6th Annual HIT Symposium

Data & Technology to Support Health Equity

October 6, 2022

Arizona Alliance FOR COMMUNITY HEALTH CENTERS

HEALTHY COMMUNITIES COLLABORATIVE NETWORK

NEVADA PRIMARY CARE ASSOCIATION

AGENDA

7:00 – 8:00am PT	**Registration & Breakfast** Breakfast sponsored by: MedCurity, Inc
8:00 – 8:05am PT	**Welcome** Lindsay Dietz, HCCN Project Director, Arizona Alliance for Community Health Centers
8:05 – 8:40am PT	**Keynote | Addressing Behavioral Health Informatics in CHCs: How Data and Value-Based Care Can Enhance Treatment** Margaret (Peggy) O'Brien, Social Science Analyst, Office of Evaluation, Center for Behavioral Health Statistics and Quality- DHHS/SAMHSA Objectives: • Understand the critical need for integrated care • Understand how data can inform treatment and care integration • Identify the potential role/use of technology and value-based care model in data-informed treatment
8:40 – 9:30am PT	**Value-Based Care as a Health Equity Strategy** Mark Stephan, Chief Medical Officer, Equality Health Objectives: • Learn how to understand your population • Obtain tips on preparing for value-based contracting and identify how to turn a value-based contract into value-based care • Understand how to measure progress • Understand how to define and measure health equity • Identify the keys to making a difference
9:30 – 10:05am PT	**The Right Balance: Human-Technology Based Outreach Approaches to Increase Engagement** Rogelio Pena, Director of Clinical Outreach Solutions, Equality Health Objective: • Understand how you can leverage digital health tools to achieve patient engagement
10:05 – 10:20 am PT	**BREAK**
10:20 – 11:05am PT	**Surviving and Learning From a Ransomware Event** Jake Wahrer, Vice President of Infrastructure and Technology, Northern Nevada HOPES Clinic Objectives: • Understand the impact of an FQHC ransomware event on patient care • Identify how to prevent and reduce the financial risk of a ransomware event to an organization
11:05 – 11:50am PT	**Arizona HIE Updates and the CommunityCares SDOH Platform** Peter Steinken, Director of Community Development, Contexture (Health Current) Andrew Terech, Director of SDOH, Contexture (Health Current) Objectives: • Obtain updates on Contexture, its current HIE programs, and new HIE offerings • Learn about CommunityCares and how AHCCCS is investing in SDOH for Arizona • Discover the CommunityCares program goals and timeline for implementation • Identify how you can participate in the CommunityCares network

AGENDA

11:50am – 12:35pm PT

LUNCH
Sponsored by: i2i Population Health

12:35 – 1:20pm PT

Population Health Platforms: The Key to Improving Health Equity
Jodi Tate, Population Health Director, Canyonlands Healthcare
Objectives:

- Understand how data analysis can be used to inform patient outreach
- Learn how to utilize cohorts to compare patient outcomes
- Discover how custom dashboard optimizes how you share and track your performance

1:20 – 1:55pm PT

Connecting Your Population Health Tool Data to Your Care Management Program
Amanda Parrell Kaczmarek, Program Manager, Progressive Community Health Centers, Inc & Lieah Wilder, Performance Improvement Program Manager, Wisconsin Primary Care Association
Objectives:

- Understand the steps to establishing a Care Management Program highlighting hypertension and self-monitored blood pressure
- Receive an introduction to HIT and population health tools utilized in clinical and outreach workflows
- Identify evaluation considerations and reporting needs

1:55 – 2:10pm PT

BREAK

2:10 – 2:55pm PT

From Data to Understanding: The DataOps Journey
Gevork Harootunian, Director of Data Science, Decision Center, Arizona State University
Objectives:

- Understand DataOps and why we need it
- Understand the difference between data and understanding
- Discover combining data to enhance understanding of complex systems
- Identify how to design visualizations to match purpose and audience

2:55 – 3:30pm PT

Closing the Gaps to Achieve Better Outcomes and Health Equity
Adam Basua, Manager Allscripts, Ambulatory Medicine Community Memorial Health System & Steve Kim, CEO & Co-Founder, Voluware
Objectives:

- Determine data is the first step in understanding where to focus
- Understand approaches must be tailored to the population
- Identify how technology is an indispensable tool
- Understand how partnership boosts the impact of the work

3:15 3:35pm PT

HCCN Update

3:35 4:00pm PT

Group Discussion & Wrap-Up

Arizona Alliance
FOR COMMUNITY HEALTH CENTERS

Primary Healthcare for All

2022 HIT Symposium

October 6, 2022

700 E. Jefferson St. | Suite 100 | Phoenix, AZ 85034 | Main: 602.253.0090 | Fax: 602.252.3620 | www.AACHC.org

Thank you to our Breakfast Sponsor!

Housekeeping

- Location of restrooms
- Format for Q&A
- Evaluation
- Certificate of Participation
- Slides

Welcome

Lindsay Dietz, HCCN Project Director

HEALTHY COMMUNITIES
COLLABORATIVE NETWORK

Addressing Behavioral Health Informatics in CHCs: How Data and Value-Based Care Can Enhance Treatment

A Presentation to the 2022 Arizona Alliance for Community Health Centers HIT Symposium

Margaret (Peggy) O'Brien (CBHSQ OE)
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

October 6, 2022

SAMHSA
Substance Abuse and Mental Health Services Administration

Road Map

- Why integration of physical and behavioral healthcare is vital
- How data can inform integrated care
- The role of value-based care in data-informed treatment
- The bigger picture

Why integration of physical and behavioral healthcare is critically important

What is integrated behavioral healthcare?

Integrated behavioral healthcare is the blending of care for both physical and behavioral health conditions in one setting.

According to the Agency for Healthcare Research and Quality:

- Providers practicing integrated behavioral health care recognize that both medical and behavioral health factors are important parts of a person's overall health.
- Medical and behavioral health clinicians work together as a team to address a patient's concerns.
- The advantage is better coordination and communication, while working toward one set of overall health goals (AHRQ, n.d.).

How common are co-occurring conditions?

- **Eight out of ten** adults hospitalized with a behavioral health disorder also have at least one physical health disorder (Owens PL et al., 2018).
- **Three out of ten** adults with a physical disorder have a mental disorder (Hagerty SL et al., 2019).
- Among Medicaid's highest-cost beneficiaries with disabilities, **six out of ten** have co-occurring physical and behavioral health conditions (Hagerty SL et al., 2019).

What are some common co-occurring conditions?

- A few examples include:
  - Increased risk of cardiovascular disease, diabetes, stroke, and metabolic syndrome for people with many serious psychiatric conditions (Pennix BWJH et al., 2018)
  - Serious brain damage associated with opioid overdose (Winstanley EL et al., 2021)
  - Injuries to the brain, heart, liver, and other organs associated with chronic alcohol use (National Institute on Alcohol Abuse and Alcoholism)

Effects of COVID-19 pandemic on behavioral health

In the last quarter of 2020, a large portion of the U.S. population reported behavioral health events that they experienced as due to the pandemic:

- Negative effect on emotional or mental health: **73.0%** (adults)
- Negative effect on emotional or mental health: **69.1%** (ages 12-17 years)
- Adults with serious thoughts of suicide: **21.1%**
- Adults who made suicide plans: **8.5%**
- Ages 12 and older, used drugs a little more or much more: **10.3%**
- Ages 12 and older, used alcohol a little more or much more: **15.4%**

Data are from the final quarter of 2020 (SAMHSA (Jan. 2022). Results from the 2020 National Survey on Drug Use and Health: Detailed Tables (Tables 13.1B, 13.2B, 13.5B, 13.7B). Available at https://www.samhsa.gov/data/report/2020-nsduh-detailed-tables).

How common are gaps in available treatment?

In its 2021 report on *Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration*, the Bipartisan Policy Center found that, prior to the pandemic:

- **57%** of adults with a mental disorder and nearly **90%** of those with a substance use disorder were untreated.
- Behavioral health provider workforce shortages were a common barrier, especially for youth and people in rural areas.
- Barriers to behavioral healthcare are often even greater in under-resourced populations, due to lack of access to adequate services, lack of culturally and linguistically competent providers, and complex social needs.

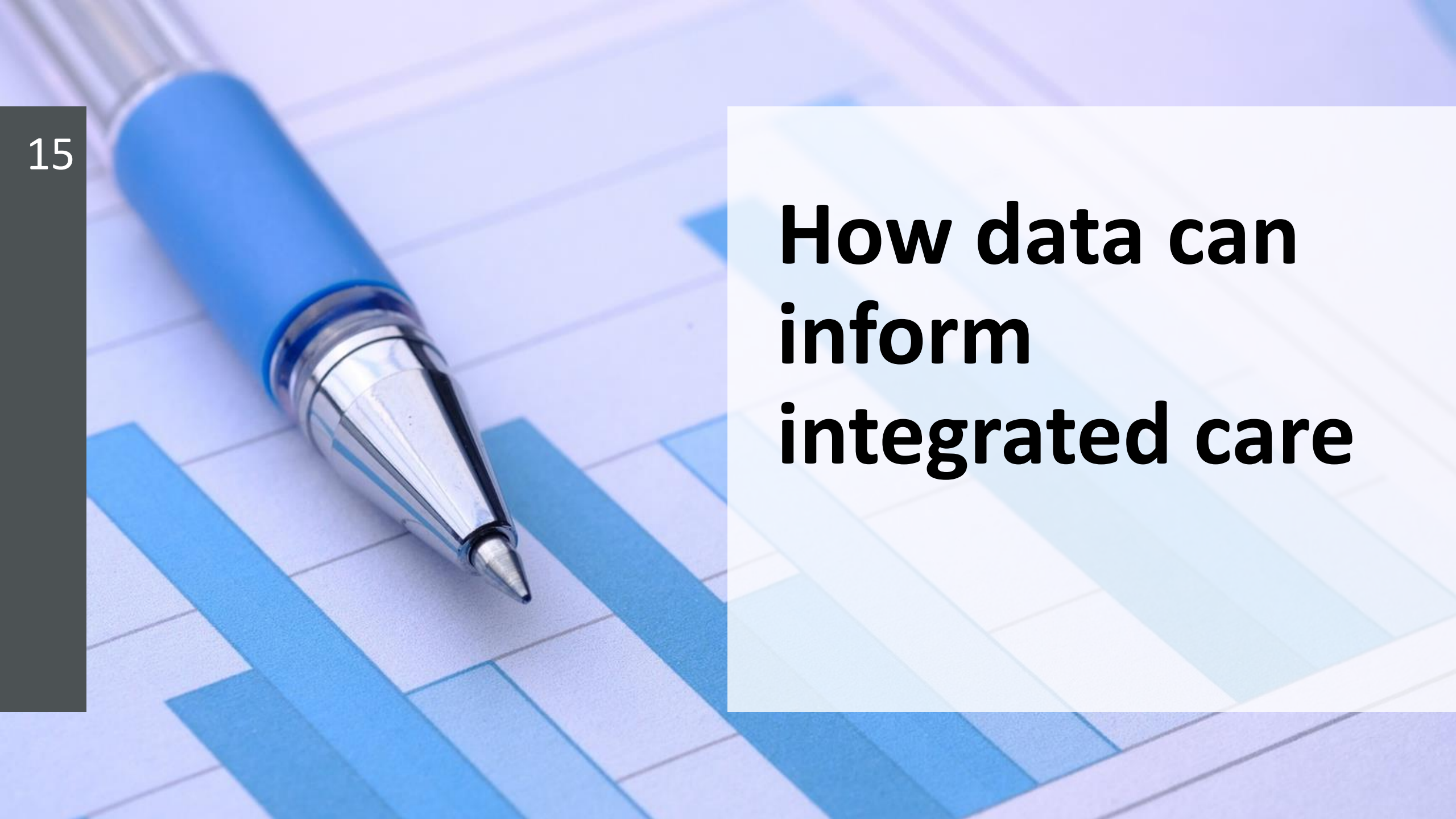
What costs are associated with co-occurring conditions?

Co-occurring conditions are associated with both economic and noneconomic costs:

- Economic: Among adults with co-occurring conditions, **nonbehavioral health care constitutes the predominant expense** (e.g., out of total health care spending among adults treated for behavioral health disorders in 2010-2013 ($672.4 billion), only 15% ($101.2 billion) was for BH care) (Thorpe K et al., 2017).
- Noneconomic: Individuals with severe mental disorders die **10 to 20 years earlier** than the general population (Liu NH et al., 2017). Families and communities experience many other losses and noneconomic costs.

Integrated healthcare is a SAMHSA priority

- Integration of behavioral and primary healthcare is a major focus of SAMHSA's work.
- A few examples of SAMHSA work in that area include:
  - The SAMHSA National Center of Excellence for Integrated Health Solutions
  - Promoting Integration of Primary and Behavioral Health Care (PIPBHC)
  - The Certified Community Behavioral Health Clinics (CCBHCs) incorporation of primary care screening into behavioral healthcare settings

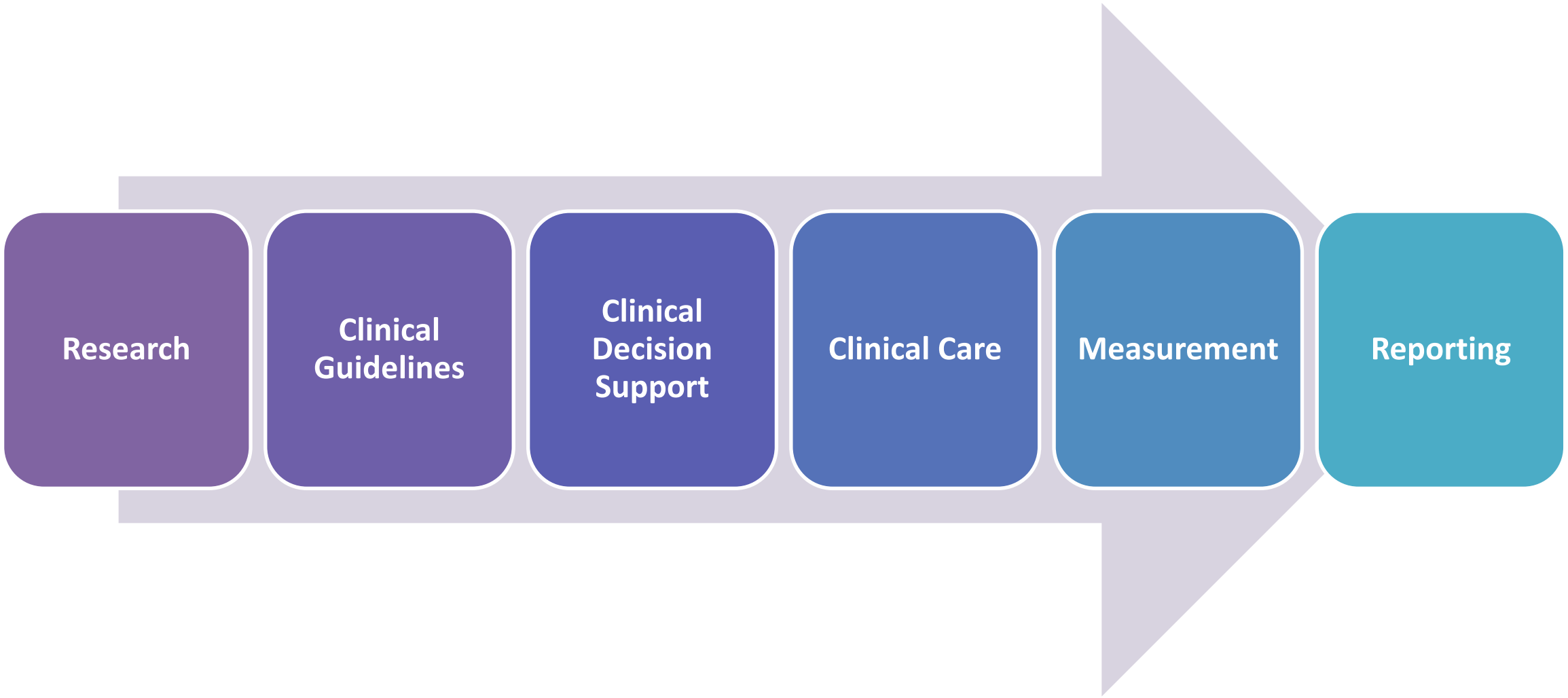


How data can inform integrated care

Assumptions

- You are all at different stages in the extent to which you are providing integrated physical and behavioral healthcare.
- Your use of data to facilitate integrated healthcare likely varies.

In (Someone's) Ideal World …



SAMHSA
Substance Abuse and Mental Health Services Administration

How data might inform and enhance integrated care

- Assessment of need in the community:
  - Service needs for primary and behavioral healthcare vs actual service availability ==> Gaps to fill
- Measurement-based care to guide individualized care planning, care delivery, and assessment of progress
  - Example for a primary care setting: clinically appropriate repeated administration of standardized instrument such as PHQ-9 or report of need related to social determinants of health
  - Example for a behavioral health setting: clinically appropriate repeated measure of HbA1c
- Measurement of access to and use of integrated care (at clinic, health system, or state level)
  - Examples might include timely measures of (1) follow-up after hospitalization or emergency department visits or (2) use of specialty services to which referred

What are some infrastructure and regulatory challenges to making this work?

- Providers without an EHR or sufficient broadband capability
- Workforce shortages (internal and for referral)
- Lack of interoperability between EHRs
- Lack of other data linkages (hospital, ED)
- Privacy requirements
- Reimbursement issues
- Other challenges

The role of value-based care in data-informed treatment

What is value-based care?

- Value-based care is usually thought of in the context of a system that incentivizes quality healthcare and, typically, seeks to reduce ultimate costs.
  - Depending on the source, the incentives may involve:
    - payments to providers or health systems that offer higher quality services, and/or
    - public reporting that permits open comparison
  - Either approach relies on data to measure some aspect of quality.

Is there another way to think about value-based care?

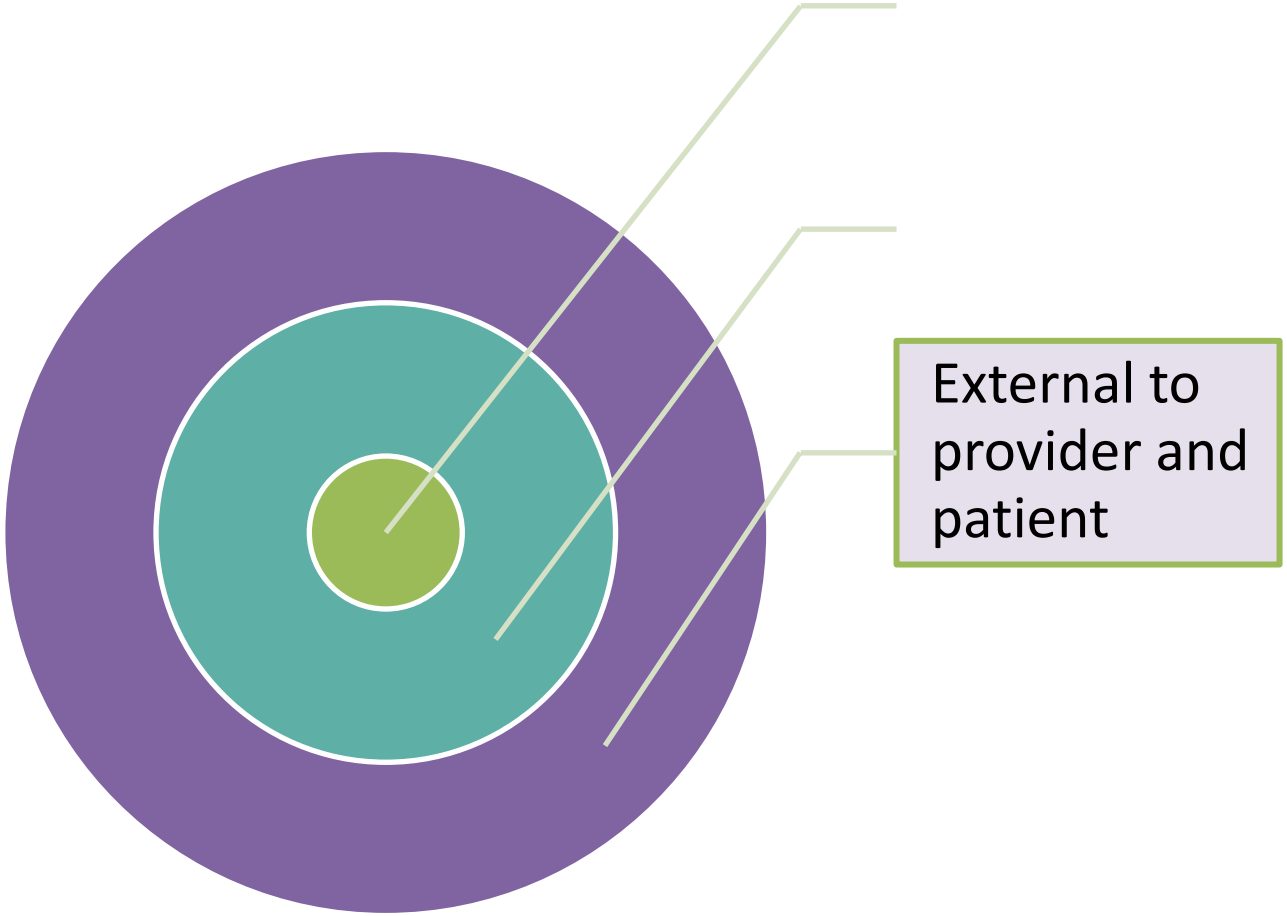
- Thinking beyond monetary incentives or public reporting, consider whether value-based care could be:
  - Internal/non-public feedback (using data) to individual providers to incentivize quality improvement
  - Individual providers who are personally incentivized towards continued improvement or guided towards clinical next steps by seeing results reflected in data
  - Individual patients or clients incentivized towards further progress by seeing results reflected in data (shared decision-making based on data)

Key questions

- What is the value? Higher quality integrated care, better patient outcomes, reduced cost?
- Who benefits from the value? The patient, provider(s), health care system overall?
- Is it value gained from continuous quality improvement based on data?
- Is it inherent value in the form of improved service quality at the provider or clinic level?
- Is it value that rests on public monitoring, comparison, and/or monetary incentives?

The bigger picture

What does data mean in the life of a patient or client?



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Substance Abuse and Mental Health Services Administration

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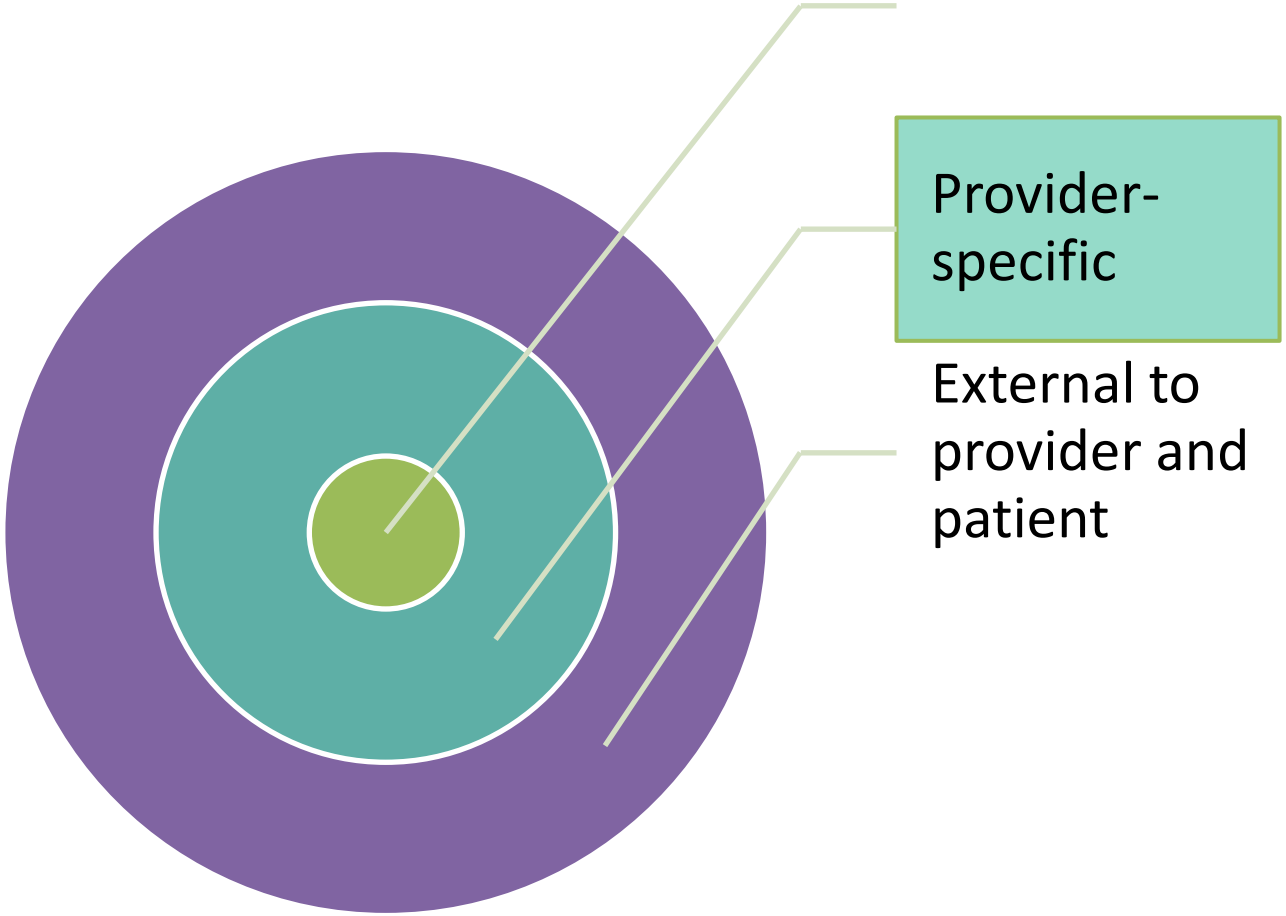

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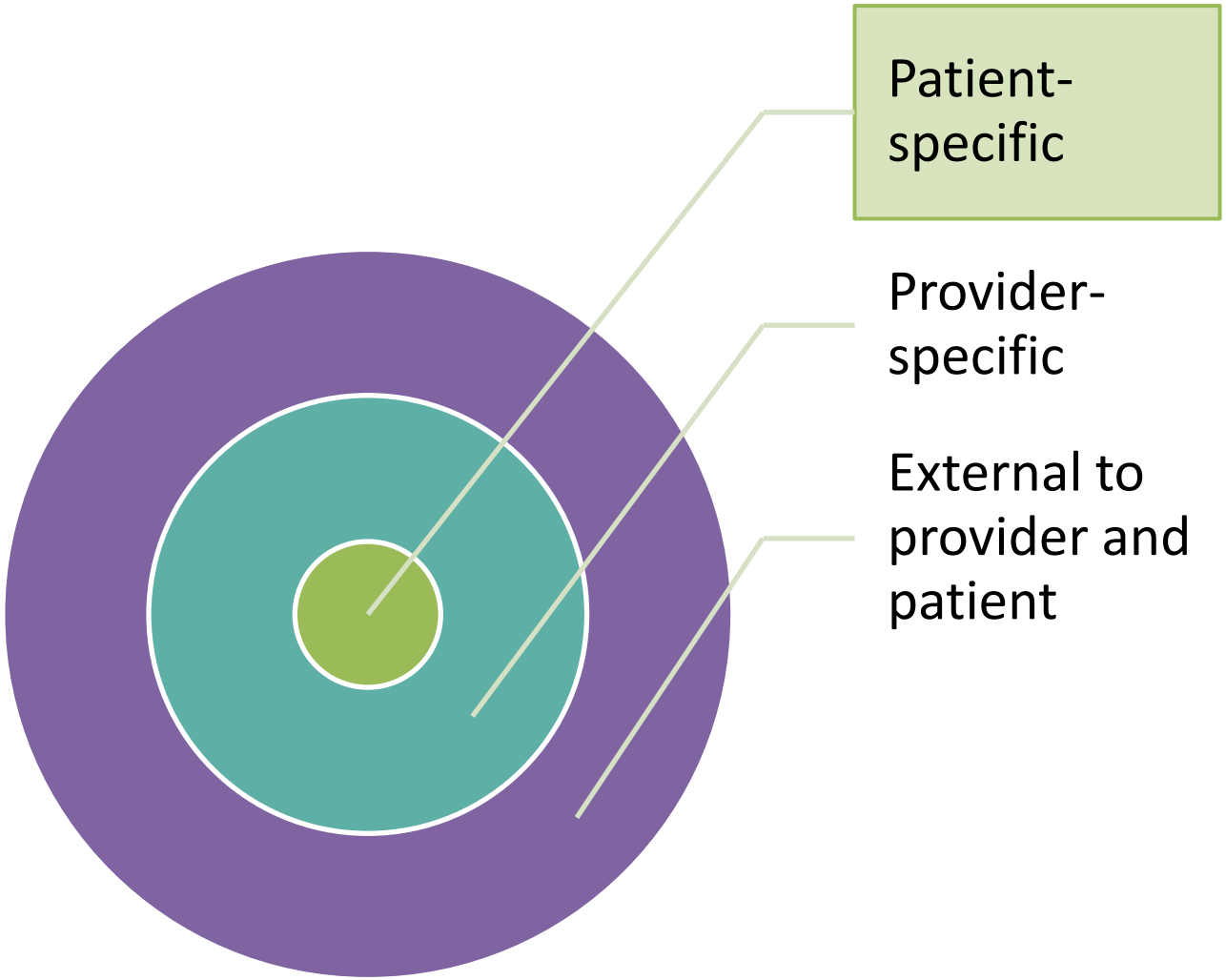
What does data mean in the life of a patient or client?



