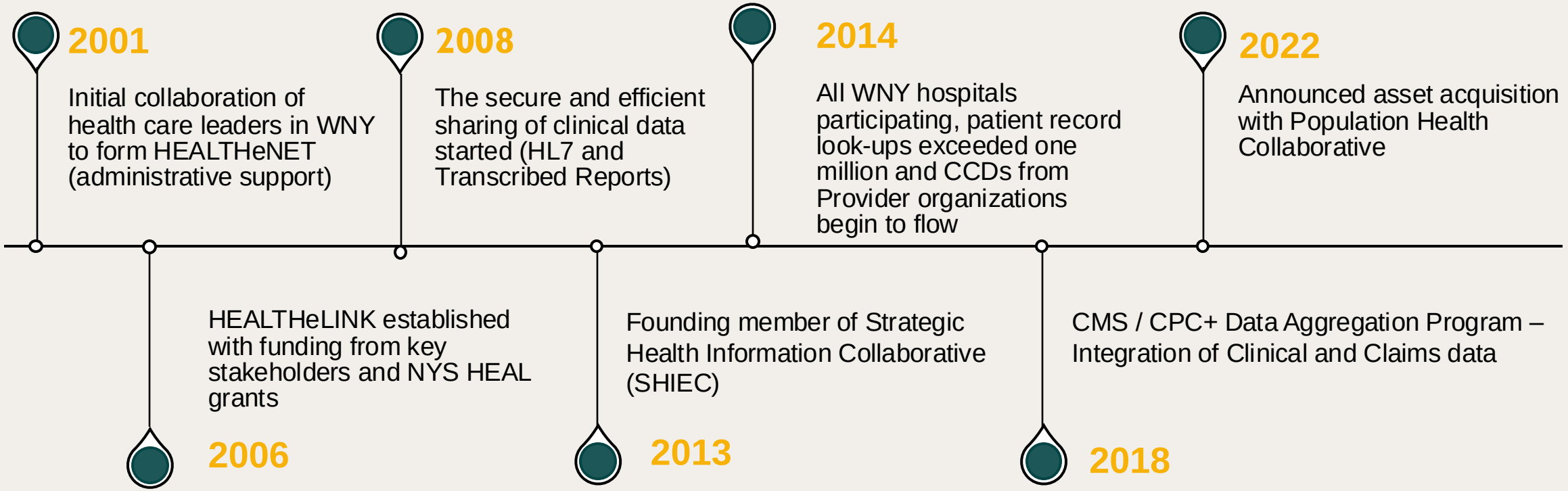
ADVANCING HEALTH EQUITY: HEALTHeLINK'S COLLABORATIVE MERGER

Dan Porreca, President & CEO, HEALTHeLINK
George Nicholas, President & CEO, Buffalo Center for Health Equity
Karen Craik, Senior Manager, Regional Health Improvement, HEALTHeLINK

2024 CIVITAS Networks for Health

Wednesday, October 15, 2024

HEALTHeLINK TIMELINE



BY THE NUMBERS

100% of WNY hospitals participating

Almost 90% of WNY practices participating

Approximately 5,500 participating providers

90% of WNY population consented

Nearly 100% of laboratory results available

More than 90% of radiology reports available

Images from more than **20** radiology facilities available

More than 500 data sources

A query of HEALTHeLINK occurs every **5 seconds**

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The Evolution of Population Health

Implementation of HEALTHeOUTCOMES,a client facing population health tool.

- Combining HIE clinical data & regional claims data for measure calculation
- Powerful backend data warehouse for customized reporting solutions

Support for CPC+ & other VBP programs.

- Offering patient registries, gaps in care, utilization data & risk stratification for practices & IPAs
- Leveraging rosters to set up patient groups for population health management

Regional Health Improvement Reporting.

- Developing regional measures and reporting using existing population health infrastructure
- Publishing measures at a zip code level stratified by race, ethnicity, gender

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MERGER 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.

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HEALTHeLINK began meeting with a wide range of community organizations and leaders starting in July 2022, to better understand efforts to overcome social barriers adversely affecting health outcomes.

STAKEHOLDER ENGAGEMENT

Types of organizations that we met with:

- Academia
- IPAs
- Health plans
- Housing
- IDD organizations
- FQHCs
- Depts of Health & Mental Health
- Behavioral Health agencies
- Community based organizations supporting maternal health & recently released incarcerated individuals

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COLLABORATION IS KEY

Pastor George Nicholas, community leader and HEALTHeLINK Board member, shares his perspective on the merger.

