August 3, 2021

THE **DOWNLOAD**

A monthly webinar diving into the intersection of healthcare and technology

MiHIN
MICHIGAN HEALTH INFORMATION NETWORK
SHARED SERVICES

Drew Murray
*Senior Community
Engagement Director*
MiHIN

Stephanie Miller
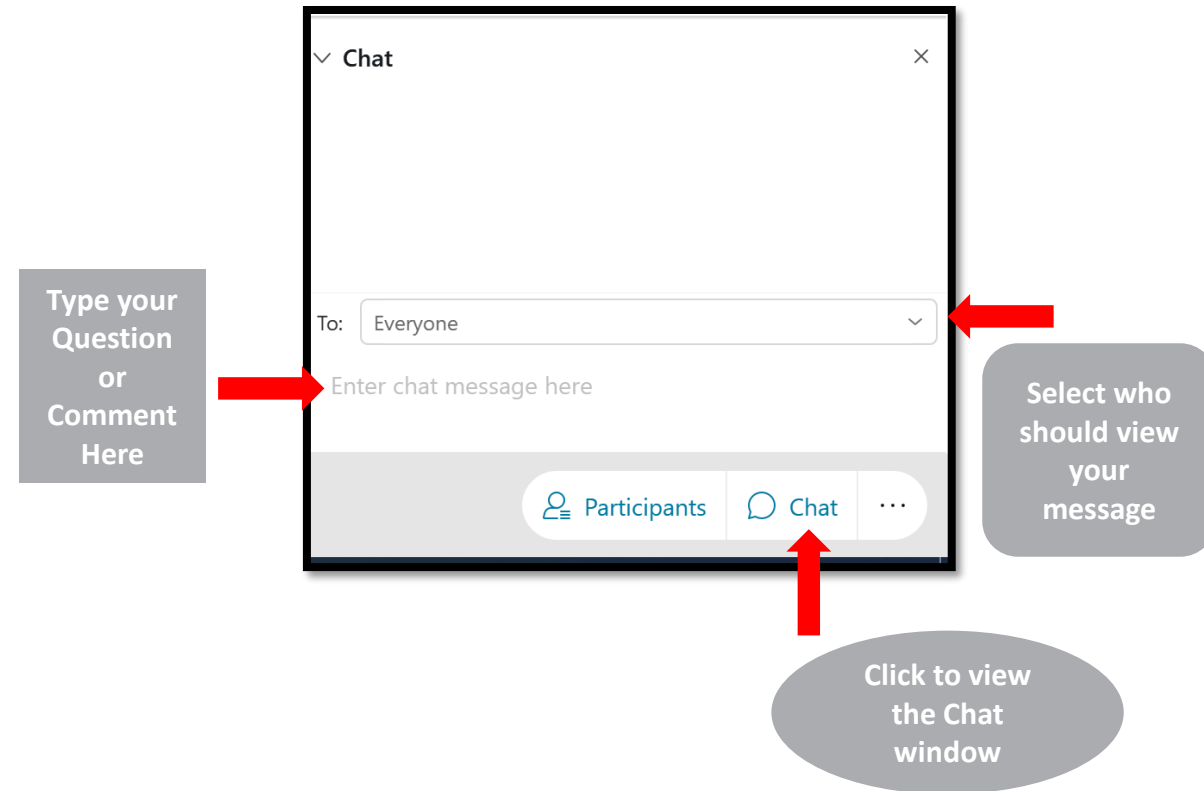*Senior Regional Account Executive*
MiHIN

- **Drew (Facilitator)**

- **Stephanie Miller (Webex Chat Moderator)**

Welcome to THE **DOWNLOAD**

Let's Get Started...

- This session is being recorded and will be available after the meeting on the MiHIN website.

- All attendees are muted

- Participating in the forum
  - Ask questions and make comments using the WebEx Chat
  - Presenters will answer your question via chat after each segment, or the moderator will read your question aloud towards the end of the webinar.
  - All unanswered questions today will be answered via email to all attendees.

- Chat Controls
  - On the right-side of your screen

Chat ×

Type your Question or Comment Here

To: Everyone

Enter chat message here

Select who should view your message

Participants   Chat   ...

Click to view the Chat window

Michigan Health Information Network Shared Services (MiHIN)

MiHIN is Michigan's initiative to continuously improve healthcare quality, efficiency, and patient safety by promoting secure, electronic exchange of health information. MiHIN represents a growing network of public and private organizations working to overcome data sharing barriers, reduce costs, and ultimately advance the health of Michigan's population.

MiHIN is a

network for sharing health information statewide for Michigan

MiHIN's Five Focus Areas

1. **Convening** people to figure out functional solutions

2. Champion Statewide **Use Cases** to fairly get data flowing and keep it moving securely among all legitimate parties

3. Operate as a **Shared Services** (Health Directory, Active Care Relationships, Security, Legal, Client Matching, etc.) as behind the scenes infrastructure

