Health IT Advisory Council

September 17, 2020

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Agenda

Agenda Item	Time
Welcome and Call to Order	1:00 PM
Public Comment	1:05 PM
Review and Approval of Minutes – August 20, 2020	1:10 PM
Connie Update	1:15 PM
State Health IT Plan Discussion	1:25 PM
Advance Directives Discussion	1:45 PM
Health Equity Data Analytics Project Update	2:15 PM
Announcements & General Discussion	2:45 PM
Wrap up and Meeting Adjournment	3:00 PM

Welcome and Call to Order

Public Comment

(2 minutes per commenter)

Review and Approval of:

August 20, 2020 Meeting Minutes

Connie Update

Allan Hackney

HIT Strategic Plan: Introduction

Terry Bequette, CedarBridge

Health IT Strategic Plan - Background

Statute Requirement:

Implement and periodically revise the state-wide health information technology plan and establish electronic data standards to facilitate the development of integrated electronic health information systems, for use by health care providers and institutions receiving state funding.

Additional requirements:

- Include provisions relating to
  - Security and Privacy
  - Data content
  - Structures, Format, Vocabularies
  - Transmission protocols
- Social Security number restrictions
- Electronic audit trail
- Compatible with national data standards
- Permit collection of health information
- Compatible with requirements for an EHR

- Develop the plan
  - Implement it
  - Re-visit and revise as needed
- Emphasis of statute is on standards to support interoperability and support the collection of health information
- Additional emphasis will support Connecticut priorities including Primary Care Transformation, Public Health Modernization, Opioid Crisis, others

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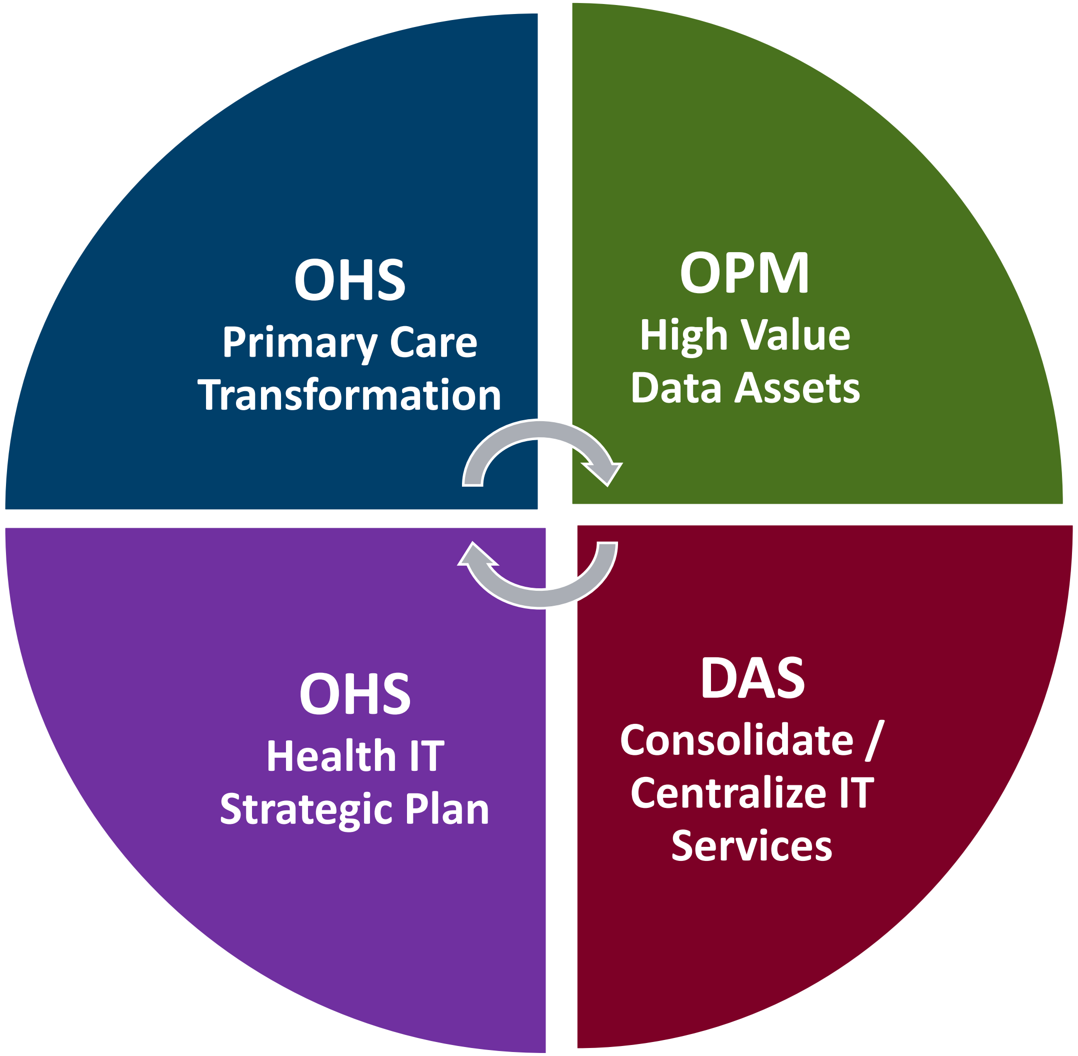
HIT Strategic Plan Alignment with Other Initiatives

- Executive Order No. 5
- Cost growth and quality benchmarks
- Primary care spending targets
- Payment and Delivery Transformation

- Health Information Technology Officer
- Electronic Data Standards
- Facilitate integrated health information systems and Interoperability



OHS
Primary Care
Transformation

OPM
High Value
Data Assets

OHS
Health IT
Strategic Plan

DAS
Consolidate /
Centralize IT
Services

- Chief Data Officer
- State Data Plan
- Catalog data assets
- Data sharing across agencies
- Data Analytics

