Massachusetts Health Data Consortium

Newsletter

August 2022

Welcome to the dog days of summer. As I write this, it's been over 90 degrees Fahrenheit and humid for more than a week. Wildfires rage throughout the world. Some of our staff members have experienced power outages and other direct or indirect effects from the heat wave.

Weather isn't something we think much about when looking at health equity, SDOH, and related issues but it can be a factor. Heat and humidity exacerbates many health conditions. So does cold and dry air (sometimes even the same conditions). So can rain or snow or wind or other types of weather. It can also affect food availability and a myriad of other issues that impact health. (Be sure to read Janice's featured article below focusing on one example of health inquiry.)

For example, rain and snow and wind make it harder for people to travel; for people already struggling with transportation issues it can be the difference that nudges someone beyond what they can successfully cope with overcoming. Someone using a walker may not be able to navigate with even an inch of snow on the ground. Someone with back problems may not be able to tolerate walking against the wind. Someone with a visual impairment may not be able to see at all when it's raining. Weather issues can cause childcare plans to fall through which in turn means having to cancel medical appointments or a planned trip to the pharmacy or grocery store. And so on.

People are starting to talk about political determinants of health; there are environmental determinants of health too. Personally, we at MHDC classify all of these issues under the bucket of social determinants of health, but it's important to note that social in this context means societal or society-wide, really any external factor outside of the direct control of the patient. As our understanding of health equity and SDOH grows and we continue to look at how to classify, collect, and exchange data in this area, it's important to be open to a wide variety of different issues that impact it. Weather is more than an irritant; it affects health too.

Denny Brennan, Executive Director

Follow Us

Be sure to follow us on [Twitter](#) and [LinkedIn](#) for live tweeting during industry webinars, insights on relevant news, and our take on interoperability, data, health equity, telehealth, APIs, and other topics of interest!

Upcoming MHDC Events & Webinars

Member Only Events:

Aug 3, 10, 17, 24, 31, 11am-12:30pm DGC Working Group
Aug 4, 9-10am NEHEN Business Users Group
Aug 26, 8:30-10am DGC Steering Committee

Free to the Public:

Aug 11, 1pm
[COVID-19: A Catalyst for Change & How It Could Transform the National Health Data Ecosystem & Health of American Communities](#)

Aug 18, 1pm
[Evaluating Behavioral Health Apps: Insights from 650 apps and 70,000 data points](#)

Sept 08, 12pm
[ClosedLoop.ai: AI=ROI: How AI drives Health Outcomes and Tangible ROI in Healthcare](#)

Sept 13, 11am
[The Vantage Point Series Interview: Larry Garber, MD, Reliant Medical Group](#)

Sept 28, 11am
[Health Equity Tracker: Informing policy, expanding data, and measuring progress](#)

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

Have an interesting topic you'd like to present? Contact us at webinars@mahealthdata.org

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.

Regulations and industry events are still a priority in our working group meetings. We completed an in-depth review of the WEDI Spring Conference that generated a lot of discussion in several interesting areas, most notably AI. As part of this, we spent time looking at different ways people are using AI across the industry, at various ways bias is introduced in AI, how to try to mitigate these biases, and (based on ONC's interest in the topic) possible regulations that could improve the way we develop and use AI. Discussions of FHIR DevDays and the CMS HL7 FHIR Connectathon are still to come, complemented by our weekly quick updates looking at new announcements across the industry. The DGC will also spend time exploring the recently released USCDI v3 and its implications for data standardization and data exchange.

We've decided to put the DGC Deep Dives on hiatus for the summer - we plan to resume them in the fall. 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.

Participation 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

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.

