CENTER FOR HEALTH LAW & POLICY INNOVATION
Harvard Law School

COMMUNITY SERVINGS
DELIVERING MEALS DELIVERING HOPE

CHILDREN'S HealthWatch

January 29, 2016

Health Policy Commission
Attn: Catherine Harrison
50 Milk St., 8th Floor
Boston, MA 02109

Dear Ms. Harrison,

The Center for Health Law & Policy Innovation of Harvard Law School, Community Servings, and Children's HealthWatch, together with our ally organizations, respectfully submit the following comments on the Proposed Accountable Care Organization (ACO) Certification Standards. We urge that Health Policy Commission ACO certification criteria be modified to require the demonstration (through appropriate documentation) of capability to address at least two critical social determinants of health (SDH) for ACO patient populations: food security and housing status.

BACKGROUND

We assert that an ACO cannot successfully fulfill its mission of improving health outcomes and quality of care while slowing cost without active engagement in addressing SDH, especially for vulnerable populations. SDH include, *inter alia*, food security (access to sufficient nutritious food for all members of a household to live active, healthy lives), stable housing, energy security, transportation, education, income, and neighborhood safety. While the most successful ACO will have procedures in place to assess and address multiple SDH for their patient populations, a well-established and growing body of research supports the link between, in particular, food security and housing status with poor health outcomes and identifies these two SDH as key drivers of healthcare costs. Given the unfortunate ubiquity of food insecurity (11.5% of households in MA are food insecure)[1] and housing instability (Massachusetts as a state experienced the second largest increase in homelessness – just behind New York – between 2013 and 2014) ,[2] we assert that every ACO will serve a patient population that demonstrates a need for resources in these two areas. Every ACO should therefore be required to demonstrate the capability to assess and address (through procedures for screening appropriate patients and provision of resource referrals) these two SDH.

Food Security Status, Health Outcomes, and Healthcare Costs

Food insecurity (lack of access to sufficient food for an active, healthy life) has been linked to postponing needed medical care, postponing medications, increased use of the Emergency Department, and hospitalizations.[3] It is further associated with increased rates of clinical evidence of hypertension and diabetes in low-income adults,[4] and with poor glycemic control and increased hypoglycemic episodes (a major healthcare cost-driver) in adults with diabetes.[5] Roughly one in three patients admitted to U.S. hospitals is malnourished.[6] Studies show that once admitted, nutritionally compromised patients have

longer hospital stays,[7] higher costs of hospitalization,[8] and are almost twice as likely as nourished patients to be readmitted within fifteen days.[9] In fact, for Medicare recipients suffering from common conditions such as heart failure, pneumonia, and chronic obstructive pulmonary disease (COPD), nutrition-related diagnosis-related groups (DRGs) are among the top ten causes of readmission.[10] Food insecurity is predictive of both high rates of healthcare utilization and high costs, independent of other SDH.[11]

Housing Status, Health Outcomes, and Healthcare Costs

Numerous research studies over the past two decades have confirmed the role of safe, stable housing as a critical social determinant of health.[12] Homelessness is associated with significantly higher rates of emergency department use and hospitalization, and with significantly high annual healthcare costs.[13] Housing instability (when defined as self-reported difficulty paying rent, mortgage, or utility bills in the past year) is associated with not having a usual source of healthcare, postponing needed medical care, postponing medications, increased Emergency Department use, and hospitalizations.[14] Unstable housing (when defined as living in a short-term occupancy hotel, residence, or motel, having moved more than once in the last year, or having received housing assistance) is associated with lower rates of medication adherence and higher healthcare utilization, including Emergency Department use, hospitalizations, and more prolonged hospitalizations, for individuals living with HIV compared to control groups of people with HIV/AIDS who have stable housing.[15] Studies also demonstrate significantly reduced hospitalizations and reduced length of hospitalizations for homeless individuals with severe and persistent mental illness who receive a housing intervention or who have access to stable and affordable housing.[16]

In particular, supportive housing (which offers clients a range of comprehensive, community-based services as well as a place to live) has consistently proven to improve health outcomes, reduce the use of public emergency services, and save money. Research from around the country has examined the use and costs of health services (including, among others, emergency room visits, hospitalizations, psychiatric care, and detox treatment) for people before and after enrolling in supportive housing and found significant reductions in use of emergency services and in health spending once people are housed. In Massachusetts, the Home & Healthy for Good (HHG) supportive housing initiative helps participants reduce emergency room visits and overnight hospital stays by at least 50% and saves the state $9,339 per tenant per year in public services costs.[17] Studies from Denver and Chicago determined that supportive housing residents improved their health status, mental health outcomes, and survival.[18] Given the importance of housing to the health of vulnerable populations, evaluating and addressing housing status should be part of ACO certification.

