Clini-Sync
Ohio Health Information Partnership
Health Information in a Heartbeat

Highway to Health: Building new roads to equity and increasing successful referrals for social determinants of health

o4a Annual Conference
October 18-19, 2023

Created in 2009 as an independent 501c(3) non-profit organization

The Ohio Health Information Partnership operates the CliniSync Statewide Health Information Exchange

Stakeholder driven & funded

Building upon a community of trust to advance the use of data to benefit a person's health and well-being

Founders

Ohio Hospital Association, Ohio Osteopathic Association, Ohio State Medical Association

Board of Directors

Physicians, hospitals, health plans, long-term care, consumer group, FQHCs & behavioral health

CliniSync Advisory Council

Physicians, hospital systems, community and children's hospitals, health plans, long-term care, behavioral health & community service organizations.

CliniSync's Existing Community

~ 1.5B
Clinical Transactions Annually

17M
Persons in the Master Person Index

180
Current or new participating Hospitals in OH, WV, KY

>400
Long-Term and Post-Acute Care Facilities

15,000
Independent and Hospital-employed Physicians

15
Health Plans (7 Medicaid MCOs or MyCare)

100+
Behavioral Health and Social Service Agencies

60
Connected EHRs

MORE
Commercial Lab, Public Health Community Service Organizations and More

CliniSync Services

RESULTS DELIVERY & ORDERS

Receive/Send lab results, radiology and other reports in near real-time. There is also an orders platform

COMMUNITY HEALTH RECORD

Authorized, treating providers access a longiudinal record of a patient's treatment history directly from EMR or Web UI. Includes a closed loop referral tool

NOTIFICATIONS

Receive and send alerts when patients have a clinical event from hospitals or post-acute care organizations direct to EMR, Web UI or through other delivery options

HISP & DIRECT MESSAGING

Connect and communicate directly with providers to coordinate care - instantly and securely through a DirectTust certified HISP

CCDA CONTRIBUTION

Connect a community through contribution of Continuity of Care Documents and data is consolidated around a patient

DATA MART/ DOS

Access information to enhance quality or care for the population you serve. Includes clinical data from Providers and claims from Health Plans

"Doing More for Less"

PERSON CENTRIC

2020 WAS THE CATALYST FOR THE CONVERSATION

The Global Pandemic & National Awareness of Racism, Equity & Health Disparity

BELL/GETTY IMAGES

JANUARY OF 2020

Medical staff members bring a patient to the Red Cross hospital in Wuhan, China. The coronavirus was first reported in Wuhan, a city of 11 million people in central China's Hubei province.

