COMMUNITY HEALTH CARE ASSOCIATION of New York State

CHCANYS NYS-HCCN presents

RHIO Conversations

HEALTHeLINK

Rochester RHIO

HealtheConnections

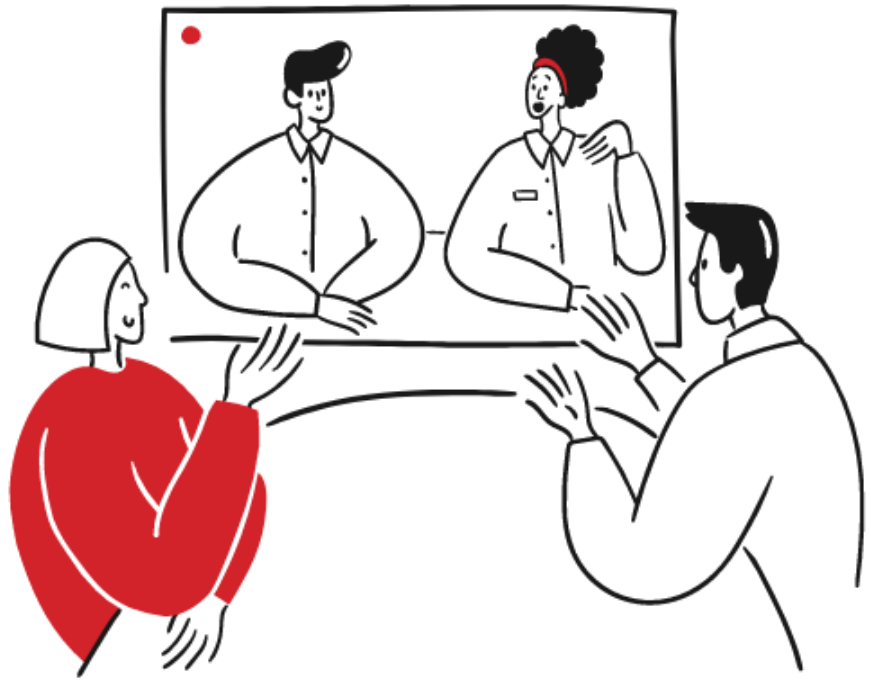
Day 1
November 15, 2023

For more information, please email Anita Li at ali@CHCANYS.org

This resource is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award to CHCANYS' New York State Health Center Controlled Network (NYS-HCCN) totaling $3,666,000 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

Zoom Guidelines

- You have been muted upon entry. Please respect our presenters and stay on mute if you are not speaking.
- Please share your questions in the chat. CHCANYS staff will raise your questions to our speakers and follow up as needed if there are unanswered questions.
- The workshop is being recorded and will be shared after the session along with the slide deck.



Agenda

- Introductions
- RHIO Core Services
- Crisis Support
- Health Equity & SDOH Projects
- Analytic Tools & Dashboards
- Q&A
- Closing & Evaluations

New York State HCCN Objectives

Project Period 2022-2025

1. **Clinical Quality**
2. **Patient-Centered Care**
3. **Provider and Staff Wellbeing**

2022-2025 Project Period

- Patient Engagement
- Patient Privacy & Cybersecurity
- Social Risk Factor Intervention
- Disaggregated Patient-level Data (UDS+)
- Interoperable Data Exchange & Integration
- Data Utilization
- Leveraging Digital Health Tools
- Health IT Usability & Adoption
- Health Equity and REaL Data Collection*
- Improving Digital Health Tools- Closed Loop Referrals*

** - Applicant Choice Objective*
Bold- Objective Carried over into 2022-2025

Schedule of Events

Day 1 (11/1)

- Interoperability Overview & Readiness

Day 2 (11/8)

- Data for Better Health
- Closing Care Gaps and Transitions of Care Promising Practices

Day 3 (11/15)

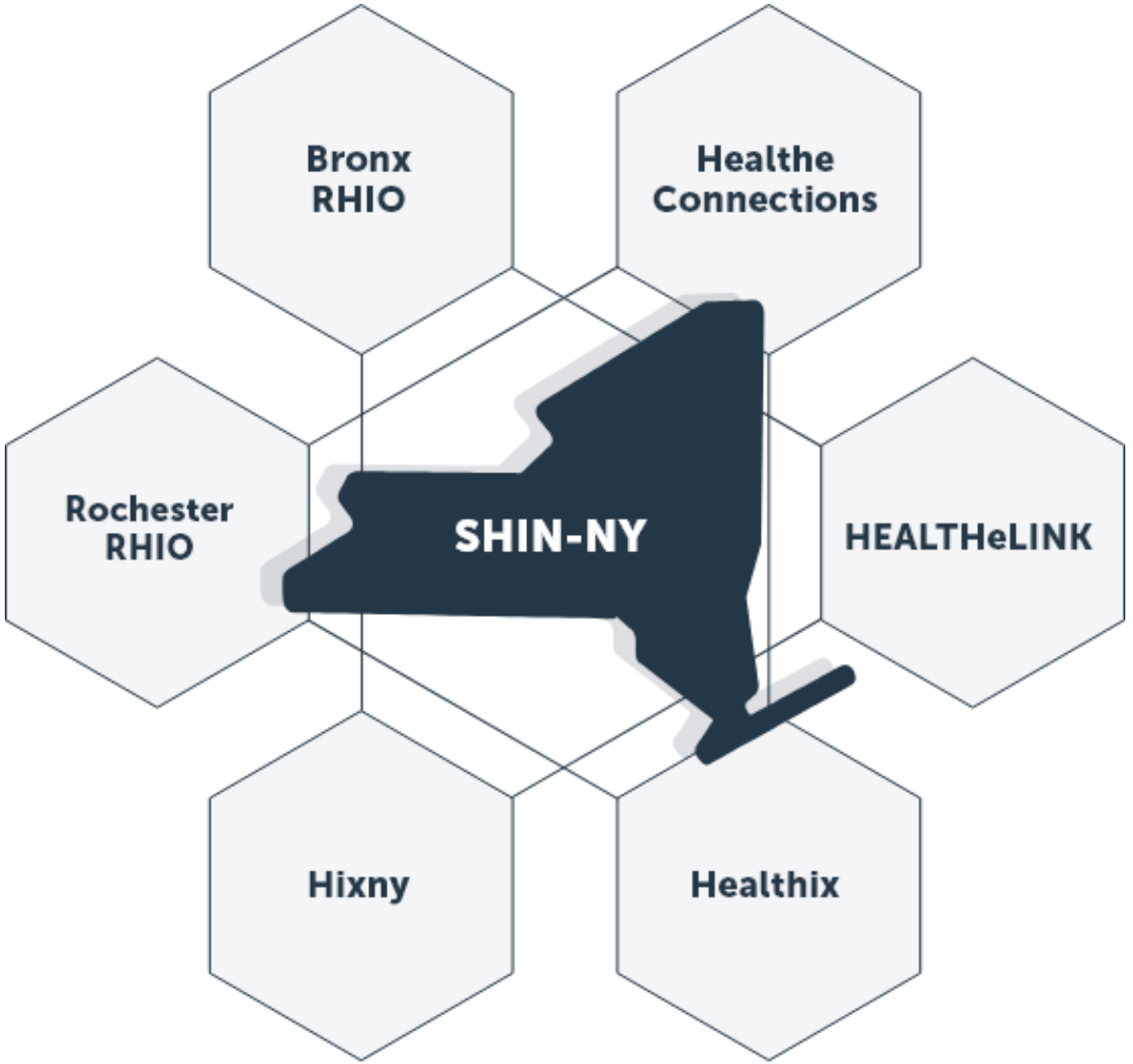
- **RHIO Conversations**
  - **HEALTHeLINK**
  - **Rochester RHIO**
  - **HealtheConnections**

Day 4 (11/16)

- RHIO Conversations
  - HIXNY
  - Healthix
  - Bronx RHIO

New York State Health Information Exchange

- RHIOs = Regional Health Information Organization
- QE = Qualifying Entities
- HIE = Health Information Exchange



Stephen Gates

Assistant Vice President,

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Teraisa Mullaney, MS

VP of Community Innovation

& Development

Tricia Williams

Director of Community

Solutions

Rachel Kramer

Senior Vice President,

Population and Public Health

Services

Alex Augustinos

Customer Engagement

Manager

Bernard Bush II, MPH, MS

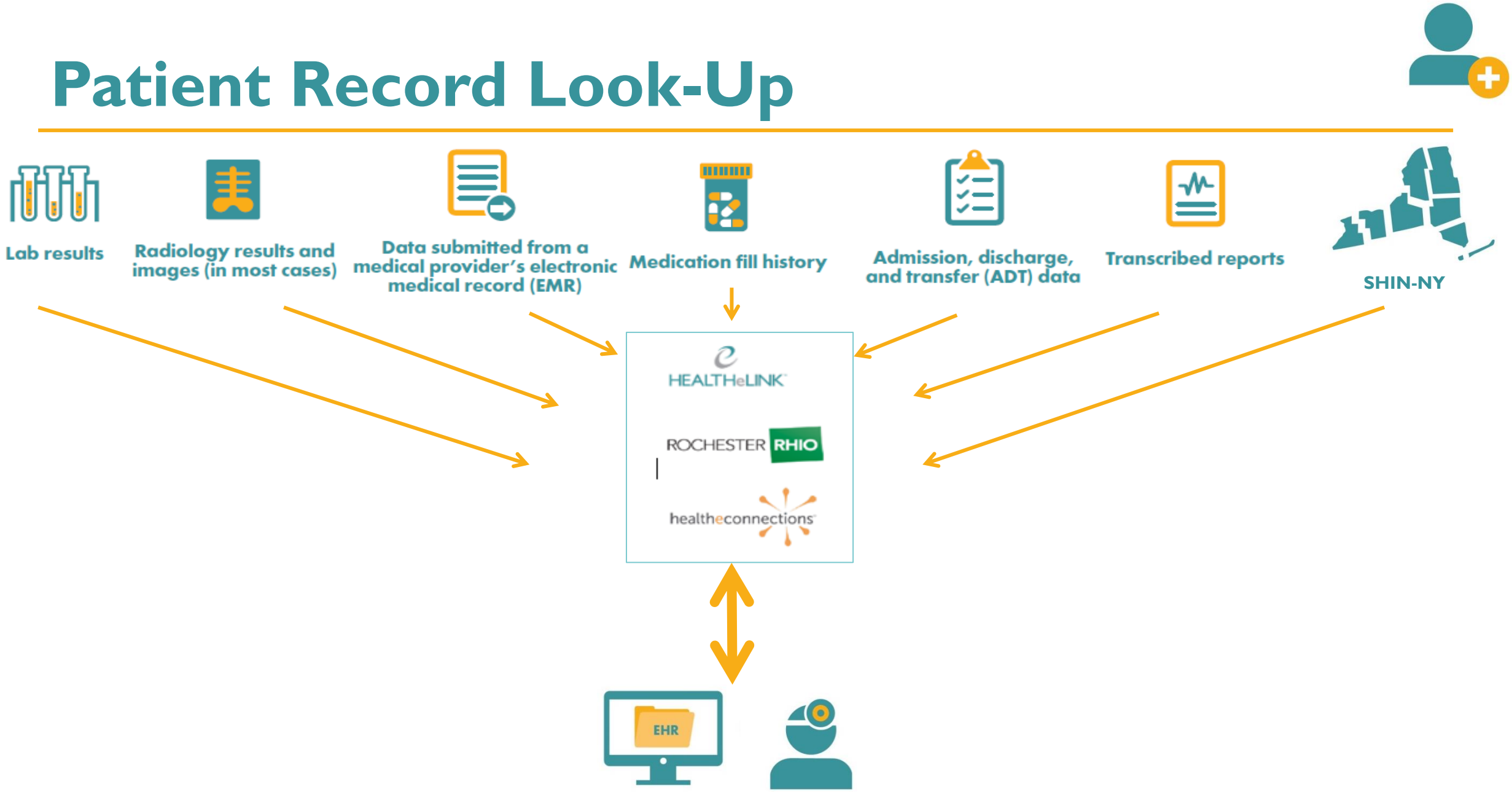
Business Analyst & Project

Coordinator | HIT Services &

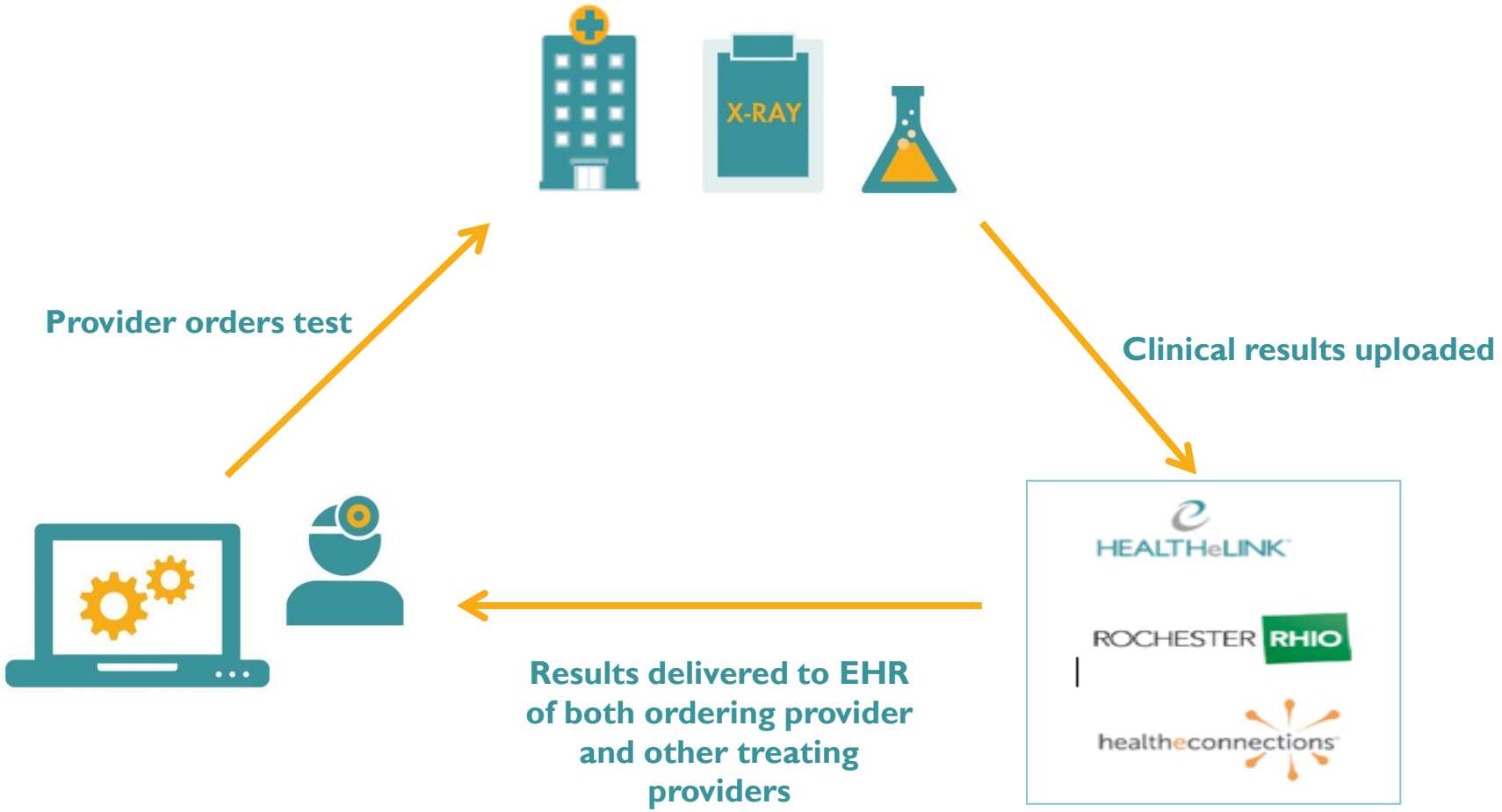
Solutions

Core Services

Patient Record Look-Up



Results Delivery



Alert Notifications

Questions & Comments

- How can they help close gaps in care with payers seamlessly?

