MedAllies

Wiring the medical neighborhood: MedAllies Direct connects providers, supports coordinated patient care

The era of the health care silo is over: The need to coordinate patient care across the care continuum is one of *the* fundamental health care lessons to emerge from the past decade.

From that lesson, the patient-centered medical neighborhood (PCMN) has emerged. The logical extension of the patient-centered medical home (PCMH), the PCMN is crucial to the ongoing success and sustainability of the health care delivery system.

As the name suggests, the medical neighborhood refers to the entire spectrum of care environments and providers from which

"Only connect ..." — E. M. Forster

a patient might receive care. The patient-centered medical neighborhood supports collaboration across these various providers and settings, including primary care, specialty care, hospital, emergency department, long-term care, mental health facilities and home care. It supports patient-centered, coordinated and informed care across the continuum.

Using EHR interoperability facilitates the flow of necessary information to the providers caring for the same patient, allowing them to better communicate with each other and coordinate the patient's care.

Why it matters: A failed status quo

Coordinating care throughout the PCMN is a lesson we're still learning, says MedAllies Chief Medical Officer Holly Miller, MD, MBA, FHIMSS. Clearly, the current fragmented and siloed approach to health care delivery wastes resources and imperils patients. For example, one study found that physicians who did not receive

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timely communication regarding referrals and consultations were more likely to report their ability to provide high-quality care was threatened.[1]

Transitions are common: Each year more than half of Medicare beneficiaries are treated for five or more chronic conditions. The average Medicare enrollee sees two primary care physicians (PCPs) and five specialists from four different practices each year.[2,3] Some may see as many as 16 different physicians in a year.[4]

Lack of communication and coordination among providers, especially at points of transitions, can be dangerous, Miller warns. And yet, poor communication among providers—especially between hospitals and PCPs—is common. The unavailability of basic patient information, such as the patient's active medications, problems and allergies, leads to adverse events.[5] Test results or records are often not available at the time of a doctor's appointment, and doctors, without access to timely information, order tests that have already been performed.[6]

The solution: a secure flow of critical clinical information. MedAllies, which operates a leading national Direct network, is making this happen, says Miller.

Technology as a catalyst

Health IT provides the mechanics of the PCMN. The Agency for Healthcare Research and Quality (AHRQ) identifies "sharing of the clinical information needed for effective decision making and reducing duplication and waste in the system, supported by appropriate health IT systems" as a key feature of a well-functioning PCMN.[7] It also identifies "limited health IT infrastructure and interoperability" as barriers to information flow and accountability in the medical neighborhood.

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It comes down to this: Becoming part of a medical neighborhood requires communicating with clinical partners. The Direct technology standard[8] established to meet Stage 2 Meaningful Use (MU2) requirements for transitions of care allows a clinician to push

[1] O'Malley A.S., Reschovsky J.D. "Referral and consultation communication between primary care and specialist physicians: finding common ground." *Arch Intern Med.* 2011 Jan 10;171(1):56-65. http://www.ncbi.nlm.nih.gov/pubmed/21220662

[2] Thorpe Kenneth E., Ogden Lydia L. ANALYSIS & COMMENTARY The Foundation That Health Reform Lays For Improved Payment, Care Coordination, And Prevention *Health Affairs,* June 2010; 29(6): 1183-1187.

[3] Pham HH, Schrag D, O'Malley AS, Wu B, and Bach PB. Care patterns in Medicare and their implications for pay for performance. N Engl J Med. 2007;356(11):1130–9.

[4] Bodenheimer, T, Coordinating Care—A Perilous Journey through the Health Care System, N Engl J Med 2008; 358:1064-71.

[5] Alper, E. et al. "Hospital Discharge" (literature review). UpToDate; updated Oct 15, 2013.

[6] Schoen et al. Taking the pulse of healthcare systems: experiences of patients with health problems in six countries. *Health Affairs,* 2005.

[7] Taylor EF, et al. *Coordinating care in the medical neighborhood: critical components and available mechanisms.* White Paper (Prepared by Mathematica Policy Research). AHRQ Publication No. 11-0064. Rockville, MD: Agency for Healthcare.

[8] Launched in March 2010 as a part of the federal government's Nationwide Health Information Network, the Direct Project was created to specify a simple, secure, scalable, standards-based way for participants to send authenticated, encrypted health information directly to known, trusted recipients over the Internet.

pertinent clinical information out of his own EHR system into the EHR of the clinician who will care for the patient next. The recipient clinician will receive critical information relevant to the specific transition of care—directly into her own EHR.

