NATIONAL ASSOCIATION OF Community Health Centers®

Social Determinants of Health (SDOH) Coverage and Payment Opportunities

Acknowledgements

This session is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $6,625,000 with 0 percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

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(participate in polls, ask questions to faculty)

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Learning Objectives

- Understand the importance of tracking SDOH needs using standardized SDOH screening tools such as PRAPARE.
- Obtain a high-level overview of the CMS Medicaid and SCHIP Authority for Reimbursement of SDOH Screening and Interventions RFA.
- Discuss the experiences of organizations using PRAPARE to improve the delivery of care for Medicaid patients through enhanced data collection.

PRAPARE and SDOH Overview

Nalani Tarrant
Deputy Director, Social Drivers of Health
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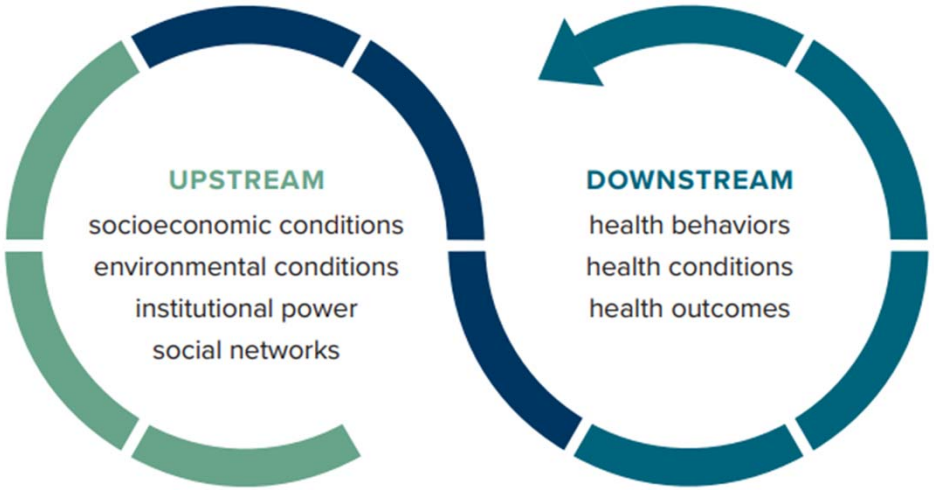
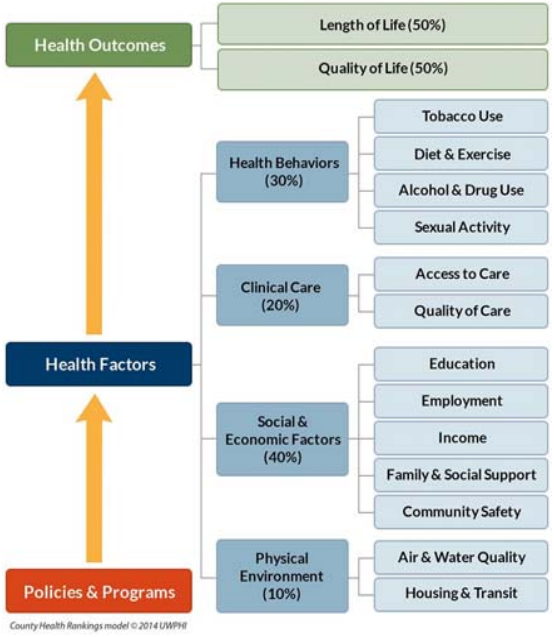
Social Drivers of Health

- Social drivers of health (SDOH): the conditions in which people are born, grow, live, work, and age. These conditions are shaped by the distribution of money, power, and resources.

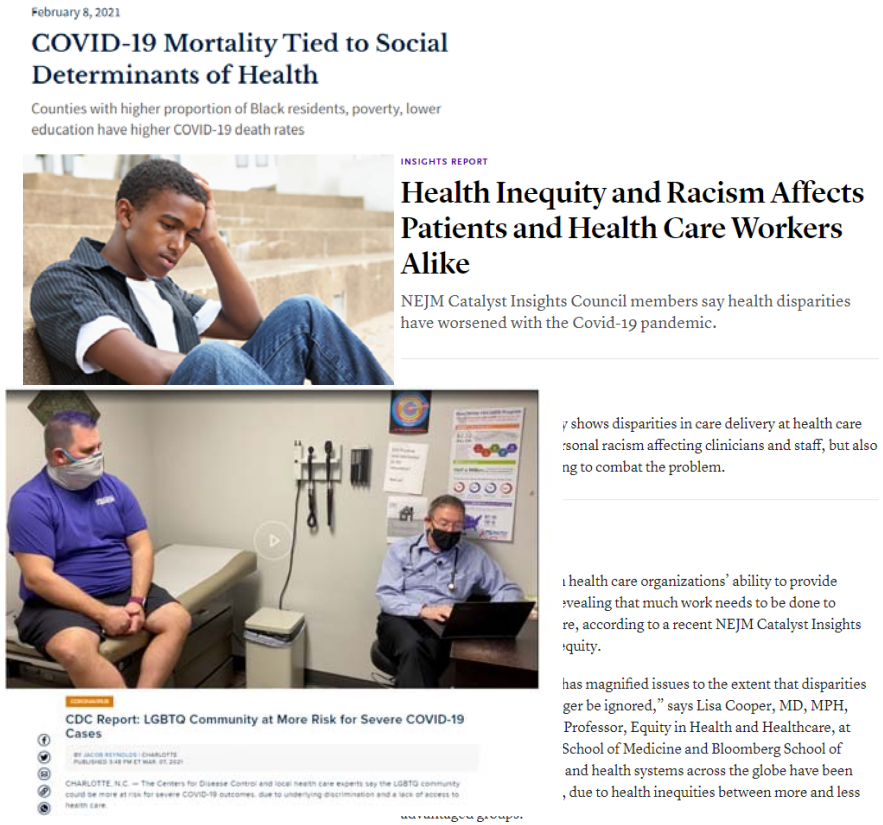




Impacted by SDOH

SDOH

Increased Awareness of SDOH during COVID-19



February 8, 2021

COVID-19 Mortality Tied to Social Determinants of Health

Counties with higher proportion of Black residents, poverty, lower education have higher COVID-19 death rates

INSIGHTS REPORT

Health Inequity and Racism Affects Patients and Health Care Workers Alike

NEJM Catalyst Insights Council members say health disparities have worsened with the Covid-19 pandemic.

...shows disparities in care delivery at health care ...sonal racism affecting clinicians and staff, but also ...ng to combat the problem.

...health care organizations' ability to provide ...vealing that much work needs to be done to ...re, according to a recent NEJM Catalyst Insights ...quity.