What are some challenges you experience with your RHIO?

- Limitations in data exchange vs portal access. more is avail on the portal such as discharge summary and not avail in interface
- Staff utilization
- It takes a long time to load patient data sometimes. You have to search for important results like mammograms and colonoscopies
- limited amount of information can be shared.
- All messages received from the RHIO in our Athena EHR do not include any patient information or clinical details.
- navigate the system for information on a patient
- *We do not get data from the RHIOs (This question is from an IPA)*
- Direct Feed into eClinicalWorks

*Best path to resolution is to work with your specific QE directly on issues such as these

Crisis Support

Ransomware Attack

Protecting downstream providers

- If you do have a cyber incident, you need to notify your HIE(s) immediately. Depending on the incident, the HIE could disconnect connections to protect community data.
- If any other incident occurs that activates your emergency preparedness plans, you should notify your HIE, so we can provide additional tools.
- HIEs can help with triaging messaging to other data users.
- If a doctor, nurse, or another clinician or care manager leaves a practice, you need to notify your HIE immediately.

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Incorporating HIE into disaster plan

- HIEs can sit in on tabletop exercises. HIEs conduct their own tabletop exercises on a routine basis.
- Incorporate HIEs into cyber security plans as options during an incident.
- HIEs can provide step-by-step instructions into incorporating into your emergency preparedness and disaster planning.

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HIE services that can be provided in EMR downtime scenarios

- Access to your facility's data
- Access to other community data
- Lost data recovery
- Potential for other services

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Regional Health Information Organization

Community Health Care Association of NYS

Tricia Williams
Director of Community Solutions

Teraisa Mullaney
VP of Community Innovation & Development

Finger Lakes Social Care Landscape & Trajectory

2015

IBM's Smarter Cities Challenge study found Rochester to be **program rich but results poor**.

2023 and Beyond

Healthcare transformation began through a coordinated community effort under the Delivery System Reform Incentive Payment Program

Social care networks began to form, working to standardize workflows and network performance

Community-wide efforts to solution for the collection, sharing, management, and care workflows related to HRSN originating from the healthcare sector.

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2023 and Beyond

Community-wide efforts to solution for the collection, sharing, management, and care workflows related to HRSN originating from the healthcare sector.

1 – Co-leading Healthcare Sector Health Related Social Need Workgroup

2 – Conducting a Community Referral Exchange Pilot

3 – Exploring Solutions for Social Care Integration Projects

Rochester RHIO's Investment in Enabling Social Care Integration through Data Exchange

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Healthcare Sector Health Related Social Need (HRSN) Workgroup

Health Related Social Need (HRSN) Workgroup

Workgroup Mission

Discuss, ideate, and build consensus on solutions for collection, sharing, management, and care workflows related to HRSN originating from the healthcare sector.

Workgroup Membership

- Health Systems
- FQHCs
- Social Care Networks
- Leads: FLPPS and RRHIO

Workgroup Goals

- Share current healthcare practices and activities related to HRSNs.
- Identify a shared vision on collecting and sharing HRSNs data in healthcare settings.
- Ideate relevant care workflows in healthcare related to HRSNs.
- Create solutions that improve health outcomes, decrease health costs, and enhance health access for the Medicaid population in the Finger Lakes region.

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Objectives

Objective 01

Understand the current state of HRSN screening, data collection, and data exchange within the healthcare sector.

Objective 02

Harness and optimize existing technical investments, such as EPIC, the HIE, community interfaces, etc.

Objective 03

Understand the current strategy and leverage the work of the Statewide-Health Information Network of New York (SHIN-NY) and NYS Department of Health related to HRSNs.

Objective 04

Identify mutual use cases for relevant care workflows.

Objective 05

Create system agnostic solutions by aligning workflows and requirements, where possible.

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Objective 06

Advance preparedness for state waivers, grants, and funding opportunities related to improving health access and health outcomes of the Medicaid population.

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NYeC I&I Pilot
Community Referral Exchange (CRE)

Purpose:

- Create use cases, design solutions, and implement workflows to enable information exchange for community referrals and HRSN data.

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NYeC I&I Community Referral Exchange

Use Cases:

A. Identifiers for person matching to enrich data and enable information exchange use cases.

B. Report to NYeC/DOH, through RRHIO, intra-network referral activity and HRSN data.

C. Send a referral to another SCN when a service is not available within home SCN.

D. Trigger a referral to a SCN given receipt of specific HRSN from health systems signifying immediate need and desire for referral follow up.

E. Enable bi-directional information sharing between SCN and/or health systems on referral activity beyond referral trigger and acceptance.

NYeC I&I CRE Goals

Advance regional readiness for SDH interoperability and information exchange as well as advance the SHIN-NY direction to serve that function.

Determine if universal standards being established by the Gravity Project can be adopted for the minimum dataset for community referral exchange.

Implement a community referral exchange process that is scalable to other platforms/solutions.

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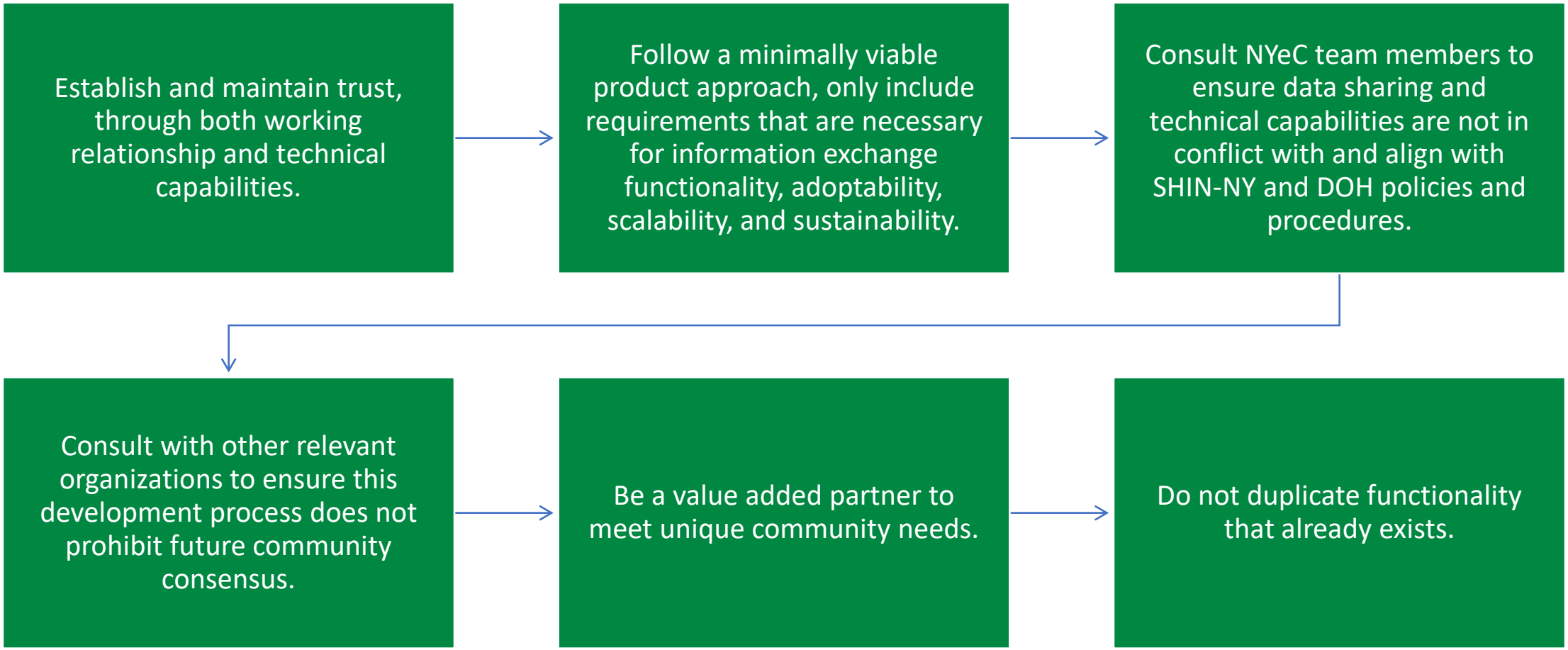
NYeC I & I CRE Project Principles



Enabling Social Care Integration

Develop integrated care workflows **enabled by data exchange** between families and the medical and education systems to ensure seamless coordination of early intervention and childhood services.

Partners include health system and children network services.

Develop integrated care workflows **enabled by secure messaging and timely data exchange** between school nurses and physicians to navigate follow up care and medication management for children with asthma.

Partners include health system and school district.

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healtheconnections®

regional activities

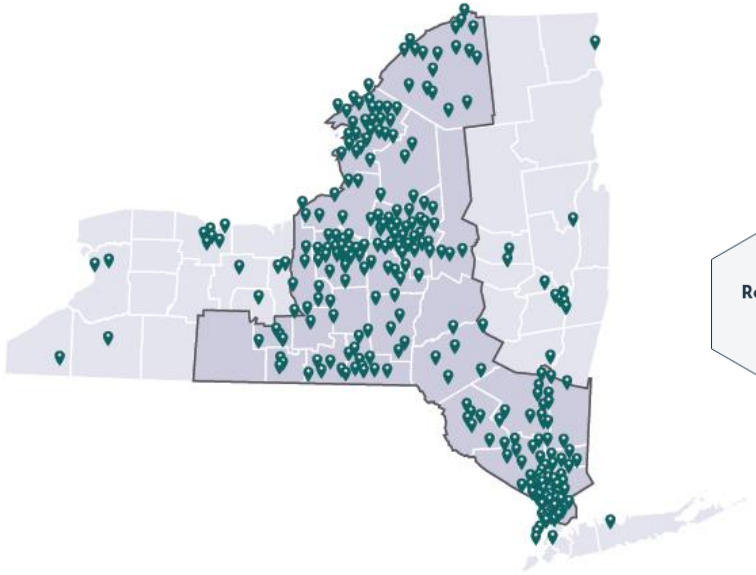
healtheConnections: who we are

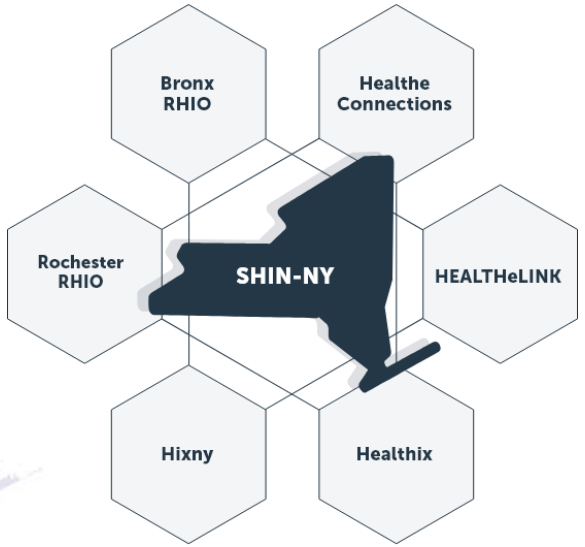
- HealtheConnections is accredited by the NYS Department of Health to operate the regional health information exchange (HIE) for 26 counties of NYS
- We help enable interoperability and the meaningful use of data for clinical care, community health and public health

1,600 participating organizations

685+ organizations providing data

records on 11 million patients





collecting social needs data

social determinants of health

What are social determinants of health?

