Congressional Social Determinants of Health Caucus: Request for Information

Section 1: Experience with SDOH Challenges

What specific SDOH challenges have you seen to have the most impact on health?

Food insecurity:

In 2018, it was estimated that 1 in 9 Americans were food insecure. That equals about 37 million Americans and includes more than 11 million children.[1]

According to a CDC study[2], food insecurity is associated with numerous chronic health conditions, including diabetes mellitus, hypertension, coronary heart disease, chronic kidney disease, and depression. Further, food insecure adults had annual health care expenditures that were $1,834 higher than food secure adults.

Implicit bias in health care & systemic racism

Implicit bias, or acting on the basis of prejudice and stereotypes without intending to do so, is prevalent in all areas of society, including health care. Studies[3] have shown that racial and ethnic minorities and women are more likely to have less accurate diagnoses, fewer treatment options, less pain management, and worse clinical outcomes.

This is seen acutely in the disparities in maternal health outcomes. Black and AIAN women[4] have pregnancy-related mortality rates that are over three and two times higher than white women. Most of these deaths are considered avoidable. Disparities exist even when all other socioeconomic factors such as education level or wealth are removed, suggesting implicit bias based on race and ethnicity are at the heart of these issues.

Outside of implicit bias health care institutions, systemic racism such as residential segregation and mass incarceration, has also been shown[5] to affect health outcomes. Residential segregation policies have been linked to increased toxic environmental exposures that lead to higher rates pre-term births, asthma, and cancer. Mass incarceration of racial and ethnic minorities has been linked to an increased rate of death, not to mention the increased spread of COVID-19 in prisons and jails.

Access to affordable broadband:

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[1] Feeding America. (2019, October 7). *What is food insecurity in America?* Hunger + Health, Feeding America. Retrieved September 2021, from https://hungerandhealth.feedingamerica.org/understand-food-insecurity/.

[2] Centers for Disease Control and Prevention. (2019, July 11). *State-level and county-level estimates of health care costs associated with food insecurity*. Centers for Disease Control and Prevention. Retrieved September 2021, from https://www.cdc.gov/pcd/issues/2019/18_0549.htm.

[3] Enekwechi, S. A. A. (2020, January 15). *It's time to address the role of implicit bias within health care delivery*: Health Affairs Blog. Health Affairs. Retrieved September 2021, from https://www.healthaffairs.org/do/10.1377/hblog20200108.34515/full/.

[4] Artiga S., & Pham, O. (2020, November 10). *Racial disparities in maternal and infant health: An overview*. KFF. Retrieved September 2021, from https://www.kff.org/report-section/racial-disparities-in-maternal-and-infant-health-an-overview-issue-brief.

[5] Bailey, Z. D., Feldman, J., & Bassett, M. (2021, September 15). *How structural racism works - racist policies as a root cause of u.s. racial health inequities*. New England Journal of Medicine - Medicine and Society. Retrieved September 2021, from https://www.nejm.org/doi/full/10.1056/NEJMms2025396.

While the increase in use of digital health tools is promising to help address some traditional barriers to accessing care – such as time and access to transportation – many of these tools rely on patients having access to high-speed broadband, which is not always the case in rural and underserved communities.

Internet usage in general has increased over the past decade for all demographic groups. However, disparities between the different demographic groups still exist. As of 2019, only 63 percent of rural Americans reported having access to broadband internet connection at home. By comparison, Americans who live in urban cities are 75 percent more likely to have access to broadband at home. What access those in rural areas do have tends to be slower than in non-rural areas.[6]

In urban areas, affordability of broadband remains a main barrier to access. According to the National Telecommunications and Information Administration,[7] those who live in higher poverty areas and on tribal lands have lower rates of home internet usage.

Transportation:
Each year, 3.6 million people in the United States do not obtain medical care due to transportation issues. Transportation issues include lack of vehicle access, inadequate infrastructure, long distances and lengthy times to reach needed services, transportation costs and adverse policies that affect travel. Transportation challenges affect rural and urban communities.