*CNN: *2020 The Year in Pictures*

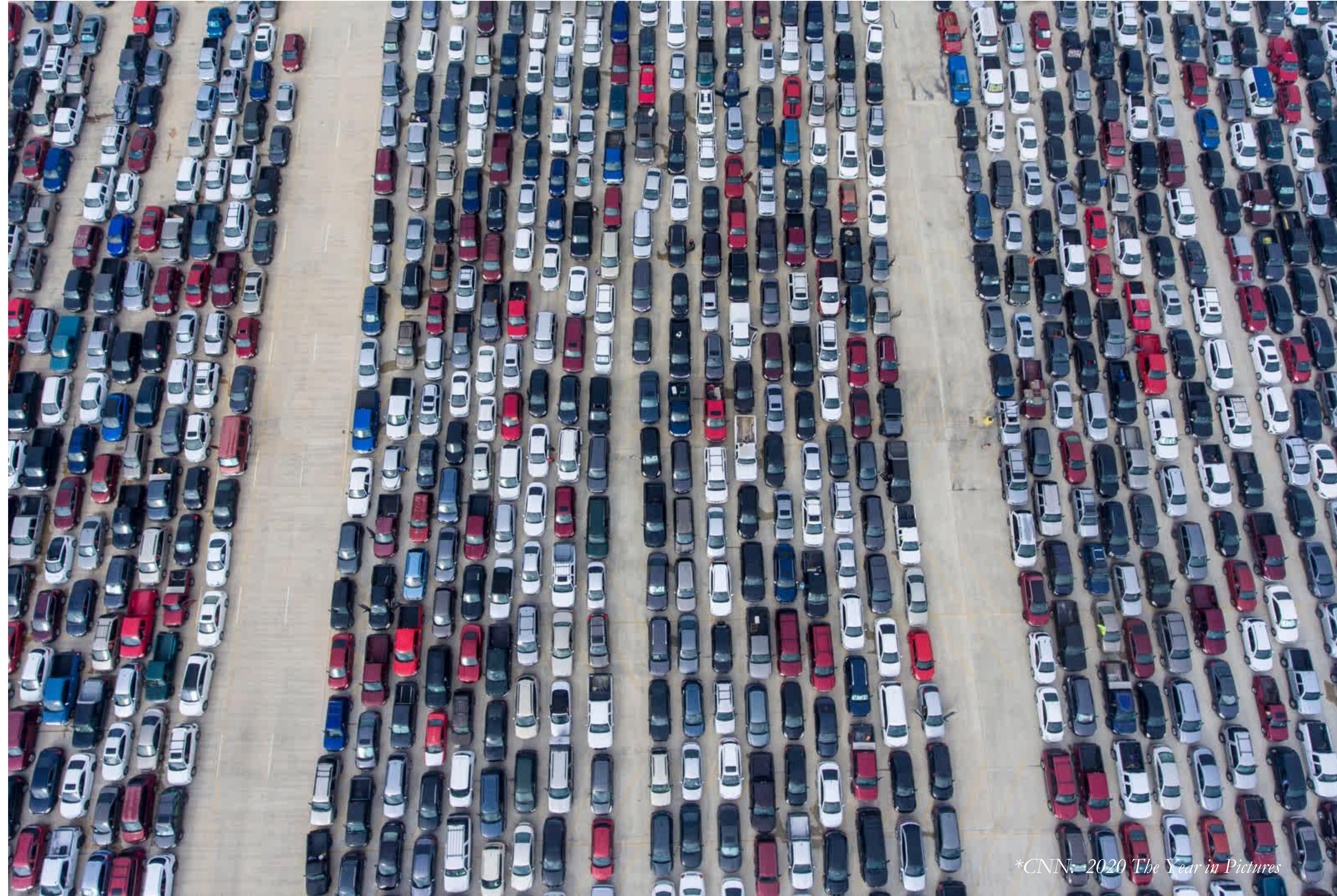
MARCH OF 2020

CNN: 2020 The Year in Pictures

Lori Spencer visits her mother, 81-year-old Judie Shape, at the Life Care Center, a nursing home in Kirkland, Washington. The facility became an early epicenter of the coronavirus outbreak

APRIL 2020

People wait in their cars for the San Antonio Food Bank to begin distributing food. The coronavirus pandemic has put millions of Americans out of work, and more and more families have turned to food banks to get by


