Community Information Exchange (CIE) in Oregon: Emerging landscape, key concepts, and future needs

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Developed by HIT Commons with input from the CIE Advisory Group, and funding support from the Oregon Health Authority

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Why Community Information Exchange?

Studies show that addressing social determinants of health (SDOH) can have a major impact on health outcomes. Traditional health care accounts for 20% of overall health outcomes, whereas various research studies have shown that SDOH account for between 40% - 80% of overall health outcomes.[1]

In response to this significant need, Oregon health care providers, Coordinated Care Organizations (CCOs), health plans, social service providers and community-based organizations (CBOs), and the Oregon Health Authority (OHA) embarked on a collaborative approach to address SDOH and achieve better health outcomes through partnerships supported by a common technology platform, which serves as the basis for a Community Information Exchange (CIE).

Addressing SDOH serves as a foundation for the Oregon Coordinated Care vision to achieve the triple aim of better health, higher quality, and better use of resources. It also directly aligns with implementation of HB 3076 Community Benefits spending floor enacted in 2019, and CCO 2.0 policy recommendations to focus on SDOH (like housing) and the social determinants of equity (like racism) towards improving health equity.

To achieve this vision, linking clinical and social service providers is critical. Efforts to date, including Emergency Department Information Exchange (EDIE) and the Collective platform (formerly PreManage), demonstrate the power of working together, and now moving upstream to fully leverage the value of connecting social resources to health care services is a natural and important step.

In this context and at the direction of the Health Information Technology (HIT) Commons Governance Board, HIT Commons began exploratory work on SDOH in early 2019 leading to the development of a CIE Advisory Group—a multi- stakeholder group chartered to develop a statewide roadmap for CIE in Oregon.

<u>CIE Advisory Group Scope and Timeline</u>

The CIE Advisory Group launched in December 2019 (see Appendix for list of members) and included statewide representation of interested stakeholders and individuals with subject matter expertise in a variety of areas, including social needs screening and referrals, and broader health information exchange (HIE). The Advisory Group held monthly meetings through March 2020, when the onset of the COVID-19

[1] Hood, C. M., K. P. Gennuso, G. R. Swain, and B. B. Catlin. 2016. County health rankings: Relationships between determinant factors and health outcomes. *American Journal of Preventive Medicine* 50(2):129-135.

pandemic suspended the workgroup, per OHA policy guidance, to allow individuals and organizations to respond to the pandemic.

The Advisory Group's charter outlined a number of topics to address as it worked to develop a CIE Roadmap. Due to COVID-19, the Advisory Group was only able to begin discussions on a short list of topics listed below in **bold**:

- **Definition, Principles and Vision for CIE**
- **Statewide Map of CIE Efforts/Gaps**
- **Social Needs Screeners/Assessments: Alignment or Best Practices**
- **Resource Directories: Alignment or Best Practices**
- **Community & CBO engagement strategies**
- Alignment with regional or early adopter CIE efforts
- **CIE platform integration & data exchange strategies**
- Alignment with OHA Medicaid screening practices and efforts
- CIE partner workflows & learning collaboratives
- Legal agreements: Alignment or Best Practices
- Metrics, reporting, shared data, & evaluation
- **Synergy with other HIT Commons initiatives (e.g., EDIE, Oregon Provider Directory (OPD))**
- Potential funding or incentive opportunities
- **Communication materials**

Changing context of COVID-19 and health equity

As the COVID-19 pandemic continued through spring and into summer 2020, HIT Commons staff provided written updates to the Advisory Group on progress with CIE implementation. Not surprisingly, the COVID-19 pandemic brought the scale of social needs to the forefront as individuals were seeking social services during periods of shelter-in-place, quarantine, and isolation, or were struggling financially due to loss of employment or other factors. The pandemic response highlighted the central role of 211info as a critical resource directory across Oregon and health system volunteers from Oregon Health Leadership Council (OHLC), HIT Commons, CareOregon, Health Share and Kaiser Permanente organized quickly to act and strengthen the quality of 211info resource data. In fact, COVID-19 served as an accelerator for health care organizations to lean into contracting discussions with CIE vendors on an expedited timeline—the road was being paved with CIE efforts in real-time.

In addition to the COVID-19 pandemic, Oregon has grappled with massive protests related to race and social injustice and the need to refocus all our work with a health equity lens. Connecting individuals to social services through culturally and linguistically specific CBOs has become a particular focus and intersection of COVID-19 response and health equity. CIE efforts are poised to support these connections and work remains to ensure that community needs are met well through this work. OHA in particular is exploring the use of CIE as an additional tool in ongoing COVID-response work.

Purpose of this report

Through conversations with OHA staff, the HIT Commons' team determined that the Advisory Group should work to summarize its work to date, point to future topics to address, and offer high level recommendations. Documenting work-to-date and pointing to future topics will allow the Advisory Group members to continue their focus and energy on COVID-19 response work, as well as implementing CIE infrastructure on the ground. Summarizing the work of the Advisory Group will also provide HIT Commons Governing Board direction and resources for potentially restarting components of this work at a later date.

Within this report you will find:

1. A working definition for CIE
2. Key Principles and a Vision for CIE in Oregon
3. CIE Environment including statewide CIE maps showing vendor footprint as well as highlights from the Advisory Group review of CIE vendor presentations
4. Social Needs Screening Tools/Assessments and statewide maps of the screening tool footprint
5. CIE Funding and Financial Incentives
6. Other Advisory Group work
7. Next Steps for CIE
8. Acknowledgements
9. Appendix: Other CIE topics explored by the Advisory Group:
    - A: Social needs screening tools/assessments: Alignment or best practices
    - B: Resource directories: Overview of 211info and related efforts
    - C: Efforts to promote data integration & exchange

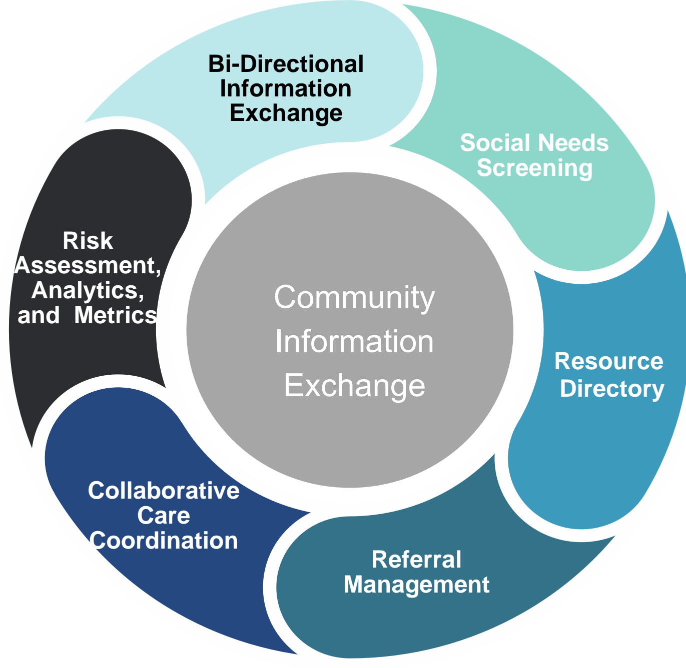
All meeting materials from the CIE Advisory Group are posted here:
http://www.orhealthleadershipcouncil.org/oregon-cie-advisory-group/

Defining Community Information Exchange (CIE)

The CIE Advisory Group aligned on the following working definition* and accompanying visual for CIE:

In general, a CIE connects health care, human and social services partners to improve the health and well-being of communities and address health disparities and health equity. A fully implemented, bi-directional technology platform supporting a CIE could provide many functions, including statewide social services directory, shared risk assessment capabilities, real-time closed loop referral management, collaborative care coordination, standardized metrics, and data analysis.

