Health Equity Now! Workgroup, Session 6

Tuesday, July 18, 2023

Introduction

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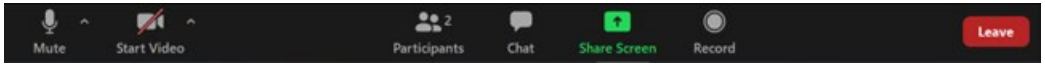

a. To ask questions, click on the **Chat** icon. At the end of the presentation, you will also be able to unmute to ask a question verbally.

b. You may adjust your audio by clicking the caret next to the **Mute** icon.

c. Resources from today's session will be shared after the call.

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Welcome to Learning Session 6!

Session 6 Objectives:

- Addressing disparities in readmissions by:
  - Developing strategies to provide culturally competent care, connect patients to resources, and address comorbidities

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Sessions will be held at 12pm EST on these dates:

Learning Sessions	February 21	March 21	April 18	May 23	June 20	July 18
HEH Sessions	March 7	April 4	May 2	June 6	June 27	August 1

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Disparities in Readmissions

Root Causes

- Determine patients, populations, and characteristics that are linked to readmissions
- Systems innovations and improvement become the natural outgrowth of a strong radar that picks up clear root causes

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Disparities in Readmissions

Root Causes

- Discharge and care transitions
- Low linkage to primary care/usual source of care
- Language barriers and access to interpreter services
- Low health literacy
- Lack of culturally competent patient education
- Social drivers of health
- Co-morbidities
- Mental health

Disparities in Readmissions

Cultural Competency

Cultural beliefs and customs influence patients' health behaviors, perceptions of care, and interpretation of medical information or advice

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Evidence for Cultural Competency

- Developed an educational program to improve nurse's cultural competence for patients in an urban Midwest city
    - Online Cultural Competency Course
    - Live PPT presentation titled "RESPECT"
    - Live PPT presentation titled "Putting it all Together"
- Resulted in significant improvement in nurse behavior around use of culturally competent discharge practices and overall reduction in 30-day ED visits

Benefits of Cultural Competence

Social	Health	Business
• Increases mutual respect and trust • Promotes inclusion • Increases community participation	• Improves patient data collection • Increases preventive care • Reduces disparities and missed medical visits	• Increases different perspectives in decision-making • Improves efficiency of care services • Decreases cost of medical errors

Guiding Principles for Cultural Competency

- Incorporates culture preservation and maintenance of care beliefs and values
- Accommodates to assist patients in adapting to or negotiating culturally congruent safe care
- Re-patterns and/or restructures harmful health behaviors for better healthcare practices and outcomes

Disparities in Readmissions

Steps Toward Cultural Competence

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Staff Training & Education

- Assess staff's knowledge on cultural competence
- Provide multiple training methods (e.g., online education, case study review, orientation)
- Provide ongoing education (e.g., periodic assessments, recorded webinars)
- Measure and track data through patient satisfaction scores and disparities

Disparities in Readmissions

Training Topics

- Health disparities for various populations (race/ethnicity, LGTBQ+, disability, etc.)
- Demographics of hospital community
- Understanding how cultural influences shape interactions and impact the clinical encounter
- Creating skills to identify service needs of patients, resolve conflicts, and respect differences

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Strategies for Culturally Competent Care

- Demonstrate respect for cultural practices and beliefs
- Engage families in care transitions and leverage cultural beliefs or practices
- Connect patients to trusted community-based educational programs
- Address cultural factors that may predict non-adherence

Strategies for Culturally Competent Care

- Implementing national CLAS standards to address cultural and communication barriers patients face when seeking services

Select your organization's stage of implemention for each practice		Currently implementing	Planning to implement	Not planning to implement at this time
1.2a	**Identify and designate a CLAS champion or champions**, who are supported by the organization's leadership, and whose specific responsibilities include (at a minimum) continuous learning about, promoting, and identifying and sharing educational resources about CLAS and the National CLAS Standards throughout the organization.	☐	☐	☐
1.2b	**Create and implement a formal CLAS implementation plan** that is (at a minimum) endorsed and supported by the organization's leadership, that describes how each Standard is understood, how each Standard will be implemented and assessed, and who in the organization is responsible for overseeing implementation.	☐	☐	☐
1.3a	**Target recruitment efforts to the populations served to increase the recruitment of culturally and linguistically diverse individuals**, through actions such as: posting job descriptions in multiple languages in local community media, holding job fairs in the community(ies) served, and/or working with leaders of local community institutions to create mentorship and training programs targeting populations served.	☐	☐	☐
1.3b	**Create internal organizational mentorship programs**, specifically targeting culturally and linguistically diverse individuals, that provide information about and support for additional training opportunities, and that links individuals in junior positions with individuals in senior positions to receive career guidance and advice.	☐	☐	☐

