Community Care
OF NORTH CAROLINA

Improving care through shared knowledge

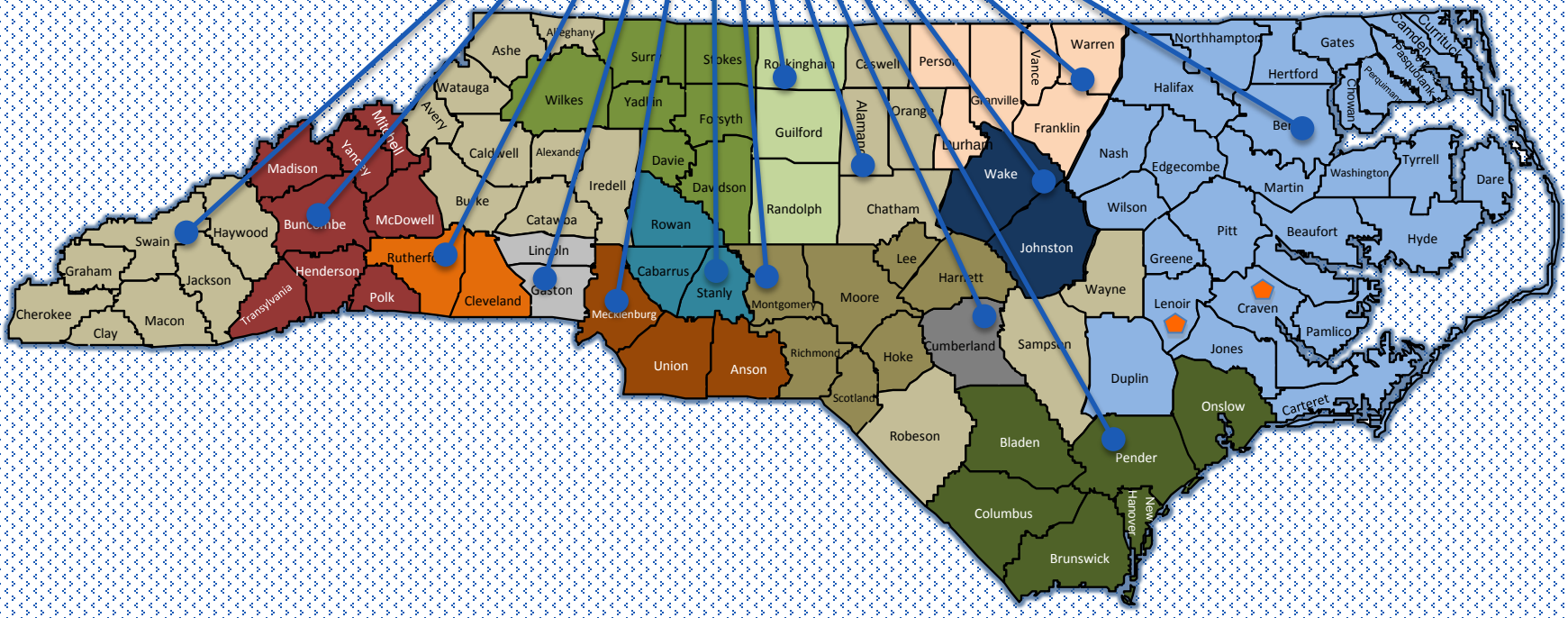
Moving Primary Care Practices Towards Effective Population and Panel Management to Achieve the Nation's Triple Aim

June 18, 2015

L. Allen Dobson, Jr., MD
Chief Executive Officer

nc department of health and human services

Community Care of North Carolina



Community Care of North Carolina

STATEWIDE NETWORK OF PATIENT CENTERED MEDICAL HOMES

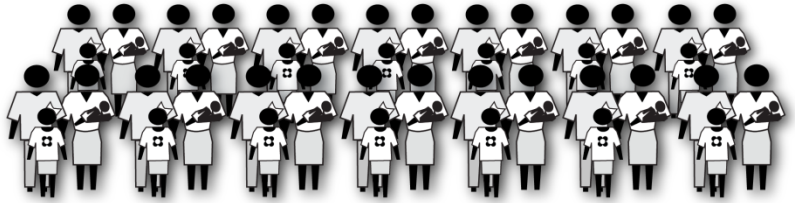
- 1.4 million Medicaid recipients including ~400,000 Aged, Blind and Disabled and other populations
- A state wide informatics center providing analytics and common care management system
- Twice-daily ADT feeds from most of the state's hospitals
- State pays monthly per-member, per month payments (risk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



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

All 100 Counties

14 Networks

Each network averages:

- 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

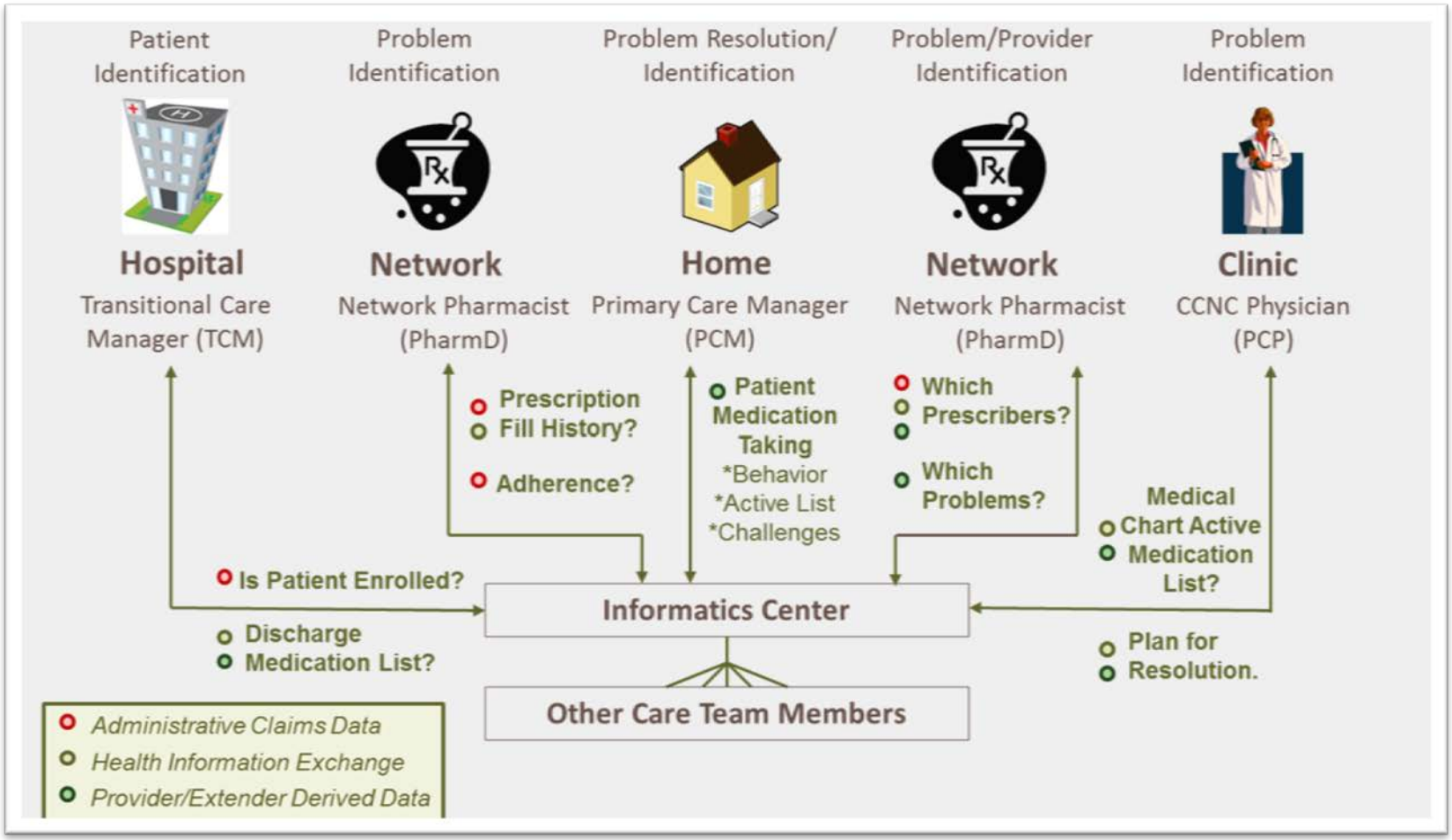
3. KEEP DATA "LIQUID"

- 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)