A successful medical neighborhood demands EHR interoperability and, not so coincidentally, that same interoperability is required to achieve MU2. MU2 moves beyond where any other health IT initiative has gone before. Other entities—labs, hospitals, fellow providers, patients, etc.—are now part of the information equation. MU2 emphasizes the ability to exchange health information between providers to improve care coordination and support transitions of care. Providers must demonstrate health IT is being *meaningfully used* (in ways that can be measured both quantitatively and qualitatively) to improve patient care and outcomes.

MU2 also directly addresses the medical neighborhood: It requires acute care facilities and eligible professionals to use electronic transmission, using Direct, for more than 10 percent of their patients transitioning or being referred. They must be able to send to facilities outside their own—their trading partners. (For details on this requirement, see sidebar.)

MedAllies' role: Connecting the neighborhood

MedAllies operates a leading national Direct network, but its implementation focus is clinically and community centered. The structure ensures everyone in the medical neighborhood will be able to send and

Stage 2 Meaningful Use Transitions of Care Requirements

Stage 2 Meaningful Use requires electronic exchange of data across disparate systems. Providers that transition or refer a patient to another setting or provider must provide an electronic summary-of-care document for more than 10 percent of these transitions. (A summary-of-care document, sometimes called a transition-of-care document, provides essential clinical information for the receiving care team.)

Providers must also conduct one or more successful electronic exchanges of a summary-of-care document with a recipient who has a different EHR vendor. This must be done over an MU2-certified EHR.

One of MU2's requirements—Core Measure 15, Summary of Care—relates to transitions of care. It includes three measures:

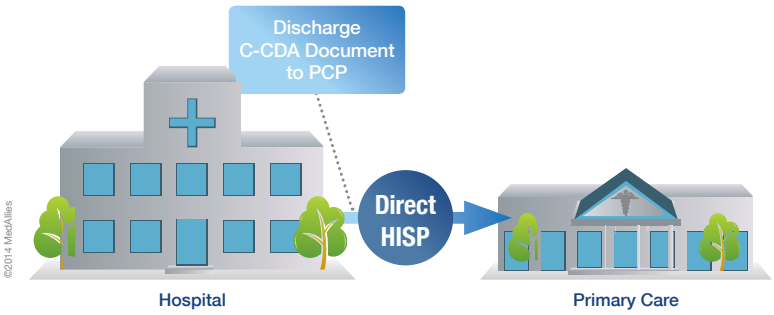
1. **Measure #1** requires a provider send a summary-of-care document for more than 50 percent of transitions of care and referrals.

2. **Measure #2** requires a provider that transitions or refers her patient to another setting of care or provider of care to electronically transmit a summary-of-care document—using certified EHR technology—to a recipient using a different certified EHR technology vendor than the sender. This must happen for more than 10 percent of transitions of care and referrals.

3. **Measure #3** requires at least one summary-of-care record to be electronically transmitted to a recipient with a different EHR vendor, or to the CMS test EHR.

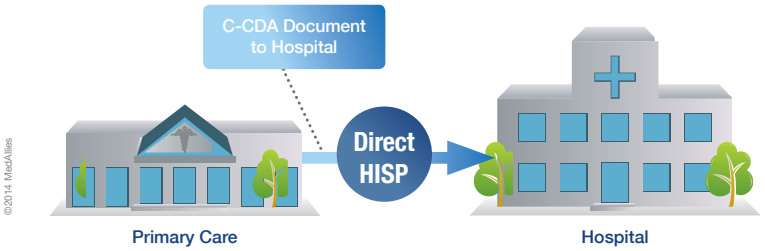
SOURCE: www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html

Direct Use Cases



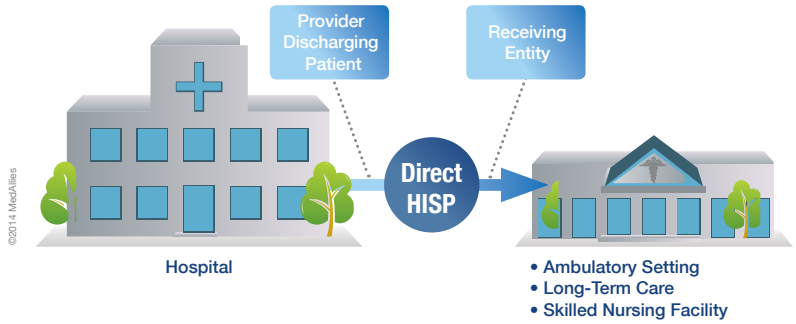
Hospital Discharge

When a patient is discharged, the hospital prepares a discharge Consolidated-Clinical Document Architecture (C-CDA) document, and sends it to patient's primary care provider via Direct.