4. **Providing tools** to support daily workflows and coordination

5. **Reporting, Conformance,** and **Analytics** from data lakes and the longitudinal health record
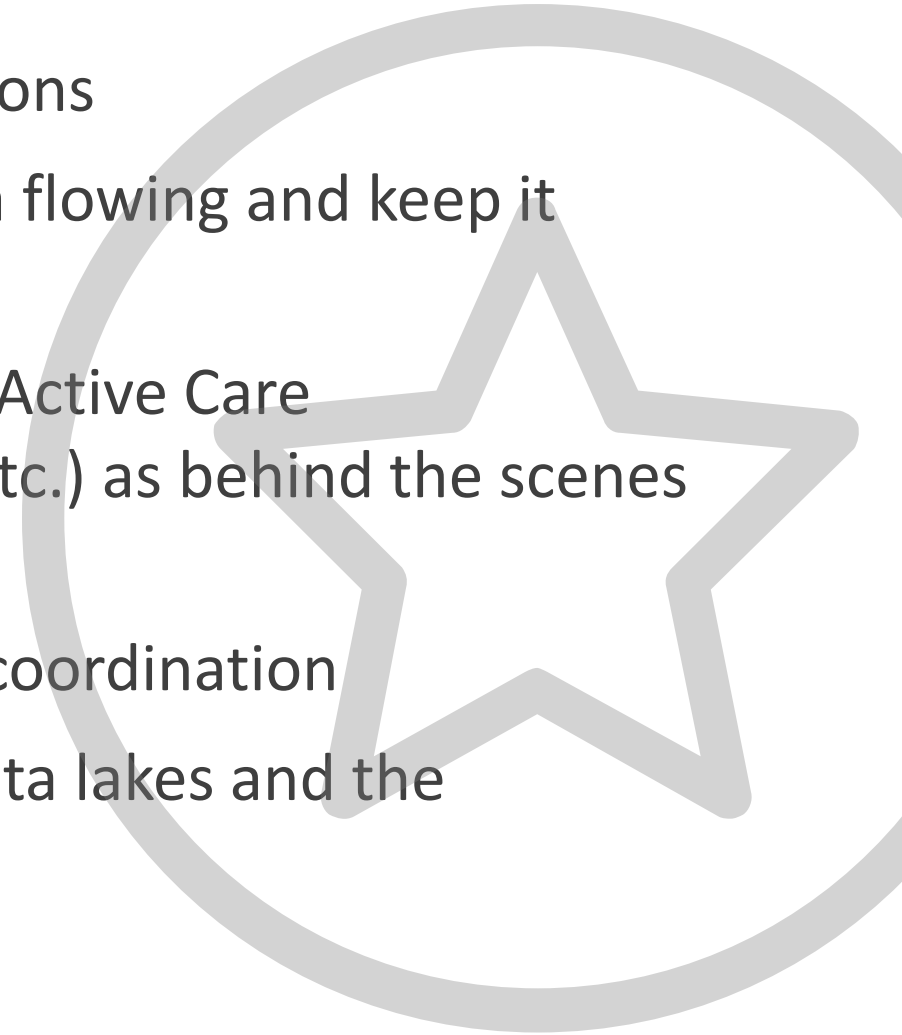
Today's Agenda

01 ● **Welcome**
Katrina Gagne

02 ● **Michigan Five-Year Health IT Roadmap**
Don Ross
CEDARBRIDGE Group

03 ● **Overview of Interoperability Institute's Interoperability Land**
Stephanie Arntson

04 ● **Announcements**
Katrina Gagne

05 ● **Q&A**
All – facilitated by Tracy Webb

Telehealth Overview

Chris Bailey
Director of National Engagement and Consumer Health Strategy

Care Convene Premise

- Advancements in health technology & care alone are unlikely to optimally improve health and related outcomes, unless these technologies and innovations in clinical workflow support improved patient health literacy and convenient access to patient-initiated care. Simply put, patients suffering from chronic conditions must be able to identify their chronic symptoms and have a convenient method to report their concerns to a clinician.

"Communication done right is at the root of most every positive experience in medicine. Conversely, communication done wrong is at the root of most every negative experience in medicine."
Jeff VanWingen MD

Care Convene Purpose

The Essential Fundamentals:

- Improve health outcomes through greater patient literacy and activation.

- Create frictionless bidirectional access between patient and care team.

- Strengthen patient-provider relationships and help providers innovate new virtual team-based care models.

The Essential Experience:

- Michigan based company with knowledge of the Michigan landscape

- Experience working with physician organizations and health systems

- Supports the PCMH Care Model and meets practices where their needs are!
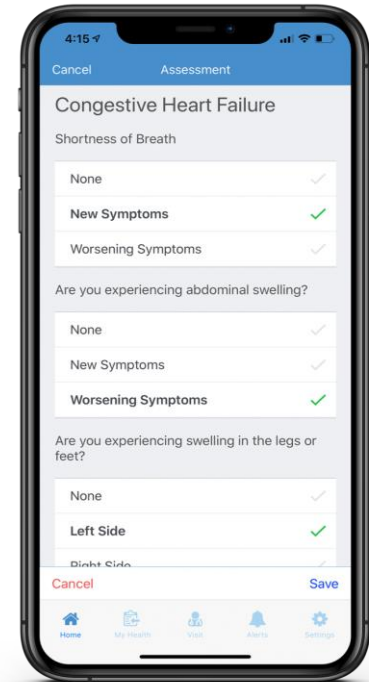
Solution: Awareness, Access & Convenience

Patient Self Management!
Challenges to Patient Engagement

Care Assessment / Virtual Visit — Intervention — Office Visit

| Low Symptomatic (CHF) | Med Symptomatic (CHF) | High Symptomatic (CHF) | Emergency Room (CHF) | Inpatient Admission (CHF) |

Symptom Management = Cost Avoidance

Very Convenient Low Cost ——— Cost / Convenience Scale ——— Not Convenient Expensive →

$50 | $140 | $1000 | $10,400

Virtual Care Resolves the Cost/Convenience Problem

1 *Symptom Awareness*
Patients with chronic symptoms don't know nor understand which symptoms need to be monitored.

