HealthInfoNet

Social Health Data Strategies for Maine's Federally Qualified Health Centers

Dedicated to helping our communities create lasting system-wide improvements in the value of patient care.

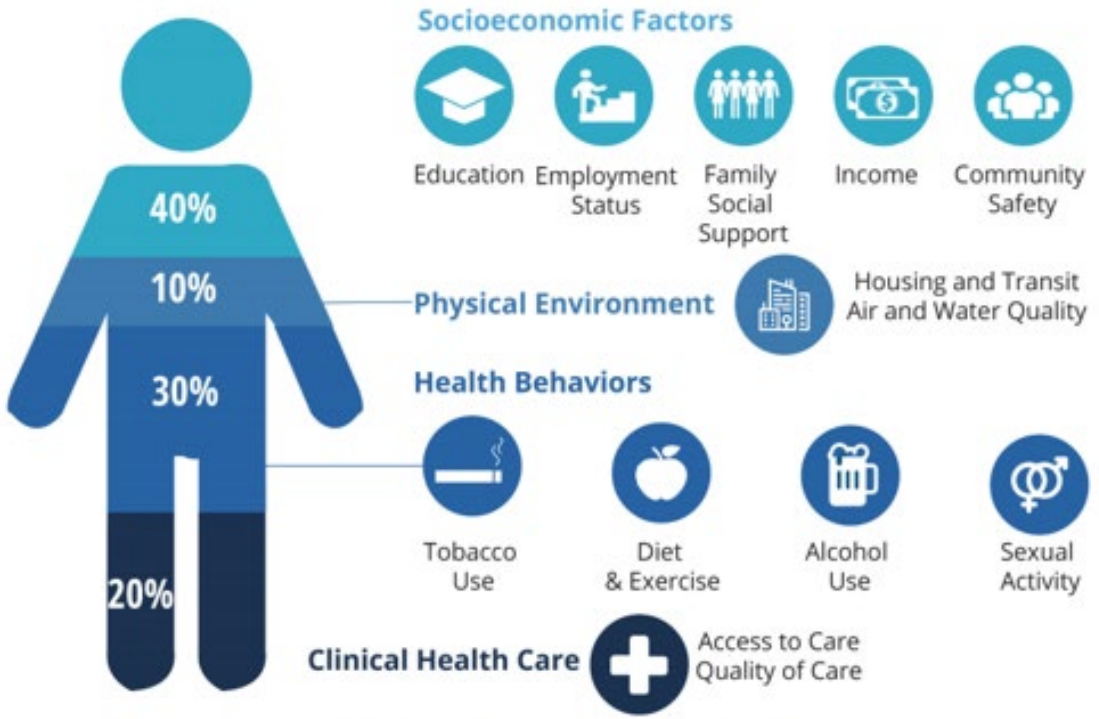
About HealthInfoNet

About HealthInfoNet and the State of Maine's Health Information Exchange.

- ✓ Designated in State law as operator of Maine's statewide **Health Information Exchange (HIE)**
- ✓ Provide a suite of **health information services** to participants, from data integration through data transmission services
- ✓ Prior and ongoing collaborations with state leaders and national learning networks to expand HIE use cases to encompass **community perspective** and **social health information**

Community Perspective

An increased awareness of how social factors impact our health outcomes.



Hood, CM, Gennuso, KP, Swain, GR, & Catlin, BB. (2015). County health rankings: Relationships between determinant factors and health outcomes. American Journal of Preventive Medicine.

There is growing recognition that the status of an individual's health is more than just the sum of their clinical encounters

There are a variety of 'upstream' factors that influence characteristics that exhibit further 'downstream'

Project Purpose

Initiating a project to understand and inform social health data strategies.

> Create a **learning group** charged with understanding the use of **social health information** among the Maine Primary Care Association's Federally Qualified Health Center (FQHC) members.

> Share recommendations directed at establishing a unified set of related **data collection**, **exchange**, and **operationalization** strategies.

> Improve the **equity of care delivery** across clinical and community settings with increased data-sharing capabilities.

Key Insights & References

Providing context to the importance of establishing social health data strategies.

Research & Advocacy

Robert Wood Johnson Foundation

Finn Diderichsen, MD, PhD

ALL IN DATA FOR COMMUNITY HEALTH

World Health Organization

Social Risk Assessments

PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

HEALTH BEGINS

Health Leads

KAISER PERMANENTE®

Data Standards

gravity PROJECT®

HRSA
Health Resources & Services Administration

The Office of the National Coordinator for Health Information Technology

Community Data Platforms

aunt bertha

ActivateCare™

Healthify

NOWPOW

Community Information Exchanges

Community Information Exchange

2·1·1
Get Connected. Get Help.™

ST. LOUIS Regional Data Alliance

Definition of Key Terms

Disentangling the use of "social determinants of health."

