SUMMIT MEDICAL GROUP

Care Management

Implementing A New Model of Care

AMGA - CMO Council Meeting
Robert W. Brenner, MD, MMM
March 13, 2013

Brief Overview of SMG

- **Formation:** 1929, Summit, NJ
- **Location**:
  - 23+ sites throughout 5 counties, Central NJ
  - 250,000 sq. ft. main campus
- **Services:**
  - 310+ Providers (238 Physicians, 100 midlevel Providers/other)
  - 70 different specialties
  - Diagnostics: Lab, X-ray
  - UCC, ASC
- **Governance**
  - For Profit
  - Physician Owned
  - Physician Leadership
- **Growth**
  - 70,000+ visits/mo
  - Managing population of 160, 000+patients (projected to be over 200,000 by 12/2013)
  - Increasing by 60+ physicians per year
  - Adding 250, 000 sq. ft. in three major hubs under development

Regional Market Trends

- Massive Consolidation and Acquisitions
  - Hospital Systems
  - Physician Groups/IPAs
- Influx of Private Equity Investments
- Formation of Hospital-Based, CMS-Based ACOs
- Shared Savings Contracts with Commercial Payers

SMG's Response

- Further the **"Triple Aim"** (Patients/Populations/Cost)
- Engage in Commercial **Shared Savings** Contracts
- Develop the Necessary **Infrastructure** to Manage Risk
- Create a Department of **Practice Transformation** to:
  - Propagate the PCMH/Team-Based Care
  - Advance the EHR
  - Oversee the Shared Savings Agreements
  - Develop Care Management as a Core Competency

SMG Care Management Team

- Six RNs Recruited from Hospitals, Payers, PCP Practices
- Internal Training Curriculum/Mentoring
- Central (#3)
  - Liaison to Payer-Based Care Managers
  - Population Health Initiatives/Quality Metrics
  - Contract Specific Oversight
  - Repository of Patients in Transitions of Care
- Embedded (#3)
  - Identify and Manage High Risk Patients
  - Management of Patients in Transitions of Care
  - Face-to-Face Visits

Care Management Resources

- Current:
  - Data Analyst (Producing Registries/Reports)
  - Solutions Manager (EHR Support; MU/PQRS Reporting)
  - Risk Stratification from Payer/Internal Audits
  - Telemonitoring/Social Service Joint Ventures
- In Progress:
  - Crimson Care Registry Software
  - Crimson Population Risk Management Program
  - Additional Care Managers & Clinical Manager of Care Management

