SOCIAL DETERMINANTS OF HEALTH ORGANIZATIONAL MEMBER PROFILE COMPENDIUM

CIVITAS
Networks for Health

DECEMBER 2022



About Civitas Networks for Health

Civitas Networks for Health is a national collaborative comprised of member organizations working to use health information exchange, health data, and multi-stakeholder, cross-sector approaches to improve health. Civitas was previously known as the Strategic Health Information Exchange Collaborative and the Network for Regional Healthcare Improvement, and today represents more than 180 local health innovators from across the US, moving data to improve health outcomes for more than 95% of the U.S. population. Civitas educates, promotes, and influences both the private sector and policy makers on matters of interoperability, quality, coordination, health equity, and cost-effectiveness of health care. Working with health innovators at state and local levels, Civitas facilitate the exchange of valuable resources, tools, and ideas—and offer a national perspective on upcoming standards and regulations, emerging technologies, and best practices.

Acknowledgements

Civitas Networks for Health would like to acknowledge the SDOH and Interoperability Workgroup for their support with the dissemination of the organizational profile survey. We would like to specially thank the SDOH Profile Subgroup for their additional attention to the development of the profile survey and for being champions of this work. We are grateful to the members who responded to the organizational profile survey with a willingness to share about their work in 2022.

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SDOH Organizational Profile Purpose

A subgroup of the Civitas Networks for Health Social Determinants and Interoperability Workgroup created an SDOH Organizational Profile Survey to compile information on the SDOH and interoperability initiatives, progress, and current work of Civitas members across the national network in 2022.

Addressing unmet social needs is a critical part of advancing health and health care improvement in our communities. Social determinants of health (SDOH) include needs related to food, housing, finances, employment, social isolation, transportation, and other non-medical factors that can impact people's ability to achieve and maintain health. Strategies for addressing unmet social needs continue to evolve. Civitas members are increasingly engaged in facilitating, leading, and supporting these efforts.

By capturing the profiles of member organizations involved in this work, Civitas seeks to advance our collective knowledge, facilitate information sharing, and highlight the important role that members play in advancing SDOH work and addressing unmet social needs in the communities they serve.

If you have any questions about the SDOH profile or process, please reach out to jritzo@civitasforhealth.org.

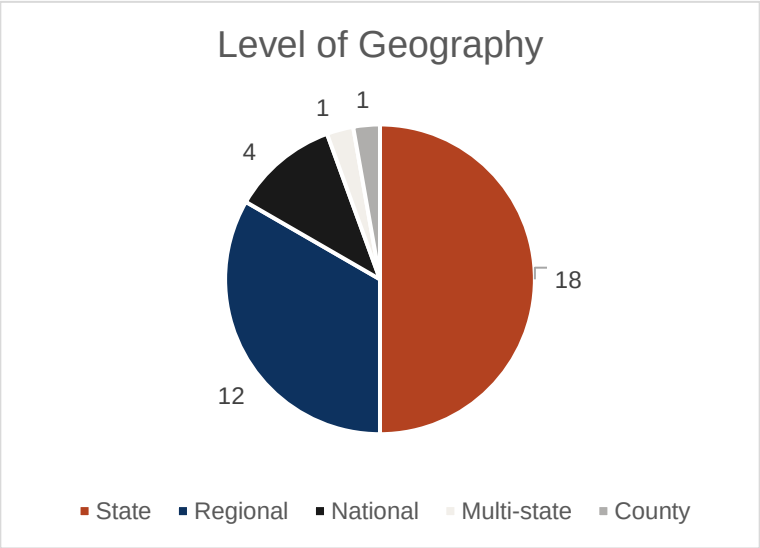
General Survey Information and Guide to Use

The 2022 SDOH Organizational Profile survey was completed by 36 Civitas Networks for Health members from regions throughout the country. All Civitas members were invited to participate in completing the SDOH organizational profile survey through various Civitas communication channels – workgroup meetings, Network News, and member communication blasts.

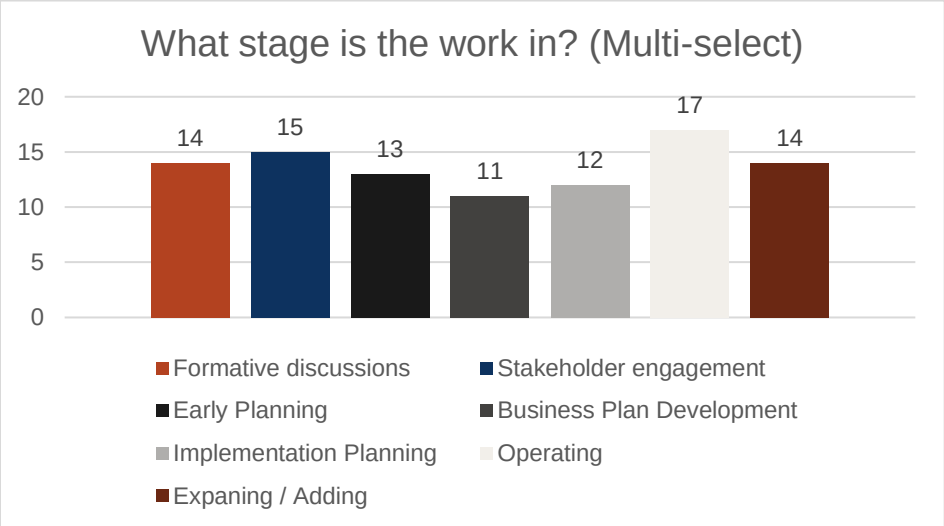
Each SDOH organizational profile found in the table of contents is displayed as submitted by the member organization. Edits were made to organizational profiles only to correct grammatical errors. Every member organization's name is hyperlinked at the top of their unique page. Civitas encourages readers to visit individual member websites for more information about their work. The intent of the information in the compendium is to increase information sharing and understanding of other members' work and to provide a picture of work that is happening across the national landscape. This compendium represents work that has happened in 2022 with the understanding that Civitas members are in action, often regarded as implementers, and this work is evolving quickly. This profile compendium is not evergreen, and we hope to refresh the data annually.

The data collected in the SDOH profile submission form was intended to be qualitative rather than quantitative. Although Civitas has pulled out key highlights for quantitative analysis, the bulk of this compendium focuses on the qualitative responses to our members' SDOH work.

Highlights from the Data

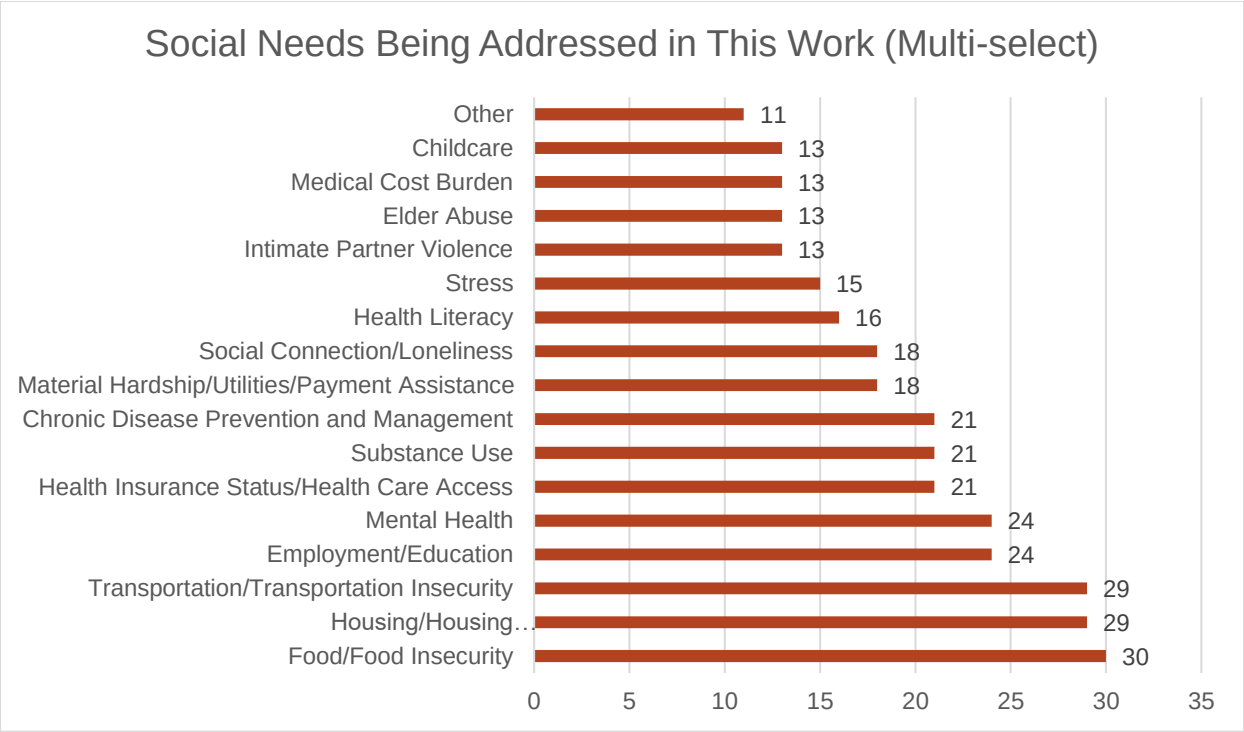


Exactly half of respondents attested that the level of geography they serve is statewide. One-in-three respondents serve a regional geography, and about one-in-ten respondents serve a national geography. For multi-state and county level, only one respondent indicated a focus for either option.



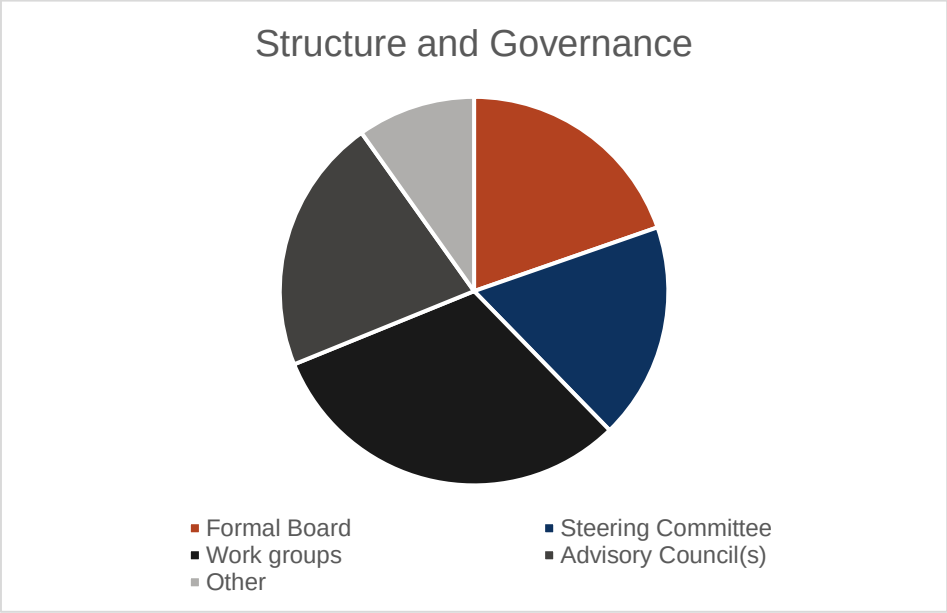
The stages of work among participants range widely though there is a close to even split across selections. It is important to note that this question allowed respondents to select more than one answer.

*Color key reads left-to-right

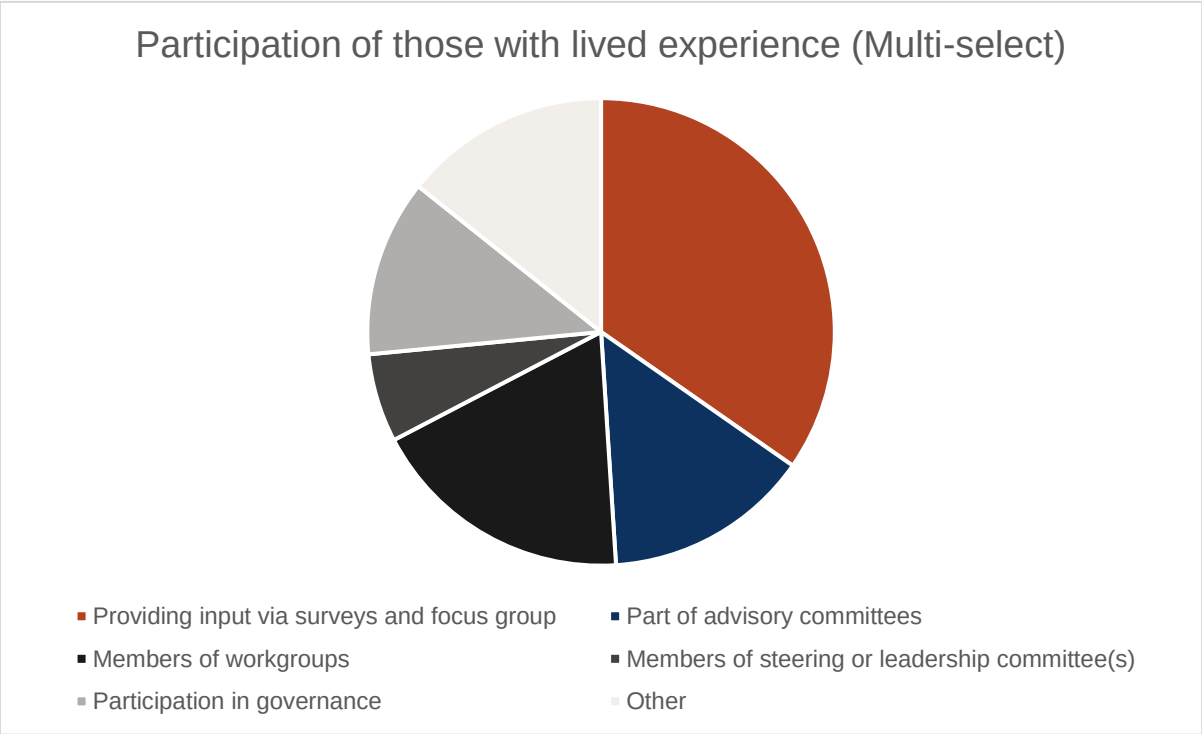


Respondents indicated a wide variety of social needs being addressed by their work. Most respondents are working to address more than one social need.

