Overview of Connected Communities

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MASSACHUSETTS eHEALTH INSTITUTE
at the MassTech Collaborative

MeHI Connected Communities

Goals

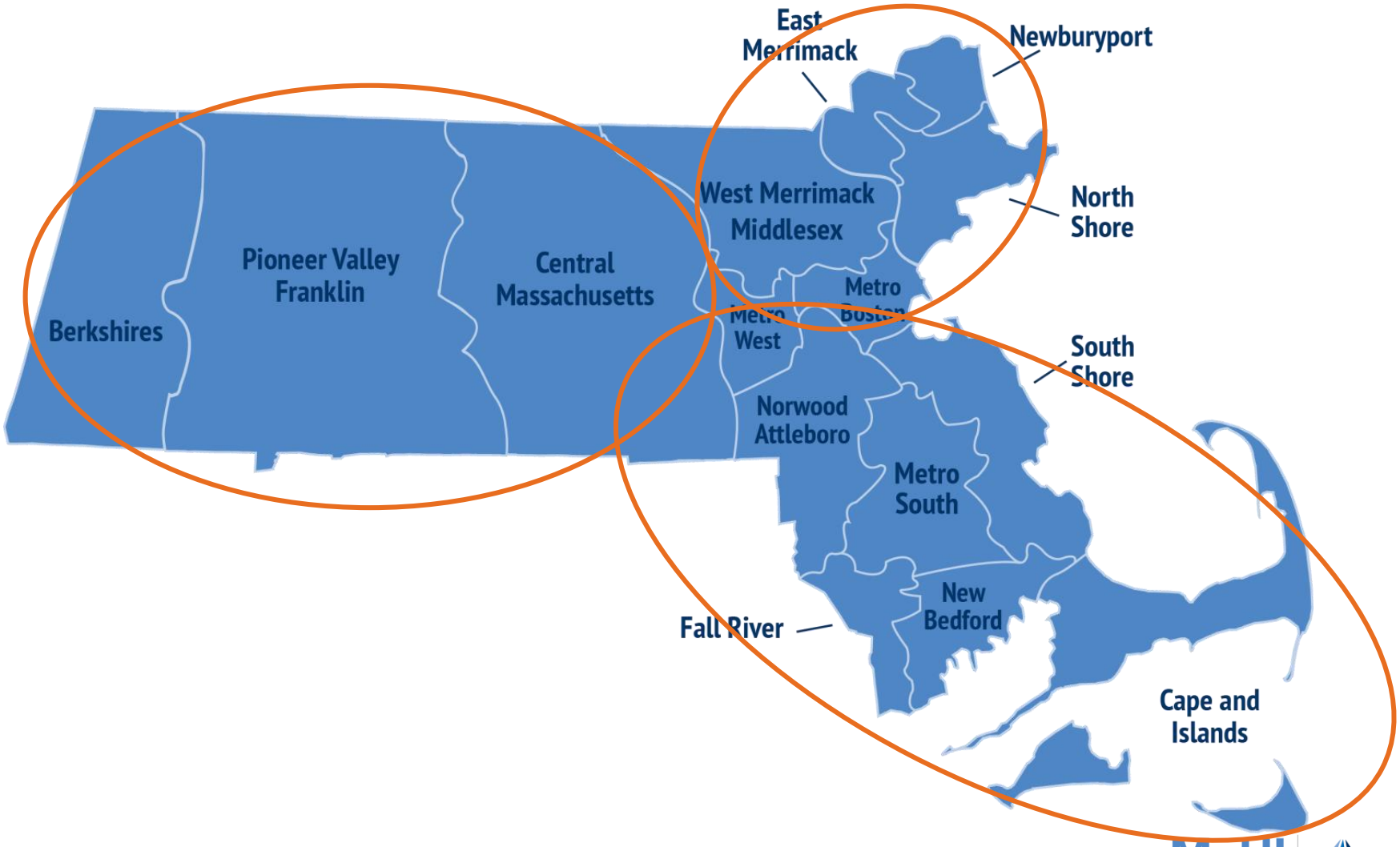
- Catalyze collaboration **among all healthcare sectors** and
- Advance the adoption and use of technologies to improve healthcare and reduce healthcare costs

