



COMMUNITY
HEALTH CARE
ASSOCIATION
of New York State

CHCANYS NYS-HCCN presents

RHIO Conversations

HEALTHeLINK

Rochester RHIO

HealthConnections

Day 1

November 15, 2023

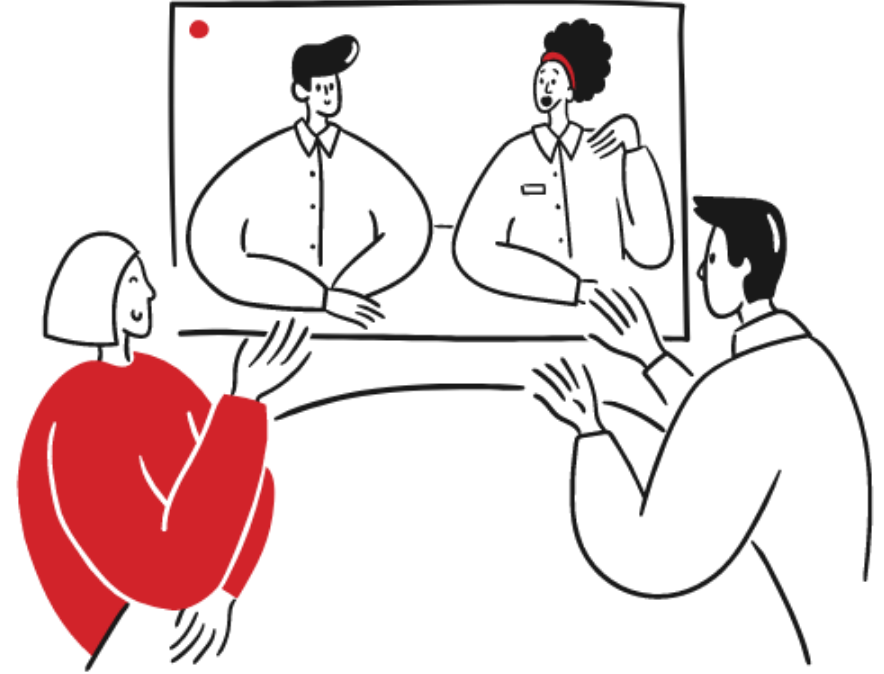
For more information, please email Anita Li at ali@CHCANYS.org



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](https://www.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 3 (11/15)

- RHIO Conversations
 - HEALTHeLINK
 - Rochester RHIO
 - HealtheConnections

Day 2 (11/8)

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

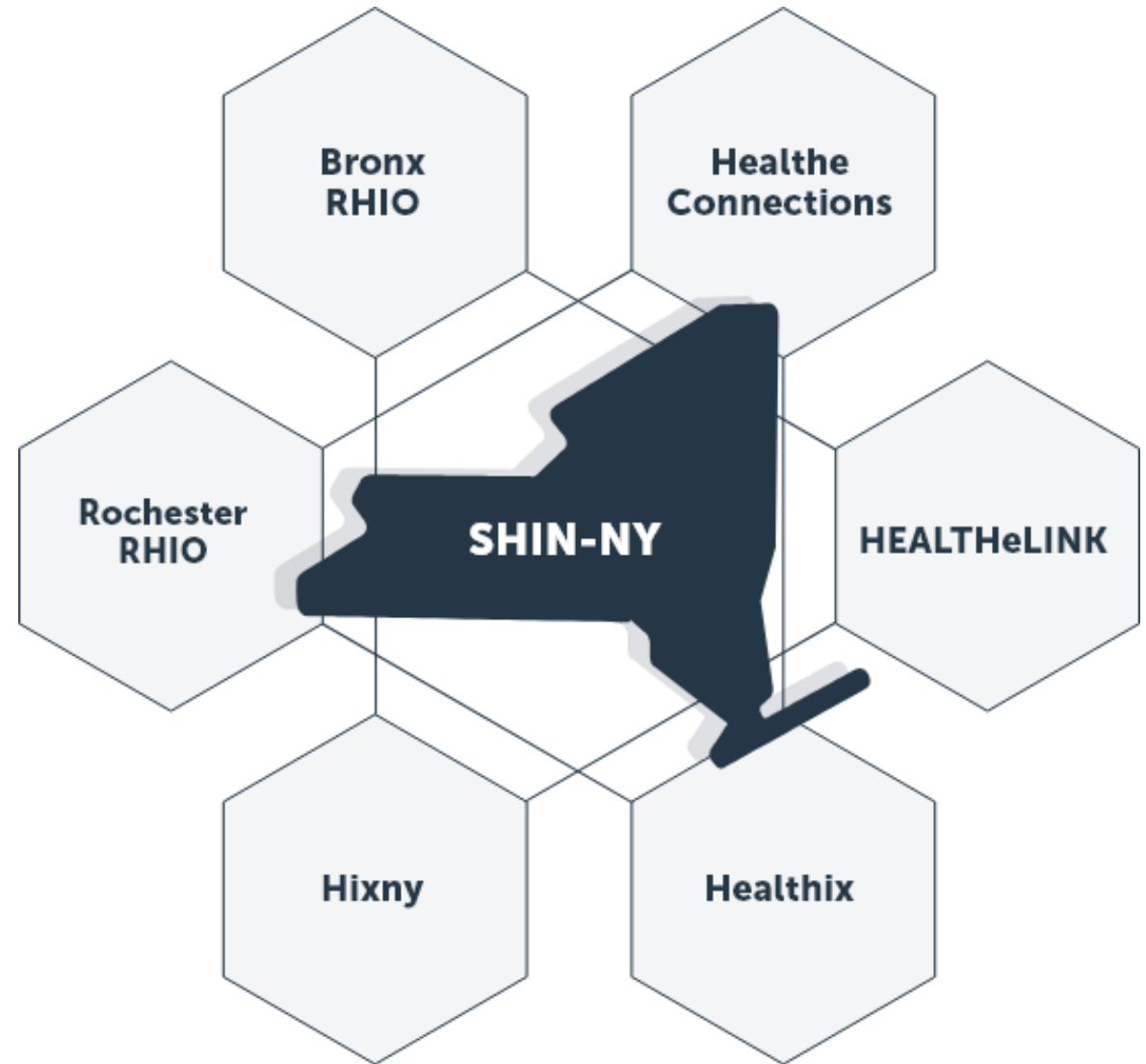
Day 4 (11/16)

- RHIO Conversations
 - HIXNY
 - Healthix
 - Bronx RHIO



New York State Health Information Exchange

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





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Manager

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Coordinator | HIT Services &
Solutions

Core Services



Patient Record Look-Up



Lab results



Radiology results and images (in most cases)



Data submitted from a medical provider's electronic medical record (EMR)



Medication fill history



Admission, discharge, and transfer (ADT) data



Transcribed reports

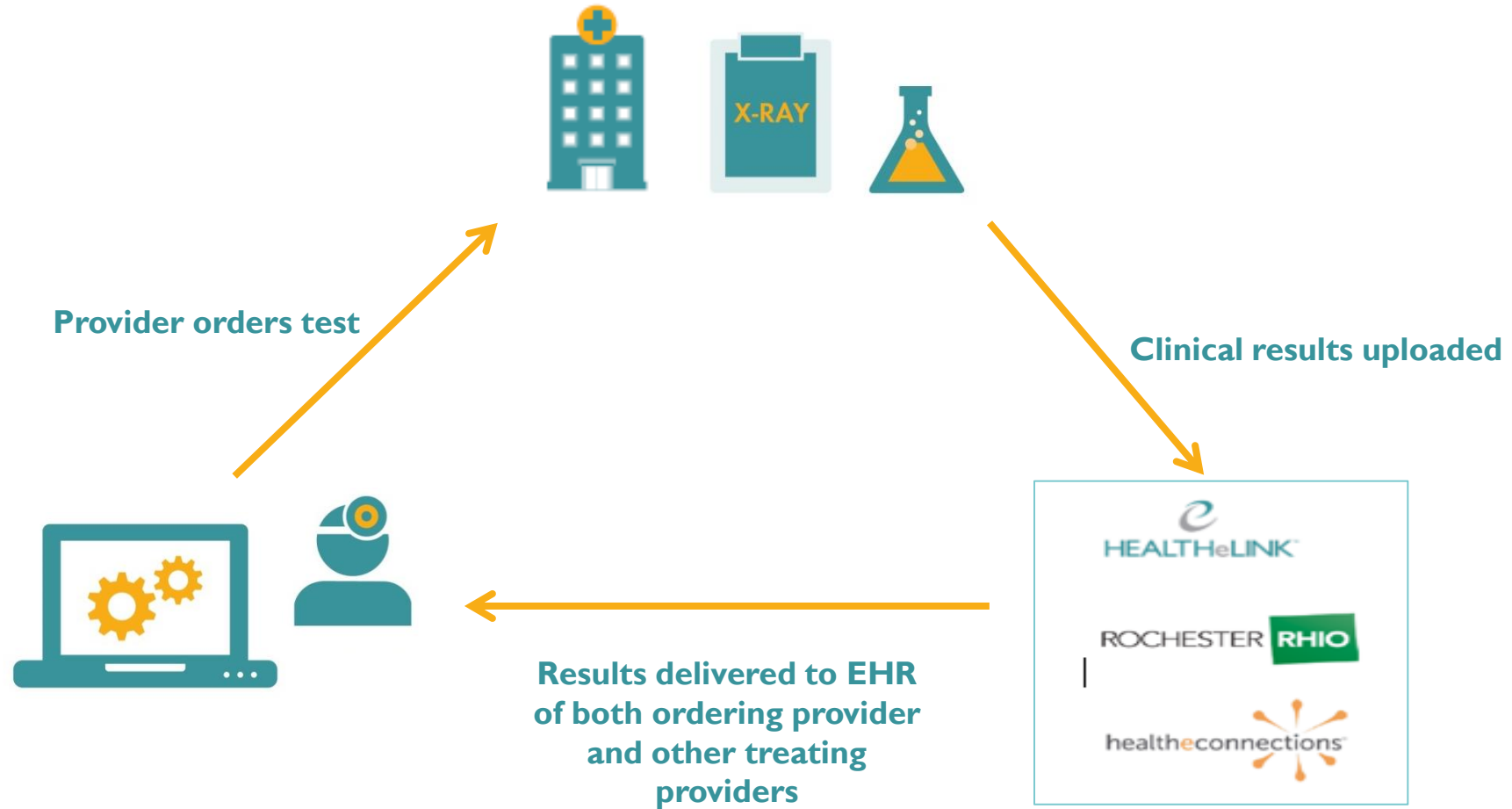


SHIN-NY

HEALTHeLINK[™]
ROCHESTER RHIO
healthconnections[™]



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**



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.



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.



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





ROCHESTER

RHIO

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.



