HealthInfoNet

Health Information Exchange Health Equity Data Action Plan

Kickoff: Overview of HealthInfoNet's Health Equity Data Action Plan

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

This convening series is possible in part from funding received from the Maine Health Access Foundation

MeHAF
Maine Health Access Foundation

Our Purpose

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)**
- Mission to support the healthcare community in creating lasting improvements in the value and quality of **patient care and population health**
- Provide a suite of **health information services** to participants, from data integration through data transmission services

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Our Data Connections

Connected to more than 870 healthcare locations throughout the state.

Over 85% of Ambulatory Facilities & All Federally Qualified Health Centers

Surescripts & MaineCare (Medicaid) Pharmacy Datasets

Maine Emergency Medical Services (ImageTrend)

All Health Systems, Acute-Care Hospitals, & Critical-Access Hospitals

NorDx, Quest, ALI, Dahl-Chase, & HETL Laboratories

Some Behavioral Health & Post-Acute Care Facilities

State DOC, Prescription Monitoring Program, & Immunization Registry (ImmPact)

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Our Data Connections (cont.)

Connected to the eHealth Exchange for nationwide HIE connections.

eHealth Exchange™

Enabling connections to the Veterans Affairs, Department of Defense, and United States Coast Guard Health Record Systems

Our Data Sources

Incorporating diverse data sources as new use cases emerge.

- Demographic Information
- Allergies & Adverse Effects
- Medication History
- Documentation & Social Determinants of Health
- Encounter History, Diagnoses & Problems
- Vital Signs & Immunization History
- Radiology Reports
- Laboratory & Microbiology Results

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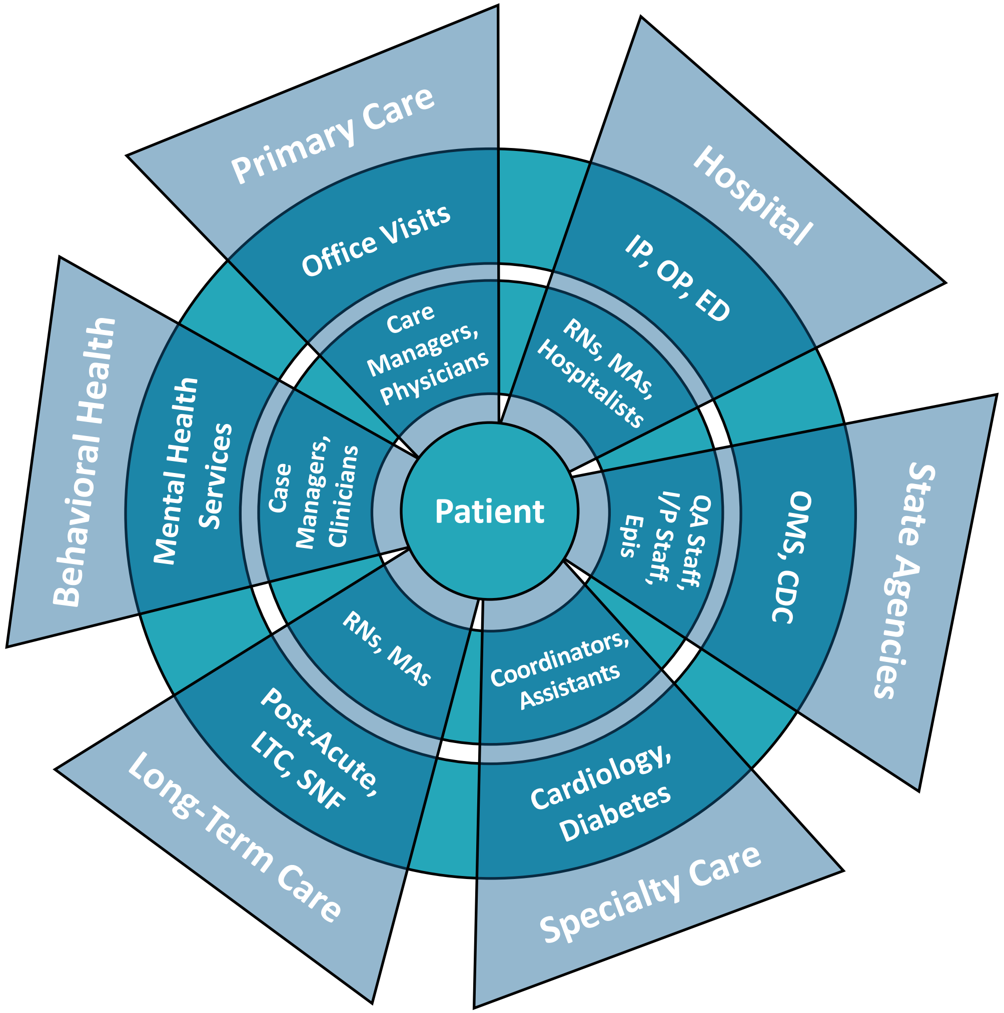
A Traditional Care Model

Initiating a paradigm shift in health information exchange.

- Primarily serves medical-based healthcare providers in **treating relationships** with patients
- Focuses on patients’ **medical-based** risks, conditions, and outcomes as a way of informing clinical decision-making and care plans
- Very little incorporation of social health information from community-, social-, and population-based stakeholders that healthcare systems depend on to deliver whole-person care



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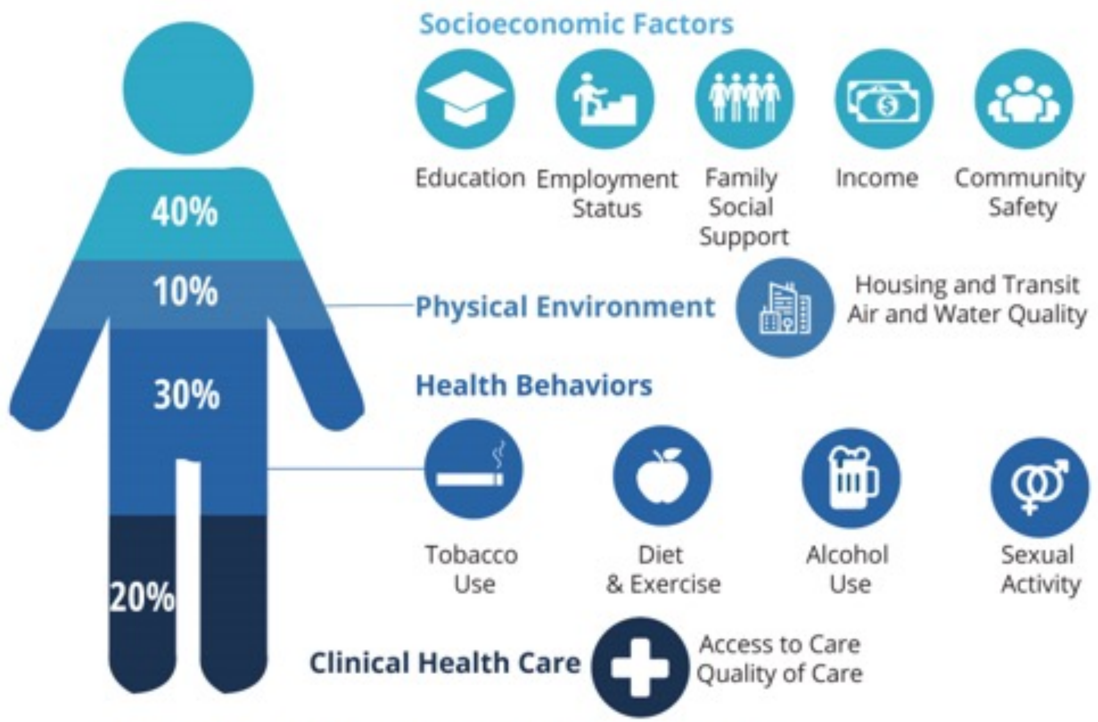
A Broader Perspective

An increased awareness of how non-medical 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.

$135 BILLION
total economic gain per year if health disparities removed

$42 BILLION
untapped productivity due to health disparities

$93 BILLION
excess health care costs due to health disparities

$175 BILLION
economic impact of shortened life spans

3.5 MILLION
lost life years associated with premature deaths

$230 BILLION
projected economic gain per year if health disparities eliminated by 2050

Business Case for Racial Equity – W.K. Kellogg Foundation

Working Within Our Purpose

Improving health equity within current parameters.

- The Health Information Exchange’s Participant Agreement allows the connection of **HIPAA covered entity healthcare provider** organizations
- Improving health equity is a **measure of our mission**
- Starting with the **clinical setting** to collect data, we can work closely with the **community setting** to determine the best and most appropriate uses of this data to effect change

Maine’s Community-First, Data-Driven Projects

Municipal Data Across Sectors for Healthy Aging

MAINE COUNCIL ON AGING
City of South Portland
AGE FRIENDLY SOUTH PORTLAND
AARP-CERTIFIED EST. 2019

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

Department of Health and Human Services
WellCare Health Plans
United Healthcare
SeniorsPlus
Anthem
Humana
aetna
ALPHAONE

Social Health Data Action Plan for Federally Qualified Health Centers

Maine Primary Care Association
NASSON Health Care
Sacopee Valley Health Center
Katahdin Valley Health Center KVHC EST. 1974
Eastport Health Care
HealthReach Community Health Centers
PCHC

Statewide Community Health Information Exchange Workgroup

MMA Center for Quality Improvement
MeHAF Maine Health Access Foundation
Department of Health and Human Services
MAINE COUNCIL ON AGING

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CHIE Framework & Components

Building toward a more integrated design to care delivery.

