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AAAs: Hub for Community Supports Addressing Social Determinants of Health

The case for effective identification and treatment of Malnutrition Risk

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AGENDA

- Payment frameworks now target Social Determinants of Health (SDOH)
- Current and changing health care landscape in Maryland
- Malnutrition's impact on healthcare cost
- How do AAAs own the mission of being the community hub – tools we will provide you to take charge

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Social Determinants of Health

- Definition of SDOH/HRSN
- SDOH screening and coding
  - ICD-10 SDOH codes - Z55-z65
- Screening tools

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Federal Legislation

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Chronic Care Act 2018

- Bipartisan Act that Congress passed On February 11, 2018
- New federal law advancing integrated, person-centered care for Medicare & dually-eligible beneficiaries
- Medicare Advantage Plans and their role

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Key Medicare Advantage & SNP* Provisions

- Expands supplemental benefits & continues VBID demonstration for chronically ill MA enrollees
- Permanently authorizes D-SNP, C-SNP, & I-SNP
- Promotes additional integrated care in D-SNPs
- Updates C-SNPs care management requirements & condition list (e.g., HIV/AIDS, ESRD, & mental illness)
- Expands tele-health access

*SNP = Special Needs Plans

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Types of Covered Services

- Adult Day Services
- In-Home Support Services
- Support for Caregivers of Enrollees
- Home and Bathroom Safety Devices and Modifications
- Transportation

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Opportunities

- Focus on health beyond medical care
- Craft new partnerships to address SDOH

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Centers for Medicare and Medicaid

- HHS spends over $1 trillion a year on healthcare for the elderly and vulnerable through Medicare and Medicaid
- In 2018 CMMI launched the Accountable Health Communities model to address the human needs that may be impacting high utilizers of healthcare
- Screenings for
  - Food insecurity
  - Domestic violence risk
  - Transportation
  - Housing and utility needs

Needs assessed : connect with community resources- pay for services

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Healthcare Influencers

& Social Determinants of Health

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American Medical Association

- Integrating training on SDOH in undergraduate medical school education
- Incorporating lifestyle medicine in medical school adopted by AMA house of delegates (USC Greenville)
- Implemented training module for providers in addressing SDOH in their practices (Steps Forward)
  - Six common domains
    - Economic stability
    - Neighborhood
    - Food
    - Education
    - Community/social support
    - Healthcare system

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American Hospital Association

- Task force to improve access and delivery of care to address SDOH (www.aha.org/ensuringaccess)
- Identified 3 ways for hospitals to engage
    - Screening and information
    - Navigation
    - Alignment
- Community conversations Toolkit for hospitals
- CMS 10 question screening tool for SDOH across 5 key domains

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Maryland Healthcare

Current and changing health care landscape

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State of Maryland Landscape

- Medicaid Service delivery (MCOs)
- Medicaid community services
- Role of Maryland Access Point (MAP)
- Maryland Primary Care Program (MDPCP)

