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American Medical Colleges**
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Submitted electronically

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Deputy Assistant Secretary for Planning and Evaluation
Office of Assistant Secretary for Planning and Evaluation
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
ASPEImpactStudy@hhs.gov

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

Dear Dr. Destro:

The Association of American Medical Colleges (AAMC or Association) welcomes this opportunity to comment on the Office of the Assistant Secretary for Planning and Evaluation (ASPE) Request for Information on provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors (SRF).

The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members are all 152 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

The AAMC appreciates ASPE's work on identifying SRFs that play a major role in health. We commend ASPE for its use of the definition of SRF provided by the National Academy of Science, Engineering, and Medicine (NASEM), which includes: 1) socioeconomic position; 2) race, ethnicity, and community context; 3) gender (gender identity and sexual orientation); 4) social relationships (marital/partnership status, social support); and 5) residential and community context (housing, social environment). We applaud ASPE for recognizing that the term gender captures social dimensions of gender and encompasses both cis- and transgender identities.

The Association supports efforts to reduce inequities in care and to improve quality, care coordination, and access to services for vulnerable populations. Accounting for risk factors in

ways that isolate inequitable differences in measured quality can raise awareness and lead to the development of interventions that reduce disparities and improve quality and efficiency. It can also improve accuracy in reporting and compensating providers fairly. Academic medical centers (AMCs) provide a disproportionate share of care to vulnerable patients. AAMC teaching hospital members represent only 5% of all hospitals yet provide 31% of all hospital charity care and treat 25% of all Medicaid hospitalizations, as well as a disproportionate share of community services, often at a financial loss. AMCs also provide highly specialized services for entire regions of the country and receive transfers from other hospitals that cannot care for patients with complex clinical and social needs.

Many of our members have been collecting data on social risk factors for the patients and communities they serve and have been leaders in developing innovative programs to improve care for patients and promote community health and health equity. These comments are informed by the experiences of our members.

DATA: CAPTURING MEDICARE BENEFICIARIES' SOCIAL RISK

ASPE requests information on how providers currently capture beneficiaries' risk. Specific feedback is also solicited on which SRFs are most important to capture, who collects the data, and whether standardized data elements for electronic health records (EHRs) might help to collect SRF data.

It is important to capture social risk factors at both the individual patient-level and the community-level as both sets (and their interactions) have independent effects on health and health care outcomes. The County Health Rankings model, which was developed collaboratively by the Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute, helps to explain the many factors that influence health and its use should be considered in an approach to improving health in the community.¹

Individual-level factors include characteristics such as education, race, income, gender, disability status, level of social support, etc. Complementary community-level factors that impact health outcomes include aspects of both the physical environment (e.g., housing, walkability, transportation options, air quality, and proximity to services) as well as the social environment (e.g., safety and violence, social disorder, and presence of social organizations). A community's compositional characteristics may also include dimensions of income, poverty, educational attainment, and employment and the proportion of racial/ethnic minority residents, single parent households, or English language proficient residents.

The health/healthcare outcome must be considered in order to determine which individual- and community-level SRFs should be collected to inform local interventions, as well as national quality measurement and risk adjustment schemes. For example, an environmental factor like

¹ 2018 County Health Rankings Key Findings Report, Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute (March 2018) (<http://www.countyhealthrankings.org/explore-health-rankings/reports>)

poor air quality might significantly impact the risk of pneumonia readmissions but have minimal influence on hip replacement readmissions.

Thus, while the national standardization of a select number of “the most relevant” SRFs is an important measurement and policy goal, we do not yet know which patient- and community-level factors “explain” the most variance for the most health/healthcare outcomes. **We urge ASPE to support research that will identify which SRFs, and interactions between them, explain the most variance for the most healthcare outcomes.**

We similarly urge ASPE not to rely solely on the data elements that are currently feasible and available. This will likely limit options to two: Medicare and Medicaid dual eligibility status (DE) and Black race as stand-ins for all SRFs, patient- and community-level alike. Given that race and DE are both correlated with SRFs that directly impact health and healthcare outcomes, their use as proxies neither helps us isolate true inequities in quality nor identifies intervention points to address such quality gaps.

