Population Health NEWS

ConcertoHealth Patient^{3D} Improves Outcomes for Vulnerable Patient Populations

by Robin Tam

Program Objectives:

- To improve outcomes for vulnerable patient populations by offering care providers real-time, clinical data and actionable insights, accessible through a browser-enabled, population health data analytics platform.
- To deliver patient experience visibility to care providers via a 360-degree, real-time view of patients' complete medical histories and consolidated records at the point of care.
- To notify care providers when there is a need for patient intervention—especially care gaps, quality improvement opportunities or medication reconciliation.
- To maximize the efficacy of the patient/provider interaction through actionable, longitudinal patient data and population health insights.

Program Description: The 8.6 million Americans who are Medicare-Medicaid enrollees and have one chronic condition or more[1] cost the U.S. healthcare system more than $300 billion annually.[2]

In value-based healthcare, payers are putting more pressure on primary care providers (PCPs) to effectively quarterback care for these patients. The reality is few PCPs are equipped to manage patients across a multitude of care settings beyond their own practice. Fewer than 5% of Medicare claims for these patients are submitted by PCPs. That means about 95% of Medicare claim expenses are outside a PCP's purview:

- Hospital claims (55% to 65%).
- Specialist claims (15% to 25%).
- Skilled nursing facility claims (10% to 20%).
- Home health agencies and other vendors (5% to15%).

ConcertoHealth® developed Patient^{3D} as a web-based, health analytics solution in response to this lack of visibility for PCPs, giving care providers a comprehensive, 360-degree real-time view of patients' complete medical histories and consolidated records. Patient^{3D} is central to the ConcertoHealth Primary Care Support Platform, which equips health plans and their provider networks with this population health tool, plus on-the-ground interdisciplinary care teams (ICTs). This model integrates clinical care with social services to offer high-touch, individualized, primary and preventive care for these vulnerable patients regardless of the setting, including the home, hospital, post-acute facility or ConcertoHealth Care Center.

Launched internally to the ConcertoHealth medical group in April 2016, Patient^{3D} makes actionable data, incorporating predictive algorithms available to providers and care managers with prompts to address gaps in care, leading to lower costs of care and improved health outcomes. The success of this solution has convinced several health plans, including MeridianCare, to engage ConcertoHealth.

MeridianCare, which operates multiple Medicare products in the state of Michigan, is partnering with ConcertoHealth to manage its most complex and costly members. With Patient^{3D}, care managers operate from a work queue based on population-specific guidelines. MeridianCare network PCPs access their patient list, prioritized by opportunities to deliver proactive care and improve outcomes. All users are able to review recent acute admissions, discharges and emergency department visits so they can conduct a timely follow-up with each patient.

In addition, Patient^{3D} users have access to a one-page *Patient Intervention Report* that lists diagnoses and quality, clinical and medication care gaps.

They are also able to view each patient's chronological history of interventions, diagnoses and medications to maintain an appropriate treatment plan. Patient^{3D} promotes ICT collaboration through shared visit notes and other documentation.

MeridianCare garnered results, including the following anecdote. A male patient from Michigan, age 46, is a paraplegic with a traumatic brain injury, requiring ongoing care coordination. ConcertoHealth activated an ICT, including a care manager, patient care coordinator, social worker, long-term services and supports coordinator, two managers and the patient's PCP. The ICT worked to change the patient's medications for residual pain, seizures and anxiety and facilitated an appointment

with a neurologist and a referral to a pain clinic. The team assisted the patient in finding a new church and obtaining a personal emergency response system.

The care plan required ConcertoHealth nurses to assess the member twice a week for pain, seizures and medication compliance. Patient^{3D} kept every team member informed at all times.

"MeridianCare and ConcertoHealth have an amazing partnership, which lends itself to a value-based relationship focused on quality of care and better outcomes for our members," says Shawn Holt, senior vice president of MeridianCare.

