ALL IN DATA FOR COMMUNITY HEALTH
• Community Health Peer Learning Program
• Data Across Sectors for Health

Training and Workflows for End Users

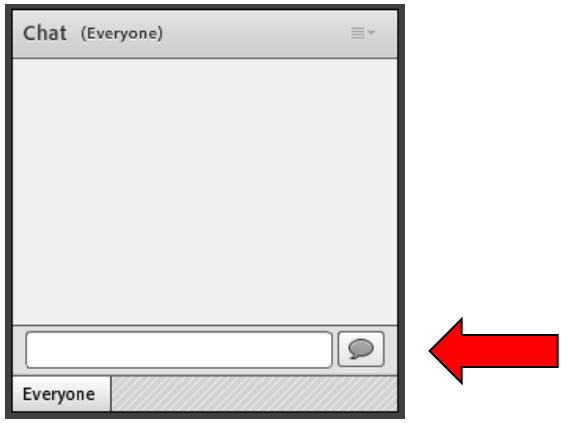
February 23, 2017
12:00 p.m. – 1:15 p.m. ET

Meeting Information

- Conference Line: 1-866-269-6685
- Conference Code: 6763836672#
- Reminders:
  - Please **hard-mute your computer speakers** and the **speakers in the web conference**
  - Please **mute your phone line** when you are not speaking to minimize background noise
- Technical difficulties? Email us at chpinfo@academyhealth.org

Chat Feature

- To share your comments using the chat feature:
  - Click in the chat box on the left side of your screen
  - Type into the dialog box and click the send button
- To signal to presenters you have a question / comment:
  - Click on the drop down menu near the person icon and choose *raise your hand*



We are All In!

COMMUNITY HEALTH PEER LEARNING PROGRAM

NPO: AcademyHealth, Washington DC

Funded by the federal Office of the National Coordinator

10 Participant (planning) & 5 SME communities

BUILD HEALTH CHALLENGE

Funded by 10 national & local funders (including Advisory Board, de Beaumont Foundation, the Colorado Health Foundation, The Kresge Foundation and Robert Wood Johnson Foundation)

18 implementation and planning awardees

DATA ACROSS SECTORS FOR HEALTH

NPO: Illinois Public Health Institute in partnership with the Michigan Public Health Institute

Funded by the Robert Wood Johnson Foundation

10 grantees

THE COLORADO HEALTH FOUNDATION: CONNECTING COMMUNITIES AND CARE

Funded by the Colorado Health Foundation

14 collaborations

All In: Data for Community Health

1. Support a movement acknowledging the social determinants of health

2. Build an evidence base for the field of multi-sector data integration to improve health

3. **Utilize the power of peer learning and collaboration**

Learning Objectives

- Hear three *All In* communities share best practices in approaching information systems training for end users in clinical and social service settings.
- Discuss ongoing challenges and lessons learned in work flow implementation.
- Provide an opportunity for participants to ask questions and dialogue with one another about challenges and opportunities.
- Identify opportunities for next steps/continuing the conversation.

Presenters

Allison C. Kenty
Director of Marketing and Communications
HealthInfoNet

Nate Tyler
Chief Operating Officer,
Simply Connect

Meghan LaMacchia,
Implementation and Account Services,
ACT.md

Sharon Bearor
Clinical Educator,
HealthInfoNet

Susan Richardson
Research Specialist,
Vermont Child Health Improvement Program

HealthInfoNet

Training & Workflow

Working Together Toward Successful Information System Adoption

Sharon Bearor, RN, BSN
Clinical Educator

Allison Kenty
Director, Communications and Marketing

HealthInfoNet & DASH

HealthInfoNet is Maine's statewide Health Information Exchange

- DASH Project
  - Working with an ACO composed of 2 CAHs, 7 FQHCs, 2 CAPs to incorporate SDOH in the HIE & Predictive Analytic tool.
  - Through the use of analytics, ACO members will work to reduce hospital/ED admissions and readmissions.

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Analytics Training

Challenge: Develop a training program around the HIN Analytics Tool, train ACO members on 4 workflows that accomplish DASH goals.

