Case Study

High-Performing Transitional Care Management

IPC Healthcare/Family Medical Associates Collaboration
Improving Transitional Care Workflow
Integrating TigerText, AccountedCare's PoC Care Coordination Solution, and GIVE Outcomes

Post-Acute Care (PAC) Planning Services 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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About the Organizations

IPC is the nation's leading physician group practice focused on the delivery of hospital medicine and post-acute care services. IPC providers manage the care of patients in coordination with primary care physicians and specialists in over 2,400 facilities in 29 states across the U.S. They provide care to over 1.5 million patients annually while maintaining high standards of quality care, aligning with the mission and objectives of the facilities they serve.

Family Medical Associates, PC based in Canton, MA is a leading provider of medical services to patients at home. FMA specializes in treating high risk, complex, and multi-diagnosed patients. FMA providers have over 15-years of experience developing Physician directed clinical teams in the home.

Summary

Family Medical Associates began their Transition of Care ToC Consult service with acute care consults for high risk patients transitioning home in 2012. The result of the acute care ToC program was a significantly lower hospital re-admission rate. The ToC consult service expanded in January 2016 to include the addition of multiple collaborators, SNF physician practices and SNFs, and the implementation of technology tools to support management and coordination across multiple inpatient locations. The addition of the ToC consult service with IPC SNF medical staff collaborators resulted in significantly lower re-admission rate for high-risk patients during their SNF stay and a low average length of stay, comparable to low-risk patients that were not consulted with the ToC service. The next step for program expansion is the inclusion of the network home care providers to track the success of the program in the home setting post-acute and post-SNF discharge for a period of 90 days to coincide with bundled payment and Accountable Care Organization initiatives.

Background

Hospitals contract with Medicare to furnish acute hospital inpatient care and agree to accept reimbursement based on predetermined rates. Payments are based on Medicare Severity-Diagnosis Related Groups, MS-DRGs, with some adjustments for market conditions, graduate medical education training, rural location, and several other factors. Greater interest in transitional care developed in October 2012 with the federal Hospital Readmission Reduction Program (HRRP) and re-admission penalties to hospitals. This

reduction in Medicare payments is based on a measure of hospital's readmission performance. Medicare began tracking 3 conditions, acute myocardial infarction, heart failure, and pneumonia. In 2015 CMS added two conditions, hip and knee replacement and chronic obstructive pulmonary disease with plans to add another condition in 2017, coronary artery bypass graft surgery. The readmission refers to an admission to the same or another acute care hospital within 30 days of discharge from an acute care hospital paid under the Medicare Inpatient Prospective Payment System (IPPS). This new Medicare ruling was a major issue for acute care hospitals since the national Medicare readmission rate at the time averaged nearly 25% for patients with those identified conditions.

In April 2012, Family Medical Associates, realizing the greater emphasis on the hospital readmission issue, developed the acute care consult service as a component of their medical home visiting program. FMA physicians joined a hospital-based task force charged with establishing the clinical and social criteria that would identify high risk for readmission candidates and create programs that would reduce potentially avoidable hospitalizations and reduce hospital length of stay.

The task force was headed by FMA founder, Dr Timothy Lowney Sr., DO, MBA, who was former founder and Chief Medical Officer at Physicians Healthcare, a home care company that specialized in treating high risk, complex, and multi-diagnosed patients. Physicians Healthcare, with fifteen years of experience developing physician directed clinical teams at home, had proven success at achieving the goals stated above. The task force consisted of hospital management, hospitalists, case management, and discharge planners.

The team quickly recognized that, in order to be successful, the process had to begin at the time of hospital inpatient admission. Thus began a multiphase project that involved careful analysis of the multiple issues and barriers that are involved with the transition of patients after an acute event. The team created solutions for each issue at each point of care in a clinical episode that works for all stakeholders. Thus the ToC consult service was launched. The hospital assisted FMA with tracking outcomes.

In 2014, FMA began the Transition of Care program with the consult service at the hospital by identifying patients at high risk for 30-dy readmission post-discharge home. The ToC team, consisting of a physician and nurse practitioner team providing a series of home visits. The hospital tracked re-admissions back to the hospital. 120 patients were seen by FMA, consulted at the hospital and followed at home, over the course of a year. Readmission rates for high risk patients were estimated to be in the 30%-40% range. The 30-day readmission rate for patients in the home program was 8.04%.

