

NNIPCamp Atlanta, May 10, 2018 4:30-5:30

Session 2 – Health

Led by Peter Eckart and Leah Hendey

Notes by Rob Pitingolo

Attendance: Groesbeck, Gouverovich, Havelca, Azola, Livengood, Pitingolo, Brown, Weinstein, Hendey, Shipley, Chun, Pritchard, Iyer

Eckart: It's unconference so you can leave when you want. Thanks for coming. I run a RWJ grant out of Illinois Public Health Institute. We're statewide in IL and for the last 3 years directed data cross-sectors for health. It's a data support project and I got connected to NNIP pretty quickly. I get questions about data a lot. I always check the NNIP website to see if there's a partner to connect them to. I was just in the session on criminal justice and now I wanted to start this. Some folks said how we have been talking about "isms" and how they are powerful forces. Someone said he thought the health people have language around social determinants of health. As I was thinking about is that the question to explore is what does NNIP and the field of being a data intermediary offer to the world of health. If you've ever heard anyone speak on health they say that when we think about health about 20% of what we understand about health is determined by the system or access to healthcare. Everything else is about social forces, genetics, environment, lucky. Culturally and economically we think about hospitals and that's only a small part of it. Even though we have investments via ACA and health reform. That pumped money into things that are good but some things that OK but not going to address health. There's a group of people and we're a part of a set of initiatives that say "what if the investment wasn't primarily about clinical encounters what if it was about trying to create capacity in local communities to do data sharing that affects other social determinants. What if we integrate health data with education, transportation, etc." For the last 3 years that's what I've been doing. In the sheet I handed out there's a map of 60 or 100 different communities. There's a bunch of people besides me working in this space. There's a group in all different places who are supporting this work. They are talking about multi sector approaches, data sharing. It's very much in alignment with what we're doing. We're doing it for health and you're doing it for community development. We think that stuff is going to be perfectly aligned for health. I'm interested in what you're working on. If there are things we can do that would be helpful to you but you also have so much to teach us.

Hendey: What projects should we try to do around health? Demonstrating the power of the network? Making cross-site projects? Demonstrating how our network adds value?

Groesbeck: I think we are pretty good and I think about the RI absenteeism that kids are absent bc they have asthma because of their houses. Getting my hands on health data is hard. I want to know how to do that.

Eckart: We can talk about that. We have a lot of examples. I can definitely tell stories about that.

Groesbeck: Our local public health department will work with us but they're a state agencies so they have rules. We can get FL charts but it's not good for local. What we have we're lucky to have. The challenge is it's not just the public health dept stuff but all the medicaid and managed care companies which contributes to a whole different level. I don't think you know that much about constraints.

Gouverovich: Information is all over the place.

Eckart: Unless you have a health info exchange.

Groesbeck: I was on the board of ours.

Eckart: I don't want to assume you know anything. They were created via ACA to create a system to trade info across systems. In your case and my case they died after fed funding went away.

Groesbeck: I was on the board representing the community and their initial concept was that data was community data but you couldn't get buy in without hospitals and when they got involved there was fighting and it fell apart. Which is unfortunate because the concept is good. I think it was too much money at once. Different people tried to own the data. The director was french and thought it was her data. Her data moved with her but she had control over own data. We came from a different perspective.

Eckart: It's really variable. In some places a lot of data is available. One place is Allegheny County. They wanted to create a synthetic population and fairly sophisticated county population. They would up with data from 4 counties but wound up having a rich dataset that covered a lot of the population. There are places where the ability to get information works but in this case I would say the public health departments are leverage. Public health has a place in HIPAA and you can take advantage. I want to say as terms of a resource that we published in March a primer on healthcare data 101. Katie reviewed it. So did Mark Abraham. Thanks everybody. Hopefully that is the NNIP stamp of approval. That's a place where if you've been doing this a while there's nothing new in there. For new folks it might be good. Two days ago we finished a 2 part series about accessing health data from other sectors. Beaumont foundation published a document - this is all on our website - it was a nice guide to how to use health data. We did a 2 part webinar where they introduced it on the 1st part. They are recorded. You can access them.

