CRISP and SDOH Data Sharing

Webinar 2023
Agenda

- SDOH Background
- CRISP and SDOH
- Live Demo of SDOH Suite of Tools
  - Direct Entry Screening Tool
  - Social Needs Data Tab: Assessments and Z-Codes
  - Referrals: Search Programs, Referral Portal CBO, Referral Portal, Referral History
- Questions
**Social Determinants of Health** are the “nonmedical factors that influence health outcomes and conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.”

**Examples of SDOH:**
- Safe housing and transportation
- Education, job opportunities, and income
- Food security and physical activity opportunities
- Polluted air and water
- Language and literacy skills
Social Determinants of Health

40-60% of health outcomes driven by patient’s SDOH

Community-based, social service providers hold the keys to improving the health of the people they serve.

- Addressing social needs is crucial to improving the health and well-being of the people in Maryland. When healthcare providers can access information about patients at the point of care who also utilize social services, only then can we provide a holistic model of care.

- CRISP serves as a place where information is shared and displayed, regardless of how/where the info was collected.

Source: Institute for Clinical Systems Improvement Going Beyond Clinical Walls. Solving Complex Problems (October 2014). The Bridgespan Group
**Value of Social Needs Data Sharing**

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<tbody>
<tr>
<td><strong>Awareness</strong></td>
<td>Identify the social risks and assets of defined patients and populations.</td>
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<td><strong>Adjustment</strong></td>
<td>Alter clinical care to accommodate identified social barriers.</td>
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<td><strong>Assistance</strong></td>
<td>Reduce social risk by connecting patients with social care resources.</td>
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<td><strong>Alignment</strong></td>
<td>Enable health care systems to understand their communities’ existing social care assets, facilitate synergies, and invest in and deploy them to positively affect health outcomes.</td>
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<td><strong>Advocacy</strong></td>
<td>Bring together as partners health care and social care organizations to promote policies that facilitate the creation and redeployment of resources to address health and social needs.</td>
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Whole Person Record

- Clinical Data
- Social Needs Data
- Social Care Intervention Data

Whole-Person record

HIE Participants
- HIPAA Covered Entities
- Non-HIPAA Covered Entities

*** Patient consent required or BAA and delegated access from HIPAA-covered HIE participant
CRISP and SDOH Interoperability

Challenges

• Regions with heterogenous needs.
• Stakeholders have made existing investments in tools, workflows, and systems.
• Clinical and social care systems and data are siloed.

Key Features

• Support interoperability and integrations first.
• Be agnostic to vendor, tool, and workflow.
• Create a whole-person record that includes clinical and social care data.
Addressing Social Needs

Problem: Patients receive a lot of resources in the community that support their health. These services are not communicated to the rest of the care team.

Goal: Allow the Care Team to understand all the social services and resources patients are receiving outside of the clinic or hospital.
SDOH Suite of Tools
Demo

Direct Entry Screening Tool, Assessments, Referrals
https://idp.crisphealth.org/#login
Referral Tool in InContext

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<td>Parkview Medical Group</td>
<td>Continuity of Care Document</td>
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• Direct Entry Screening Tool
  • Ability to enter SDOH assessments directly in CRISP

• Social Needs Data Tab
  • Assessments
    ▪ History of a patients SDOH assessment created and/or shared with CRISP
  • Z-Codes
    ▪ Social, environmental, and economic conditions from ICD-10 codes

• Referrals applications:
  • Search Programs
    ▪ Allows users to easily search for programs to refer patients to
  • Referral Portal CBO
    ▪ Allows CBOs to manage and track referrals sent to their organization
  • Referral Portal
    ▪ Allows referring users to view updates on referrals sent
  • Referral History
    ▪ Allows all members of the patients care to view a patient’s referral history
CBOs in the MD HIE Directory

