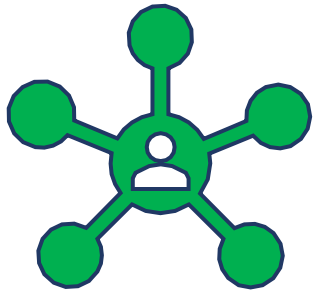

Connecting SDOH to Social Service Delivery

NATIONAL ALLIANCE TO IMPACT THE SOCIAL DETERMINANTS OF HEALTH

ED HUNTER

FEBRUARY 4, 2020

LEAVITT PARTNERS

National Alliance to Impact the Social Determinants of Health (NASDOH)

NASDOH is a group of stakeholders working to systematically and pragmatically build a common understanding of the importance of addressing SDOH as part of an overall approach to health improvement.

We seek to make a material improvement in the health of individuals and communities and, through multi-sector partnerships within the national system of health, advance holistic, value-based, person-centered approaches that can successfully impact the social determinants of health.

The success of value-based care is dependent on attention to the social determinants of health.

Current silos of **federal** spending in health and social services impair **state, local, and private-sector innovation**.

Public-private collaboration will aid in the success, scaling, and sustainability of current SDOH pilot efforts.

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NASDOH Members

Steering Committee

General Members

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NASDOH Principles

1. By addressing the **broad and interconnected array of factors that influence health** we can effectively help all people and communities to become and stay healthy, achieve well-being, and thrive economically.
2. Strategies that address the social determinants of health should be **developed with people and communities** and reflect their values, perspectives and preferences.
3. Meaningfully impacting health and well-being requires **multi-sectoral partnerships** across the private and public sectors.
4. The **private sector**, including employers and businesses, has an integral role to play through private-sector action, policy work, engaging in public-private partnerships, and civic leadership.
5. **Public health departments and human and social services sectors** are essential partners in efforts to address the social determinants of health and will need significant financial and human capital investments.
6. Efforts to address the social determinants of health should **build upon existing gains in the health care system** including ensuring access to affordable, quality care.
7. Successfully **transforming to a value-based health care system** requires care and payment models that address the social determinants of health.
8. Digital strategies should be leveraged to transform and improve health and well-being including promoting bidirectional information flow with appropriate attention to privacy, proper use, and data security as a priority in data collection, sharing, and use.
9. **Measuring the impact** of social determinants of health interventions should balance the goals and interests of sectors and affected people and communities.
10. The substantial body of successful evidence-based approaches to better integrate social determinants of health approaches into the health system can inform immediate action; however, there is a continuing **need to experiment and build the evidence base**, and for policies that encourage the development of additional evidence.

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Connecting SDOH to Social Service Delivery
A current landscape of health agencies' efforts

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February 4, 2020

VISION

State and territorial health agencies advancing health equity and optimal health for all.

MISSION

To support, equip, and advocate for state and territorial health officials in their work of advancing the public's health and well-being.

