Adverse social determinants of health (SDOH) are manifestations of more profound and fundamental root causes – poverty, disability, isolation, mental illness, and more. Healthcare's purpose in collecting SDOH data should be to improve their root causes as much as possible and to keep the root causes in mind when attempting to treat their manifestations. Measuring and (or) attempting to treat their manifestations without regard to cause is a pathway to failure for many patients.

How does a health plan or provider go about collecting SDOH data and making a difference as a result? People do not like to talk about problems that carry a social stigma or present the risk of misuse or, worse, redlining. A patient's zip code says a lot about their financial status, but that may not be relevant. What's the value of getting more information from a patient who may well resist providing it? Asking patients what accommodations or help they require to seek and receive care is a more effective approach than assuming they just need access to cheaper rideshares because they are transportation insecure, as an example. Not all disabled patients are financially insecure. They simply are unable to get to the curb for a car service or to the bus stop down the street.

Health records are permanent records. Diagnoses and procedures cannot be removed from the record by the physician or the patient. This makes using diagnoses to indicate SDOH problematic. If a patient was homeless at an earlier point in their life would their homelessness, as a diagnosis, be charted as "in full remission?" Many of us have experienced the frustration of seeing medications we have stopped taking long ago remain in the record despite multiple attempts to reconcile this inaccuracy. The permanence of inaccurate health information in the medical record will perpetuate the once-homeless patient's perception as "housing insecure" in the eyes of other clinicians viewing their records for many years after their housing situation has changed.

Capturing SDOH data is important, as is addressing the needs uncovered. However, we must do so in a way that garners patient cooperation and engages them. We want them to indicate what their specific needs are beyond generic categories so that solutions that don't address their problems aren't foisted on them. We also don't want to require them to constantly explain past life situations that are no longer relevant. This is a tall order, but understanding that one solution does not fit all patients will help us meet the challenge. Together we can make progress toward meeting the essential SDOH needs of patients in a useful and productive way.

Denny Brennan, Executive Director

Email us at newsletter@mahealthdata.org with your thoughts about this newsletter. Thank you for your continued support and participation!

MHDC Events

Upcoming MHDC meetings through April:

- DGC Deep Dive: April 6, 11am-1pm
- DGC Working Group: April 13, 20, 27, 11am-12:30pm
- DGC Steering Committee: April 13, 3-4:30pm
- NEHEN Business Users: April 7, 9-10am
- Webinar: InterSystems: April 26, 11am-12pm

Want to learn more about any of these meetings? Email info@mahealthdata.org

MHDC Webinars

Join us for our upcoming webinars:

The Rise of Consumerism and the Digital Front Door presented by InterSystems on April 26 from 11am-12:00pm.

Missed any of our webinars in 2022? Click here to see what you've missed!

Interested in holding an MHDC webinar or have an interesting topic you'd like to present? Contact us at webinars@mahealthdata.org

Spotlight Analytics Update

Spotlight Business Analytics helps healthcare organizations run custom analytics on health data including market share, patient origin, disease prevalence, cost of care, and comparative costs and outcomes for acute care hospitals.

We are partnering with the Lown Institute to add civic and care leadership measures to Spotlight. Augmenting Spotlight's market share, disease prevalence, and demographic analyses with the Institute's equity, value, and outcomes measures will

provide Spotlight subscribers with a more comprehensive, robust, and relevant view of health system performance.

We are in the process of adding the Lown data to Spotlight and creating new layouts and reports to help users better understand the data. We will schedule our next user's group meeting once this data is available. For updates and additional information about Lown or upcoming meetings please reach out to us at spotlight@mahealthdata.org.

The current data status is:

Loaded & available for use:

- Massachusetts Hospital Inpatient Discharge Data FY20
- Massachusetts Emergency Department Visit Data FY20
- Massachusetts Observation Data FY20
- Rhode Island Hospital Inpatient Discharge Data FY20

Received & ready for use soon:

- Lown Institute measures

Future planned data:

- New Hampshire Facility Discharge Data Sets (Application pending)
- Maine Hospital Inpatient and Outpatient Data (Application pending)

Please feel free to drop us a line with any questions or comments at spotlight@mahealthdata.org. In the meantime, thank you for being a Spotlight Analytics user and a member of this community! Feel free to visit our Spotlight Business Analytics page or email us at the address above for more information.