Approach

- **Organize** for growth & impact by aligning our eHealth Communities to the Health Policy Commission's (15) Secondary Service Markets, then regionalizing into (3) regions
- **Engage** stakeholders by community and sector in a statewide needs assessment
  - Statewide eHealth Plan
  - Specific Community Needs Assessments and the initiatives that will address the needs identified
- **Strengthen** the foundation for exchanging health information through the Connected Communities Implementation Grants
- eHealth Community Managers assigned by region will foster a collaborative environment

Our Communities

Aligned to Health Policy Commission | Secondary Service Markets (SSM)



Connected Communities

- **Conducted healthcare stakeholder interviews**
  - Interviewed 107 organizations including 86 patient treatment organizations representing key healthcare sectors and an additional 21 interviews with state agencies, health insurance organizations and associations.
- **Facilitated community round-table sessions**
  - Facilitated 19 community round-table sessions to refine interview responses and establish top internal issues, external barriers and clinical/business needs or **'eHealth priority areas'** related to HIT for the community, region and state.
- **Completed Community eHealth Needs Assessments**
  - Completed detailed HIT needs assessments for 13 of 15 communities. (Fall River combined with New Bedford, and Norwood/Attleboro combined with Metro West).
  - Community Needs Assessments for Northeast Region
  - Community Needs Assessments for Southeast Region
  - Community Needs Assessments for Central & Western MA

MA Stakeholders Identified High Priority eHealth Areas

Stakeholders participating in the Connected Communities program cited the following priority needs:

- Access to Clinical Data
- Exchange Discharge Summaries
- Health Information Exchange Adoption
- Implement Closed-loop Referrals
- Event Notifications
- Exchange Medication Lists
- Meet Regulatory Requirements
- Identify Care Teams

Source: MeHI Connected Communities Program, analysis of stakeholder interviews

MA Stakeholders Identified Barriers and Challenges

Stakeholders cited the following priority external barriers:

- Immature EHR Vendor to EHR Vendor Standards and Exchange Capabilities
- Navigation of Consent and Information Disclosure Laws
- Not Knowing Which Trading Partners can Send and Receive
- Trading Partners Not on Mass HIway
- Lack of Common Data Sets
- Patient Matching
- Identification of Care Teams

Stakeholders cited the following priority internal challenges:

- High Costs of HIT and Interfaces
- Shortage of Technical Expertise
- Lack of Understanding of HIE Capabilities and Value among Leadership and Clinicians

Source: MeHI Connected Communities Program, analysis of stakeholder interviews

Connected Communities Implementation Grant

- **Launched the Connected Community Implementation Grant Program**
  - Designed to support organizations in demonstrating community collaboration using HIT to address a real-world, practical, measurable healthcare need. Projects were required to include **behavioral health** and/or **long term and post-acute care organizations**.
  - **Aimed at the priorities identified in the community needs assessments** with a focus on improving two aspects of care coordination; **care transitions** and **cross-setting care management**
- Selected 9 applicants out of 24 pre-applications (Application period is closed)
- Applicant projects currently include approximately 100 collaborating organizations
- Award Notice- End of year

Connected Communities Grant Projects

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USE CASE

Medication Reconciliation after Patient Discharge from Hospital to Skilled Nursing Facility

ORGANIZATIONS

Hospital and Skilled Nursing Facility (SNF)

GOAL

Reconcile medications to improve coordination of patient's care, improve patient safety and avoid adverse drug reactions.

TRADING PARTNERS AND SYSTEMS

Hospital- EHR with access to HIE and Clinical Data Repository
Skilled Nursing Facility (SNF)- EHR with access to HIE and Clinical Data Repository

