

Is Australia Ready for Managed Care?

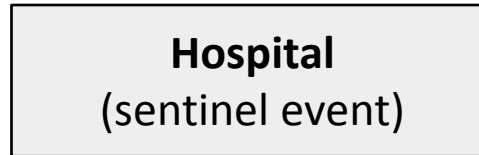
Dr Henri Becker

Preventing Admissions

Case Management



Reducing L.O.S.



Preventing Readmissions

Transitional Care

- ED Redirection
- Early Intervention
- Risk Management

Inpatient Case Management

The Team

- Case Manager(s)
- Physician(s)
- Medical Director

Proactive Review

(Reducing L.O.S.)

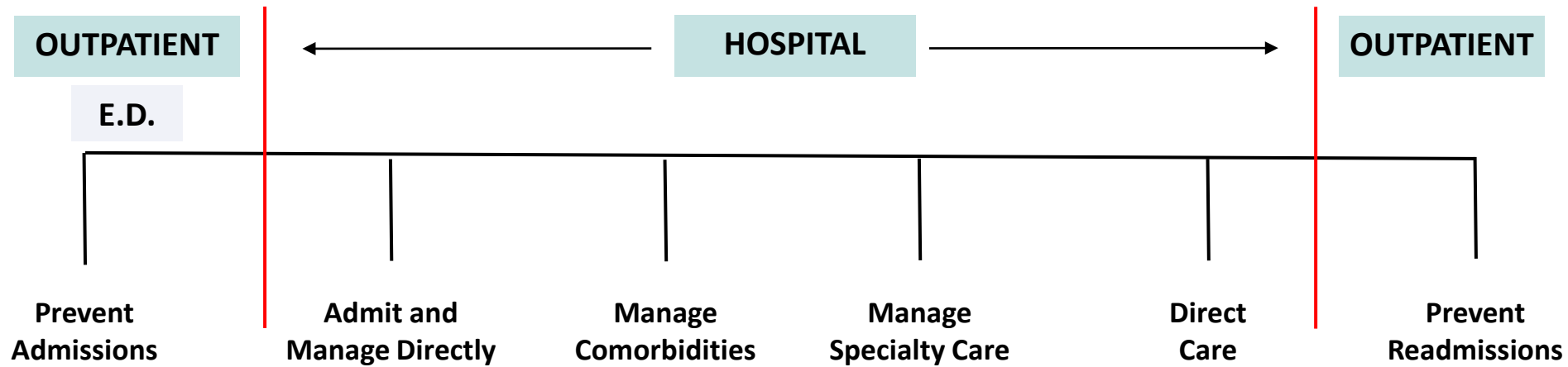
Retrospective Review

(Trend analysis measuring performance)

