NATIONAL ASSOCIATION OF CHRONIC DISEASE DIRECTORS
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Community e-Connect – Frequently Asked Questions
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How does this work with existing EMRs?
We can integrate Community e-Connect within a variety of EMRs, so yes, it does work with existing EMRs.

Can Community e-Connect be integrated with any EMR?
Yes, with a few exceptions. The experience in MA was with a variety of EMR vendors, some of which were more amenable and responsive to collaboration. EPIC moved particularly slowly, as did eClinicalWorks, and as a result, we caution against working with clinical partners who use them given the timeframe of this effort. Please reach out to NACDD to discuss further via the eligibility survey.

Do providers pay to use it? Is there an extra cost to them?
There is no extra cost to providers. State Health Departments would pay NACDD for technical assistance in implementing the system. The only burden to providers is the time needed to be trained on its use.

What do you need to use the e-Referral Gateway? How are users trained?
Access to a web browser such as Google Chrome; training on use will be provided by NACDD and their technical partners.

Who uses the e-Referral Gateway?
Typically, it is CBO staff – whether a CHW, program manager, or project coordinator, etc. - who receive and send data via the eRG. Roles should be clearly defined within the workflows established as part of implementation development.

Is the form for CBO information standard or unique to each organization?
Not all the information a CBO collects and tracks is appropriate to go back to provider. NACDD will define a standard set of information or data elements CBOs will send to clinicians that is appropriate given the health condition and intervention type. CBOs can continue with their data collection processes per usual, however only a defined subset of the information they capture will be sent through Community e-Connect. The clinical information sent to CBOs will also be uniform.
If there is additional information the CBO deems important to communicate to the provider, the system does allow a text box for open-ended information to be sent in addition to the defined data elements.

What is needed in terms of a legal agreement?
The typical agreement is a Business Associate Agreement (BAA) or Memorandum of Understanding (MOU). The agreement should define what can and cannot be shared and protect the confidentiality

and security of referral data. SHDs are not a party to these legal agreements but can assist by sharing templates as starting points for partners. However, these are only starting points and should not replace appropriate legal counsel.

Do all organizations have to comply with HIPAA?
The software is HIPAA compliant, meaning the exchange of information complies if a legal agreement is in place. The legal agreements make the information and relationship HIPAA compliant. The real protection is in the security of the software to ensure data is protected along the way.

What is the open source software?
The e-Referral Gateway uses what is called a LAMP Stack – Linux operating system, Apache webserver, MySQL database, PGP or Java is the software toolset. Those 4 modules collectively are free-ware in the open source framework.

Will you work with one EMR vendor at a time or multiple vendors simultaneously?
We are not sure yet. We anticipate working with multiple vendors at the same time, but there are many efficiencies gained by working with fewer. This will be part of our assessment of which states we can work with; creating a simpler environment with fewer EMRs would be ideal. We will look at the collection of all of this information and ensure we have a project we can complete with this funding and meeting timelines.

Who fixes issues or glitches should they arise? Who do we reach out to with questions?
NACDD technical assistance team will help the project coordinators problem solve and connect them to technical resources, as appropriate.

What are the selected states purchasing? Will clinical and community partners join at no cost?
Partners join at no cost. NACDD is providing support and technical assistance from start to finish of implementation – legal agreement templates, material and workflow development, training of state staff, and technical components.

How are clinical partners trained on using Community e-Connect?
Once integrated with a given EMR, that EMR vendor will explain use and review details with the end clinical users. To continue using the e-Referral system, there will be ongoing hosting and maintenance costs. Also, if a state plans to expand its number of e-Referral connections, there are also additional costs. The cost for hosting and maintenance for this project will be established at the outset. Expansion costs will be dealt with on a case by case basis.

Does the $65K cost cover training provided by EMR vendors? – The cost covers EMR integration via the EMR vendor, as well as access to the e-Referral Gateway. Technical training on use of the modified EMR is a small part of overall integration and something EMR vendors often do when they make updates and changes to their systems.

Are there EMRs that are better candidates for this system? This system has been used most often with NextGen, eClinicalWorks, Athena, and Allscripts. Others may be good candidates as well; please reach out to NACDD to discuss further.

Who loads the platform at the CBO? The e-Referral Gateway will be developed and customized for each CBO through our technical team. Each states' data will remain entirely separate.

Are modifications made to one vendor's system transferrable to others? Yes, and those efficiencies can occur across states lines within the same vendor, which is one of the efficiencies NACDD will consider.

Will NACDD provide support to states as they seek out partners to get a project started? Yes, NACDD can help support some of this project development. If the volume of requests is too great, it could be unmanageable. However, NACDD will be happy to talk with you about the most appropriate partners and how to discuss this with them. We will work with states on a case by case basis to determine what makes sense. Ideally states will start this project with clinical and community partners that they have already been working with.

