LeadingAge Illinois

MOMENTUM

2023 ANNUAL MEETING & EXPO

Renaissance Schaumburg
Convention Center - Schaumburg, IL

Tying It All Together-
An Interdisciplinary Team Approach to Health Equity In SNF

Presenter

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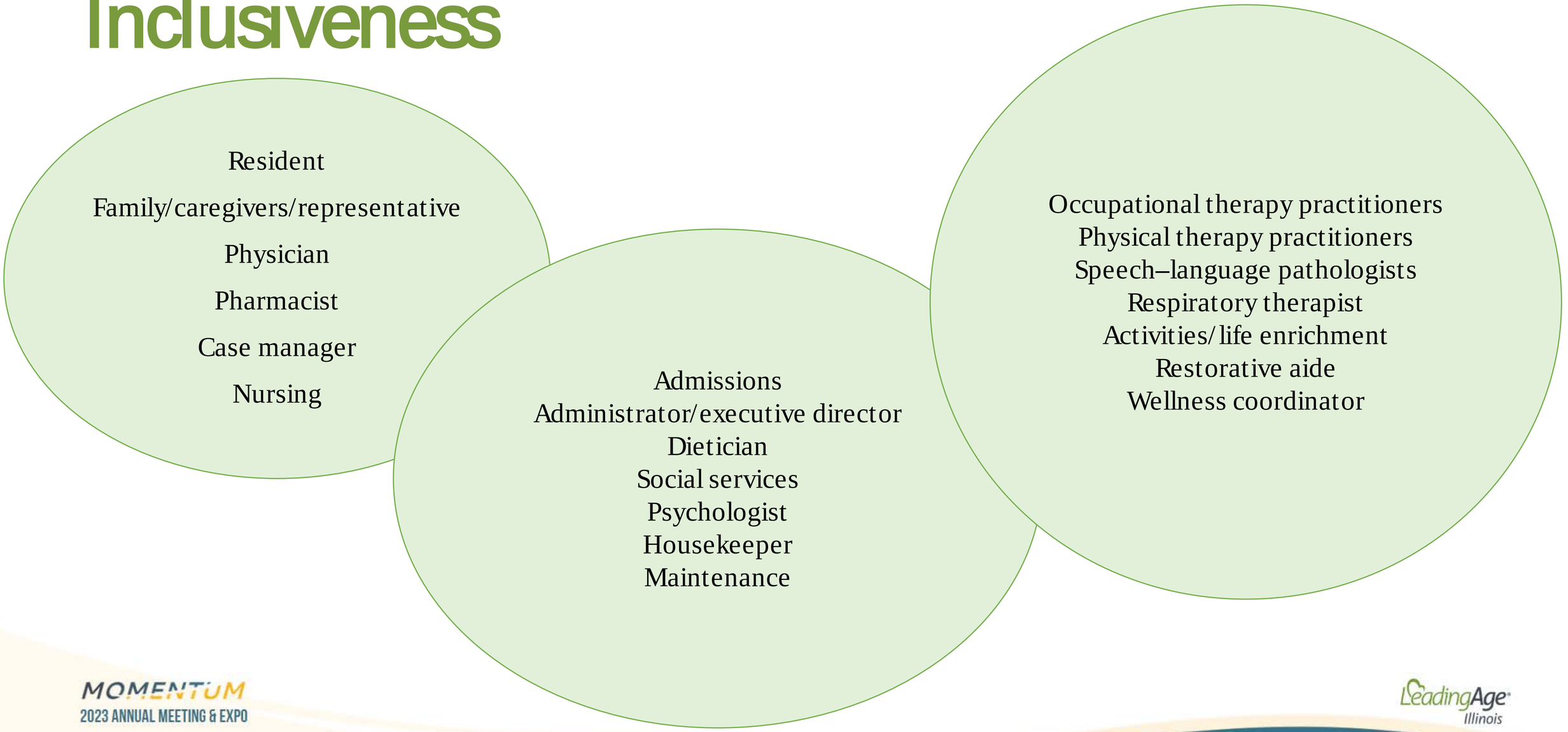
Interdisciplinary Team Collaboration

Interdisciplinary Team Collaboration- Inclusiveness



Interdisciplinary Team Collaboration- Inclusiveness

- Who is part of resident care planning?
- Who is completing MDS Section A: Identification Information?
- Who completes the BIMS?
- Who completes the PHQ-9?
- Who is responsible for discharge planning?
- How do you communicate residents' preferences and goals?
- How does your facility operate in a person-centered fashion that addresses resident choice and preferences?

