Community e-Connect

April 25, 2018

NATIONAL ASSOCIATION OF
CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

Purpose and Presenters

- Purpose
  - Learn about an opportunity to work with NACDD to implement Community e-Connect, an electronic referral system linking clinical and community groups

- Presenters
  - Susan Svencer – NACDD
  - Thomas Land – University of Massachusetts Medical School

Disclaimer

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Agenda

- Community e-Connect Overview
  - What and Why – definition and rationale
  - Who – roles
  - How – methodology
  - When – anticipated timeline
- FAQ's
- Next Steps
- Questions

The What and Why

- What is Community e-Connect?
  - Bi-directional linkage between clinical Electronic Health Records (EHRs) and community-based organizations (CBOs)

- Why do it?
  - Improve the health of patients with chronic diseases such as diabetes, pre-diabetes, cardiovascular disease and hypertension through evidence-based support beyond primary care
  - Enhance population health
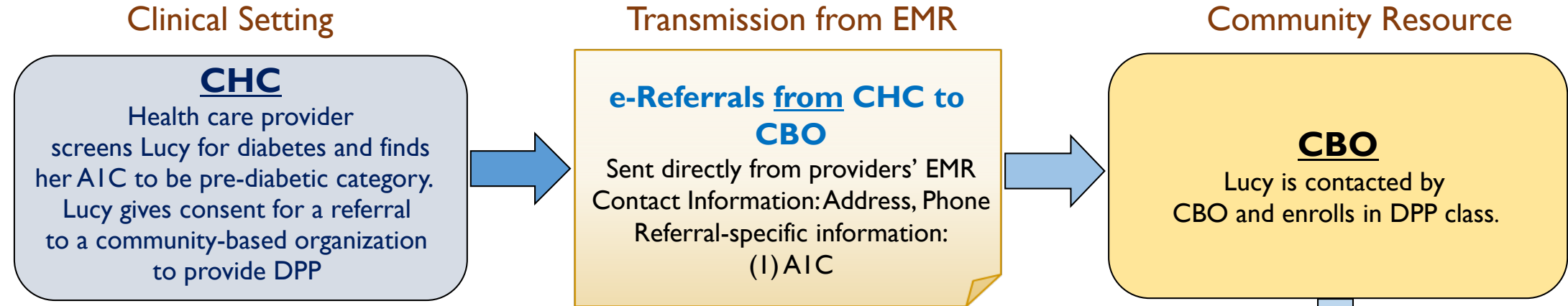 - Expand the care continuum

