Electronically Connecting the Community: Making Care Plans Easier

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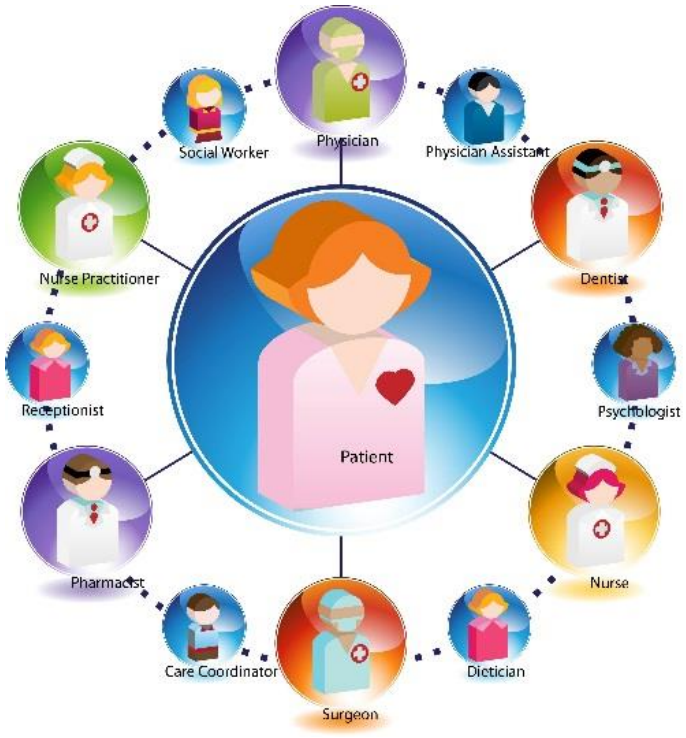
This article is part of a series devoted to hypertension and diabetes in Ohio and the prevalence of these chronic conditions. It explores the exchange of patient health information through electronic referrals in a "medical neighborhood" made up of healthcare providers and social service entities in the Central Ohio region.

A Medical Neighborhood Is Born

Four days a month, the indigent, immigrants, refugees, the uninsured and underinsured can access diabetes and hypertension screenings as well as other health and social services at a free clinic on Morse Road in Columbus, Ohio. Physicians traditionally have had a difficult time managing chronic conditions such as diabetes and hypertension in this patient population.

About 1,200 patients visit the Helping Hands Health and Wellness Center annually, which uses its electronic health record (EHR) system and additional functionality provided by the CliniSync Health Information Exchange (HIE) to overcome some of the related challenges to managing indigent and uninsured patients, especially those with chronic conditions. This electronic network connects hospitals, physicians and other providers across Ohio and is managed by the nonprofit Ohio Health Information Partnership.

Figure 1: Patient-Centric Care

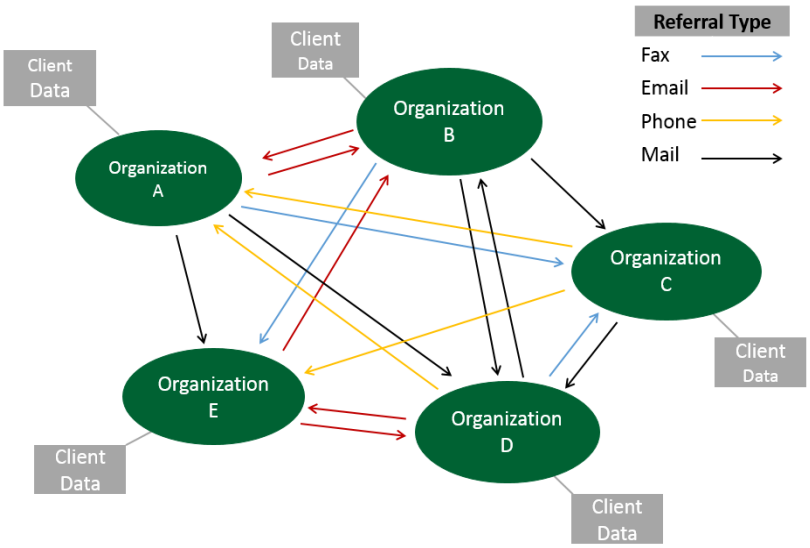


The clinic now has the technological capability to electronically refer patients to other partners in the Central Ohio community, referred to as a "medical neighborhood." This concept stems from the patient-centered medical home (PCMH) movement where the primary care practice is the hub of a coordinated care team involving other healthcare providers. While the medical neighborhood first sought to connect primary care with specialists, the community has expanded beyond ambulatory care. As you can see in Figure 1, care teams connect with one another around the patient for coordinated care.

