Developing Health IT Capacity for Successful Partnership with Health Care Entities

Aging and Disability
BUSINESS INSTITUTE

Speakers

- Beth Blair, Senior Research Associate, n4a
- Peter Eckart, Director, Center for Health and Information Technology, Illinois Public Health Institute
- Leigh Ann Eagle, Executive Director, Living Well Center of Excellence, MAC, Inc.
- Sue Lachenmayr, State Program Coordinator, Maryland Living Well Center of Excellence, a Division of MAC, Inc.
- Craig Behm, Maryland Program Director, CRISP
- Anne Montgomery, Deputy Director, Program to Improve Eldercare, Altarum Institute

The "Business Institute"

The mission of the Aging and Disability Business Institute (Business Institute) is to successfully build and strengthen partnerships between community-based organizations (CBOs) and the health care system so older adults and people with disabilities will have access to services and supports that will enable them to live with dignity and independence in their homes and communities as long as possible.

www.n4a.org/businessinstitute

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Our Funders

The John A. Hartford Foundation

Our Partners

Partners in Care
FOUNDATION
www.picf.org

Center for Healthy Aging

Evidence-Based Leadership Council

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ACL Business Acumen Grants

Learning Collaboratives for Advanced Business Acumen Skills (n4a)

- Organize and conduct 3-5 topically-based action learning collaboratives to address "next generation" issues; and to provide targeted technical assistance to networks of community-based aging and disability organizations.
  - Trailblazers Learning Collaborative
  - Health Information Technology Learning Collaborative
  - Medicare Advantage Learning Collaborative

- Create knowledge and capture insights through these collaboratives to incorporate into future curriculum for national dissemination.

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Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

THE HENRY J. KAISER FAMILY FOUNDATION

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Why the HITLC?

CBOs experience challenges with IT and data sharing with their health care partners

- 19% of respondents to a AAA survey on IT had systems to connect with their health partners (n4a and Scripps Gerontology Center, 2016)
- 66% reported that IT limitations are a significant barrier to their ability to develop a value proposition (n4a, 2018)
- 50.8% report receiving patient health outcome data through a contract with a health care partner (Business Institute, 2018)

"Data collection is very difficult. Each of our MCO partners requires we document and track client activity in their respective platforms. There is not one universal system to capture all the data…"

"The biggest issue we face is access to good, actionable data. We have very limited access to any information and most of that is not in actionable, reportable, manageable formats. It's nothing more than general information, most often on hitting timeframes. This is one of the most critical problems facing CBOs related to contracting with MCOs and health systems."

(Business Institute, 2018)

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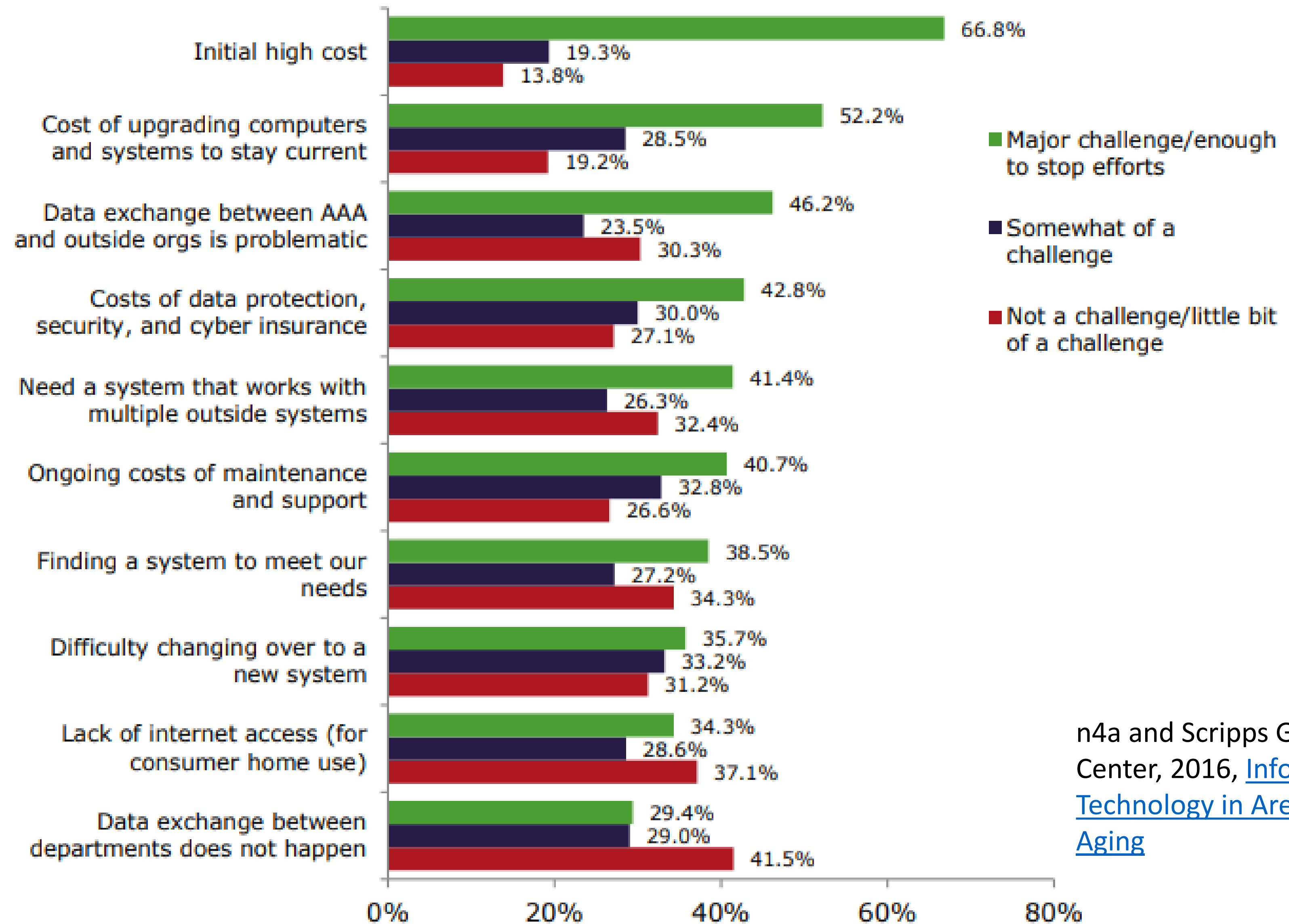
Challenges Faced by AAAs in Using IT



n4a and Scripps Gerontology Center, 2016, Information Technology in Area Agencies on Aging

Connecting Aging Services and Healthcare through Data for Better Care and Outcomes

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NASUAD HCBS Conference
August 28, 2019

HITLC Goals

Purpose: Assist participants in making strategic decisions around investing in health information technology (HIT) systems to collect, manage and analyze service data and enhance program quality, client satisfaction, and service reimbursement.

Key Outcome: Successful implementation and use of administrative data systems to grow the capacity of CBOs.

Deliverable: Tools that can assist the larger field of CBOs with the making informed decisions around data systems.

advocacy | action | answers on aging

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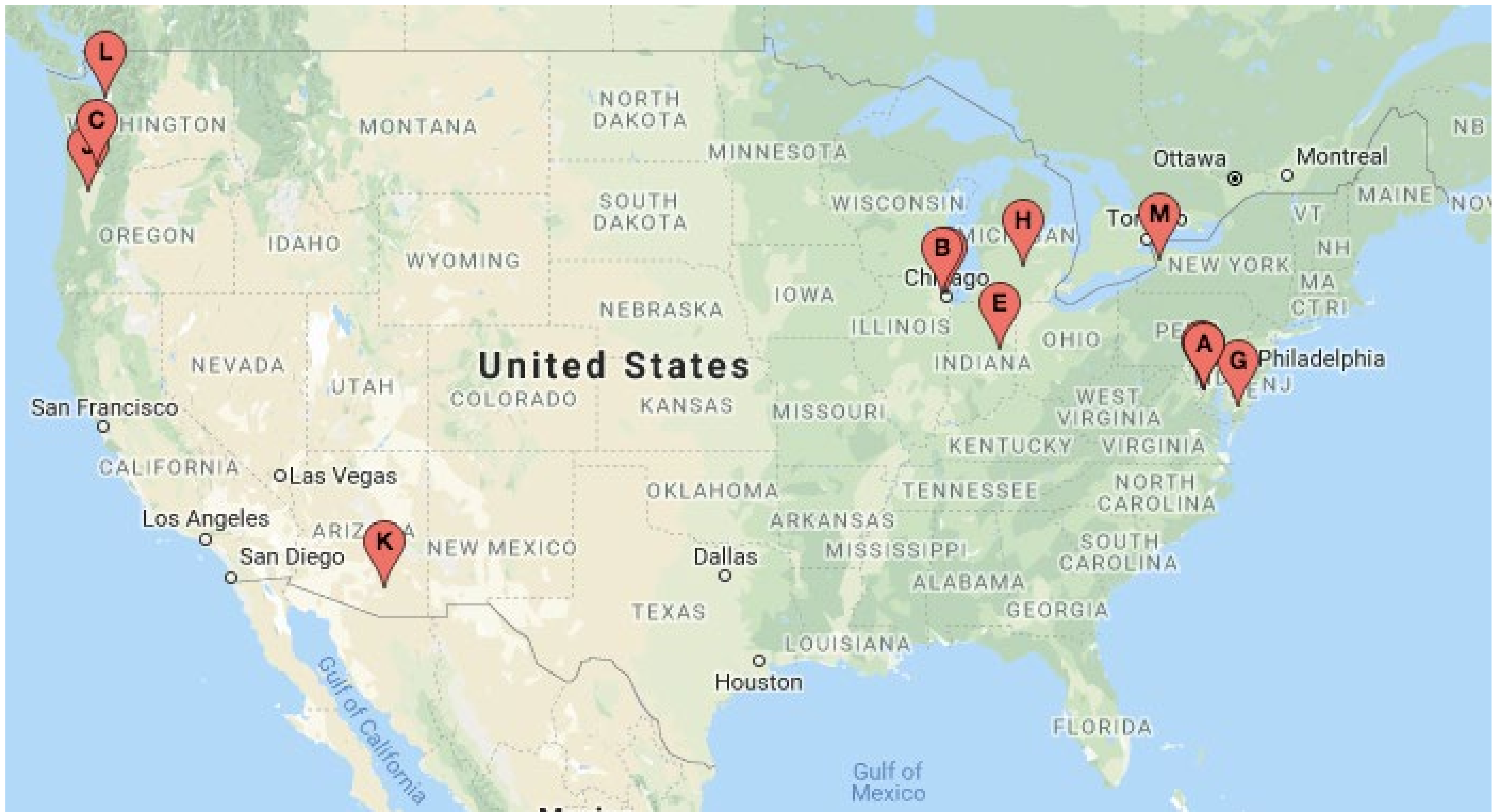
Establishing the Learning Collaboration