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What are some implications for providers?

- Whether a clinic, a health system, or an individual provider, it may mean:
  - Culture change and shifting expectations
    - A need for champions to encourage and model change
  - Changes to workflow
  - Increased or altered training for staff
  - Shifting resources (staff, funds, time)
  - Expense
  - Reward

What else might an integrated healthcare system include?

- Assistance with social determinants/drivers of health (SDOH)
- Wellness and prevention
- Outreach to get people into treatment
- Efforts to reduce stigma related to provision or receipt of behavioral health services

Questions & Discussion

References

AHRQ. What is Integrated Behavioral Health? Accessed 9/13/22 at https://integrationacademy.ahrq.gov/about/integrated-behavioral-health

Bipartisan Policy Center. March 2021.Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration. Available at https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/03/BPC_Behavioral-Health-Integration-report_R03.pdf

Hagerty SL, Ellingson JM, Helmuth TB, Bidwell LC, Hutchison KE, Bryan AD. An Overview and Proposed Research Framework for Studying Co-Occurring Mental- and Physical-Health Dysfunction. Perspect Psychol Sci. 2019 Jul;14(4):633-645. doi: 10.1177/1745691619827010. Epub 2019 Jun 7. PMID: 31173535; PMCID: PMC6778441

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Pennix BWJH, Sjors MML. Metabolic syndrome in psychiatric patients: overview, mechanisms, and implications. Dialogues in Clinical Neuroscience. 2018; 20:1. doi: https://doi.org/10.31887/DCNS.2018.20.1/bpenninx

SAMHSA (Jan. 2022). Results from the 2020 National Survey on Drug Use and Health: Detailed Tables (Tables 13.1B, 13.2B, 13.5B, 13.7B). Available at https://www.samhsa.gov/data/report/2020-nsduh-detailed-tables

Thorpe K, Jain S, Joski P. Prevalence And Spending Associated With Patients Who Have A Behavioral Health Disorder And Other Conditions. Health Aff (Millwood). 2017 Jan 1;36(1):124-132. doi: 10.1377/hlthaff.2016.0875. PMID: 28069855

Winstanley EL, Mahoney JJ 3rd, Castillo F, Comer SD. Neurocognitive impairments and brain abnormalities resulting from opioid-related overdoses: A systematic review. Drug Alcohol Depend. 2021 Sep 1;226:108838. doi: 10.1016/j.drugalcdep.2021.108838. Epub 2021 Jun 24. PMID: 34271512; PMCID: PMC8889511

Useful resources

In addition to the references on the prior slide, here are some miscellaneous resources you might find helpful on different topics mentioned in this talk:

- Lewis CC, Boyd M, Puspitasari A, et al. Implementing Measurement-Based Care in Behavioral Health: A Review. JAMA Psychiatry. 2019;76(3):324–335. doi:10.1001/jamapsychiatry.2018.3329. Available at https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2718629
- SAMHSA, Substance Abuse Confidentiality Regulations. Accessed Sept. 16, 2022 at https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs
- SAMHSA, How States Can Conduct a Needs Assessment. Accessed Sept. 16, 2022 at https://www.samhsa.gov/section-223/certification-resource-guides/conduct-needs-assessment

Thank You

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

www.samhsa.gov

1-877-SAMHSA-7 (1-877-726-4727) ● 1-800-487-4889 (TDD)

The Right Balance

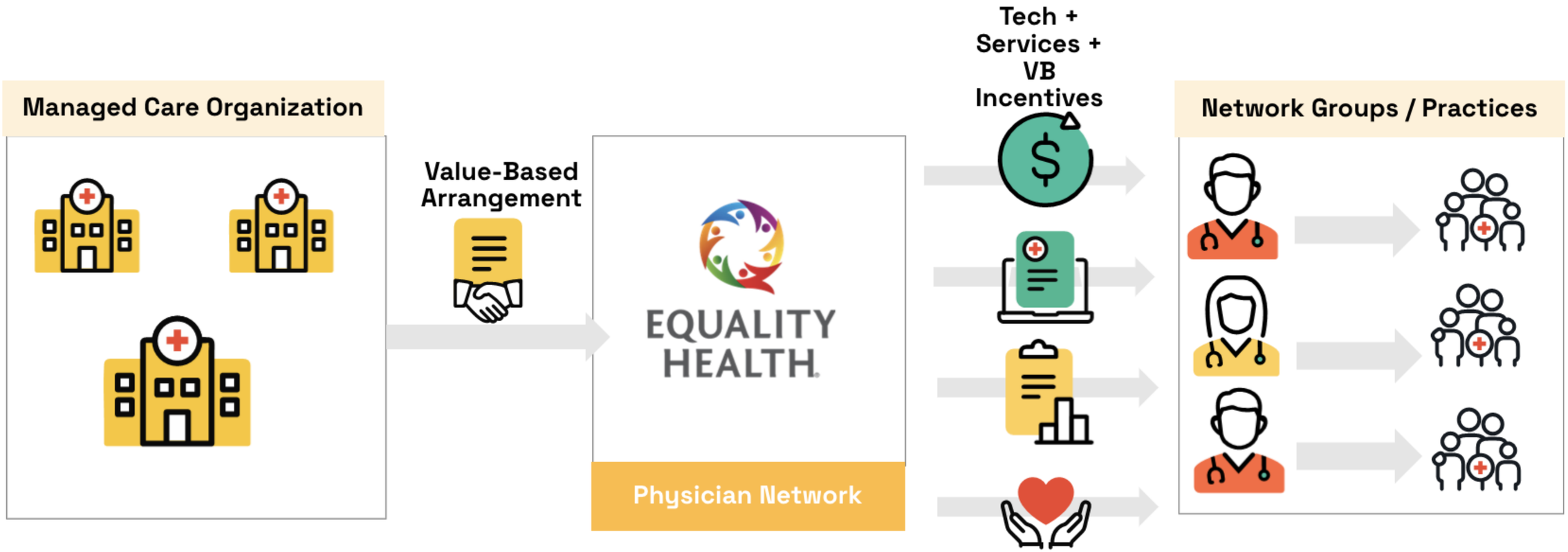
Human-Technology based outreach approaches to increase engagement

EQUALITY HEALTH

Rogelio Pena, RD

Director of Clinical Outreach Solutions

What We Do



Digital Outreach

DIGITAL OUTREACH

CHAT

CARE COORDINATION

Tailored member outreach from member attributes

- Age
- Gender
- Geography
- Diagnoses
- Stage of Change
- Risk Level
- Previous Engagement
- Quality Care Gaps
- SDOH Needs

Digital Programs

CHAT

VIDEO

EDUCATIONAL CONTENT

Designed Experiences

- Transition of Care
- Diabetes
- Behavioral Health
- Monitoring
- Pregnancy
- Wellness

Care Management

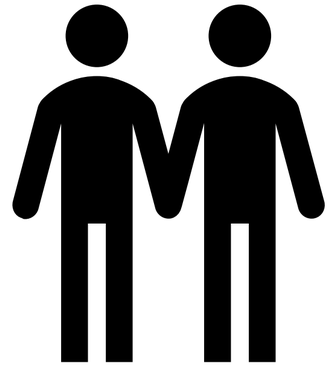
CARE COORDINATION

CARE TEAM SUPPORT

HOME VISITS

Transition of Care

High Risk Member Management

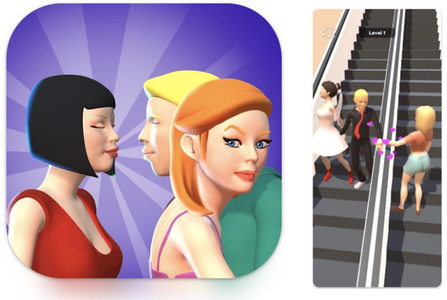


Connecting Digitally

Our Cell Phone Relationship

Google Play Games Apps Movies & TV Books Kids

Make Her Jealous



4.2★ 120 reviews | 10K+ Downloads

Install

Eat It Like

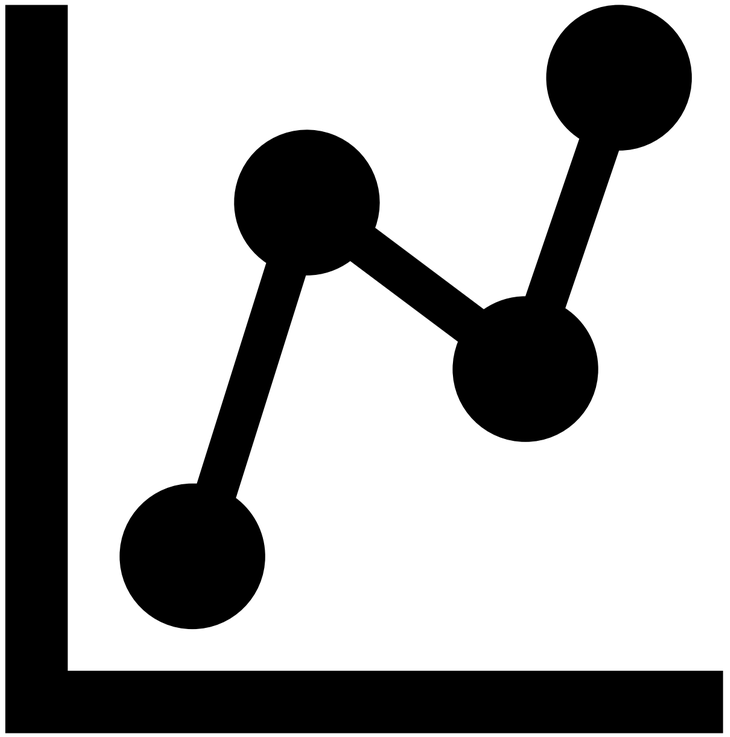
3.2★ 516 reviews | 100K+ Downloads

Install

We Had Questions

- Will Members Read These?
- Will They Opt-Out?
- Can We Really Change Behavior With A Text?
- Are We Going To Make Members Angry?

Measuring Success



- Delivery Rate
- Opt-Out Rate
- Inbound Text Rate
- Inbound Call Rate
- Behavior Metrics

Learnings:

Invest Time In An Introduction

EQUALITY HEALTH

Welcome {{MEMBER_FIRST}} to Equality Health! We partner with {{PAYER_1_GROUP_NAME}} to support {{MEMBER_FIRST}}'s needs.
We are here to help: 833-227-3100
Learn More: https://bit.ly/CARE100

Learnings:

Words Matter & Test Everything

- Start with small batches
- Develop a message approval process
- Consistently measure metrics
- Adjust quickly

Chronic Care » 1B Recent Lab Result » 08/19/21

Hi {{MEMBER_FIRST}}, this is Carina, your Equality Health Care Coordinator. I work with your doctor at {{PAYER_1_GROUP_NAME}} & would like to share a recent lab result. Please call 833-227-3100

65%
DELIVERY RATE
Message Delivered: 163

9%
RESPONSE RATE
Inbound Messages: 14

Chronic Care » 1B Recent Lab Result » 08/19/21

Hi {{MEMBER_FIRST}}, it's Carina, your Equality Health Care Coordinator. We work with your doctor, and your recent lab result is in. Please call to discuss 833-227-3100

67%
DELIVERY RATE
Message Delivered: 192

3%
RESPONSE RATE
Inbound Messages: 5

Learnings:

They Will Engage

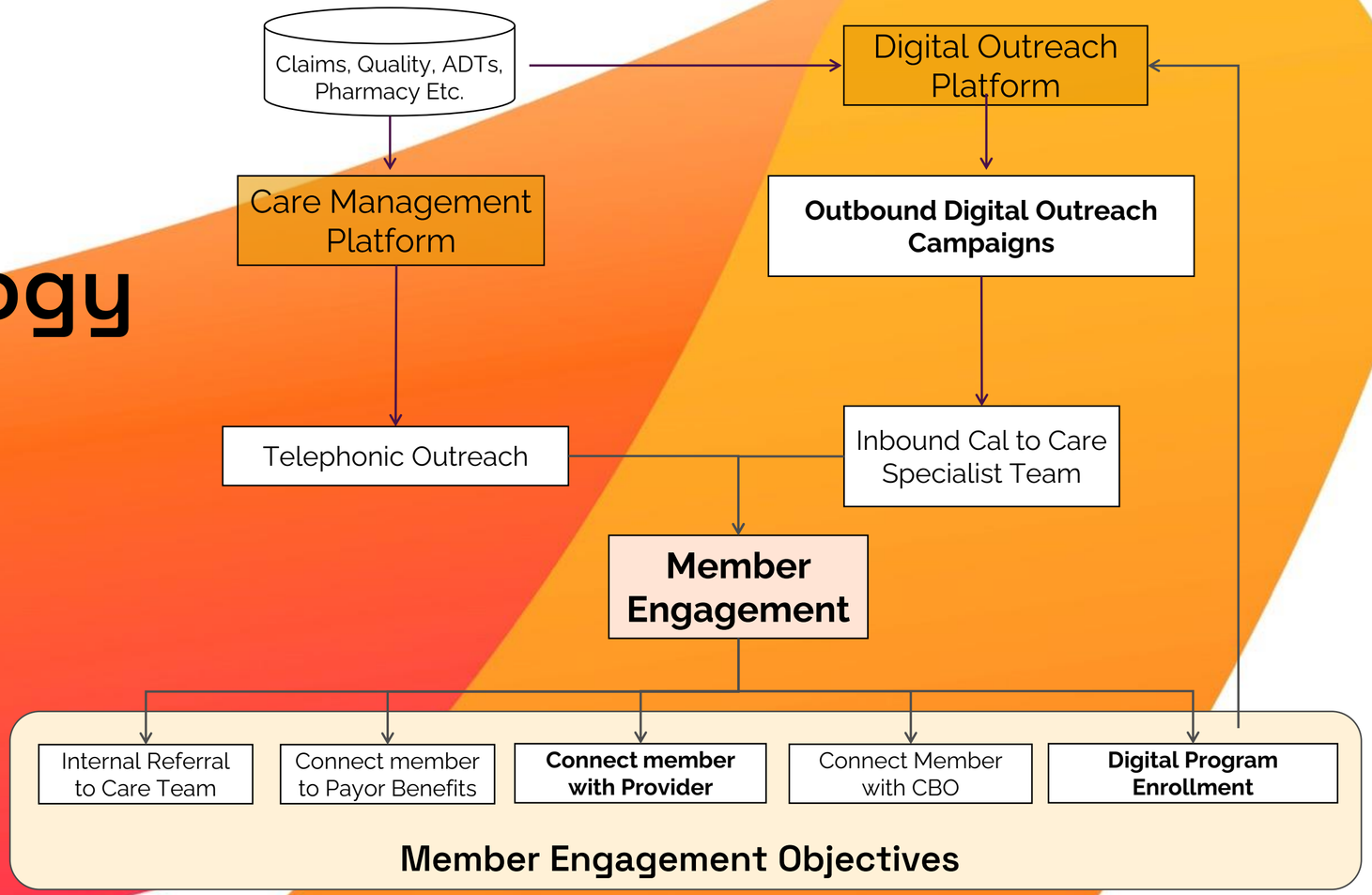
- Support the technology with People
- Blended human/technology workflows
- Provides options for methods of engagement

Hi {{FIRST}}! It's Equality Health working with {{PCP Practice}}. You may be due for an annual visit before the end of the year. Please reply or call 833-227-3100 for help scheduling.

Hi! It's Equality Health working with {{PCP Practice}}. {{First Name}} may be due for an annual well visit. Please reply or call 833-227-3100 for help scheduling.

Hello {{FIRST}}, it's Equality Health & {{PCP Practice}}. It may be time for an annual wellness visit. Reply MYVISIT to request a call from {{PCP Practice}} to schedule an appointment.

Blended People/Technology Workflows



Quick Tips

piggyback off existing member relationships

MMS has higher engagement, but some members only have SMS

links are great to measure but suspicious

internally communicate outreaches with your member engagement team

the importance of the opt-out

conversational vs professional language

Our Findings

Delivery Rate

75% Medicaid

55% Medicare

Inbound Text Rate

3.5%

Care Gap Closure

↑ 10% - 20%

*Delivered vs Undelivered

Opt-Out Rate

2.1%

Inbound Call Rate

5% - 20%

Break

NORTHERN NEVADA HOPES *your partner in health.*

Surviving and learning from a ransomware event.

Northern Nevada HOPES

- HOPES is a FQHC located in Northern Nevada
- Over 200 employees
- 10,000+ patients annually
- Patent Center Medical Home recognized by the National Council for Quality Assurance
- URAC Pharmacy recognition

Ransomware:

- Ransomware is a malware designed to **deny a user or organization access to files on their computer**. By encrypting these files and demanding a ransom payment for the decryption key, the attacker place organizations in a position where paying the ransom is the easiest and cheapest way to regain access to their files.

Cyber Liability Insurance

- In the event of a ransomware attack, Cyber liability insurance carriers may be utilized to pay the ransom.
- The insurance also pays for lost revenue during a cyber attack.
- Included services consist of, Cyber forensic teams, System administration support, Cyber liability attorney, software license reimbursement(Lost licenses/ re-establishing connection or activation)

Before the “IT apocalypse…..”

- Daily backups would be performed to both on site and off site Servers.
- Cold storage backups were performed weekly to allow for an offline solution.
- All data is encrypted both at rest and while in transit.
- IT day to day was to repair and improve existing systems.

Question #1

- If your organization was unable to perform business for 24 hours, what would be the total loss in revenue?

- The U.S. was the target of 46 percent of cyberattacks in 2020, more than double any other country.

Microsoft 10-25-21

https://www.microsoft.com/security/blog/2021/10/25/microsoft-digital-defense-report-shares-new-insights-on-nation-state-attacks/

The Attack

- The intrusion happened in the early hours of the morning two weeks before Christmas.
- The attacker deployed the ransomware through a modified GPO allowing them to deploy it to all computers on the network.
- The group then performed a backup of the file system.

The day of….

The EMR application was not loading for all employees.

Staff are unable to receive emails.

Phone calls from staff at 7 am stating they are unable to access the system.

The IT director had scheduled PTO for two week starting the next day, The system administrator had a scheduled surgery later in the afternoon with two weeks of recovery scheduled.

System Impact

- Electronic Medical Record System
- IP phone system
- Backup systems
- Desktops and Laptops
- System Servers
- Pharmacy RX system

- The average downtime a company experiences after a ransomware attack is 22 days.

Statista

https://www.statista.com/statistics/1275029/length-of-downtime-after-ransomware-attack/#:~:text=Length%20of%20impact%20after%20a%20ransomware%20attack%20Q1%202020%2D%20Q3%202021&text=As%20of%20the%20third%20quarter,United%20States%20was%2022%20days. 2021

What happened next

System admin logged in to discover a ransomware note on the Domain controller.

Phone calls from staff regarding ransom notes on their laptops and desktops.

All systems slowly went offline.

All of the backups were deleted or encrypted.

Emergency Preparedness

- CEO was immediately notified of the issue.
- IT gathered to discuss how to best recover from the situation
- Department and Executive Directors notified of incident and asked to have all work from home staff to bring their assets into the workplace.

Question #2

- How many organizations in your area have been impacted by ransomware in the last 18 months?

The Plan

- All servers, laptops and desktops were assumed to be compromised which would require completely rebuilding.
- Identified the priority of systems to restore in order to resume business.
- Began notifying patients of the outage closing operations until further notice.
- Contact our Cyber liability insurance company to discuss our options.

Migrating the Domain

- Domain controllers control all domain access, blocking unauthorized access to domain networks while allowing users access to all authorized directory services.
- The organization scheduled to change over the domain slowly to avoid downtime and outages.
- With all systems and computers requiring a rebuild it was an opportune time to migrate the domain during this outage.
- By migrating the domain during the ransomware we were able to begin building a Hybrid architecture to allow redundancy and failover in the event of a local outage.

Cold Storage and Air Gap

- **Cold Data** storage is the storage of inactive data that is rarely used and must be retained for business or compliance purposes on a long-term basis.
- An **Air Gap** is a security countermeasure that is based on the idea of creating an impenetrable barrier between a digital asset and malicious actors

Air Gap Cold Storage….

- Cold Storage had all patient records and data systems stored in a full encrypted backup snapshot.
- The SQL services remained unencrypted on the infected machines due to separate permissions. The SQL service hosted all patient records and progress notes for all clients.
- The snapshot of the data system was two weeks old which kept most of our data and systems in tact within two weeks of the instance.

- Out of 1,086 organizations whose data had been encrypted, 96 percent got their data back.

Sophos

https://secure2.sophos.com/en-us/medialibrary/pdfs/whitepaper/sophos-state-of-ransomware-2021-wp.pdf 2021

Executing the Plan

- Assembly lines were produced to begin mass rollout of laptops and desktops for re-imaging and migrating to the new domain.
- IT staff worked around the clock rebuilding all systems and servers adding them to the domain.
- The cold storage backups were deployed to recover the impacted data.
- Cyber liability firm was utilized to do a forensic analysis of the event while also contracting a system administrator to help re-establish critical systems that were impacted.

Question #3

- Does your organization currently have cyber liability insurance?

Detection and Review

- The forensic team identified the user account compromised and responsible for the attack.
- The account was compromised through a targeted spear phishing campaign.
- All systems accessed by the attackers were encrypted and the data was unavailable to them for export

- Ransomware attacks were responsible for almost 50 percent of all healthcare data breaches in 2020.

Heath and Human Services

https://www.hhs.gov/sites/default/files/2021-hph-cybersecurity-forecast.pdf 2020

Reporting responsibility in an attack

- No patient information was compromised during the attack.
- All data potentially impacted during the event was determined to be non-critical and properly protected from any external threats
- The organization did not have to disclose the event since all records and information was protected from the threat actors.

- 95 percent of cybersecurity breaches are caused by human error.

World Economic Forum Dec-17-2020

https://www.weforum.org/agenda/2020/12/cyber-risk-cyber-security-education

How to react to ransomware

- 1. Isolate the Affected Systems
- 2. Report the attack
- 3. Shut down "Patient Zero"
- 4. Secure your Backups
- 5. Disable all Maintenance Tasks
- 6. Backup the Infected Systems
- 7. Identify the Strain
- 8. Decide Whether to Pay the Ransom

https://www.lepide.com/blog/how-to-react-to-ransomware-attack-in-8-steps/

Question #4

- Is your organization prepared to recover from a ransomware attack?
- Would you have to pay the ransom, and if so could you?

Prevention:

- All backup systems should not share admin privileges or domain access with the main network.
- User education is everyone's responsibility, All users should attend annual security training to reinforce best practices.
- Managed Detection and Response (MDR) services put a security team on your network monitoring unusual network and user activity. These teams specialize in locking down potential threats before they are able to deploy any specialized attacks.

Looking Back

- In total the time it took to come back online took two weeks.
- 6 months of follow up and review to identify and review both the incident and impact.
- A forensic analysis of the incident took a month.
- 8 months to receive reimbursement from the cyber liability firm.

