CAPG Physician Groups in Medicare Advantage

Reducing Hospital Readmissions – An Innovative Model of Care

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Who We Are

- Since our inception in 1994, New West Physicians has grown to become the largest primary care group practice in Colorado
- Family practice, internal medicine, hospitalists, physician assistants, nurse practitioners, behavioral health, cardiology, and gastroenterology
- 90 providers
- 17 offices throughout the Denver Metro area.
- 300+ Employees - $58M Revenue

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Quality

- All practice sites are NCQA – PCMH Level 3
- All providers are NCQA - Heart/Stroke and Diabetes certified
- In 2011, the American Hospital Association commissioned a national study on Accountable Care and chose four delivery systems representing different models of care. New West Physicians was chosen as the primary care model for that study.
- In 2013, New West Physicians received Best Practice of the Year Award by the Colorado Academy of Family Physicians Foundation.

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Critical Issue of Readmissions

- Medicare 30 day all cause readmission rate = 18%
- Yearly cost to CMS = $17 billion
- Large impact on MA risk pools
- CMS Star 3 point measure

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NWP Readmission rate

- Medicare – 6.6%
- Commercial – 3.1%

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Reasons for Readmission

- Medication reconciliation issues
- Inadequate transition of care planning
- Delayed follow-up with PCP
- Lack of follow-up on needed post disch issues
- Communication breakdown with patient/family

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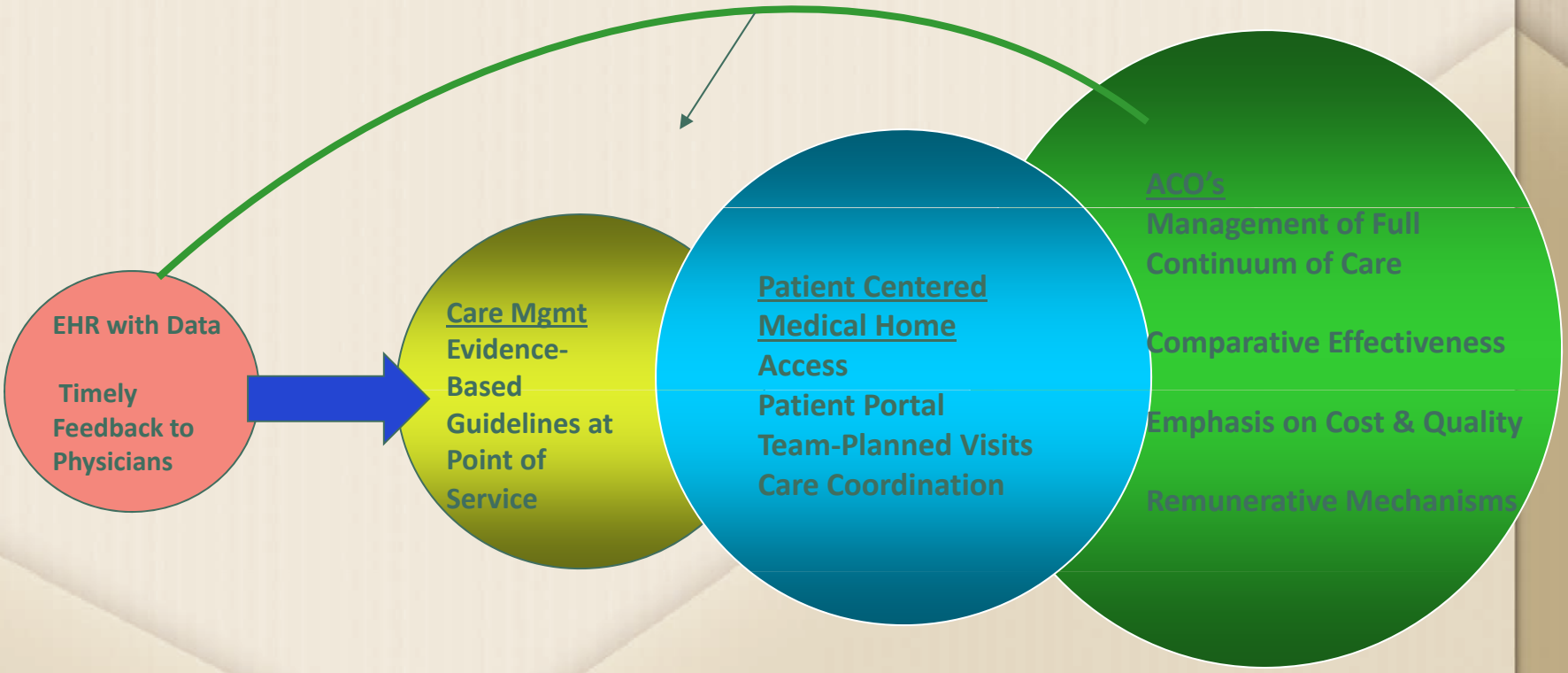
Population Health Management



