Welcome

We will begin at 2 minutes past the hour

EHRA HIMSS ELECTRONIC HEALTH RECORD ASSOCIATION

How to Participate

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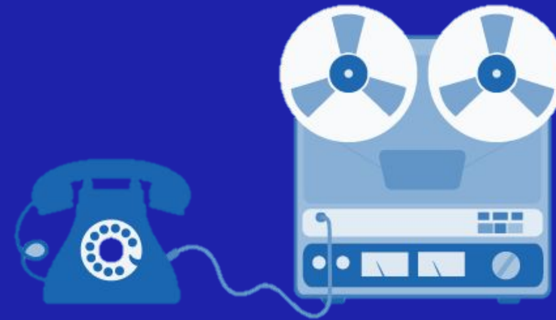
Will this webinar be recorded?

Yes! The recording will be available on EHRA's website: ehra.org



You will receive an email with notes, slides, and a link to the recording once it is finalized.

EHRA HIMSS ELECTRONIC HEALTH RECORD ASSOCIATION

Health Equity & Social Determinants of Health

Virtual Congressional Briefing
September 27, 2021

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Health Equity & Social Determinants of Health

Hans Buitendijk, M.Sc., FHL7, Cerner

Chair, Electronic Health Record Association

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Current Members

EHRA Makes A Difference

Who We Are

- Nearly 30 EHR developers
- 16 Years Strong and Counting
- HIMSS Corporate Members
- Market commercially-available products
- Represent the majority of EHR users in the U.S.
- EHR companies of all shapes, sizes, and specialties
- Committed to collaborating on issues that collectively impact member companies and customers

What We Believe

- Collaboration with stakeholders is critical
- EHR adoption is essential to improve the quality of patient care
- EHRs are a key enabler of healthcare transformation
- We foster safe healthcare delivery and innovation
- We must operate with high integrity in the market
- We are committed to users, patients, and families

The EHR Association's core objectives focus on collaborative efforts

Accelerating health information and technology adoption

Advancing interoperability

Improving the quality, safety and efficiency of care through the use of EHRs

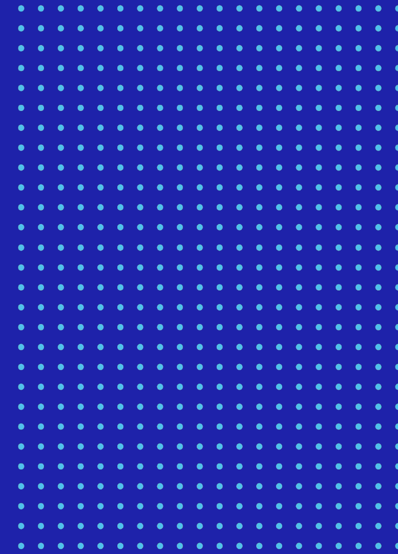
Together We:

- Advance the EHR industry as a whole
- Accelerate safe adoption of EHRs
- Provide collaborative forum for EHR developer community
- Increase value to healthcare organizations and patients
- Improve healthcare quality and productivity

Today's Agenda: Discussion of SDOH and Health Equity

1. The Developer Perspective
   - Janet Campbell, Vice President R&D Relations, Epic / PPL Workgroup Chair, EHR Association
2. The Community Perspective
   - Katie Adamson, Vice President, Health Partnerships & Policy, YMCA of the United States
3. The Ambulatory Perspective
   - Sarah Holder, Clinical Director, Raleigh Pediatric Associates
4. The Health System Perspective
   - Seraphine Kapsandoy, PhD, RN, Chief Nursing Information Officer, Intermountain Healthcare
5. Audience Q&A

SDOH & Health Equity Remarks



Leigh Burchell
Allscripts
Public Policy Leadership Workgroup Chair

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The Developer Perspective

Janet Campbell
Epic

The current landscape:

organizational maturity, successes, and opportunities

And how EHRs help

Understanding equity relies on data.

- Race, ethnicity, and language
  - **Collection is supported in EHRs today, but adherence is variable**
  - **Multi-racial individuals are not consistently represented**
- Sexual orientation, gender identity
  - **Standards are emerging, adherence is variable**
- Traditional health-related social determinants
  - **Alcohol, tobacco, substances**
  - **Collection is standard, documentation is consistent**
  - **Information can be exchanged**
- Other social determinants
  - **Transportation, housing, intimate partner violence**
  - **Standards are emerging but nascent**

Data collection

1

Recommendation: Incentivize data collection and stratify existing quality program reporting to determine program equity.

