

Access, Exchange and Use of Social Determinants of Health Data in Clinical Notes
60- Day Federal Register Notice Comments Received

Substantive Comments for 60-Day FRN				
	Date Rcvd	Commenter	Comment	Response
1	5/10/2021	Mark E. Rifkin, MS, RDN and Jeanne Blankenship Academy of Nutrition and Dietetics	<p>The Academy of Nutrition and Dietetics (the “Academy”) appreciates the opportunity to submit these comments to the Department of Health and Human Services relative to its March 11, 2021 request for comment on the information collection: Access, Exchange and Use of Social Determinants of Health Data in Clinical Notes. Representing more than 107,000 registered dietitian nutritionists (RDNs),¹ nutrition and dietetic technicians, registered (NDTRs), and advanced degree nutritionists, the Academy is the world’s largest association of food and nutrition professionals and is committed to a vision of a world where all people thrive through the transformative power of food and nutrition. Every day our members provide medical nutrition therapy for patients in clinical, public health, and other settings across the continuum of care, often via telehealth, with the flexibilities necessary due to the COVID-19 public health emergency. The Academy supports this information collection to ensure clinical care practices are optimized for all patients, regardless of demographics. To better promote health equity, it is essential that health care providers understand the relationship between social determinants of health and related costs, utilization, and outcomes, and be able to effectively adjust clinical care practices accordingly.</p> <p>Background</p> <p>The Academy strongly supports the agency’s efforts to standardize effective inclusion and application of social determinants of health (SDOH) data in health care. The importance of addressing SDOH has been widely recognized,² and is endorsed by Healthy People 2020,³ the nation’s food and nutrition experts. The RD and RDN credentials have identical meanings and legal trademark definitions. the World Health Organization,⁴ and the National Partnership for Action to End Health Disparities.⁵ It is also recognized that behavioral factors, such as physical activity level, diet quality, alcohol intake, and tobacco use contribute substantially to chronic disease risk, management and outcomes and are also influenced by SDOH.⁶ Thus, SDOH directly affect patients’ ability to effectively access culturally-appropriate quality care, and thus are a key driver of costs and health care utilization as well.⁷</p> <p>Specific Content</p> <p>Because the United States Core Data for Interoperability is an important mechanism for capturing standardized data elements to support interoperability, the Academy encourages the inclusion of SDOH-related data elements, especially those related to food security. The Academy’s support for effective capture of SDOH data is demonstrated by our participation in the Gravity Project, which focuses on identifying the data elements currently available as well as the data elements needed to represent food security and other areas that shape SDOH, such as housing and transportation.⁸ In addition, the Gravity Project addresses the need to be able to electronically capture and exchange this data across a variety of stakeholders. The interoperability gap can be addressed through the development of standardized guidance providing instructions on how data should be exchanged.</p> <p>Additionally, RDNs are an integral part of the clinical care team and are highly qualified to provide meaningful recommendations to help patients address poor food security. As a result, RDNs could provide unique, valuable data on their capture of SDOH in their clinical notes. Therefore, the Academy respectfully encourages the Department of Health and Human Services to</p> <ul style="list-style-type: none"> • include RDNs among the health care providers recruited to participate in both the qualitative and quantitative research. • include “registered dietitian nutritionist” on the options list of non-physician professionals on page four of Appendix A: Prescreening Questionnaires. 	Thank you for submitting your comment for the Office of the National Coordinator for Health IT (ONC) Federal Register Notice published March 11, 2021. This message is to advise that your comment is currently being reviewed.

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			The Academy appreciates your consideration of our comment for the information collection: Access, Exchange and Use of Social Determinants of Health Data in Clinical Notes.	
2	3/26/2021	Carol Graham Leo Pasvolsky The Brookings Institution/ College Park Professor University of Maryland	<p>See Attachment” SDOH Comment 03-26-2021 – Graham” for full comment:</p> <p>In response to the Federal Register notice of March 11, 2021 regarding the inclusion of a Social Determinants of Health component in the clinical notes of Health Providers.</p> <p>As background, I was one of the early “pioneers” in the use of well-being in economic analysis and have written numerous books and academic articles on the topic. I have done extensive work on well-being in countries around the world, with a focus on the poor. I also wrote the first paper in economics on what well-being causes, rather than what determines well-being. We showed that happier people were more likely to have better outcomes in the labor market and health arenas five years later (“Does Happiness Pay?” Journal of Economic Behavior and Organization, 2004).</p> <p>Most recently I have done extensive work on despair/lack of hope among less than college educated whites in the U.S. and show that trends in ill-being - and despair in particular - pre-dated the rise in deaths of despair by over a decade. As such the metrics can serve as warning indicators. We recently built a vulnerability indicator along these lines for states and countries across the U.S. – which now also includes places where COVID mortality and deaths of despair coincide (https://www.brookings.edu/interactives/wellbeing-interactive/). We find that white prime aged males out of the labor force are the most desperate and least healthy group, with high levels of opioid consumption and very low levels of geographic mobility (they do not move to where the jobs are), as well as high levels of anger. This research has been published, most recently, in Science, the Journal of Population Economics, and Social Science and Medicine.</p> <p>Perhaps more relevant, I have been working closely with partners at the Robert Wood Johnson Foundation on the inclusion of well-being metrics and approaches into their Culture of Health priorities. I was also was a member of a 2011-2012 National Academy of Sciences panel on well-being metrics and policy, and am now seeing a major increase in the inclusion of well-being questions in surveys such as the Fed surveys, the BLS and Census Pulse, as well as in health surveys of HHS and the CDC, and have provided comment on several of them.</p> <p>Given what we are now finding in terms of despair and premature mortality, trends which have been exacerbated by COVID, I think it would be useful to add a few well-being questions to the screening questionnaire for the participants in the SDOH focus groups, both to establish a baseline of well-being and how that varies across the socio-economic and demographic traits of participants, as well as to capture ill-being. Well-being in my view, is factor in the social determinants of health.</p> <p>I would ask you to consider asking the classic Cantril ladder of life satisfaction question as well as a second a second Cantril ladder question, immediately following the first one, asking respondents which ladder step they think they will be on in 5 years, which is a good measure of hope and optimism. This question follows the “Cantril now” question in every Gallup survey (for full disclosure, I am also a Senior Scientist at Gallup) and I find it to be an excellent measure of optimism about the future.</p> <p>We find, for example, that those most likely to be in the deaths of despair category have the lowest scores on this of all questions, and that low-income minorities, especially African Americans, are much more optimistic than low income whites. Most recently, we also find that during COVID low income African Americans remain the most optimistic race*income cohort, even though they are the most vulnerable to COVID. Their high optimism scores also link to much better mental health reports than other groups; optimism seems to have protective qualities even during the pandemic. Finally, I would also include two other questions – one on experiencing stress or anxiety frequently yesterday, and another on feelings of loneliness or feeling down yesterday (both which often link to reported depression).</p>	Thank you for submitting your comment for the Office of the National Coordinator for Health IT (ONC) Federal Register Notice published March 11, 2021. This message is to advise that your comment is currently being reviewed.