There will be a special Spotlight Analytics demonstration to introduce the Lown Institute data to MHDC members on Wednesday, September 14 at 3pm EDT. Register here.
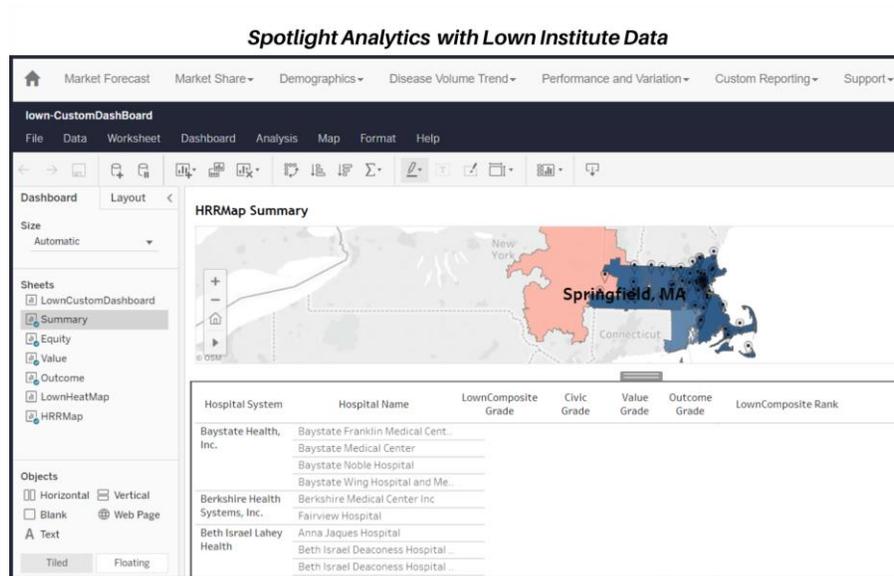
The current data status is:

Received & ready for use soon:

- Lown Institute measures
- Massachusetts Inpatient Visit Data FY21

Coming Soon:

- Massachusetts Emergency Department Visit Data FY21
- Massachusetts Observation Data FY21
- Rhode Island Hospital Inpatient Discharge Data FY21

Future planned data:

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

Please feel free to visit our Spotlight Business Analytics page or email us with any questions or comments at spotlight@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.

NEHEN is happy to announce a new payer relationship with Delta Dental of Massachusetts. Many of our members find being able to verify dental benefits for their patients valuable and, as more integrated care becomes the norm, accessing medical and dental benefits from a single source is ideal for patient care and revenue cycle operations.

Our activity supporting electronic prior authorization (ePA) adoption is firing on all cylinders. Likewise, the regulatory landscape is active in addressing the needs of the industry in support of advancing interoperability and the convergence of administrative and clinical data. We continue to support a prototype implementation of ePA transactions between New England Baptist Hospital and Blue Cross Blue Shield of Massachusetts with transactional and technical support of Olive. We recently engaged Point-of-Care Partners, the Program Manager for the DaVinci HL7 FHIR accelerator, to assist with additional prototypes or demonstration projects using the DaVinci standards.

Concurrently, we continue to collaborate with the Network for Excellence in Healthcare Innovation (NEHI) on their efforts to identify recommendations for the Health Policy Commission. These recommendations will aim to advance ePA adoption in the Commonwealth over the next two years via the use of some combination of state-wide recommendations, regulations, certifications, and technical assistance mechanisms. We agree with the industry at large that the return on investment (as well as other patient, provider and payer benefits) will far outweigh the costs and challenges of adoption over time. We look forward to more engagement with our members on these efforts.

For more information about NEHEN or ePA please contact us at nehen@mahealthdata.org.

Equity and Accessibility Issues with Patient Experience Questionnaires

One of our employees recently received a patient experience questionnaire in the mail. These are the surveys designed to capture, help improve a patient's

impression of their care journey, and make navigating the healthcare experience easier and more successful.

This particular survey may help gather the necessary information to improve the patient experience in healthcare, but only for certain types of patients. Other patients - those with certain medical conditions, certain types of disabilities, who don't read English well, or others the survey administrators want to reach - will likely experience some difficulty completing the survey. Unfortunately, we suspect most of these patients will wind up not participating.

This survey was designed to capture the patient's experience with one office visit with a specific provider. However, there were several barriers that might affect some populations taking the survey.