- A Homeade Plan
- Adventist Tacoma Park Infusion Center
- Anne Arundel County AAA
- Baltimore County AAA
- BDTrust
- Bethesda NEWtrition & Wellness Solutions
- Carroll County AAA
- Carroll County Health Department
- Catholic Charities of Baltimore
- Charles County of Regional Partnership
- Diabetes Workshop (DPP)
- Harford County Health Department
- Hungry Harvest
- Johns Hopkins – BMD Regional Partnerships
- MAC Living Well
- Maryland Food Bank
- Maryland WIC
- Meals on Wheels
- Medicaid DPP – Aetna Better Health of Maryland
- Medicaid DPP – Amerigroup MCO
- Medicaid DPP – CareFirst Health Plan MCO
- Medicaid DPP – Jai Medical MCO
- Medicaid DPP – Medstar Family Choice MCO
- Medicaid DPP – Priority Partners MCO
- Medicaid DPP – United MCO
- Medicaid FFS/Medicare/Self-pay DPP – Diabetes Workshop
- Moveable Feast
- NeighborRide
- Netrin’s Health Hypertension Management Program
- PIMR – Talbot County Health Department
- PreventionLink/TLC-MD Regional Partnership
- St. Agnes/LifeBridge Regional Partnership
- St. Mary’s County Health Department
- Swinton Homecare
- The Food Project
- University of Marland Medical Center – BMD Regional Partnership
- Western Regional Partnership – Frederick
- Western Regional Partnership – Meritus
- Western Regional Partnership – UPMC
Interested in Utilizing Tools?

• Please contact Naureen Elahi at Naureen.Elahi@crisphealth.org for:
  • Training and demos of any/all SDOH tools
  • Onboarding CBO programs to receive referrals in CRISP
  • Referral Tool Issues
  • CBO CRISP access

• **If you don’t see these SDOH applications in CRISP:** Reach out to your HIE admin to get access
Interested in an Integration?

Please reach out to Michelle Nnorom at Michelle.Nnorom@crisphealh.org for any integration or assessment requests
Questions?

Naureen Elahi (CBO Onboarding): Naureen.Elahi@crisphealth.org

Michelle Nnorom (SDOH Project Director): Michelle.Nnorom@crisphealth.org
SDOH Applications

Screenshots
Displaying Social Needs Data at the Point of Care
Direct Entry Screening Tool

Available Questionnaires: 
- Mortal SDH Screening Questionnaire
- The Accountable Health Communities Health-Related Social Needs Screening Tool
- Maryland MOMS Social Determinants of Health Screening

The Accountable Health Communities Health-Related Social Needs Screening Tool

- Housing Instability/Homelessness
  - What is your living situation today?
  - Think about the place you live. Do you have problems with any of the following? CHOOSE ALL THAT APPLY

- Food Insecurity
  - Within the past 12 months, you worried that your food would run out before you got money to buy more
  - Within the past 12 months, the food you bought just didn’t last and you didn’t have money to get more

- Transportation Insecurity
  - In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting to things needed for daily living?

- Inadequate Housing
  - In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

- Interpersonal Violence
  - How often does anyone, including family and friends, physically hurt you?
  - How often does anyone, including family and friends, insult or talk down to you?
Problem: There are multiple resources and directories, and the care team must go to multiple websites/spreadsheets, etc. to search for resources.

Goal: Allow the care team to easily find and refer to any community resource for patient needs in CRISP.
Showing results for Search Terms: "housing" in radius "15" around address "20905" Found: 37 Results

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<th>Organization Name</th>
<th>Program Name</th>
<th>Contact</th>
<th>Program Description</th>
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<td>HIE Directory</td>
<td>PIMR - Talbot County Health Department</td>
<td>333-333-3335</td>
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<td>HIE Directory</td>
<td>Catholic Charities of Baltimore</td>
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<td>Senior Housing w/o Congregate Services</td>
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<tr>
<td></td>
<td><strong>Description:</strong> Catholic Charities Senior Communities offers 24 locations of affordable, supportive rental apartments in Maryland – in Anne Arundel, Baltimore, Harford, Garrett Counties and Baltimore City.</td>
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<td></td>
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<td>Bethesda Help, Financial Assistance</td>
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Enter Referral Directly in Search Programs
Confirmation Page

Confirmation Page
2879bbf9-43eb-41a7-99fd-5ca78005bb58

Patient Information
- First Name: GLEBRT
- Middle Name: 
- Last Name: GIANE
- Date of Birth: 01/01/1904
- Home Address: 4145 EARL CACHING DRIVE
- City: WV
- Zip: 26005
- Gender: M
- Phone Number: 3456789012
- Phone Number Type: Home
- All Phone Number: Other Phone
- Email: 

Referring Provider
- Referring this patient myself: Yes
- Referring this patient on behalf of a provider: No

Provider Information
- First Name: Naureen
- Last Name: Elahi
- Phone Number: 565-855-5555

Referral Confirmation

Thank you for using CRISP Referral Services. Your referral submission has been sent to the following program(s):

Referral Program: Fitness & Exercise
Program Description: The Richard A. Henson Wellness Center at MAC offers a wide variety of programs and services targeted toward addressing the health concerns and needs of older adults. The center's goal is to enable and to empower members to be physically active and to maintain and enhance their level of independence. Gym offerings include in-person and virtual classes, equipment and personal training. Membership fees are paid monthly and scholarships are available.

