

Enabling Local Medical Homes to Coordinate Care for a State-Wide Population

Evolution and evaluation framework for a health care model for state employees, retirees and their dependents



Your Presenters

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What you'll learn

- Ensure the **successful transition** of a purchaser-provider network collaboration to an effective statewide medical home model
- Anticipate **key success factors** that vendors, provider networks, providers and purchasers must consider
- Implement an **evaluation framework** of valid, actionable metrics that shows the value of this large-scale initiative and facilitates continuous improvement

Central themes

- How can fragmented care delivery transform to an integrated, accountable population health management system?
- What are the transformative roles of...
 - Employers (focus on the state employer)?
 - Practitioners?
 - Medical home support?
 - Consultative analytics?
 - The evaluation framework?

Transforming population health management: **The employer**

Evolution of the NC State Health Plan
for Teachers and State Employees

Anne Rogers, RN, BSN, MPH

NCHEALTH
Smart
An Initiative of the State Health Plan

THE
FORUM11

State Health Plan Membership

Members: 663,103

Employees: 321,836 (480,495 inc. dependents)

Average age: 46.4

Employee only: 44.8

Enrolled in Employee Only: 75%

Children per Employee: 1.79 (Employee/Children Plan)

Dependents per Employee: 2.91 (Family Plan)

As of 6/30/2011

Snapshot of Membership

Actives, Non-Medicare Retirees and Dependents

Demographics

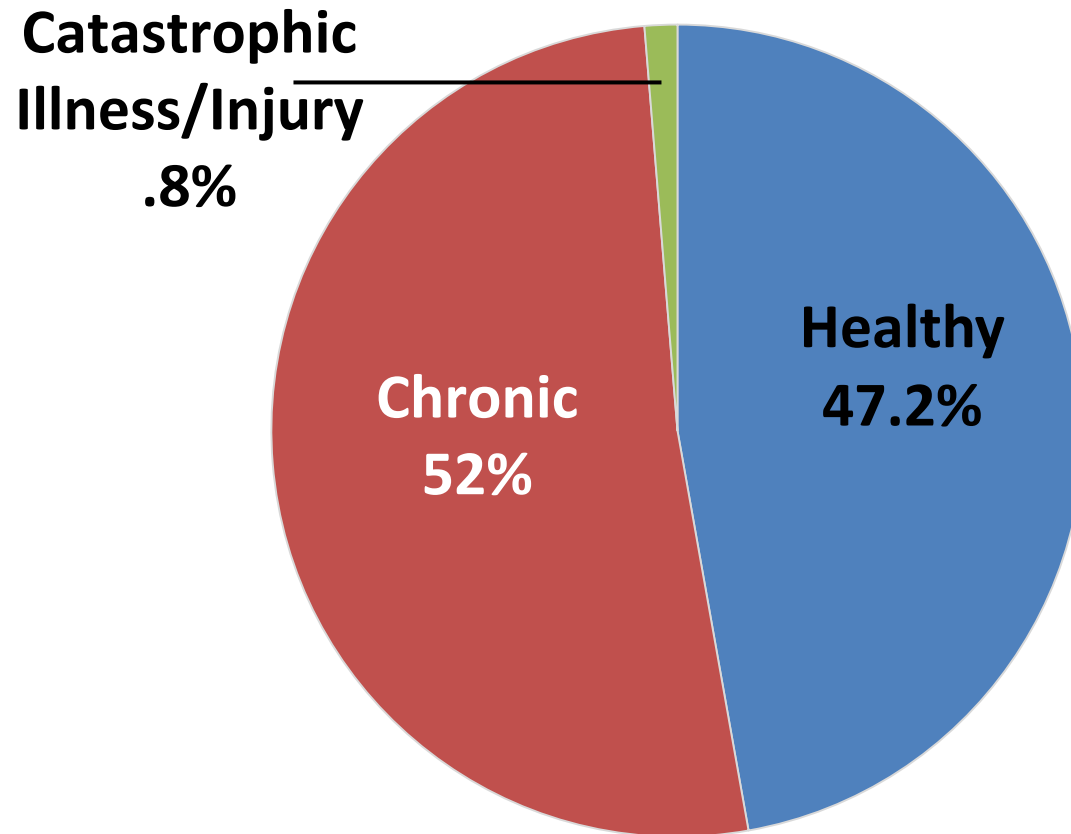
- 62% female
- 31% <30
- 14% 30-39
- 55% 40+

