Meeting Summary

Leveraging Electronic Health Records (EHR) Sourced Measures to Improve Care Communication and Coordination Option Year Web Meeting 3

The National Quality Forum (NQF) convened a multistakeholder Committee web meeting for the Leveraging Electronic Health Record (EHR) Sourced Measures to Improve Care Communication and Coordination Project on February 8, 2022.

Welcoming Remarks, Meeting Objectives, and Attendance

Chelsea Lynch, NQF Director, welcomed participants to the web meeting and reviewed housekeeping reminders. Ms. Lynch introduced the Committee co-chairs, Dr. Richard Antonelli and Dr. Gerri Lamb, who provided welcoming remarks. Ms. Lynch reviewed the project timeline, meeting agenda, and the following meeting objectives:

- Review and assess social determinants of health (SDOH) domains within the Gravity Project
- Discuss the impact of SDOH data on EHR-based care communication and care coordination
- Develop recommendations for how SDOH data can be used for care communication and care coordination quality measurement

Victoria Freire, NQF Analyst, conducted attendance for Committee members and Federal Liaisons. Ms. Lynch introduced the NQF project team and CMS staff before reviewing meeting ground rules for conducting a respectful and insightful discussion.

Recap of Web Meeting 2

Ms. Lynch proceeded to provide a brief overview of the second web meeting. She noted that the meeting provided context on the approach for interoperability and related EHR attributes. Ms. Lynch reminded the Committee that interoperability is the ability to share information easily between different systems and that the interoperable data within the EHR is essential for having optimized care communication and care coordination. The Committee also reviewed some background resources for additional context about various project-related concepts and refined recommendations for how EHRs could better facilitate care communication and care coordination.

Ms. Lynch highlighted that the Committee identified missing EHR capabilities from the recommendations, including timeliness of information shared, barriers related to motivations for health systems to share data, ability to track patient care between facilities, inclusion of shared decision making when care planning, and inclusion of the patient voice. Ms. Lynch briefly reviewed the updated recommendation themes based on Committee feedback, noting the addition of a new theme by separating the optimization of EHR usability for clinicians and patients. An example of a recommendation that would be included within this new theme is having an EHR that allows patients and their caregivers to communicate with their clinicians and non-clinical teams securely, both asynchronously with applications like email and synchronously like with the use of telemedicine.

Overview of Gravity Project

Ms. Lynch provided an overview on the Gravity Project and how it relates to EHR-based care communication and care coordination. The Gravity Project is a Health Level Seven Fast Healthcare Interoperability Resources (HL7 FHIR) Accelerator project that addresses the needs for both semantic and structural level interoperability of electronic SDOH data. It is a multistakeholder public collaborative with the goal to develop, test, and validate standardized SDOH data within the EHR using identified coded data elements. There are 18 social risk domains identified by the Gravity Project and for each one the project is attempting to create terminology work streams that will create consensus-based representative data sets for screening, diagnosing, goal setting, and intervening. The intent of the Gravity Project is not to redefine any of these elements, rather it is identifying existing ways to gather this data and capture it within the EHR so there is more standard data collected.

Ms. Lynch also reminded the Committee that HL7 FHIR is an internet-based approach to transferring and sharing health information to provide seamless interoperability and patient-centered, data-driven care. It is a representational state application programming interface (API) that includes specifications for how one system requests and receives data. It includes Resources (discrete data concepts such as patient information, family history, and medication list) and Profiles (use cases that tell the relationship and provide meaning to the Resources). Additionally, both CMS and the Office of the National Coordinator for Health Information Technology (ONC) have rules that are requiring implementation of FHIR-based APIs to support the sharing of health information and this implementation will also help move the field towards digital quality measurement.

Working Session: Purpose and Approach

Ms. Lynch outlined that the breakout sessions allow for a more in-depth discussion for the development of recommendations related to how SDOH data can be used to improve EHR-based care communication and care coordination and care communication and care coordination quality measurement. Each Committee member, Federal Liaison, and member of the public would be assigned to a breakout group with one of the co-chairs and several NQF staff. Ms. Lynch emphasized that each group would have 60 minutes to brainstorm and discuss recommendations before reporting out from the session and addressing any final points for discussion as a group.

