Social Determinants of Health Practice Module

May 2022

Implementation of Quality Improvement Initiatives to Improve Diabetes and Hypertension

Quality Insights

This publication was supported by the Cooperative Agreement Number NU58DP006516 from the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention. Publication number DEDPH-HD-053122A

Table of Contents

Purpose of Module

The Quality Insights 2022 Social Determinants of Health (SDOH) Practice Module provides a framework for identifying social needs in the clinical setting and how the health care team can work together to reduce SDOH in Delaware communities. Designed to supplement the previously released 2021 SDOH Practice Module, this update includes new statistics and expanded content for:

- Leveraging data to address SDOH;
- Identifying social needs via screening tools, including utilization of the PRAPARE tool;
- Implementing standardized, closed-loop workflows, and;
- Getting started with connecting patients to local assistance resources

Social Determinants of Health (SDOH)

are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Source: Healthy People 2030

This module can be utilized by clinic leadership to determine next steps for workflow modification and alignment with resources available in your region. Note that referenced guidelines and recommendations are to be used along with physician/clinician judgment and based on individual patients' unique needs and circumstances.

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
• Employment • Income • Expenses • Debt • Medical Bills • Support	• Housing • Transportation • Safety • Parks • Playgrounds • Walkability • Zip code/ geography	• Literacy • Language • Early childhood education • Vocational training • Higher education	• Hunger • Access to healthy options	• Social integration • Support systems • Community engagement • Discrimination • Stress	• Health coverage Provider availability • Provider linguistic and cultural competency • Quality of care

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Source: https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

Introduction: Integrating SDOH and Health Equity

SDOH are now widely recognized as important predictors of access to and engagement in health care, as well as health outcomes (Artiga & Hinton, 2018). Positive social, as well as economic and environmental, conditions are associated with a wide array of positive or improved patient medical outcomes and lower or reduced costs, while worse conditions negatively affect health and health-related outcomes, e.g. hospital readmissions rates, length of hospital stay, and use of post-acute care services (Green & Zook, 2019; Kangovi, Shreya, & Grande, 2011; Virapongse & Misky, 2018).

Health Equity

The state in which everyone has a fair and just opportunity to attain their highest level of health. Requires focused and ongoing societal efforts to address historical and contemporary injustices; overcome economic, social, and other obstacles to health and healthcare; and eliminate preventable health disparities.

Source: The Centers for Disease Control and Prevention (CDC)

Health care organizations nationwide are increasingly looking to integrate SDOH and health equity into value-based strategies. Where should these organizations focus their efforts? **Payers and providers are considering patients with chronic conditions because they disproportionately consume a significant portion of health care spending and system utilization** (Oyekan et al, 2022). For example:

Diabetes:

- Hispanics are twice as likely to be hospitalized for treatment of end-stage renal disease related to diabetes and 1.3 times more likely to die from diabetes as compared with non-Hispanic Whites.
- American Indian/Alaska Native adults are almost three times more likely to be diagnosed with diabetes, 2.3 times more likely to die from diabetes, and twice as likely to be diagnosed with end-stage renal disease as non-Hispanic Whites.

Cardiovascular Disease:

- While modest gains have been made in reducing racial health inequities in urban areas, large gaps in death rates between Black and White adults persist in rural areas, particularly for diabetes and hypertension.

Rural:

- Compared with urban areas, rural areas have higher rates of cancer, infant mortality, diabetes, drug overdose and opioid misuse, and a higher mortality rate from heart disease and stroke.

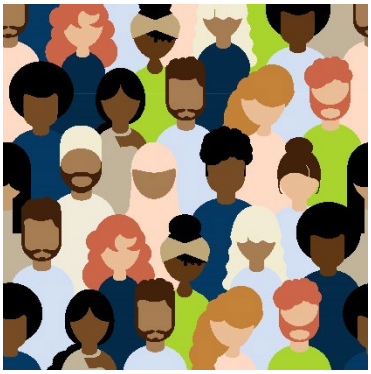
For patients with chronic conditions, strengthening linkages between clinical and social services to support screening, referrals, and programs to align health and social interventions has never been more necessary for health care ecosystem transformation to mitigate SDOH contributing to health inequities.

