Bamboo Health

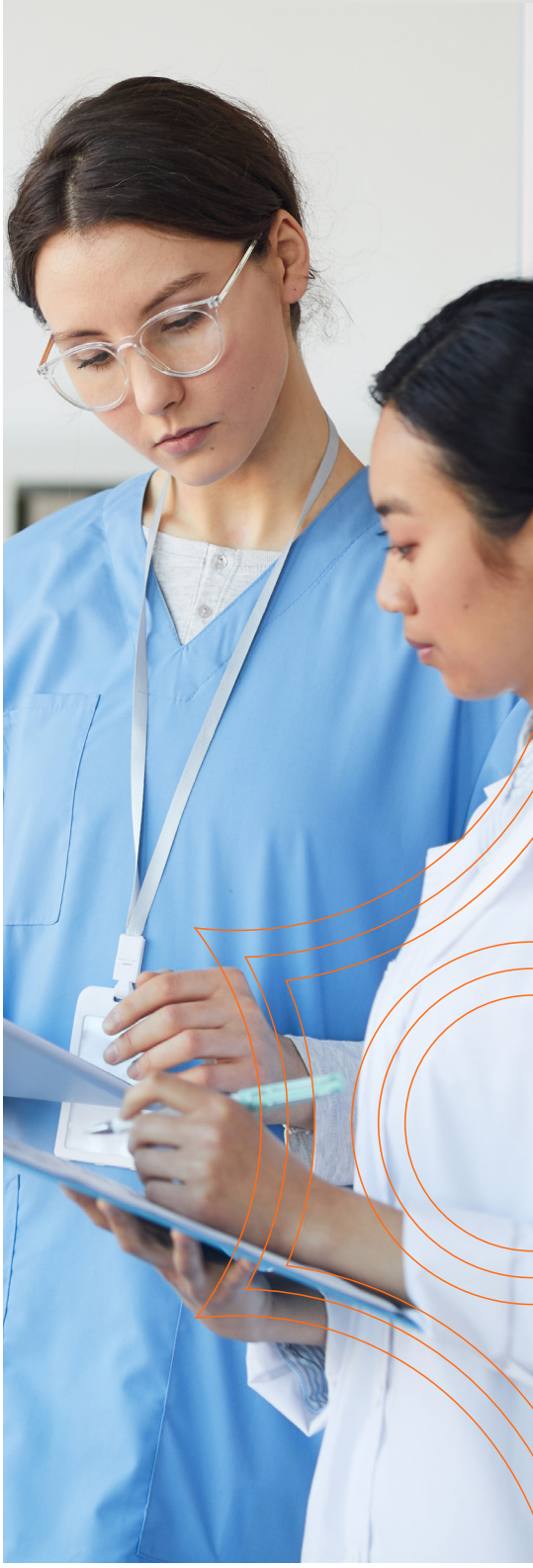
EAGLE PHYSICIANS & ASSOCIATES CASE STUDY

How Eagle Physicians & Associates Uses Pings to Improve Its Transitional Care Management Services

BACKGROUND

Eagle Physicians & Associates is a private, physician-owned and physician-led multispecialty medical group in Greensboro, North Carolina. Eagle Physicians is the largest affiliated provider organization of Triad Healthcare Network (THN) accountable care organization (ACO), consisting of six family practice sites, four specialty sites, one pediatric site, one walk-in clinic, and one endoscopy center. Their core objective is to ensure long-term, consistent health and happiness for the patients they serve.

As trends have shifted toward value-based care, Eagle Physicians began to focus on improving its Transitional Care Management (TCM) services. Prior to refining this process, Eagle Physicians' primary care providers (PCPs) were responsible for all TCM services via standardized documentation. Patients leaving acute care settings often lacked the support services necessary to ensure medication adherence at home and were not always able follow through with discharge instructions and follow-up appointments.



Eagle Physicians partnered with two payer organizations to manage patients covered under certain plans, created a Transitions of Care Team to work directly with the payer teams, and developed a Centralized Quality Team to manage care transitions.

Under this workflow, the team distributed a daily report on patient admissions and discharges from its hospital system to all Eagle Physicians practices. The report was specific only to the hospital system, meaning that the Centralized Quality Team had to run additional internal reports to accurately identify Eagle Physicians' patients. Eagle Physicians would follow up with patients within 7 to 14 days, depending on the patient's acuity level.

Because the data provided by the hospital system was delayed and sometimes inaccurate, the team ineffectively monitored patient events, resulting in missed opportunities to facilitate patient follow-up appointments, reconcile medications, and follow through on discharge plans. Eagle Physicians implemented an additional database in hopes of obtaining more streamlined patient data; however, the system still required data manipulation to gain relevant insights and did not monitor skilled nursing facility (SNF) patients. The team also had to create weekly reminders within their electronic health record (EHR) to call SNFs to monitor patient status.

Since the process was ineffective and time-consuming, Eagle Physicians looked for a solution that would allow them to monitor patients' care transitions real-time and facilitate timely follow-ups.

