

# 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...

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

# Overview

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



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# Learning Objectives for this Session

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- 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

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## **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



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## Priority 1:

Expand the Collection,  
Reporting, and Analysis  
of Standardized Data



## Priority 2:

Assess Causes of Disparities  
Within CMS Programs, and  
Address Inequities in Policies  
and Operations to Close Gaps



## Priority 3:

Build Capacity of Health  
Care Organizations  
and the Workforce to  
Reduce Health and  
Health Care Disparities



## Priority 4:

Advance Language Access,  
Health Literacy, and the Provision  
of Culturally Tailored Services



## Priority 5:

Increase All Forms  
of Accessibility to  
Health Care Services  
and Coverage



**CMS Framework for  
Health Equity Priorities**



# Aligning Quality Goals



**Improving Care  
Transitions to  
Reduce  
Unnecessary  
Hospitalization**



**Reducing  
Opioid-Related  
Adverse Events**



**Promoting  
Chronic  
Disease  
Management**



**Supporting  
Immunizations**



**Enhancing  
Patient Safety**



**Advancing  
Infection  
Control  
Strategies &  
Emergency  
Preparedness**



**Health Equity**

***Partnership for Community Health***

**Patient & Family Engagement – Health Information Technology**



## 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

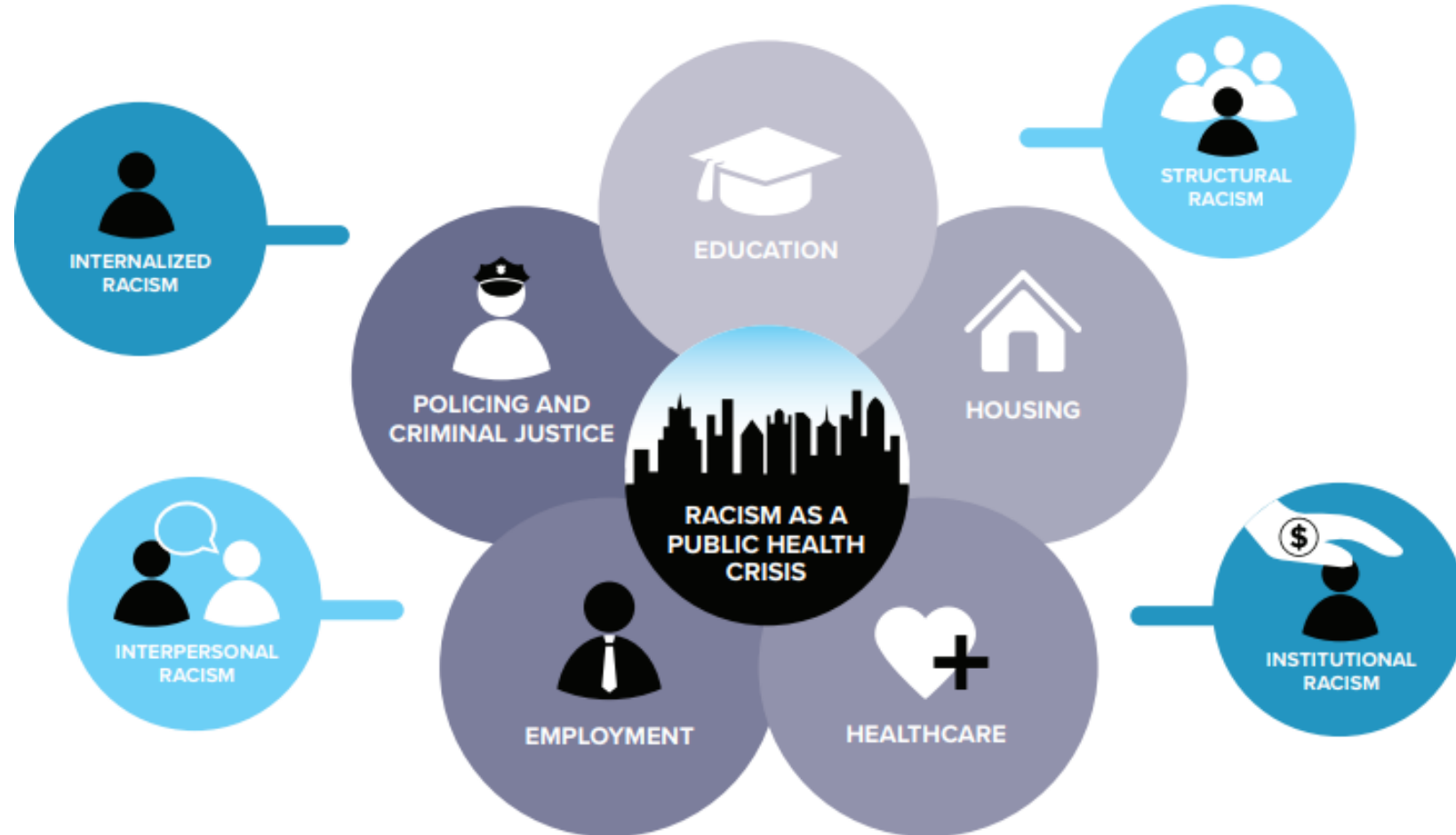
”

