AAMC
CENTER FOR
HEALTH JUSTICE

Submitted electronically via webform at https://congressionalsdohcaucus.org/

September 20, 2021

RE: Congressional Social Determinants of Health Caucus' Request for Information

The AAMC Center for Health Justice (AAMC CHJ) appreciates the opportunity to offer comments to the Congressional Social Determinants of Health (SDOH) Caucus on challenges and opportunities related to addressing the conditions in which people in the United States live, work, play, and age. Achieving health equity is about ensuring all communities have equitable beginnings, not equal endpoints, and equitable beginnings demand that all communities have the vital conditions for health including humane housing, reliable transportation, educational opportunities, adequate nutrition, high quality medical care, and freedom from discrimination and violence. These and other SDOH contribute not only to the health of individuals but the wellbeing of entire populations.

The AAMC (Association of American Medical Colleges) is a nonprofit association dedicated to transforming health through medical education, health care, medical research, and community collaborations. Its members are all 155 accredited U.S. and 17 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and the millions of individuals employed across academic medicine, including more than 186,000 full-time faculty members, 94,000 medical students, 145,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

The AAMC CHJ was founded in 2021 with the primary goal for all communities to have an equitable opportunity to thrive — a goal that reaches well beyond medical care. Achieving health justice means addressing the common roots of injustice, implementing policies and practices that are explicitly oriented toward equity. We partner with public health and community-based organizations, government and health care entities, the private sector, community leaders, and community members to build a case for health justice through research, analysis, and expertise. Additional information about the center is available at www.aamc.org/healthjustice.

The text below includes responses to the specific questions posed by the SDOH Caucus and entered into the electronic form to collect responses. In cases where the questions warranted similar or related responses to ensure a comprehensive answer, similar information has been provided in more than one response.

The AAMC Center for Health Justice is committed to advancing these efforts and would appreciate the opportunity to work with the SDOH caucus on any of the issues or recommendations discussed in our responses. We would also be happy to provide additional information on the research and policy priorities of the center, as well as potential opportunities for collaboration with our constituent community and health equity partners. For questions, please contact me (palberti@aamc.org) or Matthew Shick, Senior Director, Government Relations & Regulatory Affairs (mshick@aamc.org).

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Experience with SDOH Challenges

1. **What specific SDOH challenges have you seen to have the most impact on health? What areas have changed most during the COVID-19 pandemic?**

   SDOH impact communities at hyper-local levels and those that are most salient for one community might not be the priority for neighboring communities. Because of this, and to ensure success of the Caucus' efforts, the AAMC CHJ strongly encourages the prioritization of meaningful community engagement in order to understand not only which policy interventions will impact which communities, but to incorporate local wisdom into the development, implementation and evaluation of those policies.

   Relatedly, authentic community engagement by federal, state, and local government partners will help overcome one of the most important social barriers to community well-being: lack of trust in our institutions and organizations. While mistrust and distrust have been documented for decades and centuries, the COVID-19 pandemic has thrust into high relief the many diverse communities – and their diverse rationales – for mistrusting government, scientific, medical, public health, and other institutions. Earlier this year, AAMC CHJ released its community co-developed Principles of Trustworthiness and we encourage the SDOH Caucus to adopt these tenets as your work develops and as policies are crafted.

   Generally, however, COVID-19 has shown us that adverse SDOH can limit a community's opportunity to be healthy and stay safe. From overcrowded homes resulting from a lack of affordable housing to the absence of paid sick leave that would facilitate vaccination, to the lack of technologic infrastructure to support remote working and learning, the pandemic has made it very clear that SDOH and the vital conditions for health play *the* major role in determining which communities thrive and survive and which do not. Given that the social determinants of health are the same as the social determinants of education, of employment, of home ownership, etc., we strongly support the Caucus' effort to coordinate SDOH-related efforts across sectors to "break down barriers that impede better coordination" between medical care, public health, social services, and all other sectors in the health ecosystem. Thus, AAMC CHJ urges the caucus to explicitly engage agencies and offices beyond Health and Human Services as it works to develop a systematic, comprehensive policy agenda to address these interconnected social determinants.

   For medical care specifically, access to routine health care during COVID-19 has been significantly disrupted. For example, the Radiology Health Equity Coalition, convened by the American College of Radiology, is concerned with the losing gains made in routine imaging screening for mammography. There is a concern that the challenge of limited access to routine mammography will further exacerbate the large racial and economic gaps in health outcomes between patient populations. This dynamic is not limited to radiology and will have implications across health and medical outcomes including routine vaccinations. According to the National Foundation of Infectious Disease, "…amid overwhelmed US healthcare systems and fears of contracting COVID-19, routine vaccination rates declined significantly across all populations in the US, with demand plummeting as much as 95 percent for certain vaccines."

