Carelogics by Integrated

Case Study

Improving Quality of Life and Reducing Unnecessary Utilization Through Advanced COPD Transitional Care

PROVIDER:

Integrated Respiratory Solutions

For over 25 years, Integrated Respiratory Solutions has been offering professional clinical services to keep patients healthy at home. They have stayed focused on their key commitment of uncompromised patient care and top-level clinical support.

CHALLENGE:

Finding Benefits for All Involved in the Changing Healthcare Landscape

All sectors of healthcare today are faced with challenges. Hospitals, health systems and insurance providers are searching for ways to better utilize valuable resources and lower both hospital readmissions, length of stay, and unnecessary utilization. It's no secret that transitional care has always been a challenge, and most times a missing element to discharged patients. Steve Masters, President of Integrated, has positioned the company to help both providers and patients in this challenging time.

Astutely seeing the evolution of healthcare toward a value driven model away from the fee for service landscape of the past, Integrated has sharpened its focus on patient care services and programs to keep patients healthy at home. Integrated has recently partnered with Cigna Health and Community Healthcare System to focus on managing the chronic and complex COPD population. We will provide specialty care with the goals of improving the quality of life for their patients while also reducing hospital readmissions and shortening length of stay to lower the cost associated with re-hospitalizations.

SOLUTION:

Integrated's Carelogics Disease Management Program Utilizes Specialty Care Coordination Platform to Manage and Oversee Specialty COPD Population

Integrated's protocols have been used to clinically manage and oversee the COPD disease management program called – Carelogics. Carelogics algorithm includes:

- Informatics analysis
- Patient population identification
- Disease specific risk stratification
- RT Led care plan implementation and management
- Outcomes and measures reporting focused around clinical care and utilization

They worked in collaboration with the hospital medical director and clinical implementation team to closely develop this specialty COPD program.

Integrated's clinical team of respiratory therapists, nurses, and patient care advocates identify patients that are High-Risk and At-Risk by looking at past medical history and examining a variety of key disease factors such as exacerbation history, hospitalizations, CAT, activity level, medication complexities, and current length of stay, etc. to stratify the patients into their specific risk level category. High-Risk, At-Risk and Low Risk patients are assigned to the appropriate 30 day follow up program that will encompass home RT visits, follow up telephone outreach calls, and telehealth devices used to monitor and measure patient health status. The most important key to the program is to identify the High-Risk and At-Risk patients most probable to have an event in the COPD population and designate them for Carelogics specialty care program.

Building the relationship between the patient and the Integrated care team is the key to the success of the program. Through the process of patient coaching and encouragement, education and oversight, the Respiratory Therapist and/or clinical team member helps empower the patient to self-manage their disease process. Carelogics is structured around 5 main pillars that focus on:

1. Overseeing, monitoring, and managing breathing activity
2. Self-management skills
3. Medication management
4. Patient education
5. Best practice management.

Integrated has compiled program data and aggregate results to report these outcomes on a regular basis in an easily understandable format. The Patient Management Program allows hospitals and providers to feel confident turning their patients over to Integrated after discharge. This program will expand to include multiple co-morbidities that frequently plague this population.

RESULTS:

Successful Outcomes and Improved Patient Well-being and Satisfaction

The program achieved significant reductions in readmission rates for both this program and within the hospital COPD population, in general.

- Approximately 33% of COPD populations were determined to be High-Risk or At-Risk – In the Community Health System example this population was approximately 600 out of 1800 patients over a 12-month period.
- Readmission rates for the risk populations identified in this program were reduced from 17% to 7.7%; a reduction of 54% over a 6 month time period.
- Readmission rates for the total COPD population of Community Health System were reduced from 25% to 15%; a reduction of 40% over a 6 month time period.

Additionally, patients reported an overall improvement in their well being and were highly satisfied with the program. A well being score between 6 and 10 was reported 77.2% of the time over the past 6 months. Since the inception of the program, patients report a satisfaction score 8.95 out of 10.

Staying focused on their key commitment to top level patient care has benefited everyone involved.