ACO Transitional Care Management

Background

According to the Agency for Healthcare Research and Quality (AHRQ), nearly 20% of Medicare fee-for-service beneficiaries discharged from the hospitals are readmitted within 30 days. At least 70% of those readmissions are preventable and add up to a staggering $26 billion in costs per year. Aside from the financial burden on the healthcare system, what is more worrisome is the human cost factor. Frequent admissions and readmissions pose a tremendous threat to patient safety and overall health. Transition of Care (TCM) programs can help combat inconsistent care continuity and improve patient outcomes.

Situation

A South Carolina-based Accountable Care Organization (ACO) set a North Star goal to reduce ED utilization and readmissions to improve patients' health and reduce CMS's cost burden. However, the customer's care team needed a way to view admission and discharge information in an organized and efficient manner. The administrative burden of manually logging into portals to pull down alerts, aggregate data, and record outreach results in spreadsheets were too frustrating and time-consuming.

Solution

Partnering with The Garage, the ACO sought to connect with surrounding hospitals' ADT feeds to receive real-time admission and discharge notifications in a centralized platform. The customer established a TCM program and a centralized team of nurse care coordinators to follow up with patients' post-discharge via these direct feeds. The Garage's population health platform, Bridge, provides the ability to access a centralized view of patient activities and a TCM workflow that is intuitive and efficient. This is important for the ACO's team as the care coordinators must reach out to patients within 48 hours and ensure they receive the necessary care during their transition out of the hospital.

Outcome

The customer has successfully monitored "high-rate emergency department (ED) utilizers", reduced ED utilization and admissions, and captured TCM revenue as a bonus. In 2021, compared to all MSSP ACOs, the customer demonstrated a reduction in emergency department visits by 5% and inpatient hospitalizations by 29%, accomplishing a greater reduction in utilization compared to all other MSSP ACOs.

"The Bridge has done a great job helping us streamline our transitional care management process. Before our partnership with the Bridge, our clinical care coordinators had to log in to each hospital portal to identify ACO patients who had recently been discharged from the hospital. Shortly after our partnership with the Bridge, we established an ADT feed with one of the local hospitals for emergency department visits, hospital admissions, and hospital discharges. Setting up this ADT feed has allowed our clinical care coordinators to quickly identify our patients who need a follow-up call post-discharge or intervention in regard to overutilization of the emergency department.

Our goal is to establish more ADT feeds with other hospitals in our market this year to improve our coordination of care, reduce hospital admissions, and improve workflow efficiencies with our clinical care coordinators."

– Quality Director

Interested in learning how The Garage can empower your organization?
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