15th Anniversary

Minnesota e-Health Summit 2019

Presented by:

Department of Health

StratisHealth

Minnesota e-Health Advisory Committee

Session # 12

Sharing and Using Information to Improve Care Coordination and Health

June 13, 2019

Information That Works

https://www.health.state.mn.us/facilities/ehealth/summit/index.html

Session Objectives

- Learn about organizations implementing HIO connections for event notifications and care summaries
- Understand how these organizations are using this shared information to improve care coordination and management
- Hear how your organization can incorporate these lessons learned

Presenters

Jim Roeder
Vice President, Information Technology
Lakewood Health System

Denise Schneekloth
Executive Director
Minnesota Rural Health Cooperative

Sharing and Using Information to Improve Care Coordination and Health

Jim Roeder – VP of IT

Lakewood HEALTH SYSTEM

About Lakewood Health System

- Staples, MN
- Started in 1936
- 25 bed Critical Access Hospital
- 5 Rural Health Clinics
  - Staples, Browerville, Eagle Bend, Pillager, Motley
- Dermatology Clinic – Sartell
- Trauma Level III Emergency Dept.
- Long Term Care – 100 Bed
- 2 Assisted Living Facilities
- Behavioral Health Unit – 10 Bed

Lakewood HEALTH SYSTEM

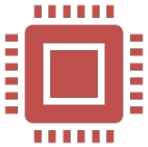
Lakewood – Koble HIO

- Q4 2018 – Lakewood awarded MN HIE Grant
  - Grant Period – 11/1/18 to 10/31/18
  - $48,000

- HIO's – Allina, Koble-MN, SCHA, Southern Prairie CC (ending in July 19)
  - Koble-MN selected

- Interfaces
  - ADT
  - CCD

Where We Are Today



ADT Interface

In Production (May 2019)

CCD Interface

Working with Epic & Essentia Health to implement

EAS Alerts

Working with AINQ to implement

EAS Alerts

Medicaid Focus (IHP Population)

Participation

&

BAA Signed

Koble Integration vs Direct Integration

Scope Issues

Dependency Issues

Integration Options

EAS PROMPT – Care Coordination Tool w/ Daily Alert File senet by SFTP

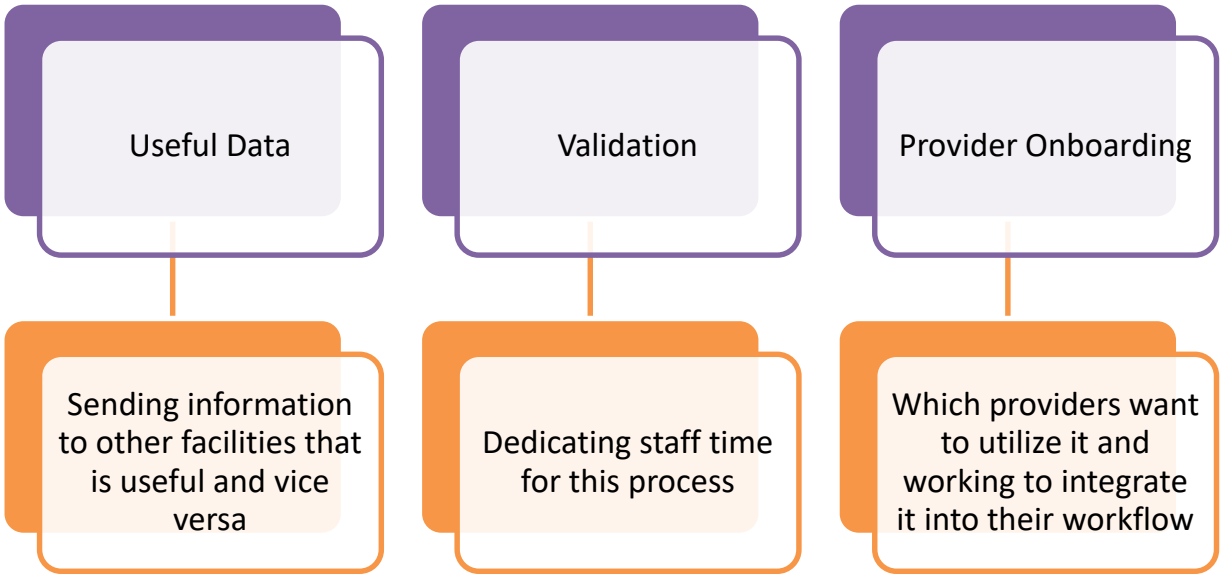
Full Integration – Epic HealthyPlanet or PCP InBasket Messages

Lakewood HEALTH SYSTEM

How To Utilize Shared Information

- Public Health
- Mental Health
- Non-Epic / eHealth Exchange

Challenges / Lessons Learned



Sharing & Using Information to Improve Care Coordination & Health

Denise Schneekloth, Executive Director
Minnesota Rural Health Cooperative (MRHC)

Minnesota Rural Health Cooperative

The Mission of MRHC

- Minnesota Rural Health Cooperative exists to provide (through its resources and services) positioning, integration and strategy in an ever-changing healthcare environment.

