Community Based Accountable Care

National ACO Summit

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Community Care of NC

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Accountability, "Systemness" & Incentives (original ACO principles)

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Core Principles	Key Design Elements
Clarify aims to emphasize better health, better quality care, lower costs – for patients and communities	▪ Pay for better value – improved overall health while reducing costs for patients
Better information that engages physicians, supports improvement, and informs consumers	▪ Provide timely feedback to providers ▪ Require providers to report on utilization and quality
New model: It's the system - Establish organizations accountable for aims and capable of redesigning practice and managing capacity	▪ Establish robust HIT infrastructure ▪ Implement cost-saving and quality-improving medical interventions ▪ Evaluate performance at the system level
Realign incentives – both financial and clinical – with aims	▪ Restructure payment incentives to support accountability for overall quality and costs across care settings

Community ACO Considerations

- Geography- how large?, all inclusive?,expansion plan
- Leadership – who convenes? Who are the required participants?, open network vs other arrangement, how to engage physicians and broad provider group
- Structure- what structure is best? Not for profit vs other- collaboration is key!
- Population- public payer (Medicaid/care) vs commercial vs all payer) scale important, the entire population in geographic area
- Data- who provides data services? Shared utility? Public?
- Incentives- are risk arrangements needed to drive delivery system reform?, what incentives or payment methods are beneficial in an incremental approach?

Key Elements

- **Network of medical homes (Primary Care foundation)**
- **Additional local resources based on population**

Care managers- embedded, transitional, high risk, specialty

Pharmacists

Mental Health

Palliative Care/other

- **Broad collaboration of providers (specialists, home care, mental health, others**
- **Actionable data**
- **Degree of transparency of performance metrics and outcomes (shared accountability)**

New Models of Care = New Data Needs

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1. Deliver to providers more complete picture of the individuals being cared for
2. Deliver to providers/communities a more complete picture of the population we are 'accountable' for
3. Couple performance measurement with *actionable* information (Don't just measure quality, *enable* quality improvement!)
4. Identify high-risk/ high-opportunity patients for targeted services
5. Equip the care *team* with tools for providing patient-centered care

Patient-Centered Medical Home programs

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- More than 40 states have some aspect of Medical Homes
- 34 states have PCMH using National Academy for State Health Policy criteria
- Central role now for NCQA criteria for defining and evaluating PCMH (Levels 1-3)
- Most PCMH initiatives begun since 2008
- Limited efforts: Pilots, short-timeframes, specific sites or regions.
- Several recent PCMH efforts related to Health Homes for Chronically Ill (Sec. 2703).

PCMH payment models vary

- PMPM payments in many states: (AL, CO, CT, IL, IO, LA, MD, MA, MI, MN, NY, OK, PA, SC, WA)
- PMPMs can be based on a number of factors:
  - ✓ Population Served
  - ✓ Child and adolescent
  - ✓ Age group
  - ✓ ABD
  - ✓ Practice size
- **Level of NCQA PCMH recognition (level 1- 3)**
- Shared Savings (LA, MD, MA, OR, PA, SC, WA)

Community Accountable Care

- Geographic Accountable Organizations (VT, OR, CO, RI, NC)
- Aim to make populations they serve healthier to reduce rate of growth in costs.
- Community-based focus to engage local leadership, stakeholders
- Tailored to local needs and resources

Vermont's effort

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- Community health teams led by a registered nurses
- Registered nurses work within physician practices to:
  - ✓ Track patients overdue for appointments or tests, manage short-term care for high-needs patients
  - ✓ Check that patients are filling prescriptions/taking medications
  - ✓ Follow up with patients on personal health management goals.
- Also in primary care practices: behavioral health counselors; community health workers, dietitians
- Referrals in both directions between primary care offices and social services.

Vermont's effort

- Medical homes integrated into Community Health Teams
- Link primary care to community-based prevention of chronic disease. They offer
- Individual care coordination, health and wellness coaching, and behavioral health counseling
- Connect patients to social and economic support services
- Perform community outreach to support public health.

Vermont's funding

- Fee-for-service payments from insurers and Medicaid.
- Plus PMPM that ranges from $1.20 to $2.39 based on NCQA score
- Five full-time-equivalent staff members for each community health team ($350k/year shared by three commercial insurers and Medicaid.
- Medicare to join Vermont's Multi-Payer Advanced Primary Care Practice Demonstration pilot

Oregon's effort

- Local "Community Care Organizations" (CCOs) get lump-sum payment ("global budget)" – risk adjusted.
- Communities have significant leeway in how they reimburse for services
- Waiver of standard Medicaid requirements/ aggregation of health, behavioral health, dental health, developmentally disabled, and other specialized services
- CCOs must reduce ER visits, identify/treat mental/ behavioral issues
- Focus on primary/preventive care, patient responsibility

North Carolina's Approach (currently 1.4 million patients)

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- 14 local, nonprofit networks led by clinicians (physicians, hospitals, health departments, etc.)
  - State PMPM to local network to provide on-the-ground care managers (600 over 100 counties), behavioral expertise, medication management from pharmacists.
  - Significant buy-in from clinicians/leaders – "our" quality standards and goals, not imposed from without.
  - Statewide informatics center provide real-time patient data at point of care; target "high preventables" to maximize ROI of interventions
- Participating: 5,000 providers, 1,500 medical practices – 94% of NC primary care providers

Community Care Networks

North Carolina's Approach

- State pays Fee-for-Service plus PMPM variable by population served (women/children vs. ABD)
- CCNC networks receive PMPM to provide care management, pharmacy services, behavioral consulting, etc.
- Portion of PMPM to Central Office for Informatics center, population management, health analytics, etc.