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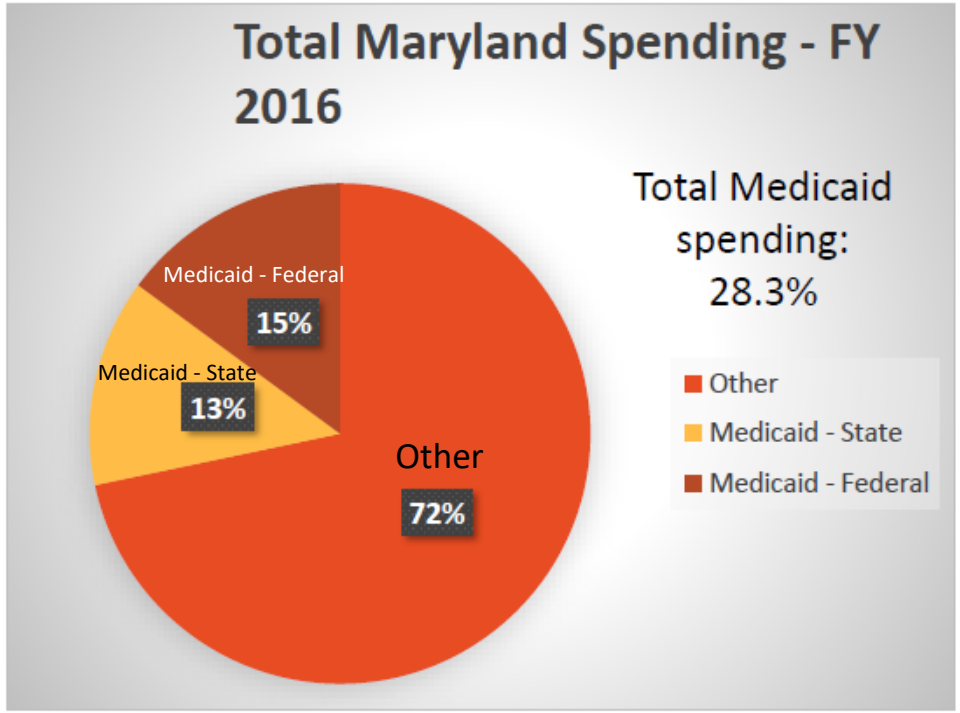
Medicaid



Maryland Medicaid's high cost areas (FY2017):

- Institutional LTSS (7.8% of enrollees)
- Hospital
- Home and community based LTSS

- In 2018, approx. 1.3 million people enrolled in Medicaid (including CHIP)
- 81.5% of enrolled beneficiaries are in Managed Care Organizations (MCOs)

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Maryland Access Point (MAP)

- Single point of entry for access to services of state agencies (https://md.getcare.com)
- 20 MAP sites in Maryland
- Funding sources are Title II and Title III
- Title III funding is for all persons 60 years and over and means testing is prohibited
  - MAP is the Aging and Disability Resource Program in Maryland. The ADRC initiative is sponsored by the federal Administration for Community Living, the Centers for Medicare and Medicaid Services and the Department of Veterans Affairs, and involves a national network operating in 54 states and territories
  - MAP is a centralized, single point of entry for anyone – individuals, concerned families or friends, or professionals – to access aging and disability programs and services provided by state agencies and private, public and community-based organizations

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Major MAP Funding Sources

Medicaid FFP
State, Local Funds, Grants, Contracts

Older Americans Act: Title IIIB	
I & A	Supportive Services: Case Management Chore Services Personal Care Homemaker

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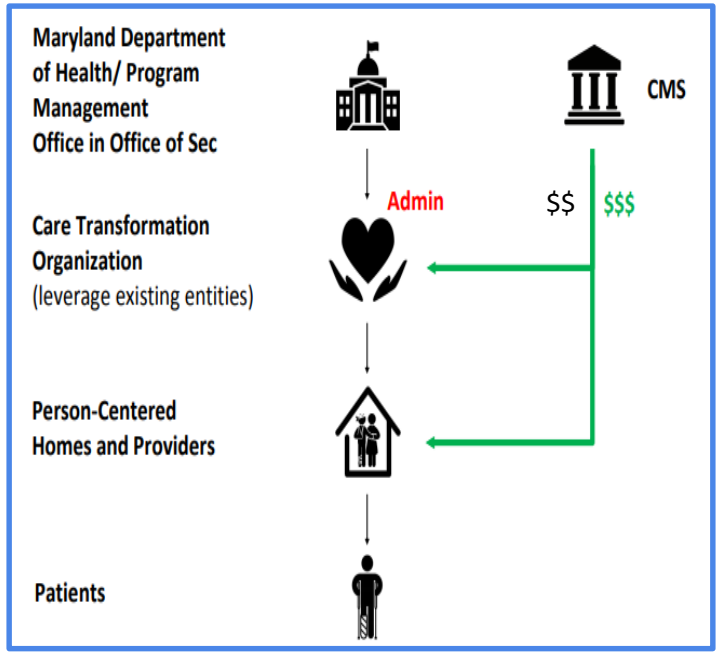
MDPCP

