

**Michigan HIMSS Fall
Conference, October 3,
2019**



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.

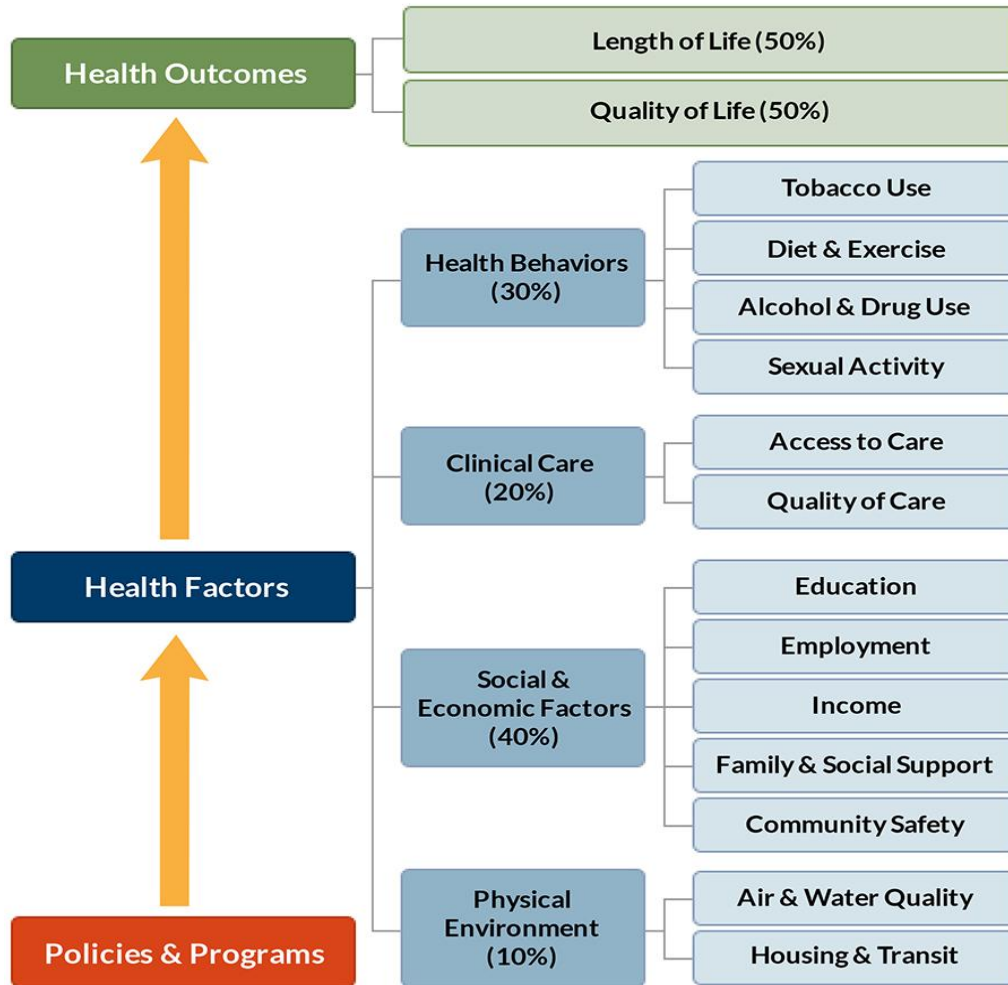
The Social Determinants of Health



- 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



