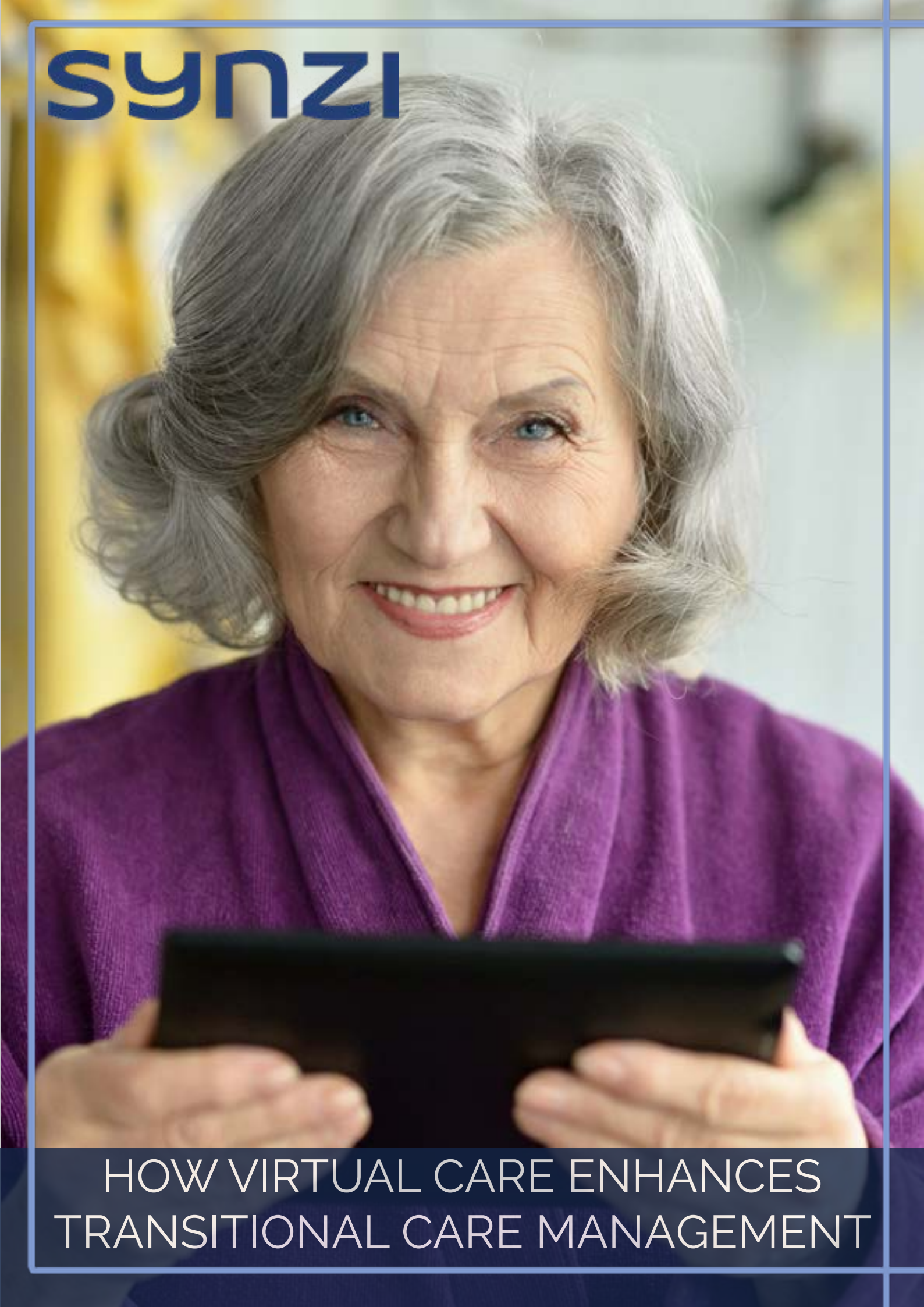


HOW VIRTUAL CARE ENHANCES TRANSITIONAL CARE MANAGEMENT

OVERVIEW OF TRANSITIONAL CARE MANAGEMENT

Transitional care management (TCM) includes services provided to a patient with medical and/or psychosocial problems requiring moderate or high-complexity medical decision making. TCM provides an essential pathway for patients who are high utilizers and those with the highest risk for readmission by bridging the post-hospital discharge gap with personalized clinical coordination across the care continuum. The transition of care includes a discharge from acute and skilled care settings such as an inpatient acute care hospital, an inpatient psychiatric hospital, an LTC hospital, a SNF, an inpatient rehabilitation facility, a hospital outpatient observation or partial hospitalization, and a partial hospitalization at a community mental health center.