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BUFFALO CENTER FOR HEALTH EQUITY

Buffalo Center for Health Equity

- Community Driven
- Committed to Structural Change
- Addressing Root Causes
- Changing the narrative
- Cultivate Inclusivity
- Raising Consciousness
- Race is at the center of our conversations to acknowledge historic and systemic institutional inequity.

www.buffalohealthequity.org

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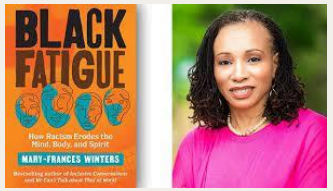
BLACK FATIGUE



STROKE

Black people are 44% more likely to die from a stroke

HIV/AIDS

Black women represent more than 66% of new HIV/AIDS cases

HIGH BLOOD PRESSURE

Black men are **30%** more likely and Black women are **60%** more likely to be diagnosed with high blood pressure

CANCER

Black women are 52% more likely to die from cervical cancer & 40% more likely to die from breast cancer than white women

BIRTH

Black women are 243% more likely than white women to die from pregnancy or childbirth related causes

HEART DISEASE

Black people are **25%** more likely to die from heart disease

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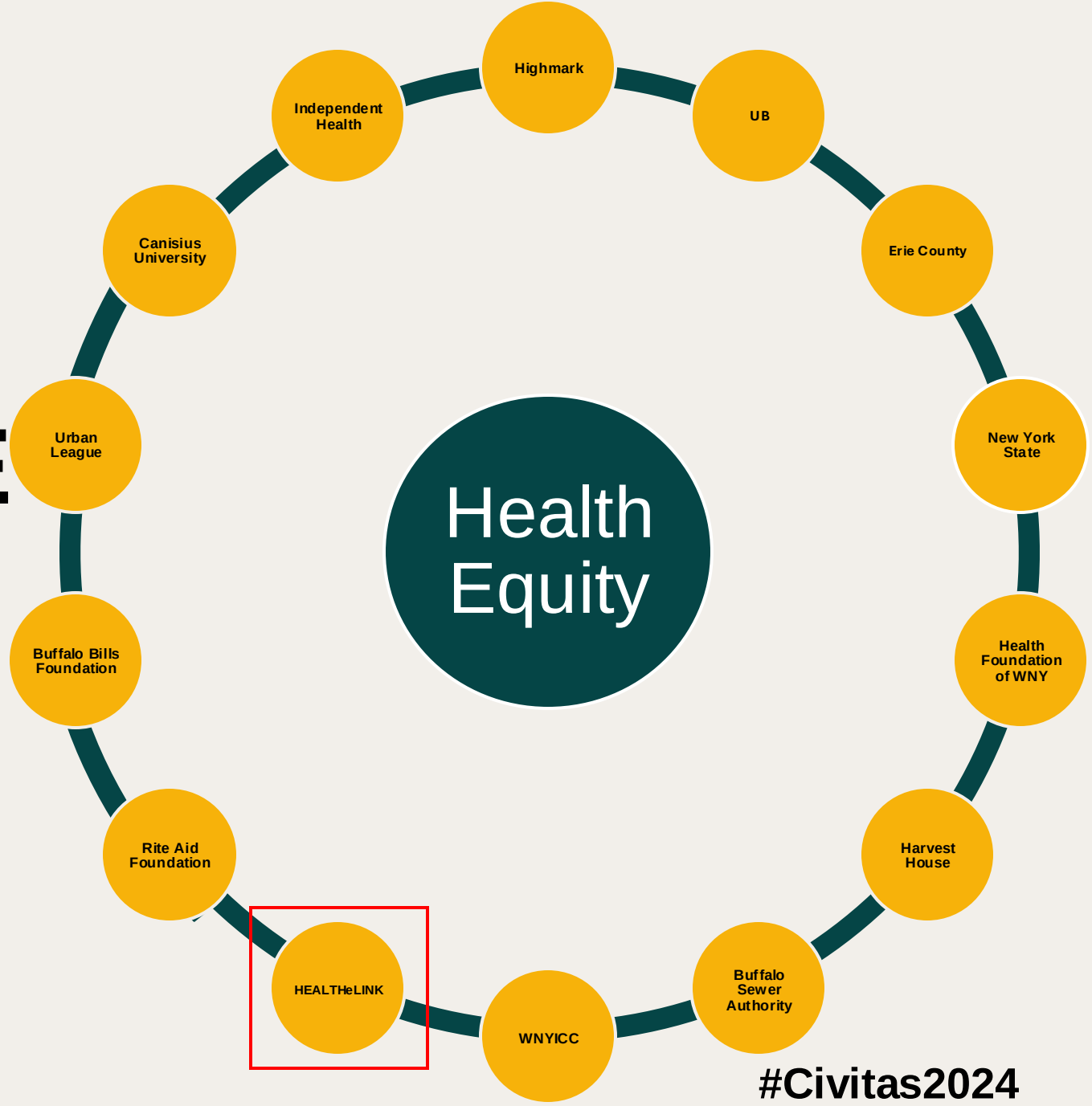
COLLABORATIVE PARTNERS



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COLLABORATION

- The action of working with someone to produce or create something.
- To achieve health equity, it is mandatory that we work in collaboration.
- To collaborate is to commit to the possibility of producing an outcome greater than one that would be developed in a silo.