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Reducing readmissions begins preadmission

- Hospitals and the Lexus assembly line concept
- Need to be admitted to be readmitted
- Culture of PCP accountability – the PCP is and always will be the primary care coordinator

PCP as Care Coordinator

Supported by data and incentives

- Quarterly un-blinded reporting of all utilization data – specialty, hospital, pharmacy, etc
- Quarterly quality/utilization incentives representing ~ 25% of income
- Monthly RAF reports by PCP with on going RAF monitoring through EMR

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PCP as Care Coordinator

- Supported by infrastructure
  - Diabetes and Nutrition Center – reflex referrals
  - Behavioral Health Center – SWAT Team
  - Urgent Care Center
  - Case management in the ER
  - TOC Program

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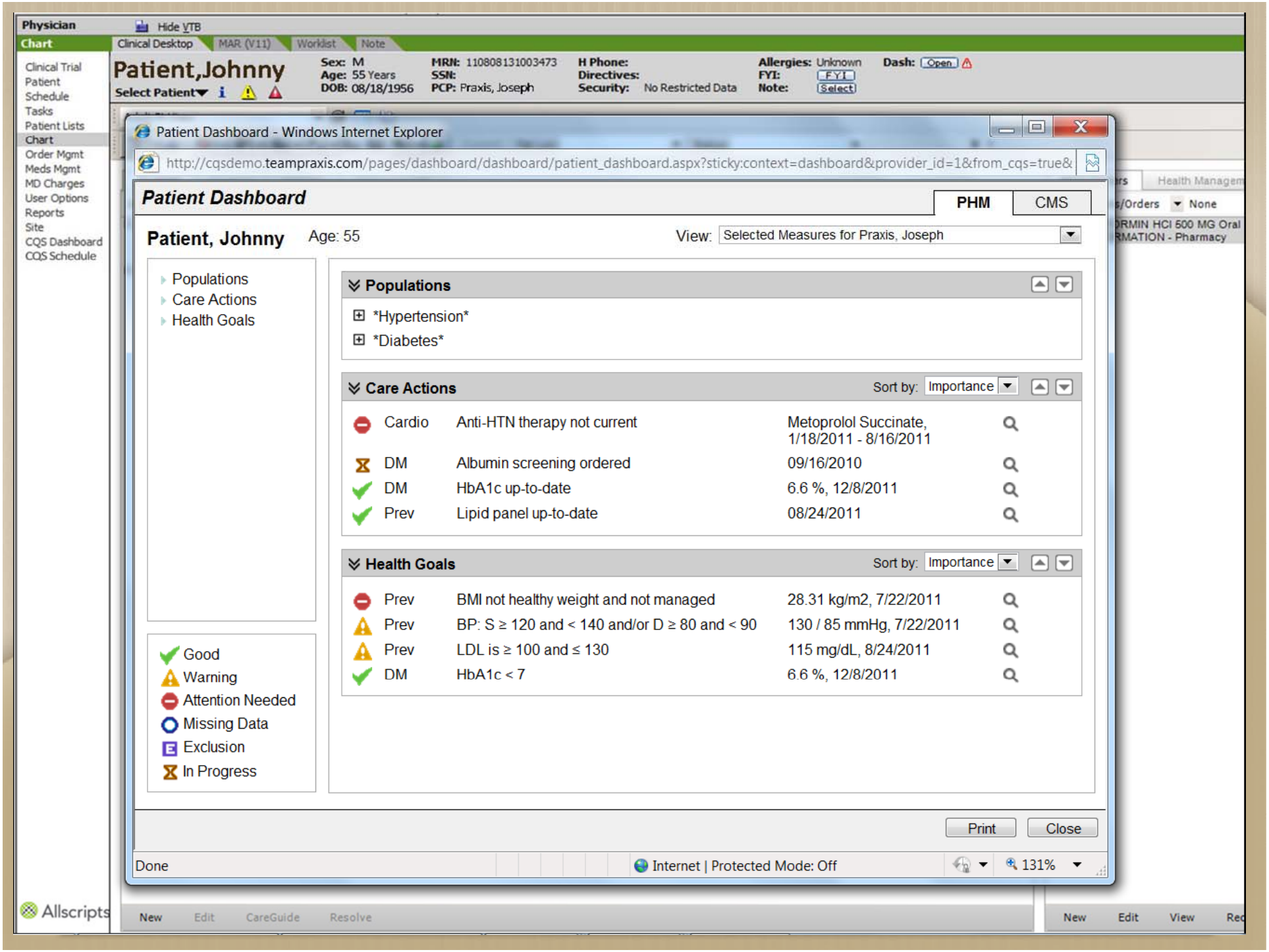
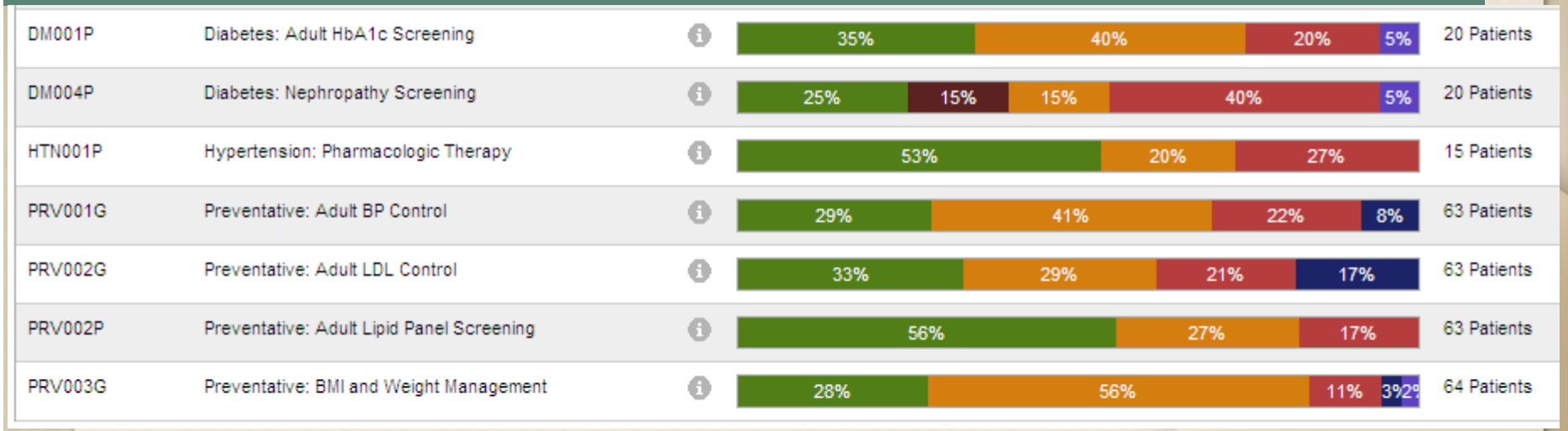
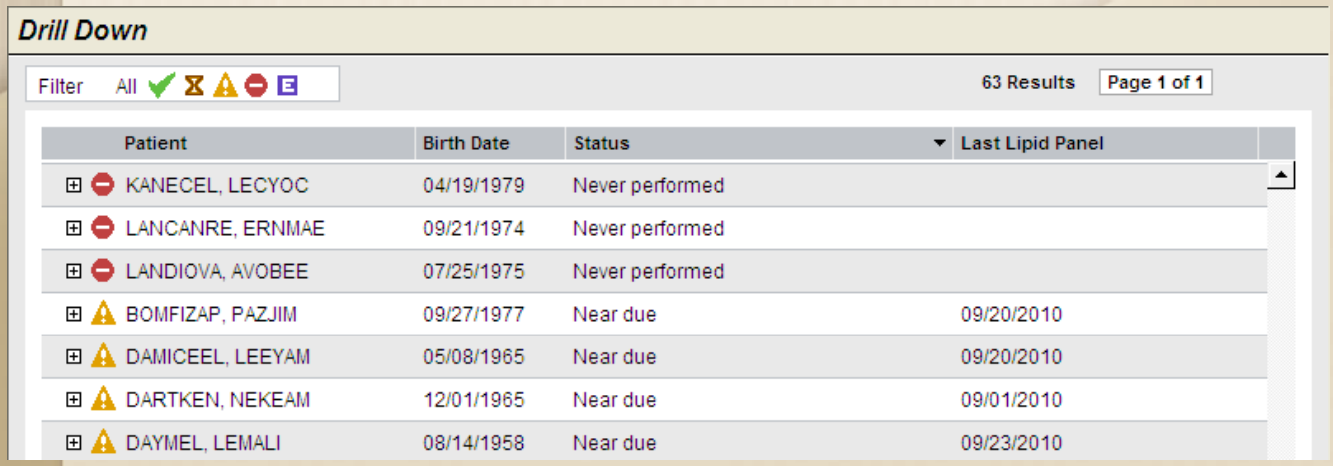

