Bits & Bytes

A monthly workshop where stakeholders can connect directly with MiHIN’s solutions’ designers & managers
Today's Agenda

01 Welcome
Joanne Jarvi

02 Emergency Department Optimization
Nancy Sehy, Clinical Solutions Lead with Collective Medical Technologies, a PointClickCare Company

03 Dynamic Discussion
All !!!
Michigan Health Information Network Shared Services (MiHIN) is a collaboratively governed, non-profit organization providing the technology and services to connect disparate care sectors, our stakeholders, to securely, legally and technically share health information.

An unbiased data trustee, MiHIN does not provide health care services, produce health care data or compete in the marketplace.

Instead, we convene to share vital health information to advance care, better outcomes and lower costs.

Technology is a tool; humans are the energy!

Technology is meant to support the human ability to connect, communicate, collaborate and make informed decisions.
Technological Infrastructure + Human Infrastructure

Real impact will move at the speed of trust.

Communication, the successful conveying or sharing of ideas, is more critical than ever.

Every communication involves (at least) one sender, a message and a recipient.

FOR ANY DATA EXCHANGE: WHAT ARE WE TRYING TO COMMUNICATE AND WHY?

Joanne B. Jarvi  
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MiHIN

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•  Joanne Jarvi (Facilitator)
•  Carlye Maher (Webex Chat Moderator)
The Group Development Model
(with special thanks to MHEF and MPHI)

1. WHY?
2. WHO
3. HOW
4. WHAT

Feedback Feedback Feedback Feedback
Data for Good
The WHAT:
The Use Case determines the Service which can be operationalized by the Solution
Nancy Sehy, Clinical Solutions Lead with Collective Medical Technologies, a PointClickCare Company, is a Registered Nurse with over 27 years of experience in healthcare and leadership. She also has an interest in education, serving on the Board of Directors for the Illinois Hospice and Palliative Care Organization for over 9 years.

Her broad background in long term care, acute care, and home care drives her desire to work with customers to help create smooth care transitions for patients. Nancy developed and implemented a palliative care program in her health system, with a focus on patients at high risk, and a goal of improving patients’ ability to manage their health successfully in the community setting. As a result, there was an 80% reduction in ED visits and a 60% reduction in hospital readmissions.

In her current role, Nancy is using her healthcare background to help support and strengthen the use of Collective and PointClickCare's innovative care collaboration platforms, which are designed to enhance communication and collaboration, driving meaningful care and quality outcomes for both patients and providers.
How does the PointClickCare platform improve care collaboration for the ED?

**Risk Identification**
Real-time analytics identify high-risk encounters and populations.

**Intelligent Notifications**
Risk-based alerts, curated into a consumable format and delivered into existing workflow.

**Activate the Care Team**
Dynamically understand who is on the patient’s broader care team that needs to be engaged to support the patient.

**Share Insights**
Connected care team shares unique patient specific insights via shared, virtual collaboration environment; insights follow the patient going forward.
Basic demographic information is entered into the hospital’s EMR at the time of triage.

Collective receives and cross-references the patient information with our nation-wide network.

If the patient meets pre-defined risk criteria, a notifications will be pushed to the provider workflow. The provider can take appropriate action with this information.
EDO Criteria for MI and Notifications

Impacts:

- More informed decisions
- Improve the quality of care for the patient
- Increase the throughput of the ED and maximize profitability.

Standard ED Notification Criteria
- 5+ ED Visits in 12 months
- 3+ ED Locations in 90 days

Care Insights

Safety & Security Events

Readmission Risk Criteria
- ED Visit Post IP d/c at This Facility - 30 days
- ED Visit Post SNF d/c - 30 days

- More informed decisions
- Improve the quality of care for the patient
- Increase the throughput of the ED and maximize profitability.
ED Visit Post IP Discharge at any facility - 30 days

ED Visit Post SNF Discharge - 30 days

- ED providers and care coordinator/discharge planners can have immediate insight into the patient's recent encounters that could affect the risk for readmission.

- ED providers are aware if a patient had an admission at a SNF within the past 30 days or a recent inpatient admission to help prevent a readmission after discharge from this visit.

- ED can contact the correct provider, review exact records needed, and can evaluate the patient with a different lens to determine the appropriate treatment plan.
Information from each of these sources can be accessed by care team members in one of two ways:

**Real-time PointClickCare notifications, delivered directly to providers at the point of care**
- ER Providers and Staff review the notification within workflow
- Do not login to or document in portal on routine basis

**Logging into the web-based PointClickCare platform**
- Case managers, social workers, and/or community partners receive a notification within workflow (text, email, printer, or EHR)
- Login to the portal for patient information, documentation and updated care insights
- Information shared on network and shared on the notification that is surfaced to the providers at the point of care
Notification ALERT:
• At the top of a Notification will be an alert for the patient who triggered the Notification. This alert will include the visit date and time, patient’s name, and Medical Record Number.
• Key risk factors are highlighted at the top, namely Security and Safety Events

SECURITY AND SAFETY EVENTS:
• A list of any security issues involving the patient at any participating hospitals in the nationwide Collective Network.
• This section includes the date, location, type (i.e., verbal, physical, etc.), and any specifics added to the event. The table to the right will provide an 18-month summation of security events by type.

