Partnering Together on Health Equity Through the National Diabetes Prevention Program and Diabetes Management to Prevent or Delay Type 2 Diabetes and Prevent Diabetes Complications

October 16, 2024

The Diabetes MATCH Initiative: Mobilizing **A**ccess **T**hrough **C**apacity Building & **H**ealth Equity

This content was supported by Cooperative Agreement Number CDC-RFA-DP-23-0021, entitled *A Strategic Approach to Advancing Health Equity for Priority Populations with or at Risk for Diabetes- Subject Matter Expertise, Training and Technical Assistance*, funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the Department of Health and Human Services.

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Welcome and Introductions

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Session Objectives

- Bridge the community-clinical divide, improve individual and population health, and increase health equity.
- Illustrate the importance of partnerships in building community-clinical linkages at the national, state, and local levels.
- Provide actionable strategies and case studies to empower attendees in fostering meaningful partnerships between clinical and community-based organizations, with a focus on tangible outcomes for improving social determinants of health (SDOH) and enhancing overall population health.

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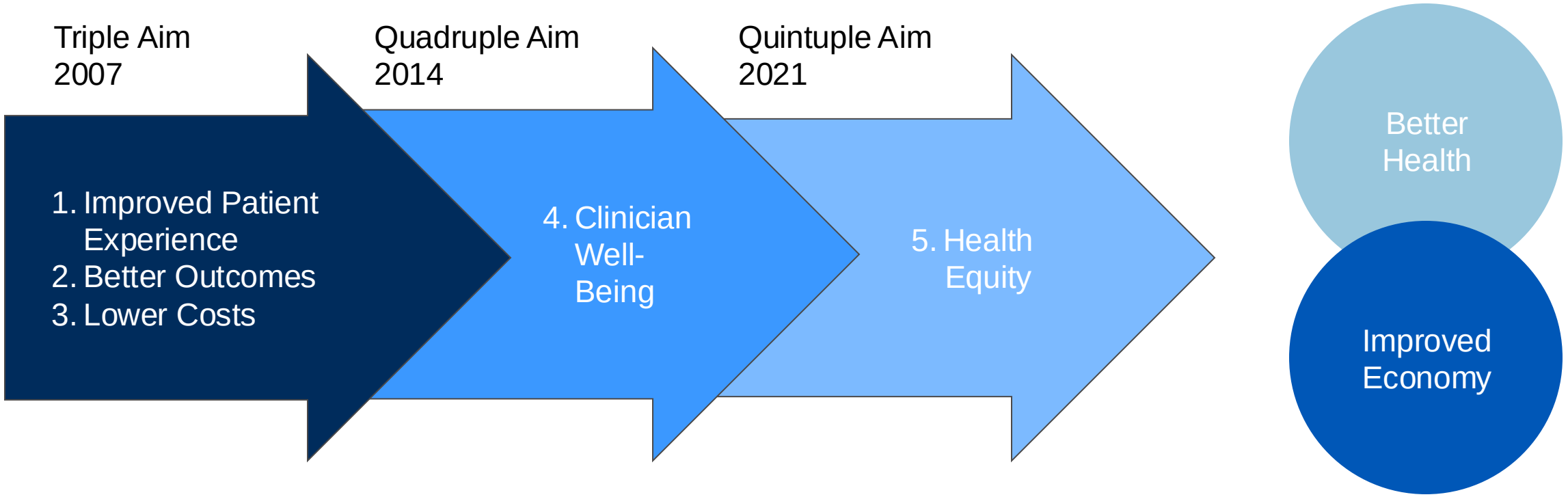
Future of Care: Quintuple Aim



Itchhaporia, D. (2021). The evolution of the Quintuple Aim: Health equity, health outcomes, and the economy. *Journal of the American College of Cardiology*, *78*(22), 2262-2264.

A Strategic Approach to Advancing Health Equity for Priority Populations With or at Risk for Diabetes, CDC-RFA-DP-23-0020

- Decrease risk for type 2 diabetes among adults with prediabetes.
- Improve self-care practices, quality of care, and early detection of complications among people with diabetes.
- Support implementation of evidence-based, family-centered childhood obesity interventions as a type 2 diabetes risk reduction strategy.
- Provide strategies based on interventions grounded in scientific and practice-based evidence.

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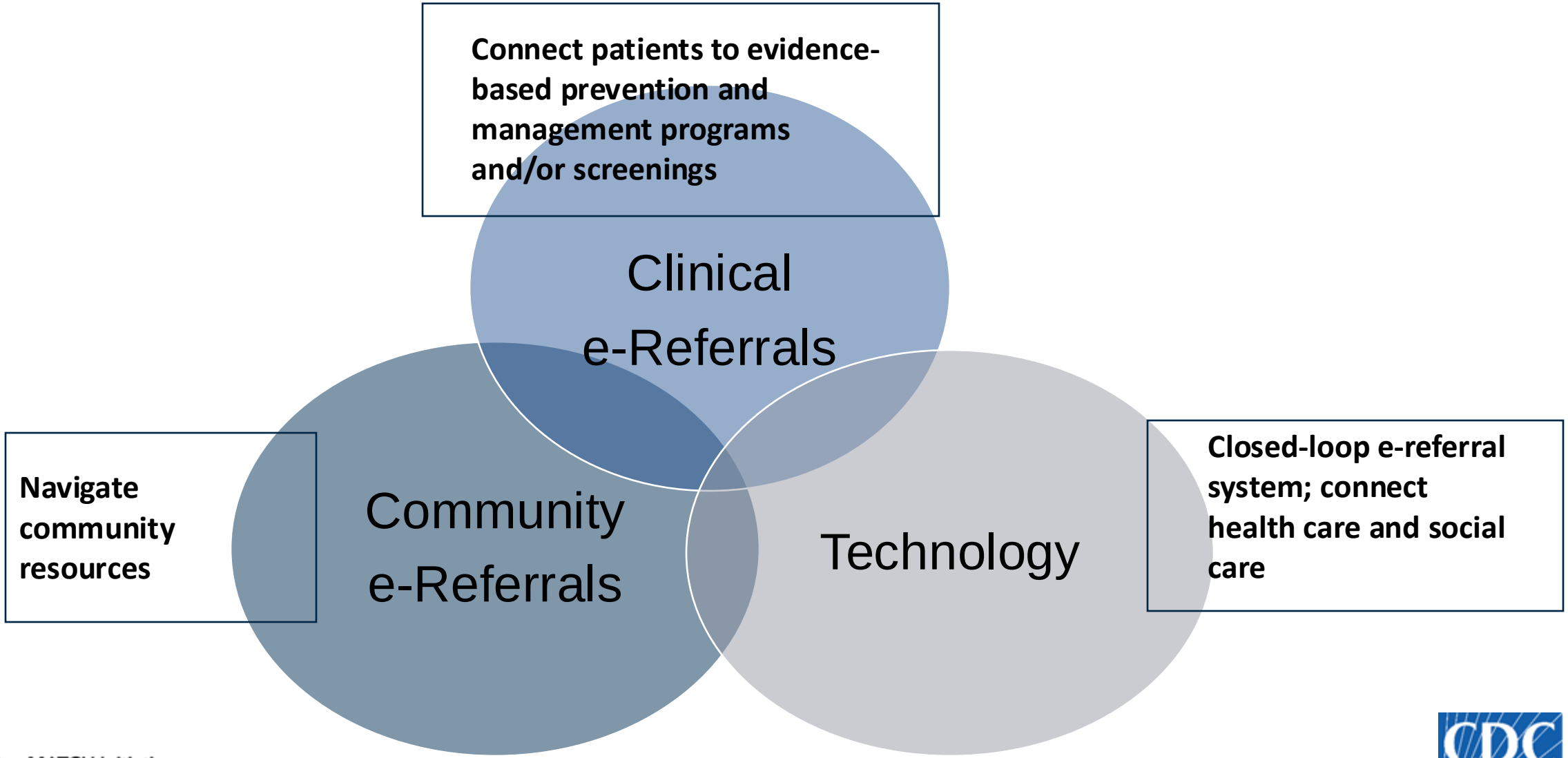
Intent of Strategy 10: Connect Health and Social Care