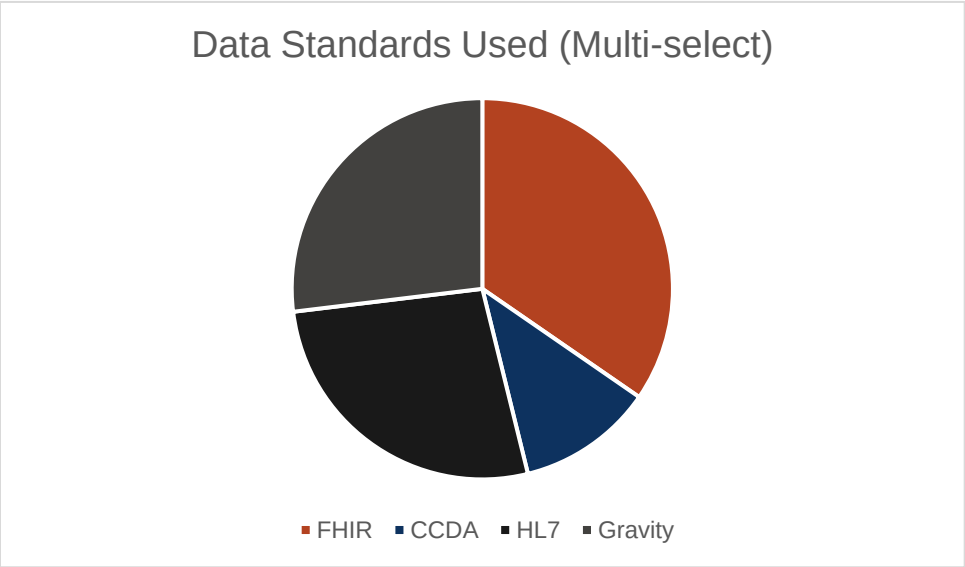
Civitas members are most often addressing the following three social needs: food/food insecurity, housing/housing instability/homelessness/inadequate housing, and transportation/transportation insecurity.



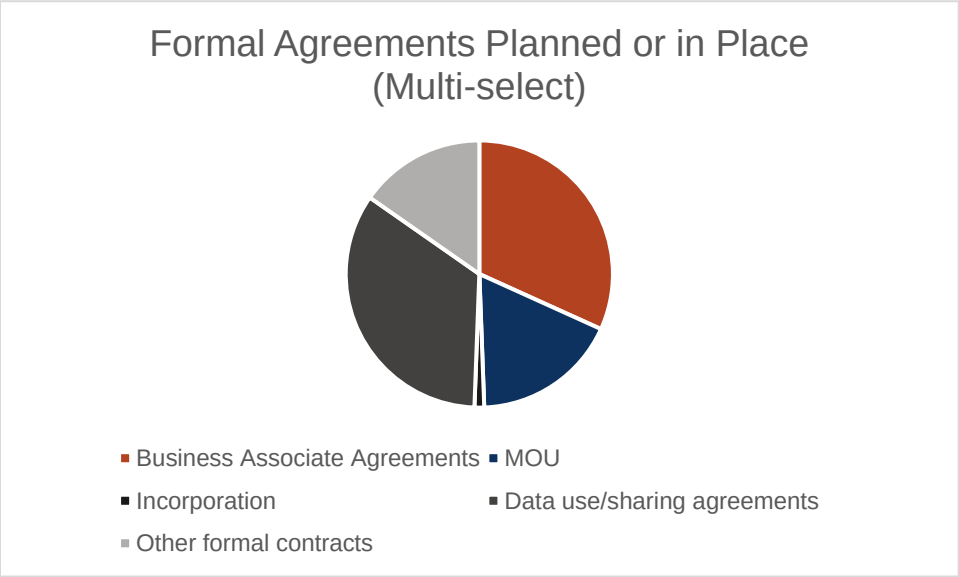
The structure and governance either planned or in place for member organization's SDOH work varies across respondents. Respondents were able to select multiple options out of the 5 listed. Most of the organizations that selected "Other" indicated that the structure and governance is to be determined.



28 of the 36 respondents indicated patients, community members, and people with lived experiences are involved in some way with their work. Most respondents attested that individuals with lived experiences are involved through providing input via surveys and focus groups. Please note that respondents were allowed to select multiple answers for this question.



Respondents filled in a free text box with what data standards they use for their SDOH work. The top four answers were FHIR, CCDA, HL7, and Gravity standards; it is important to note there are others.



Members responded in the following way to having formal agreements planned or in place. Respondents were able to select more than one answer choice. Most organizations selected multiple answers.

Organizational Member Profiles

C3HIE

SDOH opportunity/challenge/problem being addressed: To ensure that as insecurities are identified for an individual that there is appropriate awareness at the level of service and clinical providers, that the loop is closed (i.e. client receives services and status is shared), eligibility is factored early (reduce referrals to ineligible services), services that improve health outcomes are reimbursed (for sustainable models with positive financial ROI to the community), and most of all the client is respected and has a dignified experience.

Expected outcome/impact of the work: As SDOH needs are better met, health outcomes improve, Medicaid costs are reduced, and CBOs have reliable reimbursement models.

Level of geography served: State

Stage of the work: Stakeholder engagement; local communities are doing a great job pulling together CBOs and an SDOH framework. More work to engage clinical stakeholders, HHSC, and state legislators.

Social needs being addressed: Childcare; chronic disease prevention and management; elder abuse; employment/education; food/food insecurity; health insurance status/health care access; health literacy; housing/housing instability/homelessness/inadequate housing; intimate partner violence; material hardship/utilities/payment assistance; medical cost burden; mental health; social connection/loneliness; stress; substance use; transportation/transportation insecurity

Capacity or capability being built by C3HIE: Data contribution (patient/clinical/claims); Enabling data sharing and Interoperability; Referral processes and platforms

Capacity or capability being built by partners: Data contribution (patient/clinical/claims); data governance; human/process, e.g., care coordinators, community health workers, workflows, administrative hub, etc.; other technology; referral processes and platforms

Role of C3HIE in the work: Convener and/or facilitator; member of governance; quality improvement and/or data analysis

Strengths/assets brought by C3HIE to the work: As an established HIE, we primarily bring clinical data, trust, and interoperability capabilities to the table. However, we are also involved in local and State committees, relationships with HHSC and public health that can help in common statewide planning and engagement.

Other types of organizations are involved in the work: Academic/research organizations; clinics/FQHC; community-based organizations; hospitals; payors/health plan; physicians/medical groups; state Medicaid

Formal agreements in place: Business associate agreements; data use/sharing agreements

Data standards being used: Still early, but hope to leverage national standards, including vocabularies from Gravity Project and FHIR4

Structure and governance for the work: Workgroups

Involvement of people with lived experience: Members of workgroups

Funding of participation in the work: Currently not funded - all volunteer work

CareQuest Institute for Oral Health

SDOH opportunity/challenge/problem being addressed: CareQuest Institute for Oral Health® is a national nonprofit championing a more equitable future where every person can reach their full potential through excellent health. We collaborate with thought leaders, health care providers, patients, and local, state, and federal stakeholders, to accelerate oral health care transformation and create a system designed for everyone.

Expected outcome/impact of the work: Our intended impact is an oral health system of the future that is personalized and equitable, empowers consumers to be champions of their health, and leverages community resources and partners in a value-based environment.

Level of geography served: National

Stage of the work: Business plan development; early planning; expanding/adding; formative discussions; implementation planning; operating; stakeholder engagement; because of our structure and focus on advancing community-informed solutions, our work is continually iterating and expanding to identify needs and drive towards solutions.

Social needs being addressed: Chronic disease prevention and management; employment/education; food/food insecurity; health insurance status/health care access; health literacy; medical cost burden; mental health; oral health; substance use; transportation/transportation Insecurity

Capacity or capability being built by CareQuest Institute for Oral Health: "Data contribution (patient/clinical/claims); data governance; enabling data sharing and Interoperability; human/process, e.g., care coordinators, community health workers, workflows, administrative hub, etc.; other technology; referral processes and platforms

Capacity or capability being built by partners: Data contribution (patient/clinical/claims); data governance; enabling data sharing and interoperability; human/process, e.g., care coordinators, community health workers, workflows, administrative hub, etc.; other technology; referral processes and platforms

Role of CareQuest Institute for Oral Health in the work: Convener and/or facilitator; enabling interoperability of SDOH data; leverage existing data sources to fully inform social needs outcomes; quality improvement and/or data analysis

Strengths/assets brought by CareQuest Institute for Oral Health to the work: We drive meaningful change through expertise and leadership in five areas of activation — grantmaking, research, health improvement programs, policy and advocacy, and education — and two areas of influence — dental benefits and innovation advancement. Through our health improvement programs, we provide support for both dental and medical providers to build practice capacity, collect and utilize patient data, understand community needs, grow interprofessional partnerships, deliver integrated, whole-person care, and improve patient outcomes.

Other types of organizations are involved in the work: academic/research organizations; clinics/FQHC; community-based organizations; foundations/funders; national associations; other civic/state/city/county; payors/health plan; physicians/medical groups; public health department; public/government/private funders (3 options +); state Medicaid

Formal agreements in place: Business associate agreements; data use/sharing agreements; MOU; other formal contracts

Data standards being used: Health Level Seven (HL7),FHIR

Structure and governance for the work: Workgroups

Involvement of people with lived experience: Providing input via surveys and focus groups

Funding of participation in the work: Through existing business operations/mission

Other: As part of the Dental Data Exchange Project, CareQuest Institute helped develop the first implementation guides to bridge the communication gap between primary care and oral health care. These new publications, the Health Level Seven® (HL7) CDA® and FHIR® implementation guides, are designed to facilitate care coordination and create best practices for electronic exchange of patient data between dental and medical professionals. This exchange of information will support interprofessional practice, population health management, and value-based care.

Comagine Health

SDOH opportunity/challenge/problem being addressed: Comagine health seeks to improve health and reduce disparities through serving as a neutral convener and capacity builder in the communities we serve. We serve in a variety of roles including as a convener, backbone infrastructure support, data analytics and evaluation and technical assistance provider.

Expected outcome/impact of the work: We have multiple divisions working in the space to address SDOH. Expected outcomes by division:

- **Systemwide Quality Improvement**: If we are successful in collaboration with our partners, we will establish or enhance integrated referral and resource exchange networks in the states we serve that are meaningfully improving health outcomes and reducing disparities. We are also working to support increased workforce capacity for community care coordination and community health workers.
- **Research & Evaluation**: We will better understand the risk of opioid overdoses based on patient-level risk factors, and household and community prescription levels. We will also assess whether the risk of overdose among women released from prison is reduced by providing medications for opioid use disorder and support from Certified Recovery Mentors prior to and following release.
- **Data Solutions**: We will optimize our existing data assets and leverage new data sources with actionable and insightful analytics to identify historical and current disparities in health care access and quality, as well as disparities in health across our populations. Using a data-driven approach, we will ensure that interventions and actions to improve health equity are targeted and impactful, ultimately reducing disparities in health and healthcare.

Level of geography served: National

Stage of the work: Business plan development; early planning; expanding /adding; formative discussions; implementation planning; operating; stakeholder engagement; Comagine Health operates in several different states and communities to advance efforts to improve the systems that support addressing SDOH in the areas of population health data management and use, improvements in systems that support coordination between health care, social services and community based organizations; building capacity for community based organizations to engage with state and local referral

systems, and contract with health plans to provide services; increasing capacity of community health worker models and evidence based prevention and chronic disease self-management programs and supports to improve access to services in community based settings for underserved communities. All our work is data driven and measurable, and we work with our partners to collect quantitative and qualitative data to target our interventions and measure the impact of our work.

