



# Research & Policy Issue Spotlight: Health Equity

October 29, 2021

## VNSNY Overview

For more than 128 years, the Visiting Nurse Service of New York (VNSNY) has served as one of the largest not-for-profit home and community-based health care organizations in the U.S., VNSNY provides high-quality, culturally competent integrated care that meets the complex clinical and social needs of vulnerable individuals, helping them to remain safely and independently in their homes and communities.

VNSNY programs and services include skilled home health care, home health aide staffing, hospice and palliative care, population health management, community mental health, and several community programs. CHOICE Health Plans, VNSNY's managed care affiliate, specializes in Medicaid managed long-term care, integrated plans for dually eligible individuals who require long-term services and supports, and special needs plans for Medicaid enrollees living with or at risk of HIV/AIDS.

VNSNY is also home to the independent Center for Home Care Policy & Research (CHCPR), which advances the national knowledge base underpinning Home and Community-Based Services (HCBS) by conducting objective and scientifically rigorous research and supporting informed decision-making by providers, policymakers, and consumers. CHCPR focuses on improving HCBS quality, cost-effectiveness, equity, and outcomes and analyzes public policies that affect home-based care. [1]

## Health Equity

Health equity has been defined as ensuring all have a fair and just opportunity to be as healthy as possible – requiring that obstacles to health be removed such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. [2] While structural racism has long existed in our institutions, its impact on health disparities for Black, Indigenous and people of color (BIPOC), LGBTQ+ and other marginalized communities that have faced systemic discrimination is an increasing focus in federal and state policy.

## VNSNY's Commitment and Efforts to Advance Health Equity

Today, the vast majority of those whom we serve are members of ethnic and racial minority communities and/or are impacted by significant social determinants of health (SDOH). Most qualify for Medicaid and other public assistance programs, are homebound, have a significant disability or impairment, and/or are in hard-to-serve communities. VNSNY meets people where they are in their homes and communities, and to be successful, we must have an awareness of and connection to our patients and members' SDOH needs. VNSNY's services improve the lives of individuals from marginalized communities every day, yet we are always striving to improve.

## Research Findings on Health Equity

To address health disparities and advance equity, it is important to have a robust research knowledge base to inform program development and policymaking. CHCPR conducts extensive research and analysis on disparities in home health and hospice services and outcomes. Recent findings include:

**Delays in Home Health Start of Care.** The research team defined a delayed start of care as the first home visit occurring greater than 2 days from hospital discharge. CHCPR found that compared to white patients, Non-Hispanic Black and Hispanic patients had more than 60% higher odds of receiving their first home visit more than two days after hospital discharge. Having solely Medicaid insurance was associated with 56% higher odds of delayed start of care. [3]

**Worse Health Conditions for Low English Proficiency (LEP) Home Health Patients.** LEP was associated with less improvement in medication management at the end of a home care episode, a key component of care coordination, reimbursement, a publicly reported home health care clinical outcome, and a measurement used to determine patient satisfaction with services. LEP patients also had worse health conditions coming into home care (e.g., worse performance on activities of daily living) and were at more socioeconomically disadvantaged situations (e.g., higher proportion of LEP patients with Medicaid and from the Bronx). [4]

**Racial and Ethnic Disparities in Live Discharge from Hospice in Patients with Dementia and Heart Failure.** Live discharge occurs if the patient is hospitalized, seeks curative treatment for their terminal condition, transfers from the hospice service location, or experiences a stabilization in their condition making them ineligible for hospice services. Live discharge can be a disruptive transition, resulting in a loss of physician, nursing, social work, home health aides, and other sources of hospice services and support for patients and families. [5] African American and Hispanic patients with dementia had significantly higher odds of a live discharge from hospice compared with non-Hispanic white patients with dementia, likely driven by systematic differences in hospice referral patterns and access to clinical services. [6] There was a similar pattern found in heart failure patients. African American and Hispanic heart failure patients also experienced a greater odds of live discharge due to acute hospitalization compared to white patients. [7]

## Policy Implications

Given these research findings, policymakers should consider how to ensure organizations are armed with the appropriate information and resources to develop meaningful interventions and improve access, outcomes, and overall health equity.