"The Medical Neighborhood Referral Infrastructure Project (MNRI) is a collaborative effort to bring together the medical community with social service organizations and agencies in Central Ohio so we can wrap those services around the patient in a cohesive way".

John Leite, coordinator of the project for the Healthcare Collaborative of Greater Columbus

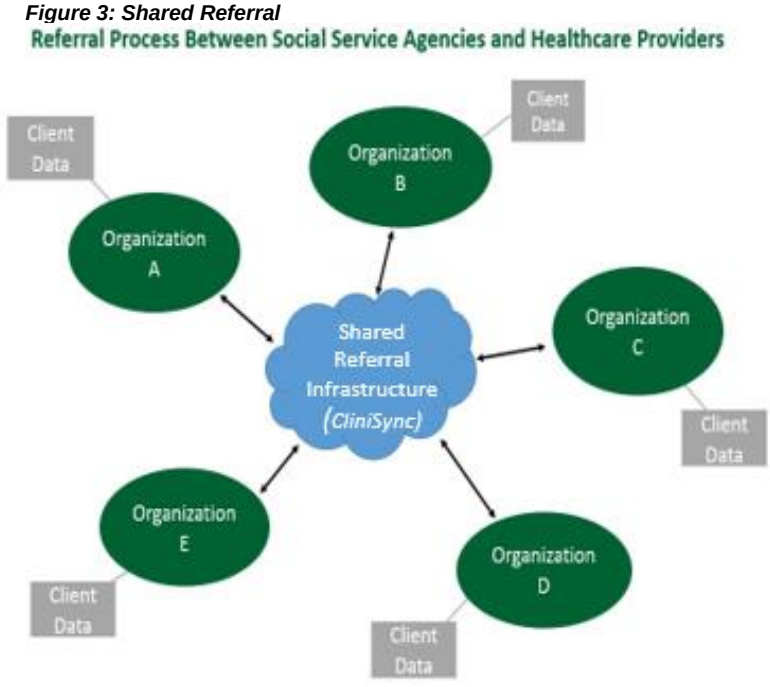
Figure 2: Paper-Based Referral Process



Historically, referrals between clinicians and social services have transpired through manual communication methods, such as fax, email, telephone, and even by mail. Even among the medical community itself, referrals among physicians could not be shared electronically since disparate health systems couldn't communicate with one another. Each EHR system operated individually without the ability to "talk" to others electronically. So, a primary care physician who needed to refer a diabetic patient to an endocrinologist would collect the critical elements of the patient's chart and fax those documents to the receiving physician. Or perhaps the physician would dictate a letter to be mailed or have a staff member make a phone call, taking time and labor. For social service agencies, this belabored process for referrals also occurred. You can see how this happens in Figure 2, where information forms a zig zag, hit-or-miss communication through conventional methods.

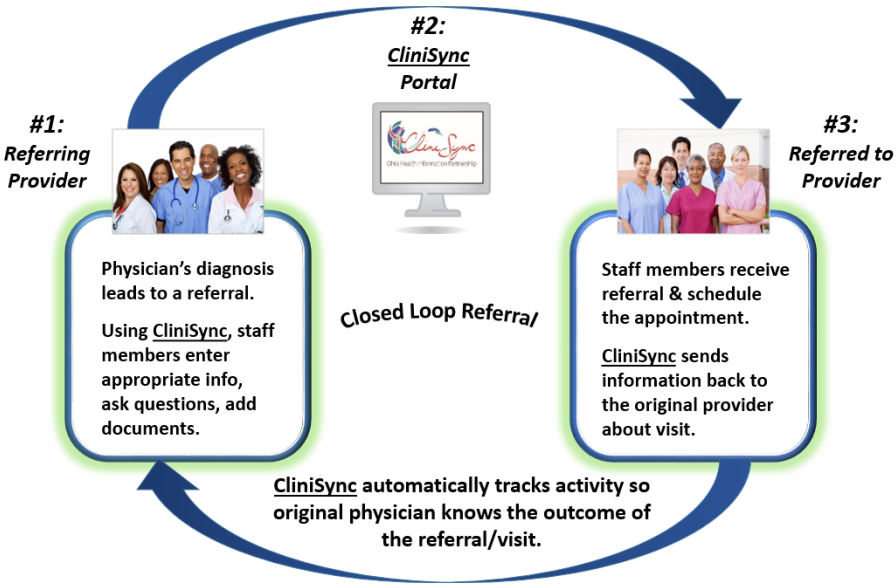
To digitize the process, eight medical facilities and 20 organizations in the Central Ohio region have come together to work through the electronic exchange of pertinent health information and also attend to the psychosocial and behavioral needs of their patients. Instead of faxing and calling, many can now electronically refer to one another through a technology solution – the referral tool – used in the CliniSync HIE.

