11/9/2022

Wednesday, November 9, 2022 8:55 AM

Local Health Improvement Coalition

City-Wide Care Coordination - November 9, 2022

Attended By

Keyonna Mayo, Stephane Bertrand, Elise Bowman, Brittany Young, Marik Moen, Ijeoma Eke, Maria Tyler, Mary White, Kristin Topel, Lorena de Leon, Sonya Kirby-Edon, Matt Morgan, Steven McGaffigan

Meeting Notes

Goal

As a group, articulate the **value proposition** and **barriers** for both sides of data sharing.

Can we form a partnership(s)/ groups to demonstrate the benefits of sharing social needs data between organizations?

Rationale

Why do we need to share social needs and utilization data?

Identification of social needs is siloed and spread across healthcare systems.

- Johns Hopkins - not sure how to document data for CRISP to access it.
- EPIC (and others) would have to change its technology in order to work across platforms and organizations.

Populations with social needs tend to have fluctuating demographic information (phone number, home address, work, etc.), affecting care coordination and payer workflows.

- Maryland's database is not always accurate
- Need up-to-date and accurate information to better coordinate care

Data is valuable for connecting patients with care.

- Care providers and CBOs need to know what services were administered and why
    - Referral
    - Service outcomes
    - Being able to close the loop
- Hospital overstays (both inpatient and emergency department) data would give insight into how healthcare provider and payer incentives are not aligned.
    - Patients who no longer require ongoing hospital care, but continued, post-acute, or subacute care
    - Care facilities have become selective about patients that care can be provided to due to staffing issues and capacity.
        - Wound care, dialysis are high cost needs that require a lot of staff
    - Better data will help us understand gaps in mental health, chronic health, etc.
- Data on connection to services can help identify "high value" community-based organization (CBO) partners and also partners who may need more support to better serve clients
- Improved communication will prevent duplication of referrals and services.
- Utilization data is helpful for understanding patterns and identifying social needs before they are

reported.
- Accurately identifying gaps in resources can drive impactful investment from hospitals.

CRISP can act as the interface between disparate data collection systems.

Value to Key Groups

Patients and Community Members

- Knowledge empowers patients and community members to make their own health decisions
- Social needs programs designed by the community are proven to be more impactful
- Addressing social needs gives patients space to address healthcare needs
- Connecting patients to social needs resources has a positive impact on their health

Front Line Staff

- Quality of care - improved understanding of patient needs
- Efficient identification of intervention or care plan
- Building trust with patients

Hospital Administration/Health Economics Teams

- Drive innovation in care delivery - prevent patients with nonemergent problems from needing to go to the emergency department
- More efficient care at the correct level of care

Public and Private Payers

- Reduction in total cost of care
- Improved medical loss ratio (public payers) and return on investment (private payers)
- Focus on members with specific needs for the best impact
    - Stratify and triage patients
    - Add in social factors
    - Putting contracts in for at-risk populations (private payers)
- Policy and reimbursement implications - knowing where the most needs are, and where to implement appropriate coverage

Other key groups who benefit:

Population health, post-acute care providers and care continuum leaders, government entities and policy makers, community based organizations (CBOs), local health improvement coalitions (LHICs), data vendors

Barriers to Implementation

Ethical and Legal

- Ethical concerns about patient confidentiality
- HIPAA prohibits the sharing of certain patient information data points
- It has become so easy to make a referral that you lose the human aspect

Capacity

- Technical issues with interoperability:
    - Formatting
    - Lack of a shared language
    - Technological capacity
- Capacity (staffing and budget) of CBOs and small providers to maintain data

Financial

- Lack of profitability
    - There is currently no incentive to share data
    - Companies (data, payers, etc.) will always look for ways to make money

- Providers and payers have already contracted with different platforms to analyze social needs data. Universalizing data sharing would derail existing efforts and cost a substantial amount of money. We need to find a balance between working individually and sharing data systems-wide.

Our Ask/Recap from the meeting with CRISP

Can we form a partnership(s)/ groups between MCOs and Hospitals or otherwise to pilot demonstrating the benefits of sharing social needs data between health plans and clinical delivery sites?

Value prop

- Leads to population analytics
- End user = MPC + Hospital Systems + Population Health + Direct Point of Care
- Improved care + care coordination
- ID unmet needs, better risk stratification
    - What does this lead to?
    - How do you move from stratification towards intervention and care?
    - How do you address needs based on this information?

Awareness - identify social risks and assets
Adjustment - alter clinical care to accommodate identified social barriers
Assistance - connect patient with social care resources
Alignment - healthcare system understands social care assets and organize them to facilitate synergies and invest in and deploy them to affect health outcomes.
Advocacy - healthcare systems work with social care orgs to promote polices that facilitate the creation and redeployment of assets to address SDOH.

Next Steps

- [ ] Kristin, reach out to Lorena at: LdeLeon@MPCMedicaid.com
- [ ] Elise - Debrief with CRISP
- [ ] When you think about your current projects, do you have the ability to demonstrate the impact of care coordination data sharing? Be prepared to let us know in the next meeting.

2022-11-09 Bi-Weekly LHIC Care Coordination Attendance

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