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Intensive Outpatient Care Program: Positive Impact on Readmissions

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Mission

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- Mission
  - Scottsdale Health Partners is a collaboration of medical professionals providing high quality, coordinated and innovative care for the patients and families we serve.
- Vision
  - Scottsdale Health Partners will transform healthcare through coordinated, patient centered care of the highest quality and value.
- Values
  - High quality evidence based healthcare
  - Focused on patient experience
  - Physician driven
  - Transparent and fair
  - Fiscally sustainable
  - Accountable to our patients and members

Joint Venture

Ownership

Scottsdale Physicians Organization(SPO)

50%

50%

Scottsdale Healthcare Hospitals (SHC)

6 PCPs, 6 Specialists

Scottsdale Health Partners (SHP)

Management Co

PCP PCP PCP SPC SPC SPC SHC SHC SHC SHC SHC SHC

Scottsdale Health Partners: Care Coordination Model
2014 - 2015

Central Care Management Department
Care Coordination Support Hub

Payor Services & Programs

SHP – TPK Hospital
Transitional Care Manager

SHP – Shea Hospital
Transitional Care Manager

SHP –Osborn Hospital
Transitional Care Manager

Post Acute Care Services

MD
Complex Care Coordination Program: Care Coordinator

MD
Complex Care Coordination Program: Care Coordinator

MD
Complex Care Coordination Program: Care Coordinator

MD

MD

Future- Patient Navigator Role

Care Management Programs

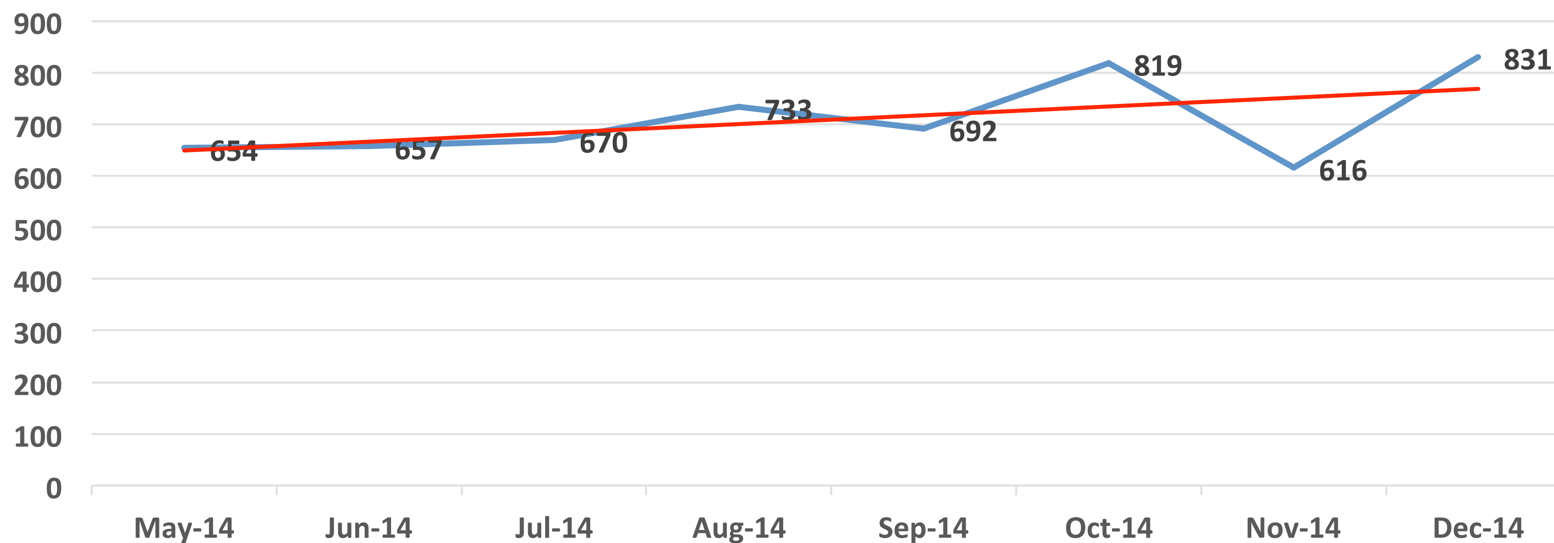
Transitional Care Management

- Available for SHP physicians/ patients
- Assist with the transitional needs of SHP patients in the hospital
- PCP Notification of admission, discharge, and emergency room visits
- Focus on maintaining clear communication to primary care physician about treatment plan

Comprehensive Care Coordination

- Intensive outpatient care program using well trained care manager embedded in a high – performing primary care team
- Creates close relationships with medically complex patients and delivers highly individualized and accessible primary care
