



Data Analytics: Social Determinants of Health

June 17, 2020



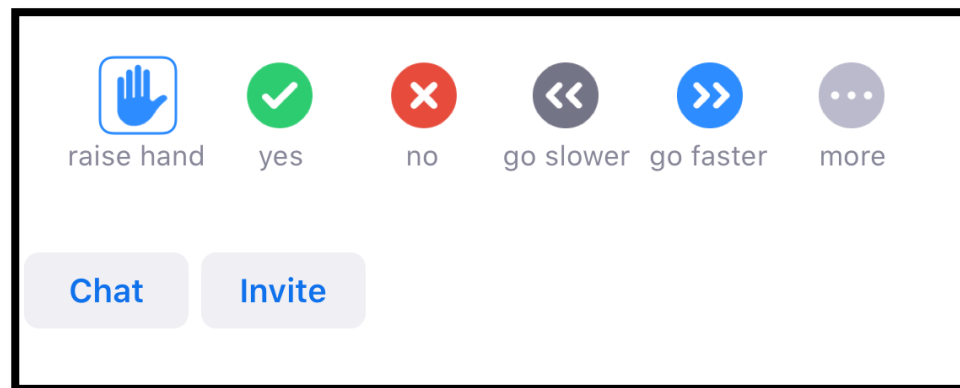
Agenda

- Welcome and Introductions
 - Claudia Ellison, Director of Programs and Services, eHI
- Overview of Today's Topic
 - Al Kinel, President, Strategic Interests, LLC
- Discussion:
 - Marc Rabner, MD, MPH, Director, Clinical Applications, CRISP
 - Laura Gustin, Director, Monroe County Systems Integration Project
 - Jill Eisenstein, CEO & President, Rochester RHIO
- Next Steps



Housekeeping

- **All participants are muted**



- Use the **raise hand** feature if you have a question
- We will then unmute you Mark Muthig <mmuthig@strategicinterests.com>; Brett Kinsler <bkinsler@strategicinterests.com> so you can ask your question directly
- Use the chat box is for *technical difficulties* and other questions / comments

Presentation slides are in the eHI resource Center
<https://www.ehidc.org/resources>

Workgroup Goals

- This workgroup will identify and share best practices to access and utilize information and analytics to improve care, lower costs, and enhance the care experience.
- Prior Year's Scope:
 - **Traditional Sources and Uses** of Data Enabled by Interoperability:
 - Transitions of Care
 - Analytics
 - Clinical and Claims Data
 - **Non-Traditional Sources and Uses** of Data:
 - Genetic Data
 - Social Determinants of Data
 - Diagnostic Imaging
 - Wearables & Patient Generated Health Data
 - Patient Reported Outcomes

2020 Workgroup Goals

- This workgroup will identify and share best practices to access and utilize SDOH data into a plan of care and interventions for individuals and communities.
- Topics to cover include:
 - Role of HIEs in SDOH data exchange
 - Categories of Data and Coding Schemes
 - Role of Telehealth, Remote Monitoring, and Patient Reported Data
 - How collaboratives align stakeholders to capture and utilize SDOH
 - IF WE HAVE TIME: Policy and operational issues surrounding surveillance and behavior





CRISP

CRISP Approach to Social Determinants of Health

Marc Rabner, MD, MPH

Clinical Advisor

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Regional SDOH Drivers (in healthcare)

Maryland Total Cost of Care Model

- CMS waiver with Maryland
- Builds upon All-Payer Model
 - Hospital global budgets
 - Incentives for care coordination and provide patient-centered care (inpatient and outpatient)

Stakeholder Innovation

- MD Medicaid
- Maryland Primary Care Program (MDPCP)
- Accountable Health Communities grant
- Maternal Opioid Misuse grant
- CoRIE (DC)