DGC Update

The Data Governance Collaborative (DGC) at MHDC is a collection of payers and providers throughout the region exploring ways to better exchange health-related data incorporating industry standards and automation as much as possible.

Our next deep dive will be on family history on April 6 from 11am-1pm. We will explore current regulation and practices, data capabilities, workflows, data exchange, privacy and consent issues, and more. The event is open to the public; we encourage you to register here.

Regulations are still a priority in our regular meetings, and we've been reviewing several recent industry events. We've also been exploring several special projects

with our Steering Committee and lending our expertise to some external projects run by others - watch this space for more information as these projects progress.

Membership in the DGC is open to any payer or provider with business in Massachusetts - big or small, general or specialist, traditional or alternative. Want to know more? Email datagovernance@mahealthdata.org

NEHEN Update

NEHEN reduces administrative burden through the adoption of standardized transactions. It is a cornerstone service for payer and provider trading partners wishing to exchange industry standard X12, HIPAA compliant transactions in a real-time, integrated manner using APIs. Because of our unique governance, non-profit status, and membership-based model, NEHEN is able to offer very competitive services relative to the market. Working with members and trading partners, NEHEN is also supporting a prototype electronic prior authorization (ePA) implementation that automates transactions using industry standard, open platform methods developed by the HL7 DaVinci Prior Authorization workgroup.

Concurrent to the prototype implementation MHDC is partnering with NEHI (Network for Excellence in Health Innovation) to create a set of recommendations for the statewide adoption of automation in support of electronic prior authorization (ePA). Several of the outcomes of this project work will include the following:

- A plain language description of the workflow and options associated with the elements of automation as well as their impact. This will include standards, operating rules, workflow, certifications, and other pertinent information.
- An assessment of the major barriers to the adoption of automated prior authorization among Massachusetts payers and providers (partly informed by the NEHEN/MHDC prototype project with Blue Cross Blue Shield of Massachusetts and New England Baptist Hospital using Olive/Verata as the technology partner).
- Recommendations for supporting implementation incentives and policy changes within Massachusetts.
- Validation of the recommendation using an Advisory Group comprising of technology service providers, payers, providers, and federal and state policy makers.

This parallel project will begin in early May and is expected to last approximately one year. Members of MHDC, NEHEN, and the DGC will be offered updates and opportunities to participate in discussions and development as we proceed.

For more information about NEHEN please contact us at members@nehen.org or visit our website at www.nehen.org. For more information about the ePA project, please email epa@mahealthdata.org.

Industry Events

Interested in webinars and online conferences in April? Here are some we recommend (they're free unless otherwise noted):