2. **What types of gaps in care, programs, and services serve as a main barrier in addressing SDOH in the communities you serve? What approaches have your organization, community, Tribal organization, or state taken to address such challenges?**

   While individual communities may and do lack specific programs and services, hence the need for hyper-local community engagement, analysis, and program development, the overarching gaps *across* communities relate to trust in and coordination of those services and programs.

While mistrust and distrust have been documented for decades and centuries, the COVID-19 pandemic has thrust into high relief the many diverse communities – and their diverse rationales – for mistrusting government, scientific, medical, public health, and other institutions. Earlier this year, AAMC CHJ released its community co-developed Principles of Trustworthiness and we encourage the SDOH Caucus to adopt these tenets as your work develops and as policies are crafted. Additional programs and services will not have the desired impact if communities are not aware of them or do not trust them.

Another major barrier that impacts all communities is the lack of coordination between SDOH-relevant sectors. To facilitate cross-SDOH coordination, the AAMC CHJ strongly encourages the Caucus to develop policies related to the data needed to ensure efficient alignment between sectors so that individual and community needs are addressed holistically. Earlier this year, AAMC CHJ held a congressional briefing, "Data for Health Equity: the Foundation for Creating Healthier Communities" which highlighted how all sectors in the health ecosystem – including housing, public health, medicine, transportation – have similar data needs related to demographics, individual-level social needs, and community-level social determinants, among others. While COVID-19 revealed that the US still lacks comprehensive data on race and ethnicity, those demographics are just the tip of the iceberg in terms of the data needed not just to identify inequities, but to identify potential *solutions* to those inequities. AAMC CHJ strongly urges the Caucus to prioritize the development of a standardized, sociodemographic data collection system – at both individual and community levels – that can be accessed, used, and shared by all sectors in the health ecosystem.

AAMC member academic medical centers have increased their role as "SDOH hubs" both before and after the pandemic via social risk screening and referral practices as well as through formal partnerships such the collaboration between University Hospital in Cleveland, Ohio and "PCs for People" which helped patients and families stay connected by donating and refurbishing 500 laptop computers, 500 hotspots, and three months of broadband service to UH patients meeting certain criteria. However, placing medical care at the center of local efforts to coordinate SDOH activity is not a sustainable or effective model at the population level. Medical care *is itself* a SDOH and cannot be responsible for addressing and mitigating all other SDOH. When thinking about programmatic and service gaps, AAMC CHJ encourages the Caucus to craft policy that will directly provide resources to SDOH sectors beyond medical care in ways that will impact entire communities, not select patients.

3. **Are there other federal policies that present challenges to addressing SDOH?**

The AAMC believes there are several federal policies that present challenges to addressing SDOH, including fraud and abuse laws, privacy and data sharing constraints, and policy decisions in the development of value-based payment programs and alternative payment models.

Fraud and Abuse Limitations (Anti-Kickback Statute) – In December 2020, HHS Office of the Inspector General finalized changes to safe harbor for value-based care regulations. These changes potentially opened opportunities to better support patients' health-related social needs, but did so in a significantly limited manner. (See 85 FR 77684; Dec 2, 2020) Specifically, SDOH are referenced in the preamble as a valid value-based purpose for value-based arrangements for patient engagement for a prospectively identified target patient population but will require value-based entities to commit to rigorous compliance demands as part of the investment of limited resources into value-based arrangements. HHS Office of Inspector General had considered, but did not finalize, more explicit policies to allow providers to assist patients with health-related needs.

Privacy and Data Sharing - In addition to needing defined, aligned data for health equity the AAMC believes that there is a need to establish appropriate and clear privacy protections for such individual data in conjunction with the HIPAA Privacy Rule. Earlier this year HHS Office for Civil Rights proposed to expressly allow Covered Entities to share protected health information with social services agencies, community-based organizations, and home and community-based service (HCBS) providers for individual-level care coordination. (See 86 FR 6446, Jan 21, 2021) Addressing community SDOH and individual health-related social needs will require both individual and population-level interventions, and as such there is a need to expand such data sharing for population-level care coordination efforts. Additionally, HHS could and should provide additional guidance on how best to engage community resource providers as non-Covered Entities and appropriate privacy protections for such collaborations. We are concerned that potentially requiring community-based organizations to meet the same privacy standards as Covered Entities is untenable and will frustrate the broader aims of such data sharing and collaboration.

Medicare Value-Based Payment and Alternative Payment Models (APMs) - As CMS continues to develop and implement a transition to paying for value, through quality pay-for-performance programs and/or APMs, the agency needs to have the tools to appropriately measure providers' value of care by accounting for patients' health-related social needs and their communities' SDOH that impact overall cost and outcomes in risk adjustment, as they similarly adjust for clinical complexity. Incorporating individual- and community-level social risk factors into risk adjustment for payment will a) incentivize better healthcare data capture of health-related social needs to better inform non-healthcare interventions and care coordination and b) ensure that providers who treat socially complex patients are incentivized, rather than penalized, under value-based payment programs and APMs. If these programs and models continue to incentivize inequity in health care transformation, we will only reinforce the foundational contributions to SDOH.

