Bree Collaborative | Social Determinants and Health Disparities Workgroup
April 15, 2021 | 8:00 – 9:30 a.m.
Virtual

MEMBERS PRESENT

Abby Berube, Washington State Hospital Association
Phyllis Cavens, MD, Child and Adolescent Clinic, Vancouver
Chris Chen, MD, Health Care Authority
Maria Courogen, Department of Health
Kevin Conefrey, First Choice Health
Subharati Ghosh, SEIU 775 Benefits Group
Yogini Kulkarni-Sharma, Molina Healthcare
Laurel Lee, Molina Healthcare
Karen Haugen, Molina WA
James M, WA Health Benefits Exchange
Rachel Madding, Highline Public Schools
Jessica Martinson, Washington State Medical Association
Carol Moser, ED, GCACH
Shaunie McLeod, Washington State Health Care Authority
Karie Nicholas, GC, MA, Washington Association for Community Health
Steven Pline DNP, Association of Advanced Practice Psychiatric Nurses
Brianne Ramos, Washington Department of Health
Rick Rubin, OneHealthPort, Healthcare Forum
Janice Tufte, PCORI Ambassador
Kate Wells, PacificSource

STAFF

Amy Etzel, Bree Collaborative
Nick Locke, MPH, Bree Collaborative
Ginny Weir, MPH, Bree Collaborative

INTRODUCTIONS AND APPROVAL OF MINUTES

Nick Locke, MPH, Bree Collaborative, opened the meeting and those present introduced themselves in the chat.

Motion: Approval of minutes
Outcome: Unanimously adopted

FOCUS AREAS

Mr. Locke reviewed the focus areas and the addition of planning as a domain. Members discussed:

- Add programming such as embed equity principles into mission, vision, and values.
- Whether there is an ongoing role for a body focused on this area, an organization that can serve as a steward and/or a conduit between national standards and state implementation.
    - Where there are national standards you do not want local standards to be duplicative.
    - How to disseminate standards developed at a national basis and interpret that.
    - American Academy of Pediatrics has a chapter in each state focused on many of the topic areas.
    - Health care standards require interpretation and is useful for people to be around the table to talk about standards. Areas of prioritization is necessary and are sharing of best practices.
    - ACHs are already doing this dissemination and interpretation.
    - There is a Washington workgroup associated with the Gravity Project that is focused on looking at concepts and sending them to the federal group. Washington is the only group doing this to help health centers have a smooth ability to send data.
- Screening and identification
    - Is some trauma-informed inquiry that is important there that should be utilized along with empathetic inquiry.
    - Empathic inquiry includes trauma-informed approach and motivational interviewing techniques
    - Emphatic inquiry is proprietary

    - Like the patient privacy, patient autonomy and how sensitive information should or could be shared across providers and between providers and people.
    - Did we include shared decision-making to allow patients to select their social risk needs and accept help?
    - There are not currently best practices in sharing information and a need to develop these best practices.
    - Inter-personal violence rather than interpersonal violence.
    - Whether to add interoperability standards.
    - E.g., existing ICD-10 codes as that is just one of the set of vocabulary codes that can be used
    - Whether to incent use of z-codes through reimbursement.
- Follow-up
    - Not many standards
    - Workflow will be very different person to person.
    - All boils down to follow-up and standards.
    - Number of measures for behavioral health follow-up. Providers struggle with the seven days standard for behavioral health follow-up.
    - Low-risk person is easier to address in a clinical workflow. High-risk person needs more clinic resources. Warm handoff is necessary similar to behavioral health workflow. The health home model is the best to template for social determinant intervention. Number of days applies in taking a person from one system to another system.
    - Health homes have federal funding dollars. Need to braid resources. Modified health homes has some home visiting structure. Lot of COVID dollars.
    - Documentation and notification instead of follow-up.
    - How many days is reasonable for follow-up.
    - How to stratify, what these standards look like. This is looking at it from a medical standpoint.
    - We are also focusing on things like changes to clinical care, for example changing diabetes medications, which could be considered a type of follow-up that doesn't address the root issue, but it does address the medical issue that the SDOH concern might exacerbate
    - HCA BH study includes 12 measures including Adult SMI population: 7 day follow-up after ED event, 7 day follow-up following hospitalization
    - May be best to recommend stratification into two groups not specify how to do that.
        - May be immediate vs longer-term not high/low
        - patient self-identified immediate social risk needs
    - Work Kaiser is doing is academically important.
    - Community information exchanges – turning into a crowded vendor field that hurts interoperability.
        - Already multiple platforms/solutions
        - Work needs to be standards based and interoperable in which we connect various systems as we won't get to one standard.
        - Department of Health will settle on standards not one system.
        - National Alliance to Impact Social Determinants of Health https://www.nasdoh.org/wp-content/uploads/2020/08/NASDOH-Data-Interoperability_FINAL.pdf Helpful to stay tuned to national conversation on interoperability
        - Community information exchanges
        - Goal is closed loop referral system that is pie in the sky and needs interoperability.
        - Do not want to create multiple registries that cannot communicate.
        - https://www.hcinnovationgroup.com/population-health-management/social-determinants-of-health/article/21211225/for-sdoh-standardization-gravity-projects-pull-creates-hope
- Incentives and investments

- Investing health care dollars in social service capacity. Now looking at pop health care through lens of public health, foundational public health. May be a pathway to talk about public health care dollars and provide care coordination based on the person's need.
- Whole goal is how we push care upstream and care upstream. Direct investment is one. Health plan that buys apartment units to house. Do not want to do things in a patchwork way. All on a journey to value. About 85% of payments are linked to value. FFS has some strengths that we don't talk about like increasing certain activities that we are interested in increasing. There is FFS within VBP for productivity measurement and monitoring outcomes.
    - Lower PMPM by race, consider racial bias.
    - Whether to make z-codes a covered visit. Primary diagnosis of homelessness. Or baking risk adjustment into capitation.
    - Do not want the health care system to be the primary place where their social needs are being met.
    - https://science.sciencemag.org/content/366/6464/447
- The impact of environmental health exposures on outcomes
- Add a bullet on investing more public health dollars in infrastructure. Could the investment be in collaboration? Everyone has a portion of a whole child that they are trying to care for than it is impacted by dollars. Need incentives for collaboration around learning how to collaborate.
- Add bullet on investment in collaboration. Needs to be continually be more focused and impactful.

CLOSING COMMENTS

Mr. Locke reminded attendees the next and final meeting will be a week earlier than the original schedule (in three weeks, on May 13th). Next steps are to clean up recommendations and public comment survey for the recommendations and the checklist for members, interviewees, and community members to disseminate. Members can email comments to Mr. Locke. Mr. Locke ended the meeting.