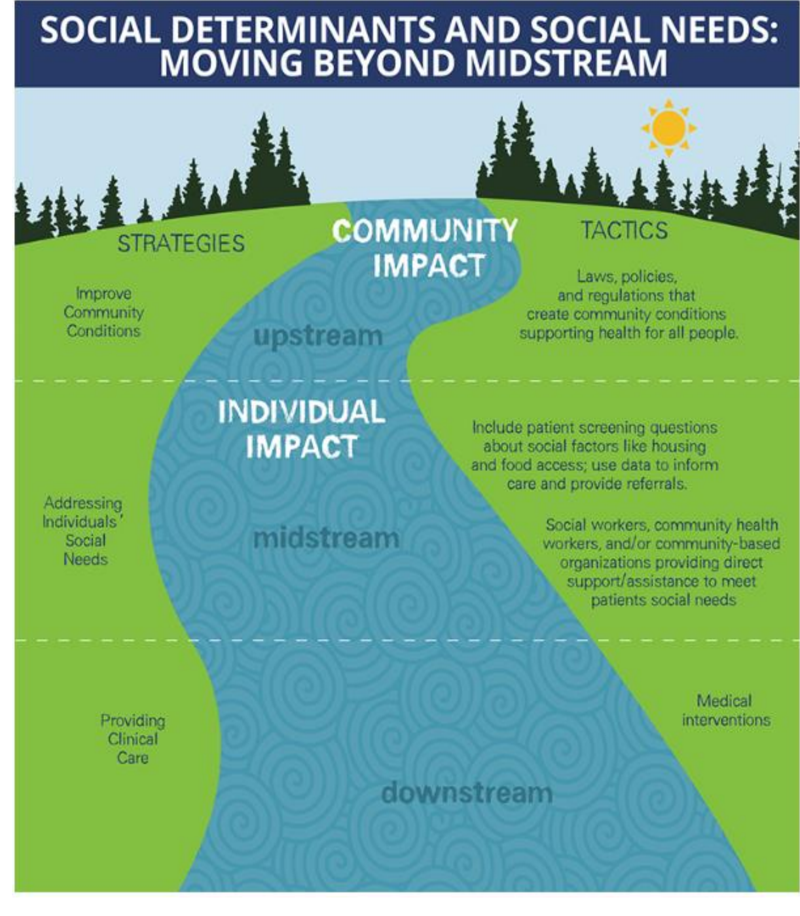
For Oregon, a statewide effort could include technology components, areas for alignment across different technologies, areas for collaborative learning, and sustainable funding and governance bodies.



**this is a working definition in a rapidly evolving space.*

The CIE Advisory Group, discussed and came to consensus on the following points that provide context for defining CIE for Oregon:

- **CIE technology does not in and of itself address SDOH but rather is one tool** of many to help address larger SDOH goals of reducing health disparities and inequities.
- **CIE efforts involve more than just technology—engaged CBOs working in tandem with clinical providers are critical** to closing the loop on social health referrals and achieving positive health outcomes.
- **CIE technology should be built with broader SDOH goals in mind** so that CIE infrastructure aligns with larger vision.
- **CIE technology components are not all required—and not all will be implemented at once** across all stakeholders. For example, some elements, such as social needs screening, will continue to exist outside CIE platforms. Risk assessment tools may be incorporated in later stages of CIE development.



Meeting Individual Social Needs Falls Short of Addressing Social Determinants of Health; Health Affairs, January 2019

- **CIE technology will need to be complemented and interoperable with other technology systems,** such as electronic health records (EHRs), robust care management platform, and hospital event notifications platforms, to enable social health referrals across the care team continuum.

Components of CIE

The Advisory Group leveraged existing materials from the Social Interventions Research & Evaluation Network (SIREN) at the University of California, San Francisco (UCSF) in developing the CIE definition. In SIREN's document, *Community Resource Referral Platforms: A Guide for Health Care Organizations (April 2019)* , key components of CIE technology platforms are outlined and included in the table below. This table and the SIREN materials more broadly served as a reference for the Advisory Group in their review and discussion of referral platform vendors and desired components for Oregon CIE efforts.

Functionality	**Description**
Primary Functionality	
Resource Directory	A searchable, regularly updated directory of CBOs and agencies providing services that can help address patients' social needs
Referral Management	The ability to send referrals to CBOs and to track referral outcomes (i.e., close the loop)
Other Functionalities & Characteristics	
Privacy protection	Compliance with HIPAA and other privacy regulations
Systems integration	The ability to seamlessly move from the referral platform to the EHR and vice versa, and to automatically transfer data between the two systems
Care coordination/case management	Longitudinal needs and care tracking, ability to define care goals and see referrals, services and other activities
Reporting and analytics	The capacity to analyze social needs screening and referral activities and outcomes
Social needs screening	The capacity to record patients' responses to a questionnaire and identify social needs
Auto-suggested resources	The ability to tailor resource lists to the patients' social needs screening results and/or other data
Vendor responsiveness and capacity	The vendor's willingness and ability to tailor the product to users' needs; The perceived capacity of the vendor to provide the desired level of product support

Key Principles for CIE Development in Oregon

Through review and refinement of its charter, the CIE Advisory Group aligned on the following key principles to guide the development of CIE in Oregon:

- Recognition of whole person needs in CIE development.
- Acknowledgement of the variety of existing CIE efforts, including several technology platforms in use in Oregon, and shared interest in looking to limit vendor proliferation and cost and promoting alignment, integration and interoperability across systems.
- Key interest in alignment of existing regional and community efforts with overall statewide CIE approach.
- Commitment to best practices sharing of CIE network design and workflows.
- Commitment to development of integration options to build toward statewide CIE coverage.
- Acknowledgement that the SDOH and CIE landscape will continue to evolve and agreement to align future recommendations for statewide CIE alignment informed by existing regional and early adopter efforts.

Centering Health Equity in CIE work

The Advisory Committee agreed that CIE work must be centered in health equity, and adopted the OHA definition of health equity, which follows:

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistribution of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

For more information on the health equity definition, see:
https://www.oregon.gov/oha/OEI/Pages/Health-Equity-Committee.aspx

Vision for Community Information Exchange in Oregon

Building from the CIE definition, key principles and leveraging early adopter efforts underway, the CIE Advisory Group aligned on the following Vision for CIE in Oregon:

For Patients and Families: Reliable referrals to organizations for patients' pressing social needs, assistance with system navigation, and overall improved health and well-being.

For Communities: More effective and efficient referrals among CBOs and with clinical providers, and community-wide social needs data to inform policy, advocacy and investment.

For Health Care Systems: Improved patient health, improved provider satisfaction, improved metrics and performance on health outcomes and well-being, reduced utilization and cost, engagement of community health partners to address patients' social needs and demonstrate community benefit investment.

For Policymakers: Alignment with state health care transformation goals, CCO 2.0 policy recommendations, and leverages the work of HIT Commons to coordinate investments in HIT, funding opportunities, and advance HIE across the state. Provide data on regional social and resource needs, and outcomes to inform policy changes and resource allocation.

Emerging CIE Efforts and Statewide Maps

The CIE space is quickly evolving across Oregon and across the nation. Prior to the launch of the HIT Commons CIE Advisory Group, HIT Commons staff developed a high-level CIE Environmental scan in 2019 involving review of existing materials on CIE efforts and technology and based on interviews with over 20 organizations/individuals across Oregon.[2]

In addition, the HIT Commons staff collaborated with the Portland State University's Population Research Center to create several maps showing the current CIE vendor footprint in Oregon and social needs screening tools in use by organizations. The purpose of these maps is to create a quick view of the emerging CIE landscape. All data shown below is accurate as of August 2020.[3]

CIE Efforts Underway[4]

Through investments by health systems, health plans and CCOs, a CIE footprint is emerging across Oregon. CCOs are playing a major role leading the implementation of CIEs in Oregon, with 12 CCOs pursuing CIE implementations as of September 2020.

Based on these investments, two vendors offering closed-loop referral functionality saw growing footprints in Oregon from 2019-2020: Aunt Bertha and Unite Us. As of August 2020, partners in 10 counties are live with a CIE and another 13 counties are represented in pricing discussions, planning or implementation. Also, in 2020, a third vendor, Activate Care, emerged into the Oregon landscape and contracted with Advanced Health CCO in Coos/Curry counties and with the Columbia Gorge Health Council in Hood River and Wasco counties. These and any additional vendors may be added to future iterations of the CIE maps.

Organizations contracting/implementing/exploring pricing as of August 2020 included:

- **Health systems**: Samaritan Health Services, Kaiser Permanente, Legacy Health

- **Health Plans/CCOs**: Kaiser Permanente Health Plan, InterCommunity Health Network (IHN) CCO, Health Share CCO and its partners, CareOregon (including Columbia Pacific CCO, Jackson Care Connect CCO) PacificSource (all lines of business, including four CCOs), AllCare Health, Trillium Community Health Plan, Cascade Health Alliance CCO, Yamhill CCO.

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[2] **HIT Commons full CIE Environmental Scan can be found here:** http://www.orhealthleadershipcouncil.org/oregon-community-information-exchange-ocie/

[3] **A link to the CIE Maps and a tutorial video may be found here:** https://pdxedu.maps.arcgis.com/apps/MapSeries/index.html?appid=a9b4fbd305094c769387127521b6250e

[4] The images below are from **Map 2: Community Information Exchange (CIE) Efforts**: https://pdxedu.maps.arcgis.com/apps/MapSeries/index.html?appid=a9b4fbd305094c769387127521b6250e

In sum, across the 15 CCOs, 3 CCOs were live with Unite Us or Aunt Bertha, 8 CCOs had contracts executed or in negotiation or were in early implementation, and 1 CCO was in pricing discussions for CIE as of August 2020.[5] Additional contracts were in discussion with Activate Care but specifics were not known at the time of this report.