Starting Point:

- No formal training approach, materials
- 1 staff person knowing the tool
- Internal training for Clinical Educator, Director of Client Services, Communications Director
- Develop training program based on user roles
- Develop supporting materials

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Understanding the Scope

- Understand Project Scope (HIN Analytics)
- Scheduled meetings with Project Team
  - Administration/Project Manager
  - Clinical Staff
  - Technical Resources
- Discussion of goals and timelines

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Understanding the Team

- Know the team
  - Roles/ Responsibilities
  - Patient panel and type of practice
- Understand the current work flow and processes
  - Role of the care manager/team
  - Managing their at-risk population
- HIE Audit
  - HIE usage statistics
  - Identify and work to close any education gaps
- Support & Philosophy
  - "I work *for* and *with* you" attitude
  - Support throughout the entire process (before-during-after)

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Training Preparation

- Outline the expectations
  - Time, technical needs, space
- Participants (Who ***needs*** to be at the table)
  - Managers
  - RN's
  - MA's
- Log-in credentials provided
- Prepare educational materials
  - Printed guides
  - Web resources

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Training

- Set-up and log-in
- Introductions
  - Roles
- Presentation
  - Goals (DASH)
  - Workflow examples
- Live Demonstration
  - Show their patient population

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Follow-Up

- Post-Training Communication
  - 2 weeks after training
  - Usage Audit
  - Verify connection for all users
  - Understand barriers, concerns
  - Coach
- Monitor usage
  - Send emails to keep in touch
  - Provide additional training as necessary

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Best Practices

- Get to know the team/develop relationships
- Meet them where they are
- Use real case studies to relate to their specific clinical setting
- Connect with others; share best practices
- Offer CEU for trainings if possible

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Challenges

- Technical implementation completed
- Resources
  - 1 trainer for Analytics & HIE
- Maine
  - Large, rural Northern New England state
- In-person training vs. virtual webinars
- Shoulder-to-shoulder with Analytics users
  - Spend time in their work environment
  - Understand workflows

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Lessons Learned

- Be flexible
- Understand this is another new change and process; be patient and understanding
- Point Person (Super User)
  - Buy-in and continued enthusiasm
- Consistent follow-up critical to success
  - Post implementation project meetings

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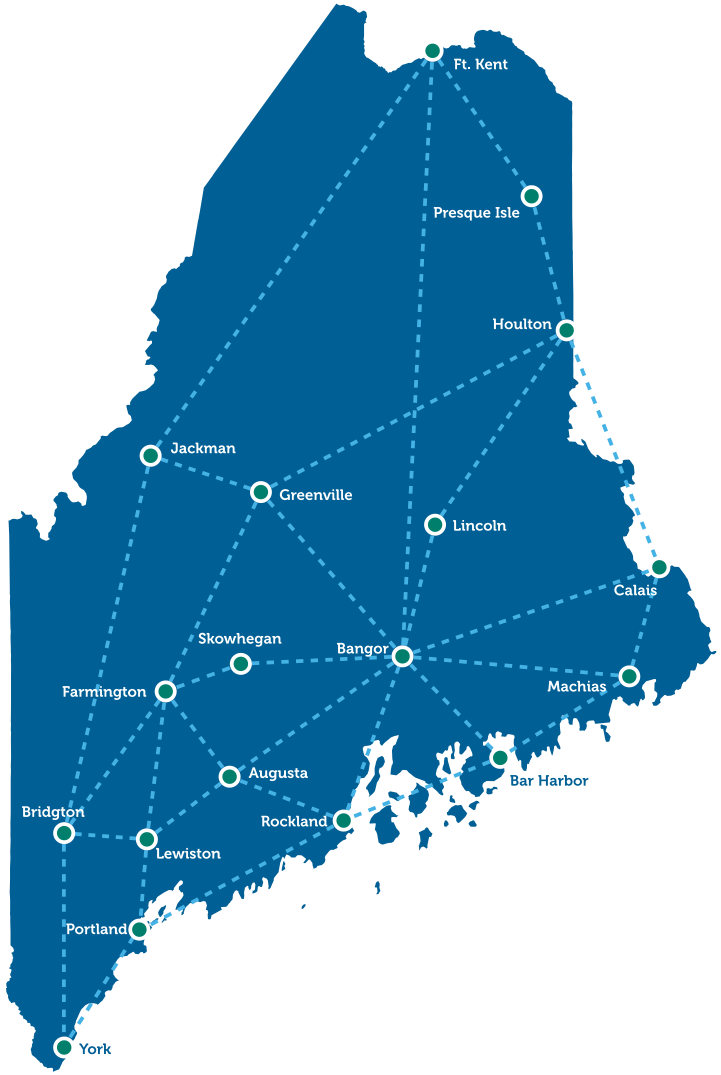

Thank you!

