



**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



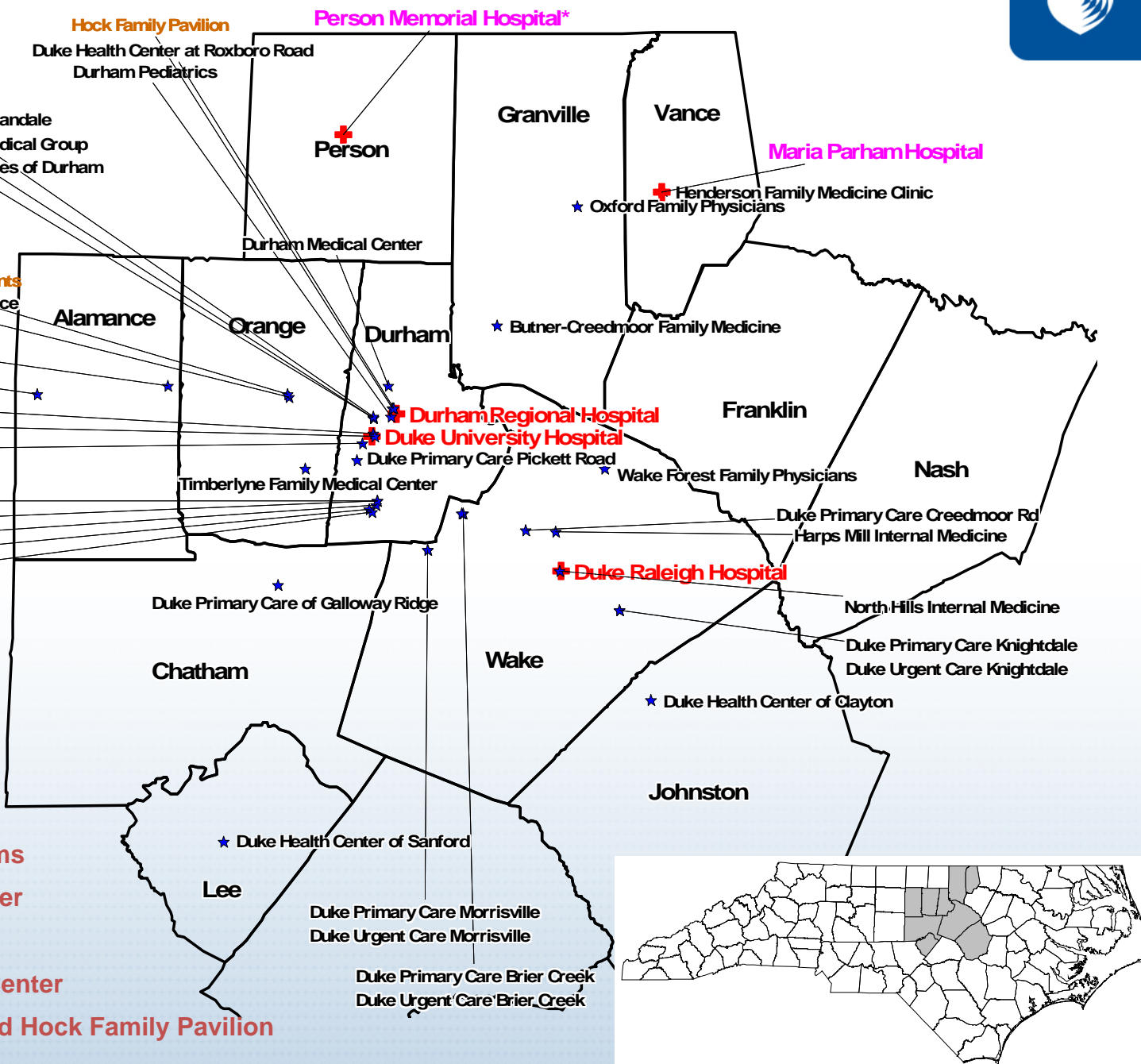
## *Caring for Our DUHS Patients in FY10*

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

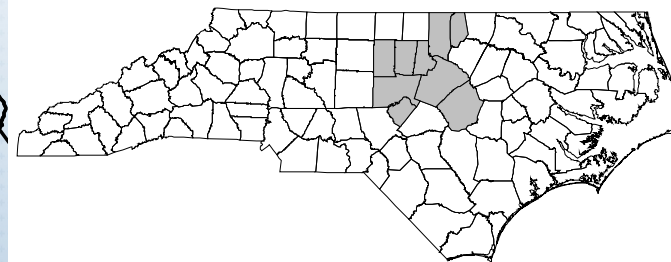
All three hospitals have received Nursing Magnet status.