2 *Frictionless Access*
Patients struggle to know when to alert their care team about their symptoms.

3 *Relationship-based Convenience*
Patients need flexible virtual access to their medical home while at work, at home, or on the go.

Maturity Model

Virtual Health Maturity Adoption Model

CONSUMER VALUE

Pre Covid-19

Covid -19

Limited Utilization!
Use of Non-HIPAA compliant tools or outsourcing of telehealth.

Emerging Discipline!
Utilization driven by need for business continuity and new reimbursement during COVID-19 pandemic.
- *Practice initiated visits only.*

Patient-Provider Linkage!
- Practice builds a virtual brand to extend patient medical home
- Patient initiated visits
- Practice initiated visits
- Symptom Reporting
- Health journal

Care Convene

Clinic Integration!
Simplify patient and provider access to health information.
- Provider-HIE: ADT, CCD, Etc
- Remote Patient Monitoring: – Alert patients and provider care teams, improve patient health awareness.

Care Convene

Consumer Autonomy!
- Consumer access to payer claims data and EMR personal data.
- Consumer Initiated Data Sharing

Care Convene

| EARLY ADOPTERS | REACTIVE & DEFENSIVE | INITIAL COORDINATION | EFFECTIVE INTEGRATION | EFFECTIVE TRANSFORMATION |

HEALTHCARE DELIVERY TRANSFORMATION

care convene – Virtual Platform

Telehealth – Secure/HIPAA Compliant Chat & Video

- Clinic-initiated or Patient-initiated "On-Demand" or "Scheduled" visits
- Supports store-and-forward (asynchronous) and synchronous chat and video interactions
- Option 1: No App Download or Registration Required – Simple, quick connection using text or email delivered web browser link
- Option 2: Android and iOS App – Full-featured Patient Experience (Symptom Reporting, Personal Health Record, Health Journal)

Virtual Care Management & Transition of Care Support

- Real-time browser & app notifications on the status of patients' care transitions
    - Statewide (ADT) Admission, Discharge, Transfer Alerts & Post-discharge Care Summary via MIHIN
- Access to Patient Care-Team and Provider Information
- Proactive Patient Engagement Tools
    - Personalized symptom reporting assessments
        - Chronic disease based, post-surgical related, or customized
    - Customize the frequency of assessment alerts
    - Goals & Healthy Habit Tracking

Patient-Consumer Access

- Patient Centered Personal Health Record (PHR)
    - Meds, Vitals, Problems, Allergies, Imms, Results, Labs, etc
- CMS Patient Access Final Rule Compliance

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Clinical Innovations

- Reduction in Readmissions - Virtual Transition of Care Pilots
- ER Clinical Coordination to Avoid Unnecessary Inpatient Admissions
- BCBSM Self Funded Employer Care Coordination & Hosted Member ADT Exchange
  - HASA HIE (Texas), ICC Dell HIE (Texas)
- Specialty Team Based Care Initiative
- Remote Patient Monitoring Pilots:
  - Congestive Heart Failure
  - Oncology
  - Diabetes
  - Maternal Health
- Patient Campaigns –Gaps in Care
  - Pilot Smoking Cessation
  - Pilot Colorectal Screening

Appendix – *Reference Slides*

Virtual Practice Based Clinic Model

Allows for greater access to quality care for more patients via a secure platform

Align principles of PCMH and PDCM

- Closing Gaps in Care
- Patient Self-Management
- Care Management & Coordination
- Social Determinates of Health Reporting

Optimize Data Sharing & Platform Integration

- Use real-time ADT/Care Summary
- REST API and FHIR Ready (RPM enabled)
- Integrated Relationship Health Solution
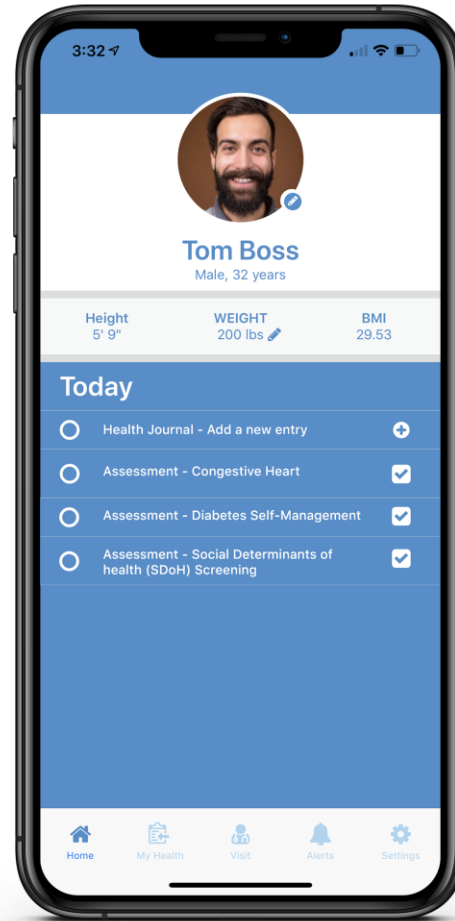
Support Greater Patient Health Literacy & Access

- Poly Chronic Symptom Management.
- Patient Activation using disease specific virtual assessments
- Targeted Patient Education

Platform Benefits

- Longitudinal and Episodic Care
- Scalable and Affordable Pricing
- Integrated Relationship Health Solution
- Practice Branding