County Health Rankings model © 2014 UWPHI



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

Spending mismatch

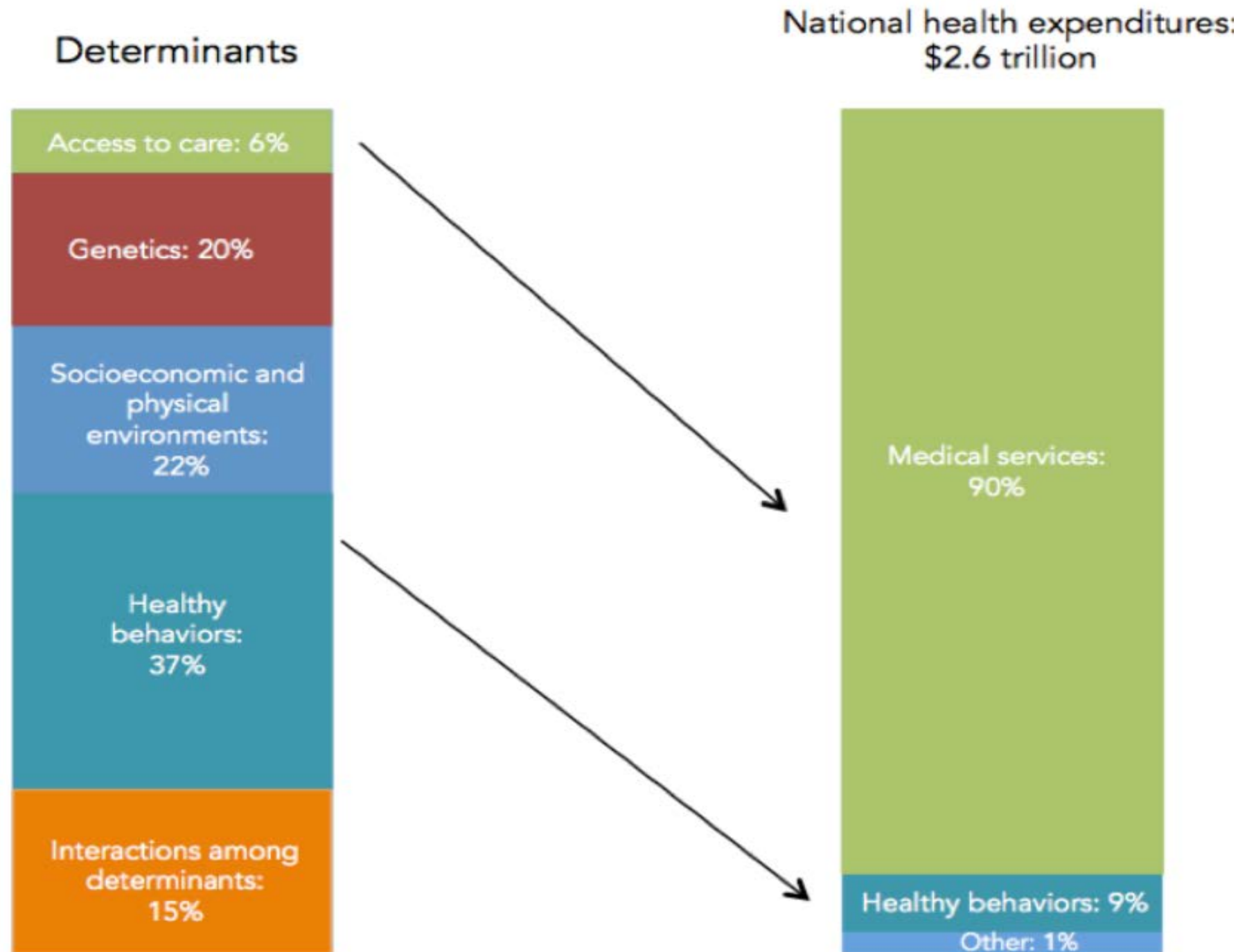
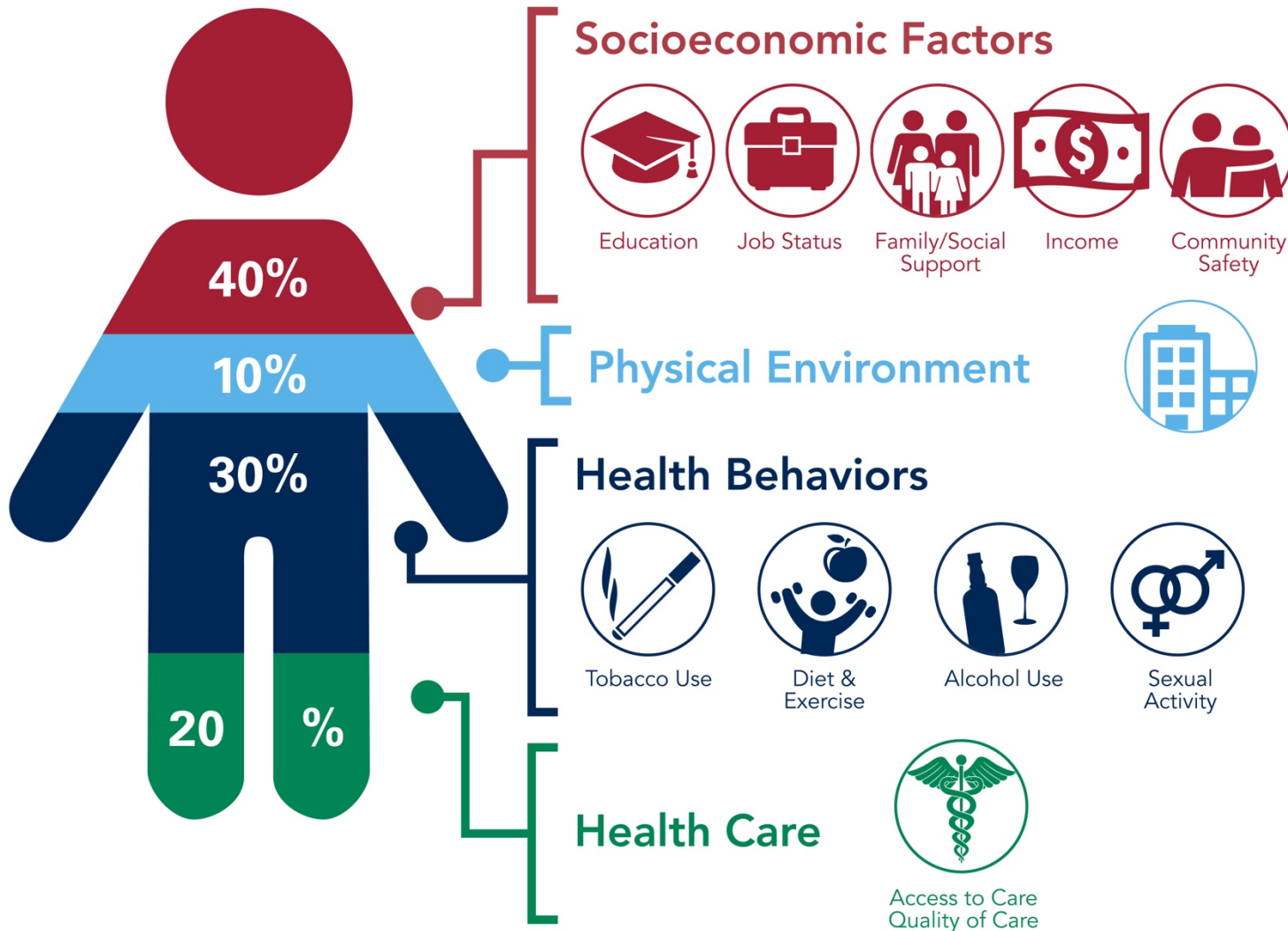