Traditional primary care

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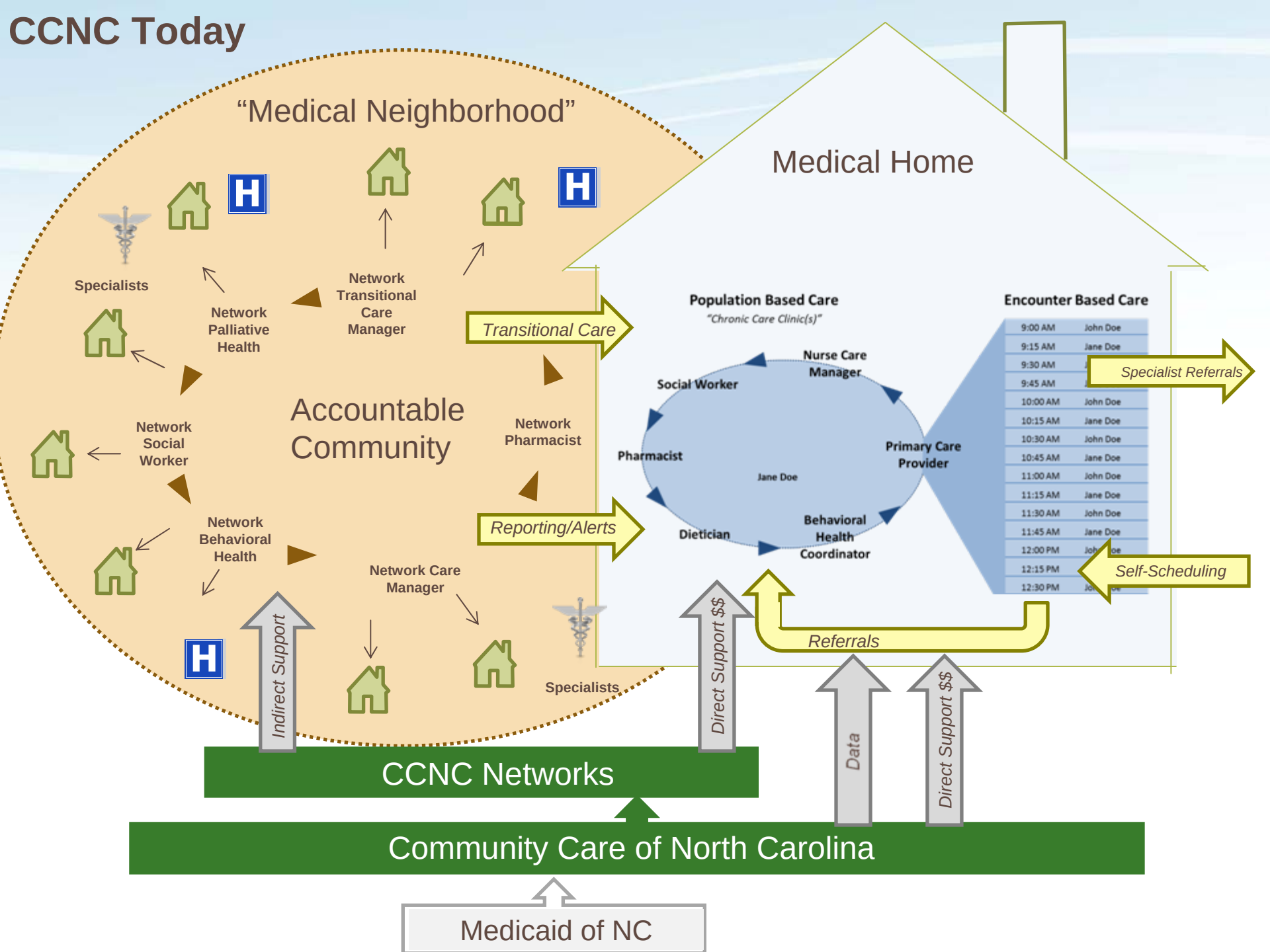
Encounter Based Care

9:00 AM	John Doe
9:15 AM	Jane Doe
9:30 AM	John Doe
9:45 AM	Jane Doe
10:00 AM	John Doe
10:15 AM	Jane Doe
10:30 AM	John Doe
10:45 AM	Jane Doe
11:00 AM	John Doe
11:15 AM	Jane Doe
11:30 AM	John Doe
11:45 AM	Jane Doe
12:00 PM	John Doe
12:15 PM	Jane Doe
12:30 PM	John Doe