Integrating data across the continuum of care – 2 examples

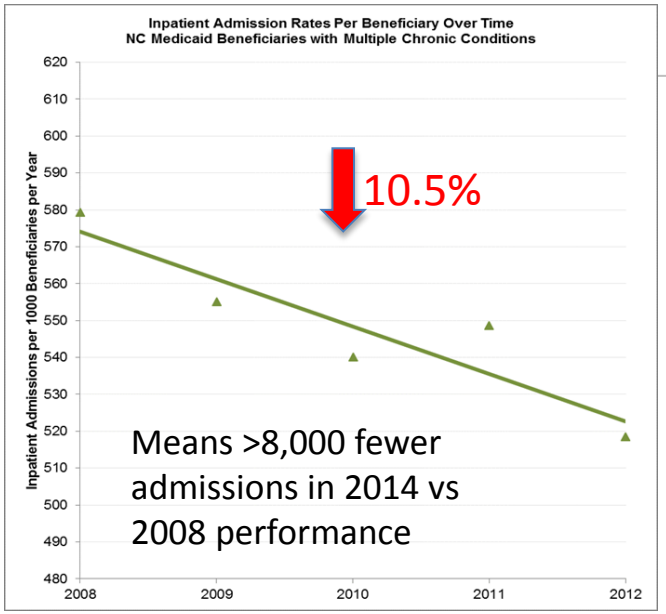
1. TRANSITIONAL CARE

- 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)

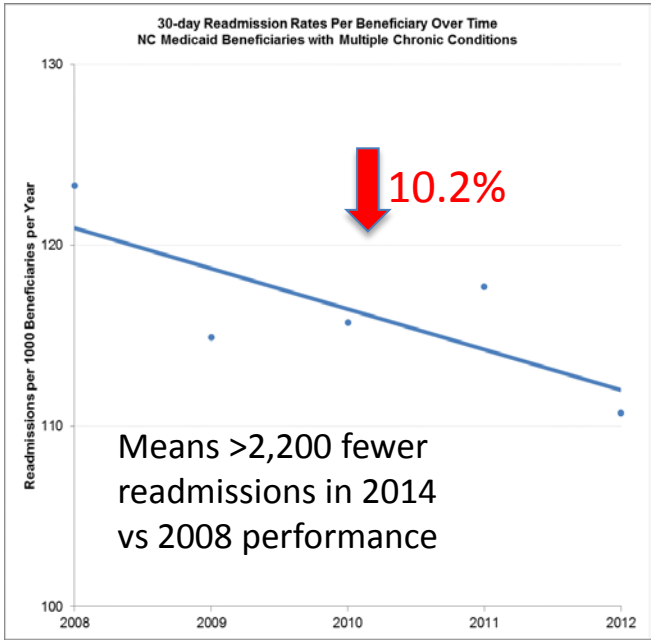
2. PHARMACeHOME

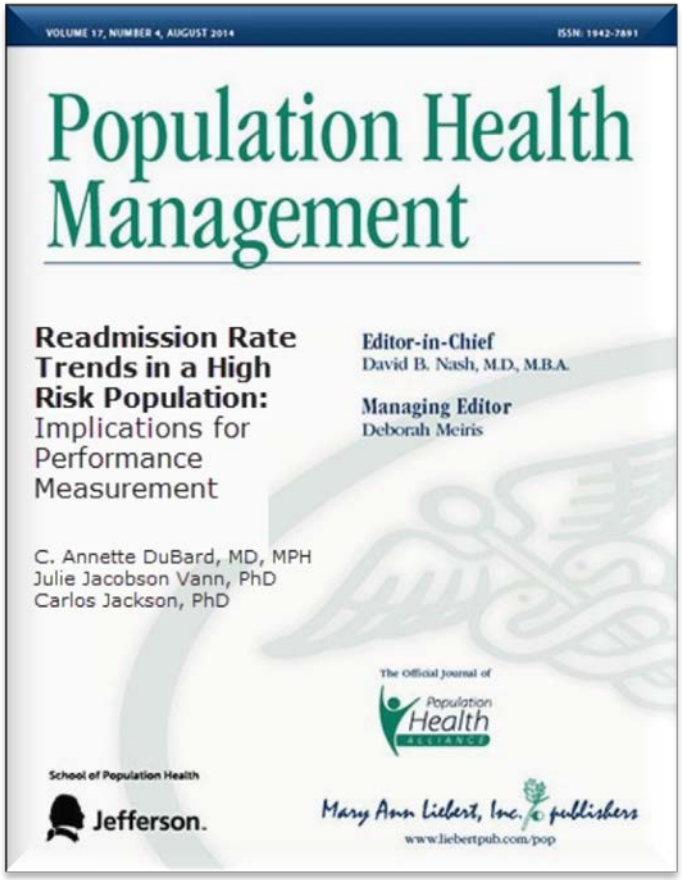
- Combines medication use info from multiple sources (claims or fill transactions, hospital discharge summary, PCP EMR, brown bag review done by care manager) into single community record
- Automated identification of medication or dosing discrepancies, potential drug therapy problems, adherence, etc.
- 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