GIVE Outcomes

In order to closely monitor patients admitted to the transitional care program, FMA utilized GIVE Outcomes software application. Developed over the last 12 years, GIVE Outcomes started as a spreadsheet of data used to help show each patient's current versus expected clinical status in real-time. Through several iterations and development phases, GIVE is now a cloud based, secure application that easily captures real time clinical data and allows the clinician to project and update patient status and create a clinical note using a simple 0-5 rating system. GIVE captures other data critical to bundle/risk payment models:

- Changes in patient disposition with detailed reasons for transfer and outcomes
- Expected dates of transfer
- Flagging system for when patients are approaching transfer date with outstanding goals
- Report on different groups of patients within a large population
- Capture of "near misses"
- Assign and edit treatment plans using templated system of goals, interventions, and signs and symptoms.

The GIVE system can be used in all of the clinical settings using different treatment plans and goals for each level of acuity with a fluid treatment plan that can be reshaped at any point in the episode of care from the hospital to home. The home-based residentialist physicians and NPs perform regular home visits to more closely monitor patient status after they return home and update current status and goals of care using the GIVE Outcomes application.

Partnerships

In the process of implementing the physician-driven transitional care program, partnerships were formed. One issue was identifying the subset of high-risk patients when they were admitted to the hospital. FMA through its hospital affiliate, worked with EMR provider Meditech and created a report that filters all inpatients for high risk criteria and identifies them upon admission. This cues the inpatient provider to consider a post-acute care consult so the transitional care team is on board as soon as possible to facilitate an efficient discharge to the most appropriate post-acute setting. This partnership was formed with the IPC acute care hospitalist physicians.

Transition of Care ToC Pilot – Phase II in the SNF Setting

The relationship with IPC then deepened with phase II of the pilot. Similar to the inpatient hospital referral process, FMA and IPC established a referral process for high-risk patients with the first point of contact at the SNF where IPC had established practices. Led by Tim Lowney, Jr, DO and Vishal Kuchaculla, MD, FMA and IPC established a SNF-based consultation service and communication model utilizing the Process of Care "PoC" system. The goal of phase II of the pilot differed from the hospital based program. The goal of lowering re-hospitalization rates after discharge from the SNF setting remained in place; however, the primary goal of phase II for ToC program implementation in the SNF setting was to understand the potential impact of the ToC provider collaboration at the SNF.

Consideration for the ToC program and consult service were based on the following criteria:

Residentialist/Transitional Care Program

Program Designed for Patients at High Risk for Re-Hospitalization

Residentialist physician/nurse practitioner is available to see patients in the home. Patients will continue to follow-up with the PCP as outpatient. Comprehensive plan of care is coordinated among primary physician and all specialists.

Patients qualify based on any *one* of the major criteria and *two or more* of the minor criteria. Reasons for a Transitional Care Program referral include but are not limited to the following:

Major Criteria

CHF	PNA
MI	COPD
IV antibiotics	Uncontrolled diabetes
Uncontrolled HTN	Dementia
5+ comorbidities	3+ hospitalizations last 6 months

Minor Criteria

Psychological disorder 6+ medications
65yo and transitioning home on antibiotics
Home on oxygen Newly diagnosed diabetic
Observation patients at moderate functional level
Two or more actively treated co-morbidities with any medical or rehab diagnosis
2+ ADL deficiencies

The Residentialist is the supervisor/advisor/mentor to the NP/PA in the home for all clinical matters and will manage communication among the following:

PCP Hospitalist Skilled Nursing Facility Specialist Home Care VNA

A key piece of the collaboration effort between FMA and IPC was their partnership initiated with AccountedCare and utilization their PoC system for communication and document management. The strategic partnership solved several issues:

- Case management notifications
- Transition notifications
- Providers communicating with team securely
- Access to critical documentation
- Additional outcomes data capture

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. As leading medical providers in the post-acute care space, IPC Healthcare and Family Medical Associates formed a unique, innovative collaboration to improve care across the continuum.

