



Massachusetts
Health Data
Consortium

May 2022 Newsletter

Moving into the brave new world of data standardization and interoperability is challenging but important. No one promised anything would be easy and, of course, it's important to keep the lights on. We must continue using existing processes and mechanisms as we move toward new ones. That doesn't mean we can let inertia win. We must move forward.

This involves new technology, new ideas, and doing things in new ways. It's not just about understanding the data and the software, you also have to understand how to implement new processes and workflows that take advantage of the data and the software needed to collect, improve its quality and consistency, and exchange it.

One key part of this is making sure the right hand is talking to the left hand in your organizations. Data isn't the only thing that gets siloed. Expertise gets siloed. Knowledge of implementation plans gets siloed. Information about new technology capabilities gets siloed. Many of the things we want to accomplish as an industry build on each other, each one getting easier after the previous one is implemented. The FHIR support needed for Patient Access APIs gets you most of the way toward the data exchange needed for Payer => Payer data exchange over FHIR and much of the way toward exchanging clinical data needed for many other purposes. It's all based on USCDI v1 support, sometimes with a few tweaks or additions. Once that's in place anywhere within an organization it can be used as the basis for doing more things - adding additional data to exchange, adding additional purposes for data exchange, adding additional exchange partners. We're creating a set of building blocks and it's not helpful if block 1 is locked away in a quality department, blocks 2 and 3 in a patient or member experience team, and blocks 4 and 5 in a care management group. All of these groups can do more, do it better, do it faster, and do it more efficiently if they all know that blocks 1-5 exist and are available to build upon further.

Obviously it's a bit more complex and there are all sorts of other process issues to address (one that immediately comes to mind is resistance to change) but the core idea stands. Let's all talk among ourselves, to each other, and figure out how to do all of this exciting (but difficult and sometimes scary) stuff together.



Denny Brennan, Executive Director

PS We got quite a bit of feedback from my last welcome message indicating that it's one thing to lay out issues around SDOH data and its collection and quite another to solve them. Per your request, we're providing some of our thoughts on things we can actually do about it in this month's feature article below. As always, we look forward to your feedback and thoughts on this message, our feature article, or any of the other content we provide.

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 May:

- DGC Deep Dive: Allergies: May 19, 2-4pm
- DGC Working Group: May 4, 11, 25, 11am-12:30pm
- DGC Steering Committee: May 11, 3-4:30pm
- NEHEN Business Users: May 5, 9-10am
- The Automation Advisory Group (TAAG): May 10, 1-3pm
- Webinar: MHQP: May 12, 1-3pm

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

MHDC Webinars

Join us for our upcoming webinars:

[What Patients Are Saying: Insights About Primary Care From MHQP's Statewide Patient Experience Survey](#) presented by MHQP on May 12 from 1-3pm.

For those of you interested, our first June webinar is coming up closely behind:

[Designing a Digital Clinic for Behavioral Health: Equity, Access, Workflow, and Technology Considerations Pt. 1](#) presented by BIDMC on June 1 from 1-3pm.

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.

We held our most recent deep dive on family history on April 6. We had a wide ranging discussion of different types of family history data, how it gets collected, privacy and consent issues, and how family history data is used in prior authorizations. Our next deep dive on allergies will be held on May 19 at 2pm. This 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 been spending some time going back to our roots in quality measures, both in terms of evaluating the current MHDC Quality Measures specification and looking at developments and announcements from NCQA and CMS. 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.

Work is moving forward on the ePA project and normal NEHEN business. Meanwhile, we are encouraged by the letter from NCVHS (National Committee for Vital Health Statistics) to CMS on March 30th with their recommendations for advancing interoperability and the adoption of rules to support electronic prior authorization. This letter included 4 recommendations:

- Recommendation 1: Publish the CMS Interoperability and Prior Authorization proposed rule, which includes the HL7 FHIR standard to support Application Programming Interfaces (APIs) to automate payer and provider prior authorization workflows.
- Recommendation 2: Adopt a standard or standards for electronic attachments as soon as possible to meet today's business needs.
- Recommendation 3: HIPAA transaction rules notwithstanding, evaluate and adopt regulatory flexibility strategies to permit HIPAA Covered Entities to

implement new technologies such as FHIR standards and implementation guides (IGs).