- Supports overall health care transformation process.
- Allows primary care providers to play an increased role in prevention, management of chronic disease, and preventing unnecessary hospital utilization.
- Voluntary program and open to all eligible primary care providers.
- Practices enrolled in the program are supported by Care Transformation (CTO) organizations and state practice coaches.
- Practices and CTO are provided additional $$ per beneficiary attributed in addition to fee for service



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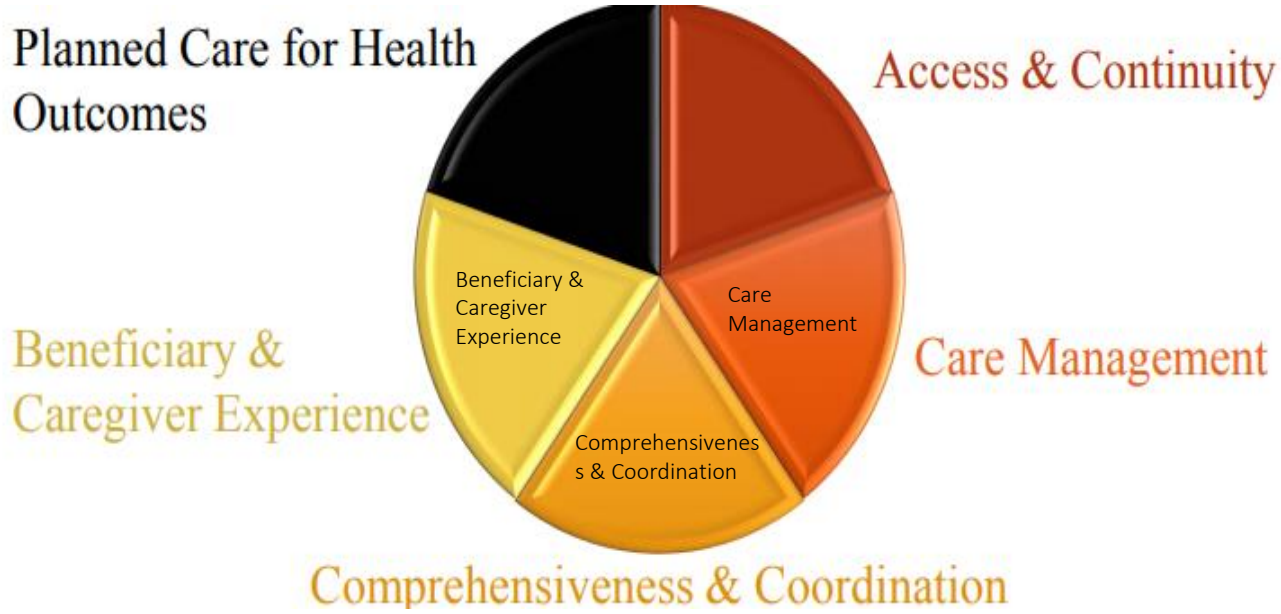
MDPCP

- Five Pillars of MDPCP
- Use of CRISP is mandatory



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Malnutrition

Impact on healthcare cost

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Malnutrition

What is Malnutrition?