Physician
Hide VTB
Chart
Clinical Desktop
MAR (V11)
Worklist
Note
Clinical Trial
Patient
Schedule
Tasks
Patient Lists
Chart
Order Mgmt
Meds Mgmt
MD Charges
User Options
Reports
Site
CQS Dashboard
CQS Schedule
Patient,Johnny
Select Patient
Sex: M
Age: 55 Years
DOB: 08/18/1956
MRN: 110808131003473
SSN:
PCP: Praxis, Joseph
H Phone:
Directives:
Security: No Restricted Data
Allergies: Unknown
FYI:
Note:
Dash: Open
Patient Dashboard - Windows Internet Explorer
http://cqsdemo.teampraxis.com/pages/dashboard/dashboard/patient_dashboard.aspx?sticky:context=dashboard&provider_id=1&from_cqs=true&
Patient Dashboard
PHM
CMS
Patient, Johnny
Age: 55
View: Selected Measures for Praxis, Joseph
Populations
Care Actions
Health Goals
Populations
Hypertension
Diabetes
Care Actions
Sort by: Importance
Cardio Anti-HTN therapy not current Metoprolol Succinate, 1/18/2011 - 8/16/2011
DM Albumin screening ordered 09/16/2010
DM HbA1c up-to-date 6.6 %, 12/8/2011
Prev Lipid panel up-to-date 08/24/2011
Health Goals
Sort by: Importance
Prev BMI not healthy weight and not managed 28.31 kg/m2, 7/22/2011
Prev BP: S ≥ 120 and < 140 and/or D ≥ 80 and < 90 130 / 85 mmHg, 7/22/2011
Prev LDL is ≥ 100 and ≤ 130 115 mg/dL, 8/24/2011
DM HbA1c < 7 6.6 %, 12/8/2011
Good
Warning
Attention Needed
Missing Data
Exclusion
In Progress
Print
Close
Done
Internet | Protected Mode: Off
131%
Allscripts
New
Edit
CareGuide
Resolve
New
Edit
View

Providers self-assess performance with an aggregate patient view



The aggregate patient dashboard motivates providers to audit themselves and improve performance.



Drill downs provide patient lists to proactively contact patients, and improve scores.

Drill Down: CQS Patient-Centered Care - M0016P - Microsoft Internet Explorer provided by New West Physicians

Drill Down

CQS Patient-Centered Care - M0016P - *Hypertension: Pharmacologic Therapy*

Hypertension patients 18 years and older currently on antihypertensive therapy

Attribution: Primary Care Physician (PCP) (Unique)
Data Set: All Providers

*PCC-Adv	81% 17% 1	58 Prov

Provider	Results	Patient
Arthur, James	70% 26% 3%	802 Pati
Atkins, Julia K.	84% 15%	462 Pati
Augustitus, V.	84% 13% 3%	765 Pati
Baker, Dawn	85% 14%	592 Pati
Baker, Elizabeth	80% 1 18%	459 Pati
Baumgartner, Werner K.	83% 13% 3%	750 Pati
Beezley, Brian	81% 16% 2	725 Pati
Bishop, Richard P.	88% 11%	770 Pati
Blitz, Scott	69% 30%	494 Pati
Boyd, James	80% 20%	115 Pati
Brumbaugh, Patricia	82% 1 16% 1	459 Pati
Carlson, Christopher	79% 20%	241 Pati
Castro, Ernest	79% 19% 1	293 Pati

Top 10 Admission Diagnoses

DESCRIPTION	Count	Claim Amount
LOC OSTEOARTHROSIS-LOWER LEG	206	$1,133,342
UNSPECIFIED SEPTICEMIA	116	$724,834
LOC OSTEOARTHROSIS-PELVIC RGN&THIGH	78	$445,706
ACUT MI SUBNDOCRDL INFARCT INIT EOC	54	$345,539
PNEUMONIA, ORGANISM UNSPECIFIED	54	$192,950
UNSPECIFIED ACUTE RENAL FAILURE	48	$144,540
OBST CHRONIC BRONCHITIS W/EXACERBAT	46	$143,862
ATRIAL FIBRILLATION	46	$102,772
CLOS FX INTERTROCH SECTION FEM	40	$214,582
ACUTE RESPIRATORY FAILURE	40	$208,121

Hospital Program

- NWP Hospitalists at our 5 main hospitals
- NWP Case management daily at all facilities
- At every admission:
  - Psychosocial evaluation
  - Home safety evaluation
  - Evaluation of any outpatient PCP deficiencies
  - Advanced directives

