



GUIDE FOR **REDUCING** DISPARITIES IN **READMISSIONS**

CMS Office of Minority Health
Revised April 2024

Introduction to Guide for Reducing Disparities in Readmissions



GOALS OF THIS GUIDE

-  **1** Highlight the importance of social determinants of health (SDOH)
-  **2** Recommend strategies to establish a multidisciplinary team
-  **3** Provide resources organizations can leverage to enact solutions and collect data to measure

HOW TO USE THIS GUIDE

This **Guide for Reducing Disparities in Readmissions** is a resource for health care practitioners, leaders, and community partners focused on quality, safety, and care design in health systems to drive change and deploy interventions that advance equity and reduce disparities in readmissions and associated health outcomes. The Guide has been designed to assist users in understanding root causes of avoidable readmissions and identifying solutions for preventing and addressing avoidable readmissions and disparities in avoidable readmissions among individuals with Medicare coverage. Throughout the Guide, key issues, strategies, and implementation examples are provided to guide organizations along their path to advancing health equity in the communities that they serve.

WHERE TO GO

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MEDICARE READMISSIONS: QUICK FACTS



IN 2018, THERE WERE
2.3 MILLION
READMISSIONS
WITHIN 30 DAYS OF DISCHARGE
COSTING ROUGHLY
\$35.7 BILLION

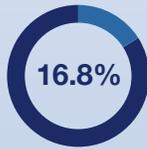


AN ESTIMATED
10%
OF THESE READMISSIONS
COULD HAVE BEEN
PREVENTED

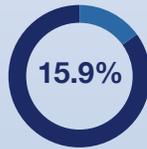
OF ALL RACIAL AND ETHNIC GROUPS, NON-HISPANIC BLACK PATIENTS EXPERIENCED THE HIGHEST RATE OF UNPLANNED 30-DAY READMISSIONS IN 2016.⁴



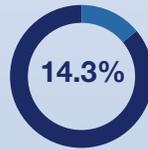
Non-Hispanic Black



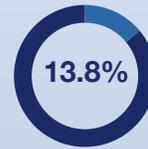
Hispanic,
any race



American Indian/
Alaska Native



Asian



Non-Hispanic
White



HOW DID COVID-19 AND THE PUBLIC HEALTH EMERGENCY IMPACTED DISPARITIES IN UNPLANNED 30-DAY READMISSIONS?

Based on data from March to July 2020, readmission risk for patients hospitalized with COVID-19 increased for those over the age of 65, with certain chronic conditions, a hospital stay in the preceding three months, and if discharged to a Skilled Nursing Facility or home health.¹⁴⁷

- Based on Medicare data from April to September 2020, use of telehealth may help increase follow-up and reduce 30-day readmissions among underserved populations.¹⁴⁸

In response to the COVID-19 Public Health Emergency, CMS expanded telehealth services under the CARES Act to increase access to care for Medicare enrollees.¹⁴⁸ While many providers successfully deployed telehealth for continuity of care, many individuals with Medicare faced barriers to telehealth engagement, including ¹⁴⁹:



41.4%
LACKED ACCESS
TO A COMPUTER
WITH HIGH-
SPEED INTERNET
CONNECTION

40.9%
LACKED A
SMARTPHONE
WITH A WIRELESS
DATA PLAN

26.3%
LACKED BOTH
FORMS OF
DIGITAL ACCESS



30-DAY POST-DISCHARGE MORTALITY RATES ROSE ¹⁹

While increases were observed across all groups, historically underserved populations saw disproportionate increases after implementation of COVID-19 emergency measures:

1.2 – 1.5%
INCREASE FOR
HISPANIC
MEDICARE
ENROLLEES

0.7 – 1%
INCREASE FOR
MEDICARE
ENROLLEES IN
RURAL AREAS

0.5 – 1.4%
INCREASE FOR
MEDICARE ENROLLEES
IN AREAS WITH SOCIAL
DEPRIVATION

Background

Since the Centers for Medicare & Medicaid Services (CMS) introduced the Hospital Readmissions Reduction Program (HRRP) in 2012, the overall rate of unplanned 30-day readmissions for targeted conditions among Medicare enrollees has appreciably declined.¹ Additionally, research shows that disparities in unplanned 30-day readmission rates have narrowed since HRRP's implementation, such as those between non-Hispanic White and Black patients.² However, despite this narrowing of racial disparities in unplanned 30-day readmissions, there remain higher base levels of readmissions for Black patients as compared to White patients.³ Broadly, a number of sociodemographic-related readmission rate disparities persist, with general patterns of underserved populations, including racial and ethnic minorities, individuals residing in rural and remote communities, individuals with disabilities, and lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI+) individuals, often experiencing higher rates of unplanned 30-day readmissions than their counterparts.⁴

Identifying and addressing the factors that drive these sociodemographic-related disparities in unplanned 30-day readmissions is at the heart of the 2022 [CMS Strategic Plan](#) and the [CMS Framework for Health Equity 2022-2032](#).⁵ Both frameworks put advancing health and health care equity at the forefront of the agency's goals and core functions, deeming it necessary to address the disparities that underlie our health care system. The CMS Office of Minority Health (CMS OMH) has created this Guide to aid health care organizations, health care providers, and their community partners in reducing avoidable 30-day readmissions and disparities in these readmissions with an emphasis on early identification of and intervention with associated social determinants – or drivers – of health (SDOH). This is part of a larger CMS effort to address SDOH and aligns with goals to incorporate screening for and access to health-related social needs demonstrated across CMS programs and activities through greater adoption of related quality measures, coordination with community-based organizations, and collection of social needs data in standardized formats.⁶ While this Guide discusses readmissions in the context of Medicare, many of the recommendations and best practices can be applied broadly to other populations.

Root Causes of Avoidable Readmission

Thirty-day readmission rates represent an important health care quality indicator as they are partly driven by substandard quality of hospital care, poor discharge planning, and ineffective coordination of post-discharge services. There are well-known clinical interventions and care transition strategies to reduce preventable readmissions. Evidence has shown that providing multifaceted intervention bundles, which include components such as pre-discharge patient education, implementation of a discharge checklist, medication reconciliation, and post-discharge follow-up, are necessary to decrease readmission rates. This Guide builds on existing evidence-based strategies to further improve care by focusing on SDOH.

Links between SDOH such as income, education,⁹ geography,¹⁰ and disparities in readmission rates have been well established. These disparities exist across race and ethnicity,⁴ gender identity and sexual orientation,¹⁰ disability status, and level of English proficiency.⁴

Disparities in Readmissions



In 2018, people with Medicare accounted for 2.3 million readmissions within 30 days of discharge, costing roughly \$35.7 billion.¹¹ Four years after the implementation of HRRP penalties in 2016, the Medicare Payment Advisory Commission (MedPAC) estimated that approximately 1 in 10 readmissions could be prevented.¹² While both 30-day readmission rates and readmission disparities have been reduced since HRRP implementation, Non-Hispanic Black Medicare FFS patients continue to experience the highest 30-day readmission rates at 19.4%, followed by Hispanic patients at 16.8%. Sixteen percent of American Indian/Alaska Native patients, 14.3% of Asian patients, and 13.8% of non-Hispanic White patients experience readmissions within 30 days of discharge.⁴

The Impact of the COVID-19 Public Health Emergency on Readmission Disparities

The COVID-19 pandemic had an impact on all Americans and perhaps most prominently on individuals who are underserved by our healthcare system.¹³ For example, Hispanic and Black people saw not only an increased incidence of COVID-19 infection but also higher mortality rates.¹⁴ The disproportionate burden of the pandemic on racial and ethnic minorities highlighted the inequities deeply embedded in the health care system, and will inform how our health care system responds to future public health emergencies.

