Ascension

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

November 16, 2018

Submitted via email: 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 Ms. Destro:

On behalf of Ascension, I appreciate the opportunity to submit comments on the Request for Information (RFI) entitled *IMPACT ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors.*[1]

Ascension is a faith-based healthcare organization dedicated to transformation through innovation across the continuum of care. As the largest non-profit health system in the U.S. and the world's largest Catholic health system, Ascension is committed to delivering compassionate, personalized care to all, with special attention to persons living in poverty and those most vulnerable. In FY2018, Ascension provided nearly $2 billion in care of persons living in poverty and other community benefit programs. Ascension includes approximately 156,000 associates and 34,000 aligned providers. Ascension's Healthcare Division operates more than 2,600 sites of care – including 151 hospitals and more than 50 senior living facilities – in 21 states and the District of Columbia, while its Solutions Division provides a variety of services and solutions including physician practice management, venture capital investing, investment management, biomedical engineering, facilities management, clinical care management, information services, risk management, and contracting through Ascension's own group purchasing organization.

We applaud the Assistant Secretary for Planning and Evaluation (ASPE) for engaging the plan and provider communities to gather input on the questions set forth in the RFI and we offer the following input for your consideration. Given the geographic variation of our Ministries, diversity of our patient populations, and breadth of services offered, Ascension represents a microcosm of the U.S. healthcare landscape writ large, able to offer insights into how promising programs can best be identified, scaled, and replicated across the country. To that end, we offer some observations and learnings from our own efforts to identify and address social risk factors among our patients and within our communities. We very much welcome the opportunity to continue engaging with ASPE on this important issue going forward.

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

How Providers Identify Medicare Beneficiaries with Social Risk Factors

In recent years, Ascension has undertaken a systemwide effort to make healthcare more equitable. Ascension's leadership has called on all our sites of care to establish national goals around healthcare equity and to reduce disparities by Fiscal Year 2022. We believe that improving health equity involves addressing the societal risk factors that have an impact on vulnerable populations' health. To achieve these goals, Ascension convened health equity forums in 2015 and 2017 attended by hundreds of our system and facility leaders. The conclaves were used to further understanding of variables driving health inequity and to develop strategies. Out of our work, a five-pronged strategy was developed that includes:

- Establishing health equity as a strategic priority for all of Ascension's care sites, including hospitals, long-term care facilities, and outpatient locations;
- Putting in place structures and processes to ensure that Ascension facilities can collect and use patient demographic and socioeconomic data **in a standardized way**—including the collection of patient race, ethnicity, and language data systemwide;
- Deploying specific strategies including clinical improvement initiatives that address social risk factors related to health;
- Decreasing the implicit bias that staff may have when delivering care, such as misunderstandings that may arise when patient and caregiver do not speak the same language, or have different ethnicities or belief systems; and
- Partnering with community organizations to improve health and health equity.

Furthermore, we have committed our organization to an Advanced Strategic Direction for 2025 that will guide our actions and decision-making in the coming years. The Strategic Direction is rooted in our commitment to provide Healthcare That Works, Healthcare That Is Safe, and Healthcare That Leaves No One Behind, for Life. To achieve the goals comprising the Advanced Strategic Direction, Ascension has committed to coordinating the development and implementation of Holistic Health Models – models that improve the health of individuals and communities throughout their lifetime by leveraging nonclinical care models to impact the social influencers of health (*e.g.*, level of patient activation and engagement, behavioral health/psychological factors, functional status, residential and community context, spiritual needs).

Given these commitments, it is critical for Ascension that our providers are able to assess and identify potential social risk factors among all patients – including Medicare beneficiaries. We have also found that it is vital to our success that our system move toward a standardized approach, which will foster the development and sharing of best practices. To accomplish this, however, we must navigate and achieve alignment across differing assessment standards that have been implemented across the myriad programs that exist today. These include the Promoting Interoperability Program, state Medicaid programs, the Accountable Health Communities Model, Comprehensive Primary Care (CPC)+, and Medical Home Models, among others.

While some helpful tools have emerged in recent years, our practitioners found themselves hindered by a relative lack of a widely available best practice screening tools. To best meet the needs of our patients and providers, Ascension independently developed a comprehensive and scalable screening tool by leveraging and building on existing options and screening questions that have been made available but have proven fragmented or otherwise limited. While existing tools, like the *Accountable Health Communities Health-Related Social Needs Screening Tool*[2] developed by the Centers for Medicare &

[2] Available at: https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf

Medicaid Services (CMS), may prove helpful for certain practices or in certain care delivery models, our organization has set out to create a single tool that can be scaled across multiple practices, states, and models. Our long-term goal is to develop one screening tool that can be used across the enterprise, which will allow us to better identify patient needs as they arise, identify and predict trends across the country, and strategically utilize resources at a national level or through community partners with whom we can engage to best address our patients' needs. As we move in this direction, we also encourage ASPE to work with the Department and CMS on ways to better align the various programs' screening and assessment requirements to create greater consistency.

