

EMDI Suncoast RHIO Pilot



Pilot Overview

Stream	Pilot Information							Status	Pilot Use Case	Li t IF
Other-Emergency Department Home Health Agency	Suncoast RHIO Pilot							COMPLETE	USE CASE 2	C H
	Hospital	Interface Vendor	Document Transfer Vendor	Transport Standard	Document Transfer Vendor	Interface Vendor	Home Health Agency /Other			
	Desoto Memorial Hospital	Meditech	Suncoast RHIO	Direct	Suncoast RHIO	Allscripts	Sarasota Memorial Hospital			
	Desoto Memorial Hospital	Meditech	Suncoast RHIO	Direct	Suncoast RHIO	N/A	Desoto Memorial Hospital Department of Health			
	Desoto Memorial Hospital	Meditech	Suncoast RHIO	Direct	Suncoast RHIO	Axxess	Desoto Memorial Home Health Agency			
	Content Standard: HL7 CCDA									
Pilot Date: Start: 15 Oct 2018 End: 13 Oct 2020										

Suncoast RHIO Pilot Summary

Organization Name	Suncoast RHIO
Piloting Organization(s) Name	Sarasota Memorial Hospital, Desoto Memorial Hospital, Allscripts, Axxess
Pilot Stream (e.g. DME, HHA)	Other (Emergency Dept.) & HHA
POC Email	lgalterio@gmail.com
Pilot Summary Date	13 Oct 2020

Category	Question/Description	Pilot Response
Background	High-level overview about the piloting organization(s)	Suncoast RHIO is an organization that is a Regional Health Information Organization, (RHIO), and which performs Health Information Exchange Services for Quality and Audit reporting. The organization supports Interoperability nationwide via certified EHR and modules, HL7, PDF, Claims and Billing Files, and X.12 for Hospitals and Practices. In addition to HIE and MIPS/hospital IQR quality reporting, Suncoast RHIO is a certified CMS esMD HIH (Health Information Handler) performing electronic audit notification and evidence response. Providers, people, and Families use RHIO services. Desoto Memorial is an acute care hospital in rural Florida.

	Describe each participating organization role in the EMDI pilot	Desoto Hospital and its Home Health Agency is the owned HHA of the Hospital. Each of the Desoto entities used different technology. Located in Arcadia City, the county Health Department Clinic refers patients for Microbiology tests to the hospital. If positive test show needed follow-up, including hospital admitting, and might be followed by Home Health after discharge. This is done by Desoto to their owned HHA or to Sarasota Memorial Hospital Acute Care and Home Health or a Skilled Nursing Facility. DME vendors are involved at discharge through the Care Manager. A third participant was Affinity Health Partners SNF in Tampa and Georgia. Due to the pandemic, Suncoast RHIO was unable to continue beyond Desoto.
	Describe what encouraged you to participate in the EMDI program	The processes of episodic illness that spans multiple care settings for any patient is a journey through unique paths of care providers and entities. It can be a traumatic journey and we feel technology PLUS the human care element makes the outcome better and the journey safer and with less burden. The patient is always at the center of the process and the technology tools are there to facilitate what amounts to burdensome activities for all and one that requires clear and specific record keeping. Without the human element, the tools can only help so much. We wanted to show this in a real setting following a structured methodology and also to show that we could measurably increase superior care outcomes, reduce cost, optimize utilization, and increase patient, family, and physician satisfaction.
	Describe the onboarding strategies used to get other organizations involved in piloting	At this time, Suncoast is a national technology vendor. In its initial days, Suncoast RHIO was a known entity in South West Florida when it started as a non-profit membership. This helped us gain trust and credibility with the regional providers that we still possess, and the management of Suncoast RHIO was proactive in spreading the word of EMDI and following the onboarding steps of EMDI.
Business Workflow/ Requirements	What are some benefits to your customers from implementing EMDI?	A clear path of accountability for the patient and the primary care provider and/or the discharging hospital. This was especially useful in insuring and calculating all intermediate time and expense in the equivalent episode bundle. It was much easier to track decisions made along the way from any point on the way. It was faster and provided clear pathways of choice for the patient and the providers' quality. There was a direct feedback loop to help in the avoidance of 30 day readmission and preparation for the endpoint home health or skilled nursing facility.
	Detailed description of how the use case(s) helped the piloting participants meet their goal	We utilized technology tools such as DIRECT, CONNECT, multiple EHR's, certified and non-certified, and billing 837 files. The DIRECT protocol is a secure and encrypted messaging platform managed by HISP organizations. Pilot dealt with 4 HISP's, some not compatible without some work on our part. We utilized HL7 to communicate between the hospital EHR and the Home Health Agency. This included billing files for payment and to OASIS post-acute care assessment formats. The combination of this technology and trained, informed clinicians teamed with technologists allowed us to reduce end-to-end timelines and expedite claim reimbursements.
	Describe any pain points that you've incurred before piloting and how electronic interoperability assisted in resolving them	Pain points were numerous including depending on Fax and phone calls to doctors at both locations of Health Department and hospital. Electronic interoperability addressed accountability and clinical accuracy, a direct benefit to patient safety. Also, ensuring complete compliance and alignment with security, privacy, and risk management, especially when going across multiple settings of care, is an "Information Governance" proactive effort that needs to be addressed at every step. We ensured that everything we found and did were aligned with NIST standards.

