Data Collection & Sharing

Social Determinants of Health (SDOH): Social Needs Screening & Referral Measure

May 2, 2023

Oregon Health Authority

ORPRN
Oregon Rural Practice-Based Research Network

OHSU

Upcoming Technical Assistance (TA) Opportunities

Webinar Series

- **OHA measure specifications**
- **Best practices** for developing screening, referral, and data sharing policies and procedures
- **Presentations from experts** in the field

For all CCO staff and community partners who may be directly or indirectly involved in implementing the Social Needs Screening and Referral Metric

Learning Collaboratives

- Identify and support **collaboration and alignment** in implementing the SDOH metric
- Next Learning Collaborative on May 9, 2023
- **Data Collection & Sharing**

For one to three representatives from each CCO most directly involved in metric implementation.

Follow-Up Fridays

- CCO drop-in session for **additional Q&A** and **opportunity to learn** from each other.
- Next Follow-Up Friday on May 26, 2023
- **Data Collection & Sharing**

For one to three representatives from each CCO most directly involved in metric implementation.

Individualized Technical Assistance

- One-on-one technical assistance is available to all CCO staff responsible for metric implementation
- Support tailored to the needs of individual CCOs

Review - Measure Year 2023 Specifications

A. Screening practices	
Collaborate with CCO members on processes and policies	Must pass
Establish written policies on training	Must pass
Assess whether/where members are screened	Must pass
Establish written policies to use REALD data to inform appropriate screening and referrals	Must pass
Identify screening tools or screening questions in use	Must pass
Establish written protocols to prevent over-screening	Must pass
B. Referral practices and resources	
Assess capacity of referral resources and gap areas	Must pass
Enter into agreement with at least one CBO that provides services in each of the 3 domains	Must pass
C. Data collection and sharing	
Conduct environmental scan of data systems used in your service area	Must pass

Agenda for Today's Webinar on Data Collection & Sharing

- Introduction
- Data collection & sharing must-pass elements
- OCHIN & The Gravity Project
- Q&A with OCHIN & The Gravity Project
- Upcoming TA opportunities

Measure Year 2023 Specifications: Data Collection & Sharing

13) Conduct an environmental scan of data systems used in your service area

To meet this element, CCOs will:

- Systematically review how any social needs screening and referral data are captured and/or exchanged at (1) the provider organizations listed in the CCO's DSN table and (2) any Community Based Organizations (CBO) with whom the CCO has contracts for addressing the three social needs domains (food, housing, or transportation needs). This review must identify any standardized codes being used to capture data about screening and referrals.

The intent of this element is for CCOs to understand how social needs screening and referral data are collected and exchanged so they can promote effective data-sharing practices.

Example of activities meeting this element:	**Example of activity *not* meeting this element:**
• The CCO conducts a survey (may be part of the same survey as Element 3, assess whether and where screenings are occurring) of provider organizations and CBOs during the measurement year and asks about data systems used for social needs screening and referral.	• The CCO collects information on what data systems are used by providers and CBOs without identifying data collection and data exchange processes.

Questions?

Introduction: OCHIN & The Gravity Project

Ned Mossman, MPH, (he/him)
OCHIN

Sarah DeSilvey, (DNP, FNP-C) (she/her)
The Gravity Project

Measuring Social Needs Assessment and Referral

A Data Driven Approach

May 2, 2023

Ned Mossman, MPH
Director, Social and Community Health

OCHIN

A driving force for health equity

OCHIN

A national network dedicated to advancing equity

Technology

6 Million
active patients across

2,000
health care delivery sites with

25,000
providers in

49
states with

1.75 Million
social needs screenings documented in the EHR

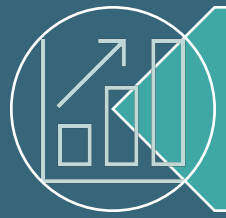
Research

Support Services

- Federally Qualified Health Centers
- Critical Access Hospitals and Rural Health Clinics
- School-based Clinics
- Correctional Facilities
- Behavioral Health Providers
- Dental Clinics
- Public Health Departments
- HIV/AIDS Care Organizations

Reasons to Collect and Integrate Social Needs Data

Provide users with point of care **context about patients' lives** and situations and the opportunity to work upstream to affect health



Population health management - high leverage activities for **targeted subpopulations**

Understanding areas of **need in the clinic and the community** for policy, advocacy, and resource allocation

Risk stratification and payment adjustment – more **complex patients** require more resources

See NASEM (2019): Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health
https://nap.nationalacademies.org/read/25467/chapter/4

Learning from the Collaborative: Member Experience

Diverse clinic membership = diverse workflows

- Proliferation of screening tools
- *Team roles and timing in visit for screening and entering data varies widely*
- Variation in outreach staffing – some clinics have CHWs/Promotores, Care Managers, Outreach Specialists

OCHIN is not prescriptive

- We encourage member organizations to screen for the SDOH domains that make the most sense for their patients, practice and community
- We are learning from members and with members
- Seeking to build library of emerging best practices

Learning from the Collaborative: SDOH Research

Key takeaways from almost 10 years of OCHIN research:

- At the clinic level, **adaptability** is key to implementing SDOH screening and action
- Other Success Factors:
  - External motivators, such as *grant or reimbursement requirements*, or encouragement from professional associations
  - Presence of a strong SDH screening *champion or advocate*
  - Clinics that *start small with a target population then scale up*

HITEQ cites three "**S**" qualities data must have to be ***actionable*** and ***interoperable***

Structured

- Is the data stored in consistent, organized, easily-queried (i.e., not free-text) fields?

Standardized

- Are the questions, answers, screeners and tools used to collect data consistent across systems?
- Are codesets or mappings used to represent the data documented and available?

