NATIONAL ASSOCIATION OF Community Health Centers®

RESPONDING TO SOCIAL NEEDS: HOW TO USE SDOH TO DRIVE DECISION MAKING AND ADVANCE VALUE-BASED CARE

NACHC Policy and Issues Forum 2023

March 9, 2023

Acknowledgement

This presentation 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 $6,719,834 with 0 (zero) 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.

Presenters

Yuriko de la Cruz
NACHC

Annie Kolarik
Cherokee Health Systems

Lisa Connors
Holyoke Health Center, Inc.

Kim Prendergast
Community Care Cooperative (C3)

David Poms
DC Primary Care Association

Robert Bangert
Whitman-Walker Health at LIZ

Learning Objectives

1. Learn how collecting SDOH data can support closed-loop referrals for SDOH-related needs and inform policy development for health equity.

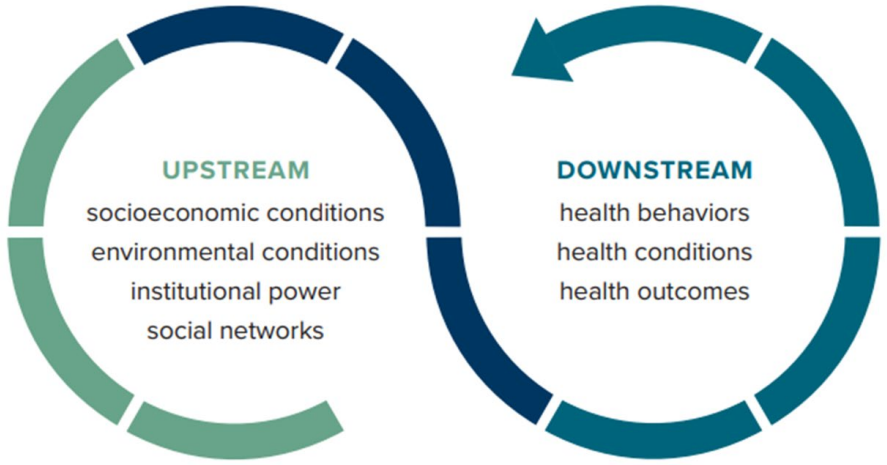
2. Describe different SDOH workflows and frameworks that have been used to address patient level SDOH needs and incorporated into value-based care reimbursement models.

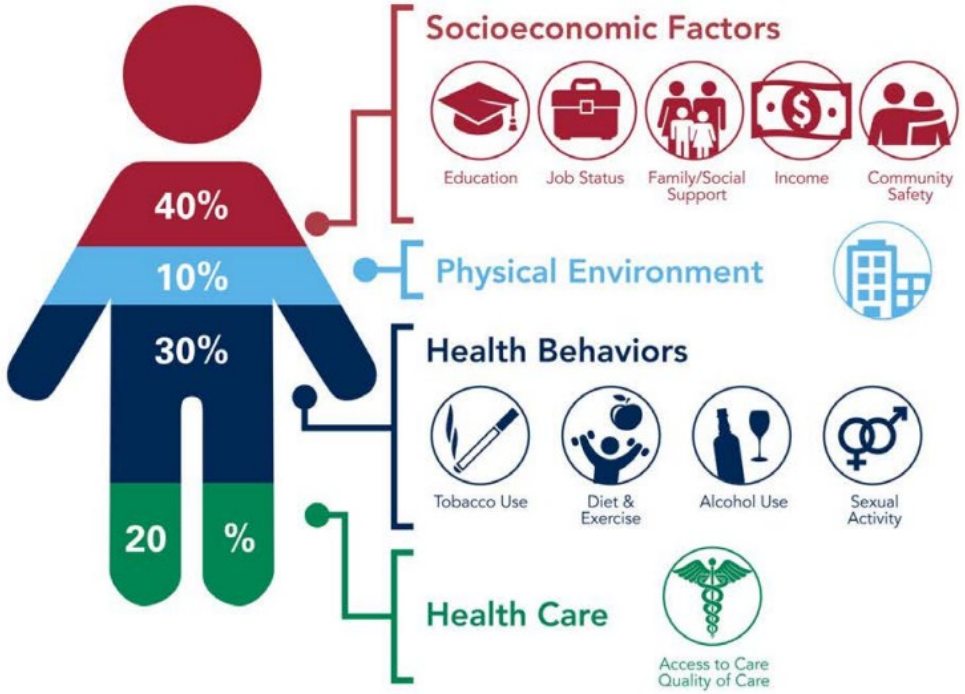
3. Learn how to optimize data capture and coding processes to better evaluate and leverage SDOH assessment and intervention data.

4. Understand opportunities to develop and/or advocate for policies that support value-based care reimbursement, including closed-loop referrals.

Why are Social Drivers of Health Important?

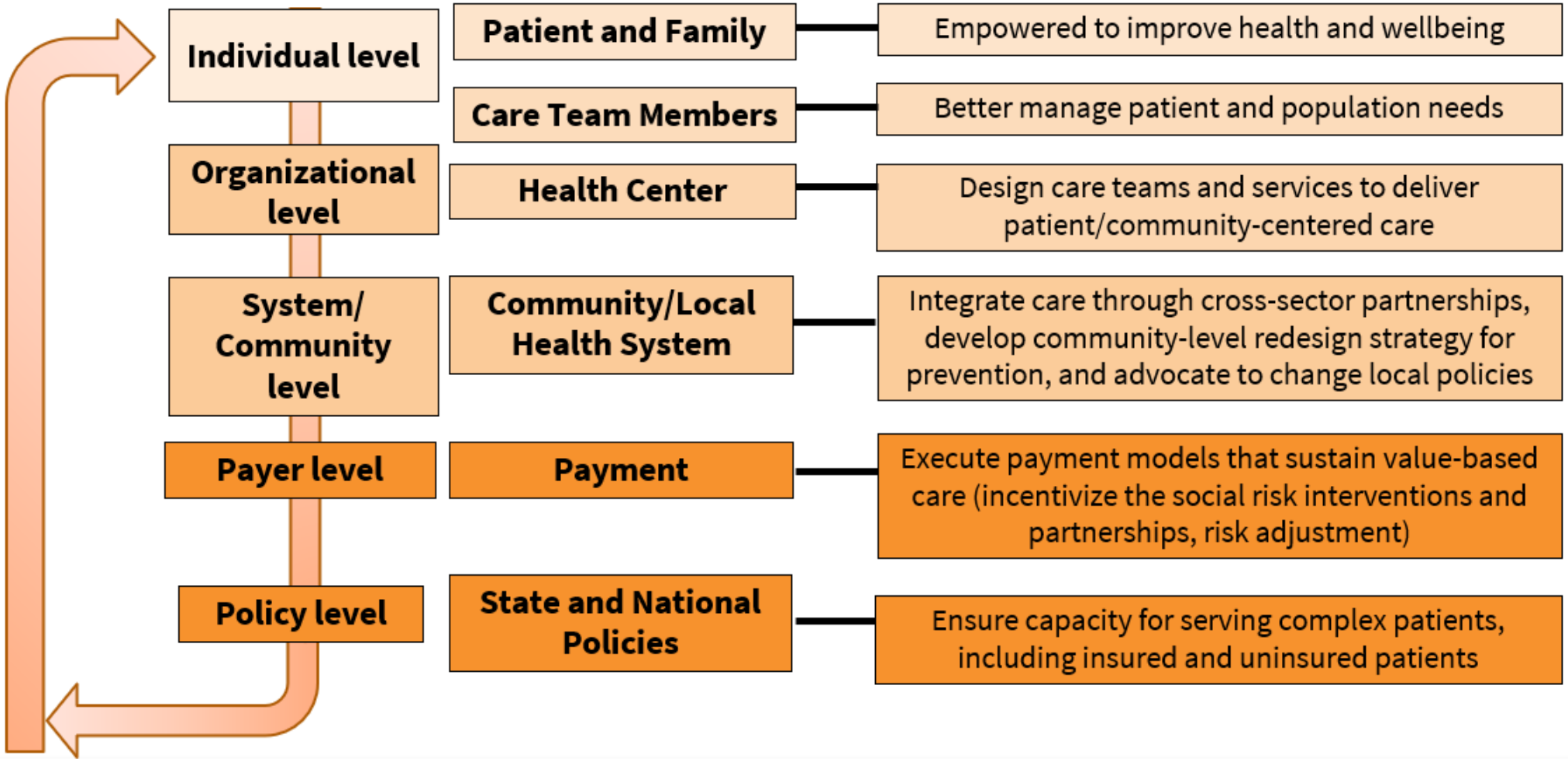
Social drivers of health (SDOH): the conditions in which people are born, grow, live, play, work, and age. These conditions are shaped by the distribution of money, power, and resources.





Source: Institute for Clinical Systems Improvement; Going Beyond Clinical Walls: Solving Complex Problems, 2014 Graphic designed by ProMedica.
Source: American Hospital Association – Addressing Social Determinants of Health, 2018.

Why Collect Standardized Data on SDOH?



CHALLENGES IN SDOH DATA CAPTURE AND EXCHANGE

- Consent Management
- Standardization of SDOH Data Collection and Storage
- Data Sharing Between Ecosystem Parties
- Access & Comfort with Digital Solutions
- Concerns about Information Collection and Sharing
- Social Care Sector Capacity and Capability
- Unnecessary Medicalization of SDOH

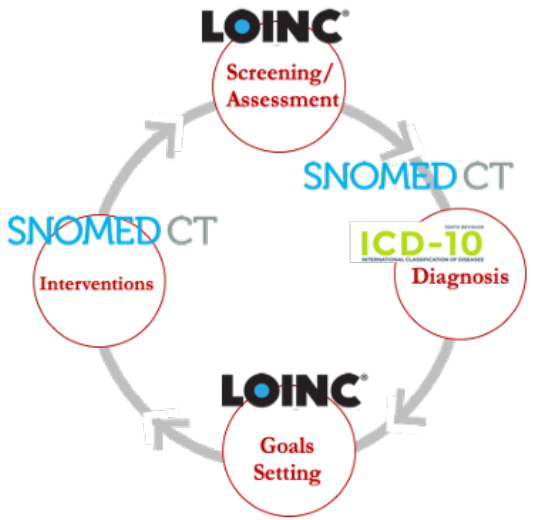
https://www.nasdoh.org/wp-content/uploads/2020/08/NASDOH-Data-Interoperability_FINAL.pdf

ACCELERATING ADOPTION

Using nationally recognized standards

Consensus Approved SDOH Data Elements

Coded SDOH Data Elements



FHIR

Fast Healthcare Interoperability Resources

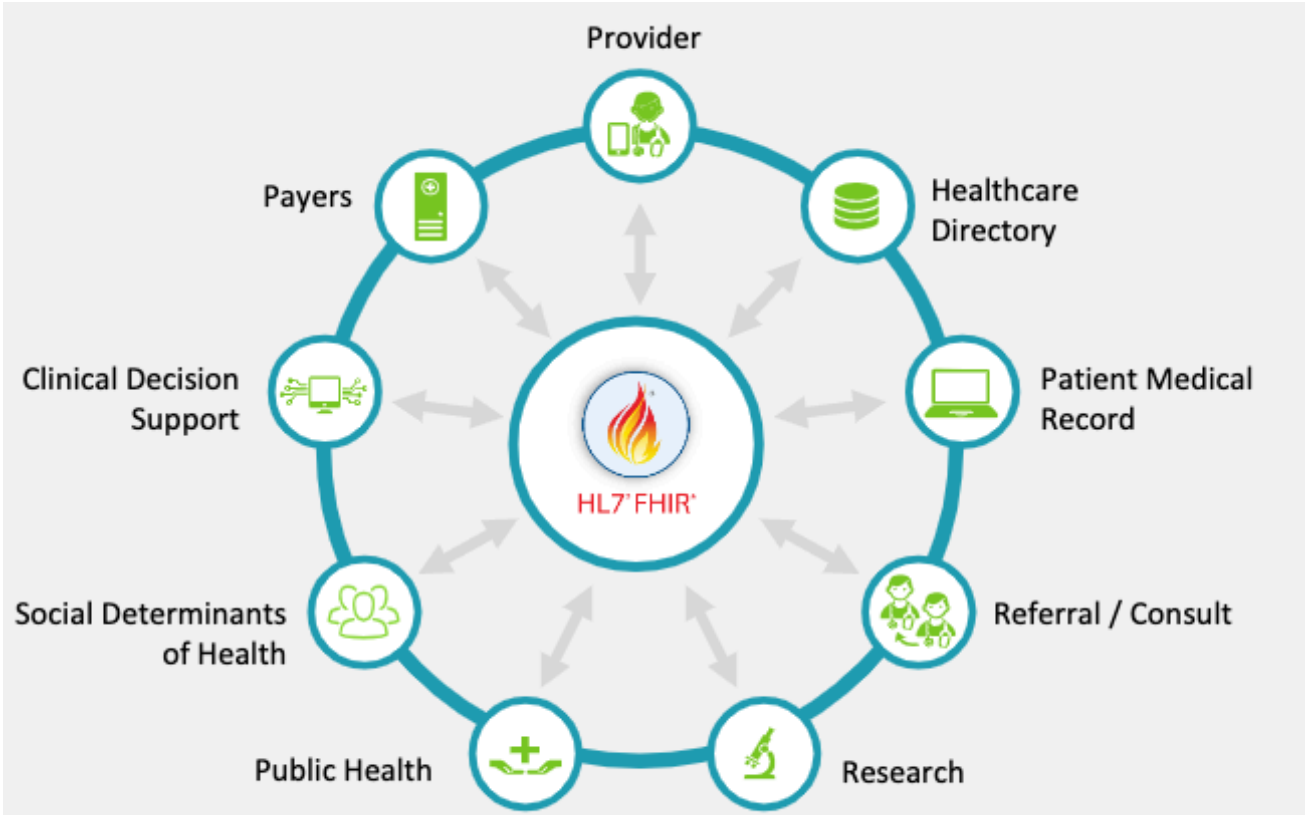


Image Source: HL7 Da Vinci Project Community Roundtable Nov. 18, 2020

Value Transformation Framework

INFRASTRUCTURE

IMPROVEMENT STRATEGY
Effectively and routinely measure and communicate information about the quality, value, and outcomes of the health care experience and use this information to drive improved performance.

HEALTH INFORMATION TECHNOLOGY
Leverage health information technology to track, improve, and manage health outcomes and costs.

POLICY
Pursue decisions, plans, and actions that help secure support and resources for health centers and expand access for under-served populations.

PAYMENT
Utilize value-based and sustainable payment methods and models to facilitate care transformation.

COST
Effectively address the direct and indirect expense of delivering comprehensive primary care to health center patients while considering the total cost of care for attributed patients.

CARE DELIVERY

POPULATION HEALTH MANAGEMENT
Use a systematic process for utilizing data on patient populations to target interventions for better health outcomes, with a better care experience, at a lower cost.

PATIENT-CENTERED MEDICAL HOME
Employ a model of care that transforms the delivery of primary care into a comprehensive, patient-centered system focused on high quality, accessible, and coordinated care.

EVIDENCE-BASED CARE
Make patient care decisions using a process that integrates clinical expertise and best-practice research with patient values and self-care motivators.

CARE COORDINATION AND CARE MANAGEMENT
Facilitate the delivery and coordination of care and manage high-risk and other subgroups of patients with more targeted services, when and how they need it.

SOCIAL DRIVERS OF HEALTH
Address the social and environmental circumstances that influence patients' health and the care they receive.

PEOPLE

PATIENTS
Intentionally and actively incorporate the patient perspective into governance, care system design, and individual care.

CARE TEAMS
Utilize groups of staff with different skills to work together to deliver and improve care, offering a wider range of services more efficiently than a provider alone.

GOVERNANCE AND LEADERSHIP
Apply position, authority, and knowledge of leaders and governing bodies (Boards) to support and advance the center's people, care delivery processes, and infrastructure to reach transformational goals.

WORKFORCE
Leverage a trained and fully engaged staff to successfully address the health center's mission and goals, with optimal joy in work.

