Supporting ACO Cost Reductions Through ED Care Collaboration

St. Luke's saved **$1 million** in unnecessary costs within the first 8 months of using the Collective Platform.

"Having a longitudinal view of these patients has been incremental in figuring out why they're returning to the hospital and not receiving care through the appropriate providers. I love having this information available on each patient chart, right in our workflow, so we can identify risks and know what to do quickly and confidently."

- Adam Robison,
MD Internal Medicine,
Hospitalist at St. Luke's Magic Valley Medical Center

St. Luke's Magic Valley Medical Center

In 2013, St. Luke's became Idaho's first Medicare accountable care organization (ACO), pioneering the shift from fee-for-service care to a value-based model focused on quality and accountability of care. Its network includes hospitals, primary care providers, behavioral health clinics, and more in its collaborative efforts to offer better, more affordable patient care.

The Problem: The High Cost and Scarcity of Healthcare

About one-half of Idaho residents lack the liquid cash to be able to pay for healthcare costs. With small businesses making up 99.2 percent of businesses in the state, health insurance can prove to be unusually expensive—or, in some cases, nonexistent. Necessary liquid cash quickly becomes tied up in business expenses, or in land as 20 percent of the state's gross income is tied to the agriculture industry—making it impossible for many people to afford steep insurance copays and deductibles.

In addition, the state is currently facing a shortage of physicians—specifically, primary care and behavioral health physicians. This means that when people do need to see a doctor, the first place they go is the nearest emergency department (ED), creating long-term problems as patients wrack up expensive hospital bills they can't afford to pay. Dr. Adam Robison, a hospitalist at SLMVMC explains:

"Some of our patients keep returning and returning, without a need to actually be in the ED. This is terrifying because they end up with hospital bills as large as $30K-$50K, which they can't afford. Not only does this mean we aren't being paid, but that there are people who are going to collections for a cost that was unnecessary in the first place."

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SLMVMC knew there had to be a better way to care for these patients that would result in fewer unnecessary ED visits or readmissions while maintaining an affordable cost of care for both patient and provider. The key was found in collaborative care, which not only helped hospital staff pinpoint patterns for readmissions but connected hospitals to the right primary care and other providers to help these vulnerable patients thrive.

The Solution: Looking Beyond ICD 10 Codes to a Collaborative Care Approach

Like many hospitals, SLMVMC had been using ICD 10 codes to track readmissions. However, for SLMVMC these ICD 10 codes had proven to be an ineffective method of determining the real reasons patients were returning to the hospital. Dr. Robison explains:

"Patients aren't ICD 10 codes. But that's how we look at readmissions. For example, we had congestive heart failure (CHF) patients coming in all the time, so it was easy to rationalize that we should be sending them to CHF clinics. But then they kept coming back. And what we realized was that the issues causing readmissions are not all captured with the ICD 10 codes that we're sorting them by—there's a more complex picture at stake."

To help providers see the full picture, SLMVMC implemented the Collective Platform, a collaboration tool that connects providers across the healthcare network. With this platform in place, Dr. Robison and other providers could see other important pieces of a patient's health history—including things like possible substance use disorder, mental or behavioral health conditions, chronic health conditions, and other factors that could be playing a role in a patient's readmissions—that were not reflected in the ICD 10 codes being tracked. These providers would then meet monthly as a committee to discuss complex patients and determine the best care plans for them.

Patient Story

SLMVMC had a patient with Crohn's disease who was frequenting the ED with a bowel obstruction. She was in multiple times a week, so physicians scheduled a colon resection for her through the nearest large hospital. She went and had the surgery, but began showing up in the SLMVMC hospital again soon after.

Hospital staff sat down to talk with the woman about her condition and asked why the woman was not following the post-operation care instructions she was given. A collaborative committee then met together to develop a plan for eliminating barriers to her follow-up care, which included looping in her surgeon and providing transportation to and from her appointments at this larger hospital. As they reviewed the woman's history, it became apparent that the woman could also be struggling with substance use disorder.

The next time the patient presented at SLMVMC, staff spoke with her about her use of narcotics. The woman admitted to having a problem, and a case manager worked with her to establish different treatment plans for her legitimate illness that would not include narcotics. That information was uploaded into the Collective Platform, discouraging providers from administering narcotics as part of the woman's treatment. Once off the narcotics, the patient began following her post-op instructions, has been attending her follow-up visits with the surgical team, and no longer frequents SLMVMC's ED.

The committee included SLMVMC ED and inpatient staff, members of the Magic Valley EMS, local primary care providers, and the neighboring psychiatric hospital. Together, these providers determined the best methods and avenues of care for each patient, recording their recommendations in the Collective Platform.

As these patients showed up in the ED, the platform would send a notification directly to the physician with the care plan available. Similar notifications were also made available for neighboring primary care and behavioral health clinics, enabling consistent care for a patient regardless of where he or she goes for treatment.

Dr. Robison relates one story with a patient who was prone to pseudo-seizures. Every time this patient began having an episode, he would call 911. The local EMS would come, ventilate and intubate him, and bring him in to the ED where the physicians would determine that the seizure was actually a pseudo-seizure. This was not only a drain on EMS and ED resources but was stressful for the patient and took already-limited staff away from other patients who needed to be seen.

Working together, the collaborative committee was able to identify these patterns of pseudo-seizures with the Collective Platform and determine a better plan of action for when the patient called 911. A care plan was uploaded into the platform, and EMS providers were notified of that plan whenever the patient called. The EMS team was then able to visit the patient and use alternative strategies to break him out of the pseudo-seizure—without bringing him back to the ED. This system has helped SLMVMC refocus its efforts on patients with more immediate needs, avoid unnecessary care costs for the ACO, and get the patient the care he needs more quickly and efficiently without having to leave his home.

Clinical Outcomes

By evaluating the full patient history—beyond the ICD 10 codes—providers at SLMVMC have been able to address more of the issues contributing to high ED readmissions. And by combining this knowledge with real-time communication between providers to direct patients to the best care, SLMVMC has seen a significant reduction in unnecessary ED readmissions and better overall patient outcomes. But there are other perks as well.

With the care collaboration facilitated by the Collective Platform, SLMVMC has been able to better track complex, vulnerable patients and direct them to a more appropriate care setting—**saving them roughly $1 million in unnecessary care costs** within the first eight months of use.

Saving on costs not only puts more money back in SLMVMC's pocket to help more patients, but it also protects SLMVMC from accruing unnecessary Medicare fines for failure to address readmissions properly. And finally, it helps patients get the quality care they really need—without accruing unmanageable debt.

About Collective Medical

Collective Medical provides the nation's largest and most effective network for care collaboration. Our risk-adjusted event notification and care collaboration platform spans across all points of care—including hospitals, payers, behavioral and physical ambulatory, and post-acute settings.

The Collective Platform uses the network to identify at-risk, complex patients and share actionable, real-time information with diverse care teams, leading to better care decisions.

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