Social Determinants of Health: Gravity Project & HIE Implementation Approaches

ONC STAR HIE Program – Health Equity Work Group

March 24, 2022

3:00 PM – 4:15 PM EST

The Office of the National Coordinator for Health Information Technology

Agenda

- Opening (~5 min)
- Overview of the Gravity Project (~10 min)
- HIE Panel: Social Determinants of Health (SDOH) Information Exchange Approaches (~30 min)
  - CyncHealth
  - Michigan Health Information Network (MiHIN)
- Discussion (~20 min)
- Wrap-up (~5 min)

Overview of the Gravity Project

Consensus-driven Standards on Social Determinants of Health

Evelyn Gallego, CEO at EMI Advisors LLC, Senior Advisor at Gravity Project

Agenda

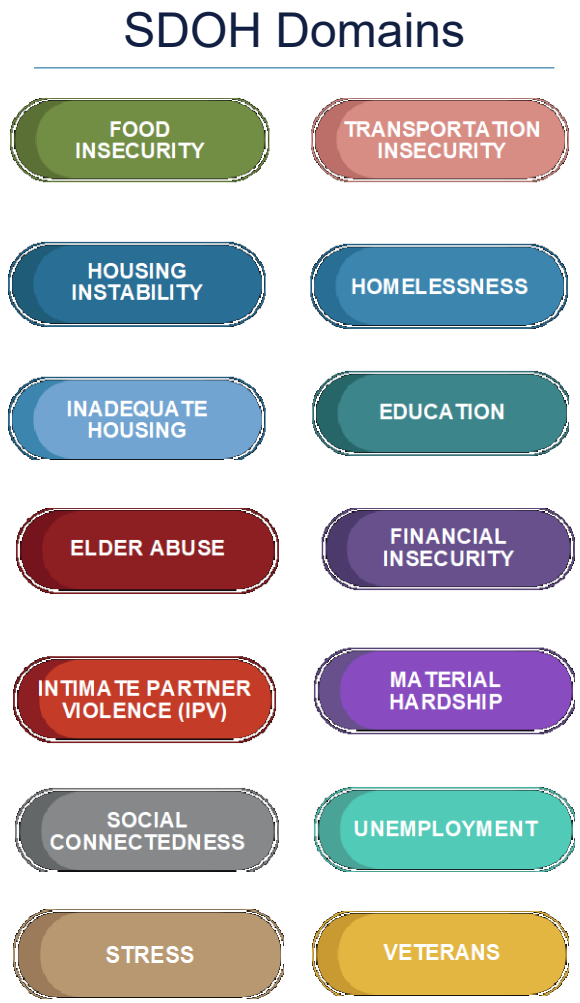
- What is the Gravity Project?
- Accomplishments to date
- Success Factors for Scalability
- How to Engage

Gravity Project

A collaborative public-private initiative launched in May 2019 with the goal to develop consensus-driven data standards to support the collection, use, and exchange of social determinants of health (SDOH) data.

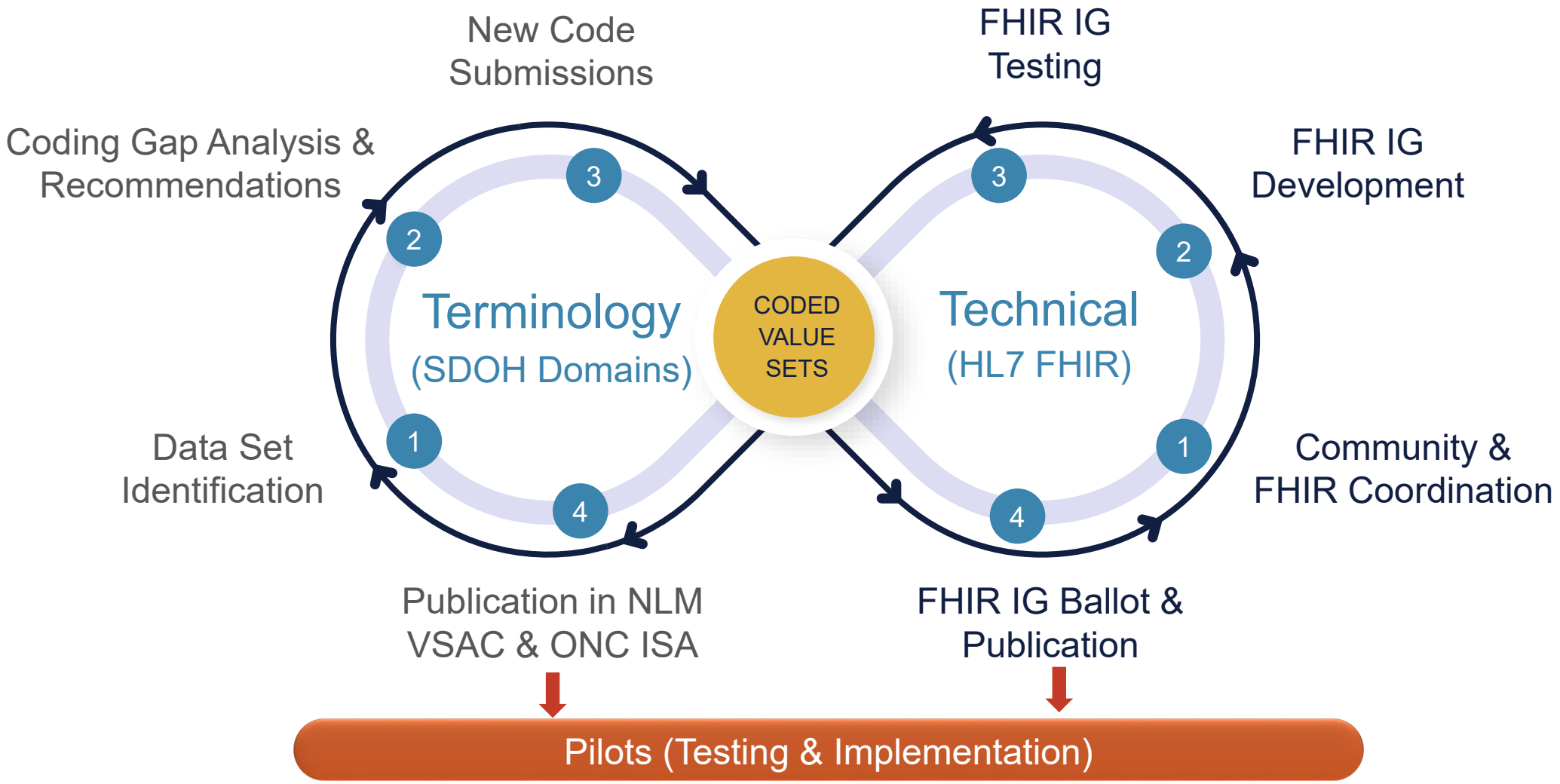
Project Scope

- Develop data standards to represent and exchange patient level SDOH data documented across four clinical activities:
  - Screening
  - Assessment/diagnosis
  - Goal setting
  - Treatment/interventions.
- Test and validate standardized SDOH data for use in patient care, care coordination between health and human services sectors, population health management, public health, value-based payment, and clinical research.



Domains grounded by those listed in the NASEM "Capturing Social and Behavioral Domains in Electronic Health Records" 2014

Project Execution:
Three Workstreams (Terminology, Technical, Pilots)



Public Collaboration

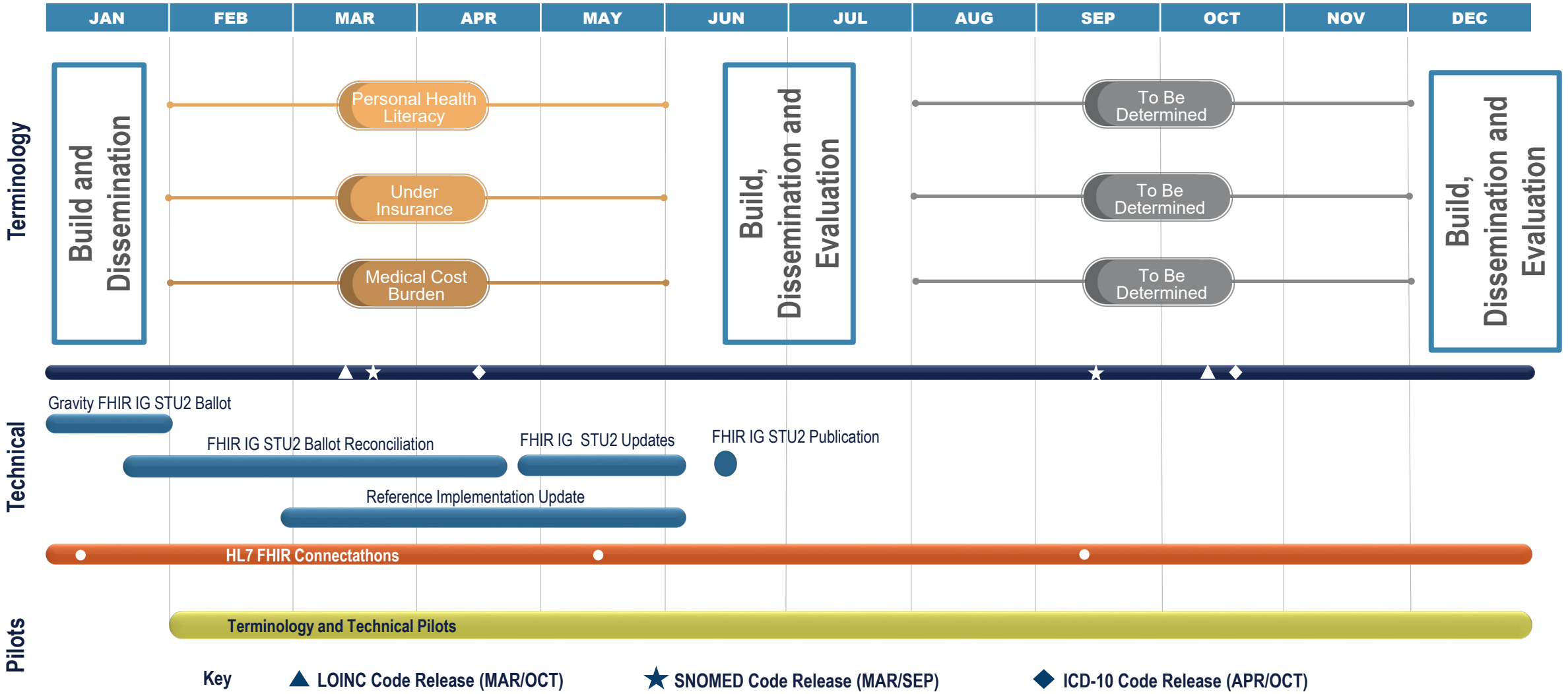
Gravity has convened over **2,000+** participants from across the health and human services ecosystem:

- Clinical Provider Groups
- Community-based Organizations
- Standards Development Organizations
- Federal And State Government
- Payers
- Technology Vendors

Public Calls 4-5:30 EST every other Thursday

https://confluence.hl7.org/pages/viewpage.action?pageId=46892669#JointheGravityProject-GravityProjectMembershipList