The Who

- Clinical providers
  - Refer patients for evidence-based services offered by CBOs like the YMCA, and Senior Centers, which meet patients' clinical needs
- CBOs
  - Document client enrollment, attendance, and program status, sending this information back to clinical organizations at agreed-upon intervals, enhancing the care continuum
- State Health Departments (SHDs)
  - Oversee and convene involved parties, build relationships, develop evidence and promote the results
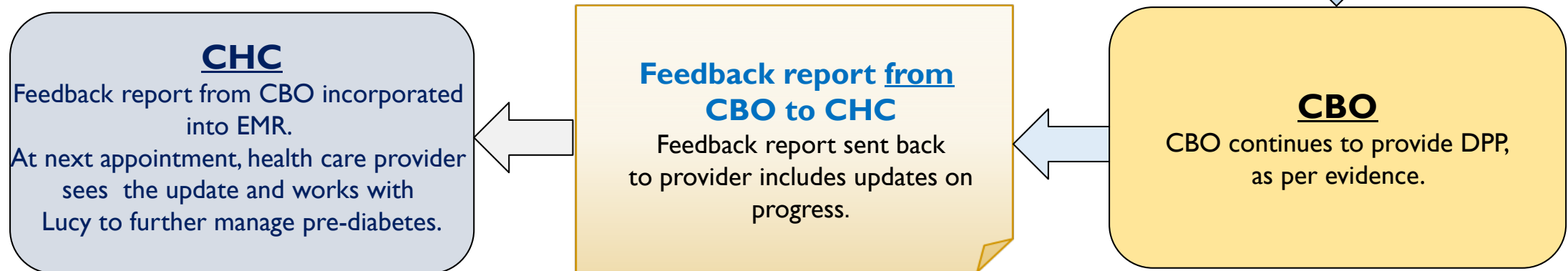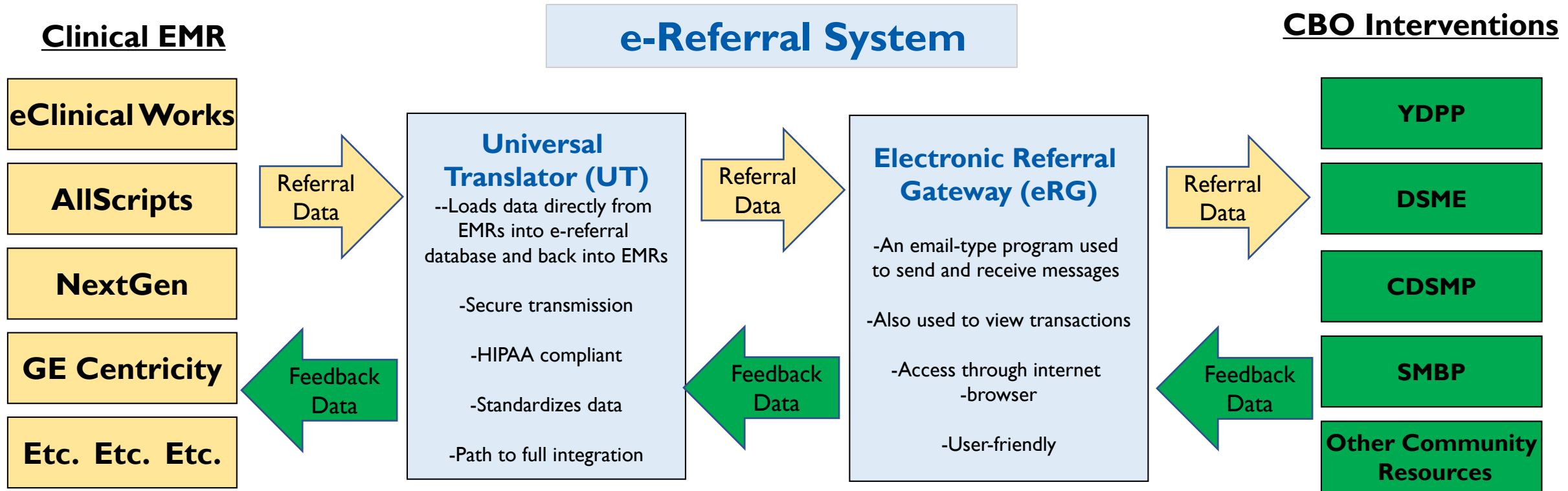
The How: Flow of Information

Referrals: Outbound Transaction

Clinical Setting

CHC
Health care provider screens Lucy for diabetes and finds her A1C to be pre-diabetic category. Lucy gives consent for a referral to a community-based organization to provide DPP

Transmission from EMR

e-Referrals from CHC to CBO
Sent directly from providers' EMR
Contact Information: Address, Phone
Referral-specific information:
(1) A1C

Community Resource

CBO
Lucy is contacted by CBO and enrolls in DPP class.

Feedback: Inbound Transaction

CHC
Feedback report from CBO incorporated into EMR.
At next appointment, health care provider sees the update and works with Lucy to further manage pre-diabetes.

Feedback report from CBO to CHC
Feedback report sent back to provider includes updates on progress.

CBO
CBO continues to provide DPP, as per evidence.

