MSO's Evolution of Care Management Driven by Data Powered by The Garage (HI360)

Background

This Management Services Organization covers a national market of various path ACO Entities, Medicare Advantage and Commercial markets, with over 180,000 beneficiaries across 26 states. Their care management strategies include centralized and decentralized care managers, social workers, and other clinical resources. With goals to minimize hospital admissions and emergency room visits, reduce the cost of care, and improve clinical outcomes and services available to the patients, they've had to be nimble in their strategies. They ultimately found that using the power of advanced data integrations and aggregation in Bridge could allow them to ease the daily burdens of care management while building focused outreach to the highest-need-highest-cost patients.

Situation

Due to multiple-payer contracts, an extensive growing network and a wide breadth of patient population needs, this customer's clinical teams needed to evolve their care management strategies so that their team members are driven to focus populations where the most significant impact can be made. This customer has utilized the Bridge Platform's GRID application to drive care management activities, **with its first version of the product released in 2019**. While initial versions of GRID were successful, they found the broad criteria released in earlier versions to be overwhelming to team members. This customer and The Garage embarked on an effort to create highly specified GRID eligibility criteria that more closely aligned with the work performed by their care management team. Care managers were also required to interact with multiple platforms outside of GRID for areas such as identifying social needs categories, referring to social services in their area, and documentation for productivity tracking.

Solution

This customer's Care Management strategy development in GRID has been multi-factorial, involving workflows for interdisciplinary teams working together to provide comprehensive care that addresses each patient's unique needs across large geographic areas.

- **GRID Initiatives**: Since its initial release, the team has designed 21 unique initiatives for patients to fall into GRID and include criteria to expire based in timing of the patient timeline and closure of initiatives based on user action taken in the platform. The goal is to keep the patient eligibility as narrow as possible to drive care management to the patients where the most significant impact to quality-of-care goals and cost reductions could be realized. As data integrations became more robust, the customer's team is experiencing Bridge's data-first approach to ensure initiatives are more clinically relevant and in alignment to quality initiatives that are heavily weighted across all payer contracts.
- **GRID Risk Level Stratification**: Historically, triaging to appropriately assign the required care source to the level of risk the patient carried quickly became overly burdensome to the

care management team, requiring extra workup time and delays in triage before patients could be appropriately assigned to a care resource. We introduced an extra layer of stratification, further distributing patients between 'Low', 'Medium', 'Medium-High', or 'High' risk categories when they meet criteria that includes a number of chronic conditions, overall spending, and a number of ER/IP discharge events. This has reduced the administrative time spent triaging and ensures the care team members are working with patients appropriate to their license level.

- **Experian Integration**: The customer's care team members found themselves with data gaps to appropriately identify social determinants of health needs due to assessment line of questioning and time required to develop trust with a patient. Through Experian Health Platform, an integration brought in individual patient category scores in four distinct buckets - Access to Care, Access to Medication, Food Insecurity, and Housing Instability. This data has never been accessible to care team members and is now aligned with their standard workflow to determine if the patient will have any barriers to care or higher needs throughout their care journey.
- **FindHelp (formerly Aunt Bertha) Integration**: FindHelp is a tool that lists various support services within a particular geographic area available to patients, with the ability to refer patients to specific services for assistance, including but not limited to financial assistance programs, food pantries, counseling services, medical care, transportation, and other free or reduced-cost help. Access to FindHelp through Bridge allows staff to refer patients to necessary service(s) to reduce barriers to ongoing treatment and medical care. Because FindHelp is integrated into GRID, care teams are saving the manual effort of using multiple portals and saving notes externally for day-to-day care management activity.
- **PCA Tracker and Productivity**: With the high volume of care management activities performed in Bridge's Grid application, this customer's team critically needed to track productivity and metrics around its custom workflows. The Garage team built a custom-designed PCA Tracker (Care Management Tracker) where every care resource touchpoint, including successful/unsuccessful outreach attempts, timeliness of initiative completions, care plan work, HRA updates, total touchpoints, and missed opportunities, can all be tracked. This empowers the conversation and initiative around even work distribution.

Outcomes

Today, a staff of **over 100 care resources** use Bridge, with an average of 70 care resources in the tool five days a week. Among all workflows outlined above and more, **an average of 415 touchpoints occurs daily in GRID**! In 2023 alone, over 8900 unique patients have been outreached to, over 800 cases have been closed/completed for patients who fall under HighRisk categorization. Since the implementation of the social intervention plan more than 200 referrals have been placed to community benefit organizations.

While every day impacts the individual patients that are served, when looking at historical performance from 2021 to 2022, **we saw a 44% reduction in IP/1000, and PMPM rate reduction of 16.6%**! We are excited to continue providing necessary solutions to the incredible care management teams to manage efficiently & effectively more than 8,100 current open cases.

"Our collaboration with The Garage has significantly improved our team's focus on patient care by utilizing a single platform. With easy access to all necessary information, we are able to effectively evaluate, monitor, and address medical and social concerns, leading to positive outcomes."

- Senior Director of Healthcare Transformation

"The opportunity to refine targeting while enhancing functionality in GRID has been a true partnership and essential to our ongoing success. Triaging and aligning cases and services to the best resource allows our teams to be more effective. Additionally, the FindHelp integration has empowered the team to quickly and accurate match our beneficiaries to community-based organizations."

- Chief Medical Officer

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