ONC Social Determinants of Health (SDOH) Information Exchange Learning Forum

Vision, Purpose, and Community Engagement

Friday, April 22, 2022
1:00 pm – 2:30 pm EST

The Office of the National Coordinator for Health Information Technology

Agenda

- Welcome
- Background and Context for SDOH Information Exchange
- Overview of SDOH Information Exchange Foundational Elements
  - Community Readiness and Stewardship
  - Mission and Purpose
- Presenters:
  - Monroe County Systems Integration Project
  - District of Columbia CoRIE Project
- Questions & Discussion
- Learning Forum Series and Small Group Opportunities
- Closing

Introductions

Greg Bloom
EMI Advisors

Kristina Celentano
EMI Advisors

Karis Grounds
211 San Diego

Brenda Kiritkumar
EMI Advisors

Liz Palena-Hall
ONC

Sheetal Shah
EMI Advisors

Whitney Weber
ONC

Evelyn Gallego
EMI Advisors

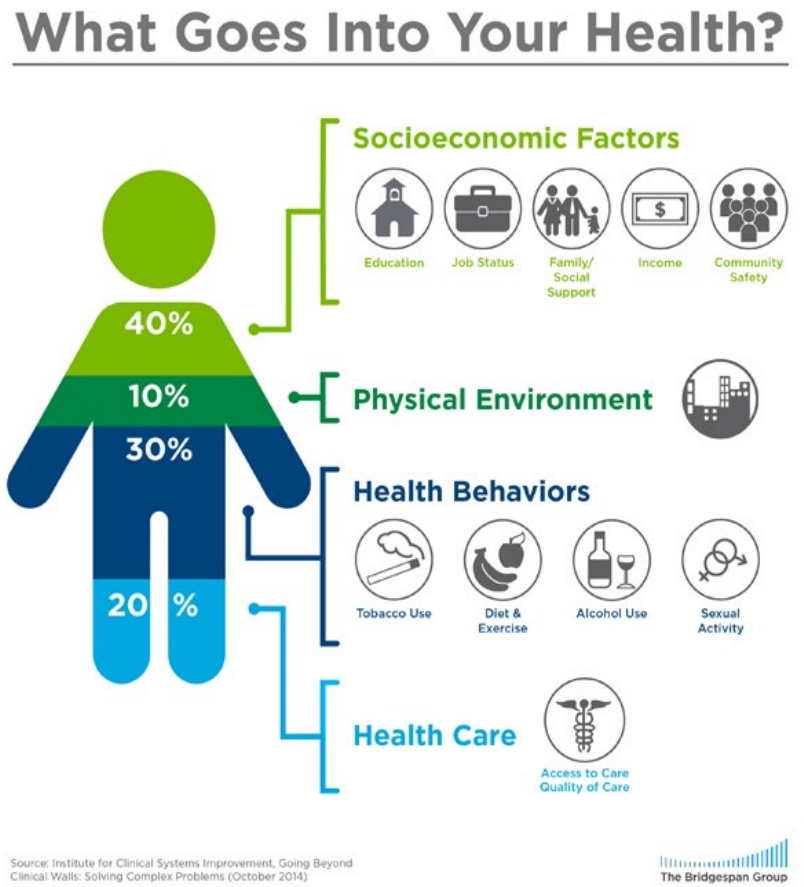
Background and Context for SDOH Information Exchange

Why Are Social Needs Important?

There is growing awareness that SDOH information improves whole person care and lowers cost. Unmet social needs negatively impact health outcomes.

- **Food insecurity** correlates to higher levels of diabetes, hypertension, and heart failure.
- **Housing instability** factors into lower treatment adherence.
- **Transportation barriers** result in missed appointments, delayed care, and lower medication compliance

Addressing SDOH is a primary approach to achieve health equity.



Sourced: Gravity Project

[1]https://www.cdc.gov/nchhstp/socialdeterminants/faq.html

[2]https://www.bridgespan.org/insights/library/public-health/the-community-cure-for-health-care-(1)

SDOH and HHS Healthy People 2030

- Healthy People 2030 sets data-driven national objectives to improve health and well-being over the next decade and was released by HHS on August 18, 2020.
- One of Healthy People 2030's 5 overarching goals is specifically related to SDOH: "Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all."

For more information, visit Healthy People 2030 & Objectives: Social Determinants of Health

ONC: Federal Health IT Strategic Plan 2020-2025

The Plan was developed in collaboration with over 25 federal organizations and is intended to guide federal health IT activities.

It includes an objective to integrate health and human services information and identifies federal strategies to:

- Strengthen communities' health IT infrastructure
- Foster greater understanding of how to use health IT
- Capture and integrate **SDOH data** into EHRs

