Iowa Health Information Network Services

One Connection

ihin
Iowa Healthcare Connected

IHIN History

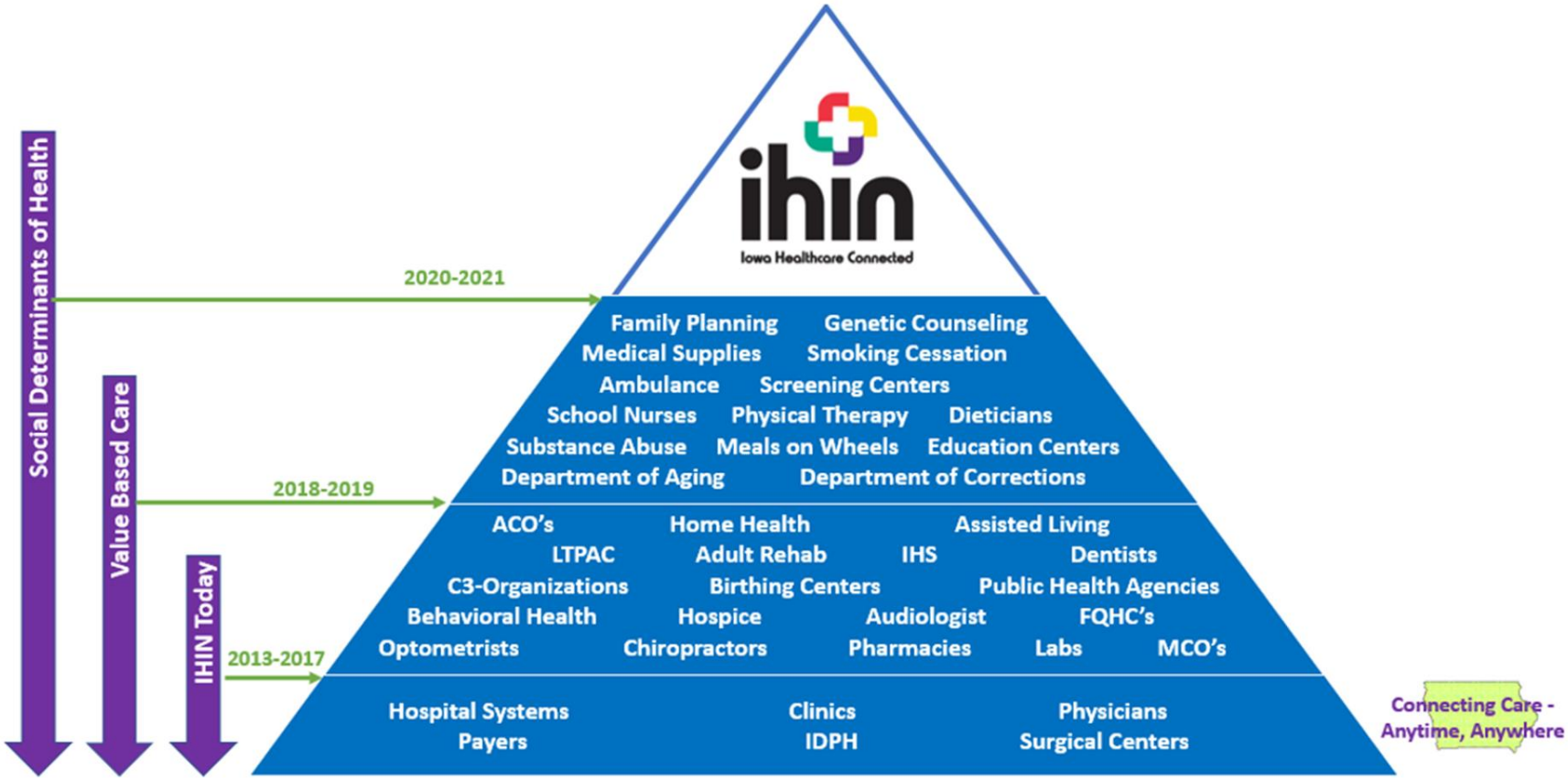
VISION

One Connection

MISSION

Provide all entities in the Iowa healthcare ecosystem with connectivity to the Iowa Health Information Network to enable the secure exchange of patient and other healthcare related information