DATA TO EXCHANGE

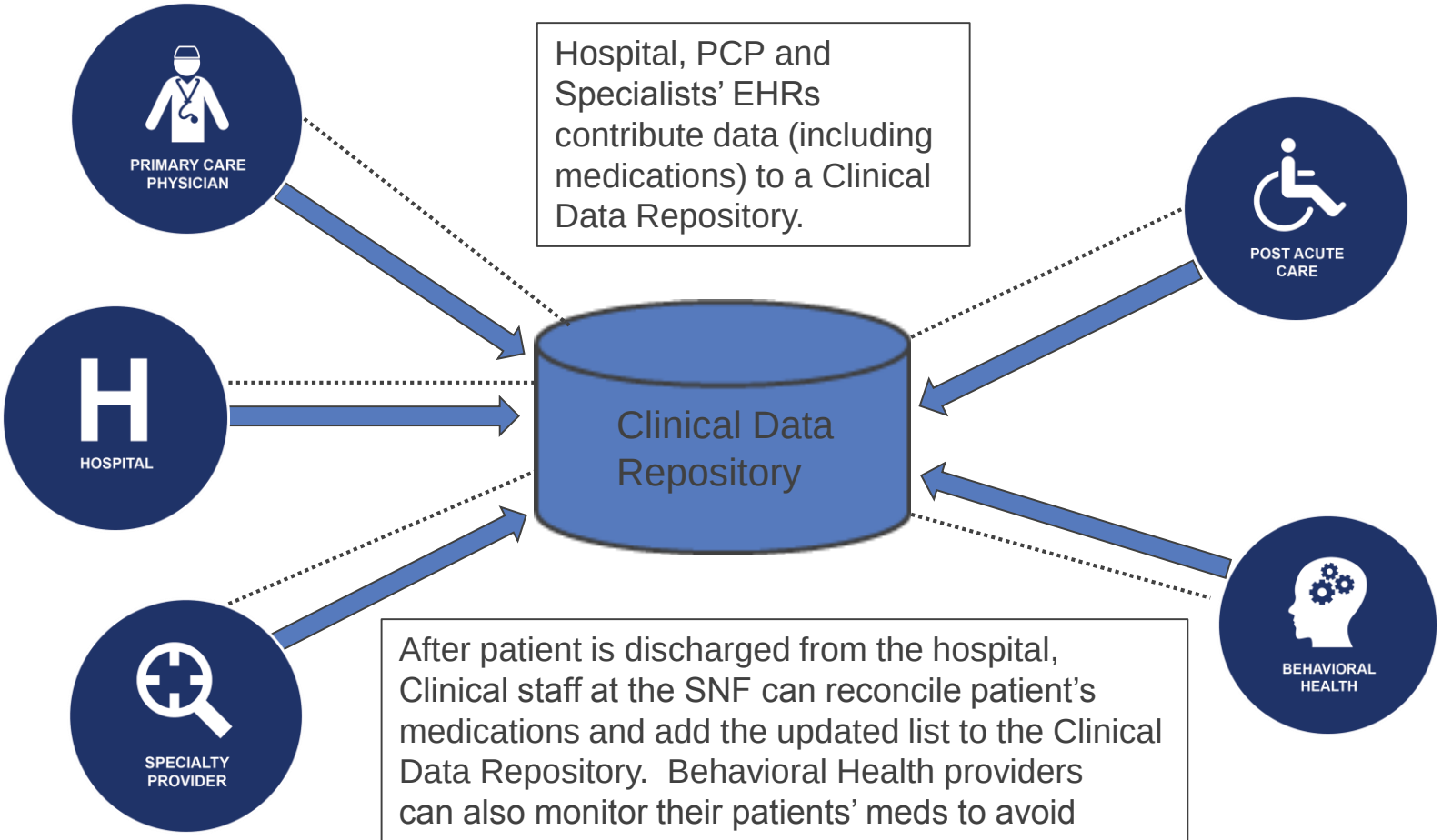
CCD with updated list of medications

STORY

As a patient and hospital-based physician prepare for the patient's discharge from the hospital, the patient opts for transfer to a skilled nursing facility as part of their care plan. The hospital-based physician sends a discharge summary, including an updated medication list to the HIE's clinical data repository.

The patient is admitted to the skilled nursing facility. Upon the written order, and with the patient's consent, clinical staff at the SNF will access the patient's aggregated medication information included in the HIE's clinical data repository (including medications prescribed from the patient's Primary Care Provider, hospital-based physician and Specialist) and reconcile the medication list.

Medication Reconciliation



Providers can view data in repository AND Contribute clinical and social data to the repository.

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USE CASE

Behavioral Health / Medical Integration Closed Loop Referral

ORGANIZATIONS

Hospital and Behavioral Health Organization

GOAL

Facilitate seamless transfer of patient referral and treatment information to improve patient safety, outcomes and overall experience.