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PARTNERSHIPS IN BUILDING COMMUNITY-CLINICAL LINKAGES

- **Federal Level**: Office of the National Coordinator, Administration for Community Living, Medicaid/Medicare

- **Nationally**: Civitas Networks for Health, 211, Data Across Sectors for Health – Illinois Public Health Institute, Michigan Public Health Institute

- **State Partnerships**: health information exchanges, community information exchanges/211s, Medicaid, hospitals and health care systems, foundations, and commercial payers

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The Challenge

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Timeline of e-Referral Evolution With CDC Funding

1422 (2014-2017)

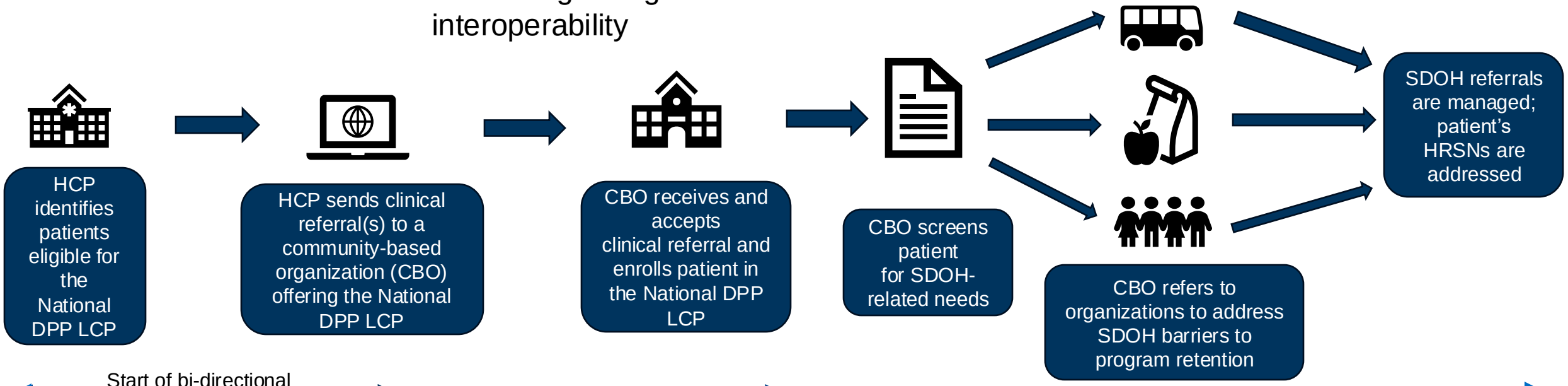
- Beginning to build community-clinical linkage and start bi-directional focus

1815 (2018-2023)

- Bi-directional e-referrals
- Beginning to close the loop on e-referrals
- Advancing linkages & interoperability

2320 (2023-2028)

- Multi-directional e-referrals
- Diabetes prevention and management requires a whole-person approach
- SDOH is recognized as a key barrier



Note: These visuals represent one example.

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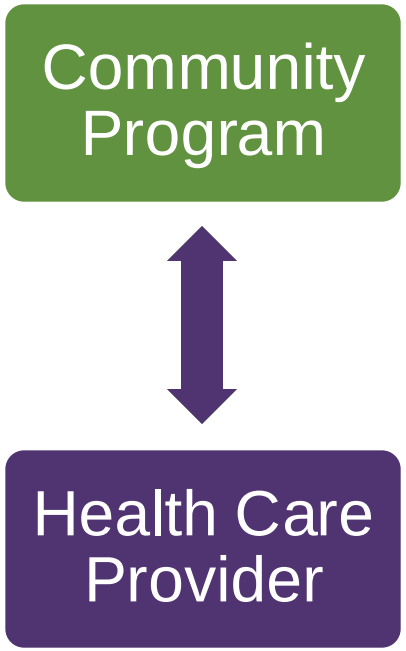
Goal – Increase Community-Clinical Linkages

Bi-directional e-referrals:

- Identify pathways for e-referral that reduce time and burden for health care providers, making the referral to community resources easier and within their normal workflows; and
- Identify pathways for sharing participant progress back with the health care provider and integrating participant outcomes into the patient's electronic health record.



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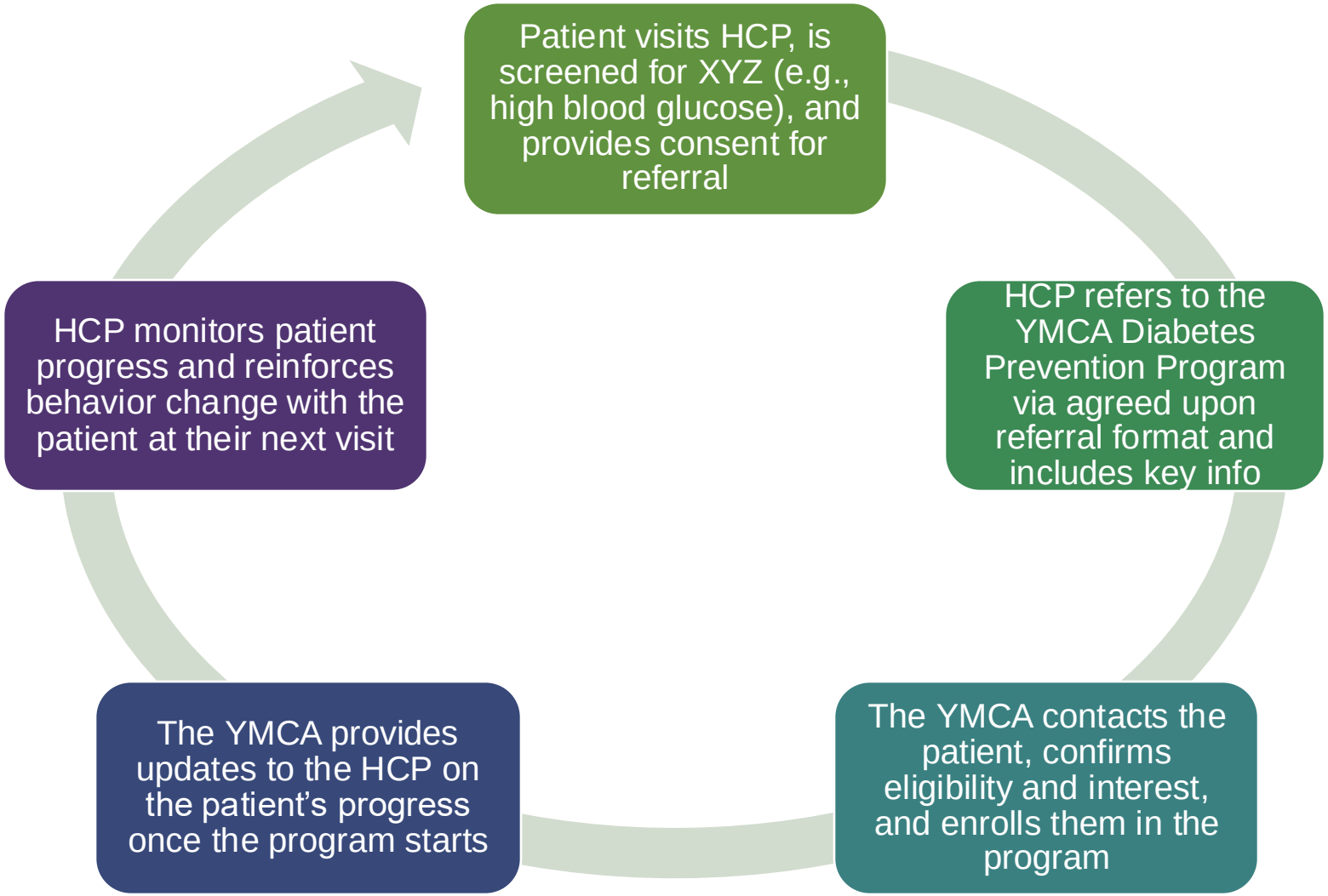
The Bi-directional Pathway



