Moving Social Determinants of Health into Action & Health Equity

US Core Data for Interoperability Task Force | July 27, 2021
Evelyn Gallego, Program Manager, Gravity Project, and CEO, EMI Advisors LLC

Topics

- USCDI version 2

- Gravity Project's 2021-2022 Roadmap

- USCDI version 3

- Observations and Recommendations

USCDI v2

USCDI v2: Appreciations

- **Thank you!** USCDI Task Force for your leadership, hard work, commitment!
- **Thank you!** ONC, National Coordinator Micky Tripathi, the Health IT Advisory Committee.
- **Thank you!** Gravity Project 2,000+ Community Members—patient/consumer advocates, clinical and community service providers, health IT vendors, payers, researchers, governments.
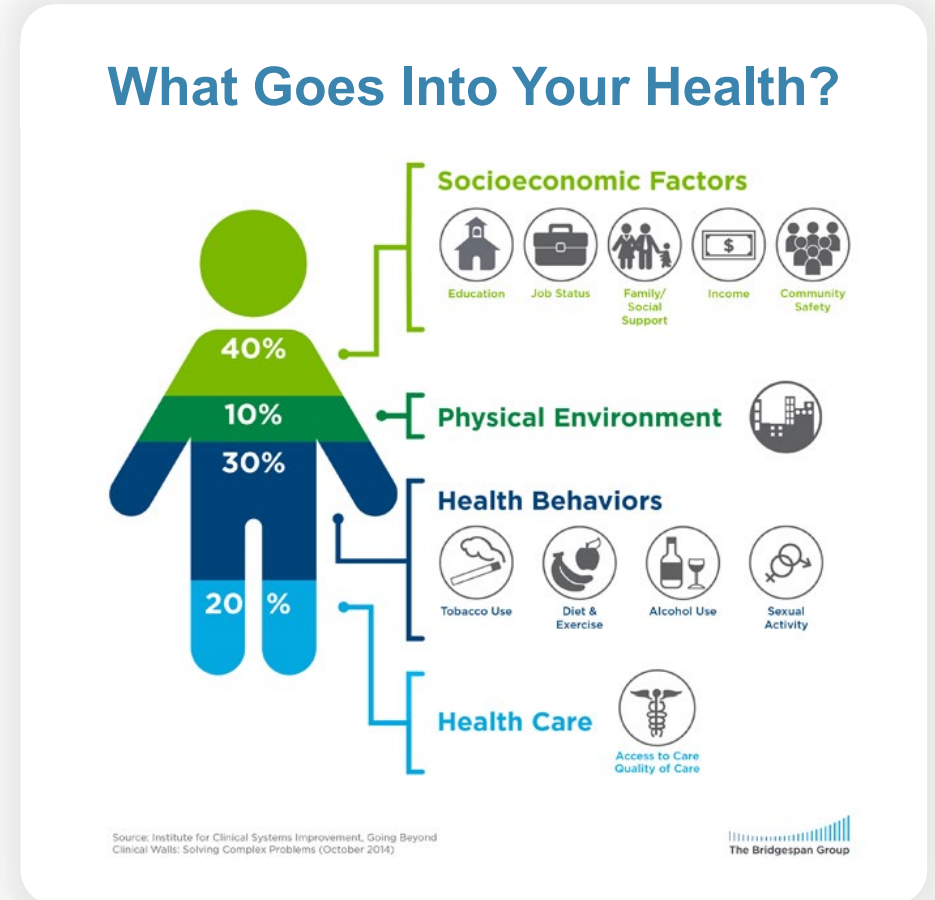
Why Addressing SDOH is Important

There is growing awareness that unmet social needs negatively impact health outcomes.

Food insecurity correlates to higher levels of diabetes, hypertension, and heart failure.

Housing instability factors into lower treatment adherence.

Transportation barriers result in missed appointments, delayed care, and lower medication compliance

Addressing SDOH is a primary approach to achieving health equity and reducing health disparities.

What Goes Into Your Health?

40% — Socioeconomic Factors (Education, Job Status, Family/Social Support, Income, Community Safety)

10% — Physical Environment

30% — Health Behaviors (Tobacco Use, Diet & Exercise, Alcohol Use, Sexual Activity)

20% — Health Care (Access to Care, Quality of Care)

Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

The Bridgespan Group

[1]https://www.cdc.gov/nchhstp/socialdeterminants/faq.html
[2]https://www.bridgespan.org/insights/library/public-health/the-community-cure-for-health-care-(1)

USCDI v2: SDOH Data Elements

- Inclusion of SDOH data elements in USCDI propels nationwide, interoperable health information exchange across the **health _and_ human services** ecosystems

- SDOH data elements—added into _existing_ data classes— become part of the clinical workflow and not treated as distinct:
  - Assessment and Plan of Treatment: SDOH Assessment
  - Problems: SDOH Problems/Health Concerns
  - Procedures: SDOH Interventions
  - Goals: SDOH Goals

- Structure facilitates the ongoing addition of new value sets and new domains (e.g., food deserts) as they are developed through the Gravity standards development process.