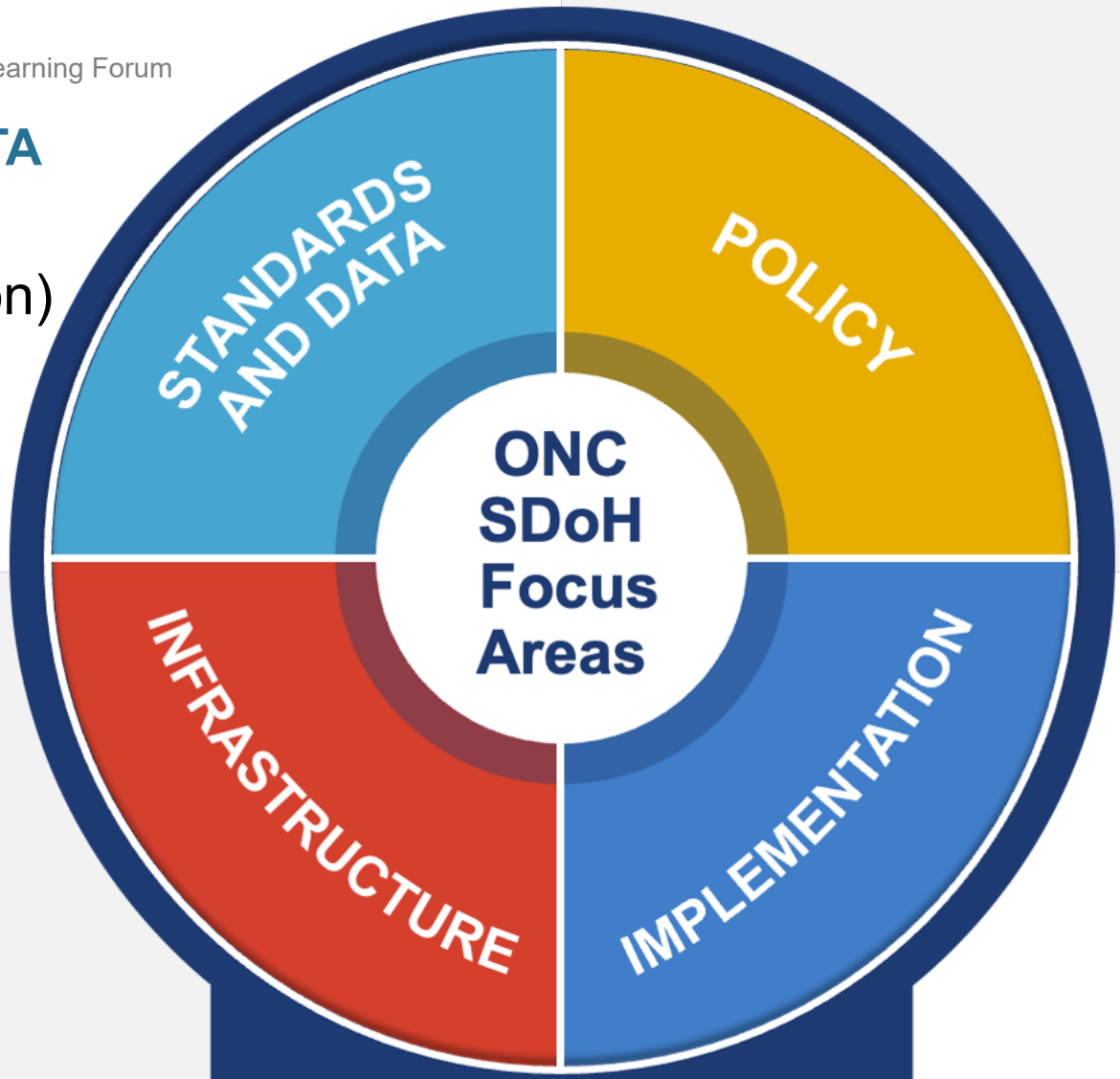
https://www.healthit.gov/sites/default/files/page/2020-10/Federal%20Health%20IT%20Strategic%20Plan_2020_2025.pdf

STANDARDS AND DATA

(Advance Standards Development Adoption)

POLICY

(Emerging Policy Challenges & Opportunities)



INFRASTRUCTURE

(SDOH Information Exchange/ Interoperable Referrals, HIE, State, & Local)

IMPLEMENTATION

(Integration, Innovation, and Health IT Tools)

Collect, Access, Exchange, Use

Overview of SDOH Information Exchange Foundational Elements

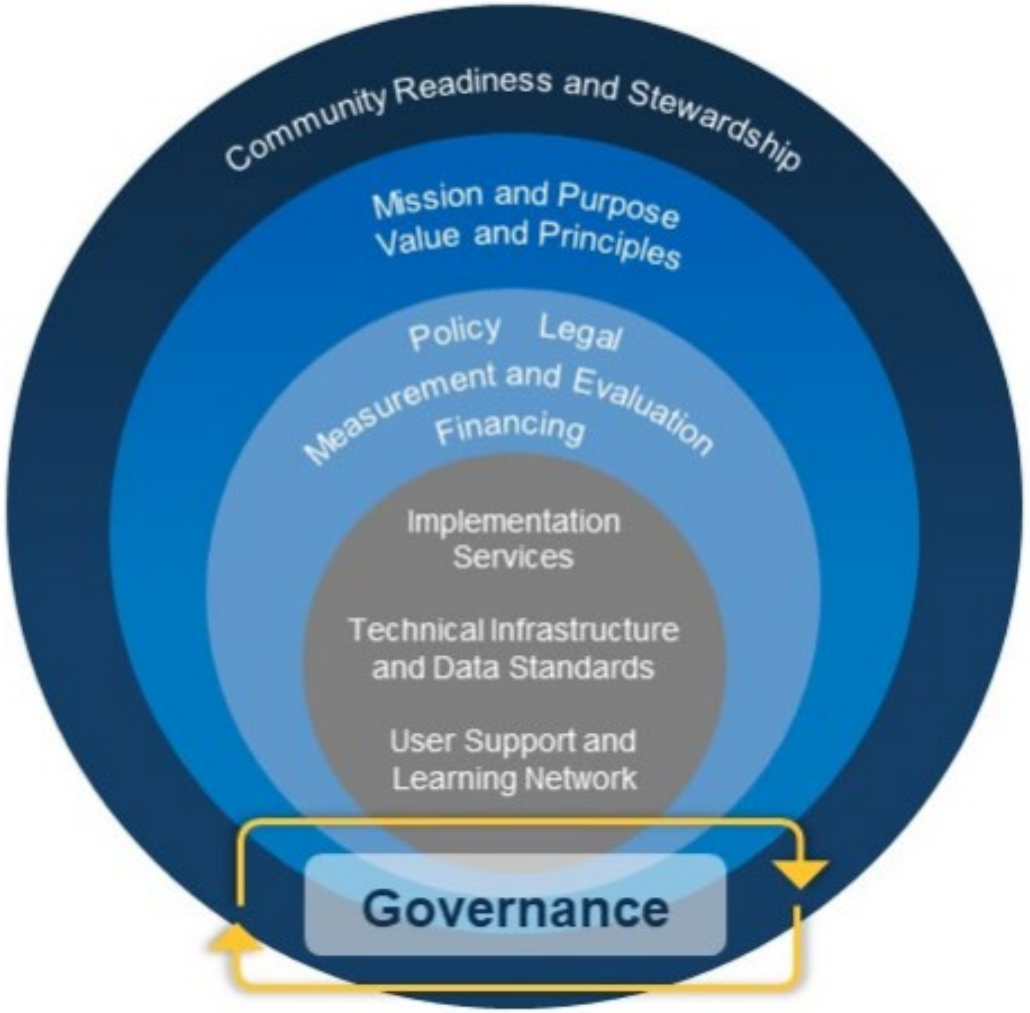
SDOH Information Exchange Toolkit

- Draft toolkit informed by a Technical Expert Panel (TEP) in 2021.
- The TEP included members from coalitions, community-based organizations, federal and state government, health care providers, health information technology (IT) vendors, payers, and philanthropic foundations.