Who/How/When to Collect Data

ASPE solicits feedback on who should collect SRF data and the best approach to collecting this information. The most appropriate data collection methodology will vary by the group being assessed. Primary care physicians (PCPs), registered nurses (RNs), or community health workers (CHWs) could be responsible for collecting the data, depending on the patient. In other instances, data collection could occur using a patient portal, either at home or in a waiting room. **We recommend that further research be conducted to determine which data collection modality (e.g. PCP, RN, CHW, portal, other) provides the most accurate social risk data for specific population groups.**

Community members, patients and families, and health system staff are the main stakeholders likely involved in SRF data collection and should be part of the research dialogue. Active engagement from each of these stakeholder groups is essential to learn how to collect SRF data in the most valid way and how best to use SRF data once available.

To identify community health priorities and salient SRFs, we suggest ASPE turn to the methodologies developed and deployed in service of non-profit hospitals’ and public health departments’ formal community health needs assessments (CHNAs). These publicly available documents will not only provide ASPE with a variety of approaches used by hospitals to define “community”, they also present an array of qualitative and quantitative SRF data collection methodologies. Further, a national review of CHNAs can focus ASPE on the handful of health conditions and social determinants deemed most important by the American people as ASPE works to identify the “most important” SRFs to collect and potentially standardize.

When engaging patients in developing patient-centered SRF data collection methods, the following questions might be considered: 1) how patients will feel about the specific questions being asked; 2) what is the best process for getting valid data from patients; 3) how would patients prefer to be asked questions and by whom; and 4) and how can the patient’s data be shared between institutions who may use different EHR vendors.

For health system stakeholders, it is important to address: 1) who is going to ask the questions; 2) what training is needed; and 3) how the collection processes can be standardized across systems or will different processes work best in different systems.

In addition to research aimed at developing data collection methods, **we urge ASPE to support research on how health systems and communities can translate SRF data collection into action.** Potential research questions include: 1) how is SRF-related information reported back to patients and families?; 2) how is the information used to improve care for patients?; 3) how can patient-specific SRF data be used in conjunction with population/community level data to identify the best treatments and local resources; and 4) how can the information be used to expand care beyond clinical care.² These issues are discussed more fully in the following section.

DELIVERY OF SERVICES AND IDENTIFICATION OF BENEFICIARIES WITH SOCIAL RISK FACTORS

ASPE is interested in understanding how beneficiaries with social risk factors are identified and services targeted to Medicare beneficiaries with social risk factors.

Hospitals and health systems are deeply investing in identifying **both patients with social risk and communities of social risk.**

Physician and health care professionals' notes contain valuable information on social risk factors. Hospitals are using automated methods for analyzing these notes within EHRs along with billing codes and other data contained in the EHR to identify patients with social risk factors. Increasingly, hospitals are also using tools to screen patients for a range of health-related social needs (e.g. housing, food insecurity, safety, transportation discounts). Hospitals use this information to form a "social needs" snapshot of patients and their community.

Since 2010, nonprofit hospitals and health systems, including teaching hospitals, have been required to conduct a triennial community health needs assessment (CHNA) that identifies and prioritizes local health needs. Each hospital must make the CHNA widely available to the public and develop an implementation strategy (IS) that describes how the hospital will address selected health needs.