SUMMIT MEDICAL GROUP

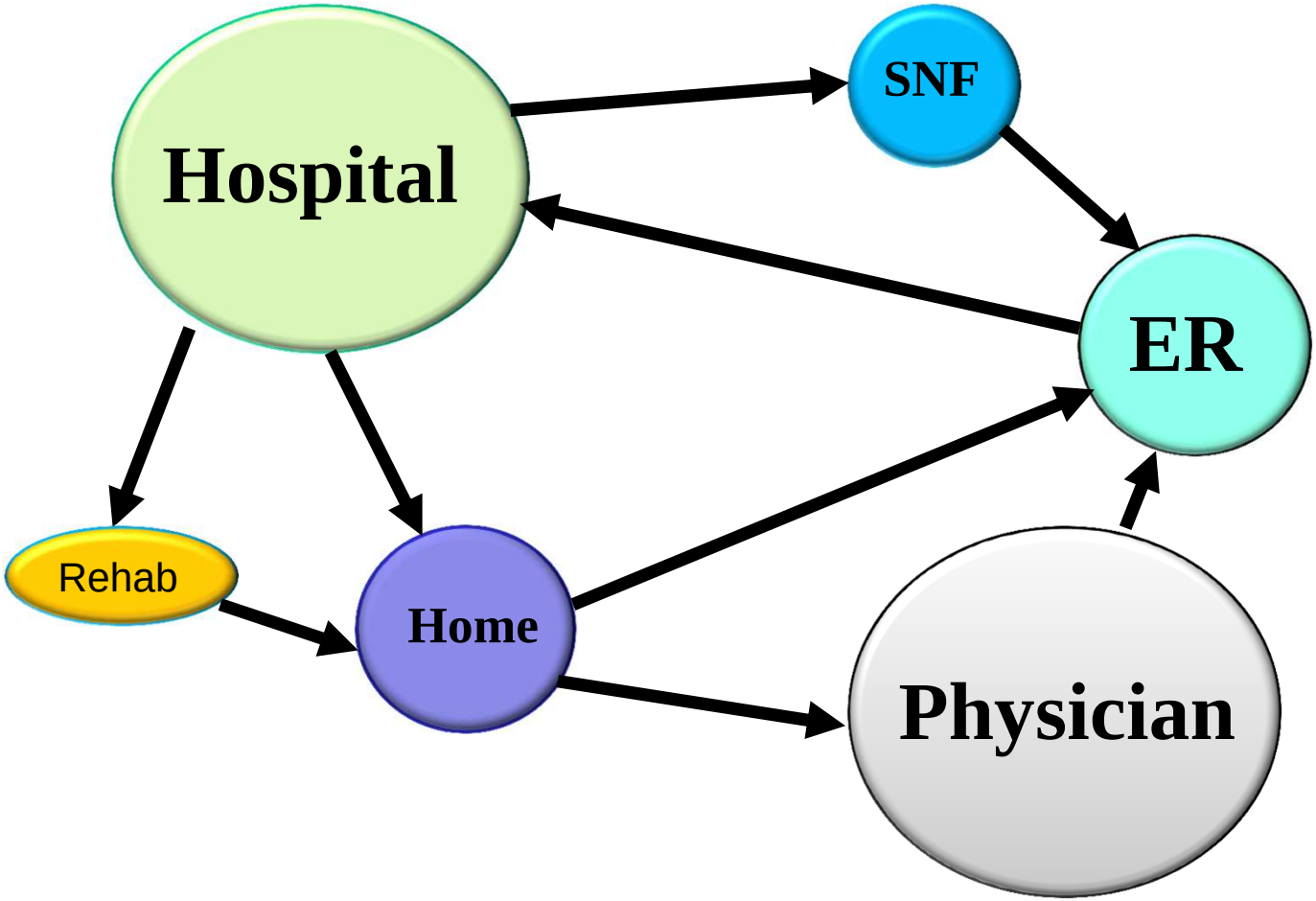
Care Management Example

Transitions in Care

A Successful Multidisciplinary Approach

SUMMIT MEDICAL GROUP

Circles of Unaccountability



Driven by disease exacerbations & gaps in communication, coordination …

TOC Redesign Overview

- **Goals:**
  - Improve Quality Patient Outcomes & Service
  - Quality Physician Services
  - Improved Communication between hospital and PCP
  - Lower Cost (Lower Admissions/Appropriate LOS/Lower Readmission Rate)
- **Interventions**
  - In-Sourced the **Hospitalist Service**
    - Midlevel Providers to Facilitate Admissions/Discharge/Communications
    - Inpatient Patient Advocate
    - Hospitalist Continuity of Care Model
    - Direct Admissions from Urgent Care Center (avoid the ED)
    - Alignment of Incentives
    - Risk Stratification
  - **Care Management Team** to Navigate High Risk Patients, Manage all Transitions
  - **Geriatrician**/NP to Capture SMG SNF Admissions
  - **Rehab Physician** to Care for Hospitalized/Post –Acute Rehab Patients
  - **Home Visits/TeleHealth Program**
  - **Expand UCC Capacity** (↓ Ambulatory Care Sensitive Visits and Admissions)

SUMMIT MEDICAL GROUP

A Day in the Life

Embedded Care Manager

- Review ER visit reports, contact patients, arrange for f/up care: 15%
- Contact newly discharged hospital patients to manage TOC: 10%
- Newly admitted patients, discuss with physicians: 10%
- Review and act on daily Notice of Admissions (NOAs) from Horizon: 5%
- High-risk patient review and outreach: 15%
- Addressing telephone encounters (mainly from providers regarding at risk patients): 15%
- Point of Care Reports (follow up items from providers): 5%
- Requesting records from other providers: 5%
- Reviewing documents and recording preventive screenings: 15%
- Misc: 5% (e.g scanning)

