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A Stronger Safety Net
In subacute and complex care settings, communication is key to positive outcomes and efficiency.

By Melissa Russom

Data-sharing. It's a term as prevalent as *value-based care* in today's healthcare world. The benefits have long been touted and are widely accepted. Simply put, providing practitioners across health systems with access to patient information eliminates blind spots that could prove costly and potentially deadly.

Sharing health information, however, is not a static engagement. Agreements and networks are constantly evolving to meet the needs of providers and patients.

On the cutting edge of this movement, Hixny has invested in engaging hospitals, primary care providers and specialists for years. In 2018, Hixny's health information exchange (HIE) took steps to strategically expand its users' collaborative capabilities by extending its network of connections to organizations that serve some of the most vulnerable individuals in communities throughout the region.

In particular, Hixny sought to improve the sharing of data among traditional healthcare providers and behavioral health organizations, skilled nursing facilities and agencies caring for people with developmental disabilities—all organizations serving populations with more complex needs and, often, more frequent healthcare encounters than the general public.

Mental Health Association of Columbia-Greene Counties, Inc. and Northern Rivers Family of Services, a multi-service agency, deliver behavioral health services to children and adults. Springbrook, a facility licensed by the Office for People with Developmental Disabilities (OPWDD), provides lifelong support to its clients. Adirondack Health and Fort Hudson Health System administer skilled nursing facilities and deliver complex care services in their communities. This year, each of these organizations became the first of its kind to share health data through Hixny.

As a result, providers throughout the region are able to access more comprehensive views of the subset of their patients who have the most complicated care needs.

Finding Solutions for Complex Care

When providers share their patients' health information, the benefits go beyond reducing the duplication of procedures like X-rays and blood work, which can be costly and uncomfortable. It can prevent potentially fatal miscommunication and errors by prompting providers to work in concert with one another.

For example, prescribing an inhaler for a patient with asthma—a well-recognized standard of care—can trigger a deadly heart arrhythmia in some patients. Prescribing a new brand of blood-thinner without discontinuing the prescription from a previous provider can effectively double the patient's dose.

In patients who are unlikely or unable to recall the details of conditions and prior health encounters like these, an HIE stands to exponentially increase the safety and efficacy of care.

The Robert Wood Johnson Foundation reports that 70 percent of individuals with mental illness have comorbid physical health conditions, while 29 percent of adults with physical health conditions also have mental illness. Equally alarming, individuals diagnosed with severe mental illness are more prone to unhealthy behaviors like smoking and substance abuse, shortening their life expectancy by 25 years, says Michael H. Gelfand, LMSW, director of quality assurance at Mental Health Association of Columbia-Greene Counties.

Effectively treating individuals with such extensive needs requires a team that reflects a spectrum of medical and behavioral health knowledge, as well as a system to help them communicate. That's where Hixny comes in.

David Rossetti, LCSW-R, chief of behavioral health services at Northern Rivers Family of Services says that his team works to build relationships with clients' primary care providers from the start. Sharing medical records in real time helps them do just that.

"We want to keep the primary care provider [PCP] involved throughout treatment," Rossetti explains. "It helps build a level of comfort. Then, when we discharge a patient and the PCP takes over medication management, they have all of our documentation and know that if they get stuck, they can call us."

This increased communication and coordination of services is often referred to as *breaking down silos*—an approach that's especially beneficial when treating individuals with multiple complex needs.

High comorbidity rates aren't unique to the behavioral health environment, either. Katherine Ramiza, pediatric nurse practitioner and chief clinical officer at Springbrook, says that patients with certain developmental disabilities are at greater risk for certain ailments, some of which can be life-threatening. Armed with this knowledge about a patient's condition, a PCP can make more informed decisions, which lead to better outcomes for the patient.

Among the developmentally disabled community, common concerns also include early onset dementia, higher rates of choking and aspiration, a greater risk of seizures and obesity that's tied to limited mobility and medication side effects, among others.

The more complex a person's condition, the more providers he or she will see for comprehensive care. With each additional intake appointment, transfer or crisis, the risk for medication errors and blind spots increases.

Better Communication, Better Care

The task of tracking and communicating health data among various new providers often falls to the patient. There may be formal requests between medical offices, but there has traditionally been no expectation that information received through these records requests is complete or accurate.

Instead, at each provider visit, a patient is asked about her health history, her family history, the medications she takes, changes to her condition since her last visit—and the list goes on.

