

November 14, 2018

Brenda Destro
Deputy Assistant Secretary for Planning and Evaluation
Assistant Secretary for Planning and Evaluation, Room 415F
US Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Submitted electronically: ASPEImpactStudy@hhs.gov

RE: Request for Information: IMPACT ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors

Dear Deputy Assistant Secretary Destro:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit comments in response to the US Department of Health and Human Services Assistant Secretary for Planning and Evaluation's (ASPE) Request for Information (RFI) on the IMPACT Act Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors. The mission of APTA is to build a community to advance the physical therapy profession to improve the health of society. Physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability by serving as a dynamic bridge between health and health services delivery for individuals across the age span. While physical therapists are experts in rehabilitation and habilitation, they also have the expertise and the opportunity to help individuals improve overall health and prevent the need for avoidable health care services. Physical therapists' roles may include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

APTA strongly believes that the understanding of social risk factors and their impact on the delivery and receipt of health care services will continue to evolve over time. Therefore, we encourage ASPE to be responsive to future developments and strategies that provide solutions for the risk adjustment of social risk factors across post-acute care settings. For example, APTA is encouraged by the National Quality Forum's (NQF) efforts to examine whether measures should be risk adjusted for socioeconomic status and other factors, and we recommend that

ASPE incorporate NQF's findings into the agency's future work. We appreciate the opportunity to provide comments to ASPE. Please find our detailed comments below.

How are providers and health plans serving Medicare beneficiaries working to improve health outcomes for beneficiaries, especially those with social risk factors?

Providers', payers', and consumers' understanding of the historical, social, and cultural processes that shape individual and collective experiences is narrow. Additionally, there is little guidance for clinicians how to improve the care experience for Medicare beneficiaries with social risk factors. As such, the extent by which providers are working to improve health outcomes for beneficiaries, especially those with social risk factors, is limited. This is likely due to many factors, including incentives for providers and insurers to avoid patients with social risk factors, underpayment to providers who disproportionately serve socially at-risk populations, and underinvestment in quality of care.¹ It is imperative that clinicians better understand the broader networks of people, ideologies, and practices in which patients are enmeshed and the historical, geographical, and cultural spaces in which they operate.

Although guidelines exist for the management of many health conditions and their associated impairments and limitations, many health care providers assume that written guidelines that accompany plan of care education or discharge paperwork is equivalent to providing the information that the patient and their families or caregivers need for successful outcomes. Determining one's communication style or a preferred learning style should occur at the first encounter and then be communicated among the members of the patient's health care team to optimize outcomes. Exploring how a person seeks and uses information may likely lead to the identification of social risk factors that require further investigation and specialized interventions. For example, some providers are working to improve outcomes for beneficiaries by modifying how they provide "education" to address the health literacy and capacity of their patients.

Factors that are important for a provider to capture and incorporate into a care plan include the patient's perceptions and expectations about their health and how their current socioeconomic status affects their ability to understand and implement the recommendations they are given at the time of the transition of care. Further, members of interdisciplinary teams should be reimbursed for the time it takes to determine the optimal transition of care plan for any individual changing care settings or transitioning to home from a care setting. Individual team members also should be reimbursed for the time and resources it takes to ensure that these recommendations are successfully implemented and to problem-solve solutions when the plan was not optimally implemented. Every provider must understand the impact their individual actions have on a patient's health and well-being. Until individuals are reimbursed for the quality of work they perform, the cultural shift needed in the US health care system will be too slow to keep up with the unprecedented growth of the older adult population.

¹ NCBI Methods to Account for Social Risk Factors in Medicare Value-Based Payment. <https://www.ncbi.nlm.nih.gov/books/NBK379198/>. Accessed November 6, 2018.

Delivery of Services

Are social risk data being used to target services or provide outreach? If so, how? How are beneficiaries with social risk factors identified?

Addressing social risk factors is important for improving health and reducing longstanding disparities in health and health care. Physical therapists use social risk data to:

- Contribute to the overall risk stratification or risk modeling of a patient or patient population
- Determine necessary referrals to address the unique and or comprehensive needs of a patient or patient population
- Determine the most appropriate treatment plan and strategies to address the unique and/or comprehensive needs of an individual patient or patient population
- Iteratively improve the care delivery process and determine appropriate areas for and or critical timing of intervention

Beneficiaries with risk factors are identified through interview, chart review, and gathering of the history. The most important source of information is often the individual, but additional sources may include the medical record, the referring clinician, and communication from or with other health care providers, family members, and caregivers.