In its current state, our screening tool allows providers to identify issues where additional information or investigation may be warranted to fully understand and address an unmet need or risk factor that may impact a patient's health status. We continue to refine and enhance this tool as we roll it out across multiple markets and care settings.

Approaches Used to Address the Needs of Medicare Beneficiaries with Social Risk Factors

To help providers address the needs of Medicare beneficiaries and other patients who are identified as facing one or more social risk factors that may impact their health status, Ascension has developed and is finalizing for dissemination a Community Inventory Tool and a Community Resource Template. When finalized, the Community Inventory Tool will offer a variety of approaches to providers for connecting patients with community resources. It supports practices in evaluating gaps in community partnerships and prioritizing specific linkages their patient population may need. It also includes office-based strategies that support the use of the Community Resource Template.

The Community Resource Template assists providers with populating a resource guide to quickly and efficiently connect patients to social services they need. It prompts practice staff to identify community agencies that offer services across a range of domains (e.g., financial assistance, food insecurity, and housing assistance), as well as specific contacts at community agencies to facilitate effective referrals from the practice to a single point of contact. The purpose is to stimulate the development of an extended set of contacts at community agencies that can meet patients' social service needs as identified by the Determinants of Health Assessment. The Template also includes a one-page domain-specific "Quick Reference", which is designed to share with patients an identified resource need in a specific area. It can be printed to provide patients with a list of resources once a need has been identified.

These tools have been designed in a manner that allows practices to leverage them in a way that makes the most sense for each practice. For example, practices that have an embedded social worker may have different needs and opportunities as compared to practices that only have the ability to provide patients with a handout containing information about community resources.

One of the publicly available resources that our providers have also found useful is Aunt Bertha[3]. Aunt Bertha is the largest closed loop referral network in the United States. The service allows consumers, patients, and providers to search for free and reduced cost social services based on zip code. Individuals seeking information and referrals can search the Aunt Bertha data base of verified programs at no cost and from a variety of platforms.

[3] https://www.auntbertha.com/

Evidence Regarding the Impact of Approaches on Quality Outcomes and Total Cost of Care

Ascension uses an "integrated scorecard" systemwide to incent improvements and gauge how well we are addressing disparities in health outcomes for certain prevalent conditions. Our success is based in part on how well we are able to manage social risk factors. For example, Ascension sites have been working to improve the health outcomes of vulnerable low-income heart failure patients. This involves individualized follow-up with these patients after hospital discharge to connect them with resources that address socioeconomic barriers that may make it harder to comply with doctors' instructions and manage chronic heart disease. Care navigators help coordinate the patients' post-acute care across multiple specialties and providers. We have also set a goal of achieving a reduction in all-cause, unplanned heart failure **admissions and readmissions** for all person served by an Ascension Medical Group (AMG) primary care provider, which similarly relies on assessing and addressing social risk factors. To date, we have achieved a reduction of 17% of avoidable admissions and improved access to care for persons with heart failure.

Ascension facilities have also increased colorectal cancer screening rates for low-income patients by partnering with churches and other community organizations to meet patients where they live, worship, and socialize in order to build awareness of the value of the screenings. To date, we have significantly improved screening rates across the system, screening roughly 100,000 additional persons.

Additionally, this past year we launched diabetes prevention programs across the entire system as part of our integrated scorecard goals in community health. We have been strengthening existing programs or starting new programs to reach more at-risk persons in their communities, encourage healthy living, generate greater diabetes awareness, and incent weight loss where applicable.

We disentangle and separately address social and medical risks using a standalone set of questions focused on specific social risk factors and then connect individuals with our community partners who can assist with the matters that have been identified.

Conclusion

Ascension appreciates the opportunity to provide this information and looks forward to working with ASPE on these important issues going forward. We would be very pleased to connect directly with ASPE and share the tools discussed above, including our standardized screening and assessment tool, the Community Inventory Tool, and the Community Resource Template, if any of these would be helpful to the Assistant Secretary. If you have any questions, or if there is any additional information we can provide, please contact Mark Hayes, Senior Vice President for Federal Policy and Advocacy at 202-898-4683 or mark.hayes@ascension.org.

Sincerely,

Reverend Dennis H. Holtschneider, C.M.
Executive Vice President and Chief Operations Officer
Ascension