The results of a recent qualitative review of nearly 100 CHNA/IS pairs from academic medical centers nationwide showed that (1) considered together, the social determinants of health (SDOH) were the 5th most prioritized community health need, and (2) food access, social support, and poverty were the top three social factors teaching hospitals targeted.³

² RoCChE: Moving EHRs Upstream Meeting. AAMC Health Equity Research and Policy. June 18, 2015 Available at <https://www.aamc.org/download/437592/data/rocchemeetingreport.pdf>

³ Teaching Hospitals' Commitment to Addressing Social Determinants of Health, AAMC, <https://www.aamc.org/download/480618/data/aamc-teaching-hospitals-addressing-sdoh.pdf>

Below are select examples of how teaching hospitals are addressing social determinants of health.⁴

Food Access:

- Hospitals are using hospital food “prescription programs” to connect patients to healthier food options.
- Hospitals are creating “Veggies in the Backpack” programs for school-aged children to bring home fresh vegetables.

Poverty:

- Hospitals are launching job creation programs for the underserved and patients with mental illness.
- Hospitals are increasing efforts to hire individuals from surrounding low-income areas.

Transportation:

- Hospitals are creating partnerships with taxi services to provide medical transport services at no cost for patients.
- Hospitals are providing vans to transport chronically ill and elderly patients to and from medical appointments.

Social Support:

- Hospitals are using SDOH screening tools to identify and address unmet social needs in a clinical setting, including social isolation.

Education:

- Hospitals are creating programs for kindergarten and college readiness.
- Hospitals are using telemedicine to reduce school absences by connecting schools and pediatricians.

Housing:

- Hospitals are creating medical respite programs to provide recuperative care for homeless men and women who are too sick to return to a shelter or the streets.
- Hospitals are employing housing retention specialists to work with patients and assess potential barriers to maintaining stable housing.

As discussed previously, caring for people with complex medical and social needs requires an approach that recognizes non-medical factors such as housing, transportation, food insecurity, and social supports. **To help address these underlying needs, many hospitals have broadened their health care teams to include community health workers (CHW) and, through Medical-Legal Partnerships (MLP), lawyers.**

Community health workers link health/social services and the community to facilitate access to services and improve the quality of service delivery. By serving as a liaison between communities and health care agencies, CHWs can help avoid unnecessary hospitalizations; enhance residents’ ability to effectively communicate with health care providers; provide health and nutrition education; coordinate follow-up services; and proactively identify and enroll

⁴ Teaching Hospitals’ Commitment to Addressing Social Determinants of Health, AAMC, <https://www.aamc.org/download/480618/data/aamc-teaching-hospitals-addressing-sdoh.pdf>

eligible individuals in federal, state and local private or nonprofit health and human services program.^{5, 6}

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. Attorneys can be embedded as specialists in a health care setting to resolve specific problems for patients while also helping clinical and non-clinical staff navigate system and policy barriers. Early results of a forthcoming, CDC-funded evaluation (analyses available upon request) of the MLP model has demonstrated not only significant “cost avoidance” post-MLP intervention, but also marked improvement in screening and referral behaviors by trainees exposed to MLP, and improved self-efficacy and empowerment of families post MLP intervention.⁷

As ASPE examines solutions to disparities, we recommend a review of the work of *Finding Answers: Solving Disparities Through Payment and Delivery System Reform (Finding Answers)*, a national program of the Robert Wood Johnson Foundation that has been a leader in implementing solutions to disparities.⁸ From 2005-2013 the program team produced 12 systematic reviews of the literature and awarded 33 grants to health care organizations with innovative interventions to identify best practices for reducing racial and ethnic disparities in care and outcomes. Based on the findings, they created the [Roadmap to Disparities](#) (Roadmap)⁹ that includes best practices and guidelines for health care organizations and policymakers to address disparities through quality improvement efforts.

In addition, we recommend ASPE examine the activities of organizations participating in the Accountable Health Communities Model funded by the Centers for Medicare and Medicaid Innovation Center. This model, which began in 2017, is testing whether systematically identifying and addressing beneficiaries’ social needs impacts total health care costs and reduces inpatient and outpatient utilization. Organizations in the model identify and partner with clinical delivery sites (e.g. physicians, hospitals) to conduct screenings of beneficiaries and make referrals to community services to address health related needs, and coordinate and connect high-risk community-dwelling beneficiaries to community services providers.

