Office of the National Coordinator for Health Information Technology

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

Community-Level Governance

12:00 – 1:30 pm ET

Thursday, February 23rd, 2023

Agenda

- Welcome
- Background on SDOH Information Exchange
- Overview of SDOH Information Exchange Foundational Elements
- Spotlight: Michigan Health Information Network (MiHIN)
- Spotlight: University of Texas (UT) Austin
- Questions and Discussion
- Learning Forum Series and Small Group Opportunities
- Closing

Welcome

Please chat in your name, role and organization.

Meley Gebresellassie
ONC

Mark Knee
ONC

Sam Meklir
ONC

Jillian Annunziata
EMI Advisors

Sara Behal
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Kristina Celentano
EMI Advisors

Evelyn Gallego
EMI Advisors

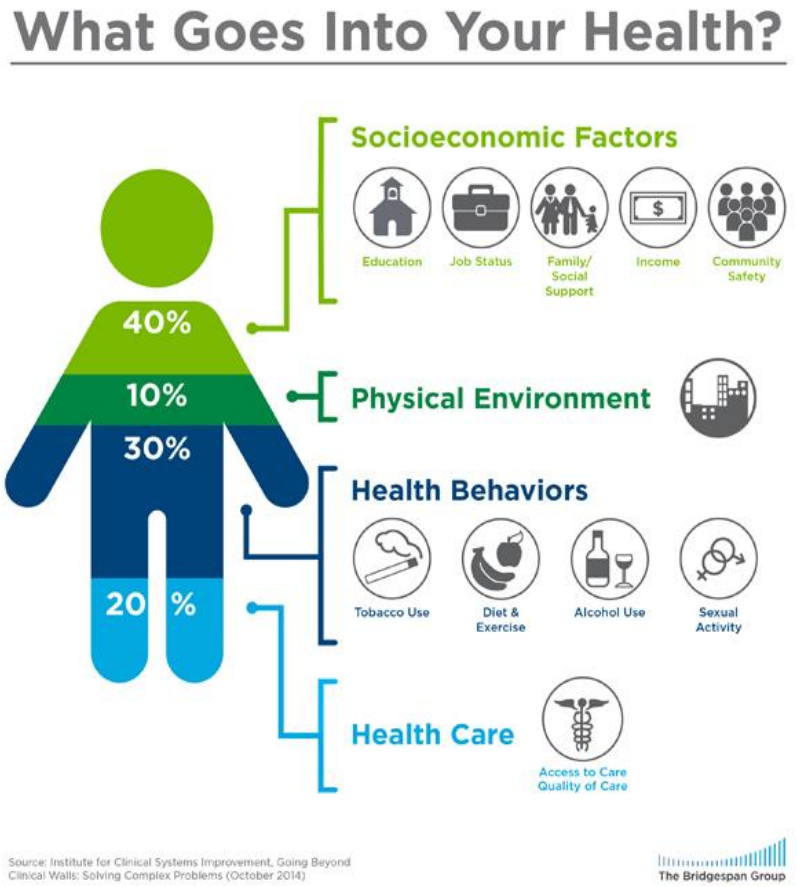
Background on SDOH Information Exchange

Why are social needs important?

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 social needs is a primary approach to achieve health equity.

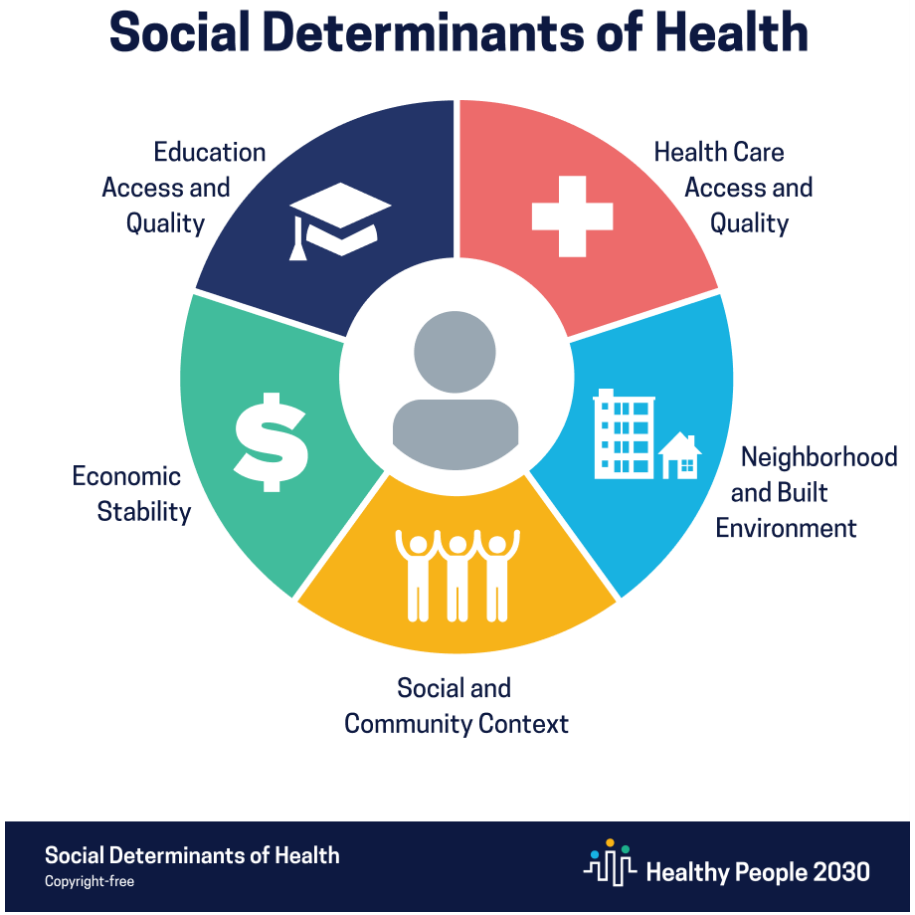


Sourced: Gravity Project

[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."

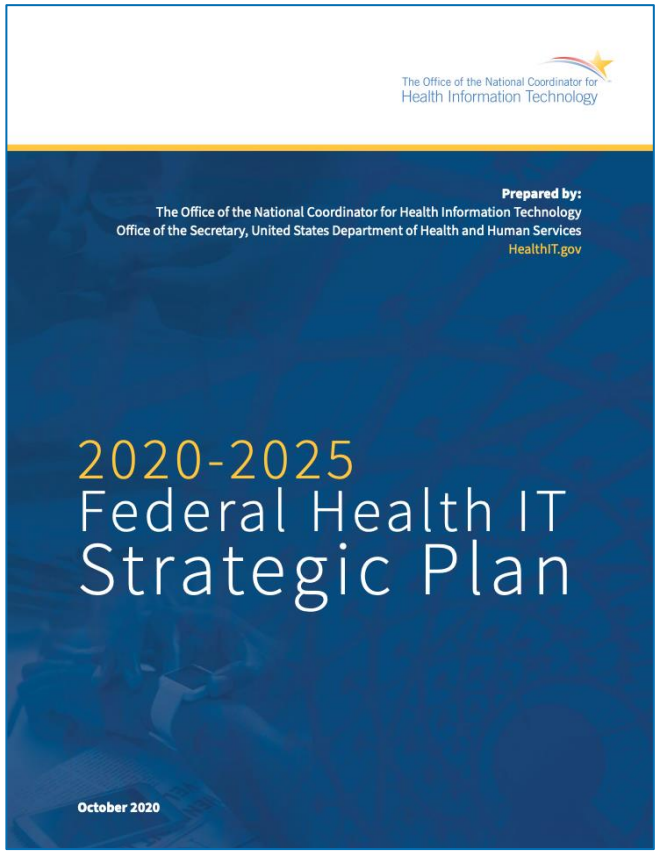
https://health.gov/healthypeople/priority-areas/social-determinants-health

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



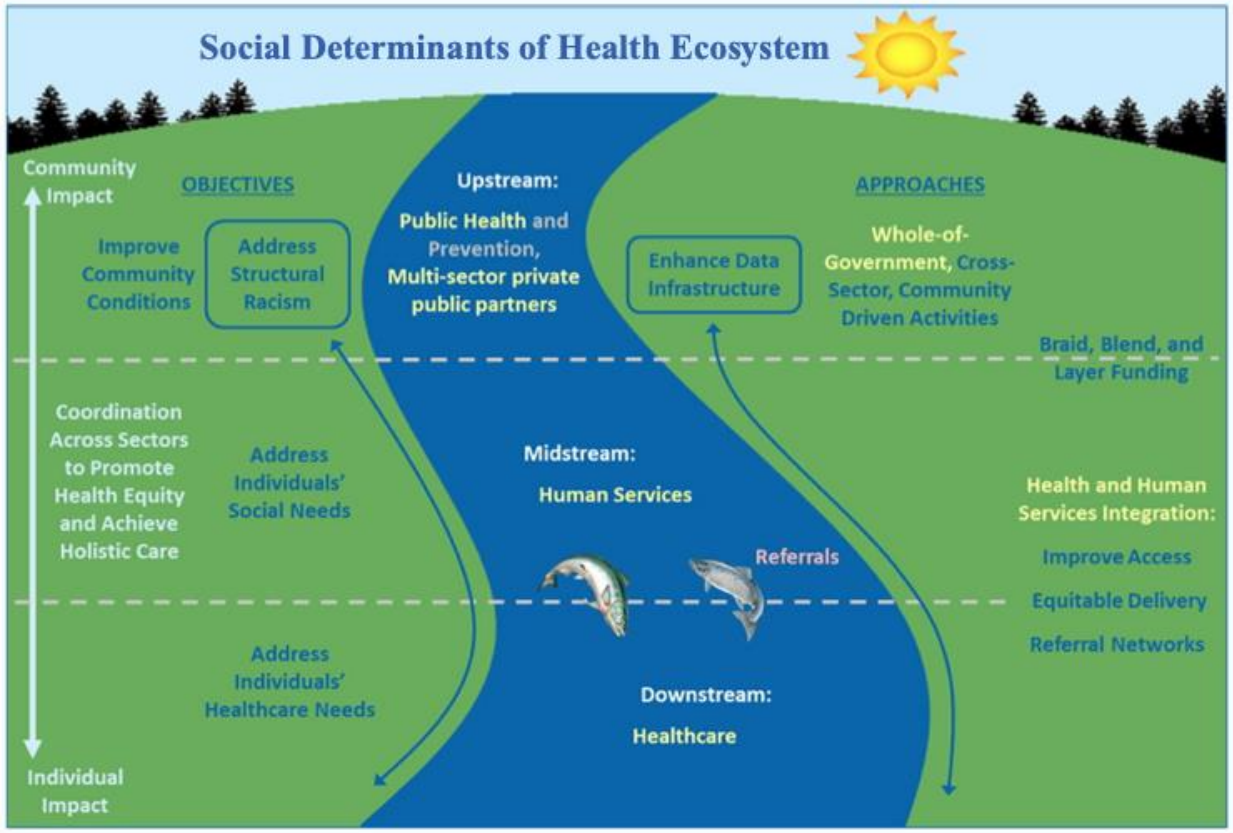
https://www.healthit.gov/topic/2020-2025-federal-health-it-strategic-plan

HHS SDOH Action Plan

Goal 1: Build a robust and interconnected data infrastructure to support care coordination and evidence-based policymaking.