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

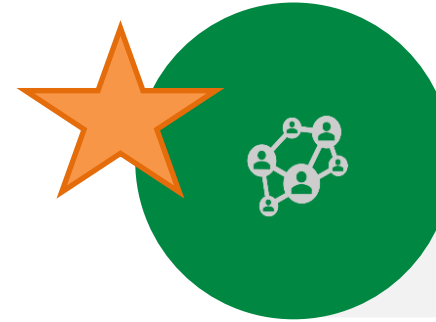


Community-wide efforts to solution for the collection, sharing, management, and care workflows related to HRSN originating from the healthcare sector.

2023 and Beyond



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



Healthcare Sector
Health Related
Social Need (HRSN)
Workgroup

ROCHESTER

RHIO



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.

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.

Objective 06

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



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.



NYeC I&I Community Referral Exchange

Use Cases:

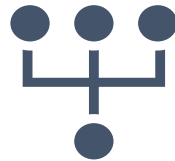
- A. Identifiers for person matching to enrich data and enable information exchange use cases. ★
- ★ B. Report to NYeC/DOH, through RRHIO, intra-network referral activity and HRSN data.
- C. Send a referral to another SCN when a service is not available within home SCN. ★
- D. Trigger a referral to a 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.

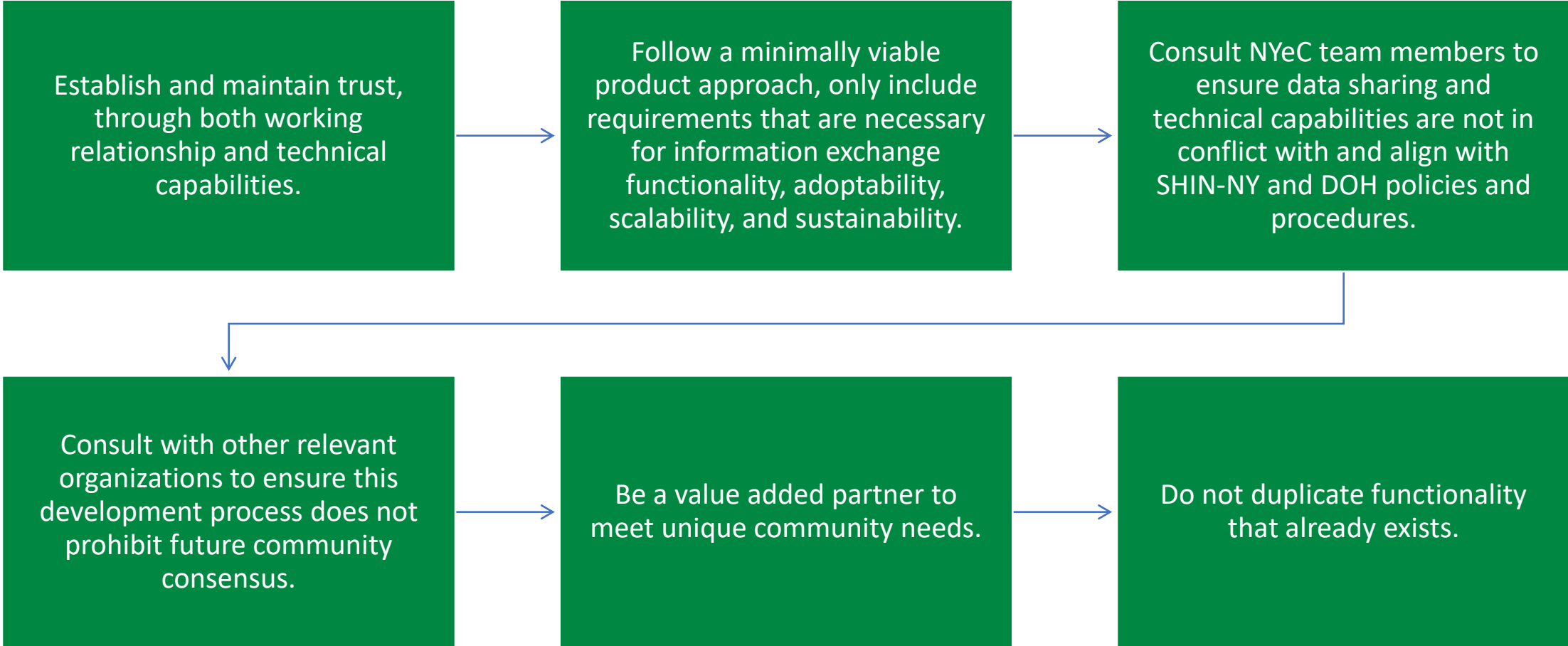


Determine if universal standards being established by the Gravity Project can be adopted for the minimum dataset for community referral exchange.



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

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.



regional activities



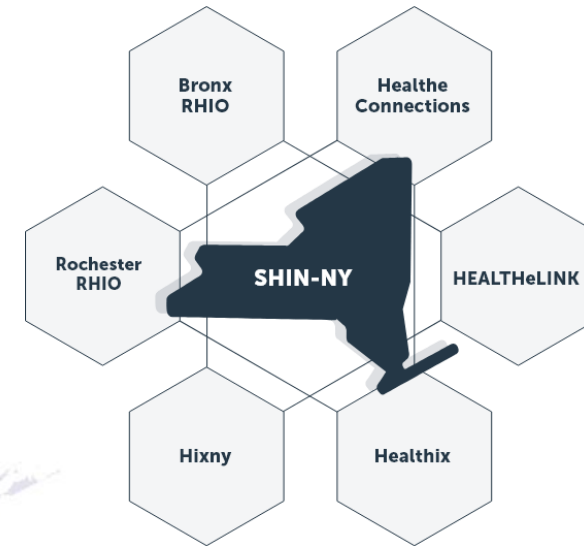
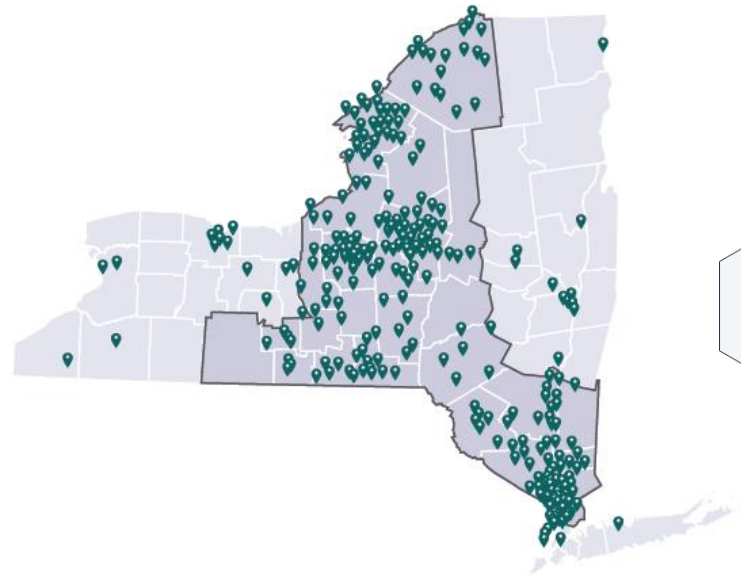
healtheConnections: who we are

- 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



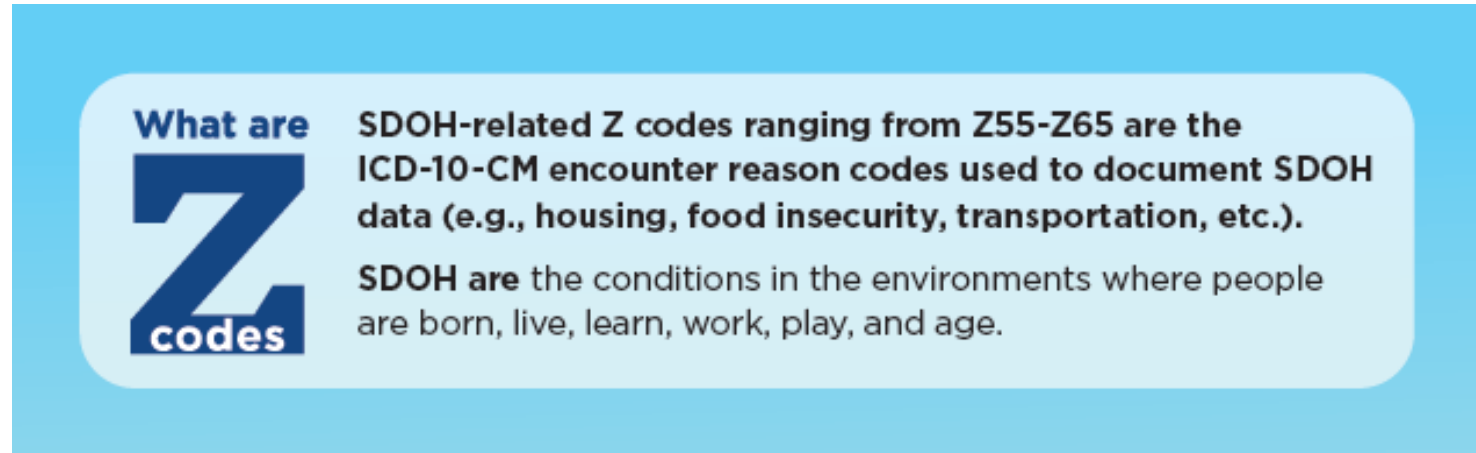
Social and Community
Context

[Social Determinants of Health - Healthy People 2030 | health.gov](https://www.health.gov/ourpriorities/healthy-people-2030)

HRSN = Health Related Social Needs

social needs data in the HIE

- coded data



What are Z codes

SDOH-related Z codes ranging from Z55-Z65 are the ICD-10-CM encounter reason codes used to document SDOH data (e.g., housing, food insecurity, transportation, etc.).

SDOH are the conditions in the environments where people are born, live, learn, work, play, and age.

- 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.”