The How: Data Sharing

Clinical EMR

e-Referral System

CBO Interventions

eClinical Works		YDPP
AllScripts		DSME
NextGen		CDSMP
GE Centricity		SMBP
Etc. Etc. Etc.		Other Community Resources

Referral Data →

Feedback Data ←

Universal Translator (UT)

--Loads data directly from EMRs into e-referral database and back into EMRs

-Secure transmission

-HIPAA compliant

-Standardizes data

-Path to full integration

Referral Data →

Feedback Data ←

Electronic Referral Gateway (eRG)

-An email-type program used to send and receive messages

-Also used to view transactions

-Access through internet -browser

-User-friendly

Referral Data →

Feedback Data ←

*The open source software was funded through a State Innovation Model Testing Award, through which Massachusetts piloted the software at 14 clinical sites.

The How: Implementation Methodology

Get Ready

- ❑ Define intervention
- ❑ Confirm legal referral agreement
- ❑ Organizational forms complete
- ❑ Kick off meeting and stakeholder buy-in
- ❑ Determine e-Referral key contacts
- ❑ Define workflows and data elements
- ❑ IT assessment

Get Set

- ❑ Confirm eRG integrated workflows/data elements with stakeholders
- ❑ Define weekly update meetings
- ❑ Confirm implementation schedule / project plan
- ❑ User training materials of eRG

Go Live

- ❑ Transition to Production
- ❑ Monitoring and Quality Control
- ❑ Evaluation

The How: Lessons Learned

- Relationships and communication
  - Clinical and community organizations must work and communicate well; building on existing relationships where possible

- Stakeholder buy-in
  - Senior leadership, legal, IT, clinicians, directors, and administrators

- Legal agreements
  - Must be in place prior to proceeding

- Patient consent
  - Must be obtained and can be built into EMR

The How: Outcomes

- In the Massachusetts' example

More than 50 community / clinical linkages were established with over a dozen referral types

Nearly 5,000 referrals were made and over 8,000 feedback reports received

Analysis of HTN referrals showed significant increases in % of patients with controlled BP and reduced SBP

The How: NACDD's Technical Assistance

- NACDD anticipates supporting 8-10 states in order to:
  - Serve as primary point of contact and overall project manager, working closely with state project coordinators and technical team
  - Provide training and trouble shooting support to state coordinators
  - Analyze state aggregate data at regular intervals, delivering a masked comparison of progress across participants

The How: Eligibility

- SHDs' selected clinical and community partners must be "ready"

Clinical Organizations	Both Clinical and Community	Community-Based Organizations
EMR vendor agrees to EMR modifications in writing	Establish or agree to establish a legal agreement defining their relationship	Have the capacity to handle an influx of referrals for
Must, at minimum, have the population necessary to refer 100 patients a year, which is roughly equivalent to 10,000 adult patients. This can be across multiple clinical entities	Are willing to share data with one another	• ADA-recognized / AADE-accredited DSME support programs • NDPP lifestyle support programs • Evidence-based lifestyle programs among patients with high blood pressure or blood cholesterol, including SMBP with clinical support
	Are willing to share aggregate data with the SHD / NACDD / CDC	

