Advancing Interoperability: Social Determinants of Health

Monday, September 21, 2020

10:00am – 3:00pm

Housekeeping: Steps for Joining the Meeting

1. You can join via phone or computer to access audio. **Please keep yourself muted to avoid background noise and turn off your webcam.**

2. Please ensure that you list your full name by hovering over your name on the participant list, clicking "More" and clicking "**Rename**." This is important so we know who you are.

3. If you have questions during the meeting, please send them via the **chat box** on your Zoom dashboard, which will be monitored by the meeting facilitators

The Office of the National Coordinator for
Health Information Technology
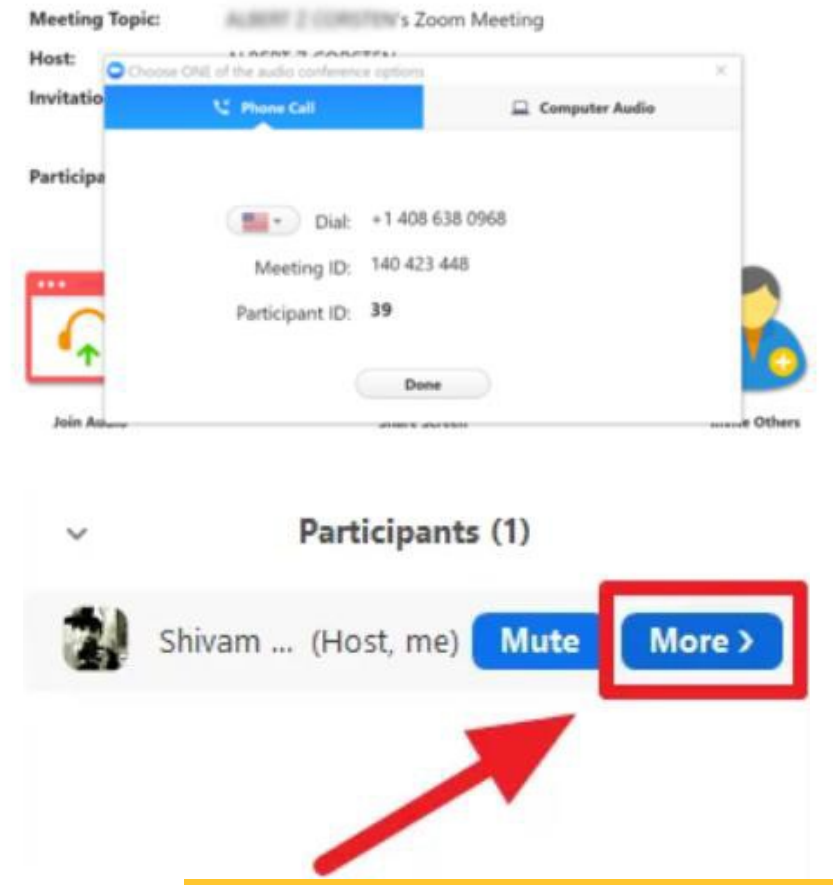
Housekeeping cont.

- How to use active speaker view

  o To view speaker's video as a large Active Speaker panel, click the Active Speaker Panel icon above the video panel.

- How to pin video

  o At the top of your screen, hover over the three dots on the video of the speaker you want to pin and click Pin Video.

The Office of the National Coordinator for
Health Information Technology
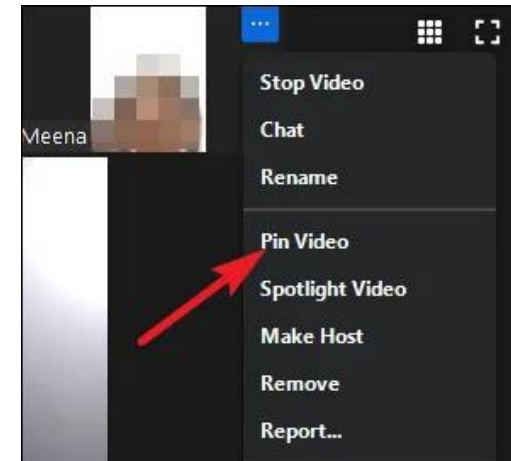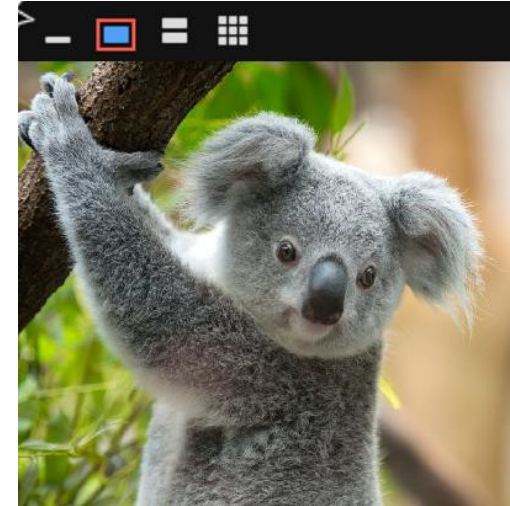
HIT Enabled SDOH Data- ONC Approach and Efforts

Al Taylor, MD

Office of the National Coordinator for Health Information Technology

September 21, 2021

The Role of Social Determinants in Health

Adapted From: Booske, B.C., Athens, J.K., Kindig, D.A., Park, H., & Remington, P.L. (2010). County Health Rankings [www.countyhealthrankings.org

The Office of the National Coordinator for
Health Information Technology

The Role of Social Determinants in Health

- SDOH are significant independent variables of health and health care outcomes

  - Housing insecurity linked to lead poisoning, asthma, other respiratory conditions

  - Food insecurity linked to hypertension, hyperlipidemia, overall poor physical and mental health

  - Unemployment linked to overall poor health, heart disease or stroke

- Assessments of social risk factors, including access to food and housing, employment and others, drive interventions such as connecting to community based organizations who provide direct assistance.

- Meeting and improving social needs has a direct impact on health care outcomes.

- Meeting APM requirements for meeting social needs to improve outcomes.

Why HIT-enabled Social Determinants data?

- Structured clinical data already available in EHRs to inform care and drive medical decision making.

- Social Determinants data may be collected but may not be available in EHRs.

    - Inefficiencies, errors and missed opportunities

- SDOH data generally not structured and/or standardized across EHR platforms (yet?).

- SDOH not shared or shareable using standardized health data exchange such as C-CDA, FHIR resource.

Why HIT-enabled Social Determinants data?

- EHRs are capable of using structured SDOH like every other type of data
  - Documenting quality care
    - Reporting quality to programs requiring use of SDOH data
    - Measuring effectiveness of interventions
  - Acting on it to provide guidance to providers
    - CDS to recommend interventions (flagging abnormal lab results)
  - Population health
    - Including social needs
  - Sharing SDOH data with other providers, payers and patients
    - C-CDA, USCDI, patient portals

Benefits

Benefits of including recommended measures in all EHRs include:
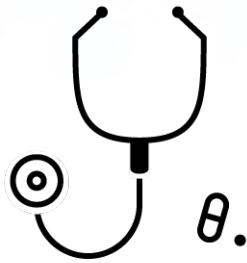
MORE EFFECTIVE TREATMENT

MORE EFFECTIVE POPULATION MANAGEMENT

DISCOVERY OF LINKAGES

American College of Physicians Recommendations

Addressing Social Determinants to Improve Patient Care and Promote Health Equity:

An American College of Physicians Position Paper

- The development of best practices for utilizing electronic health record systems as a tool to improve individual and population health without adding to the administrative burden on physicians.

- Adjusting quality payment models and performance measurement assessments to reflect the increased risk associated with caring for disadvantaged patient populations.

- Increased screening and collection of SDOH data to aid in health impact assessments and support evidence-driven decision making.

The Office of the National Coordinator for
Health Information Technology

ONC Engagement in SDOH Activities

- Standards and Certification Coordination
    - 2015 Certification Criterion on Social, Psychological, and Behavioral Health (§ 170.315(a)(15))
        - Certified Health IT Products List (CHPL)
    - Interoperability Standards Advisory (ISA)
    - Support for Health IT enabled SDOH data development
        - Gravity Project
        - Home and Community-Based Services
        - HL7® Cooperative Agreement for IG development and piloting

https://HealthIT.gov/SDOH

ONC Engagement in SDOH Activities

- Support HHS SDOH Activities
    - HHS SDOH Workgroup
    - HRSA Health Centers Technical Assistance
    - Office of Minority Health-Disability and Race standards
    - Federal Health IT Coordinating Council
    - Federal Health IT Strategic Plan 2020-2025 (Draft)

https://HealthIT.gov/SDOH

ONC Engagement in SDOH Activities

- ONC Sponsored Activities
    - HHS SDOH Workgroup

    - HRSA Health Centers Technical Assistance

    - Office of Minority Health-Disability and Race standards

    - Federal Health IT Coordinating Council

    - Federal Health IT Strategic Plan 2020-2025 (Draft)

https://HealthIT.gov/SDOH

2015 Certification Criterion - Social, Psychological, and Behavioral Health (§ 170.315(a)(15))

- Social
  - Financial resource strain-CARDIA (modified)
    - "the very basics like food, housing, medical care, and heating"
  - Social connection and isolation-NHANES panel
  - Education-highest grade level achieved (NHANES)

- Psychological
  - Depression-PHQ-2/9
  - Alcohol use-AUDIT-C
  - Stress-Occupational Stress Questionnaire™

- Behavioral
  - Exercise/physical activity-Kaiser EVS (modified)
  - Exposure to violence/intimate partner violence-HARK

2015 Certification Criterion - Social, Psychological, and Behavioral Health (§ 170.315(a)(15))

- Voluntary certification

- 93 health IT developers

- 147 unique products (out of 911 total) certified to this criterion

- These developers provide technology to more than half of all office-based clinicians and a third of hospitals

Interoperability Standards Advisory (ISA)

The Office of the National Coordinator for
Health Information Technology

Interoperability Standards Advisory (ISA)

Representing Food Insecurity

Type	Standard / Implementation Specification	Standards Process Maturity	Implementation Maturity	Adoption Level	Federally required	Cost	Test Tool Availability
Standard	LOINC®	Final	Production	Feedback Requested	No	Free	No
Standard	SNOMED CT®	Final	Production	Feedback Requested	No	Free	No
Standard	ICD-10-CM	Final	Production	Feedback Requested	No	Free	No
Standard	CPT-4	Final	Production	Feedback Requested	No	$	N/A
Standard	HCPCS	Final	Production	Feedback Requested	No	Free	N/A

Limitations, Dependencies, and Preconditions for Consideration	Applicable Value Set(s) and Starter Set(s)
- The Hunger Vital Sign [HVS] is a 2-question food insecurity screening tool based on the US Household Food Security Scale developed by Children's Health Watch. Centers for Medicare & Medicaid Services uses the HVS in the Accountable Health Communities screening tool. - SNOMED CT® is used to represent conditions, observations, and non-medical interventions related to Social Determinants of Health. - ICD-10 Z55-Z65 is used to capture diagnoses related to certain Social Determinants of Health. - CPT-4 and HCPCS is used to capture medical and non-medical procedures and interventions related to Social Determinants of Health.	- LOINC® 88121-9 Hunger Vital Sign [HVS] - LOINC® 88122-7 Within the past 12 months we worried whether our food would run out before we got money to buy more [U.S. FSS] - LOINC® 88123-5 Within the past 12 months the food we bought just didn't last and we didn't have money to get more [U.S. FSS] - LOINC® 88124-3 Food insecurity risk [HVS] - LOINC® 93025-5 Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences [PRAPARE] Panel

USCDI v1

Allergies and Intolerances *NEW

- Substance (Medication)
- Substance (Drug Class) *NEW
- Reaction *NEW

Assessment and Plan of Treatment

Care Team Members

For more info:
HealthIT.gov/USCDI

Clinical Notes *NEW

- Consultation Note
- Discharge Summary Note
- History & Physical
- Imaging Narrative
- Laboratory Report Narrative
- Pathology Report Narrative
- Procedure Note
- Progress Note

Goals

Health Concerns

Immunizations

Laboratory

- Tests
- Values/Results

Medications

Patient Demographics

- First Name
- Last Name
- Previous Name
- Middle Name (incl. middle initial)
- Suffix
- Birth Sex
- Date of Birth
- Race
- Ethnicity
- Preferred Language
- Current Address *NEW
- Previous Address *NEW
- Phone Number *NEW
- Phone Number Type *NEW
- Email Address *NEW

Problems

Procedures

Provenance *NEW

- Author Time Stamp
- Author Organization

Smoking Status

Unique Device Identifier(s) for a Patient's Implantable Device(s)

Vital Signs

- Diastolic Blood Pressure
- Systolic Blood Pressure
- Body Height
- Body Weight
- Heart Rate
- Respiratory Rate
- Body Temperature
- Pulse Oximetry
- Inhaled Oxygen Concentration
- BMI Percentile (2-20 years old) *NEW
- Weight-for-length Percentile (Birth - 36 months) *NEW
- Occipital-frontal Head Circumference Percentile (Birth - 36 months) *NEW

USCDI ONDEC (ONC Data Element and Class) Submission System

The Office of the National Coordinator for
Health Information Technology

How It Works

Step 1. Submit new data elements and classes (registered ISA users only - login or create account here)

Provide information on the use cases, applicable standards, existing use and exchange, and potential challenges of data elements. Submission may contain more than one data element.

Please note: submissions must be completed in a single session - ONDEC does not allow for saving progress and returning at a later time.

Step 2. ONC evaluates and assigns a level to each data element depending on the overall value, maturity and challenges to implementation

• Comment • Level 1 • Level 2

Step 3. ONC posts submitted data elements on the USCDI page by level

Submitters will have an opportunity to add or change information which could change its level determination.

Other stakeholders can review these submissions and contribute to their development through comments and collaboration with original submitters.

Step 4. Submissions achieving Level 2 by October of each year will be considered for inclusion in the draft of the next version of USCDI. ONC will present the draft to the Health IT Advisory Committee and the public for comment.

Step 5. ONC finalizes the next version of USCDI in July.

USCDI Version Update Process
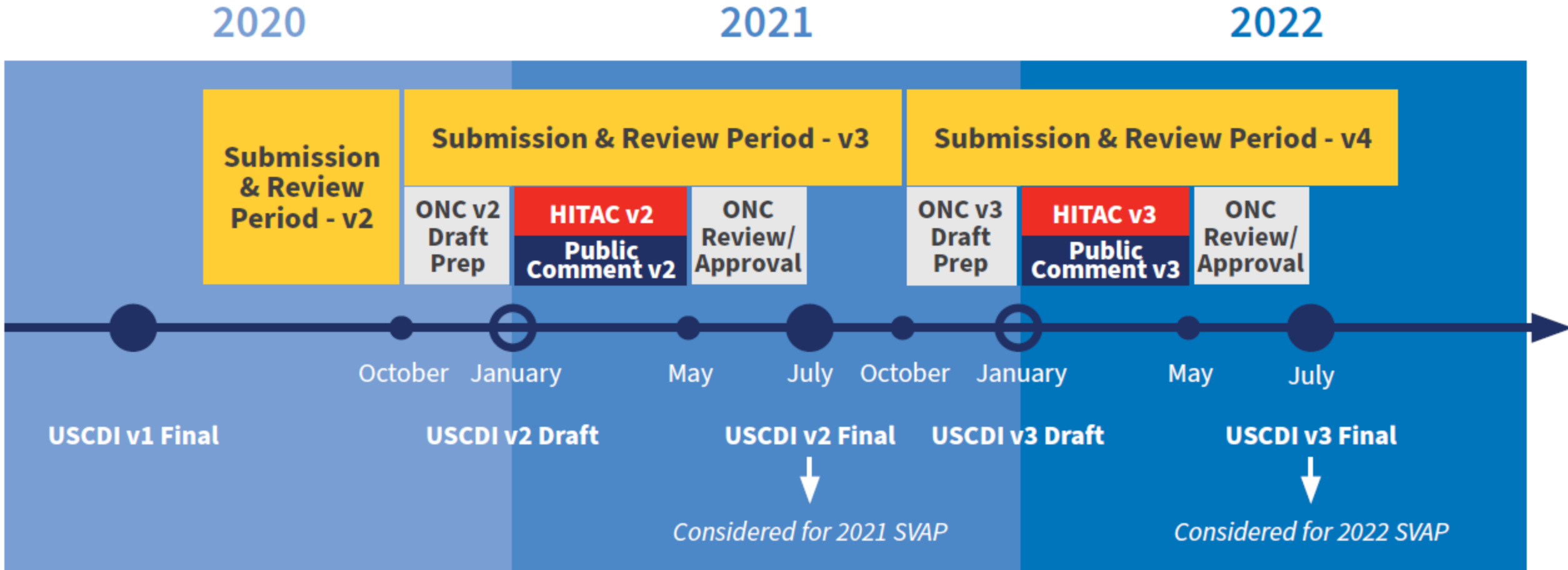
For more information on ONC activities related to SDOH:

https://HealthIT.gov/SDOH

Thank you!

