Café Connect: Optimizing Data Sharing Systems

Social Determinants of Health (SDOH) Social Needs Screening & Referral Measure

May 23, 2024

Oregon Health Authority

ORPRN
Oregon Rural Practice-Based Research Network

OHSU

Today's Agenda

- Introduction
- SDOH Informational Exchange Foundational Elements
- Natasha Dravid, Camden Coalition
- Q&A with Camden Coalition
- Poll & Large Group Discussion
- Next Steps & Upcoming TA Opportunities

Poll

Context

Data Sharing allows doctors, nurses, pharmacists, case managers, other health and social care providers and members to appropriately access and securely share a person's health and service information electronically improving the speed, quality, safety, and cost of services provided.

Creating shared data systems can advance & promote equity by:

- Providing a comprehensive view of health, demographic & social information
- Improving care coordination & collaboration among partners
- Reducing duplication of screening & support a trauma-informed approach

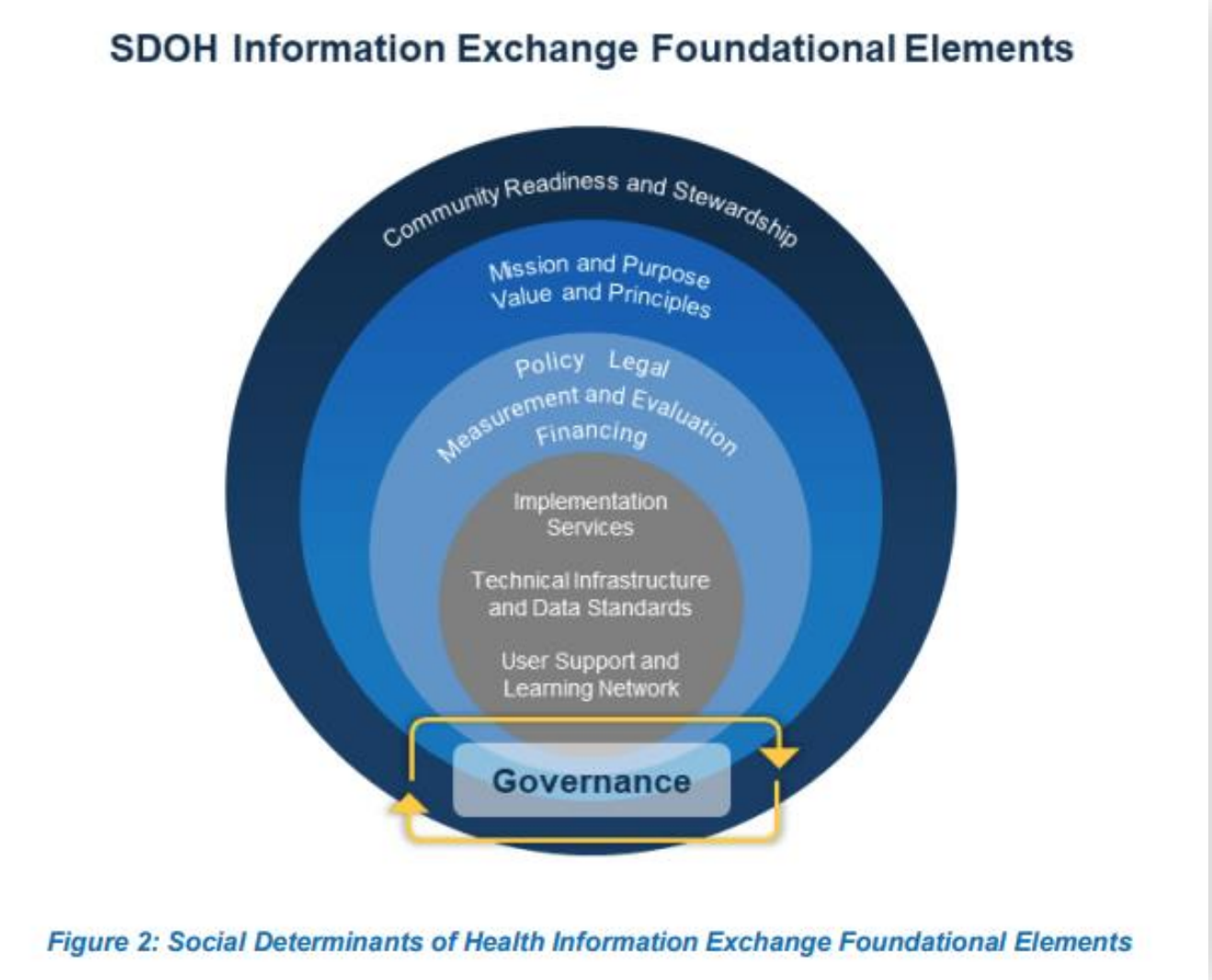


Figure 2: Social Determinants of Health Information Exchange Foundational Elements

