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Bidirectional eReferrals Between Health Systems and YMCAs

Session 83, February 12, 2019

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Conflict of Interest

Kate Kirley, MD, MS, FAAFP and Mamta Gakhar, MPH have no real or apparent conflicts of interest to report.

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Agenda

- Overview of type 2 diabetes prevention
- Exploration of bi-directional referral approaches
- Y-USA/CDC/AMA e-referral project summary
- Discussion of key drivers for bi-directional referral
- Recommendations for health systems and LCPs

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Learning Objectives

- Describe the key components of bi-directional referral processes between healthcare providers lifestyle change programs to prevent type 2 diabetes
- Identify different approaches/examples of utilizing technological solutions to facilitate bi-directional communication between healthcare providers and lifestyle change programs
- Discuss key drivers health systems and lifestyle change programs should consider when implementing technological solutions to facilitate bi-directional referrals
- Summarize recommendations for healthcare provider organizations and lifestyle change programs with different levels of HIT sophistication

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Overview

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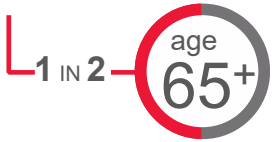
Current burden of prediabetes

A serious health condition in which plasma glucose levels are higher than normal but not high enough to diagnose type 2 diabetes

84 MILLION ADULTS HAVE PREDIABETES[1]

9 OF **10** DON'T KNOW THEY HAVE PREDIABETES[2]

1 IN **3** ADULTS HAS PREDIABETES[1]



1. Centers for Disease Control and Prevention. National Diabetes Statistics Report: *Estimates of Diabetes and Its Burden in the United States*, 2014. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2014.

2. Centers for Disease Control and Prevention (CDC). Awareness of prediabetes--United States, 2005-2010. *MMWR Morb Mortal Wkly Rep*. 2013 Mar 22;62(11):209-12.

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Audience response question

There are 262,800 minutes in a year. What percentage of that time does the average person spend at their doctor's office?

A. <0.1%
B. About 1%
C. About 5%
D. About 10%

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Evidence for the National DPP LCP

DPP Research Study: People with prediabetes who took part in a structured lifestyle change program reduced their risk of developing type 2 diabetes (at average follow-up of 3 years) compared to placebo. And the lifestyle change program was nearly twice as effective as metformin.

58% risk reduction

DPP

Intensive Lifestyle Change Program
(71% reduction for patients age 60 and older)

31% risk reduction

METFORMIN

Glucose Lowering Drug
(Currently, FDA does not approve the use of metformin for type 2 diabetes prevention)

Knowler et al. *N Engl J Med* 2002;346:393-403.

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LCP side: Y-USA lifestyle change program

The YMCA's Diabetes Prevention Program is:

- Led by a trained Lifestyle Coach
- A year-long program: 25 sessions
- A Centers for Disease Control and Prevention (CDC) - approved curriculum

Program goals:

- Reduce body weight by 5-7%
- Increase physical activity to 150 minutes per week

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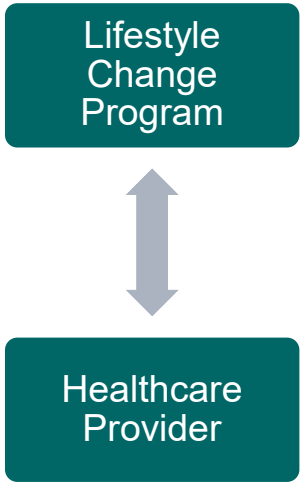
Bi-directional referrals

What are Bi-Directional Referrals?

A bi-directional referral considers both the information (referral) going from the HCP to the LCP, as well as information (feedback) going back to that referring HCP.