Transportation touches many aspects of a person's life, adequate and reliable transportation services are fundamental to healthy communities. Transportation issues can affect a person's access to health care services. These issues may result in missed or delayed health care appointments, increased health expenditures and overall poorer health outcomes. Transportation also can be a vehicle for wellness. Developing affordable and appropriate transportation options, walkable communities, bike lanes, bike-share programs and other healthy transit options can help boost health. This guide outlines transportation issues and the impact on health and health care access.

Multiple strategies may need to be employed to reduce transportation gaps for patients. This guide discusses the role of hospitals and health systems and recommends strategies for addressing transportation issues, including screening and evaluating patients' transportation needs and providing transportation services through community partnerships or programs.

What areas have changed most during the COVID-19 pandemic?

Telehealth & Remote Patient Monitoring Flexibilities

Prior to the COVID-19 pandemic, telehealth and remote patient monitoring were not prevalent in many areas of the country's health care system. While Medicare coverage of telehealth services was required by Congress in 2001, statutory restrictions kept utilization low. Save for a few exceptions (treatment for substance use disorders, telestroke services, and end-stage renal disease), CMS can only pay for telehealth services if a patient is in a medical facility in a federally defined rural area. Due to these restrictions, in 2016, the Centers for Medicare & Medicaid Services (CMS) reimbursed $27 million in telehealth services – just 0.4 percent of Medicare fee-for-service spending. [8]

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[6] Vogels, E. A. (2021, September 10). *Some digital DIVIDES persist between rural, urban and suburban America.* Pew Research Center. Retrieved September 2021, from https://www.pewresearch.org/fact-tank/2019/05/31/digital-gap-between-rural-and-nonrural-america-persists/.
[7] Farivar, C. (2021, June 18). *New federal broadband maps show stark differences in access, affordability*. NBC News. Retrieved September 2021, from https://www.nbcnews.com/tech/tech-news/new-federal-broadband-maps-show-stark-differences-access-affordability-rcna1220.
[8] (2018, March). *Report to the Congress: Medicare Payment Policy*. MedPac. Retrieved September 2021, from http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch16_sec.pdf

When COVID-19 began to spread across the country and stay-at-home orders went into place, it became clear that if Congress and CMS did not act quickly to lift statutory and regulatory reimbursement restrictions, the majority of Medicare beneficiaries would have no way to access care in the midst of a pandemic. Luckily, Congress passed legislation in early March to set the wheels in motion for CMS to issue waivers of Medicare telehealth reimbursement restrictions. CMS also acted to lift restrictions on RPM services. Because of these waivers, during the COVID-19 public health emergency period, the following can now take place:

- Providers can now bill telehealth services for patients located in their home and outside of rural areas;
- Telehealth and RPM services can be offered to both new and existing patients;
- For the most part, any Medicare-eligible provider can bill for telehealth services;
- CMS will reimburse for more than 230 telehealth services and removed the requirement to use technology with audio and visual capabilities for some services;
- Federally qualified health centers and rural health clinics can furnish telehealth services; and
- Providers can waive or offer reduced cost-sharing for telehealth services.

Over the course of the PHE, the use of telehealth has increased significantly, particularly by fee-for-service (FFS) Medicare beneficiaries. Nationally, before the PHE, about 13,000 FFS Medicare beneficiaries received telehealth services in a week – by the last week of April, that had increased to about 1.7 million beneficiaries per week. [9]

While many are concerned and assume social factors prevent racial and ethnic minorities from using telehealth, that has not been seen in telehealth utilization data during COVID. A recent study [10] found that telehealth utilization did not vary substantially by race or ethnicity. Using telehealth, health care providers are able to have more visibility into their patients' living conditions, mental state, and what are often referred to as "health-harming legal needs."[11] This provided an opportunity to utilize this technology to also address social determinants of health.