The Gravity Project: Consensus-driven Standards on Social Determinants of Health

ONC SDOH Workshop

Sept. 21, 2020

Presented By: Evelyn Gallego, EMI Advisors LLC,
Gravity Program Manager

Agenda

- Gravity Project Team
- Gravity Project Overview
- Terminology Build Approach
- Terminology Build Deliverables

Gravity Project Team

Gravity Project Management Office (PMO)

- **Caroline Fichtenberg**, Managing Director, UCSF/ SIREN

- **Evelyn Gallego,** Program Manager, EMI Advisors

- **Carrie Lousberg**, Project Manager, EMI Advisors

- **Mark Savage,** SDOH Policy Lead, USCF/SIREN

- **Sarah DeSilvey,** Clinical Informatics Director, University of Vermont

- **Bob Dieterle,** Technical Director, EnableCare

Workstream Teams

Terminology- Director, Sarah DeSilvey

- **Linda Hyde**, Coding Systems Expert, EMI Advisors

Subject Matter Experts

- **Donna G. Pertel**, Food Insecurity Co-Lead, Academy of Nutrition and Dietetics
- **Megan Sandel**, Housing Domain Lead, Children's Health Watch
- **Allison Bovell-Ammon**, Housing Domain Lead, Children's Health Watch
- **Richard Sheward**, Children's Health Watch
- **Alexandra King,** CTAA
- **Jennifer Sisto Gall**, Lyft

Technical- Director, Bob Dieterle

- **Monique Van Berkum**, FHIR Modeling Lead, AMA
- **Corey Smith**, FHIR IG Project Coordination, AMA
- **Becki Gradl,** Food Insecurity Tech Lead, Academy of Nutrition and Dietetics
- And many more!

Gravity Project Sponsorship (Financial & In-Kind)

Robert Wood Johnson Foundation

The University of Vermont
LARNER COLLEGE OF MEDICINE

Yale School of Nursing

AHRQ

CHILDREN'S HealthWatch

siren UCSF

BlueCross BlueShield Association

AMA

eat right. Academy of Nutrition and Dietetics

AAFP

UnitedHealthcare

HIGHMARK

AmeriHealth Caritas

blue california

The Office of the National Coordinator for Health Information Technology

juxly

lyft

California Health Care Foundation

nehii

Arkansas BlueCross BlueShield

Humana

onyx

ctaa
COMMUNITY TRANSPORTATION ASSOCIATION OF AMERICA

HL7 International
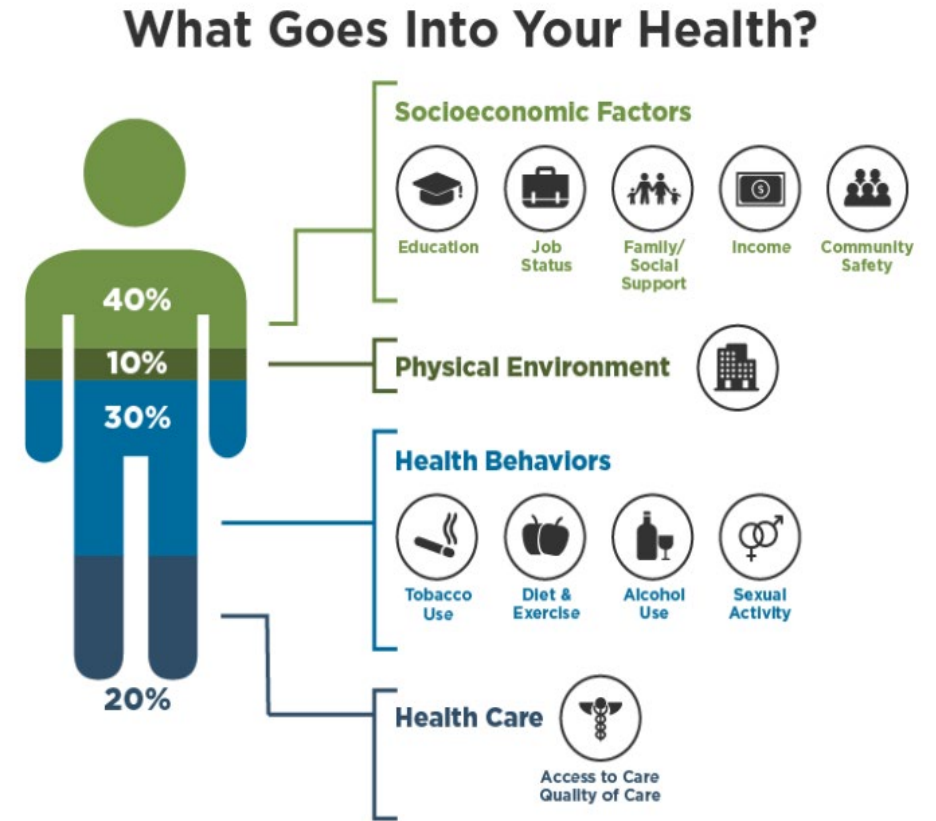
gravity PROJECT®

Overview

Gravity Project Goal

Develop consensus-driven data standards to support use and exchange of social determinants of health (SDOH) data within the health care sectors and between the health care sector and other sectors.

What Goes Into Your Health?

Socioeconomic Factors
Education · Job Status · Family/Social Support · Income · Community Safety

40%

Physical Environment

10%

Health Behaviors
Tobacco Use · Diet & Exercise · Alcohol Use · Sexual Activity

30%

Health Care
Access to Care
Quality of Care

20%

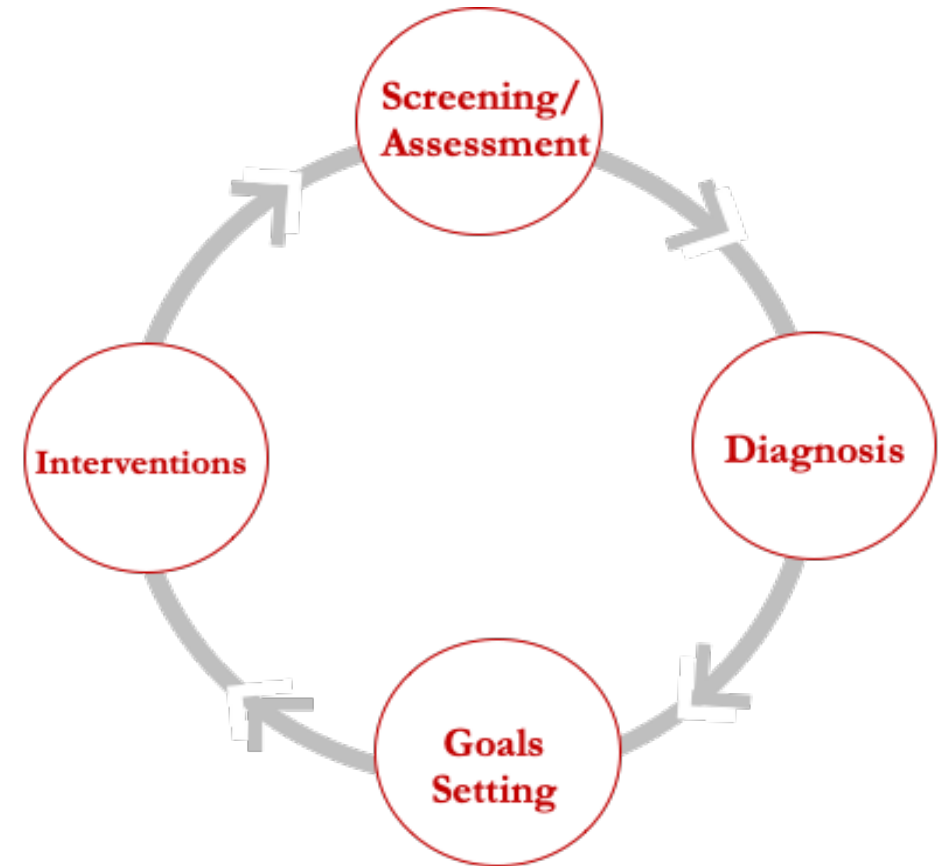Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

Adapted from The Bridgespan Group

Project Scope

Develop data and interoperability standards to represent and exchange patient level SDOH data documented across four clinical activities:

- Screening
- Assessment/diagnosis
- Goal setting
- Treatment/interventions

Data & Interoperability Standards
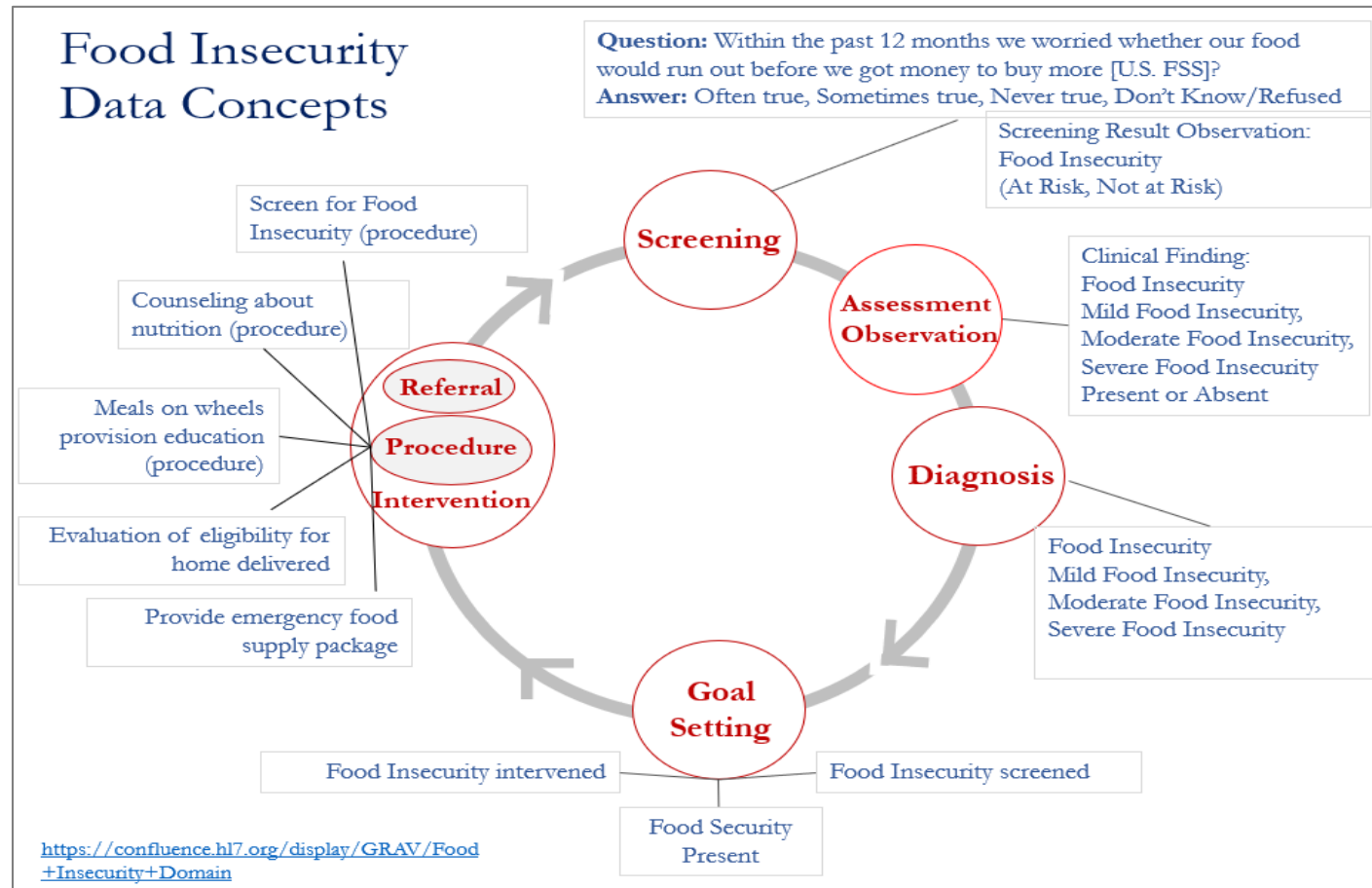
Gravity Overview: Two Streams

New Code Submissions

Coding Gap Analysis & Recommendations

FHIR IG Testing

FHIR IG Development

SDOH Domains
(Terminology)

CODED VALUE SETS

Technical (FHIR)

Community Data Set Identification

Community & FHIR Coordination

Publication in NLM VSAC & ONC ISA

FHIR IG Ballot & Publication

HL7 International

gravity PROJECT®

33
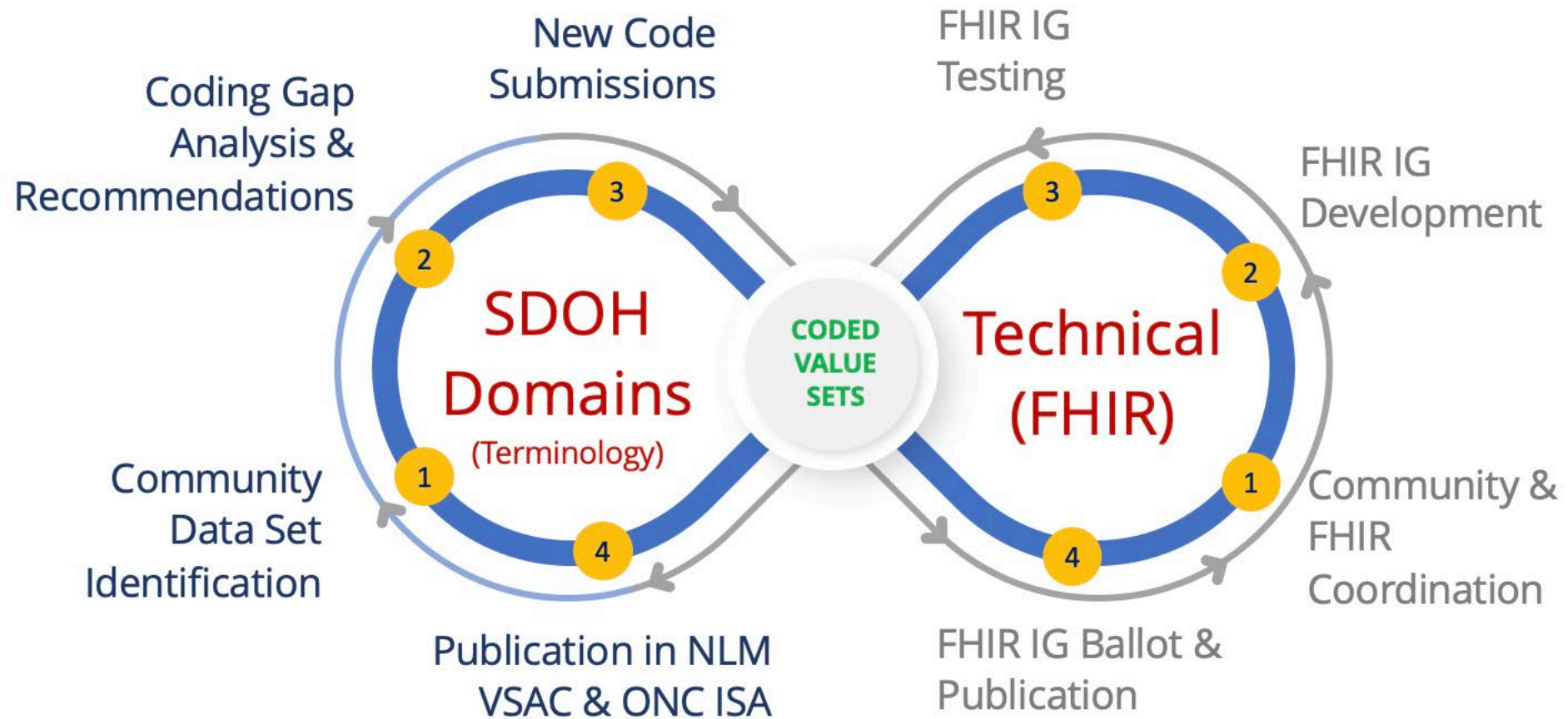
SDOH Terminology Domains

Phase 1 (2019 to 2020)

- *Food Insecurity*
- *Housing Instability and Homelessness*
- Inadequate Housing
- Transportation Insecurity
- Financial Strain
- Demographic Data (education, employment, veteran status)

Phase 2 (2021)