Therefore, payers, providers, policies and politics, pharma, patients, and current and new entrants into the health care systems must integrate and weave SDOH into all aspects of care across the health continuum. It is only then that the quest for value-based care and the Quintuple Aim (better care; healthier people; smarter spending; care team well-being; and health equity) become a reality for all (Oyekan et al, 2022).

Take the Next Step:

- NEW (April 2022): The Health Equity Challenges and CMS Resources to Help Address Them infographic outlines various barriers to health equity and related challenges that populations often face and shares CMS resources that can help close the health equity gap.
- The Health Equity Guide for Public Health Practitioners and Partners is designed to help schools, workplaces, businesses, places of worship, and health care settings adopt policies that promote health. The guide was produced by the Delaware Division of Public Health, the University of Delaware's School of Public Policy & Administration, and other partners.
- Download Delaware Focus: Health Inequities and Race in the First State. This policy brief from the University of Delaware explores how SDOH are the most important drivers of health.
- Visit the Delaware Division of Public Health's Bureau of Health Equity for additional resources targeted at ensuring everyone in Delaware achieves their full health potential by eliminating differences in health outcomes due to SDOH.

Collecting Race, Ethnicity, and Language Data



Addressing SDOH is a primary approach to achieving health equity, and progress toward eliminating health disparities requires widespread, consistent, and reliable population data. The COVID-19 pandemic has further highlighted health disparities between different races and ethnicities. In order to address these disparities, practices can work to properly document a patient's race, ethnicity, and language data, thus allowing the practice to:

- Identify the need to develop diverse patient materials
- Provide more culturally appropriate care and education
- Recognize areas where care disparities exist
- Develop quality care initiatives to ensure equitable care

Take the Next Step:

- Do you experience barriers collecting race, ethnicity, and language data? Contact your local Quality Insights Practice Transformation Specialist for no-cost technical assistance.
- Download Quality Insights Health Equity Infographic to learn more about the importance of collecting race and ethnicity data (see Appendix B).
- For in depth materials and resources related to systematically collecting race, ethnicity, and primary language data from patients, review the American Hospital Association Institute for Diversity and Health Equity's (AHA IFDHE) Disparities Toolkit.
- NEW from CMS (March 2022): Inventory of Resources for Standardized Demographic and Language Data Collection
- Target:BP™ CME Course: How to Collect Accurate and Complete Race/Ethnicity Data – A Step Toward Improving Health Equity

Screening for Social Needs

Providers need tools and strategies to identify the upstream socioeconomic drivers of poor outcomes and higher costs. With this data, they can transform care with integrated services to meet the needs of their patients, address SDOH, and demonstrate the value they bring to patients, communities and payers.

Several screening instruments are available to aid physicians in identifying SDOH in a primary care setting. The following are a small sample of options for consideration:

PRAPARE Assessment Tool

The National Association of Community Health Centers' Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences tool (PRAPARE) is both a standardized patient social risk assessment tool consisting of a set of national core measures as well as a process for addressing the social determinants at both the patient and population levels. By using PRAPARE, providers can better target clinical and non-clinical care (often in partnership with other community-based organizations) to drive care transformation, delivery system integration, as well as improved health and cost reductions. A few additional benefits include:

Electronic Health Record (EHR) Integration:

Data from the assessment can be directly uploaded into many electronic health records (EHRs) as structured data. EHR templates and video demos are available for eClinicalWorks, Cerner, Epic, athenahealth®, athenaPractice™ (formerly GE Centricity), Greenway Intergy, and NextGen (Athena users must contact their customer success managers to implement PRAPARE in their EHR).

For those who use an EHR where a PRAPARE template doesn't currently exist, there is an available paper form (available in 30 languages) and Excel file template that allows you to collect standardized PRAPARE data in Excel until a PRAPARE EHR template is developed.
When integrated into the EHR, PRAPARE automatically links to relevant ICD-10 Z codes (where applicable) that can be added to the assessment, diagnostic, or problem list.

