Fix the DAMN Road(map) to Health Equity!

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Data Across Sectors for Health (DASH)

DASH is led by the Illinois Public Health Institute, in partnership with the Michigan Public Health Institute, with support from the Robert Wood Johnson Foundation.
Defining Health Equity

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.
Defining Health Inequities

• Systematic and unjust distribution of social, economic, and environmental conditions needed for health
  • Unequal access to quality education, healthcare, housing, transportation, other resources (e.g., grocery stores, car seats)
  • Unequal employment opportunities and pay/income
  • Discrimination based upon “race,” social status, or other factors
Sharing Data is Hard, So Why Do It?

• There are things we want to do in our communities that no one person, organization, or sector can do alone.

• Accelerating interest in health equity drives support for multi-sector collaboration and data-sharing.

• Multi-sector approaches tell us more about individuals and our communities and are more responsive to complex social conditions.

• Shared community data documents the problems that we suspect, points us to new opportunities, and supports new kinds of interventions.
The Social Determinants of Health

• Social – the result of human policy decisions
• Determinants – direct and measurable
• Health – health, well-being and equity

This is a new way of thinking about health, how it is generated individually and in community
Social Determinants of Health: large impact

Health Outcomes
- Length of Life (50%)
- Quality of Life (50%)

Health Factors
- Health Behaviors (30%)
  - Tobacco Use
  - Diet & Exercise
  - Alcohol & Drug Use
  - Sexual Activity
- Clinical Care (20%)
  - Access to Care
  - Quality of Care
- Social & Economic Factors (40%)
  - Education
  - Employment
  - Income
  - Family & Social Support
  - Community Safety
- Physical Environment (10%)
  - Air & Water Quality
  - Housing & Transit

Policies & Programs

Counseling and Education
- Examples: Eat Healthy and Exercise

Clinical Interventions
- Examples: Medicine for High Blood Pressure, Diabetes

Long-lasting, Protective Interventions
- Examples: Vaccines, Smoking Cessation, Colonoscopy

Changing the Context to Make Individuals’ Default Decision Healthy
- Examples: Fluoridation, Smoke-Free Laws, Tobacco Tax

Socioeconomic Factors
- Examples: Poverty, Education, Housing, Inequality

Citation: University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps 2014. http://www.countyhealthrankings.org/ranking-methods/ranking-system
Spending mismatch

Photo via Healthy People/Healthy Economy: An Initiative to Make Massachusetts the National Leader in Health and Wellness, 2015. Data from NEHI 2013. Also featured on 18 Charts That Make the Case for Public Health, August 28, 2016.
IMPACT OF SOCIAL DETERMINANTS OF HEALTH

Social determinants of health have tremendous affect on an individual’s health regardless of age, race, or ethnicity.

Socioeconomic Factors
- Education
- Job Status
- Family/Social Support
- Income
- Community Safety

Physical Environment

Health Behaviors
- Tobacco Use
- Diet & Exercise
- Alcohol Use
- Sexual Activity

Health Care
- Access to Care
- Quality of Care

SDOH Impact
- 20 percent of a person’s health and well-being is related to access to care and quality of services
- The physical environment, social determinants, and behavioral factors drive 80 percent of health outcomes

Source: Institute for Clinical Systems Improvement; Going Beyond Clinical Walls: Solving Complex Problems, 2014 Graphic designed by ProMedica.

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HIMSS Today

• Social Determinants of Health Obstacles in 280 Characters or Less

“We asked members from around the globe to share the single most pressing obstacle to getting social determinants of health (SDOH) fully integrated into healthcare.”

Why?
In an otherwise fractured Congress, Democrats and Republicans are coming together around newly proposed, bipartisan legislation to help states and communities manage costs and improve outcomes for Medicaid recipients. Called the Social Determinants Accelerator Act, the bill was introduced on July 25 by Reps. Cheri Bustos (D-Ill.), Tom Cole (R-Okla.), Jim McGovern (D-Mass.) and Cathy McMorris Rodgers (R-Wash.).