Reaction to Emerging Data Silos

SCORE
BE A CHAMPION OF
COMMUNITY SUPPORT
FOR OUR PATIENTS



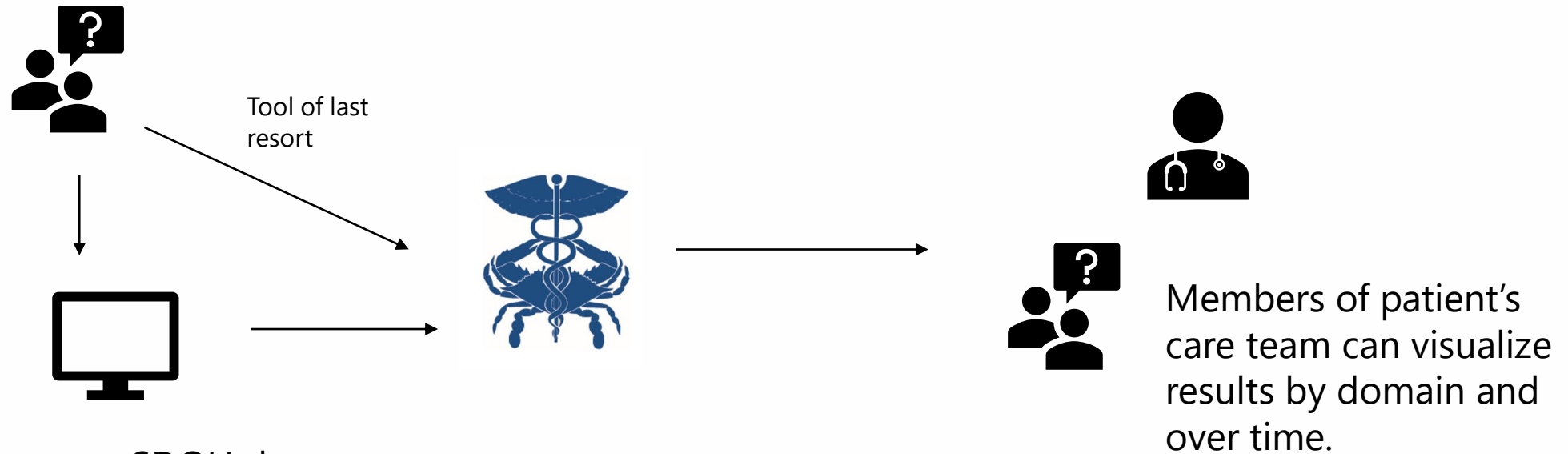


Screen

1. Partner with stakeholders to capture social needs screening results where they are happening
 - Integrations with IT & SDOH systems.
 - Map results into FHIR enabled database.
 - Pilot phase - identifying additional data sources.
2. Enable a patient's care team to easily visualize the results of prior social needs screening over time within CRISP.
 - Collapse results into social domains.
 - Show presence/absence of social need.
 - Visualize results over time.
3. Provide a tool of last resort for medical professionals to screen for social needs within CRISP.



Screen



SDOH data sources

- Hospitals
- MCOs
- Ambulatory practices
- FQHCs

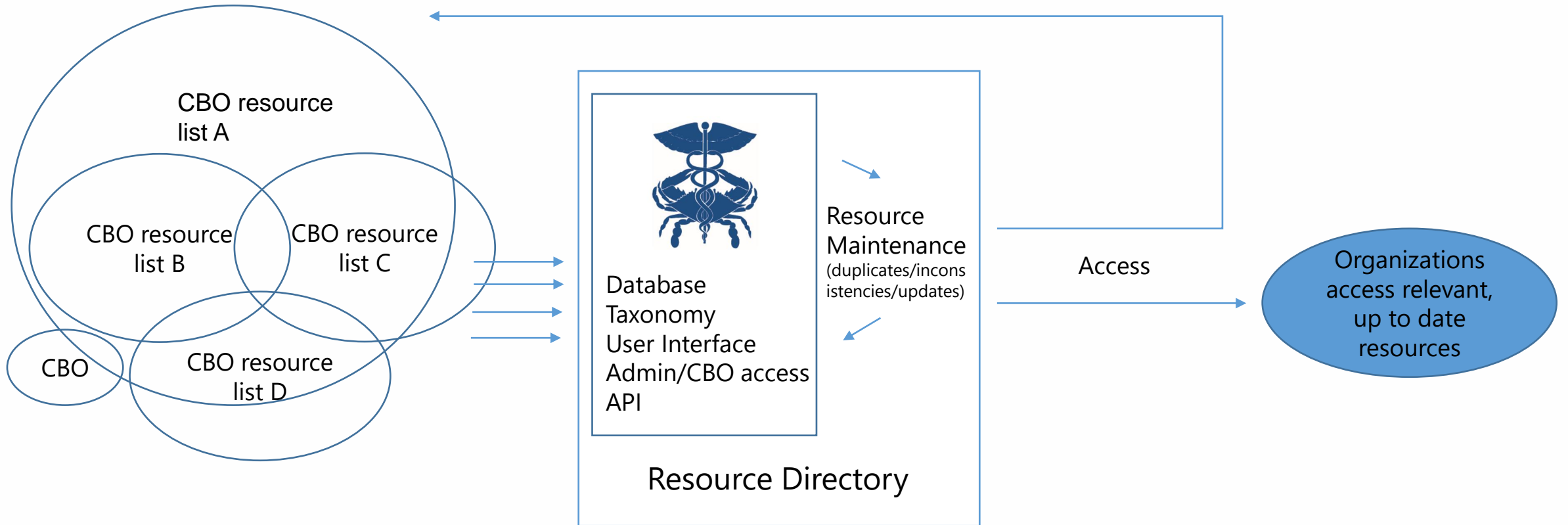


Choose (Resource Directory)

1. Host and support maintenance of a single, accurate resource directory with broad access to external systems.
 - Collate and share resources via API.
 - Integrate with EHRs and 3rd party systems.
 - Work with 3rd party to maintain resources.
2. Enable resource directory users to identify the most appropriate community based organization, based on social need and patient context.
 - Incorporate taxonomy.
 - Map to social needs.