The Values of MRHC

- Minnesota Rural Health Cooperative will be the voice of its rural hospital and clinic provider members as they deliver quality and cost-effective health care in their communities.

MRHC Vision Statement

- MRHC will deliver its services in a manner best suited to cultivate viability of its member organizations.

- Our membership currently consists of:
- 18 Critical Access Hospital (424 state licensed beds)
- 46 clinic sites (231 physicians, 196 mid-level providers)

Today's Agenda

- Share our processes, lessons learned, and expected outcomes from our effort
- Share our case study, and how connecting to DiamondView's HIO, we are leveraging event notifications and care summaries (Transitions of Care/Referrals)
- Talk about how we are using the HIO information to improve our care coordination and management
- Offer our assistance in learning more, and joining on the DiamondView HIO

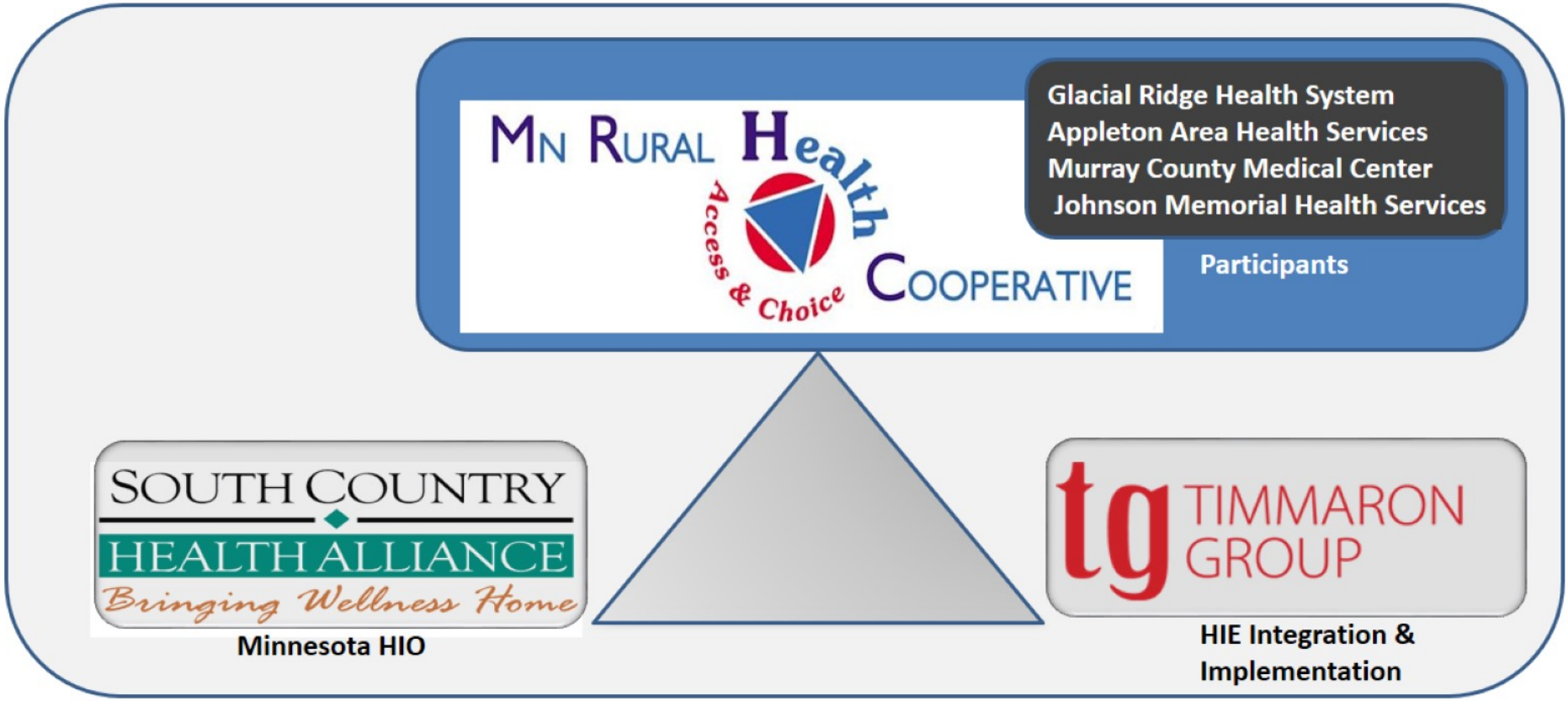
Minnesota HIE Grant Program - Maximum award $100,000