New York State Medicaid Redesign Team (MRT) Waiver Amendment

New York Health Equity Reform (NYHER): Making Targeted, Evidence-Based Investments to Address the Health Disparities Exacerbated by the COVID-19 Pandemic

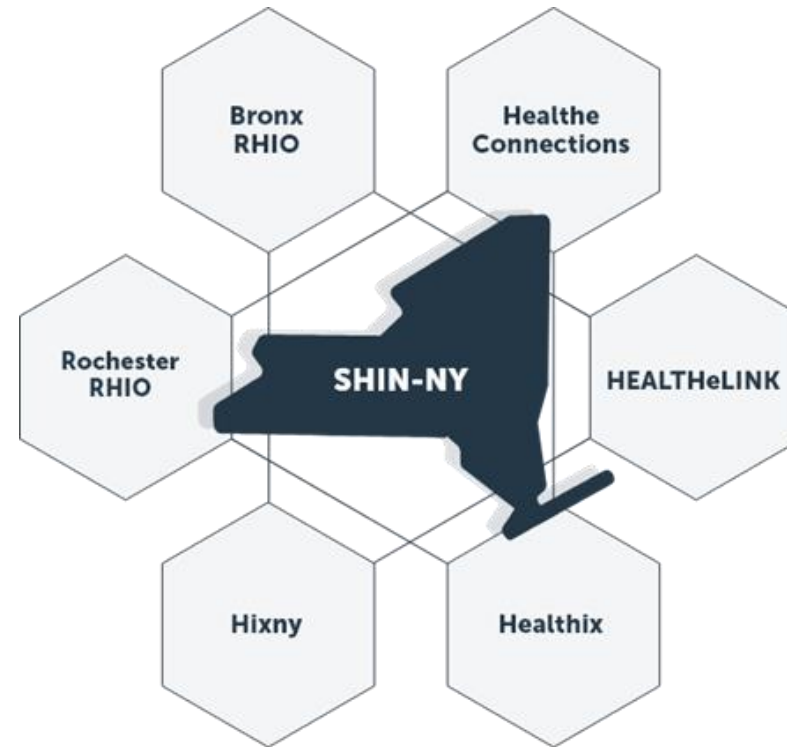
1115 Research and Demonstration Waiver Amendment
#11-W-00114/2

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

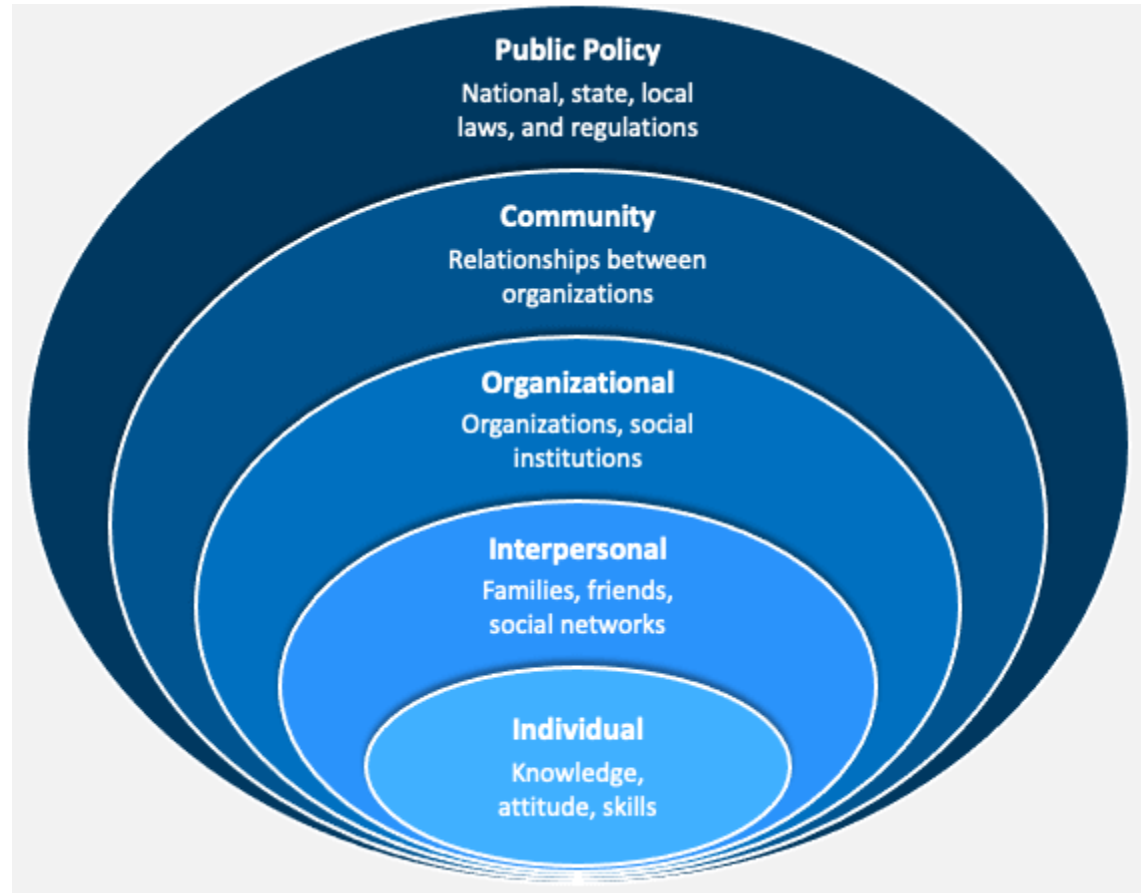
SHIN-NY data ingestion project team

- 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

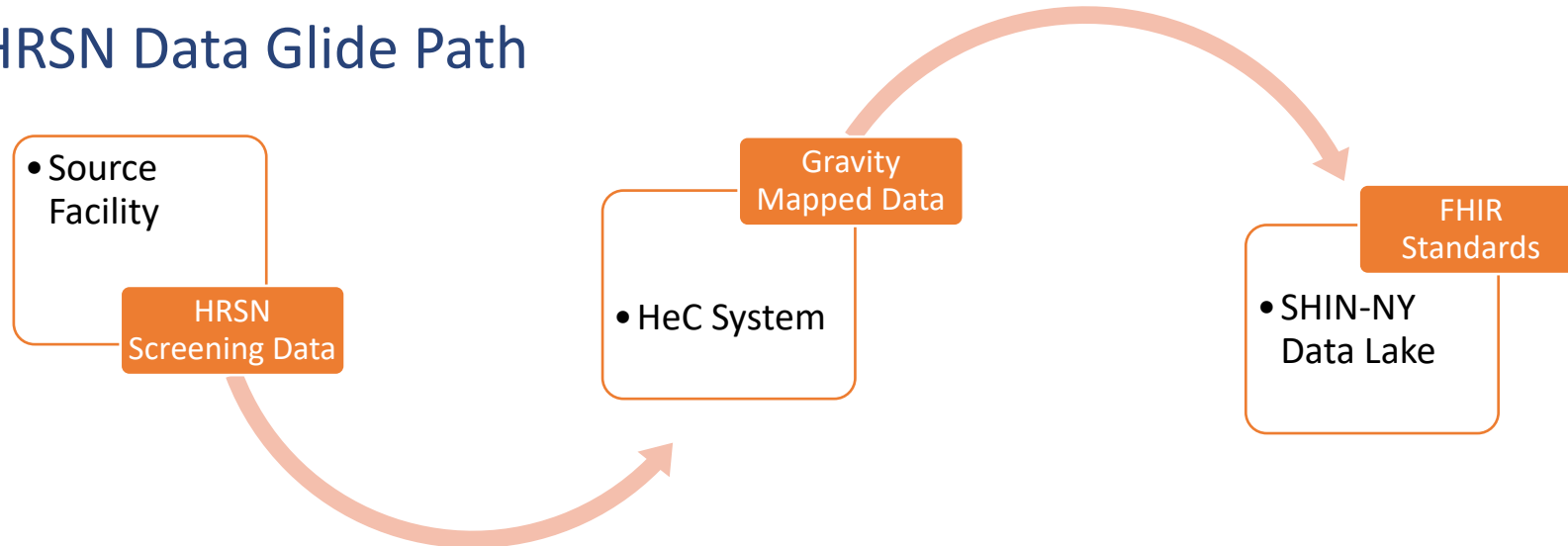


<https://thegravityproject.net/overview/>

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



Easy to Use



Easy to Understand



Ready to Take Action



Flexible and Transparent

myData- clinical registries

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

The screenshot displays the 'Clinical Registries' dashboard. At the top left, the title 'Clinical Registries' is accompanied by a logo and the text 'Active List: New myData Demo Attribution List'. At the top right is the 'HealthConnections myData' logo. The dashboard is divided into two main sections: 'DASHBOARDS' and 'BETA REPORTS'. Each section has a search bar on the right. The 'DASHBOARDS' section contains six registry categories: Arthritis, Care Coordination/NYS..., Diabetes / Prediabetes, Hospital / ED Utilization, Hypertension, and Skilled Nursing Facility. The 'BETA REPORTS' section contains sixteen registry categories: Anxiety and Fear-Relate..., Colorectal, Depressive Disorders, Disabilities, Immunizations / Vaccin..., Lifestyle/Life Managem..., Mammography, Musculoskeletal Pain, Neurodevelopmental D..., Opioid Related Disorders, Pneumonia, Preventive / Wellness Vi..., Respiratory Cancers, Socioeconomic/Psycho..., Spondylopathies / Spo..., and Tobacco-Related Disor...

patient-level data discovery

Data Discovery

Active List: New myData Demo Attribution List **Last Updated: 11/09/2023**

817 Results

HIE Last Name: myData

Jump to patient record in HIE

Patientone, Test Male 10/20/1953 (70 yrs) [HEC ID:5012201]
123 MAIN ST, ANYWHERE, NY 13367

Summary | More Patient Information | External Document Search | Patient Documents | View All Images | VADiD Documents | Statewide Data

Laboratories (17) | **Imaging (7)** | **Transcriptions (15)**

| Date | Name | Source |
|------------|------------------------|--------|
| 04/19/2016 | PTINR | AUBURN |
| 04/19/2016 | Occult Blood X3 | SD |
| 04/14/2016 | GC / CHLAMYDIA RE. | SD |
| 04/13/2016 | Trip Sure Syphilis Ig. | SD |
| 04/12/2016 | Prostate-Specific Ag. | LABCRP |
| 04/12/2016 | DRUG TOX MONITO. | QUEST |
| 04/11/2016 | Cytology Pap | CPD |
| 01/09/2015 | Hemoglobin Hematocrit | CMC |
| 01/09/2015 | INR | CMC |
| 01/08/2015 | CBC Auto Dif | CMC |
| 01/08/2015 | Basic Metabolic Panel | CMC |
| 01/07/2015 | INR | CMC |

Vitals (1397)

| Name | Value | Collected |
|-----------------|----------------|------------|
| Body mass index | 30.7 kg/m2 | 04/09/2016 |
| Body surface | 2.15 m2 | 04/09/2016 |
| Body weight | 214.00 [lb_av] | 04/09/2016 |

Allergies (12) | **Medications (113)**

| Allergen | Reactions | Reported |
|---------------|-----------|------------|
| Metronidazole | Hives | 04/07/2016 |
| NKDA | UNK | 09/19/2014 |
| Cefdinir | UNK | 02/26/2014 |

Immunizations (11)

| Vaccine | Administered | Dose |
|--------------|--------------|------|
| influenza... | | |

Ambulatory Encounters (11) | **Inpatient Encounters (4)**

| Date | Admission Type | Source |
|------------|----------------|--------|
| 04/14/2016 | CPD | CPD |
| 02/09/2015 | Elective | CMC |
| 12/29/2014 | Elective | CMC |

Conditions (92) | **Procedures (31)**

| Name | Date | Source |
|-----------------|------------|--------|
| UNILATERA... | 04/21/2016 | MMH |
| SCROTAL C... | 04/11/2016 | CLX |
| Low blood pr... | 03/23/2016 | MEDENT |

Social History (147) | **Functional Statuses (0)** | **Documen...**

| Question | Answer | Source |
|------------------------|-----------------------|--------|
| Alcohol intake | Occasional Social ... | MEDENT |
| Details of drug mis... | Denies Drug Use | MEDENT |

Edit Search Criteria

Add Search Criteria

Has Does Not Have

Dimension: (All)

Date Range: (No date restriction)

Data Source: All Data | Community Data Only | Exclude Community Data

Code/Description:

Exact Match

Search Close

View Patient Snapshot

Patient Snapshot

myData_Abernathy524, Shaun461
DOB: 02/02/1953
433 Colburn Rapid Remo, New York 13308
Consented: Yes

4 Results

| Type | Location | Date | Value |
|---------------------|-------------|------------------|--------------------|
| BMI: Most Recent | myData Demo | 10/18/2022 | 31.700000 |
| BP: Most Recent | myData Demo | 10/18/2022 23:47 | 117/77 |
| Diabetes: Diagnosis | myData Demo | 08/23/1988 | Diagnosed Pre Diab |
| LDL: Most Recent | myData Demo | 10/18/2022 | 106.000000 |


5 10 25 50 100

Emergency

hospital/ED utilization dashboard

Hospital / ED Utilization ?

