Bree Collaborative | Social Determinants and Health Disparities Workgroup
October 15th, 2020 | 8:00 – 9:30 a.m.
Virtual

Present

Cynthia Harris, Family Planning Program Manager, Washington Department of Health
Phyllis Cavens, MD, Medical Director, Child and Adolescent Clinic, Vancouver
Ginny Weir, MPH, Bree Collaborative
Alex Kushner, Bree Collaborative
Amy Etzel, Bree Collaborative
Alison Bradywood, DNP, MPH, RN, NEA-BC, Senior Director, Clinical Quality & Practice, Virginia Mason
Rick Rubin, Chief Executive Officer, OneHealthPort
Yogini Kulkarni-Sharma, AVP, Health Plan Quality Improvement at Molina Healthcare
Tom Green, MD, Orthopedic Surgery, Virginia Mason
Ashley Lile, Director of Training & Technical Assistance, Washington Association for Community Health
Laurie Bergman, Quality Integration/Population Health/Cm Manager, Confluence Health
Kevin Conefrey, Vice Present, HR & Corporate Services, First Choice Health
Julie Stroud, MD, MMM, Medical Director, Quality & Clinical Services, Northwest Physicians Network
Cheryl Berenson, RN, MS, MPH, Public Health Nurse, King County Medical Reserve Core
Mia Nafziger, Senior Health Policy Analyst, Washington State Health Care Authority
Maria Courogen, Special Assistant, Systems Transformation, Washington State Department of Health
Jessica Martinson, Director of Continuing Professional Development, Washington State Medical Association
Abby Berube, Director, Safety and Quality, Washington State Hospital Association
Janice Tufte, Patient Partner, PICORI, AcademyHealth
Christopher Chen, MD, MBA, Medical Director, Medicaid at Washington State Health Care Authority
Rachel Madding, School Mental Health Program Manager, Highline Public Schools
Zandy Harlin, MPH, RN-BC, Quality Program Manager, Population Health, Kaiser Permanente
Hugh Straley, MD, Bree Collaborative Chair
Laurel Lee, VP Network Management, Molina Healthcare
Emily Grimm, Operations Supervisor, University of Washington Medical Center
April Karam, Harborview Medical Center
Layne Croney, Product Development Strategist, Pacific Source Health Plans
Wes Luckey, Deputy Director, Greater Columbia Accountable Community of Health
Yolanda Evans, MD, MPH, Clinical Director, Division of Adolescent Medicine Seattle Children's Hospital
Karie Nicholas, GC, MA, Epidemiologist, Washington Association for Community Health

INTRODUCTIONS

Ginny Weir, MPH, Bree Collaborative, opened the meeting and those present introduced themselves.

GENERAL DISCUSSION

Ms. Weir asked the group about the Gravity Project and how the work being done there could intersect with this workgroup's recommendations.

- The Gravity Project has worked on food and housing related social determinants recommendations and have a list of tools recommended for each domain. They are currently working on transportation as a social determinant.

