Social Determinants of Health: What Is It?

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Objectives

- At the end of this session participants will have:
  1. An understanding of what social determinants of health are.
  2. An understanding of their role in addressing social determinants of health with their patients, patient's family members and their caregivers.
  3. An understanding of the Centers for Medicare and Medicaid Services (CMS) regulations for social determinant data collection for post-acute care.

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Raise Your Hand If....

If you have worked as an occupational therapy practitioner for less than a year

If you have worked as an occupational therapy practitioner for 5 years or less

If you have worked as an occupational therapy practitioner for 10 years or less

If you have worked as an occupational therapy practitioner for more than 10 years

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Raise Your Hand If.....


If you work in a hospital


If you work in a skilled nursing facility/outpatient or home health


Pediatrics


If you work in psych/mental health

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How do you define Social Determinants of Health?

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Social Determinants of Health

World Health Organization

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

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

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Social Determinants of Health

- Grouped into 5 domains:

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

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Social Determinants of Health

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Social Determinants of Health

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

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Economic Stability

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

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Economic Stability

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

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

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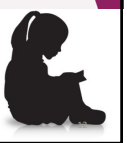
Education Access and Quality

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



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Education Access and Quality

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

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Health Care Access and Quality

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

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Health Care Access and Quality

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

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

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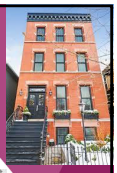
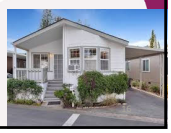
Neighborhood and Built Environment

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



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Neighborhood and Built Environment

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

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

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Social and Community Context

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


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Social and Community Context

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

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What Is CDC Doing to Address Social Determinants of Health?

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

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

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What Is CDC Doing to Address Social Determinants of Health?

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

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What Is CDC Doing to Address Social Determinants of Health?

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

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Health Outcomes

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

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

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Why Is Addressing Social Determinants of Health Important for CDC and Public Health?

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

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The National Health Expenditure Accounts (NHEA)

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

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

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

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

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

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The Occupational Therapy Practitioner Role in Addressing Social Determinants of Health

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The Occupational Therapy Practitioner Role in Addressing Social Determinants of Health

- Lack of access to resources correlates to occupational injustice and decreased health outcomes.
- Occupational therapy practitioners can address social inequities and improve access to smart technologies to live in place.

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Comprehensive Plans of Care- Going Beyond the Reason for Referral.....

- Observe the patient/resident
- Listen to the patient/resident/family/caregivers
- Review medical record
- Assess the patient/resident....go beyond the reason for referral
- Utilize standardize tests and measures
- Expand the tools in our tool boxes
- Demonstrate the distinct value of OT

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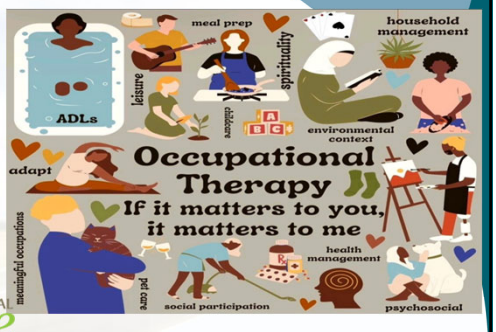
Comprehensive Plans of Care- Going Beyond the Reason for Referral.....



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Comprehensive Plans of Care

Figure 1. 4Ms Framework of an Age-Friendly Health System

What Matters
Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

Medication
If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

Mentation
Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Mobility
Ensure that older adults move safely every day in order to maintain function and do What Matters.

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http://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Documents/IHIAgeFriendlyHealthSystems_GuidetoUsing4MsCare.pdf

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Occupational therapy evaluations include the following components

- Occupational Profile and Client History
- Assessment of Occupational Performance
- Clinical Decision Making
- Development of Plan of Care

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Definitions

- Performance Deficits
- Physical Skills
- Cognitive Skills
- Psychosocial Skills

Performance deficits refer to the inability to complete activities due to the lack of skills in one or more of the categories below (i.e., relating to physical, cognitive, or psychosocial skills)

Physical skills refer to impairments of body structure or body function (e.g., balance, mobility, strength, endurance, fine or gross motor coordination, sensation, dexterity).

Cognitive skills refer to the ability to attend, perceive, think, understand, problem solve, mentally sequence, learn, and remember resulting in the ability to organize occupational performance in a timely and safe manner. These skills are observed when: (1) a person attends to and selects, interacts with, and uses task tools and materials; (2) carries out individual actions and steps; and (3) modifies performance when problems are encountered.

Psychosocial skills refer to interpersonal interactions, habits, routines and behaviors, active use of coping strategies, and/or environmental adaptations to develop skills necessary to successfully and appropriately participate in everyday tasks and social situations.