Systematically Collected

- Are only a particular subset of patients consistently screened?
- Are there distinct clinic or organizational factors like specialties (e.g., pediatrics, behavioral health), grants (e.g., HRSA 330c vs. 330h), payor mix, staffing, etc.?

See: http://hiteqcenter.org/DesktopModules/EasyDNNNews/DocumentDownload.ashx?portalid=0&moduleid=952&articleid=330&documentid=214

Examples of Structuring Social Needs and Referral Data

- Ensuring responses that *indicate an identified need* (i.e., "positive" answers) are flagged
- Ensuring *declined* answers not included in denominators
- Linking SDOH referrals to an identified need/problem/concern
- Including SDOH domains from pre-set list in question/tool definitions
  - Consider granularity (e.g., housing instability, housing quality, homeless status)
- Avoiding free text responses unless required or as supplemental context

	LINE_COUNT	FLT_KEY	FLO_MEAS_ID	COMPARE	VALUES	MAPPED_VAL	DECLINED_VALS	FLO_MEAS_NAME	DISP_NAME
13	13	FOOD-12	11405	=	Yes	2	DECLINED	R OCHIN HP FOOD INSECURITY	In the past year, did you ever eat less than you
14	14	FOOD-2	3495	>	0	2	DECLINED	R SDH FOOD WORRY MONEY TO GET MORE	Within the past 12 months, the food you bough
15	15	FOOD-3	6567	>	0	2	DECLINED	R BHN SDH FOOD WORRY MONEY TO GET MORE	Within the past 12 months, the food you bough
16	16	FOOD-4	6569	>	0	2	DECLINED	R BHN SDH FOOD WORRY RUNNING OUT	Within the past 12 months, you worried whethe
17	17	FOOD-5	1993	=	Often|Sometimes	2	Don't Know	R FOOD INSECURITY Q1	Did you worry that your household would run o
18	18	FOOD-6	1995	=	Often|Sometimes	2	Don't Know	R FOOD INSECURITY Q2	Did your household run out of food before you
19	19	FOOD-7	2255	=	Yes	2	DECLINED	R SDOH QD1: HARD TO PAY FOR: FOOD	Hard to pay for: Food

Standardization – Successes

HL7 Gravity Project

- Successful updates to ICD-10-CM Diagnosis “Z-codes”
- SNOMED/LOINC mapping updates and cataloging
- Recognized SDOH Steward for NIH Value Set Authority Center (VSAC)
- Completed (STU2+) FHIR IG for interoperability of SDOH data

SDOH Concept Recommendations incorporated in USCDI v2-3 by ONC

- Includes Assessment, Goals, Problems/Concerns

Standardization – Ongoing Challenges

- Proliferation of screening tools/questionnaires*
- Lack of Progress on CPT/HCPCS Procedure Coding
- Outcomes left out of USCDI SDOH concepts
- Inclusion/exclusion/priority of domains
- Capacity, capability, and infrastructure of CBOs is widely varied

*In February 2023, CMS posted a list of approved screening tools for housing, food, and transportation in Medicare Advantage SNP health risk assessments.
See: https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing/cms-10825

Systematic Collection – Measurement and Accountability

Current Nationwide Measurement Examples – Assessment and Identified Needs

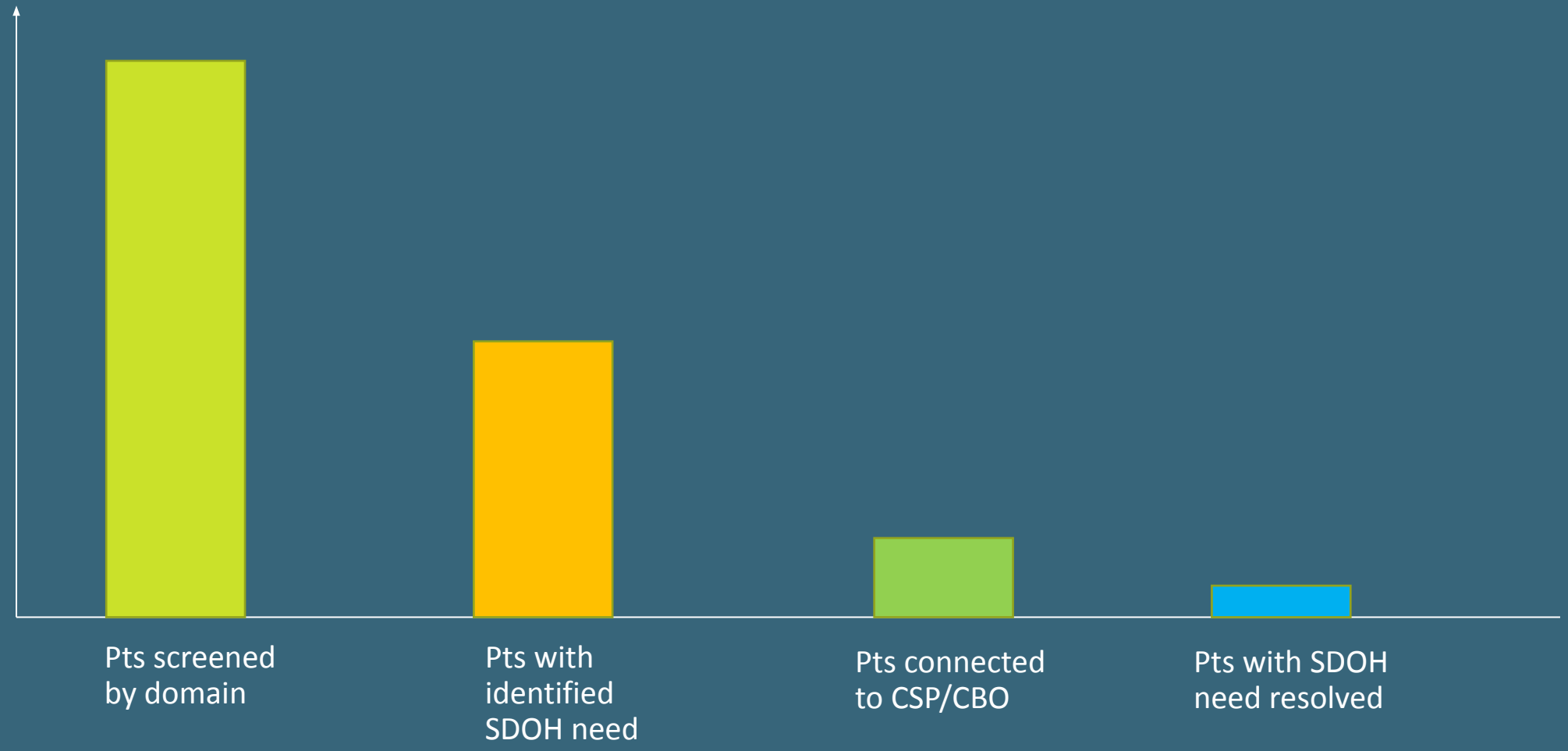
Measurement Program	HEDIS (NCQA)	Joint Commission	Inpatient Quality Reporting (CMS)	Outpatient MIPS (CMS)
Domains	Food Housing Transportation	Food Housing Transportation Medical Costs Education	Food Housing Transportation Utilities Interpersonal safety	Food Housing Transportation Utilities Interpersonal safety
Population	All health plan members	Identified in all patients or via a sample	Patients 18 years or older admitted to hospital	Patients 18 years or older in a MIPS eligible provider practice
Measure 1	% of members screened at least once for the 3 domains	6 new Elements of Performance related to health disparities, including **assessment of HRSNs**	% of admitted patients screened for all 5 domains	% of patients screened for all 5 domains
Measure 2	% of members with an identified need for one of the 3 domains who received an intervention within 30 days (per domain)		% of admitted patients screened for all 5 domains who had an identified need (per domain)	% of patients screened for all 5 domains who had an identified need (per domain)