Hendey: I sent an announcement around to the webinar.

Eckart: We had 400 register and 175 show. I don't want to lose this thread. The other piece is that all of this is relational. It's all HIPAA and other laws used as excuses. On this webinar Josh said 'no' as an answer is only the beginning of the conversation. It's almost always no at first. Now it takes a long time. That's a primary lesson we've learned. Things do happen. I want to go back to this simple idea that's quite powerful - identifying the common use case. I think it's easy

to identify but the problem is getting to the right person. Or it's finding the data steward. There is detective work involved. Sometimes it's not the institutional answer.

Hendey: Jordan want to share?

Shiple: We are starting to ramp up. We are funded by a foundation.

Eckart: Talk about your relationship with the hospital.

Shiple: There's a HUD grant. There was a HUD grant on asthma conditions. We had an investigator from the hospital. It's an initiative grant. To extend asthma research. The next step is to expand relationships - set up secure servers and set up use cases for existing asthma and lead projects. We definitely need help to do this right.

Eckart: Three things. I don't need to say much here. Contact us anytime. We maintain stories where this is happening. On the website are descriptions of all the projects. Right now you can browse. Nonprofit hospitals are required to do community benefits and needs assessment. They are required to show how they engage the community and spend some amount of money. Typically they say they provide charity care. That's a great example. You can find out the community person at any nonprofit health system. The other thing is that they model for how we pay for healthcare has changed. It used to be fee for service. Now it's pay for value or pay for success. Insurance companies are increasingly not being able to bill for units of service. The understanding is that's it's inefficient and not a good way to provide service. You're only being judged on the inputs. Pay for success is looking at the overall improvement as part of this. The reason the payers are involved is that they say they are the covered population and you'll be responsible for overall health. We'll pay you based on the health outcomes. That's the way the overall arc of payment reform comes. That's a wave of change that's moving through. Where is the opportunity? The opportunity is that we go back to the thing where healthcare is only 20% of health then the providers need to engage outside of their walls. They need to involve other people. That's the "what in it for me". Even for hospitals and doctors who have hear about this there is a structural delivery. People understand they can't treat you to wellness but that's what they're set up. Some those models that require partnerships.

Groesbeck: The recidivism issue - if you return after you got sick the hospital gets hit. Now they look at nursing homes. Why is this happening?

Eckart: There's a tension in healthcare about partnering with people who provide services or bring it in house. They've lost a good amount of staff to health systems who try to understand what public health does. There's just not a lot of capacity for using this. There's never been a mandate for common standards across systems. This is why health and housing is enjoying a moment in the sun. At least there is the management system which is a dataset proscribed by HUD for homelessness. There's a common data standard, across the whole country. I want to hear from folks about successes or frustrations. Especially successes.

Livengood: We've had success. Did pilot projects with a local clinic and they are linking their electronic records to our geographic data on social determinants. It's been great. They've been giving clean data. We are looking at a few outcomes linked to their improvement efforts. We originally reached out to health federation who was the linkers. They identified this network as a clinic that would be a place to start. Eventually we extend this to the broader network. We're working on the kinks and the legal issues. So far it's been going well.

Eckart: That's the good and bad. The good is that a good potential partner are community health centers and federally qualified health centers. These institutions by their nature work with people on the underside of the social determinants. You don't have to sell them on mutually beneficial relationships. That's the good. The downside is they have less capacity than a big group.

Livengood: We're doing a similar project with the children's hospital. That's a huge project where they're building a database. We're contributing the health disparities research. Funded by tobacco settlement money.

Eckart: Will there be a change to records. Or a one time research integration. The larger database would be used for other purposes. There has been talk about other factors. Place based factors matter and those things affect health. We are hoping is a change to come out of it. The drumbeat for social determinant has gone from moral argument to a fiscal argument. It's good that there is a merging. The hospital is not the right place for this. What other successes?