Additionally, the AAMC CHJ urges the Caucus to evaluate federal policy regarding environmental and agricultural regulations that likely impact communities' access to clean air, clean water, and healthful, quality food options. HHS recently announced the creation of a climate change office, and we encourage the Caucus to better understand how that office might be able to address SDOH-related problems.

4. **Is there a unique role technology can play to alleviate specific challenges (e.g. referrals to community resources, telehealth consultations with community resource partners, etc.)? What are the barriers to using technology in this way?**

The COVID-19 pandemic has shown how technology, particularly health technology can provide access to care and resources for communities, especially those that are rural and/or underserved. For many, telehealth has been a needed lifeline throughout the pandemic. With the expansion and optimization of telehealth programs across the country, health systems can leverage this same technology to not only provide better access and care for many patient populations, but to also connect patients and community members to community resources, such as housing, food, and transportation. This in turn can lead to better health for many. Understanding and addressing the digital divide (I.e., the divide between populations that have access to and literacy skills to use technology and those populations that do not) as it relates to health technology is an important first step if health systems are to truly expand telehealth and technology services to increase access for all.

To better identify patient health-related social needs and make the relevant referrals to community-based organizations and resources, health systems have started screening for health-related social needs, including screening for the digital divide (i.e., digital literacy skills, inaccessible platforms for those with LEP and disabilities, connectivity, device access). Through this screening, usually conducted through an electronic medical record (EMR) or external provider platform, providers can send referrals to the appropriate community partners. In fact, the Veterans Health Administration has implemented a specific digital divide consult that refers patients to a social worker who can then address device access, broadband and connectivity, and digital literacy skills, dependent on what the consult notes as a barrier. For rural areas in particular, school-based telehealth programs can use the same technology to not only keep students healthy but also keep them in school and connect their families to community services. Some programs, such as Health-e-Schools, not only make referrals to community services but also have a small pool of funding for food, school supplies, and prescription medications. Non-traditional partners, such as community centers and libraries, also have a role to play in integrating technology into their services. Placing private telehealth kiosks and loaning devices in some sites, increases access to health and social services, and provide a private space for individuals to have telehealth appointments or job interviews.

As health systems and community-based organizations implement technology-based solutions and programs, addressing the various technology barriers must be acknowledged and addressed. First, the lack of EMR interoperability prevents communication across platforms and providers, which is a barrier to providing seamless and holistic care for patients. Second, the barrier referred to as the digital divide prevents certain populations from fully accessing digital services. Ensuring broadband access for all is a notable part of addressing this gap. Additionally, there is a need for greater infrastructure of health systems, community resource partners and other sectors in the health ecosystem to implement and use the technology, including training and educating providers, patients, community organizations and community members. Addressing these barriers can ensure that technology narrows health and health care inequities rather than exacerbating them. Congress and the federal government have a role to play in addressing these barriers and can help to alleviate these issues by promoting the use of technology without mandates and incentives which impede reaching interoperability, investing in infrastructure to support technology, including broadband for all, and banning the practice of digital redlining that primarily impacts low-income communities. We are grateful that the Senate-passed Infrastructure Investment and Jobs Act includes $65 billion in broadband infrastructure as a first step to address these issues.

Improving Alignment

1. **Where do you see opportunities for better coordination and alignment between community organizations, public health entities, and health organizations? What role can Congress play in facilitating such coordination so that effective social determinant interventions can be developed?**

   The lack of coordination and alignment between community organizations, public health entities, and health organizations is a significant barrier to developing and implementing successful SDOH interventions. While there are good examples of collaborations between single institutions, public health entities and their community partners, and all types of organizations have expressed interest in working together to improve the health of communities, systemic coordination is lacking. To facilitate cross-SDOH coordination, the AAMC CHJ strongly encourages the Caucus to develop policies related to the data needed to ensure efficient alignment between sectors so that individual and community needs are addressed holistically. Earlier this year, AAMC CHJ held a congressional briefing, “Data for Health Equity: the Foundation for Creating Healthier Communities” which highlighted how all sectors in the health ecosystem – including housing, public health, medicine, transportation – have similar data needs related to demographics, individual-level social needs, and community-level social determinants, among others. While COVID-19 revealed that the US still lacks comprehensive data on race and ethnicity, those demographics are just the tip of the iceberg in terms of the data needed not just to identify inequities, but to identify potential *solutions* to those inequities. AAMC CHJ strongly urges the Caucus to prioritize the development of a standardized, sociodemographic data collection system – at both individual and community levels – that can be accessed, used, and shared by all sectors in the health ecosystem.