Intended Audience:

- Community resource referral initiatives, platforms, and technologies
- Government agencies, including federal, state, local, and tribal
- Health care provider networks
- Health information exchanges (HIEs)
- Human services providers
- IT platform developers and managers
- Networks of community-based organizations (CBOs)
- Payers
- Policymakers
- Other health and human services entities

Social Determinants of Health Information Exchange Foundational Elements



Community Readiness and Stewardship

Community Readiness & Stewardship

Community readiness is a reflection of the existing landscape of needs, assets, initiatives, opportunities, and challenges in the community of focus, including shared interests and capacities to cooperate and engage in change-making.

Community stewardship entails the development of stakeholders' shared rights and responsibilities in the process of co-design, evaluation, and decision-making.

Questions to Consider

- Which organizations are interested and willing to collaborate?
- What gaps have been identified and how will your initiative align with the identified needs?
- What existing trust has been established to begin collecting data? What steps might still be needed to establish sufficient trust? How will this trust be preserved over time?
- How will individuals from diverse populations, especially from historically disadvantaged communities, those experiencing systematic barriers, or those with high needs, participate in this process?

Mission and Purpose

Mission & Purpose

The stated mission and purpose of a SDOH information exchange initiative should:

- Address the various value propositions held by stakeholder groups, as well as the vision and scope of services, and
- Articulate the expected benefits for collecting, sharing, and using data.

Questions to Consider

- Who will decide what your mission and purpose will be?
- How will communities that may be impacted by your initiative be represented in this process?
- By working together, what steps could you take to promote health equity?
- What progress is expected to be achieved through the work?
- How will you know if you've succeeded in achieving the mission and purpose?

Monroe County Systems Integration Project

ONC SDOH Information Exchange Learning Forum

April 22, 2022

Monroe County Systems Integration Project (SIP)

Introduction

Vision

Community Readiness & Stewardship

Lessons Learned

SYSTEMS INTEGRATION
A community project at United Way

What is SIP?

- Multi-Sector Provider Network
- Person-Centered Service Delivery
- Community Information Exchange®
- Business Intelligence for Public Good

SYSTEMS INTEGRATION
A community project at United Way

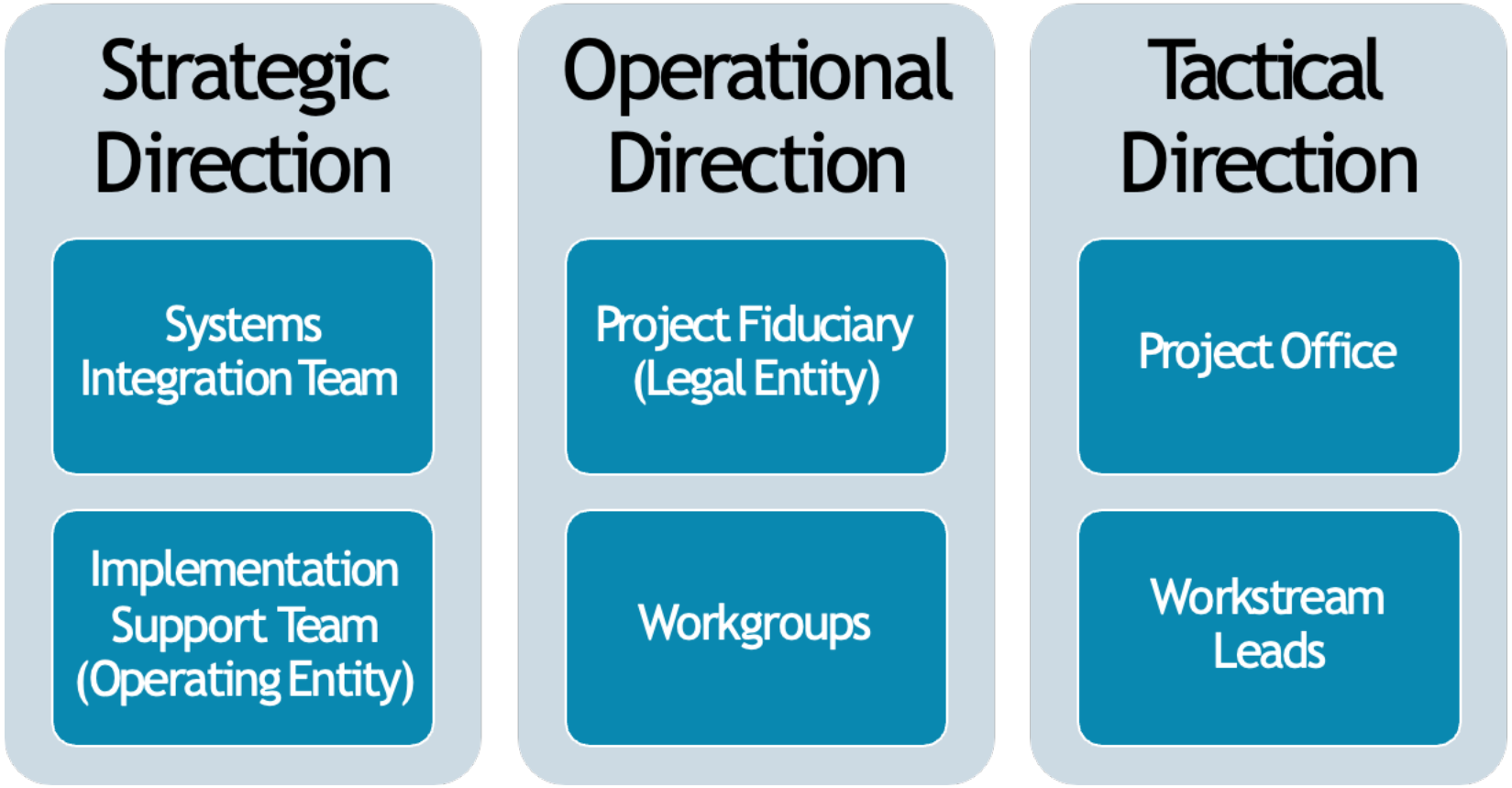
Vision and Purpose

The greater Rochester community is working across a diverse network of committed providers and community members to put **people at the center** of an **interconnected system of education, health, and human services**.

