



District of Columbia State Innovation Model
 HIE Care Coordination Work Group: Meeting Summary

September 29, 2015
 1:00 p.m. – 2:30 p.m.

Participants present (in person and/or via teleconference): Scott Afzal (CRISP), Chiledum A. Ahaghotu (Howard Univ.), Barbara Bazron (DBH), Richard Bebout (Green Door), Caroline Brozak (Children’s), Sonya Burroughs (Children’s), Matthew Caspari (DBH), Angela Duncan Diop (Unity Health Care), Tippi Hampton (DBH), Dena Hasan (DHCF), Lindsey Hasbrouck Steinberg (DCBHA), Oscar Morgan (DBH), Karen Ostlie (Catholic Charities), Justin Palmer (DCHA), Gina Pistulka (CCIN), Donna Ramos-Johnson (DCPCA), Alison Rein (AcademyHealth), Shelly Ten Napel (DHCF), Michael Tietjen (DHCF), William Ward (Catholic Charities), Arturo Weldon (DOH), Joe Weissfeld (DHCF), Rebecca Wolfson (Community Connections), Constance Yancy (DHCF).

TOPIC	DISCUSSION
<p style="text-align: center;"><u>HCRIA</u> – Definition and Current State of Care Coordination</p>	<ul style="list-style-type: none"> ● Care Coordination defined as participants involved with a patient’s care deliberately sharing information about and organizing a patient’s care activities. <ul style="list-style-type: none"> ➤ Goal is to achieve safer more effective care and improve health outcomes by meeting the individual needs and preferences of the patient. ● Components of care coordination include the following: <ul style="list-style-type: none"> ➤ Established accountability and responsibility through aligned resources; ➤ Interdisciplinary teamwork driven by the patient’s individual needs; ➤ Comprehensive care management (e.g., individual health/risk assessment, proactive care plan, effective medication management, oversight of care transitions, among others); ➤ Use of proper health information technology and exchange ● Key chronic condition prevalence data shows: <ul style="list-style-type: none"> ➤ 64,274 beneficiaries or approximately 25% of all enrollees have 2-4 chronic conditions ➤ 18,148 beneficiaries or approximately 7% of all enrollees have 5 or more chronic conditions ● Key cost data for FY14:

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	<ul style="list-style-type: none"> ➤ Average per person spending: \$10,050 (\$27,378 for FFS and 4,014 for MCO) ➤ Long-term care comprises 32% of the total Medicaid expenditures ➤ Top 1 percentile makes up 27% of total Medicaid spending <ul style="list-style-type: none"> ▪ Average per person spending: \$495,861 for FFS and \$206,125 for MCO ▪ Top 10 chronic conditions – 1) Hypertension, 2) Behavior Problems, 3) Diabetes, 4) Dementia, 5) Paralysis, 6) Cerebrovascular Disease, 7) Chronic Renal Failure, 8) CHF, 9) Hyperlipidemia, and 10) Depression ➤ Top 5 percentile makes up 60% of total Medicaid spending
<p style="text-align: center;"><u>Children’s Integrated Quality Network (CIQN)</u></p>	<ul style="list-style-type: none"> • Primarily a pediatric HIE, assists practices with implementing EHRs and connecting to eEHX for data sharing <ul style="list-style-type: none"> ➤ 55 community practices (28 in MD and 27 in VA); Goldberg Center contributes data from the District ➤ Approximately 1.85 million patients that have “opted-in” with approximately 1 million encounters per year ➤ Current data shared elements include patient demographics, eHS/CD, documents from CNHS, PSV and community practices, lab/radiology results (excluding images), sensitive PHI is blocked (e.g., STD’s, drug/alcohol use, mental health, etc.) • Current State <ul style="list-style-type: none"> ➤ Seamless integration between the Goldberg Center and community practices ➤ Single Sign On from EPIC and Cerner systems • Future goals <ul style="list-style-type: none"> ➤ Enhanced interoperability through Cerner Resonance, which will allow patient and document discovery, data exchange, and data reconciliation from disparate systems ➤ Population health initiatives to improve data-driven decision making, patient outcomes, and (eventually) improved reimbursement; also interested in creating registries (external from EHRs) based on clinical and financial data allowing for risk stratification, quality measurement, scorecard performance, and improved outreach. ➤ Priority registries – patients with medical complexities, sickle cell disease, scoliosis surgical home, and content developed by other partners