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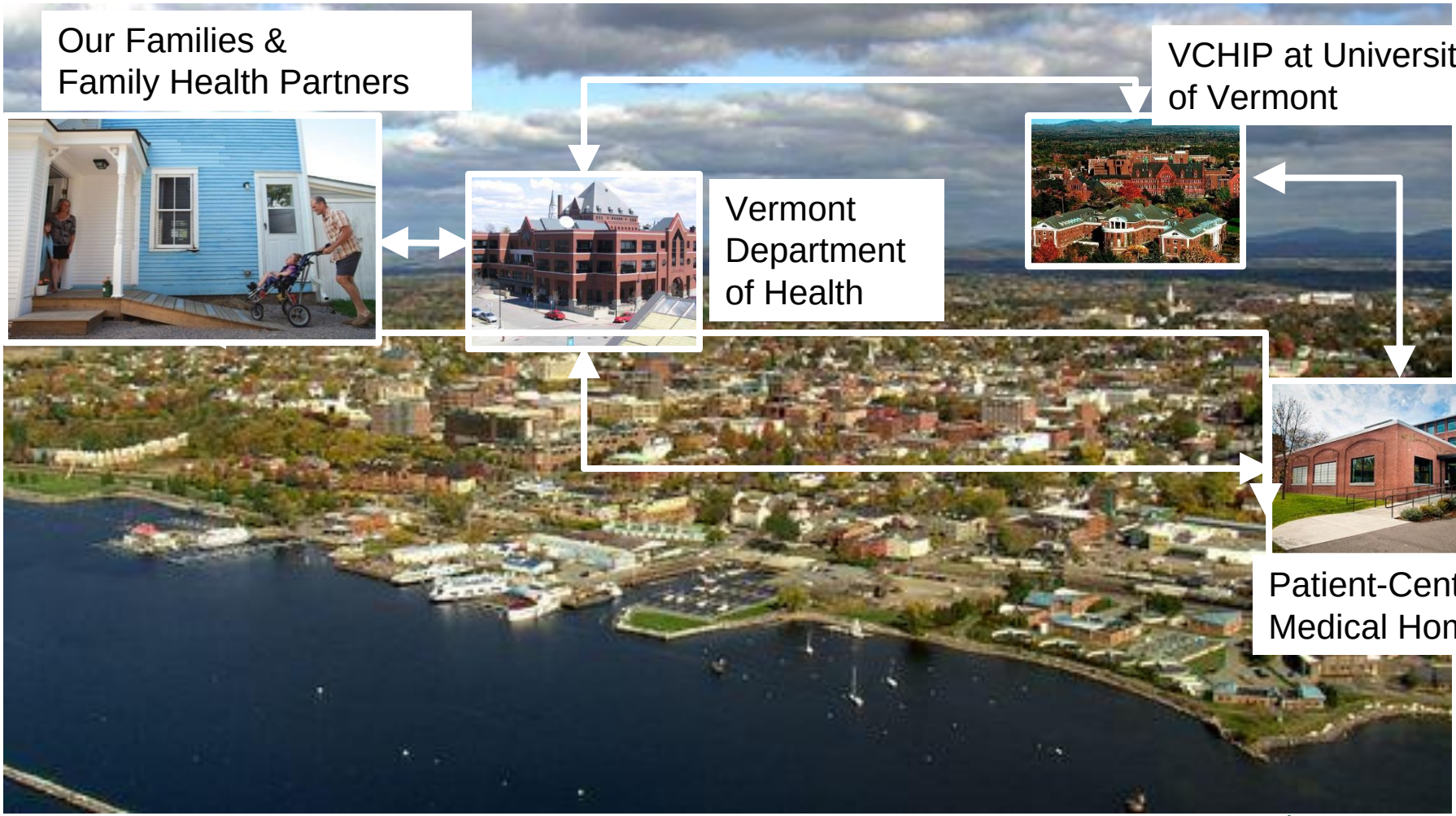
Integrating Electronic Shared Plans of Care into Clinical Workflow

February 23, 2017

VCHIP at University of Vermont electronic Shared Plan of Care (e-SPoC)



