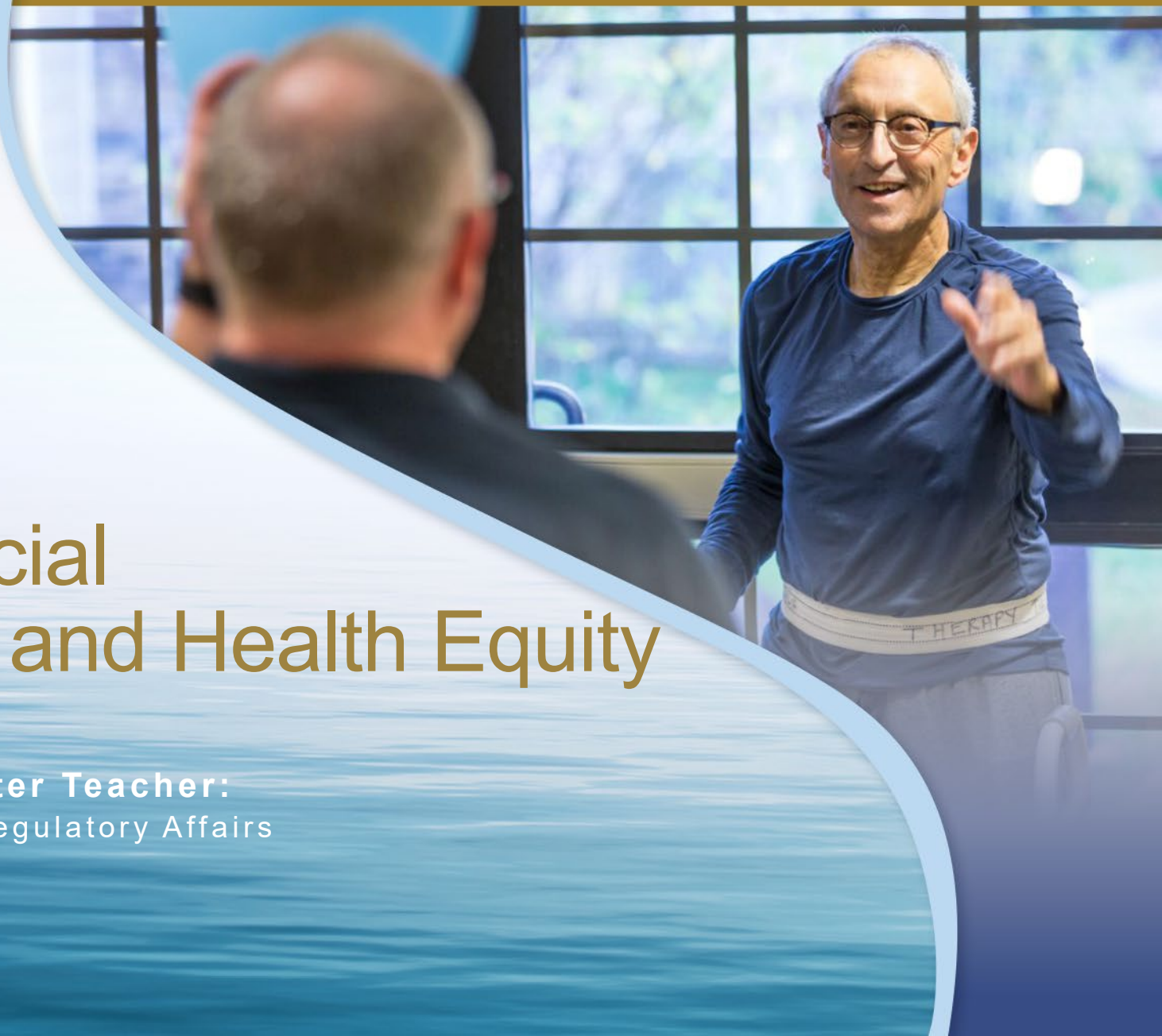
"A ***Knowledgeable*** and ***Compassionate*** partner"



BROAD RIVER REHAB

An IDT Approach to Social Determinants of Health and Health Equity

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Social Determinants of Health and health Equity

Agenda

Agenda

- Definitions
- Relevance to SNFs, Person Centered Engagement
- QRP and Health Equity
- QRP and Social Determinants of Health
- VBP Health Equity and Health Literacy
- More about Health Literacy and health Equity
- Q&A

Definitions:

- **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.