⁵ CDC. Integrating Community Health Workers on Clinical Care Teams and in the Community. Centers for Disease Control and Prevention (2018).

⁶ Scott K, Beckham S, Gross M, et al. What do we know about community-based health worker programs? A systematic review of existing reviews on community health workers. *Human resources for health*. (2018).

⁷ www.aamc.org/AHEAD

⁸ Robert Wood Johnson Foundation. Finding Answers: Solving Disparities Through Payment and Delivery System Reform Available at www.solvingdisparities.org/sites/default/files/Lessons%20Learned%20Web%20PDF%2009_25_2018b.pdf.

⁹ Robert Wood Johnson Foundation. Roadmap to Reduce Disparities, Available at <http://solvingdisparities.bytrilogy.com/tools/roadmap>

BARRIERS AND OPPORTUNITIES

ASPE requests feedback on the barriers that exist to collecting data about social risk and improving care for Medicare beneficiaries with social risk factors, and how these barriers can be overcome.

One key barrier is the lack of trust between patients/communities and the health care system. To collect data on social risk, to develop interventions, to implement changes, and to evaluate the impact of these changes requires patient- and community-engagement. Without authentic, bidirectional trust, this meaningful engagement cannot occur, imperiling the validity of data collected and undermining the effectiveness of interventions.

Another barrier is the lack of infrastructure and resources needed to promote health equity. Most health systems do not have the infrastructure, staffing, evaluation expertise, or financial incentive to develop comprehensive screening and referral protocols, community health coordination functions, data stratification and analyses, or robust, multi-sector relationships needed to address their patients' health-related social needs. Community based organizations often bring even fewer resources to the table.

To address this barrier, payment models could be designed that promote quality and financially support the development of equity-promoting structures. CMS' recent distribution of "healthcare disparities reports" that stratify pneumonia readmission rates by dual eligibility (DE) status is an important first step in terms of raising awareness, but the reports' reliance on DE status as an SRF proxy undermines both the isolation of true quality inequities and fails to suggest intervention points.

Instead, value-based payment models could encourage health care providers to prioritize disparities reduction if they (1) reward the minimizing or eradication of hospital-specific inequities over time and (2) reward hospitals for developing the data and human capacity to better identify, understand, and intervene on local healthcare disparities. Providing accurate feedback on provider performance related to disparities is also important to motivate change.

Support to promote best practices for achieving equity could be provided through several additional approaches. For example, payers could make capitated payments to institutions to promote services for at risk populations. Goals that focus on equity, such as increasing screenings in under-screened populations, in field treatment of at-risk patients, coordinating patient care, and follow-up patient care in certain counties could be established and providers could be rewarded with incentive payments for achieving these goals. Payers could provide reimbursement to providers for stratifying EMR data by social at-risk status. Patient navigators, CHWs and MLP lawyers (especially those who enhance the health system's language congruency) can also have a significant impact if their positions are adequately funded.

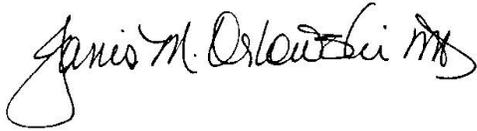
CONCLUSION

Thank you for the opportunity to provide comments on provider approaches to improve care for Medicare beneficiaries with social risk factors. We are committed to reducing disparities and

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improving quality of care for patients. If you have additional questions, please contact Philip M. Alberti, Ph.D, Senior Director, Health Equity Research and Policy at palberti@aamc.org or Gayle Lee, Director Physician Payment Policy and Quality at galee@aamc.org.

Sincerely,

A handwritten signature in black ink that reads "Janis M. Orlowski MD". The signature is written in a cursive, flowing style.

Janis M. Orlowski, MD, MACP
Chief Health Care Officer

cc: Philip Alberti
cc: Gayle Lee
cc: Ivy Baer