Questions?

THANK YOU

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Connection to Contexture

Arizona HIE Updates and the CommunityCares SDOH Platform

Welcome

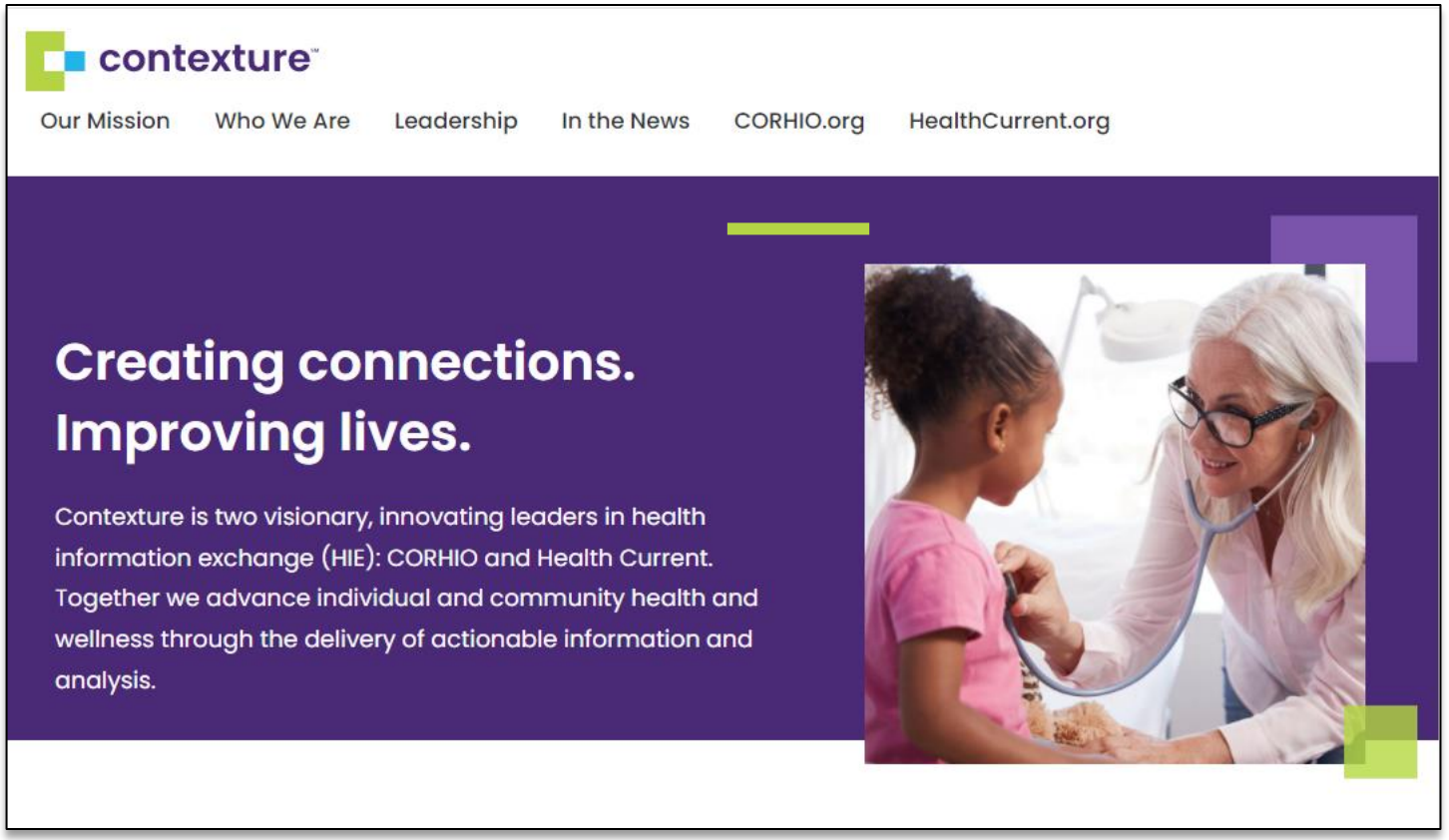
Peter Steinken, PharmD
Director, Community Development

Andrew Terech
Director, SDOH

An Update on Contexture

Peter Steinken

New brand. Same commitment to you.



Our Mission

Advancing individual and community health and wellness through the delivery of actionable information and analysis.

Contexture Participants

Organization Type	Facilities/Clinics*
Behavioral Health	415
Federally Qualified Health Center & Rural Health	180
Home and Community Based Services	171
Hospitals	202
Long-Term & Post-Acute Care	314

**Combined Arizona and Colorado*

HIE Benefits

With HIE, your organization can:

- Reduce time spent requesting and waiting for medical records from hospitals and other healthcare providers
- Be more informed about your patients' recent hospital or ED visits
- Manage high-risk and complex patients with more informed care coordination
- Better prepare for new patients to your practice by downloading their complete medical histories
- Enhance care management and follow-up activities with access to clinical records and recent test results

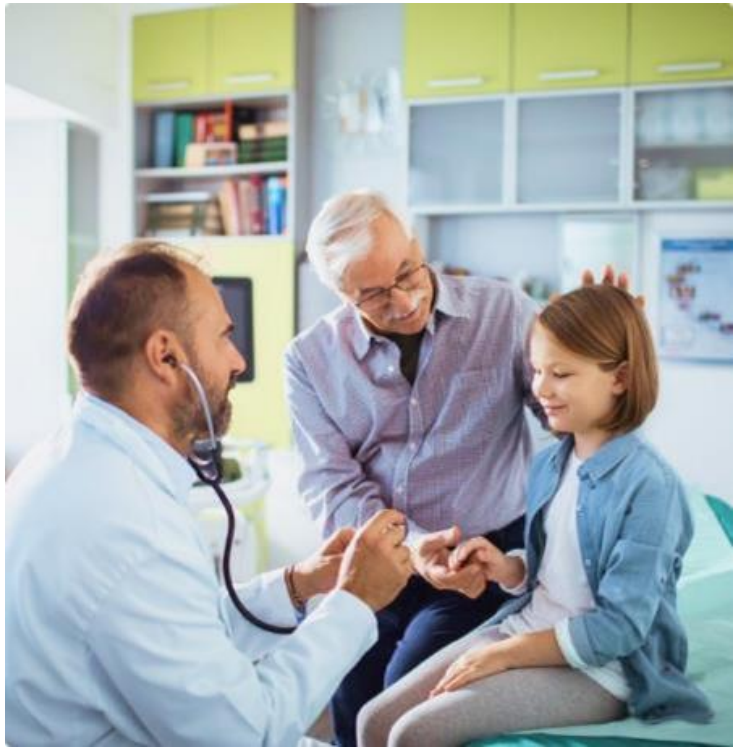
HIE Services

Contexture offers a range of HIE services designed to integrate more complete patient information into the care delivery of HIE Participants.

- Portal
- Alerts
- Direct Secure Email
- Data Exchange (Interface)
- Clinical Summary
- Controlled Substances PDMP

Core HIE Components:

- Master Patient Index
- Integration Engine
- Clinical Data Repository



Azara Healthcare

A01, A02, A03, A04's batched daily via csv (Inpatient and ED)

- The are 12 current Community Health Center roster files:
  - Adelante Healthcare
  - Canyonlands Healthcare
  - Circle the City
  - Desert Senita Community Health Center
  - Marana Health Center
  - Native Health
  - North Country Healthcare
  - Sun Life Family Health Center
  - Sunset Community Health Center
  - United Community Health Center
  - Valle del Sol
  - Wesley Community Health Center
- There are 5 additional health plan roster files
  - Arizona Complete Health
  - Banner
  - Banner (Value Based Care)
  - Care1st
  - United Health

Current HIE Programs

HIE Data Supplier Program

Receive Incentive Payment for Sending Data to the HIE

- Eligibility – Registered Medicaid Providers seeing Medicaid patients
- Requirements – HIE Participant and sending data to the HIE on or after October 1, 2021

Provider Category	Payment
Hospitals & IHS/638 Facilities	$20,000
Community Providers (26+)	$20,000
Community Providers (16-25)	$15,000
Community Providers (1-15)	$10,000
Nursing Facilities	$5,000

- Replaces historical HIE Onboarding Program ended 9/30/21
- Providers that did not previously receive a payment under HIE Onboarding Program or SHIP are eligible to receive administrative offset payments to become Data Suppliers

HIE Data Supplier Program

Common Data Elements Required for Payment

- Registration event - Admission, discharge and transfer information
- Encounter summary including (if applicable):
- Laboratory and radiology information (if applicable)
- Active medications
- Immunization data
- Active problem lists (diagnosis)
- Social history
- Treatments and procedures conducted during the stay
- Active allergies
- Basic patient demographic data including assigned provider, emergency contact and payer
- Specific Seriously Mentally Ill (SMI) data elements, as defined by Contexture (if applicable)
- COVID-19 lab test and immunization data (if applicable)

HIE Data Supplier Program

Steps to Participate

- Become an HIE Participant, if not one already
  - https://contexture.org/JoinAZ
  - Recruitmentinfo@contexture.org
- Existing HIE Participants, sending data after October 1st, 2021 contact your HIE account manager
- Sign Data Supplier Program Addendum to the HIE Participation Agreement
- Complete data sending implementation
- Receive incentive payment

Differential Adjusted Payment (DAP) Program

Benefits of Connecting:

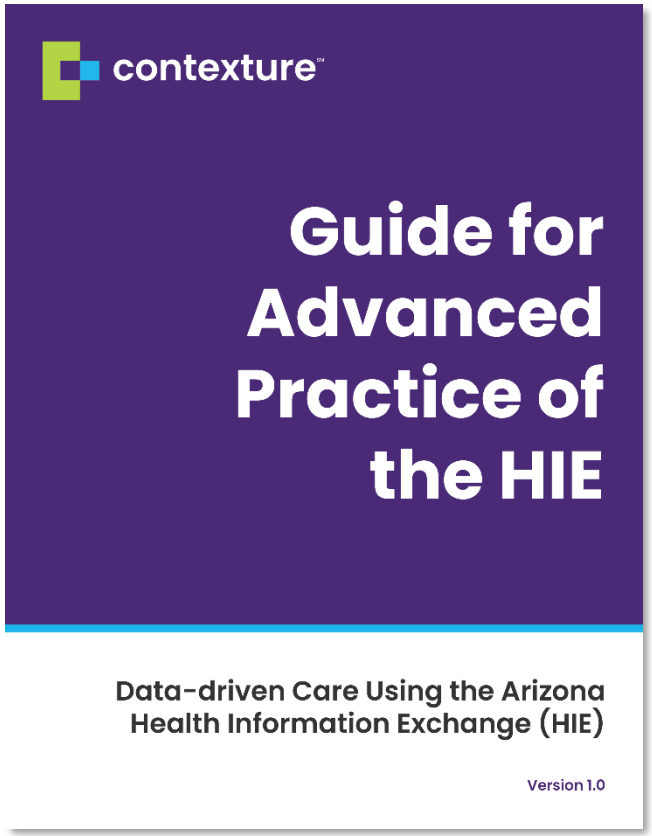
- Increase efficiency
- Improve care quality
- Save time & money
- Receive higher AHCCCS payments

Newly Eligible Provider Types:

- Physicians, MD & DO
- Physicians Assistants
- Registered Nurse Practitioners
- Assisted Living Homes & Centers
- Adult Day Health & Adult Foster Care

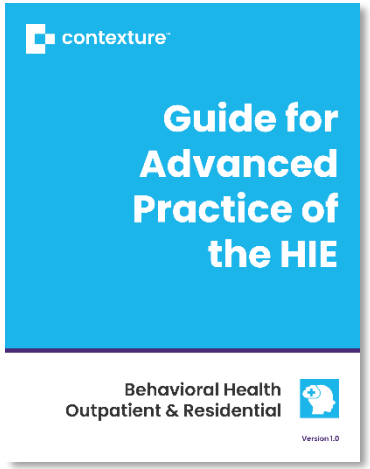
New HIE Offerings

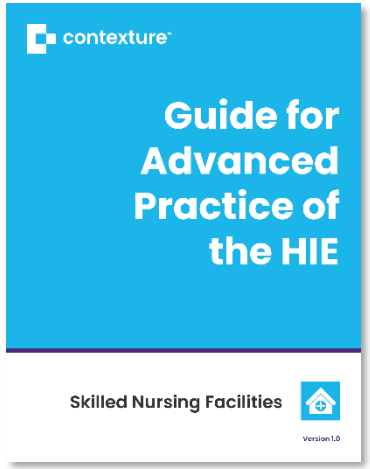
Guides for the Advanced Use of the HIE

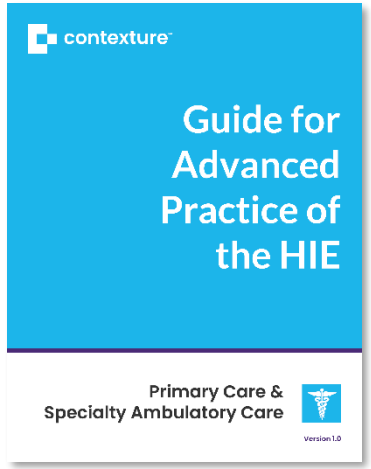


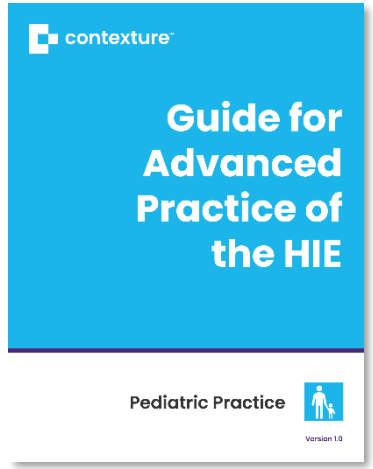
The General Guide

This introductory guide provides an overview of HIE services, discusses the basics how to apply HIE services for success and lays the foundation for our participant-specific guides.



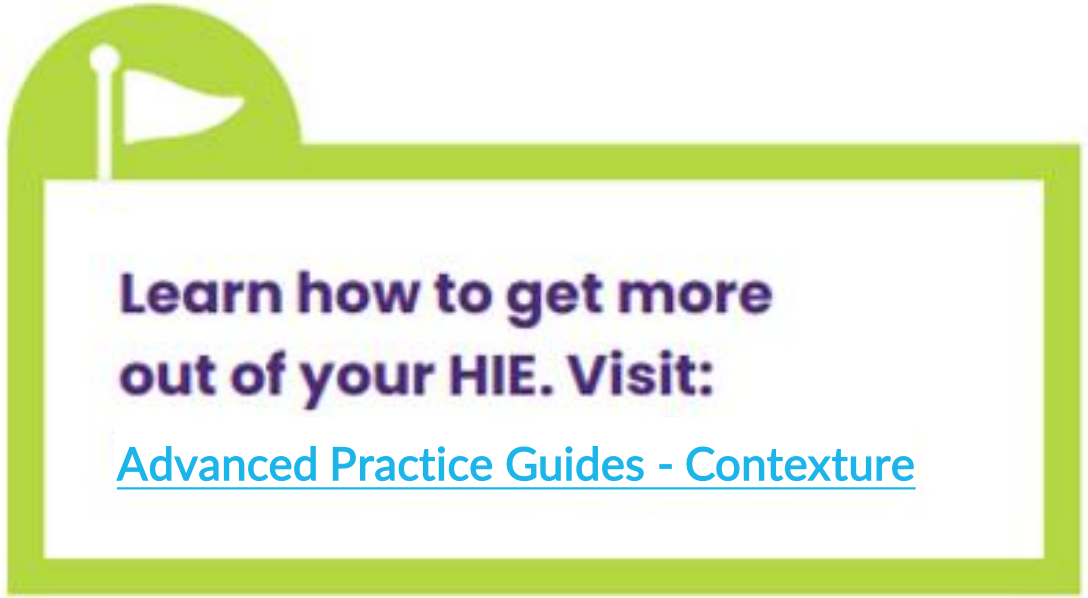






Four companion guides provide a deep dive into each specialty and cover topics specific to that provider type.

Access “Your HIE” Guides



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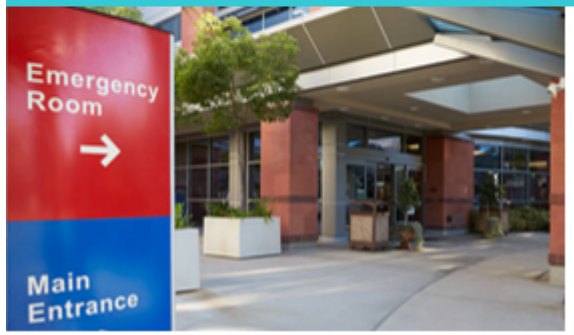
Right Care Alerts

Notifications for hospitals concerned about improper ED utilization.

Right Care. Right Patient. Right Time.

When It's Not Right, Be in the Know.



Right Care Alerts™

Notifications for hospitals, health plans and other healthcare professionals concerned about improper emergency department (ED) utilization.

Right Care Alerts Testimonial

"Health Current is in a unique position to offer valuable ED notifications that empower providers to have real-time insight into improper utilization. In addition to receiving virtually all ADT alerts in Arizona, Health Current also provides clinical information about the patient captured in the HIE not available by other ED notification services."

- Ryan Sommers PMP,
System Director, HIE and Interoperability,
IT & Digital, Dignity/CommonSpirit Health

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Imagine fully informed health

Health Current's Right Care Alerts bring inpatient and ED visit data across all participating organizations in the Arizona health information exchange (HIE) together to the point of care in the ED in real-time, providing immediate care and appropriate interventions for post-discharge care.

When a patient presents at the ED, the HIE is queried and sends a Right Care ED Utilization Risk Report back into the originating EHR system based on three threshold parameters:

# ED Visits	Duration	Notification of:
≥ 6	180 Days	High ED Utilizers
≥ 3	30 Days	ED Readmits within the last 30 days
≥ 3	90 Days	ED and/or Inpatient

To get started with Right Care Alerts, contact your designated Health Current account manager or email HIESupport@healthcurrent.org.

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Right Care Alerts

The purpose for Right Care Alerts are to give ED clinicians the information they need to make fully informed decisions so they can provide the best care possible.

Health Current – ED Notification Alert

Patient: AMYWLC, ZZTEST MRN: 3502319816

Report Date: Wed Aug 14 10:03:18 PDT 2019

Criteria Met

- 3+ ED Visits in 30 Days
- 3+ Facilities in 90 Days
- 6+ ED Visits in 180 Days

Recent Inpatient Visit Summary (90 Days)

Admit Date	Facility	Diagnosis/Chief Complaint
5/20/19 12:00 AM	St. Joseph's Hospital	THREAT LABOR NEC-UNSPEC
7/1/19 12:00 AM	El Rio Health Center	DIABETES UNCOMPL TYPE II
7/25/19 12:00 AM	El Rio Health Center	Cardiac murmur, unspecified

Recent Emergency Department Visit Summary (90 Days)

Admit Date	Facility	Diagnosis/Chief Complaint
5/30/19 12:00 AM	Mt Graham Regional Medical Center	DIABETES UNCOMPL TYPE II
6/25/19 12:00 AM	St. Joseph's Hospital	Cardiac murmur, unspecified
6/30/19 12:00 AM	Mt Graham Regional Medical Center	DIABETES UNCOMPL TYPE II
7/4/19 12:00 AM	Mercy Gilbert Medical Center	Cardiac murmur, unspecified
7/5/19 12:00 AM	Chandler Regional Medical Center	Back pain
7/10/19 12:00 AM	Kingman Regional Medical Center	Cardiac murmur, unspecified
7/20/19 12:00 AM	Kingman Regional Medical Center	Cardiac murmur, unspecified
8/1/19 12:00 AM	El Rio Health Center	DIABETES UNCOMPL TYPE II
8/10/19 12:00 AM	LAB1	DIABETES UNCOMPL TYPE II

ED Visit History (1 Year)

Facility	Visits
Chandler Regional Medical Center	1
Mercy Gilbert Medical Center	1
St. Joseph's Hospital	1
El Rio Health Center	1
Kingman Regional Medical Center	2
LAB1	1
Mt Graham Regional Medical Center	2
Total ED Visits:	9

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Mental Illness Hospitalization Alerts

ADT Event notifications from an approved psychiatric hospital based on patient panels uploaded to the HIE.

Mental Illness Hospitalization Alerts

Approximately one in four adults in the U.S. suffer from mental illness each year; nearly half will develop at least one mental illness in their lifetime. There are over 2,000,000 hospitalizations each year for mental illness in the U.S. Patients hospitalized for mental health issues are vulnerable after discharge and follow-up care by trained mental health clinicians is critical for their health and well-being.

Background

Mental Illness Hospitalization Alerts – notifications for admissions, transfers and discharges (ADTs) of patients from level-1 psychiatric hospitals – are in high demand among participants in the Arizona health information exchange (HIE). The ability to provide rapid coordination of care and assist with discharge planning upon admission to a psychiatric hospital is a key factor in reducing inpatient lengths of stay and supporting seamless transition, medication continuity and stability in community settings post-discharge.

AHCCCS

In addition, multiple value-based incentive programs including **AHCCCS' Targeted Investments** have prioritized the hospital 7- and/or 30-day follow-up HEDIS measures as an important indicator of system performance and patient well-being following an inpatient stay.

Making these important ADT alerts available to the Arizona healthcare community through the HIE has long been hampered by concerns about inadvertent disclosure of patient-identifying substance abuse treatment, diagnosis and referral information protected by 42 CFR Part 2.

Mental Illness Hospitalization Alerts

- Contexture has developed and tested a methodology for delivering Mental Illness Hospitalization Alerts without disclosing protected Part 2 substance abuse information by:

1. Validating that a psychiatric hospital provides “mixed use” behavioral health services and does not exclusively deliver Part 2 substance abuse services.
2. Applying 42 CFR Part 2 data source filtering to exclude the following data elements from the alert: Diagnosis, Treating Provider and Location.

- There are no patient consent requirements to received Mental Illness Hospitalization Alerts.

- Aurora Behavioral Health – Tempe
- Aurora Behavioral Health Systems (Glendale)
- ConnectionsAZ
- Destiny Springs Healthcare
- Horizon Health and Wellness
- Palo Verde Behavioral Health Hospital
- Recovery Innovations
- Southwest Behavioral Health Services
- West Yavapai Guidance Clinic

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Electronic Case Reporting

Electronic case reporting (eCR) is the automated, real-time exchange of case report information between electronic health records (EHRs) and public health agencies.

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Fact Sheet

Communicable Disease Surveillance & Reporting

Overview

Health Current, a Contexture organization, is pleased to introduce Communicable Disease Surveillance & Reporting (CDSR), a program designed to assist hospitals and Federally Qualified Health Centers (FQHCs) with submitting case reports to the Arizona Department of Health Services (ADHS). CDSR will support ADHS by improving the timeliness, accuracy and completeness of communicable disease reporting, especially during emergencies such as a pandemic, and will reduce hospital and FQHC burden related to state reporting requirements.

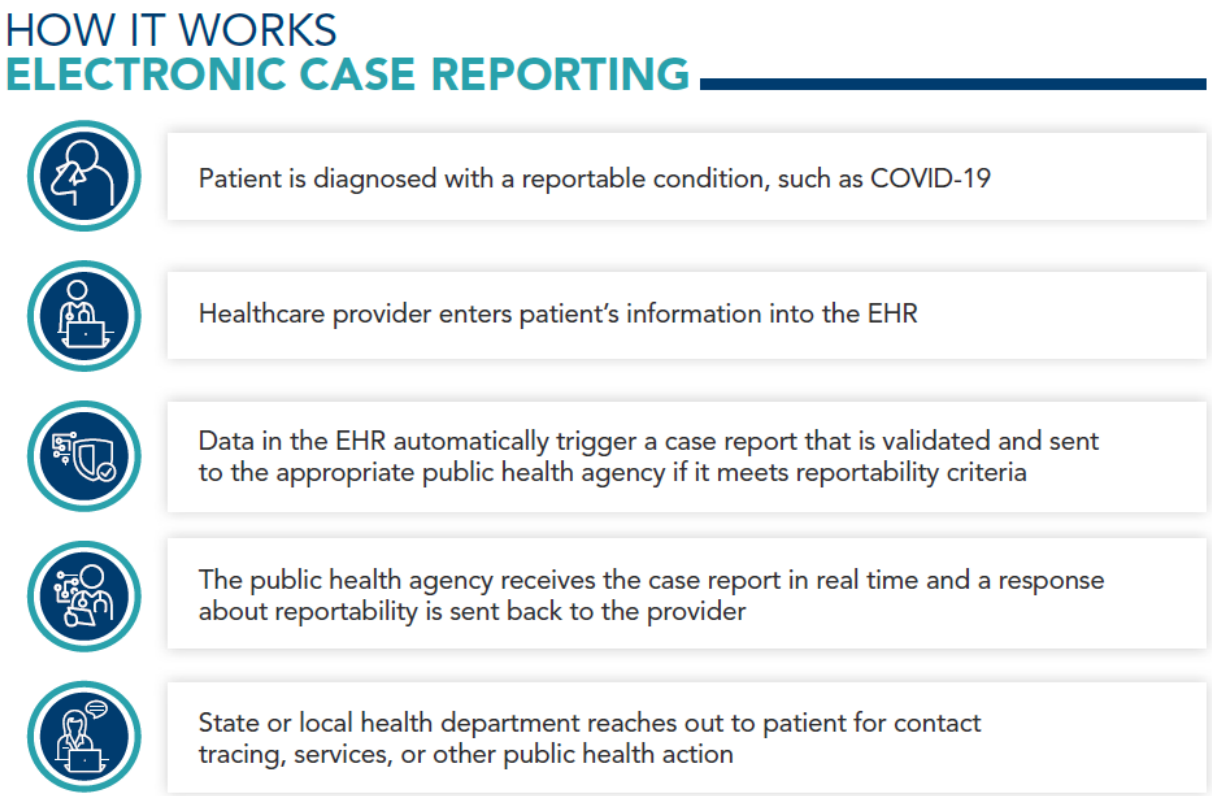
In accordance with Centers for Disease Control and Prevention (CDC) Message Mapping Guides (MMG), the scope of this project includes an approach to standardize and normalize electronic case reports from hospitals' electronic health record (EHR) systems, capture the conditions and move them through the CDC AIMS platform and deliver data in a single feed to ADHS' electronic surveillance systems.[1] Hospitals and FQHCs will receive financial compensation from Health Current by achieving specific project-related milestones.

