AccountedCare Case Study

Leading Post-Acute Care Model Re-Design

AccountedCare

AccountedCare, Inc. partners with health care organizations to establish and build high performing integrated PAC networks. Post-acute care expertise, analytics, and employing health technology are the keys to our success.

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Advanced Community Health Network/AccountedCare
Managing the ACO Post-Acute Care Episode
Implementing AccountedCare's PoC Care Coordination Solution & TigerText

About the Organizations

The Advanced Community Health Network (ACHN) is an innovative care delivery model that brings together a community of local care experts who are well known for providing quality post-acute care services to patients and their families after they leave the hospital. ACHN providers share a commitment to deliver chronic and supportive care to help improve quality of life and promote vibrant and healthy communities in the greater Waterbury, CT market. ACHN's collaboration of providers includes top physicians, advanced nurse practitioners, skilled nursing facilities, home care agencies and specialty medical providers.

AccountedCare's Process of Care "PoC" care coordination solution utilizes integrative communication tools and evidence-based treatment standards to ensure a seamless continuum of care as patients move from hospital to home. The unique, mobile communication platform brings together all of the team members so that they can collaborate and jointly care for patients. The application supports care teams within and across organizations with secure document sharing, transition notifications and communication via secure text messaging. The solution supports Clinically Integrated Networks (CINs) providing an episode plan for patients transitioning from Acute to Post-Acute level of care. The system tracks the patient's post-acute care episode and reports episode outcomes providing a view into expected and actual value delivered.

Summary

The sponsor organizations for the ACHN, Wolcott View Manor in Wolcott, CT and Meridian Manor in Waterbury, CT are family owned health care organizations started by James E. Cleary. By late 2015 both organizations were organized and structured under the predominate fee-for-service reimbursement mechanism. Movement in the market toward alternative based reimbursement started to impact referral and revenue development of both organizations. Competing groups in the market voluntarily began participating in bundle payment initiatives and began to impact referrals and census development. It could best be summized that the efforts by SNFs in the market participating in the CMS BPCI Model 3 initiative resulted in some shrinking of length of stay and the need for the same organizations to "backfill" with additional admission volume.

With the development of an Accountable Care Organization (ACO) in the Waterbury, CT market by a local health system and the prospects of another ACO by a competing hospital system, Wolcott and Meridian management decided to form a local "micro-network" to provide a turnkey solution for developing ACOs and secure market position. The goal of the micro-network strategy, to secure network status in the new and the developing ACOs.

What is a Micro-Network?

A Post-acute care Micro-Network is a physician-directed, clinically integrated, post-acute care provider network consisting of specialty care teams. Each care team includes top physicians, in-and-outpatient rehabilitation, home care, specialty service providers, and community based organizations that work together using an episode management approach. Each patient's personal care team coordinates the care and services for the patient transitioning from the hospital through post-acute care inpatient, outpatient, and in-home services. The team's goal is to deliver the most effective and efficient post-acute care services guided by the goals and expectations of the patient and the ACO.

Each patient care team uses Process of Care (PoC) standards developed in collaboration with network and specialty care team physicians. The Care Team Clinical Coordinator provides a patient specific PAC transition plan using patient preferences, goals, and expectations obtained from the patient during the assessment. All established patient providers, including PCP and Hospitalists, may provide input into the transition plan. At the direction of the patient, the PCP and other established providers are "looped" into the PAC care team communication and information sharing system.

The ACHN Network secured relationships with SNF physicians practices, APRN groups, Pulmonologists, Cardiologists, respiratory therapists, home care agencies, and other providers including: Associated Physicians of Southbury; Naugatuck Valley Cardiology Associates; ProHealth Partners; All About You Home Health; Associates in Medicine; and O2 Safe Solutions. ACHN uses the "Value Agenda" depicted in the figure below as a guide.

Advanced Community Health Network (ACHN)

Adopting the Value Agenda and Its Primary Components

Porter, Michael E. and Lee, Thomas H. M.D., The Strategy That Will Fix Health Care, Harvard Business Review, October 2013.