Gravity 2022 Roadmap

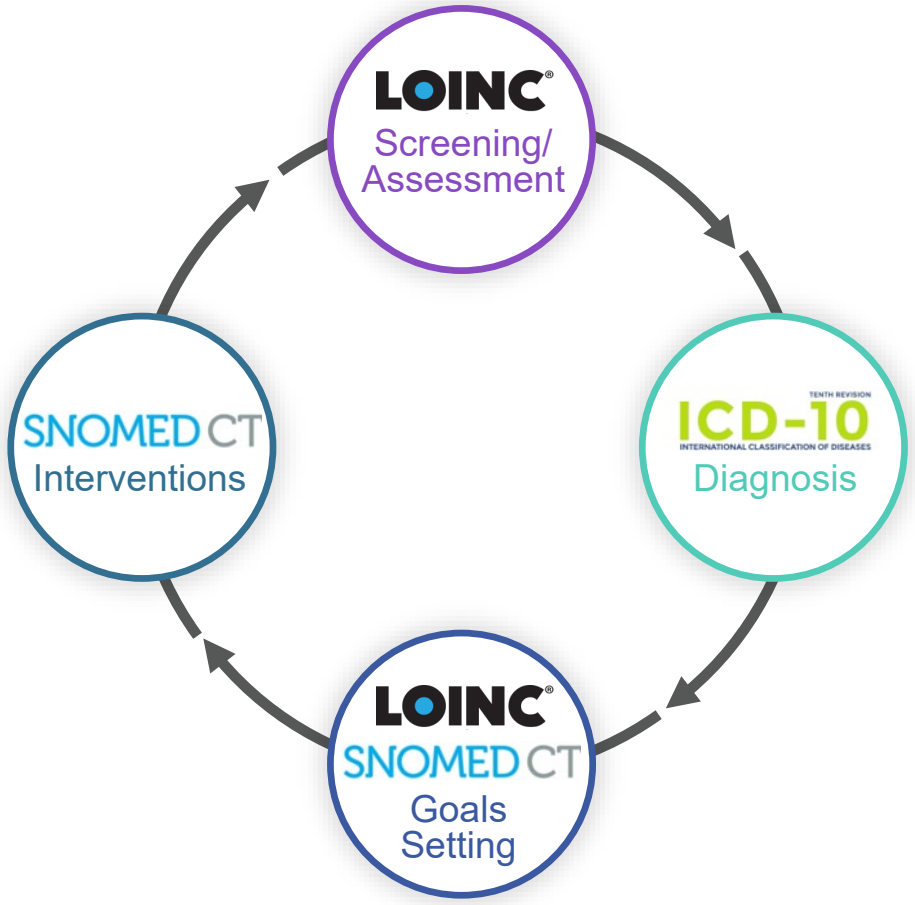


Terminology Workstream

Terminology Workstream Accomplishments

- Data definitions and code submissions for **14** SDOH Domains
- **LOINC** screener codes available for **13** domains
- **ICD-10** z-codes available for **10** domains
- **SNOMED-CT** intervention codes available for **5** domain (food insecurity)
- Published **71** value sets in National Library of Medicine (NLM)
- Data class included in ONC USCDI v2

https://confluence.hl7.org/display/GRAV/SDOH+Data+Elements+And+Status

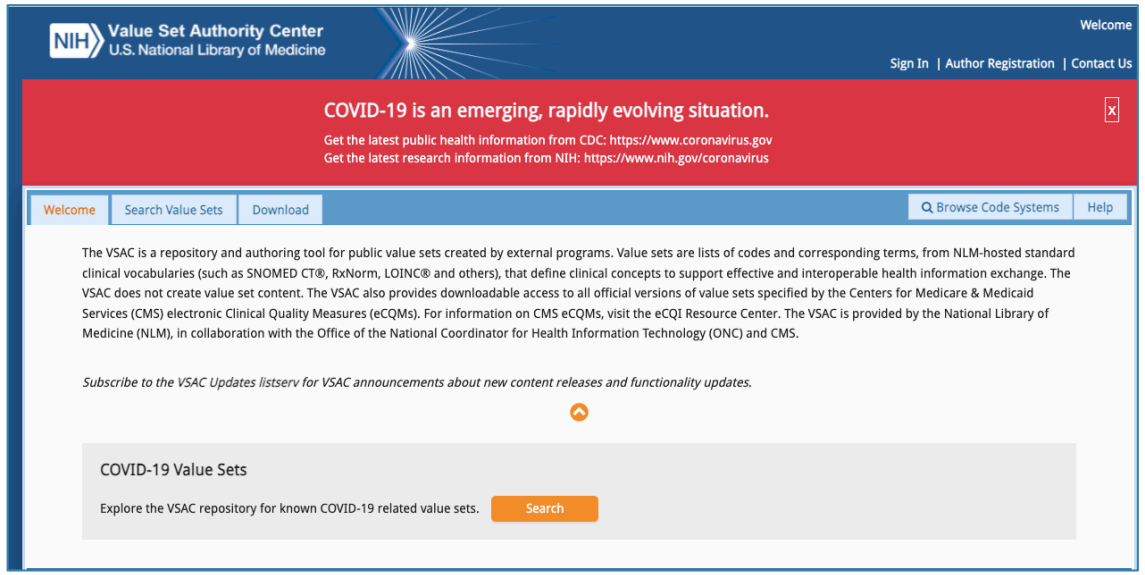


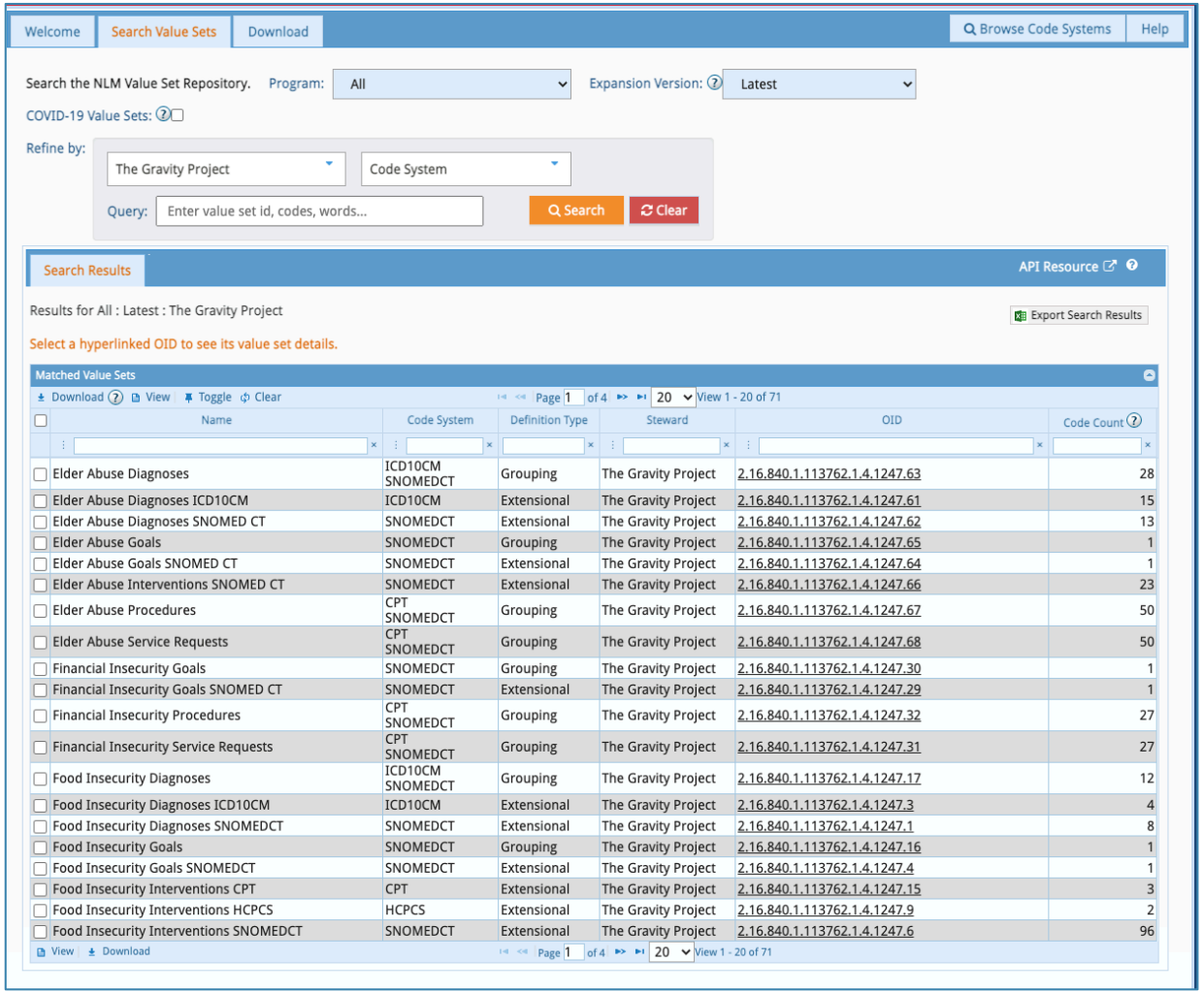
SDOH Domain Code Dashboard

Domain	Activities (Aligns with USCDI SDOH Data Class)	Select Codes Present	Comprehensive List of Codes Present	
FOOD INSECURITY	Screeners (LOINC)		x	F
	Diagnoses (SNOMED CT, ICD-10)		x	
	Goals (LOINC, SNOMED CT)		x	
	Interventions (SNOMED CT)		x	
HOUSING INSTABILITY	Screeners (LOINC)	x		H 6
	Diagnoses (SNOMED CT, ICD-10)			
	Goals (LOINC, SNOMED CT)			
	Interventions (SNOMED CT)			
HOMELESSNESS	Screeners (LOINC)	x		H 6
	Diagnoses (SNOMED CT, ICD-10)	x		
	Goals (LOINC, SNOMED CT)			
	Interventions (SNOMED CT)			
INADEQUATE HOUSING	Screeners (LOINC)	x		In 6
	Diagnoses (SNOMED CT, ICD-10)	x		
	Goals (LOINC, SNOMED CT)		x	
	Interventions (SNOMED CT)			
TRANSPORTATION INSECURITY	Screeners (LOINC)	x		Tr 7
	Diagnoses (SNOMED CT, ICD-10)	x		
	Goals (LOINC, SNOMED)			
	Interventions (SNOMED CT)			
FINANCIAL INSECURITY	Screeners (LOINC)	x		Fi 6
	Diagnoses (SNOMED CT, ICD-10)			
	Goals (LOINC, SNOMED CT)		x	
	Interventions (SNOMED CT)			

https://confluence.hl7.org/display/GRAV/SDOH+Data+Elements+And+Status

SDOH Value Sets Published in National Library of Medicine Value Set Authority Center (VSAC)





Name	Code System	Definition Type	Steward	OID	Code Count
Elder Abuse Diagnoses	ICD10CM SNOMEDCT	Grouping	The Gravity Project	2.16.840.1.113762.1.4.1247.63	28
Elder Abuse Diagnoses ICD10CM	ICD10CM	Extensional	The Gravity Project	2.16.840.1.113762.1.4.1247.61	15
Elder Abuse Diagnoses SNOMED CT	SNOMEDCT	Extensional	The Gravity Project	2.16.840.1.113762.1.4.1247.62	13
Elder Abuse Goals	SNOMEDCT	Grouping	The Gravity Project	2.16.840.1.113762.1.4.1247.65	1
Elder Abuse Goals SNOMED CT	SNOMEDCT	Extensional	The Gravity Project	2.16.840.1.113762.1.4.1247.64	1
Elder Abuse Interventions SNOMED CT	SNOMEDCT	Extensional	The Gravity Project	2.16.840.1.113762.1.4.1247.66	23
Elder Abuse Procedures	CPT SNOMEDCT	Grouping	The Gravity Project	2.16.840.1.113762.1.4.1247.67	50
Elder Abuse Service Requests	CPT SNOMEDCT	Grouping	The Gravity Project	2.16.840.1.113762.1.4.1247.68	50
Financial Insecurity Goals	SNOMEDCT	Grouping	The Gravity Project	2.16.840.1.113762.1.4.1247.30	1
Financial Insecurity Goals SNOMED CT	SNOMEDCT	Extensional	The Gravity Project	2.16.840.1.113762.1.4.1247.29	1
Financial Insecurity Procedures	CPT SNOMEDCT	Grouping	The Gravity Project	2.16.840.1.113762.1.4.1247.32	27
Financial Insecurity Service Requests	CPT SNOMEDCT	Grouping	The Gravity Project	2.16.840.1.113762.1.4.1247.31	27
Food Insecurity Diagnoses	ICD10CM SNOMEDCT	Grouping	The Gravity Project	2.16.840.1.113762.1.4.1247.17	12
Food Insecurity Diagnoses ICD10CM	ICD10CM	Extensional	The Gravity Project	2.16.840.1.113762.1.4.1247.3	4
Food Insecurity Diagnoses SNOMEDCT	SNOMEDCT	Extensional	The Gravity Project	2.16.840.1.113762.1.4.1247.1	8
Food Insecurity Goals	SNOMEDCT	Grouping	The Gravity Project	2.16.840.1.113762.1.4.1247.16	1
Food Insecurity Goals SNOMEDCT	SNOMEDCT	Extensional	The Gravity Project	2.16.840.1.113762.1.4.1247.4	1
Food Insecurity Interventions CPT	CPT	Extensional	The Gravity Project	2.16.840.1.113762.1.4.1247.15	3
Food Insecurity Interventions HCPCS	HCPCS	Extensional	The Gravity Project	2.16.840.1.113762.1.4.1247.9	2
Food Insecurity Interventions SNOMEDCT	SNOMEDCT	Extensional	The Gravity Project	2.16.840.1.113762.1.4.1247.6	96

FIRST integration of non-clinical concepts in VSAC!

