November 16, 2018

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

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

Dear Deputy Assistant Destro,

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural America, as well as inpatient rehabilitation, psychiatric, long-term acute care, and cancer hospitals. We greatly appreciate the opportunity to comment to the Office of the Assistant Secretary for Planning and Evaluation, HHS (ASPE) on the above referenced Request for Information (RFI).

The FAH commends ASPE's efforts to understand and address the challenges related to the effect of an individual's socioeconomic status (SES) on quality measures and measures of resource use within the Medicare payment programs. In particular, the FAH commends ASPE's recognition that researchers, hospitals and others have been examining the degree to which SES impacts patients, and we appreciate the agency reaching out to the community to learn what may have been discovered through the research.

Hospitals have undertaken a wide variety of efforts to improve health outcomes through the mitigation of social risk factors, and those efforts demonstrate wide variation across communities and hospital systems. There is no one mitigation strategy that has proven to be the panacea for every community. This wide variation across communities poses significant challenges to enterprise-wide efforts to reduce the impact of social risk factors and meaningful initiatives tend to be localized ones. In addition, challenges are constant and arise from varying incentives, burden of implementation including staffing and cost, and challenges to data collection.

Efforts for improving health outcomes for Medicare beneficiaries with social risk factors

Are social risk data being used to target services or provide outreach? If so, how? How are beneficiaries with social risk factors identified?

Do you routinely and systematically collect data about social risk? Who collects this data? When
is it collected? Is it collected only once or multiple times for a beneficiary? Is it collected consistently across populations (i.e. Medicare beneficiaries, Medicaid beneficiaries, patients receiving specific services, etc.)? What are the burdens of this data collection on plans, providers, and beneficiaries?

Our members focus on bolstering social risk factor mitigation through efforts to reduce readmissions, within bundle programs, and in engagements with public health departments and community coalitions. Generally, these efforts are performed through individual local hospital initiatives on a case-by-case basis rather than at the enterprise level. In other words, our hospitals work with their communities to address the problems of greatest need within those communities. In particular, a number of FAH hospitals leverage social risk factor data as one of the factors in developing patient discharge plans. Within certain hospitals, the intensity of discharge planning has increased due to a growing recognition that a particular community's social risk factors need to be addressed to remediate readmission rates in their local community. The determination by hospitals to invest in these efforts is often made as a function of knowledge of and access to local services that will help mitigate the risk factors, higher rates of readmissions at the hospital level relative to national averages, or enrollment in a bundle or value-based payment program. Hospitals generally will collect data only if it is within the hospital's sphere of influence to mitigate. As such, these efforts vary greatly and are only meaningful at a local hospital level. Our members have found it challenging to apply a program working within one community to a distinct separate community, sometimes in a different state. Local factors play a significant role in the success of social risk factor mitigation.

Challenges to addressing social risk factors

What are barriers to tailoring services to patients with social risk factors? How can barriers be
overcome?
What are barriers to collecting data about social risk? How can these barriers be overcome?

Our member health systems interested in moving towards centralized discharge planning or enterprise-level risk factor mitigation initiatives face substantial hurdles. At the local hospital level, the burden of identifying social services to which the hospital can effectively refer, the investment required to extend risk factor information gathering, and overcoming regulatory hurdles to address risk factors are among some of the barriers hospitals encounter.

The enterprise-wide sustainability of social risk factor mitigation efforts rests on the alignment of appropriate financial incentives and the moderation of current regulatory frameworks. Family discharge liaisons, social workers and the development of a social services bench requires a substantial up front investment which hospitals must weigh and balance against limited resources and competing priorities such as among improvement efforts, or necessary capital investment in, for example, health information technology and life-saving equipment. This makes it very challenging for hospitals to devote the resources needed to mitigate risk factors. While in some instances hospitals participate in state Medicaid programs' efforts to coordinate a response to address SES, no such national, coordinated effort exists for Medicare beneficiaries. Some hospitals are turning to 'social determinant' vendors in efforts to devise mechanisms for efficient, cost-effective data collection at an enterprise level. Finally, developing tighter links between hospitals and primary care

physicians and also with post-acute care setting providers would help mitigate some of these barriers.