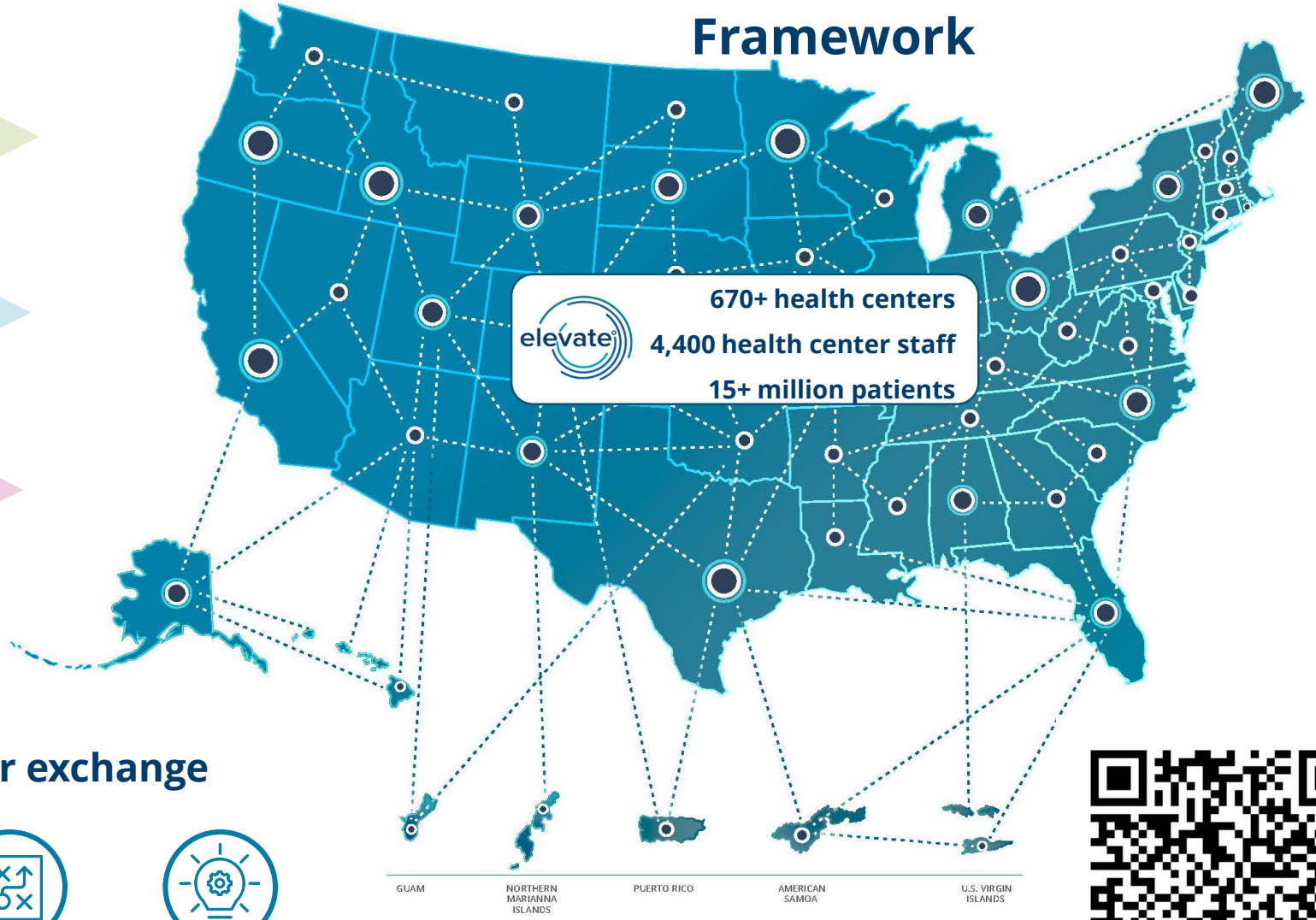
PARTNERSHIPS
Collaborate and partner with external stakeholders to pursue the Quintuple Aim.

Distills research and evidence-based practices into **clear pathways for change,** known as Change Areas

nachc.org/clinical-matters/value-transformation-framework/

Elevate Learning Forum

Guided application of the Value Transformation Framework



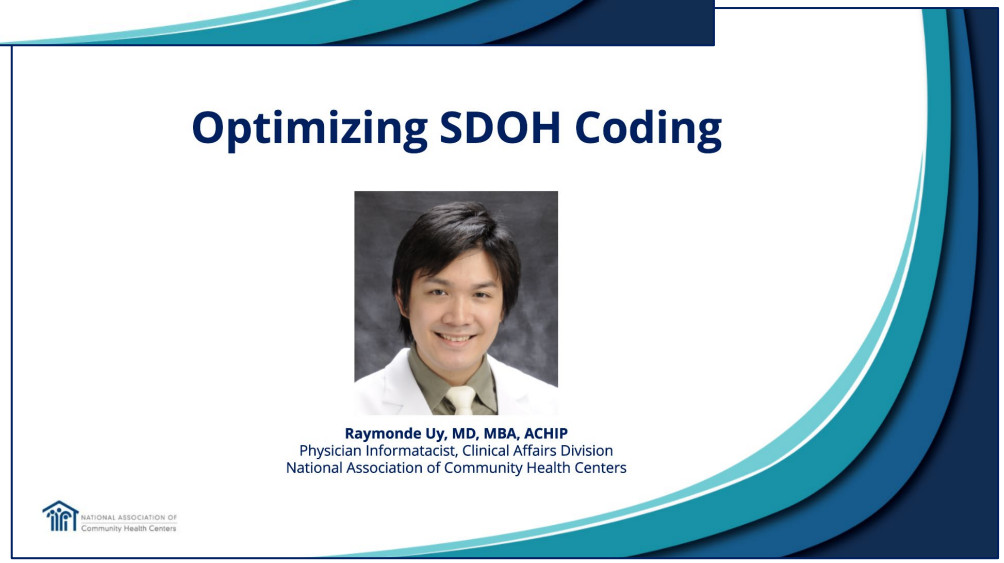
National learning forum and peer exchange

COLLABORATE · LEARN · SHARE · CREATE · INNOVATE

Register for FREE!

Elevate SDOH Resources

Recorded Learnings



NEW! Step-by-Step Action Guide

These resources and more available on the NACHC's Elevate [Docebo Online Learning Platform]

SDOH – Rapid Response to Community Need

Annie Kolarik, MD

Director of LGBTQ+ Services, Cherokee Health Systems

About my practice -

- FQHC in Tennessee with 21 urban and rural clinics – over 70,000 patients served annually
- Integrated care model
  - Behaviorist on the PC team
  - Available consulting psychiatrist
  - Shared support staff and physical space
  - Team-based co-management and care coordination with shared documentation, communication, and treatment planning

Where we started -

- Small population of TGD seeing individual providers throughout the system.
- No standardization of policies or protocols.
- Minimal staff training on gender-affirming care, especially among non-clinical staff.
- Reputation in the LGBTQ+ community: “old-fashioned,” “out-of-touch”
- Goal to grow gender-affirming services, but not much success

Identifying a Community Need

LOCAL

Fire at Knoxville Planned Parenthood was arson, investigators say

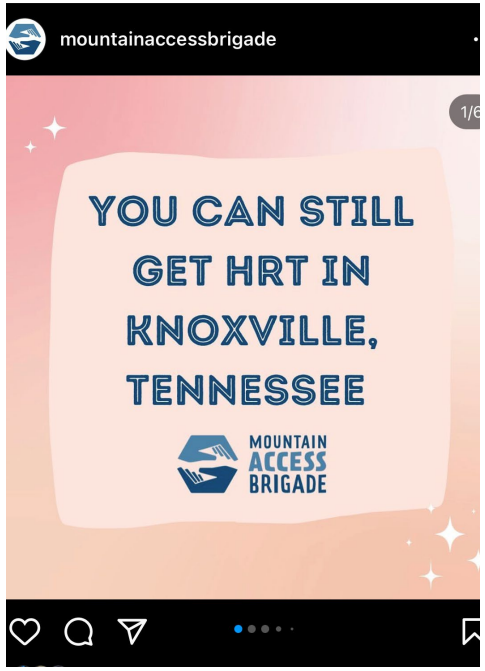
Tyler Whetstone
Knoxville News Sentinel

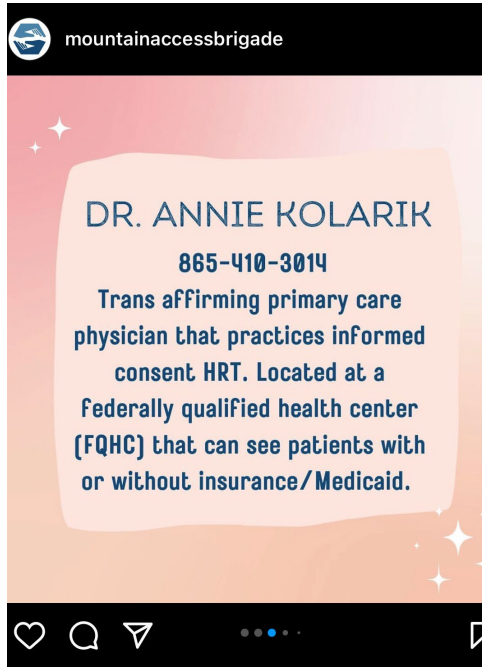
Published 5:14 p.m. ET Jan. 6, 2022 | **Updated 6:28 p.m. ET Jan. 6, 2022**

SDOH Considerations

GENDER IDENTITY

- Historic discrimination within the healthcare system.
- Hard to know where to seek care that will be welcoming, affirming.





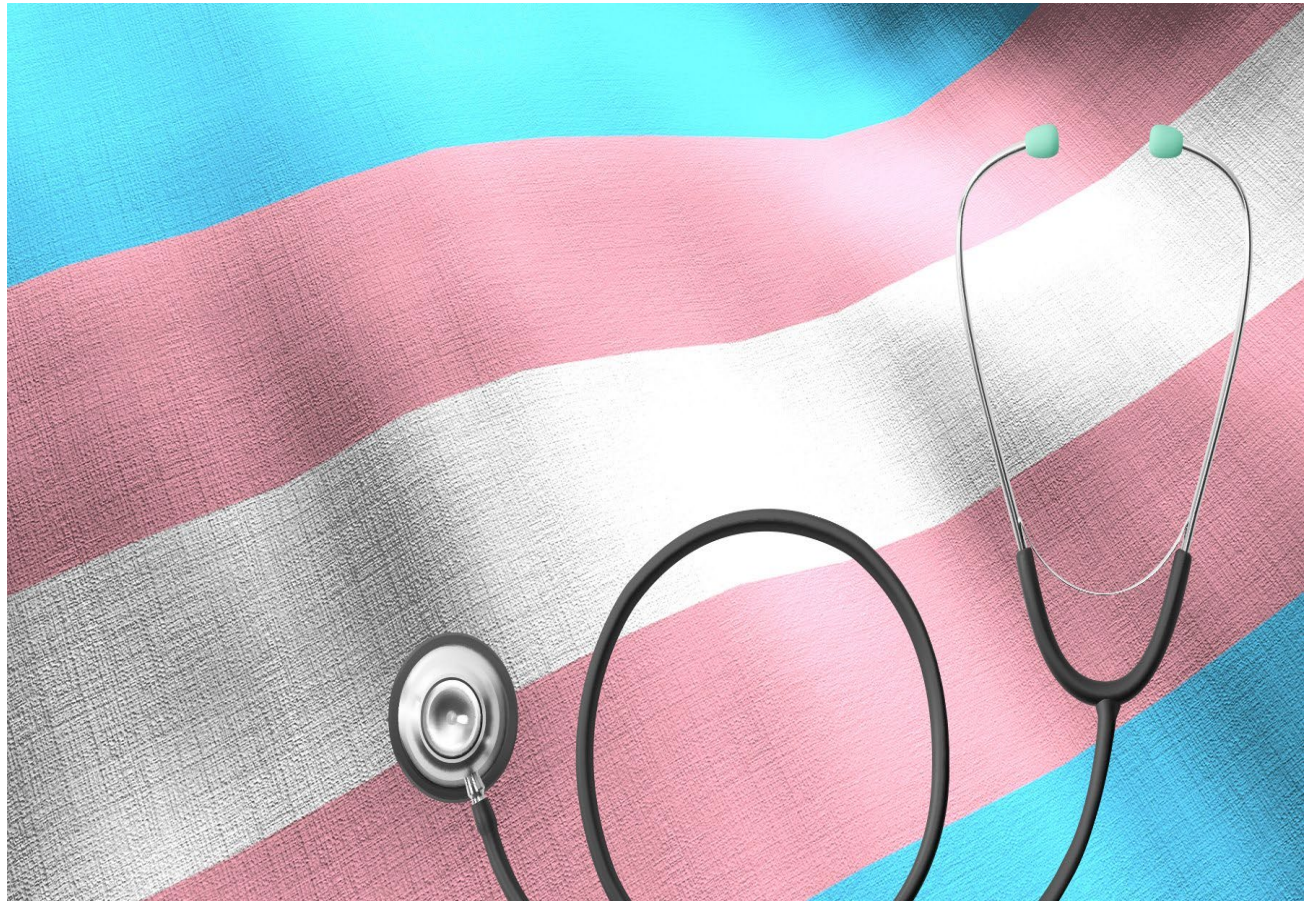
How this was addressed -

- SOCIAL MEDIA:
  - On our own social media: posts featuring our own staff and clear messaging toward the transgender community.
  - Working with community partners to get the word out.
- WELCOMING SPACES:
  - Flags, signs, gender neutral bathrooms

SDOH Consideration

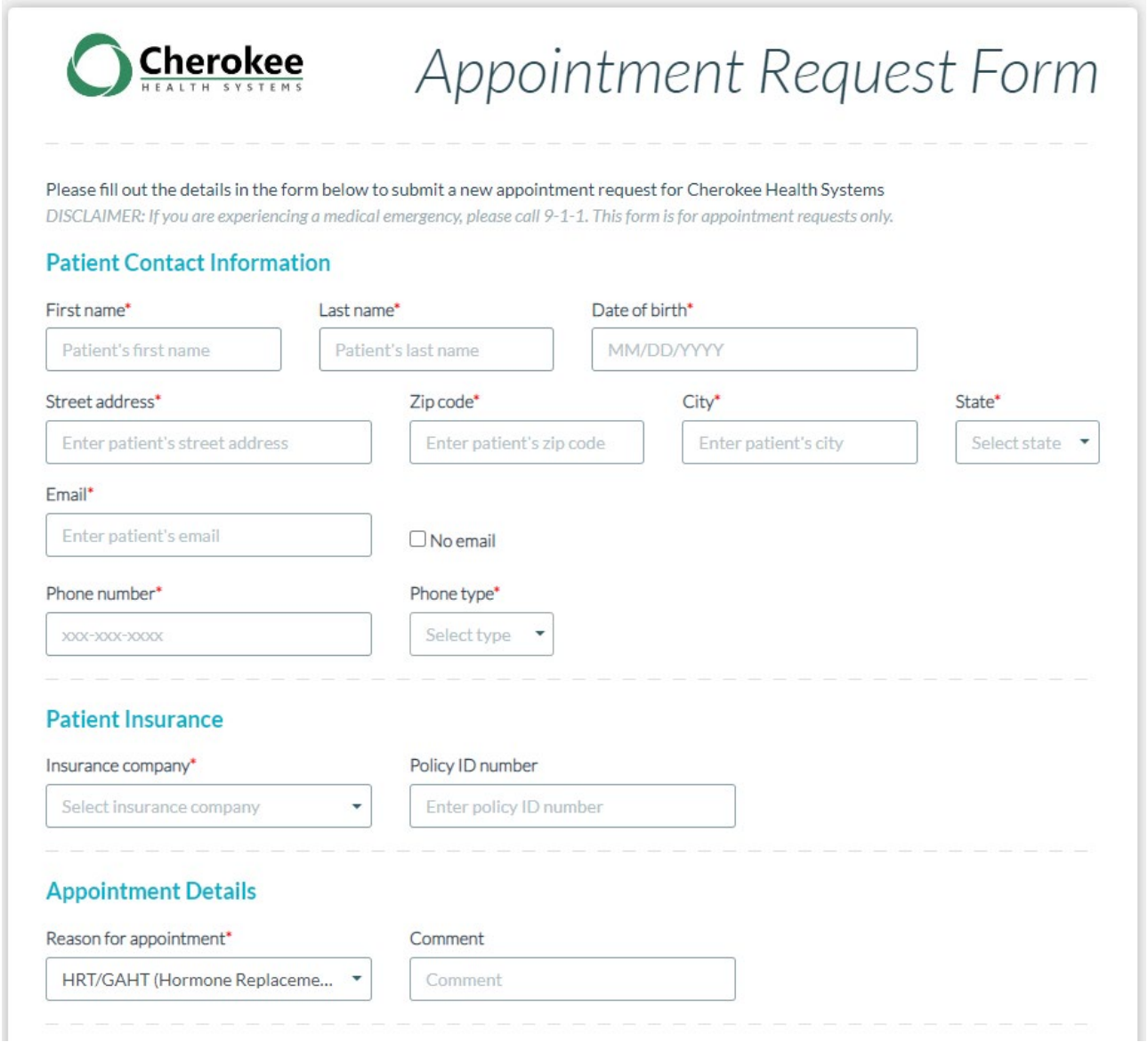
INADEQUATE ACCESS

- Fear of calling for appointments
  - Will I need to use my dead name?
  - Will I have to explain what services I need?
  - Who will answer the phone?
- Many providers do not feel adequately prepared to provide care to TGD patients (only 69% in 2018 study)



Primary Care Clinicians' Willingness to Care for Transgender Patients
Deirdre A. Shires, Daphna Stroumsa, Kim D. Jaffee, Michael R. Woodford
The Annals of Family Medicine Nov 2018, 16 (6) 555-558; **DOI:** 10.1370/afm.2298

How this was addressed – Online Scheduling Form



Cherokee HEALTH SYSTEMS

Appointment Request Form

Please fill out the details in the form below to submit a new appointment request for Cherokee Health Systems

DISCLAIMER: If you are experiencing a medical emergency, please call 9-1-1. This form is for appointment requests only.

Patient Contact Information

First name* — Patient's first name

Last name* — Patient's last name

Date of birth* — MM/DD/YYYY

Street address* — Enter patient's street address

Zip code* — Enter patient's zip code

City* — Enter patient's city

State* — Select state

Email* — Enter patient's email

☐ No email

Phone number* — xxx-xxx-xxxx

Phone type* — Select type

Patient Insurance

Insurance company* — Select insurance company

Policy ID number — Enter policy ID number

Appointment Details

Reason for appointment* — HRT/GAHT (Hormone Replaceme...

Comment — Comment

How this was addressed – Education, Staffing

- Internal training of all providers, nursing/MAs/clinical assistants, and front desk staff.
- Identifying “champions” throughout the system.
- Clear support from leadership.
- Standardization of protocols for treatment of gender dysphoria/incongruence – intake paperwork, informed consent model.

SDOH Consideration

HEALTH DISPARITIES

- Increased rates of HIV and STIs among TGD individuals
- Less likely to receive preventative health screenings
- Less likely to have health insurance
- Higher rates of behavioral health issues.

How this was addressed – Integrated Care

Where we are now -

- Large population of over 300+ TGD individuals receiving the full spectrum of CHS services – GAHT, primary care, behavioral health, and more
- Clear policies across the system to ensure the highest quality care is provided with system “champions” available for consultation
- Mandatory training in affirming care staff wide, with special focus on front-desk staff
- Clear messaging on social media and in clinic spaces
- Community reputation: “safe,” “welcoming”

Where to start?