Specialist Referrals

Self-Scheduling

CCNC Today


"Medical Neighborhood"
Medical Home
Specialists
Network Palliative Health
Network Transitional Care Manager
Network Social Worker
Accountable Community
Network Pharmacist
Network Behavioral Health
Network Care Manager
Specialists
Transitional Care
Reporting/Alerts
Population Based Care
"Chronic Care Clinic(s)"
Nurse Care Manager
Social Worker
Pharmacist
Primary Care Provider
Jane Doe
Dietician
Behavioral Health Coordinator
Encounter Based Care
Specialist Referrals
Self-Scheduling
Referrals
Indirect Support
Direct Support $$
Data
Direct Support $$
CCNC Networks
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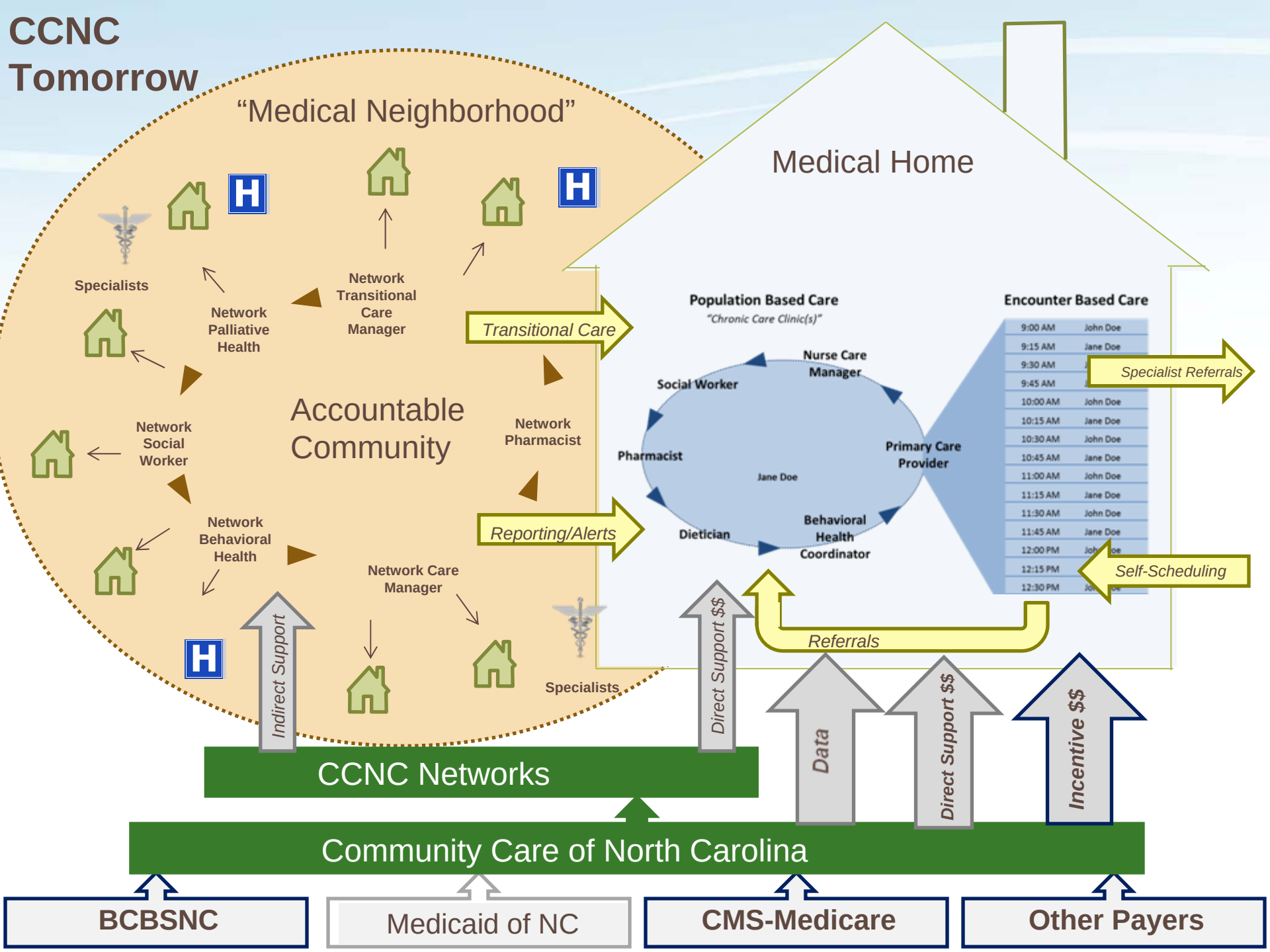
Medicaid of NC


CCNC Tomorrow
"Medical Neighborhood"
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CCNC Networks
Community Care of North Carolina
BCBSNC
Medicaid of NC
CMS-Medicare
Other Payers