# 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**

# 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>.



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# Patient-Level Factors Predicting Hospital Readmission

**Socioeconomic  
Status**

**Race and  
Ethnicity**

**Disability  
Status**

**Limited English  
Proficiency**

**Low Health  
Literacy**

# 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

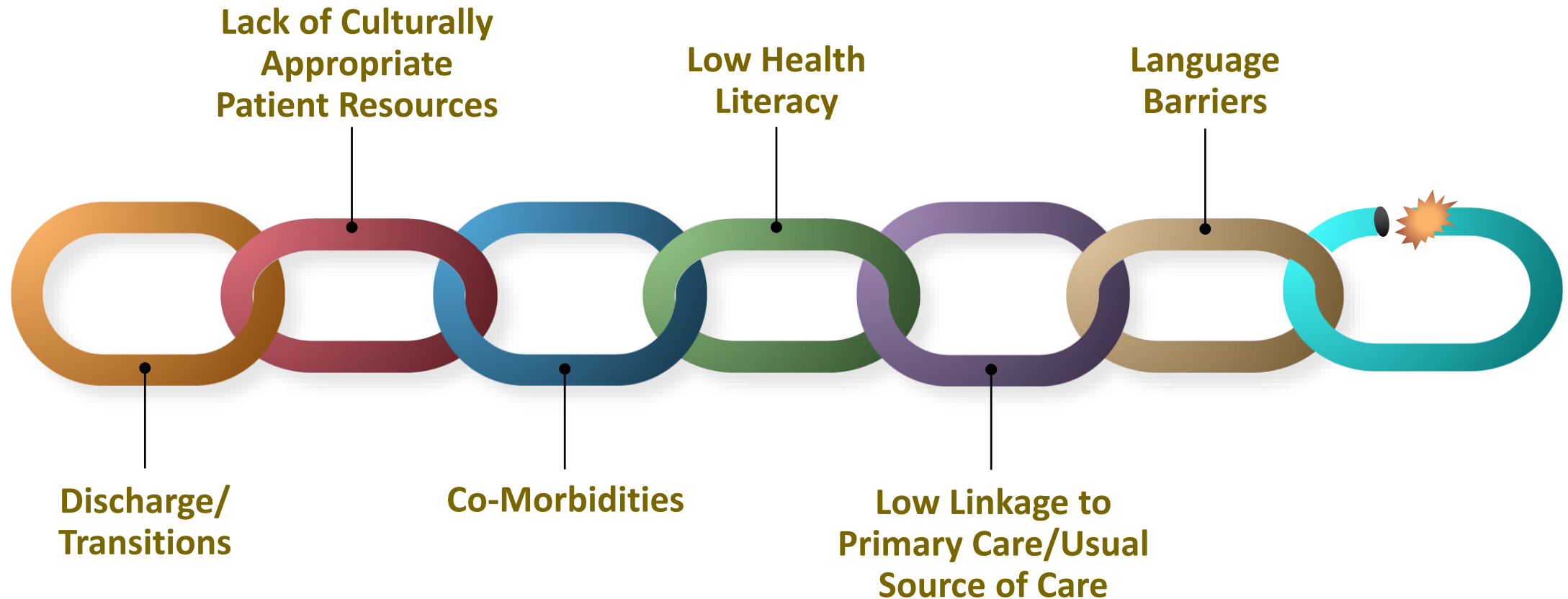
## Chronic Obstructive Pulmonary Disease (COPD)

