Texas MCO NMDOH Learning Collaborative **In-Person Meeting**

March 1, 2024

Made possible thanks to the support of the Episcopal Health Foundation and the Michael and Susan Dell Foundation

Center for Health Care Strategies
Better care where it's needed most

EPISCOPAL HEALTH FOUNDATION

TACHP Texas Association of Community Health Plans

TREATY OAK STRATEGIES

The University of Texas at Austin Dell Medical School

Michael & Susan Dell FOUNDATION

TAHP The Texas Association of Health Plans

TEXAS Health and Human Services

Welcome & Introductions

Shao-Chee Sim
Executive Vice President for Health Policy, Research & Strategic Partnerships, Episcopal Health Foundation

Kay Ghahremani
CEO, Texas Association of Community Health Plans

Emily Sentilles
Deputy Associate Commissioner, Quality and Program Improvement, Medicaid and CHIP Services, Health and Human Services Commission

Key Major Initiative Updates
HB1575 Implementation

Michelle Erwin
Deputy Associate Commissioner, Policy, Medicaid and CHIP Division, HHSC

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Health and Human Services

House Bill (H.B.) 1575

Michelle Erwin, *Deputy Associate Commissioner*
Office of Policy

Emily Sentilles, *Deputy Associate Commissioner*
Quality & Program Improvement

H.B. 1575 Summary

MCOs and Thriving Texas Families (TTF) screen pregnant women for nonmedical health-related needs and coordinate services

Pregnant women must opt-in

MCOs and TTF share results with HHSC

Community Health Workers (CHW) and doulas will be new providers of Medicaid case management for Children and Pregnant Women (CPW) services

Revised provider training for CPW services

Reports sent to the Legislature every two years

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H.B. 1575 Timeline

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Sept. 2023
HHSC drafts screening questions

Oct. – Nov. 2023
MCOs & other stakeholders give HHSC feedback

Dec. 2023 – Feb. 2024
HHSC finalizes screening questions

Jan. – Aug. 2024
HHSC drafts / finalizes MCO contract requirements (UMCC & UMCM)

May 2024
Doula and CHW begin CPW training

Sept. 2024
Contract & SPA revisions effective

Summer – Fall 2024
Doulas & CHW enrollment period in PEMS

Fall 2024
MCOs and TTF start screening & sending results to HHSC

Winter 2024 – 2025
Doulas & CHWs can submit claims for CPW services

Dec. 2024
HHSC reports back to Legislature

Upcoming Implementation Activities

Doulas and CHWs

- HHSC to begin stakeholder input process for doula credentialing criteria
- New provider training to be conducted over Summer 2024
- Doulas and CHW begin PEMS enrollment by Fall 2024

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Health and Human Services

TEXAS
Health and Human
Services

Thank You

Key Major Initiative Updates
Updates from the Office of Access and Eligibility

Hilary Davis
Senior Advisor, AES Office of the Deputy Executive Commissioner, HHSC

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HB 12 Updates

March 1, 2024

HB12 – Extended Postpartum Coverage

The Texas Health and Human Services Commission (HHSC) extended its postpartum Medicaid coverage from two to 12 months for eligible women, effective March 1, 2024.

Eligible recipients include:

- Medicaid or CHIP recipients who are pregnant or become pregnant and women who enroll because they become pregnant.
  - CHIP Perinatal (CHIP-P) recipients are not eligible for 12 months of postpartum coverage. They'll continue to receive CHIP-P coverage through the end of the month when their pregnancy ends plus two postpartum visits.
- Medicaid or CHIP recipients who were enrolled while pregnant or are no longer pregnant but are still within their 12-month postpartum period.
  - Women who transitioned from Medicaid or CHIP to Healthy Texas Women (HTW) after their pregnancy ended and who are within their 12 months postpartum period will be reinstated to full coverage Medicaid or CHIP.
- Women who received services while pregnant in Texas that would have been covered by Medicaid but who apply for Medicaid after their pregnancy ends. Medicaid applicants with unpaid medical bills can apply for coverage for up to three months before their application month. This doesn't apply to CHIP applicants.

HB12 – Extended Postpartum Coverage

- Current and former recipients do not need to reapply to have their postpartum coverage reinstated or extended.
  - Eligible recipients will receive notification of their postpartum coverage by mail or through their Your Texas Benefits account.
  - In most cases, women whose coverage is reinstated will be re-enrolled in their prior managed care plan.

- Eligible recipients will remain enrolled for the duration of their 12-month postpartum unless they:
  - voluntarily withdraw;
  - move out of Texas;
  - are determined ineligible because of fraud, abuse or perjury; or
  - die.

- Recipients will go through a renewal process about two months before the 12-month postpartum period ends.

Resources

The extended postpartum toolkit can be found at the bottom of the Women and Children webpage on the HHS website. https://www.hhs.texas.gov/services/health/women-children

Extended Postpartum Coverage

HHSC extended its postpartum Medicaid coverage to 12 months for eligible women, effective March 1, 2024. HHSC is also providing 12 months of postpartum CHIP coverage. The 12 months of postpartum coverage begins the month after a pregnancy has ended.

Downloadable Materials

General Information Flyer

This flyer (PDF) provides general information about the postpartum coverage extension.

Frequently Asked Questions Document

This document contains frequently asked questions (PDF) about the postpartum coverage extension.

Social Media Toolkit

This Social Media Toolkit (ZIP) provides social media posts and graphics you can share to increase awareness about the postpartum coverage extension.

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Health and Human Services

Thank you!

Tara Stafford
Director, Community Engagement, BSW Health Plan

Joshua Fernelius
Senior Manager, Population Health, Community Health Choice

Melanye Otto
Director of Quality Improvement & Risk Adjustment, Community Health Choice

Naomi Garcia Alvarez PhD, MBA, LPC-S, LPCC
Vice President, Behavioral Health, Molina Healthcare of Texas

Michelle Murdock
Vice President of Operations, Superior Health Plan

Dr. Salil Desphpande
CMO, United HealthPlan

Laurie Vanhoose (Moderator)
Principal, Treaty Oak Strategies

Maternal Health Panel

Engaging Medicaid Members

Identifying the Non-Medical Needs of Pregnant Members

Tara Stafford
Baylor Scott and White Health Plan

Joshua Fernelius
Community Health Choice

Melanye Otto
Community Health Choice

Naomi Garcia Alvarez
Molina Healthcare of Texas

Michelle Murdock
Superior Health Plan

Dr. Salil Desphpande
United Health Plan

Laurie Vanhoose
Treaty Oak Strategies

BACKGROUND

- Stakeholders are talking about NMDOH interventions, but Medicaid enrollees remain absent from many conversations
- EHF, MSDF, MHM, and St. David's Foundation partnered with 5 MCOs to gather member experiences and input from pregnant members
- EHF published a report summarizing key findings about their perspectives and thoughts on non-medical needs and supports by subject area:
  - Employment
  - Housing
  - Transportation
  - Food

METHODOLOGY

- Each MCO recruited enrollees who were or recently had been pregnant
- Focus groups conducted in cities throughout TX: Austin, Houston, San Antonio, Waco, El Paso, Lubbock, Brazos Valley, Abilene
- Participation voluntary, responses anonymized to maintain confidentiality, no names are included in the final report
- Funding from EHF reimbursed each participant for their time with a $50 gift card
    - Baylor Scott and White Health Plan conducted two virtual discussions with 10 participants
    - Community Health Choice conducted two virtual discussions with 14 participants
    - Molina Health Plan conducted individual interviews with 5 participants
    - Superior conducted 4 in-person discussions after baby shower events with a total of 10 participants
    - United Health Plan conducted two virtual discussion which included 10 members

KEY FINDINGS

Besides housing, employment, transportation, and food; participants also identified:

Domestic Violence

- Traumatic experience created instability, health threats to mother

Childcare

- Few had family, friends, neighbors, or community institutions to provide childcare
- No childcare = harder to make medical appointments during pregnancy, return to work after pregnancy

English Proficiency

- Accessing services more difficult for women not fluent in English

Maternity Clothing & Baby Essentials

- Relied on garage sales, second-hand stores for maternity clothing
- Worried about getting to stores, affording baby essentials two months after delivery

KEY FINDINGS

Participants also identified critical health care barriers they faced:

Continuous Insurance Coverage

- Difficult to get Medicaid coverage (more hoops to jump through than SNAP and WIC)
- Lost coverage before they could obtain coverage or even afford a new insurance plan 60 days after delivery

Access to OTC Medication

- MCOS not reimbursed for OTC medications for pregnant women unless prescribed & on Medicaid formulary

Pregnancy Education

- Most of pregnancy education came through word of mouth, could be unreliable

KEY FINDINGS

Social networks provided the most NMDOH support

Health Plans

- Role of health plan in NMDOH:
  - NOT surveying/asking questions
  - Providing resources
  - Providing info for assistance
- MCOs provided significant non-medical support to enrollees

Social Networks

- Family, friends, neighbors
  - Getting to groceries, appointments, etc.
  - Cover bills, rent, food
  - Providing info for assistance
- CBOs (limited resources, long wait times)
- Concerned about finding postpartum social groups

Providers

- PCPs & OBGYNs
  - Good medical care
  - Rarely asked about NMDOH
  - NMDOH resources available upon request, often didn't think to ask
- Would like NMDOH resource info at kiosks in office to not need to ask

EMPLOYMENT

Challenges Faced

- Difficult/impossible to work during pregnancy
  - Physically demanding, uncomfortable jobs
  - pregnancy-related health complications
  - workplace discrimination
- Some spouses/partners struggled with secure employment
- Unpaid maternity leave
  - Spouses/partners need to make ends meet on single-family income
  - Concerned that they or spouse/partner would have to take on a second job to make ends meet

Supports

- Support finding employment from MCOs
  - Job-hunting services
  - Additional supports and services needed for employment security

Continuing Needs

- Childcare assistance set up before delivery to go back to work ASAP
- Advocating for paternity leave to split burden of childcare without compromising income/risking employment security

HOUSING

Challenges Faced

- Worried about having safe & stable housing
- Insecurity predominantly due to unemployment/insecure employment

Supports

- Predominantly from mothers' MCOs
  - Finding safe, affordable housing
  - Additional supports and services needed to reduce housing insecurity

TRANSPORTATION

Challenges Faced

- Transportation to medical appointments, grocery stores, work, and school
  - Those who did not have a car or shared car with spouse/partner
  - Especially hard in rural areas
- Could not share partner's car due to partner's work
- Public transportation
  - Last mile problem
  - Lack of accessibility features at bus stops

Supports

- MCOs — transportation benefits
  - Some could not use NEMT benefits — did not have childcare to leave children at home
- Family members
- School busses
- Facebook groups for rideshares

Continuing Needs

- Unsure how to find transportation support after coverage ends

FOOD

Challenges Faced

- Low income -> food insecurity
  - Running out of food before able to buy more
  - Prioritize food or bills?
- Limited transportation to grocery store
- Hard to get healthy food
  - Expensive at store
  - Time-intensive
  - Spoils faster
  - Not common at food banks

Supports

- WIC
  - Easier than applying for Medicaid
  - Increased access to fresh foods
- MCO support applying for WIC & SNAP
- Churches & food banks
- Free school lunches for school-aged children

Continuing Needs

- Continued WIC assistance
- Travel to grocery store after coverage ends
- Getting food right before & after delivery

CONCLUSION

- Critical to include voices of Medicaid beneficiaries in addressing health disparities & improving access to care
  - CMS adopting rules that will reshape states' MCAC & create a Beneficiary Advisory group
- Reenforces need for policies like House Bill 1575 and HHSC's NMDOH Action Plan
  - Health care coverage after delivery addressed through passage and implementation of HB 12
- MCO investments in interventions provide needed support
- Additional support & policies to explore:
  - Develop partnerships between providers, MCOs, CBOs to provide NMDOH resources
  - Better connect pregnant women to community supports and resources
  - Improve education about the Medicaid transportation benefit
  - Medicaid coverage of transportation to additional locations
  - Ensure providers, MCOs, others use a trauma-informed approach to care
  - Provide a flag on MCO files indicating members receiving SNAP and/or WIC benefits
  - Allow greater OTC medication Medicaid coverage

National Policy Landscape Supporting NMDOH

Diana Crumley
Associate Director, Delivery System Reform, Center for Health Care Strategies

Center for Health Care Strategies
Better care where it's needed most

National Policy Landscape Supporting NMDOH

Diana Crumley, Associate Director, Delivery System Reform

Made possible by the Episcopal Health Foundation and the Michael & Susan Dell Foundation, in partnership with Treaty Oak Strategies

Center for Health Care Strategies

Dedicated to strengthening the U.S. health care system to ensure better, more equitable outcomes, particularly for people served by Medicaid.

Together with our partners, our work advances:

Effective models for prevention and care delivery that harness the field's best thinking and practices to meet critical needs.

Efficient solutions for policies and programs that extend the finite resources available to improve the delivery of vital services and ensure that payment is tied to value.

Equitable outcomes for people that improve the overall wellbeing of populations facing the greatest needs and health disparities.

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Trend 1: More states will cover nutrition and housing supports through Medicaid, in response to CMS guidance.

CMS Guidance on Coverage of HRSN Services (November 2023)

- Discusses 15 nutrition and housing interventions
- Outlines options under four approval pathways
  - → *In lieu* of services (ILOS), home and community-based services (HCBS) programs, Section 1115 demonstrations, and CHIP health services initiatives (HSIs)
- ***Toplines***
  - → 1115 demonstration authority is most flexible, but a lot can be done under other authorities like in lieu of services, HCBS programs, and CHIP HSIs!
  - → Services like pantry-stocking, food prescriptions, and grocery provisions can be added to 1915(c) and 1915(i) HCBS programs

https://www.medicaid.gov/sites/default/files/2023-11/hrsn-coverage-table.pdf

New Jersey: 1115 Waiver Demonstration (2023)

- Nutrition counseling and education for managed long-term services and supports (MLTSS) members
- One-time transition costs for MLTSS eligible members, including pantry stocking, who are transitioning from an institution into the community
- Short-term (no more than 30 days) grocery provision for an MLTSS members to avoid an unnecessary emergency department visit, hospital admission, or institutional placement

New York: 1115 Waiver Demonstration (2024)

- Medically tailored or nutritionally-appropriate food prescriptions, prepared meals, or fresh produce and non-perishable groceries.
  - → High-risk pregnant individuals may receive up to 11 months, including up to 2 months postpartum, in nutrition supports.
  - → Additional support is permitted for high-risk households of at-risk children and pregnant individuals

Wisconsin: CHIP HSI (2021/2022)

- Housing supports for children 18 and younger and individuals who are pregnant who have low income and do not have housing
- Asthma Care Program for children and pregnant women enrolled in or eligible for Medicaid, including: case management, in-home education, environmental assessment, provision of durables, and acute environmental hazard remediation totaling no more than $5,000.

Trend 2:

More organizations will screen for social needs, in response to new federal requirements and codes.

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New Medicare Codes (FY 2024 Fee Schedule)

- New codes
  - → SDOH Risk Assessment (HCPCS code G0136)
  - → Community health integration (CHI) services performed by certified or trained auxiliary personnel, including CHWs – 60 minutes (HCPCS code G0019)
  - → CHI services, each additional 30 minutes per calendar month (HCPCS code G0019)
- Medicaid programs can opt to cover new HCPCS codes, via small changes to medical policies and fee schedules. Others may consider using codes in alternative payment models (APMs).
  - → E.g., Colorado Medicaid now covering these new "Medicare crossover codes"
  - → E.g., CHI Service implementation and potential APMs to be discussed via *Community-Driven, Multi-Payer Health Equity Solutions: An ECHO Collaborative* (>20 community-clinical teams participating)

https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule ;
https://hcpf.colorado.gov/sites/hcpf/files/Bulletin_0124_B2400504_0.pdf
https://www.partnership2asc.org/healthequity/

New Models from the CMS Innovation Center (CMMI)

- HRSN Screening requirements in:
  - → Transforming Maternal Health Model (all states eligible to apply)
  - → States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model (all states eligible to apply)
  - → Making Care Primary model
  - → Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model (Texas participants)

New CMS Measures

- **Two Measures**
  - → Screening for Social Drivers of Health measure
    - Rates reported for five domains: food insecurity, housing instability, transportation needs, utility difficulties, or interpersonal safety
  - → Screen Positive Rate for Social Drivers of Health measure
- **Included in:**
  - → Hospital Inpatient Quality Reporting Program (mandatory reporting in 2024)
  - → 2024 MIPS (listed as a high priority process measure)

https://www.federalregister.gov/documents/2022/08/10/2022-16472/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the

Other HRSN Screening Requirements

- Special Needs Plan (SNP) Health Risk Assessments (effective 2024)
- Joint Commission Standards (effective 2023)

https://www.cms.gov/newsroom/fact-sheets/cy-2023-medicare-advantage-and-part-d-final-rule-cms-4192-f

https://www.jointcommission.org/our-priorities/health-care-equity/accreditation-resource-center/assess-health-related-social-needs/#t=_StrategiesTab&sort=%40created%20descending

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Social Needs Screening and Intervention (SNS-E) – New Quality Measure for HEDIS® 2023

- Members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.
  - *Food Screening.* Members who were screened for food insecurity.
  - *Food Intervention.* Members who received a corresponding intervention within 1 month of screening positive for food insecurity.
  - *Housing Screening.* Members who were screened for housing instability, homelessness or housing inadequacy.
  - *Housing Intervention.* Members who received a corresponding intervention within 1 month of screening positive for housing instability, homelessness or housing inadequacy.
  - *Transportation Screening.* Members who were screened for transportation insecurity.
  - *Transportation Intervention.* Members who received a corresponding intervention within 1 month of screening positive for transportation insecurity

https://www.ncqa.org/news/ncqa-updates-releases-new-quality-measures-for-hedis-2023-with-a-focus-on-health-equity-stratifying-measures-by-race-ethnicity-and-affirming-gender-identity-helps-tackle-health-disparities/

Looking forward…

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Persistent Questions

- How can providers and plans coordinate their approaches?
  - → E.g., California will leverage its Population Health Management Service and Data Exchange Framework to help providers and plans share data, including screening data.
- How can organizations ensure that their screening approach is effective and trauma-informed, and fosters trust?
  - → E.g., Accountable Health Communities in Texas have a wealth of best practices.
- What infrastructure is needed to support partnerships with CBOs?
  - → States and federal partners are increasingly thinking about required **infrastructure supports** and the role of **community care hubs** and other backbone organizations

Lunch Break
Return at 12:30

Case Study: Oklahoma's Data Sharing Experience Introduction by Lisa Kirsch

Dr. David Kendrick
CEO, MyHealth Access Networks

Lisa Kirsch
Senior Policy Director, UT Dell Medical School

Medicaid Managed Care Learning Collaborative

March 1, 2024

DATA SHARING

DATA SHARING WORKGROUP JOURNEY

- Review the data landscape for what is available with respect to NMDOH in Texas Medicaid.
- Attribution process for MCO assignment of Medicaid enrollees to primary care providers (PCPs) and other providers for alternative payment models (APMs).
- Learning more about the potential of Community and Health Information Exchange(s).
- The importance of incentives.

NMDOH DATA LANDSCAPE

December 1, 2023 Workgroup included CBO, provider, MCO and HIE speakers that described:

- What NMDOH data are you collecting?
- How is NMDOH data sharing occurring today?
- Which types of organizations are you sharing with?
- How does the data get there?
- What entities are sharing data with you? And how?

KEY QUESTIONS

- What are federal incentives that can be built upon?
- Are there reimbursement opportunities right now, or is this something that will be in the future?
- How can enrollment in federally funded programs, such as SNAP and WIC, be optimized?
- For NMDOH screenings, how can we leverage HIE to minimize duplication of efforts for multiple NMDOH screenings and track data, including for closed loop referrals?
- For a state as large as Texas, what is a statewide strategy that can still have variation regionally?

Health Data Utility & Value Based Payment Models

David C. Kendrick, MD, MPH

CEO, MyHealth Access Network

MyHealth ACCESS NETWORK

Disclosures

David C. Kendrick, MD, MPH

- Founder & CEO, MyHealth Access Network, Oklahoma's SDE for HIE
- Founder & Chair, Department of Informatics, OU School of Community Medicine
- Assistant Provost for Strategic Planning, OU Health Sciences Center
- Technical Assistance Consultant for ONC
- Founder of MedUnison and developer of Doc2Doc
- Chair, Board of National Committee for Quality Assurance (NCQA)
- Board, CIVITAS Networks for Health
- Board, Patient Centered Data Home

MyHealth ACCESS NETWORK

Agenda

- Need for HIE/Health Data Utility
  - Health Data Utility vs. Health Information Exchange
- Oklahoma's Health Data Utility
- Outcomes and Impact on Value based payment models
- Opportunities & Strategies to Consider

MyHealth ACCESS NETWORK

Agenda

- **Need for HIE/Health Data Utility**
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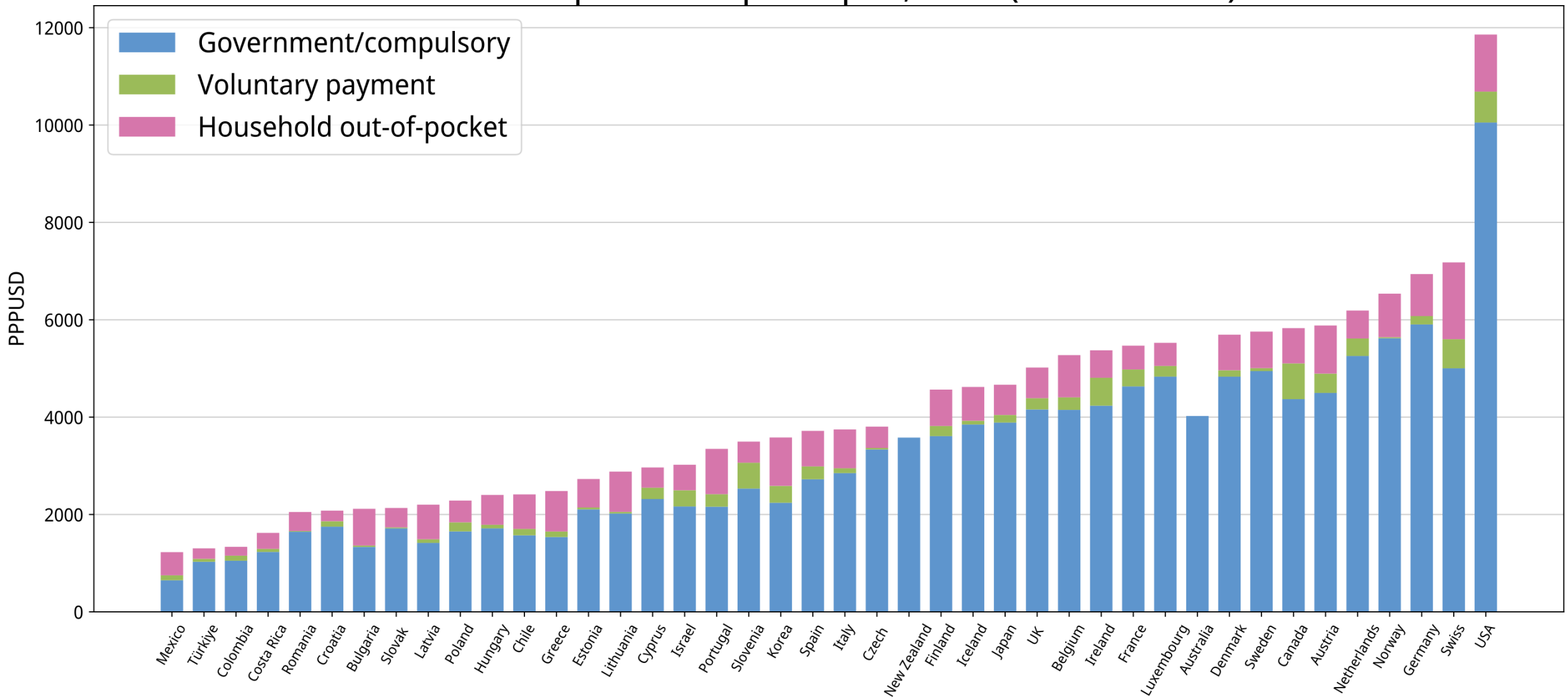
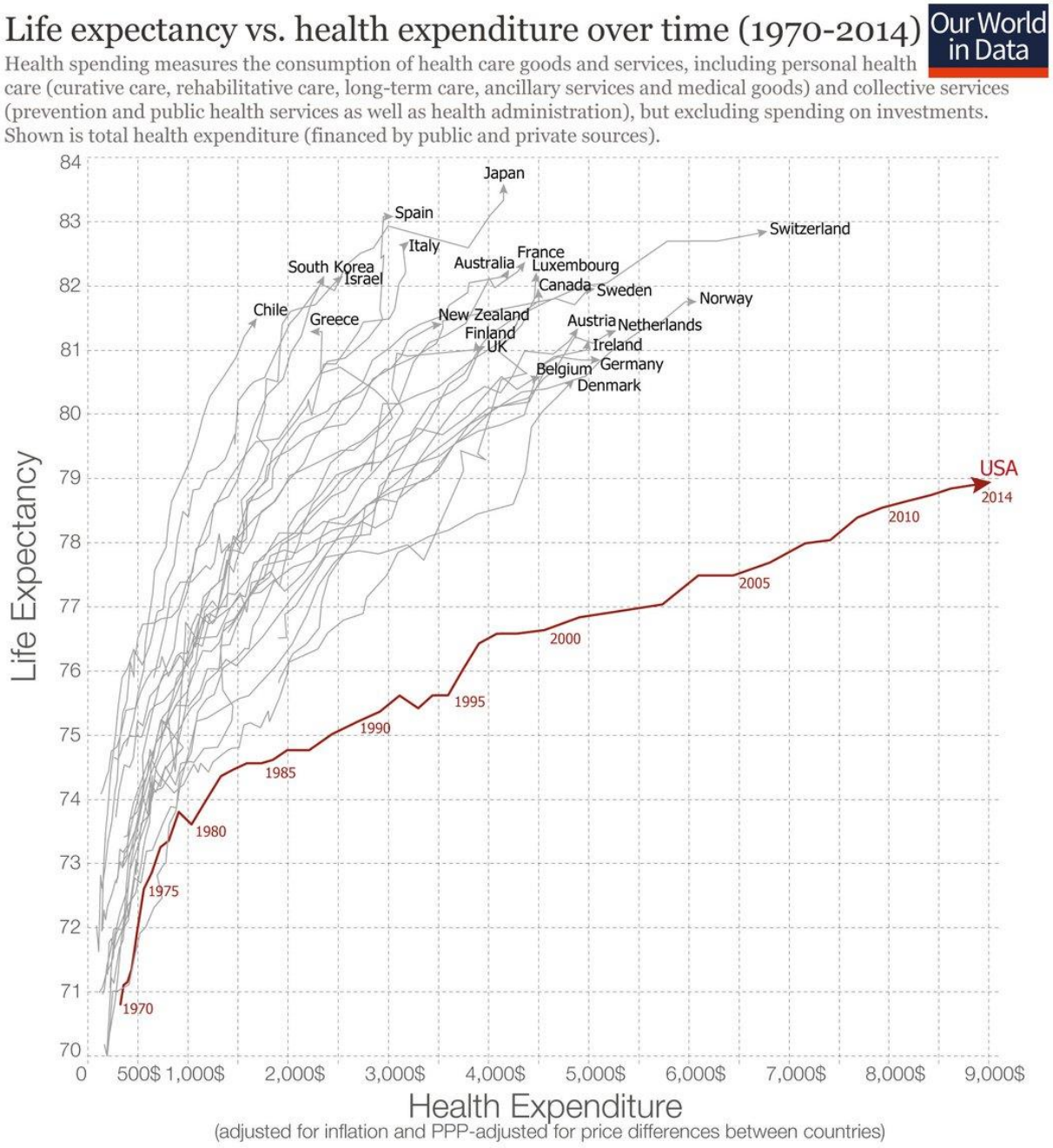
MyHealth ACCESS NETWORK

Health expenditure per capita, 2020 (OECD Health)



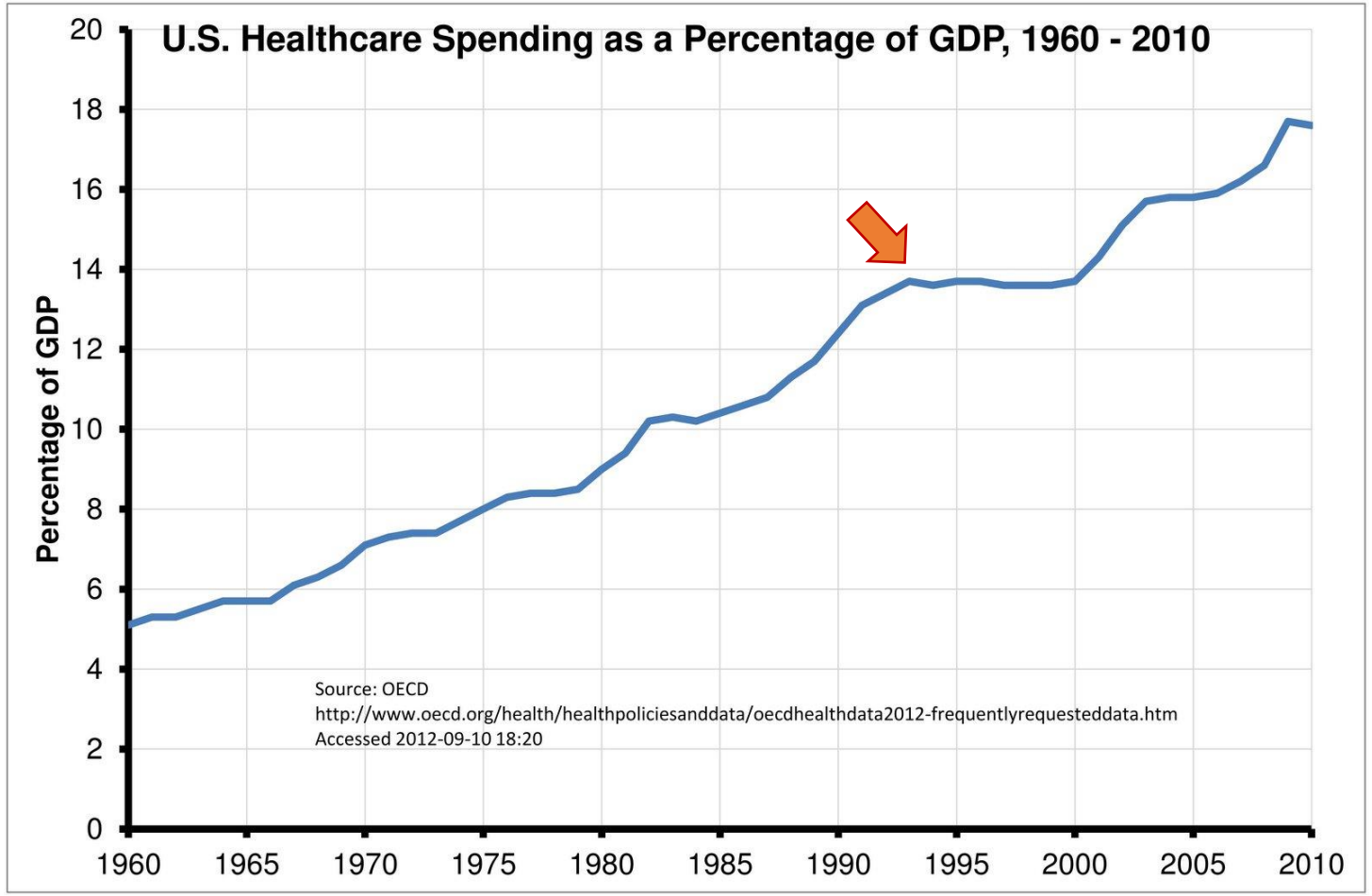
MyHealth ACCESS NETWORK

Are we getting what we're paying for?



