The New West Physicians Journey to Becoming a High-Performing Health System

By Ken Cohen, MD, FACP

New West Physicians is one of the largest physician-owned primary care group practices in Colorado. In 1994 when our group was formed, the healthcare landscape was in turmoil from the managed care backlash of the gatekeeper HMO model. Through the collapse of this model, a singular vision emerged.

The vision was simple: irrespective of future changes in the healthcare system, a physician organization that defined itself upon both the quality and efficiency of care delivery would be well poised to serve its patients. Although high-quality care was known to be critical to the success of the model, it was care efficiency that would differentiate us. The great challenge was to build a sophisticated, high-performing organization within the constraints of the finances of primary care medicine. What follows is our vision -- then and today -- for both the quality and efficiency of our organization.

From our inception, we have viewed high-quality care as the “price of entry” into the world of high efficiency care. Attempts at improving care efficiency, particularly in the 1990’s, were often met with skepticism around compromised care in light of the recent managed care backlash. We therefore determined that it was paramount to measure and report quality outcomes from the outset. Moreover, we also determined that a portion of compensation would always be linked to individual provider performance on these quality outcomes studies.

Lastly, the vision included transparent reporting of all outcomes with all providers in the organization and sharing of the data with our health plans. These were radical concepts at that time.

In 1997, the New West Physicians quality outcomes program was launched. From that point forward, studies were conducted three times yearly on a wide variety of disease entities. The results were compared with best practices in the literature and formed the foundation for a program of continuous quality improvement that remains in place today. Numerous peer-reviewed publications and grant-funded studies have arisen from this program. As information technology advanced to catch up with this vision, we embraced the tools necessary for population health management. What began ten years ago with rudimentary home-grown registries has evolved into sophisticated statistical tools with the ability to predict and manage the health of our population.

Inherent in our model was the recognition that high-quality care afforded only small improvements in efficiency. We recognized that cost of care was not linked to quality of care, and that excessive care was both costly and dangerous to patients. We observed that high-functioning healthcare systems around the globe invariably had a primary care centricity that allowed for effective care coordination. We therefore determined that future success required that we not be encumbered by the competing priorities of hospitals, specialist physicians, or health plans. Additionally, the vision was that we functioned as a cost center and not a profit center. This included a conscious decision to not own ancillary facilities for imaging, laboratory services, etc. This model allowed us to select our entire network of specialty physicians, hospitals, and ancillaries critically based solely upon their quality and efficiency.

Historically, changes in practice patterns have evolved slowly in response to new developments in evidenced-based medicine. Evidenced-based research often takes as long as five years to reach clinical practice. Part of this is due to the well-recognized phenomenon of clinical inertia. More important, however, is that the elimination of wasted care has important financial implications for physicians.

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It has been well established that new, high-quality literature is not adopted into clinical practice if it is in conflict with established practice patterns. Take for example the continuing practice by many cardiologists of performing routine nuclear stress tests on patients with stable coronary disease who are asymptomatic, despite clear and accurate literature evidence that this is wasted and potentially harmful care.

Our primary care centricity has allowed us to work closely with our narrow specialty network to eliminate much of the wasted care in our healthcare system. This necessitated the development of our “Bench to Bedside” program. The goal of the program is to review the literature for high-quality, evidenced-based research that fundamentally changes daily practice patterns. This is then fast-tracked into clinical practice over a 6-to-12-week time frame.

Patient Centric Care

The process involves meetings with primary care and specialty physicians to agree on practice consensus. Clinical algorithms are subsequently built for use by the referral department. Compliance is then monitored by the referral nurses and Chief Medical Officer.

This strategy is usually collaborative, occasionally contentious, but always based on accurate science and best evidenced-based medicine. Over time, referral streams have been truncated to support a limited network of high-quality and high-efficiency specialist colleagues. This philosophy has been replicated to extend our network to include our hospital partners, imaging centers, laboratory services, urgent care centers, skilled nursing facilities, and other ancillary providers.

Innovative models of care are required for both optimal population health management as well as achieving sustainable care efficiencies.

Some examples of these innovations include:

Oncology Care

It is well recognized that palliative care services are under-utilized and late-stage futile chemotherapy is over-utilized in our current healthcare system. We addressed this with a two-pronged strategy working closely with our oncology partner. First, we developed a shared-risk fund for oncology drugs and worked with our oncologists to begin transparent reporting of cost and quality data within the oncology practice. Next, we put a program in place to introduce palliative care to all patients with Stage II, III and IV cancers. Our group then jointly funded a position for a full-time palliative care specialist to be shared between New West Physicians and the oncology practice – imbedded within the oncology practice – to provide palliative care for our patients.

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**Post-Discharge Transition-of-Care Program**

Early readmission following hospitalization is one of the nation’s most pressing quality and efficiency problems. The current Medicare 30-day, all-cause readmission stands at almost 18 percent, with a yearly cost to CMS of $17 billion. This represents the “canary in the coal mine” of our healthcare system, as it is indicative of a fragmented system with inadequate care coordination and access.

In 1996 New West Physicians developed a team of in-patient physicians, now referred to as hospitalists, to care for our patients city-wide. These physicians have access to outpatient electronic health records and maintain direct communication with the primary care physician during the hospitalization. The hospitalists also evaluate patients in the emergency room prior to admission, with access for a direct transfer to a skilled nursing facility or rapid transition back to the office, often preventing the acute admission.

Hospitalist services are supported by the nurse case management team. These nurses provide an initial intake of hospitalized patients, looking at medical, psychosocial, and functional metrics in order to begin discharge planning needs at the time of admission. Advanced directives are also addressed. Additionally, the nurse case managers see all patients who have been transferred to a skilled nursing facility or other extended care facilities. A limited network of skilled nursing facilities was chosen based upon quality of care and 24/7 access, and we use a single, dedicated medical skilled nursing facility service, which sees all of the organization’s patients metro-wide and maintains close communication with the primary care providers and hospitalists.

Upon discharge, the hospitalist directly communicates with the primary care provider through the outpatient electronic health record to provide the details of the hospital stay as well as any needed post-discharge follow-up items. Our staff of “transition-of-care coordinators” then reaches out to patients after discharge and provides medication reconciliation, coordinate all post-discharge specialty and primary care, upload all hospital records into the electronic health record, and update medication and problem lists.

Finally, there is direct communication with the primary care physician to reinforce that all issues occurring during the hospital stay are addressed post discharge. This program has resulted in a significantly lower Medicare readmission rate of 6.7% compared to the national average of 17.4%

In summary, the sustaining force of our organization is a strong culture of accountability. With no competing priorities other than the cost-effective delivery of high-quality medical care, our decision making is clear and focused. We are transparent in all that we do.

The ultimate vision was to create a primary care organization where providers would spend the majority of their time caring for patients and be supported by an infrastructure that provided a high level of provider satisfaction.

Provider satisfaction translates into engaged and motivated individuals who constantly strive to raise the bar of their chosen art – the practice of primary care medicine.

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