2015 Davies Award Winner

Centura Health

Core Metric: Population Management

Executive Brief

About

Founded in 1996, Centura Health (Centura) manages the assets of two sponsors, Catholic Health Initiatives and Adventist Health System, under a joint operating agreement. Centura provides affordable, world-class care through an integrated network in Colorado and Western Kansas. With an EHR containing approximately 2.4 million patient records and serving more than one million patients each year, Centura is the largest integrated health network in the region. They serve patients with over 17,000 of the best hearts and minds in medicine, along with 6,000 physician partners.

Results

- Reduced heart failure patient readmission by 17.48%, annual PMPY cost of care by 7.4%, and care gap index by 15.65%
- Reduced COPD patient readmissions by 16.02%, annual PMPY cost of care by 1.64%, and care gap index by 11.25%
- Reduced diabetes patient readmissions by 10.22%, annual PMPY cost of care by 1.89%, and care gap index by 18.32%
- Achieved a 91.73% composite quality score for MSSP

Overview

Centura designed two models to manage population health, one for a large metropolitan area and one for a more rural and geographically isolated area. Both included close relationships with primary care physicians (PCP), an aspect of risk that required a personal conversation with the client or patient; active care management using longitudinal relationship building with the highest risk individuals; engaging patients in their own care; leveraging existing IT tools and EHR for care and data management; and working with partners such as insurers, health information exchanges, and government agencies with a shared vision and goal.

For the metropolitan area, Centura participated in the Accountable Care Organization (ACO) structure and joined Medicare Shared Savings Program Colorado Accountable Care (CAC). Their clinically integrated network Colorado Health Neighborhoods (CHN) consisted of 3,100 providers. Operating under this population health model, Centura significantly improved care for heart failure, COPD and diabetes patient populations.

Situation

In their ACO populations, Centura targeted several conditions for active care planning and management, including COPD, heart failure and diabetes. Interventions included population identification, risk stratification, identifying and addressing care gaps, and ensuring careful transitions of care. Committed to caring for an unknown population, Centura didn't have baseline data for any of the target conditions. However, with their baseline rate for 30-day readmission for heart failure discharges for the whole system in 2013 at 9.89 percent, Centura recognized that this rate would lead to unfavorable results in an accountable care model.

A dedicated team of post-acute care experts, care management experts and informaticists developed and maintained Centura's ACO products, contracted with payers and delivered positive financial results and patient outcomes. They developed close working ties with hospital leadership, group practices and integrated health network practices. Collaborating with CHN physicians, Centura developed clinical pathways for heart failure, COPD, asthma, CAD and diabetes. They supported care coordinator efforts with tracking and customer relations management software tools, and a 24/7 call center.

Centura received membership files monthly from each insurance carrier and used third-party software to risk stratify the population using claims data. They identified the primary care home for those high-risk individuals who would receive interventions, and managed care transitions from Centura hospitals in a post-acute care system. Patient primary care occurred in the system EHR, with care coordination also documented in the patient EHR record and documented and tracked in the CRM tool.

The care management team devoted significant time and resources to data management, reporting and analytics. These efforts supported the ACO's ability to deploy targeted, personalized interventions in response to key insights about the health of the populations managed. They tracked process measures in four domains: patient/caregiver experience, care coordination/patient safety, preventive health, and at risk population.

Outcomes

By reducing care gap indexes and providing coordination of care across all venues of care, Centura impacted the metrics for three conditions for CAC.

- Reduced readmission by 17.48 percent for heart failure patients, and reduced the overall annual PMPY cost of care by 7.4 percent.