- [Beckers: Power system-wide patient access with intelligent automation](): Apr 5, 1pm
- [EHI: Use of Innovative Technologies in Public Health](): Apr 5, 2pm
- [AHIP: Strategies to Drive Improvement in Value-Based Contracts](): Apr 6, 11am
- [Beckers: Creating an experience strategy for your health system](): Apr 6, 1pm
- [AHIP: Switching to Virtual Member Care for Chronic Disease Prevention and Management](): Apr 12, 12pm
- [ONC: 2022 Annual Meeting Part 2](): Apr 13-14
- [AHIP: Countdown to Price Transparency Compliance](): Apr 13, 1pm
- [Beckers: Using population health + predictive analytics to better target patients](): Apr 14, 12pm
- [AHIP: Food as Medicine: A New Standard of Care for Population Health](): Apr 14, 1pm
- [Beckers: The Conversation Continues: Why Healthcare Isn't Working](): Apr 19, 12pm
- [Beckers: Ransomware prevention in hospitals: 5 steps to take immediately](): Apr 19, 1pm
- [Beckers: Why focusing on the consumer experience pays off for healthcare systems](): Apr 19, 1:30pm
- [EHI: Future of Oncology Care: Delivering on Value-Based, Patient-Centered Care](): Apr 20, 1pm
- [Beckers: Generate and Capture Patient Demand for Care with Intelligent Scheduling](): Apr 21, 1pm
- [ONC: SDOH Information Exchange Learning Forum](): Apr 22, 1pm
- [Fierce: Payer/Provider collaboration to improve risk scores and positively impact the bottom line](): Apr 26, 2pm
- [Fierce: How can key healthcare stakeholders collaborate more effectively to form learning health ecosystems](): Apr 26, 3pm
- [AHIP: Deeply Engaging Difficult-to-Reach Chronically Ill Populations to Improve Quality](): Apr 27, 1pm
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- [DaVinci Community Roundtable](#): Apr 27, 4pm
- [Beckers: How Leading Health Systems Are Using Data to Predict the Future, Improve Retention, and Save Millions](#): Apr 28, 12pm
- [AHIP: Improving Member Experience: The Why and How for Health Insurance Providers](#): Apr 28, 1pm
- [Fierce: Strategies to Effectively Close the Primary Care Gap to Deliver Accessible, Quality Care for All](#): Apr 28, 2pm

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We do periodically post webinars we plan to attend on social media, so feel free to follow us on Twitter ([@mahealthdata](#)) and [LinkedIn](#) for more webinar ideas and for our take on interoperability, data, health equity, telehealth, APIs, and other topics of interest.

Have an upcoming event next month to suggest? Write us at [newsletter@mahealthdata.org](#) - no self-promotion please.

Equity and Access Issues with Automated Workflows

One of the things Covid has brought us is increased automation around appointment administration and workflows. Many of these processes increase efficiency and lower staffing needs and are likely to stick around permanently. That's great when these processes work, but it raises some equity and access issues for folks who cannot easily use all of these new mechanisms.

Some of these changes include mobile check-in via a cell phone application, an expectation of submission of online forms prior to an appointment, greater reliance on patient portal access, traffic control via mobile notifications of when to arrive, and more. Each of these present potential problems when it comes to equity.

While leaving some reception areas empty with printed instructions is not new, it has certainly become more frequent. It's always been problematic. The outpatient surgery unit at one of the Boston hospitals has had patients enter an unstaffed waiting room for years. They have a printed sign on the inner door leading to the actual facilities that indicates people should use a desk phone in an alcove to the left to call and notify someone they've arrived. We know a blind patient who arrived, walked to that inner door (directly in front of the outer door they entered through), tried to open it, found it locked, knocked several times, waited a while, started verbally yelling out asking if anyone was there, and then eventually yelling for help. Other people in the waiting room ignored this, not informing the patient what to do or helping them do it. Eventually someone from inside came out and, it turns out, they were ready for the blind patient and trying to determine if they'd arrived since they hadn't checked in. We suspect most patients would have left before reaching that point and missed their surgical appointment solely because someone decided this

waiting room format was functional. For that patient and many others it isn't. Things have not improved.

One of the great health IT folks we follow on Twitter, Lisa Bari of Civitas, posted a picture of the [check-in instructions](#) she found at a provider office. It included confusing, contradictory printed instructions taped to a touchscreen with its own small print instructions and two giant buttons filled mostly with empty space surrounding tiny one word labels. There was no staff around to clarify or to provide help for folks who need it. If a blind or visually impaired patient like the one discussed above entered the office they likely would not know there's an automated process in place at all. They certainly couldn't read any of the instructions either taped to the screen or on the screen itself. The print seems small enough that many folks who don't meet the legal definition of a visual disability would likely still have difficulty. So would folks who don't read English well or at all. Someone with mobility issues in their fingers or hands might not be able to complete any subsequent form entry, particularly if it involves tapping on an onscreen keyboard with lots of closely located keys. Similarly, someone with back or neck problems might not be able to access a set height, set angle screen without pain or possibly at all. Assuming you are actually supposed to scan a driver's license (which isn't clear) and you can locate the scanner, folks who don't have a driver's license may have a legally valid ID that isn't scannable or that isn't recognized by a system expecting a driver's license. Similarly, folks from other states may have a license that doesn't conform to the system's expectations. There are probably a ton of other possible impediments we're not considering just for this one example.

