Patient Information Sharing Framework
for Access to Quality Care (A2QC) Partners

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1. Acknowledgements

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2. Introduction

After living on the street for years, a middle-aged man had health issues best cared for in an assisted living facility. Mercy Hospital’s Medical Neighborhood Team partners worked together to identify an appropriate and willing facility, then coaxed him off the streets by providing what he most wanted immediately—a television in his room. He is now thriving in the facility with a roommate with a similar history. Their successful transition has opened the door at this assisted living facility for getting others with similar needs off the street.

A person who was seeking asylum in the U.S. had been tortured and traumatized in her country of origin. She saw four different health care providers and had three MRIs in a two-month period, with no medical indication for more than one MRI. She lacked a medical home so had no one coordinating her care. After the Medical Neighborhood Team started reviewing situations like this, unnecessary medical service utilization, like this example illustrates, was reduced.

These two examples are among many that demonstrate the successful outcomes that are possible for Portland’s most vulnerable individuals with complex medical, mental health, substance use, and housing needs when organizations are able to share appropriate information across systems to provide wrap around services and to coordinate health care. This inter-organizational collaborative support is even more important for individuals who lack health insurance and “intact natural supports,” such as family and friends who will advocate for and/or ensure their wellbeing and safety.

In October 2014, Mercy Hospital received a three-year Access to Quality Care (A2QC) implementation grant from the Maine Health Access Foundation (MeHAF) to meet the healthcare needs of people without insurance in the Portland region. MeHAF funded ten communities under the A2QC initiative to develop and implement strategies that provide high quality, coordinated health care and social services to those who remain uninsured after implementation of the Affordable Care Act. These projects strengthen service integration among different types of providers (e.g., primary care and mental health care) as well as improve coordination of care for uninsured and underinsured people. While the Affordable Care Act expanded coverage to many Mainers, thousands remain uninsured, such as undocumented immigrants, residents of fewer than five years, and lower income people who would have been covered had Maine adopted Medicaid expansion.

As Mercy Hospital built its “Medical Neighborhood Team,” one major barrier Mercy and its community partner organizations encountered was their limited ability to share patient information with each other due to privacy and confidentiality protections under federal and
state laws (e.g., HIPAA, confidentiality regulations governing substance use and behavioral healthcare). Organizational policies can also limit data sharing. By working together, Mercy and its partners were able to identify how they could move beyond these barriers. Sharing patient information among organizations is critical for vulnerable populations with complex needs and is possible only when patient authorization and legal agreements are in place.

In Fall 2015, S.E. Foster Associates conducted a case study of the Mercy Hospital A2QC grant program to help inform the efforts of the other MeHAF A2QC implementation grant communities. This case study explores the experience of the Mercy A2QC grant program, which has developed a patient information sharing framework and set of agreements. The entity they created is called the “Medical Neighborhood.” Comprised of six organizational partners, it has been in operation for three years. This case study is based on interviews with partners, observation of two Medical Neighborhood Team meetings and review of summary reports. The focus of the case study was on challenges the community experienced prior to the A2QC grant, resources required to address these challenges, effective strategies in sharing information, and individual and partner outcomes thus far. The findings of this case study also have implications for other A2QC grantee communities and for potential evaluation measures to document the positive outcomes for partners and the people they serve.

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1 For lists of key federal and state regulations as well as brief summaries, see https://www.mainequalitycounts.org/image_upload/A3_Privacy_SecurityPPT_Oct_2_2015_LS.pdf and “Selected Federal and State Statutes and Regulations Governing Key Departmental Data, Maine Quality Choices Data Integration Project, April 21, 2010
3. What challenges did health and social service organizations experience prior to forming the Medical Neighborhood Team?

Six organizations that were operating in the same neighborhood in Portland experienced a range of barriers to effectively serving their most vulnerable community members:

» Mercy Hospital patients had difficulty getting and keeping appointments because they lacked community supports such as transportation and peer outreach workers. When these individuals did not show up for appointments and did not reschedule, health care providers did not know whom to call in the community, contributing to patients’ lack of medical homes and access to primary care services. Inpatient providers felt “empty and guilty” discharging patients from the hospital because they knew that they lacked supports to prevent readmission.

» Patients had no or very limited continuity of care. Health care providers were unaware of what services individuals were receiving elsewhere, resulting in unnecessary and/or duplicative tests ordered by multiple health care providers seeing the same person.

» Individual organizations struggled on their own to serve people with complex needs, many of whom did not want to get needed care, lacked a medical home, and lacked a team that could “cover all bases.” Partners were not always aware of the individuals’ “story” or context, nor were they aware of what other services and supports and resources were available.

