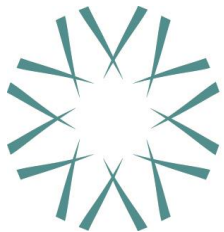


Rural Care Coordination: HIT best practices in rural networks



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Rural Health Innovations (RHI), LLC, is a subsidiary of the National Rural Health Resource Center (The Center), a non-profit organization. Together, RHI and The Center are the nation's leading technical assistance and knowledge centers in rural health. In partnership with The Center, RHI connects rural health organizations with innovations that enhance the health of rural communities.



NATIONAL
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The National Rural Health Resource Center (The Center) is a nonprofit organization dedicated to sustaining and improving health care in rural communities. As the nation's leading technical assistance and knowledge center in rural health, The Center focuses on five core areas:

- Transition to Value and Population Health
- Collaboration and Partnership
- Performance Improvement
- Health Information Technology
- Workforce

Introduction to Care Coordination

*“Care coordination involves two different, but related aspects of patient care. One **provides information to the clinician** who must be able to access from, and provide relevant clinical data to multiple sources in order to determine and provide for appropriate next steps in diagnosis or treatment. The other is to **assure that patients are in the appropriate setting as they transition** among multiple levels of care. Both are important for providing high quality care as well as mitigating excess, both must incorporate patient needs and preferences, and both are highly dependent on the ability to quickly and easily send and query health information on a given patient to and from multiple electronic sources.”*

A Health IT Framework for Accountable Care

https://www.healthit.gov/FACAS/sites/faca/files/a_health_it_framework_for_accountable_care_0.pdf

Introduction to Care Coordination

- Four Components
 - Target Population
 - Children with Type-I diabetes in zip codes...
 - Assessment Tools
 - Internally developed assessment tool, with lab results
 - Care Plan
 - Interdisciplinary Care Team
 - Diabetes Educator
 - Physician
 - School Nurse
 - Others...

HIT is a Critical Component

- Data Collection, Storage, and Evaluation
 - EHR
 - Data repositories
 - Reporting systems
- Communication Systems
 - Direct
 - HIE
 - Others (Fax...)

Value Formula

HIE Health Information Exchange	EHR Electronic Health Records		
	Templates	Clinical Decision Support	Quality Reporting
	CPOE Computerized Provider Order Entry		

Patient Portal

$$\text{Patient Value} = \frac{\text{Quality}}{\text{Cost}}$$

(Arrows indicate that Patient Portal, Clinical Decision Support, and Quality Reporting from the EHR table above point to the Quality component of the formula, and that the Patient Portal also points to the Cost component.)

HIE	Quality Reporting	Materials Management	Improved Processes
	EHR		

This Requires Teamwork!

- Knee-jerk solutions will not work!
 - “Why can’t we just all be on one EHR”?
 - “If we simply all connect to an HIE...”
- Partners will be key.
 - Many may have no, or limited EHRs
 - Some may have additional security regulations (FERPA, 42 CFR Part 2, for example)
- Take incremental steps to make fundamental change!

HIT is a Critical Component

- Let's be comfortable with an incremental approach!
 - Start with the three F's: Fax, Face-to-Face, and Phone
 - Integrate other data sources, such as payer data
 - Work with partners to implement communication technologies, like Direct and HIE

Texas Rural ACO

- Target Population
 - Top 15% of costliest patients
 - Medicare
- Care Team
 - Provider, social workers, transition nurse, care coordinator.
 - Unique for each patient
- How are they leveraging HIT?
 - Templates in EHR for care plan
 - Data repository
 - Claims data analysis

Community Health IT Network

- Target Population
 - Diabetes, behavioral health
- Care Team
 - Case manager, county public health, primary care
- How are they leveraging HIT?
 - Longitudinal health record in HIE
 - Patient data
 - Secure messaging

Critical Access Hospital Network

- Target Population
 - High-need and high health care need patients
- Care Team
 - Case manager, primary care, clinic staff, Therapists, Social Workers, County Public Health, Social Services, Housing, other agencies
- How are they leveraging HIT?
 - Aggregating data from payers and providers
 - Tele-mental health

