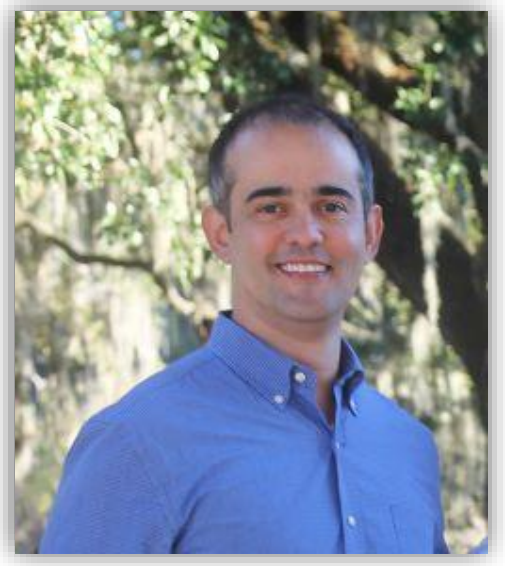
Addressing Health Equity through SDOH Data Sharing & Collaborative Efforts Across Texas

Speakers



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University of Texas at Austin

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Health Equity Collective

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What is the demonstrated need for systems changes to promote health equity in our communities?

1. Community Engagement and building coalitions with individuals, community organizations, industry, and government.
2. Governance that is not recreating community resources.
3. Technical Infrastructure through standards and strategic technical assets
   - Respond to governance, use cases and questions that need answers while Model Community (vision, coalition building, governance) is underway
   - Social and Health Information Platform (SHIP) focuses on the role of SDOH needs and referrals in clinical workflows (and schools, 211 centers, etc.)
   - HIEs ready for it with record matching, data integration and aggregation capabilities. But HIEs not ready for Role-Based Access Control (RBAC) for SDOH access and governance. *So what is the alternative?*

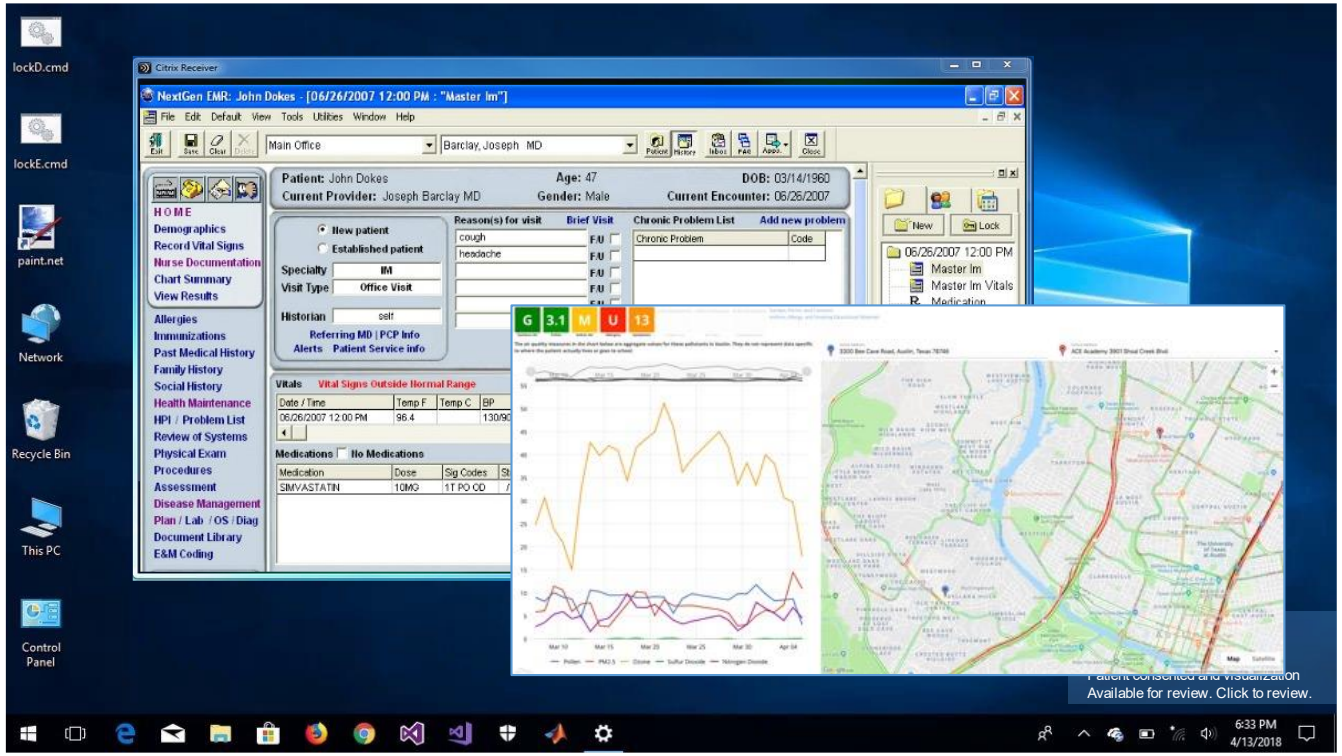
What is happening in Texas communities to achieve these improvements?

Social and Health Information Platform (SHIP)

- A digital platform that facilitates data sharing across sectors and integrates clinical and social sector data into user-friendly longitudinal records.