and

The concept of avoidable bedday

Physician Functions



The Concept of Avoidable Beddays

Definition

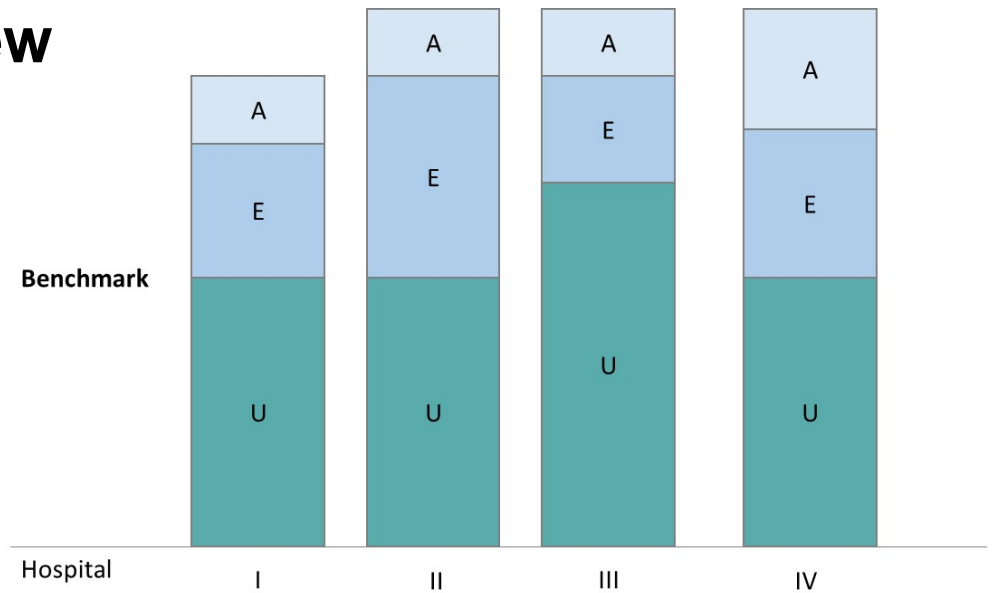
Avoidable Beddays

Hospital related	Patient related	Provider related	System related
<p>Example: Theatre fully booked, or CT scan broken)</p>	<p>Example: Refusal of discharge or inadequate supervision available at the time of discharge</p>	<p>Commonly divided into the following:</p> <ul style="list-style-type: none">• Inappropriate admission• Delay of discharge• Inappropriate level of care• Delay of service• Unnecessary service• Complications• Delay in diagnosis• Other	<ul style="list-style-type: none">• Late presentation• Readmission risk not assessed<ul style="list-style-type: none">• Lack of transitional care• Risk not identified