Will there be a project overview or summary document states could share with their partners about this? Not yet, but NACDD will post one ASAP for states to utilize.

Aren't there patient confidentiality issues?
Not if handled appropriately. Community e-Connect is HIPAA compliant, patient information is blinded, and consent recorded

Once a business associate agreement (BAA) is in place, does that remove the need for written patient consent? No, but it can be electronic consent. You still need to obtain patient consent at some point, be it at patient check-in or specific to the e-Connect related referral.

Must we have final agreement from potential partners and EMR vendors to complete the survey and submit responses by 5/2? No. We encourage those interested to complete the survey to the best of their ability / knowledge at this time. NACDD will work with potential participants to gauge the likelihood of gaining partner commitments.

Can NACDD provide documentation as to how to approach EMR vendors? At this time we advise you to work with your clinical partners to understand their interest, and when completing the eligibility survey, be sure to note their EMR vendor. NACDD's technical partner may have a relationship with that EMR vendor and/or be able to guide appropriate contact. However, we do not have blanket recommendations or materials to support EMR vendor outreach at this time.

To which types of evidence-based programs should we refer? Please review the list of programs provided by CDC in the 1815 FAQs. These are the programs to which clinical referrals should be made within the context of Community e-Connect.

Can state health departments initiate this process after year 1 of the grant cycle or do they have to begin this year? SHDs can begin implementation of Community e-Connect in year 2 of the grant cycle. If this is your intent, please notify NACDD.

Can Community e-Connect be integrated into EHRs and can additional CBO e-Referral Gateways be set up after year 1? Yes. After the initial implementations are established additional connections can be added, and there will be costs associated with doing so.

How do you envision sustainability after the funding is over? The hope is that there will be enough value in use of the system that the SHD, clinical organization, and CBO will fund maintenance and access, and/or that they can seek additional grant funding if necessary. In addition, NACDD expects to work with participants to plan for and guide sustainability as the grant winds down.

Is the intent for this software to be initiated at the CBO or clinic level? The intent is for the software to be utilized by both CBO and clinical organizations. Referrals will initiate with the clinical organization, and the CBO will provide feedback on patient progress through the system.

How does this interface with existing EMRs and/or other systems being used to track/monitor referrals to DPP and other programs? The interface with EMRs involves outbound referrals from that EMR to the Community e-Connect platform and inbound feedback reports from Community e-Connect platform, which are embedded directly within the EMR system. Technical interface specs will be defined in collaboration with EMR vendor. The eConnect platform may be able to integrate with other systems currently referring to community programs, but more detail on the systems in question is required to fully provide an answer.

What is the expense of adding an additional CBO partner? This is difficult to answer as there are a number of components that feed into costs estimates for this work. If the CBO will be receiving referrals from a clinical organization that already has the system integrated with their EMR, and it is for an intervention we have configured previously, the cost would be in the $2000-5000 range.

How do the CBOs receive the referrals? What types of systems to the CBOs need to have to participate? CBOs will use the e-Referral Gateway, which is a web browser tool that functions much like email. CBOs only need a computer with Internet access and a web browser (e.g., Google Chrome).

How can this work compliment the progress we have already made with our current HIE? NOTE: These systems and CBOs are already working together through a 1422 screen/test/refer pilot project, but the referral system is not electronic. If HCPs have existing interfaces with a local HIE, the e-Connect system could be integrated with the local HIE, thereby reducing the likelihood that HCPs would have to develop a separate interface. Existing workflows and relationships can be modified to be utilized and to support Community e-Connect.

What are the specification requirements for the content of the referral? We have pre-defined data elements for each type of referral and will provide a template.

We are in the process of identifying clinical and CBO organizations. If we don't have firm commitments from them can we still apply? NACDD will be happy to still discuss options with you, but it will be difficult for us to definitively determine if implementation is possible without an understanding of the involved partners.

Can a clinical organization who provides evidence-based programming act as the CBO and receive referrals? Referral through Community e-Connect should be for evidence-based programs provided by appropriate entities as defined by CDC in the 1815 NOFO and FAQs. If this is allowable from their standpoint, it is a potential option here.

Will this project count toward Medicaid and Medicare improving interoperability programs objective for Health Information Exchange for the practices? Most likely, yes, but it depends how interoperability is defined by CMS. You can share the objectives and requirements with NACDD, and we can then determine if there is alignment.

Does each practice have to refer 100 patients or is it 100 between practices? Is it 100 referrals or completions? Some clients may be referred and not complete the program. We are looking for a minimum of 100 patients, which can be across participating clinical organizations within your state. We understand not all clients who participate in a given program will complete, so the goal is a minimum of 100 referrals. However, processes and mechanisms must be in place to ensure every attempt is made to a) refer appropriate patients likely to complete, and b) to enroll and retain patients when they are referred.