FHCQ | Social Needs and Health Equity Steering Committee
Storing and Sharing Data Workgroup
August 9th, 2022| 8:00 – 9:00 a.m.
Virtual

MEMBERS PRESENT

Karie Nicholas, MSc, Washington Association of Community Health
Dwayne Taylor, One Health Port
Ginny Weir, MPH, Foundation for Health Care Quality

STAFF AND MEMBERS OF THE PUBLIC

Nick Locke, MPH, Bree Collaborative

WELCOME

Nick Locke, Bree Collaborative, welcomed the group to the Storing and Sharing Data workgroup, an ad-hoc workgroup of the Social Needs and Health Equity Steering Committee. Members briefly introduced themselves. With few members present, Mr. Locke requested any changes to July minutes be sent via email.

REVIEW: DATA ARCHITECTURE COMMON CAPABILITIES

Mr. Locke briefly reviewed the presentation from July on HIT Common Capabilities. Dwayne Taylor, One Health Port, answered lingering questions about the model. Those present discussed how pieces of the model fit into current barriers and opportunities for social need screening, referrals, and data analysis.

- Mr. Taylor gave a high-level overview of how the common capabilities model could be applied to social need screening.
    - Existing standards and recommendations from organizations like PREPARE or the Gravity project could provide a framework for integrating patient-facing web portals or web applications for screening, as well as suggest some standard semantics (i.e. codes) for social need screening.
    - A lot of our recommendations will depend on the use case of the data – especially the distinction between population-level data aggregation and analysis vs. individual social need data being used to facilitate referrals.
- Workgroup members asked questions about how to apply the model in various practice settings and using disparate IT resources.
    - Q: How can clinics without great IT resources use this model, such as free clinics, small FQHCs, or mental health practices?
        - A: It is best to minimize the amount of things that need to be implemented at the point of collection to facilitate ease. May be simplest to start with an EHR – integrated screener (where the clinic would just need a computer or ipad for patient to fill out forms when in the office). Some of the more in-depth APIs can be either centralized or built in later.
    - Q: How can we adopt to the reality that even though PREPARE is a good, standard resource using HL7, most clinics prefer not to use the questionnaire as it is too long?
        - A: PREPARE provides a good framework for asking the questions and mapping to HL7, but the Gravity project has done more to structure data from disparate sources using FHIR resources. Perhaps we point to the Gravity Project standards more (although there are pros and cons with each approach)

- Q: What would a HIT system with social need data capability look like in a hospital setting?
    - A: The hospital's would likely either build an HIT system or buy an existing solution (such as UniteUs) which would integrate with their HIT system. Buying can be expensive, and may include some features that are unnecessary, but not all hospitals/health systems have the resources to build their own HIT system from the ground up. One of the key features would be common standards for data fields after a social need screener is completed.
- Q: Most of the conversation has focused on data analytics. How do we respond to providers who want to use the data individually to refer their patients to social services?
    - A: We can ensure that the HIT system integrates well with existing workflows to reduce burden, and the individual organization can develop a system for keeping track of submitters in their system before the data is aggregated for population health analytics.
    - A: Regarding closed-loop referrals, this may be a different use-case that requires different capabilities, but there will be some overlap between the two systems.
- Q: How can we encourage broad participation in WA state?
    - A: We are looking at either a centralized or a federated model. The centralized model would be quicker to stand up, but might lose participation if health delivery systems refuse to participate using the same standards. A federated model would allow for delivery system flexibility, but it would require more work to consolidate all the data in a standard format.
- Comment: we should also make sure our common capabilities are protecting vulnerable populations and data sovereignty.

Mr. Locke summed up the next steps for the workgroup to build recommendations around common data capabilities. This workgroup will need to define:

- Potential use cases (especially data collection, population analytics, and closed-loop referrals)
- Fundamental capabilities required for each use case (including the ability to run assessments, collect assessments for analytics, etc.)
- Potential solutions to achieve the fundamental capabilities (building or buying HIT solutions)
- Standards (if the solutions are not already in a standard format, what needs to be done to ensure aggregation of data)

PUBLIC COMMENT AND GOOD OF THE ORDER

Mr. Locke thanked workgroup members for attending and discussed next steps. This workgroup will develop a high-level report on social need/demographic data ethics and regulations, recommend standards for data architecture based on the common capabilities model, and offer first steps for how common architecture can be implemented in Washington state. The workgroup's next meeting will be held on Tuesday, September 13th from 8:00 – 9:00 AM.