Choose





Offer (Consent)

1. Empower medical professionals to offer relevant community resources to their patients.
2. Support the patient as s/he provides consent to the desired plan of care and data sharing.
 - Initially focused on substance use disorder consent, but extensible to other use cases and data types.
 - CRISP convening other HIEs for discussion about reusable technology.



Refer

Medical Professionals

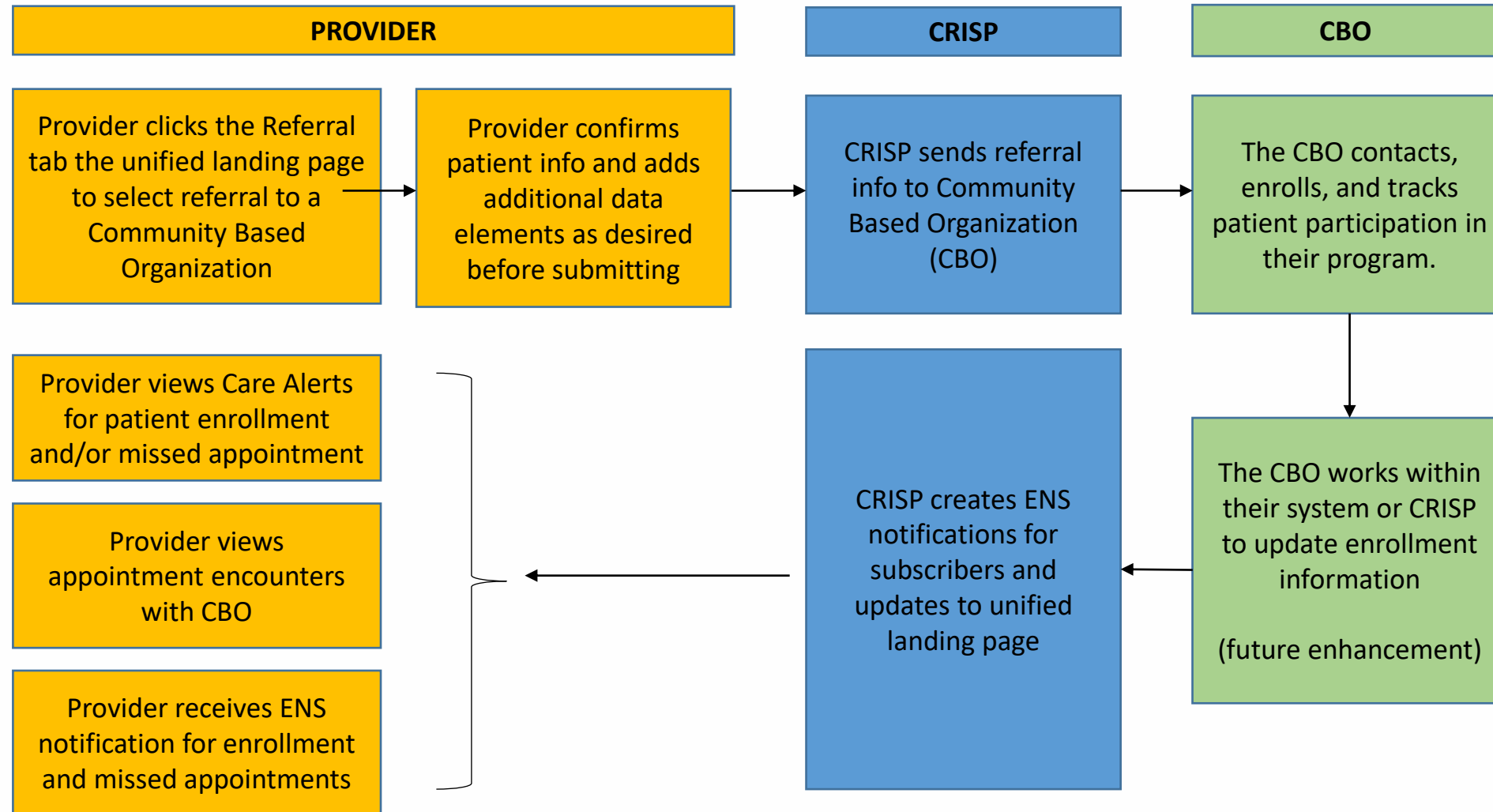
1. Send referrals from EHRs, care management platforms, or 3rd party SDOH vendors to capture referrals where they are happening.
2. Send referrals directly from basic CRISP tool.
3. Direct referrals to participating community-based organizations through CRISP.
4. Allow a patient's care team view the status and outcome of all referrals.

Community Based Organizations (CBOs)

1. Support CBOs ability to easily and quickly receive referrals and communicate the status of referrals with the referring healthcare professional.
2. Allow CBOs to use native tools for managing referrals and provide a basic tool for those unable to integrate.
 - Integration directly with CBO care management platforms.



Refer





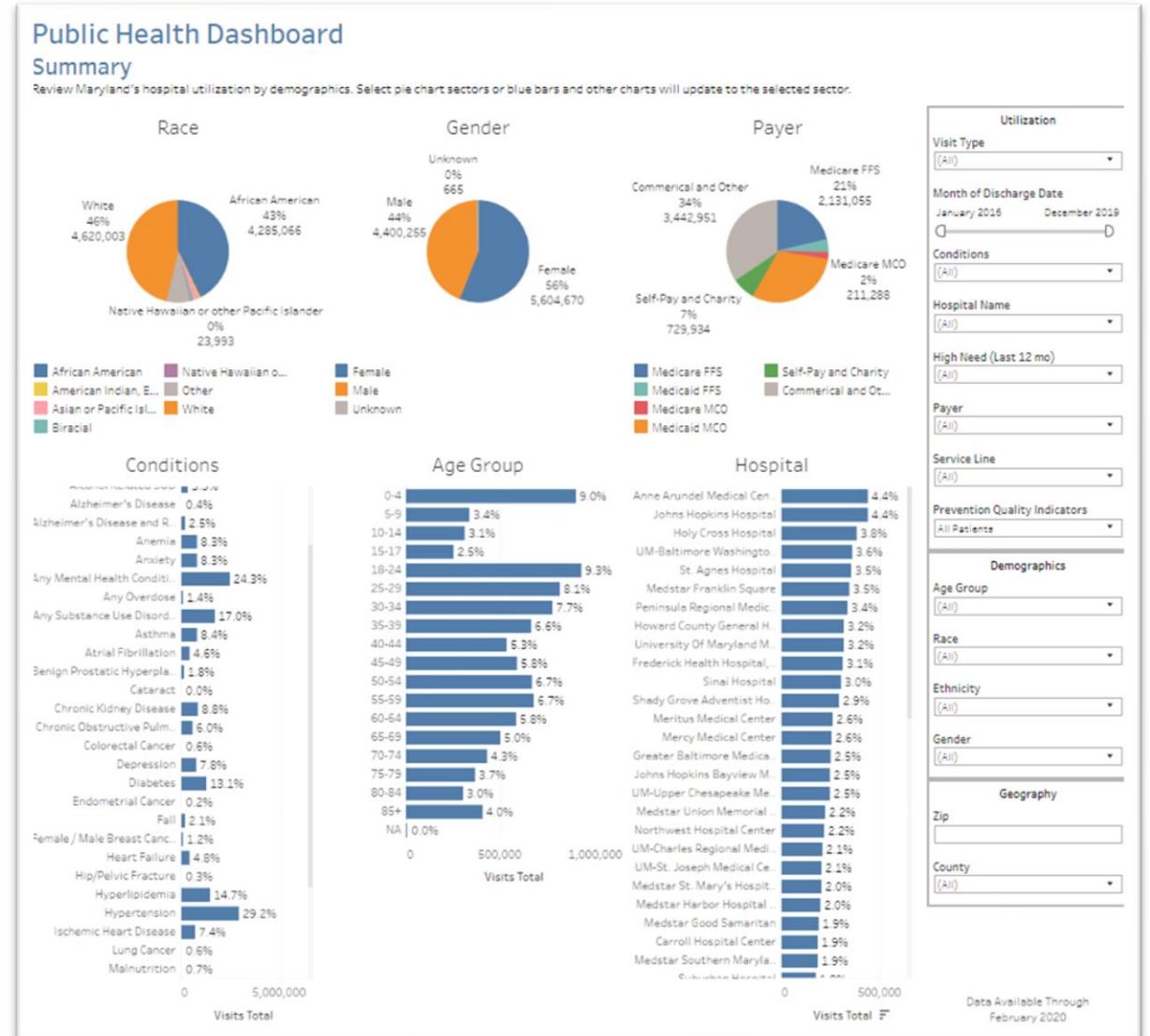
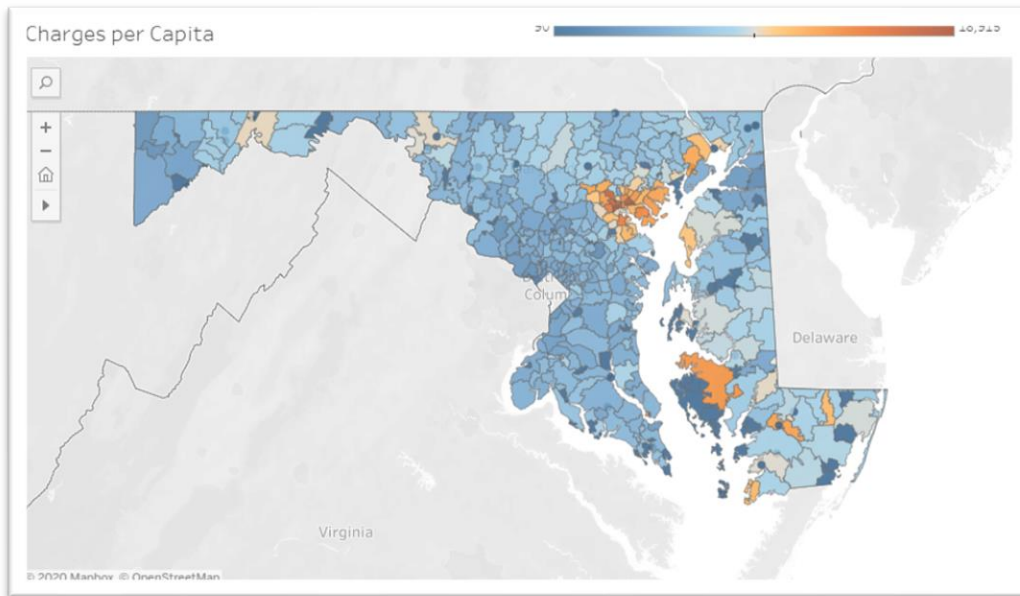
Evaluate