Quality Comes First, Savings Ensue

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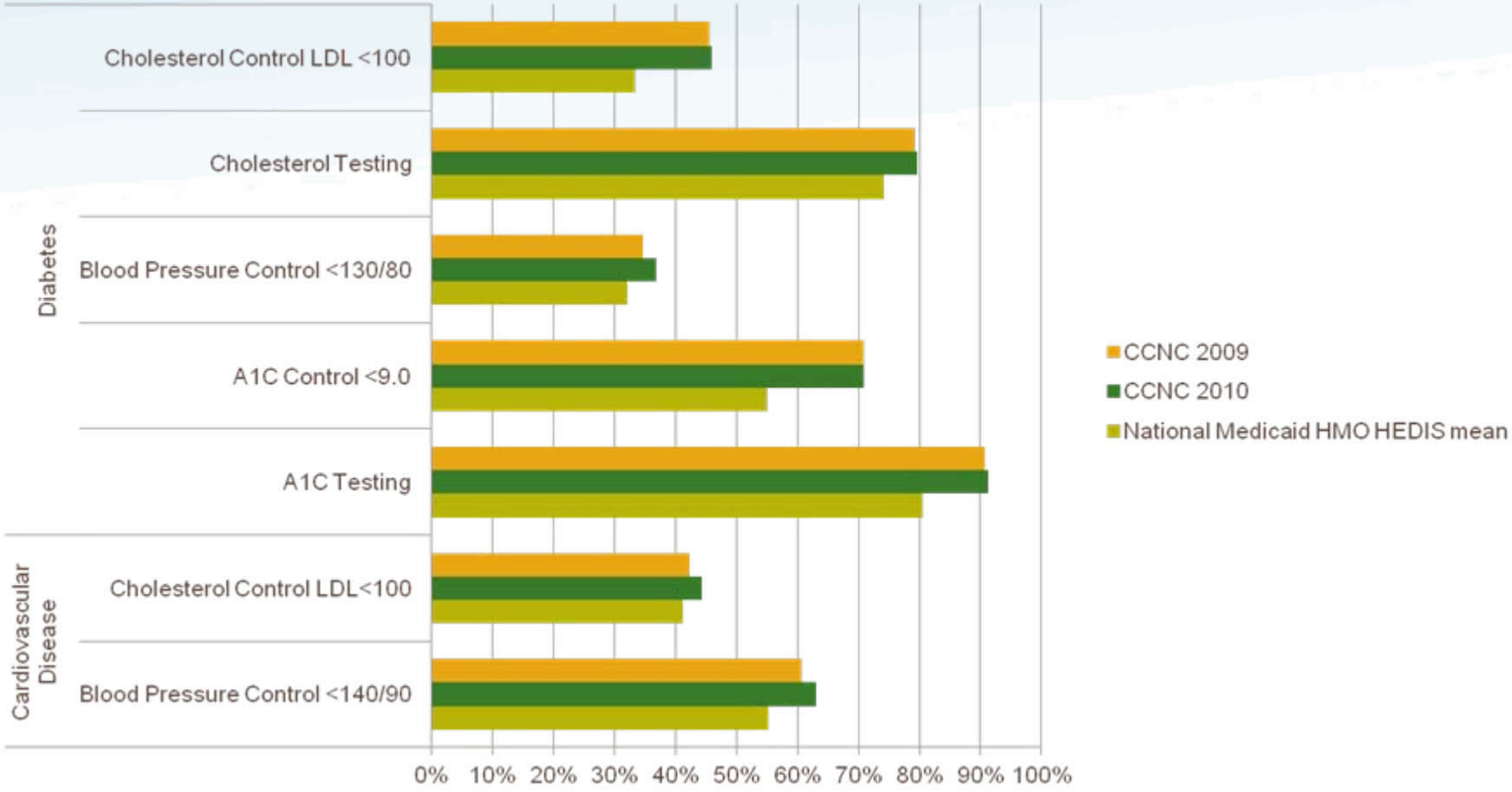

Managing transitions

- 190,000 NC Medicaid recipients admitted to the hospital each year; 31,000 multiple hospital admissions.
- Nearly 1 in 10 admissions is readmission within 30 days of a previous discharge.
- ABD only 25% of NC Medicaid recipients, but 40% of all inpatient admissions, two-thirds of potentially preventable readmissions, and 80% of total costs.
- ABD – often multiple chronic physical and behavioral health conditions, polypharmacy, low health literacy, socioeconomic stress, and multiple physicians providing care.

Managing transitions

- Cross-hospital traffic common: 23% of readmissions within 30 days of discharge occur in a different facility.
- Cross-region traffic common: for large referral centers (e.g., Duke and UNC), half of all patients come from communities outside of the locally affiliated CCNC network of primary care medical homes.

Data Use Case: Shared Statewide Pharmacy Home Process

(Patient Discharged from UNC, but lives in Onslow- Med Reconciliation Plus)

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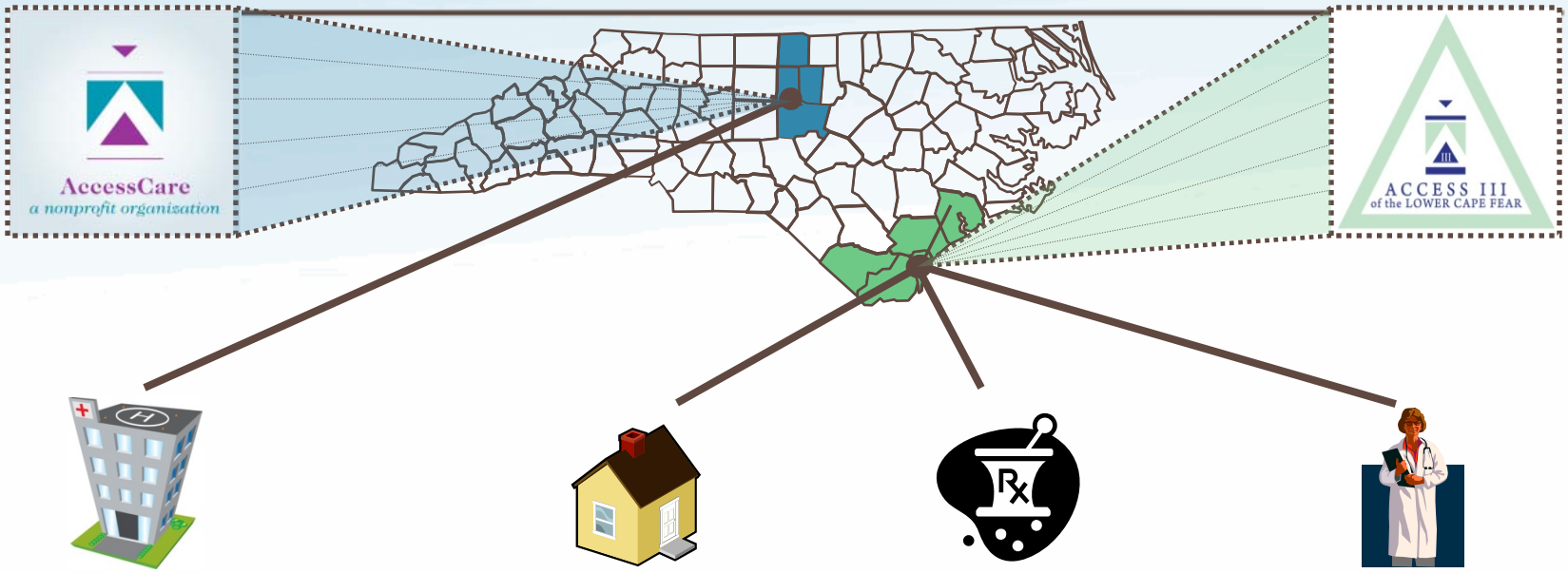