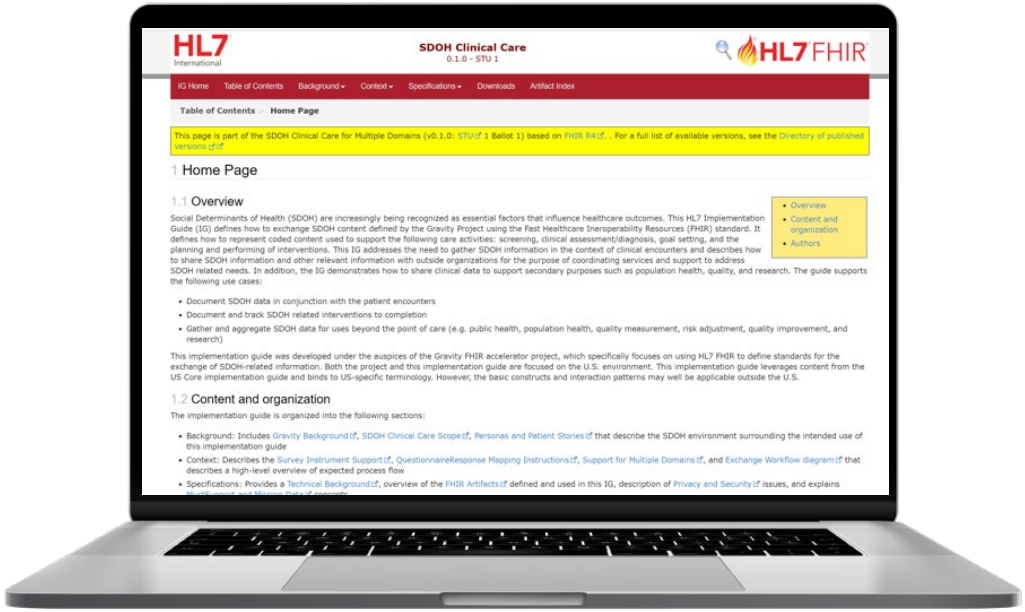
As of November 15, 2021, value sets are defined as a list of codes and corresponding terms that define **clinical and social care** concepts to support interoperable information exchange.

https://vsac.nlm.nih.gov/welcome

Technical Workstream

HL7 SDOH Clinical Care FHIR Implementation Guide

1. This is a framework Implementation Guide (IG) and supports multiple domains
2. IG support the following clinical activities
   - Assessments
   - Health Concerns / Problems
   - Goals
   - Interventions including referrals
   - Consent
   - Aggregation for exchange/reporting
   - Exchange with patient/client applications
   - Draft specifications for race/ethnicity exchange
3. STU1 published August 2021
4. STU2 balloted in HL7 January 2022 Ballot Cycle; target June 2022 publication

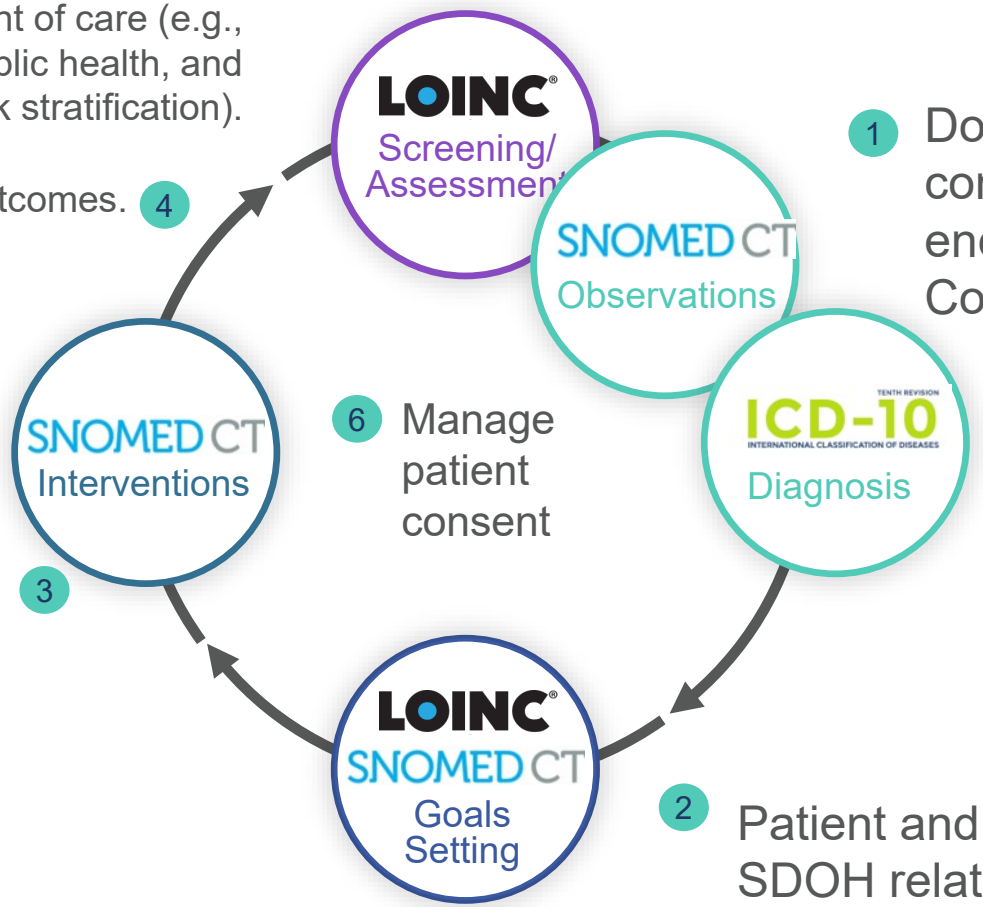


http://hl7.org/fhir/us/sdoh-clinicalcare/STU1/

Technical Workstream FHIR Implementation Guide Use Cases

5 Establish cohorts of patients with common SDOH characteristics for uses beyond the point of care (e.g., population health, quality reporting, public health, and risk adjustment/ risk stratification).

4 Measure outcomes.



1 Document SDOH data in conjunction with the patient encounter and define Health Concerns / Problems.

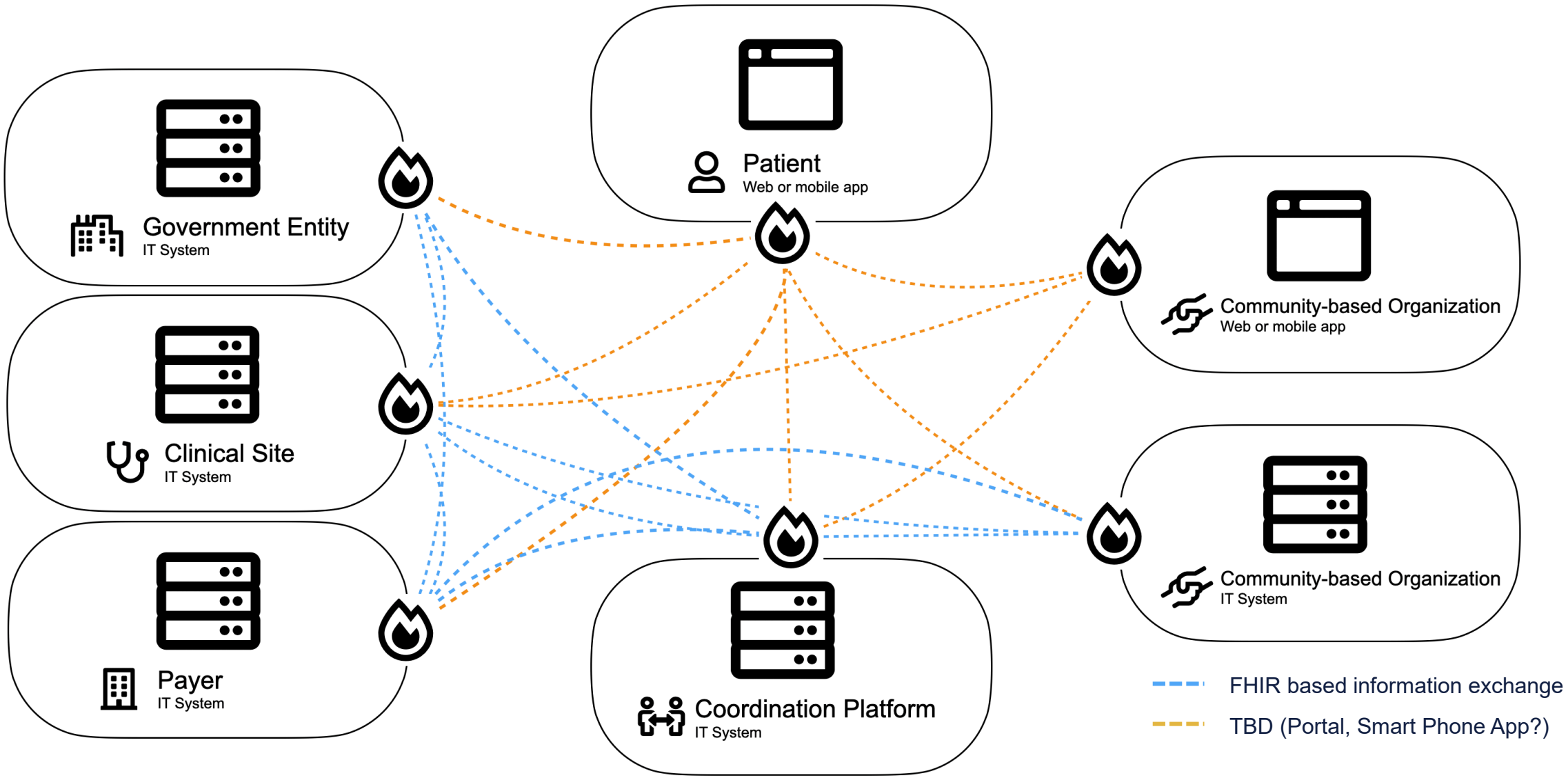
6 Manage patient consent

3 Plan, communicate, and track related interventions to completion.

2 Patient and provider establish SDOH related goals

http://hl7.org/fhir/us/sdoh-clinicalcare/STU1/

STU2: Many testable system interactions



Pilots Workstream

Call for Participation!

- We are currently seeking entities to participate in testing the Gravity defined coded concepts and/or the HL7 SDOH FHIR IG STU1 and/or STU2.
- We will be standing up a **Pilots Affinity Group** to convene participating sites via a monthly webinar.
- We are seeking entities that will serve in one or more of the following roles for testing:
  - **Referral Source** (system sending referral request).
  - **Care Coordination Platform** (system managing referrals and ensuring they are executed by appropriate service delivery organizations).
  - **Referral Recipient** (system receiving referral request and exposing FHIR restful services).
  - **Referral Recipient Light** (query for tasks on initiating Referral Source or Coordination Platform).
- Please submit your Pilot interest to gravityproject@emiadvisors.net

Success Factors

Success Factors—
Integration of Data Standards Into…

POLICY
(e.g., ONC USCDI, CMS Promoting Interoperability, State Medicaid Director Letters)

INNOVATION
New tools for capture, aggregation, analytics, and use.

PAYMENT MODELS
(e.g., CMMI SDOH Model)

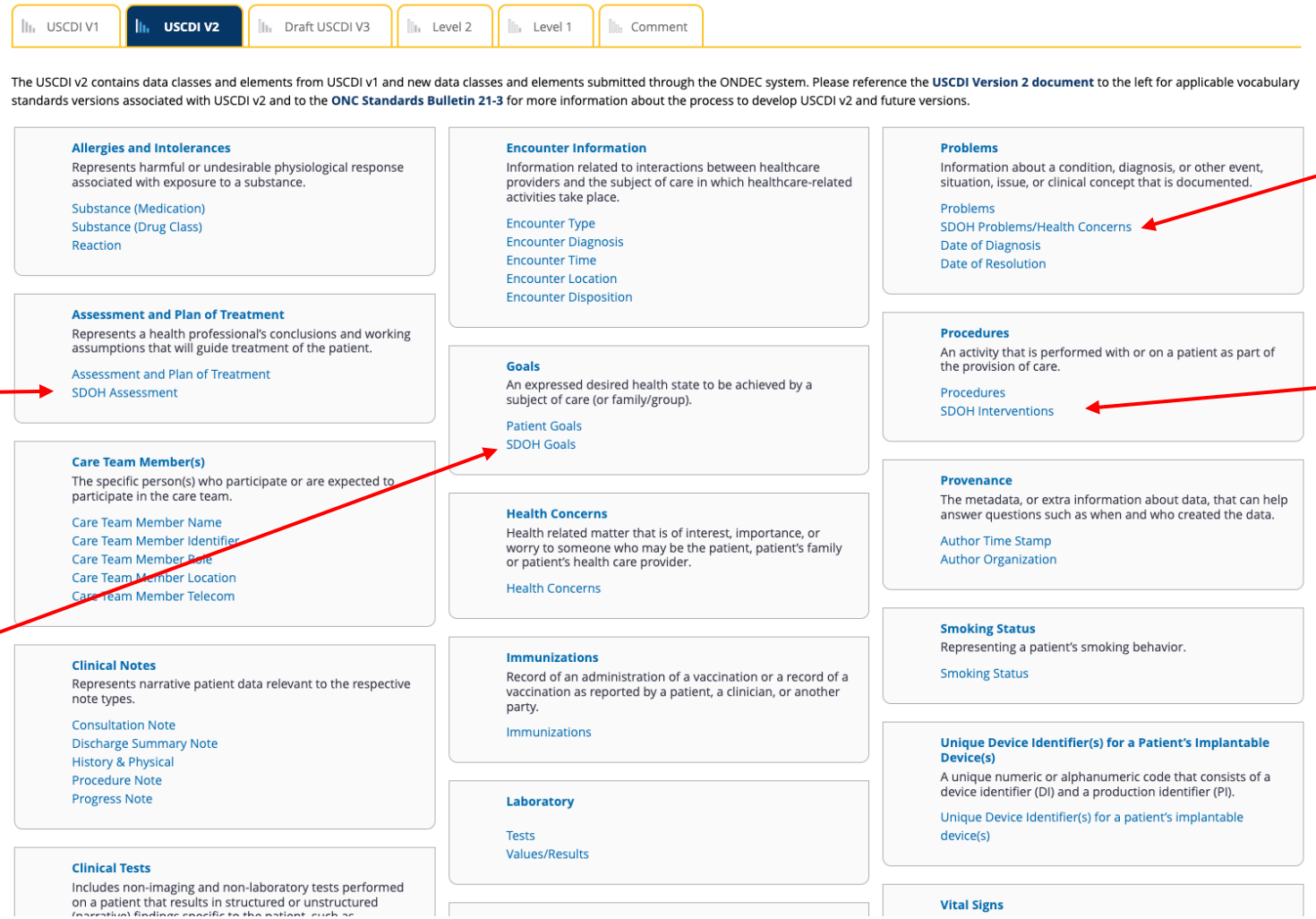
PRACTICE
(e.g., repeatable process for adoption, implementation, and use of SDOH data at practice level).