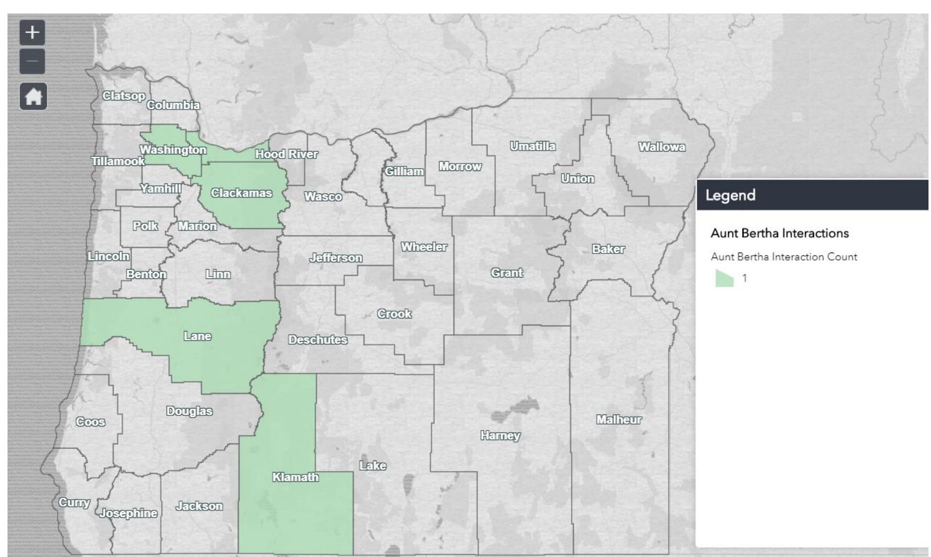
Statewide CIE Map

The map legend refers to number of "interactions". This language was used to reflect that efforts are in varying stages including: Exploring, Implementing, Live. Additionally, there may be more than one interaction per county where there are multiple sponsoring organizations—this is referenced on the maps by "Interaction Count" with 1 being 1 effort underway in the county, 2 meaning 2 efforts underway by different sponsors in the county, etc.

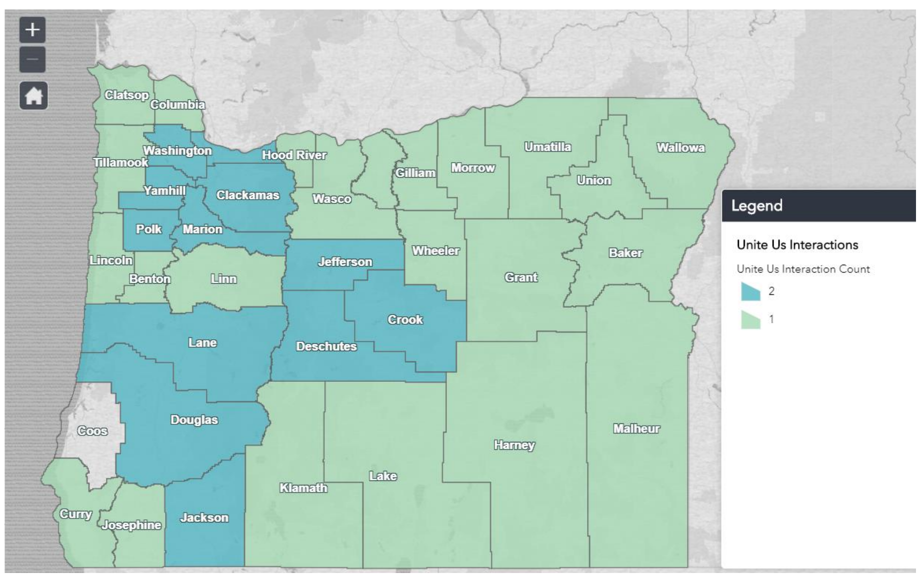
Efforts at any of the stages are shown in the map below; however, details by stage can be viewed using the live link to Map 2 listed above.

[5] At the request of its stakeholders, OHLC convened discussions beginning in Fall 2019 with health care organizations interested in leveraging the Unite Us platform as CIE technology. OHLC's initial efforts include coordinating engagement, developing a statewide pricing model, developing a statewide and local level governance model, and tracking implementation status. OHLC intends to continue this convening role for the Unite Us implementation moving forward.

Aunt Bertha Footprint as of November 2020



Unite Us Footprint as of November 2020



CIE Vendor Presentations and Review by Advisory Group

The Advisory Group's March meeting included presentations from several stakeholders implementing CIE technologies. Please see the materials and recording for the March meeting to review the presentation.[6] Following the presentations, the vendors were excused, and the Advisory Group discussed its thoughts, impressions, initial recommendations and remaining questions. Key points are highlighted below.

- **Vendors differ in their approach to engaging CBOs**
  - On the Aunt Bertha platform, CBOs choose how to engage; they are not required to adhere to network norms. Payers such as plans and CCOs can assist with CBO engagement.
  - Unite Us engages CBOs, directly, coordinates network building strategy sessions, and asks CBOs to sign a participation agreement agreeing to the network standards.
  - Vistalogic/Clara includes closed loop referral functionality and a resource directory/CBO component that is managed by their customers.
  - **Advisory Group members differed in their views on preference for type of community engagement approach.**
- **Vendor compliance/certifications should include HIPAA, 42 CFR Part 2, FERPA, FIPS and other, and is important to verify during engagement discussions.**
- **Degree of integration with EHRs and other systems should be more explicit.** Most vendors start with Single Sign On functionality, but the Advisory Group acknowledged that bi-directional data exchange from CIE platforms to/from EHRs and care management platforms is needed to build a robust CIE strategy.
- **Sustainability of CIE platforms is a long-term concern.** Support may be strong in early stages of CIE to stand up platforms, but how are these efforts sustained over the long run, with investment from health care, public funding and private philanthropy?
- **Access issues are key, included Internet availability in rural areas.** CIE technology cannot scale unless rural broadband is available.
- **To the extent the end user of CIE platforms includes the general public, usability testing and outcomes should be known.**
- **Finally, one member of the Advisory Group did raise the issue of how CIE could be used for public health emergencies like COVID-19, which had just emerged.**

[6] **CIE Advisory Group, March 2020 meeting recording/materials**: https://ohlc.egnyte.com/fl/mEL4QsfH9y#folder-link/

Social Needs Screening Tools/Assessments

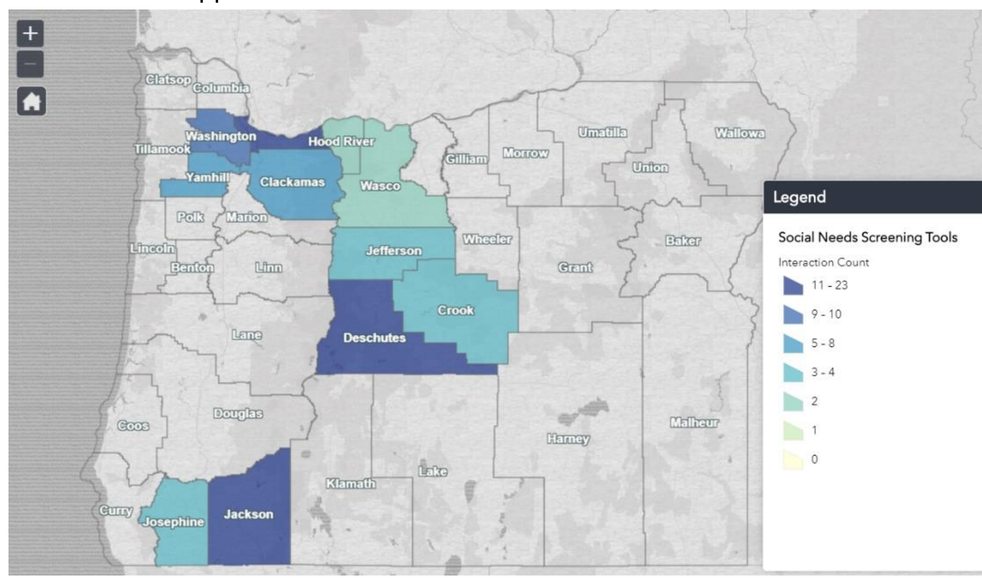
At its February 2020 meeting, the CIE Advisory Group began a discussion of common social needs screening tools (also known as screeners) in use in Oregon health care settings and key principles related to screening.[7] Screening for social needs is a precursor to referrals through a CIE, and CIE technologies have incorporated common screeners or assessment tools. Due to COVID-19, this work continued with a small subject matter expert (SME) group drawn from the Advisory Group and other key constituents to develop some initial insights and recommendations for the Advisory Group's consideration. **See Appendix A.1 for a summary of the work of this SME group.**

Social Needs Screening Tools in Use[8]

There are a wide variety of screening tools in use across counties in Oregon. The maps and information below only address screening tools in use by health care organizations and settings.