Health/Wellness Stats

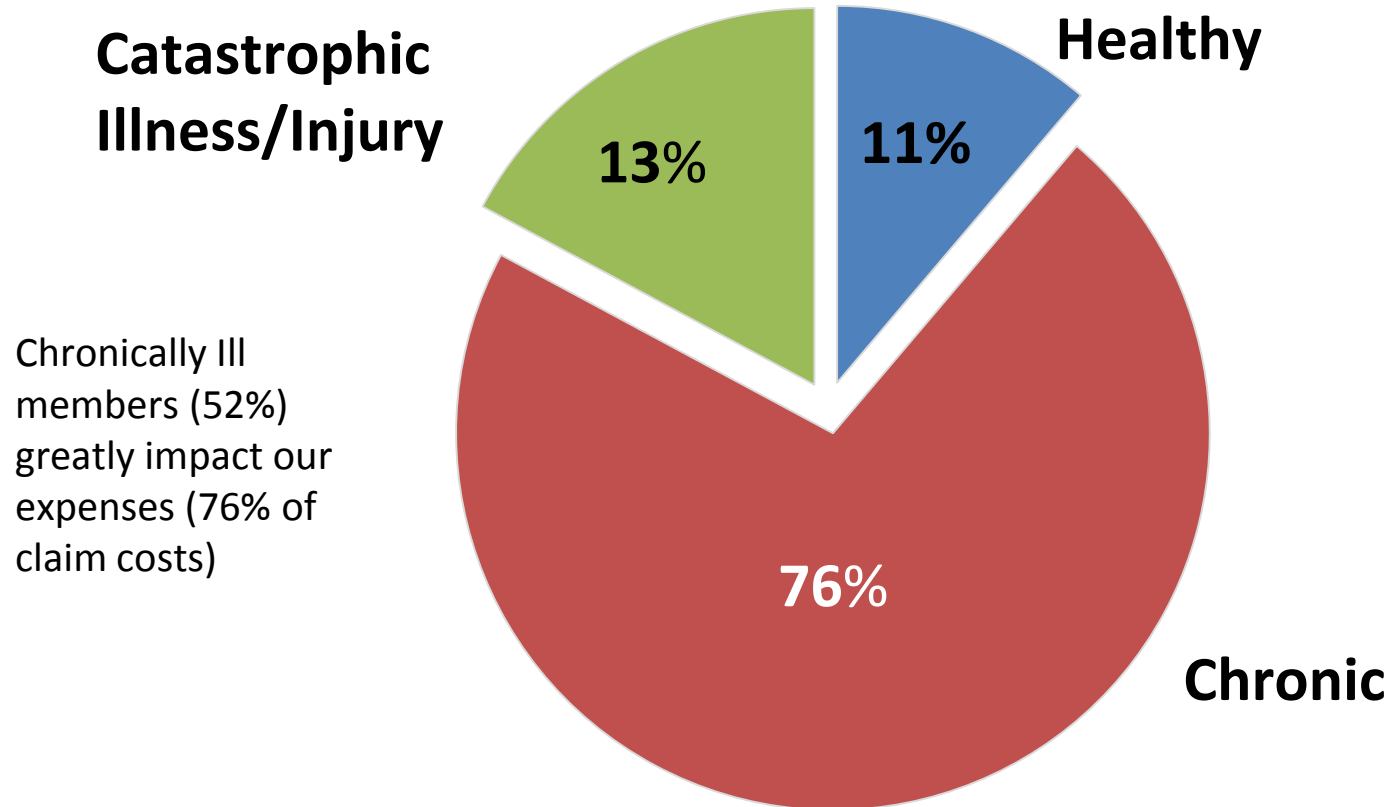
- 11-15% use tobacco*
(18.4% shift in 2010)
- 32% are obese**
- 53% have a chronic disease or catastrophic illness/injury[†]

- * Behavioral Risk Factor Surveillance Survey (BRFSS) (2009) and Health Risk Assessment (HRA) Data - Plan has 11% -15% of members who use tobacco
- ** Dr. Eric Finkelstein, Research Triangle Institute Obesity Cost Calculator, 2009
- † Aon: SFY 2010 Clinical risk analysis, January 2011

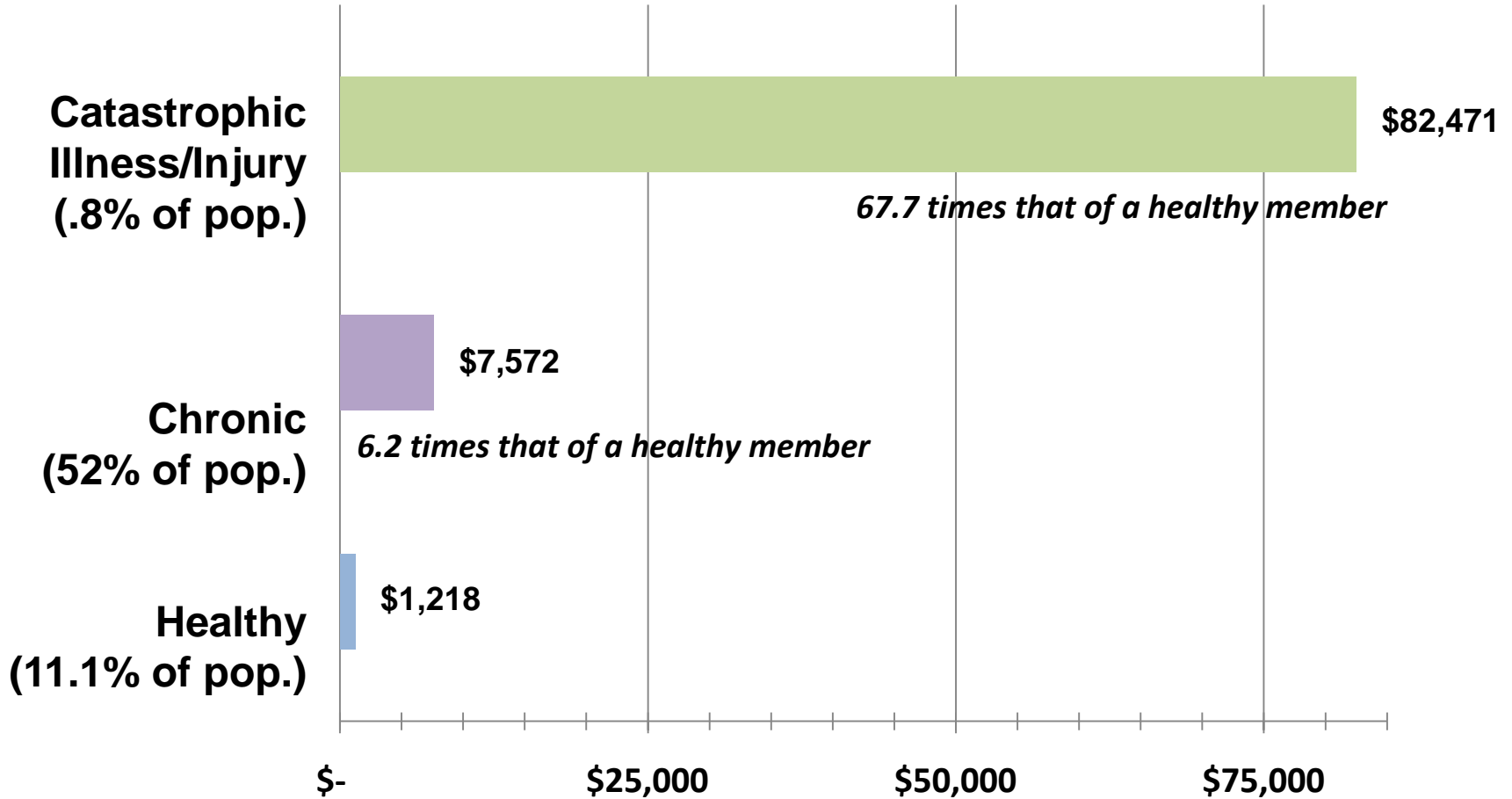
Distribution of Members by Health Status



