

November 16, 2018

The Honorable Brenda Destro
Acting Assistant Secretary and Deputy Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Avenue
Washington, DC 20201

Submitted electronically via email: ASPEImpactStudy@hhs.gov

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

OCHIN appreciates the opportunity to submit the following comments in response to the RFI IMPACT ACT Research Study. We applaud HHS's efforts as social risk factors, also called social determinants of health, are becoming more relevant in the movement towards value-based care. OCHIN has engaged in our own research on social determinants of health and we are pleased to have the opportunity to share our learnings in this space.

OCHIN is a 501(c)(3) not for profit community-based health information technology (HIT) collaborative based in Portland, Oregon. OCHIN receives support from the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) and is an HRSA-designated Health Center-Controlled Network (HCCN). OCHIN's mission is to pioneer the use of health information technology (HIT) in caring for the medically underserved. As such, OCHIN serves community health centers (CHCs), including Federally Qualified Health Centers (FQHCs), rural and school-based health centers, safety-net providers and public health and correction facilities across the nation. OCHIN's comments come through the lens of members we serve.

OCHIN encourages ASPE to consider:

- Research that specifically supports the connection between social risk factors, also known as, social determinants of health (SDH) collection, training, and education for providers and staff;
- Incorporating and standardizing SDH collection into electronic health records and workflows;
- Use of closed loop referrals for community resources;
- The importance of extending claims data to providers at the point of care for full understanding of cost of care for those treating the most complex patients; and

- Expanding community resources available to help those with risk factors.

OCHIN Comments on the IMPACT ACT Research Study

In one of OCHIN's most recent studies, we piloted several health centers' collection and integration of SDH data into the EHR.¹ Individuals with social risk factors were identified through different methods. OCHIN looked at use of geocoded community level social SDH data from publicly available resources.² This could be the median household income in a geographic area, or the unemployment rate of the same area. Using census or similar data can also create a loose outline of possible risk factors of a patient. This is the more common method of collecting social risk data.

OCHIN, as a national leader in SDH collection through the EHR, builds upon geocoded community level data by collecting additional patient data at the time of service using the OCHIN Epic PRAPARE tool.³ Through our work, we have determined where the bulk of effort is necessary to support safety-net programs for collection of SDH data. First, clinics must utilize standardized EHRs to be able to accommodate the SDH data. Second, clinics require funding and support for training and education to ensure data is properly collected. Third, clinics require associated community resources to improve patient outcomes. Finally, clinics require access to claims data to pair with their clinic data to understand their true cost of care.

I. Standardized EHRs and SDH Definitions

Currently, EHRs are permitted a certain level of variability between regions and states. This creates clear complications when data is collected on a mass scale. It also effectively limits interoperability between providers on different EHR systems. Competing or unmatched discrete fields between EHRs result in information transferring into notes fields rather than corresponding organized fields. This requires additional provider or administrative time to reorganize relevant data into fields in the second EHR to prevent providers from missing key health information of patients. This presents a real additional burden and potential for human error when EHRs transfer data between systems.

An addition into the workflow like SDH collection has the potential of drastically increasing provider burden. Collection requires training, time, cultural understanding, and relevant referrals. Without a well-established system that can overcome likely and foreseeable complications, collection

¹ Gold R, Bunce A, Cowburn S, et al. Adoption of Social Determinants of Health EHR Tools by Community Health Centers. *Ann Fam Med*. 2018;16(5):399-407.

² Bazemore A, Cottrell E, Gold R, et al. "Community vital signs": incorporating geocoded social determinants into electronic records to promote patient and population health. *J Am Med Inform Assoc*. 2016;23(3):407-412.

³ Gold R, Cottrell E, Bunce A, et al. Developing electronic health record (EHR) strategies related to health center patients' social determinants of health. *J Am Board Fam Med*. 2017;30(4):428-447.

will only increase provider burnout, cause patients additional stress, and fail to improve health outcomes for the most vulnerable patients.

With all the discussion around capturing SDH or risk factors, the efforts are complicated when no definitions are determined for what social determinants or risk factors are, how they are categorized, or measurements for them.⁴ When trying to establish if a patient is in a walkable neighborhood, what measurement is being applied? How is “healthy food” defined? To be able to research the data that is collected around these factors, having national standards is necessary for simple analysis and then subsequent application.

II. Training and Education

In OCHIN’s study, the incorporation of these new processes into the workflow posed a burden for providers.⁵ Despite the training, any large addition to workflows can result in difficulties, causing widespread stress. Providers and staff not only must learn how to navigate the unfamiliar discrete data fields, but they must learn how to appropriately ask the right questions, convey the true purpose of this data collection without frustrating patients, and then connect patients to valuable resources.