...has magnified issues to the extent that disparities ...ger be ignored," says Lisa Cooper, MD, MPH, Professor, Equity in Health and Healthcare, at ...School of Medicine and Bloomberg School of ...and health systems across the globe have been ..., due to health inequities between more and less

CDC Report: LGBTQ Community at More Risk for Severe COVID-19 Cases

Impact of SDOH during COVID-19

- Risk of getting COVID-19
- Mortality and morbidity
- Accessing care
- Impact of economic downturn
- Discrimination and bias
- Vaccination: access and hesitancy

PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences

A national **standardized** patient risk assessment **protocol** designed to **engage patients** in assessing and addressing social determinants of health

ACTIONABLE

STANDARDIZED and WIDELY USED

EVIDENCE-BASED and STAKEHOLDER-DRIVEN

DESIGNED TO ACCELERATE SYSTEMIC CHANGE

PATIENT-CENTERED

Core	
1. Race*	10. Education
2. Ethnicity*	11. Employment
3. Veteran Status*	12. Material Security
4. Farmworker Status*	13. Social Isolation
5. English Proficiency*	14. Stress
6. Income*	15. Transportation
7. Insurance*	16. Housing Stability
8. Neighborhood*	
9. Housing Status*	

Optional	
1. Incarceration History	3. Domestic Violence
2. Safety	4. Refugee Status

PRAPARE

Use Cases for PRAPARE During COVID-19

Individual & Community Level

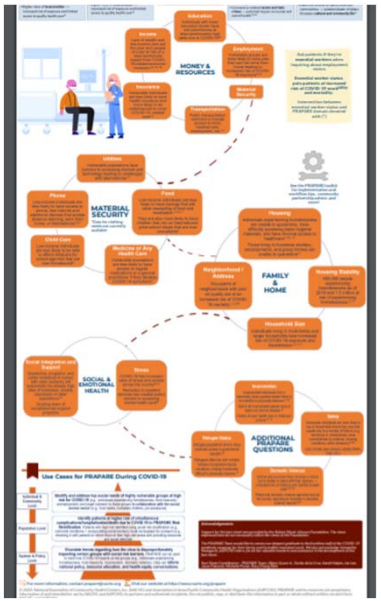
Identify and address top social needs of highly vulnerable groups at high risk for COVID-19 (e.g., individuals experiencing homelessness, food insecurity, unemployment) and target outreach to these groups **in collaboration with the social service sector** (e.g., food banks, homeless shelters, job assistance).

Population Level

Identify patients at higher risk of simultaneous complications/hospitalization/death due to COVID-19 in PRAPARE Risk Stratification. Patients with high risk identified using social risk stratification (e.g., comorbid conditions + compounding social barriers) could be targeted for outreach (e.g., checking in with patients to inform them of their high-risk status and providing resources and social referrals)

System & Policy Level

Elucidate trends regarding how the virus is disproportionately impacting certain groups with social risk barriers. PRAPARE can be used to track how COVID-19 impacts at-risk groups (e.g., individuals experiencing homelessness, food insecurity, incarceration, domestic violence). Data can **inform national policy, resource allocation, and health equity conversations.**



Fact Sheet: The Impact of COVID-19 on PRAPARE Social Determinants of Health Domains

CMS Medicaid and SCHIP Authority for Reimbursement of SDOH Screening and Interventions RFA

Vacheria Tutson
Director, Regulatory Affairs
National Association of Community Health Centers

Mary Cieslicki
Consultant
National Association of Community Health Centers

FQHC Opportunities to Address SDOH

- State plan services
- Managed care
- 1115 Demonstrations

State Plan Services

- *Rehabilitative Services* help individuals regain skills and functioning necessary to address SDOH
- *Case Management and Targeted Case Management (TCM)* assist Medicaid-eligible individuals in gaining access to needed medical, social, educational, and other services
- *Health Home Services* include comprehensive care management; care coordination and health promotion

PPS & State Plan Services

- Rehab and Case Management Services may be covered under the FQHC benefit and paid PPS or covered separately and paid the applicable state plan rate
- Health Home services are covered separately from the FQHC benefit and not paid PPS

Managed Care and SDOH

1. State directed payment
   Example--APMs that incentivize providers to screen for socioeconomic risk factors

2. Incentive payments
   Reward managed care plans that make investments and/or improvements in SDOH including implementation of a mandatory performance improvement project

3. Waiver and non-traditional services
   Approved per sections 1915(b)(3), 1915(c), or 1115 of the Social Security Act are considered state plan services that may be paid through the cap rate

Managed Care and SDOH

4. Quality measurement and improvement
   States can leverage managed care quality requirements in 42 CFR §§ 438.310 through 438.370 to address SDOH within their managed care programs

5. In lieu of services
   A managed care plan may cover services or settings that are in lieu of services and settings covered in the state plan if they are appropriate and cost effective; the in lieu of cost is reflected in the cap rate

6. Value-added services
   A managed care plan may voluntarily cover additional non state plan services but the related cost may not be included in the cap rate

1115 Demonstrations and SDOH

States can test ways to address SDOH through 1115 demonstrations if their proposals "advance the Medicaid program."

- **North Carolina's** "Healthy Opportunities Pilots," to cover non-medical services that address specific social needs linked to health/health outcomes. The pilots will address housing instability, transportation insecurity, food insecurity, interpersonal violence, and toxic stress for a limited number of high-need enrollees.

- **California's "Whole Person Care" (WPC)** pilot program aims to coordinate care (physical, behavioral health, and social services) for high-risk, high-utilizing Medi-Cal enrollees and increase integration and data sharing among county agencies, health plans, and other community-based organizations.

Source: Medicaid Authorities and Options to Address Social Determinants of Health (SDOH) | KFF

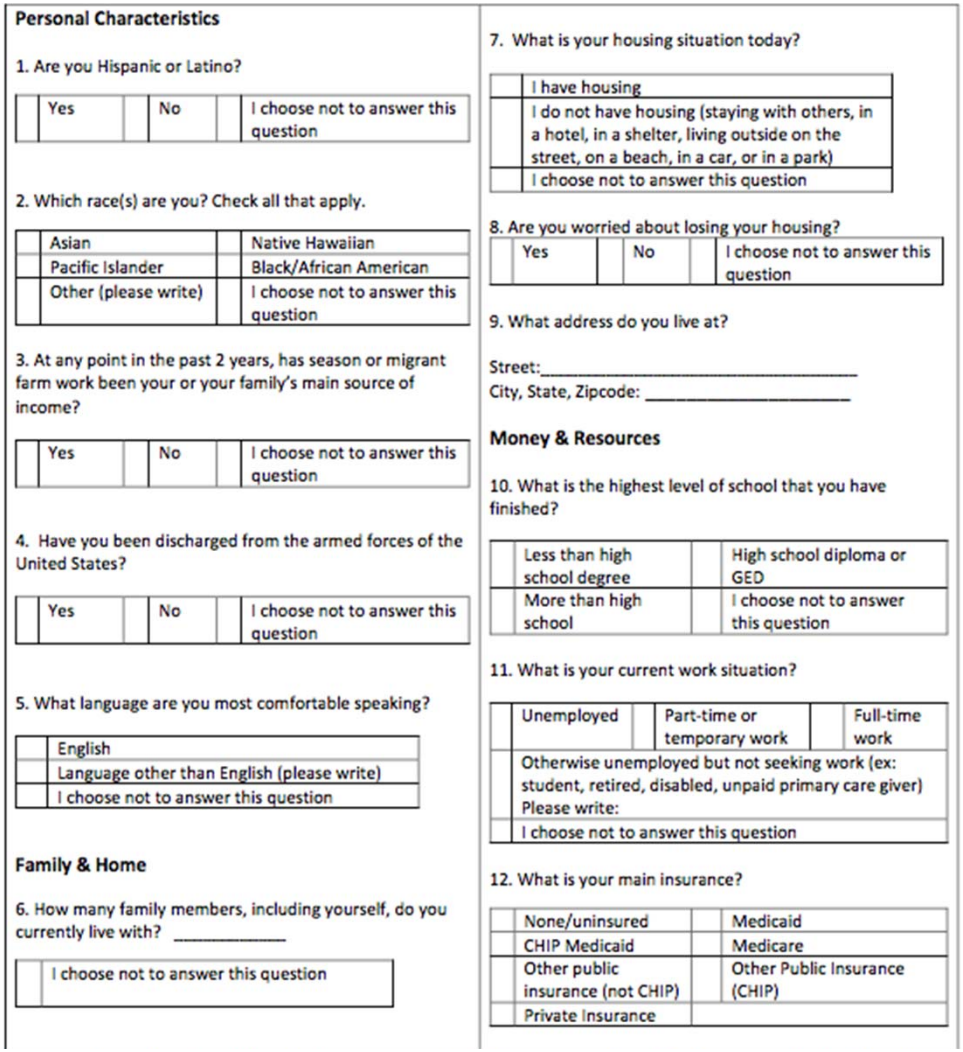
Medical-Legal Partnerships: An SDOH Intervention for Medicaid Beneficiaries

