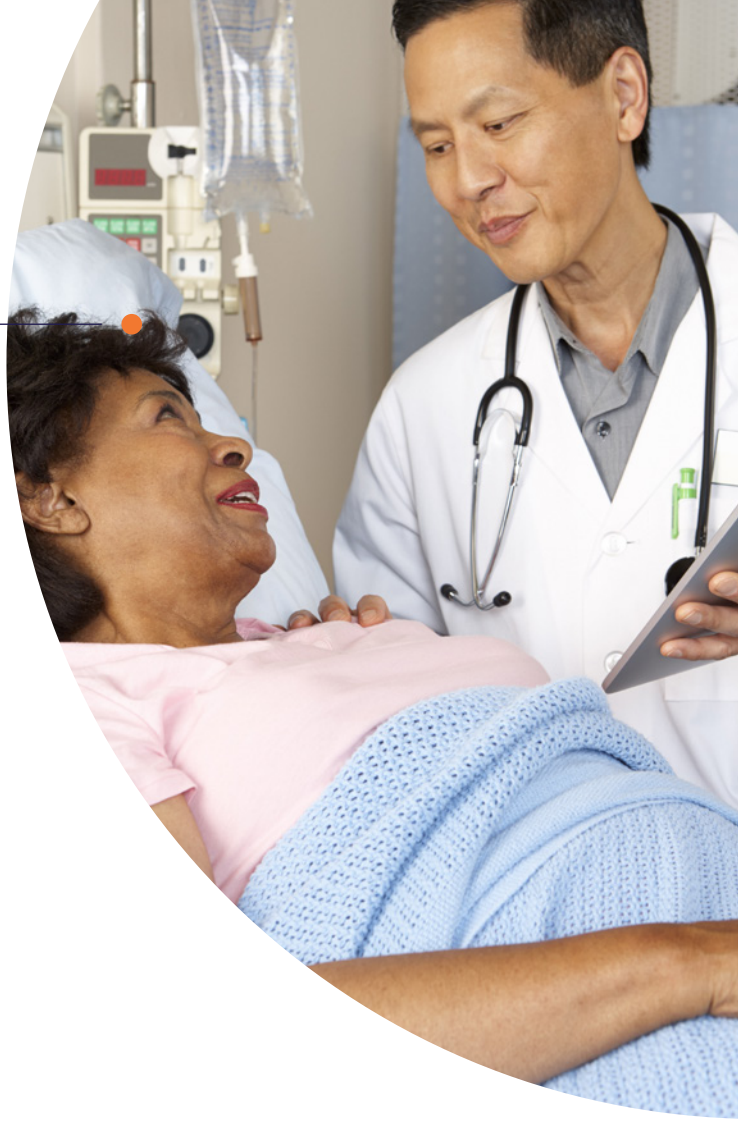
Bamboo Health

CONE HEALTH CASE STUDY



How Cone Health Avoided Unnecessary Inpatient Admissions and Saved Over $1.2M in a 9-Month Period by Using Bamboo Health's Stories Solution

BACKGROUND

Cone Health is a not-for-profit healthcare network serving patients across a multitude of North Carolina counties including Alamance, Forsyth, Guilford, Randolph, and Rockingham. Triad HealthCare Network (THN) is Cone Health's provider-led Accountable Care Organization (ACO).

THN was the first North Carolina ACO to partner with Bamboo Health in 2017 to use Pings, real-time notifications whenever patients experience care events across the continuum through admission, discharge, and transfer (ADT) data. This enabled their providers to appropriately intervene and care for their NextGen ACO population of roughly 30K lives.

Due to the positive results realized from Pings, Cone Health and Triad HealthCare Network expanded their partnership over the next few years by increasing the number of patients monitored by Pings to roughly 90K lives as well as adding on two other Bamboo Health solutions: Spotlights and Route. Spotlights, real-time performance dashboards, help to power THN's real-time analytics on skilled nursing facility (SNF) performance, 30-day readmissions, and multi-visit patients (MVPs). Route is a compliance solution for the Centers for Medicare & Medicaid Services (CMS) mandated Interoperability and Patient Access Rule E-Notifications Condition of Participation (CoP) that went into effect on May 1, 2021.

