



CIVITAS
Networks for Health



SOCIAL CARE CO-DESIGN

FINAL REPORT

DEVELOPED IN PARTNERSHIP WITH



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EXECUTIVE SUMMARY

PURPOSE

Gravity Project, a national public collaborative that develops consensus-based data standards to improve how stakeholders use and share information on social determinants of health (SDOH), engaged a diverse group of social care providers in a Social Care Co-Design effort to improve Gravity Project content and approaches. In partnership with Civitas Networks for Health – a national collaborative of membership organizations using health data utility, health information exchange, health data, and multi-stakeholder, cross-sector approaches to improve health – this phase of the Co-Design aimed to solicit, synthesize, and document social care provider feedback on Gravity data standards, subtleties between different social care provider subtypes and Gravity relevant roles, requirements, and opportunities.

A select group of social care partners including representatives of national and state-based organizations across food, housing, care coordination, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and services for older adults participated in the co-design process (see Appendix A for representatives from the 18 organizations).

The participants' insights via six, bi-weekly facilitated conversations and written submissions were far-ranging and encompassed both concrete feedback on Gravity Project activities as well as broader reflections on the health care and social care ecosystem. This report summarizes the co-design process and the findings.

MAIN TAKEAWAYS

The rich feedback from participants validated Gravity Project's hypothesis in bringing this group together: successful social care, and social and health care integration, is nuanced and more robust than articulated by the original Gravity Project conceptual model. Consistent, intentional engagement with social care experts will be crucial in creating and improving standards that enable meaningful, integrated health and social care provision. The co-design participants provided two types of feedback for us:

- 1 Conceptual: How we think and talk about social care and health care integration in the context of the Gravity Project. This includes comments on Gravity's conceptual model, definitions, diagrams, and vocabulary.
- 2 Prioritized actions: Things we need to build in the Gravity Project. Changes to the core Gravity Project terminology, data definitions, and use cases.

INTRODUCTION

BACKGROUND ON GRAVITY PROJECT, CIVITAS NETWORKS FOR HEALTH, AND THE SOCIAL CARE CO-DESIGN PROJECT

Gravity Project is a national public collaborative that develops consensus-based data standards to address the social determinants of health (SDOH). The collaborative convenes stakeholders across the health and social care ecosystem to develop SDOH data standards so this data can be documented in and exchanged across disparate digital health and human service, and community platforms. These national standards support the consistent use of the data across organizations, providers, and caregivers, and help to facilitate payment for social risk data collection and intervention activities such as referrals, counseling, care coordination, and service delivery. The Gravity Project's vision is to create a world where health and social care organizations readily share the information needed to effectively meet individuals' social needs, advance health equity, and improve health outcomes in communities by using standard terminology and technology. To learn more, please visit: <https://thegravityproject.net>.

Civitas Networks for Health is a national nonprofit collaborative of over 170 member organizations working to use health information exchange, health data, and multi-stakeholder, cross-sector approaches to improve health. Civitas educates the private sector and policymakers on interoperability, quality, coordination, health equity, and health care cost-effectiveness. As a 501(c)(3) nonprofit organization, Civitas leads multi-site grant-funded programs and projects. They are proud to support local health innovators by amplifying their voices at the national level and increasing the exchange of valuable resources, tools, and ideas. To learn more, please visit www.civitasforhealth.org.

Between November 2022 and December 2023, Civitas and the Gravity Project partnered to advance the adoption and implementation of SDOH data standards developed by Gravity. Civitas and Gravity have led four distinct but related pilot/implementation workstream efforts – regional pilots, affinity group and learning labs, social care co-design, and resource refinement and dissemination – providing customized training and technical assistance, gathering critical stakeholder feedback, and elevating the voice of community members.

Gravity Project's early scope was centered in clinical use cases and models which social care providers informed. They sought to establish standards for addressing social risk within clinical systems that referenced the wisdom of social care partners (e.g., ensuring terminology aligned with social care data standards such as the Homeless Management Information System). But, as the community evolved, it became apparent that expert social care perspectives needed to be better centered in the foundational use cases and models in order to redefine models and assumptions.

To better center the social care voice, the Gravity Project and Civitas elected to create a two-phase co-design effort that would engage social care experts within similar sectors. To facilitate this initial phase, the Gravity Project reached out to HealthBegins, a national strategy and implementation firm that helps Medicaid-serving health plans, health systems, and social service organizations achieve long-term impact for people and communities harmed by societal practices. HealthBegins facilitated the sprint series of six sessions over 12 weeks that engaged social care providers and synthesized learnings from them over the series. This final report memorializes the process and findings from this initial phase.

The objectives for this phase of Co-Design were for the social care participants to be able to:

- **Understand Gravity Project and Civitas Networks for Health** and how this series of sessions relates to other concurrent and upcoming co-design and implementation efforts.
- **Help identify technical and implementation challenges** in the current Implementation Guide and data standards.
- **Help Gravity Project team translate and frame the current Implementation Guide and data standards** in preparation for outreach and engagement with social care organizations in Gravity Project's network.
- **Find usefulness in and increase uptake** of the current Implementation Guide and data standards.
- **Help Gravity Project stakeholders understand a broader set of potential use cases from a community frame of reference** and express the subtleties that arise from different organization subtypes to inform potential new Implementation Guide(s).

Gravity Project leaders anticipate that a second phase of work will be necessary. They indicated that a future Phase 2 would be dependent on funding and multi-stakeholder member prioritization and would likely include:

- Expanding stakeholder engagement to bring in more sectors, including public health, education, tribal, and legal/carceral sectors.
- Delivering top prioritized changes and iterating on use cases, Implementation Guide, and terminologies with the community.

PARTICIPANTS

Participant Selection and Payment

Gravity Project recognizes that there are many crucial social care expert voices needed to guide this effort, and that it would not be possible to engage all of them at the outset. Understanding that successful co-design is driven by a sense of community within participants, Gravity Project sought to limit participation to less than 20 members representing social care voices missing from initial Gravity Project conversations, who would engage in all six sessions. Gravity Project also wanted to ensure that both grassroots service provision and broader national strategy perspectives were present for each stakeholder type. To narrow the list of participants to the 20-member goal, the team identified social care providers that assist clients with all domains through either navigation/coordination or service provision and organizations in housing and food/nutrition security, given the vast amount of national health care and social care programming for these two domains (e.g.s, local housing agencies, medically supportive food organizations, and national food and housing advocacy organizations).

Gravity Project works from a social justice framework and compensates all subject matter experts for their time.