AHC Screening Tool in Use as of November 2020

The Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI) made the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool to use in the AHC Model. The AHC model supports local communities to address the health-related social needs of Medicare and Medicaid by coordinating clinical and community service providers. In Oregon, the AHC model and relating screening tool is being implemented and tested by Oregon Rural Practice based Research Network (ORPRN) through a



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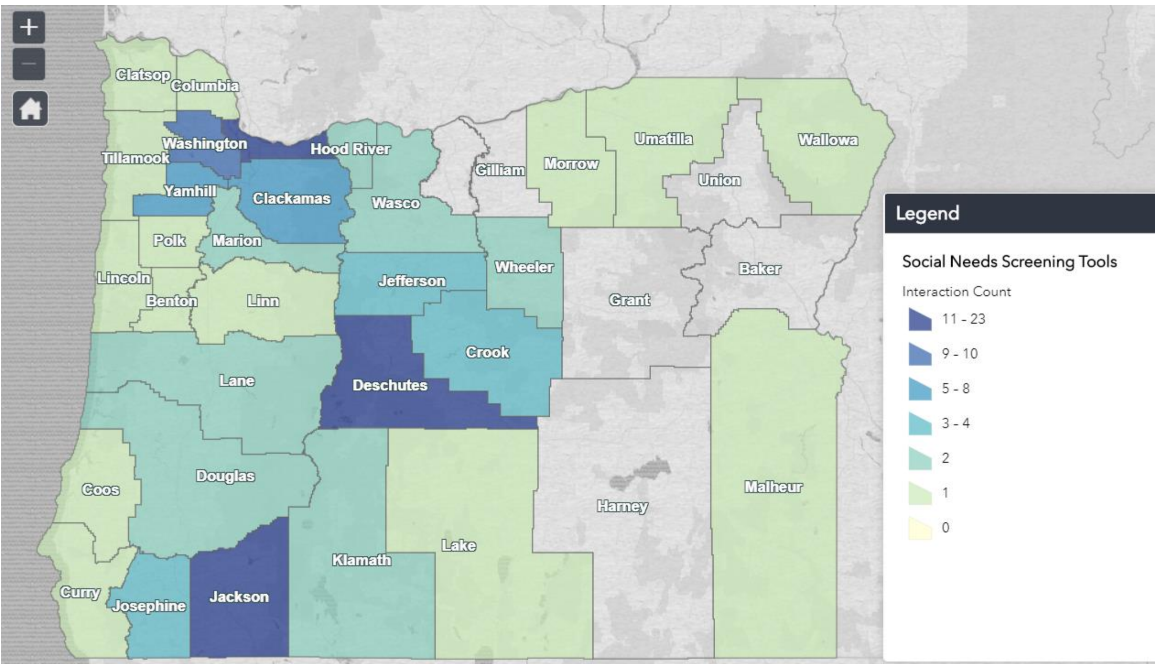
7 **CIE Advisory Group February 2020 meeting materials**: http://www.orhealthleadershipcouncil.org/wp-content/uploads/2020/02/Feb-20-2020-CIE-Advisory-Group-Handouts.pdf

8 The images below are from **Map 4: Social Needs Screening Tools:** https://pdxedu.maps.arcgis.com/apps/MapSeries/index.html?appid=a9b4fbd305094c769387127521b6250e

grant from 2017-2022.[9] The map shows counties where primary care clinics are implementing the AHC screening tool as part of the grant.

PRAPARE Screening Tool in Use as of November 2020

The Oregon Primary Care Association (OPCA) is a membership organization supporting community health centers in Oregon with technical assistance, training and policy support. OPCA has provided support to its members in the use of the PRAPARE (The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences) tool. PRAPARE includes 21 items that capture client demographics and needs related to Family & Home, Money & Resources, Social & Emotional Health, and other optional questions.
While implementation varies by community health center, the map below shows the counties where some level of PRAPARE screening and follow up referral workflows are developing:



[9] For more information on ORPRN and AHC, see https://www.ohsu.edu/oregon-rural-practice-based-research-network

Other Screening Tools in Use by Health Care Organizations as of August 2020

Through its environmental scan and Advisory Group conversations, HIT Commons learned that several major health systems—Kaiser Permanente, Legacy Health, OHSU, and Providence Health and Services—were in early stages of utilizing the Epic SDOH Wheel for social needs screening in clinical settings. The SDOH Wheel includes 10 domains, representing factors that can influence health: financial resource strain, transportation needs, alcohol use, depression, intimate partner violence, social connections, physical activity, tobacco use, stress and food insecurity. Based on patient answers to questions, sections of the Wheel turn colors from green to yellow to red based on level of risk and to help guide interventions and follow up. The intent of utilizing the Wheel is to identify social needs for a follow up referral via a CIE platform or other methods.

Due to the fluidity of screening scope and workflows across the health systems***, HIT Commons did not map the use of the Epic SDOH Wheel, but future iterations of the CIE Maps could include the Wheel and other screening tools.***

CIE Funding and Other Financial Incentives

The CIE Advisory Group did not have the opportunity to engage in a full review and discussion of potential CIE funding sources prior to the suspension of its work due to COVID-19. **However, the group did acknowledge that a wide and varied set of organizations and sectors should come together to fund these efforts.** As of August 2020, CIE investments and funding were emerging as described below.

Health care organizations (health systems, health plans, CCOs)

Health care organizations were accelerating their contracting/implementation discussions with the two leading vendors in Oregon (Aunt Bertha and Unite Us)—primarily due to the increasing recognition of critical social needs resulting from the COVID-19 pandemic.

The funding provided by the health care organizations enables: access to the CIE technology platform; licenses for clinical and social service users *(note: in some pricing models CBOs and safety net providers are provided licenses free of charge);* staff resources to organize community partners into an active CIE network; and technical and customer service support. In addition, health care organizations have contracted separately for any needed integrations with EHRs or care management platforms.

Hospital Community Benefit Minimum Spending Floor

Nonprofit hospitals have provided community-related funding through the community benefit mechanism under state and federal law to maintain their nonprofit status. This funding has provided charity care, community-building activities and other supports. In 2019, Oregon passed a new law (House Bill 3076) which expanded the categories of community benefit to include programs that address SDOH. The bill also directed OHA to set a minimum community benefit spending floor for hospitals. This mechanism provides an opportunity and potential incentive for CCOs and nonprofits hospitals to collaborate on investments in community health, including investments in CIE technology. OHA engaged in rulemaking for the bill's provisions in the fall of 2020 and will be finalizing the minimum spending floor methodology applicable to the first two-year cycle by the bill's effective date of January 1, 2021. OHA will then engage with individual hospitals in accordance with hospitals' fiscal year calendars (which vary by hospital) in order to establish individual spending floors.

Public Sector Funding

Broadly speaking, OHA and the Oregon Department of Human Services (DHS) are both current and potential funding partners for CIE-related efforts. For example, DHS has included state budget requests for 211info and the Oregon Food Bank. In addition, OHA is requesting state funding in 2021-23 to support an OHA/DHS agency-wide CIE subscription(s), the potential extension to other OHA contracted organizations, as well as support for CIE and SDOH resource directory systems integration.

Through its contracts with CCOs and CCOs' global budgets, OHA provides CCOs with the flexibility to offer health-related services (HRS) to improve the health of Oregon's Medicaid population. *"HRS are noncovered services under Oregon's Medicaid State Plan that are not otherwise administrative requirements and are intended to improve care delivery and overall member and community health and well-being. One of the purposes of HRS is to give CCOs a specific funding mechanism within their global budgets to address the social determinants of health (SDOH), including the health-related social needs of their members. For CCOs to use federal Medicaid funds to pay for HRS, they must comply with state and federal criteria."* Based on the state and federal criteria, CIE investment, with access for CCO(s), clinical and social services providers, local public health, and CBOs, could be considered HRS.

