Care Management Best Practice: HIE/ADT Implementation

HIE/ADT Workflow for Transitions of Care

August 27, 2019

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Background

Oakland Southfield Physicians (OSP) is an association of independently practicing medical group practices serving the tri-county area of Southeast Michigan. Over 77% of the network is pure primary care, including, family practice, internal medicine, and pediatrics. OSP has over 43,000 patients eligible for provider delivered care management, spanning approximately 42 primary care practices. This diverse landscape is presently serviced by a multidisciplinary care management team of 32 care managers.

Executive Summary

- The selected 42 primary care practices represent 87.3% of OSP's 2018 BCBSM patients eligible for Provider Delivered Care Management (PDCM)
- Launched an alert and notification tool organization-wide informing care managers and providers of Admissions, Discharges, and Transfers (ADTs)
- Developed and introduced standardized care coordination activities supported by ADT messages promoting Transitions of Care (TOC)
- Targeted PDCM engagement strategy and care model redesign based on ADT notification and TOC

Goal and Intervention

OSP is committed to improving access to health care and the overall health status of patients we serve. We accomplish this goal through greater alignment with community health partners, pioneering care management programs, advancing the patient-centered medical home model, and the advancement of innovative health information technology.

OSP, along with our information technology partner ANTS, partnered with Blue Cross Blue Shield of Michigan (BCBSM) and Michigan Health Information Network (MiHIN) to improve TOC performance. We targeted high-volume primary care practices to integrate Health Information Exchange (HIE) work and our primary care-based care management model.

Launched late 2016, the project innovated HIE work to promote and scale care coordination. Using physician organization (PO) and practice employed care managers, we worked to increase the adoption of ADT and Consolidated–Clinical Document Architecture (CCDAs) use within our care community, specifically designed to improve patient care management engagement and coordination of TOCs.

The PO and practice care management teams used ADTs and CCDAs applying three points of focus.

1. *Technology* promoted and scaled care coordination using ospdocs.com 'ADT Button' and OSP's internal patient registry to send real-time notification to practice-based care managers
2. *Standardized care coordination activities* supporting consistent workflow *around* ADT/HIE and TOC that assess appropriateness of care for improved accountability and productivity
3. *Care management model activities* structured to utilize ADTs and CCDAs to promote patient care management engagement strategies including medication reconciliation and TOC visits

Although the work began in late 2016, it is ongoing and will continue beyond the scope of this award.

Intervention Population

OSP focused on patients at high-volume primary care practices with an ADT event. The practices and care managers are informed of the patient's ADT event, triggering standardized care coordination activities resulting in patient outreach to begin TOC coordination.

Resources

The project was designed to impact population health through an innovative HIE solution focused on ADT notification to support patient engagement and TOC. To accomplish this goal OSP utilized the following resources:

1. Launched enhancements to OSP's website informing primary care practices of ADTs events (see Figure 1 in Appendix)
2. Real-time notification to care management team through OSP's patient registry tool (see Figure 2 in Appendix)
3. Developed and implemented standardized interventions, both clinical and administrative, that align with OSP's TOC measure set including customized action-plans. (see Figure 3 and Figure 4 in Appendix)

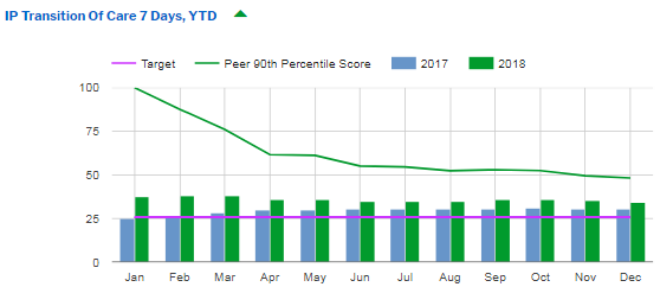
Intervention Measurement, Results, and Success

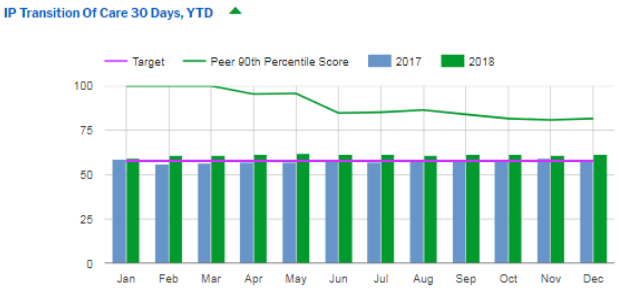
To measure improvement OSP imposed an outcome-based improvement rate methodology. Using 2017 as our baseline year compared to 2018 performance year; OSP was able to successfully increase the TOC measure set performance for both 7- and 30-Day post discharge visits. (see table and graph below).