At the individual and community level, people already at high risk for experiencing poorer health outcomes were at higher risk of contracting COVID-19 due to inequities impacting the ability to social distance, obtain timely medical care, and access personal protective equipment, testing, and treatment.¹³ As shelter-in-place restrictions went into effect, many providers successfully deployed telehealth across Medicare and Medicaid programs to maintain continuity of care.¹⁵ This use of telehealth was associated with better outcomes, particularly after a hospital admission. However, 63% of people residing in tribal lands and rural areas and 56% of people earning less than \$30,000 annually lack broadband internet access,¹⁶ limiting the ability of telehealth visits to prevent readmissions for these underserved groups.

The pandemic reduced the health care system's capacity to deliver high quality care because of severe resource limitations. In March 2020, CMS released recommendations to delay elective surgeries to free up hospital beds for COVID-19 patients. An unintended result of this recommendation was a backlog of cases of all other non-COVID-19 or emergent health conditions.¹⁴ This backlog, in combination with changes in health-seeking behaviors due to fear of COVID-19, led to about 20% of adults not getting care for serious health conditions during the pandemic.¹⁷ This led to increased average patient acuity and complexity, and ultimately an increase in post-discharge mortality rates.¹⁸

COVID-19 did not appear to have exacerbated disparities in 30-day readmission rates or 30-day readmissions for HRRP target health conditions (such as heart failure, pneumonia, acute myocardial infarction and chronic obstructive pulmonary disease). However, there were notable increases in 30-day post-discharge mortality rates between April and September 2020 for patients who lived in rural areas, areas with the highest levels of social disadvantage, Black patients and Hispanic patients.¹⁹ While 30-day readmission rates remain an important quality indicator, in the case of the COVID-19 pandemic, interpreting rates the context of this competing mortality risk is critical when considering the full impact of the COVID-19 pandemic (and future public health emergencies) on historically underserved populations.¹⁹



Social Determinants of Health as Drivers of Readmissions



The social, economic, and environmental conditions in which people are born, live, work, learn, worship, play, and age²⁰ strongly affect their health care experiences and health outcomes.⁵ The United States (U.S.) Department of Health and Human Services' (HHS) [Healthy People 2030 Framework](#) has an overarching focus on SDOH due to their contribution to health disparities and inequities. It is estimated that 50% of all health outcomes can be attributed to SDOH, while clinical care impacts only 20% of county-level variation in health outcomes.²¹ Healthy People 2030 groups SDOH into five broad domains: economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context.²² Each SDOH domain has implications for how people live their lives outside of a clinical setting and can contribute to their risk for readmission and poorer health outcomes. The HHS Strategic Plan (FY 2022 – 2026) highlights the need to invest in strategies to expand equitable access to comprehensive, community-based, innovative, and culturally- and linguistically-appropriate healthcare services while addressing SDOH (Objective 1.3).²³

Several factors contribute to the disparities associated with hospital readmission, and perhaps the most significant factor is insurance status.²⁴ Lack of insurance can increase readmission risk because of poorer access to outpatient care.^{25,26} Although individuals with Medicare are insured, various other SDOH can influence readmission rates. Lower education and income,⁹ lack of access to transportation,²⁷ lack of access to stable housing and food,²⁸ as well as lack of social support,^{9,28} have all been linked to increased readmission rates. These SDOH are influenced by political, economic, and cultural drivers that determine how power and resources are allocated.²⁸ Significant research suggests that inequitable distribution of these resources has led to unequal and disproportionately poor outcomes for racial and ethnic minority groups.^{10,29} As a result, there have been concerted efforts by researchers and clinicians to advocate for SDOH consideration in CMS hospital readmission calculations and associated penalties.^{30,31}

In addition to the direct impact of COVID-19 infection on individual health, the pandemic highlighted the importance of SDOH in exacerbating health disparities.³² Black, Hispanic, and Asian American and Native Hawaiian or Pacific Islander (AA and NHPI) individuals had much higher rates of COVID-19 infection, hospitalization, and early mortality compared to their White counterparts.¹³ The underlying causes of these disparities were complex, and included historical, structural, and institutional factors, such as racism and discrimination, economic and educational disadvantage, health care access, and neighborhood context (housing, food security, and transportation).^{14,32} Because of these systemic inequities, racial and ethnic minorities were more likely to have a disproportionate burden of underlying conditions, including diabetes, cardiovascular disease, kidney disease, and obesity.^{14,33} Racial and ethnic minorities were also more likely to live in crowded conditions, both in the context of their neighborhood and their household,³³ which made it more likely for COVID-19 to spread within a household. They were also more likely to be employed in essential jobs, which were more likely to be low wage and may have not allowed for social distancing. These factors and the aforementioned underlying conditions have been associated both with more severe cases of COVID-19¹⁴ and hospital readmissions for non-COVID-19 conditions and procedures.



Considering SDOH in Readmission Intervention Design²⁰

Education Access & Quality

- A higher level of education correlates with longer and healthier lives¹⁵⁰
- Low income, a disability, or discrimination can lead to math and reading challenges¹⁵⁰

Potential Intervention: Provide patient discharge materials that are written at a fourth to sixth-grade level, using short sentences and simple words, and including pictures.³⁴

Health Care Access & Quality

- 1 in 7 adults in the U.S. experience barriers to timely medical care³⁵
- Without primary care, important preventative measures like cancer screenings are missed¹⁵¹
- Dually eligible Medicare members experience lower quality of care in almost 40% of quality indicators, compared to the national average³⁶

Potential Intervention: Improve follow-up after hospital discharge by offering assistance with connecting to health insurance options, community based services, health care providers and multiple modalities to meet patients' needs (e.g., in- person, telehealth).

Social & Community Context

- Positive relationships at home, in the community, and at work can reduce the negative impacts of SDOH¹⁵²
- Social and community supports are critical to living a healthy life¹⁵²

Potential Intervention: Link patients to community-based programs that can enhance healthy habits at home and create a supportive environment.



Economic Stability

- 1 in 10 people in the U.S. can't afford housing, health foods, or health care¹⁵³
- Stable employment lowers chances of poverty & improves health¹⁵⁴

Potential Intervention: Screen for and connect patients to career services, and subsidies for housing, food, childcare, and health care during primary care visits as an element of care coordination.