- State CIO
- IT strategic plan
- IT consolidation
- IT centralization

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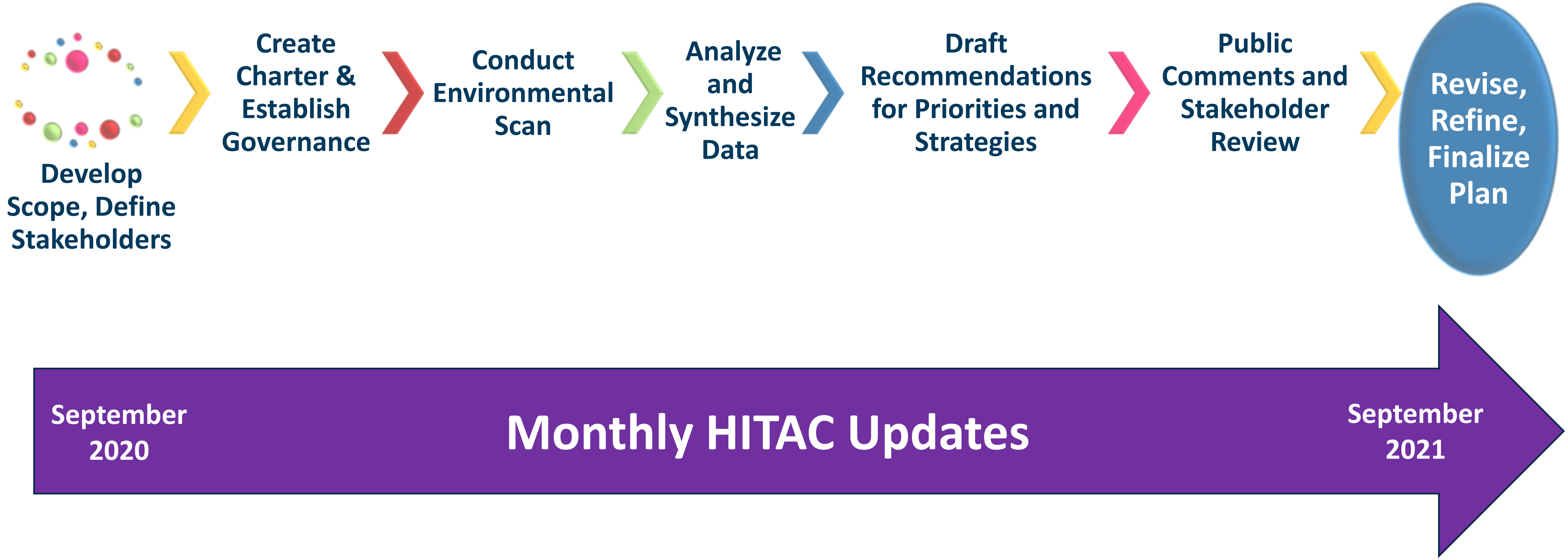
Health IT Strategic Plan Process



Develop Scope, Define Stakeholders

Create Charter & Establish Governance

Conduct Environmental Scan

Analyze and Synthesize Data

Draft Recommendations for Priorities and Strategies

Public Comments and Stakeholder Review

Revise, Refine, Finalize Plan

September 2020

Monthly HITAC Updates

September 2021

Anticipated Strategies

- Support and enhance efforts to address COVID-19 and opioid crisis
- Support primary care transformation
- Support health equity and address disparities
- Support public health modernization
- Align with CT-METS
- Align with consent management policy development
- Promote federated HIE model and continuing development of Connie
- Align with state data plan for agency systems
- Align with reorganization of state IT services
- Plan for sustainable funding
- Consider governance

Staffing and Resources

- **OHS**
  - Allan Hackney, Sponsor
  - Sean Fogarty, Project Lead
  - Other staff participation to be determined

- **CedarBridge Team**
  - Carol Robinson, Oversight & Expertise
  - TBD, Project Lead
  - TBD, Project Manager
  - Steven Hedgepath, Terry Bequette – Senior Consultants
  - CedarBridge Analysts

Advance Directives

A Landscape Overview

Work Funded By: The State of Connecticut Office of Health Strategy

Prepared by:
Thomas P. Agresta, MD, MBI, UConn Health
Rachel S. Rusnak, MPA, UConn Health
Ryan J. Tran, MHS, UConn Health

Prioritizing Advance Directives as a Use Case

October 2017

- Advance Directives/MOLST identified as a High Priority/Wave 2 Use Case by the HIT Use Case Design Group

March 2020

- COVID 19 confirmed in Connecticut
- Rapid onset
  - Patients unable to make health decisions
  - Family & caregivers unable to be present
- Heightened need for Advance Directives

April 2020

- OHS Request: UConn Health team undertake a rapid landscape analysis
  - Advance Directives
  - MOLST/POLST in CT
  - Use case opportunities

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Defining Advance Directives

Advance Directive

- Written statement of wishes for care
- A tool to ensure patients receive the medical care that they desire in times that they are unable to select for themselves

MOLST (Medical Order for Life Sustaining Treatment) / POLST (Physician Order for Life Sustaining Treatment)

- Intended for the seriously ill, signed by the clinician and the patient
- Effective immediately, regardless of patient capacity

Living Will

- Identifies life sustaining treatments patient would and would not want in the event they are not able to make their own medical decisions
- Identifies preferences for medical decisions, such as palliative care and organ donation

Power of Attorney

- Legal document, appoints an individual to make medical care decisions in the event the appointee cannot make their own

Advance Directive Foundational Components

- living will
- durable power of attorney for health care

The State of Advance Directives

Connecticut & Nationally

Research, surveys, and interviews reveal the landscape of advance directives, technologies, satisfaction, gaps, and needs in Connecticut, with a view of activities nationally.

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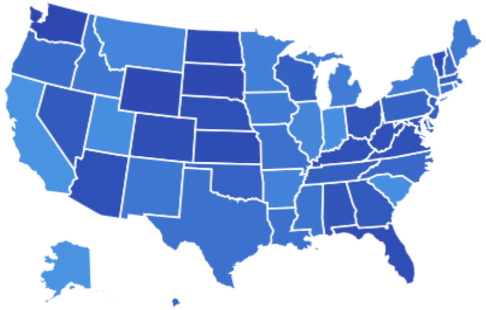
One out of every 3 adults in the US have some form of an advance care plan.



