CASE STUDY

HEALTHCARE NETWORK OF SOUTHWEST FLORIDA

About HCN

The Healthcare Network of Southwest Florida (HCN) was founded in 1977 to address the health issues of migrant and seasonal farm workers, rural poor, and other citizens in Florida's Collier County. Today, HCN's federally qualified health center (FQHC) serves the area's uninsured and under-insured population of primarily Hispanic and Haitian Creoles, where language, transportation, and social issues complicate the organization's mission. A population health management (PHM) initiative was key to helping HCN continue its efforts to provide the highest quality, comprehensive, and affordable healthcare.

Chronic Care Management Provides Entry into Population Health Management

HCN began by addressing its high-risk population of patients with chronic conditions. Because of language and transportation issues, this involved a dedicated outreach team of care givers who transport patients and visit them in their homes to help them manage medication and lifestyle, and who work with the community to find additional resources. The group quickly found that using spreadsheets and the existing athenahealth EHR to track activities was simply too cumbersome and ineffective to manage this large, complex population. With a goal to help patients move to self-management as much as possible, HCN needed an automated PHM approach that would help the team keep track of patients and their care and also better manage reporting for reimbursement.

Dr. Gregory Preston, CMO, was tapped to develop a care coordination department and a broader population health management strategy for the organization based on an initial grant from the Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services. "We convened a project team and identified resources inside the organization to develop the care coordination department," says Dr. Preston. "We found 11 people who were doing this in various ways and combined them into one department under the director of nursing, and then wrote the policies and procedures and started working with Enli to meet our needs."

The technology to support this effort includes the existing athenahealth EHR, McKesson care plan, and the Florida Health Information Exchange event notification system. Enli Central Worklist integrates with all of these to provide the PHM foundation that supports the new workflow. Requirements for documentation such as care coordination, transition of care, and addressing gaps in care are in Central Work List, while the tools to document requirements for a CMS annual wellness visit and subsequent wellness visits are done in the EHR. Data entered into the athenahealth EHR is available to the Enli dashboard by the next day, giving care teams the up-to-date information they need.

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Primary Care Adapts to a Slower-Paced, More Thorough Approach for Seniors

Dr. Preston identified the Medicare population as a primary target because of its soft revenue opportunity through CMS' chronic care management program, but broadened the scope to other adult patients. The team developed a program that supports a primary care physician and the primary care clinic team in the day-to-day practice of a program called Senior Care, which is focused mostly on patients over 64. Many are insured through Medicare Part B but about half don't have health insurance. The system is designed to convert fast-paced primary care clinics to a slower-paced, more thorough approach for seniors.

Streamlining the work and support outside of the patient's physician encounter was key to addressing the organization's challenges with a patient population that combined low literacy, non-English speakers, and multiple chronic conditions. Until recently, doctors tried to address patients' issues in a single visit, but depended on lab tests and orders that the patient often didn't follow. Now, with the use of care teams, HCN is doing as much at the point of care as possible.

For example, HCN has deployed hemoglobin A1C meters to each of its adult medicine clinics to test diabetic patients whenever they come in for an office visit, instead of asking them to go to a lab. Dr. Preston explains, "If the A1C is due, we have a standing order so the nurse does it before the patient goes in the room. There's more diabetic education that's going to go on in that encounter than would have happened if the doctor just said, 'Do you know your A1C?' and the patient said, 'No,' and he orders it and doesn't see the patient again for a year or six months. This streamlines the process and reinforces for the patient and the physician the significance of the care and teaching that goes on."

Scalable Population Health Management Requires More than Spreadsheets and EHR

Before the PHM initiative, Melissa Peregrino, Outreach Case Manager at HCN, had developed a spreadsheet-based work plan to track patients and their issues, treatment goals, and activities. "That's how we used that to keep track," she says. "It got a little overwhelming because we only have the one RN and two LPNs. With our population all very high-risk it was getting to be a challenge. At that time, we were managing about 40 patients. Right now, we have 176 in chronic care management."

HCN considered a module in the athenahealth EHR to support its PHM initiative but found that the EHR didn't give the care team actionable items for PHM. According to Peregrino, Enli's dashboard provides critical functionality to see patient data at-a-glance including outstanding orders, follow-ups, and recent activity, without having to search through the patient's chart in the EHR. Care managers can easily track patients as well as billable time and activities in the Enli software and data is automatically updated in the athenahealth EHR.