Social needs being addressed: Chronic disease prevention and management; employment/education; food/food insecurity; health insurance status/health care access; health literacy; housing/housing instability/homelessness/inadequate housing; material hardship/utilities/payment assistance; mental health; social connection/loneliness; substance use; transportation/transportation insecurity

Capacity or capability being built by Comagine Health: Data contribution (patient/clinical/claims); data governance; enabling data sharing and interoperability; human/process, (e.g., care coordinators, community health workers, workflows, administrative hub, etc.; other technology; referral processes and platforms

Capacity or capability being built by partners: Data contribution (patient/clinical/claims); data governance; enabling data sharing and interoperability; human/process, e.g., care coordinators, community health workers, workflows, administrative hub, etc.; other technology; referral processes and platforms

Role of Comagine Health in the work: Backbone/infrastructure; convener and/or facilitator; data exchange/storage; leverage existing data sources to fully inform social needs outcomes; quality improvement and/or data analysis; serving as all-payer claims database

Strengths/assets brought by Comagine Health to the work: We have a long history in the communities we serve and are uniquely positioned as a neutral convener and facilitator. We have a deep bench of expertise in quality improvement, clinical-community care coordination research and evaluation, and advanced analytics. We also serve as the All-Payer Claims Database in one state, and we are working at the forefront of the industry to combine claims and clinical data. Our health information technology team is working with state Medicaid programs to improve and modernize their enterprise systems, improving collection of SDOH data and integrating with other state systems.

Other types of organizations are involved in the work: Academic/research organizations; clinics/FQHC; community-based organizations; employer;

foundations/funders; hospitals; national associations; area agencies on aging; other civic/state/city/county; payors/health plan; physicians/medical groups; public health department; public/government/private funders (3 options +); state Medicaid; tribes; United Way/211

Formal agreements in place: Business associate agreements; data use/sharing agreements; MOU; other formal contracts

Data standards being used: Our team is following the work of the APCD Council and the common data layout as it is recommended for all payer claims databases. We follow the guidance of the ONC regarding interoperability and data collection, including new standards around race and ethnicity. We have developed data quality standards for claims and other administrative healthcare data sources that we work with, including allowances for missing, out of range, and logic checks. We apply CMS cell suppression standards and follow NCQA guidance on minimum sample size for quality measure reporting. Finally, we follow state-guidance where applicable, as many states have their own standards regarding data collection, use, and reporting. We have additional data requirements and standards that align with our different initiatives in different states and are committed to ensuring the use of best practices and evidence-based data frameworks where available for the programs we support.

Structure and governance for the work: Advisory council(s); steering committee; workgroups

Involvement of people with lived experience: Members of steering or leadership committee(s); part of advisory committees; providing input via surveys and focus groups

Funding of participation in the work: Federal funding; foundation funding; state funding

Other: Our External Quality Review team has expanded the scope of standard Medicaid EQR contracts to include SDOH-focused comparative reporting, helping the State of Washington better understand variances in health and health care access and quality between managed care organizations and regional variations across the state. This reporting program has included a deep-dive analysis into specific quality measures, identifying sub-populations whose quality measure results deviated from the overall results.

You can find our data solutions website here: https://comagine.org/service/data-solutions

Connie

SDOH opportunity/challenge/problem being addressed: In support of bold pockets of efforts already underway in our state, Connie is looking to enable social needs data sharing through the HIE to tie disparate, but critically important, efforts together in a wholistic and more impactful way. We anticipate the data to include SDOH screenings results, SDOH z-code “problems”, service needs, referrals made, programs enrolled, and care team. Per other affiliates, we are looking to implement our approach such that it is agnostic to the products individual organizations utilize to support their patients’ SDOH care coordination.

Expected outcome/impact of the work: Access to SDOH data through the HIE is particularly useful in care management where the data can inform care plans and identify potential treatment adherence issues. If successful, it will not matter where in the system a patient received an SDOH assessment, diagnosis, or referral. The patient's care team will be able to see that information and build upon it. This will reduce redundant efforts, improve care coordination, and boost follow-up on needed services. Other potential values of SDOH data include reduction in no shows, reduction in non-emergent ED visits, improved medication adherence, and more informed population health analytics.

Level of geography served: State

Stage of the work: Early planning; formative discussions; stakeholder engagement; Connie is in the process of rolling out a Conditions UI to display SDOH specific ICD-10 z-codes.

Social needs being addressed: Elder abuse; employment/education; food/food insecurity; housing/housing instability/homelessness/inadequate housing; mental health; social connection/loneliness; substance use; transportation/transportation insecurity

Capacity or capability being built by Connie: Data contribution (patient/clinical/claims); data governance; enabling data sharing and interoperability; referral processes and platforms

Capacity or capability being built by partners: Data contribution (patient/clinical/claims); data governance; enabling data sharing and interoperability; referral processes and platforms

Role of Connie in the work: Convener and/or facilitator; data exchange/storage; enabling interoperability of SDOH data; leverage existing data sources to fully inform social needs outcomes

Strengths/assets brought by Connie to the work: Connie is the health data utility for the state of Connecticut. Due to state statute, all licensed health care providers must connect to the HIE.

Other types of organizations are involved in the work: Clinics/FQHC; Community-based organizations; hospitals; private vendors of SDOH referral systems.; other civic/state/city/county; physicians/medical groups; public health department; public/government/private funders (3 options +); state Medicaid; United Way/211

Formal agreements in place: Business associate agreements; Data use/sharing agreements

Data standards being used:

Structure and governance for the work: Advisory council(s); Workgroups

Involvement of people with lived experience: Part of advisory committees

Funding of participation in the work: Federal funding; State funding

Connxus

SDOH opportunity/challenge/problem being addressed: Goal is to serve as the community data backend. This will allow data from multiple sectors to be integrated at one-stop location. Further, we can then develop community-level analysis to show the impact of SDOH work on education, health, and workforce sectors.

Expected outcome/impact of the work: Show improvement in health outcomes, education outcomes, and workforce outcomes by providing the right interventions and services to individuals and families in Central Texas.

Level of geography served: Regional

Stage of the work: Formative discussions; Stakeholder engagement

Social needs being addressed: Housing/Housing Instability/Homelessness/Inadequate Housing; As the first step, we have created entry points for individuals/families to seek help in the entry point area. We have developed tools and processes for the entry point organizations to capture individual/family SDOH needs; connect them to resources; follow-up to ensure the individuals/families receive the needed help.

Capacity or capability being built by Connxus: Data contribution (patient/clinical/claims); data governance; enabling data sharing and Interoperability

Capacity or capability being built by partners: Data contribution (patient/clinical/claims); enabling data sharing and interoperability; human/process, e.g., care coordinators, community health workers, workflows, administrative hub, etc.; referral processes and platforms

Role of Connxus in the work: Backbone/infrastructure; data exchange/storage; enabling interoperability of SDOH data; enabling interoperability of directories; leverage existing data sources to fully inform social needs outcomes; quality improvement and/or data analysis

Strengths/assets brought by Connxus to the work: Deep and long connection with community organizations that closely collaborate on solutions. We also benefit from a partnership with UT Austin as one of the largest public academic organizations in the country.

Other types of organizations are involved in the work: Clinics/FQHC; Community-based organizations; foundations/funders; hospitals; public health department; United Way/211

Formal agreements in place: Business associate agreements; data use/sharing agreements; MOU

Data standards being used: We have solutions using FHIR but have been heavily a HL7 organization for a while.

Structure and governance for the work: Steering committee

Involvement of people with lived experience: In some capacity given the research work in partnership with UT through advisory groups.

Contexture (Arizona)

SDOH opportunity/challenge/problem being addressed: We have contracted with our state Medicaid agency as the only state HIE. We are rolling out a free, statewide SDOH referral platform called CommunityCares (powered by Unite Us).

Expected outcome/impact of the work: We have three main goals: 1. Connect healthcare providers to the multitude of CBOs that support SDOH and give them the free tools to get people connected. 2. Improve whole-person care with a statewide SDOH intervention. 3. Utilize data and analytics to optimize success.

Level of geography served: State

Stage of the work: Implementation Planning

Social needs being addressed: Childcare; chronic disease prevention and management; elder abuse; employment/education; food/food insecurity; health insurance status/health care access; health literacy; housing/housing instability/homelessness/inadequate housing; intimate partner violence; material hardship/utilities/payment assistance; medical cost burden; mental health; social connection/loneliness; stress; substance use; transportation/transportation insecurity; All SDOH needs are covered. The system is free for all of Arizona.

Capacity or capability being built by Contexture AZ: Referral processes and platforms

Capacity or capability being built by partners: Data governance; human/process (e.g., care coordinators, community health workers, workflows, administrative hub, etc.)

Role of Contexture AZ in the work: Backbone/infrastructure; social care platform

Strengths/assets brought by Contexture AZ to the work: We have a strong reputation in the state of Arizona as the state's only HIE. We are a non-profit organization. We have the experience and talent to implement this statewide technology as we have demonstrated with our work as the HIE. We also have the capabilities to build out custom reporting and analytics.

Other types of organizations are involved in the work: Academic/research organizations; clinics/FQHC; community-based organizations; foundations/funders; hospitals; national associations; other civic/state/city/county; payors/health plan;

physicians/medical groups; public health department; public/government/private funders (3 options +); state Medicaid; Tribes; United Way/211

Formal agreements in place: Business associate agreements; data use/sharing agreements; other formal contracts

Data standards being used: We are utilizing the Unite Us platform

Structure and governance for the work: Formal board; workgroups

Involvement of people with lived experience: N/A

Funding of participation in the work: Other stakeholder contributions; State funding

Other: We went live in October 2021 on NowPow but had to go on pause due to Unite Us purchasing NowPow. As of 7/21/22 we are still working on a contract with Unite Us to relaunch the program. This has slowed efforts.

Contexture (Colorado)

SDOH opportunity/challenge/problem being addressed: Contexture works within Arizona (AZ) and Colorado (CO). This submission will focus on CO efforts. The AZ SDOH work is similar but functions differently, although in the process of unifying the strategy.

Contexture in CO is leveraging and enhancing existing infrastructure, such as investments in EMRs, care coordination tools, Contexture and Mile High United Way 2-1-1. We aim to develop an ecosystem of interoperability to support the automated exchange of information between healthcare providers, community organizations, public health, and state agencies.

Expected outcome/impact of the work: *For Contexture*: *Meet participants needs/wants to support SDOH program requirements and supports quadruple aim; Value of combined healthcare and SDOH data, full picture of patient; Supports equity, a Contexture company value

For Participants: One stop for all patient needs, health and social determinants of health*;* utilize the same workflow*; s*upports Quadruple Aim -- Improve patient outcomes, reduce cost of care, improve patient satisfaction, improve provider satisfaction*;* improve workflows, reduce level of effort*;* no duplicative data feeds

Level of geography served: State

Stage of the work: Business plan development; early planning; expanding /adding; formative discussions; implementation planning; operating; stakeholder engagement

Social needs being addressed: Chronic disease prevention and management; food/food insecurity; housing/housing instability/homelessness/inadequate housing; mental health; transportation/transportation insecurity; early intervention. We have been piloting many use cases, but we are expanding rapidly.

Capacity or capability being built by Contexture: Data contribution (patient/clinical/claims); data governance; enabling data sharing and interoperability; other technology; referral processes and platforms

Capacity or capability being built by partners: Human/process (e.g., care coordinators, community health workers, workflows, administrative hub, etc.; referral processes and platforms

Role of Contexture in the work: Backbone/infrastructure; data exchange/storage; enabling interoperability of SDOH data; enabling interoperability of directories; leverage existing data sources to fully inform social needs outcomes; member of governance; quality improvement and/or data analysis

Strengths/assets brought by Contexture to the work: Connection with 2-1-1; utilizing current HIE infrastructure/processes; participant engagement/trust

Other types of organizations are involved in the work: Clinics/FQHC; community-based organizations; hospitals; physicians/medical groups; public health department; public/government/private funders (3 options +); state Medicaid; United Way/211

Formal agreements in place: Business associate agreements; data use/sharing agreements; other formal contracts

Data standards being used: Gravity, but building a compendium of standards to continue growth and adoption

Structure and governance for the work: Advisory council(s); workgroups

Involvement of people with lived experience: Members of workgroups; participation in governance; providing input via surveys and focus groups

Funding of participation in the work: County funding; paid via contracts for services provide; state funding; through existing business operations/mission

CRISP Maryland

SDOH opportunity/challenge/problem being addressed: All members of an individual's health and social care teams can easily share and access relevant information about that individual to improve their health and well-being, while ensuring appropriate privacy protections.

