THE ROLE OF ADMISSION, DISCHARGE, TRANSFER NOTIFICATIONS IN IMPROVING CARE COORDINATION

How Optum uses ADT notifications to improve Transitions of Care and reduce Emergency Department and inpatient readmissions

Manifest
MEDEX

Background

Optum, formerly NAMM California, is an independent physician association (IPA) that develops and manages provider networks, representing a network of more than 600 primary care providers and 2,000 specialists in Riverside, San Bernardino, and San Diego Counties. Its affiliated groups include PrimeCare, Empire Physician Medical Group, Mercy Physicians Medical Group, Primary Care Associates, Valley Physicians Network, and Riverside Physician Network.

An innovator in healthcare for more than 25 years, Optum offers a full range of services to help physicians and other providers in their managed care and business operations. It is a leading information and technology-enabled health services business dedicated to helping make the health system work better for everyone by modernizing the health system and improving overall population health.

In August 2022, Optum's case management team launched a pilot focused on Transitions of Care (TOC) (see sidebar) to improve post discharge follow-up and reduce 30-Day Emergency Department (ED) bounce backs and inpatient readmissions.

The goal was to increase the outreach rate to high-risk patients while also reducing readmission rates. To achieve this, the care management team wanted to better understand when their patients were being discharged from an inpatient or ED setting as well as what occurred within the medical facility so that the care management team could accurately provide knowledgeable patient education and ensure the patient received the follow-up care needed.

After reviewing their ED utilization, Optum decided to focus the pilot on reducing the rate of utilization by 1% to 2% in ED and inpatient discharges from four facilities in the Inland Empire – San Antonio Regional Hospital, St. Bernardine Hospital, Community Hospital of San Bernardino, and Riverside Community Hospital – by joining Manifest MedEx, California's largest nonprofit health data network. Optum began utilizing MX's real-time admission, discharge, and transfer (ADT) notifications through MX Notify to enable case managers to identify patients who need extra help and support as well as access longitudinal patient medical records through MX Access to understand more about the inpatient stay, including lab results and discharge summaries.

Transitions of Care (TOC)

Transitions of Care ensure health care continuity, avoid preventable outcomes among at-risk populations, and promote the safe and timely transfer of patients from one level of care to another or from one type of setting to another – such as to and from hospitals, ambulatory primary care and specialty care practices, long-term care facilities, home health, and rehabilitation facilities.

Improving the transition of care after hospitalization is critical to positively impact patient outcomes, reducing readmissions, and managing costs.

Hospital readmission shortly after discharge is a marker of inpatient quality of care and a significant contributor to rising health care costs.

https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/measure1.html

Real Time, Actionable Data Drives Results

At each of these facilities, Optum employs one case manager to provide care coordination for Optum patients who enter the hospital and meet the TOC pilot criteria. For this pilot, case managers filtered notifications in MX Notify for alerts from the four pilot hospitals. Once they received the ADT discharge alert, the case manager evaluated which patients they should contact for follow-up. Because there is only one case manager per facility, they applied LACE rules (see right) to identify and prioritize patients who were most at-risk for a readmission based on factors like length-of-stay and acuity.

LACE rules are utilized to predict a patient's likelihood of being readmitted:

- L = Length patient stay in the hospital
- A = Acuity of admission of patient in the hospital
- C = Comorbidity
- E = Emergency visit

If a patient meets LACE criteria, calls were targeted within 48 hours of discharge, and the case management team used the longitudinal patient medical records found in MX Access to understand more about the visit, including chief complaint and any updated diagnoses. With this information, the case managers were able to follow-up with their patient, educate them on their hospital related condition, review discharge instructions, ensure that they were seen by their primary care provider (PCP) and appropriate specialists, and educate them on the location and use of urgent cares. Case managers also verified that durable medical equipment had been delivered, new medications were picked up, and home health had started care, if ordered.

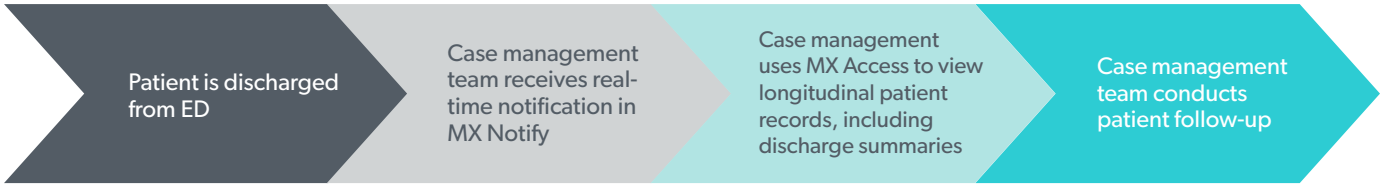
Prior to joining the network, the Optum case management team did not have real-time notifications for most visits making timely outreach after an ED visit and preventing ED bounce backs challenging.

Post-Discharge from ED Workflow Before Using MX Tools

This process leads to a higher risk of ED bounce backs because:

- Not all claims have detailed information of the patient's ED visit
- It may take several days for a claim to be filed and reach the case management team
- ED discharge reports may not be received until several days after ED discharge
- Missing patient information in discharge notes can result in miseducation or missing education from the case management team

Post-Discharge from ED Workflow After Using MX Tools



This process leads to lower ED bounce backs because:

- Real-time ADT notifications reduce the time it may take for the care management team to learn of the discharge
- The case management team may receive detailed discharge notes and chief complaint
- MX Access provides the care management team with detailed patient medical history that informs decision-making and patient education, reducing the likelihood of readmission

The Optum case management team receives daily updates and notifications for inpatient hospital admissions through their Authorizations Portal and attending inpatient rounds. For the pilot, the case management team identified additional data in MX Access, such as notes from providers and discharges summaries, that helped them understand the inpatient stay and improve care coordination.

Successful implementation of pilot leads to opportunities for expansion

With the combination of ADT notifications for ED visits and enhanced clinical data, such as labs and clinical notes, the case management team gains a broader and more detailed understanding of a patient's medical history, aiding in overall care coordination. Optum's utilization of ADT notifications in MX Notify significantly impacted their workflow efficiency and reduced their overall time spent following up with patients discharged from the ED. MX Access has also enhanced the case management team's ability to identify high-risk patients at inpatient medical facilities by providing additional data that may not have been readily available in the past.

Successful implementation of this pilot resulted in prevention of 30-day ED and inpatient readmissions and bounce backs, as well as improved patient satisfaction.

As Optum continues to look towards the future, they are interested in expanding this pilot program to additional facilities and to enhance the data they receive from their participating hospitals to continue to improve transitions of care.

> "From a workflow standpoint, utilizing MX's tools has been very helpful in streamlining our post-discharge follow-up process."
>
> – *Alexis Grigbsy, Manager, Outpatient Case Management Team*

About Manifest MedEx

As the largest nonprofit health data network in California, Manifest MedEx (MX) is an integral part of the state's health data infrastructure, combining and delivering crucial health information for more than 34 million Californians across 126+ hospitals, 13 health plans, and 1800+ providers. Together, we are transforming the healthcare landscape across the state, supporting California as a leader in affordable, proactive, and compassionate medical care.

For more information on how independent physician associations like Optum can integrate MX tools into their workflow to reduce ED and inpatient readmissions, please visit us at manifestmedex.org or contact us at info@manifestmedex.org.

Manifest
MEDEX

www.manifestmedex.org
info@manifestmedex.org

#ManifestMedEx