PROGRAMS
(e.g., Medicare Advantage, Medicaid Managed Care, Hospital QRRP, MIPS).

GRANTS
(e.g., ACL Challenge Grant, ONC Health IT LEAP)

OTHER STANDARDS
HL7 FHIR Accelerators (DaVinci, Argonaut, CARIN)

Policy Integration: Gravity USCDIv2 Submission



USCDI V1 | **USCDI V2** | Draft USCDI V3 | Level 2 | Level 1 | Comment

The USCDI v2 contains data classes and elements from USCDI v1 and new data classes and elements submitted through the ONDEC system. Please reference the **USCDI Version 2 document** to the left for applicable vocabulary standards versions associated with USCDI v2 and to the **ONC Standards Bulletin 21-3** for more information about the process to develop USCDI v2 and future versions.

Allergies and Intolerances
Represents harmful or undesirable physiological response associated with exposure to a substance.
- Substance (Medication)
- Substance (Drug Class)
- Reaction

Assessment and Plan of Treatment
Represents a health professional's conclusions and working assumptions that will guide treatment of the patient.
- Assessment and Plan of Treatment
- SDOH Assessment

Care Team Member(s)
The specific person(s) who participate or are expected to participate in the care team.
- Care Team Member Name
- Care Team Member Identifier
- Care Team Member Role
- Care Team Member Location
- Care Team Member Telecom

Clinical Notes
Represents narrative patient data relevant to the respective note types.
- Consultation Note
- Discharge Summary Note
- History & Physical
- Procedure Note
- Progress Note

Clinical Tests
Includes non-imaging and non-laboratory tests performed on a patient that results in structured or unstructured (narrative) findings specific to the patient, such as

Encounter Information
Information related to interactions between healthcare providers and the subject of care in which healthcare-related activities take place.
- Encounter Type
- Encounter Diagnosis
- Encounter Time
- Encounter Location
- Encounter Disposition

Goals
An expressed desired health state to be achieved by a subject of care (or family/group).
- Patient Goals
- SDOH Goals

Health Concerns
Health related matter that is of interest, importance, or worry to someone who may be the patient, patient's family or patient's health care provider.
- Health Concerns

Immunizations
Record of an administration of a vaccination or a record of a vaccination as reported by a patient, a clinician, or another party.
- Immunizations

Laboratory
- Tests
- Values/Results

Problems
Information about a condition, diagnosis, or other event, situation, issue, or clinical concept that is documented.
- Problems
- SDOH Problems/Health Concerns
- Date of Diagnosis
- Date of Resolution

Procedures
An activity that is performed with or on a patient as part of the provision of care.
- Procedures
- SDOH Interventions

Provenance
The metadata, or extra information about data, that can help answer questions such as when and who created the data.
- Author Time Stamp
- Author Organization

Smoking Status
Representing a patient's smoking behavior.
- Smoking Status

Unique Device Identifier(s) for a Patient's Implantable Device(s)
A unique numeric or alphanumeric code that consists of a device identifier (DI) and a production identifier (PI).
- Unique Device Identifier(s) for a patient's implantable device(s)

Vital Signs

SDOH Problems/ Health Concerns

SDOH Assessment

SDOH Interventions

SDOH Goals

https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi#uscdi-v2

Join the Gravity Project!

Learn More

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

- 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

- **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

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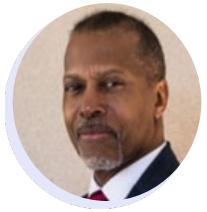

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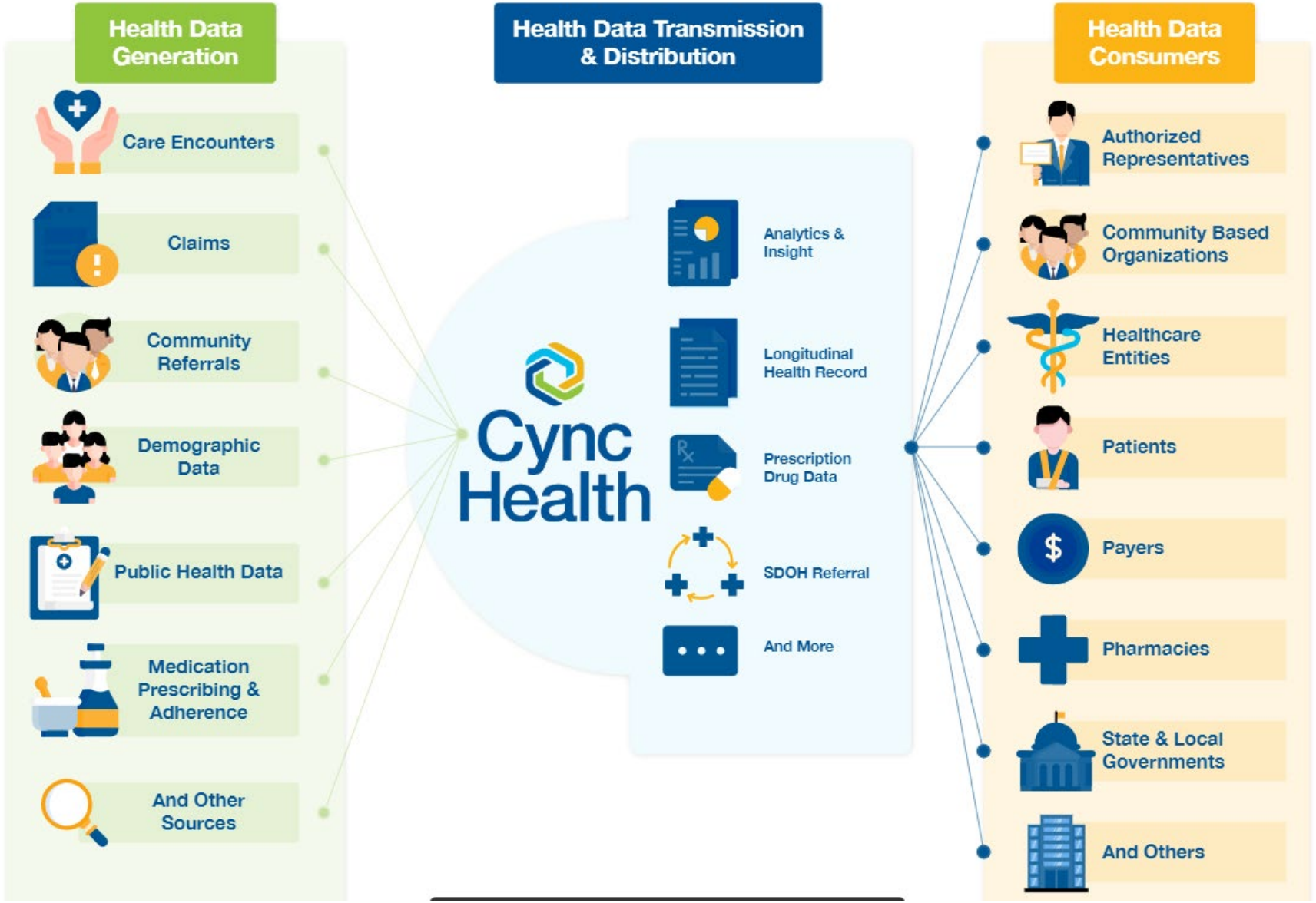
Additional questions? Contact: gravityproject@emiadvisors.net or visit https://thegravityproject.net

CyncHealth

Reflection

Technology is a solution; people are the impact



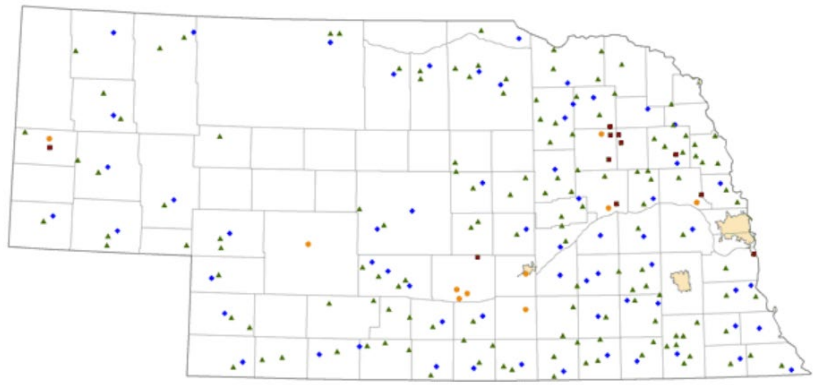
Community data points

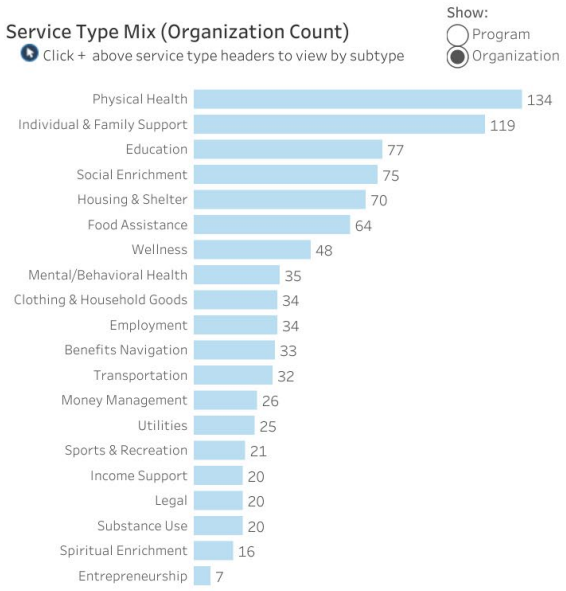
Cync Health

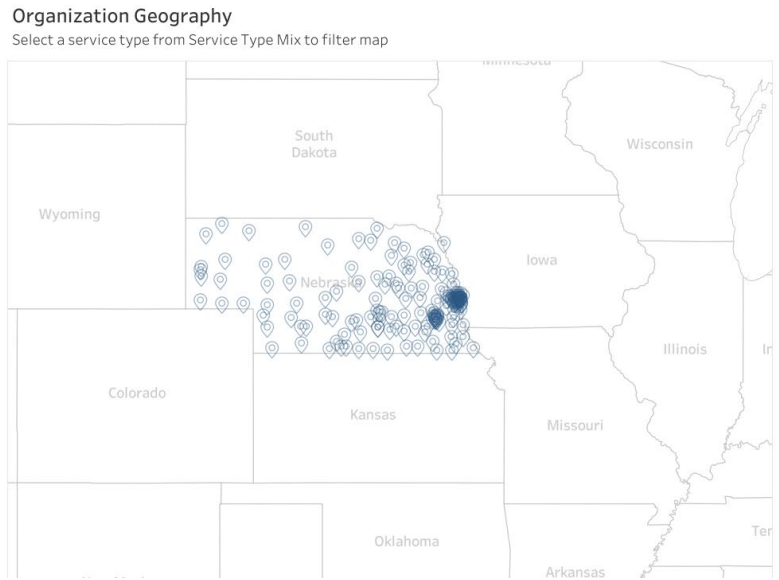
State of the State

Nebraska Rural Healthcare Facilities

63	138	11	10
Critical Access Hospitals	Rural Health Clinics	Federally Qualified Health Centers*	Short Term/PPS Hospitals*