Goal 2: Improve access to and affordability of equitably delivered health care services, and support partnerships between health care and human service providers, as well as, build connections with community partners to address social needs.

Goal 3: Adopt whole-of-government approaches, support public-private partnerships, and leverage community engagement to address SDOH and enhance population health and well- being.



Note: Adapted from Castrucci B, Auerbach J. Meeting Individual Social Needs Falls Short of Addressing Social Determinants of Health. Health Affairs Blog. January 16, 2019

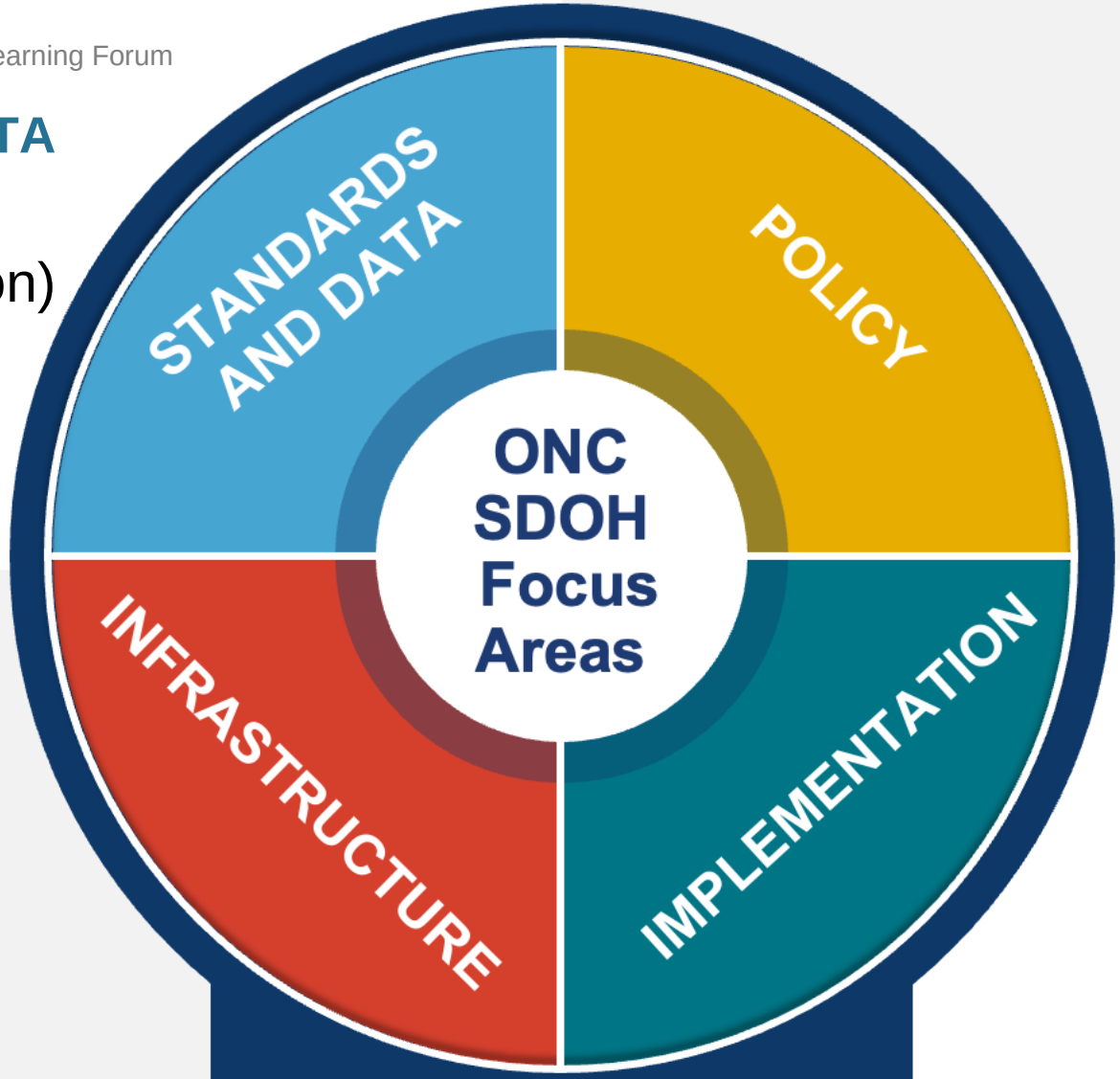
https://aspe.hhs.gov/sites/default/files/documents/aabf48cbd391be21e5186eeae728ccd7/SDOH-Action-Plan-At-a-Glance.pdf

STANDARDS AND DATA

(Advance Standards Development Adoption)

POLICY

(Emerging Policy Challenges & Opportunities)



INFRASTRUCTURE

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

IMPLEMENTATION

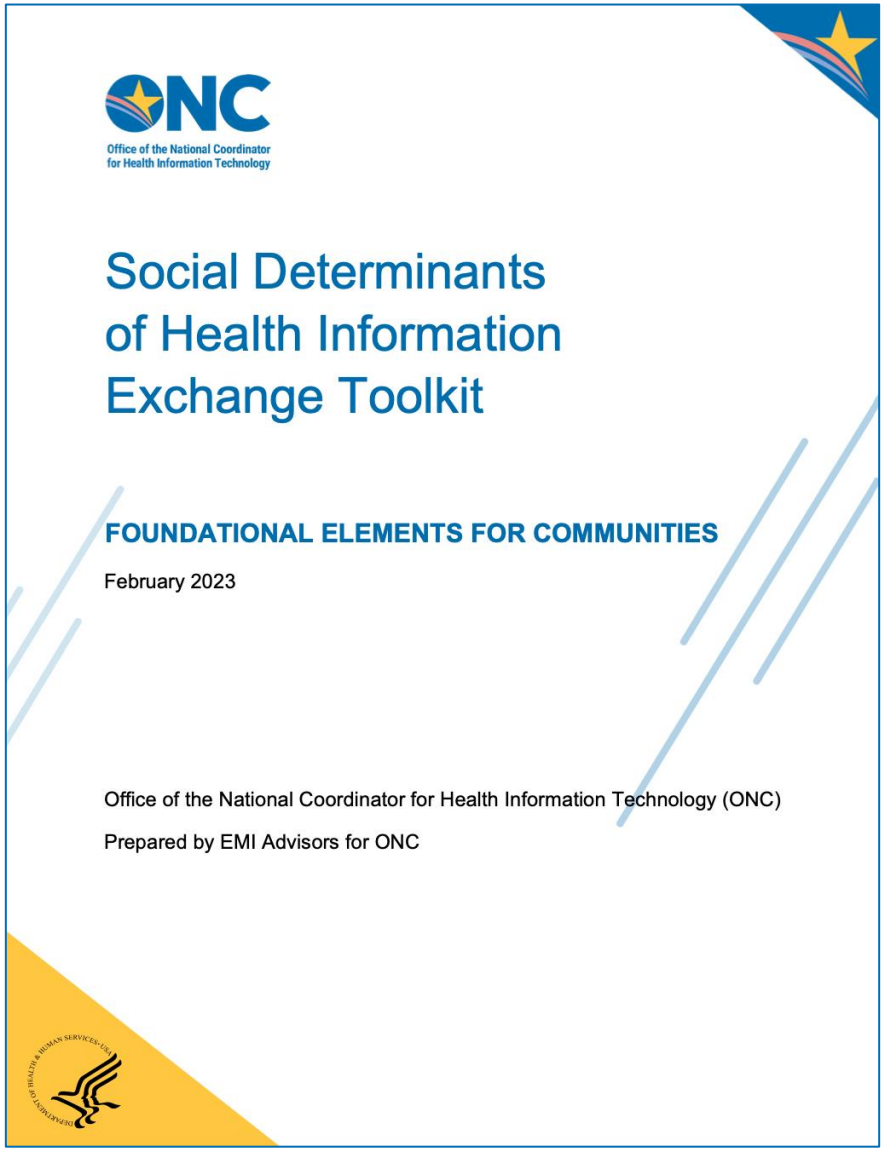
(Integration, Innovation, and Health IT Tools)