Figure 3: Shared Referral



In Figure 3, CliniSync serves as the electronic hub through which organizations can share referrals when they are HIPAA-compliant. Authorized clinicians can also search for and find a patient's cumulative medical record based upon hospital encounters, known as the Community Health Record. A few physicians are starting to contribute data to this record so office visit encounters can also be viewed. This ability to share information through CliniSync is extremely important since practices and organizations use different EHR systems.

Figure 4: Closed Loop Referral



In real life, the referral works like a closed loop, as indicated in Figure 4, where a clinician refers a patient electronically to another organization through CliniSync, and then can see and manage activity on the referral, ultimately knowing the outcome for the patient. Did the patient get a scheduled appointment? Were the appropriate questions answered and documents attached? Was he or she seen? And was the problem rectified, whatever it might be? The clinician can then close the referral loop.

For example, a physician could use this tool to refer a patient to a local YMCA or faith-based organization for an exercise and weight loss program as a means of managing or improving diabetes and hypertension. This tool would allow the referring provider to see that the organization received the referral, processed the patient and that the patient didn't miss his or her appointment.

A Closer Look at Helping Hands Health and Wellness Center

At Helping Hands Health and Wellness Center, one full-time and three part-time staff members monitor the free clinic, along with volunteer nurses, physicians and others. Within the rental space in a hall adjacent to a church, the team sets up colorful canvas cubicles – lined up like squares in a Rubik's Cube – that promote privacy and serve different functions: medical exams, lab work, pharmacy, consulting and so on.

Steve Thompson, Director of Administration at the free clinic, explains the process. "A patient may arrive and complain of feeling sick, drained and lacking energy, and a blood stick or A1c test is taken so he or she may be treated appropriately," he says.

QUICK FACTS ABOUT HELPING HANDS HEALTH & WELLNESS CENTER

- 9-year-old faith-based nonprofit sustained by private and church donations
- Rents space from Ascension Lutheran Church on Morse Road in Columbus
- Operating budget: $130,000 annually
- Cares for 1,200 patients per year; adults 18+
- Patients eligible if meet 200% of federal poverty guidelines
- Serves the indigent, immigrants, refugees, uninsured, underinsured
- Serves patients waiting for Medicare and Medicaid services
- Free clinics four times a month, Thursday and Friday, starting at 2:30 p.m.

Usually, a nurse will spend time with the patient reviewing symptoms and medical history. An Ohio State University pharmacy student will screen the patient for diabetes and complete the testing. That student may take one step further and go into the patient's Community Health Record through CliniSync to see if there is any data related to the patient's care, such as an A1c result, vitals, care plans or other documents, that may assist with a diagnosis. Often, clinicians can look at results over time to trend a patient's chronic condition.

“If the patient has a high blood glucose reading, our screeners encourage the patients to discuss the results with the physician when they are seen for their medical complaints. If more tests are needed, such as an A1c, then the physician will request them at that time,” Thompson says.

The glucose test, or an A1c, can be analyzed onsite in the lab, and then the physician can diagnose and treat the patient. The patient also can spend time with a counselor to determine eligibility for Medicare, Medicaid or the Insurance Marketplace, if needed. In the meantime, the pharmacy student can electronically refer the physician’s prescription to Charitable Pharmacy of Central Ohio and a counselor can ensure all of this is coordinated in case the patient has any other needs. For instance, another referral for patient education could be made to the Central Ohio Diabetes Association so the patient understands diabetes and how to control it.

The same workflow would hold true for a patient with hypertension. The free clinic is on a first-come, first-serve basis and the list of services stretches from basic medical care and routine screenings for chronic conditions such as hypertension, diabetes, heart disease and high cholesterol – including tuberculosis – to services that involve chiropractic, social needs, spiritual counseling, Ohio Benefit Bank Services, vision, dental referrals and more.

"Helping Hands free clinic treats the whole patient - not just their medical needs - from spiritual guidance to social services and counseling,” Thompson says. "We strive to understand the needs of the patient and help them get a better quality of life.” Whether it’s providing free food from the home-grown community garden or starting out the clinic day with a prayer circle, Helping Hands reaches beyond the medical community to connect patients to services within the community that will give them a better quality of life.