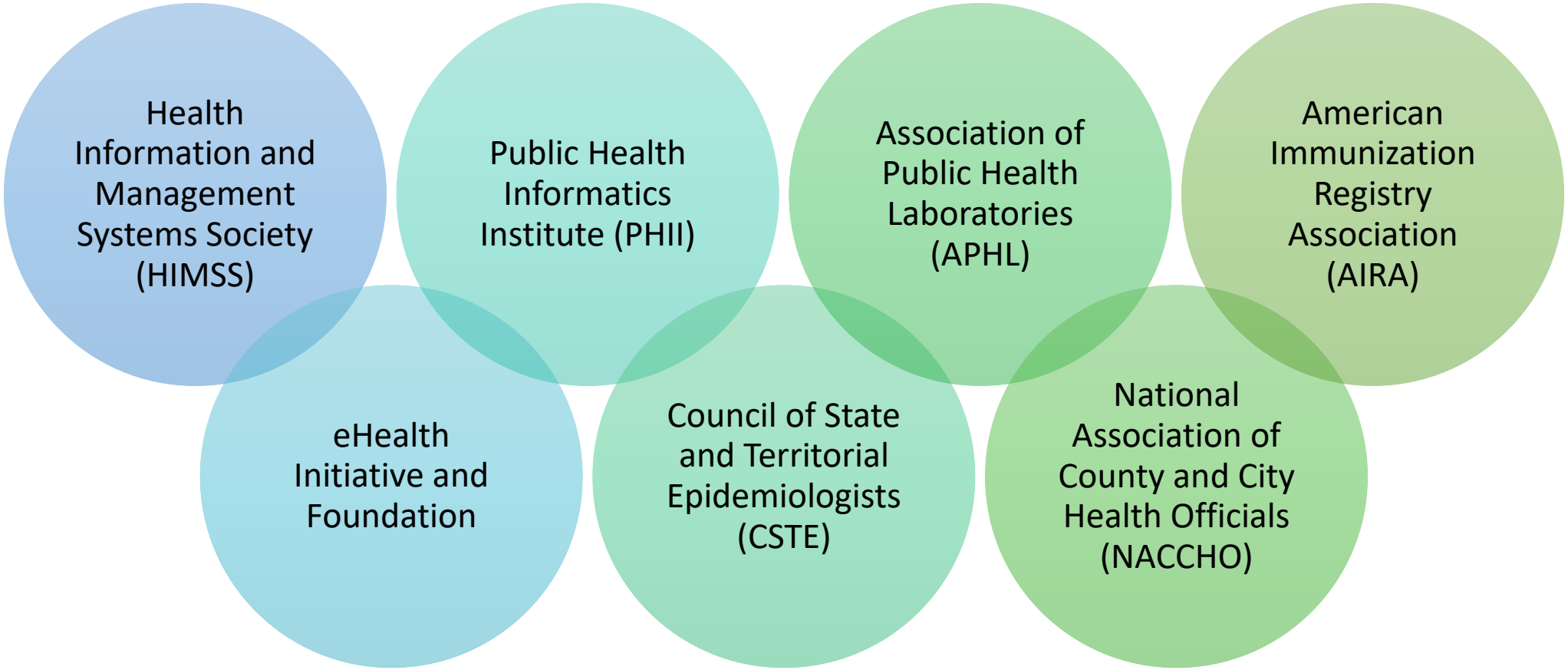
Background

Provide state/territorial health agencies with technical assistance, capacity building, promising practices, templates, and training on data & informatics

Information Resources:

ASTHO Population Health & Informatics Policy Committee, Informatics Directors Peer Network (IDPN), roadmaps and strategic plans; sample data sharing and governance policies; federal agency guidance, rules, and regulations; partners' resources; industry standards

Partners in the Space



What is Digital Bridge?

The vision of the Digital Bridge is to ensure our nation's health through a bidirectional information flow between health care and public health.

Current Efforts

Disseminating information through blogs, newsletters, policy committees, peer network groups, and other mediums

- Public Health Field Guide: How to Engage Payers in Addressing the Social Determinants of Health (2018)
- Medicaid and Social Determinants of Health: ASTHO and HHS Engage State and Local Leaders in Dialogue (2017)

Managing a project portfolio on *Cross-Sector Partnerships to Address SDOH*

Drafting a standardization of social determinants of health metrics (SDOH) policy statement

Assessing national standardization efforts (screening tools, state indices, health equity frameworks, accountable health communities, improvements in SDOH data analytics)

Working with partners to promote cross-sector, cross-agency partnerships (public health with behavioral health and social services agencies)

Advancing agencies' data sharing and governance capabilities, strategies, and national standards to promote interoperability of SDOH data across necessary stakeholders to improve public health, healthcare, and social service delivery

Improving Medicaid-public health partnerships

Compiling promising practices of building healthy and resilient communities (modeled after the ASTHO President's Challenge)

Continuing to participate in national initiatives/efforts (e.g., Gravity project for SDOH data standards)

Engaging in the Digital Bridge Collaborative

Legal/Policy Landscape of Data Sharing & Governance

*Law governs the **collection, use, sharing, and protection** of health data*

Federal

Health agencies have legal authority to conduct continuous systematic data collection, analysis and use to protect and promote the public's health

State

Each state has **disease reporting and privacy laws (sometimes beyond HIPAA)** in statute or legislation that serves a public health purpose

HIPAA sets basic national standards for privacy and security and gives patients rights regarding their health information

Public health is considered a health oversight entity

Covered entities (health care providers and health plans) are prohibited from using or disclosing identifiable health information unless required or allowed by **HIPAA privacy rule**

HIPAA Privacy Rule exceptions allow disclosure of information to public health authorities for public health purposes (e.g., surveillance, intervention, investigations)

Health agencies must protect information and secure individual privacy

No national guidelines or standards currently exist for data sharing and data governance

Building a Data Governance and Sharing Infrastructure

- Data Governance Committees/Workgroups
- Office of Informatics
- Program or Department Leads (as required)
- Legal Counsel
- Data Stewards
- External stakeholders (other agency leadership in social services)

Who

- Data Sharing Agreements
- Data Sharing Policies
- Data Governance and/or Stewardship Policies and Procedures
- Data Governance Programs

What

Use Case:
Georgia addresses violence prevention through data sharing and community partnership

Community Partnerships & Data Sharing

What is the Cardiff Violence Prevention Model?

