AAAs: Hub for Community Supports
Addressing Social Determinants of Health

The case for effective identification and treatment of Malnutrition Risk

Presenter: Livleen Gill, MBA RDN LDN
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
Social Determinants of Health

• Definition of SDOH/HRSN

• SDOH screening and coding
  • ICD-10 SDOH codes - Z55-z65

• Screening tools
Federal Legislation
& Social Determinants of Health
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
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
Types of Covered Services

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

• Focus on health beyond medical care
• Craft new partnerships to address SDOH
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
Healthcare Influencers

& Social Determinants of Health
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
American Hospital Association

- Task force to improve access and delivery of care to address SDOH ([www.aha.org/ensuringaccess](http://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
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)
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)
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
Major MAP Funding Sources

Medicaid FFP

State, Local Funds, Grants, Contracts

Older Americans Act:
Title IIIB

Supportive Services:
Case Management
Chore Services
Personal Care
Homemaker
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.
MDPCP

• Five Pillars of MDPCP
• Use of CRISP is mandatory
Malnutrition

Impact on healthcare cost
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
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

Local Prevalence of Malnutrition

Maryland Malnutrition Data

Maryland Statewide Malnutrition Data
Timeframe: Q2 2015 - Q1 2018

Maryland County Data Malnutrition Data
Timeframe: Q2 2015 - Q1 2018

Maryland County Data Malnutrition Data
Timeframe: Q2 2015 - Q1 2018
Malnutrition Risk Factors

• Clinical- Diagnosed by physicians, NPs and PAs

• Social- Diagnosed by care managers, nurses, support care personnel
The Role of the AAA

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

Figure 1. The Aging Network

- Administration on Aging (AOA)
  - State Units on Aging (SUAs) & Tribal Organizations
  - Area Agencies on Aging (AAAs)
  - Local Service Providers & Direct Services

- Access to Services
  - Outreach, Information and Assistance Regarding Services & Benefits
  - Care Management
  - Transportation

- Nutrition
  - Congregate and Home-Delivered Meals
  - Nutrition Counseling and Education

- Home and Community-Based Services
  - Home Care, Chore, Personal Care
  - Adult Day Care
  - Family Caregiver Support

- Disease Prevention & Health Promotion
  - Examples:
    - Physical Fitness
    - Chronic Disease Self-Management
    - Immunizations

- Vulnerable Elder Rights Protection
  - Long-Term Care Ombudsman
  - Prevention of Elder Abuse, Neglect, and Exploitation

Source: Prepared by the Congressional Research Service.
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.
# Multi-Disciplinary Approach

## MAP

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

### Nutrition Program

<table>
<thead>
<tr>
<th>Type of Intervention</th>
<th>Action</th>
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</thead>
<tbody>
<tr>
<td>Screening</td>
<td>• Malnutrition Screen</td>
</tr>
<tr>
<td></td>
<td>• Food Insecurity Priority Screen</td>
</tr>
<tr>
<td>Client Support Care Plan</td>
<td>• Person- centered service/meal plan</td>
</tr>
<tr>
<td></td>
<td>• Provide Social Interaction</td>
</tr>
<tr>
<td></td>
<td>• Nutrition education</td>
</tr>
<tr>
<td>Address Root Cause</td>
<td>• Nutritionally balanced food</td>
</tr>
<tr>
<td></td>
<td>• Social isolation</td>
</tr>
<tr>
<td></td>
<td>• Hydration</td>
</tr>
<tr>
<td></td>
<td>• Manage chronic conditions</td>
</tr>
<tr>
<td>Communicate Progress</td>
<td>• Track Participation</td>
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<tr>
<td></td>
<td>• Assist with hospital messages and progress</td>
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</tbody>
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## Multi-Disciplinary Approach

### Health Promotion

<table>
<thead>
<tr>
<th>Type of Intervention</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening</td>
<td>• Varies based on program and staff certifications</td>
</tr>
</tbody>
</table>
| **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 |
## Multi-Disciplinary Approach

**SHIP**

<table>
<thead>
<tr>
<th>Type of Intervention</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening</td>
<td>• Benefits Check-up</td>
</tr>
<tr>
<td>Client Support Care</td>
<td>• Identify &amp; assist with medical insurance gaps</td>
</tr>
<tr>
<td>Addressing Root Cause (s)</td>
<td>• Address gaps in insurance coverage (income)</td>
</tr>
<tr>
<td>Communicate Progress</td>
<td>• Regular follow-up for high risk clients</td>
</tr>
</tbody>
</table>
Case Study
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
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
# SDOH & ICD-10 Codes

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

• Ideal Pathway for B.B.

1. PCP refer B.B. to AAA
2. AAA does Initial outreach to B.B., including assessment of SDOH
3. Enrollment in program and follow up based on needs assessment
4. Send follow up to PCP with actions taken to address SDOH
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)
Thank you!

Livleen Gill, MBA RDN LDN
CEO of Bethesda NEWtrition and Wellness Solutions

Camalier Building
10215 Fernwood Road, Suite 630
Bethesda, MD 20817

Tel: (240) 449-3094
Fax: (240) 489-4415