Participants' hopes and aims in contributing to this effort:



“We are trying our best to help families in rough spots and we hope that readers of this report, who may be burnt out in their own way, are able to reconnect and center themselves on this shared goal of helping humans. If this co-design process has the intended effect, the participants share a hope that it will directly improve the experience of clients, participants, and families in using the system.”

- Amy Malinowski, WIC Program, Vermont Department of Health

Participants were surveyed at different points during the engagement in order to capture why they agreed to participate, as well as to understand what they hoped would come from their contributions. Participants came from diverse settings and organizations (see Appendix A), but largely shared a vision and goal of improved health for community members. At a high-level, participants expressed their desire for Gravity Project to use the influence and clout of the collective to elevate the lived experience of community members, honor the expertise of the social care providers, and advocate for the practical resource needs of both community members and the social care providers that serve them.



“Social care has to be at the table to make sure that social care is deciding how social care is integrated into the system”

- Courtney Baldrige, Business Strategy & Health Systems Integration, USAging

Social care participants stated that they joined the co-design sessions with aims to:

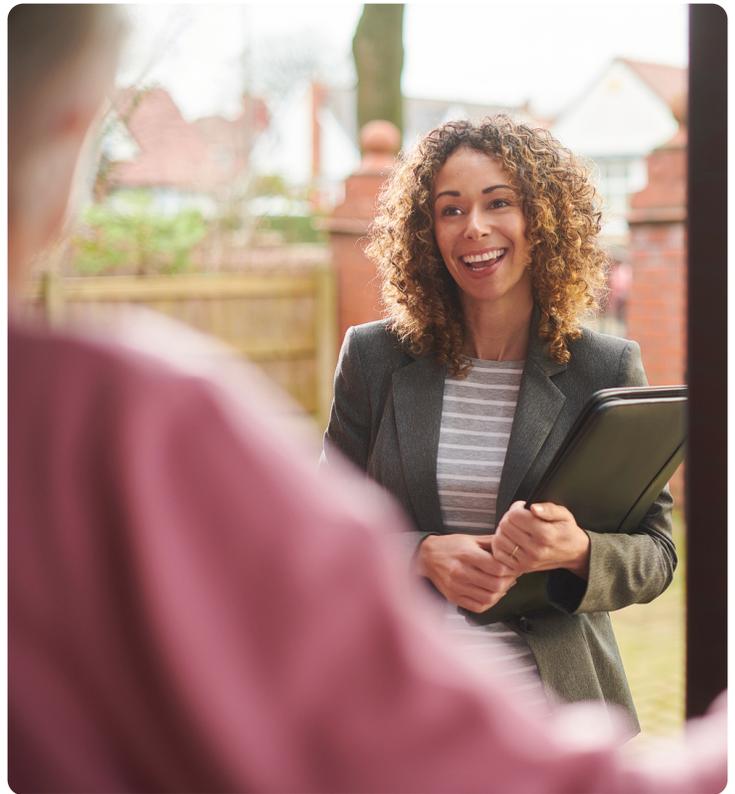
- **Support data integration to improve the effectiveness of social care partners'** service delivery in terms of both care for individual community members and for entire populations (e.g., understanding trends in the individuals you serve).
- Support bidirectional data sharing between health care and social care partners that demonstrates trust between partners and **supports seamless transitions between clinical and social services.**
- **Reduce duplication of data collection** for clients so they don't have to bear the administrator and psychological burden of repeatedly sharing sensitive and detailed information.



“We want our community to feel the changes. It shouldn't be all behind the scenes. They should know that coordination is happening.”

- Karen Flynn, WIC Program, Vermont Department of Health

- **Reduce administrative burden for social care providers,** and, as a result, increase social care provider staff retention and joy.



- Ensure **data collection structures, accountability, and processes promote health equity** rather than perpetuating historical and current structures of harm. The Co-Design participants noted that social care providers, at times, have deeper and more trusted relationships with communities impacted by structural racism and other systemic disparities than health care providers. The participants noted that health care and social care partnerships can help the entire system engage vulnerable populations with greater dignity, sensitivity, and consideration. For example, capturing social data can improve the quality of clinical care by providing more visibility into patient opportunities, barriers, risks, and needs. This requires evaluating and incorporating taxonomies that recognize the importance of intersectionality of various needs and critical family attributes and structures. It also requires systems to work together intentionally and carefully.



“We engaged community members 10,000 times over four years and of the things we heard, particularly from our most vulnerable populations, is that they felt commodified by the system. And, that they felt that receiving referrals that they did not ask for, knowing that Community Based Organizations were going to make money off of the services provided made them so upset to the point where they wanted to check out of the system overall.”

- Laura Gustin, Executive Director, TogetherNow

- **Increase efficiency and effectiveness of care coordination**, including efficiency of consent to share data. Allowing the data to be shared directly between service providers in more efficient formats than case conferences or other time-intensive forums would produce significant efficiencies.
- **Break down silos**, extending partnership and humility. There was recognition that this is a heavy lift to dismantle the complex structures currently governing each industry truly and that **“the opportunity of this increased engagement of Community Based Organizations [within the Gravity Project purview], is to back into health care the nuance and specificity of social service provider approaches, to allow the two systems to merge.”** - Social Care Co-Design Participant

THE CO-DESIGN PROCESS

This phase of Co-Design included six virtual co-design sessions running two hours each and facilitated by HealthBegins from August through October 2023. Sessions were held two weeks apart, with surveys and homework in between sessions and occasional individual outreach to select participants. Session agendas included presentations by the Gravity Project team and/or participants, small group breakouts, and large group discussions. For the final session, participants identified the pain points they experience in social care - health care partnerships. The Gravity Project then assessed which of those identified points were within Gravity's actionable scope. That refined list was presented back to participants, and they placed them against an impact-urgency matrix as a way to help prioritize the use cases and actions for Gravity's consideration (the complete list of prioritized actions can be found in Appendix B).