Mobile check-in at arrival assumes that the patient has a cell phone and that they can access whatever mechanism is supplied for that check-in. There are many folks who do not have or use smartphones either by choice or because they live in a service desert. Some folks with smartphones have limited space and won't or can't download an app just to check in to an appointment from 100 feet away. Some folks don't buy new phones until their old phone dies and may not be able to access applications requiring the latest and greatest phones. Folks with visual impairments may not be able to see the necessary apps. Folks with mobility issues in their fingers or hands may not be able to interact with the apps. And so on.

If this mobile check-in process is used to minimize the number of people in an office or waiting room at one time, that has its own issues. Many provider locations do not have significant outdoor seating available for patients who do not arrive by car and, even if they do, waiting outside in inclement weather is not feasible for most patients (especially if already sick). Folks who use public transportation need to plan to arrive early - sometimes very early - to minimize the chances of being late and being turned away for that, exacerbating the issues around waiting outside. They also may need to use a restroom or some other facility inside after a long bus or train trip; can they enter to do that before they get the "come on in" notification? If not, they may need to temporarily leave to find someplace they can take of their needs or leave for a longer period if no such place is available nearby. Folks who drive but have to pay for parking don't want to pay for extra waiting time, especially if the parking area or

other waiting areas are a distance from their appointment location and waiting in their cars means paying for an extra 10, 15, or more minutes of expensive parking time.

This type of external waiting requirement may also introduce additional issues if provider policies around arrival times apply after someone checks in - are they turned away if they don't arrive at the office within 10 minutes of being told the office is ready for them? What if their parking spot is more than 10 minutes away? What if they're nearby but have mobility issues and it takes them more than 10 minutes to walk to the office itself? What if they're not right outside because they needed to use the facilities at a nearby restaurant? Traditionally these 10 or 15 minute time windows apply from the time you check in, but traditionally you're already at the location where you're going to be seen when you do that so there's no additional wait when you're told it's time to be seen. These policies have equity issues even in their traditional form, but using them this way would exacerbate those issues (note that we do not know whether this is currently happening, but given the stated purpose of this type of policy of keeping the schedule on time it certainly could be now or in the future).

Filling out paperwork ahead of time has also been around for a long time, but there have also always been mechanisms for doing it at appointment time for folks with various issues with paper forms. For many patients emailed forms are the same as paper forms as they are often printed to be filled out. Direct electronic forms may make some of those issues go away, but they come with new problems. Electronic forms that a patient can manipulate directly may help folks with visual impairments if they can enlarge them, but those same patients often can't access a patient portal - they're notoriously difficult for patients with visual impairments to access - if that's the mechanism for getting the forms or for returning them. If the forms must be filled out in the portal directly, various disability, mobility, and language barriers can interfere with a patient's ability to complete them. Not everyone with these issues has someone able to do the work for them ahead of time; they rely on staff at provider offices - be it reception staff or translators or others - to help them complete the forms. Further exacerbating some of these issues is that the electronic forms don't prepopulate data that's already available within the system.

There are workarounds for some of these issues that may help some patients participate without manual intervention or relying on more traditional, resource intensive mechanisms, but they are not full solutions and will not make these processes available and useful to everyone. Having an 80-20 solution is great and possibly even sufficient if your goal is market share or some level of adoption. For an industry where everyone must partake and where equity is increasingly a priority it is not acceptable. Automated patient appointment administrative workflows can and should be used for those patients who can access and use them without extensive difficulty, but they cannot be the only model used moving forward if we want to provide care to the disabled, to the elderly, to folks who don't read or write English, to folks who may have trouble waiting outside until called in for an appointment, to folks who don't have the newest and best mobile phones, to folks who need training

for every app they use, to folks who don't engage in electronic information at all (yes, there are still folks who don't even have email addresses out there). We need to make sure that any new solutions or processes adopted have mechanisms for reaching as close to 100% of patients as humanly possible. Until we do we're failing.

