AcademyHealth

September 21, 2021

Congressional Social Determinants of Health Caucus
U.S. House of Representatives
Washington, DC 20515

RE: Social Determinants of Health Caucus – Request for Information, September 21, 2021

Dear Members of the Congressional Social Determinants of Health Caucus:

AcademyHealth welcomes the opportunity to provide input to the Caucus on challenges and opportunities related to social determinants of health (SDOH) and we are eager to assist the caucus at any time to identify the best evidence on the health effects of SDOH and effective strategies to address SDOH.

AcademyHealth is the professional home of health services and systems researchers, policy experts, and practitioners, including those serving the most vulnerable and disenfranchised populations. Health services and systems research examines how people get access to health care, how much care costs, and what happens to patients as a result of this care. As the leading organization for a field devoted to improving health outcomes for all, we are committed to directly addressing systemic racism, SDOH, and promoting health equity. Our strategic plan explicitly names diversity, equity, and inclusion (DEI) as a core value of our organization. Our members are leaders in studies of health equity, health disparities and social determinants of health, with over 400 active participants in our Health Disparities Interest Group. We have included links throughout these comments to relevant recent resources from AcademyHealth.

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

There is broad evidence that strongly links social risks and an individual's health and health care utilization. AcademyHealth members have identified social risks that have been highlighted by the pandemic, including: food insecurity; housing instability; transportation access; unemployment, specifically related to accessing health care; workplace safety, especially when it comes to protecting workplaces, providing vaccinations, providing paid time off; and structural racism and violence, which includes community policing, incarceration, gun violence, and environmental degradation. All of these social determinants existed before the pandemic, but the crisis caused new negative health outcomes to emerge. For example, older Americans experienced social isolation at a different level than other age groups while intimate partner violence and family abuse surfaced as more individuals remained isolated in their homes without access to community support.

Individuals incarcerated in federal, state, and local prison systems have faced disproportionate health impacts in the pandemic, as they have been significantly more likely to get infected with the virus, spread the virus in communities, and lack access to necessary treatments and care. Many states responded by implementing some measures to release more people from incarceration. Beyond the pandemic, jails are unfortunately a key source of connecting individuals with necessary social support services, rather than these resources being accessed prior to engaging the criminal justice system.

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?

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While states and the federal government financially offer a variety of programs that could effectively ameliorate the impact of SDOH, the programs are disjoined, unconnected/not interoperable, lack resources, have inadequate and antiquated infrastructure. For example, a person who wants to take advantage of all the programs must apply separately to each one, using lengthy, complicated, or costly enrollment processes that due to time alone are a barrier to use. As a result, life-saving programs are under utilized and this creates gaps in coverage and negatively affects health outcomes. This occurs across the nation for a range of programs including health insurance coverage, food security, housing security, and transportation access.

Recommendations:

- Congress should review social safety net programs and determine if eligible beneficiaries are unable to access a program due to overly rigorous or complicated enrollment processes, whether those processes can and should be streamlined using appropriate secure technology, and ensure that access to federally funded programs is modernized.

- Congress should ensure that authorized and appropriated federal programs have sufficient substantive and administrative funding to ensure participation by all eligible beneficiaries.

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

There is a robust body of research on how SDOH harm health and wellbeing. However, there is far less research on the effectiveness of interventions to address the negative health effects of SDOH. This is due to longstanding lack of investment in health services and systems research. For example, the Agency for Healthcare Research and Quality, which is the only federal agency that has statutory authorization to generate health systems research, has seen its funding level slowly erode. While the vast majority of federally funded research focuses on one specific disease or organ system, AHRQ is the only federal agency that funds research at universities and other research institutions throughout the nation on health systems and how they can work in partnership with social programs and public health departments to tackle SDOH in the lives of patients and communities. Research that focuses on health systems, not diseases, is the best way to identify where we can effectively change what we do now to ameliorate the impact of SDOH on health and wellbeing.

