CRISP and SDOH Data Sharing

Webinar 2023

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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

What is SDOH?

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

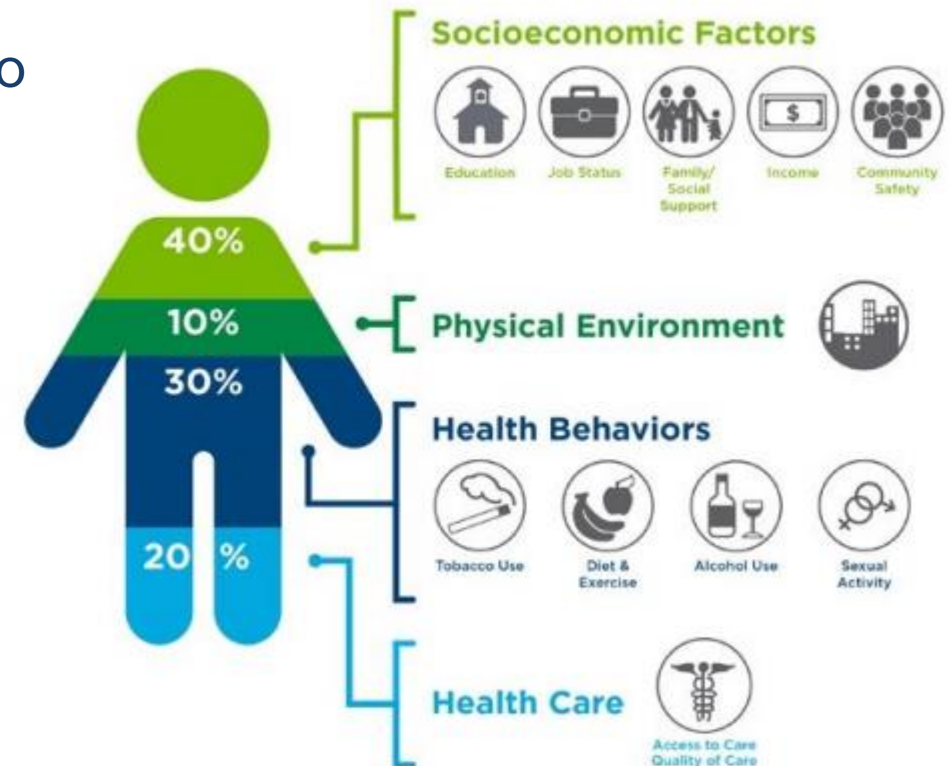
Social Determinants of Health

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.

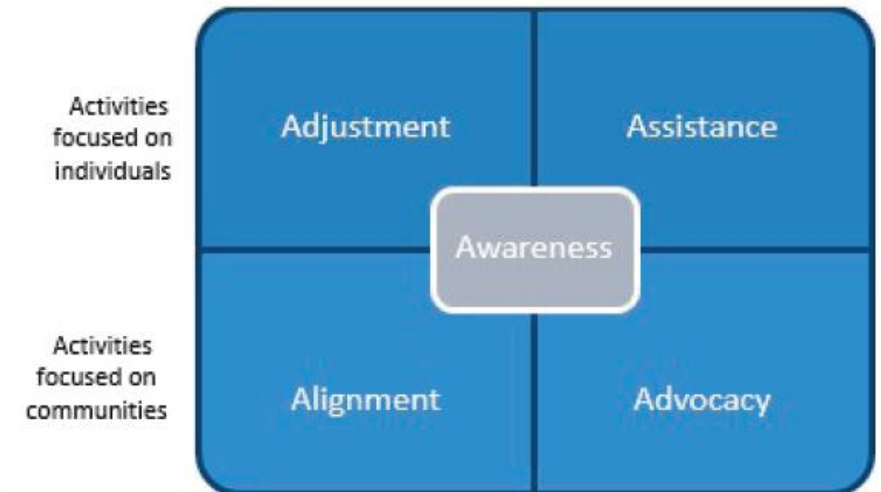
- CRISP serves as a place where information is shared and displayed, regardless of how/where the info was collected.