Data collection:

As COVID-19 began to spread through the country, states were faced with the immediate need of identifying who was at highest risk of COVID complications, as well as COVID-related complications (social isolation, lack of safe and reliable transportation, etc.). A Maryland-based task force, created to combat the COVID-19 pandemic, headed by Dr. Susan Mani, Vice President, Clinical Transformation and Ambulatory Quality at LifeBridge Health, used data to map resources and needs for vulnerable populations like homeless, elderly, and the uninsured. During their initial work, the taskforce was able to identity more than 150,000 of the highest risk individuals across Maryland.

This taskforce created a healthcare analytics organization, *Socially Determined*, which was engaged to leverage data from multiple sources to generate a COVID-19 risk index at the city, county, and community levels. One of their sources, Chesapeake Regional Information System for our Patients (CRISP), provided data on about 2.6 million Medicare and Medicaid patients. The output of the index is a visual map that allows state representative to see risk access across the state and provides insights into decision making.

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[9] "Early Impact Of CMS Expansion Of Medicare Telehealth During COVID-19, " Health Affairs Blog, July 15, 2020. DOI: 10.1377/hblog20200715.454789

[10] Gray, Josh, Tengu, Douceur, Mehrotra, Ateev. (2021, August 30). *3 Surprising Trends in Seniors Telemedicine use during the Pandemic.* StatNews. Retrieved on September 2021 from https://www.statnews.com/2021/08/30/three-surprising-trends-seniors-telemedicine-use-pandemic/.

[11] Mead, Allee. (2016, October 19). *Bringing Law and Medicine Together to Help Rural Patients*. Rural Health Info. Retrieved on September 2021 from https://www.ruralhealthinfo.org/rural-monitor/medical-legal-partnerships/.

The tools created had a precision calculated risk for every 200 meters, which make it easy to map the locations of homeless shelters, elderly homes, hospital, and pharmacies against the population density. Using the risk index to measure age, disease and social factors, 900,000 individuals from the initial data set were identified as high-risk and 150,000 were identified as highest risk, their names were provided to the health departments, and health systems and MCOs to begin outreach for testing, telehealth and care management.

Food insecurity:

In a March 2021 report,[12] Feeding America projected that 42 million people (1 in 8), including 13 million children (1 in 6) may experience food insecurity in 2021. Many of those who have been most impacted by COVID-19 were food insecure before the pandemic.

A Michigan State study of 3,219 respondents in 2020 found there was a 1/3 increase (32.3%) of households who were considered food insecure since the pandemic began, with a 35.5% increase of households that were considered newly food insecure.

Reports on food insecurity in America shows significant disparities in racial and ethnic minorities and communities. [13]

8.1%, or 1 in 12, white, non-Hispanic individuals living in food insecure households
15.8%, or 1 in 6, Latino individuals were living in food insecure households
19.3%, or 1 in 5, Black, non-Hispanic individuals were living in food insecure households
23.5%, or 1 in 4, Native American individuals were living in food insecure households

Economic flexibility:

The Household Pulse Surveys deployed by the CDC bimonthly through most of the pandemic reports major changes to many American's homes. In the weeks between April 28 and May 10, they found that nearly one in five American adults (19%) reported that they or someone in their household experiences a loss of employment income in the past four weeks. More than half of those adults surveyed (51%) reported difficulty paying for usual household expenses in the past seven days. [14]

As the crisis continues, American's medical bills have been rising. A New York Times article, states that currently the average cost of a hospitalization due to COVID is $40,000. This doesn't include emergency situations with intensive care unit or air ambulance transfers that could cost the patient much more. [15]

In a study entitled *Out-of-pocket Spending for COVID-19 Hospitalizations in 2020*, researchers studied the data from 4,075 hospitalizations. They found that 1,377 of these hospital stays were privately insured, and of those hospital stays, 71% had out-of-pocket expenses. The mean total for this spending was $788. 2.5% of the privately insured hospitalizations, out-of-pocket spending exceeded $4,000. [16]