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The Importance of Health Care Provider Engagement

Advantages of bi-directional referrals:

- Ensures information is moving both from the HCP to the YMCA and from the YMCA back to the HCP
- Increases the number of touchpoints with participants, which may increase the likelihood that they will enroll, enhance the participant experience, and improve health outcomes
- Allows HCPs to reinforce positive behaviors demonstrated when feedback is provided on a participant's progress
- Keeps the diabetes prevention and management program front of mind for HCPs, which may result in a greater number of referrals being made

Strong relationships with health care systems and settings can provide opportunities and promote sustainability in a variety of ways:

- Increased program awareness and identification of additional program champions (advocates)
- Additional program locations and opportunities to reach pockets of the community not yet served
- A foundation from which a mutually beneficial partnership can evolve
- Development and utilization of bidirectional referral pathways
- Establishment of the YMCA as a preferred provider for practice extension services

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Key Drivers

Staffing

Relationships

Health Care Champions

EHR Functions

Communication Workflows

Information Technology

Legal Needs

Training

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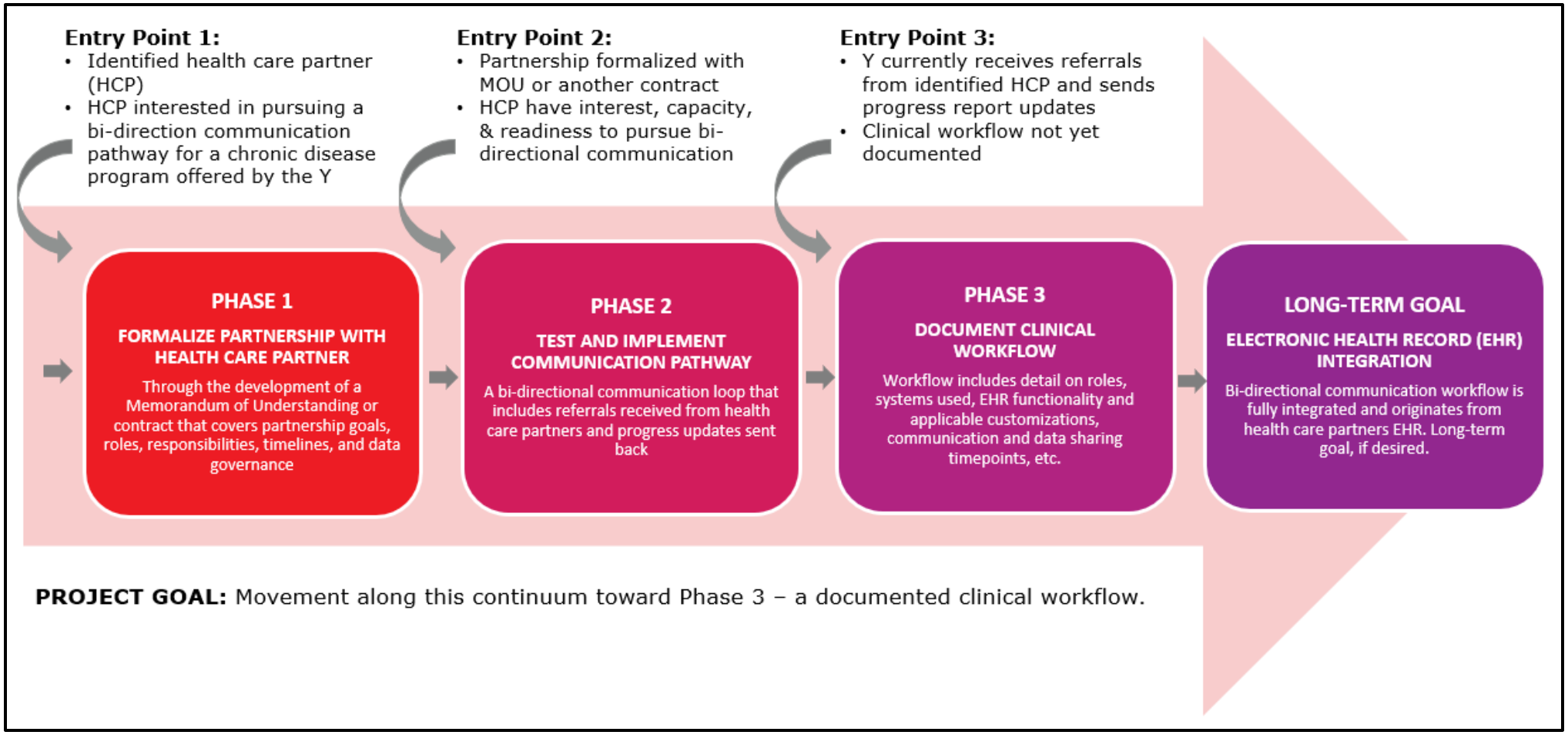
Bi-directional Communication Continuum