IHIN Roadmap



Iowa Ecosystem Environmental Scan

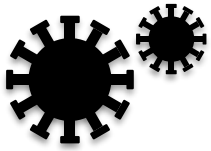
- Majority of providers currently use an EMR/EHR (84% average)
- Many engage in electronic information exchange
- All report significant data reporting requirements requiring electronic submission of data
- Most providers surveyed are doing some or all of their data analysis, aggregation, and reporting manually rather than electronically (70% average)
- Most providers surveyed (63%) believe that HIE would benefit their patients; the remainder responded primarily “Unsure”

Current IHIN Services

IHIN patient query

IHIN portal

Direct Secure Messaging



Electronic lab reporting

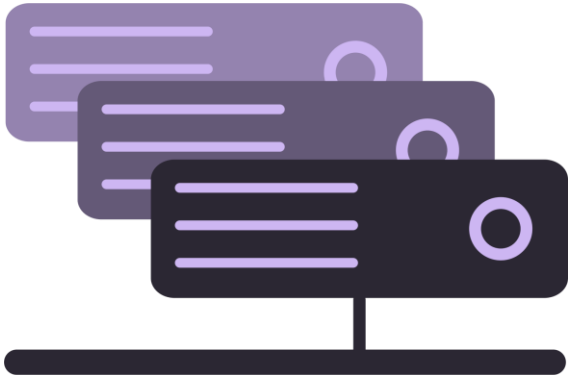
SWAN


21st Century CURES Act – Trust Exchange
Right information, right time, right format
Bi-directional connections to all healthcare provider & Direct Secure Messaging
Administrative Efficiencies
Simplified, bi-directional access to public health registries
Qualified Clinical Data Repository
Improved access and involvement for patients
The New IHIN Solution
Improved Reporting & Predictive Analytics
Exciting new applications
= Improved Care Coordination & Clinical Outcomes
= Streamlined Connectivity and Interoperability
= Improved quality, outcomes, efficiency, and cost of care
= Support VBP, MACRA, MIPs and A-APMs

Public Health Registry Integration

- Project Description
  - Integration of six Public Health Registries with IHIN enabling a single point for connection
- Desired Outcomes
  - Full registry data integration
  - Better care coordination
  - Meeting MU2 and MU3 requirements
  - Greater efficiency
  - Lower operational costs
- Timeline
  - Currently Onboarding; Completion by end of 2018

Registry Integration



Electronic Initial Case Reporting (eICR)

Iowa State Office of Medical Examiner (ISOME)

Iowa State Trauma Registry

EMS Registry (Includes integration with Image Trend)

Newborn Screening

Iowa Registry for Congenital and Inherited Disorders (IRCID)

Iowa Cancer Registry (ICR)

Prescription Monitoring Program

State Hygienic Lab

Application 1 – MediVu

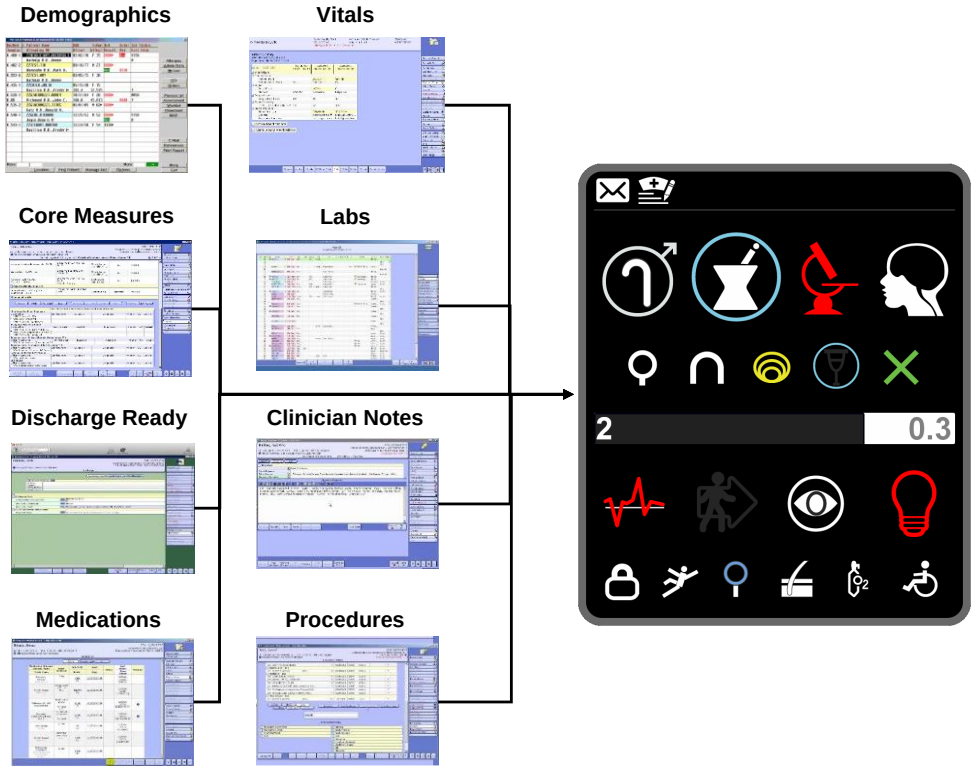
- Project Description
  - Using MediVu to simplify and improve patient care
- Desired Outcomes
  - Longitudinal patient view
  - Better care coordination
  - Significantly lower operating costs
  - Reduced readmissions
- Timeline:
  - Available June 2018; Completion expected by end of 2019

