Office of the National Coordinator for Health Information Technology

From Challenges to Solutions: Exploring ONC SDOH Information Exchange Tools and Resources

Friday, December 15, 2023

ONC Annual Meeting

Agenda

- Introductions
- HHS SDOH Action
- ONC SDOH Information Exchange
  - Background on ONC SDOH Information Exchange Activities
  - ONC SDOH Information Exchange Learning Forum Themes from the Community
- Panelists
- Audience Breakouts
- Questions and Discussion

Session Speakers

Meley Gebresellassie
ONC

John Rancourt
ONC

Lauren Girard
Contexture

Eliel de Oliveira
ConnXus, Harvard Medical School

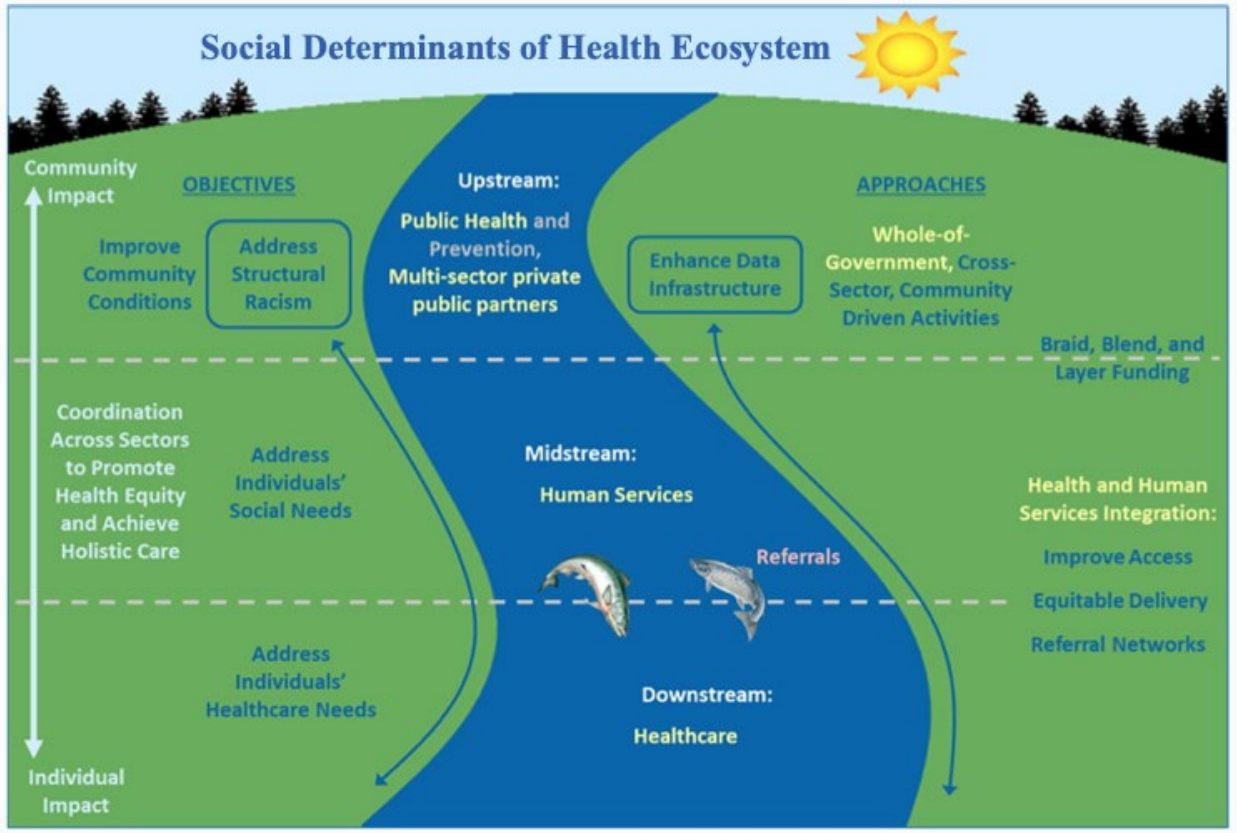
ONC SDOH Information Exchange HHS SDOH Alignment