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[12] (2021, March.) *The Impact of the Coronavirus on Food Insecurity in 2020 & 2021.* Feeding America. Retrieved on September 2021 from https://www.feedingamerica.org/sites/default/files/2021-03/National%20Projections%20Brief_3.9.2021_0.pdf
[13] Haskell, Scott. (2021, February 2). *How the Covid-19 Pandemic Affects Food Deserts.* Michigan State University. Retrieved on September 2021 from https://www.canr.msu.edu/news/how-the-covid-19-pandemic-affects-food-deserts
[14] (2020, July 21). *Household Pulse Survey Data Tables.* Census.gov. Retrieved on September 2021 from https://www.census.gov/programs-surveys/household-pulse-survey/data.html.
[15] Kliff, Sarah. (2021, September 9). *Covid Medical Bills Are About to Get Bigger.* The New York Times. Retrieved on September 2021 from https://www.medrxiv.org/content/10.1101/2021.05.26.21257879v1.
[16] Becker, Nora, Conti, Rena, Chua Kao-Ping. (2021, May 26). *Out-of-Pocket Spending for COVID-19 Hospitalizations in 2020*. MedRxiv. Retrieved on September 2021 from https://doi.org/10.1101/2021.05.26.21257879

A Commonwealth Fund study of 5,540 adults found that 16% of the respondents studied who lost their insurance during the pandemic were uninsured for longer than a year. Just about half (54%) of the respondents experienced a brief coverage of three to four months.

Among the same study, paying for medical bills or debt problems, 35% used up all or most of their savings, 35% took on credit card debt, and 27% were unable to pay for basic necessities like food or rent. [17]

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

Data Collection:

eHI has served as a convener and facilitator of important conversations around the health disparities experienced by the American Indian and Alaskan Native (AI/AN) communities. We released a whitepaper[18] that outlines the impact of COVID-19 on the AI/AN communities.

One challenge outlined in the whitepaper is the fact that federal data cannot be disaggregated at the tribal level. This makes it difficult for diverse tribal communities to make informed decisions that accurately reflect the unique needs of their members due to the pandemic in terms of infection rates, age of the population, types and quantities of resources needed and other factors. Lack of access to reliable and comprehensive data limits the ability to make policy decisions and allocate funding for much-needed resources. These data issues open tribes, once again, to underfunding during and after the pandemic—underfunding that can hinder health, social and economic recovery.

The HHS Office of the National Coordinator for Health IT (ONC) took an important step in addressing lack of standardization for collection and use of SDOH data by adopting the United States Core Data for Interoperability version 2,[19] which, for the first time, includes data elements related to sexual orientation, gender identity, and social determinants of health.

Is there a unique role technology can play to alleviate specific challenges (e.g. referrals to community resources, telehealth consultation with community resource partners, etc.)?

SDOH ICD-10-CM Z codes:

In 2016, CMS made available a set of "Z Codes" for providers to document their patients' social risk factors. Unfortunately, utilization of these codes in Medicare fee-for-service (FFS) is low. A CMS report[20] that looked at use of these Z Codes in 2017 found that only 1.4% of FFS claims included Z Codes. The use of these codes is optional and not heavily incentivized by CMS, though they, along with implementation of USCDI v2, could help better target and leverage federal funding to address social determinants of health.

[17] Ibid.
[18] (2020, October 13). *Supporting AIAN Communities Combating COVID-19.* eHealth Initiative. Retrieved on September 2021 from https://www.ehidc.org/sites/default/files/resources/files/eHI_Report_Supporting_AIAN_Communities_CCombatin_COVID19_10_13_20.pdf
[19] (2021). *United States Core Data for Interoperability (USCDI).* Office of the National Coordinator for Health Information Technology. Retrieved on September 2021 from https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi#uscdi-v2.
[20] (2020, January). *Z Codes Utilization among Medicare Fee-for-Service (FFS) Beneficiaries in 2017*. Centers of Medicare & Medicaid Services. Office of Minority Health. Retrieved on September 2021 from https://www.cms.gov/files/document/cms-omh-january2020-zcode-data-highlightpdf.pdf.

The Gravity Project was initiated in November 2018 by SIREN with funding from the Robert Wood Johnson Foundation to convene broad stakeholder groups in identifying and harmonizing social risk factor data for interoperable electronic health information exchange.