USCDI v2: Value-Driven Connections between New Data Elements

- Combination with other USCDI data elements increases benefit

- NEW Data Element: **Care Team Members**
  - Inclusion of all care team members including family members and community-based providers supports more holistic and person-centered care planning.

- NEW Data Element: **Sexual Orientation and Gender Identity**
  - Better health care and health equity
  - May further inform and improve care for particular social risk factors including intimate partner violence where there are differences by SO and GI

Gravity Project 2021- 2022 Roadmap

Gravity Overview: 2021 Roadmap
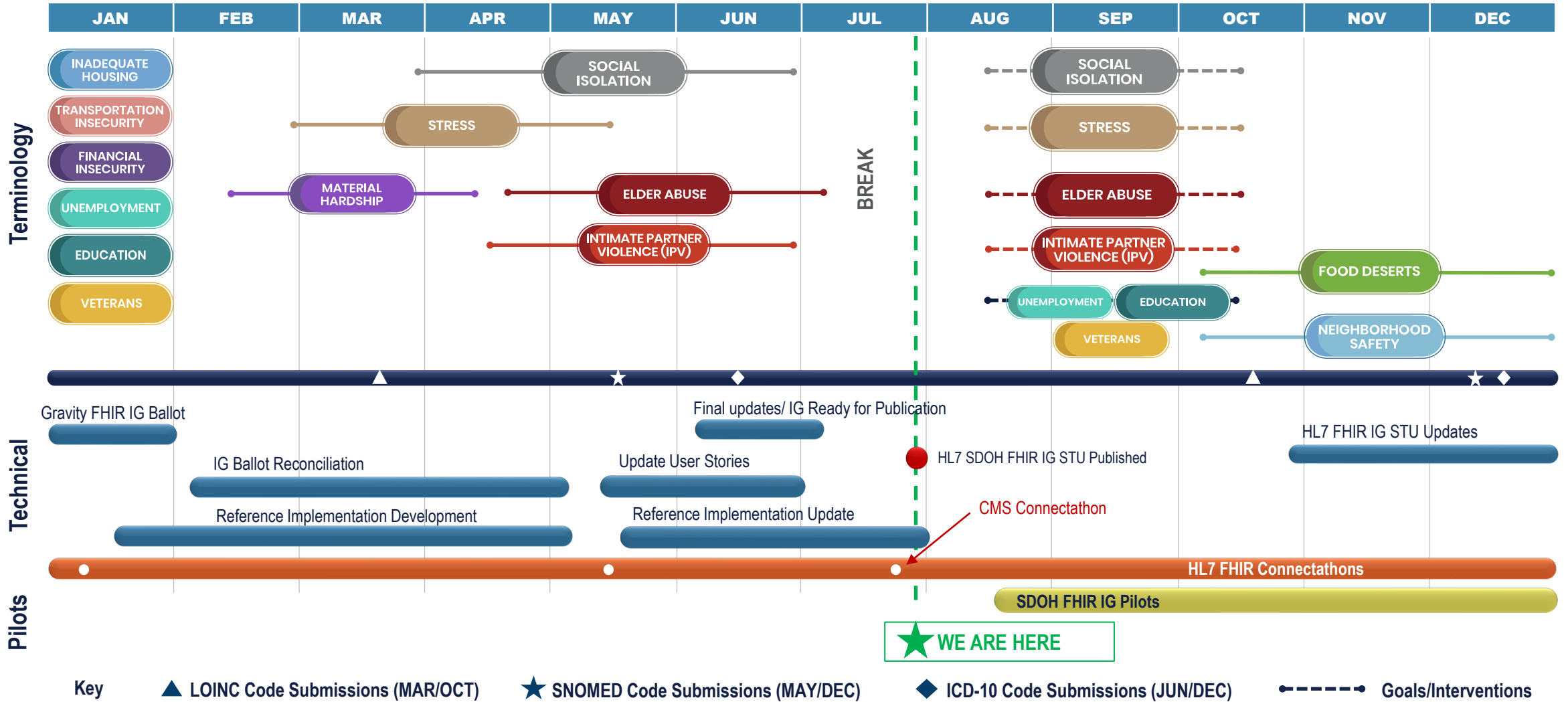
SDOH Data Elements & SDOH Clinical Care IG in Action

1. Screen for social risk and define health Concern / problem (diagnosis).

2. **Establish** patient and provider defined **goals** to address social need.

3. **Plan and track** related **interventions** to completion.

4. **Measure outcomes**.

5. **Aggregate data** for use and reporting (e.g., population health management, quality reporting, risk adjustment / risk stratification).