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Strategies for Culturally Competent Care

[INSERT Organization Name] CLAS Action Plan
Based on the Implementation Checklist for the National CLAS Standards

Activity	Assigned To:	Due By:	Status	Barriers/Challenges	Mitigation strategies
Complete the Implementation Checklist for the National CLAS Standards					
Review the background information in the "CLAS Standards" tab of this spreadsheet.					
Designate a CLAS Champion or Champions to complete the checklist					
Complete the Implementation Checklist (Pages 4-7) at Think Cultural Health					
Review the results of the CLAS Checklist & complete the CLAS Action Worksheet with a focus on practices checked as "planning to implement"					
Work with the organization's internal team and a HQI team member to estabish an organization's full CLAS Action Plan using this template					
Add practices that you plan to implement in the NEXT MONTH					
Add organizational-specific activity					
Add organizational-specific activity					
Add organizational-specific activity					
Add practices that you plan to implement in the NEXT 3 MONTHS					
Add organizational-specific activity					
Add organizational-specific activity					
Add organizational-specific activity					
Add practices that you plan to implement in the NEXT 6 MONTHS					
Add organizational-specific activity					
Add organizational-specific activity					
Add organizational-specific activity					

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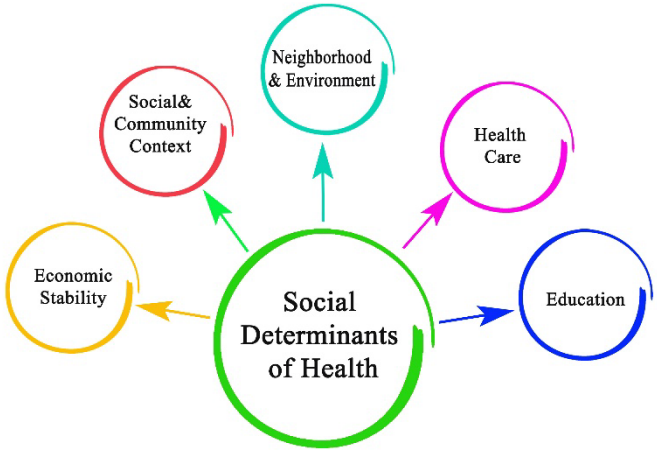
Disparities in Readmissions

Social Drivers of Health

Factors linked to social needs are associated with higher readmission rates for patients, especially at minority serving institutions



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Disparities in Readmissions

Strategies to Address SDOH

- Connect uninsured and underinsured patients with supplemental health insurance
- Encourage social support through community connections, technology, and community-based interventions
- Connect patients with community-based resources

Using Referrals to Connect Patients to Resources

- Three approaches to making referrals:
    1. Direct referrals: when hospital directly contacts service agency on behalf of patient
    2. Specific Referrals: made to specific community-based organizations
    3. Tailored resource list
- Close the referral loop by developing a bidirectional process

Social Care Coordination Platforms

- **Unite Us** (https://uniteus.com/): allows organizations to build a coordinated care network, track outcomes, and identify service gaps
- **WellSky** (https://wellsky.com/): integrates social care across the continuum through a network of social service organizations, supporting closed-loop referral capabilities
- **CrossTX** (https://crosstx.com/): closed-loop collaborative care and referral management platform
- **CharityTracker** (https://www.charitytracker.com/): ensures patients are connected to resources through partner network and allows measurement of impact

Platform Considerations

- Develop consensus on what defines a “successful referral” before platform implementation
- Examine how integration will happen and involve IT staff in conversations with vendors
- Ensure platform allows tracking of the referral outcomes your organization and its partners are most interested in
- Single sign-on platform to facilitate seamless use

Disparities in Readmissions

Platform Considerations

- Ability to provide referrals directly to patients
- Built-in translation options
- Easy communication between organizations and other staff regarding referral details

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Disparities in Readmissions

Case Study: Health Connections Initiative

- KentuckyOne utilized the LACE Index Scoring Tool to identify high utilizers alongside a "hot-spotting" map to determine where they live
- Provided home visits over the course of 90 days that focused on:
    - Setting goals for health improvement
    - Identifying barriers to health and overcoming them (e.g., housing, transportation, food insecurity)
- Decreased patient admissions by 50%, length of stay by 66%, and 30-day readmissions by 25%

