Social Health Data Strategies for Federally Qualified Health Centers in Maine & Beyond

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

A brief introduction of our presenters.

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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 visualization services
- Prior and ongoing collaborations with state leaders and national learning networks to expand HIE use cases to encompass community perspective
About Nasson Health Care

About Nasson Health Care and its community-based health center.

- Community-based health center located in Springvale, Maine, operated by the York County Community Action Corporation (YCCAC)

- Founded in 2004 to provide programs funded through Section 330 of the Public Health Services Act

- Adopt a team-based approach to providing medical, dental, and behavioral health services
Learning Objectives
An overview of key takeaways from this presentation.

- Identify opportunities for how HIEs can best engage primary care associations and FQHCs to target high-priority data strategies
- Determine ways that HIEs can integrate social health data to support meaningful workflows for stakeholders within and across systems of care
- Consider the role that HIEs can play in the transformation of data strategies to align with ‘Community Health Information Exchange’ models
Project Background

A brief history of collaboration to further social health data strategies.
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.
Key Insights & References

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

Partnering with Maine’s FQHCs to inform social health data strategies.
Project Methodology

Devising a project framework amenable to participants amidst the COVID-19 pandemic.

6-month virtual convening process held between January and June 2021

Mix of one-on-one interview-style sessions, small-group workshops, and collaborative forums to receive feedback

Creation of a formal report outlining recommended strategies for FQHCs’ social health data efforts
Project Findings

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

- FQHCs’ Leadership & Innovation Role in Redefining the Care Delivery Model
- Opportunities to Overcome Varied Data Collection Strategies by Streamlining & Prioritizing Efforts
- Counteracting Limited Internal Capacity with External Guidance to Advance Data Strategies
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


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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

- PRAPARE
- EHR Social Hx
- Custom Tool

DATA STORAGE

- EHR System

DATA EXCHANGE

- Exchanging with HIE, Discretely
- Exchanging with HIE, Non-Discretely
- Not Currently Exchanging with HIE
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

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.
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 (DRAFT)

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
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
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 (DRAFT)

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

<table>
<thead>
<tr>
<th>Food Security</th>
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<tbody>
<tr>
<td>Individuals’ access to food and/or the necessary tools to prepare meals and/or competence of how to prepare meals successfully.</td>
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<table>
<thead>
<tr>
<th>Data Element(s)/Value Set(s)</th>
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<tbody>
<tr>
<td>UDS Reporting: Appendix D, Question 12a: Please provide the total number of patients that screened positive for the following at any point during the calendar year.</td>
</tr>
<tr>
<td>Option = Food Insecurity</td>
</tr>
<tr>
<td>PREPARE Measure: 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?</td>
</tr>
<tr>
<td>Response = Food</td>
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<table>
<thead>
<tr>
<th>Example Use Case</th>
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<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td>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 lost 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.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
</tr>
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<thead>
<tr>
<th>Health Information Service</th>
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<tr>
<td>Real-time event notifications</td>
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</tbody>
</table>
Project Conclusions

Summarizing key themes and takeaways for FQHCs in Maine and nationally.

- **Social health data is complex; there is not a one-size-fits-all solution.**
  - While FQHCs are leaders in this space, each approaches the domain slightly differently.

- **To effectively care for individuals, cross-sector collaboration is critical to achieve.**
  - Community Health Information Exchange (CHIE) provides a model for an integrated system design.

- **For the CHIE model to be effective, standardized measurement is necessary.**
  - While many downstream use cases can be supported by a CHIE, upfront work is required by FQHCs to adhere to data input specifications.

- **There are many efforts in Maine and nationally hoping to evolve this work further.**
  - In Maine, the Maine Council on Aging’s and the Maine Medical Association’s efforts provide examples and guidance for future efforts.

- **This project represents an initial study of Maine’s FQHC social health data strategies.**
  - With collaboration with the MPCA, future funding may aim to overcome FQHCs’ blockers for successful data collection, exchange, and operationalization practices.
Contact Us!
For more information about this presentation, please reach out to us.

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Our final “Social Health Data Action Plan” will be made available early this fall!