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

Introduction to the Learning Forum and SDOH Information Exchange Foundational Elements

1:30 – 3:00 pm EST
Tuesday, March 29, 2022
Agenda

• Welcome
• Background and Context for SDOH Information Exchange
• Overview of SDOH Information Exchange Foundational Elements
• Spotlight: 211 San Diego Community Information Exchange
• Questions & Discussion
• Learning Forum Series and Small Group Opportunities
• Closing
Welcome

Please chat-in your name, role and organization.

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Background and Context for SDOH Information Exchange
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.
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.”
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

Collect, Access, Exchange, Use
Overview of SDOH
Information Exchange
Foundational Elements
SDOH Information Exchange Toolkit


- The TEP included members from community-based organizations, coalitions, payers, health information technology (IT) vendors, health care providers, philanthropic foundations, federal and state government.

- Intended Audience:
  - Community resource referral entities
  - Government agencies, including federal, state, local, tribal, and territorial
  - Health care provider networks
  - Health information exchanges (HIEs)
  - Human services providers
  - IT platform creators and managers
  - Networks of community-based organizations (CBOs)
  - Payers
  - Policymakers
  - Other health and human services entities
Social Determinants of Health Information Exchange Foundational Elements
Draft Foundational Elements Summary Descriptions

- **Community Readiness and Stewardship**: Exploring the existing landscape in the geographic area and/or population of focus, assessing the capacity and willingness of the community to participate, and developing stakeholders’ shared rights and responsibilities through the process of co-design, evaluation, and decision-making.

- **Mission and Purpose**: The intention of an initiative, ideally explicitly stated, that addresses the various value propositions of stakeholder groups, as well as the vision, scope of services, and expected benefits.

- **Values and Principles**: Standards for establishing a framework for action, including ethical decision-making in pursuit of health equity.

- **Financing**: Funding opportunities, sources, and plans for investments, ongoing costs, opportunities for blended approaches, and incentives for community adoption and use.

- **Implementation Services**: Inclusive of technical services (e.g., defining requirements, standards specifications, and integration with existing infrastructure and services) and programmatic services (e.g., defining use cases, workflow design/redesign), as well as support for adoption and utilization by individuals and the community.
Draft Foundational Elements Summary Descriptions

- **Technical Infrastructure and Data Standards:** Alignment of hardware, software, data, processes, and standards to enable scalable and interoperable data and IT systems.

- **Legal:** Establishing the framework of processes and operations, along with rights and obligations, to support data use and sharing and to support compliance with Federal, state, local and tribal laws.

- **Policy:** Consideration of federal, state, and local policy levers to advance the ability to collect, share, and use standardized SDOH data, as well as collaboration and alignment with other relevant efforts in the community, region, and/or state for collective impact and improved outcomes.

- **Measurement and Evaluation:** Monitoring and evaluation of performance metrics, individual and population outcomes, program effectiveness, and quality management and improvement.

- **User Support and Learning Network:** User support and learning network activities include assessment of community challenges and needs, education, communication, training, technical assistance, peer-to-peer learning, and identification of promising practices and lessons learned.

- **Governance:** Decision-making processes and groups, including as relates to institutional, administrative, and data governance.
211 San Diego Community Information Exchange
CIE San Diego & National CIE Movement
What is a Community Information Exchange?

“A Community Information Exchange (CIE) ® is a community-led ecosystem comprised of multidisciplinary network partners using a shared language, a resource database, and integrated technology platforms to deliver enhanced community care planning. A CIE enables communities to have multi-level impacts by shifting away from a reactive approach towards proactive, holistic, person-centered care. At its core, CIE centers the community to support anti-racism and health equity.”
Primary Concepts and Elements of CIE

Cultivates trust and capacity within the community.

Cultivates individual agency and understands root causes of resource gaps.

Drives systems change.

Enables cross-sector collaboration.

Community stewarded and led.

Designed to uplift and assist in providing agency to the communities who experience the starkest disparities and inequities.

Person-centered.

Multi-level impact (individual → agency → community)
Core Components

Community Stewardship
A CIE must be led by the community through a neutral convener, backbone organization or leadership structure that ensures engagement of community voice, considers the human perspective in all aspects of system design, and promotes shared power and partnership within the network. This governance infrastructure ensures data stewardship, collection and use that meets ethical standards and shares value with community members who institutions have traditionally benefited from.

Multi-Level Impact
The role of a CIE is to support the needs of the individual/family (micro), across organizations and institutions (mezzo) and the larger community (macro). A CIE is responsible for sharing and using data to highlight inequities as well as understand improvement in needs met. CIE data should be used to design community-level interventions as well as inform community-level investment and policy. Locally, a CIE inspires movement with the goal of systems change, rather than solely addressing needs of individual organizations.