*CNN: 2020 The Year in Pictures

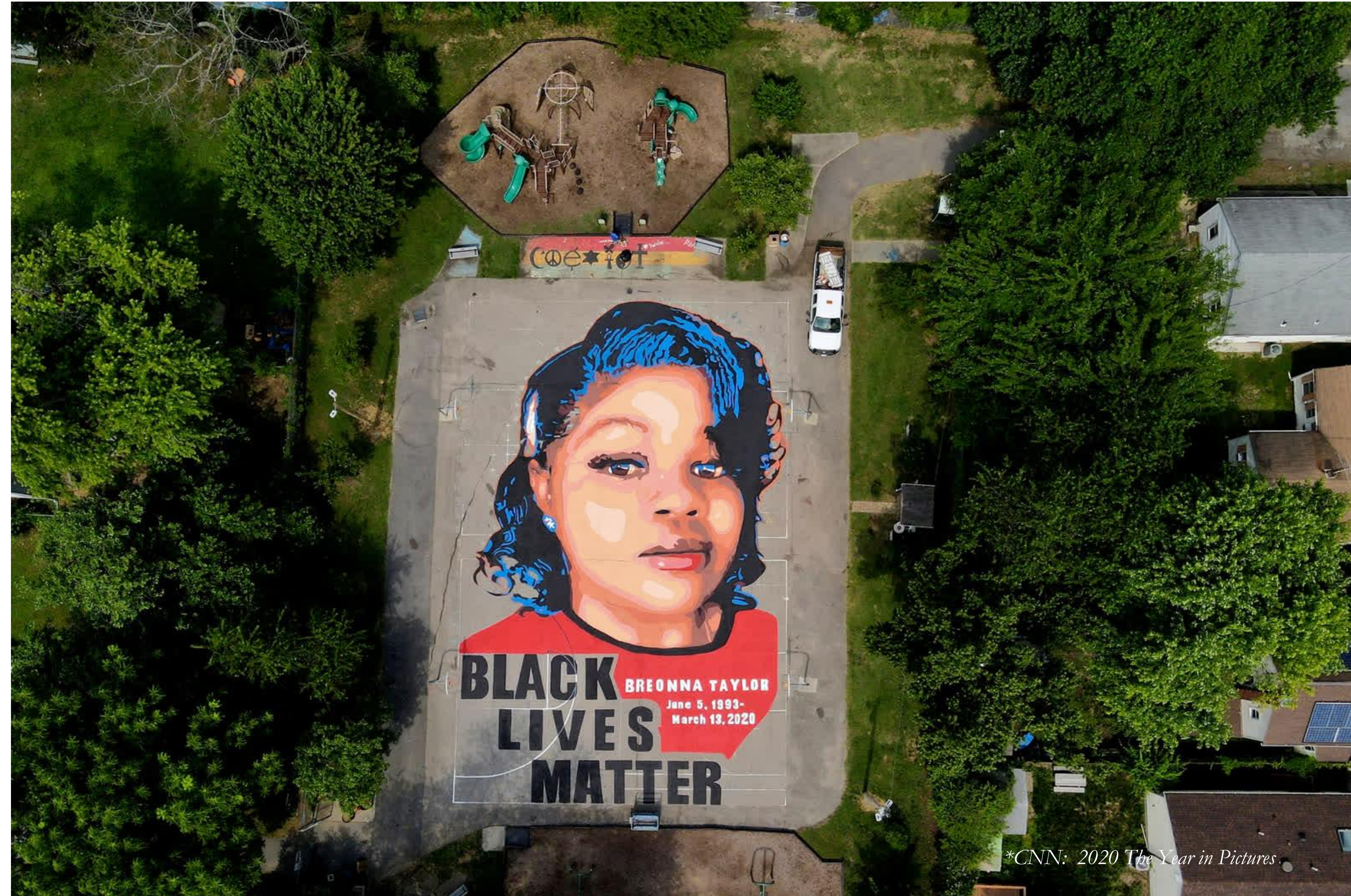
MAY OF 2020

*CNN: *2020 The Year in Pictures*

A protester carries an American flag upside down next to a burning building in Minneapolis. Protesters started rallying across the United States after the death of George Floyd,