- Recommendation 4: Streamline the process for adopting HIPAA transaction standards so that it is reliable, efficient, and timely

To say that we whole heartedly support and applaud these recommendations is an understatement. We hope that CMS acts on these recommendations without delay. We look forward to following and participating in additional industry activity around ePA including those resulting from these recommendations.

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 May? Here are some we recommend (they're free unless otherwise noted):

- [AHIP: Drivers, Challenges, and Opportunities in Value-Based Care](#): May 3, 1pm
- [Beckers: The evidence for value-based care: What's succeeded and what's failed](#): May 3, 2pm
- [PBMI: Benefits of Digital Technology and Artificial Intelligence in the PBM Market](#): May 5, 12pm
- [AHIP: Accelerating Virtual Care Adoption: Models for Success](#): May 9, 2pm
- [Beckers: Digital maps and patient apps — Real-world insights from UCHealth's patient journey transformation](#): May 11, 2pm
- [AHIP: Study Findings on Industry Trends, Challenges, and Priorities for 2022](#): May 17, 1pm
- [Fierce: How Payers Can Automate Prior Authorization at Scale with AI](#): May 17, 2pm
- [Fierce: How to Measure and Drive Impact on Health Equity](#): May 19, 12pm
- [WEDI: Spring Conference](#) (fee): May 23-26
- [Beckers: What's next in Remote Patient Monitoring: 3 health systems discuss revolutionizing care at home](#): May 23, 1pm
- [Beckers: How the future of big data and precision medicine will impact cancer care](#): May 24, 12pm
- [Fierce: AI's Role in Managing Chronic Disease](#): May 24, 1pm

- [Beckers: Consumerism: The Heart of Healthcare](#): May 25, 12pm
- [Beckers: How technology can help solve the healthcare affordability crisis](#):
May 25, 1pm
- [DaVinci Community Roundtable](#): May 25, 4pm

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.

Taking Steps Toward a Successful SDOH Program

Last month, we raised questions about the value and difficulty of collecting social determinants of health (SDOH) data. This is sensitive and personal data from patients who may be reluctant to share and suspicious of how the data will be used. We also cautioned against making false inferences from location and disability data. Lastly, we discussed how enterprise electronic medical records, or EMRs, are permanent, siloed, and difficult for patients to amend, revise, or augment to reflect their health status correctly and reliably.

Several of you wrote back and asked for more guidance on how SDOH data can be ethically and adequately collected, stored, and shared to support programs that can assist patients whose needs go beyond those the medical system meets. We are grateful that people are interested in our thoughts and a little daunted by the challenge of approaching something this complex, but here are some ideas to get you started.

While we can discuss what is required in the future to implement SDOH at scale, in this article, we have chosen to focus on a more tangible, near-term approach to the SDOH process.

We have organized this process into four steps:

1. Set limited near-term goals meaningful to patients or members with unmet needs.
2. Identify what you need to know to achieve those goals.
3. Ask for the necessary SDOH information in practical, clear, and appropriate ways.
4. Deliver and communicate progress in achieving your goals

We'll look at each step below.

Set meaningful and limited near-term goals.

The accommodations and programs required to meet the needs of patients who suffer, or have suffered, from social injustice, homelessness, food insecurity, lack of mobility, disability, loneliness and isolation, and a host of other ills that limit their access and effective use of health care are numerous, complex, and costly. While well-meaning healthcare organizations might strive to do as much as they can to address these disparities, the best place to start is not to collect as much SDOH data as one can about the populations they serve but rather to define a limited set of goals that the organization would like to achieve over the near-term.