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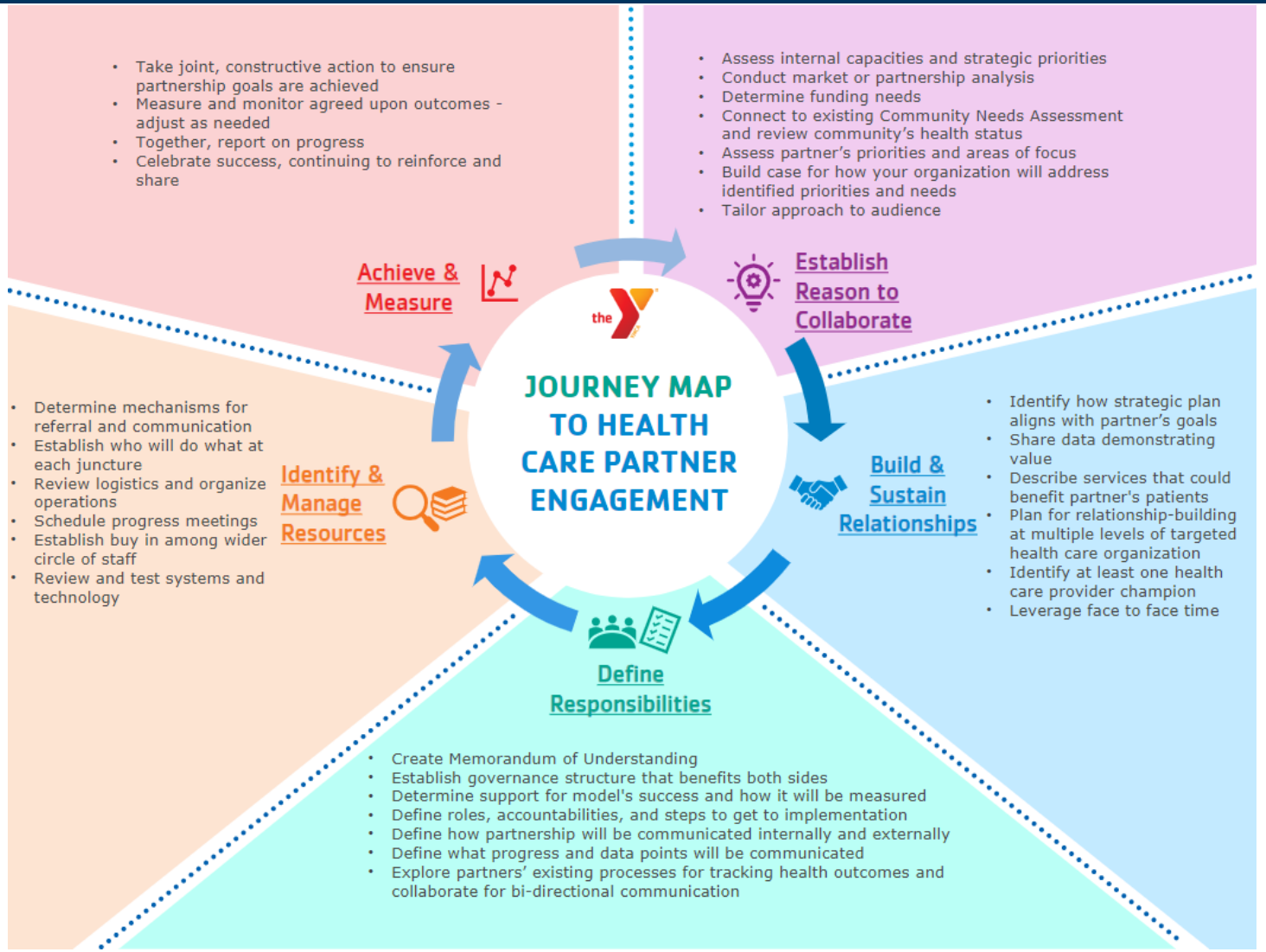
Journey Map



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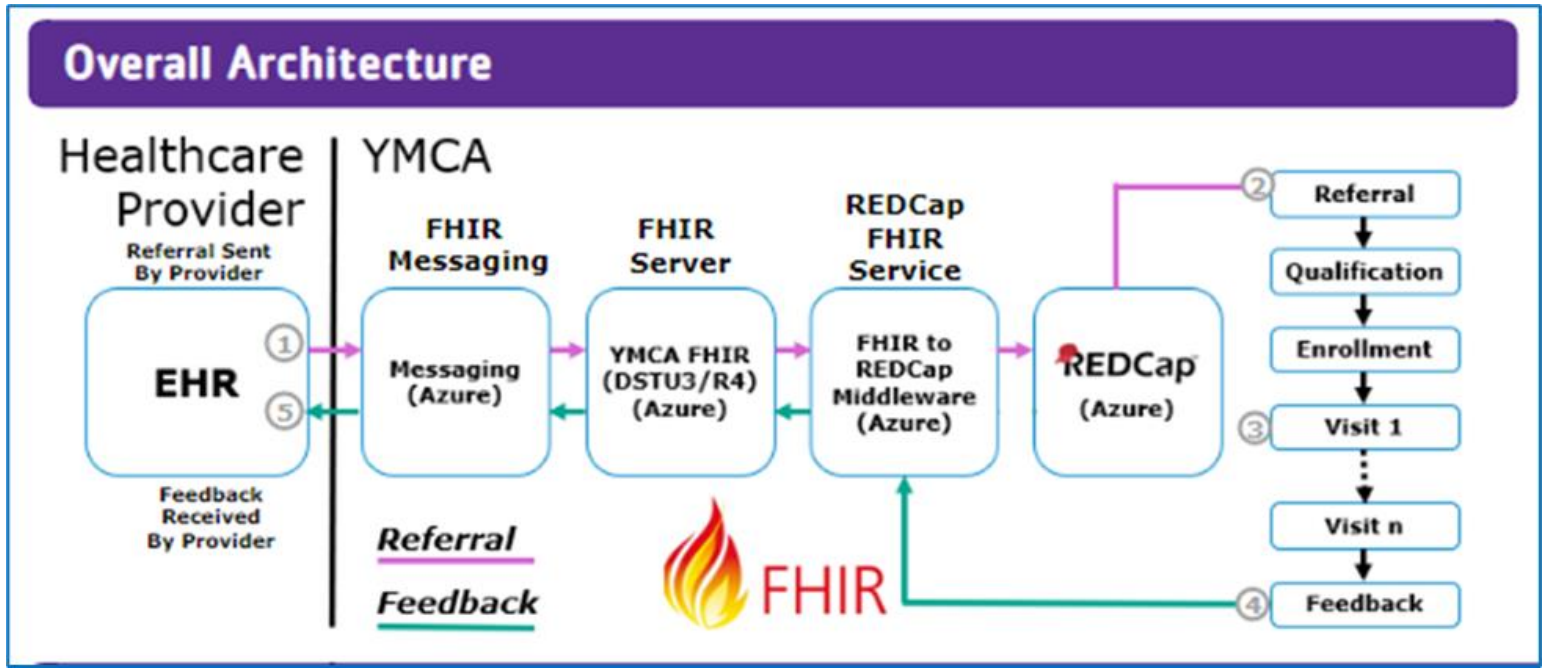
Bi-directional Services e-Referral (BSeR) Project

Goal:

- Streamline and enhance the efficacy of the exchange of health information between health care systems and community services organizations involved in addressing chronic health conditions by establishing information exchange standards for electronic referrals and referral outcome reporting
- Establish closed-loop referral capability using the bi-directional e-referral standard (BSeR) and REDCap



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Key Learning: No one size fits all

- Health care partnerships with and across YMCAs vary by the needs of each stakeholder and those they serve.
- Finding ways to systematize the work can lead to efficiency in the long run.
- Community-based organizations like the YMCA stand ready to support health improvements across the community.