Trends in Care Coordination HIT

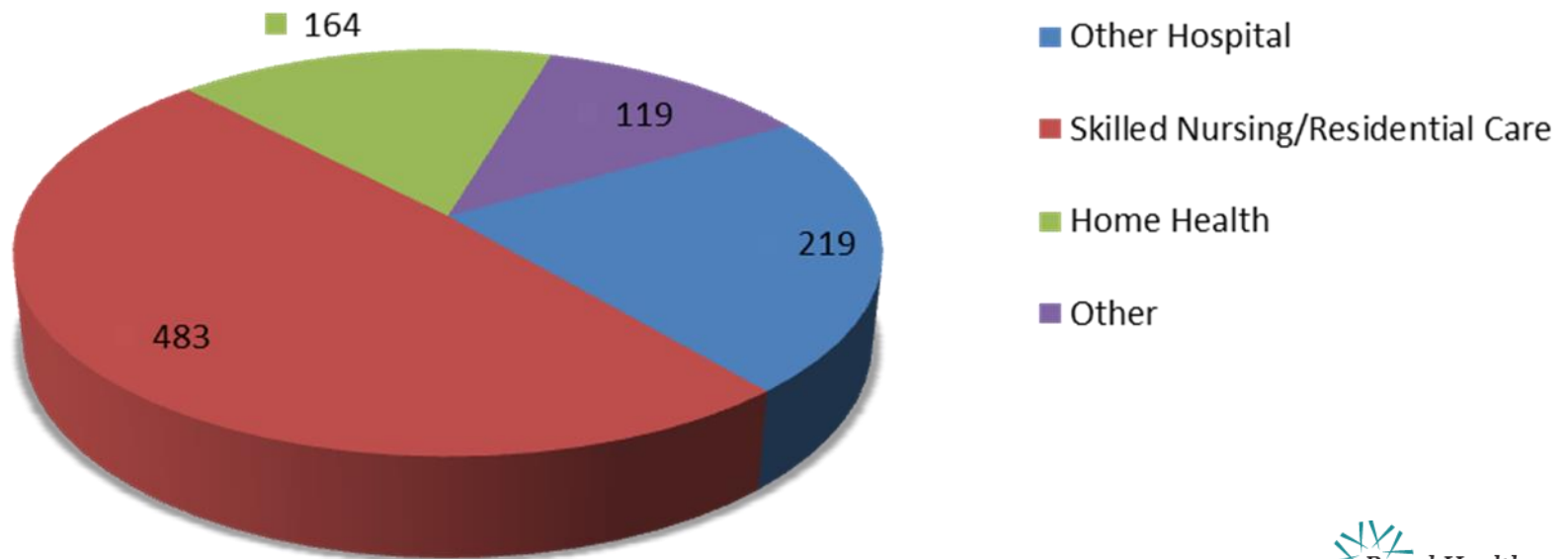
- Data Repository development first, HIE second
- Care Coordination Systems
 - Cloud-based
 - Limited effort to integrate or communicate
 - Very nice systems, but dead ended (for now)
- Direct starting to be used (why so long???)
- Incremental approach being accepted
 - Paper->Fax->Direct->HIE->Patient Portal

Your Next Steps

- Understand Referral Network

Annual Discharges from a Critical Access Hospital
(discharge to home not included)

Summary of Discharges



Your Next Steps

- Understand your target population
- Consider communication needs
 - Incremental approach is best!
 - Fax, secure email, Direct, SMS
- Use the power of the network!
 - Without a network, it is nearly impossible in rural
 - Many of your referral partners/care team may have limited IT capabilities or workforce

Your Next Steps

- Learn about regulations that may impact the care team members
 - HIPAA
 - FERPA
 - 42 CFR Part 2
 - State regulations

Challenges

- Many members of your referral network are not participating in Meaningful Use!
 - Long-Term Care
 - Homecare
 - Hospice
- HIE is not widely adopted
 - Technical reasons
 - Cost
 - “Critical Mass”
- Not everyone is on your EHR!

Resources

(Google Search Terms)

- CCHIT ACO Framework
 - An excellent IT framework for accountable care organizations or any alternative payment method
- Rural Health Networks Care Coordination Framework
 - National Rural Health Resource Center presentation on care coordination models and a framework for creating and improving a care coordination system

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