- Gender-affirming care is for everyone – not just providers! Train front desk staff, support staff, administration
- Make sure your social media reflects your population
- Clearly mark gender neutral bathrooms in your clinic and hang signs stating “gender neutral bathrooms available” on gendered bathrooms. “Baños neutros disponibles” in Spanish!
- Review patient paperwork for “M/F” binaries
- Identify and empower your clinic champions.

Our work isn't done – Legal Challenges

- HB 1895 - Transgender athlete bill – PASSED 4/22/22
- HB 1182 – Transgender bathroom bill – PASSED 5/17/21
- HB 9 – Drag Performance Ban – Passed senate and house 2/23/23, awaiting governor's signature
- HB 1 – Transgender Healthcare Ban for Minors - Passed senate and house 2/23/23, awaiting governor's signature

Thank you!

annie.kolarik@cherokeehealth.com

Building healthy communities
HOLYOKE HEALTH

A Community Health Center's Approach to Screening and Supporting Patient's SDOH Needs

Lisa Connors, RN, BSN

Chief Operating Officer

Lisa.Connors@hhcinc.org

OUR MISSION

"Improve the health of our patients through affordable, quality health care and comprehensive community-based programs to create a healthy community."

Building healthy communities
HOLYOKE HEALTH

Medical Services

- PEDIATRIC, FAMILY & INTERNAL MEDICINE
- ADULT & PEDIATRIC DENTAL
- SAME DAY CARE
- EYE CARE
- ON-SITE PHARMACY
- NUTRITION & WELLNESS
- COMPLEX CARE MANAGEMENT
- HIV/AIDS CARE MANAGEMENT
- MEDICATION ASSISTED TREATMENT
- HEALTHY WEIGHT PROGRAMS
- STI TESTING & COUNSELING
- FAMILY PLANNING
- ACUCPUNCTURE
- ALCOHOL USE DISORDER PROGRAM
- BREASTFEEDING & PARENTING PROGRAMS
- ON-SITE PHARMACY

Building healthy communities
HOLYOKE HEALTH

HOLYOKE HEALTH CENTER

230 Maple Street

Holyoke, MA

CHICOPEE HEALTH CENTER

505 Front Street

Chicopee, MA

Holyoke Health Center

PROVIDES SERVICES TO

22,000

PATIENTS
ANNUALLY

PERFORMS OVER

101,500

PATIENT VISITS
ANNUALLY

Building healthy communities
HOLYOKE HEALTH

Service Area Demographics - Holyoke, MA

27%

of Holyoke residents have MassHealth

46%

of Holyoke residents live below poverty level

48%

of Holyoke residents identify as Hispanic/Latino

Building healthy communities
HOLYOKE HEALTH

TIMELINE OF SDOH SCREENING

Pre 2019

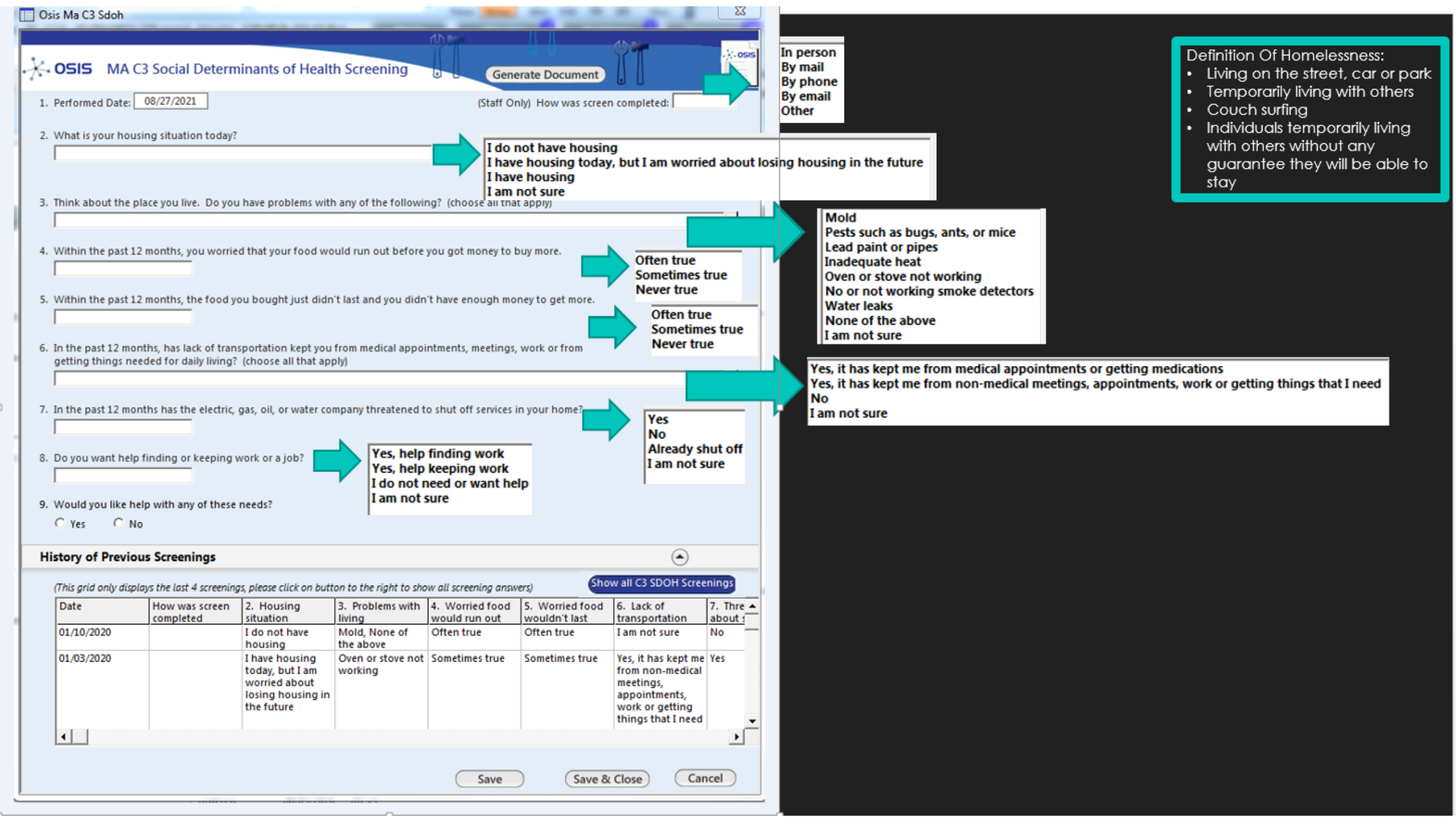
- **No comprehensive SDOH Screening Process**
- **Screening done around Food Insecurity**
- **SDOH Needs Identified by Patient Self Reporting**

2019

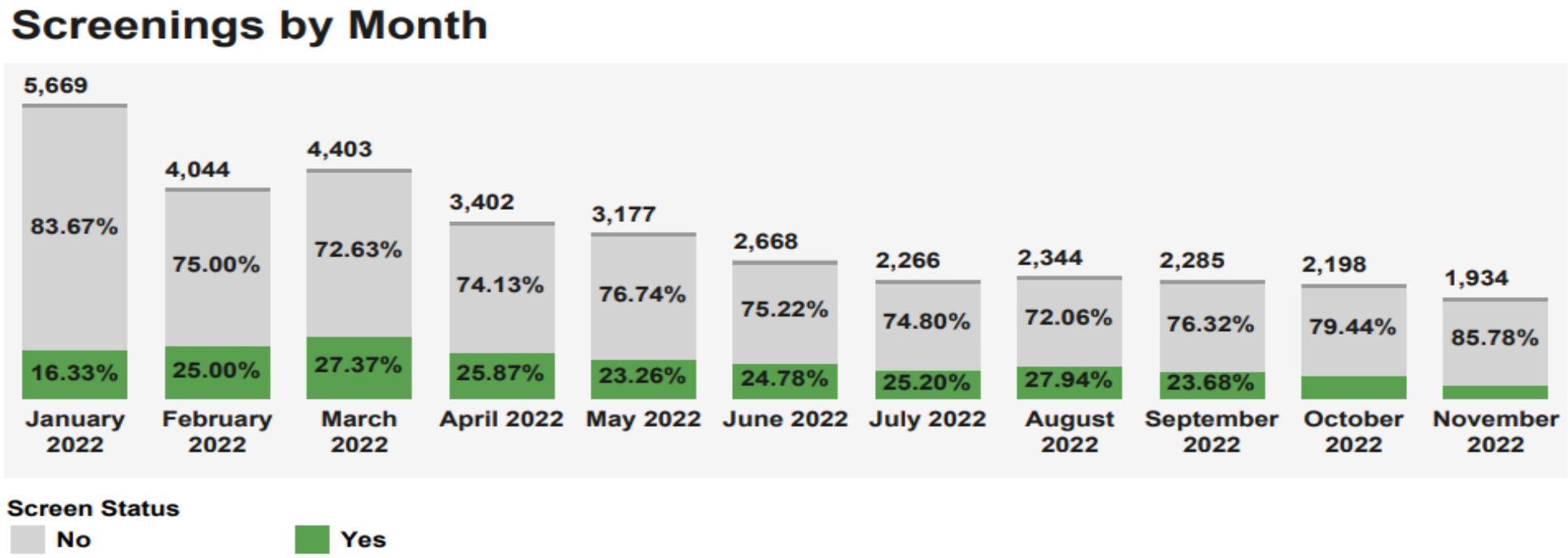
- **Requirements/Guidance from MassHealth on SDOH Screening and Questions**
- **SDOH Screening Tool built into EHR**
- **Goal: All patients Screened during Medical Office Visits once a Year and additionally with medical, behavioral changes, Care Management Intake or Self reported SDOH changes**
- **Providers coding for SDOH Positive findings and making referrals to SDOH CHW for follow up support.**

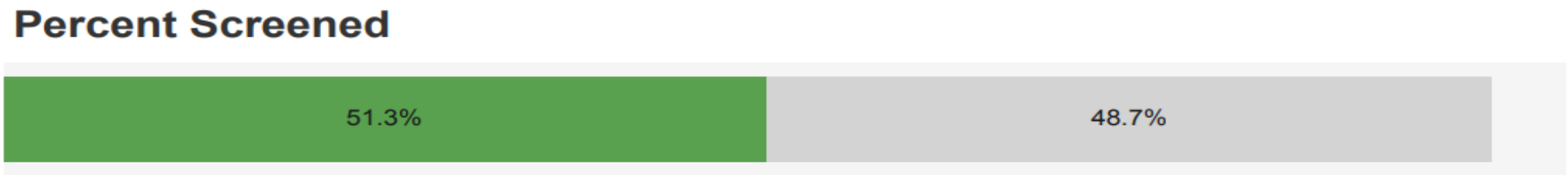
Post 2019

- **Discovered lots of missed opportunities to complete SDOH Screens**
- **SDOH Screening done on ED and Hospital Discharge Follow up Outreach Calls**
- **SDOH Screening done during Dental Visits**
- **2021: Additional Screenings done as part of additional SDOH Navigator role for HHC Lobby and Walk in Center**

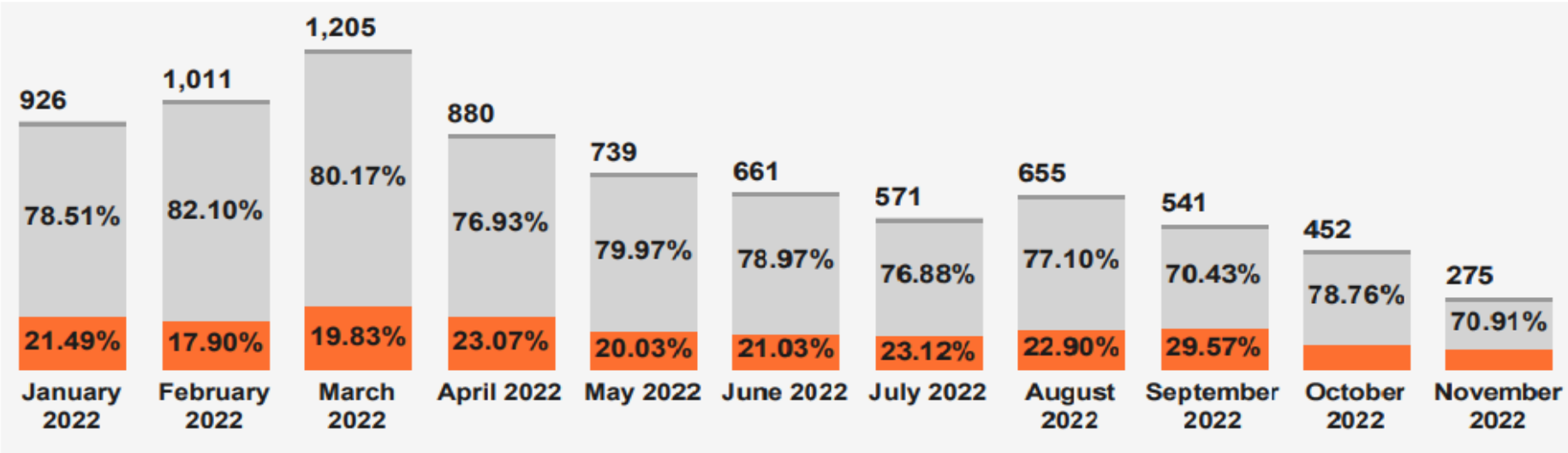

Osis Ma C3 Sdoh
OSIS MA C3 Social Determinants of Health Screening
Generate Document
1. Performed Date: 08/27/2021
(Staff Only) How was screen completed:
In person
By mail
By phone
By email
Other
2. What is your housing situation today?
I do not have housing
I have housing today, but I am worried about losing housing in the future
I have housing
I am not sure
3. Think about the place you live. Do you have problems with any of the following? (choose all that apply)
Mold
Pests such as bugs, ants, or mice
Lead paint or pipes
Inadequate heat
Oven or stove not working
No or not working smoke detectors
Water leaks
None of the above
I am not sure
4. Within the past 12 months, you worried that your food would run out before you got money to buy more.
Often true
Sometimes true
Never true
5. Within the past 12 months, the food you bought just didn't last and you didn't have enough money to get more.
Often true
Sometimes true
Never true
6. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? (choose all that apply)
Yes, it has kept me from medical appointments or getting medications
Yes, it has kept me from non-medical meetings, appointments, work or getting things that I need
No
I am not sure
7. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?
Yes
No
Already shut off
I am not sure
8. Do you want help finding or keeping work or a job?
Yes, help finding work
Yes, help keeping work
I do not need or want help
I am not sure
9. Would you like help with any of these needs?
Yes
No
History of Previous Screenings
(This grid only displays the last 4 screenings, please click on button to the right to show all screening answers)
Show all C3 SDOH Screenings
Date
How was screen completed
2. Housing situation
3. Problems with living
4. Worried food would run out
5. Worried food wouldn't last
6. Lack of transportation
7. Thre about
01/10/2020
I do not have housing
Mold, None of the above
Often true
Often true
I am not sure
No
01/03/2020
I have housing today, but I am worried about losing housing in the future
Oven or stove not working
Sometimes true
Sometimes true
Yes, it has kept me from non-medical meetings, appointments, work or getting things that I need
Yes
Save
Save & Close
Cancel
Definition Of Homelessness:
Living on the street, car or park
Temporarily living with others
Couch surfing
Individuals temporarily living with others without any guarantee they will be able to stay

SDOH SCREENS COMPLETED MONTHLY 2022

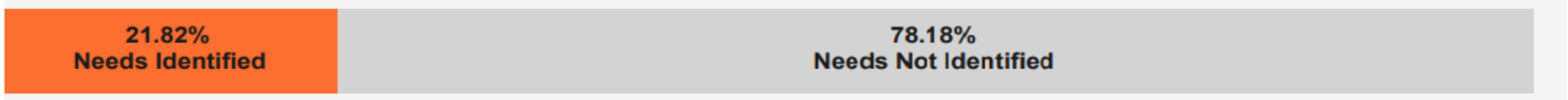




Screening Results by Month



Percent Total by Screen Result Type



EVOLUTION OF SUPPORT FOR POSITIVE SDOH SCREENS

2019

- Aunt Bertha Platform
- Intermittent Gift Cards from Project Bread
- Food Bank of Western MA

2020

- Flexible Services Programs: Support For Food Insecurity and Unstable Housing
- Representative of Food Bank of Western MA located at HHC

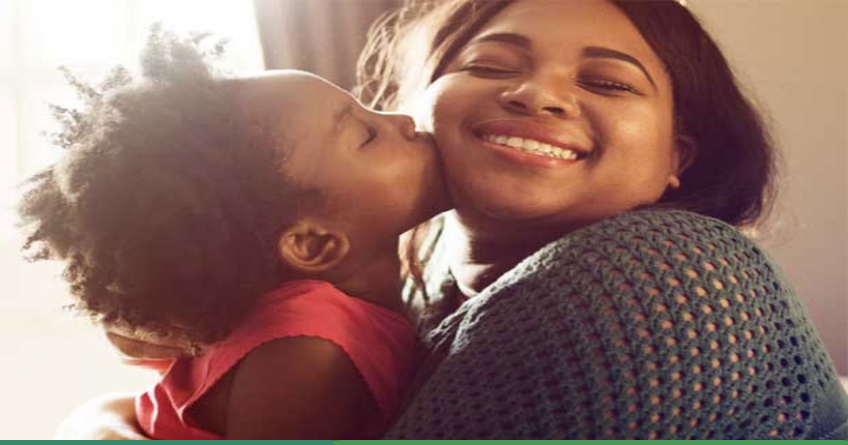
2021-2022

- Continued Flexible Services with Increased Capacity for Referrals
- Additional Resources: Gift Cards , Bus Passes, Vouchers for Emergency Shelters

WORKFLOWS CHANGES TO SUPPORT PATIENTS SDOH NEEDS

- Historically Patients Identified for SDOH Support were referred to Care Management Team
- Post Formal SDOH Screening Tool Development and Use: all SDOH positive screens were referred to SDOH CHW for support and follow up-1 CHW supporting all unless patient enrolled in Care Management Program, CHW on that team would support SDOH needs.
- 2022-2023 move towards Primary Care Capitation-Team of RN Care Manager, CHW and Care Coordinator for each clinical team-CHW supports all positive screens for patients on their clinical team. More opportunity to close the loop and collaborate with clinical teams.