The failures in the COVID-19 response can be addressed with more attention to the root causes of, and scalable strategies for addressing, barriers to healthcare access, such as SDOH. In order to achieve better health outcomes, we need to be able to differentiate which interventions work, for whom they work, and how to implement them, Health services and systems research supported by AHRQ is the process through which we develop that knowledge. For example, the effectiveness of COVID-19 vaccines has been diminished because we have not addressed a range of SDOH that have contributed to a lack of trust in institutions that developed the vaccines or that are administering them. Funding health services and systems research through AHRQ is a key part of how we will best recover from COVID-19, prepare for the next pandemic, and address failures in the healthcare system due to SDOH that Americans continue to face. For example, through HSR we can combat mistrust of vaccines by identifying and amplifying the vaccine administration processes that build trust. AHRQ Acting Director David Meyers has noted that the agency is only able to fund 6 percent of grants, leaving many life-saving programs on the cutting room floor. Research on interventions to address SDOH is simply not being conducted.

The creation of the Advanced Research Projects Agency for Health (ARPA-H) provides Congress with an opportunity to seriously respond to SDOH. ARPA-H needs to ensure that the innovations it produces are targeted to the most urgent problems in healthcare today that affect the largest number of Americans, including health disparities driven by SDOH.

There are numerous federal programs that need to be reformed, better funded, or better coordinated to address SDOH. Federal housing policy, for example, creates gaps in coverage through inadequate funding for affordable housing programs and a much-needed expansion of public housing assistance. For labor policy, the lack of federal requirements on paid sick leave is a huge barrier to workers accessing needed health care and to protect their own health and indeed the public's health through contagion. Additionally, the lack of implementation, enforcement, and staffing for OSHA standards to be applied to protect individuals at work create health disparities.

Recommendations:

- Congress should meaningfully reverse funding erosion at AHRQ and fully fund the organization at a level of at least $500 million. Over 120 health organizations wrote to House Appropriators for this funding level for FY22.

- Congress should require all federal programs to be reviewed and publicly report on their effectiveness within the frame of SDOH, identify where coverage gaps exist that harm health outcomes, and provide reform proposals.

- Congress should build health services and systems research to address SDOH into ARPA-H. This includes ensuring that funded projects include support for care delivery innovations that effectively address SDOH, with an emphasis on the discoveries being scalable, accessible, equitable, and creating high-value, equitable outcomes for patients while improving resiliency and capacity in health systems and communities. Currently, NIH devotes 5 percent of grant funding to support health services and systems research, which is an appropriate benchmark for ARPA-H on SDOH.

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?

Technology plays a key role in supporting data collection, data exchange, use and reporting, and increasingly care innovation. Our current technology infrastructure is insufficient to address SDOH. Many government programs (public health, social services, welfare, etc.) do not specify what data sources can be leveraged, nor do they promote the use of structured data in reporting and sharing of electronic information. Furthermore, there are no nationwide standards for SDOH outside the healthcare system, although there are emerging standards within electronic health records standards promulgated by the Office of the National Coordinator for Health Information Technology (ONC) at HHS. The result is an ecosystem of siloed data infrastructure at the local, regional, and state levels. Organizations, whether it be a health agency, a public agency, a state designated entity, a school system, or a community-based organization, have diverse funding mechanisms with diverse data capture and reporting requirements. These and other challenges were summarized in a report from AcademyHealth. If all the sponsors and funders aligned their data capture requirements, we would have a consistent and seamless way to capture, document, exchange, and use the data.

State and local governments and programs have desperately needed updates in technology to streamline and consolidate applications and data processing for public services. There are two specific challenges exist. The first is the myriad of service directories that exist to support the identification of a service provider to route the referral to. The infrastructure that currently exists to support these community referrals are not standards based and have spurred business models that benefit the technology provider over the individual's needs, the effectiveness of the government funding source, or the community-based

organization receiving and acting on the referral. The second challenge is the lack of capacity community-based organizations (CBOs) have to act on the referrals. Even if we have the right technology and the data sharing partnerships in place to generate the right referrals to programs, the CBOs still lack human, technology, and financial capacity to act on the referrals. Additionally, as we see the growth in community referral platforms like UniteUs and Aunt Bertha, we are hearing from more and more CBOs that they have to connect to multiple platforms at the same time. They are seeking a common authentication process or single sign on so they can receive and accept referrals. There is a need for the social services agencies to have the same easy interoperability that Congress required of electronic health records developers in the 21st Century Cures Act.