MyHealth ACCESS NETWORK

US Healthcare Spending



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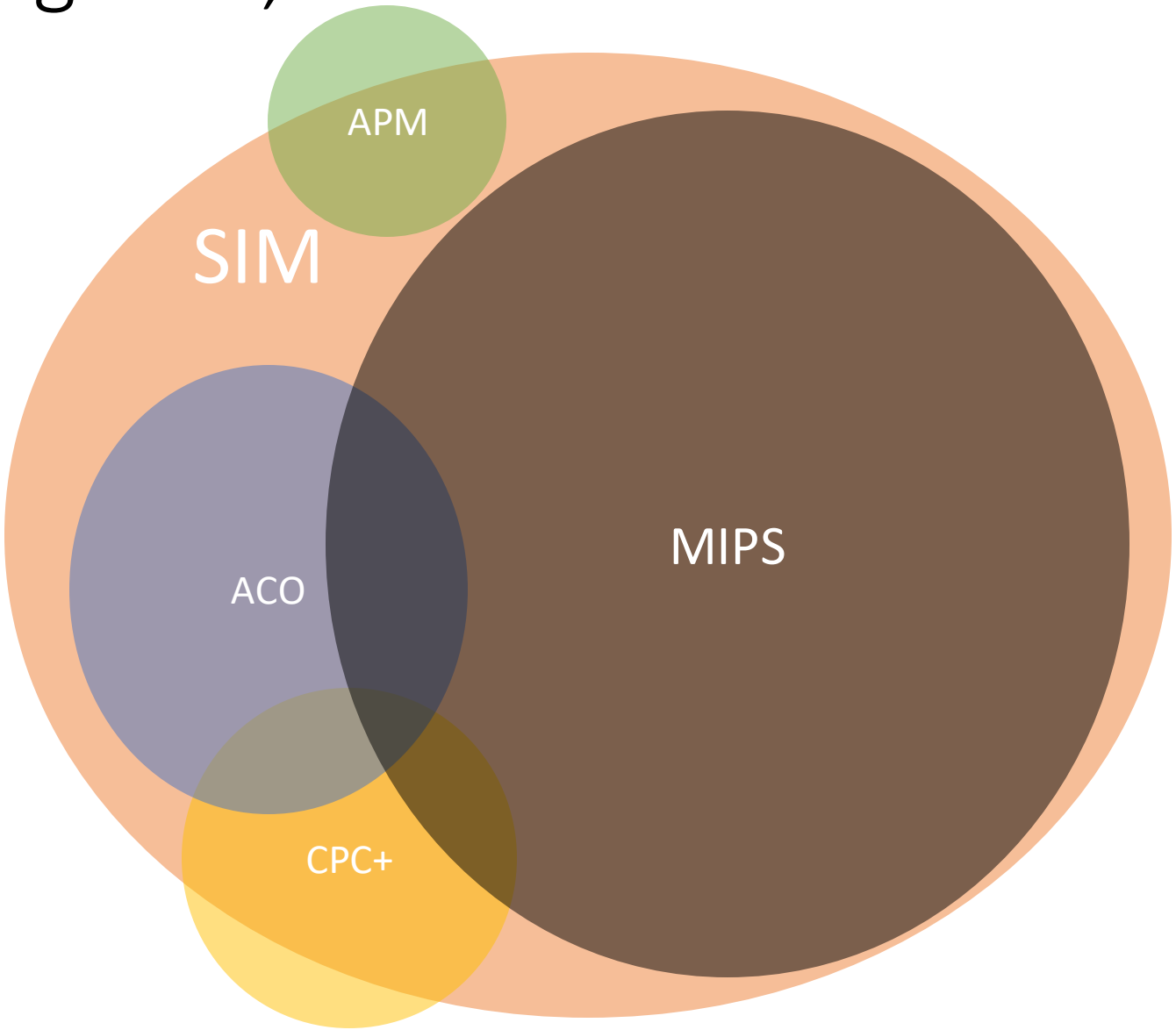
Defining Value

$$Value = \frac{Quality}{Cost}$$

MyHealth ACCESS NETWORK

Healthcare's challenge:
Many programs, common deliverables



MyHealth ACCESS NETWORK

HEALTH INFORMATION TECHNOLOGY

EXHIBIT 3

Association between practice characteristics and ability to create clinical quality reports at the practice level

Characteristic	Odds ratio	95% CI
PRACTICE SIZE (NUMBER OF CLINICIANS)		
1	0.59**	0.38, 0.93**
2–5	0.87	0.57, 1.33
6 or more	Ref	Ref
PRACTICE OWNERSHIP		
Clinician	Ref	Ref
Hospital/health system	2.88**	1.92, 4.33**
Federal	6.02**	3.65, 9.92**
Academic, other or none	1.14	0.64, 2.01
PRACTICE LOCATION		
Urban	Ref	Ref
Suburban	0.70	0.39, 1.26
Large town	1.03	0.64, 1.67
Rural area	0.61**	0.39, 0.96**
PRACTICE PARTICIPATION IN MEANINGFUL USE		
Neither stage 1 nor stage 2	Ref	Ref
Stage 1 only	1.09	0.65, 1.85
Stages 1 and 2	1.65**	1.08, 2.51**
PRACTICE PART OF EXTERNAL PAYMENT PROGRAM		
No	Ref	Ref
Yes	1.73**	1.19, 2.51**
PRACTICE PARTICIPATING IN DEMONSTRATION PROJECT		
No	Ref	Ref
Yes	1.51**	1.09, 2.09**

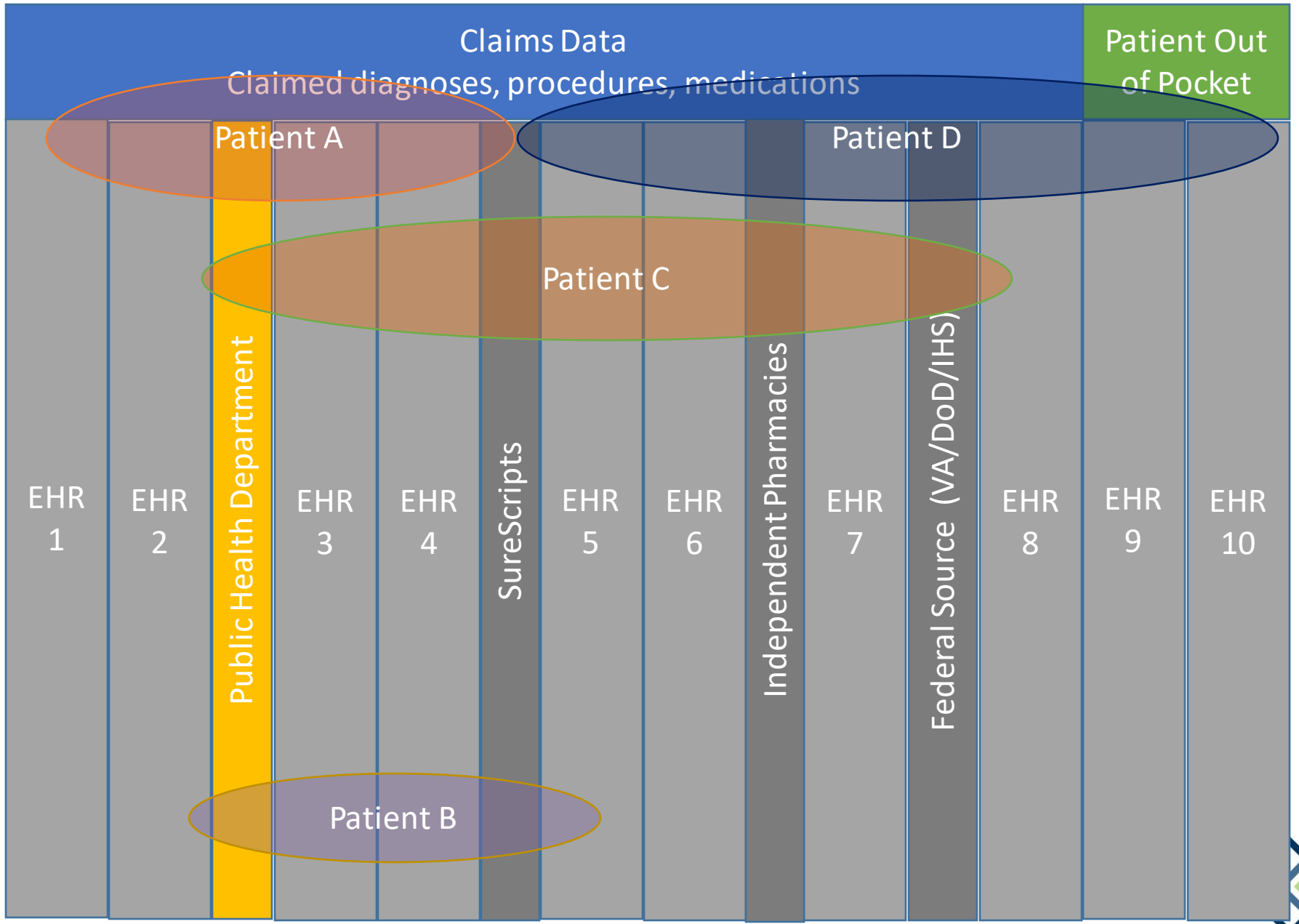
Odds that practice can report quality measures

Disadvantaged:

- Smaller practices
- Clinician owned (independent)
- Suburban and rural practices
- Academic practices
- No Meaningful Use participation
- Not participating in an external payment program
- Not participating in demonstration project

doi: 10.1377/hlthaff.2017.1254. HEALTH AFFAIRS 37, NO. 4 (2018): 635–643

MyHealth ACCESS NETWORK



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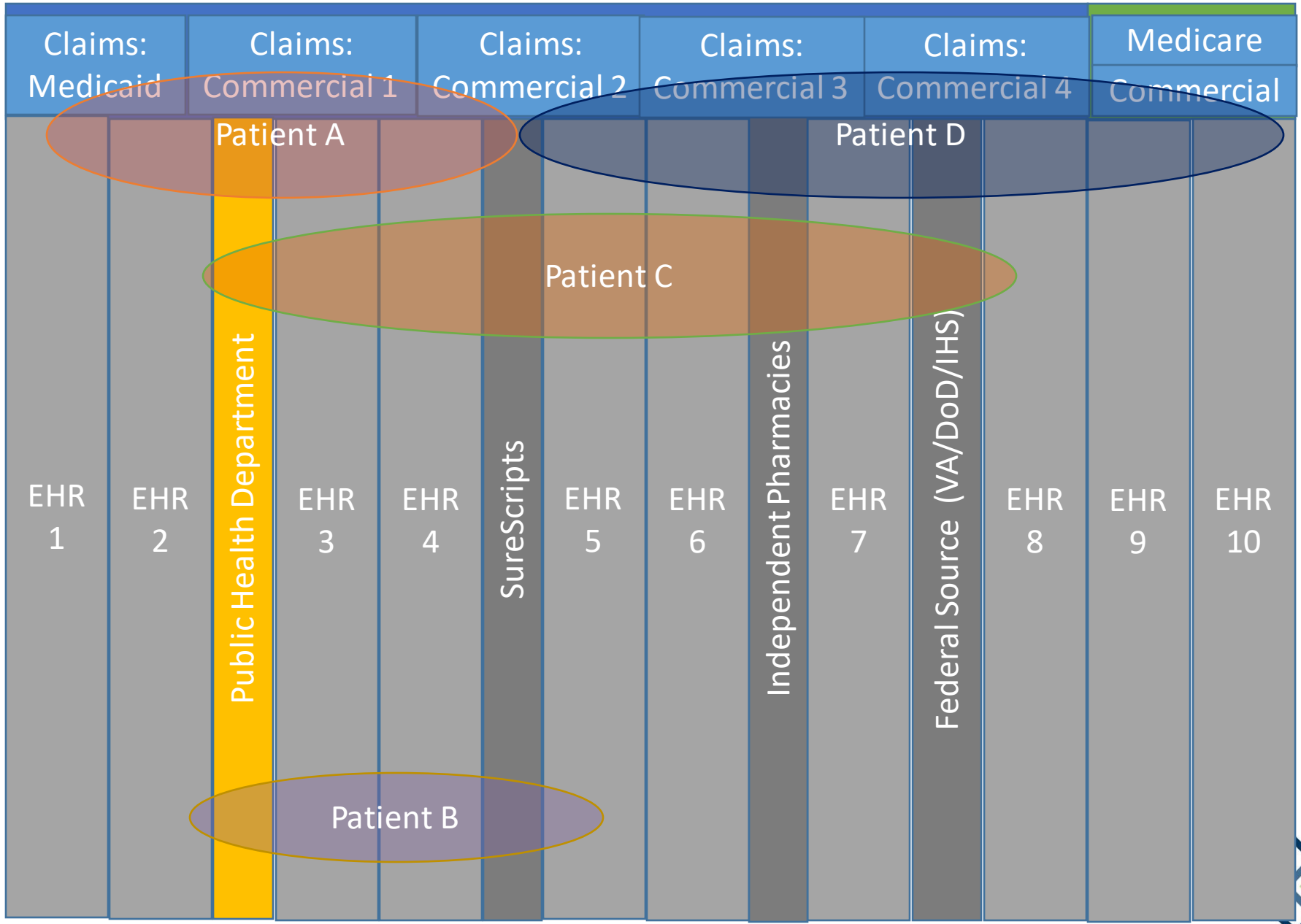
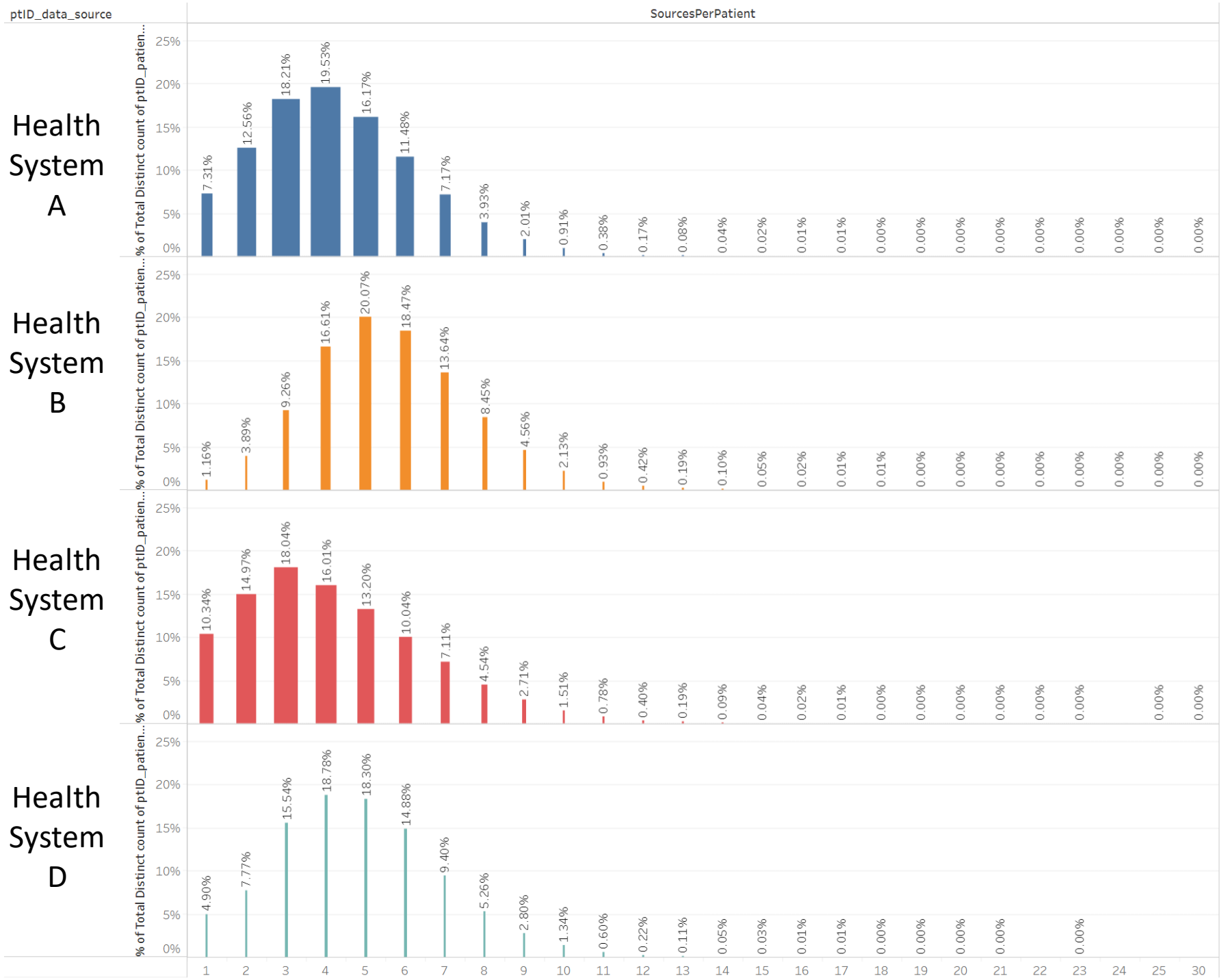


MyHealth ACCESS NETWORK

Data fragmentation by health system

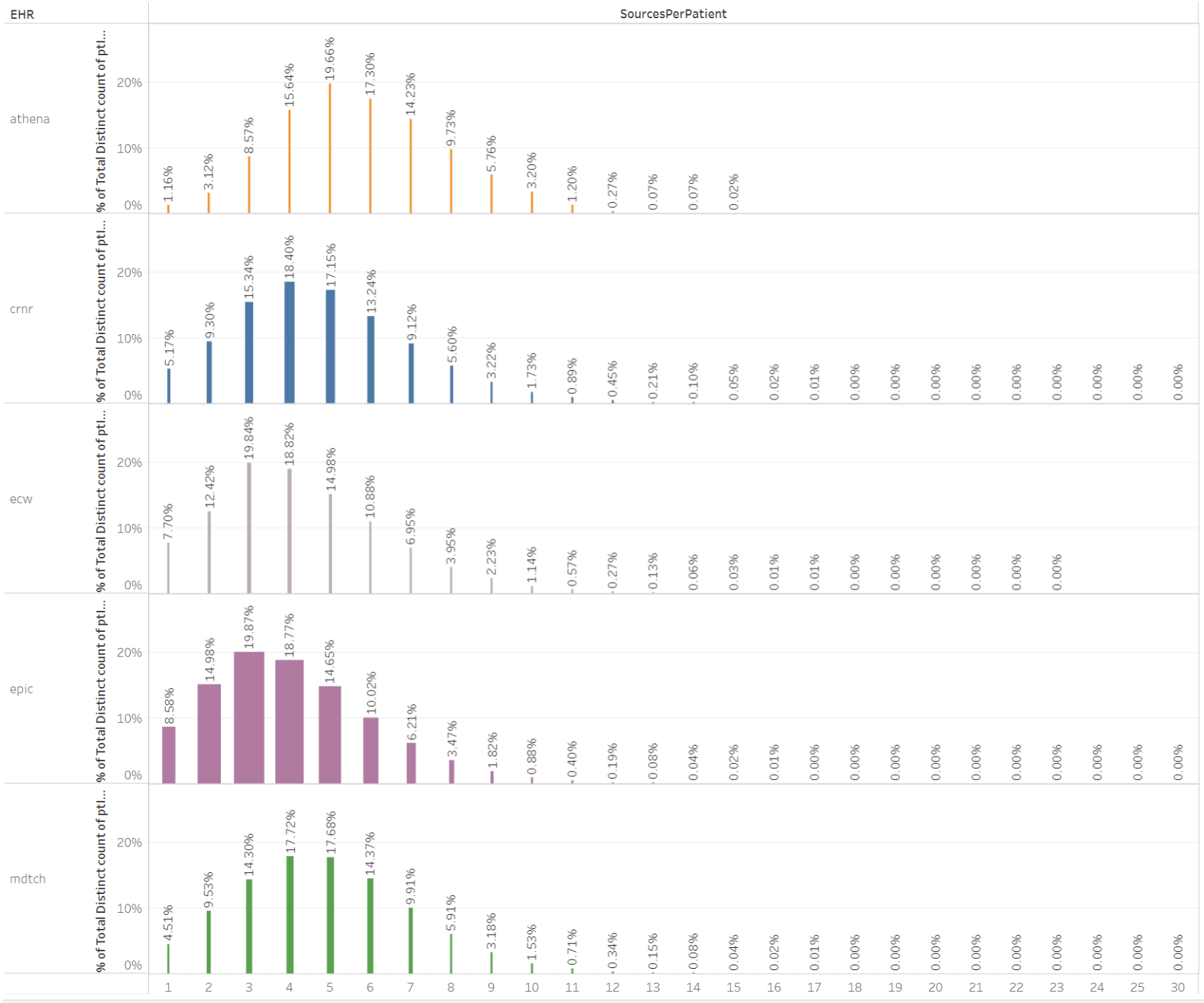


Corroboration:

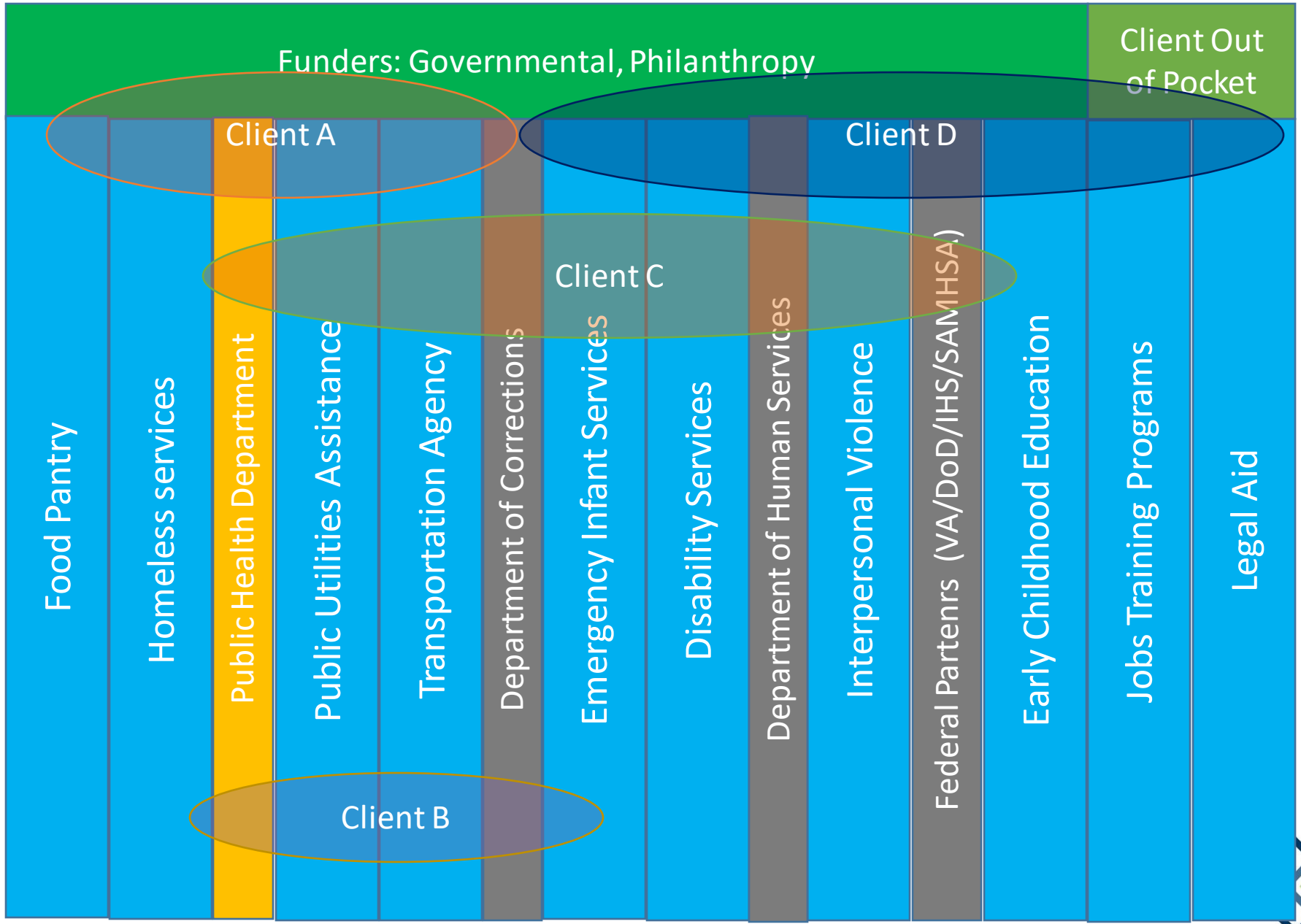
Average PCP must coordinate care with 225 other providers in 117 other organizations

Pham, HH, NEJM 2007; 356: 1130-1139

Fragmentation by EHR Vendor



MyHealth now working with social needs and early childhood programs, where data is even more fragmented . . .



MyHealth ACCESS NETWORK

Agenda

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MyHealth ACCESS NETWORK

Which methods of interoperability offer proactive, pushed data to enable communities, agencies, research and innovation?

Epic Care Everywhere

carequality

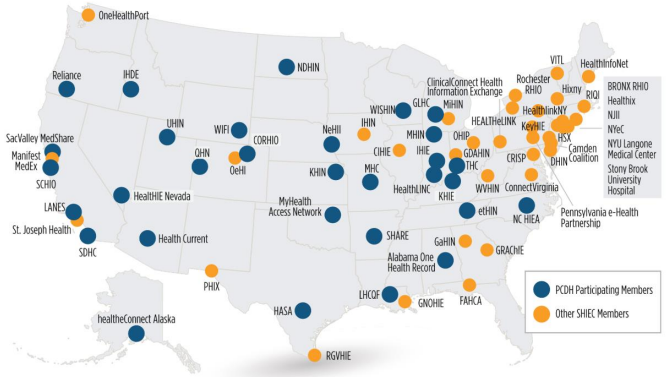
commonwell® HEALTH ALLIANCE

eHealth Exchange

DirectTrust™

ONC TEFCA RECOGNIZED COORDINATING ENTITY

CIVITAS Networks for Health



Health Data Utilities
Regional Health Improvement

MyHealth ACCESS NETWORK

Health Data Utility vs. Health Information Exchange

HDU is more than a Health Information Exchange

- Like an HIE:
  - Governance with transparency, broad participation of stakeholders
  - Trust of stakeholders
  - Committed service to a specific geography (i.e. state or region)
  - Substantial if not 100% connectivity of health data within service area
  - Cleaning and organization of individual identities and data for secondary uses
- A Utility that is more than an HIE:
  - Similar to other types of Utilities (electric, water, etc.), support broad range of use cases
  - Use cases can be implemented within the HDU or through a range of partnerships
  - Integrate data from sources beyond healthcare (social services, education, crime, etc.)
  - Work with stakeholders beyond healthcare (state agencies, tribal governments, employers, policy-makers, etc.)

MyHealth ACCESS NETWORK

Agenda

- Need for HIE/Health Data Utility
  - Health Data Utility vs. Health Information Exchange
- **Oklahoma's Health Data Utility**
- Outcomes and Impact on Value based payment models
- Opportunities & Strategies to Consider

MyHealth ACCESS NETWORK

MyHealth Vision & Mission (2009)

Vision

The Network's vision is to dramatically improve health outcomes and healthcare value for the individuals and whole communities which it serves.

Mission

The Network's mission is to achieve and sustain the highest quality healthcare at the best value in the nation using health information resources, technology and expertise.

MyHealth ACCESS NETWORK

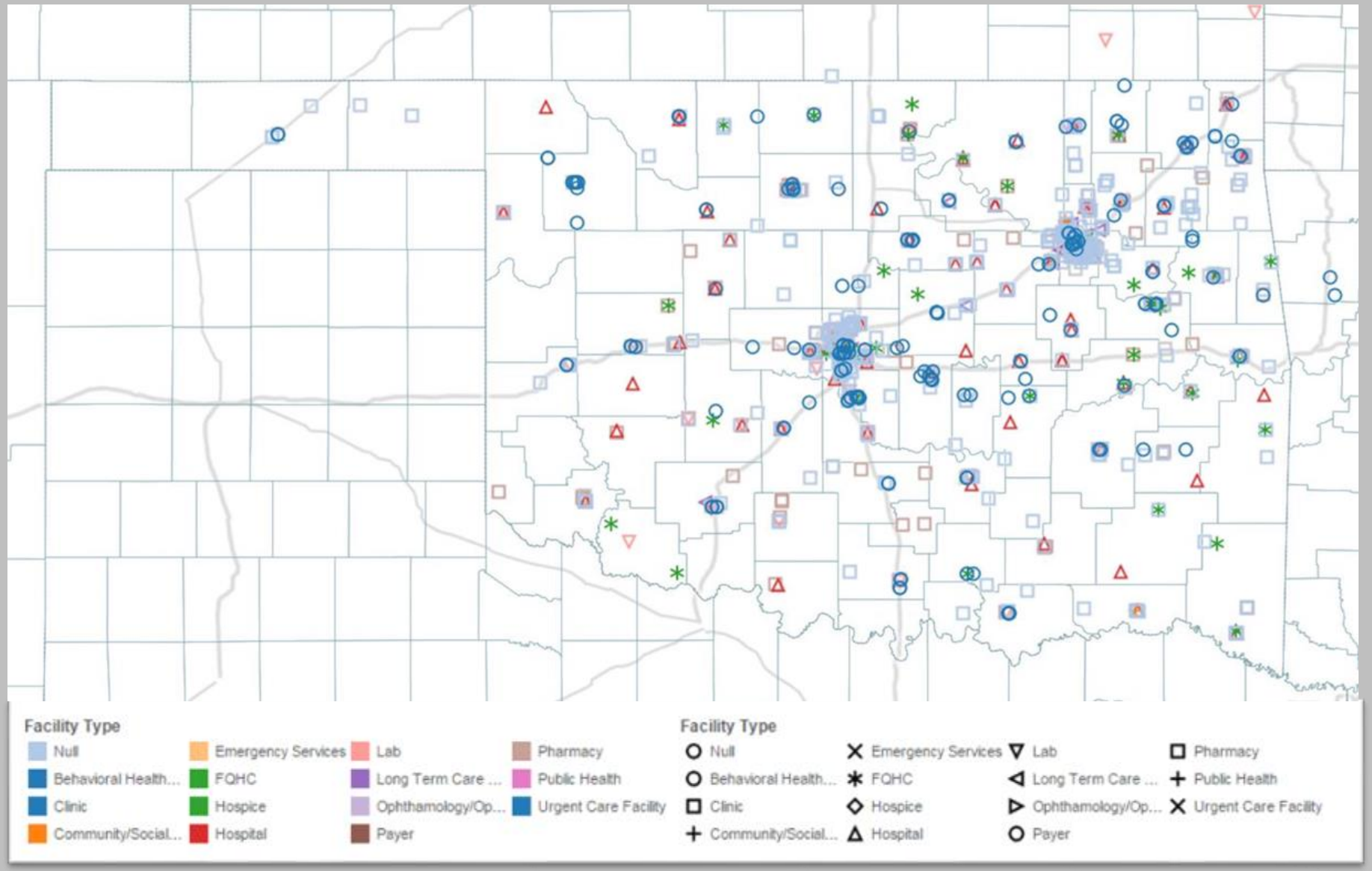
MyHealth membership is healthcare in Oklahoma: >600 organizations including

- INTEGRIS
- OU
- OSU
- Stillwater
- Mercy
- Saint John
- Saint Francis
- Saint Anthony
- Norman
- Hillcrest
- McAlister
- Lawton
- Optometrists
- Red Rock Behavioral Health
- Variety Care
- Duncan
- PPOK pharmacists
- Morton
- Variety Care
- BCBS
- CommunityCare of Oklahoma
- Humana
- OHCA
- EMSA
- Long Term Care facilities
- Cherokee
- Choctaw
- Chickasaw
- Muscogee/Creek
- OSDH

MyHealth ACCESS NETWORK

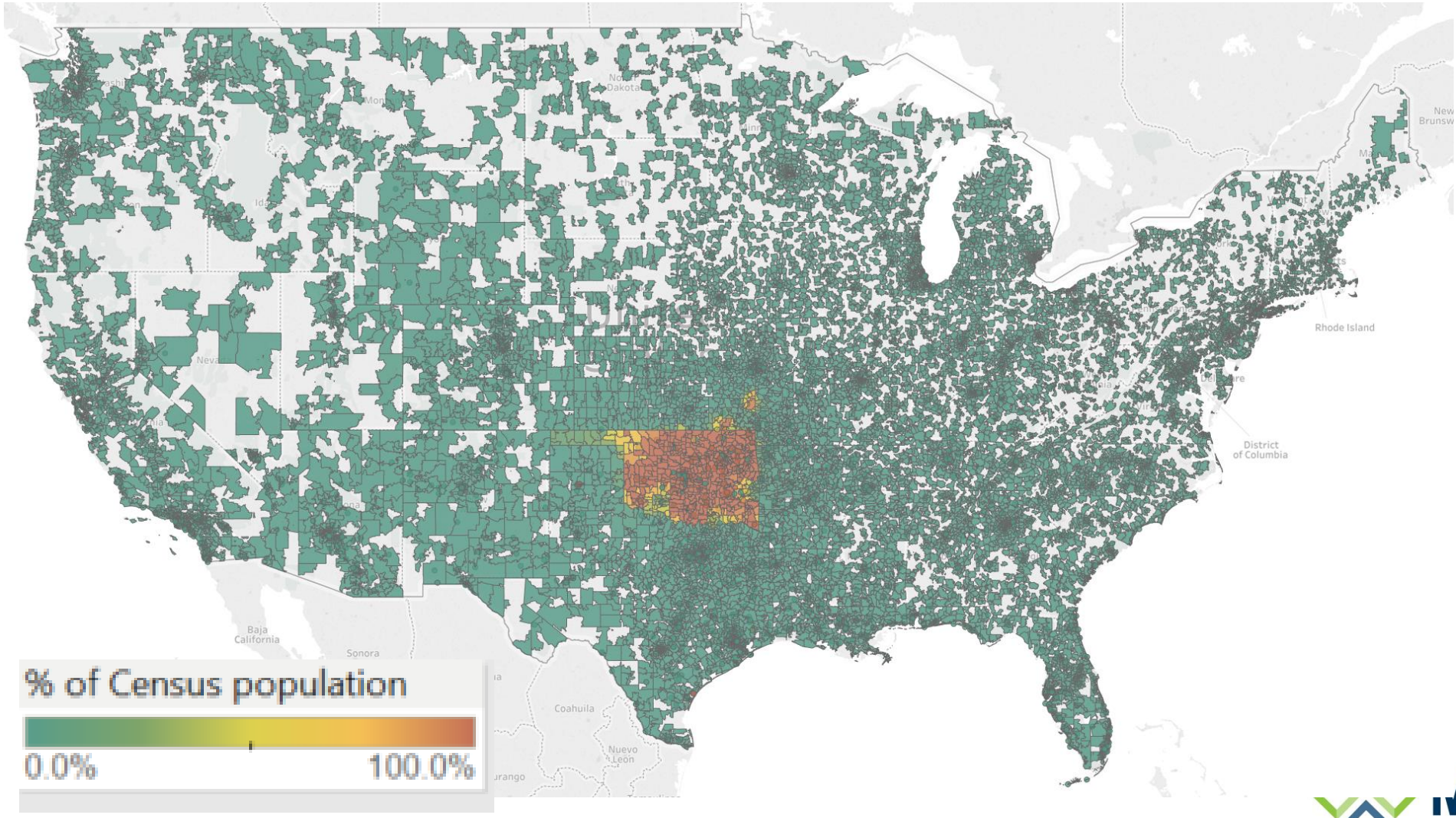
MyHealth ACCESS NETWORK

>2200 locations serving >130,000 patients daily



MyHealth ACCESS NETWORK

MyHealth Patient Population



MyHealth ACCESS NETWORK

MyHealth HDU Strategy

- Provide Infrastructure for:
  - Improving Health
  - Reducing costs
  - Supporting transitions to Value-based payment models (and any other models)
- Collaborate and partner extensively
  - Reduce provider burden
  - Reduce health IT costs to providers and State

MyHealth ACCESS NETWORK

Medicaid Annual ROI

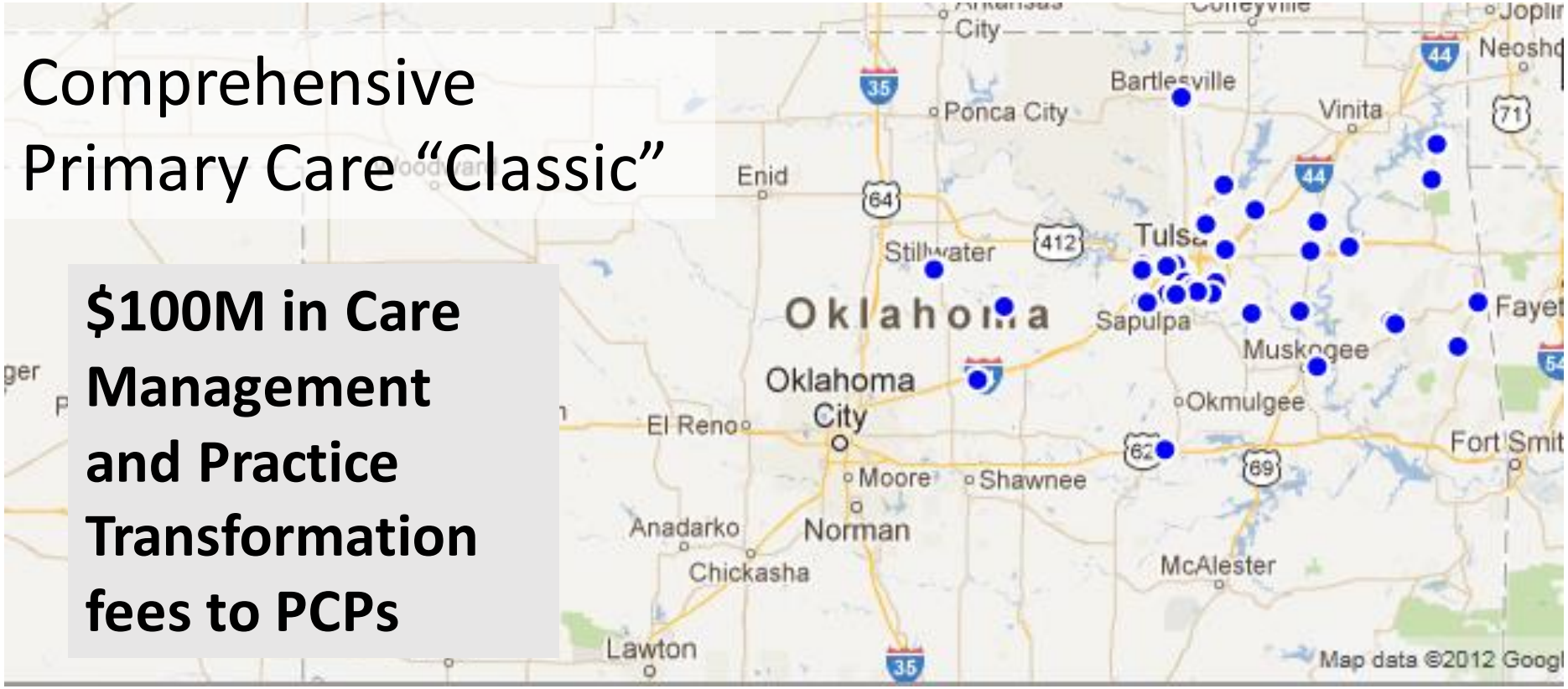
Units	HIE Impact	Cost of Item Being Saved	Current Event Count	Events At Scale	Care Benefit (Care Delays Avoided in days)	Effort Saved	Current Cost Savings	Cost Savings at Scale
$/chart pull	$(26.92)	$53.85	19200	150000	30	2 FTE	$(516,923)	$(4,038,461)
ER visits Saved per 1,000 member months	(20.37)	$990.00	10000	340139			$(2,419,560)	$(82,298,672)
Inpatient Admission Saved Per 100K Members months	(359.30)	$5,513.29	10000	111916			$(2,419,552)	$(27,078,664)
Readmissions Avoided	-10%	$5613	235	7051			$(125,642)	$(3,769,301)
						Total Cost Savings	**$(5,481,677)**	**$(117,185,098)**