MOLST

Medical Orders for Life Sustaining Treatment

The State of Connecticut

Existing MOLST program
Administered by DPH
Green Paper Forms
Patients must carry at all times
Based on National POLST Paradigm
Not endorsed by the National POLST Paradigm

3 **Primary Solutions Nationally**

- My Directives
- Advance Care Planning Registry
- Vynca

Components Reviewed

Patient Perspective

Proxy Access
Ease of Use/Accessibility

Provider Experience

Ease of Use/Accessibility

Opportunity to Engage

Current Arrangements
Prospective Arrangements
Willingness to Collaborate

Tools & Capabilities

Mobile Compatibility
Documentation Types

Technical Specifications

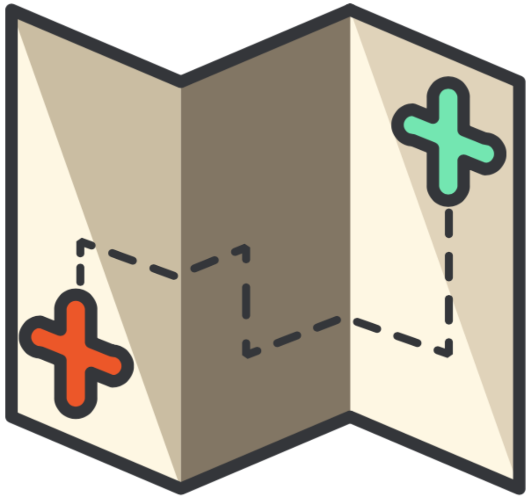
POLST/MOLST Integration
EHR Integration
Document Creation
Data Transfer
Compliance

Business Model

Current Customers
Stability
Revenue Model

The Process

The team at UConn Health engaged in a research and evaluation process in the Spring & Summer of 2020 to identify and assess the three principal advance directive vendors used in the US.