We've learned a lot so far from related projects and efforts. What's left will be the focus of our continued CHIE workgroup…

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

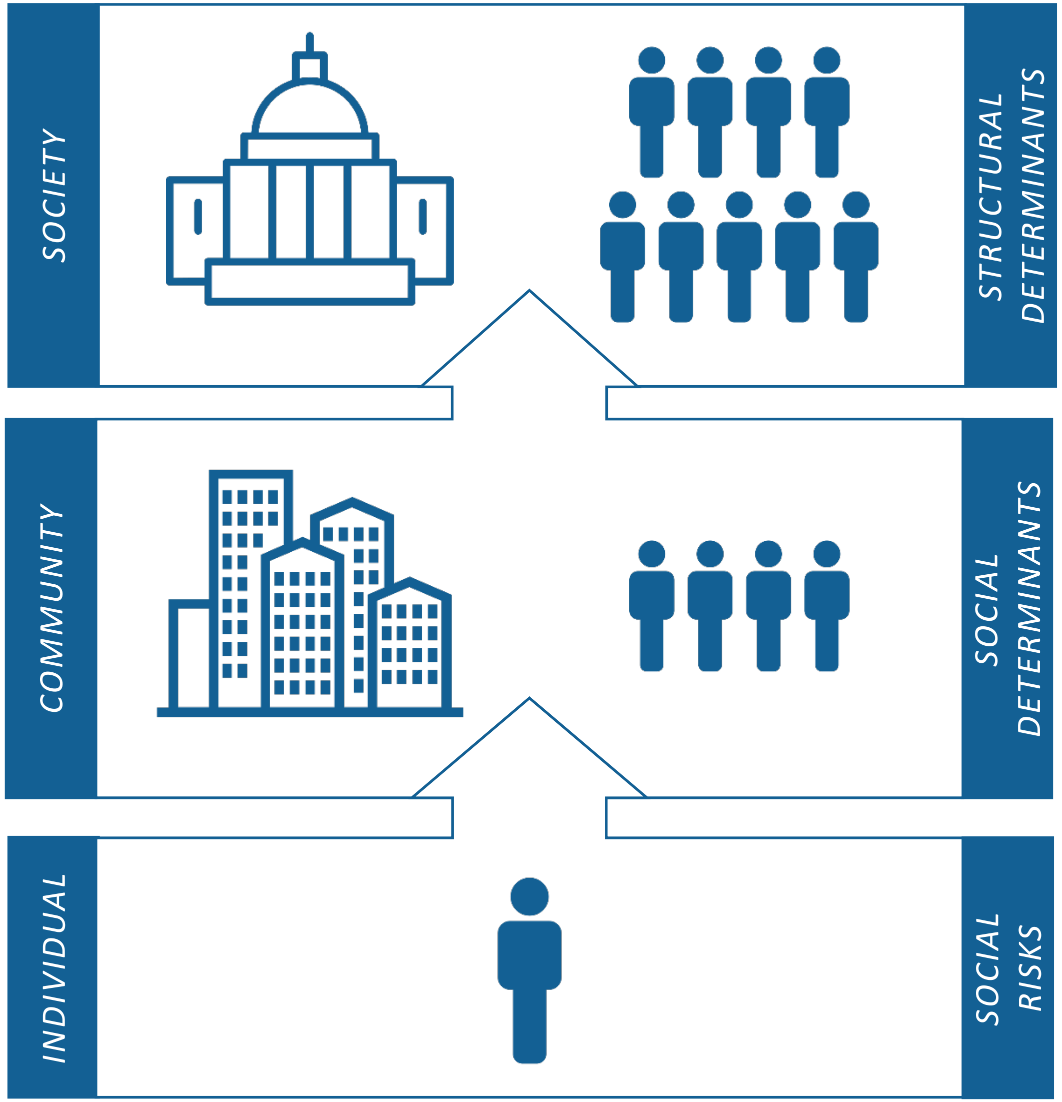
The Opportunity

Leveraging the HIE to inform whole-person care.

- Surface the individual-level **social risks** of poor health and culturally **inclusive demographic attributes** contributing to health disparities to guide proper cross-sector **care management efforts**

- Assess individual-level risks, conditions, and outcomes to inform community- and society-level **process improvement efforts**

- Leverage **health information services** to increase access and collaboration between clinical and community settings



HIE Health Equity Data Action Plan

Developing a plan to close the “last mile” of patient care strategies.

ACTIVATE LEADING-EDGE PARTICIPANTS TO HELP ACCELERATE CHANGE

CREATE A DOMINO EFFECT OF HEALTH EQUITY ACTIONS AND CHANGE ACROSS PARTICIPANTS

ADVANCE EQUITABLE CARE WITH EXPANDED WHOLE-PERSON DATA SETS

STRENGTHEN LOCAL CARE SYSTEMS BY BREAKING DOWN TRADITIONAL SILOS

FACILITATE HEALTH EQUITY INNOVATION & LEARNING THROUGHOUT THE STATE

CREATE SCALABLE CHANGE THROUGH CROSS-SECTOR FORUMS AND NEW PROGRAMS/APPLICATIONS

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 personal 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?

CHIE Use Case #1: Food Security

An older adult is gaining weight, experiencing anxiety, and has an unusually high blood pressure reading at their most recent primary care visit. They've also recently lost their driver's license – their primary means of transportation.

- Primary care provider performs **social risk screening** with patient to identify social health risks – identifies food insecurity as an issue
- Primary care provider uses **centralized resource directory** to refer patient to local area agency on aging that operates its community's Meals on Wheels service
- Due to patient's high-risk medical conditions, the area agency on aging provider signs up to receive **real-time notifications** when the patient is admitted to/discharged from IP and ED settings
- Area agency on aging is able to (a) prevent food waste and (b) ensure meals are available to patient when they need it the most!

Stakeholder Roundtable

Hearing from State and National stakeholders invested in increased information sharing.

MAINE COUNCIL ON AGING

Maine Primary Care Association

M|H|A
Maine Hospital Association

MMA CENTER FOR QUALITY IMPROVEMENT

CIVITAS
Networks for Health

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MAINE COMMUNITY INFORMATION EXCHANGE (CIE)

Steering Committee Members: Doug Michael, NLH; Meaghan Arzberger, YCCAC; Jess Maurer, MCOA; Charles Dwyer, MeHAF; Chad Macleod, HIN; Laura Vinal, GSFB; Michael Pancook, Consultant; Ellen Freedman, MaineHealth; Heather Pelletier, OMS; Lisa Letourneau, M.D., DHHS; Nikki Williams, 211; Betsy Sawyer-Manter, Seniors Plus

CIE DEFINITION

A CIE **connects social and health services** through an integrated technology platform that **coordinates care and shares information electronically to improve the health and well-being of the people it serves,** similar to the Health Information Exchange (HIE) model, the CIE model establishes an ecosystem comprised of network partners, a shared language, and an integrated technology platform that **facilitates the consensual sharing of information to inform person centered care communication and coordination.**

MAINE CIE GOAL

The goal of a CIE, as developed in Phase I of the Project, ***is better health through improved information, referral and coordination.*** *To accomplish this goal, the functionality of the CIE should generally include the ability to:*

** Collect health related social risks information using a shared language;*

** Compile and share this information individually (with permission) and in aggregate;*

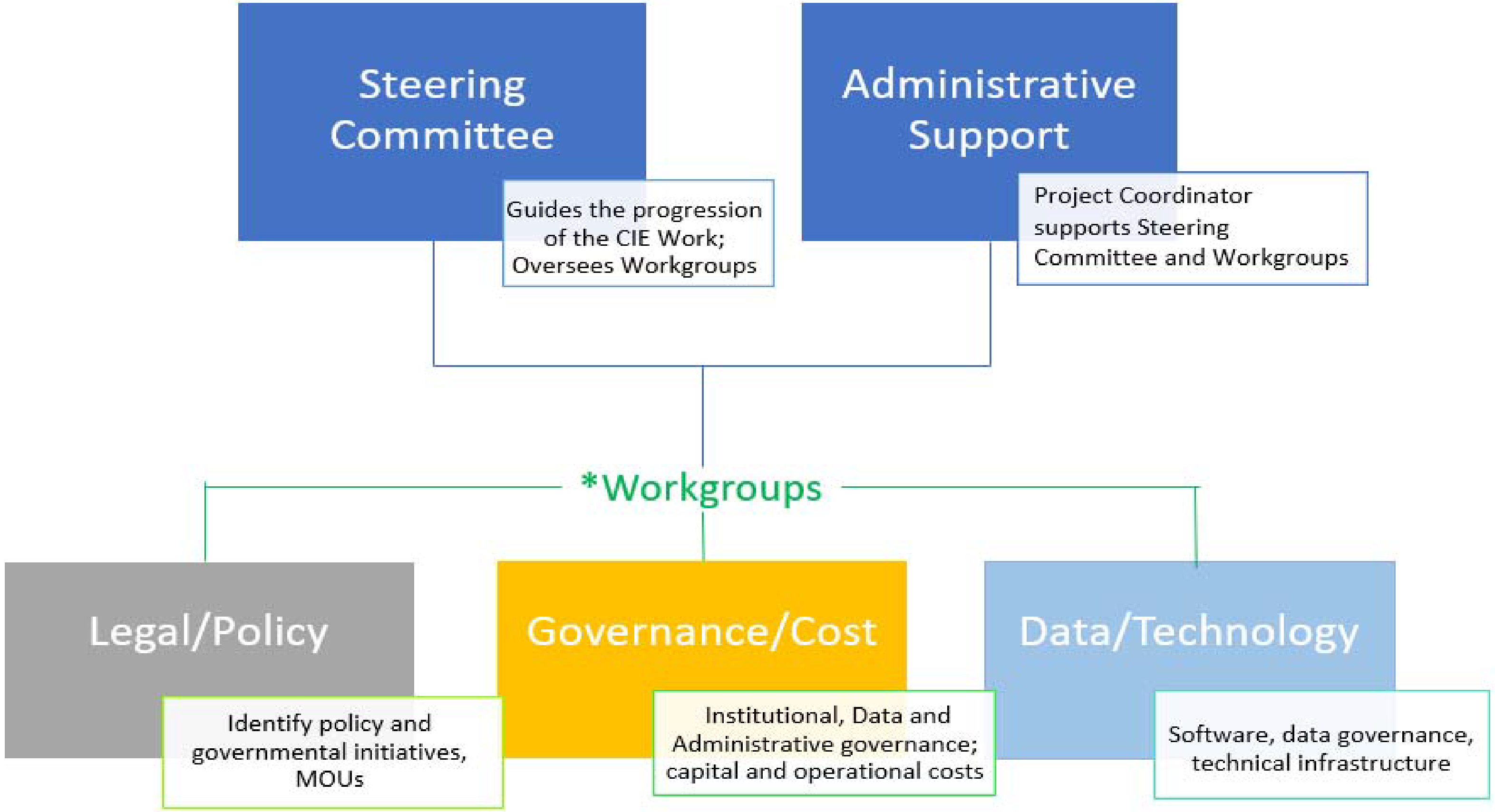
** Meaningfully refer individuals seeking assistance to providers of health and social services using an interactive resource directory platform that allows for real-time and asynchronous closed-loop communication;*