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		Each of these questions would only add 30 seconds to the survey (so a total of 2 minutes of response time) would provide a baseline of well-being/ill-being for the participants in your focus groups and might, in the end, also be included in the SDOH screening tools that result from them. Thanks in advance for your consideration and please feel free to contact me if you have any questions or would like to have the exact question phrasing in the event you are interested in using them.	
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ICR Package Requests for 60 Day FRN				
	Date Rcvd	Commenter	Comment	Responses
3	03/11/2021	Andrew Reamer George Washington Institute of Public Policy George Washington University	On behalf of the American Economic Association and the U.S. Chamber of Commerce, I request a copy of the draft ICR (including collection instruments and supporting statement) for 0955-NEW: Access, Exchange and Use of Social Determinants of Health Data in Clinical Notes, as invited by today's FR notice . I hope this is feasible and look forward to your response.	Thank you for submitting your comment for the Office of the National Coordinator for Health IT (ONC) Federal Register Notice published March 11, 2021. Per your request, a copy of the current information collection review package (ICR) (including the collection instruments and supporting statements A and B) for 0955-NEW: Access, Exchange and Use of Social Determinants of Health Data in Clinical Notes is attached. Please submit additional comments to Sherrette.Funn@hhs.gov or by calling (202) 795-7714.
4	03/16/2021	Mark E. Rifkin, MS, RDN Academy of Nutrition and Dietetics	If survey tools/instruments are available for the Information Collection " Access, Exchange and Use of Social Determinants of Health Data in Clinical Notes " (document ID 0955-New-60D), please send them (via reply all).	Thank you for submitting your comment for the Office of the National Coordinator for Health IT (ONC) Federal Register Notice published March 11, 2021. Per your request, a copy of the current information collection review package (ICR) (including the collection instruments and supporting statements A and B) for 0955-NEW: Access, Exchange and Use of Social Determinants of Health Data in Clinical Notes is attached. Please submit additional comments to Sherrette.Funn@hhs.gov or by calling (202) 795-7714.
5	3/18/2021	Meryl Bloomrosen Federal Affairs Public Affairs Premier Inc.	We noted the recent publication of the ONC Request for Comment- "Access, Exchange and Use of Social Determinants of Health Data in Clinical Notes 0955-New-60D". We are interested in responding. Can you direct us to additional information about what methods and types of data collection is being proposed. It appears that ONC is planning to identify SDOH data elements for potential inclusion in the USCDI.	Thank you for submitting your comment for the Office of the National Coordinator for Health IT (ONC) Federal Register Notice published March 11, 2021. Per your request, a copy of the current information collection review package (ICR) (including the collection instruments and supporting statements A and B) for 0955-NEW: Access, Exchange and Use of Social Determinants of Health Data in Clinical Notes is attached.

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6	3/25/2021	Hannah Martin, MPH, RDN Academy of Nutrition and Dietetics	Note: follow up of Mark Rifkin's 3/16 request. I am following up on the email from my colleague below requesting access to the survey instruments that the Department is planning to use in its exploration of including social determinants of health in the medical record. Can you please share these documents with us or connect us with someone who could?	Thank you for submitting your comment for the Office of the National Coordinator for Health IT (ONC) Federal Register Notice published March 11, 2021. Per your request, a copy of the current information collection review package (ICR) (including the collection instruments and supporting statements A and B) for 0955-NEW: Access, Exchange and Use of Social Determinants of Health Data in Clinical Notes is attached.

Out of Scope Comments for 60 Day FRN				
	Date Rcvd	Commenter	Comment	Responses
7	3/20/21	Shannon Ramsey Jimenez DO, FACP, HPF Sam Houston State University College of Osteopathic Medicine	<p>Thank you for allowing us to comment on this project. As a health policy fellow, I truly understand the need for collection of this data. However, as a physician who practiced in a rural area in a solo practice, I can tell you that requiring physicians to collect this data without paying us enough to be able to afford a social worker to collect it would put a severe burden on already strained small practices and rural clinics. We did our best to work through this problem in my clinic as I wanted to be on the cutting edge of whatever we need to do to help people the best. Here are some barriers.</p> <ul style="list-style-type: none"> • The cost of another person or persons to collect and input the data. • Once we collect the data, what do we do with it? Physicians are not social workers and are not experts at navigating those systems. • Not all EMRs have a good way to input the data. • People do not want to share this information with their doctors. They are embarrassed sometimes and are less than honest with us about their situations. • People do not want to speak their issues out loud to another person, especially in small communities. We found we got more honest answers by giving people an ipad with a questionnaire before they get to the back to the nurse or doctor. <p>This data is important but should be collected by county health departments, or Medicare and Medicaid offices. Federal or state funds can be sent there. Perhaps a partnership where people fill out a survey in the waiting room but the data is input at social services and they contact the person for services, would be the best way to go about this.</p>	Thank you for submitting your comment for the Office of the National Coordinator for Health IT (ONC) Federal Register Notice published March 11, 2021. This message is to advise that your comment is currently being reviewed.

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			When I sold my practice to a university, they were able to hire extra people and had a whole division to handle these things but small groups, private practices, rural and solo docs cannot. Thank you.	