- Social Isolation
- Stress
- Environmental Safety
- Violence

Gravity Roadmap

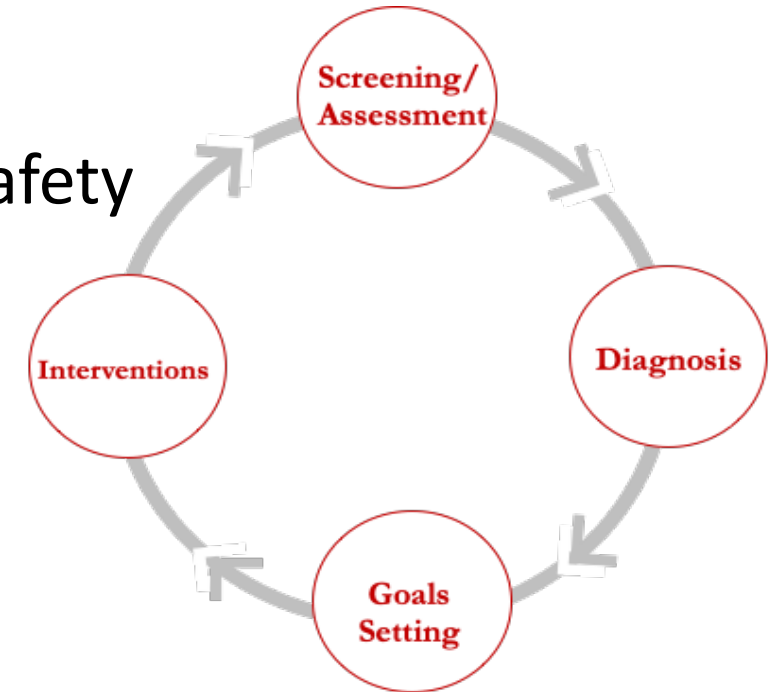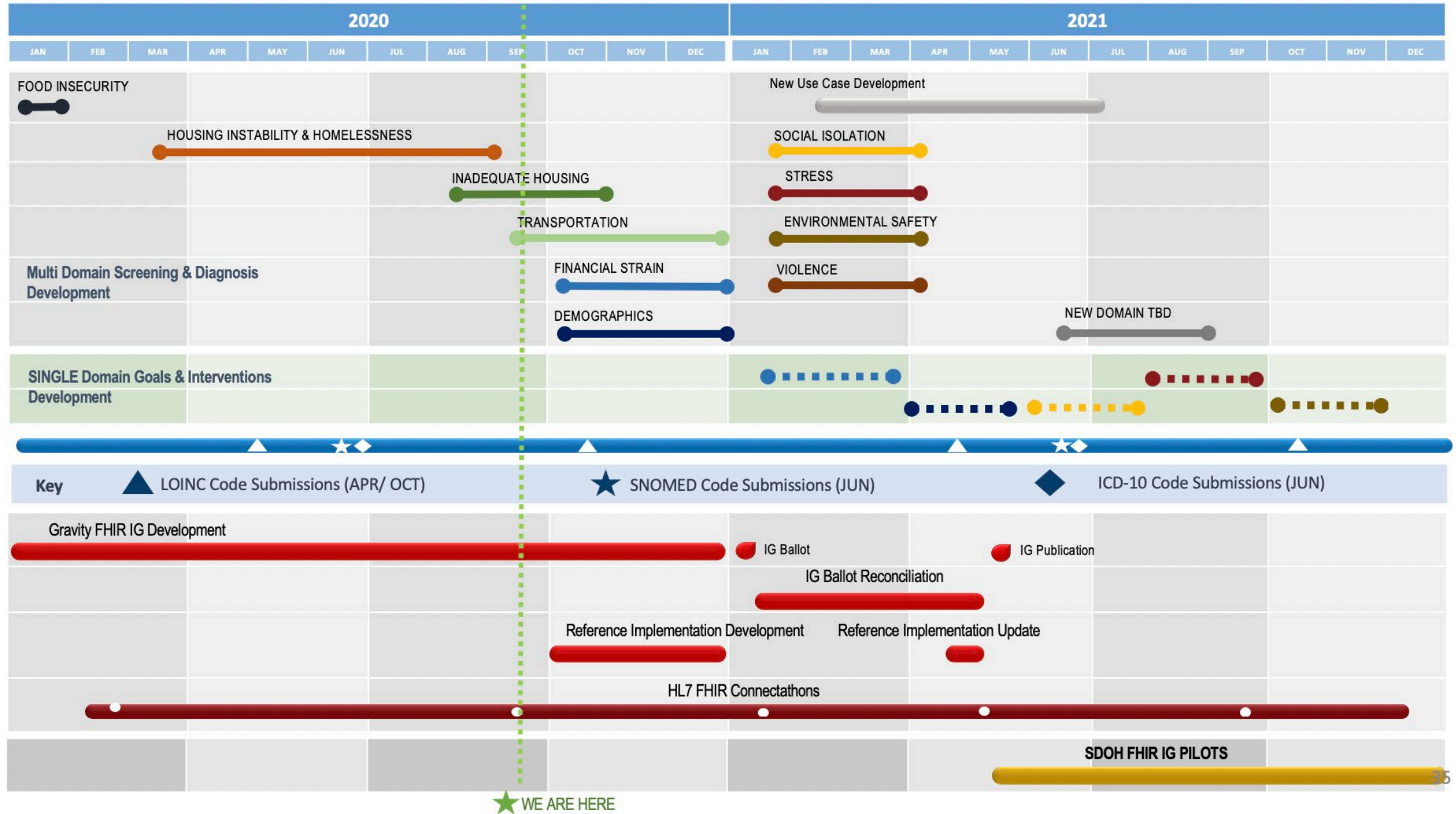		2020												2021											
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC

TERMINOLOGY

- FOOD INSECURITY
- HOUSING INSTABILITY & HOMELESSNESS
- INADEQUATE HOUSING
- TRANSPORTATION
- **Multi Domain Screening & Diagnosis Development**
- FINANCIAL STRAIN
- DEMOGRAPHICS
- New Use Case Development
- SOCIAL ISOLATION
- STRESS
- ENVIRONMENTAL SAFETY
- VIOLENCE
- NEW DOMAIN TBD

SINGLE Domain Goals & Interventions Development

Key
- ▲ LOINC Code Submissions (APR/ OCT)
- ★ SNOMED Code Submissions (JUN)
- ◆ ICD-10 Code Submissions (JUN)

TECHNICAL

- Gravity FHIR IG Development
- IG Ballot
- IG Publication
- IG Ballot Reconciliation
- Reference Implementation Development
- Reference Implementation Update
- HL7 FHIR Connectathons

PILOTS

- **SDOH FHIR IG PILOTS**

★ WE ARE HERE

35

Public Collaboration

Gravity has convened over **1,100+** participants from across the health and human services ecosystem from clinical provider groups, community-based organizations, standards development organizations, federal and state government, payers, and technology vendors.
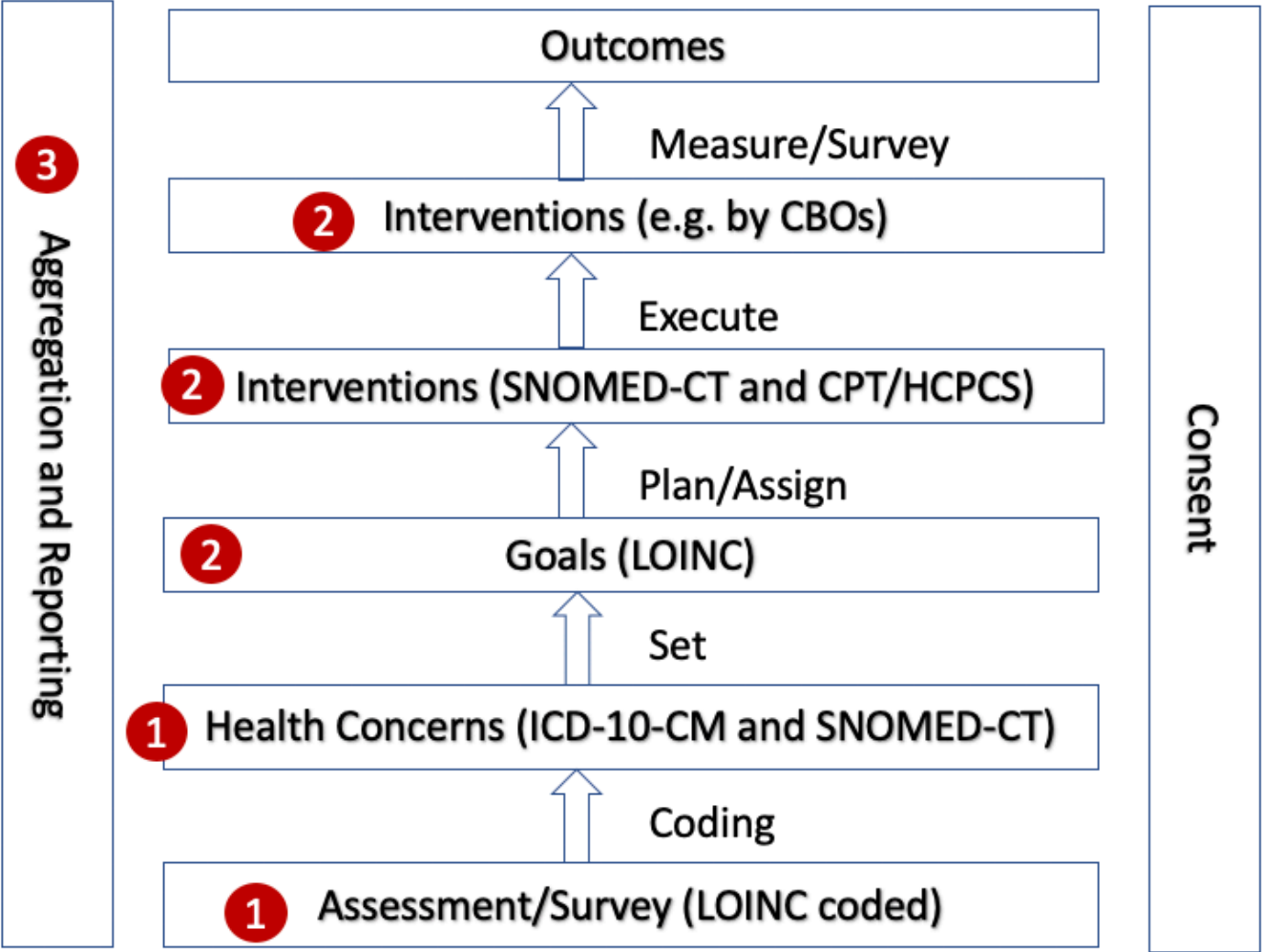
https://confluence.hl7.org/pages/viewpage.action?pageId=46892669#JointheGravityProject-GravityProjectMembershipList

Gravity FHIR SDOH Clinical Care IG "use cases" / concepts

1. Document SDOH data in conjunction with the patient encounter

2. Document and track SDOH related interventions to completion.

3. Gather and aggregate SDOH data or uses beyond the point of care (e.g. population health management, quality reporting, and risk adjustment/ risk stratification).
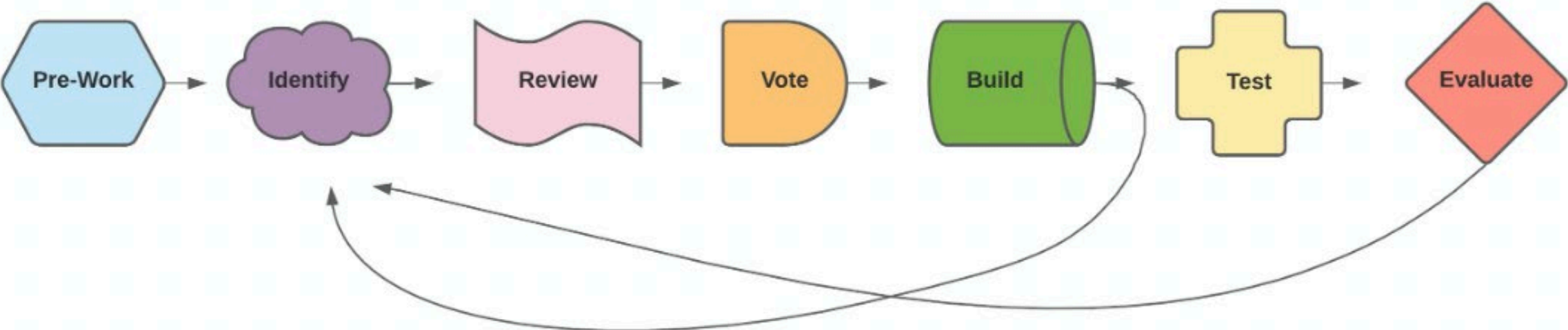
https://confluence.hl7.org/display/GRAV/Gravity+Use+Case+Package

Aggregation and Reporting

3

Outcomes

↑ Measure/Survey

2 Interventions (e.g. by CBOs)

↑ Execute

2 **Interventions (SNOMED-CT and CPT/HCPCS)**

↑ Plan/Assign

2 Goals (LOINC)

↑ Set

1 **Health Concerns (ICD-10-CM and SNOMED-CT)**

↑ Coding

1 Assessment/Survey (LOINC coded)

Consent

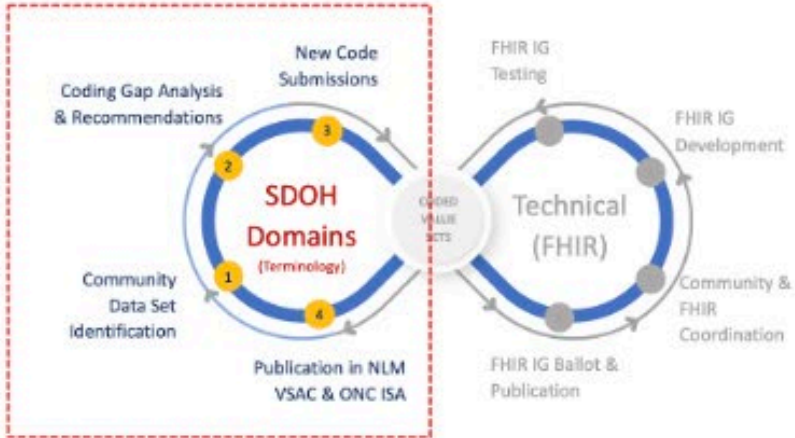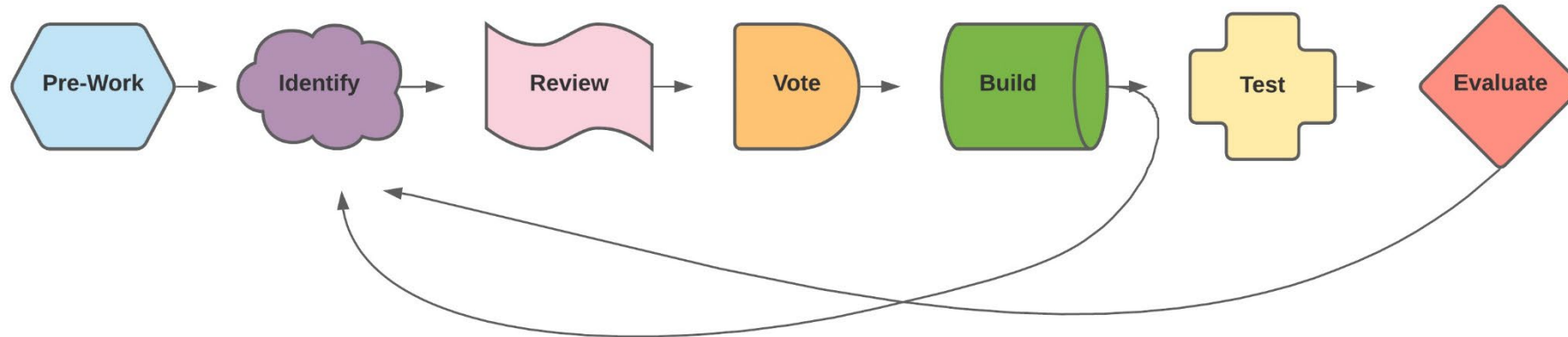http://build.fhir.org/ig/HL7/fhir-sdoh-clinicalcare/

Terminology Build Approach

# Terminology Building Approach

Terminology Building Approach

1. Start with SIREN compendium of existing SDOH terminology-–a study of what exists https://sirenetwork.ucsf.edu/tools-resources/mmi/compendium-medical-terminology-codes-social-risk-factors
2. Glean relevant terms from the compendium and adjudicate against the literature
3. Develop and refine Master List based on Public Collaborative data concept submissions (https://confluence.hl7.org/display/GRAV/Data+Element+Submission)
4. Add, refine, and define concepts until we have a representative set aligned with literature and practice
5. Conduct end-to-end review and vote on final Domain Master List
6. Conduct gap analysis and new code build recommendations
7. Submit new code applications to coding stewards (LOINC, SNOMED CT, and ICD-10)
8. *Test and pilot new codes in the field*
9. *Evaluate and refine codes based on test results*

Perspectives on Data

What **kinds of data** does the provider need to care for their patients?

- the hospital need to study the effects of provider interventions?

- the WIC office or food bank need to address the need of their clients?

- the state need to plan for population health needs?