Our goals are to (1) capture all social needs data and share it with appropriate members of the care team; (2) allow the care team to easily find any community resource for an individual's social needs; (3) enable seamless social care, closed loop referrals between healthcare, CBOs and social services; and (4) allow the health and social care teams to understand all of the relevant health and social services/resources patients are receiving inside and outside of the clinic or hospital.

Expected outcome/impact of the work: Members of a person's care team, in the community and within the healthcare setting will be better equipped with relevant data and tools to support the health and well-being of people throughout Maryland. We expect this will manifest in improved healthcare outcomes, reduced healthcare utilization and a health and social care system that works together to better the health of people across the state.

Level of geography served: State

Stage of the work: Expanding / Adding; Implementation Planning; Operating; Stakeholder engagement; Maryland is part of CRISP Shared Services (CSS). CSS allows affiliated HIEs to leverage shared business and technical infrastructure, and reuse technology to tap into economies of scale. In the case of social determinants of health, CSS has developed tools with three overarching characteristics that allow for applicability across heterogenous affiliates and stakeholders. These characteristics recognize that many stakeholders have already made investments in SDOH tools. This includes (1) supporting interoperability and integrations first; (2) being agnostic to tool, workflow, and system of record; and (3) creating a whole-person record that includes clinical and social care data. Data-sharing relies on buy-in and adoption from all stakeholders, including EHR vendors and SDOH referral platforms. We are working closely with stakeholders to prioritize integration with these platforms.

Social needs being addressed: Childcare; chronic disease prevention and management; employment/education; food/food Insecurity; health insurance status/health care access; health literacy; housing/housing

instability/homelessness/inadequate housing; material hardship/utilities/payment assistance; social connection/loneliness; stress; transportation/transportation insecurity; Our approach to SDOH data sharing is agnostic to tool, workflow, and system of record. This allows for our tools to support all social needs.

Capacity or capability being built by CRISP: Data contribution (patient/clinical/claims); data governance; enabling data sharing and interoperability; referral processes and platforms

Capacity or capability being built by partners: Data contribution (patient/clinical/claims); enabling data sharing and interoperability; human/process, e.g., care coordinators, community health workers, workflows, administrative hub, etc.; referral processes and platforms; sustainable funding mechanisms

Role of CRISP in the work: Backbone/infrastructure; convener and/or facilitator; data exchange/storage; enabling interoperability of SDOH data; enabling interoperability of directories; leverage existing data sources to fully inform social needs outcomes; member of governance; quality improvement and/or data analysis

Strengths/assets brought by CRISP to the work: State healthcare delivery reform: In a partnership with CMS, Maryland has the nation's only all payor model with hospital global budgets and a statewide focus on reducing cost and improving outcomes. This model has pushed healthcare stakeholders to be more innovative in their approach to improving population health, including addressing patients' social needs. In part, this has enabled CRISP to have close relationships with state entities who have been incredibly supportive of CRISP's work and vision.

Governance: We have established data governance that allows for thoughtful approaches to data sharing that allows for novel use cases to address social needs data sharing while protecting privacy.

Infrastructure: We have made significant investment in data-interoperability infrastructure over time within the healthcare system. We have been able to use this solid base of technology to improve social care data interoperability. In addition, our CRISP shared services approach allows Maryland to both contribute to other CSS states/jurisdictions and learn from their experiences using the same tools.

Human Resources: Our team of interoperability and technical subject matter experts have been able to engage with external stakeholders across the care continuum and create vendor agnostic tools that improve social needs data sharing.

Other types of organizations are involved in the work: Academic/research organizations; Clinics/FQHC; Community-based organizations; Hospitals; Health Services Cost Review commission – sets rates for hospital global budgets. Maryland Primary Care Program – advanced payment model for nearly 600 primary care offices throughout the state. Referral platform vendors; Other civic/state/city/county; Payors/health plan; Physicians/medical groups; Public health department; State Medicaid; United Way/211

Formal agreements in place: Business associate agreements; Data use/sharing agreements; MOU

Data standards being used: ICD-10, LOINC, FHIR, HSDS. Our work is aligning itself with the Gravity Project. We rely on our stakeholders to also adopt these standards for them to be effective.

Structure and governance for the work: Formal board; Steering committee; Workgroups

Involvement of people with lived experience: Members of workgroups

Funding of participation in the work: Federal funding; State funding; Through existing business operations/mission

Other: CRISP has developed tools that improve interoperability and data sharing across and between social care and healthcare stakeholders. We have made great progress, but full interoperability is only achievable with buy-in from all stakeholders including vendors, which has been a challenge at times.

CRISP DC

SDOH opportunity/challenge/problem being addressed: CRISP DC aims to prioritize the collection, exchange, and use of Social Determinants of Health (SDOH) data to reduce barriers and improve whole-person care in the district.

Expected outcome/impact of the work: CRISP DC seeks to address SDOH by serving as a technical solution that supports the ability to screen patients to identify social risks, assist them as appropriate, and tracking efforts that meet their needs. The DC HIE connects care partners, including health and social service providers, and fosters a culture of shared responsibility for ensuring the availability and quality of actionable information.

Level of geography served: State

Stage of the work: Expanding / Adding; implementation planning; operating

Social needs being addressed: Chronic disease prevention and management; elder abuse; employment/education; food/food insecurity; health insurance status/health Care access; health literacy; housing/housing instability/homelessness/inadequate housing; mental health; transportation/transportation insecurity

Capacity or capability being built by CRISP DC: Data contribution (patient/clinical/claims); enabling data sharing and Interoperability; referral processes and platforms

Capacity or capability being built by partners: Data contribution (patient/clinical/claims); data governance; enabling data sharing and Interoperability

Role of CRISP DC in the work: Backbone/infrastructure; data exchange/storage; enabling interoperability of SDOH data; enabling interoperability of directories

Strengths/assets brought by CRISP DC to the work: CRISP DC is also part of CRISP Shared Services (CSS). CSS allows affiliated HIEs to leverage shared business and technical infrastructure, and reuse technology to tap into economies of scale.

For the social determinants of health, CSS has developed tools with 3 overarching characteristics that allow for applicability across heterogenous affiliates and their stakeholders. These characteristics recognize that many stakeholders have already made investments in SDOH tools. These characteristics include:

- Supporting interoperability and integrations first.
- Being agnostic to tool, workflow, and system of record.
- Creating a whole-person record that includes clinical and social care data.

Other types of organizations are involved in the work: Clinics/FQHC; community-based organizations; hospitals; payors/health plan; physicians/medical groups; state Medicaid

Formal agreements in place: Business associate agreements; data use/sharing agreements; MOU

Data standards being used: All CSS technology solutions and integrations leverage a range of underlying critical infrastructure. Core to all services is the use of a Master Patient Index (MPI) to identify and reconcile unique patient identities used across a wide, distributed network. Using MPI-based matching allows the patient data from different sources to be linked together such that when a user makes a data request, clinical content from across a region can be presented in a single view for a particular patient, whether from within an EHR, a provider portal, or patient portal. CRISP uses shared MPI technology through CSS. Additionally, the use of HL7, Application Programming Interfaces (API), FHIR Referral Request data model, Open Referral, and the Bidirectional Services eReferrals (BSeR) Implementation Guide provide excellent resources and vision of facilitating data exchange of pertinent documents.

Structure and governance for the work: Formal board; Steering committee

Involvement of people with lived experience: N/A

Funding of participation in the work: Federal funding; State funding

CyncHealth

SDOH opportunity/challenge/problem being addressed: CyncHealth is committed to building a SDOH ecosystem that connects healthcare and social care. We act on this commitment by engaging community members in care that extends beyond the traditional healthcare space.

Expected outcome/impact of the work: To build a longitudinal healthcare record that includes health and social data to improve care delivery and community health.

Level of geography served: multi-State

Stage of the work: Expanding/Adding; During our experience, we have learned many lessons that we are happy to share with others at Civitas.

Social needs being addressed: Chronic disease prevention and management; employment/education; food/food insecurity; health insurance status/health care access; health literacy; housing/housing instability/homelessness/inadequate housing; material hardship/utilities/payment assistance; mental health; social connection/loneliness; substance use; transportation/transportation insecurity

Capacity or capability being built by CyncHealth: Data contribution (patient/clinical/claims); data governance; enabling data sharing and interoperability; human/process, e.g., care coordinators, community health workers, workflows, administrative hub, etc.; other technology; referral processes and platforms

Capacity or capability being built by partners: Data contribution (patient/clinical/claims); data governance; enabling data sharing and interoperability; human/process (e.g. care coordinators, community health workers, workflows, administrative hub, etc.; other technology; referral processes and platforms

Role of CyncHealth in the work: Backbone/infrastructure; convener and/or facilitator; Data exchange/storage; enabling interoperability of SDOH data; enabling interoperability of directories; member of governance; quality improvement and/or data analysis; social care platform

Strengths/assets brought by CyncHealth to the work: CyncHealth provides statewide resources ensuring social care data is not siloed by health systems and is democratized responsibly through data governance.

Other types of organizations are involved in the work: Academic/research organizations; clinics/FQHC; community-based organizations; foundations/funders; hospitals; national associations; payors/health plan; physicians/medical groups; public health department; State Medicaid; United Way/211

Formal agreements in place: Business associate agreements; data use/sharing agreements

Data standards being used: USCDI

Structure and governance for the work: Advisory council(s); formal board

Involvement of people with lived experience: Part of advisory committees; participation in governance; providing input via surveys and focus groups

Funding of participation in the work: Federal funding; grant funding; through existing business operations/mission

Other: https://cynchealth.org/services/social-determinants-of-health/

Data Across Sectors for Health (DASH)

SDOH opportunity/challenge/problem being addressed: DASH promotes equity-focused data sharing and use to shift the conditions that keep communities from realizing their aspirations for a society in which everyone has a fair and just opportunity to be healthy. This occurs at the local level when communities understand and own the data that is used in data-sharing collaboratives, and when these initiatives can scale to achieve broad health equity through state policymakers' engagement with communities and community-owned data.

Expected outcome/impact of the work: Communities achieving health equity through collaborative data sharing efforts.

Level of geography served: State

Stage of the work: Business plan development; early planning; expanding / adding; formative discussions; implementation planning; operating; stakeholder engagement

Social needs being addressed: Chronic disease prevention and management; employment/education; food/food insecurity; health insurance status/health care access; housing/housing instability/homelessness/inadequate housing; material hardship/utilities/payment assistance; mental health; substance use; transportation/transportation insecurity

Capacity or capability being built by DASH: Data contribution (patient/clinical/claims); data governance; enabling data sharing and interoperability; human/process (e.g. care coordinators, community health workers, workflows, administrative hub, etc.

Capacity or capability being built by partners: Data contribution (patient/clinical/claims), data governance, enabling data sharing and interoperability; Human/process,e.g., care coordinators, community health workers, workflows, administrative hub, etc., referral processes and platforms

Role of DASH in the work: Convener and/or facilitator; enabling interoperability of SDOH data; enabling interoperability of directories

Strengths/assets brought by DASH to the work: Funding multiple communities through various programs, collected learnings and learning, translation, and communications.

Other types of organizations are involved in the work: Academic/research organizations; clinics/FQHC; community-based organizations; foundations/funders; hospitals; other civic/state/city/county; public health department; public/government/private funders (3 options +); Tribes; United Way/211

Formal agreements in place: MOU; Other formal contracts

Formal agreements planned: Funding award contracts

Data standards being used: Social Information (currently lacking standards)

Structure and governance for the work: Multisector

Involvement of people with lived experience: Members of steering or leadership committee(s); Members of workgroups; Participation in governance

Funding of participation in the work: Foundation funding

Florida Agency for Health Care Administration

SDOH opportunity/challenge/problem being addressed: We are in the planning stage of procuring an IT vendor to provide us with the Closed Loop Referral System for our Medicaid population.

Expected outcome/impact of the work: The goal is to reduce ED admissions, enhance quality of care, and reduce health care costs.

Level of geography served: State

Stage of the work: Business Plan Development

Social needs being addressed: Employment/education; food/food insecurity; housing/housing instability/homelessness/inadequate housing; material hardship/utilities/payment assistance; mental health; social connection/loneliness; transportation/transportation insecurity

Capacity or capability being built by Agency for Health Care Administration: Data contribution (patient/clinical/claims), enabling data sharing and interoperability, human/process, e.g., care coordinators, community health workers, workflows, administrative hub, etc., referral processes and platforms

Capacity or capability being built by partners: Data contribution (patient/clinical/claims); referral processes and platforms

Role of Agency for Health Care Administration in the work: Backbone/infrastructure; Convener and/or facilitator; data exchange/storage; enabling interoperability of SDOH data; enabling interoperability of directories; leverage existing data sources to fully inform social needs outcomes; quality improvement and/or data analysis; social care platform

Strengths/assets brought by Agency for Health Care Administration to the work: State agency with resources and governance capabilities

Other types of organizations are involved in the work: Clinics/FQHC; community-based organizations; foundations/funders; hospitals; payors/health plan; physicians/medical groups; public health department; State Medicaid; United Way/211

Formal agreements in place: Business associate agreements; data use/sharing agreements; MOU

Data standards being used: CCDA, HL7

Structure and governance for the work: Unknown

Involvement of people with lived experience: Providing input via surveys and focus groups

Funding of participation in the work: Federal funding; state funding

Florida Health Information Exchange

SDOH opportunity/challenge/problem being addressed: Our goal is to enable the sharing of data between providers, health plans, and social service organizations, including state agencies, community, and faith-based organizations.