COMMUNITY CARE COOPERATIVE



Responding to Social Needs

Kim Prendergast, Vice President, Social Health
kprendergast@c3aco.org

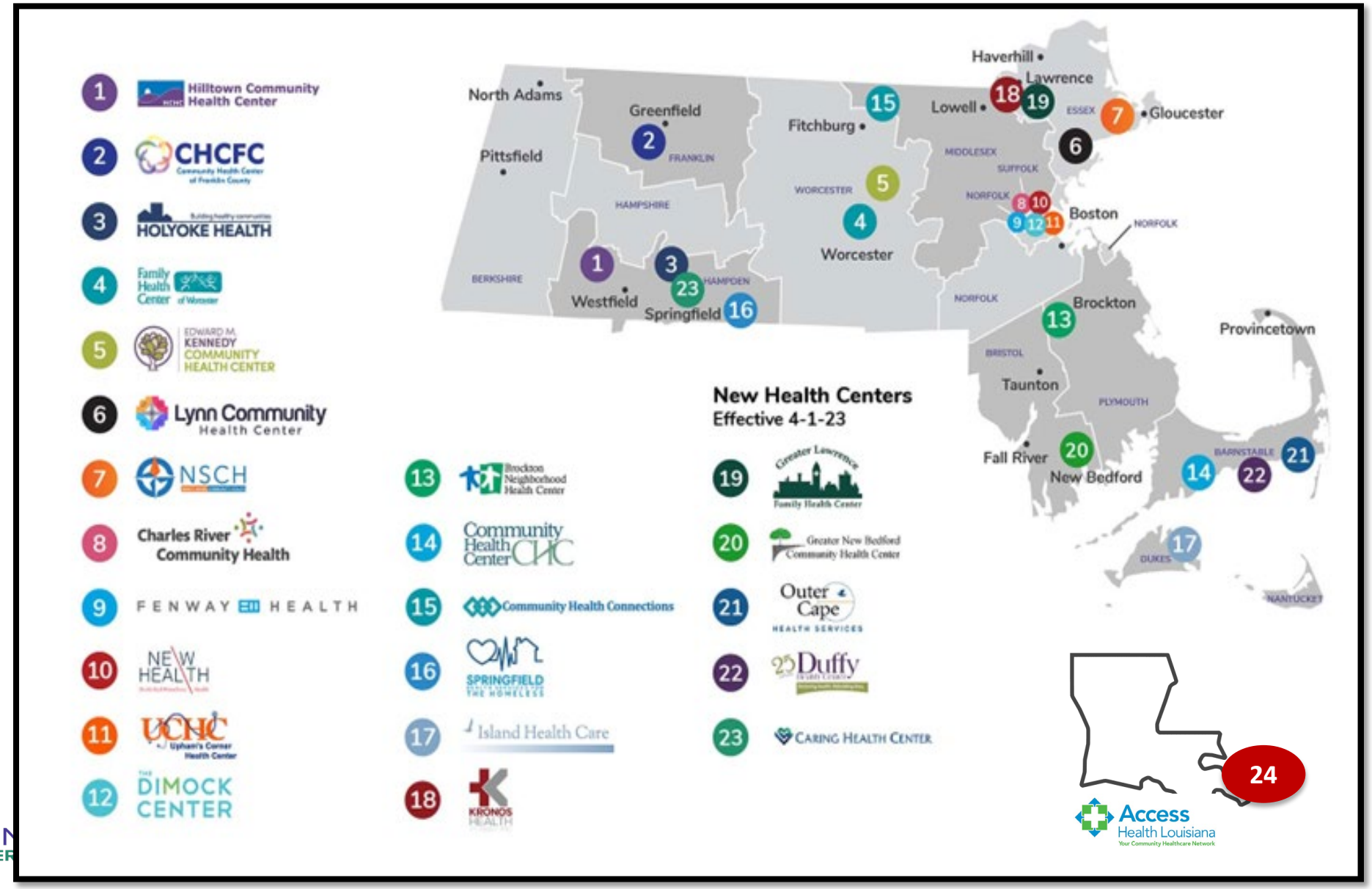
Community Care Cooperative (C3)

We are a 501(c)(3) not-for-profit organization created and governed by Federally Qualified Health Centers (FQHCs).

Our Vision is to transform the health of underserved communities. We unite FQHCs at scale to advance primary care, improve financial performance, and advance racial justice.

www.communitycarecooperative.org

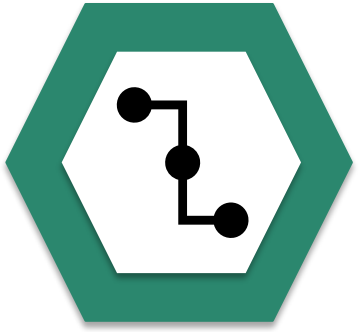
Our Health Centers



Our Approach to Addressing Health-Related Social Needs (HRSNs)

Identify & Understand Health Related Social Needs

- Annual universal screening for HRSN
- Use Accountable Health Communities screening questions
- Ongoing Performance Measurement



Connect Members to Community Resources

Equip health center and C3 staff with tools and expertise to refer members to resources to address their needs:

- findhelp.org
- Partnerships for Nutrition programs - SNAP and WIC enrollment
- Partnerships for Housing supports
- Training & webinars related to available programs and resources for members

Invest in Programs and Advocacy Efforts

- Create new programs and interventions where existing resources are insufficient for members' needs
- Advocate for policy changes that improve community conditions and promote good health

Massachusetts Flexible Services Program

Program Overview	• Section 1115 Waiver supports Medicaid funding to address food security & housing needs.
Goal	• Improve members' health outcomes and reduce Total Cost of Care.
Program Eligibility	• Medicaid ACO members who meet specific criteria for both health and social needs.
Delivery of Services	• ACOs should partner with high-capacity Social Service Organizations to provide services.

Our Flexible Services Program Approach

We built a portfolio of 20 programs with social service organization partners to address the nutrition and housing needs of our most complex members.

Food Security

For members with food insecurity, our partners assure that eligible members have the necessary assistance and navigation to meals, groceries, nutrition education, and SNAP to support a healthy diet.

PARTNERS

PROJECT BREAD

The Food Bank of Western Massachusetts

EAT WELL

AF

ESWA Elder Services Of Worcester Area

COMMUNITY SERVINGS FOOD HEALS

Tenancy Supports

For members with housing instability, our partners provide navigation to housing benefits programs, assistance with housing search and placement for homeless members, and supports for tenancy preservation and eviction prevention.

PARTNERS

Metro Housing BOSTON

PROJECT HOPE BOSTON

bhn

MOC Making Opportunity Count

Housing Assistance

Eliot

SMOC EVERYBODY MATTERS

MASSACHUSETTS COALITION FOR THE HOMELESS

Father Bill's & MainSpring NOBODY SHOULD BE HOMELESS

Food Security Interventions

Food Referral Coordination

Connect members to a Nutrition Coordinator for resource navigation, including referrals to programs like SNAP and WIC.

Provide direct services including:

- Food purchasing power and grocery access through **food vouchers**
- Rides **to the grocery store**
- Support disease management and increase healthy eating and cooking skills through **nutrition & diabetes education and coaching**
- Encourage safe and healthy cooking through provision of **kitchen items and appliances**

Other Nutrition Supports

MTM

Medically Tailored Meals

Home delivered prepared meals for members who require diet-specific meals to manage their health condition or who lack the ability or social support to prepare appropriate meals.

Meal Kits

Meal Kits

Home delivered meal kits with ingredients and easy to follow recipes, providing members with a fun cooking experience and healthy eating skills.

Fresh Produce

Produce Prescriptions

Increase access to healthy food by providing food purchasing power for fresh produce or direct delivery of produce boxes.

Tenancy Interventions

Housing Navigation & Case Management

Homelessness

Pre-tenancy supports include case management services for housing search & placement including:

- Reviewing and addressing barriers to housing
- Completing affordable housing applications
- Finding and visiting apartments
- Supporting members with transition into new housing through payment of set up costs

Eviction Prevention

Tenancy sustaining supports include case management services to provide:

- Education and advocacy on tenancy rights
- Assistance with applying for state or federal benefits, including existing programs for financial assistance with rental or utility arrears

Healthy Home Goods

Home modifications to improve housing quality including:

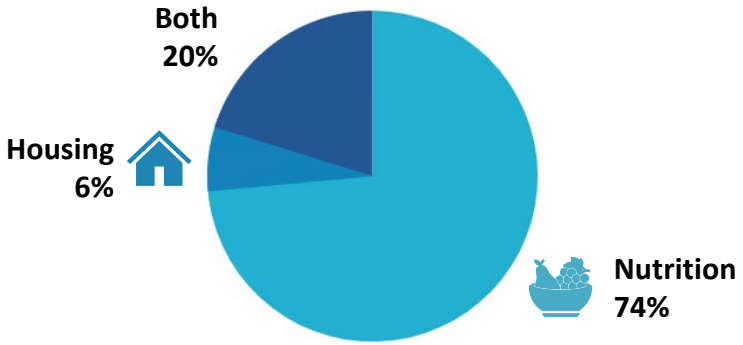
Pest Control

Supplies or extermination services to get rid of bugs, ants, or mice.

Household Supplies

Such as air purifiers and HEPA vacuum cleaners to improve air quality in the home.

Program Impact



More than 10,200 members referred

- 2,682 active members
  - 9,500 receiving nutrition supports
  - 2,800 receiving housing supports

92% of members referred are successfully connected and receive support

$16,000,000 in spending on direct services and goods

COMMUNITY CARE COOPERATIVE

*includes referrals 4/1/2020-2/15/2023

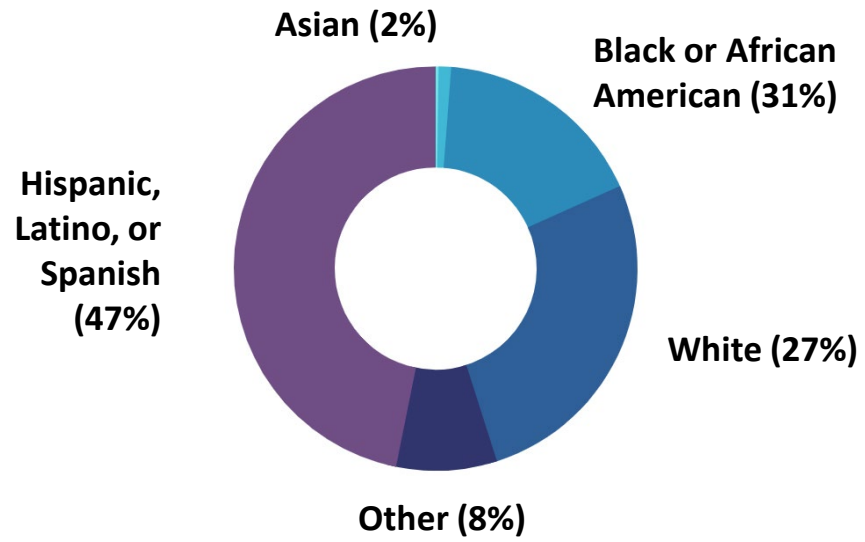
Member Demographics

Gender

58% Female

42% Male

Race/Ethnicity



Primary Language Spoken

- **Top 5 languages spoken:** English, Spanish, Cape Verdean Creole, Haitian Creole, and Arabic
- 43% of members speak a language other than English

COMMUNITY CARE COOPERATIVE

**Not displayed: we also track Sexual Orientation, Education, and Employment Status*

Services and Goods Provided

Nutrition Programs

Over $4.7 million in **food vouchers**

Over $2.1 million **home delivered medically tailored meals and meal kits**

Over $1.0 million in **kitchen supplies and appliances** for members to prepare and store healthy food

Over 750 members received individualized **nutrition education**

Housing Programs

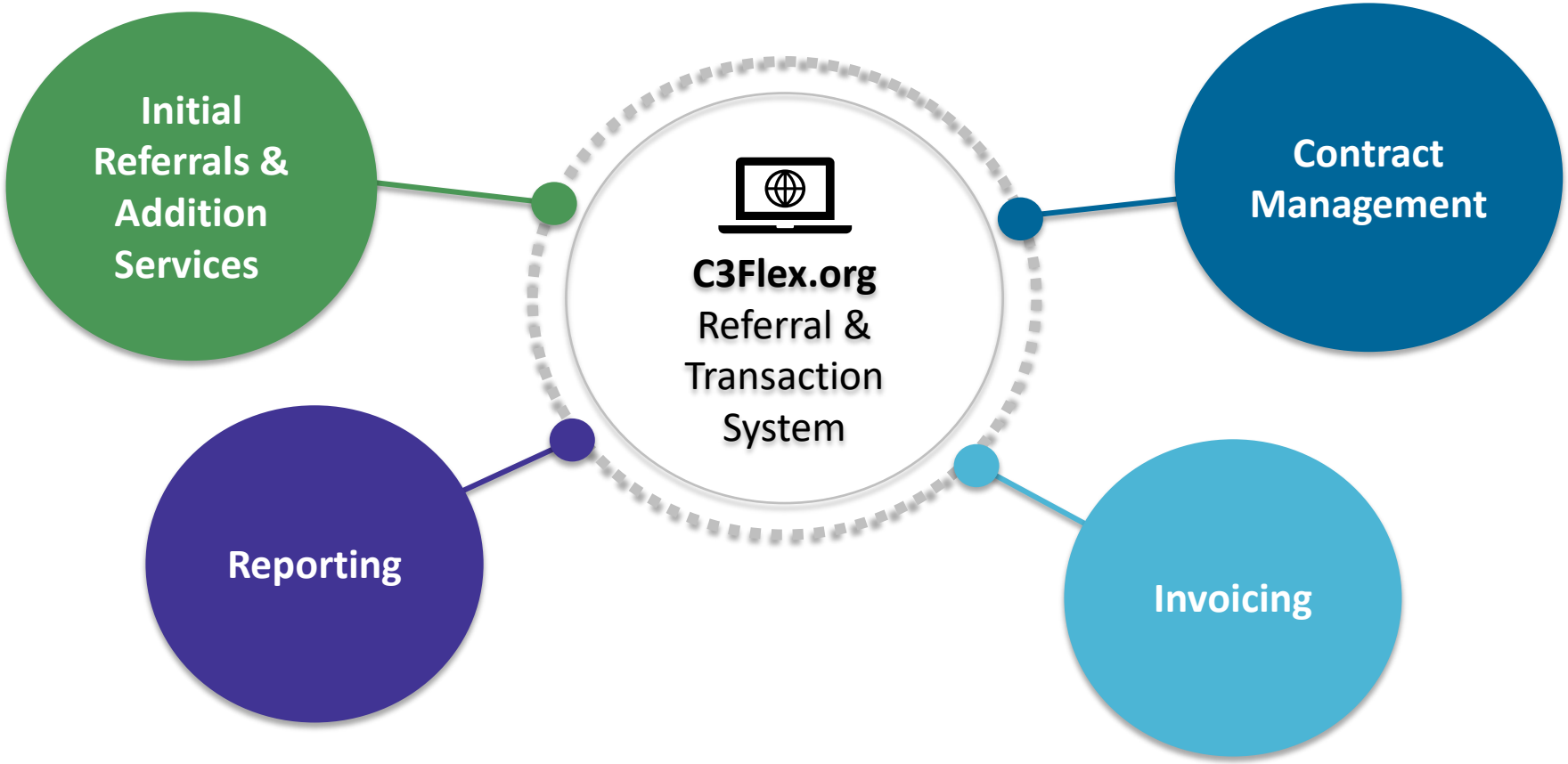
Over 2,000 members receiving **individualized case management support** for **housing stabilization** or **housing search**

Over 600 members received **healthy home goods** or **home modifications**

200+ members **received financial support** from Flexible Services for **transition into new housing**

Technology Supports our Work

Customized case management system supports program activities and closed loop referrals



COMMUNITY CARE COOPERATIVE

Program Outcomes

Overall Program: Successful Connection to Resources

- 92% of members referred to Flexible Services receive services
- 67% of members complete the program

Nutrition Program Outcomes:

1. Improved food security, diet quality & perceived health

- Increased Fruit & Vegetable intake
- Improved diet quality for patients with diabetes
- >90% of members report health status is improved or greatly improved

2. Better diabetes control & reduced cost

Medically-Tailored Meal Programs:

- HbA1c decline of 0.9%, with decline of 2.4% for those with HbA1c >9.0% upon enrollment
- Total Cost of Care Reduction of $5,552 (p<.001)

Gift card & Nutrition Education Program:

Early analysis shows average HbA1c decline 0.9 for those poorly controlled upon enrollment

Housing Program Outcomes:

1. Improvements in Housing Instability

- >250 members who were experiencing homeless became stably housed,
- 67% of those not yet housed remain engaged in housing search
- 600 members achieved stable housing, including eviction preventions

2. Members experiencing homelessness and engaged in housing search

- Total Cost of Care Reduction of $3,646 (p<.001)
- Reduction in ED Visits: 41% had 2+ ED visits in the 6 months prior to enrollment compared to 31% with 2+ ED visits in the 6 months after enrollment (p <.002)

DC Community Resource Information Exchange (CoRIE)

David Poms, MPH
Partnerships Manager,
DC Primary Care Association
dpoms@dcpca.org

The Department of Health Care Finance administers Washington D.C.'s Medicaid program and oversees the D.C. Health Information Exchange marketplace

Department of Health Care Finance

State Health IT Coordinator

DHCF leads digital health policy and strategy as well as implementation of HIE services across D.C.