8	3/30/2021	<p>Andrew J. Manos D.O 1760 Termino Suite 222 Long Beach, CA 90804</p> <p>Board Certified Family Medicine ABOFP Former Director of Medical Education, Pacific Hosp /College Hospital Long Beach Former Family Medicine Director, Pacific Hospital of Long Beach Chair of Family Medicine, Long Beach Memorial Medical Center Chief of Staff Community Hospital of Long Beach</p>	<p>As a practicing physician, I am acutely aware of social determinants of health. From a primary care stand point, we deal with these daily. These determinants include financial issues and abject poverty; more specifically: housing instability, food insecurity (both by access to healthy foods and high food cost in specific areas), transportation access, recreational access, medical care access, mental health care access, and dental care access. The social determinants are related to family support, whether physical, emotional, and/or financial. This support has strained many households with issues of mental health, child care, eldercare, and chemical dependency. Other determinants may or may not be related to poverty. These are underemployment, unemployment, alcoholism, drug addiction, physical and mental abuse.</p> <p>The role of a primary care provider is to identify and communicate with a patient to create a therapeutic relationship. With trust, the patient will provide a medical and social history and an exam necessary to form a plan of care. The plan involves patient education on the condition, the treatment, and the expected result. Care plans and patient encounters may be preventative, therapeutic, or educational.</p> <p>Unfortunately, in the last ten years, the patient-doctor relationship and overall patient satisfaction have eroded by the requirements of aggressive data collection. Benchmarks of meaningful use and preventive measures continue to evolve. The data collection in itself has not improved the quality of care or experience. Moreover, quality measures and many complicated payment schemes have been given to providers to theoretically improve quality care metrics. The question remains: if providers are 100% compliant with meaningful benchmarks, are they in fact mastering quality care or simply mastering the data collection? Additionally, patient nonadherence to a treatment plan or a refusal to consent to a health care screening is held against the provider. Thus, meaningful-use benchmarks cannot be totally mastered, due to patient noncompliance, rendering the whole process meaningless instead of meaningful. Furthermore, income for physicians is lowered for failing to achieve meaningful-use benchmarks.</p> <p>The implementation of the electronic medical record (EMR) has provided the government with many data points. These metrics include ethnic makeup of practices, drug/alcohol use, compliance with health screenings, hypertension data, BMI data, drug utilization, and disease condition management. The EMR has provided an improvement of tracking medicines, a format for documentation of preventative measures, HEDIS standards for EMR itself, and Health Care Chronic Condition standards. However, it has been an overwhelming effort to produce meaningful data. Other than providing problem lists and medication lists, this data has only verified and affirmed patient nonadherence and noncompliance to medical recommendations to the following: to treatment plans, diet planning, living style change recommendations and reaffirming non-disclosure of high-risk behavior, drug, tobacco and alcohol use by the patient. The data provided by the public to physicians is often inaccurate and unreliable. Patients do not willingly disclose drug use, alcohol use, sexual practices or high- risk behaviors. Many highly skilled clinicians miss these issues.</p> <p>Moreover, the time spent on SDOH data collection will add 10-15% more time to assessments. Imagine all patients answering questionnaires and being queried by health professions with regard to INCOME (Salary, Medicaid, Food stamps, SSI benefits, Medicare, or Pensions), FOOD access (Shopping preferences, locations, convenience, quality and cost), HOUSING issues (rent, mortgage cost, living space, utilities and number in household), and TRANSPORTATION (Public transport, taxi, special vans, ride sharing or walking). These questions will not be answered by most of my patients! Patients will ask: How do these</p>	Thank you for submitting your comment for the Office of the National Coordinator for Health IT (ONC) Federal Register Notice published March 11, 2021. This message is to advise that your comment is currently being reviewed.

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9	5/6/2021	Philip Oravetz, M.D. Chief Population	Ochsner Health System (Ochsner) thanks you for the opportunity to comment on OS-0955-New entitled "Access, Exchange and Use of Social Determinants of Health Data in Clinical Notes." We are highly	Thank you for submitting your comment for the Office of the National Coordinator for Health IT	6/9/2

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	<p>Health Officer Ochsner Health 1514 Jefferson Highway New Orleans, LA 70121 Email: mbeckstrom@ochsne r.org</p>	<p>committed to expanding access to care, addressing health disparities, and advancing health equity and strongly believe that addressing social determinants of health challenges (SDOH) for our patients is critical to this work.</p> <p>About Ochsner</p> <p>Ochsner, headquartered in New Orleans, is one of the nation's leading integrated not-for-profit academic health systems. Ochsner – as a leader in value-based care and delivery system innovation – provides a comprehensive range of services through its clinically integrated network of a combination of owned, managed, and affiliated hospitals, and nearly 200 total sites of care located throughout Louisiana and Mississippi. We are proud that our innovative partnership model through the Ochsner Health Network (OHN) allows many communities to maintain local ownership and control of their hospitals, while bringing to bear the benefit of the experience and breadth of the Ochsner clinical and operational teams. Ochsner offers a wide array of specialized and nationally ranked services with its 4,500 affiliated physicians, including more than 1,600 employed physicians practicing in over 90 specialties and subspecialties, and 30,000 employees. Each year Ochsner and its physician partners serve over 1 million individual patients who come from every state in the nation and more than 70 countries. In addition, Ochsner is the largest Medicaid provider in Louisiana and is engaged in vital public-private partnerships, managing safety-net hospitals and physician services in underserved rural and urban communities along with the state's largest combined group of graduate medical education programs.