ACCOUNTABILITY

- Standards for Success
- Moving from charity to empowerment
- What big things in a capitalist society has been accomplished with a not-for-profit model?
- Encourage and support social entrepreneurship
- Build effective and sustainable systems
- Problem solve like an engineer

OPPORTUNITY TO BUILD A COMMUNITY OF CARE

- Close wealth gap
- Big public spending through a health equity lens
- Improve the housing where people are already living
- Food is medicine. Create access to affordable healthy food
- Close educational opportunity gaps to improve outcomes
- Environmental justice in Black communities – air and water
- View violence as public health issue

MAKE EQUITY A PRIORITY

- Moral and Economic imperative

- Resource investment in the context of **priority** and not **availability**

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REGIONAL HEALTH IMPROVEMENT

Aggregate health data from various sources, such as healthcare providers, hospitals, public health agencies, and community organizations.

Contribute to public health surveillance efforts by tracking health trends and reporting relevant health data to public health authorities.

Engage in policy development and advocacy efforts to promote health policies that benefit the community

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CURRENT RHI INTIAITIVES

What are we currently working on in Regional Health Improvement?

- Maternal and Child Health Projects
- Local Health Department Reports
- NYS Grants - Reporting
- HEALTHeWNY Community Dashboard enhancements

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HEALTHeWNY™

A data visualization tool that provides a comprehensive overview of the health status and trends within WNY.

It includes key health indicators such as rates of chronic diseases, mental health statistics, health behaviors, social determinants of health.

This can be used by public health officials, policymakers, healthcare providers, and community leaders to monitor health outcomes, identify health disparities, and inform health promotion strategies.

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WHY IS HEALTHeWNY IMPORTANT?

DATA-DRIVEN DECISION - MAKING

MONITORING AND EVALUATION

RESOURCE ALLOCATION

COMMUNITY ENGAGEMENT

ADVOCACY

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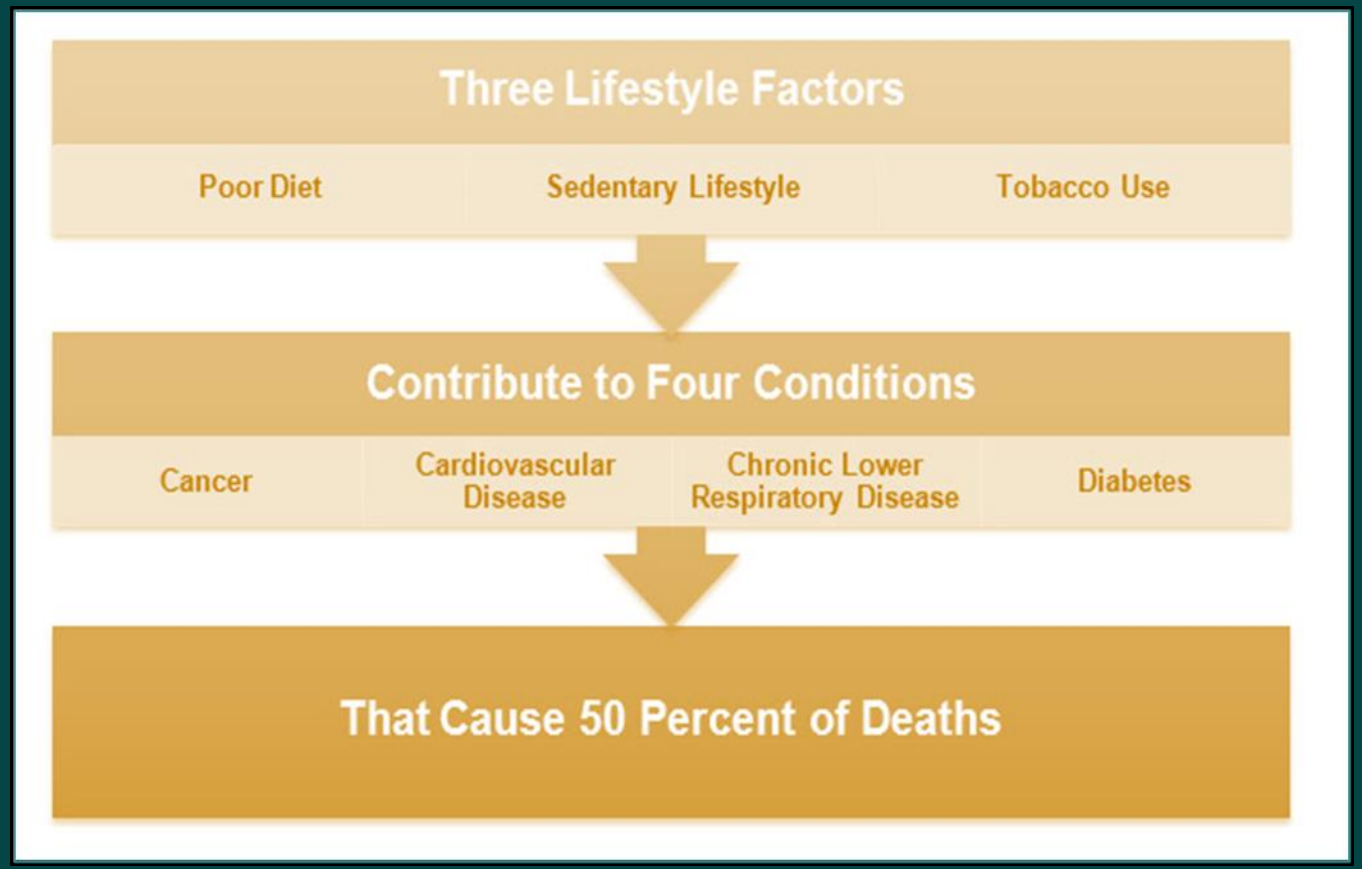
HEALTHeWNY DEVELOPMENT