1. The survey did not come with any instructions or provide options to get further assistance.
2. The survey was written in English (assuming the participants knew English)
3. The survey was dense, multi-columned, used a small font, not printed clearly, and required filling in small bubbles (like a standardized test) to complete
4. How participants answered certain questions might lead them to jump around rather than answer questions in the order presented.

These problems could impact many people. For example, without clear instructions, many may wonder if they need to use a pen or a pencil to fill out the bubbles. However, certain populations, like those with complex and chronic medical conditions, visual disabilities, non-English speakers, or those with fine motor skill difficulties, are certain to experience frustration. In order to be equitable themselves or address health equity issues experienced by patients, surveys must consider all populations in their design and implementation.

Patients with complex or chronic medical conditions

The lack of instructions and the inability to seek help, is a glaring omission for this cohort. The yes/no questions cannot always be answered that way. Guidance on whether to skip these questions, write in answers, choose to use yes or no (when the answer is maybe or sometimes), and so on, enables users to answer in some semblance of a consistent manner. Without clear instruction the resulting data is less consistent and reliable.

This is only the beginning. The first question of the survey asks if you've seen a particular physician within the last six months, without specifying or tying the questions to a specific visit. Many of the later questions then ask for additional information about this visit. This seems simple enough, but factor in the following:

- Patients with complex or chronic conditions have multiple medical appointments every month (or even every week), perhaps with a dozen or more different clinics or offices. Are they supposed to clearly remember an

encounter from six months ago (after 30, 40, 50 other visits) well enough to answer specific questions about it?

- Patients with complex or chronic conditions see certain clinicians frequently. Should they refer to the most recent visit? Use the one they remember best? Use the one where they experienced the most problems? How do they remember each specific visit? Some questions do specifically reference the most recent appointment while others just reference the patient's visit with the named provider (as if there couldn't be more than one in six months).

- Patients with complex or chronic conditions may see both a physician and other clinicians in the same office; often seeing the nurse practitioner more than their physician. Are these visits considered a visit to this doctor for the survey? If not, it may be more helpful to ask the patient about their appointments with the other clinical staff. Those may be more recent, more clearly remembered, and more indicative of the patient's experience in that office.

Later questions in the survey continue to pose problems. For example, there's a question inquiring about whether the patient has seen any specialists in the past six months and, if so, whether the doctor on the survey was familiar with the findings of those visits. It is almost certain the patient has seen multiple specialists in this timeframe and unlikely the answer to the second question is the same for all of a patient's specialists. Given the short length of appointments, even the longer ones given to more complex patients, it's unlikely all of these other visits will be discussed so the patient may not even know whether the physician reviewed most of the relevant specialist visit notes. There's no good way to answer this question. Other questions also assume minimal or homogenous experiences that are unlikely for patients in frequent contact with an office.

Other surveys include a specific visit date; while this may still cause issues, at least a patient receiving those surveys knows the visit they're supposed to evaluate.

Other changes to survey design to support these populations include offering options like "maybe", "sometimes", "periodically", "it depends on X", or being able to write in data. Open-ended questions are not as useful for research as radio buttons, but it would be better to get an accurate response than inaccurate data or no response.

Patients with visual impairments

This survey was not designed to support patients with visual impairments. There was no large print or online version of the form available (although neither of these is an automatic solution; large print standards vary greatly and many websites and online apps are not particularly good about being accessible to people with visual impairments).

The physical design of the survey - using small fonts, bubble fill-ins, and poor overall print quality - can impede involvement. Some people with visual impairment can experience headaches, dizziness, and other debilitating symptoms due to these factors. Taking these into consideration can be the difference between a participant successfully reading or not reading the form, even with available assistive devices.

Speaking of assistive devices, this style of survey (the two-column layout and the logic requiring non-linear progression), is especially difficult for some assistive devices to navigate. Finding the next survey section, when you can't easily visually scan for a particular question number is difficult. Assistive devices generally expect single column text formats.

Making the survey available online may increase the odds that a visually impaired patient will complete the survey. A successful online survey doesn't make assumptions about minimum screen resolutions, display fonts and their size, enforce specific color schemes on users, or disregards browser and computer settings in favor of enforcing a pretty (but unusable interface) on patients Having the option to dictate answers would also help.

