

Washington Health's Equity Plan Supplemental Document
Disparity-specific interventions

Disparity	Group	Population Impact	Interventions
1	Age 65 and older	Sepsis, CHF, COPD, pneumonia, acute kidney failure; SNF/HH discharges	Early follow-up, medication reconciliation, fall risk & home safety screening; caregiver-inclusive discharge education; disease-specific care
2	Ages 50 to 64	CHF, COPD, sepsis; SDOH barriers	Flexible or after-hours telehealth; education; disease-specific care
3	Medicare expected payor	Care coordination needs; chronic conditions; CHF, PNA; SNF/HH discharges	TCM of Medicare patients; high-quality SNF/HH referrals; disease-specific care
4	Medicaid expected payor	SDOH barriers; sepsis, hypertensive heart disease; alcohol related readmissions	Transportation vouchers; SDOH referrals
5	Ages 35 to 49	High ED visits post-discharge; SDOH barriers	Text appointment reminders within 48 hours; SDOH referrals
6	Asian/Pacific Islander preferred language	Sepsis, CHF, pneumonia; lack of interpreter use; older (65+)	Interpreter discharge teaching; disease-specific care; HQN HH coordination
7	Native Hawaiian/Pacific Islander race and/or ethnicity	CHF/COPD; SNF discharges; younger profile (50-64)	Cultural liaison; HQN SNF coordination
8	Male sex assigned at birth	Lower follow-up compliance; SDOH barriers	Appointment booking pre-discharge
9	Black/African American race and/or ethnicity	CHF, CKD/hypertensive heart, COPD; SDOH barriers; younger profile (35-64)	Disease-specific care; SDOH referrals
10	Male (No Behavioral Health Dx) sex assigned at birth	Lower follow-up compliance; SDOH barriers	Appointment booking pre-discharge

Acronyms:

Chronic Kidney Disease (CKD)

Chronic Obstructive Pulmonary Disease (COPD)

Congestive Heart Failure (CHF)

Emergency Department (ED)

High quality network (HQN)

Home health (HH)

Pneumonia (PNA)

Skilled nursing facility (SNF)

Social Determinants of Health (SDOH)

Transitional care management (TCM)