Expected outcome/impact of the work: Improvement in individual health outcomes and knowledge about area services that may be needed but not provided to enable strategic targeting of resources.

Level of geography served: State

Stage of the work: Early Planning

Social needs being addressed: Employment/education; food/food insecurity; housing/housing instability/homelessness/inadequate housing; transportation/transportation insecurity; safety/security at and around home

Capacity or capability being built by Florida Health Information Exchange: Data governance; enabling data sharing and Interoperability; referral processes and platforms

Capacity or capability being built by partners: Data contribution (patient/clinical/claims); data governance; enabling data sharing and interoperability; human/process, e.g., care coordinators, community health workers, workflows, administrative hub, etc.

Role of Florida Health Information Exchange in the work: Backbone/infrastructure; enabling interoperability of SDOH data; enabling interoperability of directories; leverage existing data sources to fully inform social needs outcomes

Strengths/assets brought by Florida Health Information Exchange to the work: The Florida HIE is operated by the state's Medicaid entities - we will work with the state Medicaid Managed Care plans to help facilitate interoperability; we will also work with HIE stakeholders to facilitate data exchange to the plans.

Other types of organizations are involved in the work: Clinics/FQHC; community-based organizations; hospitals; other civic/state/city/county; payors/health plan; physicians/medical groups; public health department; public/government/private funders (3 options +); State Medicaid; United Way/211

Formal agreements in place: Business associate agreements; data use/sharing agreements; MOU

Data standards being used: TBD

Structure and governance for the work: Advisory council(s); workgroups

Involvement of people with lived experience: Providing input via surveys and focus groups

Funding of participation in the work: Federal funding; state funding

Greater New Orleans Health Information Exchange

SDOH opportunity/challenge/problem being addressed: Partner with health and social service providers to find ways to leverage our network and data infrastructure to support the coordinated and integrated delivery of health and social services, aimed at achieving total health. We aim to empower patients to be activated in their care and share their health information with social service orgs or other third parties as they wish.

Expected outcome/impact of the work: Streamlined care coordination and referral practices across health and social service providers; Improved patient and provider experience; Increased use of referred social services, leading to better outcomes

Level of geography served: Regional

Stage of the work: Early planning; expanding / adding; formative discussions; operating; stakeholder engagement

Social needs being addressed: Food/food insecurity; criminal justice involvement

Capacity or capability being built by Greater New Orleans Health Information Exchange: Data contribution (patient/clinical/claims); data governance; enabling data sharing and Interoperability

Capacity or capability being built by partners: Data governance; other technology; referral processes and platforms; partnering with UT Austin Dell Med School to demonstrate the scalability of their open source, closed loop social service referral system, and the corresponding provider-facing app and patient-facing app.

Role of Greater New Orleans Health Information Exchange in the work: Backbone/infrastructure; data exchange/storage; partnering with UT Austin Dell Med School to demonstrate scalability of their open source, closed loop social service referral system, and the corresponding provider-facing app and patient-facing app.

Strengths/assets brought by Greater New Orleans Health Information Exchange to the work: Relationships and data exchange with community health centers, Medicaid, correctional health providers, others; Partnership with Dell Medical School to leverage their technology suite; Completed successful FHIR API project and eager to grow FHIR knowledge/capacity

Other types of organizations are involved in the work: Clinics/FQHC; correctional health providers; public/government/private funders (3 options +)

Formal agreements in place: Data use/sharing agreements; agreements in place with correctional health and FQHCs

Formal agreements planned: Agreements in place with correctional health and FQHCs; no agreements in place yet with local partners to support Dell Med School project

Data standards being used: ADTs for jail notifications; FHIR for sharing health data w/ correctional health providers; FHIR for Dell Med School work

Structure and governance for the work: Formal board; workgroups

Involvement of people with lived experience: TBD

Funding of participation in the work: Federal funding; partner on Dell Med School funding from ONC LEAP round 2, and applying to round 3

Other: Summary of current SDOH efforts:

- Jail notifications (live and planning for equitable scaling given sensitivity)
- FHIR APIs to share historical medical info with correctional health providers (live)
- Partner on Dell Med School work to demonstrate scalability of their open source, closed loop social service referral system, and the corresponding provider-facing app and patient-facing app. starting with synthetic data testing and planning for real-world pilot in 2024 for WIC referral use case. (early planning, focused on building FHIR capabilities)

Greater Newark Health Care Coalition

SDOH opportunity/challenge/problem being addressed: Our plan is to create/ choose a SDOH platform that can be used regionally and working with the other Regional Health Hubs (RHHs) statewide to assist our local CBO in making referrals and closing the loop.

Expected outcome/impact of the work: Addressing SDOH needs more uniformly with particular focus on the Medicaid population.

Level of geography served: Regional

Stage of the work: Early Planning

Social needs being addressed: Chronic Disease Prevention and Management

Capacity or capability being built by Greater Newark Health Care Coalition: Data contribution (patient/clinical/claims); Enabling data sharing and Interoperability

Capacity or capability being built by partners: Human/process, e.g., care coordinators, community health workers, workflows, administrative hub, etc.

Role of Greater Newark Health Care Coalition in the work: Convener and/or facilitator; Enabling interoperability of SDOH data; Enabling interoperability of directories

Strengths/assets brought by Greater Newark Health Care Coalition to the work: Convener of hospitals, insurers, and community-based organizations

Other types of organizations are involved in the work: RHHs in New Jersey

Formal agreements in place: not formulated yet

Data standards being used: not formulated yet

Structure and governance for the work: completed first roundtable discussion

Involvement of people with lived experience: not yet

Funding of participation in the work: Through existing business operations/mission

Health Impact Ohio

SDOH opportunity/challenge/problem being addressed: We improve social drivers of health, health equity, access, and quality in all communities, through community engagement and partnership; multi-stakeholder training and coaching; data collection and integration; and strategy development and deployment.

Expected outcome/impact of the work: To maximize collaboration and partnership in order to impact health equity, quality, and accessibility.

Level of geography served: Regional

Stage of the work: Expanding/adding; implementation planning; operating; stakeholder engagement. We house the Central Ohio Pathways HUB.

Social needs being addressed: Childcare; chronic disease prevention and management; elder abuse; employment/education; food/food insecurity; health insurance status/health care access; health literacy; housing/housing instability/homelessness/inadequate housing; intimate partner violence; material hardship/utilities/payment assistance; medical cost burden; mental health; social connection/loneliness; stress; substance use; transportation/transportation insecurity; maternal and child health support, recidivism

Capacity or capability being built by Health Impact Ohio: Data contribution (patient/clinical/claims); data governance; enabling data sharing and interoperability; human/process, e.g., care coordinators, community health workers, workflows, administrative hub, etc.; Referral processes and platforms

Capacity or capability being built by partners: Data contribution (patient/clinical/claims); data governance; enabling data sharing and interoperability; human/process, e.g., care coordinators, community health workers, workflows, administrative hub, etc.; other technology; referral processes and platforms

Role of Health Impact Ohio in the work: Backbone/infrastructure; convener and/or facilitator; data exchange/storage; enabling interoperability of SDOH data; leverage existing data sources to fully inform social needs outcomes; quality improvement and/or data analysis; social care platform

Strengths/assets brought by Health Impact Ohio to the work: Our work as a RHIC has allowed us to be a trusted partner in the community, breaking down silos and

encouraging open dialogue for shared goals. We are experts in coaching, collaborating, and the Pathways HUB model.

Other types of organizations are involved in the work: Academic/research organizations; clinics/FQHC; community-based organizations; foundations/funders; hospitals; national associations; other civic/state/city/county; payors/health plan; physicians/medical groups; public health department; public/government/private funders (3 options +); State Medicaid

Formal agreements in place: Business associate agreements; data use/sharing agreements; MOU; other formal contracts

Data standards being used: Pathways HUB model standards, and we are working towards interoperability with the HIE which will entail a variety of new standards.

Structure and governance for the work: Advisory council(s); formal board; steering committee

Involvement of people with lived experience: Part of advisory committees; providing input via surveys and focus groups

Funding of participation in the work: Federal funding; paid via contracts for services provided; through existing business operations/mission

Other: https://www.healthimpactohio.org/

HealthInfoNet

SDOH opportunity/challenge/problem being addressed: HealthInfoNet aims to provide the appropriate resources to our HIE participants/healthcare organizations to address the ever-changing social health needs of our unique patient landscape in the state of Maine. We are holding a convening session with various stakeholders to assess what social health data they obtain, how they store the data, how they address the data, and how they report/evaluate outcomes on interventions.

Expected outcome/impact of the work: HealthInfoNet hopes to understand what information our participants want to see in the exchange and feasibility of including certain SDOH elements. Our goal is to supplement our HIE to speak to exactly what Maine organizations want to see when evaluating their patients HIE record.

Level of geography served: State

Stage of the work: Business plan development; early planning; formative discussions; implementation planning; stakeholder engagement

Social needs being addressed: Elder abuse; food/food insecurity; health literacy; housing/housing instability/homelessness/inadequate housing; mental health; social connection/loneliness; substance use; transportation/transportation insecurity; we are currently assessing what our participants are measuring and obtaining data on, so many SDOH elements can be added to our focus as we learn more.

Capacity or capability being built by HealthInfoNet: Enabling data sharing and Interoperability

Capacity or capability being built by partners: Data contribution (patient/clinical/claims); enabling data sharing and Interoperability; human/process,e.g., care coordinators, community health workers, workflows, administrative hub, etc.; referral processes and platforms

Role of HealthInfoNet in the work: Convener and/or facilitator; data exchange/storage; enabling interoperability of SDOH data; leverage existing data sources to fully inform social needs outcomes

Strengths/assets brought by HealthInfoNet to the work: We have the largest repository of Maine clinical data than any other organization. We can build on our already established interfaces to improve the social health offerings in our exchange.

Other types of organizations are involved in the work: Academic/research organizations; clinics/FQHC; community-based organizations; hospitals; accountable care organizations; physicians/medical groups; public health department; state Medicaid; Tribes

Formal agreements in place: Business associate agreements; data use/sharing agreements

Data standards being used: TBD

Structure and governance for the work: TBD post convening sessions. HealthInfoNet is obtaining information and will likely create a work group/steering committee with our participants upon assessment of additional information

Involvement of people with lived experience: Providing input via surveys and focus groups; convening sessions with stakeholder groups (provider groups, CBOs, FQHCs), outreach to AAAs around the state

Funding of participation in the work: Through existing business operations/mission; Volunteer based involvement from HIE participants in Maine

Other: https://hinfonet.org/current-strategic-focus/

Healthy Alliance

SDOH opportunity/challenge/problem being addressed: At Healthy Alliance, our purpose is to improve health and empower the underserved. Every community has its own needs, affecting the health of those who live, learn, work, and play within them. Our network brings together organizations, big and small, to coordinate and collaborate so that all communities have reliable access to social care resources.

Our goal is to ensure every New Yorker has access to the social services they need – ranging from stable housing, healthy food, assistance with benefits navigation, clothing and household goods, transportation – and so much more.

Expected outcome/impact of the work: We believe that by addressing these social needs before they turn into medical problems, it will improve the overall health of our communities, while lowering medical costs for all.

Level of geography served: Regional

Stage of the work: Operating; Our network has grown organically over the years – both in scope and geography – and will continue to do so. Just like any public utility – gas, electricity – our work won't stop until we've created a collaborative network available to every New Yorker in need.

Social needs being addressed: Childcare; chronic disease prevention and management; elder abuse; employment/education; food/food insecurity; health insurance status/health care access; health literacy; housing/housing instability/homelessness/inadequate housing; intimate partner violence; material hardship/utilities/payment assistance; medical cost burden; mental health; social connection/loneliness; stress; substance use; transportation/transportation insecurity

Capacity or capability being built by Healthy Alliance: Data governance; enabling data sharing and interoperability; human/process, e.g., care coordinators, community health workers, workflows, administrative hub, etc., other technology, referral processes and platforms

Capacity or capability being built by partners: Data contribution (patient/clinical/claims); Data governance; enabling data sharing and Interoperability; Human/process, e.g., care coordinators, community health workers, workflows, administrative hub, etc., other technology, referral processes and platforms

Role of Healthy Alliance in the work: Backbone/infrastructure; Convener and/or facilitator; data exchange/storage; enabling interoperability of SDOH data; leverage existing data sources to fully inform social needs outcomes; quality improvement and/or data analysis; social care platform

Strengths/assets brought by Healthy Alliance to the work: Our staff is one of our strongest assets with varied skillsets and expertise.