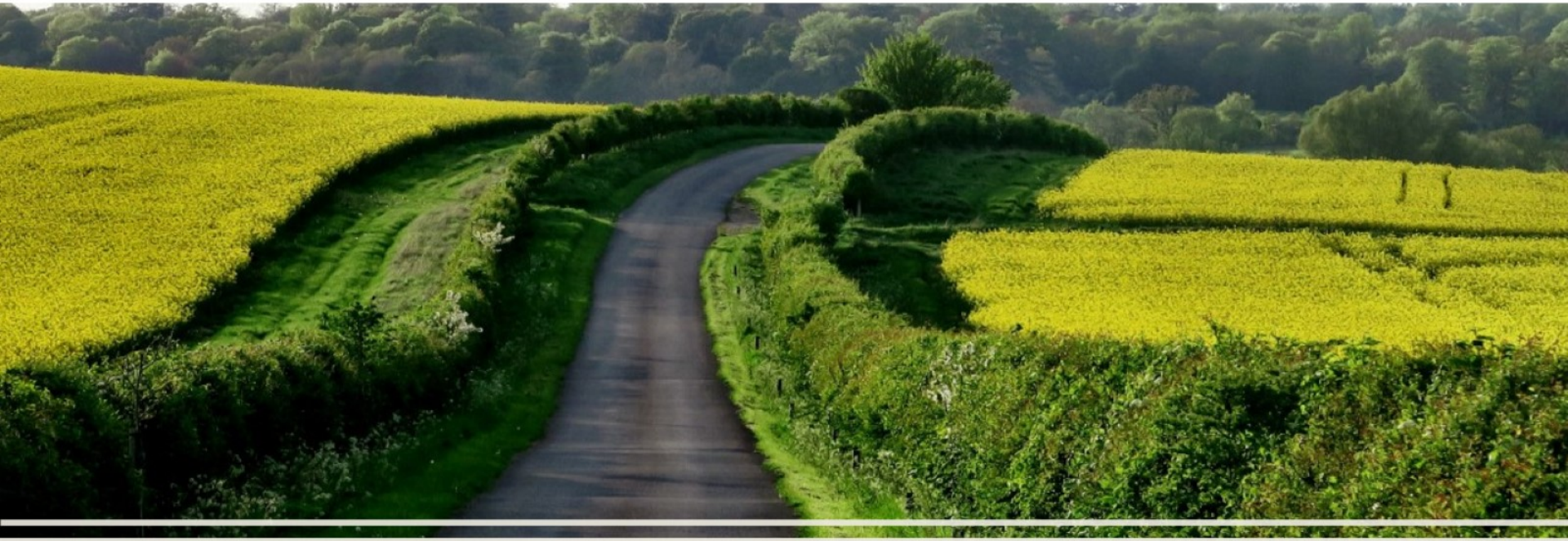
Minnesota Rural Health Cooperative Award: **$98,000**

- Funds will pay for the costs of establishing connection with a State Certified Health Information Organization, South County Health Alliance
- Additional Funding provided by grant recipient for other vendor interfaces, where needed
- Funds include up to one year's subscription costs (dependent on funding and population size)

Effective date of grant 12/05/2018. HIO connectivity by 10/31/2019 (12/04/2019?).

STEP 1: FORMED OUR PARTNERSHIPS





STEP 2: DEVELOPED PROCESSES

Engaged Stakeholders/ Formed Core Team

- We brought our community leadership from hospitals & clinics to discuss our use case study – ADTs & Alerts can be used many ways to develop care pathways
- We had representation from leadership to sponsor the work, through those on the front line who will be using the system
- We determined our case study potentials together, then continued to refine stakeholders to adjust our learning/case development

Organization Core Team (template)

- We used this template to secure our core team, and the administrative cadence on how we'd meet (saves on coordination time – don't underestimate this effort!)
  - Identify the HIE Lead
  - IT Contact
  - Case Study Participants & Roles
  - Referral Coordinator(s)
  - Community Referral Partner(s)

Include:

- Contact Name
- Title
- Organization
- Phone
- Email

Launched with Patient Consent and HIE Planning (checklist)

- **Addressed all administrative requirements upfront:**
  - Update current consent forms with regulatory language to obtain consent
  - Implement collection of revised consent forms from patients for immediate collection of consent
  - Develop consent IT exchange process with SCHA HIE
- **Built our HIE project contact list, by participating organization (those for communications, beyond core team):**
  - Contact Name
  - Title
  - Organization
  - Phone
  - Email

Set Our Timeline & Measurements for Success Together

- Identify Community Case Study Topic – Transitions of Care (COMPLETE)
- Determine Case Study Goals and Objectives
- Stakeholder Team and Leadership
- Develop Case Study Workflows