Partnering with social care in the community

Data collection

Social programs exist, but closing the loop is difficult.

- Finding applicable programs
  - What services exist in the area? Organizations typically don't know.
  - Third party program directories can fill the gap.
- Referring patients electronically, closing the loop
  - Technically possible, but extremely rare
  - Emerging standards (360X, FHIR APIs) will help, but...
  - Social programs are distributed, underfunded, and rarely have interoperable data technologies.
  - The free market will likely not advance this landscape
  - Privacy questions remain

2

Recommendation: Support social programs in purchasing and using interoperable technology.

Creating and administering social programs

Partnering with social care in the community

Data collection

Some organizations are bringing social care in-house.

- High-risk patients require high-touch care
  - Programs (goals, targets, and KPIs) can be created in the EHR.
  - Patients are enrolled and progress is tracked.
  - Requires staff, time, and funding
  - Funding: state and federal grants, Medicaid
- Program examples
  - Post-prison counseling, substance abuse programs
  - PACE, elderly services
  - Food pharmacies
  - Assertive Community Treatment (ACT)

3

Recommendation: Investigate federal reimbursement for case management and care coordination services.

How Congress Can Help

1

Data Collection and Reporting

- **Incentivize** consistent and complete data collection.
- CMS and other quality programs should **stratify existing quality reporting** by race, ethnicity, and language.
- Support **standards development** for collecting and exchanging data.

2

Working with Community Programs

- Support and fund community programs so they can purchase, implement, and use **interoperable technology**.
- Support standards for SDOH exchange, like **HL7's Gravity Project**.
- Work with HHS and others to clarify what data can be exchanged with community programs under HIPAA.
- Reimburse social care where it takes place, including coordinating activities by healthcare providers.

3

In-house Social Care by Healthcare Organizations

- Study successful programs for **lessons learned**.