Breakout Group 1 Discussion

Prior to the discussion, Dr. Lamb ensured that all group members had access to the breakout group worksheet and briefly reviewed the breakout session discussion questions:

- What impact could the Gravity Project have on EHR-based care communication and care coordination?
- What data collection considerations should be included when implementing these definitions in the EHR (e.g., data provenance, data accuracy, collection burden)?
- How should these data sets be used for care communication and care coordination quality measurement (e.g., risk stratification, risk adjustment, new measure concepts)?
- What other SDOH data beyond the Gravity Project could be used for care communication and care coordination quality measurement?

Dr. Lamb introduced the first discussion question and asked Committee members to provide feedback on the impact of Gravity Project to EHR-based care communication and care coordination. One Committee member expressed concern over the unintended consequences of a provider having access to patient data, such as insurance status, that could result in them selecting to provide care to certain patients based on perceived risk or other criteria that could lead to inequitable care. Another Committee member noted that the Gravity Project provides an advantage to the standardization of care coordination data, citing that many academic facilities are already in the process of collecting these data but are using inconsistent definitions. The same Committee member also noted that the Gravity Project will elevate patient care continuity as well as allow for the creation of quality measures to set benchmarks and track outcomes. A member of the public expressed her appreciation for the discussion surrounding SDOH data and care coordination. The member of the public noted the importance of having a unified system collecting patient information from multiple providers to reduce both redundancies and data collection burden for providers and patients. Dr. Lamb thanked the member of the public for her feedback and noted the group could review the food insecurity domain since it is the most developed domain and exemplifies the data elements being identified and developed by the Gravity Project. Another Committee member noted that the Gravity Project could support EHR interoperability, but the next steps would be integrating these data elements as certification standards from ONC. The Federal Liaison from CMS clarified that an authority must be tied to any certification requirement and that the United States Core Data for Interoperability (USCDI) is not linked to the Gravity Project. CMS is supportive of Gravity Project-based data elements and has supported two that are at the USCDI level of maturity. The Federal Liaison also noted the alterative to certification is specifying quality measures to incorporate certain SDOH data elements to help support measure stratification. Dr. Lamb summarized the discussion on the first question, adding that the Gravity Project's data elements could improve the quality-of-care planning and help to match a patient's level of need to the right level of care.

Dr. Lamb introduced the second discussion question and asked Committee members to provide feedback on the data considerations that should be included when implementing these definitions in the EHR. Dr. Lamb noted the earlier discussion surrounding the considerations for data sensitivity, privacy, and potential unintended consequences. A Committee member shared a personal anecdote about when she was asked a social risk screening question by a primary care provider (PCP) and noted the provider's unsure reaction when she asked how the provider could assist her if her response was "yes". One Committee member noted a similar experience and emphasized the importance of data accuracy. The Committee discussed the definition of data provenance, noting it is identifying where the data were created and by whom. A Committee member added that a value of FHIR standards is that they allow users to capture data provenance when it is created which becomes metadata (i.e., data about other data) that is connected to the data. When the data are exchanged, future users of the data will know where the data were created and by whom. Another Committee member emphasized the cost of data collection, especially for smaller organizations, and reiterated the considerations for data sensitivity and privacy.

Dr. Lamb introduced the last two discussion question and asked Committee members to provide feedback on how these data sets can be used for care communication and care coordination measurement and what additional SDOH data beyond the Gravity Project could be useful for care communication and care coordination. A Committee member noted that the use of Z codes (i.e., International Classification of Disease, Version 10 (ICD-10) codes that are not directly related to another clinical diagnosis) and the weight of these codes, depending on a patient's clinical needs, should be considered as well. Dr. Lamb clarified that that the weight of the Z codes is related to risk stratification as well as a clinician's differentiation for processing. Another Committee member agreed with the use of the Z codes but noted that there is a limitation of 12 codes when billing and recommended that either the limit could be increased or a process for prioritization could be implemented. The Committee member also emphasized the importance of self-reported or patient-entered data to increase accuracy and reduce burden for clinicians. Another Committee member agreed that patient-entered data would eliminate the inaccuracy of clinician-entered Z codes, noting that these depend almost entirely on the intuition of the provider. Additionally, a Committee member shared that artificial intelligence (AI) could help assign values without a human needing to enter the data which would also help reduce burden. A Committee member noted in the chat the need to include preferred language, religion, and cultural aspects for improved care communication and care coordination.