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Emergency Room Management

- Appropriate patients evaluated in ER
- Case management in ER with direct SNF transfer 24/7
- Hospitalist ER Programs
  - Atrial fibrillation
  - Syncope
  - Chest pain

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Patient Perception of Discharge

- From total care to zero care – there is no button to push!
- Passive care to active care
- Bewildering circumstances
- Degree of disability underestimated

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Transitions of Care

Three areas of responsibility

- Inpatient case manager
- Hospitalist
- Transition of care mid level provider

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Transitions of Care

Case Manager Responsibilities

- Correct level of care chosen
- All ancillaries arranged
- Family expectations clarified
- Psychosocial issues addressed

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Transitions of Care

Hospitalist Responsibilities

- PCP Contacted on day of discharge
- TOC Midlevel contacted for complex cases
- Key issues, findings, and follow-up items tasked to the PCP at time of discharge
- SNF Transfers – Snifist contacted and discharge summary completed at time of discharge

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Transitions of Care

TOC Midlevel Responsibilities

- Red/yellow/green designation – LACE Model
- Telephonic contact with patient
- Med reconciliation
- PCP Follow-up scheduled
- Specialty and ancillary follow-up arranged

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Lace Model

- **L**ength of stay
- **A**cuity of the admission
- **C**o-morbidities
- **E**mergency room visits in the prior 6 months

- **Lace scores range from 1-19 and predict the risk of death and readmission in the first 30 days post discharge**

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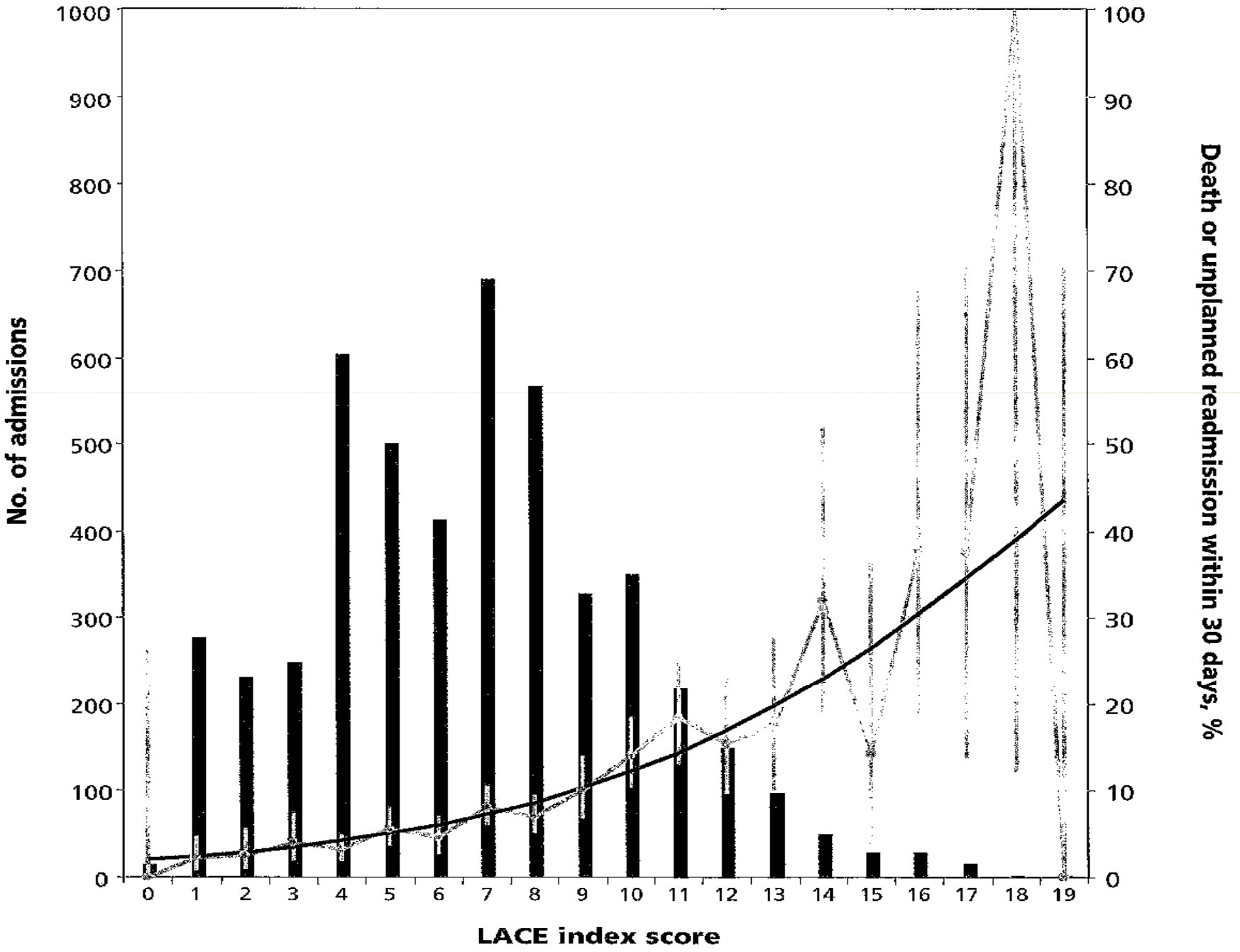
Charlson Co-Mobidity Score