October 24, 2022 ROP Updates (Example)

- F656: Develop/ Implement Comprehensive Care Plans
  - *Culturally Competent Care*
  - *Trauma Informed Care*
- Probes:
  - *Does the care plan describe interventions that reflect the resident's cultural preferences, values and practices?*
  - *For residents with a history of trauma, does the care plan describe corresponding interventions for care that are in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident?*

https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf

How do you define Health Equity?

Health Equity

- Equity is the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation).
- Health is a fundamental human right.
  - **Health equity is achieved when everyone can attain their full potential for health and well-being.**
- Health and health equity are determined by the conditions in which people are born, grow, live, work, play and age, as well as biological determinants.

https://www.who.int/health-topics/health-equity#tab=tab_1

The Path Forward: Improving Data to Advance Health Equity Solutions-

CMS Framework for Health Equity

https://www.cms.gov/blog/path-forward-improving-data-advance-health-equity-solutions
https://www.cms.gov/about-cms/agency-information/omh/health-equity-programs/cms-framework-for-health-equity

The Five Health Equity Priorities for Reducing Disparities in Health

- These priorities will inform CMS's efforts for the next ten years and how the Agency may operationalize each priority to achieve health equity and eliminate disparities.
- Each priority area reflects a key area in which CMS stakeholders from communities that are underserved and disadvantaged express that CMS action is needed and critical to advancing health equity.
- Together, the five priorities provide an integrated approach to build health equity into existing and new efforts by CMS and our stakeholders.

Priority 1:

- Priority 1: Expand the Collection, Reporting, and Analysis of Standardized Data
  - CMS strives to improve our collection and use of comprehensive, interoperable, standardized individual-level demographic and social determinants of health (SDOH) data, including race, ethnicity, language, gender identity, sex, sexual orientation, disability status, and SDOH.
  - By increasing our understanding of the needs of those we serve, including social risk factors and changes in communities' needs over time, CMS can leverage quality improvement and other tools to ensure all individuals have access to equitable care and coverage.

Priority 2:

- Priority 2: Assess Causes of Disparities Within CMS Programs and Address Inequities in Policies and Operations to Close Gaps
  - CMS is committed to move beyond observation and into action, assessing our programs and policies for unintended consequences and making concrete, actionable decisions about our policies, investments, and resource allocations.
  - Our goals are to explicitly measure the impact of our policies on health equity, to develop sustainable solutions that close gaps in health and health care access, quality, and outcomes and to invest in solutions that address health disparities.

Priority 3:

- Priority 3: Build Capacity of Health Care Organizations and the Workforce to Reduce Health and Health Care Disparities
  - CMS has a commitment to support health care providers, plans, and other organizations who ensure individuals and families receive the highest quality care and services. Health care professionals, particularly those serving minority and underserved communities, have a direct link to individuals and families and can address disparities at the point of care.
  - CMS policy, program, and resource allocation decisions must build capacity among providers, plans, and other organizations to enable stakeholders to meet the needs of the communities they serve.

Priority 4:

- Priority 4: Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services
  - CMS must ensure that all individuals we serve, including members of communities that are underserved, can equitably access all CMS benefits, services and other supports, and coverage.
  - Language access, health literacy, and the provision of culturally tailored services play a critical role in health care quality, patient safety and experience, and can impact health outcomes.
  - CMS has opportunities across our operations, direct communication and outreach to enrollees and consumers, and guidance to plans, providers, and other partners to improve health care quality, patient safety, and the experience individuals have within the health care system.

Priority 5:

- Priority 5: Increase All Forms of Accessibility to Health Care Services and Coverage
  - CMS has a responsibility to ensure that individuals and families can access health care services when and where they need them, in a way that is responsive to their needs and preferences.
  - CMS must seek direct feedback from individuals with disabilities, including physical, sensory and communication, intellectual disabilities, and other forms of disability, to understand their experiences navigating CMS-supported benefits, services, and coverage and tailor our programs and policies to ensure equitable access and quality.

How do you define Social Determinants of Health?

Social Determinants of Health

World Health Organization

- The non-medical factors that influence health outcomes.
- They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.
- These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.