Person-Centered to Community Autonomy
Centering individual and family goals, motivations and urgencies is core to a CIE. This person-centered focus prioritizes meeting the needs of the individual and family, rather than the institutions or organizations that serve them. A CIE reimagines the way care is provided and supported through a comprehensive, informed, culturally competent approach that creates space for agency and advocacy. The CIE leverages human-centered design practices and embraces learning and iteration to ensure systems are adaptable to ever evolving community needs, thus supporting community autonomy.
2-1-1 San Diego / Imperial

- National 3-digit dialing code
- Free, 24/7 service, 3-digit dialing code
- Access to community, health, social and disaster services
- Local, manage resource database of services and relationships with CBOs
- Part of United Ways or separate 501c3

Community Information Exchange

- Systems change that fosters true collaboration across networks
- Moving towards person-centered interventions and interactions across healthcare and human services
- Goal is to improve health and wellness for individuals and populations
The Problem: a lack of connections between medical and social service providers

The Impact:
Higher risk of death
Higher cost of care
Lower quality of care

- Since January 2011, 9 of 71 San Diegans who most frequently accessed local hospitals & crisis facilities had died
- From 2000-2003 529 San Diegans amassed 3,318 visits and $17.7 million in charges at two local hospitals
- High cost/high need people routinely receive lower quality care due to lack of integrated health & social services
<table>
<thead>
<tr>
<th>Impact</th>
<th>Outputs</th>
<th>Outcomes</th>
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<tbody>
<tr>
<td>Improvement in Health Indicators</td>
<td>Record Look-ups</td>
<td>Improved individual’s state of wellness</td>
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<td>Advance Quality of Life</td>
<td>Sharing Data</td>
<td>Change from domain specific work to person-centered care</td>
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<tr>
<td>Address inequities (Race, Gender, Cycle of Poverty)</td>
<td>Consents</td>
<td>Change in intervention and interaction with people</td>
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<td>Direct Referrals</td>
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Macro (Community)
- Data that Speaks
- Unmet Needs and Barriers
- Access Disparities

Mezzo (Agency)
- Bridges sectors
- System Efficiencies
- Shared language and outcomes

Micro (Family & Individual)
- Informed and Tailored Services
- Proactive Engagement

Macro Impact Examples:
- Collective aggregate community data that is provided by community members
- Wholistic data is collected, understanding connection between health and social

Link to Housing Policy Brief

Mezzo Impact Examples:
- Breaking down of siloed data systems
- Ability to search patients/members to see historical use of social services and closed loop referrals
- Shared screening or prioritization of resources and care team members receive alerts to be proactive or responsive

Link to COVID-19 Response

Micro Impact Examples:
- Families don’t have to retell their stories or trauma over and over again
- Agencies can reach out directly, instead of adding additional work on the person to follow-up with the agencies for support
- Care gets coordinated within the individual having to remember who they are working with

Example Cohorts: Homeless Older Adult
CIE Stewardship Framework

Executive Stewardship

Leaders

Working Groups/Target Populations/Initiatives

Community Voice-Community Members

CIE Advisory Board

Network Partner Meeting

Community Voice

Policy & Ethics

User Experience

Affinity

Community Advisory Board
Community Information Exchange Partners: 115

Data Sharing Partners
Community Information Exchange
Core Components

**Network Partners**
Collective approach with standard Participation Agreement, Business Associates Agreement and participant consent with shared partner governance, ongoing engagement, and support.

**Technology Platform and Data Integration**
Technology software that integrates with other platforms to populate an individual record and shapes the care plan. Partners access the system. System features include care team communication feeds, status change alerts, data source auto-history and predictive analytics.

**Shared Language (SDoH)**
Setting a Framework of shared measures and outcomes through 14 Social Determinants of Health Assessments and a Risk Rating Scale: Crisis, Critical, Vulnerable, Stable, Safe Thriving

**Bidirectional Closed Loop Referrals**
Updated resource database of community, health, and social service providers. Ability to accept/return referrals and to provide outcomes and program enrollment.

**Community Care Planning**
Longitudinal record with a unified community care plan that promotes cross-sector collaboration and a holistic approach.
Client Record Sample

Client Profile
- Demographic and important information about the client

Domains
- Examples like Housing, Food & Nutrition,
- Categorization of Needs (SDOH) & Risk Level
- Shared Assessments and Values across agencies

Care Team
- Case Managers working with client across agencies
- Contact Information

Referrals & Program Enrollment
- Agencies or programs client is referred
- Connection to Services

Alerts
- Notification of emergency services & jail
- Ability to notify Care Team Members of changes

Feed
- Ability to communicate with Care Team members (twitter-like feed)
Resource Database and Bi-directional Referrals

Agency makes referral to another Agency
Agency Referral Manager receives email and responds to referral
Accepts or Declines Referral
Outcome of Referral (Program Enrollment/Care Team)
Measurement and Evaluation
Who is in the CIE?