» Despite meetings among some partners, “nothing ever got done” because they were not able to fully share information about the people they served in common, nor provide full wrap-around services.

» One key provider could not get releases signed in time to get patient information from Mercy Hospital or other health care providers to help people with time-sensitive health needs.
4. What kind of effort was needed to address these challenges?

The major goal of the A2QC grant was to create a formal partnership among Mercy Hospital and its six partners so they could “speak freely,” meaning to be able to discuss information about the patients they each served, since no one entity had all of the information. This partnership leveraged the existing relationships among partners and patients to be more effective in coordinating comprehensive wrap-around services.

Mercy Hospital engaged legal counsel and led the effort to create a legal entity comprised of partners (the Medical Neighborhood) from the six partner organizations (see text box). In addition to its legal staff, Mercy’s financial counselors, mission manager, patient advocate, case managers, and Mercy Medical Group (primary care practices with integrated behavioral health and substance use treatment services) were deeply involved in the implementation of the Medical Neighborhood.

This legal entity includes a shared consent and comprehensive data-sharing agreement among the key partner organizations that have frequent contact with their priority population. This agreement allows information to be shared for the coordination of care and preserves patient privacy by limiting access to protected health information (such as cost data and utilization) to an as-needed basis and including detail from non-medical providers such as peers and street outreach in the development of care plans.

One exception to partners’ ability to share information without written patient consent is organizations licensed only

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<td><strong>Mercy Hospital: grant lead</strong></td>
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<td><strong>Amistad peer outreach and support</strong> (consumer-run organization for individuals with mental health and substance use disorders)</td>
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<td><strong>City of Portland Community Health Outreach Workers</strong></td>
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as behavioral health/substance use treatment providers such as Milestone. People served by behavioral health/substance use treatment providers must provide written consent to allow them to share their information with other partners, in compliance with federal and state privacy regulations protecting confidentiality of records related to patients who receive behavioral health/substance use disorder. This consent process is offered during Milestone’s intake process. Without consent, Milestone cannot let the other partners know that the individual has received or is receiving services from them. Due to the trust that partner organizations have developed with their clients, most of them do provide written consent to share their information with other partners.
5. What strategies are proving effective in sharing patient information to coordinate care for the underinsured and uninsured?

Regularly sharing clinical and other information about the patient with other partners. The Medical Neighborhood Team members communicate daily (via phone, email, visits, meetings) about their patients, including in the evenings when homeless shelters are conducting intake. Partners are willing to be contacted at off hours, but also recognize that some limits are needed to prevent burnout.

Partners share information including clinical information (for example, the status of a patient’s infected wound or diabetes, between medical partners like Mercy and Greater Portland Health). In addition, peer support and outreach workers usually have additional information about the patient’s life history and current situation that helps inform coordination of care and appropriate options for housing and other support services. Consistent themes are isolation of elders, asylum seekers, or persons with persistent mental illness; lack of social supports, no healthcare insurance; homelessness or eviction concerns; and substance use disorder. A major theme from partner interviews is that when they are able to share the different pieces of information about the client, they are much better able to prevent health issues and/or address health/housing needs in a way that is more client-centered and timely.

The Medical Neighborhood Team shares patient information in “real time.” For example, if a patient from their priority population walks into the emergency department (ED) with mental health concerns and is previously unknown to Mercy, the ED staff/case managers have been trained to offer a connection to an outreach worker and other concrete supports like housing partners via “warm handoff,” not the usual referral process. The outreach worker might meet that person afterwards for lunch or pick them up to take them to follow-up appointments, which builds trust in the providers. The outreach worker then helps the individual obtain medical care and even accompanies them to appointments if needed, which reduces the no-show rates. If an individual and an outreach worker have difficulty arranging appointments for other needed services, connecting with their partners on the Medical Neighborhood Team can facilitate getting needed services faster.
Another trigger for communication with partners occurs when Mercy examines patterns in daily emergency department (ED) utilization data. Individuals with more than two ED visits in a week are brought to the attention of the Medical Neighborhood Team to learn more about the patient from outreach workers and other partners. During regular in-person Medical Neighborhood Team meetings, partners share with each other any people they are particularly concerned about, share relevant information about their current challenge (e.g., status of medical conditions such as an infected wound, housing), relevant background information, and then the team brainstorms next steps or options to engage and support them, including who will provide which services, with the outreach worker often facilitating the coordination. All plans are driven by the patient and never imposed. Motivational interviewing is the common language and the discussion focuses on engagement and support tactics that respond to patients’ distinct needs.