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Comprehensive Plan of Care

97165	Occupational therapy evaluation, **low** complexity, requiring these components: ● An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; ● An assessment(s) that identifies 1-3 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and ● Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97166	Occupational therapy evaluation, **moderate** complexity, requiring these components: ● An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; ● An assessment(s) that identifies 3-5 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and ● Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97167	Occupational therapy evaluation, **high** complexity, requiring these components: ● An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; ● An assessment(s) that identify 5 or more performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and ● A clinical decision-making is of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.
97168	**Reevaluation** of occupational therapy established plan of care, requiring these components: ● An assessment of changes in patient functional or medical status with revised plan of care; ● An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and ● A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.

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Occupational Profile

AOTA Occupational Profile Template

"The occupational profile is a summary of a client's (person's, group's, or population's) occupational history and experiences, patterns of daily living, interests, values, needs, and relevant contexts" (AOTA, 2020, p. 21). The information is obtained from the client's perspective through both formal and informal interview techniques and conversation.

The information obtained through the occupational profile contributes to a client-focused approach in the evaluation, intervention planning, intervention implementation, and discharge planning stages. Each item below should be addressed to complete the occupational profile. Page numbers are provided to reference the description in the *Occupational Therapy Practice Framework: Domain and Process* (4th ed.; AOTA, 2020).

OCCUPATIONAL PROFILE			
Client Report	Reason the client is seeking service and concerns related to engagement in occupations (p. 16)	Why is the client seeking services, and what are the client's current concerns relative to engaging in occupations and in daily life activities? (This may include the client's general health status.)	
	Occupations in which the client is successful and barriers affecting success (p. 16)	In what occupations does the client feel successful, and what barriers are affecting their success in desired occupations?	
	Occupational history (p. 16)	What is the client's occupational history (i.e., life experiences)?	
	Personal interests and values (p. 16)	What are the client's values and interests?	
Contexts	Environment (p. 36): physical environment and human-made changes, products and technology, support and relationships, attitudes, services, systems and policies)	What aspects of their contexts (environmental and personal factors) does the client see as supporting engagement in desired occupations, and what aspects are inhibiting engagement?	
		Supporting Engagement	Inhibiting Engagement
	Personal (p. 40): (e.g., age, sexual orientation, gender identity, ethnicity, cultural identification, social background, upbringing, psychological assets, education, lifestyle)	Supporting Engagement	Inhibiting Engagement

Performance Patterns	Performance patterns (p. 41) (e.g., habits, routines, roles, rituals)	What are the client's patterns of engagement in occupations, and how have they changed over time? What are the client's daily life roles? (Patterns can support or hinder occupational performance.)	
Client Factors	Values, beliefs, spirituality (p. 51)	What client factors does the client see as supporting engagement in desired occupations, and what aspects are inhibiting engagement (e.g., pain, active symptoms)?	
		Supporting Engagement	Inhibiting Engagement
	Body functions (p. 51) (e.g., mental, sensory, neuromusculoskeletal and movement-related, cardiovascular functions)	Supporting Engagement	Inhibiting Engagement
	Body structures (p. 54) (e.g., structures of the nervous system, eyes and ears, related to movement)	Supporting Engagement	Inhibiting Engagement
Client Goals	Client's priorities and desired targeted outcomes (p. 65)	What are the client's priorities and desired targeted outcomes related to the items below?	
		Occupational Performance	
		Prevention	
		Health and Wellness	
		Quality of Life	
		Participation	
		Role Competence	
		Well-Being	
		Occupational Justice	

For a complete description of each component and examples of each, refer to the *Occupational Therapy Practice Framework: Domain and Process* (4th ed.).

Resources

American Occupational Therapy Association. (2020). Occupational therapy practice framework: Domain and process (4th ed.). *American Journal of Occupational Therapy, 74*(Suppl. 2). 7412410010. https://doi.org/10.5014/ajot.2020.74S2001

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Assessments

- Pain Assessments (i.e. Wong Baker Faces)
- Katz ADL Index
- Modified Barthel ADL Index
- Timed Up and Go (TUG)
- Berg Balance Scale
- The St. Louis University Mental Status Exam (SLUMS)
- The Routine Task Inventory (RTI)
- Geriatric Depression Scale
- Generalized Anxiety Disorder (GAD-7)
- Global Deterioration Scale
- Allen Cognitive Level (ACL)
- Perceived Stress Scale (PSS-10)
- The Delirium Rating Scale (DRS)3
- Brief Trauma Questionnaire
- Trauma Checklist
- Trauma Screening Questionnaire (TSQ)
- Occupational Profile of Sleep
- Medi-Cog

