CASE STUDY

Collective Medical Helps Providers Better Coordinate Transitions of Care

The Portland Clinic was able to **increase revenue by 30%** by increasing transitional care management coding rates by 33%.

"We came up with some really great workflows using the Collective platform and other resources. Combined with our meetings, these workflows really set the stage for breaking down silos, creating tight relationships between care team members in the community, and establishing templates for treating patients with high utilization patterns."

- Jill Leake
Population Health Manager at The Portland Clinic

The Portland Clinic

The Portland Clinic has six locations scattered throughout the Portland metropolitan area—including primary care, multispecialty, and two ambulatory surgery centers. As the clinic began to participate in more value-based payer arrangements, leaders looked for a better way to transition patients from hospital to clinic—preventing unnecessary ED readmissions and optimizing patient care.

Pioneering Transitions of Care with Primary Care Providers

Many healthcare organizations look for ways to break down silos and improve coordination with others in the community. Looking for a tool to help facilitate coordination, The Portland Clinic chose to implement the Collective platform for transitions of care (TOC).

Originally, TOC calls could only be made on patients for whom the clinic received discharge notifcations. With notifications coming through inconsistently—and from a variety of sources—leadership looked for one, comprehensive way to receive electronic notifications on their entire population.

The Portland Clinic collaborated with Collective Medical, a healthcare information sharing network, to begin connecting primary care clinics with hospitals in real time of their patients being admitted to and discharged from the hospital. The system works using an ADT-based healthcare technology network, which sends notifications between providers on the network—alerting them when patients are admitted to the ED, an inpatient unit, or discharged from the hospital. This enabled primary care staff to consistently reach out and schedule follow-up appointments with patients who had been recently discharged from the hospital and get their patients the care they needed.

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Combining Efforts for Better Results

The Portland Clinic also partnered with other clinics and care providers to pilot a community collaborative group. This group, comprised of members from the Portland Care Coordination Association (PCCA) as well as partnering hospitals and health plans, set out to align healthcare workflows across Portland using the Collective platform.

During the pilot, the group met every two weeks to review incidents and insights and collaborate on solutions to solve key issues. With the Collective platform there to bridge communication, the PCCA formed important connections for reducing high ED utilization and avoiding duplicative care. Jill Leake, population healthcare manager at The Portland Clinic and PCCA member explains:

"What was really great about this is that we all got to know each other better. Now, when we have questions or ideas regarding patients with high risk, I know who to contact, their processes and barriers, and how best to coordinate with them when I need to."

Clinic Outcomes

The switch to using Collective to initiate patient follow-up—combined with the PPCA community collaborative—proved to be highly effective. For example:

One heath plan saw a *5.1% drop in 30-day readmissions from 2015-2018*

The Portland Clinic saw a *13% reduction in ED visits* after TOC plan implementation for pilot patients with regularly-high utilization patterns

After nine months of the PCCA community collaborative pilot, the visible success meant that much of the organization's workflows were adoped by clinics in the area, and Jill and The Portland Clinic hope to expand the community collaborative work to include even more Portland area organizations. She states:

Saving Big with Transitional Care Management Coding

Using the Collective platform, The Portland Clinic was able to significantly overhaul their Transitional Care Management (TCM) workflows.

Before partnering with Collective, clinic staff had to search through faxes, emails, and voicemails to determine which patients had been admitted to the hospital and needed follow-up. With the Platform, clinic staff is now automatically notified when a patient is discharged from the hospital and in need of follow-up. Within days, a clinic triage nurse reaches out directly to schedule the follow-up visit, and providers are notified to include a TCM code.

Using Collective's annualized data, The Portland Clinic was able to **increase TCM coding rates 33%—resulting in a 30% increase in revenue.**

Overall, this meant more reimbursements, and more savings, for the clinic.

"Even though our pilot ended, the relationships continue. We still have shared cohorts and monthly phone calls... it has just bolstered and strengthened our relationships so we understand each other better and know how to work together better—inside the Platform and out."

About Collective Medical

Collective Medical provides the nation's largest and most effective ADT-based network for care collaboration. Our risk-adjusted event notification and care collaboration platform spans across all points of care—including hospitals, payers, behavioral and physical ambulatory, and post-acute settings.