Background

ADHS receives communicable disease reports for several conditions and syndromes from healthcare providers, facilities and laboratories per Arizona administrative code. These reports are received through a variety of methods, including fax, phone, emails or direct duplicative entry by users into the integrated system, the Medical Electronic Disease Surveillance Intelligence System (MEDSIS). To reduce the reporting burden, ADHS is proposing a partnership with Health Current, using the statewide HIE to provide support for electronic case reporting. Health Current will work with ADHS and assist with participant outreach as well as project management support.

[1] Developed by the Association of Public Health Laboratories (APHL), the APHL Informatics Messaging Services (AIMS) Hub is a secure, cloud-based environment that accelerates the implementation of public health messaging solutions by providing shared services to aid in the transport, validation, translation and routing of electronic data. Source: http://www.aphl.org.

Electronic Case Reporting



- These timely data are more complete than manual reporting and include patient demographics (such as race and ethnicity), diagnoses, comorbidities, occupation, travel history, immunizations, medications, pregnancy status, and other treatments.
- eCR runs securely and seamlessly behind the scenes in the EHR to automatically capture and report required information, reducing provider burden. eCR also enables immediate feedback from public health agencies to healthcare providers about reportable conditions and possible outbreaks.

Electronic Case Reporting

BENEFITS OF ELECTRONIC CASE REPORTING

eCR replaces manual case reports that are generally done by mail, phone, fax, or through an online portal.

FOR HEALTHCARE PROVIDERS

- Saves time by eliminating manual data entry and reporting
- Streamlines reporting to multiple jurisdictions
- Fulfills the CMS Promoting Interoperability Program requirements for eCR
- Can fulfill legal reporting requirements
- Can be implemented for all reportable conditions

FOR PUBLIC HEALTH AGENCIES

- Enables bidirectional data exchange
- Provides more complete data to support outbreak management
- Efficiently monitors the spread of reportable diseases
- Reduces response time with automated information
- Supports submission of case-based data (without identifiable information) to CDC through the National Notifiable Diseases Surveillance System

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Arizona Healthcare Directives Registry

Registry platform that supports secure uploading, identify verification, access and management of patient Advance Care Plans.

healthcurrent | ARIZONA Healthcare Directives Registry

What Arizona Providers Should Know About the Arizona Healthcare Directives Registry (AzHDR)

During the 2019 legislative session, the Arizona Senate passed S.B. 1352, giving healthcare providers the ability to have real-time access to patients' end-of-life wishes when they need it most. The bill improved provider access to advance directives by moving the healthcare directives registry from within the Secretary of State's office to Health Current, a Contexture organization and Arizona's health information exchange (HIE).

Health Current worked collaboratively with the Secretary of State staff on the transition of advance directive documents registered with the Secretary of State to the HIE. An initial letter was sent to all previous registrants informing them of the transfer of the registry and providing them the opportunity to opt-out. After the opt-out period ended, remaining documents were transferred, and new account login information was sent to former registrants in November 2021.

Since that time, documents continue to be received and registered with the AzHDR. Advance directive documents can be submitted to the AzHDR via postal mail, email, fax or through the participating provider portal upload tool. Registering advance directives with the AzHDR is free to Arizona residents. Individual consumers can submit forms themselves or through the assistance of a healthcare provider, attorney, or other participating provider.

- Licensed Healthcare providers, including first responders and organizations and Legal and Financial providers can become participating providers with the AzHDR **at no cost** and be able to conveniently upload advance directive documents on behalf of their clients. Participating healthcare providers can then view all registered advance directives in the AzHDR. Participating attorneys and financial planners can then view any document they have submitted.
- Advance directive documents that can be registered in the AzHDR are living wills, health care power of attorney, mental health care power of attorney and pre-hospital medical care directive/DNR. POLST forms can be included if attached to a living will or healthcare power of attorney form.
- Once documents are registered, consumers will receive information to set up their own AzHDR account so they can view their documents. Registrants will also have access to a view-only wallet card that features a unique QR code and user website URL. These will allow family members, surrogate decision makers, and healthcare providers or first responders who are not yet participating with the AzHDR to be able to access the registrant's advance directives. Here is a sample of the wallet card for reference:

My advance directives are registered with the **Arizona Healthcare Directives Registry**.

ARIZONA Healthcare Directives Registry

Name: Dummy Test
(Print your full name as it appears on your advance directive(s).)

I have registered my advance directives with the **Arizona Healthcare Directives Registry**. To view my documents, use the link or QR code below.

consumers.azhdr.org/v/MYYJXL

Questions?
Contact Health Current at either 602-368-6371 or **azhdr@contexture.org**.

For more information on how your firm can become a participating provider with the AzHDR or to have the AzHDR team speak about advance directives and the Arizona registry, contact Health Current/Contexture at info@azhdr.org.

To learn more about the Arizona Healthcare Directives Registry, visit azhdr.org.

Health Current/Contexture | 3877 N. 7th St., Ste. 150 | Phoenix, AZ 85014 | healthcurrent.org | 602-688-7200

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CommunityCares

CommunityCares

Arizona's Social Determinants of Health (SDOH) Referral System

Presented by:
Andrew Terech, LAC
Director of SDOH
Health Current/Contexture

AHCCCS Whole Person Care Initiative (WPCI)

- Officially launched the Whole Person Health Initiative in November 2019.
- Focused on role social risk factors play in influencing individual health outcomes.
- Exploring options for advancing WPCI through maximization of AHCCCS's current benefit package.

CommunityCares

The Journey Thus Far…

- Started a pilot called our Early Adopter Program in summer of 2021 for CommunityCares SDOH referral system, hosted on NowPow platform.
- Went live in October 2021 on NowPow platform.
- Winter of 2021, Unite Us acquired NowPow.
- Officially went on hold for onboarding March 1, 2022 to build our new relationship with Unite Us.
- Contexture and Unite Us agreed to terms for a statewide implementation of CommunityCares powered by new Unite Us platform.

CommunityCares Partners

CommunityCares Program Goals

- Connecting Arizona communities.
- Improving health outcomes with a whole-person care mindset.
- Data-driven approach.
- Help organizations meet AHCCCS Differential Adjusted Payment (DAP) program milestones.

CommunityCares System Features

- Closed-loop referrals with outcome tracking
- No wrong door: easily connect clients to resources across the state in one platform
- Screenings and assessments for identifying client needs
- Alerts and communications about client case progress
- Data dashboards, analytics and outcomes
- Resource directory

CBOs Success Program

Community-based Organizations (CBOs) Incentive Program

Milestone #1

Connect to CommunityCares and agree to use for 3 years.

$2,000

Milestone #2

Maintain usage metrics for 6 months.

$3,000

Milestone #3

If applicable, agree to a single sign-on integration with a source system.

$5,000

Timelines & Priorities

- AHCCCS Differential Adjusted Payment (DAP) enrolled organizations.
- Organizations that are currently on the NowPow instance of CommunityCares or were actively engaged with CommunityCares prior to pause.
- We'll also be transitioning current Arizona Unite Us customers to CommunityCares.
- Community-based organizations (CBOs).
- Regional approach (see timeline).

CommunityCares Implementation & Onboarding Timeline

Month/ Year	Aug. 2022	Sept. 2022	Oct. 2022	Nov. 2022	Dec. 2022	Jan. 2023	Feb. 2023	Mar. 2023	April 2023	May 2023	June 2023	July 2023	Aug. 2023
Wave 1	Central AZ (Maricopa)												
Wave 2						Southern AZ (Pima)							
						Northern AZ (Coconino)							
						Western AZ (Yuma)							
Wave 3									Central AZ (Yavapia, Pinal, Gila)				
									Southern AZ (Santa Cruz, Cochise, Graham)				
									Northern AZ (Navajo, Apache, Greenlee)				
									Western AZ (Mohave, La Paz)				

Next Steps

1. Visit CommunityCaresAZ.org.
2. Complete the interest survey.
3. Responses to the interest survey will connect the organization to key contacts at Contexture and Unite Us who are subject matter experts to assist in the onboarding process and next steps.
4. Agreements are completed with Contexture and Unite Us. Depending on the organization and implementation needs. these agreements may include:
   - CommunityCares Agreement;
   - CBO Incentive Program Attestation;
   - Unite Us Terms of Use;
   - Unite Us Business Associate Agreement;
   - Unite Us No Cost Order Form.
5. Onboarding for healthcare organizations may take 6 to 12 weeks, depending on size and complexity of the organization and whether the onboarding includes an electronic medical records (EMR) interface integration.

CommunityCares Contacts

Contact: sdoh.info@contexture.org

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Diana Kramer

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Senior Advisor, Social Determinants of Health
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Questions?

Contact Information

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  Peter.Steinken@contexture.org

- Andrew Terech
  Director, SDOH
  Andrew.Terech@contexture.org

  www.contexture.org

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Lunch

Thank you to our Lunch Sponsor!

Discover How Using CHWs and Population Health Platforms Improves Health Equity

Draft a New Population Health Management Blueprint

Jodi Tate, Population Health Director
Canyonlands Healthcare

Canyonlands Healthcare

Canyonlands
Healthcare

Building Blocks

To Execute a Plan Successfully, Begin with the End in Mind.

Canyonlands Healthcare

STEP ONE
Lay the Foundation

Canyonlands Healthcare

What are you using as your foundation?

Canyonlands Healthcare

STEP TWO
Construct the Framework

Canyonlands Healthcare

Constructing Culturally Aware Messaging

“Hello, this is Canyonlands Healthcare, your provider would like you to schedule a breast cancer screening. A mammogram to screen for breast cancer can save your life. Women need one every 1-2 years from age 45-75.

A) Help me schedule a mammogram,
B) I do not want one,
C) I have questions, or
D) I have had a mammogram within the past 2 years. “

Canyonlands Healthcare

Constructing Culturally Aware Messaging

“Hello, Jane, Canyonlands Healthcare is holding a Women's Wellness Day in Kaibeto on May 11, 2022, 8AM - 4PM MDT.

Reply A. If you would like us to schedule your FREE mammogram (Age 40-64)

Reply B. If you have already completed a mammogram.

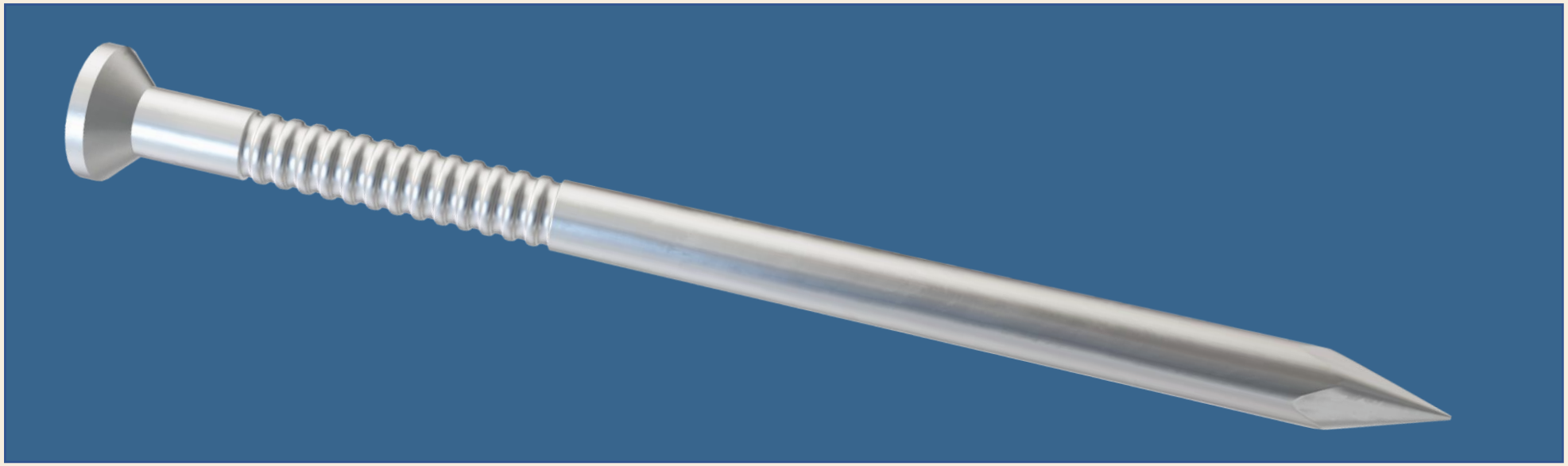
Reply C if not interested in scheduling. Call 928-645-6624 for more information.”

Canyonlands Healthcare

STEP THREE
Fastening your Joints Together

Canyonlands Healthcare

DATA DRIVEN OUTREACH CAMPAIGNS



Use a Population Health Tool to Nail Down Outreach Strategies

azara healthcare

Canyonlands Healthcare

Canyonlands Overall Hypertension Control	
UDS Report	HTN Control
2019	54%
2020	49%
2021	**60%**

Canyonlands Native American Population Hypertension Control	
UDS Report	HTN Control
2019	50%
2020	49%
2021	**52%**

Hypertension Control in Canyonlands Native American Population

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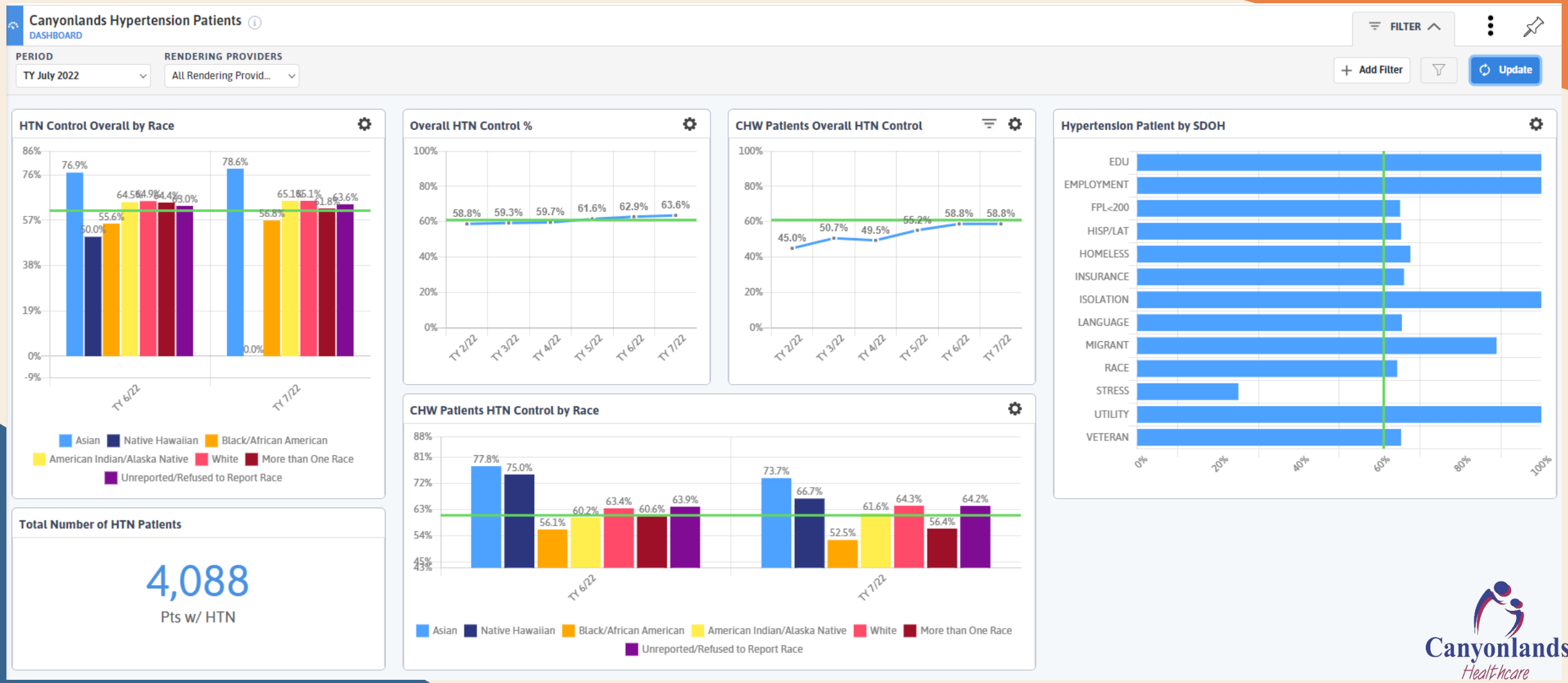
Canyonlands Native American Outreach Data



Canyonlands Healthcare

22.6% Improvement in Native American Patients

VS.

14.2% Improvement for Patients of other Races

Canyonlands Healthcare

Canyonlands Overall Hypertension Control	
UDS Report	HTN Control
2019	54%
2020	49%
2021	60%
2022	66.4%

Canyonlands Native American Population Hypertension Control	
UDS Report	HTN Control
2019	50%
2020	49%
2021	52%
2022	65.8%

Population Health Management in Action

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Dashboards

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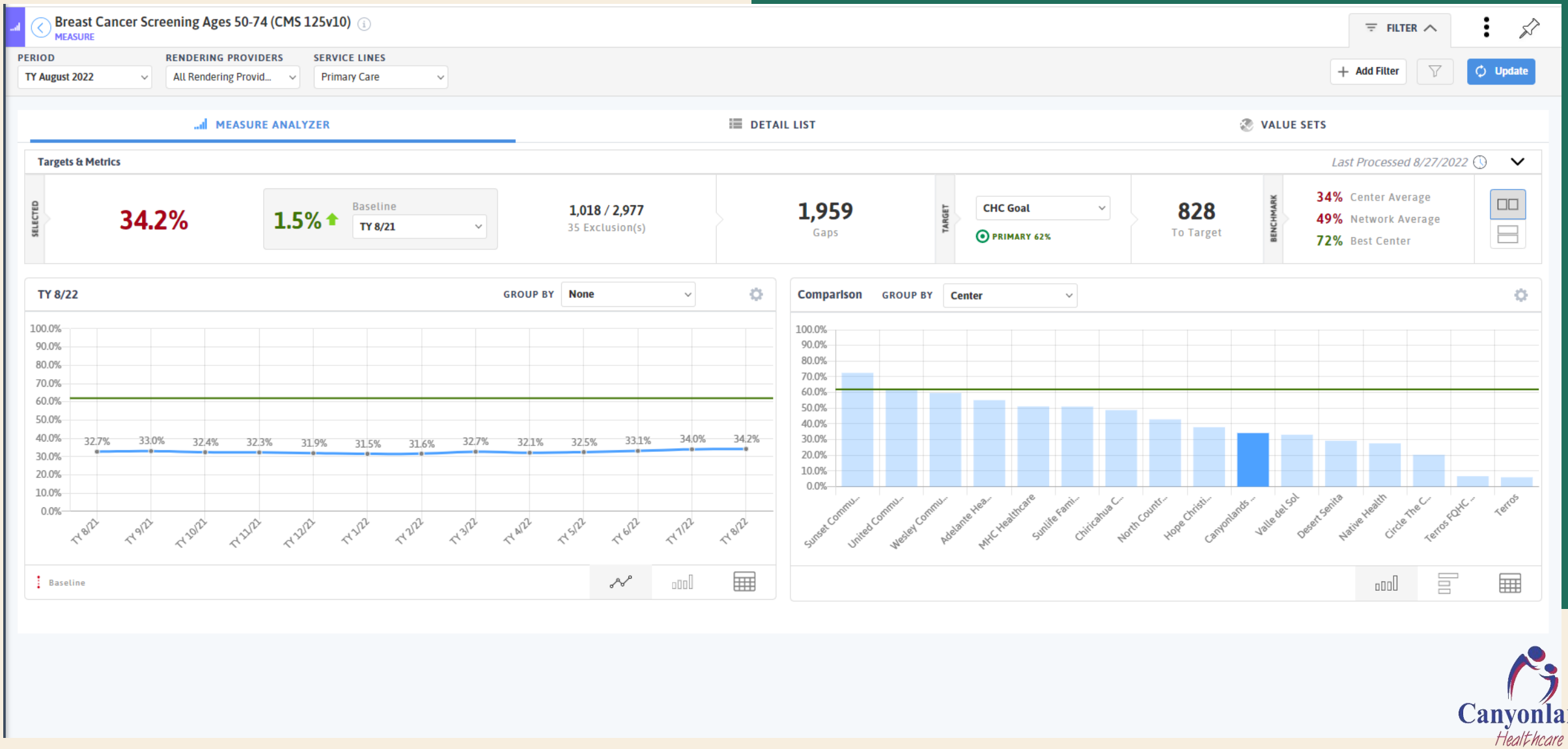
Create a Meaningful Use Dashboard



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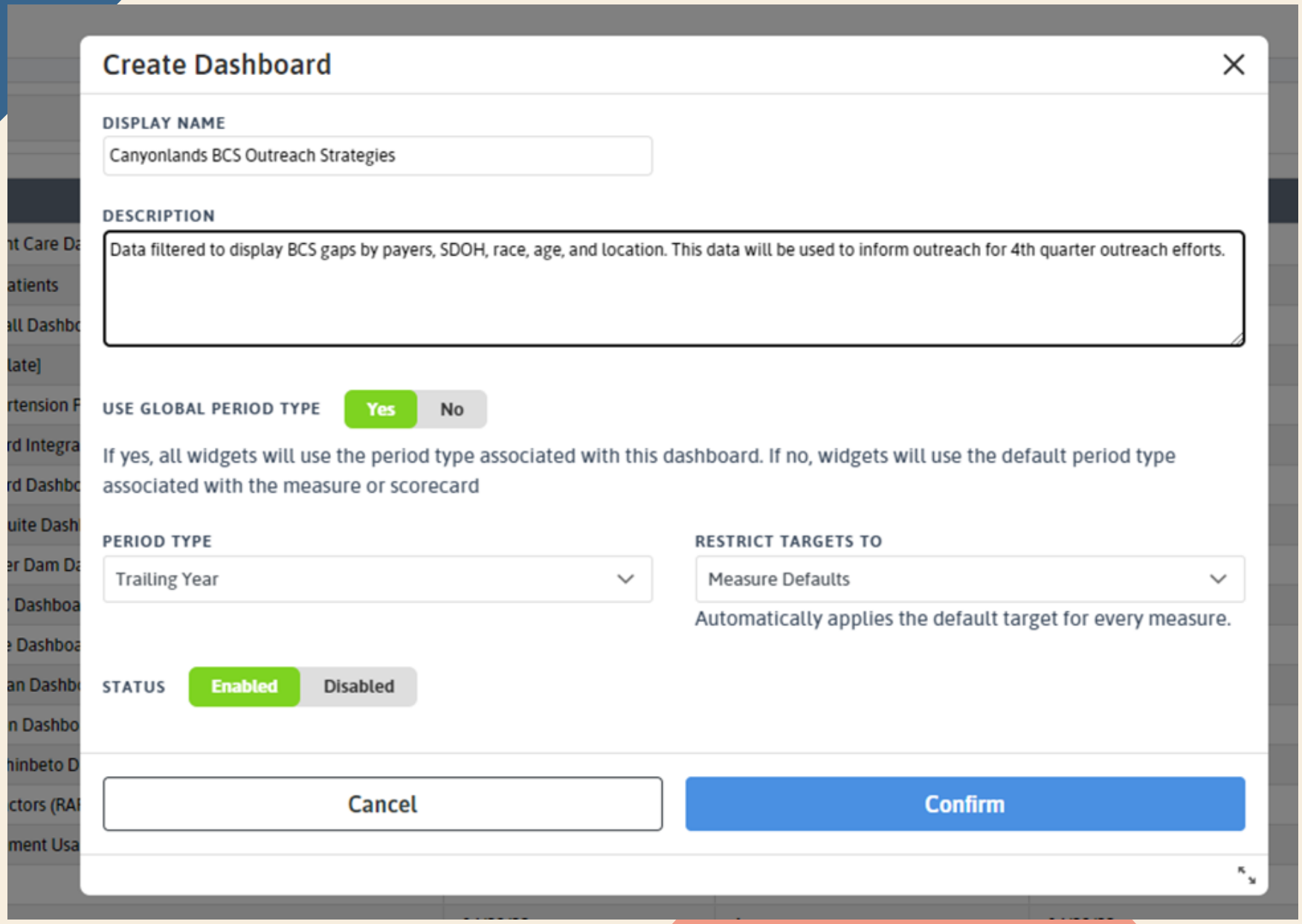

Use Specific Dates in Description

This will help others who are accessing the report use this information in the way intended.

