The impact of health disparities and social determinants of health on readmission

September 15, 2022

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

HQIC | Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

This material was prepared by the Healthcare Association of New York State, Inc., a Hospital Quality Improvement Contractor under contract with the Centers for Medicare & Medicaid Services, an agency of the U.S. Department of Health and Human Services. Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. 12SOW/EQIC/HQIC-0091-09/07/22

Today's agenda

TOPIC	PRESENTER
Welcome and introduction	Brenda Chapman BS, RNC, EQIC Program Manager Nicole Ford, MBA, CPHQ, EQIC Program Manager Maria Sacco, RRT, CPHQ, Director, Quality Advocacy, Research and Innovation, Healthcare Association of New York State
Reducing Disparities in Readmissions: The Role of Social Determinants of Health in Promoting Health & Health Equity	Julia E. Iyasere, MD, MBA Executive Director, Dalio Center for Health Justice New York-Presbyterian
	Theresa Green, PhD, MBA Director of Community Health Policy and Education URMC Center for Community Health
Q & A and Closing Remarks	EQIC staff

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

MAP sprint recap

- Step 1: Design your program
- Step 2: Identify patients who meet MAP criteria
- Step 3: Assess readmission risk
  - *Evaluate readmission risk using a standard assessment tool*
  - *Gather information from patient and care partner*
  - *Regularly review risk data to identify and mitigate risk trends*
  - **Identify and address any health equity and social determinants of health concerns for the patient**

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

MAP Framework

EQIC
EASTERN US QUALITY
IMPROVEMENT COLLABORATIVE

Multiple-admission Patient
Program Framework

STEP 1: Design your MAP program

- Create an internal multidisciplinary team
- Identify and invite community-based organizations to collaborate with your team
- Define program goals and measures
- Evaluate and adopt MAP program tools and resources
- Develop staff education for the MAP program

STEP 2: Identify patients that meet MAP program criteria

- Develop data sources for reports
- Review and determine eligible patients
- Develop EMR notifications
- Create a plan for healthcare team communication

STEP 3: Assess readmission risk

- Evaluate readmission risk using a standard assessment tool
- Gather information from patient and care partner
- Regularly review risk data to identify and mitigate risk trends
- Identify and address any health equity and social determinants of health concerns for the patient

STEP 4: Customize interventions

- Create an individualized plan for each patient
- Coordinate a discharge plan with the MAP program team
- Engage emergency department staff in MAP program
- Ensure follow-up communication with post-discharge provider(s) occurs
- Provide post-discharge support and follow up

HQIC | Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

This material was prepared by the Healthcare Association of New York State, Inc., a Hospital Quality Improvement Contractor under contract with the Centers for Medicare & Medicaid Services, an agency of the U.S. Department of Health and Human Services. Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. 12SOW/EQIC/HQIC-0075-06/02/22

EQIC
EASTERN US QUALITY
IMPROVEMENT COLLABORATIVE

Questions to run on

1. What populations do you serve, and how does your hospital or health system understand the factors that contribute to (or impede) said populations' ability to achieve good health?
2. What sources of data are you using to understand the needs of your patient and community populations?
3. How are you partnering with external organizations to better support individuals with complex health and social needs?

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

Today's faculty

Julia E. Iyasere, MD, MBA
Executive Director, Dalio Center for Health Justice
New York-Presbyterian

Theresa Green, PhD, MBA
Director of Community Health Policy and Education
URMC Center for Community Health

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

Questions

EQIC
EASTERN US QUALITY
IMPROVEMENT COLLABORATIVE

Questions to run on part 2

1. How does your organization engage in strategic planning around clinical and community partnership development?
2. How might your MAP team best work with community partners and local public health agencies to improve health outcomes?
3. Are there new partnerships – internal teams, stronger physician alliances or external community partnerships – that your MAP team should be exploring?

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

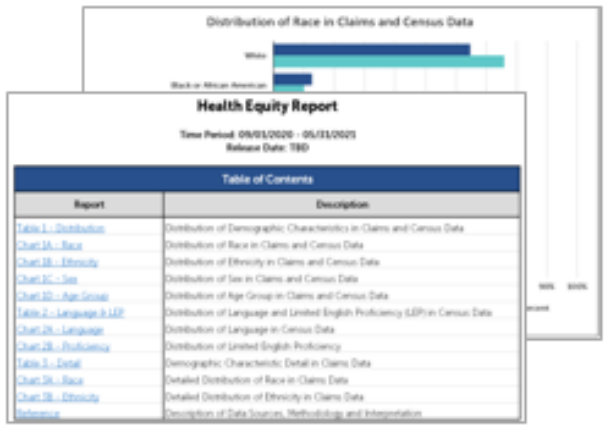
Health Equity

EQIC's health equity initiative supports the efforts of hospitals and health systems toward achieving high-quality, equitable care for all. We assist hospitals to identify and address potential healthcare disparities by:

- improving the collection of standardized race, ethnicity and language (REaL) data;
- using data to better inform patient-centered care and targeted interventions to reduce healthcare disparities; and
- implementing cross-cutting, equity-focused tactics and strategies at the unit level to promote safety across the board and reduce harm.