Photo via [Healthy People/Healthy Economy: An Initiative to Make Massachusetts the National Leader in Health and Wellness](#). 2015. Data from NEHI 2013. Also featured on [18 Charts That Make the Case for Public Health](#), August 28, 2016.

IMPACT OF SOCIAL DETERMINANTS OF HEALTH

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



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

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?

Social Determinants Accelerator Act



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

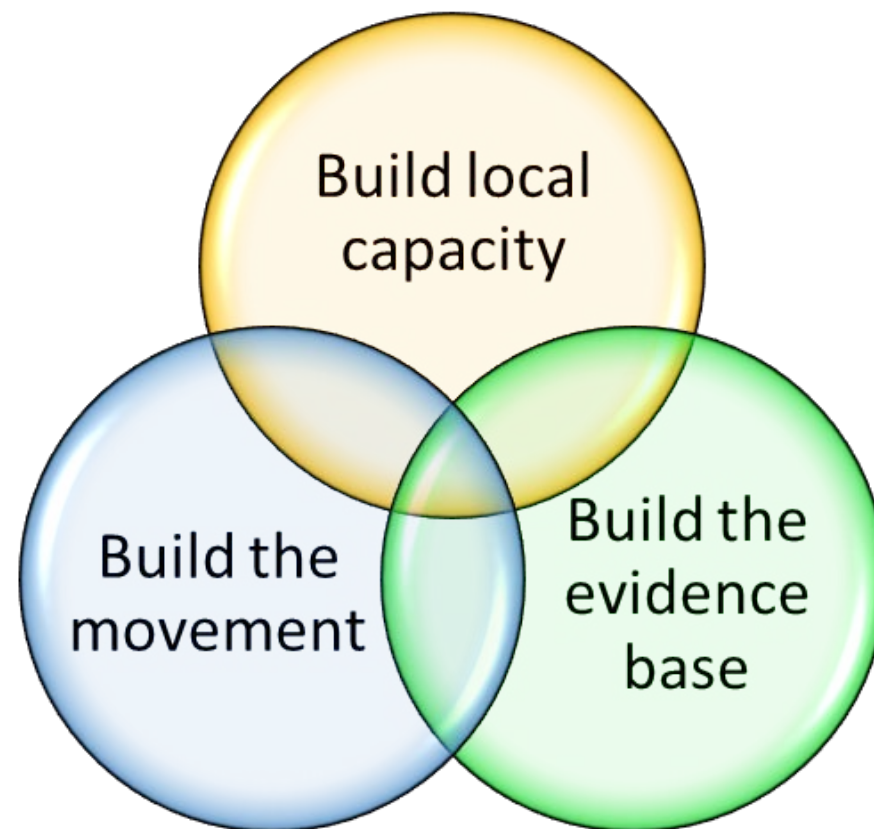


Multi-Sector

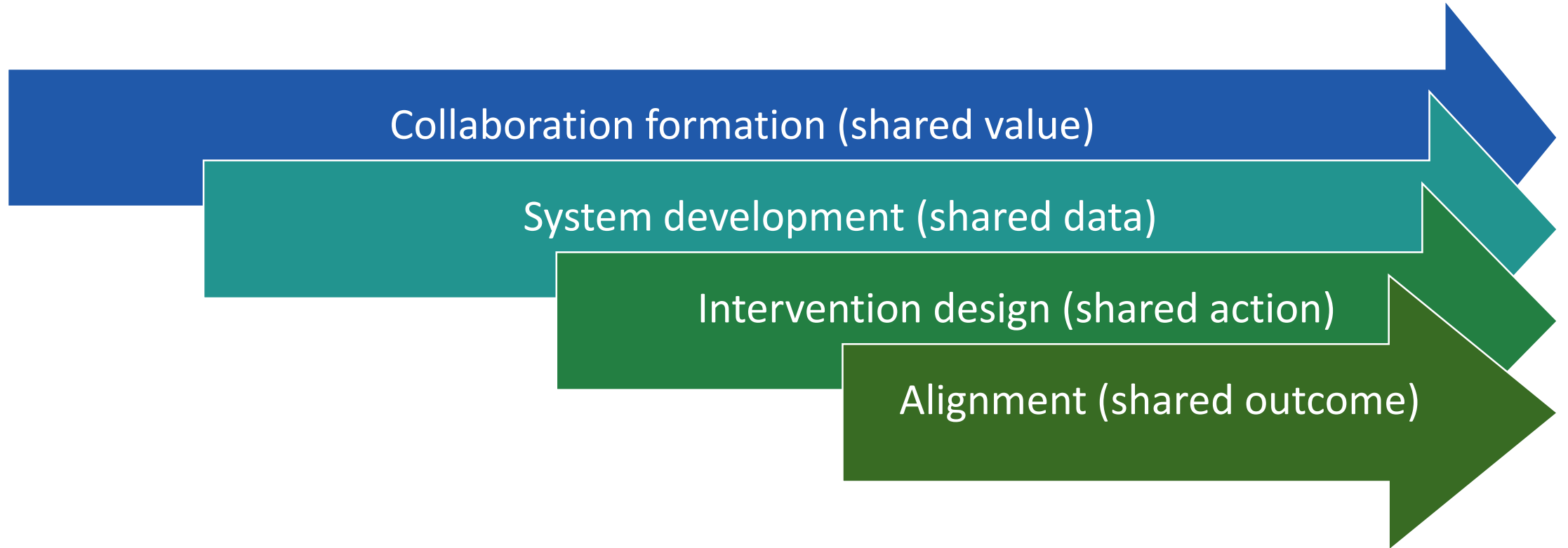


**Focused on improving the
health of communities**

DASH integrates 3 strategies



Developing Community Collaboration Capacity



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

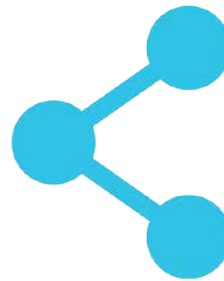
Funding Programs



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)