Collect, Access, Exchange, Use

ONC SDOH Information Exchange Toolkit publication

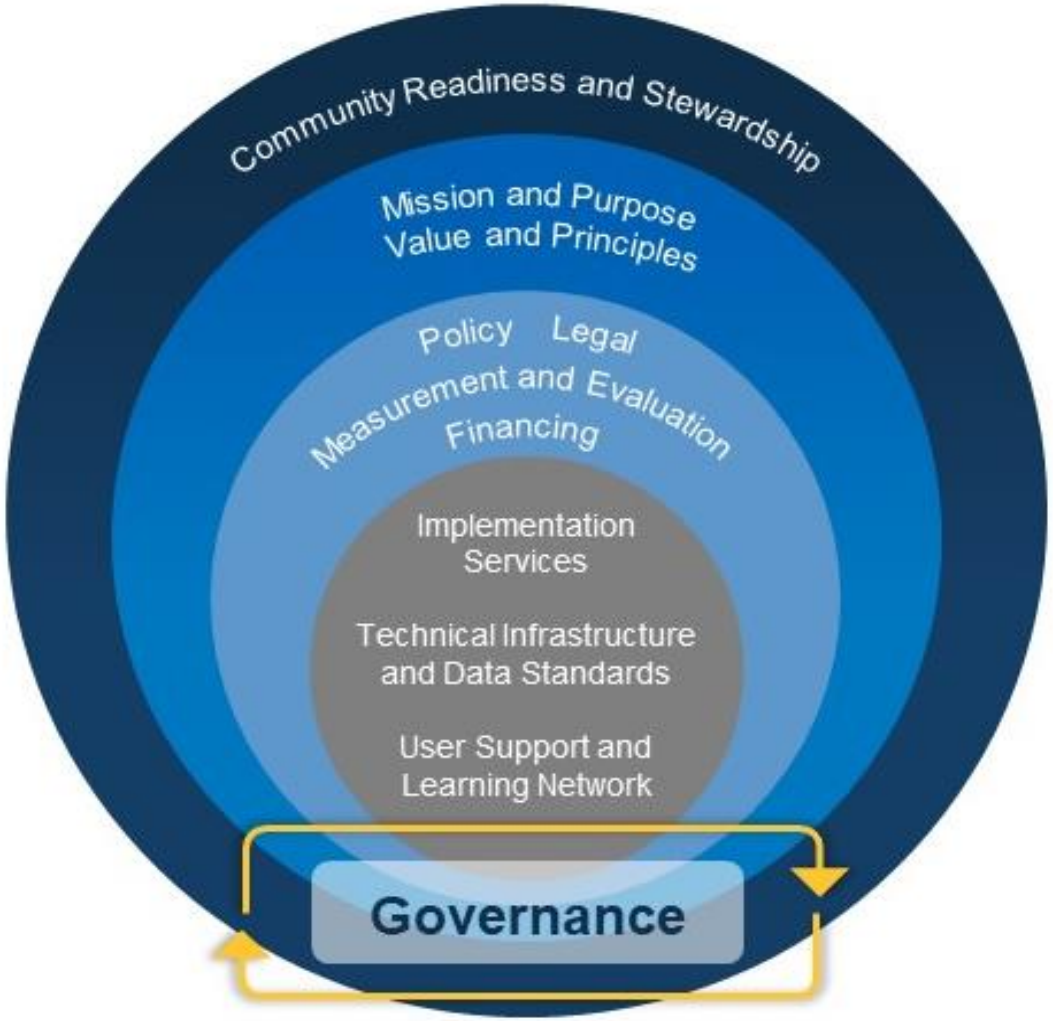
Developed by ONC with support from EMI Advisors and a panel of technical experts convened in 2020.

- Provides information on the SDOH information exchange landscape to stakeholders of all experience levels.
- Identifies approaches to advance SDOH information exchange goals through the 'foundational elements' framework.
- Provides examples of common challenges and promising approaches.
- Shares guiding questions and resources to support implementers.
- Available here: Social Determinants of Health (SDOH) Information Exchange Toolkit



Overview of SDOH Information Exchange Foundational Elements

Social Determinants of Health Information Exchange Foundational Elements



Foundational element: governance

Decision-making processes and groups, including as relates to institutional, administrative and data governance.

Governance consists of several levels of decision-making involving communities including:

- **Institutional governance**: Context in which the terms of participation are established, including the processes by which leadership and service providers are organized, administered, and removed; priorities are set and adjusted; rulemaking processes are established and changed; outcomes are evaluated; and institutional conflicts are resolved.

- **Administrative governance**: Context in which policies, as prioritized by institutional governance, are designed, implemented, monitored, and enforced—including those pertaining to regulatory compliance, agreements for information sharing and use, and operational standards.

- **Data governance**: Context in which policies established by administrative governance are implemented and enforced through processes of data stewardship, such as rules for technical standards and data collection, management, storage, exchange, verification, validation, contestation, and deletion.

Questions to consider

- **Institutional governance**
  - How will the terms of membership and participation in the initiative be established?
  - Who will decide the terms of membership and participation, and who will decide the rules of the system?

- **Administrative governance**
  - How will the policies pertaining to information sharing, incentives, and evaluation be made and changed?
  - Who will be responsible for facilitating policy making, implementation, and enforcement? Who should be subject to mechanisms of accountability?

- **Data governance**
  - What data standards and technical system design will your initiative adopt, and how will those standards be implemented and monitored?
  - To what extent will the initiative's infrastructure be "vendor-agnostic," and what provisions should be in place to ensure such terms?

Spotlight: MiHIN

MiHIN's Journey to Cross Sector Sharing of Social Care Data: The Role and Path for Governance

Lisa Nicolaou, MSNI, RN, Cross Sector Data Sharing Program Director, MiHIN

Mike Klinkman, MD, MS, Cross Sector Data Sharing Program Medical Director, MiHIN

Dawn Opel, J.D., Ph.D., Chief Operating Officer & General Counsel Food Bank Council of Michigan

MiHIN

MICHIGAN HEALTH INFORMATION NETWORK SHARED SERVICES

Meet the Team

Lisa Nicolaou, MSNI, RN

Cross Sector Data Sharing (CSDS) Program Director

Dawn Opel, J.D., Ph D.

Chief Operating Officer / General Counsel Food Bank Council of Michigan

Dr. Mike Klinkman, MD

MiHIN's CSDS Program Medical Director

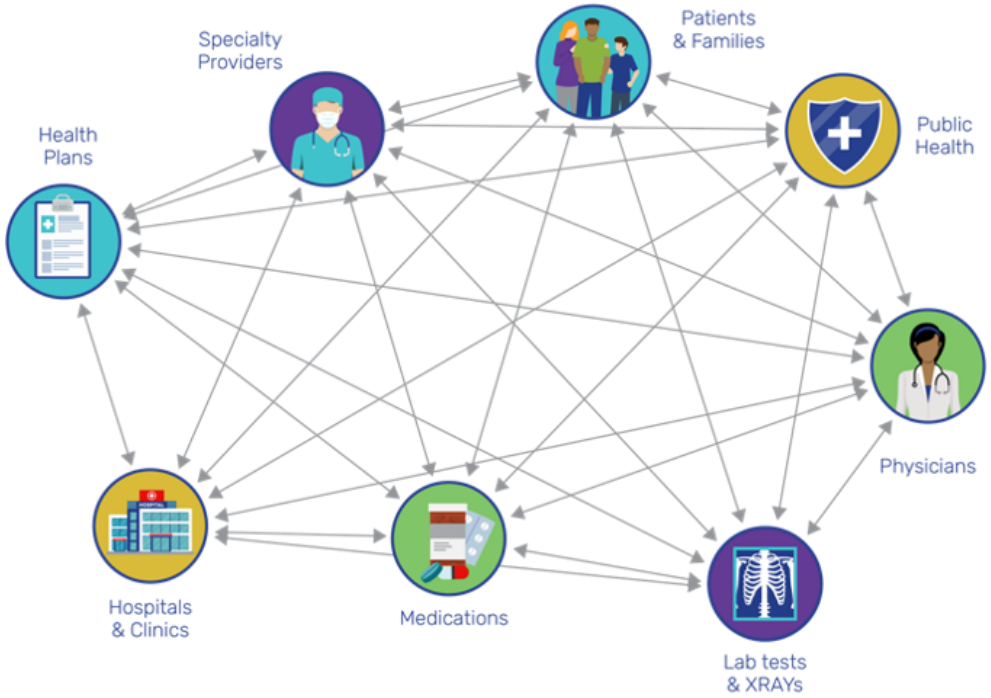
Michigan Health Information Network Shared Services (MiHIN)

MiHIN is Michigan's state-designated entity to continuously improve healthcare quality, efficiency, and patient safety by promoting secure, electronic exchange of health information. MiHIN represents a growing network of public and private organizations working to overcome data sharing barriers, reduce costs, and ultimately advance the health of Michigan's population.

Statewide Health Information Exchange Creates Efficiency

BEFORE:

Duplication of effort, waste and expense



NOW:

Connect once to access shared services

Brief History: Michigan Health Information Network Shared Services

2010 — **Federal Office of National Coordinator** establishes State Health Information Exchange Cooperative Agreement Program

Michigan forms **Health Information Technology Commission**, which establishes MiHIN.

2012 — ***Active Care Relationship Service (ACRS)*** and ***Admission Discharge, Transfer (ADT)*** **Notifications** go live

2013 — MiHIN Michigan Health Information Network

2014 — **97%** of ***Admissions Discharge Transfer Notifications*** statewide sent through MiHIN

Common Key Service introduced for patient matching

2016 — MiHIN Shared Services

2017 — Velatura Public Benefit Corporation and Interoperability Institute established

velatura

INTEROPERABILITY INSTITUTE

2019 — More than **100 M** messages routed through statewide network

2020 — More than **1 BILLION** messages routed through statewide network

MiHIN completes its corporate affiliation of Great Lakes Health Connect (GLHC)

2022 — **131,133,812** ccumulative ***Immunization*** Queries

MiHIN's Strategy to Build Capacity for Social Care Data Exchange

- **Support, connect, and scale local / regional collaboratives**
  - State Health Equity Project
- **Build on a common cross-sector care model**
  - Complimentary social and health care roles
- **Work from existing MiHIN 'toolbox'**
  - Legal, technical, convening and use case factory
- **Employ Gravity standards where possible**

MiHIN's Cross Sector Data Sharing Program: Data Exchange to Support Health Equity 8/2021

Support cross-sector care use cases

- Connect health and social care teams in providing care for an individual client/patient
- Movement of data that supports the care team
- Movement of data to support decision making about where to best use scarce resources

Provide Subject Matter Expertise

- Help build and guide technical data flow development in a currently unregulated space
- Engage in cross sector, multidisciplinary discussions within Michigan to help create the right environment to support data sharing

Act as a neutral convenor

- Bring existing referral vendors together to work on a common purpose and make siloed data interoperable
- Elevate issues brought forth by stakeholders
- Pilot CSDS instances and provide information about pilots to those who set policy in the state

MiHIN Activities

- **Existing Regional Efforts**
  - AHC and SIM efforts in Michigan; regional CIE's in place with varying governance models
  - All running into sustainability when looking for expansion
- **Interoperable Referral use case / Community of Practice**
  - Overview of MiHIN's Interoperability Pledge and Community of Practice
  - Tool vs part of governance
- **Engagement in the CIE Taskforce / other statewide issues:**
  - Health care data governance experience and lessons learned from that journey
  - Working out the governance regionally is important / balance between regional and local governance and statewide sustainability
  - Still being sorted out at a state level – one of many partners to contribute to governance discussions
  - Model or role for HDU

CBO Perspective:

- Food Bank Council of Michigan supports 7 regional food banks and 3000 hunger relief agencies across Michigan
- Seeking assistance with care coordination across sectors and payment reform for health-related social needs programs and services
- Working with MiHiN specifically on data flow to support CBOs in use cases that support their pre-existing workflows and tools
- CIE Taskforce: value proposition still evolving, depending on which sector drives the conversation

Key Learnings:

- **Not specific to Michigan**
- **Application of technology in advance of governance**
  - more complicated (costly) in the long run
- **Community generated solutions**
  - could not be imposed or single platform
- The group in MI is not convened by a group responsible for the funding; When the HUB is offering to fund the project – easier to build consensus
- **Comprehensive engagement – clarity on data movement needs**
  - Community partners need to be brought in as partners
- Cannot solve without addressing equity
  - Equity between health care and community partners to solve complex problems – easier in local / regional – more difficult when larger organizations / institutions – lack of trust
- Statewide data movement future of HDU
  - collaborative MDHHS/ MIHIN

Challenges and how they were mitigated:

- Tensions between solving locally vs statewide
- Multiple commercial vendors
- Multiple commercial and Medicaid plans
- Alignment with multiple stakeholders
  - Different drivers / mismatched value Keeping up / harmonizing with evolving standards (FHIR, HL7)

Questions?