% of Total Claim Costs by Health Status



PMPY Expenditures by Health Status



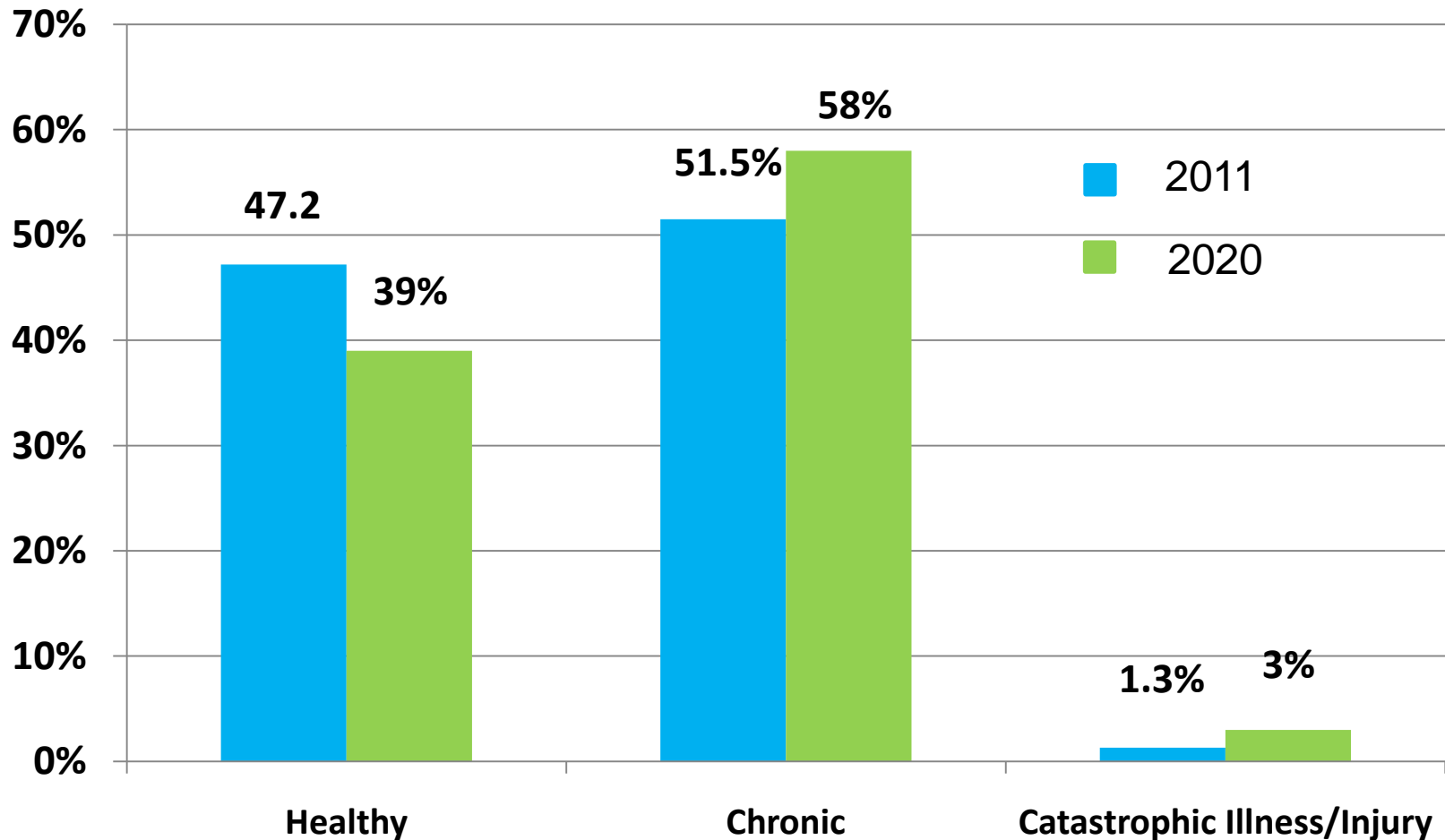
**Healthy Members have
declined 0.7% annually**

=

**An additional \$55 million in
expenditures annually**

2020 Projections

Distribution of Members by Health Status



Aon, Clinical risk analysis, Feb. 2011

Snapshot of Financials

- State fiscal pressures are resulting in eroding benefits and increased employee cost-sharing. Other solutions are needed
- North Carolina is one of 45 states facing revenue shortfalls and budget cuts
- In SFY 2010 (July 1, 2009 – June 30, 2010), the State Health Plan paid \$2.4 billion in medical and pharmacy claims

What is NC HealthSmart?

