CRISP

HIE Approach to Social Determinants of Health

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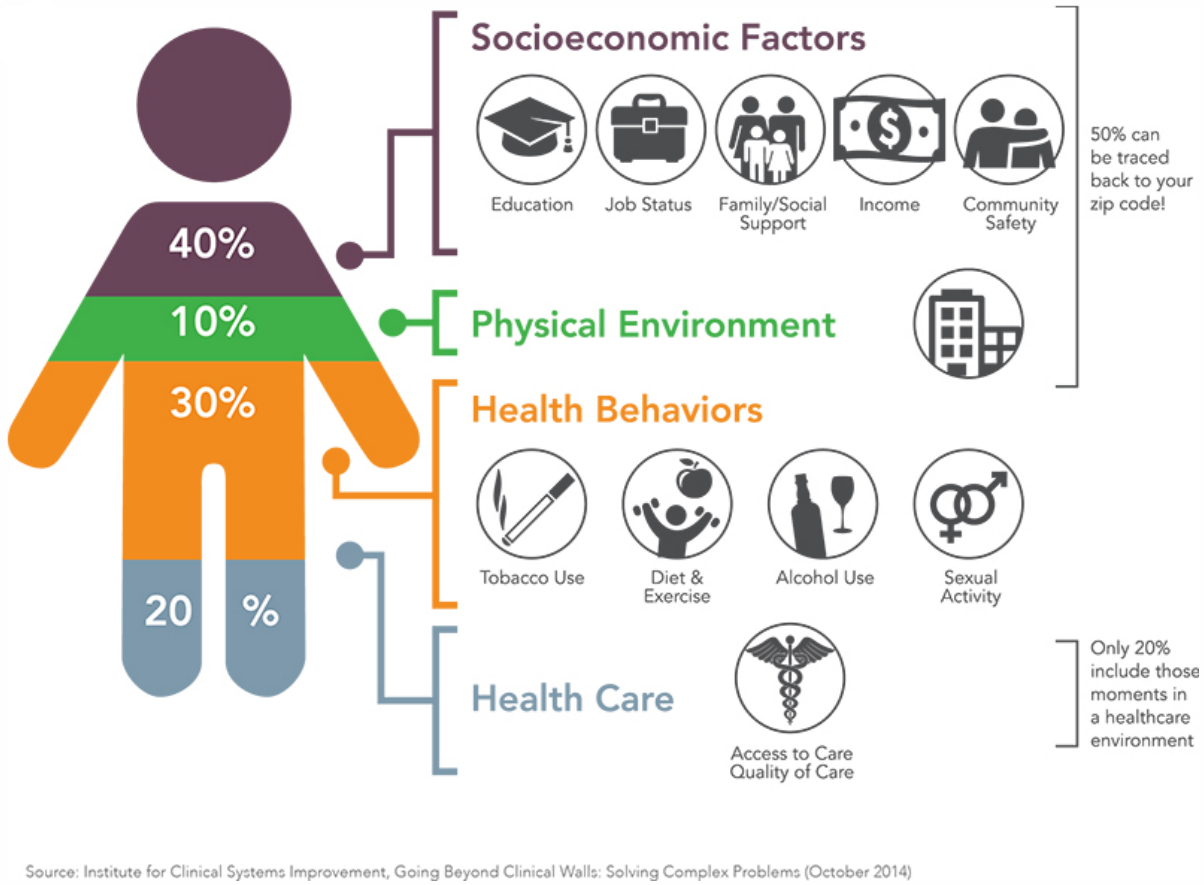
Level-Setting: What we are talking about

- Social Determinants of Health (SDOH) are "the conditions in which people are born, grow, live, work, and age"
- Interventions to address SDOH are widely desired by providers, payers, and policymakers due to the potential to improve health and reduce total cost of care
  - Example: Hospitals in Baltimore City contribute $2M to establish housing and wraparound services for homeless
  - Example: Home-delivered meal programs leveraged to proactively identify existing clients' unmet needs
- Community-Based Organizations (CBO) function outside of health care reimbursement, IT systems, data sharing and other laws



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

Sources:

- Baltimore Sun, *City, Baltimore hospitals plan to house, care for 200 homeless people*: https://www.baltimoresun.com/health/bs-md-ci-homeless-support-20190702-story.html
- Kaiser Family Foundation, *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity*: https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/
- Journal of the American Geriatric Society, *Leveraging Home-Delivered Meal Programs to Address Unmet Needs for At-Risk Older Adults*: https://doi.org/10.1111/jgs.1601
- World Health Organization, *About Social Determinants of Health*: https://www.who.int/social_determinants/sdh_definition/en/