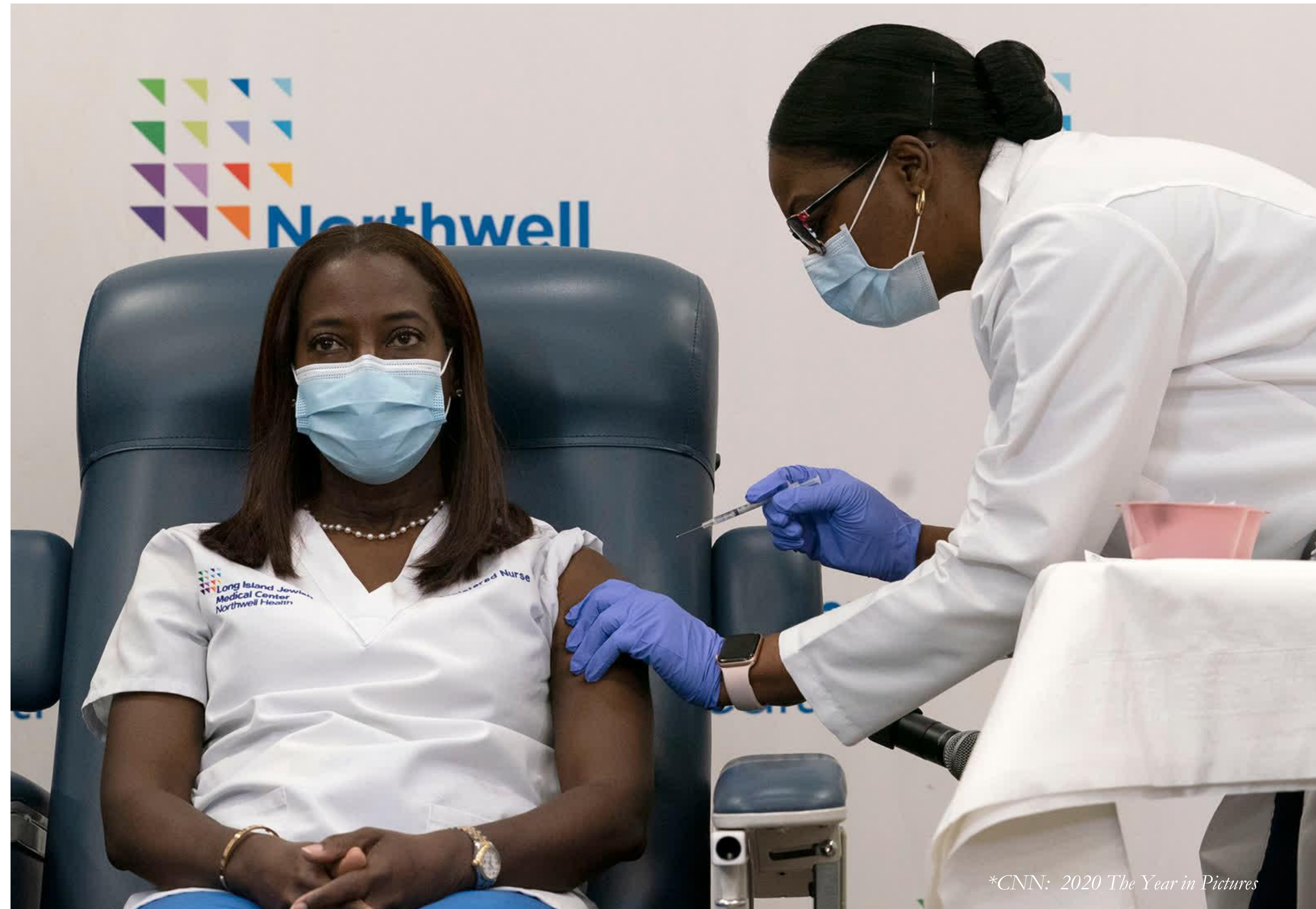
JULY 2020

Artists and volunteers descended on a basketball court in a historically Black neighborhood of Annapolis, Maryland, to paint a 7,000-square-foot mural of Breonna Taylor. Taylor's death became another flashpoint in national demonstrations. She was killed in March by police officers executing a no-knock warrant in Louisville, Kentucky. Julio Cortez/AP



CNN: 2020 The Year in Pictures

DECEMBER OF 2020



CNN: 2020 The Year in Pictures

Dr. Michelle Chester administers a Covid-19 vaccine to Sandra Lindsay, a critical care nurse at the Long Island Jewish Medical Center in New York. Lindsay was the first person in New York to get a shot of the Pfizer/BioNTech vaccine,

THE PROBLEM IS GENERATIONAL

"…Inequities in health systematically put groups of people who are already socially disadvantaged …at further disadvantage with respect to their health; health is essential to wellbeing and to overcoming other effects of social disadvantage."

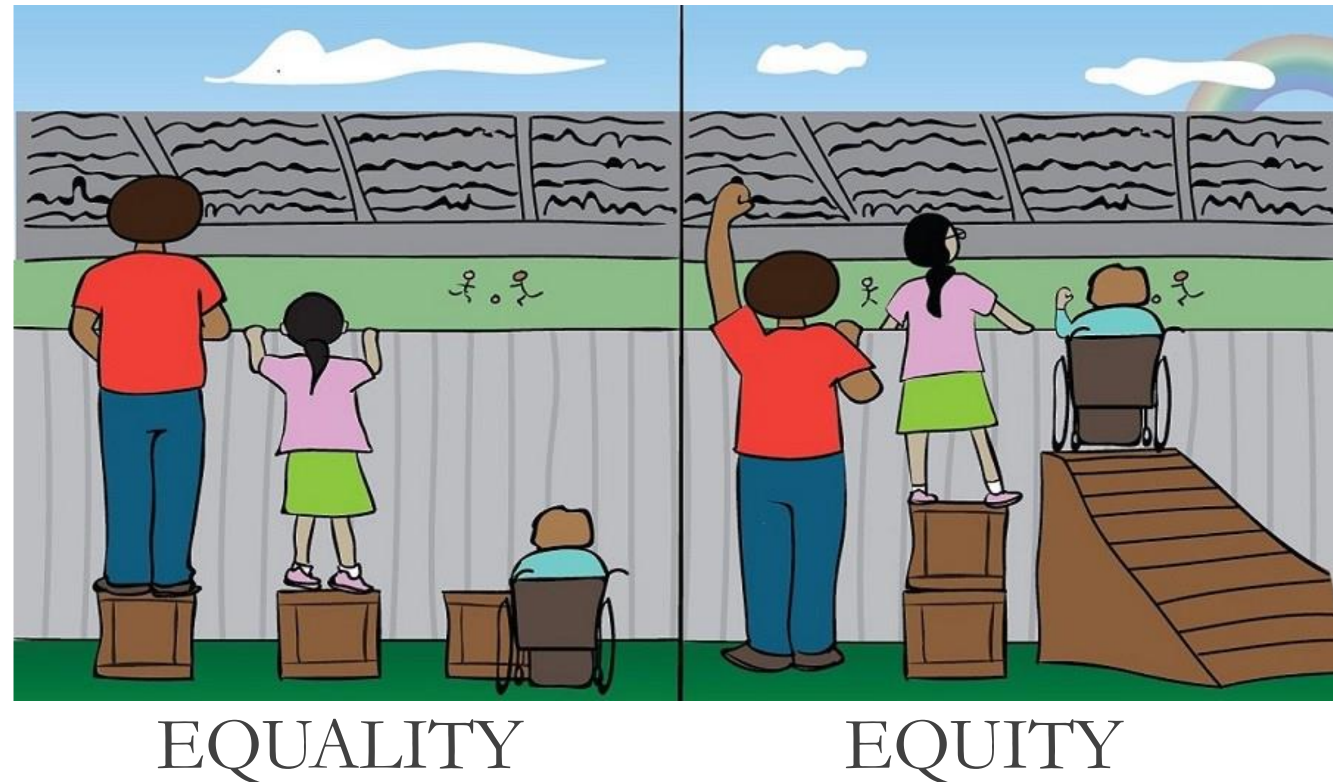
- Defining equity in health, Correspondence to: Dr P Braveman, Department of Family and Community Medicine, University of California, San Francisco, 500 Parnassus Avenue, MU-3E, San Francisco, California, 94143-0900, USA; pbrave@itsa.ucsf.edu