"Choosing Bamboo Health as our vendor to ensure compliance with the CMS E-Notifications CoP was an obvious choice for our team, as we've seen how critical these notifications are to improving care coordination, enhancing value-based care initiatives, and most importantly, transforming patient outcomes," said Valerie Leschber, MD, Chief Medical Information Officer of Cone Health. "By sharing this information about patient care encounters across provider settings, the Pings solution offers our clinical team increased IT operational efficiency to facilitate new levels of visibility and improved care."

The Challenge

Although Cone Health and THN saw many benefits from Bamboo Health's Pings, Spotlights, and Route solutions, Cone Health faced challenges with emergency department (ED) throughput, ensuring care management resources were able to operate at the top of their licenses, and preventing unnecessary admissions and 30-day readmissions. Moreover, Cone Health's ED care managers and clinical social workers often had to spend critical time doing detective work to track down the non-Cone Health community providers (i.e., SNFs, home health agencies (HHAs), and provider organizations) with which a given patient has a relationship in order to properly coordinate their care.

Cone Health prides themselves on their quality and commitment to exceptional patient care, with the patient's well-being at the center of every decision they make. Due to the increasingly overwhelming ED environment, especially driven by the COVID-19 pandemic, a specific action plan needed to be put into motion to align with their goals and commitments to providing the utmost quality emergency care in a professional and compassionate environment.

The Solution

In 2019, Cone Health signed up for a pilot for their ED to use Stories, Bamboo Health's care transitions assistant that delivers relevant patient context within clinical workflows at the point of care. In the beginning of the pilot, three employees, a care manager and two nurses, actively used the Stories platform to help understand where patients came from and why they were presenting to the ED. Cone Health employees began discussing the benefits of the solution and soon the supervisor of the Transition of Care team at their Moses Cone campus requested that the pilot be expanded to their inpatient location.

Through Stories, these ED and inpatient Transition of Care teams were able to:

Reduce readmissions and activate HHA providers by re-directing patients unnecessarily in the ED back home with a follow-up visit from their home care provider instead of admitting them to the hospital

Gain insight into recent SNF stays within the last 30 days, allowing them to re-direct patients back to the SNF they recently discharged from, helping increase continuity of care and prevent unnecessary admissions, all while avoiding the otherwise required 3-midnight stay to send the patient back to the SNF

Track high-utilizers and acute visit histories both in and out of Cone Health hospitals through the solution's "high utilizer" and "readmission risk" flags in order to understand care utilization trends and diagnosis history

Easily connect with patients' care teams through surfaced contact information, facilitating communication with community resources like ACO partners, federally qualified health centers (FQHC), and primary care physicians (PCP) in order to put together safe discharge or transfer plans as necessary

Quickly seeing the value of the data and insights from Stories, Cone Health added new fields into their care managers' and clinical social works' ED Assessment pages in their Epic Electronic Health Record (EHR) to better document the use, outcomes, and return on investment (ROI) of Stories. Such fields included transition of care time saved, whether a Ping was utilized in the transition of care assessment, whether an admission or readmission was diverted, and which types of interventions were used in that diverted admission or readmission.