- Originated in Cardiff, Wales and combines hospital violence screening data with police records

- Creates community safety partnerships to direct community resources and social services to address violence prevention and identify undetected patterns of violence

Public Health's Role

- Public Health recruited to the partnership to serve as a central data repository for data received from hospital and law enforcement partners

Establish **data sharing agreements** with law enforcement and hospitals

Map data using geographic information system (GIS) mapping software

Share aggregated data back to the partnership to inform evidence-based community violence prevention interventions

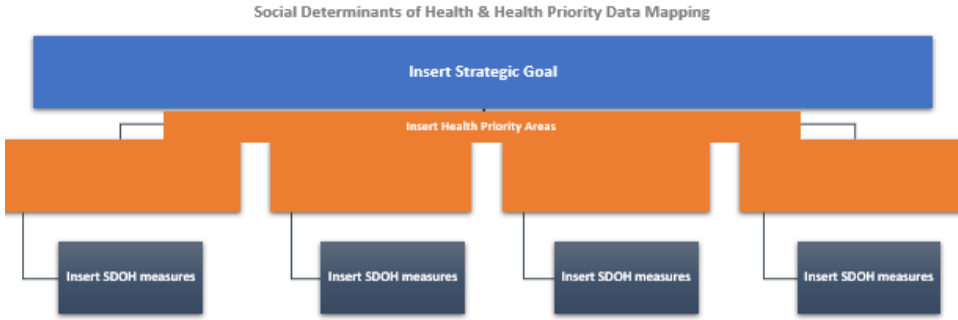
- Continue to build relationships and establish partnerships across additional sites in Georgia

- ASTHO developing guidance for health agencies on pre-implementation, implementation, and scale-up to support involvement of public health agencies

Use Case:
States advance common standards for social determinants of health data collection to inform service delivery

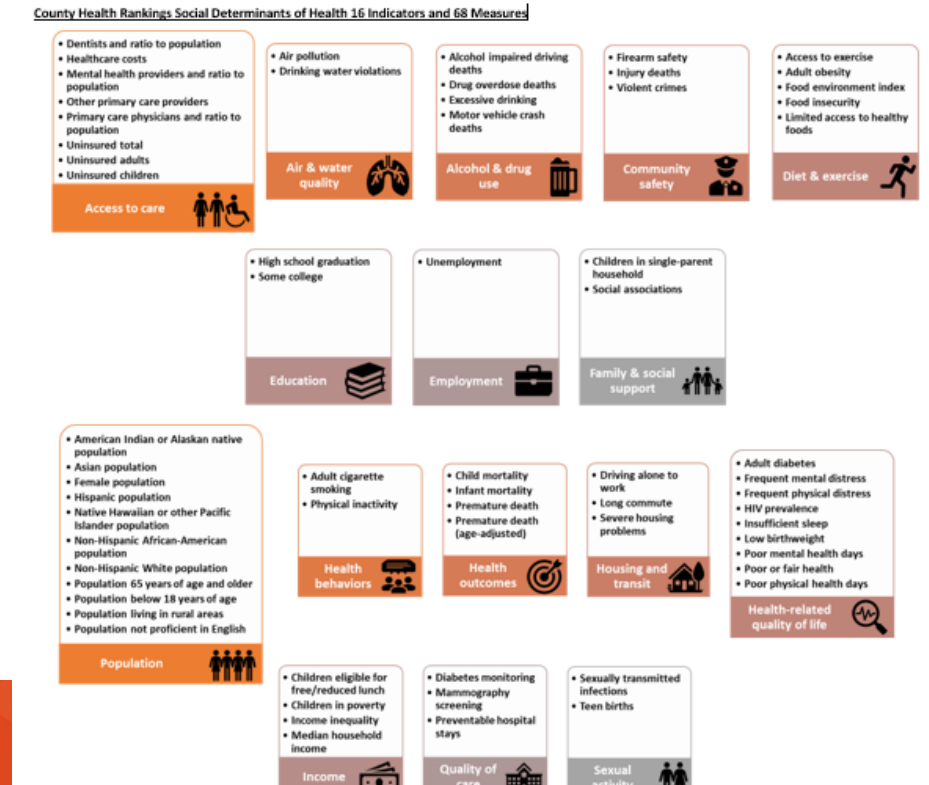
SDOH Data Mapping to Build Healthy & Resilient Communities