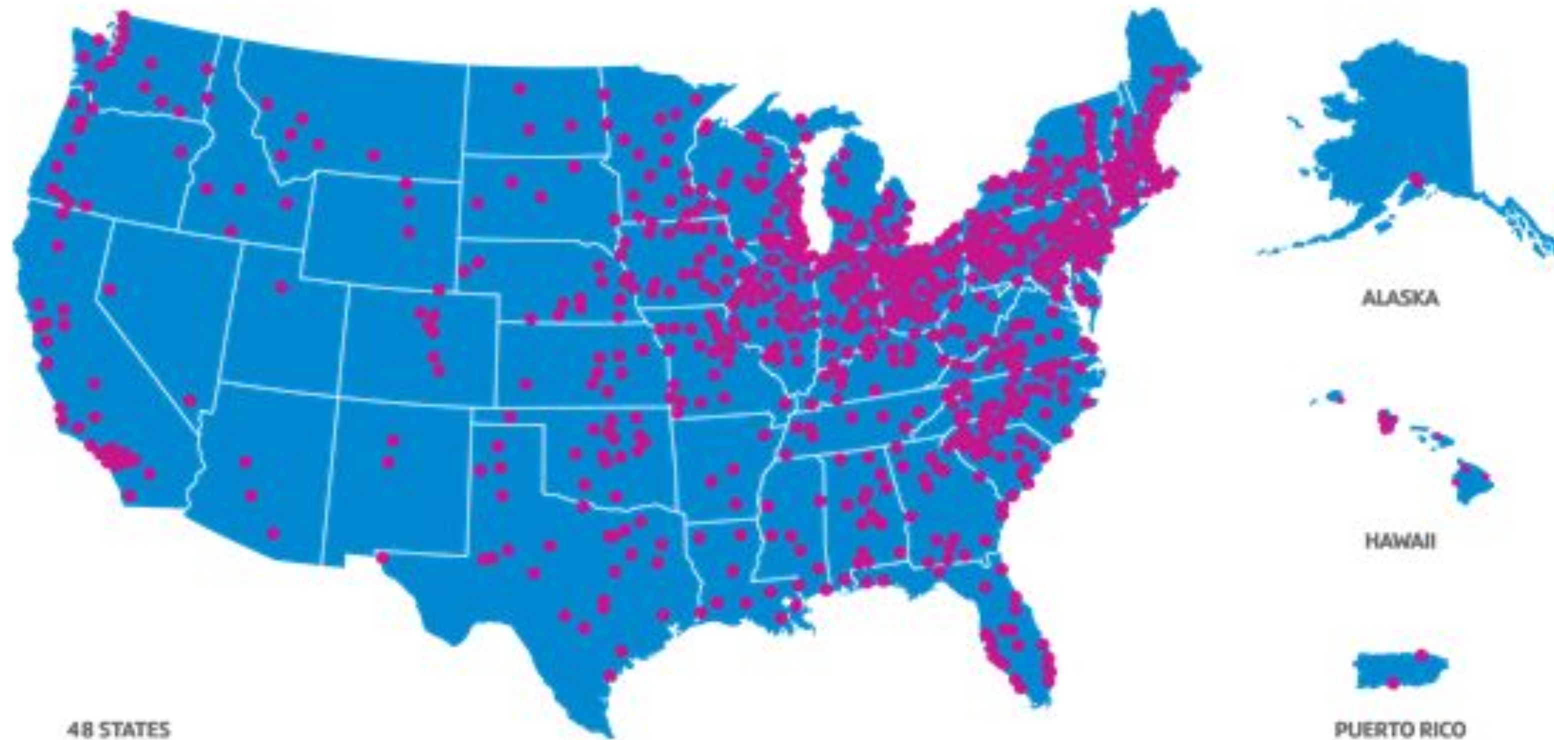
The Community Perspective

Katie Adamson

YMCA of the United States

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

THE Y AS A COMMUNITY HEALTH PARTNER ON SOCIAL DETERMINANTS OF HEALTH



- Y reaches 10,000 communities
- 2700 branches
- State and regional alliances
- Serves 22 million, including 8 million kids
- 80% of US households within 10 miles of a Y

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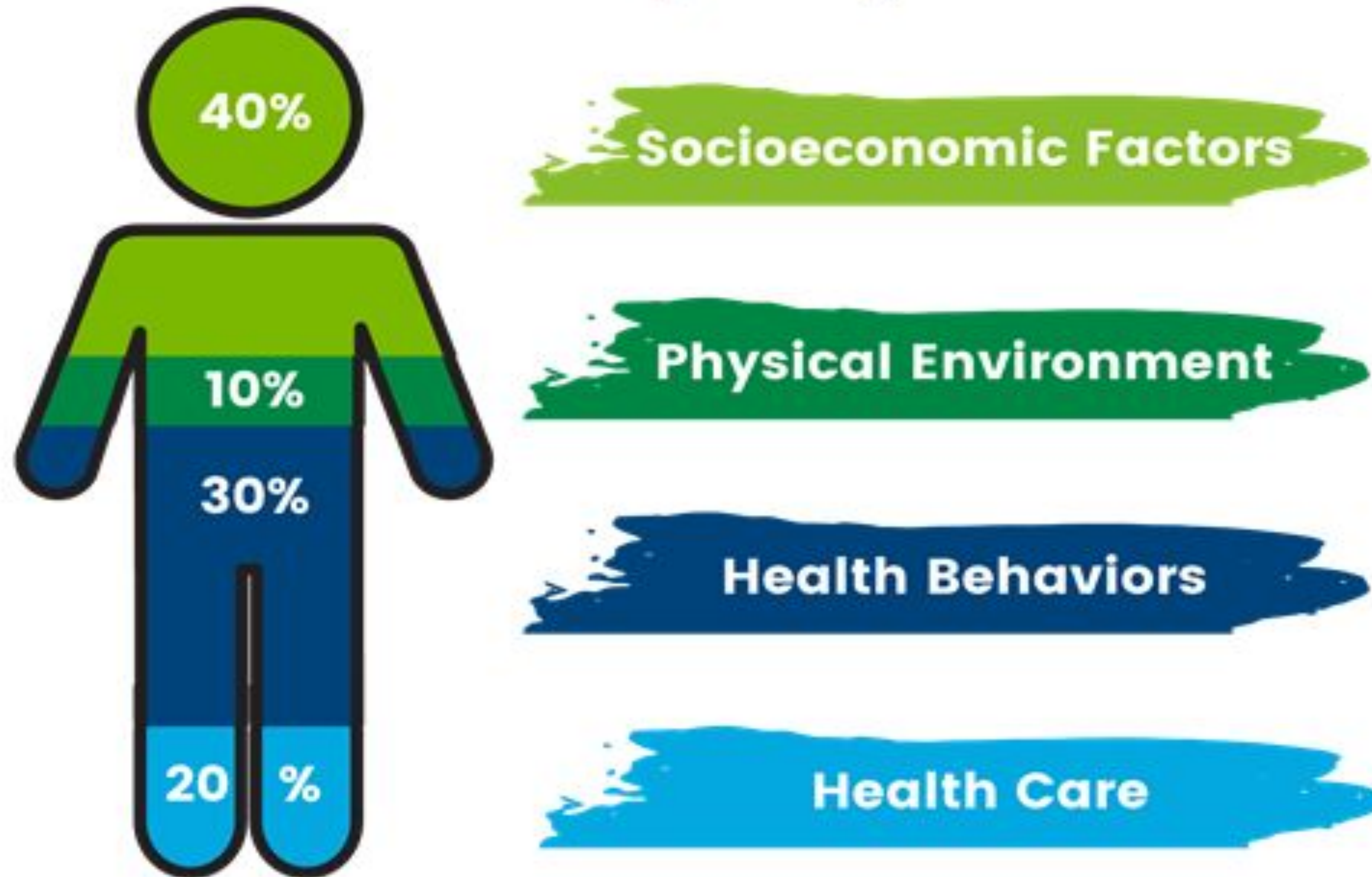
HOW THE YMCA'S COMMUNITY HEALTH APPROACH IS WORKING TO IMPROVE HEALTH OUTCOMES FOR ALL