Post Discharge Follow-up

CHF Example

Patient Care Goals and Healthy Habits

Apple iOS & Android
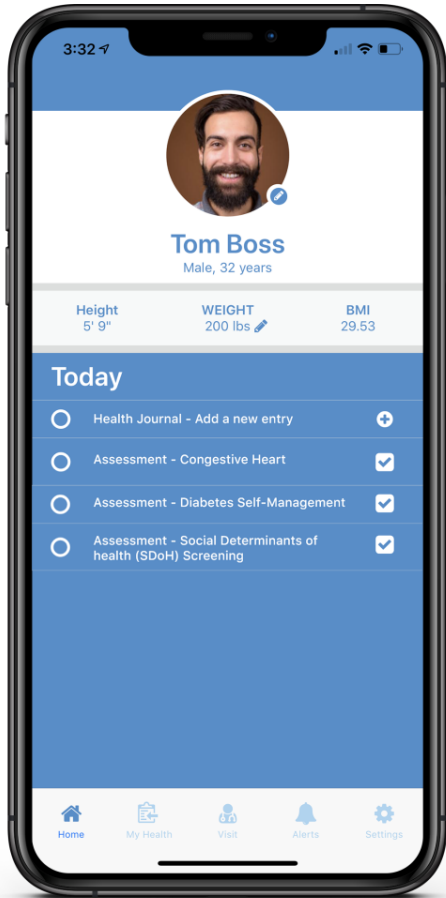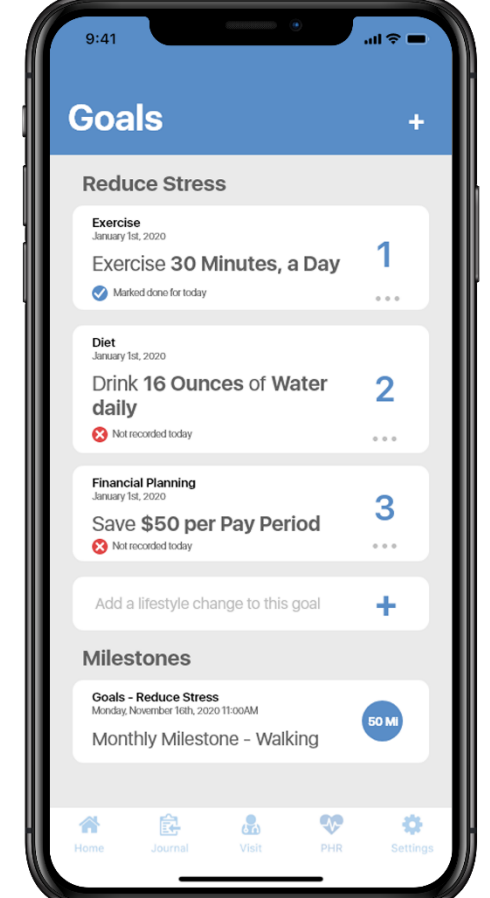