Systematic Collection – Measuring Beyond Assessment

2024 Proposed CMS MIPS Measures*	
Connection to Community Service Provider (CSP)	% of beneficiaries ≥18 years reporting they had contact with a CSP for at least 1 of their HRSNs (food insecurity, housing instability, transportation problems, utility help needs, or interpersonal safety) **within 30 days after screening** (annually)
Resolution of At Least 1 Health-Related Social Need (HRSN)	% of beneficiaries ≥18 years reporting that at least 1 of their HRSNs (food insecurity, housing instability, transportation problems, utility help needs, or interpersonal safety) was **resolved within 6 months** after screening (annually)

**Currently in CMS rulemaking process*

Cascade of SDOH Metrics – Process and Outcomes



SDOH Payment Initiatives

- 1115 Waivers

- Other initiatives:
  - CA Enhanced Care Management payment (CalAIM ECM and ILOS) https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx
  - Proposed CA SDOH Bill AB85 – would require health plans to reimburse for screening and referrals based on social needs as of 1/1/2024 https://legiscan.com/gaits/citation/560427

Thank You

OCHIN

A driving force for health equity

www.ochin.org

Gravity Project

Consensus-driven Data Standards for the Social Determinants of Health

Oregon Rural Practice-based Research Network (ORPRN) at OHSU

May 2nd, 2023

Sarah C DeSilvey, DNP, FNP-C, (she/her)
Director of Terminology
Gravity Project

Gravity Overview

A collaborative initiative with the goal to develop consensus-driven data standards to support the collection, use, and exchange of data to address the social determinants of health (SDOH).

An SDOH Lexicon

- **Health Equity:** Health equity is the state in which ***everyone*** has a fair and just opportunity to attain their highest level of health.
- **Social Determinants of Health (SDOH)**: "The conditions in which people are born, grow, live, work and age," which are "shaped by the distribution of money, power and resources.

Population & Structural-Level

<u>SDOH can offer both positive and negative forces</u>:

Positive Forces

- **Protective Factors:** Characteristics or strengths of individuals, families, communities or societies that act to mitigate risks and promote positive well-being and healthy development.