   In addition to needing defined, aligned data for health equity, there is a need to establish appropriate and clear privacy protections for such individual data in conjunction with the HIPAA Privacy Rule. Earlier this year HHS Office for Civil Rights proposed to expressly allow Covered

Entities to share protected health information with social services agencies, community-based organizations, and home and community-based (HCBS) providers for individual-level care coordination. (See 86 FR 6446, Jan 21, 2021) Addressing SDOH will require both individual and population-level interventions, and as such there is a need to expand such data sharing for population-level care coordination efforts. Additionally, HHS could and should provide additional guidance on how best to engage community resource providers as non-Covered Entities and appropriate privacy protections for such collaborations. We are concerned that potentially requiring community-based organizations to meet the same privacy standards as Covered Entities is untenable and will frustrate the broader aims of such data sharing and collaboration.

2. **How could federal programs such as Medicaid, CHIP, SNAP, WIC, etc. better align to effectively address SDOH in a holistic way? Are there particular programmatic changes you recommend?**

It is essential that that food security, housing security, and payment for/access to health care services are all recognized as critical for individual and population health. Programs that support these areas, including research, must use evidence-based approaches to learn and respond to improving equity regarding the social determinants of health.

In terms of concrete steps towards alignment across federal programs such as Medicaid, WIC, SNAP, and housing support is to reduce the burden on individuals seeking assistance. As currently set up, one must navigate each and every program's requirements and application in a separate and unique process. We believe immediate efforts to coordinate data sharing across federal programs so that a single application system could be used to ease the burden on individuals and shift these programs towards a more holistic effort to address the SDOH.

3. **Are there any non-traditional partners that are critical to addressing SDOH that should be better aligned with the health sector to address SDOH across the continuum from birth through adulthood? What differences should be considered between non-health partners for adults' social needs vs children's social needs?**

The AAMC CHJ believes that involving nontraditional partners is critical to addressing SDOH. Non-traditional partners, such as city and regional planners are valuable partners for the health sector. Community centers and libraries also have a role to play in integrating technology into their services. Placing private telehealth kiosks in these sites and having devices that can be loaned to individuals increases access to health and social services and provides private spaces for individuals to have telehealth appointments or job interviews.

Many complex health-related social problems such as poor housing conditions and unlawful denial of health/social-related benefits are beyond the scope of a health care provider and require legal expertise to address. This model, a Medical-Legal Partnership (MLP), embeds attorneys as specialists in a health care setting to resolve specific health-harming legal needs for patients while also helping clinical and non-clinical staff navigate system and policy barriers.

Academic medical centers partner with community-based organization to address patients' health-related social needs such as lack of access to transportation, housing instability, and food insecurity. Research has shown that addressing patients' social needs can lead to better health outcomes in local communities. For example, an AAMC member, Boston Medical Center, used the Hunger Vital Sign food insecurity tool to screen, identify, and monitor the status of food insecure families. In partnership with a local food bank, Boston Medical Center provides food to 7,000 to 8,000 patients and families per month. Lack of access to transportation for both rural and urban communities often limits patients' ability to seek care. Many Medicare Advantage programs cover non-emergency medical transportation to doctor's offices, pharmacies, clinics, and other health care facilities. Other strategies include Denver Health's provision of bus and taxi vouchers for patients to attend medical appointments and MedStar Health's (and a growing list of other hospitals) partnerships with Uber and Lyft to provide transportation for patients to and from appointments. To address housing instability, academic medical centers such as the University of Illinois Hospital in Chicago implemented a “housing first” initiative which helped place chronically homeless emergency department patients into permanent housing.

Additionally, the AAMC CHJ believes the Caucus should include environmental justice organizations to aid in the evaluation of federal policy regarding environmental and agricultural regulations that likely impact communities’ access to clean air, clean water, and healthful, quality food options. HHS recently announced the creation of a climate change office, and we encourage the Caucus to better understand how that office might be able to address SDOH-related problems.

4. **What opportunities exist to better collect, understand, leverage, and report SDOH data to link individuals to services to address their health and social needs and to empower communities to improve outcomes?**

The lack of coordination and alignment between community organizations, public health entities, and health organizations is a significant barrier to developing and implementing successful SDOH interventions.

A foundational opportunity to enhance our data collection efforts would be for the Caucus, working with population health scientists and practitioners, to develop a unified taxonomy and standard set of definitions for terms that are often (and erroneously) used interchangeably. The AAMC CHJ, US Centers for Disease Control and Prevention, World Health Organization and others define *SDOH* at *only* the community level as factors that exist in places where people are born, live, work and play. For example, the density/availability of affordable housing within a community would be a SDOH data point. The maldistribution of SDOH across communities puts individuals within adversely affected communities at *social risk*, risk that may turn into a *health-related social need* (HRSN) for individuals (for example, housing instability or homelessness resulting from the lack of community-level affordable housing). Thus, while many health care organizations claim they are “screening for SDOH” they are actually assessing social risks to identify patient-level HRSN that can then be intervened upon for that patient. Importantly, screening and referring for patients’ HRSN is *not*, therefore, an SDOH strategy as helping homeless patients obtain housing, while crucial for the health and wellbeing of those patients, does nothing to impact the lack of affordable housing in their community. Policy efforts are required to truly address the SDOH.