Evaluation Process:

- **Phase I, launched April 2016: ConcertoHealth internal operations.**
  - The Patient^{3D} tool was deployed internally to facilitate improved coordination among ConcertoHealth staff members who comprised each patient's ICT.
  - All ConcertoHealth clinical staff relies on Patient^{3D} for longitudinal patient history and actionable prompts when they address patient care.
  - The system is now used in more than 90% of ConcertoHealth pre-visit preparations.
  - The tool enables effective pre-visit preparation and informs high-risk patient meetings so that ICT members can address each patient's individual needs in real time.
- **Phase II, launched November 2016: Health plan network PCPs (quality program).**
  - The core clinical documentation logic produced by Patient^{3D} served as the basis for a Q4 2016 quality campaign for one health plan partner.
- **Phase III, launched May 2017: Partner health plan network PCPs (provider portal).**
  - Within two months of the provider portal launch, the total patient base represented by registered users (health plan network PCPs and their admin supports) was measured.

Results: ConcertoHealth developed Patient^{3D} as a population health data solution for care providers to gain visibility into their patients' total healthcare experience. By prompting ICT users to take action when patient intervention opportunities arise, outcomes improve. As care providers perceive the value of Patient^{3D}, adoption increases.

While models of care diversify with each new health plan partner or market entry, ConcertoHealth positions Patient^{3D} as a "living tool;" which is scalable for volume, allows for ongoing enhancements and is flexible in changing environmental needs. ConcertoHealth and MeridianCare deployed Patient^{3D} to drive health outcomes informed by quality objectives with the following results:

- **Phase II:**
  - A quality campaign resulted in 550 patients successfully receiving year-end, preventive health visits tied to Healthcare Effectiveness Data and Information Set (HEDIS) measures.
  - Of those visits, health plan network PCPs submitted 540 accurate *Patient Intervention Report* responses, which addressed patient care gaps and health plan clinical documentation (a 98% success rate).
- **Phase III:**
  - Within two months of the provider portal launch, the total patient base represented by registered users reached 33% of the health plan's qualifying membership.
  - PCPs are now equipped to own documentation accuracy, chronic condition management and HEDIS improvement in anticipation of this year's upcoming Q4 quality campaign.

Since its launch, Patient^{3D} has prompted appropriate patient interventions resulting in the following ConcertoHealth outcomes:

- Reduced average admissions per thousand by 30.3%.
- Reduced average readmission rates by 17.1%.
- Increased proportion of admissions to lower cost settings.
  - Skilled nursing facility increased from 19% to 24%.
  - Observational stays increased from 37% to 45%.

ConcertoHealth patient enrollment grew 300% from June 2016 to 2017, a testament to the Primary Care Support Platform gaining traction with health plan partners.

Lessons Learned:

- Care providers lack visibility into a patient's total healthcare experience because their view is limited to their organization's own electronic medical record (EMR) system. As patients become more vulnerable, care coordination becomes more complicated with more providers and their respective EMRs.
- Outside of these EMRs, there are additional healthcare data sources focused on patients, such as claims or admissions. When a population health analytics tool acquires and processes these data, the tool can offer users a comprehensive view of patient history.

- Patient history alone is not sufficient. It is critical to generate actionable insights, including care gaps, quality prompts and medication reconciliation. Clinical users, their office administrators and quality program leads are all able to benefit from these actionable insights.
- Users rely on an interface that is intuitive and uncluttered. They seek prioritization of the most pertinent clinical data or recommended actions and the ability to drill down into information on demand.
- Network care providers are amenable to accessing this tool either directly or through their contracted health plan's provider portal. Either way, it is essential for health plan partners to endorse widespread adoption through the alignment of quality incentives.

[1] "Calculation of Patients With One or More Chronic Conditions." Medicare-Medicaid Enrollee Information National 2011. Centers for Medicare & Medicaid Services. 2011.
[2] Bella M. "Dually Eligible Beneficiaries: Improving Care While Lowering Costs." Medicare-Medicaid Coordination Office. Centers for Medicare & Medicaid Services. Sept. 21, 2011.

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