Negative Forces

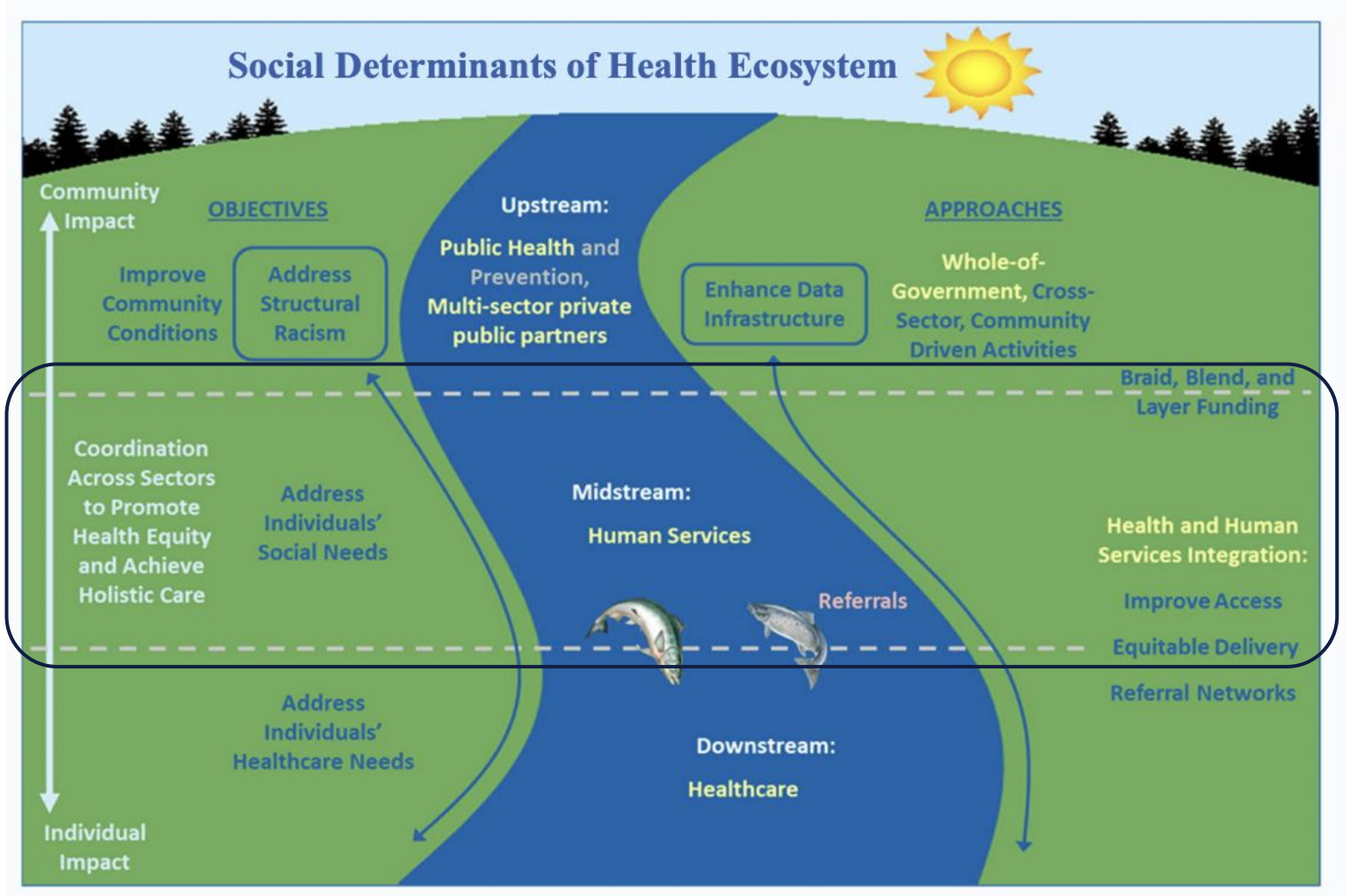
- **Social Risks:** Adverse social conditions associated with poor health.
- **Social Needs:** Patient-prioritized social risks.

Person-Level

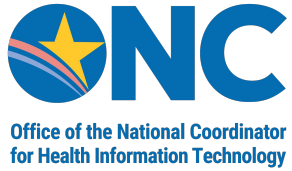
. Alderwick and Gottlieb (2019) Meanings and Misunderstandings: A Social Determinants of Health Lexicon for Health Care Systems
Center for the Study of Social Policy (2018) About Strengthening Families™ and the Protective Factors Framework

HHS Strategic Approach to Addressing SDOH to Advance Health Equity

Data standards (i.e. Gravity) to support health and human services integration



2023 Project Sponsors and Partners



★ Founding Sponsors

Special thanks to the following for your in-kind contributions to Gravity Project: AMA, Civitas Networks for Health, and Saffron Labs.

2017

SIREN Exploration

November: SIREN / Academy Health Host Multi-Stakeholder Group

2018

RWJF funds SIREN to stand up new coding collaborative

Initiation

November: SIREN contracts with EMI to initiate Gravity Project

2019

Food Insecurity

Launch

August: Gravity becomes an HL7 FHIR Accelerator Project

2020

Housing Instability

Homelessness

Transportation Insecurity

HL7 FHIR

DRAFT Gravity IG build

2021

Financial Insecurity

Inadequate Housing

Unemployment

Veterans

Education

Material Hardship

Intimate Partner Violence

Elder Abuse

Stress

Social Isolation

NIH National Library of Medicine Value Set Authority Center

November: Gravity Value Sets in VSAC

USCDI U.S. Core Data for Interoperability

July: Gravity Data Sets in USCDI v2

HL7 FHIR

August: Gravity IG STU1 Published

2022

Medical Cost Burden

Health Insurance Coverage Status

Health Literacy

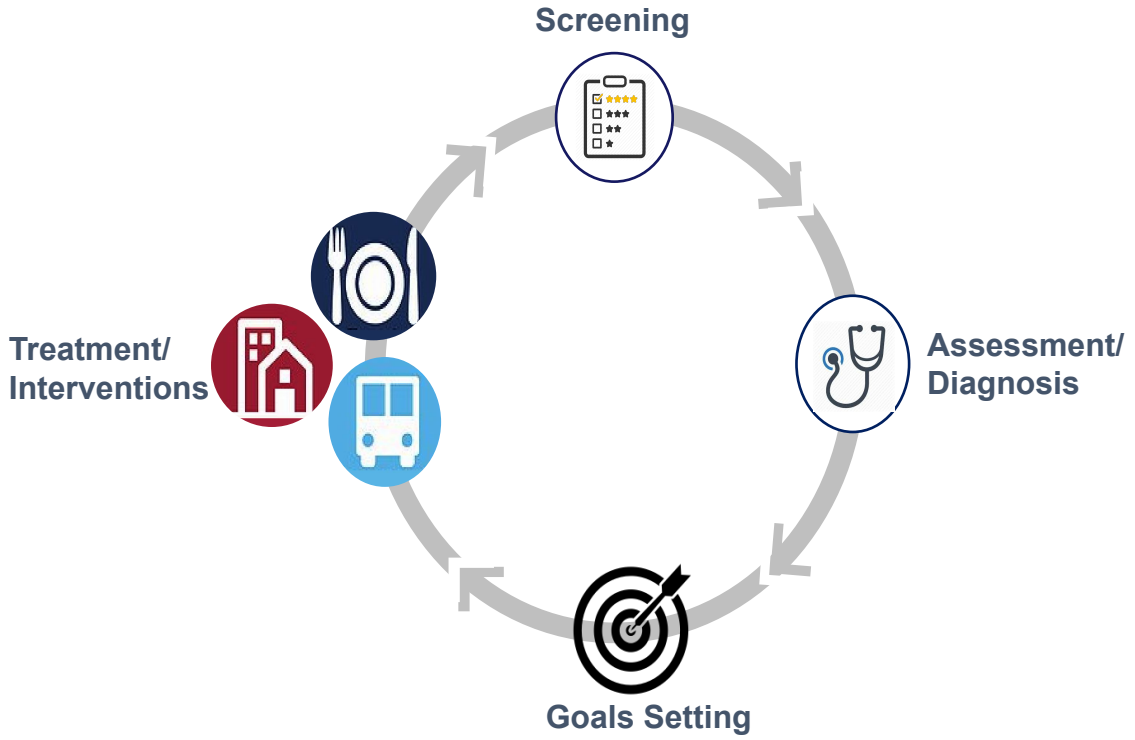
September: Gravity Pilots Affinity Group Launch

