BECKER'S HEALTHCARE | collectivemedical A PointClickCare Company

Collaboration and Care Insights

A winning formula for payers and providers

Most health plans define success as delivering member-centered, high-quality care, while simultaneously reducing costs.

These are excellent goals, but payers can't achieve them in isolation. Collaboration is essential and critical care insights frequently come from outside the payer organization.

Healthcare is delivered across a wide continuum of nodes, ranging from hospitals to ambulatory surgery centers, federally qualified health centers, home health providers, skilled nursing facilities, and more. To drive optimal clinical outcomes across the complete continuum of care, stakeholders need access to real-time information sharing, as well as easy to use and in workflow care collaboration tools.

Collective Medical, a PointClickCare company, believes shared success comes from collaboration tools used in combination with data and technology sharing. Collective Medical creates those tools, as well as the infrastructure and capabilities needed to share information bi-directionally across different participants in the patient or member journey.

To learn more about how organizations are leveraging Collective Medical's platform to achieve success, *Becker's Hospital Review* spoke with three company leaders:

- Amanda Hane, Manager, Customer Success
- Jenna Moody, Director, Customer Success
- Nicole Sunder, Director, Health Plan Solution Design

This white paper is based on these conversations and research conducted by Collective Medical.

The Importance of a Partnership Perspectived

Collective Medical's mission is to improve health outcomes and lower costs by placing the right insights at the right time in front of every stakeholder along a patient's journey. That information encourages people to take the right action and place members on the best path forward.

"Our key value proposition for customers is notifying, activating, and collaborating," Ms. Moody said. "We empower our partners to engage across the entire care continuum. We are here to support and grow the network, while putting the patient at the center of everything we do." Collective Medical's client success team uses a matrixed organization to support the free flow of data across payers and providers. The team members come from diverse backgrounds and have hands-on experience with social work, as well as clinical care.

"Many of our client success team members have experience in the same roles as our customers," Ms. Hane said. "When we talk about the benefit of our platform, that message really resonates. We can identify the workflows that we've seen work really well."

Collective Medical works with health plan clients in four ways:

1. **Generate visibility into member activity.** Real-time access to admit, discharge, and transfer (ADT) messages empowers payers to optimize and expedite notifications of admissions, streamline utilization management processes, and enhance internal data repositories.

2. **Optimize care and utilization.** Leveraging care insights help payers distill the signal from the noise in real-time and reduce the total cost of care by proactively identifying patients with chronic disease, behavioral health issues, and high or rising utilization patterns (i.e. acute care services). This means payers can intervene effectively to support their members within and across the care continuum.

3. **Optimize quality and coding.** With network information, health plans can improve their plan performance on quality scores, as well as identify opportunities to close coding gaps to enhance outcomes and risk adjustments.

"We use technology to broadcast information about a subset of a payer's population to all providers in the network," Ms. Hane said. "For example, information from a health plan can go to downstream providers like Accountable Care Organizations (ACOs) and skilled nursing facilities or upstream to hospitals. The goal is to ensure that the whole continuum of care that has a relationship with a patient is on the same page," Ms. Hane said.

Using Care Insights to Drive Success

Care insights capture patient details from healthcare providers. They often contain actionable information about how to avoid readmissions. Examples of care insights include:

- Facts about the patient that will influence care in the emergency department (ED)
- Actions or verbiage that meaningfully engages the patient and is person centered
- Information about baseline presentation, function, or symptoms
- Pain management agreements, crisis plans or advanced directives
- Contact information for care team members such as pain management providers or other known specialists

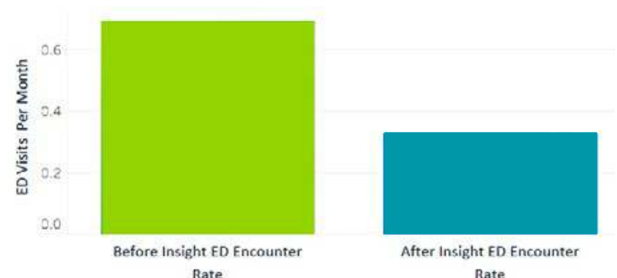
"As we think through ED diversion programs, we need to consider opportunities to influence what's happening in the emergency department," Ms. Sunder said. "That means giving staff the tools, information and insights to have more productive conversations and ensuring that there's alignment with the care plan."

