**SDOH Workshop**

**Local Breakout Session:**

April 30, 2021

This document includes:

* List of participants and facilitators
* Supplemental notes
* Chat

**Participants:**

1. Shelbi Cummings, LISC
2. Jason Fricke - Anthem Indiana Medicaid Operations
3. Tess Weathers, IU Fairbanks School of Public Health
4. Carey Gaudern - Beacon Health System - Community Impact
5. Patty Rose, Senior Quality Advisor, Purdue Healthcare Advisors
6. Jessica Brookshire - University of Notre Dame, Office of Clinical Partnerships
7. Jonathan Barclay, Jump IN for Healthy Kids
8. Dustin Hetrick - Anthem Indiana Medicaid Ops
9. Bob Parr - IU Health Information Systems
10. Angie Raymond, Angie Ostrom Workshop, Director Data Management Information Gov- IU, Maurer, Kelley School of Business
11. Angie Rollins - VA HSR, IU psychology, ACT Center of Indiana, Reg HSR
12. Emilyn Whitesell, Richard M. Fairbanks Foundation
13. Alicia Baker - Indiana Community Engagement Manager for Aunt Bertha
14. Nicolette Collins - St. Joe Regional Hospital
15. Joe Gibson, Marion County PH Dept.
16. Umberto Tachinardi – CIO, Regenstrief Institute; Professor Department of Biostatistics and Health Data Sciences.
17. Peggy Welch, Chief Advocacy Officer, Family and Social Services Admin; member of FSSA Office of Healthy Opportunities team
18. Josie Fasoldt, Senior Director of Engagement/Analytics; Management Performance Hub (MPH)

**Facilitators:**

* David Haggstrom - Regenstrief, IU School of Medicine, Indianapolis VA
* Karen Frederickson Comer, The Polis Center at IUPUI

**Supplemental Notes:**

Information Needs

*Gibson (MCPHD):*

Would like patient data stratified by wealth. Can already get SES data at the area level. Would like to get this at the individual (patient) level so that can look more closely at income/wealth as a social indicator.

*Jonathan Barclay (Jump IN for Healthy Kids):*

Jump IN is working at the organization level to change policy, systems, and environment. They do not work at the record, client, or patient level. They need data to inform their strategic planning- and would like to consume data products or portals to assist with small area (sub-county) analysis. If those that do have record level services and record level patient data can share at sub-county level, that would be valuable for their community level analysis.

*Shelbi Cummings (LISC):*

Clinical and SDOH data is very helpful to LISC. LISC is in neighborhoods and hearing from residents. When it comes to data, community residents feel excluded. Neighborhoods do not tend to benefit from the data because they are excluded from framing processes such as this one. Evidence-based practices means “what white folks need to understand”. Recommend that include residents from the neighborhoods being measured and pay them for their involvement. LISC relies on grants. Can we bring the data and the community closer together?

*Angie Raymond (Ostrum Workshop):*

Need to understand the importance of local community engagement. Populations feeling over-surveilled. Look at the COVID vaccine data – where they are talking about how what data should be gathered, how it will be shared, and with whom.

In the book “Automating Inequality” (Virginia Eubanks, 2018), Central Indiana was used as an example of a massive failure in terms of the population that we are trying to help not being part. It is about a lot more than technology and data. We have an amazing group of people. What can we do to not repeat these past mistakes?

Heard a lot about the need or desire to link individual level determinant data with individual level records. We have area-based social data without health data. And we have individual level health data without the social data. Would like to get the health data at a small area linked with the social determinants data.

*Tess Weathers (FSPH)*

 Would like group level, community level HEALTH data. Puts the onus on society to focus on addressing at the community level, not the individual level.

Engagement Needs

*Shelbi Cummings (LISC):*

CBOs are involved at the individual level – directors, program managers, etc. But it is important for the second level - the client patient, individual community residents - to be heard.

Who is missing at the table? We have organizational representatives. But that representation is not the same as having the resident voice. Both levels of constituents should be at the table. Kaiser and Camben are both doing that. Great Places 2021 – cross sector, collective impact. Spaces where people who have social capital as well as residents are included.

Why is community development in the health space? Beyond how we get the invite list right, how do we identify the strengths of each of our sectors.

*Angie Raymond (Ostrum Workshop):*

We might want to think about a fundamentally different way of SDOH. Still want to identify cancer clusters or obesity clusters – that is a research approach. But need to take that and direct resources to individuals. If doing a population survey, all of us are captured, including those that are doing well. Instead – we need a more targeted approach.

* People are willing to share specific data points if think that are contributing to solutions
* But, they don’t want their information pushed out to strangers as “referrals
* Don’t want us to use population health data to convert to referrals.

Once have all of the robust data to understand disease clusters, the next phase is to discuss how to use those data. We should not assume that the right next step is to refer services. We also need to engage the communities impacted by a certain disease to discuss what the community solutions are.

Governance

*Joe Gibson (MCPHD):*

How is 211 is being used by small groups? CBOS have their own individual needs. Hard to set up a system that meets everyone’s needs. A lot of time spent trying to understand and address the needs of an individual group.