WHAT WE FOUND

It is widely recognized that Ohio is doing a tremendous amount of work across the state to address Social Needs and Health issues. These efforts are having an impact but not to the extent hoped for

PRIORITIES AND STRATEGY

The Health Policy Institute of Ohio 2021 Dashboard, highlights the fact that equitable healthcare is **unattainable without better coordination across support organizations**



EQUALITY EQUITY

BOARD ADDS TO THE MISSION

"…improve care, health disparities and equity for all Ohioans, regardless of demographic or socioeconomic status…."

CREATING CHANGE – MULTI-STAKEHOLDER WORKGROUP

75% of outcomes are affected by SDoH

- Find the right niches that can course correct challenges
- What is attempted needs to be new, different and value added
- Technology & Data is only part of the solution
- Statewide Alignment is key
- Data driven strategy to prove success and drive sustainability
- Changing the conversation from “for” to **“with”**

THE PROPOSAL

Expand upon existing Public–Private partnerships to create a Statewide-aligned approach to improve outcomes for Ohio’s vulnerable populations by addressing social drivers of health.

Technology and data are a common points of alignment that all sectors can rally around to help ensure vulnerable individuals and families are receiving the support they need, in their communities, in a sustainable way.

Connecting this statewide-aligned approach to existing state, county and local initiatives, places Ohio in a unique position not only to succeed but be a model for the country.

Highway to Health: Building New Roads to Equity

10/19/2023| Ami Cole, Plan President

The Molina Healthcare Story

Over four decades of delivering access to quality care

Molina Healthcare was founded as a single clinic in 1980, to serve patients who wouldn’t otherwise have access to quality health care.

Our mission is to improve the health and lives of our members by delivering high-quality health care.

We provide low cost, effective and appropriate access to care, along with reliable service to both members and providers.

In 2020, Molina organized and funded the MolinaCares Foundation, an independent charitable organization committed to investing in building stronger communities with key priorities surrounding social determinants of health and equity.

MOLINA HEALTHCARE

Next Gen – New Program Spotlights

- HIE/EMR Data Exchange
- Closed Loop Referrals for SDOH Needs

Health Equity – Community Reinvestment

- Collective Impact

Focus Populations	Collective, Person-Centered Impact	Improved Outcomes & Equity
Healthy Children & Adults	Children	Preventative Screenings & Academic Success
	Adults	Preventative Screenings
Women and Infant Health	Infants WRA High Risk	Integrated Care for Mother & Baby: Maternal & Infant Mortality
Behavioral Health	Children Adults	Comprehensive and Coordinated BH Services, Drug-related Mortality
Chronic Physical & Developmental Conditions	Children Adults	Well Managed Asthma, Diabetes, and Hypertension
Older Adults		Maximal Choice and Independence

