Nov 1, 2018

The Role of Health Information Exchanges in Advance Care Planning and Social Determinants of Health

Rhode Island Quality Institute

Today's Objectives

1. Understand the value of leveraging a Health Information Exchange (HIE) for Advance Care Planning (ACP) and Social Determinants of Health (SDOH) assessment
2. Understand the capabilities of Rhode Island's HIE for collecting and disseminating ACP and SDOH information
3. Learn about a pilot initiative where these capabilities and technology are being tested in a real world setting.

Do You Know Me?

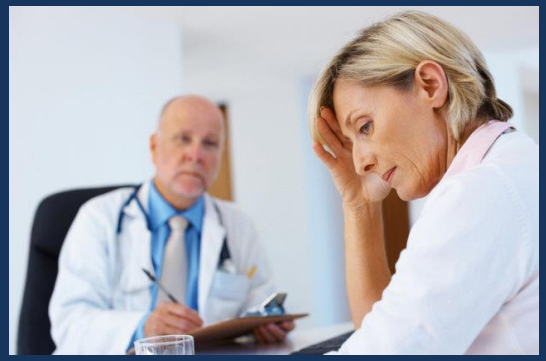
- Do you understand my wishes for when I am at the end of my life?
- Do you know what is important to me?
- Do you know about the struggles that I have to make ends meet, to get a ride to your office, to feed my child?
- Do you know that I feel alone and disconnected?

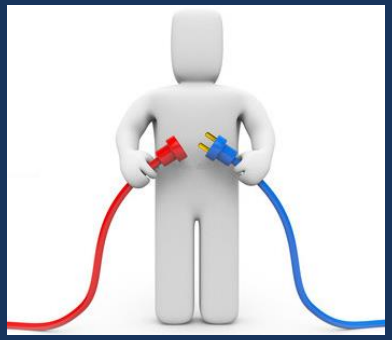
Value of Knowing End of Life Wishes

- Reduces unnecessary pain
- Reduces unhelpful procedures
- Reduces unwanted hospitalizations
- Gives loved ones peace of mind
- Minimizes stress
- Reduces potential conflicts among family members

The Challenges

- Social stigma and cultural norms
- Having the “conversation” is difficult and requires education and training
- Availability of the most current advance directive across the entire healthcare system





Value of Knowing Social Determinants

Providers:

- Recognize social factors that influence health to develop more effective treatment plans
- Address social needs through appropriate referrals to ensure adequate support

Community:

- Develop health promotion strategies that reach into communities to improve living conditions
- Conduct or support ongoing research to determine which strategies may be most effective in improving health outcomes.

The Challenges

- Social stigma and cultural norms
- Untrusted or unknown referral network to social services
- Data collection manual and not integrated
- Lack of standardized data
- Availability of the most current patient SDOH information across the entire healthcare system

How Can HIE's Help?

- Connected and centralized healthcare information database already in place
- Provide a variety of integration and sharing paths
  - EMR integration to the HIE
  - Patient generated data input through web interface
  - Provider web access to HIE
  - HIE pushing data to EMR's
- Normalize the data
- Make available for public health and research purposes

HIE Examples Nationally

End of Life Planning

- Maryland - CRISP
  - My Directives.com collaboration
- Michigan – Great Lakes Health Connect
  - Making Choices Michigan
- Virginia – Connect Virginia
  - Virginia Advance Health Care Directive Registry
- New York- Healthix & Excellus
  - eMOLST Registry

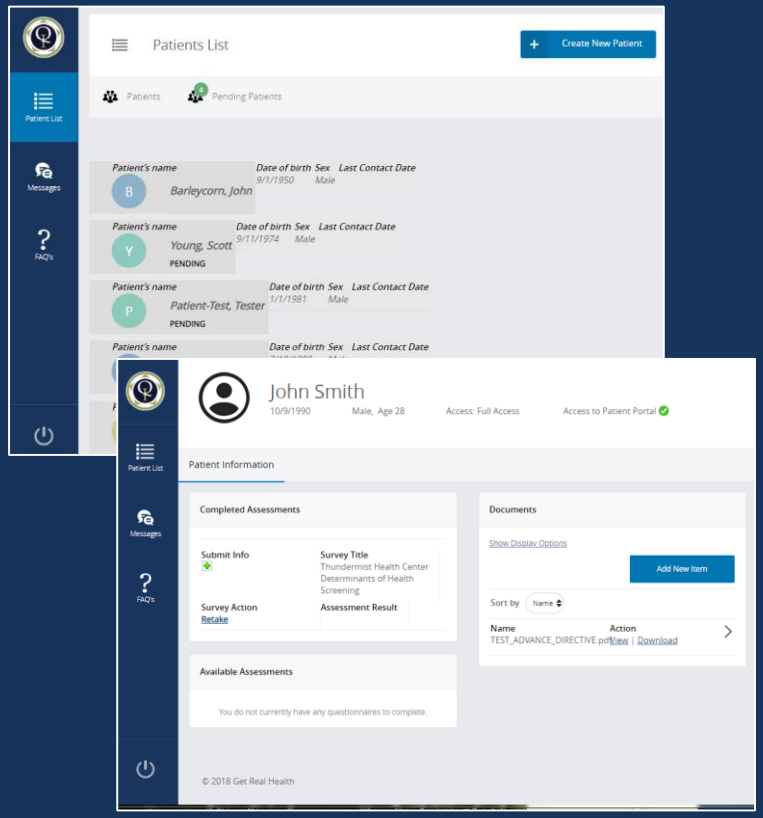
SDOH

- San Diego Health Connect & 2-1-1 San Diego
- Texas – HASA
- Michigan – Great Lakes Health Connect
- Maryland – CRISP
  - Health EC collaboration

Rhode Island HIE Initiatives

Consumer Engagement Platform Pilot

- SIM funded pilot initiative to promote advance care planning and assessments of health
- Ability for patients and providers to upload Advance Directive documents that connect to CurrentCare through a web interface
- Ability to create forms for collecting patient information such as SDOH, satisfaction surveys, and other health assessments that connect to CurrentCare
- Provider collaborative to test the platform in real world settings
- Launch in late November



Rhode Island HIE Initiatives

Social Determinants of Health

- Neighborhood Risk Score in Alerts
- SDOH online assessment tool
- Central and normalized SDOH database
  - Connected to CurrentCare (future)
- SDOH integration into CurrentCare (future)
- SDOH sift and serve applications (future)

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