- Develops a patient-specific, goal orientated treatment plan
- Geared to use mostly MA level staff to economically reach more people with the same budget
- Supported by CMS Grant: Pacific Business Group on Health (PBGH)

Transitional CM: Metrics



Comprehensive Care Coordination Program Overview

SHP **Comprehensive Care Coordination** Program

- A primary care based care management for predicted moderate to high risk patients
- Specially trained care coordinators
  - Behavioral modification interviewing
  - “Supervisit” process
  - Medication Management
  - Assessment tools:
    - SF-12 (VR-12) – measure health related quality of life and estimated disease burden
    - PAM - tool that measure patients engagement in their health care (Levels 1-4)
    - PHQ–2 & PHQ-9 – tool used to screen, diagnose, monitor, & measure severity of depression
- Mutually agreed upon “Shared Action Plan”
- High level (face to face) contact with patients and providers.
- Focus on Transition of Care and Chronic Care Management

IOCP Program: Comprehensive Care Coordination

- **Implementation**
  - Identification on high volume practices
  - Risk Stratification and Identification of patients
  - Engaging physician network
  - Team Building in practice and within TCM & CC program
  - Clinic operations
  - Training on practice EMR
  - Data collection & reporting

IOCP Program: Comprehensive Care Coordination

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- **Struggles**
  - Diverse practice models and geographic area
  - Practices with no EMR
  - Attracting & Hiring staff
  - Staff on-going training

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Comprehensive Care Coordination

- **Successes**
  - Lower readmission rate
  - Enhanced coordination of cases post acute stay
  - Low program decline rate
  - HIPAA compliant texting system
  - Strong CCC Team
  - Low variation in CCC program operations among care coordinators – (Lean Process)
  - Low readmission rates
  - Lowering costs of care on high risk cases
  - Strong patient relationship focus

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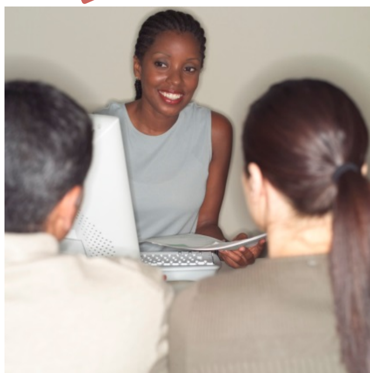
SHP - Comprehensive Care Coordination