HL7 FHIR

November: Gravity IG STU2 Published

The Importance of SDOH Data Standards

- Establish a **shared understanding of critical concepts** across the ecosystem **in the name of health equity.**
- Allow for **data visibility**, a critical aspect of **data justice.**
- Create **common methods for exchanging information** within communities to allow for **analysis and upstream, structural interventions**.



★ **Gravity is AGNOSTIC to the systems and tools used to collect, exchange, aggregate, and analyze social care data.**

Gravity Project Core Use Cases

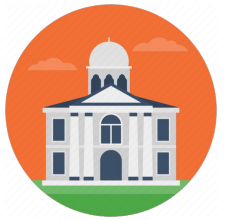
1. Documenting social care data at patient/client encounters.

2. Tracking social care interventions to completion.

3. Gathering and aggregating social care data for uses beyond the point of care.

(for purposes of population health, quality reporting, risk stratification, research, and policies to foster health equity)

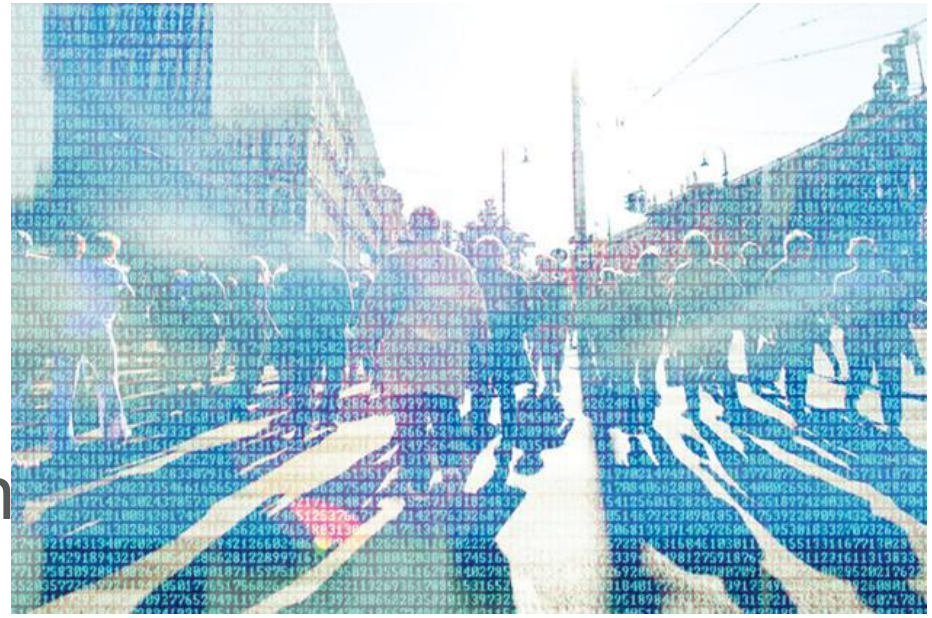
Person-Level Activities



Population & Structural-Level Activities

Gravity Data Use Principles for Equitable Health and Social Care

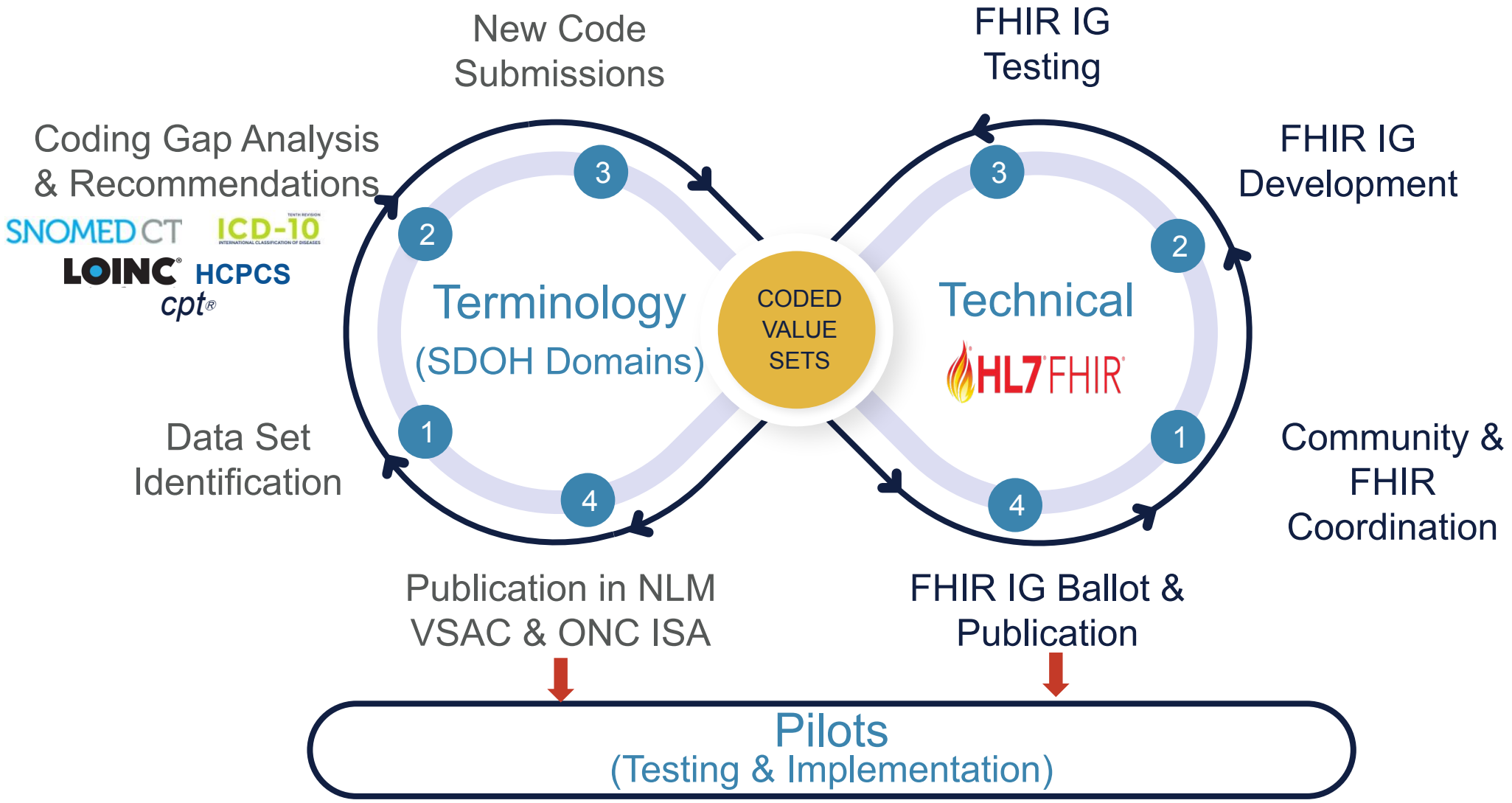
- Improving Personal Health Outcomes
- Improving Population Health Equity
- Ensuring Personal Control
- Designing Appropriate Solutions
- Ensuring Accountability
- Preventing, Reducing, and Remediatin Harm



Gravity Data Use Principles are Accessible on the Gravity Project Confluence page.

Gravity Workstreams

3 Workstreams: Terminology, Technical, Pilots

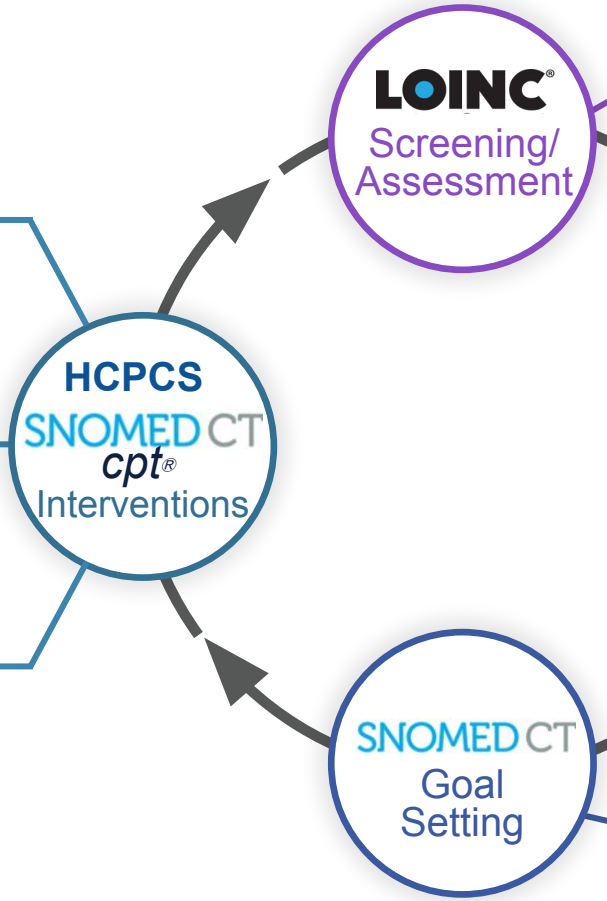