HHS SDOH Action Plan

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

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

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



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

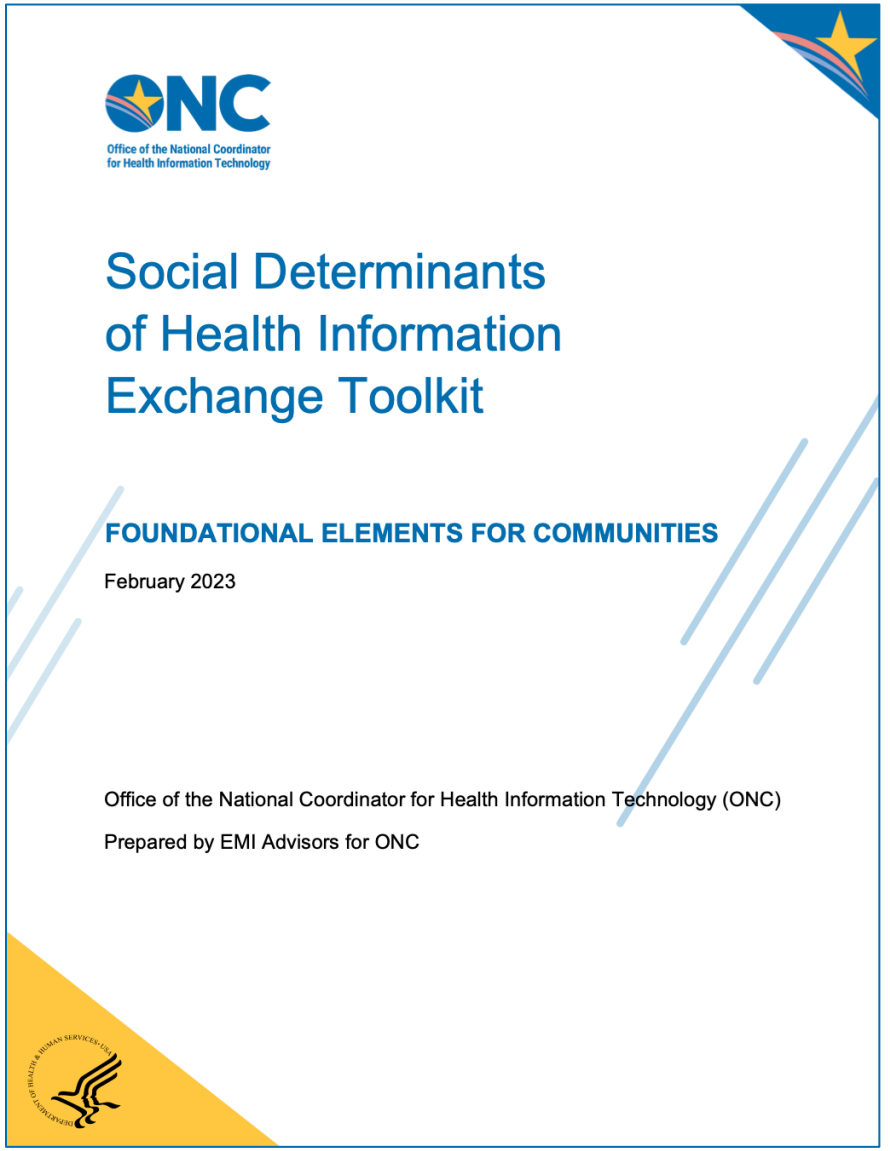
https://aspe.hhs.gov/sites/default/files/documents/aabf48cbd391be21e5186eeae728ccd7/SDOH-Action-Plan-At-a-Glance.pdf