Active List: New myData Demo Attribution List Last Updated: 11/08/2023



Patient List Size

127

Inpatient Admit - Avg. Length of Stay
IN DAYS

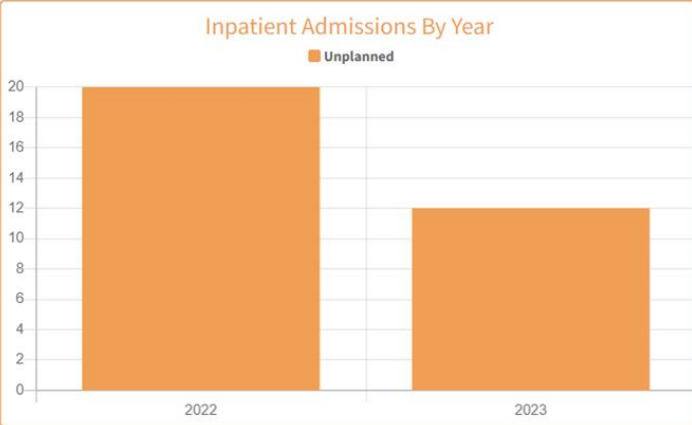
1

ER - Avg. Visit Length
IN HOURS

4.4

Inpatient Admissions By Year

■ Unplanned



| Year | Unplanned |
|------|-----------|
| 2022 | 20 |
| 2023 | 12 |

ED Visits By Year

■ Unplanned



| Year | Unplanned |
|------|-----------|
| 2022 | 70 |
| 2023 | 60 |

DISCHARGE DATE

:


mm/dd/yyyy 📅

End:

mm/dd/yyyy 📅

Inpatient Admissions By Year - 7/30/60/90 Day Re-Admissions


■ Within 07 days
 ■ Within 30 days
 ■ Within 60 days
 ■ Within 90 days



| Year | Within 07 days | Within 30 days | Within 60 days | Within 90 days |
|------|----------------|----------------|----------------|----------------|
| 2022 | 0 | 7 | 9 | 0 |
| 2023 | 0 | 0 | 7 | 0 |

ED Visits By Year - 7/30/60/90 Day Return to ER

■ Within 60 days



| Year | Within 60 days |
|------|----------------|
| 2022 | 1 |
| 2023 | 1 |

RETURN TO HOSPITAL FACILITY

- (Select All)
- Within 07 days
- Within 30 days
- Within 60 days
- Within 90 days

ADMISSION TYPE

- (Select All)
- Unplanned

DISCHARGED TO

- (Select All)
- Unknown

HOSPITAL

- (Select All)
- myData Demo

diabetes/prediabetes dashboard

Diabetes / Prediabetes ?

Active List: New myData Demo Attribution List Last Updated: 11/08/2023



Patient List Size

150

Diabetic Patients

18

Undiagnosed Diabetic Patients

2

Diagnosed Prediabetic Patients

130

Undiagnosed Prediabetic Patients

0

Diagnosed Diabetes Distribution

■ HbA1c < 7.0
 ■ HbA1c 7.0 - 9.0
 ■ HbA1c > 9.0
 ■ No HbA1c Value

Undiagnosed Diabetes Distribution

■ HbA1c < 7.0
 ■ HbA1c 7.0 - 9.0
 ■ HbA1c > 9.0
 ■ No HbA1c Value

Prediabetes Distribution

■ Diagnosed Pre Diab
 ■ Undiagnosed Pre Diab

Diagnosed Diabetes
HbA1c measurement last 2 years?

■ Yes ■ No

Diagnosed Diabetes
HbA1c measurement last 1 year?

■ Yes ■ No

Diagnosed Prediabetes
HbA1c measurement last 2 years?

■ Yes ■ No

Diagnosed Prediabetes
HbA1c measurement last 1 year?

■ Yes ■ No

Filters Reset Apply

DIABETES: DIAGNOSIS

- (Select All)
- Diagnosed Diab
- Diagnosed Pre Diab
- Undiagnosed Diab

MOST RECENT HBA1C CATEGORY

- (Select All)
- HbA1c 5.7 - 6.4
- HbA1c 7.0 - 9.0
- HbA1c < 7.0
- HbA1c > 9.0
- No HbA1c Value

HBA1C IN LAST 1 YEAR

- (Select All)
- No
- Yes

HBA1C IN LAST 2 YEARS

- (Select All)
- No
- Yes

HBA1C MOST RECENT DATE

:

End:

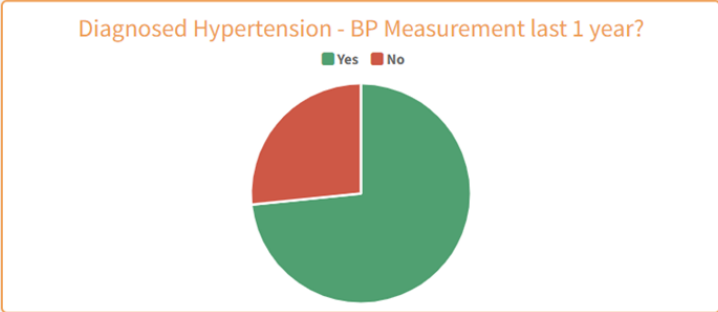
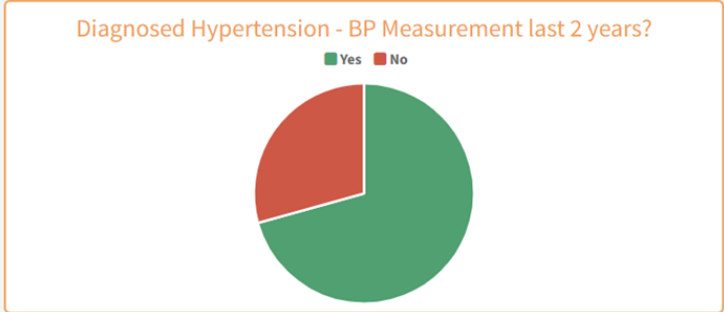
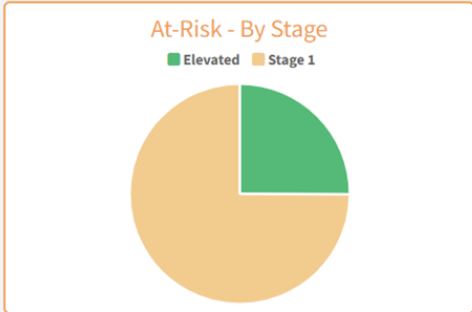
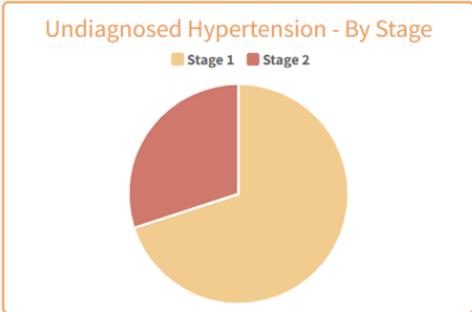
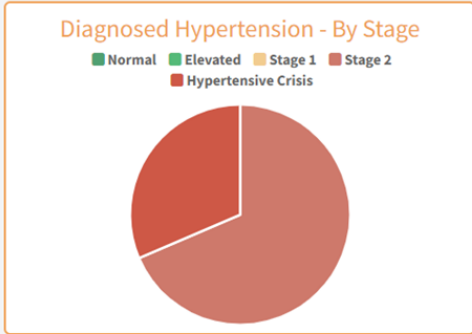
hypertension dashboard



Active List: New myData Demo Attribution List Last Updated: 11/08/2023



| | | | |
|--|---|--|------------------------------|
| Patient List Size 531 | Diagnosed Hypertension 174 | Undiagnosed Hypertension 10 | At-Risk 347 |
|--|---|--|------------------------------|



Search

- #### HTN: CATEGORY
- (Select All)
 - At-Risk
 - Diagnosed Hypertension
 - Undiagnosed

- #### HTN: STAGE
- (Select All)
 - Elevated
 - Hypertensive Crisis
 - Stage 1
 - Stage 2

- #### HAS BP MEASUREMENT LAST 2 YEARS
- (Select All)
 - No
 - Yes

- #### HAS BP MEASUREMENT LAST 1 YEAR
- (Select All)
 - No
 - Yes

BP MOST RECENT DATE

:

