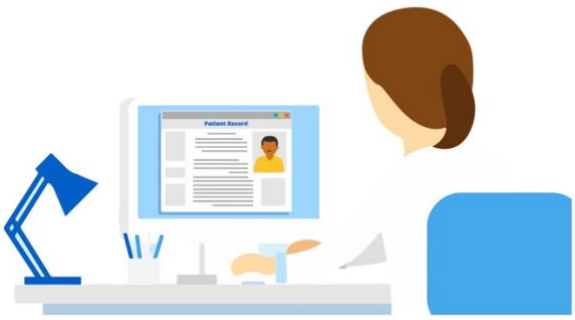

Use Case Report

ACO Transitions of Care, Hospital Care Management, Post-Acute Care Referral Management

In early 2017, Central Maine Health Care (CMHC) Accountable Care Organization (ACO) began to use HealthInfonNet's Analytics and Reporting Platform (HARP)

- Risk Stratify – CMHC patients with a high-risk of readmissions and hardwiring the referral process to their Transitions of Care partner, Androscoggin Home Care and Hospice.
- Discharge Planning – for all currently admitted high-risk patients allowing for real-time intervention while patients are still in the hospital.
- Community Paramedic Home Visitation Program Bridgton Hospital Pilot – identify patients at risk for 30-Day return to the ED for the study's patient cohort and control group to measure the pilot's efficacy with the goal of reducing Emergency Department visits.

Workflow

CMHC's Data Analytics Analyst accesses HARP Monday-Friday to identify CMHC patients with a greater than 20% risk of a 30-day hospital readmission for the Transitions of Care and Care Management Programs.

The RN Clinical Coordinator provides a clinical review of the list to exclude patients already enrolled in the Transitions of Care program, have declined the referral in the past or may be enrolled in hospice.

All CMHC admissions with a

greater than 20% risk of 30-Day Readmission

receives an automatic referral to Androscoggin Home Care and Hospice.

Transitions of Care Target Population

- All ACO patients admitted to any hospital in the state within the last 2 days
- All ACO patients discharged from any hospital in the state within the last 2 days

Care Management Programs Target Population

- All patients admitted to Central Maine Medical Center within the last 2 days

Care Managers from both programs then intervene with the patients to assess care plan questions:

- Is a primary care appointment required?
- Are community supports required?
- Are home care services required?
- What assessments are needed to qualify for a higher level of care?

Documentation

Central Maine Healthcare has created a longitudinal picture of each patient identified through HARP. The following criteria is recorded and tracked by Decision Support.

- Did this patient receive a Transition of Care referral? If so, which program?
- Did this patient receive inpatient intervention?
- Did this patient refuse the Transition of Care referral? If so, why?

Quality Impact

Targeted Transitions of Care Referrals: HARP provides a more precise and targeted list of patients eligible for Transitions of Care referrals - and subsequent charges - by identifying inpatients in real-time allowing for in-person visits. Referrals made during the inpatient visit via an in-person "warm hand-off" are more often accepted than those made post-discharge.

Patients seen while still in the hospital accept
Transition of Care referrals upwards of 90% of the time
whereas those contacted post discharge only 60% of the time.

Pilot Measurement: HARP provided the cohort used for the Community Paramedic Home Visitation pilot by identifying the patients at high-risk for Emergency Department utilization. The tool also allowed for the creation of the control group and will provide utilization measurement to evaluate the study's efficacy.

Organizational Impact

CMHC's implementation of HARP replaced time-consuming manual processes resulting in time-saving efficiencies, staff satisfaction and improved patient outcomes.

Prior to having access to HARP, staff only had access to admissions information specific to CMHC, not from all hospitals in the state. They also relied on a risk assessment tool within each patient record in the EHR that they found was too broad and not universally used across the health system.

"Adopting HealthInfoNet's Analytics has created a less manual process. We have found that augmenting analytics with clinical expertise is putting the right tools in the hands of the right people"

– Dervilla McCann, MD, Chief of Population Health,
Central Maine Healthcare