To further facilitate cross-SDOH coordination, the AAMC CHJ strongly encourages the Caucus to develop policies related to the data needed to ensure efficient alignment between sectors so that individual and community needs are addressed holistically. Earlier this year, AAMC CHJ held a congressional briefing, “Data for Health Equity: the Foundation for Creating Healthier Communities” which highlighted how all sectors in the health ecosystem – including housing, public health, medicine, transportation – have similar data needs related to demographics, individual-level social needs, and community-level social determinants, among others. While COVID-19 revealed that the US still lacks comprehensive data on race and ethnicity, those demographics are just the tip of the iceberg in terms of the data needed not just to identify inequities, but to identify potential *solutions* to those inequities. AAMC CHJ strongly urges the Caucus to prioritize the development of a standardized, sociodemographic data collection system – at both individual and community levels – that can be accessed, used, and shared by all sectors in the health ecosystem.

In addition to needing defined, aligned data for health equity, the AAMC believes that there is a need to establish appropriate and clear privacy protections for such individual data in conjunction with the HIPAA Privacy Rule. Earlier this year HHS Office for Civil Rights proposed to expressly allow Covered Entities to share protected health information with social services agencies, community-based organizations, and home and community-based (HCBS) providers for individual-level care coordination. (See 86 FR 6446, Jan 21, 2021) Addressing SDOH will require both individual and population-level interventions, and as such there is a need to expand such data sharing for population-level care coordination efforts. Additionally, HHS could and should provide additional guidance on how best to engage community resource providers as non-Covered Entities and appropriate privacy protections for such collaborations. We are concerned that potentially requiring community-based organizations to meet the same privacy standards as Covered Entities is untenable and will frustrate the broader aims of such data sharing and collaboration.

5. **What are the key challenges related to the exchange of SDOH data between health care and public health organizations and social service organizations? How do these challenges vary across social needs (i.e., housing, food, etc.)? What tools, resources, or policies might assist in addressing such challenges?**

   A challenge to the exchange of SDOH data is lack of standardization of health-related social needs and community SDOH data. Tools addressing this issue include those efforts supporting interoperability broadly. One such effort, the Gravity Project led by the Social Interventions Research & Evaluation Network, addresses provider-to-provider interoperability and has the potential to bridge the gap between stakeholders. The Congress and the federal government should draw from existing expertise by associations and other nonprofit health care organizations to educate and support providers and public health and social services organizations in participation.

   Removing barriers to the exchange of health information for coordinating care among providers, payers, and others involved in meeting patients' health-related needs will have a positive impact on patient care and health outcomes. To that end, the AAMC CHJ strongly supports giving patients greater access to and control over their own health records. One role the federal government may have in addressing the issue is to better harmonize rules addressing access to health data and interoperability, including regulations under HIPAA and the 21st Century Cures Act (regarding interoperability and information blocking).

Best Practices and Opportunities

1. **What are some programs/emergency flexibilities your organization leveraged to better address SDOH during the pandemic (i.e., emergency funding, emergency waivers, etc.)? Of the changes made, which would you like to see continued post-COVID?**

   During the COVID-19 pandemic, other non-COVID telehealth services were billed to and paid for by the Medicare program and insurance companies more easily. The AAMC continues to recommend that this flexibility in payment and billing continue post COVID-19. The current COVID-19 pandemic has highlighted the potential for telehealth to improve patient access to care. Though teaching hospitals and faculty physicians have long been at the forefront of telehealth adoption and implementation, they have rapidly expanded their telehealth capacity to continue providing care to their patients who are unable to be seen in person due to COVID-19.

   Our AAMC-member teaching hospitals and health systems are reporting significant investment in telehealth – standing up vast telehealth capabilities in a matter of weeks and transforming the way they are delivering care. Some faculty physician practices are reporting a shift to providing approximately 50% of their ambulatory visits via telehealth. Members are also reporting fewer appointment cancellations in their Medicaid populations because of their deployment of telehealth. This significant expansion of telehealth capabilities was made possible in large part by CMS' willingness to create new coverage and payment policies and provide waivers and regulatory changes under the Medicare and Medicaid programs. Furthermore, the AAMC urges the Caucus to lead efforts to support federal guidance or legislation for flexible reimbursement practices for providers offering telehealth services across state lines. Reimbursing providers for telehealth services that are provided across state lines improves patient access to services and continuity of care for patients who have relocated or traveled to receive care from a specialist in another state. These policies should continue post COVID-19 as they improve access to care particularly for vulnerable populations.