Source: World Health Organization

Definitions:

- 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.

Source: World Health Organization

Why These Concepts are Important

- **Person Centered Engagement:**
  - A person-centered approach considers the individual as multifaceted, not merely as a “receiver” of services.
  - This approach demands that providers and individuals share power and responsibility in goal setting, decision-making, and care management.
  - It also requires giving people access to understandable information and decision support tools to equip them and their families with the information to manage their health and wellness, navigate the full span of the health care delivery system, and **make their own informed choices about care.**

Source: CMS

RFI - Health Equity Data Considerations

- CMS believes that a focused health equity measure would provide specific equity data that will help providers develop innovative and targeted interventions for impacted groups and would additionally provide transparency for beneficiaries.
- They also believe that by leveraging measures to give providers access to disparity information, they would be able to use this data to make informed decisions about their quality improvement initiatives.
- In the FY 2023 Proposed Rule, CMS has sought stakeholder feedback related to Health Equity measures to be included in both the **SNF QRP and VBP** programs**.**

RFI-CoreQ Survey Instrument

- In this year's proposed rule, CMS is requesting stakeholder feedback on the inclusion of the CoreQ: Short Stay Discharge measure in the SNF QRP in future program years, including whether there are any challenges or impacts we should consider for a potential future proposal.
- The CoreQ survey instrument is used to assess the level of satisfaction among SNF patients.

CoreQ Specifics

The CoreQ: Short Stay Discharge Measure calculates the percentage of individuals discharged in a six-month period from a SNF, within 100 days of admission, who are satisfied with their SNF stay.

This patient-reported outcome measure is based on the CoreQ: Short Stay Discharge questionnaire that utilizes four items:

1. In recommending this facility to your friends and family, how would you rate it overall;
2. Overall, how would you rate the staff;
3. How would you rate the care you receive;
4. How would you rate how well your discharge needs were met.

The CoreQ questionnaire uses a 5-point Likert Scale:

Poor (1); Average (2); Good (3); Very Good (4); and Excellent (5).

Why is CoreQ's addition an important consideration for QRP?

- SNF QRP furthers CMS's mission to improve the quality of healthcare for beneficiaries through measurement, transparency and public reporting of data. The SNF QRP and CMS's other quality programs are foundational for contributing to improvements in healthcare, enhancing patient outcomes and informing consumer choice.
- In October 2017, CMS launched the Meaningful Measures Framework. This framework captures their vision to address healthcare quality priorities and gaps, including emphasizing digital quality measurement, reducing measurement burden, and promoting patient perspectives, while also focusing on modernization and innovation.
- **Meaningful Measures 2.0 builds on the initial framework by establishing a goal of increasing Patient Reported Outcomes Measures (PROMs) by 50%.**

What is Meaningful Measures 2.0

- Collection of patient experience data aligns **with the person-centered care domain of CMS's Meaningful Measures 2.0 Framework** and addresses an aspect of patient experience that is not currently included in the SNF QRP.

- CMS believes collecting and assessing satisfaction data from SNF patients is important for understanding **patient experiences and preferences**, while ensuring the patient can easily and discretely share their information and provide information to help consumers choose a trusted SNF.

Patient Reported Outcomes

- Patient Reported Outcome (PRO) is any report of the status of a patient's health condition or health behavior that comes directly from the patient, without interpretation of the patient's response by a clinician or anyone else.
- Therefore, they are an important component of assessing whether healthcare providers are improving the health and well-being of patients.