Resource: Office of National Coordinator for Health Information Technology (ONC). February 2023. Social Determinants of Health Information Exchange Toolkit. Foundational Elements for Communities. https://www.healthit.gov/sites/default/files/2023-02/Social%20Determinants%20of%20Health%20Information%20Exchange%20Toolkit%202023_508.pdf

Poll & Discussion

Natasha Dravid (she/her)
Camden Coalition

Camden Coalition

The Camden Coalition

Activating Shared Data to Strengthen Ecosystems of Care

SDOH Social Needs Screening and Referral Metric Webinar

May 23, 2024

Camden Coalition

About the Camden Coalition

About the Camden Coalition

We are a multidisciplinary, community-based nonprofit
working to improve care for people with complex health and social needs in the city of Camden, New Jersey, and across the country.

We develop and test care management models and redesign systems. We partner with consumers, community members, health systems, community-based organizations, government agencies, payers, and more

We serve as one of New Jersey's four Regional Health Hubs
to expand data sharing and collaboration between organizations so that patients across South Jersey experience seamless, whole-person care.

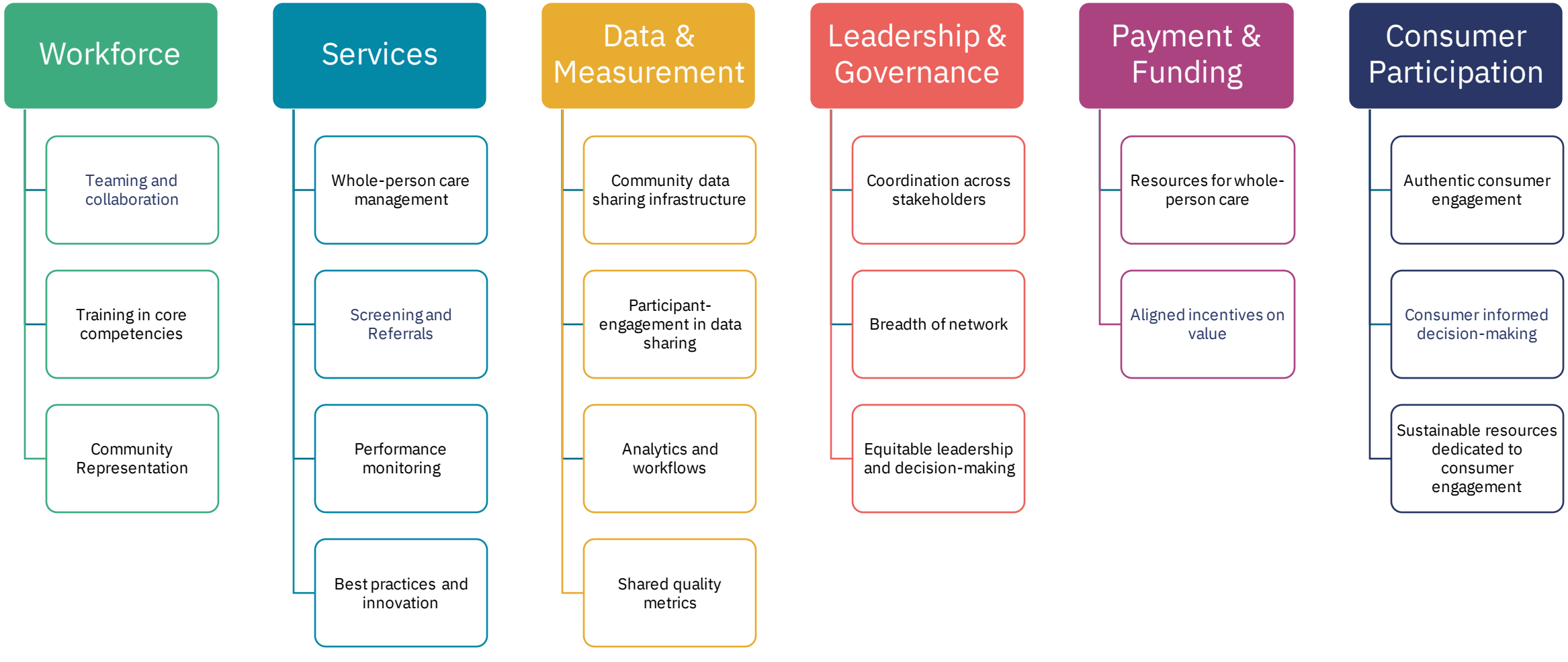
Mission

To improve the health and well-being of people with complex needs by demonstrating and advancing equitable ecosystems of care.