** Analyze results and take action to improve care coordination for patients;*

** Make the best use of resources within health and social services organizations;*

** Address unmet need in communities and increase health equity throughout the state.*

Maine CIE Phase II Work Governance/Organizational Structure



Steering Committee

Guides the progression of the CIE Work; Oversees Workgroups

Administrative Support

Project Coordinator supports Steering Committee and Workgroups

*Workgroups

Legal/Policy

Identify policy and governmental initiatives, MOUs

Governance/Cost

Institutional, Data and Administrative governance; capital and operational costs

Data/Technology

Software, data governance, technical infrastructure

*Important to engage community voices in all Workgroups

PHASE II ACTIVITIES

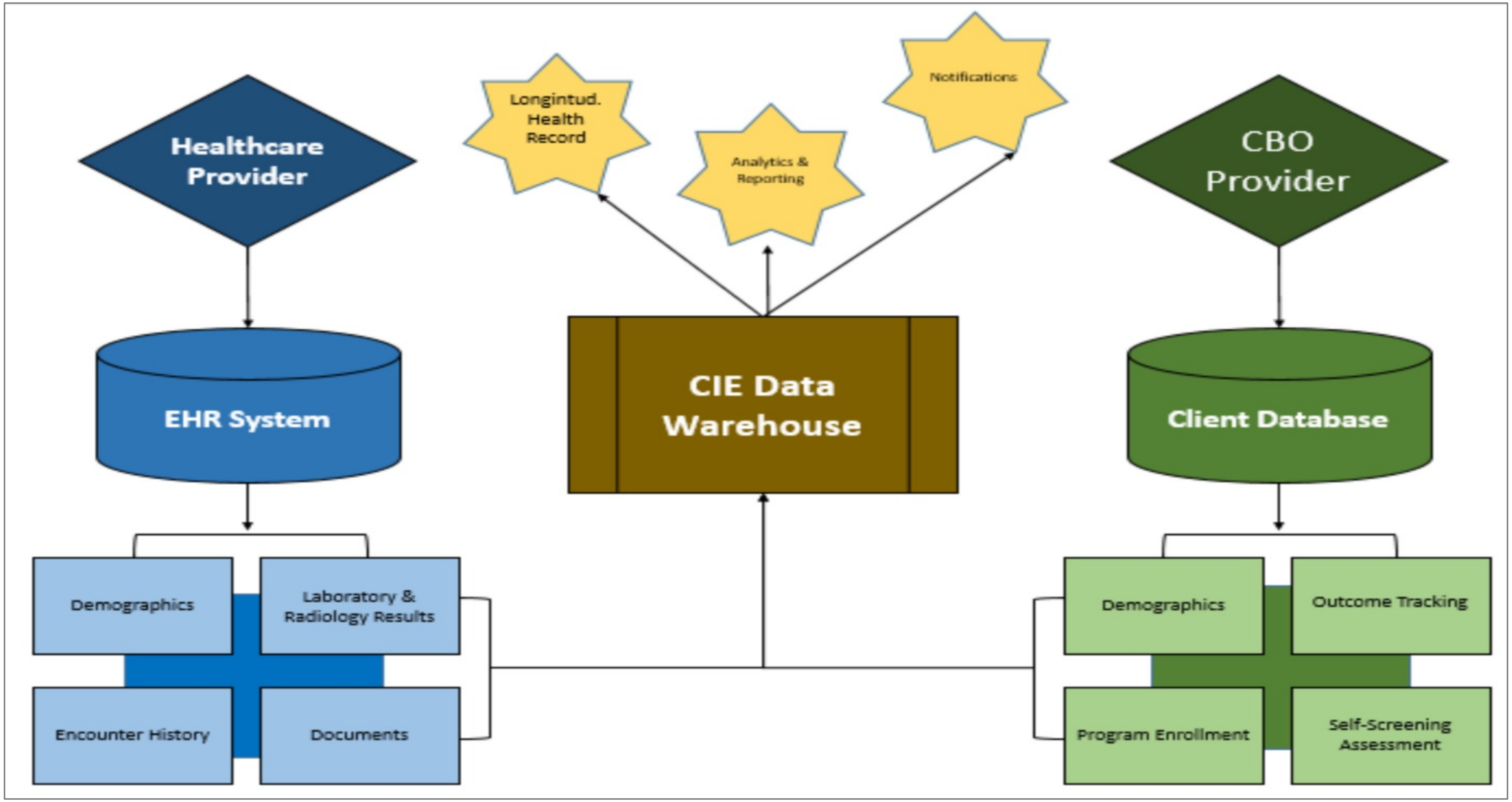
- *A Steering Committee was formed and is made up from members of the Phase I workgroup. It is tasked with the oversight of the CIE Workgroups;*

- *Three Workgroups were convened:*
  - *Data & Technology*
  - *Governance*
  - *Legal and Public Policy*

- *Workgroups developed Charters with specific Deliverables for Phase II of the CIE Project;*

- *The Data & Technology Workgroup has developed a Business Requirements document that prioritizes the longitudinal health record, identifies key technical components of this information repository, and provides 'Use Case Statement' for each of the prioritized technical components.*

LONGITUDINAL HEALTH RECORD



NEXT STEPS

- *Convene a Community Advisory Committee*
  - *Include people with lived experience to help inform/participate in decision-making*
  - *Develop Community trust*

- *Network Provider Advisory Committee will be developed after the Community Advisory Committee is established*
  - *Develop trust within network provider community*

- *Define Phase III activities/priorities*

Maine Medical Association Center for Quality Improvement

Jessica Reed, MSN, GNP-BC
Clinical Quality Manager
Maine Medical Association
Center for Quality Improvement

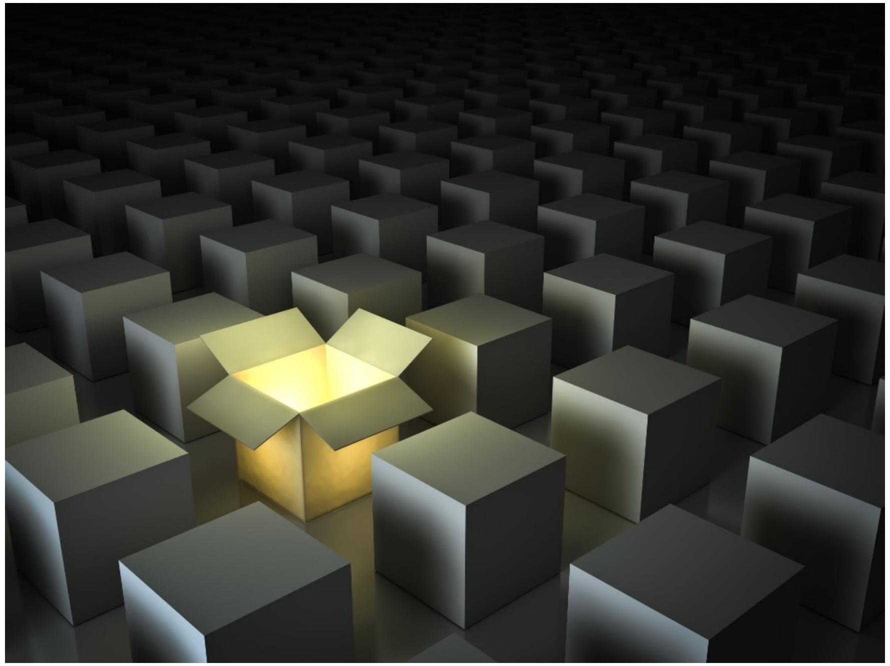
Our Mission

Our mission is to improve health by supporting clinicians in their efforts to transform health care and building clinical and community connections.

Who We Are

MMA CENTER FOR QUALITY IMPROVEMENT

- The CQI serves as a neutral convener committed to transforming health and health care in Maine.
- CQI has multiple statewide, innovative, clinical quality improvement initiatives.
- Our initiatives span the continuum of care from perinatal to older adult initiatives



Our Work

Opioid Safe Prescribing and Treatment of Opioid Use Disorder

- Board of Licensing and Medicine - MMA-CQI Learning Lab (Online educational modules on opioid-related topics)
- ME DHHS - Overdose Detection Mapping Application Program (ODMAP)
- ME DHHS - Support to hospital Emergency Departments to Initiate Buprenorphine
- ME DHHS - Overdoes Prevention Through Intensive Naloxone and Safety (OPTIONS)
    - Education and support for Options Liaisons

Maternal, Perinatal, and Child Health Improvement

- CDC - PQC4ME – Maine Center of Excellence for Perinatal Quality Improvement
- ACOG - Alliance for Innovation on Maternal Health (AIM)
- ME CDC Early Childhood Comprehensive Systems Improvement (ECCS)
- CDC - Maine Maternal Mortality Review Committee (MMRC)
- ME CDC Data Innovation Grant
- MaineHealth - Rural Maternity and Obstetrics Management Strategies (RMOM)
- ME DHHS - Maine MOM ECHO Support
- ME DHHS - Maternal Naloxone

Prevention and Other:

- Physician's Foundation – Social Drivers of Health
- Maine Cancer Foundation - HPV Vaccination Dental Project
- ME CDC and Maine Primary Care Association - Colorectal Cancer Screening Grant
- ME CDC and Maine Primary Care Association - Building Our Largest Dementia (BOLD) Infrastructure Project
- Maine AAP – COPE Grant and ECHO Series
- Maine AAP – Davis Foundation HPV Vaccination Learning Collaborative
- ME Bureau of Veteran Services - SSG Fox Suicide Prevention Grant Program

Intersection with Social Health Data

- History in working with the Maine Community Information Exchange (CIE) Workgroup
- Healthy Aging Population Initiative (HAPI) – MeHAF
- Many programs/initiatives intersect with at least one risk domain of Social Health Data
- Multiple projects include working with practice teams to improve clinical workflows

Jessica Reed, MSN, GNP-BC
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MMA
CENTER FOR
QUALITY
IMPROVEMENT

CIVITAS
Networks for Health

Introduction to Civitas and the National Social Action Planning Landscape

Our Mission and Reach

Civitas Networks for Health convenes action-oriented leaders and implementers at the local, regional, state, and national level. To achieve our mission, we drive cross-sector, multi-stakeholder, and data-informed initiatives by:

> Increasing collaboration and shared learning within and across communities that use data to ensure better health outcomes and drive health equity.
>
> Educating public and private entities regarding the benefits, functions, and roles of Regional Health Improvement Collaboratives (RHICs), Health Information Exchanges (HIEs), Quality Improvement Organizations (QIOs), All-Payer Claims Databases (APCDs), health data collaboratives, and combined organizations.

The largest network of its kind in the country with over 170 members, Civitas represents local health innovators moving data to improve outcomes that together cover more than 95% of the U.S. population.

Our Members

Health Information Exchanges (HIEs)

HIEs provide technology for the secure digital exchange of data by medical, behavioral, and social service providers to improve the health of the communities they serve. HIEs can be statewide, regional and community; government-run, for-profit and nonprofit; large and small; and hybrids that involve collaborations among diverse organizations.