HOW GRAVITY PROJECT WILL USE THESE DATA

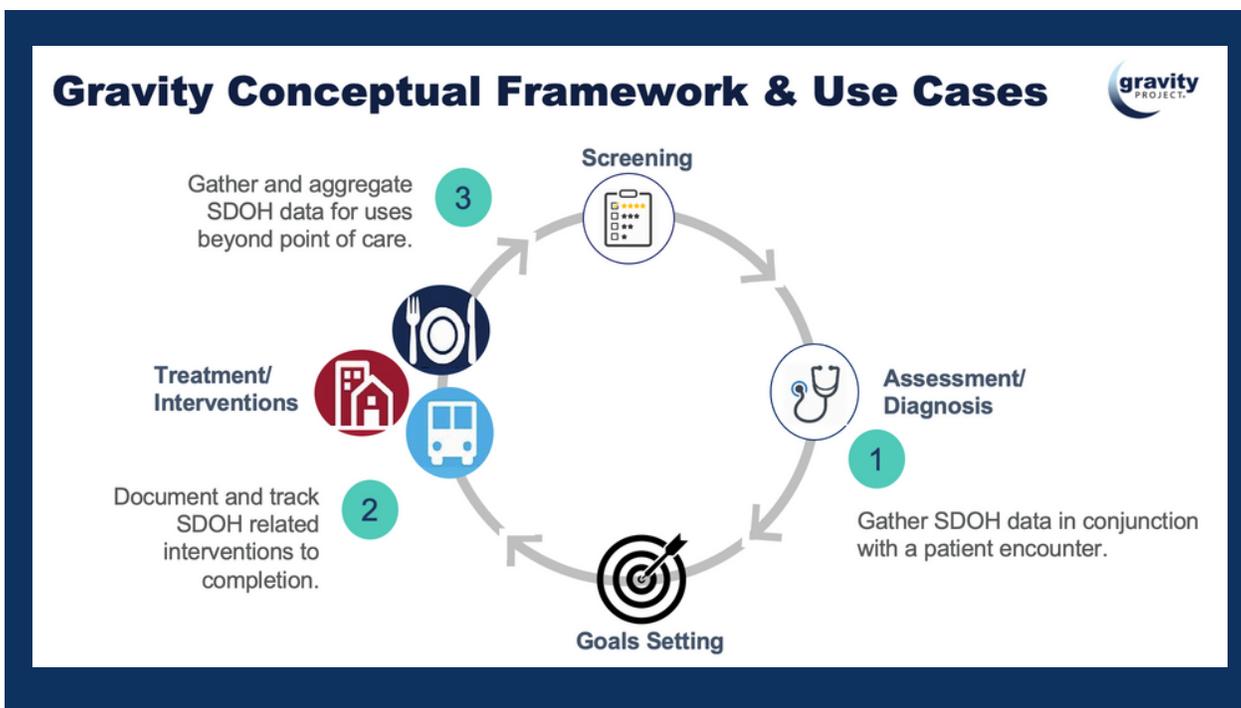
Gravity Project is an HL7® FHIR® Accelerator Project and thus operates within an open multi-stakeholder consensus process. This Co-Design process was catalyzed by recognizing that Gravity was missing the perspective of social care partners and that a focused listening session was required to balance perspectives. As we advance, the learnings from the sessions will be applied for governance and workstream insight. For governance, Gravity Project will work to ensure sufficient representation from social care organizations are selected to be part of its leadership committees by developing intentional, designated roles. On workstream insight, most of the use cases identified within co-design have since been presented to the member leadership committees for assessment and prioritization for future work. Notably, in many instances, the use cases and needs aligned with previously identified gaps, but the co-design experts offered the necessary understanding and detail required to create actionable work plans. As noted in the final co-design sessions, Gravity hopes the same social care experts from the use case activities will return to assist with development.



UPDATED GRAVITY CONCEPTUAL MODEL

Gravity Project has traditionally used the conceptual model below depicting a cycle of activities or use cases: screening, assessment, goal setting, treatment, and interventions. Revising the model was a key driver for the Co-Design process as long-standing Gravity community members perceived the model to be too clinical, and missing critical social care activities and knowledge. The team worked on a revised conceptual model containing all of the use cases that will be discussed in greater detail below, and without the lines and arrows that previously were being interpreted as a linear relationship between use cases that doesn't necessarily exist.

PREVIOUS GRAVITY CONCEPT MODEL



UPDATED CONCEPTUAL FRAMEWORK

The new eight use cases are as follows:

1. Holistic Assessment
2. Acuity Assessment
3. Care Planning
4. Health/Social Care Coordination/Collaboration
5. Eligibility and Capacity
6. Reimbursement and Investment
7. Individual Outcomes Evaluation
8. Population Aggregation Evaluation



PRIORITIZED ACTIONS

Participants also identified and prioritized actions Gravity should take based on pain points they experience with social care - health care partnerships and the urgency and potential impact of the action. In the appendix we provide a summarized listing of these prioritized actions against the corresponding use case. The highest priority needs crossed six of the use cases and included capturing contextual information about a person (including systems or structures of oppression that may be impacting the individual), shared language around acuity, minimizing data required for referral, assignment to the system with the right expertise, distinct data standards for initiation of collaborative care planning and long-term care planning, and reimbursement support.

FROM CO-DESIGN PARTICIPANTS: THE CONTEXT WE WORK WITHIN MATTERS

Participants emphasized that the current context of social care and health care partnerships must evolve to achieve the broader vision of the Gravity Project. Of course, many of the contextual challenges that social care providers described are outside of the Gravity Project's purview; they are not about standards creation or even technology. However, it was consistently and emphatically uplifted that context on partnerships, policy, and funding needed to be captured alongside the more focused comments on standards and data exchange. Below, we document some of the contextual reality and challenges these social care partners are operating within, and some opportunities for Gravity to consider.



“These systems have been so isolated that we will have to rethink how to better fit into the context of health.”

- Social Care Co-Design Participant

CONTEXTUAL 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.

Convolved 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.

Contextual Challenges and Opportunities

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

Challenge: Participants reflected that social care and health care in the US have been maturing independently of each other, which may have led to fundamental differences in the values, beliefs, functions, and vocabulary between sectors. These silos are compounded by a power differential between health and social care that can impede the development of a trusted and functional relationship between the two. One risk of this dynamic is that health care providers may choose to build social care interventions rather than contracting with existing social care organizations, despite the lower relative cost and potential superior service provision of delivering these services through experienced social care organizations. Participants posited that there is significant unlearning and new learning that needs to happen for trusted partnership to flourish.

Social care providers described feeling undervalued relative to Health Care providers ***"we are as valid and as important as other clinicians in the room."*** - ***Social Care Co-Design Participant***

Participant social care participants raised that this practice of undervaluing social care providers then translates into undervaluing the social care *data* that comes from them, jeopardizing the potential impact of data exchange between health care and social care.

Opportunity: Acknowledge and address historical dynamics underlying these partnerships while intentionally working to repair both the power imbalance and the distrust between health care and social care partners. Participants stated that if health care respected the expertise of social care providers, recognized the critical role that social care providers play especially as it pertains to reducing health disparities, and bring the requisite deference, humility, and self-awareness that accompanies that respect and recognition, then better partnerships, and ultimately better alignment on data standards and consistent sharing of data would result. Building trust between partners is paramount because data is only useful if it, and the source they come from, is believed and trusted.

"There is the same level of work being done regardless of the sector we're coming from. So we need mutual respect to really bridge the gap between sectors and make it easier to be able to meet people's needs."

