THE HERTEL REPORT

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Arizona Care Network
A Better State of Care

The BIG Idea

Care Coordination at the Heart of Arizona Care Network's Population Health Strategy
Insights, Personal Touch Help ACN Providers Deliver the Right Care

Technology continues to take healthcare in exciting new directions, informing population health strategies, uncovering patients' social determinants of health and minimizing hospital stays for millions of people.

At Arizona Care Network, our IT-infused approach to population health is closing the gaps in care, building a support system between patients and primary care physicians, and helping clinicians navigate a complex healthcare environment.

But unlike other health systems and accountable care organizations, our approach is rooted in care coordination. The idea is to put people at the center of the equation by helping physicians deliver the right care to the right patients at the right time.

We do this by connecting hundreds of thousands of ACN patients to the care they need to prevent health problems, treat new conditions and guide them through transitions of care. We also arm providers with targeted, actionable insights to manage care for their patients while reducing duplication of services and administrative inefficiencies that keep them from doing the jobs they love.

Here's how it works: we know that data and analytics are the operative words in healthcare. The challenge is not about getting information, but rather what to do with it. With this in mind, Arizona Care Network created a three-pronged program to drive its population health strategy through N Compass Care Coordination.

It starts with a population health platform that uses a proprietary algorithm to stratify patients according to their health histories, risk of inpatient hospital and Emergency Department utilization, along with medication use and level of disease control. The platform informs plans for addressing patients' rising health risks by notifying them of wellness checks and screenings while advising providers of patients who are moving to a more complex state of health.

Data collected through the platform are synthesized into a single, manageable operational source that helps providers coordinate care at their offices or with help from our team. This includes embedding ACN care coordination teams into select physician offices to lend the support of registered nurses, social workers, behavioral health coaches, navigators, population health MAs and other resources based on patient needs.

Finally, we identify and monitor patients' conditions, and then create a care summary rich with information, such as patient demographics, health risks and overall health status that providers may not otherwise know. Such an approach is beneficial to physicians, but it also helps empower ACN's 320,000 members to take control of their health by maintaining a schedule of routine screenings and managing diabetes and other chronic conditions.

Accountable care organizations like ACN were created expressly for this purpose. And while ACN already had a strong care coordination program, the improved and expanded N Compass Care Coordination, combined with a new population health strategy, is yielding promising results. Among them are greater collaboration with providers and better coordination on patients' annual wellness visit compliance.

"Most important, we are seeing positive clinical outcomes."

A case in point: In 2018, ACN improved its performance on 13 of 14 designated patient Group Practice Reporting Option measures and its care coordination model helped prevent 98 strokes and 39 heart attacks over the prior year.

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