WHITEPAPER

The Benefits of Care Collaboration for Health Plans

As the use of value-based care models continues to expand, health plans must find solutions that drive positive health outcomes for patients as well as positive financial outcomes for both providers and payers. By taking advantage of care coordination technology, health plans can gain indispensable visibility into members' movement across the care continuum and intervene in real time to provide additional resources and support.

The visibility interoperability provides allows health plans to identify at-risk members, redirecting their care towards in-network and lower-acuity care settings—saving on the total cost of care. Bidirectional communication between health plans and providers can improve care management efforts for the most vulnerable members.

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Identify Members in Real-Time

Claims are a relatively consistent and structured data source, providing a comprehensive longitudinal record for members. While robust claims data allows health plans to create stratification and risk scores, it lacks the timeliness needed to proactively help members as it can take weeks (or longer) for claims to be received and processed. Real-time information based on admission, discharge, and transfer (ADT) data from emergency department visits, inpatient stays, or Continuity of Care Documents (CCDs) can help complement the data provided from claims, allowing case managers to quickly and efficiently identify members in need of help. The real-time visibility and contact can even help increase member engagement.

Gaining Visibility at the Point Of Care

For a health plan in the Northeast, a lack of real-time information was creating a bottleneck in patient care management. Staff often wouldn't know about a member's acute encounter or other care event until the claims information came days or weeks later.

By implementing real-time, ADT-based notifications, staff was able to know when a member was in the emergency department or hospital and use this information to identify patients and alert case managers for follow up. In doing so, case managers ensured that members received more affordable in-network care and gained access to free resources.

In one incident, a case manager was able to talk with a member who had traditionally been uninterested in working with health plan staff. Because he was contacted the same day as his ED visit, he was more open to working with the case manager and receiving follow-up care. Communication at the point of care made a difference in the quality of care this member was able and willing to receive.

Boosting Member Engagement

For Aspire Health Alliance in Massachusetts, real-time information has led to real-time communications with patients. Reaching out to patients in the moment they need it most has helped lead to a 150 percent increase in patient engagement.[1] Deborah Jean Parsons, Director of Integrated Care at Aspire Health Alliance, explains:

"The event notifications are a way to find people and engage them while they're in the ED. In this acute state—this crisis state—we find a higher rate of engagement. If we send our people to the hospital, we can coordinate with a social worker to say 'Look, this is a free service from MassHealth for you. I'm here to help you get what you need; how can I help?'"

Additionally, a Pacific Northwest health plan with 2 million lives started using care collaboration technology to identify rising and high-risk members, ensuring that case managers were working to engage the right members at the right time. Armed with up-to-date member information, case managers were able to proactively reach out to members—raising engagement rates from 10-20 percent to 60-80 percent for members identified for case management. This health plan was also able to reach out to members in real time rather than waiting for claims information, decreasing post-discharge contact time from 45 days to 48 hours.

Early identification of risking risk patients allows health plans to reach out and engage members or work to enroll them in case or disease management programs.

Reduce the Total Cost of Care by Lowering Acute Episodes

In 2016, annual ED visits in the US reached 145.6 million.[2] In addition to the number of ED visits, one study shows that up to 30 percent or more of US ED visits are non-urgent.[3] This is in part because many patients are unable to access timely primary care or other providers, defaulting to the always-open emergency department.[4,5]

Additionally, clinicians in emergency departments are decision makers for more than half of hospital admissions.[5] The US spends $41.3 billion per year on readmissions, yet one study of readmitted patients showed that nearly 27 percent of studied readmissions were considered potentially avoidable.[6,7]

By reaching out to members at the point of care and being able to effectively communicate with providers, health plans can help curb unnecessary ED visits and unplanned admissions through collaborating on care, redirecting a member to a more affordable, in-network care setting, or providing a member with resources for managing their condition.