Unwinding Months of Coverage Avoided	(1.0)	$300	272000	272000			($81,600,000)	($81,600,000)

*Source: PHPG's Study on Health Coaching for HMP Population

MyHealth ACCESS NETWORK

Comprehensive Primary Care "Classic"



$100M in Care Management and Practice Transformation fees to PCPs

- 68 practices, 265 docs
- OK Payers require MyHealth Participation
- >30 hospitals affiliated
- Four payers (BCBS, CCOK, Medicaid, Medicare)
- >90% of covered lives
- Shared savings Y3-4

MyHealth ACCESS NETWORK

CMS Experience CPC:
56-60 practices, ~50,000 Medicare pts

Oklahoma CMS Shared Savings					
Year	**Gross Savings**	**% Gross Savings**	**Net Savings**	**Net Savings Percentage**	**Dollars shared with practices**
2013	~$30 M	7%	~$21 M	5%	1st year no payments
2014	~$20M	4.7%	~$11 M	2.4%	$900,000
2015	$33M	7.1%	$25 M	5.4%	$10,800,000
2016	$26 M	5.7%	$18 M	4.0%	$9,127,320
Totals	~$110 M	6.1%	**~$65M**	~5%	**$21,827,320**

+ **$56M** in Care Management Payments over 4 years

Quality Measures: Exceeded Benchmarks for all three measures

- All Cause Readmissions: Highest Benchmark
- CHF Admissions: First Benchmark
- COPD Admissions: First Benchmark

MyHealth ACCESS NETWORK

PRELIMINARY AHC OUTCOMES

Outcomes reported by CMS evaluation team

Medicaid Beneficiaries

Medicare Beneficiaries

TOTAL EXPENDITURE

INPATIENT ADMISSIONS

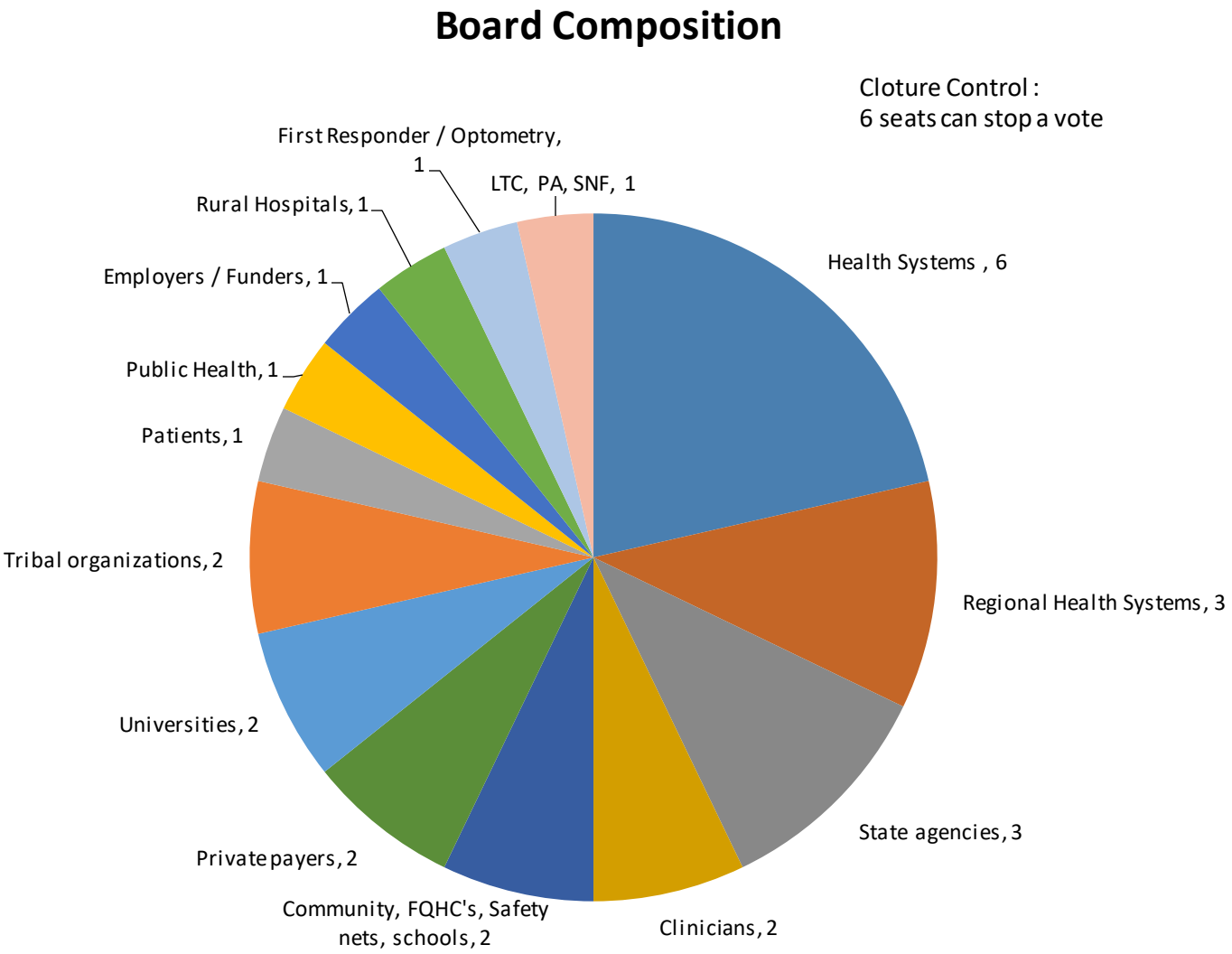
READMISSIONS

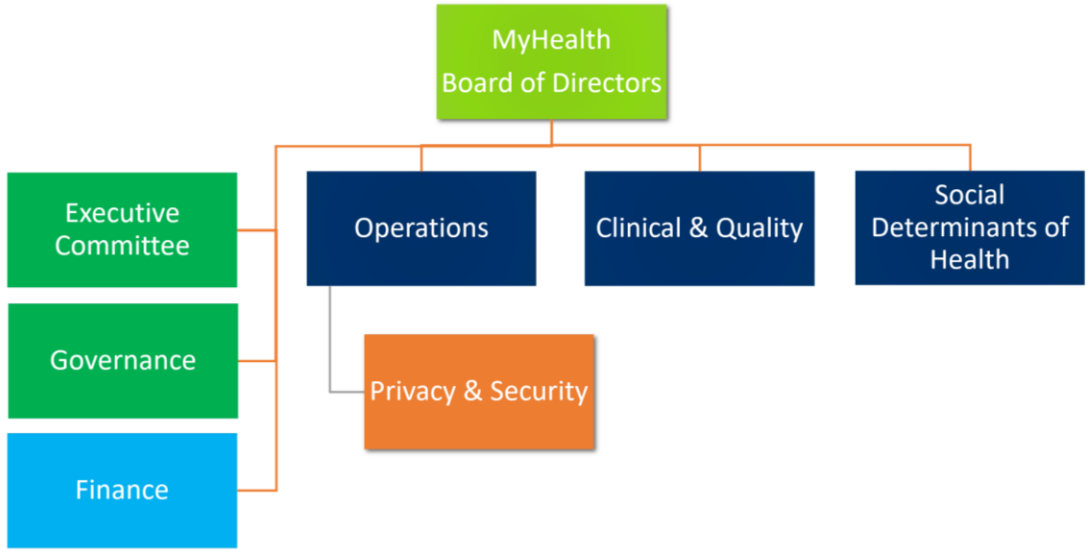
ED VISITS

Critical Voices In Governance

MyHealth ACCESS NETWORK

Governance: 13 Years of Public-Private (501c3) Partnership



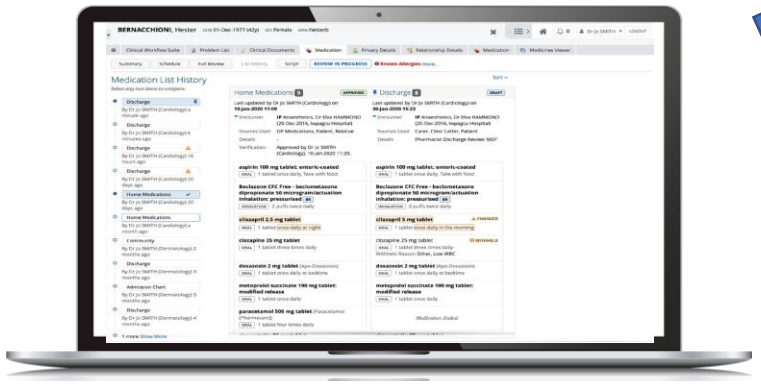


MyHealth ACCESS NETWORK

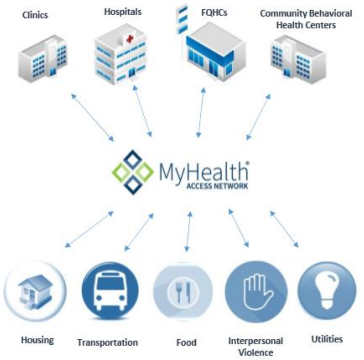
CAPABILITIES

Care Coordination/
Records Aggregation

Quality/Care
Gap Mgmt.



Portal & EMR Integrated Access



Non-Medical
Drivers of Health

Clinical and
Claims
Data Integration

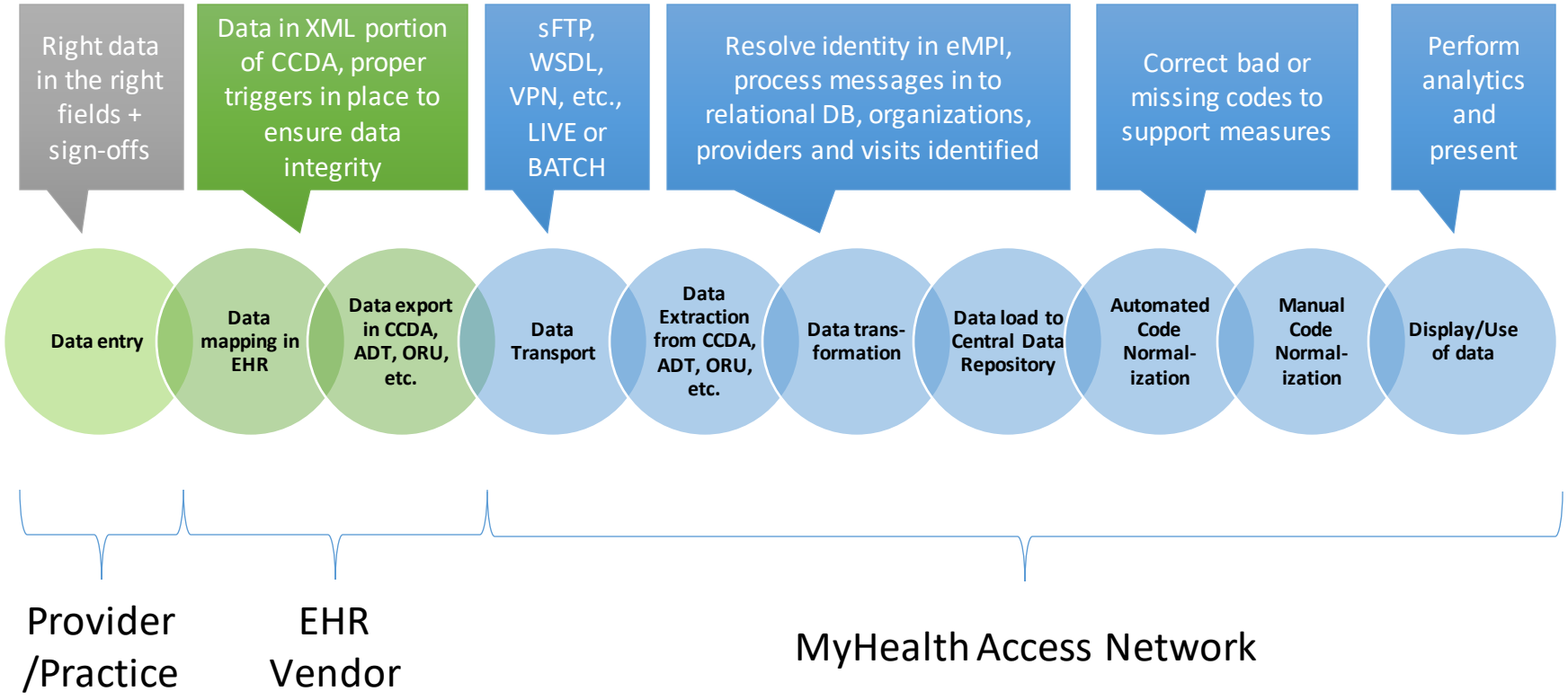
Real-time
Notifications
(CoP)

Provider and
Relationship Registry

PUBLIC HEALTH

Public Health
Reporting

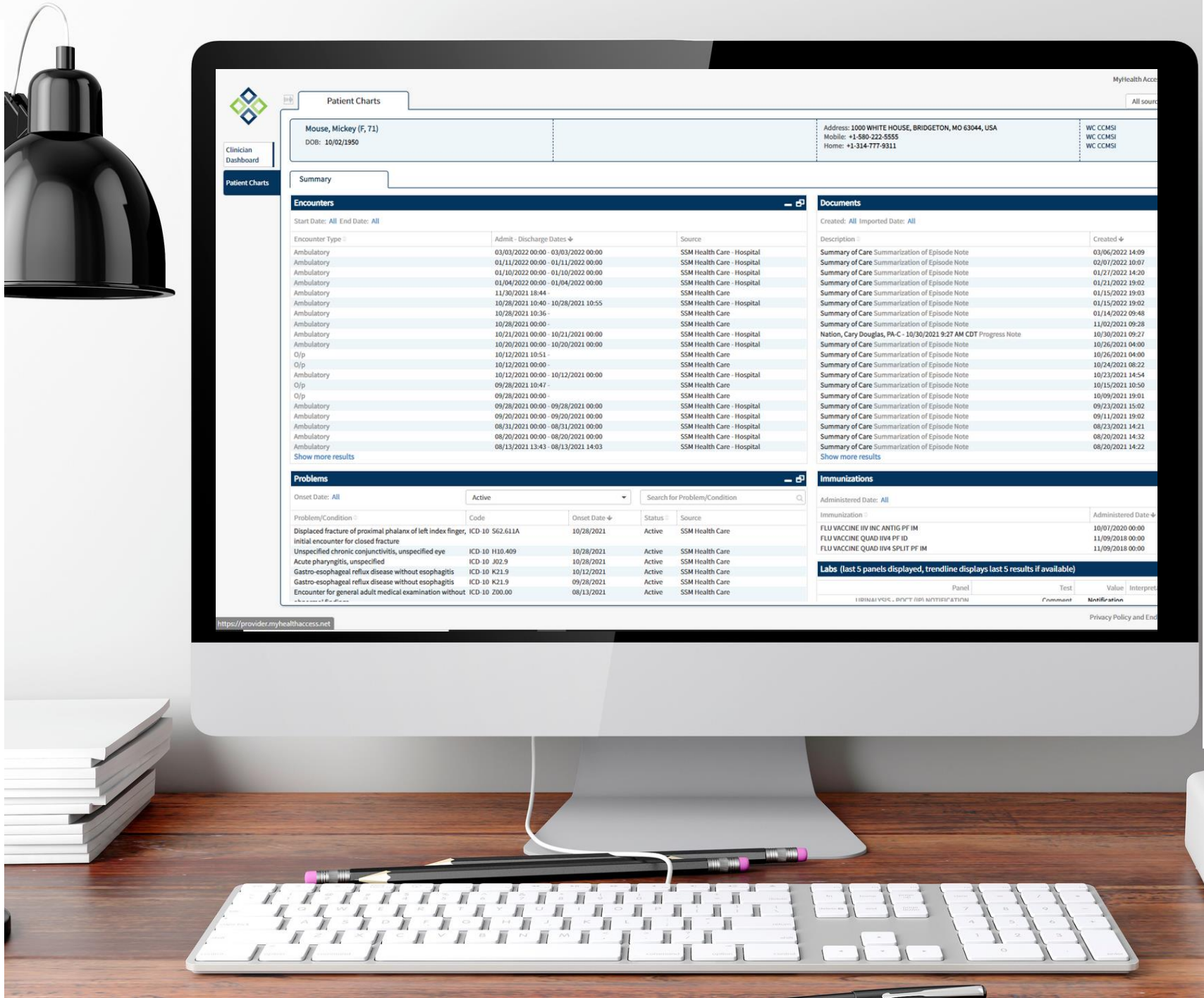
Data Quality: Chain of evidence



MyHealth ACCESS NETWORK

PROVIDER PORTAL

MyHealth® ACCESS NETWORK



Value Proposition:

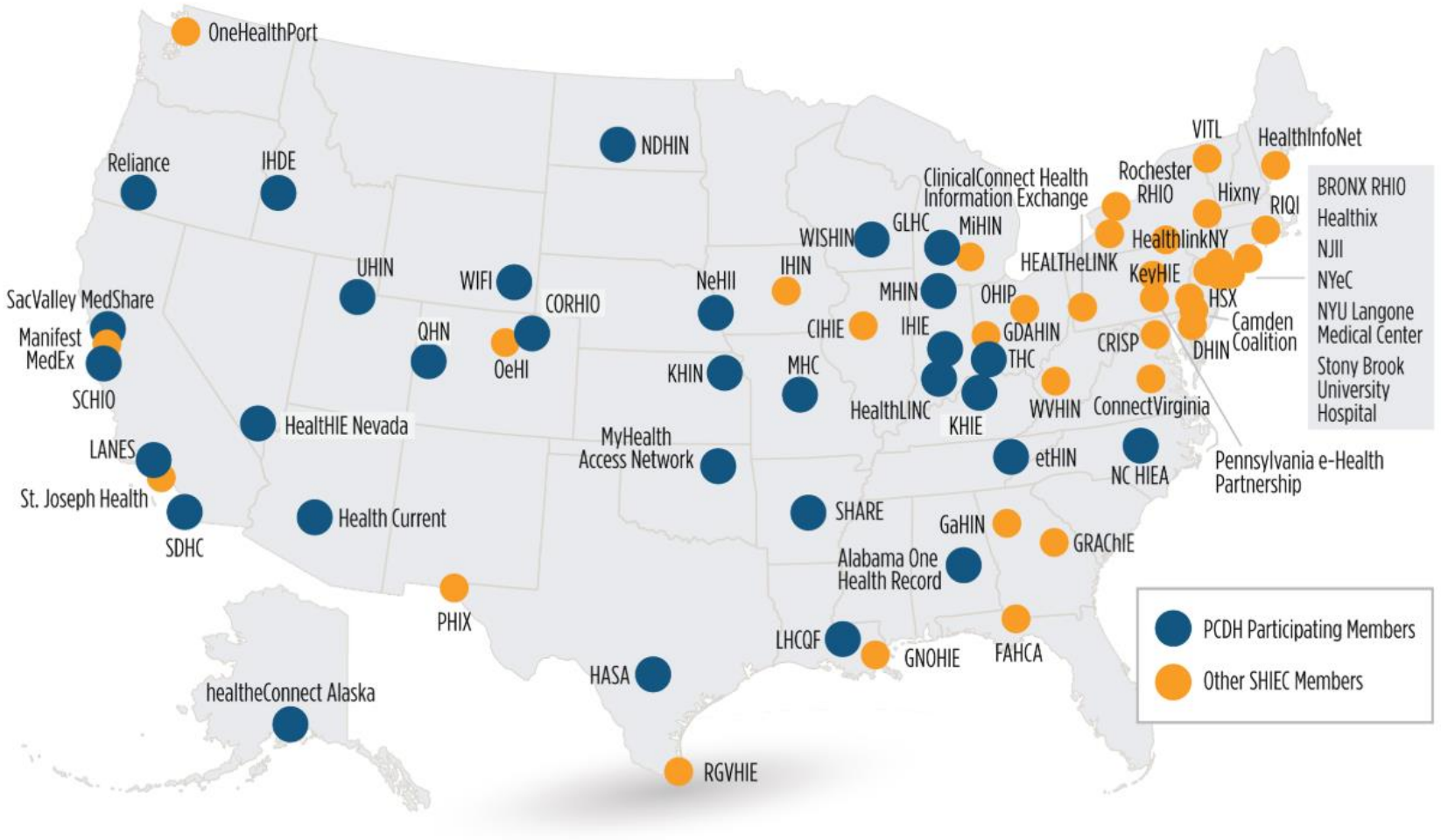
- Find the most complete records immediately.
- No need to read separate documents from every org.
- Close loops on referrals.

Rich Clinical Data

- Diagnoses
- Medications
- Allergies
- Vital signs
- Clinical documents
  - H&P
  - D/C summary
  - Operative/Procedure notes
  - Progress notes
- Lab Results
- Insurance
- Dispensed Medications
- Equipment Devices
- Related Persons
- Social History
- Family History
- Radiology

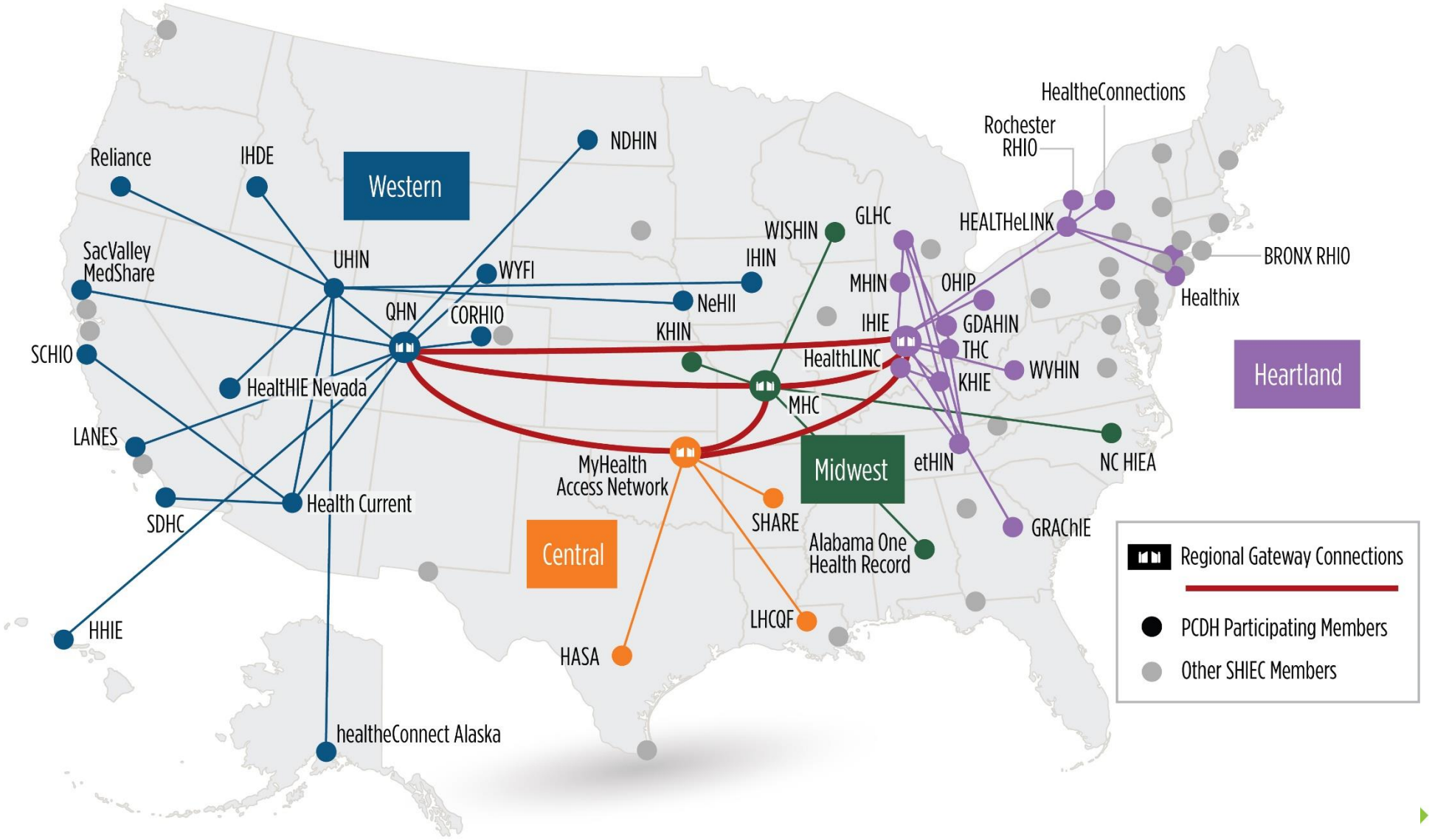
MyHealth ACCESS NETWORK

How does this model scale nationwide?



MyHealth ACCESS NETWORK

Patient Centered Data Home™ rapid growth

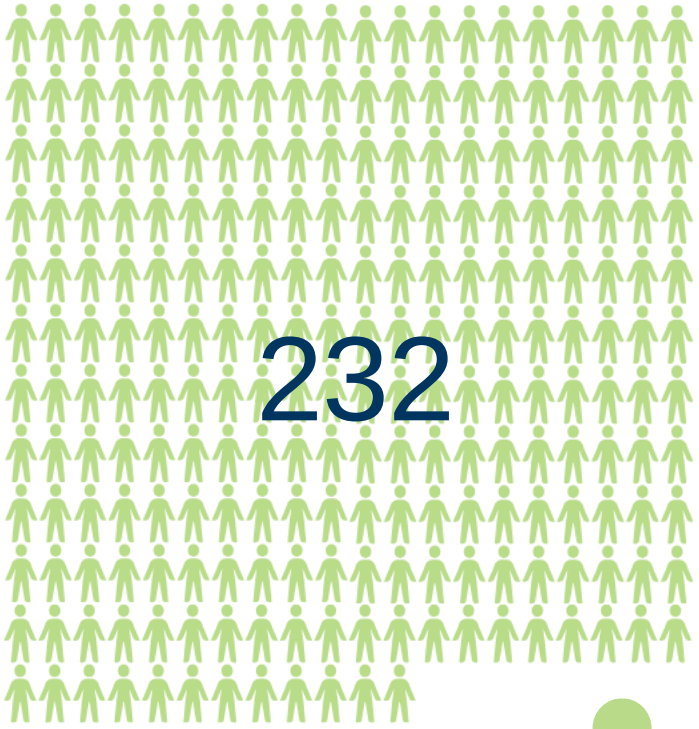


MyHealth ACCESS NETWORK

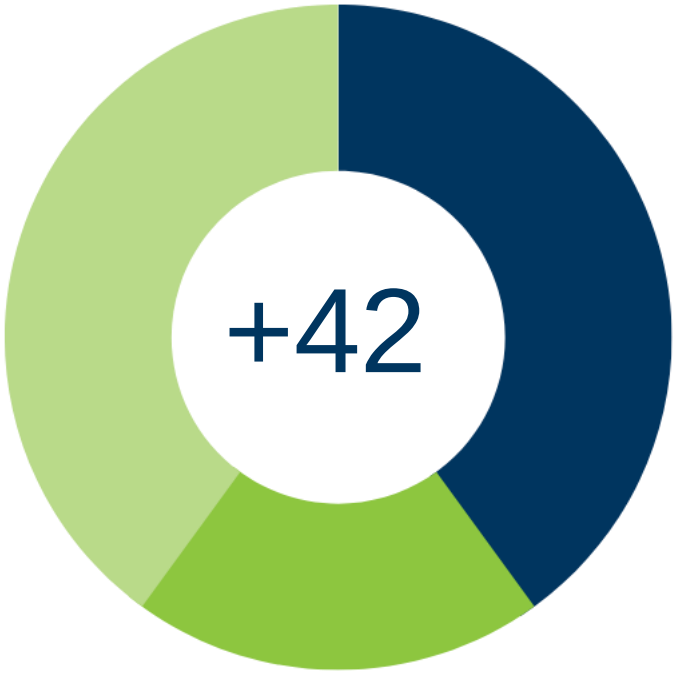
USER SATISFACTION SURVEY
Q4 2023

MyHealth ACCESS NETWORK

Responses



Net Promoter Score



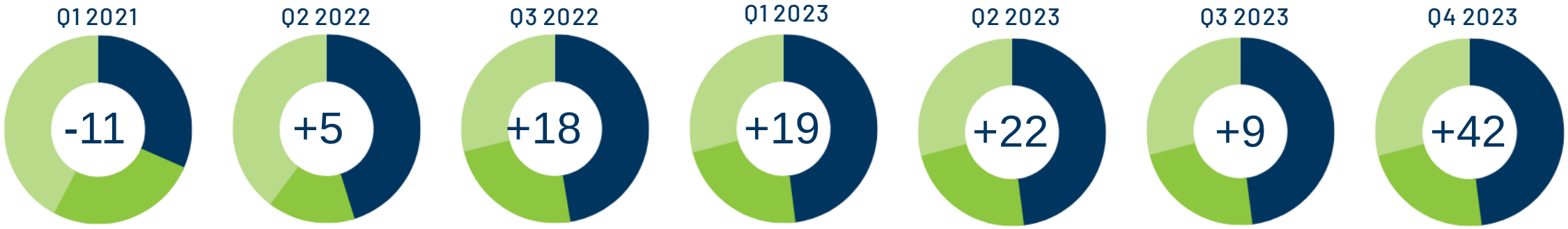
Years Active

DETRACTORS	PASSIVES	PROMOTERS
17%	24%	59%

USER SATISFACTION SURVEY

Q4 2023

Net Promoter Score



Our patients are able to talk to a nurse anytime after hours who uses evidence based decision making to provide our patients the best advice and make them feel comfortable which helps to decrease unnecessary ER visits.

-Clinician

It allows me to better serve by members by allowing me to read provider notes and elaborate instructions with members. It also assists with medication reconciliation and lab inquiries.

- Care Coordinator

It allows me to not duplicate studies and get valuable information on patients from outside facilities.

-Clinician

It assist our organization with being able to find lost to follow up clients because of the updated contact information.

- Care Coordinator

It is easy to access medical records for hospital follow-ups.

- Care Coordinator

I was able to find a discharge summary & clarify medications with a member after they discharged from hospital.

- Home Health Nurse

A client came in with psychosis and said they had no medication allergies. However, after looking in MyHealth, I was able to confirm a medication allergy. We have this medication in our inventory and could have administered it had we not had this information available.

-Care Manager

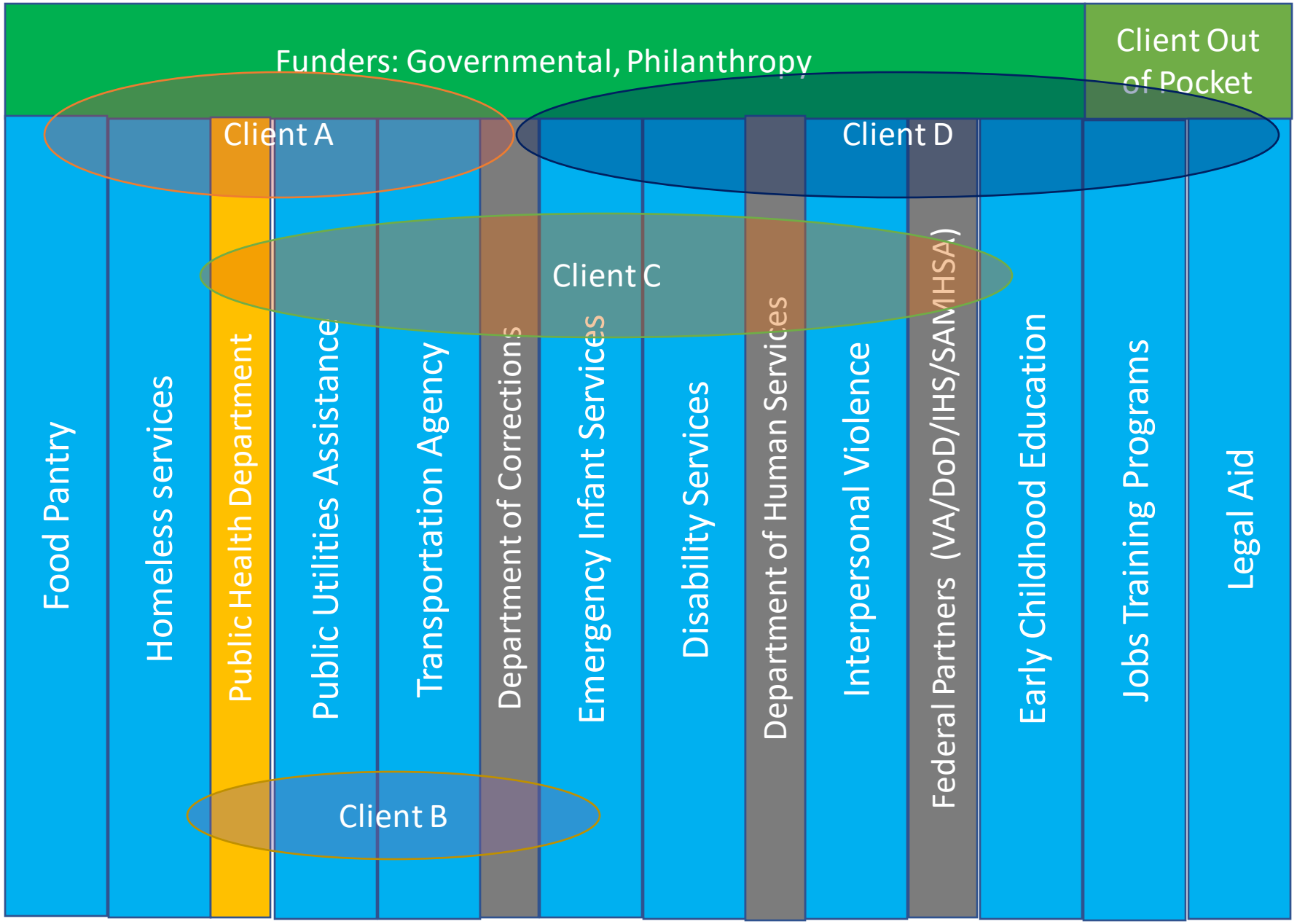
Non-Medical Drivers of Health

MyHealth® ACCESS NETWORK

Value Proposition:

- Detect and address social needs without added staff burden.
- Comply with The Joint Commission, other contract requirements.
- Factor social needs into risk and treatment planning.

