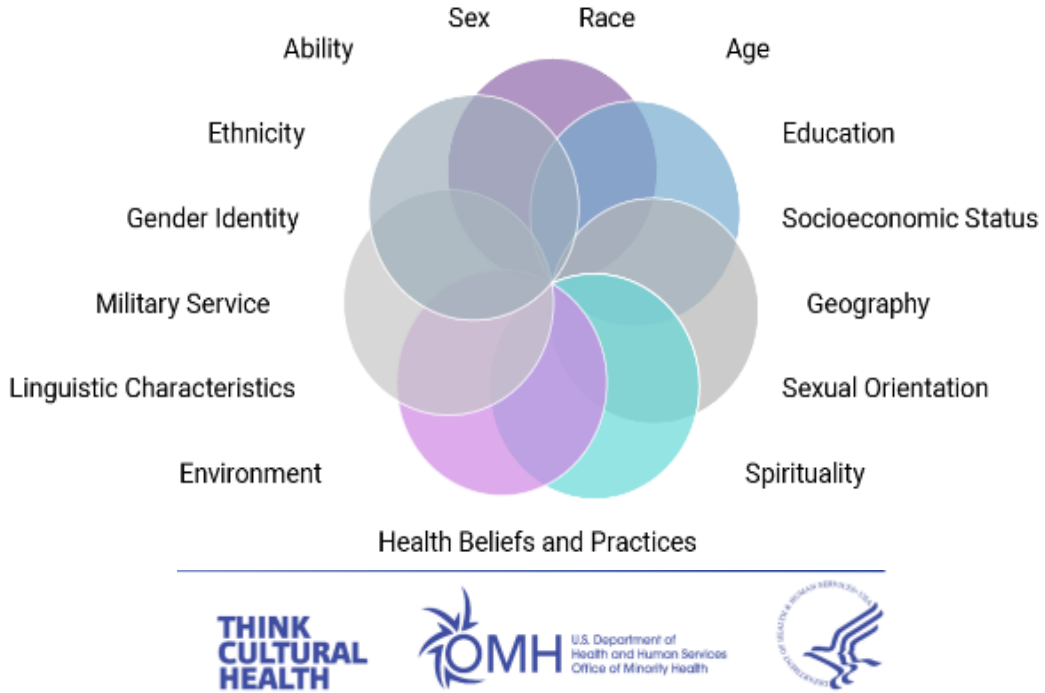
5. Consider Systems and Health-Related Social Needs (HRSN)

- Create systems responsive to the needs of diverse populations and address the health-related social needs that put them at continued risk of bouncing back.

Strategies to Close the Readmission Gap, con't.

6. Focus on Culturally Competent, Communication-Sensitive, High-Risk Scenarios

- Reducing readmissions depends on patients' ability to understand their diagnosis, the care they received, and their discharge instructions.
- Effective, culturally and linguistically appropriate patient-provider communication is key.



7. Foster Community Partnerships to Promote Continuity of Care

https://thinkculturalhealth.hhs.gov/education/behavioral-health

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Social Determinants of Health

Economic Stability	Neighborhood & Physical Environment	Education Access & Quality	Community & Social Context	Healthcare Access & Quality
• Employment • Income • Expenses • Debt • Medical bills	• Housing • Transportation • Safety • Parks • Playgrounds • Walkability • Zip code/geography	• Literacy • Language (LEP) • Early childhood education • Vocational training • Higher education	• Social integration • Support systems • Community engagement • Discrimination • Stress	• Health coverage • Healthcare access • Provider linguistic & cultural competency • Quality of care

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Adapted from Henry J. Kaiser Family Foundation, Beyond Health Care: The Role of Social Determinants of Health in Promoting Health and Health Equity

https://risk.lexisnexis.com/insights-resources/white-paper/mitigate-hospital-readmission-risk

Culturally & Linguistically Appropriate Services (CLAS)

- Improves ability to successfully communicate and provide care to patients with diverse beliefs, backgrounds, and values
- Improves the quality of services by being respectful of and responsive to:
  - individual cultural health beliefs and practices
  - preferred languages
  - health literacy levels
  - communication needs
  - social needs
- Employed by all members of an organization at every point of contact

https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf

Join Us: IPRO CLAS Series

CLAS = Culturally and Linguistically Appropriate Services

Helps make healthcare services

Understandable | Respectful | Effective | Equitable

How Can You Start Implementing CLAS?

Complete the IPRO CLAS Assessment

IPRO Assessment of Cultural and Linguistic Services

Learn where your organization is implementing CLAS

Z Codes

SDOH-related Z codes ranging from Z55-Z65 are the ICD-10-CM encounter codes used to document SDOH data.

Z55 Problems related to education and literacy	**Z60** Problems related to social environment
Z56 Problems related to employment and unemployment	**Z62** Problems related to upbringing
Z57 Occupational exposure to risk factors	**Z63** Other problems related to primary support group
Z58 Problems related to physical environment	**Z64** Problems related to certain psychosocial circumstances
Z59 Problems related to housing & economic circumstances	**Z65** Problems related to other psychosocial circumstances

Z Code Utilization for New York*

CODE	DESCRIPTION	COUNT
Z63.4	Disappearance and death of family member	11,488
Z60.2	Problems related to living alone	11,166
Z56.0	Unemployment, unspecified	9417
Z59.0	Homelessness, unspecified	5766

*As of November 4, 2022

IPRO Health Equity Resources

Resources

IPRO

- Improving Care Transitions: A Guide to Tools & Resources for Providers and Patients
- Preadmissions Planning Checklist (English)
- Preadmissions Planning Checklist (Spanish)
- IHI STAAR Root Cause Analysis Tool
- Z Codes & Social Determinants of Health Resources
- A Guide to Screening Patients for Social Isolation

Coleman

- The Care Transitions Program®

AHRQ

- Project RED (Re-Engineered Discharge)
- Project RED Toolkit for Nursing Homes

CMS

- Guide to Reducing Disparities in Readmissions

Open Forum

- What are some of your challenges and/or successes in collection demographic data?
- Has your organization taken a look at Z codes?

Remaining Complex Care Schedule

Date	Time	Activity	Registration
02/02/2023	12-12:30pm	Fredrick Health System Integrated Care Management	https://healthcentricadvisors.zoom.us/meeting/register/tZ0kce6pqT8uEtJ7mZpmGP45ROQepu7I1EzT
02/09/2023	12-12:30pm	RI Parent Information Network (RIPIN) Hospital Care Transitions Initiative	https://healthcentricadvisors.zoom.us/meeting/register/tZAlc--sqDopGN2mUz8wQnasz4snAI4KoAdq
02/16/2023	12-12:30pm	TBD	https://healthcentricadvisors.zoom.us/meeting/register/tZwrdOivrjkqG9Hax6Rzj9Jb-zFAlhdrCvMw
02/23/2023	12-12:30pm 12:30-1pm	SmartCare Mobile integrated healthcare Wrap-up and Discussion	https://healthcentricadvisors.zoom.us/meeting/register/tZwvd-ipqjorH9AxmixvEh8psZwRozepC663