The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Vice President, Health Policy
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Brenda Destro
Deputy Assistant Secretary for Planning and Evaluation
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

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

Dear Deputy Assistant Secretary Destro:

On behalf of the American College of Obstetricians and Gynecologists (ACOG), representing over 58,000 physicians and partners in women's health, I am pleased to offer these comments in response to the Request for Information on the IMPACT ACT Research Study. As physicians dedicated to providing quality care to our patients, ACOG appreciates the opportunity to provide suggestions about how best to measure social risk among our patients. We look forward to working with the Office of the Assistant Secretary of Planning and Evaluation (ASPE) to ensure patients' medical and social risk are properly evaluated and incorporated into payment systems. It is with these goals in mind that we offer the following feedback and recommendations on provider and health plan approaches to improve care for Medicare beneficiaries, as well as Medicaid and privately-insured patients, with social risk factors.

Which social risk factors are most important to capture?

There are a variety of social factors that ACOG believes are important for obstetrician-gynecologists (ob-gyns) to inquire about and document when caring for women. Social and structural determinants of health that may influence a patient's health and use of health care include access to stable housing, access to food and safe drinking water, utility needs, safety in the home and community, immigration status, and employment conditions.[i] For example, people who are homeless face significant unmet need for health care.[ii,iii] Other social risk factors that should also be captured are childcare needs, financial resources, educational attainment and health literacy level, legal status, social isolation and supports, and transportation needs.[iv]

ACOG also believes that it is imperative that federal standards for collection of race and ethnicity information in clinical and administrative data are adopted to better identify disparities. Although the existing literature is replete with examples of differences in outcomes in black and white women, more work is needed to explore disparities among American Indian, Alaska Native, and Asian women. In addition, more granular data collection on ethnicity would help to elucidate the heterogeneity of health outcomes within the broad categories of Asian, Hispanic, and other groups.[v]

ACOG also supports collecting information on sexual orientation and gender identity because of the health disparities faced by lesbians, bisexual women, and transgender individuals.[vi,vii] With each of these demographic groups, the need to better understand the prevalence among the general population is necessary because accurate estimates are lacking. It is important to note that being a lesbian does not inherently affect an individual's health status. There are no known physiologic differences between lesbians and heterosexual women. There may, however, be health behaviors or health risk factors that are more common among lesbians and bisexual women that have health consequences.[viii] Additionally, transgender individuals often face social and economic marginalization that affects education, employment, and housing opportunities and well as significant barriers to accessing health care.[ix] Knowing whether patients are a part of these demographic groups gives a more accurate picture of the social risk that they face.

ACOG also recommends measuring social risk based on locality. Significant health disparities exist between rural and urban women.[x] Access to health care for rural residents is complicated by patient factors as well as those related to the delivery of care. Rural residents are more likely to be poor, lack health insurance, or rely substantially on Medicaid and Medicare; they also travel longer distances to receive care or to access a range of medical, dental, and mental health specialty services.[xi] Standard definitions across the health care system for what constitutes urban, suburban, and rural localities are necessary.

Would standardized data elements for EHRs help you to collect social risk data? If so, how could these data elements be standardized?

ACOG believes it is important to create standard definitions for many social risk factors and believes that the electronic health record (EHR) would be an appropriate vehicle to capture this information. Some elements, however, may not need to be standardized if they are self-reported, such as sexual orientation and gender identity. ACOG recommends that if standardized data elements are created in either Systematized Nomenclature of Medicine – Clinical Terms (SNOMED-CT), Logical Observation Identifiers Names and Codes (LOINC), or RxNorm that they be included in the US Core Data for Interoperability (USCDI) to increase the likelihood of uptake by EHR vendors.

While the EHR is one option for collecting data, some social risk data are also likely being captured already in information technology (IT) systems used by other service providers, such as social workers, health plan case managers, and rehabilitation therapists. Facilitating interoperability between these recordkeeping systems and EHRs would increase the robustness of data captured and remove administrative burden of collecting this data from physicians and other health care providers delivering direct medical care. However, to achieve interoperability there would need to be standards for the data elements in these portals.

What are barriers to collecting data about social risk? How can these barriers be overcome?