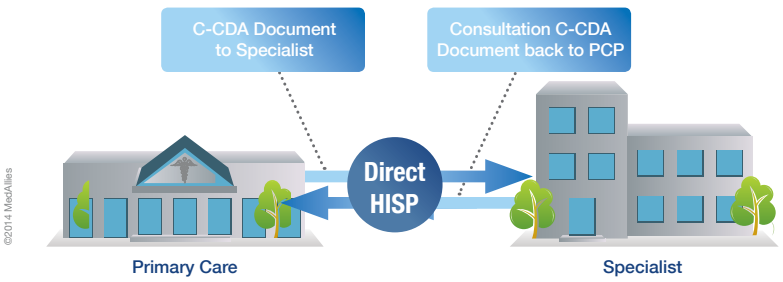
Hospital Admission

For planned hospital admissions, a primary care physician or specialist can send an admission C-CDA document to the hospital.



Hospital Discharge

The hospital will send a discharge C-CDA document via Direct to the receiving entity—for example, a skilled nursing facility. But these facilities don't always have 2014 MU2-compliant EHRs. If the patient is being transferred to any clinical entity that is not using a certified EHR (including those using paper records), the hospital can prepare the discharge C-CDA document at time of discharge and send it via Direct if the recipient uses MedAllies Mail™.



Closed Loop Referral

When a PCP is referring a patient to a specialist, the PCP sends a referral C-CDA document to the specialist. After the specialist has seen and evaluated the patient, the specialist sends a consultation C-CDA document back to the PCP.

receive patient transitions-of-care messages, thus optimizing patient care—while meeting MU2 requirements.

MedAllies Direct Solutions™ provides a simple, secure, scalable, standards-based way for participants to send authenticated, encrypted personal health information directly to known, trusted recipients via the Internet—an approach that will work across different EHR vendors. It's a tool to support the PCMN, addressing real-world health care gaps, including the lack of care coordination across care transitions.

Miller and the MedAllies team see tremendous interest from physicians who want to parlay their investment in technology to provide interoperability across EHR systems to support their patients' transitions of care. Likewise, they see increased interest from hospitals in improving care transitions, driven by myriad financial factors that include the 30-day re-admission penalties, ACOs, Meaningful Use requirements—and, of course, underlying it all, a shared desire for better patient care.

Expertise in transformation

MedAllies has its roots in supporting practice transformation through the PCMH and the PCMN. MedAllies' team includes physicians and implementation experts, focused on increased adoption and use of technology.

Over the years, MedAllies has leveraged EHR implementations to facilitate physician office redesign, improve office practice efficiencies and enhance population health. Clinician involvement is at MedAllies' core. Its leaders are doctors as well as health IT experts who understand how to work with physicians, physician organizations and health systems.

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"Our roots are in supporting practice transformation through the patient-centered medical home and medical neighborhood," Miller explains. "This expertise allows us to support better transitions of care, accelerating the path to better care, better health, lower costs—and Meaningful Use."

Focus on the clinician

Technology is a catalyst, a means to this end: MedAllies' goal is to enable transitions of care to foster care coordination in support of the three part aim: better care, improved health and reduced costs, Miller says. But technology must support, not burden, the physician.

"We know, first hand, that physicians must be able to receive information about their patients as those patients transition across care environments, and it should seamlessly flow into their EHR systems," she says. Sustainable improvements in care coordination require adoption of the necessary health IT tools. For clinicians to adopt these tools, they must be clinically relevant and efficient to use.

"Instead of receiving a 'tome of patient information,' much of which is irrelevant to the transition, the recipient gets pertinent information, delivered succinctly—giving the provider exactly what is needed to care for the patient," Miller explains. For example, all Direct transition documents carry an active medication list. Thus, all receiving providers have the patient's current medications; this means more accurate medication lists at the point of care where the next provider is making decisions about medications to order for the patient.

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This works even if the patient is being transferred to a provider or setting that is not using certified electronic health records—even one using paper-based records, such as a long-term care facility. The hospital can prepare the discharge document and send it via Direct if the recipient is using MedAllies Mail™ (See sidebar for more on MedAllies Mail.)