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Audience response question

Have you attempted to implement bi-directional e-Referrals between a clinical organization/provider and a non-clinical organization/provider

A) Yes

B) No

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Importance of bi-directional referrals

- Emphasizes prevention and the role of healthcare outside the clinical setting
- Ensures that information is moving both from the HCP to the LCP and from the LCP back to the HCP
- Increases # of touchpoints with patients which may increase likelihood for them to enroll or improve their health outcomes
- Allows HCPs to reinforce positive behaviors demonstrated when feedback is provided on a patient's program progress
- Keeps the LCP front of mind for HCPs, which may result in a greater number of referrals being made
- Improves care continuity for the patient by establishing the LCP as a practice extender and member of the care team
- **Establishing a bi-directional referral pathway can be beneficial to HCPs and LCPs alike, and ultimately enhance the patient experience and improve health outcomes**

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Project Summary

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DPP e-referral project overview

With funding from CDC's Division of Diabetes Translation, YMCA of the USA, the American Medical Association, and CDC worked with four local providers of the YMCA's Diabetes Prevention Program to build and implement bi-directional e-referral communication pathways with existing health care partners

Original Project Goals:

- Increase clinic to community linkages for bi-directional e-referrals by working with health care providers to identify pathways for e-referrals and sharing participant program outcomes
- Develop and document best practices for successful use of bi-directional e-referral models

Revised Project Goals:

- To gain a better understanding of the factors (EHR functions) to consider when approaching implementation of bi-directional e-referrals based on the learnings gained from local Ys and their health care partners throughout project

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Local Project Partners and EHRs

YMCA	YMCA EHR	Healthcare Partner	Partner EHR
YMCA of Greater Seattle	athenaNet	Multicare Health System	Epic
		University of Washington Medicine	Epic
YMCA of Greater Kansas City	athenaNet	Shawnee Mission Health	athenaNet
		Truman Medical Center	Cerner
YMCA of Greater New York	athenaNet	Mt. Sinai Health System	Epic
		New York University Medical Center	Epic
YMCA of Greater Delaware	athenaNet	Quality Family Physicians	Centricity

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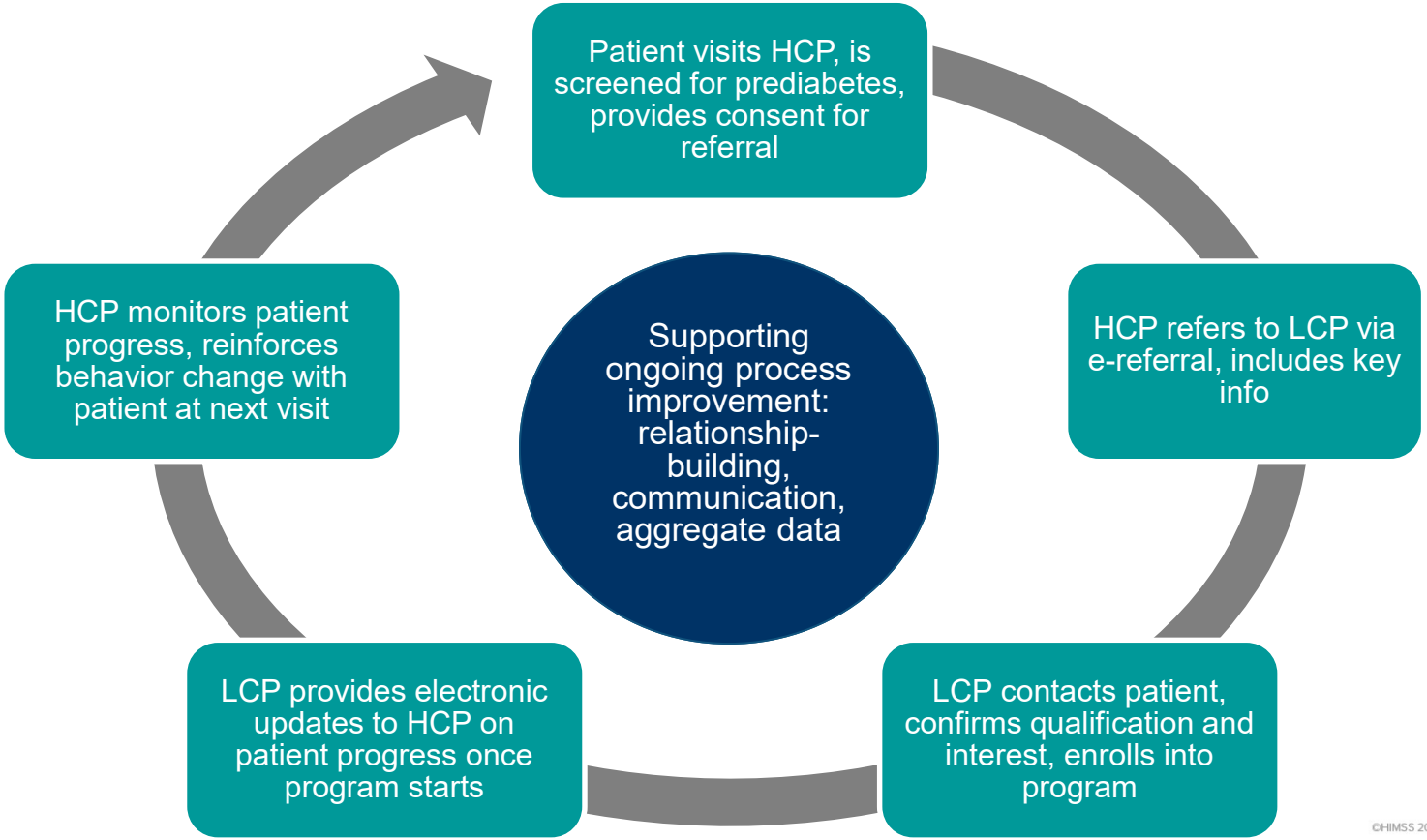
The bi-directional e-referral pathway