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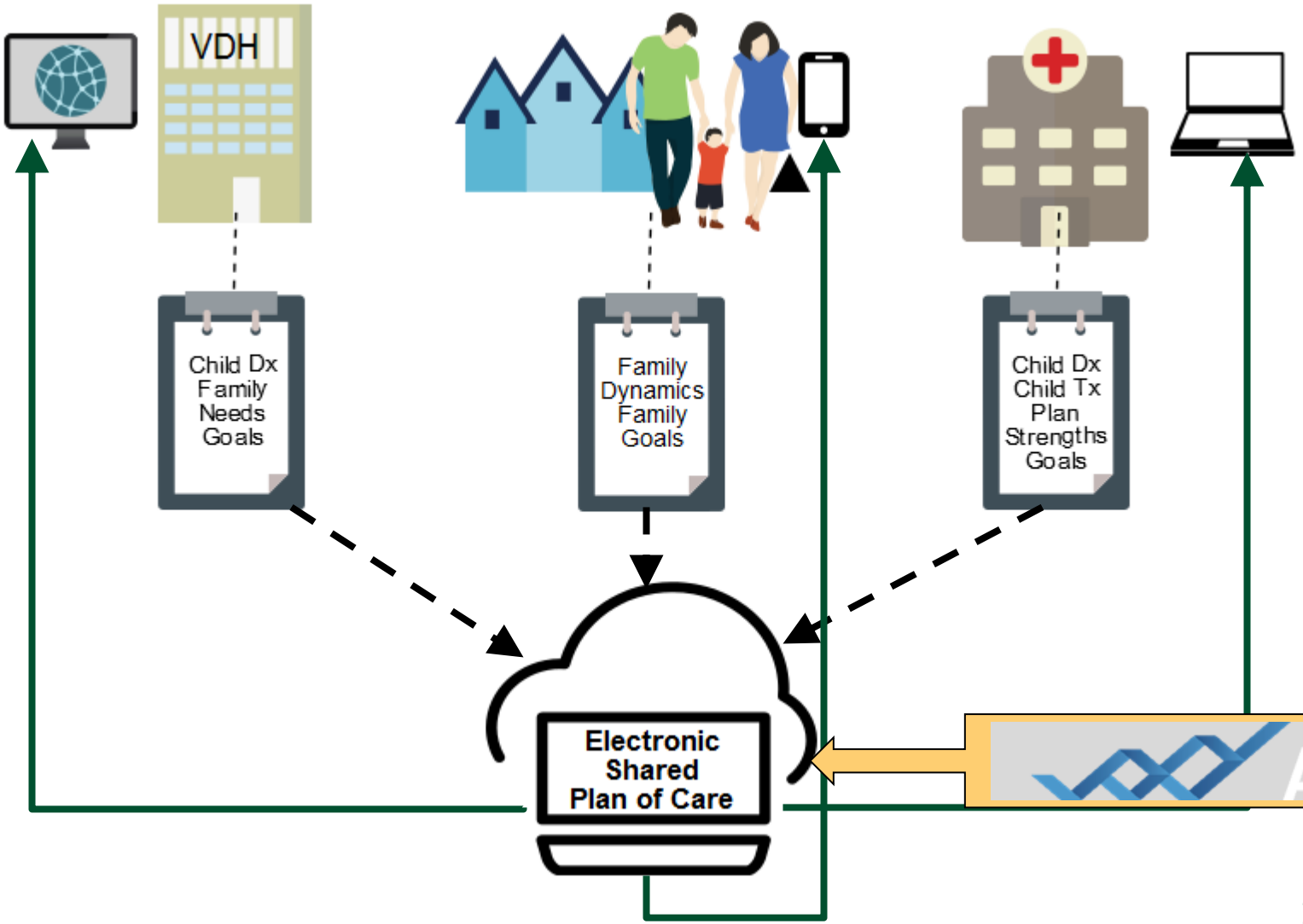
Vermont Child Health Improvement Program
UNIVERSITY OF VERMONT COLLEGE OF MEDICINE

Data Flow Diagram: electronic Shared Plan of Care



VCHIP
Vermont Child Health Improvement Program
UNIVERSITY OF VERMONT COLLEGE OF MEDICINE

