

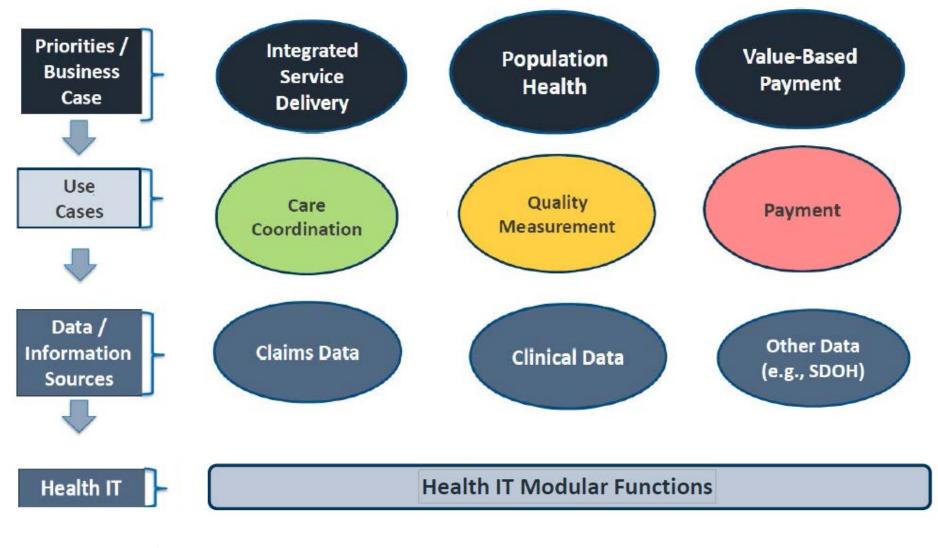


Improving Interoperability of State Health and Non-Health Information

ONC Annual Meeting – Washington, DC – November 30, 2017

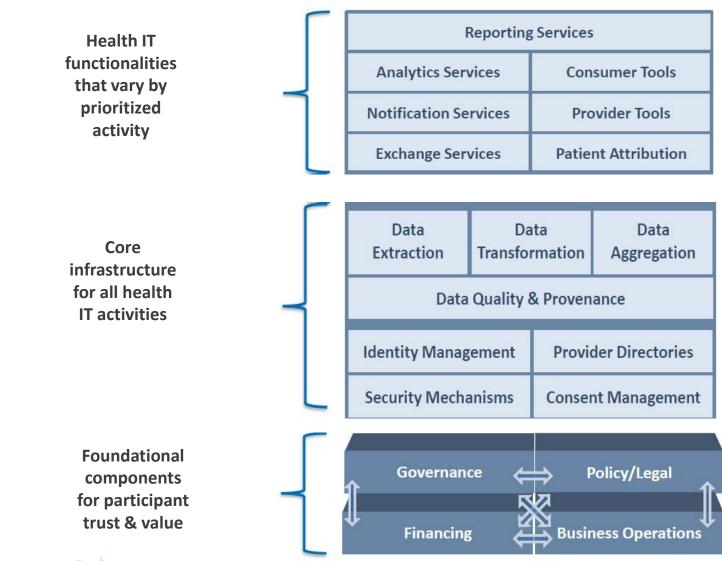


How Priorities / Business Case Drive Data and Health IT



The Office of the National Coordinator for Health Information Technology

Modular Health IT Functions - Assessing Technical Community Assets



The Office of the National Coordinator for Health Information Technology

- Execute health IT alignment supporting an integrated community of care delivery and social services addressing social determinants of health and population health priorities.
- <u>Continue to address execution</u> through Performance Measurement, Payment, and Service Delivery among <u>care and community organizations</u>
- <u>Identify activities</u> to incorporate the collection, integration, and use of data on social determinants of health into our care delivery system
 - » Who do you involve?
 - » What data do you need? Where is the data?
 - » How you are going to connect the workflows?
 - » How you blend data and payment approaches to human needs not separate budgetary need?