Other types of organizations are involved in the work: Academic/research organizations; clinics/FQHC; community-based organizations; foundations/funders; hospitals; national associations; other civic/state/city/county; payors/health plan; physicians/medical groups; public health department; public/government/private funders (3 options +); State Medicaid; United Way/211

Formal agreements in place: Business associate agreements; data use/sharing agreements; incorporation; MOU; other formal contracts

Data standards being used: We have an internal data governance board which defines our acquisition and use of data. We continue to work with our vendors and continue to evolve interoperability using national standards.

Structure and governance for the work: Advisory council(s); formal board; workgroups

Involvement of people with lived experience: Providing input via surveys and focus groups

Funding of participation in the work: Foundation funding; paid via contracts for services provided; state funding

Other: Learn more https://healthyalliance.us/
https://www.linkedin.com/company/healthyalliance/mycompany/

Hixny

SDOH opportunity/challenge/problem being addressed: Integration of social and clinical care via embedding capabilities for health care providers to make social referrals in their existing workflow.

Expected outcome/impact of the work: Increases in the number of referrals for social care and increases in the number of unique individuals making referrals.

Level of geography served: Regional

Stage of the work: Operating

Social needs being addressed: Employment/Education; Food/Food Insecurity; Health Insurance Status/Health Care Access; Housing/Housing Instability/Homelessness/Inadequate Housing; Intimate Partner Violence; Material Hardship/Utilities/Payment Assistance; Mental Health; Substance Use; Transportation/Transportation Insecurity

Capacity or capability being built by Hixny: Data contribution (patient/clinical/claims); Data governance; Enabling data sharing and Interoperability; Other technology; Referral processes and platforms

Capacity or capability being built by partners: Human/process, e.g., care coordinators, community health workers, workflows, administrative hub, etc.; other technology; referral processes and platforms

Role of Hixny in the work: Convener and/or facilitator; data exchange/storage; enabling interoperability of SDOH data; enabling interoperability of directories

Strengths/assets brought by Hixny to the work: Technical capabilities and existing tools that leverage SMART on FHIR to embed technology and information into the EHR workflow and our relationships across the community with health care providers and CBOs

Other types of organizations are involved in the work: Clinics/FQHC; community-based organizations; hospitals; physicians/medical groups; public health department

Formal agreements in place: Business associate agreements; Data use/sharing agreements; Other formal contracts

Data standards being used: OpenReferral, Gravity Project, FHIR and SMART on FHIR

Structure and governance for the work: Advisory council(s); Formal board

Involvement of people with lived experience: Participation in governance; Providing input via surveys and focus groups

Funding of participation in the work: State funding; Through existing business operations/mission

Other: https://www.hixny.org/wp-content/uploads/2022/05/Improving-Health-Equity_Hixny.pdf

IMAT Solutions

SDOH opportunity/challenge/problem being addressed: We are supporting a pilot that is demonstrating how to use ADT notifications for individuals with higher SDOH risk to receive additional advocacy services to support them during or immediately after a hospitalization.

Expected outcome/impact of the work: We expect to demonstrate this these advocacy services, triggered by knowledge of a hospitalization from an ADT alert, which has a significant positive effect on reducing readmissions.

Level of geography served: National

Stage of the work: Expanding/adding, operating

Social needs being addressed: Childcare; chronic disease prevention and management; elder abuse; employment/education; food/food insecurity; health insurance status/health care access; health literacy; housing/housing instability/homelessness/inadequate housing; intimate partner violence; material hardship/utilities/payment assistance; medical cost burden; mental health; social connection/loneliness; stress; substance use; transportation/transportation insecurity

Capacity or capability being built by IMAT Solutions: Data contribution (patient/clinical/claims); data governance; enabling data sharing and interoperability; other technology

Capacity or capability being built by partners: N/A

Role of IMAT Solutions in the work: Backbone/infrastructure; data exchange/storage; enabling interoperability of SDOH data; member of governance

Strengths/assets brought by IMAT Solutions to the work: IMAT has a very deep professional services bench with decades of experience working with data in an HIE environment. Our data is validated, normalized, deduplicated, and cleaned to be used in other software for reporting like HEDIS, ECDS, STARS, and more.

Other types of organizations are involved in the work: Academic/research organizations; clinics/FQHC; community-based organizations; employer; foundations/funders; Hospitals; national associations; other civic/state/city/county; payors/health plan; physicians/medical groups; public health department; public/government/private funders (3 options +); State Medicaid

Formal agreements in place: Business associate agreements; Data use/sharing agreements; Other formal contracts

Data standards being used: FHIR, CCDA, and many others

Structure and governance for the work: Advisory council(s); formal board; Workgroups

Involvement of people with lived experience: Participation in governance

Funding of participation in the work: Paid via contracts for services provided; State funding; Through existing business operations/mission

KC Health Collaborative

SDOH opportunity/challenge/problem being addressed: KC Health Collaborative is a regional system to increase awareness of available community resources, facilitate access to needed services, provide coordination and follow-up, and enable information sharing and data collection which can increase the effectiveness, capacity, and sustainability of services in the community to address unmet social needs and reduce the impact that unmet social needs have on health more effectively. Such a system will provide population-level insights into the needs of the community and facilitate alignment between resources and community needs. This work will strengthen partnerships and collaboration between public health, hospitals, health plans, FQHCs, and community-based social service organizations as they collectively work to address systems and policies that result in inequities and social vulnerabilities.

Expected outcome/impact of the work: More effective and appropriate identification of unmet social needs; More effective and efficient referral of people with identified needs; More collaboration between stakeholders; Coordination of services to increase likelihood that people with needs get connected to wanted and needed services; Population level insights regarding need and services that can drive better planning and resource allocation; Greater funding/sustainability for social services

Level of geography served: Regional

Stage of the work: Early Planning; Formative discussions; Stakeholder engagement

Social needs being addressed: The focus is more on connecting stakeholders, coordinating, and managing referrals. It's likely our efforts will address all of these in some way.

Capacity or capability being built by KC Health Collaborative: We are driving the convening, the planning process, and working to engage expert resources through grant funding to help us develop an implementation plan.

Capacity or capability being built by partners: Other

Role of KC Health Collaborative in the work: Convener and/or facilitator

Other types of organizations are involved in the work: Clinics/FQHC; Community-based organizations; hospitals; other civic/state/city/county; payors/health plan; physicians/medical groups; public health department; United Way/211

Formal agreements in place: We have had stakeholder organizations leadership sign a letter of support for advancing this work in pursuit of the vision

Data standards being used:

Structure and governance for the work: Steering committee; We are anticipating the following groups: 1) Leadership Team; 2) Community Assessment and Engagement Work Group; 3) Operational Model, Resources, and Sustainability Workgroup; and 4) Data and Technology Capacity Workgroup

Involvement of people with lived experience: Have not yet involved, but planning includes ensuring this work occurs

Funding of participation in the work: Federal funding; Through existing business operations/mission

MaxMD

SDOH opportunity/challenge/problem being addressed: We are supporting a pilot that is demonstrating how to use Admission, Discharge, and Transfer (ADT) notifications for individuals with higher SDOH risk to receive additional advocacy services to support them during or immediately after a hospitalization.

Expected outcome/impact of the work: We expect to demonstrate these services, triggered by knowledge of a hospitalization from an ADT alert, which has a significant positive effect on reducing readmissions.

Level of geography served: National

Stage of the work: Implementation Planning

Social needs being addressed: Food/food insecurity; housing/housing instability/homelessness/inadequate housing; transportation/transportation insecurity

Capacity or capability being built by MaxMD: Enabling data sharing and interoperability

Capacity or capability being built by partners: Data contribution (patient/clinical/claims); Human/process, e.g., care coordinators, community health workers, workflows, administrative hub, etc.; referral processes and platforms

Role of MaxMD in the work: Data exchange/storage; enabling interoperability of directories

Strengths/assets brought by MaxMD to the work: DirectTrust HISP and Interoperability Services Provider

Other types of organizations are involved in the work: Payors/health plan

Formal agreements in place: Business associate agreements; data use/sharing agreements; DirectTrust's event notifications via Direct IG

Formal agreements planned: This is one of the most burdensome aspects of the pilot.

Data standards being used: DirectTrust's event notifications via Direct IG

Structure and governance for the work: No new governance structures will be needed. Existing Governance structures should suffice. If Governance could be simplified to reduce the number of "individual governing organizations", that would be helpful.

Involvement of people with lived experience: N/A

Funding of participation in the work: Paid via contracts for services provided; Through existing business operations/mission

Michigan Health Information Network

SDOH opportunity/challenge/problem being addressed: Analyze the existing environment, partnerships, programs, barriers, and data governance of sharing data across sectors.

Elevate identified barriers to expert decision makers from multiple sectors for discussion towards a patient-centered technology resolution.

Expected outcome/impact of the work: To move data regarding social needs, diagnosis, referral, and outcomes to where the data can be used for care coordination and for policy makers to determine the best uses of scarce human and financial resources.

Level of geography served: State

Stage of the work: Business Plan Development; We are finding it is far harder and more time-consuming than many anticipate.

Social needs being addressed: MiHIN's work is about data movement and not about social need resolution.

Capacity or capability being built by Michigan Health Information Network: Data contribution (patient/clinical/claims); Data governance; Enabling data sharing and Interoperability; Referral processes and platforms

Capacity or capability being built by partners: Data contribution (patient/clinical/claims); data governance; enabling data sharing and interoperability; human/process, e.g., care coordinators, community health workers, workflows, administrative hub, etc.; referral processes and platforms

Role of Michigan Health Information Network in the work: Convener and/or facilitator; data exchange/storage; enabling interoperability of SDOH data; enabling interoperability of directories; leverage existing data sources to fully inform social needs outcomes; member of governance; quality improvement and/or data analysis

Strengths/assets brought by Michigan Health Information Network to the work: Statewide and state sponsored HIE

Other types of organizations are involved in the work: Academic/research organizations; clinics/FQHC; community-based organizations; foundations/funders;

hospitals; national associations; other civic/state/city/county; payors/health plan; physicians/medical groups; public health department; public/government/private funders (3 options +); state Medicaid; Tribes; United Way/211

Formal agreements in place: Business associate agreements; Data use/sharing agreements

Data standards being used: All data standards

Structure and governance for the work: Formal board; formal department for Cross Sector Data Sharing; Workgroups

Involvement of people with lived experience: Members of workgroups

Funding of participation in the work: Foundation funding; paid via contracts for services provided; state funding; through existing business operations/mission

Michigan Multipayer Initiatives, University of Michigan

SDOH opportunity/challenge/problem being addressed: We aim to align payers with common policies and approaches to support social needs screening and interoperable referrals in Michigan. We also work closely with the State to support the success of their SDOH initiatives and with our state HIE, MiHIN, to infuse the voice of the primary care practice in use case design and refinement.

Expected outcome/impact of the work: We have made headway on SDOH payer policy alignment and continue to do so. We produced and distributed a comparative table of payer policies on various aspects of social care requirements and incentives for providers and continue to issue updates. We also advocated for an advisory group to our state HIE to understand practice and community organization workflows so that they can inform use case design and refinement.

Level of geography served: State

Stage of the work: Operating

Social needs being addressed: Employment/education; food/food insecurity; health insurance status/health care access; housing/housing instability/homelessness/inadequate housing; material hardship/utilities/payment assistance; social connection/loneliness; stress; transportation/transportation insecurity

Capacity or capability being built by Michigan Multipayer Initiatives: We support each capability above through partners.

Capacity or capability being built by partners: Data contribution (patient/clinical/claims), data governance, enabling data sharing and interoperability; human/process, e.g., care coordinators, community health workers, workflows, administrative hub, etc., referral processes and platforms

Role of Michigan Multipayer Initiatives in the work: Convener and/or facilitator; quality improvement and/or data analysis

Strengths/assets brought by Michigan Multipayer Initiatives to the work: We are a trusted neutral entity with a track record of honoring group interests above self-interests and have convened multipayer and multistakeholder initiatives in Michigan for over a decade.

Other types of organizations are involved in the work: Academic/research organizations; clinics/FQHC; community-based organizations; employer; hospitals; other civic/state/city/county; payors/health plan; physicians/medical groups; state Medicaid; United Way/211

Formal agreements in place: Charter

Data standards being used: We track with the Gravity Project, NASDOH, etc.

Structure and governance for the work: Workgroups

Involvement of people with lived experience: Involved via practices and CBOs who are work at the frontline of patient partnership

Funding of participation in the work: Through existing business operations/mission

Other:

MyHealth Access Network

SDOH opportunity/challenge/problem being addressed: Social needs screening is rare and widely varying in its methods, and referrals for services are often not tailored to each individual's needs. Data is not standardized, and shared making understanding community needs impossible.

By providing standardized screening and referral for social needs at sites of care or by rosters and evaluating and planning for additional needs based on the data, we can dramatically improve the health of individuals, populations, and communities.