Neighborhood & Built Environment

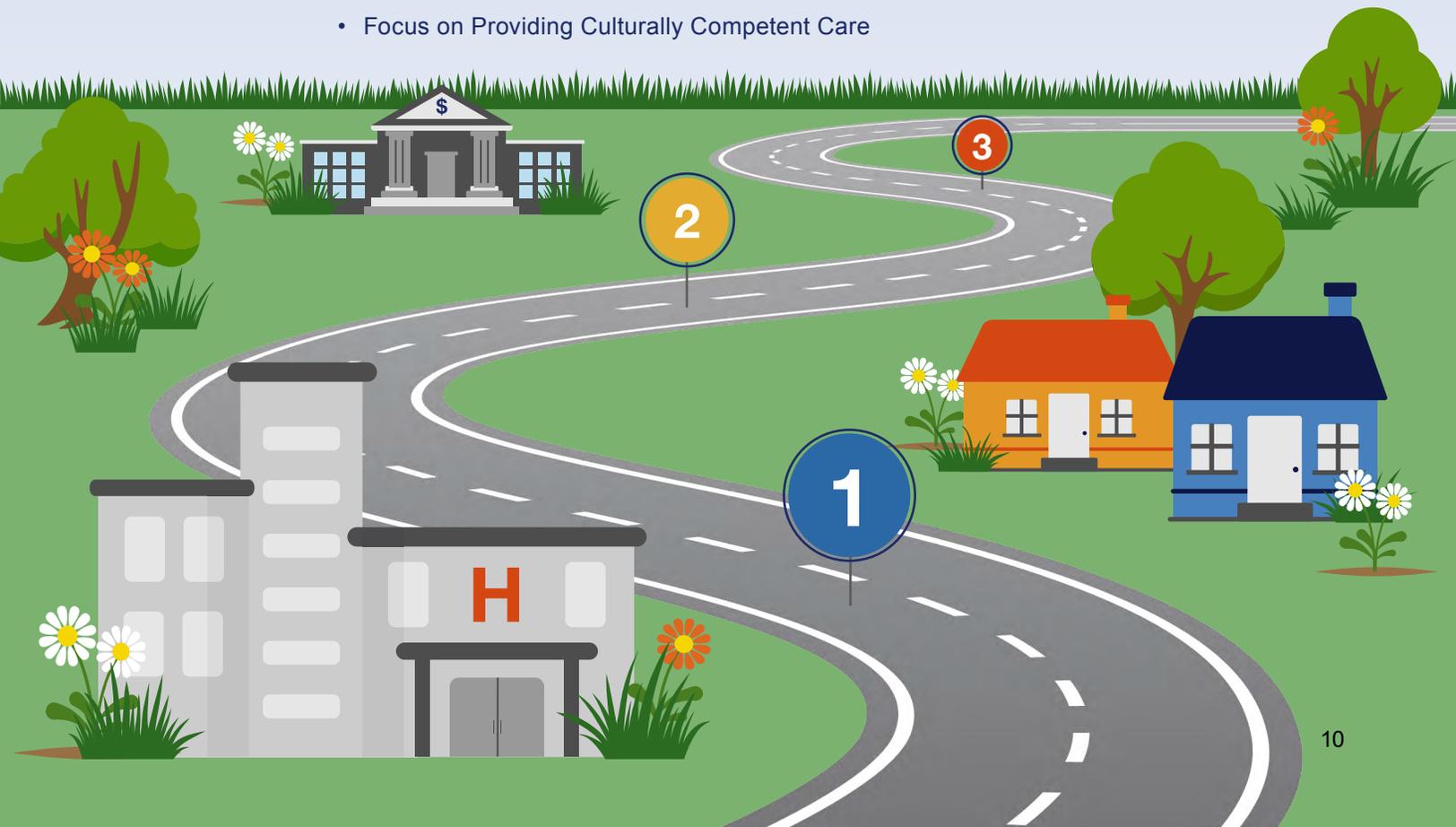
- Where people live is a determining factor for health and can enhance or inhibit your opportunities to be healthy³⁷
- Racial/ethnic minorities and those with low income are more likely to live in areas of high violence and unsafe water and/or air¹⁵⁶

Potential Intervention: Partner with programs and initiatives that aim to create safer communities where the patient population resides.

Route to Reducing Disparities in Readmissions

Where an organization is along their journey to advancing health equity and reducing disparities is influenced by a multitude of factors. The actions and strategies required at each stage of the journey vary, and it is important for an organization to understand which stage they are presently in. This section has been designed to provide guidance to health care leaders based on the present state of their organization, and to help them construct a strategy for reducing readmissions across diverse populations. While presented as a path to show how steps can and should build on each other, this is expected to be an iterative process and it is important to build in learning feedback loops at every stage.

- 1 Secure Buy-In and Develop an SDOH Data Infrastructure**
 - Secure Leadership Buy-In & Promote Organizational Change
 - Collect Critical Data
 - Identify Root Causes
- 2 Build Teams & Partnerships to Support SDOH**
 - Activate a Multidisciplinary Team
 - Foster External Partnerships and Community Linkages to Promote Continuity of Care
- 3 Implement Patient-Centered Systems and Processes**
 - Start From the Beginning
 - Respond Systematically to Social Determinants of Health
 - Focus on Providing Culturally Competent Care



Step 1

Secure Buy-In and Develop an SDOH Data Infrastructure



It is imperative to secure buy-in from leadership to establish and promote a tailored SDOH infrastructure for a community. To better understand which persons are at higher risk for readmission, it is important to collect data beyond standard clinical and demographic information. As the level of detail of the data increases, so can the specificity of any prescribed intervention.



Secure Leadership Buy-In & Promote Organizational Change

- Support from leadership at every level will be required for successful organizational change. Buy-in most commonly occurs when individuals understand what they and their organization will receive in return for their support.^{38, 39}



Collect Critical Data

- Type – At a minimum, organizations must collect Race, Ethnicity, and Language (REaL) data to meet federal guidelines.^{40, 41} In addition to REaL data, consider collecting patient-reported information in the social, behavioral, and community-level domains.⁴²
- How – Standardize the process for when you will collect the data and who will be responsible for collection.⁴³ Provide additional and ongoing training for those tasked with collecting data. This training should include content on helping the patient understand why these questions are being asked and how the information will be protected.^{42, 43}
- Z-Codes – The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) included a set of codes to be used when psychosocial risk and economic determinant-related conditions are identified. Standardize SDOH and health-related social needs recorded within a patient's chart through the assignment of the appropriate Z-Code(s) to enable data analysis to improve care coordination, quality, and patient experience.^{44, 45} Effective January 1, 2024, under the CY 2024 Physician Fee Schedule Final Rule, clinicians can bill for SDOH risk assessments, including reporting Z-Codes, for Medicare beneficiaries.⁴⁶



Identify Root Causes

- Metrics – The selection of appropriate readmission and disparity metrics is key to understanding the current and future states of the organization. Metric selection should be arrived at through consensus and validated prior to implementation.^{47, 48} In the early stages, consider selecting fewer metrics to avoid stretching resources too thin.⁴⁹
- Root Cause Analysis (RCA) – A RCA aids organizations in understanding the “why” of readmission disparities and is essential to strategy formulation.⁵⁰⁻⁵² RCAs should be conducted by a multidisciplinary team covering a patient's full care continuum and that understands the complexities of SDOH and health care equity.^{51, 52}
 - Examples of root causes of readmission include disease-related factors, such as clinical deterioration, human-related factors such as poor care coordination, or patient-related factors such as access to transportation or nutrition.⁵³

Step 2

Building Teams & Partnerships to Support SDOH



Activate a Multidisciplinary Team

- Multidisciplinary care teams have been shown to reduce readmission rates and, ultimately, early mortality.⁵⁴ To generate involvement by potential partners or colleagues, you must highlight the importance of participation and describe the potential impact care teams can have on patient outcomes.⁵⁴⁻⁵⁶
- Patients, families, and caregivers are a valuable part of the multidisciplinary care team. Patient and Family Advisory Councils (PFACs) are groups that help bring patients, providers and family/caregiver perspectives to improve care. As the COVID-19 pandemic reduced hospital visitation, conducting PFACs meetings in a virtual environment provided an opportunity for continued family/caregiver involvement (as appropriate) in patient care.^{19, 57}



Foster External Partnerships and Community Linkages to Promote Continuity of Care

- Research consistently demonstrates the relationship between continuity of care and readmission rates.⁵⁸⁻⁶¹ Maintaining a robust network of clinical providers and health organizations in the community will be central to any strategy designed to reduce readmissions. Community-based organizations can often assist with non-medical needs, such as food, housing security, and transportation.⁶² Health care organizations can leverage CMS policies such as Ad-advance Investment Payment in the Medicare Shared Savings Program to support partnerships to address enrollees' holistic needs.

Step 3

Implement Patient-Centered Systems & Processes



Start From the Beginning

- Early identification of risk factors for readmission allows for a greater impact from intervention. Data collected during outpatient encounters or preadmission testing can provide insight into which patients are at greatest risk. Once a patient is admitted, consider preadmission data in conjunction with the patient's hospital records to create a holistic picture of readmission risk.⁶⁴



Respond Systematically to Social Determinants

- Initiate the referral process early for in-home health care for patients with limited access to post-discharge care due to mobility issues, lack of transportation, or residency in a health care desert.^{60,61,65,66}
- Engage navigators, social workers, and community health organizations in multidisciplinary care meetings and discharge planning to support patients and foster trust through enhanced experience and outcomes.^{61,62,66,67}



Focus on Providing Culturally Competent Communication

- Form a person-centered care plan that adapts to a patient's cultural beliefs to increase patient and family/caregiver satisfaction and reduce avoidable readmissions.^{68, 69}
- Communicate with a patients and their families/caregivers in the language of their choice and at an appropriate health-literacy level to improve patient outcomes and foster trust.⁷⁰⁻⁷⁴

Multidisciplinary Team Roles



The multidisciplinary team plays a critical role in organizational planning, assessing a patient's physical, social, economic, and environmental needs and coordinating care appropriately to meet those needs during and after a hospital stay. Engaging the **multidisciplinary team** has been shown to positively affect factors associated with readmission, including identifying and addressing SDOH and health-related social needs that may impact a patient's readmission risk, improving both patient and provider satisfaction and patient-provider communications, and decreasing the number of adverse events and average length of hospital stay.⁵⁴ Addressing the factors associated with readmission **requires knowledge and experience** that exceeds the resources found within a single health care discipline.