Background on ONC SDOH Information Exchange Activities

ONC SDOH Information Exchange Toolkit publication

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

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



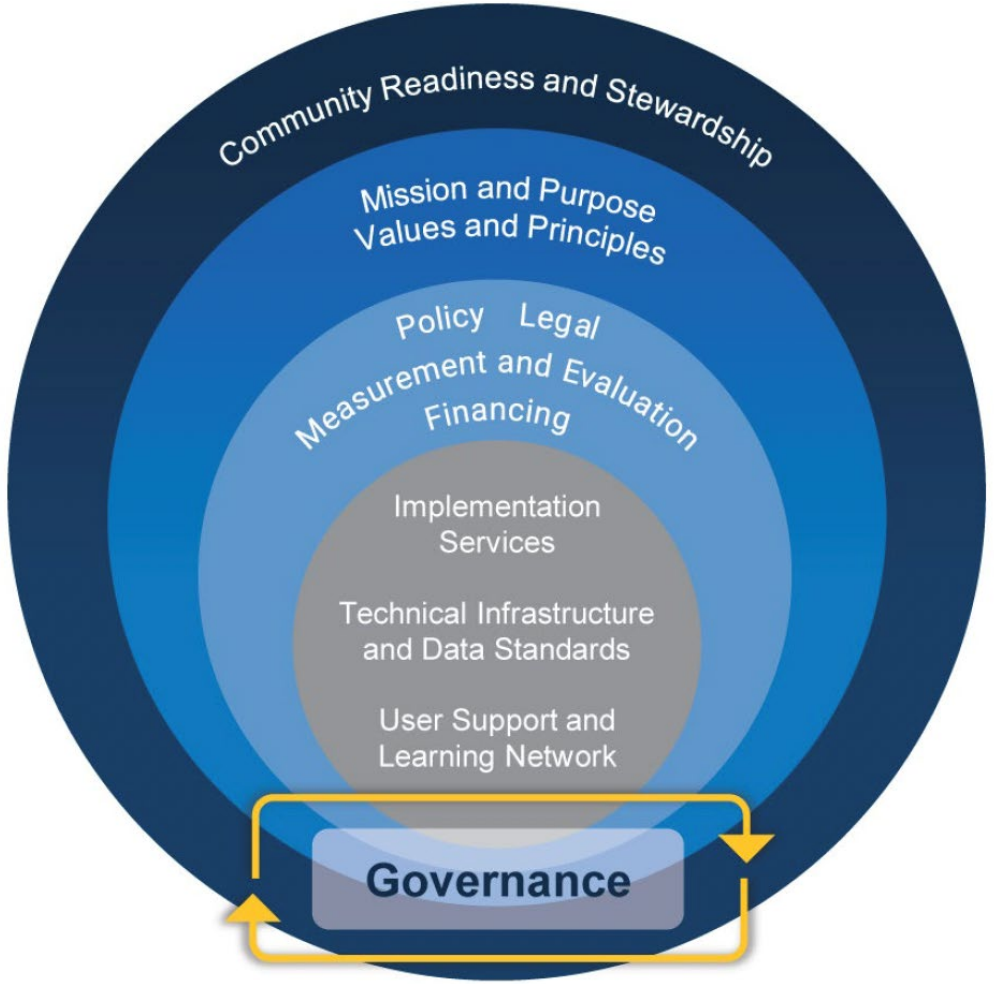
Purpose of the Toolkit

- The SDOH Information Exchange Toolkit is intended to be a practical guide that enables implementers of SDOH information exchange to learn more about the current landscape and identify key considerations and approaches to advance their goals through the consideration of important Foundational Elements.
- This Toolkit focuses on Foundational Elements for planning, implementing, and evaluating SDOH information exchange initiatives.

Intended Audience:

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

Social Determinants of Health Information Exchange Foundational Elements



ONC SDOH Information Exchange Select Learning Forum Takeaways

Learning Forum Themes from the Community

- Community stewardship and co-designed governance are critical and resource intensive
- Standards-based, vendor-agnostic approaches to SDOH information exchange will enable interoperability
- FHIR® awareness and readiness varies
- Limited awareness and understanding of policies for data sharing with non-HIPAA covered entities

The University of Texas at Austin
Dell Medical School

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Optimizing Referrals to the Supplemental Nutrition Assistance Program (SNAP) Through a Clinically Integrated, Interoperable, Standards-Based, and Scalable Social Services Referral Management System

Principal Investigator:
Eliel Oliveira
Harvard Medical School

Co-Principal Investigator:
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ONC Project Officer:
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Technical Advisor:
Evelyn Gallego
EMI Advisors

Pilot Site:
Bella Kierchner
Central Texas Food Bank

Partners

Funding from the Leading-Edge Acceleration Projects (LEAP) in Health IT from the Office of the National Coordinator for Health IT (ONC).