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

SDOH can be grouped into 5 domains:

Economic Stability

Education Access and Quality

Health Care Access and Quality

Neighborhood and Built Environment

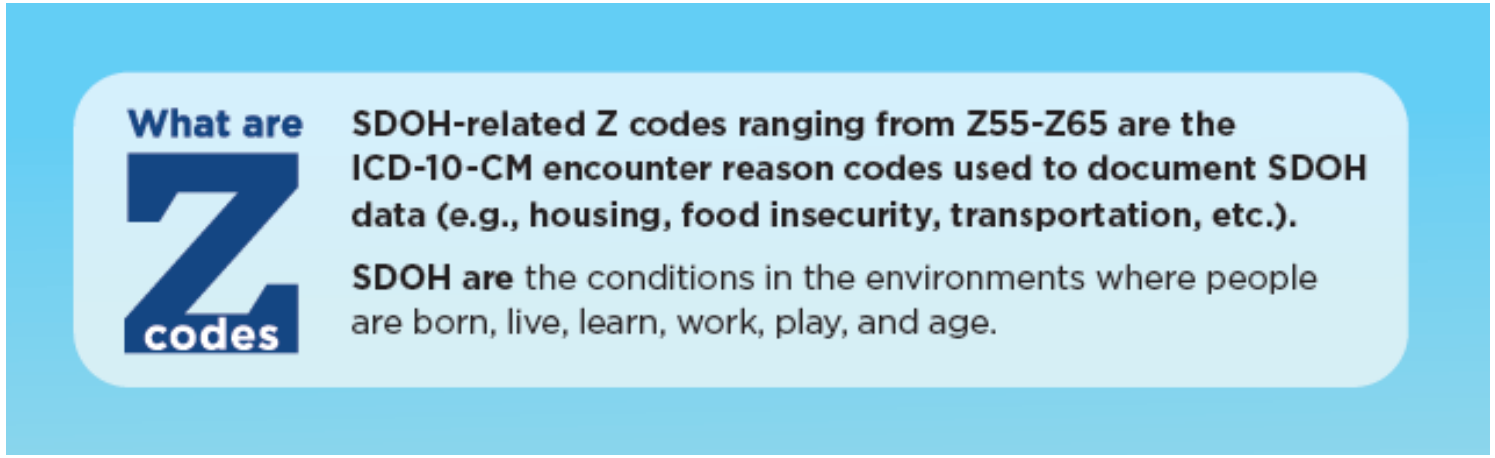
Social and Community Context

Social Determinants of Health - Healthy People 2030 | health.gov

HRSN = Health Related Social Needs

social needs data in the HIE

- coded data



- screening data
  - PRAPARE
  - AHC HRSN screening tool
  - EMR-generated questions

NYS Medicaid 1115 Waiver

- Overall Goal: “To advance health equity, reduce health disparities, and support the delivery of social care.”

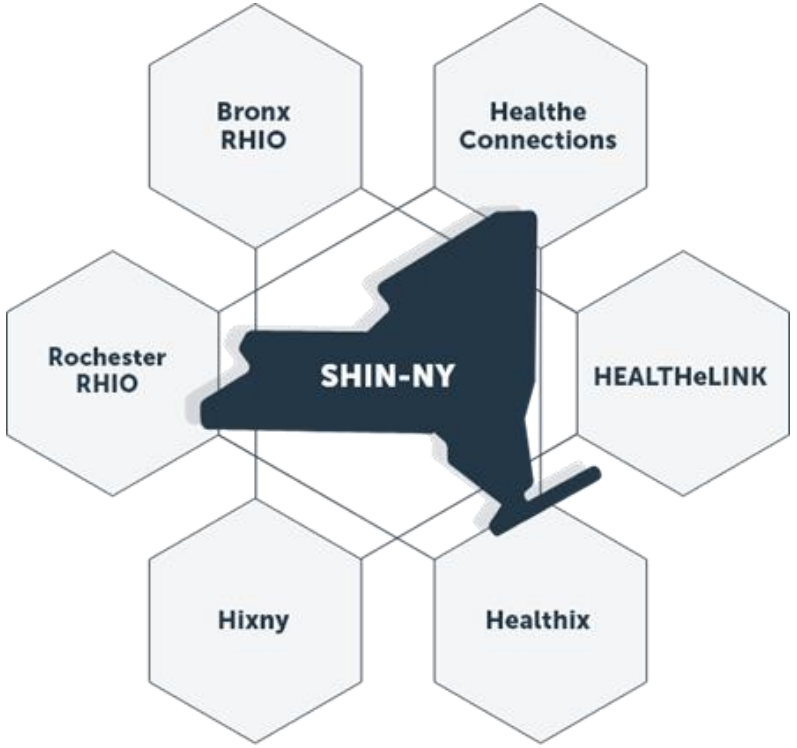
SHIN-NY role in Waiver

- infrastructure of the **Statewide Health Information Network for New York (SHIN-NY)** – will provide a statewide data store for HRSN/SDoH data and referral information
  - aggregate screenings and referrals into a statewide registry
  - enhance screenings and referrals with better demographics and clinical data
  - send data where needed

- all 6 HIEs/QEs are working together to prepare for the waiver by piloting the ingestion of screening data

SHIN-NY data ingestion project team

- As part of the SHIN-NY-wide project team, HeC will help drive implementation of Gravity Project terminology and technical standards across all NYS HIEs/QEs.
- The objective is for all HIEs to develop a standardized process for ingesting, handling and transmitting AHC HRSN survey data (using FHIR standards) to a collective SHIN-NY data lake.



importance of SDOH data in care delivery

- SDOH data gives richer insights into factors impacting health than traditional healthcare encounters do—an especially important consideration with complex and underserved populations.

challenges with collecting and exchanging SDOH data

- **Issues of Consent**
  - consent management
  - ethical data sharing
  - patient trust and concerns
- **Standardization of SDOH Data**
  - collection, exchange and storage of data
  - interoperability (data sharing across systems and sectors)
- **Social care sector capacity and capabilities**
  - access to and comfort using digital solutions
- **Unnecessary medicalization of SDOH**
  - prematurely mapping social need flagged in screening to ICD-10 clinical code in EMR record)

the gravity project & SDOH domains

- The capture of SDOH data in unstructured and/or non-standardized formats inhibits the ability to normalize, exchange, and aggregate the data regardless of the data source.

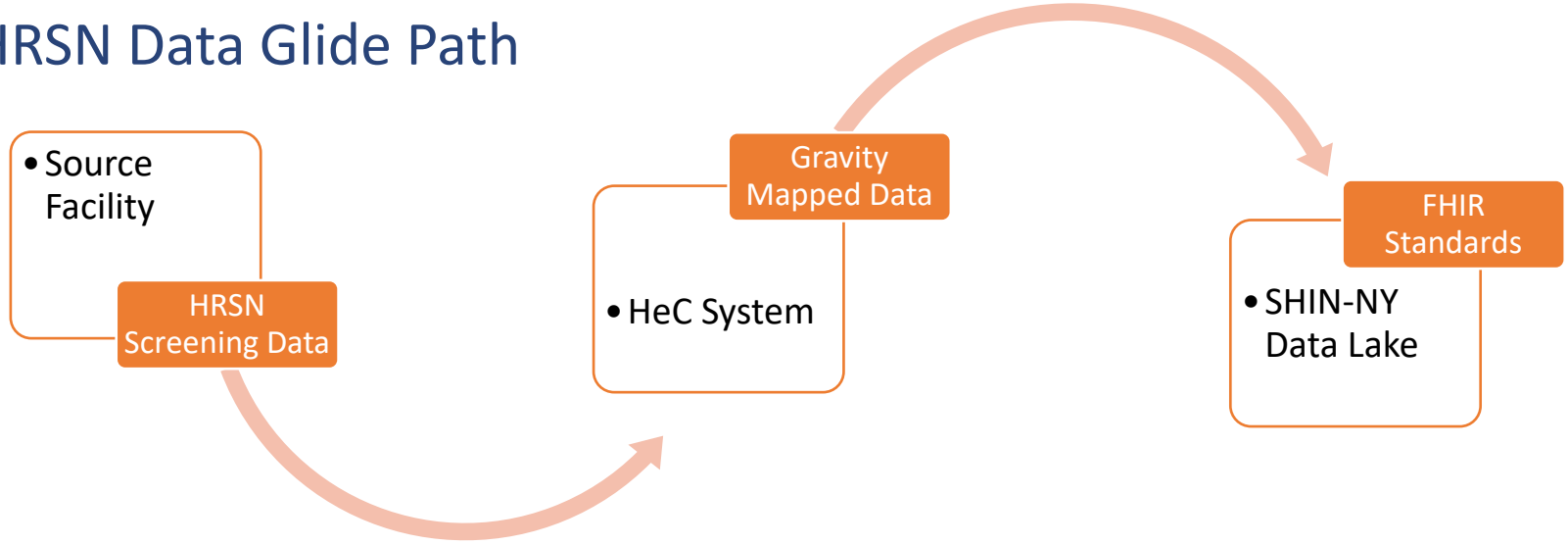
- The Gravity Project has developed consensus-driven data standards to support the use and exchange of SDOH data within the healthcare sector and between other sectors.
  - Helping advance SDOH/Health Equity Data Interoperability

https://thegravityproject.net/overview/

current activities

- HeC conducted a survey to better understand if and/or how facilities that are contributing data to the HIE are collecting/handling SDOH-related data.
- Based on survey responses, HeC selected a participant that was utilizing the AHC HRSN screening tool at their facility as a pilot partner for the ingestion project.
- Flat file will be produced for HeC to build ingestion process, data model to map to Gravity SDOH domains, and ultimately conversion to FHIR for transmission to SHIN-NY data lake.

HRSN Data Glide Path



any interest?

- The long term goal of this project is to create sustainable infrastructure that enables each QE to ingest all SDOH.
  - Irrespective of source system, data structure, or facility type (i.e. hospitals, FQHCs, health homes, CBOs, etc.)
- If there is any interest in engaging with HeC and potentially becoming a pilot partner for this work, please contact:

Bernard Bush
bbush@healtheconnections.org

myData

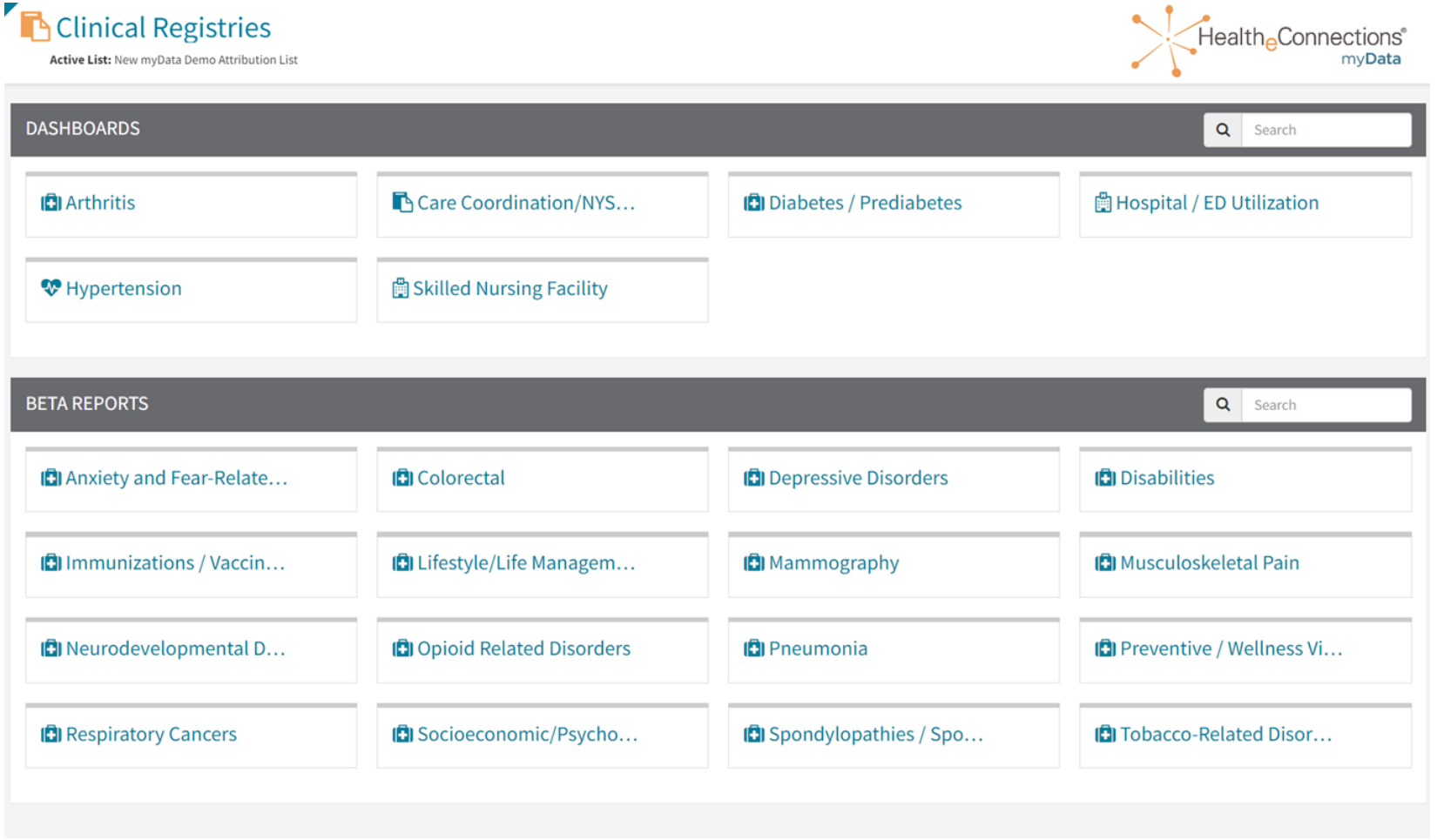
myData

- myData is an innovative application that allows a user to easily access and understand their patient profiles, identify gaps in care, and see how they rank in quality measures