Hospital

Transitional Care Manager (TCM)

Meets with Patient, Gathers Discharge instructions, Counsels and Refers to PCM

Home

Primary Care Manager (PCM)

Meets with Patient at Home, Gathers Drug Use inventory, Assessment and Self-Management

Network

Network Pharmacist (PharmD)

Reviews All Medication Lists (Discharge, Home, Claims) for Discrepancies

Clinic

CCNC Physician (PCP)

Visit Scheduled, PCP Receives Problem List and Care Coordination Plan

CCNC Pharmacy Programs Infrastructure

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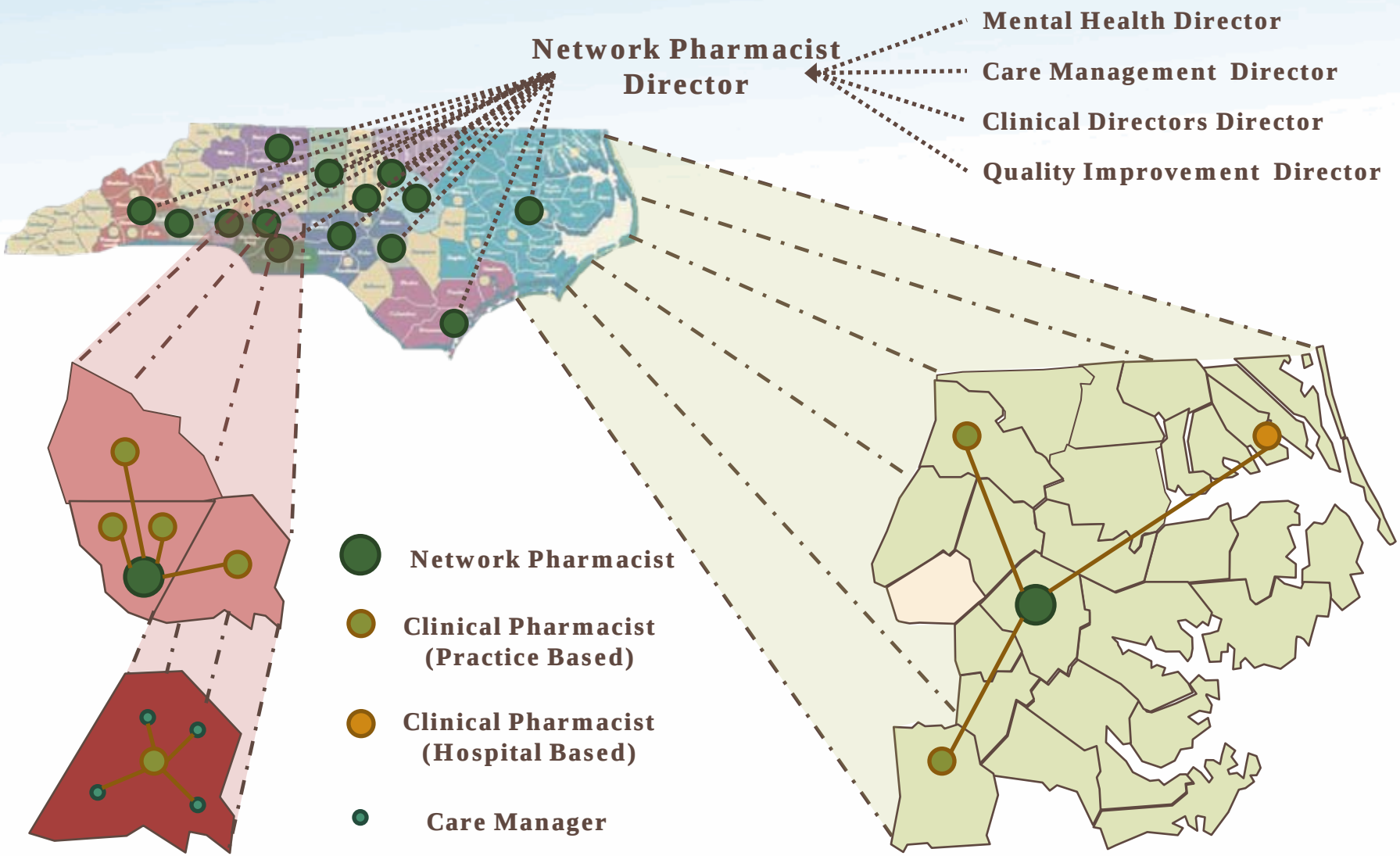