Role of Transitional Care Management

Unfortunately, high risk (and rising-risk) patients may find returning home post-discharge to be overwhelming and these patients may be at-risk for rehospitalization. TCM services help patients transition from inpatient care to the community setting by bridging the gap with extra support to help patients:

- Adjust to their new medication and treatment routine
- Address barriers to adherence and self-care
- Acclimate to any change in their functional status

The objective is to support the patient's needs while minimizing deterioration and reducing potentially preventable medical errors and rehospitalizations during the initial 30 days following discharge from an acute or skilled stay. The initial few days and few weeks are critical to reducing high-cost utilization of EDs and hospitals.

Transitional care encompasses a broad range of services and environments designed to promote the safe and timely passage of patients between levels of health care, across care settings, and amongst various providers.

A well-executed transition of care is essential to delivering the best patient-centered care throughout the care continuum. Each turning point should include the communication of a comprehensive care plan that ensures continuity and coordination of care. However, during the transfer of care, care delivery may become fragmented and disjointed. The National Transitions of Care Coalition (NTOCC) evaluated current practices and identified the following problems as main catalysts to the ineffectiveness of transition of care:

- Breakdown in communication amongst all the providers of the patient's broader care team
- Insufficient understanding about a patient's ability to adhere to the treatment and plan
- Lack of procedures and processes for managing the transition at each turning point

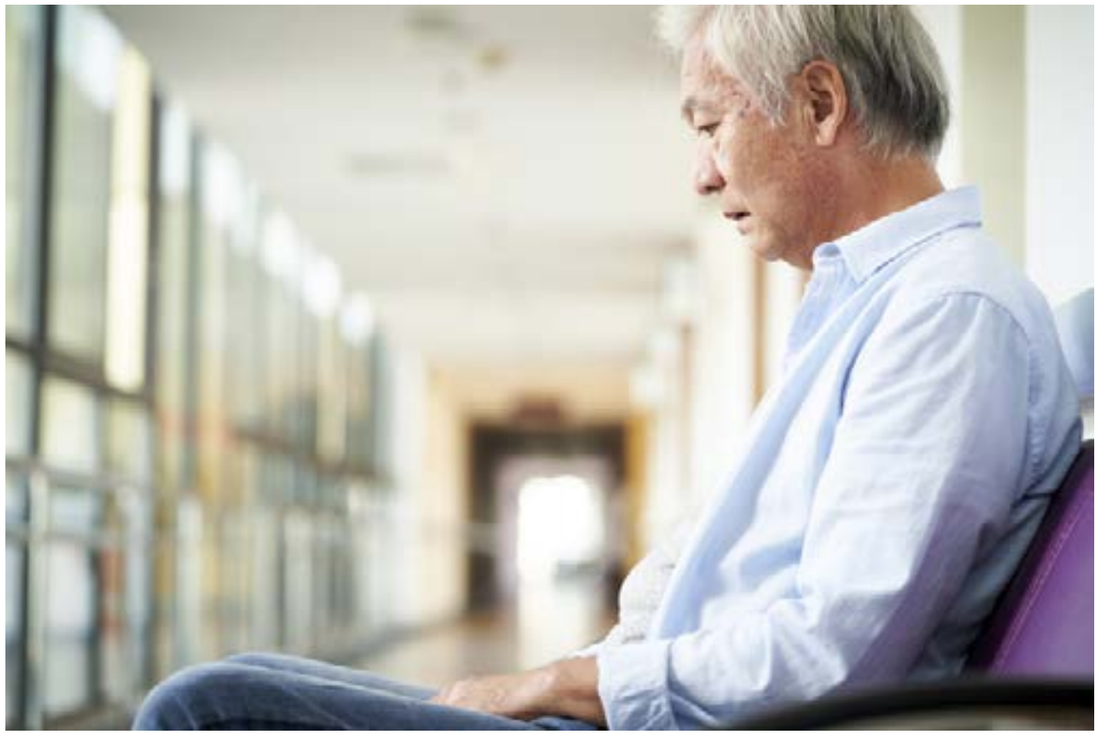
These problems can lead to adverse events, low satisfaction, and high readmission rates. Failures of care coordination is estimated to cost $27.2 billion to $78.2 billion annually, according to JAMA.