Collaboration and care insights in the real world

Collective Medical has partnered with a variety of organizations to improve collaboration and health outcomes. Here are four brief case studies that illustrate how care insights can support community and state-level success:

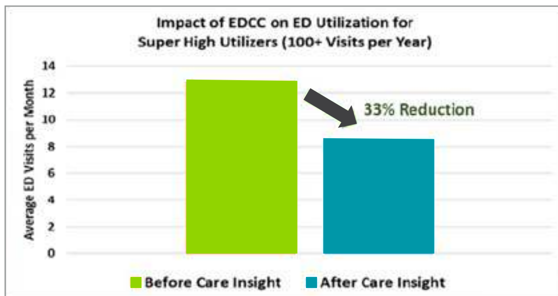
1. **A health plan focused on value-based care.** Collective Medical recently worked with a 300,000-member plan to curb ED utilization and costs. With additional care insights, the organization prioritized collaboration around the highest utilizers to improve health and financial outcomes. As a result, ED utilization decreased by 53.5%. In addition, care insights possibly helped prevent 4,564 ED encounters, representing $4.56M in savings.

Figure 1: Impact of Care Insights on ED Utilization at a 300K-Member Health Plan



2. **Virginia Health Information (VHI) in Richmond.** VHI chose Collective Medical as its technology partner for a statewide, ED care coordination program. This program focuses on two groups: "super high utilizers" (members with more than 100 visits per year) and members with 10 or more ED visits in a 12-month period. Health plan medical directors evaluated both member populations and entered care insights about the services they have in place for members. Bi-directional collaboration enabled Collective Medical to enter that patient information in the portal for teams along the entire care continuum. Among the super high utilizer group, there was a 33% reduction in average ED visits per month after care insights were entered. Among members with 10 or more ED visits per year, the average ED visits per month decreased by 20% after care insights were implemented.

Figure 2: Impact of Care Insights on VHI ED High Utilizers



20% decrease for patients with 10+ visits as well

3. **Fredericksburg, Va.-based Rappahannock Area Community Services Board (RACSB) and Anthem.** RACSB is a partner of Anthem's Virginia Medicaid health plans that runs a behavioral health home initiative for individuals who require more intensive care coordination. Each patient is tagged using the Collective Medical platform and RACSB care teams meet regularly with Anthem advocates to explore unique and innovative ways to support these individuals. The Emergency Department Care Coordination Program, in conjunction with the platform, helps case managers easily identify those patients with the highest utilization patterns. This helps the collaborative team know where to focus their efforts. With the supporting data provided by the Collective Medical platform, RACSB qualified for, and received, an $819,577 grant to build a permanent supportive housing program for homeless ifor patients with individuals with persistent, serious mental illness.

4. **Washington State.** In many states, managed care organizations (MCOs) come together with physician champions. The State of Washington calls these partnerships "accountable communities of health," or ACHs. Although ACHs don't have established relationships with patients, they connect the dots on the back end. In Washington, Collective Medical analyzed ED visit outcomes for 13,103 patients with care insights. The team found that patients with a care insight had 0.77 fewer ED visits than patients without a care insight. In addition, patients with a care insight authored by both a healthcare provider and a care coordinator had 0.93 fewer ED visits than patients without either.

