Implementation of Social Determinants of Health in Electronic Health Records

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The HIMSS Electronic Health Record (EHR) Association is a trade association of 29 EHR companies who serve vast majority of hospital, post-acute, specialty-specific, and ambulatory healthcare providers using EHRs and other health IT across the United States. Together, we work to improve the quality and efficiency of care through the adoption and use of innovative, interoperable, and secure health information technology.

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29 Members

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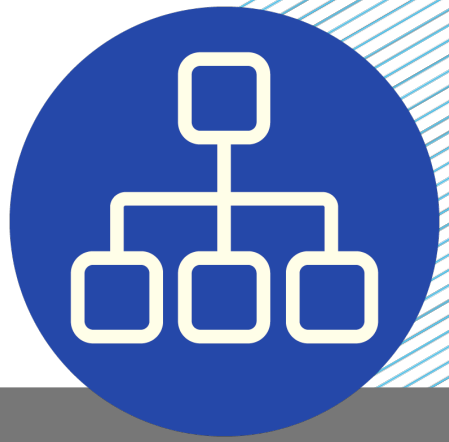
SDoH and Health Equity Task Force at EHRA

- SDoH and Health Equity Task Force was created to identify, prioritize, and address the barriers to delivering more equitable, socially informed care, focusing primarily on those barriers that an EHR is best positioned to address.

- The EHR Association and its members are committed to exploring the ways in which technology can be used to address disparities in the healthcare system more effectively.

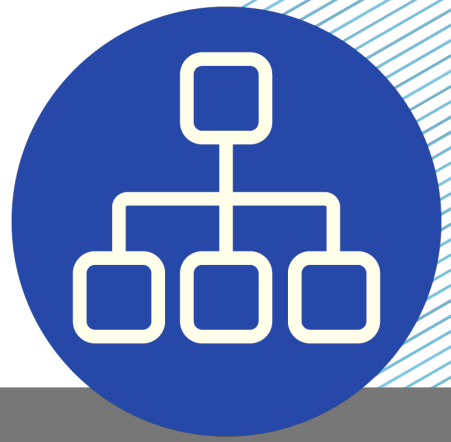
Documentation Standards in EHR



Interoperability of Social Determinants

Research & Analytics

Documentation Standards in EHR



Interoperability of Social Determinants

Research & Analytics

Documenting Social Determinants in the EHR

- *Increase in number of organizations documenting & addressing social determinants due to increased awareness and policies*
- *Commonly documented elements are Assessments and Interventions*
- *Documented in all care settings and by many roles: Physicians, nurses, care managers, social workers and more*

Common Challenges

Additional time needed during clinical visits to complete screenings and plan interventions

How Technology Can Help

- Integrate in existing clinical workflows to minimize additional burden
- Make it accessible across care settings and promote timely interventions
- Encourage patients and families to self-report social determinants prior to their visit
- Use of AI to extract social determinant information from clinical notes

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Common Challenges

Different standards and policies informing domains that should be screened for the patients

Different Standards to Assess Social Domains

- **CMS**, in its 2023 IPPS Rule, recommends the screening of five domains
- **Healthy People 2030** lists five broad domains of risk
- **The Future of Nursing 2020 -2030** lists 11 domains of risk
- **The Gravity Project**, to classify and encode a broad list, has 20 domains

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Common Pain Points

Different standards and policies informing domains that should be screened for the patients

Recommendation

- Standardization of domains to screen across care settings
- Regulation should be feasible for implementation by small and big EHRs in a consistent way

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Common Challenges

Providers hesitate to screen if they don't know how to help patients that screen positive

SDoH Interventions

Provide Education Material

Connecting with Community Partners

Referral to Social Work

Create Care Plans

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Common Challenges

Providers hesitate to screen if they don't know how to help patients that screen positive

Recommendations

- Initiatives to fund and engage community partners on an ongoing basis
- Standard Taxonomy of services to define the interventions at the right level
- Standards for closed loop referrals with the community-based organizations

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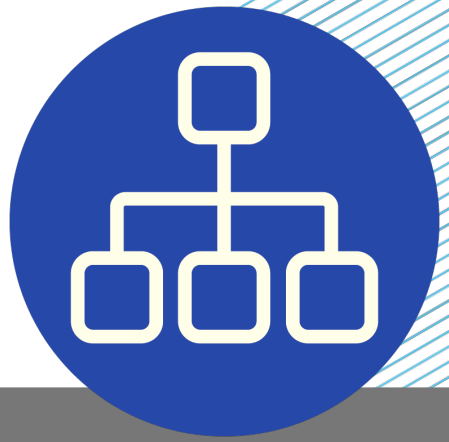