Bethany Hamilton, JD
Co-Director
National Center for Medical-Legal Partnership

National Center for Medical Legal Partnership
AT THE GEORGE WASHINGTON UNIVERSITY

Health orgs commonly screen for social problems with tools like **PRAPARE & Accountable Health Communities Tool**

What workforce or intervention can solve the problems once they are found?



Personal Characteristics

1. Are you Hispanic or Latino?

	Yes		No		I choose not to answer this question

2. Which race(s) are you? Check all that apply.

	Asian		Native Hawaiian
	Pacific Islander		Black/African American
	Other (please write)		I choose not to answer this question

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

	Yes		No		I choose not to answer this question

4. Have you been discharged from the armed forces of the United States?

	Yes		No		I choose not to answer this question

5. What language are you most comfortable speaking?

	English
	Language other than English (please write)
	I choose not to answer this question

Family & Home

6. How many family members, including yourself, do you currently live with? _____

	I choose not to answer this question

7. What is your housing situation today?

	I have housing
	I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
	I choose not to answer this question

8. Are you worried about losing your housing?

	Yes		No		I choose not to answer this question

9. What address do you live at?

Street:_____
City, State, Zipcode: _____

Money & Resources

10. What is the highest level of school that you have finished?

	Less than high school degree		High school diploma or GED
	More than high school		I choose not to answer this question

11. What is your current work situation?

	Unemployed		Part-time or temporary work		Full-time work
	Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:				
	I choose not to answer this question				

12. What is your main insurance?

	None/uninsured		Medicaid
	CHIP Medicaid		Medicare
	Other public insurance (not CHIP)		Other Public Insurance (CHIP)
	Private Insurance		

Source: www.nachc.org/research-and-data/prapare/toolkit

The Medical-Legal Partnership Approach:

Moving from screening to intervention

MEDICAL-LEGAL PARTNERSHIP is an intervention where medical, legal, and allied health professionals collaborate to help patients resolve **SOCIAL, ECONOMIC & ENVIRONMENTAL FACTORS** that contribute to **HEALTH INEQUALITIES** and have a remedy in civil law.

National Center for Medical Legal Partnership
AT THE GEORGE WASHINGTON UNIVERSITY

Screening is one of the Core Components of an MLP

1. "Lawyer in residence"

2. Formal agreement b/t health & legal orgs

3. Target population

4. Patients screened for legal needs

5. Legal staffing

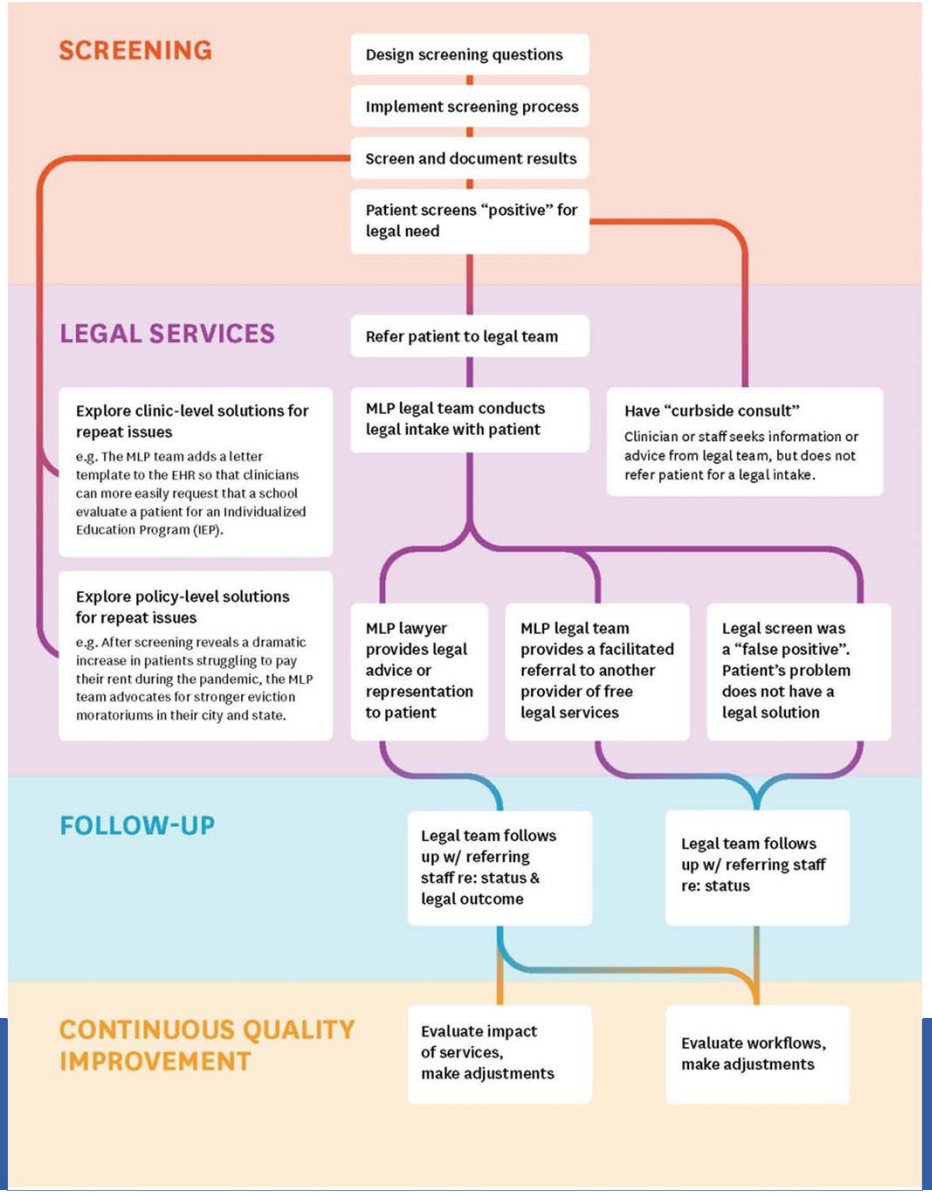
6. Training on SDOH

7. Information-sharing

8. Designated resources

The MLP Workflow:

From screening to addressing health harming legal needs and quality improvement



NCMLP Tool: Medical-legal partnership workflows for screening and legal services

https://medical-legalpartnership.org/mlp-resources/mlp-workflows/

MLPs embed lawyers as members of the health care team to provide a range of services:

Read more about the MLP response at:
https://medical-legalpartnership.org/response/

How lawyers help address patients' social needs

I-HELP™		How Lawyers Can Help
Income & Insurance		Food stamps, disability benefits, cash assistance, health insurance
Housing & utilities		Eviction, housing conditions, housing vouchers, utility shut off
Education & Employment		Accommodation for disease and disability in education and employment settings
Legal status		Assistance with immigration status (e.g. asylum applications); Veteran discharge status upgrade; Criminal background expungement
Personal & family stability		Domestic violence, guardianship, child support, advanced directives, estate planning

What does a typical health center with an MLP look like?

Health centers with MLPs tend to have larger staff, higher patient volumes, and a greater number of sites than health centers without MLPs.

MLPs tend to be found in health centers in large urban cities, but the number of MLPs in rural situation health centers is growing.

Health centers with MLPs typically have larger budgets than health centers without MLPs.

Health centers with MLPs typically utilize health IT to coordinate or provide enabling services more often than health centers without MLPs (79% versus 65%).

Source: 2016 Uniform Data System (UDS), Health Resources and Services Administration (HRSA).

Leveraging Medicaid to Support MLP Services

A Focus on Medicaid Managed Care

Potential Medicaid Funding Sources to Support MLP

Medicaid Managed Care

- **Case** Management
- **Care** Management
- **Value-Added** Services

NCMLP Resources on Financing MLP:

Fact Sheet Financing Medical-Legal Partnerships: A View From the Field

Webinar Recording "Tapping into Innovative Financing Strategies for MLPs," presented by Manatt Health Strategies, LLC for NCMLP (Tapping into Medicaid financing streams)

Medicaid Managed Care: ***Case*** Management

- Case management services an optional state benefit to "assist eligible individuals **to gain access** to needed medical, social, educational, and other services." (42 C.F.R. § 440.169)
- **Certain legal services <u>may</u> qualify as *case* management activities**

REVIEW THE LIMITS

Case management activities must <u>not</u>:

- Be "an integral and inseparable component of another Medicaid service"
  - State Medicaid Manual 4302.F
- "Constitute the direct delivery of underlying medical, educational, social, or other services to which an ineligible individual has been referred"
  - 42 C.F.R. 441.18(c)
- Be provided by "third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program consistent with §1903(c) of the Act."
  - §§1902(a)(25) and 1905(c)

See NCMLP's 2019 webinar,"Tapping into Innovative Financing Strategies for MLPs," presented by Manatt Health Strategies, LLC. Visit https://medical-legalpartnership.org/mlp-resources/medicaid-financing/.

Medicaid Managed Care: ***Care*** Management

MCOs are required to coordinate community-based non-medical care that an enrollee receives from community and social support services (42 C.F.R. § 438.208(b)(2)(iv))

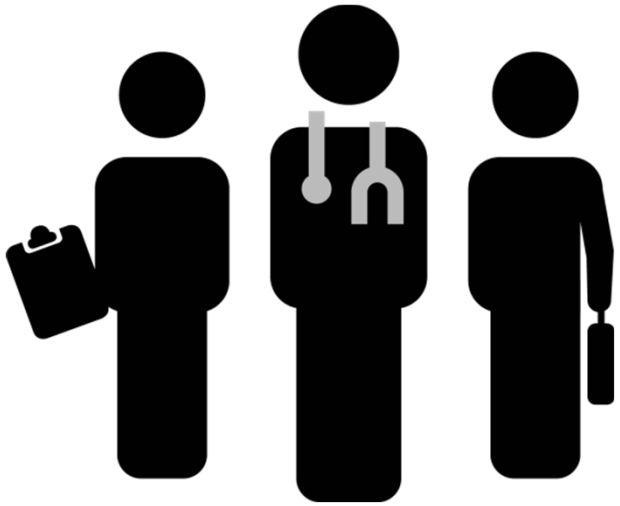
Some services provided by MLPs could fit into the definition of *care* management.

- Direct legal representation is NOT one of them.
- **Consider the broad range of MLP services and activities.** Direct legal representation may not be required and it is only one of several activities carried out by MLPs.

Types of MLP Activities
Bi-Directional Training
Curbside Consult
Initial Legal Intake / Legal Assessment / Check-up
Legal Advice to Patient
Legal Representation of a Patient
Facilitated Referral
Clinic-level change activity
Policy-level change activity

Medicaid Managed Care: ***Value-Added*** Services

Value-added services are additional services—including non-medical—that are outside of the Medicaid benefit package, but that seek to improve quality and health outcomes, and/or reduce costs by reducing the need for more expensive care. *(42 C.F.R. § 438.3(e)(1)(i))*



Consider the traditional MLP case study / example:

- ✓ With respect to MLPs, legal support can, for example,
- ✓ help patients with persistent asthma
- ✓ secure mold remediation services from landlords, and
- ✓ thereby improve health outcomes for the member

See NCMLP's 2019 webinar,"Tapping into Innovative Financing Strategies for MLPs," presented by Manatt Health Strategies, LLC. Visit https://medical-legalpartnership.org/mlp-resources/medicaid-financing/.

Examples of Medicaid Financing to Support MLP

State		Type of	Partners	Description
	IN	Medicaid Managed Care Contracts	Eskenazi Health Indiana Legal Services	In January 2017, two health centers from the Eskenazi Health system contracted with a Medicaid managed care entity to sponsor an MLP • Two-year contract • Fixed amount for legal partner, Indiana Legal Services • All patients at these centers eligible for MLP services, regardless of health plan
	OR	Medicaid Managed Care Contracts	Oregon Health & Sciences University, Richmond Clinic Lewis & Clark Law School	In August 2016, the Richmond Clinic at Oregon Health & Sciences University launched a pilot MLP program with the largest coordinated care organization (CCO) in the state • One-year pilot program • Approved through a §1115 Medicaid demonstration waiver • Legal services negotiated with CCO • Addresses medically-complex patients
	NY	Delivery System Reform Incentive Payment (DSRIP)	NYC Health + Hospitals New York Legal Assistance Group	Provided funding for MLPs • Trainings on social and legal needs • Regular data monitoring of key program measures – Volume of legal services – Uptake of legal services

Medicaid Section 1115 Waiver Example | **California**

2019: Whole Person Care waiver program

Partners	Description
Los Angeles County Department of Health Neighborhood Legal Services of Los Angeles County	Los Angeles County partnered with a number of local legal organizations to provide legal services county-wide to vulnerable MediCal beneficiaries under the Whole Person Care program. • $500,000 for legal services, technical assistance, training for the first year • **Legal services available to all patients on-site at central Whole Person Care facility** • Virtual **platform to allow community health workers and providers to screen** and refer patients

2021: California Advancing & Innovating Medi-Cal (CalAIM), New 1115 Waiver

Partners	Description
? **New waiver language resulted in uncertainty for the MLPs (counties, health care providers, and civil legal services providers)** **Work is underway to ensure that beneficiaries do not lose access to the MLP services that were addressing myriad health harming social and legal needs**	Housing Transition Navigation Services • The services provided should utilize best practices for **clients who are experiencing homelessness** and who have complex health, disability, and/or behavioral health conditions. • The services may involve additional coordination with other entities to ensure the individual has access to supports needed for successful tenancy such as County Health, Public Health, Substance Use, Mental Health and Social Services Departments; County and City Housing Authorities; Continuums of Care and Coordinated Entry System; local **legal service programs**, community-based organizations housing providers, local housing agencies and housing development agencies.