Imagine you're the caregiver for 10 children with developmental disabilities. You're 20 years old, in an entry-level position and fielding questions about everything from your client's emotional state to her tolerance for pain and her ability to move around the house unassisted.

According to Springbrook's Ramiza, this is a common scenario. "It's as if you had a very large family. We have our staff, who may have 10 people living in a home, all with very complicated medical histories. They may know these people really well, but it's very easy to say, 'Oh wait, is she the one who had the flu last winter?' Being able to recall that information from memory, for anyone, is very difficult."

Sharing information through Hixny fills these gaps in patient or caregiver memory. It also reduces the opportunity for misunderstandings.

"'Have you ever *had a problem* with anesthesia?' and 'Have you ever *had* anesthesia?' are two very different questions," Ramiza explains.

Depending on the way a provider asks a question, the patient's response and the subsequent treatment can vary enormously, with profound implications.

Amanda Waite, administrator of Fort Hudson Nursing Center and chief compliance officer for Fort Hudson Health System, sees similar translational errors with her residents, among whom about 54 percent have been diagnosed with dementia. To further complicate the situation, the healthcare proxy and default medical historian for men and women in this state is often an elderly spouse who also suffers some degree of diminished mental capacity. The healthcare proxy may find it difficult or impossible to recall procedures the patient has undergone, providers he or she has seen, medications he or she takes and other critical health information.

A 20-something man arriving at the emergency department following a car accident may have no problem sharing the medications he takes (none), past procedures (tonsil removal) and chronic conditions (asthma). But an individual with a developmental disability, a resident of a skilled nursing facility or a person with a mental illness has a much more extensive medical history and, potentially, a condition that obscures the ability to recall or state even the basics of that history. For these individuals, obtaining the details of their medical history is more than a nuisance; it can have life-and-death consequences.

An HIE Affects the Bottom Line

The Centers for Medicare & Medicaid Services (CMS) and most payers have made a concerted effort to engage providers in minimizing costly hospital readmissions. They've gone beyond public relations efforts to highlight the negative effects of unnecessary hospitalizations on a patient's care. Payers are hitting providers in their pocketbooks with penalties—in the form of lower reimbursement rate—when they experience a greater than acceptable number of preventable hospital readmissions.

The message here is clear: Provide appropriate care in the hospital and when you discharge a patient, make sure he or she is set-up to recover successfully and know what to do if the condition recurs. If the patient comes back to the hospital unnecessarily, you failed—and the quality measurement that informs your reimbursement rate will suffer.

Waite explains that hospitalizations can occur unnecessarily as a result of incomplete medical information. Among the elderly, she says, the diagnosis of a urinary tract infection (UTI) is enough to admit a patient to the hospital. “When a patient goes to the emergency room for an issue related to dementia, she’s routinely screened for a UTI. The thing is, that screen could come back positive several days after treatment has started. So we may already be treating the UTI effectively in our setting with oral or injectable medication, but the patient may be hospitalized anyway if the emergency staff are unaware of our treatment plan and in-house capabilities.”

She describes crisis situations involving mental health and dementia as just that: crises. Under these circumstances, information about extraneous conditions—such as the active treatment of a UTI—has not traditionally been transferred as clearly as it has been during routine care transfers. And, as quickly as that, her organization’s quality measurement could be negatively impacted by a preventable readmission.

According to Gelfand, mental health providers are also becoming increasingly more accountable for quality measures. By contracting with an accountable care organization (ACO), an organization delivering mental health services is now part of a team working together to reduce smoking rates, for example.

The line between medical and mental health services is blurring in favor of full-person, or *patient-centered*, health. While ACOs face pressure from CMS to advance value-based care, they subsequently pass that pressure down in their contracts, Gelfand says.

Audrey LaFrenier, LCSW-R, president and chief operating officer at Northern Rivers Family of Services, explains that, while there is not currently as much pressure on providers of children’s mental health services, the more children’s services are aligned with ACOs, the greater the integration must be between medical and mental health providers for this population as well.

The emphasis on simultaneous quality improvement and cost reduction is the focus of state and national efforts related to the transition to value-based care. It’s difficult or even impossible—at this point—for a provider or healthcare organization to avoid.

Delivery System Reform Incentive Payment (DSRIP) is a program leading the charge statewide and one in which each of these new Hixny participants shares a vested interest. By joining a performing provider system (PPS), the type of collaborative care group that works to meet DSRIP objectives, each of these Hixny participants has implicitly or explicitly committed to pursuing positive quality measurements like reducing unnecessary hospitalizations in return for sharing the financial rewards available to PPSs that achieve this standard of care.

