Bundled Payments & Chronic Pain Management

Mark, a retired patient with chronic knee pain, takes control of his healthcare journey as data is passed from a referral management platform directly to payer benefits validation in order to streamline care. Mark pulls his care plan and uses Blue Button 2.0 to determine his next steps to improve his health.

Participating Organizations: Allscripts, AHRQ, Cerner, Health Endeavors, Netsmart, NextGen, Orion Health, Virence Health

Cardiac Patient & Referral Management

Cameron reports new-onset chest pain to his PCP and is urgently referred to cardiology. His physicians determine he needs non-emergency cardiac surgery, for which he is scheduled. When he is in the hospital for bypass surgery, his medical device data and alarms prevent decompensation. During post-op, he is discharged to home with PCP follow-up. His PCP determines that the patient requires a referral to behavioral health for depression and alcohol abuse.

Participating Organizations: Draeger, eClinicalworks, Epic, ICU Medical, Masimo, MedAllies, NetSmart, Qvera
Clinical Exchange and Price Transparency

Follow Angela, a 52-year-old with rheumatoid arthritis, as she moves across the country and visits multiple care providers – primary care, specialist and emergency – in different care settings using different EHR technology platforms. Automated processes for clinical information exchange, drug price transparency, electronic prior authorization and specialty prescribing enable Angela and her care team to make better-informed treatment decisions that improve her outcomes and overall healthcare experience.

Participating Organizations: Aprima, Cerner, eClinicalworks, Epic, Nextgen, Surescripts

Comprehensive Kidney Care

Jack has End-Stage Renal Disease (ESRD), which requires life-sustaining treatments. ESRD is complex to treat, and patients with ESRD may have multiple comorbidities. These can lead to higher rates of hospital admissions and readmissions, as well as higher mortality rates among these patients than of the general population. Interoperability services can improve Jack’s outcomes by engaging him in a variety of ways, including pain management, preventative care and direct reporting of outcomes.

Participating Organizations: Care Evolution, Dell Boomi, DevCool, Meehealth, NantHealth

Consumer-Centered Care Planning

Amy creates an evidence-based care plan with her providers. The plan and clinical record are shared with care team members via a standards-based integration server platform. Care is coordinated between the PCP and specialist providers, keeping Amy included at home. ‘Sharing with protection’ demonstrates effective balance of Amy’s privacy preferences and safety concerns.

Participating Organizations: Allscripts, Elsevier, Infinitt NA, PatientLink, Perspecta, VA

Enabling Cancer Moonshot

Sophia is diagnosed with Stage 3 malignant melanoma at an outpatient facility. She is enrolled in Anti-SEMA4D Monoclonal Antibody clinical trial and referred for treatment and infusion immunotherapy. Her biomarkers, cancer staging and treatment is reported to the State Cancer Registry.

Participating Organizations: Allscripts, B Braun, CDC (State Registry), Epic, Hyland, PRA Health Sciences, SPOK, STANLEY Healthcare

Immunization Integration & CDS

Follow Aria from early childhood into adulthood as she moves through multiple care locations and receives immunizations over time. Immunization schedules have become more complex as more vaccines have been added to the routine schedule, especially for adolescents and adults. Clinical decision support for immunizations is becoming increasingly available both within local EHR systems and in response to queries to immunization information systems at the local and state levels. Throughout the care process, workflows that are demonstrated reflect the clinical capabilities tested in the HIMSS Immunization Integration Program (IIP).

Participating Organizations: Cerner, DSS, Epic, HLN, Hyland, STC, SureScripts

Mother and Infant Mortality Prevention

Jada visits her OB/GYN for routine prenatal care. She has signs and symptoms of preeclampsia and is sent to the hospital, where the diagnosis is confirmed and labor is induced. Routine fetal monitoring is performed during labor. She has a C-section for failure to progress. The baby is tagged with an RFID tag to prevent abduction and mother/baby mismatch. The baby is transferred to the NICU, and the most relevant care team is sent an alarm based on the critical lab results. Both the mother and newborn are treated for MRSA based on positive test results. Pathogen genomic sequencing is performed to rule out healthcare-associated infection in the NICU. The birth report is sent to the jurisdiction of birth and NCHS, where national birth statistics are assessed.

Participating Organizations: Allscripts, CDC, Cerner, Epic, GuardRFID, Motive Medical Intelligence, Obix, Philips, Smiths Medical, Utah DOH, Voalte
Nationwide Coordinated Care

David, a 43-year-old living in rural Washington, is diagnosed with high blood pressure. A few months later, David suffers a stroke. After stabilizing him, his community hospital ED transfers him to a larger acute hospital, where he is admitted, treated and discharged to home care, avoiding readmission. Later that year, David moves to Texas and establishes a new PCP. Regardless of where his care occurs, David and his providers have access to his health records nationwide via CommonWell Health Alliance, resulting in positive health outcomes.