COMMUNICATION BREAKDOWN

The Joint Commission Center for Transforming Healthcare estimated that 80% of serious medical errors involve miscommunication during the hand-off between medical providers. Providers do not always effectively or completely communicate important information between themselves, to the patient, or to the patient's family members or personal caregivers. Whether verbal, recorded, or written, the communication methods utilized are not suitable for ensuring a smooth transition. The Center's hand-off communication project highlighted several risk factors relating to communication:

- Expectations differ between senders and receivers of patients in transition
- Culture does not promote successful hand-off (e.g., lack of teamwork and respect)
- Hand-off procedure does not require accountability and follow-through
- Not enough time was available for the hand-off at the transition point
- Standardized procedures for conducting a successful hand-off are lacking

When several providers and/or care settings are involved, errors can easily multiply if there is not a thorough transition plan developed and discussed before, during, and after the turning point. When an error occurs, the various providers (and the patient) may not know who best to contact in order to resolve the issue in a timely manner.



Insufficient Understanding about the Patient

If a proper risk assessment is not conducted prior to planning the transfer or discharge, the forthcoming transition of care is already at risk for failing. It is necessary to understand a few salient points about the patient's individual situation such as:

- What is the number, frequency/timing, and reasons for prior readmissions?
- What is the number. frequency/timing, and reasons for prior trips to the ED?
- What is the level of health literacy and proficiency with the English language?
- How does the patient currently practice self-care (e.g., medications taken, diet adjustments, exercise/lifestyle modifications, etc.) on a daily basis?
- Will the patient be able to adhere to the forthcoming treatment plan?
- Will the patient be able to secure reliable transportation to follow-up appointments?

When providers disregard the patient's respective realities when setting up the transfer of care, the resulting transition may be inadequate or inappropriate for the patient's actual situation. If a family member or personal caregiver is not included in the transitional care planning, critical insight into the patient may be overlooked as the patient might not fully communicate the expectations identified for each transition point.

LACK OF PROCEDURES AND PROCESSES

The Center noted that the consequences of substandard hand-offs may include delay in treatment, inappropriate treatment, adverse events, omission of care, increased hospital length of stay, avoidable readmissions, increased costs, inefficiency from rework, and other minor or major patient harm.

Without a clearly defined and communicated hand-off plan, each provider might not be aware of one's respective role in the transition of care at that particular transfer point. Also, each provider might not have a solid understanding of the broader next steps and the impact of not following the agreed-upon procedures and process at each turn.

Intra- and inter-hospital patient transfers are necessary to provide the patient with the appropriate care due to the stage in one's condition. Transitions may unfortunately fail patients due to the staff's immediate focus on planning for discharge vs. setting the stage for the continuation of care. Drawbacks may include:

- Managing the transition may be a low level priority for providers and relegated to the least-experienced team member.
- Last-minute tests/consultations can delay the plan and the medication list.
- Patients (and their caregivers) may feel rushed thru a "checkout" process vs. being adequately prepared for how care will be provided – whether at a different setting or upon return home.
- The transition itself might be too closely tied to a point in time if it fails to include periodic assessments of the patient's evolving condition during and after the transition point.

The main aim of all such transfers is maintaining the continuity of care without creating additional stress for the patient and putting the patient at risk for infection or other adverse events. There is not always clear ownership of the transition and the burden of ownership may be placed onto the patient if the patient is leaving the facility – regardless of the patient being prepared to schedule and arrange the transfer, schedule and follow-up appointments, or maintain the treatment plan.

Before the patient has left any care setting, a plan for the patient to access convenient follow-up care needs to be in place to ensure that the patient remains supported, even when the patient is being transferred to another facility. Ongoing check-ins are especially needed in the first 30 days post-discharge in order to minimize the risk of costly and unnecessary readmissions.