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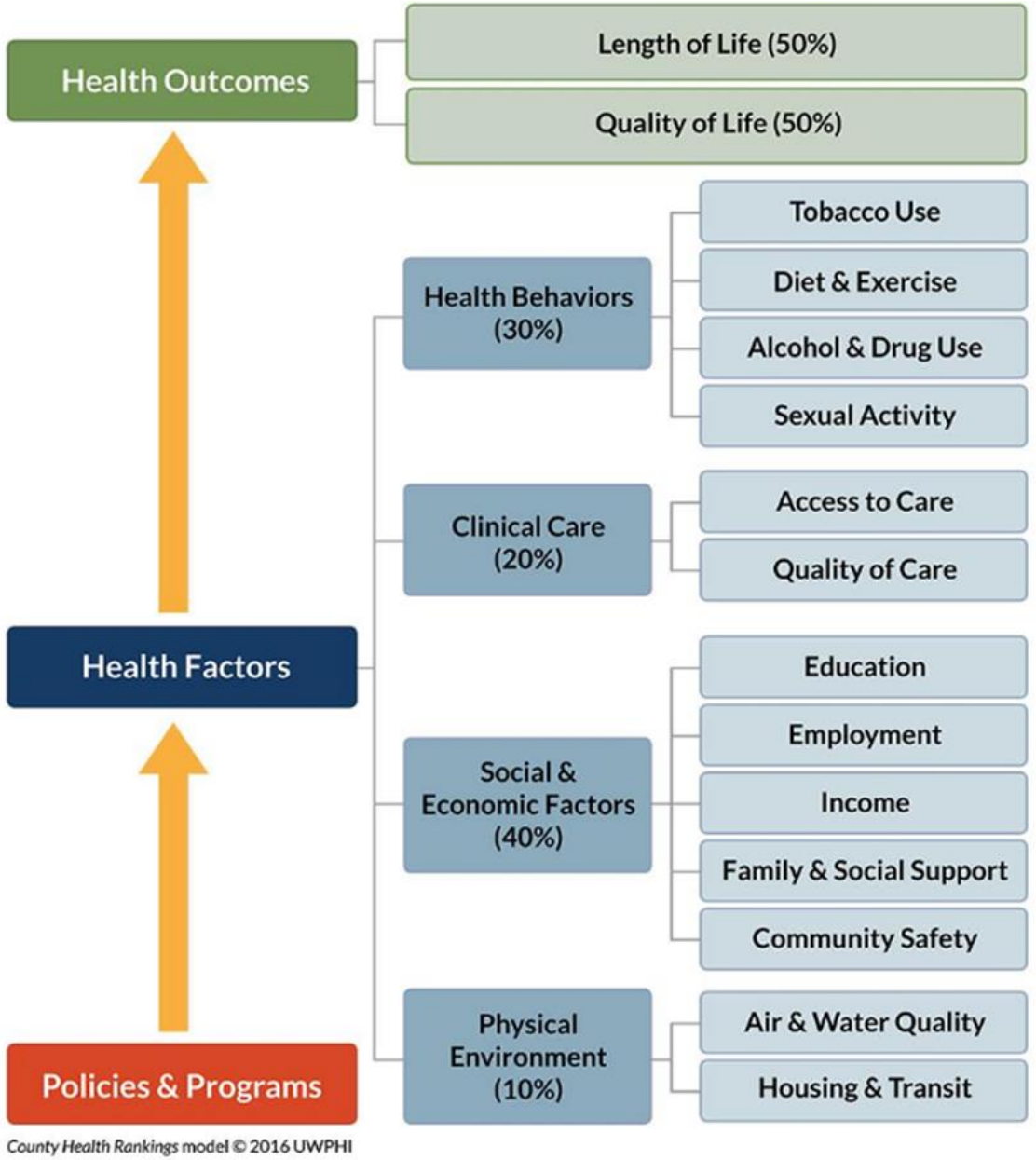
IT’S TIME TO BRIDGE HEALTH
CARE AND SOCIAL CARE

Why is there a desire to connect health care and social care?



Source: https://www.countyhealthrankings.org/

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A Social Determinants of Health Lexicon

Health equity is *"achieved when every person has the opportunity to attain his or her full health potential, and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances."*

Community Level

Social determinants of health are "*the conditions in which people are born, grow, live, work, and age," which are "shaped by the distribution of money, power, and resources."*

- **Protective factors:** characteristics or strengths of individuals, families, communities, or societies that act to mitigate risks and promote positive well-being and healthy development.
- **Social risks:** Adverse social conditions associated with poor health.
- **Health-related social needs (HRSNs):** Patient-prioritized social factors that impact health.

Individual Level

Social care: Activities that address HRSNs.

Source: Alderwick and Gottlieb (2019) Meanings and Misunderstandings: A Social Determinants of Health Lexicon for Health Care Systems
Center for the Study of Social Policy (2018) About Strengthening Families™ and the Protective Factors Framework
Physician-Focused Payment Model Technical Advisory Committee (2021) SDOH and Equity Report to the Secretary

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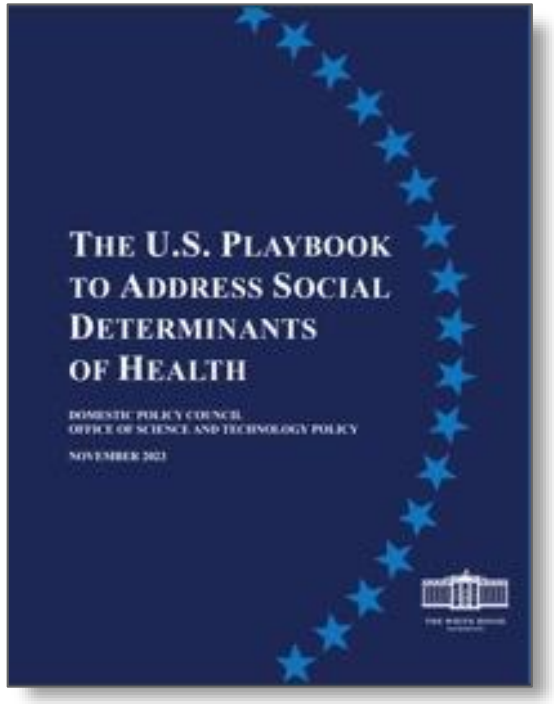
Playbook Actions: Setting the Stage to Re-Imagine Policies and Actions Around SDOH



Pillar 1
Expand Data Gathering and Sharing

Pillar 2
Support Flexible Funding to Address Social Needs

Pillar 3
Support Backbone Organizations

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Key Themes Across Pillars

- Improve **data infrastructure** for data collection and interoperability.
- Support the development of community **backbone organizations** and other infrastructure to link health care systems to community-based organizations.
- Strengthen **SDOH data collection and exchange,** including Medicaid beneficiaries.
- Remove barriers to funding access, including Medicaid, and optimize the **impact of grants and investments** provided to communities to address unmet needs.

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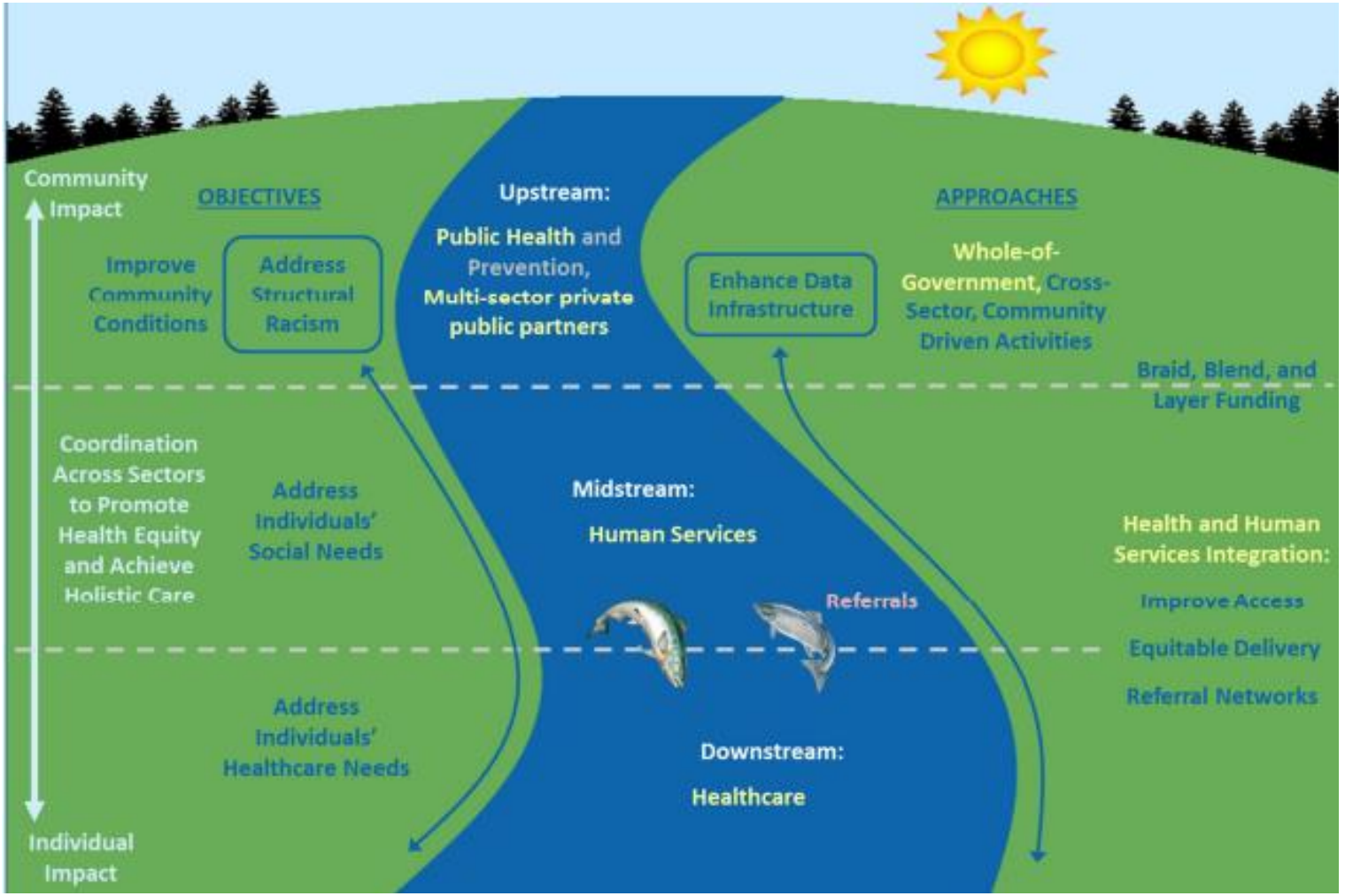
The Art of Possible: Using SDOH Data to Advance Health Equity

