



Rhode Island HIT Steering Committee

June 9, 2021

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Agenda

- Welcome and Introductions
- Review of the Minutes
- Reports/Updates:
 - Interoperability Work Group
 - Transitions of Care Workgroup
 - Quality Reporting System Sustainability
- Discussion:
 - Strategic Planning – Part 2
 - Review of Last Month’s Discussion
 - Prioritization proposal from the Planning Work Group
 - Next Steps
- Next Steps and Next Meeting – Wednesday, June 9, 2021, at 5:30 pm
- Public Comment

Interoperability Workgroup

The Interoperability Work Group is seeking to identify how best to support payers in implementation of the Patient Access API rule.

1. In May, the Committee surveyed payers to determine the current status of implementation and challenges. Results indicated all payers are developing their own Application Programming Interfaces (APIs). Challenges include, payers not receiving clinical data in a consistent standardized manner.
2. Potential Implementation Strategies include:
 - Leveraging an intermediary (such as CurrentCare or IMAT) to undertake the data standardization/conversion.
 - Seeking agreements among providers and hospitals to send payers' clinical data elements in a consistent manner, compliant with the United States Core Data for Interoperability (USCDI) rules, to help make the data available via a FHIR API to patients (and other payers).
3. Next Steps:
 - HIT Staff to conduct interviews with payers to identify sources of data. Also, we must assess level of variation/lack of standardization of data being sent to payers.
4. Challenges:
 - We are hoping to achieve buy-in from Health Care Community Stakeholders on an implementation strategy.
 - Research is in progress on other Federal Regulations from ONC, CMS, CDC to providers, hospitals and payers, in order to reach our goal of standardizing formats for data exchange.

Transition of Care (TOC) Initiative

1. In order to follow up on the work on Transitions of Care carried out before COVID continues, we are proposing to reconvene the TOC Workgroup focused on Use Case 1: Transitions of care from hospitals to community providers:

- Targeting end of June/early July.
- Rhode Island Quality Institute (RIQI) will present ideas, capabilities and challenges related to creating a TOC short form by leveraging and building upon the existing infrastructure.

2, Rhode Island Department of Health will be issuing guidance to licensed hospitals requesting the hospitals to list the 11 agreed upon TOC priority data elements at the beginning of all documents sent to community providers when a patient is discharged. The priority elements include Patient Demographics, Encounter Location/Type of Discharge (ED or Hospitals), Admission/Discharge Dates and Time, and Disposition (where the patient is discharged to).



Strategic Planning Conversation

Part 2

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Review of Last Month's Discussion

Of the top 5 initiatives chosen, there are existing activities in two of them:

- **E-referral for Social Determinants of Health**
 - Establish and coordinate the use of a statewide e-referral solution that supports care coordination and efforts to address Social Determinants of Health (SDOH), by linking healthcare and social service providers through a common platform.
- **Increasing data availability: Data Standardization/Integration of Race and Ethnicity Data**
 - Establish a statewide standard for capturing and reporting race and ethnicity data – and then adopt and integrate agreed-upon standards into healthcare and social service organizations data systems.

Community Referral Platform (CRP)



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Rationale for Community Referral Platform (CRP)

Tracking Social Determinants of Health (SDOH) Needs:

- Currently, healthcare organizations do not have enough feedback on outcomes of SDOH referrals for patients to community-based organizations (CBOs), which prevents effective follow-up and outcome measurement.
- Because social determinants are such significant drivers of health, knowing the outcome of these referrals is foundational to providers' ability to manage whole-person health.
- CBOs receiving referrals from healthcare providers generally have little to no access to the patient's health and SDOH needs, which may limit the CBOs' ability to provide holistic care.
- Individuals may be required to repeatedly share the same information with different service providers which can be a daunting process.
- **In order to effectively address health-related social needs, there must be a way to document system-level service delivery data more intentionally.**

Community Referral Platform (CRP) Overview

- The Rhode Island Executive Office of Health and Human Services (EOHHS) has procured a Community Referral Platform (CRP) from the technology company Unite Us. The Unite Us implementation team partners with the United Way of Rhode Island.
- The CRP will help connect Medicaid beneficiaries to health and social service resources within their communities. EOHHS is also committed to improving health outcomes for all Rhode Islanders and would like to see the CRP used as a statewide system. The CRP can:
 - Support AEs in systematically screening for members' health-related social needs
 - Identify appropriate resources in the community, referring members to those resources, and effectively coordinating service delivery and follow-up with CBOs.
 - Create electronic referrals and enable the CBOs to close the loop on each case file, informing the referring provider of the status or outcome of the referral.

HIT Steering Committee Role: Creating Statewide Strategic Alignment

- Existing structures:
 - EOHHS is building upon work that has been carried out by Rhode Island's Office of Veterans Services and Unite Us since 2017. In addition, Unite Us partners with KidsLink Prospect Health Services RI, and Coastal Medical.
 - At least one other similar SDOH platform is operating in Rhode Island, with a different vendor.
 - In terms of governance, Unite US has a statewide network that meets regularly. They also have an Executive Committee.
- As the state moves forward with the implementation of the Community Referral Platform, the HIT Steering Committee will define its role in the overall governance of the project to:
 - Help align these efforts.
 - Provide oversight for statewide efforts as laid out in HIT Statewide Roadmap and Implementation plan.