In addition to HRS, OHA through its CCO 2.0 contracts and Oregon Administrative Rule 410-141-3735 outlines new requirements for CCOs relating to SDOH and Health Equity and financial investments in these areas. For example, based on a legislative requirement passed in 2018 (House Bill 4018), CCOs must spend a portion of their profits on services related to SDOH and health equity, after meeting minimum financial requirements. Other requirements of the "SHARE Initiative" include spending with aligned community priorities, directing a portion of SHARE dollars directly to community SDOH-E Partners, and including a role for the CCO's Community Advisory Council.[10]

Finally, as the COVID-19 pandemic continued, OHA has and continues to explore how to support local public health authorities (LPHAs) and CBOs, especially those helping to respond in culturally- and linguistically-responsive ways, with social services and wraparound supports for individuals and families affected by COVID-19. OHA is supportive of LPHAs and CBOs, such as COVID-19 CBO grantees, interested to join CIEs in their region.[11]

Philanthropy

Health care organizations and others have identified philanthropy (including foundation, employer-based and individual philanthropy) as a key area of potential CIE funding. As early CIE efforts take root and data become available regarding social needs identified and successfully addressed, funding proposals to philanthropic organizations, such as the Oregon Community Foundation, Meyer Memorial Trust, employer based foundations, and identified interested individual donors should be explored to create a sustainable CIE funding base in Oregon.

[10] For more information on SHARE: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/SHARE.aspx

[11] For more information on COVID wraparound: . https://www.oregon.gov/oha/PH/ABOUT/Pages/Community-Engagement.aspx

Other Advisory Group Topics

Although, this report is based only on the first four months of work (December 2019-March 2020), the Advisory Group touched on several additional topics during the meeting discussions.

Social Needs Screening Tools/Assessments: Alignment or Best Practices

At its February 2020 meeting the CIE Advisory Group began a discussion of common social needs screening tools in use in Oregon health care settings and key principles related to screening. Due to COVID-19, this work continued with a small subject matter expert (SME) group drawn from the Advisory Group and other key constituents to develop some initial insights for statewide screening efforts. **See Appendix A for further information on this work.**

Resource Directories: Alignment or Best Practices

In its February meeting, the Advisory Group heard presentations from 211info and the OHA's OPD.[12] Resource directories are a key component of effective CIE efforts, enabling social need referrals to connect to CBOs. 211info is a key player in the resource directory space in Oregon and 211info's demand has increased dramatically with the impact of COVID-19. A statewide resource directory with integration capabilities is critical to a robust and responsive Oregon CIE. Sharing resource directories across CIE technologies and with other systems can provide efficiencies and improve the quality of directory data statewide. **See Appendix B for further information and exploration of this concept.**

Community & CBO engagement strategies, and communications

In its January meeting, the Advisory Group heard from a small number of CBOs and discussed communication and engagement.[13]

CIE platform integration & data exchange strategies

In its March meeting, the Advisory Group heard from stakeholders using specific CIEs and discussed integration and data exchange. CIE efforts are in the early stages of development in Oregon. As these efforts mature, functionality which allows referral integration and bi-directional data exchange across competing CIE platforms and other platforms, such as EHRs, will become more readily available. **See Appendix C for further information on interoperability and data standards.[14]**

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[12] CIE Advisory Group February meeting materials: http://www.orhealthleadershipcouncil.org/wp-content/uploads/2020/02/Feb-20-2020-CIE-Advisory-Group-Handouts.pdf

[13] CIE Advisory Group January meeting materials: http://www.orhealthleadershipcouncil.org/wp-content/uploads/2020/02/OCIE-1-21-20-Handouts.pdf

[14] CIE Advisory Group, March 2020 meeting recording/materials: https://ohlc.egnyte.com/fl/mEL4QsfH9y#folder-link/

Synergy with other HIT Commons initiatives (e.g., EDIE, OPD)
In its December meeting, the Advisory Group learned about HIT Commons initiatives and discussed synergies with CIE efforts.[15]

Next Steps for HIT Commons and CIE

CIE adoption and implementation is spreading throughout Oregon. The work summarized in this document will be provided to the HIT Commons Governance Board for a discussion of next steps and appropriate timeline. For any future work taken on by the HIT Commons related to CIE, the Advisory Group's work-to-date reflected in this document can be a starting point.

Potential future topics
Future work by OHA, HIT Commons or other organizations should seek to engage with or address the following topics, which were not addressed by the Advisory Group's early efforts and warrant additional discussion and statewide coordination:

- **Health equity and culture**
- **Social Needs Screening Tools/Assessments**
- **Resource Directories—functionality, implementation, integration**
- **Community & Community Based Organization (CBO) engagement strategies**
- **CIE platform integration & data exchange strategies**
- **Data Sharing, Privacy & Security**
- **Patient/Client Consent**
- **Measures and Metrics**
- **Governance**
- **Sustainability (organizational and financial)**
- **Workflows: CBOs, Medical Providers, Patients/Clients, Local Public Health Authorities**
- **Workforce Planning (Community and Traditional Health Workers)**

[15] CIE Advisory Group December meeting materials: http://www.orhealthleadershipcouncil.org/wp-content/uploads/2020/02/Oregon-CIE-Advisory-Group-Materials-12-12-19.pdf

In particular, several bodies of work are evolving that could impact CIE in Oregon and support an aligned, coordinated statewide CIE network. HIT Commons and OHA should track the following and consider re-engaging when these efforts mature:

- **Interoperability:** National SDOH data standards related to CIE and seek opportunities to pursue interoperability between CIE technologies and with other systems. As of August 2020, at least three efforts should be continued to be tracked for utility to Oregon's emerging CIE landscape: ONC's SDOH efforts, The 360X Project; The Gravity Project, and OPCA's Social Data Sharing Collaborative, which is exploring alternative options for social data documentation and sharing between CCO and clinical partners.
- **Statewide/centralized resource directory:** 211info and OHA's OPD are exploring this concept in 2020/2021.
- **Best Practices/Pilots**: Oregon's SDOH pilot work that relate to CIE and seek opportunities to align CIE efforts and share emerging best practices, including OPCA's Social Data Sharing Collaborative, and the AHC work.
- **Screening/Assessment**: OHA's Social Needs Measurement Advisory Group is working in 2020/2021 to develop a CCO screening metric. As CIE and social needs screening matures, additional work may be needed in areas such as risk stratification methods and payment model design to support social needs screening workflows and workforce strategies.
- **Metrics and data**: Early adopter efforts with CIE will provide available data on referral activity, community-based engagement and capacity, and scale of social needs addressed and may be helpful to guide future work.
- **Funding and sustainability:** Hospital Community Benefit rulemaking and other opportunities provide a springboard to engage around long-term sustainability of CIE in Oregon.
- **Emergency Response:** CIE should be considered to support emergency response including COVID-19 and wildfires.
- **Health Equity**: Ensuring CIE implementations promote health equity work and initiatives, including REALD data collection, in alignment with Healthier Together Oregon's State Health Improvement Plan priorities.

<u>Other Considerations</u>

As a convener and facilitator for statewide HIT initiatives, and given the work completed to date in the CIE space, the HIT Commons Governing Board should continue to pursue CIE alignment and coordination efforts to achieve statewide CIE networks.

- HIT Commons should monitor the evolving CIE environment and may consider re-engaging stakeholders to work on specific topics (such as those listed just above) to support CIE efforts across Oregon (per HIT Commons Project Selection Criteria). A key part of this work includes maintaining CIE maps, which could remain with HIT Commons or transition to OHA.
- As future efforts evolve, HIT Commons and OHA should look for ways to increase adoption and spread of CIE in Oregon while limiting vendor proliferation to the extent possible and ensuring community members and CBOs are receptive to and benefitting from the platforms. A multitude of vendors in this space complicates integration and increases burden on CBOs to receive and process referrals in a timely manner. Stakeholders can learn from CIE implementations underway and share successes, challenges and promising practices across organizations.
- Continue to center health equity in this work and seek opportunities to improve CIE support for populations that face health disparities.

This report will be presented to the HIT Commons Governance Board at its September and November 2020 meetings for discussion.

Acknowledgements

HIT Commons and OHA would like to thank the Advisory Group members for their work (see Appendix for member list). In particular, special thanks to:

Randy Morris and Spencer Keller of the PSU Population Research Center for their work in support of the maps.