Research

- Web Based
- Literature Review
- Legal

Product Testing

- Demonstrations

Interviews

- Product Reps

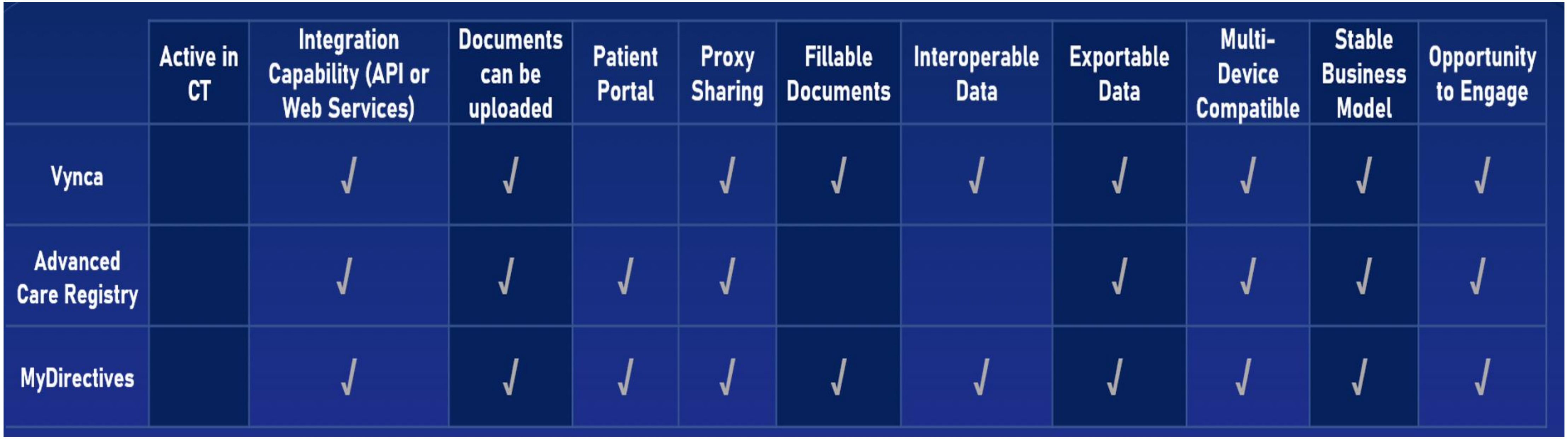
Survey

- Development
- IRB
- Deployment
- Data Collection

Analysis

- Synthesis
- Qualitative
- Quantitative

Findings

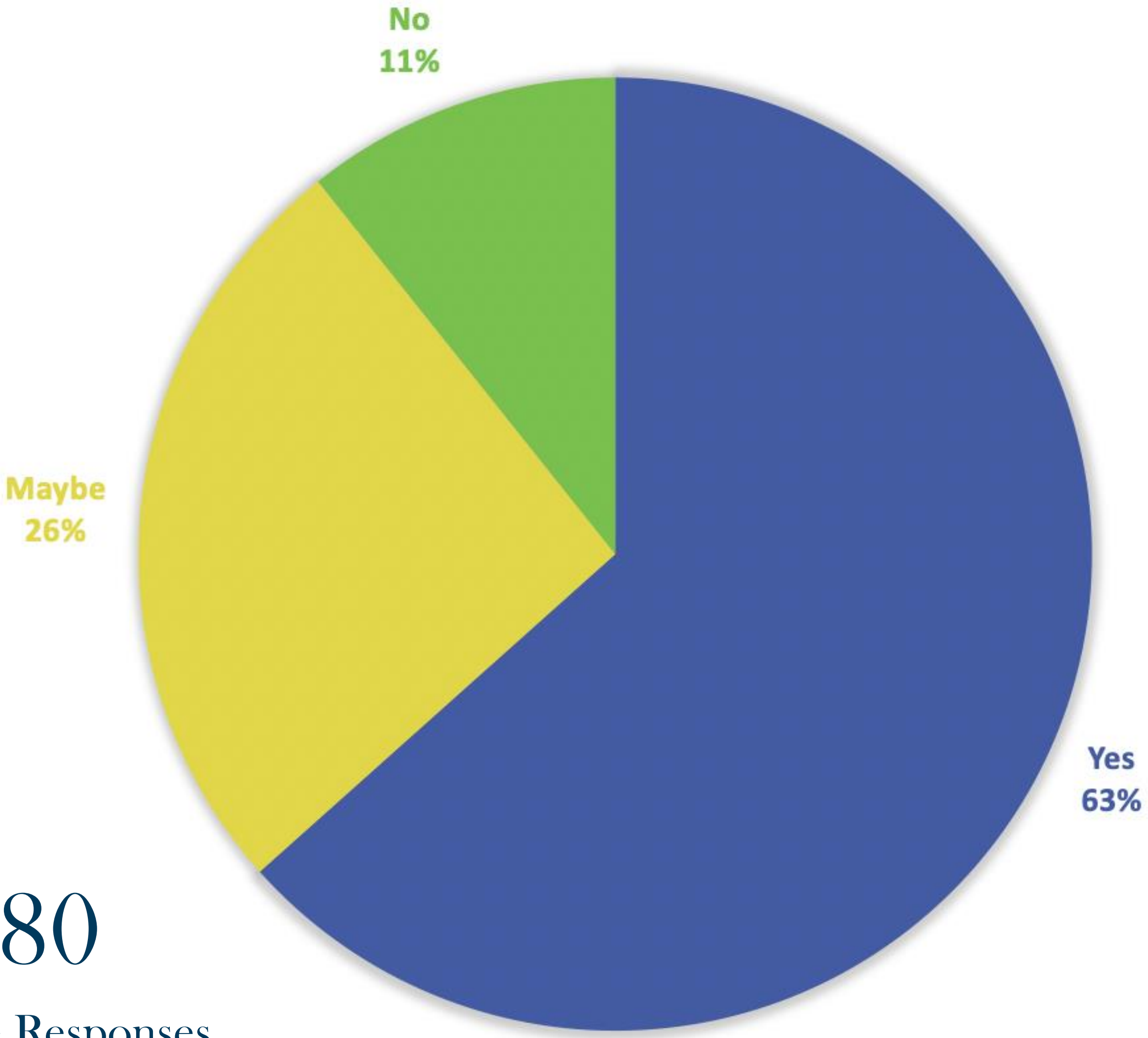


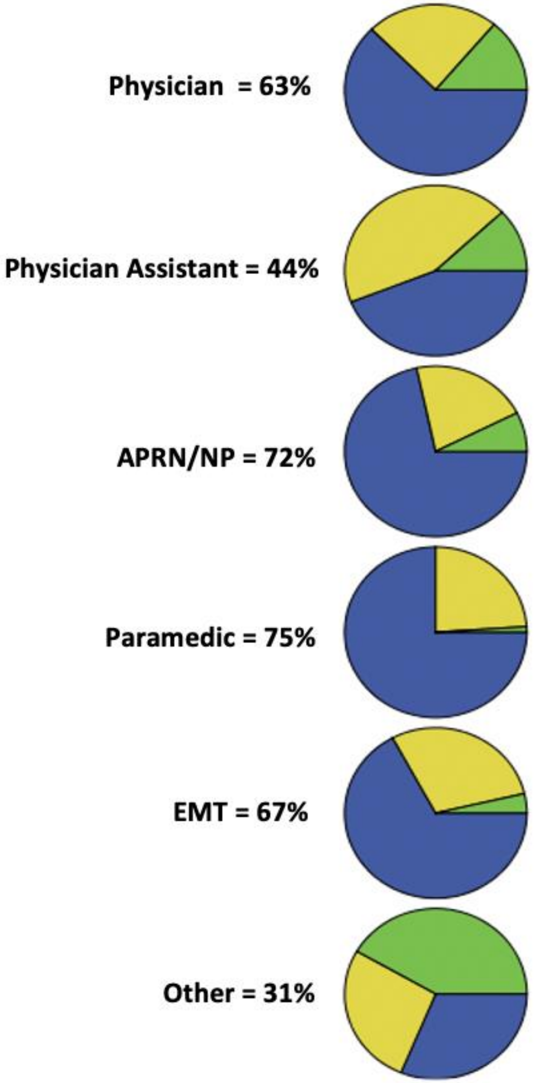
	Active in CT	Integration Capability (API or Web Services)	Documents can be uploaded	Patient Portal	Proxy Sharing	Fillable Documents	Interoperable Data	Exportable Data	Multi-Device Compatible	Stable Business Model	Opportunity to Engage
Vynca		✓	✓		✓	✓	✓	✓	✓	✓	✓
Advanced Care Registry		✓	✓	✓	✓			✓	✓	✓	✓
MyDirectives		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

“There is substantial evidence that the treatment people would choose at the end of life commonly is different from the treatment they receive. Too often individuals receive more aggressive care than they desire…preferences for where they wish to spend the end of their lives are also often not met… there is an apparent need to improve end-of-life care in the United States.”