- Social Care Co-Design Participant

Contextual Challenges and Opportunities

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

Challenge: Adequacy of funding as well as numerous funding requirements impact and influence how social care approaches data exchange opportunities.

Participants observed that funding for social care was inadequate to meet community needs. This lack of financial support translates to inadequate workforce, data, and technical expertise to adopt new data standards. Some social care providers still manage client data on paper and will require upfront and ongoing funding to move to a digital approach.

This funding is inadequate not only for social care service provision, but for the needed data infrastructure to support electronic collaboration with health care. This includes things like identity matching, costs of becoming a HIPAA compliant environment, and software platform changes needed to ensure data is specific and reliable.

Further, social care provider activities, priorities, and opportunities for health care partnerships are heavily influenced, if not explicitly dictated, by funding streams and policy governance, which can be disparate and disjointed. Funders for social care providers include philanthropy, health care, state and federal partners, and others. The current financial relationship between social care providers and health care providers can influence the social care provider's capacity to develop infrastructure and processes for data collection and exchange. Some of the participants in the co-design process reported that 80% of their caseload was referred by health care partners while others reported a much smaller percentage.

Funders may drive activities, populations served, data collection, data terminology, consent, information exchange requirements and the terminology around the activities. These variable requirements create data-related burdens due to lack of alignment and duplicative manual entry across funders.

Opportunity: Adequately fund community providers so social care has the capacity to meet community needs which necessitates not only an increase in funding but also changing, loosening or aligning the restrictions around that funding. Funding must account for the cost of infrastructure to support consistent data sharing between partners. Funding can include both in kind and direct funding. One example of in kind funding participants discussed was when health care partners create the infrastructure for partnership such as organizing meetings, sending out communications and enabling access to technology to support the partnership. Direct funding requires understanding the full scope of social care provider activities. Social care providers often engage with community members beyond the role circumscribed by their health care partner. For instance, a health plan might contract with a meals provider to deliver meals for 14 days for their recently discharged members. However, many times, the meal provider, upon delivering meals, may identify additional needs (either through observation and/or conversation with the member/family) and work to connect the client to appropriate resources. The meal delivery scope-of-work does not reimburse for this additional referral activity. Social care providers, due to their mission, commitment, and connection to community members, do their best to ensure that the member has what they need to live with dignity and independently at home in spite of funding limitations.

“[More] funding is needed to move things along and to actually strengthen the overall community... to make our communities healthier and stronger for all of us to benefit.”

- Rev. Krista Forbes

Contextual Challenges and Opportunities

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

Challenge: Social care providers may have project-specific as well as organization-specific requirements, regulations and policies around data collection and sharing. For example, one Area Agency on Aging (AAA) had as many as 25 different platforms and taxonomies dictated by the combination of their state, local authorities, and other funders including health systems. These requirements may include rules around data sharing. AAA and the WIC program both have regulations that impact data sharing. Without policies and resources aligned to streamline infrastructure and reduce barriers to data sharing, there exist serious impediments to social care's success.

Opportunity: Federal and state policy can support social care goals to reduce data complexity and burden. Without policies and resources to address funding, data sharing, responsibility and accountability, there exist serious impediments to social care's success. Here the Gravity Project has influence on policy conversations and can help advocate for social care data standards needs voiced by stakeholders, as seen in their contributions to [The U.S. Playbook to Address Social Determinants of Health](#), released by the White House on November 16, 2023.



Contextual Challenges and Opportunities

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

Challenge: Social care providers often serve families, not individuals. This is crucial for the way social care views and treats their clients, and can be at odds with the way individual data and records are traditionally maintained, shared and navigated within the health care context.

Issues around consent came up frequently in these sessions. Social care providers have to balance the personalized trust that community members have built with them against the utility and efficiency of sharing data with other care providers. Participants were often conflicted, on the one hand oversight entities and regulations may present barriers to sharing that should be relaxed. On the other hand, they wanted community members to be able to exercise greater control of their own data.

The Co-Design participants explored the potential for sharing the minimum necessary data as a way to resolve some barriers to data sharing. Some of the group cautioned that data sets that only include the minimum necessary information could result in a loss of complexity that is necessary for effective health and social care partnerships. For example, a granular example is by simplifying data about “a ride provided by a AAA,” there is potentially insufficient information shared: a ride could mean a car meeting a person in front of a building or an intensive transportation engagement where the AAA staff member enters the clients home, assists them to the vehicle, and from the vehicle to their destination.

Opportunity: Federal and state policy can support social care goals to reduce data complexity and burden. Without policies and resources to address funding, data sharing, responsibility and accountability, there exist serious impediments to social care’s success.

Here the Gravity Project has influence on policy conversations and can help advocate for social care data standards needs voiced by stakeholders, as seen in their contributions to [The U.S. Playbook to Address Social Determinants of Health](#), released by the White House on November 16, 2023.

Contextual Challenges and Opportunities

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

Challenge: Within the current system, responsibilities (the role of each organization and staff member) and accountability (the internal and external mechanisms to ensure responsibilities are fulfilled) are highly variable across care types, across communities and even across individual staff. Attempts to solidify accountability and responsibility are complicated by individual community member preferences for the role each organization and staff member play in their life. In addition, the line between social care and health care is blurring. Health care providers find themselves being required to address social needs without adequate training or support to do so. Similarly, social care providers are often having to assess whether something is a physical health or behavioral health crisis and determine the appropriate response. Some social care providers even go so far as to see themselves as having responsibility for ensuring their served population is able to access and navigate health care, such as in the case of supportive housing providers.

Opportunity: Continuously challenge ourselves to imagine the ways data standards can be supportive of both accountability and responsibility. As one example, “Individual Outcomes Evaluation,” an assessment of the results of an individual’s plan of care, had previously been removed as a named use case, but through this Co-Design process, was re-introduced as a meaningful way to support accountability both structurally as well as to the individual being served. In addition to national efforts, local processes like journey maps could help communities represent their unique collaboration and flow.

INSIGHTS, OPPORTUNITIES, AND CHALLENGES BY USE CASE

Here, we summarize each use case's insights, opportunities, and challenges. For readability and clarity, each use case is described in generally the same way the Gravity Project team provided context to participants.

Nearing the conclusion of the sessions, participants submitted their primary pain points in social care and health care partnerships. From that aggregated list, the Gravity team identified which pain points might have Gravity Project solutions. The participants used that list in the final session to map its level of urgency and level of impact on their work. That mapping resulted in three categories of the highest priority items: (1) those that the Gravity Project should tackle immediately, (2) those that the Gravity Project should “do next,” and (3) those that could be addressed if there is time. Use cases without a priority indicated were either not prioritized for Gravity action or may be prioritized outside of Gravity.

