Strategic Health Information Exchange Collaborative

ONC Validated Healthcare Directory Implementation Workshop

HIE Value: The Provider Directory

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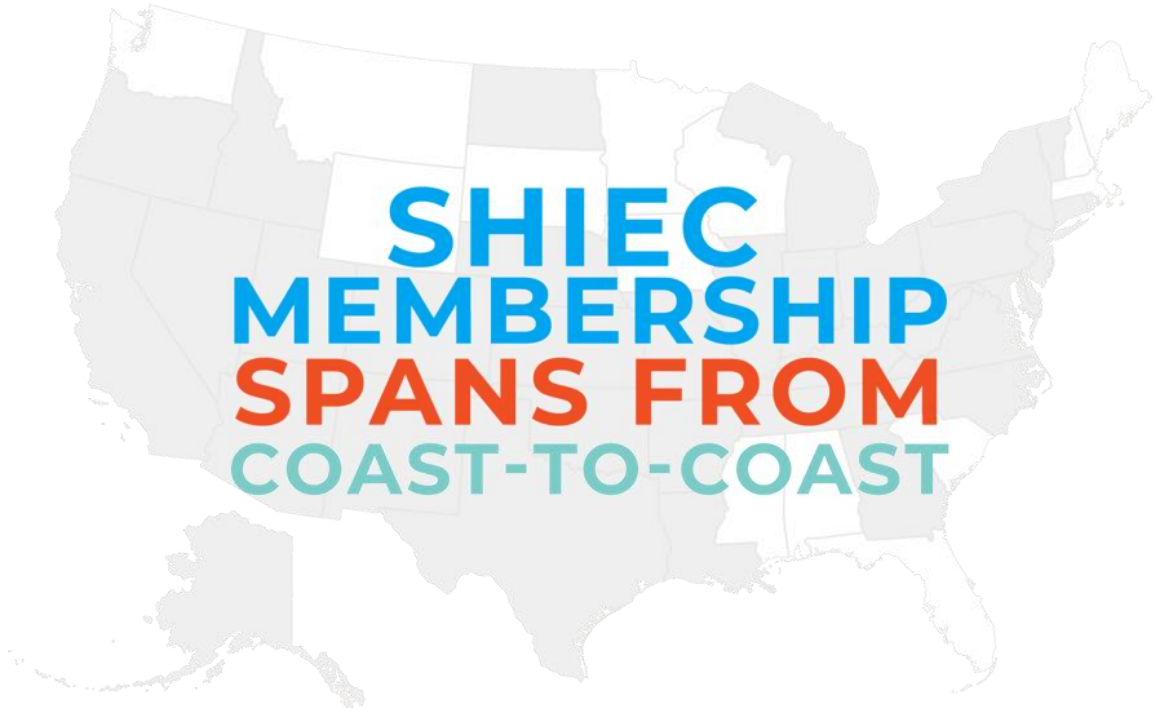
STRATEGIC HEALTH INFORMATION EXCHANGE COLLABORATIVE

A Nationwide Approach to Interoperability



More than

130

Members

70+ HIE Members

60+ SB&T Members

Providing health data to more than

75% of Americans

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Patient Centered Data Home

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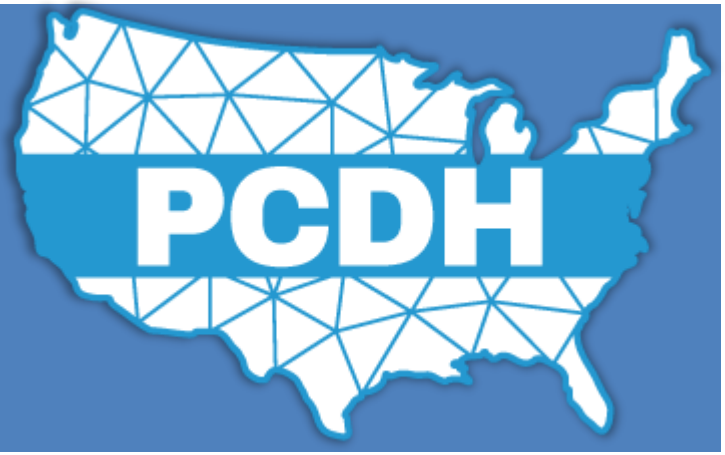
PCDH is a SHIEC initiative that creates a nationwide network connecting health information exchanges (HIEs).