Terminology Workstream — Scope

- **Develop data standards** to represent and exchange patient level social risk data documented across four clinical activities:
  - Screening,
  - Assessment/diagnosis,
  - Goal setting, and
  - Intervention/treatment
- **Test and validate** standardized social risk 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

Food Insecurity Terminology Build



Food Insecurity Screening/Assessment
Q. Within the past 12 months we worried whether our food would run out before we got money to buy more. 88122-7 (LOINC)

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

Food Insecurity Diagnoses
Food Insecurity 733423003 (SNOMED CT)

Food Insecurity Diagnoses
Food Insecurity Z59.41 (ICD-10-CM)

Food Insecurity Goals
Food Security 1078229009 (SNOMED CT)
*Feels food intake quantity is adequate for meals

PROCEDURE: Education about Child and Adult Food Program 464201000124103 (SNOMED CT)

PROCEDURE: Provision of food voucher 464411000124104 (SNOMED CT)

PROCEDURE: Referral to Community Health Worker 464131000124100 (SNOMED CT)

***Proposed. Not final.**

Gravity Project Value Sets

- Gravity Project stewards over 150 NLM VSAC value sets.
  - Social risk domain level sets for each activity (screening, diagnosis, goal setting, intervention)
  - All SDOH level value sets in line with USCDI

- Domain-level sets can be found in VSAC with Gravity Project as the Steward, or on our Confluence page under “Gravity Terminology Value Sets” https://confluence.hl7.org/display/GRAV/Gravity+Terminology+Value+Sets.