Workflow Challenges in Post-Acute Care (PAC)

The largely fee-for-service reimbursement system in the post-acute care space has created a system that is fragmented by Provider, plans are typically devised by provider not patient, measurement of health outcomes and costs is needed, and there is an absence of uniform standards and best practices. There has been little incentive to innovate and invest in information technology to improve care coordination.

The move to value-based payment models provides a tremendous opportunity for providers in the post-acute care space to collaborate, produce better care and cost outcomes for chronic patient populations and patients in episodes of care across the care continuum. The ability to work across time, space, and organization boundaries is important for improved care and safety and lower costs and this need can best be supported by enabling information technology tools to coordinate care.

Connected Post-Acute Care Providers

ACHN saw the need for improved communication with providers outside of their settings and to extend care coordination across collaborative provider groups. TigerConnect, TigerText's secure API, provided an avenue for ACHN to improve their communication and coordination with their collaborative providers. AccountedCare's PoC, integrated with TigerText, allows ACHN providers to better communicate and coordinate with other post-acute care providers. PoC allowed the care teams to do the following:

Secure Document Sharing with the Entire Care Team

ACHN care team providers identified in PoC were provided key patient documents through TigerText notifications including the ACO Nurse Navigator for ACO patients.

Transition Notifications

PoC provided secure notifications to ACHN care team providers through TigerText when patients transition to the SNF, hospital, or home. This included notifications to the ACO Nurse Navigator for ACO patient transitioning home to initiate timely follow-up calls and TCM billing.

Securely Communicate with Care Team

PoC identified providers on each patient's care team allowing for secure provider to provider and group communication through TigerText to enhance collaboration.

Tracking and Reporting

Provider utilization of PoC at the SNF allowed for PoC system tracking and reporting including reporting of outcomes for ACO patients.

In addition to utilizing PoC with TigerConnect to facilitate communication with ACHN providers, ACHN is able to leverage PoC's capabilities to provide notifications, document sharing, and outcome reporting with the ACO Nurse Navigator. The ACO Nurse Navigator was easily able to view who was on each patient's care team and communicate easily and securely using secure text messaging. The ACO Nurse Navigator had access to the plan of care for each patient including expected length of stay. Upon discharge home, the PoC notification

provided the ACO Nurse Navigator with a timely alert in order for her to follow-up with the patient at home within 48 hours per transitional care management and billing guidelines.

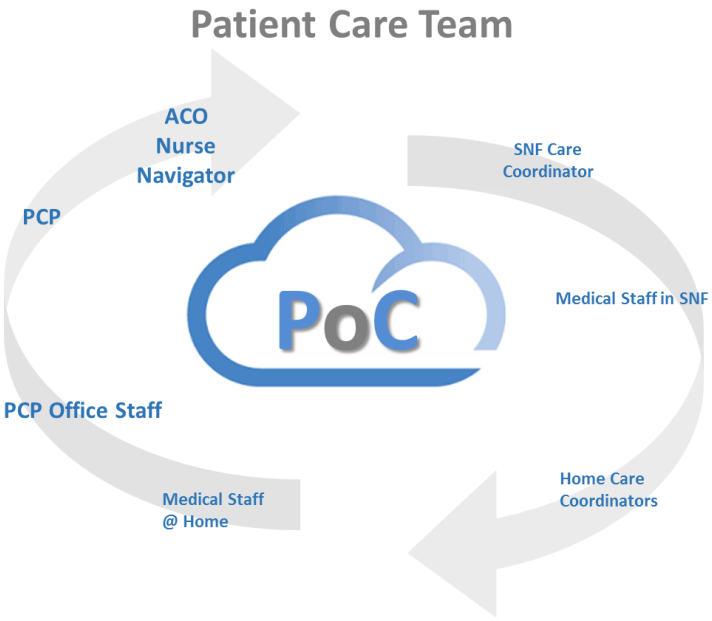
AccountedCare
PoC Process of Care Coordination & Population Health Solution

PAC Micro-Network Specialty Care Team

Each patient care team uses Process of Care (PoC) standards developed in collaboration with network and specialty care team physicians.