<u>Program Level</u>	<u>Use of Data</u>	Health IT Modular Function
Population-Level (Policy/Program Development)	 Use of data to review needed, proposed, and existing social policies and their likely impact on health 	Data Aggregation Analytics
(Policy/Program Development)	 Surveillance to examine social factors (inform program 	Data Aggregation
	development, policy, and investments)	Analytics
	 influence communities and sub-populations 	Identity Management (MPI)
	 impact intervention effectiveness and outcomes 	Provider/Resource Directory
	 how social factors relate to one another 	
Performance Measurement	Program measurement and evaluation to better understand	Reporting
	social needs and resources of the communities it serves	Provider Tools
	Program effectiveness	Analytics Learning Network
	Continuous quality improvement	Attribution
Individual-Level Interventions	• Identify who to focus on (high risk, high need) populations	Provider tools
(Targeted patient-level	through	Identity management
interventions)	 Identify interventions needed 	Provider/Resource Directory
	• Link patients and beneficiaries to community and social	Exchange services
	services	Consent management
	• Enhance integration of information across care delivery and	Provider/Resource Directory
	service delivery providers	Data Aggregation
	 Managing population(care coordination and management) 	Policy
Incentive and Performance	 Embedding measures related to social or behavioral 	Analytics
Programs	determinants of health into provider and/or health plan	Reporting
	incentive programs or performance improvement projects is	Identity Management
	another strategy state Medicaid agencies are using to advance the collection of social data	Attribution
Risk Adjustment and Rate		Analytics
Setting	 Use patient-level SDOH data in risk Adjustment calculations and to set reimbursement rates for 	Data Aggregation
<u></u>	providers. (e.g., monthly billing assessment questionnaire to	Provider tools
	determine the monthly acuity rate for each member (high,	Identity Management
	medium, low)	Attribution
Surveillance and Program	Analyzing how social factors influence communities and sub-	Data Aggregation
Quality Improvement	populations, impact interventions, and relate to one another	Analytics



State-specific examples of the Modular Health IT Functions

Challenges to Capture, Exchange, and Use of Other Data

• Lack of standardized data

- » ONC has optional standards and certification criteria for SDOH data
- » Specific standards listed in interoperability standards advisory <u>https://www.healthit.gov/isa/I-S</u>

Technical and resource barriers

» Lack of IT infrastructure among social/community based services

Lack of Effective Multi-Sector Collaboration

» To address not only who will collect data and how, but how it will be made available to health care providers

Administrative and work flow barriers

- » Point of care capture is perceived/real burden from a busy clinicians perspective but low burden approaches have been successful in Community Health Centers via the PRAPARE tool <u>http://nachc.org/research-and-data/prapare/</u>
- » Need MOUs/agreements for sharing across data owners, i.e., to share and analyze data across housing and homeless data systems and health care systems at the state and local level
- Data sharing and privacy is SDOH data Protected Health Information under HIPAA?
 - » OCR has clarified allowable capture, use and disclosure of incarceration data <u>https://www.hhs.gov/hipaa/for-professionals/faq/2073/may-covered-entity-collect-use-disclose-criminal-data-under-hipaa.html</u>
- Lack of common definitions



Disaster Response Support for First Responders

Patient Unified Lookup System for Emergencies (PULSE) connects health care entities so that providers and emergency responders have a way to access health information across systems.

Public Health

Provide for connectivity to better support public health activities and emergencies, including opioids or infectious diseases.



- John Rancourt Deputy Director, Office of Care Transformation, ONC (moderator)
- Stephen Cha, MD Director, State Innovation Group, Center for Medicare & Medicaid Innovation, CMS
- Susan Otter Director of Health Information Technology, Oregon Health Authority
- Douglas Dietzman Executive Director, Great Lakes Health Connect
- David Kendrick, MD, MPH, FACP CEO, MyHealth Access Network; and Chair, Department of Medical Informatics, Oklahoma University School of Community Medicine