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athenaNet methods tested

Remote Call Fax Forwarding (Referral)

- Analog fax line forwards either electronic or paper fax into EHR
- Typically easy to implement, especially if HCP is already using fax as primary referral method

Direct messaging (Referral)

- Fully electronic communication from EHR to EHR
- Can be difficult to implement if not part of existing clinical workflows

Clinical Letters (Feedback)

- Templates with key phrases that auto-fill patient specific info; sent electronically to HCP via EHR
- Creates challenges closing feedback loop as only patients registered in EHR can have letters sent

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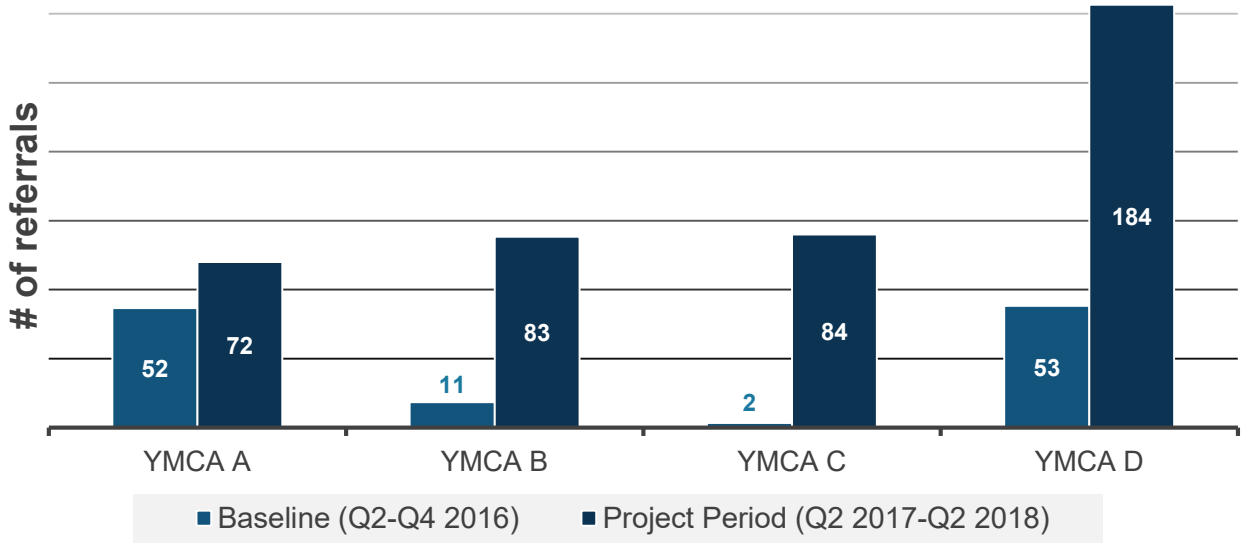
Project outcomes

423 e-referrals received over the course of the project

Each Y experienced an increase over baseline from referring HCPs



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Audience response question

If you work in a healthcare delivery organization, how many different EHRs does your organization currently utilize?