TRADING PARTNERS AND SYSTEMS

Hospital- EHR and LAND device to send and receive over MA HIway
Behavioral Health Organization - EHR / HISP to send and receive over MA HIway

DATA TO EXCHANGE

Request for BH screening document
Brief encounter form

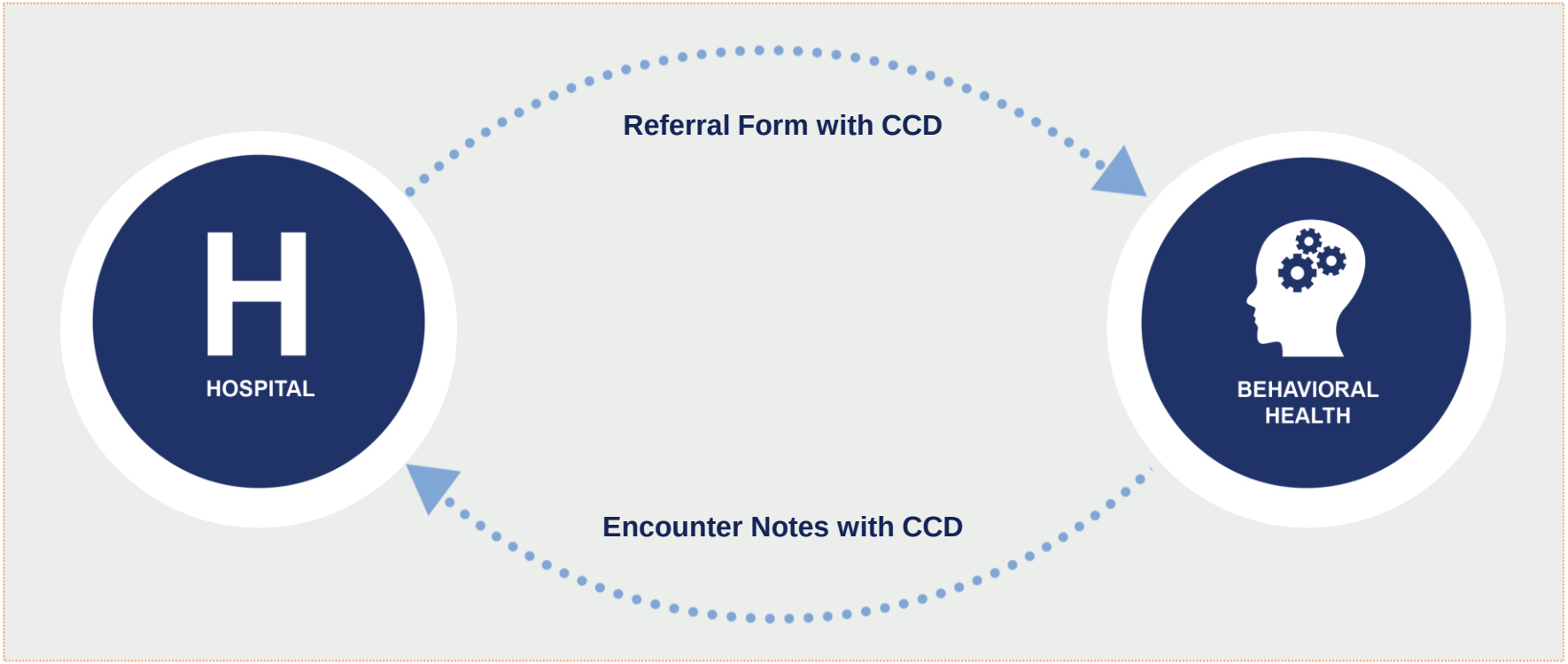
STORY

Hospital physician determines that a patient would benefit from a behavioral health screening from a BH clinician. Physician notifies the Medical Integration team (co-located) of the need for a Brief Encounter screening via text message over a secure messaging system.

Patient consent is acquired and the clinician completes a screening (in BHO's EHR), including a plan for additional services, if necessary. The clinician sends a DIRECT message to hospital's designated DIRECT mail address within one business day; the message includes CCD and electronic version of the Brief Encounter form.

If the plan includes additional BH services to be provided, the hospital creates a DIRECT message including CCD and sends it to the designated BH DIRECT address.

Behavioral Health / Medical Integration Closed Loop Referral



GOAL	Facilitate seamless transfer of patient referral and treatment information.