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

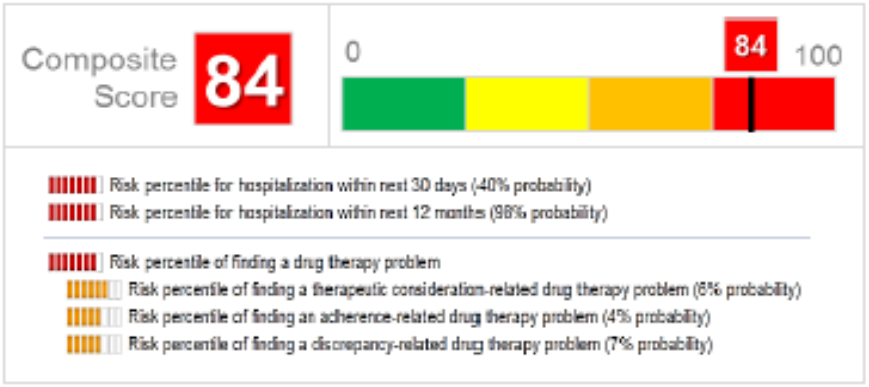
New approach to actionable data shows promise

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"

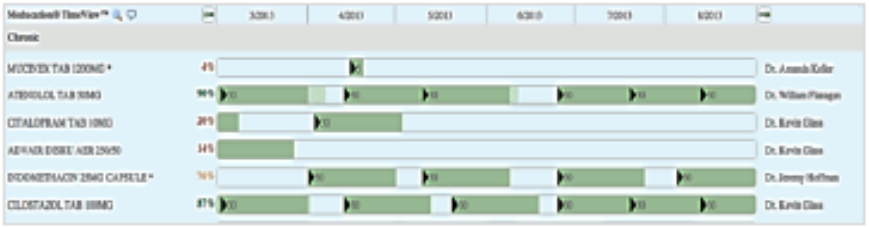
Care TRIAGE delivers patient-specific info to care managers, MD

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

So what is the impact of successful population health?

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

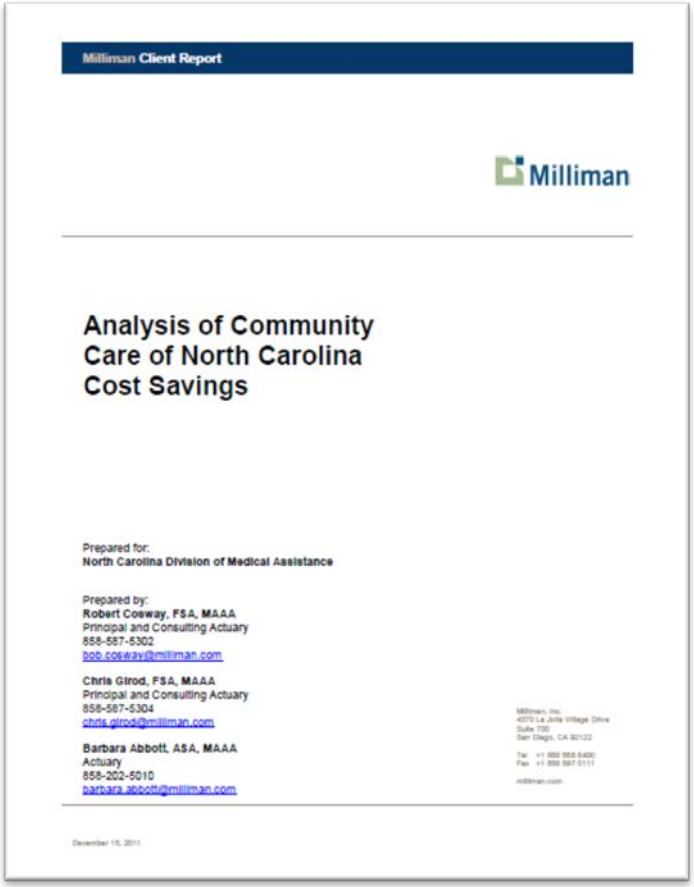
Intervention with cohort with >10 ED visits annually saves $1,800 per member over 6 months. Call Center reaches out to cohort with 2-6 ED visits in the last 12 months, saving $160 per member. **Total estimated savings: $19,572,360**

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).

So what is the impact of successful population health?

- 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



Milliman Client Report

Milliman

Analysis of Community Care of North Carolina Cost Savings

Prepared for:
North Carolina Division of Medical Assistance

Prepared by:
Robert Cosway, FSA, MAAA
Principal and Consulting Actuary
858-587-5302
bob.cosway@milliman.com

Chris Girod, FSA, MAAA
Principal and Consulting Actuary
858-587-5304
chris.girod@milliman.com

Barbara Abbott, ASA, MAAA
Actuary
858-202-5010
barbara.abbott@milliman.com