2. **Which innovative state, local, and/or private sector programs or practices addressing SDOH should Congress look into further that could potentially be leveraged more widely across other settings? Are there particular models or pilots that seek to address SDOH that could be successful in other areas, particularly rural, tribal or underserved communities?**

   Academic medical centers partner with community-based organization to address patients' health-related social needs such as lack of access to transportation, housing instability, and food insecurity. Research has shown that addressing patients' social needs can lead to better health outcomes in local communities. An AAMC member, Boston Medical Center, used the Hunger Vital Sign food insecurity tool to screen, identify, and monitor the status of food insecure families. In partnership with a local food bank, Boston Medical Center provides food to 7,000 to 8,000 patients and families per month. Lack of access to transportation for both rural and urban communities often limits patients' ability to seek care. Many Medicare Advantage programs cover non-emergency medical transportation to doctor's offices, pharmacies, clinics, and other health care facilities. Other strategies include Denver Health's provision of bus and taxi vouchers for patients to attend medical appointments and MedStar Health (and a growing list of other hospitals) partnerships with UBER and Lyft to provide transportation for patients to and from appointments. To address housing instability, academic medical centers such as the University of Illinois Hospital in Chicago implemented a "housing first" initiative which helped place chronically homeless emergency department patients into permanent housing.

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3. **Given the evidence base about the importance of the early years in influencing lifelong health trajectories, what are the most promising opportunities for addressing SDOH and promoting equity for children and families? What could Congress do to accelerate progress in addressing SDOH for the pediatric population?**

   One option is to fund multidisciplinary programs for children with special needs and chronic complex programs. Such multidisciplinary programs need to have embedded social workers and others who can help families navigate the complex social needs that children with special health care and chronic complex conditions often have. There are some existing models, but all need more funding. State Medicaid programs that serve large numbers of children need to be mandated to also consider social needs that impact health and develop plans to address those needs. Managed care Medicaid plans administered by private payors often lack experience or incentives to consider social needs, particularly for pediatric patients. For rural areas in particular, school-based telehealth programs can use the same technology to not only keep students healthy but also keep them in school and connect their families to community services. Some programs, such as Health-e-Schools, not only make referrals to community services but also have a small pool of funding for food, school supplies, and prescription medications. Social factor-related outcomes for pediatric patients could consider those factors that may have long-term effects on children, such as access to childcare, educational disparities, and barriers to education, especially those during a period of remote learning, such as the COVID-19 pandemic.

Transformative Actions

1. **Alternative payment models help to measure health care based on its outcomes, rather than its services. What opportunities exist to expand SDOH interventions in outcome-based alternative payment models and bundled payment models?**

   The AAMC supports the inclusion of quality metrics that incorporate data elements capturing an individual's social needs into the risk adjustment methodology. Quality metrics are a key component of APMs, providing details on a provider's quality performance within a model. The Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academy of Medicine (NAM) both issued reports, entitled Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs report and Accounting for Social Risk Factors in Medicare Payment: Criteria, Factors, and Methods, respectively. These reports provide evidence-based confirmation that accounting for patients' sociodemographics, health-related social needs and their community's SDOH is critical in validly assessing the quality of care. These reports demonstrate that hospitals caring for large numbers of disadvantaged patients are more likely to receive penalties in performance programs. Furthermore, the lack of adjustment for social need can worsen health care inequities because the financial penalties divert resources away from participants treating large proportions of vulnerable patients. The failure to account for social risk also misleads and confuses patients, payers, and policymakers by shielding them from important patient and community factors that contribute to poor health outcomes. Both reports clearly show that there are implementable mechanisms by which data elements capturing social needs can be incorporated into quality measures today. Moreover, these reports discuss in detail data elements that are publicly available and could be immediately tested to determine whether an empirical relationship exists between social need and the measure's outcome by the regular distribution of reports that detail performance on these accountability metrics, stratified by the data elements capturing social factors included in measurement. This will give participants in APMs a better understanding of both their performance on quality metrics, as well as their performance relative to different populations with varying social needs.

   APMs should incorporate data collection for key demographic and social factors at both individual and community levels. The AAMC supports efforts to improve data collection and believes that it should begin with the use of improved demographic data that captures self-reported gender, race, and ethnicity as an initial step in a larger process to investigate and remove inequities in health. In doing so, it must be unambiguous that those factors themselves do not represent an individual's inherent risk. Rather, such demographic factors may be critical proxies for community-based factors until it is feasible to quantify and capture the actual risks of bias and unjust distribution of resources and opportunity that create the social and structural conditions that heighten inequities. Furthermore, dual eligibility status is also often used as a proxy for social risk. This, however, does not adequately represent the impact of social need and we encourage this option to be used only as a temporary resolution until more accurate tools can be developed. Recent studies show that using dual eligibility status to predict outcomes, such as readmissions, may not always be accurate, as dual eligibility status is often confounded by other community-based factors that are in fact the key contributors to the stated outcomes.