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USE CASE

Transition and Coordination of Care for Patient with Co-Occurring Acute Medical and Behavioral Health Condition

ORGANIZATIONS

Regional Health Care Organization

GOAL

Prompt, accurate assessment and coordination of care for patient with co-occurring medical and behavioral health condition. Sharing of pertinent information on treatment and medication status, discharge summaries and care plans in order to attain better patient outcomes and reduce costly readmissions.

TRADING PARTNERS AND SYSTEMS

- Hospital ER / Inpatient
- Substance Abuse Treatment Centers
- Community Health Centers

DATA TO EXCHANGE

Standardized Clinical Documentation and data sets in Acute Care Checklist and CCD/Transition of Care Forms

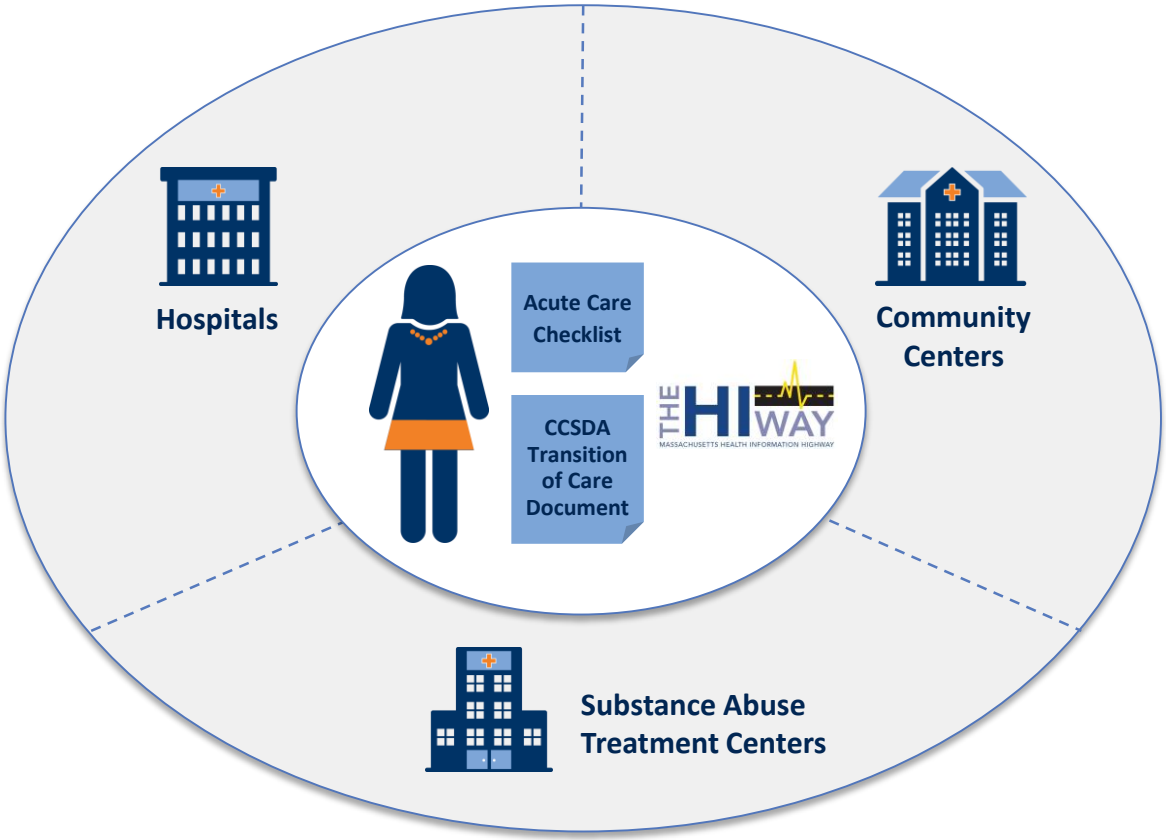
STORY

A homeless woman presents to a neighborhood Community Health Center (CHC) with acute cardiac symptoms as well as evidence of substance use disorder (SUD). She is assessed by a clinician at the CHC and transferred to an acute care hospital emergency room (ER) for treatment. The CHC clinician completes the new standardized Acute Care Checklist form and sends her to the acute care hospital ER via the Mass HIway.

Upon arrival in the ER, the patient's information from the CHC is already in the hands of the ER clinician. The patient is assessed and determined to be medically stable, but in need of treatment for SUD.