Primary care providers (Greater Portland Health and Mercy outpatient and primary care practices) communicate directly with the Amistad peer support and outreach workers who help to ensure patients keep appointments by accompanying them and/or arranging transportation if needed. Greater Portland Health indicates in a patient’s medical charts to contact Amistad. The Mercy Medical Group staff examines the appointment calendar and contacts Amistad outreach workers before some patients have appointments in case they need support in keeping the appointments. If a patient does not show up, providers call upon partners to assist the patient with rescheduling the appointment.

**Leadership, advocacy, and resources in lead organization.** As the lead grantee organization, Mercy Hospital has provided leadership and set a tone for the work of the Medical Neighborhood Team that is aligned with their mission of treating all patients with respect and dignity. They have also served as problem solver and advocate for patients with the most challenging situations. For example, if a state agency such as Adult Protective Services declines to open an investigation, Mercy’s Vice President of Mission Integration communicates directly with the state agency to provide them the information they need (sometimes medical records) to approve the needed services, sometimes even for patients of the other hospital in Portland (Maine Medical Center). In another example, an elderly man with mental illness was about to be evicted and end up homeless. Mercy Hospital prevented his eviction so that appropriate housing at an assisted living facility could be arranged. Mercy recognizes that the Medical Neighborhood Team approach requires a lead health care organization with sufficient capacity, which smaller organizations may not have.

**Having a mature network of partner organizations with a shared goal and better understanding of patients and resources.** The Medical Neighborhood Team partners consider themselves a “tight, mature network.” The partners have worked hard to educate each other about how best to serve individuals with complex health and social needs, which in turn has helped build their trust. The medical community member organizations recognize that they require help from other partners in the area. Their ability to create such an effective comprehensive care network might have been easier to achieve in Portland
because of the small geographic size of the area, the leadership in the network at Mercy, and their shared commitment to serving the needs of the most vulnerable.

The manager who attends Medical Neighborhood Team meetings has trained the health care providers about the Team, and regularly communicates any relevant patient information to primary care providers. They have been trained by the Team to celebrate patients’ small accomplishments, such as being three days sober.

Training about the role of peer support workers has been extended beyond health care providers to those who may interact with these patients, such as security guards at the Mercy ED. Security guards previously had difficulty with some patients but now are more aware of patients’ unique needs and challenges. Security contacts the outreach workers from Amistad when assistance is needed to calm down a combative patient. The Mercy inpatient census is reviewed daily so any patient with complex social or behavioral health needs is referred to Amistad peers or other partners for support. ED health care providers now know how to contact the partners directly rather than having to do so through care managers or the mission department at Mercy.

Other initiatives rely on community health workers, outreach, and peer support providers to give needed support to individuals who are homeless. For example, Portland businesses funded a transportation service for homeless individuals that connects them to Amistad or Milestone rather than the police. The partners can then work as a team to find appropriate shelter and services and/or detoxification services. Maine Medical Center and other area providers also refer patients to the Medical Neighborhood Team.

**Building trust between patients and the health care system.** The trust that patients have with peers and outreach workers has in turn helped build trust with their health care providers. They use creative means to encourage rational utilization. For example, an Amistad peer support worker promised to take a frequent ED user to a Red Sox game if he used primary care rather than the ED for one year (which he succeeded in doing).

**Linking health and social services.** Through the Medical Neighborhood Team, patients now receive services in a highly coordinated fashion. Mercy’s financial counselors and care managers work with people who are frequent users of Mercy’s emergency department to connect them to a range of services including applying for Maine Care, arranging for appointments via “warm referral” with primary care and behavioral health/substance use if needed, eliciting preferences for their providers (e.g., male/female), arranging transportation to appointments, providing clothing (Mercy sweat suits), helping repair “burned bridges” with other providers with whom patients may have been combative or had too many no shows, and medication management. For people newly arriving from out-of-state, Medical Neighborhood Team members immediately provide warm referrals to a peer who builds trust and links them to support services including a shower, clothing, food, and other support services to avoid inappropriate future use of the ED.
6. Additional Considerations

As other communities and organizations develop patient information sharing agreements, several considerations are essential:

1. Identify the level of agreement needed. For non-profit organizations not subject to the privacy regulations governing health, substance use or behavioral health (e.g., HIPAA), a simple shared release form may be sufficient to share client information; and

2. Engage the right legal expertise for the type of agreement needed and organizations involved.
7. What are the outcomes for patients and partners of sharing patient information?

Mercy Hospital has the infrastructure to devote to tracking patient referrals and outcomes. Below are some of the positive outcomes that are formally or informally being tracked and shared with the Medical Neighborhood Team partners.