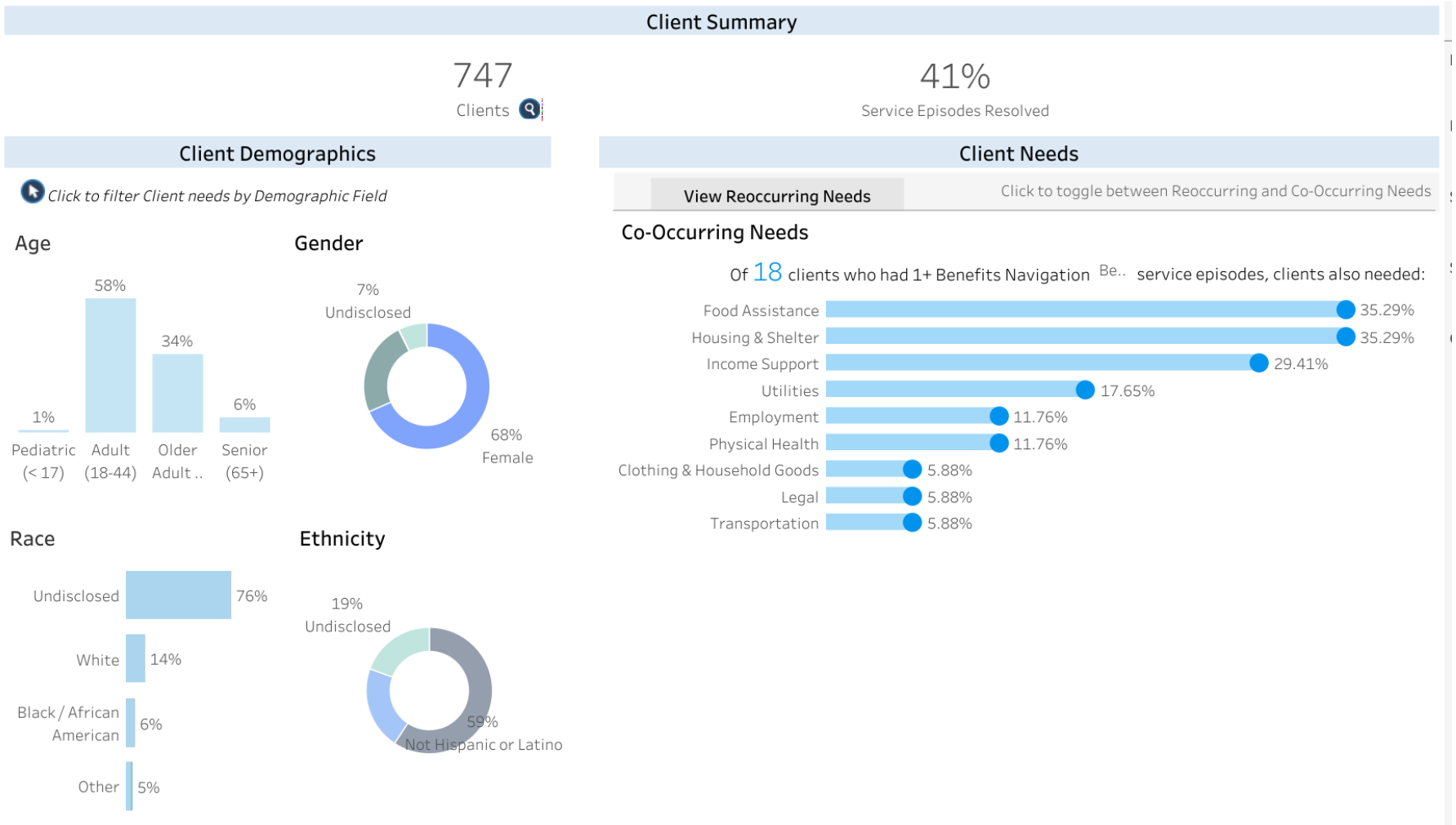






*Sites located outside of Urbanized Areas according to data.HRSA.gov. January 2022.

SDOH Demographics




CyncHealth
IOWA
CyncHealth
ADVISORS
CyncHealth
CyncHealth
FOUNDATION
Nebraska
Healthcare
Collaborative
powered by CyncHealth

Stakeholder Engagement

Cync Health

CyncHealth in Action

- Establishing real-time bidirectional connection with IIS file to establish longitudinal health record across disparate health data sources
- Regional data sharing can lead to better health outcomes and set the groundwork for further interstate data sharing
- CyncHealth as a trusted source of immunization information means LPHDs and the State has access to comprehensive data reducing the administrative burden of aggregation and analytics
- Race/ethnicity dashboards during all pandemics, not just COVID, or specific views for LPHDs based on local needs and concerns
- Tailored experience for public health departments vs. large aggregate views that blur the nuance of social factors
- Availability of comprehensive data for clinical decision making for providers

Cync Health

Policy Implications

- LB1183 introduced PDMP reporting provisions, and the subsequent Neb. Rev. Stat. §71-2454 furthered this by requiring all dispensed medications to be reported, including vaccinations
- Only PDMP in the country that collects this information, meaning CyncHealth as a trusted source of vaccination data has considerably more value
- Creation of the HIT Board allows for use of PDMP data for grants and research purposes, meaning the data collected can be used to improve lives, especially where SDOH is concerned

Cync Health

Technology is the solution; people make the difference.

- CyncHealth is building a social care ecosystem
- Closed loop referral system
- Coordination center with 2-1-1
- Longitudinal health record – HIE, PDMP and SDOH
- PRAPARE tool
- EMPI
- USCDI standards

Nebraska Healthcare Collaborative
powered by CyncHealth

What we are building….

- A social care network
- Data on social needs impact on health care utilization
- No wrong door to social care
- Leveraging community resources
- Stratification around community needs

Challenges	Opportunities
Legal challenges regarding data sharing, especially from the PDMP side can be hurdles in generating true data interoperability	The creation of the HIT Board and the policies enacted over the last decade (LB591, LB1183, and LB411) all help overcome this challenge
Competition – social determinants of health data has become envogue	Cross-sector partnerships (i.e., 211 and United Way) CyncHealth offers a long-term approach to support CBOs and health systems in the SDOH market
Lack of standards for implementation	Gravity Project
Each organization is taking a unique approach to SDOH Change management – a new way to address social care for health systems and communities	Asset-based approach Focus on community voice Innovation and creative solutions
Cross-community data sharing is specifically difficult	Regional data sharing becomes normalized with strong data governance

MiHIN

Social Care Data Exchange: The view from Michigan

Michael Taylor – MiHIN Senior Product Marketing Manager
Michael Klinkman, MD MS – MiHIN SDOH Medical Director

Michigan Health Information Network Shared Services (MiHIN)

MiHIN is Michigan's initiative to continuously improve healthcare quality, efficiency, and patient safety by promoting secure, electronic exchange of health information. MiHIN represents a growing network of public and private organizations working to overcome data sharing barriers, reduce costs, and ultimately advance the health of Michigan's population.

MiHIN is a

network for sharing health information statewide for Michigan

MiHIN's Vision for Social Care Data Exchange

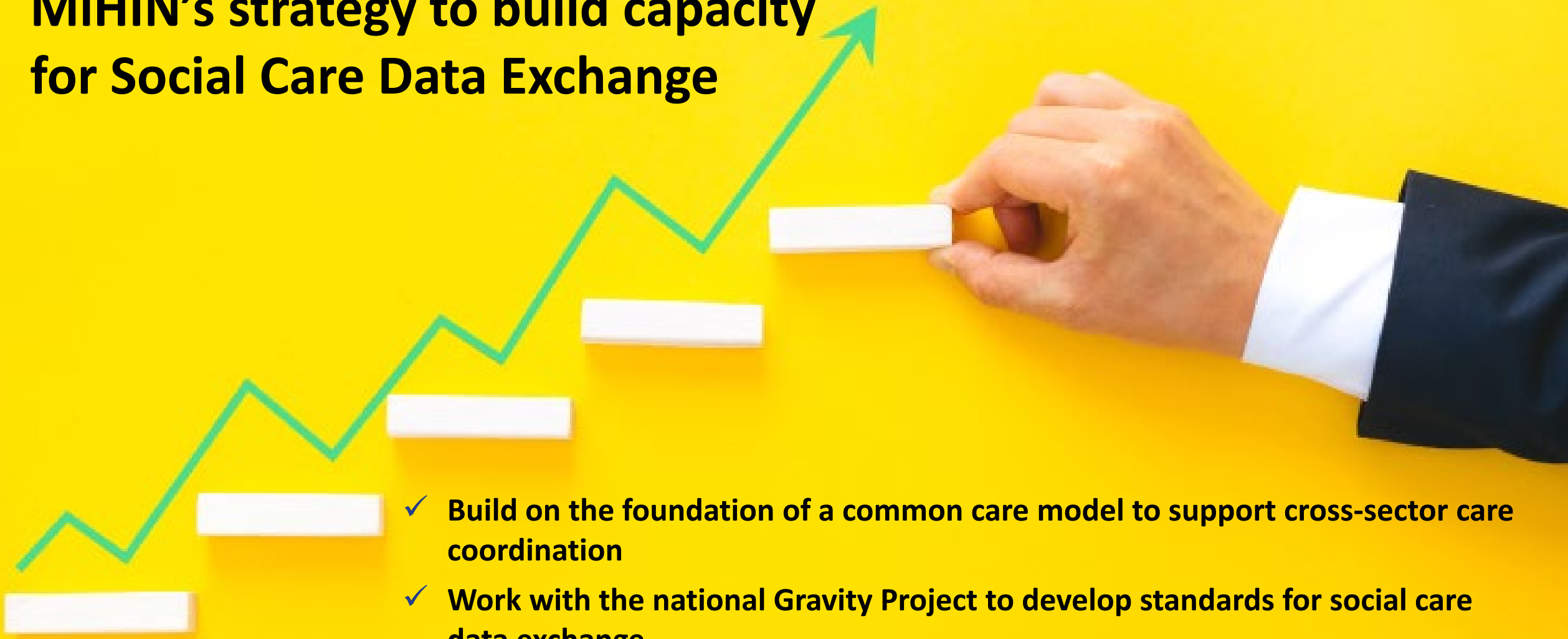
To enable the **collection and exchange of social care data at the point of care** for 2 purposes:

- ✓ To support cross-sector care coordination
- ✓ To provide comprehensive data for population health improvement

By developing and implementing **content and exchange standards** for :

- ✓ SDoH screening
- ✓ Social problems (social diagnoses)
- ✓ Social care interventions

MiHIN's strategy to build capacity for Social Care Data Exchange



- ✓ Build on the foundation of a common care model to support cross-sector care coordination
- ✓ Work with the national Gravity Project to develop standards for social care data exchange
- ✓ Use MiHIN's existing tools and services wherever possible
- ✓ Work with IT vendors willing to employ Gravity and MiHIN standards

MiHIN 'building blocks' to support cross-sector data exchange

Data type	Sector	MiHIN component	Notes
SDoH screening	All	**SDoH screening** [LOINC or domain Y/N]	SDOH screening use case v3
SDoH assessment	All	NONE	This content is local, not captured by standard
Social problems (diagnosis)	Medical care behavioral health care	**Social problem** [ICD-10-CM]	Work needed to establish valid and accurate coding
	Social services (CBOs)	**Social problem** [LA County/211 taxonomy]	Not in uniform use at present
Cross sector referrals	All	**Interoperable Referral message**	Will contain several data elements – ID, problem, sender, receiver, service requested/provided, status
Social care intervention(s)	Medical care	**Intervention/service** [CPT]	Can be embedded in IR message or separated for routing/reporting
	Social services (CBOs)	**Intervention/Service** [LA County/211 taxonomy]	Can be embedded in IR message or separated for routing/reporting
Text-based messaging	All	**Secure messaging** [Direct Secure??]	Enables all active care providers to communicate about patient/client