**not an inclusive list*

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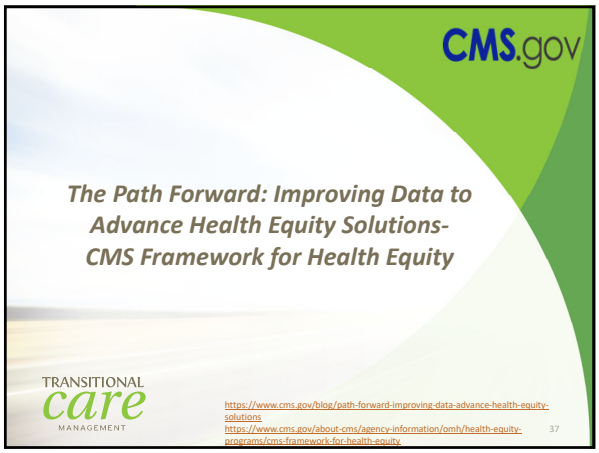
CMS.gov
The Path Forward: Improving Data to Advance Health Equity Solutions- CMS Framework for Health Equity
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https://www.cms.gov/blog/path-forward-improving-data-advance-health-equity-solutions
https://www.cms.gov/about-cms/agency-information/omh/health-equity-programs/cms-framework-for-health-equity
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The Five Health Equity Priorities for Reducing Disparities in Health
• These priorities will inform CMS's efforts for the next ten years and how the Agency may operationalize each priority to achieve health equity and eliminate disparities.
• Each priority area reflects a key area in which CMS stakeholders from communities that are underserved and disadvantaged express that CMS action is needed and critical to advancing health equity.
• Together, the five priorities provide an integrated approach to build health equity into existing and new efforts by CMS and our stakeholders.
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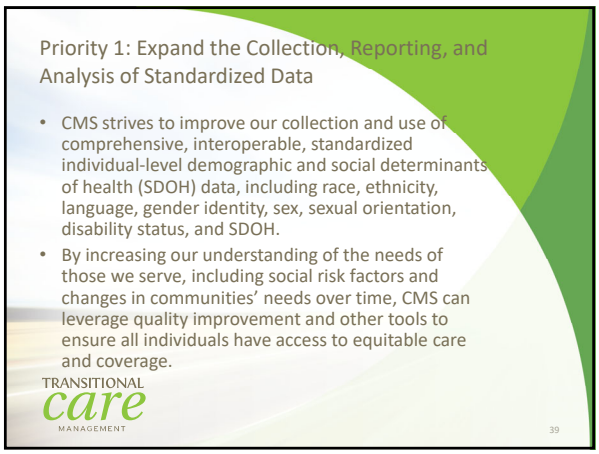
Priority 1: Expand the Collection, Reporting, and Analysis of Standardized Data
• CMS strives to improve our collection and use of comprehensive, interoperable, standardized individual-level demographic and social determinants of health (SDOH) data, including race, ethnicity, language, gender identity, sex, sexual orientation, disability status, and SDOH.
• By increasing our understanding of the needs of those we serve, including social risk factors and changes in communities' needs over time, CMS can leverage quality improvement and other tools to ensure all individuals have access to equitable care and coverage.
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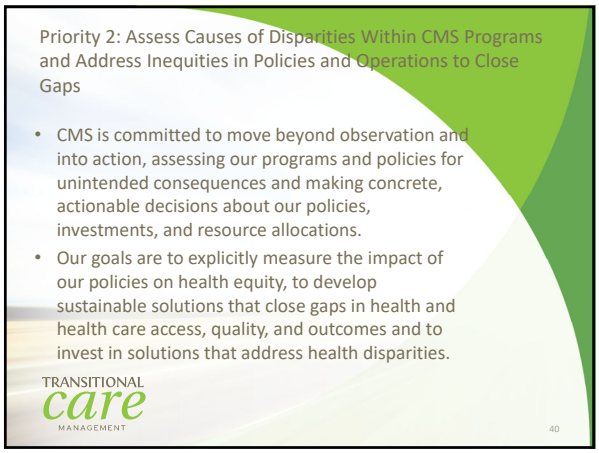
Priority 2: Assess Causes of Disparities Within CMS Programs and Address Inequities in Policies and Operations to Close Gaps
• CMS is committed to move beyond observation and into action, assessing our programs and policies for unintended consequences and making concrete, actionable decisions about our policies, investments, and resource allocations.
• Our goals are to explicitly measure the impact of our policies on health equity, to develop sustainable solutions that close gaps in health and health care access, quality, and outcomes and to invest in solutions that address health disparities.
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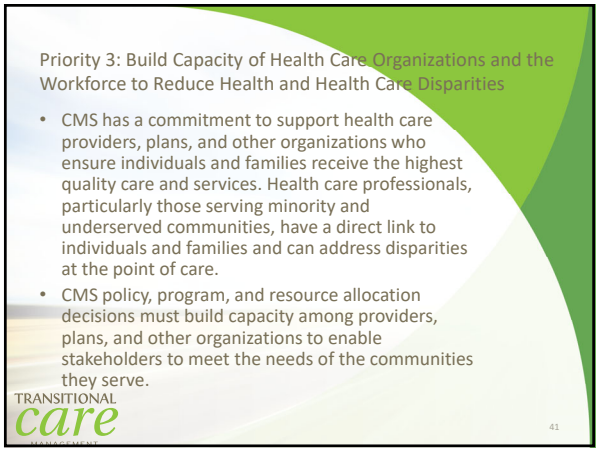
Priority 3: Build Capacity of Health Care Organizations and the Workforce to Reduce Health and Health Care Disparities
• CMS has a commitment to support health care providers, plans, and other organizations who ensure individuals and families receive the highest quality care and services. Health care professionals, particularly those serving minority and underserved communities, have a direct link to individuals and families and can address disparities at the point of care.
• CMS policy, program, and resource allocation decisions must build capacity among providers, plans, and other organizations to enable stakeholders to meet the needs of the communities they serve.
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Priority 4: Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services
• CMS must ensure that all individuals we serve, including members of communities that are underserved, can equitably access all CMS benefits, services and other supports, and coverage.