Unfortunately, data on social risk factors is not being widely collected, and in the majority of cases, even when it is collected it is not being used by providers to improve outcomes. Providers lack an understanding of how social risk factors affect short- and long-term clinical outcomes, payment, and compliance with the treatment regimen. However, even if providers do recognize the impact of social risk factors on outcomes, the regulatory and administrative burdens being imposed on them significantly influences their ability to properly account for such risk factors. For example, while many clinicians recognize that dual-eligible beneficiaries are at higher risk for poorer outcomes, they are overwhelmed with processing and responding to the ongoing changes in the regulatory and payment environment. As such, actively trying to address social risk factors is of low priority.

Are there especially promising strategies for improving care for patients with social risk?

After a clinician has gathered information about an individual's social risk factors, the clinician should start a dialogue with the patient regarding his or her desires, goals, and needs, and what actions would be most helpful. The clinician should offer advice and not only refer the individual to other services but also facilitate access to those services in a sensitive, culturally acceptable, and caring way.

Further, strategies that are designed to increase health literacy, address activation and engagement, promote coordination of care, and address resource gaps are highly effective. Early identification and intervention is critical. Collaboration and information-sharing with other stakeholders are essential elements to any successful strategy.

How are costs for targeting and providing those services evaluated?

Under the current fee-for-service model, physical therapists are not paid for delivering services that address social risk factors, and so such services generally are not part of the cost assessment of interventions. Physical therapists do, however, in the normal course of practice provide an ongoing evaluation of the patient's status to include guidance and referrals for those at risk.

However, costs for education, training, nutritional support, therapy services to address functional risk factors, and targeted transitional and ongoing care management may be evaluated in the context of a risk-bearing or bundled-payment arrangement, whereby the up-front investment reduces downstream costs for high-risk adverse events including re-hospitalization. Proper management of individuals with social risk factors that are negatively impacting disease state management and/or health status represents a return in investment in the form of avoidance of preventable high-cost adverse events.

What are the additional costs to target services, such as case management, and to provide additional services (e.g., transportation)? What is the return on investment in improved outcomes or reduced healthcare costs?

In the shift to value-based models, physical therapists should be recognized as essential components of the care team and integral to recommendations for at-risk individuals. ASPE should help to evolve health policy approaches, looking at the issue of social risk not solely from the perspective of payment and data, but also from how to improve the health of communities.

ASPE, in collaboration with the Centers for Medicare and Medicaid Services (CMS), should use its Medicare and Medicaid dollars more efficiently to transform society, taking a holistic approach to the patient. Further, ASPE should strive to develop partnerships with providers, embedding clinicians in entry points of care and creating care pathways that result in automated referrals and coordination of care based on risk factors.

For patients with social risk factors, how does patients' disability, functional status, or frailty affect the provision of services?

There is a correlation between the presence of social risk factors and the degree of patients' frailty, functional limitations, and disability. The risk of frailty is increased based on the number of negative factors impacting health, including access to adequate nutrition, necessary medications to manage chronic disease, and the ability to engage in safe and meaningful physical activity. Additionally, disability is often a factor of the influence of an environment on a patient's ability to adapt to functional impairments. Individuals with social risk factors also are more likely to experience greater environmental challenges. With limited mobility, such individuals may not be interacting with health care providers who could assist with proper resource identification and allocation.

Data

Which social risk factors are most important to capture?

Important social risk factors to capture include inadequate and/or unsafe housing; inadequate nutrition; health literacy; isolation; depression; lack of family or other support; financial insecurity; job insecurity/unemployment; unsafe environment at home (violence or other); unsafe behaviors of individual or close/responsible family member (such as smoking, or drug or alcohol

use); language barriers; cultural preferences; education; socioeconomic status; transportation; and neighborhood.

We understand that ASPE commissioned the National Academies of Sciences, Engineering, and Medicine (NASEM) to investigate social risk factors for the Medicare program, resulting in NASEM's report, "Accounting for Social Risk Factors in Medicare Payment." This report highlighted the social risk factors that may influence health care outcomes of interest to Medicare.² APTA supports the findings in this report and encourages ASPE to rely upon it as the agency engages in further efforts to capture data on social risk factors. Additionally, work performed by the NQF should be used to inform the collection and use of social risk factor data.³

Do you routinely and systematically collect data about social risk? Who collects this data? When is it collected? Is it collected only once or multiple times for a beneficiary? Is it collected consistently across populations (i.e. Medicare beneficiaries, Medicaid beneficiaries, patients receiving specific services, etc.)? What are the burdens of this data collection on plans, providers, and beneficiaries?