Family Centered

FI

Structured Quality Improvement

OhioRISE

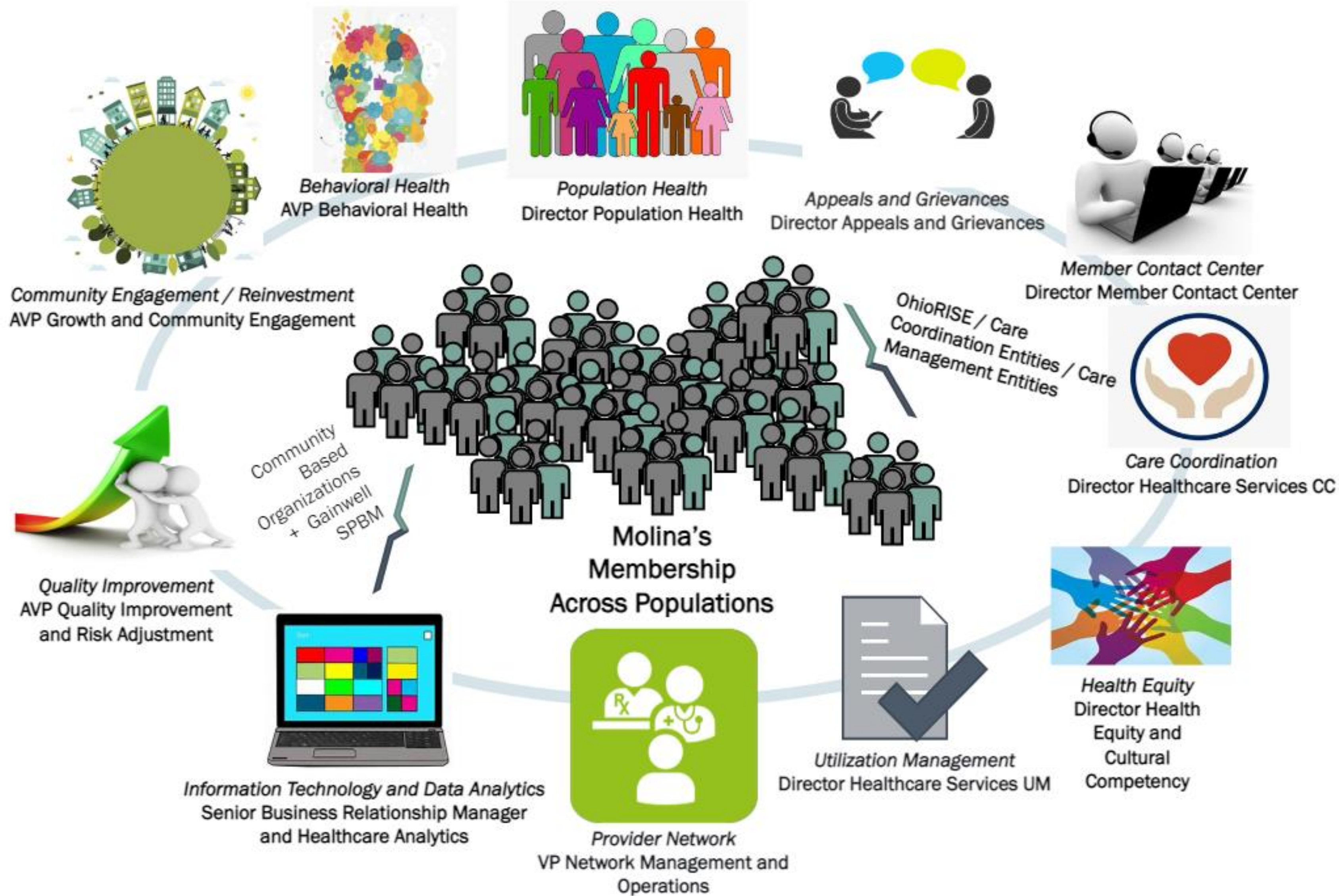
Community Engagement and Social Determinants of Health

SPBM

Next Generation Managed Care

PNM/CC

Molina Healthcare of Ohio - Quality and Population Health Enterprise Collaboration