Regional Health Improvement Collaboratives (RHICs)

RHICs provide a neutral, trusted mechanism through which the community can plan, facilitate, and coordinate the many different activities required for successful transformation of its health care system. RHICs do not deliver or pay for health care services directly. RHICs may be Health Data Collaboratives, Quality Improvement Organizations, All Payer Claims Databases, or other community health data organizations. Many HIEs are also RHICs and are developing RHIC use cases.

Affiliated Organizations

Likeminded associations and convening organizations with mission and member overlap to Civitas.

Strategic Business and Technology Members

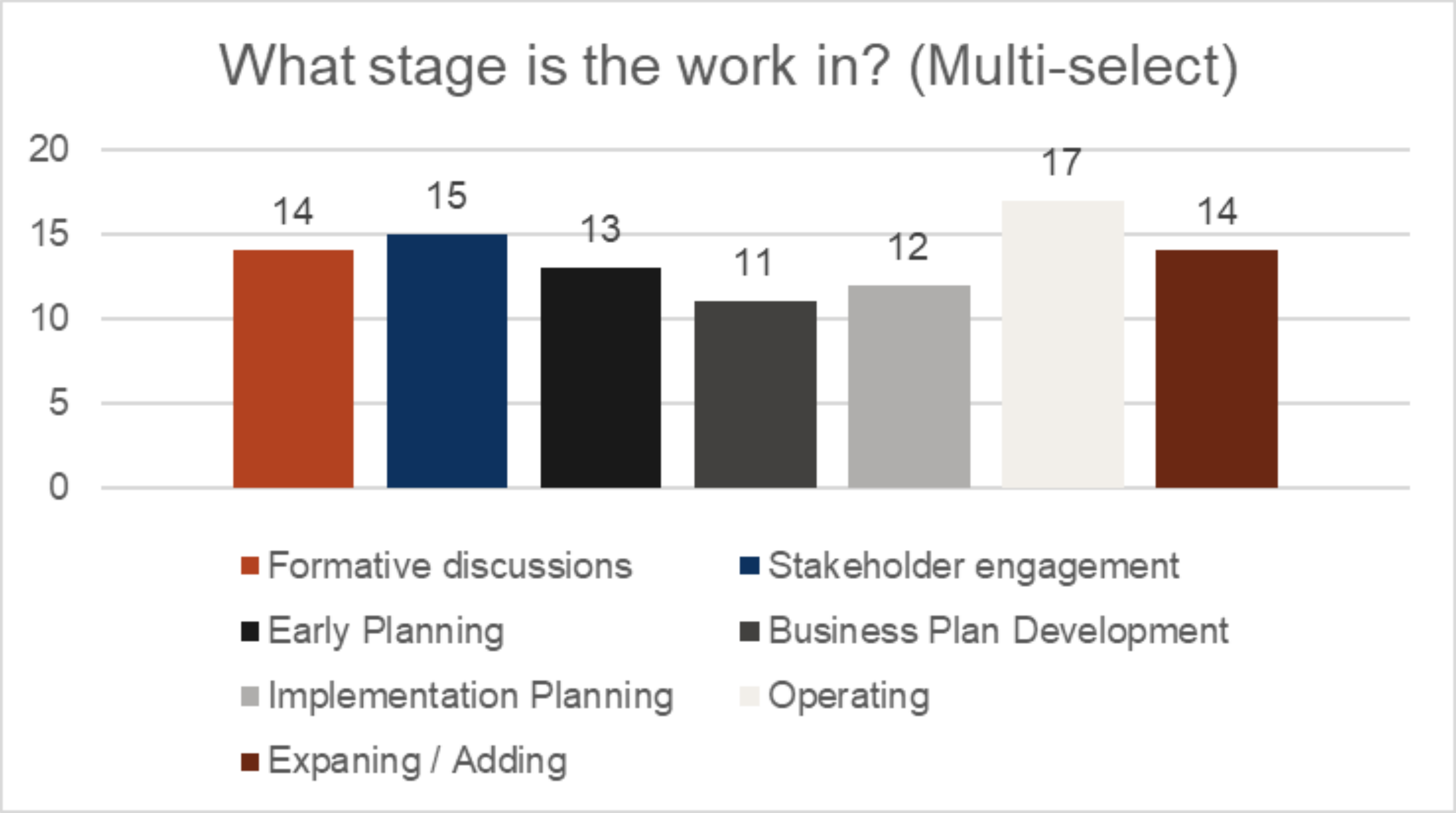
Companies that provide technology and consulting services to Civitas full and affiliate members in support of their charitable missions.

Civitas Networks for Health SDOH Organizational Member Profile Compendium Overview

General Survey Information

- 36 Civitas members responded to the survey, although all members were invited to respond
- The compendium represents work that has happened in 2022 with the understanding that Civitas members are in action, often regarded as implementers, and this work is evolving quickly
- Data collected in the SDOH profile submission form was intended to be qualitative rather than quantitative however we have some highlights to share

Data Highlights



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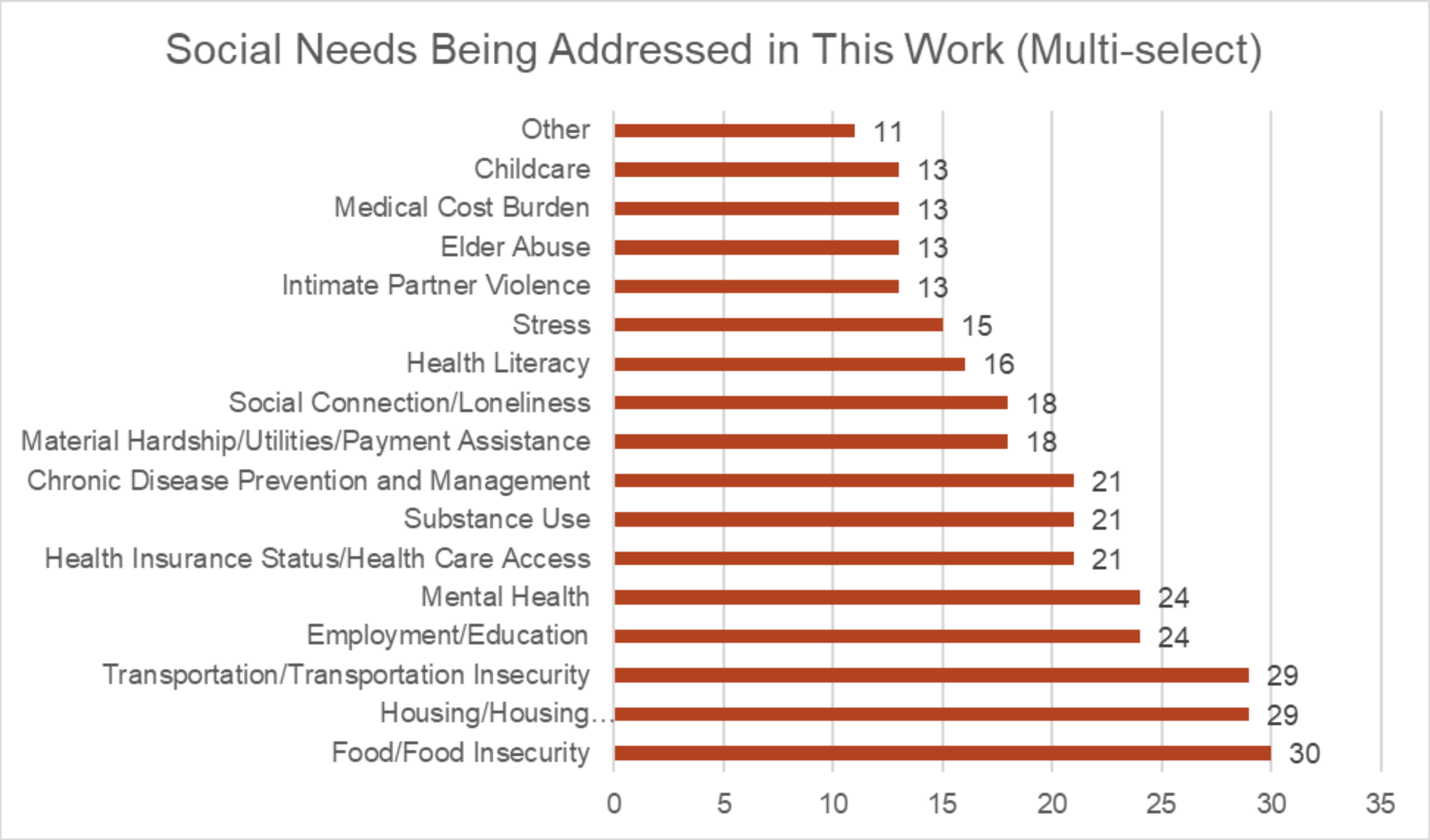
Data Highlights