Regulator

DHCF regulates HIE and manage the registration and designation process for HIEs operating in D.C.

Strategic leader and convener

DHCF convenes stakeholders through the DC HIE Policy Board and elsewhere to remain responsive to evolving digital health needs

Funder and Partner

DHCF leverages local and federal funds to support HIE infrastructure and partners with other health and human services cluster agencies to collaboratively sustain HIE

CRISP DC Health Information Exchange

District-Wide Data Sharing for Whole Person Care

Regional Health Information Exchange (HIE) serving Maryland, West Virginia, and the District of Columbia.

CRISP's main goal is to is to securely deliver the right health information to the right place at the right time to **enable safe, timely, effective, equitable, and patient-centered care.**

CRISP DC is a **non-profit organization** advised by a wide range of stakeholders who are responsible for public health throughout the District.

CRISP DC has been serving the District since 2016 and became the **District Designated Health Information Exchange** in April 2020 through a competitive process governed by DHCF.

14,000+
DC Healthcare Professionals Utilizing the HIE

1,400,000+
Patients Served Through the HIE

900+
Organizations Accessing and Contributing Data

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

Critical Infrastructure (e.g. Encounters and Alerts)

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

Consent to Share Data

Consent to Share SUD Data

-42 CFR Part 2 Data (Phase I)

-Other types of consent (Phase II)

Registry and Inventory

- Care Management Registry
- Community Resource Inventory
- Advance Care Planning

Simple and Secure Messaging

Provider Directory

> 31,000 contacts from 251 organizations

Includes data from:
-12 national sources
-20 DC/Local Data sources

Screening and Referral (e.g. SDOH)

Referral and Screening

-Mapped screening data for housing and food insecurity eReferral

-Analytics for follow-up

Advanced Analytics for Population Health Management

CRISP Reporting Services

Performance Dashboards
Phase I:
-Pay for Performance

Phase II:
-Maternal health
-Behavioral health

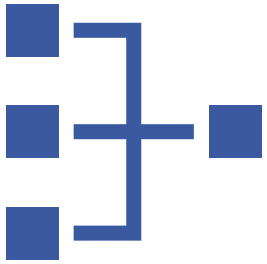
gravity PROJECT

CoRIE

Community Resource Information Exchange (CoRIE)

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

- **Screening** for social risks and share dispositions
- **Lookup resources** through a centralized community inventory (CRI)
- **Refer** to appropriate community and support services

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

CoRIE Project Tools

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

CRISP DC Social Needs Tab

- DC HIE users can view assessments captured via the CRISP DC Screening Tool or third-party platform
- DC HIE users can view conditions based on extracted z-codes

CRISP DC Care Coordination

CRISP DC Referral Tool

CBOs can

- Receive referrals for services
- Communicate with referring provider
- Close the loop
- Send referrals to other CBOs

The Gravity Project Is Accelerating Adoption Using Nationally Recognized Standards

LOINC®

ICD-10 TENTH REVISION INTERNATIONAL CLASSIFICATION OF DISEASES

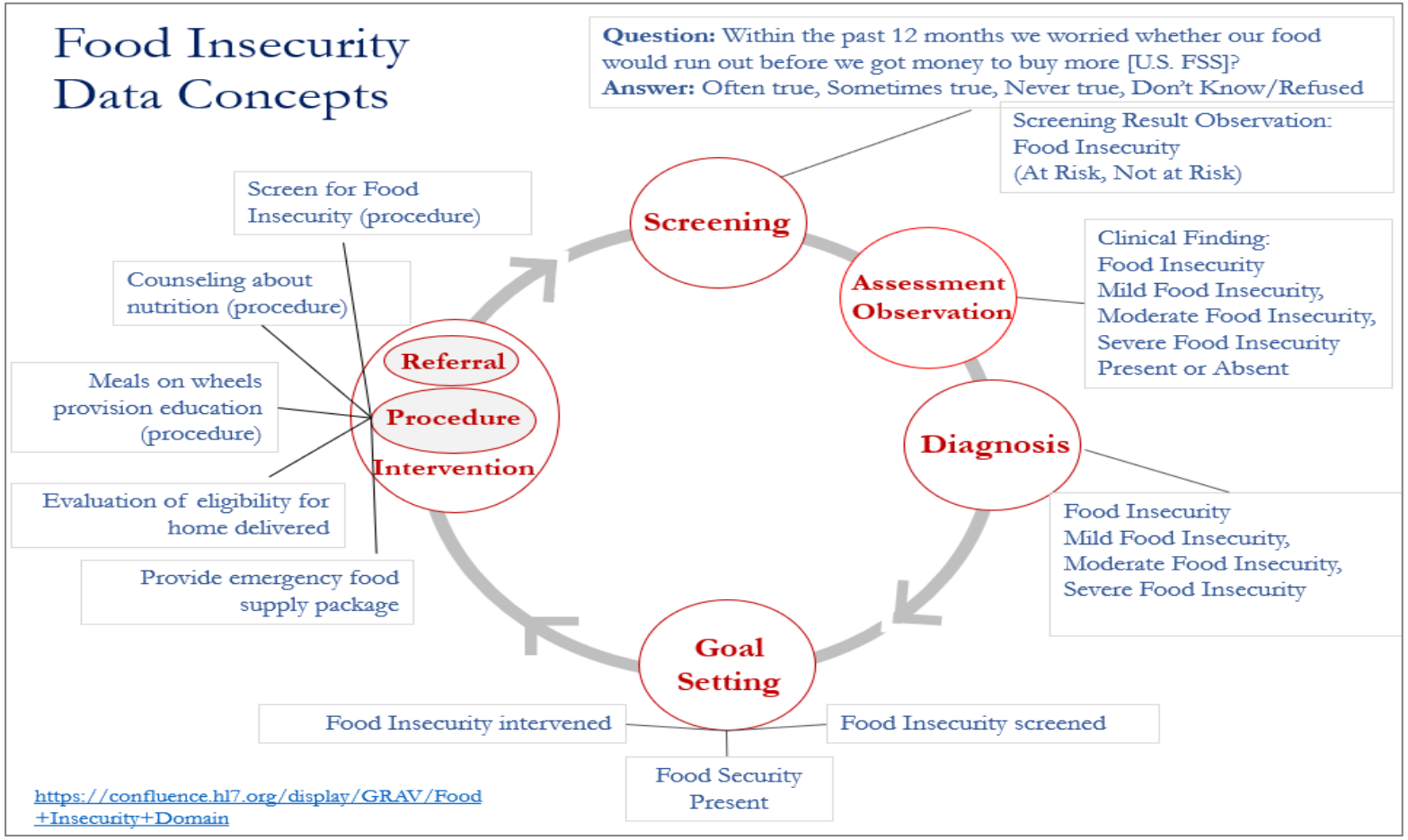
SNOMED CT

HL7® FHIR®

Fast Health Interoperability Resource

HL7® CDA®

Clinical Document Architecture (CDA)



2021 FQHC Screening Pilot: Documentation of screening and Z-code responses

- **Document screening responses/results using Z codes (diagnostic codes).**
  - Gravity-defined Z codes were added to the eCW diagnosis code drop-down list for the following domains: *food insecurity, inadequate housing, housing insecurity, transportation instability, financial instability.*
  - Documented Z codes are included in the Progress Note (i.e., CCD) that is transmitted to CRISP
- **Use new dummy Procedure Code (CPT) A0321 to indicate that a screening has occurred during a specific encounter.**
  - The new Procedure Code is transmitted to CRISP in the encounter CCD
  - The Procedure Code serves as indication that a screening was performed during that encounter

Overall Z-Code stats (2022)

- **6** health centers participating
- **13502** encounters with CPT or Z code documented
- **5758** unique patients screened

Encounters by health center

- Community of Hope: 74
- Bread for the City: 151
- La Clinica del Pueblo: 1091
- Mary's Center: 1564
- Whitman-Walker Health: 3086
- Unity Health: 7536

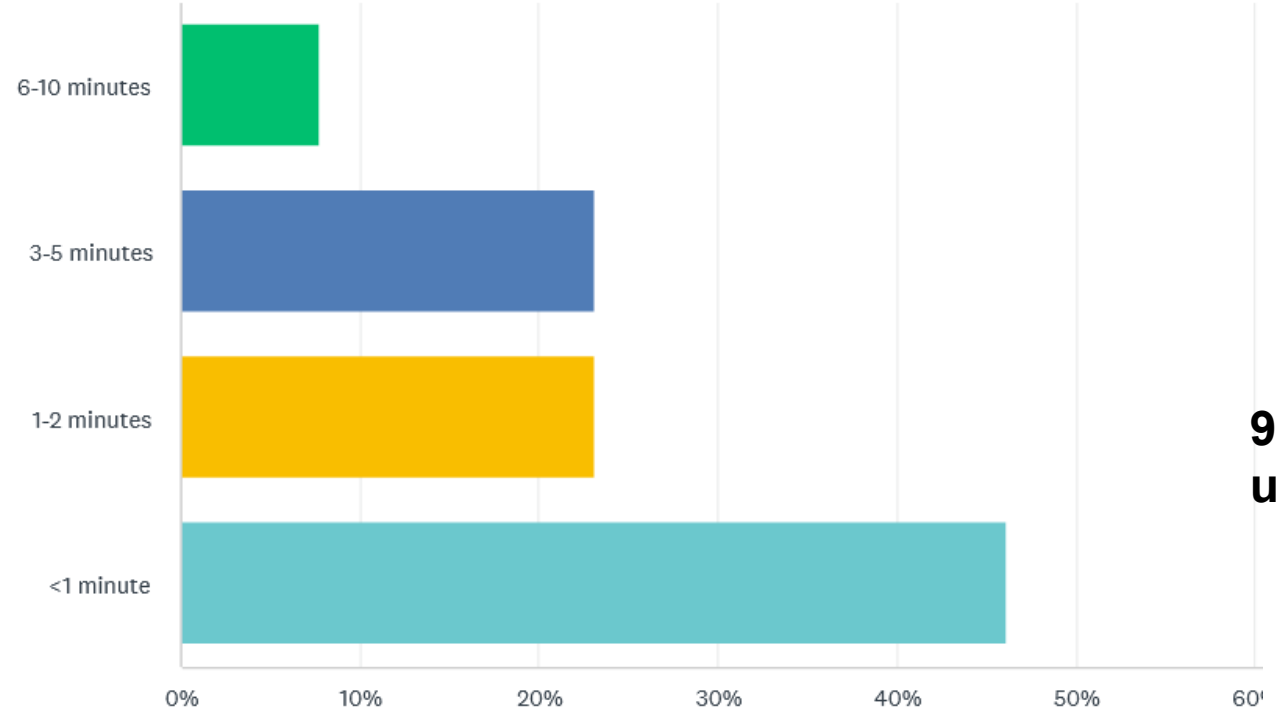
Top Z codes applied

Z-code	Z-code description	Times applied	%
Z59.0	Homelessness (unspecified/category)	3971	29.41%
Z59.89	Other problems related to housing and economic circumstances	3826	28.35%
Z59.82	Transportation insecurity (subcategory)	1430	10.59%
Z59.41	Mild food insecurity	996	7.38%
Z59.42	Moderate food insecurity	903	6.69%
Z59.86	Financial insecurity, not elsewhere classified (subcategory)	725	5.37%
Z59.4	Food insecurity	543	4.02%
Z59.81	Housing instability, housed (subcategory)	210	1.56%
Z59.868	Unable to make ends meet	177	1.31%
Z59.01	Sheltered homelessness	125	0.93%

Staff Feedback

On average, how long does it take to find the appropriate Z code in eCW?

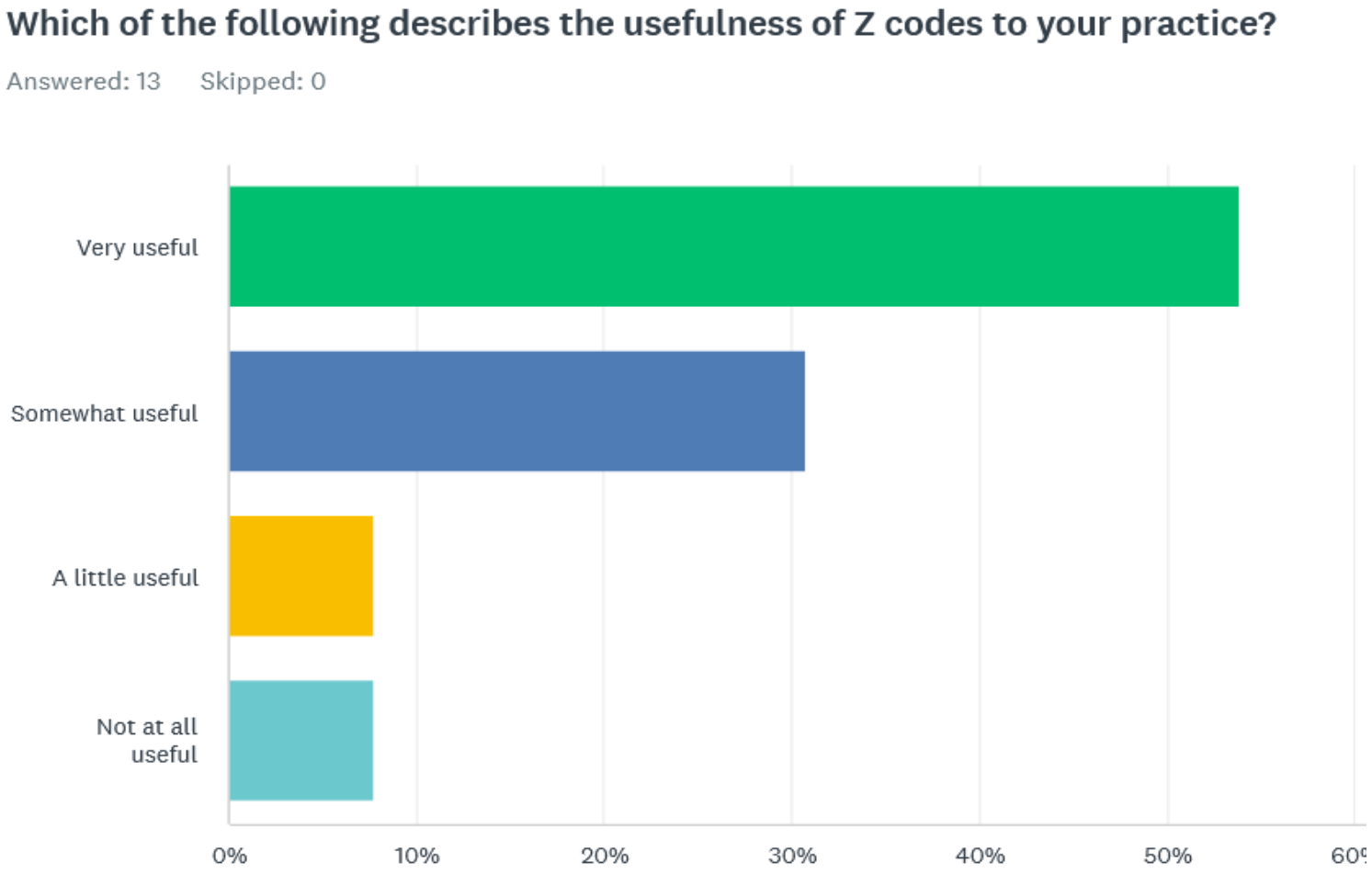
Answered: 13 Skipped: 0



9 out of 13 said under 2 minutes

SDOH Screening Pilot Staff Survey

Staff Feedback



11 out of 13 said "somewhat useful" or "very useful"

Applications and Opportunities

1. Developing an organizational strategy around social risk screening and referral
   - Multiple programs may be conducting social risk screening in silos
   - Z codes help with a standard meaning where multiple SDOH screeners are being used at a single health center
2. Provides health centers with data on the social needs of their patient populations
   - Helpful data for advocacy, grant opportunities, resource allocation…
3. Opportunity for risk stratification – incorporating Z codes with other patient characteristics in risk stratification report
   - Helps raise clinician awareness of panel social risks
   - Helps to right-size panels
   - How to incorporate CORIE social risk analytics with social needs screening data

Challenges

- Unclear when to apply the CPT code; what counts as an SDOH "screening"? This is currently health center-defined.
- Standardization of meaning is an ongoing challenge with mapping from screener to code
- Granularity of codes
  - This will likely need to be an ongoing discussion as we collectively design referral pathways
- Need for regular updating of Z codes as Gravity codes evolve
  - CoRIE CRI within CRISP provides an avenue for centralizing these updates

Recommendations to Stakeholders

- We have demonstrated capacity for Z codes to be the mechanism for social risk screening standardization. Gravity project codes should be further explored and evaluated for expansion to other practices, as they are workable in FQHC settings.

- Primary screening populations are currently Ryan White and MyHealthGPS (i.e., patient populations for whom there are existing bundled payments). Incentives are needed to expand scope of social needs screening further.

- Health centers are beginning to incorporate Z-codes into risk stratification and social risk adjustment for right-sizing panels. We want to build capacity for risk adjustment and discuss how Z-codes can inform social risk adjustment.

- Gravity codes can be utilized as metadata attached to resources in the CRI (relevant z-codes, patient goals, taxonomized interventions). The HIE Policy Board's CRI and Stakeholder Engagement subcommittees should explicate the use cases for this metadata in order to inform cost-benefit analysis.

Whitman-Walker Health
SDoH Social Needs Screening Pilot

Robert Bangert, MSW, LICSW
Senior Manager of Care Navigation
rbangert@whitman-walker.org

WHITMAN-WALKER HEALTH
we see you.