By coming together as a community, we will improve the health and economic well-being of individuals and families in Monroe County, **especially those who are vulnerable and/or impacted by poverty**.

SYSTEMS INTEGRATION
A community project at United Way

A Community-Driven Initiative



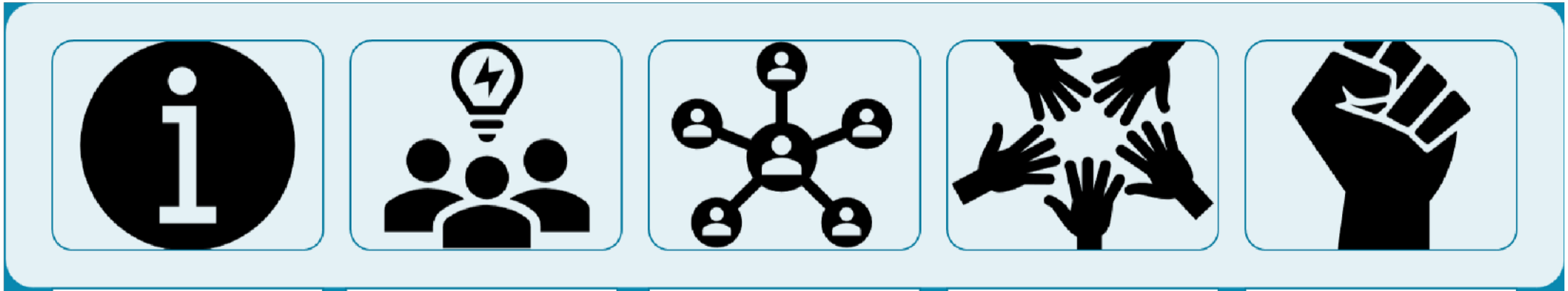
SYSTEMS INTEGRATION
A community project at United Way

Community Readiness & Stewardship

Multiple Approaches
✓ Community Voices Network
✓ Bi-Directional Communication and Support
✓ Diversity, Equity, and Inclusion Strategy
✓ Human-Centered Design
✓ Equity Review Board

SYSTEMS INTEGRATION
A community project at United Way

Spectrum of Engagement



Inform	Consult	Involve	Collaborate	Empower
Provide community members with info and assist in understanding problems, alternatives, and solutions.	Obtain community member feedback on analysis, alternatives, and decisions.	Work directly with community members and consistently consider their concerns and aspirations.	Partner with community members in each aspect of decision including the development of the alternatives and the identification of the preferred solution.	Community members are making decisions and leading solutions-based efforts.

SYSTEMS INTEGRATION
A community project at United Way

Community Readiness & Stewardship: 2022 Focus

Implement, Iterate, and Scale to Sustainably Operate an Integrated System

- Ensure Utilization of the Integrated System by the Community
- Implement Multi-Sector Integrated Delivery System
- Solidify Multi-Sector Partnerships and Aligned Incentives for Sustainability
- Implement Control System for Monitoring and Continuous Improvement

SYSTEMS INTEGRATION
A community project at United Way

Lessons Learned

- Trust-building required process orientation and time
- Invested in learning, using, and spreading human-centered design and systems thinking mindsets and tools
- Scope too broad until Covid-19 forced urgency and focus around specific domains
- NIST data privacy assessment was a critical risk mitigation step

SYSTEMS INTEGRATION
A community project at United Way

Contact Information

Email: SIPTeam@systemsintegration.org

Website: SystemsIntegration.org

Follow ***Systems Integration Project*** on LinkedIn

SYSTEMS INTEGRATION

A community project at United Way

Questions

SYSTEMS INTEGRATION

A community project at United Way

District of Columbia CoRIE Project

Community Resource Information and Exchange (CoRIE) Initiative

David Poms, DC Primary Care Association
Deniz Soyer, DC Department of Health Care Finance

April 22, 2022

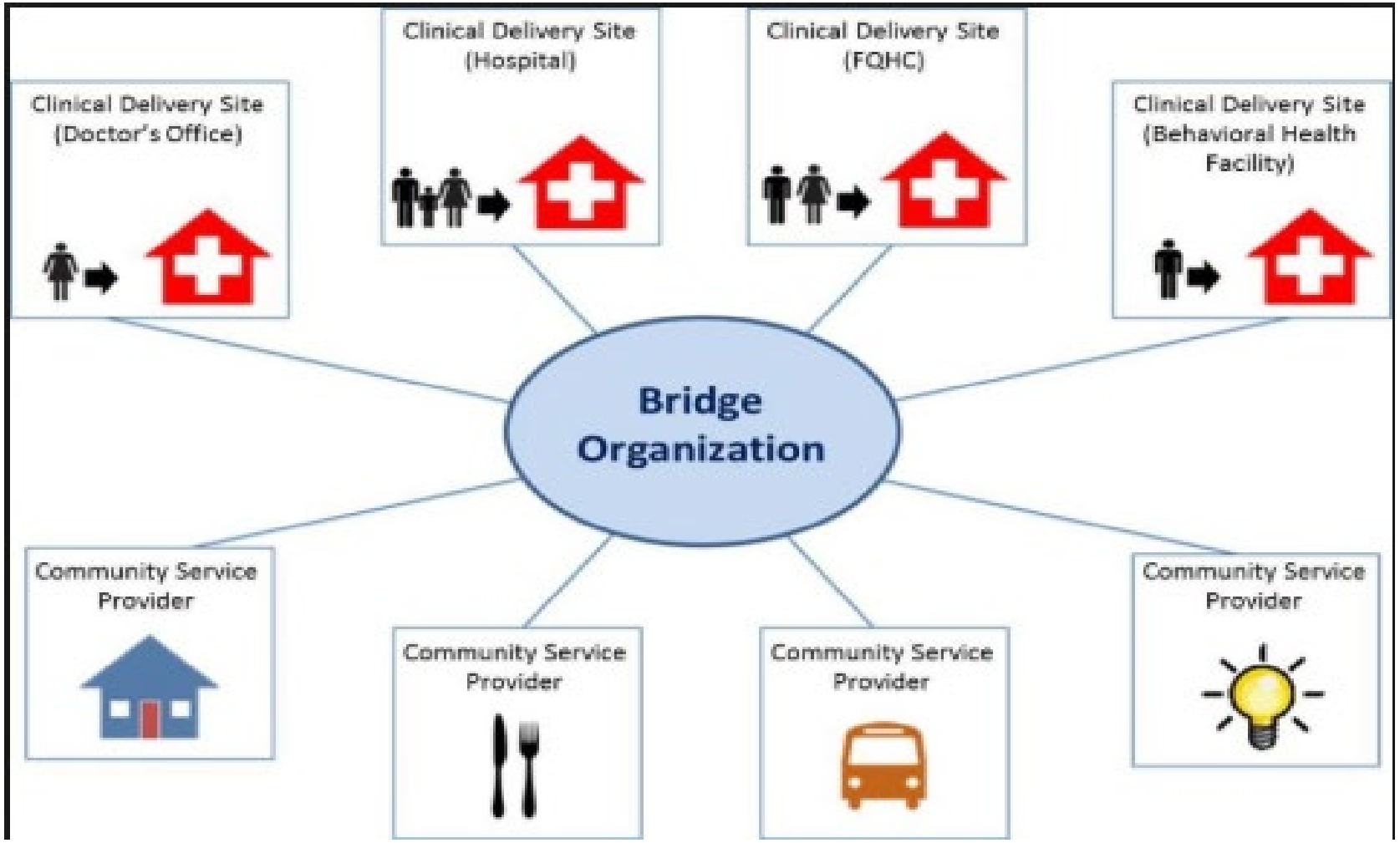
DC PACT (Positive Accountable Community Transformation) is a Collective Impact coalition effort of community providers