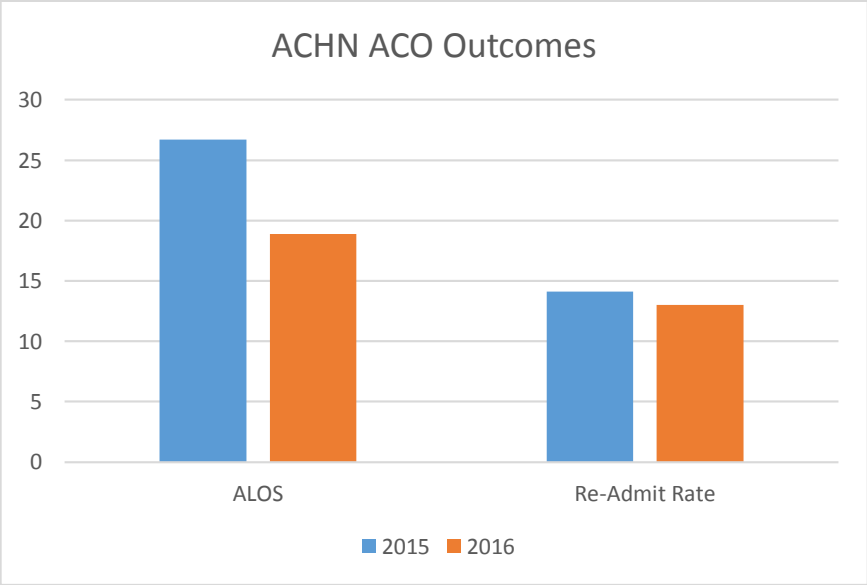
The Care Team Clinical Coordinator provides a patient specific PAC transition plan using patient preferences, goals, and expectations obtained from the patient during the assessment.

At the direction of the patient, the PCP and other established providers are "looped" into the PAC care team communication and information sharing system.



Results

For ACHN SNFs, ACO outcomes for 2016 improved over 2015, with a significantly lower average length of stay (ALOS) and lower hospital readmission rate. ALOS for ACO cases in 2015 was 26.7 versus 18.9 for 2016 and re-admission rate for 2015 was 14.1% versus 13.0% for 2016. There were 196 SNF transitions in 2016 YTD with >1,000 notifications and >500 documents shared. 23 of the 196 admissions effective October 2016 were ACO patients.



Operations Results

After ACHN implemented PoC with TigerConnect, care coordination improved. ACHN point-of-care coordination, supported by the technology solutions, addressed the primary gaps in care in the post-acute care space, including: Communicating timely and securely provider to provider; ability to identify and connect with care team providers across the care continuum; access to clinical information timely and in a usable format; and notifying care team providers of transitions and changes in condition and risk profile. ACHN has seen the following results:

Coordinate Care Effectively

Care teams able to connect and coordinate more readily. Care teams utilizing text messaging accessible by colleagues 100%.

Improve Admission and Discharge Hand-Offs

Ease of identifying care team providers and facilitating hand-offs. Ability of care team to send secure messages to care team with TigerText 100% reliable.

Improved Real-Time Communication

Accelerate communication securely through texting. Care teams utilizing text messaging accessible by colleagues 100%.

Streamline Workflow

Appropriate documentation readily available to the entire care team reducing redundancy. Availability of documents for care team at time of patient transition 100% reliable.

Improved Patient Experience

Care team informed of care plan, “on the same page”, with each other and the patient. Care teams with access to patient plan at all times with ability to communicate and collaborate.

Less Phone Tag Saving Time

Reduce delay in relaying information and improve ability to connect with colleagues. Ability to text care team 100% for participants using secure messaging.

Improve Physician Consult Process

Physicians able to communicate consult requests timely and accurately. Physician to physician communication through secure messaging available for every Cardiology consult.

Conclusion

ACHN leadership understood that proactively creating a post-acute care system of care that links together all of the key post-acute care providers forming care teams would likely result in both improved care and cost outcomes. ACHN’s collective efforts would provide a comprehensive offering that would be attractive to organizations accountable for patient populations that may need to access post-acute care services. ACHN continues to employ the technology solutions that will provide even greater network linkages and collaboration over time positioning ACHN to effectively compete with other post-acute care organizations including BPCI Model 3 participants.

ADVANCED Community Health Network
Central Connecticut's First Micro-Network for Continuing Health Care
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