Contact Information:

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Physician Organization Name: Professional Medical Corporation
Practice Name: N/A
Practice Address: N/A
How many physicians in practice: N/A – this program serves 21 practices and 41 primary care physicians
Description of care team (# of care team members and their degrees/qualifications, at the time of best practice activity): 1.0 FTE of a Licensed Practical Nurse

Executive Summary (5-8 bullet points, must include summary of results):

- Providing centralized support for the transition of care process, initiating the phone call portion of the requirements
- To-date, has completed over 1,300 transition of care encounters on over 1,100 unique patients
- Contributed to the organization's observed decline in emergency department utilization rates
- Serving the managed Medicaid, BCBSM commercial, and other commercial populations
- Coordinating and collaborating with clinical offices to ensure patients have scheduled follow-up visits
- Providing centralized supportive care management to PO-specific members free of charge

Category of submission: Reduction in Utilization

Title of Submission: Reducing Inpatient Admissions and Emergency Department Utilization Through Transitions of Care Support

On January 1, 2017, Professional Medical Corporation (PMC) began piloting streamlined, standardized telephonic transition of care assistance to high-risk, high-utilization practices with a goal of reducing inpatient readmissions and ED utilization rates. This ongoing intervention is also focused on proactively addressing social determinant barriers that may result in a missed transition of care follow-up PCP appointment.

This program was developed by PMC leadership with consulting input and guidance from the population health department at Medical Advantage Group. The formation of this particular care model was developed utilizing experience from previous program successes and building on them as social determinants of health and prompt post-discharge follow-up become more crucial to long-term patient outcomes. This model was initially developed as a part of the Michigan State Innovation Model (SIM) program but has since been expanded, increasing accessibility beyond the grant-mandated managed Medicaid population, to also serve BCBSM commercial and Medicare Advantage (MA) populations and other commercial populations. The program utilized previous program experience and success and built a model to support the goal of decreasing unnecessary emergency department and inpatient readmission utilization.

This model encompasses a centralized care delivery model that utilizes a licensed practical nurse (LPN) to monitor the MiHIN Admit, Discharge, and Transfer (ADT) feeds. This individual monitors the multiple internal ADT feeds as well as the hospital-based discharge reports and initiates a call to the patient or their caregiver within 48 hours of the patient's discharge. The LPN completes a post-discharge screen with the patient to ensure that they feel comfortable with their discharge plan, were able to obtain medications or durable medical equipment, and that they understand any follow-up care. Additionally, the LPN completes a comprehensive, validated social determinants of health (SDOH) screening tool as well as she educates the patient on what to do should they have any post-discharge concerns, encouraging them to first contact their PCP or utilize an urgent care, instead of re-presenting to the hospital's emergency department should it not be an emergency.

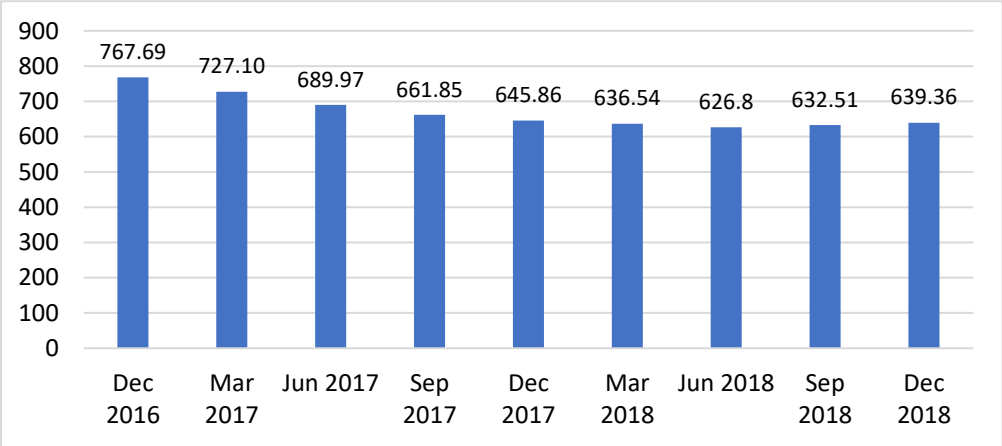
After the patient has been thoroughly screened, the LPN ensures the patient has a follow-up appointment scheduled with their primary care provider. If the patient does not yet have it scheduled, the LPN initiates a 3-way call with the patient to their primary care provider's office to schedule this appointment. In doing so, it removes the added responsibility of the patient to initiate the call to their physician's office. If the SDOH screen resulted in any positive results that would prevent the patient from completing this follow-up visit (e.g., transportation), the LPN coordinates and assists with removing those barriers. In turn, this also removes the responsibility for the embedded care manager to be conducting these calls, scheduling follow-up appointments, or coordinating social needs to ensure appointment completion. Additionally, through the LPN's conversation and screening process with the patient, if the LPN identifies any clinical needs or social needs that are beyond her scope of practice, the LPN initiates a referral to the practice's embedded care manager for more intensive, detailed follow-up and assistance. Following completion of the telephone portion of a transition of care, the LPN is documenting her interaction with the patient within the eClinicalWorks Care Coordination Medical Record (CCMR) and securely sending the practice a copy of the care plan or uploading it directly to their EMR for reference and audit purposes.