- Map case study workflows with data (data contributors, data subscribers, application interface requirements)
- Identify outcomes measures desired for improved flows

- SCHA & Community connect the data & start to share info
- Data sharing tested
- Reporting is set up for community review & approval

- Move into operational phase
- Determine administrator who will do MRHC ongoing grant reporting and operationalizing

STEP 3: DOCUMENT LESSONS LEARNED

Case Study Prioritization Process (template)

TRANSITION CHALLENGE
Medication Management / Medication Reconciliation ➢ Adherence post discharge ➢ Reconciliation prior to discharge
Pain Management ➢ Clinic to Clinic ➢ ED to Clinic
Patient Experience
ED Follow-Up from discharge
Results – ➢ When/How?
Hospital ➢ Prior Orders
Hospital/ED Discharge Flows ➢ Who needs to know?
Referral Management ➢ Closing the GAP - Timely ➢ BH follow-up with referrals: o ARMHS, ACT, Case Mgmt, Clergy, Optometry, Home Health, Care Givers, Other
Behavioral Health ➢ Communication between stakeholders ➢ Barriers to success (ER dumping, access, lack of discharge housing, court holds, health plan interference, etc. ➢ Where does information exchange provide opportunity?
Wellness ➢ Lack of patient engagement in annual visits. ➢ Care management feels invasive to patients. ➢ Low level of need, expensive to operationalize

Establish IT Work Group in parallel

- To avoid any technical roadblocks, set up a subgroup at the same time you start your case study, and allow IT to participate in the development – to align the data sources, address any interface needs, and allow them to work in parallel with the core team

- Provide an IT Contact by participating organization:
  - Contact Name
  - Title
  - Organization
  - Phone
  - Email
- Requirements for IT to address:
  - IT Assessment Completion
  - Interface Enabling
  - Administrative Contact

VALUE ACHIEVED/EXPECTED

MRHC Case Study Vision

"Referral Management Closing the Loop"

Ability to close the referral loop thru confirmation of receipt and visit from referral provider and adding efficiencies to the process by sending / receiving data at the right time, and providing a reconciliation process within our work flow to "close the loop".

Expected Results

- **MRHC and our provider network will be more effective, efficient and supportive to our care providers and community members -** with access to the ADTs, CCDs through DiamondView HIO, MRHC can share across our organizations in a meaningful way.

Expected Results

- **Better outcomes** - improvement in our information sharing with our provider network will assist in the delivery in the quality, continuity, and coordination of care for our patients, delivering desired results.

Expected Results

- **Shared information will allow our health care providers to see the special needs and assist in prioritization** - access to accurate, actionable data in a timely manner allows health care providers to respond and work with patients to schedule tests, treatments, make referrals, and address the best care possible to access, is a critical mission for us at MRHC.

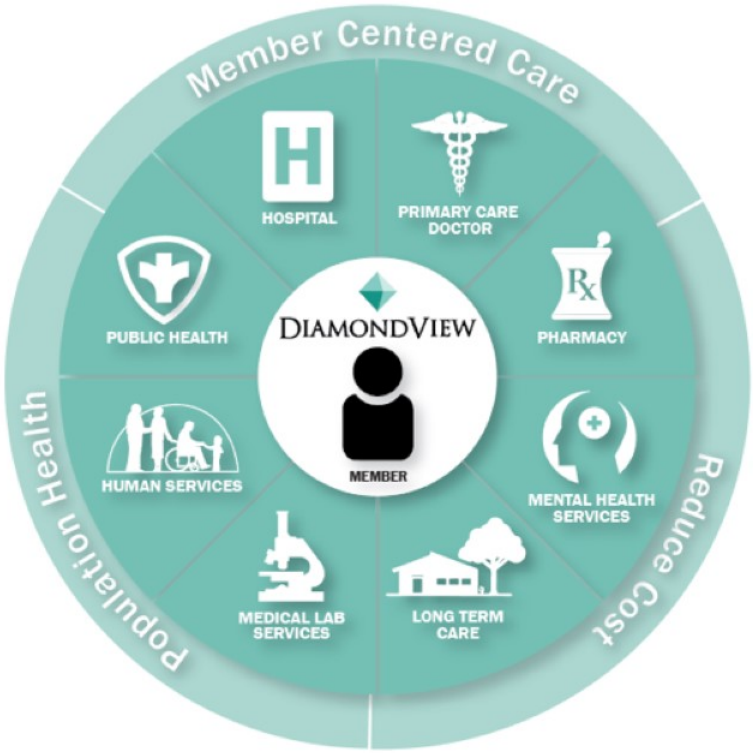
DiamondView HIE

MESSAGING

EXCHANGE

ALERTS

ANALYTICS



Thank you!

DSCHNEEKLOTH@MRHC.NET
(507)423-5300

Thank you!