- Problem Statement: Racism and the lack of accountability, alignment and investment has led to inequitable social conditions, health and well-being outcomes

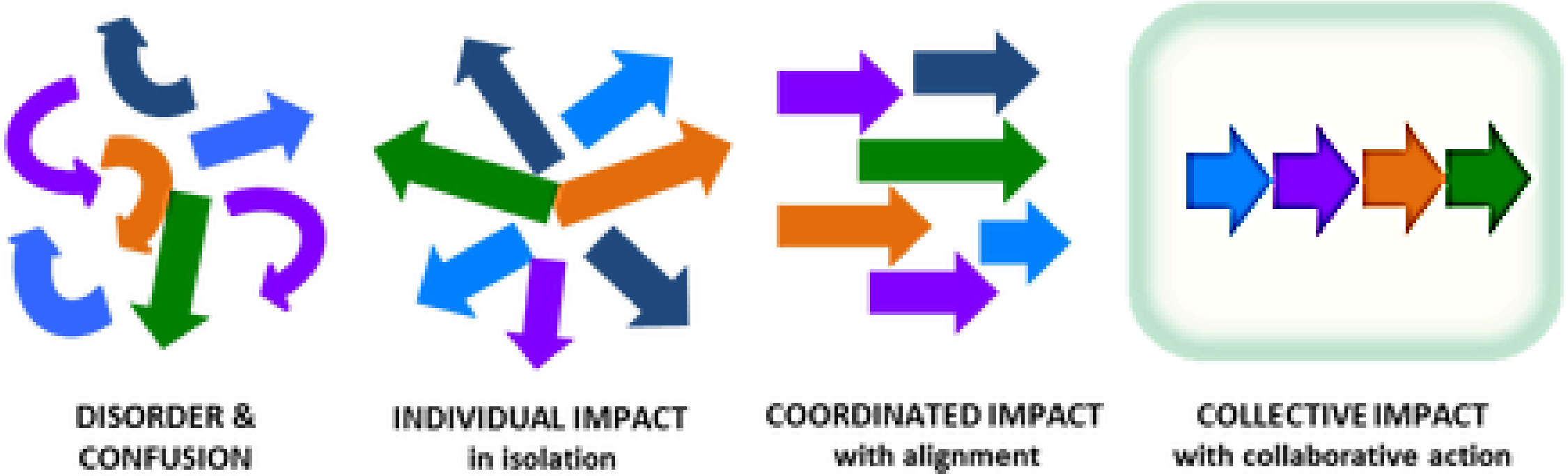
- Vision: DC functions as a seamless accountable health community that provides care and the social conditions for racial equity, health equity, and community well-being

- Mission: Build the movement to create a seamless accountable health community that achieves equitable individual and community well-being in the District of Columbia through community leadership, policy change, infrastructure development, and care improvement

Accountable Health Community Model



Collective Impact Model



- Solutions and resources are not known in advance, and typically emerge throughout the process.
- We cannot predict the solutions at the outset, and that is uncomfortable
- Initial focus on creating effective structure for interaction
- The process itself is the solution/reveals the solution

THINK: EVOLUTION

The DC PACT origin story

Partners:

AmeriGroup DC
AmeriHealth Caritas DC
Bread for the City
Capital Area Food Bank
Capitol Hill Group Ministry
CareMore Health
Children's National Medical System
Children's Law Center
Community Connections
Community of Hope
DC Behavioral Health Association
DC Greens
DC Hospital Association
DC Primary Care Association
Family & Medical Counseling Services
Food & Friends
George Washington Hospital
Health Services for Children with Special Needs
Hillcrest Children & Family Center
Howard University Hospital
Institute for Public Health Innovation
La Clinica del Pueblo
Leadership Council for Healthy Communities
Mary's Center
MedStar Hospitals
Providence Health System
Regional Primary Care Association
So Others Might Eat
Trusted Health Plan
Unity Health
Vitas HealthCare
Whitman Walker Health

Government Partners:

Department of Behavioral Health
Department of Disability Services
Department of Energy & the Environment
Department of Health
Department of Health Care Finance
Department of Human Services
Interagency Council on Homelessness
Fire and Emergency Management Services

- 2016: Came together to apply for CMS's Accountable Health Community pilot project
- 2017: Commitment to work together without CMS support through Collective Impact Model
- 2018: Completed a Common Agenda through retreats to define where we are and begin engaging more broadly
- 2019: Received DHCF Community Resource Inventory and Exchange (CoRIE) planning grant
- 2020: CoRIE technical development phase commenced, led by CRISP and DCPCA
- 2021: Updated our Common Agenda again