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Disparities in Readmissions

Case Study Lessons Learned

- Connect to the root causes
- Assess social factors and address holistic needs
- Employ a multidisciplinary team
- Link patients to community-based services

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Disparities in Readmissions

Community-Clinical Linkages (CCL)

Connects the clinical sector to organizations that provide services, programs or resources **to community members** in non-health care settings

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Sustaining CCLs

- Designate coordinators to assist in building community trust
- Include traditional and nontraditional partners that address a wide array of inequities
- Develop formal agreements with partners that:
  - Outline a health equity-focused vision or mission
  - Provide a timeline
  - List roles and responsibilities

Disparities in Readmissions

Sustaining CCLs

- Involve community members most affected by inequities in development and implementation
- Establish a formal mechanism to engage champions and community leaders
- Ensure the CCL takes a strengths-based approach
- Create structures that balance power dynamics
- Allow flexibility

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Disparities in Readmissions

Sustaining CCLs

- Recruit staff that reflect the populations you serve and have personal experience with inequities
- Include those who have expertise working with community members
- Offer regular health equity trainings

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Disparities in Readmissions

Case Example: Methodist Le Bonheur Healthcare

- **Problem**: The Black population has higher readmissions rates due to low levels of support after discharge.
- **Solution**: Began the Congregational Health Network, partnering with churches in Memphis. Enrolled individuals are flagged in health system's EHR upon admission. A navigator meets with the patient to establish post-discharge needs. Trained community members assist in meeting social needs.
- **Result**: Decreased inpatient utilization and mortality rates; higher satisfaction with care

Case Study Key Lessons

- Community members play an equal role as hospital staff and serve as links between patients and healthcare systems
- Decenter hospital power to foster connection
- Create space for authentic community-based design
- Ensure ongoing analysis, evaluation, and development
- Leverage community caregiving

Disparities in Readmissions

Co-morbidities

- Higher comorbidity is associated with increased readmissions
- Primary diagnoses of avoidable readmissions are usually complications of an underlying comorbidity
- Racial and ethnic minorities commonly have multiple co-morbidities

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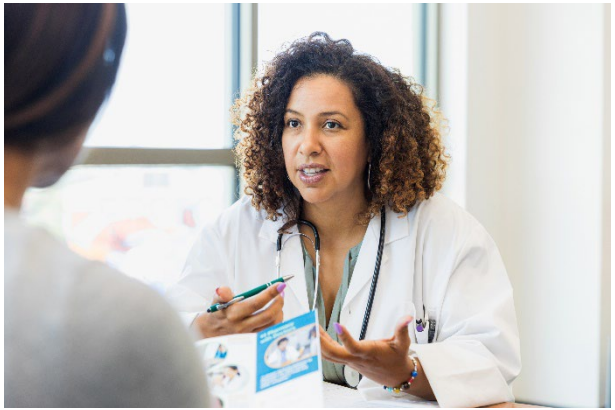
Strategies to Address Comorbidities

- Take a holistic view of the patient's health, not just the admitting diagnosis
- Ensure appropriate referral to specialty care for co-morbidities
- Implement policies that foster the use of multi-disciplinary disease management teams



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Disparities in Readmissions

Case Study: Alterna-Care Home Health

- Implemented a disease management model to reduce readmissions among patients with diabetes
- Nurses were paired with patients and worked with physician collaborators and primary care providers to develop a diabetes care map
    - Provided home visits and patient education
- Reduced hospitalizations by 51% and emergency room visits by 17.5%

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Case Study Lessons Learned

- Deploy a team of multidisciplinary team of care providers; expand care team to tailor to diverse populations
- Systems, social support, and social determinants
- Focus on communication and understanding
- Devote attention to community, coordination, and continuity

Disparities in Readmissions

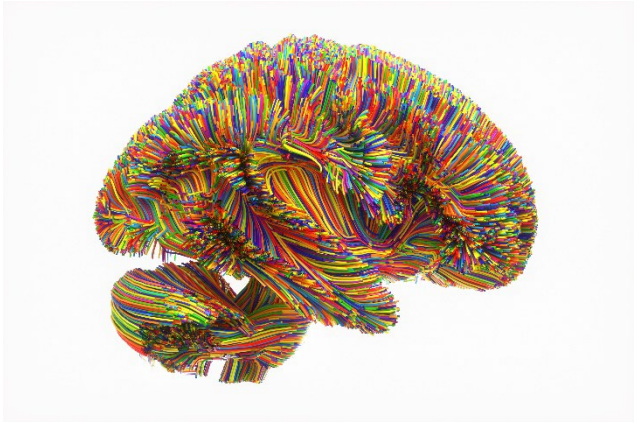
Mental Health

- 28% more likely to be readmitted within 30 days
- For the 6 conditions included in the Hospital Readmissions Reduction Program, patients with comorbid mental illness were found to be 56% more likely to be readmitted
- Patients with symptoms of depression have lower rates of adherence to medications and other treatment after discharge

