



Moving Social Determinants of Health into Action & Health Equity

US Core Data for Interoperability Task Force | July 27, 2021
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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.

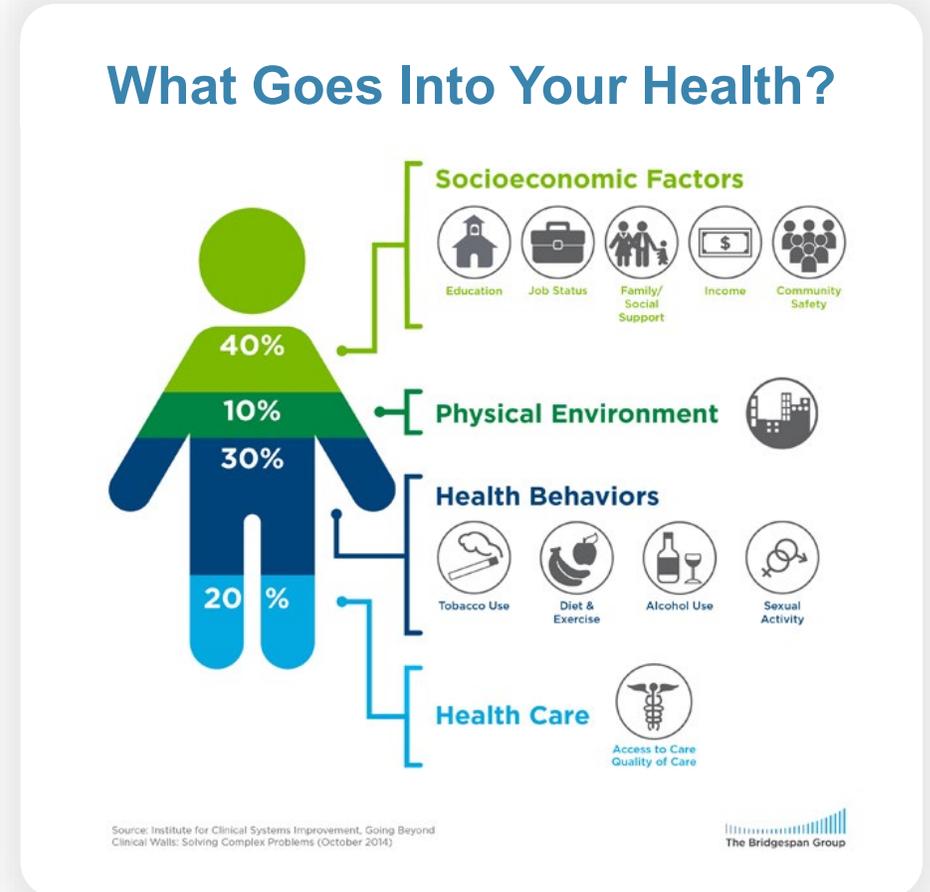


Why Addressing SDOH is Important

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.



¹<https://www.cdc.gov/nchhstp/socialdeterminants/faq.html>

²[https://www.bridgespan.org/insights/library/public-health/the-community-cure-for-health-care-\(1\)](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