Structural Determinants

The macro-level "**causes of the causes**" impacting a society's health status (e.g., labor market)

Social Determinants

The mezzo-level "**causes of poor health**" impacting a community's adverse health status (e.g., employment desert)

Social Risk Factors

The micro-level "**effects of the causes**" impacting an individual's adverse health status (e.g., unemployment)

Social Risk Screening Tools

The specific **instruments** that systematically document, evaluate, and integrate social risk factor information

Definition of Key Terms (cont.)

Disentangling the use of “social determinants of health.”

Social Determinants of Health

Social Health Data/Information

Project Objectives

Establishing social health data strategies for Maine's FQHCs.

Assess FQHCs' capacities to collect, store, and exchange social health data

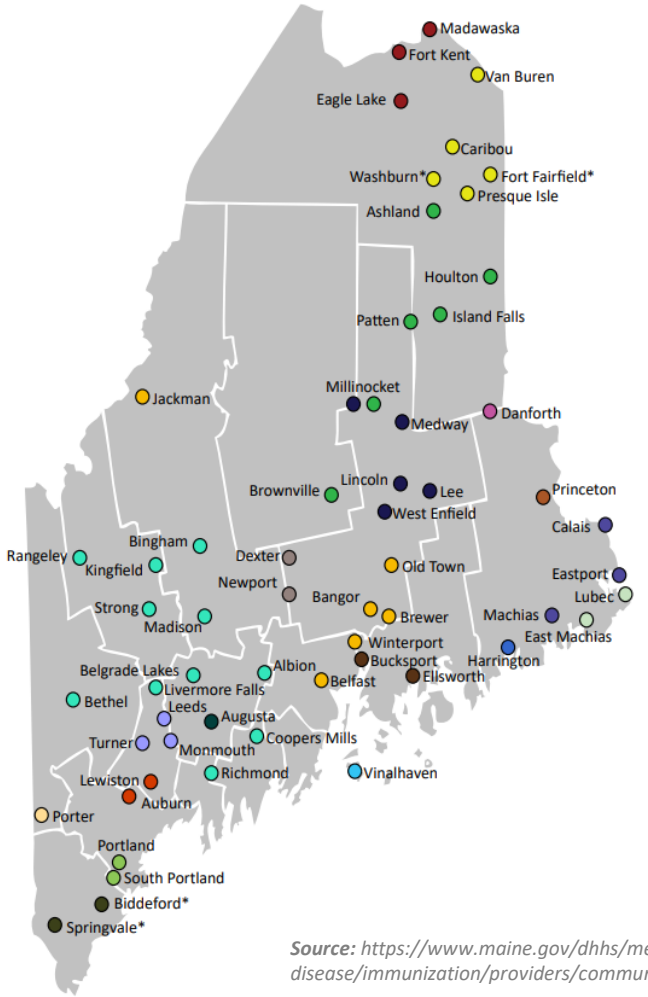
Prioritize the collection of a social health data set for care management, population health management, and/or value-based purchasing purposes

Develop recommendations outlining strategies for FQHCs' effective collection, storage, and exchange of social health data within and across systems of care

Project Finding #1

Obtaining insights from Maine's FQHCs to inform social health data strategies.

FQHCs' Leadership & Innovation Role in Redefining the Care Delivery Model



Source: *https://www.maine.gov/dhhs/mecdc/infectious-disease/immunization/providers/communications/2015/Federally-Qualified-Health-Centers-map.pdf*