The bill received support from health-care industry groups like the American Hospital Association and Aligning for Health. It proposes planning grants and technical assistance for states and communities to address individual patient non-medical needs that are closely tied to health, like food security, housing stability and employment. It also targets high-need Medicaid patients and improving the coordination of health and non-health services.
MDHHS Vision and Strategic Priorities

Vision: Deliver health and opportunity to all Michiganders, reducing intergenerational poverty and health inequity

Strategic priorities

Give all kids a healthy start
- Improve maternal-infant health and reduce outcome disparities
- Reduce lead exposure for children
- Reduce maltreatment and improve permanency in foster care

Provide families with stability to escape poverty
- Expand and simplify safety net access
- Protect the gains of the Healthy Michigan Plan

Serve the whole person
- Address food and nutrition, housing, and other social determinants of health
- Integrate services, including physical and behavioral health, and medical care with long-term support services
- Reduce opioid and drug-related deaths

Use data to drive outcomes
- Ensure all administrations are managing to outcomes and investing in evidence-based solutions
Data Across Sectors for Health (DASH)

- Shared data and information
- Collaboration
- Multi-Sector
- Focused on improving the health of communities
DASH integrates 3 strategies

- Increase capacity of local collaboratives to act to improve health
- Expand strategic relationships to support local and national alignment
- Broaden and disseminate standardized evidence for the field

- Build local capacity
- Build the movement
- Build the evidence base
Developing Community Collaboration Capacity

- Collaboration formation (shared value)
- System development (shared data)
- Intervention design (shared action)
- Alignment (shared outcome)
Strategy 1: Build local capacity

Three Major Activities

• Funding
  • OGs – Original Grantees
  • CIC-START – Community Impact Contracts: Strategic, Timely, Actionable, Replicable & Targeted
  • Mentorships – Mentors matched with cohorts of Mentees

• Peer Learning and Sharing
  • LC – The Network / All In: Data for Community Health
    • In-person Meetings and Peer site visits
    • OC – The Online Community

• Policy Development
Funding Programs

10 DASH Original Grantees
18-24 months, $200K

40 DASH CIC-START Contracts
~6 months, $25K

Mentorship
10 months
6 Mentors ($25K),
33 Mentees ($5K)

The Peer-to-Peer Network
“CIC-START was an ideal mechanism to support (our initiative) to develop a shared data dashboard and related infrastructure. It provided the key resources to support convening and community participation. The support provided by the NPO was exactly what (we) needed; from the in-person site visit that provided a spotlight on the value of community-led initiatives, to the helpful reflections and technical assistance through monthly connects and DASH emails.”
Building Local Capacity: DASH Funding

- CIC START 4: 14 Total Applicants, 56 Awardees
- Mentee: 33 Total Applicants, 38 Awardees
- Mentor: 6 Total Applicants, 10 Awardees
- CIC START 3: 16 Total Applicants, 38 Awardees
- CIC START 2: 5 Total Applicants, 25 Awardees
- CIC START Pilot: 5 Total Applicants, 11 Awardees
- Original Grantees: 10 Total Applicants, 409 Awardees
Whole Person Care Use Cases

Shared Data Use Cases: Whole Person Care (35 grantees: OG-CS3)

- Screening and assessment (of clinical and non-clinical needs): 18
- Care coordination not otherwise specified: 17
- Participant/client intake & service eligibility determination: 16
- Sending and receiving of referrals and referral reports (closed loop...): 16
- Client prioritization/targeting: 14
- Sending/pushing of alerts and notifications to clinical and non-clinical...: 14
- Quality and performance measurement: 14
- Collection and presentation of multi-sector data in a person/family...: 12
- Community Resource Directory: 12
- Appropriate setting/diversion programs: 6
Place-based Community Health Use Cases

