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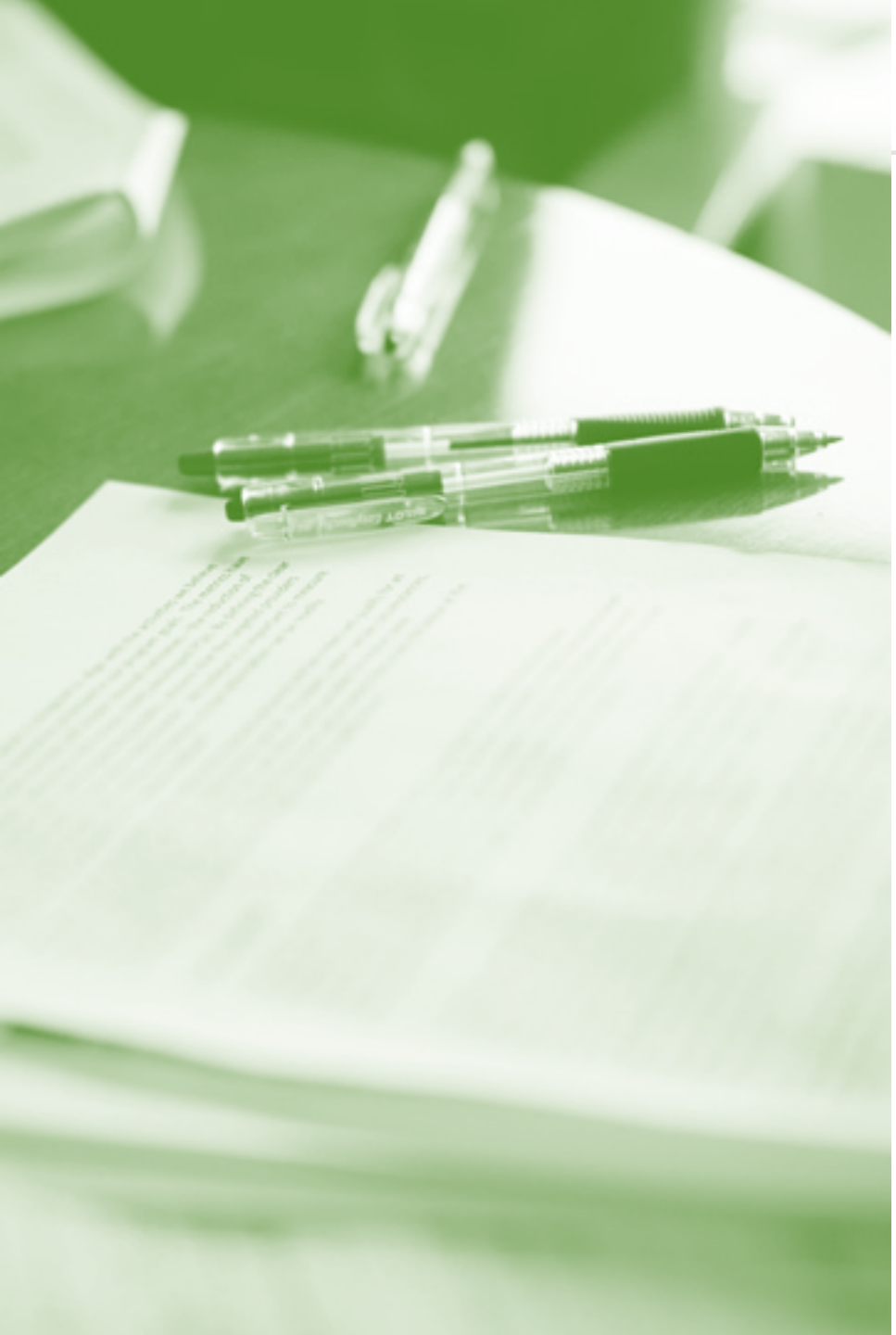
Healthy Starts Here