Breakout Group 2 Discussion

Dr. Antonelli began the discussion by reviewing the purpose of the group discussion and introduced the first topic of discussing the potential impact the Gravity Project could have on EHR-based care communication and care coordination. Committee members agreed that SDOH data are essential, but often overlooked when collecting social history and sharing information with other providers. Dr. Antonelli asked Committee members to think about when they collect this data, in what ways the system processes that information, and what do providers and payers do with this information. The Committee discussed these data could be used for quality measurement and identified the importance of timely sharing of the information with the right member on the care team to inform the patient-specific care plan.

A Committee member shared their facility is struggling with collecting SDOH data during inpatient care, noting they decreased the number of questions asked from seven to one due to the impact of the COVID-19 pandemic. The member noted when SDOH concerns are identified, community health workers are engaged to elicit additional information from the patient and concerns may be escalated to the nurses, social workers, or may stay with the community health workers. Additionally, different departments in a hospital setting may have different constraints and availability to inquire about social history for their patients. The Committee noted healthcare providers often find that this information is important but collecting the data are time-consuming, particularly with staffing shortages across different healthcare settings, which adds to the variability in SDOH data collection.

The Committee then had a robust discussion on the lack of trust in the healthcare system present in patients. Members shared their individual experiences within their professional fields and one member noted some patients may be most comfortable sharing answers to more sensitive SDOH questions with their PCP over specialty providers (e.g., dermatologist) due to their preexisting relationship. However, other members noted the PCP may not have established a trusting relationship with the patient and, therefore, the patient might be more comfortable sharing it with another provider or in another setting. One Committee member noted patients and caregivers have hesitancy in disclosing sensitive information due to numerous issues, not limited to, fear of being dehumanized, verbalizing their concerns, and feeling like a “statistic” rather than a person.

The Committee then transitioned to discuss potential solutions that can help patients build trust. One Committee member suggested creating an informed consent process before the collection of SDOH data to promote transparency to patients about the purpose and intended benefit of answering the questions. It was further suggested that the data collection process should be flexible, highlighting the complexity of the questions and allowing for the questions to be altered so they are simple enough to answer for the patients but still achieve the same results as the more complex questions. Another solution identified by Committee members was the importance of being intentional with who is asking the questions and ensuring the questions are asked in a language and method the patient understands so the patient is not minimized. It was also identified that trust is built through relationships, and it should not be forced. The Committee noted that patients must trust their healthcare providers and integrate where trust exists and expand it to other disciplines. For example, many patients receive care in many settings (e.g., inpatient, outpatient, long-term care, community-based organizations, etc.) and it was recommended that there needs to be a collaborative effort with these settings on sharing SDOH data as the level of trust might be different across settings.

Another solution identified by the Committee was providing sensitivity training to a diverse workforce including providers, community health workers, and any member of a patient's care team. A Committee member informed the group that the Case Management Society of America (CMSA) administers an advanced practice training program for case managers to assess the risk for complex and vulnerable populations and weigh that risk for health domains to target care plans to reduce identified risks. Through this risk reduction approach, when addressing trust, a primary case manager works with a patient to disseminate the information to relevant stakeholders apart of the patient's care team. The Committee noted that including community health workers and non-clinical staff in the training would be beneficial as they are part of the care team serving these vulnerable populations.

The Committee's discussion then transitioned to how SDOH data collected within the EHR could be highlighted and key information shared with the care team. A Committee member noted the SDOH color wheel from Epic is an example of how these data can be visually shared with the care team to assist them in identifying this key information. A Committee member suggested that prioritizing data to highlight SDOH data indicators that contribute the most risk is essential for providing quality care and noted the Gravity Project may be able to assist with identifying these key indicators. Another Committee member presented the approach of using predictive modeling rather than questionnaires to identify unmet social needs and inform clinical decision support tools. It was identified that a predictive modeling process could help notify a provider that a patient is at high risk but emphasized the importance of collecting individualized data to provide patient-specific care.

The Committee then discussed how SDOH data can be used for care communication and care coordination measurement. A Committee member highlighted that measuring care communication and care coordination should not be focused on financial accountability, rather it should be used to identify meaningful outcomes for patients. Another Committee member shared there are gaps in available tools (e.g., questionnaires) to obtain data related to overlooked determinants of health in healthcare settings such as inequality, housing, and food insecurity. In comparison, there are helpful behavioral health tools that, while not always patient-reported, could identify needs based on the answers provided. A potential measure concept could be how often a tool has been implemented per each healthcare encounter. Additionally, the Committee identified that performance measures cannot be appropriately analyzed if the data are not collected or shared and highlighted the importance of ensuring data are accurate before they are shared. Additional potential measure concepts identified were the use of data in an encounter where the information was not originally collected, screen positive rates for data that are collected, and applying SDOH data to related readmission measures.