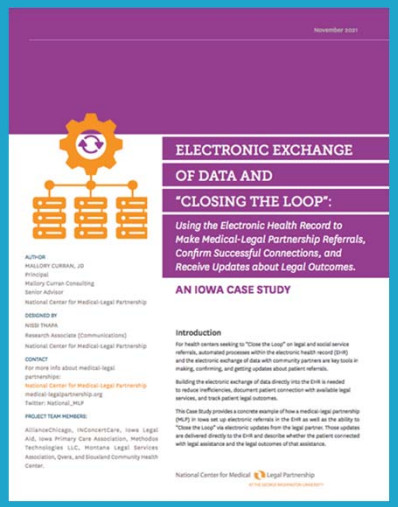
Resources Available on Our Website

Fact Sheet: Financing Medical-Legal Partnerships: A View From the Field

This fact sheet draws on national survey data MLPs to describe programs' average budgets as well as a variety of health, legal, and philanthropic funding streams that currently fund MLPs.

Toolkit: Bringing Lawyers onto the Health Center Care Team to Promote Patient & Community Health

This toolkit provides the health center community with information and resources to start, strengthen, and sustain a medical-legal partnership (MLP).



Case Study: Electronic Exchange of Data and "Closing the Loop"

This Case Study provides a concrete example of how a medical-legal partnership (MLP) in Iowa set up electronic referrals in the EHR as well as the ability to "Close the Loop" via electronic updates from the legal partner.

Access these and more at medical-legalpartnership.org/resources

District of Columbia's Partnership on Social Determinants of Health Interoperability Strategy

Connecting Health and Social Services through the DC HIE

February 2022

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Special Projects Officer
Office of State Medicaid Director
DC Department of Health Care Finance

Department of Health Care Finance Leads Health Information Technology & Exchange Implementation for the District

- Create and test new delivery system and payment models
- Quality Measurement & Improvement Strategies

- Funder: Citywide Health Information Exchange Projects
- Strategic Leader: Coordinates public input through the HIE Policy Board
- Administrator: Health IT and HIE adoption (EHR Incentive Program – MEIP)
- Steward: Claims Data
- Designator: HIE entities to ensure core services

- A system of integrated care connected through information
- Health system reforms dependent on access to information
- Continuous access to quality information

Work on SDOH Data Has Come A Long Way

Beginning April 2017, DHCF held a series of discussions and interviews on social needs

- Explored District efforts to collect and use SDOH data
- Generated a set of strategies and tactics that could be employed over the next several years to improve health outcomes
- Held 80+ person meeting with national experts "level-set" current work and shared priorities
- Hosted 20-person workshop to develop strategies to address collection and use of social need data.

DHCF Participates In DC PACT and Supports its Common Agenda

DC POSITIVE ACCOUNTABLE COMMUNITY TRANSFORMATION (PACT)
COMMON AGENDA

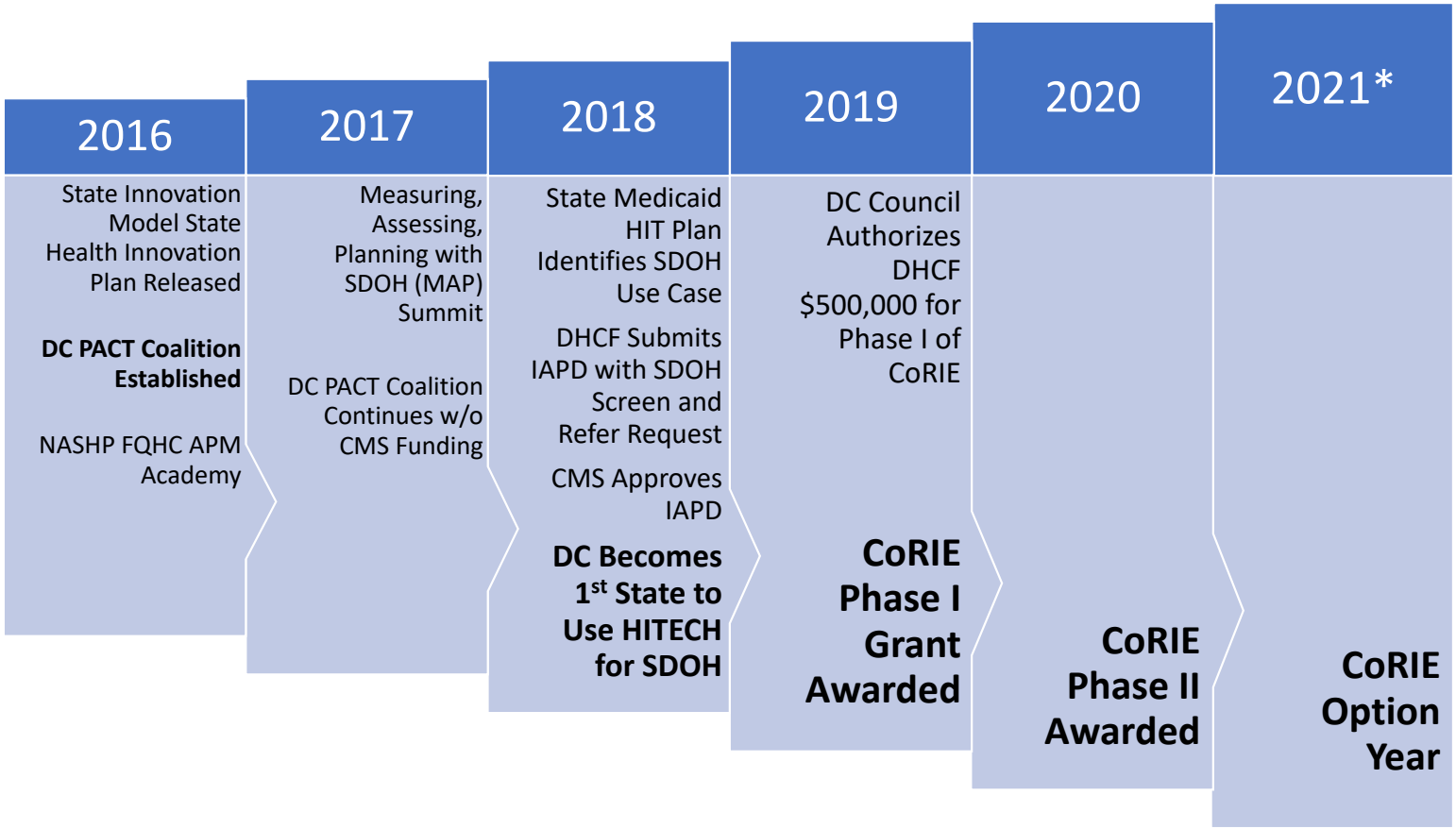
PRINCIPLES	Health and social needs are human rights for all DC residents which require the equitable and sustainable distribution of resources	Partners commit to shared responsibility, accountability, and transparency as necessary components of work performed in the service of health equity and justice	Goals and interventions will be data-focused, driven by person-centered outcomes, and transformative	Work will be coordinated across community services and sectors resulting in respectful and compassionate care that empowers District residents with the greatest health and social needs	We prioritize creativity, flexibility, innovation, and vision in determining the coalition's strategic priorities