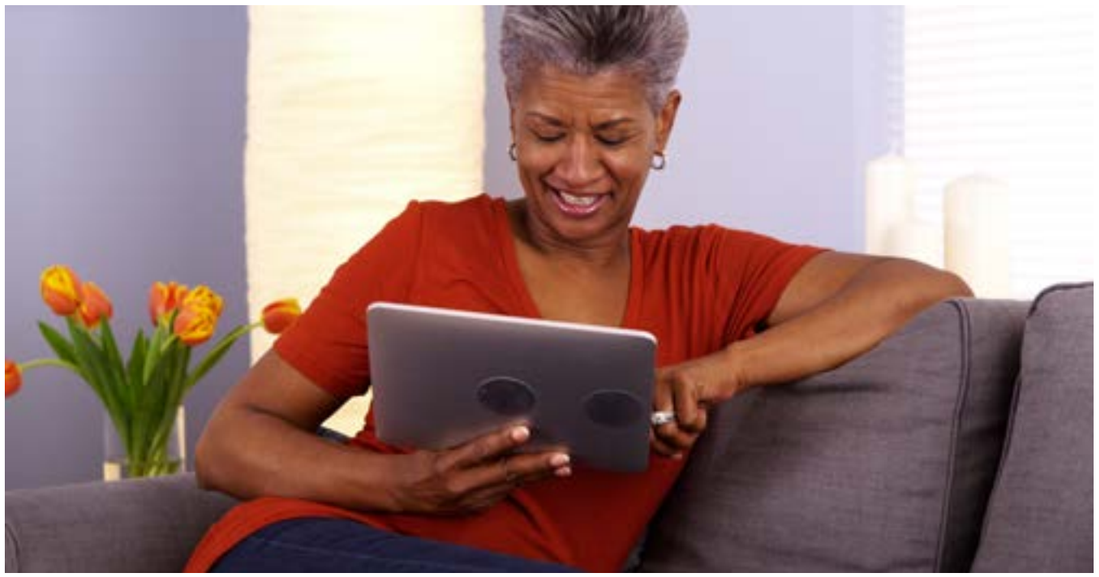
A focused TCM plan will help minimize errors and omissions, improve the experience for the sending and the receiving providers, and ensure that the patient's care, safety and overall experience remains core to everyone's subsequent actions.