HMA
Health Management Associates

Utilizing ADT Alerts For Transitions Of Care

August 22, 2018



TODAY'S AGENDA

- ❑ Welcome and Announcements
- ❑ CRISP Update
- ❑ Admission and Discharge Information:
  - ❑ Why is it important?
  - ❑ How are we using it?
  - ❑ How could we use it?
- ❑ Q&A
- ❑ Reminders

CRISP UPDATE: NEAR-TERM IMPROVEMENTS

PROMPT Joins ULP

- You will be able to access PROMPT with the same login and password as the Query Portal and Patient Care Snapshot
- ETA October 2018

Visit-based Alert Display in PROMPT

- Events that are part of a single hospital encounter will be combined as they happen to reduce duplicative notifications
- ETA January 2019

Self-Service Panel Loading

- The ability to load your own ENS panels through ULP
- ETA January 2019

CRISP UPDATE: MID-TO-LONG-TERM IMPROVEMENTS

Better Alert Classifications

- Indicate visits to Long Term Care, Urgent Care, and Home Health
- ETA: Early 2019

Observation Status Indicators

- Patients are often registered and transferred to observation—these are missing from ENS
- ETA: Mid 2019

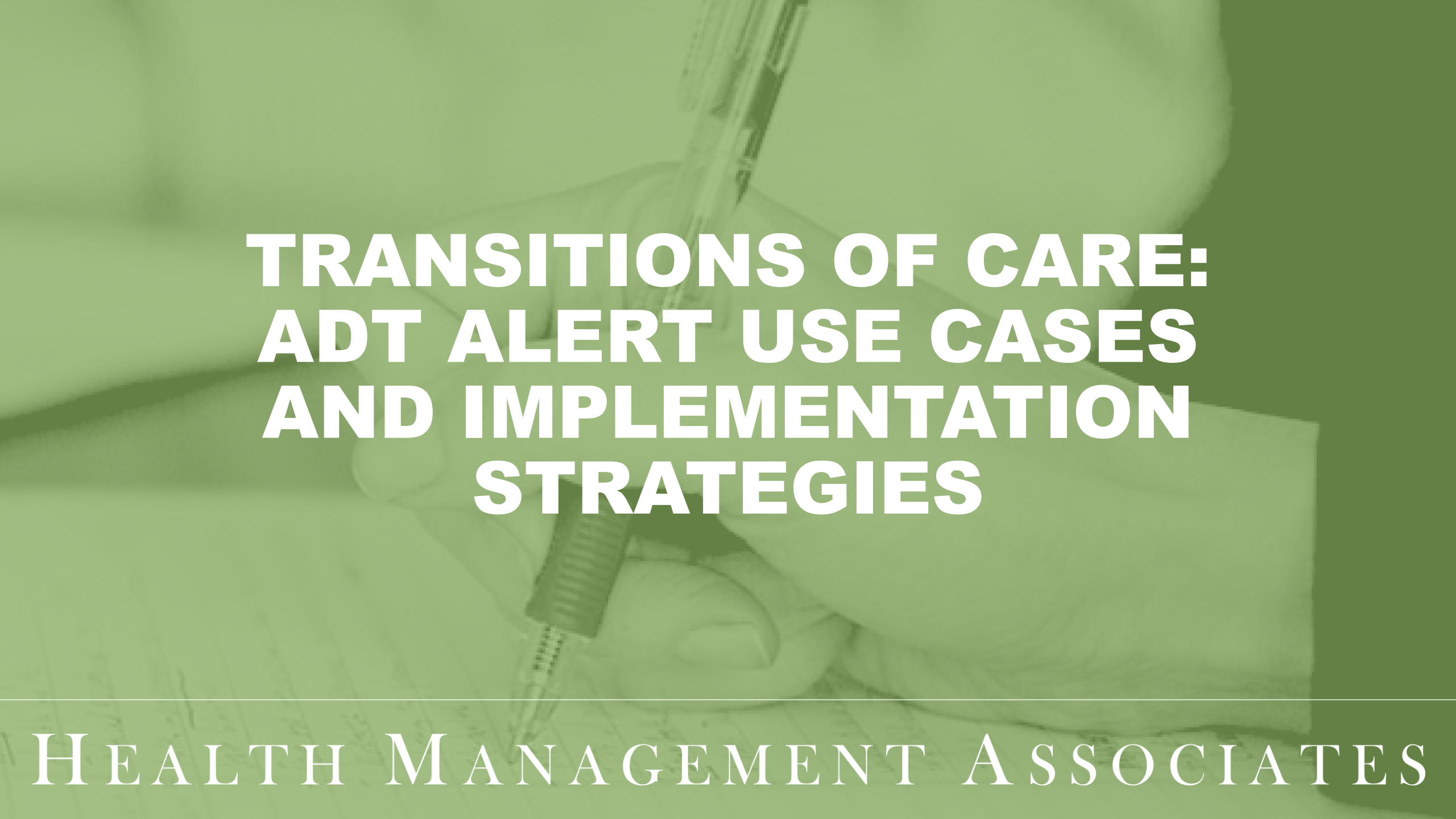
Smarter Alerts

- The ability to create rules that will trigger alerts only in certain situations, e.g., only alert me if this is the second visit in 30 days
- ETA: Mid 2019

Questions?

Comments?

And… Frustrations?



TRANSITIONS OF CARE: ADT ALERT USE CASES AND IMPLEMENTATION STRATEGIES

HEALTH MANAGEMENT ASSOCIATES

Common Reasons for Medicaid Readmissions

Principal diagnosis for hospital stay	Readmit Rate
Mood Disorders	19.8%
Schizophrenia/ psychotic disorder	24.9%
Diabetes	26.6%
Pregnancy Complications	8.4%
Alcohol-related	26.1%
Early/ threatened labor	21.2%
CHF	30.4%
Septicemia	23.8%
COPD	25.2%
Substance-related Disorders	18.5%

Source: Weighted national estimates from a readmissions analysis file derived from the Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), SID, 2011.

INPATIENT TRANSITIONS OF CARE: HOW TO USE THE ALERTS?