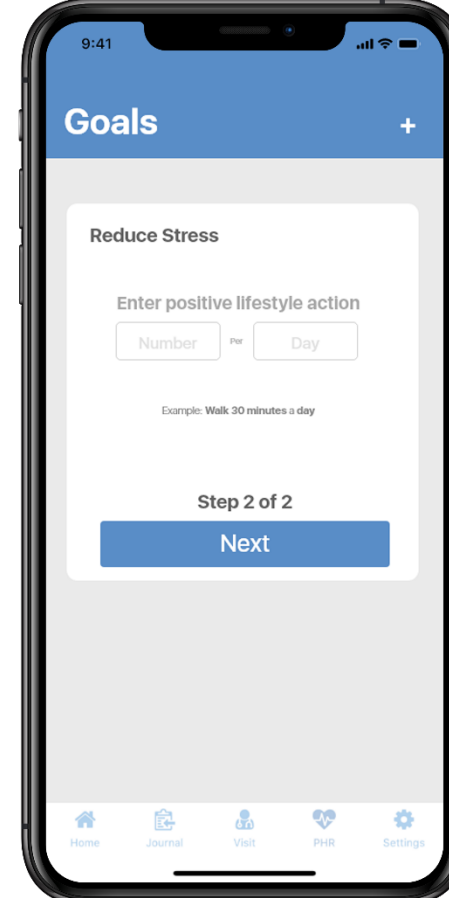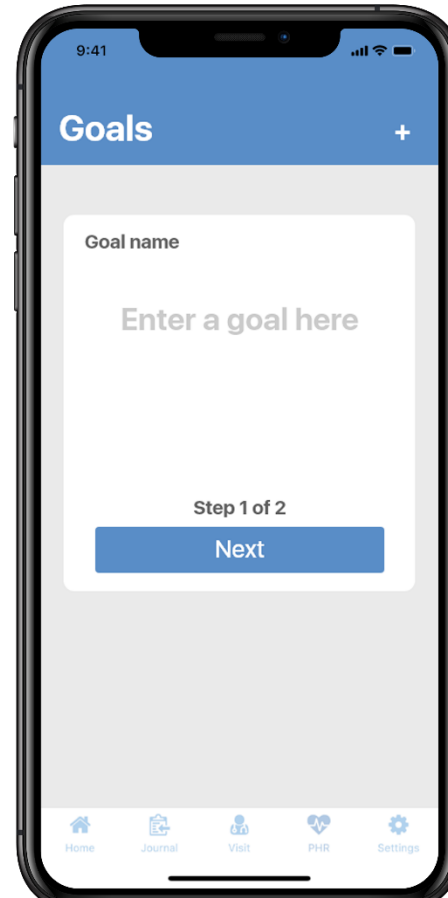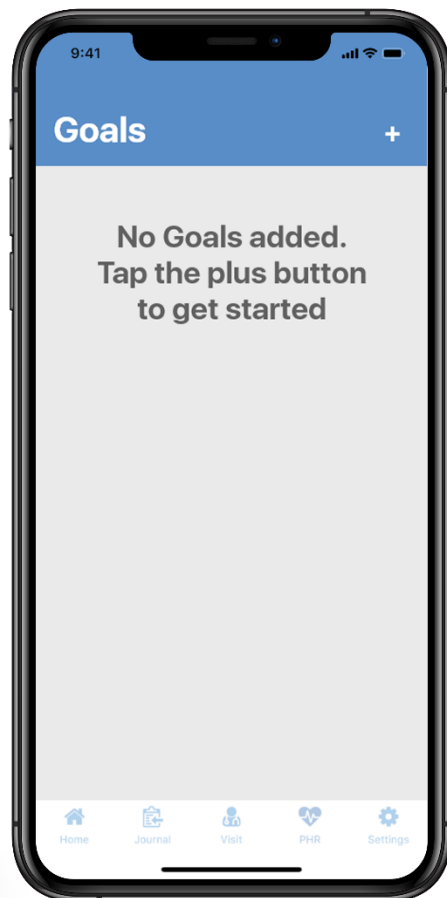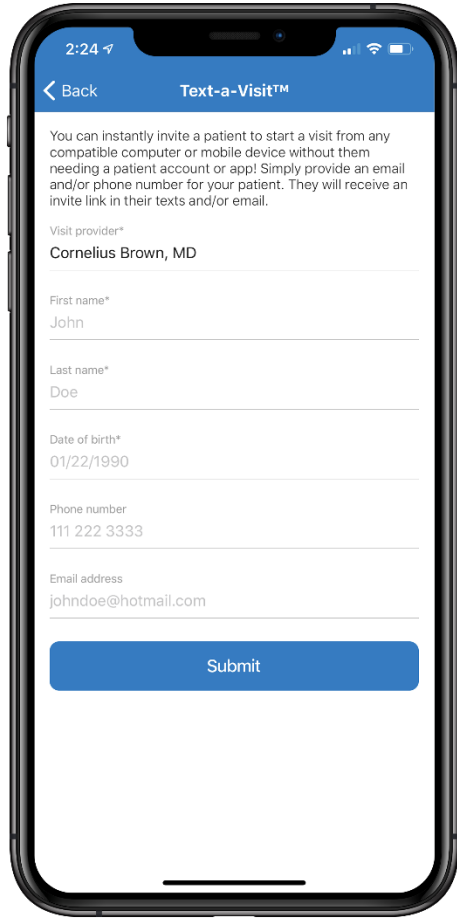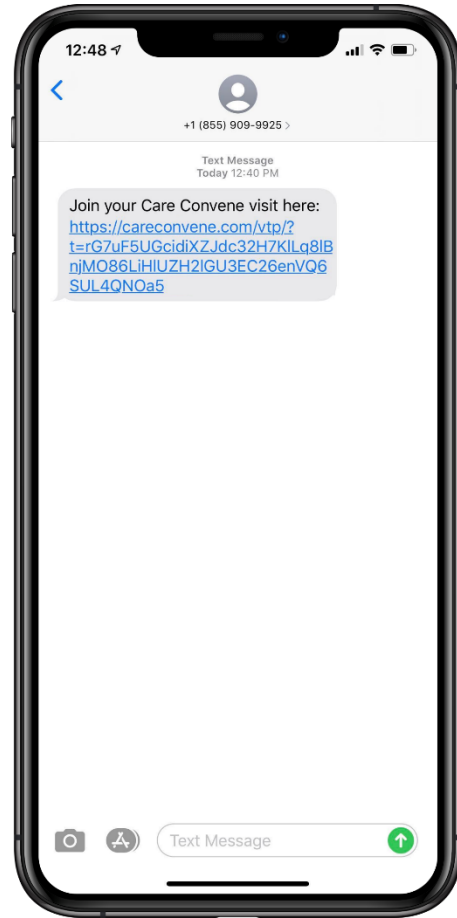