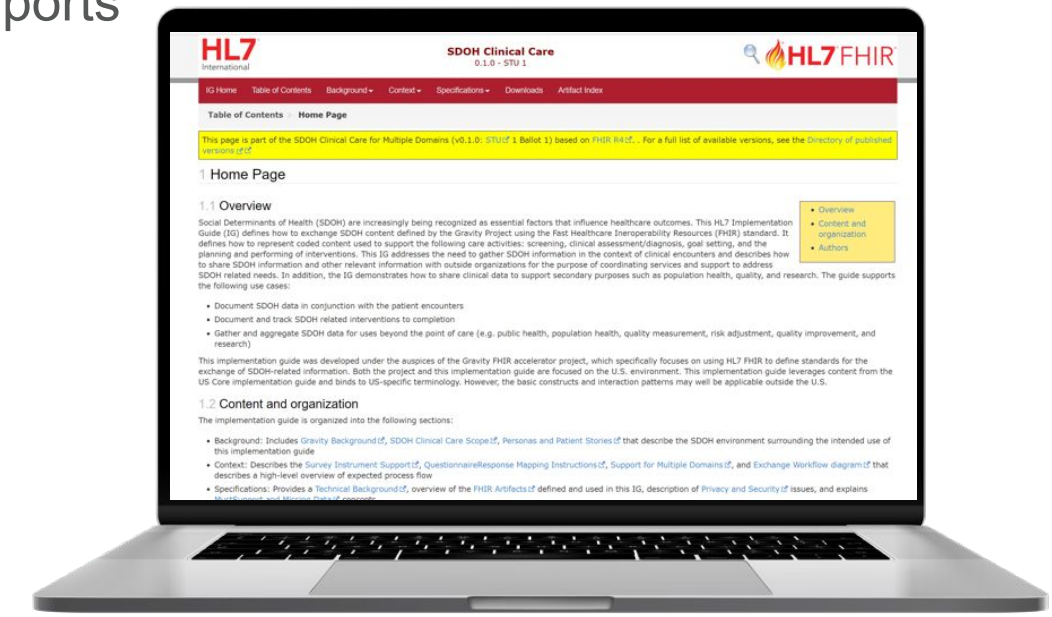
Domain	SDOH Activities	Links to Value Sets in VSAC	Downloadable Assessment Instruments Spreadsheets
FOOD INSECURITY	Assessment Instruments Question Codes (LOINC)	Work in progress	Food Insecurity Assessment Instruments Codes V1
	Assessment Instruments Answer Codes (LOINC)	Work in progress	
	Diagnoses (SNOMED CT, ICD-10)	https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1247.17/expansion/latest	
	Goals (SNOMED CT)	https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1247.16/expansion/latest	
	Procedures (SNOMED CT, CPT, HCPCS)	https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1247.7/expansion/latest	
	Service Request (SNOMED CT, CPT, HCPCS)	https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1247.11/expansion/latest	
HOUSING INSTABILITY	Assessment Instruments Codes (LOINC)	Work in progress	Housing Instability Assessment Instruments Codes V1
	Assessment Instruments Answer Codes (LOINC)	Work in progress	
	Diagnoses (SNOMED CT, ICD-10)	https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1247.24/expansion/latest	
	Goals (SNOMED CT)	https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1247.161/expansion/latest	
	Procedures (SNOMED CT, CPT)	https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1247.44/expansion/latest	
	Service Request (SNOMED CT, CPT)	https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1247.45/expansion/latest	

Technical Workstream — Scope

HL7 SDOH Clinical Care FHIR Implementation Guide (IG)

1. This is a framework Implementation Guide (IG) and supports multiple SDOH domains.

1. 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

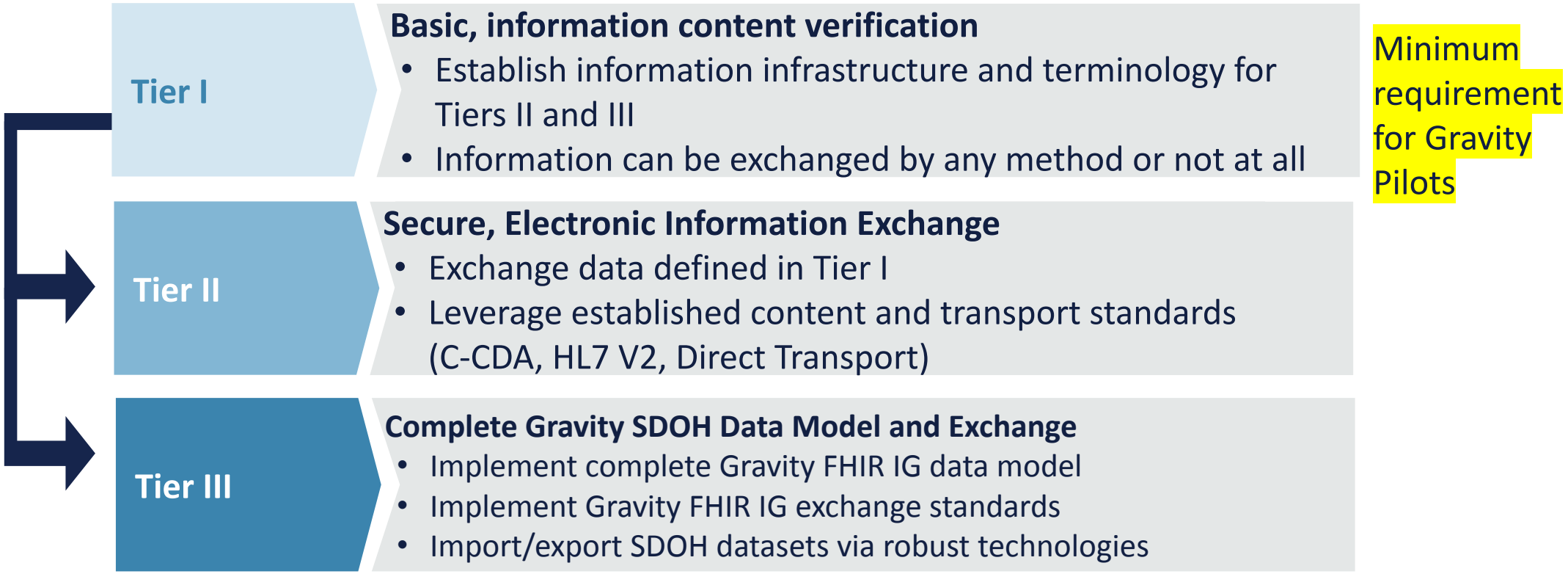


Click to access Gravity SDOH Implementation Guide (STU2)