North Carolina HealthSmart is a population health initiative that aims to:

- Empower healthy members to stay healthy;
- Help those with chronic disease or disease risk factors to better manage their health;
- Offer integrated, cutting-edge resources and programs to members at work, at home, and through their health care provider

NC HealthSmart Components

- Health Coaching
- Disease Management
- Health Assessment/Health Record/Web Tools
- Physician Support/Clinical Gap Identification
- Intensive Case Management/High Risk Maternity/NICU
- Case Management/Behavioral Health/Oncology
- ESKD/CKD Care Management
- Health Promotion & Education
- Worksite Wellness

Results

- NC HealthSmart disease management programs show results:
 - Slowed the rise in costs among members with chronic disease*
 - \$18 million saved in 2007*
 - 2:1 return on investment to date**

* State of Member Health Report 2009

** Aon: Clinical risk analysis, Dec 2008

Why Move from Traditional Model?

- Services delivered telephonically by a health plan or contracted vendor have natural limitations to engage patients
- We believe a larger proportion of patients will benefit from community-based care coordination
- Care management infrastructure in place through Community Care of NC

Approach and Timeline

Transition traditional telephonic services to community-based model with services managed or delivered by physician networks

Contracted with ActiveHealth	Spring 2010
PCMH discovery and design began	Spring 2010
Vendor telephonic services began	Jan 1, 2011
Targeted implementation begins	October 2011
75% of membership engaged in PCMH model	Plan year 2013

Transforming population health management: **The medical home**

Evolution of Community Care of
North Carolina

Allen Dobson, MD



Our Vision and Key Principles

Develop a better healthcare system for NC starting with public payers

- Strong Primary care is foundational to a high performing healthcare system
- Additional resources needed to help primary care manage populations
- Timely data is essential to success
- Must build better local healthcare systems (public-private partnership)
- Physician leadership is critical
- Improve the quality of the care provided and cost will come down
- A risk model is not essential to success- shared accountability is!

Primary Goals of Community Care

- Improve the care of the Medicaid population while controlling costs
- A “medical home” for patients, emphasizing primary care
- Community networks capable of managing recipient care and supporting the medical home
- Local systems that improve management of chronic illness in both rural and urban settings

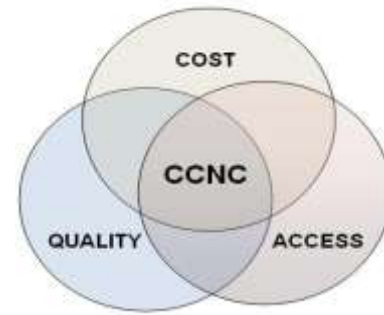


Community Care provides North Carolina with:

- Statewide medical home & care management system to address quality, utilization and cost
- A private sector Medicaid management solution that improves access and quality of care
- Medicaid savings that are achieved in partnership with – rather than in opposition to – doctors, hospitals and other providers.



Key Tenets of Community Care



- Public-private partnership
- “Managed not regulated”
- Community Care is a clinical partnership, not just a financing mechanism
- Community-based, physician-led medical homes
- Cut costs by delivering greater quality and efficiency
- Providers who are expected to improve care must have ownership of the improvement process

Community Care: “How it works”

- Primary care medical home available to 1.1 million Medicaid patients in all 100 counties
- Provides 4,500 local primary care physicians (94% of all NC PCPs) with resources to better manage Medicaid population
- Not for profit networks link local community providers (health systems, hospitals, health departments and other community providers) to primary care physicians
- Every network provides local care managers (600), pharmacists (26), psychiatrists (14) and medical directors (20) to improve local health care delivery



Community Care: “How it works”

- The state identifies priorities and provides financial support through an enhanced PMPM payment to community networks
- Networks pilot potential solutions and monitor implementation (physician led)
- Networks voluntarily share best practice solutions and best practices are spread to other networks
- The state provides the networks (CCNC) access to data
- Cost savings/ effectiveness are evaluated by the state and third-party consultants (Mercer, Treo Solutions)



Community Care Introduced Four Elements to Support Medical Home

- Provider Networks
- Population Management
 - Evidence-based programs
 - High risk case management
 - Population stratification
- Care Management / Clinical Support
 - Medical Director
 - Clinical pharmacists
 - Targeted clinical leadership – psychiatrists, palliative care, OB
 - Care Managers
- Data and Feedback



Community Care Networks

- Are Non-profit organizations
- Seek to incorporate all providers, including safety net providers
- Have Medical Management Committee oversight
- Receive a pm/pm from the State for most enrollees
- Hire care management staff to work with enrollees and PCPs
- Participating PCPs receive a pm/pm to provide a medical home and participate in Disease Management and Quality Improvement