- Application and review process
  - Criteria: maturity, readiness, scope of project
- Baseline knowledge
  - Project profiles
- Structure
  - Mix of opportunities
  - Work groups, full cohort, TA, 1-on-1
  - Activities that foster peer-to-peer sharing



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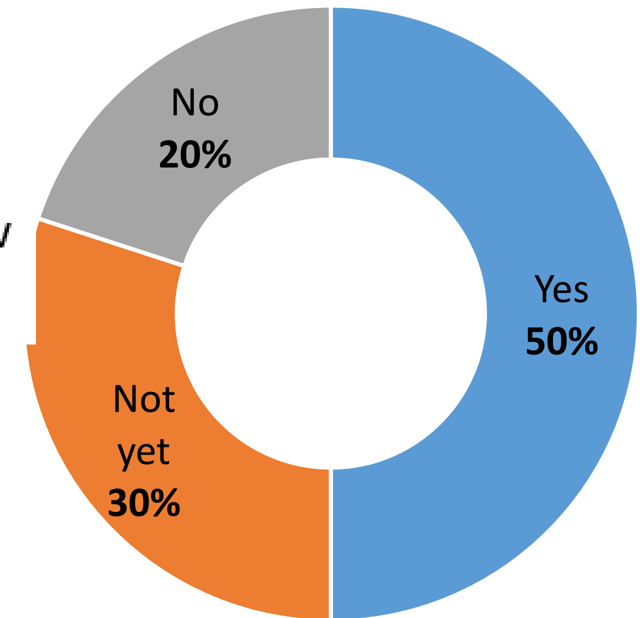
MISSISSIPPI
SOUTH CAROLINA
ALABAMA
GEORGIA
TEXAS
LOUISIANA
Houston
FLORIDA
Gulf of California
Gulf of Mexico

Cohort Characteristics



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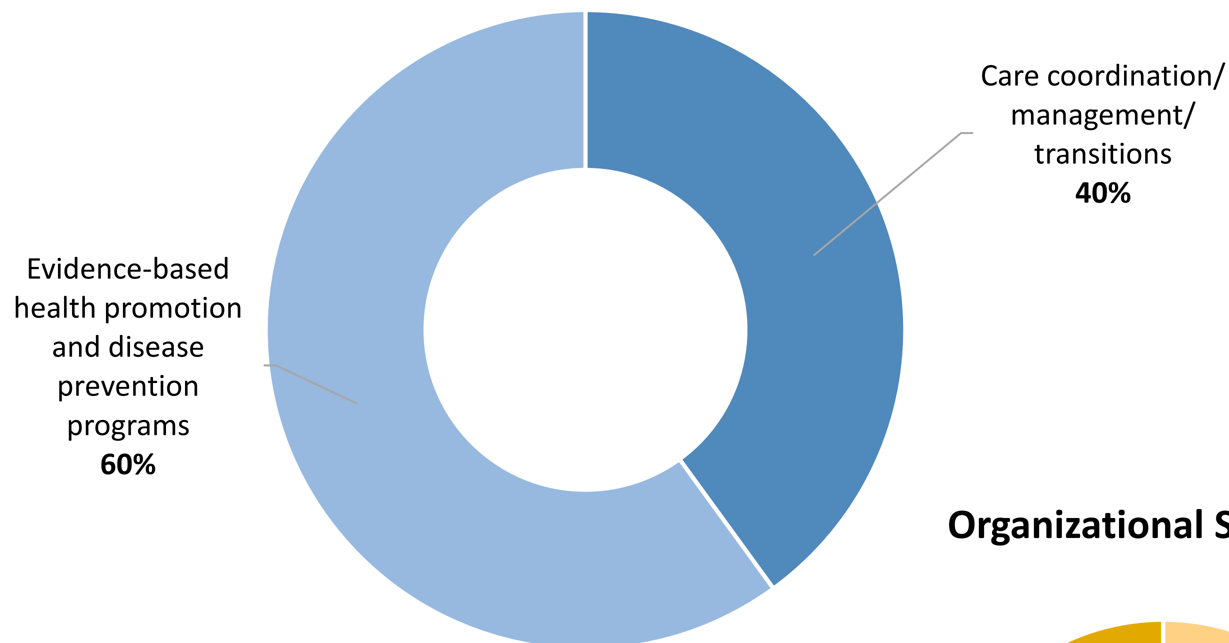
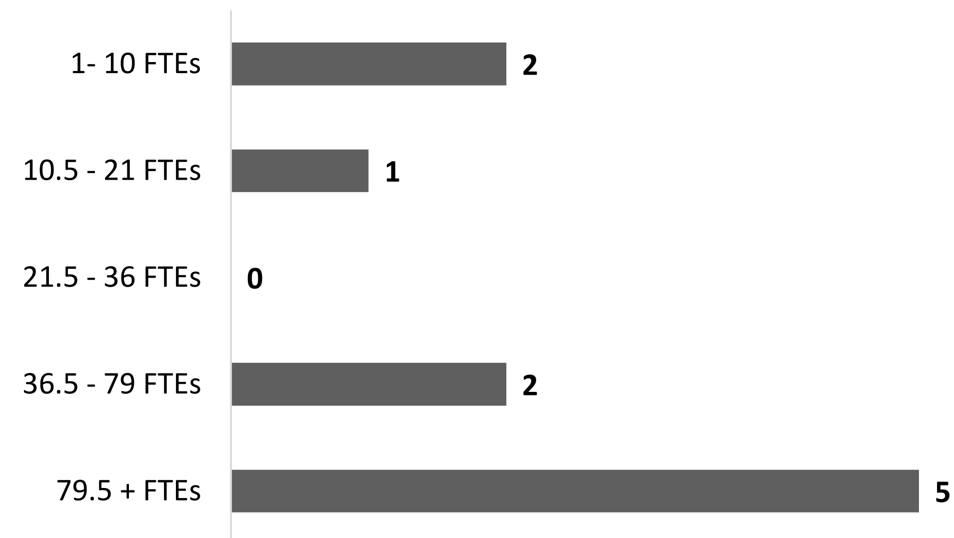
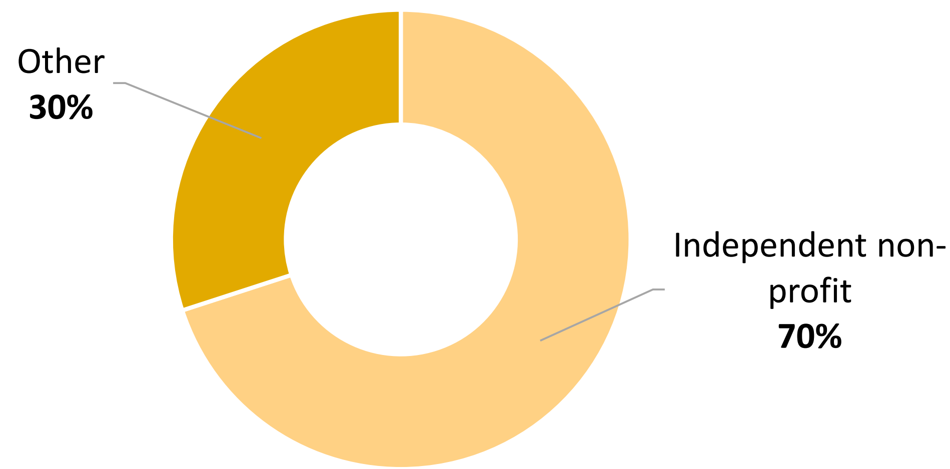
Cohort Characteristics







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Sites Needs Vary Widely

- Partner/ Relationship Development
- Case management systems
- Collecting SDOH data
- Legal: Consent, HIPAA
- Data analysis, reporting, and visualization
- Funding, Healthcare contracting
- Vendor/software selection
- Measuring outcomes
- Health care quality measures
- Integration with other systems (EMRs, HIEs, etc.)

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Sample Project Goals Across Sites

- **Track delivery/impact of EBPs provided** to older adults with multiple chronic conditions and **notify referring entities of program outcomes**, cost savings, reduced healthcare utilization.
- Establish a **Health IT portal that is efficient and easy to use, integrates with provider EHRs and member organizations' existing platforms, and links to billing claims** for ease in reimbursements for community services.
- Transform data systems to an **integrated data governance solution that serves the agency for day-to-day management of services and long-term planning**.
- **Identify ways to evaluate programs, data use, and data access in order to leverage our services when forming partnerships with other key players** addressing the health of seniors and adults with disabilities.

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Content and Activities

Topics

- Partnering with Health Care – Health Systems and Payers
- Data Systems and Sharing between AAAs and Health Care
- Contracting with Health Systems and Plans
- Bi-directional E-referral Using RedCap
- Change Management

Optional Webinars

- Overview of Data Systems Selection Process
- Trailblazer Learning Collaborative Tools
- Epic Community Connect

Assignments

- Profile Profiles
- Project Workplan and Status Reports
- Community Presentations
- TA/SME Lessons Learned
- Evaluation of Existing Tools and Resources
- Input on Cohort Tools

- Peer-to-Peer
    - Consultancy, polling, project profiles, online community

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N4a Health Information Technology Learning Collabora...

