"A ***Knowledgeable*** and ***Compassionate*** partner"

BROAD RIVER REHAB

Health Equity and Social Determinants of Health

Get to Know Your Health Equity Confidential Feedback Reports

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ACCREDITED PROVIDER
AMERICAN NURSES CREDENTIALING CENTER

APPROVAL STATEMENT DISCLOSURE

- This nursing continuing professional development activity was approved by Broad River Rehab, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.
- This course has been approved for 1.5 contact hours.

CONFLICT OF INTEREST DISCLOSURE

- Broad River Rehab is not charging for this educational offering and has no financial or other conflicts of interest regarding this program.

SUCCESSFUL COMPLETION REQUIREMENTS

- **Live, in-person**
  - In order to obtain nursing contact hours, you must attend the entire activity, participate in case study analysis, and complete the evaluation.
- **Live, virtual**
  - In order to obtain nursing contact hours, you must participate in the entire program, participate in audience polling and/or Q&A and complete the evaluation.
- **Web-Based/On-Demand**
  - In order to obtain nursing contact hours, you must view the entire program, and complete the evaluation.

DISCLOSURE OF THE EXPIRATION DATE FOR AWARDING CONTACT HOURS FOR ENDURING PROGRAMS

- Contact hours for this program will not be awarded after February 25th, 2023

Agenda

Health Equity and Social Determinants of Health

- Understand CMS' Health Equity Initiative
- Recognize the health equity score card QMs
- Comprehend the details of the scorecard measurement
- Identify possible quality improvement initiatives based on scorecard data

Skilled Nursing Facility Quality Reporting Program (SNF QRP) update

- **SNF QRP Resources:**
  - SNF QRP
  - Reporting tables for FY 2024
  - Reporting tables for FY 2025
  - SNF QRP Technical Specifications
  - COVID-19 Vaccination Among HCP Specifications
  - Influenza Vaccination Coverage Among HCP
  - Unified PAC Report to Congress
  - MDS 3.0 v1.18.11
  - Health Equity Confidential Feedback Report educational Material

IMPACT Act

- On October 6, 2014, the Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act) was signed into law.
- The Act requires the submission of standardized data by Long-Term Care Hospitals (LTCHs), **Skilled Nursing Facilities (SNFs)**, Home Health Agencies (HHAs) and Inpatient Rehabilitation Facilities (IRFs).
- Standardized data are to be collected by the commonly used assessment instruments: The Long-Term Care Hospital CARE Data Set (LCDS) for LTCHs, **the Minimum Data Set (MDS) for SNFs**, the Outcome and Assessment Information Set (OASIS) for HHAs, and the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF PAI) for IRFs.
- The IMPACT Act requires the reporting of standardized patient assessment data with regard to quality measures and standardized patient assessment data elements (SPADEs).
- The Act also requires the submission of data pertaining to measure domains pertaining to resource use, and other domains.
- In addition, the IMPACT Act requires assessment data to be standardized and interoperable to allow for exchange of the data among post-acute providers and other providers.
- The Act intends for standardized post-acute care data to improve Medicare beneficiary outcomes through shared-decision making, care coordination, and enhanced discharge planning.

IMPACT Act QMs

IMPACT Act Domain	IMPACT Act Measure	Source	PAC Setting Adopted
Skin Integrity and Changes in Skin Integrity	Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay) replaced with Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.	Assessment	IRF, LTCH, SNF, HH
Functional Status, Cognitive Function, and Changes in Function and Cognitive Functiony	Application of Percent of LTCH Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function	Assessment	IRF, LTCH, SNF, HH
	Change in Self-Care Score for Medical Rehabilitation Patients	Assessment	IRF, SNF
	Change in Mobility Score for Medical Rehabilitation Patients	Assessment	IRF, SNF
	Change in Discharge Self-Care Score for Medical Rehabilitation Patients	Assessment	IRF, SNF
	Change in Discharge Mobility Score for Medical Rehabilitation Patients	Assessment	IRF, SNF
Medication Reconciliation	Drug Regimen Review	Assessment	IRF, LTCH, SNF, HH
Incidence of Major Falls	Application of the Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	Assessment	IRF, LTCH, SNF, HH
Transfer of Health Information and Care Preferences when an Individual Transitions	Transfet of Health Information to Provider Transfer of health Information to Patient	Assessment Assessment	IRF, LTCH, SNF, HH
Resource Use Measures, including Total Estimated Medicare Spending Per Beneficiary	Medicare Spending Per Beneficiary	Claims	IRF, LTCH, SNF, HH
Discharge to Community	Discharge to Community	Claims	IRF, LTCH, SNF, HH
All-Condition Risk-Adjusted Potentially Preventable Hospital Readmissions Rates	Potentially Preventable 30-Day Post-Discharge Readmission	Claims	IRF, LTCH, SNF, HH
Meaningful Measure Domain	**IMPACT Act Measure**		**PAC Setting Adopted**
Patient Safety (Meaningful Measures 2.0)	SNF Healthcare Associated infections	Claims	SNF
Patient Safety (Meaningful Measures 2.0)	Influenza vaccination HCP	NHSN	IRF, LTCH, SNF
Patient Safety (Meaningful Measures 2.0)	COVID-19 Vaccination HCP	NHSN	IRF, LTCH, SNF