MyHealth now working with social needs and early childhood programs, where data is even more fragmented…

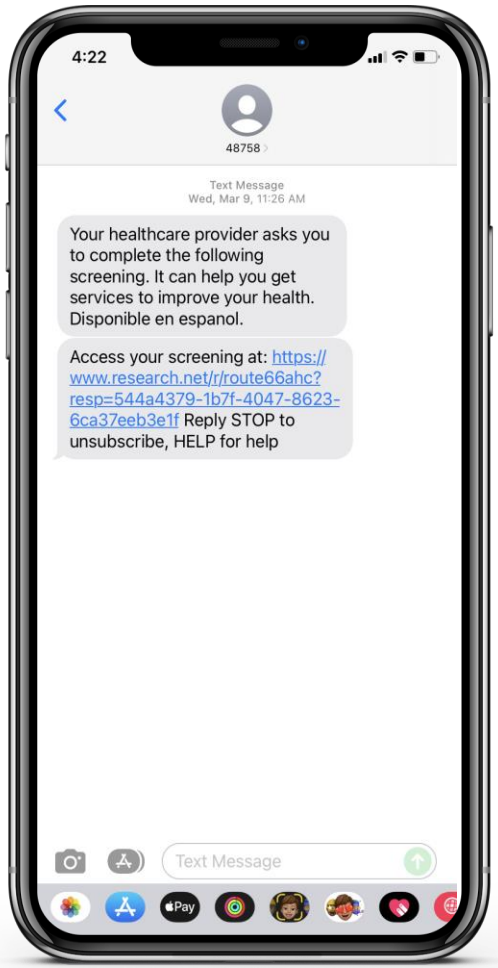


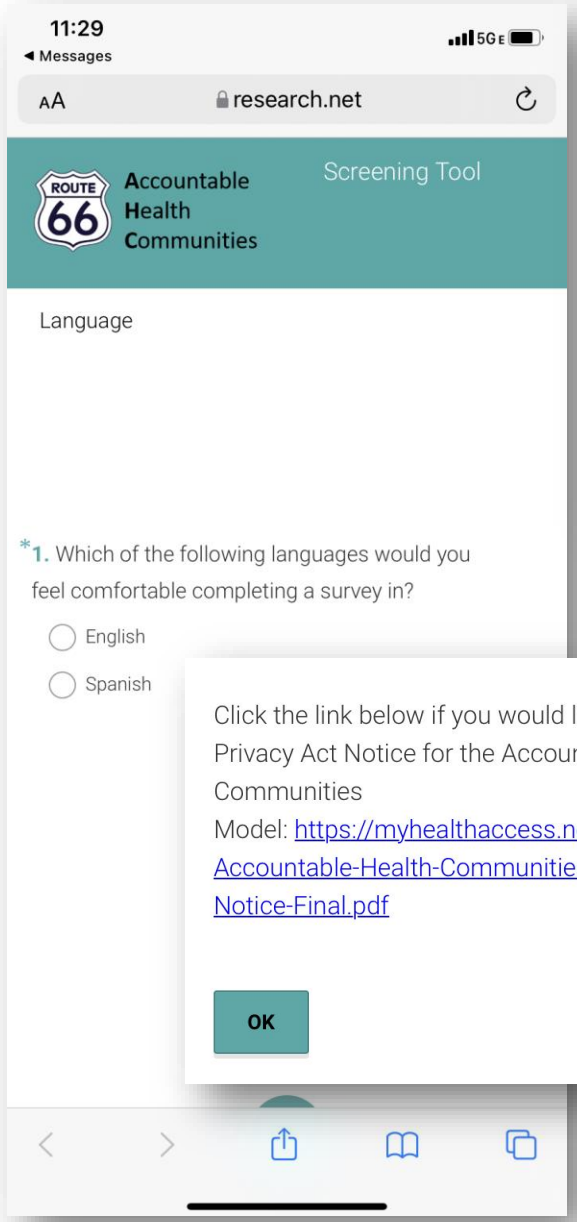
Screening & Referral Efforts Are Expensive

- AHC Instrument Time & Motion Study:
  - Screening: 12-15 minutes per patient
  - Tailored Referral: 5-10 minutes per patient
  - + EHR documentation

- Providers (inpatient, outpatient, ER) willing to take on added burden: ZERO

Mobile Screening





Click the link below if you would like to view the Privacy Act Notice for the Accountable Health Communities
Model: https://myhealthaccess.net/MyHealth-Accountable-Health-Communities-Screening-Privacy-Notice-Final.pdf

OK

7. Within the past 12 months, you worried that your food would run out before you got money to buy more.

- Often true
- Sometimes true
- Never true

9. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting to things needed for daily living?

- Yes
- No

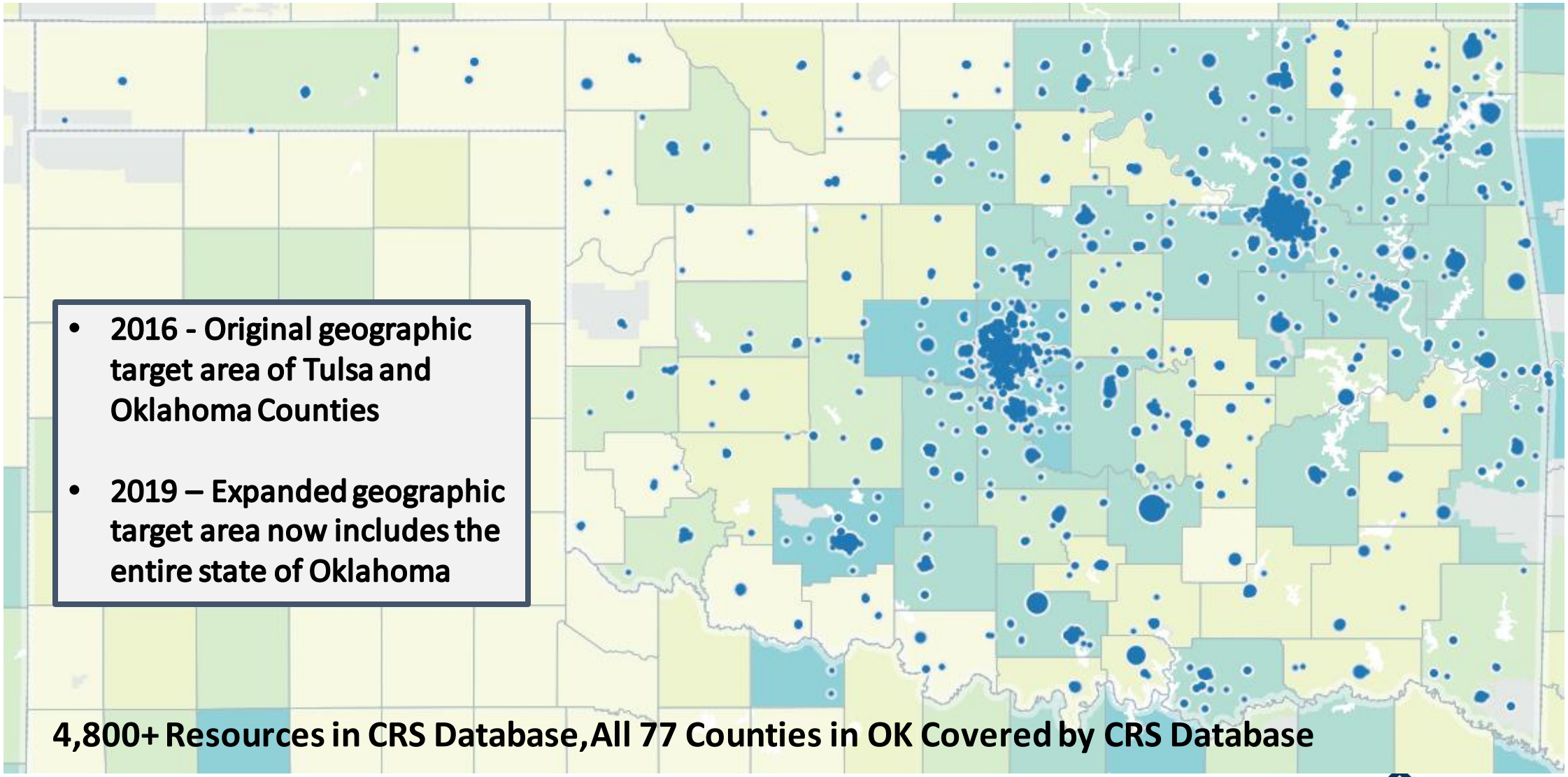
ROUTE 66 Accountable Health Communities — Screening Tool

Thank you for completing our survey! Based on your survey results you may receive an additional text message with a link to help connect you to services in your community that may improve your health. Many of these services are low cost or free of charge.

DONE

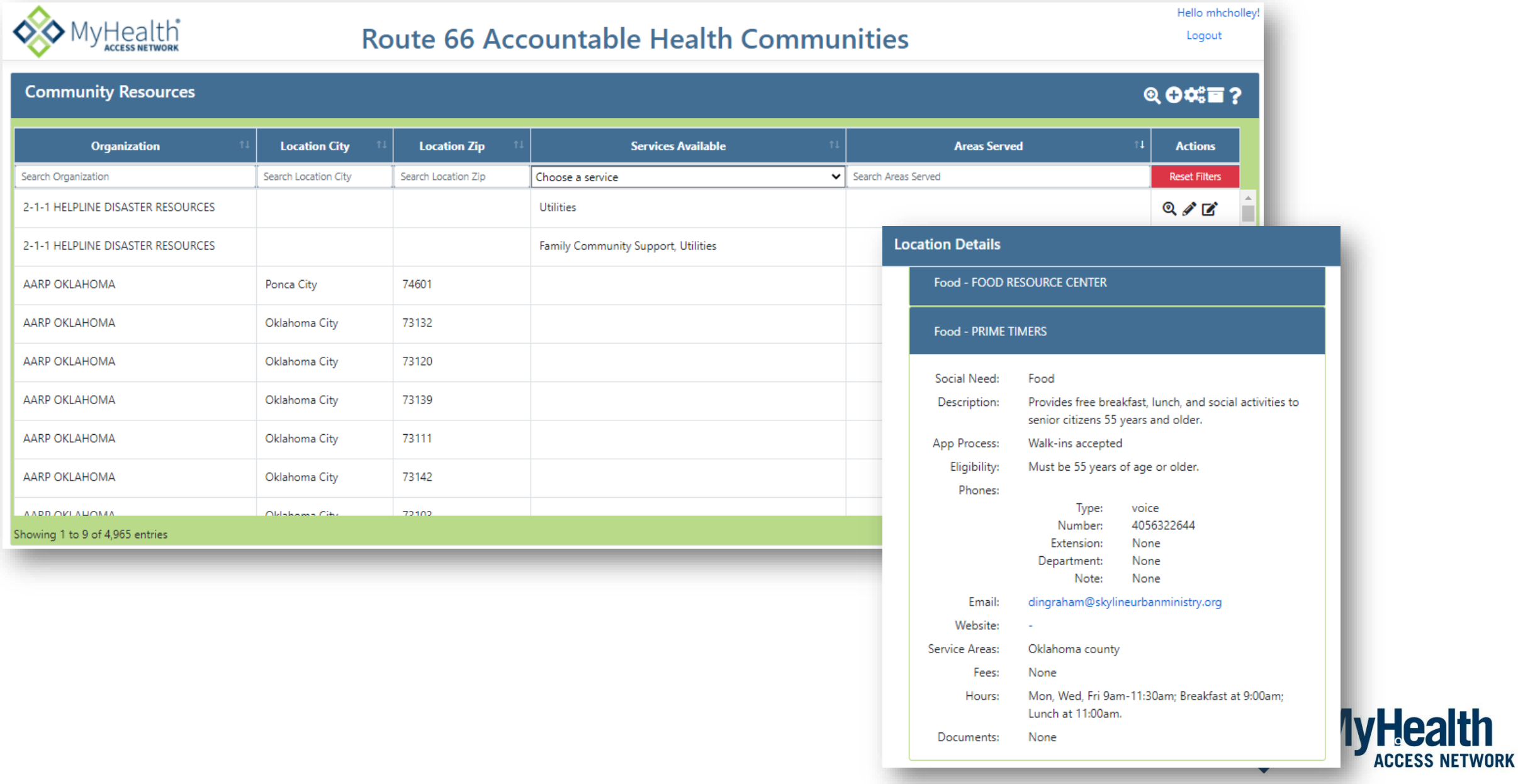
MyHealth® ACCESS NETWORK

Community Resources in Oklahoma

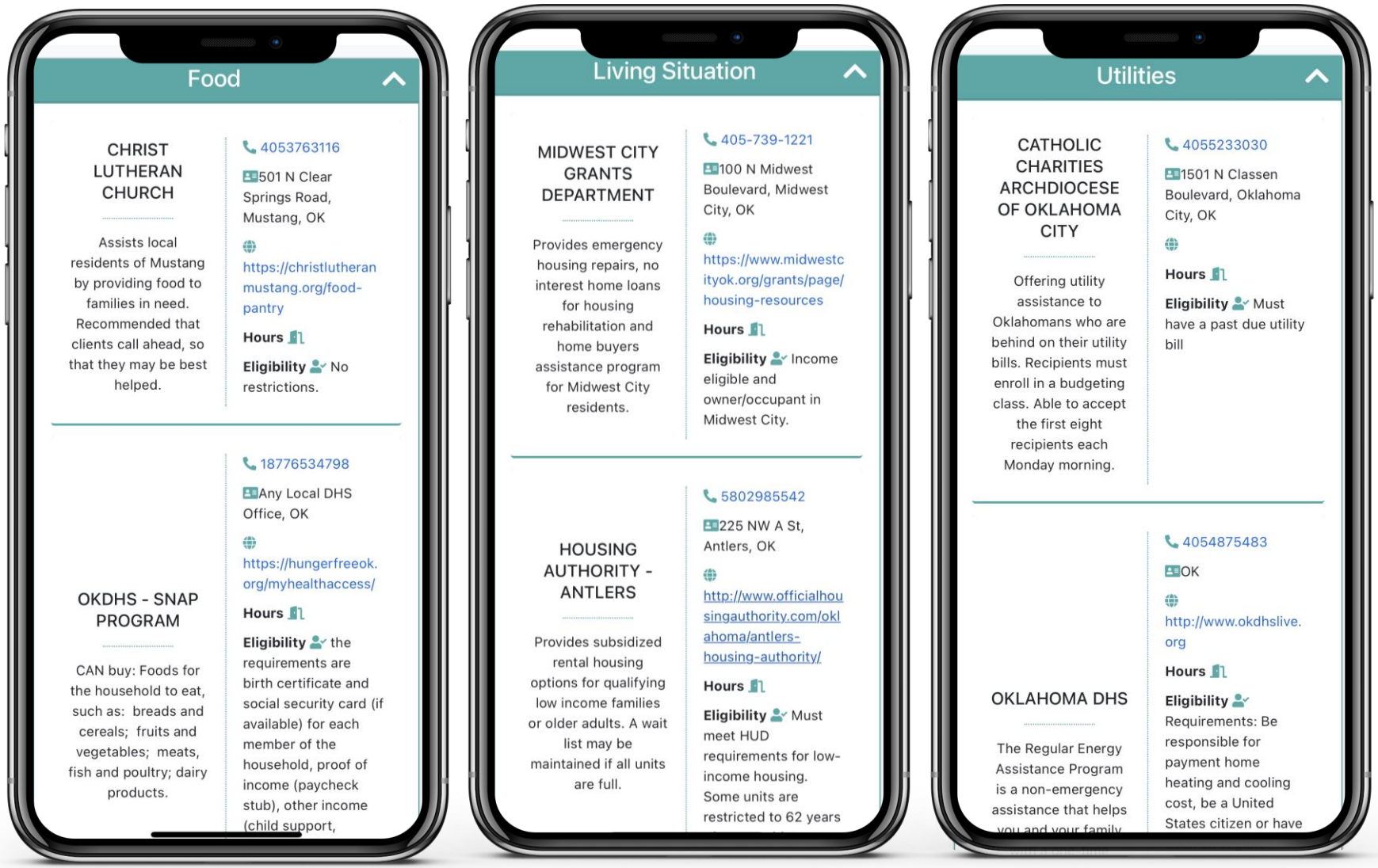


MyHealth ACCESS NETWORK

Community Resource Inventory



MyHealth ACCESS NETWORK



Community Resource Summary

Texted back to patient after completion of the screening

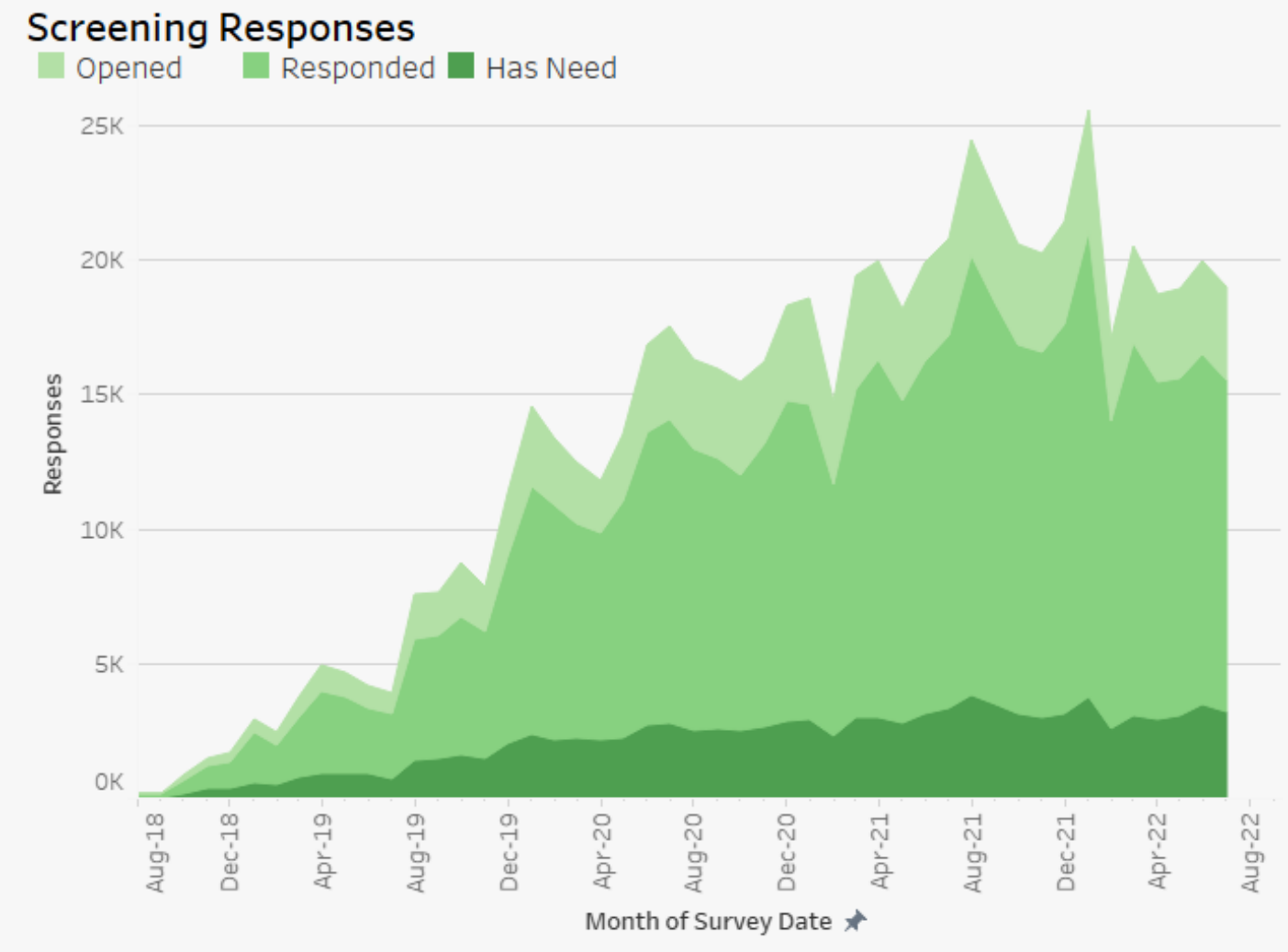
Every community resource summary includes information for 211

MyHealth ACCESS NETWORK

Accountable Health Communities

Final Screening Data

(August 2018 – July 2022) *AHC screening ended as of July 31, 2022

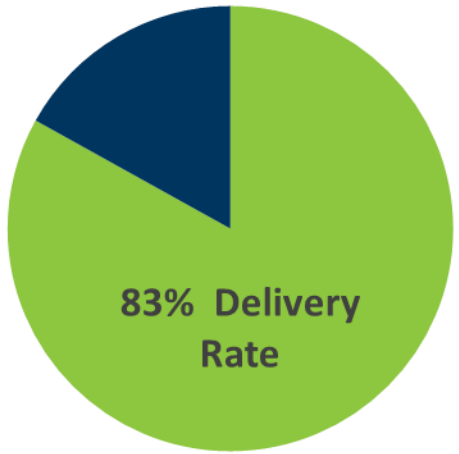


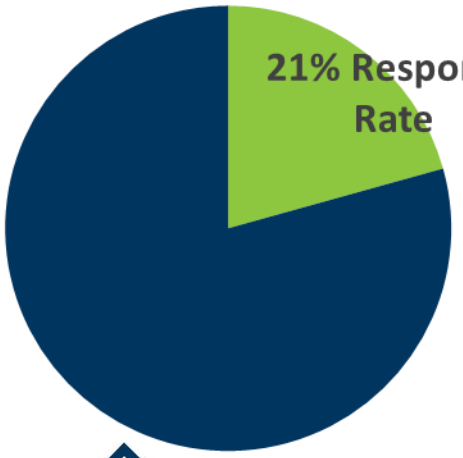
***2,988,078** Offers to Screen*

***515,146** Responses*

***102,304** Responses with a Need*

***165,020** Individual Needs Reported*



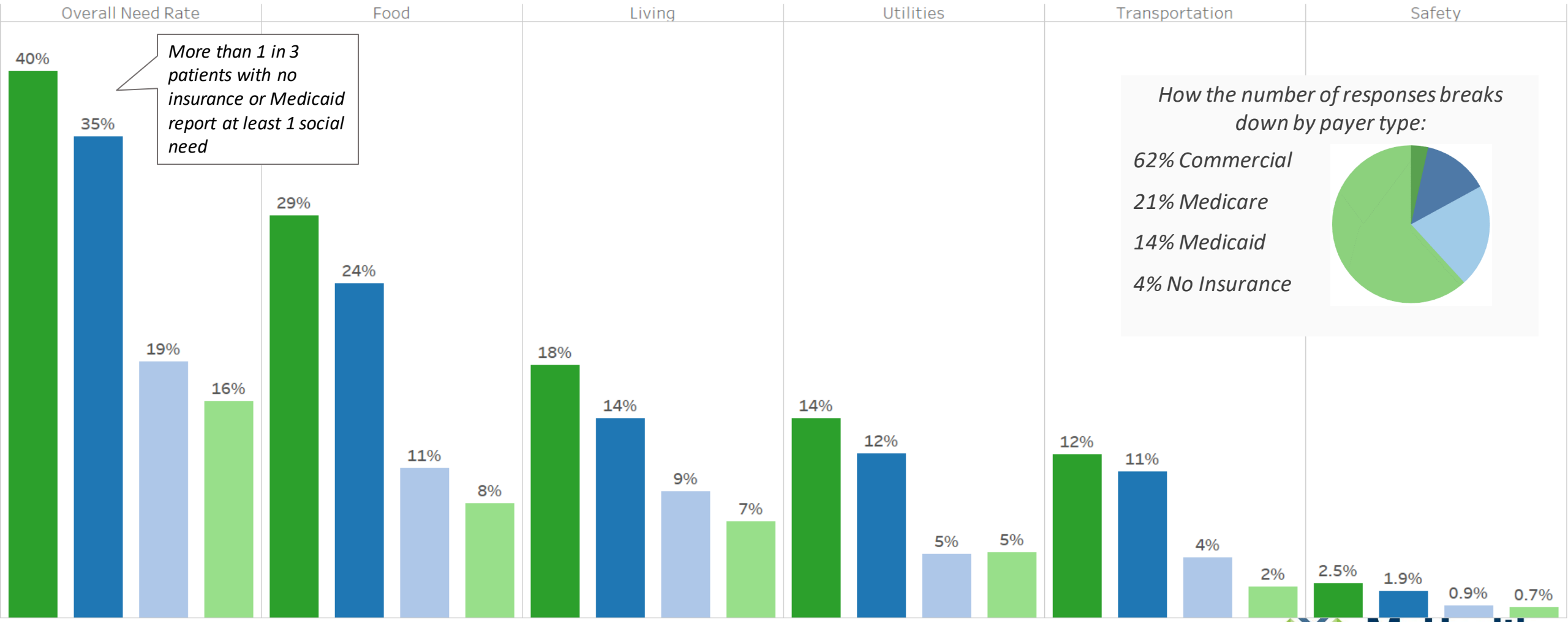


MyHealth ACCESS NETWORK

Needs Rates by Payer Type

(August 2018 –August 2022)

No Insurance - Medicaid - Medicare - Commercial



How the number of responses breaks down by payer type:

62% Commercial

21% Medicare

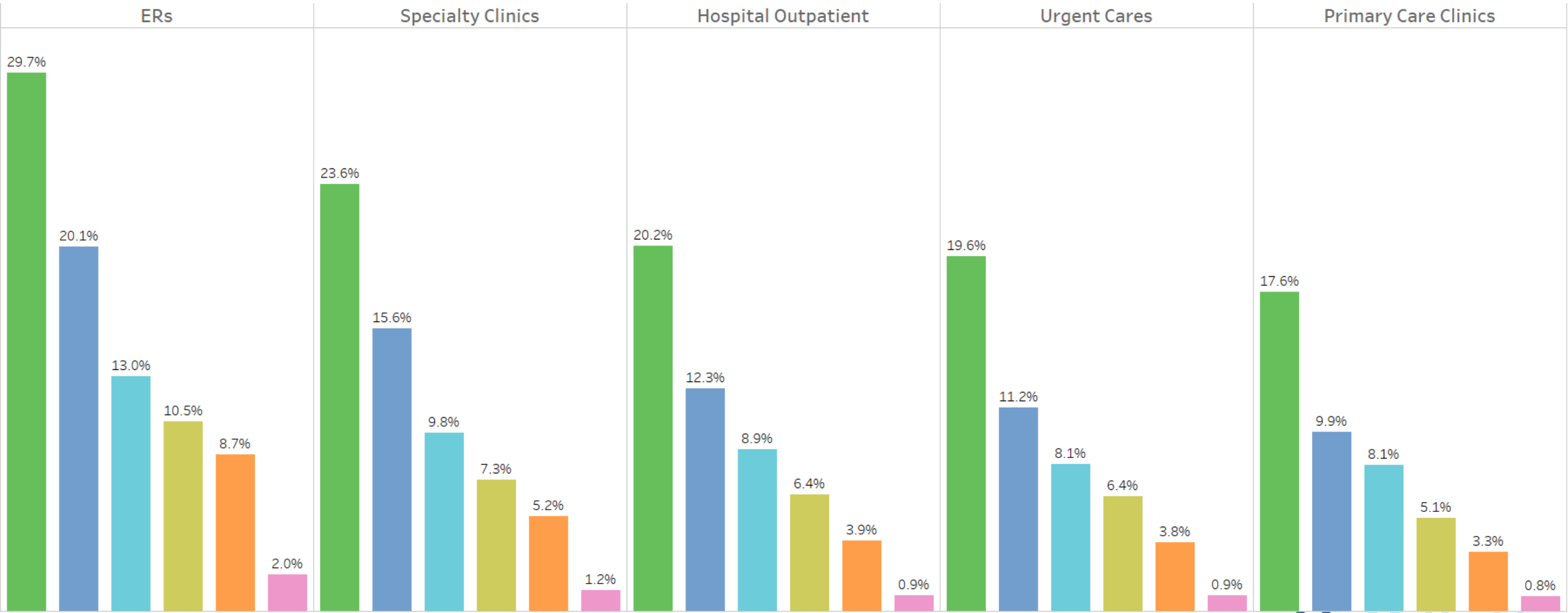
14% Medicaid

4% No Insurance

MyHealth ACCESS NETWORK

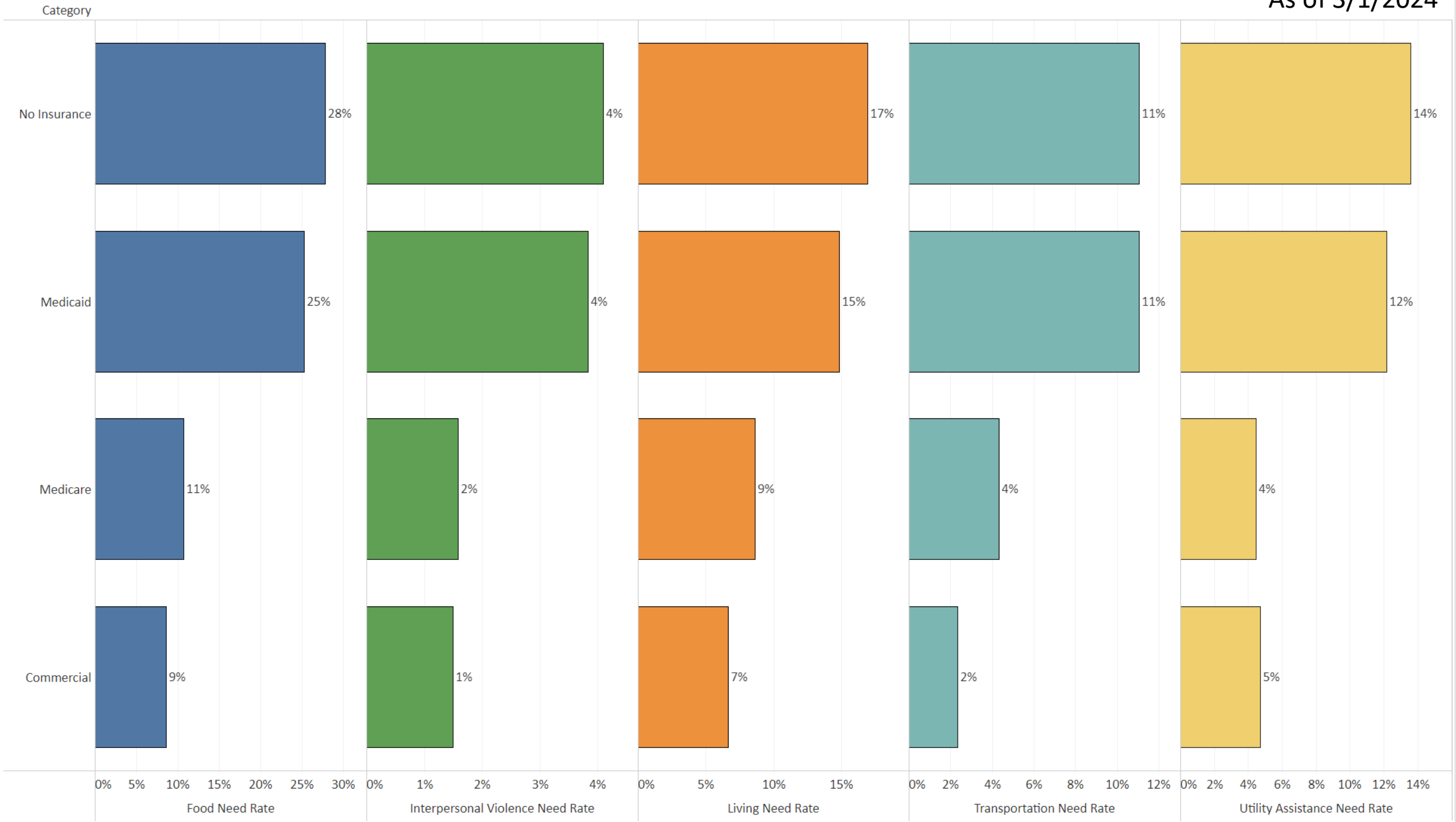
Need Rates by Clinical Delivery Site Type

Overall - Food - Living - Utility - Transportation - Safety



NMDoH Graph By Payer Type for 5 Core Needs Screened for through MyHealth's Screening & Referral

As of 3/1/2024



NMDoH Program Metrics

August 2018– November 30, 2023

MyHealth ACCESS NETWORK

By the numbers:

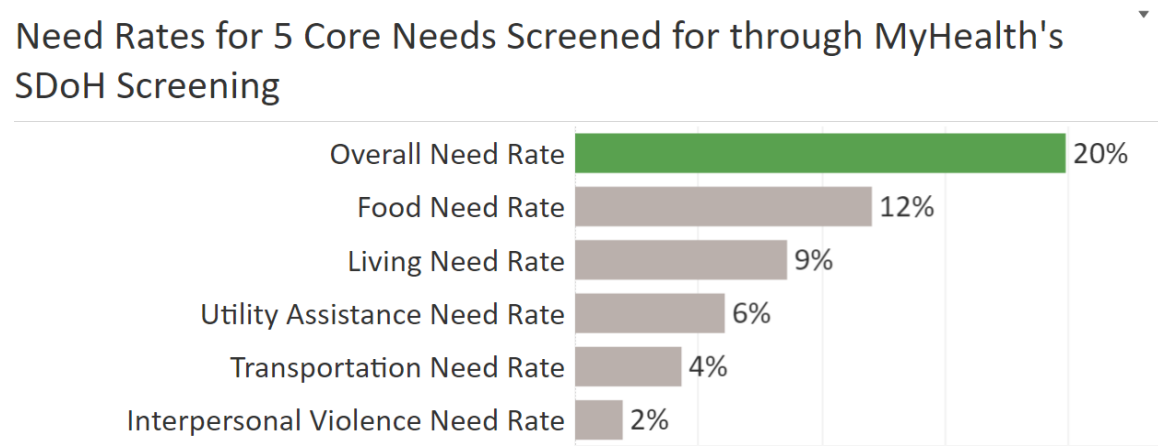
- ✓ **4.2+** million offers to screen
- ✓ **739,000+** responses
- ✓ **150,000+** responses with needs
- ✓ **250,000+** individual needs reported

Screening Delivery Rate

83%

Screening Response Rate

21%



24% of responses report 2+ needs

average of **1.7** needs are reported per need positive screening

85% of responses with a living need is due to living conditions* rather having a place to stay

**Living condition issues include lack of heating, lead paint or pipes, mold, oven or stove not working, pests, missing or not working smoke detectors, and water leaks*

Office of the National Coordinator for Health Information Technology

ONC Burden Reduction

DRAFT – Thursday, August 17, 2023

CMMI's Accountable Health Communities Model
MyHealth HIE Mobile NMDoH Screenings & Referrals

	Time	Hourly Rate
Time & Motion Study of Manual Screening & Referral Process		
Provider Administration of AHC Screening (minutes)	12	$30
Provider Generation of Tailored Resource Referral for Needs (minutes)	20	$30