Integrating new HIT

Susan Richardson,
Research Specialist

Vermont Child Health Improvement Program

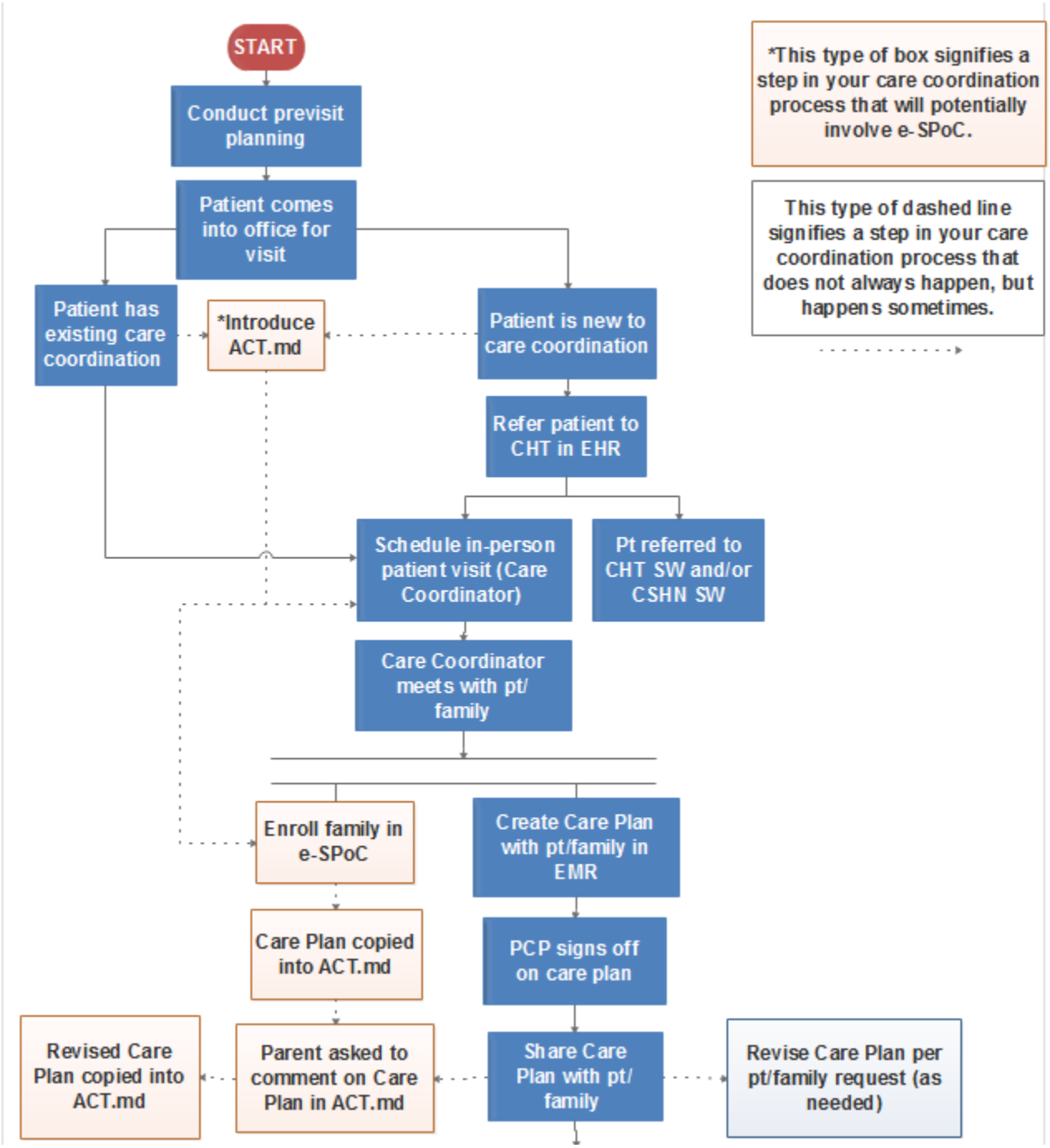
Meghan LaMacchia,
Implementation and Account Services