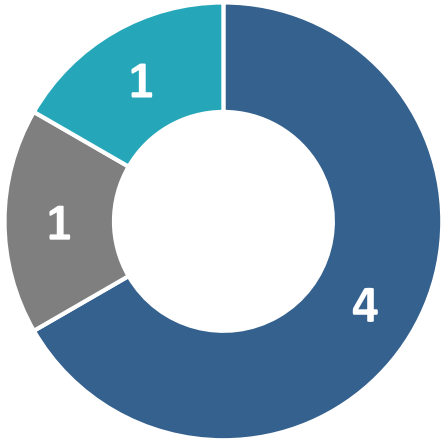
> **We are designed to do this work.**

Project Finding #2

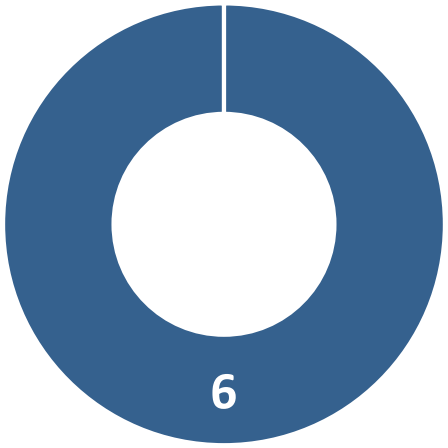
Obtaining insights from Maine's FQHCs to inform social health data strategies.

Opportunities to Overcome Varied Data Collection Strategies by Streamlining & Prioritizing Efforts

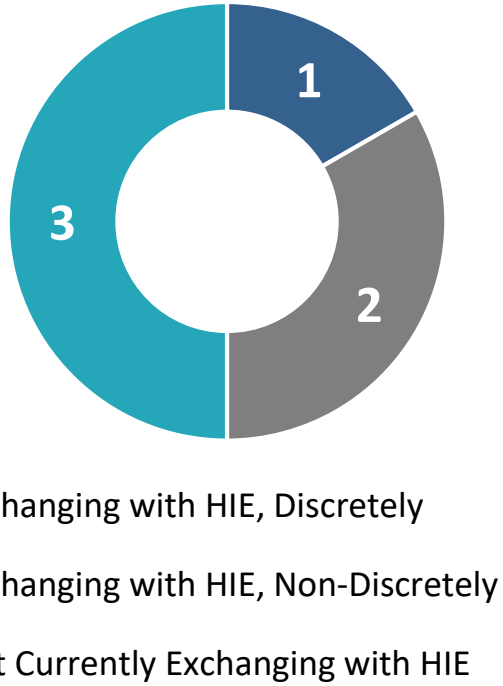
DATA COLLECTION



DATA STORAGE



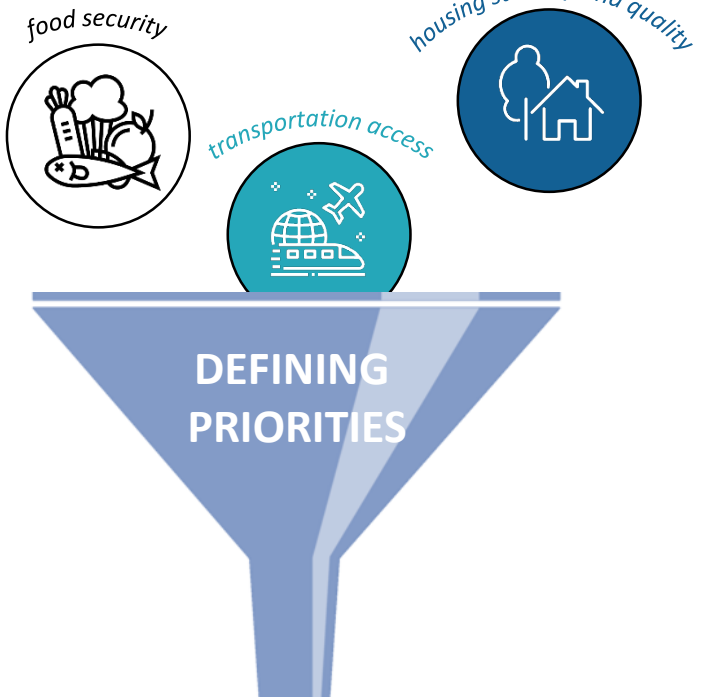
DATA EXCHANGE



Project Finding #3

Obtaining insights from Maine's FQHCs to inform social health data strategies.

Counteracting Limited Internal Capacity with External Guidance to Advance Data Strategies



TO INFORM KEY PARTNERS

> **Once the data begins flowing, figuring out how to leverage it is like putting a band-aid on some of our communities' biggest systemic problems.**

Department of Health and Human Services

Helping People. Changing Lives. MeCAP Maine Community Action Partnership

M4A Maine Area Agencies on Aging

CCPM COMMUNITY CARE PARTNERSHIP OF MAINE

KRHA

Project Recommendations

Data Collection

Collect and store a unified social risk factor data set through an electronic-based social risk screening tool that is achievable and actionable within each FQHC's current model of staff, time, and resources.