- 1 each: Myocardial infarct, congestive heart failure, peripheral vascular disease, dementia, cerebrovascular disease, chronic lung disease, connective tissue disease, ulcer, chronic liver disease, diabetes.
- 2 each: Hemiplegia, moderate or severe kidney disease, diabetes with end organ damage, tumor, leukemia, lymphoma.
- 3 each: Moderate or severe liver disease.
- 6 each: Malignant tumor, metastasis, AIDS.

Attibute	Value	Points
Length of Stay (Prior Admit	less than 1 day	0
	1 day	1
	2 days	2
	3 days	3
	4-6 days	4
	7-13 days	5
	14 or more days	6
Acute Admission	Inpatient	3
	Observation	0
Comorbidity	No prior history	0
	DM no complications, Cerebrovascular dz, Hx of MI, PVD, PUD	1
	Mild liver dz, DM w/end organ damage, CHF, COPD, Cancer, Leukemia, Lymphoma, any tumor, moderate to sever renal dz	2
	Dementia or connective tissue dz	3
	Moderate or sever liver dz or HIV infection	4
	Metastatic Cancer	6
Emergency Room visits during previous 6 months	0 visits	0
	1 visit	1
	2 visits	2
	3 visits	3
	4 or more visits	4
	Total sum of points *If 11 or greater pt is at high risk for readmission	
If LACE score 10-12:	Verify medication adherence and discharge orders	
	Verify MD follow up	
	Weekly Phone calls for 1 month	
	Determine if further complex case management needed	
If LACE score >13:	follow same recommendations as above	
	Refer to Complex case management	

Table 4: Expected and observed probability of death or unplanned readmission within 30 days after discharge, by LACE score

LACE score	Expected probability, %	Observed probability, % (95% CI)	
		Derivation group *n* = 2393	Validation group *n* = 2419
0	2.0	0.0 (0.0–61.5)	0.0 (0.0–46.1)
1	2.5	1.4 (0.2–5.1)	3.0 (0.8–7.6)
2	3.0	2.6 (0.5–7.5)	2.7 (0.5–7.8)
3	3.5	5.6 (2.2–11.4)	2.5 (0.5–7.2)
4	4.3	3.9 (2.0–6.9)	2.3 (0.9–4.8)
5	5.1	4.4 (2.2–7.9)	6.7 (3.9–10.8)
6	6.1	4.7 (2.3–8.7)	4.5 (2.0–8.5)
7	7.3	7.6 (4.9–11.4)	8.5 (5.8–12.0)
8	8.7	6.3 (3.8–9.8)	8.0 (4.9–12.2)
9	10.3	11.7 (6.8–18.8)	8.7 (5.0–14.2)
10	12.2	14.5 (9.4–21.3)	13.6 (8.7–20.2)
11	14.4	18.6 (11.5–28.4)	18.1 (10.9–28.3)
12	17.0	20.8 (11.7–34.4)	10.4 (4.5–20.5)
13	19.8	17.3 (7.9–32.9)	17.4 (7.5–34.3)
14	23.0	28.6 (12.3–56.3)	36.4 (15.7–71.7)
15	26.6	8.3 (0.2–46.4)	18.8 (3.9–54.8)
16	30.4	50.0 (18.3–100)	29.4 (9.6– 68.6)
17	34.6	33.3 (6.9–97.4)	42.9 (8.8–100)
18	39.1	100.0 (12.1–100)	–
19	43.7	0.0	–


No. of admissions
Death or unplanned readmission within 30 days, %
LACE index score
0
100
200
300
400
500
600
700
800
900
1000
10
20
30
40
50
60
70
80
90
100
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19

Use of Lace Tool

- 6-9 score – Mid level judgment as to whether to refer to case management
- 10 or above – all referred to case management
- Patients with very complex initial presentations are referred irrespective of Lace score