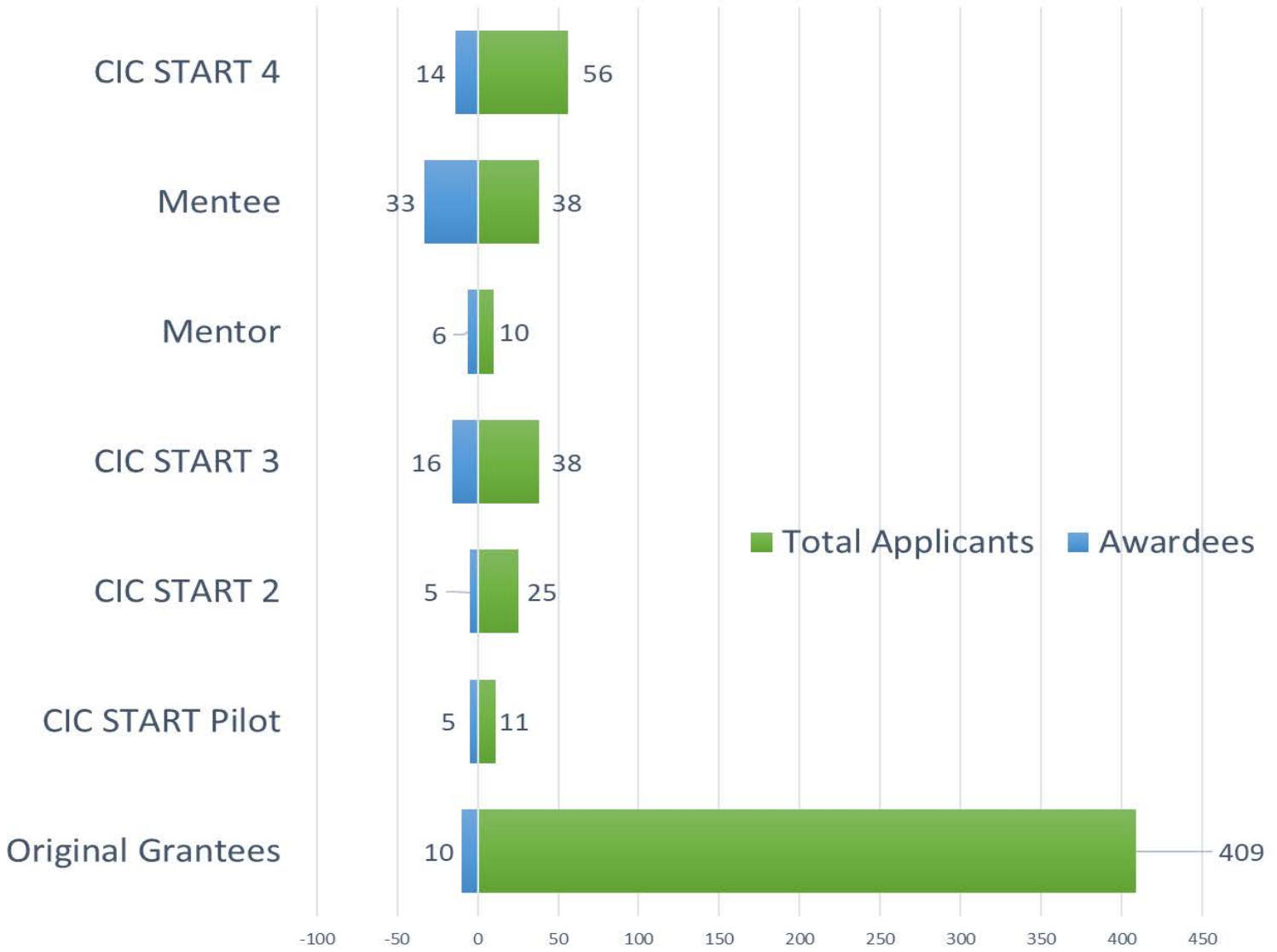
The Peer-to-Peer Network

88 Awardees



“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



DASH Framework

Community Health, Well-being, and Equity

Shared Data Use Cases

Whole-person Systems of Care

- Intake and determine eligibility
- Screen and assess patients
- Create/present shared care plan
- Send/push referrals, reports, notifications
- Query/look up client history
- Support decision-making

Total Population/Community-wide Health and Well-being

- Assess community needs and resources
- Hot spot (geographic pinpointing)
- Understand/address root causes
- Conduct surveillance
- Research, evaluate, and monitor

Community Data Sharing Capacity

