Discussion Summary and Engagement Analysis
Improving Social Determinants of Health Datasets
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High-level overview

IHMI is proposing a set of data elements to represent social determinants of health (SDOH). We hope that the increased and standardized collection of these elements will help clinicians more easily determine which patients are at risk and who might benefit from additional support or resources. The IHMI team would like discussion participants to examine this proposed data set and give feedback. Is something missing? Should something be removed? Which will be most relevant to burdensome disease areas i.e., hypertension, diabetes and asthma. Your feedback from this discussion will help us improve the quality of this dataset.

Conversation points that correlate with IHMI

This discussion is intended to gather feedback on the proposed SDOH dataset which will impact the submission to the CRG. All conversation points relate to IHMI efforts and related to the CRG submission.

Featured Experts

- Michael Cantor, MD – Head, Clinical Informatics at Regeneron Genetics Center
- Amin Hakim, MD, FIDSA, CPE, FACPE – Innovator in Health Care
- Joshua Sharfstein, MD – Vice Dean for Public Health Practice and Community Engagement, Professor of Health Policy
- Sharon Hewner, PhD, RN, FAAN – Department Chair – Family, Community and Health Systems Sciences, Associate Professor
- Jean Raphael, MD, MPH – Associate Professor at Baylor College of Medicine
- Rebekah Walker, PhD – Assistant Professor at Medical College of Wisconsin
- Kurt Johnson – VP of Operations at UnitedHealth Group

Featured Moderators

- Seth Blumenthal – Director, Clinical Review Group, AMA

Summary of relevant conversation points

In your view, what are the best currently available standards for SDOH? Where are the gaps?

- Best/useful standards depend on intent of use
    - Individual-level vs. Community-level
- Best/useful standards that can be readily coded
    - No ambiguity

In your view, what SDOH are most relevant in the remote monitoring domain?

- Affecting care transitions
    - Food
    - Housing insecurity
    - Health literacy
    - Social isolation
    - Functional ability
- Actionable at individual level
    - Physical safety
    - Work status
    - Access to transportation
    - Access to mobility and socialization venues
    - Access to nutritious food (influenced by work, income, crime, etc.)
- Psychological
    - Depression/levels of distress
    - Intellectual deficits/information access constraints
- Cultural

We'd love your feedback on these data elements.

- Community-level determinants not represented in proposed set
- Behavioral vs Non-behavioral SDOH classifications
- Set of standards that organizations can choose from depending on need
- Element of time should be considered (capturing one point vs. multiple points)
- Support for a common coding standard to fit with existing workflows (industry adoption)
- Not all published standard sets contain the same elements, potentially missing connections between elements and exhibiting that certain elements may impact others in the set.
- Linking SDOH to ICD-10 and LOINC allows for incorporation into care planning
- Wide utilization should be considered:
    - Providing a set more comprehensive than existing sets
    - Incorporate scales in the definitions to support accurate data
    - Include desired outcomes (clinical and policy)

- Consider the degree of fit for the concepts they cover (correct codding representation)
- Concepts may need multiple options or dimensions to show relation to other concepts
    - Employment Status (as discussed in Jan. CRG meeting)
    - Food Security (Financial and Transportation concepts provide in-depth assessment)
    - Housing Security (Adequacy of living situation vs. Financial aspects)
    - Financial Resource Strain (Assessment of current state and expected progression)
    - Education (Measures for cognitive ability and comprehension)
    - Social Interaction (Means of communication)
    - Abuses (Limited to only spousal abuse?)
    - Tobacco Exposure (second hand smoke option and environmental related aspects)
- Enhance the behavior items by adding questions about drug use
- Avoid redundancy
- Avoid fields where data are not collected
- Important to consider how the data will be used

Would you use IHMI's dataset?

- Yes, if linked to coding e.g. LOINC and billing (ICD) standards
- Would use subset most relevant to my patient population
- Already existing sets, so would there be value from AMA?
    - Would be nice if AMA set included scales to prompt action and recommend outcomes to support intervention and evolving SDOH
- Depends on who identifies problems and applies solution

Are you, or people you know, using SDH data today? If so, for what purpose?

- Targeting social needs
- Risk stratification
- Comprehensive shared care plans
- Family practice
- Population health planning
- Measuring outcomes
- Research studies
- Heat maps
- Referrals to resources
- Drive pilot programs (innovation)
- Elements relating to readmission or frequent ED use
- Food insecurity
- Socioeconomic factors

What in your view might be good SDH data?

- Depend on disease, e.g.
    - Air data for asthma

Resources generated from Discussion

- http://www.211.org/services/health
- https://www.healthaffairs.org/do/10.1377/hblog20190115.234942/full/
- https://sirenetwork.ucsf.edu/tools-resources/mmi/compendium-medical-terminology-codes-social-risk-factors
- https://academic.oup.com/jamiaopen/advance-article/doi/10.1093/jamiaopen/ooy051/5260817