- Conduct a strategic meeting to prioritize how improved SDOH data collection and sharing can advance social service delivery
- Identify existing health priority areas (from state health improvement plans or community health assessments)
- Use existing SDOH indicators and measures (can be developed by the agency or using a national resource – County Health Rankings) and map to health priority areas.
- Determine weighting of each SDOH indicator as it relates to health outcome
- Identify all SDOH data sources available or accessible across the agency, then across other state agencies, and then across state/territorial stakeholders
- Map available/accessible data sources to each SDOH indicator for each priority area
- Determine who manages each data source and develop a process by which that data is made available for SDOH tracking and informing progress on social service delivery



Outlined Steps

1. Identify a strategic goal and/or align with an existing strategic goal for the health agency or state/territory.
2. Identify health priority areas and/or align with existing health priority areas (e.g., identified in your State Health Improvement Plan or Community Health Assessment).
3. Using the County Health Rankings 16 indicators and 68 measures for social determinants of health (SDOH) as a starting point, your agency should decide on which indicator(s) informs, impacts, or aligns with a health priority area. If your agency has identified other SDOH indicators and/or measures for use, cross-check them with the below and then use those in this exercise.
4. Identify all SDOH data sources available across the agency in various programs and from various stakeholder partners across the state/territory.
5. Map your data sources to the SDOH indicators for each health priority area (note that some indicators may have specific measures that are only applicable to one of the health priority areas versus all of them). Some data sources are generalized (e.g., crash data) and will require identifying the exact source within the agency(ies) (e.g., surveillance system, EHRs, surveys).
6. Determine who in the agency manages each data source and develop a coordinated process/workflow by which that data will be available to inform progress in each health priority area.
7. How will the agency develop weights for each SDOH indicator to determine its statistical significance in improving outcomes for each health priority area?



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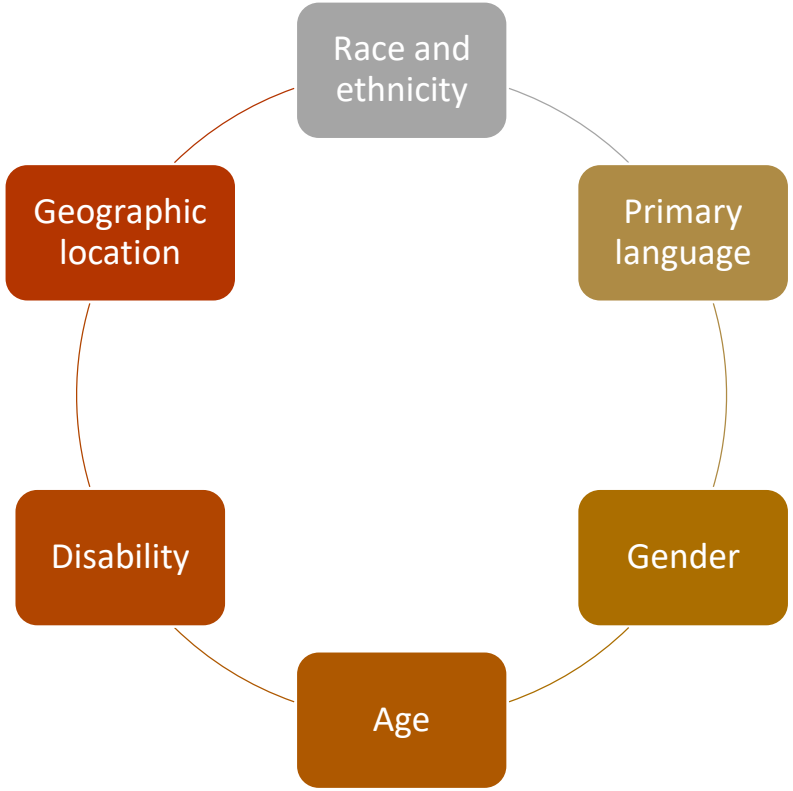
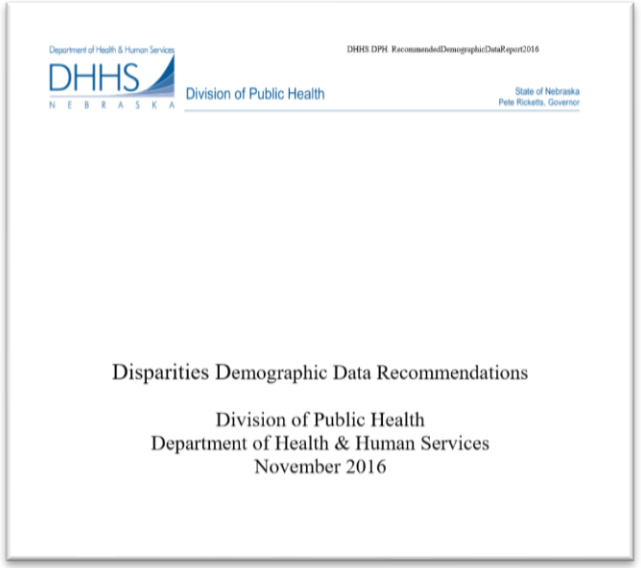
Demographics Data Collection Standards