Presented below are examples of **specific roles and associated responsibilities commonly found** on a multidisciplinary team.⁷⁵ The composition of the team and the responsibilities of the team must **adapt** to the needs of each patient and resources available. Because the care team may vary from **patient to patient**, it is critical to team success that **responsibilities be explicitly defined** at the outset.⁶⁷



SYSTEM/ HOSPITAL LEADERSHIP

(CEOs, Presidents, Vice Presidents, Service Line Leaders)

- Gathers organizational buy-in, commits resources, and structures operations to reduce avoidable readmissions and disparities in avoidable readmissions
- Sets mission, vision, and values of organization to drive culture and ensure the delivery of high-quality care
- Called upon as resource to the rest of the care team when needed



UNIT LEADERSHIP

(Unit Managers, Clinical Educators/Specialists, Shift Leaders)

- Provides training to staff on early identification of risk factors associated with readmission and ensures resources are available to coordinate patient's care plan post-discharge
- Provides staff with access to patient education and discharge instructions in multiple languages to support patient comprehension and ability to continue care and services at home



PHYSICIANS/ ADVANCED PRACTICE PROVIDERS

(MDs/DOs, Advanced Practice Nurses, Physician Assistants)

- Functions as an advisor across the multidisciplinary team, not leader
- Oversees medical care management, coordinating with nurses and other clinical staff to ensure high-quality care and improved patient outcomes
- Screens patient for SDOH and coordinates with care team to address health-related social needs



NURSES

(Outpatient & Inpatient)

- Administers clinical care to patient during inpatient stay and outpatient visits
- Advocates for patient needs and preferences to the multidisciplinary team so needs and preferences are being met
- Educates patient, caregiver, and family to help patient continue appropriate care at home
- Screens patient for SDOH needs and coordinates with Case Manager/Social Worker to address those needs outside of the clinical setting



CASE MANAGEMENT/ SOCIAL WORK

- Manages care transition from clinical setting to home or to post-acute care setting (e.g. nursing home)
- Advocates for the patient, connecting to resources appropriate for patient's psychological and social needs
- Screens patient and caregiver for SDOH and health-related social needs and connects and refers to community-based organizations and necessary resources
- Coordinates discharge plan and services and oversees follow-up care



BEHAVIORAL HEALTH SPECIALIST

(Psychiatrists, Social Workers, Addiction Counselors)

- Identifies mental and behavioral health barriers to patients' post-discharge adherence to care instructions
- Supports patient's emotional and mental health needs
- Screens patient and caregiver for SDOH and connects and refers to necessary resources



COMMUNITY- BASED ORGANIZATION

(Community Health Workers, Care Navigators, Peer Support Workers)

- Assists with housing, nutrition, primary care, or other post-discharge services at the community level
- Provides ongoing support post-discharge
- Connects patient to transportation services, medication maintenance, nutrition, personal care, and other services

Strategies & Key Areas for Reducing Readmissions



Each member of the multidisciplinary care team plays an important role in implementing strategies to address risk factors for readmission. This section highlights key issues that lead to readmissions, recommended strategies and tools, and the team members who play a role in implementing interventions. Examples of these strategies in practice are provided to support health care leaders in translating these recommended strategies into actionable change in their organizations.



DISCHARGE & CARE INSTRUCTIONS:

Understanding discharge instructions and follow-up visits has been shown to reduce readmissions^{15,65,76}

ROLES IN IMPLEMENTATION

Hospital Leadership, Unit Leadership, Providers, Nurses, Case Management

RECOMMENDED STRATEGIES

- Provide discharge materials in an appropriate manner for patient and caregiver (e.g., provided in the preferred language, use of interpreter), and conduct the teach-back method^{70,77}
- Engage patient and/or caregiver (as appropriate) as full partners in discussions around discharge planning to meet unique needs ([AHRQ IDEAL Discharge Planning](#)) throughout admission^{8,78}
- Engage multidisciplinary team to address patients' care transition needs during clinical rounds prior to discharge^{54,79,80}
- Develop strategies for medication management to support medication reconciliation and medication adherence⁸¹⁻⁸⁴
- Acknowledge health care deserts and access issues in rural areas and consider including strategies and resources on how to address health care access issues^{8,66,85,86}

STRATEGIES IN ACTION

[Project BOOST](#) is designed to reduce avoidable readmissions, improve provider workflow, reduce medication-related errors, and prepare and empower patients, families, and caregivers to improve discharge education. The BOOST approach focuses on improving patient care transitions through patient risk assessments and follow-up after discharge. This includes assessments for poor health literacy, social isolation and absence of support care. Project BOOST has been implemented in more than 200 hospitals across the U.S. and Canada. CMS recommends Project BOOST as one of the care transition models for their community-based transitions program.⁸⁷⁻⁸⁹



USUAL SOURCE OF CARE/LINKAGE TO PRIMARY CARE:

People who are medically underserved are less likely to be linked with a primary care provider⁹⁰

ROLES IN IMPLEMENTATION

Providers, Nurses, Case Management, Community Health Organizations

RECOMMENDED STRATEGIES

- Consider geographic accessibility to providers, access to transportation, patient's prior experience with health care providers, and how these factors may affect receiving care after discharge^{71,90,91}
- Identify a primary care provider and initiate referral early in discharge planning⁷¹
- Ensure primary care providers receive complete documentation of the patient's diagnostic tests, procedures, and any medication changes during hospitalization⁹²

STRATEGIES IN ACTION

The [GRACE program](#) uses a team-oriented approach to provide services to low-income older adults to ensure that they receive critical preventive care and to help them manage their chronic conditions. Proper preventive care and management services through this program has shown to improve patient outcomes, such as reducing unplanned hospital admissions and emergency department visits. As of 2021, the GRACE program has been successfully implemented within 26 health care systems other than the original site.⁹³



LANGUAGE BARRIERS AND ACCESS TO INTERPRETER SERVICES:

Limited English proficiency is correlated with multiple factors contributing to avoidable readmissions^{72,94,95}

ROLES IN IMPLEMENTATION

Hospital Leadership, Unit Leadership, Providers, Nurses, Case Management

RECOMMENDED STRATEGIES

- Notify Interpreter Services of patient needs at admission. In addition, indicate in the patient record the patient's preferred spoken and written language for providers to be aware of when engaging with the patient^{71,96,97}

STRATEGIES IN ACTION

The Wisconsin Department of Health Services developed the Culturally and Linguistically Appropriate Services (CLAS) Standards Pledge, website, and training programs to support the adoption of [CLAS standards](#). Signing the pledge demonstrates organizational commitment and provides organizations with a large network of non-profit organizations, advocacy groups, foundations, faith-based organizations, professional societies, government agencies, corporations, businesses, industry groups, colleges and universities, and individuals committed to eliminating health disparities and achieving health equity in Wisconsin.⁹⁸



HEALTH LITERACY:

Low health literacy contributes to multiple factors that increases likelihood of readmission⁹⁹⁻¹⁰¹

ROLES IN IMPLEMENTATION

Unit Leadership, Providers, Nurses, Case Management, Behavioral Health Specialists, Community Health Organizations