Practical use of Avoidable Beddays

Trend analysis

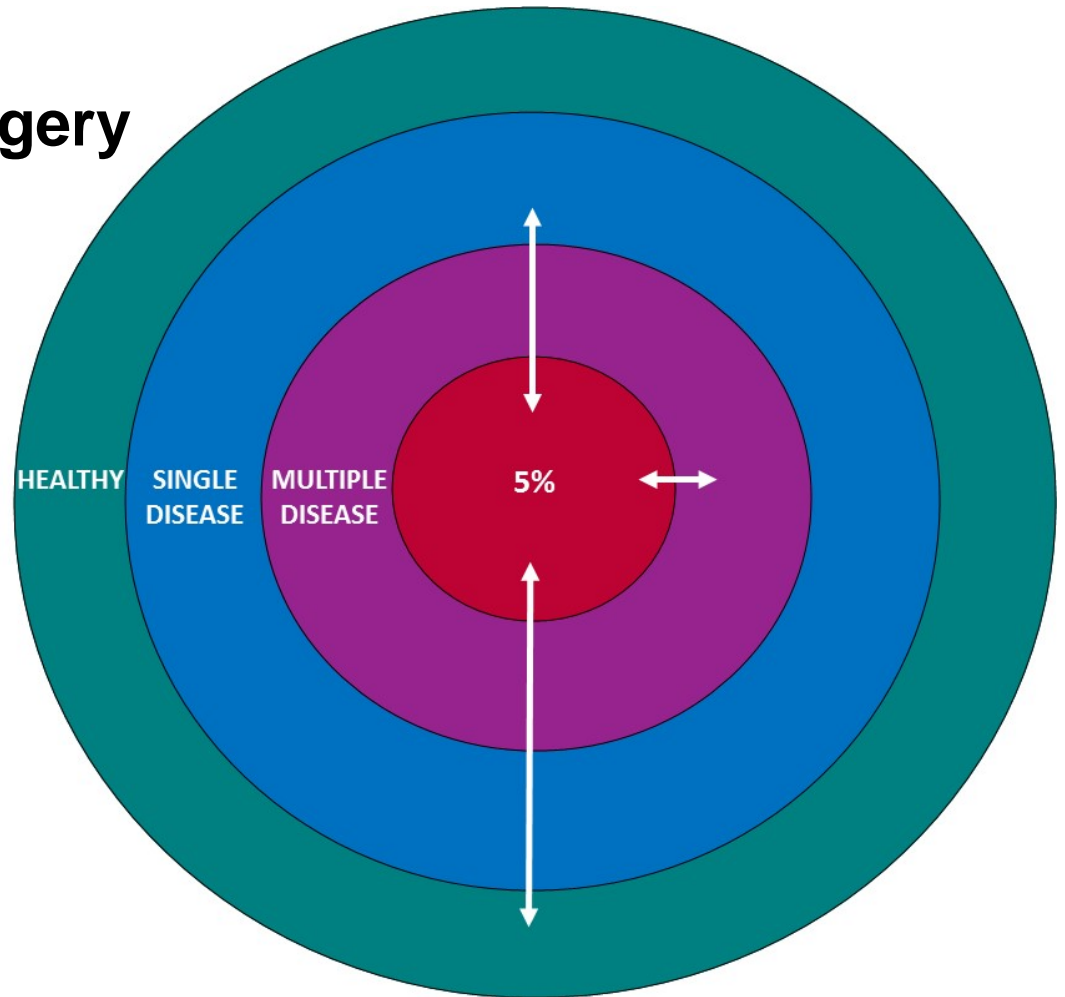
Team performance review



A = Avoidable admissions
E = Elective admissions
U = Urgent admissions

Outpatient Management

Domiciliary or GP Surgery



Transitional care
30-60 Days

Low Readmission Risk and
Low Level of Services

High Readmission Risk
and/or Complex Outpatient Services

CARE PLAN

Transitional care
(Nurses, GP, Visiting Providers)