Potential HIT Steering Committee Role

The statewide HIT Steering Committee can play important an overarching strategic role, asking the following types of questions:

- What can the state do to promote the CRP as a statewide system?
- What are the ways that Rhode Island can ensure:
 - Coordination of CBOs and providers so that they don't have to use multiple systems?
 - Data standardization/implementation of national standards (as addressed in the second HIT priority project?)
 - SDOH data interoperability with EHRs and other platforms?
 - Promoting additional SMART FHIR integrations?
- How can the state and its partners create a Sustainability Plan for the project, exploring grant opportunities and other funding?
- What other use cases can exist for the CRP besides provider to CBO referrals?

We propose a separate group discussion to take place in late June.

Demographic Data Standardization

Demographic Data Standardization

- **Race & Ethnicity Data**
 - Implement agreed-upon demographic data standards statewide (for race/ethnicity/disability/sexual orientation/gender identify), using national standards where applicable.
 - Then, adopt and integrate agreed-upon standards into healthcare and social service organizations data systems.

Demographic Data Standardization

- Rhode Island just received a \$19.6 million CDC Grant: National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities
- Among the four grant strategies is a significant investment of approximately \$2.5 Million to support our data work:
 - RIDOH will use this opportunity to enhance the State of Rhode Island's ability to significantly overhauling and improving our race and ethnicity data at points of collection; and improving our ability to provide actionable data to identify and address disparities, thus driving measurable change within the priority populations identified in our workplan.
 - The HIT Steering Committee has a role to play in the implementation of stakeholder engagement for the work.

Potential HIT Steering Committee Role

Here are a set of potential goals for the data project which the Steering Committee could help refine and then help plan to implement:

- Recommend a standard set of fields (ideally, Center for National Health Statistics)
 - Medicaid Accountable Entities (AE) could take the lead.
- Add race and ethnicity fields to HL7 for lab reporting
 - Highly important and currently lacking for disease surveillance (e.g., who is getting tested?)
 - We often only know the race and ethnicity of positive cases of any disease.
- Race and ethnicity needs to be a standard, completed field, on CCDs so a patient's self-reported demographics travel with them.
- Commit to a set of principles for data collection, including
- Self-reported, never imputed
 - Asked at each visit
 - Voluntary, but strongly encouraged (incentives for completion), etc.

We propose a separate group discussion to take place in late June or early July.

Prioritization Discussion

Remaining Initiatives to Prioritize

#1: Linking of claims, clinical & SDOH data. Use case options include:

- Establishing a system or process that supports the ability to link an individual's clinical, claims, and SDOH data
- One way to accomplish this would be to establish an on-line analytical database that aggregates and links individuals clinical health information, medical claims, and SDOH data from multiple sources (government and commercial payers, healthcare providers, social service agencies, etc.) and provides public health policy makers, epidemiologic researchers, healthcare business analysts, journalists and the public access to de-identified data views and graphical representation for discovery of new epidemiologic insights and tracking of clinical quality and cost effectiveness measures across selected populations.
- We can consider other use cases as well.
- Potential Benefits:
 - Better manage and close care gaps
 - More timely and richer health data for continuously evolving care management.
 - Deliver better value-based outcomes
 - Create robust reporting for population health development.

Remaining Initiatives to Prioritize

#2: Public Health Initiatives. Use case options include:

- Aligning and integrating electronic public health data reporting requirements across stakeholders to support electronic laboratory testing, case reporting, vaccine administration, etc.
- Leverage existing CurrentCare infrastructure for electronic reporting to RIDOH
- Seeking to streamline processes and ensure that systems support comprehensive data aggregation and accessibility for those who need to know.
- There are other use cases to consider as well.
- Potential Benefits:
 - Reduce provider burden (and possibly cost) related to reporting to RIDOH – thus improving reporting accuracy and scope
 - Better utilization of RIDOH resources, including eliminating faxing data that then needs to be electronically entered
 - Leverage existing Health Information Exchange (CurrentCare) infrastructure

Remaining Initiatives to Prioritize

#3: Enhancing behavioral health data sharing. Use cases options include:

- Align interpretation of state law/regulations to support treating providers to share behavioral health data about their clients with each other
- Develop and implement communications strategies to inform providers of interpretation of law/regulations
- Develop and support strategies to implement behavioral health data-sharing with this aligned interpretation
- Potential Benefits :
 - Opportunity to implement preventive interventions to address behavioral health needs and to help integrate physical and behavioral healthcare.
 - Provide more personalized and “whole picture” care to individual patients.
 - Allow care teams to better understand potential barriers to medication and treatment adherence.

Decision-Making Criteria

Here are the criteria that seem to apply best to this decision-making process:

- Is the initiative or project needed?
- Will it have a positive impact on Rhode Island's Healthcare System
- Will it have a positive impact on the BIPOC Community, within a Race Equity Lens
- Will it have a positive impact on Providers
- Is there a possibility of a Return on Investment?
- Complexity – Is it worth the relative risk?
- Does it promote Synergy/Alignment?



NEXT STEPS for the HIT STEERING COMMITTEE

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