Proposed New QRP Measures

Skilled Nursing Facility Quality Reporting Program (SNF QRP) update

- In addition, CMS is proposing to revise the compliance date for the collection of the Transfer of Health (TOH) Information to the Provider-PAC measure, the TOH Information to the Patient-PAC measure, and certain **standardized patient assessment data elements** from October 1st of the year that is at least 2 full fiscal years after the end of the COVID-19 PHE to October 1, 2023.
- CMS believes this date is sufficiently far in advance for SNFs to make the necessary preparations to begin reporting these data elements and the TOH Information measures and that the need for the standardized patient assessment data elements and TOH Information measures have been shown to be even more pressing with issues of health inequities, exacerbated by the COVID-19 PHE.
- **MDS 3.0 v1.18.11**

SNF QRP Proposals (TOH)

New QRP Measures	Revised MDS Section A
Transfer of Health Information to the Provider–Post-Acute Care (PAC); assesses for the timely transfer of health information, specifically a reconciled medication list. This measure evaluates for the transfer of information when a patient is transferred or discharged from their current setting to a subsequent provider	New items at A2105, A2121, A2122 have been added to accommodate this QRP measure.

SNF QRP Proposals (TOH)

- Health information, such as medication information, that is incomplete or missing increases the likelihood of a patient/resident safety risk, often life-threatening.
- Poor communication and coordination across health care settings contributes to patient complications, hospital readmissions, emergency department visits, and medication errors.
- Communication has been cited as the third-most-frequent root cause in sentinel events, which The Joint Commission defines as a patient safety event that results in death, permanent harm, or severe temporary harm.
- Failed or ineffective patient handoffs are estimated to play a role in 20 percent of serious preventable adverse events.
- When care transitions are enhanced through care coordination activities, such as expedited patient information flow, these activities can reduce duplication of care services and costs of care, resolve conflicting care plans, and prevent medical errors.

SNF QRP Proposals (TOH)

A2105. Discharge Status
Complete only if A0310F = 10, 11, or 12

Enter Code	
☐☐	01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)
	02. **Nursing home** (long-term care facility)
	03. **Skilled Nursing Facility** (SNF, swing bed)
	04. **Short-term general hospital** (acute hospital, IPPS)
	05. **Long-Term Care Hospital** (LTCH)
	06. **Inpatient rehabilitation facility** (IRF, free standing facility or unit)
	07. **Inpatient psychiatric facility** (psychiatric hospital or unit)
	08. **Intermediate care facility** (ID/DD facility)
	09. **Hospice** (home/non-institutional)
	10. **Hospice** (institutional facility)
	11. **Critical Access Hospital** (CAH)
	12. **Home under care of organized home health service organization**
	13. **Deceased**
	99. **Not Listed**

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge
At the time of discharge to another provider, did your facility provide the resident's current reconciled medication list to the subsequent provider?

Enter Code	
☐	0. **No** – Current reconciled medication list not provided to the subsequent provider
	1. **Yes** – Current reconciled medication list provided to the subsequent provider

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider
Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.

Route of Transmission	Check all that apply ↓
A. **Electronic Health Record**	☐
B. **Health Information Exchange Organization**	☐
C. **Verbal** (e.g., in-person, telephone, video conferencing)	☐
D. **Paper-based** (e.g., fax, copies, printouts)	☐
E. **Other Methods** (e.g., texting, email, CDs)	☐

SNF QRP Proposals (TOH)

Transfer of Health Information to the Patient–Post-Acute Care (PAC). This proposed measure assesses for and reports on the timely transfer of health information, i.e., a current reconciled medication list, to the patient/resident when discharged from their current setting of post-acute care	New items at A2105, A2123, 2124 have been added to accommodate this QRP measure.

SNF QRP Proposals (TOH)

- The communication of health information, such as a reconciled medication list, is critical to ensuring safe and effective patient transitions from health care settings to home and other community settings.
- Incomplete or missing health information, such as medication information, increases the likelihood of a patient safety risk, often life-threatening.
- Individuals who use PAC settings are particularly vulnerable to adverse health outcomes because of their higher likelihood of multiple comorbid chronic conditions, polypharmacy, and complicated transitions between care settings.
- Upon discharge to home, individuals in PAC settings may be faced with numerous medication changes, new medication regimes, and follow-up details.
- The efficient and effective communication and coordination of medication information may be critical to prevent potentially deadly adverse effects.
- When care coordination activities enhance care transitions, these activities can reduce duplication of care services and costs of care, resolve conflicting care plans, and prevent medical errors.

