About the series

As health care moves rapidly toward a value-based delivery model, a greater emphasis will be placed on care coordination. We must ensure that patients not only get the right care at the right time in the right setting, but also that every part of the delivery system is connected and understands that a patient's need will be critical going forward. Information technology will be instrumental in making sure that these connections take place and in providing clinicians with valuable new decision support tools.

H&HN, with the support of AT&T, has created this yearlong series called Connecting the Continuum to explore how hospitals and health systems are addressing the care continuum in their strategic and operational plans.

Each month, we will examine such topics as health information exchange, mobile health and transitions of care. Follow the series in *H&HN*, *H&HN Daily* and on our website.

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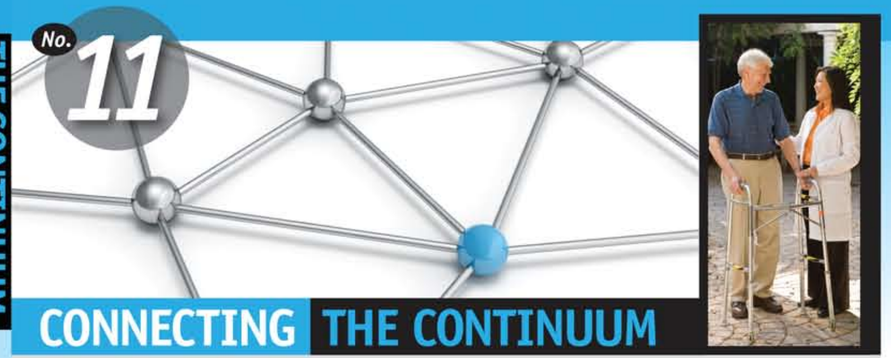

Building an IT bridge with post-acute providers

BY JOHN MORRISSEY

Well-informed post-acute care is crucial to keeping a still vulnerable patient stable and improving after an inpatient stay. According to Health & Human Services, nearly 40 percent of all Medicare beneficiaries discharged from acute care hospitals receive post-acute care. But despite its importance in the care continuum, post-acute care is arguably the most disconnected from it. And the information technology remedies are just taking shape.

Operating on thin margins, outside the reach of federal health IT adoption incentives, long-term care facilities likely still store data on paper and have little or no means to receive data electronically. "A lot of the challenge is on that side of the business, unfortunately," says Ferdinand Velasco, M.D., chief medical information officer of Texas Health Resources. The Arlington-based health system has initiated post-acute partnerships, but faces a steep technology climb in establishing meaningful information exchange.

"We have electronic health records at Texas Health. We have a health information exchange engine that we're ready to use with these providers," says Velasco. "The problem is, they don't have the systems that are able to connect to that HIE."

For now, the health system is extending to long-term care facilities and a home care partner a read-only link to its physician portal, which it has been providing to medical practices that haven't implemented EHRs. The Web-based access to the full Texas Health record can furnish post-acute facilities with a discharge summary and up-to-date details on medications, lab results, problems and the notes elaborating on them.

One way to step up acute and post-acute integration is to go beyond partnerships and bring a post-acute company into the corporate fold. In Asheville, N.C., a large post-acute company, CarePartners, recently became an affiliate member of Mission Health, extending that health system's care continuum and adding an operation that already was using an older EHR and was evaluating how to upgrade it.

Over the next year or so, the two organizations plan a complete systems integration, either a common platform or a set of interfaces and views into each other's records. Any caregiver on either side would have direct access to a patient's acute or post-acute record, says Ronald Paulus, M.D., Mission Health president and CEO. In the meantime, they're rolling out a modified HIE to share core data elements, such as medications and simple notes.

The transaction came about "because we believe that nonhospital-based sites of care are going to be increasingly important over time," says Paulus. The shift to risk-bearing and penalties for readmissions were factors, but "that's just the tip of the iceberg. The real opportunities are the untapped ones that we let slip by every day whenever care could be much more effectively coordinated across the continuum."

A federal demonstration project well under way in the Oklahoma City metro area has taken direct aim at the obstacles of low computerization and high implementation costs by equipping local nursing homes with lightweight EHR tools to enter data, as well as several low-cost avenues to receive data from two referring hospitals operated by Norman (Okla.) Regional Health System. The results in the first nine months have been stunning: a 30 percent reduction in 30-day readmissions from those homes, and a 40 percent reduction in returns to the emergency department.