RECOMMENDED STRATEGIES

- Use plain language while speaking with and in discharge instructions for all patients so they can fully participate in their health care^{71,100,101}
- Share patient education resources designed to improve health literacy, such as [CMS](#) [OMH's Coverage to Care](#)¹⁰²

STRATEGIES IN ACTION

Hawaii's [Kuleana Health](#) is an initiative developed to bring together community health centers and community organizations to partner on a health literacy program for underserved populations. Supported by an HHS grant, the program uses Project Champions to lead and facilitate the collaboration and Consortium Partners to develop and deliver programs to promote literacy on health topics including vaccination and telehealth.¹⁰³



CULTURALLY COMPETENT PATIENT EDUCATION:

Patients' cultural beliefs and customs impact how they receive and participate in their care^{68,104}

ROLES IN IMPLEMENTATION

Hospital Leadership, Unit Leadership, Providers, Nurses, Case Management, Behavioral Health Specialists, Community Health Organizations

RECOMMENDED STRATEGIES

- Assess patient's cultural beliefs and values at admission and integrate into the care plan. Providing care and education in a manner that reflects cultural beliefs and customs will support patient and caregivers' ability to provide care at home, improve patient satisfaction, and lowers risk of readmission.^{68,101,105}

STRATEGIES IN ACTION

A critical access hospital in Jefferson County, Oregon established the [Transcultural Care Project](#), funded through HRSA, to improve culturally competent patient care. In addition to incorporating cultural competency training requirements into nursing job descriptions, the hospital leadership proactively engaged with local Tribal leaders by including them in the Patient Family Advisory Council. Additionally, the hospital worked with providers from Indian Health Services (IHS) and Tribal leaders to host a summit on culturally competent patient care. Since implementing the program, survey response rates and patient satisfaction have increased, and there was a significant decrease in complaints.¹⁰⁶



SOCIAL DETERMINANTS:

Higher readmission rates are associated with restricted access to socioeconomic resources^{104,107,108}

ROLES IN IMPLEMENTATION

Hospital Leadership, Unit Leadership, Providers, Nurses, Case Management, Behavioral Health Specialists, Community Health Organizations

RECOMMENDED STRATEGIES

- Define social determinants and incorporate a SDOH framework, such as the [Healthy People 2030 SDOH](#)^{20,44,107-109}
- Conduct an analysis of resources in the community and engage in partnerships^{66,78,86}
- Engage social workers, peer support workers, and community health workers (as appropriate) in care management to connect patients to resources^{54,75,78}
- Incorporate SDOH into provider annual trainings to support knowledge on caring for the whole person¹⁰⁹

STRATEGIES IN ACTION

Health Partners Plus, a Medicaid plan in Pennsylvania, partnered with [Metropolitan Area Neighborhood Nutrition Alliance \(MANNA\)](#) to implement an evidence-based nutrition program for chronically ill Medicaid members in Philadelphia who struggle with food-related social needs. Participants receive home-delivered meals that are medically tailored to their health conditions and dietary counseling.^{62,110}



MENTAL HEALTH:

People with mental illness can experience difficulties accessing services with self-care post-discharge^{111,112}

ROLES IN IMPLEMENTATION

Providers, Nurses, Case Management, Behavioral Health Specialist, Community Health Organizations

RECOMMENDED STRATEGIES

- Include a behavioral health assessment early in the hospital admission to identify persons at increased risk of readmission due to mental or behavioral health needs^{111,112}
- Engage mental health resources including for substance use disorders, if appropriate, in discharge planning to identify outpatient sources of care to ensure continuity post-discharge^{79,113}

STRATEGIES IN ACTION

The Permanent Supportive Housing ([PSH program](#)) aids individuals with serious mental illness (SMI) enrolled in the Mercy Maricopa Medicaid managed care plan in Maricopa, Arizona. PSH offers housing vouchers that enable homeless members with an SMI who qualify through the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) to choose from one of Mercy Maricopa's permanent supportive housing options.^{114,115}



COMORBIDITIES:

The presence of comorbidities correlates with a rise in readmission risk¹¹⁶⁻¹¹⁸

ROLES IN IMPLEMENTATION

Providers, Nurses, Case Management, Community Health Organizations

RECOMMENDED STRATEGIES

- Calculate a comorbidity index upon admission to aid in early identification of patients at high risk for readmission^{117,119,120}
- Tailor multidisciplinary care team to include appropriate specialist and sub-specialist providers based on patient's comorbidities, and provide referrals upon discharge^{54,65,67,71,78}

STRATEGIES IN ACTION

Comorbidity indexes, such as the [National Cancer Institute \(NCI\) Comorbidity Index](#), have been shown to accurately predict an increased risk of 30-day readmission.¹¹⁷ The integration of comorbidity indexes early in discharge planning can allow for the identification of those at risk for readmission and allow for mitigation measures to be implemented.

Other Valuable Strategies to Advance Health Equity and Reduce Readmissions

To realize the full potential of this Guide and maximize your impact, health care leaders and community partners should consider taking the following steps:

1

Develop a *Disparities Action Plan*

Consider developing a disparities impact statement or action plan using a five step process:

- Identify health disparities and populations
- Define your goals
- Establish your organization's health equity strategy
- Determine what your organization needs to implement its strategy
- Monitor and evaluate your progress.

2

Design organizational strategies and mission to include health equity

Embed advancing health equity in your organization's strategies and mission. The CMS Strategic Plan on Health Equity is a helpful resource when looking to create a results-driven approach.⁷ CMS OMH offers the [Health Equity Technical Assistance Program](#), which provides coaching and resources on embedding health equity into your organization's strategies. The Health Equity Technical Assistance program also provides guidance on how to improve health equity, data collection and analysis, and communication through language access programs.¹²¹

3

Create a multidisciplinary care transition working group

Examine current care transition and readmission prevention processes. Identify potential opportunities for creating additional impact and recommend strategies for reducing readmissions to leadership.



4

Conduct a gap analysis to understand the change needed

A gap analysis will aid your organization in identifying the necessary steps to achieve the goal of advancing health equity and reducing readmissions. The Agency for Healthcare Research and Quality's [Gap Analysis Facilitator's Guide](#) provides direction on the process and which partners to include.¹²²

5

Create and execute both short-term and long-term readmission reduction strategies

Advancing health equity and reducing readmissions is an ongoing and dynamic process. Metrics and goals should be periodically reassessed for their continued validity. The implementation of quality improvement programs has been shown to reduce admissions.¹²³ Frameworks such as *DMAIC (Define, Measure, Analyze, Improve and Control)* can be used to guide your organization's quality improvement program.¹²⁴

6

Disseminate important information internally and externally

This Guide will only be effective if its information reaches all partners and providers with a role in reducing readmissions. To have the most significant impact on advancing health equity and reducing readmissions, care should be taken to include external partners such as community-based organizations. The approach or framework used to disseminate information should be customized to the organization, the type and quantity of information being disseminated, and the intended audience. Consider reaching smaller audiences with each effort so that messages can be tailored to the intended recipients.^{125, 126}

STRATEGIES

1. Identify a patient's risk factors for readmission early in admission to allow for early intervention and greatest impact
2. Collect and analyze critical data to form the basis of understanding the current state of your organization and identify areas on which to focus strategy
3. Use and tailor multidisciplinary teams with internal and external providers and partners to successfully reduce readmissions
4. Implement the National Standards for Culturally and Linguistically Appropriate Services (CLAS) to meet unique patient population needs and reduce disparities
5. Create programs, policies and practices that address SDOH to put health equity at the forefront of your organization

NEXT STEPS

1. Devise a plan to collect critical data
2. Engage internal and external partners
3. Create a manageable strategy for success
4. Consider creating a [Disparities Impact Statement and Plan](#)
5. Revisit often – whenever there is a question or when looking for guidance on measuring progress or setting strategy



Remember

Implementation is a dynamic and continual process that is contextual to your organization. Ongoing evaluation of process, outcomes, and goals is required.