One barrier is the stigma associated with certain social risk characteristics. For instance, as noted above, lesbian and bisexual women face considerable stigma and may not feel comfortable disclosing their sexual orientation to physicians or other medical staff during an office visit, particularly if the medical professional lacks sensitivity or is not adequately trained to elicit accurate data. Further, while patients may feel comfortable disclosing social risk to some health care providers, they may not want all of their providers who have access to their medical record to know this information, and therefore, may not share it with any health care providers. Data segmentation for privacy (DS4P) may alleviate some patients'

concerns about what information they choose to disclose to other health care providers, but it is not a panacea to address all concerns. Conversely, if a patient is asked the same questions repeatedly everywhere they seek care, they may be unwilling to provide the same data over and over again.

A related barrier is social desirability response bias where patients may be more inclined to report positive characteristics and underreport ones they believe may be perceived as negative. The consequences of disclosing negative characteristics or behaviors can have severe consequences for patients. For example, pregnant women who use substances, e.g., alcohol or opioids, may be subject to criminal or civil penalties in certain states, therefore, they may be unwilling to disclose this risk behavior or even seek care.[xii] Caution should be taken when deciding what data elements to collect and care should be taken if disclosure of a sensitive item could jeopardize a patient's safety and continued access to care. Patients will not be forthcoming if they believe disclosure of information may result in adverse actions, such as incarceration, deportation, or loss of custody.
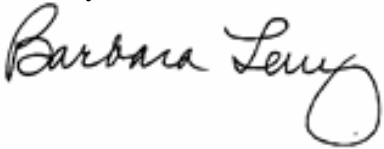
Another barrier is health care provider buy-in to collect these data elements. If it is not apparent why data are being captured or if collection disrupts clinical workflow, health care providers may be resistant to assisting in the collection of these data elements. As quality measures proliferate, health care providers are being inundated with reporting requirements that often vary by payer and many are suffering burnout as a result. Creating standardization and alignment across the health system in the collection of social risk data is essential to minimize administrative burdens on ob-gyns and other health care providers. Further, drawing data from existing systems or allowing patients to self-report directly into the EHR may also ease some of these concerns.

What do you see as promising future opportunities for improving data collection? For using existing or future data to tailor services?

Data repositories currently exist, such as vital statistics, prescription drug monitoring programs, and public health registries, that may aid in risk adjustment based on social characteristics. With patient matching, it may be possible to predict which patients are likely at-risk and, therefore, minimize the social desirability response bias. Additionally, some data elements already reside in the EHR, such as patients' zip code which would determine whether they live in a rural or urban area.

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Thank you for the opportunity to comment on the Request for Information on IMPACT ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors. We hope you have found our comments helpful, and we look forward to working with ASPE as it moves forward with its research. Should you have any questions, please contact Elizabeth Wieand, Program Director of Payment and Delivery System Policy, at ewieand@acog.org or 202-314-2356.

Sincerely,

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Vice President, Health Policy

[i] Importance of social determinants of health and cultural awareness in the delivery of reproductive health care. ACOG Committee Opinion No. 729. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;131:e43–8.

[ii] Health care for homeless women. Committee Opinion No. 576. American College of Obstetricians and Gynecologists. Obstet Gynecol 2013;122:936–40.

[iii] Baggett TP, O'Connell JJ, Singer DE, Rigotti NA. The unmet health care needs of homeless adults: a national study. Am J Public Health. 2010;100(7):1326-33.

[iv] Social needs screening toolkit. Boston, MA: Health Leads; 2018. Retrieved from: https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/?tfa_next=%2Fresponses%2Flast_success%26sid%3Dmmo8us9j5efbnuahgdfqrsc2r0.

[v] Racial and ethnic disparities in obstetrics and gynecology. Committee Opinion No. 649. American College of Obstetricians and Gynecologists. Obstet Gynecol 2015;126:e130–4.

[vi] Health care for lesbians and bisexual women. Committee Opinion No. 525. American College of Obstetricians and Gynecologists. Obstet Gynecol 2012;119:1077–80.

[vii] Health care for transgender individuals. Committee Opinion No. 512. American College of Obstetricians and Gynecologists. Obstet Gynecol 2011;118:1454–8.

[viii] Health care for lesbians and bisexual women. CO No. 525. ACOG.

[ix] Health care for transgender individuals. CO No. 512. ACOG.

[x] Health disparities in rural women. Committee Opinion No. 586. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;123:384–8.

[xi] Hart LG, Larson EH, Lishner DM. Rural definitions for health policy and research. Am J Public Health. 2005;95(7):1149-55.

[xii] Substance abuse reporting and pregnancy: the role of the obstetrician–gynecologist. Committee Opinion No. 473. American College of Obstetricians and Gynecologists. Obstet Gynecol 2011;117:200–1.