MiHIN MICHIGAN HEALTH INFORMATION NETWORK SHARED SERVICES

Current State

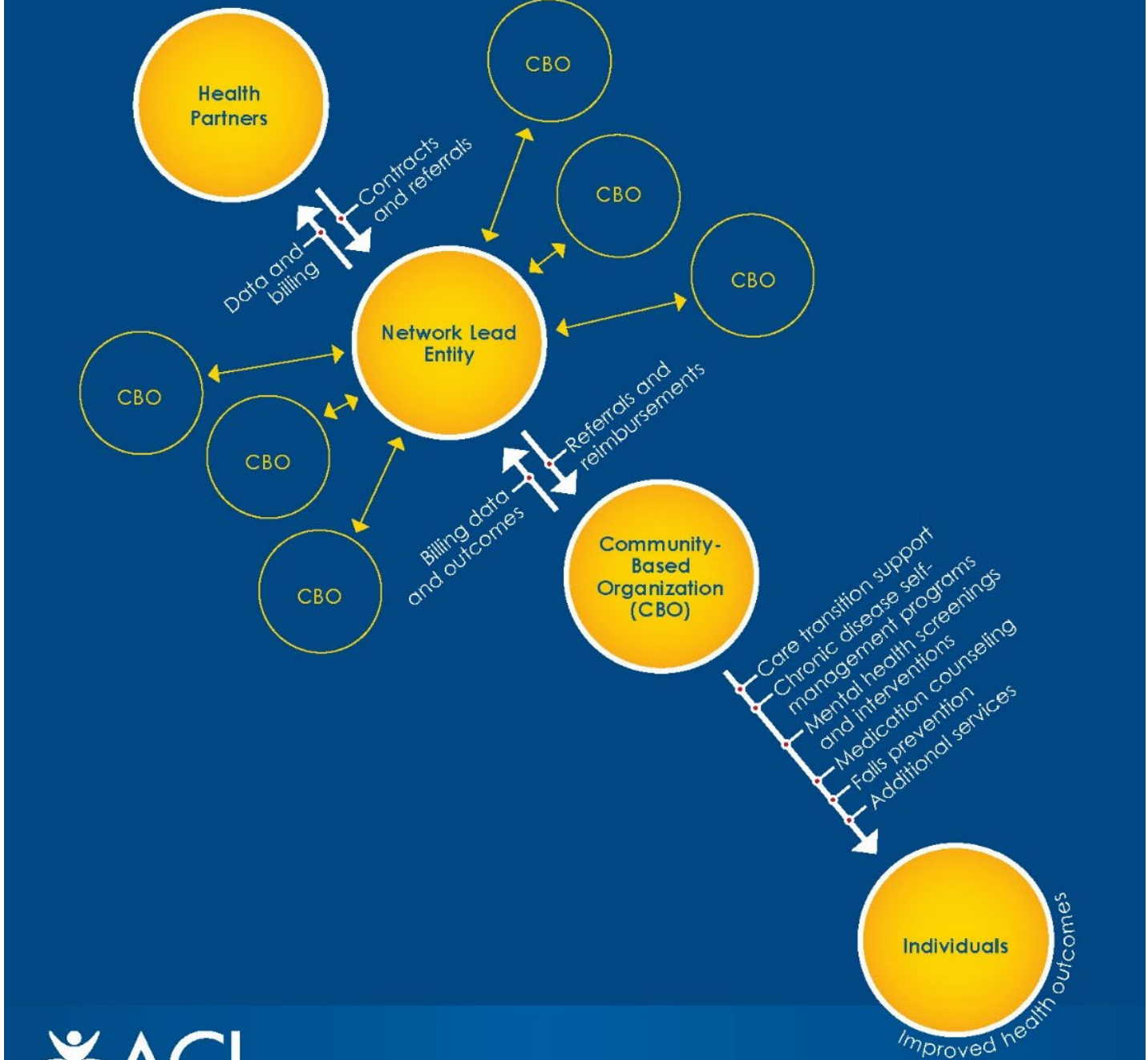
Cross-sector care initiatives in Michigan

Stakeholder alignment for implementation

- ✓ Michigan Department of Health and Human Services
- ✓ Medical care providers
- ✓ Community collaboratives (SIM CHIRs)
- ✓ Social service providers / CBOs
- ✓ Medical care payors (insurers)
- ✓ Local/regional/state/federal governments and agencies

- ✓ *Public health providers and officials*
- ✓ *Social services payors (multiple)*

Community Integrated Health Networks (CIHNs)



Source:

STRATEGIC FRAMEWORK FOR ACTION:
State Opportunities to Integrate Services and Improve Outcomes for Older Adults and People with Disabilities

Administration for Community Living

June 2020

ACL
Administration for Community Living

West Michigan Community Integrated Health Network

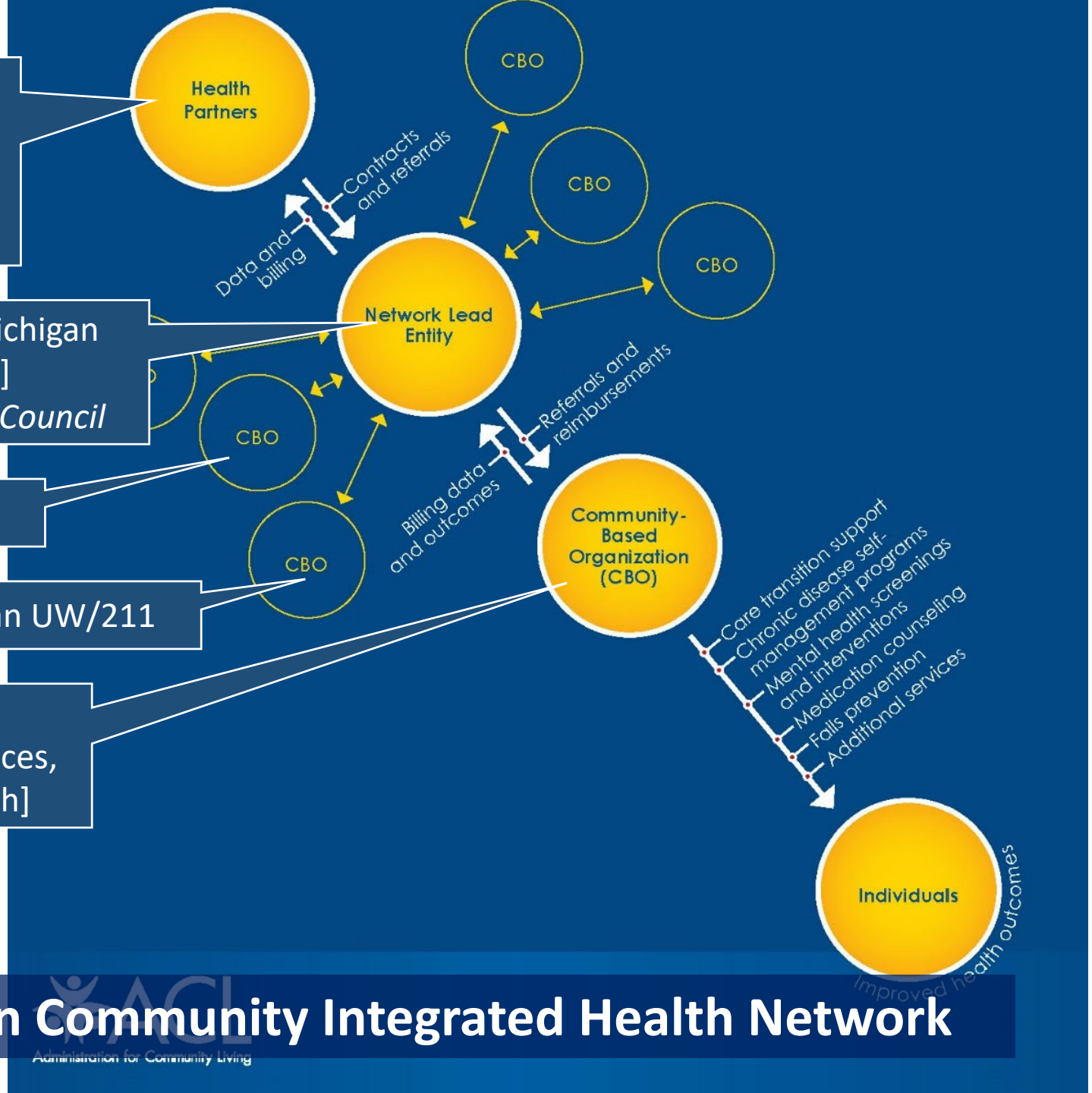
Spectrum Health
Mercy Health [Trinity]
Metro Health [U-M]
Convenor:MiCCSI

Health Net of West Michigan
[social care navigation]
+/- Population Health Council

Area Agency on Aging

Heart of West Michigan UW/211

GRACE Network
[homeless family services,
Pathways-like approach]

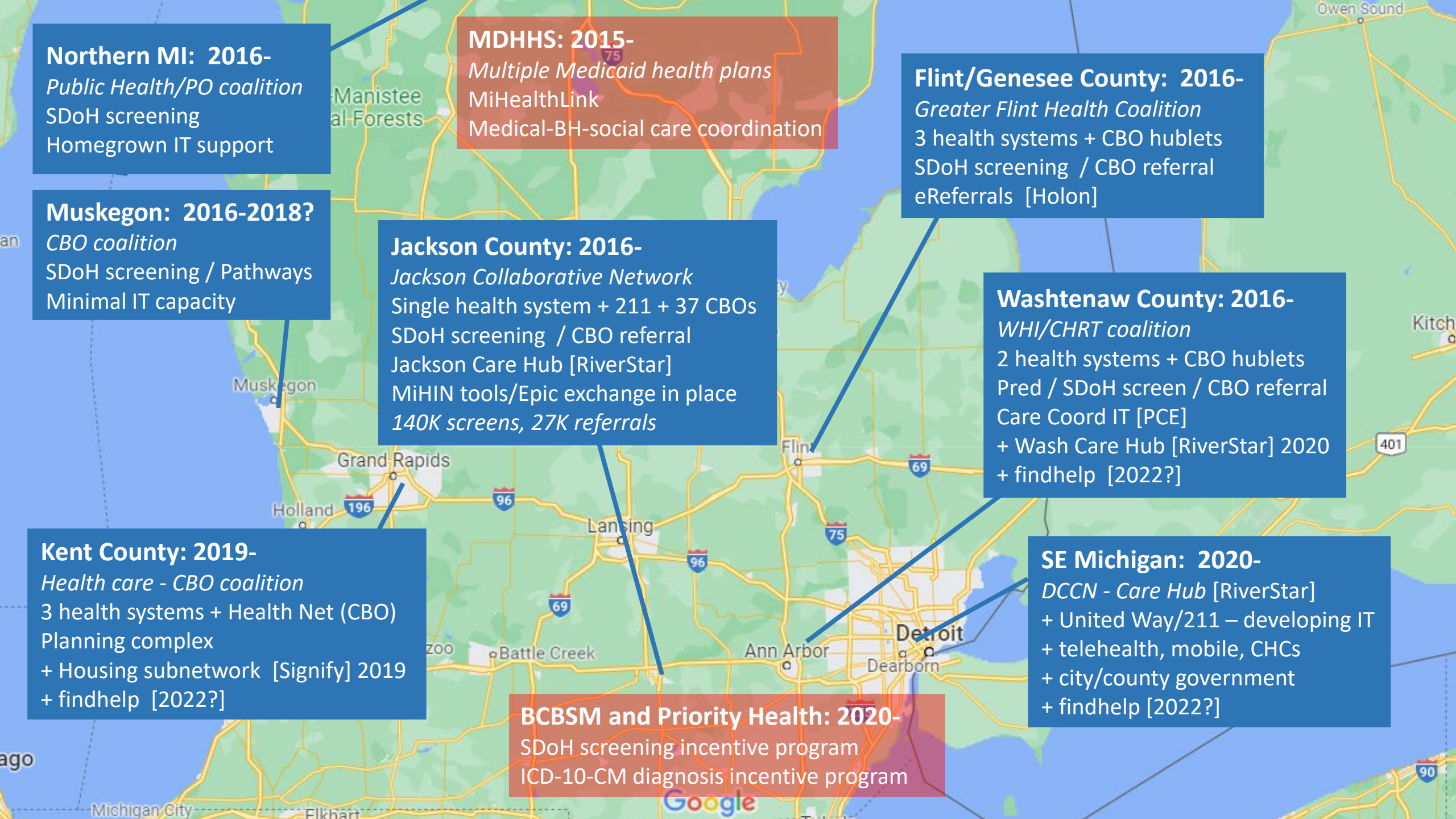


Current technology:

Epic [3 health systems]
findhelp
Signify Health
211 resource directory
TBD [Health Net]
Healthify [? CBOs]

Governance:
Still working out-
Steering Committee includes 3 health systems, Health Net, UW/211, Public Health, Payors (through MiCCSI)