- SHIP makes health-related data (i.e. clinical + social) available in the workflow of care teams, including integrating with EHRs.

- SHIP aims to:
  - turn data into easy-to-read, actionable visuals
  - facilitate efficient and comprehensive patient care and coordination for individuals
  - provide enhanced insights into community-level health issues, service gaps, and possible solutions across sectors

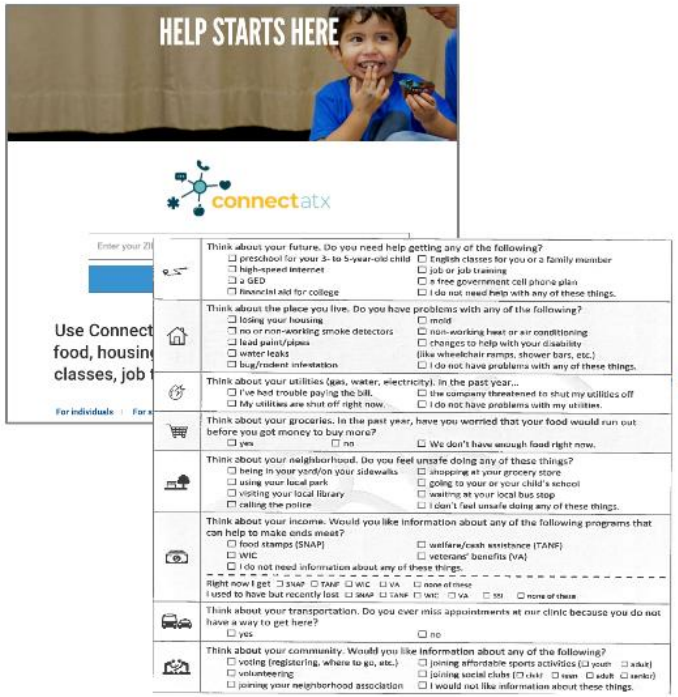


SHIP Data Sources

SDOH Needs

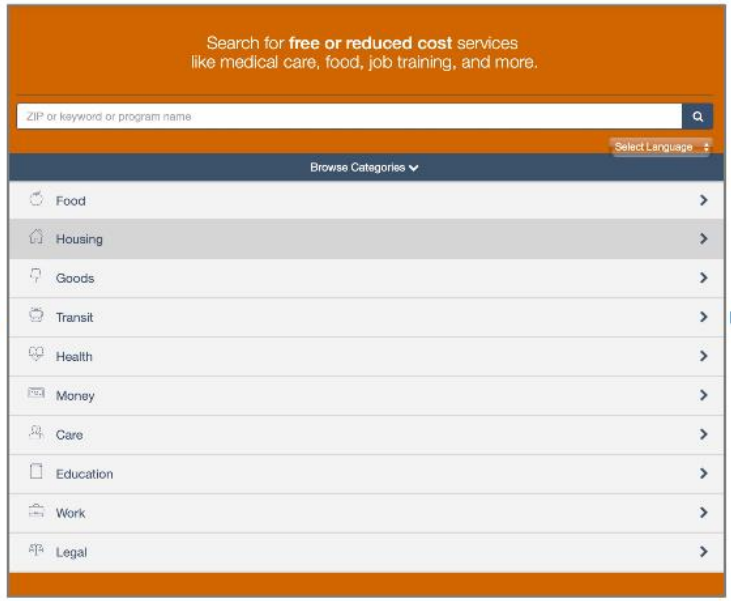
PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

United Way for Greater Austin



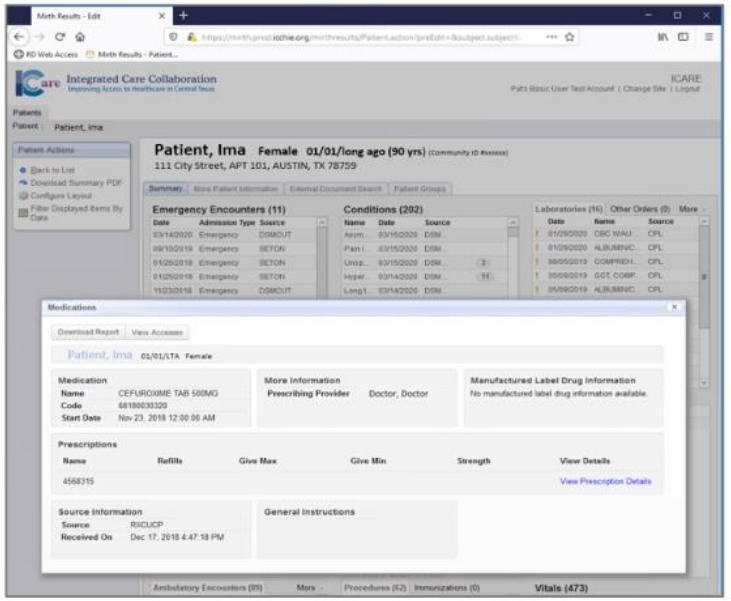
Social Services

findhelp



Clinical Services

connxus



Worklist for Community Health Workers (CWHs)

SDoH Next Steps: Assessment Needed
Consented patients with No SDoH Survey

Number of Patients: 4

Patient Name	MRN(s)	Last Survey Date ↓
Amy Campbell	710713, 710722	02/06/2021
		01/03/2021
Harry Russell	3504381	01/03/2021
		01/03/2021

Rows per page: 10 1-4 of 4

Only consented patient will be shown , non consented patient will not be shown in the list.