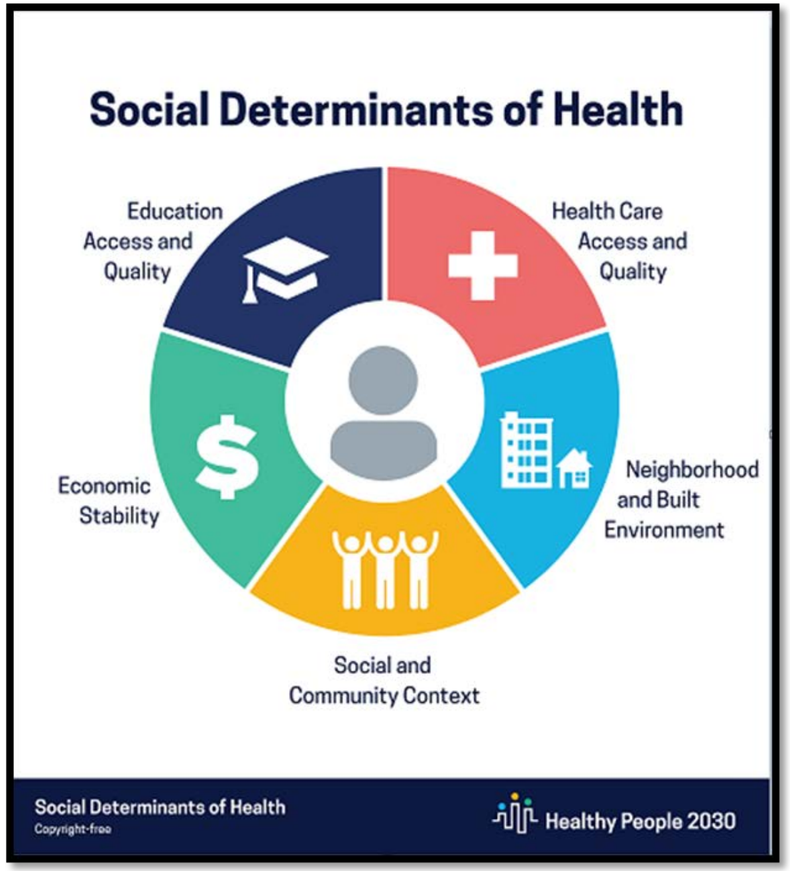
https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

Social Determinants of Health

- Grouped into 5 domains:

Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved [date graphic was accessed], from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

Social Determinants of Health



Social Determinants of Health

- The following list provides examples of the social determinants of health, which can influence health equity in positive and negative ways:
    - Income and social protection
    - Education
    - Unemployment and job insecurity
    - Working life conditions
    - Food insecurity
    - Housing, basic amenities and the environment
    - Early childhood development
    - Social inclusion and non-discrimination
    - Structural conflict
    - Access to affordable health services of decent quality

Economic Stability

- Employment
- Income
- Expenses
- Debt
- Medical Bills
- Support

Economic Stability

- Healthy People 2030 Goal:
  - Help people earn steady incomes that allow them to meet their health needs.
- In the United States, 1 in 10 people live in poverty, and many people can't afford things like healthy foods, health care, and housing.

Semega, J., Kollar, M., Creamer, J., Mohanty, A. (2019). Income and Poverty in the United States. Retrieved from https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-266.pdf

Education Access and Quality

- Literacy
- Language
- Early Childhood Education
- Vocational Training
- Higher Education

Education Access and Quality

- Healthy People 2030 Goal:
  - Increase educational opportunities and help children and adolescents do well in school.

Health Care Access and Quality

- Health Coverage
- Provider Availability
- Provider Linguistic & Cultural
- Competency
- Quality of Care
- Health IT

Health Care Access and Quality

- Healthy People 2030 Goal:
  - Increase access to comprehensive, high-quality health care services.
- About 1 in 10 people in the United States don't have health insurance.

Berchick, E.R., Hood, E., & Barnett, J.C. (2018). Health Insurance Coverage in the United States: 2017. Retrieved from https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf

Neighborhood and Built Environment

- Housing
- Transportation
- Walkability
- Safety
- Parks
- Playgrounds
- Zip code/geography

Neighborhood and Built Environment

- Healthy People 2030 Goal:
  - Create neighborhoods and environments that promote health and safety.
- According to the *American Journal of Public Health* publication from May 2020, the absence of non-urgent transportation to the point of care made about 6 million persons delay their visits.
  - Given that a large part of those patients could be disadvantaged chronic condition patients, a no-show for them could result in relapses and increased costs for providers.
  - On the contrary, non-emergency transportation (NEMT) service can help providers save up to $537 million annually, a 2019 survey reports.

https://www.managedhealthcareexecutive.com/view/how-to-add-social-determinants-collection-to-healthcare-software

Social and Community Context

- Social Integration
- Support Systems
- Community Engagement
- Discrimination
- Stress Reduction
- Health IT
- Nutrition & Healthy Eating

Social and Community Context

- Healthy People 2030 Goal:
  - Increase social and community support.