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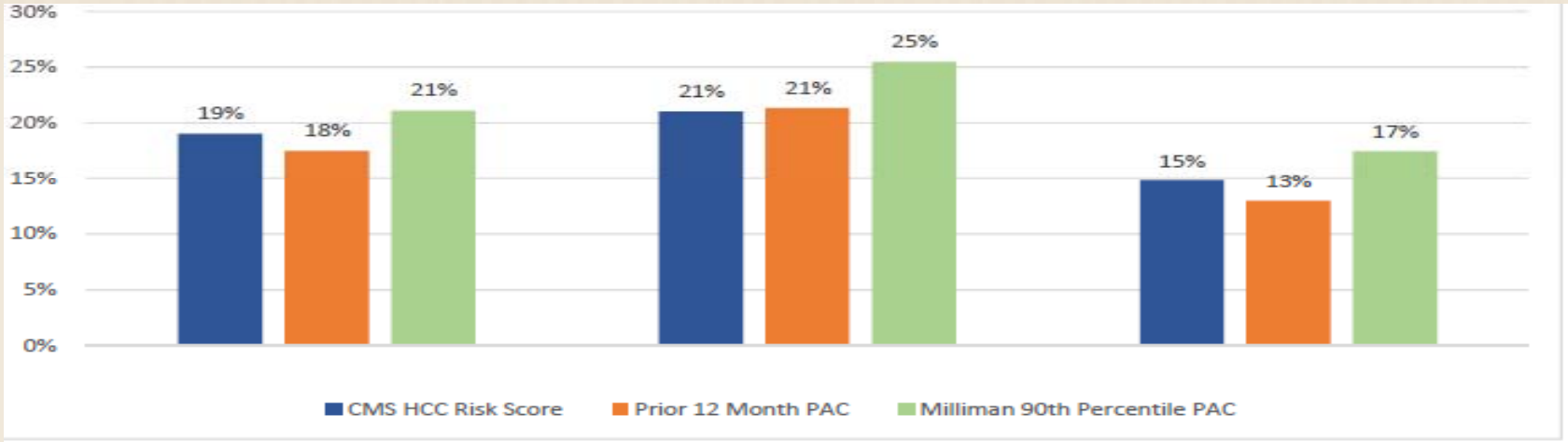
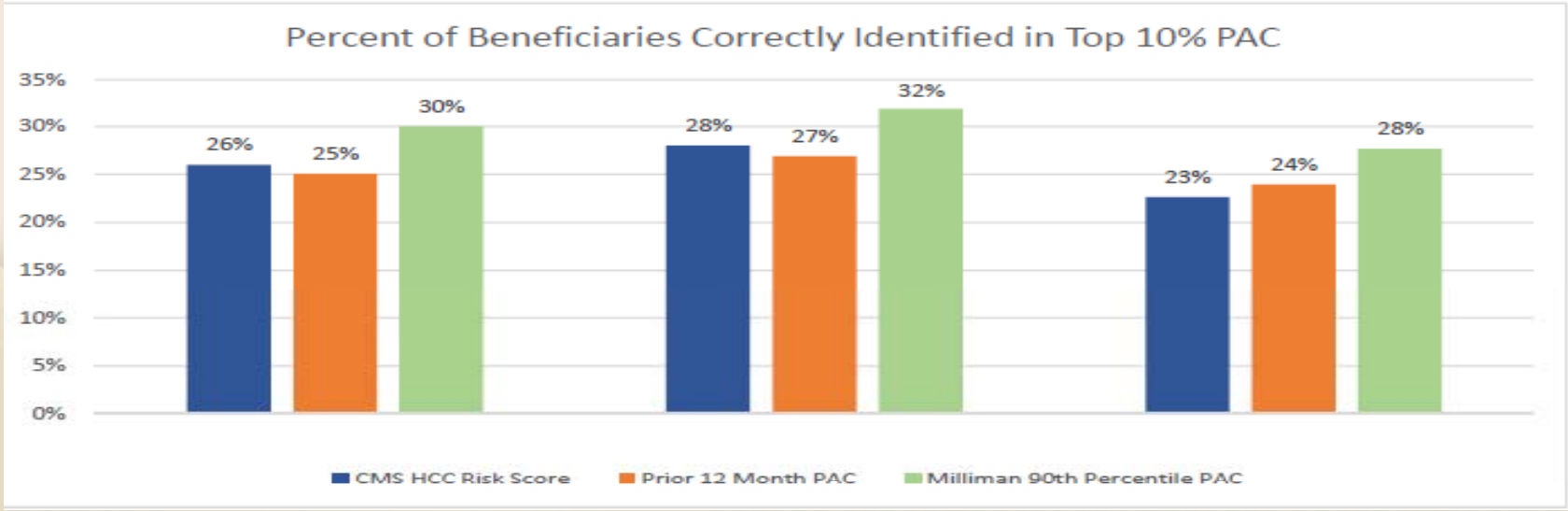
Identifying High Risk/Cost Patients