MediVu - Technology

MediVu has developed a patented visualization technology that makes data actionable for users allowing them to obtain situational awareness though a simple glance at their interface.

The information is presented using intelligent iconography engineered to use the same cognitive processing techniques the human brain employs to analyze data and make tactical decisions.

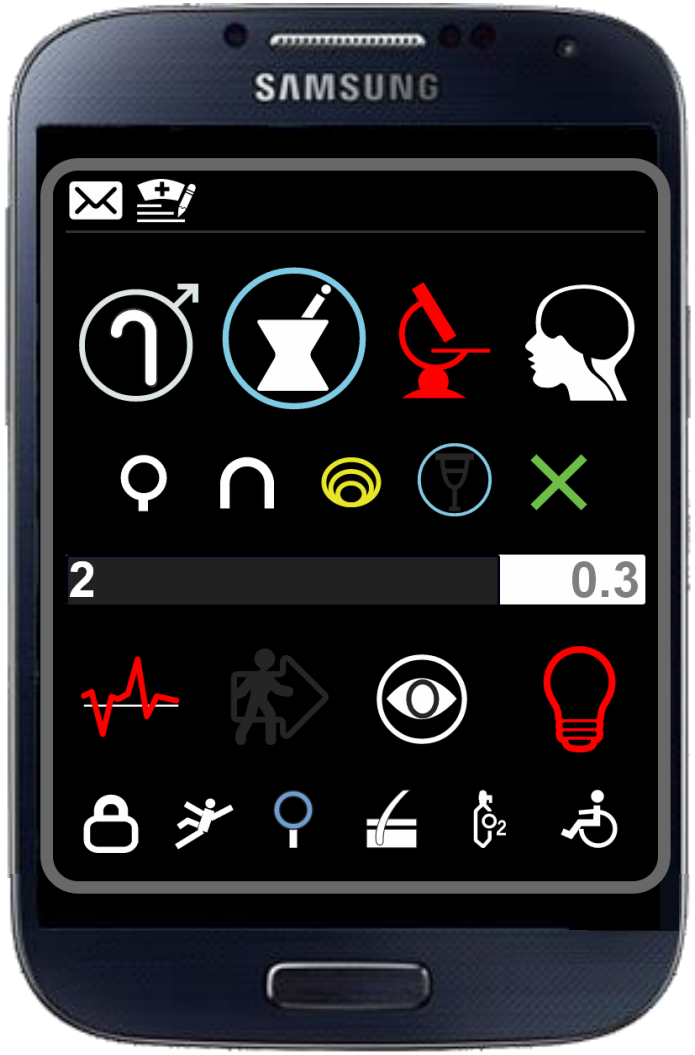
MediVu – How It Works



Data is gathered from real-time disparate sources and delivered though an intuitive display configured for the user role.

Since MediVu technology is agnostic to the data source and provides a plethora of connectivity options, it is capable to addresses most of the healthcare challenges of today and tomorrow.

MediVu – V Shield



The ability to assess a Patient's status through a simple glance is critical for any clinician. The capability to do this regardless of the patient's location, what facility is providing the service, what EHR solution is managing their data and for all Patients under their care, is a game changer.

MediVu's Clinical VShield™ presents real-time data to the user based on the information they need in their role regardless of it's storage or event location.