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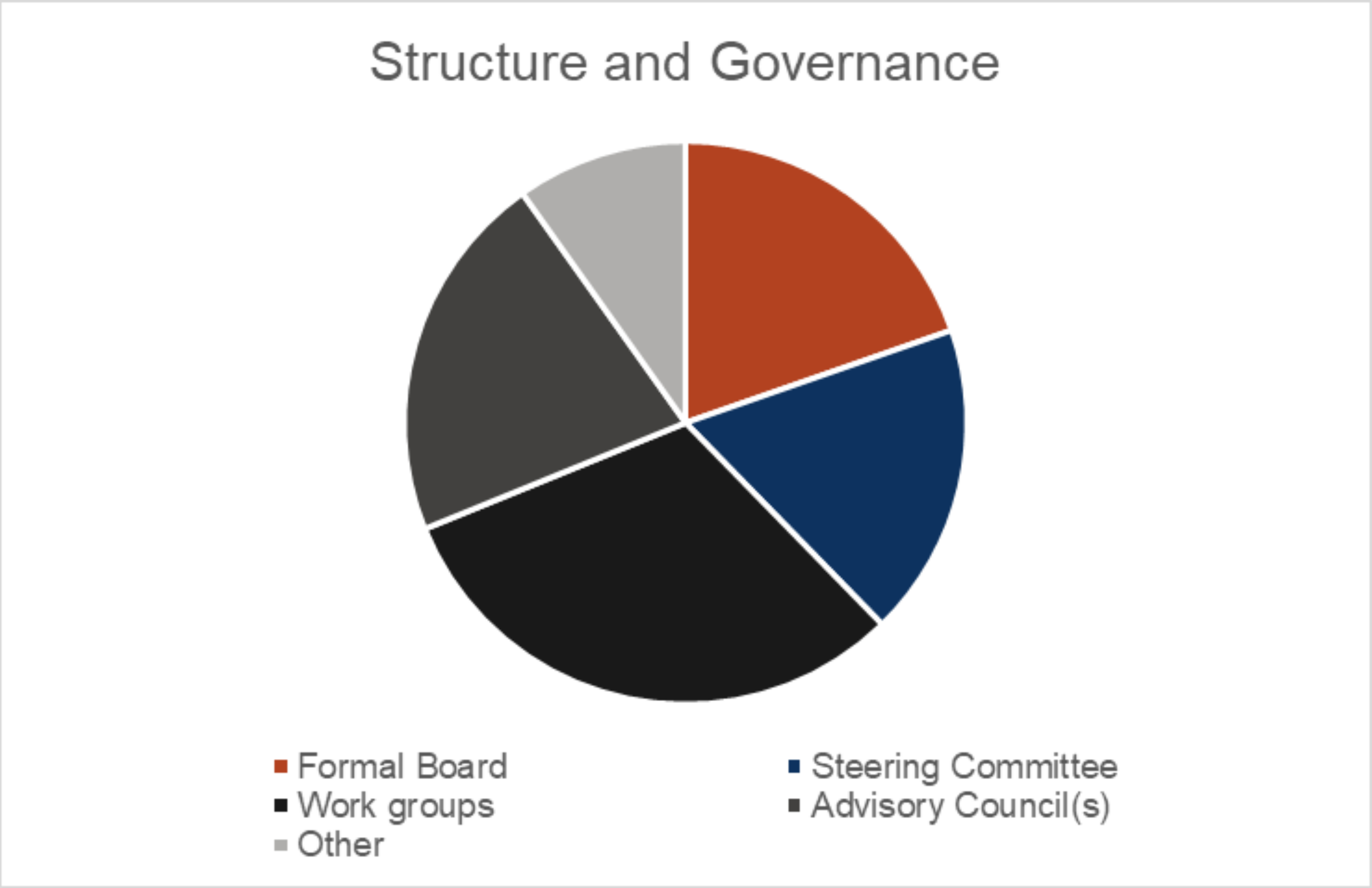

Data Highlights

CIVITAS
Networks for Health

CIVITAS
Networks for Health

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HIE Health Equity Convening Sessions Overview

Session Title	Session Date	Session Target Audience
Pre-Session: Presenter Orientation & Preparatory Discussion	*8/8- 8/19*	*N/A*
Kickoff: Overview of HealthInfoNet's Health Equity Data Action Plan	1/18; 12-1PM	All Audiences Defined in Deep Dive #1-3
Deep Dive #1: Health Equity Data Collection Methods	2/1; 12-2PM	Patient Registration/Intake, Technical Data Entry, Clinical Quality Improvement
Deep Dive #2: Health Equity Data Storage Mechanisms	2/15; 12-2PM	Integration Support, IT Support, Data Coordination, Referral Specialist
Deep Dive #3: Health Equity Data Use Cases & Actions	3/1; 12-2PM	Clinical Quality Improvement, Partnering CBOs, Advocacy Groups, Trade Networks
Post-Session: Presenter Debrief and Action Discussion	*Week of 3/13*	*N/A*
Closing: Next Steps for HealthInfoNet's Health Equity Data Action Plan	3/29; 12-1PM	All Audiences Defined in Deep Dive #1-3

Closing Remarks

What we learned and where we're going.

- Community perspective and health equity 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
- Many of the key components required for a CHIE to be effective have already or are currently being considered
- 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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HealthInfoNet

Health Information Exchange Health Equity Data Action Plan

Deep Dive #1: Health Equity Data Collection Methods

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

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MeHAF
Maine Health Access Foundation

Session Housekeeping

- This session has been designed as a conversational open forum centered around several key questions; though, we hope the discussion is organic and leads in different directions based on presenters'/attendees' emerging interests and needs
- Attendees are muted to prevent background noise and disruptions to our presenters
- Attendees have access to both the meeting **chat** and **Q&A** functions
  - **Chat:** Use to provide comments, feedback, or requests for follow-ups
  - **Q&A:** Use to pose specific questions to HealthInfoNet and/or presenters
- We will be keeping a **parking lot** of questions and topics for further discussion later in the meeting or in a future convening session (so stay tuned!)
- Attendees may be asked to share their organizations' experiences with social health and/or SOGI through **poll questions**; while we encourage your participation, the polls are optional

Session Overview

Discussion focus and presentation objectives.

Purpose

Discuss how HIE participants are collecting social health and/or SOGI information within internal clinical workflows.

Learning Objectives

1. *Learn how healthcare providers throughout the state are collecting patients' social health/SOGI information.*
2. *Identify specific tools and resources used by healthcare providers to collect social health/SOGI information.*
3. *Understand the stigma challenges (and consent options) associated with collecting social health/SOGI information.*

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Session Presenters

Welcome and introduction to today’s session presenters.

Northern Light Health

MaineGeneral Health

MaineHealth

NASSON
Health Care
A division of York County Community Action Corporation

PCHC

GREATER
PORTLAND HEALTH
CARING FOR THE WHOLE COMMUNITY

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HealthInfoNet

Health Information Exchange Health Equity Data Action Plan

Deep Dive #2: Health Equity Data Storage Mechanisms

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

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MAINE HEALTH ACCESS FOUNDATION

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Deep Dive #1 Recap – Data Collection Methods

- Presenter organizations are in different stages of data collection implementation efforts and model maturity
- Presenter organizations are continuously refining data collection methods based on best practices and lessons learned internally/externally
- Presenter organizations are offering opportunities (e.g., paper forms, face-to-face, digital) that allow patients to provide updates to relevant data points in order ensure accurate and timely information

Session Overview

Discussion focus and presentation objectives.

Purpose

Discuss how HIE participants are storing social health and/or SOGI data elements within internal clinical systems

Learning Objectives

1. *Learn how healthcare providers are storing patients' social health/SOGI information in clinical systems.*
2. *Identify if social health/SOGI information collected by healthcare providers is codified and standardized.*
3. *Determine if social health/SOGI information is made available for external exchange by healthcare providers.*

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GREATER PORTLAND HEALTH
CARING FOR THE WHOLE COMMUNITY

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HealthInfoNet

Health Information Exchange Health Equity Data Action Plan

Deep Dive #3: Health Equity Data Use Cases & Actions

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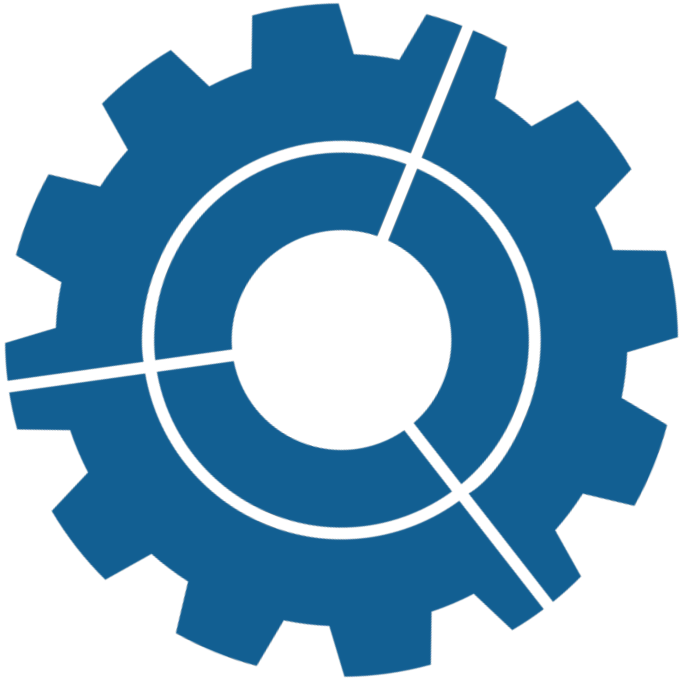
Deep Dive #2 Recap – Data Storage Mechanisms

- Presenter organizations' data storage workflows are mostly consistent
  - **In Office:** Patient completes screening/questionnaire, MA transcribes into EHR, and Clinician reviews/validates/documents
  - **Via Portal:** Patient completes screening/questionnaire, enters record immediately
- For social health information, most presenter organizations store all risk assessment processes: (a) screeners, (b) diagnoses, (c) interventions, and (d) goals
  - Primarily stored discretely; interventions may be stored non-discretely in documents
- Most presenter organizations do not store social health or SOGI information separately or differently from patients' clinical information (except for in practice management systems)
  - Concerns around sharing sensitive social health or SOGI information via patient portals (where parents/guardians have access) and with certain staff roles
- Presenter organizations can share social health and SOGI information with external partners

Session Overview

Discussion focus and presentation objectives.



Purpose

Discuss how HIE participants are operationalizing the use of social health and/or SOGI information within patient care and/or population health workflows.

Learning Objectives

1. *Learn how healthcare providers throughout the state are using patients' social health/SOGI information in workflows.*
2. *Identify specific tools and resources used by healthcare providers to make cross-sector referrals or assess person/community risk factors.*

Session Presenters

Welcome and introduction to today’s session presenters.

Northern Light Health

MaineGeneral Health

MaineHealth

NASSON
Health Care
A division of York County Community Action Corporation

PCHC

GREATER
PORTLAND HEALTH
CARING FOR THE WHOLE COMMUNITY

HIE Health Equity Convening Sessions Overview

Session Title	**Session Date**	**Session Target Audience**
Pre-Session: Presenter Orientation & Preparatory Discussion	*8/8- 8/19*	*N/A*
Kickoff: Overview of HealthInfoNet's Health Equity Data Action Plan	*1/18; 12-1PM*	*All Audiences Defined in Deep Dive #1-3*
Deep Dive #1: Health Equity Data Collection Methods	*2/1; 12-2PM*	*Patient Registration/Intake,* *Technical Data Entry,* *Clinical Quality Improvement*
Deep Dive #2: Health Equity Data Storage Mechanisms	*2/15; 12-2PM*	*Integration Support,* *IT Support,* *Data Coordination,* *Referral Specialist*
Deep Dive #3: Health Equity Data Use Cases & Actions	3/1; 12-2PM	Clinical Quality Improvement, Partnering CBOs, Advocacy Groups, Trade Networks
Post-Session: Presenter Debrief and Action Discussion	*Week of 3/13*	*N/A*
Closing: Next Steps for HealthInfoNet's Health Equity Data Action Plan	3/29; 12-1PM	All Audiences Defined in Deep Dive #1-3

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HealthInfoNet

Health Information Exchange Health Equity Data Action Plan

Closing: Next Steps for HealthInfoNet's Health Equity Data Action Plan

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

This convening series is possible in part from funding received from the Maine Health Access Foundation

MeHAF
Maine Health Access Foundation

Our Purpose

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)**
- Mission to support the healthcare community in creating lasting improvements in the value and quality of **patient care and population health**
- Provide a suite of **health information services** to participants, from data integration through data transmission services

Our Data Connections

Connected to more than 870 healthcare locations throughout the state.