SNF QRP Proposals (TOH)

A2105. Discharge Status
Complete only if A0310F = 10, 11, or 12

Enter Code	
☐☐	01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) 02. **Nursing home** (long-term care facility) 03. **Skilled Nursing Facility** (SNF, swing bed) 04. **Short-term general hospital** (acute hospital, IPPS) 05. **Long-Term Care Hospital** (LTCH) 06. **Inpatient rehabilitation facility** (IRF, free standing facility or unit) 07. **Inpatient psychiatric facility** (psychiatric hospital or unit) 08. **Intermediate care facility** (ID/DD facility) 09. **Hospice** (home/non-institutional) 10. **Hospice** (institutional facility) 11. **Critical Access Hospital** (CAH) 12. **Home under care of organized home health service organization** 13. **Deceased** 99. **Not Listed**

A2123. Provision of Current Reconciled Medication List to Resident at Discharge
At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver?

Enter Code	
☐	0. **No** – Current reconciled medication list not provided to the resident, family and/or caregiver 1. **Yes** – Current reconciled medication list provided to the resident, family and/or caregiver

A2124. Route of Current Reconciled Medication List Transmission to Resident
Indicate the route(s) of transmission of the current reconciled medication list to the resident/family/caregiver.

Route of Transmission	Check all that apply ↓
A. Electronic Health Record (e.g., electronic access to patient portal)	☐
B. Health Information Exchange Organization	☐
C. Verbal (e.g., in-person, telephone, video conferencing)	☐
D. Paper-based (e.g., fax, copies, printouts)	☐
E. Other Methods (e.g., texting, email, CDs)	☐

SNF QRP Proposals (SDOH)

- **The IMPACT Act** requires CMS to develop, implement, and maintain standardized patient assessment data elements (SPADEs) for PAC settings. The four PAC settings specified in the IMPACT Act are HHAs, IRFs, LTCHs, and SNFs. 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 these assessment instruments be modified to include core data elements on health assessment categories and that such data be standardized and interoperable. Implementation of a core set of standardized assessment items across PAC settings has important implications for Medicare beneficiaries, families, providers, and policymakers. B

SNF QRP Proposals (SDOH)

- In the FY 2020 Final Rule, CMS has finalized standardized patient assessment data elements, or SPADEs, to be reported with SNF admissions and discharges 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 co-morbidities** (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.

SNF QRP Proposals (SDOH)

- SPADES
  - 3 SPADEs for Cognitive Function.
  - 15 SPADEs to Assess for Special Services, Treatments, and Interventions.
  - 1 SPADE to Assess for Medical Conditions and Co-Morbidities.
  - 2 SPADEs to Assess for Impairments
  - 7 SPADEs to assess for a new category: Social Determinants of Health
- **Social Determinants of Health:** CMS has identified data elements for cross-setting standardization of assessment for seven social determinants of health (SDOH). The data elements are as follows:
  - 1.Race, 2. Ethnicity, 3. Preferred Language, 4. Interpreter Services, 5. Health Literacy, 6. Transportation, 7. Social Isolation

SNF QRP Proposals (SDOH)

SPADEs to assess for a new category: Social Determinants of Health	Revised MDS Sections A, B and D
Race and Ethnicity	New MDS items at A1005 and A1010 have been added to determine more specifically a resident's ethnicity and race.

- The persistence of racial and ethnic disparities in health and health care is widely documented, including in PAC settings.
- Although racial and ethnic disparities decrease when social factors are controlled for, they often remain.
- The root causes of these disparities are not always clear because data on many SDOH are not collected.
- Measuring SDOH in SNF settings is an important step to addressing these avoidable differences in health outcomes. Collecting data on race and ethnicity supports patient-centered care and informs understanding of patient complexity and risk factors that may affect payment, quality measurement, and care outcomes for SNFs.
- Improving how race and ethnicity data are collected is an important component of improving quality by identifying and addressing health disparities that affect Medicare beneficiaries.