</p> <p>Comments on OS-0955-New</p> <p>Ochsner again thanks you for the opportunity to comment on OS-0955-New. In particular, we respectfully offer the following:</p> <ol style="list-style-type: none"> 1. The United States Core Data for Interoperability (USCDI) should include a data element, which indicates that: (1) the provider has screened the patient for SDOH risk; and (2) the screening identified an SDOH risk/need or no SDOH risk/need. 2. The USCDI should include a data element(s) and z-code(s) that identify transportation as a specific SDOH, in addition to other SDOH elements that currently exist such food and housing insecurity. 3. To maximize collection of SDOH data elements that Ochsner's experience suggests lead to higher patient needs and health care costs, while at the same time reducing provider reduce burden, we offer detailed recommendations for the USCDI to maintain certain SDOH z-codes and consider eliminating collection of others that currently exist. <p>Ochsner's comments reflect our strong commitment to work with the U.S. Department of Health and Human Services (HHS) and the Office of the National Coordinator for Health Information Technology (ONCHIT) to address patients' SDOH needs, enhance quality of care, improve health outcomes, and lower total costs of care.</p> <p>1. USDCI Element to Screen for SDOH Risk/Need</p> <p>Ochsner respectfully urges the development of a new data element for the USDCI, which indicates that:</p> <ol style="list-style-type: none"> 1. the provider has screened the patient for SDOH risk/need; and 2. the screening identified an SDOH risk/need or no SDOH risk/need. <p>Immediately knowing whether or not a patient has an SDOH risk or need meaningfully helps providers during visits deliver more comprehensive and patient-specific care that better accounts for the unique SDOH challenges can lead to optimal health outcomes. Unfortunately, far too often, providers do not know whether or not patients have been screened for SDOH risk/need(s) and whether or not patient-specific SDOH interventions have been implemented to treat those risk/need(s). Thus, to foster more patient-centered care and reduce provider burden, Ochsner respectfully urges the development of a new data element that indicates that the provider has screened the patient for SDOH risk/need, as well as specify whether the screening identified an SDOH risk/need or no SDOH risk/need. The screening should occur somewhat frequently, for example quarterly, so that the most patient data is available to the provider.</p>	<p>(ONC) Federal Register Notice published March 11, 2021. This message is to advise that your comment is currently being reviewed.</p>
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			<p>5. Occupational and environmental exposure (57.0, 57.1, 57.2, 57.3, 57.31, 57.39, 57.4, 57.5, 57.6, 57.7, 57.8, 57.9): Ochsner's experience caring for patients employed by the oil and gas industries in particular has shown that occupational and environmental exposure can directly influence patient health outcomes. Such is likely the case for certain other industries and occupations across the U.S. Consequently, we suggest maintaining the z-codes for occupational and environmental exposure.</p> <p>6. Stress and social challenges (73.0, 73.2, 73.3, 73.4, 73.5): Acute and chronic stress and social challenges hinder patients' ability to maintain a healthy and beneficial social support system, which, as stated above, is important for encouraging patients to perform and maintain prescribed medical and care recommendations necessary for optimal health outcomes. As such, Ochsner suggests maintaining the z-codes associated with patient stress and social challenges.</p> <p>1514 Jefferson Highway • New Orleans, LA 70121 • phone (504) 842-3000 • ochsner.org</p> <p>Page 5</p> <p>7. Adverse childhood experiences (ACEs) (62, 62.0, 62.2, 62.21, 62.22, 62.6, 62.8, 62.810, 62.811, 62.812, 62.813, 62.819, 62.82, 62.89): Published research has shown that ACEs directly correlate with patient health outcomes.^{1 2 3} For example, ACEs contribute to a significantly higher risk and likelihood in individuals suffering from depression, chronic obstructive pulmonary disease (COPD), asthma, heart disease, and obesity/excess weight. ACEs also contribute to unhealthy behaviors such as smoking and heavy consumption of alcohol. As such, Ochsner recommends keeping the z-codes for ACEs.</p> <p>8. Civil and criminal legal issues (65.0, 65.1, 65.2, 65.4, 65.5, 65.8): Individuals confronting civil, criminal, or other legal challenges such as current or past imprisonment face a host SDOH challenges that others without such challenges often do not encounter. These individuals can experience problems with employment stability, housing stability, financial insecurity, transportation instability, and food insecurity, amongst others, that can make it difficult for them to thrive in society and suffer from poor health outcomes. Hence, Ochsner suggests maintaining the z-codes for civil and criminal legal issues.</p> <p>9. Lifestyle (72.0, 72.3, 72.4, 72.5, 72.6, 72.8): Ochsner's experience indicates that lifestyle factors such as lack of exercise, unhealthy diet and eating habits, tobacco use, high risk sexual behavior, gambling and betting problems, and others directly link to negative patient health outcomes. We therefore recommend keeping the z-codes tracking patient lifestyle choices.</p> <p>Conclusion</p> <p>In conclusion, Ochsner again thanks you for the opportunity to comment on OS-0955-New. We very much appreciate your leadership on this important initiative to address patients' SDOH needs and ameliorate health disparities across our Nation. We are eager to serve as a resource to you and your staff as you continue your work on these and other health policy matters.</p> <p>1 Monnat S and Chandler R. "Long Term Physical Health Consequences of Adverse Childhood Experiences." Social Q. 2015 Sep; 56(4): 723-752.</p> <p>2 American Academy of Pediatrics. "Adverse Childhood Experiences and the Lifelong Consequences of Trauma." 2014.</p> <p>3 Center for Youth Wellness. "Childhood adversity increases risk for long-term health and behavioral issues."</p>		
10	5/7/2021	Anthony Mader Anthem	<p>Anthem, Inc. (Anthem) appreciates this opportunity to comment on the U.S. Department of Health and Human Services' (HHS') Office of the National Coordinator for Health Information Technology (ONC) Notice of Proposed Collection for Public Comment regarding Access, Exchange, and Use of Social Determinants of Health Data in Clinical Notes published on March 11, 2021.</p> <p>Anthem is one of the nation's leading health benefits companies, serving over 116 million people through its affiliated companies, including more than 43 million within its family of health plans. As a committed participant in the healthcare markets, including the Medicare, Medicaid managed care,</p>	Thank you for submitting your comment for the Office of the National Coordinator for Health IT (ONC) Federal Register Notice published March 11, 2021. This message is to advise that your comment is currently being reviewed.	