- Higher readmission rate for Black patients

## Total Hip/Knee Arthroplasty (THA/TKA)

- Higher readmission rate for Black patients

# Key Issues for Racially and Ethnically Diverse Patients



# Closing the Readmissions Gap

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# 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



# Patient Demographic Data Collection

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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



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# 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.



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# 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)

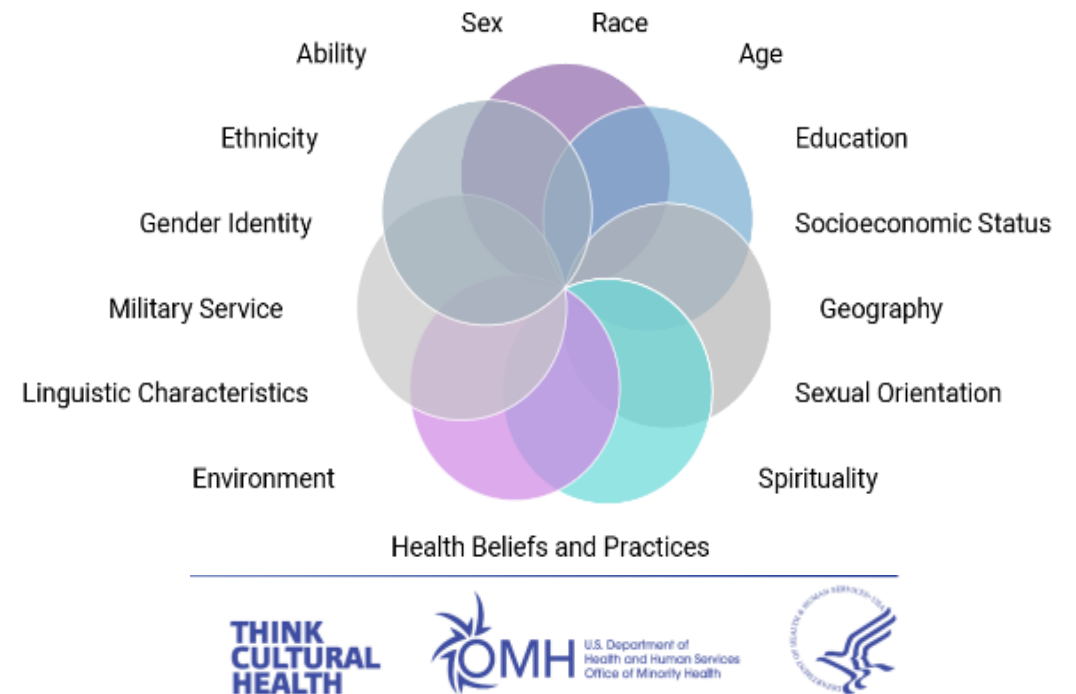
- Create systems responsive to the needs of diverse populations and address the health-related social needs that put them at continued risk of bouncing back.