ACOS SHOULD BE REQUIRED TO DEMONSTRATE ABILTIY TO ADDRESS FOOD SECURITY AND HOUSING STATUS

The critical links between food security and housing status, health outcomes, and healthcare costs make it imperative that all healthcare organization and payment models certified by the state are capable of fulfilling an outcome-driven and cost-conscious mission and are prepared and able to identify and address these SDH among their patient populations. To that end, we offer the following comments and urge the following additions and clarifications to the Proposed ACO Certification Standards.

1. **Table 1, Domain: Risk Stratification and Population Specific Interventions, #7:**

This criterion requires the ACO to have "approaches for risk stratification of its population" including, at a minimum, *inter alia*, "Social Determinants of Health (SDH)."

Requested Addition:
Further define SDH to include, at a minimum, food security and housing status.

Rationale:
Without clear guidance, an ACO could submit an approach for risk stratification that incorporates SDH, but does not include food security or housing. We believe that evidence supports the primacy of food security and housing status as key SDH for vulnerable populations and that these must be required SDH criteria incorporated into a risk stratification approach. In particular, we encourage risk stratification approaches to include implementation of the 2-question Hunger Vital Sign screening to identify patients with food insecurity.[19]

2. **Table 1, Domain: Risk Stratification and Population Specific Interventions, #8:**
This criterion requires the ACO to implement "one or more programs" targeted at improving health outcomes for the patient population, including "at least one program" that addresses "mental health, addiction, and/or social determinants or health." Comments are invited on whether the Health Policy Commission (HPC) should be more prescriptive with this requirement.

Requested Addition:
Require the ACO to; implement at least one program that targets the SDH of food security *and* housing status among patients; or implement at least two programs, if the programs address food security and housing status separately.

Rationale:
Given the evidence that supports food security and housing status as significantly associated with poor health outcomes and higher healthcare costs across multiple populations (individuals with chronic illness, seniors, and/or low-income individuals), ACOs should be required to implement at least one program that addresses these SDH. We understand the importance of addressing mental health, addiction, and other SDH and encourage HPC to require implementation of more than one program, ideally sufficient programs to address mental health, addiction, *and* SDH (food security and housing status specifically).

3. **Table 1, Domain: Cross Continuum Network: Access to BH and LTSS Providers, #9:**
This criterion requires the ACO to demonstrate and assess "effectiveness of ongoing collaborations with and referrals to" several categories of entities including, *inter alia*, "Community/social service organizations (i.e. food pantry, transportation, shelters, schools, etc.)." Comments are invited on the evidence that HPC should seek to evaluate whether ACOs assess the effectiveness of the collaboration.

Requested Addition:
Community/social service organizations should specifically include those that address food security and housing status SDH, including at least: home-delivered and congregate meal

providers, food pantries, farmers markets, organizations that help patients apply for financial food assistance, shelters, and organizations that help patients apply for financial housing assistance. Evidence of effective collaboration should include documented procedures for keeping a record of referrals and brief statements from the community/social service organizations themselves attesting to the collaboration.

Rationale:
Without increased specificity in the types of entities ACOs must collaborate with and evidence from the community-based organizations themselves that attest to the collaboration, we are concerned that ACOs will list organizations that do not address food security and housing status, and with which they have only cursory touchpoints instead of meaningful collaborations that are effective in connecting patients to resources that address these SDH. Requiring submission of statements from the community/social service organizations attesting to the collaboration will prompt some communication about the nature of the relationship between the ACO and these organizations on a regular basis.

4. **Table 1, Domain: Community Health, #15:**
This criterion requires the ACO to describe the steps it will take to invest in the population health of one or more communities where it has at least 100 enrollees through a "collaborative, integrative, multi-organization approach that acknowledges and accounts for the social determinants of health." Documentation requirements consist of "written description of plan to advance population health, along with identification of potential community partners."

