SOUTHERN PRAIRIE COMMUNITY CARE

MONTHLY NEWS BRIEF

July 2017

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OUR STORY

Welcome to Southern Prairie Community Care's monthly news brief. We are excited to share our current plans and results of our work with you. If you see something of interest, have questions or want to contribute to our monthly update, please contact us by phone or email. If you would like to be added to our email list for future monthly updates, please email us at info@southernprairie.org.

Please share our Monthly News Brief with your staff, colleagues, and cohorts.

INTEGRATED COMMUNITY CARE PROGRAM UPDATE

Southern Prairie is excited to share our most recent staffing update, we have filled the Worthington integration coordinator position! **Terri Janssen** recently joined our staff, bringing with her an array of experience. Terri has worked in acute care, long term care, school nurse, home care and case management. She most recently has worked within the Public Health arena in Nobles County as their director. Terri's diverse experiences and knowledge of the community needs in Worthington make her a perfect fit for the integration coordinator role.

Sterling Drug will be Terri's home base and SPCC is thrilled at the new partnership and potential that this arrangement will offer. Having an understanding about the work that Southern Prairie is doing has allowed Terri to hit the ground running! She can be reached at 507-591-2572 and is available for referrals or possible questions about care coordination resources and opportunities. Terri and her husband reside in Worthington. They have 3 children, 10 grandchildren, 9 living ages 1 ½ - 21. In her free time, Terri enjoys spending time with her family, time in the garden and sewing. Please help us welcome Terri to Southern Prairie!

Members of the Integrated Care staff recently partnered with our Population Health business area and kicked off the start of a year-long commitment with a *Prevent T2* course, previously known as the *I Can Prevent Diabetes* course. The *Prevent T2* is a one year collaborative, community-based, lifestyle change program designed for people with pre-diabetes. Cindy Jurgenson and Lyndsey Brown, trained National Diabetes Prevention Program Lifestyle Coaches, will facilitate the course weekly for 16 weeks and then monthly for the remainder of the curriculum. The course is being offered in Willmar with potential for additional classes in other communities in the future.

Open Door Health Center will be offering a Kids' Health Fair on Friday, August 4th from 12:00 pm – 7:00 pm. See below for more information.

HEALTH INFORMATION EXCHANGE AND ANALYTICS UPDATE

The HIE platform, CareTrac, was launched on August 15, 2016. Since that time, CareTrac has fully implemented 10 facilities, with seven more expected to be completed by September, 2017. For this update, we are going to provide a breakdown of the organizations that have been onboarded, those that are currently in-progress, and some of the high level transactions that makes CareTrac run!

Organizational Breakdown

The following is a breakdown of the organizations that have been integrated into the HIE.

- Kandiyohi Health and Human Services
- Montevideo Hospital
- Montevideo Clinic
- Redwood Area Hospital
- Southern Prairie Community Care
- Des Moines Valley Health and Human Services
- Southwest Health and Human Services
- Nobles County Health and Human Services
- Greater Minnesota Family
- Southwest Mental Health

2 Hospitals, 1 Clinic, 2 Mental Health, 4 HHS, 1 IHP.

The following seven additional organizations are currently in the process of being implemented/on boarded.

- Western Mental Health
- Woodland Centers
- Murry County Medical Center
- Cook Area Health Services
- Lake Superior Community Health Center
- Sawtooth Mountain Clinic
- Community Health Services

CareTrac was the first HIE in Minnesota to integrate behavioral data into a patient HIE record. Additional sites are slated for implementation Fall of 2017.

How Does All This work? Transactions, Services, Use

Organizations that have been implemented/on boarded into CareTrac will at a minimum be transmitting both ADT (Admissions-Discharge-Transfer) and CCDs (Continuity Care Documents). Both of these transactions are extremely important for a HIE.

Transactions

ADT messages are used to exchange the patient state within a healthcare facility. ADT messages keep patient demographic and visit information synchronized across healthcare systems. These messages are typically initiated by the Healthcare Information Systems (HIS), or a registration application, to inform a HIE that a patient has been admitted, discharged, transferred, merged, that other demographic data about the patient has changed (name, insurance, next of kin, etc.) or that some visit information has changed (patient location, attending doctor, etc.). These transactions are sent in real-time whenever the patient's record has been updated. CareTrac also uses ADT messages to deliver event notifications. These notifications are delivered to specific SPCC Care Team members when a high risk client has been admitted into the emergency room. Generally, these notifications are sent out within 60-90 seconds after ER admission. ADT Alerts went live with CareTrac on June 19, 2017.

