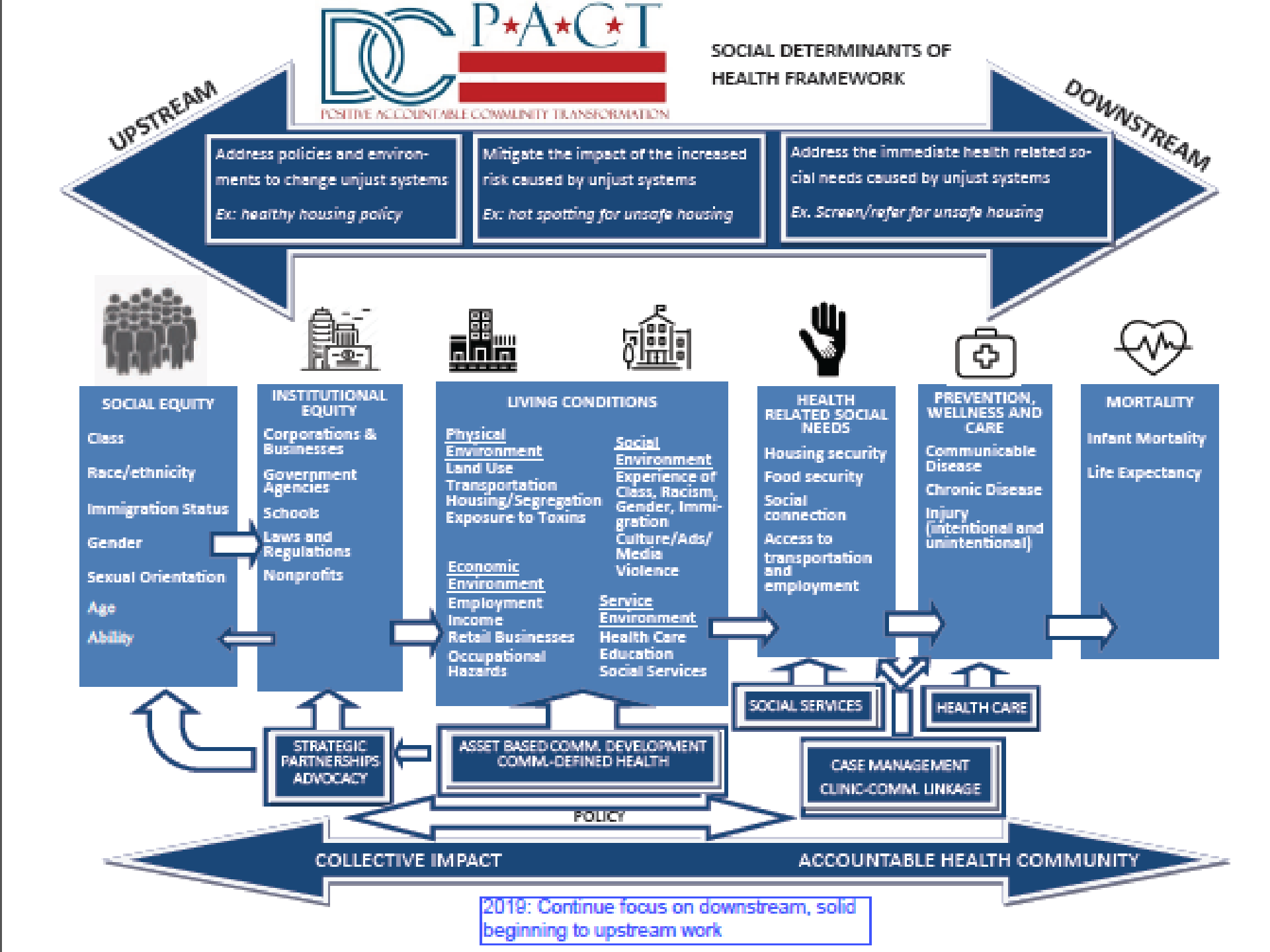
Addressing SDOH

COMMUNITY RESOURCE INFORMATION EXCHANGE (CORIE) PLANNING INITIATIVE

DISTRICT OF COLUMBIA
PRIMARY CARE ASSOCIATION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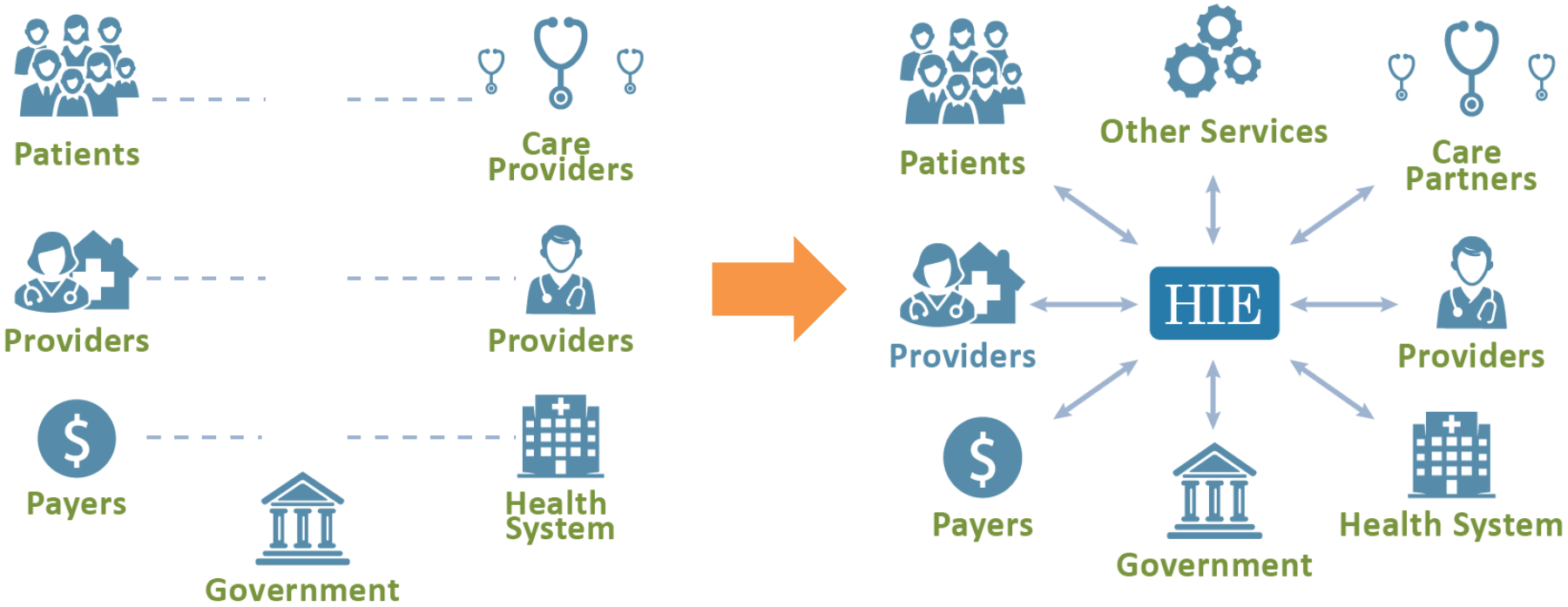
POSITIVE ACCOUNTABLE COMMUNITY TRANSFORMATION
SOCIAL DETERMINANTS OF HEALTH FRAMEWORK
UPSTREAM
DOWNSTREAM
Address policies and environments to change unjust systems
Ex: healthy housing policy
Mitigate the impact of the increased risk caused by unjust systems
Ex: hot spotting for unsafe housing
Address the immediate health related social needs caused by unjust systems
Ex. Screen/refer for unsafe housing
SOCIAL EQUITY
Class
Race/ethnicity
Immigration Status
Gender
Sexual Orientation
Age
Ability
INSTITUTIONAL EQUITY
Corporations & Businesses
Government Agencies
Schools
Laws and Regulations
Nonprofits
LIVING CONDITIONS
Physical Environment
Land Use
Transportation
Housing/Segregation
Exposure to Toxins
Social Environment
Experience of Class, Racism, Gender, Immigration
Culture/Ads/Media
Violence
Economic Environment
Employment
Income
Retail Businesses
Occupational Hazards
Service Environment
Health Care
Education
Social Services
HEALTH RELATED SOCIAL NEEDS
Housing security
Food security
Social connection
Access to transportation and employment
PREVENTION, WELLNESS AND CARE
Communicable Disease
Chronic Disease
Injury (intentional and unintentional)
MORTALITY
Infant Mortality
Life Expectancy
SOCIAL SERVICES
HEALTH CARE
STRATEGIC PARTNERSHIPS ADVOCACY
ASSET BASED COMM. DEVELOPMENT COMM.-DEFINED HEALTH
CASE MANAGEMENT CLINIC-COMM. LINKAGE
POLICY
COLLECTIVE IMPACT
ACCOUNTABLE HEALTH COMMUNITY
2019: Continue focus on downstream, solid beginning to upstream work

Health IT and HIE Connect a Disconnected Health System



Community Input Led to Focus on Social Determinants of Health

Beginning April 2017, DHCF held a series of discussions on social needs of District residents