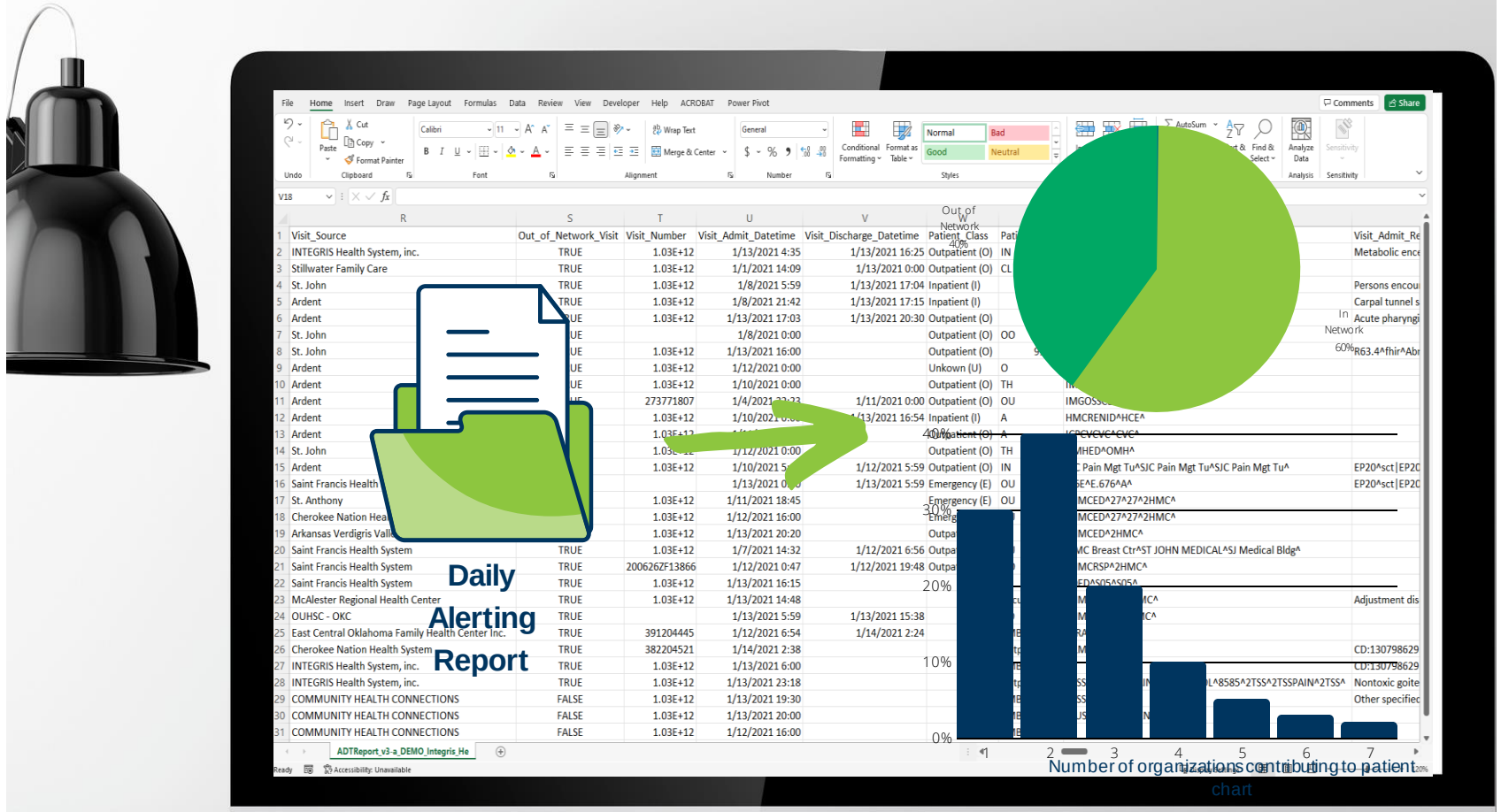
Total Number of Screenings offered	3,700,000	
Total Number of Screenings completed	850,000	
Total Number of Screenings with at least 1 need	250,000	

Total Human Screener Time Saved (hours)	170,000	$5,100,000
Total Human Tailored Resource Referral Time Saved (hours)	83,333	$2,500,000
Total Cost of MyHealth HIE SDoH Screening and Referral	0	$ 3,145,000

Net Savings Based on Staff Time and Cost Alone (hours)	253,333	$4,455,000

CARE FRAGMENTATIO N ALERTING

MyHealth® ACCESS NETWORK

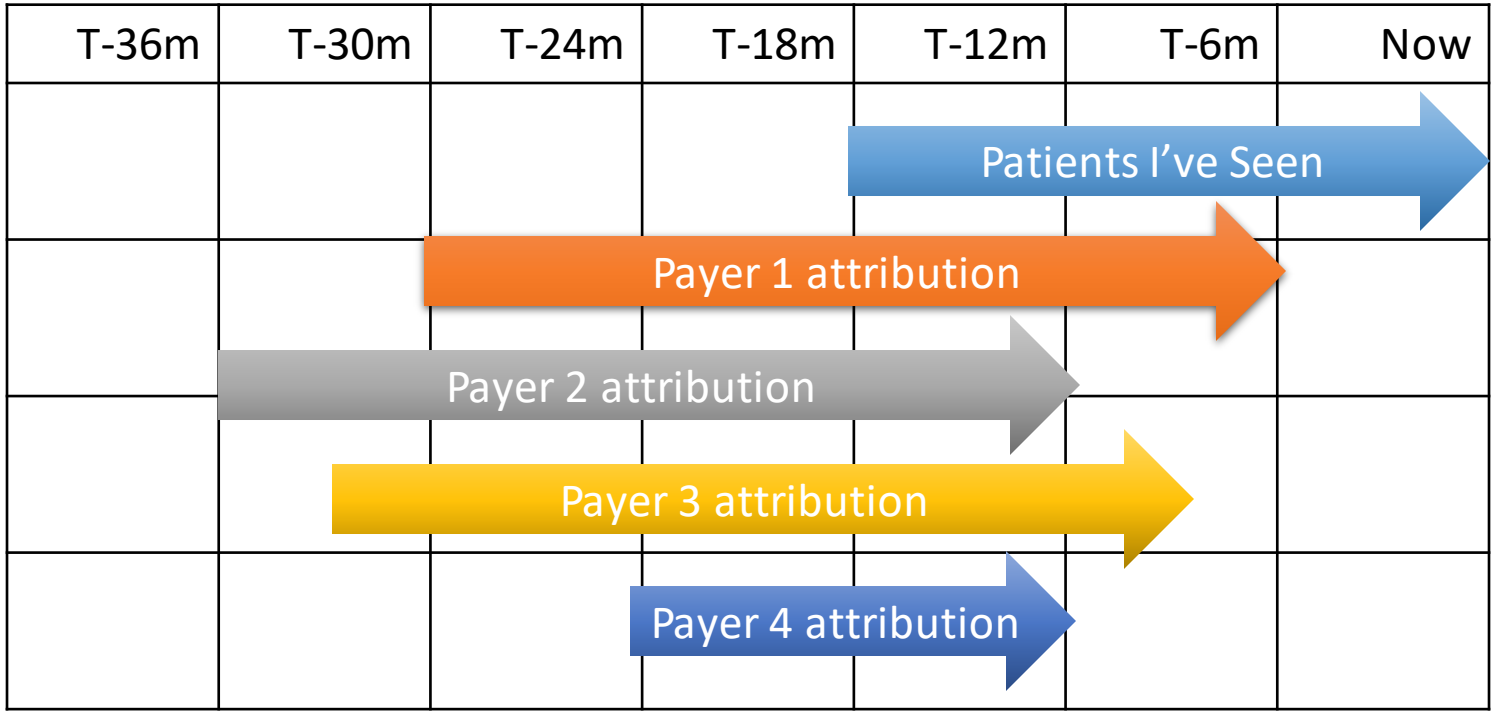


Value Proposition:

- Schedule follow-up with ER and inpatient discharges.
- Close loops on referrals.
- Understand in- and out-of-network care.

Who are my patients?

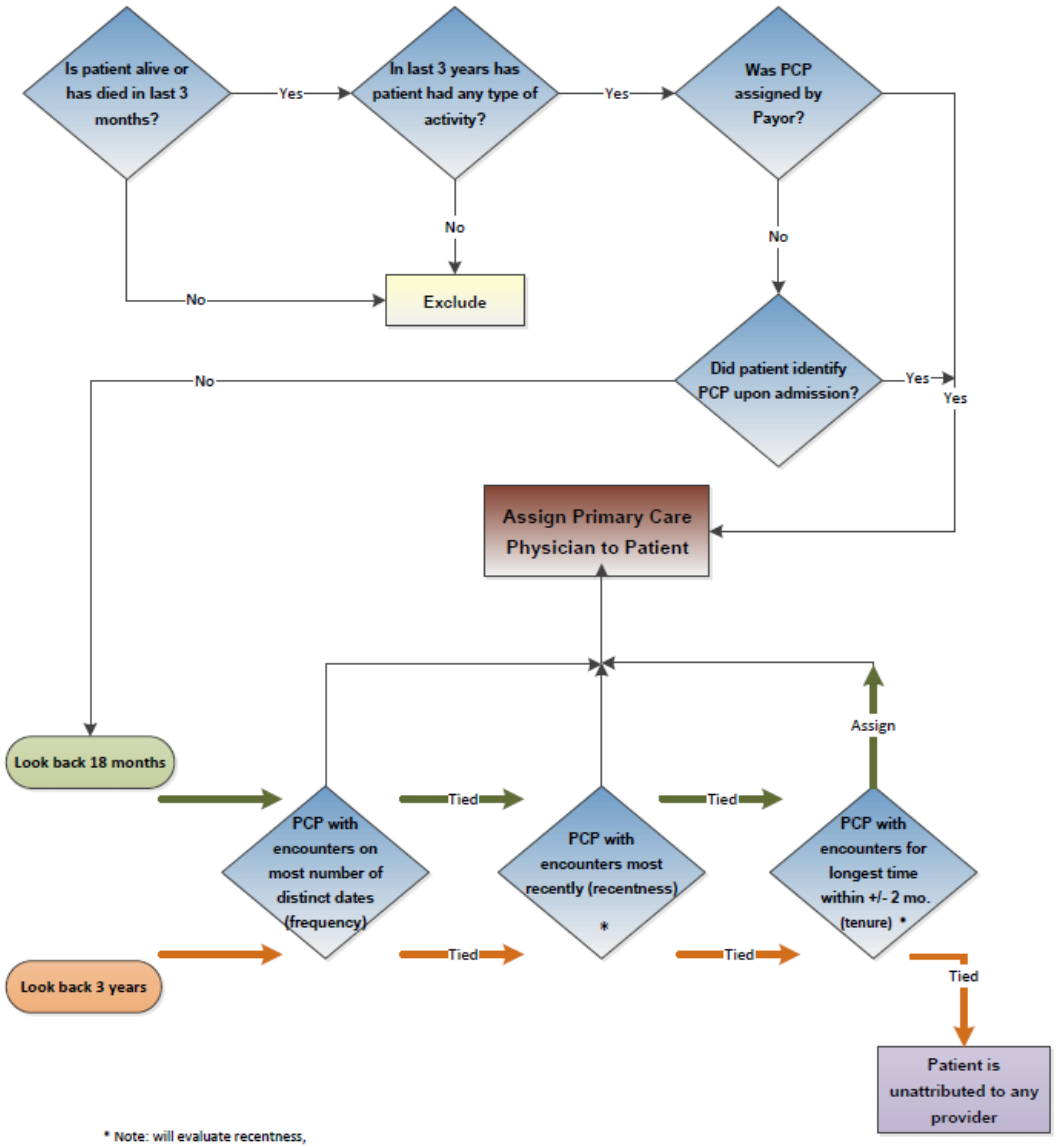
Attribution can be confusing, but is critical to understand . . .



MyHealth ACCESS NETWORK

Primary Care Physician Patient Attribution Flow Chart

DRAFT



* Note: will evaluate recentness, then tenure... as well as in reverse order – tenure, then recentness

Version 4: 12/03/2014

MyHealth ACCESS NETWORK

Undo | Redo | Revert | Refresh | Pause

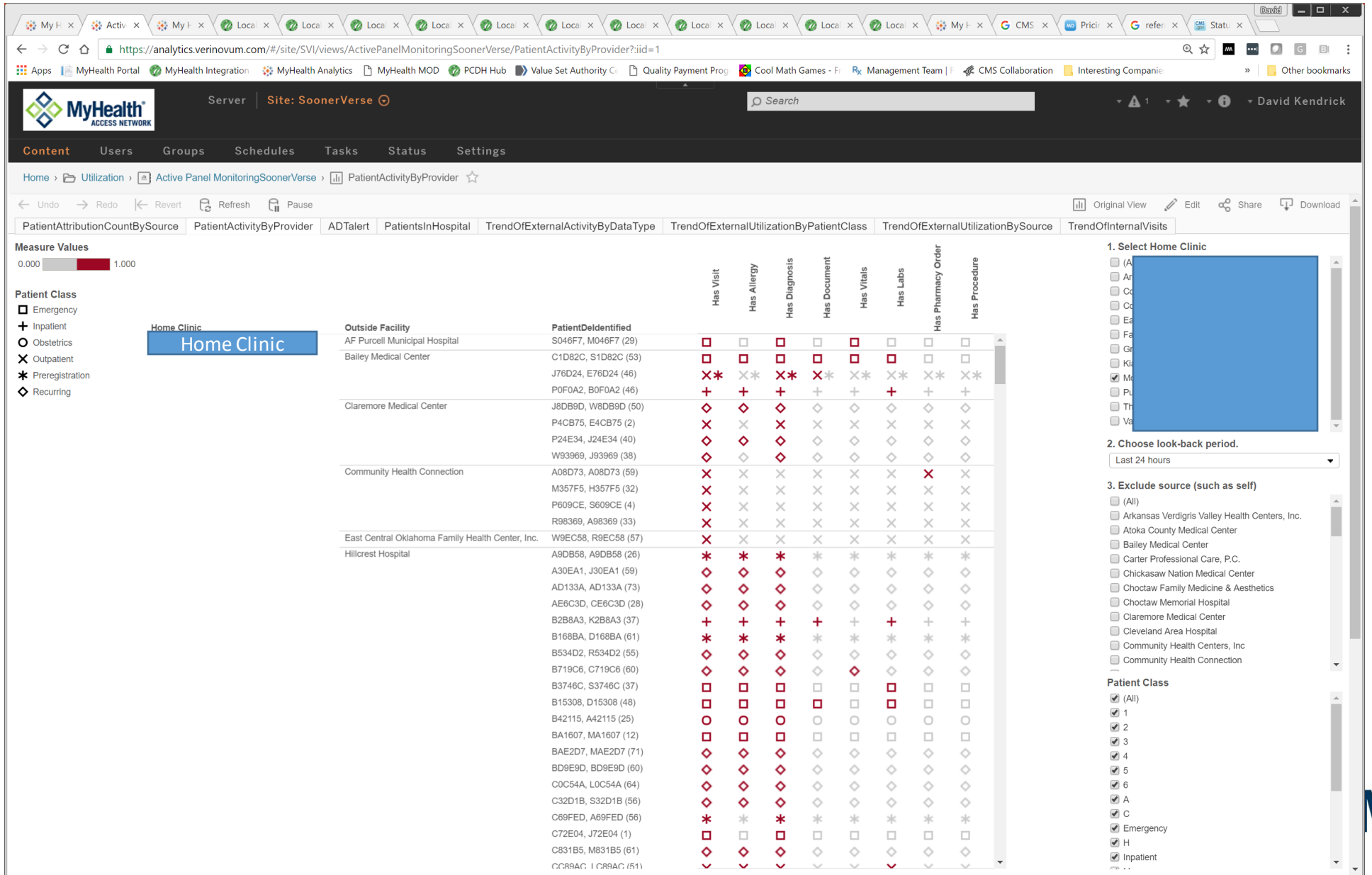
Active Panel Monitoring Dash | ADT Alerting Dash | Attribution Counts by Org | Attribution Counts by Sub Unit | Attribution Counts by Provider | Attributed Patients by Provider | Active Panel Monitoring | ADT Alerting

Attribution Method

- Highest Frequency (Last ..
- Highest Frequency (Last ..
- Highest Frequency (Last ..
- Highest Frequency (Last ..
- Payer Assigned PCP (B..
- Payer Assigned PCP (C..
- Source Assigned PCP fr..

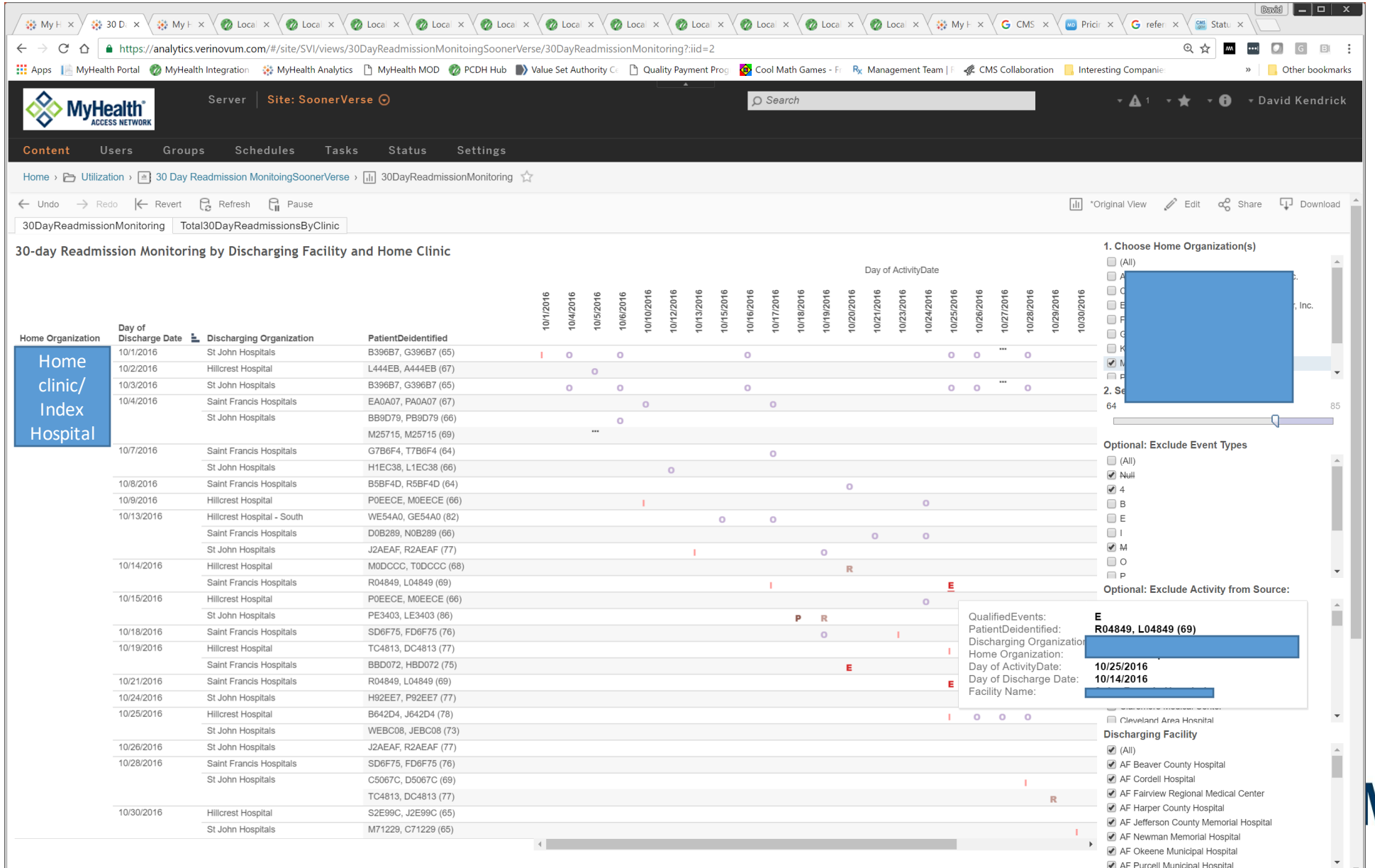
Org	NPI	Provider Name	Patient Name	Payer Assigned: Payer Assigned PCP (BCBS)	Payer Assigned: Payer Assigned PCP (CCOK)	Source A..: Source Assigned PCP from Message Data	Touch Based: Highest Frequency (Last 12 months)	Touch Based: Highest Frequency (Last 18 months)	Touch Based: Highest Frequency (Last 24 months)	Touch Based: Highest Frequency (Last 36 months)
			RE5ED, A01956 (52)	■		■	■	■	■	■
			RE9A7, A01956 (52)			■				
			RE9DD, A01956 (82)		■	■				■
			RE066, I01956 (65)				■	■	■	■
			RE501, L01956 (52)			■			■	■
			REA3E, A01956 (36)							■
			REAB4, H01956 (60)			■		■	■	■
			REAF3, Y01956 (17)			■		■	■	■
			RECD0, Y01956 (76)			■		■	■	■
			REF5F, Y01956 (43)			■				
			RF92B, A01956 (66)							■
			RF092, L01956 (25)			■				
			RF411, I01956 (22)	■						
			RF562, N01956 (3)		■	■		■	■	■
			RF628, E01956 (53)	■		■				■
			RFB39, Y01956 (68)			■				
			RFBE9, A01956 (53)			■				
			S0B6B, T01956 (51)			■				
			S0BE6, N01956 (33)	■		■				
			S0DB8, N01912 (21)		■					
			S0ECF, A01956 (40)							■
			S0F0C, S01956 (37)	■						
			S0FF7, Y01956 (32)	■						
			S1C75, Y01956 (60)			■				
			S1C97, A01A5C (76)			■				
			S1D72, W01956 (15)		■					
			S1DFD, E01956 (56)		■	■		■	■	■
			S1EDF, N01956 (25)		■					
			S2B28, Y01956 (31)	■		■				■
			S2BFE, N01956 (48)		■	■			■	■
			S2D2B, A01956 (66)			■				■
			S2DF5, A019AC (39)	■						
			S2EA2, N01956 (63)			■				
			S2EE5, L01956 (35)				■	■	■	■
			S2FE3, R0192E (46)		■					
			S3BA8, N01956 (14)			■				
			S3C2C, N01956 (22)			■				
			S3C9F, A018B8 (1)				■	■	■	■
			S3DFB, L01956 (60)							■
			S3EED, Y01956 (52)			■	■	■	■	■
			S4C3D, S01956 (75)			■				

Care Fragmentation Alerting



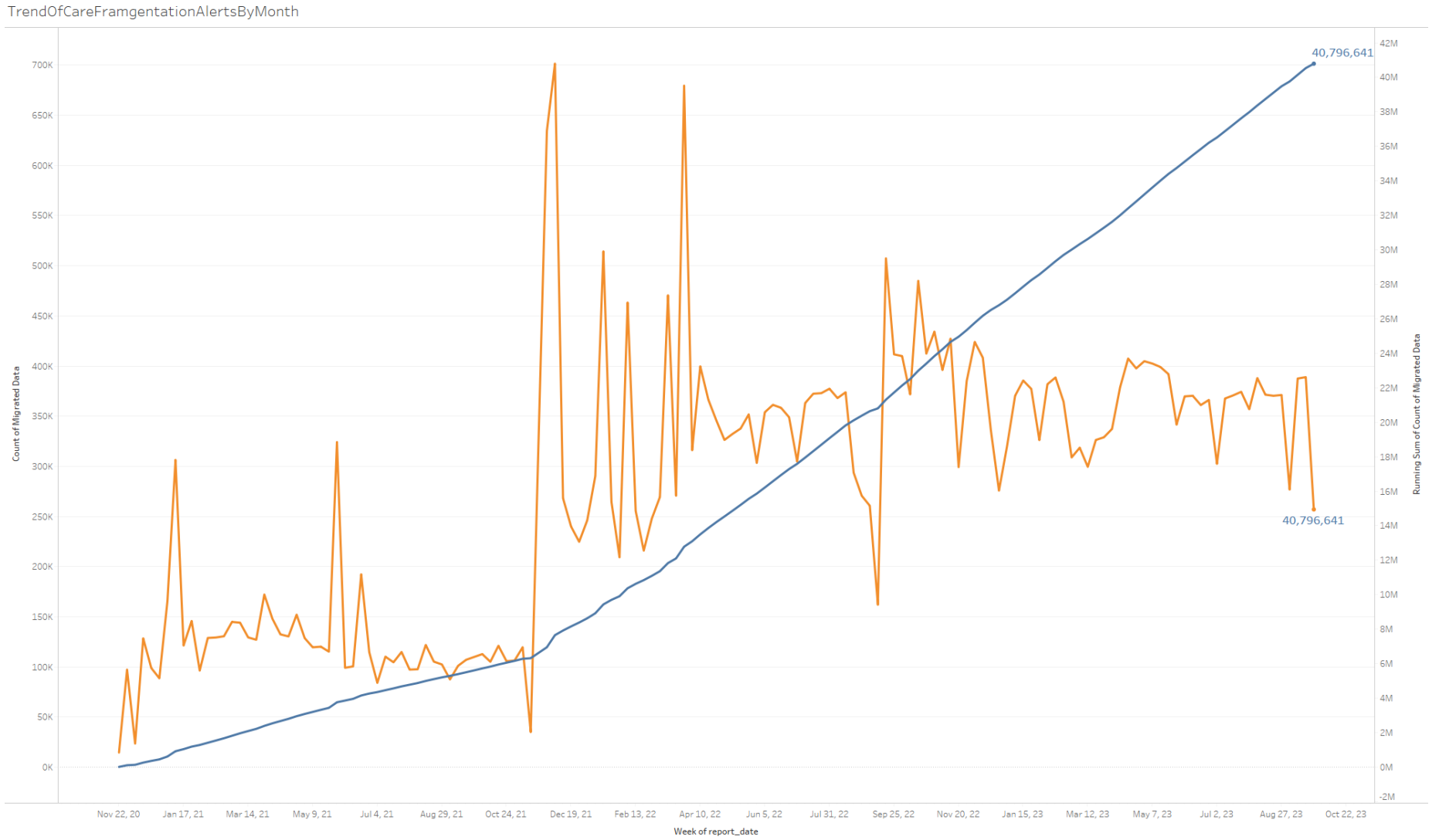
MyHealth ACCESS NETWORK

30-day readmission monitoring

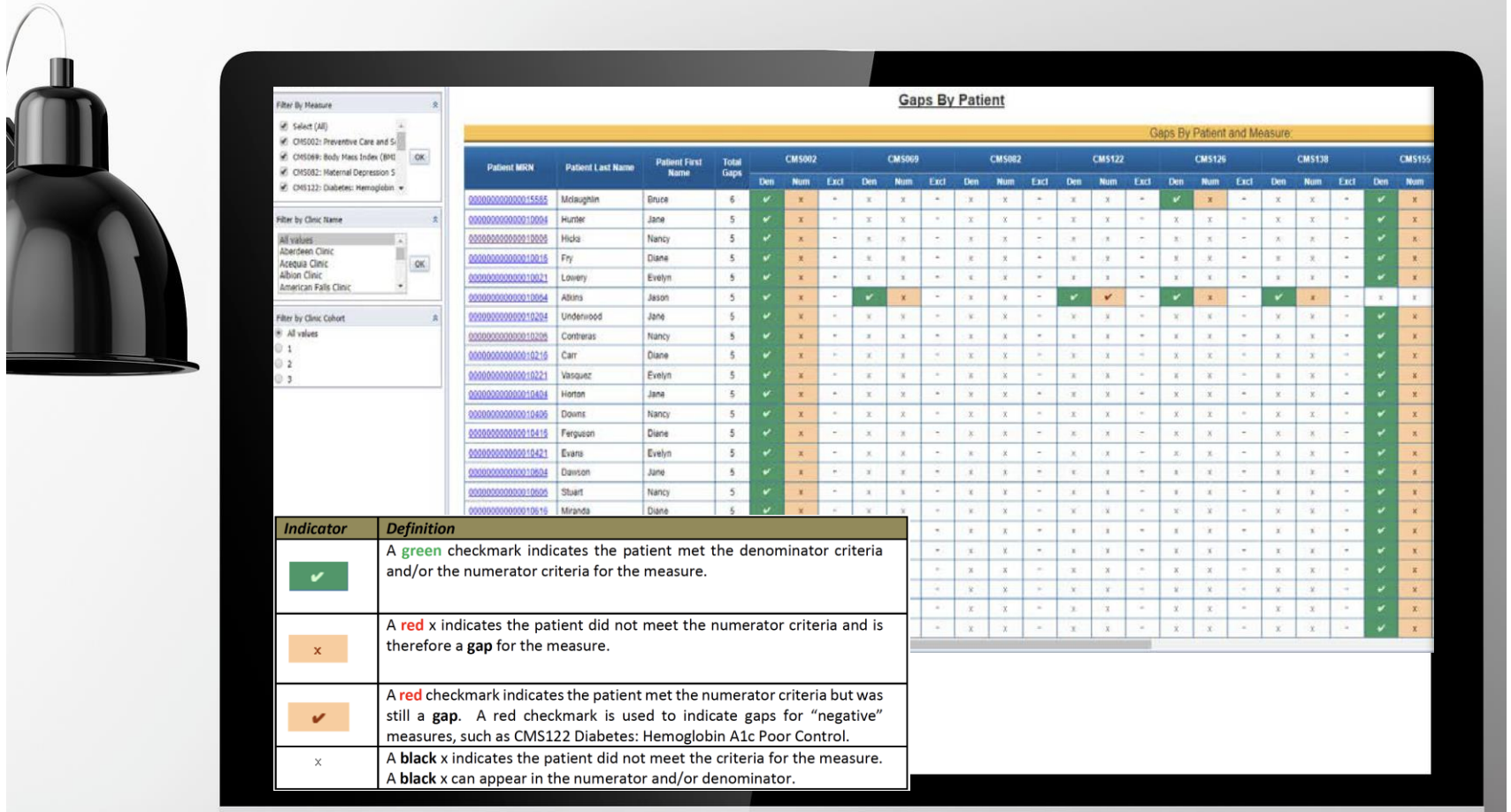


MyHealth ACCESS NETWORK

MYHEALTH CARE FRAGMENTATION - ALERTING PROVIDER



eCQM's & Care Gaps



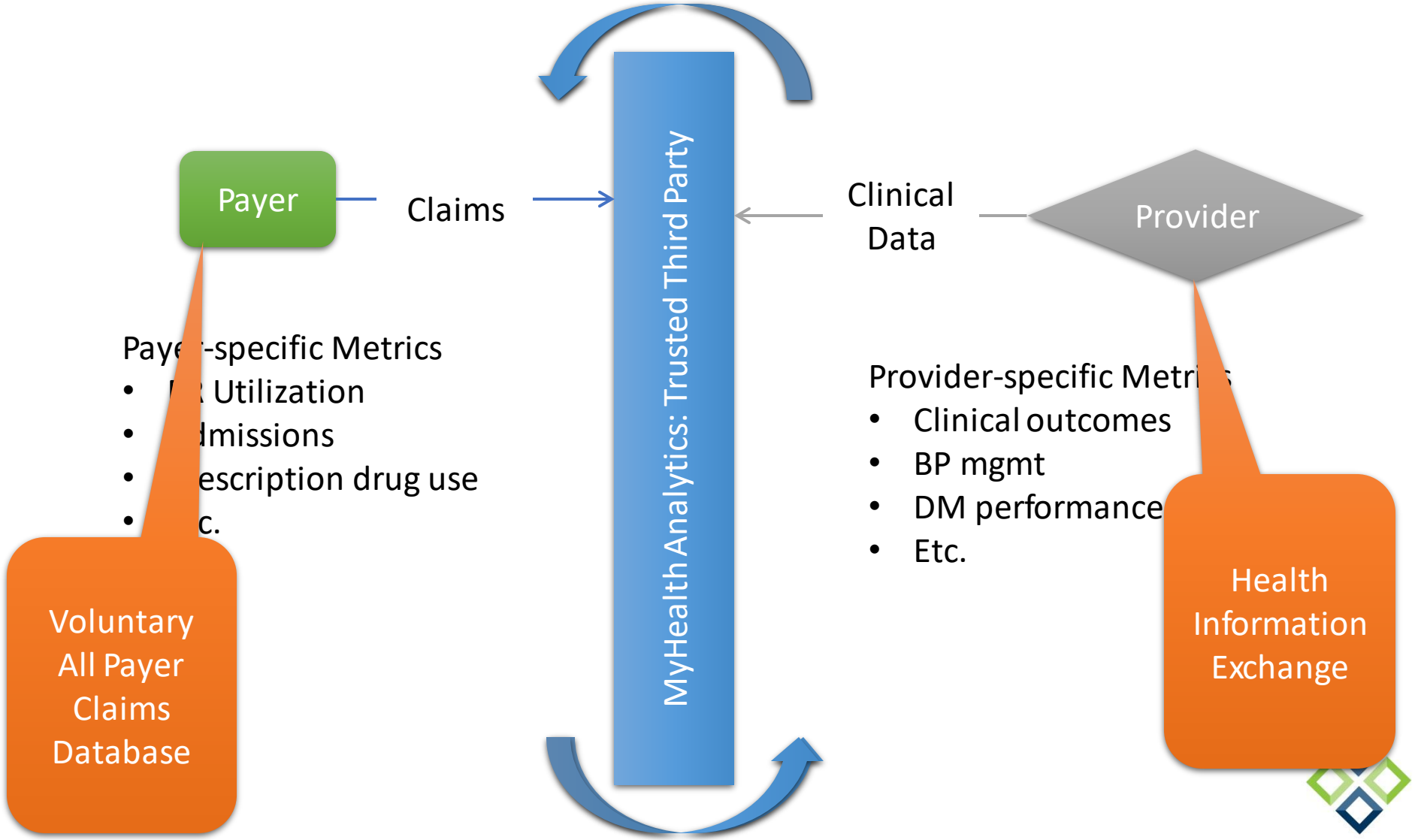
Indicator	Definition
✔	A green checkmark indicates the patient met the denominator criteria and/or the numerator criteria for the measure.
x	A red x indicates the patient did not meet the numerator criteria and is therefore a **gap** for the measure.
✔	A red checkmark indicates the patient met the numerator criteria but was still a **gap**. A red checkmark is used to indicate gaps for "negative" measures, such as CMS122 Diabetes: Hemoglobin A1c Poor Control.
x	A **black** x indicates the patient did not meet the criteria for the measure. A **black** x can appear in the numerator and/or denominator.

Value Proposition:

- Close gaps in care.
- Improve quality.
- Optimize performance in value-based payment models.