While the importance of gathering this information is critical, as it speaks to access, the vast majority of providers, including physical therapists, do not currently collect data on social risk. Not only do providers not understand the need to collect such data, but screening for social needs is different from, and typically not included in, current medical or health screening tools.

However, physical therapists do collect data in accordance with The International Classification of Functioning, Disability and Health (ICF), which is part of the "family" of international classifications developed by the World Health Organization (WHO). The ICF, with a focus on human functioning, provides a unified, standard language and framework that facilitates the description of the components of functioning that are impacted by a health condition. It is a tool that enables the collection of data as to how people with a health condition function in their daily lives rather than focusing on their diagnosis or the presence or absence of disease. The ICF describes the situation of the individual within health and health-related domains and within the context of environmental and personal factors.

Physical therapists engage in an examination process that includes taking the individual's history, conducting a standardized systems review, and performing selected tests and measures to identify potential and existing movement-related disorders. The data gathered during history taking, including answers to review-of-systems questions, enables the physical therapist to generate diagnostic hypotheses and select specific tests and measures to identify and characterize signs, symptoms, and risk of movement dysfunctions. To establish the individual's specific diagnosis, prognosis, and plan of care through the evaluation process, physical therapists synthesize the collected examination data and determine whether the potential or existing disorders to be managed are within the scope of physical therapist practice.

² NASEM Accounting for Social Risk Factors in Medicare Payment.

<http://nationalacademies.org/hmd/Activities/Quality/Accounting-SES-in-Medicare-Payment-Programs/Medicare-Social-Risk-Factors-Overview>. Accessed November 6, 2018.

³ NQF Social Risk Trial Final Report.

https://www.qualityforum.org/Publications/2017/07/Social_Risk_Trial_Final_Report.aspx. Accessed November 6, 2018.

History taking is a systematic gathering of data related to who the individual is and why he or she is seeking the services of the physical therapist. These data include demographic information, social history, employment and work information, growth and development parameters, living environments, general health status, social and health habits (past and current), family history, medical and surgical history, current conditions or chief complaints, functional status and activity level, medications, and other clinical test findings.

Data gathered from tests and measures yield a range of findings that may indicate that an intervention may be appropriate for a given individual, including:

- Risk factors, such as smoking history, falls risk, and recent trauma
- Health, wellness, and fitness, such as sedentary lifestyle, limited leg strength for squatting, and lack of understanding of plantar foot shear during recreational activities
- Pathology/pathophysiology, such as diabetes, cellulitis, and congestive heart disease
- Signs and symptoms of pathology and health condition, such as joint tenderness, pain, elevated blood pressure at rest or with activity, numbness or tingling, and edema
- Impairments to body functions and structures, such as aerobic capacity, anthropometric characteristics, balance, circulation, cranial and peripheral nerve integrity, gait, integumentary integrity, mental functions, mobility, motor function, muscle performance (including strength, power, endurance, and length), neuromotor development and sensory processing, pain, reflex integrity, skeletal alignment and integrity, sensory integrity, and ventilation and respiration
- Activity limitations and participation restrictions, such as environmental factors in built or natural environments affecting movement-related performance; need for assistive products or technology to enhance performance; and environmental or personal factors impacting an individual's quality of self-care or domestic, education, work, community, social, or civic life

An annual checkup by a physical therapist, per a template developed by APTA,⁴ includes collection of a subset of the data listed above that is most relevant to the topic being discussed. Collection of this data assists physical therapists in identifying individuals with social risk factors. It includes questions about ethnicity, race, occupation and employment status, education level (highest grade completed), adequate food, adequate housing, and access to health care.

The greatest burden of any data collection relates to the means by which the data is collected. Providers who do not have access to electronic health records (EHRs) face significant barriers. Moreover, when beneficiaries interact with multiple providers who lack interoperable EHRs, such providers, as well as beneficiaries, are placed at a significant disadvantage. In these instances, the beneficiaries are required to repeat the same or similar information for each

⁴ American Physical Therapy Association. Annual Checkup by a Physical Therapist. <http://www.apta.org/AnnualCheckup/>. Accessed November 14, 2018.

provider with no standardization and or system interoperability or integration. Additional barriers may include language, literacy, and cultural competence for beneficiaries with social risk factors.

Would standardized data elements for EHRs help you to collect social risk data? If so, how could these data elements be standardized?

Standardizing data elements for EHRs would help providers collect social risk data while also helping policymakers better understand the problems facing beneficiaries with social risk factors. APTA recommends that ASPE pursue standardizing the collection of social risk factors on a national basis. This would better allow providers and payers to understand and identify the beneficiaries who are most significantly impacted by these social risks. It also would allow quality measure developers to examine more closely the impact of these variables on patient outcomes in order to adjust risk appropriately. However, to use social risk factors as a risk adjuster for outcomes, there must first be a high degree of compliance with data collection.

