CIN Centralized Performance Management

Background

This Clinically Integrated Network in New Jersey was formed with the mission of allowing area physicians and the medical center to work more closely through a collaborative model to respond to local and national health reform and competitive pressures, while allowing private practices to remain independent, yet clinically integrate to improve care and access key opportunities with payers. They're currently composed of a Traditional MSSP ACO (Accountable Care Organization) and two VBP Risk arrangements in Medicaid and Commercial contracts with a total population of 42,000 lives.

They're focused on a lean but effective way to manage their provider network and performance outcomes. This customer manages the entire patient population via a centralized support methodology to their network practices. Their team works on initiatives such as closing care gaps, high-risk patient oversight, and even GPRO reporting under the ACO. The team of three is composed of: a Director of Population Health and Analytics, one staff member that is a Care Expeditor whose responsibility is to help patients/practices/providers navigate the healthcare system; and second staff member works to close all care gaps while training and monitoring gap closure at a practice level with on-site care coordinators.

Situation

In previous years, they attempted practice level adoption with their prior population health vendor and learned that the extra work placed a burden on already short staff practices and did not align with their strategic goal of how to support their constituents. With such a large, attributed patient panel, the customer required a lean, precise, data driven, and easy to use dashboards and tools that can empower them to effectively view macro-and-micro trends and gaps in clinical, financial, and quality performance.

Solution

This customer is heavily adopting Bridge's platform as a core of their data analytics strategy. The Insights application and its Frequently Accessed Reports alongside the Care Gaps Application are primary tools of support to the customer. Specifically, there are a few reports that have become a priority for them to continue to manage successful outcomes - including the *High-Cost Patients* report, *Lab Utilization* report, and *Specialist Comparison* report.

- ***High-Cost Patients*** report: Since the customer has a staff of 3, it is vital for them to narrow in and focus on patients that are driving cost expenditures the most. Normally these patients need a better handle on care, more frequent PCP visits or simply to be identified as a true high-cost patient due to their illness. **Having this report helps the customer focus on the bottom 20%, driving 80% of the cost**.

- ***Lab Utilization report***: Having a way to help understand lab traffic within their patient base in a key focus to differentiate which labs are being done because they are not able to be done in-house versus which they cannot but are not being done. **This FAR is a way they're looking at leakage and patient flow in and out of network**. Garage was able to bring in cost details into this FAR with hover over functionality, allowing their team to quickly understand everything in a snapshot right away.
- ***Specialist Comparison*** report: Because of their size, leakage of professional services must be a major focal point. This report allows them to get a real time snapshot of how spend is happening across all specialty and types. **This allows them in real-time to try and change referrals to the low-cost providers that offer equal quality service at a fraction of the cost**.

As they continue to keep that data first approach to population management, Bridge will continue to support their goal of financially understanding how patients are holistically affecting practice spend.

Outcomes

The unified lines of business powered by Insights has allowed their team to use the platform consistently throughout the week to work through various cost, quality and utilization lists by practice. **Via this end-to-end automation, they are not only achieving process efficiency by eliminating manual errors**, but also supporting greater clinical and operational success outcomes for their 8 practices. This has **allowed cost savings from the budgeted personal cost of 2 FTEs that can be repurposed**.

"We have only been utilizing The Garage since the beginning of this year, but we have already seen the tremendous value they bring our organization. We are a small organization so the ability to utilize The Garage to pinpoint specific data and specific patients is essential to us. We have had some success in the past within our Shared Savings arrangements and now our physicians, staff, and administrations are hungry for data on how to improve. The Garage's reports and dashboards have provided this ability to us efficiently and effectively."

– Director of Population Health and Analytics

Interested in learning how The Garage can empower your organization?
Request more information **here**.