Health Equity Report

- Hospital-specific reports highlight areas for potential data quality improvement and provide demographic data on the community served by the hospital.

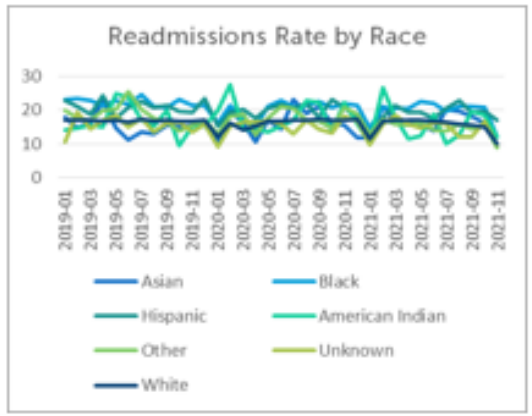


Data sources: American Community Survey and hospital-submitted claims data

Equity Data to Drive Improvement

Leverage use of equity metrics and quality improvement tools to diagnose and reduce disparities in quality of care. Hospital 30-day readmission rates are stratified by race and analyzed to:

- Track and identify inequities within vulnerable populations at high risk for readmission and explore root causes of readmission disparities.
- Develop tailored action plans and targeted QI equity-focused interventions to drive improvement in patient care and outcomes.



Health Equity Gap Analysis Tool

Supports hospital assessment and implementation of health equity best practices. Checklist elements include:

- Organizational leadership
- Workforce training
- Data collection, stratification and use
- Culture, language and health literacy
- Community partnerships

REaL Data Collection eLearning Module

- Skill-based training developed for frontline staff to improve and increase collection of patient self-reported REaL data
- Provides best practice strategies and tools (e.g., scripts, role plays) to help patients understand the importance of why we collect REaL data and how to address frequently asked questions

Health Equity Website Tools and Resources

- Best practice toolkits
- Data tools
- Gap analysis/action planning
- Publications and reports

EQIC Health Equity Gap Analysis

Checklist best practice elements include:

SDOH workforce training (data collection)

- ❑ *Hospital workforce training is provided to clinicians regarding the standardized collection of SDOH data.*

SDOH & readmission data collection, stratification and use

- ❑ *Hospital uses a self-reporting methodology to collect SDOH data*
- ❑ *Hospital stratifies measures (e.g., 30-day readmission rates) by REaL to examine differences and equity of care provided.*

Strengthening & sustaining community partnerships

- ❑ *Hospital partners with CBOs to maximize cross-sector partnerships and meet patients' and communities' needs.*

Health equity tools and resources

Hospital Toolkits for Action	Assessment & Screening Tools	SDOH Data Tools
• EQIC Health Equity Website • CMS | Guide to Reducing Disparities in Readmissions • Integrating to Improve Health: Partnership Models between Community-Based and HCOs	• PRAPARE Implementation and Action Toolkit ➢ *Workflow Implementation* • CMS | Health-Related Social Needs (HRSN) Screening Tool • Scripting Examples for SDOH Screening	• CMS Using Z Codes: The SDOH Data Journey to Better Outcomes • CDC | Data Sources & Tools for Putting SDOH into Action • ROI Calculator for Partnerships to Address SDOH

New! AHA Community Collaboration for Solutions | Health Equity Action Library

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

MAP tools and resources

EQIC Readmission website

- MAP Program Syllabus
- MAP Program Framework
- MAP Program Implementation Guide

Next steps

- **Expand your MAP multidisciplinary team**
  - continue to identify and invite community based organizations
  - use data to identify the SDoH most commonly found in your patient population
  - discuss the influence of health equity and SDoH on the MAP population and readmission
- **Develop reports and analyze your hospital specific data**
  - identify MAP program-specific patients
  - evaluate to identify trends and additional community-based organization support
  - create linkage with community services and collaborate with CBOs
- **Evaluate EQIC tools and resources-adapt or adopt**
  - consider additional products, community support services and tools to address social determinants within your patient population

MAP program curriculum

Upcoming webinars

October 20: Interventions for the MAP program

November 17: Role of the emergency department - 15 years of ED case management: Lessons learned and benefits realized

December 15: Capstone

Complete the survey

EQIC
EASTERN US QUALITY
IMPROVEMENT COLLABORATIVE

Thank you.

Nicole Ford nford@hanys.org
Brenda Chapman bchapman@hanys.org
Maria Sacco msacco@hanys.org

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE