Aligning with Local, Regional and National Initiatives

Community Information Exchange SUMMIT

- Cheryl Moder, Be There San Diego
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San Diego
Accountable Community for Health

2018 Community Information Exchange Summit

April 16, 2018

Cheryl Moder
Be There San Diego

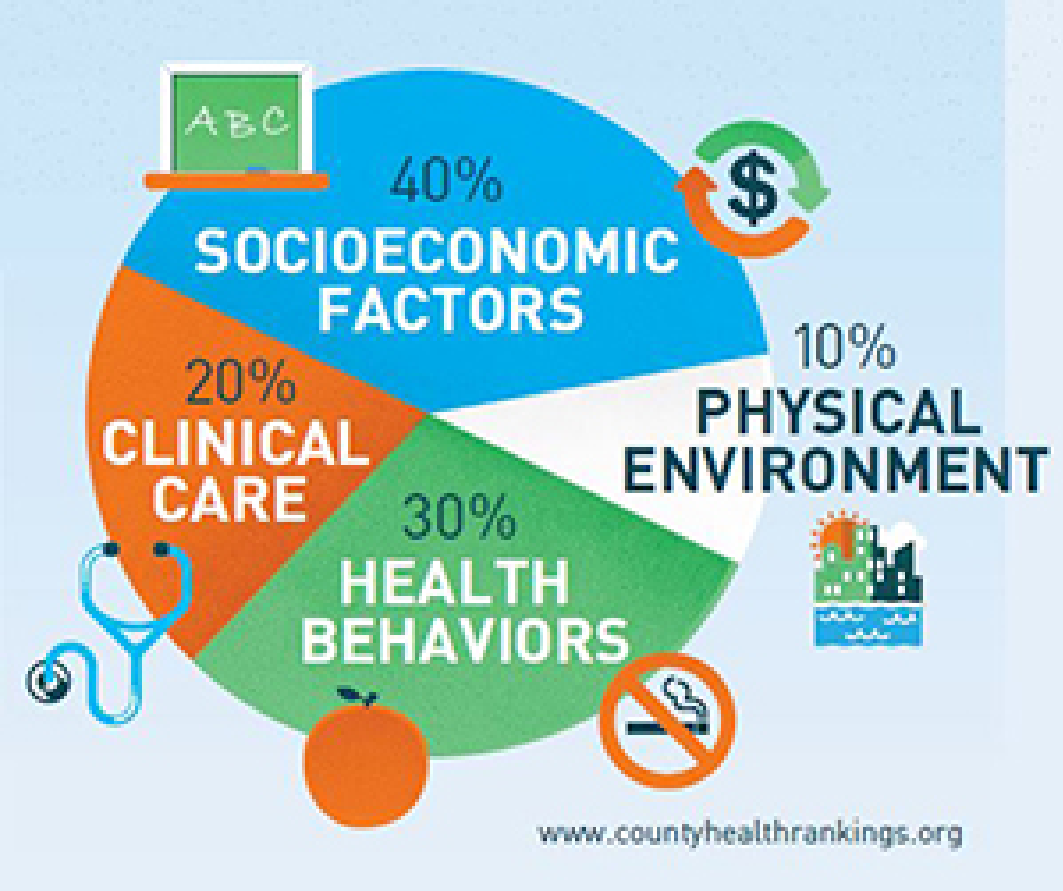
Introduction

Accountable Communities for Health

Be There San Diego | Preventing Heart Attacks & Strokes

Be There San Diego is a coalition of patients, communities, healthcare systems and others working together to prevent heart attacks and strokes in the San Diego region.

Background



ACH works to improve population health across multiple domains:

- Clinical
- Community
- Clinical-community linkages
- Policy, systems, and environments

ACH Elements

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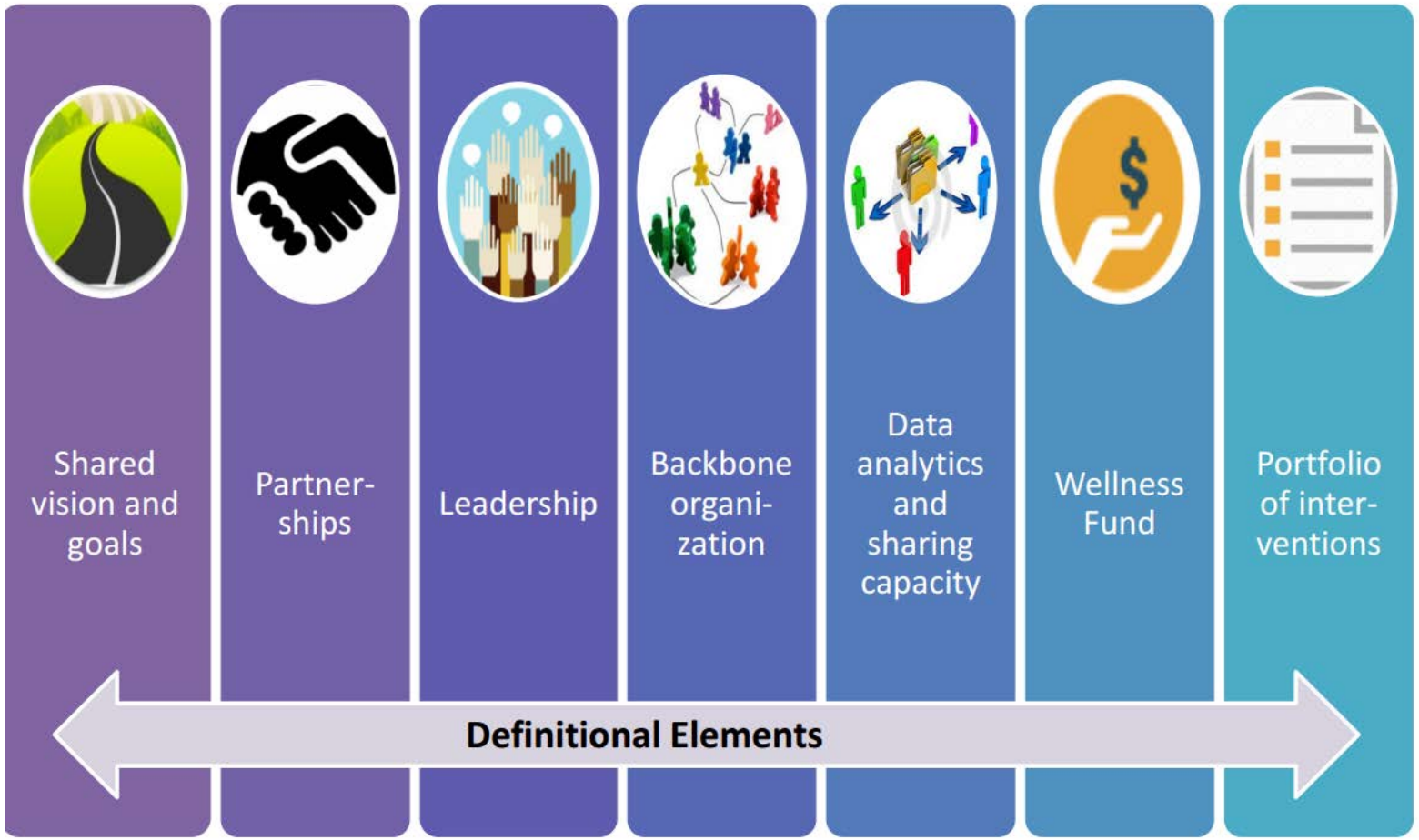

California Accountable Communities for Health Initiative

Accountable Communities for Health

Mission:
Transforming community health through partnership

Vision:
A health system that is capable of fundamentally changing health outcomes by aligning interventions for maximum impact, promoting prevention, and organizing resources to focus on the most effective strategies.

CALIFORNIA ACCOUNTABLE COMMUNITIES FOR HEALTH INITIATIVE

Funded by:

KAISER PERMANENTE®

The California Endowment

blue of california foundation

SIERRA HEALTH FOUNDATION

SD ACH Mission & Vision

Accountable Communities for Health

Mission:

To create a “wellness system” that ensures individuals, families, and communities in San Diego have access to all they need to create a lifetime of health and wellness.

Vision:

Health, wellness and equity for all of our communities, regardless of zip code.

SD ACH Core Values

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Equity – The SD ACH is committed to social justice and achieving equity, defined as providing all people and all communities with optimal opportunities and resources to attain their full potential.

Inclusivity – The SD ACH is committed to the inclusion of people of every race, class, ethnicity, sexual orientation, gender identity, age and ability.

Neutrality – We are committed to ensuring that the SD ACH is neutral and independent and does not unfairly advantage any one system, sector or organization over another.

Accountability – We are committed to putting community at the center, incorporating trauma-informed approaches and achieving accountability through transparent, open communication and conversation with community.

SD ACH Governance

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Community Stakeholders

Stewardship Group

- Provide support and guidance for ACH
- Review recommendations from workgroups
- Bring commitment, creativity and new thinking to solving complex problems
- Commit personally and/or organizationally to working together

Sustainability & Wellness Fund Workgroup

Make recommendations on priorities and structure of the Wellness Fund

Data & Metrics Workgroup

Design and monitor an ideal cardiovascular health and ACH Dashboard

Collective Action Workgroup

Develop, refine and monitor a Portfolio of Interventions

Community Resident Activation Workgroup

Assure robust and inclusive participation of community residents and organizations

SD ACH Interdependent Workgroups

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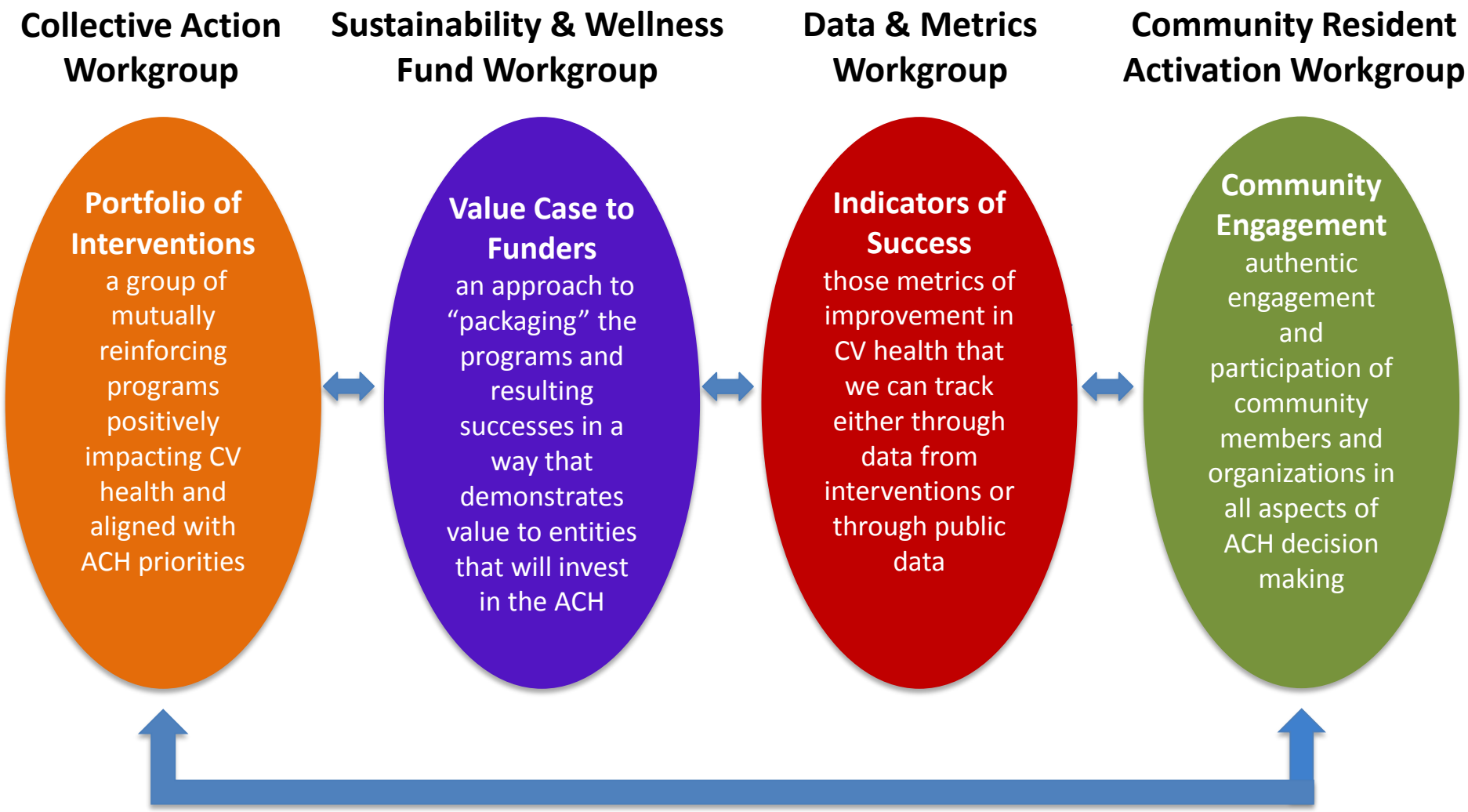

Cardiovascular Protective Factors

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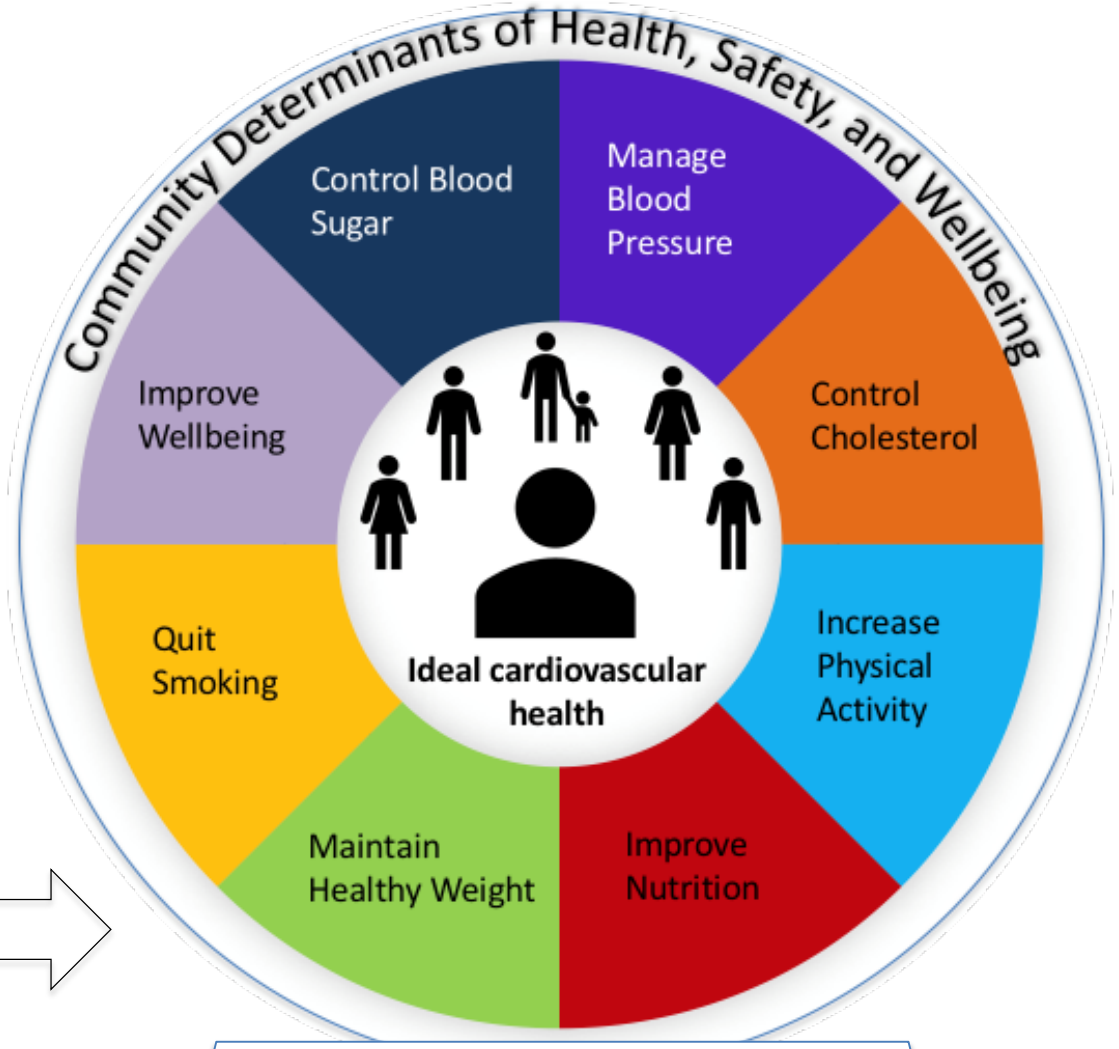
Community

Portfolio of Health Promoting Interventions across Domains
- Clinical
- Community
- Clinical - Community
- Policy, Systems & Environment



EQUITY and ACCESS

SD ACH Priority Outcomes & Indicators

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Priority Outcomes

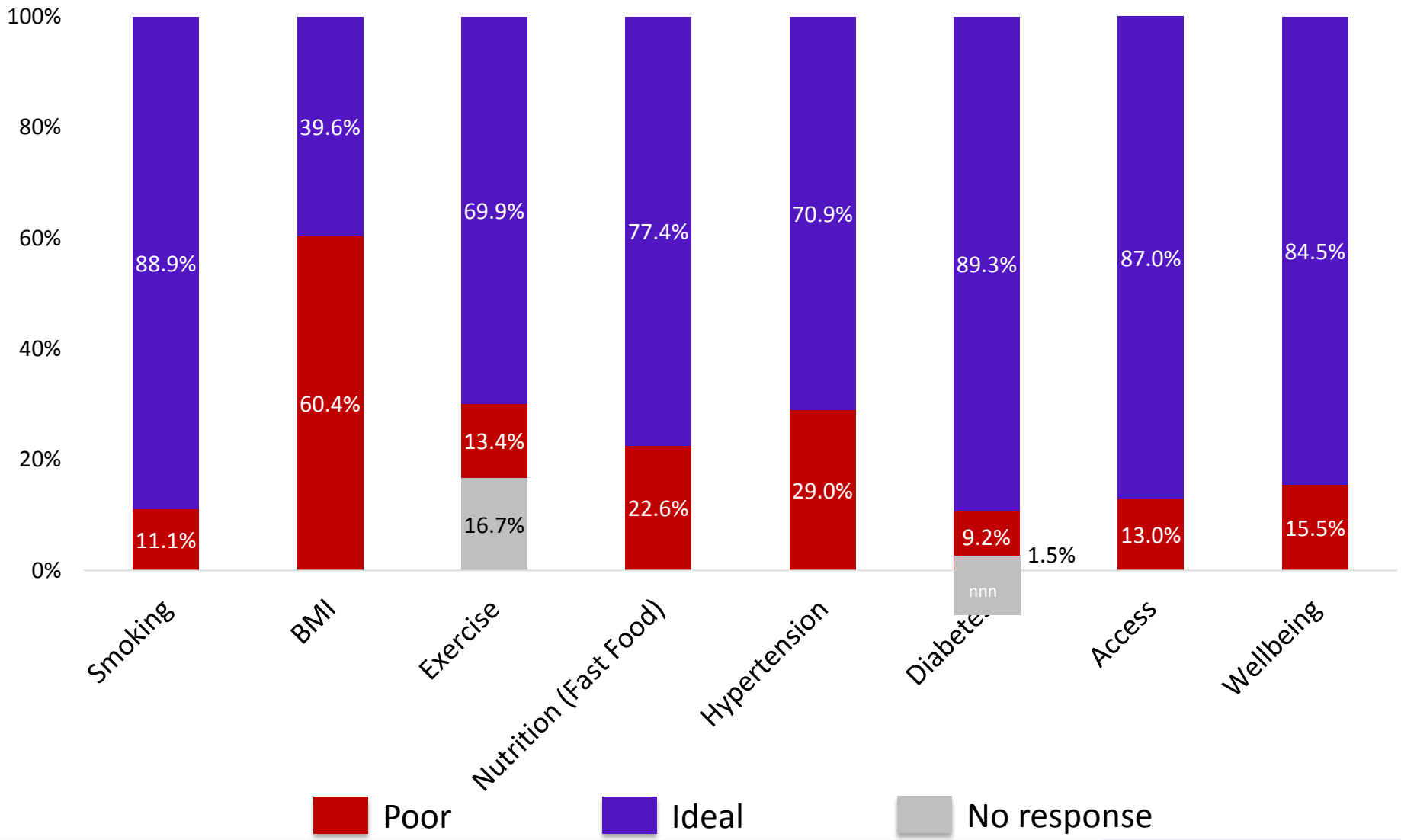
- Improve the cardiovascular health of all San Diegans by 20%* while reducing deaths, ED visits, and hospitalizations from CVD and stroke by 20%* by _____*
- Reduce health disparities

Priority Indicators

- Proxy measures for age appropriate ideal cardiovascular health (aligned with AHA Simple 7 construct, plus a San Diego construct for wellbeing)
- Death rates, ED, and hospital discharges for cardiovascular disease and stroke
- Rate of improvement of health disparities
- Proxy measures will be examined by age, gender, geographic region, race/ethnicity, socioeconomic status, and payer source

**The Data & Metrics Workgroup will set a target and date for improvement*

Baseline: Adults (San Diego County) DRAFT



Outcomes & Indicators of Success

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Priority outcomes take a long time to achieve and there are many factors impacting these outcomes…causality is impossible to prove.

Short- and intermediate-term progress toward priority outcomes will be measured by interventions that are working to address cardiovascular health across the lifespan.

Multiple Data Levels

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Priority Outcomes

Intervention-level Data

Source: organizations participating in the POI using shared data relevant to priority outcomes across ACH domains

Types of Data: process measures, outcomes measures

Example: improved healthy food access

Improve the cardiovascular health of all San Diegans by 20% while reducing deaths, ED visits and hospitalizations from CVD and stroke by 20% by _(tbd)_

Reduce health disparities

Community- level Data

Source: OSHPD, BRFSS, CHIS, UDS, Data Aggregators (Be There San Diego, San Diego Health Connect, 211)

Types of Data: Population and prevalence data

Example: % of smokers who quit

Portfolio of Interventions Process

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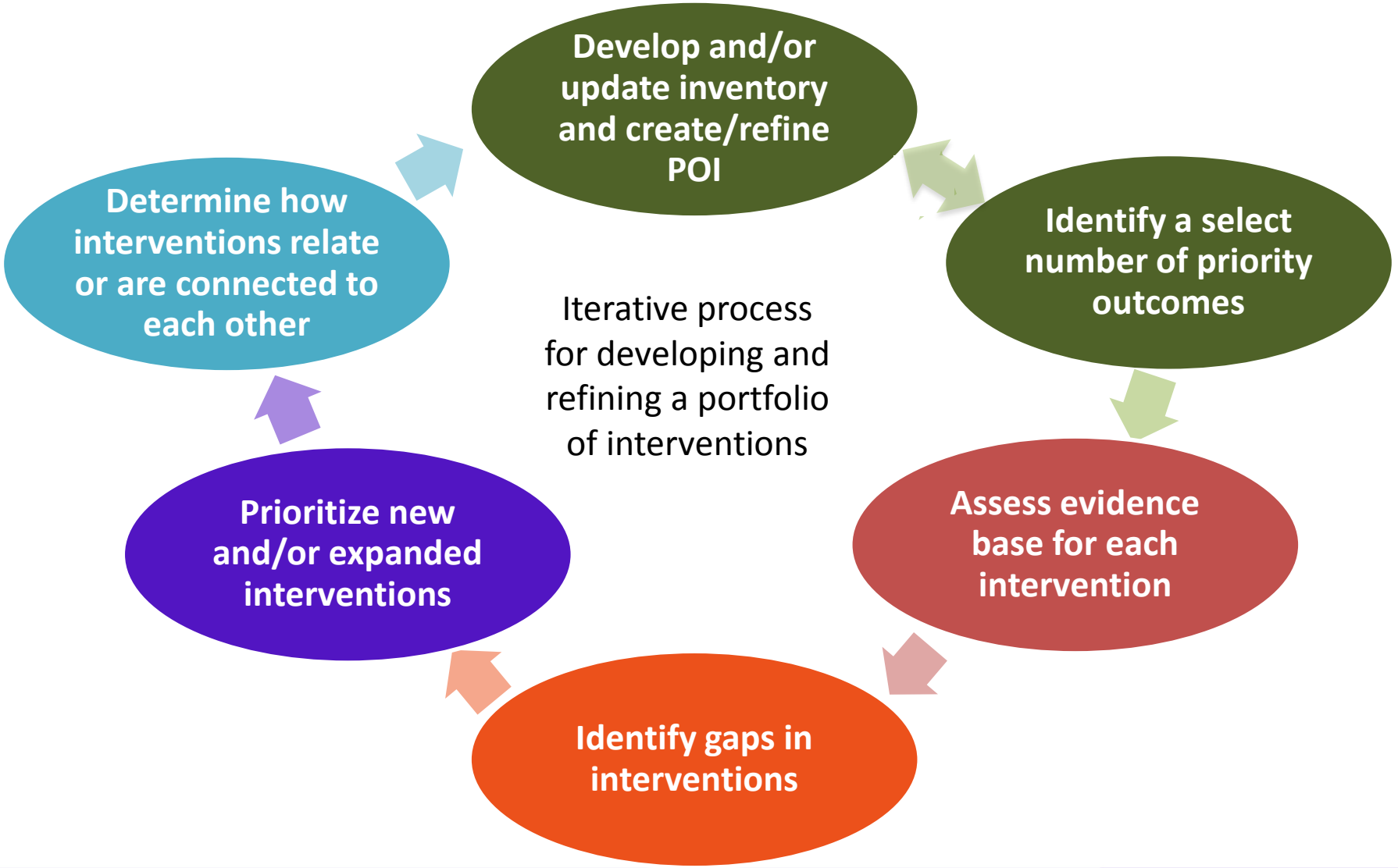

ACH Process

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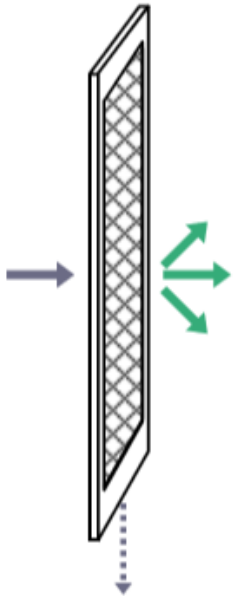
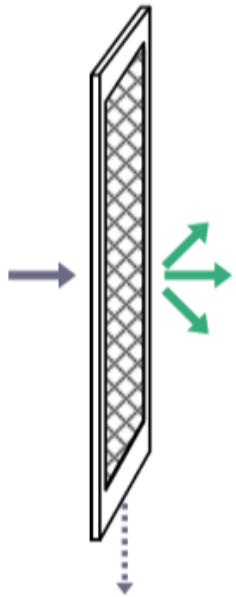
Portfolio Partners Level 1

All interventions that address cardiovascular protective factors across ACH domains



Portfolio Partners Level 2

Interventions that are able to meet additional criteria (under development) that will lead to a mutually reinforcing portfolio including linkages, shared metrics, and demonstrable outcomes



Funding Determination

Funded interventions

Interventions are screened to meet additional criteria.

Some interventions receive various levels of funding from Wellness Fund. (Inclusion in Level 2 does not guarantee funding.)

ACH Process

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Portfolio of Interventions

- Programs and services that address cardiovascular protective factors across ACH domains

Community Process

- Convenings with community residents and organizations
- Strong collaboration and mutually reinforcing activities

Data Process

- Review of intervention data to determine progress toward ACH outcomes

Prioritization & Gap Analysis

- Review of interventions to identify inequities, gaps in service, and readiness

Wellness Fund Investments

- Identified interventions that result in improved outcomes and potential ROI
- Backbone / integrator organization

Achievement of ACH priority outcomes

Contact Information

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ALIGNING ACTION FOR HEALTH℠

Greater New Orleans Data Exchange Efforts

Merging health care data with community resources

April 16, 2018

Current Landscape in New Orleans

Working Across Sectors

The Spirit of New Orleans

- Small, community-oriented
  - ~350,000 in Orleans Parish*
- Pride in resiliency
- Rich culture
- High rates of poverty
  - 26% below the poverty line*
- High rates of disease**
  - 35% obesity
  - 13% diabetes
  - 38% high blood pressure

*U.S. Census Data, 2010.

**CDC 500 Cities Data, 2015.

Relationship framework

Timeline

Timeline

- 2007 – Primary Care Access and Stabilization Grant
- 2010 – Beacon Community Program
- 2011 – GNOCHC Medicaid Waiver Program
- 2013 – Primary Care Capacity Project
- 2017 – BUILD Health Challenge Project

Community Partnerships

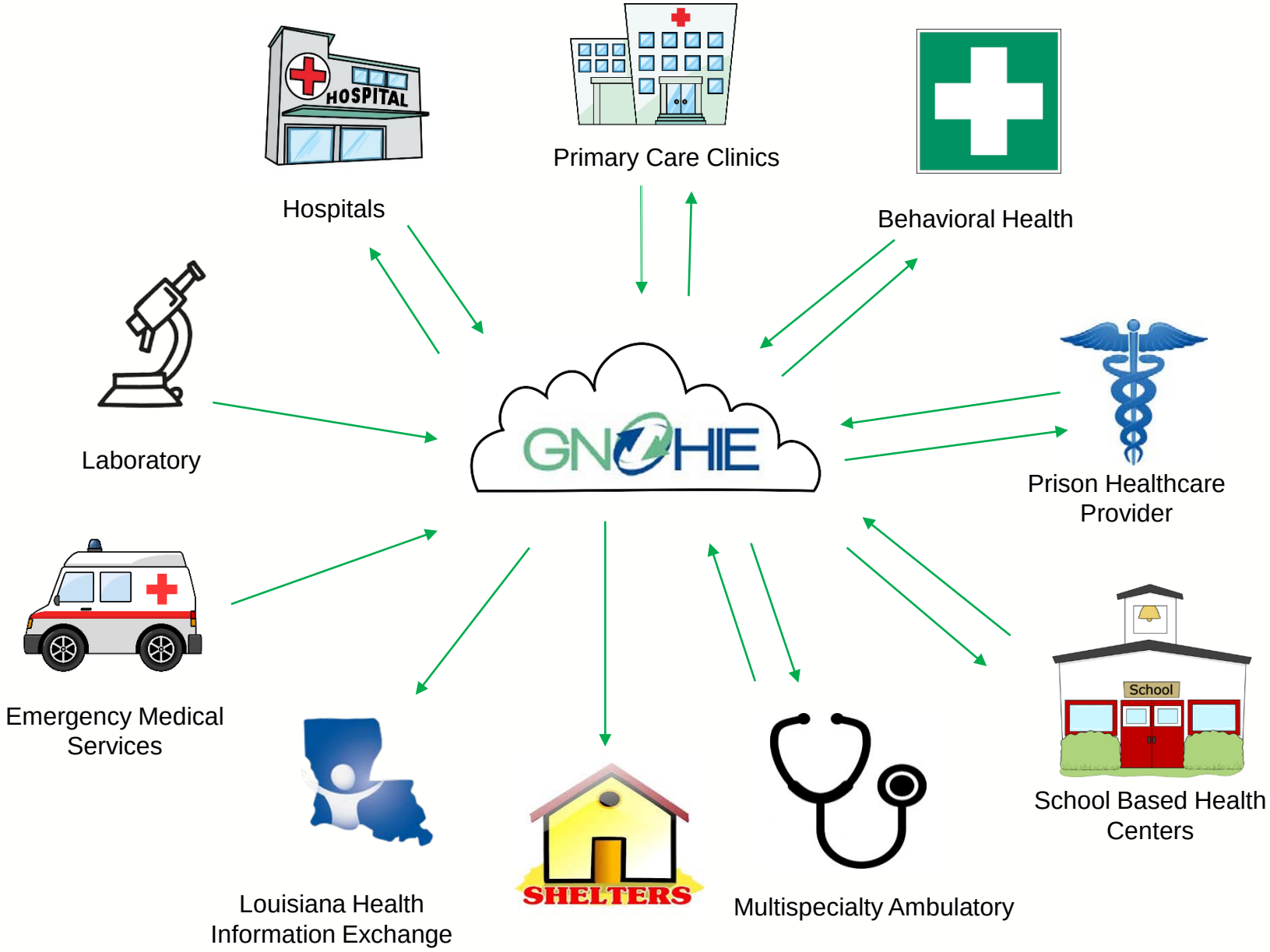
- Federally Qualified Health Centers
- Hospitals
- Payers
- Academia
- Employers
- Social services
- Crisis response and criminal justice (EMS, prison, etc.)
- Government, local and state
- Transportation organizations
- Community-based foundations

HIE in NOLA

- Greater New Orleans Health Information Exchange (GNOHIE)
- Funded in 2010
- Began exchanging data in 2012
- Community-provider led
- Public-private partnerships to develop
- Focus on event notifications for proactive follow-up

HIE in NOLA

- Strategically support non-traditional modes of community collaboration
- Support our members in a transition to a value-based care environment
- Alignment of data services and resources


HOSPITAL
Hospitals
Primary Care Clinics
Behavioral Health
Laboratory
GNOHIE
Prison Healthcare Provider
Emergency Medical Services
School
School Based Health Centers
Louisiana Health Information Exchange
SHELTERS
Multispecialty Ambulatory

BUILD Health Mobility

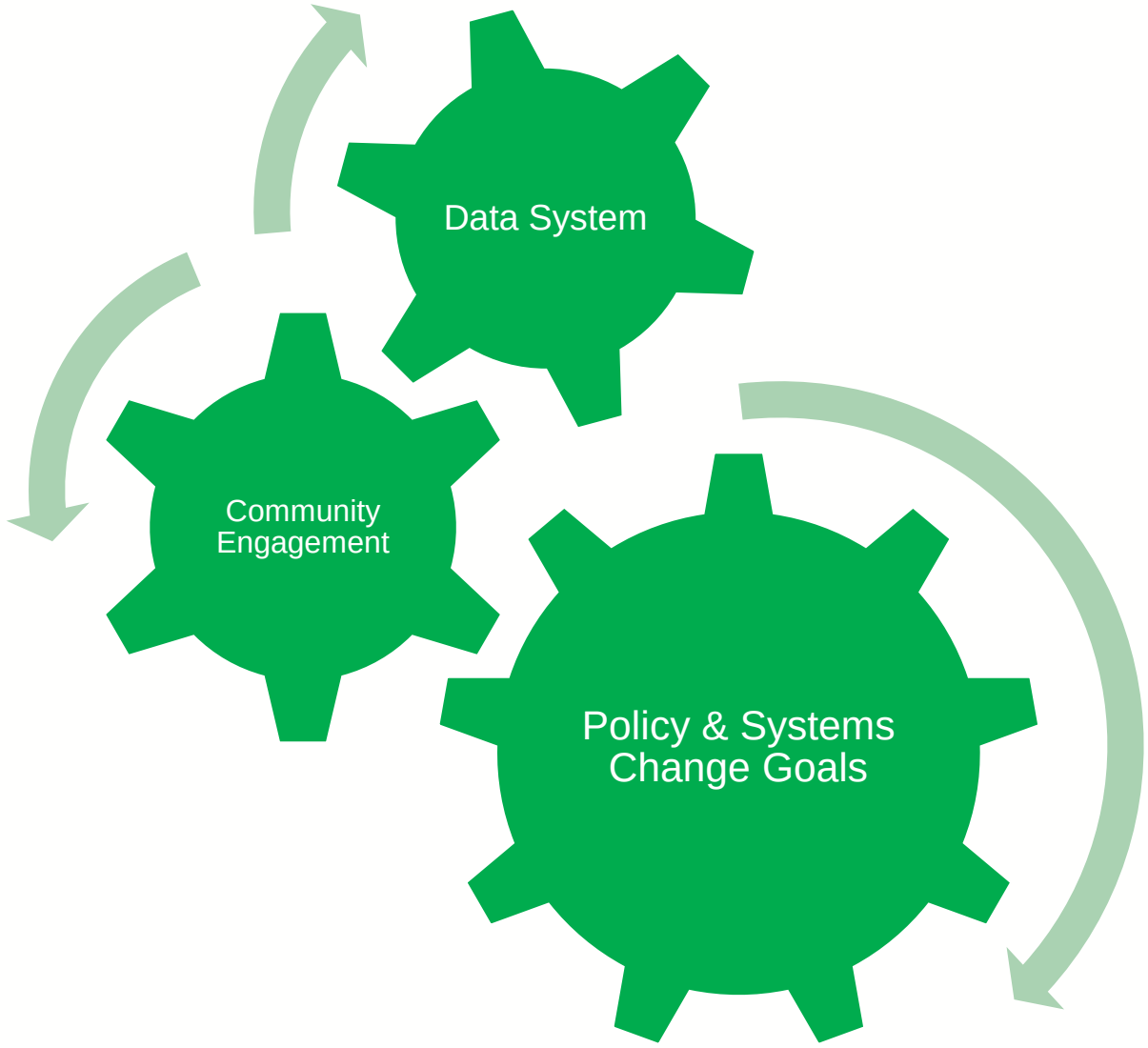
Vision:

All who live, learn, work, and play in New Orleans' Claiborne Corridor have equal access to opportunities, including the opportunity to be healthy.

Mission:

To **equitably improve health and wellbeing** in the Claiborne Corridor through **enhanced mobility and access to opportunities.** To accomplish this, we will use **locally-derived data** and **community-driven analyses** to advocate for **health considerations in mobility planning and policy decisions**.

BUILD Strategy



Existing Infrastructure

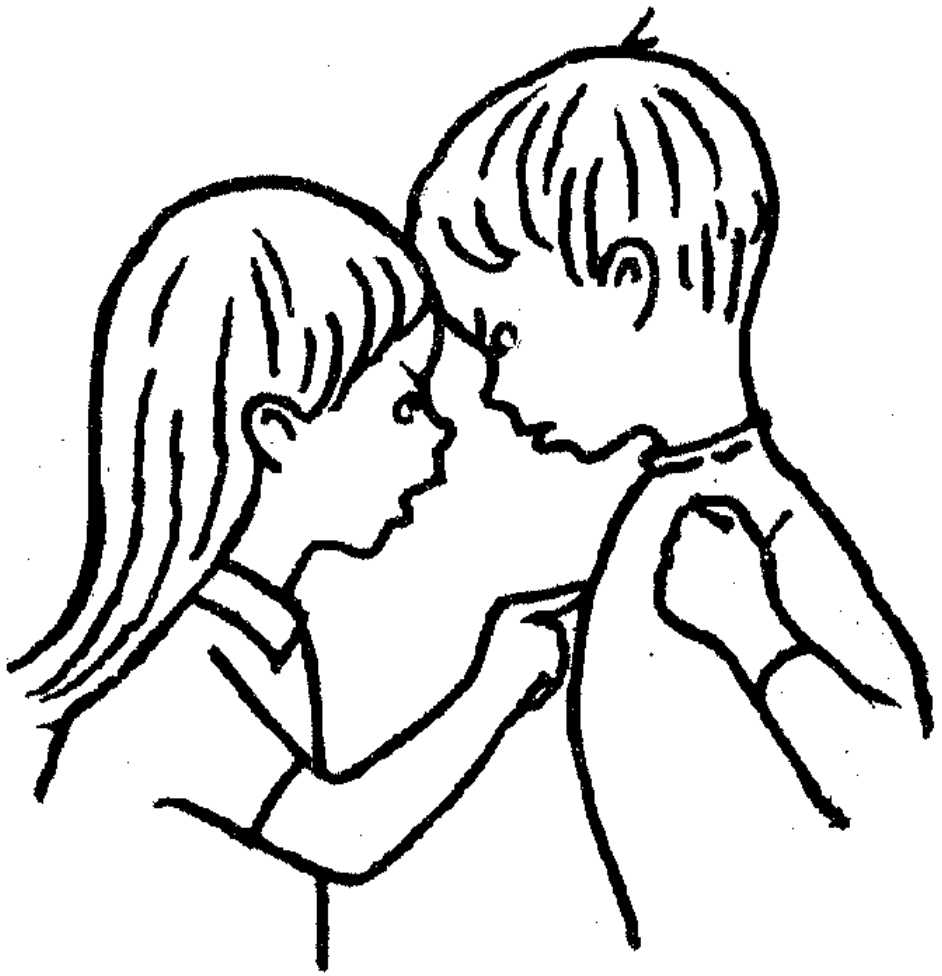
1) GNOHIE
2) REACHnet
3) Analytical tools
4) High rate of EHR adoption

Challenges to Address

1) High ED utilization
2) High rates of missed appointments
3) Patients calling 9-1-1 as a way to get to care
4) High rates of chronic disease
5) Transportation barriers to accessing health care, grocery stores, jobs, etc.

Ongoing Challenges

- Design of Infrastructure
- Stakeholder Engagement
- Funding
- Vendor Capabilities



The Future is Now

The Future is Now

Future Lines of Inquiry

Opportunities for HIE

- Are there hotspots of EMS pickups?
  - Geography
  - Time of day
- What types of data can be made available through the HIE to better support interventions that address social needs?
- What else can the HIE do to support health and social service providers to reduce high-cost hospital utilization and promote low-cost preventive utilization?

Future Lines of Inquiry

Opportunities for REACHnet and Other Tools

- What proportion of patients report transportation barriers?
- Are there geographic hotspots of patients who report transportation barriers or have missed appointments?
- What health conditions and utilization patterns are common among patients with missed appointments?
- Where could public transportation access be improved for greatest health impact?

2-1-1 Data

- Comprehensive data warehousing
- Data analytics to assess social impact
  - Hotspot reports
  - Insight about resource availability compared to actual need
- Strategy development for data-driven decision making
  - Targeted advocacy activities
  - Messaging to policy makers

Takeaways

- The work never ends, but
  it is meaningful.

- Community and regional partnerships drive change for:
  - Policy
  - Infrastructure
  - Strategy

Thank you

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