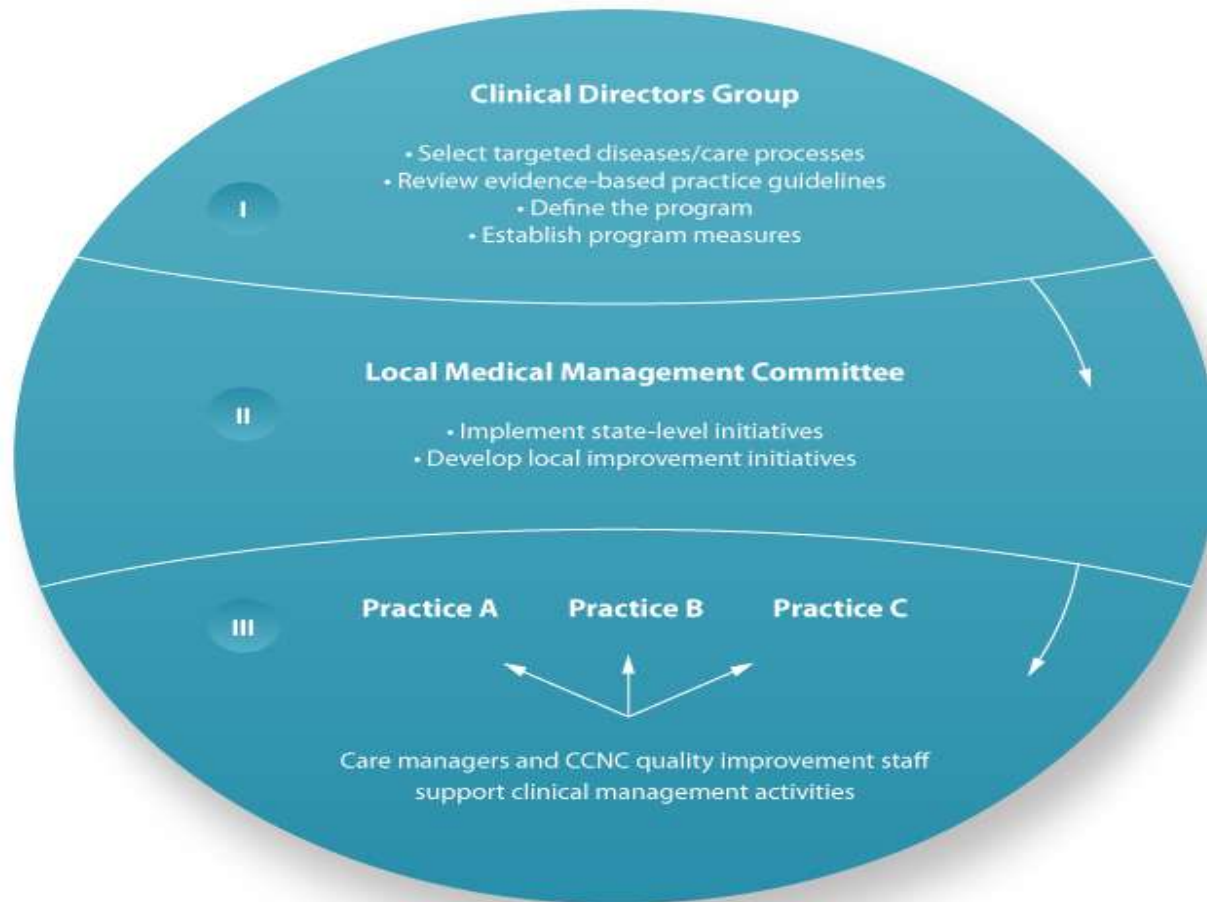


Each CCNC Network Has:

- A Clinical Director
 - A physician who is well known in the community
 - Works with network physicians to build compliance with CCNC care improvement objectives
 - Provides oversight for quality improvement in practices
 - Serves on the State Clinical Directors Committee
- A Network Director who manages daily operations
- Care Managers to help coordinate services for enrollees/practices
- A PharmD to assist with Medication Management of high cost patients
- Psychiatrist to assist in mental health integration
- Palliative Care and Pregnancy Home Coordinators



Managing Clinical Care (Spreading Best Practice)



Practices want help to “de-fragment” care

- Patient admitted and discharged from hospital without communication to medical home
 - ✓ Need effective and timely communication with hospitalists/ discharge planners
 - ✓ Need to ensure follow-up with PCP and/or specialist, medication reconciliation
- See multiple specialists without effective communication to medical home
- Multiple prescribers
- Information systems do not talk with each other



Practices want help in managing patients with multiple co-morbidities

- Medication reconciliation
- Personal health record
 - ✓ Medication list
 - ✓ Problems
 - ✓ Specialists
 - ✓ Action plan
- Help in linking with mental health
 - ✓ Who is the MH provider and how can we communicate with them?