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<p><u>Capital Partners in Care</u> – Capitol Clinical Integrated Network (CCIN)</p>	<ul style="list-style-type: none"> • Funded by CMMI, created an Integrated Care Coordination and Care Delivery System to achieve the following goals: <ul style="list-style-type: none"> • improve access and coordination of healthcare within the District <ul style="list-style-type: none"> ➤ Improve access/coordination of healthcare within the District ➤ Improve health of participant population (as measured by HEDIS) ➤ Reduce healthcare costs incurred by selected participant population over a 3 year period • Impacts health care system on multiple levels: <ul style="list-style-type: none"> ➤ Individual/Family – Increase education including role of primary care and medical facilities (e.g., ER vs Urgent Care, etc.), improve self-management of chronic illnesses through better prescription adherence and lifestyle issues ➤ Organizational – Improve clinical workflows to support participants ➤ Community – More efficient communication helping to reduce duplication of high cost medical services • Includes a variety of health IT tools: <ul style="list-style-type: none"> ➤ Health Information Exchange System ➤ Care Coordination System – Tools include health record integration, claims data monitoring and evaluating, and population health management <ul style="list-style-type: none"> ▪ Includes ability to identify and stratify high-risk patient populations based on disease, conditions markers, key cost drivers, among other criterial ▪ Collaboratively develop individualized care plans, monitor compliance and view status of interventions ▪ Analyze and report on quality, performance, outcomes, and cost savings ➤ Tele-health initiatives • Clinical Health Workers function as health system educators, navigators and care connectors for enrolled participants beginning
<p><u>CRISP</u> – Current Tools and Services</p>	<ul style="list-style-type: none"> • Clinical Query Portal: <ul style="list-style-type: none"> ➤ Allows for credentialed users to search HIE for clinical data shared between all 47 acute care hospitals in MD and 6 of 8 hospitals in the District ➤ Types of data available include patient demographics, lab results, radiology reports, Maryland

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	<p>PDMP med data, discharge summaries, history and physicals, and operative or consult notes</p> <ul style="list-style-type: none"> ➤ Single Sign On (SSO) allows CRISP to send the user directly to the patient summary screen housed in the query portal system; 10 hospitals so far have enabled this feature • Encounter Notification Service (ENS): <ul style="list-style-type: none"> ➤ CRISP currently receives Admission Discharge Transfer (ADT) messages in real-time from all Maryland Acute Care Hospitals, all Delaware Hospitals, and 6 of 8 DC Hospitals ➤ Complete Continuity of Care Documents (CCDs) are routed to subscribing providers either in real-time or daily; hospitals can auto-subscribe to be alerted when one of their past discharge patients is being readmitted within 30 days or alert the receiving hospital that patient received had been discharged from another hospital within the past 30 days ➤ Recently enhanced to include ER and IP visits within the past 6 months ➤ Can integrate notifications into EHR via ADT data; in final testing to delivery notifications directly into Epic; all other systems are already in production • In-Context Alerting <ul style="list-style-type: none"> ➤ Range of alert types (pertaining to critical information about a patient) that can be sent to the point of care or to a care manager; data includes identification of care gaps, post-discharge follow-up care missing, etc. • Data Router <ul style="list-style-type: none"> ➤ Supports connectivity, consent management, data routing to other services or data consumers, and organization of patient-provider relationships • Standardized Risk Stratification Tools <ul style="list-style-type: none"> ➤ Supports stratification of patients initially using HSCRC case mix data housed in CRS; predictive score shared through a range of tools, including query portal and ENS. • Patient Total Hospitalization (PaTH) <ul style="list-style-type: none"> ➤ Dashboard that incorporates all patient data providing a visualization of all case mix data with the ability to view individual patient utilization data. ➤ Allows care managers to identify high-risk patients in conjunction with existing or planned coordination programs ➤ Filters enable user to focus on a specific population/sub-population (e.g., dates, charges, etc.)

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<p><u>Howard University</u> – Buprenorphine Integrated Care Delivery Project</p>	<ul style="list-style-type: none"> ● Buprenorphine Integrated Care Delivery Project is a collaboration focused on linking patients (and their families) receiving therapy for chronic opiate addiction with comprehensive healthcare services <ul style="list-style-type: none"> ➤ Utilizes care coordination/patient navigation approach as supported by telehealth services and the use of a common EHR platform ➤ 700 patients targeted ; 48 members enrolled (with care plans in progress) <ul style="list-style-type: none"> ▪ Wellness screenings at community-based practices; behavioral health assessments (BHICA) and provider consultations provided via a telehealth platform ▪ Referral for either high-intensity PCMH OR on-going primary care ▪ Case management teams coordination medical appointments and other support services ● Impact on the District: <ul style="list-style-type: none"> ➤ Deaths due to drug overdose has increased by 55% over the last 10 years ➤ Potential model for creating a medical home for stabilizing opiate-addicted patients ● Foundational Elements of Care Coordination: <ul style="list-style-type: none"> ➤ Identify risks (medical, functional, social, etc.) that may lead to adverse health events ➤ Address risks through patient education, optimization of medical treatment, and integration of fragmented care settings/teams ➤ Monitor patient for programs and potential signs of complications/issues ● Care coordination is a three step process – 1) Assess and Plan, 2) Implement and Deliver, and 3) Re-assess and Adjust