Learning Health System

Social Care Delivery

Health Care Delivery



https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf

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Understanding Drivers Across Populations and Individuals

Drivers	UPSTREAM	MIDSTREAM	DOWNSTREAM
	Social Determinants of Health	**Social Risk**	**Health-Related Social Needs**
What is this driver?	SDOH includes broad policies and systems at all levels that influence where people grow, live, work, and age.	Social risk includes living conditions and specific adverse scenarios that affect health.	Social needs include individual situations and needs that affect one's ability to maintain health.
What factors influence it?	Macro-level conditions like racism, discrimination, environment, public policy, and laws.	Specific risk factors like social isolation, health care access, economic opportunities, education level, area violence, and food insecurity.	Individual factors like income, disability, ability to afford medications, access to transportation, family or caregiver support and personal behaviors like nutrition, physical activity, or smoking.
Where is the focus for action?	Public health programs; federal and state funding initiatives; legislative policies; advocacy and support for critical programs and regulations; and wide-scaled education and programs, including anti-racism policies.	Regional or local programs that address housing access, neighborhood safety, and transportation access, including food banks, employment training, income stability, and grants to improve living conditions.	Individual and family-focused interventions and support focused on increasing stability, referrals to non-profits, and individualized risk programs.

Source: https://www.thoroughcare.net/blog/understanding-social-need-social-risk-and-social-determinants-of-health

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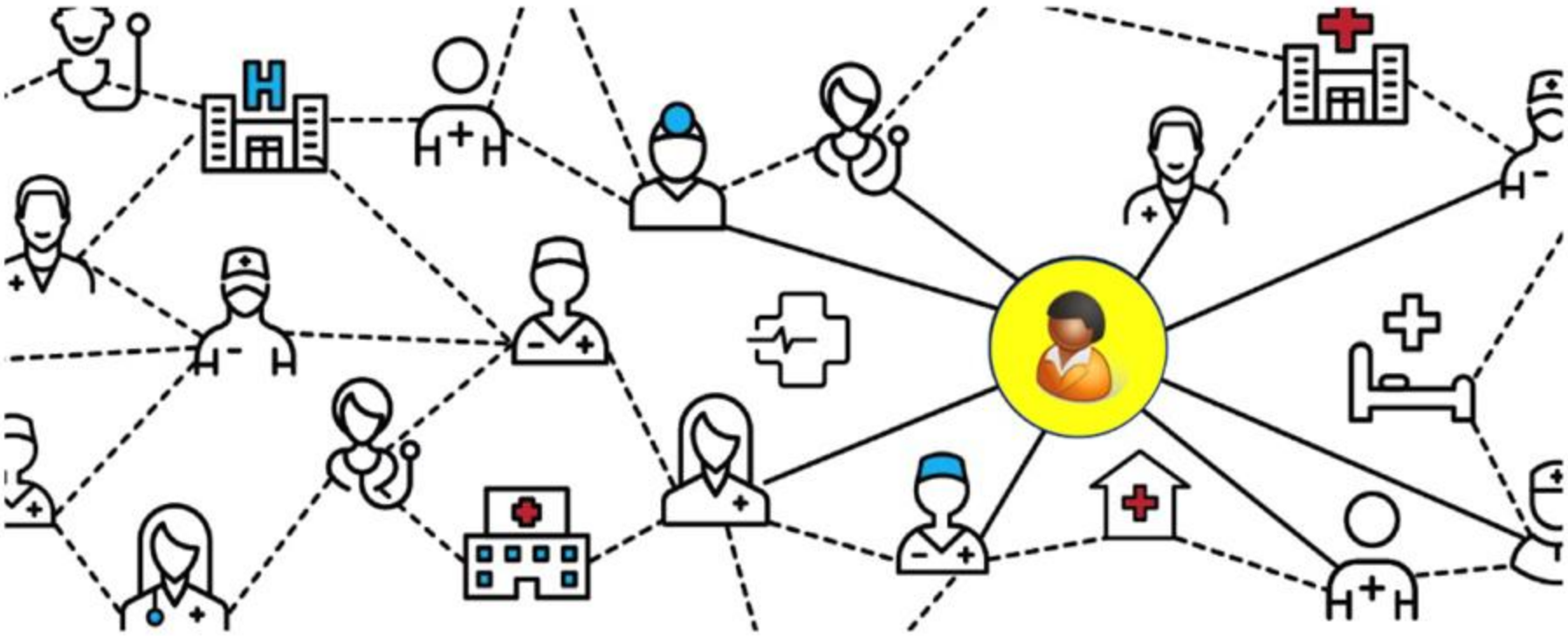
The Problem: Fragmented Health & Social Care Data Interoperability



Source: California Health Care Foundation. Why CHCF Is Investing to Improve Data Exchange Again. Published September 23, 2019. Accessed May 10, 2024. https://www.chcf.org/blog/why-chcf-is-investing-improve-data-exchange-again/

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Community-Clinical Linkages

"Community-clinical linkages are defined as connections between community and clinical sectors to improve population health."

(CDC, 2016)

Source: Centers for Disease Control and Prevention. Community-Clinical Linkages for the Prevention and Control of Chronic Diseases: A Practitioner's Guide. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; 2016.

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HOW DO WE BUILD THE LINKAGES?

Figure 1. Public Health Sector Linking Community and Clinical Sectors

Community Sector

Composed of organizations that provide services, programs, or resources to community members in non-health care settings.

Public Health Sector

Composed of public health organizations that can lead efforts to build and improve linkages between community and clinical sectors.

Clinical Sector

Composed of organizations that provide services, programs, or resources directly related to medical diagnoses or treatment of community members by health care workers in health care settings.

- E-referrals
- Landscape assessment to find intermediaries
- Partnerships

An Electronic Referral Lexicon

- **Electronic referral (e-referral)** is the automation of the referral process where one provider refers a patient to another provider, but the referring provider maintains his/her care of the patient as well.
- **A closed-loop referral** is an e-referral that ensures that the specialty service and advice are re-integrated into the patient record and providers can see the patient's progress throughout the referral process.
  - It must be supported by a **standard terminology** for communicating the status of a referral and a standard mechanism for seamlessly accessing and sharing that status across health IT platforms.
- An e-referral can be generated and managed through **various health IT or tools**, including EHRs, health information exchange platforms, telehealth modalities, mobile technologies or SMART apps, and **social care referral networks**.