Practices want help to improve quality

- Outreach to patients with gaps in care
- Prepare patient for visit
 - ✓ Synchronize patient, information and visit
- Activate patient to self manage their disease
- Feed data back to the practice and help benchmark against other practices
- Help educate and follow-up with the highest risk patients



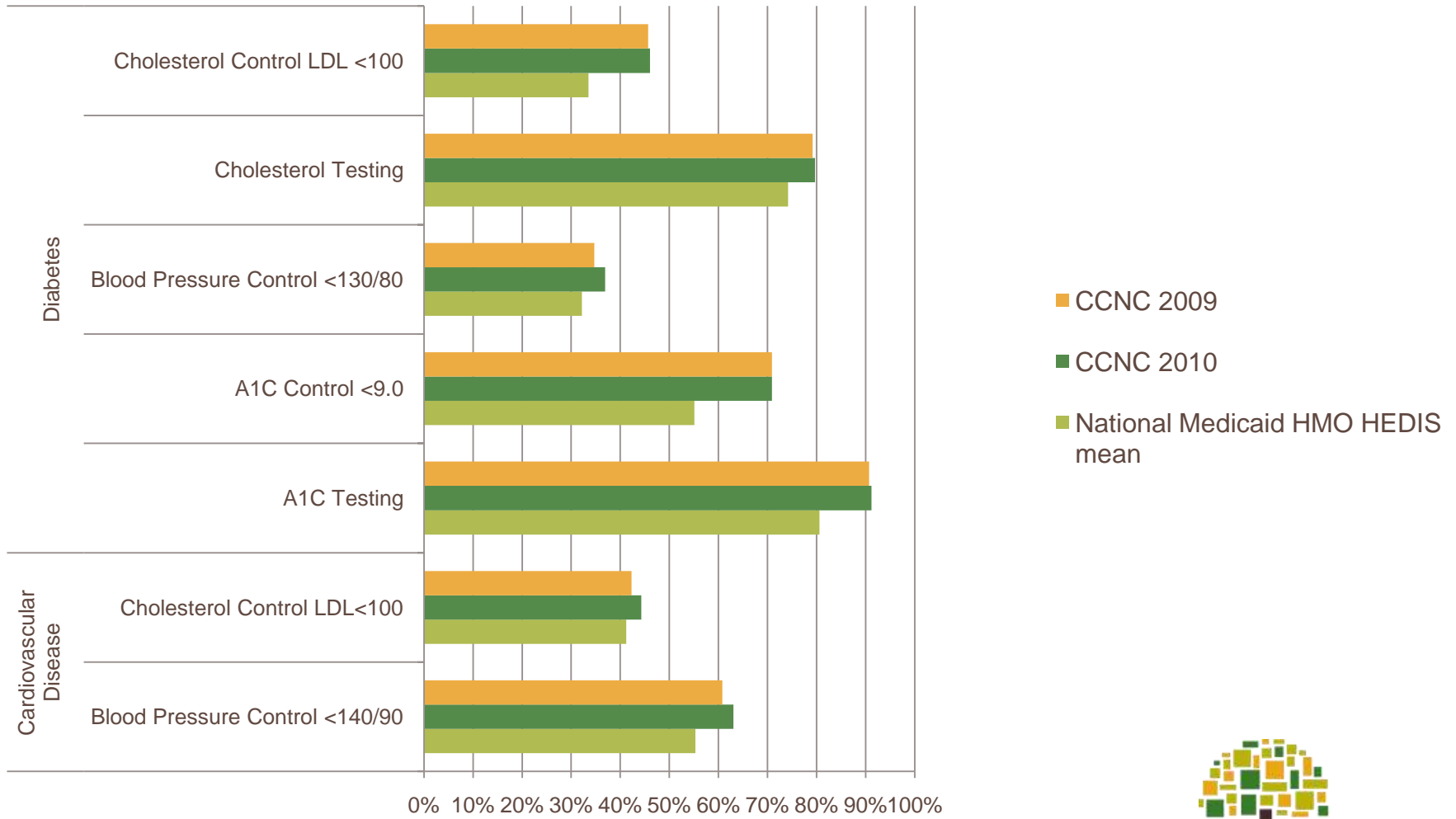
Community Care of NC – *Now in 2011*

- Focused on improved quality, utilization and cost effectiveness of chronic illness care
- 14 Networks with more than 4500 Primary Care Physicians (1360 medical homes)
- Over one million Medicaid enrollees
- Actively engaging other payers and providers
 - ✓ 646 quality demonstration ~ 44,000 duals (1/3 of the state)
 - ✓ Multi-payer demonstration in 4 networks (includes Medicaid, Medicare, BCBS and State Health Plan)
 - ✓ State-wide Partnership with State Health Plan and Active Health

System-Wide Results

- Community Care is in the top 10 percent in US in HEDIS for diabetes, asthma, heart disease compared to commercial managed care.
- Adjusting for severity, costs are 7 % lower than expected. Costs for non-Community Care patients are higher than expected by 15 percent in 2008 and 16 percent in 2009.
- For the first three months of FY 2011, per member per month costs are running 6 percent below FY 2010 figures.
- For FY 2011, Medicaid expenditures are running below forecast and below prior year (over \$500 million).
- According to Treo analysis, Community Care's work has meant that more than \$1 billion in Medicaid costs have been avoided between 2007-2009.

Quality HEDIS Measures



Source: Community Care North Carolina



Medicaid costs lower than expected

Total spending for CCNC enrollees has been lower than expected for the past 3 years.*



* Adjusting for the severity of illness in the population

Source: Treo Solutions



Lessons Learned

- Primary Care is foundational
- Data essential (timely and patient specific)
- Additional community based resources to help manage populations needed (best is located in practice)
- Collaborative local networks builds local accountability and collaboration
- Physician leadership essential
- Must be flexible (healthcare is local) and incremental



Transforming population health management: **Care coordination and analytics**

Supporting the medical home,
measuring the results

Iver Juster, MD



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Overall goals – guiding principles

“HOW’S IT WORKING” METRICS

1. Improve access to care
2. Enhance patient engagement
3. Facilitate care coordination among multiple providers
4. Foster a team-based care approach
5. Provide a clinical information system with decision support tools and fundamentals
6. Commit to transparency
7. Ensure feedback to physicians