THE Y ADDRESSES SOCIO-ECONOMIC FACTORS - 40%

YMCA Work that Focuses on Socioeconomic Factors:

- Closing the Achievement Gap
- Providing Afterschool and Early Childhood Education
- Serving as a large employer, including a youth employer
- Feeding hungry kids and families to address food insecurity
- Providing family social support / connectedness for youth and adults
- Advancing safe environments/community and child safety to prevent Adverse Childhood Experiences
- Preventing drownings/injuries with Safety Around Water programs

Socioeconomic Factors

Education

Job Status

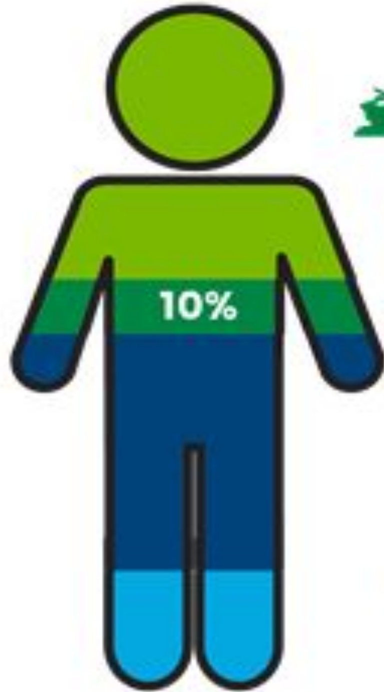
Family/Social Support

Income

Community Safety

3

THE PHYSICAL ENVIRONMENT - THE HEALTHIER COMMUNITIES' INITIATIVES - 10%



Physical Environment

YMCA Work in the Physical Environment

- Advancing Healthier Community Strategies (Adopting Healthy Eating Physical Activity Standards, Increasing Farmers Markets, Community Gardens, Trails, Safe Walking and Biking to School Programs, Healthy Schools Policies – PE, Recess, Healthy Lunches)
- Advancing Policies at the Local, State and Federal Level to Improve Community Walking and Biking

HEALTH BEHAVIORS – 30%

YMCA Work Addressing Health Behaviors
Delivering Evidence-Based Health Interventions (EBHI) that Drive Healthy Behaviors to Prevent and Control:

- ✓ **Diabetes** – YMCA's Diabetes Prevention Program
- ✓ **Hypertension** - Blood Pressure Self Management
- ✓ **Arthritis** - Enhance®Fitness / Walk with Ease
- ✓ **Cancer** – LIVESTRONG at the YMCA
- ✓ **Obesity** – Healthy Weight and Your Child
- ✓ **Falls** – Moving for Better Balance