New Measures

- Discharge Function Score (DC Function) measure FY 2025 **(5-Star October 2024)**
- COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date (Patient/Resident COVID-19 Vaccine) measure FY 2026
- COVID-19 Vaccination Coverage among Healthcare Personnel (HCP COVID-19 Vaccine) measure FY 2026

IMPACT Act

- The Improving Post-Acute Care Transformation (IMPACT) Act of 2014 also requires a report to Congress on unified payment for Medicare post-acute care (PAC).
- Medicare PAC services are provided to beneficiaries by PAC providers defined as skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), and home health agencies (HHAs).
- Each PAC provider setting has a separate Medicare fee-for-service (FFS) prospective payment system (PPS).
- A goal of unified PAC payment is to base the payment on patient characteristics instead of the PAC setting.
- This framework applies a uniform approach to case-mix adjustment across Medicare beneficiaries receiving PAC services for different types of PAC providers while accounting for factors independent of patient need that are important drivers of cost across PAC providers.
- The unified approach to case-mix adjustment includes **standardized patient assessment data** collected by the four PAC providers.

SNF Quality Reporting Program (QRP)

- The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires CMS to develop, implement, and maintain standardized patient assessment data elements (SPADEs) for PAC settings (SNF, HH, LTCH, IRF).
- The goals of implementing cross-setting SPADEs are to facilitate care coordination and interoperability and to improve Medicare beneficiary outcomes.
- The IMPACT Act further requires that the assessment instruments for each PAC setting (MDS, OASIS, LCDS, IRF PAI) be modified to include core data elements on health assessment categories and that such data be standardized and interoperable. HH, IFF and LTCH tools have already been modified to report these SPADEs. **MDS 3.0 v1.18.11 contains the data elements necessary to comply with this mandate.**
- CMS has adopted SPADEs for five categories specified in the IMPACT Act:
  - **Cognitive function** (e.g., able to express ideas and to understand normal speech) and mental status (e.g., depression and dementia)
  - **Special services, treatments, and interventions** (e.g., need for ventilator, dialysis, chemotherapy, and total parenteral nutrition)
  - **Medical conditions and comorbidities** (e.g., diabetes, heart failure, and pressure ulcers)
  - **Impairments** (e.g., incontinence; impaired ability to hear, see, or swallow)
  - **Other categories** as deemed necessary by the Secretary (Social Determents of Health)

SNF Quality Reporting Program (QRP)

- **New Category: Social Determinants of Health (cont.)**
- MDS items have been added and or revised to assess for SDOH:
  - **Ethnicity – MDS item A1005**
  - **Race – MDS item A1010**
  - **Preferred Language – MDS item A1110**
  - **Interpreter Services – MDS item A1110**
  - **Transportation – MDS item A1250**
  - **Health Literacy – MDS item B1300**
  - **Social Isolation – MDS item D0700**

SNF Quality Reporting Program (QRP)

- **Health Equity Update 2024**
- CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by CMS' programs and models, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that beneficiaries need to thrive.
- This initiative is guided by 5 priorities
- **Priority 1:** Expand the Collection, Reporting and Analysis of **Standardized Data**
- **Priority 2:** Assess **Causes of Disparities** Within CMS Programs, and **Address Inequities in Policies and Operations to Close Gaps**
- **Priority 3:** Build Capacity of Health Care Organizations and the Workforce to **Reduce Health and Health Care Disparities**
- **Priority 4: Advance Language Access, Health Literacy** and the Provision of Culturally Tailored Services
- **Priority 5:** Increase All Forms of Accessibility to Health Care Services and Coverage

SNF VBP/QRP Connection: Health Equity

CMS Framework for Health Equity 2022–2032

SNF VBP/QRP Connection: Health Equity

- The CDC defines health equity as, "…the state in which everyone has a fair and just opportunity to attain their highest level of health." "Achieving this requires focused and ongoing societal efforts to address historical and contemporary injustices; overcome economic, social, and other obstacles to health and healthcare; and eliminate preventable **health disparities**."
- The CDC also indicated that, "Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities." "Achieving health equity also requires addressing **social determinants of health** and **health disparities**."