**Improved individual outcomes.** The Medical Neighborhood Team already has several success stories helping improve the well being of patients in all aspects of their lives. Some of the positive results of the trust they have developed include patients becoming more engaged with their healthcare providers and in a healthier, sober life; better medication management (e.g., for diabetes or infections); better self-care for chronic conditions; reduced suicidal ideation; employment; appropriate and stable housing; and reconnecting with family/friends who can serve as their natural supports. During meetings, the Medical Neighborhood Team informally shares the stories and ultimate positive outcomes of patients they have supported. Patients can gradually get “weaned” from relying on the peers and outreach workers and the Medical Neighborhood Team coordination of care.

**Reduced unnecessary health care utilization and avoidable costs.** Mercy Hospital data analysts regularly produce utilization and cost reports for use by the Medical Neighborhood Team to examine patterns of ED use. Analyses show that prior to the Medical Neighborhood Team, there were hundreds of patients with five ED visits within a short time period (one patient had 20 visits within a few months), whereas now there are only about 10 patients with that level of ED utilization. The Medical Neighborhood Team communication also ensures that health care providers do not duplicate services such as MRIs. Patients are now more likely to establish a medical home.

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**Innovative Medication Management**

*Greater Portland Health stores homeless patients’ medications and ensures they take them in a timely manner, to prevent loss/theft of their medications on the street.*
relationship such as at Mercy’s Medical Group or at Greater Portland Health. Formally, Mercy can track cost avoidance and add the anecdotal stories, but this does not fully capture the impact the Team has had on the lives of patients. For example, moving a 25-year chronic alcoholic to sobriety and sober housing is challenging to measure and quantify.

**Reducing the number of uninsured.** The Medical Neighborhood Team partners work together to help patients apply for and obtain health insurance. Patients are referred to Mercy’s care managers and financial counselors who also attend Team meetings and communicate with outreach workers as needed to get documentation necessary for the health insurance application (such as birth certificates). This in turn can lead to reduced costs for Mercy and other health care providers.

**Reduced primary care no-show rates.** Mercy Medical Group has seen no-show rates drop by 50% (from 13% down to 7%), attributed to the Medical Neighborhood Team and especially outreach workers accompanying patients to appointments and building trust with health care providers.

**Improved partner attitudes, satisfaction and retention.** Through the education from the Team, health care providers have improved their approach to patients with complex needs. Primary care providers are also more motivated knowing that patients are engaged and will return for follow-up care. Seeing positive patient outcomes has helped improve job satisfaction and minimize turnover among the partners’ staff. Despite the long hours and intensity of working with these patients, peers and outreach workers find it worthwhile when they see patients “get back on their feet, get sober, live in a stable housing situation, and get a job.”

“If you can change something, it makes you want to go back [to work]... you no longer have that defeated feeling.”

—Outreach worker who is a member of the Neighborhood Team
8. Summary

The ability of the Medical Neighborhood Team to freely communicate information about individual patients via their formal partnership and information-sharing agreement allows community partners to achieve the goals of the A2QC grant, including improving coordination of health care and social services, and integrating primary care and behavioral health/substance use services. In addition, via frequent communication and cross training, they have built trust with patients and are nimble in responding to the complex needs of their most vulnerable patients. The Team has already observed positive outcomes for both patients and providers and has begun documenting some of these successes. While Mercy has the ability to track patient outcomes, their data are not yet linked with community health centers or behavioral health. Health Info Net, Maine’s statewide health information exchange, is a potential vehicle for this and could do predictive modeling that might help provide coordinated care for the uninsured, but still lacks linkages to all community health centers and behavioral health providers.
9. Next Steps

In its first three years the Medical Neighborhood Team has successfully engaged and involved the most critical and active partners in the care of Mercy Hospital patients. The key partners that remain on the periphery of this group include state adult protective services (APS), the Maine Department of Corrections, and the other hospital in Portland (Maine Medical Center). Some of the Medical Neighborhood Team partners are not as comfortable with APS and Corrections due to differences in goals. For example, outreach workers are concerned that APS will prematurely take away patients’ rights. For now, Mercy engages these entities on an ad hoc basis by inviting them to attend meetings when needed but not formally including them as part of the Medical Neighborhood Team and information sharing agreement. Other potential community resources to more deeply engage include the faith community, housing and employment services with a shared mission such as Maineworks and Community Housing of Maine. The Medical Neighborhood Team is a successful model of how community partners can work together more effectively to “meet patients where they are” when they are able to share information with each other.