Shared Data Use Cases: Population Health (35 grantees, OG-CS3)

- Evaluation, research, and/or advocacy purposes: 28
- Mapping, hotspotting, targeted outreach and service delivery: 22
- Community health assessment, improvement planning, needs & resource assessment: 21
- Planning new or altering/improving the design/delivery of existing services: 20
- Community dashboard: 18
- Monitoring or surveillance: 15
- Place based/collective impact population health unspecified: 6
Whole Person Care Coordination
Dallas, TX

Goal: Leverage a community information exchange portal and multi-sector case management tool to improve the nutrition of food bank clients with chronic conditions.

Led by: Parkland Center for Clinical Innovation—with the Parkland Health and Hospital System and North Texas Food Bank

Sectors: Academia / Research, Clinical Health Care, Food/Nutrition, Social / Human Services, Information Management Infrastructure

Use Case(s): Create/present shared care plan, Query/look up client history, Support decision-making, Screening and assessment, care coordination, Research, evaluation, and learning
Goal: Use claims data to identify where falls are happening, develop interventions to reduce the rate of falls leading to hospitalization or emergency department visit among older adults by one-third in three years.

Led by: The Baltimore City Health Department (BCHD)—with the Mayor’s Office, CRISP (HIE), and community-based organizations

Sectors: Academia / Research, Elected / Appointed Officials, Clinical Health Care, Housing / Homelessness, Public Health, Social / Human Services, Other Community-based, Information Management Infrastructure

Use Case(s): Mapping/GIS, Predictive analytics, Data manipulation, visualization and presentation, Calculation & display of metrics and indicators
Whole-person Care Coordination
San Diego, CA

CIE is a catalyst for the community-based movement to understand, value, and share social determinants of health data and use technology to bridge sector divides. The CIE facilitates a community moving from a reactive system of care to a more proactive system through closed-loop referrals and the creation of a single, unduplicated record and community-wide care plan.

Led by: 2-1-1 San Diego; Mentees in healthcare, human services, research, and public health

Sectors: Academia / Research, Elected / Appointed Officials, Clinical Health Care, Housing / Homelessness, Public Health, Social / Human Services, Other Community-based, Information Management Infrastructure

Use Case(s): care coordination, screening and assessment, appropriate setting/diversion, eligibility and enrollment in services, community resource directory, closed-loop referrals
Place-Based Community Health
Minneapolis, MN

“We have benefited greatly from CORE's advice. They advised us to connect with our County PH dept. to talk about data sharing, and they told us about the CHIP process, which we have now joined on the housing action team to great mutual benefit.”

Led by: Public Housing Authority

Sectors: Housing/homelessness, Public Health, Social Services, Other Community-based

Use Case(s): eligibility and enrollment in services, community resource directory, closed-loop referrals, planning new or improving the design of services, needs & resources assessment, research, evaluation, and advocacy
The DASH Framework, updated 2018

Community Data Sharing Capacity

Shared Data
- Workflow redesign and training
- Technical function
- Consent and privacy
- Data governance
- Pathway to ‘yes’
- Equity and evaluation

Policy and Market Environment
- Standards development/adoPTION
- Privacy and data use laws
- Technology innovation
- Market dynamics

Community Alignment
- Shared vision and language
- Collaboration and governance
- Existing data systems
- Trust and transparency
- Resources and assets
- Community engagement
- State and national investment in health and human services information systems
- Payment and funding models
- Market competition
- Knowledge management
Infrastructure for Shared Data