MediVu – Universal Viewer

In a hospital setting, the VShield™ was able to reduce hospital length-of-stay, decrease the amount of time required for the nurse shift change by 50%, and lower the cognitive load on the Clinician to gather and process Patient data.

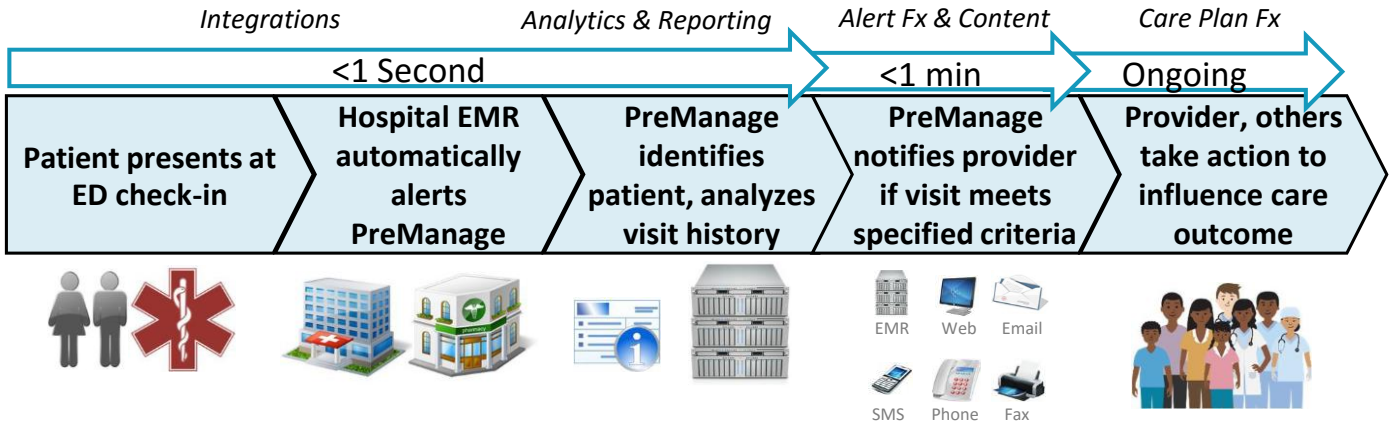
This ultimately reduced healthcare cost and provided more time for the Clinician to spend with their Patients.

MediVu

Application 2 – Collective Medical Technologies (CMT)

- Project Description
  - Patient alerts providing clinical information at the point of care
- Desired Outcomes
  - Alerts integrated into clinical workflows
  - Improved outcomes
  - Significantly lower operating costs
- Timeline
  - Starting now - SIM year 4 pilots

Collective Medical Technologies – Alerts



- Patient checks in with hospital registration
- Hospital records core identification and demographic info

- PreManage is directly integrated with the hospital EHR; no addt'l data entry required
- Patient registration data immediately sent to PreManage

- PreManage identifies patient (even if key information missing from patient's hospital record)
- PreManage cross-references patient with all prior ED, Inpatient, and ambulatory visit history, independent of location

- If visit triggers a pre-set criterion, PreManage notifies the hospital, PCP, and health plan
- Notifications contain visit history, diagnoses, prescriptions, guidelines, and other clinical meta data
- Notifications typically sent within seconds

- ED provider has the information in hand before they see patient
- Health plan, other care providers now aware of patient location and potential needs
- Patient-provider information asymmetry is closed; providers better able to make informed care decision

CMT PreManage

PreManage for Providers supports those with direct treatment responsibilities for the patient, such as Primary Care Providers, health homes, specialty care clinics, and mental and behavioral health clinics.

- *Real-Time Notifications*

  Knowing when your most complex patients have ED visits, or are admitted or discharged from inpatient care is critical. With PreManage, Real-Time Notifications with actionable information are delivered according to the criteria you specify, and sent directly to the locations you specify. All without having to be asked.

- *Patient Risk Identification*

  Identifying who your patients at the greatest risk of readmission are can be tricky. The PreManage system intuitively and automatically identifies those patients most at risk, so that you can proactively work with these patients to reduce the likelihood of readmission. Better for you, and better for your patients.

- *A More Complete Picture*

  PreManage curates data from all points of care and distills that information into actionable provider insights. Having a more complete picture of your patients across the entire care continuum gives you the insight you need to impact better outcomes.