# 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
<ul style="list-style-type: none"> <li>• Employment</li> <li>• Income</li> <li>• Expenses</li> <li>• Debt</li> <li>• Medical bills</li> </ul>	<ul style="list-style-type: none"> <li>• Housing</li> <li>• Transportation</li> <li>• Safety</li> <li>• Parks</li> <li>• Playgrounds</li> <li>• Walkability</li> <li>• Zip code/geography</li> </ul>	<ul style="list-style-type: none"> <li>• Literacy</li> <li>• Language (LEP)</li> <li>• Early childhood education</li> <li>• Vocational training</li> <li>• Higher education</li> </ul>	<ul style="list-style-type: none"> <li>• Social integration</li> <li>• Support systems</li> <li>• Community engagement</li> <li>• Discrimination</li> <li>• Stress</li> </ul>	<ul style="list-style-type: none"> <li>• Health coverage</li> <li>• Healthcare access</li> <li>• <b>Provider linguistic &amp; cultural competency</b></li> <li>• Quality of care</li> </ul>

## 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>



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# Culturally & Linguistically Appropriate Services (CLAS)

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- 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>



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## 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.

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



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# IPRO Health Equity Resources

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Committed to a Culture of Equity in our Communities

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## What is health equity?

There's no one definition, but a 2017 report from Robert Wood Johnson says health equity ensures that "everyone has a fair and just opportunity to be as healthy as possible."

How do we do that? The definition goes on:

"This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and healthcare."

[View Our Resources](#)

## What is a health disparity?

What causes health disparities?

## Why is achieving health equity important?

Providing equitable care means considering a person's circumstances, culture, and beliefs so services can be delivered to allow people to achieve optimal health.

If all aspects of a person's life are not considered amidst their overall health, they may experience health disparities resulting in worse outcomes and thus a poorer quality life. Health disparities are not just harmful, but expensive.

Disparities in the U.S. account for approximately \$9 in excess medical care costs and \$42 billion in lost productivity. Closing the racial equity gap in the U.S. States could mean gains of \$8 trillion in GDP.

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**HEALTH EQUITY UPDATES**  
November 2022

**Health Equity**




## Racial and Ethnic Differences in Bystander CPR

A study recently published in the New England Journal of Medicine shows that Black and Hispanic individuals who experienced an out-of-hospital cardiac arrest were less likely to receive cardiopulmonary resuscitation (CPR). According to the American Heart Association, CPR can double or triple a person's survival if it is administered correctly.

The researchers examined CPR rates for cardiac arrests at home and in public locations from 2013 to 2019, identifying a cohort of 110,054 witnessed out-of-hospital cardiac arrests for the study. The researchers found that 76.6% of the cardiac arrests occurred at home and 23.4% in public locations. Compared to White individuals, Black and Hispanic individuals were 26% less likely to receive bystander CPR at home and 37% less likely in public locations.

The researchers cite several reasons for these disparities, including less opportunity for individuals from racial and ethnic minority groups to receive CPR training, language barriers, lack of availability of dispatcher-assisted bystander CPR, and implicit and explicit biases. The study suggests that a multifaceted approach is required to address the disparities.

## Announcing the IPRO HEOA Affinity Group

Join us for the IPRO Health Equity Organizational Assessment (HEOA) Affinity Group, led by IPRO Health Equity SMEs. This group will work together to advance opportunities for improvement identified from your organization's HEOA report. The affinity group will give participants the opportunity to collaborate, share best practices and lessons learned while implementing the key activities in the HEOA. The first session is 12/8 and registration information is coming soon. Contact Laura Benzel for more information at [benzell@qlarant.com](mailto:benzell@qlarant.com).

## This Month National American Indian & Alaska Native Heritage Month

### NATIONAL AMERICAN INDIAN & ALASKA NATIVE HERITAGE MONTH

Each November, we recognized the heritage and diverse culture traditions, and histories of Native Americans. The CMS Division Tribal Affairs is holding a [lecture series](#) this month, two of which discuss health equity. Check out the AIAN Outreach and Education webpage for additional resources and information, and learn more about the AIAN population from the [Census Bureau](#).