Initial Metrics
Diabetes Rates
Diabetes Poor Control
Hypertension Rates
Hypertension Control
Colorectal Cancer Screening Rate
Breast Cancer Screening
Cervical Cancer Screening
Tobacco Use
Obesity Rates



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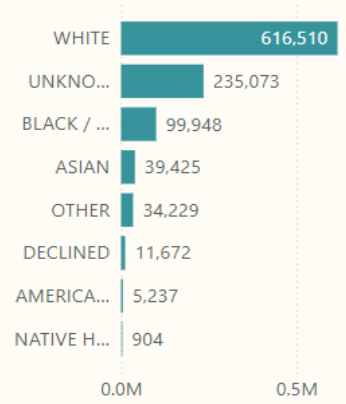
HEALTHeWNY™ DASHBOARD

Comparison Data | County: ERIE ,NY | Clear filters

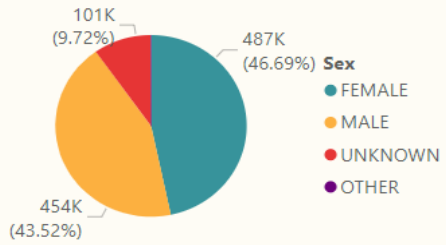
The HEALTHeLINK Population Is: 1,042,998

The Census Population Is: 762,150

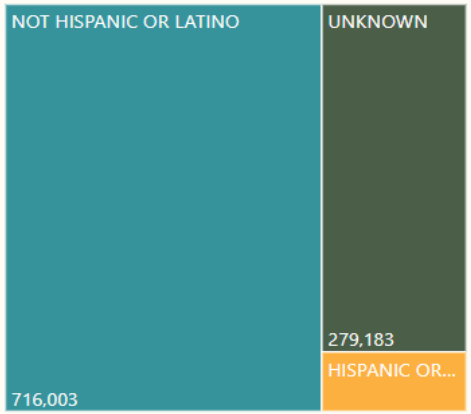
136.85% Coverage



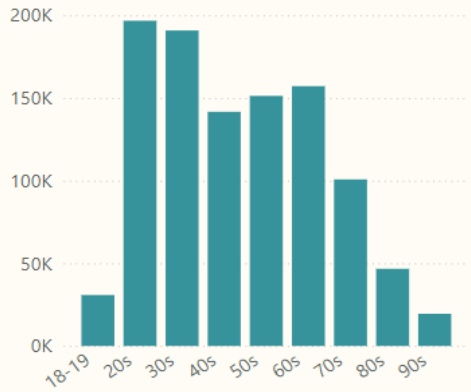
RACE DISTRIBUTION



SEX DISTRIBUTION



ETHNICITY DISTRIBUTION



AGE DISTRIBUTION

Breast Cancer Screening Rate	Cervical Cancer Screening Rate	Colorectal Cancer Screening Rate	Diabetes Rate	Diagnosed Hypertension Rate	Tobacco Use	Obesity Rate
54.4% (H)	43.5% (H)	38.7% (H)	7.9%	16.7%	7.4%	24.2%
NYS Goal 87.7%	NYS Goal 86.3%	NYS Goal 80.0%	NYS Rate 10.7%		US Goal 17.4%	NYS Goal 24.2%

Data are derived from adult Electronic Health Records (EHRs) through the WNY Regional Health Information Organization (RHIO), HEALTHeLINK, during the lookback period of 1/1/2023-12/31/2023.