The AAMC strongly supports the utilization and collection of International Statistical Classification of Diseases and Related Health Problems (ICD) Z-codes related to the SDOH to identify specific barriers to care and to allow for appropriate risk adjustment for SDS. SDOH-related ICD-10 Z-codes are claims-based codes that allow providers to have discussions around and record a patient's social needs, which can later be used for referral to community services. Many AAMC member teaching hospitals and health systems use electronic health records (EHR)-based social risk screening tools in data collection to be better informed about the broader unmet health-related social need in their communities. 85% of Academic Medical Centers (AMCs) collect this data using some sort of screening tool, whether it be EHR-based or not. While several organizations have developed standard screening tools and core questions, we have heard from members that they often modify the templates to ensure culturally appropriate dialogue with the patients and communities they serve. Addressing inequity in communities requires integrating local perspectives in partnership with health care organizations that have demonstrated trustworthiness. Dialogue and screening about social risk factors must be culturally competent and help to establish trust between patients and the providers. As this field continues to develop, we believe that CMS should pursue a policy supporting the collection of standardized, multi-sector relevant social risk information to support improved stratification and risk adjustment, balanced with allowing hospitals local flexibility to promote community-based innovation and solutions.

The SDOH Caucus might also urge CMS to explore whether there are ideas and solutions from the data science and research community on how best to standardize a roll-up of granular data for community use into a format for broader evaluation and analysis. This is a massive undertaking led by the GRAVITY Project to advance interoperable social determinants of health data, beginning with three social risk factors: food security, housing stability and quality, and transportation access. CMS could partner on an effort led by the Office of the National Coordinator for Health Information Technology (ONC) to evaluate interoperability standards that roll data collected through screening tools up into SDOH-related ICD-10 Z-codes to capture social risk factors and provide actionable data to inform intervention. From that, we could then evaluate which Z-codes are best suited to incorporation in a minimum set of social risk factor data elements to require through EHR certification.

While exploring the utility of additional individual demographic and social need data elements, CMS could also evaluate the use and validity of community-based factors for improving data analysis necessary to inform quality and equity improvement activities. For example, research shows that community-defined social risk factors cause substantial shifts in projected performance on the Readmission Reduction Program's readmission models above and beyond individual level proxies. A clear benefit of community-based analysis compared to individual-level analysis is the reduced risk of compromising individual privacy in addition to ensuring the use of holistic approaches to broad, structural inequities. To this end, the Caucus might consider ways to explore and facilitate robust partnerships between CMS and public health departments, who may already have robust data that supports neighborhood stratification. Overall, data collection and systems for social risk factors at both the individual and community level should be used in conjunction to best identify inequities in quality and equity and guide interventions for improvement.

Additionally, the Caucus may want to encourage CMS to consider a variety of policy levers to improve hospital and physician data collection to address inequities in health care. While mandating minimum data collection as a requirement may be one solution, we urge evaluation of incentives for hospital to improve data collection in part through a commitment to improving risk adjustment models for the inclusion of social factors and/or for additional stratification in hospital quality programs. The AAMC believes that patients, payers, and providers will all benefit from partnership to improve health equity. CMS should lead the effort to demonstrate the benefit of better data to inform solutions.

The Caucus should encourage CMS to incorporate demographic and social factor data into the risk adjustment methodology of all current and future APMs. As stated previously, providers caring for a significant number of patients with high health-related social needs are more likely to be penalized under value-based care arrangements. Utilizing the proposed data in the risk adjustment methodology would ensure that participants in APMs are able to treat socially complex patient populations without facing significant losses as a result. Additionally, penalties take funds away from providers who are serving the greatest number of patients with the most complex social needs. Therefore, the risk adjustment methodology for all current and future APMs should incorporate data capturing social factors to better account for the patient populations of each participant and ensure that providers have the resources and funds available to better assist these populations.

Incentives and payment bonuses should be incorporated into all current and future APMs for improving quality of care for patients with greater social needs. Providing a positive adjustment to a participant's payments or establishing a bonus payment for improving care for vulnerable patients would help create a revenue stream that providers could reinvest in their work on health equity. Precedent for an incentive payment was established in the End-Stage Renal Disease Treatment Choices (ETC) Model, which released a proposed rule in July 2021 outlining the addition of a health equity incentive. This incentive would allow for a positive adjustment to be applied to provider payments based on the proportion of patients that qualify as dually eligible or Part D Low Income Subsidy recipients that have an increase in home dialysis or transplant wait list rates. An increase in these rates would indicate that those patients are no longer receiving center-based services, a move associated with better outcomes and greater flexibility for patients. The AAMC strongly supports the inclusion of these types of bonuses within ETC, as well as within other current and future models, to incentivize health equity work. Similar incentive or bonus payments should be incorporated into all current and future APMs. For example, a health equity bonus should be included in models such as the Primary Care First (PCF) Model. This model focuses on targeting chronically ill patients who lack regular primary care. By incentivizing health equity within this APM, all patients could have better access to regular, non-emergency care to help manage their health appropriately.