Over 85% of Ambulatory Facilities & All Federally Qualified Health Centers

Surescripts & MaineCare (Medicaid) Pharmacy Datasets

Maine Emergency Medical Services (ImageTrend)

All Health Systems, Acute-Care Hospitals, & Critical-Access Hospitals

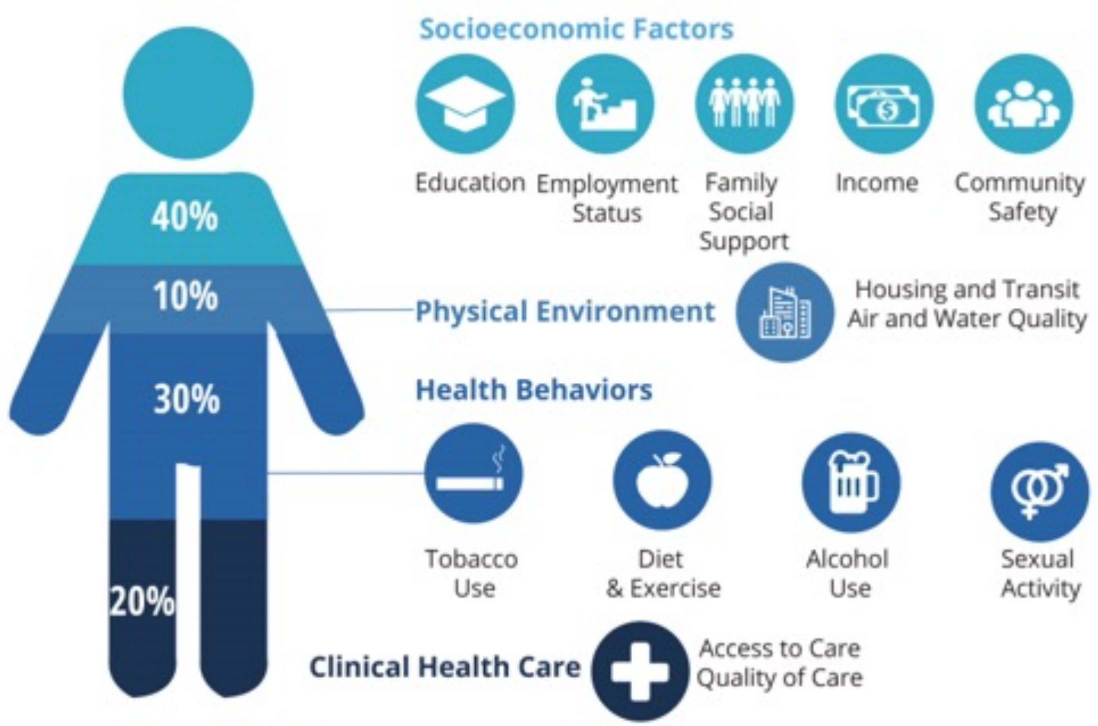
NorDx, Quest, ALI, Dahl-Chase, & HETL Laboratories

Some Behavioral Health & Post-Acute Care Facilities

State DOC, Prescription Monitoring Program, & Immunization Registry (ImmPact)

A Broader Perspective

An increased awareness of how non-medical 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.

$135 BILLION total economic gain per year if health disparities removed

$42 BILLION untapped productivity due to health disparities

$93 BILLION excess health care costs due to health disparities

$175 BILLION economic impact of shortened life spans

3.5 MILLION lost life years associated with premature deaths

$230 BILLION projected economic gain per year if health disparities eliminated by 2050

Business Case for Racial Equity – W.K. Kellogg Foundation

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Working Within Our Purpose

Improving health equity within current parameters.

- The Health Information Exchange's Participant Agreement allows the connection of **HIPAA covered entity healthcare provider** organizations
- Improving health equity is a **measure of our mission**
- Starting with the **clinical setting** to collect data, we can work closely with the **community setting** to determine the best and most appropriate uses of this data to effect change

Convening Overview

About HealthInfoNet's Health Equity Data Action Plan convening series.

Capture the ways in which healthcare providers across the state are **collecting**, **storing**, and **using** social health and sexual orientation and gender identity (SOGI) information.

Allow stakeholders from Maine's health systems and federally qualified health centers to share **knowledge**, **best practices**, **lessons learned**, and **emerging strategies** with peers.

Focus Areas

Key topics areas discussed during the convening series.

Social Health

The upstream social, economic, and political circumstances impacting the downstream health risks, conditions, and outcomes of persons, communities, and societies.

Inclusive of social risk factors (person-level), social determinants (community-level), and structural determinants (societal-level).

Sexual Orientation and Gender Identity

The ways in which individuals identify themselves biologically, emotionally, romantically, and/or sexually, and those identities' relations to health status.

Inclusive of legal names, preferred names, preferred pronouns, legal sex, sex assigned at birth, sexual orientation, gender identity, etc.

Stakeholder Roundtable

Hearing from state and national stakeholders invested in increased information sharing.

MAINE
COUNCIL
ON AGING

Maine
Primary Care
Association

M|H|A
Maine Hospital Association

MMA
CENTER FOR
QUALITY
IMPROVEMENT

CIVITAS
Networks for Health

Deep Dive Presenters

Learning from Maine's healthcare innovation leaders.

Northern Light Health

MaineGeneral Health

MaineHealth

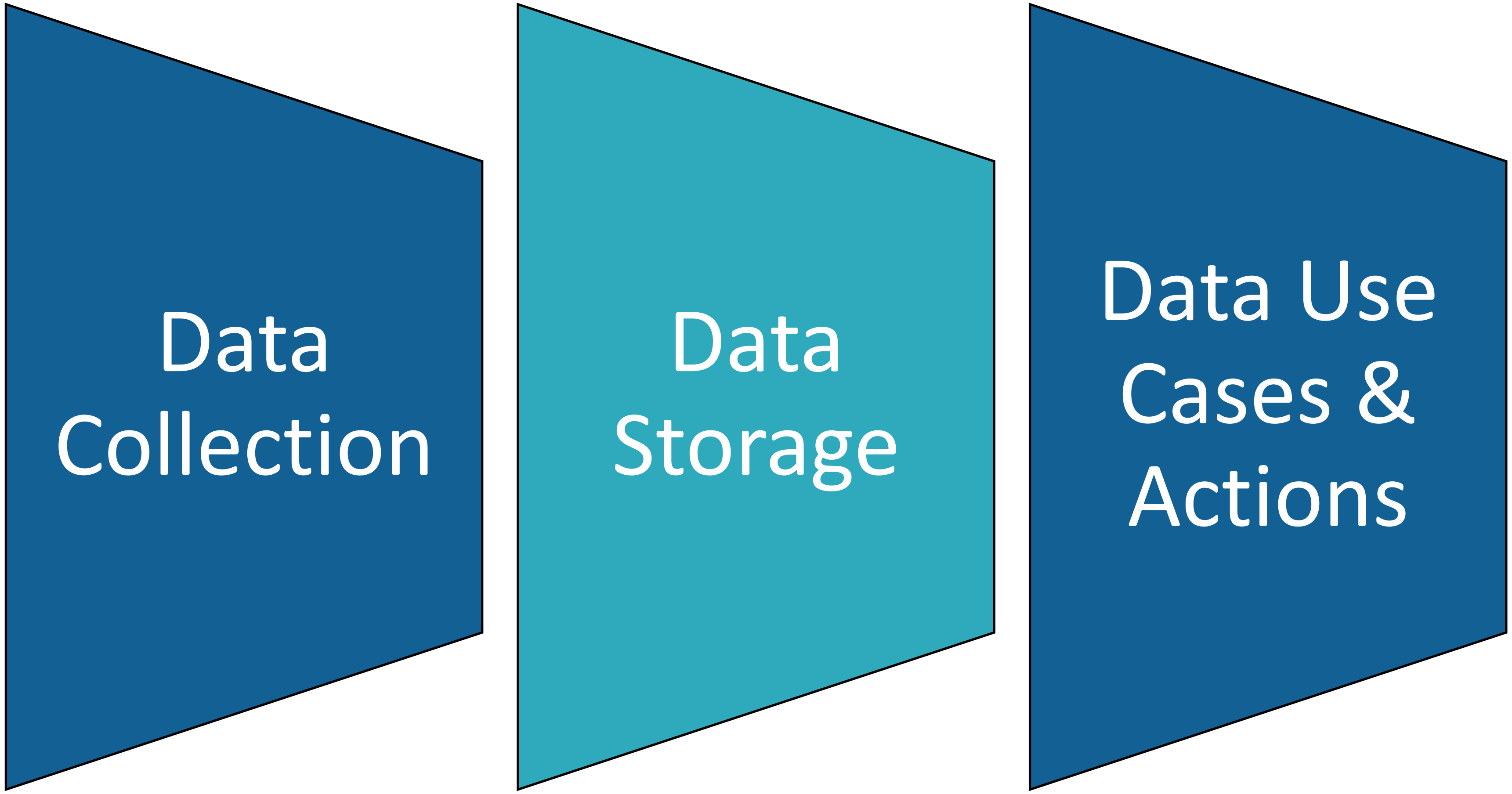
NASSON
Health Care
A division of York County Community Action Corporation

PCHC

GREATER
PORTLAND HEALTH
CARING FOR THE WHOLE COMMUNITY

Convening Results

Structuring the findings from the convening series into key workflow domains.



Data Collection

Data Storage

Data Use Cases & Actions

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Social Health Data

How Healthcare Providers Are Collecting, Storing, & Using Social Health Information Within Clinical Workflows

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

This convening series is possible in part from funding received from the Maine Health Access Foundation

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Data Collection

What social health risk assessments are healthcare providers using?

PRAPARE

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

full implementations

limited implementations

Other Common Screenings:

- Hunger Vital Signs
- Alcohol, drug, tobacco screenings
- Diaper insecurity screenings

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Data Collection

What social health risks are healthcare providers prioritizing?