6. **Record patient consent** as needed.

http://build.fhir.org/ig/HL7/fhir-sdoh-clinicalcare/
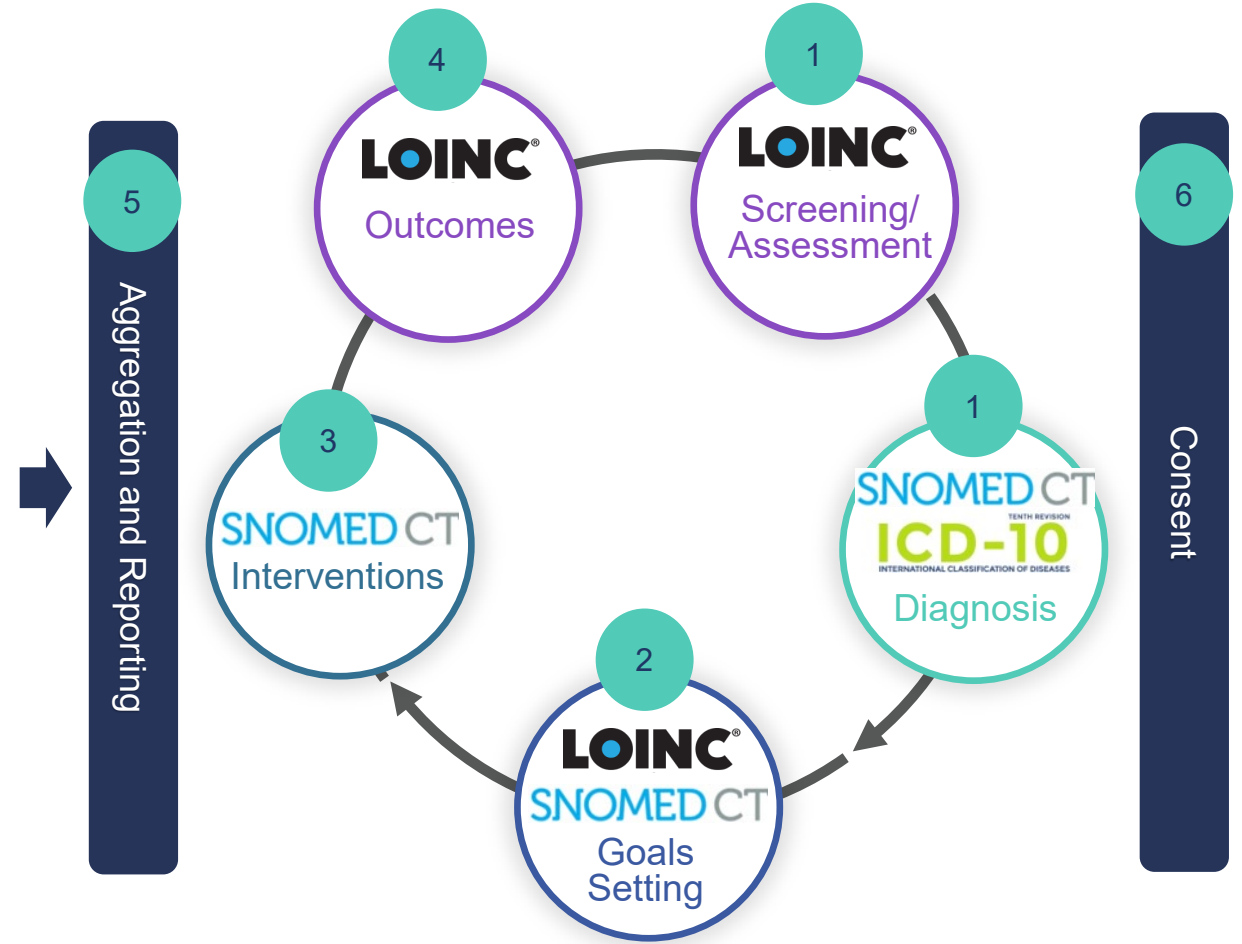
USCDI v3

Gravity Project Vision: USCDI v3 and Beyond

FHIR Implementation Guides / Use Cases	Data Elements	Domains*	Code Systems / Value Sets