Health Behaviors

Tobacco Use

Diet & Exercise

Sexual Activity

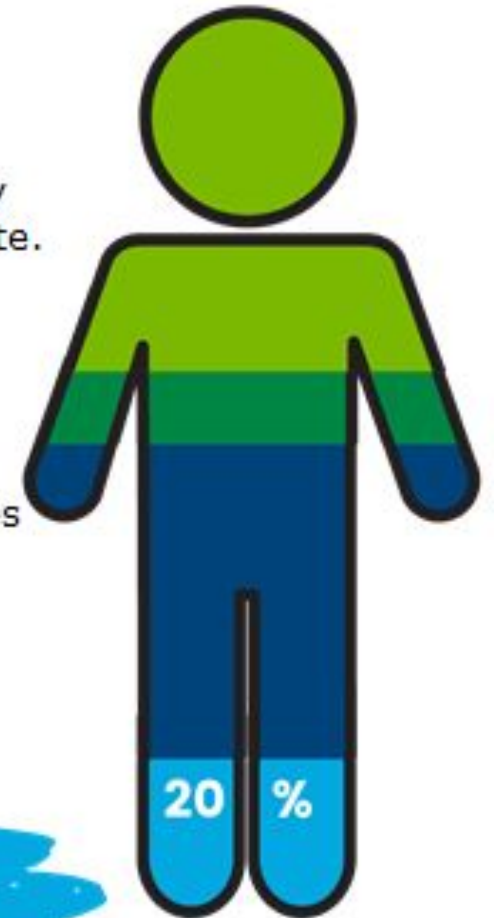
Alcohol Use

5

ACCESS TO HEALTH CARE – 20%

YMCA Work with Health Care

- Working with **private and public payers to improve health outcomes with EBHIs** (Diabetes, Hypertension, Arthritis, Cancer, Childhood Obesity) and Medical Membership Models (EBHIs plus Health Coach plus Y Membership) at the Y. In many states Ys are using shared service agreements with other Ys to serve the whole state.
- **Partnering with State Health Departments to scale EBHIs** with funding the states receive from CDC and addressing health disparities in chronic disease and injury
- **Co-Building facilities and sharing space** with Health Care and other providers addressing socioeconomic factors
- **Working to build systems to support referrals** for health outcomes and services to address social needs between health care providers and the community
- Training community organizations to conduct **health detailing** for lifestyle health programs and social support services
- Exploring how the Y can contract to provide Special Supplemental Benefits to the Chronically Ill (SSBCI) in **Medicare** which address social determinants



Health Care

6

How Congress Can Help

1. *Support funding for multi-sector SDOH partnership both at CDC and CMS/Medicaid*

2. *Pay for lifestyle health, social connectedness, transportation, food and more in Medicare and Medicaid and work with existing partners in the community providing these services.*

3. *Whatever technology is designed to refer to social services and pay for those services must be available and accessible to community-based organizations and designed with them in mind and at the table*

The Ambulatory Perspective

Sarah Holder, RN
Raleigh Pediatric Associates
North Carolina

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RALEIGH
PEDIATRIC
ASSOCIATES

Developing a Social Needs program in an independent physician practice

- Standardize screening questions - assessed best practices
- Narrow domain focus based on patient population
- Build a resource list - picked up the phone and used state resources
- Utilize existing technology assets - EHR, consumer-facing apps
- Physician buy-in is critical
- Sustainability in mind, adjusting as we go

Blog Post on our work: https://bit.ly/39wW7gg

How Congress Can Help

1

Provide funding *for community resources*

- Grants, loans, education expenses, direct program funds at the local level

2

Incentivize *primary care to screen and coordinate connections with community resources*

- Reimbursement for screening tools / time and staff resources: should not be applied to patient responsibility but covered automatically as preventive care
- Incentives to practices to incorporate SDOH into daily activities

3

Require *better payer coverage of mental health services*

- Reduce out of pocket expense and barriers to seeking mental health services

The Health System Perspective

Seraphine Kapsandoy, PhD, RN
Intermountain Healthcare

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EHRA Health Equity & SDOH Virtua Briefing