ONC Office of the National Coordinator for Health Information Technology

Providers

Integral Care

Central Texas Food Bank

People's Community Clinic

HIEs

connexus
Central Texas

GNOHIE Greater New Orleans Health Information Exchange
New Orleans

Connected Care Exchange
Rio Grande Valley

Technical

emi ADVISORS

gravity PROJECT

findhelp

UNITE US

Project Aims

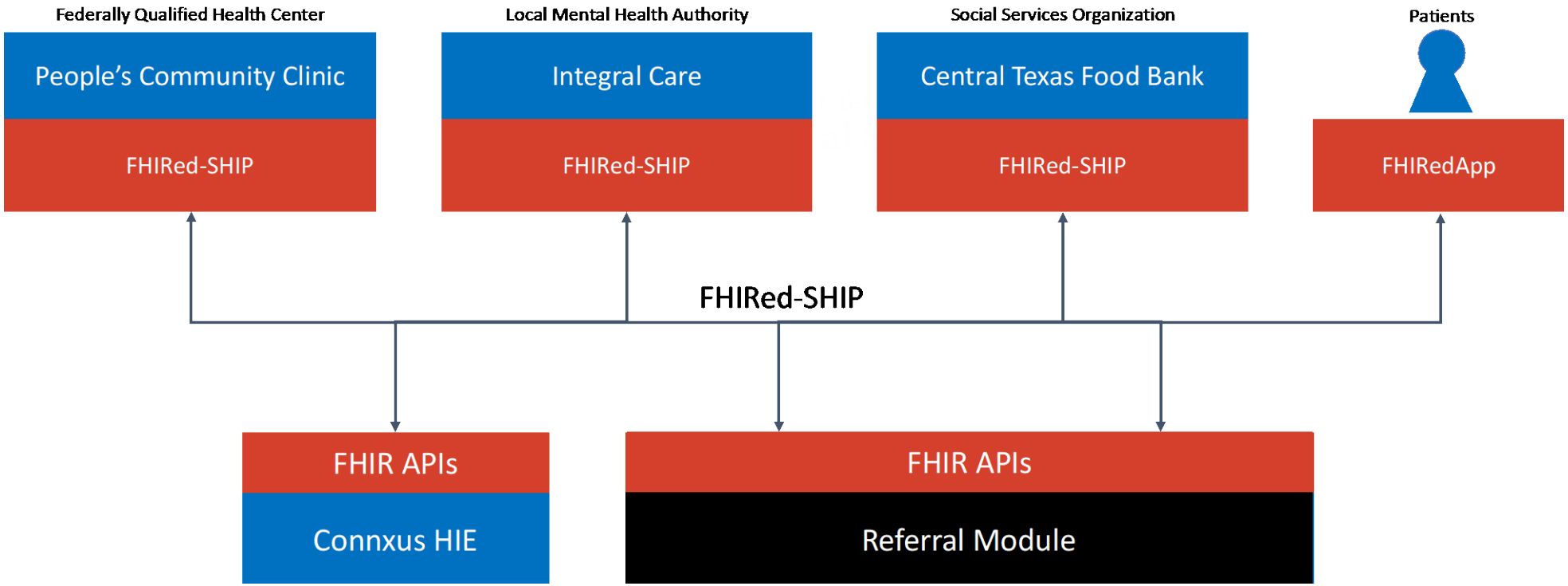
Aim 1 Develop an open-source, “closed loop” social services referral management system, ***FHIRed-SHIP***, using IT standards and FHIR APIs in an FQHC and LMHA

Aim 2 Demonstrate the feasibility of ***FHIRed-SHIP*** to fulfill the Gravity Project Use Cases Package for SDoH for screening, diagnosis, planning, and interventions in selected patients

Aim 3 Develop and implement a toolkit to pilot ***FHIRed-SHIP*** as a referral management system with the HIEs in Harlingen, TX and New Orleans, LA