SNF QRP Proposals (SDOH)

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, or Spanish origin
☐	**X.** Resident unable to respond

SNF QRP Proposals (SDOH)

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

SNF QRP Proposals (SDOH)

Preferred Language and Interpreter Services	New items at A1110 have been added to more specifically determine a resident's preferred language and whether he or she needs or wants an interpreter.

- More than 64 million people in the United States speak a language other than English at home, and nearly 40 million of those individuals have limited English proficiency (LEP).
- Individuals with LEP have been shown to receive worse care and have poorer health outcomes, including higher readmission rates. Communication with individuals with LEP is an important component of quality health care, which starts by understanding the population in need of language services.
- Unaddressed language barriers between a patient and provider care team negatively affect the ability to identify and address individual medical and non-medical care needs, to convey and understand clinical information, and to convey and understand discharge and follow-up instructions, all of which are necessary for providing high-quality care.

SNF QRP Proposals (SDOH)

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

SNF QRP Proposals (SDOH)

Health Literacy	New items at B1300 have been added to help determine the resident's health literacy, which is how often he or she needs to have help when reading written material provided by a doctor or pharmacy. New MDS item B1320 has been added to assess for health literacy on discharge.

- Similar to language barriers, low health literacy can interfere with communication between the provider and resident or patient and the ability for residents and patients or their caregivers to understand and follow treatment plans, including medication management.
- Poor health literacy is linked to lower levels of knowledge about health, worse health outcomes, receipt of fewer preventive services, higher medical costs, and higher rates of emergency department use.

SNF QRP Proposals (SDOH)

B1300. Health Literacy

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

Enter Code	
☐	0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 8. Resident unable to respond

SNF QRP Proposals (SDOH)

Transportation	New MDS items at A1250 have been added to assess for whether a lack of transportation has kept a resident from medical appointments, meetings, work, or from getting things needed for daily living. New MDS items at A1270 have been added to assess for this on discharge.

- Transportation barriers commonly affect access to needed health care, causing missed appointments, delayed care, and unfilled prescriptions, all of which can have a negative impact on health outcomes.
- Access to transportation for ongoing health care and medication access needs, particularly for those with chronic diseases, is essential to successful chronic disease management.
- Adopting a data element to collect and analyze information regarding transportation needs across PAC settings will facilitate the connection to programs that can address identified needs.

SNF QRP Proposals (SDOH)

A1250. Transportation Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?	
↓	**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**

SNF QRP Proposals (SDOH)

Social Isolation	New MDS items at D0700 have been added to assess for social isolation, that is how often a resident feels lonely or isolated from persons around them. New MDS items at D0720 have been added to assess for this on discharge.

- Distinct from loneliness, social isolation refers to an actual or perceived lack of contact with other people, such as living alone or residing in a remote area.
- Social isolation tends to increase with age, is a risk factor for physical and mental illness, and is a predictor of mortality.
- PAC providers are well-suited to design and implement programs to increase social engagement of patients and residents while accounting for individual needs and preferences.
- Adopting a data element to collect and analyze information about social isolation in SNFs and across PAC settings would facilitate the identification of residents and patients who are socially isolated and who may benefit from engagement efforts.

SNF QRP Proposals (SDOH)

D0700. Social Isolation How often do you feel lonely or isolated from those around you?	
Enter Code ☐	0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 8. Resident unable to respond

Request for Comment on a SNF VBP Program Approach to Measuring and Improving Health Equity

- As CMS continues assessing the **SNF VBP** Program's policies in light of its operation and its expansion as directed by the Consolidated Appropriations Act, CMS requests public comments on policy changes that they should consider on the topic of **health equity**.
- CMS specifically requests comments on whether they should consider incorporating adjustments into the **SNF VBP** Program to reflect the varied patient populations that SNFs serve around the country and **tie health equity outcomes to SNF payments under the Program**.
- These adjustments could occur at the measure level in forms such as stratification (for example, based on dual status or other metrics) or **including measures of social determinants of health (SDOH)**.
- These adjustments could also be incorporated at the scoring or incentive payment level in forms such as modified benchmarks, points adjustments, or modified incentive payment multipliers (for example, peer comparison groups based on whether the facility includes a high proportion of dual eligible beneficiaries or other metrics).
- CMS requests commenters' views on which of these adjustments, if any, would be most effective for the **SNF VBP** Program at accounting for any health equity issues that CMS may observe in the SNF population.