Resources for Reducing Readmissions Among Diverse Populations



Please note that CMS does not endorse the outside resources provided here. CMS does not intend to suggest that it is endorsing the information or resources provided by these organizations over information or resources that might be provided by other organizations.

<i>Resource</i>	<i>Description</i>	<i>Source</i>	<i>Resource Type</i>	<i>Recommendation</i>
<u>Race, Ethnicity, and Language Data: Standardization for Healthcare Quality Improvement</u>	Helps primary care practices reduce the complexity of health care, increase patient understanding of health information, and enhance support for patients of all health literacy levels. Broken down into various tools for ease of implementation.	Institute of Medicine	Report	Collect Critical Data
<u>Reducing Health Care Disparities: Collection and Use of Race, Ethnicity, and Language Data</u>	Roadmap to increase the collection and use of race, ethnicity, and language (REaL) data to drive elimination of disparities in care.	American Hospital Association	Guide	Collect Critical Data
<u>A Framework for Stratifying Race, Ethnicity, and Language Data</u>	Guide with framework for hospitals and care systems to stratify patient data for the purpose of identifying health care disparities.	American Hospital Association	Guide	Collect Critical Data Identify Root Causes
<u>AHA Disparities Toolkit</u>	Designed to help hospitals, health systems, community health centers, medical group practices, health plans, and other users understand the importance of collecting accurate data on race, ethnicity, and primary language of persons with limited English proficiency and/or who are deaf or hard of hearing.	American Hospital Association and Health Research and Educational Trust	Toolkit	Collect Critical Data Identify Root Causes
<u>Creating Equity Reports: A Guide for Hospitals</u>	Guide to creating equity reports: leading the effort, collecting the data, measures, presenting data, using the report.	The Disparities Solutions Center, Massachusetts General Hospital	Guide	Collect Critical Data Identify Root Causes
<u>Tools to Address Disparities in Health: Data as Building Blocks for Change</u>	Provides the rationale and importance of collecting and analyzing data on race, ethnicity, and primary language, an in-depth view about how to collect and analyze the data, and examples of innovative strategies and models being implemented by health insurance plans.	America's Health Insurance Plans	Toolkit	Collect Critical Data Identify Root Causes

<i>Resource</i>	<i>Description</i>	<i>Source</i>	<i>Resource Type</i>	<i>Recommendation</i>
<u>Health Disparities Measurement</u>	Report provides guidance to NQF Steering Committee charged with selecting and evaluating disparity-sensitive quality measures, describe methodological issues with disparities measurement, and identify cross-cutting measurement gaps in disparities.	The Disparities Solutions Center, Massachusetts General Hospital	Report	Collect Critical Data Identify Root Causes Start from the Beginning
<u>Improving Health Equity through Data Collection and Use: A Guide for Hospital Leaders</u>	Guide for hospital leaders including key strategies for collecting patient race, ethnicity, and language data and leading practices for using the data.	Hospitals in Pursuit of Excellence	Guide	Collect Critical Data Identify Root Causes Start from the Beginning Foster External Partnerships Secure Buy-In
<u>Building an Organizational Response to Health Disparities</u>	Short guide on tips and tricks to reducing health disparities and lowering costs through data collection, data analysis, culture of equity, and quality improvement with key interventions and resources.	Centers for Medicare & Medicaid Services	Guide	Collect Critical Data Identify Root Causes Start from the Beginning Foster External Partnerships Secure Buy-In
<u>A Leadership Resource for Patient and Family Engagement Strategies</u>	Provides hospital and health system leadership with practical steps to improve patient and family engagement in their organization. Generalized guide, not focused on health disparities.	American Hospital Association	Guide	Multidisciplinary Team Foster External Partnerships Secure Buy-In
<u>Building a Culturally Competent Organization: The Quest for Equity in Health Care</u>	Guide explores the concept of cultural competency and builds the case for the enhancement of cultural competency in health care. Tips include: collect REaL data, identify, and report disparities, providing culturally and linguistically competent care, develop culturally competent disease management programs, increase diversity and minority workforce pipelines, involve the community, make cultural competency an institutional priority.	American Hospital Association, Equity of Care	Guide	Collect Critical Data Identify Root Causes Multidisciplinary Team Culturally Competent Care Foster External Partnerships

<i>Resource</i>	<i>Description</i>	<i>Source</i>	<i>Resource Type</i>	<i>Recommendation</i>
<u>Capturing Social and Behavioral Domains and Measures in Electronic Medical Records: Phase 2</u>	Identifies domains and measures that capture the social determinants of health to inform the development of recommendations for the meaningful use of EHRs. This report is the second part of a two-part study. The Phase 1 report identified 17 domains for inclusion in EHRs. This report pinpoints 12 measures related to 11 of the initial domains and considers the implications of incorporating them into all EHRs.	Institute of Medicine	Report	Collect Critical Data Identify Root Causes Start from the Beginning Respond to SDOH
<u>Inventory of Resources for Standardized Demographic and Language Data Collection</u>	List of resources organized by resource type (e.g., webinar, report, guide) highlighting data collection, best practices, and guidelines for organizations to implement standardized data collection, training tools and webinars to educate staff on best practices and articles and books that provide in-depth discussion of issues, challenges, recommendations, and best practices.	Centers for Medicare & Medicaid Services	Catalog of Resources	Collect Critical Data Identify Root Causes Start from the Beginning Respond to SDOH
<u>Equity of Care: A Toolkit for Eliminating Health Care Disparities</u>	“How-to” guide to help accelerate the elimination of health care disparities and ensure leadership teams and board members reflect the communities we serve. Framework of next steps and resources to guide work.	American Hospital Association	Toolkit	Collect Critical Data Identify Root Causes Start from the Beginning Multidisciplinary Team Culturally Competent Care Foster External Partnerships Secure Buy-In
<u>Guide to Patient and Family Engagement in Hospital Quality and Safety</u>	Guide to help hospitals develop effective partnerships with patients and family members, implement IDEAL Discharge Planning strategy, bring the perspectives of patients and families directly into the planning, delivery and evaluation of care	Agency for Healthcare Research and Quality	Guide	Start from the Beginning Culturally Competent Care

<i>Resource</i>	<i>Description</i>	<i>Source</i>	<i>Resource Type</i>	<i>Recommendation</i>
<u>Healthcare Disparities and Cultural Competency Consensus Standards</u>	Report on the 2011 project for development of a commissioned paper focused on measurement implications for healthcare disparities and identifying performance measures for healthcare disparities and cultural competency.	National Quality Forum	Report	Start from the Beginning
<u>LACE Index Scoring Tool</u>	Risk assessment scoring tool for death and readmission	Ottawa Hospital Research Institute	Tool	Start from the Beginning
<u>International Validity of the HOSPITAL Score to Predict 30-Day Potentially Avoidable Hospital Readmissions</u>	Report externally validates the HOSPITAL score in an international multicenter study to assess its generalizability.	JAMA	Report	Start from the Beginning
<u>Making CLAS Happen: Chapter 3 – Collect Diversity Data</u>	Presents tools to assist agencies in the process of collecting diversity data.	Massachusetts Department of Public Health, Office of Health Equity	Guide	Collect Critical Data Competent Care Foster External Partnerships
<u>National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare: A Blueprint for Advancing and Sustaining CLAS Policy and Practice</u>	Provide guidance on each national CLAS standard with the ultimate goal of reducing racial and ethnic health care disparities.	U.S. Department of Health and Human Services, Office of Minority Health	Guide	Collect Critical Data Multidisciplinary Team Culturally Competent Care Foster External Partnerships
<u>Re-Engineered Discharge (RED) Toolkit</u>	A set of activities and materials for improving the discharge process, called the Re-Engineered Discharge (RED). This toolkit was developed to assist hospitals to replicate the RED. Finding showed RED was effective at reducing readmissions and post-hospital ED visits.	Agency for Healthcare Research and Quality	Toolkit	Start from the Beginning Multidisciplinary Team Culturally Competent Care
<u>Risk Assessment – 8P Project Boost Implementation Toolkit</u>	Toolkit to assist hospitals implement an evidence-based approach to improving care transitions and reducing readmissions.	Society of Hospital Medicine	Toolkit	Start from the Beginning Culturally Competent Care