### Standardize the collection of patient data, including on social determinants of health (SDOH).

Standardize the definitions of start-of-care timeliness in home health, as well as the methodology/timeline for processing referrals and authorizing services. Data such as a patient's ethnicity, preferred language, interpreter services, health literacy, transportation access, and level of social isolation is essential for the provision of effective and individualized care. Questions on race and ethnicity as well as sexual orientation and gender identity should be comprehensive and all-inclusive. SDOH data should remain uniform for seamless transitions between different care settings.

### Increase HHA funding for hard-to-serve patients and communities.

Lack of access to care, a key driver in promoting health equity in outcomes, is largely driven by difficulty staffing hard-to-serve communities and patient refusal of services. These tend to be more prevalent in communities where there are conditions more highly correlated with poverty and lack of caregiver support. Differential funding could be used for enhanced cultural competency and SDOH training and incentives via provision of transportation, higher wages, etc. for staff who commit to serving these communities.

### Encourage staff education to minimize implicit bias.

Implement evidence-driven trainings to improve staff's cultural competency to minimize the racial and ethnic disparities existent in hospitalization, live discharge, and other end-of-life medical interventions. Additionally, there is reluctance among some patients to answer questions of race, sometimes out of fear that certain answers could lead to discrimination. The development of provider education and strategies on asking SDOH and Sexual Orientation and Gender Identity (SOGI) questions will be crucial for: 1) obtaining sensitive measures, and 2) utilizing the data to advance equity.

### Ensure patients understand their prognosis, care, and social support.

It is important for patients to understand hospice and home health, as well as their own prognosis. Social support is a key indicator in health outcomes. Therefore, it is imperative that patients and caregivers are engaged in discussions about managing chronic conditions and advanced illness management and planning. Organizations should strengthen policies that support family care partners' knowledge of what occurred during the hospital stay, the importance of accepting home health services, and what to expect from home health care and hospice.

## Sources

- [1] Center for Home Care Policy & Research. Visiting Nurse Service of New York. (2021, September 23). Retrieved October 8, 2021, from <https://www.vnsny.org/for-healthcare-professionals/vnsny-research-center/>.
- [2] Braveman, P., Arkin, E., Orleans, T., Proctor, D., & Plough, A. (2017). (rep.). Robert Wood Johnson Foundation. Retrieved October 8, 2021, from <https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html>.
- [3] Song, J., Zolnoori, M., McDonald, M.V., Barrón, Y., Cato, K., Sockolow, P., Sridharan, S., Onorato, N., Bowles, K., Topaz, M. (2021: in-press) Factors Associated with Timing of the Start-of-care Nursing Visits in Home Health Care. *Journal of the American Medical Directors Association*.
- [4] Miner, S., Squires, A., Ma, C., McDonald, M., Jones, A. (2020) Detecting disparities in medication management with limited English proficiency home health patients. *Home Health Care Management & Practice*. 32(1):28-33.
- [5] Luth, E., Russell, D., Xu, J., Lauder, B., Ryvicker, M., Dignam, R., Baughn, R., Bowles, K., Prigerson, H. (2021). Survival in hospice patients with dementia: the effect of home hospice and nurse visits. *Journal of the American Geriatrics Society*.
- [6] Luth, E., Russell, D., Brody, A., Dignam, R., Czaja, S., Ryvicker, M., Bowles, K., Prigerson, H. (2020) Race, Ethnicity, and Other Risks for Live Discharge among Hospice Patients with Dementia. *Journal of the American Geriatrics Society*. 68(3):551-558.
- [7] Russell, D., Baik, D., Jordan, L., Dooley, F., Hummel, S., Prigerson, H.G., Bowles, K.H., Masterson-Creber, R. (2019). Factors Associated with Live Discharge of Heart Failure Patients from Hospice: A Multimethod Study. *Journal of the American College of Cardiology*. 7(7):550-557.