Simplified "Stairstep" Framework for Population Health Management

Develop System

Get/Keep Individuals in the System

Identify Higher Risk (sub) Populations

Provide Best-evidenced Care or Enhanced Services

Maintain and Support Lifecourse Continuity

System Development

Data exchange key to success

Access to Services

Continuity of Care

Value Added Benefits

Strategic Partnerships

Clear & Culturally Competent Communication

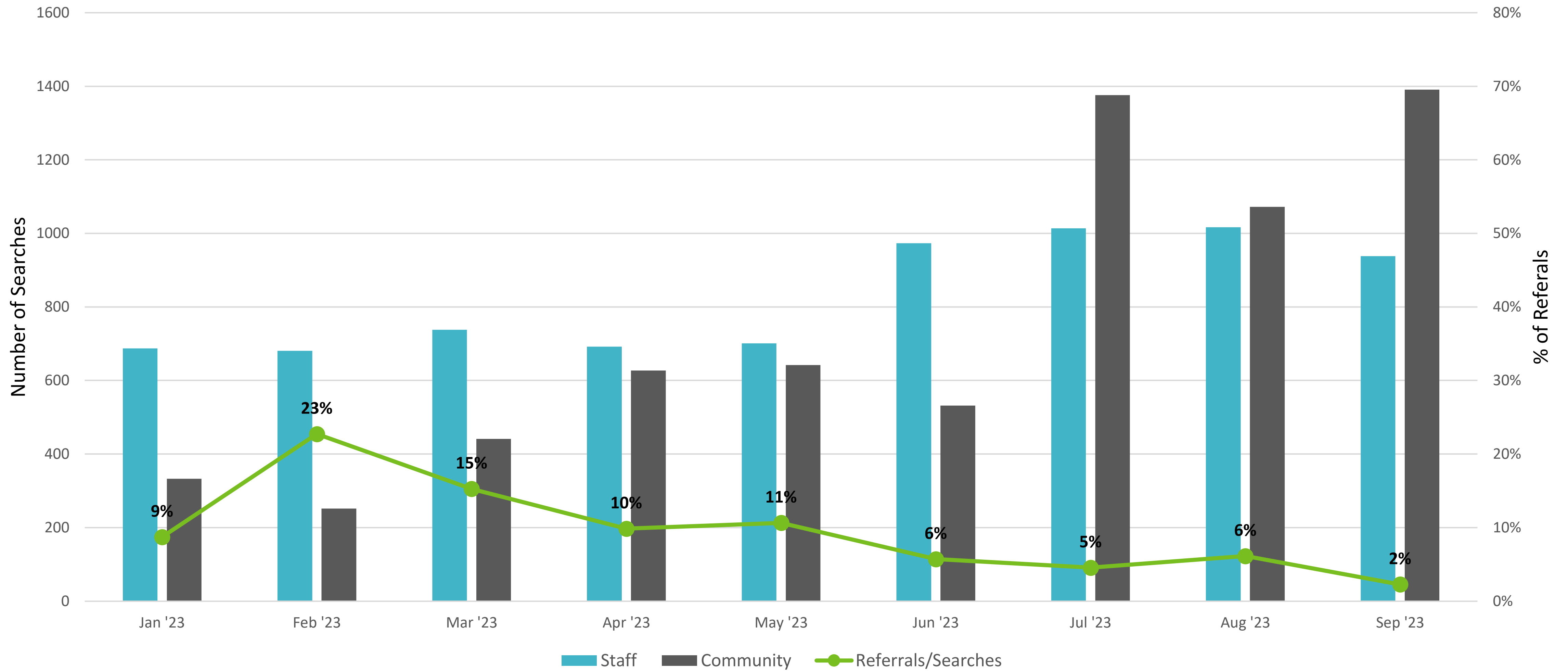
MOLINA HEALTHCARE

MyCare Ohio – Quality Spotlight

- Plan All Cause Readmissions - HEDIS
- Annual Flu Vaccine – CAHPS Survey
- Follow-up after Hospitalization for Mental Illness – HEDIS
- Controlling Blood Pressure – HEDIS (hybrid)
- Medication Adherence for Diabetes – PDE
- Encounter Data – Admin
- Minimizing Institutional Length of Stay – CMS Core Report
- Medication Reconciliation Post-Discharge – HEDIS (hybrid)

Closed Loop Referrals

Molina Community Partner Searches and Successful Referrals



MOLINA HEALTHCARE

Closed Loop Referrals

Quick Stats - Successful Referrals

Top Searches

- Food
- Paying for Utilities
- Housing

MOLINA HEALTHCARE

Health Equity – Community Reinvestment

Collective Impact

2023

- Collective impact program – 7 Medicaid plans work collaboratively
- Collective Community Reinvestment Plan - support population health strategies within Ohio communities
- Proposals received and under evaluation to award funds in 2023
- Annual evaluation

2024 Planning

- OH Mcaid plans contracted with the Center for Community Solutions (CCS) as facilitator
- Two identified counties of focus: Cuyahoga and Athens
- Regional Advisory Committees (RAC) established
- Currently developing evaluation plan for 2024 projects