Source: Institute for Clinical Systems Improvement Going Beyond Clinical Walls. Solving Complex Problems (October 2014). The Bridgespan Group

Value of Social Needs Data Sharing

Awareness	Identify the social risks and assets of defined patients and populations.
Adjustment	Alter clinical care to accommodate identified social barriers.
Assistance	Reduce social risk by connecting patients with social care resources.
Alignment	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.
Advocacy	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.



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.

Medical professional refers patient to community resource

Social Care Provider Systems (CBO, social service, govnt agency)

SDOH Network Referral Platforms

CRISP closed loop referral tool

Feedback Loop

SDOH Suite of Tools

Demo

Direct Entry Screening Tool, Assessments, Referrals

CRISP Portal Link

https://idp.crisphealth.org/#login

Referral Tool in InContext

HIE InContext

ANA CADENCE
Female | Jan 11, 2014

6

- PATIENT INFORMATION
- MEDICATION MANAGEMENT
- CLINICAL DATA
- CARE COORDINATION
- SOCIAL NEEDS DATA
- DATA FROM CLAIMS
- CONSENT TOOL
- CREATE REFERRAL

OPEN IN NEW TAB

HEALTH RECORDS | ENCOUNTERS | PROBLEMS | STRUCTURED DOCUMENTS | IMMUNIZATIONS

Structured Documents

Hide Home Facility Data

Date	Source	Title	Type	Size (KB)
2022-06-22	University of Maryland Medical System-REL UMMS	Summary of Care	Summarization of Episode Note	—
2022-02-08	HUFPP Internal Medicine Suite 5000	Summary of Care	SUMMARIZATION OF EPISODE NOTE	—
2022-02-08	HUFPP Internal Medicine Suite 5000	Summary of Care	Summarization of Episode Note	—
2021-10-20	Mary s Center for Maternal and Child Care, Inc	Summarization of Episode Note	SUMMARIZATION OF EPISODE NOTE	—
2021-10-20	Mary s Center for Maternal and Child Care, Inc	Summarization of Episode Note	Summarization of Episode Note	—
2021-06-16	South West Virginia Health System, LPC_Lincoln Primary Care	Encounter Summary	Summarization of Episode Note	—
—	Frederick Health Medical Group Primary Care	Continuity of Care Document	Summarization of Episode Note	—
—	Parkview Medical Group	Continuity of Care Document	Summarization of Episode Note	—

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SDOH Suite of Tools

- 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

Resources

Social Needs Data User Guide

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@crisphealth.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

ontext

MEDICATION MANAGEMENT

CLINICAL DATA

CARE COORDINATION

SOCIAL NEEDS DATA

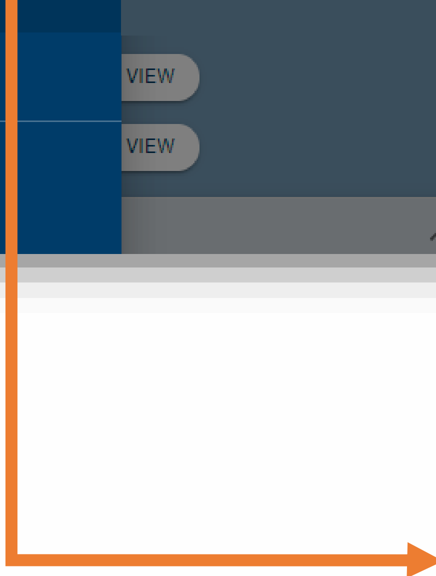
DATA FROM CLAIMS

HIE PORTAL

Probable

VIEW

VIEW



HIE InContext

GILBERT GRAPE

Male

Jan 1, 1984

Probable

4145 Earl C Adkins Dr, River, WV 26000

80 Infection Control Alerts VIEW

4 Next of Kin VIEW

ASSESSMENTS CONDITIONS REFERRAL HISTORY

Assessments

Date	Source	Description
2021-03-19	JHHREL	AHC Screening
2021-03-19	JHHREL	CMS Screening
2020-02-15	JHHREL	AHC Screening
2020-02-15	JHHREL	CMS Screening

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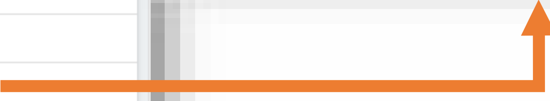

AHC Screening

2020-02-15

Housing

What is your living situation today?

