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LEONARD DAVIS INSTITUTE of HEALTH ECONOMICS

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I am a nurse scientist whose research focuses on improving health outcomes for people with intellectual and developmental disabilities (IDD), a population that experiences profound and well-documented health disparities. My work uses large, multi-state data to examine how health system factors influence outcomes such as hospital readmissions, length of stay, and mortality among adults with IDD. I am concerned about the proposed restrictions on DEI-related activities (§200.300).

Across my published research, I have demonstrated that adults with IDD experience disproportionately poor hospital outcomes, including elevated readmission rates (approximately 17–18%) and increased risk of mortality, driven by a complex interplay of social determinants of health, comorbidities, and system-level factors. These findings highlight that individuals with IDD face structural inequities in care delivery that require targeted, evidence-based solutions.

My work further shows that hospital system factors, particularly nursing resources, play a critical role in shaping these outcomes. For example, I found that each additional patient added to a nurse's workload is associated with 7–9% higher odds of 30- and 60-day readmissions for patients with IDD. In related work, more supportive nurse work environments and higher proportions of registered nurses are associated with shorter hospital stays, reducing patients' exposure to complications and improving care delivery. These findings indicate that system-level investments can meaningfully improve outcomes for this population.

As part of a federally funded Diversity Supplement, I built on this body of work through a program of research focused specifically on identifying risk and improving care for hospitalized individuals with IDD. While this work generated multiple peer-reviewed studies, the culmination, a risk stratification tool designed to help clinicians identify which patients with IDD are at highest risk and require additional hospital resources, was terminated before completion due to the loss of funding.

This disruption has direct consequences for patients and families. Individuals with IDD are hospitalized at higher rates and often require more intensive, coordinated care; without tools to identify risk and allocate resources appropriately, they remain vulnerable to preventable complications, prolonged hospitalizations, and avoidable readmissions. The loss of this research delays the translation of rigorous evidence into practical tools that clinicians can use to improve care at the bedside.

More broadly, restricting research support aimed at understanding and addressing disparities will reduce the evidence base available to policymakers, health systems, and clinicians, and risks

worsening existing inequities in healthcare access, quality, and outcomes for already vulnerable populations.

I respectfully urge OMB to withdraw this provision (§200.300) and preserve research support that improves health outcomes for underserved populations.

Disclaimer: The views expressed here are my own and do not represent those of the University of Pennsylvania Health System (Penn Medicine) or the University of Pennsylvania.