Product Guide

WWW.MYHEALTHACCESS.NET

MYHEALTH@MYHEALTHACESS.NET

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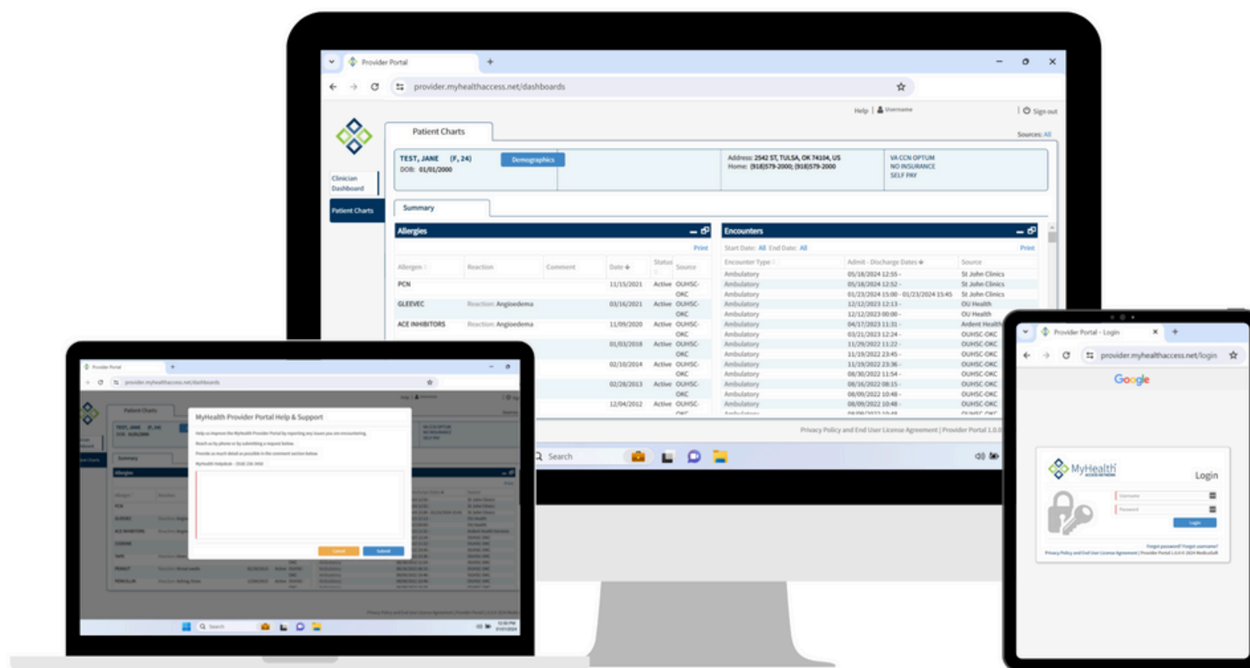
Provider Portal



MyHealth's Provider Portal offers healthcare providers a centralized and secure platform to access their patients' records from various healthcare facilities such as hospitals, clinics, labs, and pharmacies. Through this portal, members can securely share electronic health records (EHR), facilitating over 130,000 patient encounters daily across Oklahoma.

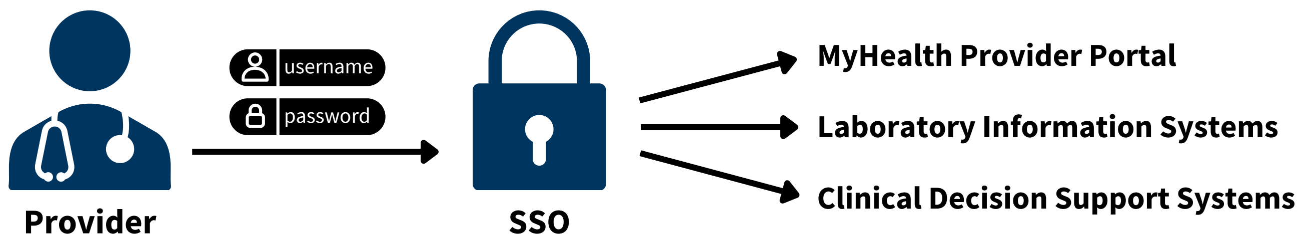
With the Provider Portal, users gain instant and secure access to patient health information from more than 1,500 locations. Utilizing a master person index, the portal links records for the same patient across multiple organizations, enabling providers to:

- Monitor and enhance patient care effectively
- Reduce healthcare costs associated with redundant testing, hospital admissions, and emergency department visits
- Enhance care coordination during transitions between different healthcare settings
- Improve patient experience and satisfaction
- Elevate the quality of care provided across the state of Oklahoma, benefiting its nearly 4 million patients

View Provider Portal Role Permissions Guide

Single Sign-On

Single Sign-On seamlessly integrates access to the MyHealth Provider Portal with the user's EMR, allowing for a smooth transition with just a single click, and enabling users to effortlessly view the same patient across platforms.



This technology is the solution to access and data security concerns in healthcare. By enhancing password security and streamlining user productivity, Single Sign-On reduces the costs associated with password management.