Next to use cases, we have indicated where participants had prioritized activities for the Gravity Project with the following icons:



Highest Priority: “Do it now”



Secondary Priority: “Do it next”



Lowest Priority: “Do it if/when there is time”



CROSS-CUTTING MULTIPLE USE CASES

When participants named and prioritized their pain points in social care-health care partnerships, there was one theme that cut across multiple use cases: the need for tracking systems and structures of oppression (including community-specific factors influencing the presentation of need in an individual). Participants noted that one of the inherent flaws in health care data systems, and as a result, in the Gravity coding process, is that it links attributes only to individuals (needs and interventions) and so it doesn't necessarily provide the data structure to acknowledge and track community-level factors such as incidences of hate crime, the presence of explicit or implicit racism, and the lack of living wages or a low minimum wage.

Another noted flaw with tracking is that the vocabulary itself can be problematic, for example, clients whose primary access point to the broader health system is through a social care partner are not, by definition, patients. However, “patient” is the term that is used to identify these individuals, which misrepresents their relationship to the health system. The participants encouraged the Gravity team to continue to consider how to create data language and infrastructure that supports a broader lens on need and systemic solutions.

SCREENING USE CASE

Screening is a population-level activity to identify unmet social needs. When this function is performed in health care settings, a person who screens positive for a need may be referred to a social care provider for a specific intervention, a social risk assessment, or a holistic assessment. Co-Design participants emphasized that a person who screens positive for a need should ideally receive a further assessment. Many individuals have more than one need and /or may benefit from multiple interventions. Screening is conducted in several different ways (verbally, in paper form, electronically, etc.), can cover a wide range of domains, requires a highly variable amount of time, and is administered by staff with a range of knowledge and skills around social needs. Participants noted that screening is not necessary for individuals to receive social need-related interventions. To reflect this, the revised model moved screening up to the population/community level activities.

OPPORTUNITY

The participants identified that the core opportunity for improvement in screening is **reducing duplication of effort** for both care teams and patients. This duplication includes:

- Repeating the exact same screening within or across organizations (within a short timeframe) because the screening results are not shared or shareable between organizations
- Failing to send adequate or complete referral information, which requires the receiving social care provider to rescreen
- Referring to social care services for which the person is not eligible. When screening happens without an eligibility assessment, the person may get inappropriately referred to a program for which they are not eligible. This requires an assessment around eligibility (often necessitating referring to another organization and requiring the person to re-share basic information). Participants caveated this with the observation that some eligibility assessments require expertise in social care interventions and may not be able to be performed within health care settings.



While Gravity Project has developed significant terminology around screening, there may be opportunities outside of Gravity to continue to explore how those terminologies support (or fail to support) reduction in duplication.

SOCIAL RISK ASSESSMENT USE CASE

Social Risk Assessment was the only use case highlighted in the original conceptual framework. Participants recommended that this use case be distinguished from a Holistic Assessment and an Acuity Assessment. Now their use cases are listed below. Participants described this use case as evaluating one presenting need rather than a full holistic assessment. Social Risk Assessment requires a more person-centered interview around the specific need. This process is the social needs parallel to “diagnosing,” a need to understand better the necessary details for a care plan or intervention. Participants also noted that this process is often iterative and may occur at a cadence and frequency dependent on the client’s presenting need.

OPPORTUNITY

The primary opportunity in this use case concerns the standardization of domains and data collected in the assessment. In some cases, the social sector has a standardized process for this assessment or there may be local standards. Federal programs, such as WIC, also have a standardized assessment process. The Gravity Project has an opportunity to map to the terms already used in these standardized assessments. Gravity standardization may enable social care providers without standardized assessments and standardized terminology, such as some care coordination entities, to engage in health care more effectively. Outside of Gravity's scope, a related point is that some Co-Design participants felt strongly that this assessment required a “social care expert,” ideally a person housed in a social care organization. Sometimes, this person may have specific licensure, like a licensed social worker. Funders may define the requirements for this role.



Gravity project originally had one assessment use case (see, Social Risk Assessment, above). The Co-Design participants identified a distinction between a Social Risk Assessment (assessing one social need in depth) and a Holistic Assessment. Both types of assessment are iterative, administered by a person with skill, and performed by both individuals with professional expertise and lived expertise. In discussing the opportunity for a new Holistic Assessment use case, participants articulated that holistic assessment is a robust, comprehensive assessment of social, physical, emotional, and ecosystem context to identify risks, needs, strengths, and supports toward the aim of establishing priorities and goals. It was a way to assess and build trust and a relationship with the client. Unlike the social needs assessment, it typically focuses on the whole person rather than a discrete need. Participants also noted that this process is often iterative and may occur at a cadence and frequency dependent on the client's presenting need.



OPPORTUNITY

Participants prioritized the inclusion of assessment of ecosystem/context (such as things like whether a person lives in a food desert) as an actionable priority for Gravity standards solutioning. The co-design participants noted that holistic assessments may include both assessments needed to address a temporary or emergency need and assessments for long-term supports and care. For example, a person may be placed in temporary housing with the goal of long-term supportive housing. During the period of waiting for permanent housing, multiple assessments and interventions may be offered/required. For example, some social care providers may offer a hotel to a person waiting for alternative short-term housing and may do multiple reassessments in the time leading up to finding a more permanent solution.

ACUITY ASSESSMENT USE CASE



The participants discussed a need for a shared language around urgency or acuity for both receiving referrals from health care and sending referrals to health care.



OPPORTUNITY

In both cases, a trusted terminology around acuity would allow for an appropriate speed of response. This is uniquely important in social care, where capacity may impact how quickly a community member receives the needed service. For example, the Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPIDAT) has historically driven prioritization processes for limited housing resources. One AAA described using a self-sufficiency matrix tool, which rated each need on a scale of 1 (most acute) to 5 (no present need). One of the challenges for standardizing acuity is that what might be a crisis to one family may not be a crisis to another.

INTERVENTION REFERRAL USE CASE

The Co-Design participants discussed the process of intervention referral as directing someone to needed services after those needs have been identified. Participants described the significant gap between referral and connection to care. The gap between referral and connection to care can be tracked and improved through a process often referred to as “closing the loop” where the referring entity seeks to follow-up and assess whether the connection was made. Participants also noted that closing the loop can mean different things to different organizations and funders which will impact payments and processes. In addition, the Co-Design participants discussed the role of intervention referral as it pertains to empowering individuals to navigate themselves when desired and appropriate. For example, in TogetherNow’s “MyWayfinder” people can do their own self assessment, and self-referrals. In this model, people can see who is on their care team, where they have been referred, refer themselves if that’s available, and see where they have program enrollments. The intervention referral use case may be an ideal opportunity to give a member control of their own data and care plan. Participants noted that this original use case did not include the subtlety needed to capture the Eligibility and Capacity use case and Reimbursement and Investment use case.