And what are the principles we need to consider to keep patients at the center?
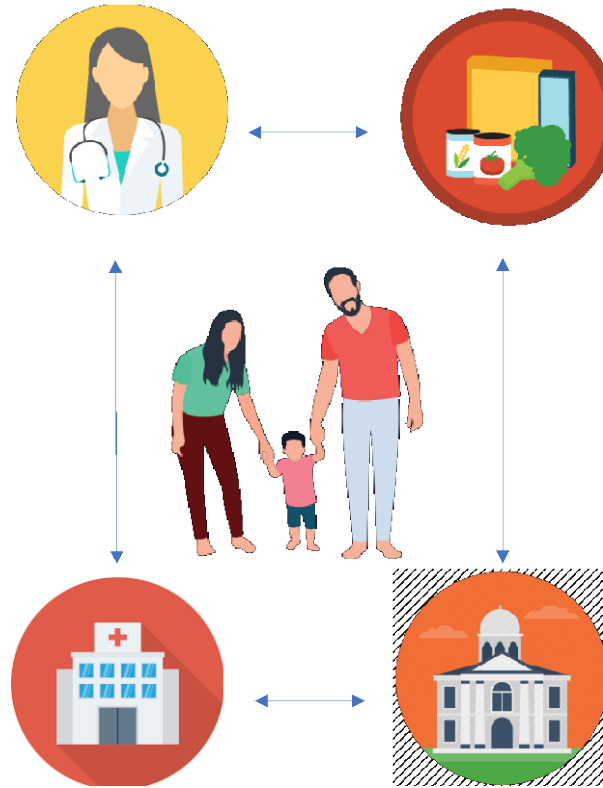
Gravity Project Data Use Principles for Equitable Health and Social Care

- Improving Personal Health Outcomes
- Improving Population Health Equity
- Ensuring Personal Control
- Designing Appropriate Solutions
- Ensuring Accountability
- Preventing, Reducing, and Remediating Harm

https://confluence.hl7.org/display/GRAV/Gravity+Data+Principles

Terminology Build Deliverables

Food Insecurity: Establishing a Consensus Definition

Common definition July 18, 2019 "An economic and social condition of limited or uncertain access to adequate food for an active, healthy life" (United States Department of Agriculture, 2017)

Consensus definition- Uncertain, limited, or unstable access to food that is: adequate in quantity and in nutritional quality; culturally acceptable; safe and acquired in socially acceptable ways

- *Includes the primary domains of food insecurity: quantity, quality, cultural acceptability, safe and being acquired in socially acceptable ways*
- *Includes the modifiers of food insecurity status: uncertainty in the present, limitation, and stability (which allows for fluctuations over time)*
- *Logically inverse and computable*.

https://confluence.hl7.org/display/GRAV/Food+Insecurity+Domain

Diagnoses and Risk: Two Methods

1. When there is a gold standard tool for a domain, diagnoses risk is a continuum along a common spectrum

   - For Example- **Food Insecurity** and The USDA Food Security Module

     - Mild Food Insecurity > Moderate Food Insecurity > Severe Food Insecurity

2. When there is no gold standard tool, risk is represented by subdomains aligned with the literature.

   - For Example- **Housing Insecurity**

     - Housing Instability

     - Homelessness

     - Inadequate Housing

Diagnoses: Housing Instability and Homelessness

Concepts	ICD-10-CM (Proposed)
Housing Insecurity	
- **Homelessness**	Z59.0
- **Homelessness, sheltered** - Homelessness, sheltered, doubled up	Z59.01
- **Homelessness, unsheltered**	Z59.02

- **Housing instability, housed**
  - Housing instability, housed, behind on rent or mortgage
  - Housing instability, housed, history of multiple moves
  - Housing instability, housed, severe housing cost burden
  - Housing instability, housed, at risk of eviction
	Z59.81

- **Housing instability, housed, with imminent risk of homelessness**	Z59.811
- **Housing instability, housed, homelessness in past 12 months**	Z59.812

https://confluence.hl7.org/display/GRAV/Housing+Instability+and+Homelessness+Domain

gravity PROJECT®

Goals: Housing Instability and Homelessness

HOUSING SECURITY

ACCESS HOUSING RESOURCES

SAFE SLEEPING

ACCESS PERMANENT HOUSING

ACCESS SHELTER

STAY AS I AM

https://confluence.hl7.org/display/GRAV/Housing+Instability+and+Homelessness+Domain

Interventions Framework

Gravity Term	Definitions
Assistance/ Assisting	**To give support or aid to; help**
Coordination	**Process of organizing activities and sharing information to improve effectiveness**
Counseling	**Psychosocial procedure that involves listening, reflecting, etc. to facilitate recognition of course of action / solution.**
Education	**Procedure that is synonymous with those activities such as teaching, demonstration, instruction, explanation, and advice that aim to increase knowledge and skills.**
Evaluation of eligibility (for <x>) Subtype of Evaluation	**Process of determining eligibility by evaluating evidence**
Evaluation/ Assessment	**Determination of a value, conclusion, or inference by evaluating evidence.**
Provision	**To supply/make available for use**
Referral	**The act of clinicians/providers sending or directing a patient to professionals and/or programs for services (e.g., evaluation, treatment, aid, information, etc.)**

Interventions: Food Insecurity

Program	Definition
Food pantry program	A community based supportive food and nutrition program offering food to individuals for consumption. https://www.feedingamerica.org/our-work/food-bank-network, https://www.fns.usda.gov/fdpir/food-distribution-program-indian-reservations
Food prescription program	Prescription from a health care provider to access foods recommended, which also includes vegetables, fruits, and prescriptions for other foods.
Home delivered meal program	Meals delivered to a client's place of residence supported or subsidized by a charitable, social, or government agency.
Medically tailored meal program	Meals delivered to individuals, living with assessed illness, tailored to the medical needs of the recipient by a Registered Dietitian Nutritionist (RDN) http://www.fimcoalition.org/our-model
School meal and snack program	Meals and snacks that meet specific nutrition standards and are available to school-aged children throughout the year. (https://www.fns.usda.gov/school-meals/faqs)
Senior congregate meal program	Meals offered in community settings for eligible older adults, and along with eligible supportive individuals.
Senior farmers market program	Financial incentives or matching programs to promote consumption of produce by older adults. https://www.fns.usda.gov/sfmnp/senior-farmers-market-nutrition-program
Special supplemental nutrition program for women, infants, and children (WIC) program	Supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk. (https://www.fns.usda.gov/wic)
Summer meal and snack program	A program that reimburses program operators who serve free healthy meals and snacks to children and teens in low-income areas. (https://www.fns.usda.gov/sfsp/summer-food-service-program)
Supplemental nutrition assistance program (SNAP)	A government based nutrition benefit program to supplement the food budget of qualified families for purchasing food. The US program is currently call the Supplemental Nutrition Assistance Program (SNAP).(https://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program)
WIC farmer's market program	Coupons for participants of the WIC program to purchase food at farmers markets. https://www.fns.usda.gov/fmnp/wic-farmers-market-nutrition-program

https://confluence.hl7.org/display/GRAV/Food+Insecurity+Domain

Food Insecurity: Building Concepts Into Code

- **Food Insecurity Screening Tools-** LOINC V2.68 released 6/17/20
  - The three USDA Screeners submitted by Gravity are included in this release (U.S. Household Food Security (18), U.S. Adult Food Security (10), U.S. Household Short Form (6)
  - Additional screeners from the Food Insecurity Master List are being prepared to submit for consideration in the December LOINC release.

- **Diagnoses/Problems and Interventions-** SNOMED CT
  - Submitted concepts are currently being reviewed by SNOMED

- **Diagnoses-** ICD-10
  - Food insecurity diagnoses from the master list have been submitted for review

https://confluence.hl7.org/pages/viewpage.action?pageId=55938680#FoodInsecurityDomain-CodingSubmissions

Questions?

Evelyn Gallego evelyn.gallego@emiadvisors.net

Twitter: @egallego

LinkedIn: linkedin.com/in/egallego/

Additional questions? Contact: gravityproject@emiadvisors.net

@thegravityproj

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

Assessing and Addressing the Social Determinants of Health Using

PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

Michelle Proser
Director of Research

Julia Skapik
Medical Director Informatics

National Association of Community Health Centers

ONC Advancing Interoperability: SDOH Workshop
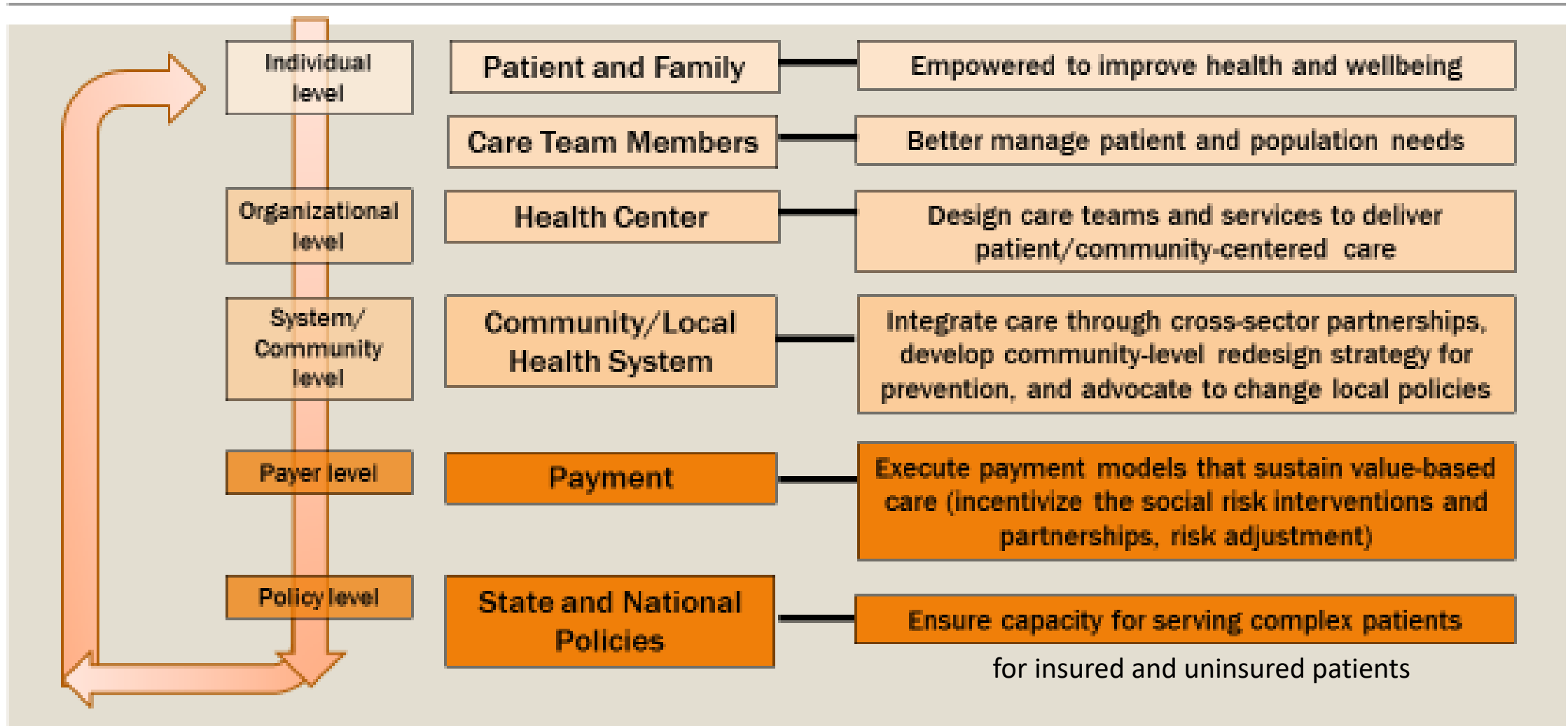September 21, 2021

What Is PRAPARE?

A national **standardized** patient risk assessment **protocol built into the EHR** designed to **engage patients** in assessing and addressing social determinants of health

Customizable Implementation and Action Approach

Assess Needs → Respond to Needs

At the Patient and Population Level

From Patient to Policy Level

Individual level	Patient and Family	Empowered to improve health and wellbeing
	Care Team Members	Better manage patient and population needs
Organizational level	Health Center	Design care teams and services to deliver patient/community-centered care
System/ Community level	Community/Local Health System	Integrate care through cross-sector partnerships, develop community-level redesign strategy for prevention, and advocate to change local policies
Payer level	Payment	Execute payment models that sustain value-based care (incentivize the social risk interventions and partnerships, risk adjustment)
Policy level	State and National Policies	Ensure capacity for serving complex patients

for insured and uninsured patients

PRAPARE

WHAT MAKES PRAPARE UNIQUE?

- **STANDARDIZED and ALIGNED with national efforts**

- **EVIDENCE-BASED and STAKEHOLDER-DRIVEN**

- **FREE EHR Templates** NextGen, eCW, GE Centricity, Greenway Intergy, Epic, Cerner, Meditab (others in progress)

- **FREE PRAPARE Implementation and Action Toolkit**
  - Accompanying resources, BPs, & lessons learned to guide users on PRAPARE implementation

- **WORKFLOW AGNOSTIC**
  - Can fit within existing workflows and be combined with other tools/data

- **PATIENT-CENTERED and ACTIONABLE**
  - Meant to facilitate conversations and build relationships with patients
  - Standardize the need rather than the question
  - Actionable at patient and population level

PRAPARE

PRAPARE DOMAINS

Core	
UDS SDH Domains	**Non-UDS SDH Domains (MU-3)**
1. Race	10. Education
2. Ethnicity	11. Employment
3. Veteran Status	12. Material Security
4. Farmworker Status	13. Social Isolation
5. English Proficiency	14. Stress
6. Income	15. Transportation
7. Insurance	
8. Neighborhood	
9. Housing Status and Stability	

Optional	
1. Incarceration History	3. Domestic Violence
2. Safety	4. Refugee Status

PRAPARE

USER EXPERIENCES

- Easy to administer
- Possible to implement using various workflows and staffing models
- Builds patient-provider relationship
- Identifies new needs
- Leads to positive changes at the patient, health center, and community/population levels
- Facilitates collaboration with community partners
- Importance of targeted messaging and staff support
- Demonstrates patients are complex

PRAPARE

HOW PRAPARE DATA ARE BEING USED: EXAMPLES

- **Patient-level improvements:**
  - Matching Rx and Tx plans to patient circumstances
  - In-house and community assistance programs
- **Organizational and Community level actions**
  - Expand enabling services
  - Mobile outreach
  - Prioritize and develop community partnerships
  - Referral resource guides and referral networks
  - Risk segmentation and stratification
- **System level**
  - Payer and delivery system partner engagement
  - Alternative payment methodologies

PRAPARE

Enabling, Spreading, and Innovating PRAPARE

- Research and evaluation: impacts of multiple SDH

- Risk stratification

- Enhance population health analytics and reporting

- Coding and documenting interventions

- Support data-driven collaborations with social services and CBOs

PRAPARE

HIGH RISK VS. GENERAL POPULATIONS: PERCENT OF PATIENTS WITH NUMBER OF SOCIAL DETERMIANT RISKS

General Population
Mean SDH Risks/Patient= 5.74

Both Groups Mean SDH Risks/Patient= 7.36

High Risk Population
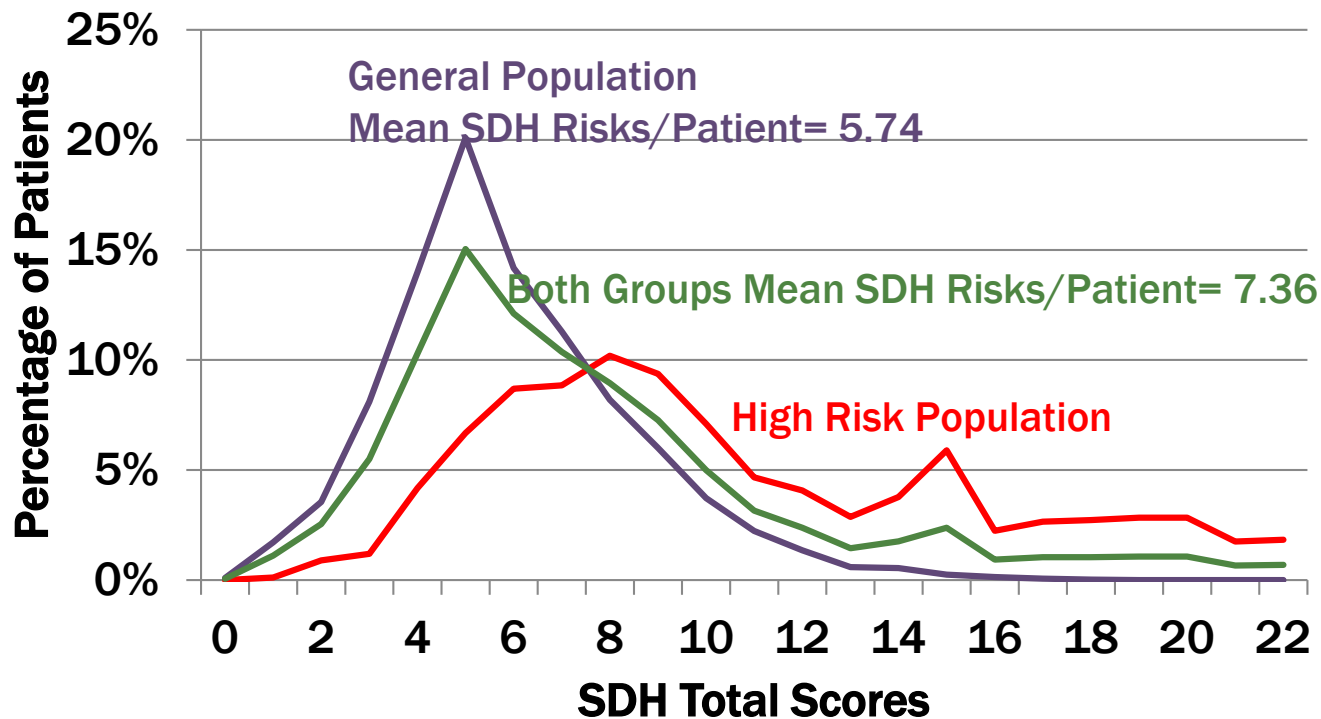
— High Risk Total (N= 2,679)
— General Pop Total (N = 4,432)
— Overall Total (N = 7,111)

Publication pending. Do not quote or distribute without permission from NACHC.