SDoH Next Steps: Referrals Needed
Consented patients with SDoH need and no referral placed

01/01/2018-01/20/2022

Number of Patients: 2

Patient Name	MRN(s)	SDoH Needs w/o refe
Amy Campbell	710713, 710722	

Rows per page: 10 1-2 of 2

Only consented patient will be shown, non consented patient will not be shown in the list.

SDoH Next Steps: Follow-Up Needed
Consented patients with no status update on referrals for 14+ days

01/01/2018-01/05/2022

Number of Patients: 8

Patient Name	MRN(s)	Number of referrals requ
Amy Campbell	710713, 710722	
Harry Russell	3504381	

Rows per page: 10 1-4 of 4

Only consented patient will be shown, non consented patient will not be shown in the list.

- Assists CHWs by organizing their 3 main SDoH-related tasks (left to right):
  1. completing SDoH assessments for individuals that don't have a current assessment
  2. placing referrals for identified SDoH needs, or
  3. updating the status of the ones with referrals made.

Patient-Level Summary of SDoH Assessments/Needs

Summary of SDoH Survey Results & Referrals: Patient

Breakdown of SDoH Survey Results and Any Referrals Placed in Aunt Bertha

Survey Date 02/05/2021

Domains need follow-up

Name of SDoH Survey: connectatx-help-form-archived-00

Facility Name: connectatx

Total number of social needs: 3

ALL OPEN REFERRALS

SDoH Domain	Need Exist?	# Referrals Placed	Referrals Open	Organization	Program	Referred On
care	Yes	0	0	works	youth	05/09/2022
education	Yes	0	0	works	youth	05/09/2022
food	Yes	0	0			05/09/2022
money	No	0	0	works	youth	05/09/2022

- Quickly summarizes past SDoH survey results, across organizations.
- Lists the org/program for any referrals placed, by SDoH domain (e.g. food).

Summary of Community SDoH Referrals, by outcome

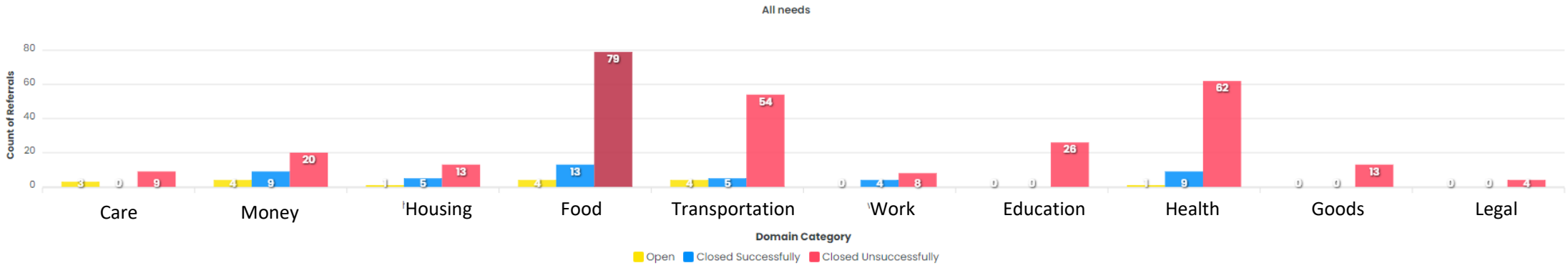
Summary of SDoH Referrals and Referral Statuses: Caseload

Breakdown of referrals made in Aunt Bertha by organization and specific program

Summary of Needs of All Patients

05/01/2018-05/05/2022 Show %

Number of patients displayed: 12



Domain: care

Patient Name	MRN(s)	Organization	Program	Referred On (latest ...	Days Since Referral ...	Referral Outcome	Who Placed Ref...
Harry Russell	3504381	Cook Country Department of Public Health	The Adverse Pregnancy Outcome Reporting System High Risk Infant Follow-up APORS	08/03/2021	22	helped not	vineetbioinfo@gmail.com

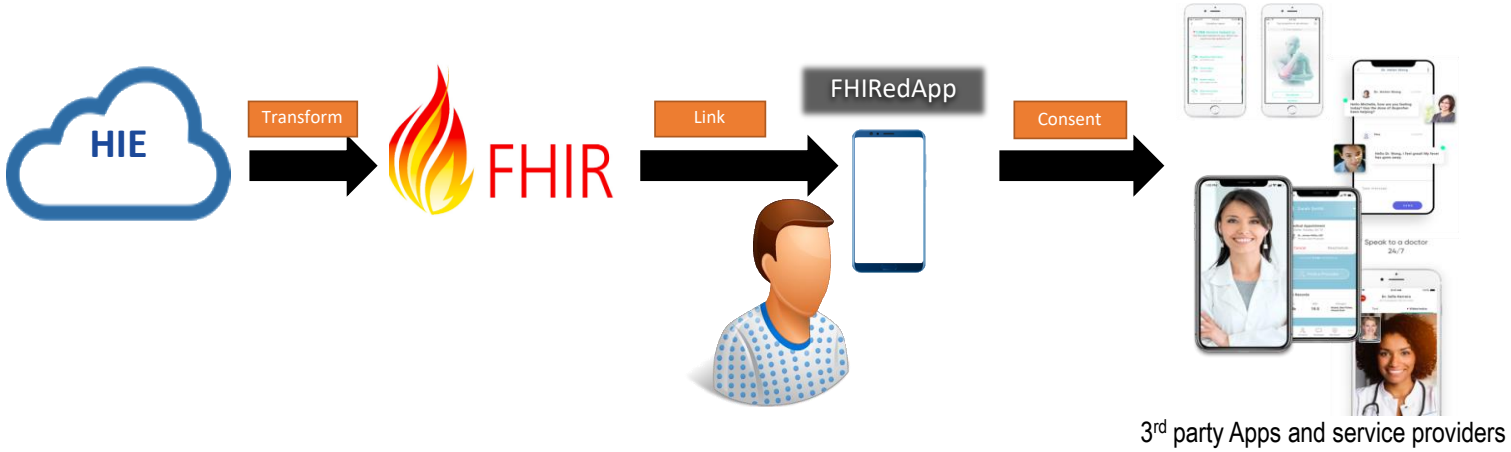
- Quickly summarizes outcome of referrals (red/yellow/blue) by SDoH domain
- Drill down: org name, referral date, patient, e-mail of staff who placed referral, etc.