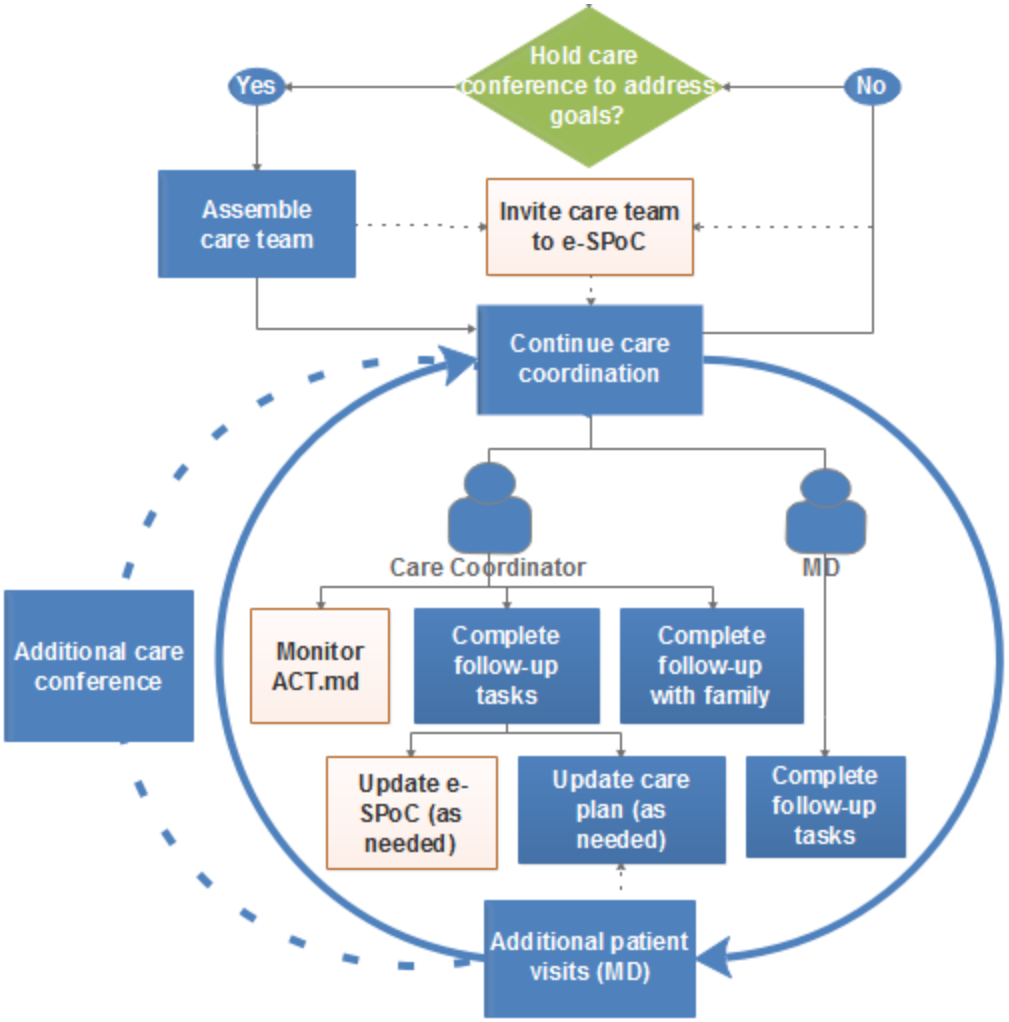
ACT.md

Workflows

The “who, what, where, when and how things get done in your clinic. This includes both clinical and administrative work.” –AHRQ Health IT Tools and Resources Workflow Assessment

- Our Focus
  - How does care coordination happen in your clinic now
  - Highlight areas where new HIT will change/add to workflow


START
Conduct previsit planning
Patient comes into office for visit
Patient has existing care coordination
*Introduce ACT.md
Patient is new to care coordination
Refer patient to CHT in EHR
Schedule in-person patient visit (Care Coordinator)
Pt referred to CHT SW and/or CSHN SW
Care Coordinator meets with pt/ family
Enroll family in e-SPoC
Create Care Plan with pt/family in EMR
Care Plan copied into ACT.md
PCP signs off on care plan
Revised Care Plan copied into ACT.md
Parent asked to comment on Care Plan in ACT.md
Share Care Plan with pt/ family
Revise Care Plan per pt/family request (as needed)
*This type of box signifies a step in your care coordination process that will potentially involve e-SPoC.
This type of dashed line signifies a step in your care coordination process that does not always happen, but happens sometimes.


Hold care conference to address goals?
Yes
No
Assemble care team
Invite care team to e-SPoC
Continue care coordination
Care Coordinator
MD
Monitor ACT.md
Complete follow-up tasks
Complete follow-up with family
Update e-SPoC (as needed)
Update care plan (as needed)
Complete follow-up tasks
Additional patient visits (MD)
Additional care conference

Workflow

Challenges we faced:

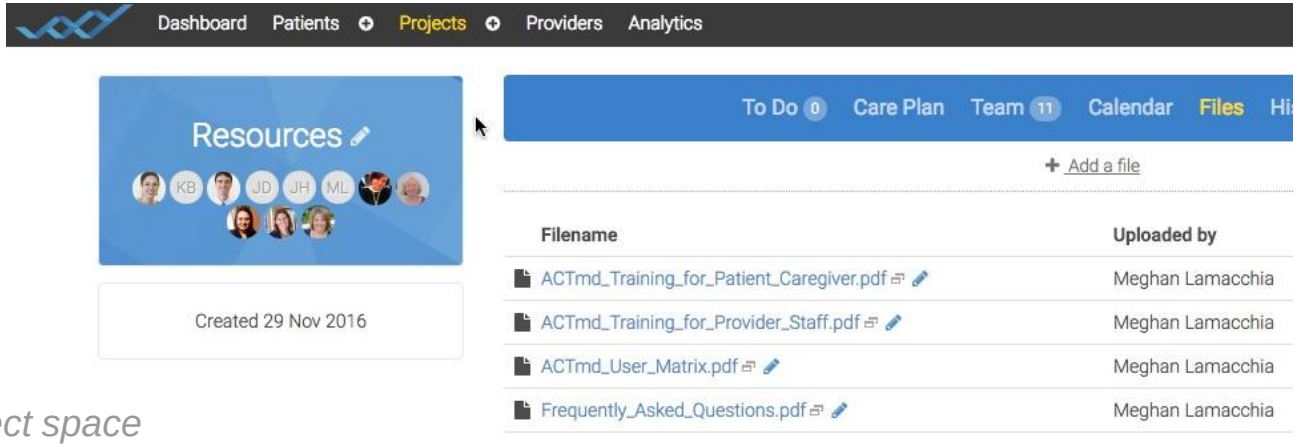
- Different roles=different perspectives
- Big picture vs Little Picture

How we overcame them:

- Review workflow with multiple users
- Group time for big picture review
- Site visits to troubleshoot procedural issues

Training and Support

- Pre-launch: Demo Site
- At-the-elbow training
- Zoom training (online)
- Webinars
- Training Content Development
- Other



ACT.md project space

Training and Support

Challenges we faced:

- External Provider engagement

How we overcame them:

- Explain the value
- Provide user specific training content
- Personalization
- Constant follow-up

Lessons Learned

Workflow

- Take the time to know what you are doing now
- Gather multiple perspectives on workflow

Training

- Formal monthly meetings/practice visits
- Superusers

Resources

Resources

- AHRQ Workflow Assessment for Health IT Toolkit

https://healthit.ahrq.gov/health-it-tools-and-resources/workflow-assessment-health-it-toolkit

- ACT.md

http://act.md/

http://act.md/product/care-coordination-record/

SIMPLY CONNECT
Health Information Exchange

ALTAIR

Event Notification

Patient/Person Receiving Services
[With a PHR]

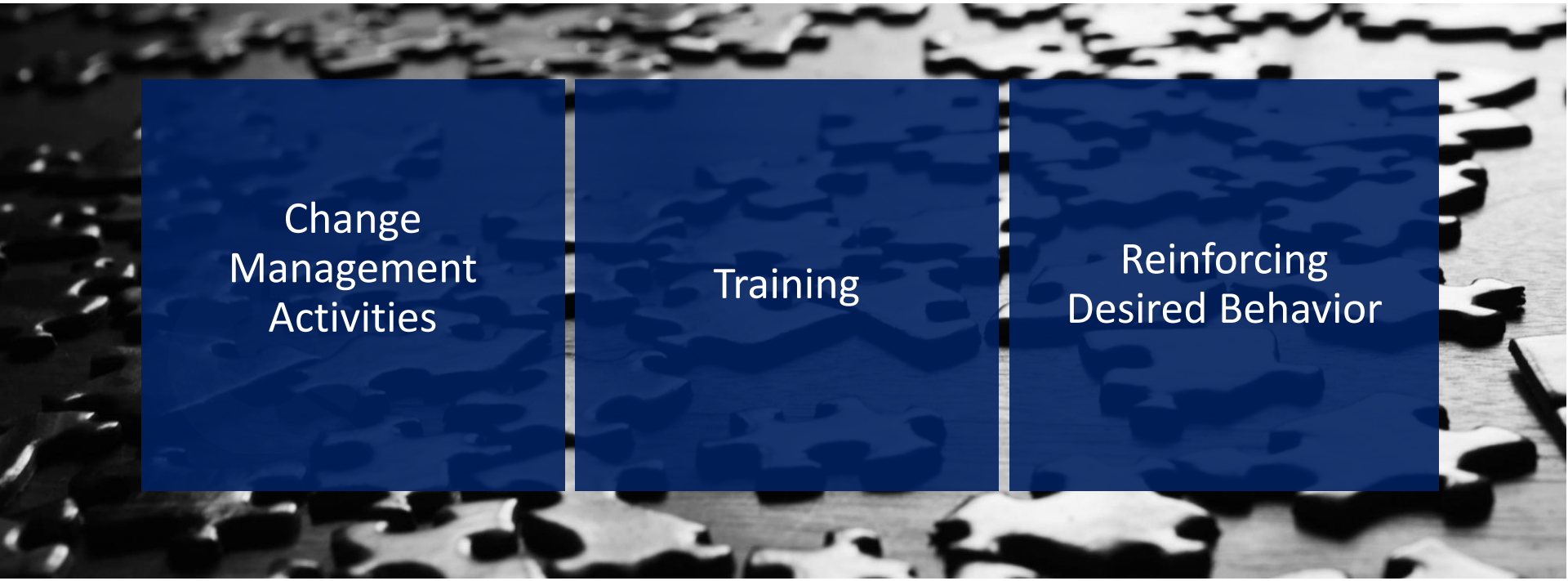
Event Driven Bi-Directional & Actionable Communications