Implementation Tools for Practices:

PRAPARE Readiness Assessment Tool: Use this tool to help identify your organization's readiness to implement PRAPARE.
Implementation Strategy Work Plan: Outlines tasks, roles, responsibilities, and provides space to document progress.
Training: Free webinars and resources are accessible from the PRAPARE website and the PRAPARE YouTube Channel

Take the Next Step:

- Recent guidance (2021) from the Centers for Medicare and Medicaid Services (CMS) provides new clarity on Medicaid and State Children's Health Insurance Program (SCHIP) authority for reimbursement of SDOH screening and interventions in particular circumstances. The National Association of Community Health Center's released (2022) a publication demonstrating opportunities to use SDOH screening tools such as PRAPARE to improve the delivery of care through enhanced data collection and relationships with safety-net programs. Download Social Determinants of Health – Medicaid Coverage and Payment.
- The best first step to get started with PRAPARE and/or evaluate your current use of this tool is to review the PRAPARE Implementation and Action Toolkit. If you need assistance or have questions, please contact your local Quality Insights Practice Transformation Specialist.
- Download Quality Insights' Social Determinants of Health and Your Practice: Tools to Reduce Health Disparities. This two-page resource includes helpful tips for utilizing the PRAPARE tool and addressing SDOH in your practice.

2 Centers for Medicare & Medicaid Services (CMS) Accountable Health Communities' Health-Related Social Needs Screening Tool

The CMS ten-question Health-Related Social Needs Screening Tool is meant to be self-administered. The tool can help providers find out patients' needs in five core domains that community services can help with, including housing instability, food insecurity, transportation problems, utility needs, and interpersonal safety.

Utilizing ICD-10-CM Codes ("Z Codes")

ICD-10-CM codes included in categories Z55-Z65 ("Z codes") identify non-medical factors that may influence a patient's health status.

Existing Z codes identify issues related to a patient's socioeconomic situation, including education and literacy, employment, housing, lack of adequate food or water or occupational exposure to risk factors like dust, radiation or toxic agents. Utilizing Z codes allows clinics and hospitals to better track patient needs and identify solutions to improve the health of their communities.

In 2021, CMS Office of Minority Health published a Data Highlight reviewing SDOH Z Code utilizations among Medicare Fee-for-Service (FFS) Beneficiaries in 2019.

The top five Z Codes representing the largest shares of all Z Code claims are highlighted on the next page.

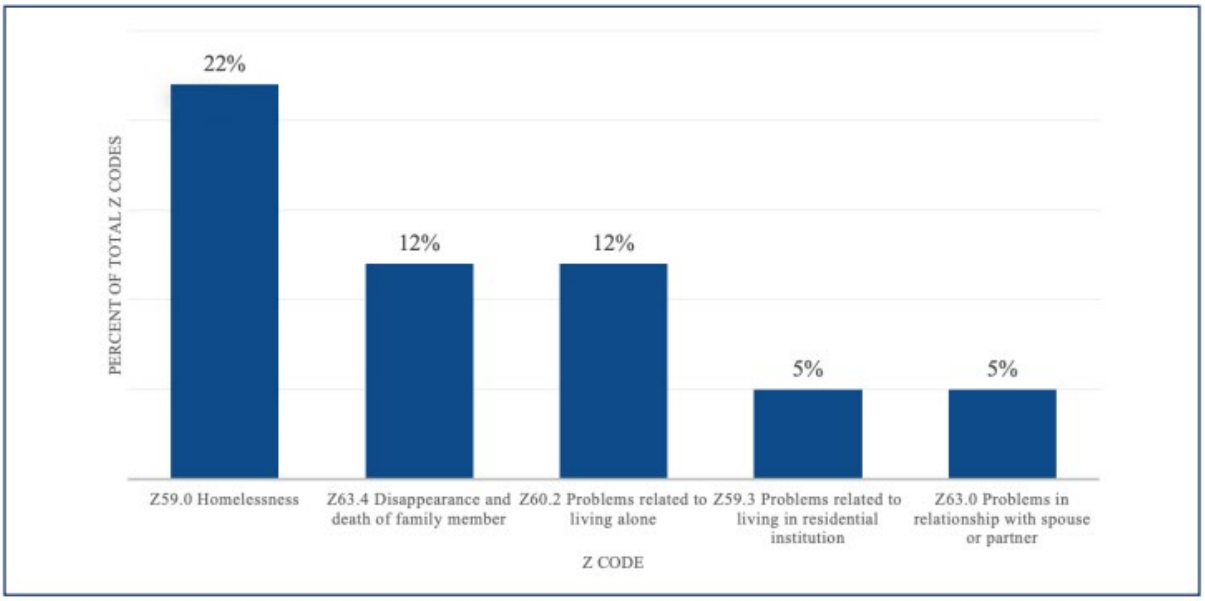
Key Statistics from the 2021 CMS Office of Minority Health Data Highlight:

Among the 33.1 million continuously enrolled Medicare FFS beneficiaries in 2019, 1.59 percent had claims with Z codes, as compared to 1.31 percent in 2016.

The top five provider types representing the largest proportions of Z codes were family practice physicians (15 percent), internal medicine physicians (14 percent), nurse practitioners (14 percent), psychiatry physicians (13 percent), and licensed clinical social workers (12 percent).

Black and Hispanic beneficiaries accounted for 8.8 percent and 5.9 percent of the overall FFS population, respectively, but represented 24.8 percent and 9.2 percent, respectively, of those with a Z59.0 – Homelessness claim.

Top Five Z Codes Representing the Largest Shares of All Z Code Claims (N=1,262,563) in 2019



Source: Maksut JL, Hodge C, Van CD, Razmi, A, & Khau MT. Utilization of Z Codes for Social Determinants of Health among Medicare Fee-For-Service Beneficiaries, 2019. Office of Minority Health (OMH) Data Highlight No. 24. Centers for Medicare and Medicaid Services (CMS), Baltimore, MD, 2021.

Take the Next Step: Explore more information about ICD-10 Z codes, including coding categories, frequently asked questions, and addressing common barriers:

- Quality Insights: Provider's Quick Guide to Social Determinants of Health ICD-10 Codes
- CMS: Using Z Codes: The Social Determinants of Health (SDOH) Data Journey to Better Outcomes Infographic
- American Hospital Association: ICD-10-CM Coding for Social Determinants of Health
- 2022 CMS ICD-10-CM Official Guidelines for Coding and Reporting
- e-Health Initiative Explains ICD-10-CM Coding for Social Determinants of Health

Care Team Workflow

A successful, integrated workflow that prioritizes SDOH screening, coding, and referrals to community resources truly necessitates the coordination of the entire care team. **The following SDOH workflow model referenced in this section is summarized from Chapter 5 of the PRAPARE Implementation and Action Toolkit.**

The Five Rights Framework

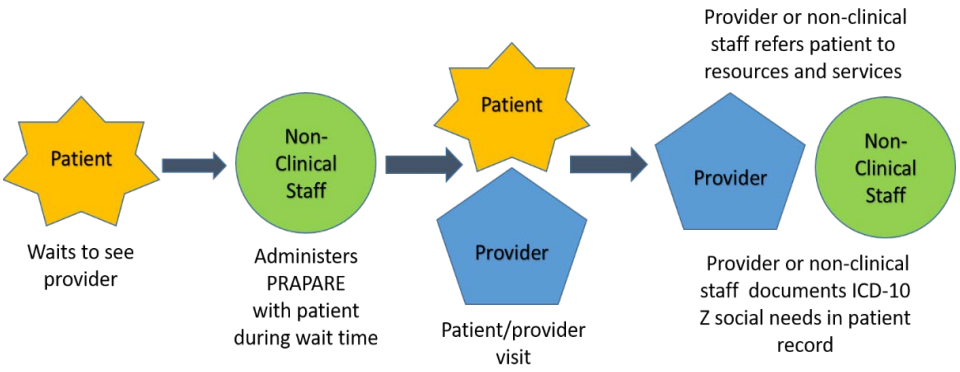
Collecting data on SDOH using PRAPARE can be accomplished in a variety of ways. There is no absolute "right way"—only what works best in your setting. The Five Rights Framework is one option to determine the best data collection and response workflow for your own setting.