INTERVENTION REFERRAL USE CASE (Cont.)

OPPORTUNITIES

The co-design participants identified several areas for potential improvement, all of which would result in efficiencies for community members and social care providers:

 **Referral appropriateness:** Both social care providers and health care organizations could better assess the appropriateness of referrals. Many health care-based social needs screening workflows provide patients with lists of all available resources without any preceding eligibility screen or assessment to determine the best or most appropriate referral. Participants noted that providing community members the best referrals rather than all referrals may be an important strategy to ensure members don't become overwhelmed or defeated by their level of need and the number of potential resources they need to assess. Laura Gustin, TogetherNow, noted that in her experience, **“Most individuals can't handle more than 2 to 3 referrals at one time.”** However, the group discussed and recognized that many people with social needs have a constellation of social needs that must be addressed in concert. Co-Design participants emphasized the unique expertise of comprehensive social care providers, such as AAAs in making efficient and effective intervention referrals.

 **Timeliness and completeness of referral:** Social care providers reported that they often need more information about why the referral was provided, other referrals already provided to the client, and reliable client contact information impacting successful follow-up. Some social care providers are receiving referrals through fax or delayed processes. In addition, Co-Design participants communicated a need for more clarity on what information can and should be shared.

 **Streamline referrals:** Some participants reported a need to streamline the amount of data needed at the point of referral to reduce administrative burden.

 **Duplication of referrals:** Sometimes, clients receive multiple referrals to the same place.

 **Closing the loop:** Participants described a need to be able to close the loop (assess whether a person connected and engaged successfully with an organization to which they were referred).

Electronic infrastructure investments: The co-design participants noted the significant cost of electronic infrastructure to support referrals (both in terms of the software/technology and the time). They also discussed the potential for this kind of electronic infrastructure to support better closing the loop.

INTERVENTION: COORDINATION & PROVISION USE CASE

Some social service providers lead coordination across a multi-sector team while others focus on the provision of a particular service. The participants stated that inherent in coordination is collaboration. There was not much discussion on this use case and no specific opportunities were uplifted at this time.



Before the Co-Design Process, the Gravity Project had terminology on “evaluation of eligibility for.” The Gravity Project team reflected on learnings from early conversations that establishing eligibility has varying degrees of complexity for health care partners, from programs where eligibility can be established in clinical settings to eligibility that can only be established within social care settings and program expertise. Participants discussed the need to include the process of recertification required by programs like the Supplemental Nutrition Assistance Program (SNAP) and WIC to maintain eligibility as part of the eligibility use case.

Participants described two types of eligibility:

- 1 Intervention Eligibility** (which might be linked to z-codes or diagnoses) means that someone could benefit from the service. For example, a person with severe and persistent mental illness may meet the social care provider’s intervention eligibility for supportive housing.
- 2 Service/program-specific eligibility** is whether or not a person meets the criteria for the available service. Factors like age, income, criminal justice involvement, or history may make a person ineligible for a service even though the intervention is appropriate for their need. The Co-Designers noted that the biggest barrier to service eligibility is capacity. Some social care providers may have delays in outreach or engagement. In contrast, some social care providers, such as housing, manage prioritization processes by using assessment information to determine how quickly a person will receive a service.

OPPORTUNITIES

In addition to the opportunities inherent in the definitions (clarity between intervention and service eligibility and the distinction between capacity and prioritization), participants noted the following:

- **Eligibility terminology:** As noted in the definition, the opportunity for terminology includes intervention eligibility, service eligibility, enrollment, and recertification.
 - **Collaboration and coordination:** WIC has a unique coordination issue around recertification. Under current federal waivers, WIC programs can complete recertification processes virtually if they collect key clinical measurement data within 60 days of the WIC appointment.



Inclusion of logistical details: Participants noted that eligibility and capacity data standards must capture critical logistical coordination details such as WIC timeframe requirements to maintain active program participation.

- **Eligibility criteria alignment across social care services:** Many social resources have different eligibility criteria and processes. Alignment would significantly improve access to care and could reduce duplication of data needed for eligibility. The group acknowledged that this alignment would be immensely challenging given that many stakeholders would need to be involved and committed and that it may require significant changes for many entities, including changing federal policy.

OPPORTUNITIES (Cont.)

Prioritization of population in need: Prioritization of waiting lists presents a unique opportunity for communication and coordination across the health care and social sectors in that sharing of information might provide more complete and accurate information to ensure that individuals with critical needs get served first and to address inequities in these processes.

SHARED CARE PLANNING USE CASE



Participants defined shared care planning. Some of the unique aspects of their definitions were:

- Should reflect **community and individual needs and strategies**. For example, transportation may be both an individual need and a result of community bussing challenges.
- Some participants described that **social care providers who provide whole-person support often lead shared care planning teams**. Participants noted that most social care providers are single-issue and may not provide shared care planning support.
- **Social care plans are dynamic** and will change based on input from the entire care team, especially from the community members, who should have overall control. Shared care plans require constant re-evaluation.



“Gravity can advocate around sharing of care, not just sharing of data.”

- Courtney Baldrige

Participants asked that the Gravity Project think about the sharing of care as a critical part of the sharing of data. Sharing of care means that health care providers understand the role that social care providers play and develop partnership structures to allow both health and social sector partners to deliver effective care. As an example, the proposed physician fee rule and inpatient hospital rule require social needs screening but do not require the sharing of care (or have the funding or policy support for that sharing of care). Often, these health care-based social needs screenings workflows identify specific social needs and result in single issue referrals. This process does not take into account the critical role of care coordination organizations like AAAs who provide whole person assessment and develop robust long-term care plans. These whole person social care providers are critical to not just addressing short-term crises but addressing long-term underlying issues contributing to ongoing social needs and episodic crises.

OPPORTUNITIES

Participants reported that shared care planning happens most frequently between two social care partners (see Appendix D for examples of what data is exchanged in shared care planning). Looking at how these partnerships function could be a template for how health care-to-social care partnerships could function. Participants noted that there are two types of shared care planning: initiation of short-term care planning and long-term care planning:



Initiation of a shared care plan and short-term shared care planning: Participants noted that even for short-term shared care planning, more health information may improve the quality of the care plan. For example, if a person has diabetes, that may impact the food insecurity options that are ideal for that person.

