CarePort powered by WellSky®

Allegheny Health Network

Driving success in transitional care management

About Allegheny Health Network

Location: Western Pennsylvania

Solutions in use: CarePort Connect

Profile:

- Ten hospitals with 2,200+ beds
- 120,000+ annual discharges and observations per year
- 2,500+ physicians employed
- 200+ primary-care and specialty-care practices

Program goals

Beyond increasing transitional care management (TCM) encounters post-discharge, Allegheny Health Network (AHN) program goals include:

- Increased seven-day follow-up visits post-discharge
- Improved medication reconciliation completion post-discharge
- Optimized TCM revenue stream
- CarePort expansion across entire AHN provider base

Allegheny Health Network (AHN), a Highmark Health Company, is an integrated healthcare delivery system serving counties throughout the greater Western Pennsylvania region. The network is comprised of more than 250 clinical locations, including 10 hospitals, a comprehensive research institute, health and wellness pavilions, a Clinically Integrated Network (CIN), a home and community care service line, and a group purchasing organization.

As part of AHN/Physician Partners of Western Pennsylvania's Practice Transformation initiative, the AHN team led by Bill Johnjulio, MD, Medical Director of Physician Partners of Western Pennsylvania and Chairman of the Allegheny Health Network Primary Care Institute, wanted to optimize their transitional care management (TCM) process using CarePort. For AHN, the CarePort platform is a vehicle for improving interoperability and the comprehensiveness of the data that AHN receives. To reduce inefficiencies, improve outcomes, and drive revenue, AHN partnered with CarePort to better track and manage patients across care settings using CarePort Connect.

Obstacles to seamless patient transitions into the community

TCM is a set of services conducted during the patient transition to the community following discharge from the acute or post-acute setting. These services aim to improve patient transitions back into the community,

reduce avoidable emergency department (ED) visits and hospital readmissions, and minimize gaps in care. TCM components include an interactive contact and certain non-face-to-face and face-to-face services. Interactive contact is one TCM component in which the discharging provider must contact the patient or caregiver via telephone, email, or in-person within 48 hours post-discharge in order to set up a face-to-face follow-up visit and bill for TCM services. Interactive contact is one TCM component in which the discharging provider — whether acute care hospitals, inpatient rehabilitation hospitals (IRFs), long-term acute care hospitals (LTACHs), or skilled level of care — must contact the patient or caregiver via telephone, email, or in-person within 48 hours post-discharge in order to set up a face-to-face follow-up visit and bill for TCM services.

AHN handles more than 120,000 discharges and observations per year but lacked comprehensive, interoperable data feeds to efficiently monitor all transitions of care — including discharges from non-AHN acute and post-acute providers. AHN also faced challenges in identifying and contacting patients that qualify for these for post-discharge interactive contact (phone calls) and subsequent face-to-face visits. To improve the timeliness with which practices are notified of completion of care in order to complete the TCM process, and to ultimately optimize patient transitions and reduce readmissions, AHN leveraged the interoperability capabilities and established post-acute network of the CarePort platform — which was already embedded in existing workflows — and implemented CarePort Connect at 119 clinical locations.

CarePort Connect expansion across AHN practices

CarePort Connect has been implemented by 65% of AHN providers and is used by more than 600 active users ranging from office assistants to physicians.

> "The CarePort platform takes away all of the manual detective work in transitional care management. The platform provides us with the contextual information we need, in real-time, to better monitor patient transitions across the continuum of care."
>
> **Bill Johnjulio, MD**
> *Chair, AHN Primary Care Institute and Medical Director, Physician Partners of Western Pennsylvania*

Streamlined TCM visits, increased revenue stream, and improved medication reconciliation

CarePort Connect flags patients discharged — at the time of discharge — from acute and post-acute care that fall within AHN's CIN. Using CarePort Connect, AHN is able to identify those patients to conduct TCM services within 48 hours of discharge and to schedule follow-up office visits seven to 14 days post-discharge.

After implementing CarePort Connect to augment their practice transformation initiative, the AHN Primary Care Institute and Physician Partners of Western Pennsylvania generated improved value-based program performance through increased care coordination, as well as the following results:

- 49% year-over-year increase in TCM encounters
- 44% year over-year-revenue increase
- 10% increase in medication reconciliation compliance post-discharge in one at-risk entity within the CIN

Learn more! Contact a CarePort® representative for more information.

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