© 2022 Whitman-Walker

DCPCA's & DC PACT's City-Wide Vision for Screening and Referrals

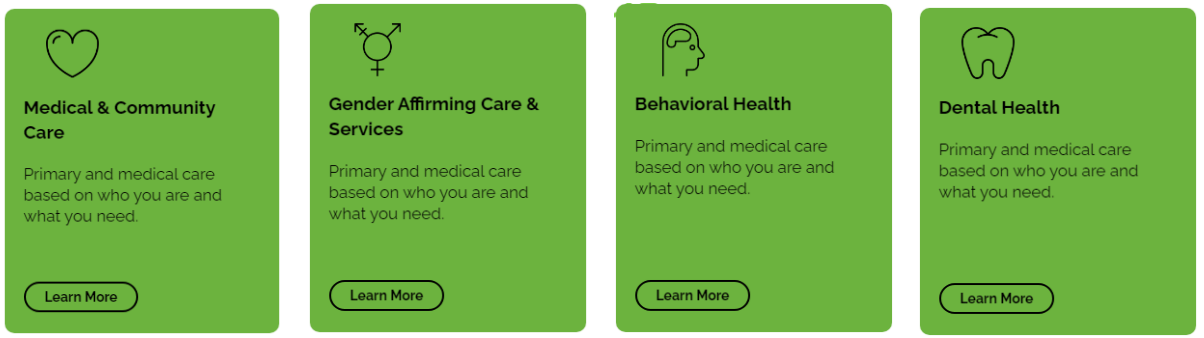
By improving the accuracy, timeliness, and ease of collecting social needs data, it will allow providers to better identify and address social needs.

As a network, we will be able to advocate more effectively for sustainable payment systems to support holistic care, including upstream community change.

Quintuple Aim: Better Health, Lower Costs, Increased well-being of patient and staff, and Improved health care disparities

Care Navigation at WWH

- Care Navigation offers patients living with HIV personalized support and guidance through the health center and outside resources
- Care Navigators also support medical care plans, including for those living with multiple chronic health conditions, and their treatment goals
    - Examples of care plans and treatment goals include: re-engaging with HIV Care, getting to and staying undetectable, working with their provider on lifestyle changes to support healthy blood pressure, attending an outside medical referral, or connecting with outside housing resources
- Team of 10 + one Senior Manager
    - 5 Care Navigators + 1 Youth & Family Care Navigator
    - 1 Mobile Care Navigator
    - 1 Community Support Specialist
    - 2 Community Health Workers

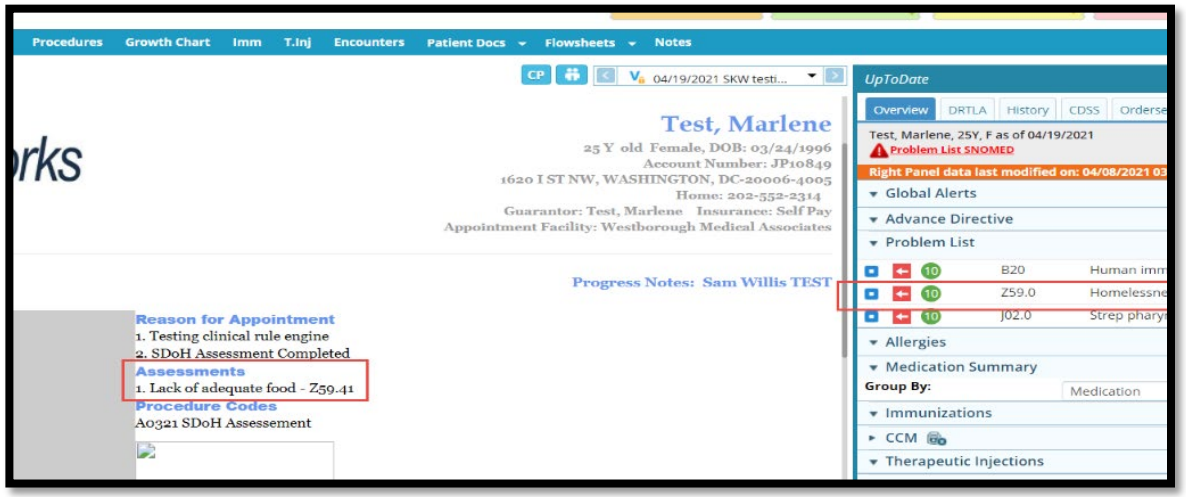


SDoH Social Needs Screening at WWH

Team of Care Navigators will apply

1. CPT codes (A0321: SDOH Assessment) to document when a patient is assessed for social needs
2. ICD codes (Z-codes) to document what the identified needs were in these domains:
    - Food insecurity
    - Housing insecurity
    - Transportation instability
    - Financial instability

- Staff are instructed how to interpret patient responses and connect that to the assessment →



WWH Pilot Selections					
Domain	Z	ICD Code Description	WWH Assessment, section header	WWH assessment, Q	WWH assessment, A
Housing	z59.81	Housing Instability	Social Determinants of Health	Housing, current status?	"Unstably housed"
Housing	z59.022	Residing on the street	Social Determinants of Health	Housing, current status?	"Living on street"
Housing	z59.01	Sheltered homelessness	Social Determinants of Health	Housing, current status?	"Homeless shelter"
Housing	*NA*	*No need to code*	Social Determinants of Health	Housing, current status?	"Stable housing"
Food	z59.42	Food insecurity	Social Determinants of Health	Food, current status?	"Food insecurity"
Food	*NA*	*No need to code*	Social Determinants of Health	Food, current status?	"Stable access to food"
Financial	z59.86	Financial insecurity, not elsewhere classified	Social Determinants of Health	Financial, current status	Used your judgement based on the selections for this question to determine if client is financially insecure.
Transportation	z59.82	Transportation insecurity	Medication & Appointment Adherence barriers	Use if "transportation" is selected.	

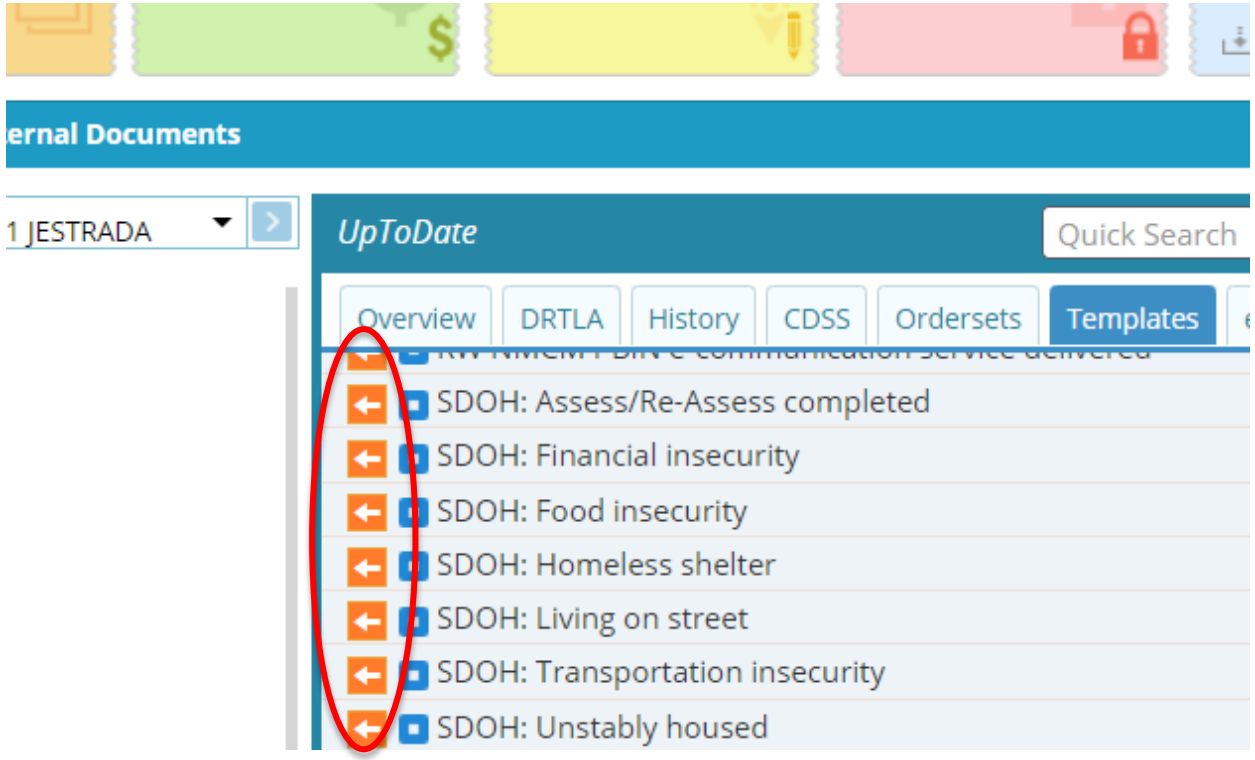
Workflow

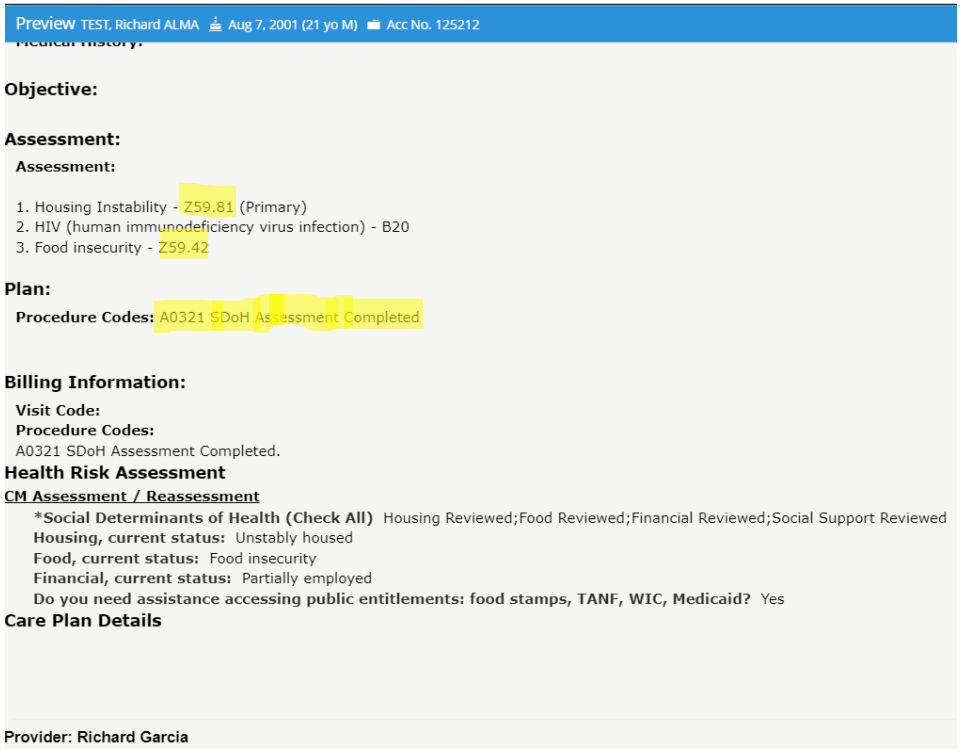
- Before launching the pilot, Population Health & Quality created several templates in the EMR which included CPT codes for Assessments and z-codes for SDoH
- As Care Navigators meet with patients to help support HIV care coordination, they complete various intakes, assessments, or reassessments to document a patient's health goals, care plans, and barriers to care (including SDoH)

*Social Determinants of Health (Check All)	Housing Reviewed;Food Reviewed;Financial Reviewed;Social Support Reviewed
Housing, current status:	Unstably housed
Food, current status:	Food insecurity
Financial, current status:	Partially employed
Family or friends who assist/support you socially/emotionally?	Yes
Do you need assistance accessing public entitlements: food stamps, TANF, WIC, Medicaid?	Yes

Workflow

- When an assessment is completed, and if an SDoH need is documented, Care Navigators can pull the appropriate template (including assessment and z-codes) into their visit documentation with one click
- The PHQ team is then able to track the structured documentation data and generate reports



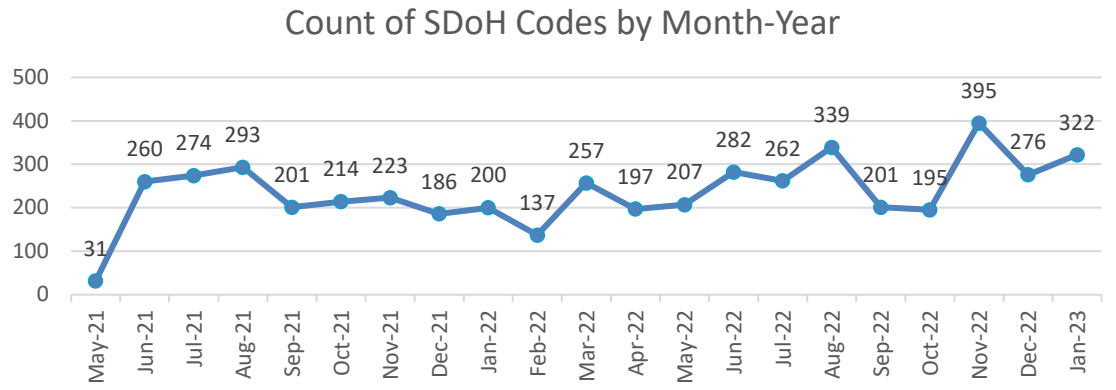


Data (May 2021-January 2023)

- Since the Pilot began in May 2021, Care Navigators have completed 144 SDoH Assessments
- Within those Assessments, they have also documented over 5,000 instances of patients with social needs by adding the appropriate z-code to the EMR
- Transportation Insecurity is the most common social need identified at 41%, with Financial Insecurity and Food Insecurity next with 26% for both
- *Housing Instability also includes the z-codes for Sheltered homelessness and Residing on the street

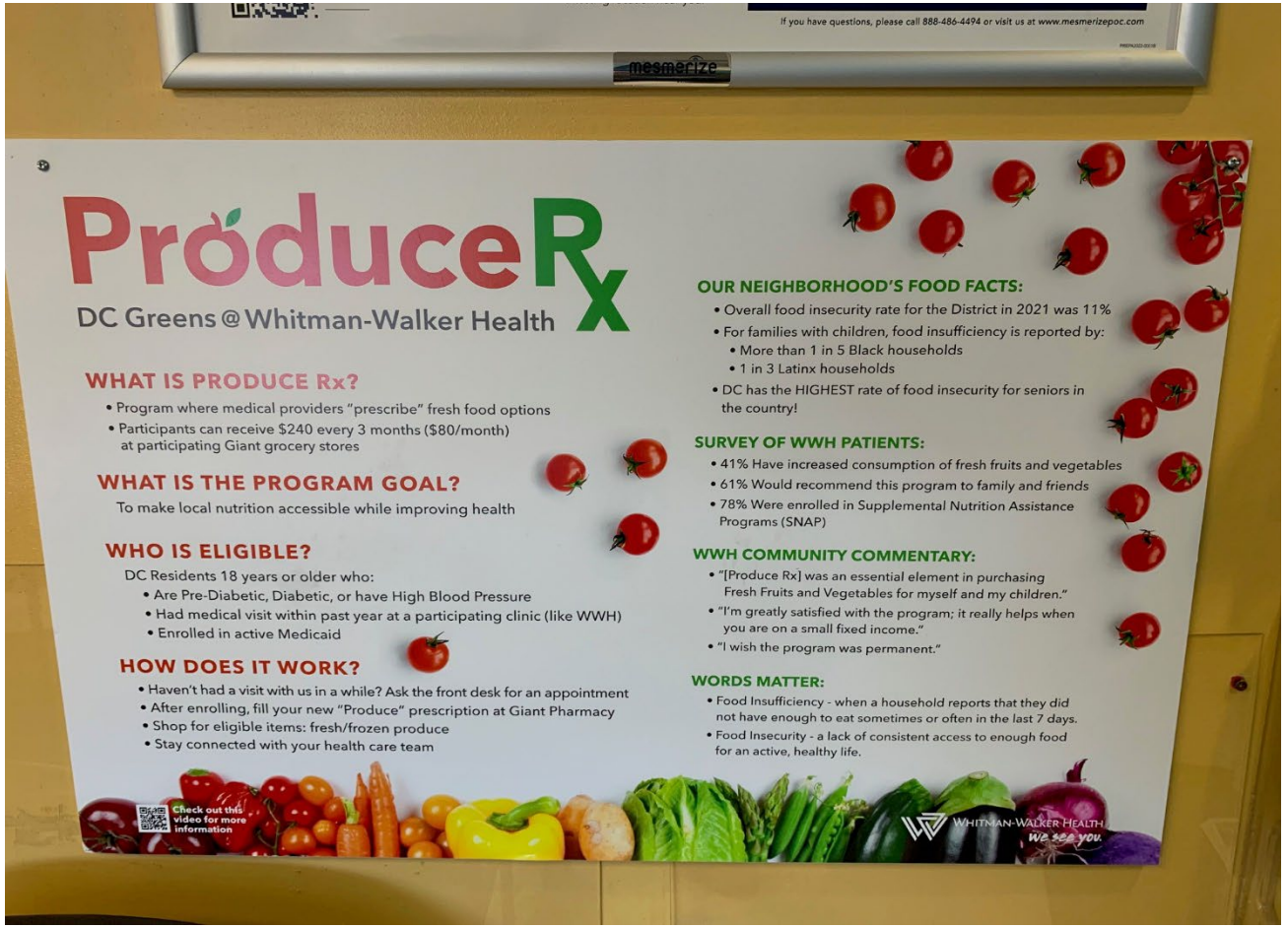
CPT Code	
	n
SDoH Assessment Completed	144

SDOH Z-Code Type		
	n	%
Transportation insecurity	2047	41%
Financial insecurity	1300	26%
Food insecurity	1308	26%
Housing Instability*	371	7%
Grand Total	5026	100%



Produce Rx (Lobby at Max Robinson Center in SE DC)