Lisa Nicolaou

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Mike Klinkman

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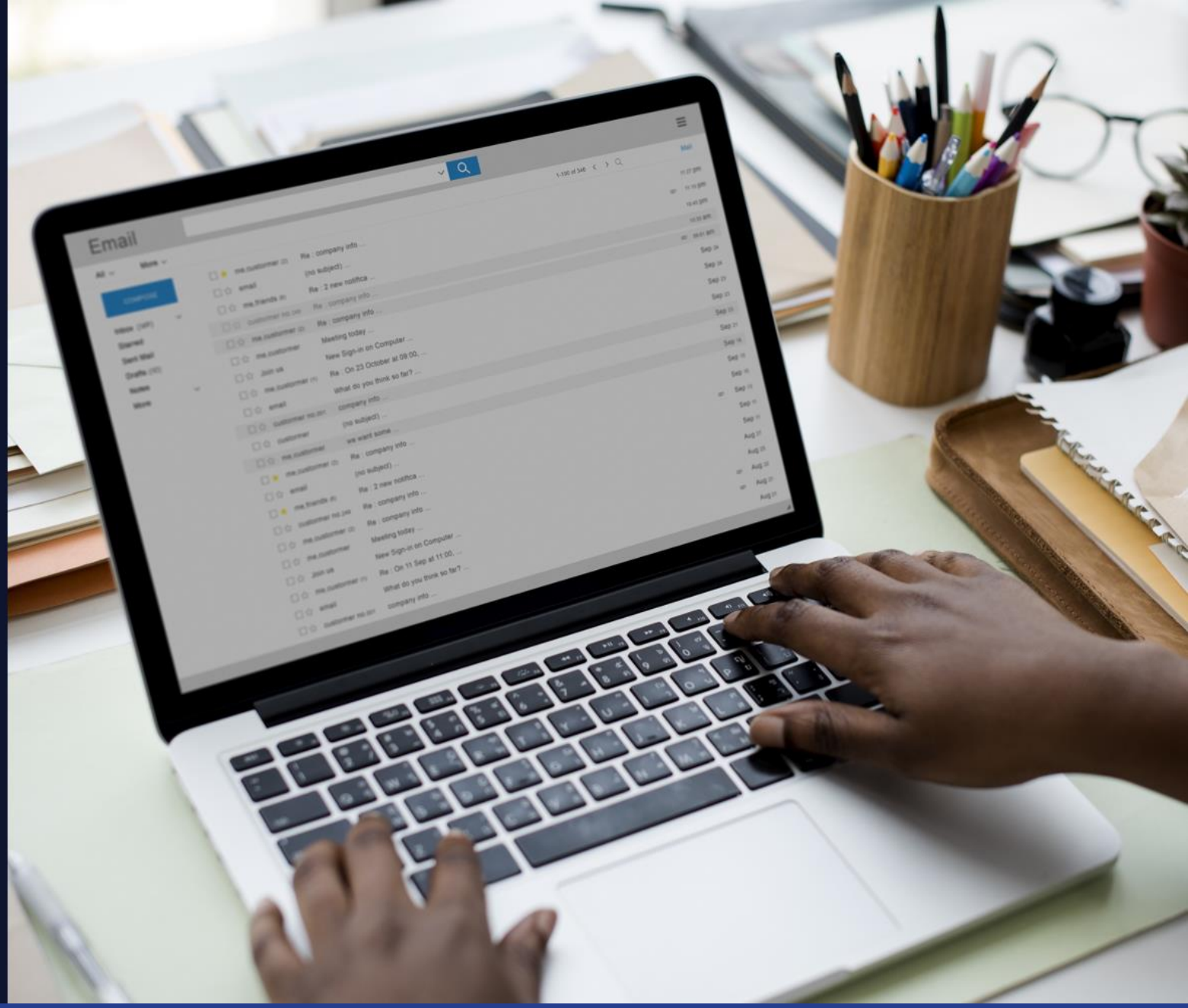
Dawn Opel

dopel@fbcmich.org



THANK YOU

LET'S CONNECT

mihin.org

@MiHIN

linkedin.com/company/mihin

Questions and Discussion

Spotlight: UT Austin

The Development of a Model Community in Central Texas

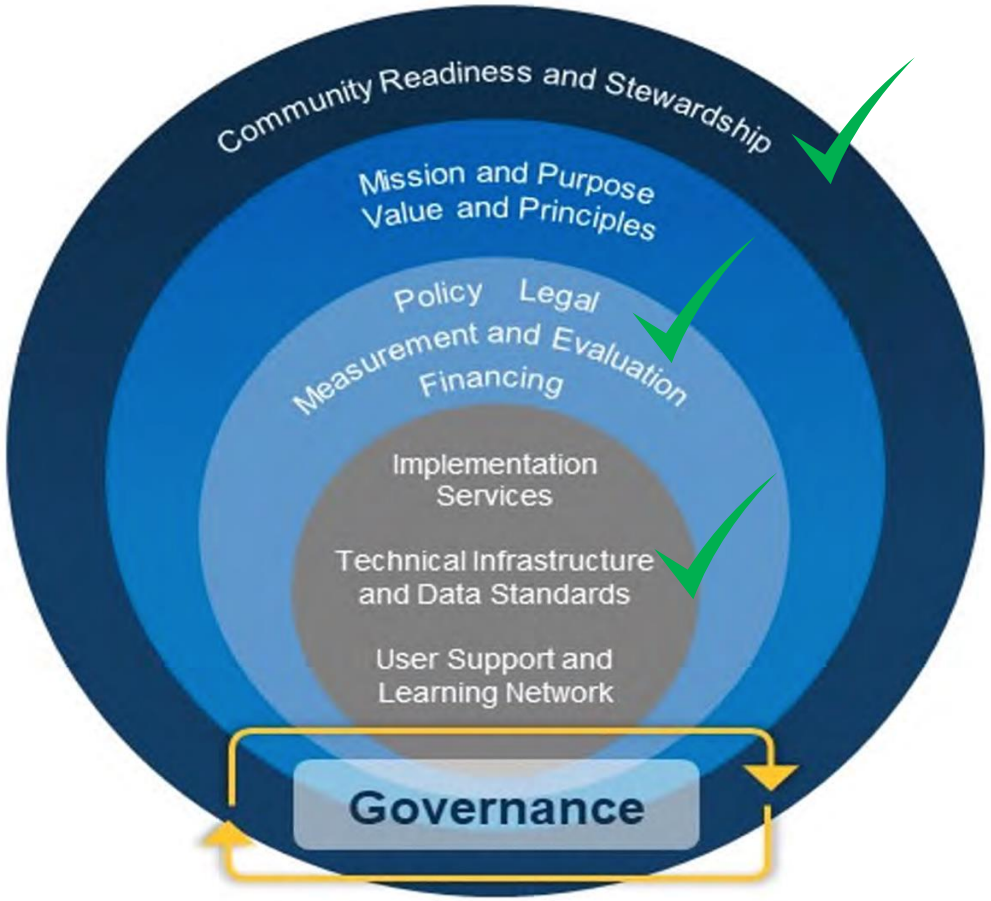
Vidya Lakshminarayanan, MS
Assistant Director, Research and Innovation
Dell Medical School

Anjum Khurshid, MD PhD FAMIA
Faculty & Chief Data Scientist
Department of Population Medicine
Harvard Medical School & Harvard Pilgrim Health Care Institute

Akram Al-Turk, PhD
Director of Research and Evaluation
Ending Community Homelessness Coalition

Eliel Oliveira, MS MBA
Director, Research and Innovation
Dell Medical School

Social Determinants of Health Information Exchange: Foundational Elements



Source: https://www.healthit.gov/sites/default/files/2022-04/ONC_SDOH_Learning_Forum_Primer_032822_508.pdf

Austin Metro Growth

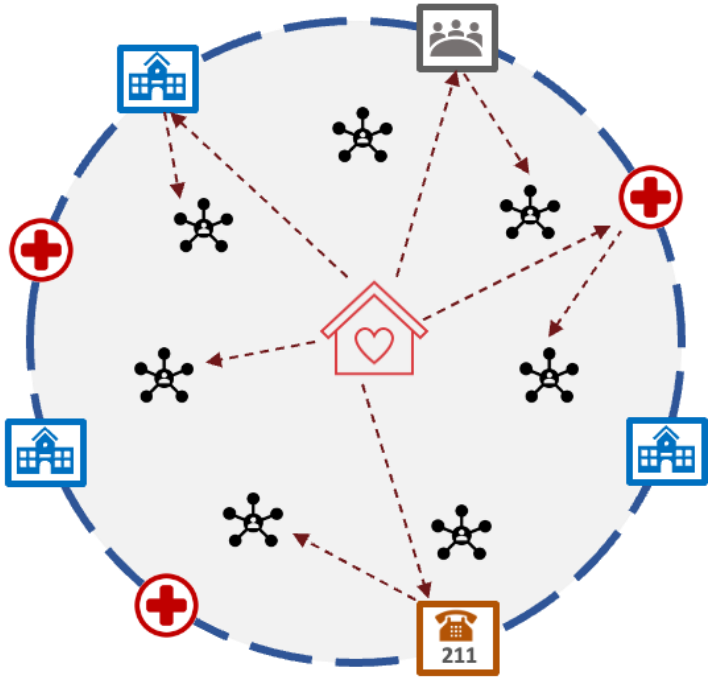
- Fastest growing for about 10 years.
- Median home value increased by over 60% in the last two years. The increase holds in the last 5 years.
- Persons experiencing homelessness increased from 2,755 in Feb 2021 to 4,611 today (Feb 2023). About 60% increase.
- More growth expected: Tesla, Oracle, Samsung, Google, Amazon, Dell Apple, others.
- Increased growth has led to increased pressure on social determinants of health and to increased disparities in the community

Model Community and Integrated Health

A person-centered, community led effort to co-create a shared data ecosystem that helps persons, organizations and the broader community improve outcomes, address disparities and transform our systems of care for Central Texas Residents.