SNF VBP/QRP Connection: Health Equity

- **New Category: Social Determinants of Health**
  - CMS has identified data elements for cross-setting standardization of assessment for seven social determinants of health (SDOH).
  - **Healthy People 2020 defines SDOH** as, *"…the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."*
  - **World Health Organization** – *"Social determinants of health (SDH) are 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. The SDH have an important influence on Health Inequities - the unfair and avoidable differences in health status seen within and between countries. In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health."*
  - *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.*

SNF VBP/QRP Connection: Health Equity

- **Health Equity Update SNF PPS FY 2024**
  - CMS' National Quality Strategy identifies a wide range of potential quality levers that can support CMS' advancement of equity, including:
    - (1) establishing a **standardized approach for resident-reported data and stratification**;
    - (2) employing quality and **value-based programs to address closing equity gaps**; and
    - (3) developing **equity-focused data collections, analysis, regulations, oversight strategies, and quality improvement initiatives**.

SNF VBP/QRP Connection: Health Equity

- **Health Equity Update SNF PPS FY 2024**
- CMS is committed to developing approaches to meaningfully incorporate the advancement of health equity into the SNF QRP. One option we are considering is including **social determinants of health (SDOH) as part of new quality measures**.
- CMS is considering whether health equity measures we have adopted for other settings, such as hospitals, could be adopted in post-acute care settings.
- CMS is exploring ways to incorporate SDOH elements into the measure specifications. For example, CMS is considering **a future health equity measure like screening for social needs and interventions**.
- **With 30 percent to 55 percent of health outcomes attributed to SDOH**, a measure capturing and addressing SDOH could encourage SNFs to identify residents' specific needs and connect them with the community resources necessary to overcome social barriers to their wellness.

SNF VBP/QRP Connection: Health Equity

- **Health Equity Update SNF PPS FY 2024**
- CMS could specify a health equity measure using the same SDOH data items that we currently collect as standardized patient assessment data elements under the SNF.
- These SDOH data items assess health literacy, social isolation, transportation problems, and preferred language (including need or want of an interpreter).
- CMS also sees value in aligning SDOH data items across all care settings as we develop future health equity quality measures under our SNF QRP statutory authority.
- This would further the NQS to align quality measures across our programs as part of the **Universal Foundation**.

Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

- **Value Based Purchasing**
  - The Centers for Medicare & Medicaid Services (CMS) awards incentive payments to skilled nursing facilities (SNFs) through the SNF VBP Program to encourage SNFs to improve the quality of care they provide to Medicare beneficiaries. Performance in the SNF VBP Program is currently based on a single measure of all-cause hospital readmissions.
  - In Section 215 of the Protecting Access to Medicare Act of 2014 (PAMA), Congress added sections 1888(g) and (h) to the Social Security Act, which required the Secretary of the Department of Health and Human Services (HHS) to establish a SNF VBP Program. The Program began affecting SNF payments on October 1, 2018.
  - PAMA specifies that under the SNF VBP Program, SNFs:
    - Are evaluated by their performance on a hospital readmission measure;
    - Are assessed on both improvement and achievement, and scored on the higher of the two;
    - Receive quarterly confidential feedback reports containing information about their performance; and
    - Earn incentive payments based on their performance.
    - All SNFs paid under Medicare's SNF Prospective Payment System (PPS) are included in the SNF VBP Program. Inclusion in the SNF VBP Program does not require any action on the part of SNFs.
  - As required by statute, CMS withholds 2% of SNFs' Medicare fee-for-service (FFS) Part A payments to fund the program. This 2% is referred to as the "withhold".
  - CMS is required to redistribute between 50% and 70% of this withhold to SNFs as incentive payments. CMS redistributes 60% of the withhold to SNFs as incentive payments, and the remaining 40% of the withhold is retained in the Medicare Trust Fund.

Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

- **Value Based Purchasing (Cont.)**
  - In Section 111 of the Consolidated Appropriations Act, 2021, Congress amended Section 1888(h) of the Social Security Act to allow the HHS Secretary to apply up to nine additional measures to the SNF VBP Program for payments for services furnished on or after October 1, 2023 (fiscal year [FY] 2024).
  - In the FY 2023 SNF PPS final rule, CMS adopted two additional measures for use beginning in the FY 2026 SNF VBP Program year: **1)** Skilled Nursing Facility Healthcare-Associated Infections (SNF HAI) Requiring Hospitalization measure; and **2)** Total Nurse Staffing Hours per Resident Day (Total Nurse Staffing) (including Registered Nurse [RN], Licensed Practical Nurse [LPN], and Nurse Aide hours) measure. CMS also adopted one additional measure for use beginning in the FY 2027 SNF VBP Program year: Discharge to Community (DTC)—Post-Acute Care Measure for SNFs (National Quality Forum [NQF] #3481).

Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

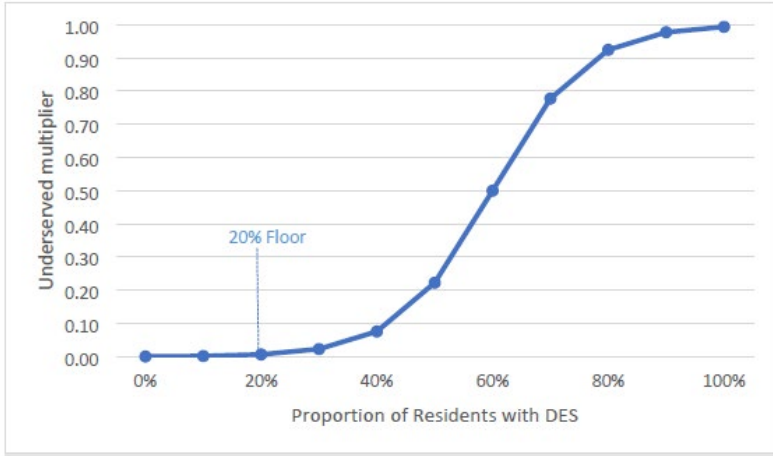
- **Value Based Purchasing Measures**
  - NQF 2510: Skilled Nursing Facility Readmission Measure (SNFRM) Current
  - Skilled Nursing Facility (SNF) Healthcare Associated Infections (HAI) Requiring Hospitalization FY 2026
  - Total Nursing Hours per Resident Day Staffing (Total Nurse Staffing) measure FY 2026
  - Discharge to Community (DTC) FY 2027
  - Nursing Staff Turnover Measure FY 2026
  - Long Stay Hospitalization Measure per 1000 long-stay resident days FY 2027
  - Discharge Function Score measure FY 2027
  - Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) FY 2027
  - Skilled Nursing Facility Within Stay Potentially Preventable Readmissions (SNF WS PPR) FY 2028

Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

- **Value Based Purchasing FY 2024 SNF PPS**
  - To prioritize the achievement of **health equity** and the reduction of disparities in health outcomes in SNFs, CMS is adoptingof a Health Equity Adjustment in the SNF VBP Program that rewards SNFs that perform well and whose resident population during the applicable performance period includes at least 20% of residents with dual eligibility status.
  - This adjustment would begin with the **FY 2027 program year and FY 2025 performance year**.
  - CMS is adjusting the scoring methodology to provide bonus points to high-performing facilities (CMS is proposing to define a top tier performing SNF, as a SNF whose score on the measure for the program year falls in the top third of performance, or greater than or equal to the 66.67th percentile) that provide care to a higher proportion of duals.
  - In the FY 2024 SNF PPS rule, CMS is requesting comments about possible future methodologies for selecting and prioritizing quality measures to focus on underserved populations.

Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

- **Value Based Purchasing FY 2024 SNF PPS**
  - In addition, CMS will increase the payback percentage policy under the SNF VBP program from current 60% to a level such that the bonuses provided to the high performing, high duals SNFs do not come at the expense of the other SNFs. The estimates for FY 2027 program year is 66.02%.
  - Bonus Scoring Methodology (if 20% DES):
    - **Measure Performance Scaler**: 2 bonus points for each VBP measure scoring in the top 66.67th percentile.
    - **Underserved Multiplier**: the number representing the SNF's proportion of residents with DES out of its total resident population in the applicable program year, translated using a logistic exchange function
    - **HEA bonus points** = measure performance scaler × underserved multiplier



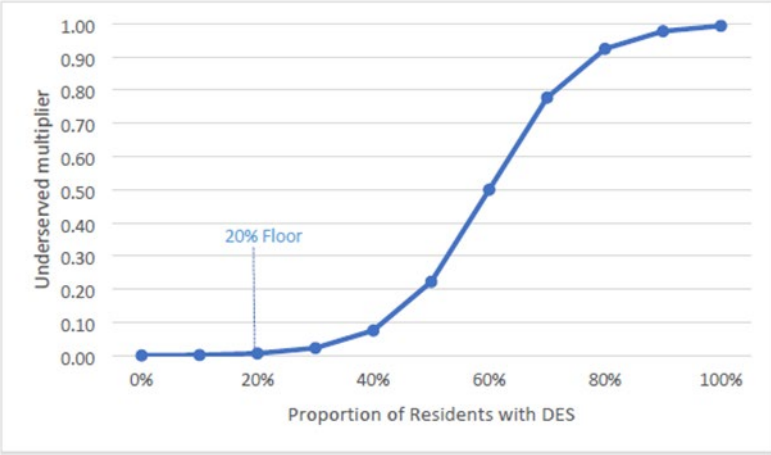
Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