Preventing Readmissions for CHF

According to a Healthcare Cost and Utilization Project (HCUP) study, congestive heart failure (CHF) was the top condition associated with the most all-cause, 30-day readmissions (134,500 readmissions for Medicare patients aged 65 years and older).[6] Readmissions for CHF were associated with $1.7 billion in total costs in 2011.

After implementing care collaboration technology, staff at a Northeastern health plan identified three members with CHF that had been discharged from the ED without proper resources. With real-time, ADT-based notifications case managers were able to quickly reach out and get the three members into programs the health plan provided for free—including medically-tailored meals and home telemonitoring.

Medically-tailored meals are designed not to aggravate a patient's condition and home telemonitoring allows a nurse to keep an eye on a member's symptoms. For example, nurses can catch when a member with CHF gains three ounces of fluid and adjust medication accordingly—rather than waiting until the patient gains a noticeable three pounds of fluid, warranting an ED visit. The timely and proactive approach taken by case managers helped avoid preventable readmissions for the CHF patients.

Reducing Unnecessary ED Utilization

The emergency department has become the front door to the US healthcare system for many patients. Using care collaboration to gain real-time visibility, coordinate care for at-risk patients, and redirect care to lower-acuity settings can help health plans curb unnecessary ED utilization—leading to improved financial outcomes.

A study of the impact of care collaboration technology on commercial health plans found that health plans that implemented Collective's platform have shown a 3.7 percent to 8.6 percent reduction in ED visits within two years for members under age 65 in commercial health plans with greater than 500,000 lives.

Additionally, data collected by Collective Medical on a health plan in the Pacific Northwest found that written care insights helped decrease ED utilization by nearly 54 percent, contributing to 4,564 fewer ED visits and over $4.5 million in saved costs.

Collaborating Across the Care Continuum

Relationships between providers and health plans are key to managing avoidable acute care utilization and maximizing financial opportunities. To improve transitions of care, health plans in the Portland, Oregon area participated in a community collaborative group comprised of the Portland Clinic, members from the Portland Care Coordination Association (PCCA), and partnering hospitals.

This pilot group set out to align healthcare workflows by meeting every two weeks to review incidents and collaborate on solutions for reducing high ED utilization and avoiding duplicative care.

This collaborative care and bidirectional communication paid off for all participants. A health plan working with The Portland Clinic in the collaborative pilot group saw over a 5 percent reduction in 30-day readmissions from 2015-2018.[8] Additionally, the Portland Clinic saw a 13 percent decrease in ED visits after transitions of care plans were implemented for pilot patients with high utilization patterns.[9]

Taking Healthcare Home

Home health can be an effective way to control care costs. Research has found that home care is associated with over $5,000 in care cost savings per beneficiary and over $4,500 in Medicare payment savings per beneficiary when compared to post-acute care in a skilled nursing facility.[10]

Housecall Providers, a member of the CareOregon family, helps care for complex patients in their own home. A participant in the Medicare Independence at Home (IAH) Demonstration, Housecall Providers aims to show the quality of home-based care through factors like readmission rates. Using care coordination technology has allowed Housecall Providers to meet or exceed IAH metrics, saving Medicare $1.8 million in care costs in just one year.[11]

Improve Care Management for Vulnerable Populations

Improving care management for vulnerable populations—including members struggling with behavioral health conditions, high-risk conditions or comorbidities, and those affected by social determinants of health—can help decrease acute care utilization. By helping these at-risk members gain access to resources and quality care in lower-acuity settings, health plans can improve both clinical and financial outcomes.

In 2011, some of the top conditions associated with the most 30-day all-cause readmissions were mood disorders, diabetes, congestive heart failure, and septicemia.[6] In 2016, the top seven conditions with the highest number of 30-day all-cause readmissions were blood diseases, neoplasms, infectious/parasitic diseases, endocrine/metabolic diseases, respiratory system diseases, mental/behavioral disorders, and circulatory system diseases.[12] Providing additional support to members struggling with these conditions can help keep members out of the hospital.

