SIMPLE BUT POWERFUL SOLUTIONS THAT PRODUCE RESULTS

Complex Cases Can Swiftly Wipe Out Your Shared Savings Opportunities….

I thought this vignette, created by my colleagues at ZOlO Healthcare solutions, John Bakke, MD and Deb Lowry might powerfully highlight just one the challenges associated with risk arrangements.

The failures of a delivery system in managing and coordinating the care for complex patients are real and costly. Complex cases emerge quickly, can overwhelm your system and eliminate your potential shared savings. Complex cases may occur at any time including on Day One of your new ACO or bundled payment arrangement. Are you ready?

Delivery system changes can be instituted to prevent the following case from falling into the 1% of most expensive cases. The complications are predictable and readmission is avoidable with an operationally effective program.

Complex Patient Case Study (an actual case)

A previously healthy woman presented earlier this year to medical center, now a Pioneer ACO, with fatigue and cough. In the ER she was found to be in acute renal failure and to have multiple pulmonary infiltrates; she was admitted. The suspected diagnosis of Goodpasture's Syndrome was confirmed on renal biopsy. She was placed on dialysis and received aggressive therapy for Goodpasture's. Her three week stay was complex but one of steady improvement and she was discharged home, remaining on outpatient dialysis and continuing on immunosuppressive treatment. Though she remained in renal failure, her prognosis was felt to be good.

She and her family live about two hours drive from the hospital. The family, like others in the community, has meager financial resources and is medically unsophisticated. From the family's perspective, the discharge process was both sudden and hectic, though the patient was very relieved to finally get home. The patient kept her thrice weekly appointments for dialysis and other follow-up care. However, after two weeks she began to feel weaker and she lost her appetite. Over a long weekend in bed she became too weak to attend dialysis on Monday morning. The next day she was much worse and was taken by her family back to the hospital ER; she was readmitted with uncontrolled hypertension, new hemiplegia and a small intracerebral bleed. Six hours after admission she was transferred by life-flight to the neuro-ICU of an academic medical center two hundred miles away. Her subsequent course was lengthy, very complex, and very, very

expensive.

Analysis

One patient, such as the one described or one with a more common complex condition can have a significant impact on a small ACO's financial performance. Better monitoring of this patient's status after she was discharged would have led to earlier intervention and amelioration of the complexity of the re-hospitalization, or possibly its avoidance altogether.

While disease management, population health management, PCMH development, care coordination efforts, HIE etc. all will return financial benefit to the delivery system over the long run, these efforts are time consuming and thus costly to implement and usually slow to show a positive ROI. However, Complex Case Management (CCM) is dramatically different. And CCM should have been all over this patient from the first day of her initial hospitalization, when it was abundantly clear that her subsequent outpatient management would be extremely complicated. It was obvious that she was in that one percent of patients who, if she survived, would almost certainly consume far more resources than the vast majority of patients for many months to come.

In the volume based reimbursement environment, the failure to rapidly and reliably detect the deterioration of a patient's clinic condition after discharge has not, in the past, been financially hazardous to the provider (outside of the legal consequences of gross negligence). New penalties for readmissions certainly change this fact, at least to some extent. However, for a small ACO, especially one participating in the new Medicare Shared Savings Program, the lack of appropriate CCM can wipe away a significant portion of the annual potential financial gain for the entire program, putting the program itself at risk.

An aggressive CCM function is necessarily a high priority for any delivery system which participates in a value and risk-based reimbursement system. And this, of course, is a central purpose of value based reimbursement. These programs offer enormous financial benefit for both large and small delivery systems, but realizing that benefit requires knowing how to build the necessary structures to assure success. Good CCM is itself complex, and the rapidly evolving technology of home monitoring and home health, while greatly enhancing the power of CCM, adds to the challenge of building an effective and efficient CCM program.

We Can Help

The brief clinical vignette above illustrates a number of failures in the system: failure of care coordination, transition planning, etc., but primarily a failure of being patient centered and of assuring patient/family activation and involvement. These critical factors are key drivers to the success of any organization participating in an ACO project or other innovative reimbursement program.

The patient described here had needs that were clearly known, a high probability of predictable complications and an avoidable readmit. This case is likely to result in high additional costs and possibly a bad outcome. The investment of a long, high tech, multiple specialist hospitalization is put at risk by a lack of care coordination and patient

focus.

What are the elements of a successful primary care complex case management program?

– A system to identify complex patients
– Protocols and special services needed to manage complex cases
– Patient-specific care coordination by a multidisciplinary team led by a PCP
– Ability to fast track arrangements for post-acute care services, e.g. DME, home health, PT, etc.
– Dedicated time for complex case management activities

The delivery system changes required to manage patient care successfully involve both changes in process and culture that need thoughtful prioritization. Further, a health system will need to facilitate a shift in roles and a sharing of accountabilities and responsibilities. Hospitals will need to become patient-centered rather than provider-centered and specialists will need to accept a new role for primary care as orchestra leader for the care delivery team.

Hindin Healthcare Advisors and ZOLO Healthcare Solutions can help you identify and overcome the challenges to establishing a new model of care. We can help you design and implement your complex case management program and other elements of a coordinated care system. ZOLO's senior consultants include physicians, nurses and executives with significant experience operating in fully integrated managed care organizations. We can complete a high level assessment of your system, provide a comprehensive "gap" analysis for becoming a patient-centered and coordinated care system, design a new patient centered coordinated delivery model and help you implement your new model.

For additional conversation, please call or email me or Deb Lowry at 925-388-6211or deb@zolohealthcare.com

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