- NACDD will work with CDC to ensure programs and measures align with their intent and needs
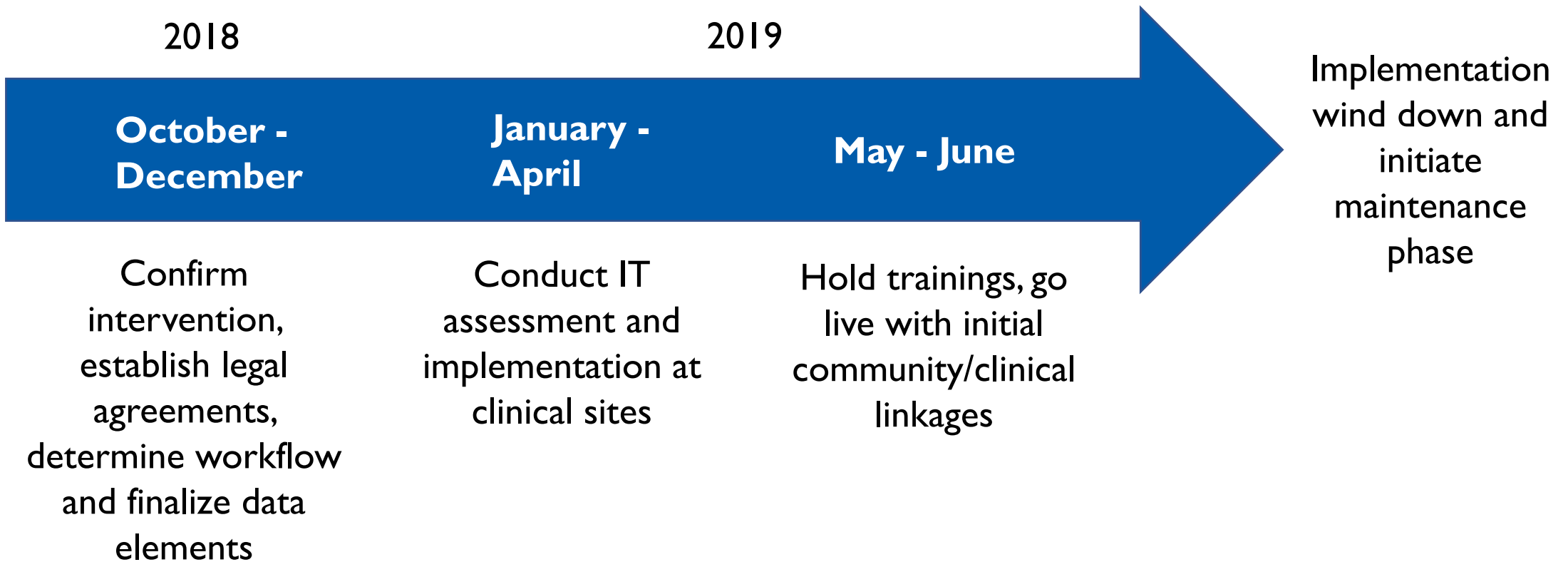
The How: SHD Considerations

- Participating SHDs should plan to implement referrals for pre-diabetes or diabetes *and* hypertension or cholesterol
- Recommend a project coordinator (~ .25 - .75 FTE), as well as ~.25-.5 FTE for an epidemiologist; depending upon number of connections
- Start up phase cost (year 1: 9 months) will be roughly $60-65K
- Maintenance phase cost (year 2 and beyond) will be roughly $20-25K, which includes light TA from NACDD and technical costs

The When: *Estimated* Timeframe

2018

2019

October - December

January - April

May - June

Implementation wind down and initiate maintenance phase

Confirm intervention, establish legal agreements, determine workflow and finalize data elements

Conduct IT assessment and implementation at clinical sites

Hold trainings, go live with initial community/clinical linkages

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FAQs – EMR Integration

Q: Can Community e-Connect be integrated with any EMR?

A: Yes, with a few exceptions

Q: How are clinical partners trained on using Community e-Connect?
A: Once integrated with a given EMR, that EMR vendor will explain use and review details with the end clinical users

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

Next Steps

- Review and discuss your state's response to the NOFO and resource allocation

- Determine potential partners to implement Community e-Connect who have the potential to meet the eligibility requirements detailed here

- Reach out to NACDD to discuss approaches, partners, and feasibility – we will send a survey link to all registrants to record eligibility responses tomorrow, 4/26

Next Steps (cont'd)

- May 2nd: complete eligibility survey
- May 9th: NACDD will reply with questions and determination of eligibility
  - NACDD will work with each eligible state to finalize budget and narrative details
- Contact Susan Svencer (ssvencer@chronicdisease.org) with questions. Answers, webinar recording, slides to be posted on the NACDD website

Questions?