Community Input Led to Focus on Social Determinants of Health

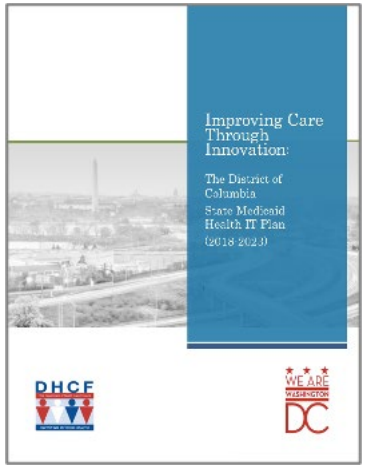
Beginning April 2017, DHCF held a series of discussions on social needs of District residents

- Explored District efforts to collect and use SDOH data
- Generated a set of strategies and tactics to improve health outcomes
- Held 80+ person meeting with national experts “level-set” current work and shared priorities
- Hosted 20-person workshop on strategies to address collection and use of social need data

MAPing (Measuring, Assessing, Planning) the Use of Social Determinants of Health Data in the District

2018 District of Columbia State Medicaid Health IT Plan (SMHP) prioritized use of SDOH data

- Current Landscape of Health IT and HIE
- Stakeholder Perspectives and Priorities
- 5-year Health IT and HIE Roadmap
  - District health IT and HIE goals
  - Priority Areas/Use Cases
    - Supporting Transitions of Care
    - **Social Determinants of Health**
    - Population Health Management
    - Public Health
    - Telehealth
    - Behavioral Health Transformation



2022 SMHP Update released March 2022: https://dhcf.dc.gov/hitroadmap

Collaborated with DC PACT to create an HIE Action Team and conduct a community-wide needs assessment

DC PACT HIE Action Team

- DC PACT HIE Action Team was established in 2018 as a multidisciplinary group of District stakeholders (government, health care providers, payers, CBOs) tasked with developing a set of recommended actions to utilize HIE and health IT to move SDOH information.
- Conducted small environmental scan of SDOH health IT initiatives across the country – North Coast Health Information and Innovation Network (NCHIIN); NowPow (Chicago); San Diego 2-1-1; and Camden Coalition.

Community-wide Needs Assessment

- Community resource inventory needs assessment sought to gather technical requirements by engaging 45 District organizations
- Led DC Primary Care Association in partnership with Clinovations Gov+Health
- Included interviews, questionnaire-based assessments, and focus groups

Community-wide needs assessment and findings of the DC HIE Action Team led to a set of recommendations for a technical solution

1	**General Functions**	• Easy-to-use • Compatible with provider EHRs • Compatible with existing CBO tools and workflows • Solution should be iteratively built to build consensus
2	**Priority SDOH Domains**	• Recommended domains for early focus: food, housing, social wellness • Additional domains for review in later phases: transportation, employment/income, public benefit enrollment and eligibility, child development • Phased consensus building domain by domain
3	**Screening**	• Enable standardized screening through structured data capture and referrals through multiple interfaces • Focus on “answer set” standardization for capture and exchange instead: Assess opportunities for Z-codes and leverage emerging standards (HL7 Gravity Project)
4	**Referral**	• Support closed loop referrals with notifications and confirmations to both provider and CBOs • Enable notifications to a patient's care team that alerts providers or case manager to follow-up

Stakeholders considered 3 technical options based on current SDOH workflows and priority key domains

1 BUY

- Involves the purchasing of a third-party solution
- Procurement of a solution via this approach assumes the purchase or license of a commercially available product, software-as-a-service, or integrated platform and services approach.

2 BUILD

- Involves building out current infrastructure.
- Assumes custom software development that may consist of a work-for-hire solution that is hosted and maintained within DC HIE or managed by the selected developer.

3 BRIDGE

Expanding current infrastructure capabilities ("Build") **and integrating with other platforms** that leverage community investments ("Buy").

District Stakeholder Recommendation: BRIDGE Option

- Build upon current DC HIE capabilities.
- Identify and assess gaps in current capabilities that could be addressed via a 3rd party platforms to maximize adoption and use.
- Focus on optimizing of existing workflows that enhance community partnerships and achieve buy-in from system leaders through iterative development and quick wins.

Since 2018 the DC HIE Demonstrated Substantial Progress to Expand the Network of Participating Users

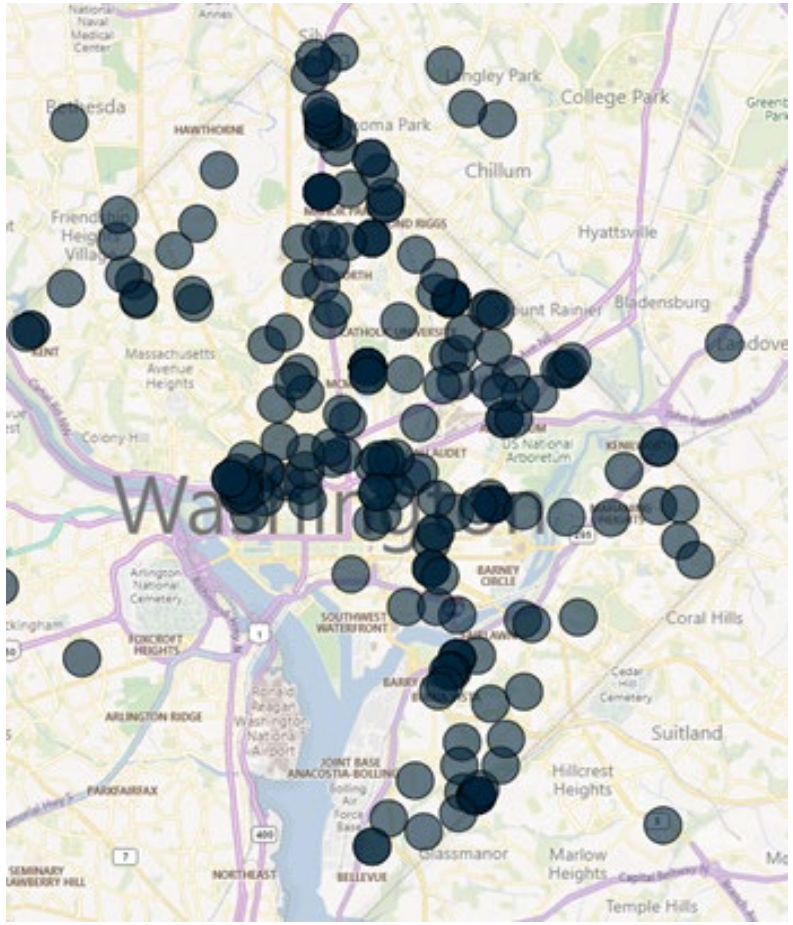
Today Major Providers and Health Systems are Connected