- Notification of hospitalizations triggered by real-time alerts prompting coordination with discharge planner
- Follow-up within 2 business days of discharge
- What to touch base on with patients:
  - Contact information
  - Schedule a follow-up appointment
  - Update the care plan
  - Medication reconciliation
  - Educate about specific warning sign recognition and response
  - Coordinate with community-based services and any new home supports

ADT ALERTS FOR TRANSITIONS OF CARE: WHAT IS THE IMPACT?

- Right Technology + Right Model + Right Transitions in Care Workflows = Biggest Impact
- 40% less likely to have a 30 day readmit with 7-day timely follow-up, post discharge
- DC financial implications of readmissions – MHGPS, FQHCs, MCO P4P

MHNConnect Activity July 2014 – January 2018
7 Day Timely IP Follow-up

MHNConnect 30 Day Repeat IP Rate	
Timely IP Follow-up	Non-Timely IP Follow-up
11.4%	13.5%
9.2%	17.6%
10.5%	17.3%
10.2%	16.8%
10.1%	**16.6%**

Estimated Inpatient Savings July 2014-Dec 2017 @ 25% Follow-up Rate on 70K Lives	
7 Day ER Timely Follow-up Rate	25%
# of readmissions avoided	186
(using $8,188 average facitlity readmission cost)*	$1,525,706
Savings per 1,000 Admits @25%	$132,153
Savings per timely follow-up	$529

* Savings projected since ACO

ACTING ON ADMISSIONS INFORMATION: FROM AN ADT ALERT

- You receive a notification that a patient was **admitted**. The patient is attributed to your site AND enrolled. What do you do?
- MHGPS Example: Providence
  - Visit the patient *in the hospital* if possible.
    - Update contact info and other data as needed.
    - Offer to set up an appointment. OR if patient already has an appointment, verify that the patient can still make it.
  - Coordinate with the rest of the care team and document touches.
- Additional Options:
  - If you speak with the patient, family member, clinician, and/or care coordinator, you can bill for that (Group 1).
  - Prior to reaching out to the patient, check the Clinical Query Portal and the Patient Snapshot.