Private Group **9** Members

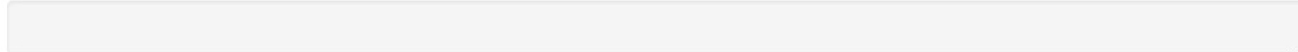
Request Membership

FORUM HOME REQUEST MEMBERSHIP RESOURCE LIBRARY EVENTS 0 MEMBERS 9 PHOTOS 0

MANAGE

UPDATES

What's new in N4a Health Information Technology Learning Collaborative (HITLC), Jenna?



Anna posted an update in the group N4a Health Information Technology Learning Collaborative (HITLC) 8 days ago

Welcome to our online space for the NA4 HITLC!

Our team has been enjoying the initial calls to get to know each team a bit more. Next week, we'll post a document with short profiles of each site and an agenda that you can preview for the Kickoff Webinar on Wednesday November 7 from 1-2:30 pm CT.

Peter posted an update in the group N4a Health Information Technology Learning Collaborative a month ago

Well, everything is new in the n4a Health IT LC, cuz we're just getting started!

GROUP INFO

This learning collaborative led by the Illinois Public Health Institute (IPHI) will support community-based organizations (CBOs) – including Area Agencies on Aging, Centers for Independent Living, and other community-based aging and disability service providers – in making strategic decisions around investing in Health Information Technology.

GROUP ADMINS

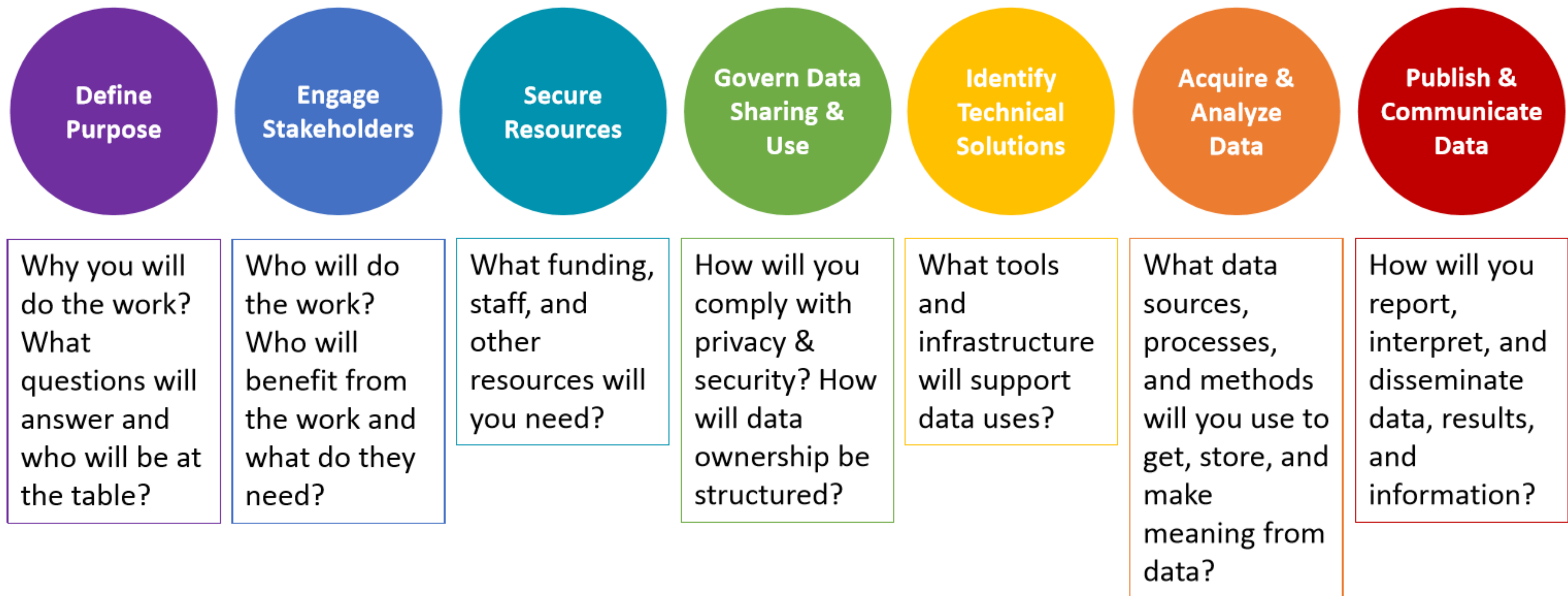
GROUP MEMBERS

Questions? Contact us!

Feedback Shared on Activities to Date

- *The learning has been really helpful even if it is just confirming to know the issues are universal.*
- *Enjoyed info on building a data analytics team, will be discussing with our members.*
- *It was especially interesting to hear about the approach to creating and supporting a dedicated analytics dept (distinct from general IT)*
- *It was extremely helpful to hear about the process for selecting and implementing systems.*
- *Important to have a wide range of people representing different functions and agencies involved in change management efforts.*
- *Just have to say thank you for another great webinar!! In our conversation with healthcare the importance of closed loop and bi-directional communication have surfaced across all populations. We are seeing payment being driven based upon closed loop referrals and the technology to support that and the bi-directional communications.*

What we've been learning; it's a Process



Aha Moments from Sites to Date: Partnerships

- **Stay persistent** in building relationships - both with internal champions and external organizations - and work to 'speak the same language' when pursuing health systems or plans.
- **Meet with a variety of staff** in different departments at health systems and plans to find your champion. Cultivate relationships at multiple levels.
- **Drive the timeline:** Having a solid workplan can help you drive the timeline when working with partners that may not have as much flexibility / momentum.

Aha Moments from Sites to Date: Data Systems

- **Define your use case:** One size does not fit all, different data systems may be needed for internal data management, analysis and reporting vs. for data that is shared with external entities (hospitals, payers, etc.)
  - Most have found there is no single software / vendor that can "do it all." Understanding your requirements and the needs of your partners can help streamline your workflows and narrow down which system(s) can provide efficiencies and achieve your goals.
- **Navigating legal barriers** and consent management can be complicated. VPN is one solution to securely share data with health plans. Online training solutions exist for HIPAA compliance. All of it takes time. Nonetheless, important to get it right.
- **Software selection** and negotiations are an ever-evolving target, and even after many conversations, vendors may still slow or halt contracts. Collaborations with others who have purchased a software or engaged with the vendor are also helpful.

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Project Spotlight 1: Sound Generations

Project Enhance: Evidence-based program offered nationwide to address chronic health conditions for those aging with and into disability

Goals:

- 1) Pilot a referral and EBP outcome feedback loop with health care provider
- 2) Review, assess and adopt best practices in demonstrating HIPAA-compliance and data security organization wide
- 3) Create standardized data sharing and BAA agreements

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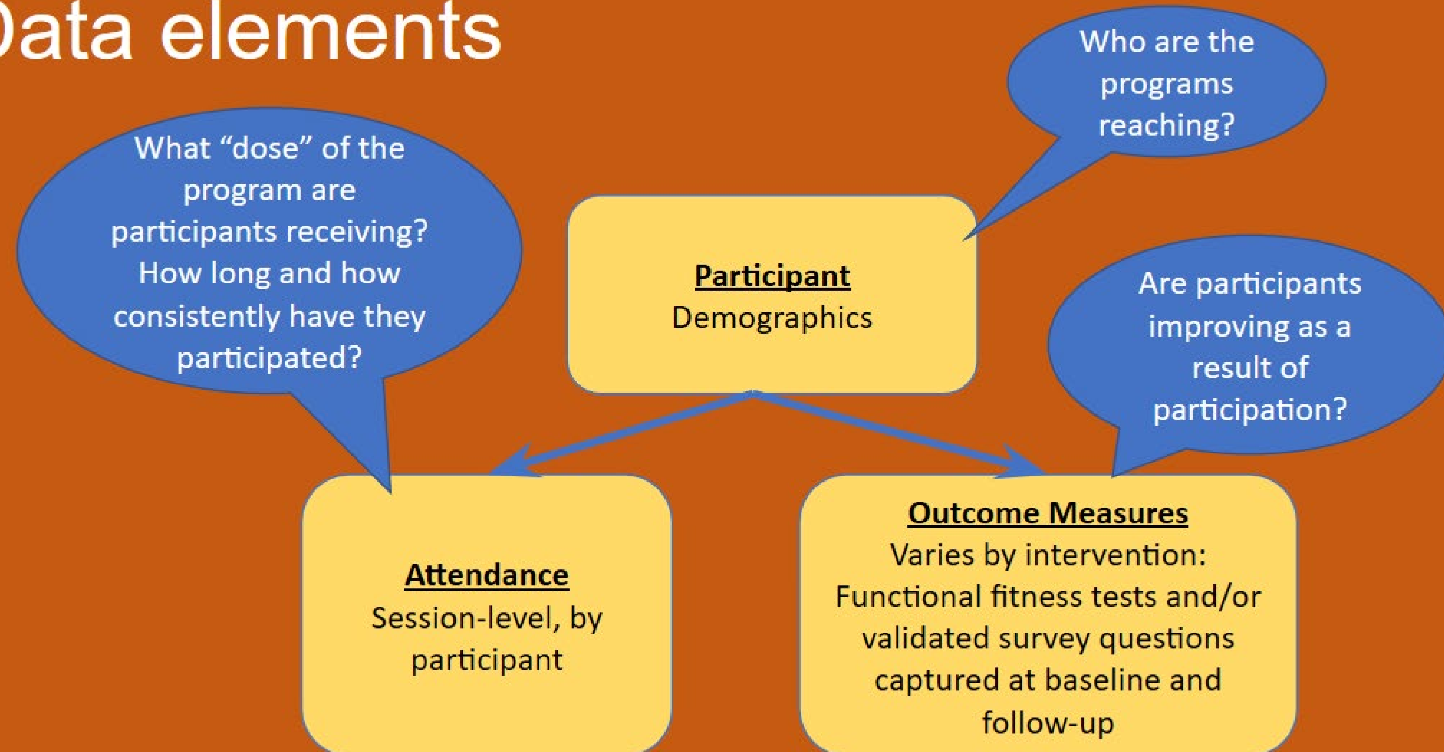
Project Spotlight 1: Sound Generations cont'd

Different data matching processes for different payers

Kaiser: SG matches program participant data against a list of eligible policyholders suppled by Kaiser, and submits that list monthly