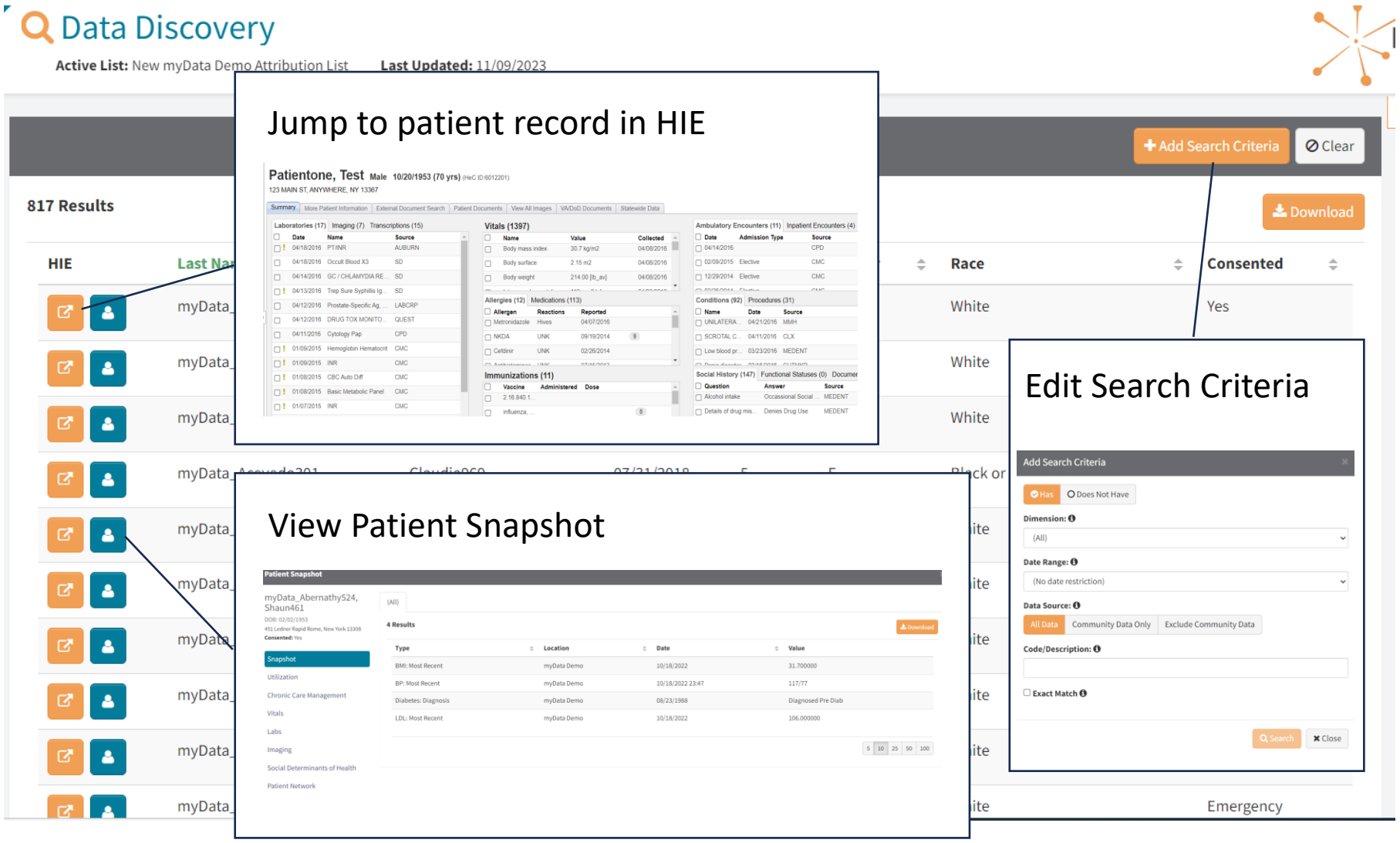
- HealtheConnections' community data will combine with your patient information to help you get the most complete picture of your patient panel

myData- clinical registries

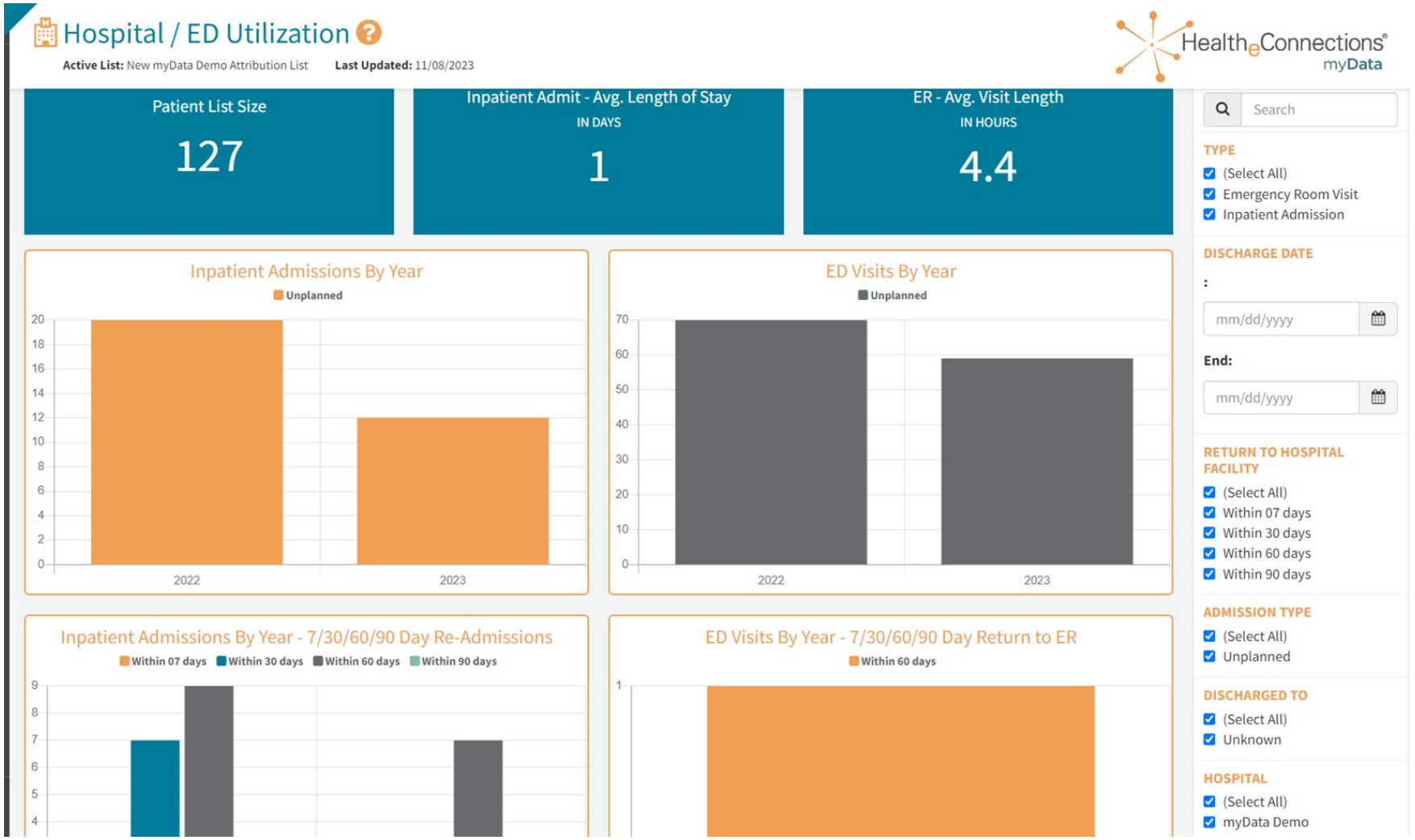
- Access to a variety of Clinical Registries built around PCMH, HEDIS, and UDS measurement models



