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
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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

Clinical Setting

- **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.

Transmission from EMR

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

Community Resource

- **CBO**
  - CBO continues to provide DPP, as per evidence.
The How: Data Sharing

**Clinical EMR**
- eClinical Works
- AllScripts
- NextGen
- GE Centricity

**e-Referral System**

- **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

- **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

**CBO Interventions**
- YDPP
- DSME
- CDSMP
- SMBP
- Other Community Resources

*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”

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<thead>
<tr>
<th>Clinical Organizations</th>
<th>Both Clinical and Community</th>
<th>Community-Based Organizations</th>
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<tbody>
<tr>
<td>EMR vendor agrees to EMR modifications in writing</td>
<td>Establish or agree to establish a legal agreement defining their relationship</td>
<td>Have the capacity to handle an influx of referrals for</td>
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<td>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</td>
<td>Are willing to share data with one another</td>
<td>• ADA-recognized / AADE-accredited DSME support programs</td>
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<td>Are willing to share aggregate data with the SHD / NACDD / CDC</td>
<td>• NDPP lifestyle support programs</td>
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<td>• Evidence-based lifestyle programs among patients with high blood pressure or blood cholesterol, including SMBP with clinical support</td>
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- 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

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

2019

January - April
- Conduct IT assessment and implementation at clinical sites

May - June
- Hold trainings, go live with initial community/clinical linkages

Implementation wind down and initiate maintenance phase
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.
FAQs – e-Referral Gateway

Q: What do you need to use the e-Referral Gateway? How are users trained?
A: Access to a web browser such as Google Chrome; training on use provided by NACDD

Q: Who uses the e-Referral Gateway?
A: Typically it is CBO staff who receive and send data via the eRG. Roles should be clearly defined within the workflows established

Q: Aren’t there patient confidentiality issues?
A: Not if handled appropriately. Community e-Connect is HIPAA compliant, patient information is blinded, and consent recorded
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 2\(^{nd}\):** complete eligibility survey

• **May 9\(^{th}\):** 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?