Communication training is a large portion of SDH data collection. The lack of trust between the patient and staff or provider, and a suspicion of what the information is to be used for is a substantial barrier. This is not an entirely unfounded concern, as it is unclear how payers will utilize this information in their cost and reimbursement calculations. Additionally, when a parent brings in a child for a cough, and the provider begins asking about the household income, the parent may not understand the purpose, and become agitated by the providers seemingly unconnected interest. Navigating this situation takes compassion and finesse.

This lack of trust exists on all levels, as patients rarely accurately inform providers about the extent of their destructive habits, for example. Not many people disclose the true answers to many of these questions. For those suffering consequences of social risks, shame often tempers the response. Similarly, when there are cultural differences between staff and patients, it can almost equate a language barrier, making accurate collection more complicated. In some cases, there is an actual language barrier.⁶

Extensive training can overcome these barriers. It can help staff and providers ask the right questions, give the proper explanation of how the information is going to be used, and even anticipate cultural differences to learn how to successfully communicate. Given the uniqueness of each clinic,

⁴ DeVoe J, Bazemore A, Cottrell E, et al. Perspectives in Primary Care: A Conceptual Framework and Path for Integrating Social Determinants of Health Into Primary Care Practice. *Ann Fam Med.* 2016;14(2):104-108.

⁵ Laforge K, Gold R, Cottrell E, et al. How 6 Organizations Developed Tools and Processes for Social Determinants of Health Screening in Primary Care: An Overview. *J Ambulatory Care Manage.* 2018;41(1):2-14.

⁶ Li V, McBurnie M, Simon M, et al. Impact of Social Determinants of Health on Patients with Complex Diabetes Who are Served by National Safety-Net Health Centers. *J Am Board Fam Med.* 2016.29(3):356-370.

these trainings will need to look different for each, to accommodate differences in population, workflows, and available community resources. These trainings should be ongoing to handle unforeseen communication and data collection issues.

Training and education requires extensive funding. Losing funding and reimbursement continues as one of the largest concerns of community health centers. Risk-based payments structures result in facilities serving more complex patients receiving less funding, as successful outcomes are difficult to obtain. Clinics should not be punished for the complexity of their patients, but instead for their ability to serve all patients, regardless of income or health complexity. The safety net requires a robust network of well-funded clinics to secure this population's health and welfare. SDH data has the capability of conveying the complexity of these patients, which can be integrated into value payment calculations, ensuring safety net clinics are not financially neglected.

III. Community Resources

It is critical to have robust community resources available for each social determinant/risk identified. Staff and providers have expressed the importance of being able to transfer the patient over to a community service. The referral process allows staff and providers to feel that there is a purpose to asking the questions beyond simply inputting the information into the EHR for later analysis. Having the ability to organize a referral, staff and providers can speak to the value of this data collection with confidence, resulting in more successful communication with the patient, leading to more accurate data collection.

Referrals come in the form of targeted services and outreach. The providers have (or need to have) community resources to refer patients to depending on their specific needs and the care they seek. Referrals in the form of concrete appointments or warm hand offs (to a community resource on site) result in higher rates of follow ups. Closed-loop referrals for these community resources then provide better data to assist clinics in determining the success of their efforts, or how to improve them. This essentially means having the community resource electronically confirm that the patient was seen and the service rendered.

Staff indicated having these resources available is essential to their confidence in identifying and addressing social determinants. However, staff noted it is important to inquire as to whether the patients desire assistance. Many of those who indicated a social determinant declined assistance. For example, during OCHIN's study, only 15% from one clinic and 21% from another requested help. We believe this reflects the need for intense communication training and valuable community resources.

IV. Clinic and Claims Data

For pilot clinics, it is difficult to determine costs of services when there is no access to claims data. The value of clinic and claims data for providers is not only beneficial for those integrating SDH workflows, but for all of those supporting those within the safety net. Pending changes in reimbursement systems require clinics to be able to analyze their own costs of care to determine how best to increase the value of their services and risk stratify the high-risk population they serve.

This data collection has potential to improve value of care by accounting for some of the difficulties associated with these risk factors. Having awareness of these social risk factors allows providers to change their treatment plans to accommodate issues like housing insecurity, food scarcity, or exposure to violence. With the movement towards providing solutions for patients' social needs, the support system only works as well as the data collection itself. It is clear more research is required in this area of health management.^{7,8}

We appreciate your consideration of our comments. Please contact Jennifer Stoll at stollj@ochin.org should you have any questions.

Sincerely,



Jennifer Stoll

VP, Government Affairs and Public Relations

⁷ Gottlieb L, Cottrell E, Park B, et al. Advancing Social Prescribing with Implementation Science. *J Am Board Fam Med.* 2018; 31(3): 315-321.

⁸ Cottrell E, Gold R, Likumahuwa S, et al. Using Health Information Technology to Bring Social Determinants of Health into Primary Care: A Conceptual Framework to Guide Research. *J Health Care Poor Underserved.* 2018;29(3):949-963