Families engage community support through key entry points:

- CBOs/NPOs (Goodwill, ECHO)
- Health: community clinics
- Education: schools and other education providers
- Workforce: training programs
- 211 and ConnectATX (United Way)

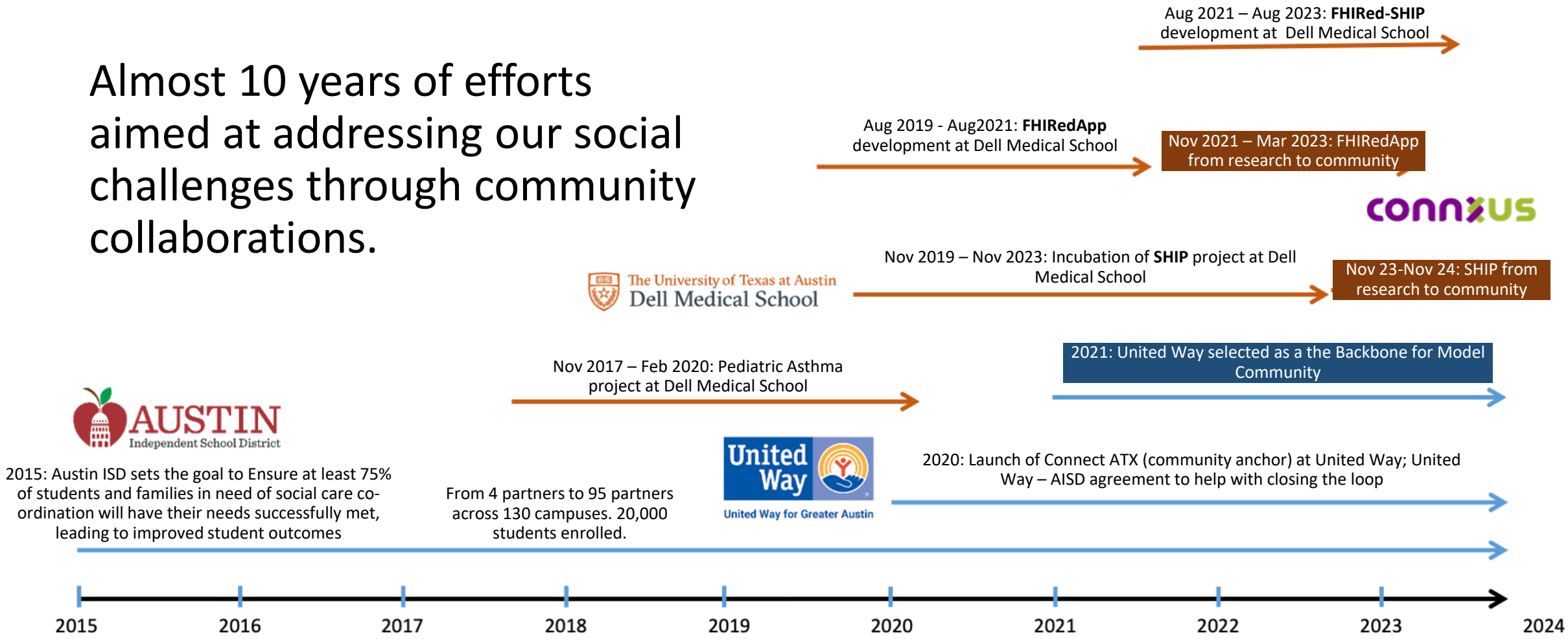


In order to coordinate support and ensure needs are met, Model Community:

- Coordinates social needs between SDoH surveys and across the community
- "Closes the loop" with streamlined referrals and follow-up processes
- Develop community solutions to problems (e.g. for patients, for gaps, successes, etc.)

Timeline

Almost 10 years of efforts aimed at addressing our social challenges through community collaborations.



Partners


St David's
FOUNDATION


ONC
Office of the National Coordinator
for Health Information Technology


The University of Texas at Austin
Dell Medical School


Michael & Susan Dell
FOUNDATION


ECHO


emi
ADVISORS


gravity
PROJECT


United
Way
United Way for Greater Austin


WIC
Women Infants & Children


connexus


AUSTIN
Independent School District


HEALTHY PLACES
HEALTHY PEOPLE


APH
Austin
Public
Health
PREVENT. PROMOTE. PROTECT.


CommUnityCare
HEALTH CENTERS


PEOPLE'S
COMMUNITY
CLINIC


CENTRAL
TEXAS
FOOD
BANK


CENTRAL HEALTH

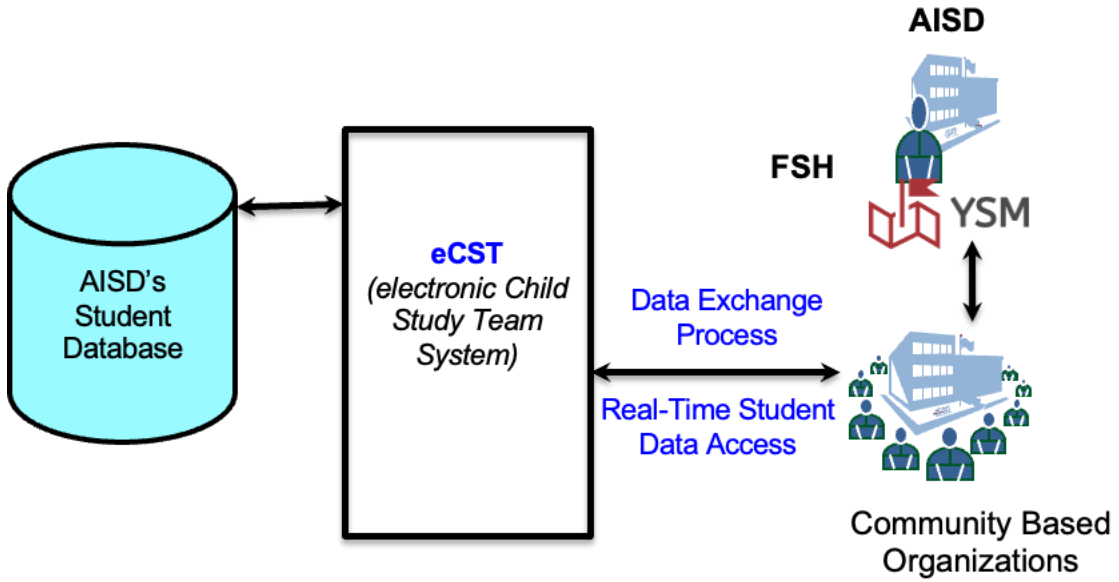

Lone ★ Star
Circle of Care


findhelp


Integral Care

SDOH Data Exchange in Schools: Early Experiences

Austin Independent School District (AISD)



YSM – Youth Services Mapping
Student-Level Resource directory

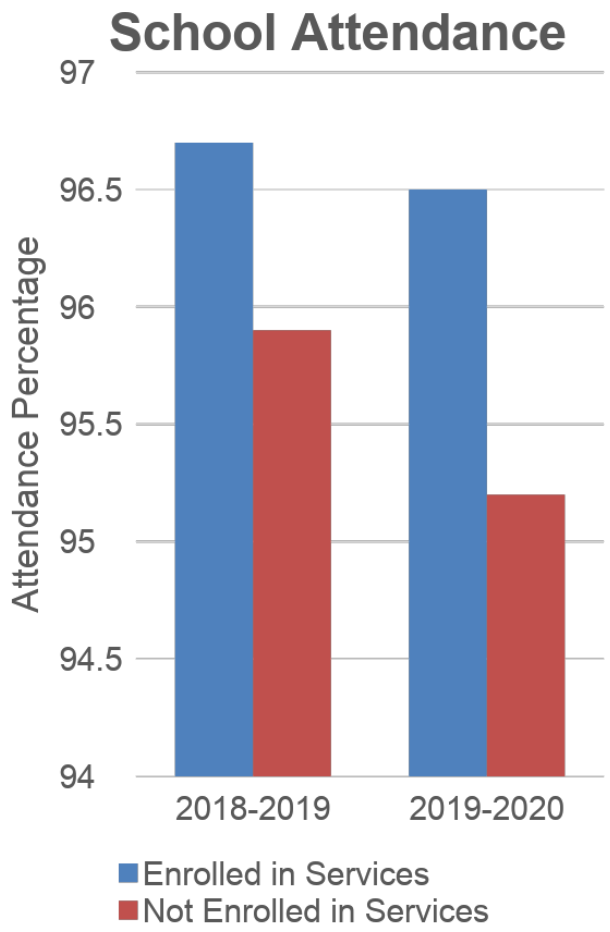
FSH – Family Support Hub
Family-Level Resource directory