ONC LEAP work on closed-loop referrals:

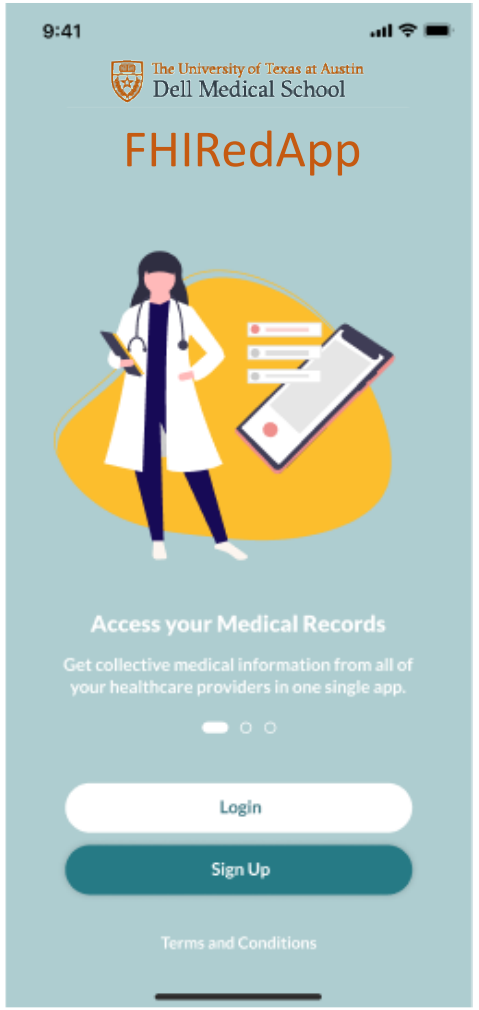
FHIRedApp & FHIRed-SHIP

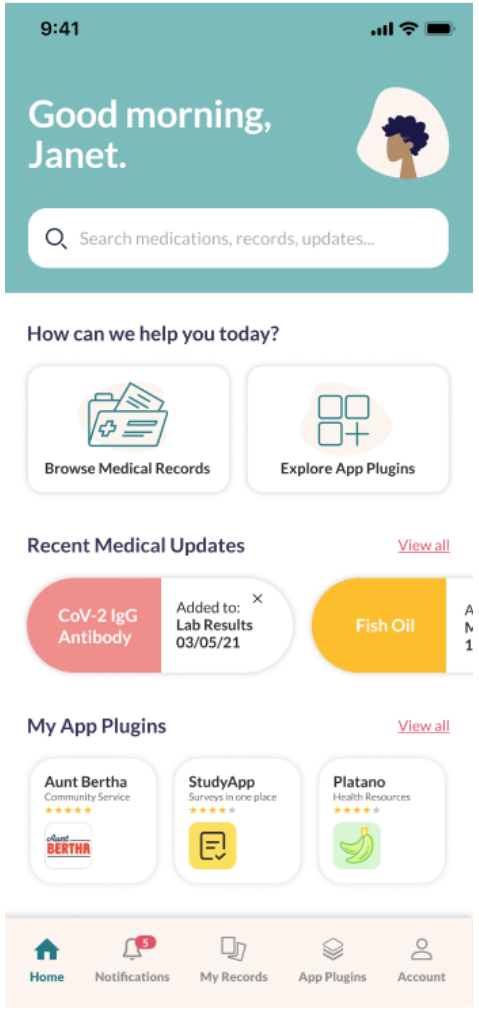
FHIRedApp – ONC LEAP 2019

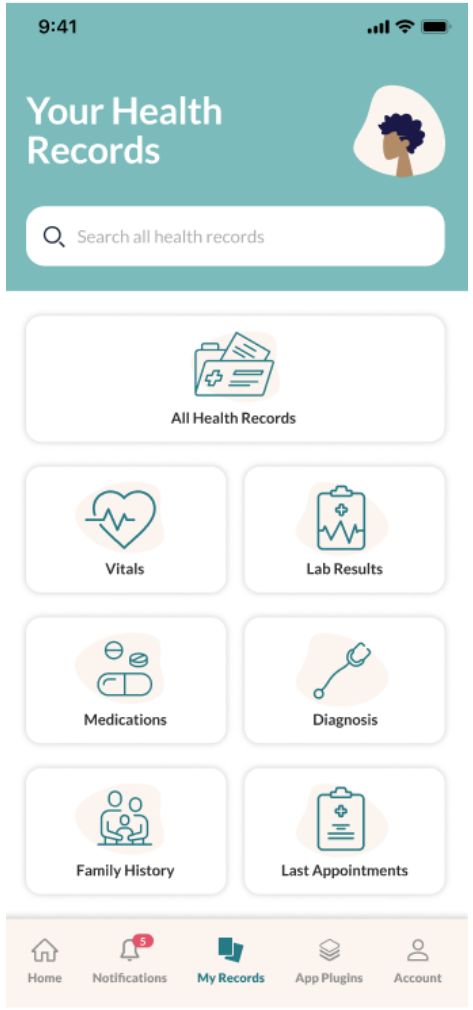
- FHIRedApp is a Patient Engagement Technology that makes it easy for patients to gain access and provide access to their own health data, as defined in the 21st Century Cures Act.
- Designed through Community Engagement Studios (CES) and Human-Centered Design (HCD) approaches to focus development on lowering barriers to underserved communities accessing their own health data.