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HEALTHeWNY™ DASHBOARD

ZIP CODE | COUNTY SCREENING RATES

Compare By County (Diagnoses) | Compare By Population (Screenings) | Compare By Population (Diagnoses) | Clear filters

Click here to follow link

Filters

Age: 18 – 122

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

Race: All

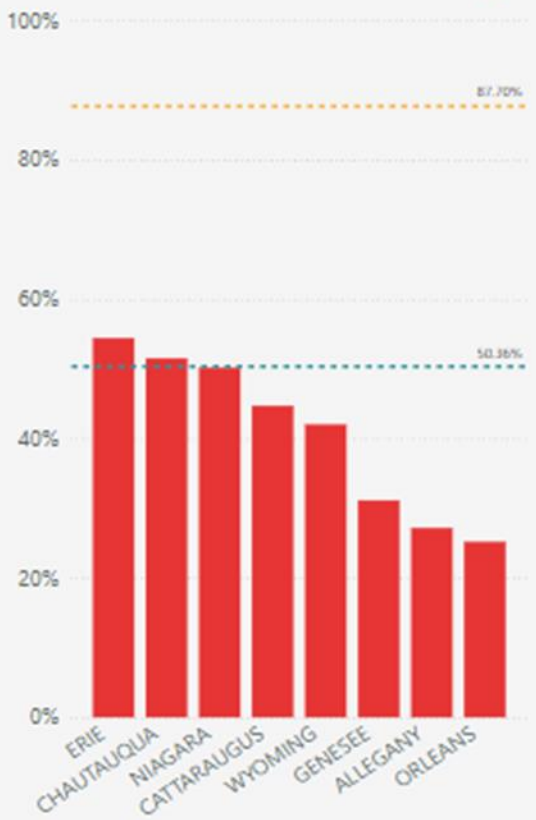
