# How Pioneer Valley Accountable Care uses PatientPing to Lower Costs and Improve Care Coordination

PATIENTPING

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# BACKGROUND

Pioneer Valley Accountable Care (PVAC) is an Accountable Care Organization (ACO) located in western Massachusetts serving Medicare fee-for-service beneficiaries throughout the Pioneer Valley. PVAC has a 21-member Board of Managers, consisting of 14 physicians and three health system executives, all of whom are PVAC provider participants, two managed care organization executives, one Medicare fee-for-service beneficiary, and one Consumer Advocate. The Board of Managers oversees PVAC's operations and strategic direction.

PVAC is affiliated with Baycare Health Partners, Inc., a physician-hospital organization that serves the four Baystate Health hospitals and about 175 medical practices with approximately 1,400 physicians. Baycare is an alliance of the medical staff and Baystate Health hospitals, and collaborates in improving the quality, safety, efficiency, and sustainability of healthcare in their community.

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# APPROACH

Prior to implementing PatientPing, PVAC lacked standardized communication protocols with their skilled nursing facility (SNF) partners. While PCPs would sometimes receive discharge packets from SNFs, SNFs within PVAC's network were unable to identify if one of their patients was a part of PVAC's ACO. SNFs worked only from a paper list of PVAC's primary care physicians. They relied exclusively on this list to match patients to PVAC by their attributed PCP, leading to inaccurate PVAC patient identification. This antiquated process made it challenging for PVAC to hold facilities accountable for care quality and instruction adherence for their patients.

In 2015, PVAC partnered with PatientPing, a real-time notification tool, to receive alerts on their patients' events. Once PVAC and their SNF partners implemented PatientPing, all parties could, in real time, identify whenever PVAC patients were admitted and discharged from their SNFs. PatientPing enabled SNFs to accurately recognize whether a patient was attributed to PVAC. Through PatientPing, the facilities also now had information about the patient's primary care physician and, critically, how and when to contact the ACO care manager.  This was a revolutionary, yet surprisingly simple step forward in coordinating care in real time.

Furthermore, the ability for PVAC to standardize discharge communications with their SNFs through PatientPing was critical to improving care quality around transitions. SNFs would now receive standardized discharge instructions for all PVAC patients that specify PVAC's discharge summary requirements and communication protocols. This was an instrumental step forward for the SNFs-ACO partnership, as the SNFs now knew not only how to get in contact with PVAC, but also what to do to maximize care for PVAC's patients.

PVAC is now able to monitor compliance and develop a culture of accountability across its SNF network.  PVAC relies on a care management team to oversee utilization review and care management for their patients in SNFs. This requires SNFs to keep their data up-to-date (meaning patient data must be inputted in PatientPing within 24 hours) so PVAC knows where their patients are seeking care at all times.

Based on the success of their SNF network, PVAC is implementing similar care protocols with their hospitals for inpatient events. Through PatientPing, PVAC also receives notifications when one of their patients is admitted to a hospital, emergency room, or being seen by the VNA. These care teams can then see the personalized care instructions for high- and average-risk PVAC patients and engage in the appropriate communication and transitions in care protocols designed for PVAC patients to safely transition to the next site of care.

# IMPLEMENTATION

When PVAC initially began looking for technology to implement, one of their biggest concerns was ensuring that their post-acute partners' workflows were not disrupted unnecessarily. They felt strongly that technology should fill gaps and be simple to use. PVAC knew how important it was to engage their partners immediately with the new platform, so PVAC spent close to a year engaging with the post-acute providers to better understand how they were using PatientPing and to make sure that it was fully engrained in their workflows.

Below is an example of a high-level workflow using the PatientPing tool:

PVAC receives a notification that one of their patients, Mary Smith, is at Baystate Medical Center. PVAC can see how long Mary's been at BMC and if she is a frequent flier. PVAC can call other facilities to coordinate Mary's care because they have more insight into long-term discussions regarding her care plan. The PVAC inpatient case manager can call the outpatient care manager and let them know, for example, that Mary is going to a preferred SNF and was started on a new anticoagulant medication. Once the patient goes to the SNF and the SNF admissions coordinator enters Mary's information into PatientPing, the SNF can see that she is a PVAC patient. They flag her profile as such, and proceed to follow the care protocol for Mary provided through PatientPing. PVAC's SNF care manager receives notification that Mary is in the SNF and is able to follow Mary's care there. Once Mary is ready for discharge, the SNF can send the standardized SNF discharge packet to the PCP and PVAC care manager.  VNA was arranged for Mary and Mary's PVAC care manager receives notification in PatientPing when the VNA nurse has seen the patient and the VNA nurse can follow PVAC's VNA care protocols.

# RESULTS

Key Outcomes:

- Improved care coordination
- Refinement and engagement of post-acute network
- Delivered appropriate post-acute utilization
- Decreased overall costs

| SNF Average Cost per Case Baseline | SNF Average Cost per Case (2 years later) | % Change |
|---|---|---|
| $13,300 | $10,033 | - 25% |

> *PatientPing was and is an invaluable tool helping us to seamlessly deliver coordinated care at the right place at the right time for our patients. It allows us to connect in real time with partners in our patient's care team that were previously invisible to us because we simply didn't know where our patient had gone. It's a simple but eloquent solution to some of the pitfalls with managing patients across the care continuum.*
>
> *- Dr. Adrianne Seiler, Medical Director of Pioneer Valley ACO*