<i>Resource</i>	<i>Description</i>	<i>Source</i>	<i>Resource Type</i>	<i>Recommendation</i>
<u>PRAPARE (Protocol for Responding to and Assessment Patient Assets, Risks, and Experiences)</u>	Nationally standardized and stakeholder-driven, the Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE) is designed to equip healthcare and their community partners to better understand and act on individuals' SDOH. PRAPARE, when paired with the Implementation and Action Toolkit, empowers users to leverage data to improve health equity at the individual, community, and systems levels.	National Association of Community Health Centers	Tool	Start from the Beginning Respond to SDOH
<u>A Framework for Educating Health Professionals to Address the Social Determinants of Health</u>	A Framework for Educating Health Professionals to Address the Social Determinants of Health that also puts forth a conceptual model for the framework's use with the goal of helping stakeholder groups envision ways in which organizations, education, and communities can come together to address health inequalities.	National Academy of Sciences	Framework	Start from the Beginning Respond to SDOH Foster External Partnerships
<u>Social Needs Screening Toolkit</u>	Shares the latest research on how to screen patients for social needs.	Health Leads	Toolkit	Respond to SDOH
<u>Tools for Putting Social Determinants of Health into Action</u>	Centers for Disease Control and Prevention (CDC) tools and resources that can help practitioners take action to address SDOH.	Centers for Disease Control and Prevention	Tools and Resources	Culturally Competent Care
<u>Compendium of State-Sponsored National CLAS Standards Implementation Activities Tracking CLAS Tool</u>	Compendium of CLAS standards implementation resources and activities support and undertaken by state government agencies. Highlights different state findings.	U.S. Department of Health and Human Services, Office of Minority Health	Catalog of Resources	Culturally Competent Care
<u>The SHARE Approach: Using the Teach-Back Technique: A Reference Guide for Healthcare Providers</u>	Reference guide for health care providers on using the teach-back method.	Agency for Healthcare Research and Quality	Guide	Culturally Competent Care

<i>Resource</i>	<i>Description</i>	<i>Source</i>	<i>Resource Type</i>	<i>Recommendation</i>
<u>The SHARE Approach: 5 Essential Steps of Shared Decision Making</u>	Five-step process for shared decision-making that includes exploring and comparing the benefits, harms, and risks of each option through meaningful dialogue about what matters most to the patient.	Agency for Healthcare Research and Quality	Framework	Culturally Competent Care
<u>AHRQ Health Literacy Universal Precautions Toolkit, 2nd Edition</u>	Helps primary care practices reduce the complexity of health care, increase patient understanding of health information, and enhance support for patients of all health literacy levels. Broken down into various tools for ease of implementation.	Agency for Healthcare Research and Quality	Toolkit	Culturally Competent Care
<u>Health Literacy Universal Precautions Toolkit, 2nd Edition (Tool #5, Teach-Back Method)</u>	Teach-back method tool within the Health Literacy Universal Precautions Toolkit.	Agency for Healthcare Research and Quality	Toolkit	Culturally Competent Care
<u>Always Use Teach-back! Training Toolkit</u>	To help all health care providers learn to use teach-back—every time it is indicated—to support patients and families throughout the care continuum, especially during transitions between health care settings. Includes an introduction, an interactive learning module, tips and tools and other resources.	Always Use Teach-back!	Toolkit	Culturally Competent Care
<u>Improving Patient Safety Systems for Patients with Limited English Proficiency: A Guide for Hospitals with Team STEPPS Enhancing Safety for Patients with Limited English Proficiency Module</u>	Guide to help leaders better understand how to address the issue of patient safety for limited-English-proficient and culturally diverse patients.	Agency for Healthcare Research and Quality, The Disparities Solutions Center, Massachusetts General Hospital	Guide	Culturally Competent Care Secure Buy-In
<u>8-Step Process for Leading Change</u>	Framework for 8 steps to leading change in an organization.	Kotter International	Framework	Secure Buy-In

<i>Resource</i>	<i>Description</i>	<i>Source</i>	<i>Resource Type</i>	<i>Recommendation</i>
<u>Improving Quality and Achieving Equity: A Guide for Hospital Leaders</u>	Guide aims to present evidence for racial and ethnic disparities in health care and provide rationale for addressing them, highlight model practices, and recommend a set of activities and resources to initiate an agenda for action in this area.	The Disparities Solutions Center, Massachusetts General Hospital	Guide	Secure Buy-In
<u>Disparities Impact Statement</u>	Worksheet to support organizations in defining goals and establishing a strategy.	CMS Office of Minority Health	Tool	Collect Critical Data Multidisciplinary Team Secure Buy-In
<u>CMS Framework for Health Equity 2022–2032</u>	Provides action oriented, results-driven approach for advancing health equity by improving the quality of care provided by hospitals and other healthcare providers.	CMS Office of Minority Health	Framework	Collect Critical Data Identify Root Causes Respond to SDOH Culturally Competent Care
<u>Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations</u>	Examines organizations participating in Transforming Complex Care (TCC) Initiative considerations for using SDOH data to improve patient care.	Center for Health Care Strategies Inc.	Report	Collect Critical Data
<u>ICD-10-CM Coding for Social Determinants of Health</u>	Information on guidance for using Z codes, including additional tools and resources to improve health equity.	Centers for Medicare & Medicaid Services	Tool	Collect Critical Data
<u>Using Z Codes: The Social Determinants of Health (SDOH) Data Journey to Better Outcomes</u>	Steps for providing SDOH Z Code Data.	CMS Office of Minority Health	Tool	Collect Critical Data
<u>A Practical Guide to Implementing the National CLAS Standards: For Racial, Ethnic and Linguistic Minorities, People with Disabilities and Sexual and Gender Minorities</u>	Toolkit provides practical tools and examples of CLAS and enables health-care organizations to implement the National CLAS Standards.	CMS Office of Minority Health	Toolkit	Culturally Competent Care

<i>Resource</i>	<i>Description</i>	<i>Source</i>	<i>Resource Type</i>	<i>Recommendation</i>
<u>Guide to Providing Effective Communication and Language Assistance Services</u>	Free online educational program designed for health care administrators and providers to help implement effective communication and language assistance services.	Department of Health and Human Services	Learning Module	Culturally Competent Care
<u>Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health</u>	Workbook for community organizations to assist in addressing health disparities and develop and test interventions that address social determinants of health equity.	Centers for Disease Control and Prevention	Guide	Collect Critical Data Multidisciplinary Team Secure Buy-In
<u>Health Equity Organizational Assessment</u>	Assessment tool to understand hospitals' health equity efforts, address potential gaps and disparities in care, and focus efforts and technical assistance.	Michigan Health & Hospital Association	Tool	Collect Critical Data Multidisciplinary Team Secure Buy-In
<u>Health Equity Organizational Assessment</u>	Assessment tool to understand health care organization's level on various strategies to implement and determine next steps for improving health equity.	Health Quality Innovation Network	Tool	Collect Critical Data Multidisciplinary Team Secure Buy-In
<u>Accountable Health Communities Health-Related Social Needs Screening Tool</u>	Provides guidance on the health-related social needs (HRSN) Screening. Tool from the Accountable Health Communities (AHC) Model and share promising practices for universal screening.	Centers for Medicare & Medicaid Services	Tool	Collect Critical Data
<u>Resources for Integrated Care</u>	A collection of resources and products including briefs, concept guides, learning collaboratives, tip sheets, assessment tools, podcasts, videos, and webinars on issues related to integrated and coordinated care. Topics include care coordination, disability competent care, cultural competency, patient and family engagement, identifying root causes.	CMS Medicare-Medicaid Coordination Office	Tools and Resources	Identify Root Causes Start from the Beginning Multidisciplinary Team Respond to SDOH Culturally Competent Care Foster External Partnerships