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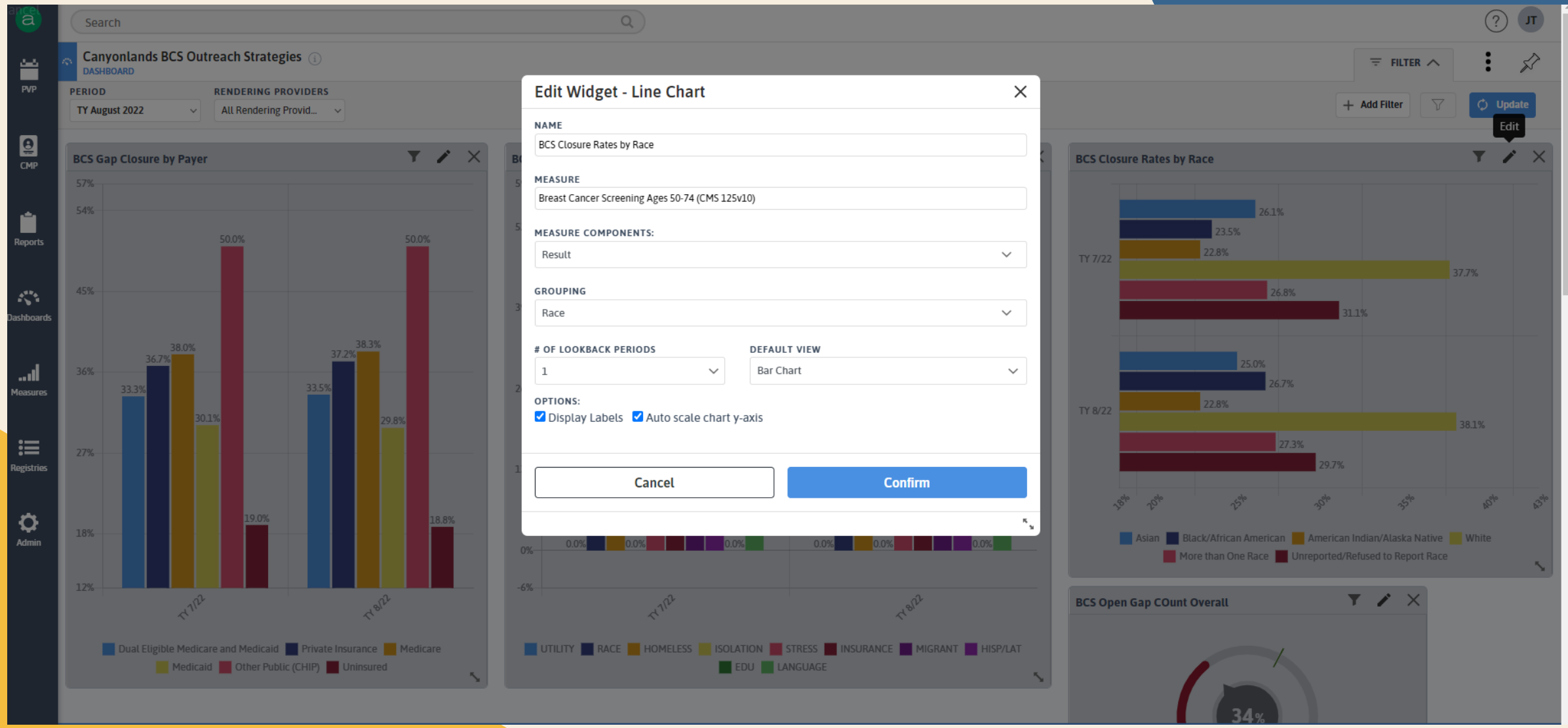

Selecting Dashboard Widgets

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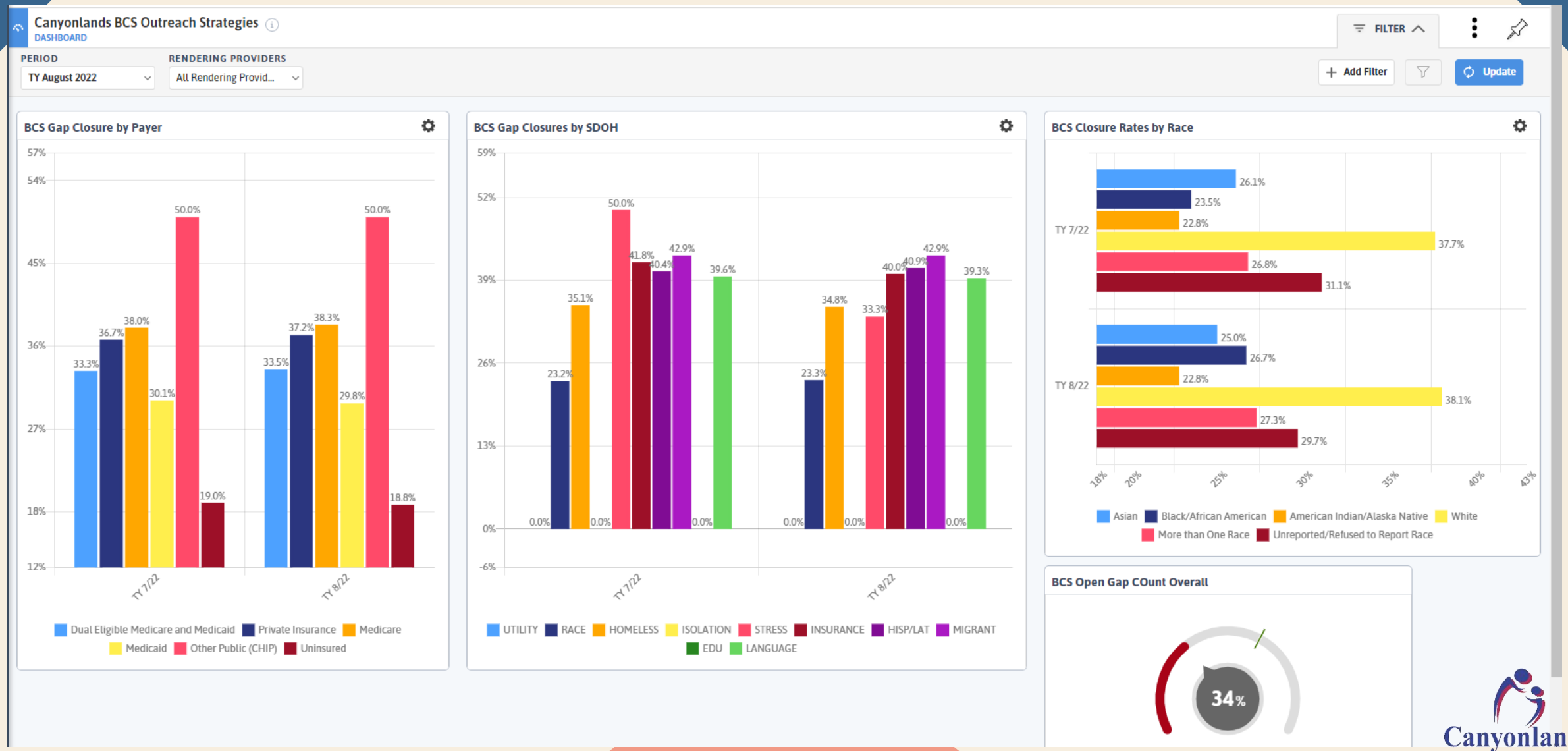
Analyze Data



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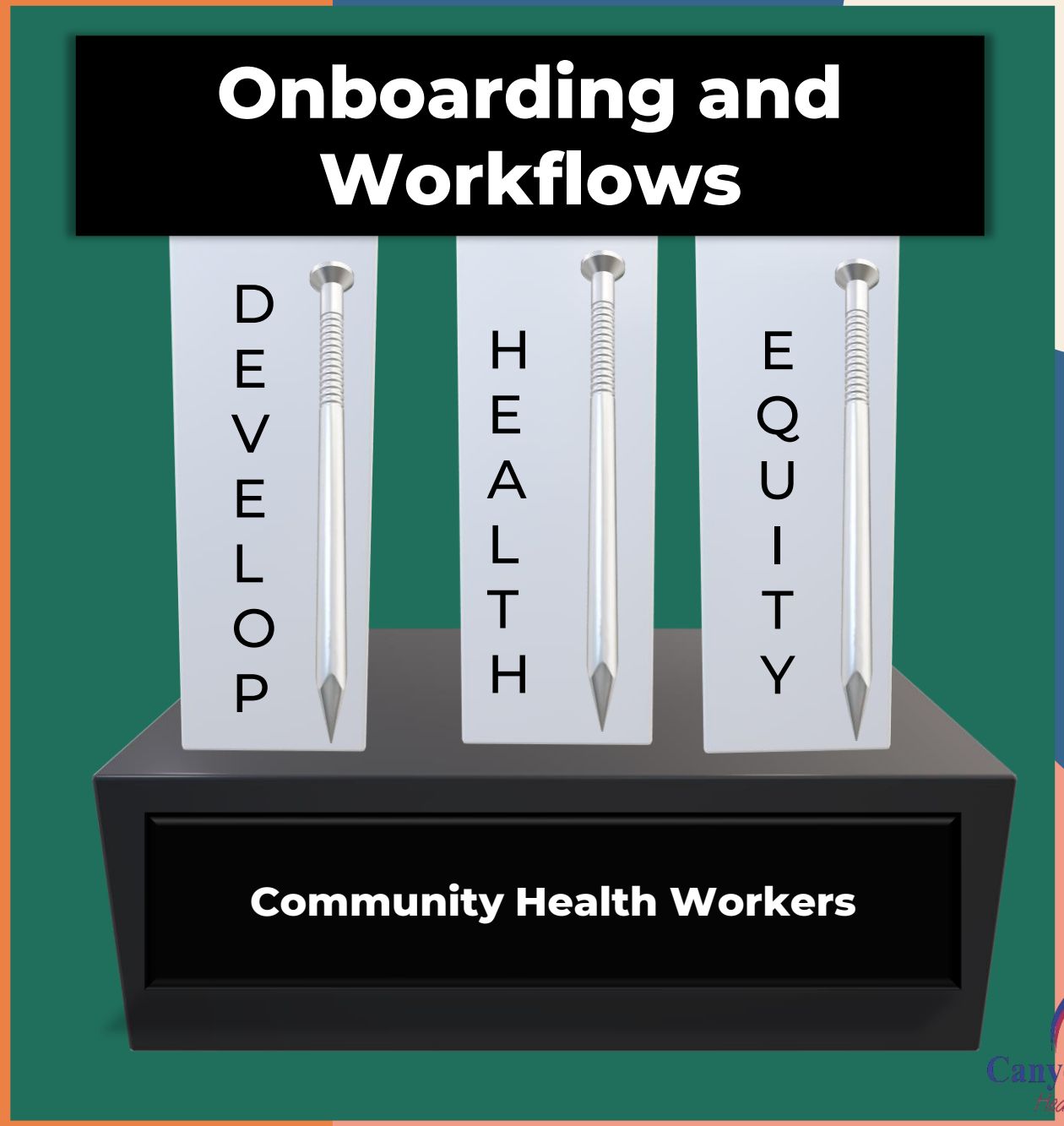
STEP FOUR
Place Support Beams



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CHW ONBOARDING

Click here for CHW Onboarding Example for Canyonlands

Click here for CHW Quarterly Training Agenda

Onboarding Outline Should be a Living Document

Give Specific Timelines for Training Completion

Organize Quarterly Training for CHW Team

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Snapshot of CHW Onboarding Process

Canyonlands Healthcare CHW New Hire Training

Section 1: Site Orientation, Canyonlands Orientation and Grant Introduction

Information	Timeline	Demonstrated by teach back	Trainer	Trainer sign-off	Date
Site Specific Instruction and information as necessary	Week 1		Self-guided		
Medtrainer	Week 1		Self-guided		
Canyonlands Orientation	1 month		Admin		
Introduction to Grants or Projects related to their position	1 month		Supervisor or Peer		
Meet community partners and ongoing meeting requirements	1 month		Supervisor or Peer		

Section 2: Job Description, Core Competencies, Ethics, Social Determinants of Health, Boundaries, Motivational Interviewing

Information	Timeline	Demonstrated by teach back	Trainer	Trainer Sign-Off	Dat
CHW Description and Introduction CHW Introduction	Week 1		Supervisor		
CHW Role in Arizona Rural Healthcare Click here for more information	Week 1		Supervisor		
CHW Training with AZCHOW	1 Month		Supervisor		
Motivational Interviewing Motivational Interviewing Introduction Motivational Interviewing Worksheet			Supervisor		
Maintaining Healthy Boundaries Healthy Boundaries Healthy Boundaries Worksheets	Week 1		Supervisor		
Social Determinants of Health Click here for training webinar (A) Click here for training video (B)	Week 1-2		Supervisor		

Section 3: Electronic Record Documentation, Scheduling, and Communication with Clinical Staff, Encouraging Questions

Information	Timeline	Demonstrated by teach back	Trainer	Trainer Sign-off	Date
Overview of Electronic Health Record Training of telephone mplate, documenting emplate, entering rical data)	Week 2-4		IT Staff		
duling and menting patient in Understanding your edule and provider edules)	Week 2-4		Site CSR Trainer		
HW Template Workflow (Care Coordination)	Week 2-4		Supervisor		
CHW-Clinical Staff Communication Procedures CHW Communication with Clinical Staff	Week 2-4		Supervisor		
Encouraging Patient Questions Encouraging Questions Introduction	Week 2-4		Supervisor		
Azara Login and Training	Week 2-4		Supervisor		

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Caring for our Communities Since 1973

July 13th, 2022 Quarterly Canyonlands CHW Training Agenda

CHW Quarterly Training Agenda		
10:00 AM	Attendance and Opening Remarks	Jodi Tate

10:03 AM-10:20 AM	CHW Core Competency #2
	• Interpersonal and Relationship Building Skills
	  ○ Communication Skills
	  ○ Body Language
		Mallory Williams

10:20-10:40 AM	Care Message Scripting • Upcoming Appointments • Missed Readings • Missed Appointments • Checking in • Follow up Appointments	Mallory Williams
10:40 AM-10:50 AM	Break	
10:50 AM -11:20 AM	Health Equity and Cultural Humility	Mallory Williams
11:20 AM- 11:30 AM	CHW Program 3rd Quarter Goal Setting and Review of Onboarding Training	CHW Team
11:30 AM-11:35 AM	Meeting Summary and Follow Up Questions	Mallory Williams
11:40 AM	Meeting Adjournment	

CHW Training Agenda Sample

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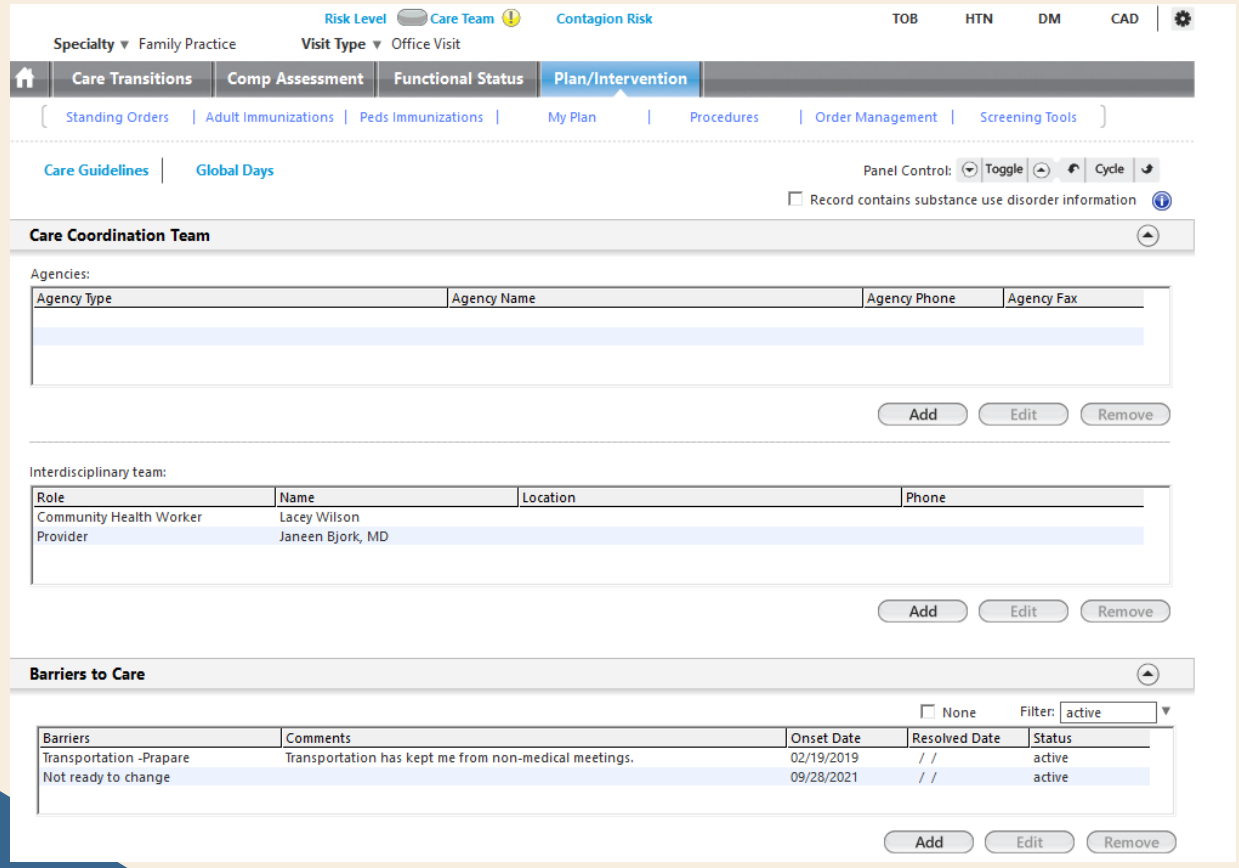
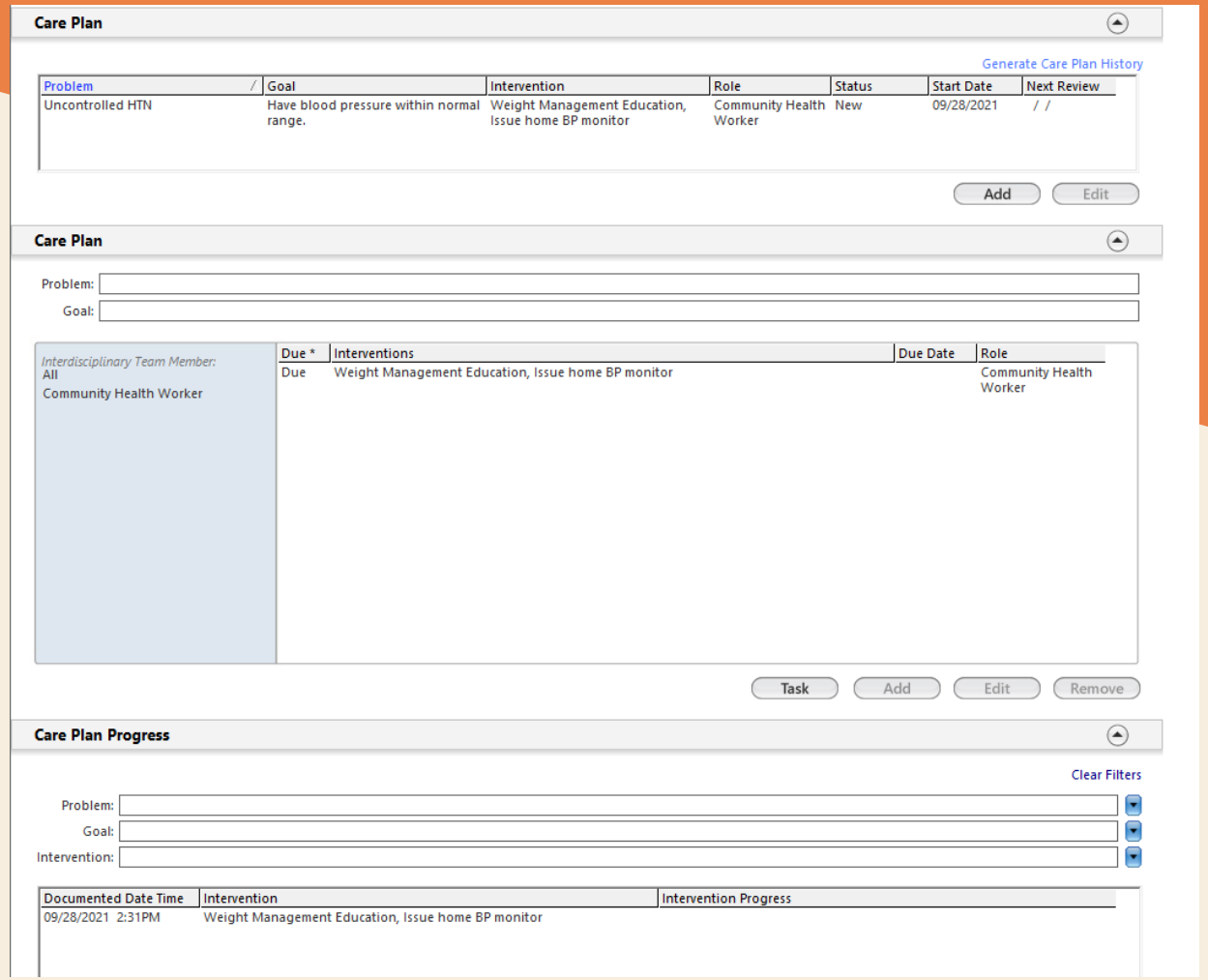
NextGen Care Management Template



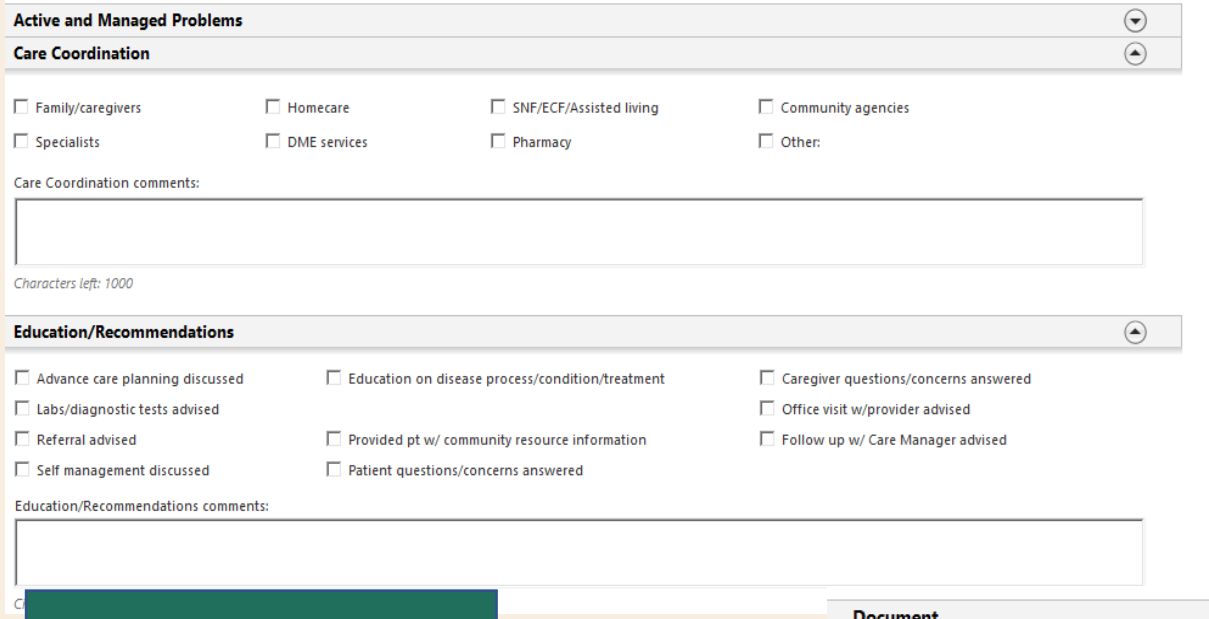


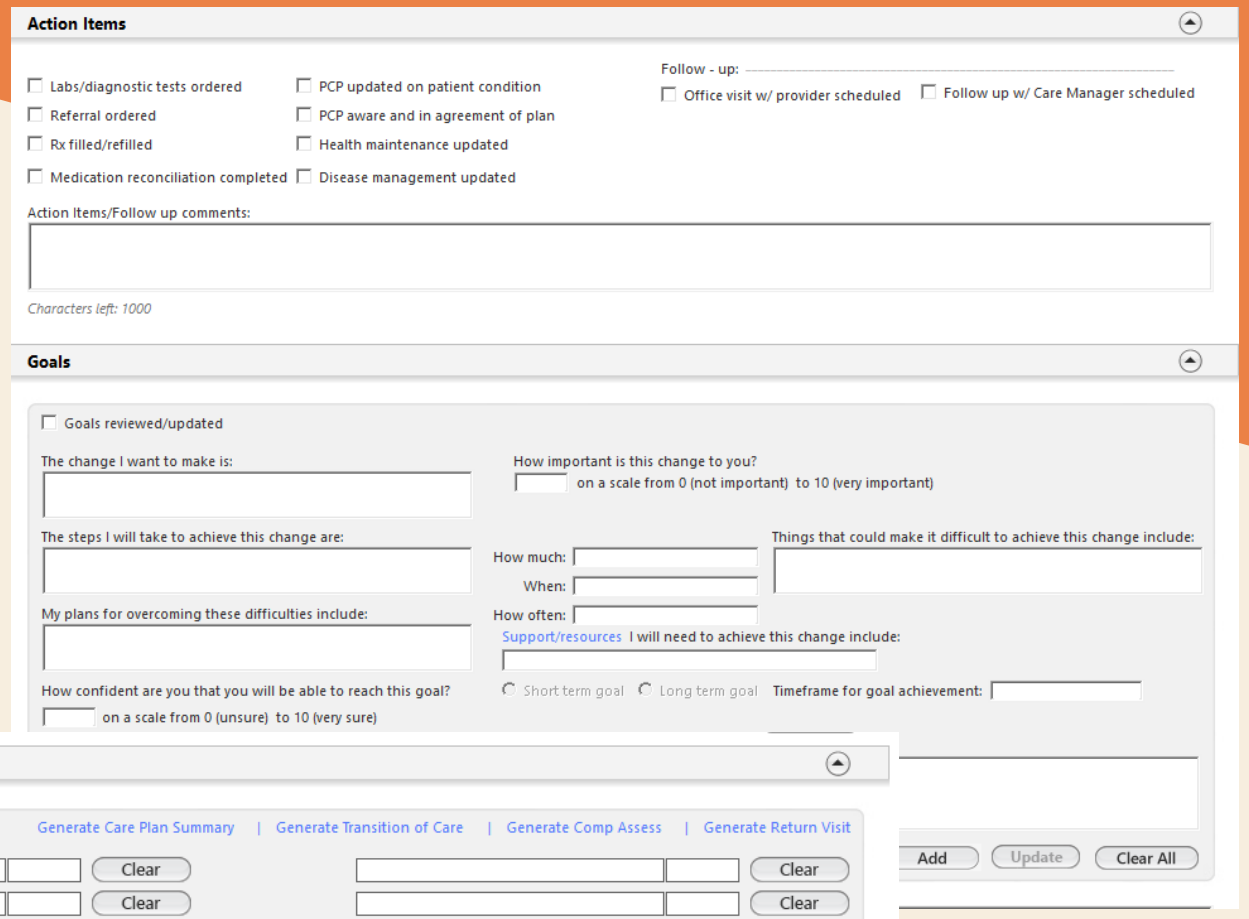
- ✓ **Assess Barriers**
- ✓ **Establish a Care Plan**
- ✓ **Document Progress on Care Plan**