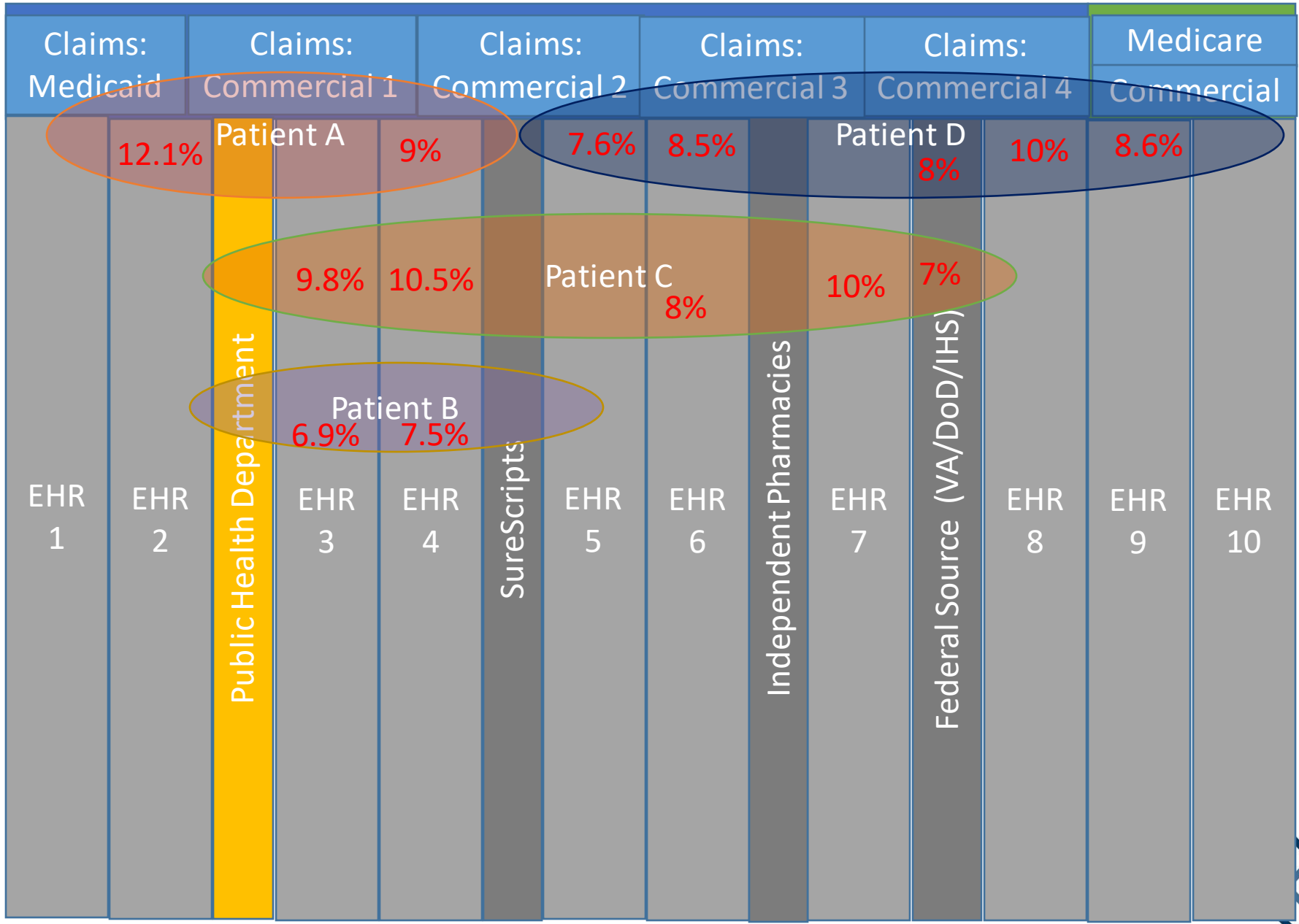
MyHealth® ACCESS NETWORK

Trusted 3rd Party for Measurement



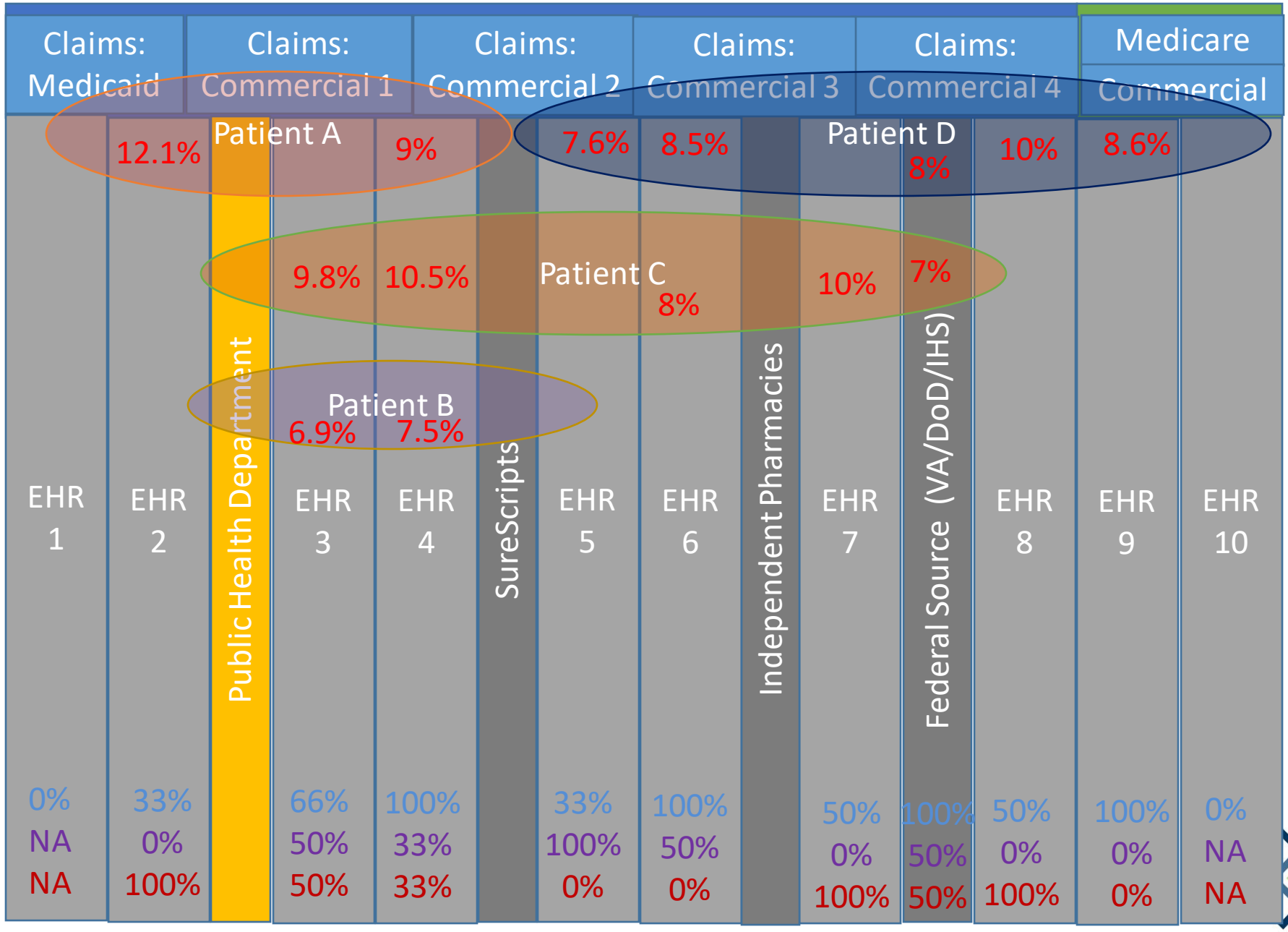
MyHealth ACCESS NETWORK

Example: HbA1c control– what is the correct answer for each provider? Patient? Payer?



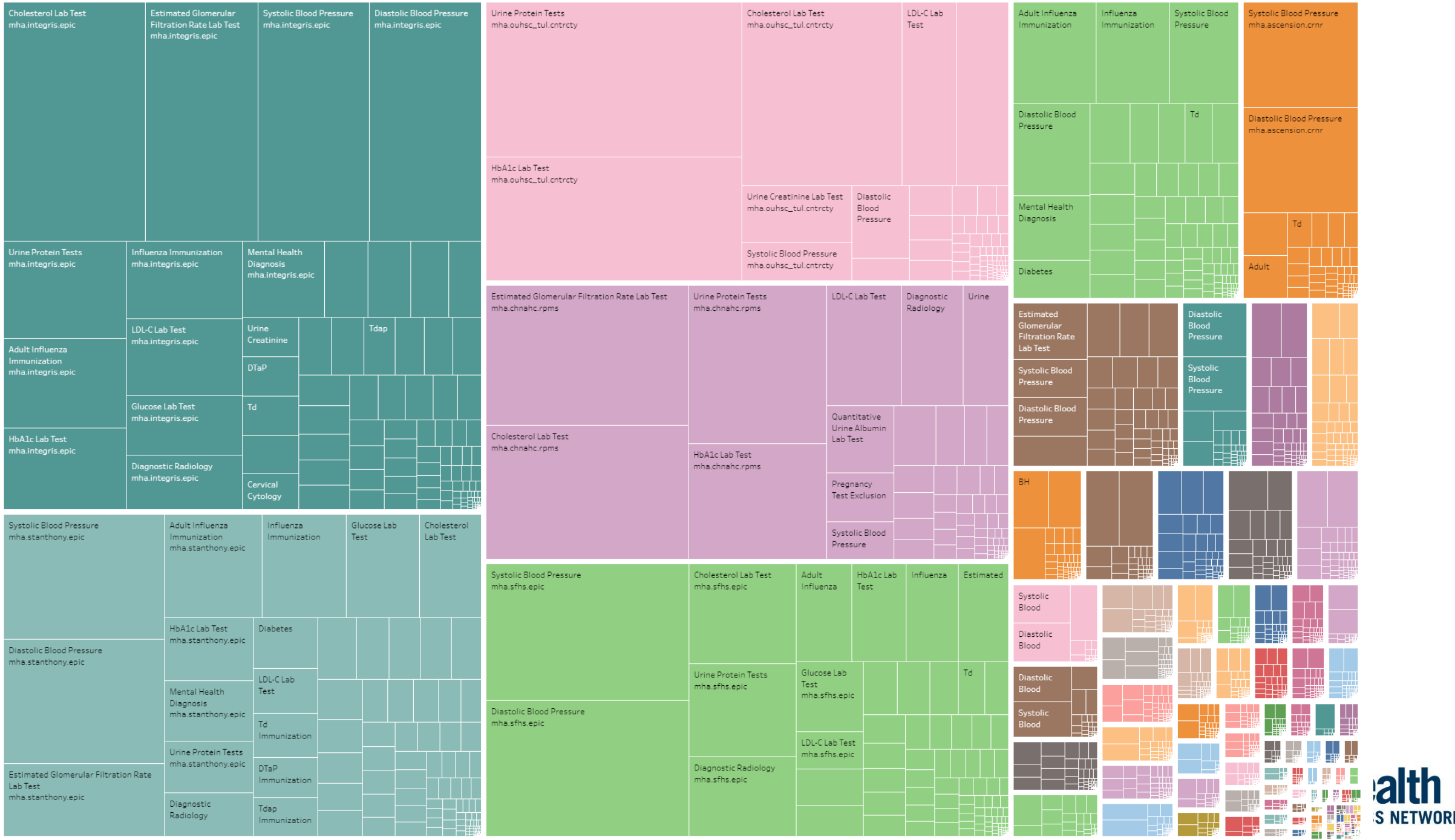
MyHealth ACCESS NETWORK

Take 3 diabetes measures: 1) Appropriate Testing, 2) Control <8, 3) Out of Control >9



MyHealth ACCESS NETWORK

CareGapsBySourceForrestPlot for measures: All and Versions: All



Take 3 Diabetes Measures:

Source	Appropriate HbA1c Testing	DM in control (A1c<8)	DM out of control (A1c>9)
EHR 1	0%	NA	NA
EHR 2	100%	0%	100%
EHR 3	66%	50%	50%
EHR 4	100%	33%	33%
EHR 5	33%	100%	0%
EHR 6	100%	50%	0%
EHR 7	50%	0%	100%
EHR 8	50%	0%	100%
EHR 9	100%	0%	0%
EHR 10	0%	NA	NA
VA/DoD/IHS	100%	50%	50%
Population:	?	?	?

Payers will get multiple scores on the same patient– what do they do with that?

Looking at populations, we cannot roll these up . . .

Isn't this what we *really* want to know?

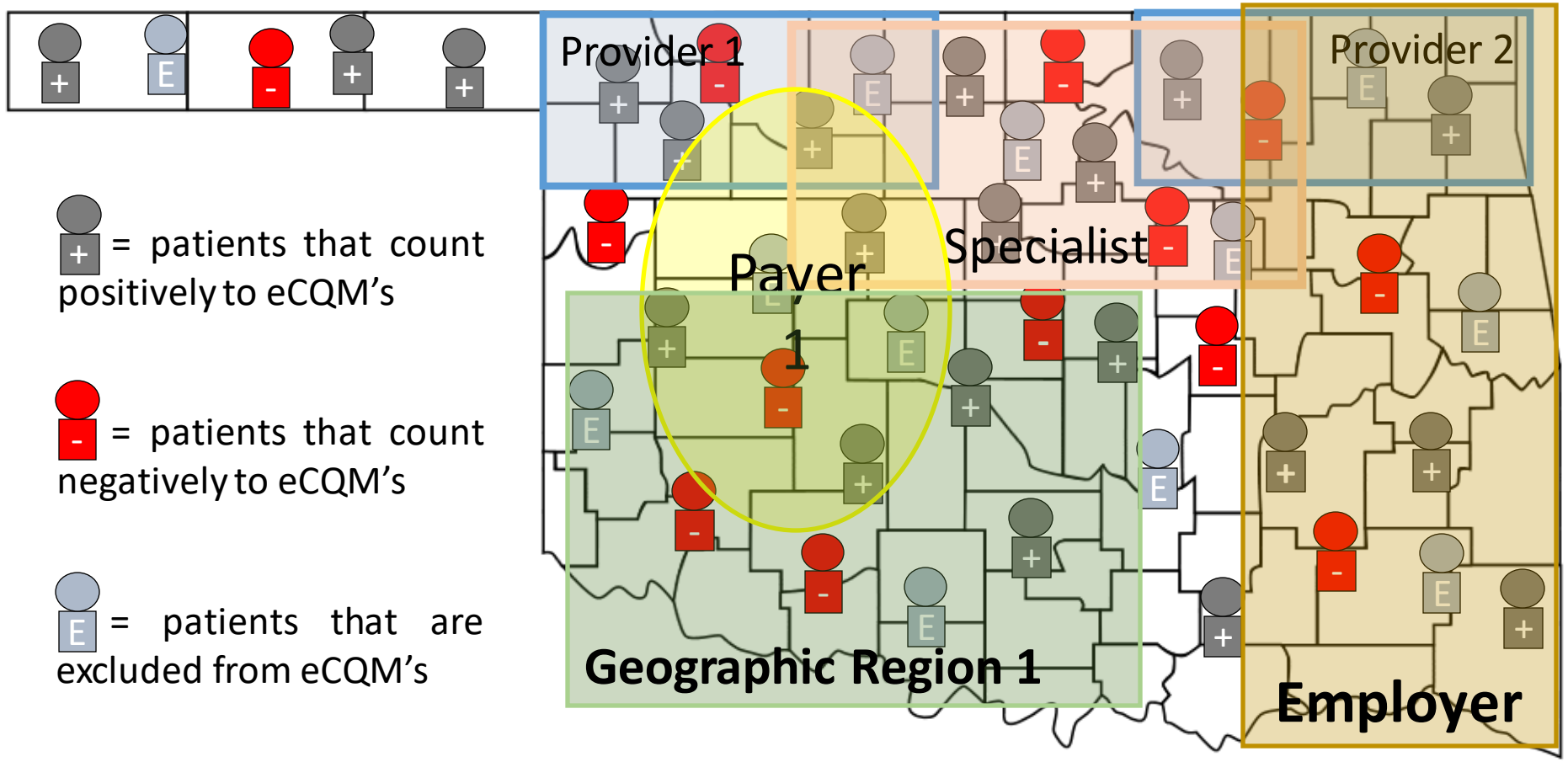
Patient	Appropriate HbA1c Testing	DM in control (A1c<8)	DM out of control (A1c>9)
Patient A:	100%	0%	0%
Patient B:	100%	100%	0%
Patient C:	100%	100%	0%
Patient D:	100%	0%	0%
Population:	**100%**	**50%**	**0%**

MyHealth ACCESS NETWORK

Patient-centric measurement

Measure once, reuse many times for many perspectives . . .

4+, 3-, 3E = 4/7 = 57%



+ = patients that count positively to eCQM's

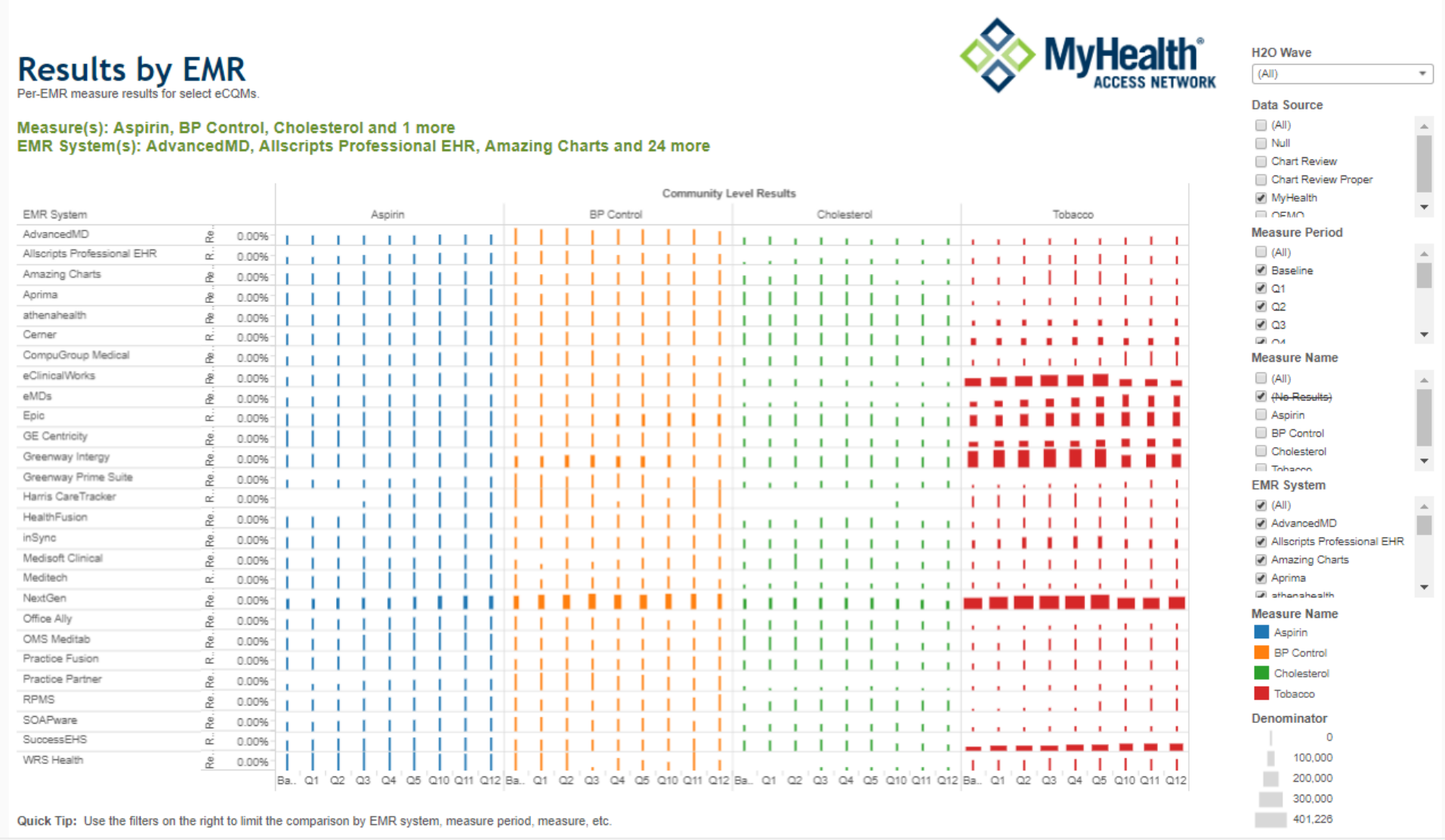
- = patients that count negatively to eCQM's

E = patients that are excluded from eCQM's

eCQM's calculated in real time based on changes in a patients cross-community data by placing a box around any portion of a population.

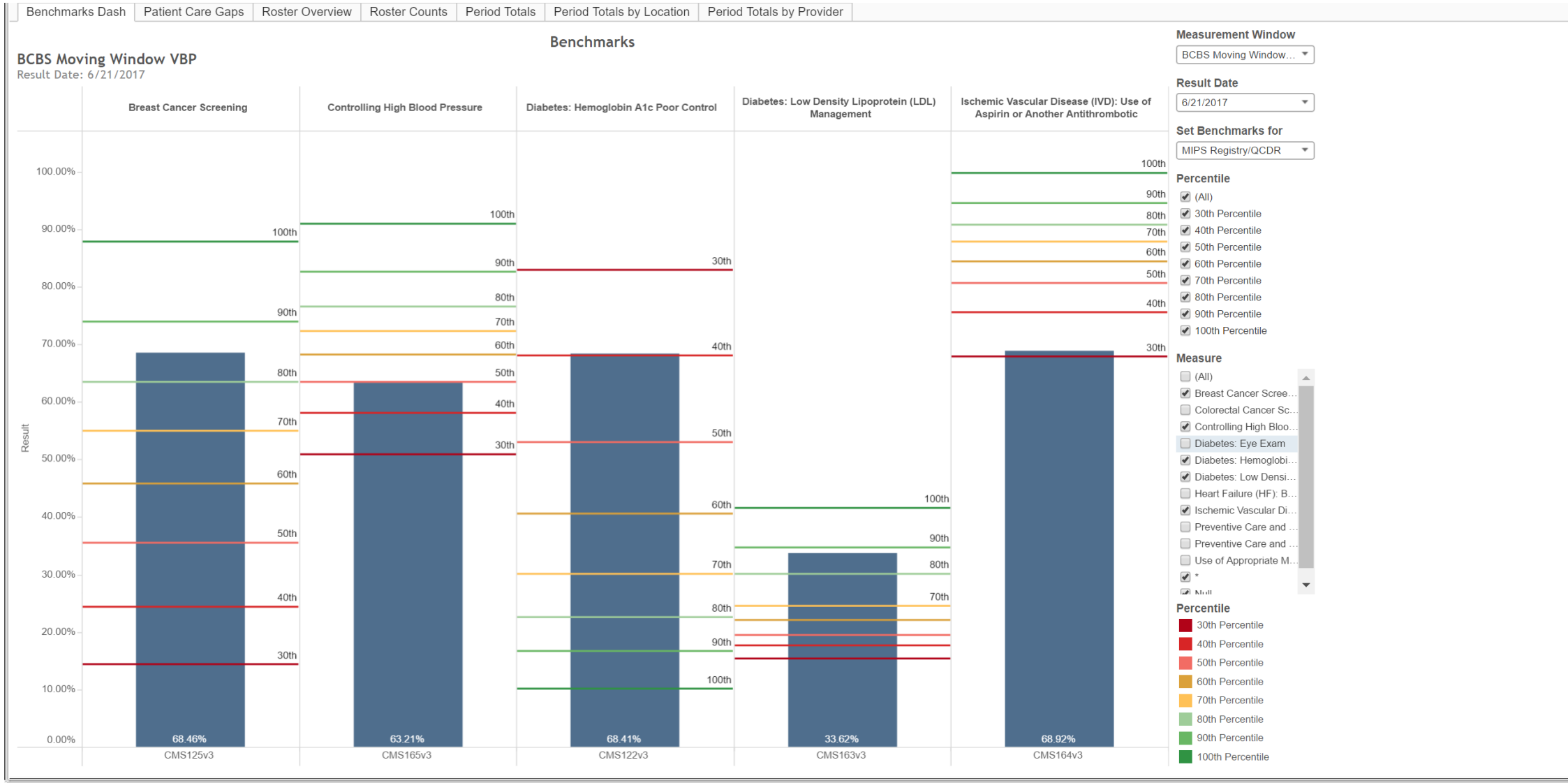
MyHealth ACCESS NETWORK

Measure performance across many systems and EHR platforms

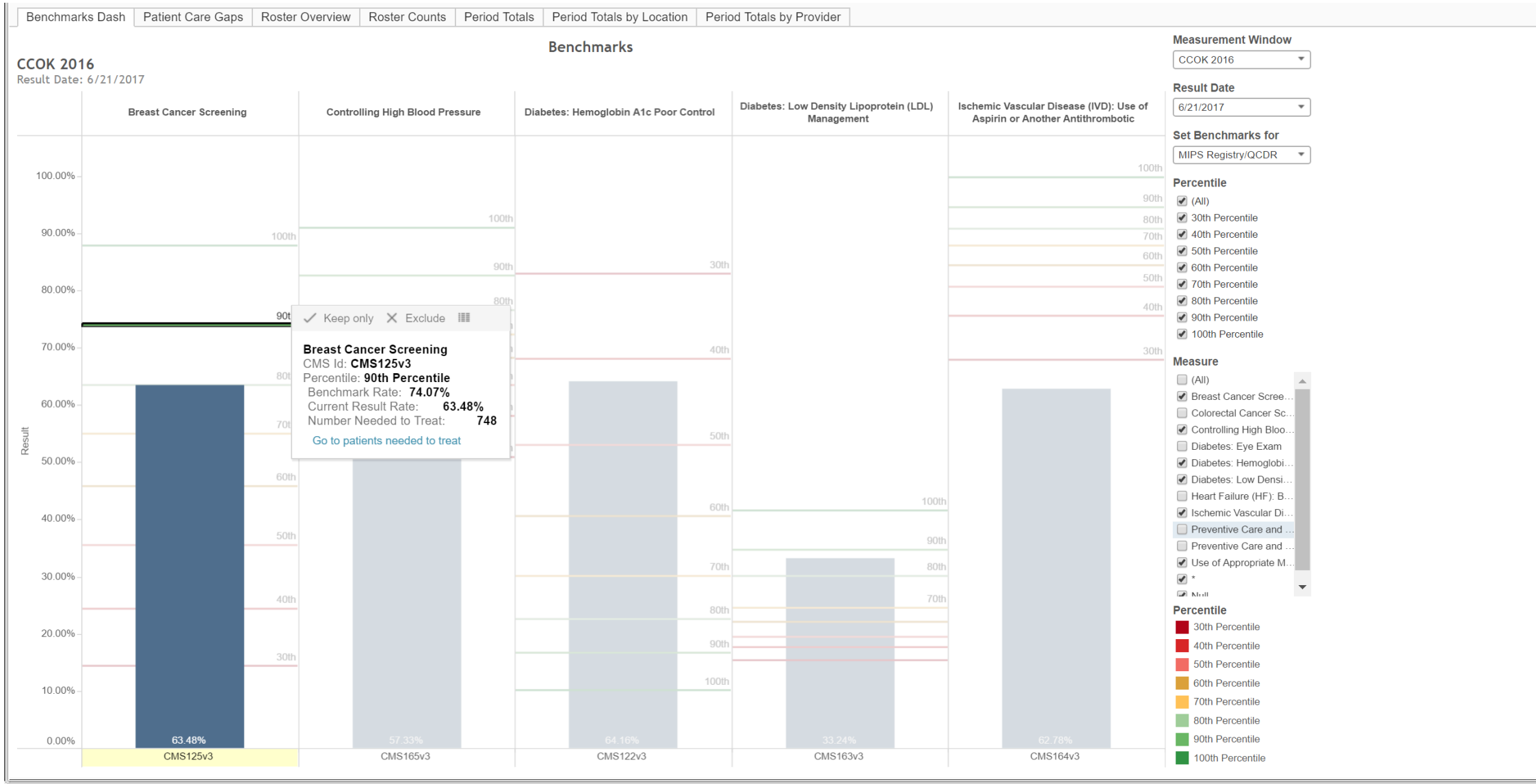


MyHealth ACCESS NETWORK

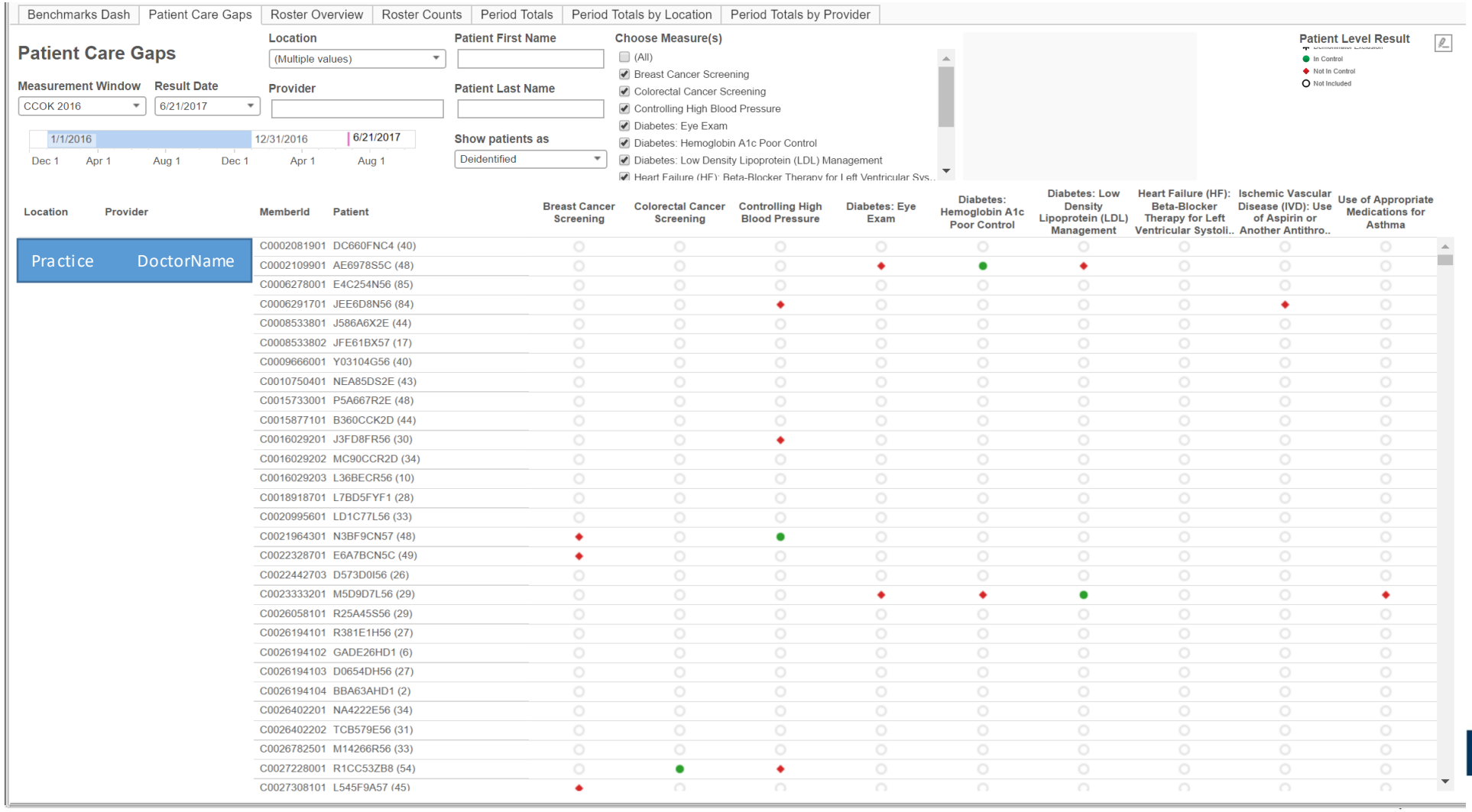
MIPS View of Quality Measures



Actionable: Number needed to treat



Care Gap Closure = Better Performance



MyHealth ACCESS NETWORK

Predicting Performance Guides Activity

MyHealth ACCESS NETWORK

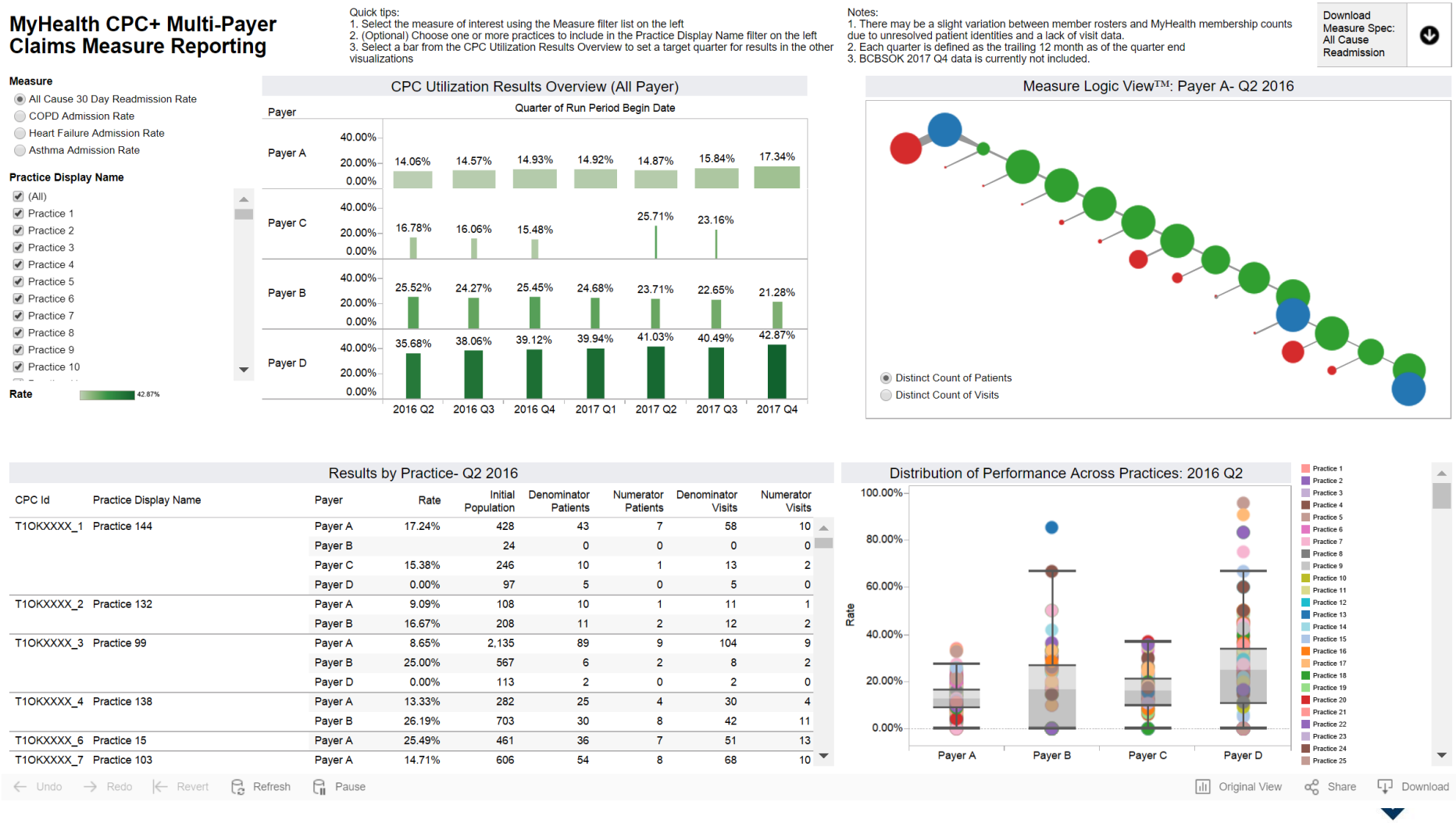
Market Strategies to Optimize Health

MyHealth® ACCESS NETWORK

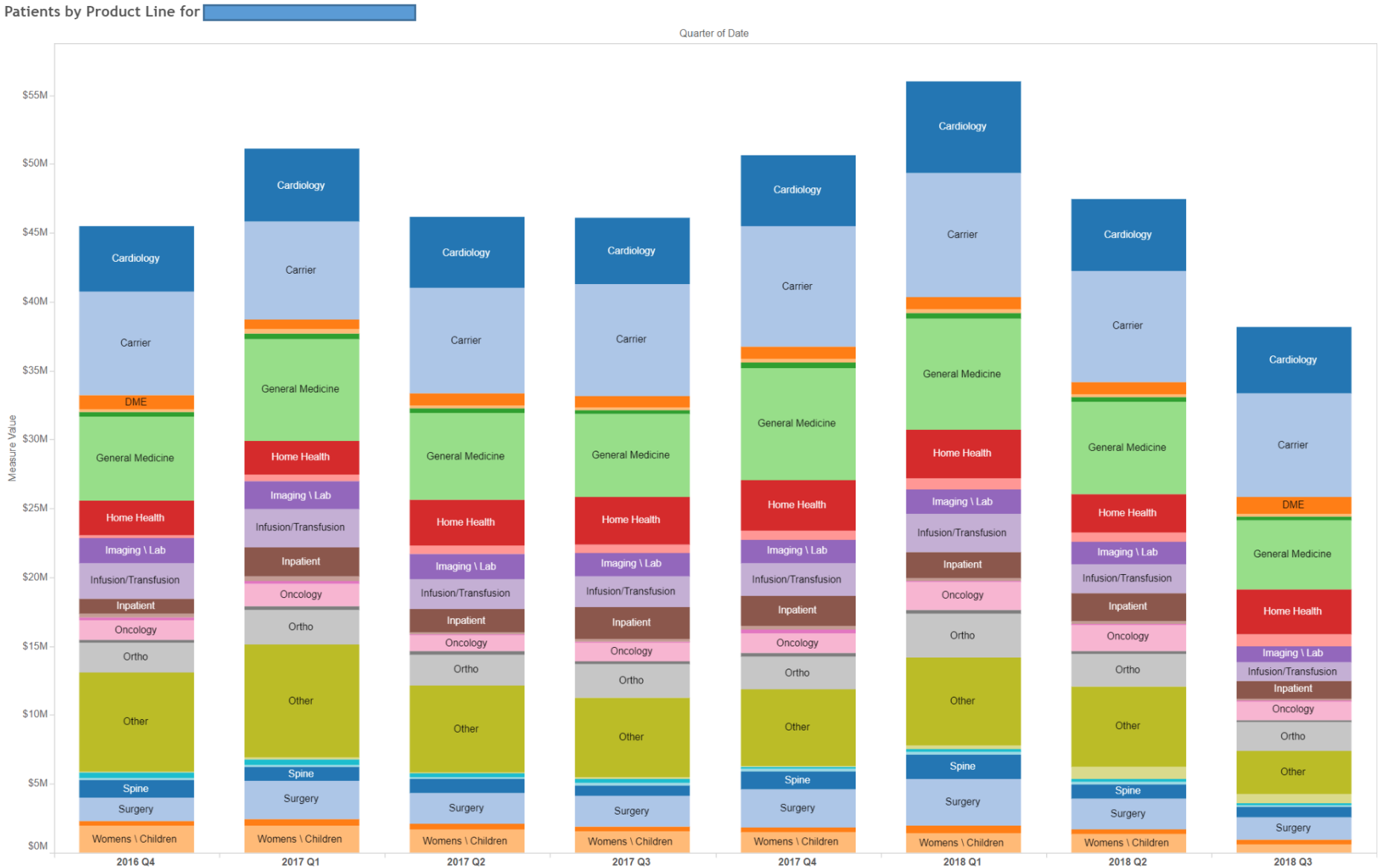
Value Proposition:

- Understand care fragmentation and leakage.
- Plan expansion, partnerships.
- Identify risk points.

