CASE STUDY

Bridges Health Partners Supports Physician-Led Care Teams with Vital Population Health Data

THE CHALLENGE

Coordinate care across a vast healthcare system

Created as a result of the Affordable Care Act of 2010, Bridges Health Partners is a physician-led accountable care organization (ACO) that supports the care coordination of their assigned beneficiaries throughout their partner healthcare systems across Western Pennsylvania. Bridges Health Partners also has a CIN (Clinically Integrated Network) division that manages the contractual arrangements with commercial payers.

In 2020, Bridges Health Partners expanded its partnership by bringing in Genesis Medical Associates (GMA), a group of eight family practices, and a host of other specialties, including podiatrists, dermatologists, and obstetricians. The purpose of this partnership was to expand the Bridges' geographical footprint in the region and to leverage the success of the clinical proficiency that GMA has achieved.

THE SOLUTION

Provide top-quality care at the lowest cost possible

The responsibility to provide care coordination for multiple healthcare organizations means that Bridges Health Partners has to meet the health needs of more than 90,000 people. To effectively perform their mission, they rely on a variety of clinical staff and tools, of which the NextGen Population Health application is the cornerstone.

"The solution helps us match people with the care they need when they need it," said Sheldon Bogos, MBA, PMP, director, information technology and compliance for Bridges Health Partners. "As an ACO, our focus is to provide top-quality care at the lowest cost possible. We use the NextGen Population Health application to help us make determinations of which patients are most at risk and have the highest probability of hospital readmissions, or other high-risk factors."

"For example, we review the per member per month (PMPM) data. The solutions may show us we run at a cost of $9,500 per member per year (PMPY). Then CMS tells us that we ought to be able to care for patients, on average, for about $10,100 PMPY. If you do the math, we achieved a $600 savings PMPY," said Bogos. "When extrapolated out over the entire CMS population and factored by our Quality Reporting results, you get the substantial savings we have been able to achieve."

As a result, Bridges Health Partners can demonstrate how they are saving money while administering quality care.

CLIENT PROFILE

Bridges Health Partners

Location: Warrendale, Pennsylvania

Mission: To be a physician-led organization that improves the health of populations by providing accessible, high-quality, cost-effective, patient-centered care through member collaboration and innovation.

Background: Bridges Health Partners is a partnership among four independent non-profit health systems in the Pittsburgh region (Butler Health System, Excela Health System, St. Clair Hospital, and Washington Health System).

This clinically integrated network consists of:

- More than 1,000 physicians
- More than 100 primary care access points
- Seven value-based payer programs
- More than 90,000 contracted lives

HEALTHCARE SOLUTIONS

- NextGen® Population Health
- NextGen® Population Health Data Warehouse

HIGHLIGHTS

Achieved a level of success with shared savings in the CMS ACO program that fewer than 5% of ACOs achieve in their first 3 years of operation

Ensured accuracy of quality metrics to receive bonuses from commercial payers

Addressed the care needs of 90,000-plus covered lives in traditional Medicare, Medicare Advantage, Commercial, and Medicaid contracts

Connect with patients in need

Ahead of meeting with their joint partnership practices, Bridges Health Partners' care managers and nurses use data from NextGen Population Health to determine the patients who need a little extra help.

For example, a patient was discharged from a hospital under the Bridges Health Partners' umbrella and couldn't get a prescription filled because they weren't given instructions upon discharge. The patient was also supposed to be enrolled in a congestive heart failure (CHF) cardiac rehab program but never received proper details. The Bridges Care Team reached out to the primary care provider (PCP) and hospital to ensure that the medication was prescribed and made sure arrangements were made for the patient to attend the rehab program.

"We start every meeting with one of these stories because we try our very best to never lose sight of what's most important—the patients," said Bogos. "We will help patients get the transportation they need to visit their doctors and pick up their medications, arrange for meals, help arrange for home health, or remove a whole litany of other Social Determinants of Health (SDOH). Many of these interactions with our patients are made possible because of the knowledge and insights that the NextGen Population Health tool gives us."

Ensure quality metrics are met

Bridges Health Partners receives fees for care coordination from their commercial payers; however, they must provide evidence of reaching different quality metrics each month or quarterly to get paid. Based on claims and clinical data, metrics capture the number of colonoscopies, cancer screenings, breast cancer screenings, and several other key clinical measures.

NextGen Population Health helps confirm the number of patients tested based on the combination of data coming from the EHRs and payer claims data, which ensures that Bridges receives the full payment earned for achieving contractually established metrics. Some commercial payers will give an additional bonus when specific tiers of clinical care and performance are reached.

"In one particular case, a payer stated we met only seven of ten metrics according to their claims data, which prevented us from receiving the tiered bonus. I compared the payer's data with the clinical data from the application, and it showed that we had, in fact, met eight of the ten metrics. This extra effort to ensure we did the right things for our patients provided us a substantial bonus," said Bogos.

Bridge the gaps

Bridges Health Partners pulls data from the NextGen Population Health system to identify care gaps related to colon cancer, breast cancer, falls risk screenings, influenza and pneumonia shots, and several other gaps in care.

The gaps are identified in bi-monthly reports to providers who proactively reach out to patients and arrange for these preventative health care activities. These reports were created by the Bridges team using the data available from the back-end data warehouse.

> "If we didn't have our partners send data to NextGen Population Health, probably two-thirds of the ADTs that we follow up on would not be possible. We'd never be able to incorporate this vital information into the patient's care."

Sheldon Bogos, PMP, MBA
Director, Information Technology and Compliance
Bridges Health Partners

nextgen healthcare

Keep tabs on ADTs

The clinical team leverages the solution to access and review hospital admissions, discharge, and transfer (ADT) notifications across the partner health systems every morning. Bridges Health Partners specifically looks for people who have had any hospital event and then reaches out to these patients to make sure they have their discharge instructions, medications, and follow-up visits arranged.

Bridges was able to augment the ingestion of their partner's eight hospitals with ADT information from every hospital across Pennsylvania by working with the Western Pennsylvania Health Information Exchange (called Clinical Connect). This gives Bridges visibility to hospital events that would otherwise not be known or acted upon.

"We want to do everything we can, when possible, to keep dollars spent on healthcare within the Bridges network of providers and facilities," said Bogos. "When staff reaches out to patients, they're going to say, 'I know the doctor from the hospital wants to see you, but we also need you to see your primary care provider as well.' This helps our care teams stay in the loop of the patient's progress and ensures their care needs are met within our network."

"If we didn't have our partners send data to NextGen Population Health, probably two-thirds of the ADTs that we follow up on would not be possible," said Bogos. "We'd never be able to incorporate this vital information into the patient's care."

HOW CAN WE HELP?

Partner with us at **855-510-6398** or **results@nextgen.com**