Expected outcome/impact of the work: Our vision is that Oklahoma Becomes the First State to Have Universal Social Needs Screening and Referral.

Outcomes expected: Improve overall health by identifying and removing barriers to accessing social services. Develop community wide partnerships that will make the greatest impact on the needs of Oklahomans. Increase system capacity to improve health by identifying individual, population, and community needs

Level of geography served: State

Stage of the work: Expanding/adding; operating; Was a part of the CMMI AHC study. Currently have additional grants and funding through members. Also looking at foundation grants and other sources of funding to braid together to keep the work going.

Social needs being addressed: Food/food insecurity; housing/housing instability/homelessness/inadequate housing; intimate partner violence; material hardship/utilities/payment assistance; transportation/transportation insecurity; started with the 5 required in CMMI AHC study. Will likely expand over time.

Capacity or capability being built by MyHealth Access Network: Data contribution (patient/clinical/claims); data governance; enabling data sharing and interoperability; human/process, e.g., care coordinators, community health workers, workflows, administrative hub, etc.; other technology; referral processes and platforms

Capacity or capability being built by partners: Data contribution (patient/clinical/claims); human/process, e.g., care coordinators, community health workers, workflows, administrative hub, etc.; referral processes and platforms

Role of MyHealth Access Network in the work: Backbone/infrastructure; convener and/or facilitator; data exchange/storage; enabling interoperability of SDOH data;

leverage existing data sources to fully inform social needs outcomes; member of governance; quality improvement and/or data analysis; serving as all-payer claims database

Strengths/assets brought by MyHealth Access Network to the work: HIEs like MyHealth bring a unique role to this SDOH work. We are perfectly situated to assist with and facilitate SDOH data standards and data sharing. We can also be a community convener and bridge to all types of other organizations.

Other types of organizations are involved in the work: Academic/research organizations; clinics/FQHC; community-based organizations; employer; foundations/funders; hospitals; other civic/state/city/county; payors/health plan; physicians/medical groups; public health department; public/government/private funders (3 options +); state Medicaid; Tribes; United Way/211

Formal agreements in place: Business associate agreements; data use/sharing agreements; MOU

Data standards being used:

Structure and governance for the work: Formal board; steering committee

Involvement of people with lived experience: Providing input via surveys and focus groups

Funding of participation in the work: City funding; federal funding; paid via contracts for services provided; through existing business operations/mission

Pennsylvania eHealth Partnership Program, PA Department of Human Services

SDOH opportunity/challenge/problem being addressed: Integrating HIE with a closed-loop resource and referral tool platform for addressing unmet SDOH needs.

Expected outcome/impact of the work: Statewide RRT integration with statewide HIE ecosystem.

Level of geography served: State

Stage of the work: Implementation Planning; PA Medicaid is using American Recovery Act funding for grants to regional health information exchange organizations to select and become interoperable with a statewide RRT.

Social needs being addressed: Childcare; chronic disease prevention and management; employment/education; food/food insecurity; health insurance status/health care access; housing/housing instability/homelessness/inadequate housing; medical cost burden; mental health; social connection/loneliness; stress; substance use; transportation/transportation insecurity

Capacity or capability being built by PA eHealth Partnership Program: Data contribution (patient/clinical/claims); data governance; enabling data sharing and interoperability; human/process, (e.g., care coordinators, community health workers, workflows, administrative hub, etc.,), referral processes and platforms

Capacity or capability being built by partners: Data contribution (patient/clinical/claims); data governance; enabling data sharing and interoperability; human/process, (e.g., care coordinators, community health workers, workflows, administrative hub, etc.; referral processes and platforms

Role of PA eHealth Partnership Program in the work: Backbone/infrastructure; convener and/or facilitator; data exchange/storage; enabling interoperability of SDOH data; enabling interoperability of directories; leverage existing data sources to fully inform social needs outcomes; member of governance; funding; quality improvement and/or data analysis; social care platform

Strengths/assets brought by PA eHealth Partnership Program to the work: Leveraging existing federated statewide HIE ecosystem.

Other types of organizations are involved in the work: Clinics/FQHC; community-based organizations; hospitals; other civic/state/city/county; payors/health plan; physicians/medical groups; state Medicaid; United Way/211

Formal agreements in place: Business associate agreements; data use/sharing agreements

Data standards being used:

Structure and governance for the work: Leveraging the Pennsylvania Patient and Provider HIE Trust Community Committee

Involvement of people with lived experience: Providing input via surveys and focus groups

Funding of participation in the work: State funding; ARP funding

Quality Health Network

SDOH opportunity/challenge/problem being addressed: Quality Health Network (QHN) has a history of innovative, forward-thinking solutions. We were the first in Colorado to create an HIE. We then added Community Resource Network, CRN, a Community Information Exchange (CIE), to serve the whole person in need of more coordinated care considering their medical, behavioral, and social needs with a focus on prioritizing the needs of our rural communities.

Expected outcome/impact of the work: To integrate medical, behavioral, and social data to drive actionable, whole person solutions for the betterment of our communities by implementing a closed-loop system using the NinePatch platform.

Level of geography served: Regional

Stage of the work: Expanding / Adding; Operating; We are currently working with 10 counties and have 146 partners utilizing the CRN platform, as of 2nd quarter 2022.

Social needs being addressed: Childcare; chronic disease prevention and management; elder abuse; employment/education; food/food insecurity; health insurance status/health care access; health literacy; housing/housing instability/homelessness/inadequate housing; intimate partner violence; material hardship/utilities/payment assistance; medical cost burden; mental health; social connection/loneliness; stress; substance use; transportation/transportation insecurity

Capacity or capability being built by Quality Health Network: Data contribution (patient/clinical/claims); data governance; enabling data sharing and interoperability; human/process, e.g., care coordinators, community health workers, workflows, administrative hub, etc.; referral processes and platforms

Capacity or capability being built by partners: Data contribution (patient/clinical/claims); data governance; enabling data sharing and Interoperability; Human/process, e.g., care coordinators, community health workers, workflows, administrative hub, etc.; other technology; referral processes and platforms

Role of Quality Health Network in the work: Backbone/infrastructure; Convener and/or facilitator; data exchange/storage; enabling interoperability of SDOH data; leverage existing data sources to fully inform social needs outcomes; quality improvement and/or data analysis; social care platform

Strengths/assets brought by Quality Health Network to the work: QHN leverages our collaborations, credibility, and information exchange expertise to pilot our latest innovation—Community Resource Network (CRN). CRN includes traditional and non-traditional health partners and helps them collaborate and coordinate services to address the overall needs of the individual.

Other types of organizations are involved in the work: Academic/research organizations; clinics/FQHC; community-based organizations; foundations/funders; hospitals; national associations; other civic/state/city/county; payors/health plan; physicians/medical groups; public health department; public/government/private funders (3 options +); state Medicaid; United Way/211

Formal agreements in place: Business associate agreements; data use/sharing agreements; other formal contracts

Data standards being used:

Structure and governance for the work: Formal board; steering committee; workgroups

Involvement of people with lived experience: N/A

Funding of participation in the work: Federal funding; foundation funding; other stakeholder contributions; paid via contracts for services provided; state funding; through existing business operations/mission

Ready Computing

SDOH opportunity/challenge/problem being addressed: Our flagship product, Channels 360, provides organizations with essential tools to connect residents with available resources.

We have worked with clients to enable creative and impactful solutions for Substance Use Disorder, SDOH screening, closed loop community-based referrals and health plan integrations.

We have the infrastructure to integrate disparate community resource directories into a single source of truth and have enabled both connected and non-connected agencies to manage referrals and close the loop.

Expected outcome/impact of the work: Healthier communities, fewer avoidable emergency room and hospital visits, and better coordinated whole person care.

Level of geography served: Regional

Stage of the work: Expanding/adding; operating; We provide infrastructure to support organizations working to improve communities.

Social needs being addressed: Childcare; chronic disease prevention and management; elder abuse; employment/education; food/food insecurity; health insurance status/health care access; health literacy; housing/housing instability/homelessness/inadequate housing; intimate partner violence; material hardship/utilities/payment assistance; medical cost burden; mental health; social connection/loneliness; stress; substance use; transportation/transportation insecurity

Capacity or capability being built by Ready Computing: Enabling data sharing and interoperability; referral processes and platforms

Capacity or capability being built by partners: Data governance; other technology

Role of Ready Computing in the work: Backbone/infrastructure; data exchange/storage; enabling interoperability of SDOH data; enabling interoperability of directories; leverage existing data sources to fully inform social needs outcomes; quality improvement and/or data analysis; social care platform

Strengths/assets brought by Ready Computing to the work: Ready Computing has a proven track record of integrating clinical data. We are members and engaged with

HL7, IHE and work with the Gravity and DaVinci projects. Our expert Solutions Architects and Product Delivery teams can provide flexible and expandable end-to-end solutions around workflow management, data integration, closed loop referrals and secure hosting/managed services.

Other types of organizations are involved in the work: Academic/research organizations; Clinics/FQHC; Community-based organizations; Foundations/funders; Hospitals; National associations; Other civic/state/city/county; Payors/health plan; Physicians/medical groups; Tribes; United Way/211

Formal agreements in place: Other formal contracts

Data standards being used: HL7, Gravity, ICD, CPT, LOINC, Custom

Structure and governance for the work: Advisory council(s); Steering committee; Workgroups; We work on behalf of our clients in each of these capacities as needed.

Involvement of people with lived experience: We work at the discretion of our clients.

Funding of participation in the work: Paid via contracts for services provided

Other: https://readycomputing.com/en-offerings-channels-complete-clinical-program-management-solution/

https://readycomputing.com/wellbase/

San Diego Health Connect

SDOH opportunity/challenge/problem being addressed: We hope to partner with another organization in San Diego County (211 San Diego) to enhance our current information exchange that will improve SDOH in the County especially for those most marginalized and experiencing the greatest health inequity.

Expected outcome/impact of the work: Same as above: Improve SDOH in the County especially for those most marginalized and experiencing the greatest health inequity.

Level of geography served: Regional

Stage of the work: Business plan development; early planning; expanding/adding; formative discussions; stakeholder engagement

Social needs being addressed: Employment/education; food/food insecurity; housing/housing instability/homelessness/inadequate housing; material hardship/utilities/payment assistance; mental health; social connection/loneliness; stress; substance use; transportation/transportation insecurity; This could include more than those checked

Capacity or capability being built by San Diego Health Connect: Enabling data sharing and Interoperability

Capacity or capability being built by partners: Data contribution (patient/clinical/claims); data governance; enabling data sharing and interoperability; human/process, e.g., care coordinators, community health workers, workflows, administrative hub, etc.; referral processes and platforms

Role of San Diego Health Connect in the work: Backbone/infrastructure; convener and/or facilitator; data exchange/storage; enabling interoperability of SDOH data; leverage existing data sources to fully inform social needs outcomes; quality improvement and/or data analysis

Strengths/assets brought by San Diego Health Connect to the work: We are a fully established HIE with strong relationships with related stakeholders.

Other types of organizations are involved in the work: Clinics/FQHC; Community-based organizations; hospitals; other civic/state/city/county; payors/health plan; physicians/medical groups; public health department; Tribes; United Way/211

Formal agreements in place: Business associate agreements; data use/sharing agreements; MOU; other formal contracts

Data standards being used: HITRUST, HIPAA, etc.

Structure and governance for the work: Workgroups

Involvement of people with lived experience: Part of advisory committees; providing input via surveys and focus groups

Funding of participation in the work: Federal funding; paid via contracts for services provided; state funding; through existing business operations/mission

Santa Cruz Health Information Organization (SCHIO)

SDOH opportunity/challenge/problem being addressed: SCHIO aims to extend the Whole Person Care pilot program to a fully developed Community Information Exchange (CIE). The CIE would leverage the existing robust HIE infrastructure and organization. SCHIO supports a shared vision of sustaining and building upon existing standardized and secure exchange of health and social service information across organizations to facilitate person-centered, comprehensive care.

Expected outcome/impact of the work: In short, SCHIO is seeking achievement of the quintuple AIM.

Level of geography served: County

Stage of the work: Operating; The pandemic was incredibly disruptive in the very positive trend of our implementation. SCHIO is in the process of assessing and relaunching.

Social needs being addressed: Childcare; chronic disease prevention and management; food/food insecurity; health insurance status/health care access; housing/housing instability/homelessness/inadequate housing; intimate partner violence; mental health; stress; substance use; transportation/transportation insecurity

Capacity or capability being built by SCHIO: Enabling data sharing and Interoperability; Human/process, e.g., care coordinators, community health workers, workflows, administrative hub, etc., and referral processes and platforms to support comprehensive care coordination

Capacity or capability being built by partners: Data contribution (patient/clinical/claims); human/process (e.g., care coordinators, community health workers, workflows, administrative hub, etc.; referral processes and platforms; Outreach

Role of SCHIO in the work: Backbone/infrastructure; data exchange/storage; enabling interoperability of SDOH data; enabling interoperability of directories; leverage existing data sources to fully inform social needs outcomes; member of governance; identity and consent provision

Strengths/assets brought by SCHIO to the work: Trusted 3rd party partner with a rich, credible history in the community.