What Is CDC Doing to Address SDOH?

This graphic shows the six pillars of CDC's work to address SDOH, which is depicted as the interplay of social and structural conditions, and that SDOH is one factor that contributes to overall equity.

https://www.cdc.gov/about/sdoh/cdc-doing-sdoh.html

What Is CDC Doing to Address Social Determinants of Health?

- **Data and surveillance:** Embed a consistent SDOH approach to standardization, collection, analysis, and dissemination of data across the agency.
- **Evaluation and evidence building:** Advance evaluation and build evidence for strategies that address SDOH to reduce disparities and promote health equity.
- **Partnerships and collaboration:** Establish criteria, actionable steps, and strategies for partnerships, collaborations, and relationships that result in improved health outcomes over the long term.

What Is CDC Doing to Address Social Determinants of Health?

- **Community engagement:** Foster meaningful, sustained community engagement across all phases of CDC intervention planning and implementation.
- **Infrastructure and capacity:** Strengthen and sustain infrastructure such as workforce, training, and access to financial resources required to address SDOH and reduce health disparities.
- **Policy and law:** Identify evidence, tools, and resources to enhance communication about policies that affect SDOH with policy makers and other stakeholders

Health Outcomes

- Mortality
- Morbidity
- Life Expectancy
- Health Care Expenditures
- Health Status
- Functional Limitations

https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

Why Is Addressing SDOH Important for CDC and Public Health?

- Addressing differences in SDOH makes progress toward health equity, a state in which every person has the opportunity to attain their highest level of health.
- SDOH have been shown to have a greater influence on health than either genetic factors or access to healthcare services.
  - For example, poverty is highly correlated with poorer health outcomes and higher risk of premature death.[1] SDOH, including the effects of centuries of racism, are key drivers of health inequities within communities of color. The impact is pervasive and deeply embedded in our society, creating inequities in access to a range of social and economic benefits—such as housing, education, wealth, and employment. These inequities put people at higher risk of poor health.

The National Health Expenditure Accounts (NHEA)

- U.S. health care spending grew 2.7 percent in 2021, reaching $4.3 trillion or $12,914 per person.
- As a share of the nation's Gross Domestic Product, health spending accounted for 18.3 percent.

https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical#:~:text=U.S.%20health%20care%20spending%20grew,spending%20accounted%20for%2018.3%20percent.

CMS Office of the Actuary Releases 2021-2030 Projections of National Health Expenditures

- Annual growth in national health spending is expected to average 5.1% over 2021-2030, and to reach nearly $6.8 trillion by 2030.
- Medicare: Medicare spending growth is projected to average 7.2% over 2021-2030, the fastest rate among the major payers.
- Medicaid: Average annual growth of 5.6% is projected for Medicaid spending for 2021-2030.
- Private Health Insurance and Out-of-Pocket: For 2021-2030, private health insurance spending growth is projected to average 5.7%.

https://www.cms.gov/newsroom/press-releases/cms-office-actuary-releases-2021-2030-projections-national-health-expenditures#:~:text=Private%20Health%20Insurance%20and%20Out%2Dof%2DPocket%3A%20For%202021,is%20projected%20to%20average%205.7%25.

Added 7 Standardized Patient Assessment Data Elements (SPADEs)

Added 7 Standardized Patient Assessment Data Elements (SPADEs)

- Data Element Collection:
  1. Race
  2. Ethnicity
  3. Preferred language
  4. Need for interpreter
  5. Health literacy
  6. Transportation
  7. Social isolation

Draft October 2023 MDS Items

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual

A1005: Ethnicity (new item and responses added)

A1005. Ethnicity Are you of Hispanic, Latino/a, or Spanish origin?	
↓ **Check all that apply**	
☐	**A.** No, not of Hispanic, Latino/a, or Spanish origin
☐	**B.** Yes, Mexican, Mexican American, Chicano/a
☐	**C.** Yes, Puerto Rican
☐	**D.** Yes, Cuban
☐	**E.** Yes, another Hispanic, Latino/a, or Spanish origin
☐	**X.** Resident unable to respond
☐	**Y.** Resident declines to respond

