# Inland Empire Foundation for Medical Care (IEFMC) / Foundation Accountable Care Network (FACN) ACO optimizes post-discharge workflow and reduces readmissions rate with MX tools

## Background

The Inland Empire Foundation for Medical Care (IEFMC) is one of the most comprehensive preferred provider organization (PPO) networks in Southern California, comprised of more than 2,000 physicians, ancillary providers, and 27 hospitals in Riverside and San Bernardino counties.

Organized by IEFMC, the Foundation Accountable Care Network (FACN)® is a Medicare Shared Savings Program ACO, a voluntary Centers for Medicare & Medicaid (CMS) alternative payment model that encourages groups of doctors, hospitals, and other health care providers to come together and provide coordinated, high-quality care to their Medicare fee-for-service (FFS) beneficiaries. As a Shared Savings Program ACO, FACN is accountable for the quality, cost, and experience of care for their assigned beneficiary population.

FACN ACO's mission is to provide better care for individuals, improve health for populations, and lower per capita growth in expenditures for Medicare FFS beneficiaries. FACN strives to ensure that patients, especially the chronically ill, receive the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. This requires seamless care coordination and timely post-discharge follow-up after a patient is seen at the hospital. Post-discharge follow-up not only improves patient satisfaction but can also reduce total cost of care over time by preventing costly readmissions, ensuring the acute problem prompting the ED visit has not worsened, and optimizing management of chronic disease. According to CMS, nearly one in five Medicare beneficiaries experiences a readmission to the hospital within 30 days, costing the healthcare system more than $26 billion each year. Twenty percent of readmissions are likely to be prevented in patients with three or more chronic conditions, if they are contacted by a provider of care within 14 days of discharge.[2]

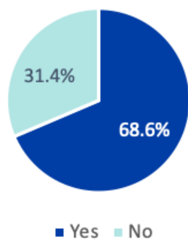
[1] https://innovation.cms.gov/files/fact-sheet/cctp-fact-sheet.pdf
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4369604

## Solution

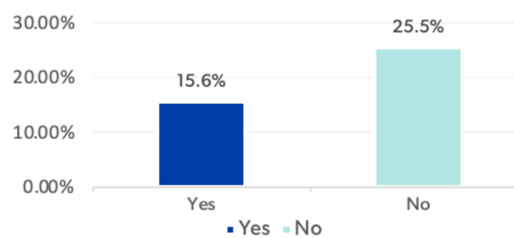
IEFMC's FACN ACO has been a participant of Manifest MedEx (MX) since 2018 and relies on MX's admission, discharge, transfer (ADT) notification services, MX Notify, and MX's longitudinal health records, MX Access, to initiate prompt post-discharge follow-up, coordinate high-quality care, and prevent avoidable readmissions.

FACN's Administration team provides ACO practices with the most current MX Notify alerts – generated when a patient is seen in the ED or is admitted or discharged from the hospital – so they can promptly and efficiently initiate post-discharge follow-up within seven days of hospital discharge. FACN receives on average 190 notifications per month for their patient panel of 9200 patients. FACN reports that seven-day post-discharge follow-up visits are extremely high due to the use of MX Notify. Of a total cohort of 9,200 patients in 2021, 68.6% of patients were evaluated within 7 days of hospital discharge, and 31.4% were not. For those who were not evaluated within 7 days, the readmission rate was 25.5%, in sharp contrast to the readmissions rate for those who were – 15.6%. This data demonstrates a substantial readmissions rate reduction in an ACO utilizing a workflow that includes MX Notify alerts.

7-Day Post-Discharge Follow-Ups




30-Day All Cause Readmission Rates




**39.4%** ↓
reduction in patient readmissions

**3.1%** ↓
reduction in ER visits

**5.3%** ↓
reduction in ER visits leading to hospitalizations

With MX Access, the ACO care coordination team can gain a view of patient histories to determine who needs the most help. MX Access combines clinical and encounter data (e.g., claims) to create a more thorough picture of a patient's healthcare utilization and medical history, including past prescriptions and test results. For example, with MX Access, FACN ACO can identify high ED utilizers with more than four ED encounters in the last six months and target these patients for interventions. The data also identifies patients with multiple chronic conditions and need additional management.

Since joining MX, FACN ACO has seen a 39.4% reduction in patient readmissions post-discharge. The ACO has also seen a 3.1% reduction in ER visits and a 5.3% reduction in ER visits leading to hospitalizations, compared to their outcomes in 2017. Also, per-beneficiary per-year spending has decreased dramatically compared to the previous year, helping patients live healthier lives more affordably. In 2020, FACN saved approximately $9 million under the Shared Savings Program.

**For more information on how ACO providers can use MX tools to improve patient care and reduce readmissions, please visit us at www.manifestmedex.org or contact us at info@manifestmedex.org.**

*"Utilizing alerts from MX, we know exactly when our ACO patients have gone to the ER or been admitted to any hospital in the Inland Empire. Our ACO has seen improved care for patients and reduced healthcare costs. It's time to connect to health data networks. Stop waiting. Physicians and patients need this data to be put to work."*

- Dolores Green, CEO, Inland Empire Foundation Medical Care