California Precision Medicine Advisory Council
Data Integration Working Group
Meeting Summary
3.30.21

Meeting Purpose

- Learn about ongoing efforts in SDoH data integration
- Outline next steps for the project
- Come to consensus on working group's definition of SDoH

Previous meeting's Action Items

Task	Status
Update project schematic with more precise language about our role	Ongoing
"Minimum viable product"	Not Started
Contact Gravity Leadership to understand how we can work together and if it would be worth it for CIAPM staff to join as members	Done
Consider reaching out to other (national) groups	Not Started
Look into what other states have accomplished	In progress
Send out example SDOH definitions for consideration at next meeting	Done

Meeting Report Back: SIREN

Participants

- Laura Gottlieb, Director
- Caroline Fichtenberg, Managing Director

Discussion

- CA policy can catapult Gravity's effort
  - Incentivize SDoH Integration
  - Fund pilot projects
- Reticence at the physician level to screen for SDoH:
  - "Once I screen for SDoH, the referral system to social programs isn't robust enough to be useful to me or my patient."
  - "Even if data collection will help the greater good, it won't do anything for my patient right now."
- However
  - People rate being asked about SDoH as "acceptable"/"very acceptable", not expecting that a physician will address it, but expecting that their physicians should still know about it

- Screening helps care providers think about SDoH and data collection, and having the information is important for whole person care
- Just being screened can improve health even without an intervention (unpublished)
- Collecting SDoH data can elevate the standard of care; e.g., adjusting insulin doses at the end of the month when SNAP benefits run out (unpublished)

Meeting Report Back: 211 San Diego, a Gravity Project Partner

Participants

- Camey Christenson, Chief Business Development Officer
- Karis Grounds, VP Health and Community Impact

Discussion

- Community Information Exchange: A multidisciplinary network of partners that use a shared language, a resource database, and an integrated technology platform to deliver enhanced community care planning
- Takeaway: Social issues for those most in need won't be solved by purchasing expensive software. Communities still need resources to provide services.

Companies in this space (some are already partnering with organizations like 211 San Diego)

- Unite Us
- Healthify
- NowPow

Current HIE Efforts

Other States

- Nebraska Health Information Initiative, now CyncHealth, has partnered with Gravity
- Princeton State Health & Value Strategies

Newsom Administration

- CalAIM: California Advancing and Innovating Medi-Cal
  - "….provide for non-clinical interventions focused on a whole-person care approach via Medi-Cal that targets social determinants of health and reduces health disparities and inequities."
  - Some of the guiding principles
    - Deliver person-centered care that meets the behavioral, developmental, physical, long term services and supports, and oral health needs of all members.
    - Work to align funding, data reporting, quality, and infrastructure to mobilize and incentivize toward common goals.
    - Build a data-driven population health management strategy to achieve full system alignment.

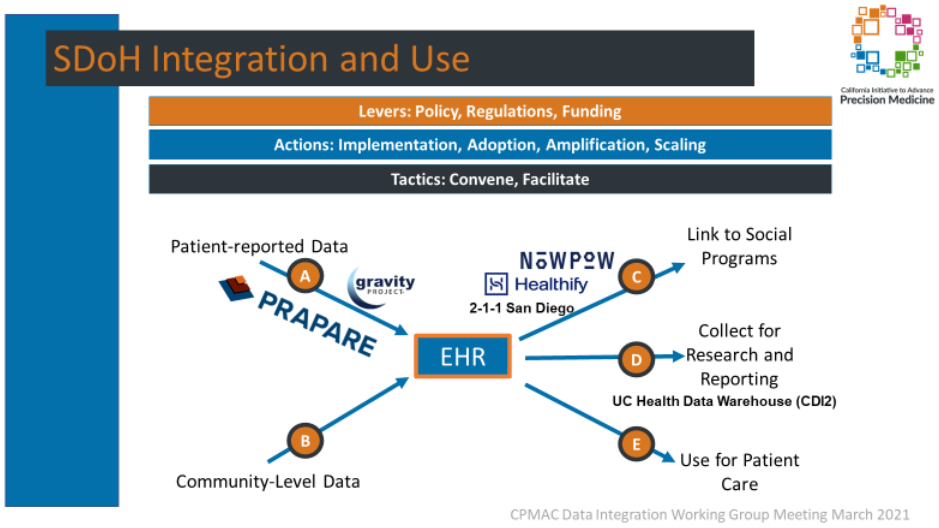
- Identify and mitigate social determinants of health and reduce disparities and inequities.
- Support community activation and engagement.

California State Legislature

- AB 1131: Health Information Networks
- AB 1231: Health Information Exchange: Demonstration Projects
- SB 371: Health Information Technology

Examples of existing efforts in interoperability

- San Francisco universal health care option
- Post-Acute Care Interoperability (PACIO): Dr. Schultz is Co-Chair
- UC Data Warehouse: Keith and Ben to contact Atul Butte to ask about SDoH integration
- PRAPARE: Protocol for Responding and Assessing Patient Assets, Risks, and Experiences



The PRAPARE assessment tool consists of a set of national core measures as well as a set of optional measures for community priorities. It was informed by research, the experience of existing social risk assessments, and stakeholder engagement. It aligns with national initiatives prioritizing social determinants (e.g., Healthy People 2020), measures proposed under the next stage of Meaningful Use, clinical coding under ICD-10, and health centers' Uniform Data System (UDS). PRAPARE emphasizes measures that are actionable. PRAPARE Electronic Health Record templates exist for eClinicalWorks, Cerner, Epic, athenaPractice (formerly GE Centricity), NextGen and more and are freely available to the public as part of our PRAPARE Implementation and Action Toolkit.

SDoH Definition

Ran out of time to discuss; CIAPM staff will send around survey soliciting feedback about proposed definition.

Outstanding questions

- Is there a way to check the quality/completeness of the community-level information? Are some communities better represented than others?
- Are there existing, perhaps proprietary databases that we can work to implement? Kaiser?
- How do we serve up the information in a way that will maximize clinical utility?

Updated Action Items

Task	Status
Continue updating and refining project roadmap	Ongoing
Contact Gravity Leadership to understand how we can work together and if it would be worth it for CIAPM staff to join as members	Done
Consider reaching out to other (national) groups	Not Started
Continue looking into what other states have accomplished	In progress
Minimum Viable Product	Not started
Seek feedback on SDoH definition from members	Done
Keith and Ben to talk to Atul Butte about integrating SDoH into UC Health Data Warehouse	