Using the Five Rights Framework to Plan Workflow for PRAPARE Data Collection and Response		
5 Rights	**Workflow Considerations**	**Response Workflow Considerations**
Right Information: WHAT	What information in PRAPARE do you already routinely collect? • Part of registration • Part of other health assessments or initiatives	What information and resources do you have to respond to social determinants data? • Update your community resource guide and referral list with accurate information • Track referrals, interventions and time spent
Right Format: HOW	How are we collecting this information and in what manner are we collecting it? • Self-Assessment? • In-person with staff?	How will intervention and community resource information be stored for use and presented to patients? • Searchable database of resources (in-house or via partner)? • Printed resource for patients to take with them? • Warm hand-off for referrals?
Right Person: WHO	Who will collect the data? Who has access to the EHR? Who has contact with the population of focus? Who needs to see the information to inform care? • Providers and other clinical staff? • Non-Clinical staff?	Who will respond to social determinants data? • By a dedicated staff person? • By any staff person who administers PRAPARE with the patients? • By the provider?

Right Channel: WHERE	Where are we collecting this information? Where do we need to share and display this information? • In waiting room? In private office? • Share during team huddles? Provide care team dashboards?	Where will referrals and/or resource provisions take place? • In private office? • In the exam room?
Right Time: WHEN	When is the right time to collect this information so as to not disrupt clinic workflow? • Before visit with provider? (before arriving to clinic, while waiting in waiting room, etc.) • During visit? • After visit with provider?	When will referrals take place? • Immediately after need is identified? • After the patient see the provider? • At the end of the visit?

PRAPARE Tool: Sample Workflows

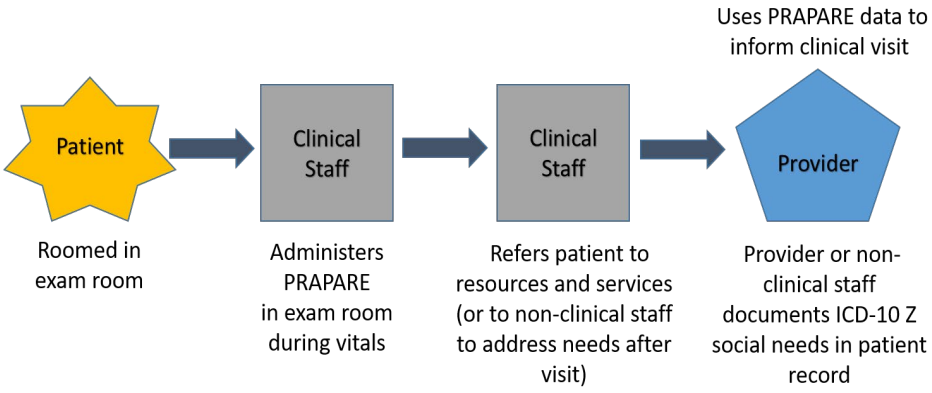
Option 1: Using Non-Clinical Staff Before the Clinical Visit



Option 1 Advantages:

- PRAPARE data informs clinical visit to ensure appropriate treatment plan developed.
- Uses "value-added" time when patient would otherwise be waiting.