A) None

B) 1

C) 2-5

D) 6 or more

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Key Drivers

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Key drivers and barriers

- Organizational strategy
- Relationship development
- Resource needs
- Technology and EHR use
- Interoperability
- Data security and handling

= Healthcare provider organizations (HCPs)

= Lifestyle change programs (LCPs)

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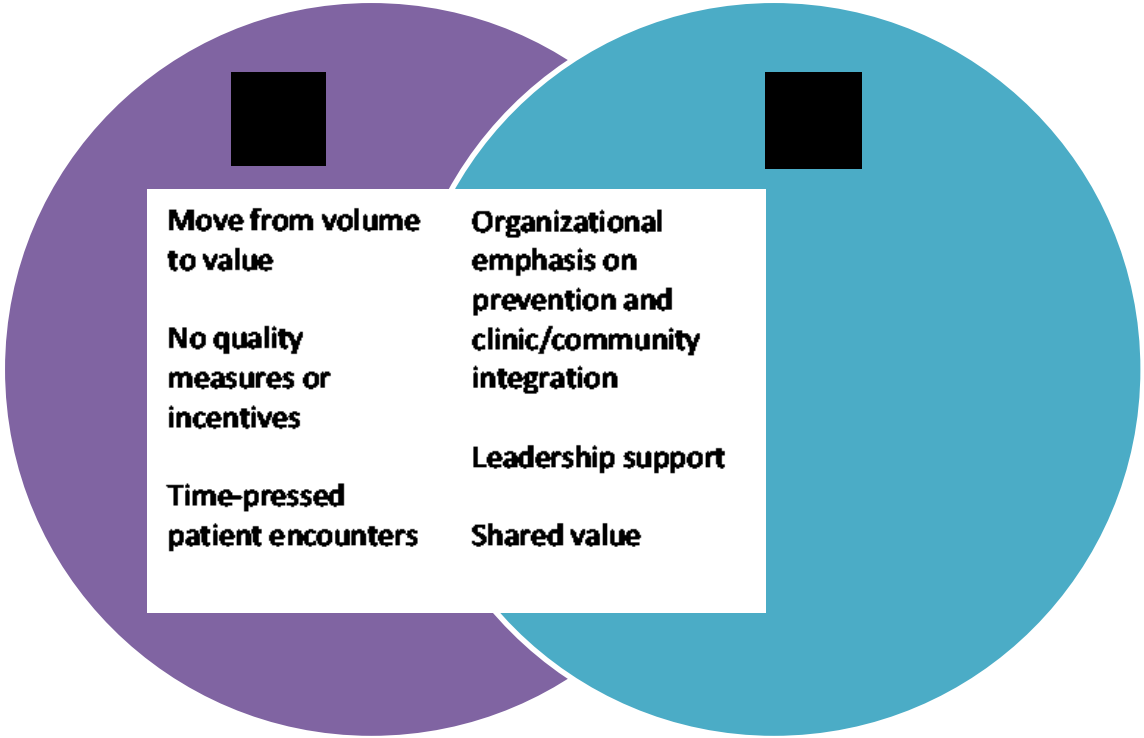
Organizational strategy



