Intensive Outpatient Care Program: Positive Impact on Readmissions

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Mission

• 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

Scottsdale Physicians Organization (SPO)

Scottsdale Healthcare Hospitals (SHC)

Ownership

50%

50%

Scottsdale Health Partners (SHP)

Management Co

6 PCPs, 6 Specialists
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

Scottsdale Health Partners
Inpatient Census
May - December 2014
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

• **Struggles**
  – Diverse practice models and geographic area
  – Practices with no EMR
  – Attracting & Hiring staff
  – Staff on-going training
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
SHP - Comprehensive Care Coordination

Scottsdale Health Partners: Care Management Program
Comprehensive Care Coordination Services
Cases Volume Per Week (October 2014 - January 2015)
12 active cases deceased & 13 of > 400 active cases declined the CCC Program
TCM Metrics: Readmission

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

Shp Transitional Case Management Data:
Readmission Trends: 5/2014 - 12/2014

Note: SHP August Readmission Rate 3% - 2013 CMS data: AZ State Avg Readmission rate is 15.9%

<table>
<thead>
<tr>
<th>Month</th>
<th>Readmission</th>
<th>Avg. Readmits/Day</th>
<th>Linear (Readmission)</th>
</tr>
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<tbody>
<tr>
<td>May-14</td>
<td>30</td>
<td>1.4</td>
<td></td>
</tr>
<tr>
<td>Jun-14</td>
<td>33</td>
<td>1.6</td>
<td></td>
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<tr>
<td>Jul-14</td>
<td>18</td>
<td>0.82</td>
<td></td>
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<tr>
<td>Aug-14</td>
<td>22</td>
<td>1.05</td>
<td></td>
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<tr>
<td>Sep-14</td>
<td>19</td>
<td>0.9</td>
<td></td>
</tr>
<tr>
<td>Oct-14</td>
<td>14</td>
<td>0.61</td>
<td></td>
</tr>
<tr>
<td>Nov-14</td>
<td>23</td>
<td>1.28</td>
<td></td>
</tr>
<tr>
<td>Dec-14</td>
<td>20</td>
<td>0.91</td>
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<tbody>
<tr>
<td>Readmission</td>
<td>30</td>
<td>33</td>
<td>18</td>
<td>22</td>
<td>19</td>
<td>14</td>
<td>23</td>
<td>20</td>
<td>179</td>
</tr>
<tr>
<td>Avg. Readmits/Day</td>
<td>1.4</td>
<td>1.6</td>
<td>0.82</td>
<td>1.05</td>
<td>0.9</td>
<td>0.61</td>
<td>1.28</td>
<td>0.91</td>
<td>1.077</td>
</tr>
<tr>
<td>% Readmission</td>
<td>5%</td>
<td>5%</td>
<td>2.7%</td>
<td>3%</td>
<td>3%</td>
<td>2%</td>
<td>4%</td>
<td>2%</td>
<td>3%</td>
</tr>
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</table>
**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.

<table>
<thead>
<tr>
<th>Nov 2013 - Nov 2014</th>
<th>Nov-14</th>
<th>Dec-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>2- Inpatient stays 4 - Emergency room visits 2- OP visits</td>
<td><strong>Enrolled in CCC Program 1. An Initial Home Visit:</strong> found patient in crisis; involved in 2 hit and runs over the previous weekend; mistaking narcotic medications (overdosing); incontinent, admitted to hospital - (ARF)</td>
<td><strong>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:</strong> Tramadol 1 QD</td>
</tr>
<tr>
<td>8 - Lab visits for multiple tests</td>
<td><strong>Supervisit:</strong> Found patient to be very fearful of being alone. CC assessment also found patient to have a LTC insurance policy</td>
<td></td>
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<tr>
<td>6 - radiology procedures</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Patient FM Identified via Risk Manager

<table>
<thead>
<tr>
<th>Last PCP Visit: 06/09/2014</th>
<th>Last Ambulatory E/M Visit: 06/11/2014</th>
<th>No. of Ambulatory E/M Visits in Last 12 Months: 4</th>
</tr>
</thead>
</table>

### Risk Level (Prospective)

- Very Low
- Low
- Moderate
- High
- Very High

### Risk Scores

<table>
<thead>
<tr>
<th>Risk Score</th>
<th>Value</th>
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</thead>
<tbody>
<tr>
<td>Demographic Prospective Risk Score-MEDICARE</td>
<td>1.11</td>
</tr>
<tr>
<td>Concurrent Risk Score</td>
<td>8.22</td>
</tr>
<tr>
<td>Prospective Risk Score</td>
<td>4.40</td>
</tr>
<tr>
<td>Predictive Risk Score</td>
<td>6.36</td>
</tr>
<tr>
<td>LOH-Top 2%</td>
<td>No</td>
</tr>
<tr>
<td>HCC-Top 1%</td>
<td>No</td>
</tr>
<tr>
<td>Prospective Risk Cat</td>
<td>High</td>
</tr>
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</table>
Patient FM: Started on CCC Program 6/2013

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