Data Exchange

Exchange discretely stored social risk factor data sets with the statewide HIE for further normalization, standardization, and aggregation in support of actionable downstream use cases and services.

Data Operationalization

Identify common social health risk domains challenging Maine's FQHCs and expand the HIE's existing health information services to supplement internal care management and population health management efforts.

Project Recommendation #1

Guiding Maine's FQHCs in their social health **data collection** strategies.

1.1 Select and configure a screening tool convenient to your organization, with preference given to the PRAPARE instrument when feasible

1.2 Prioritize the collection of UDS data elements using the PRAPARE assessment's measure set to unify data collection efforts

1.3 Enable the discrete storage of social risk factor data elements/value sets within internal data warehouses

1.4 Add prompts within and throughout operational workflows to remind staff to complete assessments during visits

Project Recommendation #2

Guiding Maine's FQHCs in their social health **data exchange** strategies.

2.1 Electronically share discretely stored social risk factor data sets (minimum: screener value sets) with the statewide HIE

2.2 Transform local social risk factor value sets into national coding vocabularies consistent with The Gravity Project's and the USCDI v2's specifications

2.1.1 Conduct a technical assessment of each FQHC's current data submission capabilities in alignment with the HIE's requirements

Project Recommendation #3

Guiding Maine's FQHCs in their social health **data operationalization** strategies.

3.1 Incorporate transformed social risk factor data sets within the statewide HIE's health information services, with focus on (1) food security, (2) housing stability and quality, and (3) transportation access risk domains

3.2 Identify community-, social- and population-based stakeholders that may benefit from becoming a participant of the statewide HIE to obtain access to its suite of integrated health information services

3.3 Adopt the use of 'community health information exchange' to describe HealthInfoNet's suite of integrated services in place of the traditional 'health information exchange' definition

Project Use Cases (Example)

Offering use case examples of integrating and using social health data.

Food Security

Individuals' access to food and/or the necessary tools to prepare meals and/or competence of how to prepare meals successfully[6].

Data Element(s)/Value Set(s)

UDS Reporting:[35] Appendix D, Question 12a: Please provide the total number of patients that screened positive for the following at any point during the calendar year.

Option = Food Insecurity

PRAPARE Measure:[6] Question 14: In the past year, have you or any family members you live with been unable to get any of the following when it was really needed?

Response = Food

Health Information Service

Real-time event notifications

Example Use Case

An at-risk, older adult individual visits their primary care provider at their community's FQHC service location. Recently, the individual has been gaining weight and experiencing increased anxiety, and their visit also identifies that they have unusually high blood pressure results compared to previous encounters.

Upon administering their organization's social risk screening tool, the provider observes that the individual also lacks access to the necessary food resources due to having recently loss their driver's license. As a result the individual's traditional means of routinely visiting the grocery store to obtain nutritious meals has been removed.

One of the provider's actions is to refer the individual to a local area agency on aging that operates its community's Meals on Wheels service, which delivers a set of freshly prepared and ready to eat meals to homebound, older-adult clients on a weekly basis.

However, because the individual is at increased risk for severe illness as a result of several underlying health conditions, they often need to be hospitalized for short periods of time. To prevent food waste, the Meals on Wheels service preemptively signs up for HealthInfoNet's real-time event notifications to receive alerts when the individual is admitted to and discharged from inpatient or emergency department settings.

As soon as the individual is admitted to the hospital, the Meals on Wheels service is notified, at which point it chooses to pause further food delivery services. Then, once the individual is safely discharged from the hospital back to their home, the Meals on Wheels service is again notified, at which point it immediately resumes its services so that the individual can have a meal waiting for them at home.

Maine's Community-First, Data-Driven Projects

Social Health Data Action Plan for Federally Qualified Health Centers in Maine & Beyond