Shared Data

- Workflow redesign and training
- Technical function
- Consent and privacy
- Data governance
- Pathway to yes

Community Alignment

- Shared vision and language
- Collaboration and governance
- Existing data systems
- Trust
- Resources and assets
- Community engagement

Policy and Market Environment

- Standards development/adoption
- Privacy and data use laws
- Technology innovation

- State and national investment in health and human services information technology
- Payment and funding models
- Market competition

Whole Person Care Use Cases



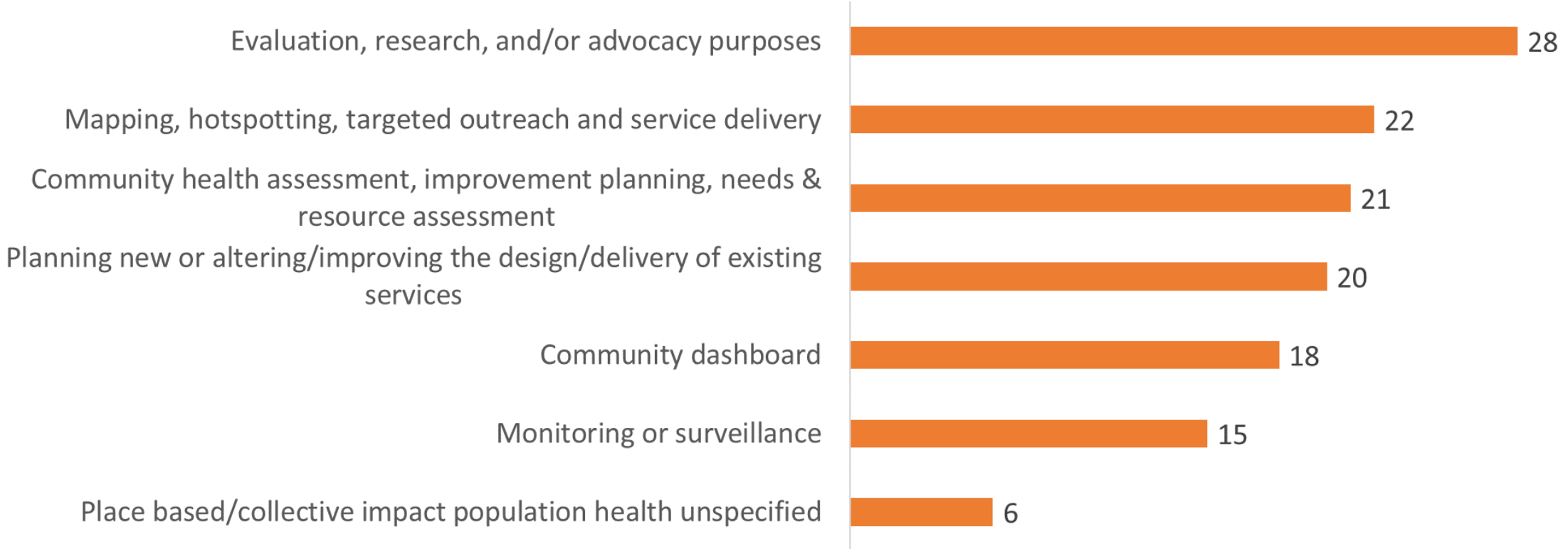
Shared Data Use Cases: Whole Person Care (35 grantees: OG-CS3)