Abstract: **Background.** The Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE) is a nationally recognized standardized protocol that goes beyond medical acuity to account for patients' social determinants of health (SDH). *Aims.* We described the magnitude of patient SDH barriers at health centers. **Methods.** Health centers across three PRAPARE implementation cohorts collected and submitted PRAPARE data using a standardized data reporting template. We analyzed the scope and intensity of SDH barriers across the cohorts. **Results.** Nationally, patients faced an average of 7.2 out of 22 social risks. The most common SDH risks among all three cohorts were limited English proficiency, less than high school education, lack of insurance, experiencing high to medium-high stress, and unemployment. **Conclusions.** Findings demonstrated a high prevalence of SDH risks among health center patients that can be critical for informing social interventions and upstream transformation to improve health equity for underserved populations.

ACKNOWLEDGMENING OUR FUNDERS

NACHC-Vendor PRAPARE Tiger Teams

- Working with EHR vendors to establish improved workflow for SDOH data entry

- Goal to bring together documentation and communication with actionable response to essential and social needs

- Working directly with customers to identify opportunities for improvement, additional local requirements and user interface requirements

NACHC SDOH Management: e-Care Plan
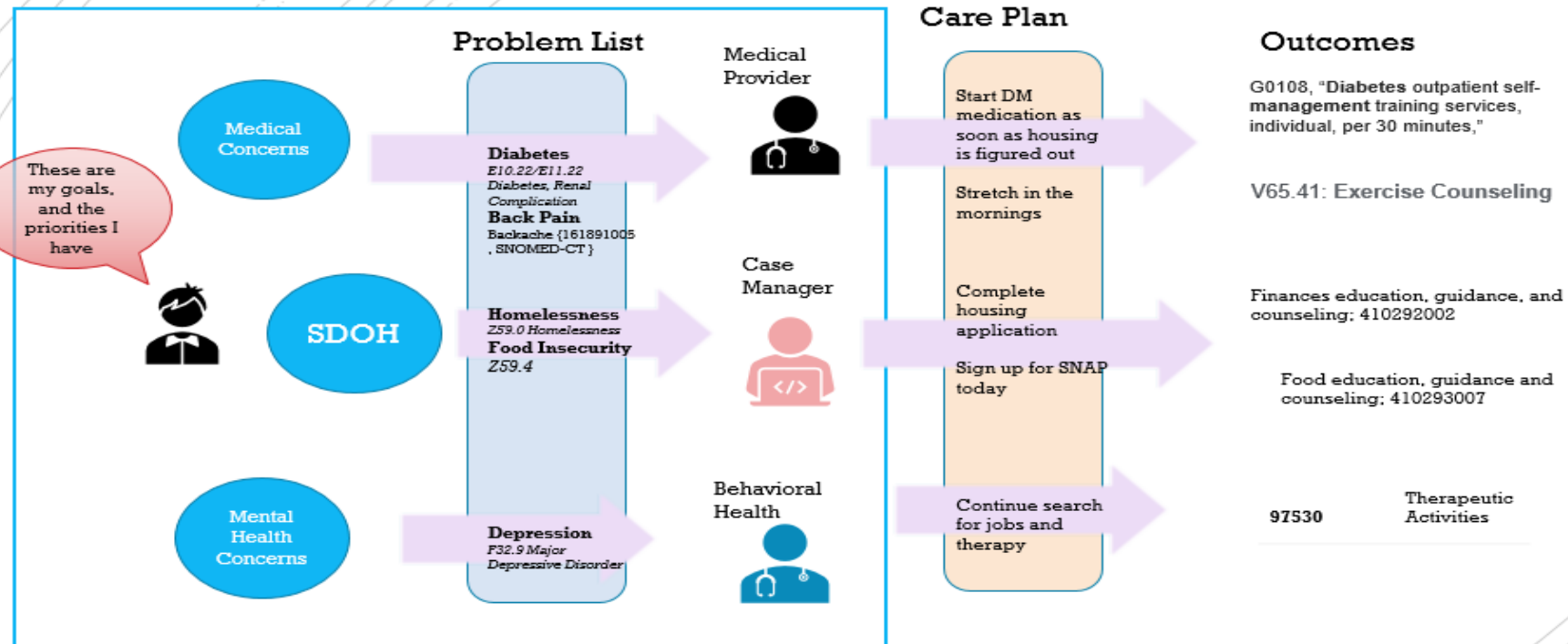
Advancing SDOH Interoperability in FQHCs

- Engaging FQHCs and their interoperability partners (Health Center Controlled Networks (HCCNs) and Primary Care Associations (PCAs)) in promoting PRAPARE and other SDOH to USCDI

- Working to standardize terminologies and maps to essential services and other social interventions

- Testing both components in a risk calculation framework

- Establishing best practices for SDOH capture, data quality and management

NATIONAL ASSOCIATION OF Community Health Centers®

Takeaways

- NACHC has established the PRAPARE tool in all 50 states at FQHCs and other sites

- PRAPARE is practical– designed for routine use in clinical care– not intended to be comprehensive for all SDOH

- PRAPARE 2.0 is in development

- NACHC is a ground level member of Gravity and the two projects are designed to be complementary

- NACHC continues to innovate on standardizing workflow, payment and coding around essential and social services

FOR MORE INFORMATION

PRAPARE website: www.nachc.org/prapare

- Sign up for PRAPARE listserv and newsletter
- Access the PRAPARE Implementation and Action Toolkit
- Available in 26 languages!

NACHC CONTACTS
Michelle Proser, Director of Research mproser@nachc.org **Julia Skapik, Medical Director Informatics** jskapik@nachc.org

- The authors declare no conflict of interest
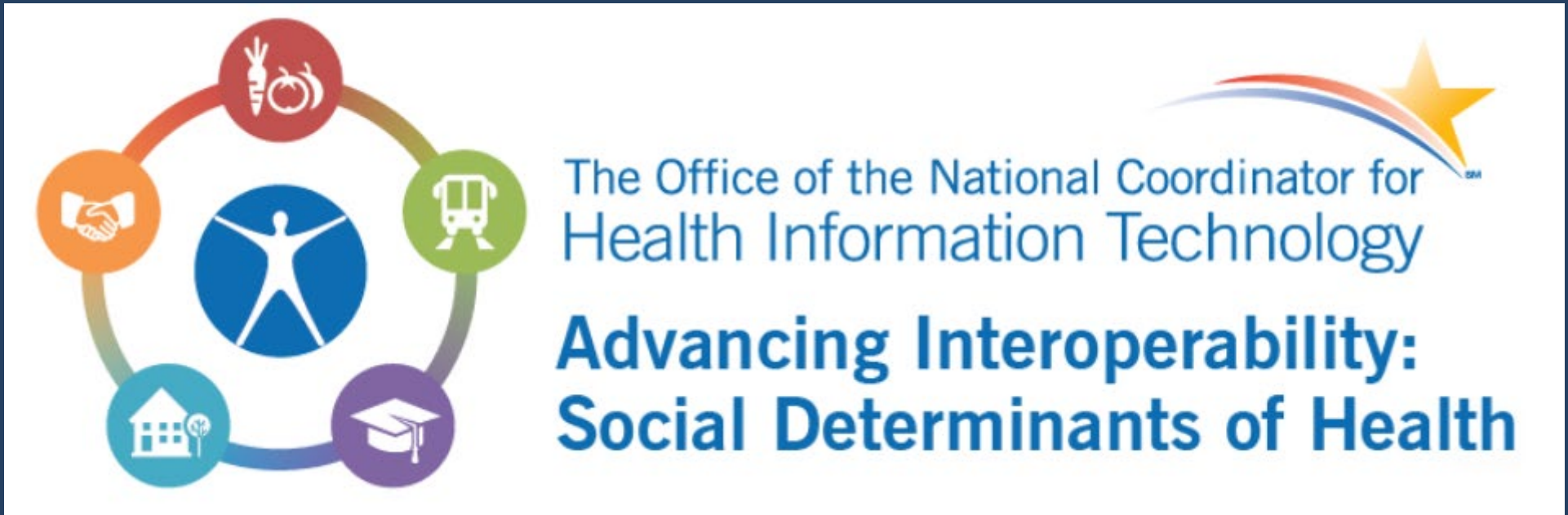
The Office of the National Coordinator for Health Information Technology

Advancing Interoperability: Social Determinants of Health

Acknowledgments

Learner Objectives

- In the context of SDOH, Community Resilience, and the COVID-19 Pandemic:
  - Describe the use of the Omaha System as ontology and clinical terminology within SNOMED CT and LOINC
  - Describe the use of Simplified Omaha System Terms in MyStrengths+MyHealth
  - Describe use of clinical- and consumer-generated Omaha System data for knowledge discovery

The SDOH Problem in COVID-19 Times: Data

- Now, more than ever, vast volumes of {Whole-person} data need to examined quickly to identify trends and point to action steps.

Simple.
Recognized.
Interprofessional.
Taxonomic.
Public Domain.
Interoperable.
Psychometrically
sound.

Used in EHRs.
Used in Guidelines.
Used in Research.

Whole-person heatlh.
SDOH/SDBH.
Resilience.

Data Collaborative.
Community of Practice.

Omahasystem.org

The Omaha System (Martin, 2005)

Problem Classification Scheme

Intervention Scheme

Problem Rating Scale for Outcomes

has 4 Domains

has 4 levels

measures

has 3 rating scales

Environmental

Client Specific Information

identifies

describes

1=lowest, 5=highest

Psychosocial

Target

assessments and outcomes

Physiological

services

Health Related Behaviors

Category

Knowledge   Behavior   Status

has 4

has 12

has 18

has 8

that address each

related to each of the

Definitions

have unique

Signs and Symptoms

Problems

used for documenting

standardized terms

which are

codes

Official SNOMED CT & LOINC Mappings to Operational Omaha System Definitions

- Social and behavioral determinants of health as defined by IOM (2014a and 2014b) = 19 SNOMED CT codes

- Environmental, Psychosocial, and Health-related Behaviors signs/symptoms as defined and operationalized by Omaha System signs/symptoms (Martin, 2005) = 283 SNOMED CT Codes

- Resilience as defined by assets/strengths and operationalized by status ratings of 4 (minimal s/sx) or 5 (no s/sx) by problem = 84 LOINC Codes

- Whole person health as health across all Omaha System Domains includes SDOH and Resilience = 508 SNOMED CT / 84 LOINC Codes

