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Care Management

It's More Than Population Health

A Frost & Sullivan White Paper

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50 Years of Growth, Innovation and Leadership

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INTRODUCTION

Most US-based providers acknowledge that implementing a robust revenue cycle workflow is a needed component in a functional population health management (PHM) support structure. Clinical and financial outcomes of PHM programs can only be maximized by harnessing the potential of coordinated care. In a world where providers straddle fee-for-service and value-based care payments, managing episodes of care is important to success.

Provider executives confess that the desired level of leadership willingness, technological robustness and operational agility doesn't exist among most US provider organizations, who still struggle to overcome the first hurdle of PHM, i.e., normalizing disparate patient data from siloed care departments for informed decision making at point of service. Despite incumbent challenges, the US provider market is determined to align almost 50% of net patient revenue to value-based reimbursement. Hence, provider attention has quietly shifted to a more feasible and possibly more results-oriented, but definitely not mature, patient care approach that promotes automated care management.

VALUE-BASED CARE AND EPISODE MANAGEMENT HELP THE BOTTOM LINE TODAY

According to Frost & Sullivan, approximately 50% of all US-based providers demonstrate both willingness and ability to integrate the culture of value-based care within their core care delivery ecosystem today. Despite strong interest in value-based care initiatives, most US-based providers have not reported substantial growth in corporate revenue. Today, most providers pursue care coordination at a department level (e.g., emergency department, radiology, and primary care). These providers struggle to establish effective care coordination between in-patient, out-patient, and long-term care entities and thus fail to benchmark patient risk profiles (chronic or comorbid) in real time and involve caregivers to develop customized health plans that complement each patient's unique care needs across the care continuum.

"We need to identify early on who is covered under a bundled payment program. Often we don't know until halfway through the episode of care if the patient is under a bundled payment."

As a result, these providers suffer underpayments due to higher readmissions, report higher incremental costs due to preventable system utilization, and eventually lose profitability. Between 2012 and 2014, the average adjusted Medicare fee-for-service collection (as a percentage of total claims) declined from 97.75% to 95.93%. Last year, approximately 50% of all US hospitals had to sacrifice $500 million worth of reimbursement due to readmission-related inefficiencies. Therefore, providers and payers are in dire need of an IT-oriented business strategy that improves both the efficiency of care delivery and the financial health of the enterprise overall.

The need to improve how patients are tracked and coordinated across various care settings is emerging as one of the critical needs in an era of episodic care management, a scope which combines all patients being treated and all patients during a 30-day or 90-day post-discharge phase. Value-based payment arrangements encourage effective care coordination between acute care hospitals, physician practices and post-acute care providers, but implementation remains difficult and communication channels are not standardized.

A truly rewarding care management approach that improves clinical outcomes, secures regulatory incentives and augments patient satisfaction mandates patient-centric collaboration between all stakeholders. Providers should strive to empower each and every patient to pursue self-care and seek tailored support from anywhere through any device across the care continuum, but especially during post-acute care transitions, since those patients remain most vulnerable to readmissions in absence of personalized care coordination and patient engagement enablers from their providers.

Patients need to be connected with their full care team across any healthcare setting through a confluence of EHR-integrated online tools, patient portals, medical devices and interactive advisory programs. On the other hand, providers must be well equipped to facilitate seamless patient data exchange among multiple disparate health systems across the continuum to ensure effective monitoring, management and benchmarking of care plan adherence by patients.

TRANSITIONS IN CARE: AUTOMATING INFORMATION FLOWS TO BETTER MANAGE POST-ACUTE TRACKING OF THE PATIENT

Most providers that are part of episodic payment programs struggle to optimize post-acute care management processes for at-risk patients, who would report better clinical outcomes if intuitively monitored and proactively activated with a more holistic patient care approach. Provider leaders are actively trying to connect with every patient across the care continuum and encourage seamless data interoperability among them to devise a single source of truth, based on each patient's clinical, financial and operational context.