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

- **Value Based Purchasing Expansion with QRP Measures**
  - CMS is also proposing to adopt an additional quality measure for the SNF VBP Program beginning with the FY 2027 program year:
    - Discharge to Community (DTC) – Post-Acute Care (PAC) Measure for Skilled Nursing Facilities (NQF #3481).

Revised QRP Measures	Revised MDS Section A
Discharge to Community–Post Acute Care (PAC); assesses successful discharge to the community from a PAC setting, with successful discharge to the community including no unplanned rehospitalizations and no death in the 31 days following discharge. This measure has been revised to exclude baseline NF residents or Residents who had a long-term NF stay in the 180 days preceding their hospitalization and SNF stay, with no intervening community discharge between the long-term NF stay and qualifying hospitalization.	New MDS items at A1805 and A2105 have been added to assess for where a resident entered from and the resident's discharge status to accommodate more specifically this revised QRP measure exclusion of baseline NF residents.

Health Literacy Defined

- The U.S. Department of Health and Human Services (HHS) defines health literacy as “the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions
- Health literacy challenges may impact older adults more than other age groups. On average, adults age 65 and older have lower health literacy than adults under the age of 65. Low health literacy among older adults is associated with increased reports of poor physical functioning, pain, limitations of daily activities, poor mental health status

Prevalence of Limited health Literacy

POPULATION SUBGROUP	PREVALENCE
Race/ethnicity	
White	28%
Asian/Pacific Islander	31%
American Indian/Alaska Native	48%
African-American	58%
Hispanic	66%
Age (years)	
19–24	31%
25–39	28%
40–49	32%
50–64	34%
65+	59%

Methods to Improve Literacy

- Improvements in health practice that address low health literacy are needed to reduce disparities in health status.
- As limited health literacy is common and may be difficult to recognize, “experts recommend that practices assume all patients and caregivers may have difficulty comprehending health information and should communicate in ways that anyone can understand.”
- Examples include:
- Simplifying communication; confirming comprehension for all patients to minimize risk of miscommunication; making the health care system easier to navigate; and supporting patient’s efforts to improve their health.

More on Health Equity

- **Health equity** means the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes. CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our enrollees need to thrive.

National Quality Strategy

- **Embed Quality into the Care Journey**
- **Advance Health Equity**
- **Foster Engagement**
- **Promote Safety**
- **Strengthen Resilience**
- **Embrace the Digital Age**
- **Incentivize Innovation & Technology**
- **Increase Alignment**

National Quality Strategy and Health Equity

- **Advance Health Equity:** Address the disparities, structural racism, and injustices that underlie our health system, both within and across settings, to ensure equitable access and care for all.

Broad River Rehab Memory Lane Program

- Program Information Sharing
- The “All About Me” Autobiographical Questionnaire
- Treatment List Task
- Video Share

Conclusion

- Social Determinants of Health and Health Equity are concepts that we need to adap to I our SNF communities.
- CMS has been clear that the path forward is to measure these issues through the SNF QRP and VBP programs tying SNF adaptation to payment
- Better adaptation leads to better outcomes.
- Health literacy is a start. Identifying disparities tied to social determinants of health will create a roadmap for the consumer of healthcare that they can navigate for successful engagement related to their unique healthcare needs.
- Get prepared by engaging these concepts as they are adopted in the SNF QRP and VBP programs. MDS v1.18.11 is on its way! The FY 2023 Final Rule will be here in August.

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- Final Specifications for SNF QRP Quality Measures and Standardized Patient Assessment Data Elements (SPADEs), https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/Final-Specifications-for-SNF-QRP-Quality-Measures-and-SPADEs.pdf
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QUESTIONS?

Find Out More

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