Funding:
CMS – AHC [Health Net]
MHEF planning grant
CDC -Health Equity


Northern MI: 2016-
Public Health/PO coalition
SDoH screening
Homegrown IT support
MDHHS: 2015-
Multiple Medicaid health plans
MiHealthLink
Medical-BH-social care coordination
Flint/Genesee County: 2016-
Greater Flint Health Coalition
3 health systems + CBO hublets
SDoH screening / CBO referral
eReferrals [Holon]
Muskegon: 2016-2018?
CBO coalition
SDoH screening / Pathways
Minimal IT capacity
Jackson County: 2016-
Jackson Collaborative Network
Single health system + 211 + 37 CBOs
SDoH screening / CBO referral
Jackson Care Hub [RiverStar]
MiHIN tools/Epic exchange in place
140K screens, 27K referrals
Washtenaw County: 2016-
WHI/CHRT coalition
2 health systems + CBO hublets
Pred / SDoH screen / CBO referral
Care Coord IT [PCE]
+ Wash Care Hub [RiverStar] 2020
+ findhelp [2022?]
Kent County: 2019-
Health care - CBO coalition
3 health systems + Health Net (CBO)
Planning complex
+ Housing subnetwork [Signify] 2019
+ findhelp [2022?]
SE Michigan: 2020-
DCCN - Care Hub [RiverStar]
+ United Way/211 – developing IT
+ telehealth, mobile, CHCs
+ city/county government
+ findhelp [2022?]
BCBSM and Priority Health: 2020-
SDoH screening incentive program
ICD-10-CM diagnosis incentive program
Manistee
al Forests
Muskegon
Grand Rapids
Holland
Lansing
Flint
Battle Creek
Ann Arbor
Detroit
Dearborn
Owen Sound
Kitch
Michigan City
Elkhart
Google

Coordination Platform Vendors active in Michigan

findhelp

RIVERSTAR

hōlon

Healthify
powered by WellSky

NOW POW

CareAdvisors

pce Systems

signifyhealth

UNITE US

Key successes … and Challenges… in Michigan

- ✓ Active Multi-Payor SDoH Workgroup - incentives for SDoH data exchange
- ✓ Community engagement - co-design of clinical-community linkages in several communities
- ✓ MDHHS partnership – building capacity for SDoH data capture and exchange

- ✓ Establishing shared vision
- ✓ Maintaining multisector alignment
- ✓ Data governance and stewardship issues
  - ✓ *Who 'owns' SDOH data?*
  - ✓ *Is it HIPAA-protected?*
  - ✓ *Consent and sharing?*
- ✓ Solving value and reimbursement issues for social care sector

MiHIN MICHIGAN HEALTH INFORMATION NETWORK SHARED SERVICES

On the horizon…

Priorities for work in Michigan

Our next phase of work will be sociotechnical, not purely technical

Implementation will require broad multi-stakeholder alignment and agreement, very difficult to create and sustain - and a very different approach than standards development

Developing methods and tools to support a multiplatform/multivendor space

Most regions in Michigan already have multiple IT platforms in place – EHRs, CBOs, community referral platforms. We need to minimize disruption and expense to stakeholders, and we need to connect platforms through a Social Care Data Hub

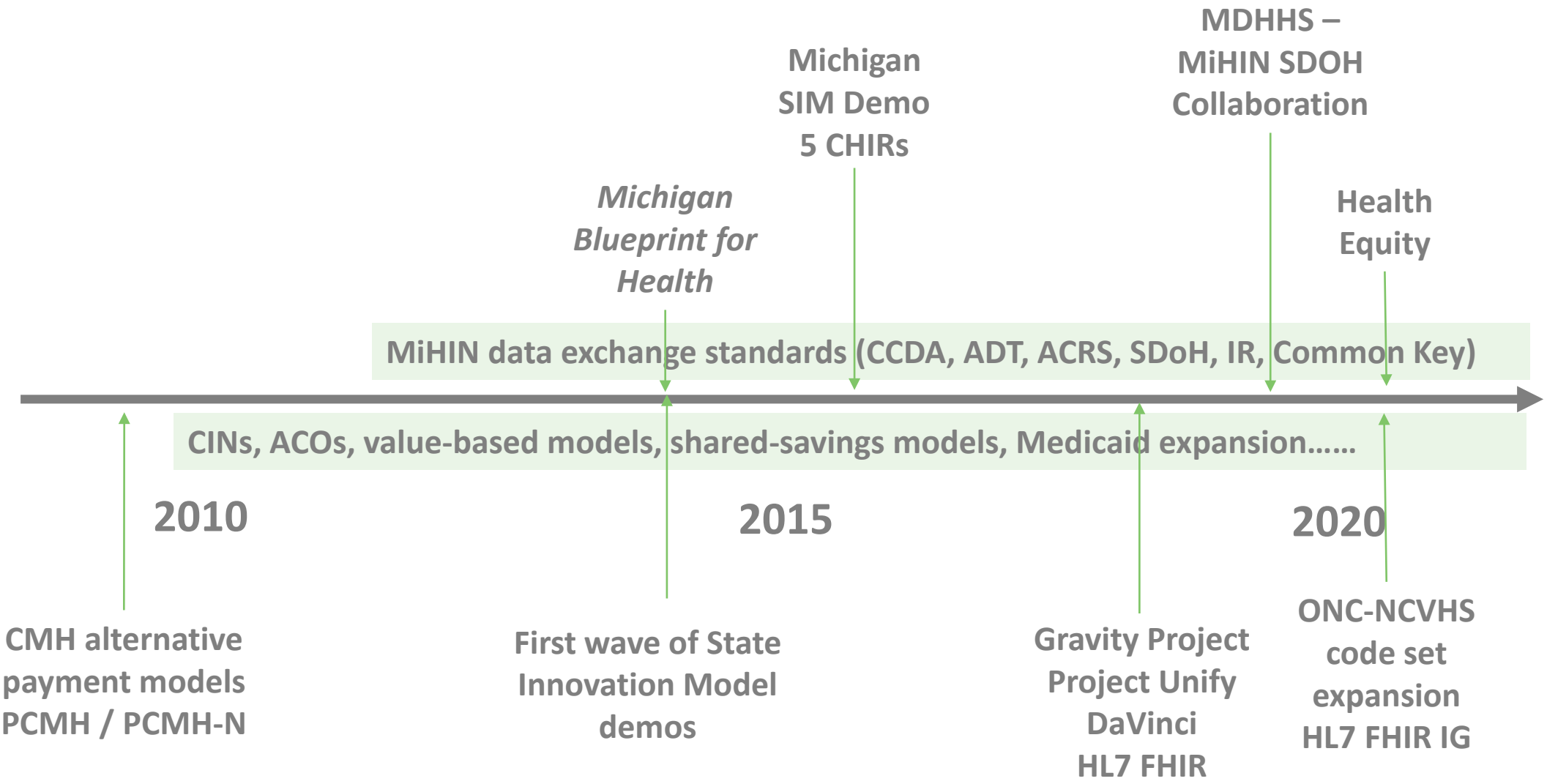
Addressing data governance and stewardship issues

What principles will guide consent and cross-sector data sharing? Who has the authority to create rules guiding use of social care data for direct care and second-level use?

Solving the ‘value proposition’ for the community

Why should community stakeholders invest time and scarce resources to support social care data exchange “just to solve the health care systems’ problems”?

Milestones in Michigan's SDoH journey



Thank you!

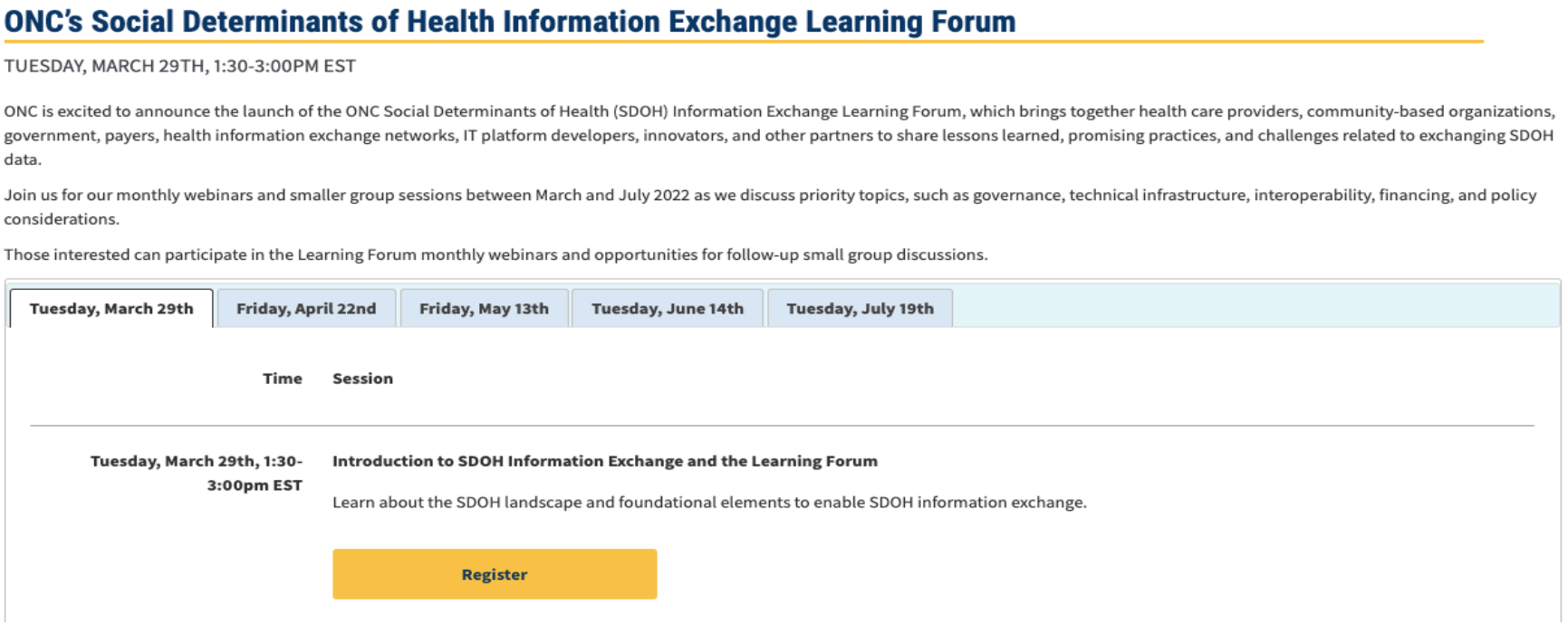
Discussion

Wrap-up

ONC SDOH Information Exchange Learning Forum

The ONC SDOH Information Exchange Learning Forum will be held March – July and consist of monthly webinars and small group learning sessions.

Register for webinars here: https://www.healthit.gov/news/events/oncs-social-determinants-health-information-exchange-learning-forum



ONC's Social Determinants of Health Information Exchange Learning Forum

TUESDAY, MARCH 29TH, 1:30-3:00PM EST

ONC is excited to announce the launch of the ONC Social Determinants of Health (SDOH) Information Exchange Learning Forum, which brings together health care providers, community-based organizations, government, payers, health information exchange networks, IT platform developers, innovators, and other partners to share lessons learned, promising practices, and challenges related to exchanging SDOH data.

Join us for our monthly webinars and smaller group sessions between March and July 2022 as we discuss priority topics, such as governance, technical infrastructure, interoperability, financing, and policy considerations.

Those interested can participate in the Learning Forum monthly webinars and opportunities for follow-up small group discussions.

Tuesday, March 29th | Friday, April 22nd | Friday, May 13th | Tuesday, June 14th | Tuesday, July 19th

Time	Session
Tuesday, March 29th, 1:30-3:00pm EST	**Introduction to SDOH Information Exchange and the Learning Forum** Learn about the SDOH landscape and foundational elements to enable SDOH information exchange. Register

Polling Question: After the ONC STAR HIE Program period of performance ends, would you like to voluntarily continue to meet regularly under the Health Equity Work Group to continue peer to peer learning and collaborative discussions on HIE approaches to addressing health equity and SDOH?