Further, standardized data elements for EHRs would allow for more consistency in the comparison of individuals and populations, and would improve providers' ability to standardize care based on common risk factors. These elements could be standardized based on available evidence related to meaningful and predictive social risk factors. Moreover, by standardizing data collection, CMS would be better able to make sound decisions about cost-effective benefit design.

What are barriers to collecting data about social risk? How can these barriers be overcome?

Barriers include a lack of standardization and a lack of system interoperability. Private practices are particularly challenged by the financial outlay and information technology expertise required to adopt an interoperable medical record. Additional barriers include:

- Lack of ongoing shared access or interoperability to meaningful data
- Inflexible care delivery models that fail to support providers and patients in matching resources to identified needs
- Barriers to addressing the comprehensive needs of patients, including nonmedical health needs such as limits in payment
- Barriers to timely access to the most appropriate provider, including but not limited to prior authorization, a need for a referral, and visit limits

The barriers can be overcome by:

- Educating clinicians on the value (cost vs benefit) of and need (avoiding adverse outcomes) to address social risk factors
- Educating patients and caregivers on the availability of services, and the importance of self-advocacy and accessing available resources
- Expanding community resources through local, state, and national efforts

Collecting data about social risk also is difficult given the significant reliance on patients to self-report. Patients may not understand the importance of collecting this information and may believe that disclosing information about themselves will lead to discrimination. For this reason,

patient education is critical. Clinician and policymaker education also is important, as neither group is fully aware of how social risk factors influence patient outcomes. As a result, as previously stated, clinicians may fail to understand the importance of collecting data on social risk factors. While including standardized data elements in EHRs is a step in the right direction, it will not be the sole driver of data collection. It is critical that payers, working alongside clinicians and policymakers, better highlight the need for the collection of this data. Financial and administrative incentives also must be properly aligned for clinicians to collect and use this information in a meaningful way.

There also must be a better understanding of health disparities and bias in health care. Addressing bias must be a conscious decision, but to avoid making assumptions, providers should commit to screening for social determinants of health across their entire patient population.

What do you see as promising future opportunities for improving data collection? For using existing or future data to tailor services?

APTA supports the National Prevention Strategy, which prioritizes prevention by integrating recommendations and actions across multiple settings to improve health and save lives. The strategy “envisions a prevention-oriented society where all sectors recognize the value of health for individuals, families, and society and work together to achieve better health for Americans.”⁵ To fully support Americans in leading longer and healthier lives, it is critical that collection of social risk factor data and utilization of such data is increased. To do so, we recommend that ASPE, in conjunction with other federal and state agencies, place a greater emphasis on the need to collect data on social risk factors and how to use the data to tailor practice and improve population health.

For example, to improve data collection and patient outcomes, we recommend that ASPE rely on specialty society registries to test the collection of this data. Additionally, ASPE should engage and work with EHR vendors to standardize how this information is collected. Additionally, ASPE should consider how the development of a standardized tool for data collection would ensure consistency across providers and settings. As the growth of value-based models continues, requiring social-risk data collection and sharing could be a condition of participation.

Within and outside of the health care system are other opportunities to address social risk factors. We are encouraged that as of 2017, 19 states require Medicaid managed care plans to screen for and/or provide referrals for social needs.⁶ APTA recommends that ASPE work with CMS, Centers for Disease Control and Prevention, US Department of Housing and Urban Development, state Medicaid agencies and managed care organizations, commercial payers, health professional associations, and patient advocacy groups to build upon existing evidence to shape future strategies to fully address disparities in health.

⁵ Centers for Disease Control and Prevention Surgeon General National Prevention Strategy. <https://www.surgeongeneral.gov/priorities/prevention/strategy/index.html>. Accessed November 6, 2018.

⁶ Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. Kaiser Family Foundation. <https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>. Accessed October 29, 2018.

Conclusion

APTA thanks ASPE for the opportunity to respond to the RFI on improving care for Medicare beneficiaries with social risk factors. Should you have any questions regarding our comments, please contact Kara Gainer, director of regulatory affairs, at karagainer@apta.org or 703/706-8547. Thank you for your consideration.

Sincerely,

A handwritten signature in black ink that reads "Sharon L. Dunn". The signature is written in a cursive, flowing style.

Sharon L. Dunn, PT, PhD
Board-Certified Clinical Specialist in Orthopaedic Physical Therapy
President

SLD: krg