With Single Sign-On, users no longer need to resort to insecure practices like writing passwords on sticky notes or creating easily forgettable passwords. It eliminates the need to repeatedly type in passwords whenever accessing patient information, saving valuable time.

In the healthcare industry, various specialized electronic medical systems are utilized, each with its own user management, authentication, and authorization processes. This can create a complex web of navigation and usage. Single Sign-On simplifies this process by providing a cohesive workflow, reducing the need for users to remember multiple passwords and minimizing disruptions to clinical workflow. Additionally, it addresses challenges related to managing permissions for different healthcare provider roles.

Care Fragmentation Alerting

Care Fragmentation Alerting from MyHealth addresses the challenge of fragmented patient care by delivering timely alerts to participants whenever care is administered to their attributed patients. This daily report ensures swift action and follow-up on all care events, whether they occur within or outside the participant's organization.

Analysis of clinical data indicates that over 70% of patients within MyHealth have records from multiple sources. Fragmented or missing medical histories pose risks of errors, overuse, and inefficiencies in healthcare. Care Fragmentation Alerting notifies providers when patients receive care in emergency rooms, hospitals, or other clinics within the past 24 hours, providing crucial visibility. This tool helps organizations:

- Reduce 30-day readmissions
- Reduce avoidable ER utilization
- Maximize follow-up revenue
- Close referral loops
- Guide care management activities
- Succeed in value-based payment models

Members securely share electronic health records, including over 130,000 patient encounters per day throughout Oklahoma

Key information included in the report:

- Reason for the visit's appearance in the report
- List of MRNs for individuals within the participant's organization
- Patient's first, last, and middle names
- Patient's date of birth Patient's gender
- Patient's home zip code
- Original data source that sent information on the visit
- Date and time of patient admission
- Date and time of patient discharge HL7 Patient Class for Visit
- HL7 Patient Type for Visit
- Reported location the patient is attributed to
- Normalized National Provider Identifier for the admitting provider
- Indication if the admitting provider is an individual or group/organization
- NPPES name for the admitting provider
- Normalized National Provider Identifier for the attending provider
- Indication if the attending provider is an individual or group/organization
- Date and time of the procedure
- Non-normalized description of the procedure

Care Gap Reporting

Care Gaps Reporting is a powerful tool designed to assist healthcare providers in identifying and addressing gaps in patient care with precision and efficiency. By leveraging advanced data analytics and real-time reporting capabilities, this innovative solution empowers providers to gain actionable insights into patients' health status and treatment adherence, thereby facilitating targeted interventions to improve patient outcomes.

One of the key features of Care Gaps Reporting is its ability to present the most recent patient health data based on the provider's specified valueset. This ensures that providers have access to up-to-date information that is relevant to their clinical practice and patient population. By analyzing this data within the context of evidence-based guidelines and best practices, providers can identify gaps in care, such as missed screenings, overdue vaccinations, or uncontrolled chronic conditions, that may impact patient health outcomes.

Armed with these insights, providers can proactively identify opportunities for intervention and develop targeted care plans to address identified care gaps. This may involve implementing preventive measures, scheduling follow-up appointments, adjusting medication regimens, or providing patient education and support to promote self-management and adherence to treatment recommendations.

By enabling providers to take a proactive and data-driven approach to care delivery, Care Gaps Reporting helps to optimize patient outcomes, improve care quality, and enhance the overall efficiency and effectiveness of healthcare delivery.

Example:
Let's consider a patient named Sarah who has been diagnosed with diabetes. Sarah's healthcare provider uses Care Gaps Reporting to monitor her health status and ensure that she receives timely and appropriate care. Through the reporting tool, Sarah's provider identifies that she is overdue for her annual diabetic eye exam, a critical preventive measure recommended for patients with diabetes to detect potential vision problems early.

Armed with this information, Sarah's provider proactively reaches out to her to schedule the overdue eye exam. During the exam, the ophthalmologist detects early signs of diabetic retinopathy, a complication of diabetes that can lead to vision loss if left untreated. Thanks to the timely intervention facilitated by Care Gaps Reporting, Sarah's provider is able to initiate appropriate treatment and management strategies to prevent further progression of the condition and preserve her vision.

In this example, Care Gaps Reporting helps Sarah's provider identify and address a gap in her care, ultimately leading to better health outcomes and improved quality of life for Sarah. By proactively monitoring and addressing preventive care needs, Care Gaps Reporting empowers patients like Sarah to stay ahead of potential health issues and receive the care they need to live healthier lives.

Social Drivers of Health (SDOH)

Social Drivers of Health (SDOH) are the conditions in which people live and work, such as their income, education, and environment. These factors greatly influence health outcomes. For example, individuals in low-income neighborhoods may face challenges accessing healthcare and nutritious food, leading to poorer health. Understanding and addressing SDOH are crucial for improving overall health and reducing health disparities.