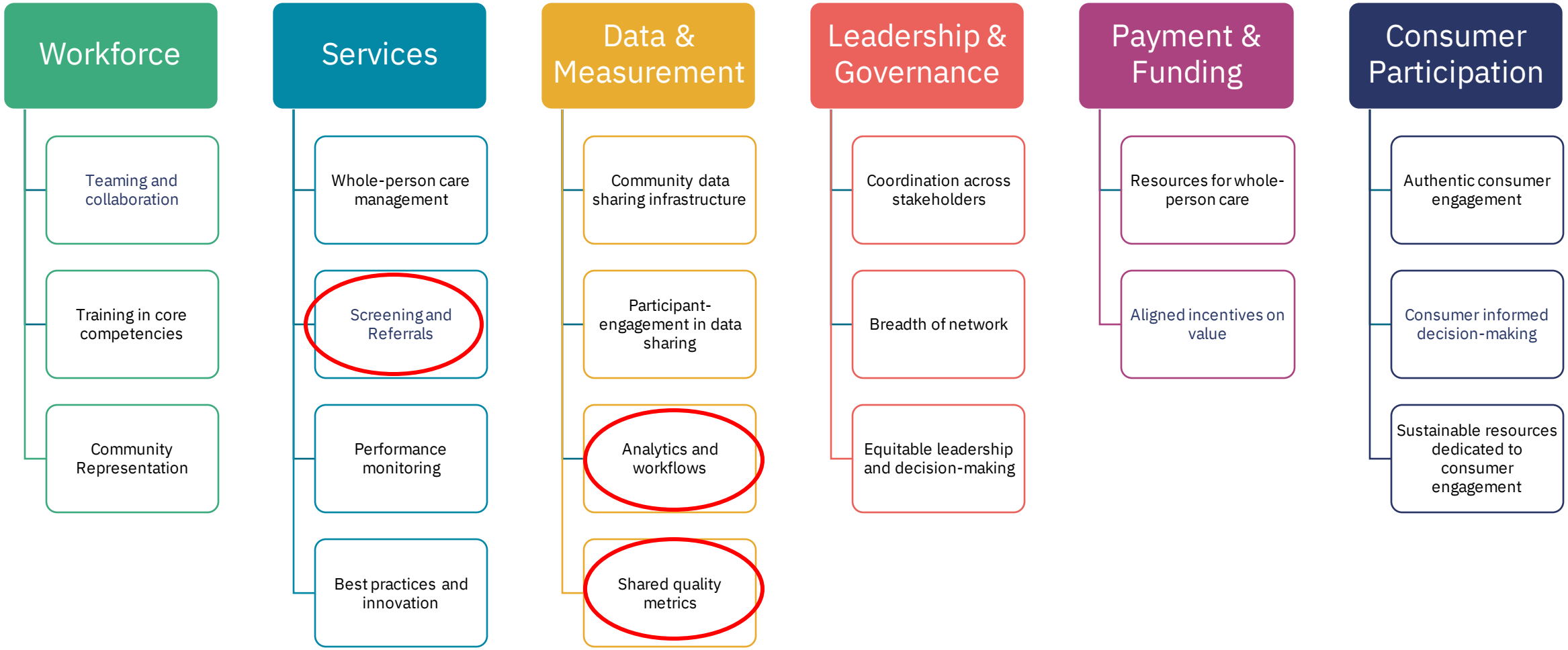
Vision

Transformed health and social systems that ensure every individual receives person-centered care rooted in authentic healing relationships.

We work to strengthen ecosystems of care by focusing on key domains



Today we'll focus on projects that exemplify the work we've done related to SDoH screening and data-driven workflow activation