Inpatient Discharge Workflow

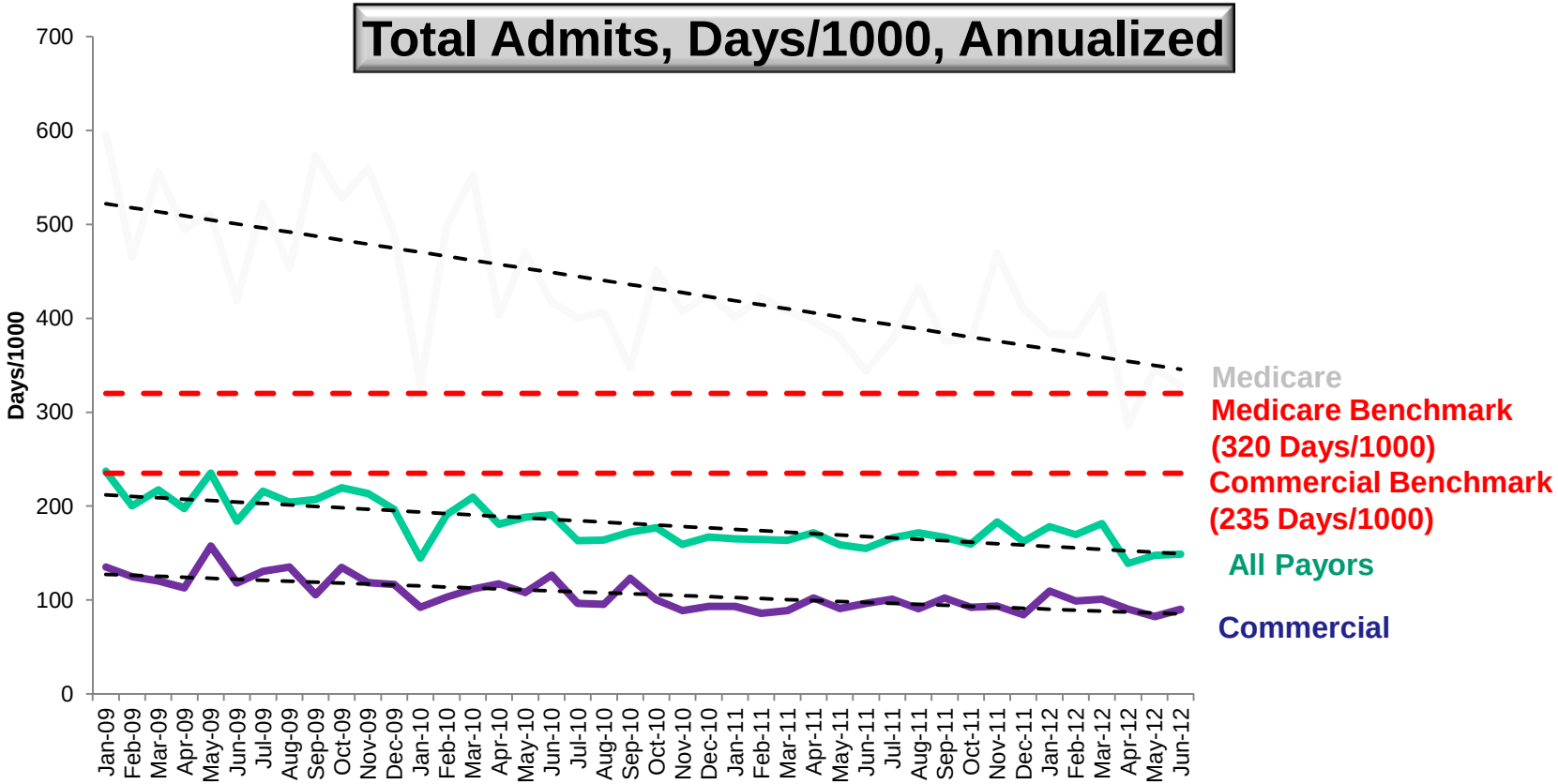
- PA dictates discharge summary at time of discharge
- PA creates Hospital Discharge Task in EEHR
- These tasks all in Care Management Team taskview.
- Care Manager contacts patient, reconciles meds, reviews discharge instructions, updates problems, arranges for follow up visits and care
- Care Manager documents all TCM services in TOC Note and sends Sign Note task to physician
- For patients at highest risk of re-admission: Care Manager will follow for 30 days