Place-based Community Health Use Cases



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



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

Place-Based Community Health Baltimore, MD



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

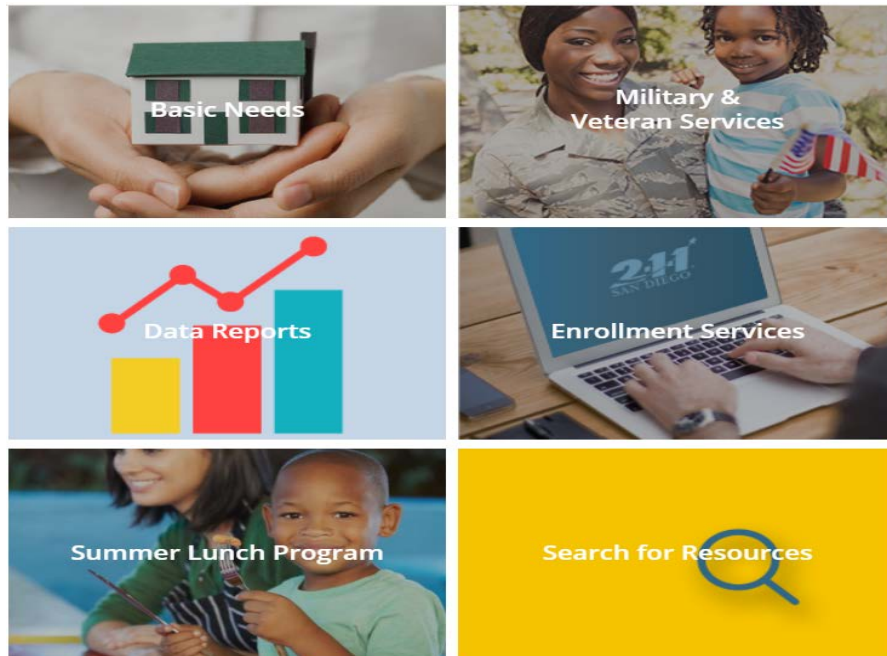
Sectors: Academia / Research, Elected / Appointed Officials, Clinical Health Care, Housing / Homelessness, Public Health, Social / Human Services, Other Community-based, Information Management Infrastructure

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

Policy and Market Environment

Shared Data

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

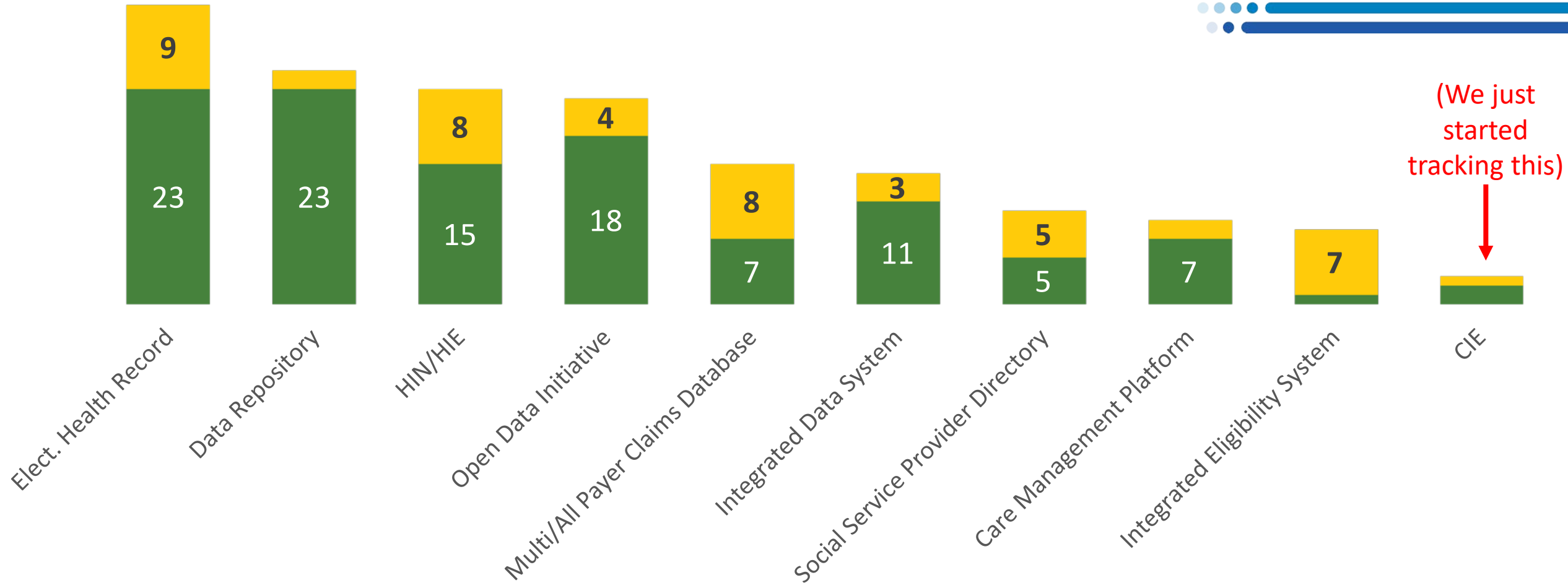
- Standards development/adoption
- Privacy and data use laws
- Technology innovation
- Market dynamics

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



- Present in our community but not a driver or resource for data sharing
- Present in our community & currently being OR will be leveraged for data sharing

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

Equity and Alignment

Denver, CO



“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.