Accessing telehealth requires broadband internet access, which is not universally available infrastructure, especially in rural communities, low-income communities, and communities of color. This inequity in access and usage may correlate with worse health outcomes, but this has not been determined yet.

Technologies that improve accessibility and interpreter/translation services are also critical. For example, many social services programs have websites that are not accessible to those with visual impairment, or those for whom English and Spanish are not primary languages. Technological barriers that fail to meet individuals at their communication needs create health detriments.

Recommendations:

- Congress should fund investments in community broadband – both rural and urban – to ensure that all patients have the resources necessary to access telehealth.

- Congress should provide AHRQ with the necessary funding to study the expansion and efficacy of telehealth, including in identifying barriers to access, compliance with health care privacy, and quality of services. H.R. 8067, the Addressing COVID-19 Health Disparities Act, was introduced in the 116th Congress and provides a strong framework to consider.

- Congress should require that federally funded social services agencies use open source data systems that operate under established standards, preferably that are the same as the traditional health care system, so that traditional healthcare and social services agencies data systems can be efficiently used and the data can be holistically studied.

What potential do you see in pooling funding from different sources to achieve aligned goals in addressing SDOH? How could Congress and federal agencies provide state and communities with more guidance regarding how they can blend or braid funds?

There is significant potential in pooling funding, especially if there are data capture, sharing and reporting requirements that center on data standards. If all these programs agreed upon, or were funded and required to, use common standards to represent and exchange the data, then we would alleviate ongoing siloed infrastructure development. There should be consistent way to represent SDOH data by HHS agencies, by Defense agencies, Transportation, Education, Housing, Homeland Security, Agriculture, and Labor.

Congress should consider community investment funds, which pool together housing, transportation, green industry development, infrastructure (including broadband) and allow for community investments that can meet multiple needs at once. Models are emerging in communities of cross sector collaboration to address SDOH and improve population health.

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 Gravity Project is developing standards for the representation and exchange of electronic SDOH data across disparate systems, from the clinical electronic health record to a community information exchange platform, to the local case management system, and ending at the individual benefits or wellness mobile app. The standards can be further promoted for use across these variable systems so individual data can be connected—and most important, information about the person follows them as they transition or receive services in a healthcare setting, a community-based organization, or a state benefits agency.

For example, there are numerous ways that food insecurity leads to worse health outcomes, such as a patient that is food insecure spending their limited resources on food instead of health care, which would likely worsen chronic health conditions. An empowered community could refer this individual to a food bank for nutrition or creating a rideshare program that gives the individual affordable and accessible transportation to health appointments. These are both low-cost social interventions that have the potential of reducing low-value medical interventions and providing better care. The patient's social needs can be identified in a clinical setting and documented in a standardized way for easy review and actions by other agencies.

The creation of this infrastructure and programming needs to be accomplished in concert with community organizations and the voices of the impacted individuals. These organizations can identify and communicate the needs of individuals first, and then systems can be created in reverse to understand how data systems can support them. Consider for example the Pacific Islander Center of Primary Care Excellence (PI-CoPCE), which created a COVID-19 response team of Native Hawaiian and Pacific Islander (NHPI) researchers, health experts, community leaders and advocates to plan and implement infrastructure for informing and supporting families and communities about COVID-19.

Additionally, collecting, analyzing, and reporting data can only accomplish so much without other policy changes that implicate SDOH, such as raising the minimum wage, providing affordable housing, accessible health care, and labor safety protections. For optimum results, all of these policy issues need to be engaged along side better data systems.

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?

There are perennial challenges, such as a lack of interoperability between different systems, inconsistent data protection and privacy between health and social services organizations, and a lack of funding for smaller organizations to purchase and license secure information technology.