• Language access, health literacy, and the provision of culturally tailored services play a critical role in health care quality, patient safety and experience, and can impact health outcomes.
• CMS has opportunities across our operations, direct communication and outreach to enrollees and consumers, and guidance to plans, providers, and other partners to improve health care quality, patient safety, and the experience individuals have within the health care system.
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Priority 5: Increase All Forms of Accessibility to Health Care Services and Coverage
• CMS has a responsibility to ensure that individuals and families can access health care services when and where they need them, in a way that is responsive to their needs and preferences.
• CMS must seek direct feedback from individuals with disabilities, including physical, sensory and communication, intellectual disabilities, and other forms of disability, to understand their experiences navigating CMS-supported benefits, services, and coverage and tailor our programs and policies to ensure equitable access and quality.
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Added 7 Standardized Patient Assessment Data Elements (SPADEs)
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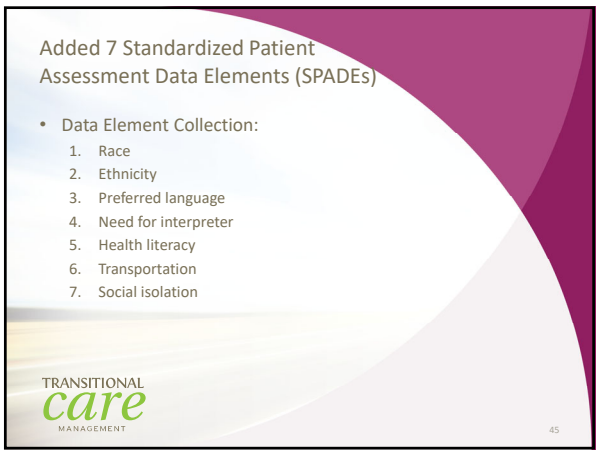
Added 7 Standardized Patient Assessment Data Elements (SPADEs)
• Data Element Collection:
1. Race
2. Ethnicity
3. Preferred language
4. Need for interpreter
5. Health literacy
6. Transportation
7. Social isolation
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Draft October 2023 MDS Items

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A1005: Ethnicity (new item and responses added)

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

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A1010: Race (new item and responses added)

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

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A1110: Language (new items and responses added)

A1110. Language

Enter Code ☐

A. What is your preferred language?

B. Do you need or want an interpreter to communicate with a doctor or health care staff?
0. No
1. Yes
9. Unable to determine

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A1250: Transportation (new item and response added)

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

↓ **Check all that apply**

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

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B1300: Health Literacy (new item and response added)

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

Enter Code ☐

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?
0. **Never**
1. **Rarely**
2. **Sometimes**
3. **Often**
4. **Always**
7. **Resident declines to respond**
8. **Resident unable to respond**

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

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

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

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

1. Symptom Presence
   0. No (enter 0 in column 2)
   1. Yes (enter 0-3 in column 2)
   9. No response (leave column 2 blank)
2. Symptom Frequency
   0. Never or 1 day
   1. 2-6 days (several days)
   2. 7-11 days (half or more of the days)
   3. 12-14 days (nearly every day)

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

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