CMT EDIE

- EDIE enables hospitals to divert medically-unnecessary patient volume to more appropriate care settings, leaving ED clinicians free to focus on high-value, ED-appropriate encounters. The result? Hospitals reduce costs, and better allocate critical ED resources

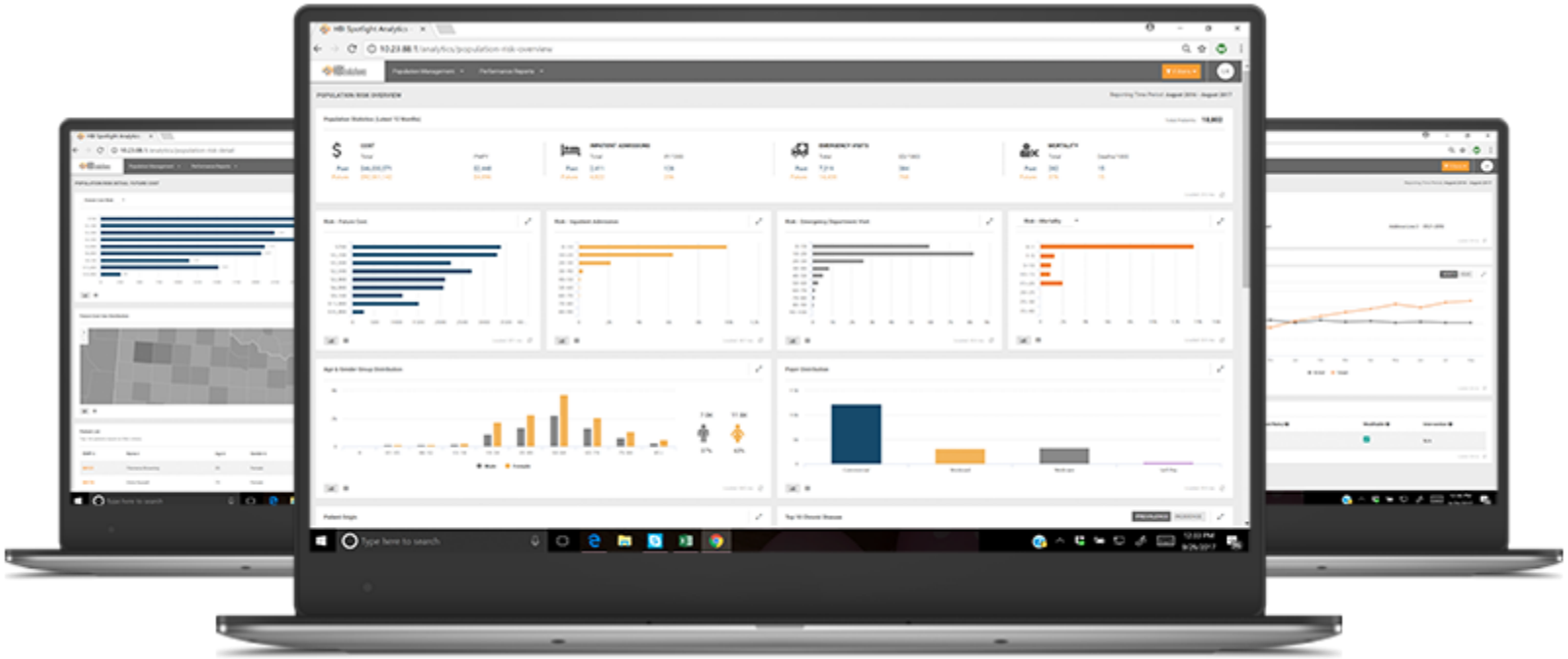
- The patient context that EDIE provides enables ED providers to make more objective and better-informed care decisions in a format that can be digested in 60 seconds or less, while helping them to eliminate medically-unnecessary patient encounters, and work-ups. The result? Faster and more accurate identification of patient needs.

- EDIE improves patient outcomes by following the patient across all points of care to prompt and inform physician action. This ensures that each provider operates from the same playbook every time, even when they're not playing on the same field. The result? Better care and better outcomes for patients.

