Moving Primary Care Practices Towards Effective Population and Panel Management to Achieve the Nation's Triple Aim

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STATEWIDE NETWORK OF PATIENT CENTERED MEDICAL HOMES

- 1.4 million Medicaid recipients including ~400,000 Aged, Blind and Disabled and other populations
- A state wide informatics center providing analytics and common care management system
- Twice-daily ADT feeds from most of the state’s hospitals
- State pays monthly per-member, per month payments (risk adjusted) to support CCNC

COMMUNITY FOCUS

- Networks are 501(c)(3) organizations, with participation from hospitals and health departments
- Primary care doctor leads diverse team of health care professionals
- Flexibility around local preferences, resources, provider capacity
- Many care managers embedded in medical practices, hospitals and EDs
The CCNC Footprint Statewide

- 6,000 primary care providers
- 1,800 practices
- 90% of PCPs in NC

All 100 Counties

- 1.4 million Medicaid Patients
- One of nation’s largest longitudinal population health databases
- 150,000 in other populations

14 Networks

- 1.4 Medical Directors
- 42.8 Local Case Managers
- 1.8 Pharmacists
- 1.0 Psychiatrist
Four key principles for advanced PCMH & “purposeful” data use

1. POPULATION HEALTH NEEDS DIFFER FROM ENCOUNTER-BASED CARE
   - Two essential elements of data used in population health:
     - Prompts to action; and
     - Dynamic care plan connecting PCP to community supports

2. INSIGHTS, NOT RECORDS
   - 86-page Continuity of Care Documents do not change care delivery or health outcomes
   - Don’t “transfer records” -- hand off actionable insights that inform PCP and team members

3. KEEP DATA “LIQUID”
   - Require data liquidity for care plans from all electronic systems of record
     - Pharmacist, urgent care, primary care provider must have some common view

4. “IT TAKES A VILLAGE” OR COMMUNITY!
   - Standards ideally apply across all provider types and settings
It Takes a Village (defining the community system of care)
1. TRANSITIONAL CARE
   - Integrates real-time hospital data with claims-based risk segmentation methods to send real-time alerts to community-based care team.
   - Flags when high-risk patients are admitted to the hospital, with intervention guidance (high vs. low-intensity transitional care support, optimal timing of outpatient follow-up appointment)

2. PHARMACeHOME
   - Combines medication use info from multiple sources (claims or fill transactions, hospital discharge summary, PCP EMR, brown bag review done by care manager) into single community record
   - Automated identification of medication or dosing discrepancies, potential drug therapy problems, adherence, etc.
   - Enables more robust, efficient medication reconciliation process, integrating community pharmacy, medical home, and community based care managers into a common workflow
Admission and Readmission Rate Trends

Study: NC Medicaid Beneficiaries with Multiple Chronic Conditions, 2008-2012

Means >8,000 fewer admissions in 2014 vs 2008 performance

Means >2,200 fewer readmissions in 2014 vs 2008 performance
Other fruitful efforts

1. DISEASE REGISTRIES
   • Making disease registries and other data available at point of care of improves decision-making

2. IMMUNIZATION REGISTRIES
   • Effective partnership with state, local entities key to building immunization registries

3. WORKING WITH SMALL PRACTICES
   • Supporting independent physicians in attaining Meaningful Use and Medical Home
   • Support smaller practices with additional resources improves performance (smaller rural practices often have the highest risk patients)
   • Other data such as social determinates and public health information empowers community level action
Use of Small Data may help bridge the gap

New approach to actionable data shows promise

WORKING WITH THE DATA THAT’S READILY AVAILABLE EVERYWHERE

• CCNC collaborated with pharmaceutical giant GSK to develop a practice “small data” solution: Care TRIAGE™
• Pharmacy data can provide a wealth of information
• Key strategy: identify the “near sick”
Care TRIAGE delivers patient-specific info to care managers, MD

1. **Composite Score.** Calculated using analytics that predict both hospital admissions and drug therapy problems, which reflects the patient’s overall risk.

2. **Patient clinical needs and interventions.** Specific clinical needs of the patient along with the intervention(s) that could address these needs.

3. **Medication details.** Additional medication details that could be helpful to users in delivering the intervention or addressing the clinical need, such as a visual view of adherence to medications over time.
So what is the impact of successful population health?

PEER-REVIEWED STUDIES

*Population Health Management*
- Significant savings for 169,667 non-elderly, disabled Medicaid recipients
- $184 million savings over 5 years; higher per-person savings for patients with multiple chronic conditions

*Health Affairs*
- 20% reduction in readmissions for patients with multiple chronic conditions in the transitional care program
- Benefit persists far beyond the first 30 days; for every six interventions, one hospital readmission avoided

*North Carolina Medical Journal*
- Medicaid recipients with schizophrenia and chronic medical who received CCNC transitional care management were 30% less likely to experience a readmission over the following year

*Annals of Family Medicine*
- Risk segmentation strategies to inform optimal timing of outpatient follow-up after hospital discharge for specific patient cohorts
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**INTERNAL RETURN ON INVESTMENT STUDIES**

*Transitional Care*
‘Transitional Care Priority’ population benefits from intensive care management when hospitalized. Saves $6,000 per transitional care episode for high-risk patients and $2,000 per episode for lower risk patients. **Total estimated savings: $75,504,000**

*Care Management of Priority Population*
Working with beneficiaries with above-expected costs for their clinical risk group generates variable savings as high as $6,000 for some patients, with average savings of ~$800 per patient over 6 months. **Total estimated savings: $19,022,400**

*Palliative Care*
Link individuals likely in their last year of life to palliative care supports at savings of $1,800 per member. **Total estimated savings: $9,000,000**

*ED Super-utilizers*
Intervention with cohort with >10 ED visits annually saves $1,800 per member over 6 months. Call Center reaches out to cohort with 2-6 ED visits in the last 12 months, saving $160 per member. **Total estimated savings: $19,572,360**

*Medical homes*
Network of 1,882 medical homes generate total cost of care savings ranging from 4.5% to 7.4% per member. Impacts hospital utilization (-12% for SFY 2014), ED utilization (-12% for SFY 2014), and potentially preventable readmissions (-41% for SFY 2014).
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• Analysis of Medicaid data by actuarial firm Milliman, Inc.

• CCNC saved North Carolina *nearly a billion dollars* over a four-year period from 2007 through 2010

• Study validates CCNC’s “quality first” approach