Activating Data in the Accountable Health Communities model

Accountable Health Communities

Screening

Navigation

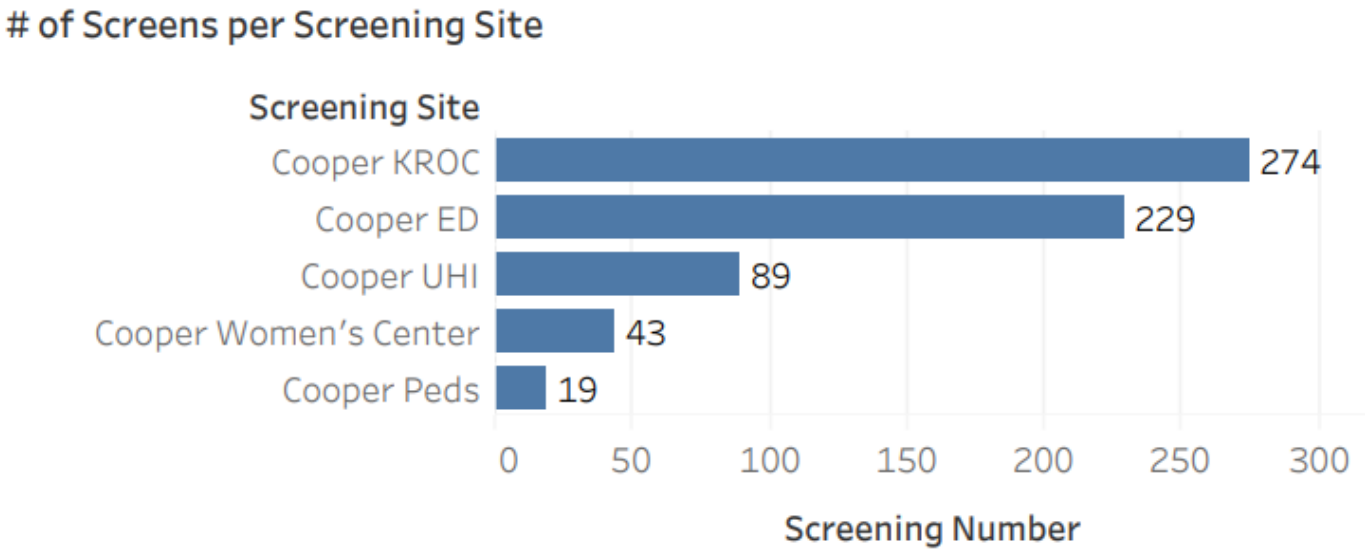
Data Sharing

Screening

findhelp

Leveraging FindHelp for Screening Workflows

- Worked with FindHelp to build the AHC screener into our white label **"My Resource Pal"**
- Enabled **"kiosk" mode**
- **Consent was built in** – notifying patients that treating providers would receive their social data
- Leveraged AHC funding to recruit health system partners to deploy **FindHelp Epic integration**
- Built **"favorites folders"** for each domain (tailored for our 3-county geography)
  - Relevant resources would print for everyone who flagged in any domain
- All screening data pushed into a **SQL database** that our data team had access to



Submitted Screenings

273 screens were completed at your site!

Individuals with at least 1 need flagged

100 individuals (38.5%) flagged positive for one or more domains.

Individuals Eligible for Navigation

25 individuals (9.6%) were eligible for navigation.

Individuals who Opted in to Navigation

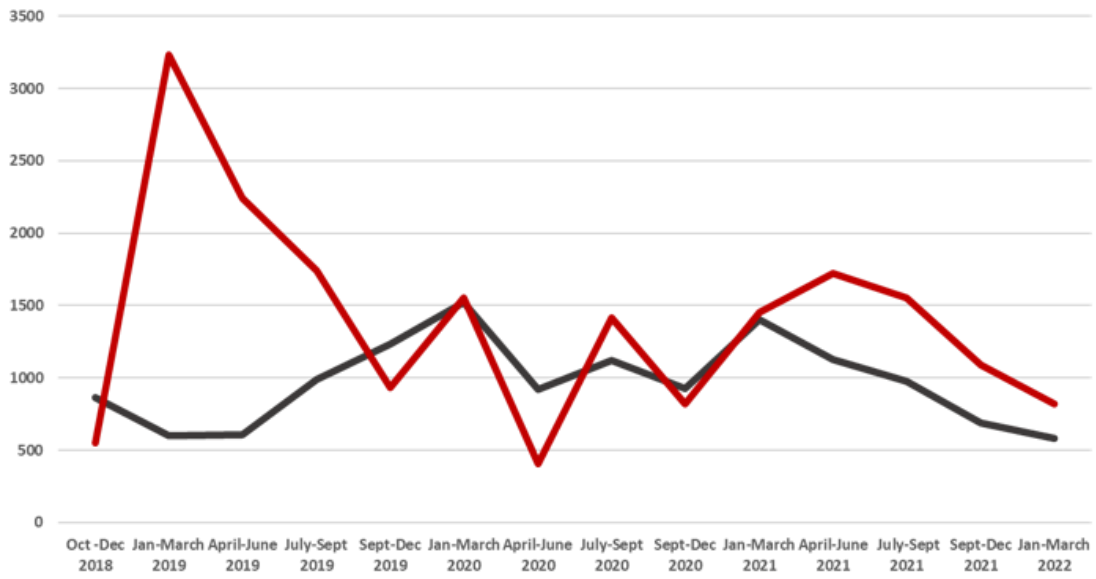
1 individuals opted in for navigation.

