For Immediate Release

Central Ohio Physician Group Advances Ohio's Health Information Exchange

First practice in Ohio to send lab results to hospitals

(Columbus, OH) March 20, 2019 - As Central Ohio Primary Care Physicians (COPCP) grew from 33 to 419 providers over the past two decades, so did its technological trajectory.

COPCP is the first physician group in Ohio to electronically transmit lab data to hospitals via the Clinisync Health Information Exchange (HIE) for the direct benefit of their patients.

Traditionally, it's the other way around – hospitals send test results to primary care practices. But with a "bidirectional" exchange, both physicians and *hospitals* who treat the same patient can provide more informed, higher quality patient care based on greater access to comprehensive clinical data - which translates to better care for all patients.

Robert Strohl, Director of Health Informatics at COPCP, explains how this exchange helps patients when their past lab data is immediately available. A patient may go to the ER with high levels of creatinine in the blood, a potential indicator of kidney damage. "With high creatinine levels, it would be very important for the physician to be able to see previous creatinine levels to determine if the patient has kidney damage," he explains.

The bidirectional exchange of patient lab results between primary care and hospital settings allows physicians in *both* settings to provide better diagnostic care because the lab data is immediately available, he explains.

EARLY INVOLVEMENT IN HIE

In 2011, Central Ohio Primary Care Physicians (COPCP), began a clinical data sharing relationship with the Clinisync Health Information Exchange (HIE) - a statewide clinical data network that includes 151 hospitals and thousands of physician practices and clinical facilities across the state of Ohio.

The goal was simple - facilitate a physician's ability to provide comprehensive care to their patients through real time exchange of key clinical data that is vital to the care of the patient.

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> Rob Strohl, Director of Health Informatics

“This exchange of clinical information is so beneficial to every patient in our community” says Strohl. “For the physician, the benefits of accessing critical healthcare data to facilitate informed care of the patient cannot be overstated. For the patient, suddenly admitted to the hospital, the benefits of having an informed physician at their bedside with proper access to their clinical status – priceless! Who wouldn’t want that?”

COPCP’s primary care providers serve 400,000 patients, roughly 30% of the population of Columbus. “Being able to share clinical data with doctors who are caring for our patients outside of COPCP is a critical component to the productive care of our patients,” Strohl says.

COMMUNITY HEALTH RECORD

Authorized physicians who have a care relationship with the patient have access to a Community Health Record, which is a longitudinal patient health record that contains near real-time lab results, reports, visits to the hospital, diagnoses, problem lists, face sheets, and summaries of care that go into detail about medications prescribed and discharge instructions.

COPCP’s early attempts to create interfaces with hospitals were largely unsuccessful because of the cost and challenges of building individual interfaces with each hospital, Strohl recalls. He worked from the ground up on initial committees for the new HIE, eager to get access to one connection that would give access to many hospitals, Fairfield Medical Center, Licking Memorial Health Systems, Adena Health System, and Central Ohio hospitals such as Mount Carmel, OhioHealth and OSU Wexner Medical Center.

William Wulf, M.D., the CEO of COPCP and an Ohio Health Information Partnership Board Member, helped establish the physician group in 1997 and has consistently pushed it towards more robust exchange of patient health information.

“Access to complete clinical information and the ability to use that information at the bedside is critical to the delivery of timely and effective patient care,” Dr. Wulf says.

POPULATION HEALTH

As the technology became more sophisticated, so did COPCP, with the group often leading the way for more advanced uses of the HIE, including population health initiatives.

“We’re heavily involved in population health, which is the concept of improving the quality of care for our entire patient population by proactively engaging patients based on effective analysis of their clinical status. The focus is on the quality of care given to a patient and not on the volume of patients seen,” Strohl says.

“You can’t effectively mine data from a paper chart or evaluate the health of your population from a paper chart or exchange key clinical data with other health systems through a paper chart.”

Rob Strohl,
Director of Health Informatics

“Being able to analyze our data greatly increases our ability to trend diabetic A1C values, blood pressure control values, lab values that

come from hospitals. Using a daily dashboard, our doctors can view trends in the health of their patient population and engage at risk patients proactively," Strohl says.

DATA ANALYSIS

This type of data sharing and analysis allows COPCP physicians to identify patients who are "at risk" of hospitalization – such as diabetics with an A1C greater than 9 or hypertensives with blood pressure above 140 over 90. The physician can focus on patient populations that haven't had the proper screening, such as mammograms, colorectal screening, or high body mass index (BMI) values.

"This analysis of our data to proactively improve the overall health of our patients is critical to COPCP. The laboratory, radiology and transcription interfaces that come to us through CliniSync greatly facilitate that initiative," Strohl says.

EMERGENCY NOTIFICATIONS

COPCP also receives notifications when one of its patients is admitted to or discharged from the hospital or Emergency Department.

"We can focus on patients with high admission rates or readmission rates allowing our physicians to schedule follow up appointments with patients after discharge," Strohl says.

"Physician follow-up within seven days of discharge reduces readmission rates dramatically. The hospital can be a bewildering experience. Follow up with your primary care provider is essential to maximizing the benefits of the hospital visit and decreasing the cost of overall health care through the reduction of readmissions rates."

BIDRECTIONAL EXCHANGE OF DATA

The bidirectional exchange of Continuity of Care Documents (CCDs) will give physicians the ability to access key clinical information from the HIE. COPCP is also publishing these summaries of care to the HIE so other physicians can see them within the Community Health Record.

"The sharing of key clinical data among physicians who have an active care relationship with the patient is a major step forward in creating a viable Community Health Record. "Patients benefit from more informed care, physicians benefit from improved access to data and healthcare in general benefits due to improved quality of care and decreased cost through appropriate data sharing and trending," Strohl says.

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