Patient Home

Production Release (March 30, 21)

Care Convene 3rd Party App /Payer Integration
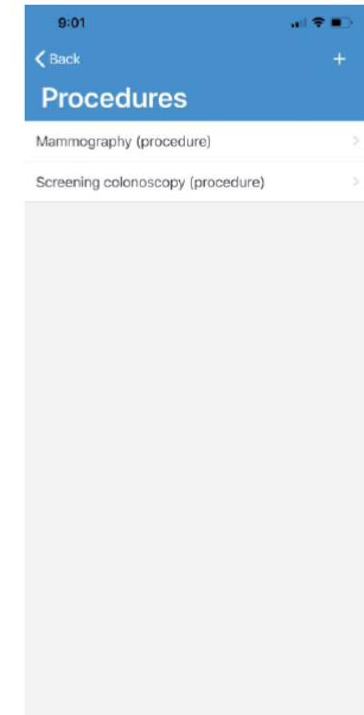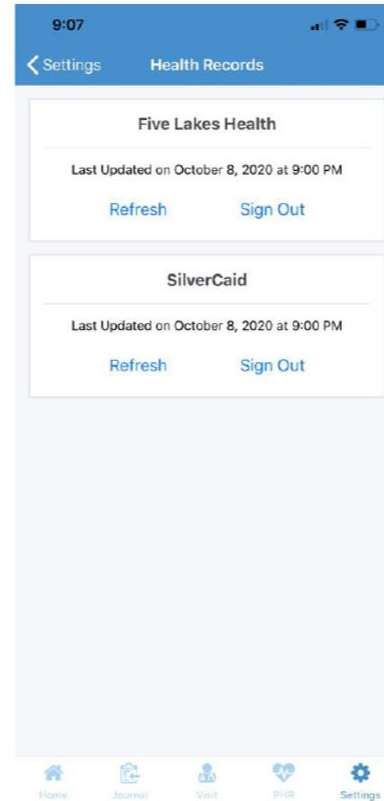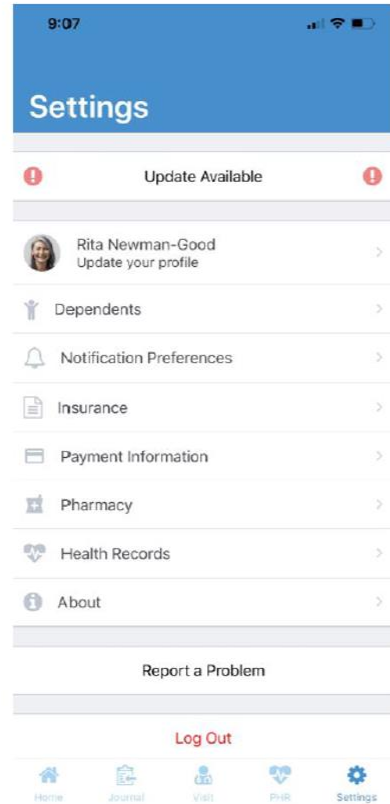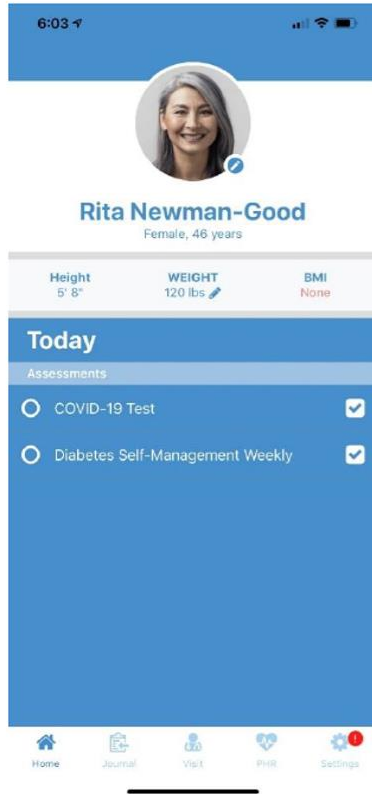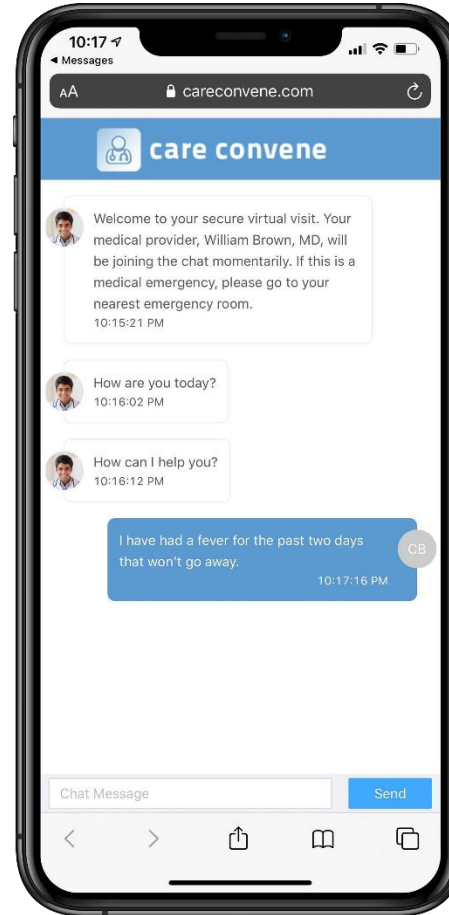
Text-a-Visit Experience