Application 3 – HBI Solutions

- Project Description
  - Provide predictive data analytics capabilities using real time clinical information
- Desired Outcomes
  - Full predictive data analytics package
  - Better outcomes
  - Lower operating costs
- Timeline
  - Available mid-Summer; Ongoing

Data Analytics - HBI



Application 4 – Orion Coordinate

- Project Description
  - Care coordination application using real-time clinical data and information
- Desired Outcomes
  - Improved cross organizational care coordination
  - Better outcomes
  - Lower operating costs
- Timeline
  - Available now; Ongoing

Orion Coordinate

The right information, at the point of care
Coordinate provides the tools to turn aggregated information into action: monitor a cohort of patients using a variety of lists; individualize a care plan with defined goals and actions; view and manage relationships and support networks for the patient; and follow defined care pathways specific for a patient. This helps to improve time management, and remove duplication of effort.

Easily identify at risk patients
Tight integration with Orion Health Amadeus's simplifies the process of transforming insights from population health analysis into meaningful care coordination initiatives. Users can organize a cohort of patients that can be monitored and accessed by those responsible for caring for them. This can help to rapidly close gaps in care to achieve improved health and financial outcomes.

Multidisciplinary approach to care
The use of a shared care plan through Orion Health Coordinate, means members of a patient's circle of care can securely communicate, create and assign tasks, and monitor a patient's progress. This helps to improve team efficiency, and makes truly integrated care possible.

Support patient engagement
Paired with Orion Health Engage, Coordinate provides for easy and effective patient engagement, encouraging them to set their care goals, identifying the tasks and actions they need to perform to achieve their goals, and highlighting barriers that may get in the way. Promoting patient self-management is beneficial, as patients are the most underutilized resources in healthcare today.

Application 5 – Orion Engage

Circle of Care

Forming the basis of Engage is the Circle of Care, where a patient connects the key individuals involved in their care and treatment. This permits easy, secure communication and the sharing of information. Patients can upload and share images and reports via the Engage portal for their care team to access, and in this way, providers can also share files and information with patients

Care Plan

Care Plan enables an individual to set and manage specific goals. It outlines actions necessary to achieve those goals, potential barriers they may encounter or concerns they may have. For each goal, progress can be captured, displayed and tracked over time. Circle of Care members can edit and insert comments against a goal, which can be filtered to show which goals have been achieved and those that are still in progress.

Empowering Patients

Engage empowers patients to actively participate in, and contribute to, their ongoing care and personal health record. With the Engage mobile and web applications, patients can access their health record data from anywhere, add and edit information, and get support from their Circle of Care team, which may include friends and family members. Supporting patients in their homes and communities can lead to improved outcomes and reduced financial costs.

Single Source of Information

All of the data available on Engage is sourced from the same source as the clinical shared record data, so patients can view their complete holistic health record, not just a segment. Engage increases the level of information and education around a patient's condition, leading to better educated patients who are actively involved in their care. Engage also enables care team support, access to documentation, wellness goals, a health library, medication lists, lab results, and more, all from a single, instant access, source of truth.

Application 6 – FEi Consent2Share

- Project Description
  - Behavioral Health tool to help patient's provide and streamline the consent process
- Desired Outcomes
  - Improved and timely consent process
  - Better patient outcomes
- Timeline
  - Available July 2018; Ongoing

Behavioral Health – Consent2Share (FEi)

Consent2Share

Patient Benefits

- Patient Driven: Puts the control of consent management in the patients hands
- Improved patient care and outcomes
- Better care plans
- Emergency Consents
- Reduced efforts in responding to audits for patient consents

HIE Benefits

- Data Sharing Interoperability between multiple EHRs and HIEs
- Enables data redaction, segmentation and management of patient consent preferences
- Provides patient engagement & empowerment
- Patients can create consents without coming into the office
- Transforms paper consent workflows into electronic based workflows

Application 7 – Quality Clinical Data Registry

- Project Description
  - Clinical Data Registry for reporting Quality Measures to multiple entities
- Desired Outcomes
  - Single source for reporting CQM's
  - Improved Quality reporting process
- Timeline
  - Available December 2018; Ongoing