PROBLEM DEFINITION	A structural lack of shared accountability and collaboration amongst health systems and community resource organizations in addressing social needs has contributed to poor health outcomes and health inequity	VISION	DC functions as a seamless accountable health community that addresses unmet social needs to improve health and increase equity	MISSION	Build the movement to reframe the culture of care delivery to address social needs, improve health outcomes, and increase health equity in the District of Columbia

STRATEGIC GOALS	By December 2020, leverage a bidirectional cloud-based health information exchange to identify the social needs of patients, facilitate high quality care coordination, and enable staff to provide effective referrals that can be tracked in a standardized process	By December 2020, for the highest risk/cost members, leveraging all information and assessments currently available, address unmet social needs for 90% of the target population
	By December 2020, standardize social needs screening citywide and establish DC PACT expertise on analysis, reporting, and dissemination of social needs and health outcomes data	By December 2020, position DC PACT as a clearinghouse and hub for health system action to address social needs and improve health equity

2018 Work Plan	<u>Social Needs Information Exchange working group</u> 1) Process map and gap analysis of organizational referral processes 2) Write a resource and governance plan for data exchange 3) Develop a data dictionary for health exchange 4) Create partnership development plan for exchange users	<u>Addressing Unmet Social Needs working group</u> 1) Define and map target population 2) Map resources available 3) Gap analysis between target population and resource availability 4) Develop service and outreach plan

Community Engagement Catalyzed the CoRIE Project



DC HIE Demonstrated Substantial Progress to Expand the Network of Participating Providers

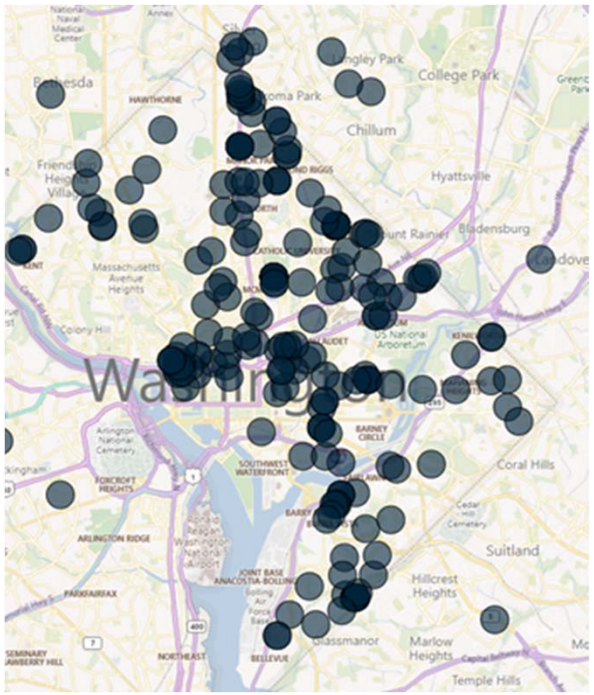
Today Major Providers and Health Systems are Connected:

- 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

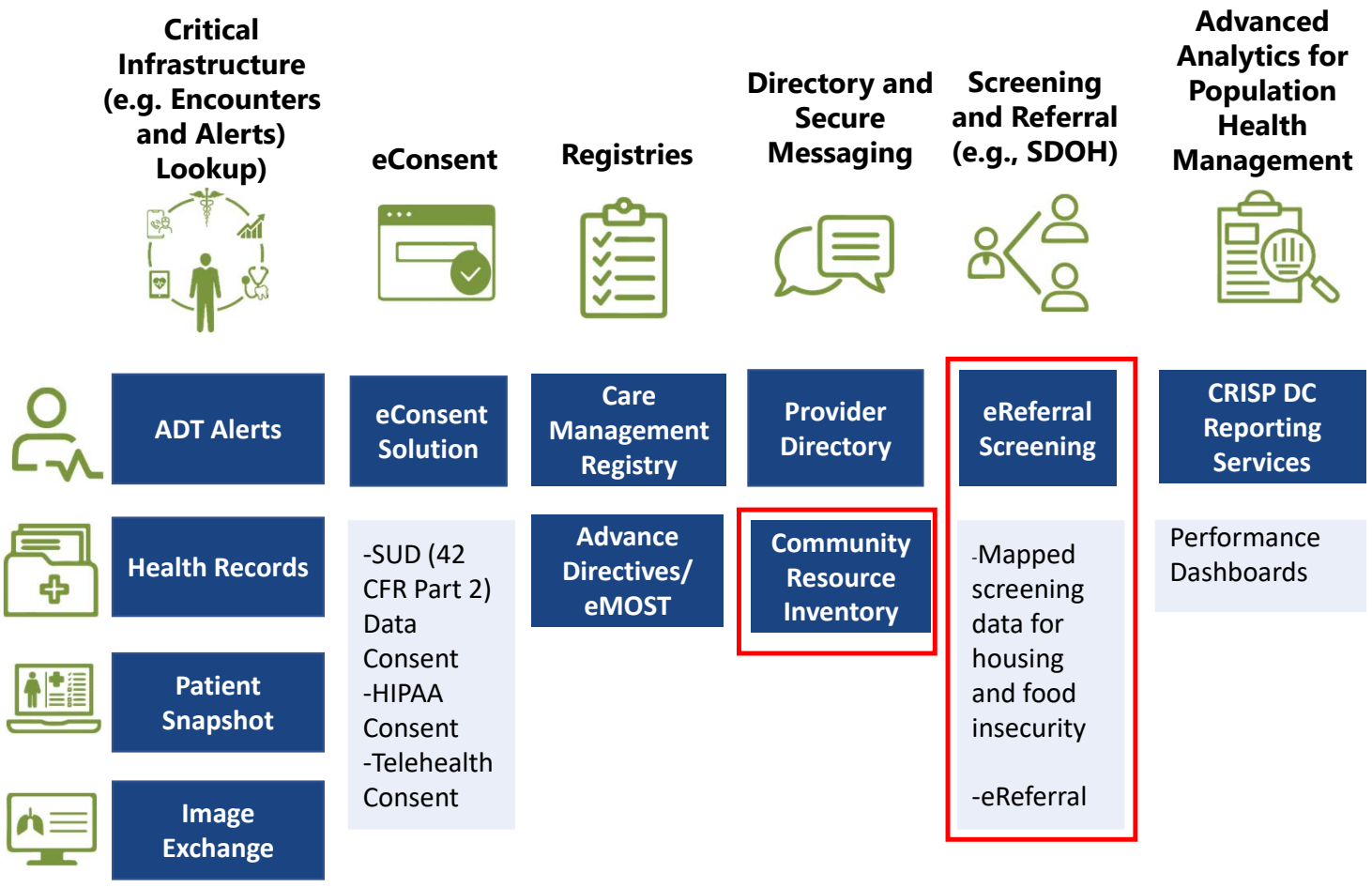
DC HIE Use at a Glance (as of October 2021):