Silver&Fit: Sites generate a monthly attendance report which is then used for reimbursement



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Project Spotlight 2: Age Options

Closed Loop Referrals with Health Care

- Testing the impact of a closed loop referral system (NowPow) with a hospital and a network of primary care practices for adults on Medicare
- Includes EMR social determinant screen
- If patient is flagged for nutritional risk, they are referred to AgeOptions
- AgeOptions screens, refers for meals, follows up, and reports back through NowPow

Project Spotlight 3: Pima Council on Aging

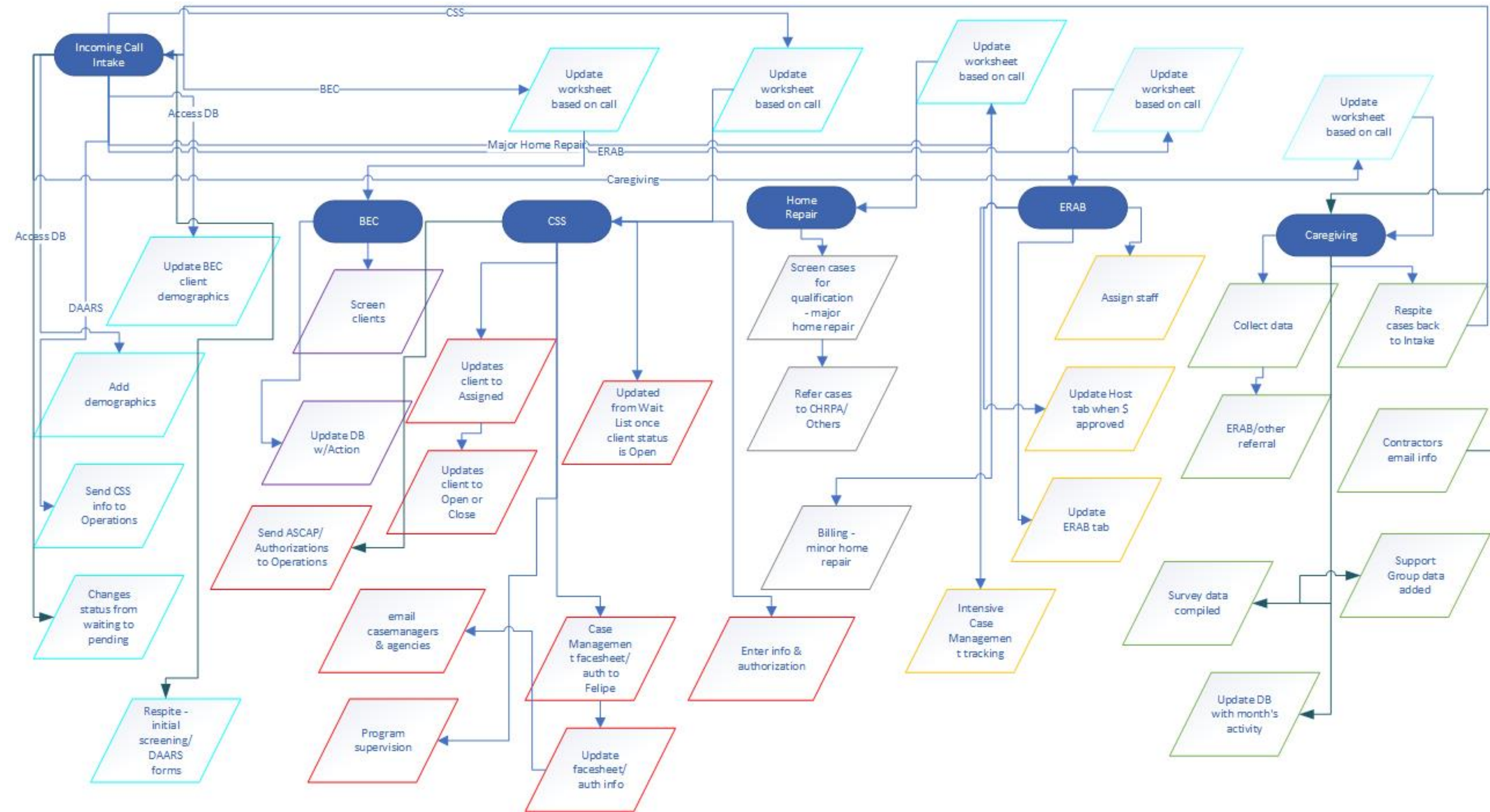
PCO Is a AAA serving 28,000 Pima County, AZ residents

Opening a new Healthy Aging Center

Operate Pima Care at Home

Challenges addressing:

- Disparate data systems
- Move to better data analytics
- Contract with insurers/managed care
- HIPAA compliance



Data Flow Diagram

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Project Spotlight 3: Pima Council on Aging (Cont'd)

Latest News:

1. After mapping workflows, outlining requirements, and viewing product demonstrations, they decided they will <u>not</u> purchase a new system and instead are concentrating on modifying the existing state-implemented system.
2. PCOA is working with the state to build the specifications together and will approach the vendor to discuss platform expansion
3. Working to develop pilot project for data collection, data warehousing and visualization.

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Project Spotlight 4: Western New York Integrated Care Collaborative

Shared Use of EHR

- WNYICC is contracting with a physician practice who will provide access to their EHR portal without having to pay an upfront cost.
- Physician practice provides clinical oversight on programs such as chronic care management and will handle the billing.
- WNYICC will provide the health coaching.
- Challenges: Takes time to develop HIPAA and data use policies and schedule meetings with the physician practice

Project Spotlight 5: Oregon Wellness Network

- **OWN** is a division of Oregon Association of Area Agencies on Aging and Disabilities (O4AD) and serves as a network hub for the 17 Area Agencies on Aging (AAAs) in Oregon.

Use of Solera in the Diabetes Prevention Program.

- For the Diabetes Prevention Program they use Solera for data entry.
- People are signed up for this program by HealthInsight and Solera who refer people to OWN via email. OWN also does in-person and online sign-ups.
- OWN gets reports from Solera which are useful for them in terms of DPP and tells them participants have met program metrics. Solera produces a report in the DPP format.

Project Spotlight 5: Oregon Wellness Network

Solera payment and enrollment process

- Step 1: Participant identified, screened and enrolled in a workshop (done either online or call).
- Step 2: Participant enrolled through Solera portal for payer coverage.
- Step 3: Participant attends in-person DPP. Data is tracked in Solera portal.
- Step 4: As participant meets reimbursement milestones, OWN receives payment from Solera and passes on payment to local program supplier. an email is also sent to the participant informing them that they reached a certain milestone and receives an incentive for them

HIT LC Tools – in Development

Partnering with Health Care: Key Takeaways

- Who to talk to / finding the right people at health systems plans
- What agreements around data sharing should be included in the contract

Software Vendor Grid

- Attributes and definitions

HIT Resource List

- Feedback on the utility of various resources shared by teams and facilitators over the course of the learning collaborative

AAA and CBO Strategic Software Investment Guide

- Specific considerations for CBOs/AAAs for identification, selection, and implementation

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All In: Data for Community Health

100+
COMMUNITY
COLLABORATIONS
ARE *ALL IN*!

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A Division of MAC, Inc.

Leigh Ann Eagle, Executive Director

Sue Lachenmayr, State Program Coordinator

MARYLAND Living Well CENTER of EXCELLENCE

CHRONIC DISEASE SELF-MANAGEMENT EDUCATION PROGRAMS

WALK WITH EASE
a program for better living

Living Healthy with High Blood Pressure

Who We Are, What We Do

- Area Agency on Aging (AAA) for 4 rural counties on Maryland's lower Eastern Shore
- Successful Implementation of the evidence-based Chronic Disease Self-Management Education resulted in transfer of statewide license and database from Maryland Department of Aging in 2015
- 2015/2018 CDSME Sustainability Grant and 2016/2019 Falls Sustainability Grant from the Administration for Community Living
- Established a statewide hub for licensing, training, technical assistance, data collection/reporting and quality assurance monitoring of evidence-based program implementation
- Partnership with Maryland AAAs
    - Contracts with 29 MD Hospitals
    - Collaboration with Chesapeake Regional Information System for Patients (CRISP) Maryland's Health Information Exchange

Services

- Screening for Social Determinants of Health (SDoH) and referral to appropriate services and evidence-based programs
- Statewide calendar for registration/referral to evidence-based program workshops
- Living Well website with tools, resources, marketing materials for participants, leaders and coordinators, and health care providers
- Quarterly reports on patient activation, engagement, and long-term goals
- Participant satisfaction/engagement and quality assurance monitoring of leader fidelity and competency
- Collection individual and population health outcomes
- Tracking of pre-/post-clinical measures

Matching Services to SDoH Needs

Care Planning	Maryland Access Point (MAP) No Wrong Door Information & Referral
Nutrition	Nutrition counseling, education, and care planning; Meal programs: delivered to homes or senior centers; List of community food resources; Meal enhancements and nutritional supplements
Financial	Application for financial aid, including SNAP, Medicaid, the State Health Improvement Program (SHIP), energy-assistance programs, income-tax assistance, Medicare prescriptions, and Part B premiums; Medication and supplement grants
In-Home Care	Assistance with in-home care, sitters list, assisted living subsidies, Community First Choice; Telephone reassurance; Options Counseling
Medical Conditions	Medication management Assistance for dental, eye care, and hearing aids
Social Support	Senior centers (exercise, socialization); Support groups (Alzheimer, caregivers, stroke, renal); Lifelong learning; Volunteer opportunities; Senior employment
Environmental Assistance	Counseling on housing and assisted living; Education about local transportation systems; Training for assistive technology equipment & adapted telephones; Ramp assistance
Health and Wellness	EBP Programs: Chronic disease, diabetes self-management; cancer thriving and surviving; Diabetes prevention program; Malnutrition workshop: Stepping Up Your Nutrition; Fall-prevention workshops Stepping ON, OTAGO; Depression care management: PEARLS

Partners Across Clinical and Nonclinical Services

The Maryland Living Well Center of Excellence (LWCE) at MAC, Inc. and Maryland's Health Information Exchange - Chesapeake Regional Information System (CRISP)