Dual-Eligible Special Needs Plan Long-Term Care Data-Sharing Requirements

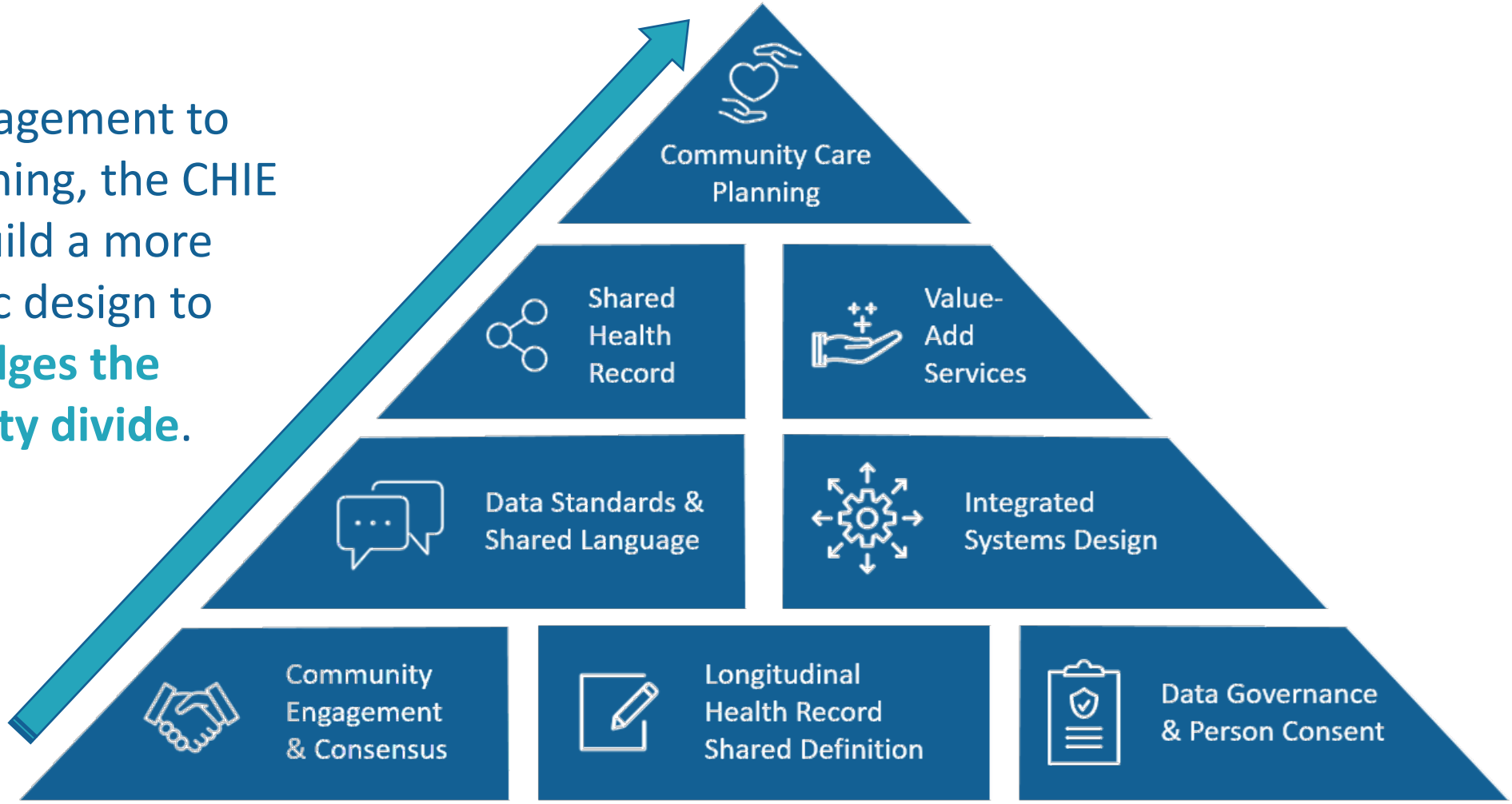
Municipal Data Across Sectors for Healthy Aging

Statewide Community Health Information Exchange Workgroup

CHIE Framework & Components

Building toward a more integrated design to care delivery.

From community engagement to community care planning, the CHIE framework aims to build a more integrated and holistic design to care delivery that **bridges the clinical and community divide**.



Why Do These Efforts Matter?

Each of us require **different types and amounts** of services to improve our health, wellness, and wellbeing

Available health-related resources to assist us vary by county, city, neighborhood, and person situations

So we must think more creatively by building solutions that can **forecast, prepare, and proactively respond** to emerging risks and needs

Community-level health information exchange aims to eliminate racial, ethnic, socioeconomic, geographic, and age disparities to **improve access and outcomes of care**

