CAPG Physician Groups in Medicare Advantage

Reducing Hospital Readmissions - An Innovative Model of Care

October 2014
Ken Cohen, MD, FACP, CMO
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.
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.
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
NWP Readmission rate

- Medicare - 6.6%
- Commercial - 3.1%
Reasons for Readmission

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

- EHR with Data
- Timely Feedback to Physicians
- Care Mgmt Evidence-Based Guidelines at Point of Service
- Patient Centered Medical Home Access
- Patient Portal Team- Planned Visits Care Coordination
- ACO's Management of Full Continuum of Care
- Comparative Effectiveness
- Emphasis on Cost & Quality
- Remunerative Mechanisms
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 ongoing RAF monitoring through EMR
PCP as Care Coordinator

- Supported by infrastructure
  - Diabetes and Nutrition Center - reflex referrals
  - Behavioral Health Center - SWATTeam
  - Urgent Care Center
  - Case management in the ER
  - TOC Program
Patient Dashboard - Windows Internet Explorer


Patient Dashboard

Patient, Johnny
Age: 55
View: Selected Measures for Praxis, Joseph

- Populations
  - *Hypertension*
  - *Diabetes*

- Care Actions
  - Cardio: Anti-HTN therapy not current
  - DM: Albumin screening ordered
    - 9/16/2010
  - DM: HbA1c up-to-date
    - 6.6%, 12/6/2011
  - Prev: Lipid panel up-to-date
    - 8/24/2011

- Health Goals
  - 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%, 12/6/2011
Providers self-assess performance with an aggregate patient view

<table>
<thead>
<tr>
<th>Provider</th>
<th>Condition/Screening</th>
<th>HbA1c</th>
<th>BP Control</th>
<th>LDL Control</th>
<th>Lipid Panel</th>
<th>Weight Management</th>
<th>Patients</th>
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<td>56%</td>
<td>11%</td>
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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 - Hypertension: Pharmacologic Therapy**

Hypertension patients 18 years and older currently on antihypertensive therapy

**Attribution:** Primary Care Physician (PCP) (Unique)

**Data Set:** All Providers

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<th>Provider</th>
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<th>765 Pat</th>
<th>592 Pat</th>
<th>459 Pat</th>
<th>750 Pat</th>
<th>725 Pat</th>
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</table>
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
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
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
Transitions of Care

Three areas of responsibility

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

Case Manager Responsibilities

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

- **Length of stay**
- **Acuity of the admission**
- **Co-morbidities**
- **Emergency 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**
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.
<table>
<thead>
<tr>
<th>Attribute</th>
<th>Value</th>
<th>Points</th>
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<td>4 or more visits</td>
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**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
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<th>Validation group ( n = 2419 )</th>
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<td>8.3 (0.2–46.4)</td>
<td>18.8 (3.9–54.8)</td>
</tr>
<tr>
<td>16</td>
<td>30.4</td>
<td>50.0 (18.3–100)</td>
<td>29.4 (9.6–68.6)</td>
</tr>
<tr>
<td>17</td>
<td>34.6</td>
<td>33.3 (6.9–97.4)</td>
<td>42.9 (8.8–100)</td>
</tr>
<tr>
<td>18</td>
<td>39.1</td>
<td>100.0 (12.1–100)</td>
<td>–</td>
</tr>
<tr>
<td>19</td>
<td>43.7</td>
<td>0.0</td>
<td>–</td>
</tr>
</tbody>
</table>
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
Identifying High Risk/Cost Patients

### Percent of Beneficiaries Correctly Identified in Top 10% PAC

<table>
<thead>
<tr>
<th>Score Type</th>
<th>CMS HCC Risk Score</th>
<th>Prior 12 Month PAC</th>
<th>Milliman 90th Percentile PAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>高端风险/COST患者识别百分比</td>
<td>26%</td>
<td>25%</td>
<td>30%</td>
</tr>
<tr>
<td>高端风险/COST患者识别百分比</td>
<td>28%</td>
<td>27%</td>
<td>32%</td>
</tr>
<tr>
<td>高端风险/COST患者识别百分比</td>
<td>23%</td>
<td>24%</td>
<td>28%</td>
</tr>
</tbody>
</table>

### CMS HCC Risk Score, Prior 12 Month PAC, Milliman 90th Percentile PAC
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
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
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
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.

A

**CARDIOPULMONARY RESUSCITATION (CPR)**

- **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

**MEDICAL INTERVENTIONS**

- **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

**ANTIBIOTICS**

- No antibiotics. Use other measures to relieve symptoms.
- Use antibiotics when comfort is the goal.
- Use antibiotics.

Additional Orders:

D

**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"

  *Length of trial: Goal:*

- Long-term artificial nutrition/hydration by tube.

Additional Orders:

E

**DISCUSSED WITH:**

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

**SUMMARY OF MEDICAL CONDITION(S):**

**ACTION RESERVED FOR FUTURE USE**
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
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
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.”