Patients with fine motor skills difficulties

Patients with mobility issues in their hands or other restricted fine motor skills could have trouble filling in the small bubbles on the survey. Patients with severe issues could even have trouble holding the form or turning the pages.

Again, open-ended answer options might help, as would being able to note the appropriate answer outside of the bubbles. Having the option to dictate answers would also help here.

Patients who do not read English well

The survey is written in English with no other translations provided in the mailing and no mechanism to request the survey in another language. With an online survey, there are automated mechanisms for translation, but not with a paper survey. Someone with only a basic understanding of English could also have problems with the terminology used. Current recommendations for patient medical information should be written at a fourth-sixth grade level. The more complex the language used, the harder it is for this population to understand.

Offering the survey in different languages should be a no-brainer. If this is expensive, then offer participants an online option or a call-in translation service. Surveys cost money, but if you want accurate results then do your best to ensure equity.

On the subject of accessibility

This survey does not address accessibility in any way. There should be some mechanism to ask this question - even a simple "if applicable, did you encounter any

accessibility issues during your visit?". Ideally, the survey would separate questions exploring physical issues, staff issues, and issues related to the physician. Another approach might be to ask participants if they would be willing to take a follow up survey on accessibility. This would allow a more detailed set of questions to capture specific areas the physician or physician office needs to work on to improve the experience of patients with various disabilities.

The onus is on the patient

Hidden away in the very bottom right-hand corner of the final page are two questions:

1. Did anyone help you with this survey?
2. If so, how?

This last question includes options like "someone read me the survey" and "someone translated the survey for me" so the survey authors know some respondents might not be able to complete the survey as is. However, they put the onus on the patient to overcome the difficulties. Assuming these patients will have someone to help them is presumptuous at best, especially during a pandemic that restricts contact. Many of those likely to have trouble completing the survey on their own are also likely at highest risk for bad outcomes from Covid. They are elderly, disabled, ethnic and racial minorities, patients with co-morbid conditions, etc. These patients often live alone and are still under greater restrictions than the general population. Having someone from outside enter their domain to help them deal with a paper survey (one that can't be handled remotely) is not feasible.

Collecting data from patients about their experiences within the healthcare system should be applauded. But until we do so in a way that is easy and encourages the various underserved populations, the efforts and data are flawed. We must adjust our processes to consider those who are most likely to encounter difficulties and who need the current status quo to change.

Industry Events

Webinars and online conferences we recommend (they're free unless otherwise noted):

- [AHIP: How Insurance Providers Can Address Post Acute and Home Healthcare Challenges](): Aug 3, 1pm
- [ONC: EHI Sharing Workshop](): Aug 4, 1pm
- [AHIP: Prioritizing Health Equity to Close Gaps in Care](): Aug 5, 1pm
- [ONC: Workshop on eConsent](): Aug 16, 12pm

- [AHIP: Digital Transformation: Adoption and Impact on Payers](): Aug 19, 11am
- [Beckers: AI Technology That Is Transforming Imaging](): Aug 23, 1pm
- [DaVinci: Community Roundtable](): Aug 24, 4pm
- [AHIP: The No Surprises Act, Transparency, and You](): Aug 30, 12pm

We periodically tweet out additional webinars we plan to attend, so feel free to follow our Twitter account [@mahealthdata]() for more webinar ideas and for our take on interoperability, data, health equity, telehealth, APIs and other topics of interest.

Regulatory Deadlines

Don't forget these health data exchange deadlines, including from ONC and CMS:

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)

APR 1

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

JUL 1

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

PAYER PRICE TRANSPARENCY (ENFORCED, PRE-NSA)

CURRENT ·

OCT 6

INFORMATION BLOCKING USES EHI (NO LONGER LIMITED TO USCDI)

DEC 15

ONC ANNUAL REAL WORLD TESTING PLAN DEADLINE

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

MAR 15

ONC ANNUAL REAL WORLD TESTING RESULTS

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 at info@mahealthdata.org.