Requested Addition:
Specify that social determinants of health include but are not limited to food security and housing status. The plan to advance population health should include, at a minimum, evidence of contact with potential community partners that address SDH, such as letters from the ACO to community partners that make the community partner aware of the entities within the ACO and the ACO's desire to form collaborative relationships.

Rationale:
Requiring this form of documentation will ensure that ACOs do a meaningful scan of the resources in communities where they serve a significant number of patients and, at a minimum, make these resource providers aware of the ACO's existence and mission.

CONCLUSION

In order for ACOs to truly fulfill the promise of improving care coordination and integration, access to services, and accountability for quality outcomes and costs, ACOs cannot afford to ignore or only pay lip service to SDH. We believe that as ACOs continue to see the benefits of increased coordination and flexibility in financing, they will naturally move toward investing more rigorously in engaging with the SDH that are major drivers of health outcomes and costs. The ACO Certification Standards represent an immediate and important opportunity to require ACOs to give primary SDH, such as food security and

housing status, more prominence in the development of ACO organizational structure, policies, and procedures. We believe implementation of the requested additions and clarifications above would add a minimal administrative burden to ACOs while yielding a significant and meaningful benefit for patients and for the Commonwealth.

About the Center for Health Law & Policy Innovation at Harvard Law School
The Center for Health Law and Policy Innovation of Harvard Law School (CHLPI) advocates for legal, regulatory, and policy reforms to improve the health of underserved populations, with a focus on the needs of low-income people living with chronic illnesses and disabilities. CHLPI works with consumers, advocates, community-based organizations, health and social services professionals, food providers and producers, government officials, and others to expand access to high-quality healthcare and nutritious, affordable food; to reduce health disparities; to develop community advocacy capacity; and to promote more equitable and effective healthcare and food systems. CHLPI is a clinical teaching program of Harvard Law School and mentors students to become skilled, innovative, and thoughtful practitioners as well as leaders in health, public health, and food law and policy.

About Community Servings
Community Servings is a Boston based nonprofit that provides medically tailored home-delivered meals and nutrition support services to severely ill individuals in 20 cities and towns in Massachusetts. The vast majority of Community Servings' clients live within 200% of the Federal Poverty Level. Founded 25 years ago to serve individuals dying of AIDS wasting syndrome, the organization has since expanded its mission to serve individuals coping with any life-threatening illness, including cancer, diabetes, and heart disease.

About Children's HealthWatch
Children's HealthWatch is a nonpartisan network of pediatricians, public health researchers, and children's health and policy experts committed to improving children's health in America. The organization strives to improve the health and development of young children by informing policies that address and alleviate economic hardships. Children's HealthWatch collects real-time data in urban hospitals across the country on infants and toddlers from families facing economic hardship, and analyzes and shares findings with academics, legislators, and the public. Children's HealthWatch currently has pediatricians and researchers located in urban hospitals in five cities across the United States: Boston, MA; Baltimore, MD; Little Rock, AR; Minneapolis, MN; and Philadelphia, PA.

Respectfully Submitted,

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Together with the following ally organizations:

Health Care For All (Boston, MA)

Massachusetts Law Reform Institute (Boston, MA)
The Greater Boston Food Bank (Boston, MA)
The Open Door (Gloucester, MA)
Fresh Advantage® LLC (Cambridge, MA)
Groundwork Lawrence (Lawrence, MA)
Boston Alliance for Community Health (Boston, MA)
Health Care Without Harm (Reston, VA with New England regional division)
Health Services, Action for Boston Community Development, Inc. (Boston, MA)
Mass Farmers Markets (Waltham, MA)