- Explored District efforts to collect and use SDOH data
- Generated a set of strategies and tactics to improve health outcomes
- Held 80+ person meeting with national experts “level-set” current work and shared priorities
- Hosted 20-person workshop on strategies to address collection and use of social need data

DHCF Prioritized Four Areas to Improve Connection and Navigation

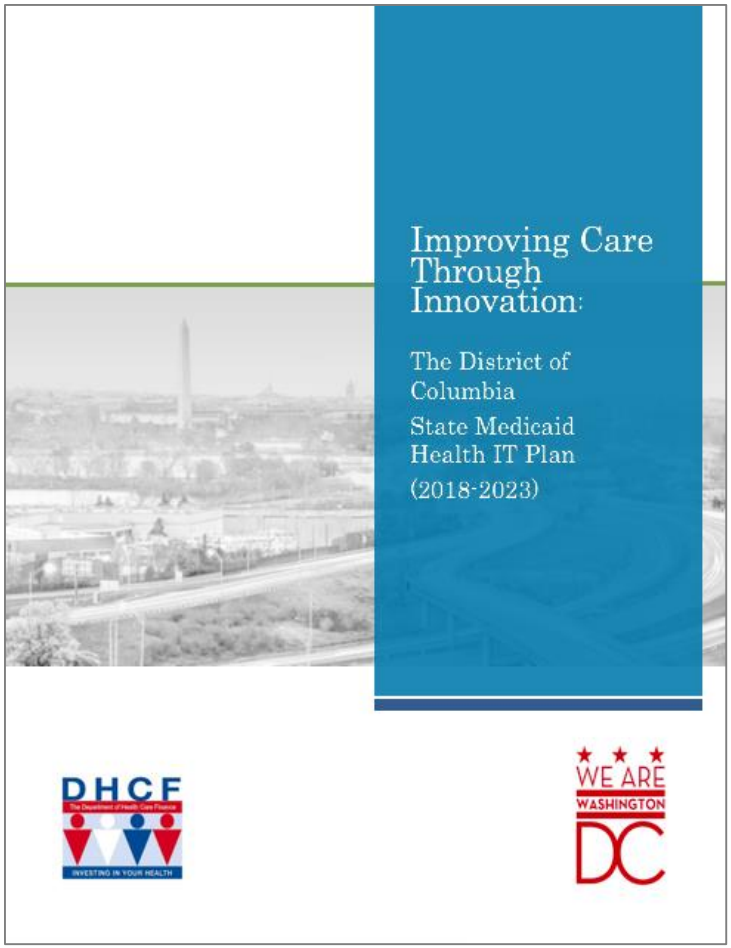
- **Support Transitions of Care**
- Help community service providers communicate across care settings, make timely referrals and exchange summary records, and assess resources such as social supports

- **Collect and Use Social Determinants of Health Data**
- Support health care and social service providers to maximize the effectiveness of interventions to support individual health. Encourage standardized SDH information collection to facilitate whole person care.

- **Analytics for Population Health**
- Facilitate stakeholders ability to use data tools, algorithms and visualizations to target improvements in care quality and outcomes, and support providers' value-based purchasing efforts.

- **HIE for Public Health**
- Work with existing DOH programs to expand public health HIE connectivity, facilitate public health reporting, and support public health registries for all providers in the District.

2018 State Medicaid Health IT Plan



- Opportunities to Improve Health Care
- Current Landscape of Health IT and HIE
- Stakeholder Perspectives and Priorities
- Health IT and HIE Roadmap
  - District health IT and HIE goals
  - Four use cases that drive priorities
  - Proposed projects and timeline
- Evaluation Framework to Measure Health IT and HIE Improvements
- Appendices and Supporting Materials

Two Grants Comprise the Community Resource Information Exchange (CoRIE) Project

Phase 1: CRI (THIS GRANT)

*Community Resource Inventory Needs Assessment and Design Grant**

- Develop **Standardized Screening Tool**
- Design and Develop **Community Resource Inventory**
- Gather Technical Requirements for **Community Resource Information Exchange Technical Solution**