- Track individuals across hospitalization, primary care providers, and community-based organizations (CBOs)
- Implement evidence-based programs and interventions to address social determinants of health
- Issue care alerts to providers and hospitals regarding CBO programs and services provided and clinical care services needed
- Demonstrate impact of evidence-based program and provision of non-clinical services on healthcare costs and participant quality of life

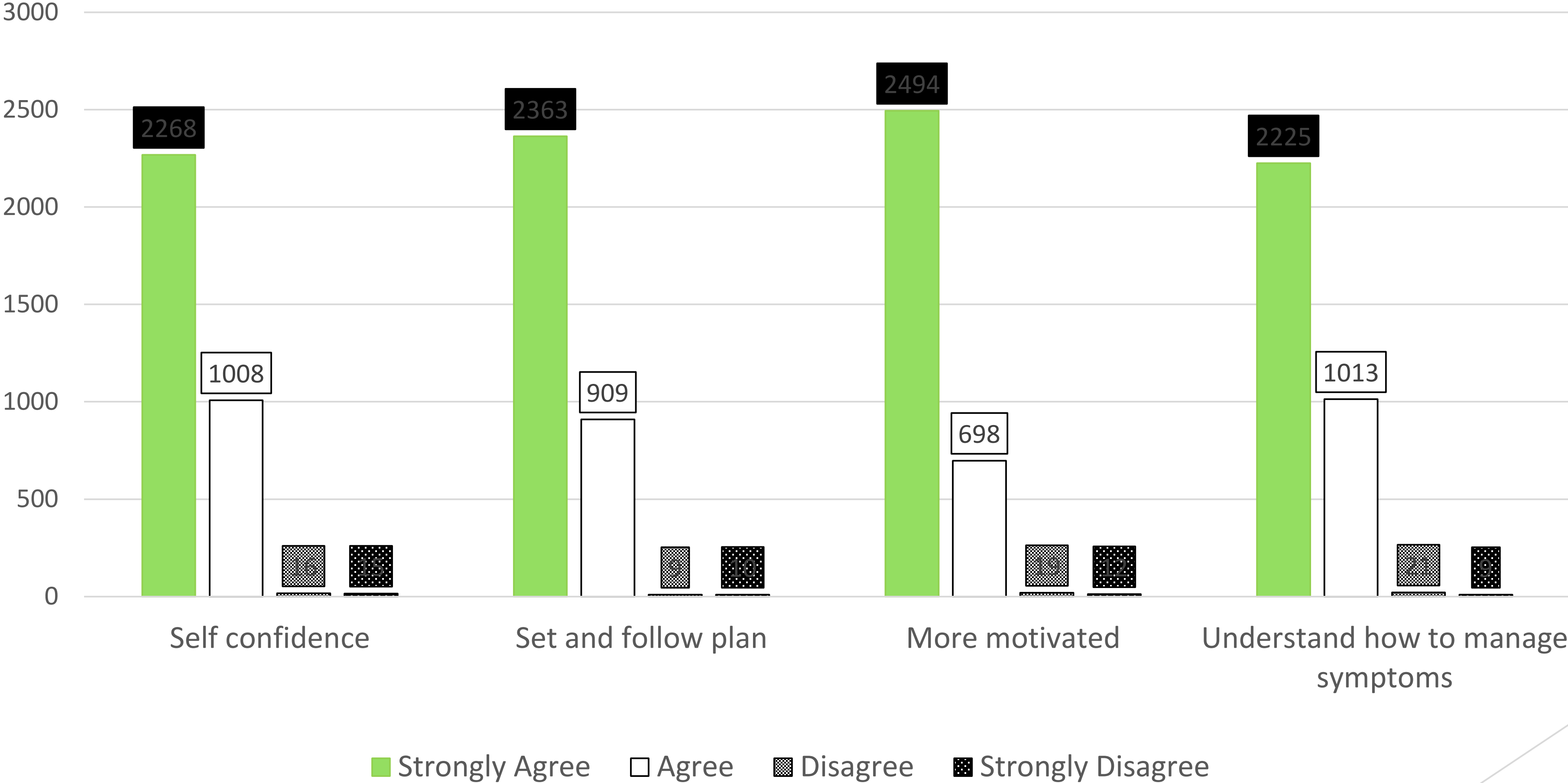
40 Organizations Offering CDSME Workshops at 500+ Locations

MD Living Well Center of Excellence	**MedStar St. Mary's Hospital**	St. Mary's County AAA
Prince George's County AAA	MCVET	Carroll County AAA
Anne Arundel County AAA	Charles County Department of Health	Meritus Medical Center
Howard County AAA	Keswick Community Health	MedStar Montgomery Medical Center
UM Upper Chesapeake Health	Calvert Memorial Hospital	Charles County Dept of Community Services
MedStar Washington Hospital Center	UM St. Joseph Medical Center	MedStar Franklin Square Medical Center
Frederick Regional Health System	Baltimore County AAA	UM Upper Chesapeake Hospital
Cecil County AAA	Medstar Good Samaritan Hospital	Allegany County Health Department
Calvert County Health Department	UM Charles Regional Medical Center	Holy Cross Health
Washington County AAA	Allegany County AAA	Anne Arundel Medical Center
Baltimore City AAA	Garrett County AAA	Howard County Health Department
University of Maryland Medical System	Medstar Harbor Hospital	Cecil County Health Department
Holy Cross Health	Howard County General Hospital	MedStar Southern Maryland Hospital Center
Hopkins Bayview		

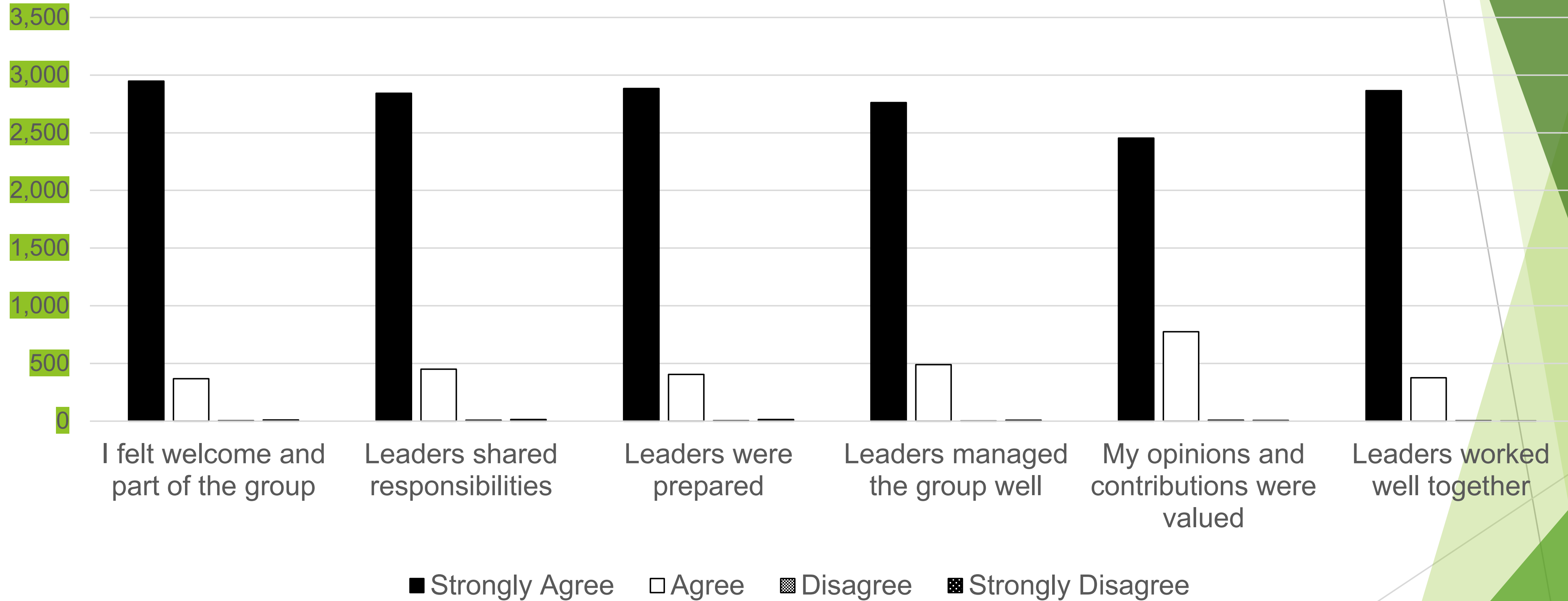
22 Organizations Offering Stepping On and/or EnhanceFitness

MAC Inc	Frederick County Senior Services Division
Washington County Health Department	University of Maryland Medical System
Baltimore County AAA	Johns Hopkins Bayview
Baltimore City AAA	Allegany County AAA
Anne Arundel County AAA	Cecil County AAA
UM St. Joseph Medical Center	Meritus Medical Center
Montgomery Co Dept of Health & Human Svc	Cecil County Health Department
Howard County AAA	Holy Cross Health
Keswick Community Health	UM St. Joseph Medical Center
UM Upper Chesapeake Health	Washington County Health Department
Washington County AAA	Prince George’s County AAA

Participant Activation and Self-Management Scores



Quality Assurance Measures



Impact and Healthcare Cost Savings of SDoH Services/EBPs: Early data results of patient panel submissions for CDSME 12 months pre/post; Falls 6 months pre/post for 1 hospital

Chronic Disease Self-Management Programs

Patients with Pre visit	Patients with Post visit	Pre %	Post %	% of Change
52	44	71.2	60.3	-11.0
At least 1 visit Pre-/Post	**Total Charges Pre**	**Total Charges Post %**	**Average Charge Post %**	**Ave $ reduction per patient**
55	$435,834	$227,423	$5,169	-$3,212

Falls Prevention Programs

Patients with Pre visit	Patients with Post visit	Pre %	Post %	% of Change
17	16	3.1%	0	-3.1%
At least 1 visit Pre-/Post	Total Charges Pre	Total Charges Post %	Average Charge Post %	Ave $ reduction per patient
19	$208,480	$64,185	$4,012	-$8,251

Contact Information

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- Sue Lachenmayr, State Program Coordinator
  Phone: 908-797-5650 E-mail: bslach@earthlink.net

Maryland's Health Information Exchange

7160 Columbia Gateway Drive, Suite 100
Columbia, MD 21046
877.952.7477 | info@crisphealth.org
www.crisphealth.org

About CRISP

Regional Health Information Exchange (HIE) serving Maryland, West Virginia, and the District of Columbia, and the State-Designated HIE in Maryland

Vision: To advance health and wellness by deploying health information technology solutions adopted through cooperation and collaboration

Guiding Principles

1. Begin with a manageable scope and remain incremental.
2. Create opportunities to cooperate even while participating healthcare organizations still compete in other ways.
3. Affirm that competition and market-mechanisms spur innovation and improvement.
4. Promote and enable consumers' control over their own health information.
5. Use best practices and standards.
6. Serve our region's entire healthcare community.