- **Elect. Health Record**: Present in our community but not a driver or resource for data sharing
- **Data Repository**: Present in our community but not a driver or resource for data sharing
- **HIN/HIE**: Present in our community & currently being OR will be leveraged for data sharing
- **Open Data Initiative**: Present in our community & currently being OR will be leveraged for data sharing
- **Multi/All Payer Claims Database**: Present in our community & currently being OR will be leveraged for data sharing
- **Integrated Data System**: Present in our community & currently being OR will be leveraged for data sharing
- **Social Service Provider Directory**: Present in our community & currently being OR will be leveraged for data sharing
- **Care Management Platform**: Present in our community & currently being OR will be leveraged for data sharing
- **Integrated Eligibility System**: Present in our community & currently being OR will be leveraged for data sharing
- **CIE**: (We just started tracking this)
Trust and Transparency
Santa Cruz, CA

Goal: an interactive dashboard that includes both publicly available data, streamlining the process of finding, comparing and mapping that data; and also provides an opportunity for local initiatives to share goals and progress towards addressing those goals.

Led by: Health Improvement Partnership of Santa Cruz County: United Way, Community Foundation, Food Bank, Arts Council, County Human Service

Sectors: Health Care, Education, Elected / Appointed Officials, Public Health, Social / Human Services, Information Management Infrastructure,

Use Case(s): Community Dashboard, Health Needs/Resource Collection, Calculation & display of metrics and indicators
Workflow Redesign and Governance
Linn County, IA

Goal: Advance State Innovation Model Community Care Coalition work to address social determinants of health by selecting and testing a community-vetted assessment tool integrated with the social services care coordination platform.

Led by: Linn County Department of Health- with community health coalitions, United Way

Sectors: Public Health, Social / Human Services, Clinical Health, Information Management Infrastructure, Other community-based

Use Case(s): Screening and assessment, Care coordination, Research, evaluation, and learning
“Data is the language of those with power and money. It drives decision-making at a large scale. A (community indicators) process like this translates the realities of communities into the language of those decision-makers.”

Led by: The Civic Canopy —working with East5ide Unified/Unidos, community-based organizations, and community members.

Sectors: Elected / Appointed Officials, Public Health, Social / Human Services, Other Community-based, Information Management Infrastructure

Use Case(s): Data collection, upload, storage, Calculation & display of metrics and indicators
The DASH Framework, updated 2018

Community Data Sharing Capacity

- Shared Data
  - Standards development/adoptions
  - Privacy and data use laws
  - Technology innovation
  - Market dynamics

- Community Alignment
  - State and national investment in health and human services information systems
  - Payment and funding models
  - Market competition
  - Knowledge management
The roadmap: a series of strategic steps that can facilitate more effective state engagement on multi-sector data sharing

1. **Frame the problem:** Define the specific issue at hand driving impetus for state engagement on data sharing

2. **Assess opportunity:** Test state context against a structured set of criteria to identify entry points for local engagement

3. **Tailor message:** Identify ways to align local data sharing efforts with broader policy, leadership, or other state priorities

4. **Identify stakeholders:** Map critical stakeholders across sectors for buy-in, resources, and partnership

5. **Facilitate collaboration:** Explore mechanisms for coordinated action and relevant roles for local and state stakeholders

6. **Deploy levers to overcome barriers:** Take action to overcome common state roadblocks (e.g., technical, legal)

- Elements of the roadmap are interdependent and inform one another
- Communities may proceed through the roadmap in a non-linear fashion, depending on context
- This process can be a foundation for engaging a state, but can also be referenced once data sharing has already begun
Big and interrelated challenges

» Operationalizing health equity and engaging people with lived experience (aka patients, clients, service recipients, residents, etc.)

» Sustainability, the lack of (market) incentives to support multi-sector work and the wrong and long pocket problems

» Evaluating and measuring the impact of multi-sector interventions

» Interoperability

» Real and perceived legal barriers
ALL IN

Current Program Partners

BUILD Health Challenge
Data Across Sectors for Health
Network for Public Health Law
New Jersey Health Initiatives
Public Health National Center for Innovations
Population Health Innovation Lab

Past Partners

Community Health Peer Learning Program
Connecting Communities and Care
All In Learning Network

