CASE STUDY
CATASTROPHIC CASE MANAGEMENT

How a smooth transition to acute care pulled a first responder through a traumatic brain injury.

TYPE: Municipality
EMPLOYEES: >4,000
SOLUTIONS:

- Discharge Coordination
- Transportation
- Catastrophic Care & Case Management

BACKGROUND:

In April 2017, this firefighter's future was bright. The 45-year-old with nearly two decades as a first responder, had a wife, a son who just got his driver's license, and a passion for fostering rescue dogs.

A downtown structure fire changed everything. While fighting the fire, he fell from a 20-foot ladder, and was knocked unconscious. He had sustained multiple fractures to his head, shoulder, chest and right arm, and had suffered a traumatic brain injury (TBI). He was in a coma, was nonresponsive and nonaudible. After four weeks in he began to squeeze his wife's hand, and speak. It was at this point his care team determined it was time to transition him to begin proactive recovery at an acute care facility.

PCS managed the transportation and transition.

Transitions between facilities and providers can expose patients to preventable errors and adverse events. Patient discharge from the intensive care unit (ICU) to an acute care is one of the most challenging and high-risk transitions of care.

For receiving providers to effectively continue care following transfer, crucial information on patient conditions, tests performed, and treatments received is communicated between providers. An effective transition is rooted in a solid, choreographed process to provide accurate, thorough and vital patient care information. This process ensures that the transfer of accountability and responsibility for the continued care of the patient is successful with no interruption in care.

With the help of PCS, the transition was smooth and considered a success by all parties involved.

The best care team, at the right facility.

A TBI requires an interdisciplinary team to treat physical issues, cognitive issues, behavioral, and/or emotional issues. PCS identified a facility close to the family home staffed with top notch, specialized care providers.

The inpatient team had the patient and his family at the core, as well as rehab nurses, behavior attendants, language pathologists, neuropsychologists, speech therapists, physical therapists, occupational therapists, patient and family counselors, insurance adjusters, and the FCM.

Through its negotiated rate, PCS was able to cut the facility's daily rate by more than $2,150.

Quality of care and team produce amazing outcome.

Based on the extent of his injuries, it was estimated the patient would require several months of inpatient treatment to make a meaningful recovery.

However, the patient progressed so quickly, he was released after only three weeks. He was cognizant, and required no special modifications to his home or vehicle.

The PCS difference.

PCS is the specialty managed care services and network provider best equipped to manage the daunting transition process in a catastrophic case.

By turning to PCS, the municipality was able to maximize cost containment, and the patient was able to obtain a high-quality outcome.

SUMMARY

- Smooth transition with thorough communication enabled fast assessment and treatment planning
- Comprehensive, consistent communication eliminated interruption in care
- High quality facility and care team resulted in faster recovery
- All-inclusive daily rate compressed payer costs by more than 24%