Screening/Assessment SMEs Group Members:

- Carly Hood-Ronick, CCO Strategy & Health Equity Director, OPCA
- Kristin Kane, Practice Director, Social Needs & Community Partnerships, NW Permanente
- Emily Fanjoy, Health Programs Coordinator, Tides of Change (ToC) (Formerly known as Tillamook
- County Women's Resource Center)
- Anne King, Project Director, Accountable Health Communities, OHSU/ORPRN

Presenters at CIE Advisory Group Meetings:

- Lynn Knox, Oregon Food Bank
- Jeff Blackford, C.H.A.N.C.E.
- Andy Nelson, Impact NW
- Kristin Kane, Kaiser Permanente
- Ann Kirby and Megan McAninch Jones, Providence St. Joseph Health
- Anne King, OHSU/ORPRN
- Carly Hood-Ronick, OPCA
- Dan Herman and Cara Kangas, 211info
- Suzanne Cross, Columbia Gorge Health Council
- Keary Knickerbocker, Vistalogic
- Amanda Cobb and Ron Harper, Trillium Community Health Plan CCO
- Michelle Crawford and Ronda Lindley-Bennett, Samaritan Health System/IHN CCO
- Chris Bryan, Aunt Bertha
- Anna Becker and Read Holman, Unite Us

Community Information Exchange (CIE) in Oregon:

APPENDIX

OTHER CIE TOPICS EXPLORED BY ADVISORY GROUP

A: SOCIAL NEEDS SCREENING TOOLS/ASSESSMENTS: ALIGNMENT OR BEST PRACTICES 26

B: RESOURCE DIRECTORIES: OVERVIEW OF 211INFO AND RELATED EFFORTS 31

B: EFFORTS TO PROMOTE DATA INTEGRATION & EXCHANGE 35

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Social Needs Screeners/Assessments: Alignment or Best Practices

During 2020 and with OHA's support, at least two efforts were focused on social needs screening as a key component of CIE efforts: The OHA SDOH Measurement Workgroup was charged with recommending a social needs screening measure for potential inclusion in the CCO Incentive Metrics program; and The CIE Advisory Group was charged with developing a statewide CIE Roadmap including recommendations around key CIE components including social needs screening.

At its February 2020 meeting the CIE Advisory Group began a discussion of common social needs screeners in use in Oregon health care settings and key principles related to screening. Due to COVID-19, this work continued with a small subject matter expert (SME) group drawn from the Advisory Group and other key constituents (see SME contributors listed below) to develop some initial insights and recommendations for the Advisory Group's consideration.

Social Needs Screening Sources

With the SME group, HIT Commons staff facilitated a review of the following screeners and questionnaires:

- Epic Wheel implementations from Kaiser Permanente and Providence Health & Services
- Accountable Health Communities (AHC) Medicare/Medicaid Screener
- PRAPARE (The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences)
- State of North Carolina Social Needs Screener for NCCARE360
- Universal Data Elements in HUD's Homeless Management Information Systems (HMIS)
- Race, Ethnicity, Language and Disability (REALD) Standards

A comprehensive spreadsheet of the above items was provided to the OHA SDOH Measurement Workgroup and a 'starter set' of items for common client intake and social needs screening for future consideration can be found on at the end of this section.

Highlights of Screener Review

The review of above screeners and questionnaires yielded the following findings:

- **Tremendous overlap** in both domains and questions asked across the resources included in the review.
- **Epic Wheel items were notable for including more preventive care questions** (e.g., tobacco, physical activity) and for excluding housing questions. Epic is expected to include housing items in future release of the Wheel.
- **Some screeners ask more eligibility-type questions for program enrollment**, such as income level, SNAP eligibility, which the SME group viewed as more suited to "Intake" vs. "Social Needs Screening."
- **Many screener items will require domain specific follow up**, e.g., housing insecurity may trigger a full "Housing Assessment" for a client.

- **Given the onset of the COVID-19 pandemic,** the SME group agreed that questions about **stress and social connections** should be included in screeners.
- The North Carolina NCCARE360 screener was a strong example of a short, accessible screener for all populations—but it might be revised to include a "Decline to Answer" option.
- Most of the questionnaires originate from health care settings and **additional outreach is needed** to domain experts in **social services organizations and community-based organizations** for specific input, e.g., intimate partner violence, corrections.
- **Clinical partners will continue to use screening tools already implemented** such as Epic, PRAPARE and AHC to screen and refer patients to social services providers, such as CBOs, for **needs such as housing, food, transportation and other, non-clinical issues.**

<u>Principles for Social Needs Screening</u>

Based on the CIE Advisory Group discussion at its February meeting and the SME input that followed, the following principles may provide input into future social needs screening instruments and workflows:

- **Use validated questions wherever possible.**
- **Align with Oregon-specific initiatives such as REALD standards.**
- **Maintain brevity while remaining inclusive of critical social needs.**
- **Standardize most responses** to simplify for the client/individual and to support streamlined data collection around volume of social needs.
- Identify opportunities to clarify need for and subsections of questions likely collected elsewhere across a common **Intake,** a **Social Needs Screener**, and **Domain-Specific Assessments:**
    - For example, designated intake questions, while not a formal part of social needs screening, are often required for alternate funding/data collection processes across a variety of entities. These are critical data points used to understand inequities and disparities, often by demographic characteristics, and may be asked at different stages of engagement with a client. While they are not formally part of the social needs screener and do not necessarily need to be asked at every visit, it is imperative that partners determine where in the process they ARE collected to ensure comprehensiveness.
- **Recognize that in many domains, a positive social needs screen will trigger a deeper social needs Assessment** to properly connect a client to needed resources.
- **Acknowledge that not all social need referrals must start with a formal social needs screening as requiring it is not consistent with a trauma-informed approach.**
- **Inclusion of the Housing Management Information System (HMIS) Universal Data Elements** in Patient Intake and Housing Assessments could facilitate more adoption and use of CIE technology among housing program staff.
- Based on the review of screeners and known social needs among populations, **key domains to consider for inclusion in social needs screening** are:
    - Food

- Housing
- Transportation
- Interpersonal Safety
- Stress
- Social Connections
- Urgency/Readiness (for client to address or receive support for social need)

Below is a grid illustrating the mapping of the 7 domains by source domain.

Domain	AHC Domain	PRAPARE Domain	EPIC Wheel Domain
Food Insecurity	Food	Money & Resources	Food Insecurity
Housing	Living Situation	Family & Home	Financial Resource Strain
Transportation	Transportation	Money & Resources	Transportation
Interpersonal Safety	Safety	N/A	Intimate Partner Violence
Stress	Mental Health	Social & Emotional Health	Stress
Social Connection	Family & Community Support	Social & Emotional Health	Social Connections
Urgency/Readiness*	N/A	N/A	N/A

*Note: Domain related to Urgency/Readiness was sourced from the State of North Carolina which has a statewide screening tool.

CIE Advisory Group Supporting SME Experts

The SME group providing additional input to the Advisory Group review of social need screeners included the following experts:

- Carly Hood-Ronick, *CCO Strategy & Health Equity Director, Oregon Primary Care Association (OPCA)*
- *Kristin Kane, Practice Director, Social Needs & Community Partnerships, NW Permanente*
- Emily Fanjoy, *Health Programs Coordinator, Tides of Change (ToC) (Formerly known as Tillamook County Women's Resource Center)*
- Anne King, *Project Director, Accountable Health Communities, OHSU/ORPRN*

#	Type	Domain	Question	Answer Options	Source/Screener
1	SDOH	Food Insecurity	Within the past 12 months, you worried that your food would run out before you got money to buy more.	Yes, No, Decline to Answer	Prov, KP, AHC, PRAPARE, State of NC
2	SDOH	Food Insecurity	Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.	Yes, No, Decline to Answer	Prov, KP, AHC, PRAPARE, State of NC
3	SDOH	Housing	Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?	Yes, No, Decline to Answer	KP, State of NC
4	SDOH	Housing	Are you worried about losing your housing or concerned about your ability to pay your rent or mortgage?	Yes, No, Decline to Answer	PRAPARE, State of NC (combined questions)
5	SDOH	Housing	Within the past 12 months, have you been unable to get utilities (heat, electricity, oil, water etc) when it was really needed?	Yes, No, Decline to Answer	PRAPARE
6	SDOH	Housing	Think about the place you live. Do you have problems with any of the following:	Pests (such as bugs, ants, or mice), Mold, Lead Paint or Pipes, Lack of heat, Oven or stove not working, Smoke detectors missing or not working, Water leaks, None of the above	AHC
7	SDOH	Transportation	In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?	Yes, No, Decline to Answer	Prov, KP, AHC, PRAPARE, State of NC
8	SDOH	Interpersonal Safety	Ask yourself: Does my partner/caregiver/other give me space to be with friends or family?	Yes, No, Decline to Answer	Futures Without Violence
9	SDOH	Interpersonal Safety	Ask yourself: Does my partner/caregiver/other shame or humiliate me in public or in private?	Yes, No, Decline to Answer	Futures Without Violence
10	SDOH	Interpersonal Safety	Ask yourself: Does my partner/caregiver/other support my decisions about if or when I want to have children?	Yes, No, Decline to Answer	Futures Without Violence
11	SDOH	Interpersonal Safety	Ask yourself: Does my partner/caregiver/other hurt me, threaten me, or make me feel afraid?	Yes, No, Decline to Answer	Futures Without Violence
12	SDOH	Stress	Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How often do you feel stressed?	Never, Rarely, Sometimes, Often, Always, Decline to Answer	PRAPARE - modified
13	SDOH	Social Connection	How often do you feel lonely or isolated from those around you?	Never, Rarely, Sometimes, Often, Always, Decline to Answer	AHC
14	SDOH	Social Connection	How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)	Less than once a week; 1-2 times a week; 3-5 times a week; More than 5 times a week; Decline to Answer	PRAPARE
15	SDOH	Urgency/Readiness	Are any of your needs urgent? For example, you don't have food for tonight, you don't have a place to sleep tonight, you are afraid you will get hurt if you go home today.	Yes, No, Decline to Answer	State of NC
16	SDOH	Urgency/Readiness	Would you like help with any of the needs that you have identified?	Yes, No, Decline to Answer	State of NC