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		<p>individual (both on- and off-Exchange), small group, and large group markets, we look forward to working with HHS to identify data elements reflecting Social Determinants of Health (SDOH) for future inclusion in the United States Core Data for Interoperability (USCDI).</p> <p>Standardization across Screening Tools is Necessary to Reduce Administrative Burden and Improve Patient Health Outcomes.</p> <p>Although the USCDI's standardized set of health data classes and data elements facilitate important interoperable health information exchange, data reflecting SDOH – the conditions in which people live, learn, work, and play – is much more limited. There is a growing recognition that by capturing, accessing, and sharing SDOH data during the course of care and treatment, providers can more easily address non-clinical factors such as food insecurity, housing instability, and transportation.</p> <p>2</p> <p>National standards related to SDOH are needed to resolve inconsistencies and avoid gaps in patient histories when they move among healthcare and social service providers. Population health is at risk when patients do not receive appropriate and effective care and treatment due to misaligned clinical decision support tools. The lack of standards also creates an administrative burden since critical data cannot be efficiently shared among providers using different health record systems.</p> <p>Furthermore, SDOH standards are necessary for payers and providers to collect and share interoperable SDOH data for research and analytics that would document and support efforts to provide greater technical and financial resources to the critically important Community Based Organizations (CBOs). This would ensure robust CBO participation in the healthcare ecosystem.</p> <p>Anthem Supports the Health Level Seven (HL7) Gravity Project's Submission to Include SDOH in the USCDI, Version 2 (v2), for Better Care and Better Health Nationwide.</p> <p>ONC developed a revised USCDI expansion process, which established the ONC New Data Element and Class submission system, used by stakeholders to submit data elements and classes to be considered for future versions of USCDI. Consistent with the revised expansion process, the industry-led Gravity Project submitted two alternative proposals¹ to include SDOH in USCDI v2:</p> <p>☐ Submission 1: New SDOH data class, organized by SDOH functional domains to reflect diverse factors that affect health status; and,</p> <p>☐ Submission 2: New SDOH data class, organized by SDOH activities in clinical care.</p> <p>Regardless of whether ONC includes the SDOH data class and data elements defined, respectively, in Submission 1 or Submission 2, the Gravity Project frames a consistent approach to defining data elements and supporting terminologies and value sets necessary to describe priority social domains across core healthcare activities.</p> <p>Documenting and sharing SDOH-related assessment, diagnosis, and treatment information using coding and data exchange standards has the potential to improve whole person health and well-being, as well as health outcomes. Social and environmental factors impact both individual and population health. As highlighted by the COVID-19 pandemic, the delivery of traditional healthcare accounts for just a small percentage of health. Providers, payers, and vendors are now recognizing this in their adjustments to care coordination and related data collection. Both of the Gravity Project's proposals would add critical domains such as food insecurity, housing instability, transportation insecurity, social isolation, and stress to the USCDI. These domains would be integrated into core clinical activities such as assessments, diagnoses, interventions, and outcomes.</p> <p>¹ 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, dated October 23, 2020. Accessed at https://www.healthit.gov/isa/sites/isa/files/webform/uscdi_webform/1701/Gravity%20Project%20to%20ONC%20on%20SDOH</p>	
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			<p>%20Data%20Class%20for%20USCDI%20v2%202810-23-2020%29.pdf 3</p> <p>Anthem is focused on improving the health and well-being of the communities we serve by focusing on all health indicators, including SDOH, to help every individual address barriers to healthcare and overall health and well-being. A standards-based integration of SDOH data into USCDI v2 is critical to this mission. The inclusion of SDOH as a new data class in the USCDI would support the policy objectives of HHS that focus on improving the experience of care, improving the health of populations, and avoiding unnecessary costs in healthcare.</p> <p>We value the partnership that we have developed with HHS and welcome the opportunity to discuss our recommendations for including SDOH data in the USCDI v2. Should you have any questions or wish to discuss our comments further, please contact Lisa Watkins at (202) 508-7889, or lisa.watkins2@anthem.com.</p>	
11	5/10/2021	Samantha Burch American Hospital Association	<p>On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, we appreciate the opportunity to provide feedback to the Office of the National Coordinator for Health IT (ONC) on the exchange and use of social determinants of health (SDOH) data. Hospitals and health systems are working to address their patients' social needs and the broader SDOH in the communities they serve. This includes societal and environmental conditions such as food, housing, transportation, education, violence, social support, health behaviors and employment. Robust data related to patients' social needs is critical to hospitals' efforts to improve the health of their patients and communities, and we appreciate the ONC's consideration of how best to leverage certified electronic health records (EHR) as a tool to advance health equity.</p> <p>The AHA supports the addition of data classes and elements to future versions of the U.S. Core Data for Interoperability (USCDI) that will enable standardized capture of SDOH. EHRs can be an important tool to support collection of these data necessary to gain key insights at the patient and population health levels and build data-driven interventions. Yet, many of the challenges in collecting these data are not technical in nature, but rather stem from the need to create a value proposition for patients to share highly personal information and provide training and resources to support those engaging directly with patients in data collection. Additionally, the proliferation requests to collect and share SDOH data in non-standard ways adds complexity and duplication for health care providers as well as for patients.</p> <p>As the ONC considers the future direction of its work to support the collection, access and exchange of SDOH data, including through expansion of the USCDI, we make the following suggestions:</p> <p>Prioritize Technical Infrastructure Development. ONC has indicated it will focus on four key areas for using health IT to advance the use of SDOH data: standards, infrastructure, policy and implementation. With numerous federal initiatives underway to explore policy levers to impact SDOH and improve health equity, we encourage ONC to maintain its focus on developing the technical infrastructure needed to support standardization of data elements that are clearly defined to enable robust exchange. We believe ONC is well positioned to lead this foundational work with stakeholders to build the data capabilities within EHR systems that hospitals and health systems need to better identify and address the issues impacting the health of their patients and communities.</p> <p>Incorporate Lessons Learned in Future USCDI Versions. We appreciate the open, transparent process ONC has established to solicit new data classes and elements for potential inclusion in future versions of the USCDI and gather feedback from a broad range of stakeholders as well as the federal Health IT Advisory Committee (HITAC). However, we question whether the approach of finalizing a new USCDI version every year allows enough time to fully evaluate, define, implement and improve on each version. Particularly with respect to SDOH and other equity data, we believe lessons learned should inform future direction. We</p>	Thank you for submitting your comment for the Office of the National Coordinator for Health IT (ONC) Federal Register Notice published March 11, 2021. This message is to advise that your comment is currently being reviewed.