The Committee then discussed if there are any missing elements in the Gravity Project domains. The Committee identified disability status, sexual orientation, need for complex care/treatment for chronic illness, access to care, and connection to primary care were missing. In addition, a Committee member noted the Gravity Project is centered around the healthcare system rather than where a patient seeks care, adding the need to be more inclusive to where patients receive care and healthcare resources (e.g., community pop-up center).

Working Session: Breakout Group Report Outs

Ms. Lynch welcomed everyone back from the breakout sessions before asking Dr. Lamb and Dr. Antonelli to share key recommendations from the breakout group discussions. First, Dr. Antonelli shared the report out for breakout group 2 followed by Dr. Lamb's report out for breakout group 1.

Breakout Group 2 – Report Out

Dr. Antonelli shared an overview of the main themes that his group discussed during the breakout session. Dr. Antonelli emphasized the importance of building trust between a patient and the healthcare team, identifying how to communicate with patients the purpose of collecting SDOH data, and identifying for the patient the tangible things that the data might be used for. A recommendation identified by the group was to develop and sustain a diverse workforce that includes community health workers and other non-clinical staff in all healthcare settings. The group also discussed having an informed consent process to help facilitate transparency between the patients and the care team about how the data might be used. Another recommendation was to build an integrated process amongst the care team to ensure timely, accurate data collection to limit the repetitiveness of answering SDOH questions by the patient. It was elaborated that this should not be an extensive listing of a patient's SDOH history to the next provider but an alert system that allows key information (e.g., identified barriers or risks) to be shared with everyone on the care team. Another recommendation was to provide sensitivity training to the care team to standardize the interactions they are having with multiple medical and non-medical providers. The group also discussed that there are few performance measures for care coordination and SDOH. Due to this, the frequency, accuracy, and continuity over time of data utilization are limited in determining if patients are receiving quality care. Ms. Lynch emphasized that the data collection process should match the workflow of the healthcare setting to help limit the data collection burden for clinicians. Additionally, the standardization of SDOH data collection will allow for identifying which SDOH indicators are most impactful and can influence outcomes. A Committee member mentioned that another key factor related to lack of trust is due to the mishandling of demographic data (e.g., name, date of birth) which can lead to more distrust and hesitancy to disclose more sensitive information like SDOH questions.

Breakout Group 1 – Report Out

Dr. Lamb shared an overview of the breakout group's discussion on the Gravity Project and recommendations for how to use SDOH data for care communication and care coordination. Dr. Lamb began by sharing the impact the Gravity Project could have on care communication and care coordination. Dr. Lamb emphasized the group's recommendations related to data sensitivity and privacy, noting the potential unintended consequences related to the access of patient data. Dr. Lamb also noted the importance of standardizing SDOH data elements for seamless communication and connections across the care continuum to reduce redundancies and burden of care. The group also noted that standardization of data elements could enable the tracking and benchmarking of outcomes, the tracking of patient referrals, and the tracking of data across providers. Dr. Lamb noted that the Gravity Project would allow providers better linkages to community-based organizations and enable providers to track patients' progress. The group also addressed the implications of Gravity Project data elements for EHR certification standards. Dr. Lamb addressed the data considerations that the group discussed including privacy and sensitivity surrounding patient data, the cost of data collection especially for smaller organizations, Z codes and their weight, and the importance of data accuracy. The group briefly discussed the future of AI and the human-tech interface of care communication and care coordination. Dr. Lamb also added that these SDOH data provide an opportunity to identify the potential sources of non-compliance by highlighting the barriers and taking actions to alleviate them.

Member and Public Comment

Ms. Freire opened the web meeting to allow for public comment. No public comments were offered.

Next Steps

Ms. Freire reminded the Committee that any additional input on the SDOH domains, ideal capabilities, and capacities of EHRs, or feedback from previous web meetings could be shared via email to EHRCarecoordination@qualityforum.org. Ms. Freire also noted that the next web meeting will be held on Monday, March 21, 2022. Ms. Lynch, Dr. Lamb, and Dr. Antonelli offered final remarks and concluded the meeting.