NMHIC Webinar Series

October 22, 2019

Welcome and Housekeeping

- All stakeholders in New Mexico’s healthcare community are welcome
- We will record today’s webinar
- Lines will be muted as we begin
- To comment or to ask a question, please ‘raise your hand’ and unmute your line, or
- Direct your question or comment (to everyone, to the presenter, or to the host) in the chat box

April Salisbury, MBA-HCM
Agenda

• News and Information – April Salisbury
• Featured Presentation: ‘Social Determinants of Health and Health Information Exchange’ – Margaret J. Gunter, PhD, and Eugene Hill, MA
• Guest Presentation: Presbyterian Community Health & Accountable Health Communities – Valerie Quintana, Director, Community & Clinical Linkages, and Sharz Weeks, Community Health Epidemiologist

NMHIC News and Information

April Salisbury, MBA-HCM
• The Department of Defense now has information available on Active Duty Military, Retirees, and Families in the HIE clinical portal, using our link to the eHealth Exchange.

• Call to set up training to use this feature.
OptStat Data-Driven Training Program

OpStat: a FREE data-driven training program sponsored by NMHIC and the New Mexico Department of Health

Mr. Eugene Hill, MA
Data Manager/Reporting Analyst

Next class – November 26
training@nmhic.org to register

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New Mexico Health Information Collaborative (NMHIC)

Presents
The Fourth Annual HIE Users’ Conference

Sharing Health Information Success Stories:
Empowering Partners in Health Care

November 22, 2019
8:00 am – 5:00 pm

Join us in person at
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

Or ask your local hospital or association to host a simulcast in your area.
Agenda Highlights

• Keynote by Allen Ausford
• Hot topics:
  o Successful HIEs
  o HIE and Telehealth
  o Social Determinants of Health
  o Emergency Preparedness

Social Determinants of Health and Health (SDOH) and Health Information Exchange

Margaret J. Gunter, PhD
Director of Medical Outcomes Research
Lovelace Respiratory Research Institute
Senior Advisor for Population Health and Outcomes Research
LCF Research/NMHIC

Eugene Hill, MA
Data Manager/Reporting Analyst
LCF Research/NMHIC
Webinar Topic Overview

- What are Social Determinants of Health (SDOH) and why are they now viewed as highly important to health care?
- Examples of SDOH initiatives in NM and elsewhere and their impact
- Involvement with NM DOH and opioid grant—relevance of SDOH factors in overdose predictive models
- NMHIC data analytics and training initiatives relevant to integrating SDOH into the NMHIC clinical database
- Presbyterian example of Pilot SDOH program
- Discussion of options for NMHIC to pursue to assist its users in addressing SDOH issues to improve care

What are Social Determinants of Health?

- Non-medical factors that can affect a person’s overall health and health outcomes
  - Early child development
  - How much education a person obtains
  - Food insecurity
  - What kind of work a person does
  - Being able to get and keep a job
  - How much money a person earns
  - Housing status
  - Discrimination and social support
  - Having access to health services and the quality of such services
  - Neighborhood and household safety
Determinants of Population Health

- 25% due to genes, biology, health behaviors
- 75% due to other factors
  - Social environment (social determinants of health)
  - Physical environment/total ecology
  - Health services/medical care
Why are social determinants important?

- Social determinants (SDOH)—**Much more important to health outcomes than medical care itself, especially for low-income populations**—basis for health inequities and disparities
- Research reports—medical care accounts for only 10% of health outcomes. Remainder is due to socioeconomic, environmental, and behavioral factors—which are outside the walls and “control” of the clinical offices and hospitals.
- U.S. spends **much less on social services and much more on health care** than other industrialized nations.
- Growing interest in SDOHs in recent years (more value-based payment, case management of high risk populations)—**SDOH: next stage of value-based care**
- Case managers have long understood the importance of social factors to their patients’ outcomes
- Providers also understood, but have felt unable to help address social determinants.

Interventions to Address Negative SDOH Impact

- **Art Kaufman, MD**: Early SDOH innovator--NM and U.S.
- Vice Chancellor for Community Health, UNM Health Sciences Center—placed medical students in clinical roles in underserved areas.
- Spearheaded “Beyond Flexner”, nat'l. effort to change how academic medical centers address social determinants that play a pivotal role in health risks and outcomes.
- **Created UNM’s HEROs program**—Health Extension Rural Offices, based on agricultural extension model
- **IMPaCT Grants**: Adapted the HEROs model to create primary care improvement infrastructure to reach small primary care practices
- Recognized by UNM HSC as its 2018 Living Legend
UNM HEROs Program

- Led by Health Extension agents based in rural communities—shift focus from UNM to community. Currently 10 statewide; need 20.
- What do HEROs agents do? (Depends on community needs). For example:
  - Mental Health First Aid classes for laypeople
  - Help communities to write grants
  - Working to change health policies
  - Helped start a school-based clinic
  - Helping in primary care practice transformation to meet ACA goals
- IMPaCT project--focus on primary care practices: 34 NM primary care practices participated, nearly half in rural areas and nearly half minority-led.
- Supported by Community Health Workers, focus on SDOH’s for the individual. Intimate community knowledge and trust, cultural and linguistic competence, ability to screen for and address SDOHs, know many resources, are working now to embed CHWs into clinics (welcome relief for overwhelmed providers).
- HEROs programs addresses SDOH at community level.

Federal and Local Initiatives related to SDOH

- US most expensive health system in the world—but not better outcomes. **Partial reason:** Other nations spend $2 for social services per dollar for healthcare vs. US spends 55 cents on social services per dollar on healthcare.
- Healthy People 2020
  - Measuring and monitoring social determinants and disparities
  - 4 indicators met targets or above (15.4%); 10 are improving (38.5%)
  - Fewer adults smoking; fewer children exposed to second-hand smoke; more adults doing physical activity; fewer teens using alcohol or illicit drugs
- Federal Interagency Working Group on Environmental Justice
  - Identify and address federal agencies whose programs have adverse health effects on low-income or disadvantaged communities
- CMS: Awards to implement Accountable Health Community Models
  - Address SDOH (food insecurity, inadequate transportation, and unstable housing
- Older Americans Act:
  - Meals on Wheels, legal services, transportation services.
Federal and Local Initiatives Related to SDOH

• State and Local Initiatives
  o Medicaid Initiatives
    • 19 States require Medicaid Managed Care Plans to screen for or provide referrals for social needs in 2017.
    • Recent survey of Medicaid Managed Care Plans found 91% of plans reported activities to address SDOH.
    • Medicaid reform initiatives, e.g., Colorado and Oregon, include focus on linking health care and social needs.
  o CMMI State Innovation Models Initiative (SIM):
    • Some states are engaged in multi-payer and delivery reforms that include a focus on population health and recognize the role of social determinants.

• State and Local Initiatives (continued)
  o Community partnerships with public and private entities
    • New Jersey:
      o Identify high utilizers, provide resources, reduce barriers
    • State program in Vermont
    • Medical-legal partnerships
    • Partnerships between medical community and businesses
      o Fruit and Vegetable Prescription Program—hospitals, community health centers, food hubs, farms, and retail outlets—for low-income individuals and families
Harnessing the Power of Non-traditional Data

- Analysis of SDOH (social and behavioral health factors)—avoid making decisions on partial data. **Incorporate social determinant factors into clinical data analytics.**
- Offers a thorough picture on where and how to invest resources to keep populations and health providers/plans healthier and sustainable.
- **Improve access issues:** Uninsured/underinsured can’t afford health plan costs or live in areas with few providers, so end up in EDs. Higher cost for “superutilizers”.
- Improve care, costs, and accuracy
- Drive **positive health outcomes**
- **Serve communities** (siloed healthcare and social services systems come together to serve their communities, contain costs, and improve health outcomes.)

HIE SDOH Example

- **Community Resource Network:** Quality Health Network (QHN) in Colorado and Stella Technology
- QHN created an HIE platform to connect health care entities in rural western Colorado
- Community Resource Network—next step—**better coordination through data sharing between social services and medical professionals.**
- All win with better data sharing. Patient/client gets the services she needs. Care coordinators help in the most efficient manner. Community gets healthier, reducing health care costs.
- Semifinalist for Robert Wood Johnson Foundation’s Social Determinants of Health Innovation Challenge (1 of top five of 110 applicants).
The CMS Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool

• What’s in the AHC HRSN Screening Tool?
• **Purpose:** To identify health-related social needs of Medicare and Medicaid beneficiaries to address them and see if **any effect on total HC costs and outcomes across the 32 Accountable Health Communities**

• **10 items in 5 Core Domains + 8 supplemental domains**
  - Housing stability
  - Food insecurity
  - Transportation problems
  - Utility help needs
  - Interpersonal safety
  - Financial strain
  - Employment
  - Family/community support
  - Education
  - Physical activity
  - Substance use
  - Mental health
  - Disabilities
PRAPARE

- Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences
  - Proprietary screener produced by National Association of Community Health Centers (NACHC), Assn. of Asian Pacific Community Health Organizations, and Oregon Primary Care Association (2016).
  - 21 questions—5 domains
    - Personal characteristics
    - Family and home
    - Money and resources
    - Social and emotional health
    - Optional added questions (recent jail time, refugee, physical and emotional safety, fear of partner)

SDOH: NMHIC Background

NMHIC involvement with opioid usage data

NMHIC/NMDOH Opioid Grant Agreement
  - Sponsored by the CDC, executed at start of 2019, provides for NMHIC performing a variety of data services to state Department of Health
  - Fully utilizes both lab and encounter data in HIE
  - Provided for OpStat statistical training program: live and webinar-based classes covering statistical training in health care, with an emphasis on opioid usage statistics in NM.

Bernalillo County Legal
  - Provided opioid usage stats in connection with possible legal action against the pharmaceutical supply chain nationwide
SDOH: Data Availability

- Selection of SDOH Data
  - **TransUnion** is tentative vendor
  - **Individual Attributes**
    - 241 total in about 20 categories
    - Offered by individual
  - **Aggregated Credit Data**
    - Laws do not permit this data to be reported on individuals
    - Accordingly, data is aggregated at the zip-plus 4 address level
    - Values for individuals are estimated based on this address grouping

| AddressZip4 |
| BankruptcyFileDate |
| CriminalArrestDetail |
| CriminalWarrantDetail |
| CurrentAge |
| Employer |
| NeighborsDateOfBirth |
| NeighborsFullName |
| PersonalJudgment |
| PersonalLienFilingCount |
| PropertyAssessment |
| PropertyMortgage |
| PropertyPurchase |
| PropertySale |
| RelativesDateOfBirth |
| RelativesFullName |
| VehcilesVehicleType |

Sample individual attributes in TransUnion data set

SDOH: Methodology

- **Statistical Approach**
  - NMHIC will create control and test groups using de-identified HIE data based on opioid grant work with NMDOH
  - Will apply techniques including, but not limited to, logistic regression and machine learning
  - Emphasis will be on changes in SDOH measures, not just current values.

- NMHIC will use R statistical software for SDOH analysis
  - Open source, allows shareable testing processes and results if data is properly de-identified

Sample script in R Studio, the development environment for R
SDOH: Security and Privacy

NMHIC will apply the same level of care in managing SDOH data as it does protected health information (PHI)

- NMHIC is aware of the sensitivity of the information being provided and related privacy concerns
- Will keep data completely de-identified during the course of study
- Will follow its existing best practices with respect to safe data transfer and encryption
- Will restrict usage of SDOH to only the least sensitive attributes that are found to have meaningful predictive value

Pause for Q & A

Please use the Zoom tool bar to unmute your line, or use the chat window to ask your question.
Presbyterian Community Health
Valerie Quintana, Director – Community & Clinical Linkages
Sharz Weeks, Community Health Epidemiologist

Addressing the Social Determinants of Health (SDOH)

- 5-year, $4.5 million cooperative agreement through CMS
- Screen and refer Medicaid and Medicare beneficiaries with social needs who reside in Bernalillo County
- Food Insecurity, Transportation, Housing, Safety & Utilities
- Examine the impact on the Triple Aim
- Align health and social service systems
- Locations
  - PHS, UNM, First Nations, & ABQ Ambulance Service
Rent and mortgage payment assistance

City of Albuquerque - Family & Community Services - East Central Health & Social Service Center  
Distance: 5.48 mi  
7525 Zuni Rd SE Albuquerque, NM 87108  |  Language: English, Spanish, Vietnamese  |  Fees: Free  |  Hours: Mon, Tue, Wed, Thu, Fri 8:00 AM - 5:00 PM  

First Nations Community Healthsource - Truman Clinic - Linkage Program  
Distance: 5.84 mi  
625 Truman St NE Albuquerque, NM 87110  |  Language: English, Spanish  |  Fees: Free  |  Hours: Mon, Tue, Wed, Thu, Fri 8:00 AM - 5:00 PM  
(505) 248-2990  |  http://www.fnch.org

Affordable housing

YES Housing, Inc. - Vista Grande Apartments  
Distance: 3.63 mi  
12801 Copper Ave NE Albuquerque, NM 87123  |  Language: English, Spanish  |  Fees: Sliding Fee  |  Hours: Mon, Tue, Wed, Thu, Fri, Sat, Sun 24 Hours  
(505) 293-5300  |  office@vistagrandeapts.net  |  http://www.yeshousing.org/New_Mexico_Properties.aspx

Newlife Homes - Sundowner Apartments  
Distance: 5.82 mi  
6101 Central Ave NE Albuquerque, NM 87108  |  Language: English, Spanish  |  Fees: Self Pay  |  Hours: Mon, Tue, Wed, Thu, Fri 9:00 AM - 5:00 PM  
(505) 266-5414  |  http://www.newlifehomesnm.com

Our goal for Addressing Health-Related Social Needs and the Social Determinants of Health

https://healthierususa.org/resource-library/roadmap/
Pause for Q & A

Please use the Zoom tool bar to unmute your line, or use the chat window to ask your question.
4 Options for HIE re Social Determinants

Which would be most useful to NMHIC Users and our state?

1. **Repository for SDOH information** accessible by anyone involved in patient care (medical, behavioral health, social services, community resources)

2. **Provide access to smart web form** that any authorized provider could use to document SDOH information.
   - PRAPARE
   - CMS Accountable Health Communities (AHC) Health-Related Social Needs (HSRN) Screening Tool
   - Other local, regional, or national standard tool
   - Completed form stored in HIE—available to those authorized—can be updated by a provider

3. **Provide SDOH from TransUnion or other services through NMHIC portal and stored in clinical doc repository**

4 Options for HIE re Social Determinants (2)

4. **Be repository for shared care plan** for medical, behavioral health, social services, community resources.

5. Any combination of above 4.

**AUDIENCE DISCUSSION OF OPTIONS**
Q & A

Please use the Zoom tool bar to unmute your line, or use the chat window to ask your question.

Contact Us

Not an HIE User yet?

(505) 938-9909 or info@nmhic.org

Look for us on LinkedIn and Twitter!
Miss a webinar?

Check out our events page for handouts and recordings, as well as upcoming events.

www.nmhic.org

Looking Ahead

No webinar next month, please join us for our annual conference on November 22 at the Indian Pueblo Cultural Center and again on December 17, 2019, 11:30 am-12:30 pm for Data Visualization