Advance Directives and Advance Care Planning 2008 report to Congress

Interest in Participating in a HIA Sponsored Solution





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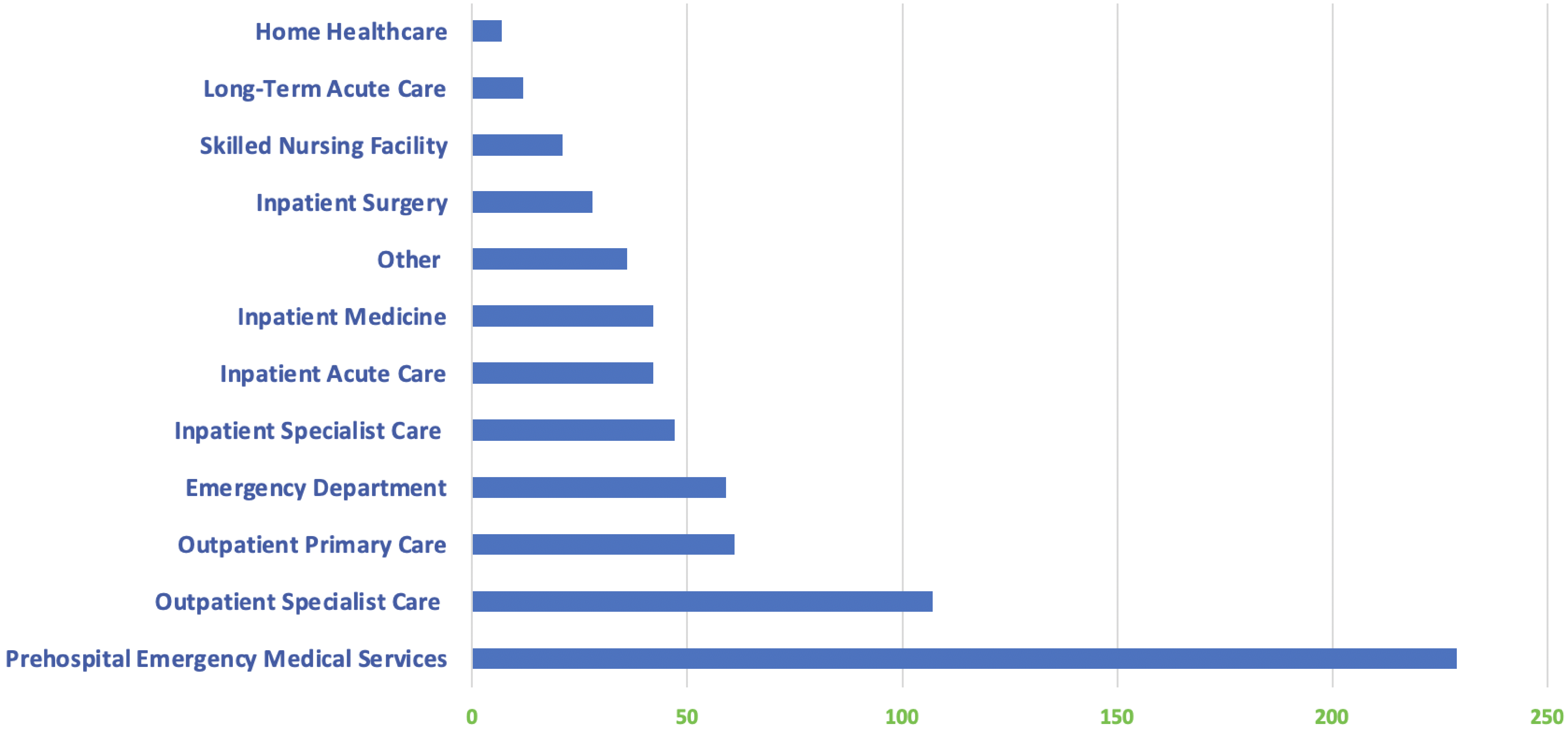
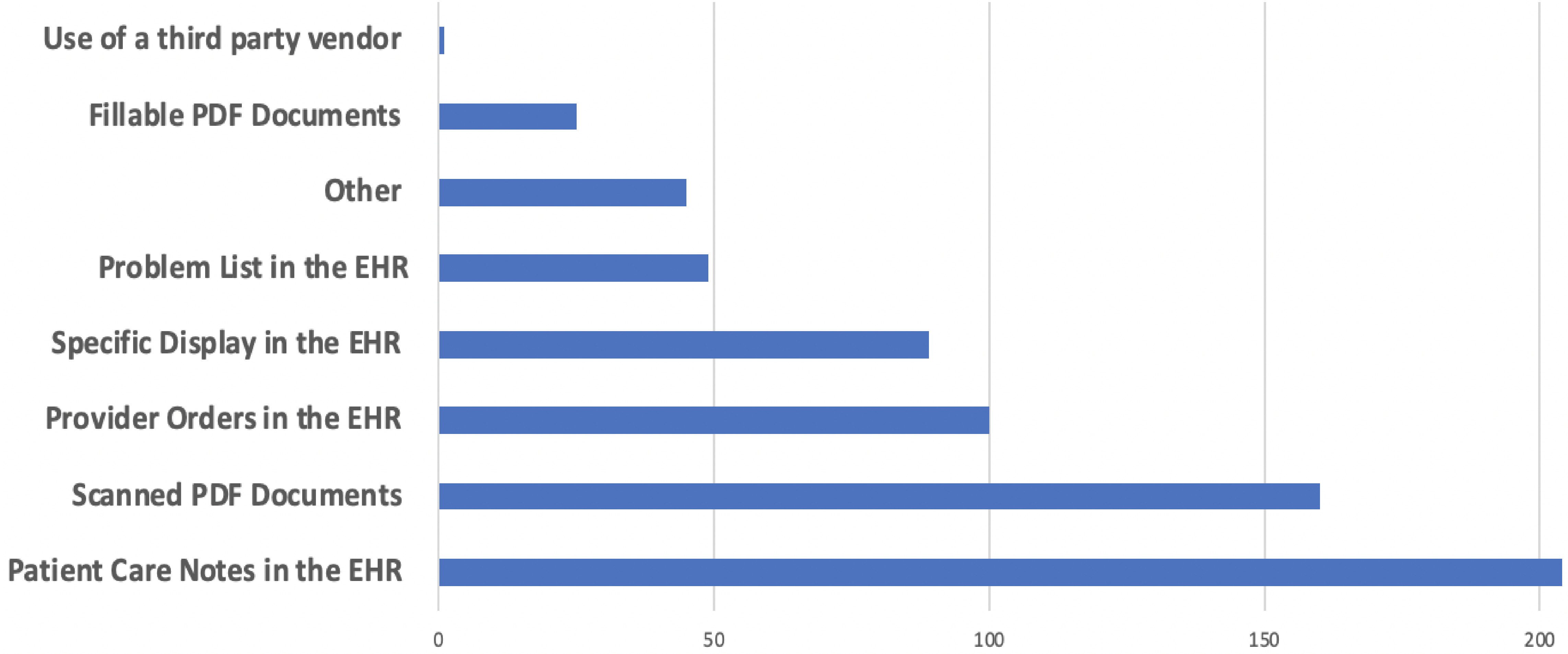
Complete Responses

Responding Provider Practice Setting



Storing Advance Directives in the EHR: Possible Locations



What Providers are Saying

"Family member on scene could not provide DNR order, senior living staff did not have a copy… life-saving measures were initiated. (patient) ended up in the ER for hours before passing …."

"many examples of when intervention (possibly futile) was provided because I was not able to access documents pertaining to patient's wishes or patient/family was not clear about the decisions already made."

"I have encountered several patients that have had procedures performed on them against their wishes… due to not having proper paperwork with the patient or not having the ability to contact the appropriate people who had the paperwork or information for the patient."

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Opportunity

- Facilitate the delivery of a significant, and needed service to Connecticut's residents, health care providers and health systems.