3. **Standard for Trial Use 2 (STU2) published November 2022!**

Three-Tiered Piloting Approach

Incremental approach for testing Gravity terminology and technical standards. Entities may participate at any Tier.



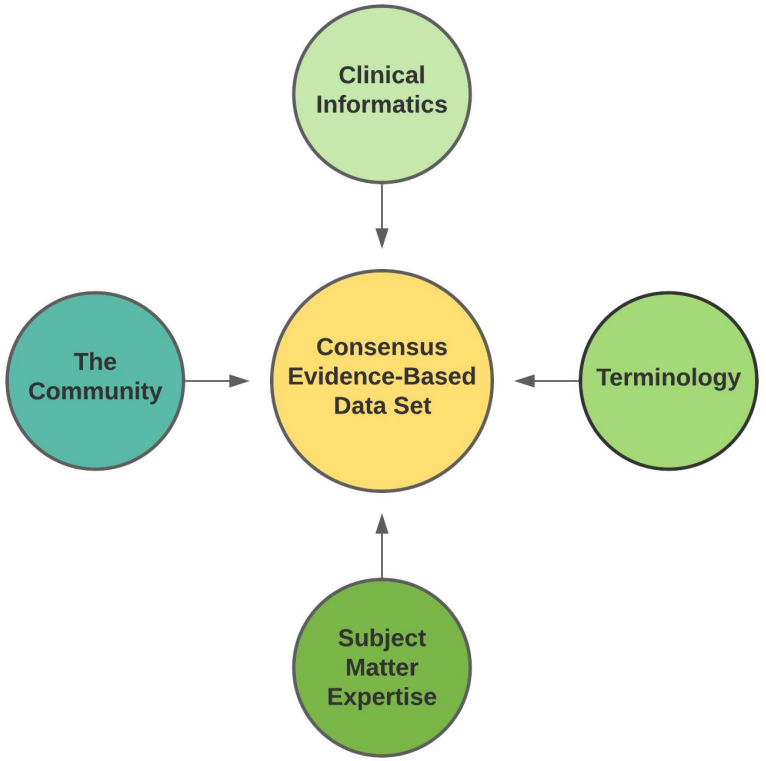
Pilot Workstream — Scope

- The goal of the Pilot Workstream is to drive implementation of Gravity Project terminology and technical standards and evaluate these standards for continuous improvement.
  - Gravity Pilots Affinity Group:
    A peer-to-peer learning forum for entities participating in the real-world testing of Gravity standards.
  - Supported Pilots: Intentional relationships offering technical assistance to pilot teams and direct feedback on Gravity deliverables.

A Deep Dive Into Evidence and Standards

Terminology Process > A Path to Quality

- Subject Matter Expertise and Literature Review
  - Validity
  - Evidence based definitions with attention to risk
- Clinical Informatics and Terminology
  - Integration into health and social care terminologies/taxonomies
- Community
  - Pragmatics
  - Thoroughness
  - Fairness



Gravity and Quality, eCQM, and dCQM

- The Gravity Project VSAC value sets were originally crafted to support clinical and social data standards through levers such as USCDI
- However, because of the foundation of evidence, they are now leveraged as the base set by many measures and measures in development
  - Face-validated screening instruments
  - Aligned diagnoses
  - Interventions aligned with all core federal programs (USDA, OAA, HUD/HMIS)

- **HEDIS, CMS D-SNP, and the upcoming revision of the IPPS IQR measure**

How to Engage

Gravity convenes participants from across the social care ecosystem via the following virtual meetings:

1. Terminology Workstream: **Bi-weekly** Public Collaborative meetings **2nd and 4th Thursday 4 to 5:30 pm ET** (Starting May 11th)
2. Technical Workstream: **Bi-weekly** Implementation Guide/Connectathon Work Group meetings **Wednesdays from 3 to 4:00 pm ET**
3. Pilots Workstream: **Monthly** Pilots Affinity Group meetings - **Last Thursday each month 2:30 to 4:00 pm ET**

View the HL7 calendar for meeting details: https://www.hl7.org/concalls/

Become a Member as a Gravity Project sponsor!

https://thegravityproject.net/sponsors/

Learn more!

Visit us at:

Gravity Website:
https://thegravityproject.net/

Gravity Confluence Page:
https://confluence.hl7.org/display/GRAV/The+Gravity+Project

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

Ned Mossman, (he/him)
OCHIN

Sarah DeSilvey, (she/her)
Gravity Project

Questions?

Upcoming Technical Assistance (TA) Opportunities

- **Data Collection & Sharing Learning Collaborative**
  - May 9, 2023, 12 p.m. PST – Register Here
- **Follow-Up Friday**
  - May 26, 2023, 10 a.m. PST – Register Here
- **Past TA Event Recordings**
  - OHA Transformation Center Website - SDOH Screening and Referral Metric
- Please contact **Claire Londagin** (londagin@ohsu.edu) for one-on-one TA with Anne King and Nancy Goff

Measure Contacts

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