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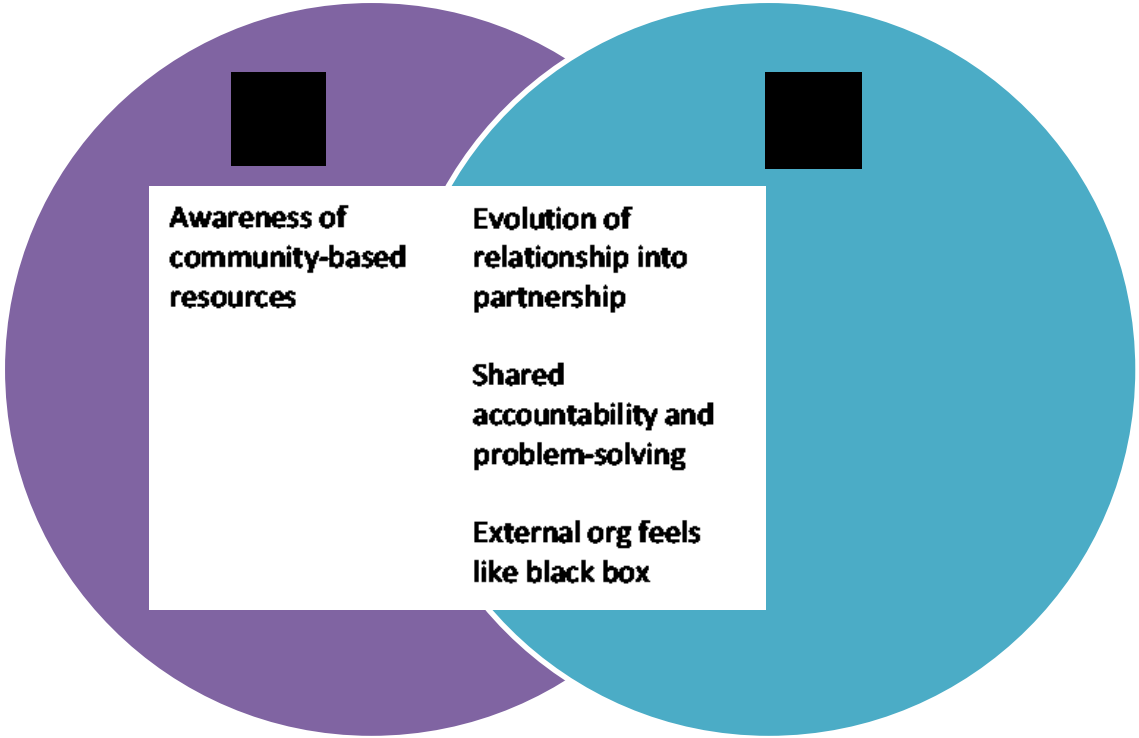
Relationship development



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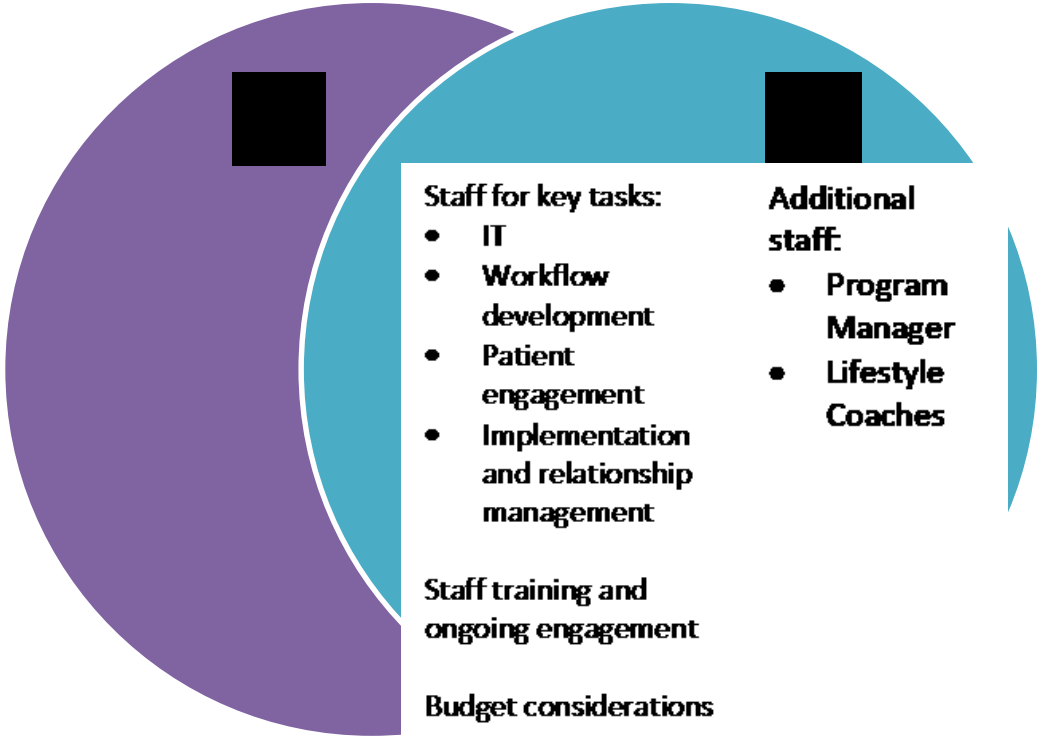
Resource needs