HOW VIRTUAL CARE MAKES A TCM PROGRAM HIGH TOUCH AND HIGH TECH

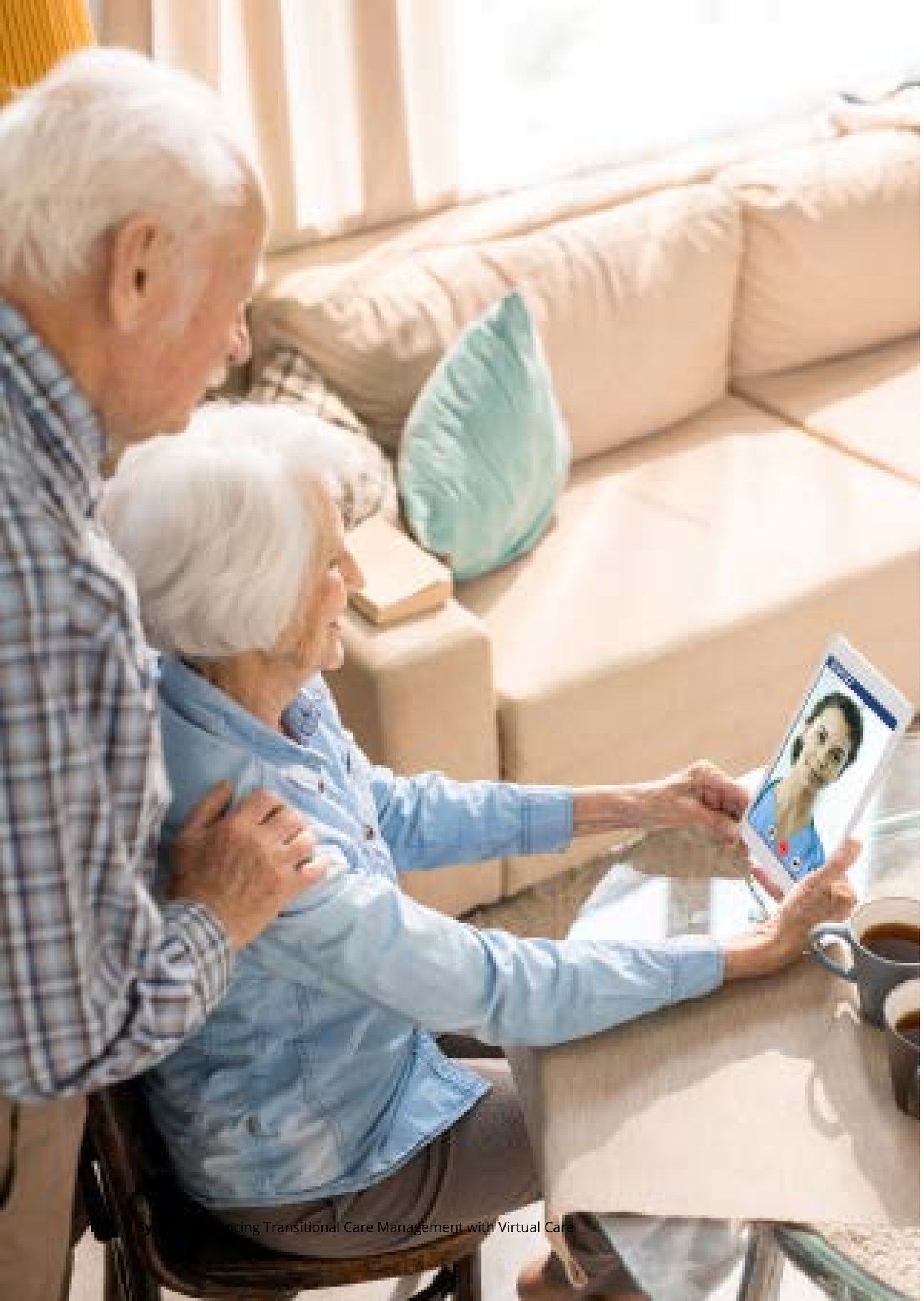
Traditional TCM programs may prove ineffective in engaging at-risk and rising-risk patients the critical 30 day period post-discharge. TCM succeeds when a provider can efficiently and effectively coordinate and champion support for all medical conditions, psychosocial needs and ADL requirements.

Virtual care enables post-acute care organizations to streamline communications between the care setting, the primary care physician (or other specialists), additional services (such as DME and home infusion) and the patient – while helping the patient safely transition to care at home. Synzi's HIPAA-compliant virtual care platform helps clinicians:

- ***Conduct a face-to-face virtual visit prior to the patient's discharge from the acute care setting.*** This initial call can set expectations with the patient. Remote family members and a medically certified interpreter can be included in the video call to drive understanding and alignment on next steps. Discharge information can be reviewed along with the need for and/or follow up on pending tests or treatments. Initial education can be provided to patient and family caregivers to help support the patient's role in self-care and return to ADL.



- ***Check-in with a patient over video to assess the patient's condition and answer questions in real-time.*** Medication reconciliation and management can be conducted during these virtual visits with the prescribing physician and pharmacist included in the call. Additional members of the broader care team can review the need for any follow-up diagnostic tests or treatment and also discuss referrals and community resources needed for the patient's regaining activities of daily living.
- ***Schedule and send a cadence of ongoing messages to help promote patient understanding of one's condition(s) and the importance of medication adherence.*** The messaging can be tailored to reflect the patient's multiple conditions and translated into the patient's primary or preferred language.
- ***Conduct assessments in between in-person and video visits to gauge the patient's health.*** Clinicians can gain insight into the patient's progress in between visits and explore if the plan of care may need to be changed or if the patient's change in condition necessitates a more immediate intervention.
- ***Monitor and manage the patient on key vital sign with remote patient monitoring technology.*** With RPM, post-acute care organizations can leverage patients' everyday devices (such as smartphones, tablets, and PCs) while easily and securely obtaining patient data on key measures. Patients can easily share vital signs from their smartphone, tablet, or PC and Bluetooth-enabled devices. The solution monitors a wide range of health data such as weight, blood pressure, blood sugar, blood oxygen levels, heart rate, etc. The platform provides real time patient health data directly to an organization's dashboard and triggers alerts when patient data is out of normal range, helping teams (and referral partners) better monitor patients' condition(s) and identify compliant and non-compliant patients.