MyHealth is Oklahoma's CPC+ Data Aggregator for All Payers and Practices

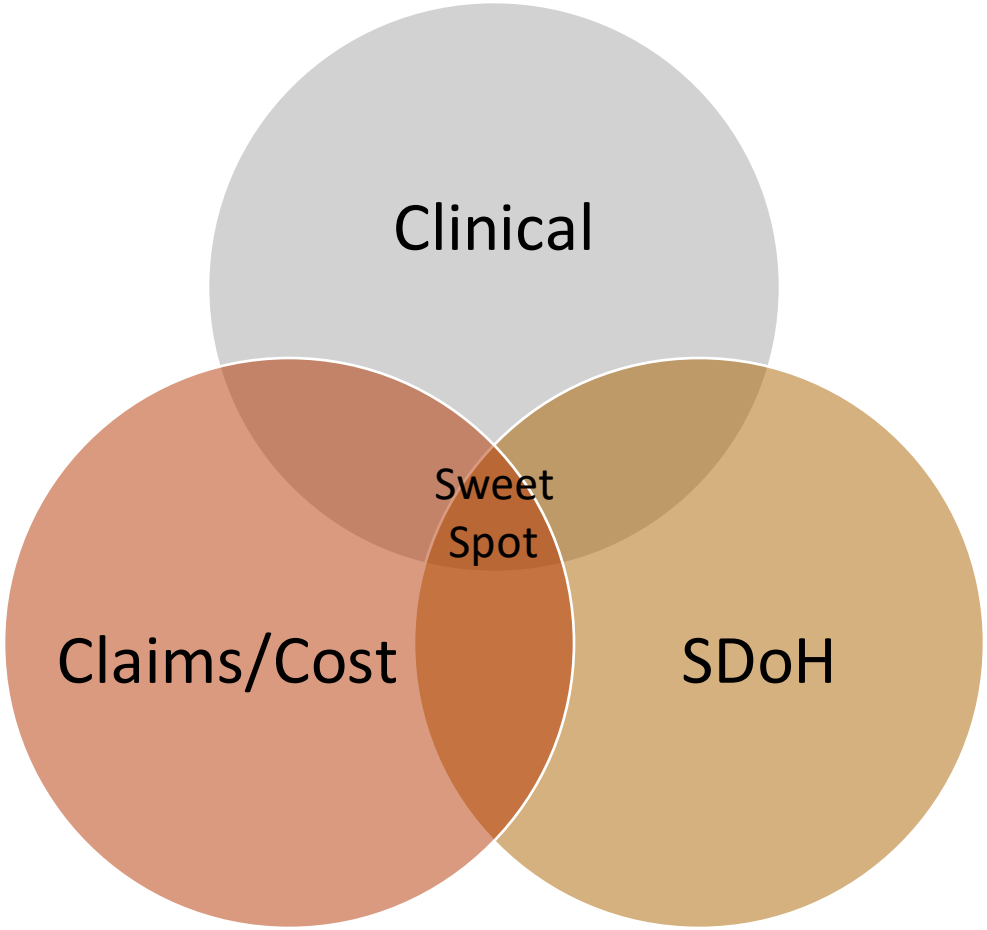


CPC+ Expenditures by Product Line



MyHealth ACCESS NETWORK

Putting it all together

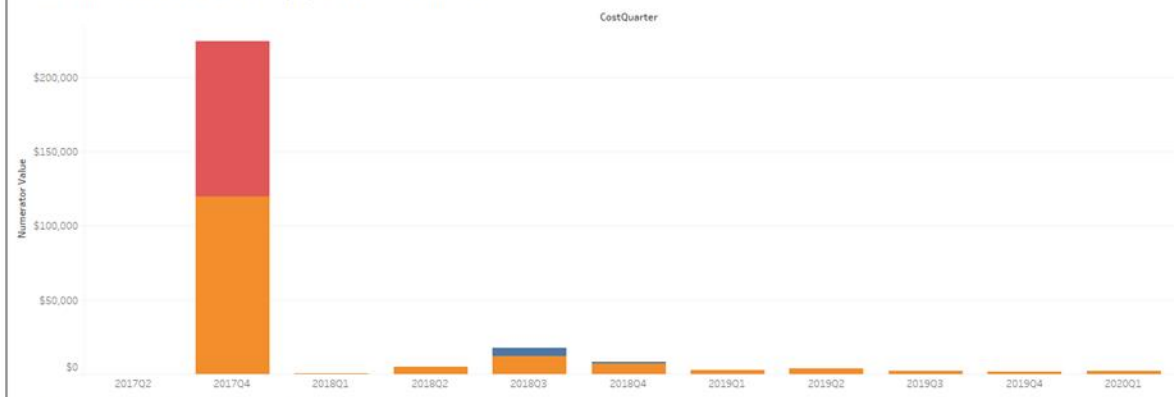


MyHealth
ACCESS NETWORK

Population Health Command & Control

Visits for Oklahoma Cancer Specialists and Research Institute, OU Physicians Tulsa, St. John and 2 more attributed patients on 11/14/2021 report

Patient DeIdentifi..	Patient Class	Visit Source	Day of Visit Admit ..	Day of Visit Discha..	Any Social ..	Payer	Measure Va..
Abe49b6c,F5f8d1b..	Emergency (E)		November 10, 2021	November 11, 2021	No	Medicare	$1,865,018
C0e8de4e,S5df482..	Inpatient (I)		November 5, 2021	Null	No	Medicare	$716,524
C12c4dc9,R5df4ad..	Inpatient (I)		November 12, 2021	Null	No	BCBSOK	$819
Ce558c1e,D5df490..	Inpatient (I)		November 7, 2021	Null	No	Medicare	$74,509
D5ed04bf,B5df49..	Emergency (E)		November 12, 2021	November 12, 2021	No	Medicare	$193,580
Df945f20,T5df491..	Inpatient (I)		October 18, 2021	November 12, 2021	No	CCOK	$16,790
F12ad919,C5df47..	Inpatient (I)		November 13, 2021	November 13, 2021	Yes	Medicare	$78,022
F78ff0d6,S5df493..	Inpatient (I)		November 12, 2021	Null	Yes	OHCA	$560
Ff942c63,J5df492..	Inpatient (I)		November 2, 2021	Null	No	BCBSOK	$21,087
G12b68c8,A5df48..	Inpatient (I)		November 2, 2021	November 8, 2021	Yes	BCBSOK	$39,116
Gca741d8,C5df49..	Inpatient (I)		November 12, 2021	Null	No	Medicare	$279,115
Ha73f32a,H605721 (83)	Inpatient (I)		November 10, 2021	November 12, 2021	No	Medicare	$192,100
			November 12, 2021	November 13, 2021	No	Medicare	$192,100
Hcbf457f,V5df548 (37)	Emergency (E)		November 13, 2021	Null	No	BCBSOK	$2,737
				November 14, 2021	No	BCBSOK	$2,737
He5660df,K5df4b4 (71)	Emergency (E)		November 13, 2021	Null	No	Medicare	$20,474
				November 13, 2021	No	Medicare	$20,474
He587595,J5df56..	Inpatient (I)		November 12, 2021	Null	No	CCOK	$19,922
Hf940967,K5df48..	Inpatient (I)		November 11, 2021	Null	Yes	BCBSOK	$1,440,031
Hf961829,D5df4f3..	Inpatient (I)		November 8, 2021	November 12, 2021	No	Medicare	$24,463
L7900548,R5df496 (82)	Inpatient (I)		November 13, 2021	Null	No	Medicare	$3,429
					Yes	Medicare	$3,429
Lf93f374,T5df48a ..	Inpatient (I)		November 8, 2021	November 11, 2021	No	Medicare	$468,220
Mf933bbd,S5df477 (76)	Inpatient (I)		November 10, 2021	Null	No	BCBSOK	$20,460
						Medicare	$13,141
					Yes	BCBSOK	$20,460
						Medicare	$13,141
Mf946909,R5df49..	Emergency (E)		November 14, 2021	Null	No	Medicare	$675,624
Ncbca2dc,C5df48e (79)	Inpatient (I)		November 12, 2021	Null	No	Medicare	$77,457
					Yes	Medicare	$154,914
P78f4beb,M5df47d (88)	Emergency (E)		November 10, 2021	November 11, 2021	No	Medicare	$91,353
			November 10, 2021	November 11, 2021	No	Medicare	$91,353
R3cb31f2,C5df48d..	Inpatient (I)		November 4, 2021	Null	Yes	Medicare	$134,072
R78ef35c,P5df474 (75)	Emergency (E)		November 10, 2021	November 11, 2021	No	Medicare	$274,185
	Inpatient (I)		November 11, 2021	Null	No	Medicare	$274,185
R5971313,L5df49a (54)	Emergency (E)		November 13, 2021	Null	No	Medicare	$73,852
					Yes	Medicare	$147,703
	Inpatient (I)		November 13, 2021	Null	No	Medicare	$73,852
					Yes	Medicare	$147,703
S5ed0ab8,M5df49..	Inpatient (I)		October 31, 2021	November 12, 2021	Yes	Medicare	$2,411,925
S78f1945,M5df47..	Emergency (E)		November 10, 2021	November 11, 2021	No	Medicare	$90,153
Se0254bd,H5df47..	Emergency (E)		November 13, 2021	November 13, 2021	No	Medicare	$512,088
Sf943db8,S5df494..	Emergency (E)		November 10, 2021	November 10, 2021	No	BCBSOK	$709
T3cb40c8,D5df48f..	Inpatient (I)		November 10, 2021	Null	No	Medicare	$80,479
T4874dce,N5df48c..	Emergency (E)		November 10, 2021	November 10, 2021	No	Medicare	$51,258
W6d01283, W5df4ab (86)	Emergency (E)		November 13, 2021	Null	No	Medicare	$74,661
				November 13, 2021	No	Medicare	$149,323
W12b4e35,N5df48..	Emergency (E)		November 4, 2021	November 4, 2021	No	Medicare	$86,008
W598c4f1,K5df503 (62)	Emergency (E)		November 13, 2021	Null	No	BCBSOK	$351,807
				November 13, 2021	No	BCBSOK	$351,807



SDoH for Mf933bbd,S5df477 (76), All

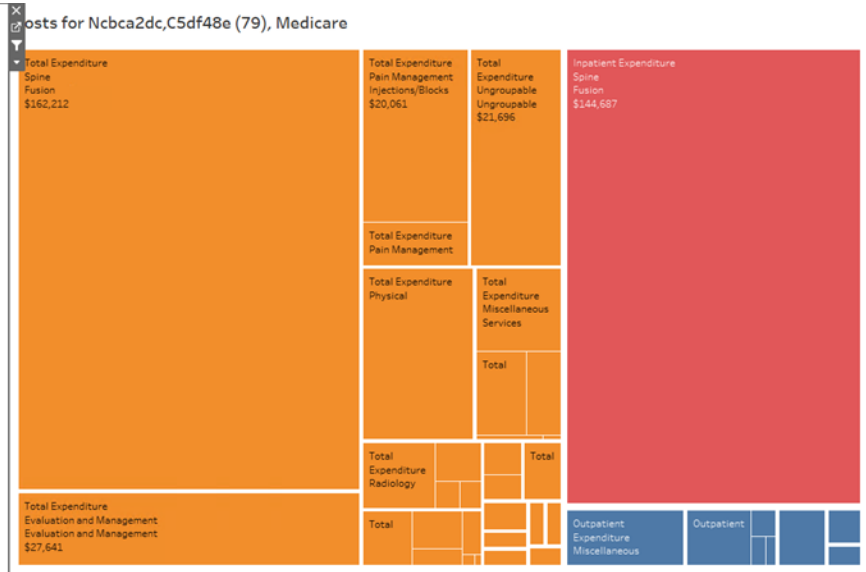
Day of Date Of Visit	Food Need	Housing Need	Transportation Need	Utility Need	Safety Need
April 23, 2021	No	Yes	No	No	No
July 31, 2021	No	No	No	No	No

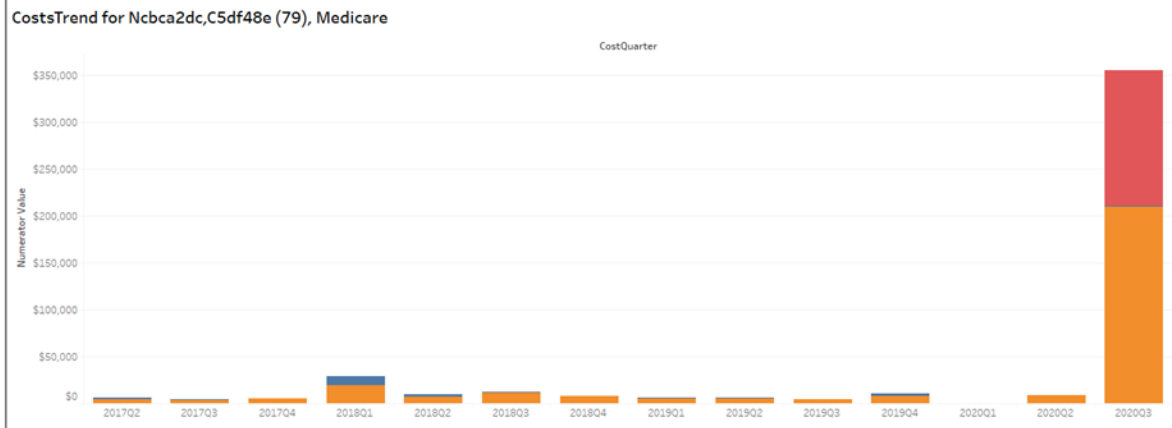
MyHealth ACCESS NETWORK

Population Health Command & Control

Visits for Oklahoma Cancer Specialists and Research Institute, OU Physicians Tulsa, St. John and 2 more attributed patients on 11/14/2021 report

Patient DeIdentifi..	Patient Class	Visit Source	Day of Visit Admit ..	Day of Visit Discha..	Any Social ..	Payer	Measure Va..
Abe49b6c,F5f8d1b..	Emergency (E)		November 10, 2021	November 11, 2021	No	Medicare	$1,865,018
C0e8de4e,S5df482..	Inpatient (I)		November 5, 2021	Null	No	Medicare	$716,524
C12c4dc9,R5df4ad..	Inpatient (I)		November 12, 2021	Null	No	BCBSOK	$819
CeS58c1e,D5df490..	Inpatient (I)		November 7, 2021	Null	No	Medicare	$74,509
D5ed04bf,B5df49..	Emergency (E)		November 12, 2021	November 12, 2021	No	Medicare	$193,580
Df945f20,T5df491..	Inpatient (I)		October 18, 2021	November 12, 2021	No	CCOK	$16,790
F12ad919,C5df47..	Inpatient (I)		November 13, 2021	November 13, 2021	Yes	Medicare	$78,022
F78ff0d6,S5df493..	Inpatient (I)		November 12, 2021	Null	Yes	OHCA	$560
Ff942c63,J5df492..	Inpatient (I)		November 2, 2021	Null	No	BCBSOK	$21,087
G12b68c8,A5df48..	Inpatient (I)		November 2, 2021	November 8, 2021	Yes	BCBSOK	$39,116
Gca741d8,C5df49..	Inpatient (I)		November 12, 2021	Null	No	Medicare	$279,115
Ha73f32a,H605721 (83)	Inpatient (I)		November 10, 2021	November 12, 2021	No	Medicare	$192,100
			November 12, 2021	November 13, 2021	No	Medicare	$192,100
Hcbf457f,V5df548 (37)	Emergency (E)	SO	November 13, 2021	Null	No	BCBSOK	$2,737
				November 14, 2021	No	BCBSOK	$2,737
He5660df,K5df4b4 (71)	Emergency (E)		November 13, 2021	Null	No	Medicare	$20,474
				November 13, 2021	No	Medicare	$20,474
He587595,J5df56..	Inpatient (I)		November 12, 2021	Null	No	CCOK	$19,922
Hf940967,K5df48..	Inpatient (I)		November 11, 2021	Null	Yes	BCBSOK	$1,440,031
Hf961829,D5df4f3..	Inpatient (I)		November 8, 2021	November 12, 2021	No	Medicare	$24,463
L7900548,R5df496 (82)	Inpatient (I)		November 13, 2021	Null	No	Medicare	$3,429
					Yes	Medicare	$3,429
Lf93f374,T5df48a..	Inpatient (I)		November 8, 2021	November 11, 2021	No	Medicare	$468,220
Mf933bbd,S5df477 (76)	Inpatient (I)		November 10, 2021	Null	No	BCBSOK	$20,460
						Medicare	$13,141
					Yes	BCBSOK	$20,460
						Medicare	$13,141
Mf946909,R5df49..	Emergency (E)		November 14, 2021	Null	No	Medicare	$675,624
Ncbca2dc,C5df48e (79)	Inpatient (I)		November 12, 2021	Null	No	Medicare	$77,457
					Yes	Medicare	$154,914
P78f4beb,M5df47d (88)	Emergency (E)		November 10, 2021	November 11, 2021	No	Medicare	$91,353
			November 10, 2021	November 11, 2021	No	Medicare	$91,353
R3cb31f2,C5df48d..	Inpatient (I)		November 4, 2021	Null	Yes	Medicare	$134,072
R78ef35c,P5df474 (75)	Emergency (E)		November 10, 2021	November 11, 2021	No	Medicare	$274,185
	Inpatient (I)		November 11, 2021	Null	No	Medicare	$274,185
R5971313,L5df49a (54)	Emergency (E)		November 13, 2021	Null	No	Medicare	$73,852
					Yes	Medicare	$147,703
	Inpatient (I)		November 13, 2021	Null	No	Medicare	$73,852
					Yes	Medicare	$147,703
S5ed0ab8,M5df49..	Inpatient (I)		October 31, 2021	November 12, 2021	Yes	Medicare	$2,411,925
S78f1945,M5df47..	Emergency (E)		November 10, 2021	November 11, 2021	No	Medicare	$90,153
Se0254bd,H5df47..	Emergency (E)		November 13, 2021	November 13, 2021	No	Medicare	$512,088
Sf943db8,S5df494..	Emergency (E)		November 10, 2021	November 10, 2021	No	BCBSOK	$709
T3cb40c8,D5df48f..	Inpatient (I)		November 10, 2021	Null	No	Medicare	$80,479
T4874dce,N5df48c..	Emergency (E)	SO	November 10, 2021	November 10, 2021	No	Medicare	$51,258
W6d01283, W5df4ab (86)	Emergency (E)		November 13, 2021	Null	No	Medicare	$74,661
				November 13, 2021	No	Medicare	$149,323
W12b4e35,N5df48..	Emergency (E)		November 4, 2021	November 4, 2021	No	Medicare	$86,008
W598c4f1,K5df503 (62)	Emergency (E)		November 13, 2021	Null	No	BCBSOK	$351,807
				November 13, 2021	No	BCBSOK	$351,807





SDoH for Ncbca2dc,C5df48e (79), Medicare

Day of Date Of Visit	Food Need	Housing Need	Transportation Need	Utility Need	Safety Need
April 20, 2020	No	Yes	No	No	No
June 25, 2020	No	No	No	No	No

MyHealth ACCESS NETWORK

Questions & Discussion

info@myhealthaccess.net

MyHealth ACCESS NETWORK

Key Texas Activities: Data Sharing Panel

Bella Kirchner
Director of Health and Wellness, Central Texas Food Bank

Shreela Sharma, PhD, RDN, LD
Professor and Director, Center for Health Equity, UTHealth Houston School of Public Health

Eliel Oliviera, MS, MBA, FAMIAI
CEO, Connexus

Phil Beckett, PhD
CEO C3HIE

Lisa Kirsch (Moderator)
Senior Policy Director, UT Dell Medical School

CENTRAL TEXAS FOOD BANK OVERVIEW

40 YEARS
serving 21 counties across Central Texas

70,000
Individuals served each week

53 MILLION MEALS
provided in FY23 through Food Distribution and SNAP assistance

100,000
Volunteer hours each year

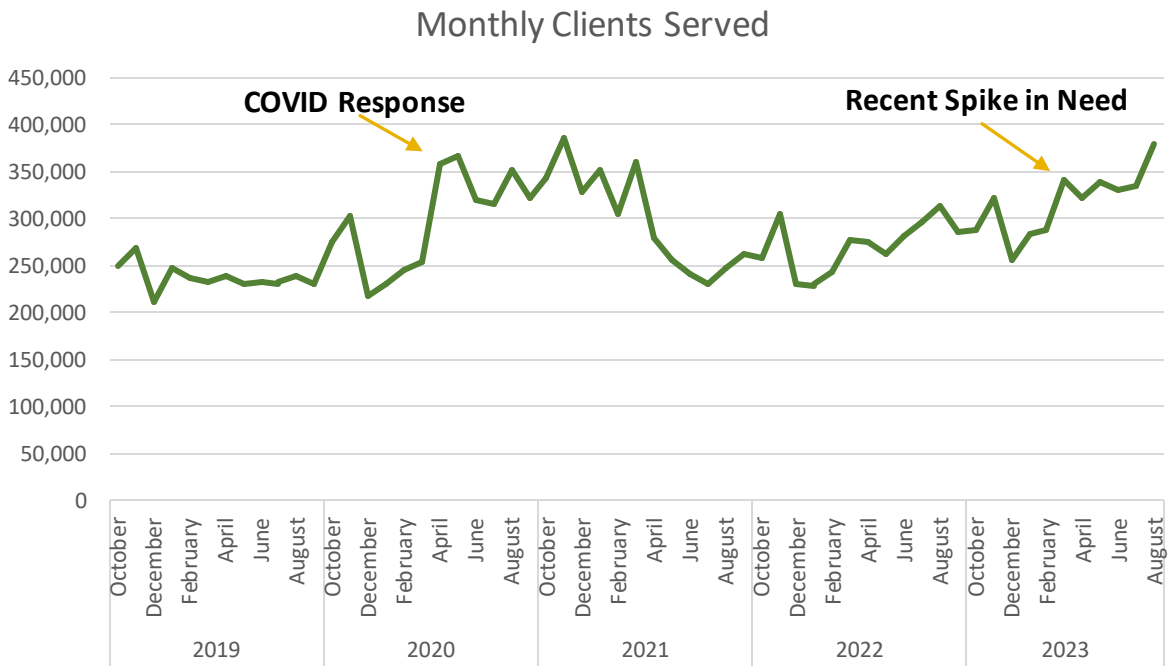
Children	Older Adults	Families	Health and Wellness	Empowerment
• After School Meals • Back Pack Program • NSLP • Summer Meals • Kids Cafe • School Pantries • College Pantries	• CSFP – Senior Food Box Program • HOPE – Healthy Options for the Elderly	• Mobile Pantry + Food Fairs* • Partner Agency Network (groceries and meal service) • Home Delivery • Military Pantries	• Nutrition and Garden Education • Food is Medicine Initiatives • Mobile FARMacy • Healthcare Pantries	• State Benefits Assistance • Helpline • Referral Partner Program • Onsite Pantry • Workforce Training Employment Resources

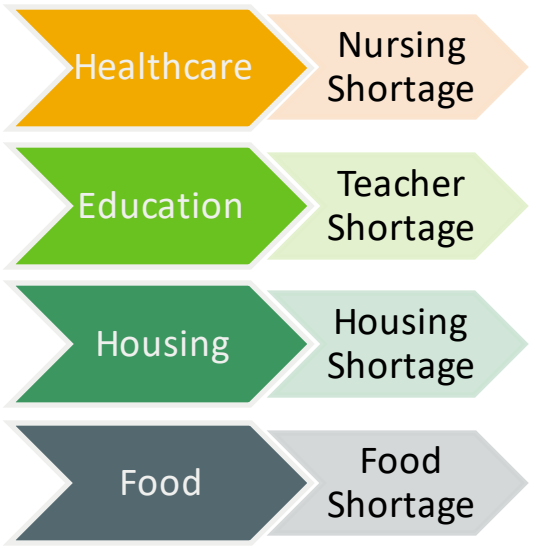
CENTRAL TEXAS FOOD BANK

Bella Kirchner, Director of Health and Wellness
bkirchner@centraltexasfoodbank.org

CHALLENGES WITH SUPPLY ACROSS SECTORS

Demand is high and supply isn't consistent.






BUSINESS

Donations to food banks can't keep up with rising costs

Updated December 23, 2022 · 5:04 PM ET

MARY YANG


SNAP benefits set to return to pre-pandemic levels

by Jamel Valencia | Thursday, January 19th 2023

EBT Accepted Here

VIEW ALL PHOTOS

(File Photo by Scott Heins/Getty Images)

EL PASO, Texas (KFOX14/CBS4) — Supplemental Nutrition Assistance Program's emergency allotment will come to end in February.

Congress passed legislation making February the last month eligible households can receive emergency SNAP benefits

CENTRAL TEXAS FOOD BANK

SNAP IMPACT AND ENROLLMENT

SNAP Dollars = Healthcare Savings

Source
Source

- Reduces likelihood of a senior's admission to a hospital by 14 percent and a nursing home by 23 percent.
- Every $10 increase in monthly SNAP benefits = decreases potential for additional days in the hospital and shortened nursing home length of stay.
- Increased medication adherence in food insecure populations.
- Increased access to SNAP = $2,100 in annual healthcare savings per senior enrolled.

Enrollment

Source

- Texas ranked 46th nationally for SNAP participation rates by eligible individuals and families (2018).
- SNAP Utilization Rates → Texas = 75%
  → Oklahoma = 82%
  → Florida = 84%

CENTRAL TEXAS FOOD BANK

GETTING NEIGHBORS ENROLLED

- CTFB = Level 4 Certified Organization
- Referrals to Benefits Enrollment
  - On-site partnerships
    - Community health centers
  - Connect ATX (social care referral platform)
    - Inbound referrals from United Way-211, community health centers
    - Closed loop
  - FHIRedApp (patient engagement app)
    - Inbound referrals from community health center
    - In-app communication with patient and health center staff
    - Document upload
    - Closed loop
- Receive monthly approved /denied numbers from HHSC but not person-specific data

Benefits Enrollment includes:
SNAP, Medicaid, CHIP, TANF, Healthy Texas Women, and Medicare Savings Program

CENTRAL TEXAS FOOD BANK

OPPORTUNITIES USING A SYSTEMIC APPROACH

- People are having to choose between food and healthcare:

  "Low income, food-insecure households are more likely to make trade-offs between food and paying for medical bills as they are more likely to experience negative life events such as a major change in financial status, death of a spouse, losing a job and homelessness, which can lead to more health challenges and greater needs for medical spending." source

- If people are going to **choose to food first**, how does the system incentive organizations like ours to make interventions?

The Medicaid member is
the community college student is
the SNAP enrollee is
the FQHC patient is
the workforce trainee is
the school district parent is
the neighbor at the food pantry.

HIE Support for a Learning Health Systems in Central Texas

A Learning Health System (LHS) is one "in which science, informatics, incentives, and culture are aligned for continuous improvement and innovation, with best practices seamlessly embedded in the delivery process and new knowledge captured as an integral by-product of the delivery experience" (Institute of Medicine, 2007).

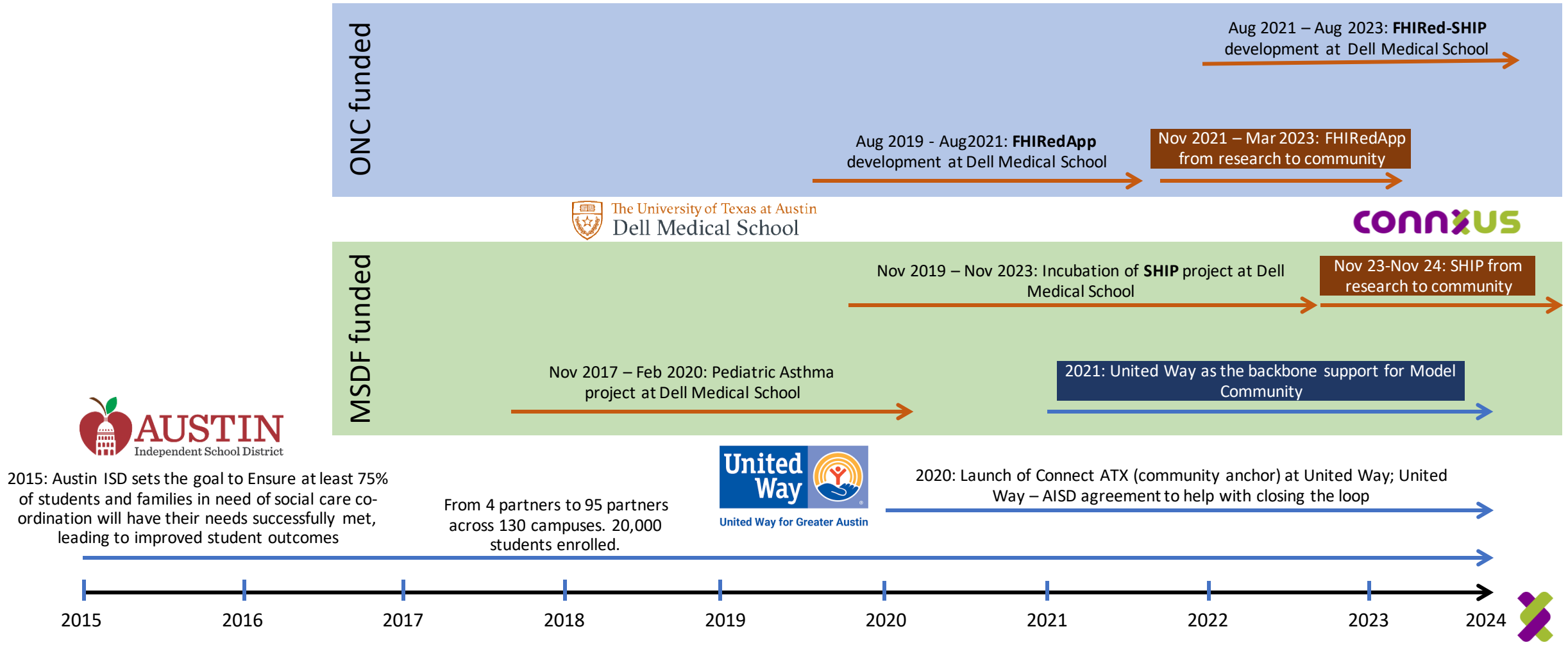
Eliel Oliveira, MS, MBA, FAMIA
CEO, Connxus

How?

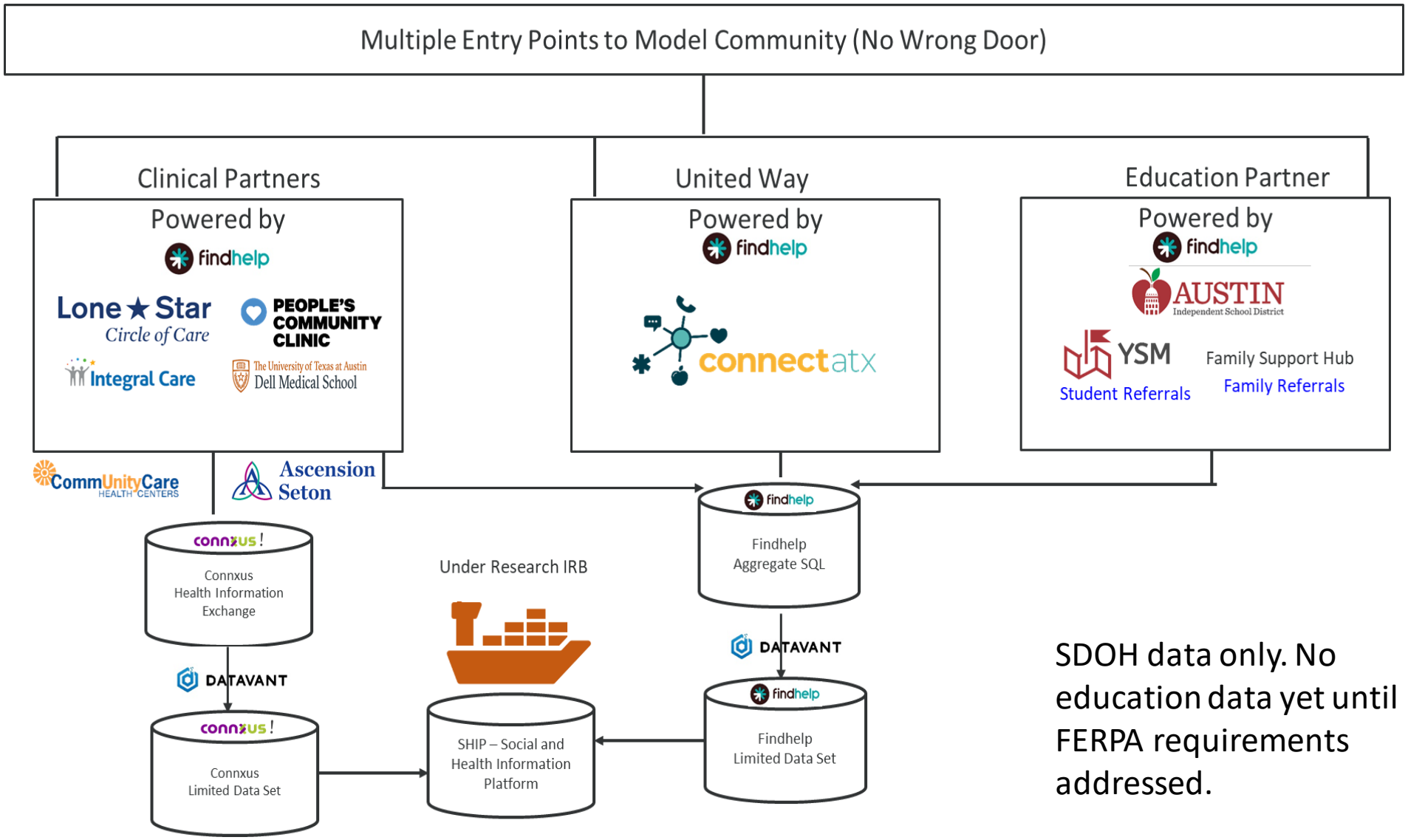
- Data Aggregation and Tech Development Following National Standards, Compliance, and Legal Assets
- Systems Integration with Patients, Clinical, and Social Providers (or any organization)
- Community and Partnership Building Across all Sectors

NMDOH Example

Almost 10 years of efforts aimed at addressing our social challenges through community collaborations.