## National Diabetes Month



November is also National Diabetes Month. According to the CDC, 37 million Americans are affected by diabetes. There is a [webpage](#) with information about the disease and a [toolkit](#) to promote the theme: Diabetes Management Takes a Team.

Diabetes is more common in racial/ethnic groups and with lower socioeconomic status. The CDC Advancing Health and Equity webpage discusses ways to reduce disparities in diabetes care.

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## A Guide to Screening Patients for Food Insecurity

Access to healthy, quality food can help individuals achieve and maintain optimal health. The connection between nutritious food and a healthy, active life are well documented and supported by robust scientific study. But due to food insecurity, many people lack access to adequate food.

According to the U.S. Department of Agriculture (USDA), 1 in 8 people – or 38 million Americans – were food insecure in 2020. The USDA defines food insecurity as a household-level economic and social condition of limited or uncertain access to adequate food. Hunger is an individual-level physiological condition that can result from food insecurity.

**Impacts of food insecurity:**

- Associated with some of the most costly and preventable diseases in the U.S.
- Exacerbates health disparities, especially for racial/ethnic minorities.
- Increases the risk of malnutrition.
- Increases likelihood of skipping or underuse of prescribed medications.
- Increases the risk for mental health conditions.
- Contributes to higher healthcare costs.

Healthcare providers can play an important role in identifying and addressing food insecurity. Screen all patients and refer those who need help.

**The recommendation is that you screen all patients for food insecurity**

Use the validated [Hunger Vital Sign](#)™ two-question screening tool to screen your patients for food insecurity:


- "Within the past 12 months, we worried our food would run out before we got money to buy more."
- "Within the past 12 months, the food we bought just didn't last and we didn't have money to get more."

**Patients screen positive for food insecurity if they respond "often true" or "sometimes true" to either or both statements.**

If a patient screens positive:

- First, ask the patient if they would like help.
- If they say yes, refer them to support services. Please see the Resources section of this flyer.
- Document and code\* the results in the patient's electronic medical record:
  - ICD-10-CM Diagnosis Code Z59.41 (Food insecurity)

\*Please consult with a coding specialist to ensure proper coding of patient conditions.



# Resources

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## 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	<a href="https://healthcentricadvisors.zoom.us/join/registration/tZ0kce6pqT8uEtJ7mZpmGP45ROQepu7I1EzT">https://healthcentricadvisors.zoom.us/join/registration/tZ0kce6pqT8uEtJ7mZpmGP45ROQepu7I1EzT</a>
02/09/2023	12-12:30pm	RI Parent Information Network (RIPIN) Hospital Care Transitions Initiative	<a href="https://healthcentricadvisors.zoom.us/join/registration/tZAlc--sqDopGN2mUz8wQnasz4snAl4KoAdq">https://healthcentricadvisors.zoom.us/join/registration/tZAlc--sqDopGN2mUz8wQnasz4snAl4KoAdq</a>
02/16/2023	12-12:30pm	TBD	<a href="https://healthcentricadvisors.zoom.us/join/registration/tZwrdOivrjkqG9Hax6Rzj9Jb-zFAlhdrCvMw">https://healthcentricadvisors.zoom.us/join/registration/tZwrdOivrjkqG9Hax6Rzj9Jb-zFAlhdrCvMw</a>
02/23/2023	12-12:30pm	SmartCare Mobile integrated healthcare	<a href="https://healthcentricadvisors.zoom.us/join/registration/tZwvd-ipqjorH9AxmixvEh8psZwRozepC663">https://healthcentricadvisors.zoom.us/join/registration/tZwvd-ipqjorH9AxmixvEh8psZwRozepC663</a>
	12:30-1pm	Wrap-up and Discussion	



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