While DSRIP and other state and federal value-based programs offer incentives without penalties (upside risk-sharing), the healthcare industry as a whole is moving toward downside risk-sharing, in which providers and organizations are penalized for missing quality and cost-reduction benchmarks. In fact, in August, CMS proposed a rule that pushes ACOs toward downside risk-sharing arrangements.

The stakes are real and growing. According to a study from the University of California, San Francisco, one in four hospital readmissions could be prevented by better communication among providers. That includes providing adequate information to decision-makers in the hospital and providing thorough discharge instructions to subacute and primary care providers.

Participating in an HIE like Hixny allows providers to drastically reduce miscommunication. With a full record of care at hand, a hospital provider can see that an elderly patient with dementia is receiving care for a UTI, for example, and determine that treatment in the subacute setting is sufficient, thereby preventing a hospital admission. As a result, the subacute provider's quality rating remains intact.

Streamlining the Workflow

When a resident is admitted to Fort Hudson Nursing Center, the first medical order is for a ward clerk at the facility to retrieve all of the resident's medical history from every practitioner and facility he or she has encountered, including primary care, specialists and hospitals just to start.

While this may sound simple enough, Fort Hudson's Waite says it has often taken up to a week to receive all of the medical history for a single new resident.

"It hasn't been rare for us to chase down a proxy to sign a consent and send it to a specific hospital department, only to find that the department requires a unique consent. So we had to start over," she explains.

With an average of 20 admissions every month, Fort Hudson staff—and those like them—found the paper chase a significant burden. Springbrook's Ramiza notes that the sheer volume of paperwork was just one part of the delay. Clarity of the records slowed processing because scanned physician notes can be even harder to read than originals, which made it impossible to determine when a resident could return to school or eat his regular diet, among other discharge instructions. With these compounding challenges, sometimes three weeks would pass between anticipating an admission and receiving the patient's full medical record.

At Springbrook, this delay affected business efficiencies. In this setting, staff training related to residents' specific diagnoses—for example, diabetes or wound care training—must be completed and documented before staff can provide those care services. Now, with medical conditions clearly identified in patients' Hixny records, administrators can determine exactly which trainings are required before residents arrive to ensure a sufficient number of team members are prepared.

In short, rather than chasing records, team members can spend their time focusing on the individuals in their care, which is a win-win for the patient and the providers.

"Having access to a wider range of information and more expansive history directly, immediately and significantly improves the transition process into our settings, expands our knowledge of patient needs and results in better care," says Andy Cruikshank, chief executive officer of Fort Hudson Health System. "There is simply no downside to having more information of a higher quality in a timely manner."

For those with complex needs and the provider community serving them, this access and broadening of knowledge proves even more crucial in clinical *and* administrative settings.

[Sidebar]
Sharing Relationships (Not Just Data)

Hospitalization is rarely, if ever, a comfortable process. Imagine how much more foreign and frightening it may be to a teenager who has just attempted suicide and is being admitted to the hospital's psychiatric unit for the first time.

Think of a young man diagnosed with bipolar disorder. For months, he might have attended routine counseling sessions at a local behavioral health clinic and taken his medication on schedule. His therapist had finally gained his trust. Then, his girlfriend convinced him he didn't need his medication. After he stopped taking it, he spent weeks swinging back and forth between depression and hyperactivity. Finally, he tried to take his own life and was immediately transported to the hospital.

Now, picture this young man already at the point of crisis. He's in a new environment, surrounded by new faces and being asked incredibly personal—even embarrassing—questions by strangers. No matter how skilled the members of the hospital care team are, they don't know him.

But his counselor does. And when she receives a Hixny alert that the young man has been admitted to the hospital, she's able to call the care team directly and draw their attention to vital information in her notes in his Hixny record that might affect the treatment methods they choose—information that took months of interactions with the patient for her to uncover.

This is more than data-sharing, it's relationship-sharing. The counselor can ensure that the hospital care team knows her client writhes at the sight of needles. She can tell them what church he attends and the strength of his support system there—something it took her weeks to uncover. She can even explain that the presence of the young man's mother will increase his anxiety and cause him to shut down.

As a trusted professional colleague who has a deep familiarity with the young man, she can offer the team ideas about how best to make him comfortable as quickly as possible, giving them the opportunity to treat him both physically and mentally as effectively as possible.