New York-Presbyterian Conference on Innovations in Health Care Reform: Experience of Academic Medical Centers
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Innovative Care Delivery Models Panel

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Agenda

• Brief Overview
  – Duke University Health System (DUHS)
  – Community Care of North Carolina (CCNC)
    • Northern Piedmont Community Care (NPCC)
      – Key Initiatives
      – IT

• Inclusion of Health Professional Students and Residents

• Overall Successes and Challenges
DUKE MEDICINE – Who We Are Today

• Components of Duke Medicine

• Duke University Health System
  • Duke University Hospital
  • Durham Regional Hospital
  • Duke Raleigh Hospital
  • Duke HomeCare and Hospice
  • Duke Primary Care
  • Patient Resource Management Org.

Duke University Hospital
- 957 Beds (19 Psych)
- Ranked #10 by USNWR
- 38,205 discharges in FY11

Durham Regional Hospital
- Leased 1998
- 369 Beds (23 Psych, 30 Rehab)
- 15,413 discharges in FY11

Duke Raleigh Hospital
- Purchased 1998
- 186 Beds
- 7,382 discharges in FY11
DUKE MEDICINE – Who We Are Today

Caring for Our DUHS Patients in FY10

- 61,000 Discharges
- 1,927,635 Outpatient visits
- 169,493 ED visits
- 66,693 Surgical cases

All three hospitals have received Nursing Magnet status.
• 3 Hospitals
• 28 Primary Care Sites
  – 22 Duke Primary Care
  – 6 PDC/CPDC sites
• 5 Urgent Care Sites
• 2 Wellness/Lifestyle Programs
  – Duke Diet & Fitness Center
  – Duke Center for Living
• Davis Ambulatory Surgery Center
• Hospice at Meadowlands and Hock Family Pavilion
Duke Medicine – Where We Are Going

• Develop true integrated care delivery from medical center to community

• “High Tech & High Touch” Care delivered in State-of-the-Art Facilities through Specialized Centers of Excellence

• Community Care with novel models of care provider team (physician assistants, nurse practitioners, registered nurses, laypersons)

• Use innovative IT for clinical information capture, connectivity, remote monitoring and decision support
Community Care of North Carolina

Brief Overview
Key Tenets of Community Care

- Public-private partnership
- “Managed not regulated”
- CCNC is a clinical partnership, not just a financing mechanism
- Community-based, physician-led medical homes
- Cut costs primarily by greater quality, 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 individuals in all 100 counties.
- Provides 4,500 local primary care physicians with resources to better manage Medicaid population.
- Links 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 access to data
- Cost savings/ effectiveness are evaluated by the state and third-party consultants (Mercer, Treo Solutions).
Key Initiatives

- Medical Home – providing resources and facilitating practices application for national certification (e.g. e prescribing, multi-payer, tool box)
- Care Management for Medical Homes – standardized assessments and care plans, Motivational Interviewing training, informatics and registries
- Population management Initiatives
  - Disease Management (COPD, CHF, Diabetes, Asthma and Sickle Cell)
  - Palliative Care in outpatient setting
  - Behavioral Health Integration
  - Pharmacy (Formulary Management)
  - Pregnancy Medical Home and CC4C
  - Healthcheck/Healthchoice
- Transitions – focus on patient moving from inpatient setting to outpatient setting
  - Collaborative with NCHA.
  - Home visit post discharge and Pharmacist – Medication Reconciliation
  - County wide opioid initiative with ED
Our NPCC Care Management Team

<table>
<thead>
<tr>
<th>Role</th>
<th>FTE’s</th>
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<tbody>
<tr>
<td>Dietitians</td>
<td>3.0</td>
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<tr>
<td>Health Educators</td>
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<tr>
<td>Community Health Workers</td>
<td>7.5</td>
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<tr>
<td>Nurses (mostly RNs)</td>
<td>6.0</td>
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<tr>
<td>Social Workers</td>
<td>3.0</td>
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<tr>
<td>Pharmacist(2)/Pharm Tech(2)</td>
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<tr>
<td>Occupational Therapist</td>
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<tr>
<td>MD Champions(8)</td>
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NPCC COACH CDSS
Appropriate Provider, Appropriate Information, Just in Time
Outcomes

- Community Care is in the top 10 percent in US in HEDIS for diabetes, asthma, heart disease compared to commercial managed care.

- More than $700 million in state Medicaid savings since 2006.

- 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 2009 figures.

- For FY 2011, Medicaid expenditures are running below forecast and below prior year (over $500 million).
Inclusion of Residents and Health Professional Students

- Longitudinal Curriculum
- Participation with Care Management Teams
- Community Engaged Research
  ✓ One-year course covering:
    • the elements of community-engaged population health research,
    • population health measures and study designs, and
    • the steps of community-engaged research based population-health improvement.
  ✓ A mentored project in community health improvement that builds off of and contributes to ongoing community health initiatives.
  ✓ Journal Club, in which residents learn to critically assess research.
Successes and Challenges

• Home visits and Med Reconciliation
• IP admits for IOM chronic conditions
• Participation of Specialists
• State Budget Crisis
• Predicting the Future
Resources

• Community Care of North Carolina
  – http://www.communitycarenc.org

• North Carolina Division of Medical Assistance
  – http://www.ncdhhs.gov/dma/