Discharge to GP

Risk Resolved

30 – 60 day review

Risk(s) Persist

**Enrol in
long term program**

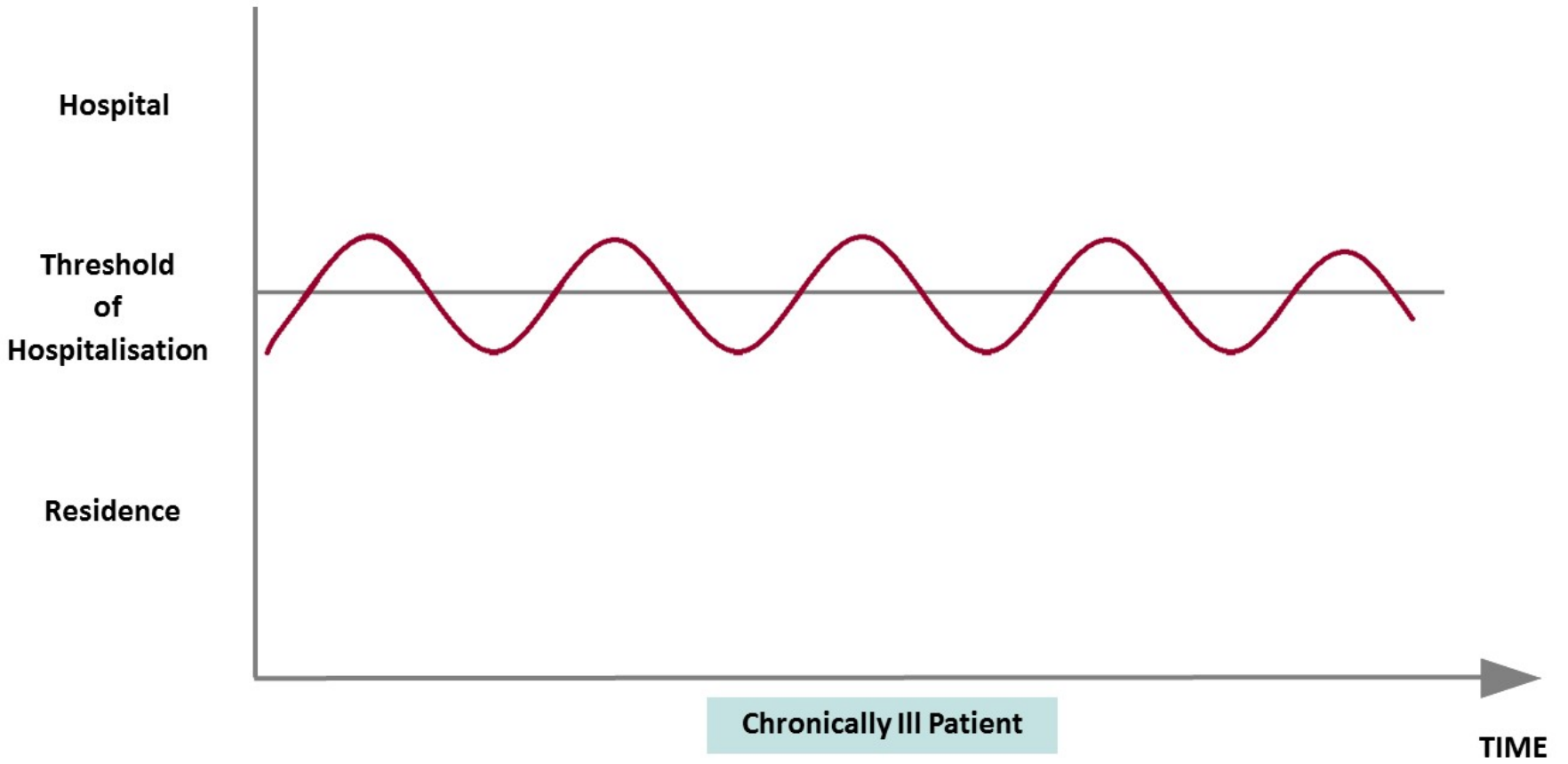
Low Readmission Risk