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			<p>encourage ONC to create a roadmap for adoption of expanded versions of the USCDI in regulation that lays out a clear process for collecting and incorporating feedback from end-users.</p> <p>Continue Investments in Real-World Testing. As ONC works across the Department of Health and Human Services (HHS) and with the private sector in its health IT coordination role, we encourage a strong focus on real-world testing of technology solutions to support SDOH data exchange in defined use cases. The AHA was pleased to see that ONC will be funding work related to referral management to address SDOH as part of the Leading Edge Acceleration Projects (LEAP) in Health IT in FY2021. This investment in piloting health IT standards and non-proprietary approaches for managing care referrals for social services and support is needed to test and advance exchange of electronic information across health care and community-based organizations. We encourage ONC to continue to support innovations in technology that enable collaboration between organizations to address the social risks of the individuals served commonly across settings. Findings from these ONC-funded projects should be widely disseminated to support the field in scaling bi-directional SDOH data exchange efforts.</p>	
12	5/10/2021	MaryAnne Lindeblad, BSN, MPH Washington State Health Care Authority	<p>The Washington State Medicaid Agency (SMA), the Health Care Authority (HCA), submits the following comments in response to the March 11th U.S. Department of Health and Human Services (HHS), Office of the Secretary (OS), Office of the National Coordinator for Health Information Technology (ONC) Request for Comment (RFC) on access, exchange and use of Social Determinants of Health Data (SDOH) in clinical notes. Comments are due by May 10th.</p> <p>Background: In the Information Collection Request (ICR), HHS states that:</p> <ul style="list-style-type: none"> • access, exchange and use of health information is essential to better manage patient health care needs and share information with providers and caregivers; and • many hospitals and physicians possess capabilities that enable patients to view and download their health information, yet additional steps are needed to make health information more accessible and useful to both clinicians and patients. <p>HHS requests comments on the burden estimates included in the RFC and on any other aspect of the ICR, including on the following subjects the:</p> <ol style="list-style-type: none"> 1. necessity and utility of the proposed information collection for the proper performance of the agency's functions; 2. accuracy of the estimated burden; 3. ways to enhance the quality, utility, and clarity of the information to be collected; and 4. use of automated collection techniques or other forms of information technology to minimize the information collection burden. <p>HCA Comments:</p> <p>The Washington State Medicaid Agency (SMA), the Health care Authority (HCA), offers the following comments regarding the ICR entitled, "Access, Exchange and Use of Social Determinants of Health Data in Clinical Notes (Document identifier 0955–New– 60D)".</p> <p>The HCA agrees, as described in the ICR, that:</p> <ul style="list-style-type: none"> • access, exchange and use of health information is essential to better manage patient health care needs and share information with providers and caregivers; • many hospitals and physicians possess capabilities that enable patients to view and download their health information; and • additional steps are needed to make health information more accessible and useful to both clinicians and patients. <p>The comments and recommendations offered by HCA are intended to support the creation, exchange, and use of Social Determinants of Health (SDOH) data:</p> <ol style="list-style-type: none"> 1. Many providers across the care continuum (e.g., behavioral health providers, long-term care providers and community-based organizations) have lower technology adoption rates than physicians and hospitals. 	<p>Thank you for submitting your comment for the Office of the National Coordinator for Health IT (ONC) Federal Register Notice published March 11, 2021. This message is to advise that your comment is currently being reviewed.</p>

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			<p>As a result, the ability of these providers to “access, exchange and use of health information” including SDOH data is significantly limited as is the ability to manage patient health care needs and share information with other providers, patients, and caregivers is limited.</p> <p>Comment: We recommend that Federal Government, including ONC and CMS, implement programs to support the adoption and use of interoperable technology by behavioral health providers, long-term care providers and community-based organizations and that such technologies support the creation, exchange, and use of SDOH data. For example, programs could include:</p> <ul style="list-style-type: none"> • financial incentives for these providers to adopt and use interoperable technology; and/or • grants to states making available an enhanced federal match (e.g., 90/10) to design, develop, and implement programs for these providers to adopt and use interoperable technologies. <p>2. The United States Core Data for Interoperability (USCDI) Version 1 (v1) is limited in terms of included SDOH data. Content in the USCDI is referenced in the ONC EHR certification criteria. However, the ONC EHR certification criteria lacks needed specificity to support the interoperable creation, exchange, and re-use SDOH data.</p> <p>The Gravity Project has identified the following codes sets for the following activities:</p> <p>Comment: We recommend that ONC include in the USCDIv2 the:</p> <p>(i) SDOH data class and the domains identified by the Gravity Project (i.e., screening, diagnosis, goal setting, and interventions (including referrals));</p> <p>(ii) specific terminologies (i.e., LOINC, SNOMED-CT, and ICD-10-CM) identified by the Gravity Project for the SDOH domains; and</p> <p>(iii) update future versions of the USCDI as additional SDOH domains and linked terminologies are identified via the Gravity Project and published by terminology coding stewards.</p> <p>3. There is a growing body of literature regarding the value of collecting and using SDOH data to identify and address risks for individuals and populations, the relationship between SDOH domains and health care costs, and interventions and strategies to address these risks^{1,2,3}. For example:</p> <ul style="list-style-type: none"> • Food Insecurity: Food insecurity has been linked in several studies to poor outcomes and higher costs. For example, a 2014 study of low-income diabetic persons found “a cyclic pattern of hospitalizations for hypoglycemia, with rates of hospitalization steadily increasing throughout the course of a month and peaking at the end of the month. ... suggesting that the increase in hypoglycemia-related hospital admissions among low-income individuals at the end of the month occurs concurrently with the exhaustion of food budgets at the end of the month.” <p>A large national insurer focused on food insecurity and offered Supplemental Nutrition Assistance Program (SNAP) benefits to purchase food to members who screened positive for food insecurity. The insurer reported that the number of days those patients were either physically or mentally not well were cut in half, reducing the insurer’s per member per month (PMPM) costs.</p> <ul style="list-style-type: none"> • Transportation Insecurity: A health care delivery system reported reducing its PMPM spending (from \$2,800 to \$1,300) by increasing access to office visits by providing a (non-billable) transportation benefit to persons with diabetes and realizing a reduction in hospital admissions for this population. • Homelessness and Housing Instability: Research shows that: (1) (a) homelessness is associated with increased hospital and emergency department admissions, and (b) housing instability is associated with postponing needed medical care and increased use of emergency department and hospital services; and (2) addressing housing needs can result in significant reductions in hospitalizations and emergency department visits. <p>The preceding examples suggest many of the complexities and challenges of efficiently capturing and using SDOH data, including the need for:</p> <ul style="list-style-type: none"> • Provider and payer systems to connect with social service programs and systems to exchange and (re)use SDOH data. 	