September 27, 2021

Seraphine Kapsandoy, PhD, RN
Chief Clinical Information Officer

Intermountain Healthcare Scope & Stewardship

25*Hospitals
*One Virtual Hospital

6 States, plus Alaska
525,000+ Virtual Interactions

225
Physician Clinics

42,000
Caregivers

900,000
SelectHealth Members

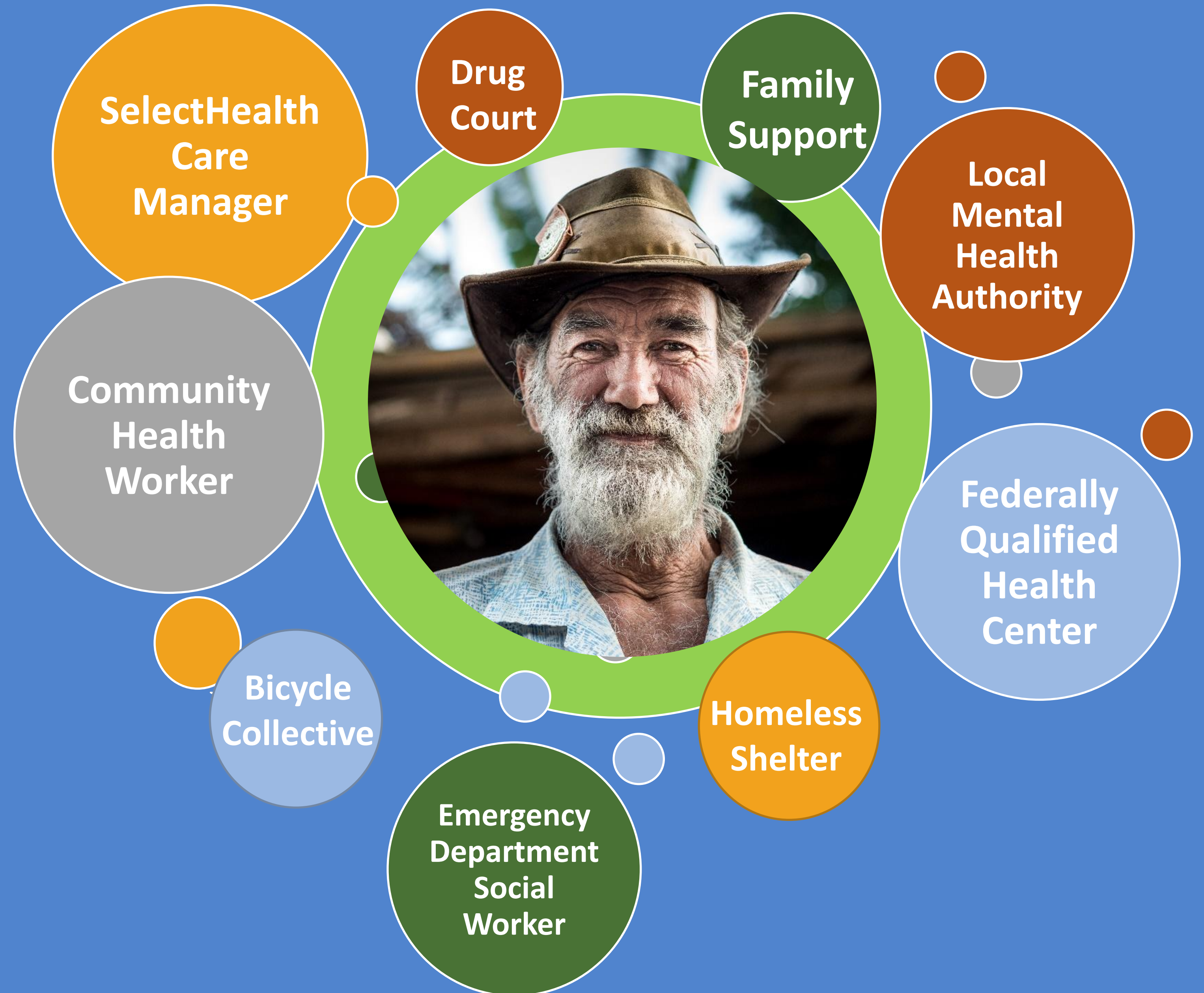
$225M
Charity Care

50% of Utahns Receive Services Annually

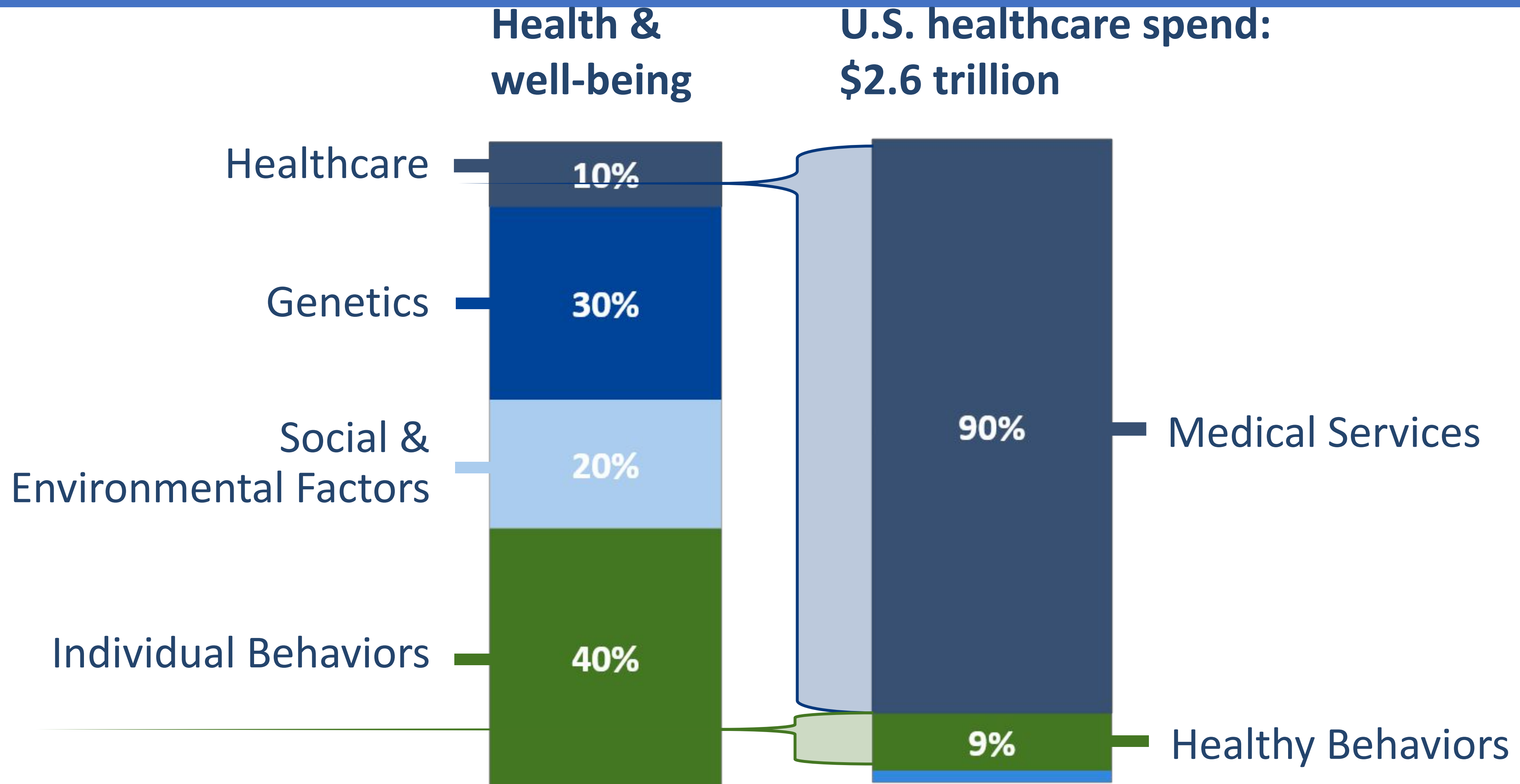
10,000+ Enrolled in Student Placement Programs Annually

$2.7B Annual Supply Chain Spend

The Alliance for the Determinants of Health



Mismatch Between Drivers of Health and Spending



Intermountain Healthcare

Barriers and Opportunities

Value Based Reimbursement

- Models that include community health workers and other roles focused on social needs
- Services rendered from community-based organizations
- Coding and provider reimbursement for clinical social care

Interoperability & Regulations

- Interoperability to share social and insurance data in real time
- Flexibility within STARK, patient inducement, and member recruitment regulations that impede social care assistance
- HIPAA requirements for social care referrals on patient's behalf
- National master person identifier

Funding & Rewards

- Rural communities addressing resource gaps (housing, transportation)
- Waivers that support innovation and best practices for social care
- Funding for costly technology that supports social care coordination
- Value based social care reimbursement models for providers, states, health plans, or a combination of these organizations

Panelist Discussion

David Bucciferro, Moderator

Foothold Technology

Katie Adamson

YMCA of the United States

Janet Campbell

Epic

Sarah Holder

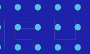
Raleigh Pediatric Associates

Seraphine Kapsandoy

Intermountain Healthcare

Thank you!

Please reach out to knicholoff@ehra.org with questions following today's call.



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