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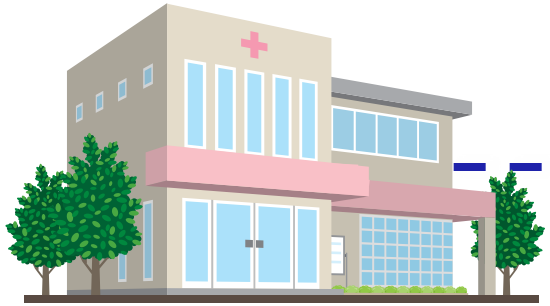
Terminology for SDoH Assessments



Domain → Source → LOINC

Questions → LOINC

Answers → LOINC

Intervention → SNOMED

Your Organization

External Organization

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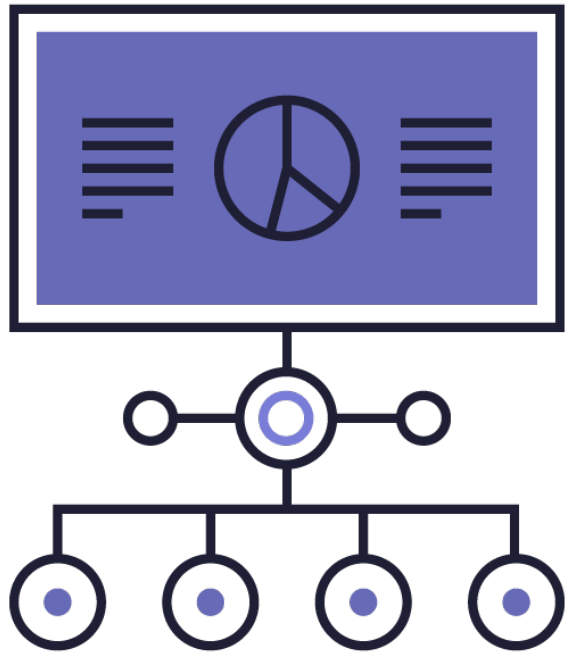
USCDI

FHIR

Barriers

- Regulatory programs at the national or state level might suggest using screeners for which LOINC codes do not exist yet
- Different verbiage across different screeners causes deviation from LOINC mappings
- Mapping of screeners to domains is not standardized



Recommendations for Interoperability

- ***Standardized code set to represent domains***
  For example: Housing Insecurity [Z Code XXX]
- ***For each domain, standard way to represent domain risk***
  For example: Housing Insecurity is present
- ***Optional coded value indicating the method of instrument or assessment used***
  For example: Housing Insecurity is present, assessed using PREPARE

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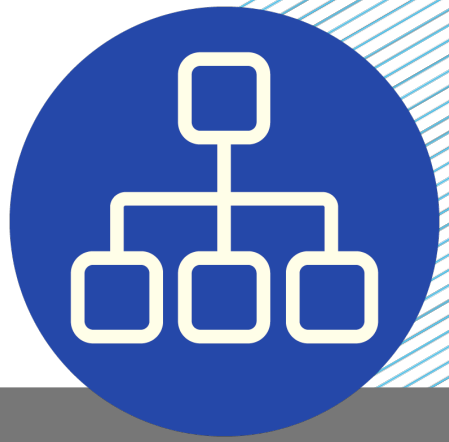

Interoperability of Social Determinants

Research & Analytics

Support for Analytics & Research

Augment the depth of research with:

- Standardized SDoH Screening Data & Domain Risks
- Surfacing disparities with community level screening data

Analytics to Help with Strategic Initiatives

Surface screening rates and positivity rates to understand trends

Are individuals reporting increased housing & transportation need?

Understand the impact of social determinants on health outcomes

How does a patients A1C change if they lack access to transportation?

Augment the research with data sets: Area Deprivation Index (ADI) & Social Vulnerability Index (SVI)

Identify the most vulnerable population by locating communities with both high (SVI) scores and reported food needs?

Stratify by Race, Ethnicity, Language etc. to promote equity

Do African Americans have greater housing and transportation needs?

Thank You

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