Sex: FEMALE | OTHER | MALE | UNKNOWN

Key

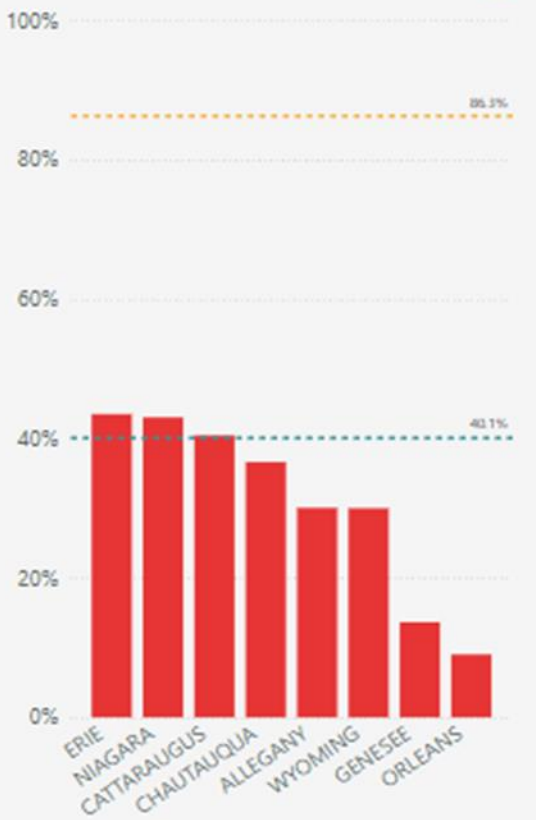
WNY Regional Rate

State or National Goal

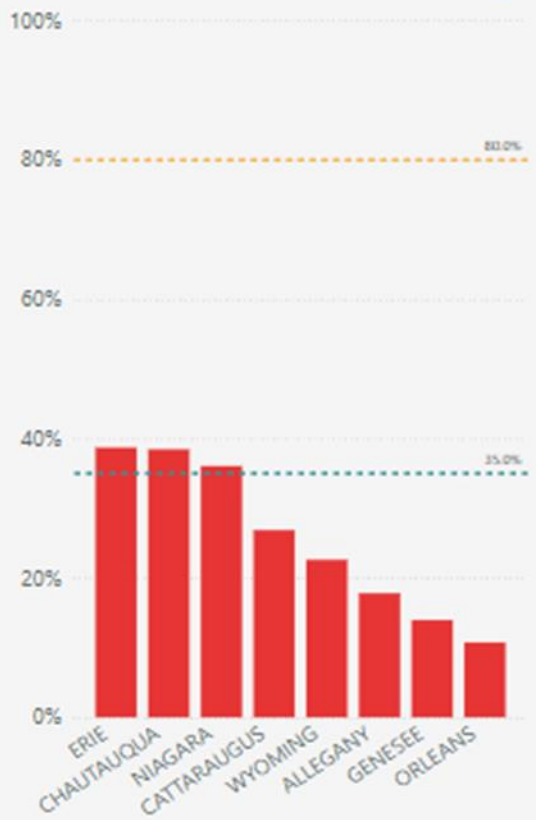
Breast Cancer Screening Rate



Cervical Cancer Screening Rate



Colorectal Cancer Screening Rate



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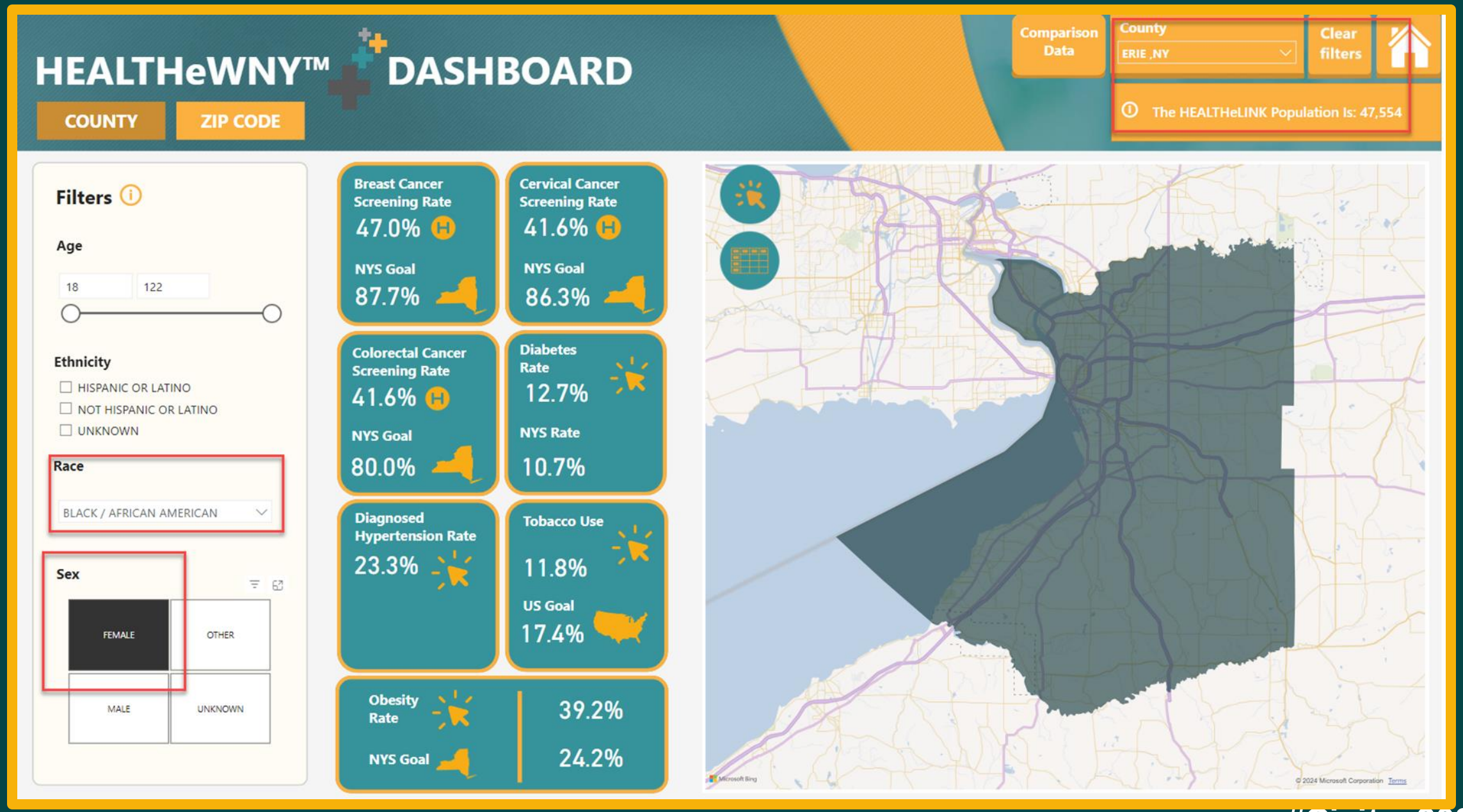