The patient requests treatment for her SUD and is discharged to a Substance Abuse Treatment Center. The ER clinician prepares the Standardized Transition of Care Document and sends it to the SUD via the Mass HIway.

Transition and Coordination of Care for Co-Occurring Acute Medical and Behavioral Health Conditions



- Prompt, Accurate Assessment and Coordination
- Sharing of pertinent information between providers via Mass HIway
- Attain better patient outcomes
- Reduce readmissions

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USE CASE

Care Coordination for Substance Abuse Disorder Patients

ORGANIZATIONS

Federally Qualified Community Health Center

GOAL

Better coordination of care for patients with substance use disorder, sharing eReferrals, treatment and medication status, discharge summaries and care plans in order to attain better patient outcomes and reduce costly readmissions.

TRADING PARTNERS AND SYSTEMS

- Hospital
- Substance Abuse Treatment Centers
- Mental Health Facilities

DATA TO EXCHANGE

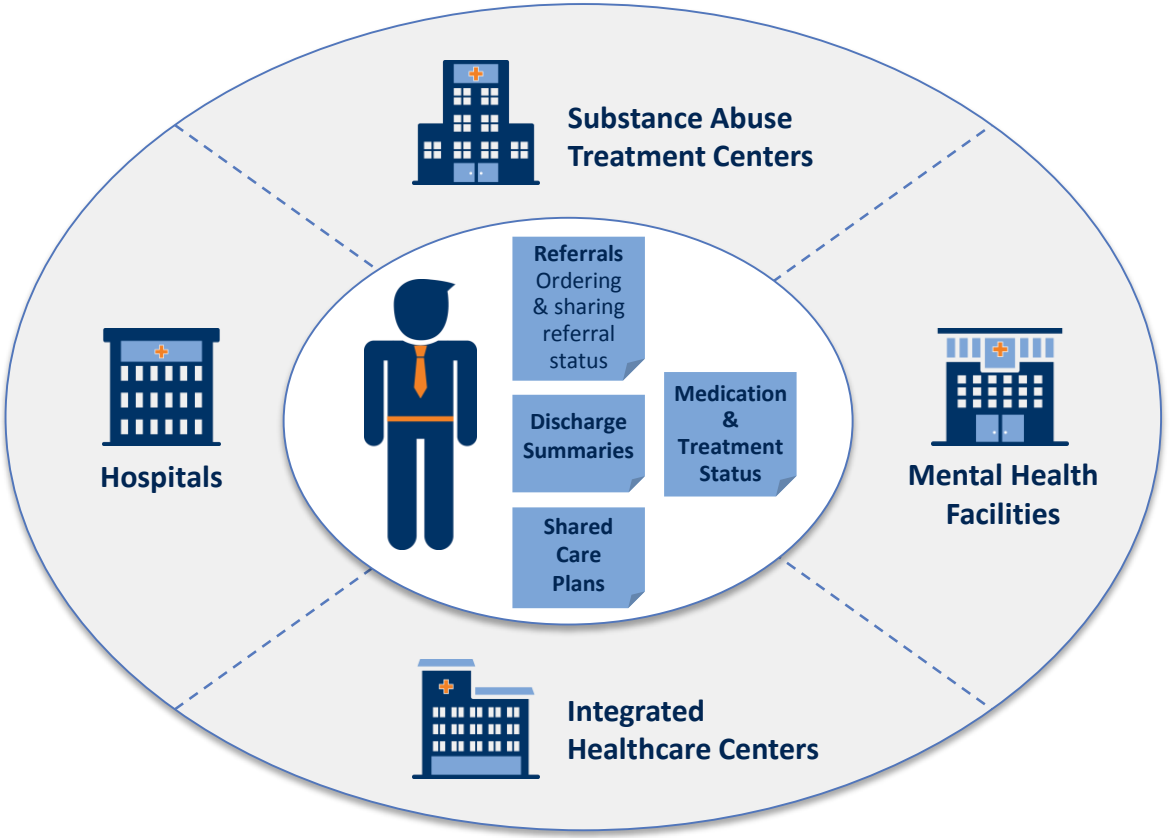
Referrals, medication and treatment status, care plans, discharge summaries, consents

STORY

Joe is struggling with opioid abuse issues and he is facing a healthcare system that is **not well coordinated** between primary care, hospitals and behavioral health providers. Yet, Joe is **a very high risk patient, who is complex to manage.** Joe and others with **SUD are the most frequent patients to visit the ER. Tight coordination between treatment providers is essential** in order for Joe to attain a successful patient outcomes. Care for Joe will be more tightly coordinated across the care continuum which **will prevent relapses and hospital re-admissions**. **Avoiding relapses** is a critical goals since many deaths **due to drug overdoses** occur immediately after relapses.