Supporting transformation to the statewide medical home and measuring the results

- Laying the foundation: Integrate the data and provide care coordination and medical home transition/ support
- Provide enabling technologies: linking systems to support PCMH delivery
- Transform in phases
- Evaluate the results: A framework of actionable measures
- A path of continuous health improvement

Integrate the data for understanding, decision support, and workflow

- Data integration: Membership, eligibility, claims, pharmacy, lab results, program engagement, utilization, financials
- Incorporate self-report data from patients, care managers, practitioners
- Feed clinical decision support and provider/patient portals
- Support and enhance workflow
- Feed practitioner and care manager analytics

Provide care coordination and medical home support services

- Aiming for proactive integration of care management services driven by data, actionable analytics and workflow
- Transitioning from telephonic to local... point of care... community-based



Establish enabling technologies

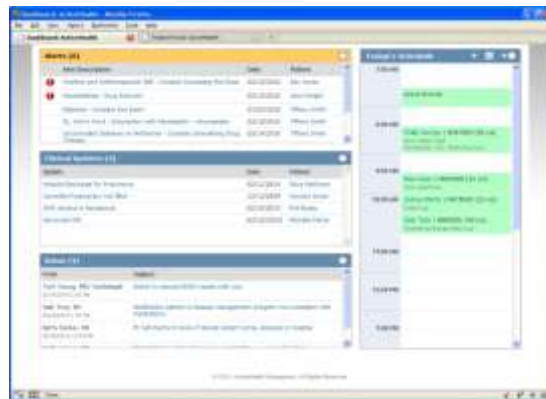
Health Information Exchange

Standards-based data ingested, moved among, and appropriately accessed across the continuum of care



Provider Portal: Integrate analytics and workflow

... Displayed to all providers in a way that can be readily used to identify health improvement opportunities and take actions to optimize quality ...

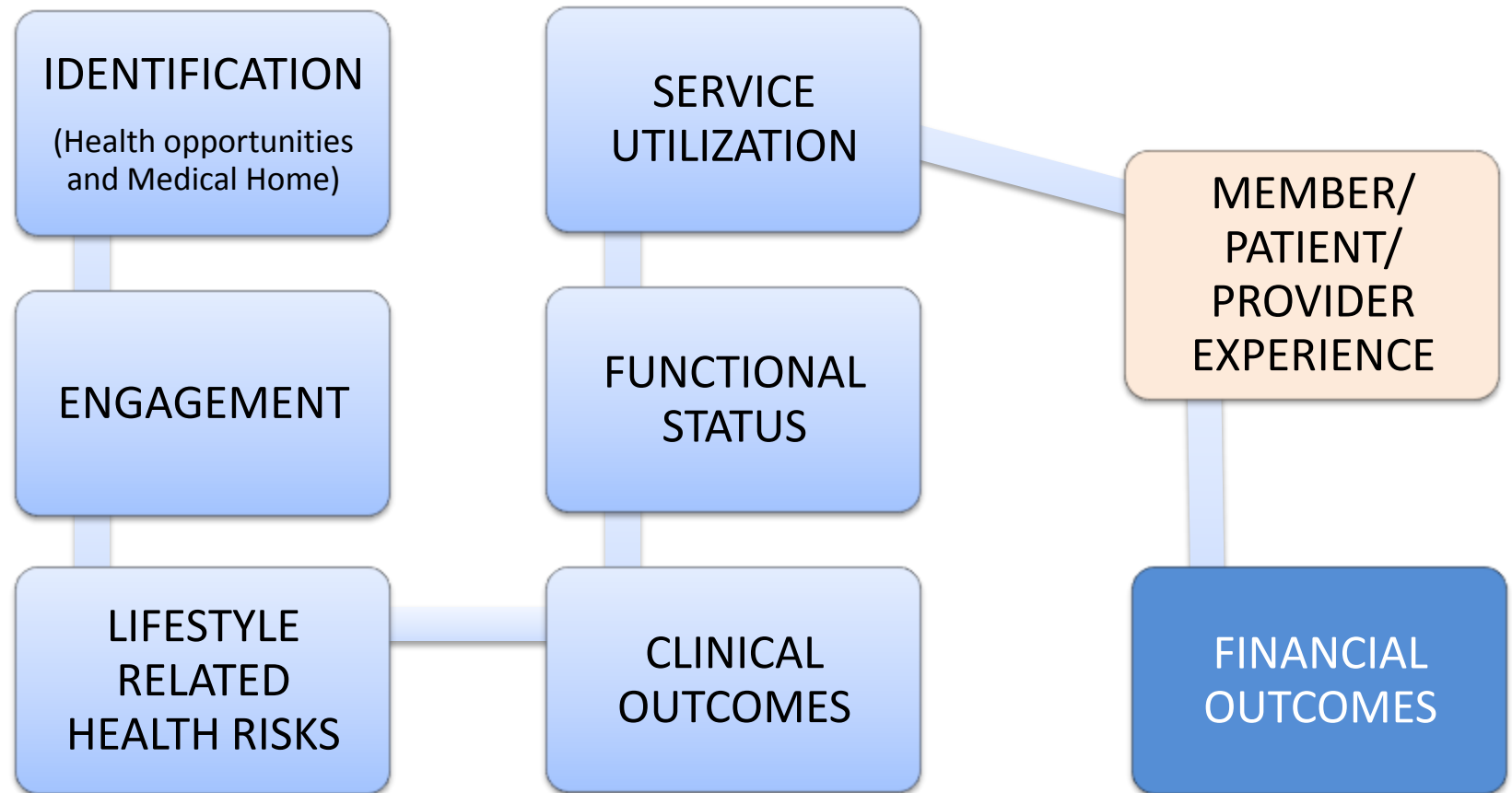


Patient Portal

... Where patients can access their health information in a way that empowers them to act on their own care plans (treatment/prevention)