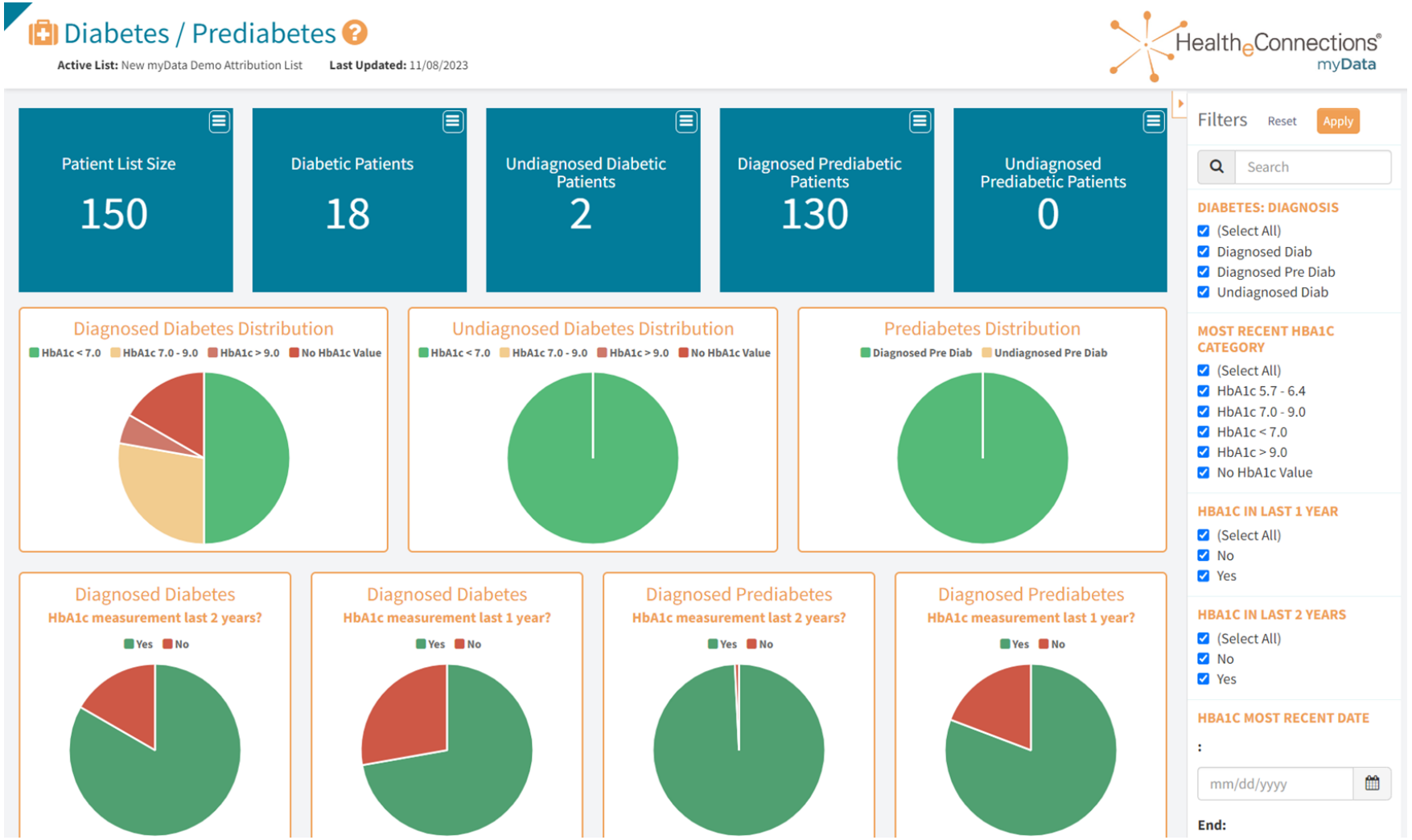
patient-level data discovery



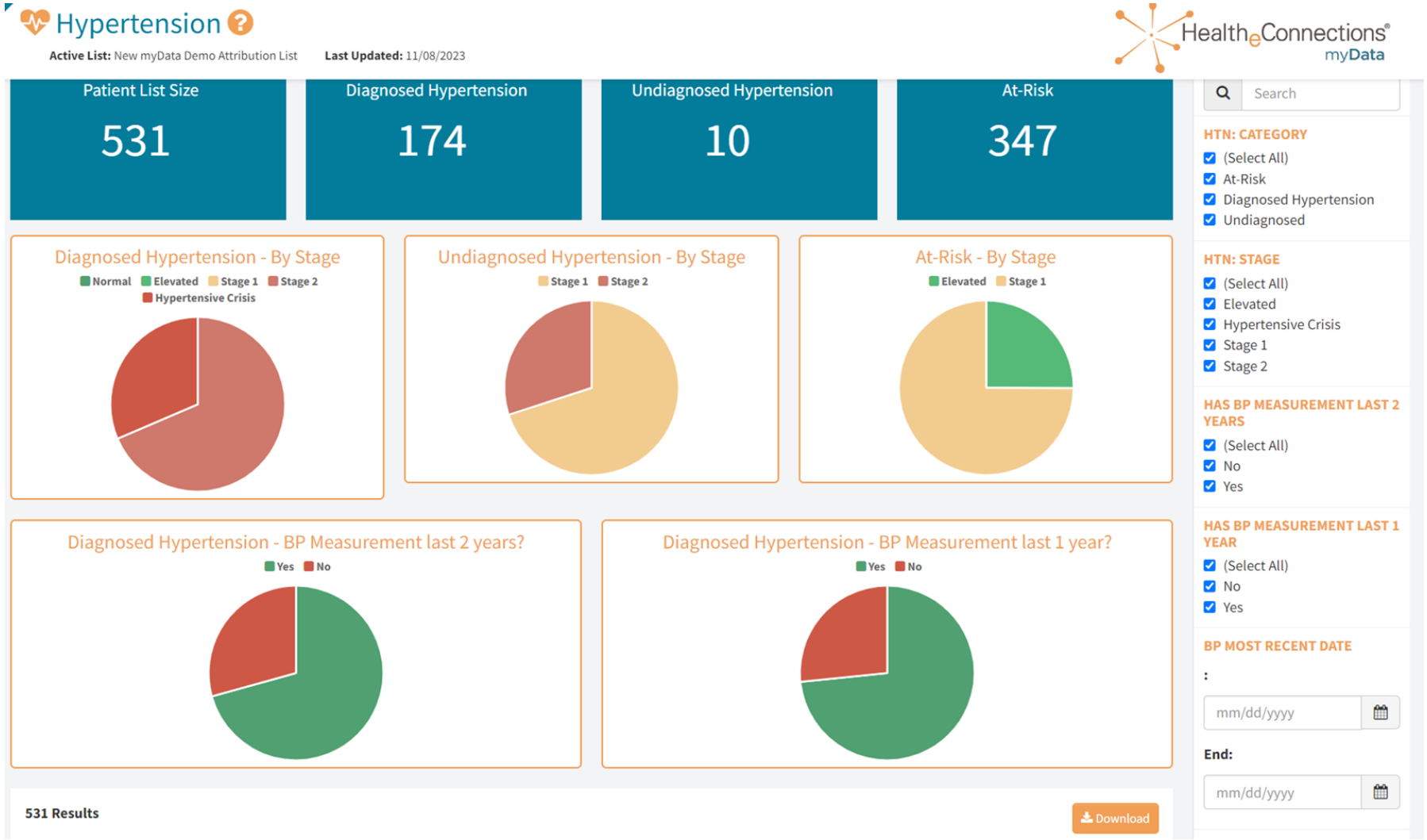
hospital/ED utilization dashboard



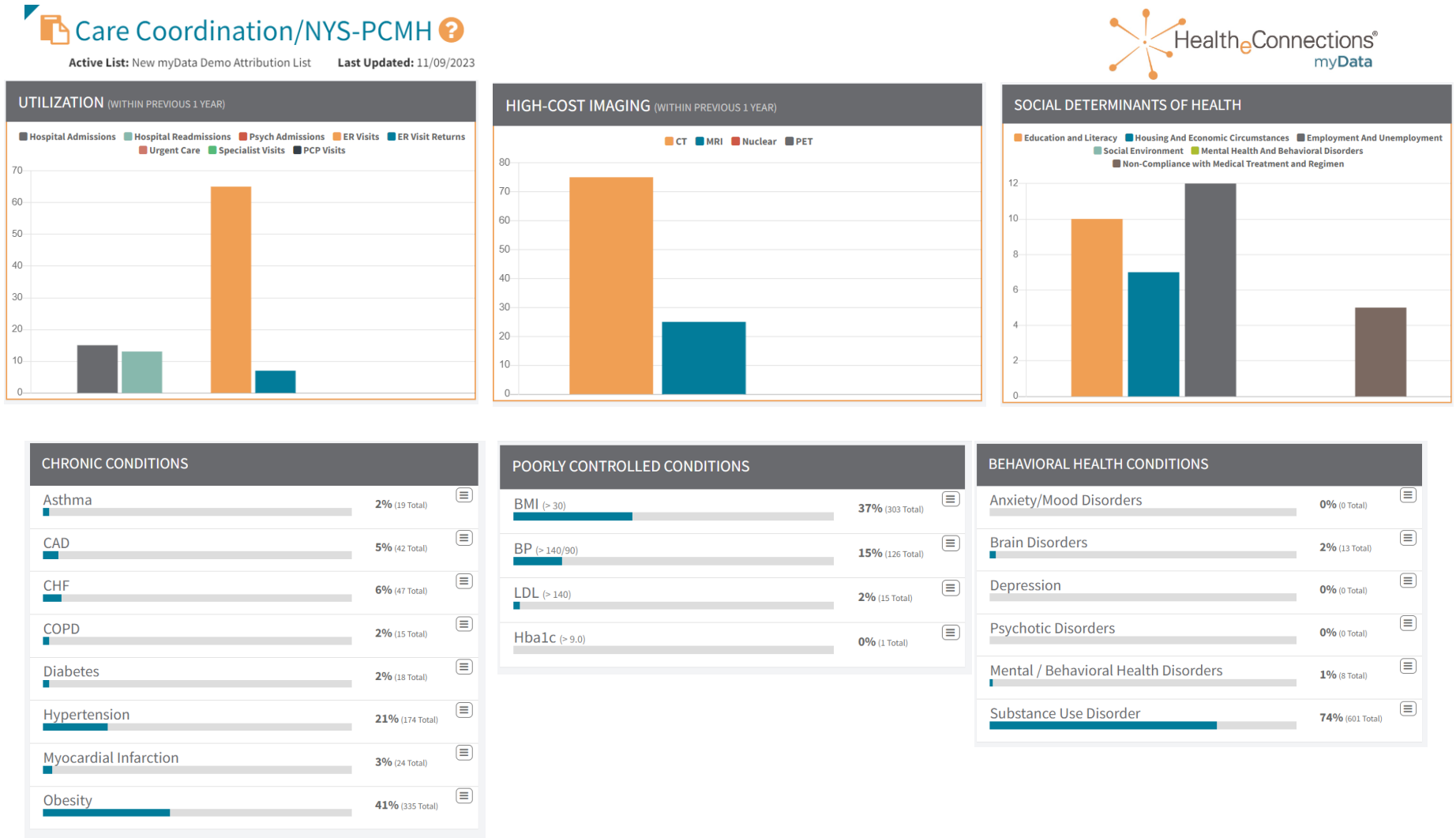
diabetes/prediabetes dashboard



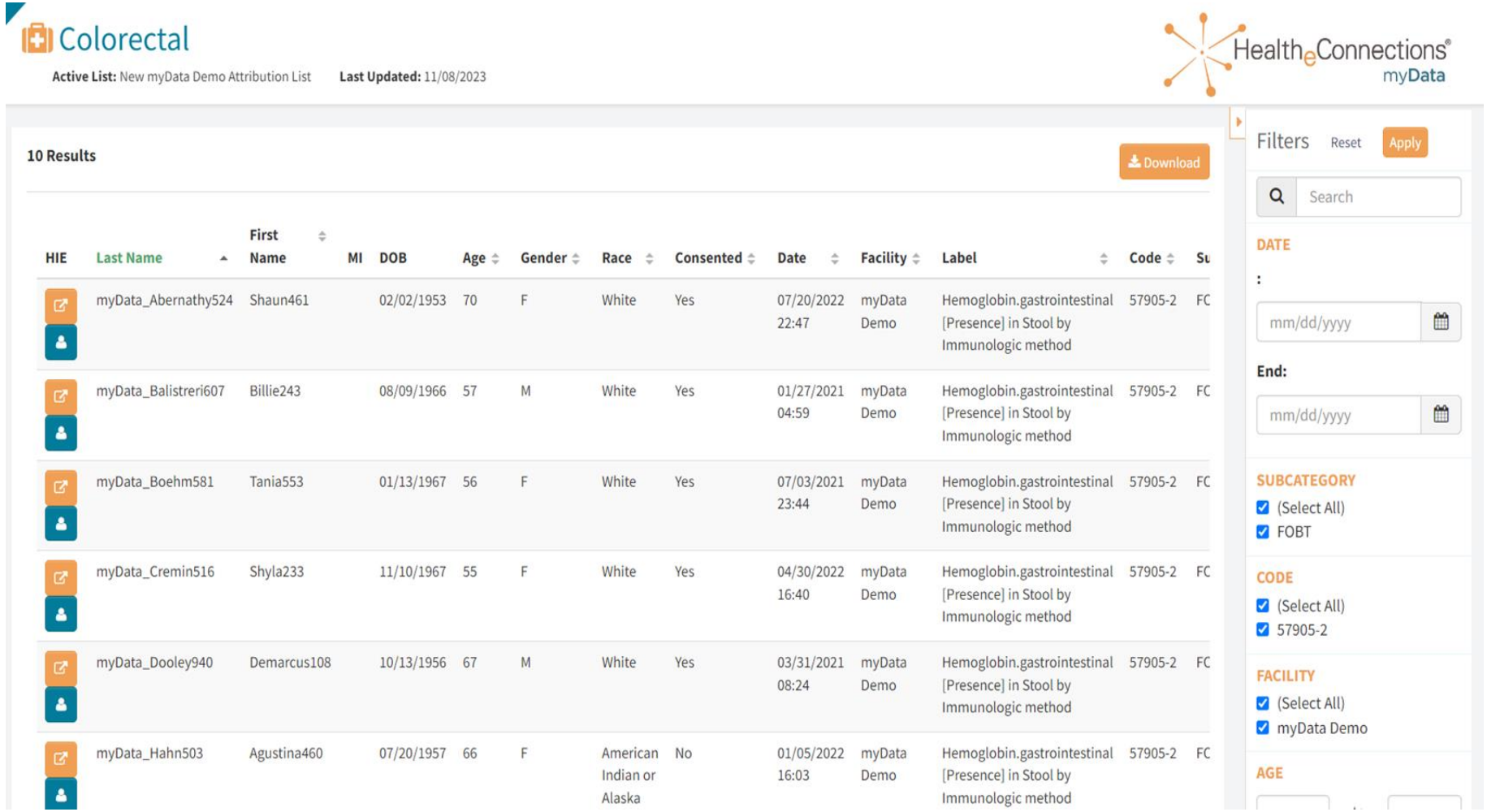
hypertension dashboard



care coordination/NYS-PCMH dashboard



colorectal beta report



HIE	Last Name	First Name	MI	DOB	Age	Gender	Race	Consented	Date	Facility	Label	Code	Su
	myData_Abernathy524	Shaun461		02/02/1953	70	F	White	Yes	07/20/2022 22:47	myData Demo	Hemoglobin.gastrointestinal [Presence] in Stool by Immunologic method	57905-2	FC
	myData_Balistreri607	Billie243		08/09/1966	57	M	White	Yes	01/27/2021 04:59	myData Demo	Hemoglobin.gastrointestinal [Presence] in Stool by Immunologic method	57905-2	FC
	myData_Boehm581	Tania553		01/13/1967	56	F	White	Yes	07/03/2021 23:44	myData Demo	Hemoglobin.gastrointestinal [Presence] in Stool by Immunologic method	57905-2	FC
	myData_Cremin516	Shyla233		11/10/1967	55	F	White	Yes	04/30/2022 16:40	myData Demo	Hemoglobin.gastrointestinal [Presence] in Stool by Immunologic method	57905-2	FC
	myData_Dooley940	Demarcus108		10/13/1956	67	M	White	Yes	03/31/2021 08:24	myData Demo	Hemoglobin.gastrointestinal [Presence] in Stool by Immunologic method	57905-2	FC
	myData_Hahn503	Agustina460		07/20/1957	66	F	American Indian or Alaska	No	01/05/2022 16:03	myData Demo	Hemoglobin.gastrointestinal [Presence] in Stool by Immunologic method	57905-2	FC

Thank you!

315-671-2241 x5
healtheconnections.org

HEALTHeLINK™

Regional Health Improvement

Merging with the Population Health Collaborative

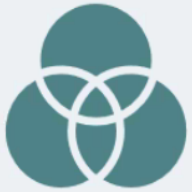
This partnership combines the unique capabilities of HEALTHeLINK with Population Health Collaborative's experience in bringing together community resources to deliver health and wellness programs.

Working with providers, public health and community resources to develop strategies to improve patient care, while at the same time confronting health equity and addressing social determinants of health.

Layering clinical data, with Social Determinants of Health Data will help to identify areas of the community in need and create a baseline for determining the success of programs aimed at improving health.

HEALTHeLINK Approach

Bring people together to agree on common priorities



Create a single, trusted source of data that's meaningful and powerful

Make data transparent to empower decision makers

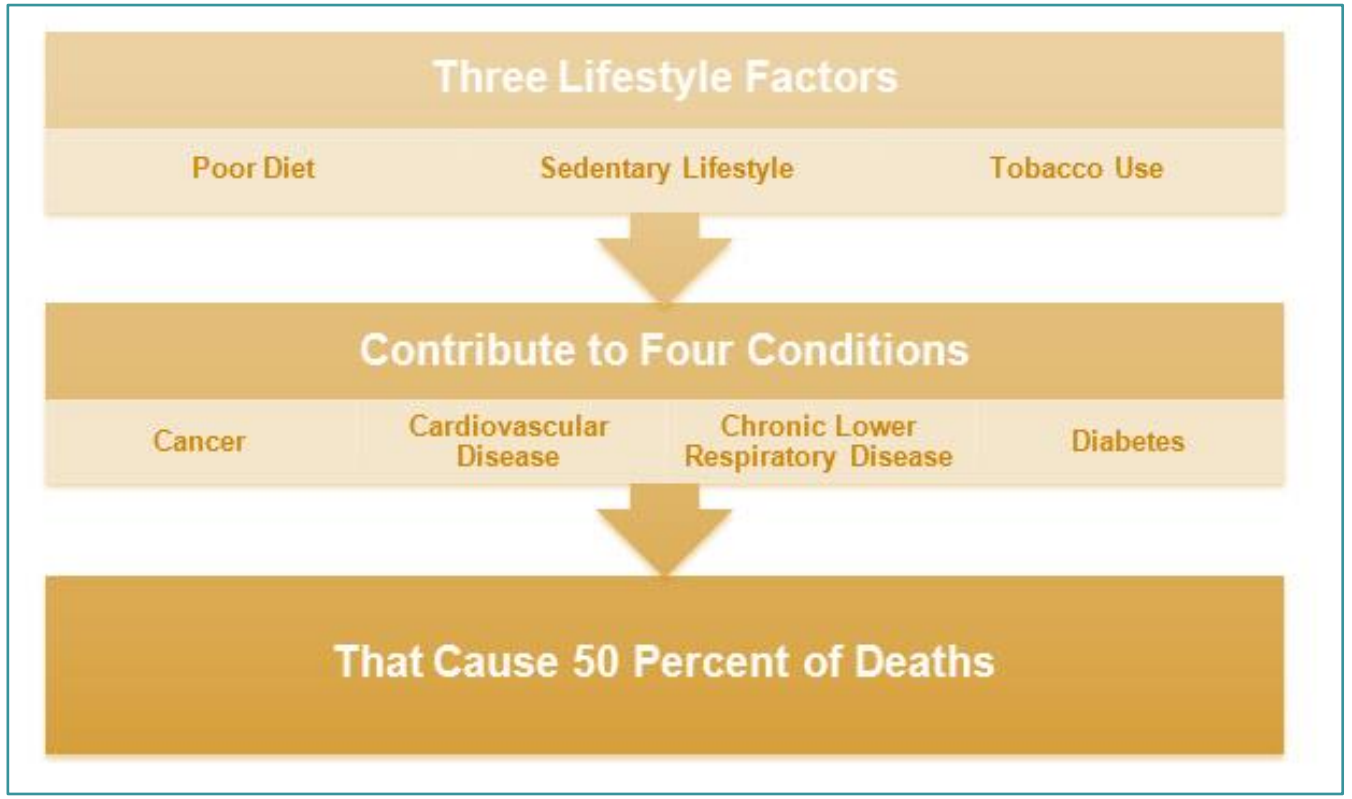
RHI Mission

Identify opportunities for improving the health and health care of the communities in WNY and facilitate planning and implementation of strategies for addressing those opportunities to achieve health equity.