Patients are identified for this program through the monitoring of ADT feeds from multiple MiHIN sources that flow into an internal registry reporting program. Managed Medicaid and select commercial plan patients were identified as eligible if they were discharged from the hospital within the previous 48 hours from any hospital. Additionally, the LPN has gained access to hospital-based discharge reports to ensure that all discharges are captured given expected ADT imperfections. Lastly, the LPN is utilizing registry and health plan-based reports that identify patients who are high, inappropriate, and preventable emergency department utilizers who may warrant further follow-up either by telephone or arranging an in-practice visit with their primary care physician.

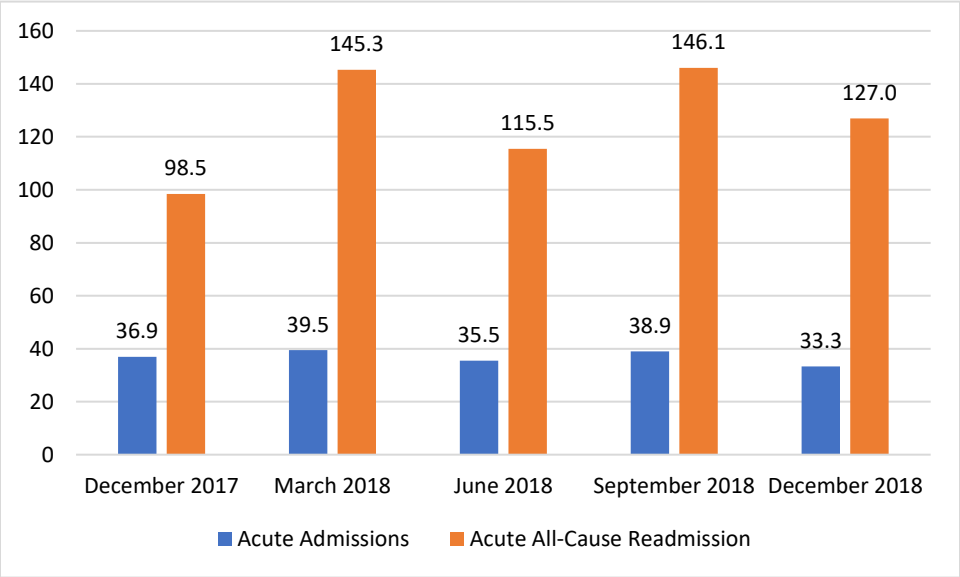
Program success is measured by both process-based and outcome-based measures. Process-based success was defined as the number of practices who utilized this LPN to complete their telephonic follow-up portion of a transition of care. This was viewed as a success measure as many practices were initially hesitant with an "outside" entity contacting patients on their behalf.

Additionally, PMC set internal performance benchmarks to ensure program success. LPNs have an outcome-based goal to successfully complete telephonic outreach to 60% of hospital discharges within 48-hours of discharge.

Professional Medical Corporation has identified key results from this program. Within 2.5 years, the LPN has completed over 1,300 transition of care outreach calls on over 1,100 unique patients on almost all participating primary care practices. The LPN is monitoring multiple ADT sources as well as hospital discharge feeds and is successfully reaching out to 100% of discharged patients within 48 hours of discharge. Additionally, PMC has observed a clear decline in emergency department utilization rates of almost 17% among Medicaid beneficiaries since beginning this pilot program, as noted below (in rate per 1,000 members).



Additionally, PMC has maintained exceptionally low hospital acute admissions and low hospital acute readmissions among Medicaid beneficiaries since inception of this pilot program, as noted below (in rate per 1,000 members).



To deploy this pilot program, PMC invested primarily in additional resources. The physician organization hired a 1.0 FTE Licensed Practical Nurse to be responsible primarily for the transition of care outreach. Additionally, PMC invested in refining tools and processes which ramped up and streamlined the ADT feeds that PMC was receiving. Through assistance from MAG IT, PMC was able to obtain more complete and comprehensive notifications, ultimately reducing emergency department utilization and avoiding readmissions. PMC also implemented a centralized approach to telephonic outreach to patients within 48-hours of discharge and initiating a 3-way call with both the patient and the practice on the line to ensure appointment scheduling.

PMC is exceptionally proud that observed reductions in emergency department utilization as well as inpatient admission and readmission rates can be attributed to this centralized telephonic TOC program. Not only is the LPN ensuring that the patient feels comfortable with their discharge plan and immediate care plan, but they are also promoting the concept of a Patient Centered Medical Home (PCMH) by completing a social determinants of health questionnaire. This LPN is building confidence in the patient's mindset for their PCP by the LPN completing this follow-up call on behalf of their physician, not only ensuring they're confident with their healthcare needs but also addressing the patient's SDOH needs and connecting them to community assistance programs if needed.

If awarded Best Practice funding, PMC will utilize the funds to support this centralized transition of care delivery model for long-term support of PMC's practices by expanding the program to 2.0 FTE LPNs. Currently, the program is limited to a number of PMC's primary care practices but winning such an award would allow transition of care services to be expanded to all of PMC's patients, regardless of practice or payer type. It would also allow for continued success of PMC's performance in impacting emergency department utilization and inpatient admission and readmission rates.