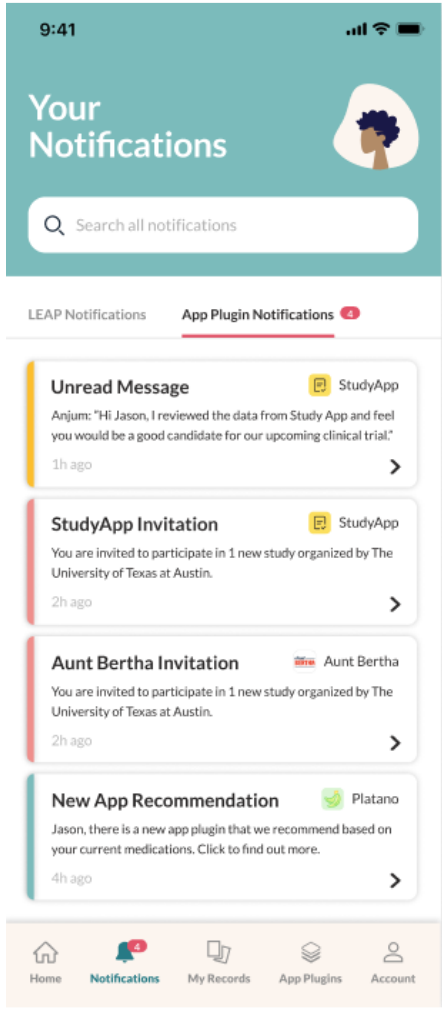


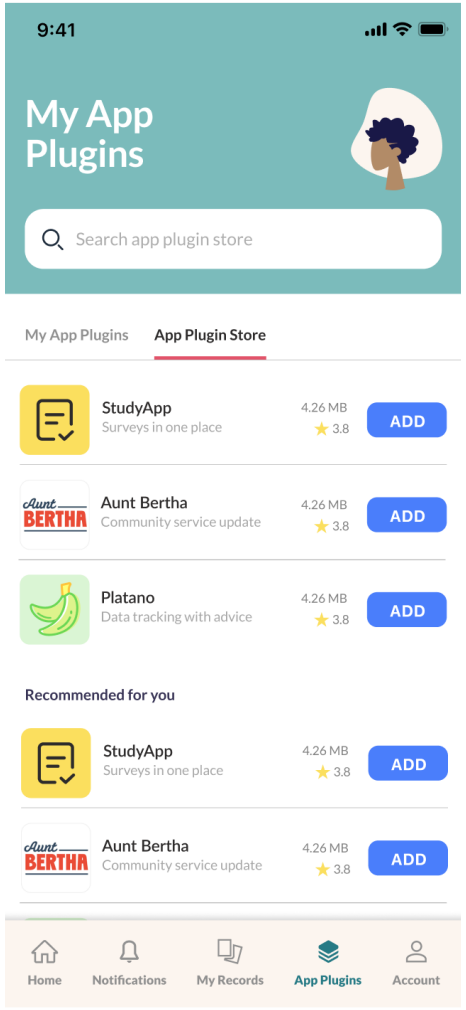
Available on iOS and Google Play stores



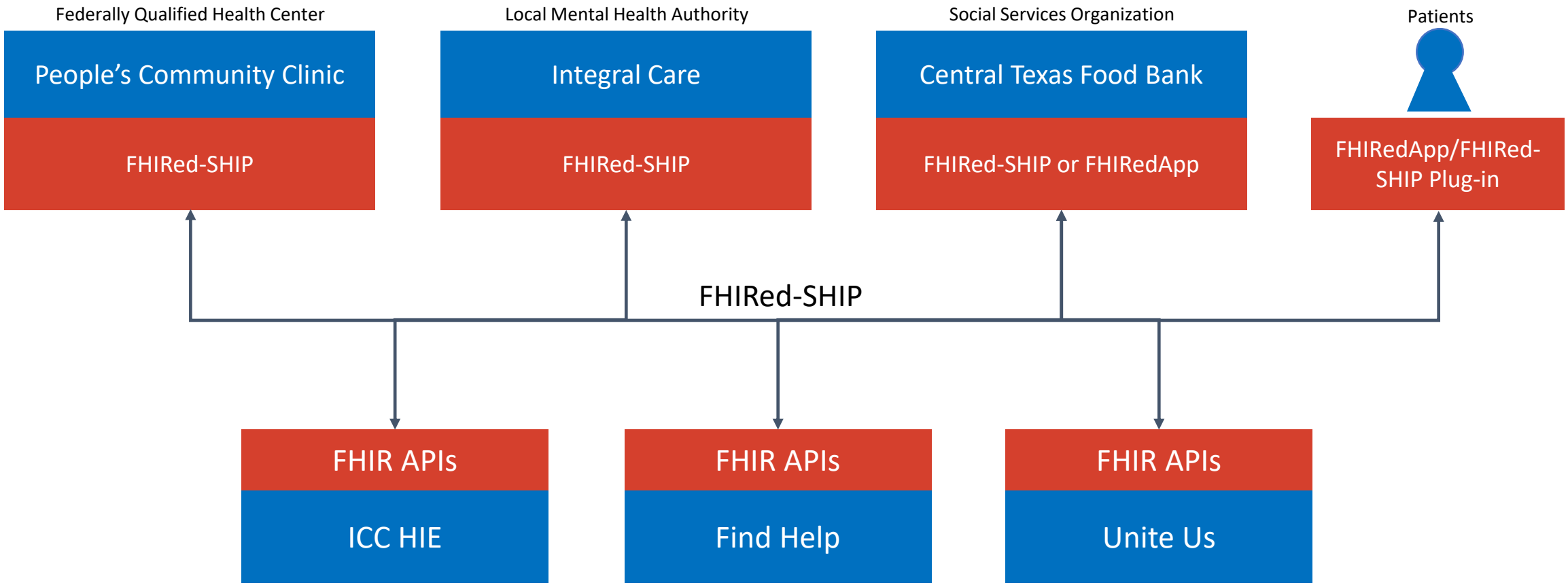