Simplified Omaha System Terms: Achieving Community-Clinical Interoperability

- Linguistic validity attained through consensus with community participation

- Omaha System readability = 16th grade

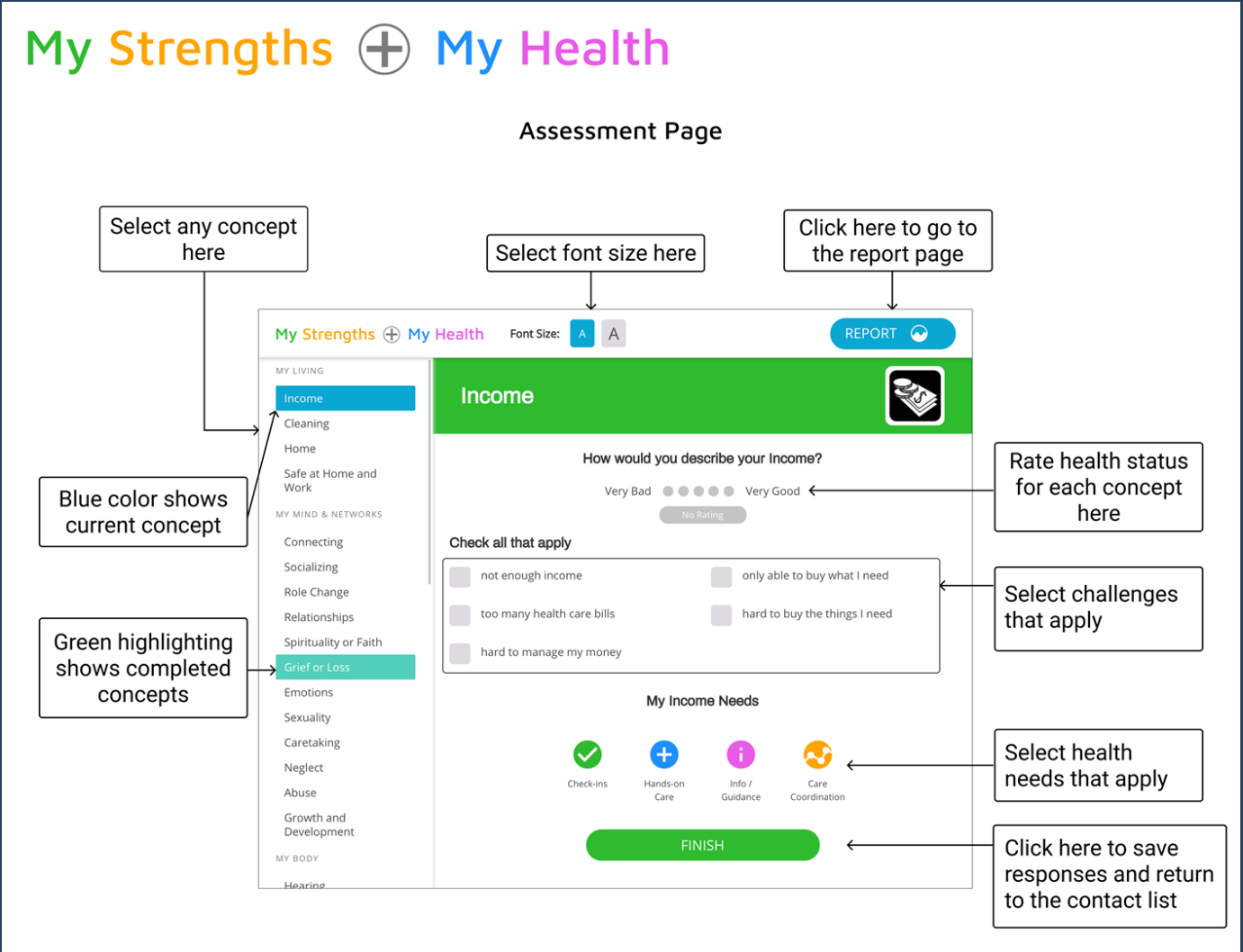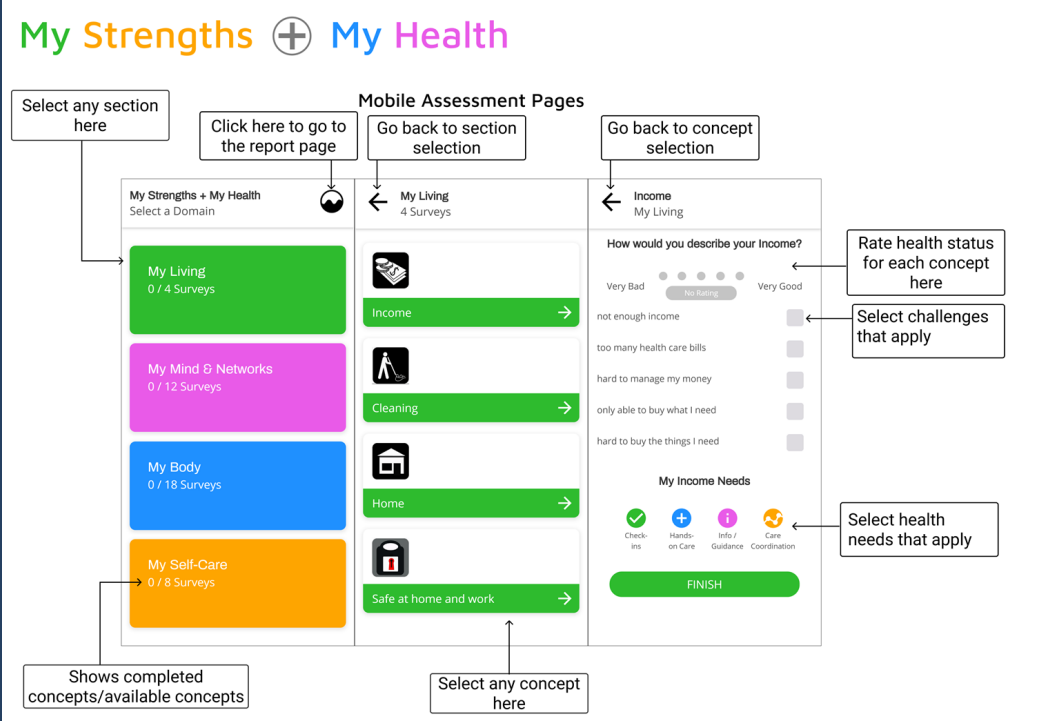- Simplified Omaha System terms readability = 5th grade
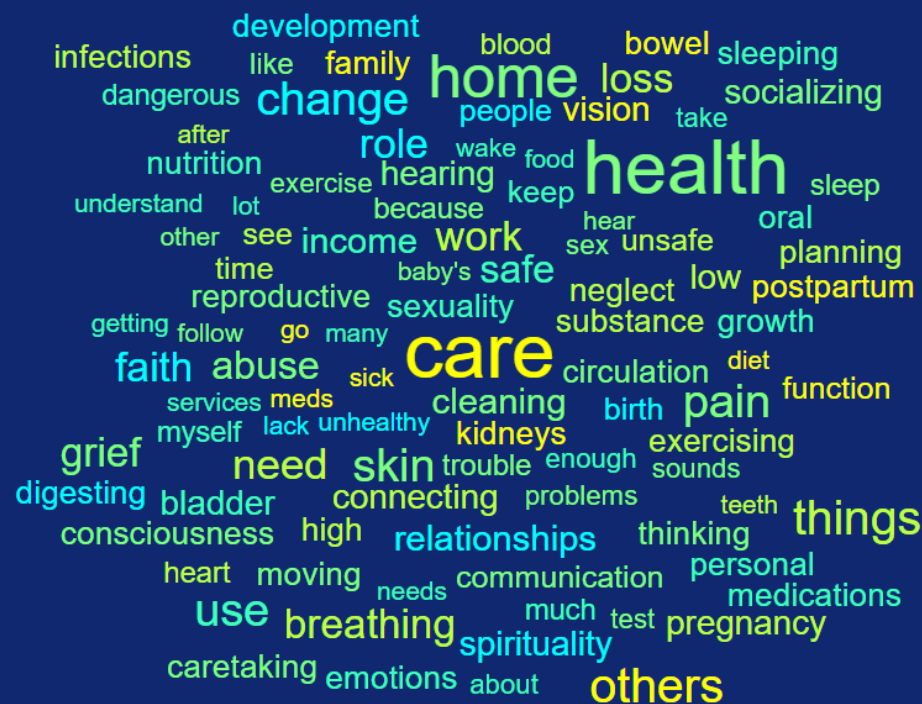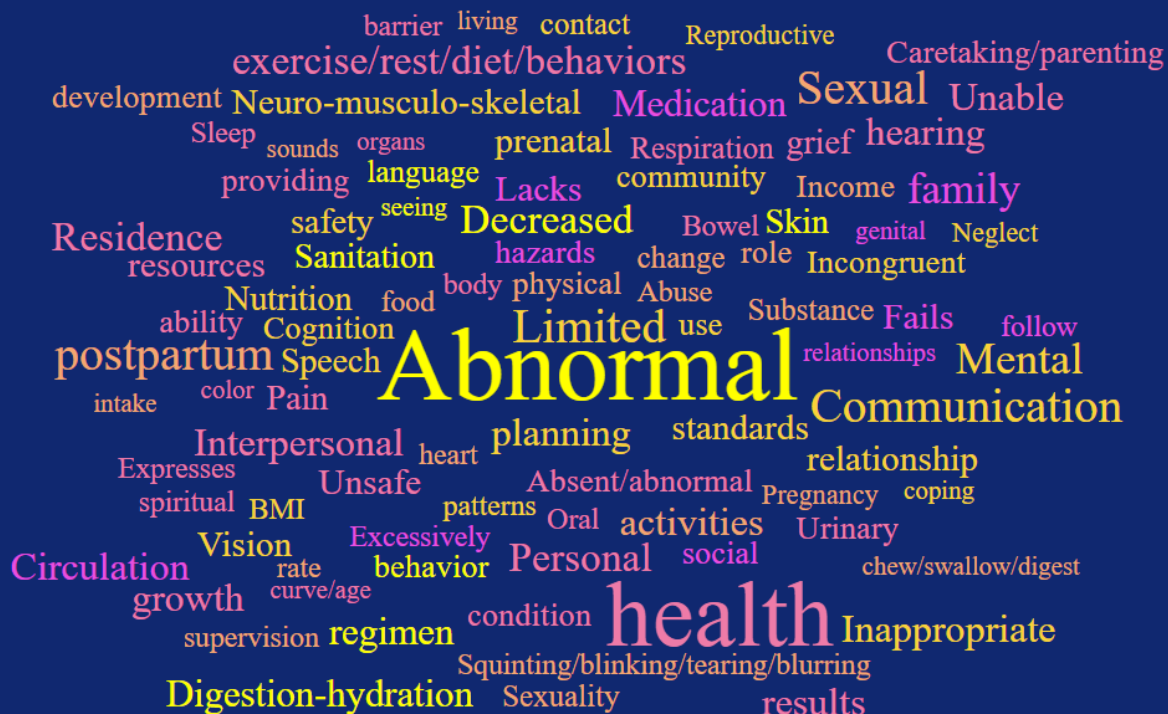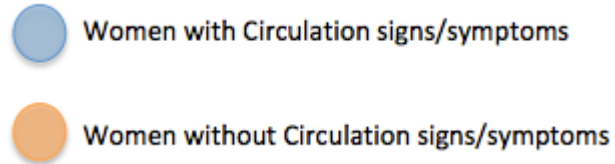
MyStrengths+MyHealth

- Free for clinicians, educators, and researchers
- Consumer-friendly
- Comprehensive, holistic
- Whole-person perspective
- Data downloads
- Dashboard
- Available in English
  - Translations in Spanish
  - And Mandarin available soon

Mobile and Tablet/PC views

75

Picture Whole-Person Health of Individuals and Populations

- Strengths

Women with Circulation signs/symptoms had more strengths, challenges, and needs than Women without Circulation signs/symptoms

The trajectories across domains differed for the two groups

Similarities and differences are easy to view and discriminate in a bubble chart

Bubble size: amount of
X axis: percentage of
Y axis: Domains

- Challenges

- Needs
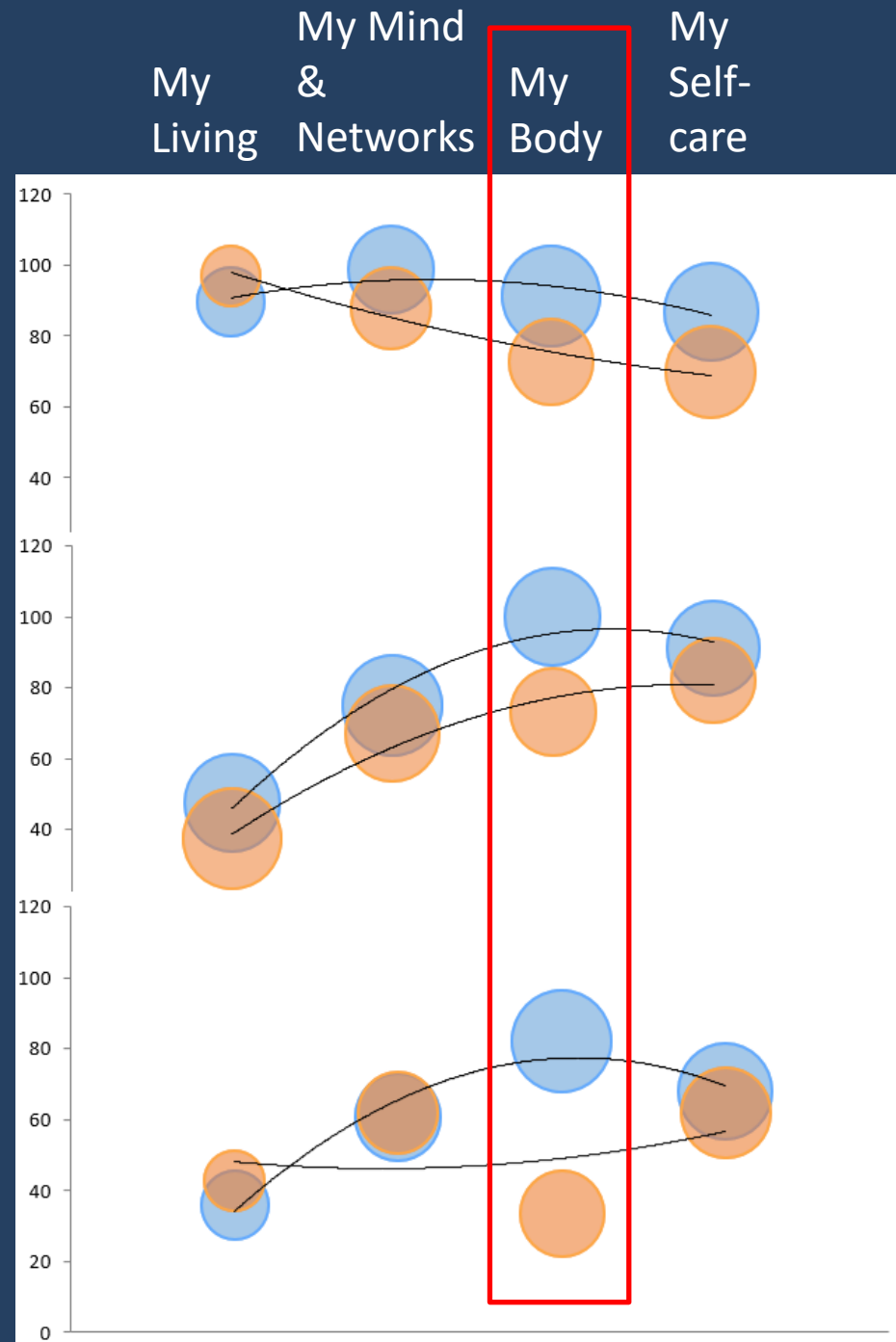
Equivalent, Interoperable Whole-Person Data

- MSMH and Omaha System Partnership Data allow parallel investigation of whole-person health including SDOH and resilience for individuals and populations

Fully Integrated SDOH Within Multi-level Datasets: Resilience in Community and Population

Consumer-generated dataset (N=383)
Communication with community resources strength was highly correlated with other strengths across domains

Clinically-generated dataset (N=50,906)
Sleep and rest patterns strength was highly correlated with other strengths across domains

Documentation Burden – SDOH Clinical Data

- Getting to whole person health clinical documentation:
  - Invite the consumer/patient voice and perspective
  - Examine data across settings, populations, and programs
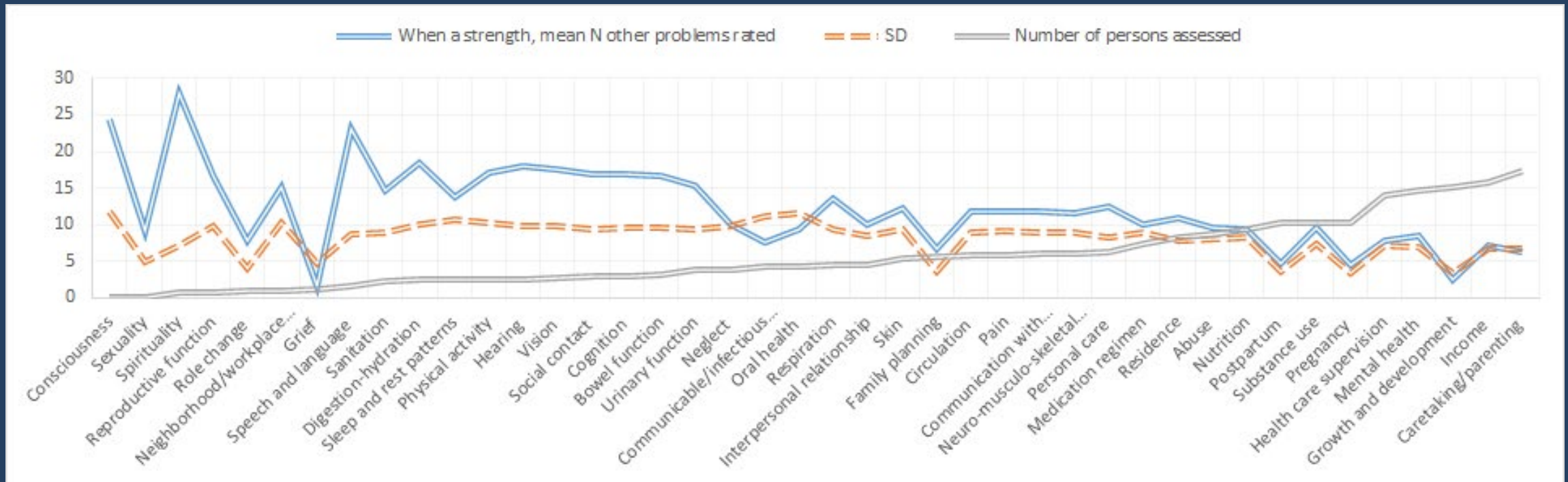
Challenges and Strengths Patterns

- Persons having the challenge of "tired" were less likely to have strengths in Mental Health (-0.3), Circulation (-0.17), Pain (-0.14), Physical Activity(-0.14), Digestion/Hydration(-0.11), Caretaking/Parenting(-0.1) than others

- Persons having the challenge of "fearful" were less likely to have the strength Mental Health (-0.19) than others

Implications

- SDOH can and should be self-reported as part of a whole-person health assessment

- Clinical assessments can also provide valuable whole-person data; this is less burdensome when incorporated within the workflow and dataflow of a comprehensive holistic assessment

- Whenever possible, both community-generated and clinically-generated data should be used together

- Self-report of whole-person health using the Omaha System in clinical and community-generated platforms can be customized, compared, combined, and used in clinical care and research

- There is potential to identify community-generated strengths to understand resilience during the pandemic, to aid communities in efforts to promote wellbeing and help community members meet basic needs and manage chronic conditions

