Bridges Health Partners

Transforming Healthcare Delivery with Digital Care Coordination

About Bridges Health Partners

Bridges Health Partners is a partnership among four independent non-profit health systems that began in 2017 in the Pittsburgh metropolitan market and surrounding communities.

Consisting of Butler Health System, Excela Health System, St. Clair Health, and Washington Health System, each partner system, along with their independent and employed medical staff, are committed to transforming how healthcare services are delivered by implementing an integrated, regional network of care that supports all patient populations, no matter the payer.

Bridge's mission is to be a physician-led organization that improves the health of populations by providing accessible, high-quality, cost-effective, patient-centered care through member collaboration and innovation.

Bridges Challenge and Objectives

Bridges' primary objective was to ensure all groups came together as one, but still functioned as their own regional system.

"We didn't want to lose that local flavor. That was a challenge."

This included making sure providers were:

- Clinically aligned
- Driving to similar value-based outcomes

Initially, different practices were in different places along the continuum of buying into a value-based approach.

To build trust with their providers and ensure an optimal approach to patient care - Bridges sought out standardized tools to enable patient populations to be managed uniformly across the organization, utilizing evidence-based guidelines as a foundation for success.

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Bridges implements ThoroughCare software for standardized care coordination across patient populations

The Solution

In 2018, Bridges selected ThoroughCare's Care Coordination application to deploy a consistent care management approach across patient populations. Primary users include Registered Nurse (RN) Care Managers and Non-RN Care Coordinators. ThoroughCare features and functionality most frequently utilized by Bridges have been care plan development, assessments and interventions, documentation, and scheduling. In 2022, Bridges began using ThoroughCare Analytics for dashboard data visualization and enhanced clinical reporting.

The Value

Utilizing ThoroughCare's software enabled Bridges to provide care management consistently, across the ACO. Specific areas of value enhancement via ThoroughCare include:

Clinical Workflow: Not all Bridges Care Managers have Electronic Health Record (EHR) access. ThoroughCare enables Care Managers to have remote, clinically relevant, personalized engagement with their patients. Additionally, automated documentation enables consistent internal reporting and communication back to the provider, saving valuable time and reducing staff burden.

Care Plan Development: ThoroughCare enables Bridges to generate care plans with associated interventions, based on individual patient assessments. This automation has helped tailor the care experience to the patient, and nurture greater patient and provider relationships. It has also been a significant patient pleaser, reducing redundancy and discrepancy in clinical information gathering.

Patient Engagement: ThoroughCare's call scheduling functionality and documentation has enabled Bridges to seamlessly cover for staff that may be off, reducing gaps in patient communication. As a result, Bridges has been able to reach more patients while using ThoroughCare. Documentation and analytics have enabled more effective report generation, which enables the ACO to better understand its population.

Social Determinants of Health (SDOH): SDOH is a strong focus area for payers and can be difficult to address for providers. ThoroughCare has helped Bridges identify SDOH needs within its patient population. A large volume of patient outreach is done by Care Coordinators. The Care Coordinators address patient-specific SDOH through tailored questions within their care plan assessments and connect patients to relevant resources.

ThoroughCare enables Bridges' Care Managers to document health data and feedback important to them, and the patient. With ThoroughCare, users can click on relevant conditions and access tools to ask patients pertinent questions and provide appropriate education.

Bridges Patient Success with ThoroughCare Care Coordination

Brief patient history/status pre-care management:

A patient with a history of coronary artery disease, diabetes (20+ years) and nephropathy had been in the hospital due to a coronary blockage, which required Coronary Artery Bypass Grafting (CABG).

Care Management Intervention:

The Bridges care manager reached out to the patient the day following his discharge.

The patient stated he wanted to focus on getting "healthier." Both his A1C (8.1%) in March and weight were higher than optimal. He started cardiac rehab and although initially limited by pain and general recovery, he began to walk and concentrate on his diet.

The care manager reviewed the provider's plan of care, which was reinforced in her interactions with the patient.

The care manager encouraged efforts to increase physical activity and educated him on the importance of medication compliance and diet in managing blood sugar levels. Specifically, the importance of incorporating protein and vegetables, the role carbohydrates have in blood sugar control, and avoiding processed foods were discussed and reinforced with the patient.

Outcome:

Since becoming more engaged in his health journey, the patient has reduced his A1C to 6.4% and lost 14 pounds.

> "ThoroughCare allows us to engage and educate patients consistently using evidence-based medicine as a guiding tool. Care plan development and documenting outreach and interventions have enhanced our clinical workflow and operational effectiveness, enabling us to reach more patients and develop consistent standards of care across disease states and patient populations."
>
> - Kristina Hahn RN, MSN, Executive Director of Population Health Operations at Bridges Health Partners

ThoroughCare

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