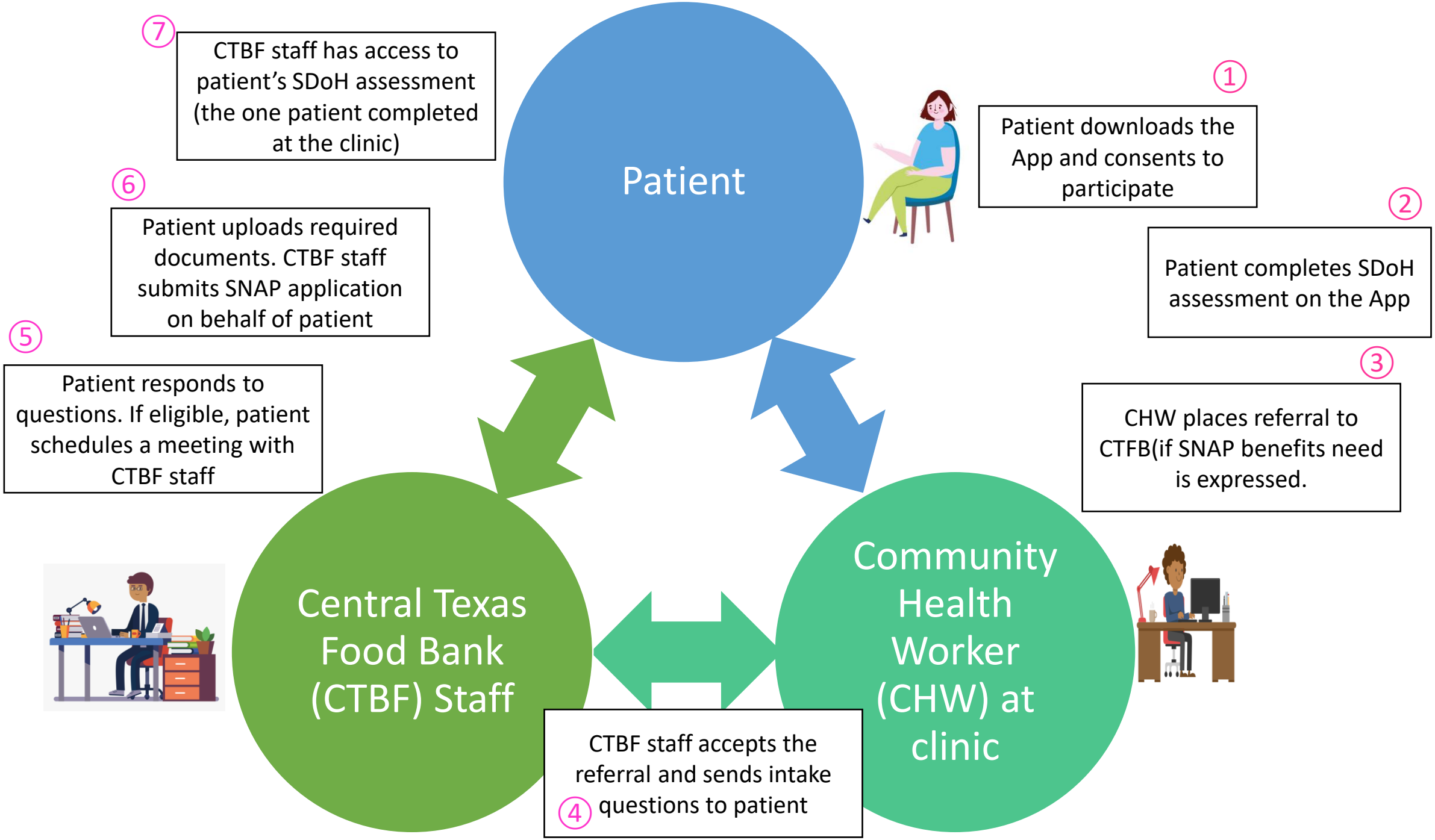




LEAP 2021: FHIRed-SHIP Architecture



FHIRed-SHIP linking patients, CBOs, referral systems and healthcare organizations via FHIR APIs