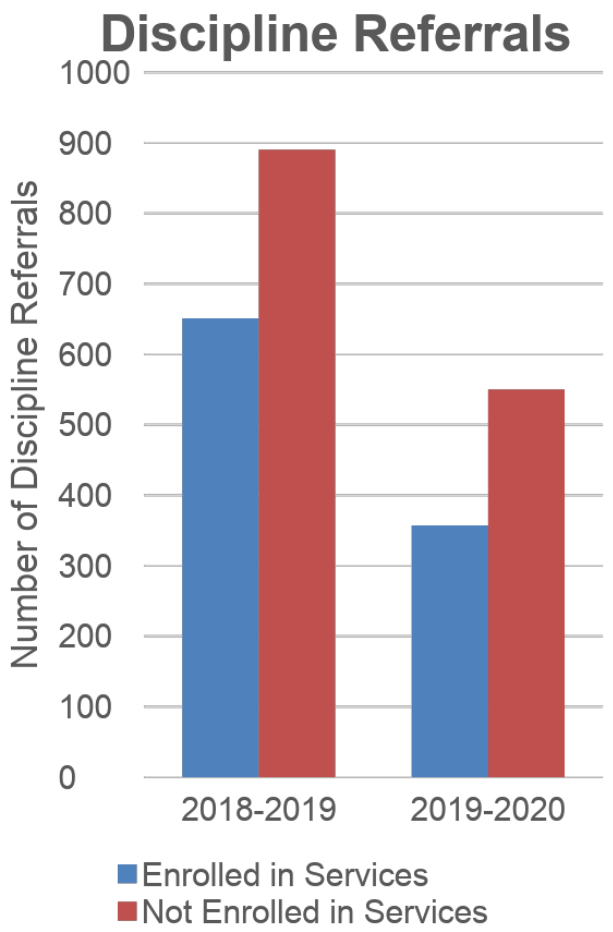
- CBOs register their organization, programs (offered to students on YSM; offered to families on FSH), and locations in resource directory
- CBOs providing direct services to students; complete partnership agreement with the district
- Role based access is granted to CBOs for real-time data access (with appropriate Data Sharing Agreements and Parent Consent)

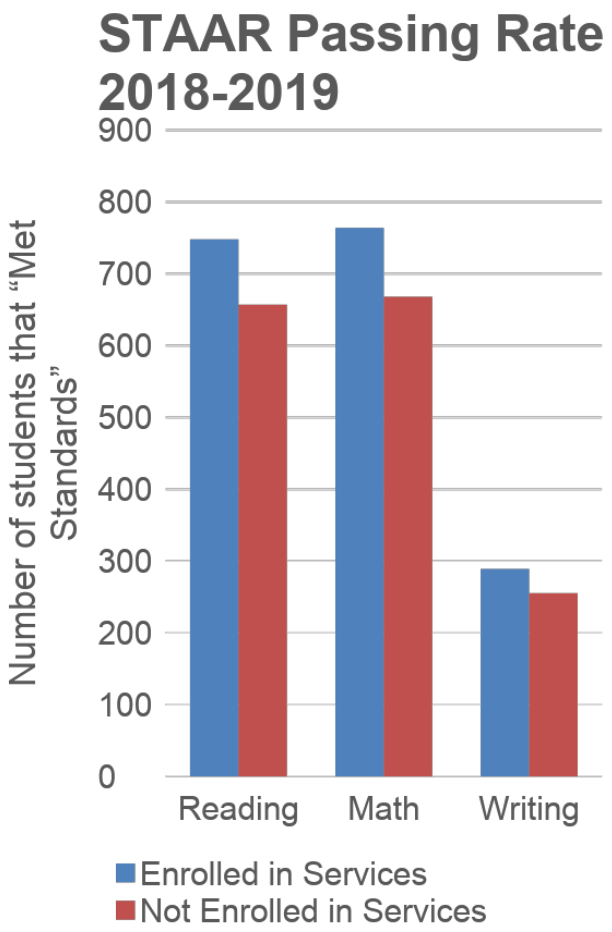
AISD Governance

- CBOs providing direct services to students renew their partnership with the district annually – as part of their renewal process, they update their program information on YSM annually
- CBOs uploading student rosters to eCST receive access to aggregate reports (can track students longitudinally) and comparison reports. AISD collects parent consent at the time of student registration for accepting rosters from CBOs
- CBOs providing case management services to students can access real-time student-level data with data sharing agreements and parent consent (the data sharing agreements are also renewed as part of the annual renewal process)

Impact


School Attendance
97
96.5
96
95.5
95
94.5
94
Attendance Percentage
2018-2019
2019-2020
Enrolled in Services
Not Enrolled in Services

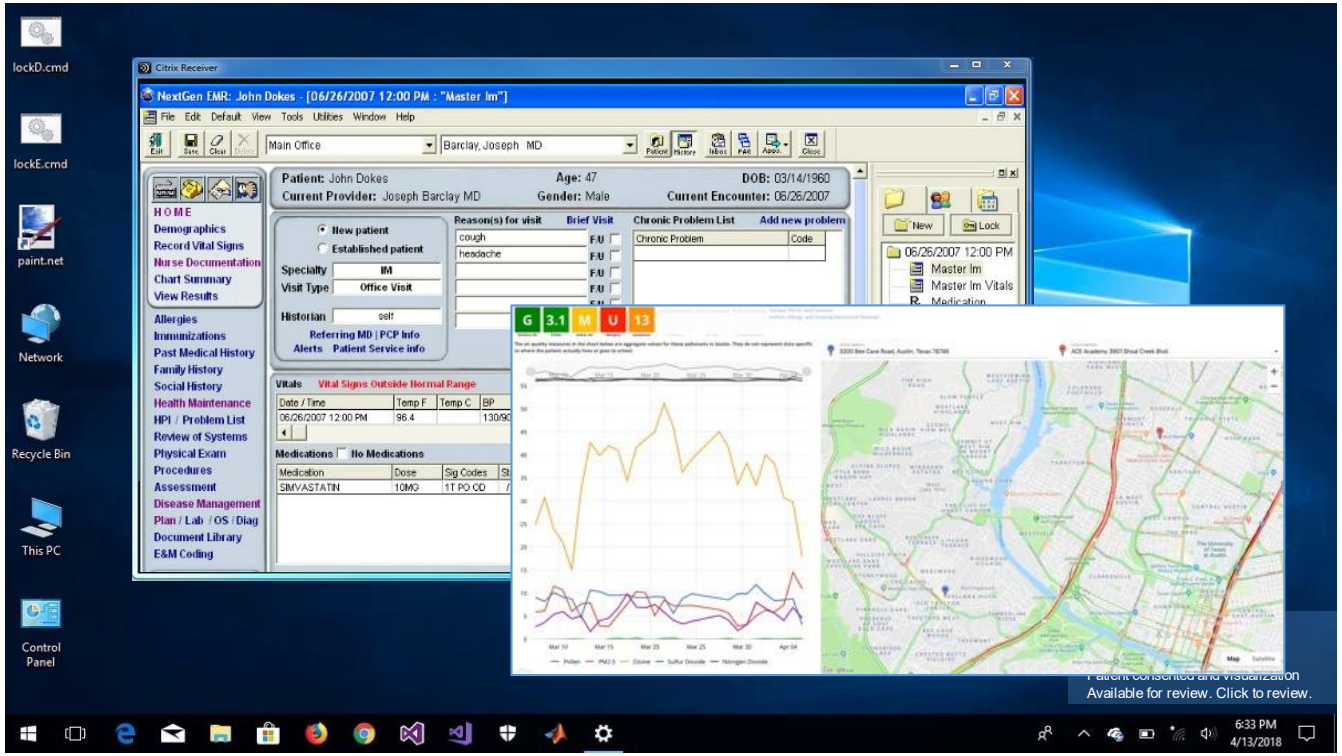

Discipline Referrals
1000
900
800
700
600
500
400
300
200
100
0
Number of Discipline Referrals
2018-2019
2019-2020
Enrolled in Services
Not Enrolled in Services


STAAR Passing Rate 2018-2019
900
800
700
600
500
400
300
200
100
0
Number of students that "Met Standards"
Reading
Math
Writing
Enrolled in Services
Not Enrolled in Services

SDOH Data Exchange in Health: Model Community Effort

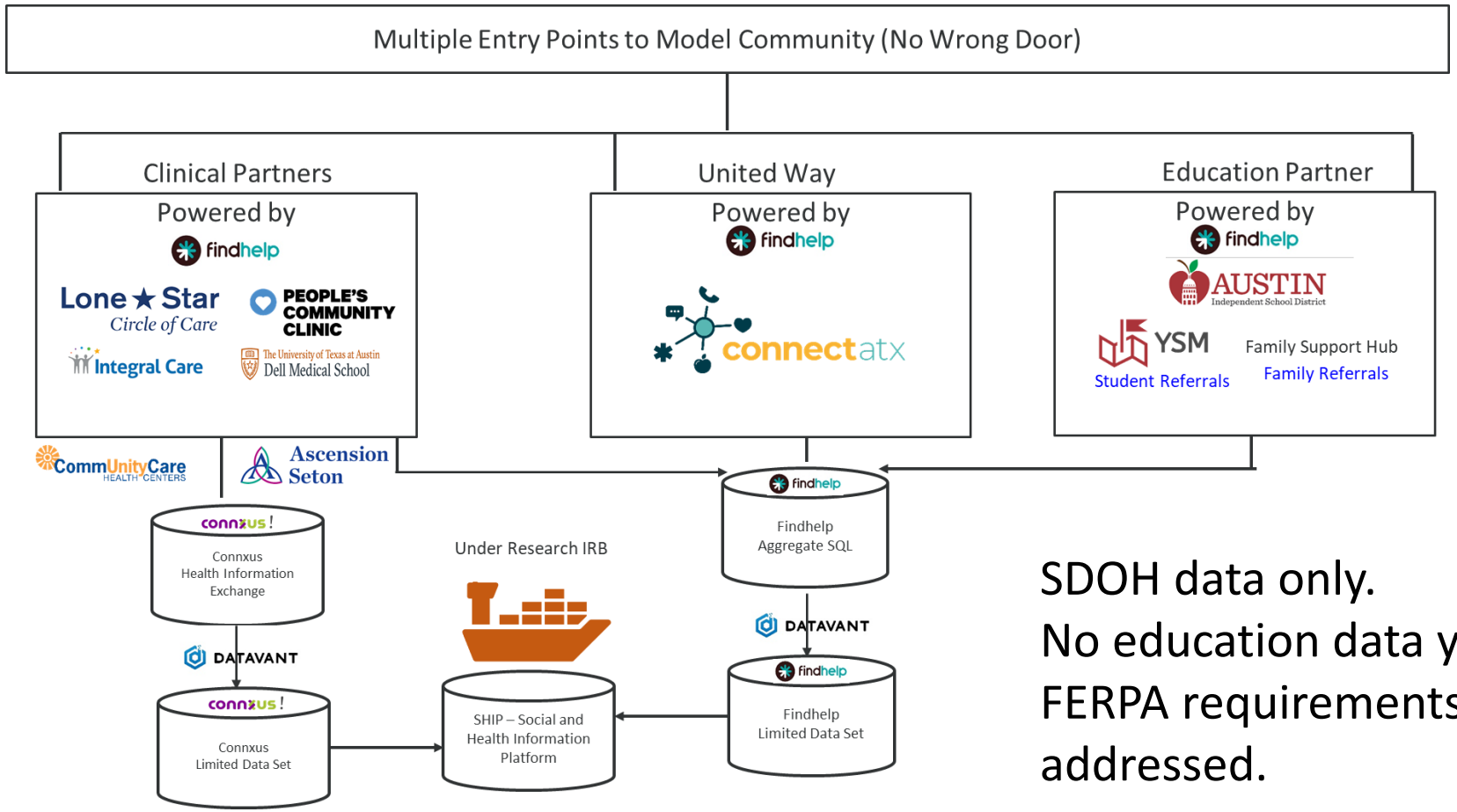
Social and Health Information Platform (SHIP)