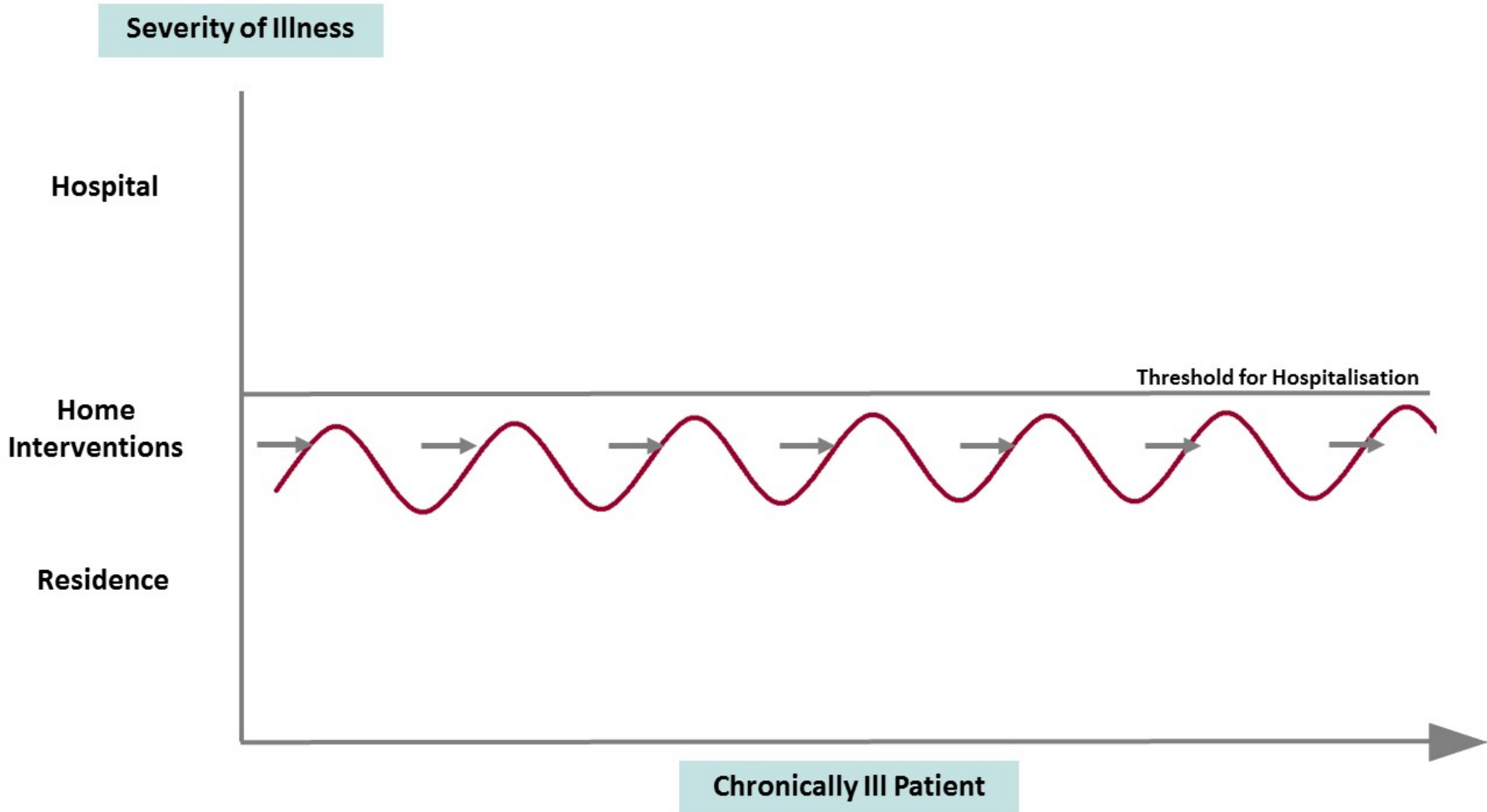
High Readmission Risk

Initial Evaluation

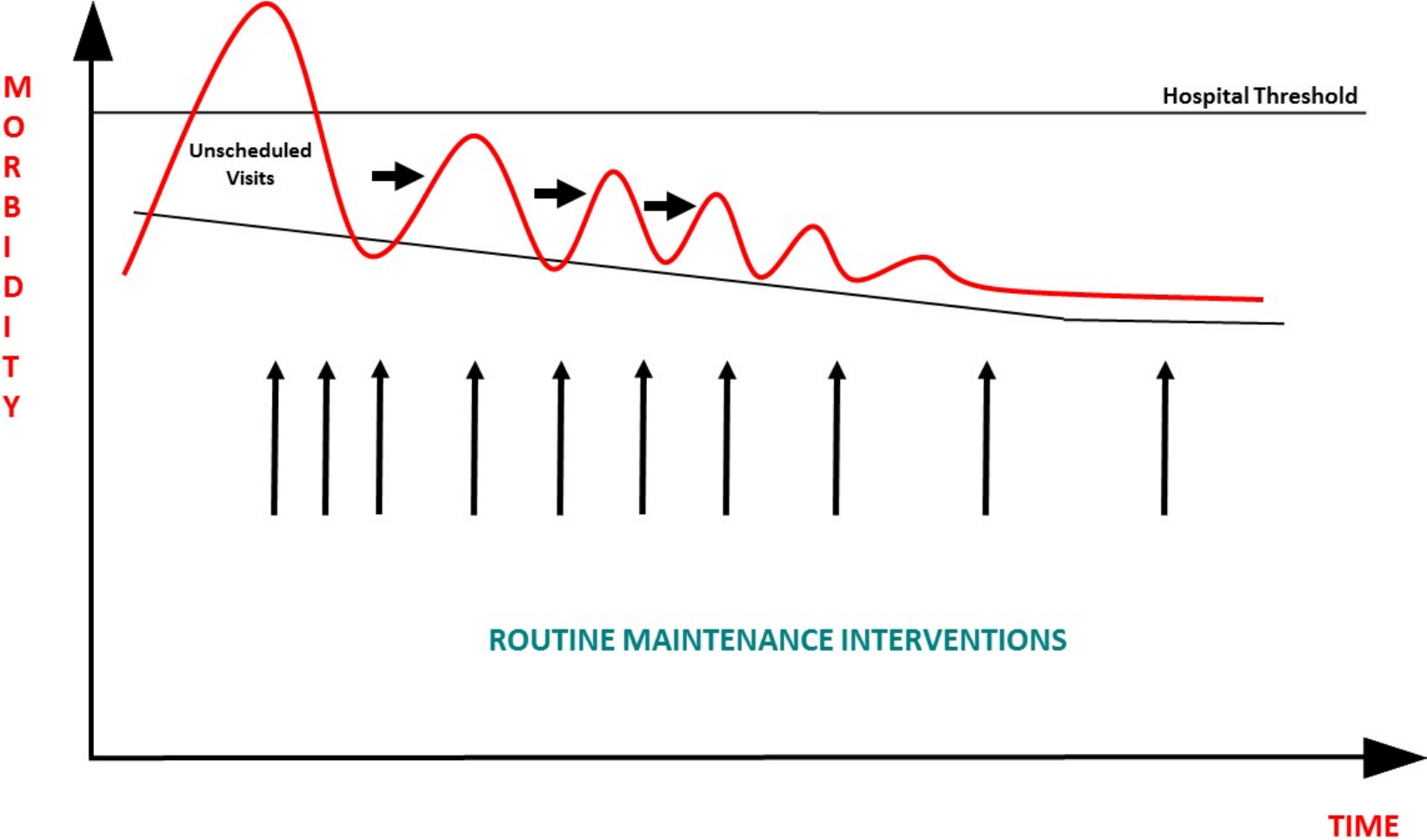
Periodic Retrospective Hospital Utilisation