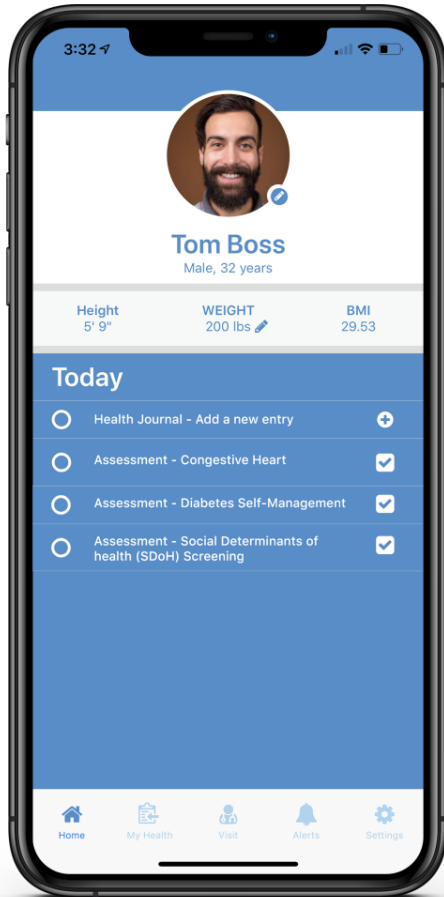**Patient Invite**

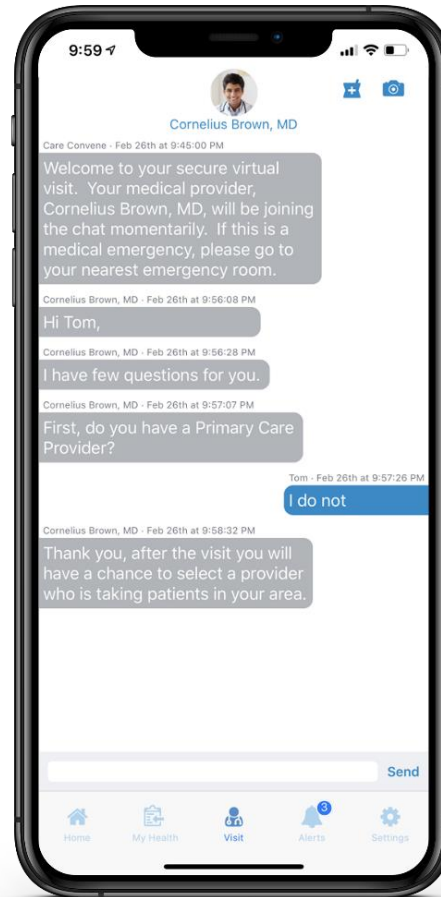**Patient Invite Link**

Patient Chat

Patient Video

Patient Care Experience
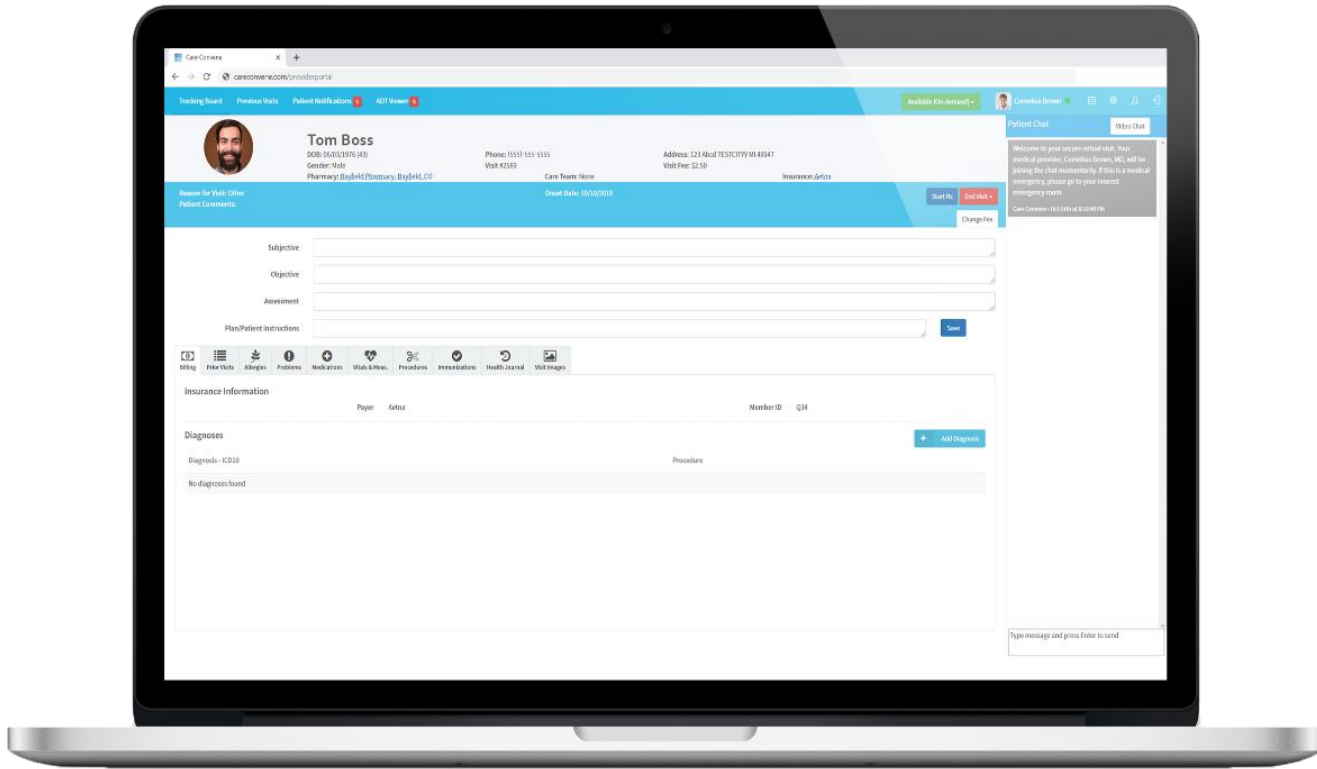
Apple iOS & Android
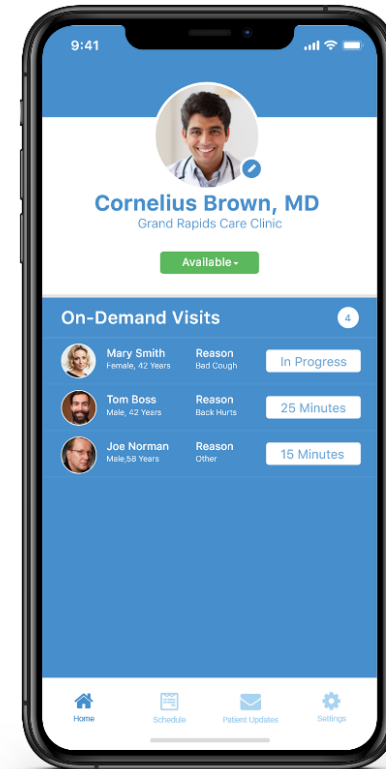