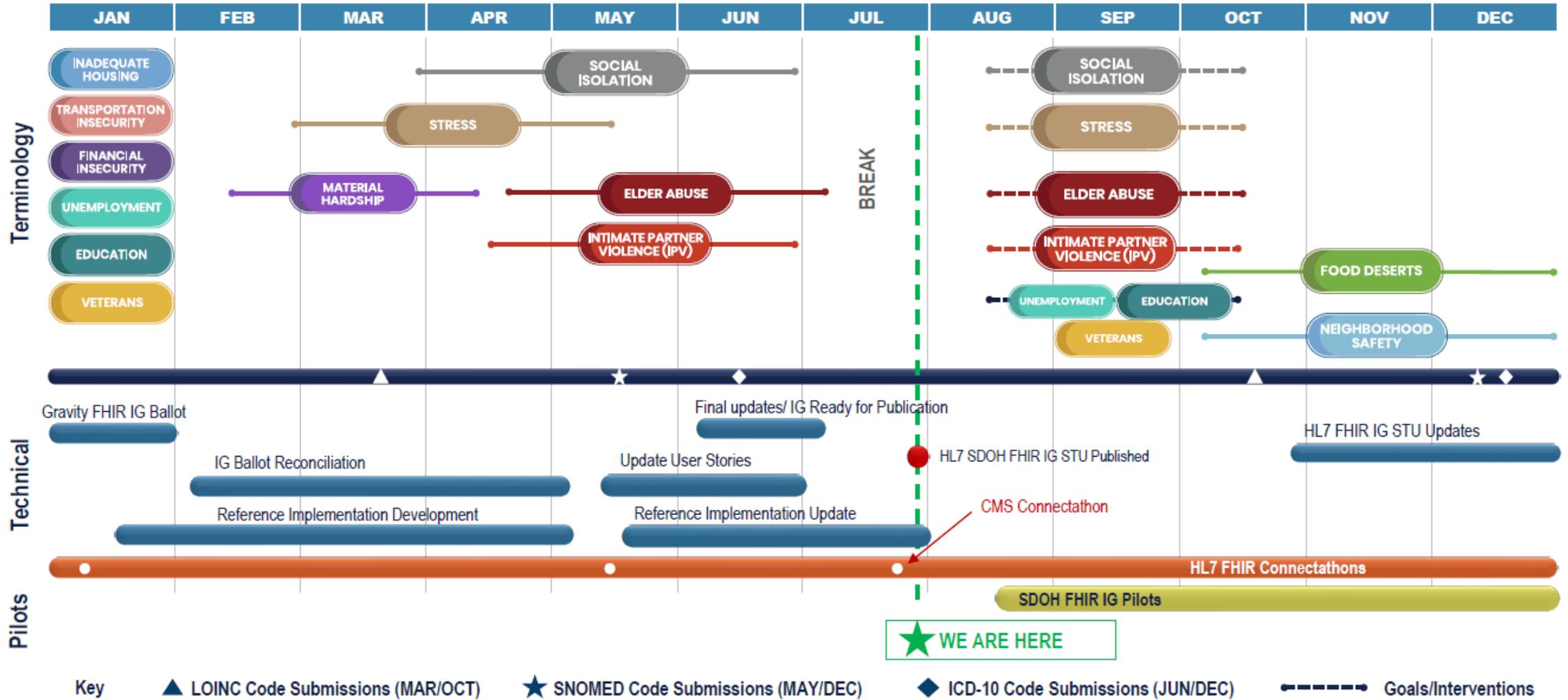
- Combination with other USCDI data elements increases benefit
- NEW Data Element: **Care Team Members**
 - Inclusion of all care team members including family members and community-based providers supports more holistic and person-centered care planning.
- NEW Data Element: **Sexual Orientation and 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