Clearly Defined Care Team

Clearly Defined Events

Life Events	Gen. Change	Med Errors	Adv. Reaction	Coercive Sex	Illness	Accident	Hospitalization
ER Visit	Exploitation	Injury	Depression	Abuse	Srvc Barrier	Behavior Chng	Aggression

Areas of focus



SIMPLY CONNECT
Health Information Exchange

ALTAIR

Change Management

- Ensure each stakeholder group understood the ‘why’
- Demonstrate the wins for each group required to take action
- Create champions at each organizational level

Innovation in Action

Lutheran Social Service of Minnesota is very excited to announce that we are moving forward to connect our systems with the state certified Health Information Exchange, Simply Connect. The decision to connect was driven by our desire to provide the best care possible for the people receiving our supports and comply with the goals laid out by the Centers for Medicare and Medicaid Services (CMS).

Thanks to the support of CMS’s Centers for Medicare and Medicaid Innovation and the Minnesota Department of Health’s State Innovation Model, 100% of cost of this innovative two-year project was funded. As a participating member of the Altair ACO, we see the addition of the HIE as an opportunity to connect with our Altair ACO partners and increase our ability to provide a true continuum of support within a trusted disability competent network. Utilization of the HIE throughout the Altair ACO will enhance our ability to provide an integrated and efficient coordinated care approach.

What is Health Information Exchange?

Electronic health information exchange (HIE) allows doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a patient’s vital medical information electronically. – healthIT.gov

As participants in the U.S. health care system, each time any of us visit a health care or community service provider data is created about details of the visit. Unfortunately, until recently information was held by each provider independently. With Health Information Exchange all of this information can be aggregated into one true picture of your health record.

Why is it important?

- Better communication, increased patient safety and higher-quality of care for the service recipient/patient
- Enables Health Care Providers to access and confidentially share individuals’ vital medical history no matter where they are receiving care.
- Supports safer, more effective care that leads to a more cost-effective health care system
- Provides the individual and their parent/guardian access to their Personal Health Record (PHR) so they always have access to collaborate closely with the care team and their latest medical information.

Functionality will be specifically tailored to meet the needs of a person receiving services in the community. With Simply Connect’s care team management features, the defined care team becomes proactive with situations impacting the recipient’s quality of life, positively or negatively. This will facilitate conversation and actions amongst the care team in a way consistent with a person-centric delivery model.

ALTAIR

Member Organizations and Simply Connect Participants

Bluestone Physician Services

FRASER

Hammer

HealthStar HOME HEALTH

LifeWORKS

LIVING WELL

Lutheran Social Service of Minnesota

MOUNT OLIVET ROLLING ACRES

OpportunityPartners

ube.com/watch?v=XrxXEIFtfoQ

on - https://innovation.cms.gov/

e.mn.us/e-health/

If you have questions, please contact:

Training: College of Direct Support

DirectCourse

SIMPLY CONNECT
Health Information Exchange

ALTAIR

Behavior Change

Project Champions

Incentives

Frequent Reinforcement

Q
&
A

Connect with Us!

- Continue the conversation on the online platform
- Sign up for news from *All In*
- Contact information for speakers
  - Sharon Bearor - sbearor@hinfonet.org
  - Allison Kenty - akenty@hinfonet.org
  - Susan Richardson - susan.richardson@uvm.edu
  - Meghan LaMacchia - meghan@act.md
  - Nate Tyler - nate.tyler@simplyhie.com
- Evaluation
- A resource list, slides, and recording will be available