Service Expansion
Community Dashboard Development

Priority Metrics

- ✓Diabetes Rates
- ✓Diabetes Poor Control
- ✓Hypertension Rates
- ✓Hypertension Control
- ✓Colorectal Cancer Screening Rate
- ✓Breast Cancer Screening
- ✓Cervical Cancer Screening
- ✓Tobacco Use
- ✓Obesity Rates



Community Dashboard Development

- Using health outcomes data, stratify using demographic data:
  - Geographic Location – County, Zip, Census Track
  - Race
  - Ethnicity
  - Language
  - Gender
  - Age
  - Insurance Type

HEALTHeLINK DASHBOARD

HEALTH EQUITY & WELLNESS

In our region, country, and world, **the environments where we are born, live, learn, work, play, worship, and age affect our health and quality of life.** The conditions of these environments are called social determinants of health (SDOH). SDOH contribute to wide health disparities and inequities.

This dashboard was created to present the current state of population health in Western New York (WNY) to give an impression of where and how to focus efforts **to improve the health of our community and reduce health disparities within it.**

The U.S. Department of Health and Human Services (DHHS) along with New York State, have set specific prevention goals related to chronic conditions like heart disease, cancer, and diabetes.

The icons below are used to designate where these public health goals came from.

HEALTH BY POPULATION

HEALTH BY LOCATION

METRICS & RESOURCES

HOW TO USE THIS DASHBOARD

Click on a map or chart to filter and drill down. **Ctrl+Click** allows multiple selections. **Right Click** allows a data table view.

Use screen shots to save information for needs assessments, grant applications, or presentations.

This icon designates **a measure with HEDIS restrictions.** To learn more, visit our Resources page.

The data in this dashboard is derived from adult Electronic Health Records (EHRs) through the WNY Regional Health Information Organization (RHIO), HEALTHeLINK, during the lookback period of 1/1/2020 - 12/31/2022.

HEALTHeLINK DASHBOARD

Comparison Data

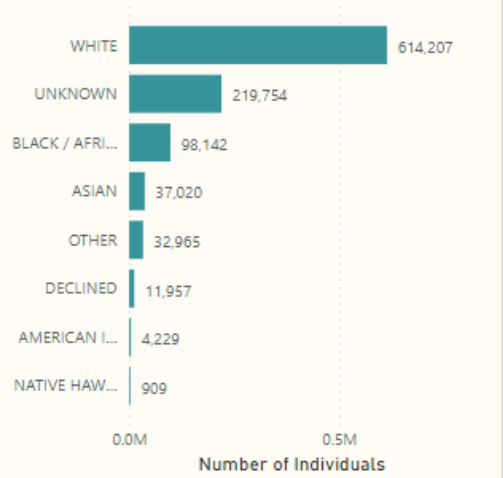
County: ERIE ,NY

Clear filters

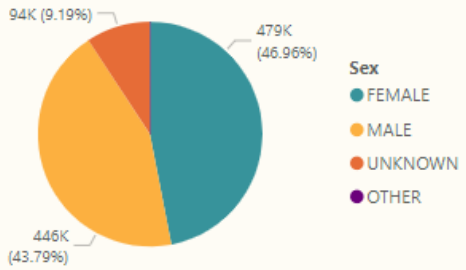
The HEALTHeLINK Population Is: 1,019,183

The Census Population Is: 731,777

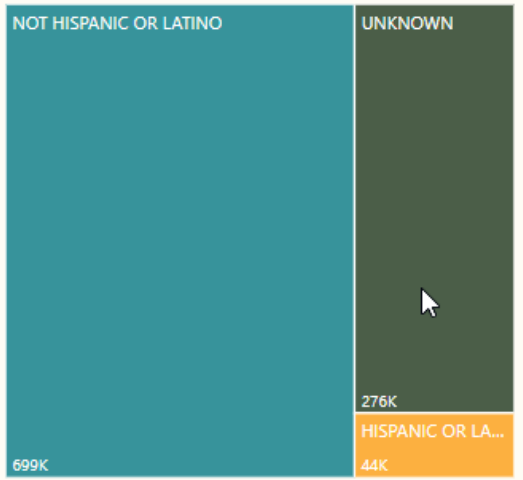
Data is derived from adult Electronic Health Records (EHRs) through the WNY Regional Health Information Organization (RHIO), HEALTHeLINK, during the lookback period of 1/1/2020 - 12/31/2022.



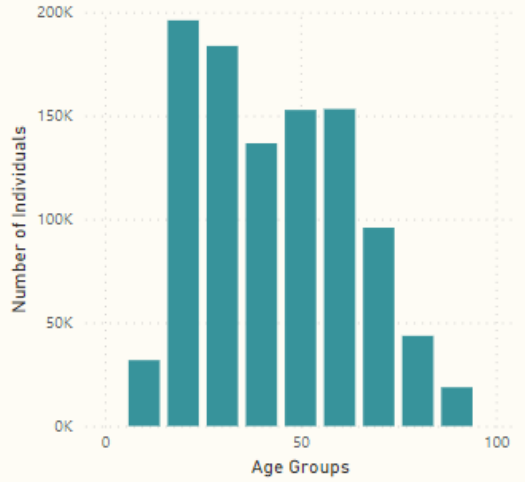
RACE DISTRIBUTION



SEX DISTRIBUTION



ETHNICITY DISTRIBUTION



AGE DISTRIBUTION

Breast Cancer Screening Rate	Cervical Cancer Screening Rate	Colorectal Cancer Screening Rate	Diabetes Rate	Hypertension Rate	Smoking Rate	Obesity Rate
59.9% H	48.2% H	42.6% H	9.2%	16.6%	9.0%	26.4%
NYS Goal 87.7%	NYS Goal 86.3%	NYS Goal 80.0%	NYS Rate 10.7%	US Goal 18.9%	US Goal 17.4%	NYS Goal 24.2%

HEALTHeLINK DASHBOARD

HEALTH EQUITY & WELLNESS

In our region, country, and world, **the environments where we are born, live, learn, work, play, worship, and age affect our health and quality of life.** The conditions of these environments are called social determinants of health (SDOH). SDOH contribute to wide health disparities and inequities.

This dashboard was created to present the current state of population health in Western New York (WNY) to give an impression of where and how to focus efforts **to improve the health of our community and reduce health disparities within it.**

The U.S. Department of Health and Human Services (DHHS) along with New York State, have set specific prevention goals related to chronic conditions like heart disease, cancer, and diabetes.

The icons below are used to designate where these public health goals came from.

HEALTH BY POPULATION

HEALTH BY LOCATION

METRICS & RESOURCES

HOW TO USE THIS DASHBOARD

Click on a map or chart to filter and drill down. **Ctrl+Click** allows multiple selections. **Right Click** allows a data table view.

Use screen shots to save information for needs assessments, grant applications, or presentations.

This icon designates **a measure with HEDIS restrictions.** To learn more, visit our Resources page.

The data in this dashboard is derived from adult Electronic Health Records (EHRs) through the WNY Regional Health Information Organization (RHIO), HEALTHeLINK, during the lookback period of 1/1/2020 - 12/31/2022.

HEALTHeLINK DASHBOARD

COUNTY | ZIPCODE

Comparison Data

County: NIAGARA ,NY

Clear filters

The HEALTHeLINK Population Is: 221,992

The Census Population Is: 167,867

Filters

Age

18 — 121

Race

All

Ethnicity

- [ ] HISPANIC OR LATINO
- [ ] NOT HISPANIC OR LATINO
- [ ] UNKNOWN

Sex

FEMALE	OTHER
MALE	UNKNOWN

Breast Cancer Screening Rate
55.1% (H)
NYS Goal
87.7%

Cervical Cancer Screening Rate
47.1% (H)
NYS Goal
86.3%

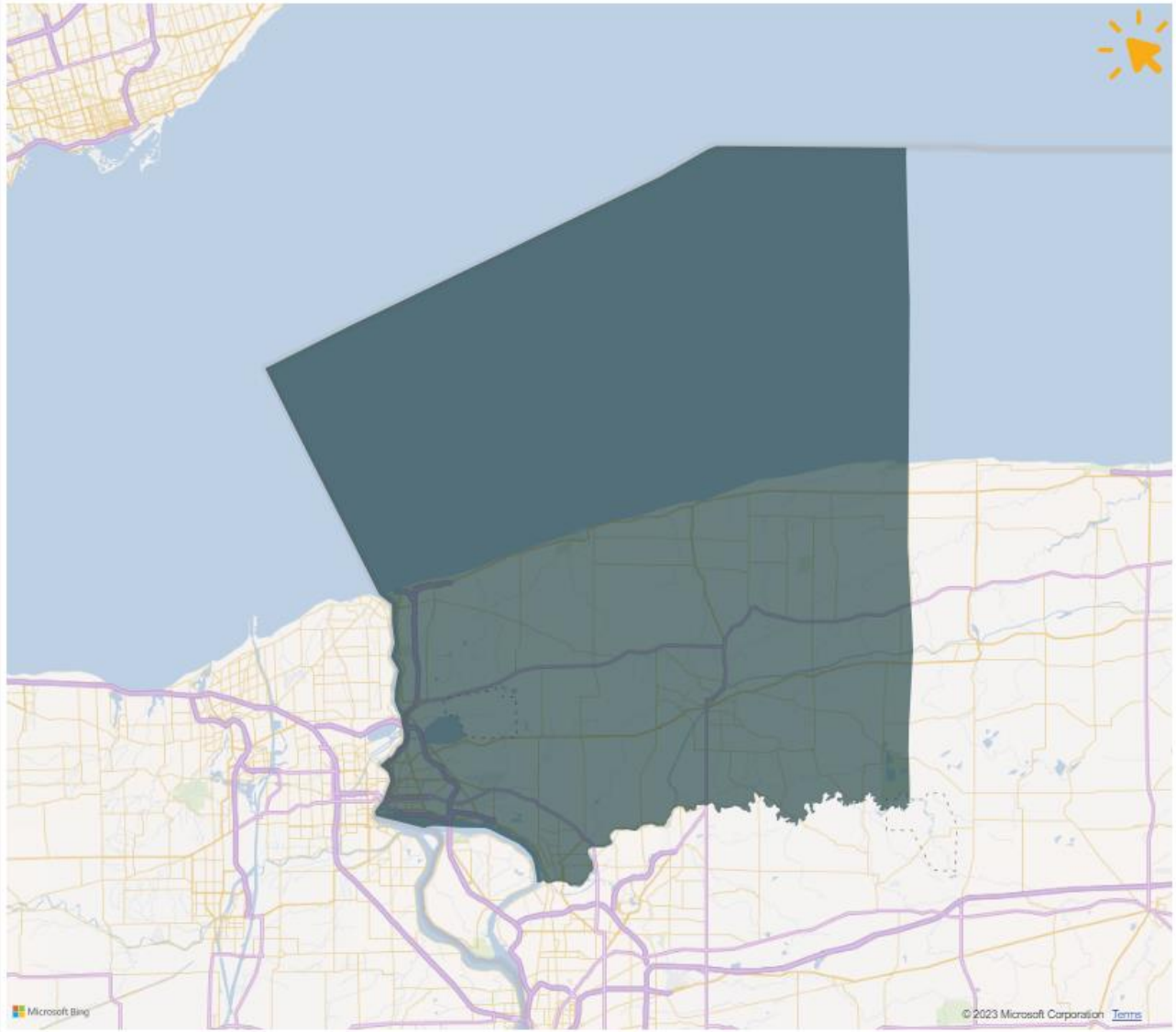
Colorectal Cancer Screening Rate
39.6% (H)
NYS Goal
80.0%