The scarcity of data to identify patients and monitor progress further challenges the development and implementation of strategies for improving care for patients with social risk factors. Without real-time data there is no way to identify or monitor progress. There is a dearth of aggregate level data that is standardized at a national level and easily accessible.

The acquisition of patient level data presents another level of complexity due to the sensitive nature of the data being collected as well as cultural or social apprehensions on the part of patients. This type of data is not something patients may be willing to reveal. For example, a patient experiencing the need to make a tradeoff between paying for food or medications may be reluctant to acknowledge that. Another example is the lack of comfort some patients elicit with letting home health agencies into their homes for the purpose of assessing social risk factors. The FAH encourages ASPE to develop suggested strategies for improving risk factor data collection. It would be helpful to hospitals for ASPE to articulate promising future opportunities for improving data collection and for using existing or future data to tailor services.

Suggested strategies for improving data collection of risk factors

The lack of standardization of data elements makes it challenging to use risk factor data because this adds to the burden of collecting the data as well as providing limitations in the ability to monitor progress of programs. However, beyond data standardization, the qualitative nuance of the data that needs to be gathered requires best practices education and training. Many of these questions are not satisfied with basic" yes/no" answers. For instance, in order to identify an adequate caregiver, it is not sufficient to ask the patient if he/she has a caregiver. There needs to be an assessment of competence and access to the caregiver as a function of the level of need of the patient. The same is true for transportation; the quality and nature of the access to transportation needs to be assessed as a function of the patient's needs. Discharge or Enrollment liaisons would benefit from standardized questions that have been developed with consideration of the qualitative nuances required. Liaisons responsible for gathering this data at an individual level should also have cultural competency training and be familiar with techniques for eliciting data of a sensitive nature.

A promising future opportunity lies in the development of a strategy for assessing appropriate organisms for data collection and sharing. Such a mechanism will become important to assess the best sources and organizations for the collection of data. Certain data is more easily accessible to payors versus acute hospitals versus post-acute facilities. Upstream data dependencies across the care continuum will need to be evaluated. For instance, acute care hospitals would benefit from payors making some of this social risk data available to them. In the same vein, rehabilitation hospitals rely on acute care hospitals to provide information upon discharge related to behavioral health, symptoms of spousal or familial abuse, etc.

Potential sources of data include hospitals (acute versus rehabilitation or post-acute), Medicare or Medicaid as the vehicle to assist with social determinants of health gathering, payors, and public health offices. Looking at outcomes that public health agencies have gathered will help identify opportunities. Medicaid could be seen as a vehicle to assist with social determinants of health. Traditional Medicare could play a role in delivering data and

resources to support beneficiaries. There is access to a lot of state level data at a federal data level and this could be leveraged to tap into state-level data.

<u>What Data is important to collect</u>

Which social risk factors are most important to capture?

The FAH provides the items below with the social risk factors that are important to capture at an individual level with some examples of the types of questions used to capture them:

- Educational level of the patient
- Health literacy of the patient
- Patient Activation Measure
- Health behaviors
- Payor status (What is covered by the patient's insurance? Can the patient afford the care they need?)
- Caregiver (Does the patient have an adequate care giver who is able to support the patient in the way she needs?)
- Home Environment and Housing Insecurity (Is the patient in a supportive and safe home environment? Does the patient have safe and comfortable housing?)
- Community Environment (Is the patient in a safe and supportive community?)
- Transportation (Does the patient have adequate and reliable means of transportation to get to follow-up appointments or to acquire medications? Does the patient live in a location where transportation is not easily accessible?)
- Food (How far away from the patient's house is the nearest grocery store? Does the patient have access to the nutrition he needs to get better? Does the patient have dietary problems?)
- Barriers to social support services
- Financial (What financial trade-offs must the patient consider against purchasing prescribed drugs?)
- Frailty/Functional Status/Disability
- Domestic or spousal abuse symptoms

The FAH appreciates the opportunity to respond to the RFI and to offer these suggestions for improving data collection and the use of social risk factor data for improving patient care. If you have any questions about our comments or need further information, please contact the FAH staff at (202) 624-1500.

Sincerely,

Claudia Salzberg, PhD
Vice President, Quality