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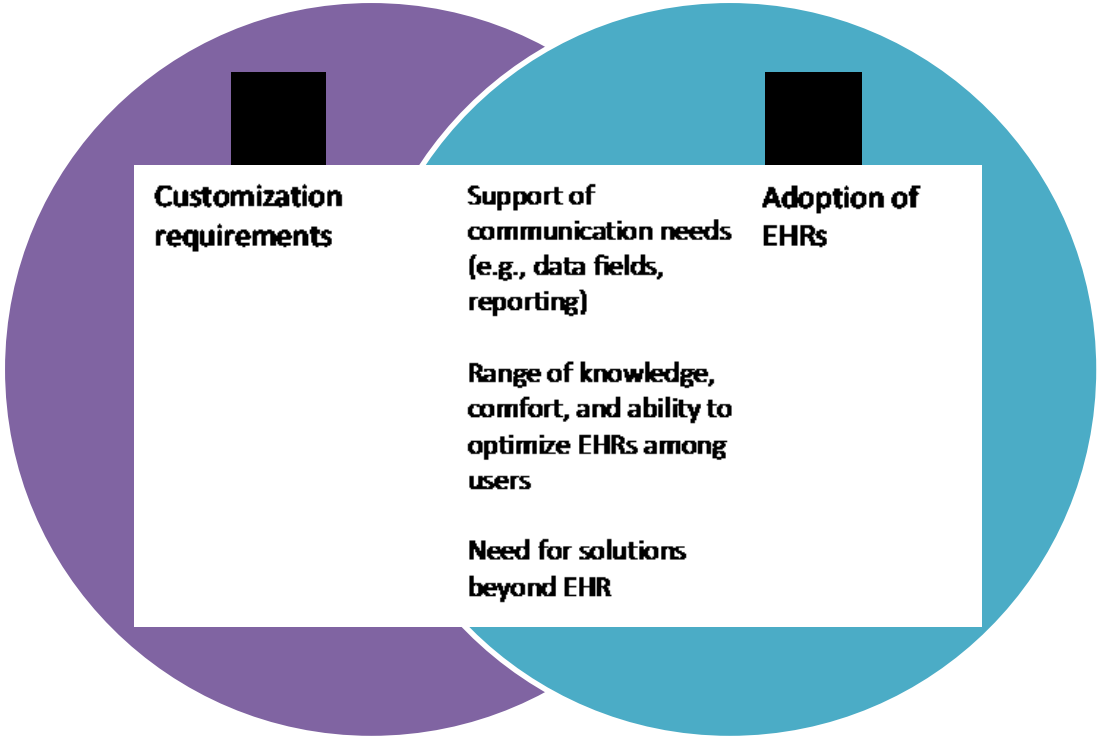
Technology and EHR use



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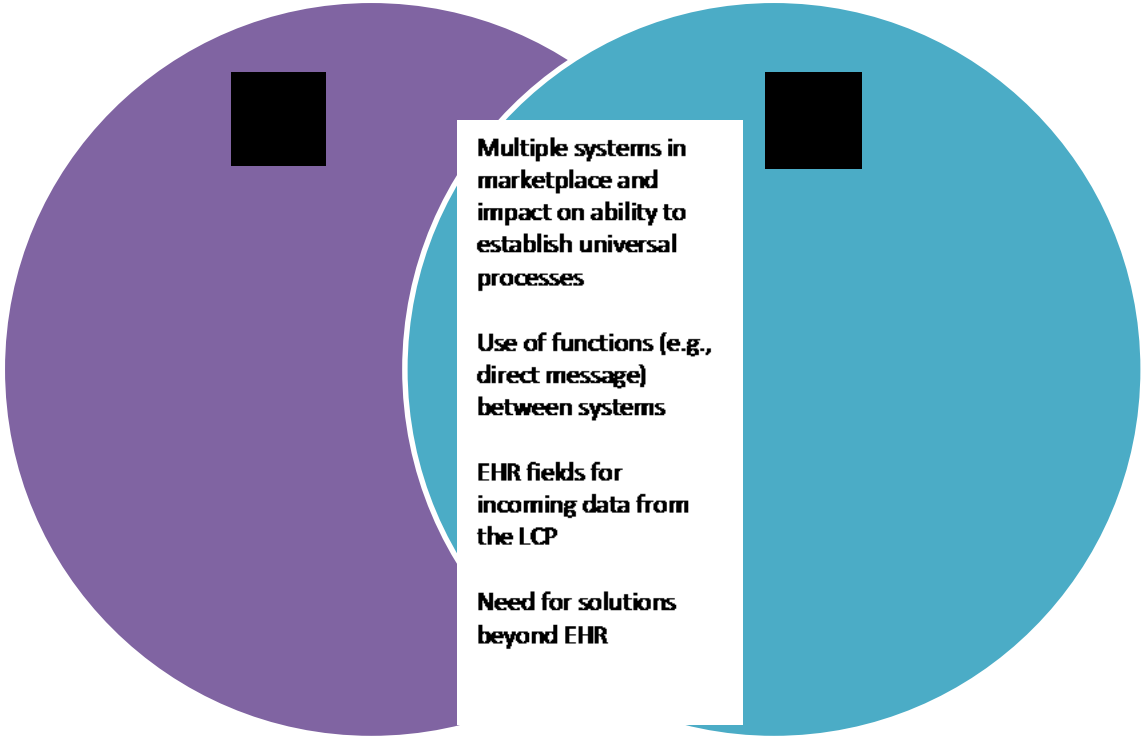
Interoperability