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HEALTHeWNY™ DASHBOARD

COUNTY

Compare By Zip Code

County: All

Clear filters

The HEALTHeLINK Population Is: 186,751

Filters

Zip Code: Multiple selections

Age: 18 – 122

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

Race: All

County: All

Sex
- FEMALE
- OTHER
- MALE
- UNKNOWN

Breast Cancer Screening Rate
43.4% (H)
NYS Goal
87.7%

Cervical Cancer Screening Rate
34.6% (H)
NYS Goal
86.3%

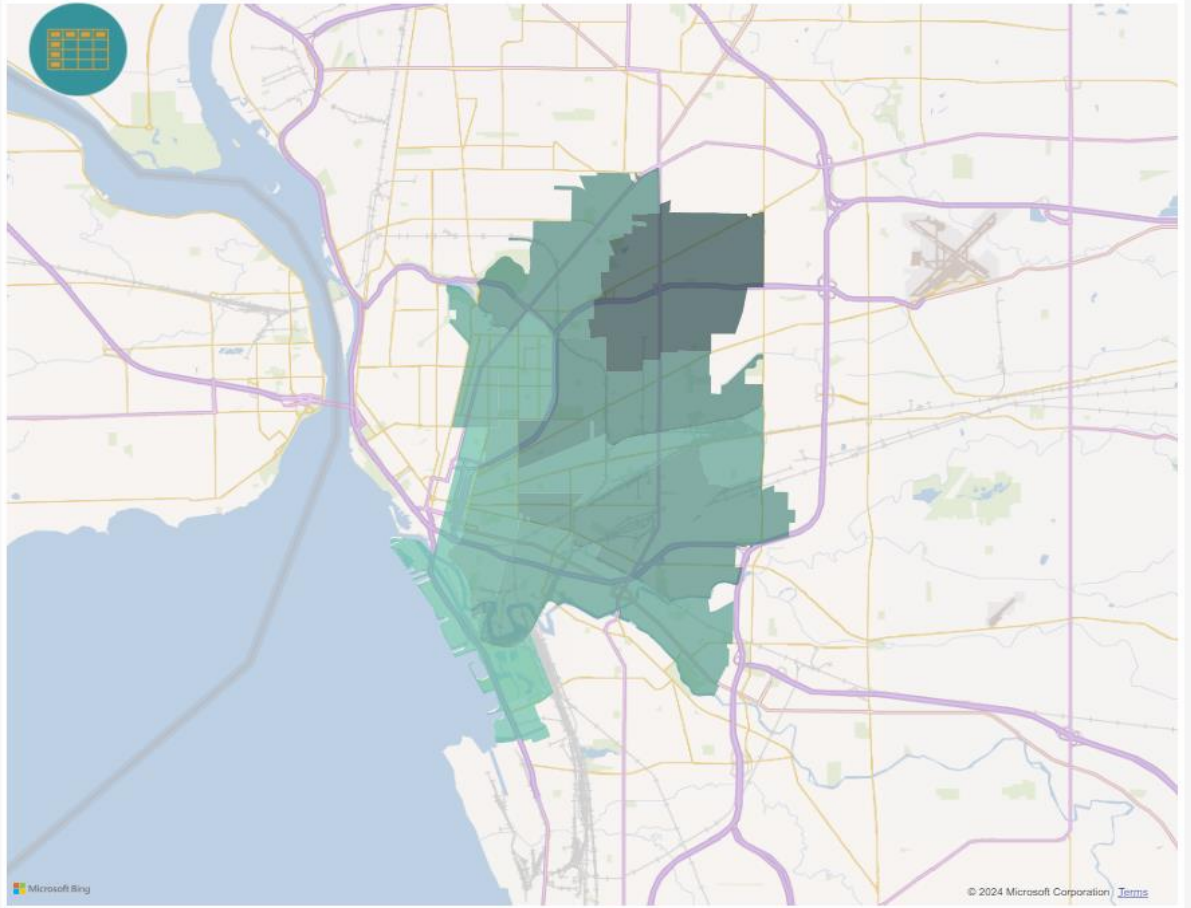
Colorectal Cancer Screening Rate
29.2% (H)
NYS Goal
80.0%

Diabetes Rate
8.9%
NYS Rate
10.7%

Diagnosed Hypertension Rate
15.3%

Tobacco Use
9.0%
US Goal
17.4%

Obesity Rate
22.8%
NYS Goal
24.2%



Data are derived from adult Electronic Health Records (EHRs) through the WNY Regional Health Information Organization (RHIO), HEALTHeLINK, during the lookback period of 1/1/2023 - 12/31/2023. The ZIP code associated with a health record is based on the patient's address, not the medical clinic location where services were rendered.