Health Information Exchange Connects the Community

So where does Health Information Exchange come into the picture? In Figure 5, you can see the varied members of the community, including Allied Health agencies and organizations outside of the traditional medical field. If you think of HIE as a *verb*, you can visualize that everyone who touches a patient’s life can be involved in the medical neighborhood through electronic sharing of information, including insurance companies and others that have not been a traditional part of exchanging electronic communications. The key is ensuring that patient information is protected, secure and accessible only to providers of care, which is why an exchange like CliniSync becomes so critical.

Figure 5: Connecting the Community

With a new referral tool that will debut during the fourth quarter of 2016, social services agencies that are not HIPAA-compliant will be able to join the medical neighborhood. The data they will receive will be nonclinical – only demographics and basic information – so that when a referral comes through for

transportation, housing, nutrition, or other basic human needs, the clinical data will be parsed out and remain protected.

One scenario might be that a primary care physician has a patient who is in need of nutritional services, such as Meals-On-Wheels, which is managed by LifeCare Alliance in Central Ohio. The physician or authorized staff can log into the referral tool, enter the required patient information, query for LifeCare Alliance, complete the required fields in the tool and attach additional information, if necessary, and send the referral. Staff can then receive an update that the information was received, processed and the patient seen, closing the loop so the physician knows the patient has been scheduled to receive nutritional meals.

Creating a Medical Neighborhood Starts with the Right Tools
To create a medical neighborhood, you can start out slowly. Just begin with the tools that you need to connect to other providers in your region. Here are available services provided by CliniSync:

Results and Reports Delivery: Receive results/transcribed reports into an EHR or into a CliniSync inbox.

Community Health Record: Access individual patient community health records that include encounters at hospitals and practice visits. Also allows access to Ohio's Prescription Drug Management Program known as OARRS.

Referrals: Electronically send and receive customized patient referrals with confirmation and tracking in real time.

Direct Messaging: Use our HISP (Health Information Service Provider) to send and receive secure, encrypted messages and patient information using the national Direct protocol, a standard used nationwide by members of the eHealth Exchange.

Notify: Receive notifications when a patient is admitted or discharged as an inpatient or Emergency Department patient.

Contribute: Publish patient clinical data to CliniSync's longitudinal Community Health Record.

Single Sign On: Enables a view of the Community Health Record from within their EHR without the need for additional login information.

CliniSyncPLUS: A team of experts who can assist with quality reporting, such as Meaningful Use, payment reform initiatives, audits and security.

The services CliniSync offers at no cost to practices will continue to assist physicians and other providers with the tools and technological solutions they need to make electronic communications faster, more accurate and more complete.

With this Medical Neighborhood Referral Infrastructure, a model in Ohio can be replicated in other regions. Leite concurs that the possibilities for connections among healthcare providers and community services will continue to grow and improve patients' lives. As new tools evolve, patient care will be broadened further, so that patients become the center of their health care with active involvement in their treatment – no matter what their socioeconomic status or geographic location may be.

"The medical neighborhood model not only seeks to improve healthcare services in our community, but also takes into account that a person's health is impacted by many factors outside of the provider's office," Leite says. "Connecting healthcare providers to social service agencies in our community allows them to coordinate care accountably and efficiently to improve the lives of patients."

A special thank you to Steve Thompson of Helping Hands Health and Wellness Center and John Leite of the Healthcare Collaborative of Greater Columbus for their assistance in developing this article and the webinar that was presented on August 9. Their experience and passion for improving the health of Central Ohioans, especially those in the safety net community, is so appreciated!

Please visit the CliniSync website: www.clinisync.org for copies of other articles and webinars that were developed for the *Improving Ohio's Health* series. Listed below are just a few of the article titles:

- *Controlling Diabetes and Hypertension: Ohio Hospital Inpatient Discharges for Diabetes and Hypertension*
- *Effectively Using EHR Functionality to Manage Patients with Hypertension & Diabetes*
- *Establishing a Chronic Care Management Program in an Independent Group Practice*
- *Technology Tactics to Make Patient Engagement Easier: Improving the Health of Patients with Hypertension & Diabetes*
- *So What's the Scoop on New Chronic Care Management Coding? CMS Is Asking You for a "Do Over" for Chronic Care Management*
- *Technology to Support Your Patients with Chronic Conditions – It Doesn't Have to be Painful!*

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