Patient Home

Patient Chat

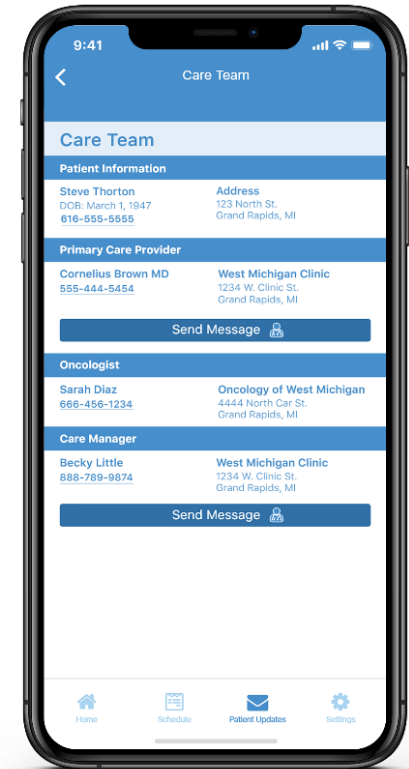**Patient Video**

Provider / Care Team Access

Web Browser, Apple iOS, Android
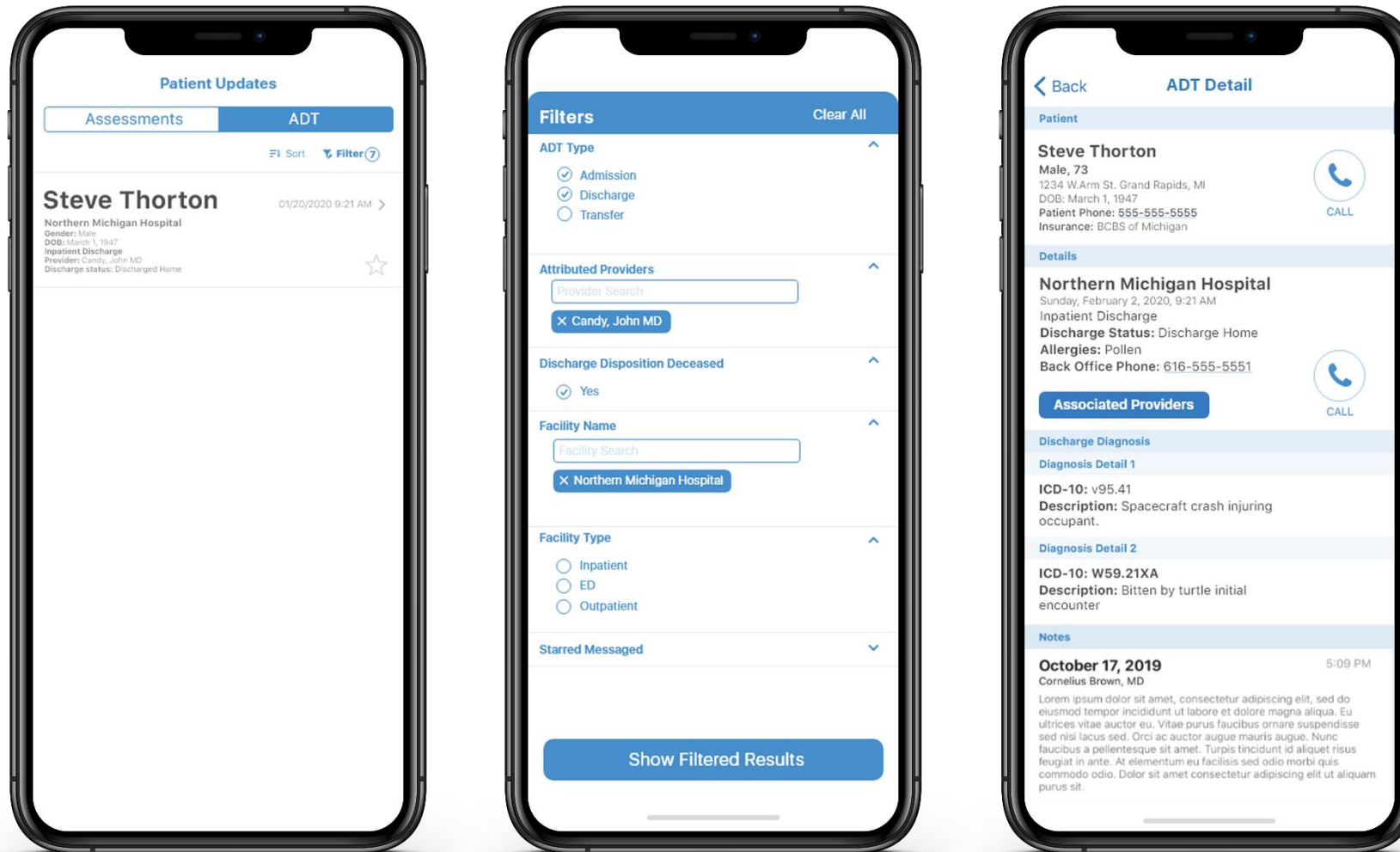

Provider Web Portal

Provider Tracking Board

Care Team Viewer

ADT Filtering/Notifications -Smart App

QUESTIONS?

Join us for the next **DOWNLOAD** on

September 7, 2021

THANK YOU!