- 8 Hospitals (all)
- 36 Long Term Care Facilities, including 15 Nursing Facilities;
- 20 Home Health Providers
- 8 Federally Qualified Health Centers (all)
- 30 Behavioral Health Providers
- **8 Community Based Organizations**

DC HIE Use at a Glance (as of March 2022)

- **13,000+ approved users of the DC HIE**
- **Patient Care Snapshot (Monthly Query)**
  - 1,156 users
- **Encounter Notification Services access**
  - 619 locations
- **Sharing Admit, discharge, transfer**
  - ~300 locations
- **Sharing Clinical care documentation**
  - 200+ locations

DC HIE Connectivity: DC and beyond the borders of the District



CRISP DC is the District of Columbia's Designated HIE

The DC HIE is a health data utility with 6 reliable core capabilities that include SDOH screening, resource inventory, referral functions

Critical Infrastructure (e.g. Encounters and Alerts) Lookup)

- ADT Alerts
- Health Records
- Patient Snapshot
- Image Exchange

Consent

- eConsent Solution

-SUD (42 CFR Part 2) Data Consent
-HIPAA Consent
-Telehealth Consent

Registries

- Care Management Registry
- Advance Care Planning

-Advance Directives
-eMOST

Directory and Secure Messaging

- Provider Directory
- Community Resource Inventory

Screening and Referral (e.g., SDOH)

- eReferral Screening

-Social needs screening

-eReferral to community resources and supports

Advanced Analytics for Population Health Management

- CRISP DC Reporting Services

Performance Dashboards

- Vaccine Tracker

What is the Community Resource Information Exchange (CoRIE) Initiative?

CoRIE is a Partnership

- DHCF, CRISP DC, DC Primary Care Association, and DC Hospital Association are collectively known as 'CoRIE Partners'
- Committed to supporting and sustaining technical solutions and enabling coordinated whole person care across health, human, and social service providers in the District.

CoRIE is a set of 3 technical functionalities to address SDOH

- Technical functionalities:
  1. Screening for social risks and share dispositions.
  2. Lookup resources through a centralized community inventory (CRI).
  3. Refer to appropriate community and support services.
- Together these 3 functionalities enable data sharing among health system stakeholders to address individuals' social needs.

CoRIE is a Vendor Agnostic Approach

- Enables screening and referral information to be shared and displayed regardless of how it was collected
- Ensures care partners can view the same information via DC HIE regardless of the vendor platform they use

CoRIE is an Interoperable System within the DC HIE

- Digitally connects care partner, including health and social service providers, through the DC HIE health data utility
- Provides shared services across the region
- Fosters a culture of shared responsibility for ensuring the availability and quality of actionable information

District stakeholder continue to be actively engaged in informing the development and implementation of the CoRIE Initiative components

- **Over 100 representatives** from healthcare systems, managed care organizations, government agencies, coalitions/multi-stakeholder groups, community-based organizations **are actively engaged in informing the development of the CoRIE Project components**.
  - CBO Design Group (informing the general design of the referral platform and CBO analytics)
  - Community Resource Inventory (CRI) Action Team (developing and testing CRI)
  - Standardization Action Team (standardizing screening and referral information)
  - DC HIE Policy Board CRI Subcommittee (developing governance standards)
- Active in **national SDOH standardization effort** led by the Gravity Project.
- Discussions underway with key stakeholders to agree upon a **minimum set of common screeners for housing, nutrition, and behavioral health**, which can be implemented within CoRIE infrastructure in FY22.
- Promote CoRIE technologies among stakeholders and the broader community of users
  - Support population-level screening via care coordination programs, etc.
  - Promote or require eReferral

DC's 2022 SMHP Update prioritizes continued engagement CBOs and partnership with clinical providers to expand access and use of social needs information HIE

- Access and exchange of social needs information – particularly housing and nutrition – through the HIE supports whole person care.
- Develop refinements to the HIE functionality that promote access and engagement in the DC HIE among CBOs / social service agencies.
- Explore what new use cases would be most beneficial for CBOs, the provider network, and Medicaid beneficiaries to integrate social needs data, drive their interest, and maximize value.
- Diversify Boards and Committees across various governance structures to ensure that the full breadth of partners – particularly those that are representing new and emerging use cases – including CBOs and other less-well represented groups, including behavioral health and long-term care.
- Fund pilot projects to test use cases and specific value-added collaborations between clinical providers and non-clinical CBOs/social services agencies.

What does success look like for DC PACT?

- Build capacity for **organizational and system change**
- Build **shared measurement** consensus for strategic goals through action teams
- Provide a **strong collective framework** that engages the health, social and public sectors in moving toward a seamless accountable health community that increases health equity in the District of Columbia

Appendix

CoRIE is designed to enable social needs screening and referral through DC HIE infrastructure *without* requiring a single District-wide platform

Providers, MCOs, and health system stakeholders use different systems to:

- Collect social needs information from patients
- Make referrals to community services

CoRIE allows 4 pathways to capture and share SDOH screening and referral data with care partners through the DC HIE

Choose 1 of 4 pathways to capture and share SDOH screening and referrals

Each pathway contributes data to the DC HIE

DC HIE Users can view screening and referrals from each pathway in the social needs tab

1. **Use 3rd Party SDOH Network Platforms** (findhelp, mahmee)
   → Vendor integration with CRISP enables transmission of screening and referral data

2. **Use an EHR** (eClinicalWorks, Epic, Cerner, Other EHRs)
   → CSV files containing referral data
   → CSV files containing screening data elements
   → Z-codes extracted from CCDs reflecting screening dispositions

3. **Use CRISP DC Direct-entry Screening Tool to capture SDOH screening/assessment**
   → Screening and assessment data elements