A1010: Race (new item and responses added)

A1010. Race What is your race?	
↓ Check all that apply	
☐	**A.** White
☐	**B.** Black or African American
☐	**C.** American Indian or Alaska Native
☐	**D.** Asian Indian
☐	**E.** Chinese
☐	**F.** Filipino
☐	**G.** Japanese
☐	**H.** Korean
☐	**I.** Vietnamese
☐	**J.** Other Asian
☐	**K.** Native Hawaiian
☐	**L.** Guamanian or Chamorro
☐	**M.** Samoan
☐	**N.** Other Pacific Islander
☐	**X.** Resident unable to respond
☐	**Y.** Resident declines to respond
☐	**Z.** None of the above

A1110: Language (new items and responses added)

A1110. Language

Enter Code ☐

A. What is your preferred language?

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

B. Do you need or want an interpreter to communicate with a doctor or health care staff?

0. No
1. Yes
9. Unable to determine

A1250: Transportation (new item and response added)

A1250. Transportation (from NACHC©)
Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?
Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1

↓ Check all that apply	
☐	**A.** Yes, it has kept me from medical appointments or from getting my medications
☐	**B.** Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
☐	**C.** No
☐	**X.** Resident unable to respond
☐	**Y.** Resident declines to respond

B1300: Health Literacy (new item and response added)

B1300. Health Literacy
Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1

Enter Code ☐

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

0. **Never**
1. **Rarely**
2. **Sometimes**
3. **Often**
4. **Always**
7. **Resident declines to respond**
8. **Resident unable to respond**

The Single Item Literacy Screener is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License.

D0150: Resident Mood Interview (PHQ-2 to 9©) (new items and item responses, PHQ-9 item retired)

D0150. Resident Mood Interview (PHQ-2 to 9©)

Say to resident: "*Over the last 2 weeks, have you been bothered by any of the following problems?*"

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the resident: "*About **how often** have you been bothered by this?*"
Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. **Symptom Presence**
   0. **No** (enter 0 in column 2)
   1. **Yes** (enter 0-3 in column 2)
   9. **No response** (leave column 2 blank)

2. **Symptom Frequency**
   0. **Never or 1 day**
   1. **2-6 days** (several days)
   2. **7-11 days** (half or more of the days)
   3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. *Little interest or pleasure in doing things*	☐	☐
B. *Feeling down, depressed, or hopeless*	☐	☐
If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview.		
C. *Trouble falling or staying asleep, or sleeping too much*	☐	☐
D. *Feeling tired or having little energy*	☐	☐
E. *Poor appetite or overeating*	☐	☐
F. *Feeling bad about yourself - or that you are a failure or have let yourself or your family down*	☐	☐
G. *Trouble concentrating on things, such as reading the newspaper or watching television*	☐	☐
H. *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*	☐	☐
I. *Thoughts that you would be better off dead, or of hurting yourself in some way*	☐	☐

Tying it all Together….

How To Operationalize

MDS Completion

- Needs to be an interdisciplinary team approach
- SDOH items are not to be rushed and need to be completed by a team member who understands the questions and can create individualized care plans that care culturally competent and trauma informed
- MDS Section A can assist facilities in their multi-pronged approach to identifying a resident's history of trauma as well as his or her cultural preferences
- Need to consider training and implementation of standardized health literacy assessment tools

Discharge Planning

- Should include an assessment of the discharge living environment to determine if it is a safe location/environment
- Should include an assessment of transportation access to medical appointments, pharmacy and grocery store
- Should include an assessment of social support and risk of social isolation
- Discharge documents should be individualized for health literacy and language preferences
- Using social determinants of health when developing a resident's discharge plan can assist in identifying and addressing potential risks that could adversely affect the resident's ability to safely discharge back to the community

CMS

- By collecting common data elements across the four PAC provider types, the SPADEs will make it possible to measure and compare quality, outcomes, patient acuity, and resource use consistently across PAC settings and longitudinally, guiding policies and PAC payment reform based on patient/resident populations.
- MDS data will be used to review discharge planning to ensure that the facility is incorporating SDOH elements
- MDS data will be used to review facility demographics
- MDS data will be used to review resident care plans to ensure that the facility is utilizing the SDOH data to create individualized plans of care

Tying it all Together

- Review current policies and procedures
- Review staff training plan and competencies
- Review current processes:
  - Care planning
  - Discharge planning
  - Care coordination meetings
  - Completion of MDS item sets

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MARCH 7-8, 2023

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