- Yes
- No
- Unsure

The Office of the National Coordinator for Health Information Technology

Contact ONC

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Health IT Feedback Form: https://www.healthit.gov/form/healthit-feedback-form

Twitter: @onc_healthIT

LinkedIn: Search "Office of the National Coordinator for Health Information Technology"

HealthIT.gov

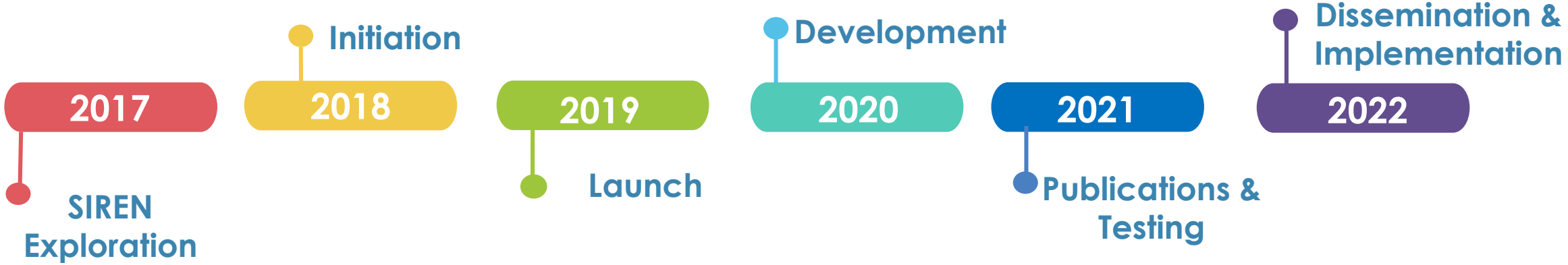
Subscribe to our weekly eblast at healthit.gov for the latest updates!

Appendix

The Gravity Project creates impact.

By working with early adopters and innovators to create a trusted problem-solving space focused on taking action to advance health equity.

Gravity Timeline

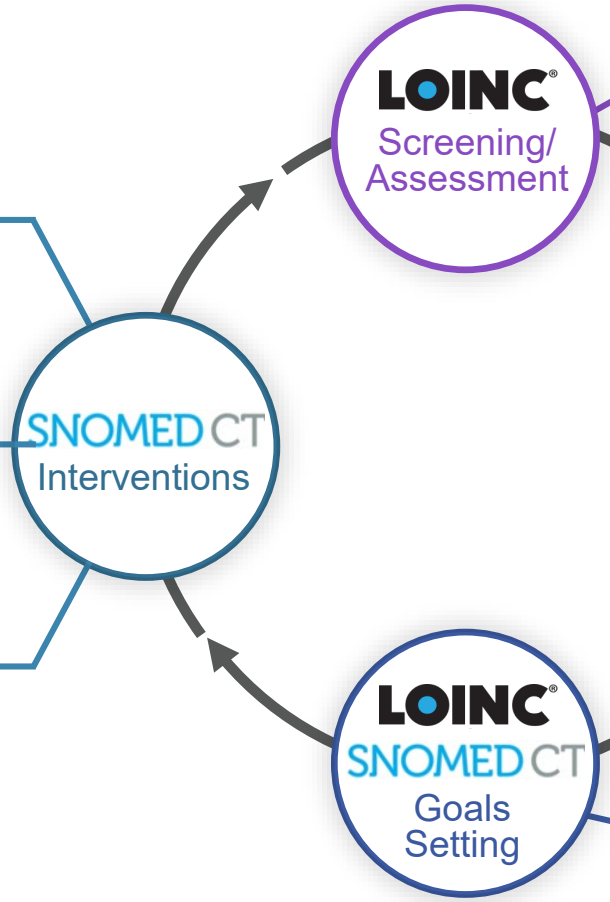


Project Founders, Grants, and In-Kind Support To-Date

PROVIDER	SOCIAL SERVICES	PAYER	TECHNOLOGY VENDOR	GOVERNMENT
AAFP	Children's HealthWatch	Humana	CyncHealth	The Office of the National Coordinator for Health Information Technology
Kaiser Permanente	Robert Wood Johnson Foundation	Kaiser Permanente	SAFFRON labs	CMS Centers for Medicare & Medicaid Services
Yale School of Nursing	sirenUCSF	Arkansas	ATA	ACL Administration for Community Living
Highmark	lyft	AmeriHealth Caritas	juxly	AHRQ
The University of Vermont Larner College of Medicine	Academy of Nutrition and Dietetics	BlueCross BlueShield Association	Interoperability Institute	CDC
California Health Care Foundation	CTCA	NC	find help.org	
AMA		blue california		
		UnitedHealthcare		
		Highmark		
		GuideWell		
		Idaho		
			ontada	

https://confluence.hl7.org/display/GRAV/Gravity+Project+Sponsors

Food Insecurity Terminology Build



Q. Within the past 12 months we worried whether our food would run out before we got money to buy more. **LOINC 88122-7**

A. Often true, Sometimes true, Never true, don't know/refused. **LOINC LL4730-9**

Food Insecurity Observation: Food Insecurity **SNOMED 733423003**

Food Insecurity Diagnoses ICD-10-CM: Food Insecurity **Z59.42 ***

Food Security, Has adequate number of meals and snacks daily, Has adequate quality meals and snacks*

PROCEDURE: Education about Child and Adult Food Program **SNOMED 464201000124103**

PROCEDURE: Provision of food voucher **SNOMED 464411000124104**

REFERRAL: Referral to Community Health Worker **SNOMED 464131000124100**

*Proposed. Not final.

Interventions Framework

Gravity Term	Definitions
Assistance/Assisting	To give support or aid to; help
Coaching	Method of instruction, direction, or promoting that can include demonstration, reinforcement, motivation and feedback to improve performance, or achieve a specified goal.
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.)

FOOD INSECURITY FOOD DESERTS

Applicable Intervention Codes for Older American Act (OAA) Nutrition Programs

Intervention	SNOMED-CT Code/ Data Element
Assistance/ Assisting	467801000124106: Assistance with application for Community meal Program 467731000124106: Assistance with application for Home-Delivered meals Program
Education	464351000124105: Education about Congregate Meal Program 464211000124100: Education about Community Meals Program 464261000124102: Education about home-delivered meals program 464341000124108: Education about Senior Farmers' Market Nutrition Program
Evaluation of eligibility	467661000124106: Evaluation of eligibility for Community Meal Program 464621000124105: Evaluation of eligibility for home-delivered meals program
Provision	464421000124107: Provision of home-delivered meals 464431000124105: Provision of medically tailored meals
Referral	464151000124107: Referral to Congregate Meal Program 464081000124100: Referral to home-delivered meals program 464091000124102: Referral to medically tailored meal program 464171000124102: Referral to Senior Farmers' Market Nutrition Program

https://www.nlm.nih.gov/healthit/snomedct/us_edition.html

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

Program Integration: CMS Medicare Advantage Proposed Rule

- On January 12, 2022, CMS published proposed policy and technical changes for **Medicare Advantage** in 2023.
- Proposes MA Special Needs Plans (SNPs) include standardized questions on **housing stability, food security, and access to transportation** as part of their currently required health risk assessments.
  - CMS intends to **align the required standardized questions with the SDOH Assessment data element** integrated in **USCDI v2!**
- Additional issues for comment:
  - Should CMS include other domains besides food, housing, and transportation, such as health literacy or social isolation?
- **Comments due March 7, 2022.**

Program Integration: CMS State Health Official Letter

On January 7th, 2021, CMS released guidance for states on opportunities under Medicaid and CHIP to address SDOH.

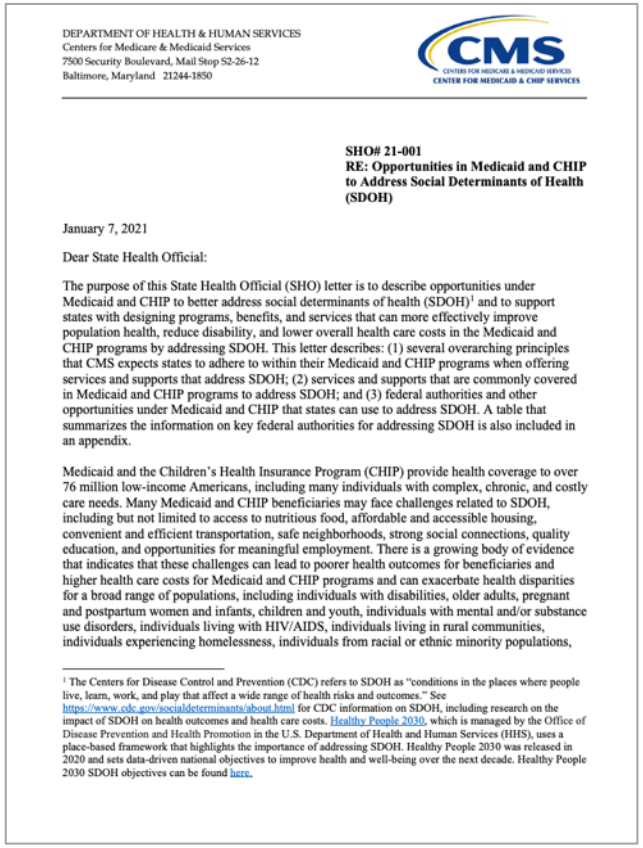
The guidance acknowledges that states can leverage Medicaid resources to support data integration and data sharing to assist state health systems to identify individuals with SDOH needs and link them to appropriate medical and social supports.

States are required to design technical infrastructure for Mechanized Claims Processing, Information Retrieval Systems, and care coordination hubs that are **interoperable** with human services programs, HIEs, and public health agencies, as applicable.

States must ensure alignment of the claims processing and IRS systems with CEHRT.

States are encouraged to review ISA SDOH standards and review and participate in the Gravity Project.

https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SHO# 21-001
RE: Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH)

January 7, 2021

Dear State Health Official:

The purpose of this State Health Official (SHO) letter is to describe opportunities under Medicaid and CHIP to better address social determinants of health (SDOH)[1] and to support states with designing programs, benefits, and services that can more effectively improve population health, reduce disability, and lower overall health care costs in the Medicaid and CHIP programs by addressing SDOH. This letter describes: (1) several overarching principles that CMS expects states to adhere to within their Medicaid and CHIP programs when offering services and supports that address SDOH; (2) services and supports that are commonly covered in Medicaid and CHIP programs to address SDOH; and (3) federal authorities and other opportunities under Medicaid and CHIP that states can use to address SDOH. A table that summarizes the information on key federal authorities for addressing SDOH is also included in an appendix.

Medicaid and the Children's Health Insurance Program (CHIP) provide health coverage to over 76 million low-income Americans, including many individuals with complex, chronic, and costly care needs. Many Medicaid and CHIP beneficiaries may face challenges related to SDOH, including but not limited to access to nutritious food, affordable and accessible housing, convenient and efficient transportation, safe neighborhoods, strong social connections, quality education, and opportunities for meaningful employment. There is a growing body of evidence that indicates that these challenges can lead to poorer health outcomes for beneficiaries and higher health care costs for Medicaid and CHIP programs and can exacerbate health disparities for a broad range of populations, including individuals with disabilities, older adults, pregnant and postpartum women and infants, children and youth, individuals with mental and/or substance use disorders, individuals living with HIV/AIDS, individuals living in rural communities, individuals experiencing homelessness, individuals from racial or ethnic minority populations,

[1] The Centers for Disease Control and Prevention (CDC) refers to SDOH as "conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes." See https://www.cdc.gov/socialdeterminants/about.html for CDC information on SDOH, including research on the impact of SDOH on health outcomes and health care costs. Healthy People 2030, which is managed by the Office of Disease Prevention and Health Promotion in the U.S. Department of Health and Human Services (HHS), uses a place-based framework that highlights the importance of addressing SDOH. Healthy People 2030 was released in 2020 and sets data-driven national objectives to improve health and well-being over the next decade. Healthy People 2030 SDOH objectives can be found here.

Grant Integration (Federal)

- **Administration for Community Living (ACL) Social Care Challenge Grant:** Requires awardees to use of Gravity defined data elements. https://acl.gov/programs/acl-announces-social-care-referrals-challenge-phase-1-awardees
- **ONC Leading Edge Acceleration Projects (LEAP)** in Health IT Notice of Funding Opportunity: Referral Management to Address Social Determinants of Health Aligned with Clinical Care https://www.healthit.gov/topic/onc-funding-opportunities/leading-edge-acceleration-projects-leap-health-information
- **Administration for Children and Families (ACF) Human Services Interoperability Innovations Grant:** Promotes the use of HL7 FHIR specification and standards for SDOH data capture and exchange as defined by the Gravity Project. https://www.grants.gov/web/grants/view-opportunity.html?oppId=329037

Promoting Interoperability at State/Local Level

- Incorporate terminology and data exchange standards in **payment contracts and reporting requirements**
- Provide specific **technical guidance** for a provider to use in their procurement specifications
- **Embed incentives** for adopting technology capable of sharing standards based SDOH information
- Form **health IT procurement "commons"—**participate in building shared, national resources for procurement specifications, interoperability and data-sharing quality measurement, testing and certification of plug and play technologies, and recognize common standards and architecture
- **Finance testing and piloting** of the terminology and data exchange standards with data sharing partners

Pronovost, P., M.M. E. John, S. Palmer, R.C. Bono et al. *Procuring Interoperability: Achieving High-Quality, Connected, and Person-Centered Care*. Washington, DC: National Academy of Medicine. www.nam.edu/interoperability