CASE STUDY

How Harbor Health Plan Uses PatientPing to Monitor High Utilizers and Reduce Readmissions

PATIENTPING

CONTENTS

BACKGROUND

Harbor Health Plan, headquartered in Detroit, MI, is a Managed Care Organization (MCO) serving members throughout the state of Michigan. Harbor Health Plan was certified as a Clinic Plan in 1996, a Qualified Health Plan in 1998, and a licensed HMO in December 2000. Harbor Health Plan was purchased by Trusted Health Plan in March of 2018, and works to ensure that its members' medical needs are met, recognizing that its providers are key to achieving this goal.

Harbor Health Plan's integrated care management team, which consists of a social worker, community health worker, and a registered nurse, works with members faced with complex medical and behavioral health conditions. The team's core objective is to reduce unnecessary hospital readmissions by connecting these members with the services necessary to ensure stable transitions back into the community.

Prior to implementing PatientPing, the Harbor Health Plan team received a monthly spreadsheet listing their highest-cost members, along with the number of times those members presented to the ED within the 30 day window. The data included was typically anywhere from 60 to 90 days old, which made it difficult for the team to follow up with members.
Harbor Health Plan was looking to implement a solution that provided them with insights into patient events, in real time, from their surrounding hospitals and health systems in order to maximize their care coordination and patient outreach efforts.

Harbor Health Plan implemented PatientPing in January of 2015. Their integrated care management team was onboarded and trained by the PatientPing team and given recommendations on how to integrate the platform into Harbor Health Plan's existing workflows.

PATIENTPING IMPLEMENTATION & WORKFLOWS

Each morning, Harbor Health Plan's social worker runs a report in PatientPing on members who have been admitted to or discharged from an acute care setting within the last 24 hours. The list is disseminated across team members, where the events are then color-coded and assigned to the appropriate person for follow up. Harbor Health Plan's social worker is responsible for all inpatient discharges. The community health worker follows up on all ED discharges and maternity-related events, and the R. N. handles the events relating to complex care members.

The team has two business days to follow up with the patient post-discharge to determine the reason for their admission, as well as to complete a health risk assessment. They then facilitate follow-up appointments with the patient's primary care physician (PCP). For patients without an assigned PCP, the team will help to connect them with one within 24 hours, and schedule an appointment for them within seven days.

By running daily reports through PatientPing, the team is able to monitor patients who frequently present to acute care settings, as well as patients at risk for readmission. In many instances, the team finds that the readmissions are related to mental or behavioral health issues, lack of education on alternate settings where care can be received, a lack of PCP, or socioeconomic factors such as homelessness. The team will educate patients, connect them with medical and behavioral health services, develop care plans, or eliminate any other barriers the patient might have to receiving care, in an effort to avoid further readmissions. Harbor Health Plan also uses PatientPing's search feature, which allows them to monitor any recent acute care events and continue outreach as needed.

PATIENTPING IMPLEMENTATION & WORKFLOWS

Additionally, Harbor Health Plan refreshes PatientPing throughout the day to stay informed of patient events as they occur in real time. Often, the team will quickly intervene by driving to the hospital or facility where the patient is present. The team also uses PatientPing to learn more about the patient's care team. By having the care team contact information, Harbor Health Plan can reach out to them to discuss alternate care plans, prior visit histories, and any additional medical information, ensuring that the patient receives the appropriate care.

HARBOR HEALTH PLAN DAILY WORKFLOWS

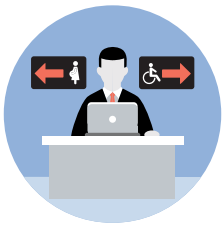
1.

Each morning, the Harbor Health Plan team runs a report in PatientPing on members who have been admitted to or discharged from an acute care settings within the last 24 hours.

2.

The report is divided among the integrated care management team members to review prior to performing outreach.

SOCIAL WORKER
Inpatient Discharges

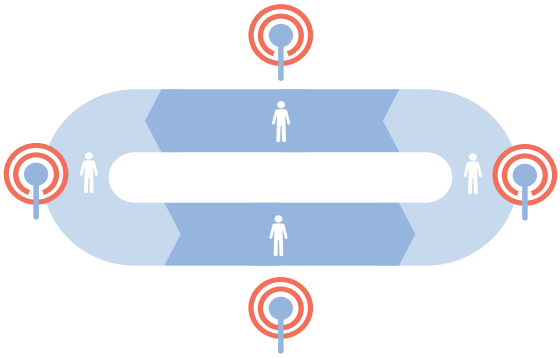


COMMUNITY HEALTH WORKER
ED Discharges & Maternity Related Events

NURSE
Complex Care Members

3.

The team performs outreach to members within 2 days post-discharge and conducts health risk assessments.



A. Reasoning for patient admission is determined. If is is found that the reason is due to mental or socioeconomic factors, the patient is connected with the appropriate medical/ behavioral health services for further treatment.

B. Appointments are facilitated with PCPs within 7 days post-discharge. Patients without PCPs are matched with one within 24 hours.

4.

Patients are monitored within PatientPing to ensure no future unnecessary admissions occur.

REAL-TIME NOTIFICATIONS WORKFLOW

1. PatientPing is refreshed throughout the day so that the team is aware of admissions and discharges in real time. 2. Once a Ping is received, the team reviews the patient's Care Team and Visit History information. 3. Team performs outreach to the patient's care team, or drives to the organization where the patient is present. 4. Team determines appropriate care plans for the patient, and provides ongoing support.

PATIENT SUCCESS STORY

On multiple occasions, Harbor Health Plan has used PatientPing's real-time notifications and patient insights to quickly intervene on patient care events. In one instance, approximately one year ago, the Harbor Health Plan team received a Ping on a high-utilizing patient who had presented to a nearby ED. The team responded by driving to the hospital to speak with the patient. Once there, the team discovered that the patient had stopped receiving dialysis treatments, thus resulting in numerous ED presentations. The team was able to work with the patient to develop an alternative treatment plan to get her back on dialysis. Since the intervention, the patient has not presented to the ED.

In another instance, in late 2016, Harbor Health Plan received several Pings on a patient who had presented to nearby EDs for severe singultus (hiccups). The team discovered that the patient was being admitted for inpatient stays an average of one to two times per week, sometimes for multiple days at a time. After numerous unsuccessful attempts to contact the patient directly, the integrated care management team drove to the ED to speak with the patient in person. The patient did not like to speak on the phone due to his excessive hiccups, which is why the team had not been able to reach him sooner. The condition had landed him back into the ED on several occasions, as the hiccups caused the patient to vomit continuously, resulting in severe dehydration. The patient was experiencing symptoms of depression, and had recently lost his job and housing. Ultimately, the team realized that the patient had not been following up with his PCP, and that the hiccups were a result of psychological, anxiety, and depression disorders.

The team worked with the patient and his PCP to develop a care plan and provided the patient with medical and behavioral health services, which greatly improved his condition. The patient has not presented to the ED since November of 2016.

RESULTS & IMPACT ON BUSINESS METRICS

In just the past six months, Harbor Health Plan has seen a **7%** decrease in recidivism for their high-utilizing patients. They have also been able to flag 15 of their ED "super utilizers" (defined as patients who have presented to the ED two or more times per week), seven of which they have been able to engage to connect them with the appropriate medical or behavioral health services, resulting in a **40%** reduction of ED visits for their high-utilizing members.

Decrease in recidivism for high-utilizing members	Reduction of ED visits for high-utilizing members
⬇ 7%	⬇ 40%