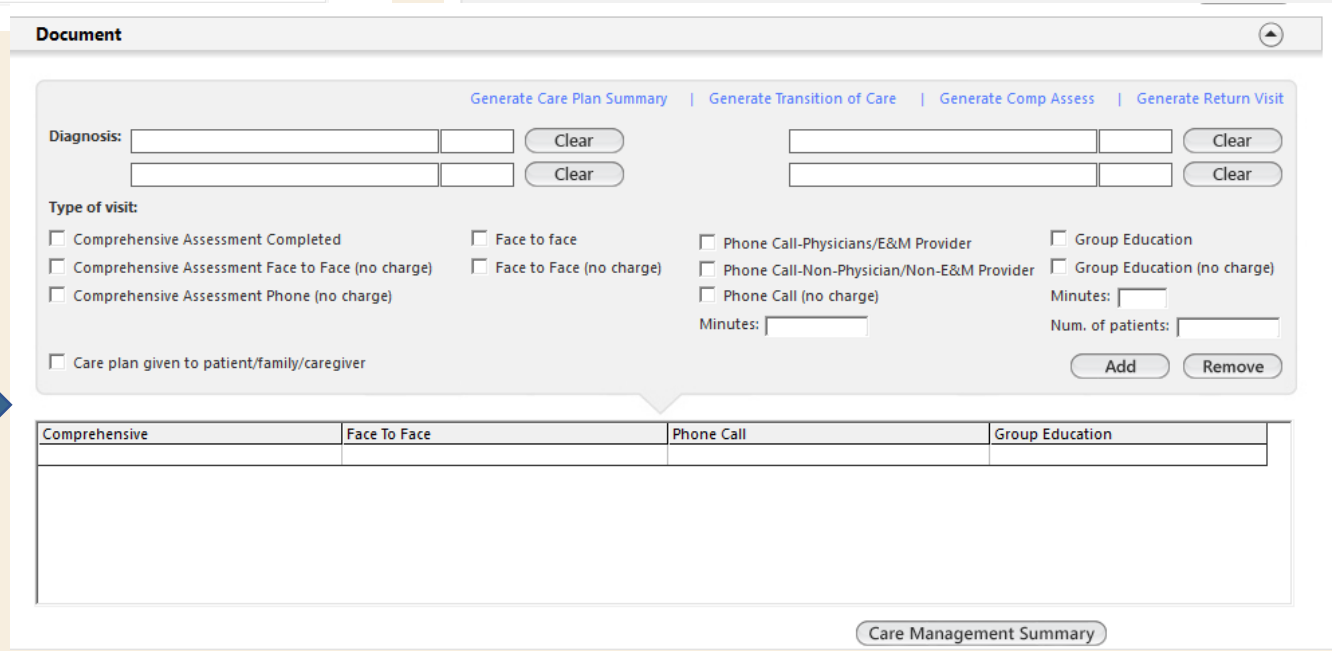
nextgen healthcare

Canyonlands Healthcare

NextGen Care Management Template







- ✓ Resources or Education
- ✓ Action Items
- ✓ Goals
- ✓ Type of Visit

Documentation for the Medicaid Billing Guidelines

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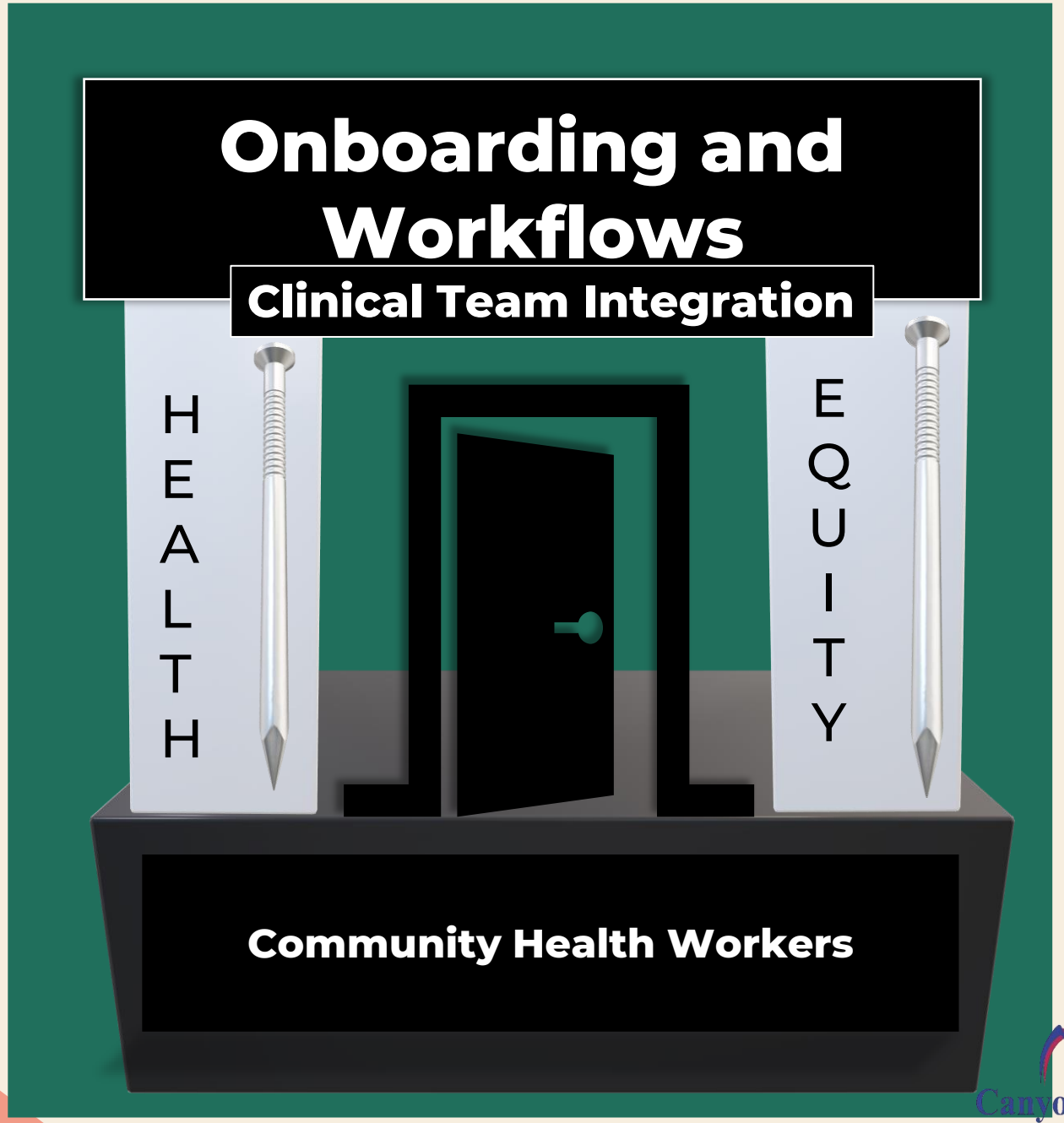
STEP FIVE
Create an Entryway



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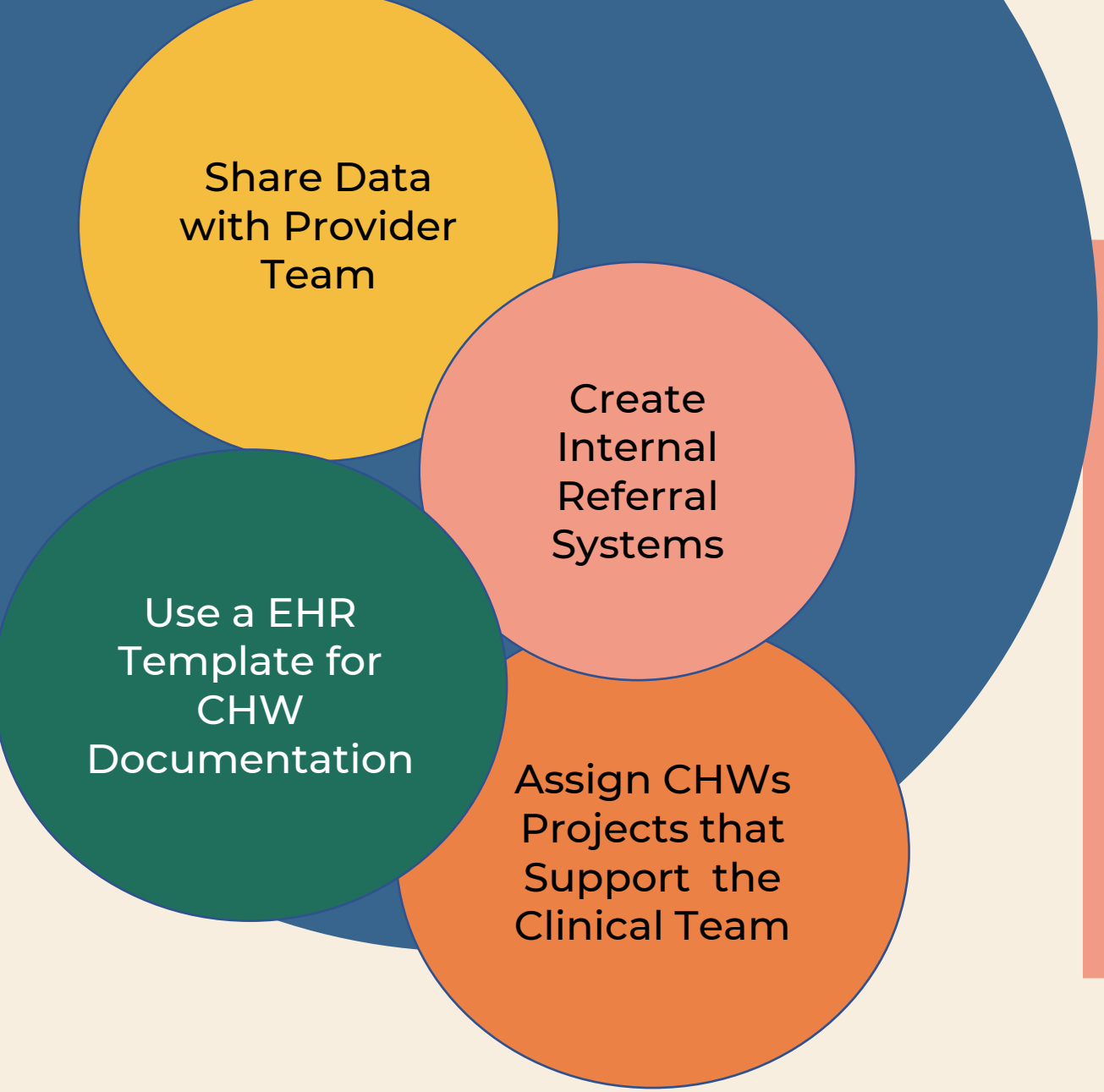

STEP FOR CHW INTEGRATION INTO CARE TEAM

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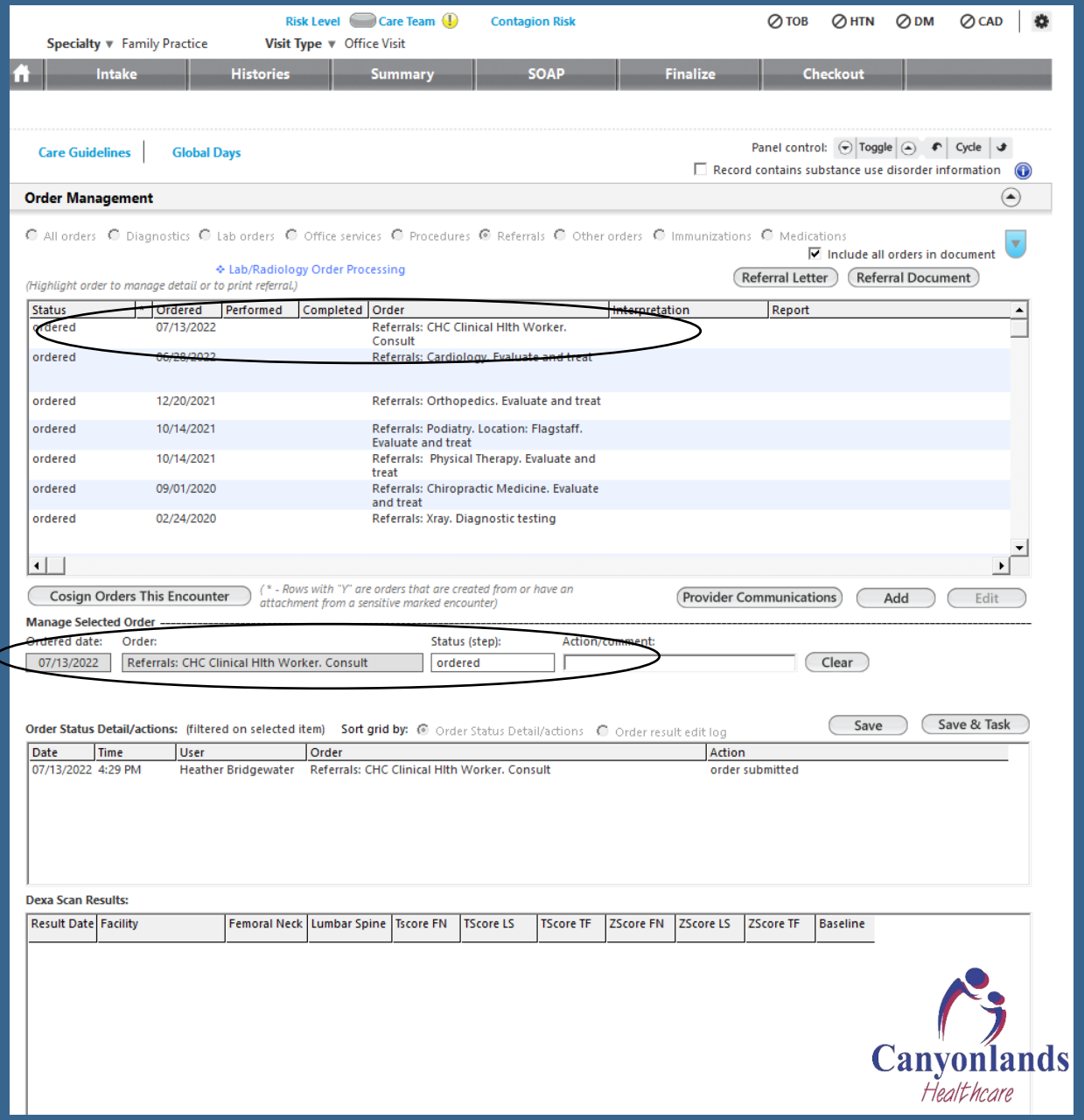
CHW Internal Referral



Trainings and Re-Education Created by CHWs

CHWs Can Work with Support Staff to Create Educational Trainings that Support Health Center Goals

Confirmatory BPs Improved by 10% as a Result of this Training

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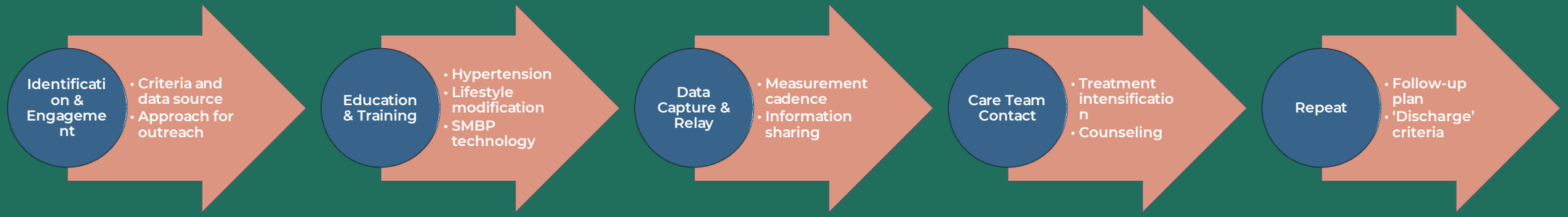
The Blueprint in Action



- ✓ With the use of our population health tool Azara, we identify patients who have their most recent reading out of range. (greater than 140/90).
- ✓ CHWs then reach out to the patients and invite them to participate in the RPM program.

- ✓ Patients are given guidelines of how and when to take their BP and are given a consent form.
- ✓ CHWs reach out via phone, home or clinic visits and our text messaging application to check in on PTs.

- ✓ **Data is retrieved and uploaded weekly into NextGen with the help of our CHWs.**
- ✓ **Providers are provided with a cohort dashboard to monitor the patient's progress.**

- ✓ Patients are scheduled to see their providers 4-6 weeks after receiving the device.
- ✓ The provider then recommends treatment based on a more comprehensive view of the patients daily BP.
- ✓ Medication changes or Clinical Pharmacist visits may be recommended.

- Pt is seen again 4-6 weeks later.
- If control is achieved, they are recommended to continue use of device for self-monitoring purposes.
- If control is not reached, provider and patient discuss possible treatment changes.

Canyonlands Healthcare

Start Where You Are

Use What You Have

Do What You Can

-Arthur Ash

Canyonlands Healthcare

THANK YOU

Canyonlands Healthcare

Connecting Population Health Data Tools to Care Management Program

Amanda Parrell Kaczmarek
Program Manager
Progressive Community Health Center

Progressive℠ Community Health Centers

Our Mission

Progressive Community Health Centers exists to improve the health and quality of life of the community by providing culturally competent services that address identified needs.

Progressive℠
Community Health Centers

Our Patients

2021 Demographics

- 14,540 patients
- 41,389 clinic visits
- 83% African American
- 91% live in poverty
- 61% Medicaid
- Female: 60%/Male: 40%
- Children under 18: 28%
- Age 50+: 24%

Progressive℠ Community Health Centers

Where it all began…March 2021

- Team formed!
  - CMO and Medical Director – clinical guidance
  - Care Management – device distribution, patient education
  - QI Director and Clinical Data Analyst – manage data, write/test reports and dashboards for monitoring
  - HIT consultant – EHR enhancements, workflow and training documents
  - Development Director – grant writing, HRSA communication
  - Program Manager – project administration, grant reporting
- Baseline Hypertension Control – 60%

Progressive℠ Community Health Centers

Anticipated Outcomes

- Staff Training
- Outreach
  - Offer program to over 50% of eligible patients
  - Uniform documentation
- Device Distribution
- Functional reporting
  - Discreet documentation
  - Dynamic rosters within Epic
  - NO MANUAL CHART REVIEW
- **70% Hypertension Control (UDS metric)**

Progressive℠ Community Health Centers

Resources and Tools

- OCHIN Epic
  - Smart Data Elements
- Azara DRVS
- Device – Omron Silver
- Text Outreach
- Dedicated and experienced team to develop workflows and pilot before launch

Progressive℠ Community Health Centers

Outreach

Months	(All)

Count of MRN	1st Call Type		
Program Participation Status	**On Site**	**Outgoing**	**Grand Total**
Declined for now	3	546	549
Participate - No Smartphone		3	3
Participate in Program	130	372	502
Refused to Participate		24	24
(blank)	2	17	19
Grand Total	**135**	**962**	**1097**

- Methodology
  - In person
  - Text messaging
- Tracking
  - Demonstrate effectiveness to prioritize efforts
  - Follow up outreach with "Decline for now"

Progressive℠ Community Health Centers

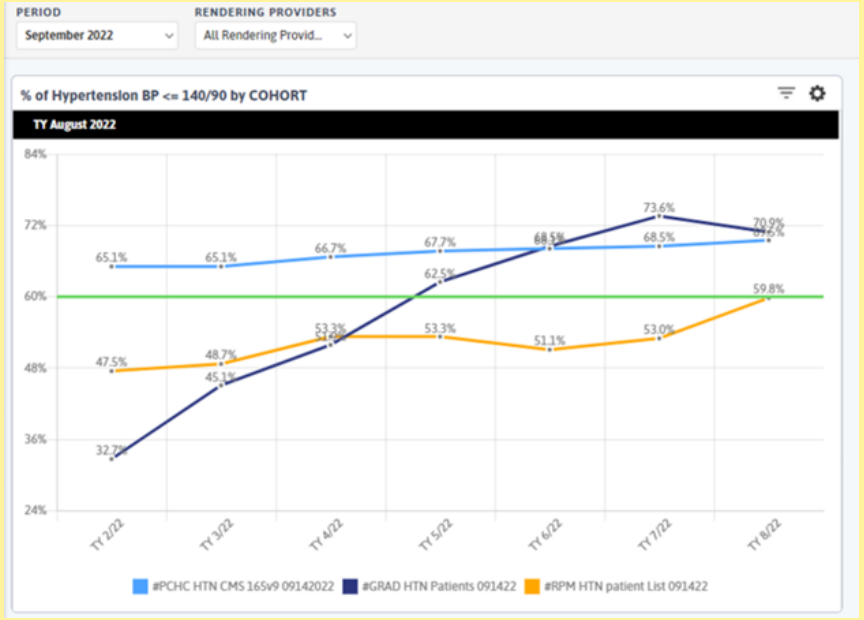
Device Distribution and Integration

- Smart phrase for device distribution
  - Need to anticipate key variables to success
  - Can help identify issues
- Challenges
  - Phone limitations
  - Troubleshooting after distribution

Count of MRN		Connection Status			
MobilePhone Type	Phone Connection	Successfully connect	Unable to Connect	(blank)	Grand Total
Android		**12**	**62**	**1**	**75**
	Apple HealthKit	1			1
	Google Fit	3	7		10
	(blank)	8	55	1	64
iPhone		**44**			**44**
	Apple HealthKit	43			43
	(blank)	1			1
(blank)		**14**	**1**	**2**	**17**
	Apple HealthKit	4	1		5
	Google Fit	10			10
	(blank)			2	2
Grand Total		**70**	**63**	**3**	**136**

Progressive℠ Community Health Centers

Program Participation & Completion



- Typical enrollment
  - 3 months with high touch follow up with Care Coordinator
  - Can extend as needed
- Finalizing graduation definitions

Progressive℠ Community Health Centers

Current Successes

- Outreach
  - 1214 patients
- Device Distribution
  - 347 SMBP devices in distributed
  - 326 submitted results
- Program Graduates
  - 71 patients
- Current Hypertension Control
  - 69% (as of 8/31/2022)

2022	Has Summited Results	Grand Total Outreach	%
Meeting Date	**Results #**	**Total #**	**%**
3/17/2022	37	225	16.44%
4/12/2022	81	389	20.82%
5/11/2022	136	661	20.57%
6/7/2022	165	749	22.03%
7/13/2022	241	1009	23.89%
8/10/2022	284	1102	25.77%
9/14/2022	**326**	**1214**	26.85%

Progressive℠ Community Health Centers

Question?

Contact:

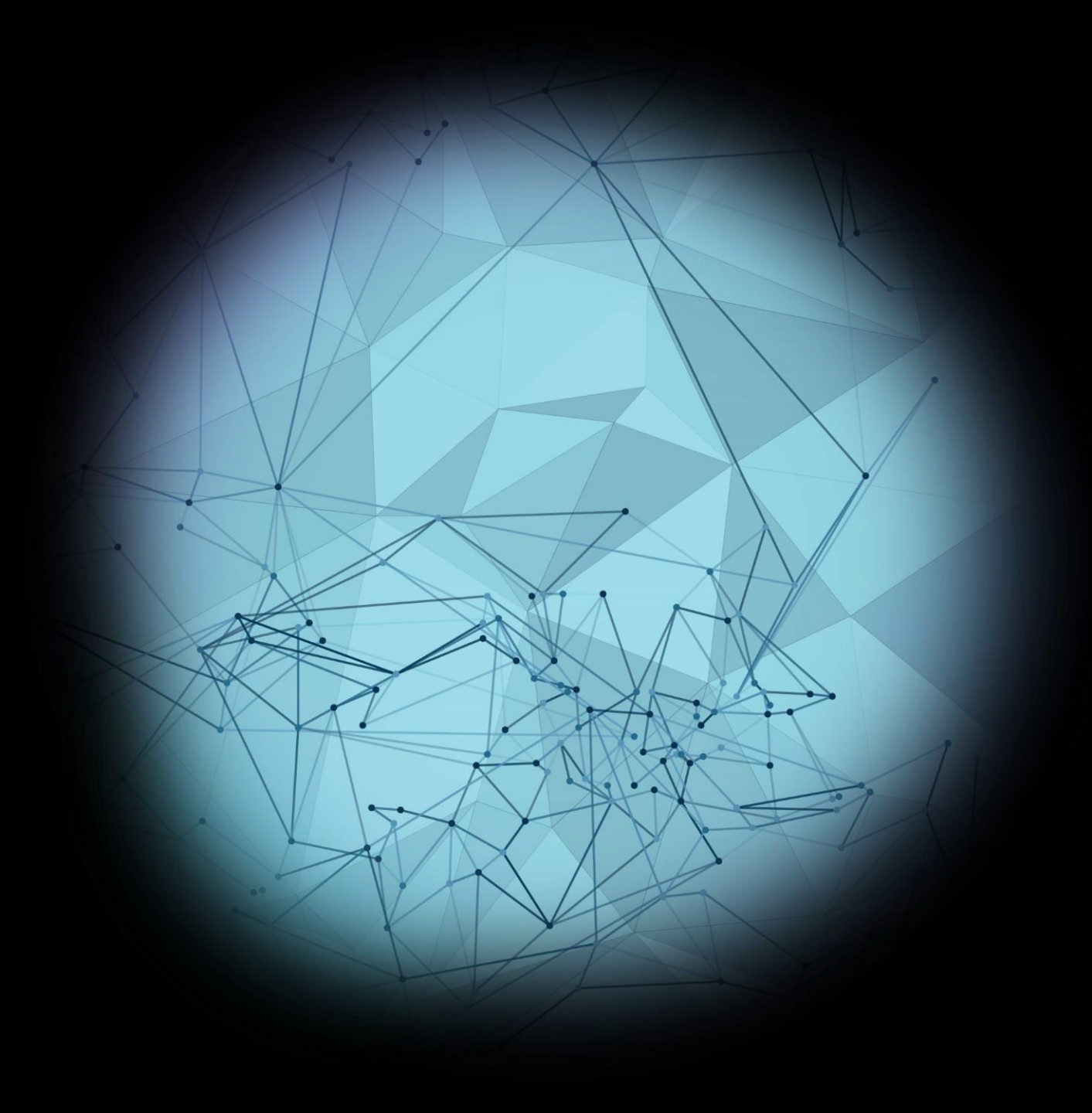
Amanda Parrell Kaczmarek

Amanda.ParrellKaczmarek@ProgressiveCHC.org

414-882-2029

Progressive℠ Community Health Centers

Break



From Data to Understanding

THE DATAOPS JOURNEY

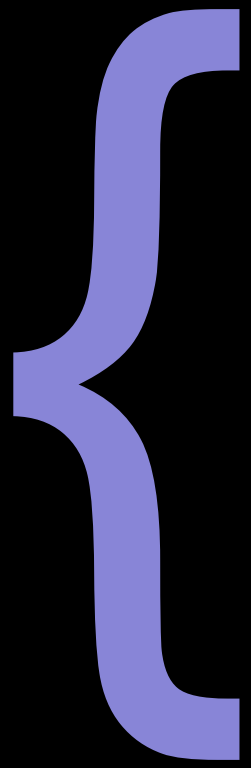
Introductions

Gevork Harootunian

Director of Data Science

Decision Center

Outline



The struggle with analytics

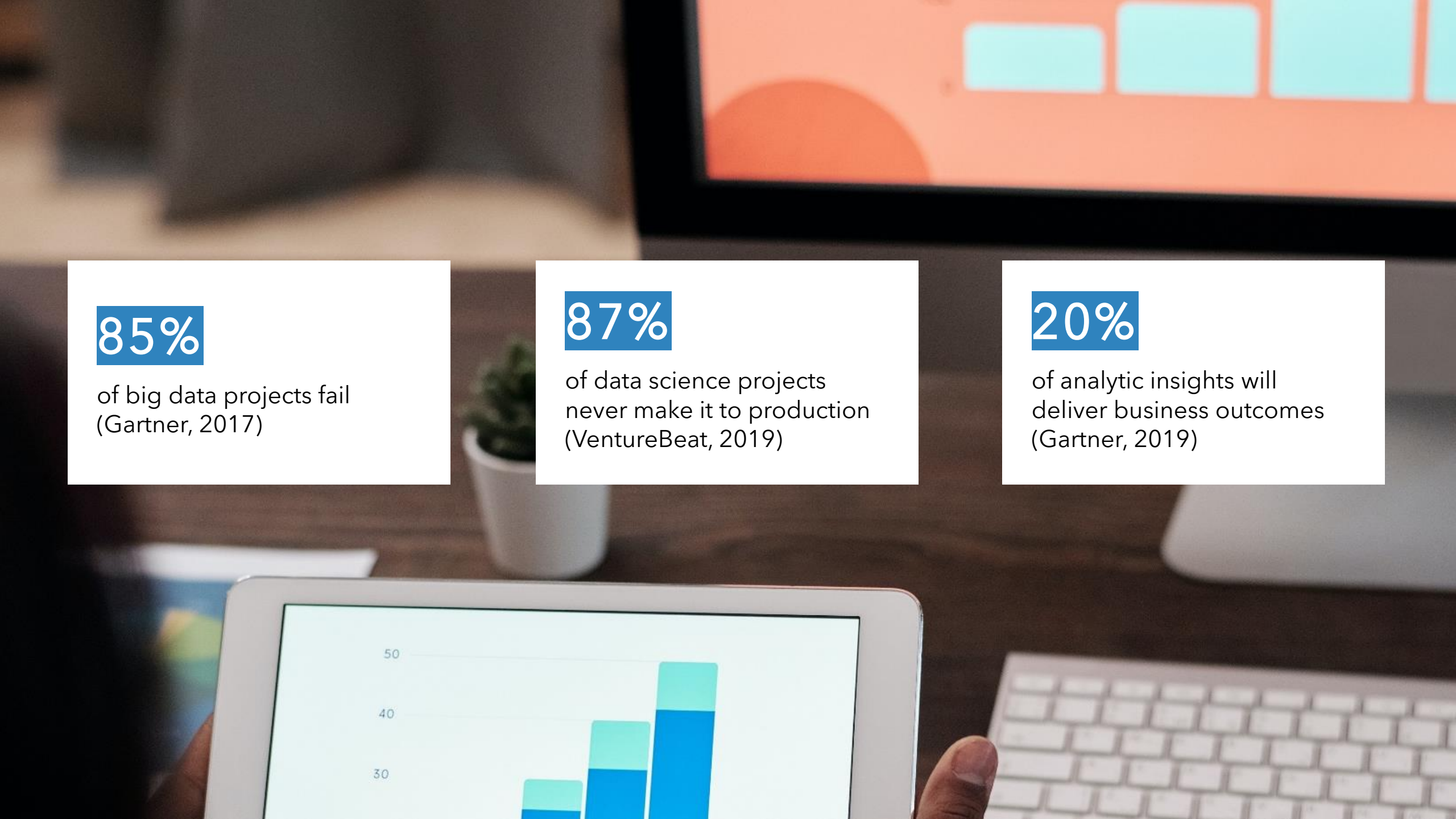
DataOps

Data integration

Data vs information vs knowledge

Dashboards and visualizations

The struggle with analytics



85%

of big data projects fail
(Gartner, 2017)

87%

of data science projects
never make it to production
(VentureBeat, 2019)

20%

of analytic insights will
deliver business outcomes
(Gartner, 2019)

The struggle

Some of the major reasons why data projects fail include

01 The wrong **data**

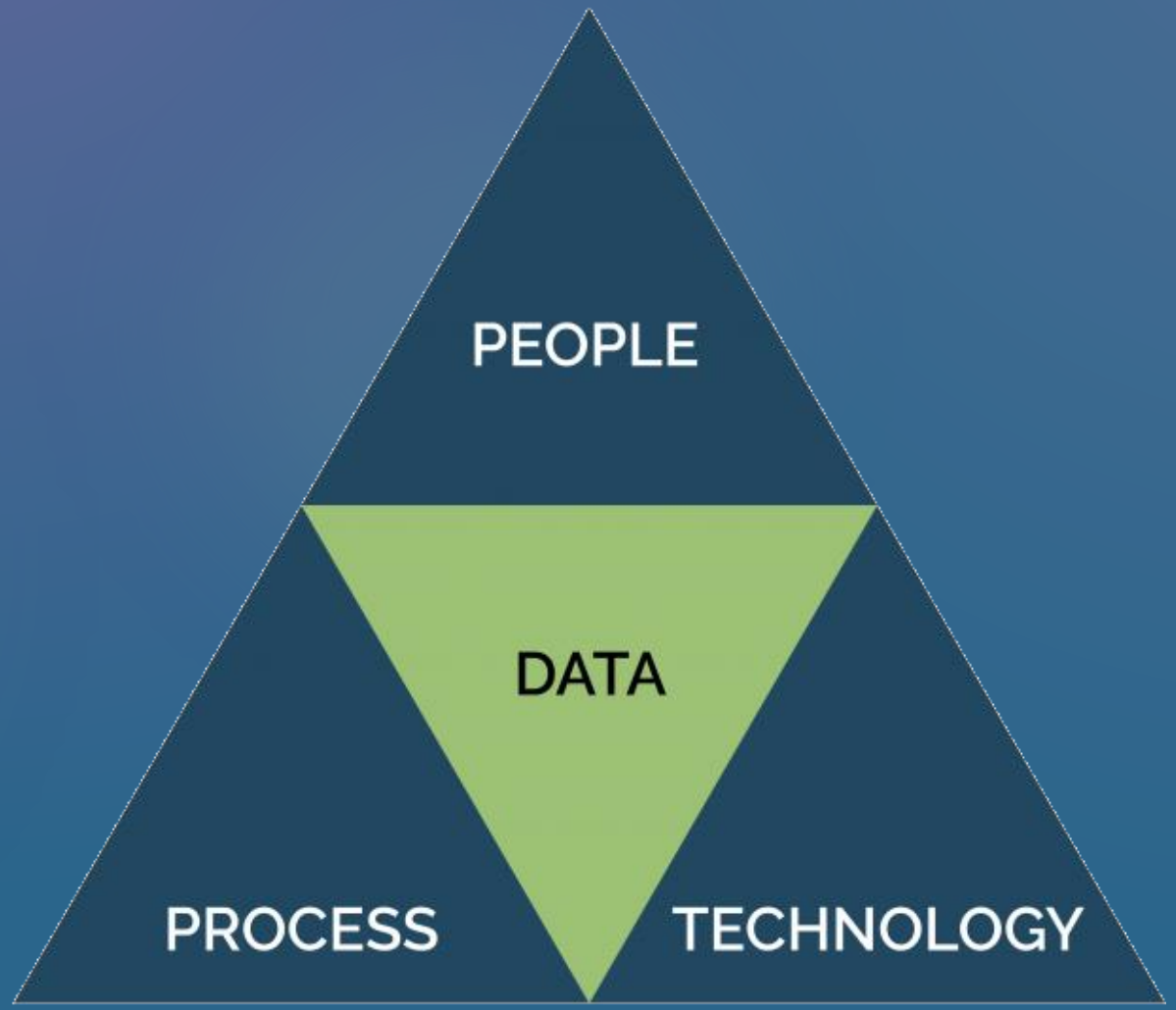
02 The wrong **talent**

03 The wrong **processes**

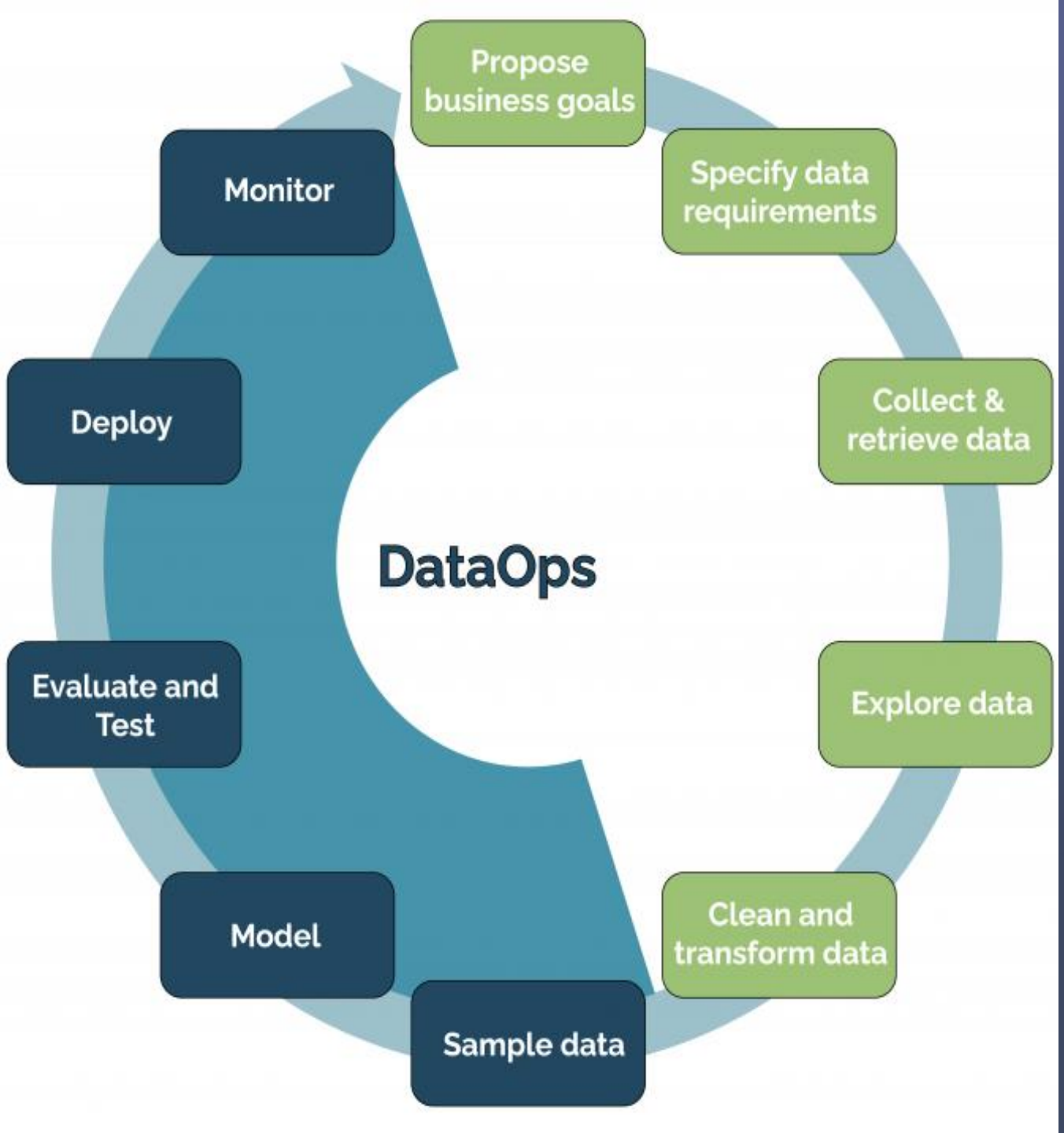
04 The wrong **technology**

05 The wrong **problem**

06 The wrong **culture**



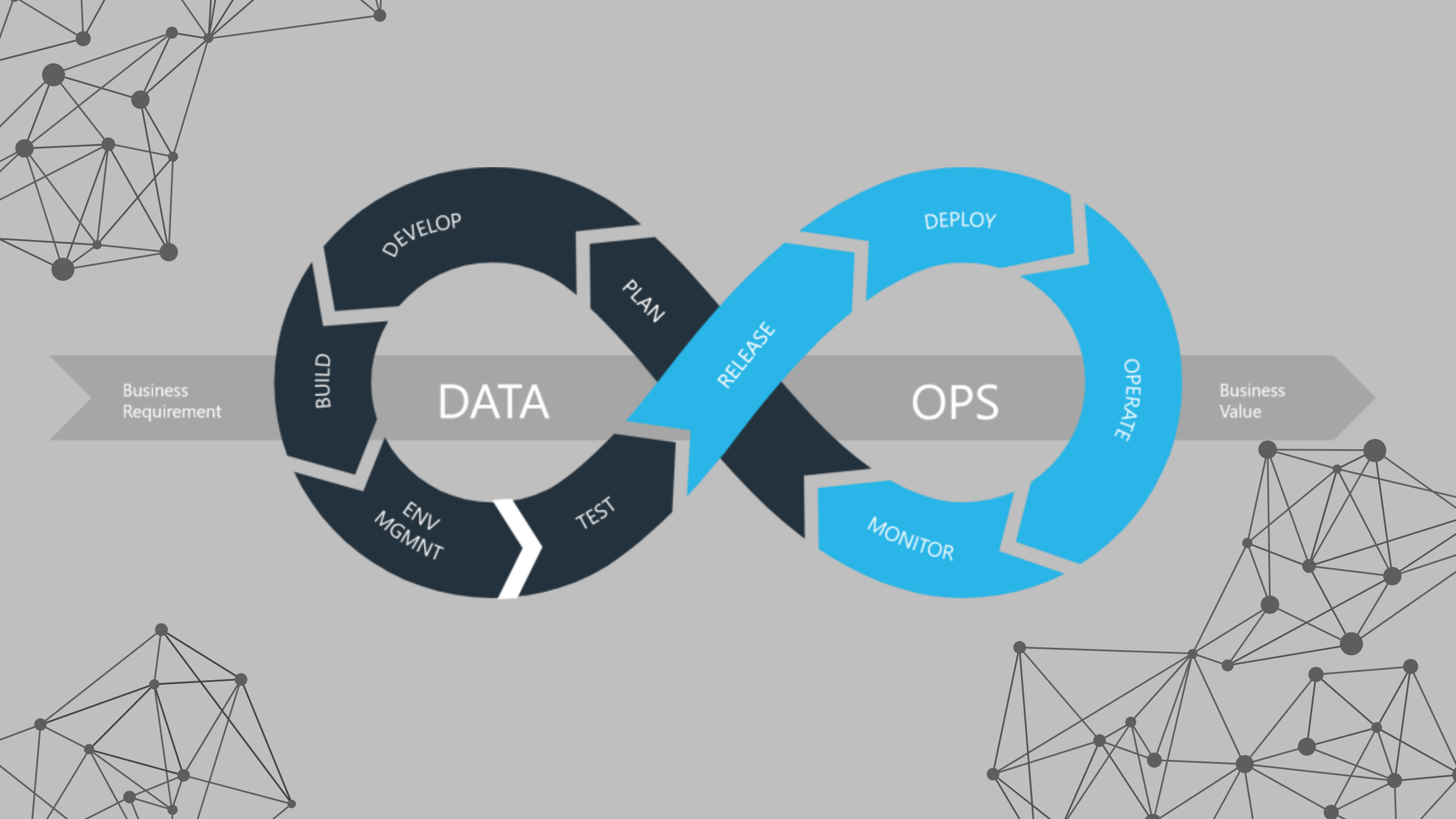
Data Operations



Data Ops

- An approach to data analytics from an operational lens
- Captures the entire lifecycle of data from planning and data capture to reporting and action
- Aligns technology, processes, and people along key goals
- Think of it as a factory or kitchen. Lots of different steps. All prone to error. The key to a good data product is error reduction
- Improved collaboration, communication, integration and automation all throughout the process
- Foundation of data culture and democratization

Get it!	Data capture, data integration, ETL (extract, transform, and load)
Find it!	Data discovery, metadata
Rule it!	Data governance, automation, monitoring, and maintenance
Work it!	Data & analytics life cycle
Live it!	Goals, roles, culture


DEVELOP
PLAN
BUILD
ENV MGMNT
TEST
DEPLOY
RELEASE
OPERATE
MONITOR
Business Requirement
DATA
OPS
Business Value

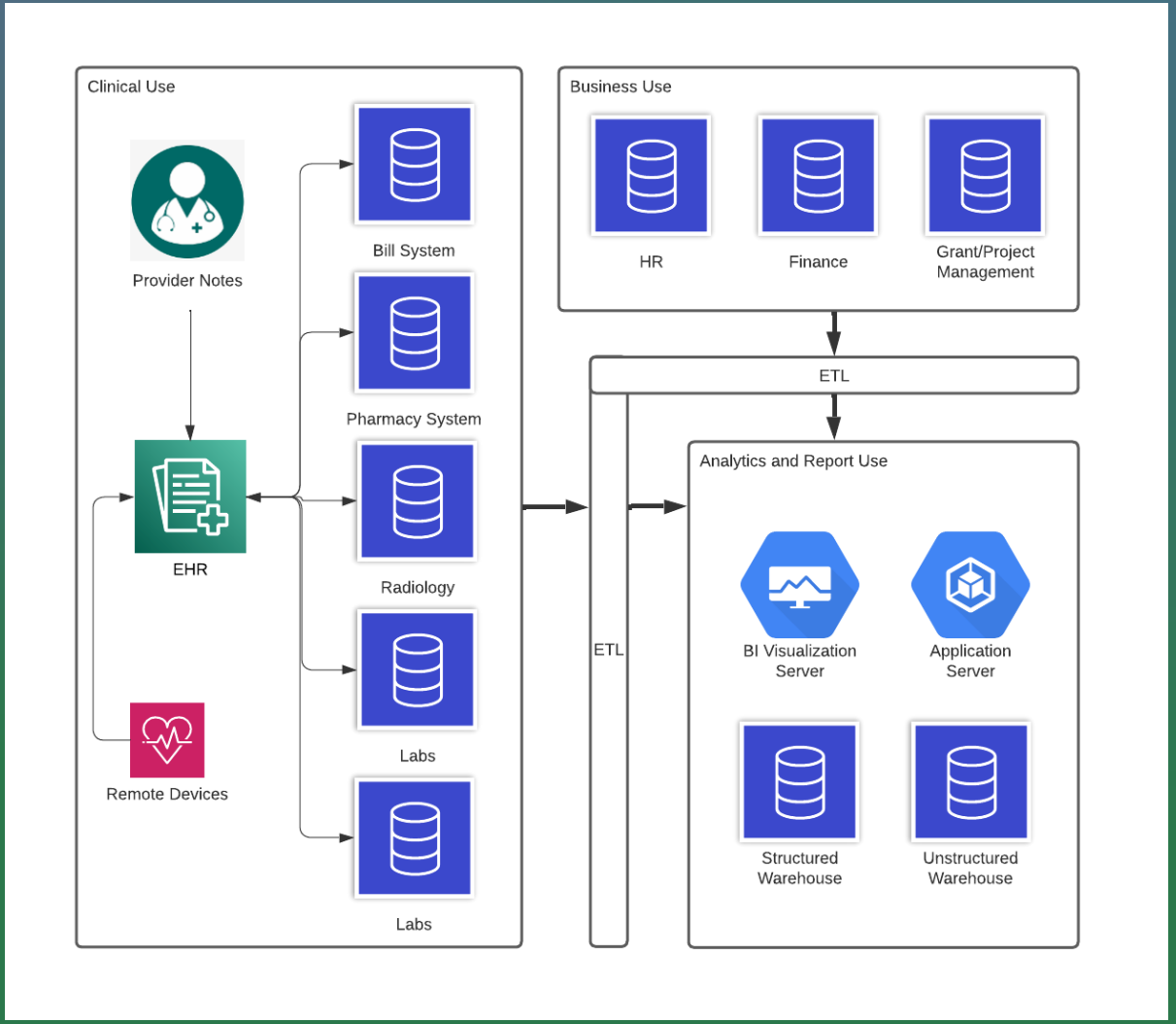
Data integration

Data Integration

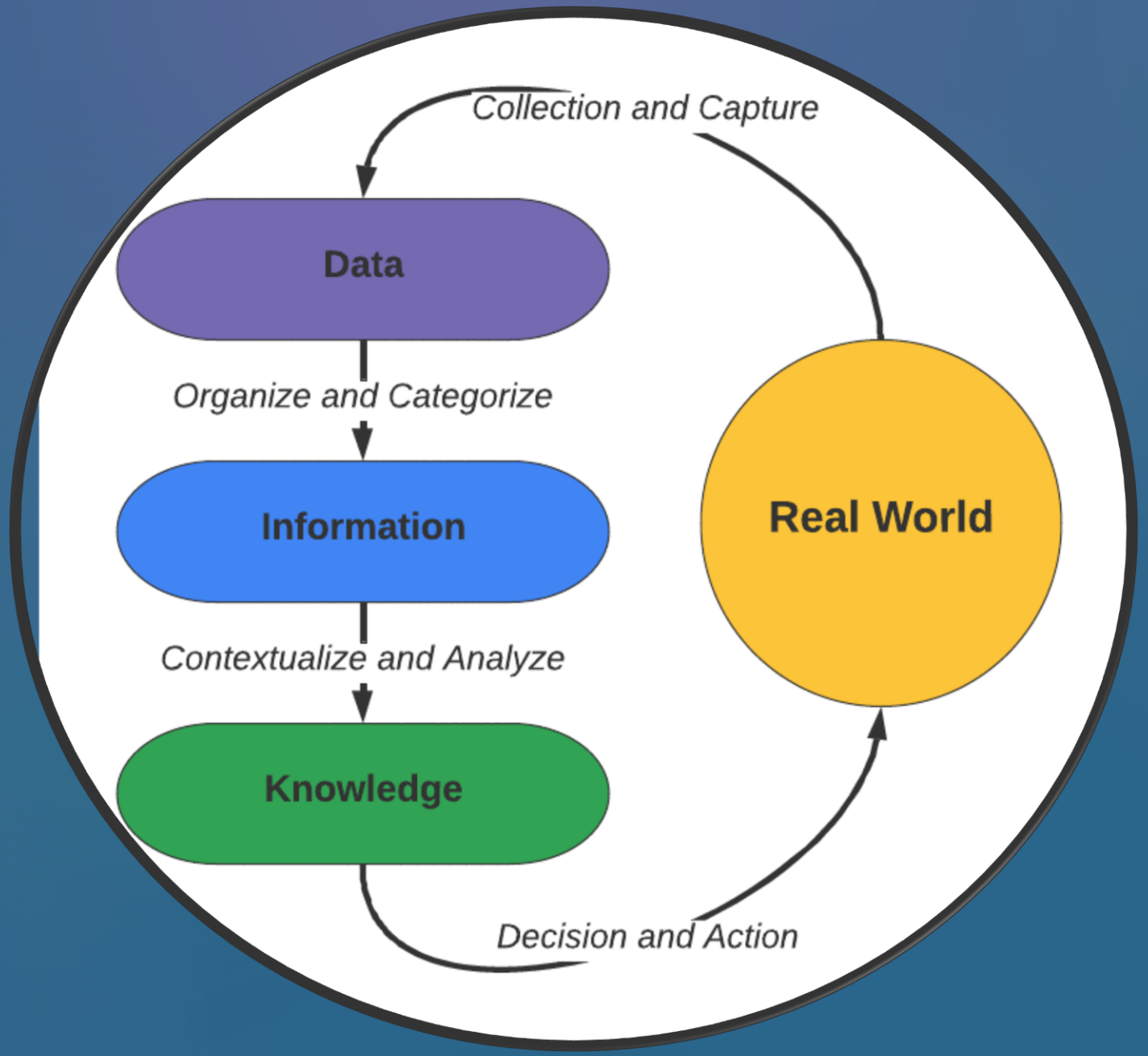
Having an analytical warehouse is essential in your DataOps strategy with many benefits

- Innovative medical solutions
- Rich context for complex system
- Reliable decision making

- System performance
- Security and compliance
- Automation and sustainability



Data is not knowledge


Collection and Capture
Data
Organize and Categorize
Information
Contextualize and Analyze
Knowledge
Real World
Decision and Action

Dashboards & visualizations

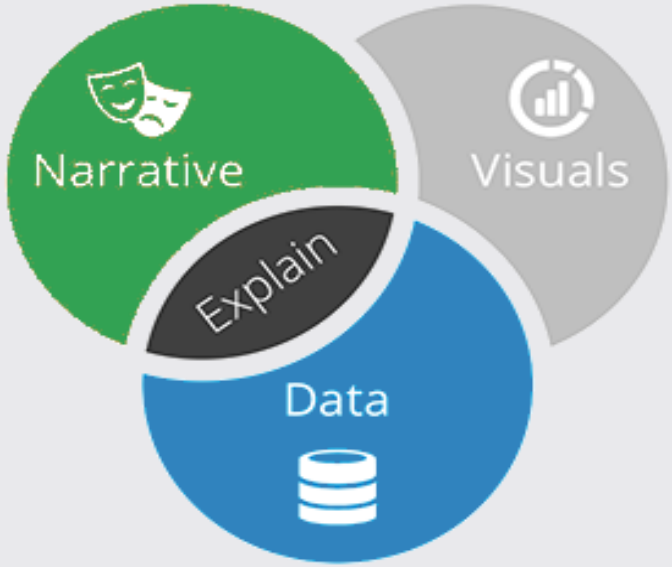
What makes a dashboard effective

- A clear well articulated purpose
- Awareness of the intended audience
- Well designed and relevant metrics
- Actionable
- Coherent flow and context
- Color, style, and layout
- Sparse, minimum necessary
- Chart selection
- Iterative

