



TECHNICAL DESIGN FEATURES OF THE JACKSON CARE HUB



OVERVIEW

The Jackson Care Hub provides the IT infrastructure supporting a local Community Information Exchange in Jackson, MI. The Hub is the technical centerpiece of a broad community initiative to integrate care for physical and behavioral health, substance abuse, and social issues that directly impact personal health and self-sufficiency. It provides the following:

1. Screening and assessment tools for SDoH, behavioral health, self-sufficiency and functional status
2. A closed-loop referral system
3. Communications tools to link active care providers
4. Data exchange functionality between community and EHR platforms
5. Reporting tools for process and outcome monitoring

1. SCREENING AND ASSESSMENT FUNCTIONS

- A community-designed 10-item SDoH screening instrument. Positive response to an item triggers a short assessment to clarify specific needs and link to the taxonomy embedded in the Michigan 2-1-1 resource database; a short list of best community service agency options to meet the need is created and one or more can be selected to start the referral process (see below).
- A standardized CMS-approved, HIPAA-compliant behavioral health/substance abuse screening, diagnostic and outcome tracking module supplied by Melagro Technology. The validated diagnostic module, based on the MINI, supports adult and pediatric DSM-V diagnostic assessment. Some payors allow billing for screenings conducted.

- A self-sufficiency assessment and monitoring tool derived from the Arizona Self-Sufficiency Matrix, used to determine intensity of need for assistance in identified social domains and to track improvement over time.
- A real-time interface between Hub and the Michigan 2-1-1 database to provide a complete and regularly updated list of available community and regional resources for social services care.

2. CLOSED-LOOP REFERRAL SYSTEM (CLRS)

- Once specific domain needs are identified in the screening process described above, the Hub queries the local instance of the Michigan 2-1-1 resource database in real time to locate local (or regional, or national) providers/resources/agencies available to address each need. The query returns a filtered and manageable list of providers/resources/agencies.
- The Hub displays this filtered list for each domain need, enabling staff to request additional information about specific providers when needed and to select providers to receive referral(s).
- Once a provider is selected, a referral 'task' is created and electronically posted to the Hub inbox of participating providers or faxed to non-participating providers. Providers follow their usual workflow to manage referrals once received, and update the status of referrals in the Hub as work progresses.
- Referral status (sent, received, unable to contact, in progress, unable to meet, redirected, completed) is tracked and displayed, and can be used by staff to manage referral workloads in the community.

3. COMMUNICATIONS TOOLS

- The Hub maintains an ‘Active Care Team’ roster of providers actively engaged in care with a client. All members of the team can see the client’s basic Hub record (screening results, referrals in progress, and text case notes) and exchange 1:1 or 1:many text messages regarding shared clients.
- A restricted access area has been created for ‘confidential’ areas such as substance abuse and domestic shelter referrals.

4. DATA EXCHANGE FUNCTIONALITY

- Linking medical and ‘non-medical’ providers is critical to the success of care coordination. This requires integration with EHR(s) in the community (for Jackson, Epic). Data exchange between Hub and Epic is currently carried out using HL7 v2 protocols, and will be migrated to FHIR protocols as soon as they are available. The Hub supports four types of EHR integration:
 1. Embedding a ‘mirrored’ SDoH screening/assessment tool in Epic; medical practice staff can complete screening in Epic and electronically post results to the Hub for community follow-up.
 2. Embedding the Hub referral engine in Epic, enabling medical practice staff to send community referrals from directly inside Epic.
 3. Importing results of Hub screenings and referrals into Epic, so screening and referral data from both Hub and EPIC are available to all care team members.
 4. Creating a single sign on link to the Hub in Epic; this enables medical practice staff one-click access to carry out screening and referral tasks directly in the Hub.

5. REPORTING TOOLS

The Hub database contains time-stamped data on SDoH screening and assessment, behavioral health screening, assessment, and tracking, referrals created, referral status changes, text care notes and all messages created and exchanged. Reports can be

configured to track community metrics of interest or support custom queries. Examples include:

- Monthly and cumulative reports of community service referrals created and current status, tracking by provider or SDoH domain.
- Tracking time between referral and provision of service.
- Tracking unmet SDoH and behavioral health needs by provider and domain.
- Tracking an individual client’s progress towards self-sufficiency over time.

The Hub is intended for use by any credentialed and registered community service provider, health care provider or public health worker as part of the community’s ‘no wrong door’ screening policy. Tiered access to Hub content is created for approved users after training is completed. RiverStar has designed the Hub to conform with health information exchange standards where possible, employing the state’s Provider Directory, Master Key (patient ID), Active Care Relationship Service, Secure Direct messaging and ADT notifications process.

Using the Hub as a screening and referral application enables community services staff to connect with many more service providers in a fraction of the time it would take to connect manually through multiple telephone or email messages. This should allow staff to manage more cases in less time with fewer misdirected referrals, improving accuracy and efficiency, while enabling multiple service providers to share client data, communicate directly, and effectively collaborate together to optimize treatment and track outcomes. The RiverStar Hub also establishes a lightweight connection between community and medical information silos, so that the most critical information needed to coordinate care and answers to questions such as: “Who else is working with Mr. Jones? What other needs were identified? Were they met? How is he doing now?” are easily available to all members of the care team.

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Learn more about Jackson County’s health initiatives at:
<https://www.co.jackson.mi.us/369/Services>