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Transitions of Care

TOC Midlevel/PCP Integration

- PCP tasked with all details of communication
- Medication list reconciled/rx's sent if needed
- Problem list updated including new RAF codes
- All hospital records forwarded
- Follow-up appointment scheduled

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SNF Management

- Dedicated SNF Network
  - Admissions 24/7 including ER
  - High quality/efficiency facilities
  - Single SNF practice covers citywide
  - Hospitalists contacted prior to transfer
  - Case managers on site for review and meetings twice weekly

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Advanced Care Planning

- Transitional care program – designed for intensive home based 3 month case management for advanced and/or complex illness
- Palliative care program – mandatory for oncologists to introduce palliative care for all Stage III and IV cancers
- Hospice care program integrated with the above two programs

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SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Colorado Medical Orders for Scope of Treatment (*MOST*)

- **FIRST** follow these orders, **THEN** contact Physician, Advanced Practice Nurse (APN), or Physician Assistant (PA), for further orders if indicated.
- These Medical Orders are based on the person's medical condition & wishes.
- Any section not completed implies full treatment for that section.
- May only be completed by, or on behalf of, a person 18 years of age or older.
- **Everyone shall be treated with dignity and respect.**

Last Name		
First Name/Middle Name		
Date of Birth		Sex
Hair Color	Eye Color	Race/Ethnicity

A Check One Box Only

CARDIOPULMONARY RESUSCITATION (CPR) — Person has no pulse and is not breathing.

☐ **No CPR** Do Not Resuscitate/DNR/Allow Natural Death

☐ **Yes CPR** Attempt Resuscitation/ CPR

When not in Cardiopulmonary arrest, follow orders B, C, and D

B Check One Box Only

MEDICAL INTERVENTIONS — Person has pulse and/or is breathing.

☐ **Comfort Measures Only:** Use medication by any route, positioning, and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort.
Do not transfer to hospital for life-sustaining treatment.
Transfer only if comfort needs cannot be met in current location; EMS-Contact medical control.

☐ **Limited Additional Interventions:** Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. *Transfer to hospital if indicated. Avoid intensive care;* EMS-Contact medical control.

☐ **Full Treatment:** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
Transfer to hospital if indicated. Includes intensive care. EMS-Contact medical control.

Additional Orders: _____ (EMS=*Emergency Medical Services*)

C Check One Box Only

ANTIBIOTICS

☐ No antibiotics. Use other measures to relieve symptoms.

☐ Use antibiotics when comfort is the goal.

☐ Use antibiotics.

Additional Orders: _____

D Check One Box Only

ARTIFICIALLY ADMINISTERED NUTRITION AND HYDRATION

*****Always offer food & water by mouth if feasible******

☐ No artificial nutrition/hydration by tube. (NOTE: Special rules for *proxy by statute* on page 2)
☐ Patient has executed a "Living Will" ☐ Patient has not executed a "Living Will"

☐ Defined trial period of artificial nutrition/hydration by tube.
(Length of trial: _____ Goal: _____)

☐ Long-term artificial nutrition/hydration by tube.

Additional Orders: _____

E Check All That Apply

DISCUSSED WITH:
☐ Patient
☐ Agent under Medical Durable Power of Attorney
☐ Proxy (per statute C.R.S. 15-18.5-103(6))
☐ Guardian
☐ Other: _____

(SECTION RESERVED FOR FUTURE USE)

SUMMARY OF MEDICAL CONDITION(S):

Optio Care Support – Pilot of NWP and Denver Hospice

Collaborative approach with Registered Nurse and Licensed Social Worker – In home and telephonic

- **Focus:**
  - **Engagement with primary care physician**
  - **Medication reconciliation and management**
  - **Red Flag education – Steps to recognize change in health and empower client to take appropriate action**
  - **Address psychosocial needs that are inhibiting the client to manage health**
  - **Successful hand-off at end of care cycle to case manager within PCP practice**

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Who Will Succeed?

- Shift from patient to population management
- Comprehensive care at all levels and locations, and across all specialties
- Accurate, timely and actionable data
- Focused case management
- Aligned compensation model

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Thank you and Opportunity for Questions

The mission of New West Physicians is "to enhance the physical, mental and spiritual health of communities we serve through an integrated, primary-care owned and patient centered healthcare delivery system."

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