For simplicity, let's refer to non-EHR tools as '**intermediaries**.'

Source: Liddy C, Hogel M, Blazkho V, Keely E. The current state of electronic consultation and electronic referral systems in Canada: an environmental scan. Stud Health Technol Inform. 2015;209:75-83.

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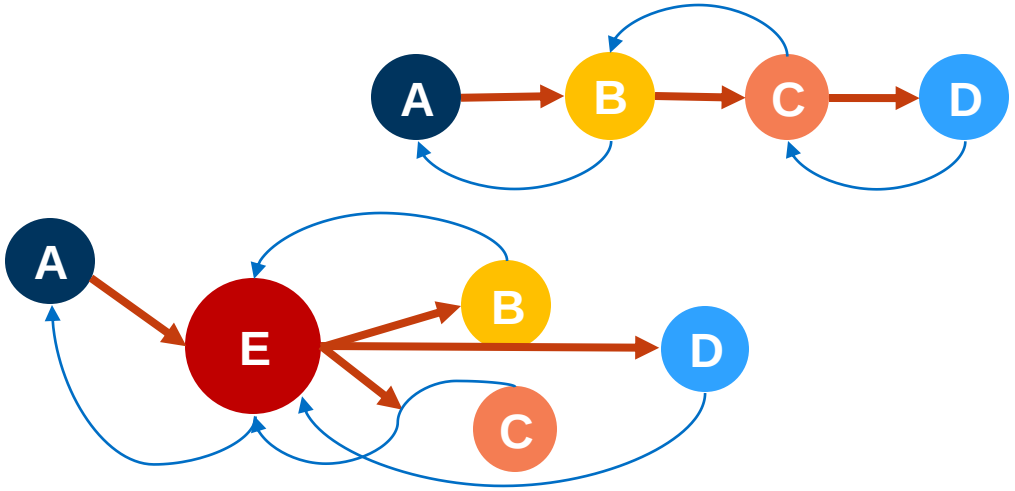
e-Referral Types

Unidirectional. The referral placer (A) sends an electronic message to (B), but no response on the outcome is returned to (A).

Bidirectional. The referral filler (B) responds to the electronic message from (A) and provides information on the outcome back to (A).

Multi-directional. The electronic message from (A) is sent to multiple organizations (B), (C), (D) for multiple needs or goes to one place (E) and then is routed.



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Define: Intermediary

- Intermediaries are **organizations that link institutions or people together**. Intermediaries seek to **establish trust** with each institution and **provide skills or capacities** that are lacking in the organizations they connect. They **enable a connection of medical care and social services** to produce improved health, allowing these sectors to work together seamlessly. *Examples: platforms that exchange information or data, health information exchanges (HIEs), community information exchanges (CIEs), community care hubs (CCHs), and e-referral platforms.*

We recognize that terminology related to intermediaries may vary by state or entity and evolve over time.

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Intermediary Examples

Health Information Exchanges

Community Information Exchanges

Community Care Hubs

211s

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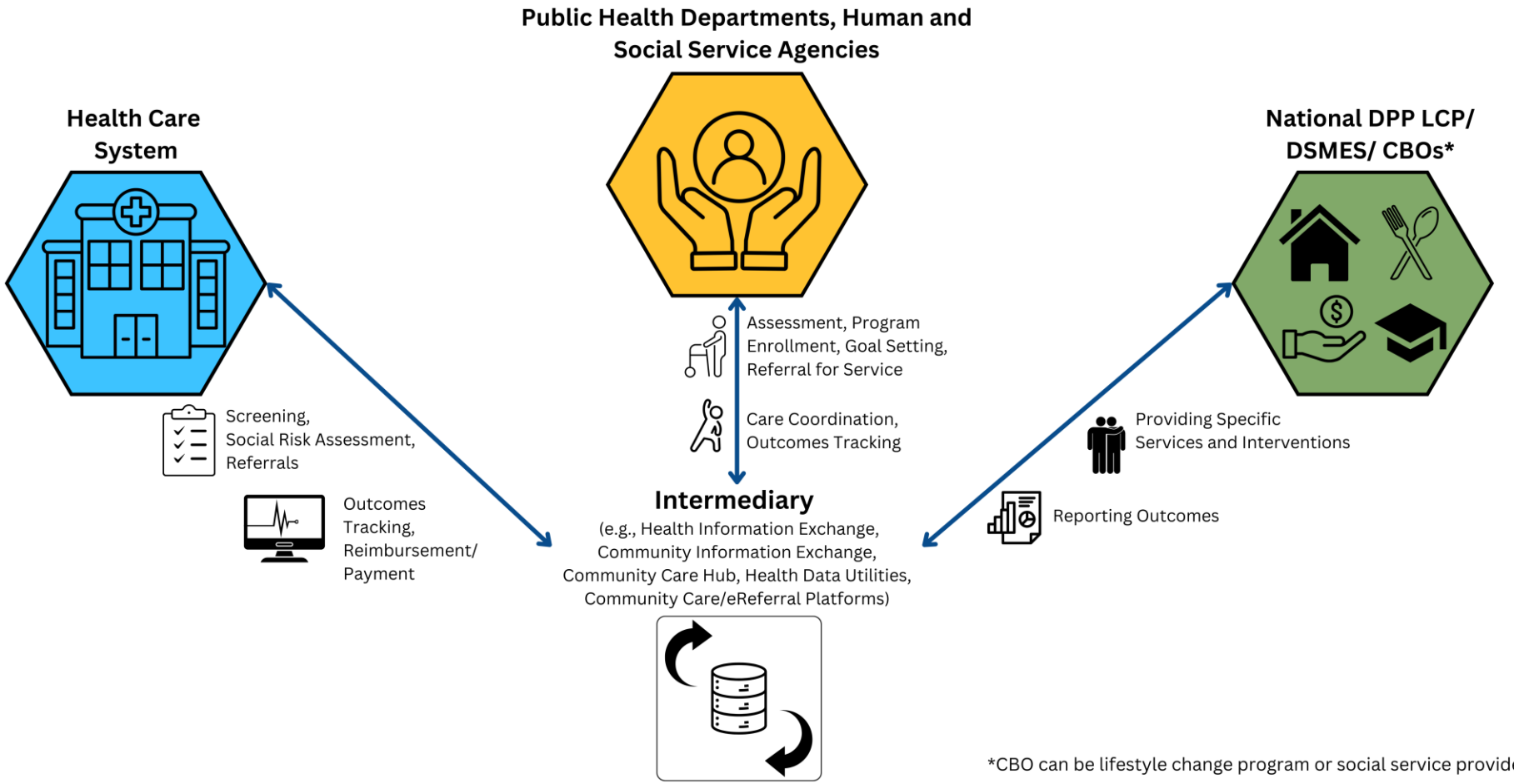
Intermediaries as Connectors Enabling Information Exchange