SUMMIT MEDICAL GROUP

Actual Outcomes

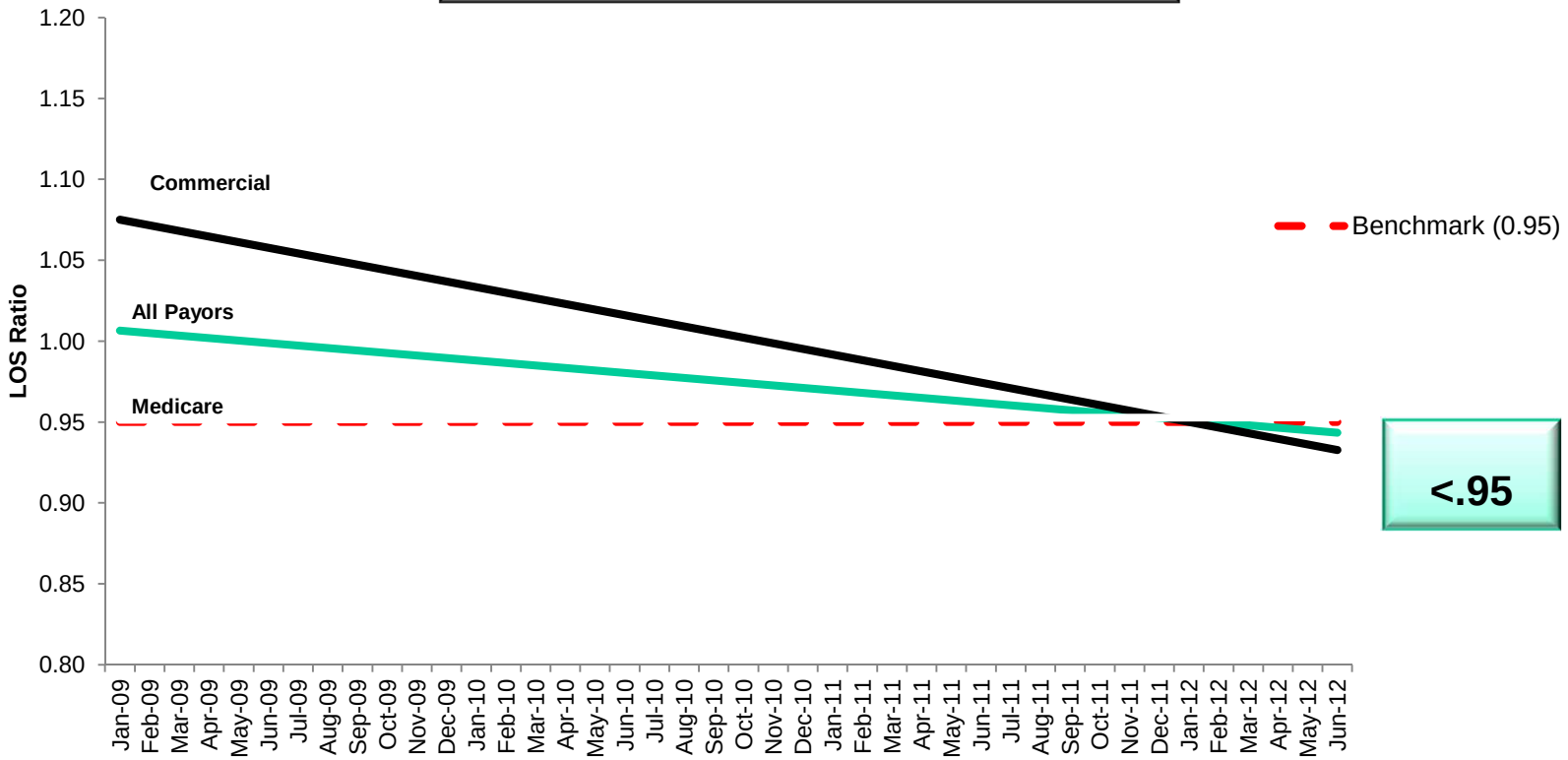
SUMMIT MEDICAL GROUP

Total Admits, Days/1000, Annualized

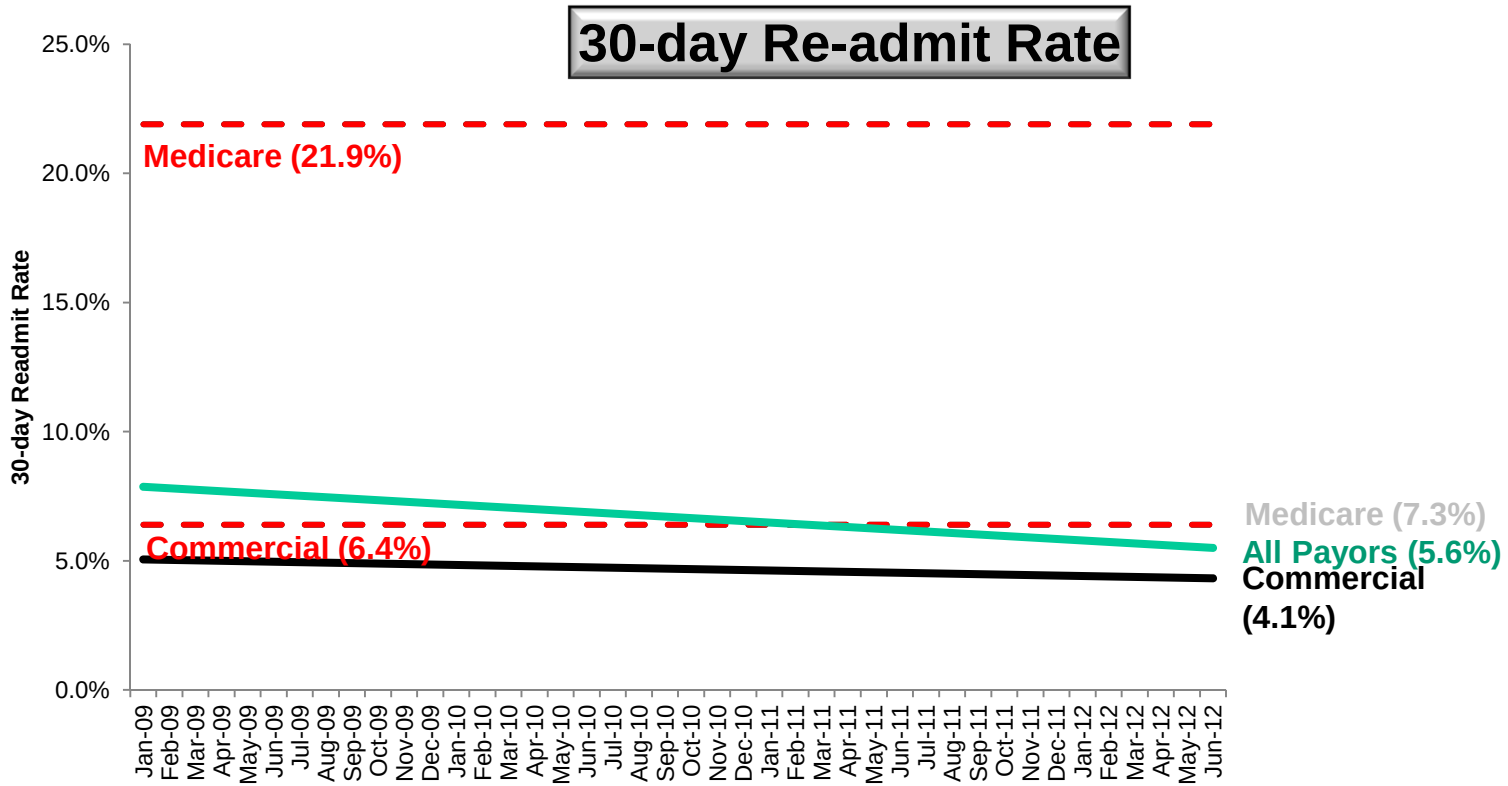


SUMMIT MEDICAL GROUP

LOS Ratio = Actual/Expected



SUMMIT MEDICAL GROUP



SUMMIT MEDICAL GROUP

Estimated Savings From Reduced Bed Days/1000 Patients				
3 Year Savings = $50M				
Year	Total Days	Days/1000	Days Saved	$ Saved
2009	20,559	211		
2010	18,538	176	3,693	$11,077,500
2011	18,912	166	5,130	$15,390,000
2012	20,645	154	7,581	$22,743,000
Totals	**78,654**	**707**	**16,404**	$49,210,500

Assumptions

2009 is base year

NJ Average Cost per day is $3000

Overall ALOS is 3.0

Increase in ambulatory services not in calculus

SUMMIT MEDICAL GROUP

Business Case/ROI

- Contractual Obligations (ex. CMS CPCI)
- Care Management Fees
- New CMS 99495/6 TCM Codes (See Handouts)
- Shared Savings Benefits

SUMMIT MEDICAL GROUP

Questions