CRISP DC Social Needs Tab

- DC HIE users can view referral history made in non-DC HIE systems
- DC HIE users can view conditions based on extracted z-codes
- DC HIE users can view assessments captured via the CRISP DC Screening Tool or third-party platform

4. **Use CRISP DC Referral Tool to send referral to CBO**

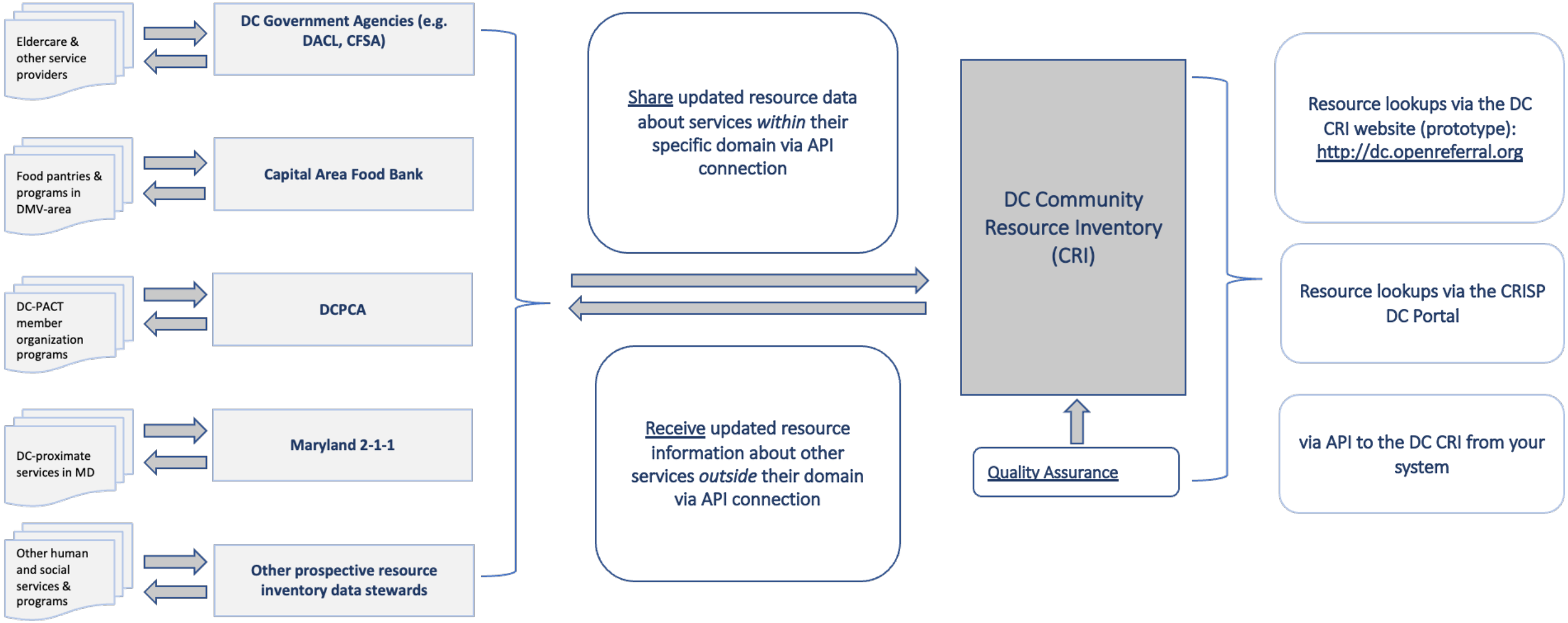
CRISP DC Referral Tool

CBOs can

- Receive referrals for services
- Communicate with referring provider
- Close the loop

The DC CRI requires community participation to ensure records for programs and services offered are up-to-date

1. Community program and service info from disparate sources is fed to various regional data stewards
2. Designated stewards assume responsibility for info from each source in their domain ("Registers")
3. Each individual resource inventory seamlessly contributes information to the DC CRI while retrieving information on programs outside of their domains according to the standards and governance set to support a cooperative network by the DC HIE Policy Board CRI Subcommittee
4. DC CRI is a component of the DC HIE health data utility – it is (for now) managed by the CoRIE project partners
5. There are 3 ways to publicly access the same information about community programs and resources in the DC CRI



Questions & Discussion

Learning Forum Series and Small Group Opportunities

Learning Forum: Webinar Series Schedule

Topic	Date & Time	Learning Objectives
SDOH Information Exchange: Vision, Purpose, and Community Engagement	April 22nd 1:00pm – 2:30pm EST	Learn about promising practices to engage with community stakeholders and define a mission and purpose.
SDOH Information Exchange: Governance	May 13th 1:30pm – 3:00pm EST	Learn about different levels of governance for stakeholders engaged in SDOH information exchange initiatives.
SDOH Information Exchange: Technical Infrastructure and Interoperability	June 14th 1:00pm – 2:30pm EST	Learn about data systems and standards to enable SDOH information exchange.
SDOH Information Exchange: Policy and Funding	July 19th 1:30pm – 3:00pm EST	Learn about privacy and security considerations, as well as financing models to support organizations pursuing SDOH information exchange.

https://www.healthit.gov/news/events/oncs-social-determinants-health-information-exchange-learning-forum

Learning Forum: Small Group Opportunities

ONC is also offering additional opportunities for interested stakeholders to participate in small group learning.

- Groups of approximately 10-15 individuals across a diverse set of stakeholder groups.
- Paired with a facilitator and subject matter experts who will guide and support learning and engagement.
- Discussion questions and focus areas will be collaboratively developed.
- Topics will align with the Learning Forum monthly webinar series.

To express interest in small group participation, please email oncsdohlearningforum@hhs.gov for more information on how to join.

Upcoming Small Group Sessions

Upcoming small group sessions:

- May 6th, 12:00pm – 1:00pm EST
- May 6th, 2:00pm – 3:00pm EST
- May 9th, 12:00pm – 1:00pm EST

To express interest in the small group sessions, email oncsdohlearningforum@hhs.gov for more information on how to join.

Thank You!

The Office of the National Coordinator for Health Information Technology

Contact ONC

Learning Forum contact information:
oncsdohlearningforum@hhs.gov

Phone: 202-690-7151

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