Scope and Reach of CCNC Transitional Care

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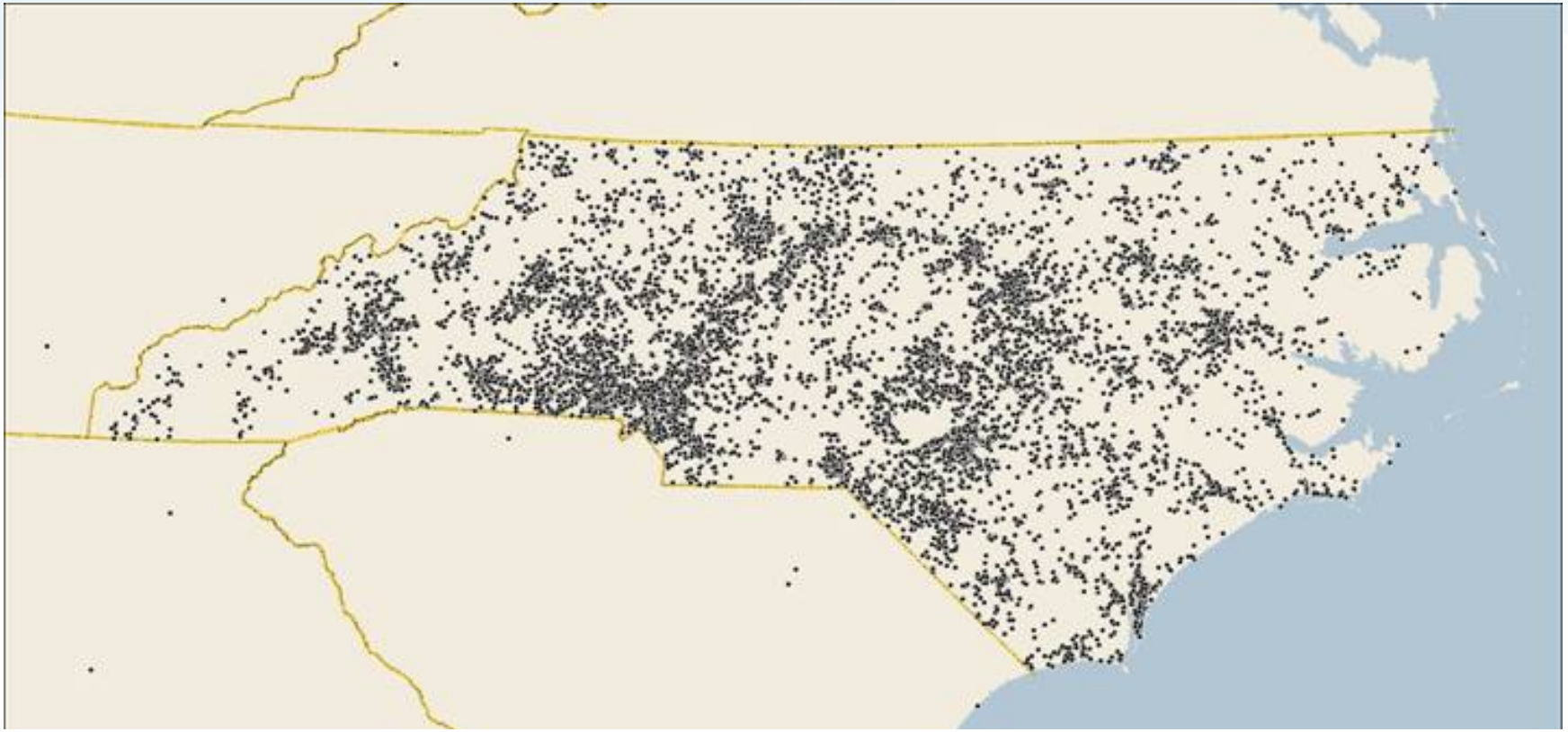
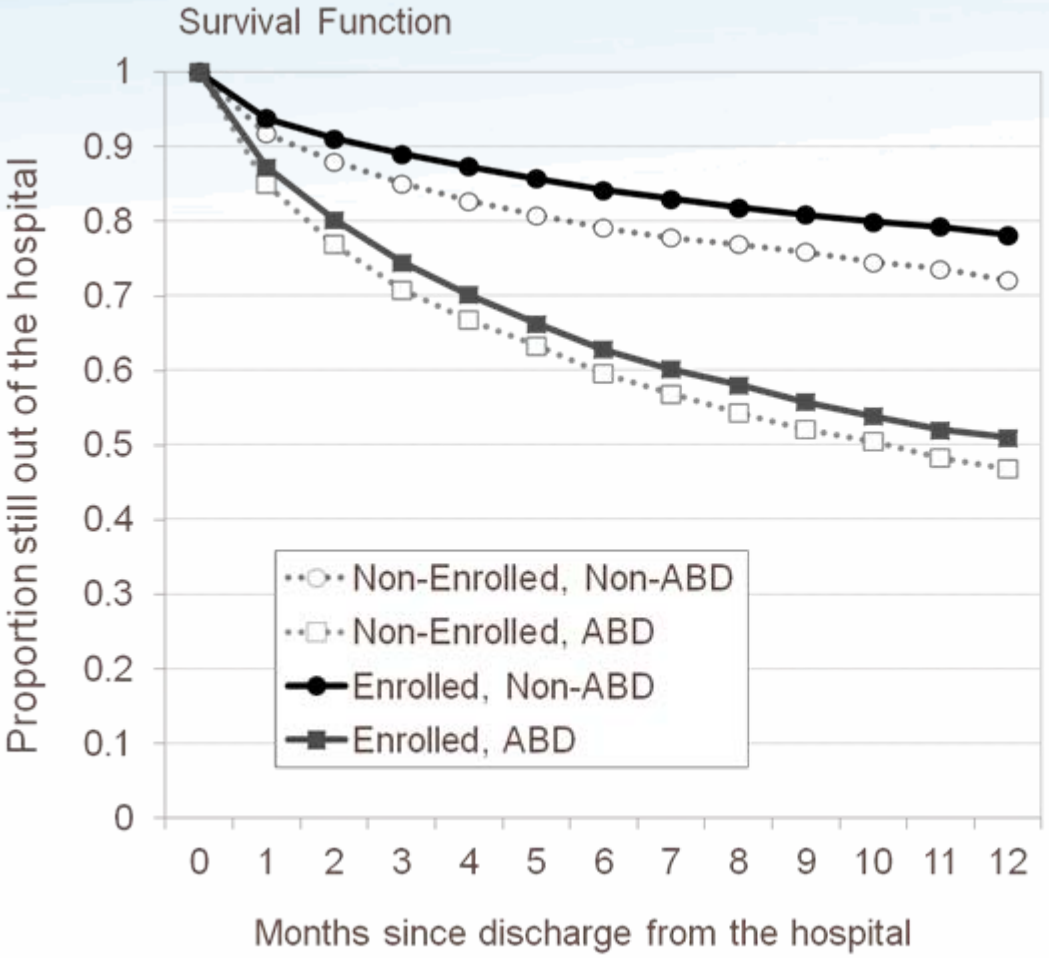


