October 23, 2020

The Honorable Donald Rucker, M.D.
National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
330 C Street SW, 7th Floor
Washington, D.C. 20201

Re: The Gravity Project's Submission To Include Social Determinants of Health in the U.S. Core Data for Interoperability, Version 2, for Better Care and Better Health Nationwide

Dear National Coordinator Rucker,

On behalf of Providence St. Joseph Health, we write to lend our support to the two alternative approaches submitted by the Gravity Project to include key social determinants of health in the U.S. Core Data for Interoperability (USCDI), version 2, for better care and better health nationwide.

At Providence St. Joseph Health we are committed to providing for the needs of the communities we serve, with a special focus on those who are poor and vulnerable. We are dedicated to high-quality, compassionate health care for everyone - regardless of coverage or ability to pay. Together, we share a singular commitment to improve the health of our communities through digital innovation, population health and clinical quality strategies, mental health, specialty institutes, research and education. Our diverse family of organizations employ 120,000 people who serve in 51 hospitals, 1,085 clinics, a health plan, senior services and housing, and many other health and educational services across seven western states. Each year we work to provide care and services where they are needed most, including investments in community benefit that in 2019 totaled $1.5 billion.

Experts have long known that social and environmental determinants of health explain most of a person's and population's health status. For the past nine months, the COVID-19 pandemic has highlighted this reality daily across the nation. The Gravity Project's submissions would add critical domains such as food insecurity, housing instability, transportation insecurity, social isolation, and stress to the USCDI, integrated with core clinical activities such as assessments, diagnoses, interventions, and outcomes. **Providence St. Joseph Health supports these submissions to include key social determinants of health in the USCDI version 2.** The information that follows summarizes the Gravity Project's submission to the Office of the National Coordinator (ONC).

Background

The need for inclusion of Social Determinants of Health (SDOH) as a new data class in USCDI arises from an uncontroversial collaborative effort focused on prioritizing use cases with a high impact on the triple aim, the widely accepted policy objective of HHS that refers to improving the experience of care, improving the health of populations, and reducing per capita costs of healthcare. The well understood

fact that SDOH is deterministic for 80 percent of health status at a population level *and* that there is no consistent method to document and communicate these factors during a healthcare encounter highlights the urgency of a standard approach across the health care system. The implementation of these standards is necessary to drive reductions in missed appointments, cost savings from preventable health events, increased care plan compliance, reduced administrative burden, directing effective investment in community health programs, and leveraging critical data to improve patient outcomes.

A national standard is needed for SDOH to resolve inconsistency when patients move between health care providers. Because there is no national standard, those major EHR vendors which do collect and record some SDOH data elements are primarily implementing these elements as custom, non-interoperable fields. The lack of a standard creates risks to individual patients by creating gaps in medical histories for patients that move between providers. It creates risk to the health of populations since broad groups of patients may be assigned to incorrect or ineffective treatment due to misaligned clinical decision support tools. Furthermore, the lack of standards creates an onerous administrative burden since critical data cannot be efficiently shared between providers using different health record systems.

The healthcare industry transition from a fee-for-service model to value-based care adds an additional imperative for SDOH since these elements will become increasingly necessary for payment and reimbursement of healthcare service providers. Going forward, tangible evidence will be needed to demonstrate improvement in quality of care while sustainably lowering healthcare cost. SDOH standards not only provide the necessary data to drive improvements to patient care, they also provide a clear record and evidence for appropriate reimbursement.

USCDI Submission

The Gravity Project has submitted two alternative approaches for adding a new data class, *Social Determinants of Health*, to USCDI version 2. **Providence St. Joseph Health supports the Gravity Project's alternative approaches for adding new social determinants of health data to the USCDI.** The approaches are intended to provide options for consideration by ONC for the structural organization of the new data class since each approach has strengths that should be carefully considered.

Submission 1: SDOH data class, organized by SDOH domains

Gravity is submitting a new SDOH data class for inclusion in USCDI v2 that will contain functional domains organized according to individual health status. The taxonomy of submitted domains are described by *Food Insecurity, Housing Instability and Homelessness, Inadequate Housing, Transportation Insecurity, Financial Strain, Social Isolation, Stress, Interpersonal Violence, Education, Employment, and Veteran Status.* Additional domains beyond this list will be added in the future, but this list contains domains that Gravity can support for USCDI v2. Each of these domains will contain a repeated set of elements with specific vocabularies for: Assessments (LOINC); Goals (LOINC); Problems/Health Concerns (ICD-10-CM (billing) and SNOMED-CT (clinical)); Interventions (SNOMED-CT and/or CPT/HCPCS); Outcomes (LOINC); and Consent. The approach also includes data elements supporting Consent, if and where needed, related to the use and sharing of SDOH data to and among relevant stakeholders.