Making it personal, supporting transformation

For many organizations, MU2 requirements represent a significant change from how they have implemented health IT in the past. Not only are there internal technical and workflow changes to be made, but there are also inter-organizational outreach and communication that must occur with an organization's clinical trading partners to be successful in the implementation of a PCMN.

That's why MedAllies places particular emphasis on clinician onboarding—working directly with the provider through a three-track, three-phase process. "We provide as much or as little support as an organization or community needs," Miller says.

As part of this onboarding process, MedAllies helps organizations identify clinical trading

"You can be a good neighbor only if you have good neighbors."

— Howard E. Koch, playwright and screenwriter

partners with whom they can exchange information. A Direct exchange requires at least two dance partners, she explains. "Each practice identifies clinical partners—those with whom it has frequent patient care transitions. Then MedAllies helps the organization assess their partners' needs and, if appropriate, engage them." This aspect is particularly important to helping providers meet MU2 transitions-of-care goals. The more clinical trading partners health care organizations are exchanging information with, the broader the medical neighborhood and the more likely it is that information will flow as needed to support patients as they transition across care settings.

That's more than a health IT function, she adds: It's building a patient-centered medical neighborhood.

> *"Now is the time to build our neighborhoods."*
>
> **— Holly Miller, MD, MBA, FHIMSS**

Facing the challenges

Change can be challenging. Becoming part of a medical neighborhood requires not only internal practice transformation, but also participating in efforts that extend across an entire health care delivery community. The nation is at the tipping point with the alignment of available technology and financial incentives for the adoption of that technology. All MU2-certified EHRs must include the Direct technology standard for interoperability. A required element to achieve MU2 is to use Direct for physician-to-physician communication for patient care transitions.

The technology is in place, the incentives are available and the need is clear, Miller says. "Now is the time to build our neighborhoods." MA

Connecting to the entire neighborhood: MedAllies Mail™

Not everyone in the neighborhood has sophisticated EHRs—or even EHRs at all. MedAllies Mail v1.0 provides a secure method for providers to communicate with health care organizations that are not 2014 Meaningful Use-certified. This Direct medical email can be bundled with MedAllies Direct Solutions offerings or provided as a standalone option. It follows an email paradigm that meets Direct specifications.

Like the broader MedAllies Direct Solutions offering, MedAllies Mail includes a provider directory that supports multiple Direct service addresses for any given health care provider, and relationships with any number of organizations and endpoints. Through MedAllies Mail, customers can achieve comprehensive reach to the entire community or medical neighborhood, allowing for streamlined transitions of care even with organizations that are paper-based. By doing so, MedAllies Mail accelerates the path to Stage 2 Meaningful Use compliance for provider organizations in need of additional clinicians to meet transitions of care requirements. (To learn more and watch a demo, go to www.medallies.com/MedAlliesDirectSolutions_2.html.)

Holly Miller, MD, MBA, FHIMSS

As chief medical officer for MedAllies, Miller optimizes MedAllies' strategic implementations of certified EHR systems to improve patient quality and outcomes and enhance care coordination. The implementations are designed not only to meet the efficiency needs of time-pressed physicians, but also to fulfill government requirements for meaningful use of EHR systems. She is the MedAllies physician liaison for all implementation projects and works closely with the team to design a change management program ensuring optimal utilization of the EHR tools within different practice environments. Miller develops organizational structure and strategic vision, approves and oversees staffing to implement all aspects of MedAllies' consumer initiatives. Miller is a frequent presenter at national meetings on health IT and personal health records, and serves as vice chair on the HIMSS board of directors. She is the lead author on a book about PHRs, *Personal Health Records, The Essential Missing Element in 21st Century Health Care,* published in 2009.

About MedAllies

MedAllies, founded in 2001, has extensive experience with EHR implementations and workflow redesign to improve clinical care. It provides unmatched expertise in interoperability, health information exchange and Direct services. As one of the ONC Direct Reference Implementation vendors, MedAllies has provided Direct services since the Direct Project's inception. MedAllies Direct Solutions builds on existing technology to achieve interoperability. It focuses on provider adoption and use of EHRs for clinical workflow integration beyond the walls of their organizations over the MedAllies Direct Network. Physicians use their current EHR systems, allowing information to flow across disparate EHR systems in a manner consistent with provider workflows. MedAllies Direct Solutions is a tool to advance primary care models that emphasize care coordination and improved care transitions, and support patient-centered care.

Do you want to learn more?

Call us at (845) 896-0191 x3076 or send us a request through our website, ***www.medallies.com/ContactMedAlliesDirectSolutions_1.html.***