- Reduce unwanted, nonbeneficial care, financial burden and emotional distress

- Revenue Generation
    - Serve as a Reseller
    - Purchase Bulk Access
    - Purchase on Behalf of Residents

Considerations

Role of the HIE

- Consolidated Information Source
- Query & Retrieve
- SMART on FHIR
- Access: patients & providers
- Legislation
- Formal Use Case Development

Technical & Policy

- Interoperability
    - Interface/Integrate
- Product Usability
- Reimbursement
- End Users
- Barriers & Interventions

Further Research

Product Demonstrations

Interviews & Data Gathering

Present to the OAC for Use Case Development

Identify Additional Stakeholders

- ER Clinician
- EMT/Paramedics
- State Agencies

Develop Survey Result Report

Evaluate HIE Integrations

- Advance Directives
- POLST
- MOLST

Questions

Health Equity Data Analytics

Project Update

Health Equity Solutions

Health Equity Data Analytics Project
September 17, 2020

Mark Abraham
DataHaven

Karen Wang, Tara Rizzo
Yale ERIC

eric Equity Research and Innovation Center
Yale School of Medicine

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HEALTH EQUITY SOLUTIONS

CONNECTICUT HEALTH INFORMATION TECHNOLOGY OFFICE

UCONN UNIVERSITY OF CONNECTICUT AIMS Analytics & Information Management Solutions

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HEDA Project Overview

Health Equity Solutions, Inc. (HES)
- Tekisha Dwan Everette, PhD, Executive Director
- Dashni Sathasivam, MPH, Manager

DataHaven
- Mark Abraham, Executive Director

Yale School of Medicine: ERIC
- Karen Wang, MD, MHS, Instructor
- Marcella Nunez-Smith, MD, MHS, Director
- Tara Rizzo, MPH, Deputy Director

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HEDA Project Goals

- Develop proposed use case(s) utilizing health equity data elements to demonstrate potential for driving predictability of and progress towards better patient health outcomes at the population level
- Recommend short and long-term strategies to ensure that initial and future health equity data elements are utilized to optimize equity
- Outreach with stakeholders (community-based organizations and state agencies) to learn more about both potential value propositions and potential concerns regarding use of health equity/SDoH data in forthcoming statewide HIE.

Health Equity Data Elements Recommendations

- Race/Ethnicity
- Address and zip code & corresponding census tract-level neighborhood measures
- Insurance status

Note – final version HEDA Report was released in June 2019

User Stories Report

- **Section I** – HEDA Project Background
- **Section II** – Purpose of User Stories & definition of elements
- **Section III** – Key End Users of Health Equity Data
- **Section IV** – Use Cases
- **Section V** – Summary of Socialization & Refinement of User Stories
- **Section VI** – Key Takeaways & Next Steps

Purpose of User Stories

.

- Describe essential information related to work activities of specific end users

- Standard format:, **“As a (type of user), I want (to achieve a certain goal), so that (some reason/value)”**.

- Establish a consistent understanding between system developers and end users of that system to ensure alignment of goals and functionality.

Parts of a User Stories

A	**Identifies a high-level outcome of the user story**
A1	(1) Defines a specific **user/stakeholder** that would interface with or benefit from statewide data sharing and the exchange of health information through their role, (2) followed by a statement of means outlining the action that they want to achieve or a requested feature of the system, and (3) culminates with a business value proposition that refers to the anticipated benefit or solution to an acknowledged problem, . "As a stakeholder, I want to do [something], so that I can [solve this problem]"
Value	Outlines the end goal, which is the reason for accomplishing the user story. This includes bullets that clarify the means by specifying the needs that are addressed by this solution.
Additional data sources	Details known data sources that would or could contribute to achieving the user-specific outcome.

Alternatives: Provides the limitations related to the status quo also known as the current alternative state of operation without statewide data sharing and the exchange of health information.

Dependencies: Provides essential underlying functionalities that must occur or be in place for this use case to operate as outlined in the user story.

Key End Users of Health Equity Data

- Health Systems
- Providers
- Policymakers & State Officials
- Community-Based Organizations
- Healthcare Consumers

Use Cases

- All Payer Claims Database (APCD) Analytics
- Virtual Health Record
- Health Equity Dashboard
- Health Enhancement Communities
- Environmental Health Dashboard

All Payer Claims Database (APCD) Analytics User Stories

Desired Outcome: Identifying patient needs and facilitating linkages to clinical and community programs

Key Users

- **Providers** want to know if their patients are facing instability (e.g. housing, insurance, food insecurity, etc.) at the point of care to better understand factors impacting a patient's health and well-being.
- **Health systems** and **community-based organizations** want to identify individuals who could potentially benefit from enrollment in care management programs offered at hospitals or in the community.

Desired Outcome: Facilitating understanding of barriers faced by vulnerable communities to inform policy priorities and program aims

Key Users

- **State officials** and **policymakers** need access to data related to health outcomes that can provide justification for policies supporting healthcare reform by advancing health equity.

Alternatives:

- No standardized, high-quality, easily-accessible data source collecting health equity data elements) for providers or healthcare systems
- No data source easily tracking insurance status across the lifespan

Dependencies:

1. Ability to maintain data quality
2. Provider willingness to use ICD-9 and ICD-10 codes

Virtual Health Record

Desired Outcome: Enabling synthesis of accessible health information through a single-use interface

Key Users

- **Healthcare Consumers** need access to their personal medical information and the personal medical information of their **dependents** so they can manage my family's health.
- I am a **provider** working in an urgent care or Emergency Department setting. At the point of care, it is equally important for me to understand my patient's medical needs and encounters as it is to know their lived circumstances
- I am a **community health worker**, working at a **community-based organization**. I would like to meet the essential needs of my clients by offering the right services and referrals

Desired Outcome:Understanding the impact of VHR in reducing healthcare redundancy and improving outcomes

Key Users

- It is important for a **healthcare system** to have the capacity to measure the impact of consumer ownership of personal health data.

Alternatives:

- Onus on patient to identify resources to support their own healthcare needs.
- Providers have limited time and capacity to support (SDOH) needs beyond direct medical care.