References

- Lai AM, Hsueh P-YS, Choi YK, Austin RR. Present and Future Trends in Consumer Health Informatics and Patient-Generated Health Data. *Yearb Med Inform*. 2017;26(1). doi:10.15265/IY-2017-016.
- Woods SS, Evans NC, Frisbee KL. Integrating patient voices into health information for self-care and patient-clinician partnerships: Veterans Affairs design recommendations for patient-generated data applications. *J Am Med Informatics Assoc*. 2016;23(3):491-495. doi:10.1093/jamia/ocv199.
- Rosenbloom TS. Person-generated health and wellness data for health care. *J Am Med Informatics Assoc*. 2016;23(3):438-439. doi:10.1093/jamia/ocw059.
- Martin KS. (2005). The Omaha System: A key to practice, documentation, and information management (Reprinted 2nd ed.). Omaha, NE: Health Connections Press.
- Austin, R.R. (2018). Picturing patterns in whole-person health: Leveraging visualization techniques with structured consumer-generated mHealth data. Retrieved from the University of Minnesota Digital Conservancy, http://hdl.handle.net/11299/202216.
- Austin, R.R., Gao, G., & Monsen, K. A. (2017). Feasibility of using the MyStrengths+MyHealth™ app by older adult women with heart disease to document strengths, challenges, and needs. In Home Healthcare, Hospice, and Information Technology. Washington, DC, USA.
- Austin, R.R., Jones, R.C., Monsen, K.A., Eder, M., Martin, K. A. (under review). Development and validation of a simple translation of the Omaha System.
- Austin, R.R., Kirk, L.A., Mathiason, M.A., Oghumah, I., & Monsen, K.A. (under review). Quantified whole-self: Perceptions of older adults using MyStrengths+MyHealth™
- Austin, R.R., Mathiason, M.A., Lindquist, R.A., McMahon, S.K., Pieczkiewicz, P., & Monsen, K.A. (under review). A novel approach to the capture of standardized consumer-reported data to understand differential expression of women's strengths, challenges, and needs.
- Austin., R.R., Mathiason, M.A., Monsen, K.A., (2019). Assessing strengths-based whole-person health for older adults using MyStrengths+MyHealth™ application. In Home Healthcare, Hospice, and Information Technology. Seattle, WA, USA
- Monsen, K. A., Chatterjee, S. B., Timm, J. E., Poulsen, J. K., & McNaughton, D. B. (2015). Factors explaining variability in health literacy outcomes of public health nursing clients. *Public Health Nursing, 32*(2), 94-100. doi: 10.1111/phn.12138
- *Gapp, N*., Weber, J., Monsen, K. A., & Darst, E. (2015). Feasibility of using the Omaha System for assessment to determine optimal living situation for persons with severe and persistent mental illness. *Annals of Psychiatry and Mental Health, 3,2,1026.*
- Monsen, K. A., Peters, J., *Schlesner, S*., Vanderboom, C. E., & Holland, D. E. (2015). The gap in Big Data: Getting to wellbeing, strengths, and a whole person perspective. *Global Advances, 4*, 3, 31-39.
- Monsen, K. A., Brandt, J. K., Brueshoff, B., Chi, C. L., Mathiason, M. A., *Swenson, S. M.*, & Thorson, D. R. (2017). Social determinants and health disparities associated with outcomes of women of childbearing age receiving public health nurse home visiting services. *JOGNN, 46 (*2), 292-303. doi: 10.1016/j.jogn.2016.11.014. *Gao, G., Maganti, S.*, & Monsen, K. A. (2017). Older adults, frailty, and the social and behavioral determinants of health. *Big Data and Information Analytics*, epub, 1-12. doi:10.3934/bdia.2017012
- *Gao, G., Maganti, S.*, & Monsen, K. A. (2017). Older adults, frailty, and the social and behavioral determinants of health. *Big Data and Information Analytics*, epub, 1-12. doi:10.3934/bdia.2017012
- Monsen, K. A. *Rudenick, J. M., Kapinos, N., Warmbold, K.*, McMahon, S. K., & Schorr, E. N. (2019). Documentation of social determinants in electronic health records with and without standardized terminologies: A comparative study. *Proceedings of Singapore Healthcare*, *28*(1), 39-47.
- Whitney RL, Ward DH, Marois MT, Schmid CH, Sim I, Kravitz RL. Patient perceptions of their own data in mhealth technology–enabled N-of-1 trials for chronic pain: Qualitative study. *JMIR mHealth uHealth*. 2018;6(10). doi:10.2196/10291 \
- Sminkey P V. The "whole-Person" Approach : Understanding the Connection between Physical and Mental Health. *Prof Case Manag*. 2015;20(3):154-155. doi:10.1097/NCM.0000000000000094

Lunch Break
Please return by 12:30 pm EDT

The Office of the National Coordinator for
Health Information Technology

SDOH CHALLENGES IN MATERNITY CARE

Catherine H. Ivory, PhD, RNC-OB, RN-BC, FAAN

September, 2020

Maternal Health Information Initiative Background

Birth Certificate

ACOG Antenatal form

NPIC

MQIP

TJC PC Measures

Nursing Quality

Measurement

ACOG Birth Registry Project

- Aim: to help decrease the high maternal mortality rate in the United States and improve maternal care more broadly by enabling healthcare providers to identify and address the variations in care that currently exist between facilities.

- SDOH factors essential, often missing

CHALLENGES

- Where SDOH data is captured vs. where care happens
- How SDOH data is captured
- Including the voice and preferences of the childbearing woman
- Systemic racism

Emerging Best Practices and Challenges in SDOH Data Collection:
Where the Physical Therapy Profession is Headed with Documentation of Social Determinants of Health

September 21, 2020

NONC's Advancing Interoperability: Social Determinants of Health Workshop

Defining and Framing SDOH, Our Space, Place, and Responsibility

APTA Positions on Social Issues and Health

DELIVERY OF VALUE-BASED PHYSICAL THERAPIST SERVICES HOD P06-19-20-47 [Initial: HOD P06-15-17-09] [Position]

USE OF DATA TO IMPROVE THE QUALITY OF PHYSICAL THERAPIST SERVICES

1. APTA supports meaningful and standardized data collection by physical therapists through the adoption of interoperable electronic health record (EHR) systems in all practice settings that can advance patient services, improve quality, and demonstrate the value of physical therapist services to patients and clients, payers, policy makers, and the provider community.

2. APTA supports the collection and tracking of data to improve the quality of physical therapist services. The functionality of data-collection systems should allow analyses that:

a. Identify clinical practice patterns;

b. Promote adherence to clinical practice guidelines;

c. Guide payment policies;

d. Support quality-improvement initiatives; and

e. Promote health services research on delivery, utilization, and outcomes to further establish the value of physical therapist services.

3. APTA supports and promotes participation in quality

Health Priorities For Populations And Individuals

SEPTEMBER 20, 2019

- House position: APTA supports the following health priorities for populations and individuals in the areas of prevention, wellness, fitness, health promotion, and management of disease and disability.

APTA.

"APTA…priorities…

- Physical therapists provide education, behavioral strategies, patient advocacy, referral opportunities, and identification of supportive resources after screening for the following additional USNPS health priorities:

☐ Tobacco Free Living

☐ Preventing Drug Abuse and Excessive Alcohol Use

☐ Healthy Eating

☐ Active Living

☐ Mental and Emotional Well-Being

☐ Reproductive and Sexual Health

☐ Injury and Violence Free Living

APTA.

Role Of PT Diet Nutrition
SEPTEMBER 20, 2019

- House position: Diet and nutrition are key components of primary, secondary, and tertiary prevention of many conditions managed by physical therapists.

HEALTH AND SOCIAL ISSUES HOD P06-19-46-21 [Initial: HOD P06-87-14-23] [Position]

- The American Physical Therapy Association responds to and acts upon health and social issues that are consistent with its vision and mission.

APTA.

The Role of the Physical Therapist and the American Physical Therapy Association in Behavioral and Mental Health

AUGUST 20, 2020

- House position: Supports interprofessional collaboration in behavioral and mental health to enhance the overall health and well-being of society consistent with APTA's vision.

Role of the Physical Therapist and the American Physical Therapy Association in Sleep Health

AUGUST 20, 2020

- House positon: Supports collaboration between physical therapists and sleep medicine professionals to enhance the health and well-being of society.

APTA.

What's in the Works?

PT Registry Outcomes

Annual Physical Therapy Visit

- Pediatrics
- Adults
- Aging
- Smoking, Sleeping, Physical Activity
- Enough food, Adequate Housing, Adverse Childhood Events

APTA.
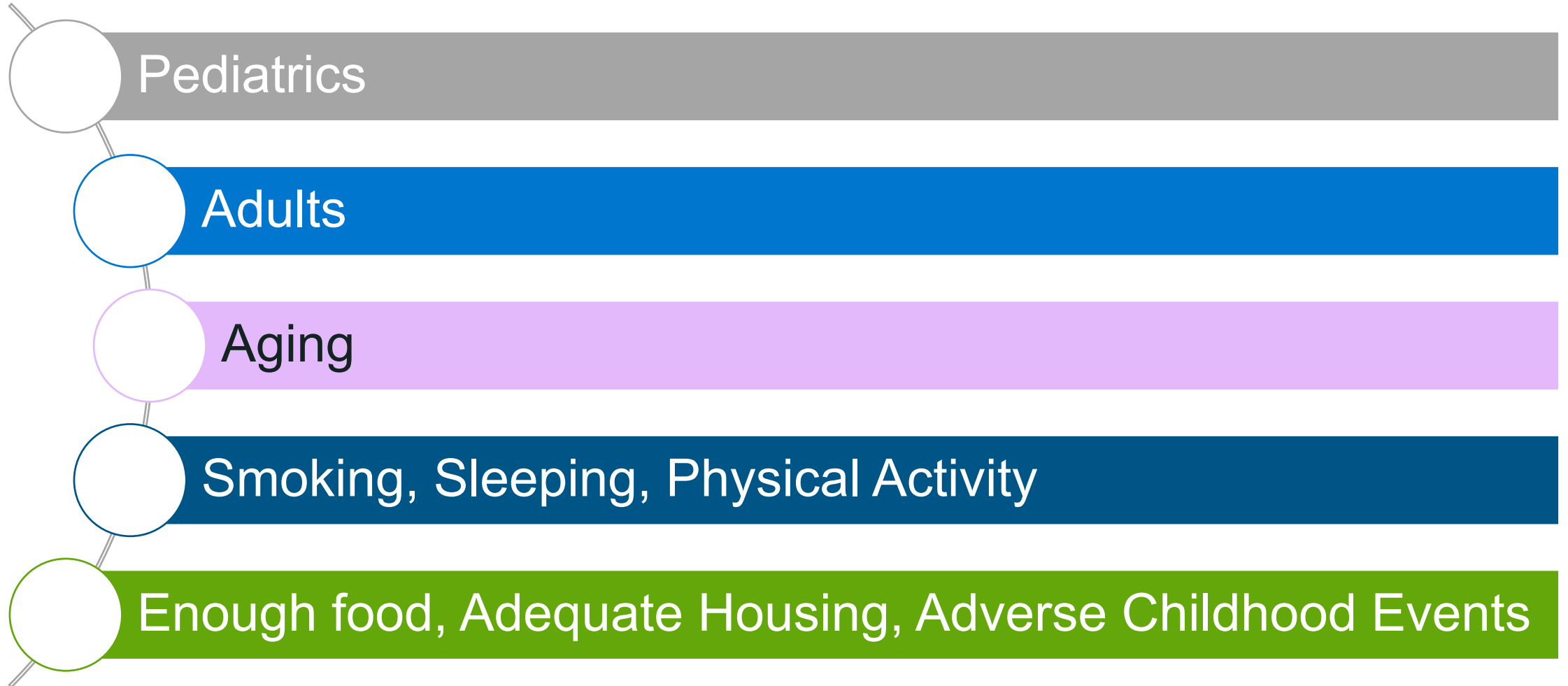
Questions & Answers

APTA

Thank You

Building a community that advances the profession of physical therapy to improve the health of society.

APTA

Social Care Screening from a Social Work Perspective

Anna Mangum, MPH, MSW
Deputy Director, Programs

Washington, DC
September 21, 2020

NASW
National Association of Social Workers

NASW
National Association of Social Workers

National Association of Social Workers

- Founded in 1955
- Represents the interests of 700,000+ professional social workers nationwide
- 55 chapter/territory offices
- Largest membership association of professional social workers

Social Work and SDOH

- Profession founded over a century ago
- Largest provider of mental health and social care in the nation
- Diverse settings:
  – Healthcare (hospitals, nursing homes, etc.)
  – Schools
  – Community agencies
  – Veterans/military
  – Correctional
  – Child and older adult protection

NASW
National Association of Social Workers

Person in the Environment: Foundational Social Work Model

Influences

COMMUNITY/ECONOMICS — LAWS — SCHOOL/EDUCATION — NORMS — FAMILY — MEDIA — CHURCH — INDIVIDUAL — PEER — ADULT ROLE MODELS — SPOUSE — HISTORY — WORK SETTING — POLITICS — NEIGHBORHOOD SETTING
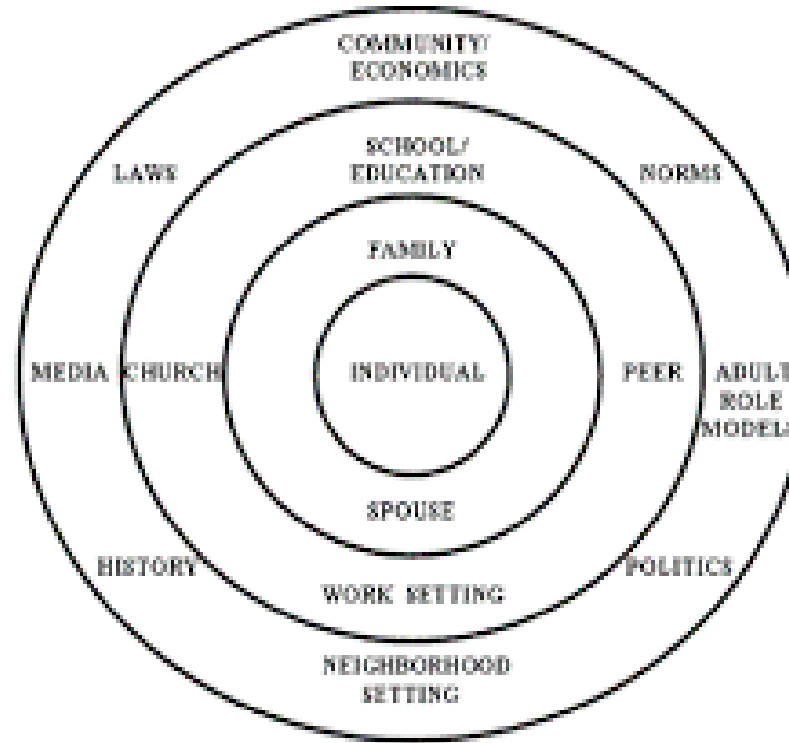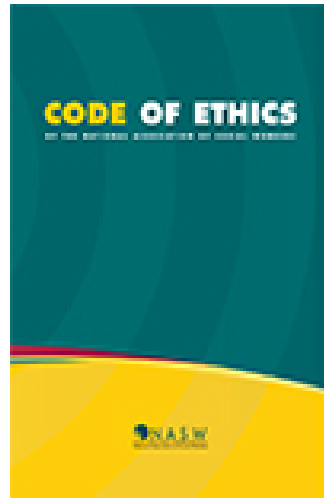
The primary **mission** of the **social work** profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty.

Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health

The National Academies of SCIENCES ENGINEERING MEDICINE

Improving social conditions remains critical to improving health outcomes, and integrating social care into health care delivery now more than ever is relevant in the context of the COVID-19 pandemic and increased strains placed on the U.S. health care system.

nationalacademies.org/SocialCare

Consensus Study Background

- National Academies of Science, Engineering and Medicine (NASEM)

- Released September 2019

- Interdisciplinary study committee
  - Social work
  - Health care

Social Work's Distinctive Role

"Social workers are specialists in providing social care who have a long history of working within health care delivery, and in-depth training and credentialing. With expertise in patient and family engagement, assessment, care planning, behavioral health, and systems navigation, social workers identify and address multiple factors that contribute to health and well-being."

Definitions

Health	A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity; this includes affording everyone the fair and just opportunity to be as healthy as possible.
Social care	Activities that address health-related social risk factors and social needs.
Social determinants of health	The conditions in which people are born, grow, work, live, and age that affect a wide range of health, functional, and quality of life outcomes and risks.
Social needs	A patient-centered concept that incorporates a person's perception of his or her own health-related needs.
Social risk factors	Social determinants that may be associated with negative health outcomes, such as poor housing or unstable social relationships.
Social services	Services, such as housing, food, and education, provided by government and private, profit and nonprofit, organizations for the benefit of the community and to promote social well-being.

NASW
National Association of Social Workers

Activities focused on individuals

Adjustment | Assistance

Awareness

Activities focused on communities

Alignment | Advocacy

Traditional health care data
Claims, EHR care management
HIPAA covered entities

Health data that are not HIPAA regulated
- Sensors and wearables
- Health data entered into an App

Non-health data on which inferences about health are based
Census; American Community Survey; Housing stock; Criminal justice records; Retail/consumption data

User-generated health data
Health-related social needs from surveys

Not traditionally HIPAA covered entities

User-generated non-health data that may or may not correlate with health
Social media

Recommendations

- Engage diverse community stakeholders in providing input on which social care needs to track and how to specify them

- Invite CBOs to share information back to hospital, etc.

- Address the most pressing social needs and disparities (starkly evident with pandemic)

- Telehealth: opportunities and challenges in screening

NASW
National Association of Social Workers

Recommendations (cont'd)

Support National Alliance to Support the SDOH (NASDOH) principles, including:

- Capture the full spectrum of social risk (e.g., loss of employment, social isolation, family conflict, social displacement) in all communities and all persons regardless of socioeconomic status, race, gender identity, sexual orientation, religion, ethnicity, etc.

- Ensure appropriate consents and protections are built into the screening process to ensure that the social needs data is utilized to promote clinical excellence and not to discriminate (e.g., via insurance coverage, access, or services) on the basis of any social needs factors.