TABLE 20: Example of the HEA Bonus Points Calculation

Example SNF	Measure Performance Scaler [A]	Proportion of Residents with DES (%) [B]	Underserved Multiplier [C]	HEA bonus points [D] ([A]*[C])
SNF 1	16	50	0.22	3.52
SNF 2	14	70	0.78	10.92
SNF 3	10	10	0	0
SNF 4	2	80	0.92	1.84

TABLE 21: Example of the HEA Bonus Points Calculation

Example SNF	Normalized Sum of all Points Awarded for each Measure [A]	HEA Bonus Points (Step 3, Column [D]) [B]	SNF Performance Score ([A] + [B])
SNF 1	80	3.52	83.52
SNF 2	65	10.92	75.92
SNF 3	42	0	42.00
SNF 4	10	1.84	11.84



Health Equity/Social Determinants of Health in Practice

- **Health Equity/Social Determinants of Health Application**
  - In a recent column in McKnight's LTC News, it was noted that, "According to the Centers for Disease Control and Prevention"
  - "social isolation can increase a person's risk of premature death from all causes and increases the risk of dementia by 50%."
  - "Social isolation is a lack of social connections. Social isolation can lead to loneliness in some people, while others can feel lonely without being socially isolated."
  - **"Health Risks of Loneliness:** Although it's hard to measure social isolation and loneliness precisely, there is strong evidence that many adults aged 50 and older are socially isolated or lonely in ways that put their health at risk. Recent studies found that:
    - Social isolation **significantly increased a person's risk of premature death** from all causes, a risk that may rival those of smoking, obesity, and physical inactivity.[1]
    - Social isolation was associated with about a **50% increased risk of dementia**.[1]
    - Poor social relationships (characterized by social isolation or loneliness) was associated with a **29% increased risk of heart disease** and a **32% increased risk of stroke.**[1]
    - Loneliness was **associated with higher rates of depression, anxiety, and suicide**.
    - Loneliness among heart failure patients was **associated with a nearly 4 times increased risk of death, 68% increased risk of hospitalization, and 57% increased risk of emergency department visits**.[1]

Health Equity/Social Determinants of Health in Practice

- **Health Equity/Social Determinants of Health Application**
  - Black Americans' High Gout Rate Stems From Social Causes (Medscape): Gout prevalence is more common in Black Americans than white Americans, and the disparity in prevalence is attributable to social determinants of health, according to a recently published article in *JAMA Network Open.*
  - Age-standardized prevalence of gout:
    - 3.5% in Black women and 2.0% in white women.
    - 7.0% in Black men and 5.4% in white men
    - Similar differences were found in the prevalence of hyperuricemia between Black and white Americans.
  - This research concluded that the increased prevalence of gout in Black Americans, compared with white Americans, does not arise from genetics. The conclusion was that it was due to social determinants of health. "When we adjusted for all socio-clinical risk factors, the racial differences in gout and hyperuricemia prevalence disappeared. Importantly, stepwise regression analysis showed **the two biggest drivers of the racial difference in gout prevalence among women were poverty itself, and excess BMI, which can be influenced by poverty.**"
  - The authors suggested that Primary care providers need to adopt a holistic approach to gout management that involves counseling about good nutrition, smoking cessation, regular exercise, and limiting alcohol consumption, in addition to medication adherence.

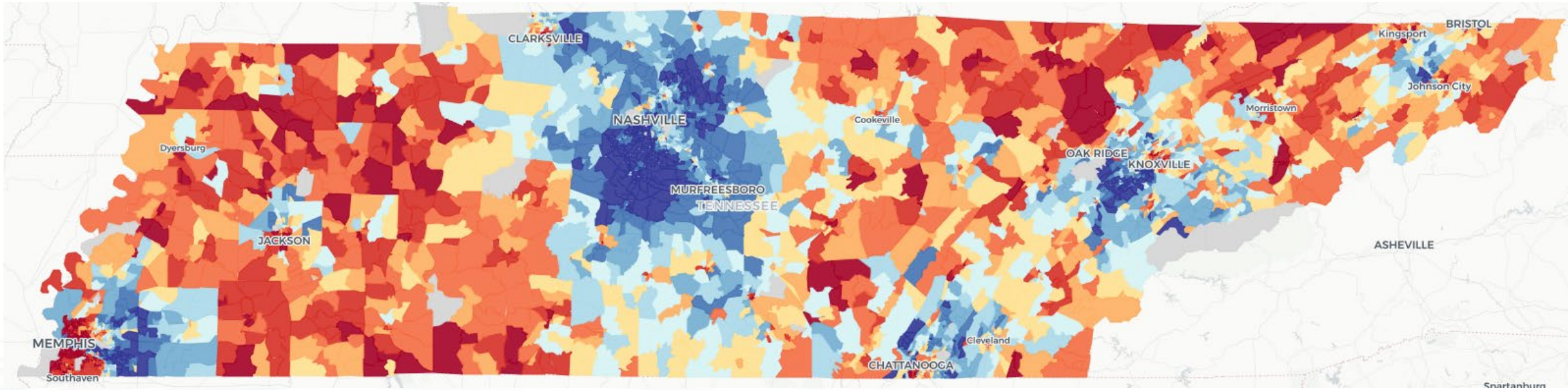
Health Equity/Social Determinants of Health in Practice