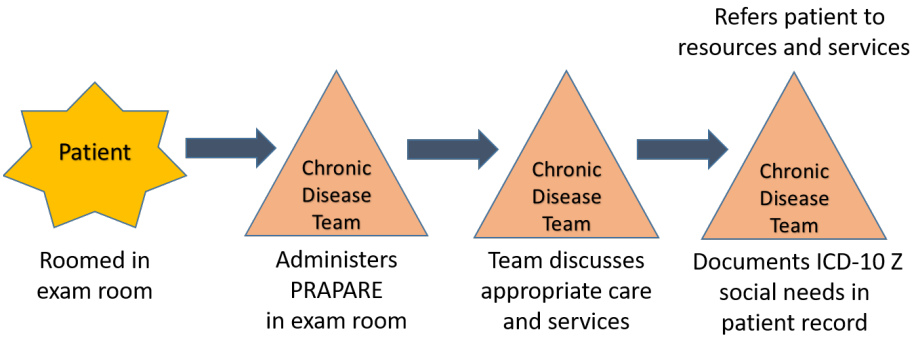
Option 2: Using Clinical Staff During Clinical Visit



Option 2 Advantages:

- Administering PRAPARE in exam room ensures privacy.
- Use PRAPARE data to inform clinical visit with provider to ensure appropriate treatment plan developed.

Option 3: Using Chronic Disease Management Team



Advantages of Option 3:

- Comprehensive team to assess and address patient's social determinant needs and use data for care planning.
- Eases burden on staff who conduct other screenings.

Take the Next Step:

- Share the sample workflows above with your care team by downloading Quality Insights *PRAPARE Social Determinants of Health Screening: Sample Workflows*.
- Nine unique, standardized SDOH screening workflow options are available to review in the PRAPARE Implementation and Action Toolkit. Click here to find a SDOH workflow that compliments your practice environment.

Locating Resources & Referral Partners

Getting Started: Where to Find Assistance in Times of Need

Once a patient's needs have been assessed, the next important step is identifying available community partners for coordinating appropriate referrals.

The following options are provided as a means to help you locate available resources in your region:

- Unite Delaware: Partners in the network are connected through a shared technology platform, Unite Us, which enables them to send and receive electronic referrals, address people's social needs, and improve health across communities. Unite Delaware is a bidirectional system for practices and community based organizations to bring resources to their patients that is sponsored by ChristianaCare.
- Findhelp.org (Aunt Bertha): Visit this website to learn more about how patients can find food assistance, help paying bills, and other free or reduced cost programs in their region.
- 211 Helpline Center (United Way): From help with a utilities bill, to housing assistance, after-school programs for kids, and more, patients can dial 211 or text their zip code to 898-211 to talk with a resource specialist for free.
- Supplemental Nutrition Assistance Education Program (DE SNAP-Ed): The University of Delaware offers a variety of ongoing food, nutrition and health programs as the implementing SNAP-Ed agency in Delaware. More information about the availability and format of class offerings can be found by visiting the website or by contacting your local county extension office.
- Food Bank of Delaware: Provides nutritious foods to Delawareans in need and facilitates long-term solutions to hunger and poverty through community education and advocacy.
- Delaware Healthy Neighborhoods: This is initiative is an innovative approach to addressing population health challenges. Healthy Neighborhoods is focused on creating sustainable interventions by convening local stakeholders to improve health in their communities.
- My Healthy Community: Provides community-level statistics and data that can be used to understand and explore health and related factors that influence health.
- Delaware State Service Centers: Provides information regarding state services centers
- Delaware Division of Services for Aging and Adults with Physical Disabilities
- HelpIsHereDE - Behavioral health and substance use resources
- National Library of Medicine: Providing Multilingual and Multicultural Health Information Resource List
- National Library of Medicine: Providing Multilingual and Multicultural Health Information Resource List

Delaware Emergency Medical Diabetes Fund

The Delaware Emergency Medical Diabetes Fund provides diabetes services, medications, and supplies to residents of Delaware on an emergency need basis. It provides a maximum payment of $500 per client, per 12 consecutive months, for items directly related to diabetes that will eliminate or alleviate the medical condition.

Eligibility Requirements*:

- Individual has diabetes (type 1, type 2, gestational, or other) or prediabetes.
- Medical need is present that could result in serious impairment of health, prolonged hospitalization, complications, or death.
- Individual is without resources immediately accessible to meet his/her health needs.