Phase 2: CoRIE

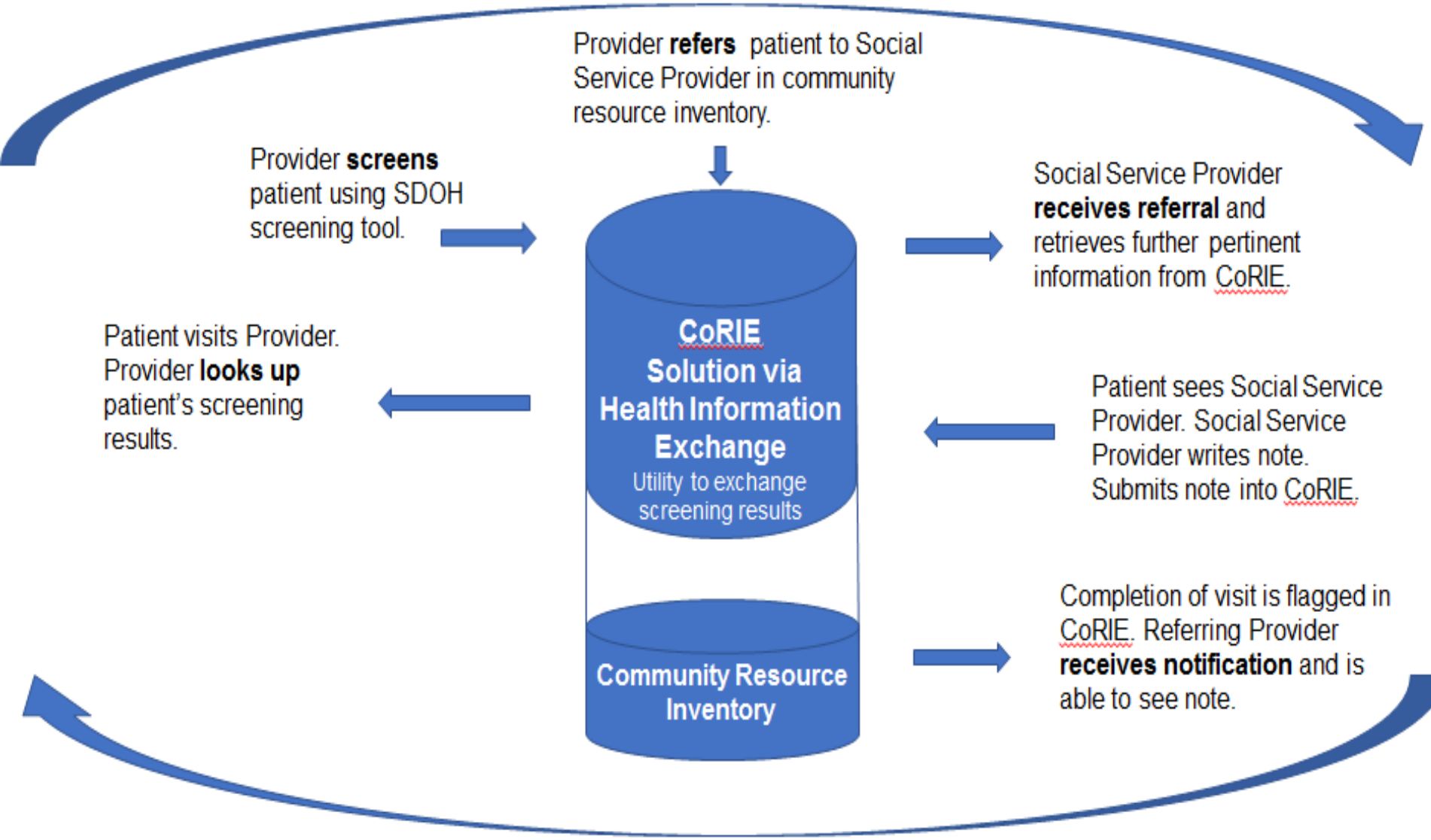
Community Resource Information Exchange Technical Solution Development Grant

Develop and Implement **Community Resource Information Exchange Technical Solution with the following possible capabilities:**

- Implement **Standardized Screening Tool** to address individual or family social needs
- **Utility to exchange screening results** with other providers
- Utilize **Community Resource Inventory**
- **Referral Function** allowing providers to make referrals to social service providers
- **Close-Loop Function** allowing referring providers to be notified patient has seen referred provider

*Also known as the CoRIE Planning Initiative, Awarded to DCPCA,

Information Flow of CoRIE



Overarching question for the CoRIE Planning Initiative: what solutions should DHCF prioritize in building a system that allows for this

CoRIE Planning Initiative Discussion

- **Use:** How does your organization want to use health/social needs data?
- **Technology:** How well do your organization's existing technical solutions support screening, exchange of health/social needs information, and referral?
- **Governance (privacy, security, oversight):** What governance structures are necessary and feasible to promote health/social needs data collection, exchange and referral?
- **Future state/change:** What are the potential benefits or disadvantages of standardizing the collection and exchange of health/social needs data?