	<p>Detailed description of the implementation of the use case (s)</p>	<p>Before pilot implementation, manual processes were used between hospitals and Health Department, like, phone calls and Fax. These communication processes were used for patient testing, registration, request admittance, transfer, or discharge. A patient is admitted to inpatient and transferred to either Home Health agency or discharged to home, may require a Durable Medical Equipment. The pre-pilot process was performed by Care Manager who works with the patient and choices of DME vendors on approved list is normal discharge operation. During this pilot, we Demonstrated improved registration of patient and creation of CCDA with Desoto Hospital Meditech EHR System. We illustrated how to send a response back to Health department using Direct with an attached CCDA that was translated into PDF for readability supported Home Health EHR which was not capable of injecting native CCDA. (Florida Health Department System does not yet absorb CCDA from outside sources at the time of this writing.) The pilot focused on implementing following workflows after patient is discharged or transferred: A) Send functional CCDA to Desoto Home Health Agency and B) then to Sarasota Memorial Inpatient via Emergency Department C) the admitting scenario sent to Sarasota Memorial related Home Health, or other Home Health Agency that could absorb CCDA. The CCDA was either stored for potential IHE and CONNECT processing using CCDA to PDF conversion tool, or CCDA was absorbed by EHR or CommonWell and/or Carequality to send using direct message.</p> <p>Note: The Admitting scenario with Sarasota Memorial was not performed due to delays introduced by pandemic but was performed for Desoto Memorial Home Health "AXXCESS" System.</p>
<p>Technical Specifications</p>	<p>Describe the lessons learned while implementing the technical standards</p>	<p>Without addressing the human element and workflow, new technology will not work. Hospital workers USE technology, they are not technologists. There is a need for a support organization such as a RHIO to be able to focus on this without impacting the jobs of clinicians, administrators, and IT staff from their operational duties. This is even more pronounced when mixing rural area healthcare organizations with those in other settings that may or may not be in a rural area across the care continuum. This benefits patients as well. A second major lesson was that "no one size fits all". Change is constant and an architectural approach is superior to mandates. We then showed how DME involvement with DIRECT communications tool can be used to collect and show DME inventory to the discharged patient. It worked at the same time of when patient was discharged to home or to another facility.</p> <p>Note: DME System did not absorb CCDA, for transfer of "inpatient to home case" patient needs readable CCDA, (or potential via API to Blue Button). This is suggested scenario for future implementations. However, Inpriva HISP DIRECT supports CCDA In Readable form.</p>