ACTING ON DISCHARGE INFORMATION: FROM AN ADT ALERT

- You receive a notification that a patient was **discharged**. The patient is attributed to your site AND enrolled. What do you do?
- MHGPS Example: Providence
  - Reach out to patient *via phone*:
    - Update contact info and other data as needed.
    - Offer to set up an appointment. OR if patient already has an appointment, verify that the patient can still make it.
  - Coordinate with the rest of the care team and document touches.
- Additional Options:
  - If you speak with the patient, family member, clinician, and/or care coordinator, you can bill for that (Group 1).
  - Prior to reaching out to the patient, check the Clinical Query Portal and the Patient Snapshot.

- During an office visit, a patient reports that he/she was just in the hospital or ED. What do you do?
- How can CRISP help you?
  - Find out more detail:
    - When exactly the patient was in the hospital/ED.
    - Verify reason:
      - Discharge summary, diagnosis, primary complaint.
      - Check the Clinical Query Portal and the Patient Snapshot.
    - Follow-up with hospital as needed.
  - What else can you find out or verify?

Medical Home Network enables real time communication and collaboration across the ecosystem

28 Hospitals

15 BH & Social Service Organizations

200+ Primary Care Medical Homes

1M Real-time alerts per year

DISPARATE DATA SOURCES + + + +

- Real-Time Hospital Alerts
- Medical Claims & Pharmacy
- Physical & Behavioral Health Care Management
- HRA & Social Determinants
- Community-Based Services

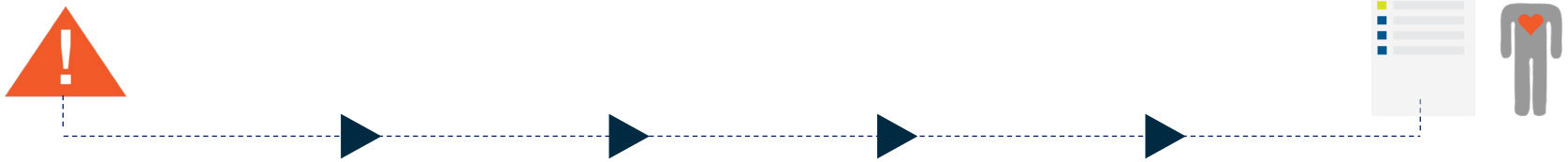
MHN CONNECT

360° PATIENT VIEW

Actionable, Standardized Workflows & Prioritized Tasks for Effective Care Management

Care Coordination Exchange & Longitudinal Record

Communication, Collaboration & Coordination



As patients move through the health care system, MHNConnect is the hub for communication and collaboration across all venues and settings—linking care teams to patients, data, and one another

MEDICAL HOME NETWORK DEMO: TRANSITIONS OF CARE SUPPORT

- MHN manages TOC all in one system, including tabs for inpatient admissions and discharge information.
- MHN uses a TOC “bundle”, a checklist for follow-up and CM activities.
  - Initial touch/call, updates for Week 1, Week 2, and beyond.
  - Ability to document and adapt workflow in response to provider/patient input.
- Opportunities for MHGPS sites:
  - Use the data available through ENS feed/ADT Alerts. (ability to export to Excel)
  - Develop your own checklist and workflows for follow-up.
  - Improve process and communications with community providers to decrease readmissions.


QUESTIONS?
COMMENTS?
HEALTH MANAGEMENT ASSOCIATES

REMINDERS AND ANNOUNCEMENTS

- Work with your site coach to develop and/or evaluate your workflows for transitions of care and ask questions about today's webinar.
- Provide input for this and future session using the feedback form.
- Schedule and complete your CRISP trainings.
- Save the dates for the next My Health GPS Learning Collaborative Series Webinars.
  - September 12: Assessments and Care Plans
  - September 26: Patient Engagement
  - October 10: Behavioral Health Scenarios According to Acuity Level
  - More invites to come as we finalize dates for the rest of 2018 and into 2019.

Enjoy the last few weeks of summer…Thank you!