2. **A critical element of transformation, particularly for new models of care, is measurement and evaluation. With SDOH in mind, which are the most critical elements to measure in a model, and what differences should be considered when measuring SDOH outcomes for adult's vs children?**

It is crucial to discover which and how outcomes measured by a new model of care are influenced by community SDOH and by health-related social needs, using a reliable and rigorous statistical model, incorporating previous studies and literature about the current connection between SDOH/patient social needs and outcomes. The connection should be evaluated considering its impact on providers participating or potentially participating in new models of care. Once the connection between SDOH/health-related social needs has been fully established, it should be ensured that those factors are appropriately measured and accounted for in performance measures, both quality and utilization. The measurement should incentivize and require the collection of appropriate data while considering the burden on providers. This could include the use and/or requirement for SDOH-related Z-codes as appropriate.

Further, the evaluation of appropriateness of measurement should be ongoing, with regular reports on measurement to providers.

SDOH outcomes for pediatric patients could consider those factors that may have long-term effects on children, such as access to childcare, educational disparities, and barriers to education, especially those during a period of remote learning, such as the COVID-19 pandemic.

3. How can Congress best address the factors related to SDOH that influence overall health outcomes in rural, tribal and/or underserved areas to improve health outcomes in these communities?

To help address the nonmedical factors that affect health outcomes and can result in unfair, avoidable health inequities, the AAMC endorses the Social Determinants Accelerator Act (SDAA, H.R. 2503). This legislation — introduced by Reps. Cheri Bustos (D-Ill.), Tom Cole (R-Okla.), Jim McGovern (D-Mass.), and Markwayne Mullin (R-Okla.) — would authorize an interagency technical advisory panel on SDOH and create planning grants for state, local, and tribal governments to establish accelerator programs that address SDOH.

In previous Congresses, the SDAA was part of the Health Equity and Accountability Act, which includes proposals to addresses health care disparities experienced by communities of color, rural communities, and other underserved populations by improving culturally appropriate care and data collection and reporting. The HEAA also strives to strengthen the health care workforce through expanded and sustained financial support for the Health Resources and Services (HRSA) Title VII health professions and Title VIII nursing diversity pathway and workforce development programs.

Additionally, to summarize our responses to other questions in this RFI, the AAMC recommends that Congress:

- Increase community engagement initiatives using the Principles of Trustworthiness
- Engage agencies and offices beyond the Department of Health and Human Services
- Consider recommendations from the AAMC CHJ congressional briefing, "Data for Health Equity: the Foundation for Creating Healthier Communities" to facilitate national, standardized, comprehensive, and routine collection of sociodemographic data for people and communities, supported by resources, incentives, and community engagement to ensure validity and data collection.
- Promote the use of technology without mandates or incentives that impede reaching interoperability, invest in infrastructure to support technology, including broadband for all, and ban the practice of digital redlining that primarily impacts low-income communities.
- Coordinate data sharing across federal programs to a single application system to ease the burden on individuals and shift these programs towards a more holistic effort to address the SDOH.
- Permanently extend the current telehealth waivers after the public health emergency expires, specifically those that allow patients to receive telehealth services in any location, including their home, and to allow payment for audio-only services.
- Include SDOH in fraud and abuse laws, privacy and data sharing constraints, and policy decisions in the development of value-based payment programs and alternative payment models.
- Ensure that Community Health Needs Assessments (CHNAs) include strategies to address SDOH challenges, as further described in response to question 4 in this section.

4. What are the main barriers to programs addressing SDOH and promoting in the communities you serve? What should Congress consider when developing legislative solutions to address these challenges?

Programs should consider impacts on providers of high-needs patients and the impact on their practice and payment. One barrier to achieving this goal is the lack of standardized, actionable data that could support programs addressing SDOH in provider communities. A solution for lack of data should consider (a) what type of data is most needed for programs addressing SDOH, (b) who will collect this data and who will bear the cost of collection, and (c) how to make the burden of collection lower for providers.

AAMC recommends that the SDOH Caucus ensure that the required Community Health Needs Assessments (CHNAs) include strategies to address SDOH issues to help not for profit hospitals and health systems better allocate their community benefit dollars. There is also a critical need to consider the effects of systemic racism across all missions within health care, such as research, clinical, education, community, etc. Additionally, AAMC recommends the SDOH Caucus consider the effects of the increased closures of safety net hospitals. The closure of these hospitals needs should be addressed as a contributor to SDOH challenges in marginalized communities.