Connected Post-Acute Care Providers

IPC Providers were familiar with the TigerText secure text messaging platform, using the solution within their hospital and post-acute care practices. IPC saw the need for improved communication with other Provider groups outside of their practice settings and to extend care coordination across collaborative provider groups. TigerConnect, TigerText's secure API, provided an avenue for IPC to improve their communication and coordination with their collaborative practices. AccountedCare's PoC, integrated with TigerText, allows IPC Providers to better communicate and coordinate with FMA and other post-acute care providers. PoC allowed the care team to do the following:

Secure Document Sharing with the Entire Care Team

ToC Care Team providers identified in PoC were provided key patient documents through TigerText notifications.

Transition Notifications

PoC provided secure notifications to ToC Care Team providers through TigerText when patients transition to the SNF, hospital, or home and provided the ability for IPC SNF providers to consult FMA timely.

Securely Communicate with Care Team

PoC identified ToC providers on each patient's Care Team allowing for secure Provider to Provider and group communication through TigerText to enhance collaboration.

Tracking and Reporting

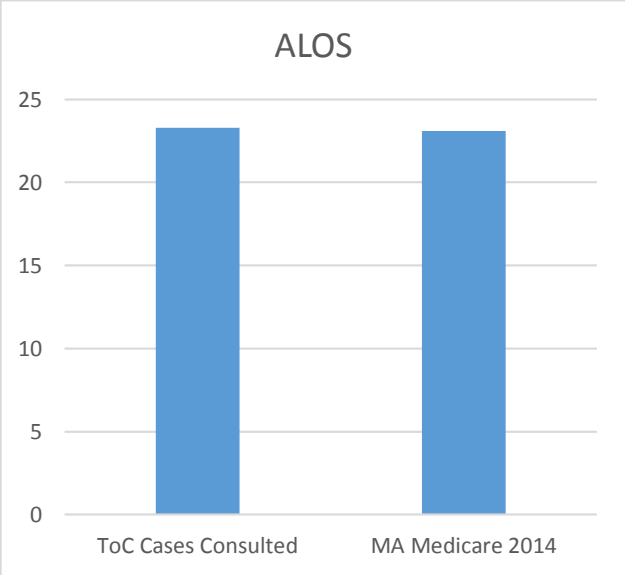
Provider utilization of PoC at the SNF allowed for PoC system tracking and reporting for ToC Care Team members.

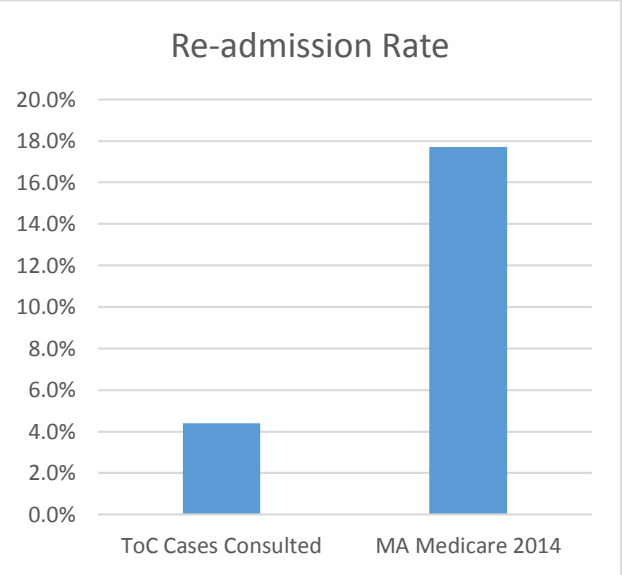
In addition to utilizing PoC with TiggerConnect to facilitate communication with IPC providers, FMA is able to leverage PoC's capabilities to work with its GIVE Outcomes solution in the SNF setting. With PoC, FMA was able to better communicate and disseminate notifications with IPC providers and within their practice when the GIVE Outcomes solution identified patients that needed added intervention due to a change in condition and risk for hospital readmission.