General SDOH intervention translated to HIE use cases

1.	Screen patient for needs beyond health care	Access standardized questions within typical workflows to identify potential inhibitors to a patient's health and understand what kinds of interventions may be appropriate. Share domain-specific results with other members of the care team and review changes in screening results from all sources over time.
2.	Identify appropriate community resource	Review a current list of organizations by geography, services, capacity, funding source, and other relevant details, in order to recommend the most appropriate service to the patient based on his or her screening outcome and specific circumstances.
3.	Refer patient and receive confirmation of enrollment	Orchestrate a handoff to the selected organization from a convenient workflow within existing health IT systems. Securely transmit relevant, minimum necessary patient data. Receive confirmation from the organization that the patient has been contacted and either accepted or rejected services.
4.	Measure and report utilization and outcomes	Track all referrals made by service type and organization over time at both the patient and population level. Understand the effectiveness of different interventions in order to optimize patient outcomes. Understand costs related to services and avoidable health care utilization to potentially make investment decisions.

Current engagements

Maryland Primary Care Program and Hospital Global Budgets

- Innovations through the Total Cost of Care Model to enhance primary care practices through integrated behavioral health, care management resources, and transformation coaches and allow hospitals to care for populations of patients
- HIE produces claims-based reports, shares care team and other clinical information, and supports transitions of care with encounter notifications; care managers express need for standard screening tools and additional information about their patients

Accountable Health Communities (AHC)

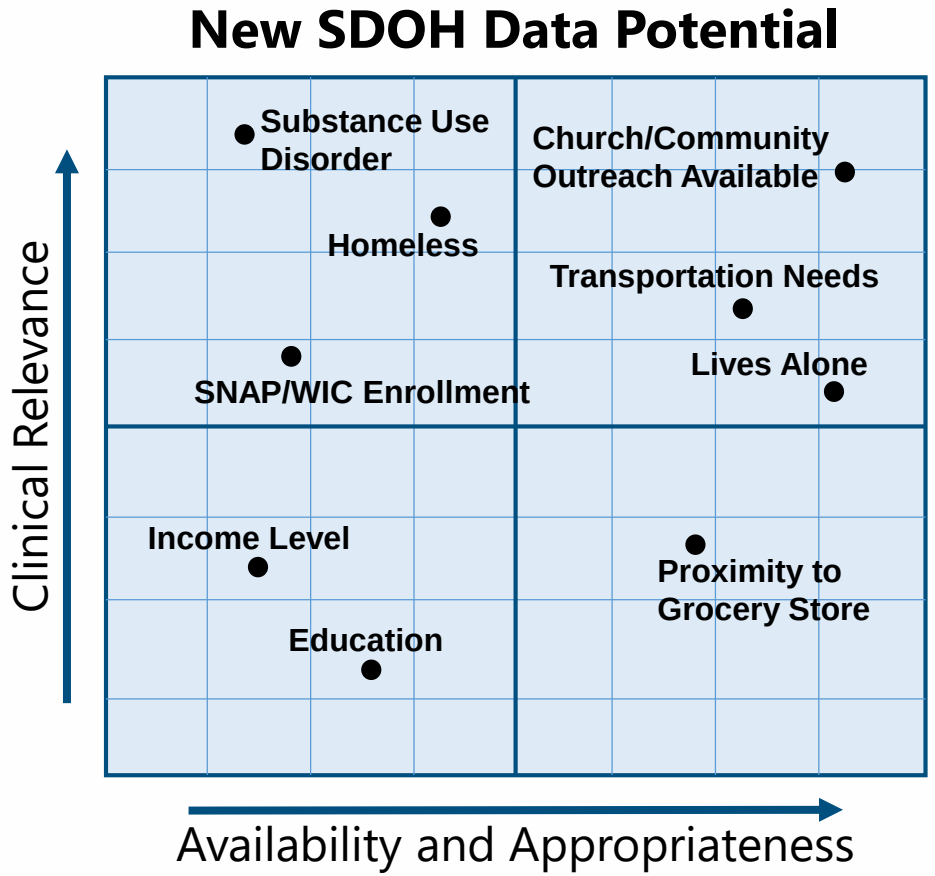
- Baltimore City Health Department engaged health care stakeholders and CBOs, released a certified screening tool, and published a resource directory
- HIE is securely transmitting screening results from hospital EHRs to AHC tool; planning future development and hosting to expand screening and resource directory statewide as open-source platform

Maternal Opioid Misuse (MOM) Model

- Managed Care Organizations will be providing intensive coordination services to Medicaid beneficiaries who are pregnant or postpartum and have an opioid use disorder
- HIE will show clinical documents and care team relationships; send event notifications; interface with resource directories; conduct reporting

Near-term focus and barriers

- New types of information to inform clinical decision-making and additional support
  - Check for relevance and availability
- Expanded consent options with patient engagement
  - Allow HIPAA authorization and 42 CFR Part 2 consent to be collected at scale
- Integration with EHRs and CBO IT systems to exchange data
  - Stand up manual tools of last resort
- Identify a business model for increased volume and sustainability



Questions and discussion

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