Leveraging data to sustain screening momentum with providers

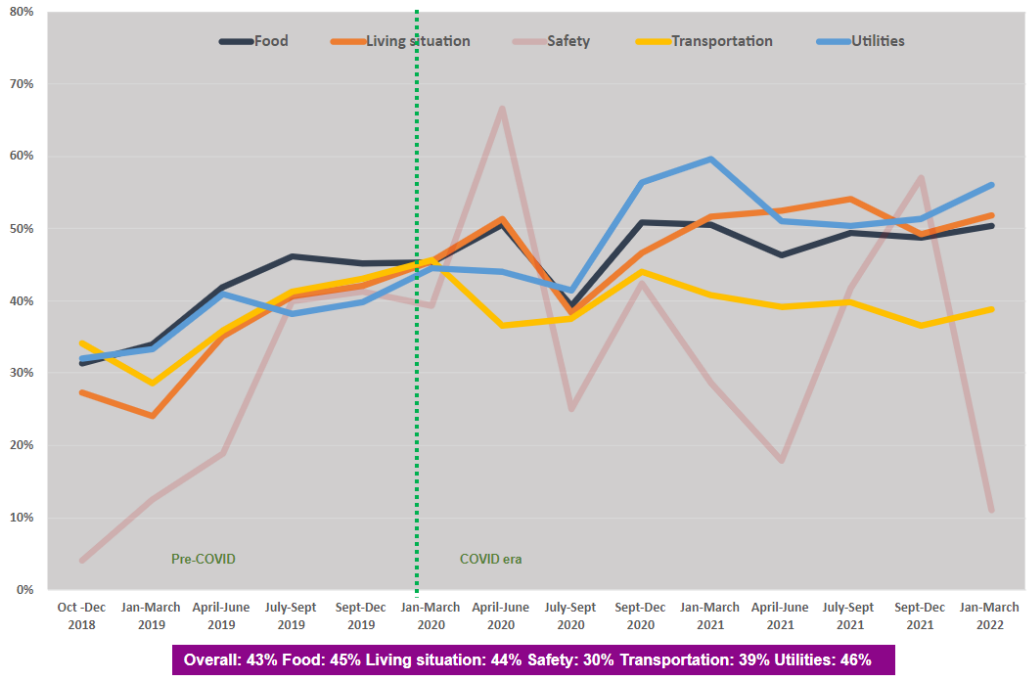
- SQL data pushed into Tableau for monthly scorecards
- Met with sites independently to drive QI efforts
- Included navigators in meetings to highlight patient stories

Leveraging regional screening and navigation data to drive engagement of the FindHelp platform and identify opportunities to address gaps

Quarterly screens by site type (outpatient or ED/L&D)



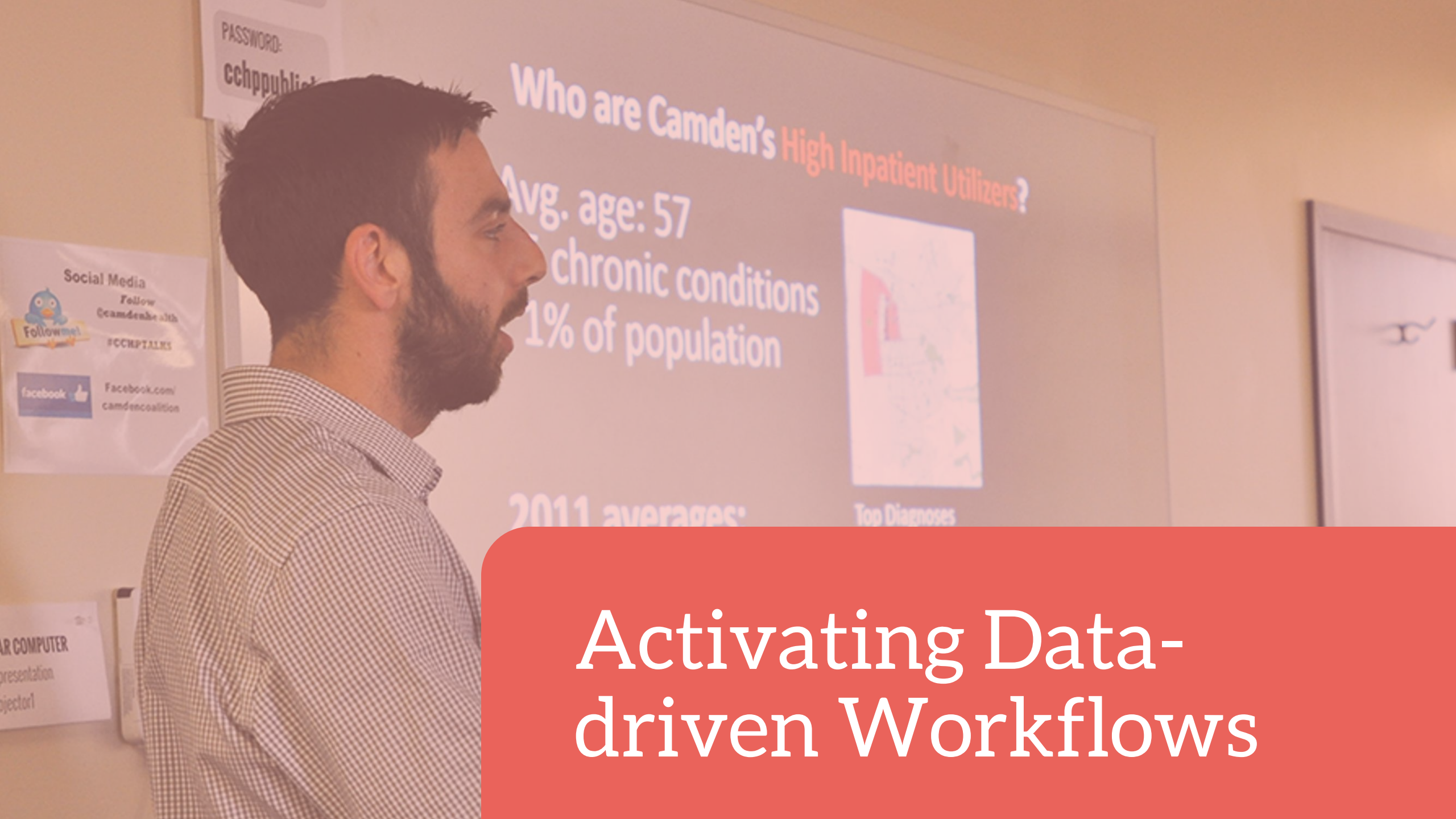
Percentage of needs resolved for navigation cases