- Produce Rx (part of DC Greens) is a program where medical providers “prescribe” fresh food options for patients
- Eligibility: DC residents 18+ enrolled in Medicaid with a qualifying chronic health condition (including Pre-Diabetes, Diabetes, or Hypertension)
- If Care Navigation staff identify Food Insecurity during a social needs screening, they can help connect patients with this program
- By enrolling in Produce Rx, patients can receive $240 every 3 months ($80/month) at participating Gian grocery stores

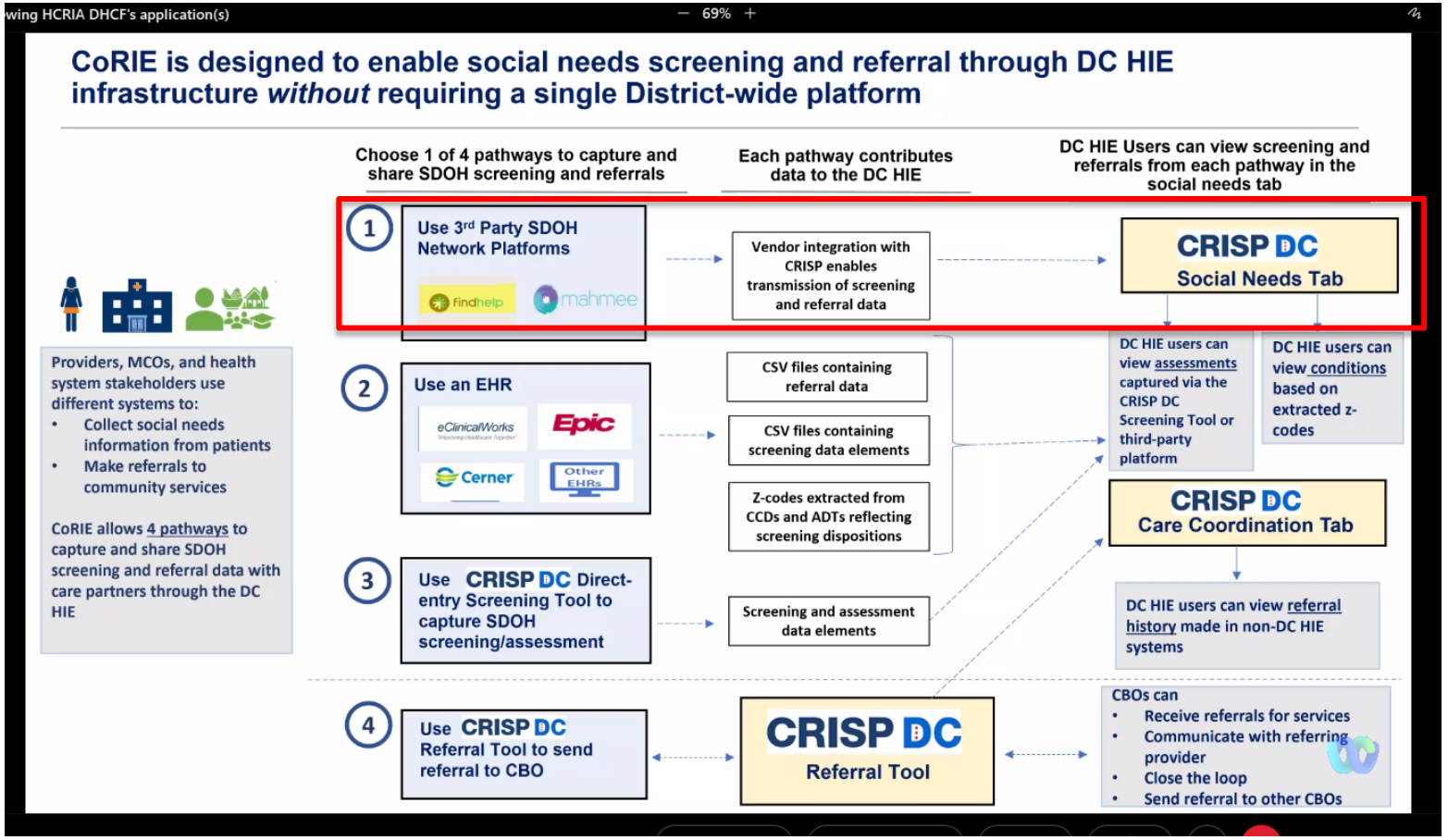


FUTURE STATE: Closed-loop Referral Tools: FindHelp (fka Aunt Bertha)

Find Help is a 3rd party SDoH screening and closed-loop referral platform

Staff can screen/refer to community partners, or <u>patients can self-navigate</u> to find services

- With support from the DCPCA, WWH is exploring how we can use FindHelp to close the referral loop and connect patients to resources
- FindHelp is also another way WWH can contribute SDoH screening data to the DC HIE and CRISP



Thank you.

WHITMAN-WALKER HEALTH
we see you.

202.745.7000 whitman-walker.org

Whitman-Walker Health
1525 14th St., NW
Washington, DC 20005

Whitman-Walker at LIZ
1377 R Street, NW, Suite 200
Washington, DC 20009

Max Robinson Center
2301 Martin Luther King Jr. Ave., SE
Washington, DC 20020

QUESTIONS?

THANK YOU!

NATIONAL ASSOCIATION OF
Community Health Centers®

PLEASE VISIT US ONLINE nachc.org

Additional Resources/Slides

DC Community Resource Information Exchange (CoRIE)

David Poms, MPH
Partnerships Manager,
DC Primary Care Association
dpoms@dcpca.org

Community Resource Inventory

What is the CRI?

- District-wide, publicly available directory that provides information about regional health, human, and social service organizations in the community that are available to District residents.
- Data available in the CRI include information such as organization and program description, location, contact information, service category, service eligibility, and more

Who is involved?

- Built in collaboration with various regional data stewards that curate information about community-based and social service organizations that address unmet social needs
- Component of the DC HIE and is currently maintained by the DC Primary Care Association, in partnership with the Open Referral Initiative, with technology developed by Sarapis.

How can it be used?

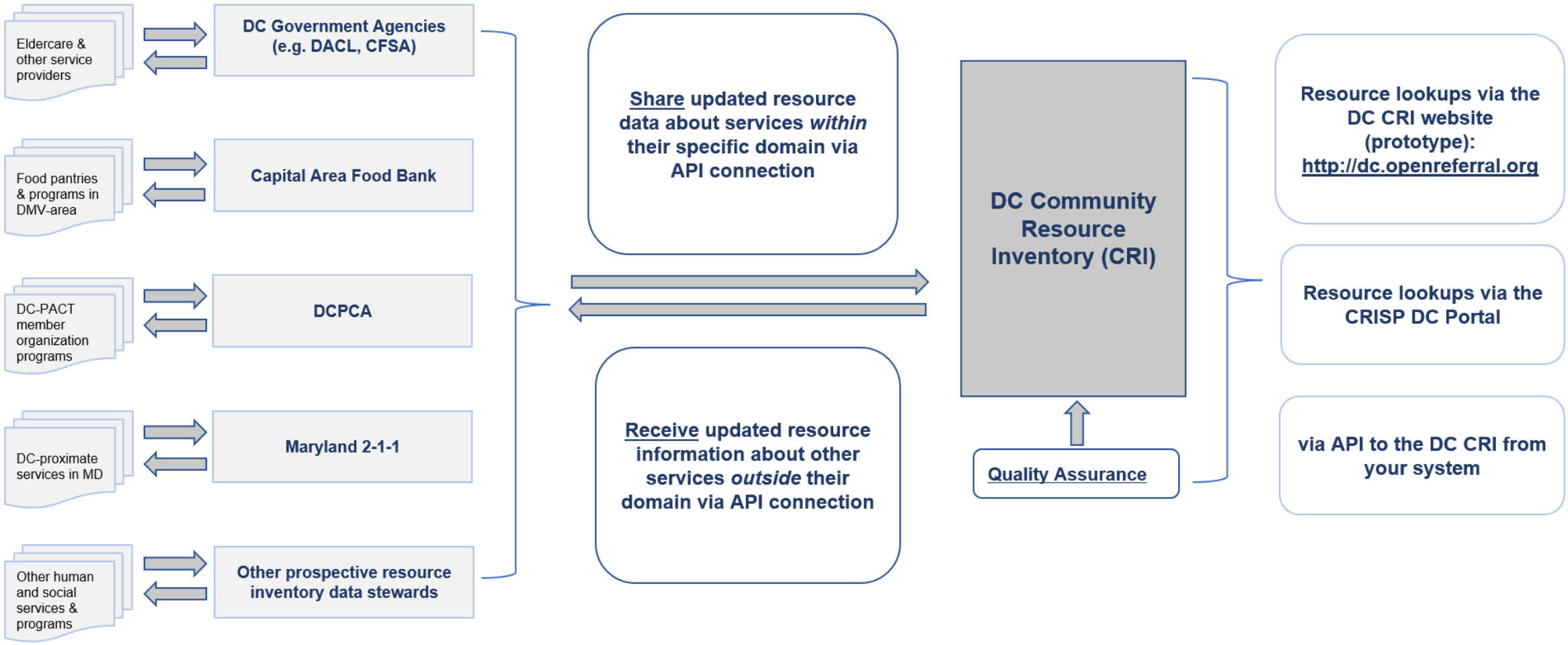
- Lookup and identify resources
- Refer to appropriate community and support services using the contact information available for each organization, which can include phone number, email, and address

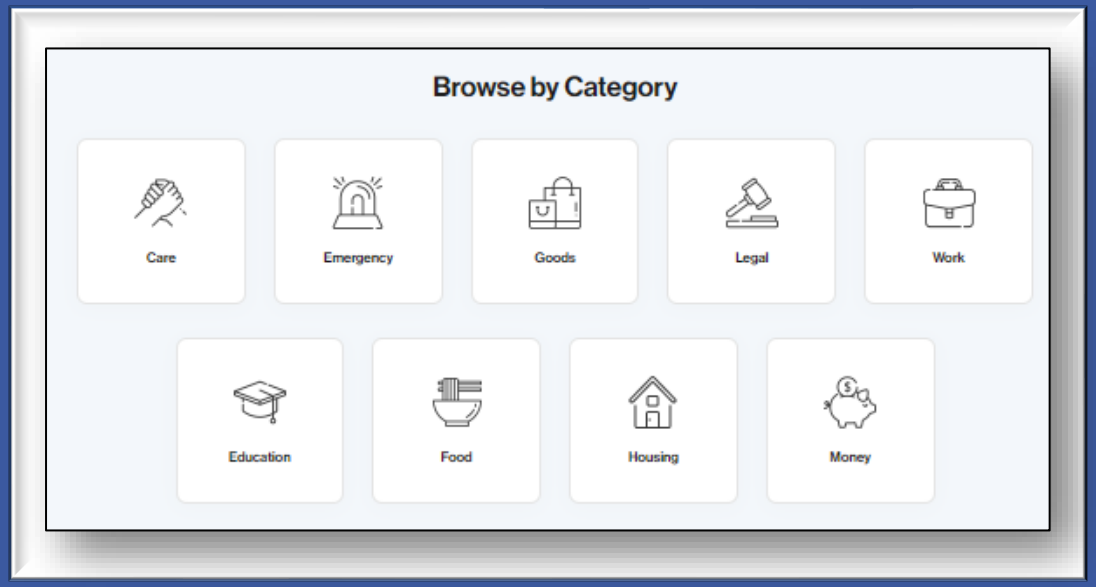
How can resource data be shared with the CRI?

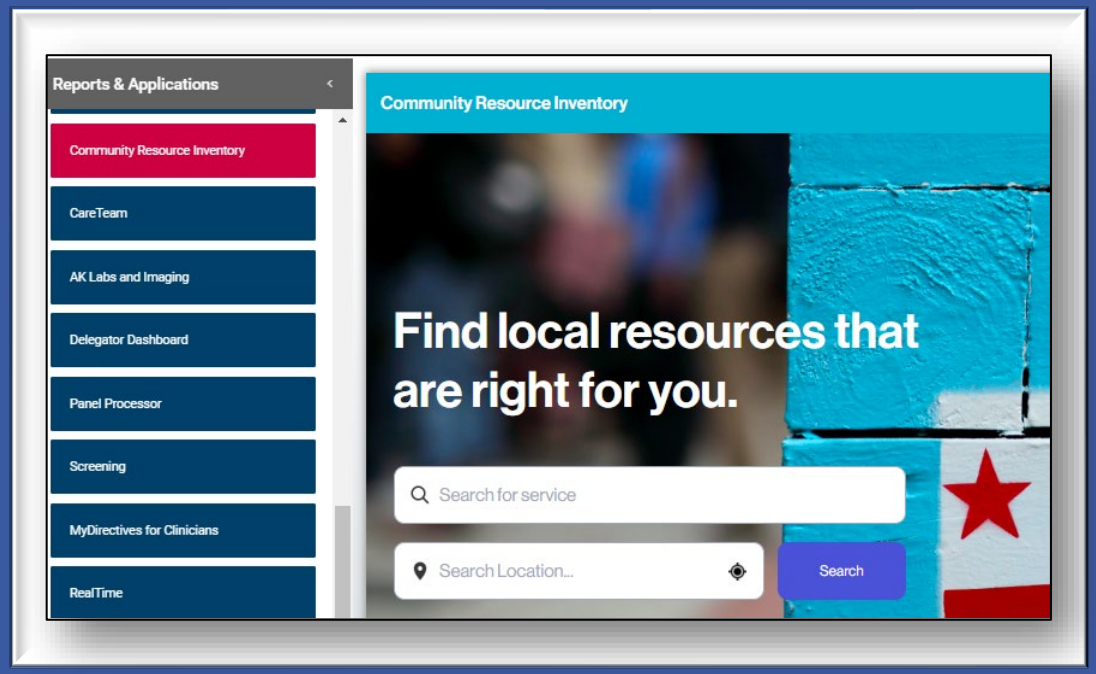
- Organizations can share their own resource data with the CRI by agreeing to become a CRI data steward
- Users can recommend organization data be made available in the CRI by reaching out to David Poms, DCPCA Partnerships Manager

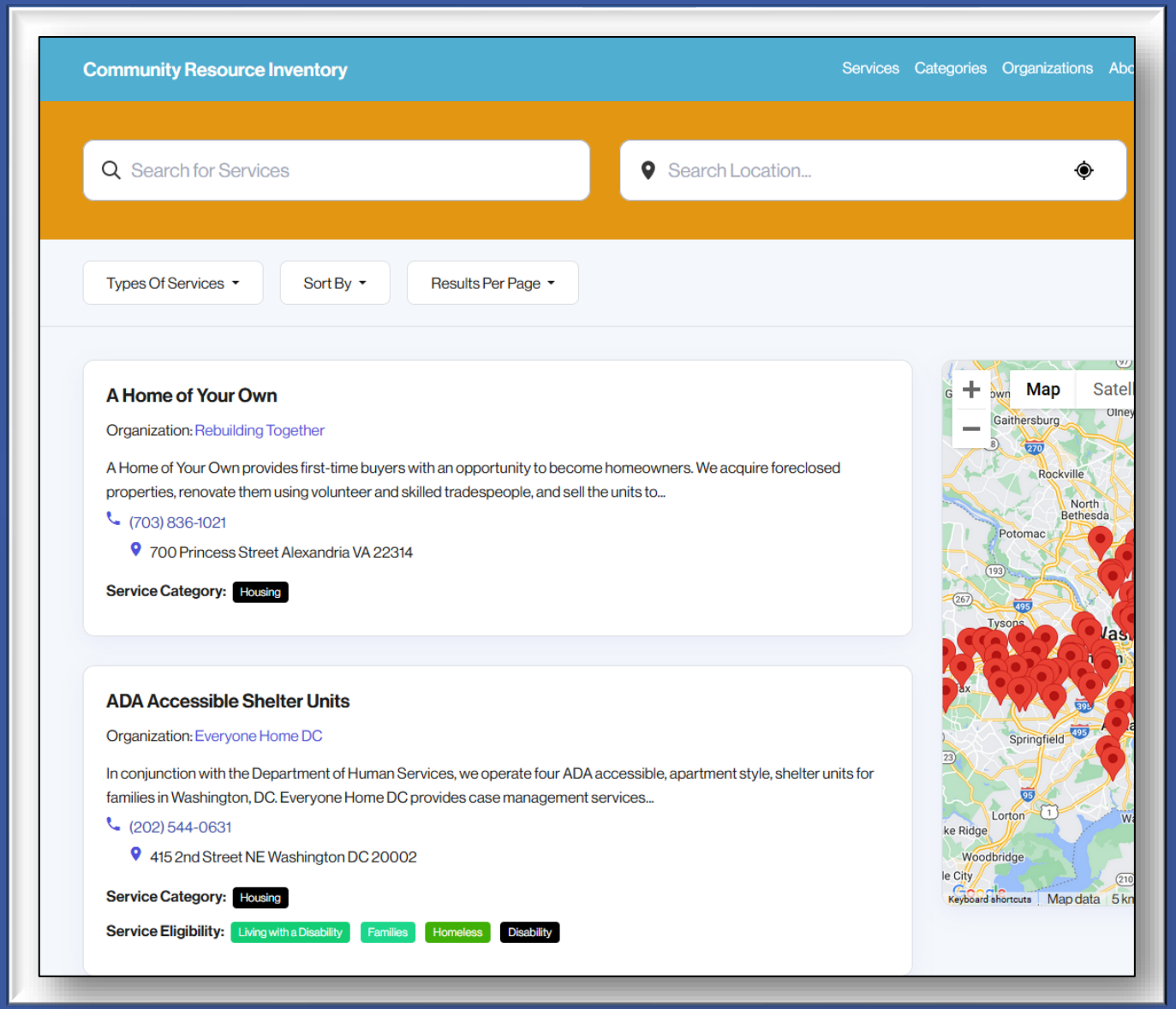
Community Resource Inventory

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




Browse by Category
Care
Emergency
Goods
Legal
Work
Education
Food
Housing
Money


Reports & Applications
Community Resource Inventory
CareTeam
AK Labs and Imaging
Delegator Dashboard
Panel Processor
Screening
MyDirectives for Clinicians
RealTime
Community Resource Inventory
Find local resources that are right for you.
Search for service
Search Location...
Search


Community Resource Inventory
Services
Categories
Organizations
Search for Services
Search Location...
Types Of Services
Sort By
Results Per Page
A Home of Your Own
Organization: Rebuilding Together
A Home of Your Own provides first-time buyers with an opportunity to become homeowners. We acquire foreclosed properties, renovate them using volunteer and skilled tradespeople, and sell the units to...
(703) 836-1021
700 Princess Street Alexandria VA 22314
Service Category: Housing
ADA Accessible Shelter Units
Organization: Everyone Home DC
In conjunction with the Department of Human Services, we operate four ADA accessible, apartment style, shelter units for families in Washington, DC. Everyone Home DC provides case management services...
(202) 544-0631
415 2nd Street NE Washington DC 20002
Service Category: Housing
Service Eligibility: Living with a Disability Families Homeless Disability
Map
Gaithersburg
Rockville
North Bethesda
Potomac
Tysons
Springfield
Lorton
Woodbridge
Keyboard shortcuts
Map data

Business Drivers

- The objectives of the CoRIE project and Gravity pilot align and are driven by the following:

DHCF's State Medicaid Health IT Plan

The DC Department of Healthcare Finance's State Medicaid Health IT Plan (SMHP) prioritizes that the "*collection, exchange, and use of SDOH data will maximize interventions to support individual health, reduce barriers to access, and improve the efficiency of person-centered services*".