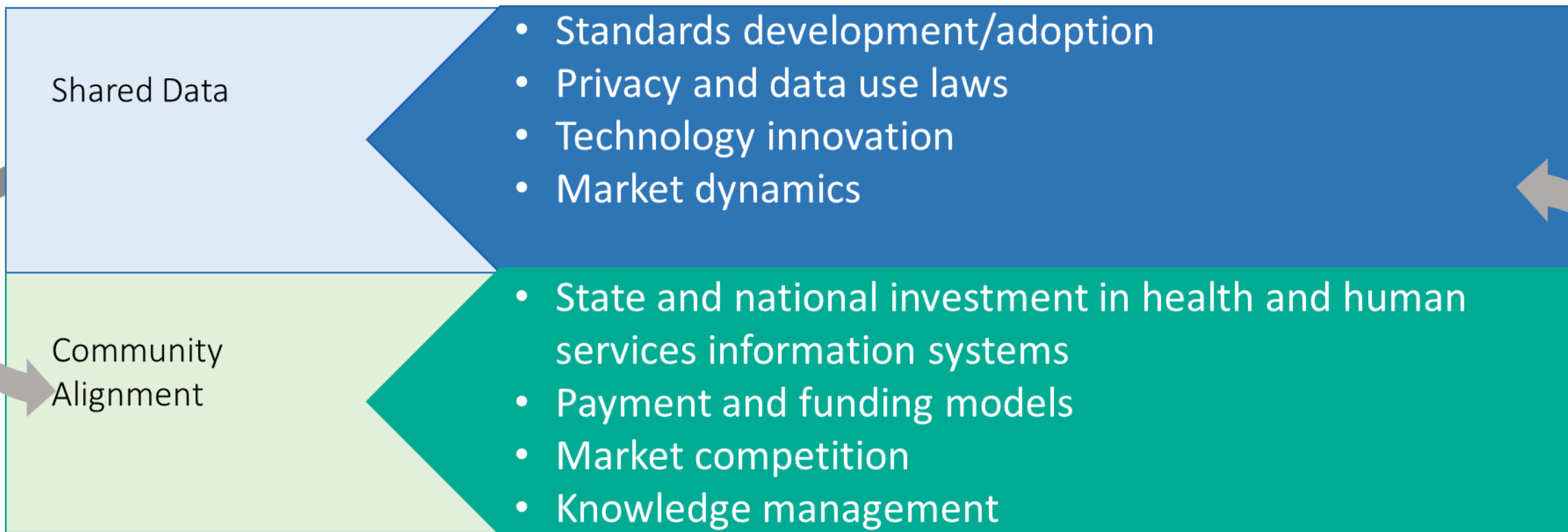
Sectors: Elected / Appointed Officials, Public Health, Social / Human Services, Other Community-based, Information Management Infrastructure

Use Case(s): Data collection, upload, storage, Calculation & display of metrics and indicators

The DASH Framework, updated 2018

Community Data Sharing Capacity

Policy and Market Environment



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

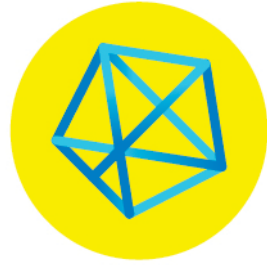
6 Deploy levers to overcome barriers: Take action to overcome common state roadblocks (e.g., technical, legal)

