CASE STUDY

Optimizing Patient Care and ED Utilization Through Care Coordination

CareOregon has **reduced its 30-day hospital readmissions rate to 7-8%** using a care transitions program

"We use Collective on a daily basis to see why, when, and where our patients are admitting—and navigate the best care plans for them going forward."

- Summer Sweet,
Triage and Data Integration Manager of Population Health at CareOregon

CareOregon

CareOregon is a nonprofit that provides health plan services for low-income individuals in Oregon. It aims to improve patient outcomes and community health, emphasizing the importance of collaboration, partnerships, and innovation. To optimize patient wellbeing, CareOregon takes a holistic approach to patient care, looking at all facets of patient care to help drive better patient outcomes.

Prioritizing Care Through Better Reporting Systems

CareOregon provides transitional care for its large population of dual-eligibility members transitioning from hospital inpatient stays to skilled nursing facilities or home. But tracking these members was difficult, which meant a lot of resources were spent calling hospitals in the area, asking if the members were there.

To help save time, CareOregon began tagging each patient through Collective Medical—an ADT-based care collaboration platform.

With the platform, care coordinators can easily tag and track patients based on population segmentation, special needs, or patient engagement. Automated daily reports are run and delivered to coordinators from the platform to help identify and prioritize the need for follow-up.

By receiving everything the coordinators needed in one, automated report—instead of four different, manually-run reports—CareOregon is able to improve patient follow-up while minimizing work. Summer Sweet, Triage and Data Integration Manager of Population Health at CareOregon, explains:

"With our own efforts, our coordinators' ability to see where our members were going was limited to the major metropolitan hospitals in their area. We were missing people, and a huge portion of our populations were not getting the outreach they needed. Meanwhile, our clinical team was tied up in the administrative burden of trying to find these members by calling each hospital individually to ask about the patient.

With Collective, we could see easily where members were going across the state—and beyond—allowing us to better prioritize and facilitate our outreach and improve transitions of care."

The Collective platform offers an aggregate view of observation views, inpatient visits, and trends across hospital systems. By grouping members via tags, CareOregon can assign follow-up care from the coordination team more easily and equalize work across care teams. Sweet continues:

"Tagging patients and automating reports has reduced the time our coordinators spend on administrative tasks like calling hospitals and waiting for faxes to come through. Without the same administrative load, these coordinators are better able to prioritize care with our members and arrange in-person visits for members within 72 hours of hospital discharge."

Streamlining Authorizations for Utilization Management

Utilization Management (UM) can be a nightmare for many health plans. And like many others, CareOregon's team was struggling with the constant barad of faxes. When many of these faxes were for events that had happened weeks, or even a month, ago, it created a bottleneck that made proactively engaging with members impossible.

To quicken the process, CareOregon began feeding Collective's HL7 ADT feeds directly into its UM platform. With almost all notifications coming from one spot, the team was able to more quickly address the care each member was receiving—and proactively reach out to help facilitate care moving forward often before the patient had even left the hospital. Many authorizations were processed almost instantly, freeing up the bottleneck for both CareOregon and its providers.

A Holistic Approach to Patient Care

While a medical concern may be what the member lists as his or her chief complaint, often times there are outside factors that contribute to when the member presents at the ED.

Understanding this, CareOregon provides many member benefits that are not traditional for health plans, including two weeks of meal delivery post-discharge, community connections for housing, and transportation services.

In addition, nurses or behavioral health specialists make at-home visits for members with high risk within 72 hours of discharge. Pharmacy staff is also deployed to visit and ensure that the patient is properly managing the medication assigned, offering guidance as needed to help the patient take the right medications the right way at the right times. Sweet explains:

"When we're able to get into a member's home, we can see how post-discharge care is really going. We're able to get a better look into both the member's health and social needs, and further assign clinics for follow-up and transitional support as needed."

Strengthening Follow-up Through Facilitated Collaboration

CareOregon places Care and Outreach Specialists (COS) in four of its major hospitals. When a member presents at one of these hospitals, the outreach specialist receives an alert from Collective Medical. The specialist can then meet with the member for an initial assessment to determine next steps.

Each specialist has a background in medical assisting, or alcohol or substance use disorder counseling, and can help direct beneficiaries for further care with the most appropriate clinical resources—including behavioral health resources, RNs, specialist physicians, case managers and social workers. Outreach specialists are also able to connect members with non-medical resources to help address social determinants of health like transportation or housing. Sweet explains:

"Our care teams work to wrap around and fully support our members—ensuring all of their needs are getting met. Each care and outreach specialist works to identify the driving force behind each admission, even if it's not immediately apparent, so we can address the root of the condition. For example, we have individuals presenting at the ED with medically complex conditions whose primary complaint is something physical, but in reality, those physical upsets are driven by a behavioral health condition or social determinant. By looking at the patient as a whole to identify what is driving these episodes, we can better address, predict, and prevent these situations for better patient outcomes."

CareOregon teams then work to ensure that these patients receive the appropriate follow-up care, connecting care team members through the platform. With behavioral health specialists, primary care providers, pharmacists, case managers, and hospital teams working together, plans are created for these patients and housed in the Collective platform—where they are available and distributed to the patients care team at the point of care. By streamlining and unifying this communication, transitions of care, follow-up, and patient outcomes improve.

Outcomes: Reducing ED Utilization and Readmissions

When CareOregon first began its transitions of care program, 30-day hospital readmission rates were high—and heavily penalized as a result. Sweet explains:

"When we first started our transitions program, it was out of necessity. Our readmissions were high and heavily-weighted, and we were not doing well. Since implementing this program, we have been able to reduce that rate to 7-8 percent, which is well within the national average for a Full Benefitted Dual Eligible Plan."

About Collective Medical

Collective Medical provides the nation's largest and most effective ADT-based network for care collaboration. Our risk-adjusted event notification and care collaboration platform spans across all points of care—including hospitals, payers, behavioral and physical ambulatory, and post-acute settings.

Collective's platform helps identify at-risk, complex patients and share actionable, real-time information with diverse care teams across the network, leading to better care decisions.