- **Long-term shared care planning:** The current Gravity Project supports initiating collaborative care planning and simple data sharing. There is an opportunity for the Gravity Project to develop terminology specific to the ongoing and intensive close collaboration required for some community members. This would be especially important for community members with multiple case managers and unique goals in many systems.

HEALTH/SOCIAL COLLABORATION AND COORDINATION USE CASE



Health and social care collaboration and coordination is when the social and health needs are so interconnected that the community member requires a care plan that encompasses health care needs and social needs that are echoed by both health care and social care providers. This use case is a parent use case spawned from multiple use cases within the co-design sessions. Two examples of this use case are WIC and supportive housing. Within the WIC program, participants may have a care plan that includes components around things like diet and health behaviors that should ideally be mimicked in the clinic care plan. The supportive housing provider may deliver the behavioral health and substance use care plan within supportive housing. Typically, this use case requires the ongoing sharing of specific clinical data and a clinical care plan that may mirror or repeat components of the social care plan and vice versa.



The focus of the reimbursement and investment conversation in the Co-Design process was health care reimbursement of social care activities. Participants emphasized the importance of these reimbursement and investment-related data standards. Participants of the Co-Design process discussed that one of the primary challenges with reimbursement may be that a lot of the accounting for care challenges are rooted in restricting reimbursement for social services rather than creating clear and simple pathways for reimbursement. Many of the participants discussed the need to ensure equitable and sufficient reimbursement for social care services without additional administrative burden.

OPPORTUNITIES

- **High administrative burden:** Participants noted that there is a high administrative burden for social care to contract with health care providers for the following reasons:
- **Variation between payers:** Each managed care organization (MCO) may require its own protocols and workflows. For example, 211 in California has contracts with several MCOs, each with different intake surveys. This variation makes efficiency challenging. Some social care providers expressed that they are starting to communicate to payers that they have a standardized approach they will follow.
- **Mandated use of payer documentation systems:** Payers frequently require that documentation occur in their own portal, which becomes increasingly burdensome as social service providers contract with multiple payers.
- **Health-related social needs:** Medicaid programs often require that Medicaid reimbursement be tied to “health-related social needs.” Some participants struggle to distinguish between health-related and non-health-related social needs.



CASE STUDIES

People Assisting the Homeless (PATH): PATH is contracted with seven health plans (which will convert to four in 2024) to provide Community Supports under Medi-Cal, California’s Medicaid program. Data issues related to billing are a significant barrier to successful delivery. Examples of issues include the client not being enrolled in that plan or the authorization documentation is incomplete. This results in significant exchanges between the plan and PATH—which is both administratively burdensome and costly. In addition, clients often do not know that their plan or Medicaid enrollment has changed. They also may have worked with plan staff but unsure who or how to reach them. Finally, when clients switch plans, the PATH team has to obtain new authorization forms.

Area Agency on Aging: AAAs receive core funding through federal appropriations and have contracts with hospitals and MCOs. Payment structures are different from contract to contract. Even within one organization, different lines of business may have different portals, systems, and requirements. Some reimbursements are Per Member Per Month and some are tied to complete assessments. Others (such as adult protective services) are tied to expense reimbursements. Some AAAs are set up as Medicare or Medicaid providers, have their own billing IDs, are accredited by the National Committee for Quality Assurance, and bill through as health care providers. Others have contracts or memorandum of understandings focused on care transitions, medication management, and hospital contracts. Services can have a wide range of resource use and intensity

Community Servings: Community Servings is contracted with 10 Medicaid Accountable Care Organizations through a Medicaid 1115 waiver. Community Servings also works with four MCOs, three home hospital programs, two Medicare Advantage plans, commercial carriers, and a provider network, and two community health centers. Individuals switching plans after a referral is made is a challenge. One promising solution is that Massachusetts Medicaid has a 90-day grace period so that if someone leaves a plan without Community Servings will still be reimbursed for 90 days. Another challenge that Community Servings faces around reimbursement is that authorizations from plans don’t always match what they deliver. For example, the plan might authorize seven meals a week but Community Servings only delivers in increments of 10 meals.

INDIVIDUAL OUTCOMES EVALUATION USE CASE



Individual Outcomes Evaluation is an assessment of the results of an individual's plan of care. Individual outcomes are critical for continuous quality improvement and developing the evidence necessary to calculate return on investment. This evidence base is critical to securing sustainable funding streams.



OPPORTUNITIES

Participants described a need for the ability to track outcomes for individuals served including tracking over time to see if the intervention had a long-term impact on self-sufficiency or if the person requires the same support and interventions year-over-year. In addition, participants want to track across multiple systems to evaluate system performance and return on investment linked to individual clients. Metrics to track this would need to include not only outcomes on the patient's side but key metrics on resources allocated such as the number of care coordinators supporting that person across the system.

POPULATION-LEVEL OUTCOMES USE CASE



This use case aggregates social care data to better understand community-level trends and outcomes.

OPPORTUNITIES

Co-Design participants discussed that by creating mechanisms for identifying structural and systemic forces impacting individuals and changes in those systemic forces, health and social care providers could have information and technology infrastructure to support systemic change. This structure is necessary because none of the current taxonomies have a method to capture how changes in bus lines, racism, redlining, food deserts, and other community-level factors are impacting the health of individuals and to measure and drive positive changes in these systems.

CONCLUSION

An Invitation from Gravity Project

The rich discussion and wisdom of the Social Care Co-Design participants led to valuable insights and actionable recommendations for Gravity Project. Additionally, there are many activities that participants are interested in, such as adequate payment of social care providers or consent policies and procedures, that fall outside the direct purview of the Gravity Project's influence. Recognizing that there is power in advocacy and consensus, the Gravity Project hopes that all social care providers will welcome the invitation to be engaged by assessing how Gravity social care data standards may serve their work, continuing to participate in Gravity convenings, and collaborating with Gravity. There remain opportunities beyond the conclusion of this specific Co-Design process to use collective voice to improve Gravity standards and achieve broader goals. If you are interested in remaining engaged with the Gravity Project, please join the Gravity Project community by visiting:

<https://confluence.hl7.org/display/GRAV/Join+the+Gravity+Project+Community>.