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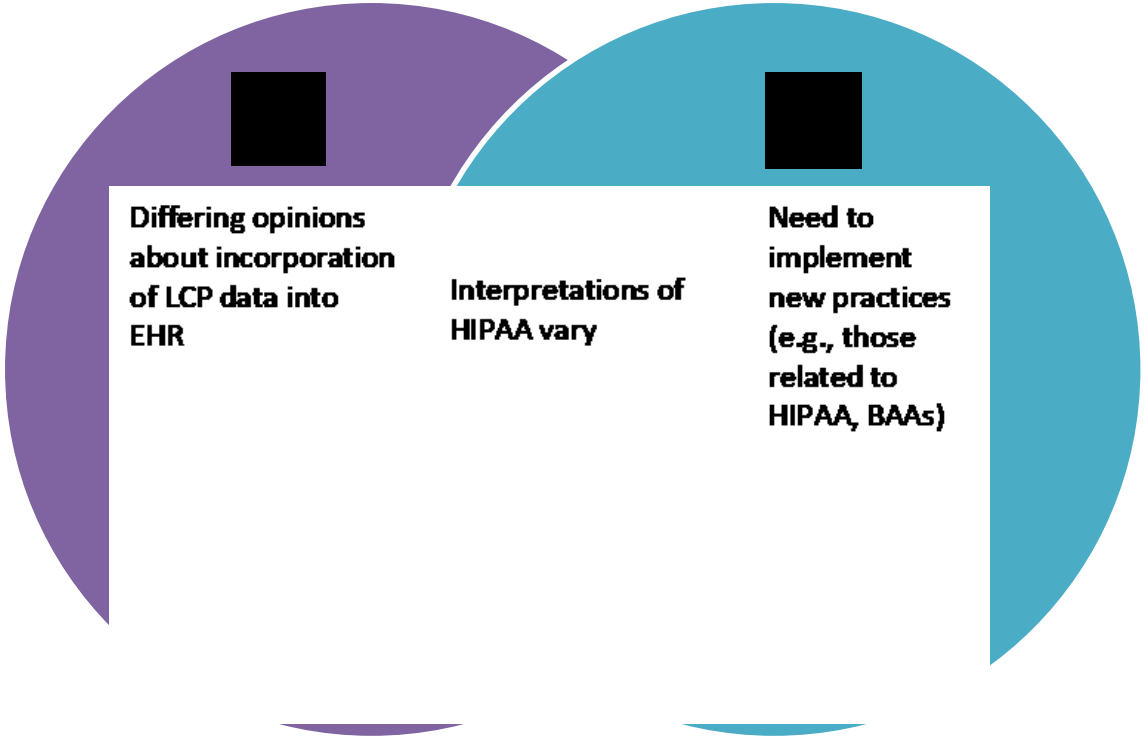
Data security and handling



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Learnings and Recommendations

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The relationship is the centerpiece

Find the right people

- Leverage existing relationships
- Form new relationships
- Identify your intended audience type

Address key needs

- Ask questions to understand both organizations “pain points”
- Ask questions to understand the value each organization provides to the other

Define your opportunity

- Use conversations to inform your strategy and build relationships

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Establishing a project team

Using a team-based approach can increase buy-in and accountability and ensure continuity in the event of staff turnover