NASW
National Association of Social Workers

Contact Information

Anna Mangum, MSW, MPH

Deputy Director, Programs

National Association of Social Workers

750 First St NW
Washington DC 20001

Amangum.nasw@socialworkers.org

PQA is a national quality organization that operates in 4 industry cross-cutting roles

Measure Developer

Medication use measures for **medication safety, adherence, and appropriate use**

Consensus-driven process to draft, test, refine, and endorse measures

Measures fill gaps in high-priority areas of healthcare, aligning with the National Quality Strategy

Quality Educator

Promoting the use and impact of PQA measures and other healthcare quality topics

Quality Workshops and Webinars, Member Education, Academic Education, Patient Education

Content at the **PQA Annual Meeting and PQA Leadership Summit**

Researcher

Close gaps in medication use quality and explore & promote **novel solutions & best practices**

Inform & evaluate quality measurement

Collaborative research projects in **medication use quality** (adherence, medication safety), **medication access & SDOH, pharmacist-provided care,** and **patient engagement**
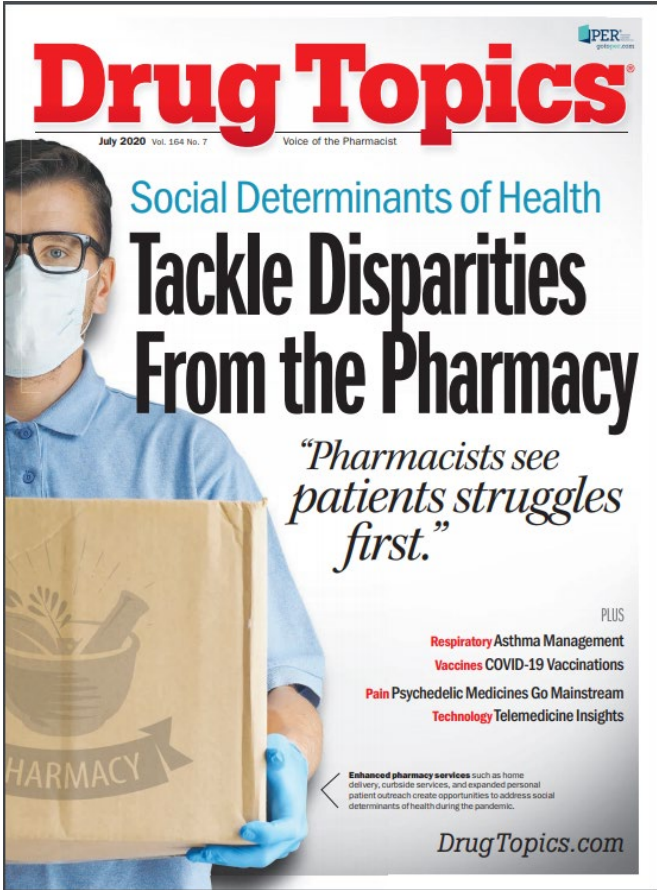
Convener

Fostering relationships with **diverse stakeholders** to advance shared goals

Roundtables, Collaborations, Task Forces

Networking at the **PQA Annual Meeting and PQA Leadership Summit**

PQA
Pharmacy Quality Alliance

Pharmacists have a role in screening & addressing social determinants of health

Drug Topics

July 2020 Vol. 164 No. 7 — Voice of the Pharmacist

Social Determinants of Health

Tackle Disparities From the Pharmacy

"Pharmacists see patients struggles first."

PLUS

Respiratory Asthma Management
Vaccines COVID-19 Vaccinations
Pain Psychedelic Medicines Go Mainstream
Technology Telemedicine Insights

Enhanced pharmacy services such as home delivery, curbside services, and expanded personal patient outreach create opportunities to address social determinants of health during the pandemic.

DrugTopics.com

---

dsn DRUG STORE NEWS

PHARMACY OF THE FUTURE: INTEGRATING SDOH TO UNDERSTAND PATIENT NEEDS

03/30/2020 - Jill Regan of LexisNexis Risk Solutions Health Care examines how retail pharmacy leaders continue to respond to market changes in the new decade.

Pharmacy Times®

Pharmacists' Role in Tackling Social Determinants of Health

At the first educational session of PQA, the speakers discussed pharmacists' roles in influencing outcomes associated with social determinants of health in the US population.

2020 Trends in Pharmacy Care: Value-Based Pharmacy and Social Determinants of Health

The shift from fee-for-service to a value-based care payment model represents the growing understanding of the value of health care providers in improving overall patient outcomes.

https://www.drugtopics.com/view/tackle-disparities-from-the-pharmacy
https://drugstorenews.com/pharmacy-future-integrating-sdoh-understand-patient-needs
https://www.pharmacytimes.com/conferences/pqa-2020/pharmacists-role-in-tackling-social-determinants-of-health
https://www.pharmacytimes.com/news/2020-trends-in-pharmacy-care-value-based-pharmacy-and-social-determinants-of-health

PQA
Pharmacy Quality Alliance

Medication access has traditionally been indirectly measured using adherence

- Indicator for patients who have access to medication(s)

- Does not give information on why nonadherent

- Does not address the social determinants

March 2019

Access to Care:

Development of a Medication

Access Framework for

Quality Measurement

The Medication Access Patient Journey (MAPJ)

March 2019

Access to Care:

Development of a Medication

Access Framework for

Quality Measurement

MAPJ: Medication Access Patient Journey   https://www.pqaalliance.org/assets/Research/PQA-Access-to-Care-Report.pdf

A key challenge in addressing health inequities lies in SDOH data and data interoperability

Data capture and reporting
- Feasibility
- Level needed
  - Patient
  - Community

Pharmacy workflow integration
- Pharmacist-provided services
- Consistent documentation
- Adoption of standards

Pharmacists can be part of the solution

Standardized data to support national policy efforts

Localized data to inform community health efforts

"If you can't measure it, you can't improve it." Peter Drucker

PQA

Pharmacy Quality Alliance

The Pharmacist eCare Plan is an interoperable standard (C-CDA & FHIR)

Multiple uses:
- Care Coordination
  - *Social History*
- Payment
- Quality Assurance

Based on the Joint Commission of Pharmacy Practice Pharmacist Patient Care Process
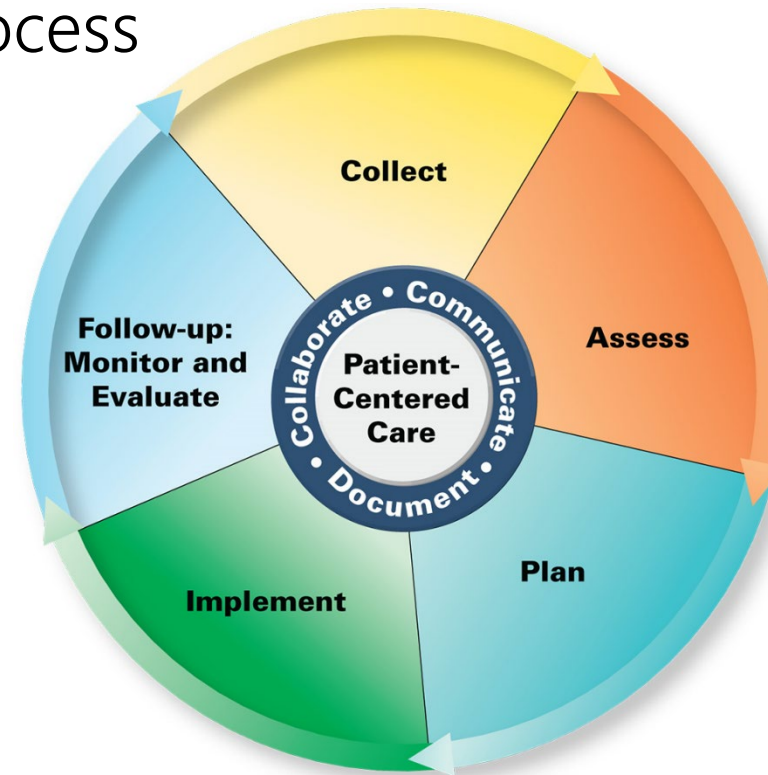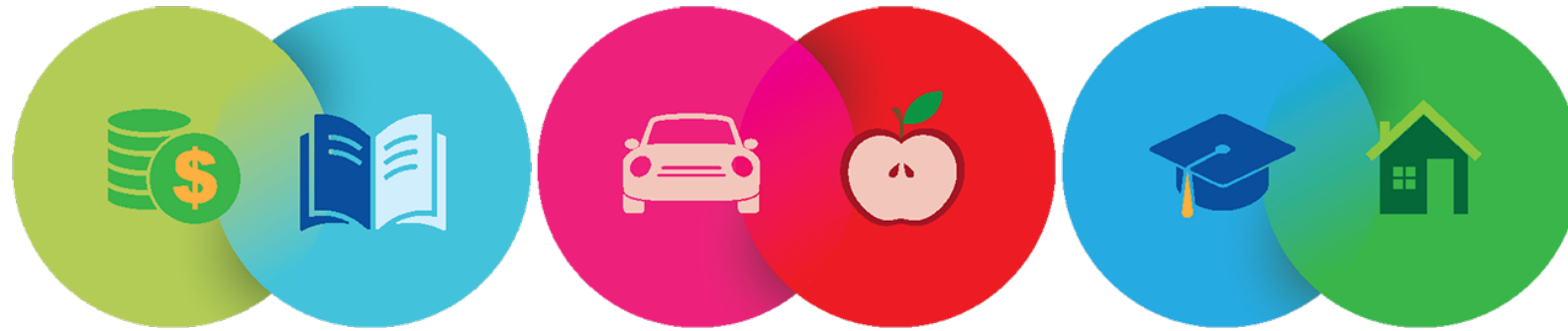
PQALEADERSHIP
SUMMIT | NOVEMBER 5, 2020

COLLABORATING TO ADDRESS SOCIAL DETERMINANTS OF HEALTH

PQA
Pharmacy Quality Alliance

Adopting Standards Based Approaches to SDOH Data Needs

Emily Webber, MD, FAAP, FAMIA

Al Taylor, MD

September 21, 2021

The Office of the National Coordinator for
Health Information Technology

Adapting Practice Guidelines to leverage HIT

- USPTF Recommendations
    - Asymptomatic Bacteriuria in Adults: Screening pregnant persons
        - Reduced pyelonephritis and other complications in pregnancy

- Some are or can be easily translated into computable guidelines using Clinical Decision Support or Clinical Quality Measurement technology already built in to EHRs.
    - CDS uses triggers to begin to apply rules to determine recommended course
        - Trigger could be "access patient record" in OB clinic
        - Rule could include "is there a urine culture in the record since last positive pregnancy test in record"
            - If not, activate order set ("New OB labs")

Adapting Practice Guidelines to leverage HIT

- Clinical Quality Measurement uses
  - Often, not always, retrospective to demonstrate quality
    - Same set of rules apply
  - Can be use prospectively as population health tool
  - Asymptomatic bacteriuria not currently specified as eCQM

The Office of the National Coordinator for
Health Information Technology

Adapting Practice Guidelines to leverage HIT

- Some guidelines/measures are not easily translated into computable guidelines may need to be modified
    - example HEDIS measure "Chlamydia Screening in Women" eCQM
        - Measure applies to "sexually active women 16-24 years of age"
            - Screening questions are sometimes only proxies for "sexually active"
                - includes "ever had vaginal intercourse" question
                - includes oral contraceptive prescriptions
                - includes imaging studies "indicating sexual activity"

The Office of the National Coordinator for
Health Information Technology

Integrating SDOH data into guidelines

- Same set of questions apply as for clinical guidelines

  - Do the desired SDOH data elements have associated codes

  - Can they be included in computable rule sets

  - Can they be turned into appropriate interventions-before, during or after visits

- Example screening for global SDOH needs

  - May not be required for each visit

  - Trigger again may be "access patient record" or "schedule appointment"

  - Rule could include "are there SDOH screening results in the record for last ### period

    - There can be a supplemental rule such as "is this patient diabetic" to focus screening on food insecurity

    - This rule assumes the SDOH data element is captured to be acted on by EHR or pop health platform.

Integrating SDOH data into guidelines

The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

ACOG COMMITTEE OPINION

Number 729 • January 2018

(Replaces Committee Opinion Number 493, May 2011)

Committee on Health Care for Underserved Women

This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Health Care for Underserved Women in collaboration with committee members Carolyn Sufrin, MD, PhD, Autumn Davidson, MD, MS, and Glenn Markenson, MD.

Importance of Social Determinants of Health and Cultural Awareness in the Delivery of Reproductive Health Care

ABSTRACT: Awareness of the broader contexts that influence health supports respectful, patient-centered care that incorporates lived experiences, optimizes health outcomes, improves communication, and can help reduce health and health care inequities. Although there is little doubt that genetics and lifestyle play an important role in shaping the overall health of individuals, interdisciplinary researchers have demonstrated how the conditions in the environment in which people are born, live, work, and age, play equally as important a role in shaping health outcomes. These factors, referred to as social determinants of health, are shaped by historical, social, political, and economic forces and help explain the relationship between environmental conditions and individual health. Recognizing the importance of social determinants of health can help obstetrician–gynecologists and other health care providers better understand patients, effectively communicate about health-related conditions and behavior, and improve health outcomes.

Integrating SDOH data into guidelines

ACOG Recommendations

The American College of Obstetricians and Gynecologists makes the following recommendations for obstetrician–gynecologists and other health care providers to improve patient-centered care and decrease inequities in reproductive health care:

-Inquire about and document social and structural determinants of health that may influence a patient's health and use of health care such as access to stable housing, access to food and safe drinking water, utility needs, safety in the home and community, immigration status, and employment conditions.

-Maximize referrals to social services to help improve patients' abilities to fulfill these needs.

-Provide access to interpreter services for all patient interactions when patient language is not the clinician's language.

-Acknowledge that race, institutionalized racism, and other forms of discrimination serve as social determinants of health.

-Recognize that stereotyping patients based on presumed cultural beliefs can negatively affect patient interactions, especially when patients' behaviors are attributed solely to individual choices without recognizing the role of social and structural factors.

-Advocate for policy changes that promote safe and healthy living environments.

https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/01/importance-of-social-determinants-of-health-and-cultural-awareness-in-the-delivery-of-reproductive-health-care

Thank you!

DISCLOSURES

- I have no relevant financial disclosures.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

- It is much more important to know what sort of a patient has a disease than what sort of a disease a patient has.
  - Attributed to William Osler

AMERICAN ACADEMY OF PEDIATRICS

- 67,000 pediatricians

- Committed to the optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults

- Policy, advocacy and education

- https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Pages/Social-Determinants-of-Health.aspx

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

EXISTING RESOURCES

Policy, Guidelines, and Publications

- **Early Childhood Adversity, Toxic Stress, & the Role of the Pediatrician: Translating Developmental Science into Lifelong Health** (2012, reaffirmed 2016) – Policy statement providing an overview of how a child's environment interacts with biological predispositions to affect lifelong physical and mental health. Discusses how to meld early identification of developmental concerns with interventions to reduce threats to healthy brain growth.

- **The Evaluation of Suspected Child Physical Abuse** (2015) – Policy statement on the role that pediatricians play in identifying suspicious injuries, reporting physical abuse to the proper authorities, supporting affected families, and coordinating with resources in the community to provide immediate and long-term care for the child.

- **The Lifelong Effects of Early Childhood Adversity and Toxic Stress** (2016) – Report presenting an ecobiodevelopmental framework that shows how early experiences can impact genetic predispositions that affect brain architecture and long-term health outcomes.

- **Mediators and Adverse Effects of Child Poverty in the United States** (2016) – Technical report describing current evidence on the impact of poverty on child health and development.

- **Poverty and Child Health in the United States** (2016) – Policy statement discussing the impact of poverty on child health and ways in which pediatricians can help mitigate the effects of poverty, both for individual patients and through broader advocacy.

- **Promoting Food Security for All Children** (2015) – Policy statement providing guidance on how pediatricians can play a key role in screening and identifying children at risk for food insecurity, connecting families with needed community resources, and advocating for federal and state policies supporting access to healthy food.

Tools, Trainings, and Other Resources

- **Addressing Food Insecurity: A Toolkit for Physicians** - Toolkit providing guidance on incorporating the food screening process into practice workflow, choosing the right tool, and intervening to help address food insecurity.

- **Peds-21: The Trauma-Informed Pediatrician: Identifying Toxic Stress and Promoting Resilience** - Recordings from the American Academy of Pediatrics 2015 Peds-21 symposium explaining how pediatric health care providers can identify and address toxic stress in their patients and access resources to promote resilience.

- **Poverty and Child Health** - AAP resources on the impact of poverty on children's health, including practice tips and advocacy ideas.

- **The Resilience Project** - Resources assisting pediatric health care providers in building resilience in children exposed to trauma, including a training toolkit, practice and provider resources, assessment tools, and past webinars.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

GUIDING PRINCIPLES

- Pediatric care is founded on social determinants

- "New" sources of history taking

  – Burden of burnout

  – What are we replacing or optimizing?

- Patient and family integration into the medical home

AAP POLICY

- Policy implementation challenges

- Integration into clinical recommendations

- Net "new" health IT enabling

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

POLICY, PRACTICE EXAMPLES

- A policy documentation in the EHR

- A collaborative to close gaps in health IT for children and adolescents

- A webinar outlining the best way to organize asynchronous data telling the story of the patient and the social determinants

- How should I?....

  – Prescribe apps

  – Gather known elements that predict asthma outcomes

  – Prioritize the elements of population health we need in an HPI

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

THANK YOU

- Emily C. Webber, MD FAAP FAMIA
- @pedshospdoc
- ewebber@iuhealth.org