The project is a direct response to recommendations and calls to action around creating national standards for representing SDH data in EHRs. Growing evidence demonstrates strong links between social risk and an individual's health and health care utilization. This correlation has increasingly led health systems to incorporate social risk data into clinical decision making to improve health outcomes and help reduce costs.

The Gravity Project seeks to identify coded data elements and associated value sets to represent social determinants of health data documented in EHRs across four clinical activities: screening, diagnosis, planning, and interventions. The project is focused on three specific social risk domains: food insecurity, housing instability and quality, and transportation access. These domains were selected based both on existing research linking these factors with health and utilization and on active experiments related to these domains, including in federal, state, or local demonstration projects. The scope for Phase 1 of Gravity includes the following activities and deliverables:

- Develop use cases that will serve to guide development of recommendations about documenting SDOH data in EHRs or related systems.
- Identify common data elements and associated value sets to support the use cases.
- Develop recommendations on how best to capture and group these data elements for interoperable electronic exchange and aggregation.
- Initiate development of an HL7 Fast Health Interoperability Resource (FHIR) Implementation Guide based on the defined use cases and associated data sets in order to set up the next phase in 2020.

Gravity Project Phase 2 deliverables (2020+) are:

- Collaborate with coding and terminology suppliers to address coding gaps defined in Phase 1.
- Develop and test coded SDOH data sets for use in FHIR through Connectathon events.
- Develop and ballot an HL7 FHIR SDOH Implementation Guide.

Digital tools:

Digital tools, such as telehealth and consumer applications, can provide care and resources at patients' fingertips. As previously stated, telehealth can help identify and address SDOH. Additionally, consumer applications – available through smartphones, which a majority of Americans own [21] – can provide patients self-management tools and access to resources that may not be available close to their home/place of residence, such as resources for the LGBTQ+ community.

Further, once data collection and standardization are improved, those data can be used to power artificial intelligence and machine learning (AI/ML) tools. Because health providers are already asked to do so much in our society, adding requirements around SDOH screening – while all would agree is beneficial – can be extremely stressful and burdensome for providers. Some health systems are already utilizing AI/ML tools like natural language processing to help screen for SDOH and flag issues for their community partners.

Platforms that encourage communication between providers and community health resources:

[21] (2021, April 7). *Mobile Fact Sheet*. Pew Research Center. Retrieved on September 2021 from https://www.pewresearch.org/internet/fact-sheet/mobile/.

Referrals are not new in the health care system. Patients are often referred for specialized testing and treatment to aid in their treatment. What is new, however, is the view of referrals and referral networks as encompassing more than addressing traditional health care needs and including social needs.

Digital platforms, such as NowPow, integrate directly with health care providers EHRs or an HIE to help provide their patients with direct “referrals” or “prescriptions” to community resources, such as food banks or financial assistance centers.

What are the barriers to using technology this way?

Temporary telehealth reimbursement policies:

Congress must act to provide for permanent Medicare telehealth reimbursement, free from artificial barriers on utilization such as requirements for in-person visits prior to the use of telehealth and geographic and originating site restrictions.

Protecting patient privacy:

Once patient information leaves a covered entity or business associate, as defined by the Health Insurance Portability & Accountability Act (HIPAA), it loses many security and privacy protections that would otherwise be protected while being held and used by a traditional health care actor. This gap in federal privacy protections is discussed in detail in a report published by eHI and the Center for Democracy & Technology.[22]

Many of those who experience inequity in health care access and outcomes belong to communities who have experienced unfair, unequal, and unauthorized use of their personal information. Without a federal privacy law that protects against data misuse, many of those who could benefit most from the use of digital tools may be hesitant to utilize such tools. During COVID-19, this was highlighted by the low utilization of contact tracing digital applications.

Section II: Improving Alignment

Where do you see opportunities for better coordination and alignment between community organizations, public health entities, and health organizations? What role can Congress play in facilitating such coordination so that effective social determinant interventions can be developed?

Improved Data Collection:

Congress can provide incentives for providers who participate in federal health care programs (Medicare, IHS, etc) to collect SDOH data. Further, Congress can provide incentives for health IT developers to rapidly adopt USCDI v2.

