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CASE STUDY

Locking closed-loop referrals with seamless community resource data integration using the FHIR Data Platform

The challenges

With the shift to value-based payment models, addressing problematic social determinants of health has become a major focal point in population health management. Connecting community resources with patients in real-time is necessary to enable timely interventions to improve outcomes for at-risk populations and achieve cost containment. Closing the referral loop in this scenario becomes the key to the successful use of community resources.

A leading Accountable Community of Health (AHC) based out of Pierce County, Washington wanted to tighten the care coordination process for their partners in the community distributed across many practice sites. The ACH was challenged to integrate data from different kinds of electronic health records (EHRs) and close referral loops for hundreds of patient records.

The challenges

To enable closed-loop patient referrals with community resources, and tighten care coordination with both social services and providers, the ACH had to first address some key issues:

Patient data was housed in numerous disparate sources including EHRs, ADT feeds, Health Information Exchange (HIE) feeds, claims files, X12 835/837 files, and CCDA documents. Absence of a common standard for storing and sharing patient data resulted in data silos and operational inefficiency.

Decentralized care coordination staff and complicated workflows made task handoffs difficult and hampered the process of closing the referral loop across the continuum.

Since the patient data was distributed across the continuum, the primary care providers (PCP) had little visibility into the entire care program and its impacts.

The network required thorough analyses of episodes, network leakages, and gaps in synchronization with social resources. By using analytics, they wanted to lead the way to effective population health management.

Enabling complete healthcare data integration for smooth care delivery

With Innovaccer's proprietary FHIR Data Platform, the network was able to aggregate healthcare data from various sources including EHRs, claims, pharmacies, hospitals, and labs. With rich analytics on patient data, custom insights, and dashboards, the network leveraged a comprehensive view of their population health. The FHIR Data Platform enabled real-time decision support and automated workflows for care teams, and point-of-care alerts for providers for efficient and smooth care delivery.

Automated referral management
Physicians were also able to view the prior referrals made for a particular patient with InNote and schedule new referrals to increase their in-network activity. The physicians could generate varied referrals for patients based on specialization, payer, or even their preferred language and geography. The physicians could also keep track of the cost associated with the specialist and the quality of care, which led to increased efficiency and transparency between the referring physician and the specialist.

Physicians could also view the details of the extended care team associated with the patient and collaborate with them to streamline the care program across the network.

Locking closed-loop referrals with seamless community resource data integration With Innovaccer's FHIR Data Platform, the network was able to lock closed-loop referrals with a wide breadth of social assistance services such as food, housing, financial and legal assistance, and other health services. The platform helped ACH providers to easily identify and refer patients to these social services. The ACH organization could enable end-user mobile apps for community resource workers and for end-to-end synchronization between providers and social resources. This ensured closed-loop referrals throughout their health network and an improved care delivery process for better patient outcomes.

Results

With Innovaccer's FHIR Data Platform, the ACH was able to achieve the following outcomes:

Patients were aligned with community resources in real-time, and the ACH helped its partners successfully address critical medical and social service needs for their patients.

Elevate Health ensured seamless communication with community health resources and successfully obtained insights into their network performance.

The ACH unified patient records gathered from multiple data sources and leveraged them to track the patient journey while measuring and analyzing the met and unmet patient needs.

Seamless coordination of providers and numerous community resources throughout the community's continuum of care enabled enhanced care delivery for lives across the ACH's community of residents.

Innovaccer Inc., the Health Cloud company, is dedicated to accelerating innovation in healthcare. The Innovaccer® Health Cloud unifies patient data across systems and care settings, and empowers healthcare organizations to develop scalable, modern applications that improve clinical, financial, and operational outcomes.

Innovaccer's solutions have been deployed across more than 1,600 care settings in the U.S., enabling more than 96,000 providers to transform care delivery and work collaboratively with payers and life sciences companies. Innovaccer has helped its customers unify health records for more than 39 million people and generate over $1B in cumulative cost savings.

Innovaccer is the #1 rated Data and Analytics Platform by KLAS, and the #1 rated population health technology platform by Black Book.

For more information, please visit innovaccer.com

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