**Requests are evaluated on case-by-case basis, using established Delaware State Service Center financial screening and eligibility criteria. More detailed eligibility information may be accessed here.*

Learn more about eligibility and referral by downloading this flyer for providers and patients (Spanish language flyers are available on the Quality Insights website). This program is administered by the Delaware Division of State Service Centers. Referrals can be made by calling the Delaware Diabetes & Heart Disease Prevention and Control Program at **302-744-1020**.

The Healthy Heart Ambassador - Blood Pressure Self-Monitoring Program (HHA-BPSM)

Help your patients improve their hypertension with a new, evidence-based program that empowers them to manage their blood pressure (BP) while learning ways to eat healthier and be more physically active. This **NO COST program** from the Delaware Division of Public Health (DPH) provides **specially trained health coaches to teach simple yet proven ways for patients to better manage and understand their BP, increase physical activity, adopt healthier eating habits, and more.**

Participants who enroll in the HHA-BPSM program receive:

- A BP monitor (if needed) and training on how to measure & track BP at home
- Virtual support from specially trained facilitators & virtual learning sessions
- Cooking demos & nutrition education
- Support to help people with hypertension make real changes for heart health

Learn More

Quality Insights invites you to explore more information and refer patients to the HHA-BPSM program by reviewing the links below:

- For Providers: Learn about the HHA-BPSM program, participant requirements, and program referral details.
- For Patients and Delaware State Employees: Explains program features, requirements and includes contact information for participation.
- HHA-BPSM Program Provider Enrollment Fax Form: Practices can complete this form to refer patients by fax. A phone number, 302-208-9097, is also included on the form as additional option for making a referral.
- HHA-BPSM Provider "Script Pad" Referral Flyer: This document can be given to patients to encourage them to learn more about the program and enroll.

Get Involved: Become a HHA-BPSM Volunteer Program Facilitator

If you, or someone you know, has a desire to help people living with high blood pressure achieve better control through a supportive, evidence-based, holistic approach, Quality Insights and Delaware DPH is now offering a great opportunity to get involved. Download this HHA-BPSM Volunteer Program Facilitator flyer to learn more about the program and related qualifications. Clinical background is not required. **Apply to become a Volunteer Program Facilitator by calling (302) 208-9097.**

Free Blood Pressure Screening Locations by County

Delaware residents can have their blood pressure measured for free at a variety of locations across Delaware. **Find locations in your community to share with your patients by downloading these flyers (updated January 2022) from Quality Insights:**

- New Castle
- Kent
- Sussex

Closing the Care Loop: Follow-Up Guidance

Tracking the outcome of a referral is often the only way to know if a social needs intervention was effective. Follow-up outreach to patients with known social needs is recommended to ensure their needs have been met, to identify any new concerns, and help the referring provider narrow down which resources are the most helpful for patients in their community.

The *Kaiser Permanente COVID-19 Social Health Playbook (2019)* offers the guidance below for following up with patients post-referral to community-based services.

Where available, use existing follow-up protocols.

If existing protocols are not available, identify individuals (e.g. navigators, care coordinators) to do follow-up outreach. If available, a risk score can be used to prioritize patients for follow-up outreach.

When determining timeframe for follow up, consider patient acuity, the nature of their social need(s), and the availability of resources.

- Suggested timeframes:
  - Follow up in one week: Patients at high risk for medical decompensation due to their social need and/or a high-risk transition
  - Follow up after one week or longer:
    - Patients not currently experiencing acute medical symptoms. Follow up as clinically indicated or per existing program follow up protocol
    - Example: Patient experiencing food insecurity but without any nutrition-related medical conditions and is self-sufficient or has caregiver support in following up on resource information.