Is it working? An evaluation framework



Evaluation framework: **Health risk factors**

- Prevalence of lifestyle-associated health risk factors*
(data: claims, providers, biometrics, self-report)
 - Improving/preventing risks → reduce developing chronic disease/ complications; increase productivity; lower cost
- Measure changes in risk factors over time:
 - In the population
 - For members engaging in health opportunities

* Examples: Excessive alcohol, blood pressure, BMI, Total/LDL cholesterol, HDL cholesterol, certain chronic conditions, physical activity, tobacco, stress, health perception, safety belt use, life satisfaction, illness days in past year

Evaluation framework: **Clinical measures**

CONDITION/SCENARIO	MEASURE
ASTHMA	Appropriate use of controller meds
	Beta-agonist overuse
	ED visits for asthma
	Hospitalizations for asthma
DIABETES	Annual HbA1c monitoring
	Eye exam
	Annual LDL monitoring
	Screen for or treat nephropathy
HEART FAILURE	LV function testing
	Hospitalizations for heart failure
	30-day readmissions (for heart failure)
MEDICATION ADHERENCE (% WITH MPR \geq 80%)	Ischemic vascular disease: Statins
	Diabetes: Statins
	Systolic heart failure: ACE or ARB
ADULT PREVENTION	Mammography
	Cervical cancer
	Colorectal cancer
WELL-CHILD VISITS IN FIRST 15 MONTHS OF LIFE	0, 1, 2, 3, 4, 5, 6+ visits
	At least 1 visit
WELL-CHILD VISITS in yrs 3, 4, 5, 6	Met criteria
ADOLESCENT WELL CARE	1 year
	3 year
INFLUENZA VACCINE	People age 50 and older

Evaluation framework: **Utilization measures**

In addition to 4 utilization-related clinical measures

- All-cause and ‘Most-impactible*’ hospitalizations/ER
- Readmission rates
- Preference-sensitive utilization, e.g.
 - Hip, bariatric, hysterectomy, lumbar, prostate
- Maternity: Potentially-preventable utilization
 - Antenatal (e.g., hyperemesis, diabetes, early/threatened labor, hypertension)
 - Premature and low weight births
 - NICU



* *Ischemic vascular disease, CHF, Diabetes, Asthma, COPD; and CMS' Ambulatory Care-Sensitive Utilization*

Evaluation framework: **Functional status**

- SF-12v2* will be used to assess changes in physical and mental component scale scores for members in Complex Case Management
 - Whether provided by service vendor or via the Medical Home
- Responses to the 12 individual items and 8 individual scales will be used to guide workflow

* © *QualityMetric*

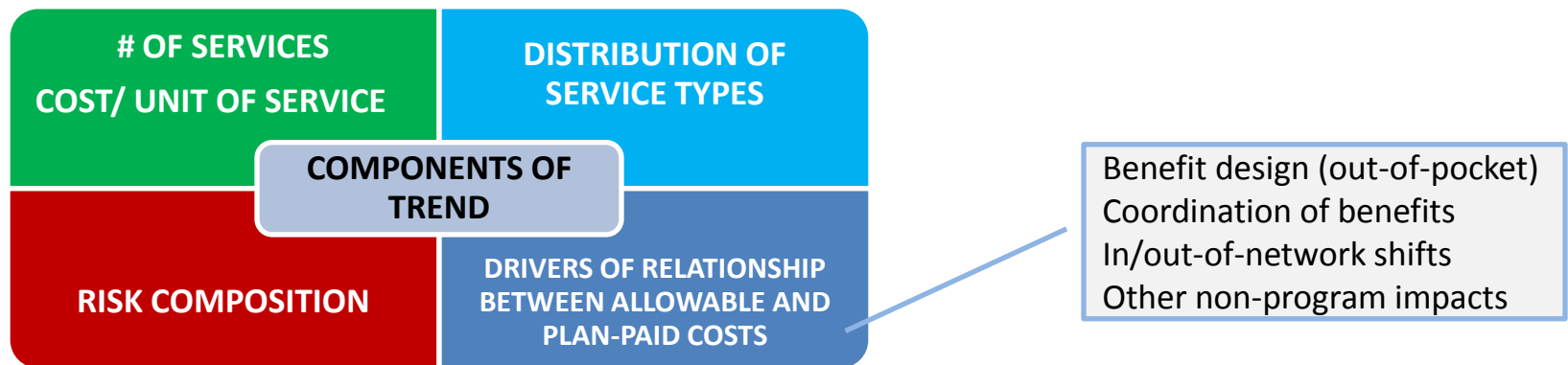


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Evaluation framework: **Economic measures**

- Overall economic performance will be measured by comparing observed to expected cost trends
 - Expected: Retrospectively-adjusted trend based on components not impacted by HealthSmart
- Measured economic performance will be bolstered by utilization and clinical trend-drivers outcomes



A path of continuous improvement

- We have embarked on a journey together
- Our Evaluation Framework—measuring against our key goals—will be our guide and compass
- Ultimate goal: Improve or maintain health status cost-effectively with favorable experiences (satisfaction) for patients and providers



Thank You!



San Francisco from Sausalito