

COMMUNITY HEALTH RECORD: CONSOLIDATED PATIENT INFORMATION AT YOUR FINGERTIPS



The Community Health Record is a Web-based software tool that allows qualified health care providers to access aggregated patient records from multiple hospitals and medical labs throughout a community. It's sometimes called a "longitudinal health record." For example, if a patient has visited two different hospital emergency rooms in the past year, all of the data from their lab tests, reports, physician notes, and more would be accessible in the Community Health Record—all easily viewable under that patient's name. Having a wealth of information neatly organized and accessible in one place helps providers find the information they need more easily and quickly, saving time and reducing frustration.

The Community Health Record benefits patients by reducing redundant and avoidable diagnostic tests, which saves time and costs associated with repeated tests. In some cases, avoiding repeat tests also eliminates discomfort or risk, such as additional radiation exposure. And when providers have the full picture of a patient's health care history, they can provide more accurate diagnoses and treatment. This could improve outcomes for the patient and also give them a better experience with their provider.

HOW IT WORKS

Access to a patient's longitudinal health information in the Community Health Record is provided via a secure, Web-based portal, PatientCare 360®, available by participating with CORHIO. The portal can be accessed via an application on a desktop, laptop, or tablet computer. After training from CORHIO, and with policies and procedures in place, an authorized clinician or caregiver can search for a patient and access a longitudinal view of that patient's medical history. For example, a specialist can look up a new patient and find out their history before the visit so that they're better prepared to discuss the patient's condition. Or a home health nurse can review what happened with a patient at a recent hospital stay, improving the transition of care.

PROTECTED ACCESS

CORHIO protects access to patient information within the Community Health Record. Only health care professionals responsible for clinical patient care and their direct support staff are allowed access. Qualified care staff can search by name to find clinical results on a patient from past encounters at a hospital, lab or some provider offices that are participating in CORHIO's HIE.

A provider must have an existing relationship with a patient to view the information. If a provider tries to access a patient for which there is no previously established relationship, the Community Health Record application will require the provider to specify a reason for their need to access the information, such as "new patient" or "emergency medical services." This access information is recorded and regularly audited to prevent unauthorized access to patient information.

Please note: Patients can choose to opt out of having their information included in the Community Health Record if they prefer not to participate and receive the benefits of the information exchange.

For more information on CORHIO's Community Health Record available via PatientCare 360, please visit www.corhio.org or contact us at info@corhio.org or 720-285-3200.

What information is included?

- ▶ Patient (H&P) history
- ▶ Laboratory results
- ▶ Pathology results
- ▶ Radiology reports
- ▶ ADT information
- ▶ Discharge summaries
- ▶ Consult reports
- ▶ Hospital ER, admit, and discharge alerts
- ▶ Newborn screening results
- ▶ Continuity of Care Documents

In addition, CORHIO's technical team is working on adding immunization queries, lab and radiology ordering, diagnostic-quality medical images, and public health alerts and modifications to the Community Health Record.

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