Other types of organizations are involved in the work: Clinics/FQHC; Community-based organizations; hospitals; payors/health plan; physicians/medical groups; public health department; public/government/private funders (3 options +); State Medicaid; United Way/211

Formal agreements in place: Business associate agreements; data use/sharing agreements

Data standards being used: USCDI, CCD, SDOH

Structure and governance for the work: Steering committee

Involvement of people with lived experience: Members of workgroups; Part of advisory committees; Providing input via surveys and focus groups

Funding of participation in the work: County funding; Paid via contracts for services provided; Through existing business operations/mission; Program funding

Stratis Health

SDOH opportunity/challenge/problem being addressed: Supporting social needs is not only important for improving overall health and well-being of people and their communities, but also for promoting equity and reducing health disparities that are often rooted in social and economic disadvantages. Our aim is to co-create a sustainable shared solution for exchanging social needs resource referrals via supporting technology statewide between health care and community organizations. The co-creation process is being facilitated by Stratis Health and Collective Action Lab and has been shaped by participating community, health care, and payer organizations acting through a Guiding Council of representatives selected by their peer organizations.

Expected outcome/impact of the work: The expected outcomes/impact:

1) bring together the existing systems in place across Minnesota in a seamless and easy to navigate way for both the referral resource providers and people seeking to access those resources,

2) ensure resource directories are inclusive, culturally responsive and avoid duplication and redundancy,

3) address current needs and anticipate future opportunities,

4) provide for investments in organizational capacity to support people and sustainable funding, and

5) offer a “closed loop” feedback mechanism to indicate to health care organizations whether and how specific referrals are addressed and acted upon.

Level of geography served: State

Stage of the work: Business Plan Development; Early Planning; Formative discussions; Stakeholder engagement; The work aims to advance equity via both process and outcomes. Rather than inviting participating organizations into a process designed by others, participants are designing the very process they are joining. This advances equity in that it assures voice, agency, and power distribution to impacted organizations regardless of their current power or resources and fosters inclusive decision making towards an equitable solution. With respect to outcome, this initiative seeks to advance meaningful access to housing, food, transportation, and other

resources that are relevant across culture and statewide geography, which is essential in assuring health equity.

Social needs being addressed: Childcare; chronic disease prevention and management; elder abuse; employment/education; food/food insecurity; health insurance status/health care access; health literacy; housing/housing instability/homelessness/inadequate housing; intimate partner violence; material hardship/utilities/payment assistance; medical cost burden; mental health; social connection/loneliness; stress; substance use; transportation/transportation insecurity

Capacity or capability being built by Stratis Health: Enabling data sharing and interoperability; human/process, e.g., care coordinators, community health workers, workflows, administrative hub, etc., referral processes and platforms

Role of Stratis Health in the work: Backbone/infrastructure; convener and/or facilitator

Strengths/assets brought by Stratis Health to the work: Team of expert facilitators, expertise in governance, stakeholder engagement, process and workflow design, process improvement

Other types of organizations are involved in the work: Academic/research organizations; clinics/FQHC; community-based organizations; hospitals; MN-based professional and trade associations; other civic/state/city/county; payors/health plan; physicians/medical groups; public health department; state Medicaid; tribes; United Way/211

Formal agreements in place: N/A

Data standards being used: N/A

Structure and governance for the work: Advisory council(s); Workgroups

Involvement of people with lived experience: Members of steering or leadership committee(s); members of workgroups; part of advisory committees; participation in governance; providing input via surveys and focus groups

Funding of participation in the work: Other stakeholder contributions; paid via contracts for services provided

The Health Collaborative

SDOH opportunity/challenge/problem being addressed: To better connect clinical and community data -- across hospitals and community-based organizations in meeting the needs of community to reduce health disparities, specifically in a sustainable model that is data-driven and community informed.

Expected outcome/impact of the work: Reduced health disparities, interoperability across systems, data-driven decisions, have a secure financial backing/sustainability model.

Level of geography served: Regional

Stage of the work: Business plan development; formative discussions; implementation planning; stakeholder engagement; ongoing evaluation/re-assessing is critical with an emphasis on the development and creation of a sustainable funding model for the franchised work and the innovative work that allows us to connect to the people who need it most (those not traditionally part of HIEs and health systems)

Social needs being addressed: Chronic disease prevention and management; employment/education; food/food insecurity; health insurance status/health care access; housing/housing instability/homelessness/inadequate housing; medical cost burden; mental health; substance use; transportation/transportation insecurity

Capacity or capability being built by The Health Collaborative: Data governance; enabling data sharing and Interoperability; Human/process, e.g., care coordinators, community health workers, workflows, administrative hub, etc., other technology - often share analytic responsibility across our organizations and partnerships, Other - data contribution of workforce diversity/capacity and community health needs assessment.

Capacity or capability being built by partners: Data contribution (patient/clinical/claims); data governance; enabling data sharing and interoperability; human/process, e.g., care coordinators, community health workers, workflows, administrative hub, etc., other technology

Role of The Health Collaborative in the work: Backbone/infrastructure; convener and/or facilitator; data exchange/storage; enabling interoperability of directories; leverage existing data sources to fully inform social needs outcomes; member of governance; subject matter expertise on collaboration/problem solving; state alignment

for shared visions/solutions (including sustainable financing); quality improvement and/or data analysis

Strengths/assets brought by The Health Collaborative to the work: Broadly distributed knowledge base through almost all aspects of healthcare; being SME as HIE and Regional Health Improvement Collaborative; trusted brand in community (for tough conversations and collaboration).

Other types of organizations are involved in the work: Academic/research organizations; clinics/FQHC; community-based organizations; employer; foundations/funders; hospitals; national associations; other civic/state/city/county; payors/health plan; physicians/medical groups; public health department; public/government/private funders (3 options +); State Medicaid; United Way/211

Formal agreements in place: Business associate agreements; data use/sharing agreements; MOU

Data standards being used: Gravity; HL7, X12, Healthy People 2030; Previously CMS for Accountable Health Communities.

Structure and governance for the work: Advisory council(s); Workgroups

Involvement of people with lived experience: Members of workgroups; providing input via surveys and focus groups

Funding of participation in the work: Federal funding; foundation funding; through existing business operations/mission

Other: Work has historically been driven by compliance models (e.g., AHC, IRS/CHNA), and we are shifting future work to be more responsive to community needs and supported as a community asset.

University of Texas Health Science Center - Health Equity Collective

SDOH opportunity/challenge/problem being addressed: The Health Equity Collective is a multi-sector coalition that is strengthening capacities of healthcare and social service organizations in the Greater Houston region to coordinate care for our patients and clients and improve access to the services that they need.

Expected outcome/impact of the work: Improved health outcomes and health equity

Level of geography served: Regional

Stage of the work: Business Plan Development; We are following the Collective Impact approach

Social needs being addressed: Chronic disease prevention and management; employment/education; food/food Insecurity; health insurance status/health care access; health literacy; housing/housing instability/homelessness/inadequate housing; mental health; substance use; transportation/transportation insecurity; Using a Framework for Building Better Health Together, that links drivers of health with actions

Capacity or capability being built by Health Equity Collective: Data contribution (patient/clinical/claims); data governance; enabling data sharing and interoperability; human/process (e.g., care coordinators, community health workers, workflows, administrative hub, etc.); referral processes and platforms; multi-sector care coordination with end user (community voice) engagement

Capacity or capability being built by partners: Data contribution (patient/clinical/claims); data governance; enabling data sharing and Interoperability; human/process (e.g., care coordinators, community health workers, workflows, administrative hub, etc.); other technology; referral processes and platforms; linking the CIE development to the established HIE

Role of Health Equity Collective in the work: Backbone/infrastructure; convener and/or facilitator; data exchange/storage; enabling interoperability of SDOH data; enabling interoperability of directories; leverage existing data sources to fully inform social needs outcomes; member of governance; quality improvement and/or data analysis; serving as all-payer claims database; social care platform; UTHealth plays all

these roles and is building linkages between these efforts through the Health Equity Collective.

Other types of organizations are involved in the work: Academic/research organizations; clinics/FQHC; community-based organizations; employer; foundations/funders; hospitals; national associations; other civic/state/city/county; payors/health plan; physicians/medical groups; public health department; public/government/private funders (3 options +); State Medicaid; United Way/211

Formal agreements in place: Data use/sharing agreements; MOU

Formal agreements planned: Developing all the above and interested in learning from others who have established these legal agreements

Data standards being used: FHIR; HL7; open standards; etc.

Structure and governance for the work: Advisory council(s); steering committee; workgroups

Involvement of people with lived experience: Members of workgroups; providing input via surveys and focus groups; building end user community voice engagement

Funding of participation in the work: City funding; county funding; foundation funding; other stakeholder contributions; through existing business operations/mission

West Virginia Health Information Network

SDOH opportunity/challenge/problem being addressed: We capture and provide data to enhance whole person care and create interoperability for social care data. We facilitate sharing of data to reduce gaps in care.

Level of geography served: State

Stage of the work: Operating

Social needs being addressed: Childcare; chronic disease prevention and management; elder abuse; employment/education; food/food insecurity; health insurance status/health care access; health literacy; housing/housing instability/homelessness/inadequate housing; intimate partner violence; material hardship/utilities/payment assistance; medical cost burden; mental health; social connection/loneliness; stress; substance use; transportation/transportation insecurity

Capacity or capability being built by West Virginia Health Information Network: Data contribution (patient/clinical/claims); enabling data sharing and interoperability; referral processes and platforms

Role of West Virginia Health Information Network in the work: Data exchange/storage; enabling interoperability of SDOH data; enabling interoperability of directories

Other types of organizations are involved in the work: Clinics/FQHC; foundations/funders; hospitals; payors/health plan; State Medicaid; United Way/211

Formal agreements in place: Business associate agreements; data use/sharing agreements; MOU; other formal contracts

Data standards being used: N/A

Structure and governance for the work: N/A

Involvement of people with lived experience: N/A

Funding of participation in the work: City funding; federal funding; foundation funding; through existing business operations/mission

Other: The West Virginia Health Information Network (WVHIN) is part of CRISP Shared Services (CSS). CSS allows affiliated HIEs to leverage shared business and technical infrastructure, and reuse technology to tap into economies of scale.

Leveraging the work of our CSS colleagues, the WVHIN is working with West Virginia stakeholders to use and adapt existing tools and technology to meet specific state-specific use cases. Our current efforts include:

- Displaying SDOH Z-codes: Using existing admit, discharge and transfer (ADT) feeds, we are displaying SDOH Z-codes for West Virginia patients in the Social Needs tab of our portal. The information displayed includes the date the Z-code was reported, the sending facility name, and the Z-code description.
- Ingesting and sharing SDOH assessments: Understanding that many facilities and organizations in West Virginia are screening for SDOH, we are working with organizations to ingest and share assessment data. We can accept any standard or non-standard SDOH assessment. We will display the full results of the assessment via PDF as well as identify SDOH needs identified by the assessment in the Social Needs tab of our portal. We are currently working with one Athena FQHC as well as Maximus, the state's Medicaid enrollment broker.
- Sharing SDOH referral data: The WVHIN is open to partnering with social needs platforms as well as provider EMR vendors to ingest and display referrals for SDOH. We have an active partnership with findhelp for WVHIN participants who are using the paid version of the findhelp tool. Two West Virginia managed care organizations (MCOs) have signed on as pilot sites and we are working to ingest the referral data from findhelp and display in the Social Needs tab of our portal.
- Using existing tools for new use cases: The WVHIN is actively engaged with stakeholders across the state on opportunities to use our SDOH tools as well as other technology, such as our Part II consent tool, to meet specific use cases. For example, the WVHIN has partnered with Marshall Health who recently received a grant from the City of Huntington to support individuals with SUD who are at risk of being lost to care. The WVHIN is collaborating with Marshall Health on opportunities to use the WVHIN platform to meet the medical, behavioral health and SDOH needs of enrolled patients.

WYFI

SDOH opportunity/challenge/problem being addressed: WYFI is currently not looking to address SDOH through the HIE, and we will continue to watch the landscape so that we can learn from larger and more mature HIEs. Other groups in the state are focused on it though, and WYFI hopes to play a role in the future.

Expected outcome/impact of the work: N/A

Level of geography served: State

Stage of the work: Early Planning; Formative discussions

Social needs being addressed: N/A

Capacity or capability being built by WYFI: N/A

Capacity or capability being built by partners: N/A

Role of WYFI in the work: Assessing

Other types of organizations are involved in the work: United Way/211

Formal agreements in place: Business associate agreements; Data use/sharing agreements

Data standards being used: N/A

Structure and governance for the work: N/A

Involvement of people with lived experience: N/A

Funding of participation in the work: N/A