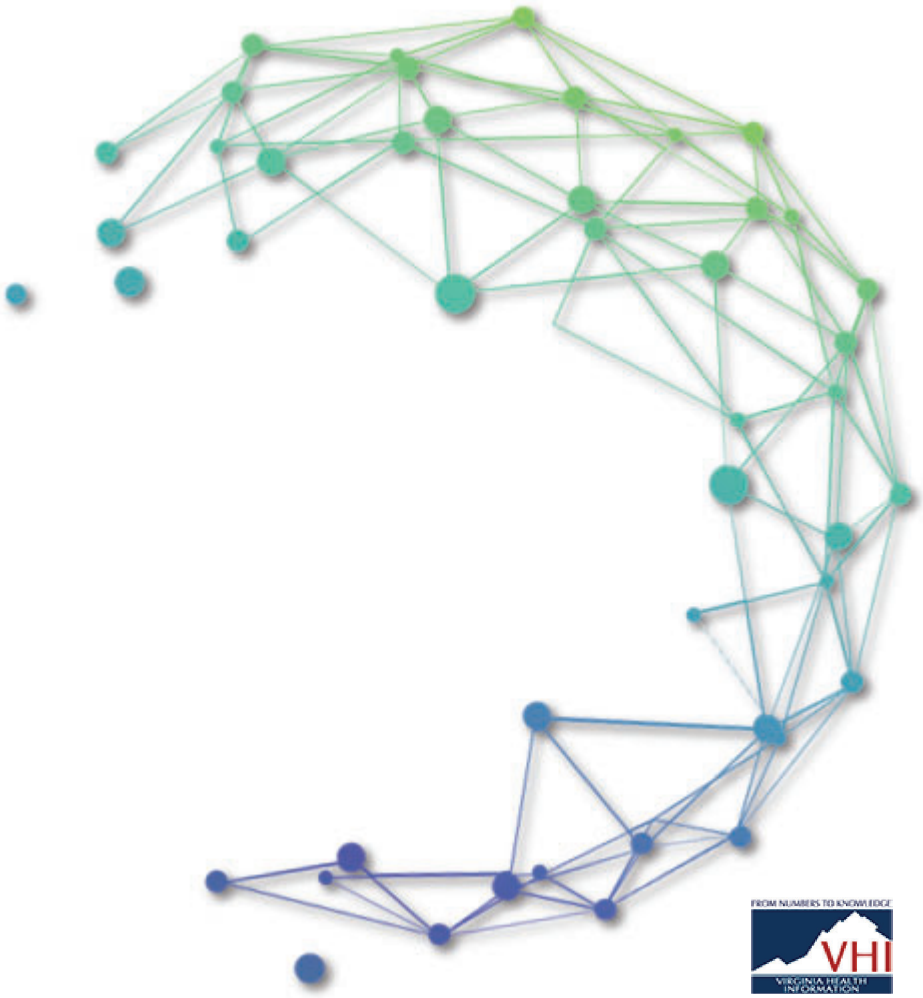
HOSPITAL
CASE
STUDY



Bon Secours Mercy Health:

Revolutionizing Healthcare and Reducing Readmissions

Bon Secours Mercy Health is one of the largest and strongest Catholic healthcare systems in the US. With a number of Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program, Bon Secours Mercy Health needed a way to effectively care for its vast and varied patient population while keeping costs affordable for all involved.

The Challenge

Providing Personalized Care for Large Populations

Bon Secours Mercy Health (BSMH) is currently the fifth largest Catholic healthcare ministry in the country with 48 hospitals and thousands of healthcare professionals providing over 1,000 points of care. BSMH is among the top 20 largest health systems and provides almost $2 million per day in community care in addition to the care provided for its own members.

This extensive reach meant that BSMH needed a way to appropriately care for its patients while eliminating unnecessary care costs. But with such a large patient population, how could BSMH staff know where to focus their efforts and appropriately care for each patient? Dara Rader, Director of Population Health Solutions at Bon Secours Mercy Health, explains:

> ***"Bon Secours Mercy Health identified the need to fuse technology and communication. Healthcare organizations look at standard metrics such as utilization and quality outcomes. We needed a better way to share this information with providers without interrupting their workflow or violating patient privacy. With increasing pressures on our physicians and provider teams, we identified a way to systematically provide insights into patient histories, registries and gaps in care."***

The Solution

Collaboratory Care Plans

BSMH implemented the EDCC Program utilizing Collective Medical's technology—a care collaboration platform that uses smart analytics to identify patients at risk for things like high ED utilization, substance use disorder, behavioral health conditions or social determinants of health.

Once these patients were identified, care teams at BSMH met together as physicians, nurses, case managers, pharmacists and community resources to determine what could be done to help these patients thrive. Care plans were developed, housed in Collective's platform and delivered in real-time to providers when these patients presented—allowing for consistent communication and delivery of care, regardless of the facility or care setting. Rader explains:

> ***"The patient should receive the same level of care no matter what location or provider. By utilizing care insights and guidelines, patients receive consistency of care even when traveling between hospitals and providers who are able to streamline care without compromising on quality."***

BSMH also relies on collaborative care to better serve their palliative care populations. Caring for the poor, dying and underserved is a key element of the BSMH mission bringing inpatient, outpatient, home health and primary care providers across BSMH together to address patients with serious illnesses.

BSMH combined Virginia's Emergency Department Care Coordination (EDCC) Program with technology-provided data analytics to pinpoint patients with high risk and develop succinct plans of care. This effort helped BSMH ensure that these patients receive the individualized care they need in the most streamlined care settings possible.

With increased coordination among providers, patients are getting better transitional care. Post-discharge follow-up rates increase, readmissions decrease and patient outcomes are improved.

Focusing on collaborative care, BSMH reduced readmission rates for high-risk patients by 23%. For medium-risk patients, these readmission rates were reduced 27%.

Clinic Outcomes

As a participant in the Medicaid Shared Savings Program, BSMH continues to expand its collaborative care efforts to reduce readmissions for palliative care, post-acute care and other high-risk patients—ultimately improving patient care while saving unnecessary care costs.

Patient Stories

BSMH was referred a patient with a primary concern of SUD. As staff began to look more into the patient's care history, it became clear that the patient was frequenting EDs across five states—also looking for and receiving opioid pain medication.

With the EDCC Program, the patient's care team was able to recognize her pattern of ED utilization across the east coast and immediately identify her high risk of overdose. The care team was then able to work with the patient to determine a better plan of care including guidelines for pain management. Collaborating patient care, BSMH has seen a 78% reduction in ED visits from this patient.

Quote

"We live in a data rich society, which can be very overwhelming and lead to analysis paralysis. Bringing together, in a thoughtful and very intentional way, data and technology through the use of care guidelines has helped us get the right data in the right hands and at the right time in a way that's impactful."

Dara Rader
Director of Population Health Solutions
Bon Secours Mercy Health

Contact

To learn more about Virginia's Emergency Department Care Coordination Program: **Support@ConnectVirginia.org.**

For Collective Platform technical assistance: **Support@CollectiveMedical.com.**