Recommendations:

- Congress should support investments into local public health organizations to build up and maintain data infrastructure and staffing, including but not limited to improved information security at the program level, and, where necessary, ensure that the use of SDOH about a person does not expose that person to adverse business decisions such in mortgage underwriting, life insurance, or other potentially discriminatory activity.

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?

Our membership has relied on numerous emergency flexibilities to better address SDOH that they have called for continuing. They include: emergency food and housing assistance; emergency grant assistance; food assistance programs like EBT benefits, food pantries, and direct delivery; SNAP eligibility that does not include work requirements; housing protections such as the eviction moratorium and alternatives to eviction; and unemployment assistance.

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?

AcademyHealth has led numerous programs and initiatives to bring innovative community models together to learn and improve. For example, the AcademyHealth Payment Reform for Population Health program identified four key elements to effectively addressing SDOH: shared data, a trusted environment, alignment of clinical and community resources, and payment and financing models to incentivize investments in SDOH, including the role of Medicaid. The AcademyHealth Community Health Peer Learning Program (funded by ONC) identified several themes that were critical to community success in addressing SDOH: peer learning, technical assistance, financial sustainability, and data capture, integration and use. Our membership has also identified the Administration for Community Living Standards (ACL) Social Care Referrals Challenge Competition as a successful model. Launched in March 2020, this program will award prizes for developing and optimizing interoperable and scalable technology solutions that foster connections between community-based organizations and health care systems in support of holistic health and social care for older adults and people with disabilities. They have also pointed to NCCARE360, which is a statewide network that unites health care and human services organizations with a shared technology that enables a coordinated, community-oriented, person-centered approach for delivering care in North Carolina. They have additionally highlighted the California Transformative Climate Communities Initiative, which empowers the communities most impacted by pollution to choose their own goals, strategies, and projects to reduce greenhouse gas emissions and local air pollution.

To be most successful, these programs should be accompanied with grants for capacity building to ensure that disadvantaged and under-resourced communities have sufficient human capital to develop and execute a planning initiative.

Recommendation

- Existing and new programs should be consistently evaluated to understand their effectiveness overall and how that effectiveness varies by community and population served, and how effectively those programs connect to (interoperate with) other programs.

- Any new programs should ensure attention to long term sustainability financially and technologically, including financing and its coordination with Medicaid, Medicare, and other insurance programs.

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?

Health care systems should not act alone to reduce SDOH. However, they have a critical role to play in partnership with other community organizations, employers, and health departments. AcademyHealth has

long worked to help identify the many ways that payment models could contribute to addressing SDOH. The Payment Reform for Population Health program specifically explored a number of payment issues and published several reports. The Payment for Progress initiative examined this issue specifically to address SDOH in children.

Payment programs to incentivize attention to SDOH effectively, minimize gaming by providers, and not penalize those who serve disproportionate numbers of individuals experiencing SDOH, require well designed quality measures and appropriately accounting for risk. The National Quality Forum has been working on these issues and held a summit in 2019 on addressing SDOH. They also led a trial of risk adjustment of a subset of quality measures which revealed challenges in obtaining data on social risk factors, including data granular enough to accurately reflect individuals' social risk. There is much more work that needs to be done on the science of quality measurement to account for SDOH.

- Congress should support health services and systems research at AHRQ to focus on the science of quality measurement of SDOH in the context of payment programs.

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?

As Congress considers legislative solutions to address SDOH, it should consider the many ways that structural discrimination including structural racism, as described by Yearby et al. is driving SDOH. Structural racism is a root cause of inequality and ill health in this country that prevents investments in communities of color. Structural racism is the normalized and legitimized range of policies, practices, and attitudes that routinely produce cumulative and chronic adverse outcomes for people of color. Racism, bias, and discrimination prevent the creation, funding, dissemination, and implementation of policies that would otherwise eliminate health inequities. As such, it is incumbent upon Congress to evaluate all SDOH solutions within a broad health equity lens. Policymakers should rely on diverse perspectives, including through direct and meaningful engagement with under-resourced communities.

Thank you for the opportunity to discuss social determinants of health. For further comment, clarification, or inquiry, please email Josh Caplan at Josh.Caplan@AcademyHealth.org.