FHIRed-SHIP

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

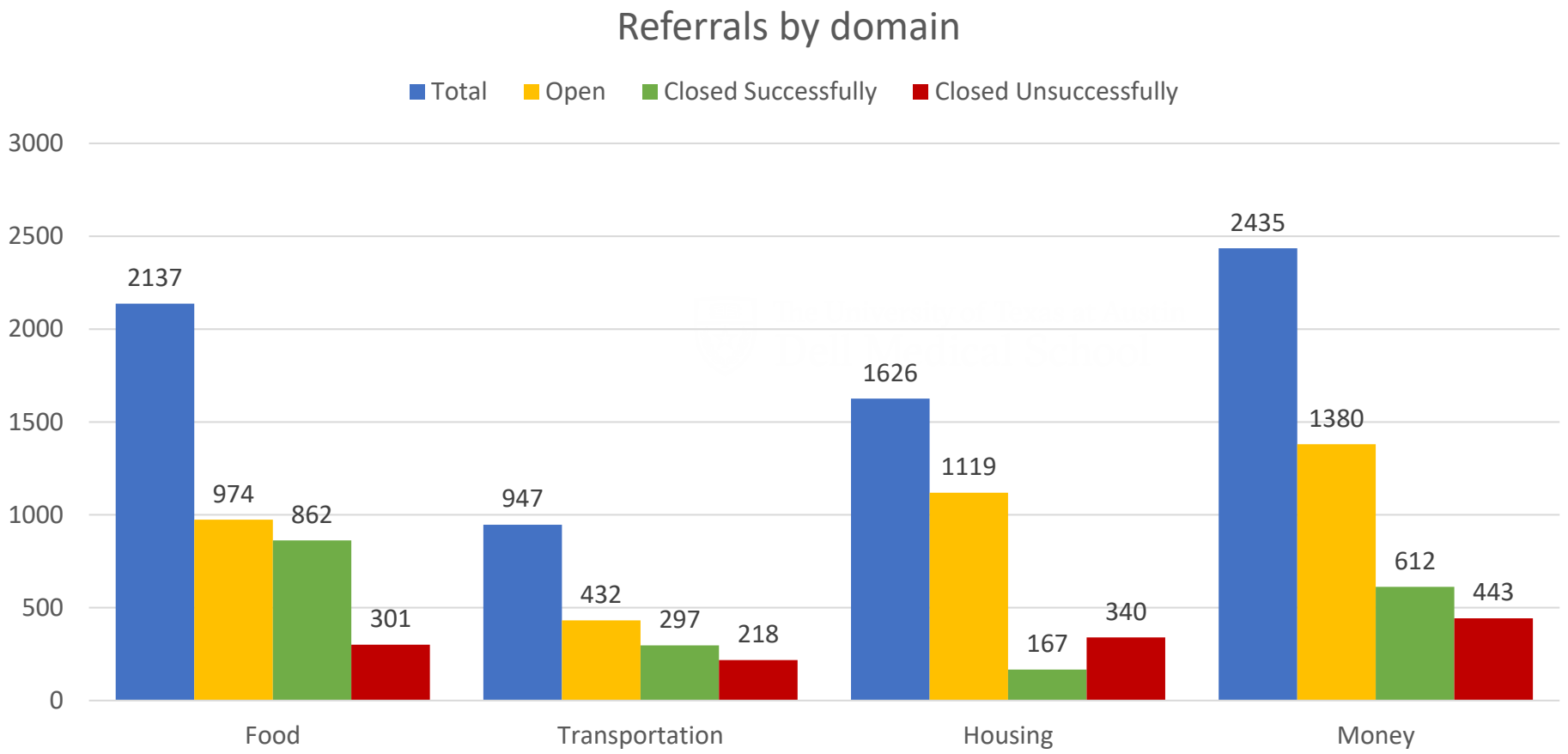


Supplemental Nutrition Assistance Program (SNAP)

- One of the most effective national programs to improve food security, reduce poverty, and improve health of millions
- Over 33 million individuals in the US still live in food-insecure households
- Clinical referrals to Community-Based Organizations (CBOs) increases SNAP access
- Referral systems have only increased access by 6% to 8%
- Lack of data sharing between clinical and social providers

- Keith-Jennings B, Llobrera J, Dean S. Links of the Supplemental Nutrition Assistance Program With Food Insecurity, Poverty, and Health: Evidence and Potential. Am J Public Health. 2019 Dec;109(12):1636-1640. doi: 10.2105/AJPH.2019.305325. PMID: 31693420; PMCID: PMC6836787.
- United States Department of Agriculture. How Many People Lived in Food-insecure Households?https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/key-statistics-graphics/#insecure
- Carpenter B, Kuchera AM, Krall JS. Connecting Families at Risk for Food Insecurity With Nutrition Assistance Through a Clinical-Community Direct Referral Model. Journal of Nutrition Education and Behavior, Volume 54, Issue 2, 2022. Pages 181-185. https://doi.org/10.1016/j.jneb.2021.09.014
- Stenmark SH, Steiner JF, Marpadga S, Debor M, Underhill K, Seligman H. Lessons Learned from Implementation of the Food Insecurity Screening and Referral Program at Kaiser Permanente Colorado. Perm J. 2018;22:18-093. doi: 10.7812/TPP/18-093. PMID: 30296400; PMCID: PMC6175601.