Federal Privacy Protections:

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[22] (2021, February). *Proposed Consumer Privacy Framework for Health Data.* eHealth Initiative. Center for Democracy and Technology. Retrieved on September 2021 from https://www.ehidc.org/sites/default/files/eHIDCT_Consumer_Privacy_Framework.pdf.

In order to build trust between health care providers, community resources, and the individuals both seek to serve, Congress must provide federal privacy protections for sensitive data that is held and used outside of the traditional health system and therefore not protected by HIPAA.

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)?

A wide variety of screening tools are currently used in clinical settings to capture data about the social determinants of health.[23] These tools, programs and platforms being 'sold' to provider and health organizations are often helpful, but they are each very different. As previously discussed, a lack of data standardization is a major barrier to the collection, exchange, and use of SDOH data. A 2019 HHS study notes that due to the variety of methods, industry stakeholders have a hard time sharing data with others who are not collecting similar data or data similarly.[24]

Amy M. Andrade, MS, Assistant Vice President of research at Meharry Medical College and founding director of Meharry Medical College's Data Science Institute notes in a Health IT Analytics article that "national standards of care are largely based on causation patient data." Being unable to access information about minority and underserved patient populations only exacerbates the deficit stakeholders see in their critical data sets.[25]

In a 2018 survey by the American Academy of Family Physicians, they found that 80% of family physicians feel like they don't have time to discuss social determinants during routine consults. 64% of the same respondents didn't believe that they even have the staff or resources to do anything about the risk factors even if they're able to identify them. Ensuring physicians, especially those in primary care settings who see a wide range of patients on a regular basis, have the resources they need to address social determinants with their patients is critical. Additionally, any digital tool introduced should fit within existing workflow to ensure physicians can maximize their time with patients. [26]

What tools, resources, or policies might assist in addressing such challenges?

- Platforms that are integrated into provider workflow
- Use of innovative technologies, such as AI/ML
- Education about collection and use of patient health data
- Standardized expectation of certain data to be collected and consistent definitions of each piece of data

Section III: Best Practices and Opportunities

[23] Kent, Jessica. (2020, February 17.) *Top 3 data challenges to addressing the social determinants of health.* Health IT Analytics. Retrieved on September 2021 from https://healthitanalytics.com/news/top-3-data-challenges-to-addressing-the-social-determinants-of-health.

[24] (2019, December). *Leveraging Data on the Social Determinants of Health: Roundtable Report.* Center for Open Data Enterprise (CODE). Office of the Chief Technology Officer at HHS. Retrieved on September 2021 from http://reports.opendataenterprise.org/Leveraging-Data-on-SDOH-Summary-Report-FINAL.pdf.

[25] Kent, Jessica. (2018, November 6.) *Socioeconomic Data Will Play Key Role in Population Health for Minorities*. Health IT Analytics. Retrieved on September 2021 from https://healthitanalytics.com/news/socioeconomic-data-will-play-key-role-in-population-health-for-minorities.

[26] (2017.) *Social Determinants of Health (SDoH): Family Physicians' Role.* American Academy of Family Physicians. Retrieved on September 2021 from https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/sdoh-survey-results.pdf.

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?

CMS Telehealth & Remote Patient Monitoring Waivers:

1. **Remove Obsolete Restrictions on the Location of the Patient:** Congress should permanently remove the current Social Security Act Section 1834(m) geographic and originating site restrictions to ensure that all patients can access care at home and/or other appropriate locations. The response to COVID-19 has shown the importance of making telehealth services available in rural and urban areas alike. In order to bring clarity and provide certainty to patients and providers, we strongly urge Congress to address these restrictions in statute by striking the section 1834(m) geographic limitation on originating sites and allow beneficiaries across the country to receive virtual care in their homes, or location of their choosing, where clinically appropriate and with beneficiary protections and guardrails in place.