Disparities in Readmissions

Mental Health

- Anxiety and depression disproportionately impact certain minority groups
- Poor mental health has been shown to affect access to services and self-care after discharge



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Strategies to Address Mental Health

- Assess patients for depression
- Assist patients in accessing culturally competent mental health services
- Support culturally-relevant coping mechanisms (e.g., spirituality, mindfulness)
- Address stigma about diagnosis and variation in the cultural meaning of depression

Disparities in Readmissions

Mental Health Assessment

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Column Totals _____ + _____ + _____

Add Totals Together _____

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Considerations for Selecting an Assessment

- Evidence-based & reliable
- Select broader assessment tools then narrow to specific area target
- Who is completing the screening tool
- Cultural considerations

Disparities in Readmissions

Root Causes

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- Mental health

Disparities in Readmissions

Building Interventions

- Develop preventative efforts that range from pre-admission to post-discharge
- Systems should aim to assess risk prior to admission and address those factors during admission
- Focus on:
    - Systemically addressing social drivers
    - Cultural competency
    - Building community partnerships

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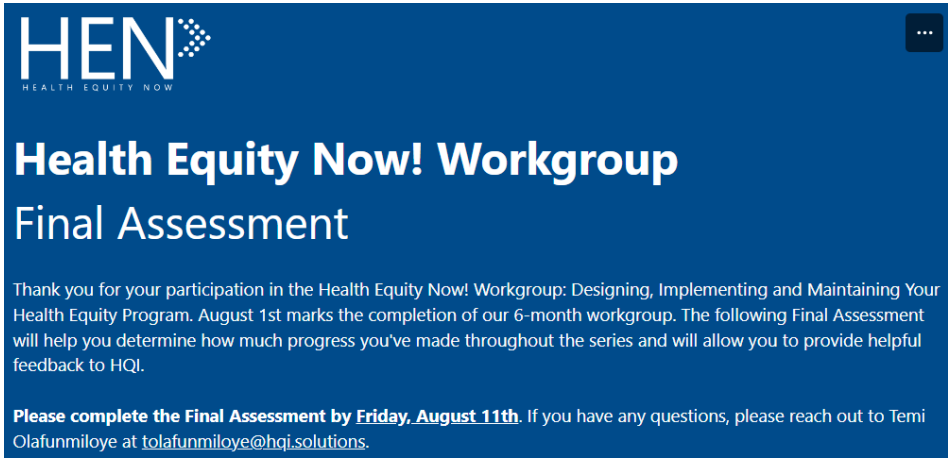
Looking Ahead

For Discussion:

- Final Assessment
- Refer to your pre-work, what were your aims and how far have you come?
- Based on your progress, what is your path forward?



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Resources

1. Guide to Disparities in Readmissions
2. Guide to Preventing Readmissions Among Racially and Ethnically Diverse Medicare Beneficiaries
3. Becoming a Culturally Competent Health Care Organization
4. Implementation Checklist for CLAS Standards
5. HQIN CLAS Action Plan
6. From the Memphis Model to the North Caroline Way: Lessons Learned from Emerging Health System and Faith Community Partnerships
7. Community Resource Referral Platforms: A Guide for Healthcare Organizations
8. Patient Health Questionnaire (PHQ-9)

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Recorded Sessions

Learning Session 1, February 21

- Webinar: https://youtu.be/NLVlb6vQwFs; Slides: https://hqin.org/resource/health-equity-now-workgroup-session-1-slides/

Learning Session 2, March 21

- Webinar: https://youtu.be/OQ9kYVwnk70; Slides: https://hqin.org/resource/health-equity-now-workgroup-session-2-slides/

Learning Session 3, April 18

- Webinar & Slides: https://hqin.org/resource/health-equity-now-workgroup-session-3-slides/

Learning Session 4, May 23

- Webinar & Slides: https://hqin.org/resource/health-equity-now-workgroup-session-4/

Learning Session 5, June 20

- Webinar & Slides: https://hqin.org/resource/health-equity-now-workgroup-session-5/

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