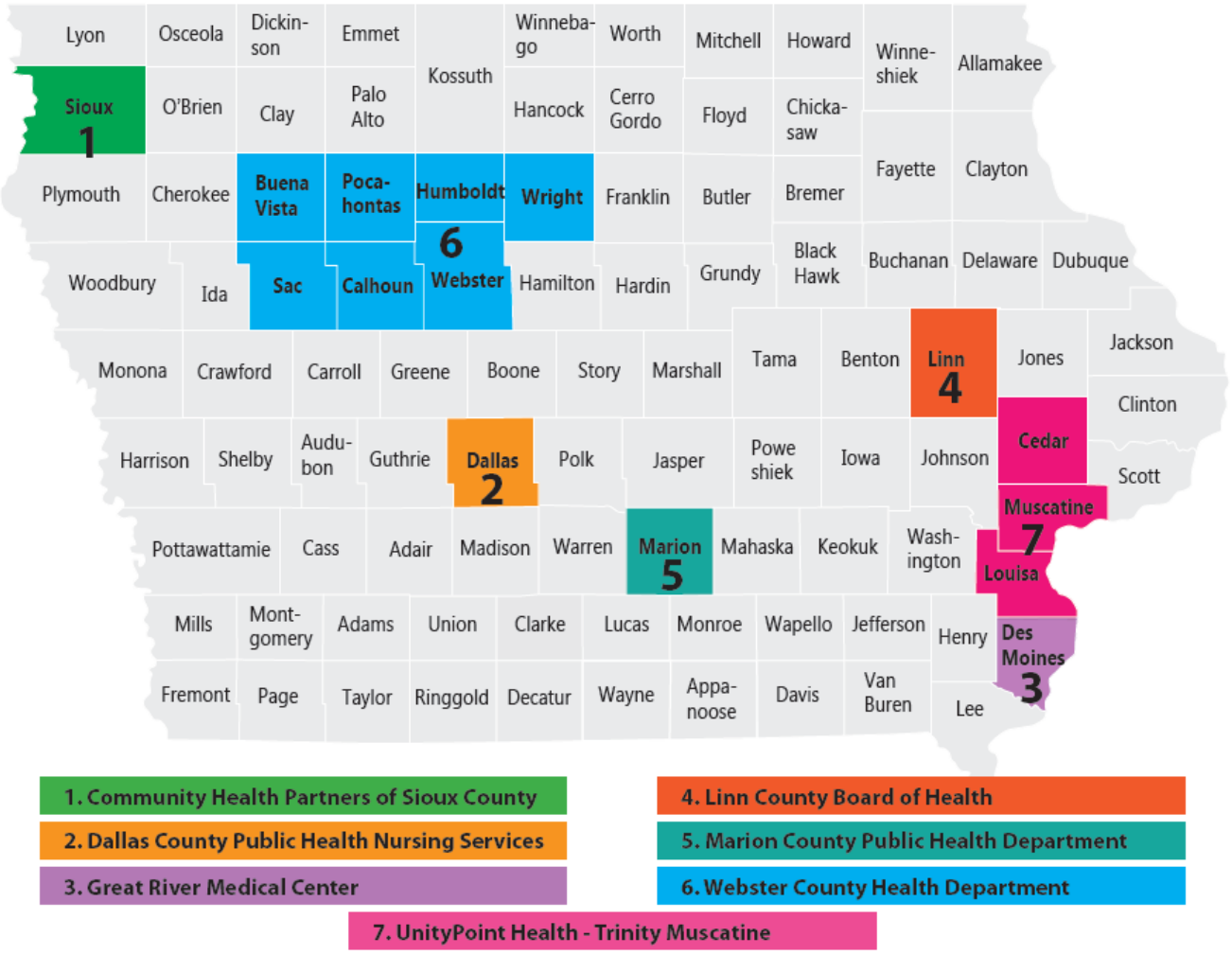
Application 8 – electronic Clinical Quality Measures (eCQM)

- Project Description:
  - Electronic clinical data reporting for all reportable quality measures
- Desired Outcomes
  - Simplified quality reporting process
  - Timely quality reporting process
- Timeline
  - Available December 2018