* How do you design something that helps all of these groups?
* How do you design a system?

Imagining a federated systems versus centralized system.

*Alicia Baker (Aunt Bertha)*

Don’t want to force groups to use a particular tool (e.g., Aunt Bertha). We have a strong commitment to interoperability. They want to support people getting access to the care they need. “Web hook”. They want to support interoperability.

Looking for integrated services. Other cities do this successfully. The data piece and referral piece are just part of getting to integrated services. The data people are an important piece, but how do we link to the other pieces like sustainable funding, implementation, etc. etc.

**Chat comments:**

Engagement

09:56:38 From Jonathan Barclay : Boards may pay bigwigs to be on corporate boards. Are we good enough at paying CBOs and community members to serve--long-term--on our planning committees and stakeholder advisory and implementation groups? Is that a strategy we should pursue more aggressively--ensuring funding to **incentivize broad participation in our structural teams**?

10:00:59 From Tess Weathers : @Jonathan - Yes we should! We have had a heck of a time trying to pay our **resident steering committee members** from the university.

09:59:07 From Angela Rollins : Summary for who has been missing (or just light in representation) in the workshop: **people of color, criminal justice, fair housing reps, Indiana civil rights commission, faith based groups, Community mental health centers** (the ones not part of large health systems), other CBOs

Asset Mapping

10:11:05 From Josie Fasoldt : **Health and Wellbeing Atlas**: <https://www.in.gov/fssa/hoosier-health-and-well-being-atlas/>

10:18:09 From Alicia Baker : Searches on the Aunt Bertha network also happen at the zip code level as well

10:22:13 From Alicia Baker : We should definitely consider doing some **asset mapping**, to go off of Angie’s point too.

Regional Networks

10:26:10 From Jessica Brookshire : Could we consider **regional networks** throughout the state?

10:26:26 From Patty Rose : **CTSI** has a **County Engagement Team** (of which I am a part of), that are currently conducting "listening sessions" with community members of Blackford County, a county that was determined having a great need for social/health related needs- obviously, there are a lot of pieces to this puzzle- disconnect of who is doing what is a big issue- as Angie noted. Getting the right people to the table is correct! I work directly with small rural provider and many would like to implement SDOH into their practices, but do not have the resources, pandemic has hit them hard- some have implemented SDoH into their practice workflow, yet not sure what to do next with all this data.

10:26:46 From Joe Gibson : **regional networks** is a great idea!

10:28:20 From Patty Rose : Yes, Joe is correct! I've seen that work in CADI, Cardiovascular and Diabetes Initiative coalition, in having regional discussions, and it was amazing the disconnect of what others are doing in our great State-

10:28:57 From Joe Gibson : We've got folks in this workshop who have done a lot of "what do people need" work. Pulling that together could be enough.

Interoperability

10:40:12 From Shelbi Cummings :[**https://openreferral.org/**](https://openreferral.org/)

10:40:16 From Patty Rose : **INTEROPERABILITY** is huge...closing those referral loops is a big issue across this state! electronic health records is a big obstacle

10:40:39 From Shelbi Cummings : [**https://docs.google.com/document/d/1xjXYN0zzUVWK3GdINP3erO-Jm0LUz75962SyRF0ggIA/edit**](https://docs.google.com/document/d/1xjXYN0zzUVWK3GdINP3erO-Jm0LUz75962SyRF0ggIA/edit)

10:41:11 From Shelbi Cummings : [**https://l.antigena.com/l/ViO09bvaLafkV5bytoCHZwZGLogqATG84Ap\_mUtqSwJ-nKSihCpSCk4OkRTwqyDHsjqxq~MXkdM-GeG9nUcnZPOh~3y1w2MBuqmDp25i1mWt\_UsQ95MJ2XpFJCqU97Dolym9vqYLbreFl4a4y\_t4SFeQ7mlTTQiVdQvrijjYsLTDXNtXAojuUtAiWwA2**](https://l.antigena.com/l/ViO09bvaLafkV5bytoCHZwZGLogqATG84Ap_mUtqSwJ-nKSihCpSCk4OkRTwqyDHsjqxq~MXkdM-GeG9nUcnZPOh~3y1w2MBuqmDp25i1mWt_UsQ95MJ2XpFJCqU97Dolym9vqYLbreFl4a4y_t4SFeQ7mlTTQiVdQvrijjYsLTDXNtXAojuUtAiWwA2)

10:42:09 From Shelbi Cummings : These 3 links that I just shared is one way interoperability is being looked at with Greg Bloom.

10:45:57 From Angie Raymond : Ohhh- good point translational research- explain how ‘this’ converts to ‘policy’ ‘funding’ etc

10:52:18 From Patty Rose : patient engagement...hearing their success stories- help others in community engage as well!

10:52:47 From Shelbi Cummings : yes, Angie. Let's get together to discuss the frameworks that exist that are doing just that!

10:53:49 From Angie Raymond : @Shelbi- AGREE!

10:54:01 From Angie Raymond : All- Angie angraymo@indiana.edu LOVED this

10:54:15 From Alicia Baker : Yes, great conversation!!