Pings Implementation

Eagle Physicians' affiliated ACO, THN, began using Pings to effectively monitor and manage their patients' care events. Eagle Physicians soon saw the value that Pings provided to THN and implemented the platform to improve care across the entire Eagle Physicians network.

They began implementation with six of their primary care sites, as well as their pediatric site. Over the following weeks, the Bamboo Health team and the Centralized Quality Team facilitated in-person onboarding meetings with each Eagle Physicians site and team, which included practice administrators, clinical supervisors, front administrative supervisors, and one pod member identified as a Pings "super user." During these meetings, Bamboo Health provided each site with a demo to review the platform, as well as an overview of customized best practices and workflow recommendations.

Workflows

Currently, Eagle Physicians' workflows for its hospitals are as follows:

1. At the beginning of each day, the Centralized Quality Team's lead patient care advocate **signs into Pings and views all patients who have been admitted to or discharged from a surrounding hospital within the last 24 hours.**

2. The patient care advocate then uses **the Pings solution's export feature to pull a report on these care events.** The report includes patient demographic information (age, sex, address, phone number, etc.), primary care provider/care team information, admission diagnosis, event location, and date of event.

3. **Care events are then divided among team members based on patient location.** From here, patients are prioritized based on their level of complexity, with highly complex patients receiving the first outreach.

4. The Centralized Quality Team then **calls recently-discharged patients and schedules appointments with their respective PCPs within 7 to 14 days.** They also ensure that any other necessary appointments with specialists or home health services are in place. The Centralized Quality Team also uses this outreach to perform a complete medication reconciliation, troubleshoot any potential acute care events by answering questions or concerns, and facilitate appointments with patients' PCPs sooner if needed.

Eagle Physicians rolled out a similar transitions of care process for its SNF patients. By being able to easily identify which patients are admitted to or discharged from SNFs through Pings, the Centralized Quality Team ensures that patients' needs are met immediately following the care event, avoiding potential unnecessary acute care readmissions.

This outreach increases follow-up visits, improves overall TCM services and bolsters patient satisfaction.

Eagle Physicians' Centralized Quality Team also monitors the Pings Platform throughout the day to view real-time events. The team can receive text and email notifications on new events and view them within the web application to ensure timely intervention and safer patient transitions.

The Centralized Quality Team, having only been using the platform for three months, is continually exploring the use of new features, such as the "High Utilizer" flag, which flags patients with three or more ED presentations in the last 60 days, as well as the Pings "Readmission Risk" flag, which flags patients with an inpatient discharge within the last 30 days. The team also hopes to start using the Pings solution's data to monitor specific patient segments based on diagnoses; specifically, their chronic obstructive pulmonary disease (COPD) patients.

Patient Success Story

In one instance, the Centralized Quality Team received a call on a patient who had been discharged from a SNF. With limited information on the patient's care event, the Centralized Quality Team searched for the patient within Pings, and determined that the patient's PCP was within the Eagle Physicians network. The team called the PCP's office, and discovered they had not been able to facilitate an office visit due to several failed attempts to get ahold of the patient or her family.

The Centralized Quality Team noted a unique phone number listed within Pings under the patient's demographic information. Upon calling the new number, the team was able to reach the patient, and learned that she had moved to live with a family member, obtained a new PCP, and had sustained a C5 fracture. The team was able to gather the patient's new information, while also providing support for the patient's family members regarding where the patient could receive care.

By accessing Pings, the Centralized Quality Team was not only able to get in touch of the patient after numerous failed attempts, but was also able to determine discharge information and update the patient's information—all of which are important for quality metric reporting and for the appropriate flow of patient records. Additionally, the team was able to provide support to the patient and her family and educate them on alternative settings where the patient could receive care for her injury.

Results & Impact on Business Metrics

Since implementing Pings, Eagle Physicians' Centralized Quality Team has **contacted 67% more patients for SNF transitions of care follow-ups.**

Eagle Physicians has also experienced a **25% increase in the number of TCM visits** that were billed for their THN patients.

INCREASE IN SNF TRANSITIONS OF CARE FOLLOW-UPS	INCREASE IN TCM VISITS BILLED FOR THN PATIENTS
⬆ 67%	⬆ 25%

About Bamboo Health

Bamboo Health (formerly known as Appriss Health + PatientPing) is a healthcare technology solutions company, focused on fostering care collaboration and providing information and actionable insights across the entire continuum of care. As one of the largest, most diverse care collaboration networks in the country, our technology solutions equip healthcare providers and payers with software, information, and insights to facilitate whole person care across the physical and behavioral health spectrums. **By serving 2,500 hospitals, 8,000 post-acute facilities, 25,000 pharmacies, 32 health plans, 45 state governments, and over one million acute and ambulatory providers through more than 500 clinical information systems electronically, we impact over 1 billion patient encounters annually in provider workflow.** Health systems, payers, providers, pharmacies, governments, individuals, and other organizations rely on Bamboo Health to improve care and reduce cost.

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