Some studies suggest that behavioral health conditions are among the most costly to treat in the US, with annual spending over $200 billion for mental disorders and around $35 billion for substance use disorders.[13,14]

Finally, research shows that social determinants of health (SDOH) can affect up to 90 percent of the contributors to a patient's health outcomes, making the issue critical to address when looking to improve both financial and clinical outcomes.[15]

Here's how three healthcare organizations have used care collaboration technology to improve care management for members with complex or at-risk conditions.

Focusing on the Members Who Need the Most Help

A health plan serving communities in Oregon and Washington was making post-discharge phone calls to every member within 48 of discharge. Several staff members were needed to make these phone calls—about 3,000 per month. Using a readmission risk score, health plan staff were able to predict which patients were at the highest risk for readmission and prioritize as needed.

Now, staff only make post-discharge phone calls for patients with a higher risk of readmissions as well as for members with certain chronic illnesses like congestive heart failure, asthma, and chronic obstructive pulmonary disease. This change has reduced phone calls from 3,000 to 500 per month, freeing up staff time to focus on other important work. Focusing on the most vulnerable members has also helped the health plan improve readmit observed over expected scores from .72 to .52 in one year.

Helping At-Risk Behavioral Health Patients

MassHealth, the Massachusetts Medicaid system provides healthcare to one fourth of the state's population. Around five percent of the state's most vulnerable population account for about 50 percent of the MassHealth budget.[16] To help address this, Aspire Health Alliance partners with organizations and clinics throughout Massachusetts to provide better care for those struggling with behavioral health challenges.

Using real-time notifications helps Aspire case managers follow-up with patients and connect them to appropriate resources. In one instance, an inebriated patient presented at South Shore Hospital. A care coordinator at Aspire who had previously tried to reach this patient received an ADT-based notification and was able to call the hospital, explain the situation, and get permission to visit the patient. Working collaboratively, a hospital social worker and the care coordinator sat down with the patient to discuss available resources and potential care plans with the patient. They were able to sign him up for the Behavioral Health Community Partner program and get an appointment set up with a medication assisted treatment facility the next day.

Addressing Social Determinants of Health

Over the past several years, many payers have invested millions of dollars into addressing social determinants of health due to the costs and outcomes associated with social determinants. In fact, it's estimated that social determinants account for 80-90 percent of the modifiable contributors to health outcomes.[15]

In 2018, a group of commercial payers along with other organizations formed a coalition—Aligning for Health—to explore how addressing SDOH can improve both clinical and financial outcomes.[17] In 2020, America's Health Insurance Plans (AHIP) along with other organizations showed support for the Social Determinants Accelerator Act (H.R. 4004), introduced in the House in 2019.[18]

Providence Health, which serves seven states in the American West, started noticing many patients had needs than extended beyond the walls of hospitals and clinics. Providence launched the Better Outcomes [thru] Bridges (BOB) program at its Oregon locations to help facilitate community-centered care and target SDOH.

Those involved in the BOB program met regularly to discuss the needs of vulnerable individuals frequenting the ED. They identified solutions and created care plans that were then hosted in the Collective platform. This program has helped connect individual patients to a number of resources addressing issues like lack of housing, substance use disorder, unemployment, and other challenges. In 2018, BOB program patients saw a 41 percent reduction in ED utilization through the increased community coordination and focus on SDOH.[19]

About Collective Medical

Collective Medical provides the nation's largest and most effective network for care collaboration. Our risk-adjusted event notification and care collaboration platform spans across all points of care—including emergency departments, hospitals, payers, behavioral and physical ambulatory, and post-acute settings. This technology integrates seamlessly with existing workflows and allows payers and providers to identify and support at-risk patients in real time—avoiding preventable admissions and utilization and providing better care.

Learn more at collectivemedical.com

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