#	Type	Category	Question	Answer Options	Source/Screener
1	Intake	Identification	First and Last Name	Fill in blank	HUD
2	Intake	Demographics	Gender	Choose from pick list	HUD
3	Intake	Identification	Date of Birth	Fill in blank	HUD
4	Intake	Identification	Social Security Number	Fill in blank	HUD
5	Intake	Demographics	What address do you live at (include street and zip code)?	Fill in blank	AHC, PRAPARE
6	Intake	Demographics	How many family members, including yourself, do you currently live with?	#, Decline to Answer	AHC, PRAPARE
7	Intake	Demographics	What is your current work situation?	Umemployed and seeking work; Part time or temporary work; Full time work; Otherwise unemployed but not seeking work (student, retired, disabled, unpaid primary care giver), Decline to Answer	PRAPARE
8	Intake	Demographics	What is the highest level of school that you have finished?	Less than a high school degree; High school diploma or GED; More than high school; Decline to Answer	AHC, PRAPARE
9	Intake	Demographics	What is your main insurance?	None/uninsured; Medicaid, CHIP Medicaid, Medicare, Other public insurance (not CHIP), Other public insurance(CHIP), Private insurance	AHC, PRAPARE
10	Intake	Demographics	During the past year, what was the total combined income for you and your family members you live with? This information will help us determine if you are eligible for any benefits.	#, Decline to Answer	PRAPARE
11	Intake	Demographics	At any point in the past 2 years, has seasonal or migrant farm work been your or your family's main source of income?	Yes, No, Decline to Answer	PRAPARE
12	Intake	Demographics	Are you a veteran?	Yes, No, Decline to Answer	HUD
13	Intake	Demographics	Do you receive any public benefits such as SNAP, SSI, TANF, or VA benefits?	Yes, No, Decline to Answer	Unite Us
14	Intake	Demographics	Do you currently have housing benefits? (e.g. Section 8 housing or HUD)	Yes, No, Decline to Answer	Unite Us
15	Intake	Demographics	Are you a refugee?	Yes, No, Decline to Answer	PRAPARE
16	Intake	REALD	Do you need written materials in an alternate format (Braille, large print, audio recordings, etc.)?	Yes, No, Don't Know/Unknown, Declined to Answer	OHA - REALD
17	Intake	REALD	How do you identify your race, ethnicity, tribal affiliation, country of origin, or ancestry?	Fill in blank	OHA - REALD
18	Intake	REALD	Which of the following describes your racial or ethnic identity? Please check ALL that apply.	Multiple choice pick lists	OHA - REALD
19	Intake	REALD	If you selected more than one racial or ethnic identity above, please CIRCLE the ONE that best represents your racial or ethnic identity.	Circle one from pick lists	OHA - REALD
20	Intake	REALD	In what language do you want us to speak with you:	Fill in blank	OHA - REALD
21	Intake	REALD	In what language do you want us to write to you:	Fill in blank	OHA - REALD
22	Intake	REALD	Do you need a sign language interpreter for us to communicate with you?	Yes, No, Decline to Answer	OHA - REALD
23	Intake	REALD	Do you need an interpreter for us to communicate with you?	Yes, No, Decline to Answer	OHA - REALD
24	Intake	REALD	How well do you speak English?	Very well, Well, Not Well, Not at all, Don't Know/Unknown, Don't want to/Decline to answer	OHA - REALD
25	Intake	REALD	Are you deaf or do you have serious difficulty hearing?	Yes, No, Don't Know/Unknown, Declined to Answer. If yes, at what age did condition begin?	OHA - REALD
26	Intake	REALD	Are you blind or do you have serious difficulty seeing, even when wearing glasses?	Yes, No, Don't Know/Unknown, Declined to Answer. If yes, at what age did condition begin?	OHA - REALD
27	Intake	REALD	Does a physical, mental, or emotional condition limit your activities in any way?	Yes, No, Don't Know/Unknown, Declined to Answer. If yes, at what age did condition begin?	OHA - REALD
28	Intake	REALD	Do you have serious difficulty walking or climbing stairs?	Yes, No, Don't Know/Unknown, Declined to Answer. If yes, at what age did condition begin?	OHA - REALD
29	Intake	REALD	Do you have difficulty dressing or bathing?	Yes, No, Don't Know/Unknown, Declined to Answer. If yes, at what age did condition begin?	OHA - REALD
30	Intake	REALD	Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?	Yes, No, Don't Know/Unknown, Declined to Answer. If yes, at what age did condition begin?	OHA - REALD
31	Intake	REALD	Because of a physical, mental, or emotional condition, do you have serious difficulty doing errands alone such as visiting a doctor's office or shopping?	Yes, No, Don't Know/Unknown, Declined to Answer. If yes, at what age did condition begin?	OHA - REALD

Overview of 211info Resource Directory and Related Efforts

211info is a nonprofit organization funded by state and municipal contracts, foundations, United Ways, donations and community partners in Oregon and Southwest Washington. 211info's mission is to empower Oregon and Southwest Washington communities by helping people identify, navigate and connect with the local resources they need. The organization has four key capabilities: contact center, statewide resource database, outreach and social media, and data analytics and reporting. 211info has a $4M annual budget; 55% from state contracts, 30% from municipal contracts, and 15% from healthcare and other miscellaneous contracts.

211info has a directory of over 2,600 organizations that are updated on an annual basis. Currently, 211info uses a platform from RTM Designs called ReferNet to house their database. They have existing API connections with Clara/Vistalogic and as of August 2020 are in process to build an API connection with Unite Us.

Below is an example of a web survey form which illustrates the type of information collected by 211info on each organization record in their database.

ASHLAND EMERGENCY FOOD BANK

Section 1 - Location

ASHLAND EMERGENCY FOOD BANK
ASHLAND EMERGENCY FOOD BANK
{INFO10986 - 1}
☐ This location is temporarily inactive
☐ This location is permanently closed
edit...

560 Clover Lane
Ashland, OR 97520
Jackson County
- This address is not confidential.
- No public transportation is available at this location.
edit...

Mailing Address
PO Box 3578
Ashland, OR 97520
Jackson County
- This address is not confidential.
edit...

Email Address *(for organization)*
info@ashlandfb.org
edit...

Website Address
www.ashlandefb.org
edit...

Publish Location?
Include this location in printed directories.
Include this location in public web sites.
edit...

Phone information
541-488-9544 Main phone
edit...

New Telephones *(add or edit new telephone information)*
edit...

Section 2 - Contact & Business Info *(click to hide details)*

Administrator
Traci Darrow Executive Director
info@ashlandfb.org

- Information is confidential.

edit...

Additional Contacts
(Additional contact info not released to the public.)

Contact 1
Click 'edit' to add first contact person information.

edit...

Contact 2
Click 'edit' to add second contact person information.

edit...

Contact 3
Click 'edit' to add third contact person information.

edit...

Funding information
Click 'edit' to add funding information.

edit...

Accessibility
Wheelchair access

edit...

Business Status Information
Agency type: Nonprofit
Federal tax ID number: 931329669
IRS Designation: 501(c)(3)

edit...

Section 3 - Additional Information *(click to hide details)*

OVERVIEW
Provides emergency food assistance.

edit...

ADMINISTRATIVE HOURS
Monday-Friday 9:30am-12:30pm

edit...

SITE HOURS

edit...

TRAVEL/LOCATION INFORMATION
Located on the east side of I-5, across the street from the Holiday Inn Express. Clover Lane is a small side street off of Ashland Street (Highway 66).

edit...

COVID–19 Impact on 211info and Database Health

As COVID-19 began to hit Oregon, and the stay and home orders were issued, 211info so a huge spike it calls for services and referrals. At one point in late March, calls spiked to 377% of normal. 211info reached out to Health Share of Oregon for support and a small work group was quickly stood up to support 211info. With project management support from HIT Commons, a team with members from Health Share, CareOregon, OHLC, and 211info was formed to develop a plan for temporary loaner staff to act as temporary 211info Resource Specialists. Filling the Resource Specialists role with loaner staff allowed existing 211info Resource Specialists to move to Contact Center roles in the interim to handle a major influx in call volumes from community members in need. Eighteen loaner resource staff equivalent to 11.6 FTE from four organizations were trained to support this initiative.

