AMRPA
AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

November 16, 2018

The Honorable Brenda Destro
Acting Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Delivered electronically to: ASPEImpactStudy@hhs.gov

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

Dear Assistant Secretary Destro:

These comments are submitted on behalf of the American Medical Rehabilitation Providers Association (AMRPA) with respect to the above captioned Request for Information.[1] We welcome the opportunity to offer input to the Department of Health and Human Services (HHS) to inform its second report to Congress on the effect of socioeconomic status on quality and resource use measures as mandated by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. AMRPA supports the principles and objectives of the Act and remains committed to working with HHS and the Assistant Secretary for Planning and Evaluation (ASPE) to achieve them.

AMRPA is the national trade association representing more than 625 freestanding inpatient rehabilitation hospitals and rehabilitation units of general hospitals (collectively referred to as inpatient rehabilitation facilities (IRFs) by Medicare), outpatient rehabilitation service providers, long-term care hospitals (LTCHs), and several skilled nursing facilities (SNFs).

Inpatient rehabilitation hospitals and units (IRH/Us) provide hospital-level care, which is significantly different in intensity, capacity, and outcomes from post-acute care (PAC) provided in non-hospital settings. AMRPA members help their patients maximize their health, functional ability, independence, and participation in society so they are able to return to home, work, or an active retirement. The vast majority of our members are Medicare participating providers and, on average, Medicare Part A payments represent more than 60 percent of IRH/U revenues.[2] In 2016,

[1] https://aspe.hhs.gov/system/files/pdf/259906/ImprovingCareMedicareBeneficiariesSocialRiskFactorsRFI.pdf

[2] Medicare Payment Advisory Commission, Report to Congress, Medicare Payment Policy, 267 (Mar. 2018).

RICHARD KATHRINS, PhD · CHAIR, AMRPA BOARD OF DIRECTORS
Chief Executive Officer, Bacharach Institute for Rehabilitation
1710 N Street NW, Washington, DC 20036 · Phone: 202-591-2469 · Fax: 202-591-2445

IRH/Us served approximately 350,000 Medicare beneficiaries, representing more than 391,000 stays.[3]

AMRPA's responses to the questions posed in ASPE's Request for Information follow below.

1. **Are social risk data being used to target services or provide outreach? If so, how? How are beneficiaries with social risk factors identified? How is this data collected?**

IRH/Us use a multidisciplinary and comprehensive set of evaluative, diagnostic and therapeutic interventions focused on restoring functional capacity, activities of daily living and cognitive function. In fact, IRH/Us are required by CMS regulations to provide multiple disciplines of care, including physician, nursing, physical therapy, occupational therapy, speech and language therapy, and clinical social work, and to hold weekly interdisciplinary team meetings. The interdisciplinary team meeting allows members of the treatment team, which includes clinical social workers, to coordinate care and communication regarding the patient's plan of care and treatment goals. Interdisciplinary and coordinated care is essential to getting patients back to their homes and work sooner and gives them improved physical, social and emotional functioning and wellbeing.

Rehabilitation hospital care is patient-centric and accountable for each patient's exposure to potential risk factors. Social risk factors are most certainly taken into account on a patient-by-patient basis, especially as part of the discharge planning process. Discharge planning begins at – and ideally before – a patient admission to the IRH/U. The interdisciplinary team collaborates to evaluate the patient's medical, social support, and financial support needs, and develops a discharge plan that addresses those needs accordingly. Specifically, a social work care management team meets with the patient and caregivers to conduct psychosocial and socioeconomic evaluations and to collect information about how social risk factors can influence an anticipated trajectory of care. This information is fed back to the clinical team at the interdisciplinary team conference to help inform the discharge planning process.

A person-centered approach means identifying the type of support and reasonable adjustments that enable each person's needs to be met. The clinical social worker helps plan for long-term management of health care needs, including referrals to resources in the community to promote the highest level of independence. While this data may not be collected based on an industry-standardized platform, IRH/Us gather many data points and pay close attention to each patient's unique situation and respond accordingly.

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

A patient's disability, functional status, or frailty has a profound impact on the service they will need. The more severe a patient's disability or impaired their functional status, the more challenging it can be for providers to ensure that the patient is receiving all the necessary care. Furthermore, the impact of socioeconomic status (SES) factors are oftentimes much more

[3] *Id.*

pronounced for lower-functioning patients who are likely to require multiple professional services after discharge; however, low SES individuals are less likely to be insured and are more likely to avoid medical care due to cost.[4]

It is undeniably more challenging for certain patients to reenter the community following their IRH/U stay. As an example, some brain injury patients with cognitive impairments demonstrate risk-seeking behavior and might not have the adequate social resources (family or friends) to turn to for support. In instances where patients lack a social support network for a hospital to turn to, the hospital case worker recognizes that lifelong institutionalization may be a likely outcome for this patient. Similarly, with regard to frailty, many older patients do not have living relatives nearby to turn to for caregiver support.