- A digital platform that facilitates data sharing across sectors and integrates clinical and social sector data into user-friendly longitudinal records.
- SHIP makes health-related data (i.e. clinical + social) available in the workflow of care teams, including integrating with EHRs.
- SHIP aims to:
  - turn data into easy-to-read, actionable visuals
  - facilitate efficient and comprehensive patient care and coordination for individuals
  - provide enhanced insights into community-level health issues, service gaps, and possible solutions across sectors



Khurshid A, Oliveira E, et al. Developing a real-time EHR-integrated SDoH clinical tool. AMIA Jt Summits Transl Sci Proc. 2020 May 30;2020:308-316.

Social and Health Information Platform (SHIP)



SDOH data only.
No education data yet until FERPA requirements addressed.

The University of Texas at Austin
Dell Medical School

Office of the National Coordinator for Health Information Technology

Leading Edge Acceleration Projects

FHIR-enabled Social and Health Information Platform (FS): Integrating a closed-loop social services referral system into electronic health records in Federally Qualified Health Centers using FHIR

Principal Investigator:
Eliel Oliveira

Expert Clinical Informaticists:
William Tierney, MD
Anjum Khurshid, MD PhD

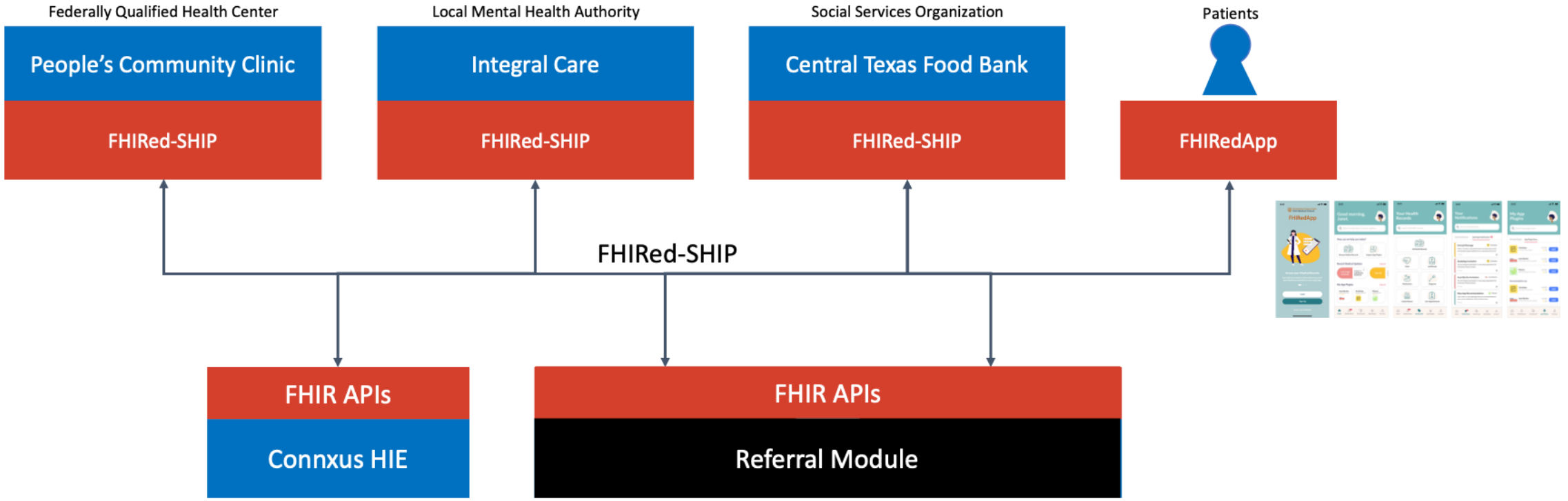
Community Engagement:
Ricardo Garay

Technology:
Vidya Lakshminarayanan
Vishal Abrol

Aug 2021 – Aug 2023

FHIRed-SHIP

FHIR-based integration of a Patient Engagement Technology (FHIRedApp) and a Social and Health Information Platform (SHIP) to allow for real-time care coordination between social and health care providers, and patients.



Community Engagement

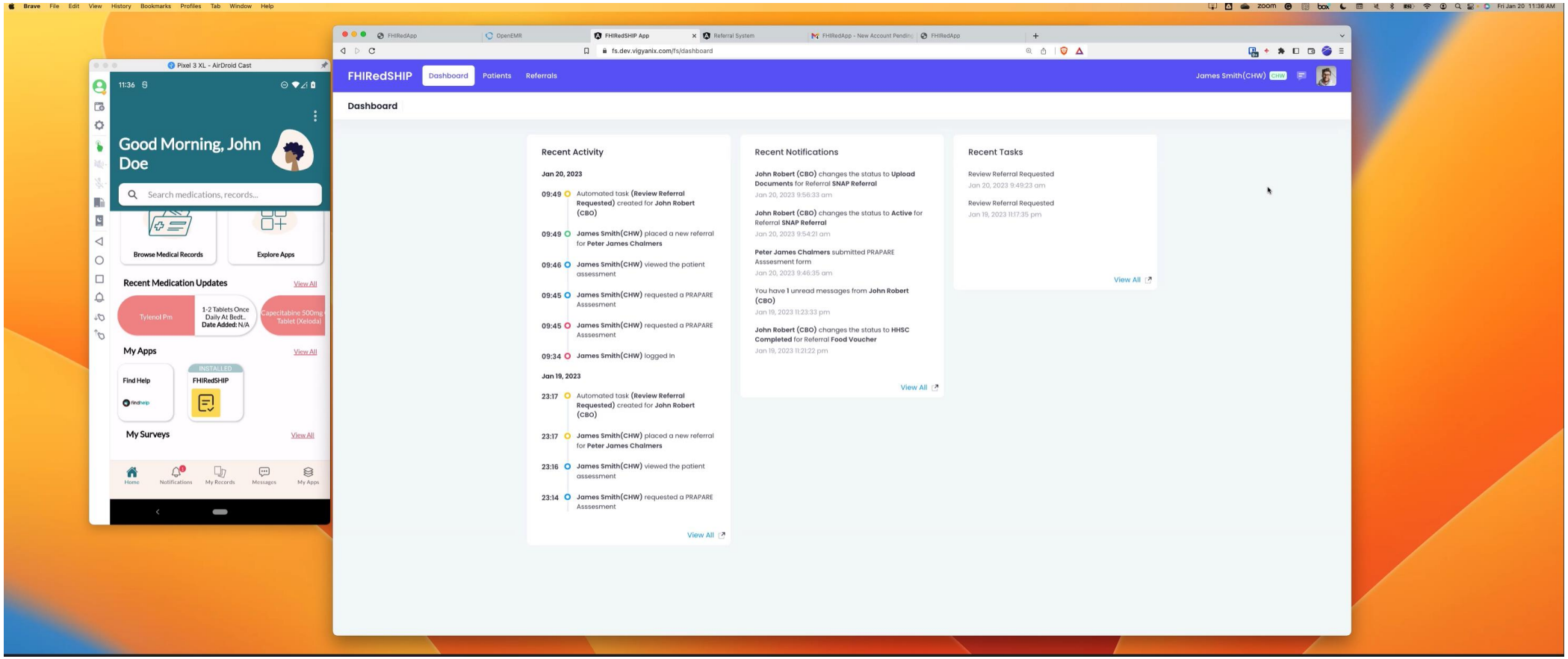
- Community Strategy Team (CST)*
  - ✓ Community leaders
  - ✓ Advise on project scope and community engagement
  - ✓ Help recruit CAB members
- Community Advisory Board (CAB)
  - ✓ Researchers and community members
  - ✓ Guidance on community engagement aspect of projects
  - ✓ Help recruit CES members
- Community Engagement Studios (CES)**
  - ✓ Members in each CES studio
  - ✓ Help gain community insights on participation retention strategies, survey design, ethical considerations, simplifying consent process, etc.
  - ✓ Represents underserved and underrepresented communities in Travis County

** Community Strategy Team: https://dellmed.utexas.edu/units/department-of-population-health/community-strategy-team*

*** Valdez C, et al. Expansion of the Community Engagement Studio Method: Deepening community participation in healthcare innovation. Progress in community Health Partnerships. 2022*

FHIRed-SHIP Pilot

Supplemental Nutrition Assistance Program (SNAP) application coordination



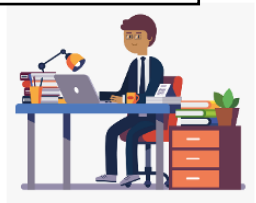
1. Patient downloads the App and consents to participate