mm/dd/yyyy

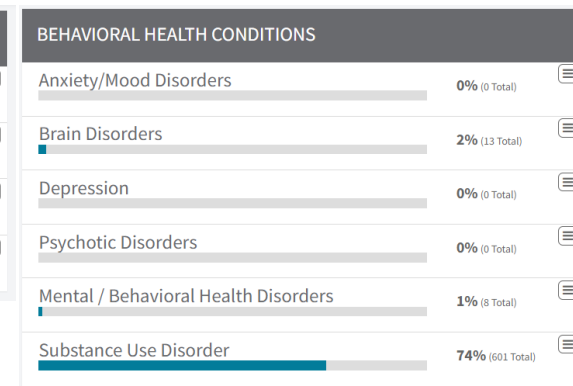
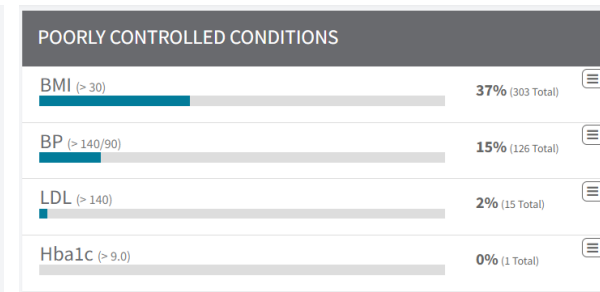
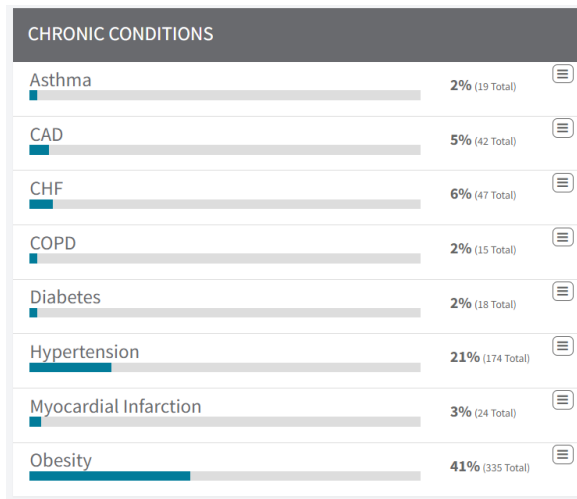
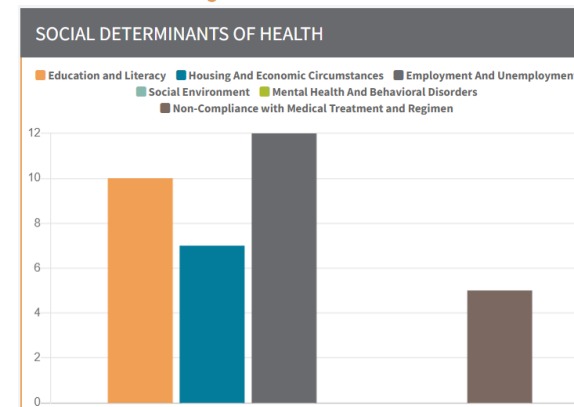
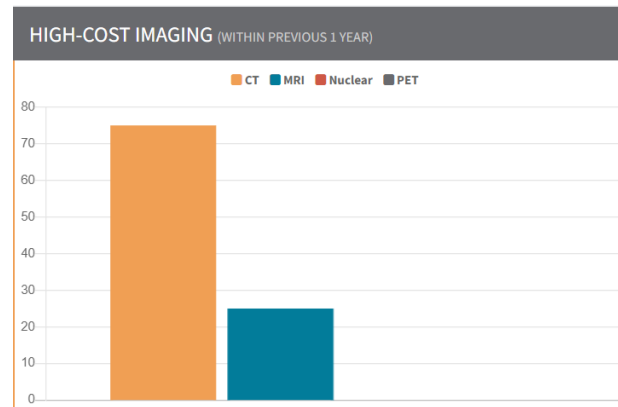
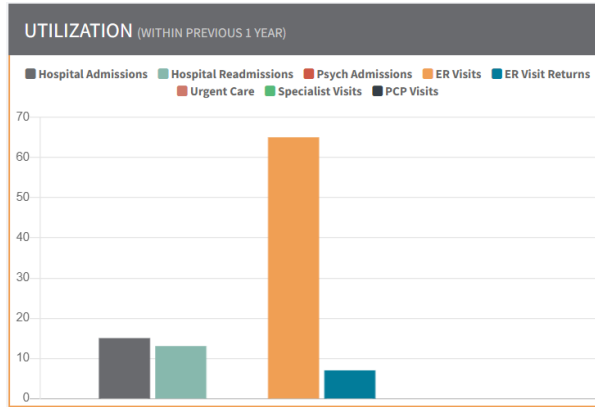
End:

mm/dd/yyyy

care coordination/NYS-PCMH dashboard

Care Coordination/NYS-PCMH ?

Active List: New myData Demo Attribution List Last Updated: 11/09/2023



colorectal beta report



Active List: New myData Demo Attribution List Last Updated: 11/08/2023



10 Results
Download

| 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 |

Filters Reset Apply

Q Search

DATE

:

mm/dd/yyyy

End:

mm/dd/yyyy

SUBCATEGORY

(Select All)

FOBT

CODE

(Select All)

57905-2

FACILITY

(Select All)

myData Demo

AGE

Thank you!

315-671-2241 x5

healthconnections.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.

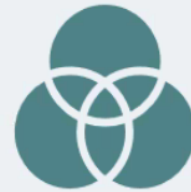


Layering clinical data, with Social Determinants of Health Data will help to identify areas of the community in need and create a baseline for determining the success of programs aimed at improving health.

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

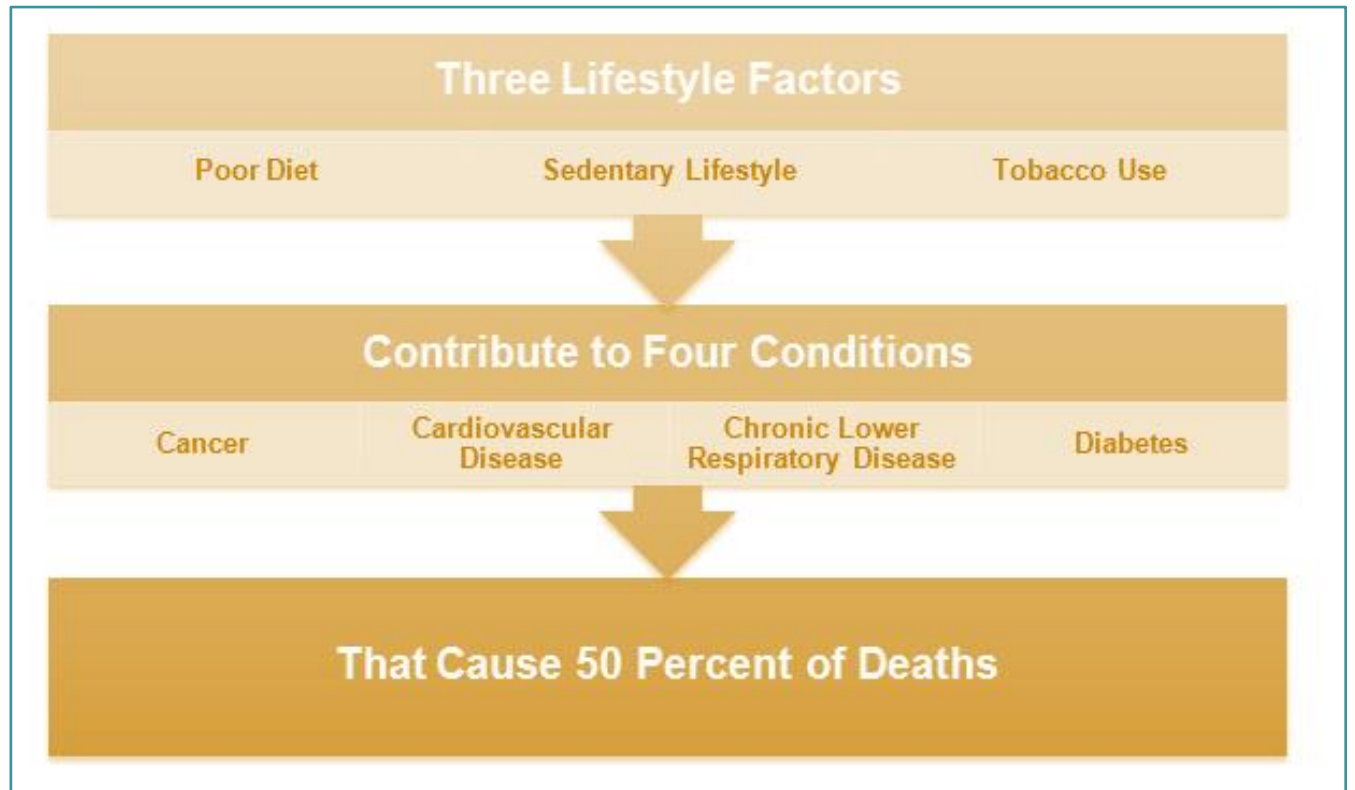
Identify opportunities for improving the health and health care of the communities in WNY and facilitate planning and implementation of strategies for addressing those opportunities to achieve health equity.



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 Tract
 - Race
 - Ethnicity
 - Language
 - Gender
 - Age
 - Insurance Type

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

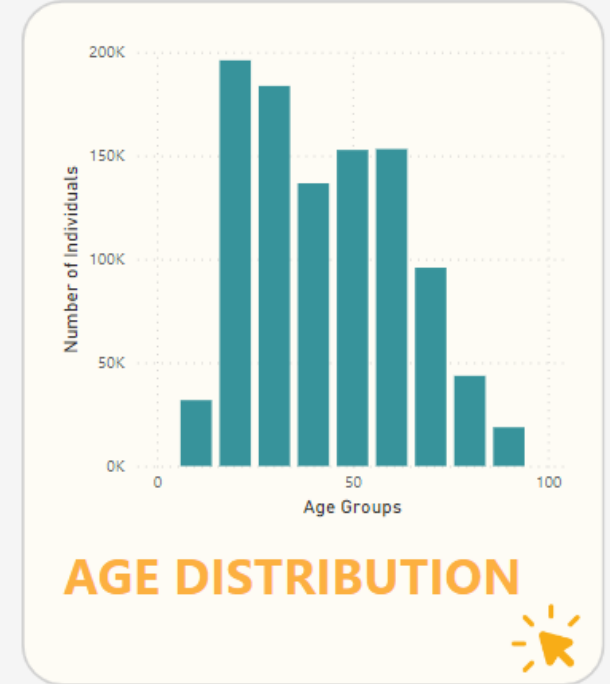
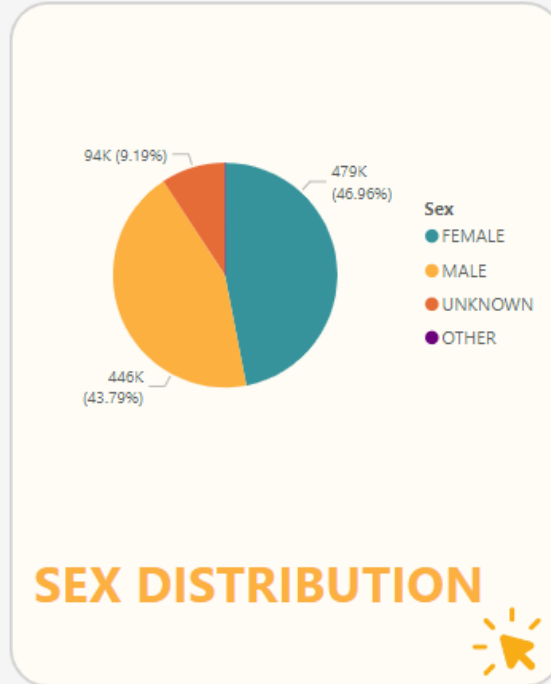
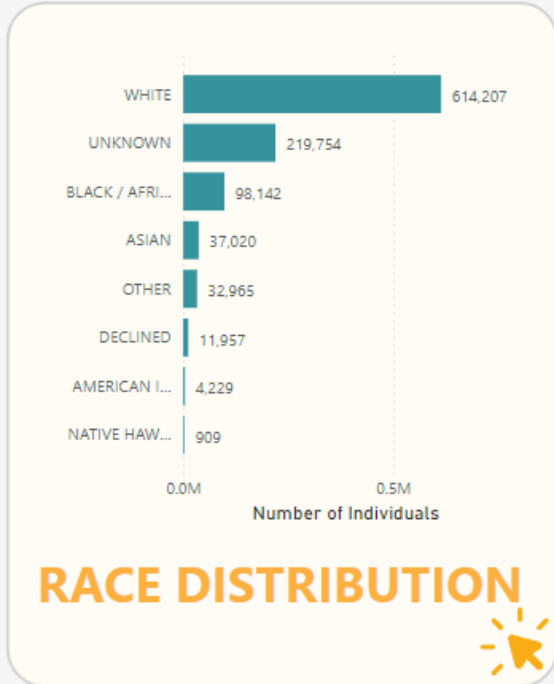
-  **Click** on a map or chart to filter and drill down. **Ctrl+Click** allows multiple selections. **Right Click** allows a data table view.
-  **Use screen shots** to save information for needs assessments, grant applications, or presentations.
-  This icon designates **a measure with HEDIS restrictions.** 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.