I have a steady place to live

Think about the place you live. Do you have problems with any of the following?

Mold

Lead paint or pipes

Food

Transporation

Direct Entry Screening Tool

HOME

Search Applications & Reports

Reports & Applications

- Panel Processor
- Screening
- RealTime
- Clinical Information Staging
- Search Programs
- MyDirectives for Clinicians
- Snapshot Staging
- InContext
- Reports Role Manager
- PopHealth
- DC VAC

Direct Entry Screening Tool

Name: GILBERT GRAPE | Gender: male | DoB: 1984-01-01 | Phone: home: 7889007666

Available Questionnaires: Show Date

Search

- Meritus SDOH Screening Questionnaire
- The Accountable Health Communities Health-Related Social Needs Screening Tool
- Maryland MOM Social Determinants of Health Screening

The Accountable Health Communities Health-Related Social Needs Screening Tool

Name	Value	Units
Housing Instability/Homelessness		
What is your living situation today?	Select one	
Think about the place you live. Do you have problems with any of the following? CHOOSE ALL THAT APPLY	Select one	
Food Insecurity		
Within the past 12 months, you worried that your food would run out before you got money to buy more.	Select one	
Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.	Select one	
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?	Select one	
Inadequate Housing		
In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?	Select one	
Interpersonal Violence		
How often does anyone, including family and friends, physically hurt you?	Select one	
How often does anyone, including family and friends, insult or talk down to you?	Select one	

Identifying Resources

<u>Problem</u>: There are multiple resources and directories, and the care team must go to multiple websites/spreadsheets, etc. to search for resources.

<u>Goal</u>: Allow the care team to easily find and refer to any community resource for patient needs in CRISP.

Referral Program Selection

Organization Name

* Search for Organization Name [Find Organization]

Search Area

Search Resources: * Food | Address, City, or Zip: * 21046 | Search Radius (In Miles): * 10 [Search] [Clear]

Showing results for Search Terms: "Food" in radius "10" around address "21046" Found: 11 Results

Source	Organization Name	Program Name	Contact	Program Description
MD211	None or unknown	Church at Severn Run, The, Food Pantry	410-551-6654	
MD211	Faith-based	Happy Helpers For The Homeless, Food & Clothing Distribution	443-433-2416	
MD211	Government - County	COVID-19 HoCo Farms Connect		
MD211	Faith-based	Open Doors Food Pantry	301-854-2324	

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Elastic Search

Referral Program Selection

Organization Name

* Search for Organization Name

Find Organization

Search Area

Search Resources

* housing

Address, City, or Zip

* 20905

Search Radius (In Miles)

* 15

Search

Clear

Search Results

Showing results for Search Terms: "housing " in radius "15" around address "20905" Found: 37 Results

	Source ↑	Organization Name	Program Name	Contact	Program Description
☐	HIE Directory	PIMR - Talbot County Health Department	PIMR	333-333-3335	⌄
☐	HIE Directory	Catholic Charities of Baltimore	Senior Housing w/o Congregate Services		⌃

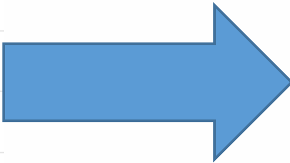
Description: Catholic Charities Senior Communities offers 24 locations of affordable, supportive rental apartments in Maryland – in Anne Arundel, Baltimore, Harford, Garrett Counties and Baltimore City.