Each dot represents the location of a person who received transitional care during a 6-month period from May – October 2011.

Impact of Care Coordination



Impact of Care Coordination

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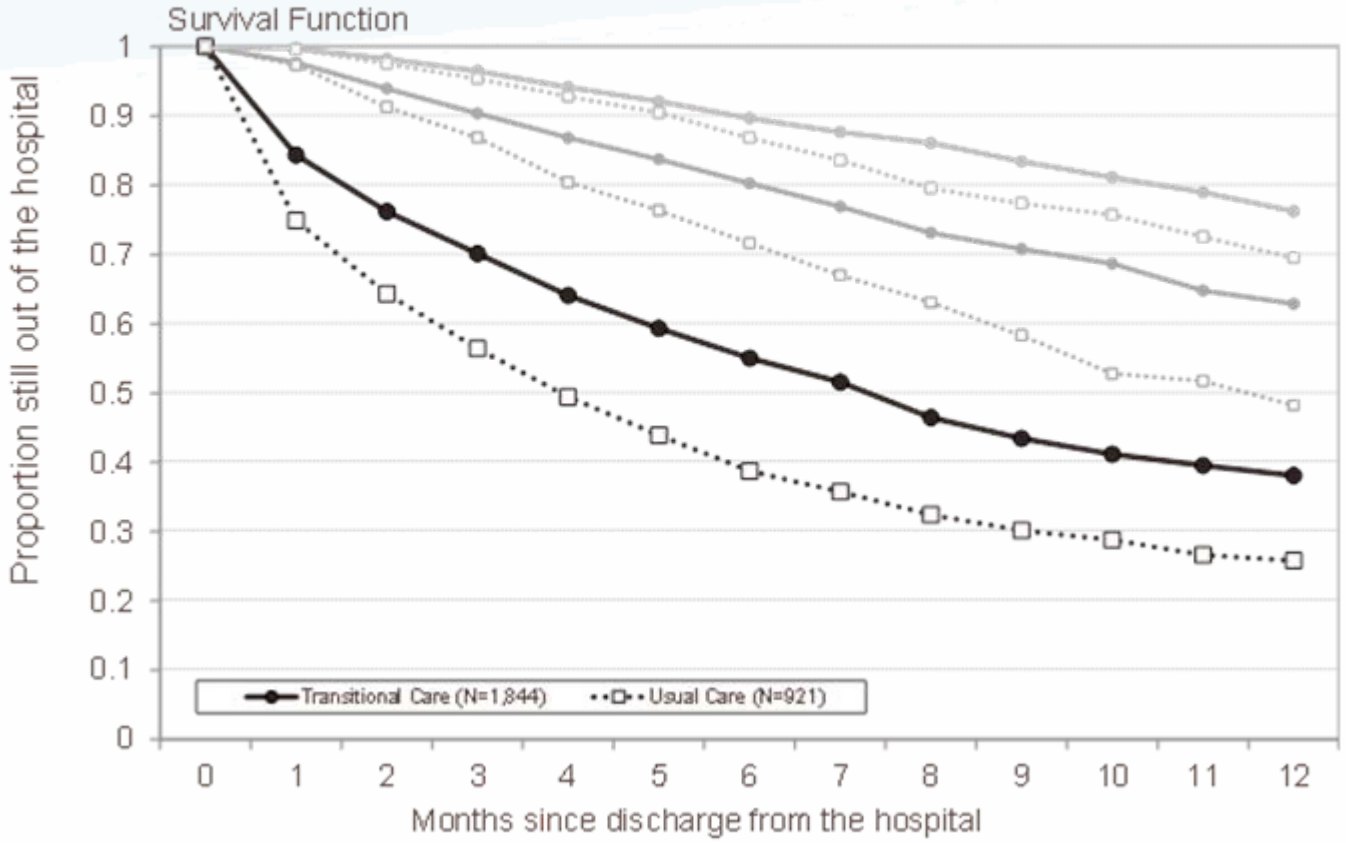
Time to First Readmission for Patients Receiving Transitional Care Versus Usual Care
Lighter shaded lines represent time from initial discharge to second and third readmissions
(Significant Chronic Disease in Multiple Organ Systems, Levels 5 & 6)