The EHR's clinical documentation tool assists in capturing Activities of Daily Living (ADL), a key measure of whether patients are getting better or slipping into a crisis. Once documented on paper at the end of shifts, ADLs and vital signs have migrated to 98 percent real-time documentation, says Brian Yeaman, M.D., Norman Regional's chief medical informatics officer and principal investigator for the $1.7 million Health Information Exchange Challenge Grant from the Office of the National Coordinator for Health IT.

In addition, hospital discharge summaries are sent to nursing homes via the metropolitan health information exchange called SMRTNet (Secure Medical Records Transfer Network), an automated process that alerts the long-term care facilities to the status of patients they receive from the hospital or the ED, Yeaman says. Lastly, the standard point-to-point exchange protocol Direct has been installed in all the facilities, enabling referral information to be sent from hospital to receiving facility, and also to furnish information from nursing home to ED on patients who need to be sent there.

CASE STUDY

One of the first priorities for Norman Regional in computerizing record-keeping at five referral nursing homes was to give them an honest-to-goodness terminal to use. "When we went to them initially, a lot of them didn't even have a computer at all," says CMIO Yeaman. "And if they had a computer, it was in someone's office locked up."

With a computer in the house, a 15-minute learning curve was all it took to get aides to document patient ADLs. That gave nursing directors the chance to watch a computer dashboard for changes in patient status. If vital signs fell out of range, for example, the lightweight EHR sent an alert to step up intervention according to a decision-support algorithm and avoid an admission or readmission.

Use of the Direct protocol via SMRTNet whisked a continuity-of-care document from the hospital summarizing treatment there, and the same process allowed interchange of the nursing equivalent of a progress note called SBAR (situation, background, assessment, recommendation), which Yeaman says was "one of the best things we've done in terms of provider satisfaction." That's because in the emergency department or the long-term care site, "you're not sure what was done on the other side, what was treated, what the diagnosis was. The discharge summaries can be slow coming out," he says.

The costs to a nursing home: $2,000 a year for the EHR clinical documentation tool, $600 to $800 for the Direct tool, and $1,000 for HIE access. "It's a game changer," says Yeaman, "and it doesn't break the bank."

CASE STUDY

Too many, the notion of post-acute care likely is synonymous for care of elderly people, but Mission Health CEO Paulus says the need for such care spans the full range of patient characteristics and needs. The integration between Mission and CarePartners, freed of certain regulatory information-sharing restrictions as well as questions about who gets paid for what, can spur solutions to situations in which there's no place to discharge some patients from the hospital.

For example, in some cases, babies born addicted to drugs "might stay for months in the neonatal intensive care unit; but if they're shifted to different forms of detox, that would require home visits, things that no one's getting paid for, and, therefore, no one's going to do," Paulus says. "In this case, we know that we can get them out of the intensive care unit dramatically faster, but only if they're going to have reliable home-based monitoring after they're discharged."

Similarly, the health system is working with a community shelter to care for homeless people. "Right now, we have no place but to keep them in the hospital indefinitely, until they're completely able to go out on their own." Providing nurse staffing and other services to the shelter can enable safe discharge to a place where homeless patients can get food, their dressings changed, and clinicians to check on them, Paulus says. ●

Common challenges to integrate post-acute care into HIE at the state level

1 | LACK OF FUNDING/PAYMENT INCENTIVES
States generally are focused on health care providers, and the path to greater integration is largely unclear and not uniform among states.

2 | INACCESSIBILITY OF DATA
Clinical data often are fragmented due to antiquated record systems that collect only a portion of a patient's health information.

3 | WORKFORCE ISSUES
IT workforce in post-acute care is characterized by high turnover and typically lower education and health care training.

4 | LACK OF EHR STANDARDIZATION
Data collection in various post-acute settings is not standardized, leading to challenges in coordinating care functions such as treatment history, referrals and transfers.

5 | MULTIPLE, COMPETING STATE HEALTH INITIATIVES
As states work to sustain Medicaid, implement health care reform, control health costs, and award meaningful-use incentives for providers, fewer resources are left for post-acute care.

Source: NGA Center for Best Practices, Issue Brief: "Health Information Technology Integration in Long-Term Care: Challenges, Best Practices, and Solutions for States," 2011.