Transitions of Care
Federal Government Intervention

- **Care Summary sent to the next care provider – Meaningful Use Program**
  - Stage 1 (2011-2013): Perform a test to send to another organization
  - Stage 2 (2014-2016): Send 10% electronic and 50% by any means to another organization
  - Stage 3 (2017-2019): (Proposed) Send **and Receive** Care Summaries into EMR
- **Preventable Readmissions (Within 30 days) for Medicare Patients**
  - Year 1 (2013): Up to 1% penalty for total Medicare reimbursements
  - Year 2 (2014): Up to 2% penalty for total Medicare reimbursements
  - Year 3 (2015): Up to 3% penalty for total Medicare reimbursements
  - 2015 - Indiana average .59%, national average .61%
- **Comprehensive Care for Joint Replacement Program (starts 1/2016 for Medicare)**
  - 75 Metro Areas including Indianapolis, Evansville, South Bend
  - Bundled payment for all providers involved in procedure and follow up care
  - Includes costs 90 days post procedure

Transitions of Care
Indiana's Story

- **Indiana leads the nation in supporting transitions of care.**
  - For 20 years, Indiana HIEs have provided care summaries to the next provider of care – both scheduled and unscheduled transitions.
  - In most states, HIEs did not provide care summaries to the next provider of care until 2014. In 2015, transitions of care support is limited.
  - In 2015, Indiana HIEs will provide over 25 million care summaries for unscheduled transitions and over 1 million scheduled transitions.
  - In 2015, Indiana HIEs will deliver over 200 million clinical results to the providers involved in treating patients.
  - In 2015, over 4,000 physicians will receive clinical results from Indiana HIEs directly into their EMR.

Transitions of Care
Hospital and Physician Office Use Cases

- Within minutes of a patient's registration at a hospital, a care summary from all care received in the HIE network is available to the care team. IHIE generates 2 million care summaries monthly to over 100 Indiana hospitals.
- When a patient has clinical tests and procedures performed in an inpatient or outpatient setting, IHIE delivers the clinical results to the patient's care team (ordering, attending, consulting, etc). IHIE delivers 17 million results monthly to an EMR, a web-based clinical inbox, or a fax within minutes.
- When a patient is discharged from a hospital, the hospital sends a discharge summary to IHIE who delivers the summary to the next provider. Historically, it took hospitals 2-4 weeks to send this to IHIE. Since 2014, care summaries are sent to IHIE at the time of discharge. IHIE delivers 120,000 summaries monthly upon discharge.

Transitions of Care
Long Term Post Acute Care (LTPAC) Use Cases

- When a patient is discharged from a hospital to a long term care facility, a care summary is delivered to the long term care facility. Within minutes of registration, the care team has access to care provided by all healthcare providers in the IHIE network for that patient.
- With the new Medicare bundled payment program for joint replacement procedures, hospitals and LTPAC facilities will coordinate post-procedure care.
- When a nursing home patient is transferred to the hospital, the nursing home monitors patient treatment at the hospital and prepares for the patient's return.

Transitions of Care
Population Health and Payment Reform

- **What is population health and what is the impact?**
  - Improving quality, safety, and efficiency of care for a defined population.
    - Affordable Care Act has led to Accountable Care Organizations, Patient Centered Medical Homes, Bundled Payment Programs and Clinical Integrated Networks
    - Health Plans (including self-insured employers)
  - Payment Reform - Migration from Fee for Service to Value Based (Prevention/Outcomes)

- **New Services from HIEs and other organizations**
  - Notification of Registrations and Discharges
  - Care Management Support
  - Analytics Tools and Services

Transitions of Care
Population Health Use Cases

- When members of a population health program (ACO, health plan, etc.) are registered or discharged, a notification and clinical value report is sent to the population health program to coordinate follow up care. Care Managers can also access members medical histories.
- Administrators of a population health program query the IHIE repository of clinical and claims data about their membership. This helps measure effectiveness of Disease Management programs.
  - **Example 1**: Over the last year, what is the trend of employees with diabetes with an A1C over 9 with no hospital visits?
  - **Example 2**: How many employees have a chronic condition? How many have 2 chronic conditions? 3? 4? Trend this over time.

Gloria Cue: Finish on an upbeat note!

- First thought: Colts beat the Broncos!
- Second thought: For IU and Purdue fans, football season is almost over and basketball is starting!

- Seriously, I am more encouraged about the direction of healthcare now than ever before. Why? Because many CEOs acknowledge that the trend from fee for service to a value based approach is real. As this happens, disruption and innovation will follow. Care will be better coordinated, costs will decrease, and outcomes will improve.