*CBO can be lifestyle change program or social service provider

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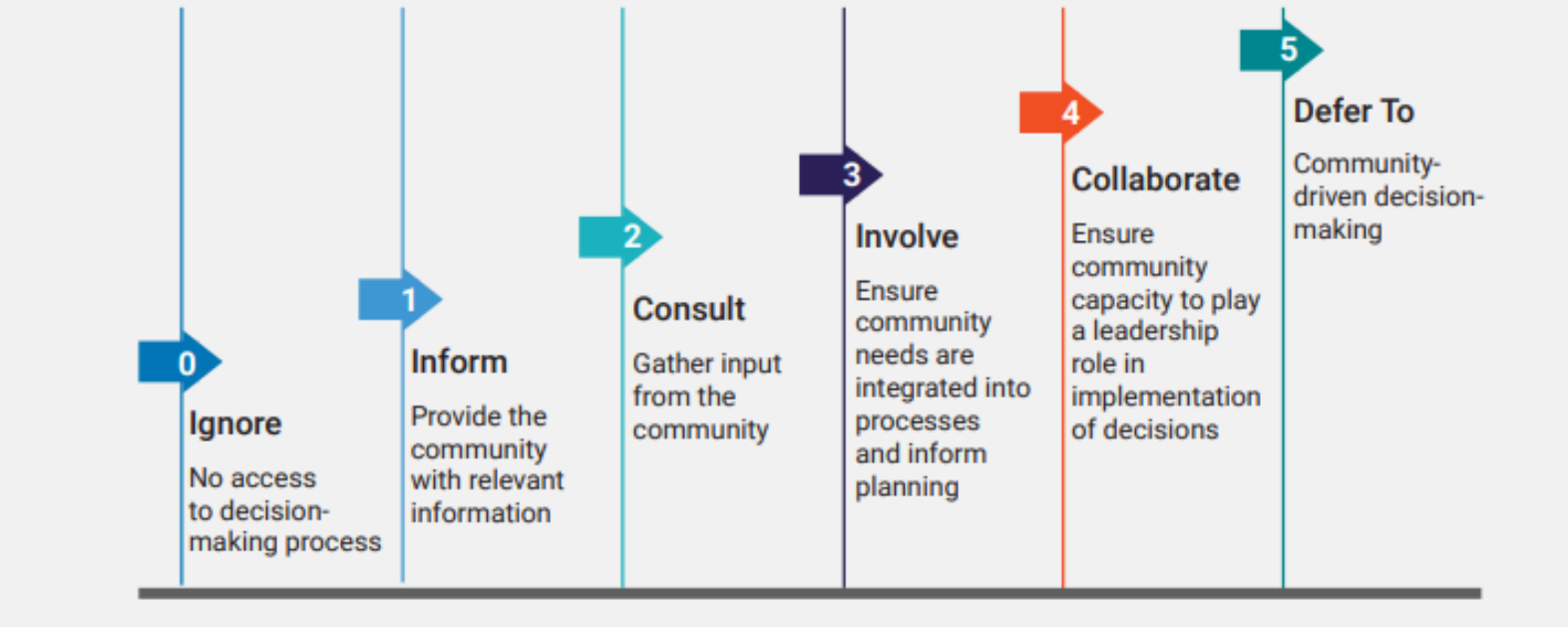
What We Are Learning

- Trust
- Power in co-creation
- Partnership
  - Lived experience
  - Diverse experiences
  - Teamwork
- Reflection in action
- Asset-based
- Multiple solutions
- Data > Information > Knowledge > Wisdom



Source: https://www.cdcfoundation.org/recommendations-strengthening-partnerships-HDs-CBOs?inline

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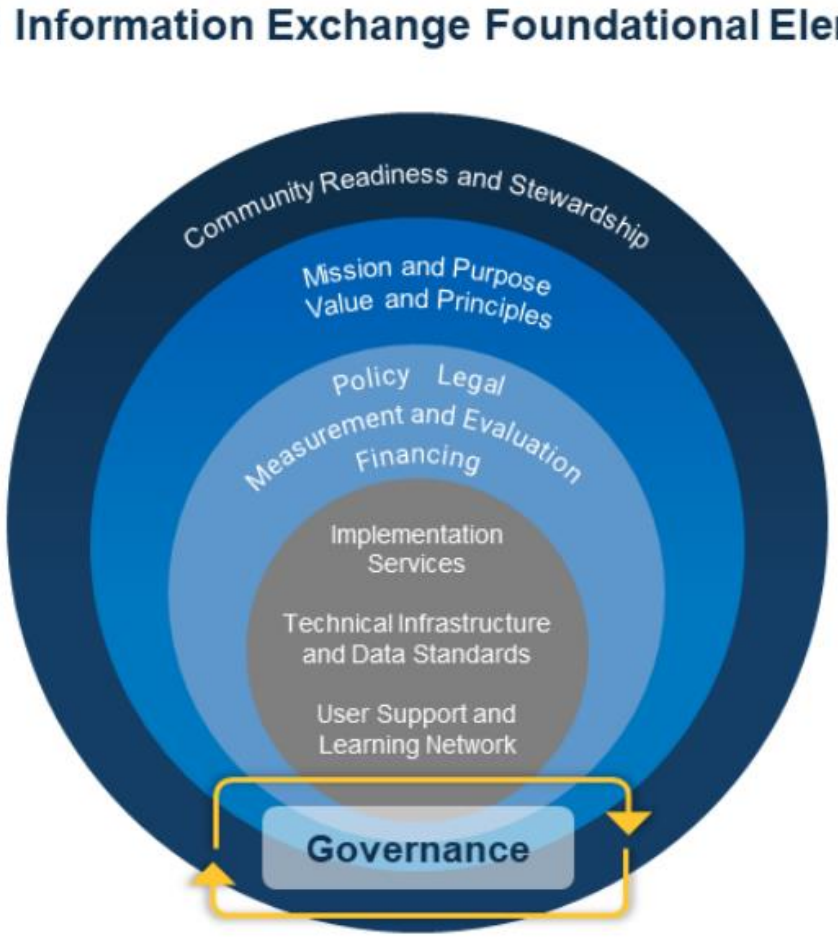
Grounded in Governance



Source: https://www.healthit.gov/sites/default/files/2023-02/Social%20Determinants%20of%20Health%20Information%20Exchange%20Toolkit%202023_508.pdf

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Future Direction

The Diabetes MATCH Initiative: Mobilizing **A**ccess **T**hrough **C**apacity Building & **H**ealth Equity

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Challenges and Opportunities

Power structures within health and social care restrict effective national data integration.

Social care funding is inadequate and disjointed, making it difficult for organizations to capitalize on the modern data integration efforts.

Convoluted policy and regulatory requirements add another layer of data complexity for social care providers.

Data sharing controls being balanced with administrative burden for consent proves challenging for already small social care organization workforces.

Current health care and social care partnership systems lack clear accountability and responsibility.

Source: https://www.civitasforhealth.org/wp-content/uploads/2024/02/FINAL-Co-Design-Report-Gravity-Project-and-Civitas-Networks-for-Health.pdf

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Building Towards an Equitable Future

Focus on interoperability in a secure, protected manner

Integrate data standards (i.e., Gravity Project, FHIR Standards)

Combine health care and social needs management into one ecosystem

Advocate for policy decisions that support health equity and positive health outcomes

Promote partnerships to reduce clinician burden

Source: Data Sharing to Build Effective and Efficient Benefit Systems - https://bdtrust.org/data-sharing-to-build-effective-and-efficient-benefits-systems_january-2023.pdf

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Call to Action

The U.S. Department of Health and Human Services envisions a future in which everyone, regardless of their social circumstances, has access to aligned health and social care systems that achieve equitable outcomes through high-quality, affordable, person-centered care.

- **INVITE** public health and social care organizations to the decision-making table.
- **THINK** about how CDC and other government funding sources can help support infrastructure. **ENGAGE** them!
- **ENSURE** technology and conversations support FHIR standards to continue to move toward interoperability.

Source: https://aspe.hhs.gov/reports/hhs-call-action

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Thank You!

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