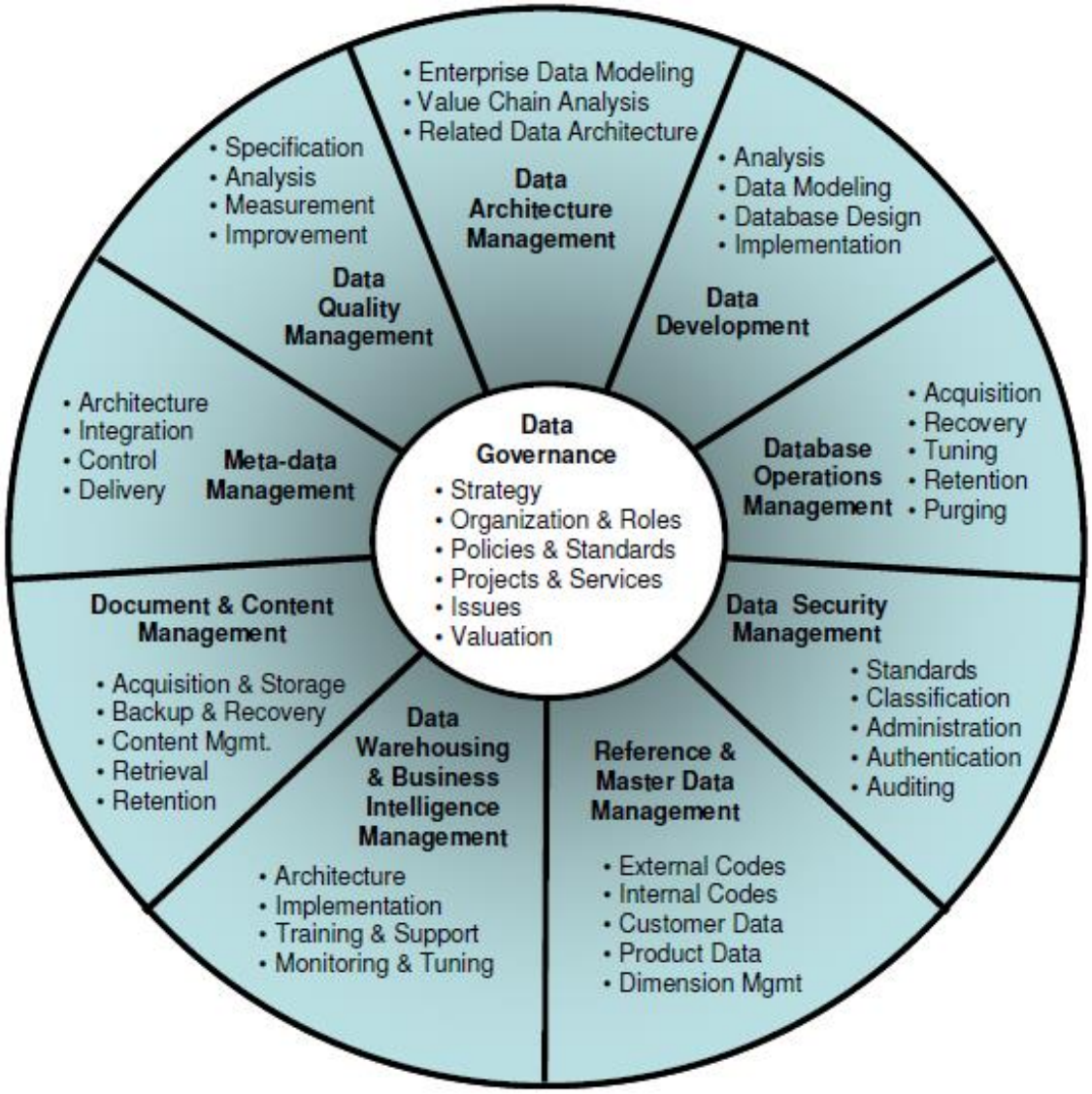
Application 9 – Social Determinants of Health (SDoH)

- Project Description
  - Integrating SDoHs into the patient EHR for availability during an encounter
- Desired Outcomes
  - Inclusion of SDoH in patient care
  - Utilization of SDoH during the care encounter to improve patient care coordination
- Timeline
  - Available December 2018

C3 Pilot Program



Data Governance



How to Get Started

Participation Agreement & BAA

VPN

Technical Onboarding

Workflow

Training & Clinical Onboarding

IHIN Benefits

Streamlined Connectivity and Interoperability

Allows Access to All Patient Information in the Iowa Healthcare Ecosystem

Accessible Patient Data in Real Time

Integrated with the Participants EHR

Reduced Duplication of Documentation and Logging into Multiple Sites

Improved Care Coordination and Outcomes

High-Quality, Cost-Efficient Care with Improved Outcomes

Connects Providers of All Types Including Non-Clinical Determinants of Health

Real Time Patient Information Available at the Point of Care

Provides Patient Access and Ability to Manage Their Own Medical Records

Improved Quality, Efficiency + VBP, MACRA, MIPs, APMs

Accessible and Actionable Clinical Quality and Claims Data

Automated Tools for Data Aggregation, Analytics and Population Health

Timely, Accurate Submission of Clinical Quality Measure Reporting

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