2. Patient completes SDOH assessment on the App

3. CHW places referral to CTFB, if SNAP benefits need is expressed.

4. CTBF staff accepts the referral and sends intake questions to patient

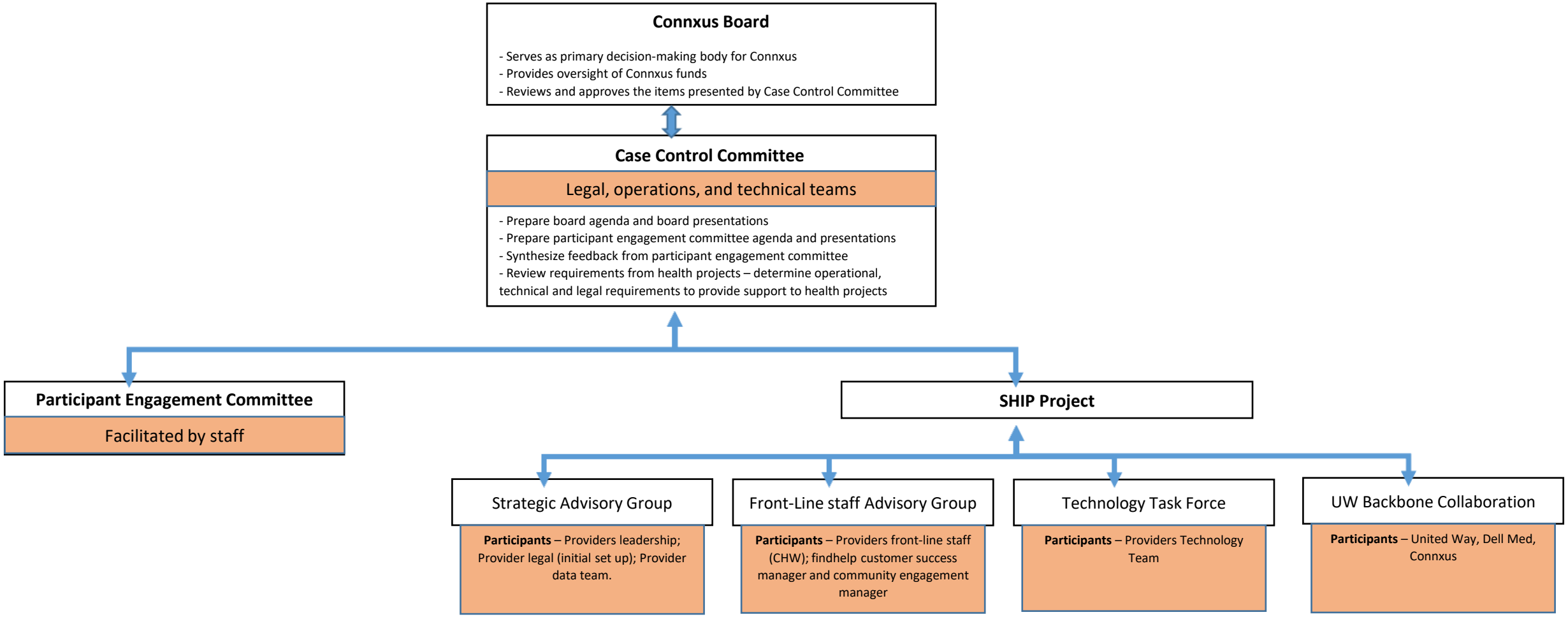
5. Patient responds to questions. If eligible, patient schedules a meeting with CTBF staff



6. Patient uploads required documents. CTBF staff submits SNAP application on behalf of patient

7. CTBF staff has access to patient's SDoH assessment (the one patient completed at the clinic)

Connxus (HIE) and SHIP



Use Case: Homelessness

Perspective from ECHO

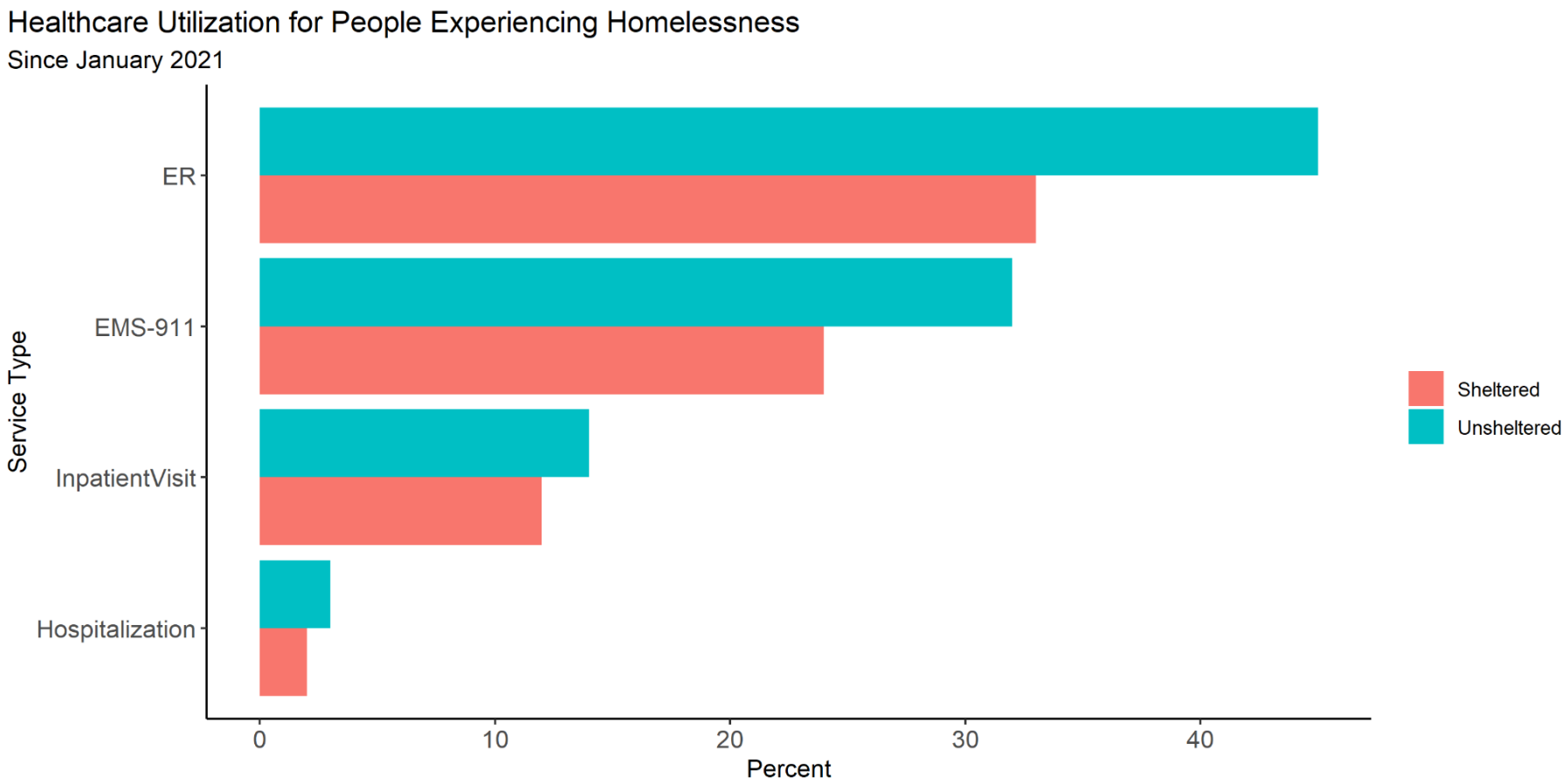
About the Ending Community Homelessness Coalition (ECHO):

- ***Coordinates*** data-driven strategies and funding to end homelessness in the community
- ***Works*** with service providers who are connecting people with housing and supportive services
- ***Manages*** the housing intake process to connect people with housing and services that meet their needs
- ***Administers*** centralized database (HMIS) to track demographics and service needs over time

Data Sharing with Connxus:

- ***In September 2021,*** ECHO became a member of Connxus.
  - HMIS has its own consent process
  - Connxus approved data sharing through its data release task force and board of directors using guidance from HHS's OCR

Perspective from ECHO



Short-term Impact of Data Sharing

Using only self-reported data (HMIS) → **Understanding healthcare utilization** → Assessing medical vulnerabilities

Perspective from ECHO

Long-term Impact of Data Sharing:

- ***Better care coordination*** between housing providers and medical providers
- ***Prioritization*** of most medically vulnerable people for certain homelessness interventions
- ***More accurate evaluation*** of the benefits of housing to healthcare outcomes

AT Home Initiative (2023-2027)

Target Population

- *Eligibility*: Below 200% federal poverty, Austin / TC resident, chronic homelessness
- *Referral*: Referral sources / targeted outreach to **engage high utilizers of public systems**

Intervention

- *Services*: Permanent Supportive Housing, including case management w/ **integrated health care**
- *Housing*: Scattered & single site units and vouchers

Provider

- *Medical* : CommUnity Care
- *Case management, behavioral health, other :* 1+ PSH providers
- *Referrals*: Various community organizations

Scale, Duration & Budget

- *Scale*: ~210 people
- *Duration*: 5 years
- *Total Budget*: $16M (covered by City, County, private foundations, and federal grants)

The Development of a Model Community in Central Texas

Vidya Lakshminarayanan, MS
Assistant Director, Research and Innovation
Dell Medical School

Anjum Khurshid, MD PhD FAMIA
Faculty & Chief Data Scientist
Department of Population Medicine
Harvard Medical School & Harvard Pilgrim Health Care Institute

Akram Al-Turk, PhD
Director of Research and Evaluation
Ending Community Homelessness Coalition

Eliel Oliveira, MS MBA
Director, Research and Innovation
Dell Medical School

Questions and Discussion

Learning Forum Series and Small Group Opportunities

Feedback

You may enter into the chat your thoughts on these two questions:

- How useful did you find today's ONC SDOH Information Exchange Learning Forum webinar on Governance?
- What other content or information would be useful for you in your efforts?

Other feedback or suggestions?

Email: **oncsdohlearningforum@hhs.gov**

Webinar series schedule

DESCRIPTION	Meeting Date/Time (EST)	Registration Link
Phase I Webinars		
Introduction to SDOH Information Exchange and the Learning Forum	March 2022	View past meeting materials and recordings here
Vision, Purpose, and Community Engagement	April 2022	
Governance	May 2022	
Technical Infrastructure and Interoperability	June 2022	
Policy and Funding	July 2022	
Phase II Webinars		
Community-level Governance	Thur, February 23,12-1:30pm	Register here
Values, Principles, and Privacy	Tue, March 28, 2-3:30pm	Register here
Implementation, Measurement, and Evaluation	Tue, May 23, 1-2:30pm	Register here
SDOH Information Exchange Learning Forum Summary	Thur, June 29, 12-1:30pm	Register here

Small group opportunity: March 15th

Join us on March 15th from 12-1pm ET to engage a small group conversation on the topic of governance.

- 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 webinar series.

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

Office of the National Coordinator for Health Information Technology

THANK YOU!

Office of the National Coordinator for Health Information Technology

Contact ONC

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Phone: 202-690-7151

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