- Nebraska DHHS has developed recommendations for a minimum core data set of health disparities data
- Community partners/stakeholders are advised to use this in their data collection efforts to advance standard and uniform reporting that can improve public health programming and services




Department of Health & Human Services
DHHS
NEBRASKA
Division of Public Health
DHHS DPH RecommendedDemographicDataReport2016
State of Nebraska
Pete Ricketts, Governor

Disparities Demographic Data Recommendations

Division of Public Health
Department of Health & Human Services
November 2016

Disability

Option 1:

1. Are you deaf or do you have serious difficulty hearing? (1) Yes (2) No
2. Are you blind or do you have serious difficulty seeing even when wearing gla (1)Yes (2) No
3. Because of a physical, mental, or emotional condition, does this person have s concentrating, remembering, or making decisions? (1) Yes (2) No
4. Does this person have serious difficulty walking or climbing stairs? (1) Yes
5. Does this person have difficulty dressing or bathing? (1) Yes (2) No
6. Because of a physical, mental, or emotional condition, does this person have d alone such as visiting a doctor's office or shopping? (1) Yes (2) No

Option 2:

1. Are you limited in any way in any activities because of physical, mental, or en
2. Do you now have any health problem that requires you to use special equipme wheelchair, a special bed, or a special telephone? Include occasional use or us circumstances.

Option 3:

1. Are you limited in any way in any activities because of physical, mental, or en

Geographic location

1. Which county (state) do you live in?
   (If state is recorded, use full word as 2-letter abbreviations are often misused.)
2. What is the 5-digit zip code of your home address? _____

Race/Ethnicity

1. Are you Hispanic or Latino? (1) Yes (2) No
2. What is your race? (please select all that apply)
   a) White
   b) Black or African American
   c) American Indian or Alaska Native
   d) Asian;
   e) Native Hawaiian or other Pacific Islander
   f) Some Other Race (Please specify:_____)

Primary Language

1. How well do you speak English? (5 years old or older)
   a) Very well
   b) Well
   c) Not well
   d) Not at all

Optional details to add if collection of specific language spoken at home is desired:

2. Do you speak a language other than English at home? (5 years old or older) (1) Yes (2) No
3. What is this language? (5 years old or older)
   a) Spanish
   b) Other Language (Identify:_____)

Gender

What is your gender? 1. Male 2. Female

Age

Option1: (Preferred): What is your birthdate? ___/___/____ (mm/dd/yyyy)

Option 2: What is your birthdate? ___/____ (mm/ yyyy)

Option 3: Current age in completed years. Should only be used for surveys; year of survey must be recorded.

Option 4: Selection of age range categories based on program's needs. Must be recorded along with survey year.

Future Direction

Finalize policy statements

Ensure health officials' perspectives on national initiatives

Work with partners to advance data sharing and interoperability of data to be exchanged to improve social service delivery

Prepare health agencies for SDOH standardization of metrics, codes, data collection, and data sharing

Questions/ Discussion