In setting limited goals meaningful to some, but not all, patients who are adversely affected by SDOH, healthcare organizations acknowledge that an agile and iterative approach is in the best interest of all their disadvantaged patients. Better stewardship of the limited resources available for these programs improves the likelihood that money will not be wasted on more extensive, more time-consuming, and less well-defined programs. Nearer-term success generates momentum for continued improvement and investment and improves the organization's knowledge and expertise in extending and expanding SDOH-related initiatives.

What are examples of these meaningful, limited goals? Improved access to health services is broad and challenging to implement as a goal. Does it refer to improved access to facility-based care or virtual care? Does it refer to inpatient or outpatient services? A much narrower and more likely goal might be to improve access for patients to telehealth services, including audio telehealth. It might be narrowed further to improve access to audio telehealth services for patients who face obstacles accessing and using the technology required for telehealth video visits.

Identify the SDOH data you need to achieve these goals.

SDOH span a vast amount of data. Most of this data is of little use when making tangible progress at an organizational level with specific accommodations that improve a socially disadvantaged person's healthcare. SDOH as defined are in their infancy. The primary policy and standards-setting organizations are adopting a top-down approach, starting with the broad domains of social inequities, and deriving data elements whose collection will inform efforts to improve those inequities. The US Department of Health and Human Services, the World Health Organization, and HL7's Gravity Project have defined different SDOH domains. None have identified specific programs to support these domains, and the definition of data elements is only just starting. For organizations eager to implement meaningful improvements for disadvantaged patients, these top-down approaches offer little practical guidance.

To identify the data needed to meet specific SDOH goals, organizations need to focus on things they can implement to improve healthcare for those who will benefit most from them (such as our audio telehealth example). Keeping one eye on the

evolving standards for SDOH while implementing focused initiatives is a more practical and actionable approach.

In planning a data collection effort, one should require clear, actionable definitions for each element of data needed and understand how it informs a program designed to achieve the defined goal. Less data means more concise and targeted questionnaires. These questionnaires can be more easily used in various settings, including before our illustrative telehealth call when a poll asking critical questions can be administered.

Ask for needed data in practical, clear, and appropriate ways.

The best way to collect SDOH data is to ask the patient or member rather than infer it from geographic, social, or medical data. For example, do not assume that patients who take a particular medication or have a specific test have a particular condition that you need to address - not everyone who takes Metformin has diabetes, not all folks who are vision-impaired want or need audio telehealth.

To continue our telehealth example, one needs to prepare a succinct and easily understandable explanation, in the patient's spoken language, of why the patient or member is being surveyed (and how the collected data will be used, stored, and exchanged). Once they understand why, ask each of them which visit type they prefer (in-person, video, or audio telehealth), their scheduling preferences, their willingness to speak to a non-physician professional (if appropriate), and no more than two or three additional questions. Each question should be preceded by a brief and intuitively comprehensible explanation of the question, why it's important to ask, and how the answers will be used.

Do what you said you would do and share your progress with the affected patients or members.

Once you have collected the data essential to implementing a program to support patients or members who need it, set a baseline detailing your status concerning the related offerings. Track your organization's progress in making these options increasingly available to the individuals who need or want them. Revisit your progress with those folks who helped you in your data collection efforts and ask how well the new programs are (or are not) meeting their needs. In addition to accessing progress, these outreach efforts engage patients and members who recognize that their needs are essential to the organization and that their opinions and insights are valued and accepted.

Summing Up

Before we look to collect everything under the sun related to SDOH and exchange all this data among a large group of folks inside and outside of the traditional healthcare system, we need to put practices into place to guide the more extensive data journey. Start small, then expand to larger projects. This builds respect for the sensitive nature of this data, understanding that not everyone with a particular issue

is the same, and respect for those differences while modeling behaviors that reflect your patients and their many needs.

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)

APR 1

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

CURRENT

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 REQUIREMENTS 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.

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