Maryland's Total Cost of Care Model

- In July 2019, Maryland and CMMI entered into a new initiative to improve quality and reduce the growth in health care spending
  - Modernized the 40-year-old Medicare Waiver by allowing policies and programs aimed at care redesign
  - Hospital global budgets set under an all-payer model are aligned with non-hospital settings and geographic populations
- Hospitals, physicians, and policymakers chose to invest in shared technology infrastructure
  - Existing state-designated Health Information Exchange leveraged and expanded upon
  - Shared tools, resources, and data encourage industry-led innovation and better care coordination

CRISP Services

1. **POINT OF CARE: Clinical Query Portal & In-context Information**
   - Search for your patients' prior hospital records (e.g. labs, radiology reports, etc.)
   - Monitor the prescribing and dispensing of PDMP drugs
   - Determine other members of your patient's care team
   - Be alerted to important conditions or treatment information

2. **CARE COORDINATION: Encounter Notification Service (ENS)**
   - Be notified when your patient is hospitalized in any regional hospital
   - Receive special notification about ED visits that are potential readmissions
   - Know when your MCO member is in the ED

3. **POPULATION HEALTH: CRISP Reporting Services (CRS)**
   - Use Case Mix data and Medicare claims data to:
     - Identify patients who could benefit from services
     - Measure performance of initiatives for QI and program reporting
     - Coordinate with peers on behalf of patients who see multiple providers

4. **PUBLIC HEALTH SUPPORT:**
   - Deploying services in partnership with Maryland Department of Health
   - Pursuing projects with the District of Columbia Department of Health Care Finance
   - Supporting West Virginia priorities through the WVHIN

5. **PROGRAM ADMINISTRATION:**
   - Making policy discussions more transparent and informed
   - Supporting Care Redesign Programs

Service	Typical Week
Positive InContext Requests	525,000
Data Delivered into EMRs	1,400,000
Patients Searched in Portal	62,000
Patients Searched from EMR	65,000
ENS Messages Sent	760,000
Clinical Documents Processed	350,000
Portal Users	40,000
Live ENS Practices	1,400
Reports Accessed	500
Report Users	600

Point of Care: Unified Landing Page & Snapshot

All CRISP applications in a single, secure site with one username and password

- Snapshot: View of critical patient data including care alerts, care teams, and prior visits with customizable widgets
- PDMP (authorized users only per State mandate)
- Health Records: Labs, radiology, images, and other clinical documents

CRISP Unified Landing Page™

HOME | PDMP | QUERY PORTAL WIDGET | QUERY PORTAL | PATIENT SNAPSHOT | PROMPT | PANEL MANAGEMENT APPLICATION

FAQ | HELP | CRAIG BEHM (SIGN OUT)

New Search > Modify Search

Patient Snapshot

Patient Name: GILBERT GRAPE Gender: Male Date of Birth: 01-01-1984

Profile Sections

Collapse/Expand All

Patient Demographics

	GILBERT GRAPE		4145 EARL C ADKINS DR. RIVER, WV 26000
Gender	Male	D.O.B.	01-01-1984
	(111)-222-3334		

Clinical Documents

Date	Description	Source
09/04/2018	Summary of Care	Meritus
08/28/2018	Summary of Care	Meritus
08/28/2018	Summary of Care	Meritus
08/28/2018	Summary of Care	Meritus
08/20/2018	Summary of Care	Meritus
08/20/2018	Summary of Care	Meritus
08/20/2018	Summary of Care	Meritus
08/20/2018	Summary of Care	Meritus

Care Alerts

Date	Source	Description

Encounters From ADT

Emergency | Inpatient | Outpatient

May | Jun | Jul | Aug | Sep | Oct

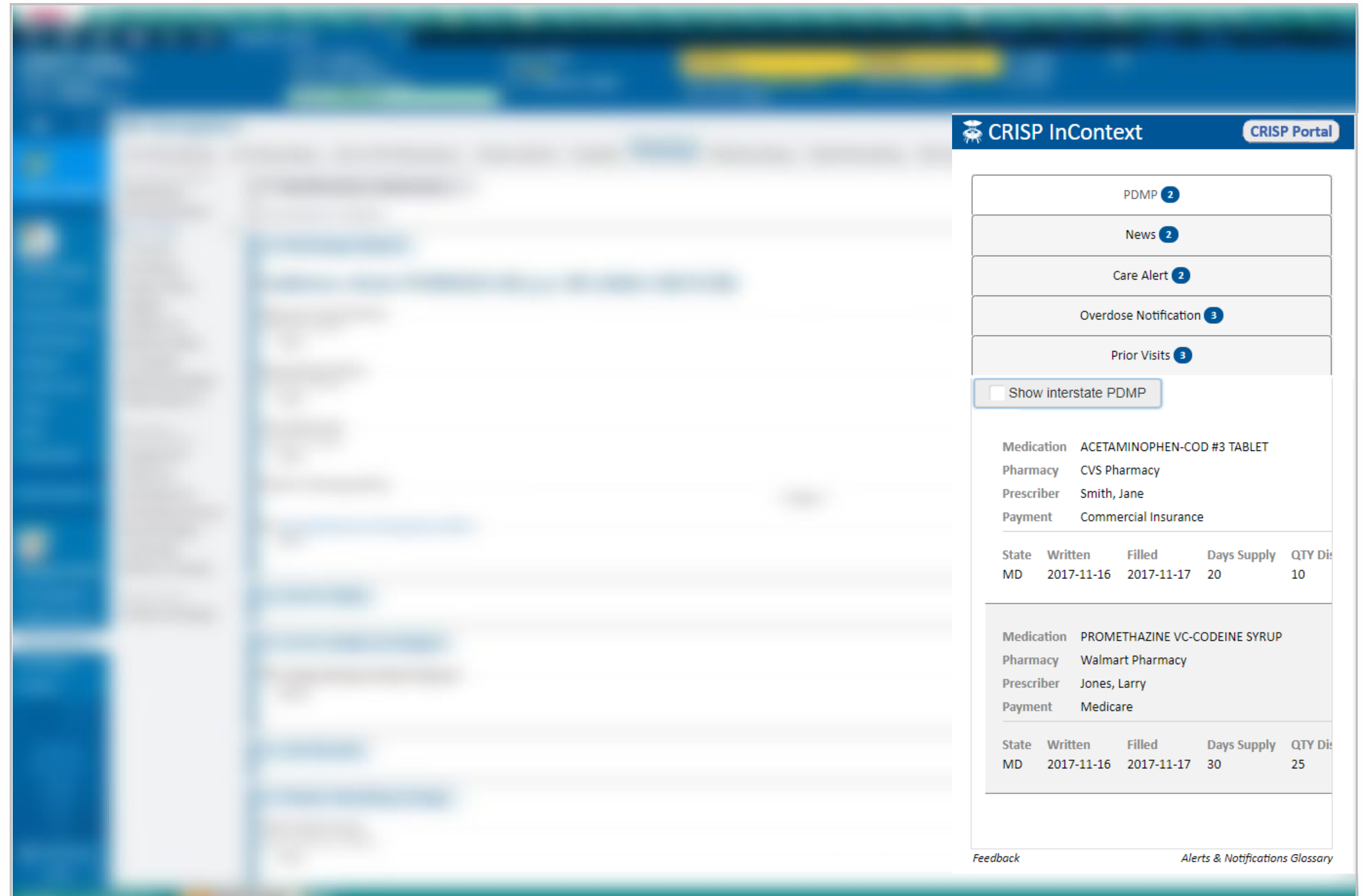
2018

1y | 6m | 3m | 1m | 7d | 04/08/2018 to 10/08/2018 | Apply | Clear

Event Source Name	Event Type	Date
Meritus Medical Center	Outpatient Registration	08/20/2018
Test - Solarwinds	Outpatient Appointment check-in	08/15/2018

Point of Care: InContext Data Delivery

- View of critical patient data, pulled from multiple repositories and embedded in the end user's EHR
- Integrations can occur in EHR native app stores or through API queries
- CRISP delivers nearly **1.5M** pieces of data per week through this method (and rising)



Care Coordination: ENS ProMPT

- Real-time or batch alerts to appropriate providers based on treatment and care management relationships
- User interface within CRISP secure portal or messages delivered into Direct or EHRs

ENS Encounter Notification Service® | PROMPT *Proactive Management of Patient Transitions*

cbehm

Filter by Name or MRN | CHF Program | Add Filters

7/23/16 6:29 AM
ER Registration
YEX30388Stomach Pain YOV29902LOW B/P

DEBORAH REILLY (018687697)
Mount Sinai Hospital
7/22/16 7:23 AM
IP Transfer
HIL6Stomach Pain FES27982LOW B/P

IRENE KEMP (948752605)
Toronto General Hospital
7/22/16 1:43 AM
ER
KEM1Stomach Pain XOJ082LT LEG PAIN/FOOTBALL

JODIE LUTZ (423091650)
Toronto General Hospital
7/21/16 6:14 AM
IP Transfer
NAR92636HEAD INJ PEJ4325LOW B/P

MARTY QUINN (406996551)
Toronto General Hospital
7/20/16 1:22 PM
IP Discharge
PAP5Stomach Pain NIB19LT LEG PAIN/FOOTBALL

