

November 16, 2018

Submitted electronically to ASPEImpactStudy@hhs.gov

Attention: Assistant Secretary for Planning and Evaluation (ASPE)

Re: Request for Information; IMPACT Act Research Study: Provider and Health Plan Approaches to Improve Care for Medicare Beneficiaries with Social Risk Factors

These comments are submitted by the Pennsylvania Homecare Association (PHA) in response to the above named Request for Information (RFI). PHA is an industry trade association representing homecare, home health and hospice providers that serve Medicare and Medicaid beneficiaries in their homes. The nature of this care demands that providers be aware of and adjust for a patient's social risk factors. Clinicians are providing care in an individual's own home, surrounded by their family and, in the case of hospice services in particular, they are providing services to those family members as well. The risk factors identified by ASPE in the RFI—socioeconomic position, race, ethnicity, social relationships and residential/community context—have an impact on how homecare providers interact with the patient and their informal caregivers and how the agency structures a care plan that will meet the patient's needs.

As noted by ASPE, however, there continues to be gaps in this information and inconsistencies in how health plans and CMS collect and share this information with providers who need it.

Key Social Risk Factors for Home-Based Care

Because home-based care is delivered and coordinated right at home, providers have found that the most important risk factor to consider for the patients they serve is whether they live alone. The absence of informal caregivers and support often compounds these patients' chronic care needs and leaves them with less ability to perform activities of daily living without assistance from a provider agency. Patients who live on their own are more likely to experience poor living conditions and food insecurity, which can exacerbate their illness or lead to falls and other preventable injuries.

Homecare providers report that while information about living conditions is captured at the time of referral, it is not uniformly shared or tracked in a way that can show a statistical impact on care. Agencies document this information in the patient's record with the goal of better informing caregivers and clinicians who will be involved in that individual's care and visiting the home most often. However, there are no prepackaged interventions that are generally applied for patients who live alone. Rather, each agency has its own approach to caring for this

population.

Aside from living alone, another risk factor that impacts the patient's homecare has to do with the neighborhood or location of their home and its effect on the ability to adequately staff all of the hours of care the individual requires. Dangerous neighborhoods, rural areas and unique cultural community needs are some of the data points that providers seek from referral sources in order to plan for the patient's care. For instance, the individual might live in a community where almost all residents speak just one language and an agency will attempt to accommodate those needs. The agency might need to plan sufficient travel time for clinicians to travel to secluded rural areas to staff the case. These needs are not always obvious upon referral, but could be the key to providing competent and complete care.

Barriers to Collecting & Tracking Social Data

The biggest barrier that providers report when collecting social risk data is the inability of electronic medical records to capture the information in a useful way. Many software systems offer a text or narrative field for providers to insert information like this, but this does not offer a mechanism for providers to aggregate and track data on their patient population and corresponding interventions and outcomes, if any. While agencies are asking patients and families for key information that will impact their care, as discussed above, they are not currently examining outcomes or trends because of the lack of uniformity in electronic records.

Another reason providers report for minimal activity in tracking social determinants of health is that payers and licensing bodies are not currently requiring it. Clinicians in the home are already stretched thin to collect all required information while providing person-centered care and putting patients ahead of paperwork. For example, the initial home health assessment could take two to three hours to complete under today's regulatory requirements. It is very difficult for clinicians to collect any additional information from a fatigued patient and family who are focused on getting well. The best way to secure information on social risk factors from all patients is for payers and CMS to mandate its collection as part of the agency's routine procedures.

Suggestions to Improve

No one in the healthcare industry would dispute that social risk factors have a great impact on a patient's wellbeing and the ability to care for Medicare and Medicaid beneficiaries. However, there are very few providers or payers that can analytically show how best to account for these needs and care gaps to compensate for the patient's socioeconomic circumstances. Below are some suggestions to improve the lack of data in this area:

- Work with state Medicaid agencies to aggregate and analyze data collected from dual-eligible beneficiaries as part of the nursing facility clinically eligible (NFCE) and financial determination assessments. These instruments collect valuable data related to income, living situation and other factors to understand how patients' financial health impacts

their physical health. The right information is already being collected by both Medicare and Medicaid, but there is very little crossover or opportunity for comparison.

- Aggregate OASIS data at a national level to better understand how a patient's living situation (M1100) impacts their care needs and outcomes.
- Insert standard, required fields on patient electronic medical records as a condition of federal funding so that providers and payers will be better able to track and trend this information rather than collecting it in narrative form on the patient's record.
- Fund pilot testing activities for payers and providers to develop best practices for tracking social risk factors and triggering certain health interventions to determine their impact.

Thank you for the opportunity to provide feedback on home-based care providers' experience with patient social risk factors. PHA applauds CMS and ASPE for continuing this work as it grows more and more vital each year as the senior population grows to address these needs for dual eligible and other Medicare beneficiaries.

Sincerely,

A handwritten signature in black ink that reads "Vicki Hoak". The signature is written in a cursive, flowing style.

Vicki Hoak, CEO