Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

November 5, 2018

The Department of Health and Human Services
Attn: Office of the Assistant Secretary for Planning and Evaluation (ASPE)
Washington, DC
ASPEImpactStudy@hhs.gov

RE: Comments from the Catholic Health Association of the United States regarding ASPE's *Request for Information (RFI): IMPACT ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors*

The Catholic Health Association of the United States (CHA) is pleased to submit comments in response to the Assistant Secretary for Planning and Evaluation (ASPE)'s *Request for Information: IMPACT ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors*.

CHA is pleased that ASPE is examining the role of individuals' socioeconomic status on the Medicare program and its beneficiaries because there is a growing recognition that social risk factors play a key role in health. For the past year, CHA has studied how social risk factors (also known as social determinants of health) influence the health and well-being of low-income individuals and their communities and the role of hospitals in addressing these factors. As health care providers, we know that health does not occur in a vacuum. In addition to access to health care, biology and behaviors, the health of all individuals, including Medicare beneficiaries, is shaped by their physical environment, social and economic conditions. While these risk factors are defined in several ways, our work focused on these categories:

- **Social and community context**, including social cohesion, discrimination, community engagement
- **Education,** including literacy and language
- **Neighborhood and built environment,** including safety from crime and violence, transportation, clean air and water
- **Economic stability,** Including housing and food security and income.

The Role of the Healthcare System

While the health care system cannot solve problems related to social risk factors alone, hospitals and other health care organizations have a responsibility to address these factors within their organizations and communities. CHA recommends that our members engage these issues at three levels: in the clinical encounter, in community relationships, and in organizational structures and processes.

The clinical level

Many hospitals are screening Medicare beneficiaries in their emergency rooms and primary care settings for food and housing security as well as other determinants of health. When problems are identified, such as running out of food by the end of the month, not having access to healthy food or living in housing that is unsafe, patients and their families are referred to community agencies when possible. If community resources do not exist, hospitals work with community organizations to help develop needed resources. Our members have found that when problems related to social needs can be resolved, patient outcomes improve, and unnecessary, costly admissions can be prevented.

The community level

Having a network of community partners enables hospitals to be part of community-wide solutions to serious problems and to have access to a cadre of community resources for patient referrals. Hospitals work with community partners to conduct their health community health needs assessment which identify health needs and the root cause of these needs which often include social risk factors. Dealing with problems such as food and housing insecurity requires coordinated effort by health care, public agencies and community partners to promote access to healthy food and affordable housing and to advocate for policies addressing such needs.

The organization level

Poverty is at the root of many social risk factors. To address communities' economic conditions, healthcare organizations can and should consider community wellbeing in their operations. For example, when hiring, they can focus on community members including persons who might be disadvantaged in the job market because of disability or discrimination. When they contract or invest, they can look to local and minority vendors and businesses, thereby supporting the economies of their communities.

Screening for Social Needs

Our members tell us that the most frequently identified needs they are uncovering are food security, transportation, and financial stress. Patients often report they are skipping medications to save money, which certainly impacts the effectiveness of prescribed treatments. Screening also reveals practical needs including eyeglasses, dentures, help with managing healthcare bills, resources for caregiver supports, access to prescription assistance, and assistance with maintaining their homes.

Food insecurity is a frequently identified need and some patients must choose between buying food and taking care of other needs. These patients are referred to food banks and agencies that can provide on-going nutritional support.

Here is an example of a patient helped through screening for social risk factors:

"Sharon" is low functioning and is unable to read or write. With the help of hospice, she is taking care of her husband who has dementia. She identified the need for food security and was immediately set up with food banks in the area. She also had outstanding medical bills and the hospital helped her process financial aid applications. She also needed assistance with managing funds so that she could afford the co-pays on her prescriptions.

Sharon needed new dentures because what she had no longer fit and she had problems when eating. The hospital staff helped her fill out an application for new dentures and she was approved through a local foundation for ongoing dental care.

Because she heats her trailer with chopped wood, the hospital helped her to reach out to Habitat for Humanity for aid in upgrading her heat source from chopped wood and to do a home inspection for improved insulation and door and window repairs.

Below is the screening instrument used to help Sharon and other patients seen by her hospital.

		Circle One
	In the last 12 months, were you worried that your food would run out before you got money to buy more?	**YES** NO
	Are you worried or concerned that in the next 2 months, you may not have stable housing that you own, rent, or stay in as a part of a household?	**YES** NO
	In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?	**YES** NO
	In the last 12 months, did you skip medications to save money?	**YES** NO
	In the past 12 months, has lack of transportation kept you from the doctor, work, or from meeting other needs?	**YES** NO
	Are you worried about your physical or emotional safety where you currently live?	**YES** NO
	Do you ever need help reading medical materials?	**YES** NO
	Would you like to receive help with any of these needs?	**YES** NO
	Are any of your needs urgent? *For example: I don't have food tonight, I don't have a place to sleep tonight*	**YES** NO

Many hospitals use the screening tool designed for Centers for Medicare and Medicaid Innovation Center's Accountable Health Community Model. This model calls for screening for social needs and referring for needed services.

One of CHA member hospitals using the model reported to us:

> *"If patients are high-risk, they receive a Community Health Worker/Advocate to assist them. They are interviewed for face to face screening and a home visit occurs. The key things we see is lack of caregiver support, transportation needs (on-going not only to appointments but for day to day needs), food insecurity, utility assistance, medication and durable medical equipment assistance, inadequate health and social supports by family, lack of financial resources, housing insecurity and/or inadequate housing or safe housing. We see elder abuse as well, which continues to be a huge problem. We are also seeing an increase in aging homeless individuals. The last one that I got a call on was for a 91 year old whose family just "dropped him off" and indicated, he is your problem now. He ended up in our hospital and eventually passed away in Hospice."*

Loneliness and Social Isolation

A need frequently identified by our members among older patients is related to loneliness and social isolation. The *Archives of Internal Medicine* has reported that 20-43 % of adults age 60 or older experience frequent or intense loneliness (https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1188033). AARP's Public Policy Institute reports that not only is social isolation a serious risk factor, contributing to poor health and even premature death, but is also a significant cost to Medicare. A recent study by the AARP Policy Institute found that a lack of social contacts among older adults is associated with an estimated $6.7 billion in additional Medicare spending annually. According to AARP, Medicare spends an additional $1608 annually for each socially isolated older adult, even more than for arthritis. (https://www.aarp.org/content/dam/aarp/ppi/2017/10/medicare-spends-more-on-socially-isolated-older-adults.pdf) Clearly, this is a need that should be screened and addressed. Many of our member hospitals and other hospitals and health care organizations are working with faith communities (parishes, synagogues, mosques) and other community and volunteer organizations to provide home visits and opportunities for social interaction to address loneliness and isolation. (See: https://www.chausa.org/docs/default-source/eldercare/improving-the-lives-of-older-adults-through-faith-community-partnerships_final-oct-192016.pdf?sfvrsn=0)

Conclusion

While in these comments we have focused on the role and experience of hospitals, we also recognize, as does ASPE, the role of managed care plans and Medicare Advantage organizations. They can help

Medicare beneficiaries and their care givers by recognizing the importance of social risk factors and the need for screening. They can also support community organizations in investing in needed support services to address these needs.

Thank you for allowing the opportunity for the Catholic Health Association to provide these comments. For any questions related to them, please contact Julie Trocchio, CHA Senior Director of Community Benefit and Continuing Care, at 202-721-6320 or email Jtrocchio@chausa.org.