[1] *Map the Meal Gap 2013 Food Insecurity Rates: Massachusetts*, FEEDING AMERICA, available at http://map.feedingamerica.org/county/2013/overall/massachusetts (last visited Jan. 15, 2016).
[2] *2014 Annual Homelessness Assessment Report (AHAR) to Congress* (Oct. 14), U.S. DEP'T HOUSING & URBAN DEV., 8.
[3] Margot B. Kushel et al. *Housing Instability and Food Insecurity as Barriers to Health Care Among Low-Income Americans*, 21 J. GENERAL INTERNAL MED. 1, 71-77, 76 (2006).
[4] Hilary K. Seligman et al. *Food Insecurity is Associated with Chronic Disease Among Low-Income NHANES Participants*, 140 NUTRITION 2, 304-310 (2010), correction at 141 NUTRITION 3, 542 (2011).
[5] Hilary K. Seligman et al. *Food Insecurity is Associated with Hypoglycemia and Poor Diabetes Self-Management in a Low-Income Sample with Diabetes*, 21 J. HEALTH CARE POOR UNDERSERVED 4, 1227-1233,
[6] *E.g.*, Katherine Gamble Coats et al., *Hospital-Associated Malnutrition: A Reevaluation 12 Years Later*, 93 J. OF THE AMERICAN DIETETIC ASS'N 27, 31 (1993); *see also* Manuel Giner et al., *In 1995 a Correlation Between Malnutrition and Poor Outcome in Critically Ill Patients Still Exists*, 12 NUTRITION 23, 25 (1996) (malnourishment upon admission to intensive care unit); David R. Thomas et al., *Malnutrition in Subacute Care*, 75 AM J CLIN. NUTR. 308, 308, 310 (2002) (malnutrition upon admission to subacute-care center).
[7] Mark R. Corkins et al., *Malnutrition Diagnoses in Hospitalized Patients: United States, 2010*, 20 J. OF PARENTERAL AND ENTERAL NUTRITION 1, 3, 7 (2013).
[8] *Id.*
[9] Su Lin Lim et al., *Malnutrition and Its Impact on Cost of Hospitalization, Length of Stay, Readmission, and 3-year Mortality*, 31 CLINICAL NUTRITION 345, 348-350 (2012).
[10] Sam Beattie et al., *Reducing Readmissions with Nutrition Management: Briefing White Paper*, Mom's Meals NourishCare (2011), *available at* http://my.momsmeals.com/content/pdf/White_Paper_Reducing_Readmissions_with_Nutrition_Management.pdf.
[11] Valerie Tarasuk et al. *Association Between Household Food Insecurity and Annual Health Care Costs*, CANADIAN MED. ASS'N. J., 5, (2015).
[12] See, e.g., research studies listed at http://shnny.org/research-reports/research/health/.
[13] The difference in average annual healthcare costs (based on MEPS data) between homeless individuals and the control group in observed levels of healthcare utilization for office-based care, emergency department visits, and hospitalizations was, in total, was $3,339. Stephen W. Hwang and Melford J. Henderson, *Health Care Utilization in Homeless People: Translating Research into Policy and Practice*, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY WORKING PAPER No. 10002, 6 (Oct. 2010).
[14] Margot B. Kushel et al. *Housing Instability and Food Insecurity as Barriers to Health Care Among Low-Income Americans*, 21 J. GENERAL INTERNAL MED. 1, 71-77, 75 (2006).
[15] Chad A. Leaver et al. *The Effects of Housing Status on Health-Related Outcomes in People Living with HIV: A Systematic Review of the Literature*. 11 AIDS BEHAVIOR, S-85-S100, S96 (2007).
[16] Tanya Kyle and James R. Dunn, *Effects of Housing Circumstances on Health, Quality of Life, and Healthcare Use for People with Severe Mental Illness: A Review*; 16 HEALTH AND SOCIAL CARE IN THE COMMUNITY 1, 1-15, 8-9 (2008).
[17] *Home & Healthy for Good Progress Report*, MASSACHUSETTS HOUSING AND SHELTER ALLIANCE, Jan. 2015, http://www.mhsa.net/sites/default/files/January%202015%20HHG%20Report.pdf.
[18] *Housing is the Best Medicine: Supportive Housing and the Social Determinants of Health*, Jul. 2014, CORPORATION FOR SUPPORTIVE HOUSING, http://www.csh.org/wp-content/uploads/2014/07/SocialDeterminantsofHealth_2014.pdf.
[19] See *The Hunger Vital Sign™: A New Standard of Care for Preventive Health*, Children's HealthWatch Policy Action Brief, May 2014, *available at* http://www.childrenshealthwatch.org/wp-content/uploads/FINAL-Hunger-Vital-Sign-2-pager1.pdf.