Building Custom Solutions for Real-Time Care Coordination

Centura Health’s Approach

BACKGROUND

Founded in 1996, Centura Health is Colorado’s largest health care provider, with 18 hospitals, 13 affiliate hospitals, and more than 21,100 professionals. In 2012, recognizing the need to strengthen the hospital-based system’s ambulatory care abilities, Centura developed the Colorado Health Neighborhood (CHN), a physician-led network, clinically aligned with the health system. Since its inception, CHN has led many initiatives to provide high-quality, cost-effective care for more than 160,000 patients, including those attributed to its 8 accountable care contracts. One of CHN’s most effective population health management strategies has been its development of a fully integrated health information exchange (HIE) interface to inform real-time care coordination.

APPROACH

Early in the ACO’s development, CHN created care coordination teams to manage high-needs patients across the network’s at-risk populations. In order to successfully support these chronically ill patients, CHN leadership recognized the importance of providing its care coordination teams with access to real-time data on emergency department (ED) use, hospital discharges, and other utilization. By equipping care coordinators with actionable notifications, these teams could immediately ensure that the appropriate follow-up care is delivered, mitigating expensive readmissions and improving outcomes.

In 2014, CHN started the first iteration of this work with a daily hot spotter report on ACO-attributed patients utilizing Centura facilities. However, because ACO patients also receive care from non-Centura providers, the health system needed a way to collect real-time utilization updates from out-of-network hospitals. In January of 2016, Centura partnered with the Colorado Regional Health Information Organization (CORHIO) to gain access to ADT data from every hospital in the state (one hospital pending) through CHN’s fully integrated HIE interface.

To build this interface, CHN leveraged its Salesforce care coordination platform to automatically create unique identifiers for each of its 160,000 ACO patients. Using these identifiers, CHN posts a list of patients to CORHIO’s secure FTP site each month. CORHIO then matches CHN patient identifiers with statewide ADT data using demographic information and automatically returns the list back to the Salesforce platform. CHN designed its platform to seamlessly commence care management for patients identified in the CORHIO data. The platform identifies the patient’s primary care provider, automatically creates a new encounter and care plan, and alerts the assigned care coordinator to follow up within two business days or upon hospital discharge. If a patient is already enrolled in CHN care coordination and has an active care plan in place, the plan automatically updates with new information.

Additionally, CHN has customized its Salesforce platform to create a visual timeline for each patient, which is auto-populated with the encounter data from CORHIO, including notification date, type, and exact facility. The visual timeline also includes care coordinators’ touchpoints with patients, including calls and emails, to capture a comprehensive and longitudinal care history. The visual timeline allows coordinators to readily identify the dates of patient utilization and encounters without reading through each note.

After the initial follow up, care coordinators provide transitional care management for at least 30 days post-discharge, ensuring that patients secure a primary care visit, are able to understand and fill all necessary medications, and are connected with the network’s licensed clinical social worker for additional support when needed. CHN has 15 RN care coordinators who each receive approximately 50-75 patient notifications each week, having about 300 patients on service at any given time. CORHIO notifications are assigned to coordinators based on the patient’s primary care provider, as coordinators are aligned with primary care practices within a given geographic region.

RESULTS TO DATE

CHN has achieved shared savings in three of its ACO contracts, and is open to new carriers. Within one of its smaller commercial ACO populations, CHN has had a 0% hospital readmission rate for over 12 months. The readmissions rate across its entire commercial value-
based portfolio is under 5%. CHN has also seen a reduction of 5-13% in ED utilization in two of its commercial ACOs, as well as the MSSP population. Much of this reduction can be attributed to the care coordination program.

Anecdotally, CHN’s providers have been pleased with the CORHIO integration. Turnover rates for nurse care coordinators are very low, and they appear to enjoy the flexibility and ability to provide proactive care coordination. The primary care physicians appreciate the real-time utilization data and the hands-on assistance of care coordinators, viewing them as part of the practice care team.

TOOLS & VENDOR PARTNERS

CHN began using Salesforce long before its CORHIO integration, building its entire custom care coordination platform with the technology. CHN is very pleased with its Salesforce experience, finding the software intuitive, highly customizable, and cost effective.

To begin this work to gather more real-time data on its patient population, CHN’s Director of Care Coordination initiated a dialogue with the Colorado-supported HIE, CORHIO. During these discussions, a pilot was developed to attain real-time data from all participating Colorado acute facilities. Centura had an existing contract with CORHIO prior to the integration, and CHN was able to “piggyback” on that contract so the initial startup costs were minimal.

CHALLENGES WITH IMPLEMENTATION

Initially, CHN planned to receive all notifications from CORHIO but quickly decided to remove services that did not require any action from care coordinators (e.g., mammograms, labs). It took two months to refine the list of actionable HL7 messages that CHN thought warranted automated notifications; then, the group wrote the logic to carve out the services that should not trigger a notification. Another challenge was CHN’s dependence on how the sending facility sent their HL7 messages. For example, one large health care system with several locations sends its HL7 messaging as if all services are coming from the main campus regardless of the actual facility, making it difficult to determine where patients are actually receiving services.

In addition to these technical challenges, CHN has encountered issues with providers wanting the same level of care coordination for all patients in their panel, not just those attributed to the ACO. This presents a bit of challenge, as not all practices can invest in a similar care coordination resource for their other patients.

KEY LEARNINGS

- Partner with state or regional organizations – Leverage state HIEs and other resources to gain access to data, share learnings, and develop creative solutions.
- Invest in flexible technology – Choose a software platform that is highly customizable, intuitive, and has adequate technical support, preferably one with which you have prior experience.
- Technology is just a tool – Without strong, capable care coordination teams, CHN’s CORHIO integration would be meaningless. Prioritize staff training and development.
- This work takes time – Be prepared to invest time in refining and implementing this technology.

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