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.



Breast Cancer Screening Rate
59.9%

NYS Goal
87.7%

Cervical Cancer Screening Rate
48.2%

NYS Goal
86.3%

Colorectal Cancer Screening Rate
42.6%

NYS Goal
80.0%

Diabetes Rate
9.2%

NYS Rate
10.7%

Hypertension Rate
16.6%

US Goal
18.9%


Smoking Rate
9.0%

US Goal
17.4%

Obesity Rate
26.4%

NYS Goal
24.2%

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. 

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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.



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HEALTHeLINK DASHBOARD

Comparison Data

County

NIAGARA ,NY

Clear filters



COUNTY

ZIPCODE

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%

NYS Goal

87.7%

Cervical Cancer Screening Rate

47.1%

NYS Goal

86.3%

Colorectal Cancer Screening Rate

39.6%

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

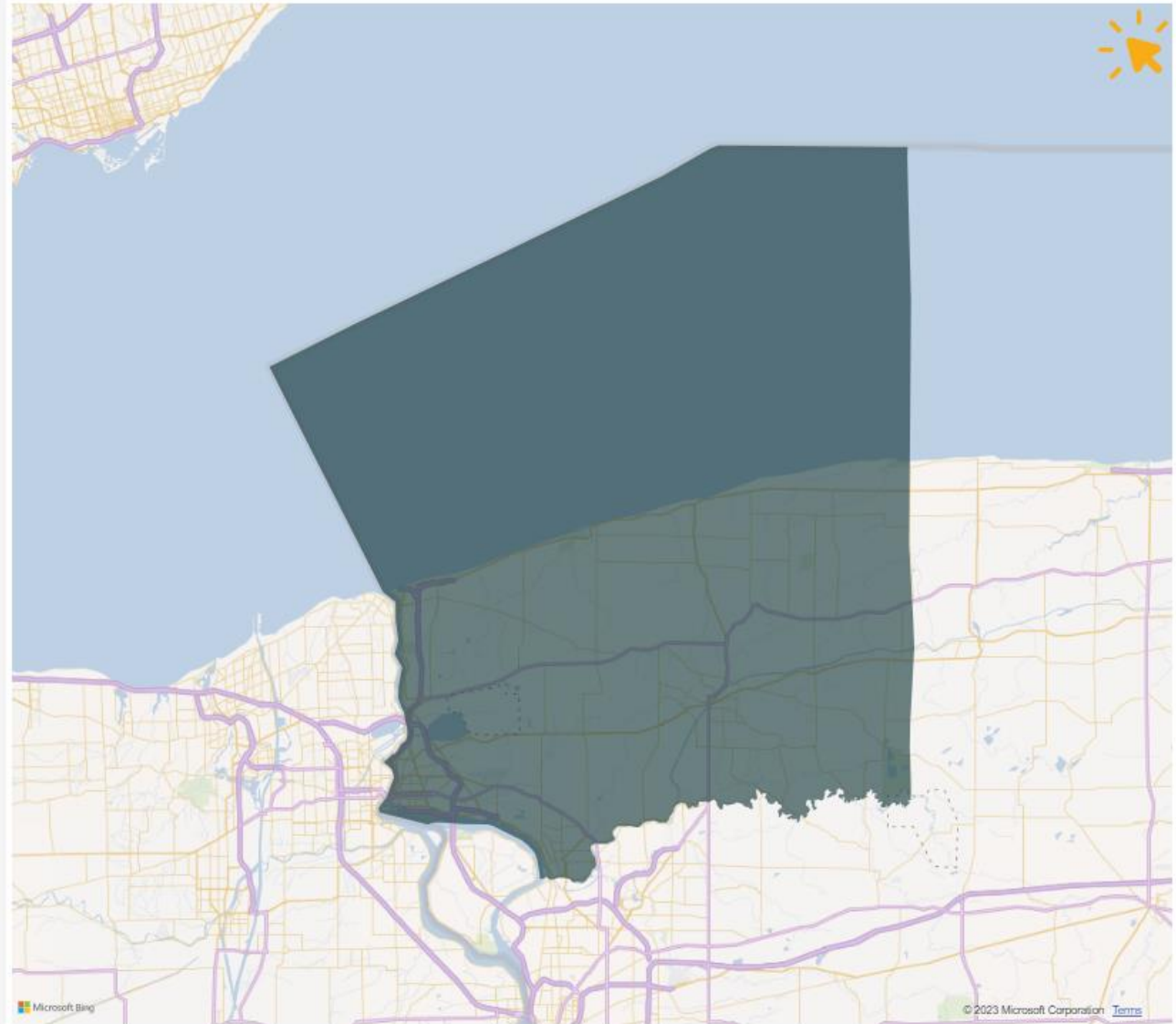
30.2%

NYS Goal

24.2%

30.2%

24.2%



County

NIAGARA ,NY

Clear filters



The HEALTHeLINK Population Is: 221,992

Filters

Age

18 121



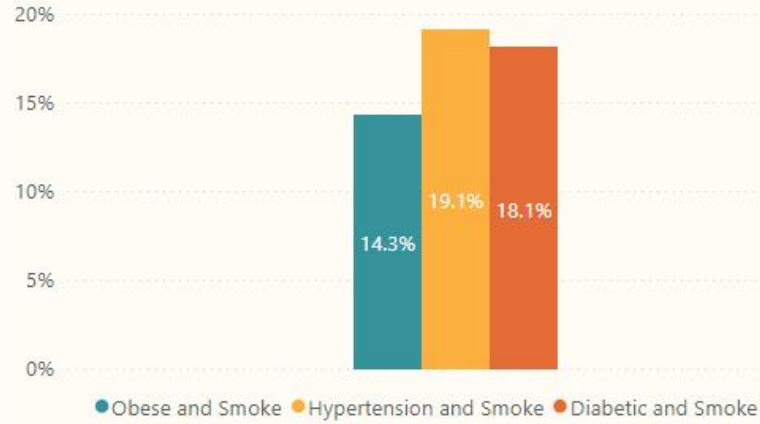
Ethnicity

- HISPANIC OR LATINO
- NOT HISPANIC OR LATINO
- UNKNOWN

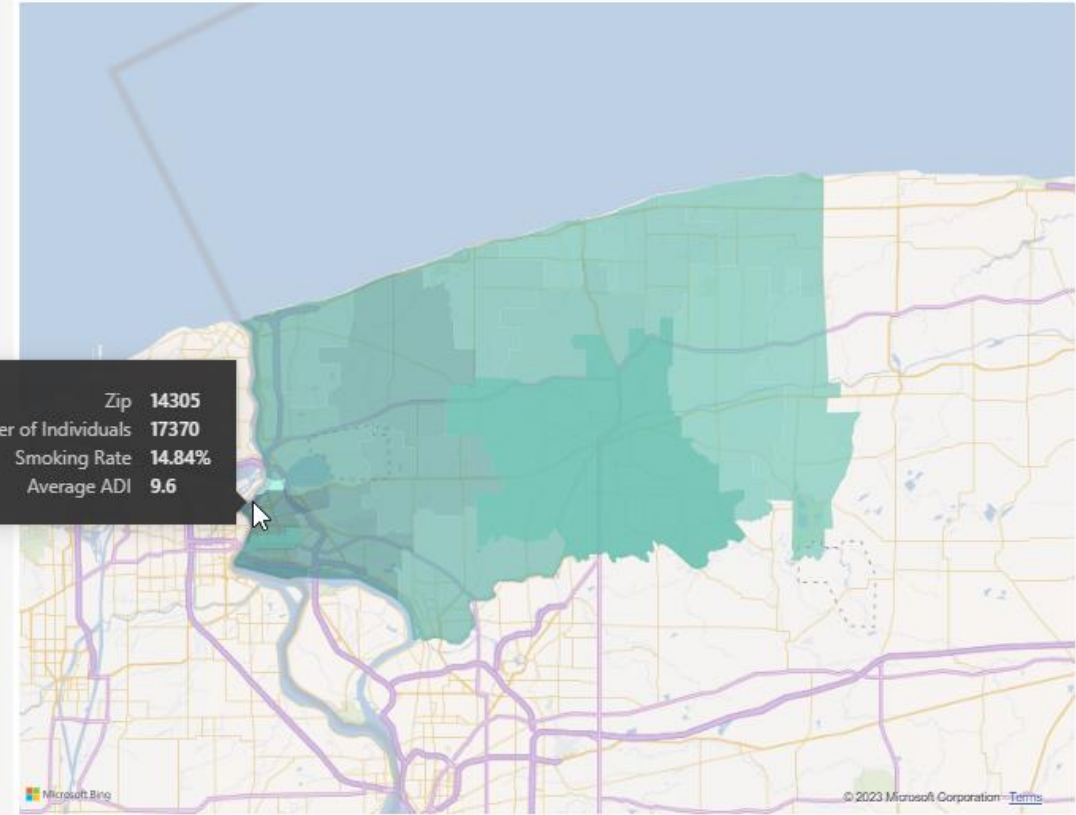
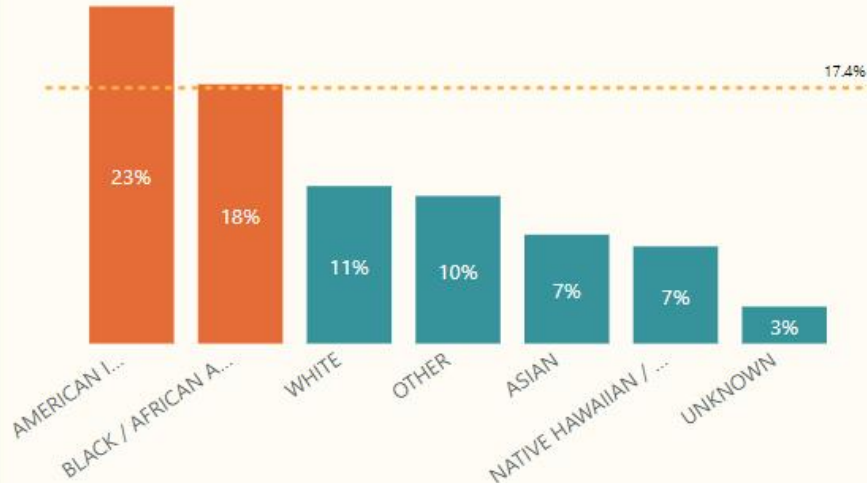
Sex

| | |
|--------|---------|
| FEMALE | OTHER |
| MALE | UNKNOWN |

COMORBIDITIES WITH SMOKING



SMOKING RATE BY RACE



Smoking Rate | 9.7%

US Goal | 17.4%

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.