DARRICK ALVAREZ (321311855)

MARTY QUINN (406996551)

003-331-7142

DOB: 1/28/68
Address: 904 South White Fabien Boulevard
City/State: Glendale, WV
Race: White
Ethnicity: Not Hispanic or Latino

PCP: Xavier Newman
NPI: 1939129716
ACO: CHF Program

Most Recent Event
Event Date: 7/20/16 1:22 PM
Event Type: IP Discharge
Event Location: Toronto General Hospital
Practice Location: Chevy Chase
Hospital Service: Diagnosis
Patient Diagnosis: NIB19 LT LEG PAIN/FOOTBALL
Discharge Disposition: Discharged/transferred to an intermediate care facility ICF
Discharge to Location: Hospital
Patient Complaint: PAP5 Stomach Pain
Admit Source: Transfer from a hospital

Status Log

Event History

	Date	Details	Location	Type	Event
+	5/29/16 9:50 PM	Diagnosis: DUB348LOW B/P Complaint: BAPHEAD INJ	Toronto Western Hospital	ER	Discharge
+	5/20/16 5:01 AM	Diagnosis: BEG19170LOW B/P Complaint: TAH2793Stomach Pain	Shouldice Hospital	ER	Registration

Community Information Exchange

- Goal: To leverage existing technology to enable health care practitioners to connect with resources in the community
- Start by providing tools to fill gaps in the following overarching workflow:
  1. Identify appropriate interventions
  2. Select existing service providers
  3. Refer patient to selected resource
  4. Confirm patient enrollment
  5. Report on process and outcome measures

Program Referral Pilot

CRISP Unified Landing Page™ | HOME | PDMP | HEALTH RECORDS | PATIENT CARE SNAPSHOT | eREFERRAL | FAQ | HELP | PILOT USER (SIGN OUT)

CRISP Program Referral

Patient Information

* First Name	Middle Name	* Last Name
Luna	L	LoveGood (2)

* Date of Birth (Format MM/DD/YYYY): 02/13/1981

* Home Address 1	* Phone Number	* Type
4 Privet Drive	410-934-1234	Mobile

Home Address 2	Alternate Phone Number	Type
Cupboard Under Stairs	443-934-1234	Mobile

* City	* State	* Zip	Email
Little Whinging	Surrey	934934	luna.lovegood@dumbledoresarmy.cc

Program Information

(1) Referral Program: Total Wellness Healthcare
- Total Wellness Healthcare
- MedStar St. Mary's Hospital
- Calvert Internal Cardiology

(3) Please enter all relevant information that you would like relayed to the accepting provider below:

Example: Luke Skywalker is a 44 y.o. male who presented to ABC Family Practice and qualifies for enrollment into a DPP. Per most recent encounter on 4/1/19, BMI is 32, HbA1c level is 6.2. No previous diagnosis of DM1 or DM2. Counseled patient on lifestyle changes including healthy eating habits and fitness regimens.

lease keep a copy of this referral for your records.

(5) Submit | Clear | (4) Patient Consent ? Please council and gain patient consent before submission.

1. Referral Programs
2. Validate Patient
3. Supply Note
4. Patient Consent
5. Submit

Contact and Resources

Training materials, recorded webinars, and patient education flyers can be found at:
https://crisphealth.org/resources/

A full user guide is available at:
https://userguide.crisphealth.org

Craig Behm, Executive Director, CRISP Maryland
Office: 410.872.0823
Cell: 410.207.7192
Email: craig.behm@crisphealth.org

Questions for you

- Does your state unit currently collaborate with a Health Information Exchange to share data?
  - If yes, please share what you are doing
  - If no, please share barriers/challenges you've had in making the connection
- As the state unit, what do you see as the barriers to helping the aging network transition to outcomes-based reporting?
- Is your state unit considering making changes to IT systems to enable AAAs to better document services and programs that could be embedded into Medicare reimbursement?
- As a state unit, are you working with your network to coordinate standardization of assessing/reporting SDoH (HCBS or LTSS) services so outcomes/impact can be measured?
- Does your state currently or are you considering funding or other support to increase CBO/grantee capacity for data sharing, including and especially for the development of CBO-focused IT infrastructure?

ALTARUM

SOLUTIONS TO ADVANCE HEALTH

Building IT Capacity for Home and Community Based Services (HCBS): Developing Successful Partnerships with Health Care Entities

Anne Montgomery, Deputy Director, Program to Improve Eldercare, Altarum

Health IT Capacity in HCBS

Challenge

Scant attention and little federal funding for IT has been directed to community-based providers (AAAs, CBOs) providing HCBS services

2009 HITECH federal program that led to widespread adoption of electronic health records did not initially benefit HCBS

Solution

February 2016 State Medicaid Director (SMD) letter begins to address gap by announcing need to link community-based systems to EHRs

Partnership with providers encouraged to meet Meaningful Use (MU) objectives

Medicaid HCBS & Health IT Capacity

"One of the lessons learned from the MU EHR Incentive Payment Program is that just adopting EHRs via health IT incentives does not ensure interoperability. There are in fact many foundational components that need to accompany EHR adoption to develop out a **fully functioning health IT ecosystem** to accomplish the Medicaid program objectives. This includes **non-EHR considerations** such as robust identity management capabilities, provider directories which include **all HCBS providers**, and data analytics platforms functioning in real time using e-specified measures for the basis of quality and payment."

Excerpted from ONC HCBS Toolkit:
https://www.healthit.gov/sites/default/files/5_HCBS_Health_IT_Toolkit_V1.pdf

CBOs Need Upgraded IT to Work with Medicaid, Medicare, HCOs Serving These Enrollees and Commercial Populations

Creating Data-Sharing Relationships for Care Transitions, Care Coordination, Supportive Services

Hospitals

Medical Providers

Clinic

Health Plans

Area Agency on Aging Case Management

Fall Prevention

Food

Transportation

Medication Reconciliation

Home Modifications

Caregiver Support

State Medicaid Director letters & IT Funding

Medicaid Management Information Systems (MMIS) matching funds

Federal / State Match
Develop – 90% / 10%
Support – 75% / 25%

SMD 10-016

Availability of HITECH to Connect with Other Medicaid Providers

Use APD process for 90% / 10% match through 2021

SMD 16-003

State Medicaid Director Letters & IT Funding

Leveraging Medicaid Technology to Address Opioid Crisis

- Care Coordination
- Case Management
- Telehealth

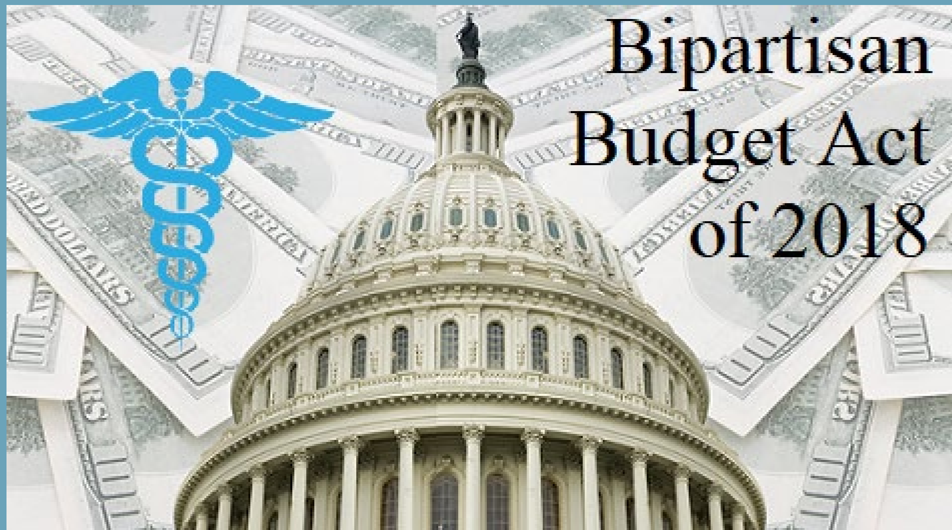
SMD 18-006

Delivery Systems for Adults with Mental Illness or Children with Emotional Disturbance

Wide range of waivers for federal IT funding

SMD 18-011

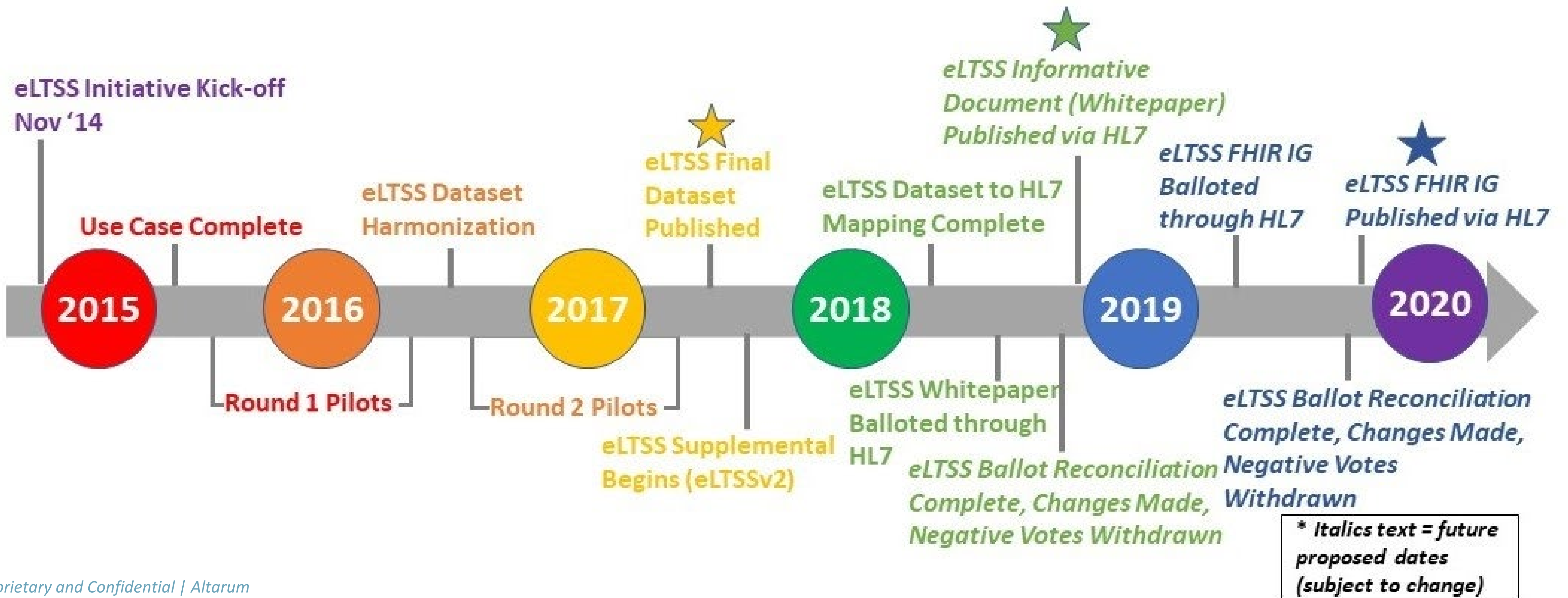
Medicare Advantage Plans Now Experimenting with Offering Limited LTSS



