

Attachment—Additional Questions for the Record

Subcommittee on Health Hearing on “Empowered by Data: Legislation to Advance Equity and Public Health” June 24, 2021

Faisal Syed, M.D., National Director of Primary Care, ChenMed

The Honorable Richard Hudson (R-NC)

1. A number of public and non-profit safety net hospitals who serve large populations of low income and diverse patients who are challenged by numerous social risk factors have come together to share and innovate best practices. One major identified need is data platforms that track both medical and social conditions and facilitate access to services that respond to these needs. Another is support for “learning laboratories” that will advance identification and dissemination of promising innovations to improve care to these aforementioned populations.

a. Would you agree that investments into entities working to help advance best practices related to social determinants of health could drive progress in improving health inequity?

While there may be value in such investments, I do not believe that would be the highest value place to invest. The greatest lever policy makers could pull would be to encourage and enable fully capitated (“budget based”) care – that is appropriately risk adjusted – where health providers own the risks of bad (expensive) health outcomes and the benefits of good health outcomes.

There clearly remains much to be learned about how to overcome social determinants of health and how to ensure the best health and wellness outcomes for people with social barriers. However, there are two issues to consider.

First is that research into best practices and the process of dissemination and adoption is a long process. It’s often [cited](#) that it takes 17 years for evidenced-based practices to become widely adopted. While research should be undertaken, we don’t have that long to wait for the payoff. Moreover, the best way to generate research is not to directly pay for it, but rather to create real world “learning laboratories” by giving providers the incentive to improve health for populations with social determinant of health challenges.

The second issue is that the system is not set up to encourage the needed learning, even with funding, because the foundational operating model remains “payment

by the piece” for what is billable in the existing healthcare system. Up to 80 percent of modifiable health outcomes are based on a person’s lifestyle, and the work of a health care professional to influence in that 80 percent is not on a fee schedule. It’s that work that is necessary to help populations struggling with complex social inequities and bring about equitable results. Said differently, healthcare delivery models that are based on the patient’s ability to pay (or the provider’s ability to bill) do not address social inequities because they only focus on the pathophysiology when medical conditions warrant immediate attention.

Fully capitated models take “ability to pay” and “ability to bill” out of the equation. Providers not only have the pre-established budget to invest in services, but they have the pressure to make sure they solve whatever issue – medical or social – is driving bad health outcomes. Investing in getting more providers to operate on these fully capitated models will create a natural learning lab where people can see what is working and emulate each other out of their aligned economic incentives to improving and equalizing health outcomes.

b. What do you consider to be the investment of most immediate need in ensuring that health care, social risk, and other data are being collected on vulnerable populations and what do you see as the best steps for coordination among stakeholders on these efforts?

There are organizations collecting and organizing health care data based on social risk factors. The biggest problem, however, is that there is no standard. Which data elements must be captured? What possible responses (field values) should be in the answer option set? These are not defined and that undermines running useful performance research by appropriate population segments.

Secondarily, there is no incentive (“carrot” or “stick”) to gather important information beyond basics of age, gender, etc. Given the known inequities by socioeconomic, race/ethnicity, educational status, and more – plus the fact that 70 to 80 percent of modifiable health outcomes are based on social issues – there needs to be a forcing mechanism for providers to capture more defining data.

Coincidentally, moving more providers to capitation models (as described in the prior question) where business success relies upon finding the root cause of health issues and then addressing them, creates an incentive for more data capture. But, they still need standardization to capture data in a comparable way that allows for more study, more performance comparison across providers, and more identification of best practices in overcoming health inequities.