HCPs

- Project Lead
- Physician Champion
- Population Health Manager or Physician Practice Manager
- Health IT staff
- Marketing/communications staff

LCPs*

- Project Lead
- Project support
- IT staff
- Program Manager
- Lifestyle Coach
- Data entry specialist

*one individual may fulfill multiple roles

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For HCPs: Key team members

- Project Lead – coordinates and leads planning and implementation activities, often taken on by one of the other team members outlined below
- Physician Champion – engages other physicians and the care team to raise awareness, engages leadership to gain organizational buy-in, and supports care team training
- Population Health Coordinator/Manager or Physician Practice Leader/Manager – coordinates design of referral workflow from physician to LCP
- Health IT Staff Person – supports the Project Lead in using EHR to identify patients and assist in leveraging EHR for queries, registries, reporting, etc.
- Marketing/Communications Staff – develops and launches patient communication materials and ensures that your program continues to reach new patients

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For LCPs: Key team members

- Project Lead – coordinates and leads all activities around planning and implementation, often taken on by one of the other team members outlined below
- Project support – provides additional administrative support to project
- IT Staff – supports Project Lead in identifying/testing system functionality for receipt of inbound referrals and data sharing with HCPs
- Program Manager – manages implementation of lifestyle change program, conducts enrollment conversations with referred patients
- Lifestyle Coach – facilitates lifestyle change program, primary relationship-holder with patient
- Data entry specialist – enters patient and program data into EHR

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Project planning and scope

- Work collaboratively to ensure mutual understanding on timeline, communication channels, staff roles, & plans for ongoing evaluation
- Develop workflows (building off existing workflows) feasible for implementation. Incorporate processes for:
  - how referrals will be handled once received
  - information needed as part of referral
  - information needed as part of feedback loop
  - how/when data can be shared
  - how success will be measured
- Confirm any required legal agreements and HIPAA practices are in place

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Implementation and evaluation

- Begin implementation ASAP and focus on joint and immediate problem solving
- Consider starting initially with paper referrals to streamline process
- Be prepared to test different approaches over time to find out which works best within the context of each partnership
- Communicate regularly to share feedback, and use data when possible to assess your work and recalibrate your work

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Recommendations for HCPs: Utilize a project management approach

- Identify project team
- Select LCP offering – internal or external
- Train health care team on process
- Identify eligible patients
- Determine and enact patient engagement process
- Generate patient referral to LCP
- Select process for communicating patient's clinical progress between referral source and LCP

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For HCPs: Other pearls

- Secure leadership buy-in by tying to other organizational priorities
- Engage key stakeholders early (internal and external)
- Use existing people, processes, and tools when possible
  - Infrastructure used for managing diabetes can be leveraged to prevent type 2 diabetes
- When seeking a new solution, choose one that can apply to other initiatives/conditions
- Work with varying levels of HIT
- Plan for care team engagement training, and repeat
- Start low-tech to learn, then phase in tech to scale

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Recommendations for LCPs: Other pearls

- Identify current approach, resource needs, and future goals
- Develop a pitch to demonstrate program value – incorporate national statistics and local program/community data into this pitch
- Talk to health system partners to see how they work with other non-traditional providers of services; they may have a solution that works
- Develop a working knowledge of the EHRs that will be used to generate and receive referrals
- Become familiar with EHR add-on modules or non-EHR platforms or software (Par8o, Aunt Bertha, REDCap, ReferralMD, Fibroblast, etc.) that can be used to facilitate linkages with the healthcare community
- If operating without an EHR, consider working with a Health Information Service Provider to explore options for e-referrals
- Each partner may be unique and require slightly different approaches for bi-directional communication – be flexible!

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Future focus and exploration

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Future focus and exploration

- Continued support of clinic-to-community linkages among networks
- Implementation of FHIR (fast healthcare interoperability resources) standards for bi-directional communication and compatibility with systems (both EHR, and non-EHR)
- Leveraging referral management solutions and Health Information Exchanges
- Defining opportunities for LCPs to capture and share other meaningful data to inform patient care (e.g., behavior change strategies, social determinants of health)
- Demonstration of financial impact in value-based care

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Questions

Want to chat more? Come to our office hours in the AMA Exhibit Booth tomorrow, February 13, 10:00–11:00am

Please complete the online evaluation!

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