Community Impact



Average number of days a referral is open – 26 days

% of open referrals high – need to further investigate

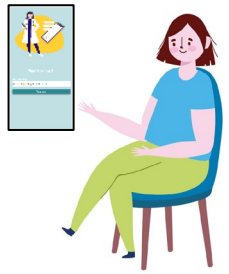
Referral closure rates vary by domain, demonstrating the inherent difficulty in closing some needs such as housing where supply is not sufficient to meet demand

Patient

Central Texas Food Bank (CTBF) Staff

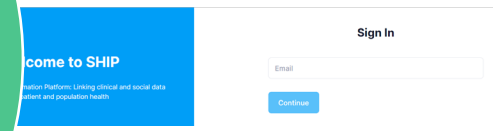
Community Health Worker (CHW) at clinic

① Patient downloads the App and consents to participate



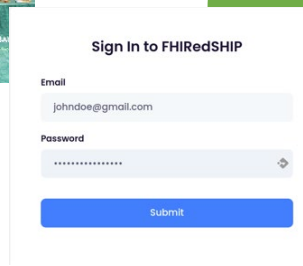
② Patient completes SDoH assessment on the App

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



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

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



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

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

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Creating connections. Improving lives.

Social Data Exchange
Colorado and Arizona Use Cases

Lauren Girard
Vice President, Business Line Management
Contexture

December 15, 2023

Health Information Exchange (HIE) Expertise

Building Networks

- Community and Stakeholder Networks
- Technical Efforts

Privacy and Security

- Extensive experience and knowledge about HIPAA
- Data sharing agreements and contracting, and

Data Normalization and Translation

- Health data today
- Social data today

Colorado

Technical Infrastructure and Data Standards

Support Vendor Agnostic Approaches to SDOH Information Exchange

e-Referral

Contexture

SDOH Notifications

Contexture

Community Resource Network (CRN)

Quality Health Network (QHN)

E-Referral

- Utilize existing HIE connections
  - Continuity of Care Documents (CCD)
  - 211 API
- Closed Loop Referral
  - CCD ➔ eFax or API to external system ➔ CCD
- Use Cases
  - Boulder County Connect
  - Developmental Screening Referral, Early Intervention with Colorado Department of Public Health and Environment (CDPHE)

SDOH Notifications

- Utilize existing HIE infrastructure
- Push data model
  - Route based on member files
  - Feed directly to EHR, Case Management system or secure folder
- Ongoing data assessment
  - Scalable to new use cases
- Use Cases
  - Positive Assessments, supports Hospital Transformation Program
  - Referral Activity

Community Resource Network (CRN)