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

Early identification of social risk factors enables IRH/Us to better prepare for potential services or supports that patients may additionally need after discharge from the rehabilitation hospital. To do this, the IRH/U team is highly proactive in liaising and dialoguing with the referring hospital, oftentimes as part of the pre-admission assessment, to get key information such as the patient's unique living situation, social support, geography and payer status.

When it comes to successful strategies, however, perhaps the most prominent are those providers use to minimize the negative impact of a patient's lack of coverage when their payer does not cover downstream post-acute services, such as home health or skilled nursing care. To address the needs of these patients, IRH/Us employ proactive and targeted strategies such as:

- Utilizing a paramedicine program to conduct home visits for patients who could not receive home health benefits. This type of program helps ensure that patients are progressing along their care trajectory as expected and can also help mitigate potentially preventable hospital readmissions.
- Providing financial guidance services to help patients understand and navigate their benefits. In some instances, when a primary payer does not cover services such as skilled nursing care, IRH/Us will assist patients and their caregivers in applying for Medicaid to obtain coverage for these services after IRH/U discharge.
- Providing financial assistance programs for underfunded patients.
- Partnering with other providers along the care continuum to help defray the costs of certain services (*e.g.*, sharing the cost of durable medical equipment or medications with the acute care hospital), and facilitating smooth downstream transitions of care (*e.g.*, leveraging relationships with downstream providers to help an unfunded patient gain access to those services after IRH/U discharge).

Post-discharge, some IRH/Us also use "transition clinics" to provide a transitioning physician for patients being discharged who do not have a primary care physician overseeing their routine care.

[4] Institute of Medicine, America's uninsured crisis: consequences for health and health care. National Academies Press; 2009. p. 214.

4. **How are costs for targeting and providing those services evaluated? 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?**

Successful care management that facilitates a safe patient transition to the next site of care is a fundamental component of rehabilitation hospital care. The primary return on investment for providing case management and other services, such as those discussed above, are better outcomes as a result of helping patients access necessary post-acute services and transitioning them to the next setting in a timely manner. A post-stroke patient who is able to receive continuous rehabilitative services – from intensive therapy at the IRH/U to continuing to work with a therapist in home health – will achieve greater functional gains more quickly, and is less likely to need additional services in the long run. Hence, an investment in PAC in the shorter term will pay tremendous dividends in the long run. Facilitating transitions along the care continuum enhances efficiencies and reduces costs to the healthcare system overall (*e.g.*, reduced lengths of stay). There are also costs to the provider of investing in experienced social work staff resources, as described further below.

5. **What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?**

Health care providers with demonstrated depth in social work resources are successful in connecting patients with local and regional social service organizations. In that regard, the clinical social workers seated within the interdisciplinary team at rehabilitation hospitals support the entire continuum of care by arranging and furnishing these unique services.

A rehabilitation hospital's patients often come from a wide geographic area and beyond the hospital's immediate market. Accordingly, IRH/Us must develop and leverage partnerships with various entities throughout and beyond their market – including upstream referral sources and social service organizations – as those entities are more familiar with the local supports and resources within a patient's community. IRH/Us also proactively reach out to social service organizations to develop relationships with resources in the community.

Indeed, it takes time and experience for a social work team to cultivate these relationships and it is an investment of a hospital's staff resources. Some IRH/Us take a centralized approach by having a dedicated case worker assigned to patients who may be more challenging to discharge safely (and have a greater need for social services). These dedicated social workers have developed relationships with external partners to readily connect patients with community support services.

6. **What lessons have been learned about providing care for patients with social risk factors?**

Our members note that the unpredictability of engaging these patients has been an important lesson, as well as a challenge they continue to grapple with and adapt to. Sometimes, despite a

hospital's best efforts to develop a comprehensive patient-centric discharge plan and support the patient's adherence to it, the patient and/or their caregivers do not follow through with the plan for reasons unknown to the hospital. There is also tremendous value in investing in external partnerships and relationships with other entities along the care continuum, and in staff resources within such as experienced social workers and case managers.

7. **What are barriers to tailoring services to patients with social risk factors? How can barriers be overcome?**

From our members' perspective, the following factors can be significant barriers to developing services tailored for a patient's unique care needs and situations:

- **Payer source or funding**: As described above, it is much more challenging for rehabilitation hospitals to ensure that un-/underfunded patients will be able to receive necessary post-discharge care. Hospitals undertake a variety of strategies to try to help patients overcome these barriers, such as offering paramedicine home visits or financial support services, as detailed above.