Every person deserves to have their complete, longitudinal health record available whenever and wherever it is needed for decisions that affect their health and well-being

Deliver patient health information across state lines and across health systems, improving the patient experience by making their health information available whenever and wherever their care occurs.	Based on triggering episode alerts, PCDH notifies providers a care event has occurred outside of the patients' "home" HIE, and confirms the availability and the specific location of the clinical data, enabling providers to initiate a simple query to access real-time information across state and regional lines and the care continuum.

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HIE Services

- **Provider Directory**
- Master patient index / patient matching services
- ADT or other alerting services
- IHE Query/Retrieve services
- Clinical data repository
- HISP / secure messaging between Providers
- Clinician Portal
- Data quality / mapping services
- Public Health Data delivery/interface to state Dept. of Health
- Results / clinical message delivery
- Population Health Management data service
- Transitions of Care services
- Referral Services
- Patient focused services

Provider Directory Use Cases

- As a product line to those participants wishing to **supplement and enrich their own directories a**cross the community
- **HL7 v2 routing** with results delivered via EMR interface, fax or web inbox
- Automated **routing by the provider to Direct** messaging
- **Supplement messages forwarded to payers** (require NPIs in the area and participants rarely include these in their native messages)
- **Results delivery**
- **Alert delivery**
- **Referrals**
- **Provider credentialing/confirmation.**
- **Automated routing** by provider 24-hour reports
- **Transitions of care**
- Local tables for **access to a provider portal web application**

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HIE Use Cases

- **Georgia**—School Nurses—*immunization information to school nurses & rural counties*
  —American Heart Assoc. & World Economic Forum Heart Failure Projects: *reduce readmissions and improve outcomes*
- **Louisiana**—Coroners and Prisons—*supports transitions in care*
- **Colorado**—Youth Services and Medical Clinics—*supports care coordination*
- **New York—**Discovered cancer diagnosis of a resident—*comprehensive record*
  —Provided access to records during ransomware attack
- **Nebraska**—PDMP—*leading HIE and PDMP partnerships: 1M+ records*
- **Indiana**—Population Health—*caring for the community across the continuum*
- **Pennsylvania—**Payers—*serves as data aggregator to calculate quality measures, supports CMS CPC+ program*
  — *MANNA—identify consumers who are not home to receive food deliveries*
- **Kentucky**—Public Health Data—*deliver to state agencies, specialized registries*
- **Michigan**—End of Life Care—*provide patient preferences POA, POLST, Organ Donation*
- **New Jersey—**Cross Sector Data Sharing—*partnering with community leaders*
- **Arizona**—Part 2 Data—*sharing comprehensive patient information*
- **California**—Wild Fires—*supporting thousands of displaced residents and patients*
- **Maryland—**Smart on FHIR App—*allows providers to integrate various data: labs, radiology, transcriptions*
- **Missouri—**Veterans—*developing in a new opt out approach*
- **Oklahoma**—Real Time Data—*text between patient and provider screens*

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Impact on Patient Care

- Significant part of the **value proposition**
- Routing of results for **timely absorption into the provider's EHR**
- Supports providers in **care transitions**
- Shares **valuable information** necessary to take care of their patients and to meet measures
- Delivers test **results to multiple providers quickly and automatically**
- Delivers clinical **results to ordering and cc providers in a timely manner directly to their EMR**
- Supports **quality of data**—provider database must be accurate and up to date to effectively exchange data
- It impacts the **accuracy of data delivery** to the community. Outdated information would mean either an organization would receive something they shouldn't, or they will not receive something they should.
- Providers are **notified in near real time** of results for patients as opposed to waiting for results to be faxed or delivered in some other manner
- Discharge encounter notification **alerts** are routed successfully to PCPs and other care team members who **follow up with patient care post discharge**

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To learn more about

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