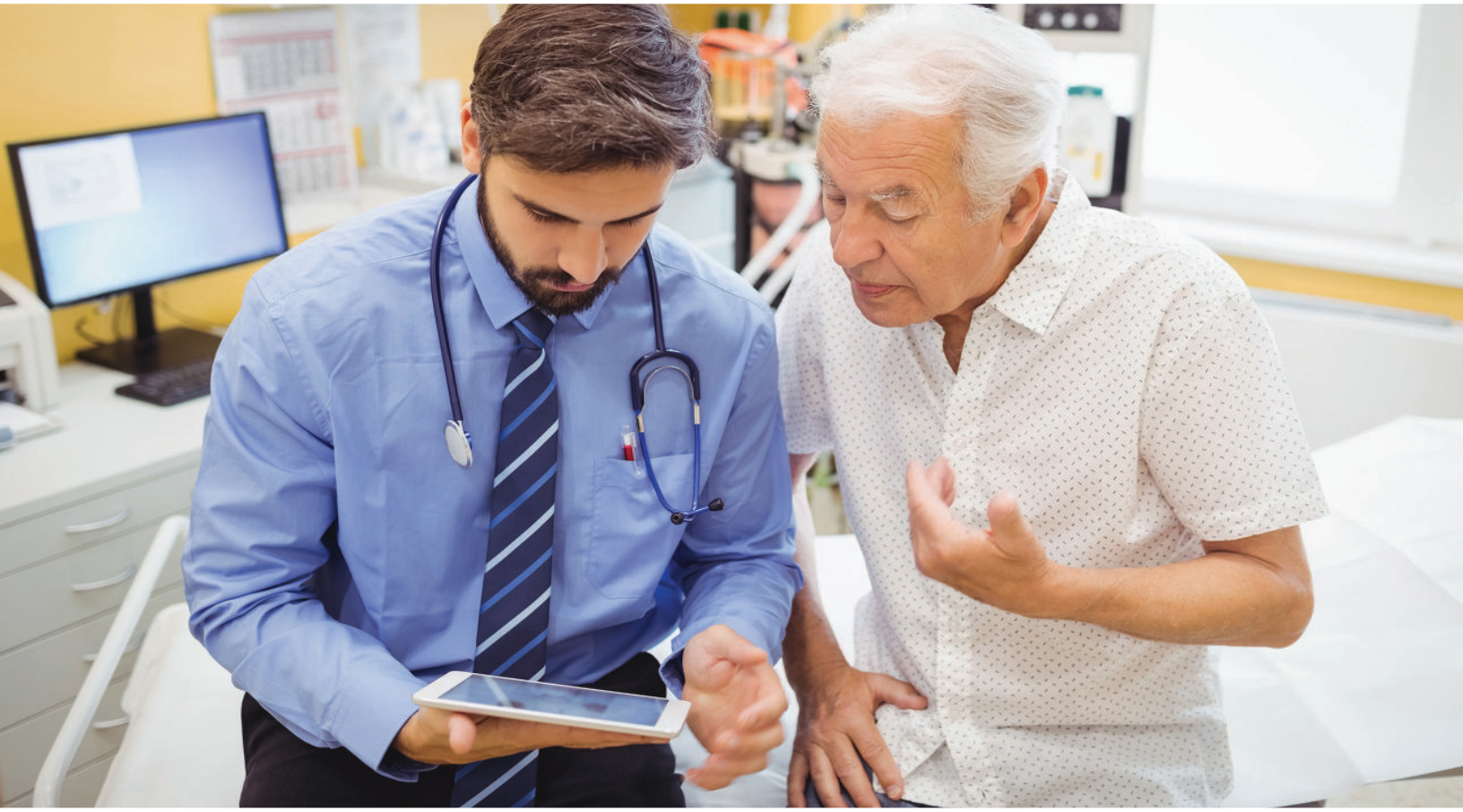
The Actively Connected Physician



How Automated Health Event Notifications Lead to Improved Patient Care

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Healthcare Connectivity Continues to Make Great Strides

As more health delivery networks, hospitals and physicians achieve core healthcare reform requirements for transitions of care and patient referrals, many new stakeholders have begun participating in automated health information exchanges.

Long term and post-acute care providers are leveraging secure health information exchange to improve care delivery and health outcomes while reducing total cost of care. Health plans that need to improve health care quality and performance and consumers who want uncomplicated access to their health data have emerged as new participants in the health care connectivity ecosystem.

As more hospitals elect to provide secure messaging as part of their provider outreach strategy, the technology has expanded to the complete referral network, including long term care, home health, skilled nursing facilities, physical therapists, pharmacies, care managers and others. With clear standards now in place, it is time for healthcare systems to leverage those solutions that can have an immediate impact by improving patient outcomes and driving down healthcare utilization costs.

The electronic sharing of clinical information enhances collaboration, helps improve productivity, reduces preventable readmissions and supports efforts to reduce patient treatment risks and limit unnecessary costs. It also helps add to the overall patient experience by providing communication tools to connect with their care providers.

To this end, automated health event notifications have been shown to reduce readmissions by up to 18%,[1] lower administrative costs and boost both provider and patient satisfaction.