- **Caregiver presence/availability**: The presence and willingness of family or community supports are critical drivers for IRH/Us when deciding upon a patient's appropriate discharge destination. For example, even though a patient has met the goals of a rehabilitation hospital admission (*e.g.*, regained household level ambulatory function and is able to walk on level surfaces at discharge), if he or she lives alone in a third floor walkup without handicap access, a discharge home may not be safe. Although a return to home or the community is the gold standard, it is not always the safest discharge setting. Even when the caregiver's presence is expected at the outset, situations often change and families/caregivers' involvement may shift as they come to appreciate the extent of support needed. To help mitigate this phenomenon, IRH/Us are proactive and engage caregivers throughout the patient stay to educate them on the anticipated post-discharge care needs.

- **Patient activation, engagement, and agency:** An individual's level of activation in managing their own health – patient activation model measure (PAM) – can determine the patient's ability and motivation to "buy into" their care plan. This may vary according to age, education level, health literacy, motivation and illness. Providers aim to communicate health information in ways that are tailored and accessible to patients as one way of overcoming this barrier.

- **Cultural factors:** With regard to language barriers, IRH/Us and health care providers have invested in translation technologies to facilitate their communication with diverse patient populations. In rehabilitation, there is even a greater need for having a live translator due to the highly dynamic nature of clinician-patient interactions in an intensive therapy session. IRH/Us help patients overcome language barriers by providing on-hand translators in therapy.

8. **Which social risk factors are most important to capture?**

To AMRPA members, some of the most important factors to capture are payer status, caregiver availability/presence, and geographic location.

9. **Would standardized data elements for EHRs help you to collect social risk data? What do you see as promising future opportunities for improving data collection? For using existing or future data to tailor services?**

As described above, IRH/Us collect information on social risk factors to inform the development of a patient-centered care plan, and specifically a discharge plan. The data collection process is already well integrated into a hospital's clinical workflow and furthermore is likely to have been adapted to suit the needs of the hospital, community, or region. At this time, it is unclear how standardizing data collection in EHRs, in a global aggregate sense, could help providers improve upon how they collect and use this information for care planning purposes for individual patients.

There is a benefit to adjusting for social risk factors in Medicare payments and quality reporting programs. AMRPA strongly supports a methodologically sound approach to risk-adjustment for social risk factors, which we have recommended in the past. Our members perceive dual-eligible status, low-income subsidy status, and geographic area of residence as important factors that are also more readily accessible in currently available data sources. In evaluating provider performance, CMS should compare quality performance and resource use for providers that have comparable proportions of similar patients, such as low-income beneficiaries. We also strongly encourage CMS to develop a way to account for family/caregiver status and/or community supports. Research shows that beneficiaries who lack the adequate caregiver support have higher rates of readmission and lower rates of discharge to the community following PAC.[5,6] CMS should be cognizant of these factors as it continues to consider options to increase transparency in Medicare's quality programs.

10. **What are barriers to collecting data about social risk?**

One barrier is resources – a hospital must have the adequate financial health to be able to invest in developing the depth of its social services bench. In addition, because IRH/Us oftentimes rely on the upstream referring hospital for this information, another common barrier is limited availability of pertinent information from the acute care hospital.

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AMRPA appreciates the opportunity to provide input to the ASPE for a follow-up report to Congress on how providers serve beneficiaries with social risk factors. AMRPA is a strong supporter of the principles and objectives of the IMPACT Act, and remains committed to

[5] Everink IH, van Haastregt JC, van Hoof SJ, Schols JM, Kempen GI. Factors influencing home discharge after inpatient rehabilitation of older patients: A systematic review. BMC Geriatrics 2016; 16: 5.

[6] Rodakowski J, Rocco PB, Ortiz M, et al. Caregiver integration during discharge planning for older adults to reduce resource use: a metaanalysis. J Am Geriatr Soc 2017; 65: 1748–1755

working with HHS to achieve the Act's objective to enhance how socioeconomic status and social risk factors are accounted for in Medicare programs. If you have any questions, please contact Mimi Zhang, AMRPA Senior Policy and Research Analyst (mzhang@amrpa.org).

Sincerely,

Richard Kathrins, PhD
Chair, AMRPA Board of Directors
President and CEO, Bacharach Institute for Rehabilitation

Suzanne Kauserud, FACHE, MBA, PT
Chair, AMRPA Quality Committee
Vice President, Continuing Care Division - Inpatient
Carolinas Rehabilitation / Atrium Health