- Malnutrition is the inadequate intake of nutrients, particularly protein, over time and may contribute to chronic illness and acute disease or illness and infection

Impact of Malnutrition

- Frailty
- Disability
- Loss of independence
- Increased risk for falls
- Increased risk for infections
- Delayed wound healing
- Increased medical complications for other other diseases
- Hospital readmissions
- Increased length of stay
- Decreased effectiveness of medical treatment

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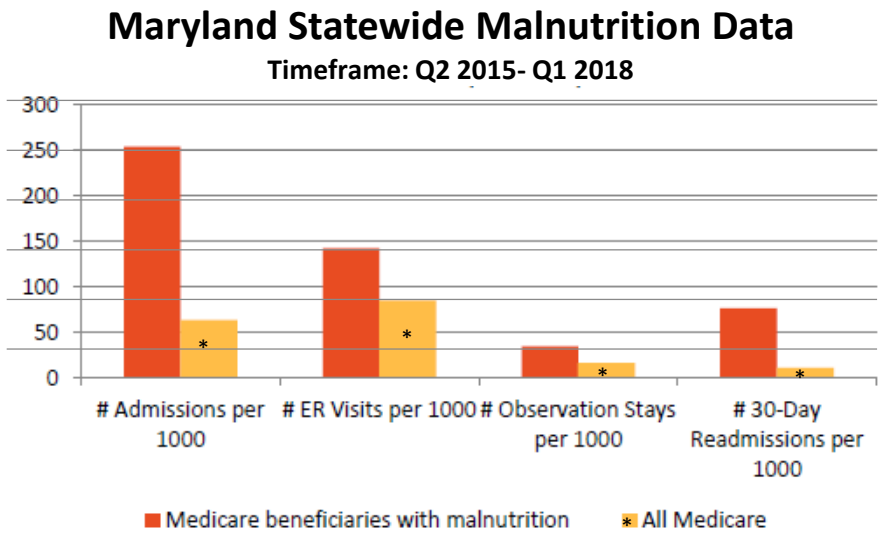
Prevalence of Malnutrition in Care Settings

- Acute care
  - 20-50% of all patients are at risk for or are malnourished at the time of hospital admission (1)
  - Only 7% of patients are typically diagnosed with malnutrition during their hospital stay (2)
- Post-Acute care
  - 14- 51% of seniors are malnourished
- Community
  - Estimated 6-30% of seniors are malnourished

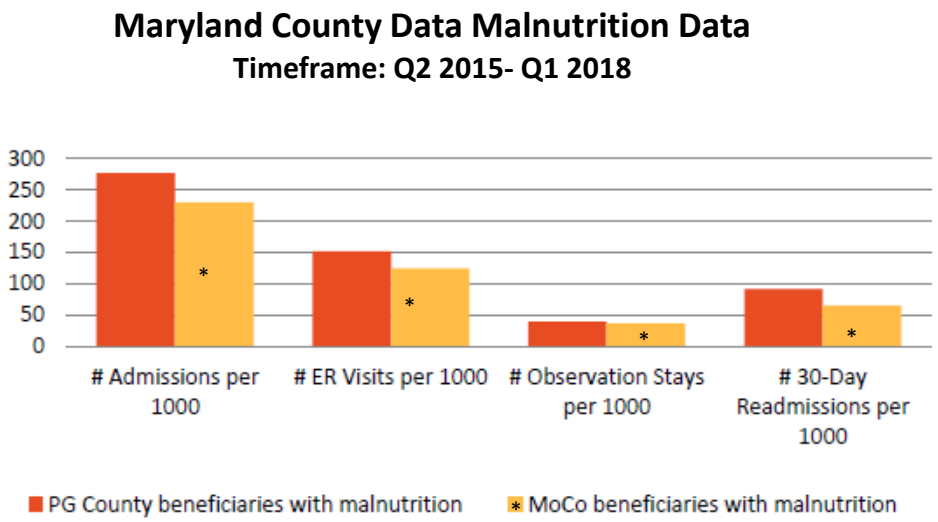
1 Barker LA, Gout BS, Crowe TC. Hospital malnutrition: Prevalence, identification, and impact on patients and the healthcare system. Int J Environ Res Public Health. 2011;8:514-527.
2 Weiss AJ, Fingar KR, Barrett ML, Elixhauser A, Steiner CA, Guenter P, Brown MH. Characteristics of hospital stays involving malnutrition, 2013. HCUP Statistical Brief #210. Rockville, MD: Agency for Healthcare Research and Quality. Available at: http://www.hcup-us.ahrq. gov/reports/statbriefs/sb210-MalnutritionHospital-Stays-2013.pdf.