	Source ↑	Organization Name	Program Name	Contact	Program Description
☐	HIE Directory	Catholic Charities of Baltimore	Senior Housing w/ Congregate Services		⌄
☐	MD211	Nonprofit - Incorporated	Bethesda Help, Financial Assistance	301-365-2022	⌄
☐	MD211	Government - County	Montgomery County Government COVID-19 Information Portal	240-777-0311	⌄

Enter Referral Directly in Search Programs

Source	Organization Name
HIE Directory	MAC Living Well
HIE Directory	MAC Living Well
HIE Directory	MAC Living Well
HIE Directory	MAC Living Well
HIE Directory	MAC Living Well
HIE Directory	MAC Living Well
HIE Directory	MAC Living Well
HIE Directory	MAC Living Well
HIE Directory	MAC Living Well
HIE Directory	MAC Living Well

Create Referral for Program



Referral Program Selection

Back to Program Selection

Patient Information

First Name: GILBERT
Middle Name
Last Name: GRAPE
Date Of Birth: 01/01/1984
HomeAddress1: 4145 EARL C ADKINS DRIVE
HomeAddress2
City: RIVER
State: WV
Zip: 26000
Gender: M
Phone Number *: 9999994349
Phone Number Type *: Mobile
Alt Phone Number
Alt Phone Number Type
Email
Spoken Language
Race or Ethnicity

Patient Insurance

Carrier
Carrier Type *
Group ID
Member ID

Referral Programs

Organization: MAC Living Well

Fitness & Exercise — HIE Directory

Please enter all relevant information that you would like relayed to the accepting provider

Referring Provider

I am referring this patient myself
I am referring this patient on behalf of a provider

Provider Information

First Name *
Last Name *
Organization *
NPI *
Phone Number *

Clear
Submit

I attest that the patient identified in this form (or his or her duly authorized representative, if applicable) ("Patient") has granted permission to be referred, and has executed an authorization and consent for the disclosure of the health information listed in this form to the referral organization(s) and/or program(s) identified herein ("Authorization"). I further attest that such Authorization is compliant with all applicable laws and regulations, including but not limited to 45 C.F.R. Parts 160 and 164 (the "HIPAA Rules") and 42 C.F.R. Part 2.

Confirmation Page

Referral Program Selection

Back to Program Selection

Confirmation Page

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

Patient Information

First Name	Middle Name	Last Name
GILBERT		GRAPE
Date Of Birth	**HomeAddress1**	**HomeAddress2**
01/01/1984	4145 EARL C ADKINS DRIVE	
City	**State**	**Zip**
RIVER	WV	26000
Gender	**Phone Number ***	**Phone Number Type ***
M	9999994349	Mobile
Alt Phone Number	**Alt Phone Number Type**	**Email**
	OtherPhone	

Spoken Language Documents Race or Ethnicity

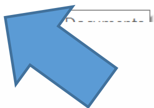
Referring Provider

- (selected) I am referring this patient myself
- I am referring this patient on behalf of a provider

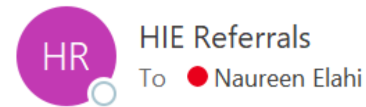
Provider Information

First Name *	Last Name *	Organization *	NPI *	Phone Number *
Naureen	Elahi	CRISP Internal Users - Break		555-555-5555

Download



Referral Confirmation



HIE Referrals

To Naureen Elahi

2:30 PM

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 centers 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

Referrals Overview

CBO/Provider Referral List

Look up Referral

Name (last, first)	Gender	DOB	CBO	Ref. Date	Referral Status ↓
Fields, Minie		Jun 30, 1990	Min CBO	Jul 17, 1997	Pending
Fields, Schema		Jan 1, 2001	Min CBO	Aug 26, 2020	Pending
optOut, test	Prefer Not to Say	Jun 30, 1990	Min CBO	Sep 15, 2020	Pending
Tester82, Someone	Male	Jan 22, 1972	CBO 1	Sep 24, 2020	Pending
Tester84, Someone		May 2, 1963	CBO 1	Sep 30, 2020	Pending
Tester83, Someone	Female	May 2, 2000	CBO 1	Sep 24, 2020	Accepted

Export to Excel

ANNA CADENCE
Female | Nov 16, 1981

CONDITIONS REFERRAL HISTORY

Referral History

Date of Referral	Program Name	Status	Last Updated
2021-11-18	Meals on wheels	Pending	2021-11-18
2021-11-24	WIC	Pending	2021-11-24
2021-11-24	Moveable Feast Medical Nutrition Program	Pending	2021-11-24
2021-11-24	HCAM	Pending	2021-11-24
2021-11-24	Prescription assistance	Pending	2021-11-24