- **Demographics & Personal Characteristics**
- Employment
- **Food Security**
- Housing Stability & Quality
- Incarceration History
- Childcare Needs
- Utilities
- Safety & Domestic Violence
- **Social Integration and Support**

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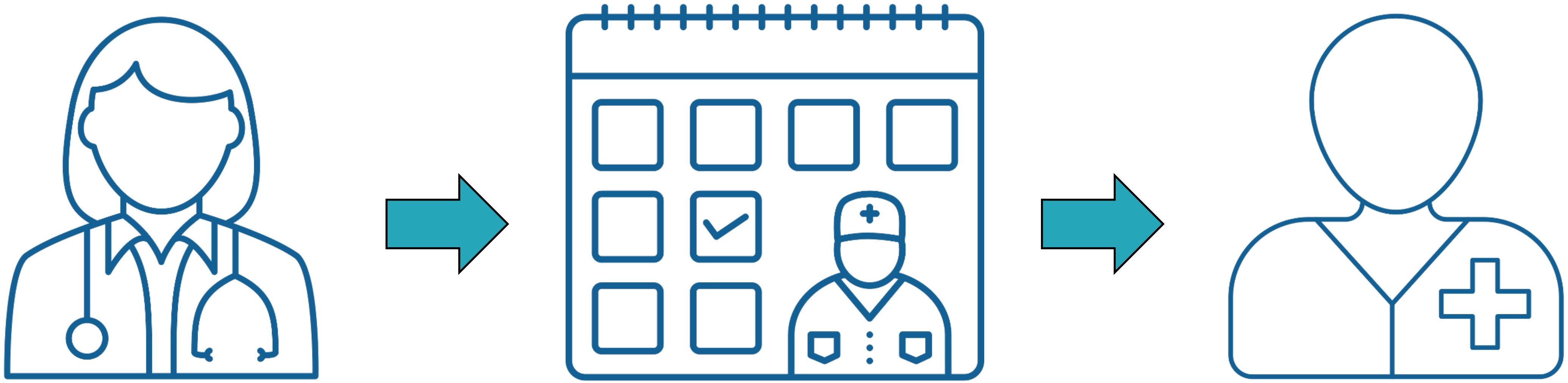
Data Collection

When/how are social health risk assessments used by healthcare providers?



Primary Care Practices

(and some Behavioral Health Settings)

Annual Visits

(or more frequently as needed)

All Patients

(if younger than 18 years of age, engage parent/guardian)*

** some providers do not require parent/guardian for patients older than 13 years of age*

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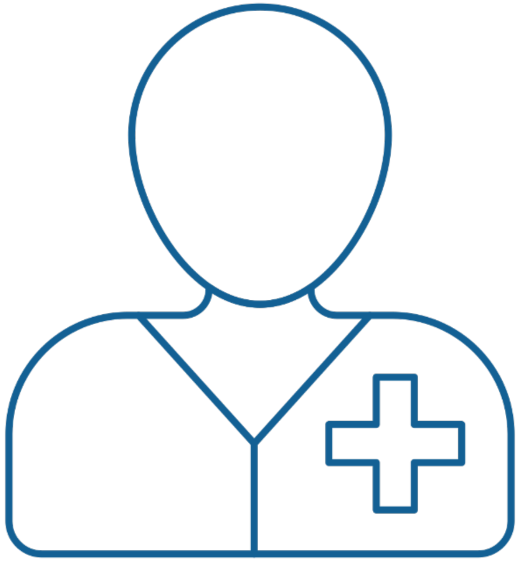
Data Collection

How are patients able to complete social health risk assessments?



- Online Patient Portal Prior to Visit
- Self-Service Kiosks During Registration
- Print Forms During Intake
- With Nurses, Care Managers, Case Managers, and/or Community Health Workers During Intake

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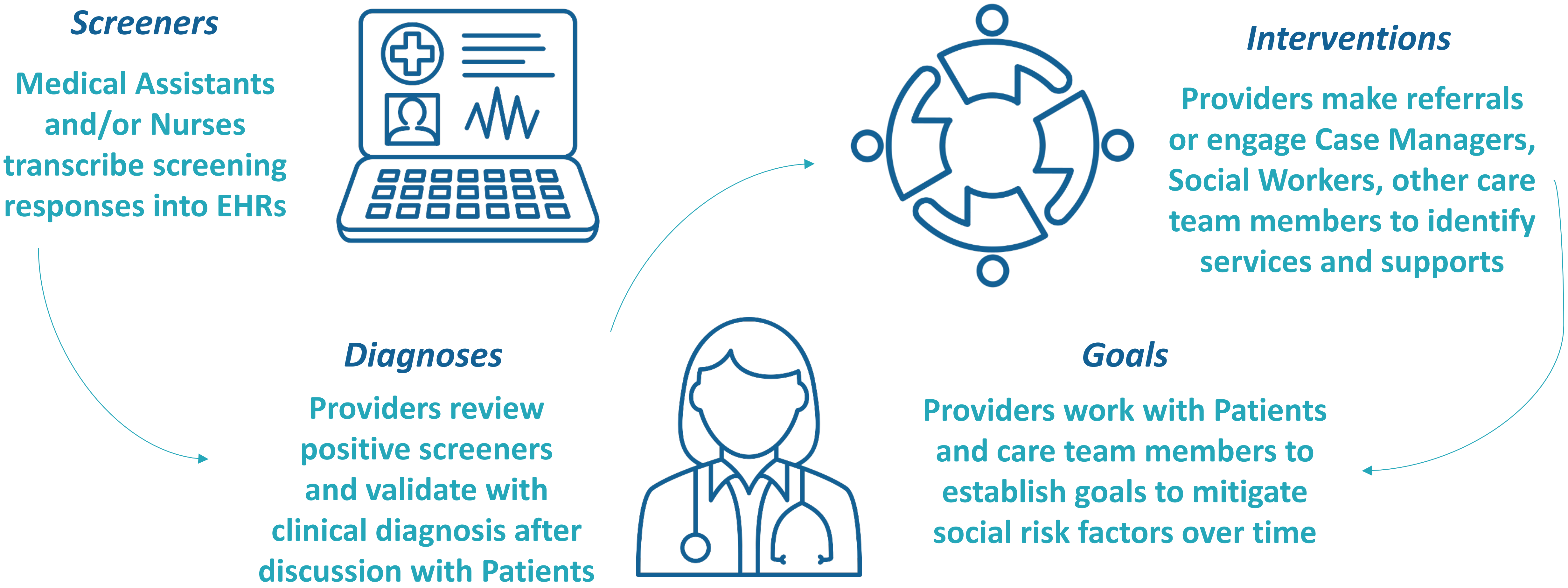
Data Collection

What happens with patients' social health risk assessment inputs?



Screeners

Medical Assistants and/or Nurses transcribe screening responses into EHRs

Interventions

Providers make referrals or engage Case Managers, Social Workers, other care team members to identify services and supports

Diagnoses

Providers review positive screeners and validate with clinical diagnosis after discussion with Patients

Goals

Providers work with Patients and care team members to establish goals to mitigate social risk factors over time

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Data Collection

What challenges are faced when attempting to collect social health information?

- **Assessment Availability**
  Availability of assessments in diverse languages to meet cultural needs

- **Question Interpretation**
  Interpreting assessment questions for patients with varying health literacy levels

- **Response Inconsistencies**
  Identifying inconsistencies in risk/need between survey responses and provider-patient conversations

- **Duplicate Assessments**
  Creating fatigue from having to answer similar assessment questions at different provider locations

- **Data Collection Automation**
  Technically being able to automate data collection within electronic systems versus paper-based mechanisms

Data Collection

How are challenges being mitigated to more successfully collect social health information?

- **Assessment Availability**
  Working with Community Health Workers to serve as “care navigators”
- **Question Interpretation**
  Training and deploying the right staff members who understand how to have sensitive conversations
- **Response Inconsistencies**
  Normalizing social health risk/need as a form of “healthiness” (like medical treatment plans)
- **Duplicate Assessments**
  Determining how to share social health risk assessment outcomes across patients’ care teams
- **Data Collection Automation**
  Continuing to challenge the status quo and urge contemporary solutions to combat social needs

Data Storage

What technical systems are healthcare providers using to store social health information?

nextgen® healthcare

Epic

Allscripts®

Cerner®

athenahealth

Data Storage

How are social health data elements stored in technical systems?

Screeners

- *Stored discretely and in the form of documents*
- *Kept in the form of local coding; sometimes transformed into standard coding*

Diagnoses

- *Stored discretely and in the form of documents*
- *Included in Active Problems Lists, Office Visit Notes, Encounter Records*
- *Often transformed into standard coding*

Interventions

- *Stored discretely and in the form of documents*
- *Kept in the form of local coding; sometimes transformed into standard coding*

Goals

- *Stored discretely and in the form of documents*
- *Kept in the form of local coding; sometimes transformed into standard coding*

Data Storage

How are social health data elements stored in technical systems?

> **Although codifying diagnosis and moving toward intervention is the objective, the whole system needs to be documented to improve patients' wellbeing.**

Data Storage

What technical safeguards are in place to protect patients’ social health information?

Confidential Modifiers for Billing Purposes

Patient Portal Restrictions for Kin (Parents, Spouses)

Considerations for Youth and Behavioral Health Patients

Role-Based Permissions for Staff Members

Data Use Cases & Actions

What are healthcare providers' "perfect situations" for using social health information?

Address access to care and health equity issues for the most vulnerable, underserved populations

Dissolve stigma associated with social health risks/needs

Partner more closely with community-based organizations to connect patients with the necessary cross-sector supports and services (without fear of availability issues)

Meet patients where they are at by focusing on health literacy education and health care engagement

Reduce the amount of times that patients are asked to "tell their story"

Data Use Cases & Actions

How do healthcare providers use social health data elements at the point of care?

Trend Assessment Results (Screeners) Over Time

Review Active Problems Lists
(Diagnoses) to Inform Decision-Making

Establish Referral (Intervention)
to Mitigate Social Risk / Meet Social Need

Engage Case Workers to Help
Track Outcomes (Goals)

Data Use Cases & Actions

How are intervention recommendations communicated to relevant care teams?