Overall: 43% Food: 45% Living situation: 44% Safety: 30% Transportation: 39% Utilities: 46%

Efforts to incorporate health and social data via the Health Information Exchange and Find Help

- AHC screening data was incorporated into patient HIE records through periodic imports out of SQL database
- On-boarding community-based organizations onto the HIE
- Recently connected our FindHelp instance with our HIE through a FHIR integration
- Working to activate regional FindHelp “coalition” with data sharing agreements in place



Activating Data-driven Workflows

Safer Childbirth Cities

Leveraged the HIE to identify pregnant individuals in 13 EDs across the region

Assigned them to 6 partner sites for outreach

Engaged and established trust

Script and expertise in engaging in early pregnancy conversations

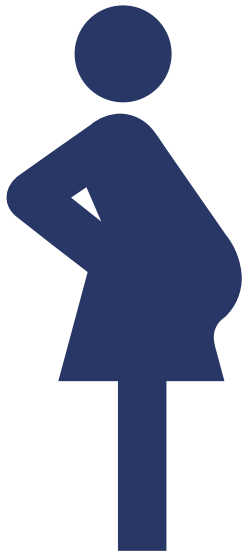
Shifted to a proactive model of care delivery

Scheduled prenatal visits and addressed social determinants with a small flexible patient costs fund

Strengthened t he ecosystem of care around the perinatal population

Outreach sites became well-versed in activating referral pathways for other clinical and social care as needed

Safer Childbirth Cities

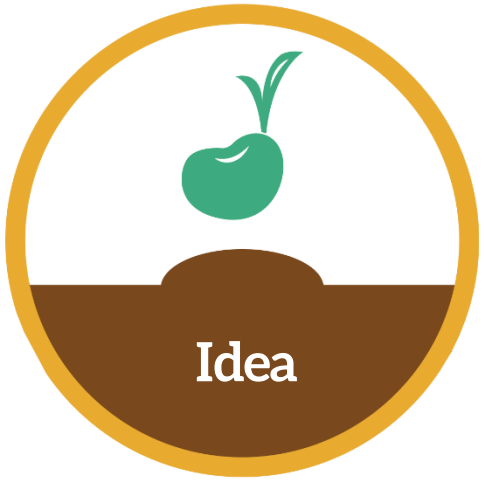


Learnings from standing up a new data-driven workflow

- It was possible to enlist clinical and community-based sites to do these daily outreach calls with **existing staff**
- **Patient costs funds** went a long way and served as burn-out prevention
- Outreach teams needed to **learn how** to have these conversations (did not use a screening tool)
- Patients picked up the phone more than half the time and were generally **open and appreciative**
- Almost half of the people we spoke to **accepted support**

Pledge to Connect

Embedding CCBHC case managers in the ED to connect pts with mental health needs to outpatient BH care



Created protocols, PDSA cycles. Connected outcome metrics to NJ Medicaid pay for performance program

In 2022, began to scale the pilot to 4 health systems & initiate regional triage and case conferencing