1. Record data within HIE to track key metrics over time.
 - Process and outcome measures.
 - Grant reporting requirements.
2. Measure and report on the impact of social needs and CBO referrals on patient health outcomes, healthcare utilization, and cost.
 - Leverage existing infrastructure.
 - Partner with other orgs.
3. Provide CBO's with "pre-post" reports.



Evaluate

Creating infrastructure to evaluate the impact of social needs & referrals on cost, utilization, and outcomes.



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FOR OUR PATIENTS





CRISP

Questions & Discussion

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SYSTEMS INTEGRATION

A community project at United Way

Systems Integration and Cross Sector Data Exchange in Monroe County, NY

Focus on Health, Not Only Healthcare

ROCHESTER

RHIO

- **Treating the whole person**
 - Medicaid transformation and value-based payment models incentivize holistic view of health
 - Healthcare system expanding concept of “treatment” to include food and housing insecurity, domestic violence, transportation
 - Focus on social determinants of health to reduce need for “healthcare”.
- **Community-based organizations**
 - Impact of Medicaid Transformation, access to funding for IT
 - Example: Transportation.
 - Need reliable transportation to work, to day care, to supermarket
 - Looking beyond transportation to healthcare appointments

Regional Poverty

- Overall poverty rate for Rochester is 38%
 - 50.5% of children in Rochester live in poverty.
 - Poverty impacts 15% of Monroe Co. residents, 33% of whom live in suburbs.
 - High poverty rate persists, despite hard work of many in community.
- System Integration Initiative
 - Led by Congressman Joe Morelle, United Way, FLPPS (UR Medicine, RRH)
 - Health, Social Services, Education
 - Referrals and information exchange across systems
 - Connect existing tools and infrastructure, such as 211
 - Charting new territory