ED CARE INSIGHTS:
• Care Guidelines eliminate duplicative case management resource expenditure by clearly enabling a single lead case manager to “quarterback” the patient’s care management activities, which leads to a common care guideline across stakeholders.
• Enables more informed decision making with easy to consume, summarized Care Histories, including medical and surgical, infections, chronic conditions, substance use, behavioral, social, and radiation.

RECENT ENCOUNTERS:
• This section will show a patient’s detailed encounter history for a select period.
• Included in this visit summary are the Visit Date, the Location of the visit, encounter type and any available Diagnoses information.

ED ENCOUNTER COUNT:
• This is where you will see a total count, by facilities visited, of known ED visits by the patient within a 12-month period.

CARE TEAM:
• This is where you will find a listing of a patient’s care providers—including Primary Care Provider information—if that information is available in the Collective Network.
• If available, the Provider’s name, Provider type, phone number and service dates will be listed.

Example of a Collective Notification
Collective Systems Integration

ED Track Board Integration

EDO Notification

COLLECTIVE NOTIFICATION 2/24/2021 12:53 Walters, Noel MRN: 34340371

Criteria Met
- 5+ ED Visits in 12 Months
- Security and Safety
- Care Guidelines
- Insights
- History of Housing Insecurity

Security and Safety

Date Location Type Specifics
5/5/20 County Community Hospital Physical Patient physically assaulted a care provider, staff or patient.
1:51 AM

Security Events (12 Mo.) Count
Physical 1

Total 1

Care Insights - Usual State of Health
Last Updated: 7/14/2022 6:40 PM Sutter - Eden Medical Center
- Patient suffered from a CVA in 2020 that left him with residual left sided weakness. Patient is typically alert and oriented x 3. Patient typically presents with altered mental status in the setting of an acute UTI. Patient straight cath's at home.
- Patient has a history of ESRD. Patient is scheduled for hemodialysis on MWT, but frequently misses appointments. Pt is a dialysis patient at US Renal Care - Downtown location. Dialysis SW is xxxx xxxx and can be reached at xxx-xxxx-xxxx

Care Insights - Medical/Surgical History
Last Updated: 7/14/2022 6:40 PM Sutter - Eden Medical Center
- Patient has a history of atrial fibrillation and is taking warfarin 3 mg daily (last updated 1/10/2022). If patient suffers a fall with suspected head injury, please call 911 or take patient to the emergency department.
- Patient experiences prolonged QT intervals when administered Meltopenid. Please avoid if patient experiences acute delirium.
Emergency Department Optimization (EDO) Demonstration
Questions/Next Steps
Success Stories

• St. Anthony achieved a 50% reduction in unnecessary ED encounters from patients identified as frequent users of the ED within six months, a 66% reduction in LWBS rates within 18 months, and $200,000 in cost savings within the program’s first year.

• Legacy Salmon Creek Medical Center achieved an 81% reduction in the ED encounter rate by high utilizers within 18 months, and a reduction in ED encounters by patients with high ED utilization from 3,081 per year to 573.

• In the first year of the program for the State of Washington, Medicaid ED costs fell by nearly $34 million through a reduction in ED visits. ED visits by Medicaid patients declined by nearly 10%, with rates of visits by high utilizers (5+ visits/year) declining by approximately 11%. For less serious conditions, the visit rate decreased by more than 14% over the year. Finally, visits resulting in the prescription of controlled substances fell by 25% for the Medicaid population.
Appendix
Embedded Workflow - Collective Integration via SMART on FHIR

- Direct integration of the Collective Platform within the EMR for content contribution and notification
- Documentation of Security Events, Care Guidelines and Insights from within the EMR is auto-invoked into the Collective Portal
- Role based access – expands the scope of users and engagement for increased coordination of care
- Easier auditability of user interaction and notifications

Examples of Documentation within the EMR
Interested in working with MiHIN?

The first step is to **identify a use case** with a manageable scope that can grow incrementally.

Does my organization have health data that other members of the care team would find valuable or vice versa?

**Why do I want to share the data?**

What is the data going to be used for?

From there, let’s work together to identify policy or governance challenges and figure out how to create a technology solution to enable that data sharing.

What use cases has my organization onboarded to? How is it working for us? What is the value?
The Michigan Health Information Network Shared Service (MiHIN), as the state designated entity for health information exchange and a lead entity in our state’s 5-year HIT Plan, is responsible for understanding the current state of information flow to support end of life care.

Join the workshops to level set on:

- Who is MiHIN, and what role has MiHIN played in ACP to date?
- Historical development of ACP in Michigan and nationally
- Current literature on ACP outcomes
- Difference between ACP as a process and ACP data movement

The goal of these workshops are to understand, from care teams, nurses, doctors, payers and hospital perspectives, what data/documents are important to make available to clinicians, along with when, how and why.