- **12,000+ approved users of the DC HIE**
- **Patient Care Snapshot (Monthly Query)**
  - 1,208 users
- **Encounter Notification Services access**
  - 572 locations
- **Sharing Admit, discharge, transfer**
  - ~300 locations
- **Sharing Clinical care documentation**
  - 160+

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



The DC HIE is a Health Data Utility with Six (6) Reliable Core Capabilities for Providers

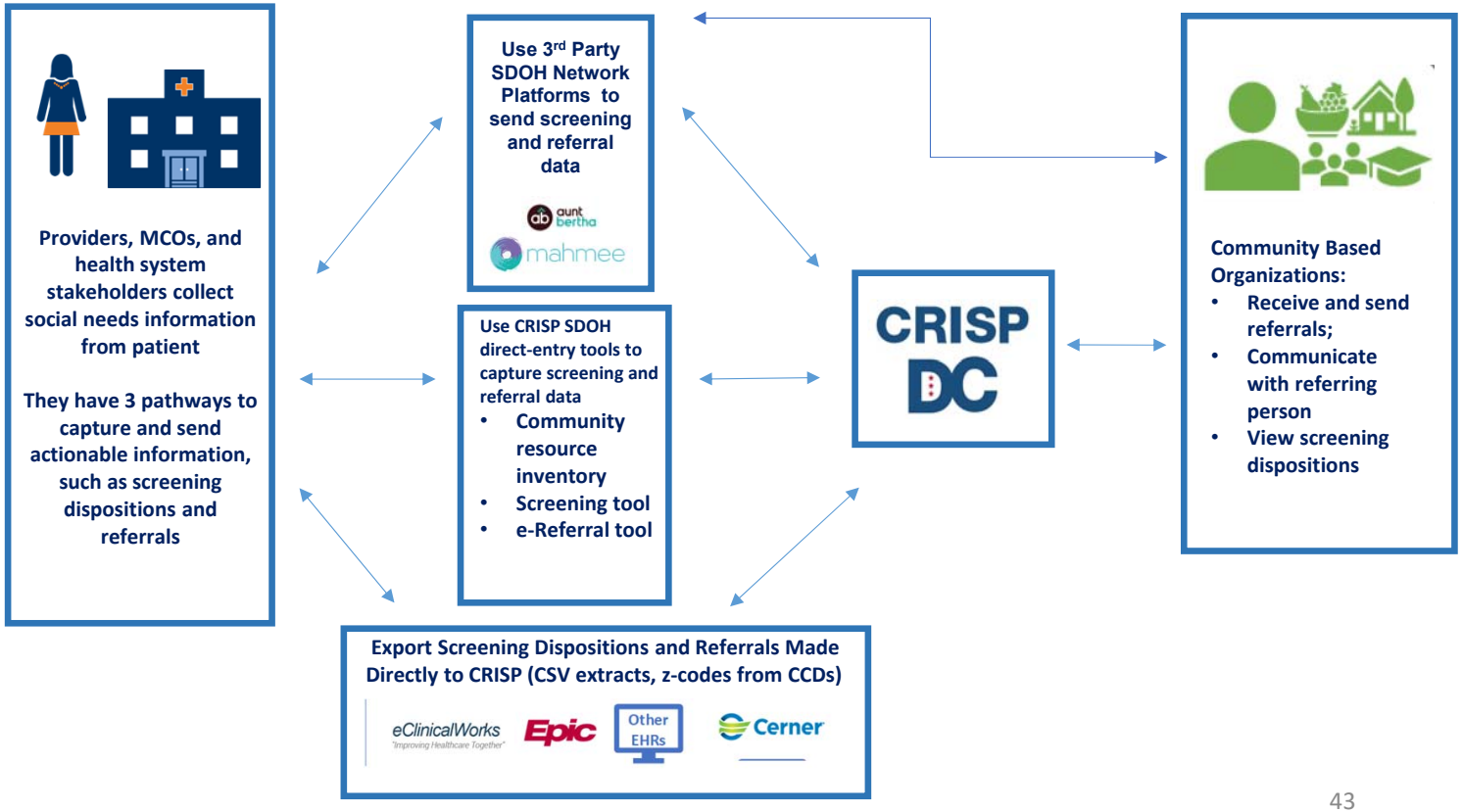


CoRIE Project Supports Whole Person Care by Connecting Health and Social Services through the DC HIE

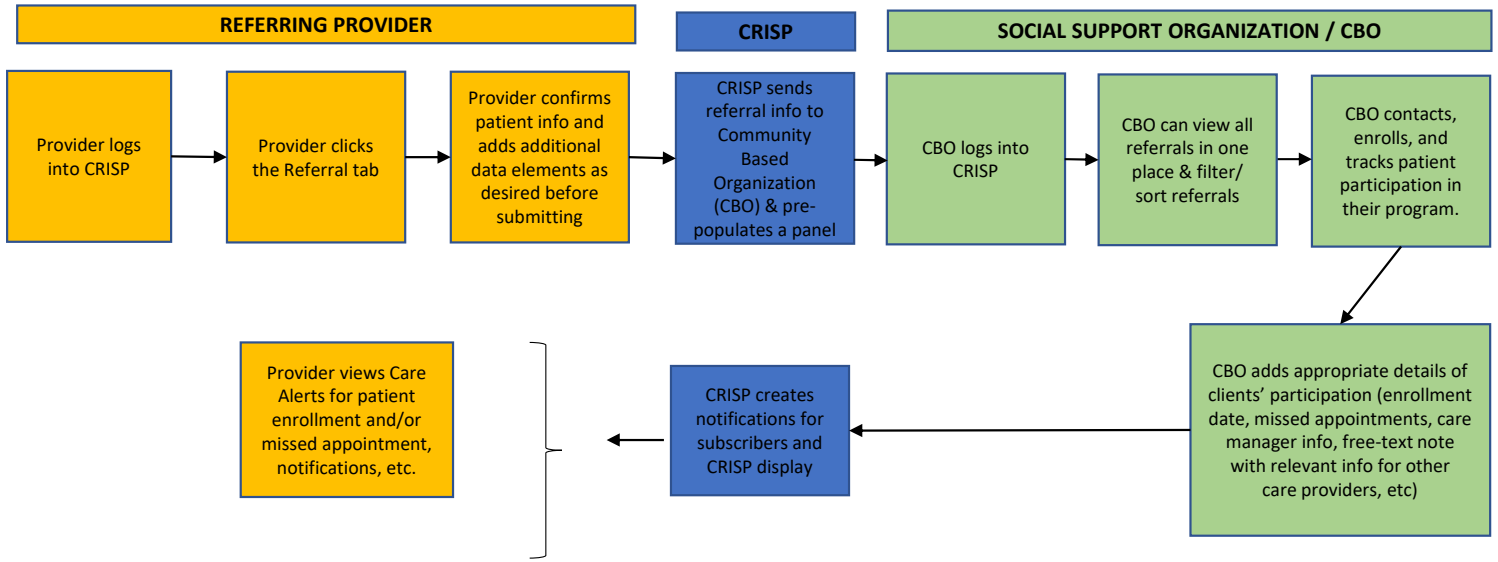
- **CoRIE project will enable data sharing among health system stakeholders to address individuals' social determinants of health (SDOH) by:**
  - Screening for social risks,
  - Lookup through a centralized community resource inventory (CRI),
  - Enabling referrals to appropriate services, and
  - Using analytics to ensure residents needs are being met
- **CoRIE project takes a vendor agnostic approach** by using the DC HIE as a place where screening and referral information can be shared and displayed regardless of how it was collected.
- **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)
  - *NEW HIE Policy Board CRI Subcommittee* (developing governance standards)

