Bamboo Health

PIONEER VALLEY CASE STUDY

How Pioneer Valley Accountable Care uses Pings to Lower Costs and Improve Care Coordination

BACKGROUND

Pioneer Valley Accountable Care (PVAC) is an accountable care organization (ACO) located in western Massachusetts serving Medicare fee-for-service (FFS) beneficiaries throughout the Pioneer Valley. PVAC has a 21-member Board of Managers, consisting of 14 physicians and three health system executives, all of whom are PVAC provider participants, two managed care organization executives, one Medicare FFS beneficiary, and one Consumer Advocate. The Board of Managers oversees PVAC's operations and strategic direction.

PVAC is affiliated with Baycare Health Partners, Inc., a physician-hospital organization that serves the four Baystate Health hospitals and about 175 medical practices with approximately 1,400 physicians. Baycare is an alliance of the medical staff and Baystate Health hospitals, and collaborates in improving the quality, safety, efficiency, and sustainability of healthcare in their community.

The Challenge

Prior to implementing Bamboo Health's Pings solution, PVAC lacked standardized communication protocols with their skilled nursing facility (SNF) partners. While primary care physicians (PCP) would sometimes receive discharge packets from SNFs, SNFs within PVAC's network were unable to identify if one of their patients was a part of PVAC's ACO. SNFs worked only from a paper list of PVAC's PCPs. They relied exclusively on this list to match patients to PVAC by their attributed PCP, leading to inaccurate PVAC patient identification. This antiquated process made it challenging for PVAC to hold facilities accountable for care quality and instruction adherence for their patients.

In 2015, **PVAC partnered with Bamboo Health to use Pings, a real-time notification tool, to receive alerts on their patients' events.** Once PVAC and their SNF partners implemented Pings, all parties could, in real time, identify whenever PVAC patients were admitted and discharged from their SNFS as well as accurately recognize whether a patient was attributed to PVAC. Through Pings, the facilities also now had information about the patient's PCPs and, critically, how and when to contact the ACO care manager. This was a revolutionary, yet surprisingly simple step forward in coordinating care in real time.

Furthermore, the ability for PVAC to standardize discharge communications with their SNFs through Pings was critical to improving care quality around transitions. **SNFs now receive standardized discharge instructions for all PVAC patients that specify PVAC's discharge summary requirements and communication protocols.** This was an instrumental step forward for the SNFs-ACO partnership, as the SNFs now know not only how to get in contact with PVAC, but also what to do to maximize care for PVAC's patients.

The Solution

By using Pings, PVAC is now able to monitor compliance and develop a culture of accountability across its SNF Network. PVAC relies on a care management team to oversee utilization review and care management for their patients in SNFs. This requires SNFs to keep their data up-to-date (meaning patient data must be inputted in the Pings platform within 24 hours) so PVAC knows where their patients are seeking care at all times.

Based on the success of their SNF network, PVAC is implementing similar care protocols with their hospitals for inpatient events. **Through Pings, PVAC also receives notifications when one of their patients is admitted to a hospital, emergency room, or being seen by the Visiting Nurse Association (VNA).** These care teams can then see the personalized care instructions for high- and average-risk PVAC patients and engage in the appropriate communication and transitions in care protocols designed for PVAC patients to safely transition to the next site of care.

When PVAC initially began looking for technology to implement, one of their biggest concerns was ensuring that their post-acute partners' workflows were not disrupted unnecessarily. They felt strongly that technology should fill gaps and be simple to use. PVAC knew how important it was to engage their partners immediately with the new platform, so PVAC spent close to a year engaging with the post-acute providers to better understand how they were using Pings and to make sure that it was fully engrained in their workflows.

"Pings was and is an invaluable tool helping us to seamlessly deliver coordinated care at the right place at the right time for our patients. It allows us to connect in real time with partners in our patient's care team that were previously invisible to us because we simply didn't know where our patient had gone. It's a simple, but eloquent solution to some of the pitfalls with managing patients across the care continuum."

- Dr. Adrianne Seiler,
Medical Director of Pioneer Valley ACO

The Results

HIGH-LEVEL WORKFLOW EXAMPLE

PVAC receives a notification that one of their patients, Mary Smith, is at Baystate Medical Center (BMC). PVAC can see how long Mary's been at BMC and if she is a frequent flier. PVAC can call other facilities to coordinate Mary's care because they have more insight into long-term discussions regarding her care plan. The PVAC inpatient case manager can call the outpatient care manager and let them know, for example, that Mary is going to a preferred SNF and was started on a new anticoagulant medication. Once the patient goes to the SNF and the SNF admissions coordinator enters Mary's information into the Pings platform, the SNF can see that she is a PVAC patient. They flag her profile as such, and proceed to follow the care protocol for Mary provided through Pings. PVAC's SNF care manager receives notification that Mary is in the SNF and is able to follow Mary's care there. Once Mary is ready for discharge, the SNF can send the standardized SNF discharge packet to the PCP and PVAC care manager. VNA was arranged for Mary and Mary's PVAC care manager receives notification in the Pings platform when the VNA nurse has seen the patient and the VNA nurse can follow PVAC's VNA care protocols.

SNF AVERAGE COST PER CASE BASELINE	SNF AVERAGE COST PER CASE (2 YEARS LATER)	% CHANGE
$13,300	$10,033	-25%

KEY OUTCOMES:

- Improved care coordination
- Refinement and engagement of post-acute network
- Delivered appropriate post-acute utilization
- Decreased overall costs

About Bamboo Health

Bamboo Health (formerly known as Appriss Health + Patient Ping) 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

HOW CAN WE HELP? TELL US YOUR NEEDS.
BAMBOOHEALTH.COM/CONTACT/