Database Health is vital to the success of 211info. Typically, each agency is updated annually with the exception of Accountable Health Communities (AHC) which are updated bi-annually. Database Health is calculated as follows: Active Agencies updated in past 365 days/Total Active Agencies. The dashboard below shows the progressive improvements in database health as the loaner resources conducted email and phone outreach to CBOs. As of June 1, 2020, overall database health stood at 98.8%. This is the strongest database health reported by 211info in the last several years.

Database Health by Line of Business
(Active Agencies updated in past 365 days/Total Active Agencies)

	4/15/2020	4/28/2020	5/5/2020	5/11/2020	5/19/2020
AHC	62.0%	60.1%	77.6%	90.6%	96.0%
Child Care	82.0%	86.0%	91.4%	92.3%	96.6%
Foster	98.0%	98.3%	95.6%	96.9%	95.4%
MCH	90.0%	93.9%	95.6%	95.2%	95.0%
SNAP	89.0%	92.5%	94.6%	95.5%	97.0%
Southwest Washing..	99.0%	98.5%	99.2%	99.5%	99.0%
Overall	92.5%	95.3%	96.9%	96.5%	97.3%

Strong database health and increased visibility in the community have allowed 211info to successful ask for and receive $1M in funding from the State of Oregon. These funds will be used to maintain operations and support community outreach across 2020.

OPD Discovery Work

In early 2020, the HIT Commons team convened a meeting with OHA Oregon Provider Directory (OPD), MiHIN (the OPD vendor), and 211info to explore a possible partnership. There was clear interest from all parties to explore the feasibility of having 211info CBO data feed into the OPD to enhance the database.

Below is a brief overview provided by Dan Pasch, OHA Office of Health Information Technology Implementation Director.

The Oregon Provider Directory (OPD) team partnered with 211info to expand the OPD data exchange to include community-based organization (CBO) data. In the first phase of this 'proof of concept' work, the OPD will act as a replica of 211Info data and provide other data partners a hub to retrieve CBO directory information. In later phases the OPD hopes to serve the same role with CBO data as it does with Behavioral and Physical health resources – serving as a single central directory of mastered, stewarded, and trusted data for partners to enhance their own data and better serve Oregonians. A central directory of CBO resources is an important part of the emerging CIE landscape in Oregon and will allow all CIE networks to reference a single source of truth about CBOs for navigation and referrals.

A Timeline

Phase 1

OPD as Replica

RTM

Navigator

Steward

System boundary

The wider world

OPD

- Begin Construction in September
- Ready for use end of 20/start of 21

There is a gap here

Due to budget questions we do not want to have 211Info reliant on OPD

So only start on the larger vision once budget questions are resolved

Phase 2

OPD as Central Directory

RTM

Navigator

System boundary

The wider world

OPD

Steward

- Begin design second half of 2021

Efforts to Promote Data Integration & Exchange

As of 2020, CIE data exchange and integration were still in early stages of development. The efforts listed below could provide useful insights and tools to assist with these issues as CIE continues to develop.

The 360X Project

The 360X Project was launched in 2012 at the federal level as an initiative of HHS' Office of the National Coordinator for Health Information Technology's (ONC) State Health Information Exchange Cooperative Agreement Program, a component of the Health Information Technology for Economic and Clinical Health (HITECH) Act (2009). The initial focus of the 360X project was to create the technical specifications and protocols for a specific use case of referral management between a primary care provider and a specialist. Additional work of the 360X project is to create technical specifications for acute to SNF transfers for patients as part of discharge planning.

Although the 360X project is focused on referrals among clinical providers, the advancement of these standards will no doubt improve referral coordination between and among all members of a patient's care team, including clinical and social health referrals.

As of March 2020, the specifications and protocols for 360X had been successfully tested across multiple EHR vendors and had been demoed at ONC Interoperability Forums. Piloting 360X referrals was set to begin in early 2020 and broad adoption across EHR vendor platforms and including in ONC EHR certification requirements will assist in the implementation of this standard across the industry. *For more information, see:* CONTINUITY ACROSS THE SPECTRUM THROUGH UTILIZATION OF 360X

The Gravity Project

The Gravity Project was launched in 2018 by SIREN to identify and harmonize social risk factor data to promote interoperable electronic health information exchange (HIE). The project is focused at this time on three specific social risk domains: food insecurity, housing instability and quality, and transportation access. More details can be found at: https://www.hl7.org/gravity/

Oregon Primary Care Association (OPCA): Social Data Sharing Collaborative

With funding from Cambia Health Foundation, OPCA initiated a learning collaborative in mid-2020 for Oregon's Medicaid payment and delivery systems around social needs and social determinants of health data sharing. The objectives of the collaborative are:

1) Create a resourced space for pilot sites to explore existing and alternative options for social data documentation and sharing between CCO and clinical partners;

2) Develop a core set of replicable questions to consider and key partners to engage when embarking on data sharing efforts between payers and clinics; and

3) Improve standardized documentation and social data sharing across the health system, including opportunity for integration with state or regional level health information exchange efforts

Among the goals of the collaborative are to improve patient experience and whole person care. *For more information, see below – Medicaid Payment and Delivery System Social Data Sharing Collaborative*

MEDICAID PAYMENT AND DELIVERY SYSTEM SOCIAL DATA SHARING COLLABORATIVE

WHAT

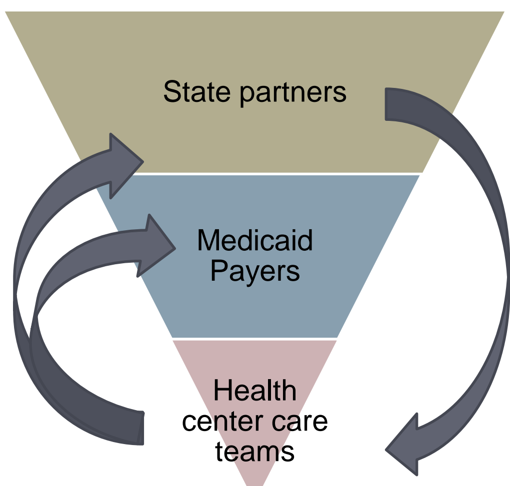
Payers and health care organizations recognize the importance of non-clinical factors for their impact on outcomes, cost and utilization of health care services.

Community health centers (CHCs), whose roots are in the social justice movement, have been working steadily for decades to improve the health and social risks of families and communities experiencing poverty.

Despite their recognized value, incorporating social data in medical records, care plans, and in communication with health system partners and payers is not standardized. Both primary care clinicians and Coordinated Care Organizations (CCOs) play a critical role in identifying and addressing social needs for their patients and members to improve health and the structural barriers to health.

WHY

Social needs information sharing across Oregon's Medicaid system



With funding from Cambia Health Foundation, OPCA is leading an innovative, 12 month **learning collaborative** for Oregon's **Medicaid payment and delivery systems** to come together and explore documentation and **data sharing as it relates to social needs** and **social determinants of health.**

COLLABORATIVE OBJECTIVES

This collaborative will create a space to innovatively explore a new kind of data sharing across health system partners, with the goal of improving patient experience and whole person care. Specifically, this 12-month opportunity has the following objectives:

1) Create a resourced space for pilot sites to explore existing and alternative options for social data documentation and sharing between CCO and clinical partners;

2) Develop a core set of replicable questions to consider and key partners to engage when embarking on data sharing efforts between payers and clinics; and

3) Improve standardized documentation and social data sharing across the health system, including opportunity for integration with state or regional level health information exchange efforts.

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2020 - 2021 TIMEFRAME AND CONTENT:

Grant events and timeline	Mar 20	Apr 20	May 20	Jun 20	July 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
Webinars with national partners	■				■				■			■	
State level face-to-face workshops			■					■					■
CCO + CHC partner calls	■	■		■	■	■	■		■	■	■	■	

Benefit to…

HEALTH CENTERS

- Develop/expand partnership with your CCO on a concrete and ongoing project;
- Increase opportunity to share social data on member/patient assignment;
- Refine clinical workflows and documentation of social needs with TA support;
- Develop aggregate reporting for social needs identified to demonstrate value;
- Contribute to state and national best practices as it relates to z-code usage; and
- Opportunity to inform larger state health information exchange conversations.

COORDINATED CARE ORGANIZATIONS

- Develop/expand partnership with your local health center(s) on a concrete and ongoing project;
- Begin to aggregate social information on your membership for population health efforts;
- Create better care coordination and payment alignment for your members;
- Opportunity to inform larger state health information exchange conversations.

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Want to learn more?

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HIT Commons CIE Advisory Group

We thank the members individually and their organizations for sharing their time and expertise on this important work to improve health care for Oregonians.

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C.H.A.N.C.E. (Communities Helping Addicts Negotiate Change Effectively)
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