> **Sometimes the greatest challenge is not the specific social risk identified; it's how you get the patient connected to the services that can help them – and that process is a social risk in itself.**

Data Use Cases & Actions

NASSON Health Care
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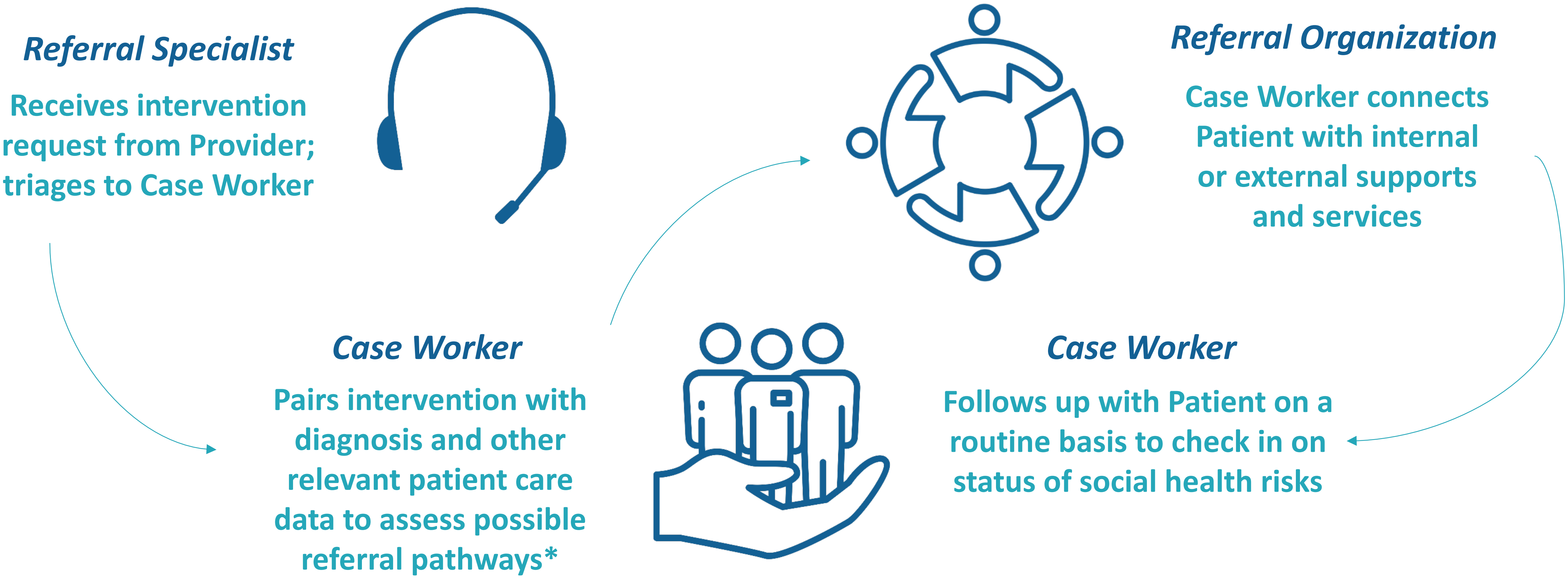
Use Case

How are intervention recommendations communicated to relevant care teams?



Referral Specialist

Receives intervention request from Provider; triages to Case Worker

Case Worker

Pairs intervention with diagnosis and other relevant patient care data to assess possible referral pathways*

Referral Organization

Case Worker connects Patient with internal or external supports and services

Case Worker

Follows up with Patient on a routine basis to check in on status of social health risks

**sometimes the intervention assessed during the clinical encounter varies from the intervention determined by the Case Worker with the Patient*

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Data Use Cases & Actions

How are healthcare providers finding available resources?

findhelp

OpenBeds®

2·1·1 Maine

Internal Resource Directories

Department of Health and Human Services

Helping People. Changing Lives.
MeCAP
Maine Community Action Partnership

Department of Health and Human Services

M4A

Maine Area Agencies on Aging

Data Use Cases & Actions

In what kinds of reporting are healthcare providers using social health data?

- Patient-level risk modeling (in conjunction with medical data)
- Population-level risk modeling and resource availability assessments
- Grant and other funding opportunities / requirements (e.g., HRSA UDS reporting)

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SOGI Data

How Healthcare Providers Are Collecting, Storing, & Using Sexual Orientation and Gender Identity (SOGI) Information Within Clinical Workflows

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

This convening series is possible in part from funding received from the Maine Health Access Foundation

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Data Collection

What SOGI data elements are collected by healthcare providers?

Legal Sex	*A person's sex that is recognized by law or insurance*
Sex Assigned at Birth	*A person's sex that is assigned at birth most often based on anatomical and/or biological characteristics*
Gender Identity	*A person's inner sense of being a female or male, something else, or having no gender at all*
Preferred Pronouns	*The words people should use when they are referring to another person without using their name*
Sexual Orientation	*How a person characterizes their emotional or sexual attraction to others*
Organ Inventory	*An anatomical inventory form that captures a person's organ diversity*

Data Collection

MaineHealth **Use Case**

How is SOGI information collected by healthcare providers?

- Partnered with Fenway Health to determine data collection approach
- Operationalized within ambulatory (2018) and inpatient (2019) locations; all settings by 2024
  - No standardized way in which data is being collected; different departments collect different data elements based on need/use case
  - Targeted training for gender clinic, emergency department, psychiatric department, and obstetrics/gynecology clinic settings; no specific scripting, just training scenarios
- Collected primarily during pre-registration (My Chart) or on-site registration by clinical / admin staff
  - Best if staff collecting the information have established relationships with patients
  - Even better if patients can fill out the information independently before their visits
- Current data collection challenges include:
  - Not always clear which staff role and/or department should collect the information
  - Not a mandatory clinical practice; most successfully with patient-entered data

Data Collection

How is SOGI information collected by healthcare providers?

- Collected primarily during registration via paper forms and during visits via conversation with providers
  - Increasingly including within pre-registration (patient portals) or self-service registration (kiosks)
- Additionally adding questions to patient satisfaction/experience surveys to determine how organizations are doing with SOGI data collection efforts
  - Northern Light Health's upcoming "Why We Ask" communication campaign
- Current data collection challenges include:
  - Lack of clinical / administrative staff training/education on how to have sensitive conversations
  - Lack of registration process/workflow associated with optimally collecting the information
  - Lack of recognition of standardized approach and/or purpose for collecting the information beyond healthcare organizations (e.g., payers, funders, referring organizations, etc.)

Data Storage

MaineHealth **Use Case**

How are SOGI data elements stored by healthcare providers?

- Storing most data elements discretely in Epic SmartForm
  - Preferred Pronouns are stored as non-discrete data elements in a free-text comment box
- Made changes to the Epic SmartForm to store the data aligned with the health system's needs
  - Information is stored in a separate tab alongside patients' clinical records
  - Preferred pronouns are also displayed within patients' clinical records for ease of viewing
- The Epic SmartForm always shows patients' most recent information
  - Though, any changes in information are audited and reviewed by providers at the point of care
- The Epic SmartForm is not protected/confidential; the information is available to anyone with registration or clinical permissions within the organization
  - The information is also stored in patients' portals (My Chart)

Data Storage

How are SOGI data elements stored by healthcare providers?

- Variation across healthcare providers in the way the data elements are stored
  - Some are stored discretely, others in the form of documents
  - Some are made more visible in patient charts (e.g., Sex Assigned at Birth, Preferred Pronouns) than others (e.g., Legal Sex, Gender Identity)
- The information is not protected/confidential; the information is available to anyone with registration or clinical permissions within the organization
  - May only be blocked (i.e., requiring privacy seal break) if collected by behavioral health setting

Data Use Cases & Actions

MaineHealth **Use Case**

How is SOGI information used by healthcare providers?

Education/Training

Provides greater opportunities to work with registration and clinical staff on how to use the data elements to improve patient care and outcomes

Point of Care

Gives providers more confidence in their treatment plans and decision-making abilities (e.g., pregnancy risk, relevant screenings, intersex and difference in sexual development, etc.)

Admission/Rooming

New system-wide policy (2022) that prioritizes patients' rooming based on their gender identity (if available) then legal sex (if gender identity is unavailable)

Referrals

Establishes an open dialogue between patients and providers to make necessary referrals to MMC Gender Clinic and/or community-based LGBTQIA+ supports and services

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Data Use Cases & Actions

How is SOGI information used by healthcare providers?

Staff education/training opportunities

Federal reporting requirements, grant and other funding applications

Point-of-care treatment care plans (e.g., relevant screenings) and decision-making capabilities

Referrals to external LGBTQIA+ community-based supports and services

New gender-affirming program development

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Health Equity Data Action Plan

How HealthInfoNet Can Support Healthcare Providers' Ongoing Data Collection, Storage, & Use Efforts

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

This convening series is possible in part from funding received from the Maine Health Access Foundation

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Engagement Opportunities

How can HealthInfoNet establish greater relationships to assist participants?

Expand HIE Participation

- Identify CBOs meeting the HIE's participation requirements (e.g., Area Agencies on Aging, Community Action Program Agencies, etc.)
- Onboard and receive CBO participants' client service information and healthcare provider participants' health equity information to create a cross-sector electronic longitudinal health record

Enhance HIE Partnerships

- Establish tighter relationships with existing cross-sector information technology systems (e.g., 211 Maine, findHelp, Open Beds, etc.)
- Create a directory of participants' homegrown community resource lists identifying supports in their areas
- Partner with health equity SMEs to help train/educate participants and other HIE stakeholders on the appropriate uses and best practices of relevant data sets to inform person-centered care

Support CIE Efforts

Continue to serve as a technical advisor, SME, and invested stakeholder in the statewide Community Health Information Exchange (CHIE) workgroup planning efforts in the aim of advancing cross-sector interoperability to improve whole-person care and population health management throughout Maine

Service Opportunities

How can HealthInfoNet enhance its services to assist participants?

Clinical Portal

- Incorporate health equity data sets within patients' electronic longitudinal health records to bridge clinical and community care settings
- Clearly identify when health equity data sets are updated within health records to help reduce duplicative screening processes and stigmatic experiences
- Expand role-based permissions to provide cross-sector stakeholders with the minimum information necessary within comprehensive health records to meet use case and workflow needs

Notifications

- Develop new notification subscriptions that enable real-time alerting of person-centered health equity related events of care (e.g., person is identified as food insecure, person's demographic information changes, etc.)

Analytics & Reporting

- Build a new report that presents available health equity information for FQHCs' attributed patient populations in support of their UDS requirements
- Generate a new report that identifies health equity trends across the state by incorporating participants' and other third-party data sets
- Enable stratifications of clinical reports by key health equity data elements (e.g., ED utilization among individuals positively screened for food insecurity)

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Next Steps

What's To Come With HealthInfoNet's Health Equity Data Action Plan?

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Next Steps

What's to come with HealthInfoNet's Health Equity Data Action Plan?

- Determining how to create a conduit among participants to keep these conversations going and to encourage networking opportunities
- All convening session recordings, slides, and materials will be shared with attendees
- A survey will be sent to all HIE participants to ask about their social health and SOGI data collection, storage, and use case experiences
- The Health Equity Data Action Plan recommendations will be considered within HealthInfoNet's upcoming strategic planning conversations
- Progress on short- and long-term recommendations will be reported through key communication methods

To continue discussions about health equity information, contact us at clinicaleducation@hinfonet.org

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