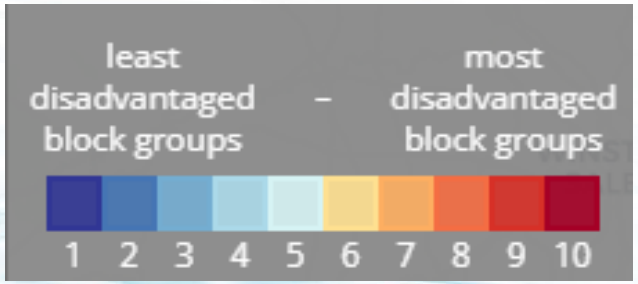
- **Health Equity/Social Determinants of Health Application**
  - This research discovered that significantly more black women and men were currently taking diuretics, compared with their white counterparts and therefore, clinicians should give more thought to medical therapies prescribed for conditions like high blood pressure to patients with gout or at risk for gout.
  - One author indicated that diuretic use is a driver of gout and stated, a prescriber "may want to consider different therapies that present a lower risk of gout if someone has hypertension. There could be greater consideration for prescribing alternatives to diuretics."

Health Equity/Social Determinants of Health in Practice

- **Health Equity/Social Determinants of Health Application**
  - Study: Socioeconomic factors influence stroke outcomes: A new study published in *Neurology* reveals that how well you fare after a stroke or other neurological event may come down to where you live.
    - Researchers used three years' worth of Medicare claims to identify nearly a million people aged 65 and older who had been hospitalized for various neurologic conditions like stroke, Alzheimer's disease, Parkinson's disease, epilepsy, coma, multiple sclerosis
    - The address of each of these patients was reviewed using a measurement called the **Area Deprivation Index (ADI)** to determine whether or not they lived in a socioeconomically disadvantaged neighborhood. The ADI takes things like the **housing quality**, **education**, **income** and **employment of neighborhood residents** to assign a score, and neighborhoods that score higher on the index are at a greater disadvantage. The study team then used these scores to look at which Medicare recipients died within a month after their hospitalization for one of the neurological conditions listed.
    - According to the report, 14.6% of stroke victims in the most disadvantaged neighborhoods died within the first month after their stroke, compared to 14.1% in advantaged neighborhoods.
    - For degenerative conditions like Alzheimer's disease and Parkinson's, 9.7% of the patients studied died within a month of hospitalization compared to 8.7% in advantaged neighborhoods.
    - Another 7.7% died within a month of hospitalization for epilepsy in disadvantaged neighborhoods compared to 6.8% in advantaged neighborhoods.
    - The study authors suggest that these results highlight the need for healthcare providers to examine neighborhood level access to care and how it can impact patient outcomes.

Area Deprivation Index: Tennessee





Center for Health Disparities Research
University of Wisconsin School of Medicine and Public Health

Health Equity/Social Determinants of Health in Practice

- “Living in a disadvantaged neighborhood has been linked to a number of healthcare outcomes, including higher rates of diabetes and cardiovascular disease, increased utilization of health services, and earlier death. Health interventions and policies that don't account for neighborhood disadvantage may be ineffective.” https://www.neighborhoodatlas.medicine.wisc.edu/
- **The Area Deprivation Index (ADI) …**allows for rankings of neighborhoods by socioeconomic disadvantage in a region of interest (e.g., at the state or national level). It includes factors for the theoretical domains of income, education, employment, and housing quality. It can be used to inform health delivery and policy, especially for the most disadvantaged neighborhood groups.

Health Equity Confidential Feedback Reports

- The goal of the Health Equity Confidential Feedback Reports is to compare measure outcomes between Fee-for-Service Medicare-Medicaid dually enrolled patients (duals) and non-duals, as well as between Non-White and White patients.
  - Non-White patients" include patients of the following races/ethnicities: AA and NHPI, Black, Hispanic, and American Indian/Alas ka Native. AA and NHPI: Asian American and Native Hawaiian or other Pacific Islander.
- The current reports measure population outcomes for these populations related to the two SNF QRP PAC measures, **Discharge to Community (DTC)** and **Medicare Spend Per Beneficiary (MSPB)**.
- Data is for these measures stratified. Stratification involves the calculation of certain outcomes separately for different populations. Stratified measure outcomes can provide valuable insight on how different patient populations perform on a given measure.
- The PAC Health Equity Confidential Feedback Reports will stratify the DTC and MSPB measures by dual-enrollment status and race/ethnicity.