Dependencies:

1. Reliability of patient-generated data
2. Provider/Patient concerns with data security and privacy

Health Equity Dashboard

Desired Outcome: Facilitating planning, communications, and advocacy activities related to improving the health of all Connecticut residents

Key Users

- **Policymakers** can better understand barriers to health and well-being.
- **Community-based organizations** and **health systems** want to understand key health conditions among the population living in a neighborhood or service area and use that information to inform planning and advocacy
- **Qualified local agencies** want high-security, protected features that allow to access real-time transmission of information useful for **public health reporting** and the prevention of outbreaks

Alternatives:

- Policymakers, community-based organizations, and health systems must rely on information from disparate sources.
- Reliable data may not be readily accessible at the neighborhood level.

Dependencies:

1. Capacity to collect and analyze accurate data at the neighborhood level
2. User friendly design
3. Data timeliness and longitudinal storage capacity:

Health Enhancement Communities

Desired Outcome: **Harnessing the power of data sharing to enable more effective funding and organizational structures throughout the state that can foster multi-sector collaboration and accountability to promote community health improvement and equity**

Key Users

- **HEC initiative leadership** can track improvements and/or reductions in health equity within HEC geographies and within small population groups residing within the HEC area.
- **HEC initiative leadership** can use disaggregated data to more effectively engage and empower the populations residing within the service area.
- **State policymakers and HEC funders** can analyze disaggregated data to create HEC performance measures that relate to populations at greatest risk of poor health outcomes, and use that information to monitor progress or award funding

Alternatives:

- No standardized, high-quality, easily-accessible data source collecting health equity data elements for providers or healthcare systems
- Risk of overlooking the fact that even if health and well-being conditions are improving for a region overall, they may be worsening for a specific group.

Dependencies:

1. **Limited and/or known reporting biases**
2. **Incentives for HECs to use equity within performance measures**

Environmental Health Dashboard

Desired Outcome: **Notifying providers of environmental hazards or risks at point of care**

Key Users

- A **health system** wants clinicians to be notified of environmental risks facing patients at the point of care, so that they can prevent greater harm among patients.
- I am a **clinician**, specializing in family primary care. Understanding environmental risks that my patients are exposed to is critical to informing treatment decisions and providing additional resources
- I am a **community health worker (CHW)**. I want to be able to assist my clients by reducing their exposure to environmental hazards and addressing their other social determinants of health, while helping connect them to clinical care and community resources.

Desired Outcome: **Promoting the safety of communities and advancing accountability efforts to mitigate environmental health risks**

Key Users

- I am an **advocate**. I need health data to help me talk to policymakers about supporting policies that seek to decrease environmental risk factors

Alternatives:

- Policymakers, community-based organizations, and health systems must rely on information from disparate sources.
- Reliable data may not be readily accessible at the neighborhood level.

Dependencies:

1. Capacity to collect and analyze accurate data at the neighborhood level
2. User friendly design
3. Data timeliness and longitudinal storage capacity:

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Key Takeaways from Socialization

To ensure a robust and responsive platform and data system:

- Organize community sessions to solicit initial feedback from each type of end user
- Develop educational materials to accompany the data (depending on various user groups) is crucial to the rollout. This includes developing accompanying text with numerical representations.
- Build ongoing feedback system for calibration into rollout and continued support mechanisms
- Apply and equity lens when developing systematic evaluation of these platforms.

Summary of Stakeholder Interviews

Stakeholder Interviews

Conducted exploratory interviews with (n = 7) community-based organizations and state agencies.

- Timeline: April 2020 to August 2020
- Telephone interviews

Targeted outreach with goal of gathering information regarding the following areas:

- Data, systems storage & privacy
- Perceived benefits and opportunities
- Identified challenges and concerns of participation

Community-Based Organizations:

- Hispanic Health Council - Hartford, New Haven, Meriden
- Thames Valley Council for Community Action, Inc. (TVCCA) - New London County
- Connecticut Community Cares (CCC) - Statewide

State Agencies:

- Department of Housing
- Department of Mental Health & Addiction Services
- Department of Public Health
- Department of Social Services

Stakeholder Findings

Data Systems: CBOs

CCC

- Connexus - organizational internal electronic record
- Data duplicate entry into DSS database systems

HHC

- Apricot – newly implemented tablet-based organizational electronic record across two programs. Hope to expand across agency
- Microsoft Access - historic in-house database
- Other program specific databases: Ryan White, WIC, Hospitals, Immunizations, SNAP
- Data duplicate entry into DSS & DPH database systems

TVCCA

- Fuelware – energy assistance program database
- Tribeware – case management program database
- Other program-specific databases: Head Start (ChildPlus), Housing (HMIS)
- Databridge to DSS

Data Systems: Agencies

DOH

- Homeless Management Information System (Case Worthy)
- HMIS links to DMHAS Data portal (DDAP)

DSS

- IMPACT - 2 primary eligibility systems
- Interfaces with external systems, such as federal repositories (DOL)

DPH

- Various disparate state & federal databases and wide range of sharing capacities depending on data sharing agreements

DMHAS

- 30 homegrown databases
- No internal interoperability
- Data use agreements needed between 8 state-operated health facilities

Stakeholder Technical Challenges

Varying levels of data infrastructure:

- Multiple antiquated and disparate internal and external informatics systems
- CBOs with internally developed databases or electronic records have flexibility to customize or buildout data fields. This does not extend to external informatics systems.
- Agencies have limited flexibility to alter data bases due to mandates or logistic challenges even when they own the data system.