DC PACT Strategic Goals

A DCPCA-led SDOH coalition, whose strategic goals state that by December 2024, we should:

- Successfully incorporate social risk management into DC Medicaid value-based payment and quality improvement forums
- Ensure all relevant DC PACT partner staff are using DC HIE-connected solutions for social risk assessment and analytics, resource location, and care team coordination

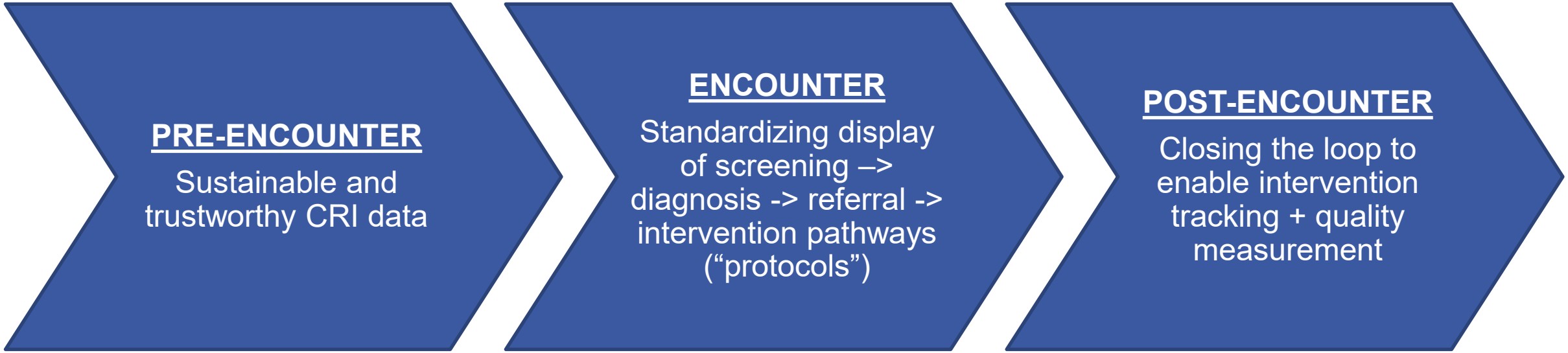
CRISP DC Goals

CRISP DC, as part of CRISP Shared Services, is driven by ensuring that the HIE connects care partners, including health and social service providers, and serves as a hub for actionable social needs data

Pilot Goals

Hypothesis: We can enhance the navigation + referral process by creating sustainable and trustworthy referral protocols within our CRI using Gravity Project codes as service-level metadata

- Deploy z-code search within the CRI
- Deploy z-code search + intervention tracking in CRISP referral tool and patient record



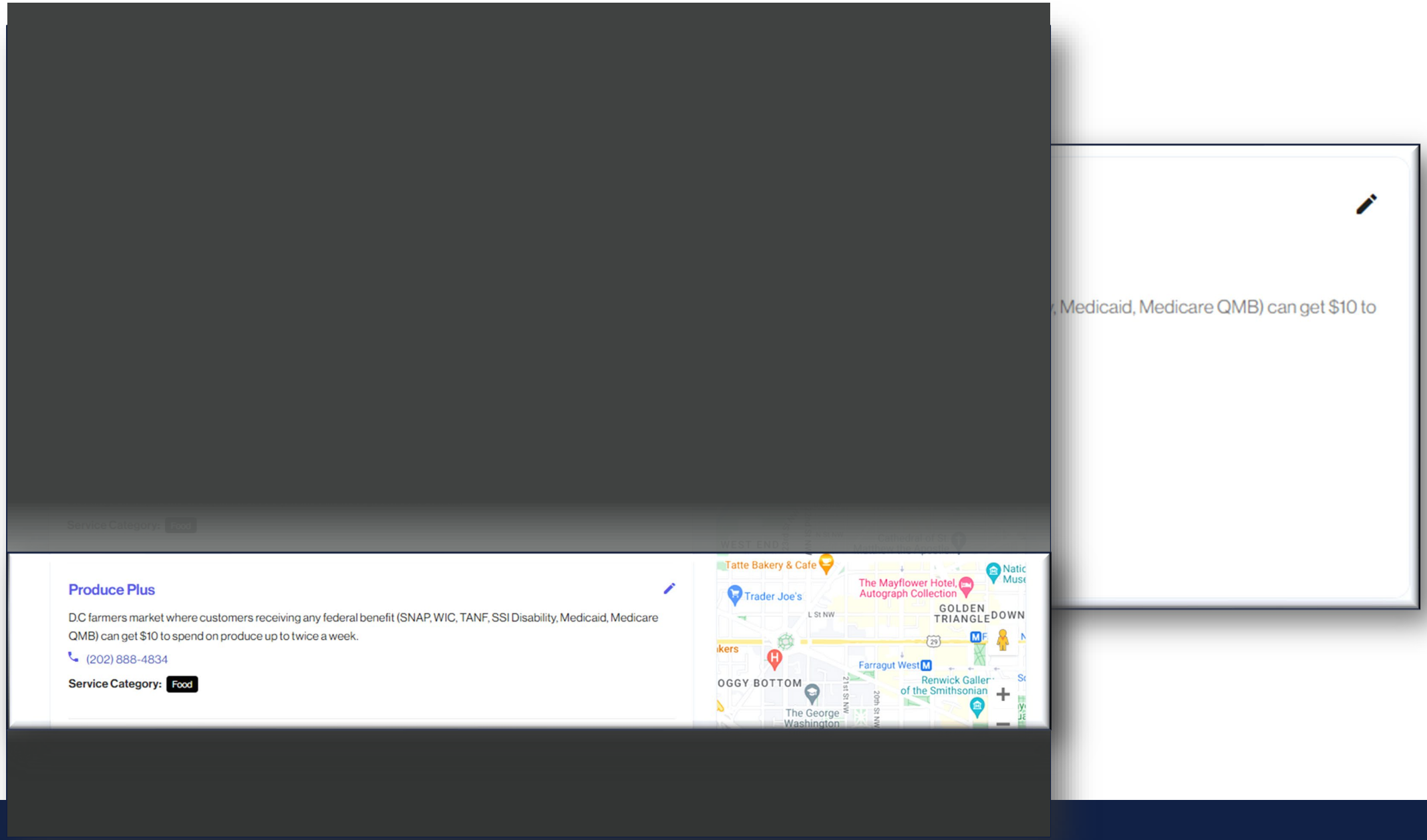
CRI Database Management – SDOH Codes

- CBOs are listed in our prototype CRI tool – dc.openreferral.org

- The CBOs (or an intermediary) may utilize the tool –
  - Organizations may log-in to the tool to verify information or maintain the accuracy of all human-readable fields associated with the CBO or service offered
  - Organizations may classify their services using various taxonomy schema, including:
    - **Gravity Project** (Conditions, Goals, and Procedures)
    - Human Services Data Specification (HSDS)
    - 211 LA/ MD
    - Open Eligibility (FindHelp)

SDOH Code	SDOH Code Category	SDOH Code Resource	SDOH Code Resource Element	SDOH Code Description	SDOH Code Type	Rating	Service	Grouping	Organization
Z56.6	Employment Status	Condition	Condition.code	Other physical and mental strain related to work	ICD-10-CM	1	Asthma Home Visiting Services		Yachad
Z56.6	Employment Status	Condition	Condition.code	Other physical and mental strain related to work	ICD-10-CM	1	Access Helpline (call for any DBH services)		DC Department of Behavioral Health (DBH)
None	Food Insecurity	Procedure	Procedure.grouping	Provision	Gravity Grouping	3	Produce Plus		DC Greens
706875005	Food Insecurity	Condition	Condition.code	Insufficient food supply (finding)	SNOMED CT US	3	Produce Plus		DC Greens
Z91.110	Food Insecurity	Condition	Condition.code	Patient's noncompliance with dietary regimen due to financial hardship	ICD-10-CM	3	Produce Plus		DC Greens
G-8	Food Insecurity	Goal	Goal.description	Has adequate quality meals and snacks	Gravity	3	Produce Plus		DC Greens
G-7	Food Insecurity	Goal	Goal.description	Has adequate number of meals and snacks daily	Gravity	3	Produce Plus		DC Greens
467811000124109	Food Insecurity	Procedure	Procedure.code	Assistance with application for Farmers' Market Nutrition Program for Women, Infants and Children (WIC)	SNOMED CT US	3	Produce Plus	1070	DC Greens

Example: Addressing Food Insecurity



Categories

- Employment Status
- Financial Insecurity
- Food Insecurity ☑
- Housing Instability/Homelessness
- Inadequate Housing
- Material Hardship
- Stress
- Transportation Insecurity
- Veteran Status

Food Insecurity

Conditions

Lack of safe drinking water or inadequate supply of drinking water	Empty
Nutrition impaired due to limited access to healthful foods (finding)	Empty
Severe food insecurity ("The stage in the food insecurity spectrum best characterized by effects on food quantity")	Empty
Moderate food insecurity ("The stage in the food insecurity spectrum best characterized by effects on food quality and variety and safety")	Empty
Lack of adequate food and safe drinking water	Empty
Patient's noncompliance with medical treatment and regimen	Empty
Lack of adequate food, inadequate food, or lack of food	Empty
Food insecurity (finding)	Empty
Insufficient food supply (finding)	3

Health-Related Social Conditions, also known as Z-Codes. Select any relevant domains in the blue boxes, and then use a dropdown menu from 1-3 to describe how appropriate this service would be as a first referral for the listed condition, where 1 is not appropriate, 2 is contextually appropriate, and 3 is almost always appropriate.

Activities

- Assessment ☐
- Assistance with application ☐
- Coordination ☐
- Counseling ☐
- Education ☐
- Evaluation of eligibility ☐
- Provision ☑
  - Provision of home-delivered meals (procedure) ☐
  - Provision of food prescription (procedure) ☐
  - Provision of fresh fruit and vegetable voucher (procedure) ☑
  - Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes ☐
  - Provision of infant formula prescription ☐
  - Provision of medically tailored meals (procedure) ☐
  - Provision of food voucher (procedure) ☐
  - Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 mintues ☐
  - Provision of food (procedure) ☐
  - Medical nutrition therapy; re-assessment and intervention, individual, face-to- face with the patient, each 15 mintues ☐

Service-level Intervention Activities: Use the checkboxes under each relevant domain to describe relevant components of this service.

Standards and Technologies Under Consideration

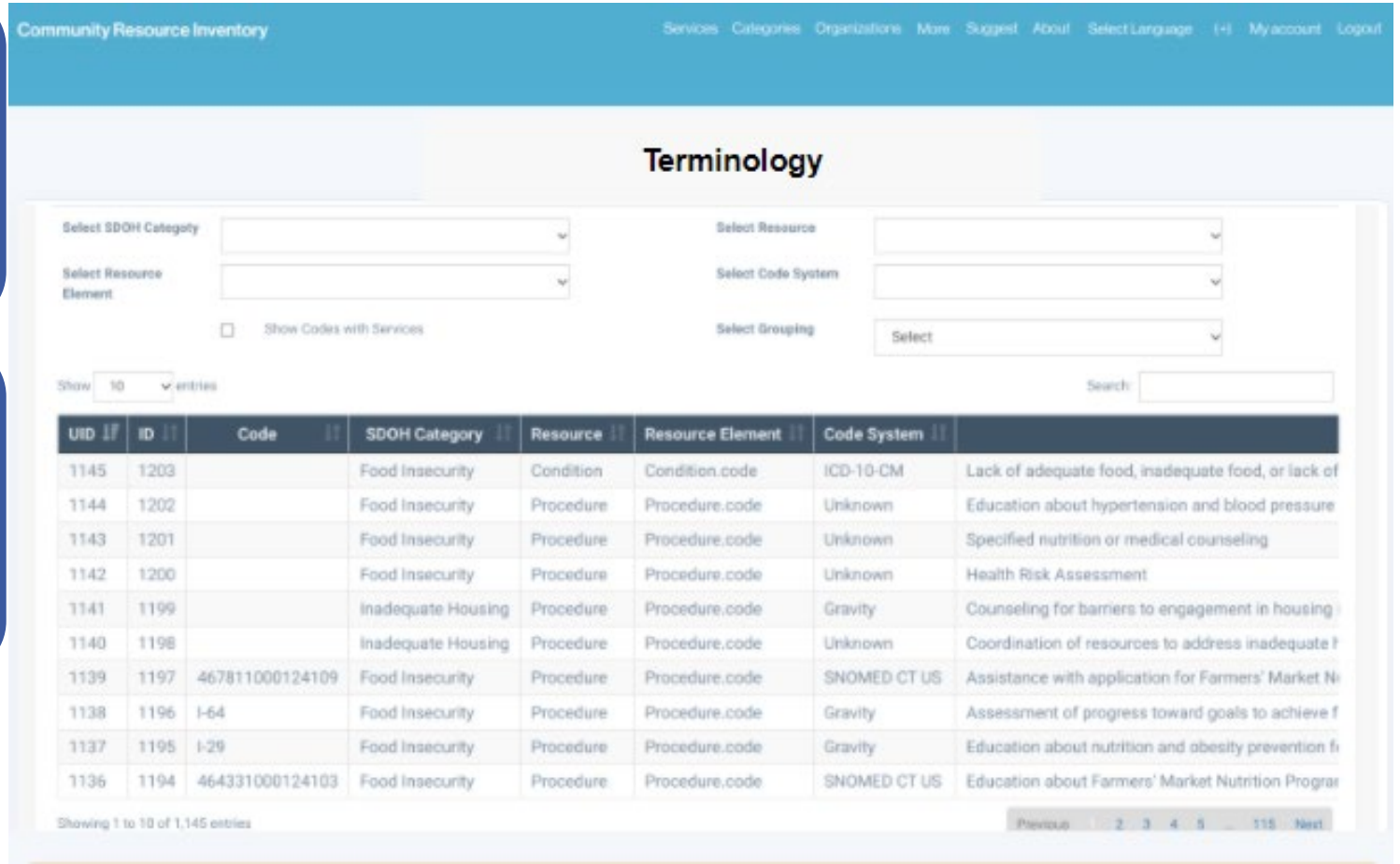
SDOH Domain	Gravity Terminology	Exchange Standards
• Food insecurity • Inadequate Housing • Housing Insecurity • Transportation Instability • Financial Instability	• Diagnosis (SNOMED-CT, ICD-10-CM) • Goals (SNOMED CT) and • Interventions (SNOMED-CT, CPT, HCPCS)	APIs, C-CDA

Pilot Workflow

Phase 1: The DC CRI team will add gravity metadata to at least 50 service records in the CRI across the domains of food, housing, transport, and finance.

Phase 2: The DC CRI will collect z-code data and enable the ability the search for z-codes on the CRI home page

- DCPCA will reach out to 5 DC FQHCs with an existing z-code workflow to search for programs using the CRI
- DC FQHCs will provide feedback on whether search results indicate appropriately coded services and organizations



Pilot Workflow

Phase 3: CRISP DC to build out an internal program directory for the CRISP Referral Tool, which will support searching for programs based on location, service category, eligibility and associated z-codes pulled from the CRI

- CRISP DC will enable HIE-connected providers to make closed-loop referrals using z-code metadata on programs pulled from the CRI
- Captured Z-code information will be part of a patient's referral record
- A patient's care team will be able to view the z-code that led to a social needs intervention at point-of-care

Pilot Logistics

- Timelines and Milestones

- Challenges
  - FQHC bandwidth to pilot and provide feedback
  - Onboarding CBOs to the CRISP Referral Tool that have gravity metadata in the CRI

Success Metrics

- Increase in FQHCs, and other provider types, using the DC CRI to search for and by z-codes
- Increase in FQHCs, and other provider types, using z-codes to search for programs in the CRI and make closed-loop referrals
- Providers at point-of-care being able to see the z-code that led to a social needs intervention
- Population health analytics allowing longitudinal cohort comparisons stratified by social health interventions

Resources/References

Public link to DC CRI

- Home | Community Resource Inventory (openreferral.org)

DHCF 2022 SMHP

- State Medicaid Health IT Plan (SMHP) and Roadmap | dhcf (dc.gov)

DCPCA - DC PACT

- dcpca.org/dc-pact
- CRI Background on Open Referral Blog
- CHCS Issue Brief on data sharing - Data Across Sectors for Health

CRISP DC Webpages

- www.crispdc.org/screening
- www.crispdc.org/referrals
- www.crispdc.org/CRI