The reminder function within Enli Work List allows the organization to scale its PHM activities. "Now that the nurses have so many patients, it's getting more and more difficult for them to follow up," says Peregrino. "But when they know that a patient has had a doctor's appointment, they can put that on the reminder and know that they need to look at that patient's chart after the appointment, to see if there were any changes and to follow up."

She adds, "If we didn't have the Enli software, we wouldn't be able to do it. I can't see keeping track of that many patients in athena. Follow-up is a huge component, and this enables us to keep track. It's just wonderful."

Connie Aguirre, HCN Nurse Care Manager, agrees. "As soon as we log into Enli, we have that list of patients and we can see who we've contacted, so it keeps us on track. That's very important because if we have something going on with the patient, or certain goals that we want a patient to meet, we need to have a visual every day to see where we are with this patient and where do we want to be."

Another important benefit of the Enli software is the ability to support PHM needs across clinics. While patient data was accessible from the EHR, a member of the care team still had to manually search records to find a patient's care needs. Enli software allows a patient to be seen at any one of HCN's six adult medicine clinics with full care management details.

"We moved the patient-centered medical home from the clinic to the patients," explains Dr. Preston. "Wherever they go, all this information follows them and is available at the point of care. That, to me, is a home run. I've evaluated these programs all over the country over the past few years, and everybody comes up with sort of a similar idea, but Enli's so far has been the easiest to use."

Integration Is Key for Seamless Workflow

Janie Montero, IT Support Services Manager was the project manager for the PHM initiative. She emphasizes the importance of an integrated technology stack to support provider workflows and bring all data back into the EHR record. "Providers don't want to have to go looking in multiple systems," she explains. "It needs to be able to integrate and be almost a seamless operation for the doctor when he's seeing patients." Montero and her team worked closely with Enli and athenahealth to meet the EHR's strict protocols on data integration between Enli Central Worklist into Athena and to McKesson.

Montero was working toward a deadline of early April 2018, about 14 months after the program launched, to have at least 800 Medicare patients into the system for the organization's HRSA grant deadline. "Once we were able to hit that deadline and we knew that information was in there, that was a defining moment for us; that was a really important milestone to hit." In fact, in the site visit to support the HRSA grant and ensure compliance with all of the rules, HCN passed its HRSA site audit with 100 percent satisfaction, in the shortest exit time the examiners had ever seen.

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Outcomes and Next Steps Focus on Improvements in Quality and Revenue

HCN is in the process of being assigned to an affordable care organization (ACO) owned by another FQHC in Manatee County called the Managed County Rural Health System. This will give HCN new revenue opportunities supported by Enli's software and the PHM initiative it supports.

"We were not doing a very good job of billing Medicare because as a FQHC, we weren't eligible to provide many of the services that CMS recognizes," says Dr. Preston. "But after a year of setting this all up, we went from no patients in the ACO to about 700, and we started doing all this work with our new technology stack."

Care management is a big part of ACO performance. By doubling its Medicare footprint and performing well in the ACO in both quality measures and cost management, HCN also expects to significantly increase its revenue stream. Because Enli's software identifies gaps that need to be closed, HCN expects it will help lead to an improved CMS star rating for quality measures. To get to that point, HCN will roll out the Central Work List with half of its primary care physicians right away and to the rest a few months later.

"Our quality people love the ability to assess gaps in care at the practitioner and clinic level," Dr. Preston says. "We were looking at another application to do clinical informatics around quality and once they saw Central Work List, we stopped looking. That just lets you know how enthusiastic the quality department was."

Dr. Preston explains the importance of being paid for care coordination and transition of care management. "That's a big deal because that was an untapped resource previously. If we can treat these 700 or 800 patients we expect to be assigned to the ACO, then we're going to be about 15 percent of the ACO's membership, and that's going to be a big number for us to manage effectively. When we double our enrollment, we expect to be 20 or 25 percent of the ACO's membership. That makes us a major stakeholder, which means our performance is going to affect the way the whole ACO works and how it performs." The ACO also has other FQHC partners, and while HCN is currently the only one using Enli software today, Dr. Preston says they're watching HCN's successes closely.

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