<i>Resource</i>	<i>Description</i>	<i>Source</i>	<i>Resource Type</i>	<i>Recommendation</i>
<u>Advancing Partnerships to Align Health Care and Human Services</u>	Resources for community-based organizations to build successful partnerships for delivering social services.	Administration for Community Living	Tools and Resources	Respond to SDOH Foster External Partnerships
<u>Health Equity Technical Assistance</u>	CMS OMH offers health equity technical assistance resources, aimed to help health care organizations take action against health disparities.	CMS Office of Minority Health	Tools and Resources	Collect Critical Data Identify Root Causes Multidisciplinary Team Respond to SDOH Culturally Competent Care
<u>Coverage to Care Consumer Resources</u>	Set of resources for consumers to promote understanding of health coverage, including posters, brochures, and fact sheets in 9 languages.	CMS Office of Minority Health	Tools and Resources	Foster External Partnerships

Appendix A: Disparities in Top Conditions in CMS Hospital Readmissions Reduction Program



Below you will find an overview of the epidemiology of the conditions in the CMS Hospital Readmission Reduction Program. You will also find information on racial and ethnic disparities in condition prevalence and 30-day readmission rates, along with the cost associated with avoidable readmissions among people enrolled in Medicare.

<i>Condition</i>	<i>Overall U.S. Prevalence</i>	<i>Racial and Ethnic Disparities by Condition</i>	<i>Overall 30-Day Readmission Rate</i>	<i>Racial and Ethnic Disparities in 30-Day Readmission Rates</i>	<i>Total Cost of All-Cause, 30-Day Readmissions</i>
Acute Myocardial Infarction (AMI)	8.8 million (3.1% of adults ≥20 years) ¹²⁷	AMI highest prevalence is among non-Hispanic White males (4.4%) followed by non-Hispanic Black males (3.9%), Hispanic males (3.7%), non-Hispanic Asian males (2.7%), non-Hispanic Black females (2.3%), Hispanic females (2.1%), non-Hispanic White females (2.0%), and non-Hispanic Asian females (0.7%) ¹²⁷ 30-day mortality rate post-AMI is higher among Black individuals (5.0%) vs non-Black individuals (4.0%) ¹²⁸	15% ¹²⁸	One study found that while 30-day readmission rates have declined since HRRP implementation, Black patients continue to experience readmission rate at a higher rate (17.4%) compared to non-Black patients (14.5%) ¹²⁹	No data available
Chronic Obstructive Pulmonary Disease (COPD)	15.7 million (6.4% of total population) ¹³⁰	African Americans are at a higher risk of having undiagnosed COPD vs non-Hispanic Whites ¹³¹	19.8% ¹²⁸	Non-Hispanic Blacks experienced readmission at the highest rate (21.5%), followed by Hispanics (19.5%) and non-Hispanic Whites (19.1%) ¹³²	\$1.2 billion ¹¹

Condition	Overall U.S. Prevalence	Racial and Ethnic Disparities by Condition	Overall 30-Day Readmission Rate	Racial and Ethnic Disparities in 30-Day Readmission Rates	Total Cost of All-Cause, 30-Day Readmissions
Congestive Heart Failure (CHF)	≈6.0 million (2.4% adults ≥20 years) ¹²⁷	Highest prevalence is among non-Hispanic Black males (3.6%) and non-Hispanic Black females (3.3%) ¹²⁷ Age-adjusted incidence for hospitalization was found to be higher in Black males (38 per 1000) and Black females (31 per 1000) compared to White males (12.3 per 1000) and White females (9.9 per 1000) ¹²⁷	21.3% ¹²⁸	A study examining heart failure patients from 2010 through 2018 in a Southeastern U.S. health system found Black patients were more likely to have a 30-day readmission compared to White patients (20.6% vs 13.5%) ¹³³	\$2.8 billion ¹²⁷
Pneumonia	1.5 million diagnoses in the U.S. each year ¹³⁴	No data available	16.7% ¹³⁵	A study found that Black patients were more likely to be readmitted within 30-days after pneumonia diagnosis compared to White patients ¹³⁶	\$1.1 billion ¹¹
Total Hip Arthroplasty (THA) Total Knee Arthroplasty (TKA)	THA: 2.5 million (0.83% of total population) TKA: 4.7 million (1.52% of total population) ¹³⁷	Age and sex-standardized rates of THA vary greatly by race with White patients having the highest incidence at 140 per 100,000 followed by Black patients at 89 per 100,000 and Hispanic patients at 49 per 100,000 ¹³⁸ One study found Black and Hispanic patients to have a TKA rate 22% and 32%, respectively, lower than White patients ¹³⁹	4% ¹³⁵	After TKA, Black patients have been found to be at increased risk for readmission, complications, mortality, and requiring revision compared to White patients. ¹⁴⁰	No data available

Appendix B: Disparities in Top Three Chronic Conditions



Below you will find an overview of the epidemiology of the three top chronic conditions prioritized by CMS OMH. You will also find information on racial and ethnic disparities in condition prevalence and 30-day readmission rates. Additionally, the cost associated with avoidable readmissions among people enrolled in Medicare.

<i>Condition</i>	<i>Overall U.S. Prevalence</i>	<i>Racial and Ethnic Disparities by Condition</i>	<i>Overall 30-Day Readmission Rate</i>	<i>Racial and Ethnic Disparities in 30-Day Readmission Rates</i>	<i>Total Cost of All-Cause, 30-Day Readmissions</i>
Chronic Kidney Disease (CKD)	37 million (15% of US adults) ¹⁴¹	CKD is most common in non-Hispanic Black patients (16.3%) followed by Hispanic patients (14%), non-Hispanic Asian patients (13%), and non-Hispanic White patients (13%) ¹⁴¹	28.6% ¹¹	Black patients were readmitted at a rate of 25.3% compared to 22.3% for White patients. ¹⁴²	\$538 million ¹¹
Diabetes	37.3 million (11.3% of population) ¹⁴³	The highest prevalence of newly diagnosed cases is with Hispanic males (15.3%) followed by non-Hispanic Asian males (14.3%), non-Hispanic Black females (13.2%), Hispanic females (13.1%), non-Hispanic Black males (12.8%), non-Hispanic White males (10.8%), non-Hispanic Asian females (10.1%) and non-Hispanic White females (7.5%) ¹²⁷	26.4% ¹⁴⁴	A study of Medicare participants with Type 2 found non-Hispanic Black patients to have the highest readmission rate (12.2%), followed by Hispanic patients (10.9%), non-Hispanic White patients (10.2%), and Asian patients (9.9%) ¹²⁷	No data available

<i>Condition</i>	<i>Overall U.S. Prevalence</i>	<i>Racial and Ethnic Disparities by Condition</i>	<i>Overall 30-Day Readmission Rate</i>	<i>Racial and Ethnic Disparities in 30-Day Readmission Rates</i>	<i>Total Cost of All-Cause, 30-Day Readmissions</i>
End Stage Renal Disease (ESRD)	809,103 (0.23% of total population) ^{145, 146}	<p>3 times more likely than White people to develop ESRD, and for every 3 non-Hispanic people who develop ESRD 4 Hispanic people will develop the disease</p> <p>Black patients wait longer for transplant (59.9 months) compared to White patients (41.3 months). Non-Hispanic patients wait only 47.4 months for transplant compared to Hispanic patients who wait on 55.8 months on average^{141,142}</p>	31.2% ¹⁴⁶	Of adult patients on dialysis, readmissions rates were highest in Black patients (36.4%) compared to White patients (34.9%), Hispanic patients (33.8%), and Asian patients (29.6%) ¹⁴⁶	No data available

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