General Demographics

- **Age Group**
  - Under 20: 20%
  - 20-29: 21%
  - 30-39: 27%
  - 40-49: 18%
  - 50-59: 12%
  - 60-69: 11%
  - 70-79: 6%
  - 80+: 2%
  - 90+: 0.4%

- **Gender Identity**
  - Woman: 67%
  - Man: 33%
  - Other: 1%

- **Race/Ethnicity**
  - Alaska Native/ Native Indian: 1%
  - Asian/Pacific Islander/ Hawaiian: 5%
  - Black/African American: 16%
  - Hispanic/Latino: 37%
  - White/Caucasian: 33%
  - Bi-Racial/ Multi-Racial: 4%
  - Other: 4%

- **Military/Veteran**
  - Military/Veteran: 10%
  - Not Military/Veteran: 90%

- **Household Size**
  - 1: 20%
  - 2: 13%
  - 3: 10%
  - 4: 6%
  - 5: 3%
  - 6+: 0.2% (other)

- **Number of Children**
  - 0: 17%
  - 1: 13%
  - 2: 7%
  - 3: 3%
  - 4: 1%
  - 5: 0.6%
  - 6+: 0.2%

Socioeconomic Indicators

- **Education**
  - Less than High School: 18%
  - High School or Equivalent: 37%
  - Some College, No Degree: 28%
  - Associate: 6%
  - Bachelor’s Degree: 3%
  - Master’s Degree: 3%

- **Employment**
  - Full-Time: 18%
  - Part-Time: 14%
  - Disabled/Unable to work: 15%
  - Not in the Labor Force/Retired: 11%
  - Unemployed: 34%

- **Area Median Income**
  - 31-50K: 14%
  - 51-80K: 8%
  - 81K or More: 3%
  - 30K or Less: 32%
  - 50K or Less: 30%
Financing

• Not one source of funding
• Can be used or leveraged for any organization and financially support CIE infrastructure

• Blended/Braided Funding Model
  • CIE Membership for Healthcare Systems, Healthcare Providers, Government & For-Profit
  • Foundations
  • Grants
Lessons Learned

- Influence of Governance: Varied starting place (based on initiative or policy) and representation (Healthcare, CBO Consortium, etc.)

- Leveraging local infrastructure, existing relationships and services
  - Importance of building trust and capacity

- Requires evolution/agile approach to the work

- Measurement and Evaluation are challenging because of the many players involved and need to show return on investment to continue the work
Learning Forum Series and Small Group Opportunities
# Learning Forum: Webinar Series Schedule

<table>
<thead>
<tr>
<th>Date &amp; Time</th>
<th>Topic</th>
<th>Learning Objectives</th>
<th>Registration Link</th>
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<tbody>
<tr>
<td>March 29th 1:30 – 3 pm EST</td>
<td>Introduction to SDOH Information Exchange</td>
<td>Learn about the SDOH landscape and foundational elements to enable SDOH information exchange.</td>
<td>Register here</td>
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<tr>
<td>April 22nd 1 – 2:30 pm EST</td>
<td>SDOH Information Exchange: Vision, Purpose &amp; Community Engagement</td>
<td>Learn about promising practices to engage with community stakeholders and define a vision and purpose.</td>
<td>Register here</td>
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<tr>
<td>May 13th 1:30 – 3 pm ET</td>
<td>SDOH Information Exchange: Governance</td>
<td>Learn about different levels of governance for stakeholders engaged in SDOH information exchange initiatives.</td>
<td>Register here</td>
</tr>
<tr>
<td>June 14th 1 – 2:30 pm ET</td>
<td>SDOH Information Exchange: Technical Infrastructure &amp; Interoperability</td>
<td>Learn about data systems and standards to enable SDOH information exchange.</td>
<td>Register here</td>
</tr>
<tr>
<td>July 19th 1:30 – 3 pm ET</td>
<td>SDOH Information Exchange: Policy &amp; Funding</td>
<td>Learn about privacy and security considerations, as well as financing models to support organizations pursuing SDOH information exchange.</td>
<td>Register here</td>
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Learning Forum: Small Group Opportunities

ONC will also have 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.
Upcoming Small Group Sessions

Upcoming small group sessions:

• Wednesday, April 6th, 2:00 - 3:00pm EST
• Thursday, April 7th, 1:00 - 2:00pm EST
• Friday, April 8th, 1:00 - 2:00pm EST

To express interest in small group participation, email oncsdohlearningforum@hhs.gov for more information on how to join.
Thank You!
Contact ONC

Learning Forum contact information: oncsdohlearningforum@hhs.gov

Phone: 202-690-7151

Health IT Feedback Form: https://www.healthit.gov/form/healthit-feedback-form

Twitter: @onc_healthIT

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