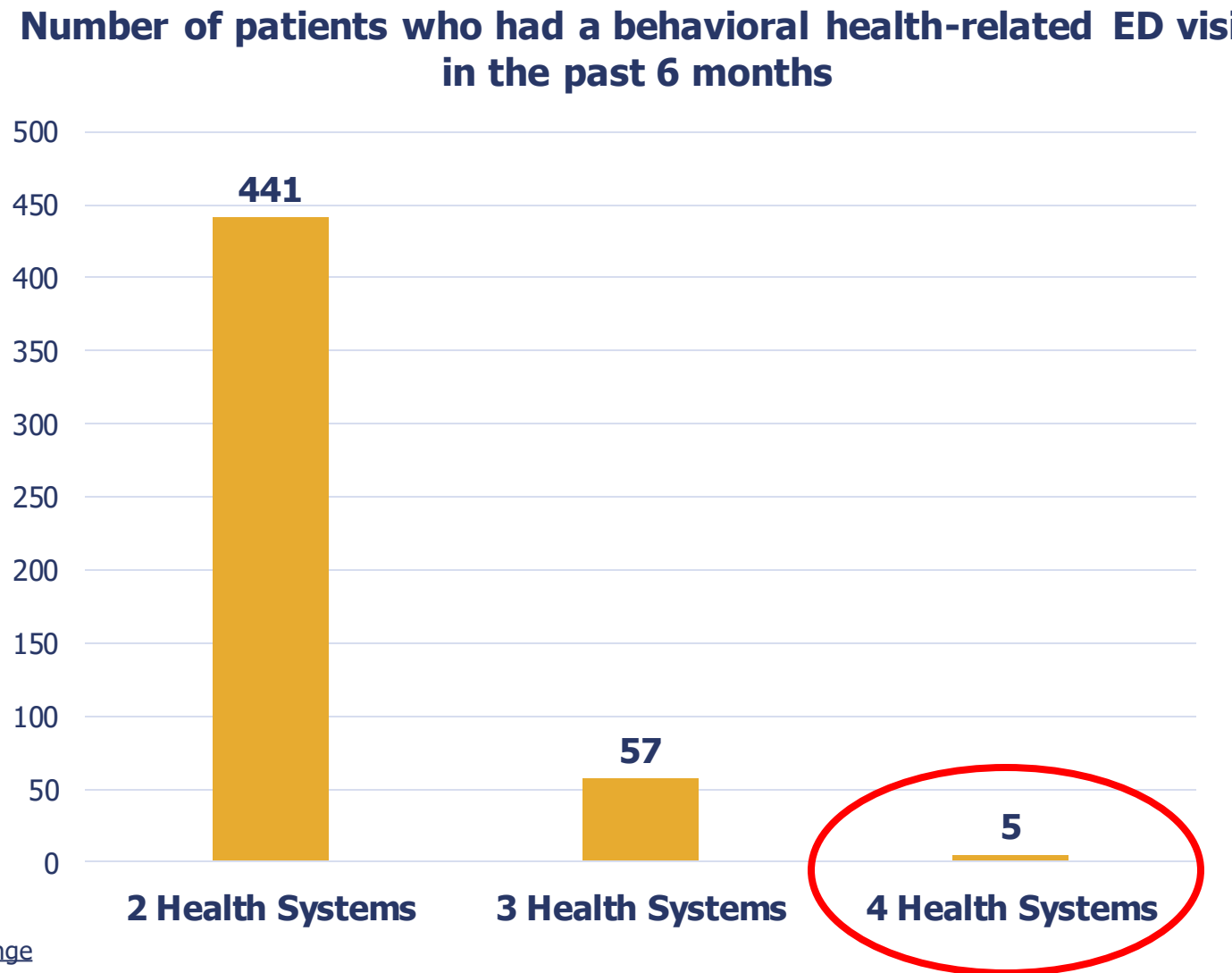
Pledge to Connect

In 2022, began to scale the pilot to 4 health systems & initiate regional triage and case conferencing

- Since January 2022 there have been over **7,000** referrals into this program for **6,386** individuals
- **84%** of those determined eligible for the program received outreach.
- **90%** of patients who received in-person support were successfully engaged, compared to 50% telephonically.
- Of the patients who accepted support, nearly **80%** got a scheduled appointment. 44% of those patients attended their appointments.