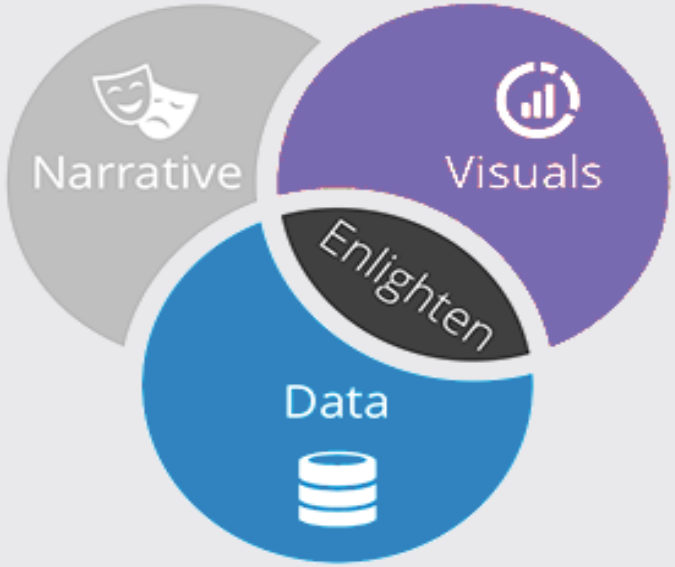
Types of dashboards

- Traditional BI categorization of dashboard types
  - Strategic
    - High level metrics to monitor long term goals
  - Operational
    - Like strategic dashboard but for shorter term goals or more real time operations
  - Analytical
    - Data and information rich with intent to deep dive on a issue
- Additional classifications
  - Exploratory
  - Explanatory
    - Answers ‘why’

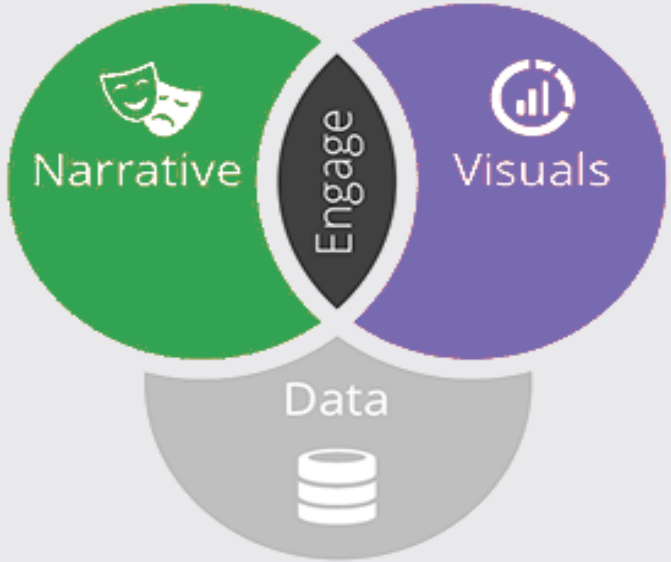
How to present findings



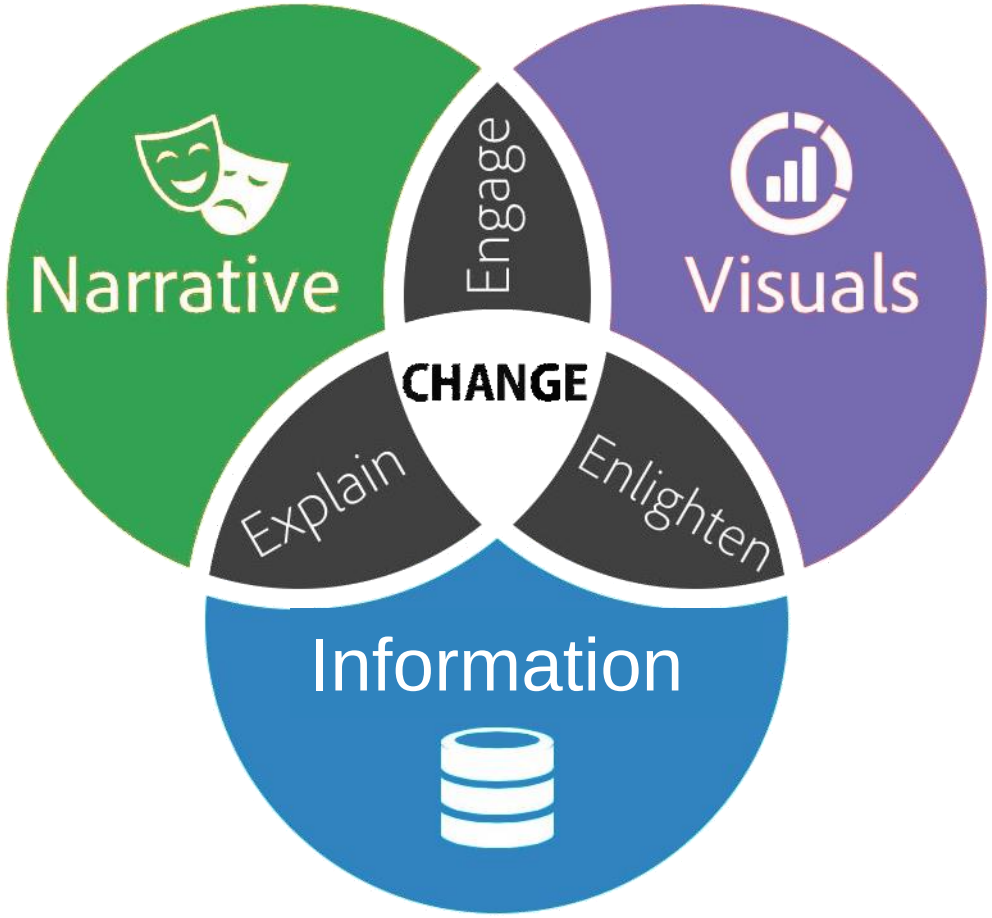
Traditional Reports



Dashboards or Visualizations



Storytelling



We don’t make decision on rationale alone

- Curate your dashboard to drive context and knowledge
- Let the flow of the dashboard naturally tell the story
- Don’t be afraid of using multiple screens or pages. Let each page be absorbed
- Combine exploratory and explanatory aspects to include the audience in the discovery process so that they are engaged in the decision

Thank you

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gharootu@asu.edu

Closing Referral Gaps to Achieve Better Outcomes and Health Equity

6th Annual HIT Symposium

Data & Technology to Support Health Equity

Community Memorial Health System + Voluware™

Guest Speakers

Adam Basua

Manager- Allscripts,
Referral Coordinators,
Surgery Schedulers
Community Memorial Health System

> From averaging 3,500-4000 referrals per month to over 7,000 per month with VALER -- and not being fully staffed.

> As a physician partnering and helping our clients who are struggling with manual referrals and auths is our delivery of care model.

Steve Kim, MD

CEO & Co-founder
Voluware, Inc.

Objectives

Four Key Insights in Closing Referral Gaps:

01 Data is the first step in understanding where to focus

02 Approach must be tailored to address population needs

03 Technology is an indispensable tool

04 Partnership boosts the impact

Voluware

Tailoring to Your Population's Referral Needs

Patients

- Using patient data to improve health and care

AND

Services

- Using digital technology to improve outcomes

Together

- Bridging the health equity divide

Voluware

Key Referral Challenges & Gaps

Time-consuming Manual Referrals

Faxes, phone calls, & payer web portals

EHR Workflow Integration

Manual data entry & errors

Limited Referral Status Tracking & Visibility

Referral backlogs, access delays, & bottlenecks

Closing-the-Loop on Referrals

Manual follow-ups with specialists

Where to Focus

Patient

Evolving patient needs

Analysis

Continuous evaluation

Collaboration

Continuous iteration

As your patient population changes and care shifts you need digital technology that is nimble and works with your needs.

01 Data

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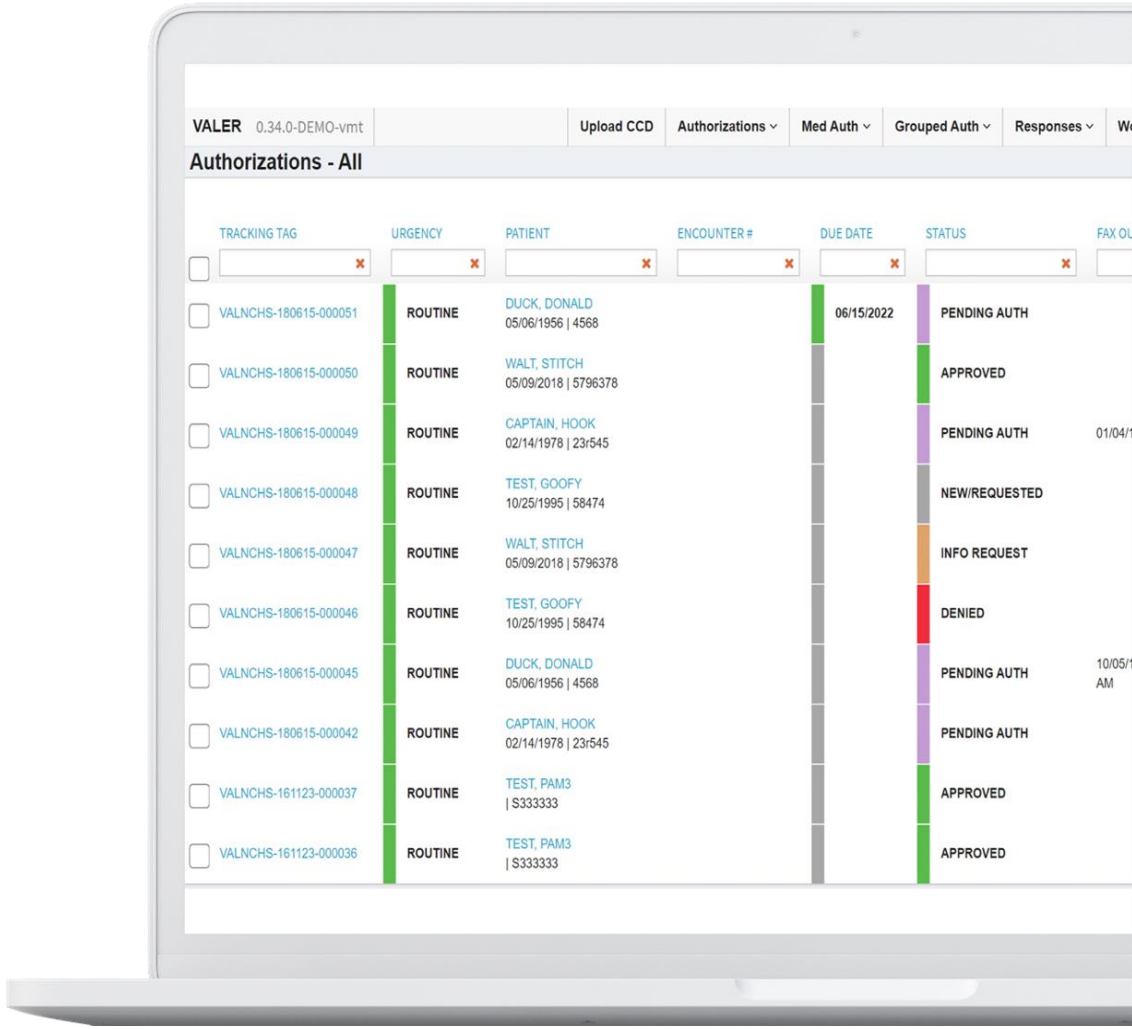
Referral Data Capture

CMHS needed **one place** to **streamline**, **automate**, and **manage** referrals & authorizations

- Staff referral productivity
- Identify bottlenecks and gaps
- Real-time referral status visibility
- Referral backlogs/close-the-loop
- Increased patient engagement



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02 Approach

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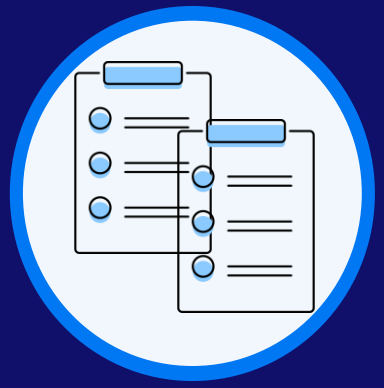
Determining Approach from Data Analysis

Patient Data

- Drives
  - ✓ Provider Specialties
  - ✓ Referral Types



Clinical Review

- Timing
  - ✓ Transformed processing speeds

Improve Outcomes

- Communication
  - ✓ Tracking
  - ✓ Visibility

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03 Technology

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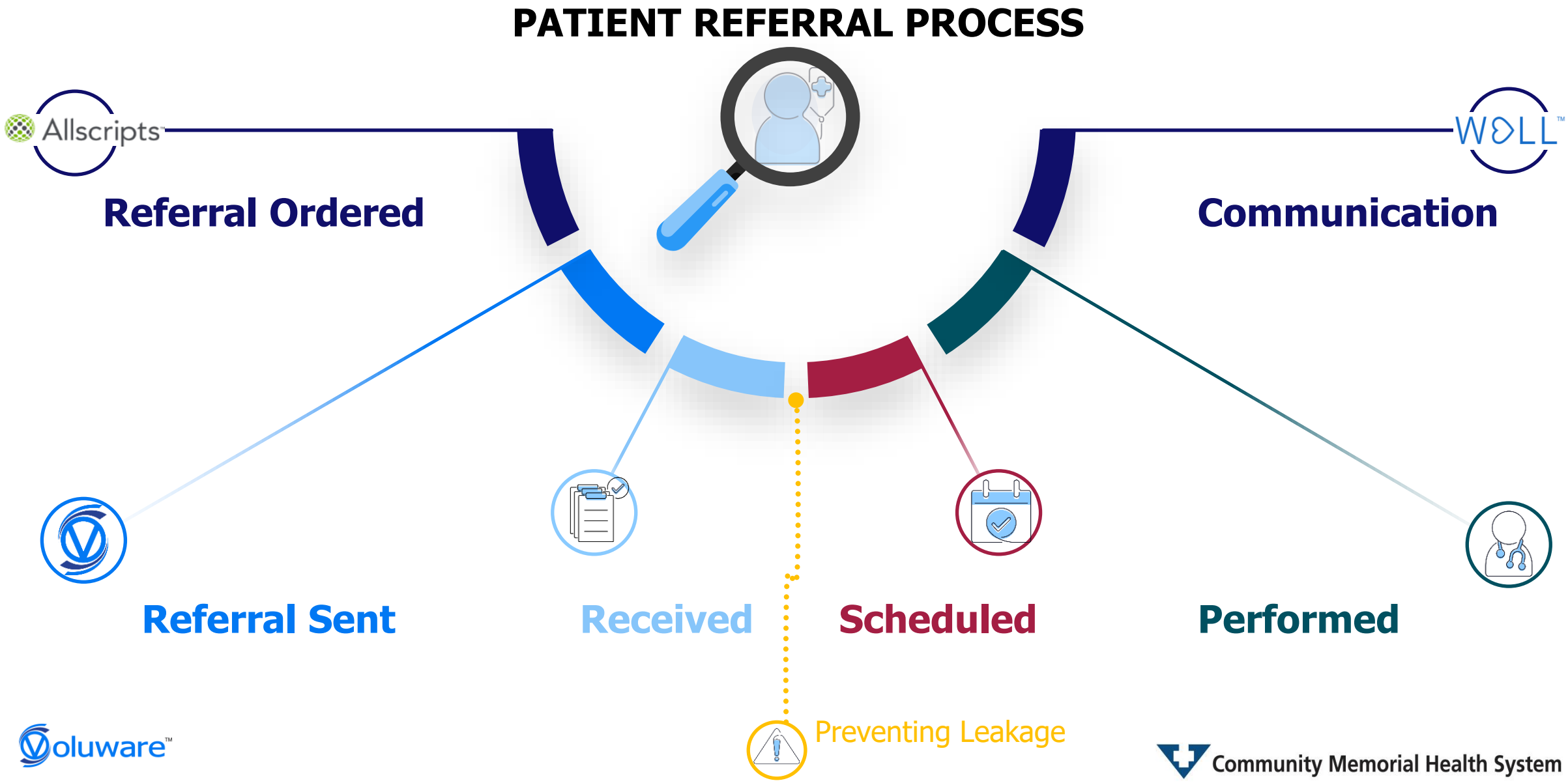
Technology is an Indispensable Tool



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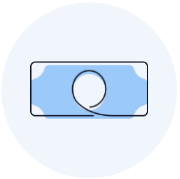
VALER Comprehensive Referrals & Authorizations



Across All Payers

Fax, Web Portals

Professional, Facility, & Technical

All Service Types

- Surgeries
- Diagnostic Imaging
- Procedures, Labs
- Infusion therapy
- Specialty medications
- E&M consults
- Worker's Comp
- Notice of Admissions

All Specialty & Service Lines

- Cardiology
- Oncology
- Orthopedics
- Spine Surgery
- ENT
- Transplant
- Neurosurgery
- Ophthalmology
- Urology
- General Surgery
- Plastic Surgery
- Breast Surgery
- Radiology
- Radiation Oncology
- Thoracic Surgery
- Cardiothoracic Surgery
- Vascular Surgery
- Dermatology
- Hematology
- GI Surgery
- OB/GYN
- Primary Care
- Pediatrics
- Neurology
- Sleep
- PT/OT
- Botox

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Enterprise Visibility and Reporting Options

Continuously measure and evaluate timely, relevant comparative data for actionable strategies and sustained performance improvement

Last Touched Referral

Date of last touched referral by clinic staff

Nudges (providers + patients)

Reminders regarding pending clinicals, and/or unsigned notes

Time to Obtain New Referral

How long it takes staff to get a new referral

Staff Productivity

Staff members output each day

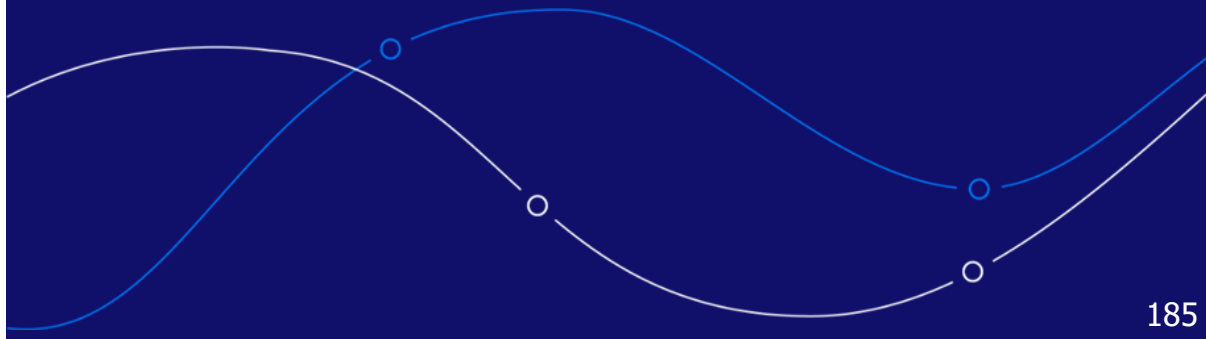
Technology Benefits

Gain

- **Real-time** referral status & visibility
- **Improve** referral productivity
- **Identify** referral bottlenecks

Reduce

- Patient access delays
- Care coordination gaps
- Referral backlogs



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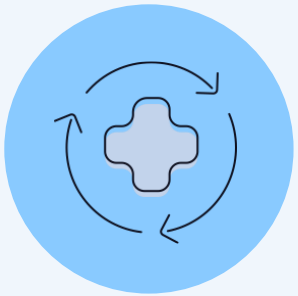
CMHS Referral & Authorization ROI

Improved Staff Productivity

52% increase in referral volumes

with only 24% increase in staff



Reduce Referral Backlogs

Referral backlogs from 4-5 weeks

to

4 days despite increased volumes

Improved Referral Close-the-Loop

100% referrals closed

vs.

~20% of referrals (pre-VALER)

Manual Time Reduction

50% of manual processes replaced with VALER.

21 FTEs

Staff Accountability

Staff now held accountable with daily output reports

Recognize high achievers

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04 Partnership

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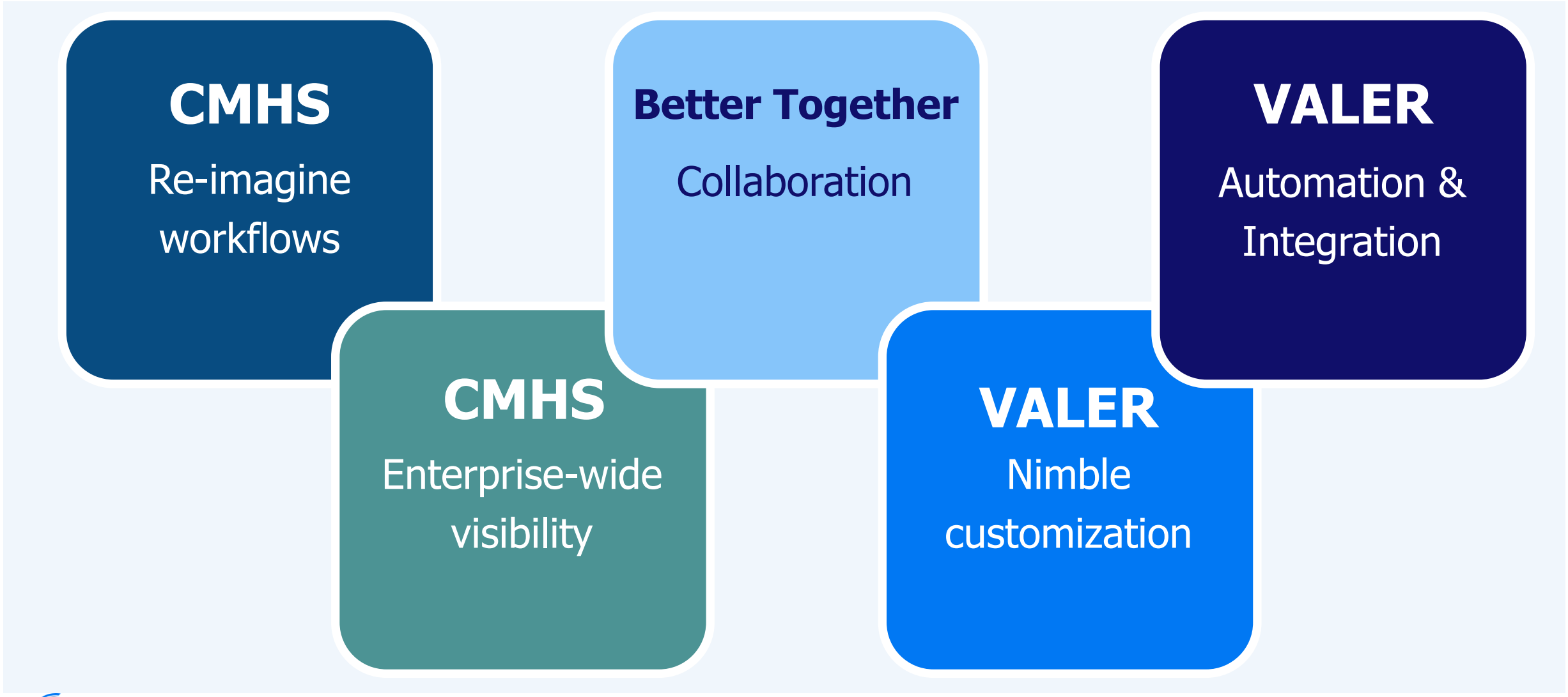
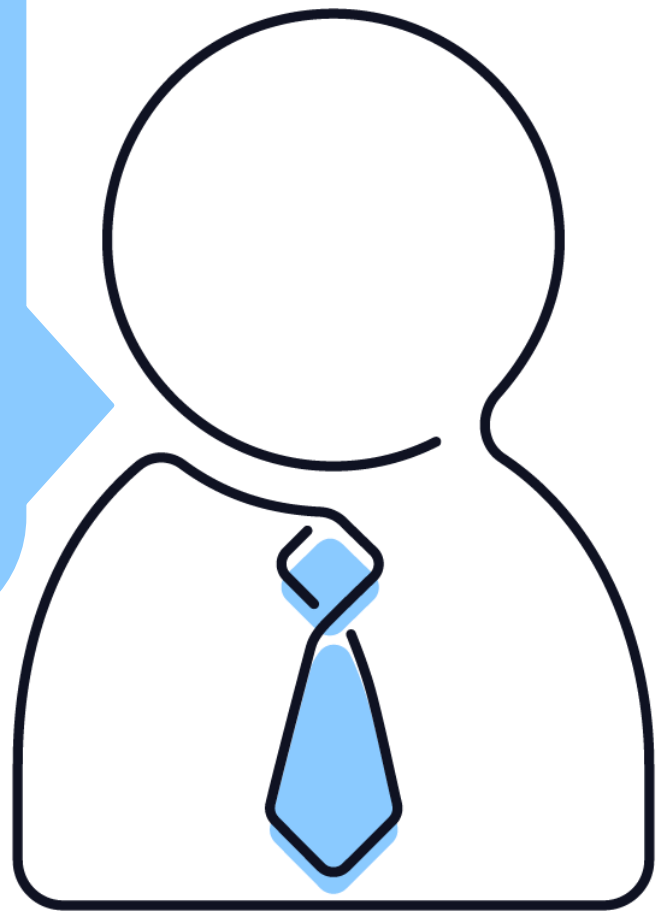
PARTNERSHIP Boosts the Impact



WISH LIST



Q&A

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** Appendix **

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Integrated EHR Referral & Auth Workflow

VALER referrals & authorization automation

Order from EHR → VALER

EHR

Automated Push

Specialists

Facilities

Ancillary Providers

Labs, DME, Pharmacy

Fax forms

Close-the-Loop

←info sent back into VALER

Group Discussion & Wrap-Up

HCCN Update

Arizona Alliance
FOR COMMUNITY HEALTH CENTERS

Primary Healthcare for All

Thank you!