• SDOH Clinical Care IG
• **Social Care IG**
• **SDOH Quality Measurement IG**
• **Population Health IG**
• **SDOH Public Health IG**
• **Social Directory IG**
• **SDOH Research IG**
	• Assessments
	• Problems/Health concerns
	• Goals
	• Interventions
	• **Outcomes**
	• **Consent**
	• **Data Aggregation**
	• **Billing**
	• **Health Insurance**
		• Food insecurity
		• Housing instability
		• Homelessness
		• Inadequate housing
		• Transportation insecurity
		• Financial insecurity
		• Material hardship
		• Employment status
		• Educational attainment
		• Veteran status
		• Stress (general)
		• Social connection
		• Intimate partner violence
		• Elder abuse
		• **Food deserts**
		• **Neighborhood safety**
		• **Health literacy**
		• **Minority and Relationship stress**
		• **Racism/discrimination/bias (beyond mid-2022)**
			• **LOINC**
			  ▪ Assessments
			  ▪ Goals
			  ▪ Outcomes (e.g., quality measures
			• **SNOMED-CT**
			  ▪ Problems/Health concerns (clinical)
			  ▪ Goals
			  ▪ Interventions (clinical)
			• **ICD-10-CM**
			  ▪ Problems/Health concerns (billing)
			• **CPT/HCPCS**
			  ▪ Interventions (billing, where available)

*List not exhaustive for 2022 and beyond. Domains are grounded in then Institute of Medicine's "Capturing Social and Behavioral Domains in Electronic Health Records" (2014).

USCDI v2 & v3:
Observations & Recommendations

USCDI v2 Opportunities

- Informs health industry what SDOH data elements should be collected and what standards should be used to represent and exchange this data electronically

- Facilitates SDOH data integration at a national scale to meet growing COVID-19 response

- Provides glide path for standards development for technical capacity into real-world implementation

- Creates framework for providers and payers to scale FHIR APIs into social care and health equity focused initiatives

USCDI v2 Challenges

- Learning curve for social care data integration and use

- Limited use of CEHRT and FHIR based solutions (industry is just ramping up to meet CMS rule requirements)

- Ongoing development and publication of SDOH value sets—Food Insecurity and Housing most complete to-date

- SDOH Clinical Care IG just published by HL7—needs real-world testing, implementation, and iteration beyond FHIR Connectathons

- Proliferation of Community Referral Platforms—not fully integrated into existing health ecosystem or regulated as CEHRT

- Ensuring equitable use of SDOH data for good, not harm, discrimination, or profiling. To this end, the Gravity Project has developed data principles for equitable use

USCDI v3 Recommendations for Task Force

- Consider data elements individually **and** in combinations. They are building blocks for multiple purposes and use cases.
  - Expanding Care Team Members integrates members helping with SDOH.
  - Linking functional and cognitive status data elements with SDOH data elements will identify and help reduce health disparities in vulnerable populations (e.g., frail adults, elderly, and disabled).
- Consider need for multi-directional electronic information exchange for true interoperability, not just referrals
  - Patients, family caregivers, community-based providers may be primary source of SDOH data, especially outcomes and patient-reported outcomes for value-based care.
  - Assessments initiated by community or social service organizations

USCDI v3 Recommendations for Task Force

- Explore how elements support person-centered and advanced care planning with patients, providers, and other care team members
  - Significant benefit for transitions of care, care coordination, health equity, value-based care, and prevention.

- Consider how elements advance other core use cases beyond clinical care (or upstream and downstream use of data):
  - E.g., COVID-19 and pandemic response, population health, public health, digital quality measurement, risk adjustment.

Questions?

Join the Gravity Project!

Learn More
https://confluence.hl7.org/display/GRAV/Join+the+Gravity+Project

- Public Collaborative meets weekly on Wed

- Workgroup meets bi-weekly on Thursdays' 4:00 to 5:30 pm ET

- SDOH FHIR IG Workgroup s. 3:00 to 4:00 pm ET

- Give us feedback on the Data Principles: https://confluence.hl7.org/display/GRAV/Gravity+Data+Principles

- Submit SDOH domain data elements (especially for Interventions): https://confluence.hl7.org/display/GRAV/Data+Element+Submission

Help us with Gravity Education & Outreach

Use Social Media handles to share or tag us to relevant information

@thegravityproj

https://www.linkedin.com/company/gravity-project

Help us find new sponsors and partners

Partner with us on development of blogs, manuscripts, dissemination materials

Gravity PMO Team

Evelyn Gallego
Program Manager

evelyn.gallego@emiadvisors.net

🐦 @egallego

in linkedin.com/in/egallego/

Carrie Lousberg
Project Manager

carrie.lousberg@emiadvisors.net

🐦 @carrielousberg

in linkedin.com/in/carrie-lousberg-pmp-63603415/

Mark Savage
SDOH Policy Lead

MarkSavage.eHealth@pacbell.net

🐦 @SavageMeHealth

in linkedin.com/in/mark-savage-34aa03126/

Bob Dieterle
Technical Director

rdieterle@enablecare.us

in linkedin.com/in/bob-dieterle-82a88211/

Sarah DeSilvey
Clinical Informatics Director

sarah.desilvey@med.uvm.edu

🐦 @sarcandes

in linkedin.com/in/sarah-desilvey-fnp/

Lenel James
Payer Advisor

in linkedin.com/in/lenel-james-4435ba