2. **Maintain and Enhance HHS Authority to Determine Appropriate Providers and Services for Telehealth**: Congress should provide the Secretary with the flexibility to expand the list of eligible practitioners who may furnish clinically appropriate telehealth services. Similarly, HHS and CMS should maintain the authority to add or remove eligible telehealth services – as supported by data and demonstrated to be safe, effective, and clinically appropriate – through a predictable regulatory process that gives patients and providers transparency and clarity.

3. **Ensure Federally Qualified Health Centers and Rural Health Clinics Can Furnish Telehealth Services after the PHE**: FQHCs and RHCs provide critical services to underserved communities and have expanded telehealth services after restrictions were lifted under the Coronavirus Aid, Relief, and Economic Security (CARES) Act. Congress should ensure that FQHCs and RHCs can offer virtual services post-COVID and work with stakeholders to support fair and appropriate reimbursement for these key safety net providers.

4. **Make Permanent HHS Temporary Waiver Authority During Emergencies:** Congress has given HHS authority under Section 1135 of the Social Security Act to waive restrictions during the COVID-19 pandemic. However, the waiver authority is specific to the COVID-19 PHE. Congress should ensure HHS and CMS can act quickly during future pandemics and natural disasters. These priorities were included in a June 29, 2020 letter to Congress which the eHealth Initiative signed.

For RPM services, CMS should allow beneficiary consent to be obtained once annually and to allow RPM services for both new and established patients and for patients with both chronic and acute conditions.

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?

Humana Bold Gold's *Basic Needs Program*

- At the beginning of the COVID-19 pandemic, Humana collected data through proactive outreach to members and from members who called for assistance.
- Food insecurity was heightened and amplified by a lack of access to healthy and affordable food caused by limited transportation, instructions for vulnerable populations to stay home, and supply chain interruption.
- To combat food insecurity Humana created a *Basic Needs Program*.
    - *Basic Needs Program* has provided more than 900,000 meals by coordinating with national, local and regional partners.
    - The issues Humana was seeing weren't siloed into a single SDOH issue, and alone with food insecurity, they knew a multitude of housing barriers would cause similar issues.
    - Humana recognized that not all individuals receiving the meals had a place to store items perishable items.
        - They used predictive analytics to identify members who might become food insecure in the future, Humana began to provide shelf-stable food.
    - As of august 2020, Humana has conducted 3.3 million screenings to identify food related needs, executed SDOH pilots to more than 60,000 members, potentially reached 6.5 million people in 16 Bold Gold communities.

CareMore Health, a care delivery system and subsidiary of Anthem that serves Medicare and Medicaid patients, introduced a program to combat isolation of their elderly population.

- *Togetherness Program* is a comprehensive initiative aimed at identifying and intervening in the loneliness of its senior patients
    - The program initially enrolled 1,000 lonely senior patients in an intensive intervention that included weekly phone calls, home visits, encouragement and connection to community-based programs using "Togetherness Connectors" (social workers and volunteer associate phone pals.)
    - By the end of 2018, they reported incredibly changes in the lifestyles and health of these once-lonely, individuals.
    - *Some of the largest outcomes from the study include:*
        - Participation in exercise programs increased by 56.6% for the program participants compared to those not involved in the program
        - ER utilization among enrolled participants decreased by 3.3% compared to the program participants' baseline, while ER use of the intent to treat population increased by 20.3%
        - Hospital admissions per thousand members among program participants are 20.8% lower than admissions among the intent to treat population.

Section IV: Transformative Actions

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?

When Congress starts to make decisions about ways to address these SDOH challenges, they must recognize that this is not just a healthcare issue. Challenges and barriers to leading a healthy, productive life can be found in every part of a patient's life. Changes in policies that may seem unrelated, like highway and bridge

refurbishment, public transportation, English proficiency, high school graduation, protection of data health data, and a myriad of other examples can be found in each of department of the president's cabinet, each chamber's committees and caucuses.

Congress should consider the CDC's Health in All Policies approach to the integration of health considerations in community planning decisions. These health impact assessments are used to anticipate and prevent triggers of negative social determinants. It allows policy makers at federal, state and local levels to integrate health considerations into government-implemented policies like transportation, infrastructure and urban planning.