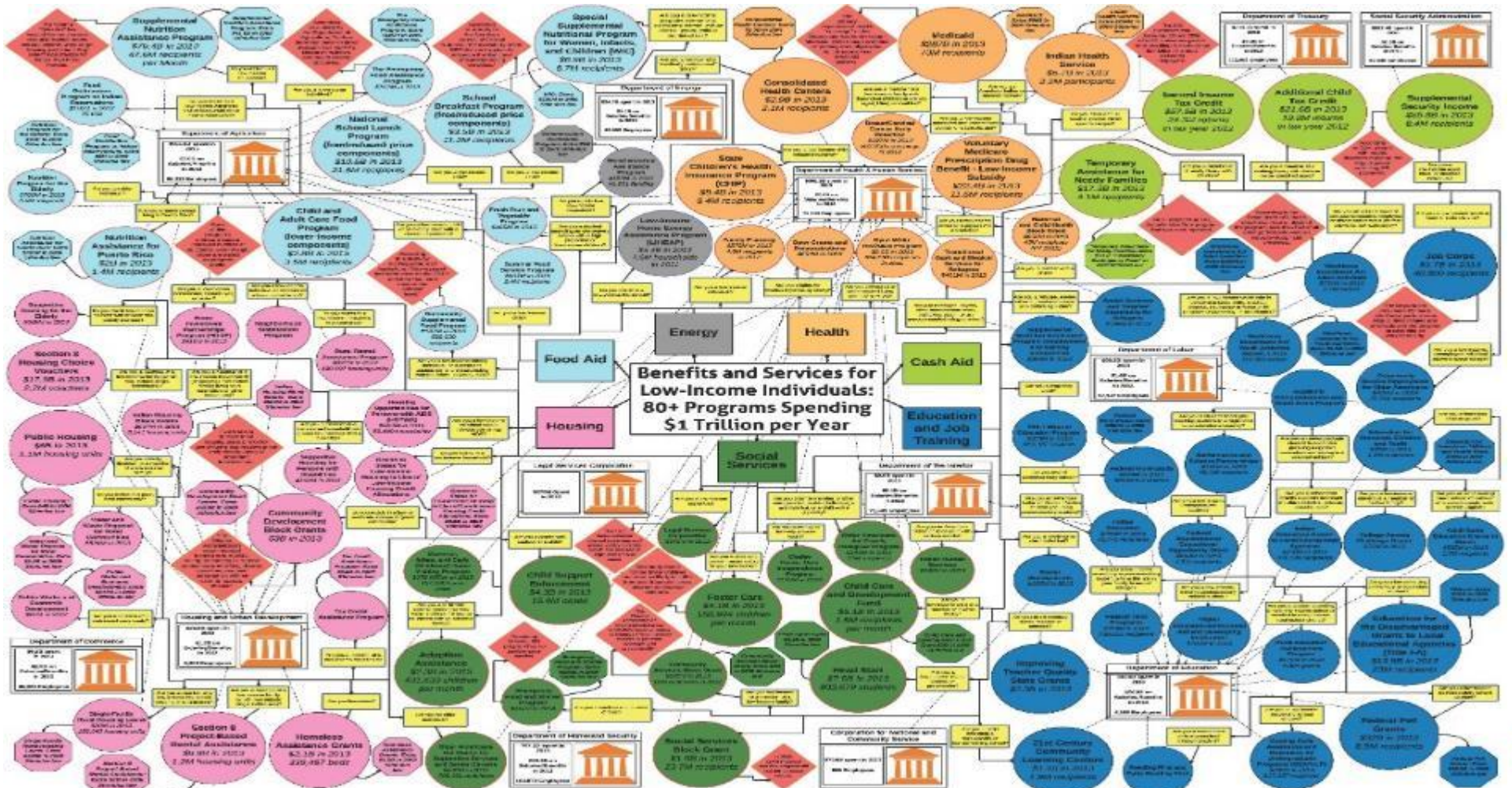
SYSTEMS **INTEGRATION**

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“The System”- Web of Services Available to People in Need

Federal Service Sectors

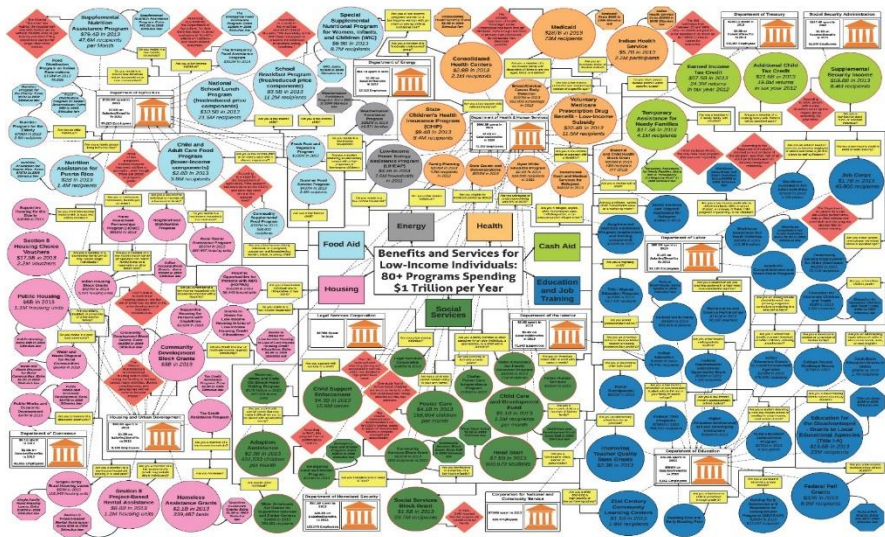
- Social Services
- Cash Aid
- Health
- Education/Job Trng
- Housing
- Food Aid
- Energy



Source: House Ways and Means Committee staff, using Congressional Research Service reports and other data.

Monroe County Systems Integration Project

The greater Rochester community is working across a diverse network of committed providers to build an **interconnected, person-centered system** of health, human services, and education leveraged by a **unified information platform**, to improve the **health and economic well-being** of individuals and families, especially those who are **vulnerable and/ or impacted by poverty**.