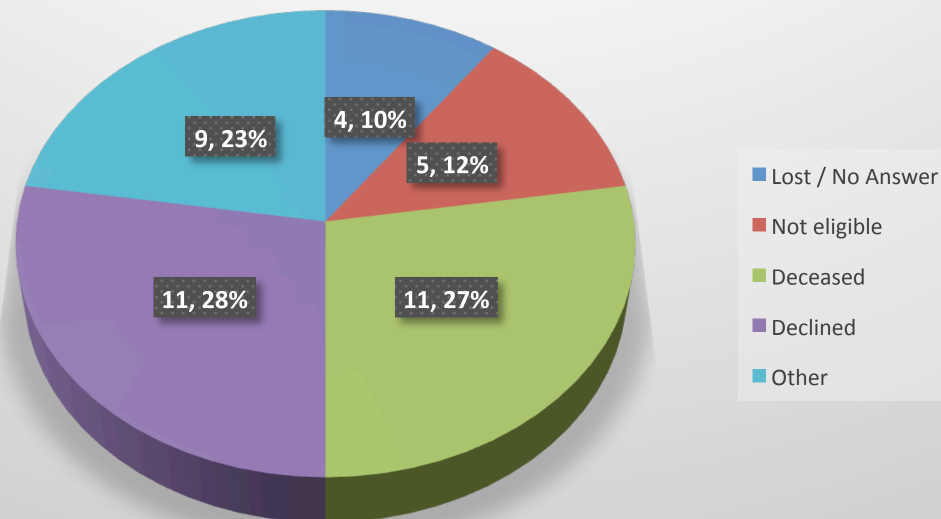
Scottsdale Health Partners: Care Management Program
Comprehensive Care Coordination Services
Cases Volume Per Week (October 2014 - January 2015)

Week	Cases
10/3/2014	254
10/10/2014	271
10/17/2014	286
10/24/2014	303
10/31/2014	314
11/7/2014	314
11/14/2014	325
11/21/2014	344
11/28/2014	350
12/5/2014	358
12/12/2014	370
12/19/2014	379
12/26/2014	387
1/2/2015	388
1/9/2015	409

SHP- CC Metrics…*continued*….

*12 active cases deceased & 13 of > 400 active cases declined the **CCC Program***





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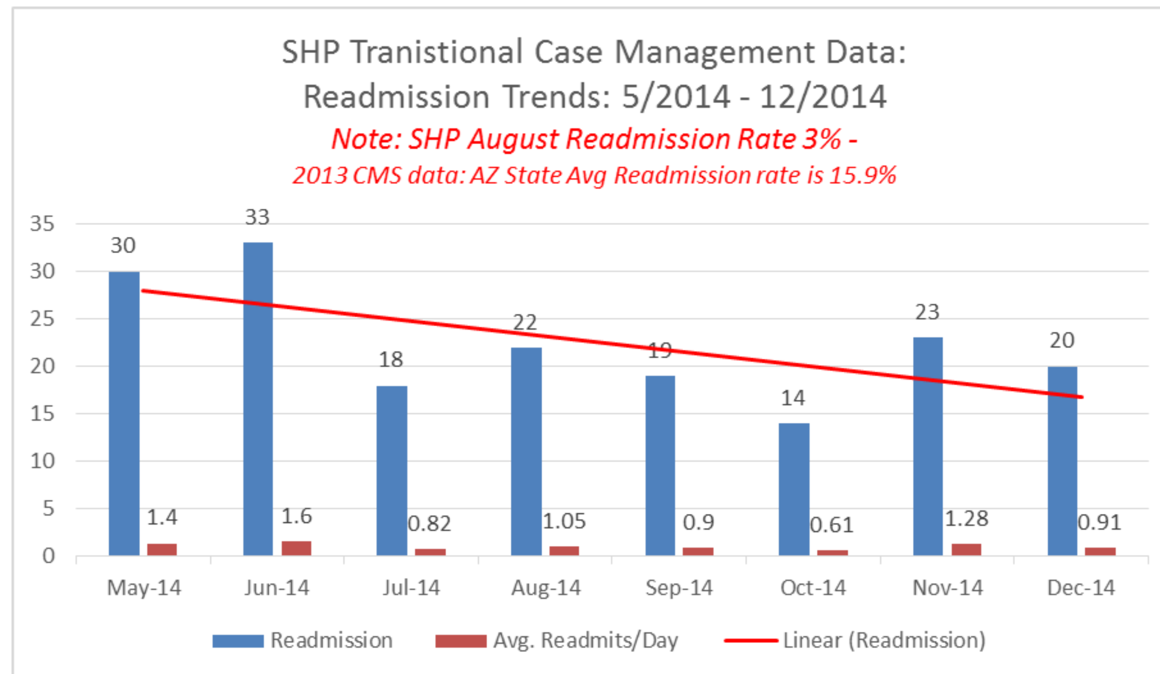
TCM Metrics: Readmission