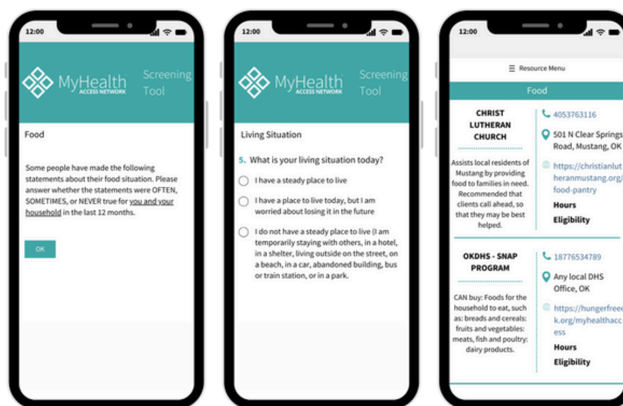
MyHealth's SDOH Program aims to:

- Conduct systematic health-related social needs screenings of patients in partner clinics
- Refer patients to community services that may be able to address the identified social needs
- Align community partners to optimize the capacity to address health-related social needs.

MyHealth Access Network's goal is for Oklahoma to become the first state to have universally available social needs screening and referral. As a 501(c)3 organization, MyHealth is committed to improving health and well-being throughout Oklahoma MyHealth has created a Social Needs and Referral funds to support this program and allows us to continue to offer it as a base service for Oklahomans.

Social Needs Screening

MyHealth has implemented a streamlined mobile screening process to identify health-related social needs among patients. Upon registering at the clinic or ER, patients receive a text message containing a link to complete the SDOH screening. This efficient method requires minimal effort from healthcare facilities while providing valuable assistance to patients. After completing the screening, patients receive a customized list of resources tailored to their identified needs via text message, based on their home address. This seamless process enhances patient care without adding to the workload of healthcare providers. We currently extend this program to over 140 providers throughout Oklahoma, enabling them to utilize the MyHealth mobile-based Social Needs Screening tool as part of our base membership package. However, it's important to note that for mobile screening, an ADT Clinical Data connection feed is required.



Social Drivers of Health (SDOH)

Roster Based Screening

MyHealth's SDOH Roster Based Screening, often referred to as the referral program, operates based on a predetermined roster provided by the organization, scheduling screenings up to four times a year. For instance, the program might aim to screen 100 patients daily, specifically on Mondays, Wednesdays, and Fridays. Patients included in the roster receive a text message prompting them to complete the SDOH screening via a provided link on their mobile device. Upon completion, the screening is scored, and patients receive a tailored list of resources based on their home address, sent back to them via text message. Importantly, the results of the screening are also shared with the organization for further action and follow-up.

SDOH Results Report

SDOH Results Report is a vital component of our Social Drivers of Health (SDOH) program, offering crucial insights into the social needs identified through our screenings. This report is generated daily and encompasses all screenings completed within the past 24 hours. By providing this information via a flat file format, we ensure that healthcare organizations have access to timely and comprehensive data regarding their patients' social drivers of health. This allows providers to promptly address any identified social needs, facilitating targeted interventions and support to improve patient outcomes. The SDOH Results Report serves as a valuable tool in enhancing care coordination, promoting proactive interventions, and ultimately contributing to the delivery of more holistic and patient-centered healthcare services.

E-Notification (CoP)

MyHealth's E-Notification (CoP) ensures that hospitals, psychiatric hospitals, and critical access hospitals fulfill the requirements set by CMS for conditions of participation.

When a patient is admitted, transferred, or discharged at a participating member location, an ADT message is promptly sent to MyHealth. Our system then processes this message through our master patient index, checking for any opt-outs, and identifies the relevant care providers to notify. Near real-time notifications are subsequently delivered to these identified care providers. Additionally, audit logs are shared with participating members to facilitate future reporting and analysis.

MyHealth E-Notification is instrumental in helping hospitals adhere to CMS Hospital Conditions of Participation (CoP) Electronic Notification requirement (CMS-9115-F). This mandate necessitates that hospitals transmit electronic notifications to a patient's providers whenever the patient undergoes admission, discharge, or transfer (ADT) procedures at the hospital.

Electronic Clinical Quality Measures (ECQM)

MyHealth's Electronic Clinical Quality Measures (ECQM) platform serves as a reliable intermediary for clinical quality measurement by integrating cross-community Electronic Health Record (EHR) clinical data with payer claims data. This integration results in a comprehensive and detailed view of patient care, empowering healthcare providers with timely alerts regarding care gaps and facilitating accurate calculations of value across the care delivery continuum.

By leveraging this combined data set, MyHealth enables healthcare professionals to assess and monitor the quality of care delivered to patients more effectively. The platform's advanced analytics capabilities help identify areas for improvement in care delivery, allowing providers to implement targeted interventions and enhance patient outcomes.

Furthermore, MyHealth's ECQM platform plays a crucial role in promoting collaboration and coordination among healthcare stakeholders. By facilitating the seamless exchange of clinical data between different healthcare settings and payer organizations, the platform fosters a more integrated approach to patient care and supports the delivery of high-quality, value-based care.