Local Prevalence of Malnutrition

Maryland Malnutrition Data



County Specific Malnutrition Data



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Malnutrition Risk Factors

- Clinical- Diagnosed by physicians, NPs and PAs
- Social- Diagnosed by care managers, nurses, support care personnel

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The Role of the AAA

Own the mission of being the community hub – tools we will provide you to take charge

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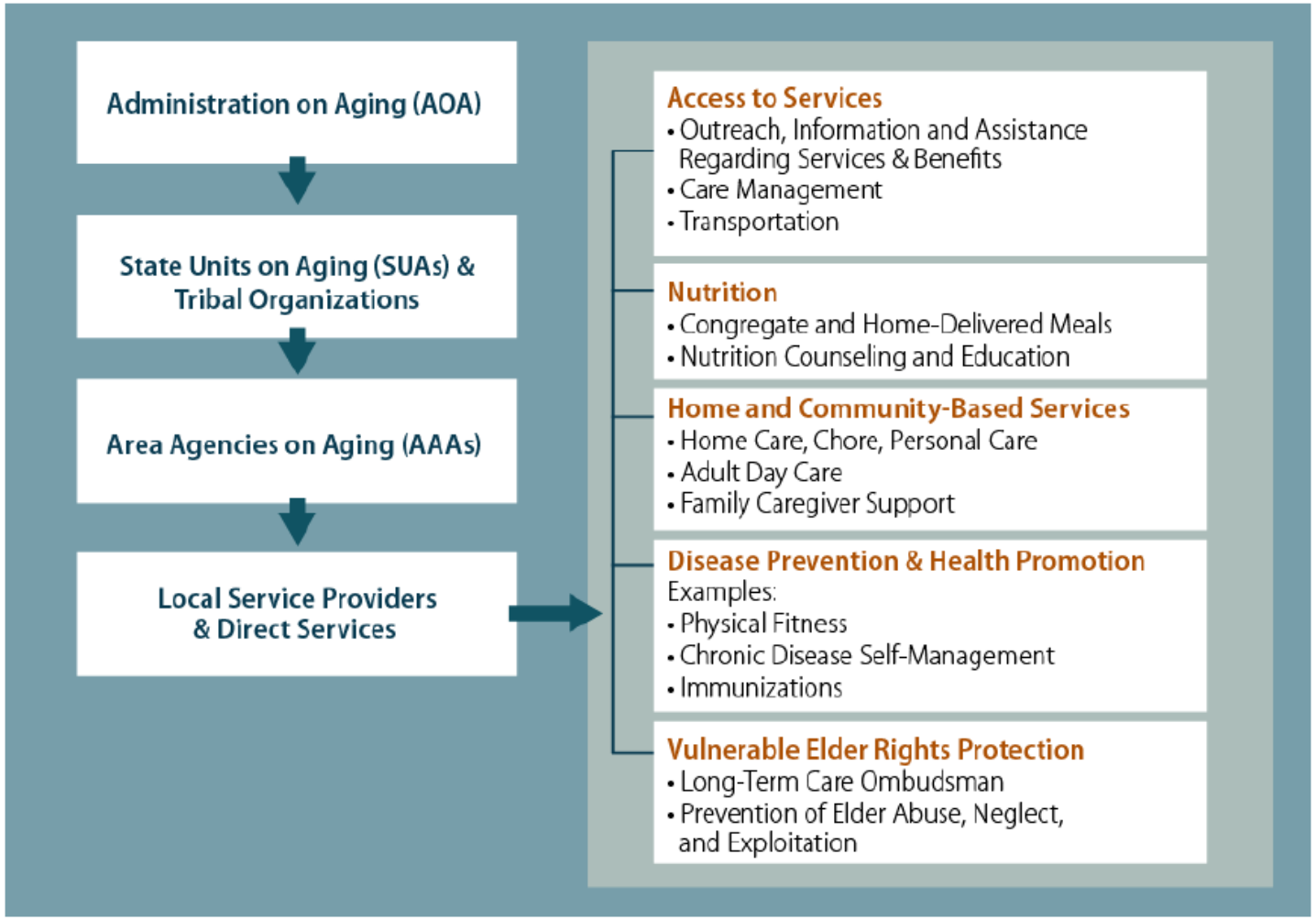
Aging Network Overview