Action Steps for Frontline Care Team

- Conduct outreach:
  - Ask if previously offered resources were used and/or helpful.
  - Ask if patient has new or additional needs. If possible, conduct a full screening (see "Screening for Social Needs" section of this module).
  - Connect to new/additional resources as needed (see "Locating Resources and Referral Partners" section of this module).
- Document status/outcome to follow up (i.e. needs met, connected to resources, any additional follow up needed).

Evidence-Based Support for Addressing SDOH

Business Case Strategy

LexisNexis® Risk Solutions: 3 Steps for Building a SDOH Business Case

This playbook is designed to help your organization build a strong business case for implementing SDOH initiatives that will positively affect the health outcomes for your patient population and provide a methodology that can be used to scale into larger, more encompassing programs over time. Because measuring success throughout the process is vital to understand the effect of SDOH initiatives and because different stakeholders look at different metrics, measurement suggestions and/or key takeaways for consideration for your business case are provided throughout each of the steps. Click here to learn how to build a successful business case aimed at getting your SDOH initiative off the ground.

Return on Investment (ROI) Calculator for Partnerships to Address SDOH

This calculator is designed to help community-based organizations and their health system partners plan sustainable financial arrangements to fund the delivery of social services to high-need, high-cost (HNHC) patients. The tool is intended for health systems, payers, medical providers, social service providers, and community-based organizations seeking to address SDOH. Access the calculator here.

Build an Organizational Response to Health Disparities

Focused quality improvement efforts should be targeted to populations at risk for disparities. Explore this guide from CMS for resources and concepts key to addressing disparities and improving health care quality throughout your organization. Download *Building an Organizational Response to Health Disparities* here.

Advance Health Equity

Leverage Data to Reduce Health Inequities

Gathering social care data at scale can meaningfully contribute to advancing health equity, and analyzing the relationship between health and social care data can lead to valuable insights about how to improve overall health. But how can this realistically be achieved in the practice setting?

A 2022 Unite Us white paper, *Leveraging Data to Advance Health Equity*, outlines five principles of practice that are critical to reducing health inequity:

1. Ensure communities and individuals most impacted have power to make decisions.
2. Leverage the power of referral data to improve access to social care.
3. Measure and evaluate.
4. Remove barriers to data sharing.
5. Use data to drive action.

Explore each of these principles in detail by downloading the white paper on the Unite Us website.

Understand the Relationship between Health Equity and Primary Care

Primary care settings play a vital role in ensuring population health and equity by providing whole-person care, advocating for polices to accelerate practice transformation, and partnering with sectors outside of clinical medicine like social programs. Explore concrete actions primary care stakeholders can pursue to reduce inequities and take steps toward achieving health equity in this new report (May 2022) from the Primary Care Collaborative, *Primary Care: A Key Lever to Advance Health Equity*.

Address SDOH in Rural Communities

The Rural Health Information Hub (RHIhub), formerly the Rural Assistance Center, is funded by the Federal Office of Rural Health Policy to be a national clearinghouse on rural health issues. In 2020, they published a *Social Determinants of Health in Rural Communities Toolkit*, which serves as an evidence-based compilation of promising models and resources.

View the toolkit on the RHIhub website, and learn about addressing SDOH in rural communities by reviewing their topic guide, *Social Determinants of Health for Rural People*.

Make Progress on Standardization of SDOH Data with the Gravity Project®

Launched in May 2019 by the Social Interventions Research and Evaluation Network (SIREN) with funding from the Robert Wood Johnson Foundation, the mission of the Gravity Project® is to create and maintain a consensus-building community to expand available SDOH core data for interoperability and accelerate standards-based information exchange by using Health Level Seven International (HL7®) Fast Healthcare Interoperability Resources (FHIR®). The project is a direct response to recommendations and calls to action around creating national standards for representing SDOH data in electronic health records (EHRs).

The success of the Gravity Project depends on the contribution of volunteers who are eager to make rapid progress on the standardization of social determinants of health data. We need experts to contribute to and validate definitions for SDH related data elements and value sets. Participants are asked to join the project at any time either as a **Committed Member** or **Other Interested Party** as part of the HL7 Consensus Process. To join the project, **sign up here**.