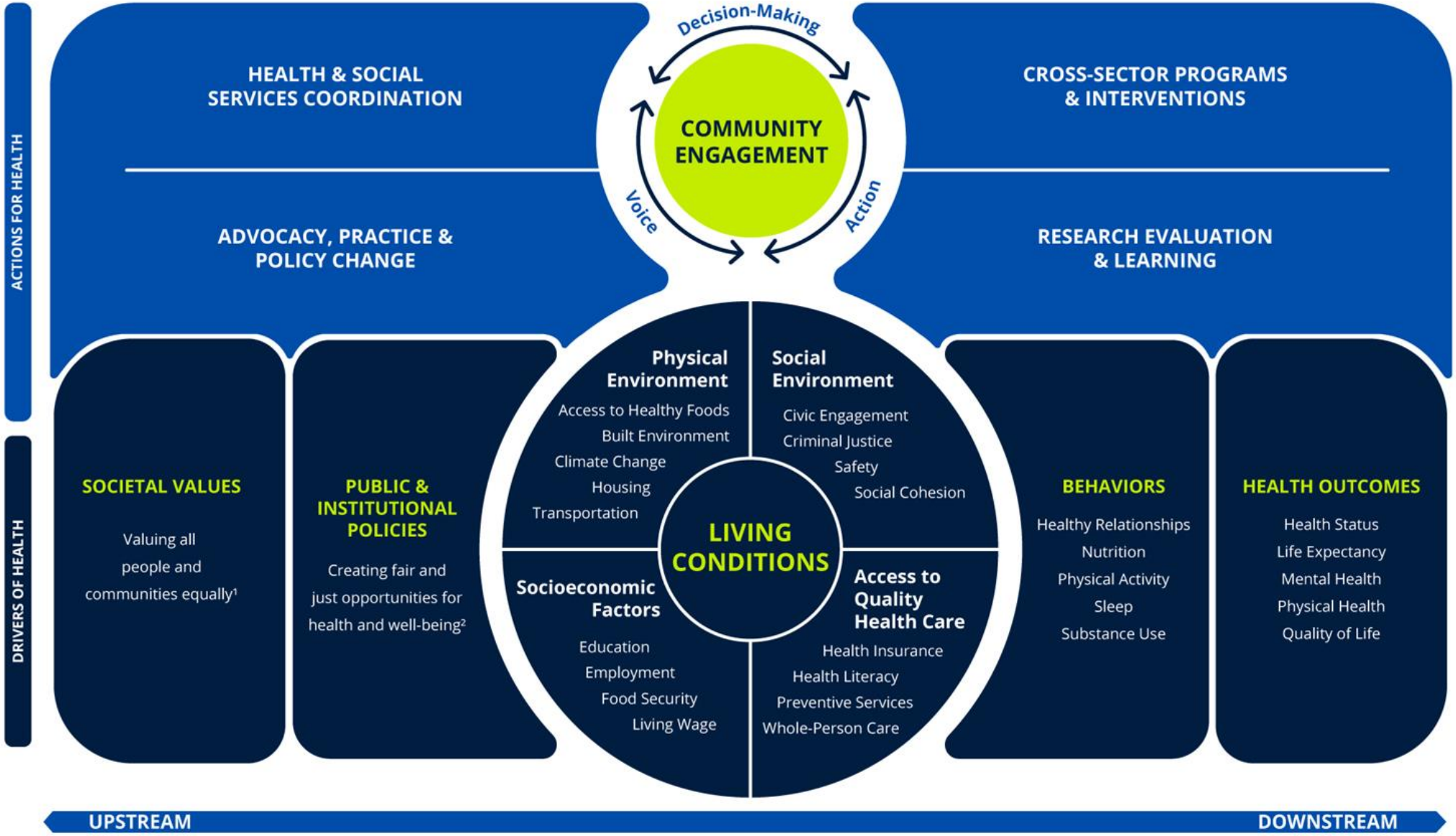

Patient
1
Patient downloads the App and consents to participate
2
Patient completes SDoH assessment on the App
3
CHW places referral to CTFB(if SNAP benefits need is expressed.
Community Health Worker (CHW) at clinic
4
CTBF staff accepts the referral and sends intake questions to patient
Central Texas Food Bank (CTBF) Staff
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)

LBK Community Network

Health Equity

- Health Department Role
- Birth of a Network
- Addressing Health Related Social Needs

HEALTH EQUITY COLLECTIVE'S FRAMEWORK FOR ACHIEVING BETTER HEALTH TOGETHER



Developed by the Health Equity Collective's Social Determinants of Health Framework & Common Metrics Workgroup and adapted from the Bay Area Regional Health Inequities Initiative.
(1) Introduction to Health Equity and Social Determinants of Heath (C. Jones), National Academies Press (2019); (2) Robert Wood Johnson Foundation (P. Braveman, et. al.) rwjf.org (2017)
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WORKGROUP MEMBERS