SYSTEMS INTEGRATION

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What will be different?

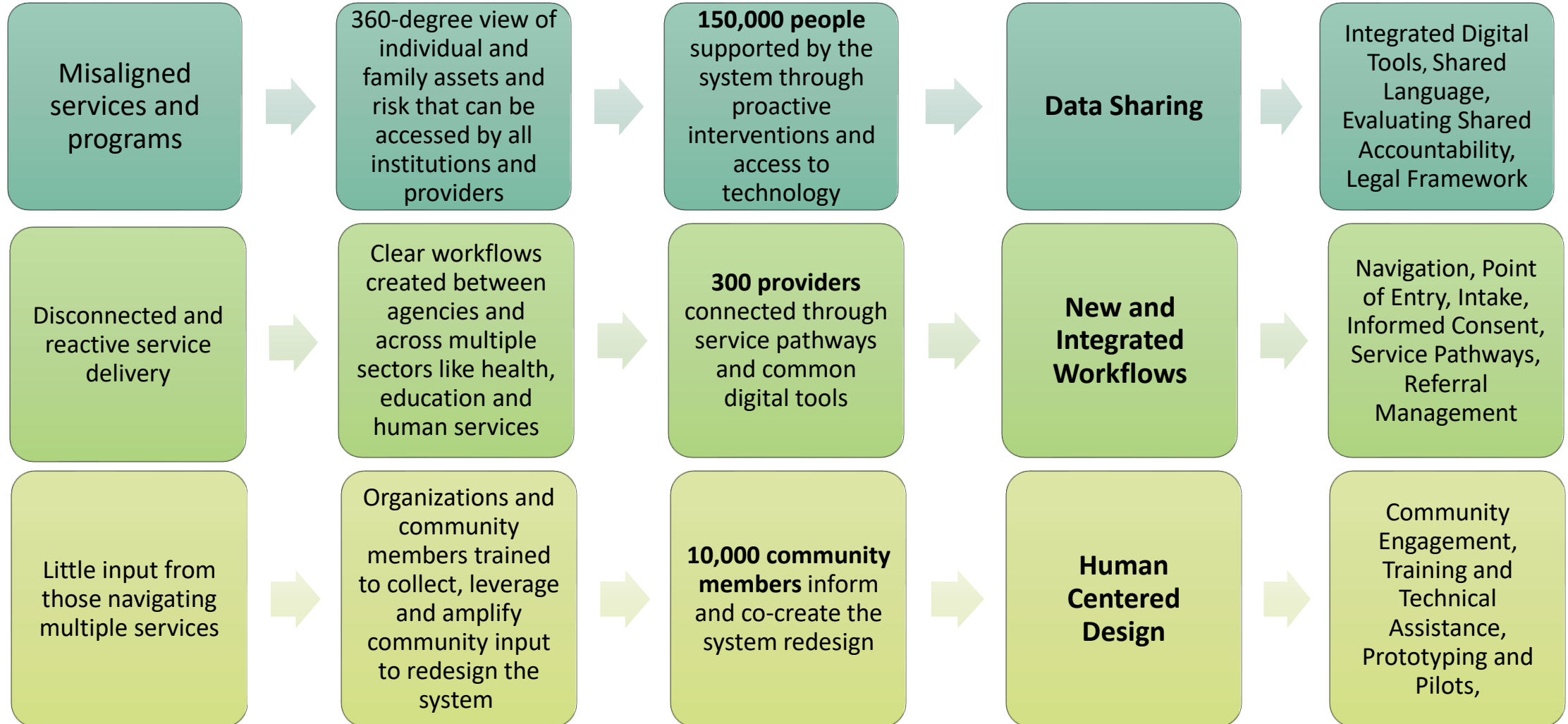
Current System

Future System

Impact

Strategies

Tactics



Key Tool: Shared Language



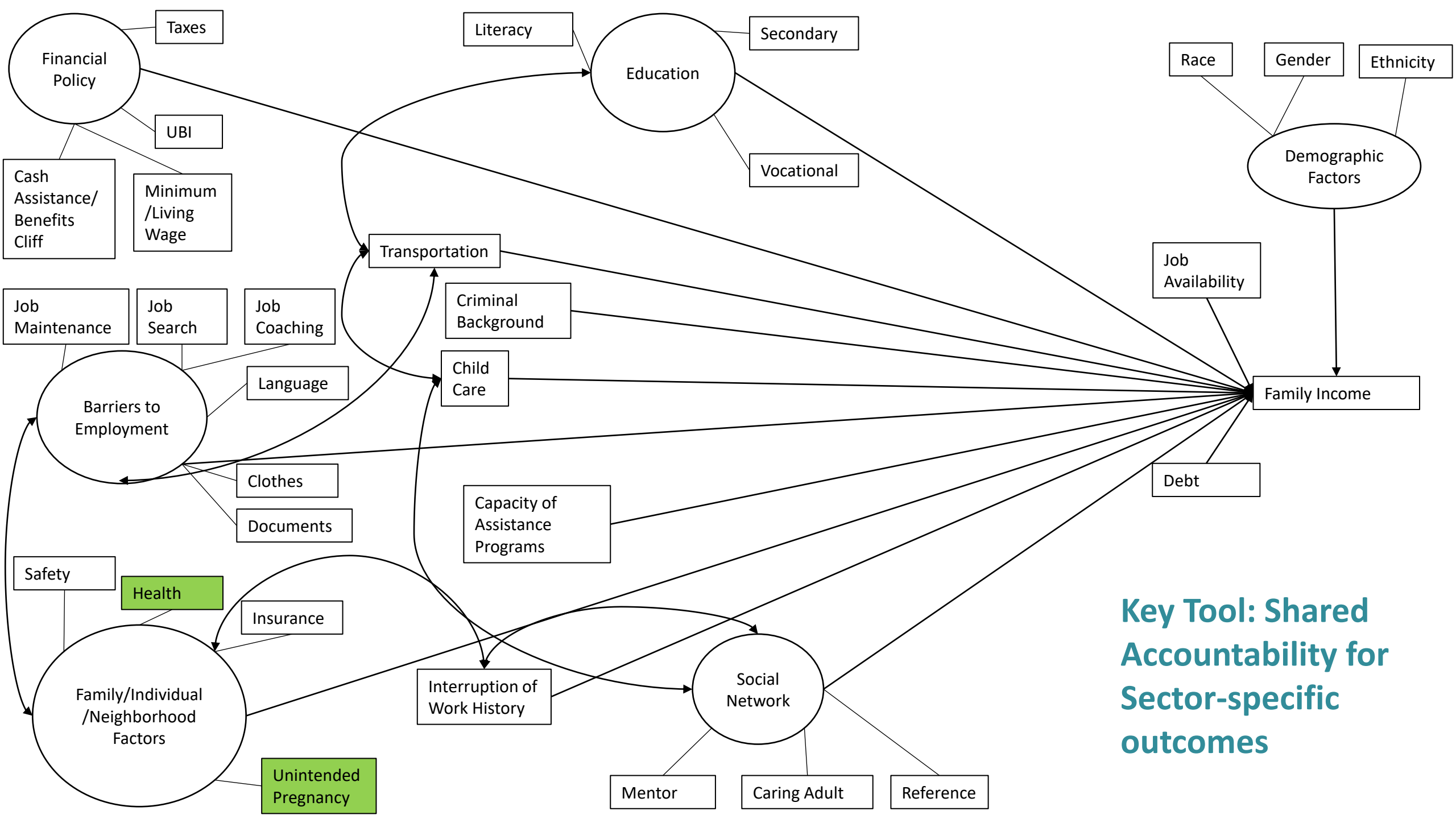
- **Shared Language does:**

- Communicate an individual's well-being across sectors
- Allow quick interpretation of individuals' holistic well-being
- Provide standardized, clear way of communicating outcomes for research
- Allow people served by the system to understand their own data
- Be Person-Centered



- **Shared Language does not:**

- Replace sector-specific language or system of record
- Come from only one sector
- Replace clinical judgment
- Diagnose an individual



Key Tool: Shared Accountability for Sector-specific outcomes

Key Tool: Closed Loop Referral Management



Key Tool: Systems Redesign



SYSTEMS THINKING



DESIGN THINKING



MODULARIZATION

SYSTEMS INTEGRATION

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Cross Sector Data Exchange

ROCHESTER 

- Systems Integration Project will build cross sector data exchange for social services, education and health care organizations
- Leverage experience and infrastructure of regional health information exchanges
 - Policy and Legal framework
 - Technical infrastructure
 - Tools and skill set for data sharing, data governance, data quality, data aggregation & analytics
 - Build on experience in community collaboration

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Cross-Sector Data Exchange Today

- Incarceration data from jails
- Death data from counties
- Housing vulnerability assessment from HMIS
- Developmental assessments for 3 year olds
- Encounters (ADTs) from community-based organizations
- Law enforcement data
- Zip code and secondary data sources
- Consumer surveys (food insecurity, housing, transportation)



Challenges Ahead

- Legal and Privacy hurdles
- Purpose of use
- Gaining trust of participating CBOs and staff
- Consumer trust
- Investment in IT systems and security across sectors



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SYSTEMS **INTEGRATION**

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Discussion?

Next Meeting Date

- Next meeting date: July 22