IMPACT OF VIRTUAL CARE

Multi-channel communications and increased touchpoints have resulted in better outcomes for the high-risk and rising-risk patient populations:

- Patients are more likely to stay in a virtual TCM programs.
- No-show's for scheduled visits and virtual visits have decreased.
- Adherence to medicine and treatment plans have increased.

Patients are better managed from a frequency and personalized perspective, leading to better clinical outcomes for the patient and better financial outcomes for payors, referral sources, and home health providers.

These virtual interactions are even more critical amid the COVID-19 pandemic as patients (and their family caregivers) may be restricting in-person visits for fear of infection and/or transmission. In a recent Harvard Medical School blog, Lee H. Schwamm, MD, shared that ***"telehealth, the virtual care platforms that allow health care professionals and patients to meet by phone or video chat, seems tailor-made for this moment in time… The current crisis makes virtual care solutions like telehealth an indispensable tool."*** He believes that the role of telehealth is vital to our country as ***"it can help flatten the curve of infections and help us to deploy medical staff and lifesaving equipment wisely."***

With Synzi, TCM organizations are able to keep patients at-home and on track with their treatment while protecting patients, staff and limited PPE supplies.

Importance of Engaging The Patient & The Family Caregiver

Remote family members and personal caregivers can also participate in the video calls so all involved are both aware of and aligned with the various roles and next steps in the upcoming transition. A comprehensive transition program which engages patients and their respective family caregivers can help reduce readmissions.

- Engaged patients are less likely to be readmitted. In a pilot with >350 chronic heart failure patients, a Philadelphia hospital was able to reduce its 30-day readmissions by 10% by using email and text message reminders with patients for follow-up appointments.
- Including patients' caregivers into the discharge process can minimize hospital re-admittance. In a study published in the Journal of the American Geriatrics Society, integrating caregivers during discharge planning resulted in a 25% reduction in the risk of elderly patients being readmitted to the hospital within 90 days of discharge and a 24% reduction in the risk of readmission within 180 days.

VIRTUAL CARE & THE TRIPLE AND QUADRUPLE AIMS OF HEALTHCARE

Providers can use virtual care technology to better communicate and manage the process of transitional care as patients move between levels of health care, across care settings, and amongst providers.

TCM is also gaining traction as a driver of the Triple Aim of healthcare. As Marc Price, D.O. shared with AAFP, ***"We noted a decrease in our hospital readmission rate, a small increase in Medicare payment, improved communications with outside organizations and greater patient satisfaction. I also found an unexpected benefit -- an improvement in my staff's job satisfaction. They felt more proactive in caring for our patients. They took ownership and pride in providing care to our patients as part of a team. Not only did they become endeared to our patients, but the patients became endeared to them, too."***

Given the immediacy and impact of virtual care, it is not surprising that the combination of TCM and virtual care can drive greater staff satisfaction, retention, and engagement – thus, helping a healthcare organization achieve the Quadruple Aim of healthcare.

With the increase in the aging population, these challenges will only multiply. Now is the time to use virtual care to enhance TCM in order to deliver the best patient-centered care.

> "Synzi helps optimize the post-discharge experience for high-risk and rising-risk patients by enabling a seamless and successful journey from inpatient to outpatient. Using a combination of touchpoints, our virtual care platform helps post-acute care organizations increase satisfaction and outcomes for patients while actively reducing the number, length, and related costs/penalties of hospital stays," Lee Horner, CEO, Synzi

Technology is advancing, impacting the way we live and presenting new opportunities to improve the delivery of healthcare. Synzi leverages these innovations every day, developing state-of-the-art solutions that make it possible for healthcare professionals to do what they do, only better. We enable better performance for healthcare organizations, better access for patients, and better outcomes for all. Our goal is to continuously improve our platform and future-proof offerings that simplify complexity and inspire positive change among healthcare professionals and in the lives of patients.