The CoRIE Ecosystem: Interoperability First!

Connecting health and social service providers through a technical solution, using HIE, *without* requiring a single District-wide technology platform



CRISP Closed Loop Referral Tool Enables Greater CBO Participation in Integrated Care



Future optional integration track allows CBOs to access referrals and automatically send feedback from their own platforms, eliminating the need to log into CRISP

Definitions:
Care Alerts = free-text, short message available to treating providers in CRISP
Panel = roster or list of patients/clients

DC HIE establishing technical and governance solutions for a shared Community Resource Inventory (CRI)

- CoRIE initiative funded a District-wide aggregation of resource data from a range of already-existing resource directory databases.

- DC CRI live prototype currently contains approximately 500 records and represents directories contributed by District organizations:
  - ***Access via Web Browser–*** Data and resource lookups are available through live, publicly accessible website: http://dc.openreferral.org/.
  - ***Retrieve/contribute content via application programming interface (API) –*** District organizations able to retrieve the contents of the directory via as well as contribute batch uploads: http://api.dc.openreferral.org/.
  - ***Access via DC HIE –*** CRISP DC users will be able to access the DC CRI through a tab in the CRISP Unified Landing Page (early 2022)

- DC HIE Policy Board established a formal subcommittee to develop standards related to the use, exchange, sustainability, and governance of CRI data through the DC HIE infrastructure.

DC PACT CRI Action Team

Established and convened the CRI Action Team (initial meeting on 4/14/21) to conduct Phase 2 testing and evaluation activities:

- Comprised of data stewards who currently maintain independent resource data inventories
- Collaboration mechanisms: bimonthly convenings, individual testing and evaluation of data transformation tools, 1:1 with CoRIE CRI leads, data steward listserv
- Participating data stewards include: Department of Aging and Community Living, Bread for the City, Criminal Justice Coordinating Council, Maryland 2-1-1, Capital Area Food Bank

New HIE PB CRI Subcommittee Est. April 2021

Mission: Build the capacity of HIE stakeholders to share, find and use information about resources available to address health related social needs and improve health equity.

Purpose: Develop recommendations for consideration by the HIE Policy Board that are related to the use, exchange, sustainability, and governance of community resource directory data through the District HIE infrastructure.

Composition: A minimum of three (3) HIE Policy Board members, and a minimum of three (3) non-Board members with actively maintained District community resource directories ("CRI Data Stewards")

- Subcommittee Chair: Luizilda de Oliveira (La Clinica del Pueblo)
- Vice Chair: David Poms (DC Primary Care Association)
- Other HIE Policy board members: Amelia Whitman (Department of Health Care Finance), Dr Eric Marshall (Medstar)
- Data Stewards: Stacey Johnson (Bread for the City), Luis Diaz (Criminal Justice Coordinating Council), Tamara Moore (Department of Aging and Community Living), Sabrina Tadele (Capital Area Food Bank), *Ariana Wilson (Maryland 2-1-1)*
- Community: Tommy Zarembka (Food & Friends)

CRI Subcommittee Responsibilities

- Evaluate the DC PACT CRI Action Team's recommendations for data maintenance, including systems to:
  - Standardize resource data terminologies and categories/taxonomies
  - Establish and evaluate operations related to resource data provision
  - Schedule resource data updates and other data maintenance processes
  - Facilitate a cooperative resource data management process
- Review and recommend prospective models for governance, financial and operational sustainability of the CRI infrastructure
- Review and recommend policy measures that can promote and support the operations of the CRI, such as procurement and service registries
- Support the evolution of CRI governance model and assess the timeline for integration into existing HIEPB committees

Significant progress has been made on the CoRIE Project Components in FY21

CRI	• **CRI prototype of ~500 records** is available through live, publicly accessible website: http://dc.openreferral.org • Orgs can also **retrieve CRI contents via API connection** as well as **contribute batch uploads:** http://api.dc.openreferral.org • 2 **District agencies (DACL, CJCC) actively testing the CRI** prototype to manage their own domains and inventory data • **CRI deployed into CRISP** testing environment**,** expected to be live in ULP in 2022
SDOH Screening	• **Four (4) organizations –** MedStar hospitals (WHC, GUH, NRH) and Carefirst MCO – **contributing SDOH screening and assessment data.** • **Five (5) FQHCs** piloting **sending ICD-10 diagnosis codes for SDOH (z-codes) that have been mapped** to existing screeners • Actively documenting screening responses and results using z-codes within EHR progress note which is then transmitted to the DC HIE. • 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**. • **Two (2) 3rd party vendors** (Aunt Bertha, Mahmee) signed MOU to display screening data

Social Needs Referrals	• Initial pilot conducted with Gerald Family Care in late 2020.
	  • More than **70 referrals** sent to Giant Nutrition for *Virtual Services for Heart Health, Prediabetes and Diabetes, and Healthier You.*
	  • Ability to tracking follow-up to nutritional counseling services and view follow up notes
	• **Twelve (12) organizations** are now using the CRISP referral tool.
	• In July, **Aunt Bertha and CRISP signed an MOU to display referral history** from AB in DC HIE starting with MedStar hospitals.

Nationally, Payers and Providers Are Driving the Next Generation of SDOH Efforts; DHCF is Among the Leading States

Next generation population health management strategies will use CoRIE to design and test interventions to improve health equity:

- **Innovation Grants**: Testing scope and strategies to improve effective delivery of SDOH interventions among diverse populations.
- **Value-based Purchasing Models**: Aligning financial incentives to sustainably support SDOH interventions.
- **Alignment with Other Programs or Creation of Accountable Care Organization**: Building a stronger network of community-based organizations and collaborations with providers.
- **Quality**: Evaluating the effectiveness of SDOH interventions and greater use of SDOH data.

Questions and Discussion

Resources

- www.prapare.org
- Social Determinants of Health (SDOH) State Health Official (SHO) Letter (medicaid.gov)
- https://www.kff.org/medicaid/issue-brief/medicaid-authorities-and-options-to-address-social-determinants-of-health-sd

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