

November 16, 2018

U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

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

To Whom it May Concern,

BJC HealthCare (“BJC”) represents fifteen acute care hospitals across the St. Louis metropolitan region, as well as part of mid and southeastern Missouri and southwest Illinois. Those hospitals range from large, urban teaching hospitals serving a disproportionate share of economically disadvantaged patients, to suburban community hospitals, to Critical Access Hospitals in rural areas. BJC’s Center for Clinical Excellence is responsible for improving clinical quality and facilitating change throughout the organization. As such, BJC’s Center for Clinical Excellence holds a broad view of the potential impacts of changes to the national health care landscape, and sincerely appreciates the opportunity to comment for the IMPACT Act Research Study.

BJC strongly supports the Department of Health and Human Services’ (“HHS”) interest in social determinants of health (“SDOH”) and is encouraged by the thoughtful, deliberate approach to this complex area. We know that social determinants play an outsized role in our community’s health and well-being and appreciate HHS’s desire to spur change across the country. Having been actively engaged in addressing social determinants of health in our community for a number of years, we appreciate the opportunity to share our experience and provide commentary on a number of key points as HHS continues to evaluate its next steps.

Our comment is divided into the following sections:

- 1) Our experience in collecting and using data on social determinants of health
- 2) Capturing data on social determinants of health
- 3) Using data to impact social determinants of health and improve the health of our community

Experience with Social Determinants of Health

Social risk factors and their effect on health care, have been a substantial focus for BJC over the last few years. BJC is actively working to integrate social determinant of health data to support providers and communities in disparities elimination in a number of ways:

- 1) Targeting community health interventions: BJC personnel collaborated with the Missouri Hospital Association to develop the Missouri ZIP Health Rankings tool available via the [Explore MO Health](#) public online data platform that combines hospital and census-type data to map SDOH and outcomes at the ZIP code level

- for use by hospitals, foundations, public health organizations, and community organizations to identify high priority areas for interventions. These data as well as similar analyses conducted internally are being used in selected BJC markets to target interventions.
- 2) Standardized collection: BJC is in the process of standardizing SDOH collection across its hospitals and is involved in a regional collaborative of community health centers, hospital systems, public health, and social service agencies working to standardize SDOH collection regionally.
 - 3) Quality reporting: BJC has introduced an equity domain into its enterprise-wide quality reporting scorecard and is beginning an internal peer learning network to support use of social risk factors data in projects using an equity lens.

Capturing SDOH

Throughout our experience in working with SDOH, the collection of actionable data has been a challenge. We have the following recommendations and key considerations for ASPE, which we will explain in more detail below:

- 1) Standardize fields for SDOH data: HHS should follow CMS' [Accountable Health Communities](#) ("AHC") model when considering which fields should be captured and used to better understand SDOH. We would recommend the establishment of a "minimum" data set using the AHC model as a framework.
- 2) Provide incentives for standardization: HHS should provide incentives for providers (through the Promoting EHR Interoperability Program) to implement standardized collection of SDOH data.
- 3) Capture SDOH data across the social safety net: HHS should explore opportunities to align SDOH data collection among health care providers, other community service providers (e.g. food banks), and other governmental agencies (e.g. U.S. Department of Agriculture). This would require incentives to support a robust data infrastructure for community-based organizations/non-profits and mechanisms to enforce standardization of data collection.

Standardize fields for SDOH data

BJC along with our partners in the St. Louis metropolitan region are strong supporters of the Accountable Health Communities demonstration program. Although our region is not participating in the CMS-sponsored initiative, we are continuing work to implement its components, specifically in capturing standardized fields.

The Accountable Health Communities model focuses on collecting data in the following subject areas:

- Housing instability
- Food insecurity
- Transportation problems
- Utility help needs
- Interpersonal safety

We think capturing data in these areas is a great place to start. In addition to being comprehensive, many regions across the country are already working on standardized data collection for these fields. Leveraging existing work and research could significantly cut down on the implementation time for this effort.

We also would advocate that HHS examine coding practices and guidelines to ensure that SDOH data can be adequately captured by hospital and outpatient providers. Specifically, we would ask HHS to support guidance to ensure that ICD-10 coding can be consistently applied to capture patient responses to AHC or other SDOH screening tools. We also would urge continued support for allowing coders to use data from non-physicians (e.g. care coordinators), including across all care settings and with new healthcare roles such as community health workers.

Provide incentives for standardization

In addition to identifying the appropriate fields for collection, it is important that healthcare (and other) providers are capturing the same information and in a similar manner. We think HHS can accomplish this goal by creating an incentive for capturing specific SDOH fields through the Promoting EHR Interoperability Program (formerly Meaningful Use).

Should SDOH data be used to compare hospital performance to one another, it is vital that data collection be standardized across the country. CMS is already using the Promoting Interoperability Program to standardize best practices for addressing the national opioid epidemic. We think a logical next step would be to use the program to help advance the important SDOH work.

We strongly support standardized data collection and using existing CMS payment programs to incentivize this work across the country.

Capture SDOH data across the social safety net

An important component of capturing relevant SDOH data is acknowledging the role of non-healthcare providers in the process. The data collection burden cannot be on hospitals alone. We know that patients with SDOH challenges encounter the social safety net at multiple points. It is important to gather information on patients' health and other risk factors throughout their interactions in order to paint a robust picture of their SDOH challenges. Having more comprehensive information would allow for better targeting of support services and interventions to improve health.

Much of this data could be collected via existing government programs and agencies (e.g. the U.S. Department of Agriculture's food assistance programs). However, many community-based social service providers are not currently equipped to collect and share this data. Therefore, we would ask that HHS should engage its interdepartmental stakeholders and other community-based providers in a process to standardize this information beyond the healthcare sector. We also would ask HHS to consider making funding available to social services organizations to develop the technology systems needed to collect SDOH data, and to support ongoing licensing fees.

Using Data to Impact Social Determinants of Health

It's one thing to collect robust data on social determinants of health. But using that data to impact change in our communities is a challenge. To achieve success, there needs to be a robust support infrastructure between healthcare organizations and other community services providers. Our recommendations and key considerations to help build such an infrastructure are:

- 1) Support for Behavioral Health: In our community, many patients with SDOH challenges and high healthcare utilization also have behavioral health comorbidities. Therefore, it is important to identify pathways for behavioral health screening, referral, and navigation in addition to the work to identify and impact SDOH.
- 2) Increase social service provider capacity: SDOH screening, referral and navigation by clinical providers has limited utility when there is a lack of downstream social service providers in a given sector or geographic area. We think it is vital for HHS to provide support to service organizations in areas with diminished capacity via reimbursement to social service agencies.
- 3) Develop and support alternative care models: HHS should sponsor models, like the Accountable Health Communities and Community Health Workers initiatives, to support addressing SDOH challenges and to foster partnerships between healthcare providers and their communities.

To conclude, we sincerely appreciate the opportunity to provide comment on this important topic. We encourage the government's involvement in helping to find solutions to these challenges and look forward to an active partnership.

Sincerely,



Wm. Claiborne Dunagan, MD, MS
Senior Vice President and Chief Clinical Officer, BJC HealthCare
Director, Center for Clinical Excellence