Figure 3: Impact of Care Insights in the State of Washington

			Care Insights			Control Group				
Type of Facility	Patients with Care Insights	Number of Patients with Control Group Matches	Ave ED Visits One Year Prior	Ave ED Visits One Year Post	Decrease in ED Visits in Care Insights Group One Year Pre to One Year Post	Ave ED Visits One Year Prior	Ave ED Visits One Year Post	Decrease in ED Visits in Control Group One Year Pre to One Year Post	Difference	Stat Sig
All	47,148	13,103	6.9	4.7	-2.2	7.6	6.2	-1.4	-0.77	<.0001
Hospital	43,900	11,733	6.8	4.6	-2.2	7.6	6.1	-1.5	-0.77	<.0001
Care Coordinator	2,193	896	5.6	3.4	-2.1	7.1	5.9	-1.2	-0.93	0.0075
Payer	575	257	10.1	9.1	-0.9	7.8	7.1	-0.7	-0.21	0.8129
Mental Health	183	119	12.4	8.7	-3.7	7.7	6.6	-1.1	-2.60	0.2276
Clinic	167	50	10.1	6.6	-3.5	8.4	8.8	0.5	-3.92	0.0749
Multi-Service Behavioral Provider	109	48	10.9	11.7	0.8	16.7	10.3	-6.4	7.17	0.1785

- Patients with a Care Insight have 0.77 fewer ED visits compared to those without Care Insights.
- Patient with a Care Insight at hospitals and have a care coordinator have a statistically significantly fewer ED visits compared to those without (0.77 and 0.93 fewer respectfully)
- Patients with a Care Insight at both mental health facilities and clinics had fewer ED visits compared to those without (2.60 and 3.92 fewer respecctively) but was not statistically significant due to small sample size

Clinical Collaboration Groups Improve Stakeholder Engagement Across the Care Continuum

Clinical collaboration groups, or CCGs, build a foundation of processes and resources that are systematic and sustainable. Their objective is to drive engagement among providers, MCOs, and members. CCGs identify populations of focus, share data about those groups, set goals in a regional context, share best practices from other regions, and evaluate their processes, outcomes and shared goals.

"CCGs often establish goals related to ED diversion, reducing readmission risk or addressing social determinants of health," Ms. Sunder said. "Collective Medical can assist by turning the collaboration dial up or down to ensure that everyone gets the information they need to be effective."

Sturdy Memorial Hospital in Attleboro, Mass. is a CCG success story. A patient living with a behavioral health diagnosis visited the ED 48 times over the course of 2017. In response, the ED care team met with the outpatient care manager and put a plan in place. Whenever the patient presented to the ED, the team was instructed to contact the outpatient care manager, rather than connecting the patient with the ED's behavioral health team. The plan was added to the patient's care insights, ensuring it would be delivered to any ED in the Collective Medical network immediately upon presentation.

Over the following nine months, after adding the care insights, the patient had only 12 ED encounters—a reduction of nearly 75%. When the patient did present, the lengths of stay were reduced from more than six hours to less than one hour in most cases, since the outpatient care manager intervened shortly after the patient's arrival in the ED.

Conclusion

Payers and other stakeholders throughout the care continuum need tools, information, and insights to enable more productive collaboration and greater alignment with patient care plans. Facilitating that information exchange, however, isn't always easy. If there isn't a shared electronic health record (EHR), information must find a different path.

"Collective Medical supports an innovative care continuum using a platform that isn't available anywhere else on the market," Ms. Moody said. "By capturing information and care insights, we assist providers, payers, risk-bearing entities and anyone who touches the patient. We have a hands-on ability to affect the patient journey."

With a suite of fully integrated applications powered by cloud-based healthcare software, Collective Medical, a PointClickCare company, leads the way in care coordination by helping care providers connect, collaborate, and share data within their network. The recent joining of Collective Medical with PointClickCare enables the companies to provide diverse care teams across the care continuum real-time patient insights at any stage of a patient's healthcare journey, empowering better decision making and improved clinical outcomes at lower cost. Over 21,000 long-term and post-acute care providers and over 1,300 hospitals use PointClickCare and Collective Medical today.

Connect with the Collective Medical team to learn more.
collectivemedical.com

BECKER'S HEALTHCARE