Referral History

Community Health Worker
Date Updated: 2021-11-18

Referral Sender

- ***Referring Provider:*** Betty Test
- ***Referring Provider Organization:*** Jai Medical System
- ***Referring Provider Phone:*** Not Provided
- ***Referring Person:*** Doctor Who
- ***Referring Person Organization:*** Cheasapeake Regional InformationSystem for our Patients
- ***Referring Person Email:*** referrals@crisphealth.org

Referral Recipient

- ***Organization.*** Meals on Wheels
- ***Program:*** Home Delivered Meals
- ***Program Description:*** Generic Program Description 8
- ***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**

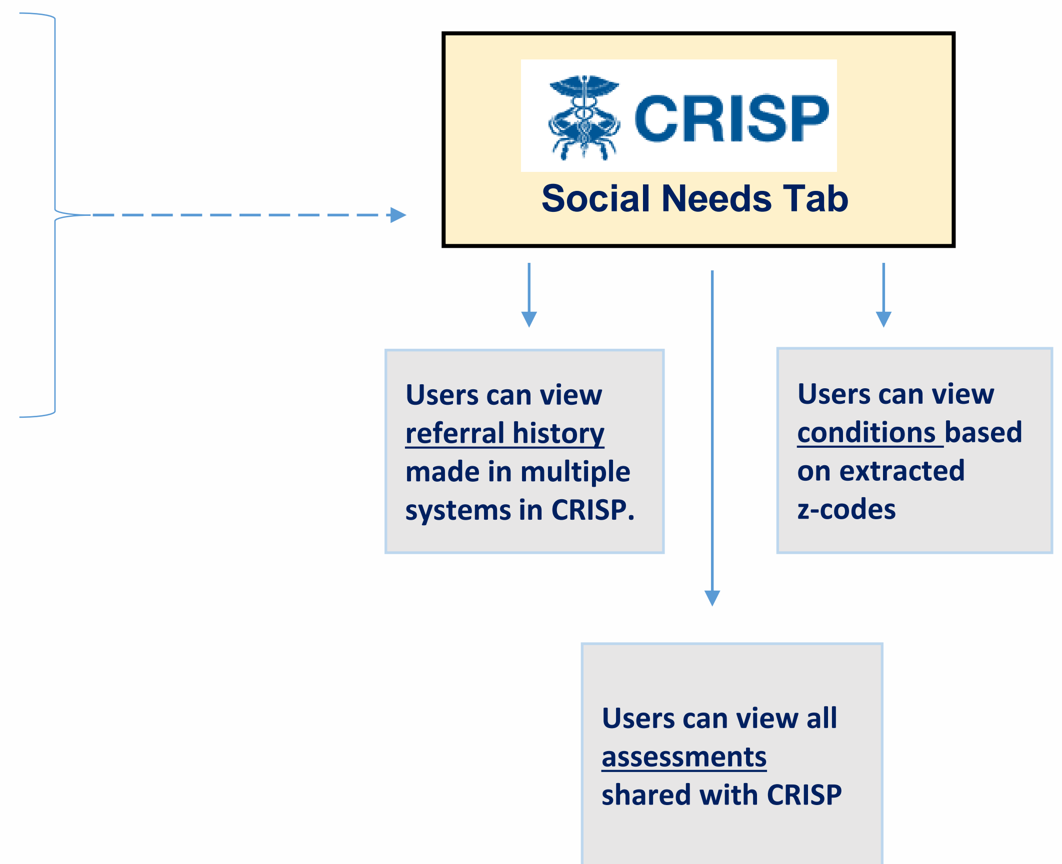
CBOs can
- Input and save SDOH screening assessment data
- View the screening data they have collected

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



Onboarding Requirements (HIPAA-Covered CBOs)

- If HIPAA-covered and not a participant of CRISP, sign the standard CRISP participation agreement for HIPAA-covered agencies
  - 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

Office of Civil Rights: HIPAA Allowance for Closed Loop Referral

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."