- Expanded supplemental benefit flexibility for MA plans takes effect in 2020
- Bipartisan Budget Act of 2018 authorizes supplemental optional benefits to improve, maintain health of chronically ill beneficiaries, which do not have to be "primary health related"
- **AAAs/CBOs can ramp up efforts with Medicaid agencies for HCBS "use cases" that can be funded through APD process. Can also discuss with MA plans how to make IT investments that improve their ability to offer limited LTSS**

LTSS Funding & Proposed Interoperability Rule (CMS-9115)

- eLTSS language may open up new federal funding opportunities for development and promotion of IT that is designed for sharing LTSS information



Altarum’s APD Projects

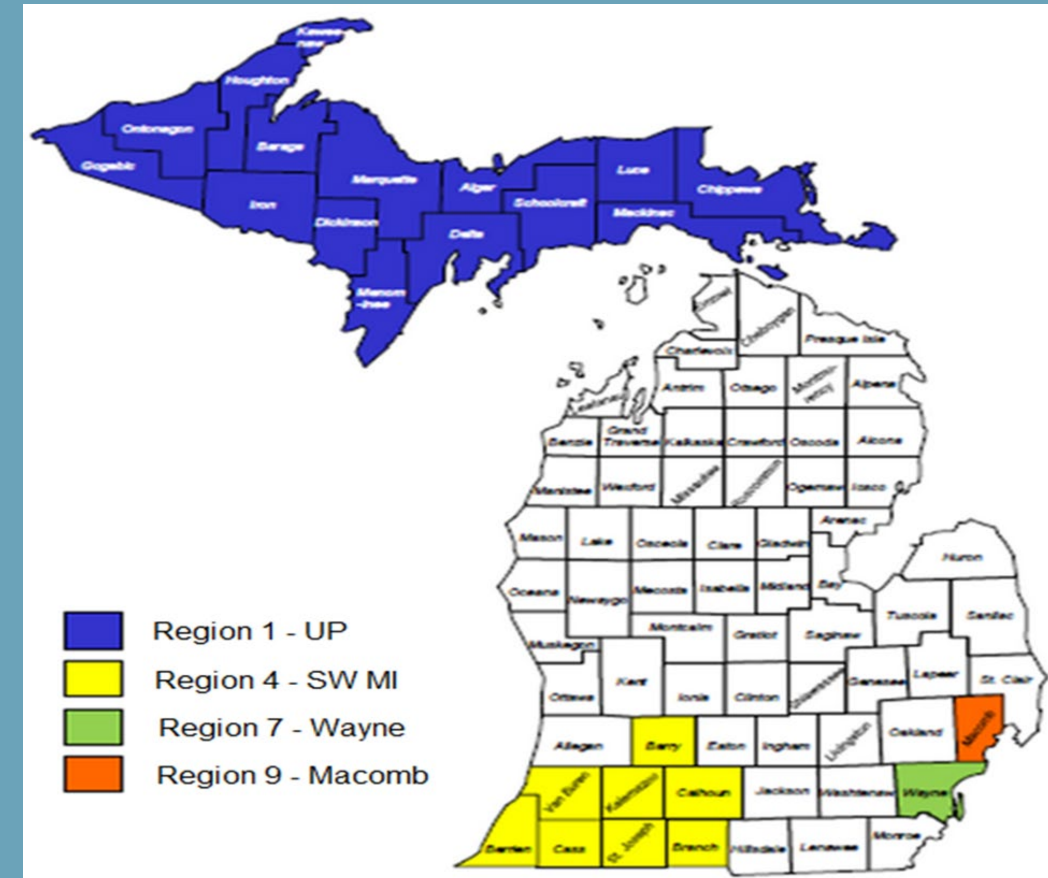
PROJECT NAME
Michigan Center for Effective IT Adoption (M-CEITA)
Michigan Center for Effective IT Adoption (M-CEITA) Long-Term and Post-Acute Care (LTPAC) Technical Assistance
Michigan Disease Surveillance System (MDSS)
Michigan Syndromic Surveillance System (MSSS)
Michigan Cancer Surveillance Program
Michigan Birth Defects Surveillance Program
Michigan Vital Records Program
Newborn Screening (NBS) Critical Congenital Heart Disease (CCHD)
Newborn Screening (NBS) Blood Spot
Newborn Screening (NBS) Early Hearing Detection and Interventions (EHDI)
Blood Lead Test Results and Workflow Analysis
MI Health Link Integrated Care Bridge Record (ICBR) Project
Michigan’s Dental Registry (MiDR^{SM})

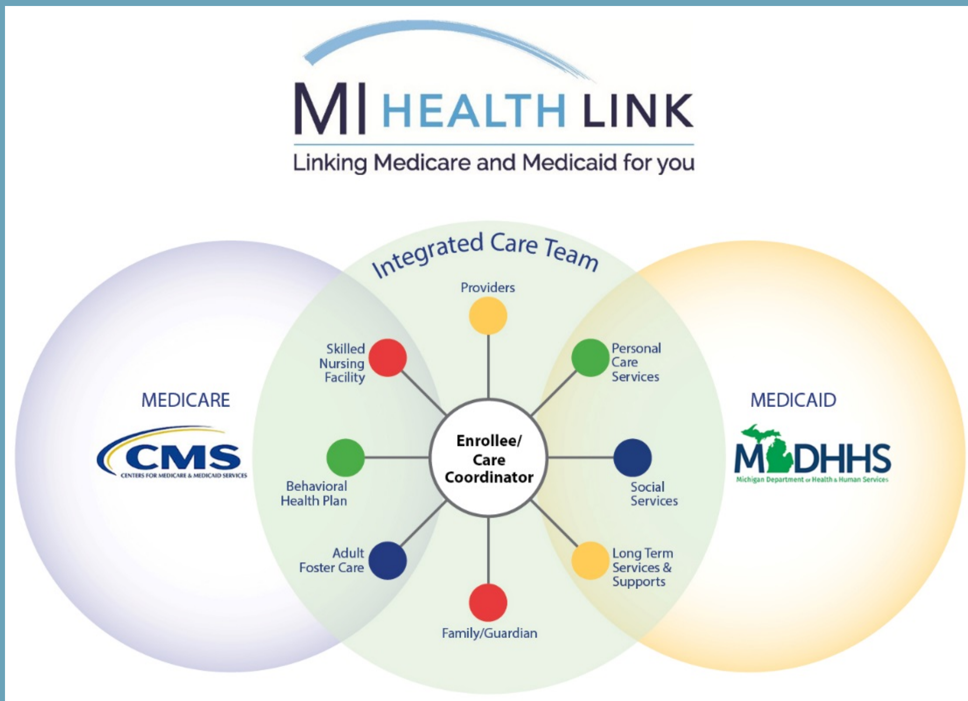
MHL Demonstration Overview

- MI Health Link is a health care option for Michigan adults, ages 21 or over, who are enrolled in both Medicare and Medicaid, and live in one of **four demonstration regions** of Michigan.

- MI Health Link offers a broad range of medical and behavioral health services, pharmacy, home and community-based services, and nursing home care, all in a single program designed to meet individual needs.

- The MHL Demonstration kicked off March 1, 2015 and extends through December 31, 2020.





MI Health Link Care Plan

- C-CDA Specification – Care plan elements translated into HL7 standardized format to promote content sharing across payers and providers
- Care Plan Viewer – User friendly version of the Care Plan
- Care Plan C-CDA Validator – Ensures data quality when exchanging data across organizations

C-CDA: Consolidated-Clinical Document Architecture
HL7: Health Level 7 (international health standards organization)

Care Plan Viewer

- Provides a human readable view of the C-CDA data
- Ability to generate and print a customized view of the standardized Care Plan
- Ability to leverage the standardized C-CDA for reporting to MDHHS/CMS electronically
- Standardized Data & View for everyone
- User Customizable View
- Consolidated Data
- Attached Documents may be viewed from a consolidated location (e.g. PDF, WORD, …)
- Work group consensus on the content and organization of the style sheet

Care Plan Viewer – Human Readable

Integrated Care Bridge Report

Member	Eve Betterhalf	D.O.B	May 1, 1975	Sex	♀ Female	ICO Referral Number	refnum1234	Document Intent Indicator	Care Plan	PIHP L2A Record Number	PLRN5678

Member Details

- Allergies
- Integrated Conditions Concerns Problems
- Integrated Care Team
- Signatures
- Initial Screening
- Most Recent Claims
- Likes and Interests
- Residential or Non Residential Setting Preferences
- Supports and Services
- Waiver Services
- Assessments and Reassessments
- Goals
- Concerns Goals Interventions
- Level I Assessment
- Level II Assessment
- NFLOCD
- Social History
- Medications
- Health Status Summary
- Personal Preferences
- Attached Documents
- Personal Care Services
- Personal Care Assessment
- Risk Factors
- Interventions

Table of Contents

- Collapse/Expand all
- Show all
- Restore Layout
- Print Layout

Questions

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Anne Montgomery, Deputy Director, Program to Improve Eldercare, Altarum