Participating Organizations: Brightree, Cerner, CommonWell Health Alliance, eClinicalWorks, ELLKAY, Greenway Health, MEDITECH, OneRecord

Opioid Crisis: The Person & The Population

Stella presents to the ED experiencing an overdose. The Prescription Drug Monitoring Program (PDMP) is queried, confirming high-risk behavior. The PDMP is able to identify Stella’s other providers, enabling care coordination. After she is stabilized, a clinician starts a telehealth session with a behavioral health provider to identify symptoms, diagnose and refer her for further treatment. Stella is transferred to a behavioral health facility, where she is admitted for medication-assisted treatment. Based on the information in her chart, an electronic initial case report is sent to public health to initiate surveillance and intervention. This data is available for visualization and monitoring of population health impacts by providers and public health.

Participating Organizations: AIMS, American Well, APHL, CareEvolution, CDC, Conduent, CSTE, Epic, FormFast, Michigan Department of Health and Human Services, Netsmart, National Consortium of Telehealth Resource Centers, Tennessee Department of Health, Utah Department of Health, Washington State Department of Health

Patient Centered Interoperability
(Satellite Location: Hall A, Booth 888)

Leo Simpson is a 42 year old auto body painter with asthma and pre-diabetes. He utilizes a personal health record (PHR) to manage, aggregate, and share his health information among multiple providers. Leo sends information from his PHR to his primary care provider. The PCP is able to facilitate a referral to the YMCA for a pre-diabetes program. After seeing the PCP, he is also referred to a specialist for his asthma. Leo sends his updated information to the specialist. The specialist creates a care plan with Leo and informs him that his job is the cause of his asthma, requiring him to find new work. Payments for his medications are facilitated by electronic transfer of information between the 340B qualified clinic and the pharmacy. Over the ensuing months, Leo’s asthma symptoms resolve and his blood sugar improves.

Participating Organizations: AllianceChicago, Allscripts, CDC, PatientLink, Virence, Walgreens

Safe Medication Management

Richard has a history of pulmonary hypertension and congestive heart failure and had a recent syncope that resulted in a fall. He complains of pain and is unable to stand on his leg, so he is taken to the hospital ED. He undergoes a radiological exam, which is positive for leg fracture and requires surgery. Richard is tracked across care areas. Antibiotic, pain and cardiovascular medications are ordered. A connectivity platform optimizes formulary management and data exchange, protecting against medication errors and supporting diversion detection.

Participating Organizations: BD, Epic, Spok, STANLEY

School Telehealth

Wendy is a 10-year-old a student visiting a rural school clinic. She is assessed through telehealth resources and receives referrals for both dental and endocrinology care that would otherwise not be provided. Network continuity, telemedicine, and other applications all come together to ensure the best care for an underserved population.

Participating Organizations: Altarum, Arista, eClinicalWorks, Epic, National Consortium of Telehealth Resource Centers, ViTel Net
**Telehealth Consult & Acute Care**

Charlie is short of breath, and his wife schedules a telehealth virtual consult with his Cardiologist. The Cardiologist recommends an admission and consults with an ER Physician. Charlie is admitted into the ICU, treated and discharged to home care. A nurse visits Charlie and continues to provide follow-up care and education.

**Participating Organizations:** Baxter, Cerner, Draeger, Epic, Masimo, Philips, Rhapsody, Vidyo

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**Treating Pediatric Cancer**

James, a 12-year-old vacationing away from home, is diagnosed with neuroblastoma when a tumor is discovered on his adrenal gland. He undergoes surgery to remove the tumor and begins chemotherapy. All the clinical data captured during his diagnosis, surgery and ongoing treatment is shared with James’s healthcare providers and specialists, as well as with external registries, in order to make the best treatment decisions and return James to a normal life.

**Participating Organizations:** California Cancer Registry, Cerner, Endosoft, Epic, Health Gorilla, ICU Medical, Mindray, Olympus

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**Unlocking Payer Data to Improve Care**

Dara, a 78-year-old, seeks care that spans across primary care, specialty care and hospitalization. The Da Vinci Project supports the ability to exchange information between payers and providers and allows seamless exchanges, including payer-scheduled appointments, retrieving benefit information and incorporating it into the patient’s clinical record, integrating coverage requirements in the provider’s clinical workflow, and support for automatic reporting of quality measures.

**Participating Organizations:** CMS, Da Vinci, HL7, RUSH