Assisting elderly patients in understanding, coordinating, and communicating discharge care to prevent readmissions



<30 day readmit all cause	5/1/2014	6/1/2014	7/1/2014	8/1/2014	9/1/2014	10/1/2014	11/1/2014	12/1/2014	YTD
Readmission	30	33	18	22	19	14	23	20	179
Avg. Readmits/Day	1.4	1.6	0.82	1.05	0.9	0.61	1.28	0.91	1.077
% Readmission	5%	5%	2.7%	3%	3%	2%	4%	2%	3%

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Case Review

Oct 23, 2014 - LK is a 72 year old female lived alone, and found to be in crisis thru phone calls to PCP office. PCP recommended CCC Program.

Nov 2013 - Nov 2014	***Nov-14***	Dec-14
2- Inpatient stays 4 - Emergency room visits 2- OP visits 8 -Lab visits for multiple tests 6 - radiology procedures	***Enrolled in CCC Program 1. An Initial Home Visit: found patient in crisis; involved in 2 hit and runs over the previous weekend; mis-taking narcotic medications (overdosing); incontinent, admitted to hospital - (ARF) 2. Supervisit: Found patient to be very fearful of being alone. CC assessment also found patient to have a LTC insurance policy***	Patient now off all narcotics; Started on outpatient PT for balance and chronic pain management; and activated LTC policy so patient now has daily care givers in home. Patient doing well with no hospitalizations, ED or Urgent care visits, and is under PCP care on a regular basis. Only pain medication is: Tramadol 1 QD

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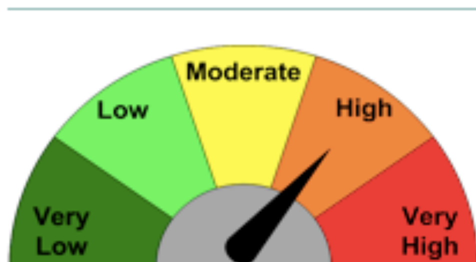
Patient FM Identified via Risk Manager

Last PCP Visit: 06/09/2014 **Last Ambulatory E/M Visit:** 06/11/2014 **No. of Ambulatory E/M Visits in Last 12 Months:** 4

Risk Level (Prospective)



Risk Scores	
Demographic Prospective Risk Score-MEDICARE	1.11
Concurrent Risk Score	8.22
Prospective Risk Score	4.40
Predictive Risk Score	6.36
LOH-Top 2%	No
HCC-Top 1%	No
Prospective Risk Cat	High

Patient FM: Started on CCC Program 6/2013

Expense & Utilization	2013	YTD 2014
Overall	$387,195.90	$63,279.16
Inpatient	$335,934.60	$48,628.05
Outpatient	$49,311.11	$11,589.62
Rx	$1,950.19	$3,061.49
Imaging	$6,439.14	$1,803.94
Acute Admits	15	5
Total Days (Acute Admits)	53	21
Acute Readmits (30 Days)	9	2
ER Visits	30	11

Care Management Program

- Strategic Plan 2015
  - Transitional Care Management (TCM) Program:
    - Increase Resources:
      - Enhance TCM coverage for inpatient cases
      - Enhance TCM activities in the ED
      - Enhanced TCM coverage for post-acute settings
  - Comprehensive Care Coordination Program
    - Increase SHP - PCP practice’s with trained Care Coordinators
    - Send current Care Coordinators to Advanced Care Coordinator training
    - Move paper documentation to electronic – Orion Project

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Questions