No matter where the patient presents, trading partners can easily refer the patient to be treated at the most appropriate provider. Patient consents, medication and treatment information will be shared across providers to provide for a tighter, more inclusive care continuum with no gaps.

Substance Abuse Referral & Care Coordination In Response to the Opioid Crises



- Developing workflows at each provider
- Consistent referral and privacy protocols between providers
- Content, data set and formatting standards
- Developing technical infrastructure to support
- Some facilities will be building connections to the MA HIway

Next Steps for the Connected Communities Program

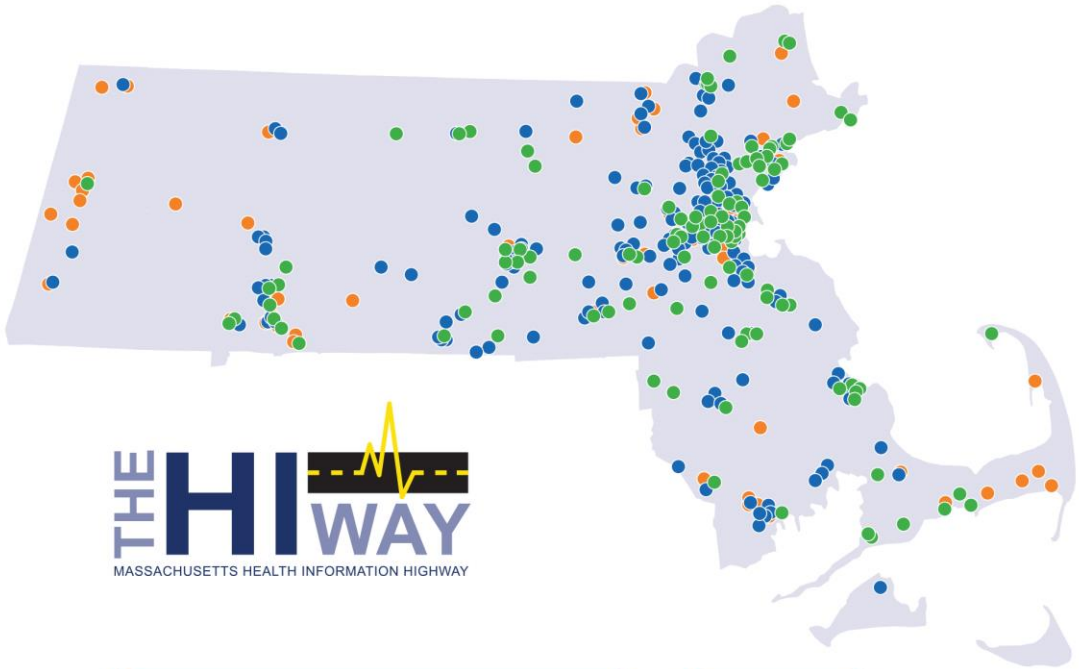
Launch initiatives that will address the priority needs identified through the Community Needs Assessments

- Access to Clinical Data
- Exchange Discharge Summaries
- Health Information Exchange Adoption
- Implement Closed-loop Referrals

Communities Grantees and their collaborators to develop best practices and tools in the areas of…

- Implementing **Patient Consent**
- Implementing **Event Notification Services**
- Increasing **Trading Partner Networks**
- **Standardizing Data Sets** needed for each healthcare sector
- Performing **Medication Reconciliation**

Mass HIway Directory Map



THE HIWAY
MASSACHUSETTS HEALTH INFORMATION HIGHWAY

200 TRANSACTING

333 CONNECTED

83 IN-PROGRESS

Mass HIway Directory

HIway Connection Status

- Transacting
- Connected
- In-Progress

HIway Transactions

27.3M Since Inception

3.2M October 2015

49% Growth Rate in Last Three Months

Updated October 31, 2015

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