Severity of Illness





Patient Management Program

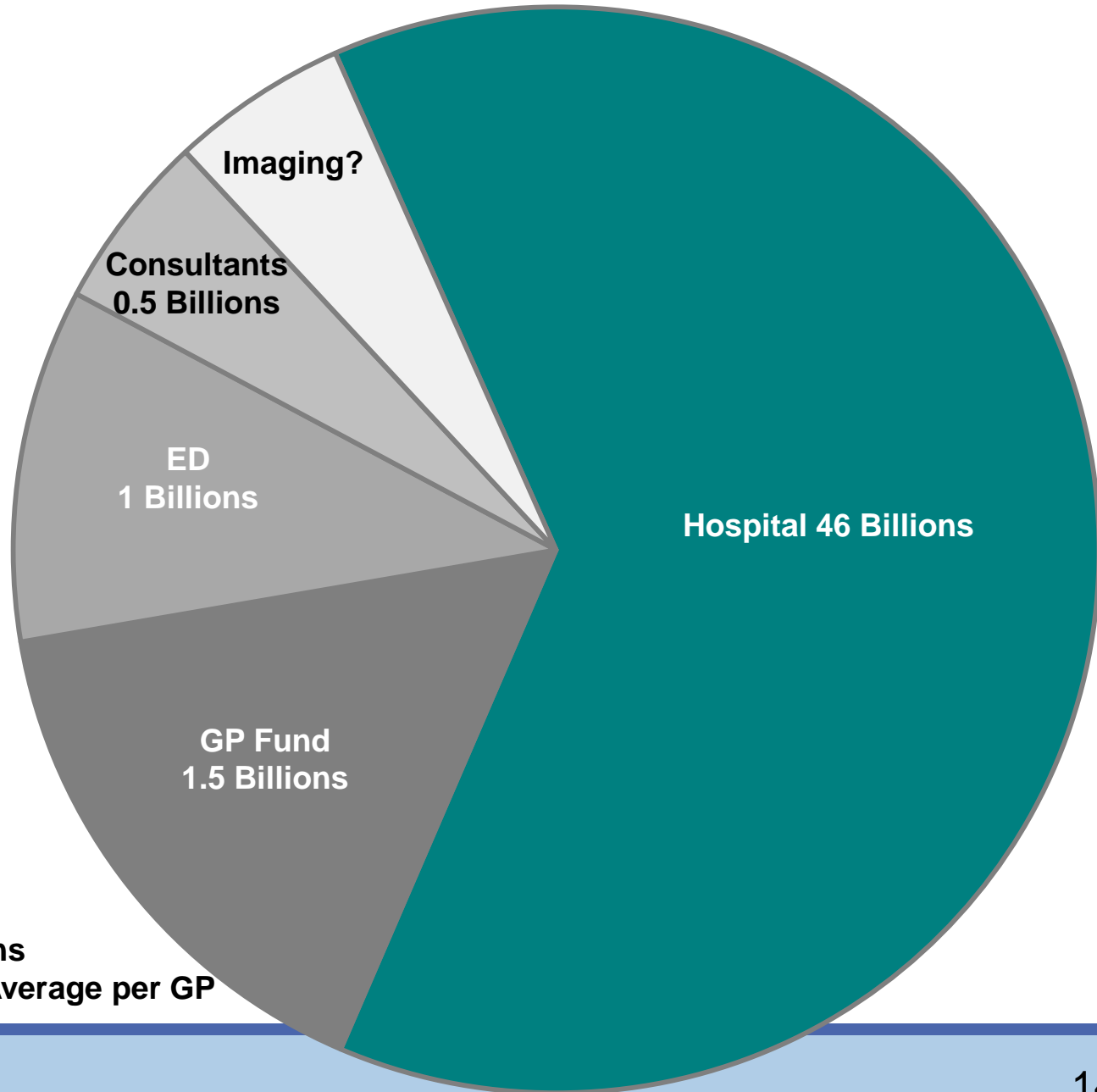


Case Management Stratification

LONG TERM RISK MANAGEMENT DAY TO DAY RISK MANAGEMENT (ACUTE EVENT)	<div style="border: 1px solid black; padding: 5px; display: inline-block;">LEVEL I</div> LOW RISK	<div style="border: 1px solid black; padding: 5px; display: inline-block;">LEVEL II</div> MODERATE RISK TELEPHONIC MANAGEMENT	<div style="border: 1px solid black; padding: 5px; display: inline-block;">LEVEL III</div> HIGH RISK HIGH COMPLEXITY NON MEDICAL ISSUES
BASELINE NO EVENT	PERIODIC TELEPHONIC CONTACT	PERIODIC TELEPHONIC CASE MANAGEMENT	PERIODIC HOME PROVIDER VISITS FREQUENT VISITS TO G.P. SURGERY
ACUTE EVENT LOW MORBIDITY	CASE MANAGED UNDER DOCTOR ACTION PLAN VISIT TO THE G.P. OPTIONAL	CASE MANAGED UNDER DOCTOR ACTION PLAN VISIT TO THE G.P. MANDATORY FOLLOW UP MANDATORY	UNSCHEDULED PROVIDER VISIT OR VISIT TO G.P. - FOLLOW UP MANDATORY