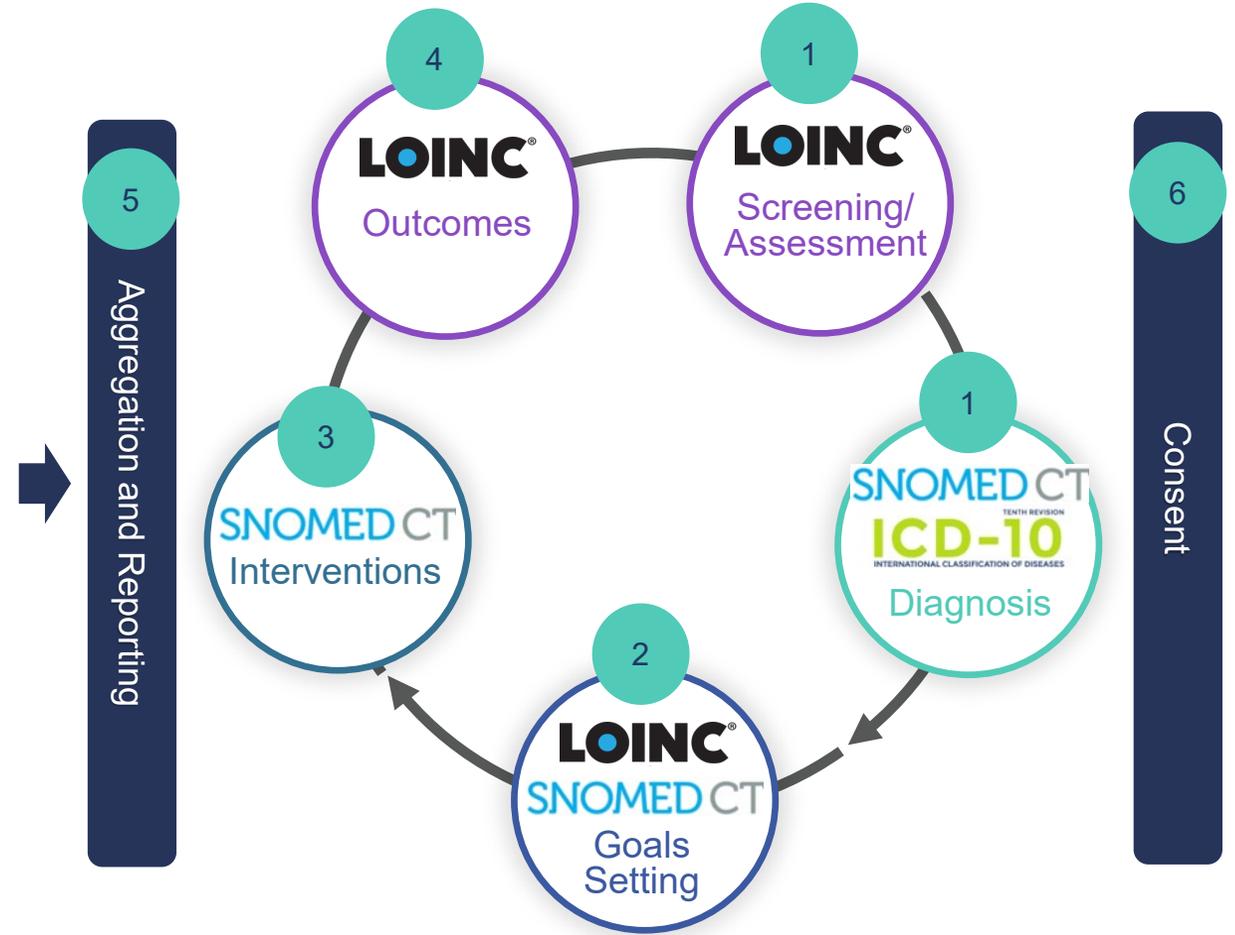


Gravity Overview: 2021 Roadmap



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
<ul style="list-style-type: none"> • SDOH Clinical Care IG • Social Care IG • SDOH Quality Measurement IG • Population Health IG • SDOH Public Health IG • Social Directory IG • SDOH Research IG 	<ul style="list-style-type: none"> • Assessments • Problems/Health concerns • Goals • Interventions • Outcomes • Consent • Data Aggregation • Billing • Health Insurance 	<ul style="list-style-type: none"> • 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) 	<ul style="list-style-type: none"> • LOINC <ul style="list-style-type: none"> ▪ Assessments ▪ Goals ▪ Outcomes (e.g., quality measures) • SNOMED-CT <ul style="list-style-type: none"> ▪ Problems/Health concerns (clinical) ▪ Goals ▪ Interventions (clinical) • ICD-10-CM <ul style="list-style-type: none"> ▪ Problems/Health concerns (billing) • CPT/HCPCS <ul style="list-style-type: none"> ▪ 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>

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