Iyer: We have a different organization called Hilltop Center that houses medicare and medicaid data. We partnered with them on healthy homes study. We have education data so we could show after the intervention that absenteeism went down. That was a nice, but difficult, display of complementary data. We'd love to do more.

Eckart: Maryland has a universal healthcare budget. Come into play?

Iyer: I don't know.

Eckart: What the state spends is money allocated by uses and outcomes. It's a state based approach to this pay for success. How about massive failures?

Hendey: Wait, Children's National has their own HIE for pediatrics. They have more than 100 doctors they don't have 100% of children but maybe 60 or 70 percent. We met with the chief data officer. They don't have any money. It's all fee for service. No incentive to make kids healthier. Trying to come up with a project to work together in this context.

Livengood: We can help come up with something.

Hendey: We have housing data.

Eckart: I'm not convinced. I'm hopeful at this point that there's low hanging fruit out there in terms of capturing expenses that would have been spent on care by diverting to less expensive modes of care.

Hendey: For burns they mapped it and started doing education about heaters. Once they did education the burns dropped. They had to map the data.

Eckart: There's not an economic incentive.

Livengood: They can't pay for an intervention.

Eckart: Wrong pocket of problem. In this case you had to spend money to map and spend money on outreach. Burns went down. The value is in the school system because kids are in class more. School system gets paid per kid day. School system benefits. The local economy benefits because parents are taking kids to doctors. This is the wrong pocket problem. Money is spent by mappers but somebody else gets the benefit. This is a big issue. It's an issue across all public expenditures. It's a very specific issue that people in health are trying to address.

Pritchard: They tried screening for social determinants. As an opportunity you could do a predictive model. Could be useful as a substitute. They've given it a good shot.

Groesbeck: Hospitals are not the place. They have some but not all data. As we move to more community based care and see more freestanding ERs. They may be in the network but it's insurance companies who have data. As a client I can go to different places. I can go out of network. The only one who knows is insurance. Any models with insurance?

Eckart: Anybody work with all payer claims databases. I don't know how widely this is. I think IDs are interesting at getting admin data behind the scenes. The reason people are excited about this thing is that there's less restrictions.

Iyer: I don't think we know what social determinants are. Some indicators are not obvious but probably are determinants. We are looking at declining population as an indicator. Thinking through the real social determinants from a neighborhood perspective. They can't necessarily help with all of that. What does it mean for someone to live in a declining neighborhood. Population loss is a sign of that.

Eckart: There's a proxy data in Chicago - high school graduation rate. That's a proxy but it's a good one. There's a lot of interest now in indicators but I think the conversation is about health equity. This is another way in. Even if people aren't morally committed. Trying to push upstream to understand all the impact turns all the social determinants into measurements of the big three isms. I think there is an exciting opportunity for some new ways of measuring the long term effects of racism and classism. I think that's an opportunity to engage across sectors. Equity demands a multi-sector approach.

Weinstein: We are trying to take on health partners. There's a big hospital and they closed during Katrina and funding is now dispersed to different systems. They had a needs assessment and asked us to look at it. It was wrong the way they did it. They did a survey but didn't know the basic demographics to control and weigh responses. So what I'm seeing is people in health asking for us for help. But they don't even know what we can do and how it relates.

Eckart: I think that's true but again is a great opportunity for all of you. There are a lot of things happening in a lot of places. There are a lot of pastors but few good ones. Everyone has to do a community assessment but only the ones true to the spirit do it well.

Iyer: The reason it's true is because not even public health folks understand community. I might not know about health but maybe we make common ground.

Eckart: I want Seema to have the last word because I think this is the obvious opportunity. OK lastly there's a lot happening with us, lots of resources. We maintain online learning collaborative. I will connect you to people useful to you. We represent a lot of interesting work.

Hendey: They do webinars.

Eckart: We're doing one next week on county indicators. Sign up for our newsletters.