"With knee and hip replacements, multiple hands are involved in post-acute care, and often we don't have enough data and interaction to manage these entities effectively."

Providers also trying to explore better ways to exchange information with post-acute care facilities that are rarely connected via aligned clinical systems, such as EHRs, that enable two-way data exchange. Today, most providers initiate care coordination for transiting patients manually. Implementing IT-driven solutions that are interoperable but cost effective can support better patient communications across primary, in-patient and long-term care facilities. Simple communication tools such as email exchanges that are automated and provide frequent updates can keep the various provider entities in the care continuum informed and stimulate needed interventions. These tools can also support holistic episodic care management, which is key to successfully meeting goals of better outcomes and lower costs.

For example, nearly all of the physician groups (99%) who are members of the Silver State ACO in Las Vegas are daily users of CareCertainty. CareCertainty gives them real-time visibility, daily usage reports, data on outreach success and no-show rates. When patients go to emergency departments across Las Vegas, their doctors are sent real-time alerts when patients are admitted and discharged.

Upon discharge, office staff at each practice receives real-time emails with secure delivery of discharge details, a Continuity of Care Document, and an online, client-designed checklist which provides details the user needs in order to contact the patient, schedule a follow-up visit, and days later confirm the visit occurred.

Throughout the continuum of care, the solution will use automated rules to generate notifications, such as admission or discharge, letting all providers know the status of the patient. Included with this communication is pertinent clinical information such as test results, medications prescribed and discharge instructions.

The beauty of this system is that it is a real-time, two-way communications channel. Anyone in the community can request answers to questions. The system itself will prompt providers to update the patient status, and then disseminate the latest information to the rest of the care coordination team. Triggers automatically alert the team to any changes in patient status, such as alterations to discharge date or adjustments to post-acute care needs. Based on this timely information, a provider may choose to follow up to learn more about what's going on with the patient.

This unique platform enables all stakeholders to be on the same page with virtually no training. The closed-loop nature of this solution means the email communications remain fully secure and compliant with privacy regulations, while enabling the diverse provider community to send and receive communications to help coordinate care and assure the care plan is followed.

Taking advantage of this type of care coordination ultimately leads to reduced patient readmissions and supports the management of post-acute costs.