	<p>Detailed description of the pilot participants workflow before and after the EMDI use case(s)</p>	<p>"To Be" Model was demonstrated in Practice - New Process between hospital and Health Department using certified EHR with SaaS database, Direct accounts in Pharmacy, Microbiology Department; FAX, with initial oversight by Suncoast RHIO (to be phased out later). We demonstrated Desoto Hospital transmission of working CCDA to Desoto Home Health System with capability to absorb CCDA via Suncoast RHIO HIE /EHR with CCDA intermediary capability. We demonstrated hospital Meditech EHR interacting with AXXCESS Home Health. We showed CCDA's being sent to other health providers of patient with EHR's capable of absorbing HL7 CCDA and to State of Florida ENS (Event Notification System) via ADT feed. Data saved and audit trail stored in Suncoast RHIO repository. Due to pandemic, the following capability demonstration, though prepared and working, was unable to be presented due to limited ability to work with post-acute care organizations: 1) absorb CCDA for interaction and interoperability with Affinity systems. 2) Demonstrate links to MatrixCare, used for Skilled Nursing Facilities. 3) Show components for eMAR (Electronic Medical Administration Record); ACCUflo, and YARDI property management software. We planned to show interoperability with large physician group, "Eventus" that provides onsite primary care services to residents, home health, and hospice providers. We achieved this but could not demonstrate due to restrictions on physical access. We were able to show over a 30% reduction in claims denials due to improvements in technology in the pilot departments and a 50% increase in provider response time for query and missing documentation responses. When extrapolated to the hospital as a whole, this resulted in \$500,000 in savings.</p>
	<p>Detailed description of why you've chose certain industry standards for piloting the use case(s)</p>	<p>Industry standards are key when working within and across so many settings of care. We would never have been able to perform and attain success with EMDI if we had to work with a hodge-podge of different technologies and without the common denominator of a "normalization engine" by having this capability in a standardized enforcement repository which the Suncoast RHIO provided in software, data, and people. Therefore, we used HL7 CCDA, CONNECT, IHE, DIRECT (over multiple and sometimes, non-communitive HISP's which we connected), ADT feeds, 2015 certified EHR integrated with EHR certified modules and integrated with both non certified EHR products and Fax. We had planned to demonstrate HL7 FHIR but the pandemic cut that effort off.</p>
	<p>Describe the level of effort used for the infrastructure when using the document transfer vendor or describe how you had to improve your infrastructure to align with EMDI</p>	<p>Some of the initial systems' processes we found in pre-pilot had to be significantly revamped or replaced. Training clinical staff was important. Communicating with various personnel needed to be standardized as many new players came and went. The administrators of the hospital- CFO, CEO, and CIO, were supportive and without their help, this would have been impossible. The clinical staff was proactive. In short, the level of effort required was only moderate and not overly burdensome because of this support and the Suncoast RHIO having personnel able to understand and be fluent in hospital, technical, and clinical workflow.</p>
<p>Recommendations</p>	<p>Note any recommendations for the EMDI program</p>	<p>Work with hospitals to learn their needs and drivers. Don't just depend on technology companies to affect change without a partnership with those most affected. Include compliance guidance and cross system and facility Information Governance.</p>

	Note your experience with CMS and Scope Infotech under the EMDI program	Our experience with Scope Infotech as very positive. They were willing to learn and understand our "real world" challenges and were flexible. We were lucky by being an esMD HIH which gave us an advantage in knowing who to communicate with if we had to reach CMS, but in general, Scope Infotech ran as intermediary between Suncoast RHIO as CMS when needed.
Additional Considerations	Note any additional implications	Don't rush into FHIR. Client systems need time to understand, adopt, and catch up. This is not a vendor project in a vacuum, it affects the entire Healthcare space
	Note any suggestions for expanding the EMDI use case (s)	Expand to Part B providers, Part C Medicare Advantage Plan participants, ACO's, and participant providers in strictly commercial plan arrangements. Find a way to educate the patient and get the word out to the public.

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Related Links
Suncoast RHIO