40+ leaders from more than 30 Houston-based public health, health care and social service organizations

Donna Alexander	DGA Healthcare Consulting
Nakita Anthony	Legacy Community Health
Nomita Bajwa	Wellness Geeks Consultants
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Jane Bavineau	BakerRipley
Stephanie Berno	Houston Food Bank
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Ellen Fiesinger	Patient Care Innovation Center
Sean Haley	Center for Civic & Public Policy Improvement
Blake Harper	The University of Texas MD Anderson Cancer Center
Palak Jalan	Access Health
Suzanne Jarvis	Houston Recovery Center
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Alicia Johnston	Humana
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Frances Nguyen	University of Houston
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Karen Tseng	Harris Health
Michael T. Walsh, Jr.	The University of Texas MD Anderson Cancer Center
Reginald Young	Houston Food Bank
Sharon Zachary	Alliance of Community Assistance Ministries

Goals of HEC Implementation

Technology Capacity (CIE)

- Access to services for all, meeting people where they are: Resource directory exchange infrastructure.
- Ease of referral and care coordination: Referral Network Infrastructure

Human Capacity (CHW)

- Facilitate CHW Network for the Greater Houston area to coordinate efforts.
- CHW workforce development and training to meet SDoH needs in the community.
- CHW access to CIE.
- CHW employer engagement.

Community Voice

- Building community voice and community engagement strategies to inform the CIE and CHW efforts.
- Community voice to inform policy.

Priority outcomes

Improved SDOH care

Improved food security

Improved mental health

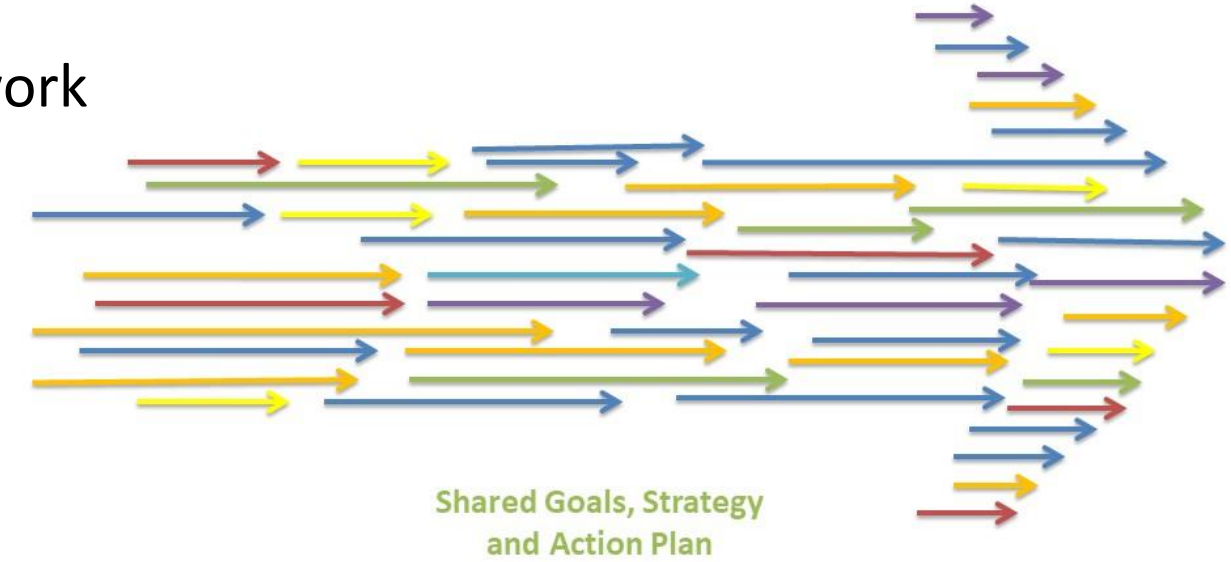
Establishing continuous learning and evaluation model of care
Develop policy agendas, inform policy implementation, evaluate policy

Texas SDoH Workgroup

- Fast moving train
- Learning collaborative
- Health Equity, Wellness, and Growth focused
- Forward thinkers & Systems and Policy minded
- Texas Proud

Opportunity for Impact through Collaboration

- Communities across Texas are working to develop ecosystems of care to improve health and health equity by addressing non-medical drivers of health outcomes.
- Many recognize the opportunity for connecting across state
  - Texas 2036
  - Texas Health Improvement Network
  - Texas Health Institute HUB
  - And more!



How do we sustain and pay for these systems changes? Is this population health infrastructure?

- Two main ways – a combo of both is needed:
  - build a use-case one at a time and prove impact and outcomes, or
  - have consistent, substantial, and accountable funding (Utility Model)
- Model keeps HIEs relevant, with sources of funding/opportunity
- COVID has accelerated health equity and SDoH as top priorities
- Strategy needed to integrate data across systems (e.g. social and healthcare)
- Medicaid an interested party in all states
- Outcomes/ROI from addressing SDoH = payer reimbursement. In TX, pushing for reimbursement around care coordination and holistic person health
- Come together as providers to get local support (e.g. goals, use cases, funding)

Call To Action

Questions

THANK YOU

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