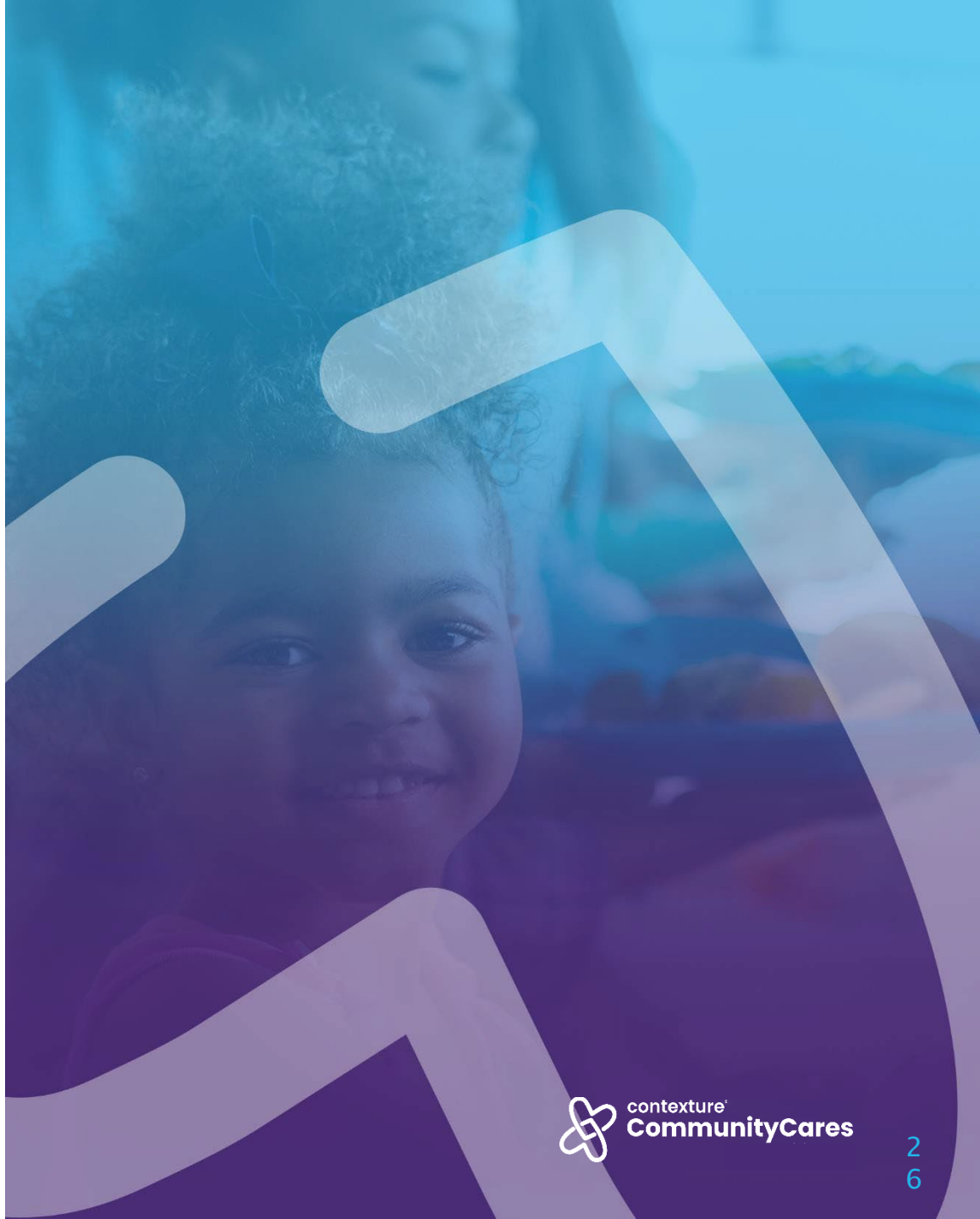
Quality Health Network (QHN)

- CRN was developed to enable providers of medical, social and behavioral health services to:
  - Better communicate
  - Collaborate
  - Share data
  - Coordinate the care of their patients/clients
- Integration with HIE, sharing pertinent data elements into CRN
- Integration with 211

CRN Community RESOURCE NETWORK

Arizona: CommunityCares

- Community Readiness and Stewardship
- Codesign SDOH Information Exchange Governance
  - Arizona Medicaid, Whole Person Care Initiative
  - Community convening, diverse stakeholders
    - Built requirements for RFP process
  - Quality and incentive programs
  - Participant best practice facilitation
  - Ongoing stakeholder engagement
  - Partnership with 211



contexture® CommunityCares

Audience Breakout

Audience Breakout

Themes:

- Community stewardship and readiness
- Codesigning SDOH information exchange governance
- Information privacy, security, and individual consent
- Supporting vendor-agnostic approaches
- FHIR awareness & readiness
- Social sector engagement in information exchange standards development

Considerations:

- The problem
- The big idea
- The impact
- The return on investment
- Any assumptions and risks

Questions?

Resources

Learn More About SDOH Information Exchange! (links below)

- SDOH Information Exchange Toolkit
- 2020-2025 Federal Health IT Strategic Plan
- ONC Social Determinants of Health Webpage
- Addressing Social Determinants of Health in Federal Programs
- HHS's Strategic Approach to Addressing Social Determinants of Health to Advance Health Equity – At a Glance
- Social Determinants of Health Data Sharing at the Community Level
- The U.S. Playbook to Address Social Determinants of Health
- ACL Community Care Hubs

Office of the National Coordinator for Health Information Technology

Contact ONC

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