Confirmation Number: 2879bbf9-43eb-41a7-99fd-5ca78005bb58

Sincerely,
CRISP - Health Information Exchange
Addressing Social Needs – Feedback Loop

CBO/Provider Referral List

Referral History
- Referring Provider: Betty Test
- Referring Provider Organization: Jai Medical System
- Referring Provider Phone: Not Provided
- Referring Person: Doctor Who
- Referring Person Organization: Chesapeake Regional Information System for our Patients
- Referring Person Email: referrals@crisphealth.org

Program: Meals on Wheels
- Program Description: Generic Program Description
- Referral Coordinator: Evan
- Referral Coordinator Phone: 333-555-5555
- Referral Coordinator Email: solange@crisp.org

Referral Recipient Updates
- Date: 2021-11-18
- Note: Test referral data 1
CRISP Social Determinants of Health (SDOH) Suite of Tools for Community-Based Organizations

1. Use CRISP Referral Tool to send referral to CBOs
   - CBOs can
     - Receive referrals for services
     - Communicate with referring provider
     - Close the loop
     - Send referral to other CBOs

2. Use Direct-entry Screening Tool to capture SDOH screening/assessment or Share Current Screening Tool
   - CBOs can
     - Input and save SDOH screening assessment data
     - View the screening data they have collected

3. Use the CRISP Directory to look up social services
   - CBOs can
     - View up-to-date social service organization and program info
     - Use the available contact information to connect their patients to the appropriate available resources

4. Coming soon: Consent Tool to capture consent to view HIPAA-protected patient information
   - CBOs can
     - Access clinical and social needs information in the HIE upon capturing a HIPAA authorization consent form for their patients

Screening and referral information captured by CBOs will be available for other members of a patient's care team to view in the HIE.

Users can view referral history made in multiple systems in CRISP.

Users can view conditions based on extracted z-codes.

Users can view all assessments shared with CRISP.

Users can view up-to-date social service organization and program info.
Onboarding Requirements (HIPAA-Covered CBOs)

• If HIPAA-covered and not a participant of CRISP, sign the standard CRISP participation agreement for HIPAA-covered agencies
  o If HIPAA-covered and is a current participant of CRISP, fill out the below forms only:

• Fill out a **Program Description document**, which will document the name and descriptions for each program the organization would like on the CRISP Referral Tool

• Fill out the **Bulk User document**, which lists the staff who should have access to the CBO Referrals tab in the CRISP Portal to accept referrals
Onboarding Requirements (Non-HIPAA Covered CBO)

- Sign the **CRISP non-HIPAA covered entity participation agreement**, which authorizes the use of CRISP for the purpose of sending and receiving SDOH referrals, entering and viewing your own screening data, and capturing patient HIPAA consent to view clinical information.

- Sign the **CRISP Program document**, which confirms the organization’s willingness to receive program referrals through the CRISP Referral Tool.

- Fill out a **Program Description document**, which will document the name and descriptions for each program the organization would like on the CRISP Referral Tool.

- Fill out the **Bulk User document**, which lists the staff who should have access to the CBO Referrals tab in the CRISP Portal to accept referrals.
HIPAA, with few exceptions, treats all health information, including mental health information, the same. HIPAA allows health care providers to disclose protected health information (PHI), including mental health information, to other public or private-sector entities providing social services (such as housing, income support, job training) in specified circumstances.

For example:

- A health care provider may disclose a patient's PHI for treatment purposes without having to obtain the authorization of the individual. Treatment includes the coordination or management of health care by a health care provider with a third party. Health care means care, services, or supplies related to the health of an individual. Thus, health care providers who believe that disclosures to certain social service entities are a necessary component of, or may help further, the individual's health or mental health care may disclose the minimum necessary PHI to such entities without the individual's authorization. For example, a provider may disclose PHI about a patient needing mental health care supportive housing to a service agency that arranges such services for individuals.

- A covered entity may also disclose PHI to such entities pursuant to an authorization signed by the individual. HIPAA permits authorizations that refer to a class of persons who may receive or use the PHI. Thus, providers could in one authorization identify a broad range of social services entities that may receive the PHI if the individual agrees. For example, an authorization could indicate that PHI will be disclosed to “social services providers” for purposes of “supportive housing, public benefits, counseling, and job readiness.”