ACUTE EVENT HIGH MORBIDITY	TIMELY PROVIDER HOME VISIT OR VISIT TO G.P. ALERT HOME SERVICES FOLLOW UP	TIMELY PROVIDER HOME VISIT HOME SERVICES REPEAT VISIT 1- 2 DAYS	TIMELY PROVIDER HOME VISIT DAILY HOME SERVICES

Financial and Reimbursement Considerations

Funding



Potential savings **\$9 Billions**
Goal 60% **\$5.4 Billions**
50% Back to GP **\$100,000 Average per GP**

G.P. Reimbursement

FFS

- Disadvantages
- Advantages

Mixed Model

PM PM

FFS

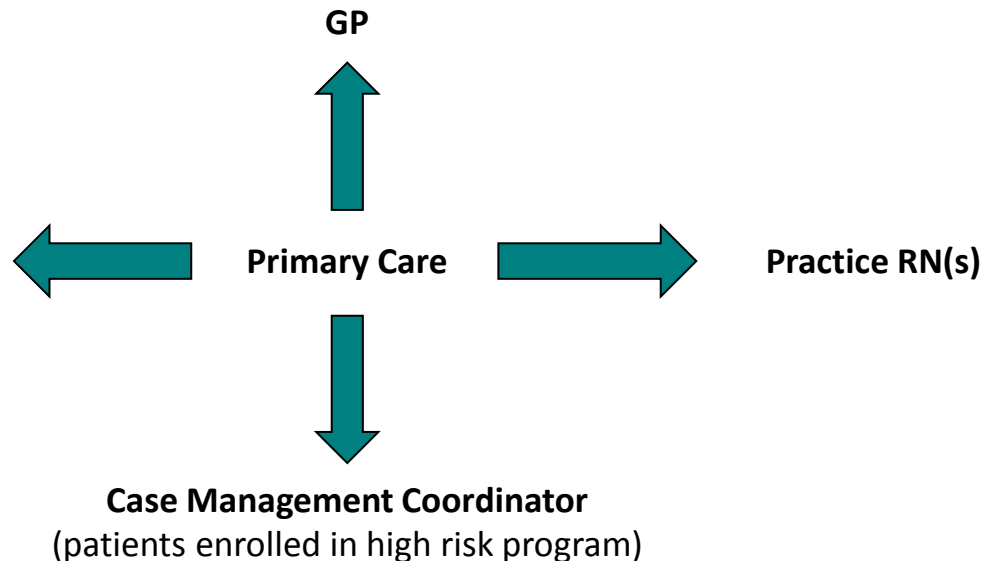
Risk Pool Participation

The General Practitioner

- Supervision
- High risk management
- Difficult or high morbidity patients (acute)
- Home hospitalisation
- Transitional care
- Connection with ED + inpatient team

- Triage
- Telephonic medicine
- Acute domiciliary intervention

**On call RN
Co-ordinator**
(after hours
general
population)



Thank you

Questions?

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