Chronic Disease Management: CHF*					
Months	Benchmark (Norm)	CAC 2013 Avg	CAC 2014 Avg	CAC 2015 YTD	% Change From 2013
Utilization Data					
PMPY	$33,830	$31,073	$30,274	$28,775	-7.40%
Readmission Rate	22.65%	20.37%	18.50%	16.81%	-17.48%
Quality Data					
Care Gap Index	11.28	11.06	10.62	9.33	-15.65%
Efficiency Indices					
Cost Index (Actual Costs/Predicted Costs based on Relative Risk Score)	1.00	1.15	1.10	1.00	-13.24%
Admission Utilization Index (Actual Admits/Predicted Admits)	1.00	1.18	1.12	1.02	-13.22%
ED Utilization Index (Actual/Predicted ED Visits)	1.00	1.19	1.31	1.38	15.63%

- Reduced readmissions by 16.02 percent for COPD patients.

Chronic Disease Management: COPD*					
Months	Benchmark (Norm)	CAC 2013 Avg	CAC 2014 Avg	CAC 2015 YTD	% Change From 2013
Utilization Data					
PMPY	$23,887	$19,579	$19,568	$19,258	-1.64%
Readmission Rate	20.37%	16.84%	15.91%	14.14%	-16.02%
Quality Data					
Care Gap Index	9.29	9.03	8.72	8.02	-11.25%
Efficiency Indices					
Cost Index (Actual Costs/Predicted Costs based on Relative Risk Score)	1.00	1.06	0.99	0.90	-14.56%
Admission Utilization Index (Actual Admits/Predicted Admits)	1.00	1.04	0.97	0.90	-13.51%
ED Utilization Index (Actual/Predicted ED Visits)	1.00	1.12	1.14	1.17	4.47%

- Reduced readmissions by 10.22 percent for diabetes patients.

Chronic Disease Management: Diabetes*					
Months	Benchmark (Norm)	CAC 2013 Avg	CAC 2014 Avg	CAC 2015 YTD	% Change From 2013
Utilization Data					
PMPY	$16,360	$13,878	$13,878	$14,141	1.89%
Readmission Rate	18.85%	15.56%	13.80%	13.97%	-10.22%
Quality Data					
Care Gap Index	8.91	10.38	10.02	8.48	-18.32%
Efficiency Indices					
Cost Index (Actual Costs/Predicted Costs based on Relative Risk Score)	1.00	1.03	1.00	0.97	-6.00%
Admission Utilization Index (Actual Admits/Predicted Admits)	1.00	1.03	1.00	0.95	-8.51%
ED Utilization Index (Actual/Predicted ED Visits)	1.00	1.08	1.08	1.13	4.43%

- Achieved a 91.73 percent composite quality score for MSSP, compared to an 84-86 percent national median score. Centura attributed this to establishing personal relationships with both their PCPs and highest risk clients to gain trust and cooperation with recommended process measures and action plans.

Financial Considerations

Centura invested heavily in designing the processes to support ACO activities. Annual costs included: $500,000 for four FTEs and $250,000 in software maintenance fees. System EHR and content development changes required about 100 hours of planning and consensus building. Report development costs were approximately $11,000.

Centura's initial financial benefits included:

- PQRS payment incentives: Centura's owned group practice (CHPG) received approximately $71,000 in PQRS incentive payments for 2014. (Since the ACO files GPRO on behalf of CHPG, there will be no payment adjustments for 2015 forward.)
- Raised the PMPM from $2.50 to $7 last year for one of Centura's private insurance ACOs.
- Reduced total cost of care by six percent for another private insurance ACO.
- Reduced total cost of care by $1 million for clients in Centura's self-insured program with frequent emergency department use.
- Reduced total cost of care by $1.7 million for CAC's chronic disease population.

Lessons Learned

Centura shared these insights:

- Committed business leaders and passionate clinical leaders are keys to our success in the ACO model.
- We have maximized the support we deliver through our system EHR, but have been willing to look to other more specialized software for unique aspects of the project. Knowing that care coordination across many locations of care and many EHRs is the key, we have learned to use a suite of IT tools for care management, client tracking and condition-based registry management.
- Our next step is to apply lessons learned to other applicable populations.