Health Equity Confidential Feedback Reports

- For each of the comparisons, your facility/agency will receive a categorization to describe whether your patient populations are performing statistically significantly "Better than," "No different from," or "Worse than" the following comparison groups.
- **ACROSS-PROVIDER COMPARISONS**
  - COMPARISON TO THE NATIONAL PERFORMANCE AMONG ALL PATIENTS: Compares the measure outcome for your facility/agency's patient population to the national performance across all patients in your care setting. (e.g., your SNF's duals' DTC rate versus the national DTC rate across all SNF patients).
  - COMPARISON TO THE NATIONAL PERFORMANCE AMONG THE SAME POPULATION: Compares the measure outcome for your facility/agency's patient population to the national performance among the same population in your care setting. (e.g., your SNF's duals' DTC rate versus the national DTC rate among all duals in SNF's nationwide).

Health Equity Confidential Feedback Reports

- **WITHIN-PROVIDER COMPARISONs**
  - Compare measure outcomes between patient populations within the same facility/agency. (e.g., your SNF's duals' DTC rate versus your SNF's non-duals' DTC rate).
- **Measure performance period for Fall 2023 reports**: Fiscal Year (FY) 2021-2022.
- Health Equity Confidential Feedback Reports will be updated annually.
- Medicare Part A and B claims are used to calculate measure outcomes and conduct risk-adjustment.

Health Equity Confidential Feedback Reports

Table 1- Comparison Against the National Rate for All Patients (Summary): Shows how the average DTC and MSPB Amounts for your patient populations differ from the national average DTC and MSPB Amount for all patients in your care setting.

Population	Difference from National Rate
Dual	Worse Outcome than National Rate
Non-Dual	Outcome is No Different than National Rate
White	Outcome is No Different than National Rate
Non-White*	Worse Outcome than National Rate
AA and NHPI	Better Outcome than National Rate
Black	Worse Outcome than National Rate
Hispanic	Worse Outcome than National Rate

CMS Health Equity I Confidential Feedback Reports fall 2023 Webinar

Health Equity Confidential Feedback Reports

Table 2 - Patient Composition at Your Facility and Similar Geographic Locations: Provides your patient composition (dual non-dual, white, non-white) and the patient composition (dual non-dual, white, non-white) among facilities in similar geographic locations as you.

Population	Your Facility	Same Rural/ Urban Location	Your CBSA	Your State	Your Region	National
		Urban	Washington-Arlington-Alexandria, DC-VA-MD-WV	District of Columbia	South Atlantic	
Total Number of Stays	300	72,00	5,000	3,200	17,300	97,500
Dual	20.0%	13.0%	20.0%	25.0%	21.0%	35.0%
Non-Dual	80.0%	87.0%	80.0%	75.0%	79.0%	65.0%
White	43.0%	80.0%	43.0%	82.0%	80.0%	68.0%
Non-White	57.0%	20.0%	57.0%	18.0%	20.0%	31.0%
AA and NHPI	11.0%	7.0%	11.0%	5.0%	8.0%	2.0%
Black	24.0%	7.0%	24.0%	9.0%	9.0%	20.0%
Hispanic	17.0%	5.0%	17.0%	3.0%	2.0%	7.0%

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Table 3 - Comparison of Performance Against the National Rate for All Patients (Detail): Shows the average MSPB Amount and DTC rates for Patients at Your Facility, Compared to All Patients Nationwide.

Population		DTC Rate	Performance Relative to National Rate		
			Difference (Your Facility - National Rate)	Confidence Interval	Category of the Difference
Comparison Points (All Patients)	National Rate	20.00%	--	--	--
	90th Percentile Facility	28.00%	--	--	--
Your Facility	Dual	10.00%	-10.00%	[-13.00%, -7.00%]	Worse Outcome than National Rate
	Non-Dual	17.00%	-3.00%	[-7.00%, 1.00%]	Outcome is No Different than National Rate
	White	16.00%	-4.00%	[-10.00%, 2.00%]	Outcome is No Different than National Rate
	Non-White	13.00%	-7.00%	[-10.00%, -3.00%]	Worse Outcome than National Rate
	AA and NHPI	27.00%	7.00%	[6.00%, 8.00%]	Better Outcome than National Rate
	Black	12.00%	-8.00%	[-12.00%, -4.00%]	Worse Outcome than National Rate
	Hispanic	6.00%	-14.00%	[-20.00%, -8.00%]	Worse Outcome than National Rate

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Table 4 - Comparison against the National Rate among Patients of the Same Population: Compares the average MSPB Amount and DTC rate of each of your patient populations with their national average amount.