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		<ul style="list-style-type: none"> • Multiple systems (e.g., used by payers and providers across the care continuum) to create, receive and (re)use SDOH data for multiple purposes (e.g., screening/assessment, diagnosis, goal setting, interventions, referrals, and analytics). • Systems linkages between health care providers/payers and non-healthcare data sources (e.g., social service programs such as TANF, SNAP). <p>Efficient collection of SDOH data at the point care and (re)using this data to improve individual and population level outcomes, and decrease costs will require that providers, payers, and programs have and use automated collection techniques or other forms of information technology to:</p> <ul style="list-style-type: none"> • minimize the information collection burden; • support information exchange between providers (i.e., health care, behavioral health, and social service providers), payers, and programs; and • enable analytics to monitor and improve patient-level outcomes and manage population health. <p>However, as noted above, many providers across the care continuum lack needed technology to access, exchange and use of health information, including SDOH data.</p> <p>Further, while we applaud and appreciate the essential work that the Gravity Project is undertaking (e.g., identifying code sets for SDOH domains and data elements), we do not believe this is sufficient to support and increase the collection and use of SDOH data.</p> <p>In January 2020, CMS published a report entitled, “Z Codes Utilization Among Medicare Fee-for-Service (FFS) Beneficiaries in 2017”. The report:</p> <ul style="list-style-type: none"> • noted only 1.4% of Medicare fee-for-service claims in 2017 were accompanied by a Z code; and • highlighted several challenges and solutions that could increase the use of Z codes (e.g., need to address lack of awareness of Z codes and confusion as to who can document Z codes; and need for more widely adopted and consistent documentation related to Z codes). <p>We also reviewed the CMS infographic, “Using Z Codes: The Social Determinants of Health (SDOH) Data Journey to better Outcomes”. The infographic notes that:</p> <ul style="list-style-type: none"> • SDOH data may be documented in the problem or diagnosis list, patient or client history, or provider notes; • ICD-10-CM Z encounter codes (Z55-Z65) are available to document SDOH data; • Encourages use the ICD-10-CM Browser tool to search for ICD-10-CM codes and information on code usage; and • Indicates that health care administrators can understand how SDOH data can be gathered and tracked using Z codes (including investing in EHRs to facilitate data collection and coding and deciding which Z code data to use and monitor). <p>Comment: We appreciate the work undertaken by the Gravity Project and information provided by CMS regarding the use of SDOH Z codes. We believe more work is needed to support the:</p> <ol style="list-style-type: none"> (i) collection and use of SDOH data; (ii) enhance the quality, utility, and clarity of collected SDOH information; and (iii) use of automated collection techniques or other forms of information technology to capture SDOH data. <p>We do not believe the level of guidance provided in the CMS Z Code infographic is sufficient for physical health, behavioral health, and social service providers; payers; social service programs; and information system vendors to understand:</p> <ul style="list-style-type: none"> • the complex and multiplicity of workflows that could be involved in the exchange and re-use of SDOH data; and • when to use various code sets (i.e., ICD-10-CM, SNOMED, LOINC) for different purposes. <p>We agree with the CMS report that more widely adopted and consistent documentation related to Z codes is needed.</p>	
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			<p>Toward that end, we recommend that the ONC in collaboration with CMS:</p> <ul style="list-style-type: none"> • summarize the literature regarding the: <ul style="list-style-type: none"> o costs and benefits of providers and payers (including Medicaid) of collecting and using SDOH data; and o population health management activities that have been undertaken by providers and payers (including Medicaid) • develop a toolkit that could be used by providers, payers, and programs regarding the collection and use of SDOH data, including how SDOH codes could be included on claims and for what purposes; and • develop guidance on the workflows that could be used to support the collection, exchange, and use of SDOH data. Specifically, we recommend that these workflows be developed for: <ul style="list-style-type: none"> o providers (physical health, behavioral health, and social service providers); o payers (including Medicaid); o social service programs (e.g., TANF, SNAP, schools); and o the interoperable exchange and re-use of SDOH content between these organizations. <p>Finally, we recommend that Federal Government, including ONC and CMS, support investments in the infrastructure needed to support Community Information Exchange (CIE). For example, the Federal Government could award grants to State Medicaid Agencies (SMA) for the design, development, and implementation of the infrastructure needed for CIE. Such grant program could:</p> <ul style="list-style-type: none"> • Require that the SMA partner with other state agencies to identify shared needs for SDOH data and opportunities to re-use SDOH data across agencies; and • Require the SMA to design a CIE infrastructure that: <ul style="list-style-type: none"> o Supports the creation and re-use interoperable SDOH data at the point of care; o Enables the exchange and re-use of interoperable SDOH data between providers (physical health, behavioral health, and social service providers), payers, social service programs, and between state agencies to improve patient outcomes, decrease costs, and enable needed population health analytics; o Leverages, re-uses, and extends information system functionalities required by CMS and ONC (e.g., the Provider Directory requirements in the CMS Interoperability Rule and use of the ONC International Standards Advisory); and o Makes available financial incentive payments and other supports for the adoption and use of interoperable technologies that enable the creation, exchange, and re-use of SDOH data by physical health, behavioral health, and social service providers. <p>Thank you for your time and consideration of our comments.</p>	
13	5/10/2021	Lauren Choi, MA, JD Blue Cross Blue Shield Association	<p>The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to respond to the Office of the National Coordinator's (ONC) request for comments on Access, Exchange, and use of Social Determinants of Health Data in Clinical Notes, as published in the Federal Register on March 11, 2021 (86 FR 13908). BCBSA is a national federation of 35 independent, community-based and locally operated Blue Cross and Blue Shield (BCBS) companies (Plans) that collectively provide health care coverage for one in three Americans. For more than 90 years, BCBS companies have offered quality health care coverage in all markets across America – serving those who purchase coverage on their own as well as those who obtain coverage through an employer, Medicare and Medicaid.</p> <p>BCBSA believes that everyone should have access to high-quality health care regardless of race, ethnicity, national origin, sex, gender identity, sexual orientation, religion, education level, age, geography or disability. BCBS Plans across the country are actively engaged in hundreds of initiatives to advance health equity, with every Plan operating at least one local initiative. Many of BCBS Plans' initiatives focus on addressing social determinants of health (SDOH) across crucial areas like food insecurity, housing and transportation. Other BCBS companies' initiatives address health disparities within a specific health</p>	<p>Thank you for submitting your comment for the Office of the National Coordinator for Health IT (ONC) Federal Register Notice published March 11, 2021. This message is to advise that your comment is currently being reviewed.</p>