ENTERING THE HIGHWAY – AAA PERSPECTIVE

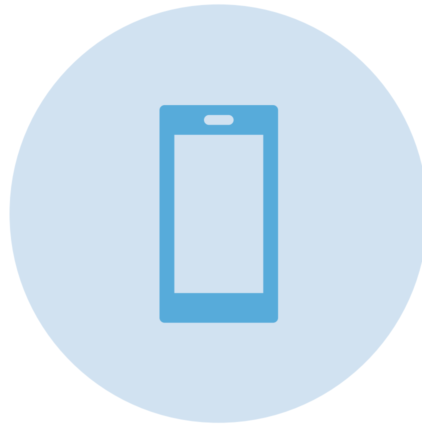
ABBY MORGAN - COO

DIRECTION HOME

AKRON CANTON AREA AGENCY ON AGING & DISABILITIES

STATE OF SYSTEMS

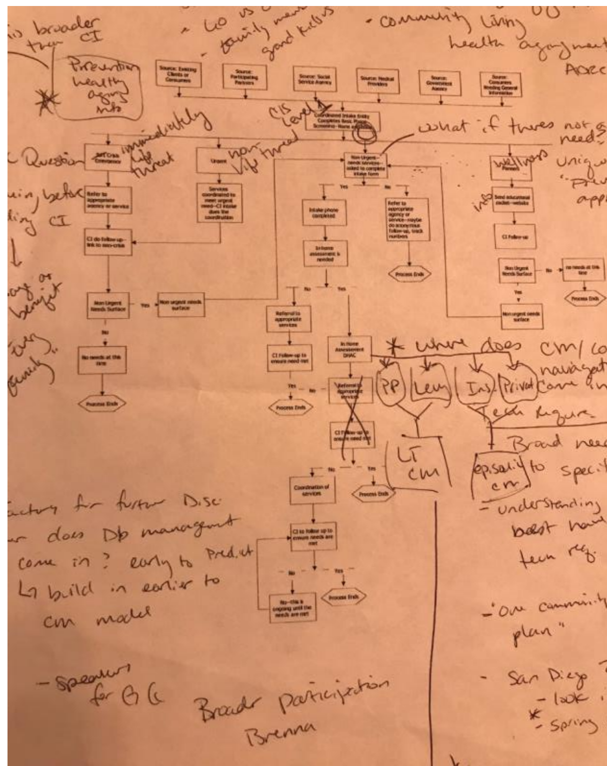
SCREENERS WORK OUT OF 8 SYSTEMS/PLATFORMS

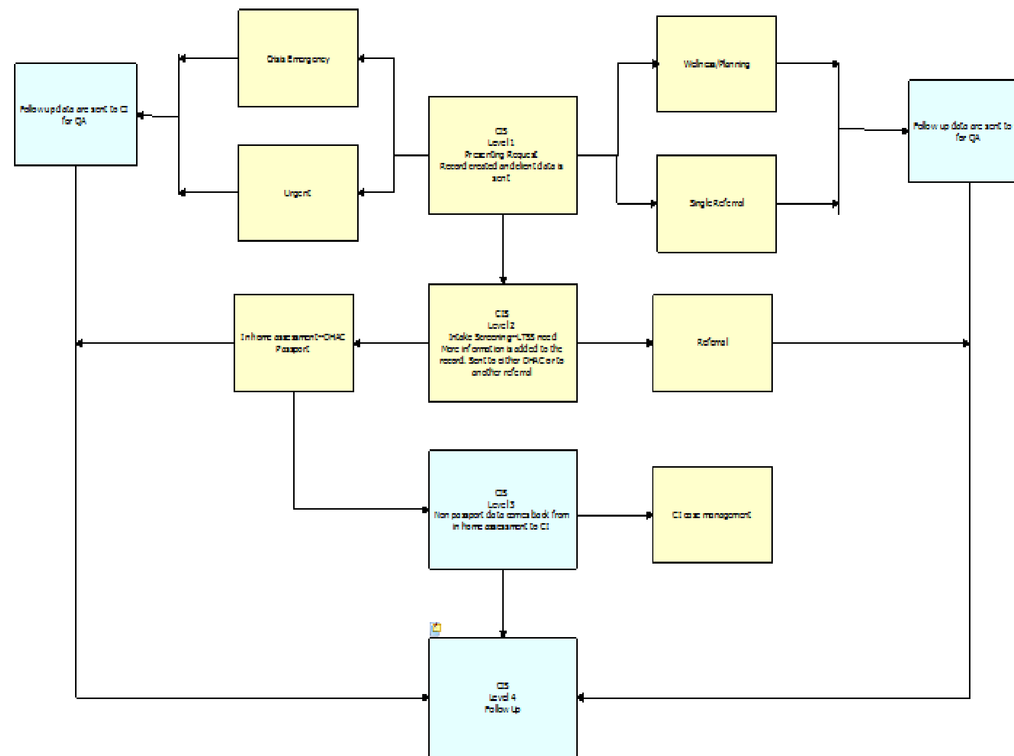


CARE MANAGERS WORK OUT OF 4 PLATFORMS

DATA IS PUSHED TO US VIA EXCEL FILES

COORDINATED INTAKE PILOT





- Data elements mapped by program
- Core data set defined
- Information Sharing - Agreements

- Ah ha! moments
  - Services

DIRECTION HOME CLOSE LOOP REFERRALS

Weekly Electronic Referrals

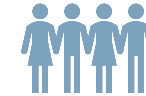
- Secure online form
- Promoted to healthcare partners
- Monthly average: 250+
- Assessment outcome shared w/ referring physician

Admission Date and Facility

Discharge Date

Date of Home Visit

Complete Medication Reconciliation and Medication List



Referrals to other community services

Patient Goals for 30 days

PHYSICIAN LETTERS

Standard PDF File shared with PCP after an acute care transition intervention

WHAT BRINGS US TO THE TABLE

Opportunities	• Collective impact through shared data and resources
Clinisync CBO Network Committee	• Workflow, Integration, Resources & Funding
Data standards	• Z codes