Figure 1. The Aging Network



Source: Prepared by the Congressional Research Service.

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Screening for SDOH at MAC

Chronic Disease Assessment: 1) Do you have 2 or more chronic medical conditions? 2) Are you taking more than 5 medications? 3) Do you have difficulty managing your condition(s)?

REFER TO LIVING WELL, COMMUNITY RESOURCES, HEALTHCARE

Falls Risk Assessment for patients over 65: 1) Have you fallen in the past year? 2) Do you feel unsteady when standing or walking? 3) Do you worry about falling?

REFER TO FALLS PREVENTION WORKSHOPS, EXERCISE PROGRAMS, COMMUNITY RESOURCES

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Screening for SDOH at MAC

Depression Screen: Over the past two weeks, how often have you been bothered by any of the following problems? 1) Little interest or pleasure in doing things? 2) Feeling down, depressed or hopeless?

REFER TO PEARLS, COMMUNITY RESOURCES, ATTEND SENIOR CENTERS/ CONGREGATE MEALS

Malnutrition: 1) Have you recently lost weight without trying? 2) If yes, how much weight have you lost? (MST – Malnutrition Screening Tool)

REFER TO STEPPING UP YOUR NUTRITION, FALLS PREVENTION, LIVING WELL, MEALS PROGRAMS, EXERCISE PROGRAMS AS APPROPRIATE. IF FOOD INSECURE, FOOD PANTRIES AND OTHER RESOURCES.

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Multi-Disciplinary Approach

MAP	
Type of intervention	*Action*
Screening	• Malnutrition Screen • Falls Screen • Depression Screen
Client Support Care Plan	• Enroll/refer to Nutrition, HP and/or SHIP • Transportation to healthcare appointments and referral sites
Address Root Cause	• Program Eligibility • Refer to Behavioral Health, caregiver support, Physician, CHW • Grocery program, pet food, call reassurance, etc
Communicate Progress	• Track Referrals • Incorporate client Options Counseling goals • Assist with hospital messages and progress

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Multi-Disciplinary Approach

Nutrition Program	
Type of Intervention	*Action*
Screening	• Malnutrition Screen • Food Insecurity Priority Screen
Client Support Care Plan	• Person- centered service/meal plan • Provide Social Interaction • Nutrition education
Address Root Cause	• Nutritionally balanced food • Social isolation • Hydration • Manage chronic conditions
Communicate Progress	• Track Participation • Assist with hospital messages and progress

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Multi-Disciplinary Approach

Health Promotion	
Type of Intervention	*Action*
Screening	• Varies based on program and staff certifications
Client Support Plan	•Exercise • Strength • Nutrition • Chronic Disease Management
Address Root Cause (s)	• Social isolation • Manage chronic conditions • Falls risk
Communicate Progress	• Track Referrals • Share Client goals with healthcare team • Assist with hospital messages and progress

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Multi-Disciplinary Approach

SHIP	
Type of Intervention	*Action*
Screening	• Benefits Check-up
Client Support Care	• Identify & assist with medical insurance gaps
Addressing Root Cause (s)	• Address gaps in insurance coverage (income)
Communicate Progress	• Regular follow-up for high risk clients