Wouldn’t It Be Helpful To Understand…

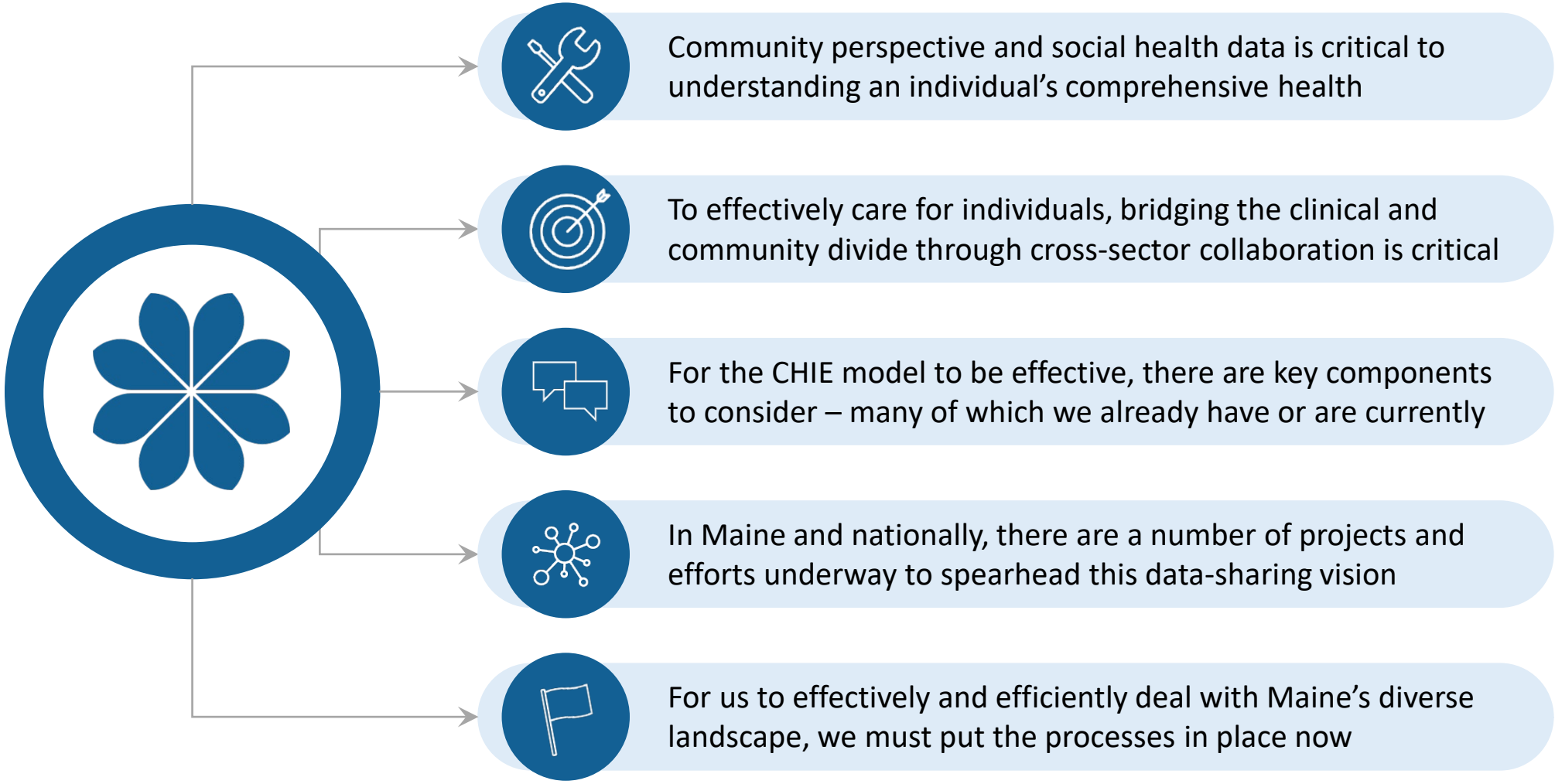
Which patient populations, identified by select demographic characteristics, are more vulnerable to certain social risk factors (e.g., food insecurity, housing instability, social isolation)?

Of those patient populations, are there any patterns of medical conditions or risks contributing to their social risk factors that could be mitigated through closer collaboration between clinical and community providers?

How can an at-risk patient (socially, medically) receive greater quality, safer, and more timely care through improved clinical-community interventions?

Closing Remarks

What we learned and where we're going.



- Community perspective and social health data is critical to understanding an individual's comprehensive health
- To effectively care for individuals, bridging the clinical and community divide through cross-sector collaboration is critical
- For the CHIE model to be effective, there are key components to consider – many of which we already have or are currently
- In Maine and nationally, there are a number of projects and efforts underway to spearhead this data-sharing vision
- For us to effectively and efficiently deal with Maine's diverse landscape, we must put the processes in place now

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