Performance Measures – Table

Performance Measures	2017 (Baseline)	PY 2018
Transitions of Care within 7 Days	28.14%	34.92%
Transitions of Care within 30 Days	58.03%	64.80%

Performance Measures – Graph





OSP is proud that this project has positively impacted patient-centered care, during high-stress transitional care events, by harmonizing technical (HIE/ADT) innovation with personal care management services. This is why this work matters, technology in the absence of compassionate care is meaningless.

Fund Allocation

If OSP receives this care management *Best Practice* award, funding will be used to expand foundational work underway to both sustain and scale interventions. OSP will continue to focus on TOC, while expanding our innovation to reduce hospital readmissions, reduce post inpatient discharge ED visits, and expand home-based care management services for patients recently discharged.

Appendix

Figure 1-ADT Screen

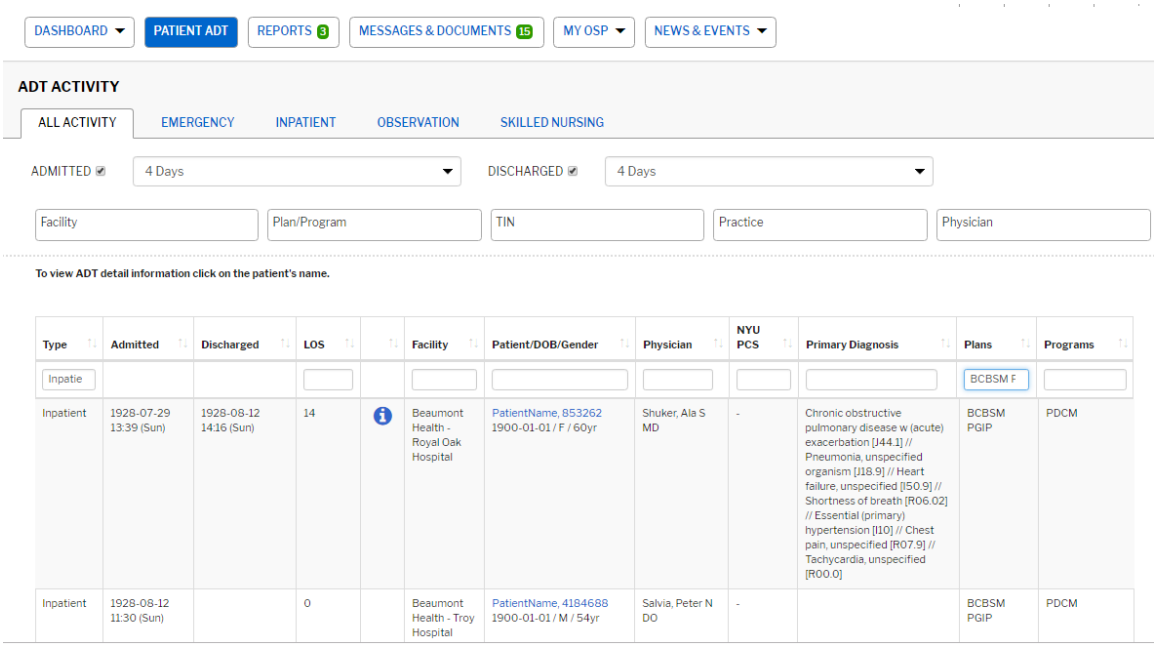


Figure 2-Patient Registry Alerts

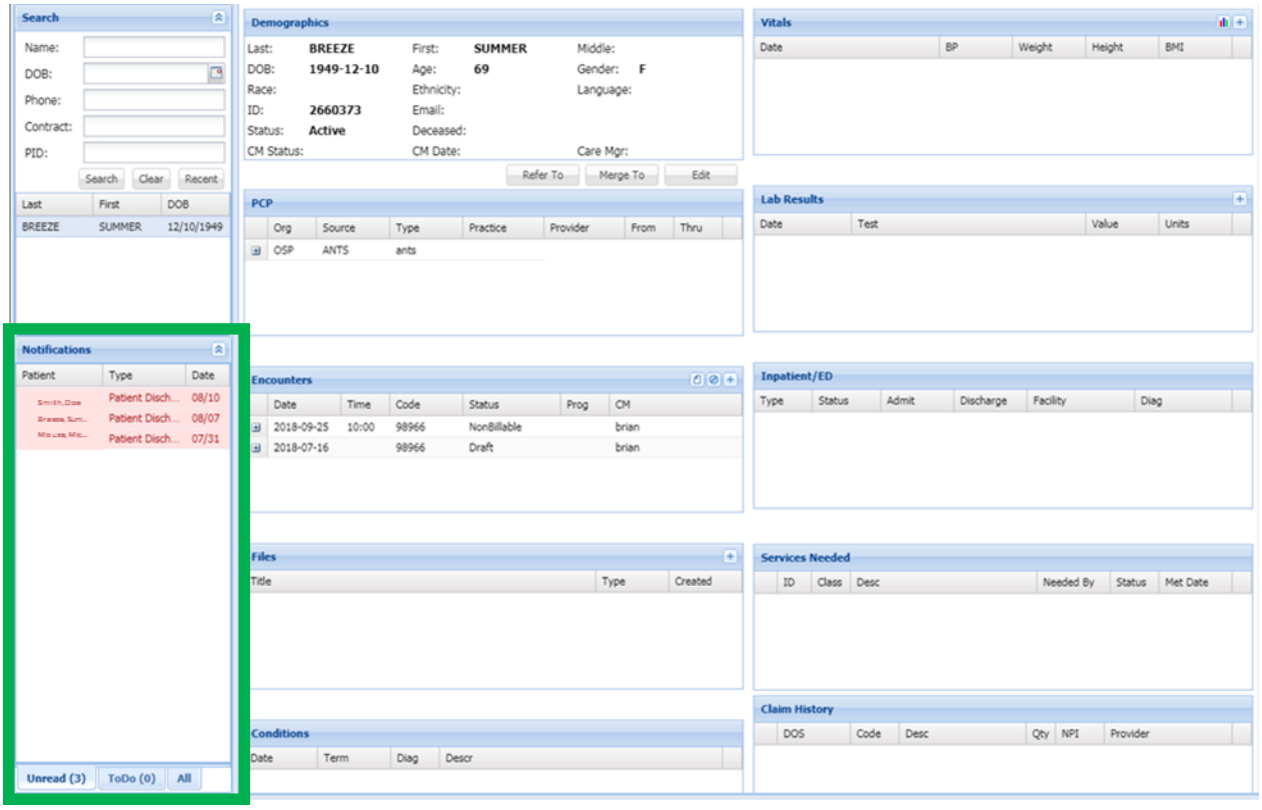
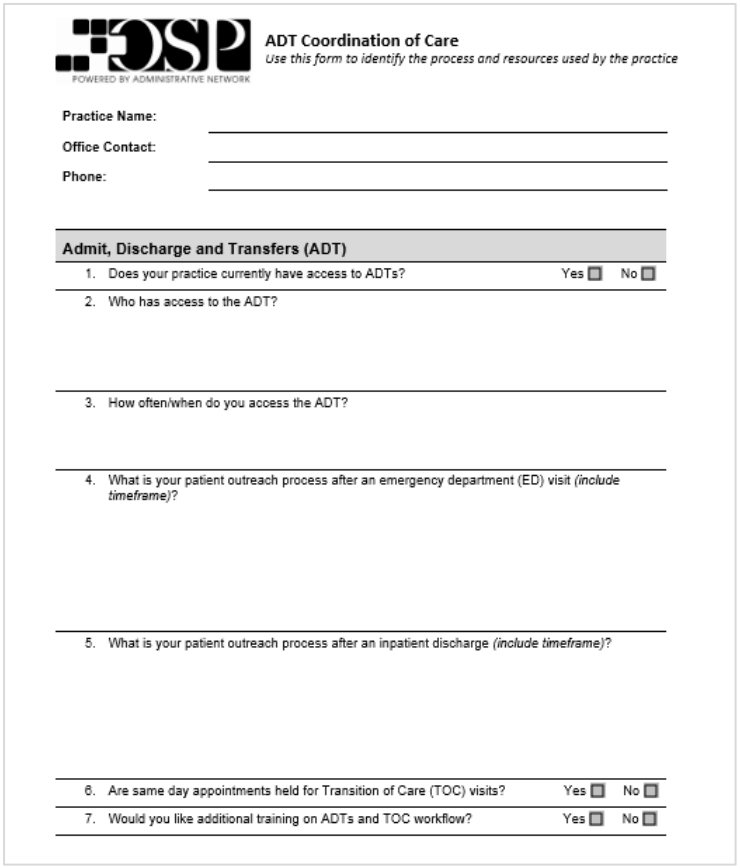


Figure 3-ADT Event Care Coordination



ADT Coordination of Care

Use this form to identify the process and resources used by the practice

Practice Name: _____

Office Contact: _____

Phone: _____

Admit, Discharge and Transfers (ADT)

1. Does your practice currently have access to ADTs? Yes ☐ No ☐
2. Who has access to the ADT?
3. How often/when do you access the ADT?
4. What is your patient outreach process after an emergency department (ED) visit *(include timeframe)*?
5. What is your patient outreach process after an inpatient discharge *(include timeframe)*?
6. Are same day appointments held for Transition of Care (TOC) visits? Yes ☐ No ☐
7. Would you like additional training on ADTs and TOC workflow? Yes ☐ No ☐

Figure 4-TOC Workflow