    - Another attendee added that the project is not about workflow at all; it is about creating coded data sets that can be used with any tool. The data sets in each domain are for intervention, patient goals, diagnoses, and questions.
    - A lot of Gravity's resources are related to FHIR as information needs to be structured around a national standard so that it is easily shareable.
    - Another attendee added that security is a concern when dealing with this amount of data—the richer the data, the more it can be compromised.
    - The goal of the Gravity Project is to facilitate interoperability between health systems and social care (like a food bank, for example)
- Julie Stroud, MD, MMM, Medical Director, Quality & Clinical Services, Northwest Physicians Network mentioned using Collective medical and Unite Us software at her clinic to connect patients with SDoH resources.
- The group discussed the importance of creating standardized systems for SDoH. Rick Rubin, Chief Executive Officer, OneHealthPort spoke about his hope that the group would develop a standardized assessment for Washington on SDoH.
    - Another attendee mentioned that it is hard to do this due to the number of different domains for SDoH and that there are different needs across different providers. It is also important to not add too much administrative burden.
- Another attendee mentioned the problem of provider frustration when there are screening tools but no ability to refer. They also mentioned the possibility of using big data to do predictive analytics and risk stratification.
- The group seemed to have some consensus around the idea that there needs to be minimum standards around screening; once the group establishes those, it would make sense to talk about more in-depth assessments in different domains.
- Zandy Harlin, MPH, RN-BC, Quality Program Manager, Population Health, Kaiser Permanente spoke about Kaiser's process of standardizing SDoH screening internally across its clinics. It has been a years-long process to develop and will take years to implement.
    - If the Bree is too prescriptive about the exact screening tool that should be used, it will alienate organizations like Kaiser that already have a system implemented.
    - Ms. Weir suggested that this group could recommend the screening domains without necessarily giving a specific tool.
    - The situation that Mr. Rubin wants to avoid is everyone rushing to make their own SDoH tool and then having information be impossible to share across clinics and settings.
- Karie Nicholas, GC, MA, Epidemiologist, Washington Association for Community Health spoke about feedback she has heard on the PREPARE tool.
    - Some of the questions did not seem to connect patients with resources.
    - Some found it too long
    - Native health centers seemed to be adopting it less.
- Ashley Lile, Director of Training & Technical Assistance, Washington Association for Community Health spoke about a pilot group of 11 health centers she is working with who are screening for SDoH. They are not prescribing any particular tool or domain and are encouraging pilots not to screen for all domains and instead look at which are important to their populations. Pilot will be a 9-month virtual learning collaborative.
- Ms. Nicholas spoke about Rogue Community Health Center's pre-screening tool that is abbreviated.
    - Alison Bradywood, DNP, MPH, RN, NEA-BC, Senior Director, Clinical Quality & Practice, Virginia Mason said that Virginia Mason is using a 7-question pre-screening tool. They are not using PREPARE because the demographic questions are more detailed than patients are comfortable with.
- The group seemed to have a large consensus around self-report being the best method for screening—it helps patients be more comfortable during the process.

    - However, Ms. Nicholas mentioned that while self-report is valid for many domains, others are more sensitive and self-report may not be as accurate for those (e.g. domestic violence). This might be a good opportunity for the workgroup to weigh in by distinguishing domains that are valid for self-report from those that should be administered by a provider or behavioral health specialist.
    - Dr. Stroud mentioned that she is using a self-reported SDoH questionnaire for remote patient monitoring.
- Christopher Chen, MD, MBA, Medical Director, Medicaid at Washington State Health Care Authority mentioned that, from the state's perspective, there are many social services programs that collect SDoH screening info outside of the medical system. The state is working on interoperability between these programs.
- Ms. Weir summarized that a couple of the themes of the discussion thus far were defining domains that are good for self-assessment and screening standardization. Interoperability is also important from the perspective of reducing paperwork that patients are being bombarded with.
- Ms. Harlin noted that even if a provider does not have the resources to help with an SDoH need, that info can greatly inform and help their care plan.
- Other important SDoH questions were brought up: people should be asked about their internet access, if there is a gun in the house, and suicidality. Gun ownership and suicidality could comprise a "safety" SDoH domain.
- The group agreed that it would be helpful to consider which demographic groups would need a specialized workflow for SDoH. For example, maternity care and older adults might need a modified workflow.
- Ms. Weir spoke about what the end product from this group might look like.
    - Create a state standard, but the scope of that is going to be determined by the group.
    - Interoperability and how to ask SDoH questions should be covered.
    - Workflow recommendations.
- For next time, the group was asked to think about who these standards are for and what role the health plans will play.
    - Mr. Rubin said that the high-level goal is interoperability—everyone needs to be speaking the same language across different sectors.
    - It would be great for the health plans to help distribute SDoH info.
- It might also be worth thinking about including a tool to help clinics determine which SDoH domains are most applicable to their populations.

CLOSING COMMENTS

Ms. Weir thanked all for attending. The meeting adjourned.