Population	DTC Rate		Performance Relative to National Rate among the Same Population		
	Your Facility	National Rate	Difference (Your Facility - National Rate)	Confidence Interval	Category of the Difference
Dual	10.00%	19.00%	-9.00%	[-11.00%, -7.00%]	Worse Outcome than National Rate for Dual Patients
Non-Dual	17.00%	20.00%	-3.00%	[-6.00%, 0.00%]	Outcome is No Different than National Rate for Non-Dual Patients
White	16.00%	22.00%	-6.00%	[-13.00%, 1.00%]	Outcome is No Different than National Rate for White Patients
Non-White	13.00%	18.00%	-5.00%	[-12.00%, 2.00%]	Outcome is No Different than National Rate for Non-White Patients
AA and NHPI	27.00%	21.00%	6.00%	[-2.00%, 14.00%]	Outcome is No Different than National Rate for AA and NHPI Patients
Black	12.00%	5.00%	7.00%	[-4.00%, 18.00%]	Outcome is No Different than National Rate for Black Patients
Hispanic	6.00%	19.00%	-13.00%	[-27.00%, 1.00%]	Outcome is No Different than National Rate for Hispanic Patients

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Tables 5 and 6 - Within-Facility Comparison: Show the differences in Average MSPB Amount and DTC rates Within Your Facility for both Dual Status and Race/Ethnicity characteristics.

Table 5

	DTC Rate		Difference in DTC Rate		
	Duals	Non-Duals	Difference (Duals – Non-Duals)	Confidence Interval	Category of the Difference
National Rate	19.00%	20.00%	-1.00%	--	--
Your Facility	10.00%	17.00%	-7.00%	[-11.00%, -4.00%]	Worse Outcome for Dual Patients at Your Facility

Table 6

	DTC Rate		Difference in DTC Rate		
	Non-White	White	Difference (Non-White – White)	Confidence Interval	Category of the Difference
National Rate	18.00%	22.00%	-4.00%	--	--
Your Facility	13.00%	16.00%	-3.00%	[-7.00%, 1.00%]	Outcomes are No Different for Non-White and White Patients at Your Facility

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Table 7 - Patient Outcomes among Facilities in Similar Geographic Location: Provides the average MSPB Amount and DTC rates of your patient populations and the average MSPB Amount and DTC rates for the same populations among patients in similar geographic locations.

Population	Your Facility	Your Rural/ Urban Location Category	Your CBSA	Your State	Your Region	National
Dual	10.00%	17.00%	10.00%	13.00%	11.00%	19.00%
Non-Dual	17.00%	18.00%	17.00%	23.00%	16.00%	20.00%
White	16.00%	15.00%	16.00%	19.00%	21.00%	22.00%
Non-White	13.00%	12.00%	13.00%	15.00%	10.00%	18.00%
AA and NHPI	27.00%	20.00%	27.00%	19.00%	23.00%	21.00%
Black	12.00%	6.00%	12.00%	11.00%	7.00%	5.00%
Hispanic	6.00%	11.00%	6.00%	20.00%	15.00%	19.00%

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Table 8 - Patient Outcomes among Facilities with Similar Patient Composition: Provides the average MSPB Amount and DTC rates of your patient populations and the average MSPB Amount and DTC rates for the same populations among patients at facilities with similar patient composition. (Risk brackets (1-10) are calculated based on your average expected DTC rate across all your stays, and average expected MSPB amount across all your episodes, as predicted through risk adjustment.)

Population	Your Facility	Facilities with:			National
		Same Risk Bracket: Bracket #3	Similar Proportion of Duals	Similar Proportion of Non-White Patients	
Dual	10.00%	11.00%	9.00%	13.00%	19.00%
Non-Dual	17.00%	16.00%	19.00%	17.00%	20.00%
White	16.00%	16.00%	21.00%	18.00%	22.00%
Non-White	13.00%	12.00%	8.00%	10.00%	18.00%
AA and NHPI	27.00%	25.00%	19.00%	29.00%	21.00%
Black	12.00%	9.00%	8.00%	12.00%	5.00%
Hispanic	6.00%	5.00%	13.00%	6.00%	19.00%

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Conclusion

- Health equity and Social determinants of health are now embedded into CMS' expectations for how we care for our residents.
- New MDS items have been added to begin the conversation, don't ignore them!
- New Quality measures for both SNF QRP and SNF VBP are also resident focused and can be used to address SDOH and Health Equity.
- Include a focus on SDOH and Health Equity in your CAAs, care pathway development and discharge planning (ex. social isolation in CAA 4, 5, 7 and 18).
- Consider that this is a significant opportunity to approach our residents from a new perspective.
- Spend some time with your confidential feedback reports.

QUESTIONS?