Funder Acknowledgement

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Partner Acknowledgement

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APPENDIX A: Co-Design Participants and Project Team

Organization	Name	Grassroots vs. National Perspective	Area of Expertise
211 San Diego	Alana Kalinowski	Grassroots - San Diego, California	Community Referral Network
Administration for Children and Families	Ken Salyard	National	Human Services
Area Agency on Aging (AAA)	Courtney Baldrige	National	Area Agencies on Aging
Community Action Agency - Association of Community Action Agencies	Amanda Shelton	Grassroots - Texas	Community Action Agency
Community Servings	Jean Terranova	Grassroots - Massachusetts	Food
Concho Valley Community Action Agency	Mike Burnett	Grassroots - West Texas	Community Action Agency
Everyone Home DC	Abby Sypek	Grassroots - Washington, DC	Housing
Feeding America	Jerry Jones	National	Food
Greater Flint Health Coalition	Janée Tyus	Grassroots - Flint, Michigan	Social Care Coordination
National Alliance to End Homelessness	Joy Moses	National	Housing
National WIC Association	Christina Chauvenet	National	WIC
Ohio District 5 AAA	Duana Patton	Grassroots - Ohio	Area Agencies on Aging

Organization	Name	Grassroots vs. National Perspective	Area of Expertise
Partners in Care Foundation	Ester Sefilyan	Grassroots - California	Care Coordination
People Assisting the Homeless (PATH)	Hanan Scrapper	Grassroots - California	Housing
St. John Baptist Church	Krista Forbes	Grassroots - Maryland	Faith-based Organization
TogetherNow	Laura Gustin	Grassroots - Fingerlakes/Rochester Region, New York	Care Coordination
WIC Program, Vermont Department of Health	Karen Flynn	Grassroots - Vermont	WIC
WIC Program, Vermont Department of Health	Amy Malinowski	Grassroots - Vermont	WIC

Gravity Project, Civitas Networks for Health, and HealthBegins Project Team

Name	Organization
Jessica Little	Civitas Networks for Health
Demri Henderson	Civitas Networks for Health
Heidi Penix	Civitas Networks for Health
Mwikali Kamami	Civitas Networks for Health
Sarah DeSilvey	Gravity Project
Corey Smith	Gravity Project, American Medical Association
Mike Klinkman	Gravity Project, Michigan Health Information Network Shared Services (MiHIN)
Vanessa Candelora	Gravity Project, Point-of-Care Partners
Kathryn Jantz	HealthBegins
Rishi Manchanda	HealthBegins
Sadena Thevarajah	HealthBegins

APPENDIX B: Prioritized Actions

Highest Priority: “Do it now”

These actions present the highest urgency of need and potential for impact.

Holistic Assessment Use Case

- Need to capture assessment of the ecosystem/context, including social supports, strengths, and community factors (such as systemic racism) impacting the individual.

Acuity Assessment Use Case

- Need shared language around acuity/level of crisis.

Care Planning Use Case

- Data standards are needed for initiating collaborative care planning, simple data sharing, AND ongoing and intensive close collaboration across many systems.

Health/Social Collaboration and Coordination Use Case

- Integrated clinical and social care for care that requires clinical collaboration.

Intervention Referral Use Case

- Need to be able to assign to system/provider with the right expertise.
- Need to streamline the amount of data needed at the point of referral.

Reimbursement and Investment Use Case

- Needs to support reimbursement between CBOs and health care contracts, including assessment/referral and payment for actual services.

Across Multiple Use Cases

- Tracking systems and structures of oppression (incl. community-specific factors influencing the presentation of need in an individual).

Secondary Priority: “Do it next”

These actions present a high urgency of need and/or potential for impact.

Intervention Referral Use Case

- Needs to accommodate duplicate referrals provided to the same organization or for the same service.
- Need to be able to close the loop (assess whether a person connected and engaged successfully with an organization to which they were referred).
- Needs more standardization and clarity on what information should be shared for a referral.

Eligibility & Capacity Use Case

- Needs to incorporate logistical coordination details (i.e., WIC timeframe requirements to maintain active program participation).

Lowest Priority: “Do it if/when there is time.”

These actions are of value but have relatively lower urgency of need and/or potential for impact.

Individual Outcomes Evaluation Use Case

- Need the ability to track across sectors to look at overall system performance and ROI.
- Need to understand how intervention influences individual and family self-sufficiency over time.

APPENDIX C: Screening Data Exchange

Screening data fields the Co-Design participants wanted to send to health care and to receive from health care.

Examples of Desired Screening Data Elements to be Shared Between Health Care and Social Care Providers		
Examples of Data <i>from</i> Health Care		Examples of Data <i>to</i> Health Care
Last Name First Name Gender Date of Birth Home Contact Cell Contact Emergency Contact Name, Number, Relationship Home Address (Street, City, State, Zip) Primary Insurance Secondary Insurance Primary and/or Secondary Insurance Number Primary Care Provider Name and Contact Diagnosis Date of Diagnosis Medications ER Visits Pharmacy (where medications are sent) Reason For Referral/Service Requested (including social risk screening completed) Any Outcome Data From Services Provided As Part Of Our Partnership ICD Codes, if applicable	Patient Class (Inpatient, Emergency) Admit Date Admit Time Hospital Discharge Date Name of Discharge Facility Readmission Data Length of Stay Medical Record Number Hospital social worker name Hospital social worker contact	Outreach dates and outcomes Home visit dates and outcomes Assessment dates and outcomes Assessment data (e.g., needs identified) Care coordination data (gaps identified from assessment and what we did to close those gaps) Services provided Medication report Any outcome data Additional demographic data identified Name of social care provider primary point of contact Contact information for social care provider primary point of contact Unmet needs Missed episodes of service Environmental risks (hoarding, unsafe homes) Observed changes in health status

APPENDIX D: Shared Care Planning Data Exchange

As part of the homework for session 4 of the Co-Design process, participants were asked to respond to the following question “What information is necessary for longitudinal care planning?” in advance of the meeting. Some of the data elements that participants noted that were unique to shared care planning were the following:

- Individual’s preferences, personal goals, and informal support systems (such as family members).
- Roles and responsibilities of everyone involved in the person’s care. Ideally with Specific, Measureable, Achievable, Relevant and Time-Bound Goals attached to each person. This includes medical providers, hospital/health care social workers, mental health providers, housing case managers, legal providers, and any other supportive roles. A process for moving forward collaboratively so that if one person on a care team can’t address an issue another one can.
- Community context including:
 - Comparative study of SDOH and shifts of impact over time—income shifts in an area, recreational outcomes, shifts in education access, impact of faith organizations over time, etc.
 - Lifestyle—rural vs. urban; active (physically) vs sedentary; family dynamic; social activity access
 - Food desert/swamp areas vs. food oasis areas over time—any shifts?
 - Municipality development plans addressing mid-range income needs for housing, food, pharmacy, and transportation expansion in needed areas
 - Environmental trends for the area involving such things as water and soil compliance measures and long-term impacts on a community
- WIC-specific data elements: Anthropometric and blood iron data at various time points, consents in place, referrals made, accepted, and declined, documentation of communications between service providers and individual/family, and between service providers to each other.