- 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

Past 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



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



Making Connections: – By Types of Data Used



Service (EHRs, case management) data



Surveillance data



Administrative data



Outcomes data



Geographic data



Community-generated data



Personal demographic data

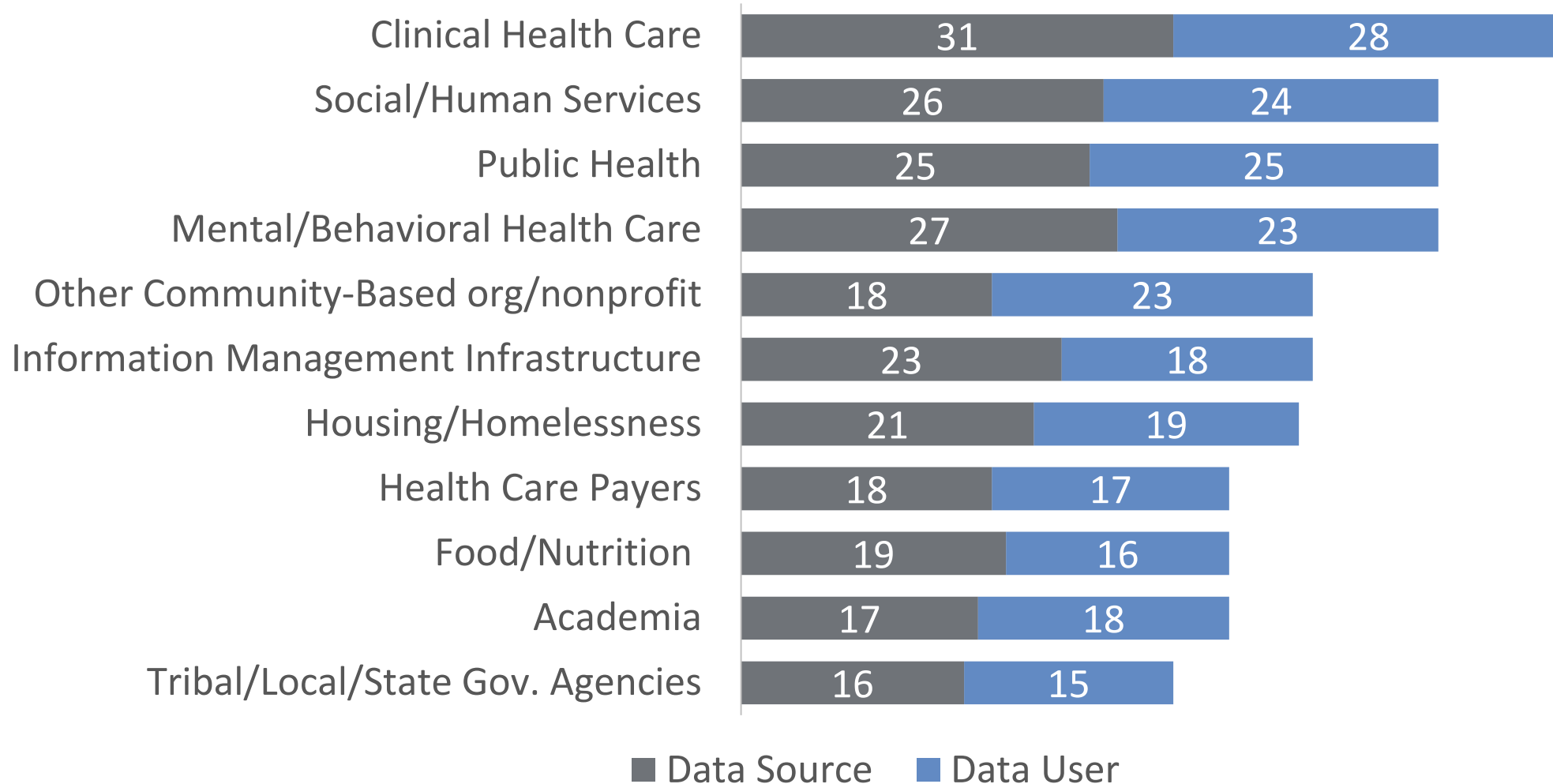


Census and civic data

Making Connections: – By Sectors Engaged



Top Participating Sectors



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.



289

USERS ARE ALL IN!

GETTING STARTED

Learn More About All In: Read our [blog](#) and sign up for the All In Newsletter [here](#).

RECENT DISCUSSIONS

- SHARE YOUR EVENT
1 day, 2 hours ago
- Funding Opportunities

EVENTS CALENDAR

Nov 2017

S	M	T	W	T	F	S
			1	2	3	4

The screenshot shows the website's header with the 'ALL IN' logo and 'DATA FOR COMMUNITY HEALTH' text. Below the header, there is a welcome message and three main content blocks: 'Recent Discussions' with a list of items, 'Getting Started' with a '1,537 USERS ARE ALL IN!' badge, and an 'Events Calendar' for August 2019. The calendar shows dates from the 4th to the 10th. A 'Questions? Contact us!' button is visible in the bottom right corner.

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	Social Determinants	Health Inequities	Health Disparities
<p>The opportunity for everyone to attain his or her full health potential.</p> <p>No one is disadvantaged from achieving this potential because of socially determined circumstance.</p> <ul style="list-style-type: none">•Equal access to quality education, healthcare, housing, transportation•Equitable income•Equal opportunity for employment•Absence of discrimination based upon social status	<p>Life-enhancing resources whose distribution across populations effectively determines length and quality of life.</p> <ul style="list-style-type: none">•Food supply•Housing•Economic relationships•Social relationships•Transportation•Education•Health Care	<p>Systematic and unjust distribution of social, economic, and environmental conditions needed for health.</p> <ul style="list-style-type: none">•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	<p>Differences in the incidence and prevalence of health conditions and health status between groups based on:</p> <ul style="list-style-type: none">•Race/ethnicity•Socioeconomic status•Sexual orientation•Gender•Disability status•Geographic location•Combination of these

Slide Source Acknowledgements

- Various slide decks from Data Across Sectors for Health (DASH) and All In, from the Illinois Public Health Institute.
- 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.
- Healthy People 2020 Progress Review: Social Determinants of Health and Lesbian, Gay, Bisexual, and Transgender Health, CDC 2015.
- Module 1: Determinants of Health, Association for Prevention Teaching and Research.
- Edward P. Ehlinger, Advancing Health Equity: Policy and Program Strategies to Address Social Determinants of Health, Minnesota Department of Health, 2015.