Publications

Online Platform

Peer Site Visits

Webinars

Newsletters

National & Regional Meetings and Workshops
Network Engagement

- Online community
  - Affinity Groups

- Webinars

- Newsletter
  - In-person meetings
  - and site visits
Making Connections: – By Types of Data Used

Service (EHRs, case management) data
Administrative data
Geographic data
Personal demographic data

Surveillance data
Outcomes data
Community-generated data
Census and civic data
Making Connections:
– By Sectors Engaged
Top Participating Sectors

- Clinical Health Care: Data Source 31, Data User 28
- Social/Human Services: Data Source 26, Data User 24
- Public Health: Data Source 25, Data User 25
- Mental/Behavioral Health Care: Data Source 27, Data User 23
- Other Community-Based org/nonprofit: Data Source 18, Data User 23
- Information Management Infrastructure: Data Source 23, Data User 18
- Housing/Homelessness: Data Source 21, Data User 19
- Health Care Payers: Data Source 18, Data User 17
- Food/Nutrition: Data Source 19, Data User 16
- Academia: Data Source 17, Data User 18
- Tribal/Local/State Gov. Agencies: Data Source 16, Data User 15

Data Source | Data User
Virtual Collaboration: the “Splat”

Welcome to the All In: Data for Community Health Virtual Collaboration Platform!

The All In virtual collaboration platform is an online community of individuals dedicated to improving community health through multi-sector data sharing and collaboration. It is designed to help you connect with other professionals tackling common challenges, share resources and news, and learn about new ideas and best practices. Click here to learn more about the All In Network. Read our blog and sign up for the All In Newsletter here.

If you would like to sign up to use this collaborative platform, please use the link in the upper right of the window. Be sure to fill out your profile so that we can approve your membership.

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USERS ARE ALL IN!

allin.healthdoers.org
Your questions for me
Halloween Candy Can Be Scary!

Go Fair Trade with your treats to protect farmers and children

www.slavefreechocolate.org
A Highlight of Popular Resources

» Top Resources of 2018
» Blog Posts: Getting Started Tips
  » Biggest Challenges, Questions to Ask When Getting Started, The Secret to a Healthier City: Sharing Data, The Universal Difficulty (but not Impossibility) of Sharing Data
» Data Sharing Agreements: Making Thoughtful Requests
  » Accountable Communities for Health Data Sharing Toolkit
  » Blog Post: Insights from Data Driven Health Collaborations
» Considerations for Multi-sector Data
  » Webinar: Approaches to Collecting and Using SDOH Data, Blog: Social Determinants of Health: Making the Juice Worth the Squeeze
### Essential Definitions

**Health Equity**

The opportunity for everyone to attain his or her full health potential.

No one is disadvantaged from achieving this potential because of socially determined circumstance.

- Equal access to quality education, healthcare, housing, transportation
- Equitable income
- Equal opportunity for employment
- Absence of discrimination based upon social status

**Social Determinants**

Life-enhancing resources whose distribution across populations effectively determines length and quality of life.

- Food supply
- Housing
- Economic relationships
- Social relationships
- Transportation
- Education
- Health Care

**Health Inequities**

Systematic and unjust distribution of social, economic, and environmental conditions needed for health.

- Unequal access to quality education, healthcare, housing, transportation, other resources (e.g., grocery stores, car seats)
- Unequal employment opportunities and pay/income
- Discrimination based upon social status/other factors

**Health Disparities**

Differences in the incidence and prevalence of health conditions and health status between groups based on:

- Race/ethnicity
- Socioeconomic status
- Sexual orientation
- Gender
- Disability status
- Geographic location
- Combination of these
Slide Source Acknowledgements

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• American Hospital Association, Addressing Social Determinants of Health.

• Gwendolyn A. Daniels, Social Determinants of Health: The Basics, part of Promoting Health Equity, A Resource to Help Communities Address Social Determinants of Health.


• Module 1: Determinants of Health, Association for Prevention Teaching and Research.