Four-year % Change in Preventable Admissions and Preventable Readmissions CCNC vs. Unenrolled

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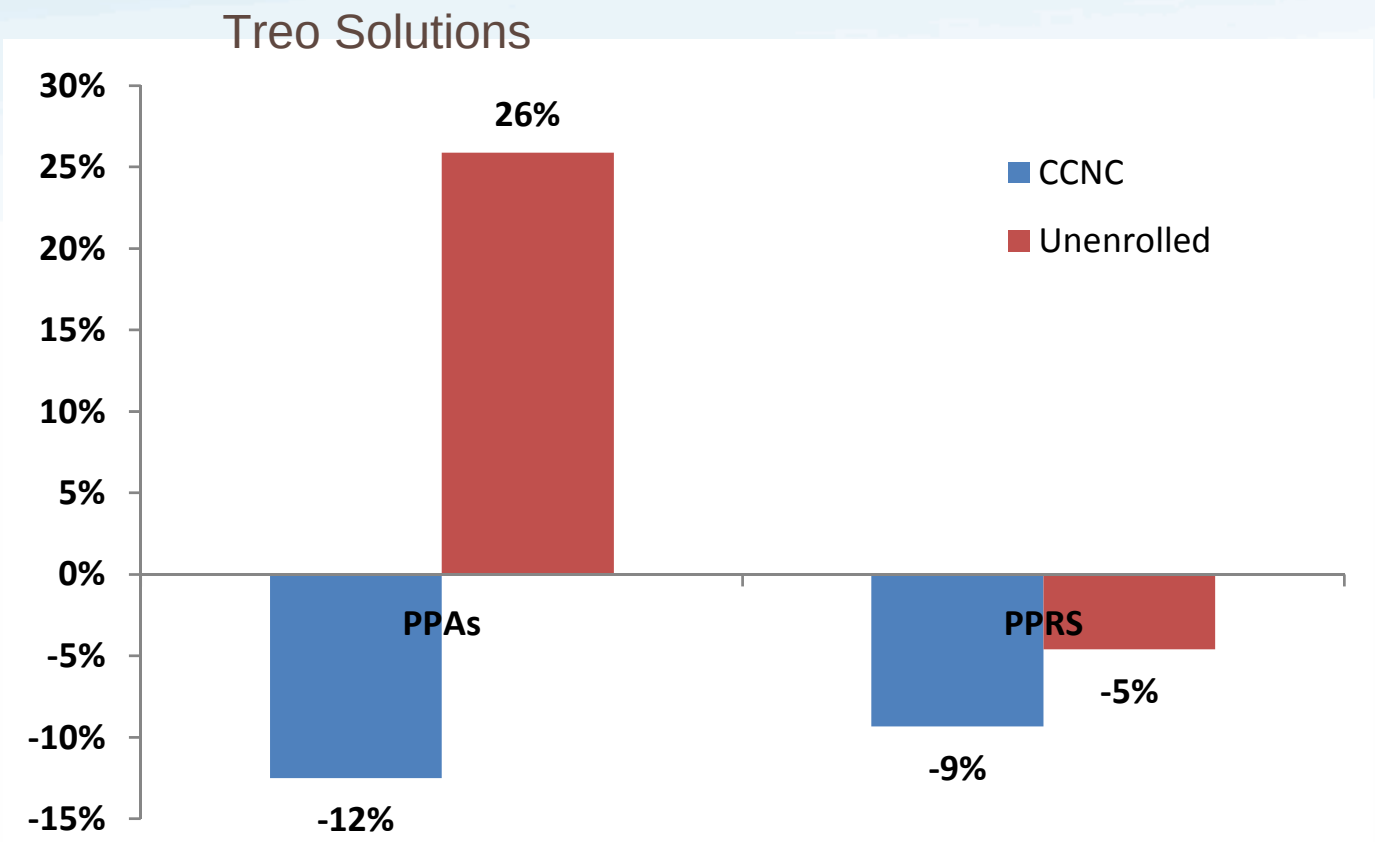

Milliman CCNC savings estimate (net cost of program)

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State Fiscal Year	Per-Member, Per-Month	Total Annual Savings
2007	$8.73	103,000,000
2008	$15.69	204,000,000
2009	$20.89	295,000,000
2010	$25.40	$382,000,000
		$984,000,000

Analysis of Community Care of North Carolina Savings, Milliman, Inc. December 2011

Lessons Learned

- Physician leadership and collaboration is critical
- Better health care system can start with public payers
- Strong primary care is foundational to a high performing healthcare system
- Additional resources needed to help providers better manage populations
- Timely, actionable data is essential to success
- Must build better local healthcare systems (public-private partnership)
- Improve the quality of the care provided and cost will come down

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Additional information at:

www.communitycarenc.org