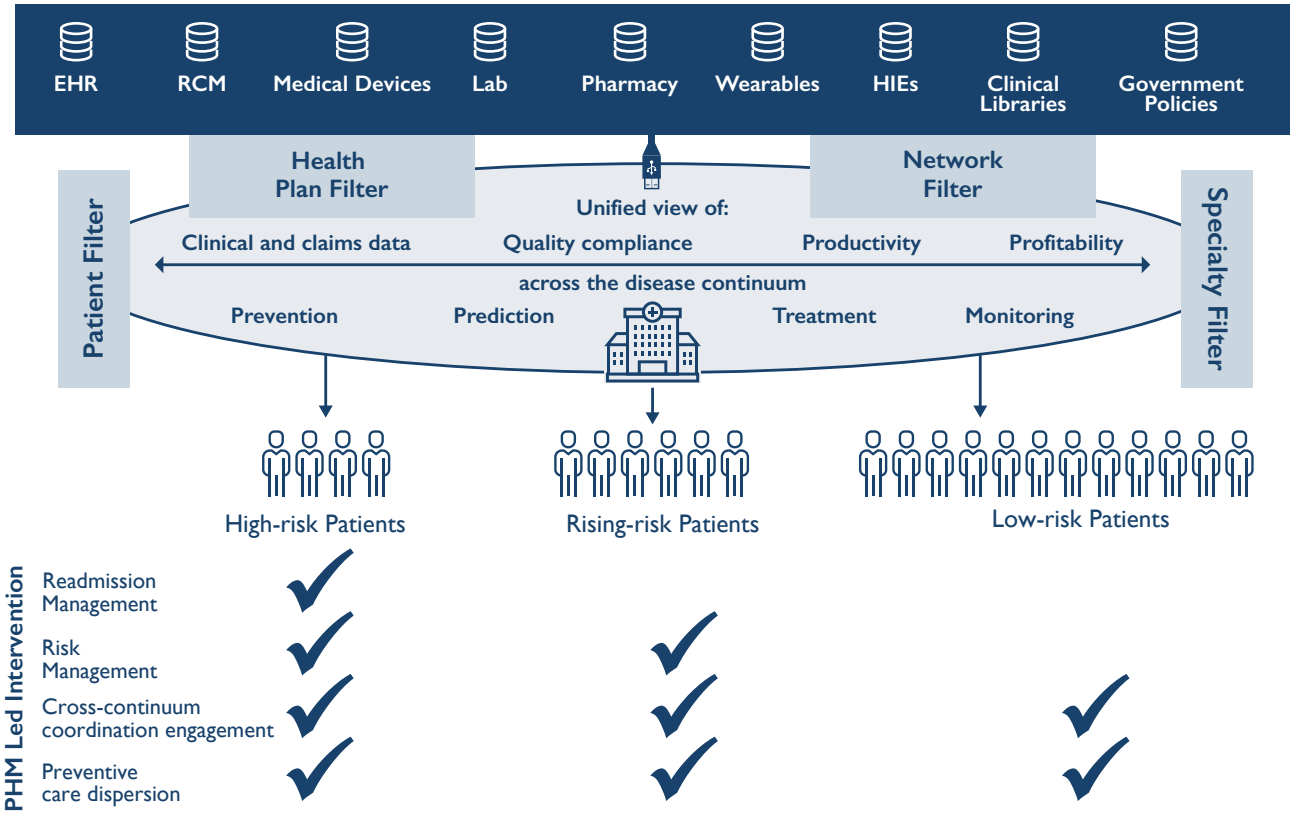
LEVERAGING DATA AND ANALYTICS TO IMPROVE EPISODE MANAGEMENT

One of the key aspects of episodic care management is quality reporting for performance management. Providers realized that in order to tangibly benefit from enrolling in episodic care programs, they must highlight, assess and benchmark utilization trends (admission, ER visits, diagnostic and lab results, discharge, and payer responses) by patient mix. The value proposition, which is conceptually straight-forward, requires diligent attention from the C-suite, physicians and point-of-care staff. The analytics platform worthy of provider investment should be intuitive enough to source cross-continuum patient data specific to end user commands and deliver error-free clinical, financial and operational reports to help providers pursue activity-based costing for every episode of care. These reports should be EHR integrated, dashboard oriented, churned at near real time and supported by advanced visualization features for easy reference and comprehension of care gaps, care duplication, intervention standards and patient feedback.

CALL TO ACTION

- Providers must initiate customized intervention based on an individual patient's primary conditions and potential risk profile.
- With the use of a defined and agile intervention approach, patient care can be streamlined across the continuum. Ideally, communications linking providers across the care continuum can be automated and updated regularly, stimulating action when needed.
- Unnecessary utilization and readmission, which result in reduced payer reimbursement, can be averted. Providers should start to use risk stratification and care coordination tools to review patient conditions holistically, so that homogenous, risk-specific patient clusters are created across the continuum of care.
- The overarching objective should be to track, predict and manage the cost of patient care effectively.
- Ecosystem-level collaboration can pave the way for better patient outcomes. Those that are easy to implement will have the highest likelihood of success.
- Results-oriented business strategies that strike a balance between cost, time within workflows and results in episode management are poised to be most receptive by providers.

Contextual Workflow of a Best-in-Class Care Management Ecosystem



Source: Frost & Sullivan

NEXT STEPS

- **Schedule a meeting with our global team** to experience our thought leadership and to integrate your ideas, opportunities and challenges into the discussion.
- Interested in learning more about the topics covered in this white paper? Call us at 877.GoFrost and reference the paper you're interested in. We'll have an analyst get in touch with you.
- Visit our **Digital Transformation** web page.
- Attend one of our **Growth Innovation & Leadership (GIL)** events to unearth hidden growth opportunities.

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