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		<p>condition, including diabetes, heart disease, behavioral health and maternal health – areas known to adversely affect underserved communities in America.</p> <p>Our efforts to advance health equity also involve ways to leverage advanced technologies and analytical models that focus on multiple factors including SDOH data and outcomes rather than cost alone, as well as balancing the potential for unintended skewed results from the use of these novel technologies.</p> <p>Additionally, thoughtful and secure application of novel technologies could help advance population health at the community level by raising awareness and providing utilization metrics that surface actionable insights for industry initiatives and community programs.</p> <p>To better identify and address health disparities, and to improve the current and future application of novel technologies, we believe it will be important for the Department of Health and Human Services (HHS) to support the standardization of SDOH data with electronic health records (EHRs). We encourage HHS to continue to engage with public-private initiatives to develop, identify and incorporate SDOH data elements and classes as well as implementation guides to support seamless access, exchange and use of SDOH data. With these goals in mind, we provide the following priority recommendations in response to the proposed collection for public comment.</p> <p>☑ Continue the methodical and stakeholder-driven process for considering data elements and classes to include in the U.S. Core Data for Interoperability (USCDI) standard. We appreciate the process that the HHS Office of the National Coordinator for Health IT has undertaken and believe that public stakeholder input is critical for the continued evolution of the USCDI standard.</p> <p>☑ Standardized social determinants of health data is critical to empowering providers and payers to better identify and address patients’ holistic health and social needs. Stakeholder-driven efforts like the HL7 Gravity Project are leading the way in developing standards and implementation guides to enable the access, exchange and use of social determinants data.</p> <p>☑ Social determinants of health data should be included in future versions of the USCDI. We support the inclusion of social determinants data classes and elements in future versions of the USCDI. We specifically support the two approaches recommended by the Gravity Project in its December 2020 letter to ONC urging the inclusion of a social determinants data class to the USCDI Version 2.</p> <p>In what follows, we expand on the above recommendations and offer additional details regarding the access, exchange and use of SDOH data in clinical notes.</p> <p>Issue: Expanding the USCDI</p> <p>The 21st Century Cures Act (Cures Act) requires HHS and ONC to improve the interoperability of health information. ONC's Cures Act Final Rule also identifies important data elements that should be made electronically available and exchanged through the use of health information technology (IT). The United States Core Data for Interoperability (USCDI) is a standardized set of health data classes and constituent data elements for nationwide, interoperable health information exchange.</p> <p>ONC has developed a process for expanding the current USCDI Version 1, including a submission system through which stakeholders may submit data elements and classes to be considered for future versions of USCDI. As a result of this public input process, ONC released the draft USCDI Version 2 in January of this year, which proposes to modestly expand the data elements included in the USCDI. ONC has also begun the process of soliciting feedback and reviewing stakeholder submissions for USCDI Version 3, which will be released in January 2022.</p> <p>Recommendation:</p> <p>BCBSA supports the use of USCDI as the clinical data standard in required Application Programming Interfaces (APIs) and for health data exchange across entities; the use of a standardized set of data classes of codes is critical to enable the seamless exchange of health information.</p> <p>Rationale:</p>	
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Access, Exchange and Use of Social Determinants of Health Data in Clinical Notes
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		<p>BCBSA applauds ONC’s methodical and stakeholder-driven process for considering data elements and classes to include in the USCDI. The USCDI is a good representation of the data providers need to direct care, and which consumers need to facilitate their care, and should continue to be reflective of such needs moving forward.</p> <p>Issue: Standardizing SDOH Data</p> <p>As ONC notes in the proposed collection for public comment, the access, exchange and use of social determinants of health data is much more limited than other health data.</p> <p>Recommendation:</p> <p>BCBSA believes that documenting and sharing SDOH-related assessment, diagnosis and treatment information using progressive coding and data exchanges standards has the potential to improve whole-person care, well-being, and health outcomes. Therefore, we strongly support the standardization and inclusion of social determinants data elements, enabling seamless access, exchange and use of such data for patient care.</p> <p>Rationale:</p> <p>BCBSA agrees with ONC that accessing social determinants of health data during the course of care will allow providers and payers to better identify and address patients’ social needs and improve health outcomes. Unfortunately, previous efforts to align and standardize health data across EHRs and other systems of record has largely been limited to clinical data.</p> <p>With rapidly increasing interest in collecting social risk data, the HL7 Gravity Project is a direct response to calls-to-action around the development of national standards for SDOH data reported in EHRs. The Gravity Project convenes broad stakeholder groups and over 1200 nationwide collaborators in “identifying and harmonizing social risk factor data for interoperable electronic health information exchange.” BCBSA and BCBS Plans are proud to be founding and active members in the Gravity Project’s collaborative efforts to reduce the current barriers to integration of social risk data into clinical decision-making.</p> <p>The Gravity Project has developed use cases to support the documentation of specific social domains; identified common data elements and their associated value sets; identified gaps in current data elements and value sets and developed recommendations to fill them; developed recommendations on how to best capture and group data elements for interoperable electronic exchange and aggregation; and created a Fast Healthcare Interoperability Resources (FHIR) Implementation Guide based on the defined use cases and associated data sets.</p> <p>The Gravity Project’s collaborative efforts have set a foundation for standardizing critical SDOH data, enabling its integration into EHRs and for interoperable electronic health information exchange.</p> <p>Issue: Including SDOH Data in the USCDI</p> <p>HHS and ONC proposes to identify social determinants of health data elements for potential inclusion in the USCDI in the future.</p> <p>Recommendation:</p> <p>BCBSA supports the inclusion of social determinants of health data elements in the USCDI and recommends that ONC use the approaches recommended by the Gravity Project, as described in its December 2020 letter to ONC.</p> <p>Rationale:</p> <p>BCBSA believes a standards-based integration of SDOH data into the USCDI is a time-sensitive action for interoperable data exchange to improve the health and well-being of those we serve.</p> <p>The inclusion of SDOH as a new data class in USCDI is a requisite for better identifying social needs and capturing social risk. Incorporating and enabling the interoperable exchange of such data will support a focus on, and prioritization of, use cases with a high impact on the triple aim—HHS’ widely accepted policy</p>	
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		<p>objective that refers to improving the experience of care, improving the health of populations, and reducing per capita costs of health care.</p> <p>As noted, BCBSA and BCBS Plans are active participants in the Gravity Project and have contributed to the Gravity Project’s consensus-driven, multi-stakeholder efforts to “develop standard terminology, vocabulary and codes to refer to and implement SDOH concepts in the EHR context.”</p> <p>These efforts led to the development of two alternative approaches for adding a new data class, Social Determinants of Health, to the USCDI:</p> <p>☑ Submission 1: SDOH data class, organized by SDOH domains</p> <p>5</p> <p>☑ Submission 2: SDOH data class, organized by SDOH activities in clinical care</p> <p>The first approach, would create a new SDOH data class that is organized by SDOH domains, including Food Insecurity, Housing Instability and Homelessness, Inadequate Housing, Transportation Insecurity, Financial Strain, Social Isolation, Stress, Interpersonal Violence, Education, Employment, and Veteran Status. The domains include elements with specific vocabularies for Assessments, Goals, Problems/Health Concerns, Interventions, Outcomes, and Consent.</p> <p>Alternatively, the second approach would create a new SDOH data class that is organized by data elements that reference SDOH activities and tools used in clinical care. The data elements would likewise include Assessments, Goals, Problems/Health Concerns, Interventions, Outcomes, and Consent. Each element would contain a taxonomy of SDOH health status that can be leveraged to describe conditions across multiple SDOH domains.</p> <p>BCBSA strongly believes that the approaches recommended by the Gravity Project should be considered for forthcoming versions of the USCDI – thus enabling more seamless access, exchange and use of SDOH data.</p> <p>* * *</p> <p>Thank you for the opportunity to comment on the importance of accessing, exchanging and using social determinants of health data in EHRs.</p>	
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