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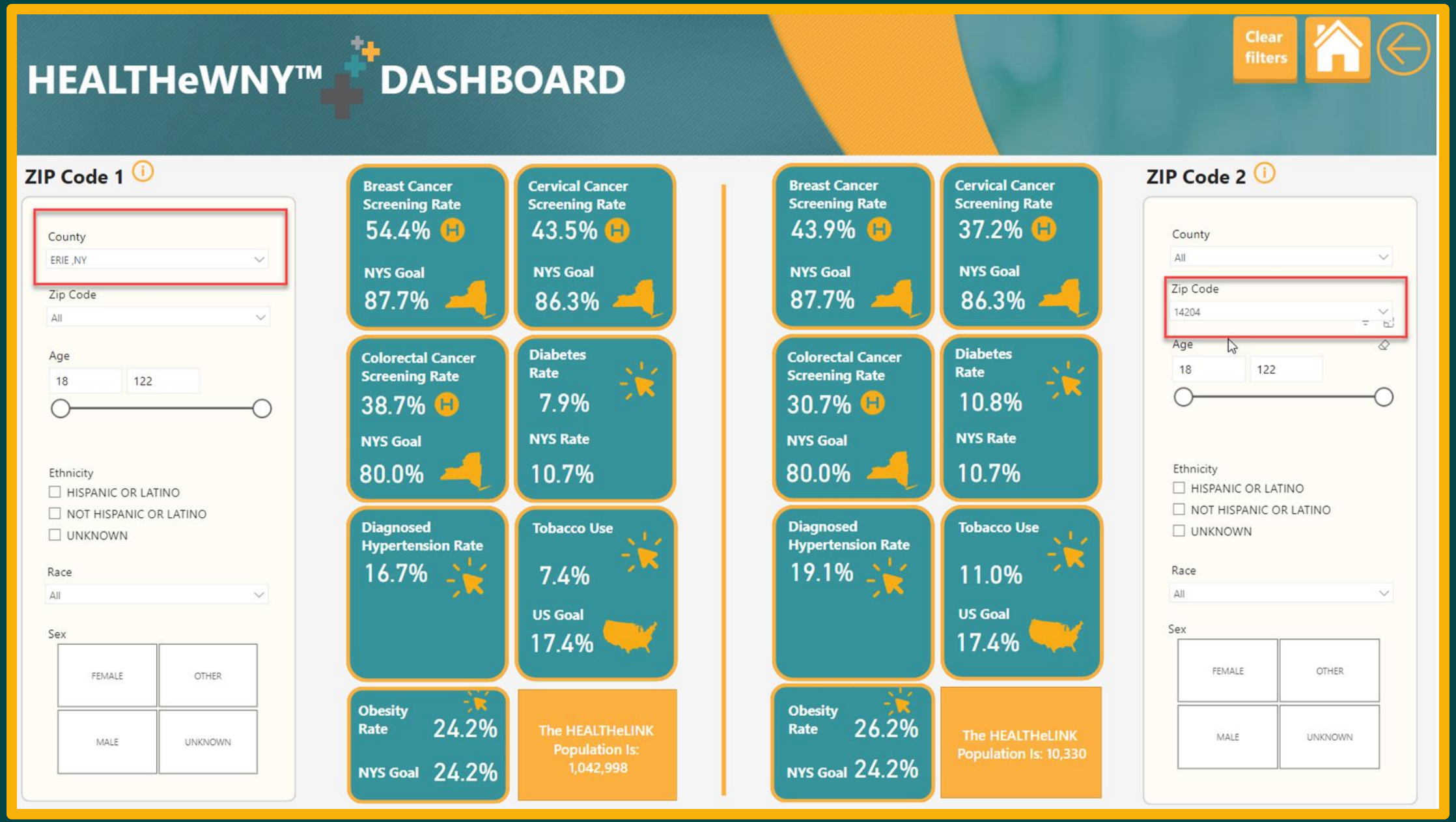

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WHAT'S NEXT?

Working with user groups in the community to obtain feedback on the Dashboard.

Rolling out the Dashboard to CBOs to help support their grant and funding efforts.

Present the Dashboard to local elected officials to demonstrate its capabilities

Local Health Departments using the Dashboard to support their annual Community Health Assessments.

CONNECT WITH US!

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