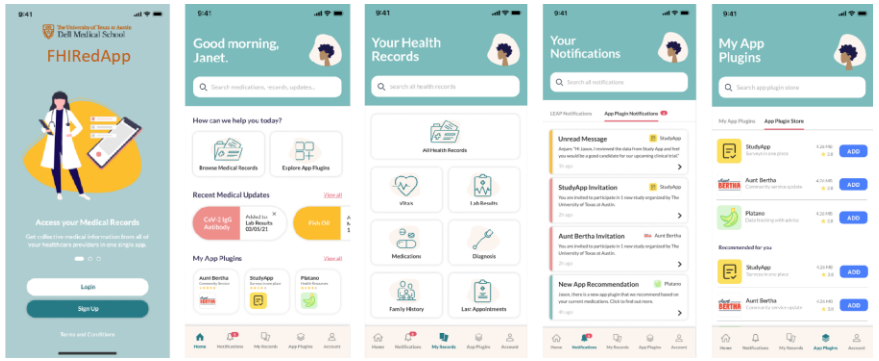


Data Aggregation

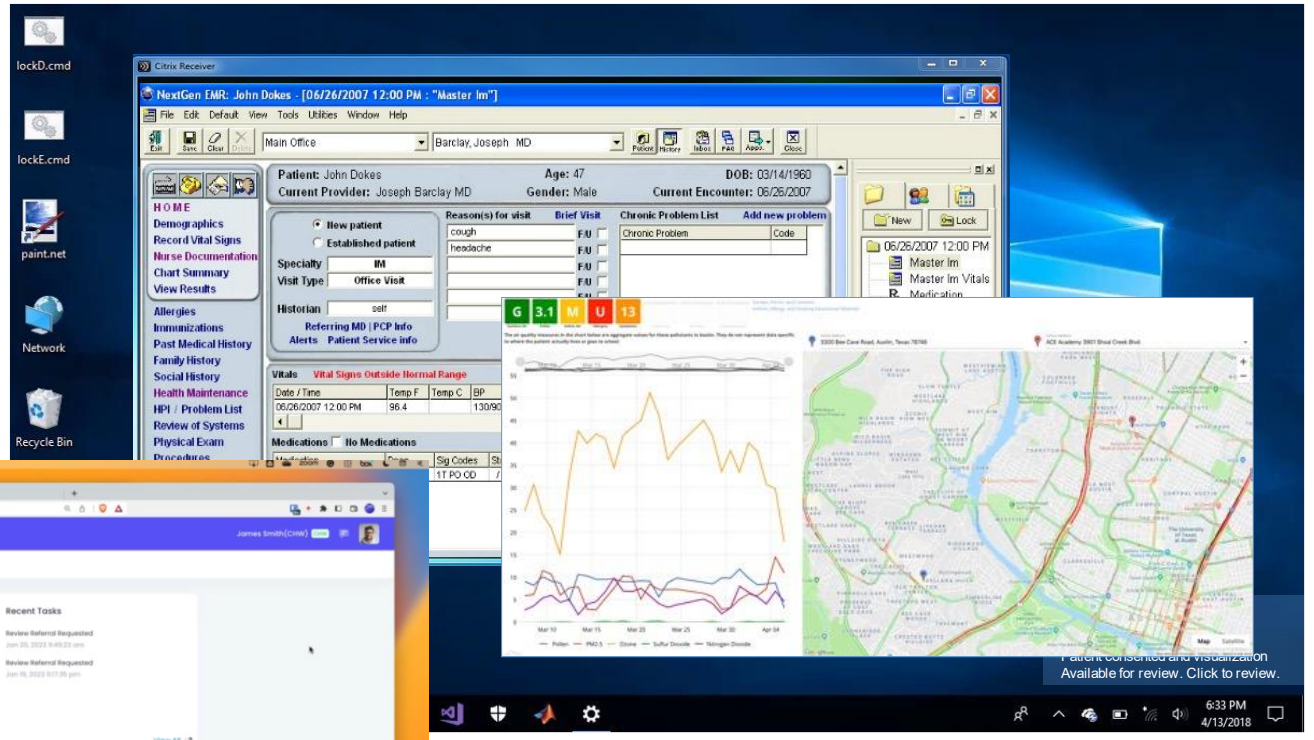


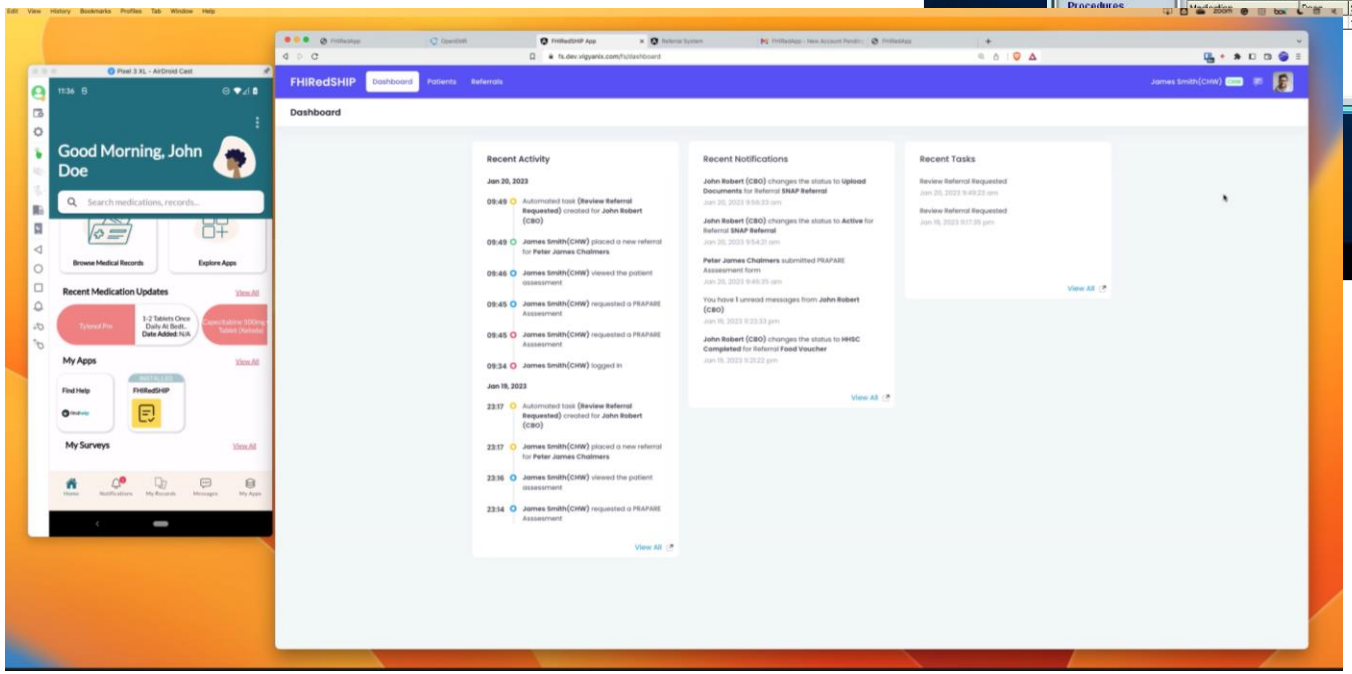
SDOH data only. No education data yet until FERPA requirements addressed.

Clinical, CBO, and Patient Decision Support



Patient Engagement Technology





System-Agnostic (EHRs, CRMs, or others) workflow integration

Community and Partnership Building

- Lone Star Circle of Care
- United Way Austin
- People's Community Clinic
- PACIO Project (LTPAC)
- Ascension Seton
- Texas Association of Rural Hospitals
- MyHealth Access Oklahoma
- Ending Community Homelessness Coalition (ECHO)
- St. David's Hospital
- Michael and Susan Dell Foundation
- Texas Health Services Authority
- Dell Medical School
- Unite Us
- Integral Care
- The Gravity Project (NMDOH)
- Texas Association of Community Health Centers
- Austin Public Health
- St. David's Foundation
- UT Austin
- Central Health
- Office of the National Coordinator for Health IT (ONC)
- Harvard Medical School
- Texas Homeless Network
- Central Texas Food Bank
- findhelp

Patient

Central Texas Food Bank (CTFB) Staff

Community Health Worker (CHW) at clinic

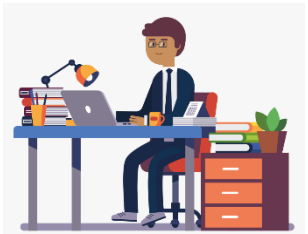
① Patient downloads the App and consents to participate

② Patient completes SDoH assessment on the App

③ CHW places referral to CTFB (if SNAP benefits need is expressed.

④ CTFB staff accepts the referral and sends intake questions to patient

⑤ Patient responds to questions. If eligible, patient schedules a meeting with CTFB staff



⑥ Patient uploads required documents. CTFB staff submits SNAP application on behalf of patient

⑦ CTFB staff has access to patient's SDoH assessment (the one patient completed at the clinic)

Connxus, Next Steps

- Enhance the collection of assessments and referral navigation
- Patient Attribution across all participants
- Support for quality measurement
- Management of Patient NMDOH consent and data sharing


connexus
together.

UTHealth Houston
School of Public Health
Center for Health Equity

Data Sharing

Fostering innovation through collaboration

Shreela Sharma, PhD, RDN, LD
Professor & Vice Chair of Epidemiology,
Director, Center for Health Equity
UTHealth Houston School of Public Health

go.uth.edu/CHE

UTHealth Houston
School of Public Health
Center for Health Equity

The Center for Health Equity

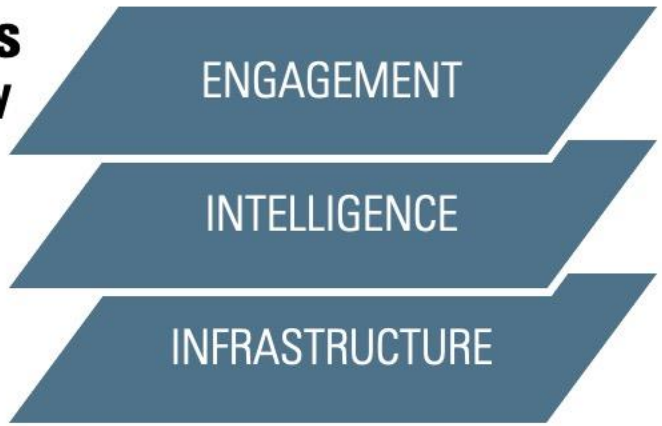
OUR VISION We see a world populated by healthy people across flourishing communities.

"Health Equity means that everyone has a fair and just opportunity to be as healthy as possible."
– Robert Wood Johnson Foundation

PURPOSE

HOW WE WILL CREATE SHARED VALUE

3 Layers of Activity



- Community Voice
- Evidence-based Programs and Interventions

- Innovative Data Analysis
- Dynamic Insights
- Customizable Actions

- Collective Impact Efforts
- Systems Design
- Capacity Building Focus

OUR VALUES

Human-Centered Design
Innovation through Collaboration
Transparency
Courage
Impact

MISSION

WHY WE DO WHAT WE DO

To build sustainable solutions that promote health across diverse communities.

WHAT WE DO

Provide expertise
for social and structural determinants of health to inform local and national research, policy, and practice

Lead education and training
of the next generation of public health researchers and practitioners

Work at the forefront
of health equity research and advocacy

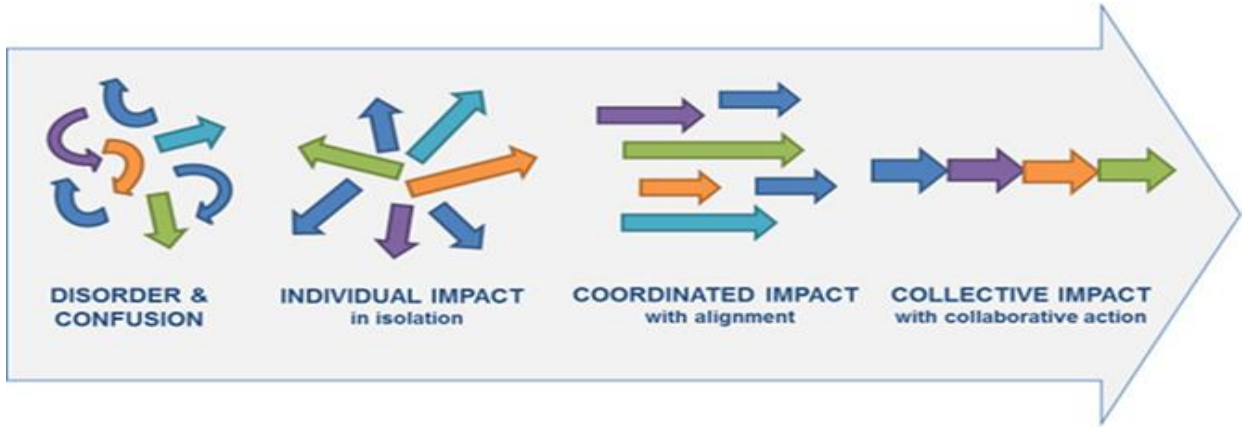
Data for action
to expand and strengthen the health equity ecosystem and drive systems change

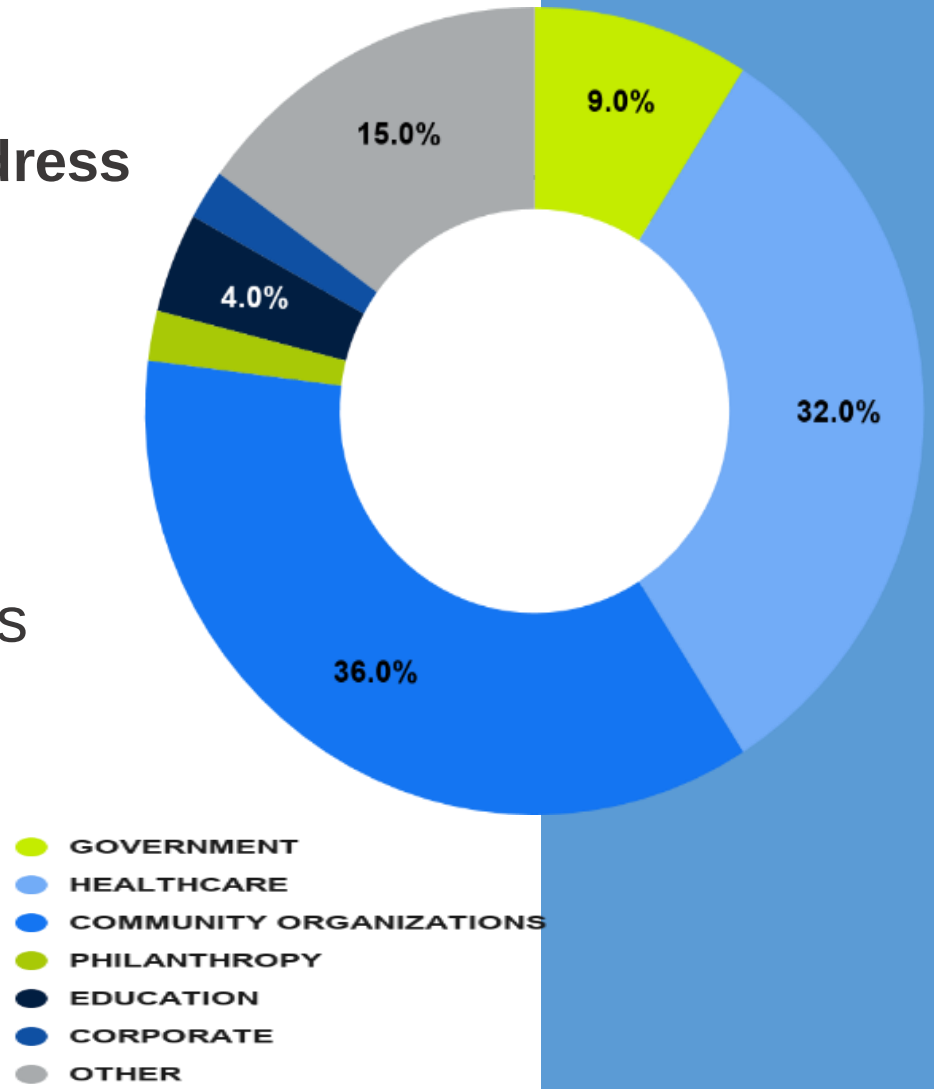
Convene, collaborate, communicate
as a Facilitator, Leader, and Ally

https://sph.uth.edu/research/centers/che/

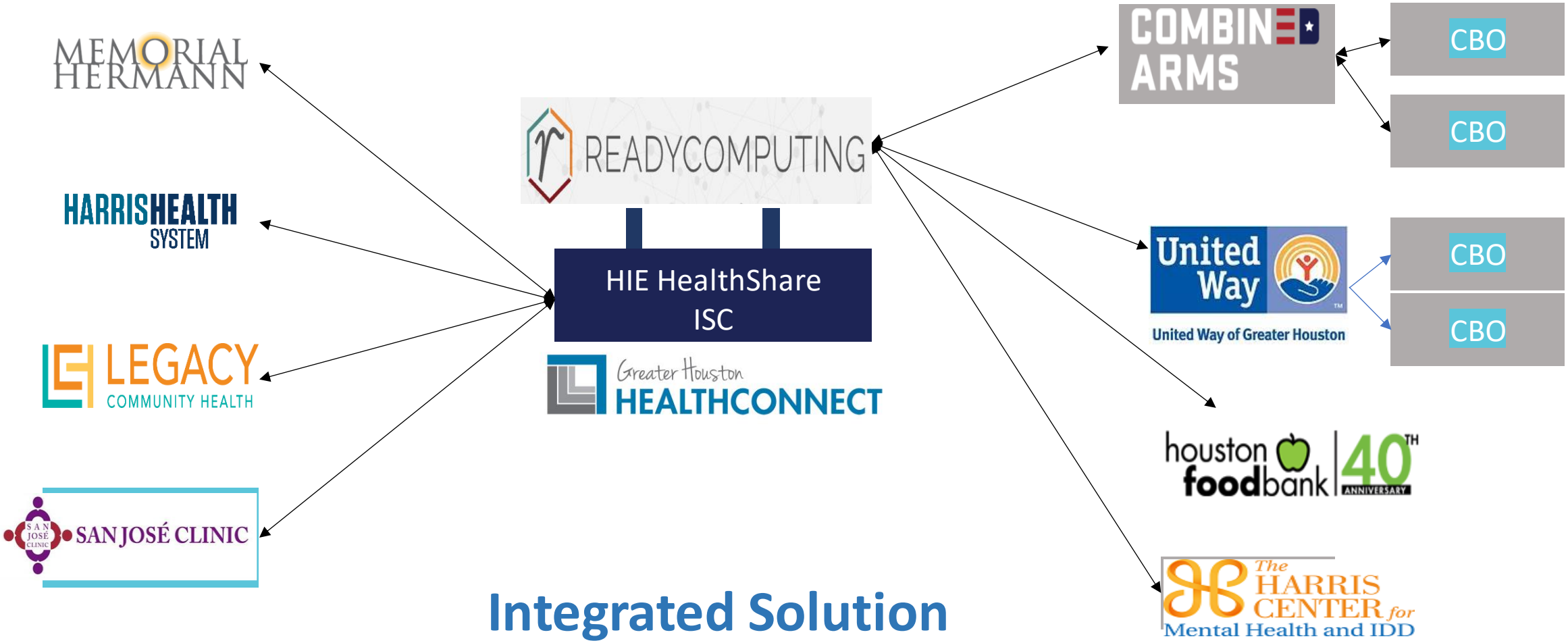
Layer of Infrastructure –
Systems collaboration

- **Health Equity Collective (HEC) – a Greater Houston systems-level collective impact-driven coalition to address social determinants of health needs** is supported by the Center for Health Equity as a part of UTHealth's backbone organization role.
- Established in Dec 2018
- Systems coalition – 200+ organizations; 50+ coalitions





Health Equity Collective Closed Loop Referral Demonstration project



Integrated Solution

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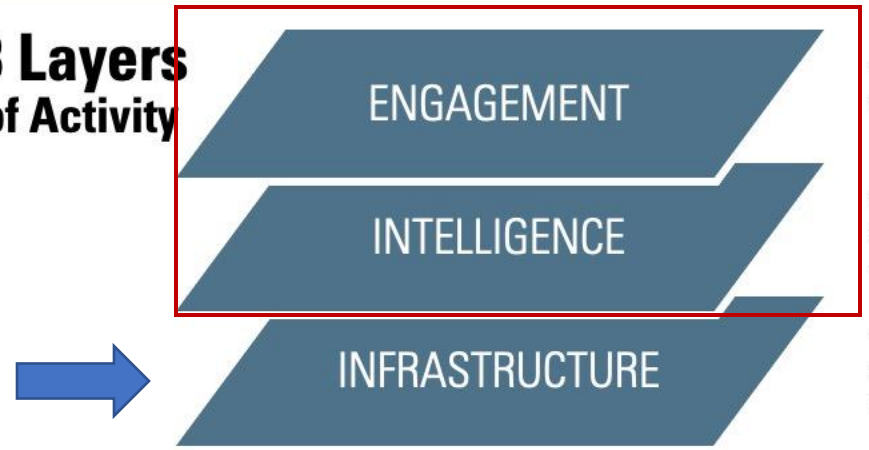

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https://sph.uth.edu/research/centers/che/

Food Rx Evaluations in Pregnant Mothers – Building evidence to inform policy and practice

COHORT 1

Community Health Choice & Houston Food Bank

High- risk pregnant women who are receiving care through Community Health Choice

Food prescription redeemed through home delivery or food pantry pick up

Food Rx Frequency: Bi-weekly

COHORT 2

Texas Children's Health Plan & About Fresh

High-risk pregnant mothers receiving care through Texas Children's Health Plan

Food prescription: retail card with $100 to purchase produce at local retail stores

Food Rx Frequency: Card loaded monthly

COHORT 3

Harris Health Systems, Brighter Bites & Planet Harvest

High risk pregnant mothers receiving care at Harris Health Systems

Food prescription: home delivery of 20-25 pounds of 8-12 different varieties of fresh produce

Food Rx Frequency: Bi-weekly

Using a human-centered design approach, we are designing, implementing and evaluating the impact of three comprehensive food prescription (Food Rx) program strategies on gestational weight gain, other pregnancy and birth outcomes, and food and nutrition security in low-income, ethnically diverse, at-risk women in Houston, TX.

The studies will evaluate 1200+ pregnant mothers across 3 cohorts.

All women will receive food prescription incentives starting in early pregnancy through 60 days post-partum.

The outcomes of interest are:

- Weight gain during pregnancy
- Food security
- Nutrition security & diet quality
- Diagnosis of gestational diabetes
- Diagnosis of pregnancy-induced hypertension
- Pre-term birth
- Program implementation costs

“I mean, honestly, there's times that we all struggle at some point. Right? And we just want to have something to rely on”

“Because of my health, I was trying to get the right food so that I could stay healthy, so I wouldn't have to be a burden and take so much medication…”

- *Patients with uncontrolled diabetes experiencing food insecurity in Houston, TX*

Thank You

Email us:
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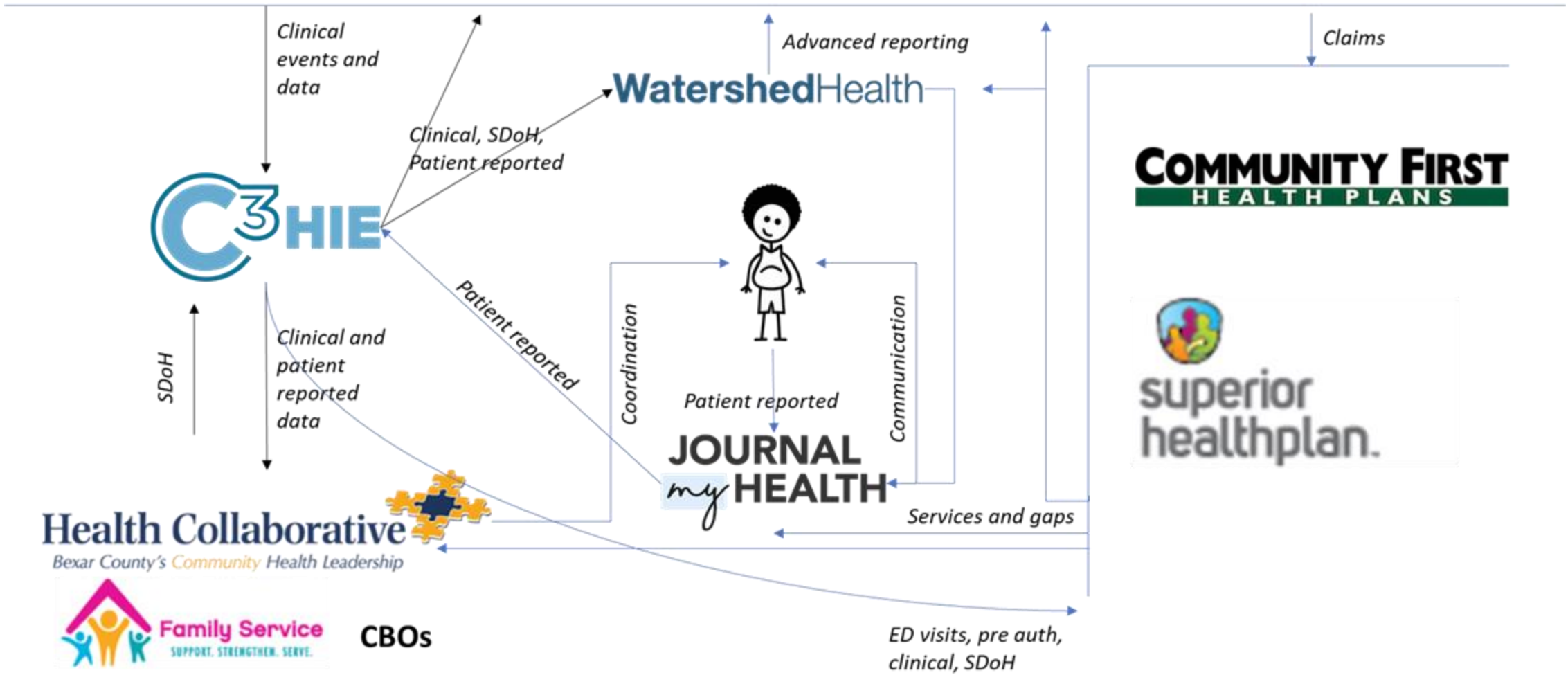
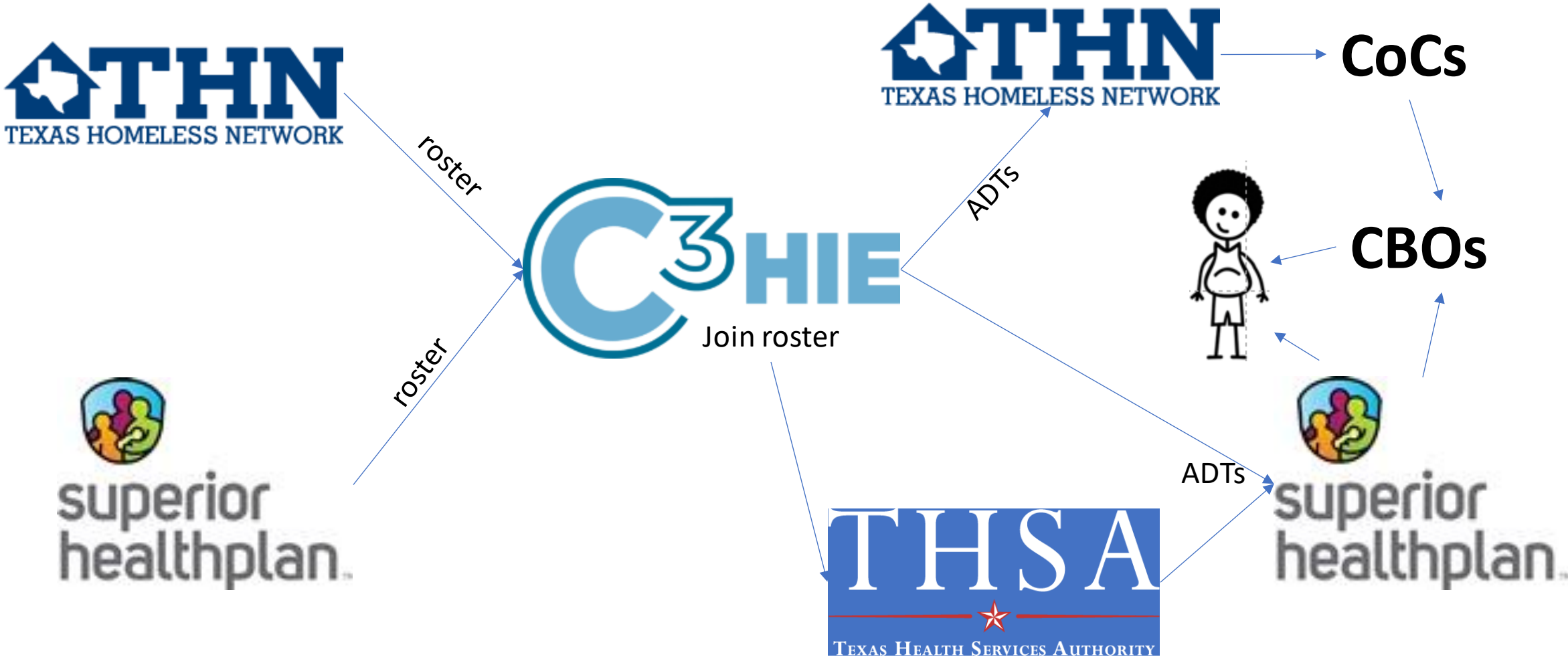
CHRISTUS Health

CommuniCare

Methodist HEALTHCARE



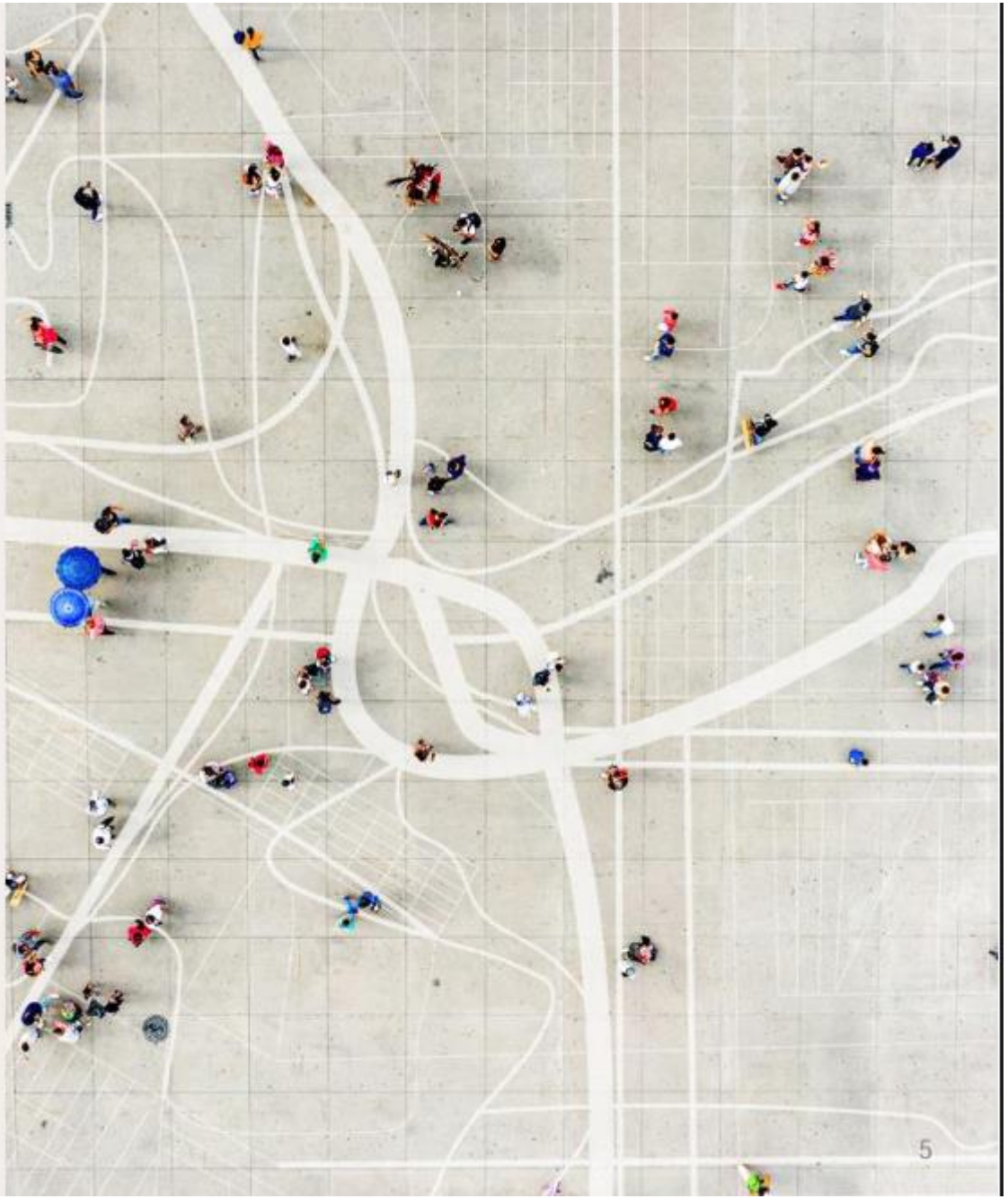
Texas Homeless Network



Health Data Utilities

Civitas' Emerging Definition

Health Data Utilities (HDUs) are statewide entities that **combine, enhance, and exchange electronic health data** across care and services settings for treatment, care coordination, quality improvement, and public and community health purposes. They enable specific, defined use cases, with extra protections to ensure patient privacy and appropriate data use.



CIVITAS
Networks for Health

Sample Use Cases

Access

Query health records based on permitted purposes, including relevant public health data

Care Delivery

ADT/event notifications, alerting, lab results, prescription drug monitoring, imaging, overdose alerts

Social Care

Referral management, resource directories, social determinants of health referrals

Public Health

Enhancing immunization and other disease registries, facilitating reporting and notifiable conditions, heat maps, situational awareness

Consumer

Patient education, individual access, patient-generated data

Quality

Reporting, analytics, benchmarks, provider dashboards

Closing Remarks

Shao-Chee Sim
Executive Vice President
for Health Policy, Research
& Strategic Partnerships,
Episcopal Health Foundation

Lisa Kirsch
Senior Policy Director, UT
Dell Medical School