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The Case for Notifications

Real-time patient information can make the difference between a patient successfully recovering at home after discharge or being readmitted to the hospital for reasons that may have been preventable had their primary care physician been aware of a change in their status. Readmissions are detrimental to patient health and frustrating for patients and providers alike. They place undue financial strain on the entire health system and have cost Medicare $17 billion annually.[2]

As the Centers for Medicaid and Medicare Services (CMS), Quality Payment Program continues to evolve, providers are still faced with two options for value-based reimbursement – either Advanced Alternative Payment Models (APMs) or Merit Based Incentive Payment System (MIPS). While MIPS has proven to be complex and difficult to associate with high-value care, other risk-based and value-based performance APMs are expected to continue. Regardless of the model used, providers still need to leverage an interoperable secure messaging network to properly address quality and value.

Communication is Key

Recent studies indicate a ten-fold increased risk of hospital readmission for patients who are not seen by a physician within 30 days of discharge. Considering that fully one-third of primary care physicians are never notified that their patient was hospitalized, it is not surprising that many patients are not receiving appropriate follow-up care.[3]

The onus has been placed on the medical community to ensure that important information is shared among the patient care team in an appropriate, safe and thoughtful manner in order to proactively address readmission risk. The call for better outpatient follow-up highlights the critical need for improved and timely communication between hospitals, physicians, and patients using a means that is acceptable and accessible to all parties involved.

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In 2013, CMS began reimbursing physicians for timely follow-up care using Transition of Care Management codes, CPT codes 99495 and 99496 in an attempt to foster improved transitions.

As a requirement for use of these codes, providers must:[4]

- Communicate (in-person contact, telephone or electronic) with the patient and/or caregiver within two business days of discharge.
- Make a medical decision of moderate complexity and high complexity respectively during the service period. Low complexity decisions are excluded.
- Have a face-to-face patient visit within 7 calendar days and 14 calendar days of discharge.

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In addition to providing physicians with a framework for effective post-discharge follow-up to promote improved patient outcomes and reduce readmission risk. This provides a financial incentive for physicians to rigorously adhere to the required communication and examination schedule.

It also gives them the leverage needed to insist upon receiving timely information from the treating hospital. Fortunately, the proliferation of health information exchange streamlines communications and makes it relatively easy for HIEs or hospital systems to provide information whenever a patient is admitted, discharged or transferred.

Active 'Push' Communication is Essential to Success

HIEs across the country have access to Admit, Discharge and Transfer (ADT) information from hospitals and the ability to actively push critical event information derived from this data to physicians. The active nature of the information exchange is vitally important in order for primary care physicians, specialists, long-term care providers, care managers and others to be able to receive and act upon the health data in a timely manner. The information can be received in a manner that the physician or practice can act upon either within or outside of the Electronic Health Record system.

Unless the provider was already aware that their patient has been hospitalized, query based solutions are not sufficient. Passive by design, these systems rely upon the provider to initiate the patient record search. Although they can be excellent tools for accessing historical patient data, they are ill-suited for proactively managing the recently hospitalized patient.

HIEs and hospitals provide physicians with the active point of care patient information they need to manage patient health and address potential readmission risk by adding secure messaging to their existing IT infrastructure. Once in place, physicians can receive instantaneous push notifications whenever one of their patients has been hospitalized, discharged or transferred.

Workflow Compatibility is Critical

For a notification system to have a positive impact on patient outcomes, it must be a good fit within the physician's workflow. Since no two physicians work in exactly the same way and information needs often vary by medical specialty, the ability to customize the messaging system is essential for success.

For example, behavioral health providers want instant notification when a patient is admitted so they are able to visit their patient in the hospital. But OBGYNs want notifications when their newly delivered patients are discharged so they can schedule appropriate post-natal care. Geriatric specialists and oncologists need their notifications bundled together in order for both volume and timing of alerts to be manageable within the constraints of their day.

Customization provides a necessary level of control to the physician. The inability to provide

notifications in a manner that complements provider workflow carries the potential risk for overlooked notifications and missed opportunities to provide needed interventions.

Going Beyond ADT Events

Events are not limited to admissions, discharges and transfers. Immediate notifications for abnormal or high priority lab results, changes in patient status and requests for long term care placement are just some examples of events healthcare providers need to learn about in real-time. Delays in notifying the provider can adversely affect patient outcomes or lead to readmission.

Success providing physicians with crucial information about their patients comes from leveraging automated health event notifications via Direct, EMR, mobile health alerts, and other existing data flows in use at the hospitals, HIEs and lab information systems.

Right Patient, Right Provider

One of the most important challenges faced by any notification system is patient attribution – correctly matching the patient to his or her provider. There are multiple approaches to patient attribution:

- **Automated extraction:** Matching patients to providers based on the data embedded in the ADT.
- **Provider-driven:** Healthcare providers use patient rosters to determine what notifications they want to receive for any group of patients.
- **Patient-driven:** Patients use an application to designate healthcare providers as well as emergency contacts who should be notified of any health event.

The most robust systems will use a combination of these methods to achieve the highest level of patient-provider matching accuracy possible within the available data set. Systems that use simpler patient attribution methods inherently carry a greater level of risk that some communications may be delayed or undeliverable due to a poor patient-provider match.

Conclusion

The healthcare industry is continually exploring new avenues to improve patient care in the most cost effective manner possible. Automated event notifications present the ideal opportunity to do both by using the timely delivery of patient information to support the physician's ability to offer critical follow-up services to improve patient care and reduce the likelihood of a costly hospital readmission.

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