This approach has the benefit of consistency *with* and logical evolution *of* the 2015 Edition Health IT certification criteria. While previously adopted certification criteria specified 8 domains and specific standards (Financial resource strain, Education, Stress, Depression, Physical activity, Alcohol use, Social

connection and isolation, and Exposure to violence), the Gravity Project's submission would be an expansion of prior practice under a newly minted *class* for SDOH. In addition, the proposed changes broaden the scope of prior vocabularies that limited users to *assessment* of conditions, but ***did not*** specify a standard for other critical activities, including goals, health concerns, interventions, or outcomes. The addition of these standards will enhance interoperability among users that are not only interested in measuring or recording the existence of a condition but documenting and initiating or ordering substantive interventions toward improved patient health. ONC will want to consider how this (and other) SDOH submissions would interact with the existing module in the 2015 Edition.

Submission 2: SDOH data class, organized by SDOH activities in clinical care

The Gravity Project also submits a new SDOH data class for inclusion in USCDI v2 organized instead by data elements that reference SDOH activities and tools used by providers in a typical clinical care workflow. The data elements in the new SDOH data class, listed along with their appropriate vocabularies will be: Assessments – LOINC; Problems/Health Concerns – ICD-10-CM (billing) and SNOMED-CT (clinical); Goals – LOINC; Interventions – SNOMED-CT (clinical) and CPT/HCPCS (billing); Outcomes – LOINC; and Consent. Each element will contain a taxonomy of SDOH health status (code sets) that can be leveraged to describe conditions across multiple domains (e.g. Food Insecurity, Housing Instability and Homelessness, Inadequate Housing, Transportation Insecurity, Financial Strain, Social Isolation, Stress, Interpersonal Violence, Education, Employment, and Veteran Status). Organizing the SDOH data class by activities that reference the various relevant code panels and profiles for SDOH allows stakeholders to add SDOH domains as consensus is reached on each.

By including an externally maintained list of domains, activities and value sets, this approach can accommodate the rapid innovation that is required as the SDOH data class matures and becomes a common feature of clinical care, and more SDOH domains are added. As additional domains, vocabularies, and value sets are published, the hierarchy and nomenclature of the named data elements will remain consistent. The addition of these standards will enhance interoperability among users and will reduce regulatory lag for updates to USCDI for SDOH domains.

Although the Gravity Project will not have completed the full set of gap analysis and code set development at the time of submission, they do expect all to be resolved by the time ONC would make its decision in May-June, 2021, about the final definition of version 2. This tracks the approach ONC took with the social, psychological and behavioral data certification criterion in the 2015 Edition, where ONC noted that some code sets remained to be finished but identified the structural placeholder in the proposed rule and identified the appropriate standard(s) in the final rule.

Need and Maturity

The SDOH Data class is undergoing rapid development and iterative cycles of maturation due to the urgent need for standard methods to aid healthcare delivery to patients. Inclusion as a standardized SDOH data element in USCDI is a necessary step so the field can move forward, and stakeholders can properly plan and prepare for inclusion of these critical data in patient care.

The value of collecting and coding SDOH data for clinical care and other use cases, and the value of collecting and coding assessments, goals, health concerns, and interventions of SDOH for clinical care,

are well established in the literature.[1] They are also core expectations of the Federal Health IT Strategic Plans, both for 2015-2020, and the current draft for 2020-2025.[2] As the (then) Institute of Medicine summarized the evidence in 2014, in its opening paragraph of *Capturing Social and Behavioral Domains in Electronic Health Records, Phase I*:

> *Substantial empirical evidence of the contribution of social and behavioral factors to functional status and the onset and progression of disease has accumulated over the past few decades. . . . Electronic health records (EHRs) provide crucial information to providers treating individual patients, to health systems, including public health officials, about the health of populations, and to researchers about the determinants of health and the effectiveness of treatment. Inclusion of social and behavioral health domains in EHRs is vital to all three uses.*[3]