A CCD is a clinical summary document that provides information about the patient in a structured format. These documents generally contain information regarding the patient's demographics, allergies, medication, problems, procedures, diagnosis, and other relevant clinical information. These documents are submitted to CareTrac upon patient discharge. If the sending organization has the ability to facilitate bi-directional exchange, CareTrac upon patient admission, will send the organization a consolidated CCD of all new relevant information about the patient that has been aggregated from other HIE partners. This information is integrated directly into the participants EMR and does not require them to go outside of their normal workflow. CCDs are also used heavily in analytics as the information that is contained in them can be parsed and extracted for advanced analytics purposes.

Services

CareTrac provides query based exchange access to all HIE participants. This means if a participating healthcare provider has the necessary consent for the patient, they will be able to query the HIE for all clinical information that has been submitted for the patient from other participating HIE organizations. Currently all CareTrac participants are using the HIE in this form. Additional services include ADT alerts (discussed above), and Advanced Analytics. The goal of CareTrac Analytics is to provide SPCC with the ability to manage the performance of their Integrated Health Partnership (IHP) through continuous evaluation of quality, financial performance, and related factors at the IHP and provider level, and to develop and evaluate intervention strategies aimed at improving quality and financial outcomes. This is completed by marrying IHP source data sent from DHS (usually 90 days old) with more real-time data extracted from the HIE.

Use

Currently all stated HIE participants are actively using the query base exchange. This functions allows them, with proper consent, to review all clinical information about the patient that has been aggregated from other HIE partners. ADT Alerts were officially launched in June 2017. SPCC Care team members are actively using this service for high risk members that are admitted into the ER. The service will be rolled out to all HIE partners in the next 30-60 days. HIE Patient Portal will be launch in October, 2017. This patient portal is unique from others as it will incorporate dates sources beyond a single healthcare systems, but display a universal record for the patient from all HIE partners. This will give the patient a much more comprehensive view of their clinical history and also allow them to reach out to their provider directly from the portal. Advanced Analytics will launch by the end of August, 2017. Initially these reports will only be available to SPCC staff, but the goal is to roll out organizational reports for each IHP member in the Fall of 2017.

Southern Prairie Center for
Community Health Improvement
Improving Together

At CCHI we believe that good health evokes purpose and value. Our solutions to health are original and community-based.

Through wellness learning experiences, cultural liaison services, and trauma-informed community practices good health is achieved.

JULY 2017 CCHI NEWS

Population Health

Staffing Update

This month we welcome **Trista Radunz** to the Southern Prairie team. Trista is housed in the Willmar office and will be acting as a Program Coordinator managing business for the Center for Community Health Improvement and engaging in marketing and communications across the SPCC business areas. She joins us with experience in business management, marketing, and communications in various roles. For the past three and half years, Trista worked in many capacities with Kandiyohi County Public Health. Her primary roles were to support Women, Infant, and Children (WIC) clinic and events and develop outreach strategies to serve as many people as possible face-to-face in the Public Health offices as well as in community or home-based visits. Prior to Public Health, Trista worked for several years in marketing and business management at Jennie-O Turkey in Willmar, MN. Trista and her family (husband and two daughters) live just outside of Willmar. They are a very active family in the Willmar community in addition to the Southern Prairie region as a whole. Please join us in welcoming Trista to the team!

3 years ago the Population Health program began to address the need to prevent and reduce Prediabetes and Type 2 Diabetes. Since then, our team has established a formal wellness program that provides lifestyle change education to anyone across the 12-county region. Check out a snapshot of where we came from and where we are now.

Project Initiation:

- **Preventative medicine**
- **Health concern:** Type 2 Diabetes
- **Target population:** people at risk to develop prediabetes or a diagnosis of prediabetes.
- **Base of evidence**: elevated blood glucose levels and/or CDC lifestyle risk factor questionnaire
- **Additional factors:** overcoming social determinates of health for access to health education

Program Development:

- **Wellness Cultivation**
- **Goal**: Prevent and reduce the onset of Type 2 Diabetes and other chronic disease.
- **Services**:

Prevent T2 (Formerly I Can Prevent Diabetes [ICPD])

- 1 year long program - 4 months of weekly meetings and 8 months of monthly meetings
- National Diabetes Prevention Program evidence-based curriculum
- Goals
- 5% - 7% weight loss
- 150 minutes/week of physical activity
- Increased intake of fruits and vegetables

Reimagine Wellness

- 4-6 week program
- CCHI lifestyle change education (currently in a pilot project phase)
- Goals
- Eat better, move more
- Improved health, decreased stress, increased sense of overall well-being

To date, we have supported or partnered in hosting 10 ICPD or Prevent T2 courses and 3 Lifestyle Coach trainings. We have hosted 6 Reimagine Wellness classes since development in April will offer a new class in Willmar on August 2nd. Class locations, dates, and times are typically determined through community requests or through data driven intervention strategies and outreach in partnership with the Integrated Care business area.

If you are interested in attending or hosting classes, please contact Samantha, Luci, or Trista.