2016 Medical Home Summit

Reducing Hospital Readmissions – An Innovative Model of Care

June 2016

Scott Clemens, MD

Who We Are

- Since our inception in 1994, New West Physicians has grown to become the largest primary care group practice in Colorado
- Primary care, hospitalists, mid levels, and selected specialties
- 100+ providers
- 17 offices throughout the Denver Metro area.
- 360+ Employees - $58M Revenue

New West PHYSICIANS

Quality

- 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 the Colorado Best Practice of the Year Award by the Colorado Academy of Family Physicians Foundation.
- In 2015 the AMGA awarded NWP the Acclaim Award for the organization which most closely approaches the ideal health system as measured by the IOM "Triple Aim"

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%

New West PHYSICIANS

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

PCP as Care Coordinator

Supported by infrastructure

- Diabetes Center
- Behavioral Health Center – SWAT Team
- Urgent Care Center
- Case management in the ER
- TOC Program

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

Emergency Room Management

- Appropriate patients evaluated in ER
- Case management in ER with direct SNF transfer
- 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 – SNFist 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

- **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**

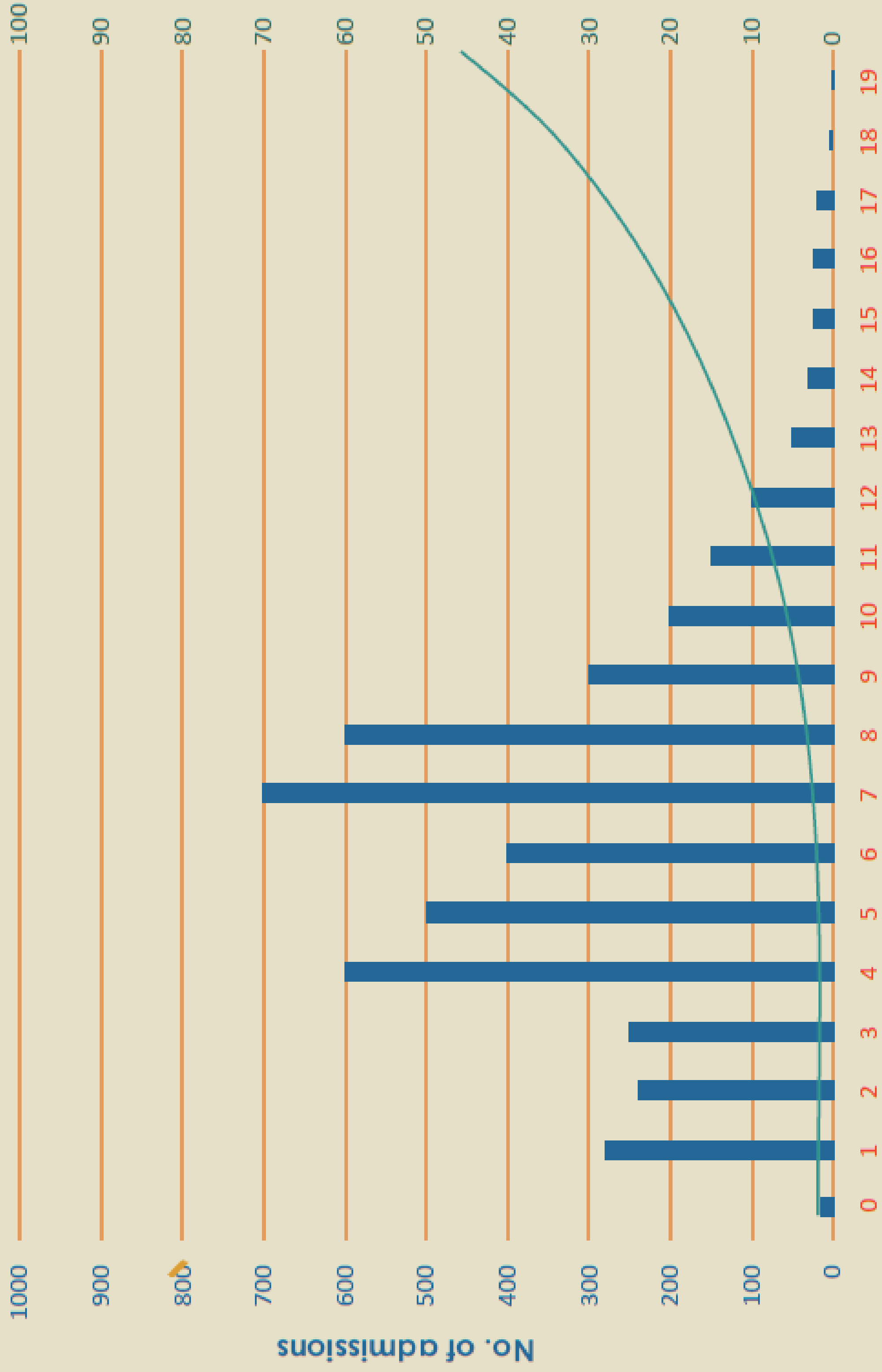
NewWest PHYSICIANS

Charlson Co-Morbidity 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 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	–



Death or unplanned readmission within 30 days, %
0
10
20
30
40
50
60
70
80
90
100
No. of admissions
0
100
200
300
400
500
600
700
800
900
1000
LACE Index Score
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

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

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

NewWest
PHYSICIANS
We put your health first

Who Will Succeed?

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

Thank you and Opportunity for Questions

Scott Clemens, MD
9950 W. 80th Ave Ste 23, Arvada, CO 80005
scott.clemens@nwphysicians.com
303-425-1018

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."