In addition to the considered findings by the Institute of Medicine, some health systems have documented substantial exchange and use because they have already integrated the collection and coding of SDOH data and activities such as assessments and referrals into their current systems.[4] A study of EHR vendors with the largest market shares, by authors at HHS's Centers for Medicare and Medicaid Innovation and Office of the Assistant Secretary for Planning and Evaluation as well as NORC, finds the same.[5] The wholesale support among the Gravity Project's 1,200+ collaborators nationwide, across

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[1] E.g., Abigail Arons, Sarah DeSilvey, Caroline Fichtenberg & Laura Gottlieb, Documenting social determinants of health-related clinical activities using standardized medical vocabularies, 2 J. Am. Med. Info. Ass'n 81, __ (Apr. 2019), available at https://doi.org/10.1093/jamiaopen/ooy051; see also Institute of Medicine, Capturing Social and Behavioral Domains in Electronic Health Records, Phase 1 (2014), available at https://www.ncbi.nlm.nih.gov/books/NBK195994/pdf/Bookshelf_NBK195994.pdf ; Institute of Medicine, Capturing Social and Behavioral Domains in Electronic Health Records, Phase 2 (2014).

[2] Office of the National Coordinator for Health Information Technology, *Federal Health IT Strategic Plan 2015-2020*, p. 11 (Sept. 2015) ("Many health and social determinants outside of care delivery influence individuals' health and well-being, and the federal government can play an important role to guide the inclusion of these determinants into the electronic information stream for decision-making by individuals, providers, and communities, as well as the organizations and technology developers that support them."), available at https://www.healthit.gov/sites/default/files/9-5-federalhealthitstratplanfinal_0.pdf; Office of the National Coordinator for Health Information Technology, 2020-2025 Federal Health IT Strategic Plan: Draft for Public Comment, p. 11 (Jan. 15, 2020) ("The shift to value-based care has resulted in new incentives . . . [that] place greater importance on addressing social determinants of health and patient health behaviors . . . ."), available at https://www.healthit.gov/sites/default/files/page/2020-01/2020-2025FederalHealthIT%20StrategicPlan_0.pdf.

[3] Institute of Medicine, Capturing Social and Behavioral Domains in Electronic Health Records, Phase 1, p. 1 (2014), available at https://www.ncbi.nlm.nih.gov/books/NBK195994/pdf/Bookshelf_NBK195994.pdf; see also Institute of Medicine, Capturing Social and Behavioral Domains in Electronic Health Records, Phase 2, p. 1 (2015) ("To provide better patient care, improve population health, and enable more informative research, standardized measures of key social and behavioral determinants need to be recorded in electronic health records (EHRs) and made available to appropriate professionals."), available at https://www.ncbi.nlm.nih.gov/books/NBK268995/pdf/Bookshelf_NBK268995.pdf.

[4] Nicole Friedman & Matthew Banegas, Toward Addressing Social Determinants of Health: A Health Care System Strategy, 22 Permanente J. __ (Oct. 22, 2018) ("The novel electronic health record-based tools developed by KPNW [Kaiser Permanente Northwest] have led to standardized, measurable, and actionable SDH data being used to tailor and target specific resources to meet the identified needs of our patients."), available at https://doi.org/10.7812/TPP/18-095.

[5] Maysoun Freij, Prashila Dullabh, Sarah Lewis, Scott R. Smith, Lauren Hovey, Rina Dhopeshwarkar, Incorporating Social Determinants of Health in Electronic Health Records: Qualitative Study of Current Practices Among Top Vendors, 7 JMIR Med. Inform. e13849 (June 7, 2019) (in a study of EHR vendors with large market shares, "Vendors

diverse stakeholder segments, including Providence St. Joseph Health, illustrates the ecosystem's deep need for, and the immediate value of, collecting and coding SDOH data for interoperable exchange and care.

Thank you for the opportunity to provide our comments as you consider updates to the USCDI. For more information, please contact Sarabeth Zemel, manager, federal regulatory affairs and engagement, at (425) 525-3228 or via email at Sarabeth.Zemel@providence.org.

Sincerely,

Rod Hochman, MD
President and CEO
Providence St. Joseph Health

indicate they are actively developing products to facilitate the collection and use of SDH data for their clients and are seeking solutions to data standardization and interoperability challenges through internal product decisions and collaboration with policymakers. Due to a lack of policy standards around SDH data, product-specific decisions may end up being de facto policies given the market shares of particular vendors. However, commercial vendors appear ready to collaboratively discuss policy solutions such as standards or guidelines with each other, health care systems, and government agencies in order to further promote integration of SDH data into the standard of care for all health systems"), available at https://medinform.jmir.org/2019/2/e13849/.