Clinical Results

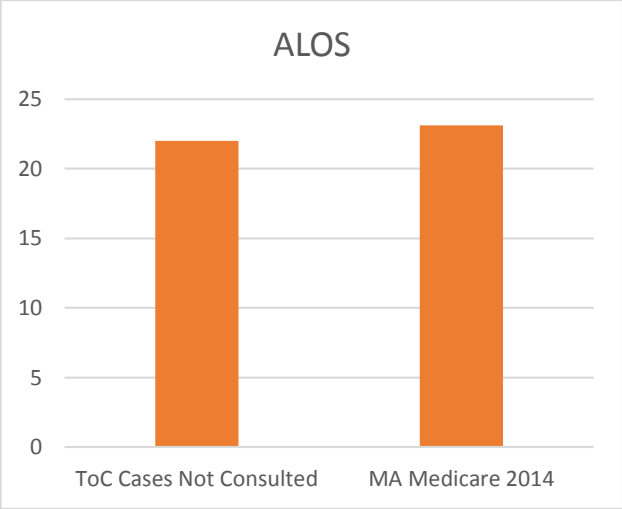
The Transitional Care Pilot ran for a period of 7 months from January 15, 2016 through August 15, 2016. 115 admissions from 2 local acute care hospitals where tracked. Of the 115 admissions, IPC SNF medical staff consulted FMA on 71 cases or 61.7% of the cases using the ToC consult criteria. 43 of the 71 cases consulted with FMA's ToC program transitioned home, 2 readmitted to the hospital, and the rest remained long-term or were still skilled in the SNF at the conclusion of the pilot. Of the 27 patients that were not consulted 26 returned home and 1 was readmitted to the hospital. The hospital re-admission rate for patients in the SNF consulted for the ToC program, higher risk patients, was very low, 4.4%, and the average length of stay, 23.3 days, was near equivalent to the state average of 23.1 days. The lower risk group that was not consulted was similar, a 3.7% re-admission rate and 22.0 average length of stay.

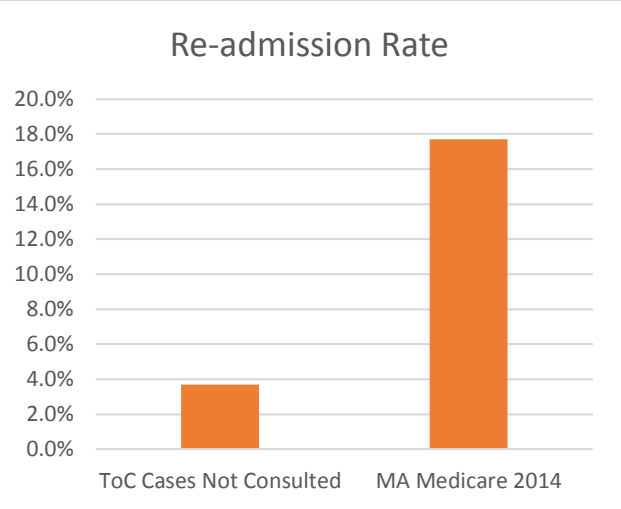
High-Risk Cases Consulted with ToC Program





Low-Risk Cases NOT Consulted with ToC Program





Operations Results

After IPC and FMA implemented PoC with TigerConnect and with GIVE Outcomes, care coordination improved. The Transition of Care program, 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. The transition of Care program has seen the following results:

Coordinate Care Effectively

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

Improved Real-Time Communication

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

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.

Improve Physician Consult Process

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

Transition and Risk Profile Notifications

Care Team knows when transitions occur and when risk profiles change and who to communicate with to follow-up and intervene. Notification reliability 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.

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.

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.

Conclusion

As they had in the acute care setting, Family Medical Associates and IPC successfully implemented the ToC consult service process for high risk patients planning to return home from the SNF using technology solutions to communicate, share information, assess patients, and collaborate. The ability of FMA and IPC to expand the ToC program process from the acute to home settings to the acute to SNF to home setting provides promise for similar outcomes. In addition to the potential for improved outcomes post-SNF in the home with the ToC program, results of the FMA and IPC collaboration at the SNF level was encouraging. Average length of stay and readmission rates at the SNF level of care for high-risk patients of 23.3 days and 4.4% re-admission rate is a positive sign for impact of the ToC consult service at the SNF level of care with the SNF attending medical providers.

For next steps, given the current emphasis on post-acute care outcomes for 90-day episodes with bundled payments and Accountable Care Organizations, the success of phases I and II of the ToC program warrants an expanded assessment of the program for 90-days after an acute care stay. The ability to track and assess the impact of the program would require the participation of key network home care providers.