Limited Interoperability:

- CBOs: Bridging internal data systems with external state or programmatic systems is challenging resulting in significant duplicate data entry and additional administrative burden
- Agencies: Variable levels of internal interoperability depending on agency

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Stakeholder Legal & Operational Challenges

Legal:

- Federal and state statutes and HIPAA regulations dictate data sharing capacities
  - E.g. Medicaid data may only be shared under conditions that support the administration of DSS programs.
  - DMHAS operated facilities are considered 8 separate entities
- Data security, privacy and client consent were identified as greatest risk to participation

Operational:

- Nonstandard data collection and tools
- Varying levels of SDOH analytical capacity depending on program and outcomes of interest
  - Limitations:
    - Lack of staff time and resources
    - Lack of access to real-time data (CBOs)

Collection of Race & Ethnicity Data

DPH Minimum Standard	DPH Ideal Standard	DSS	DHMAS	HHC
American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White Hispanic or Latino Not Hispanic or Latino (OMB 1997)	American Indian or Alaska Native; specify tribal affiliation: Asian Asian Indian Korean Chinese Taiwanese Filipino Vietnamese Japanese Other Asian; specify: Black or African American Native Hawaiian or Other Pacific Islander White Other race; specify:	White Black or African American American Indian or Alaska Native Hispanic or Latino/a Asian Indian Chinese Filipino Japanese Korean Vietnamese Other Asian Native Hawaiian Samoan Guamanian or Chamorro Other Pacific Islander	American Indian/Native Alaskan Asian Black/African American Native Hawaiian/Other Pacific Islander White/Caucasian Other Unknown	White (European, Middle Eastern, Arab, North African) Black/African American (African, African American, Haitian, Jamaican, Dominican, West Indian) American Indian/Alaskan Native Asian (Chinese, Vietnamese, Cambodian, Asian Indian, other) Native Hawaiian/Other Pacific Islander Other:
DOH OMB 1997 + Client Doesn't Know Client Refused Data Not Collected	Hispanic or Latino Cuban Mexican Puerto Rican South or Central American Other Hispanic/Latin culture or origin, regardless of race; specify: Not Hispanic or Latino	Mexican Mexican-American Chicano/a Cuban Puerto Rican Other Hispanic, Latino/a or Spanish *Renewal of Eligibility form	Hispanic-Other Non-Hispanic Hispanic-Puerto Rican Hispanic-Mexican Hispanic-Cuban Unknown	Puerto Rican Mexican Cuban Dominican Central American (Salvadorian, Honduran, Guatemalan, other) South American (Colombian, Ecuadorian, Peruvian, other) Other Hispanic/Latino: *Breastfeeding Heritage & Pride program intake

Collection of Insurance Status

DHMAS	DOH	DPH	TVCCA	HHC
No health insurance Other private insurance Medicare Champus Medicaid Husky C HMO (including Managed Medicaid) GA-SAGA ATR-Access to Recovery Self Pay Medicaid LIA Husky D Medicare Part A Medicare Part B Money Follows The Person (MFP) Nursing Home Waiver Medicaid BHH Medicaid- Husky A Medicaid BHH - Waiver Other Unknown	• Yes • No •Client Doesn't Know • Client Refused *(Statewide Coordinated Access Network Intake)	Not included in either minimum or ideal standard sociodemographic data collection	Direct purchase Employment Military Medicaid Medicare CHIP State insurance adult, none, unknown, unreported	Program dependent. Breastfeeding program does not collect

Perceived Benefits & Opportunities: Community-Based Organizations

- Enabling real-time data pulls
- Preventing duplicate data entry
- Easy access to state data to develop resources for CHWs and support statewide initiatives (e.g. resource development for CHWs)
- Integrating health information and social service data embedded in other state agencies into programmatic work and organizational processes
- Optimizing workflow (e.g. integration of CHWs services, streamlining outreach currently dependent on waiting on provider sending records.

Perceived Benefits & Opportunities: State Agencies

- Elevating existing data with greater granular detail to highlight the disparities, inform programs and resource distribution.
- Improving surveillance and addressing data lag through enabling data to be captured directly from providers.
- Enabling data matches with other state agencies and increasing possibility of cross-agency collaborations.
- Comparative data analytics across payers.
- Matching missing data (e.g. race & ethnicity for surveillance; data needed by provider to optimize delivery of care)

Desired Data Analytic Capabilities

Agencies

- Cross-payer examination of equity issues. (e.g. ACE, birth outcomes etc. and areas of the population that are missed when focusing exclusively on Medicaid.)
- Projections on populations more likely to need housing resources and cross analyzing with cost of resources.
- Analytics that demonstrate the impacting the agency on individuals and populations (E.g Data on factors supporting and impeding recovery (housing, primary care.)
- Data matching to mitigate unknown race & ethnicity data (e.g. COVID-19 data) and support improvement of data collection

CBOs

- Standardized and verifiable tool to capture SDOH. Combining data collected on individual's functional ability or disability with SDOH data for population analytics and individual outreach.
- Easy access to granular county, city and neighborhood data to support community needs assessments and help shape programming to meet unique needs of their population.

Desired Technical Assistance

Community-Based Organizations:

- **Increasing analytic capacity**: Support with determining how to optimize the data being exchanged and types of analytics possible to further organization's mission
- **Technical connectivity:** expediting adoption of electronic record across organization and configuring interface between state agency or funder-manded databases.

Agencies:

- **Technical handshake** with diverse EMRs and systems to enable receipt of a standard format of data or case report
- **Support for providers** who are working with agency to sustain adoption
- **Legal assistance** to navigate various statutory and funding obligations. For example, Opt-in/Opt-out and if specific mental-health opt-in or other accommodations are possible

Recommendations from Stakeholder Outreach

Organizations and agencies had **varying levels of knowledge and understanding** of the HIE. As a result, many stakeholders were unable to contemplate their organization’s readiness or TA needs.

- Investing in educational and development of easily digestible and shareable materials
- Engaging CBOs and agencies in Opt-in/Opt-out education and feedback

Data completeness and quality of health equity data elements varies widely across stakeholders

- Supporting uniform standard of collection of health equity data elements would help to increase quality and future analytic capacity of the HIE.

Final Data Report Recommendations

- Set standards for data collection and roll-up of granular data
- Set policies that require health systems, organizations and agencies to collect and report granular REL data in standardized mechanisms through state legislation
- Invest in the creation of a Health Equity Data Officer position and team
- Perform an equity audit to assess the ways that patients and consumers are being engaged
- Form an interdisciplinary team inclusive of social scientists (e.g critical race scholars), data ethics and informatics experts to guide decisions around future equity-driven standards for data collection, sharing, exchange and use

Questions?

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HEALTH EQUITY SOLUTIONS

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The Twenty Fifth Year

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Announcements and General Discussion

Allan Hackney, Council Members

Wrap up and Next Steps

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https://portal.ct.gov/OHS/HIT-Work-Groups/Health-IT-Advisory-Council