HEALTHeLINK DASHBOARD

OBESITY

County: **ERIE, NY** Clear filters Home Menu

The HEALTHeLINK Population Is: 1,019,183

Filters i

Age

18 121

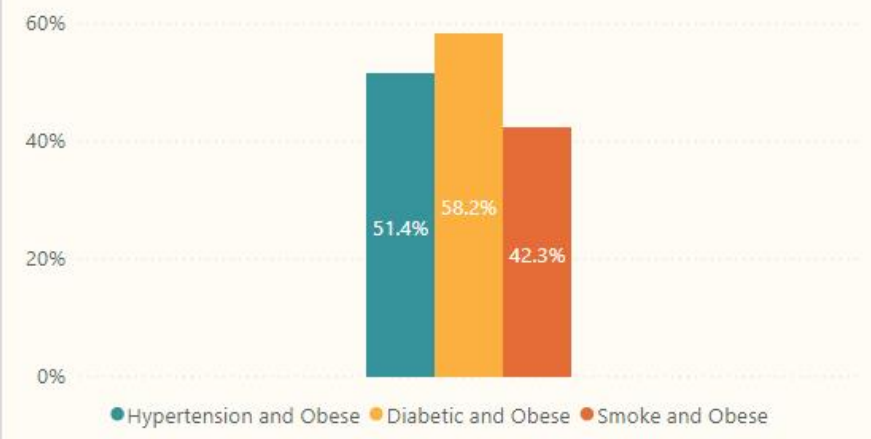
Ethnicity

- HISPANIC OR LATINO
- NOT HISPANIC OR LATINO
- UNKNOWN

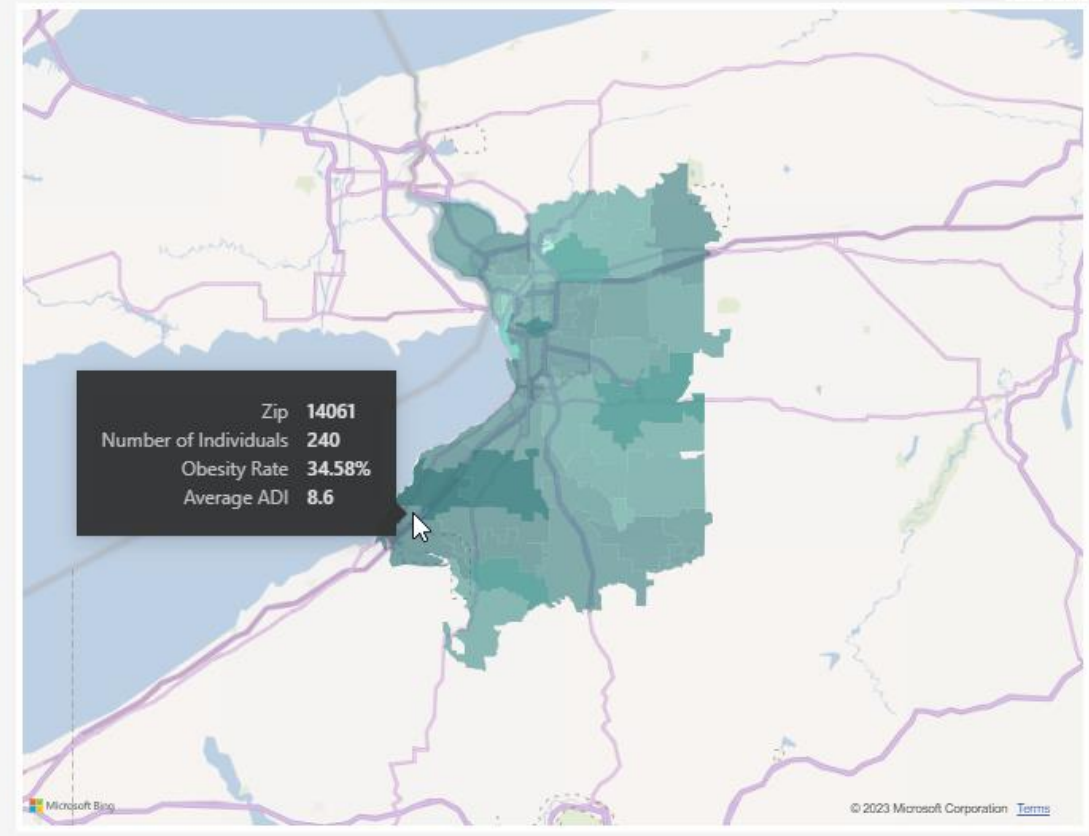
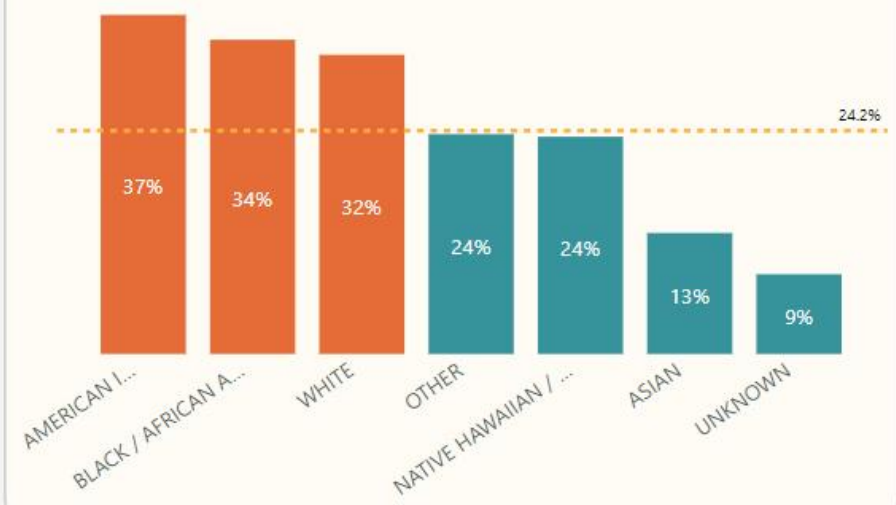
Sex

| | |
|--------|---------|
| FEMALE | OTHER |
| MALE | UNKNOWN |

COMORBIDITIES WITH OBESITY



OBESITY RATE BY RACE



Obesity Rate | 26.4%

NYS Goal | 24.2%

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.

County

ERIE, NY

Clear filters



The HEALTHeLINK Population Is: 10,105

Filters i

Age

30 60



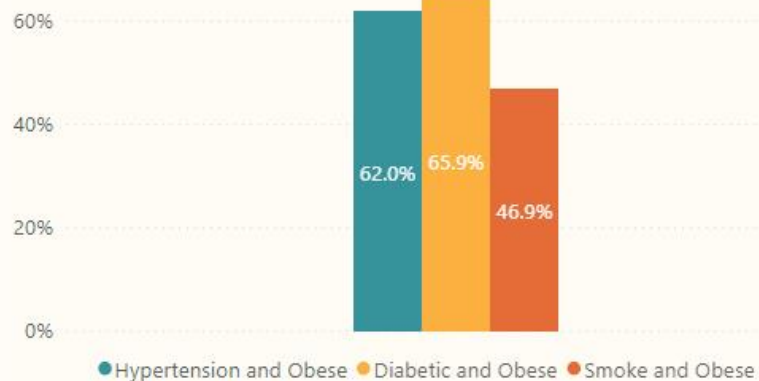
Ethnicity

- HISPANIC OR LATINO
- NOT HISPANIC OR LATINO
- UNKNOWN

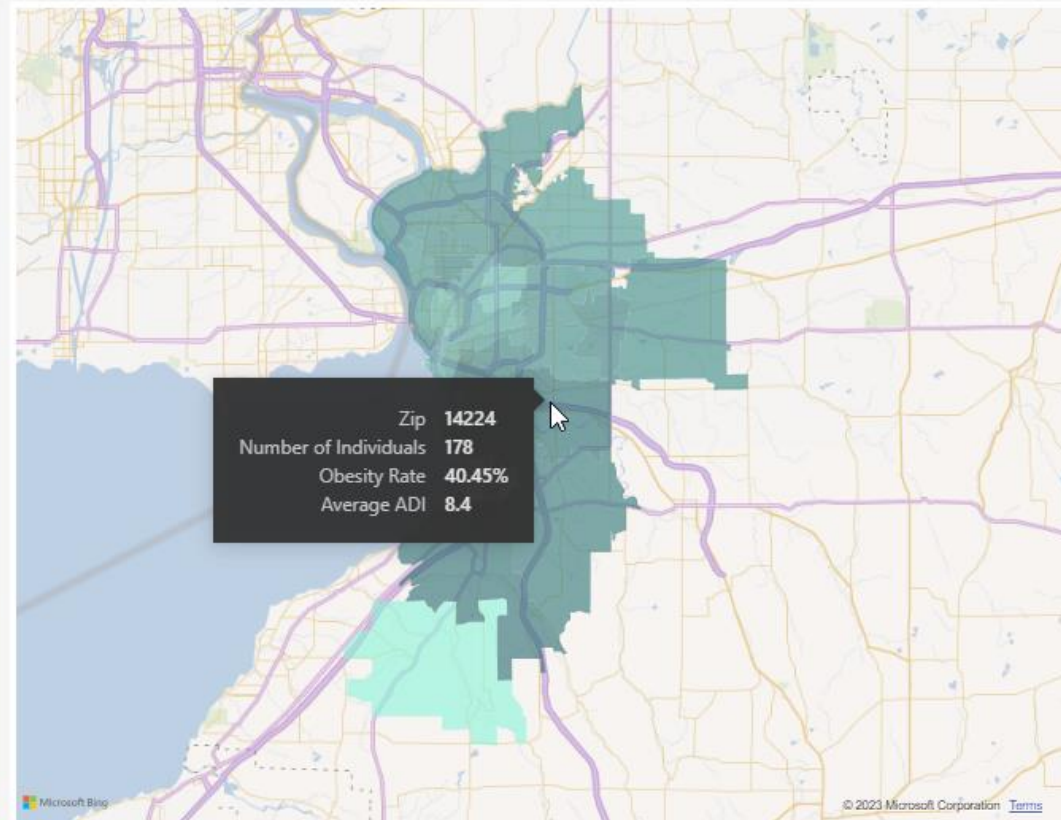
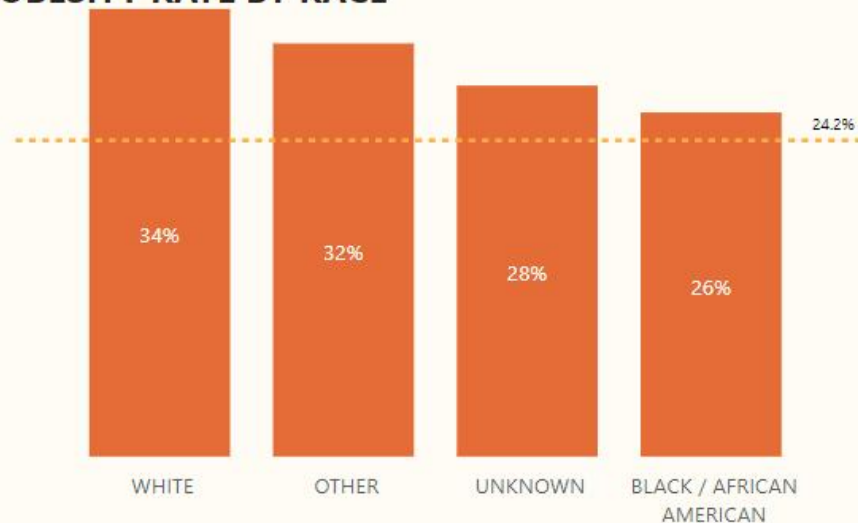
Sex