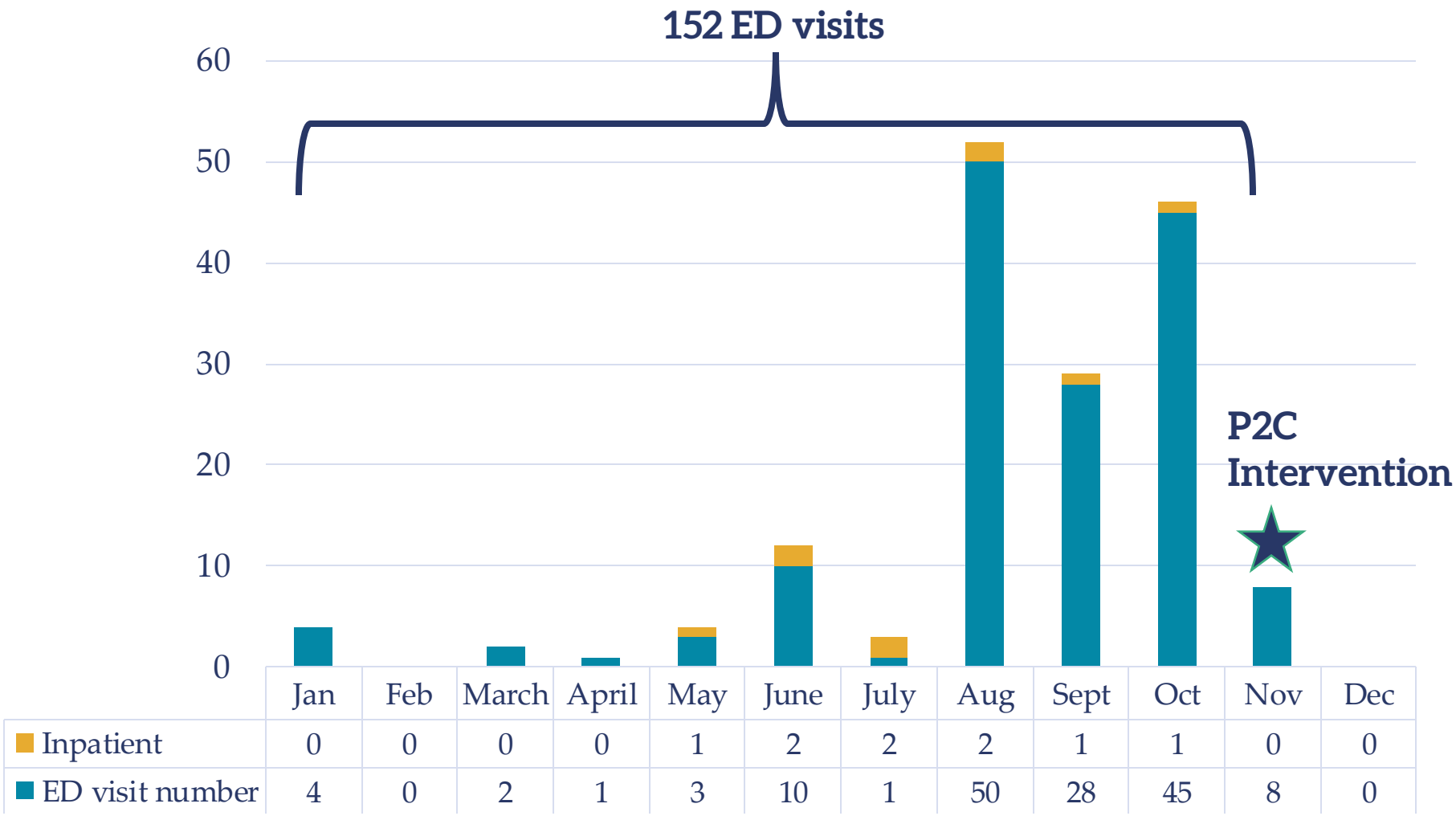
Pledge to Connect

- Convenings for multi-system partners
- Integration of BH data into our HIE
- Regional triage pilot



Data compiled through the Camden Coalition Health Information Exchange

Pledge to Connect



	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Inpatient	0	0	0	0	1	2	2	2	1	1	0	0
ED visit number	4	0	2	1	3	10	1	50	28	45	8	0

- Was **cycling in & out** of EDs, psych hospitals, nursing homes & boarding homes with high behavioral and cognitive complexity.
- Required **high touch collaboration around discharge planning** with Oaks as primary contact, included funding for short-term stay.

Thank you

Camden Coalition

Natasha Dravid, (she/her)
Camden Coalition

Questions?

Next Steps

★ Check out the latest release of the **SDOH Metric FAQ**

2024 CCO LC Playbook – Coming Soon!

Upcoming Metric TA Opportunities

- **LC: Addressing Resource & Referral Gaps through use of REALD data**
  - May 30, 2024, 3 p.m. PST – Registration Link
- **Value Sets Round Table Session 1**
  - June 14, 2024, 10 a.m. PST – Registration Link
- **Value Sets Roundtable Session 2**
  - June 18, 2024, 3 p.m. PST – Registration Link

Measure Contacts

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