Diabetes Rate
11.2%
NYS Rate
10.7%

Hypertension Rate
18.6%
US Goal
18.9%

Smoking Rate
9.7%
US Goal
17.4%

Obesity Rate
30.2%
NYS Goal
24.2%



HEALTHeLINK DASHBOARD

SMOKING

County: NIAGARA ,NY | Clear filters

The HEALTHeLINK Population Is: 221,992

Filters

Age

18 — 121

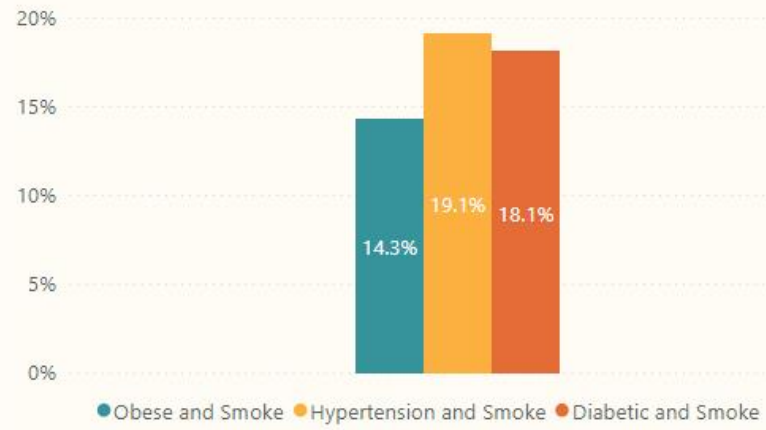
Ethnicity

- [ ] HISPANIC OR LATINO
- [ ] NOT HISPANIC OR LATINO
- [ ] UNKNOWN

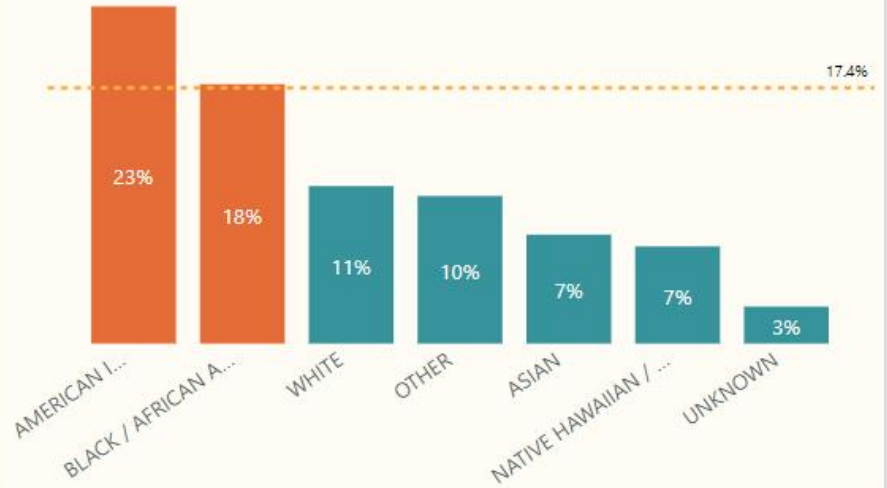
Sex

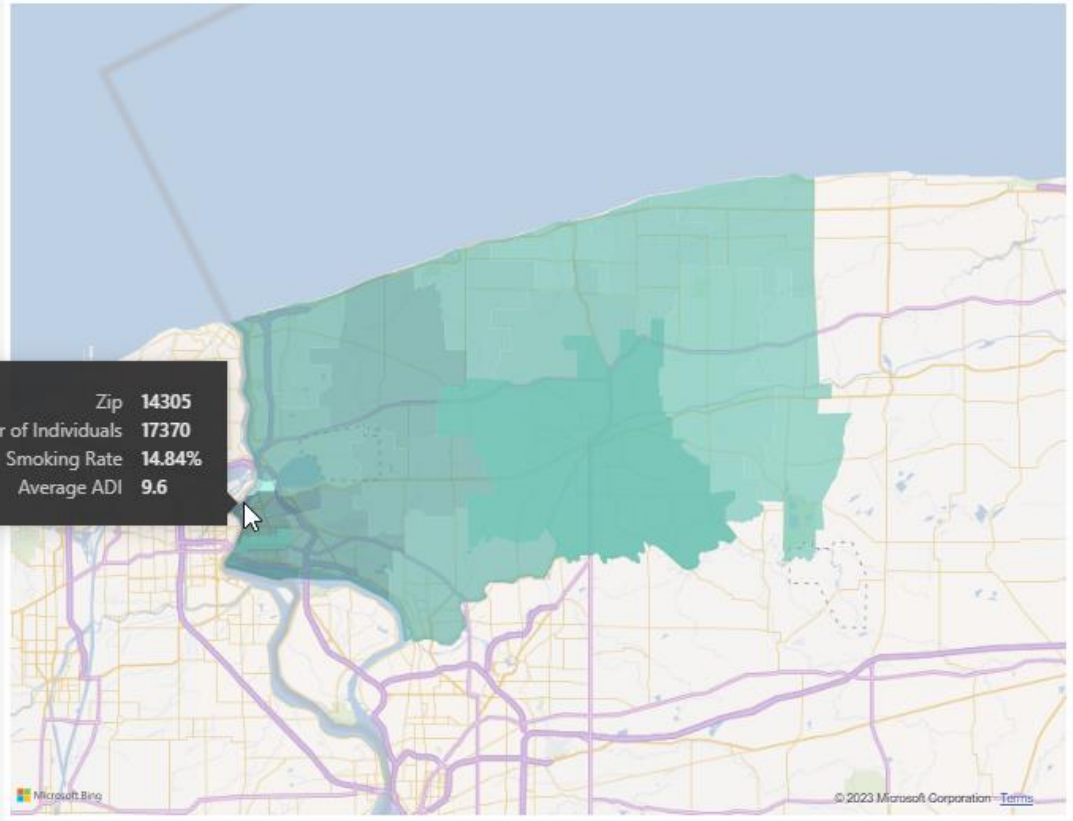
FEMALE	OTHER
MALE	UNKNOWN

COMORBIDITIES WITH SMOKING



SMOKING RATE BY RACE





Smoking Rate	9.7%
US Goal	17.4%

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HEALTHeLINK DASHBOARD

OBESITY

County: ERIE ,NY | Clear filters

The HEALTHeLINK Population Is: 1,019,183

Filters

Age

18 — 121

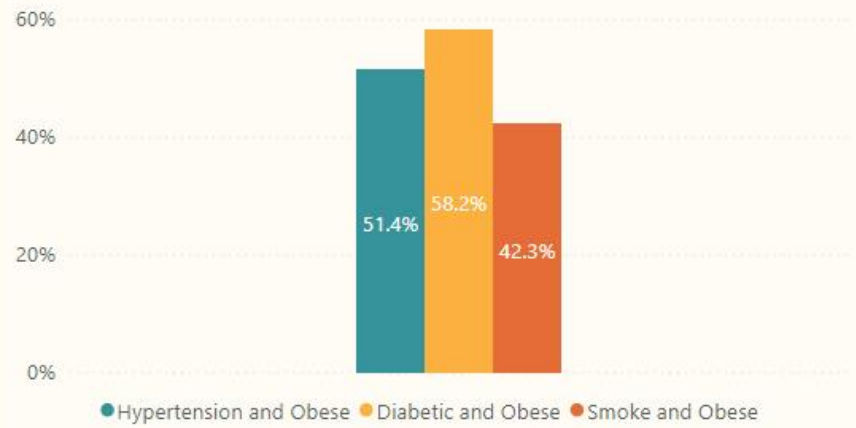
Ethnicity

- [ ] HISPANIC OR LATINO
- [ ] NOT HISPANIC OR LATINO
- [ ] UNKNOWN

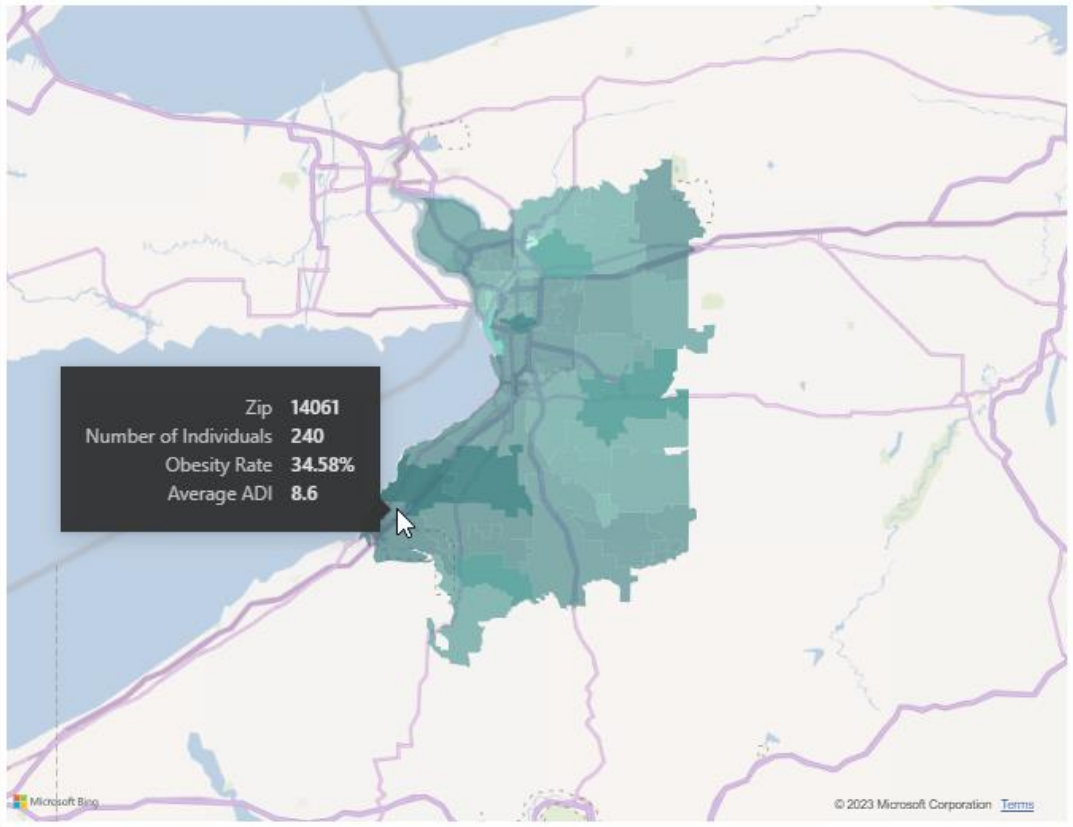
Sex

FEMALE	OTHER
MALE	UNKNOWN

COMORBIDITIES WITH OBESITY



OBESITY RATE BY RACE



Obesity Rate	26.4%
NYS Goal	24.2%

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HEALTHeLINK DASHBOARD

OBESITY

County: ERIE ,NY | Clear filters

The HEALTHeLINK Population Is: 10,105

Filters

Age

30 — 60

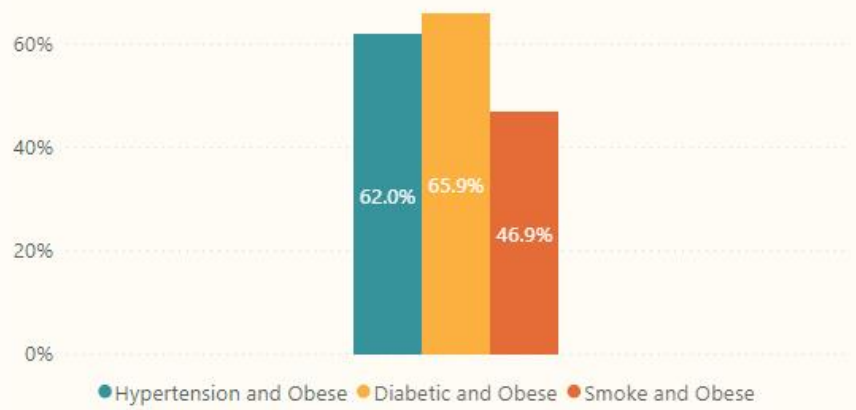
Ethnicity

- [x] HISPANIC OR LATINO
- [ ] NOT HISPANIC OR LATINO
- [ ] UNKNOWN

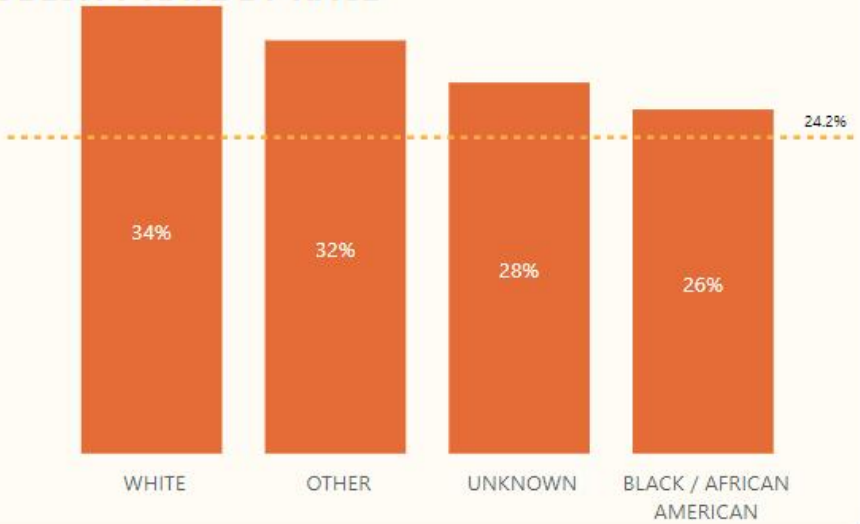
Sex

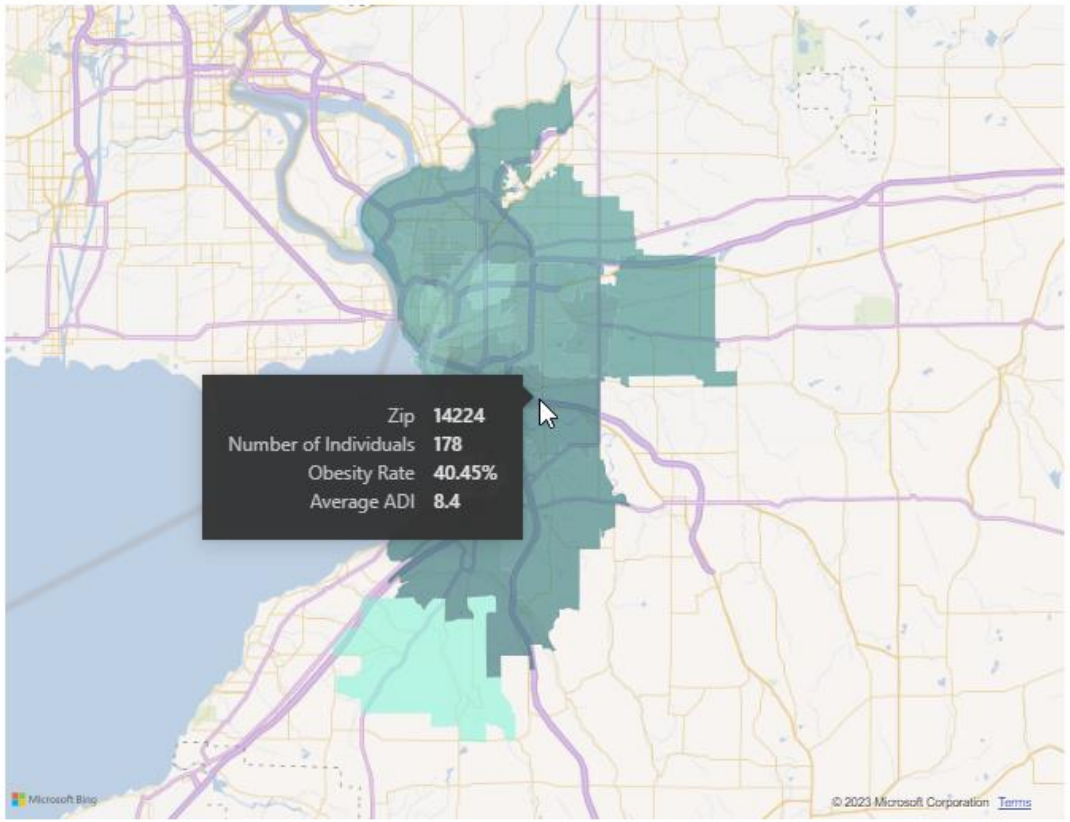
FEMALE | OTHER | MALE | UNKNOWN

COMORBIDITIES WITH OBESITY



OBESITY RATE BY RACE





Obesity Rate	31.9%
NYS Goal	24.2%

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HEALTHeLINK DASHBOARD

COUNTY | ZIPCODE

Comparison Data

County: NIAGARA ,NY

Clear filters

The HEALTHeLINK Population Is: 13,811

Filters

Age

18 — 121

Race

All

Ethnicity

- [ ] HISPANIC OR LATINO
- [ ] NOT HISPANIC OR LATINO
- [ ] UNKNOWN

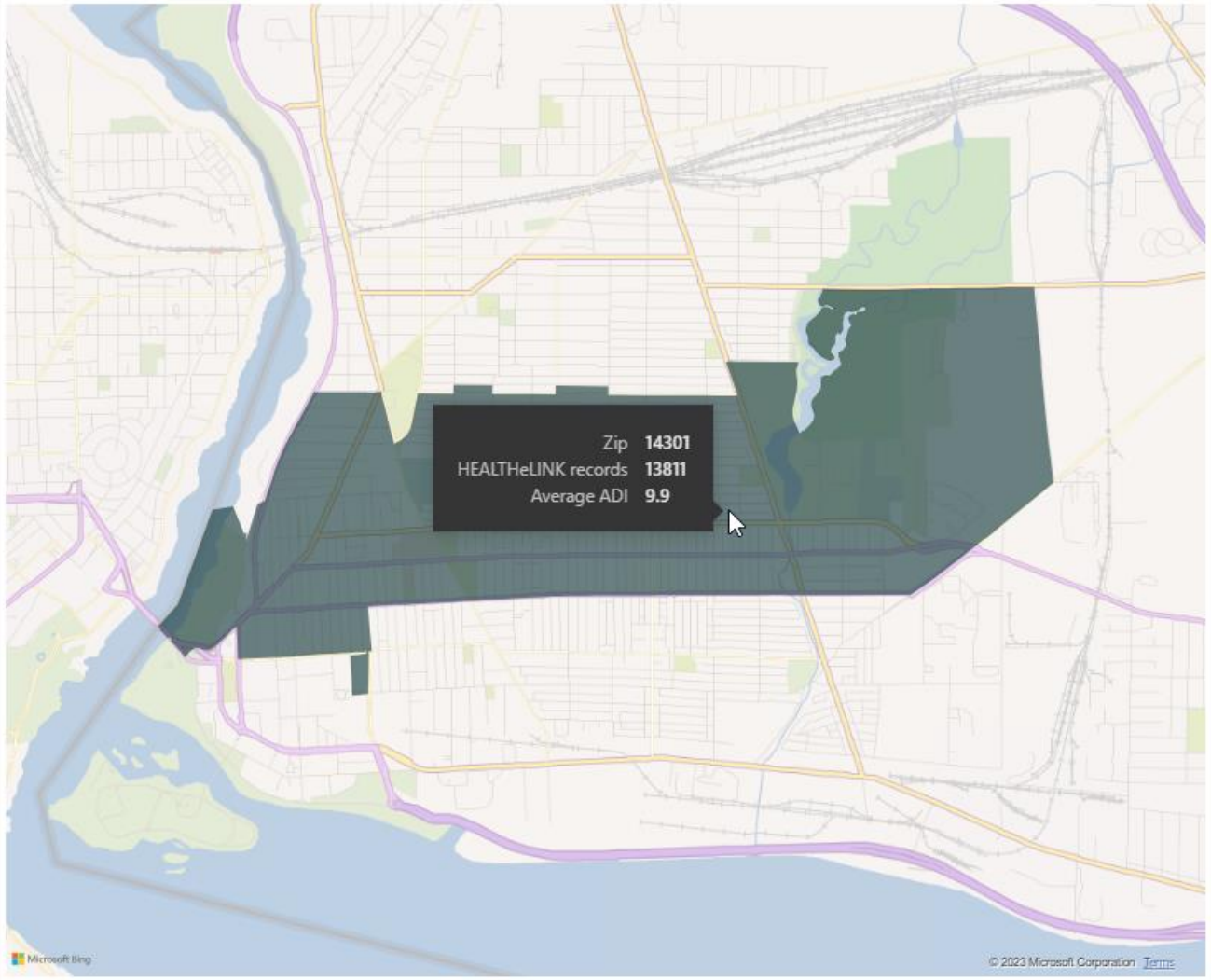
Sex

FEMALE	OTHER
MALE	UNKNOWN

Zip Code

14301

Breast Cancer Screening Rate	34.5% (H)	NYS Goal 87.7%
Cervical Cancer Screening Rate	32.6% (H)	NYS Goal 86.3%
Colorectal Cancer Screening Rate	22.9% (H)	NYS Goal 80.0%
Diabetes Rate	12.0%	NYS Rate 10.7%
Hypertension Rate	18.0%	US Goal 18.9%
Smoking Rate	15.7%	US Goal 17.4%
Obesity Rate	28.3%	NYS Goal 24.2%



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HEALTHeLINK DASHBOARD

Clear filters

The HEALTHeLINK Population Is:

ZIP Code 1

County: ERIE ,NY

Zip: 14211

Age: 18 – 121

Ethnicity
- HISPANIC OR LATINO
- NOT HISPANIC OR LATINO
- UNKNOWN

Race: All

Sex: FEMALE, OTHER, MALE, UNKNOWN

		NYS Goal
Breast Cancer Screening Rate	47.2% (H)	87.7%
Cervical Cancer Screening Rate	38.9% (H)	86.3%
Colorectal Cancer Screening Rate	29.2% (H)	80.0%
Diabetes Rate	12.0%	NYS Rate 10.7%
Hypertension Rate	19.0%	US Goal 18.9%
Smoking Rate	11.3%	US Goal 17.4%
Obesity Rate	26.9%	24.2%

		NYS Goal
Breast Cancer Screening Rate	69.7% (H)	87.7%
Cervical Cancer Screening Rate	61.4% (H)	86.3%
Colorectal Cancer Screening Rate	54.1% (H)	80.0%
Diabetes Rate	6.5%	NYS Rate 10.7%
Hypertension Rate	14.5%	US Goal 18.9%
Smoking Rate	4.7%	US Goal 17.4%
Obesity Rate	23.3%	24.2%

ZIP Code 2

County: ERIE ,NY

Zip: 14032

Age: 18 – 121

Ethnicity
- HISPANIC OR LATINO
- NOT HISPANIC OR LATINO
- UNKNOWN

Race: All

Sex: FEMALE, UNKNOWN, MALE

HEALTHeLINK DASHBOARD

COUNTY | ZIPCODE

Comparison Data

County: ERIE ,NY

Clear filters

The HEALTHeLINK Population Is: LOW

Filters

Age

18 — 121

Ethnicity

- [ ] NOT HISPANIC OR LATINO
- [ ] UNKNOWN

Race

ASIAN

Sex

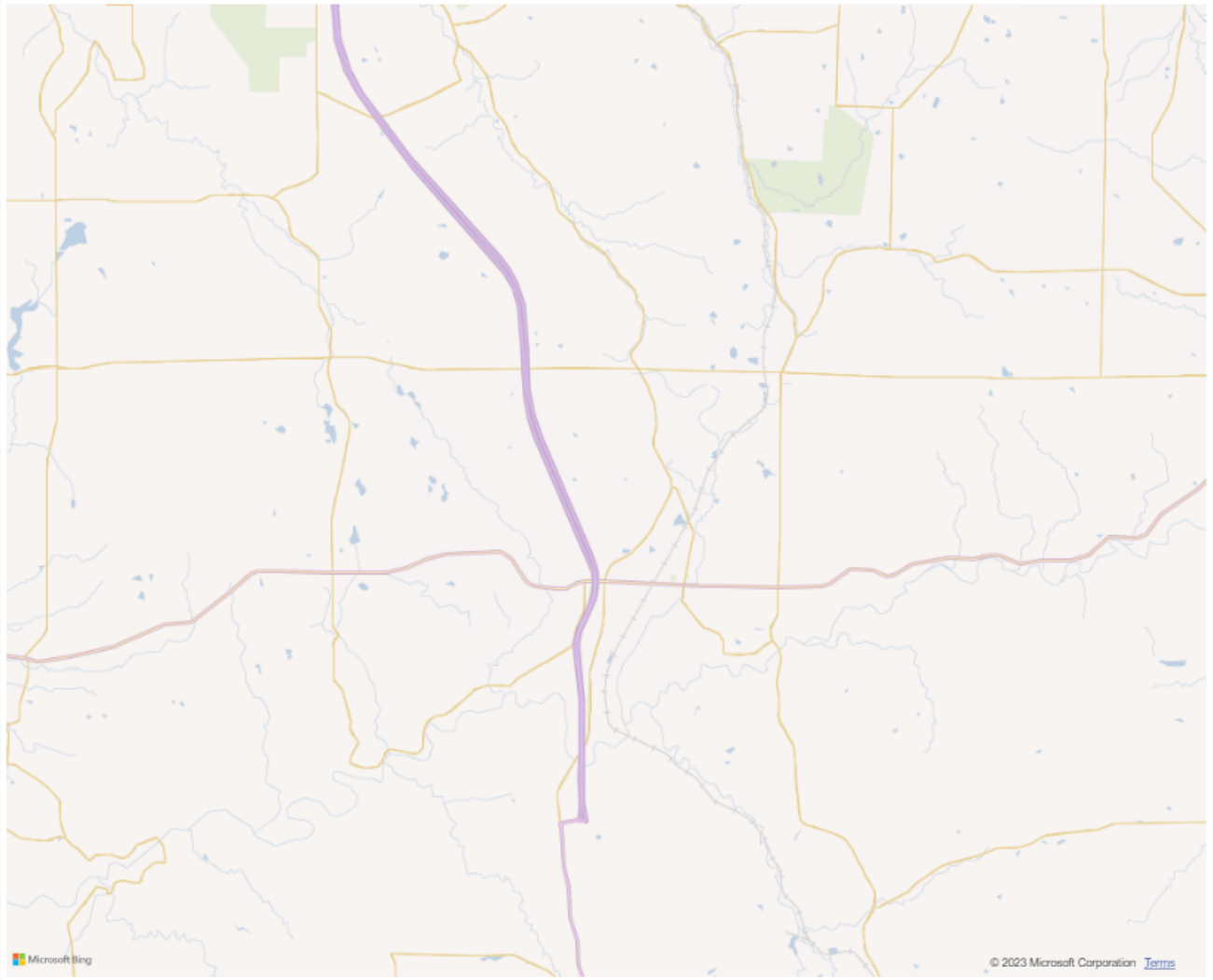
FEMALE

MALE

Zip Code

14141

Breast Cancer Screening Rate	0.0% (H)	NYS Goal 0.0%
Cervical Cancer Screening Rate	45.5% (H)	NYS Goal 0.0%
Colorectal Cancer Screening Rate	0.0% (H)	NYS Goal 0.0%
Diabetes Rate	6.3%	NYS Rate 10.7%
Hypertension Rate	0.0%	US Goal 18.9%
Smoking Rate	12.5%	US Goal 17.4%
Obesity Rate	12.5%	NYS Goal 24.2%



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Questions?

wnyhealthelink.com

716-206-0993

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@healthelink

YouTube.com/healthelink

HEALTHeLINK


Q
&
A

Continue the Conversation

RHIO Conversations will continue tomorrow!

Wed, Nov 15

- HEALTHeLINK
- Rochester RHIO
- HealtheConnections

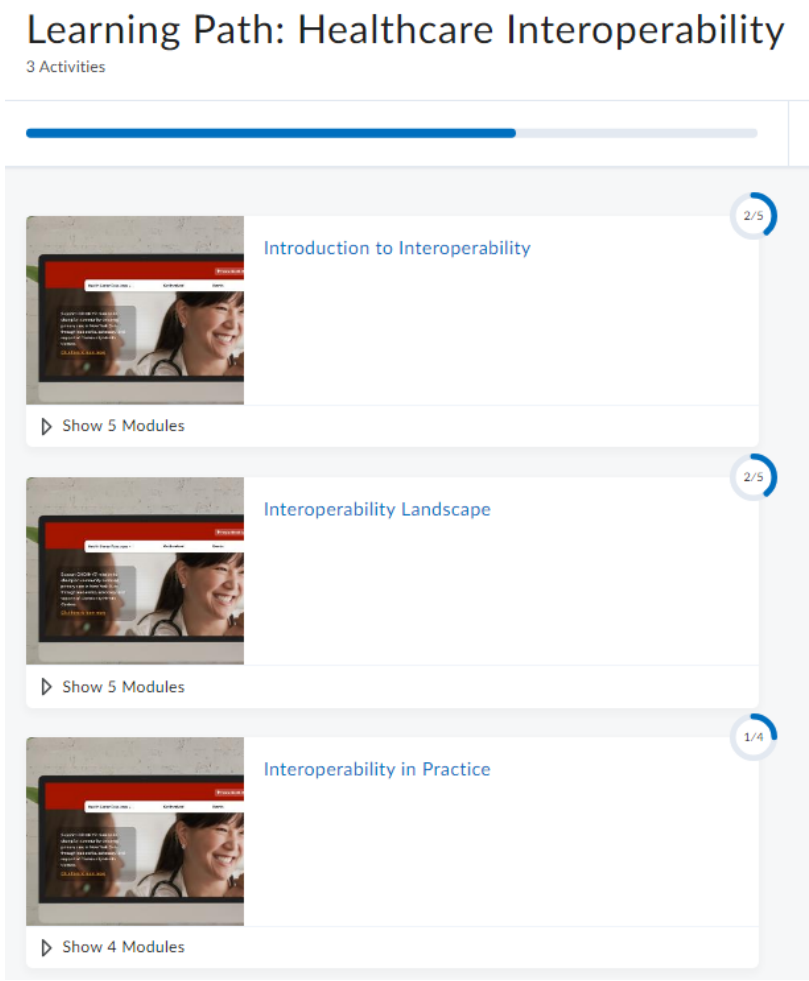
Thurs, November 16

- HIXNY
- Healthix
- Bronx RHIO

We hope to see you then!

Interoperability 101 Course

- Join the CHCANYS Hub!



Healthcare Interoperability

View Here

This **Healthcare Interoperability Learning Pathway** includes 3 courses and is designed for technology and EHR staff that are interested in learning the basics about interoperability in health care.

Thank you for joining us today. Please share your feedback using the survey link in the chat, the QR code below, or the link in the follow up email!