| | |
|--------|---------|
| FEMALE | OTHER |
| MALE | UNKNOWN |

COMORBIDITIES WITH OBESITY



OBESITY RATE BY RACE



Obesity Rate

31.9%

NYS Goal

24.2%

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.

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%

NYS Goal

87.7%

Cervical Cancer Screening Rate

32.6%

NYS Goal

86.3%

Colorectal Cancer Screening Rate

22.9%

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

NYS Goal

28.3%

24.2%



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.

Clear filters



The HEALTHeLINK Population Is:

HEALTHeLINK DASHBOARD

ZIP Code 1

County
ERIE, NY

Zip
14211

Age

18 121

Ethnicity

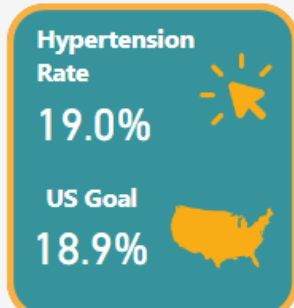
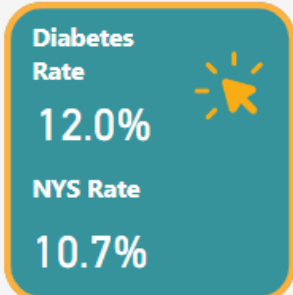
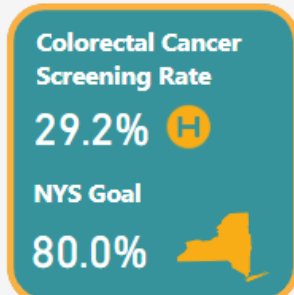
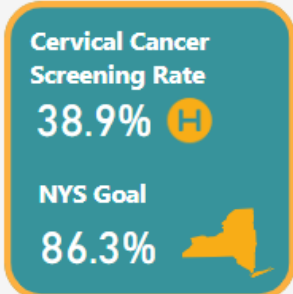
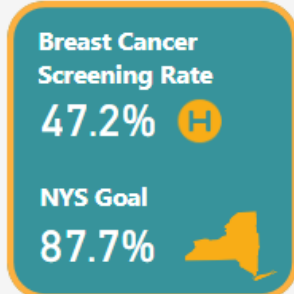
- HISPANIC OR LATINO
- NOT HISPANIC OR LATINO
- UNKNOWN

Race

All

Sex

| | |
|--------|---------|
| FEMALE | OTHER |
| MALE | UNKNOWN |



ZIP Code 2

County
ERIE, NY

Zip
14032

Age

18 121

Ethnicity

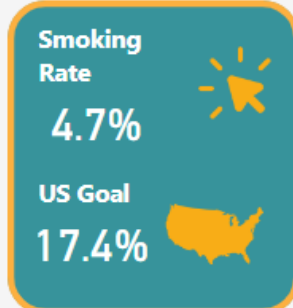
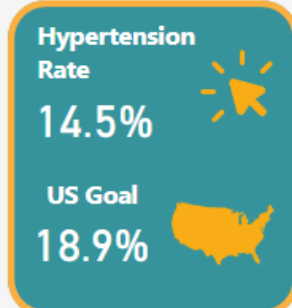
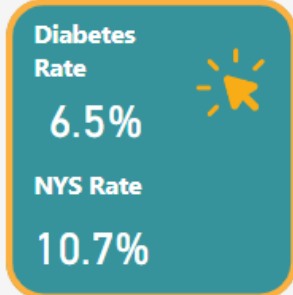
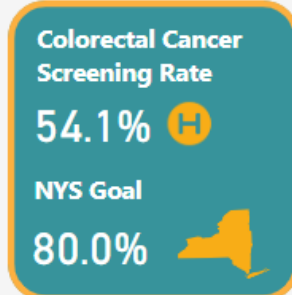
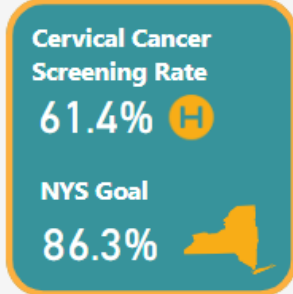
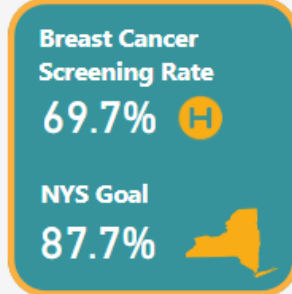
- HISPANIC OR LATINO
- NOT HISPANIC OR LATINO
- UNKNOWN

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%



NYS Goal

0.0%



Cervical Cancer Screening Rate

45.5%



NYS Goal

0.0%



Colorectal Cancer Screening Rate

0.0%



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

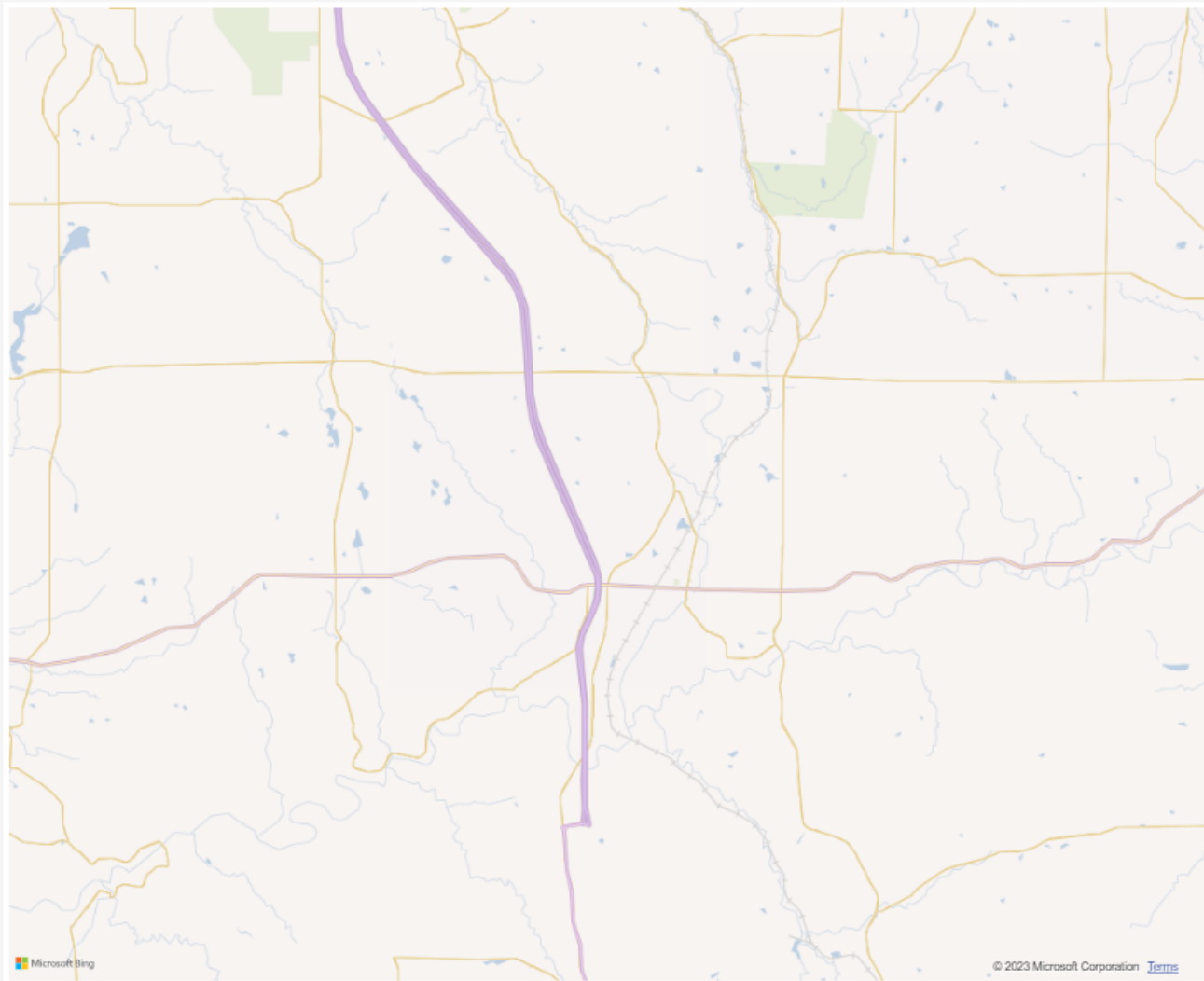


12.5%

NYS Goal



24.2%



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.



Questions?

wnyhealthelink.com

716-206-0993



facebook.com/healthelink



[@healthelink](https://twitter.com/healthelink)



YouTube.com/healthelink



HEALTHeLINK







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

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.

[View Here](#)

Learning Path: Healthcare Interoperability

3 Activities

The screenshot displays a learning path interface with a progress bar at the top. Below the bar, three activity cards are listed, each featuring a video thumbnail on the left and a title on the right. The first card is titled 'Introduction to Interoperability' with a '2/5' progress indicator. The second card is titled 'Interoperability Landscape' with a '2/5' progress indicator. The third card is titled 'Interoperability in Practice' with a '1/4' progress indicator. Each card includes a 'Show X Modules' button below the title.

- Introduction to Interoperability** (2/5)
Show 5 Modules
- Interoperability Landscape** (2/5)
Show 5 Modules
- Interoperability in Practice** (1/4)
Show 4 Modules

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!