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Case Study

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Case Study

- B.B. is an 85 year old woman who was referred to our practice in early February 2018. She presented socially well and was always well groomed.
- She had 42 ER visits to the local hospital in 2018
- She had two mini fires in her apartment
- She had not filled medications at the pharmacy since late 2017
- Calls would average between 2-8 times in a given day

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Case Study

- Our practice provided telephonic touch points, office visits, home visits, information to EMS, hospital SW, contacted family
- We provided food items, supplements
- Finally reported to APS as things kept escalating after 3 months
- APS kept an eye on her but could not really do much
- In January 2019 was delirious and admitted to hospital psych unit
- APS filed for temporary guardianship

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SDOH & ICD-10 Codes

SDOH Domains	ICD-10 codes for SDOH
Living Situation including housing and utilities	Z59 – Problems related to housing and economic circumstances Z60 – Problems related to social environment • Z60.2 – Problems related to living alone
Food	Z59 – Problems related to housing and economic circumstances • Z59.4 – Lack of adequate food and safe drinking water
Safety	Z60 Problems related to social environment
Financial Strain	Z59 – Problems related to housing and economic circumstances
Employment	Z56 – Problems related to employment and unemployment
Family and Community Support	Z63 – Other problems related to primary support group, including family circumstances Z60 – Problems related to social environment
Education	Z55 – Problems related to education and literacy
Mental Health	Z64 – Problems related to certain psychosocial circumstances Z65 – Problems related to other psychosocial circumstances

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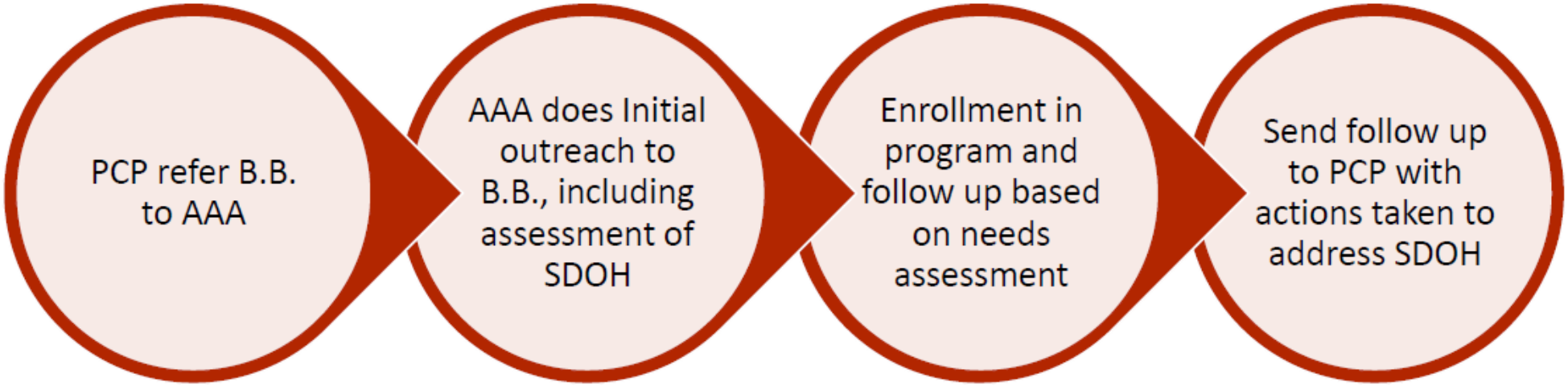
Case Study

- Ideal Pathway for B.B.



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Next Steps: Tools to Take Charge

- Malnutrition Toolkit draft one week before in person meeting:
  - Rationale for community-based interventions
  - Community-based Malnutrition care pathway
  - Professional role delineation
  - Template presentations
  - Billing codes to match interventions
- In person meetings to solicit feedback on feasibility of draft toolkit (February)→incorporate feedback in toolkit (March)
- Web meeting to disseminate toolkit (March/April)

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Thank you!

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