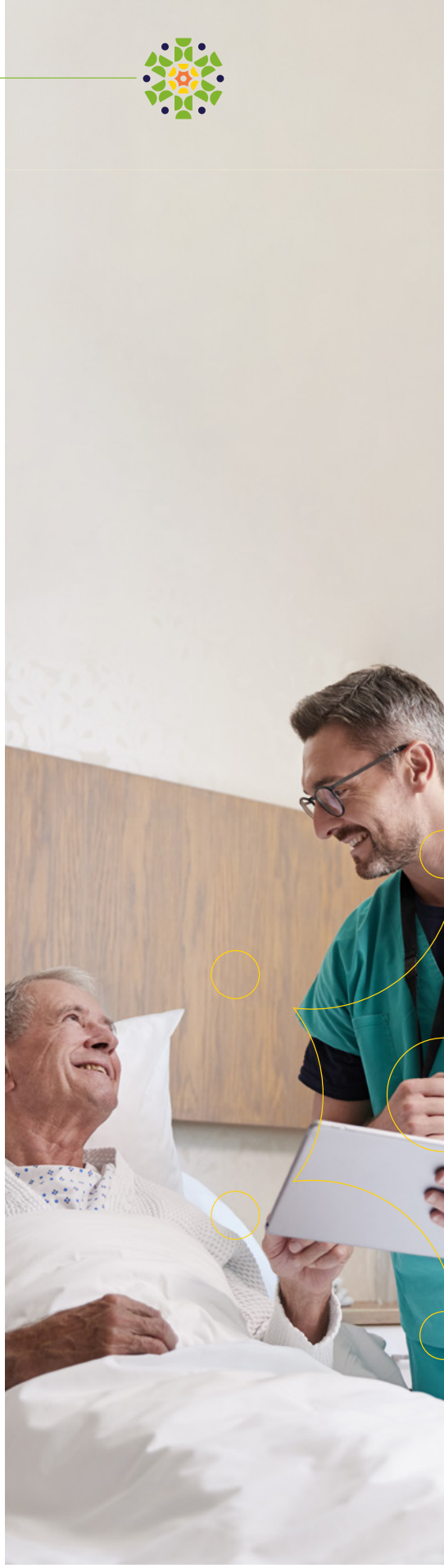
The Results

The Stories pilot was a success. **Roughly three months after going live, the ED care managers and clinical social workers saved on average 18-20 minutes per patient assessment.** Moreover, they reported having more time to have meaningful conversations with patients because they didn't have to spend time asking repetitive intake questions since that information was available in Stories. This benefit has become increasingly valuable during the COVID-19 pandemic during which the ED has been overwhelmed with cases. Saving time by not having to ask patients the same set of questions during their stay is paramount to providing the best possible care.

As a result of the successful pilot, Cone Health decided to implement Stories in all of their campuses in August 2021. **This increased the number of employees using Stories from three to roughly 70,** which includes case managers, nurses, clinical social workers, and care guides in both inpatient and ambulatory settings.

The expanded use of Stories also improved care planning, coordination, and management of their high-risk Medicaid population, helping Cone Health adhere to North Carolina's Medicaid Managed Care contracts as a Tier 3 Advanced Medical Home.

Additionally, they monitor THN lives for their "Keeping Care Local" initiative. The initiative aims to increase continuity of care and network integrity by understanding trends in out-of-network care usage, ensuring timely follow-up by providers and coordinating with patients' PCPs for increased care quality and patient engagement. For this population, Cone Health is leveraging Pings on a SmartRoster, which dynamically attributes any patient that discharges from a Cone Hospital to a roster in real time and then allows them to receive Pings on those patients for an allotment of time post-discharge.



Since the Stories expansion in 2021, Cone Health has seen more astounding results due to Stories:

Saved 20-30 minutes on average per patient assessment since Stories provides prior care history, which aids in more knowledgeable conversations with patients as well as increased employee satisfaction because they have a tool that easily connects them with patients' other care provider teams

Avoided 106 admissions from April 2021 – January 2022 by redirecting patients to previous or more appropriate post-acute care, **amounting to over $1.2M.** This doesn't take into account potential 30-day readmissions avoided, so the savings could be even higher

"Our Transitions of Care teams have appreciated this expansion because it allows a patient's care timeline to be captured without asking multiple, often duplicative, questions. We know the saved time in chart reviews equals more quality time with our patients, thus promoting the true value of healthcare to our patients and their care teams."

Rhonda Rumple, RN, MSN, BSN, CCM
Interim Vice President of Care Management
Cone Health System / Triad HealthCare Network

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About Bamboo Health

Bamboo Health (formerly known as Appriss Health + PatientPing) is a healthcare technology solutions company, focused on fostering care collaboration and providing information and actionable insights across the entire continuum of care. As one of the largest, most diverse care collaboration networks in the country, our technology solutions equip healthcare providers and payers with software, information, and insights to facilitate whole person care across the physical and behavioral health spectrums. **By serving 2,500 hospitals, 8,000 post-acute facilities, 25,000 pharmacies, 37 health plans, 45 state governments, and over one million acute and ambulatory providers through more than 500 clinical information systems electronically, we impact over 1 billion patient encounters annually in provider workflow.** Health systems, payers, providers, pharmacies, governments, individuals, and other organizations rely on Bamboo Health to improve care and reduce cost.

Bamboo Health

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