Arab American Heritage Month

April is Arab American Heritage Month, but did you know it's only officially been celebrated once before? President Biden signed the official proclamation last year. Welcome to year two!

Want to learn more about the Arab American experience? Check out the Arab American Museum (physically located in Dearborn, Michigan):

https://arabamericanmuseum.org/

Not all Arab Americans are Muslim and not all Muslims are Arab American, but the Initiative on Islam and Medicine has a lot of research on the intersection of Muslims and medicine including information on disparities and the experiences of Muslim practitioners:

https://www.medicineandislam.org/mission

April is also Autism Awareness Month, Parkinson's Awareness Month, and Sarcoidosis Awareness Month.

You can learn more about Autism here

You can learn more about Parkinson's here

You can learn more about Sarcoidosis here

Have a favorite article or event of your own? Let us know at newsletter@mahealthdata.org.

Wrapping Up

Before we go, here's a reminder of upcoming health data exchange deadlines including those from ONC and CMS (including the CMS rule that's currently frozen, as noted by *):

2022

JAN 1 PAYER ⟶ PAYER EXCHANGE (OFFICIAL)
NO SURPRISES ACT (NSA) ENFORCEMENT BEGINS
- EMERGENCY SERVICES CLAUSES
- RULES AND PAYMENT MODELS FOR OUT-OF-NETWORK PROVIDERS AT IN-NETWORK FACILITIES
- PATIENT CONSENT REQUIREMENTS FOR SIGNING AWAY OUT-OF-NETWORK PROTECTIONS FOR NON-EMERGENCY SERVICES
- GOOD FAITH ESTIMATES FOR UNINSURED/SELF-PAY PATIENTS COVERING A SINGLE PROVIDER/FACILITY
- DISPUTE RESOLUTION FOR UNINSURED/SELF-PAY PATIENTS
- EXTERNAL REVIEW ELIGIBILITY
- GAG CLAUSE PROHIBITION
- COORDINATION OF CARE CLAUSES (GOOD FAITH EFFORT)
- INSURANCE ID CARDS (GOOD FAITH EFFORT)
- PROVIDER DIRECTORY (GOOD FAITH EFFORT)
- DISCLOSURES, EDUCATION, NOTIFICATIONS, AND PROMOTION (GOOD FAITH EFFORT)

CURRENT ·

APR 1 INCREASING THE FREQUENCY OF FEDERAL-STATE DATA EXCHANGE (OFFICIAL)

JUL 1 INCREASING THE FREQUENCY OF FEDERAL-STATE DATA EXCHANGE (ENFORCED)

OCT 6 INFORMATION BLOCKING USES EHI (NO LONGER LIMITED TO USCDI)

DEC 27 NSA: REPORTING REQUIRMENTS FOR PLAN AND PHARMACY DATA (ENFORCED)

DEC 31 PROVIDER FHIR APIS

2023

JAN 1 NSA: CONSOLIDATED GOOD FAITH ESTIMATES FOR UNINSURED/SELF-PAY CONTAINING ALL PROVIDERS/FACILITIES FOR A SINGLE SERVICE

DEC 31 FULL EHI EXPORT SUPPORT

TBD

NSA: ESTIMATE AND DISPUTE CLAUSES FOR INSURED PATIENTS
PAYER ⟶ PAYER EXCHANGE (ENFORCED)
ELECTRONIC PRIOR AUTHORIZATION *
PAYER ⟶ PROVIDER APIS *
PAYER ⟶ PAYER EXCHANGE OVER FHIR *
PRIOR AUTHORIZATION FEATURES IN EXISTING EXCHANGES *

* CMS RULE THAT'S CURRENTLY FROZEN

And that's it, folks. Loved it? Hated it? Have an idea for next time? Send us feedback and suggestions about this newsletter at newsletter@mahealthdata.org or send us feedback and suggestions about anything else at info@mahealthdata.org.