- 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

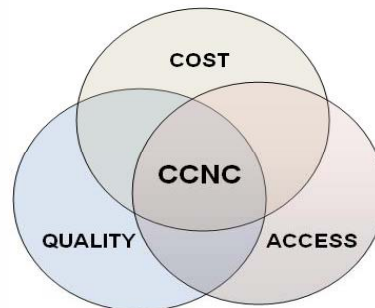


Community Care  
of North Carolina

# 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”

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- 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”

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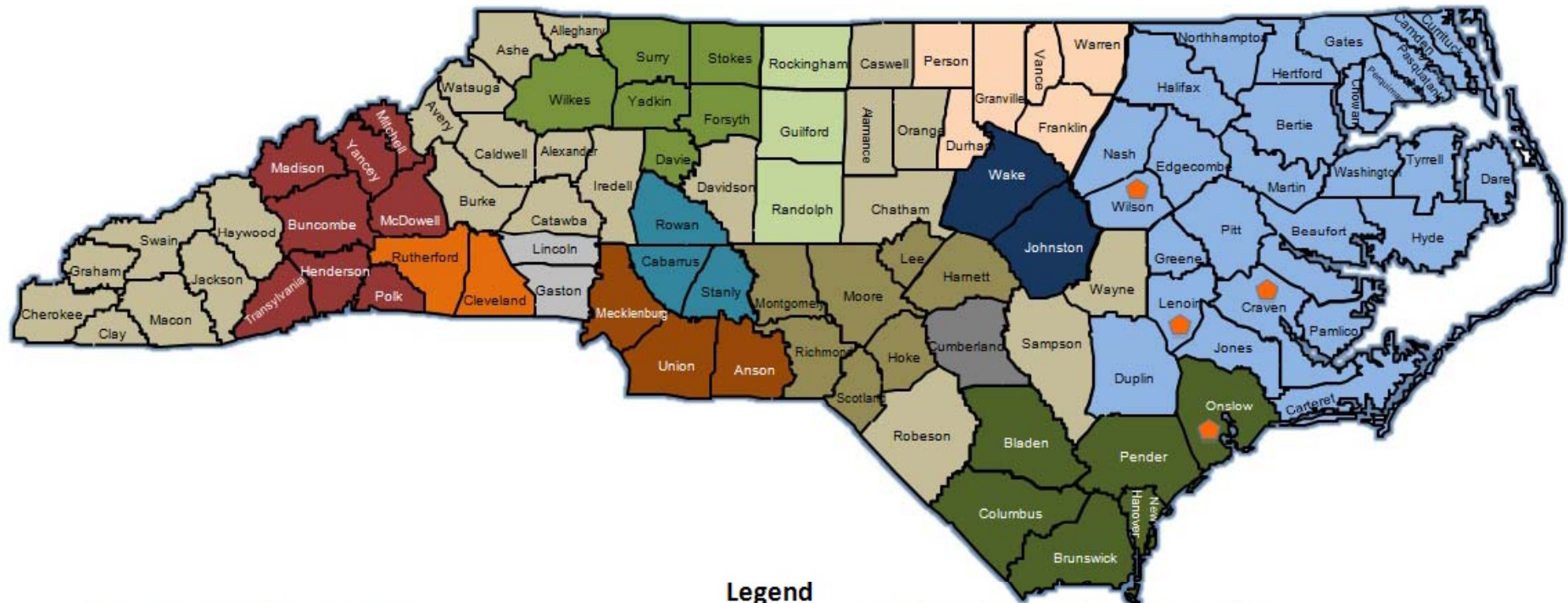


- The state identifies priorities and provides financial support through an enhanced PMPM payment to community networks
- Networks pilot potential solutions and monitor implementation (physician led)
- Networks voluntarily share best practice solutions and best practices are spread to other networks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

# Community Care Networks



Community Care  
of North Carolina



- ◆ AccessCare Network Sites
- AccessCare Network Counties
- Community Care of Western North Carolina
- Community Care of the Lower Cape Fear
- Carolina Collaborative Community Care
- Community Care of Wake and Johnston Counties
- Community Care Partners of Greater Mecklenburg
- Carolina Community Health Partnership

## Legend

- Community Care Plan of Eastern Carolina
- Community Health Partners
- Northern Piedmont Community Care
- Northwest Community Care
- Partnership for Health Management
- Community Care of the Sandhills
- Community Care of Southern Piedmont

# 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

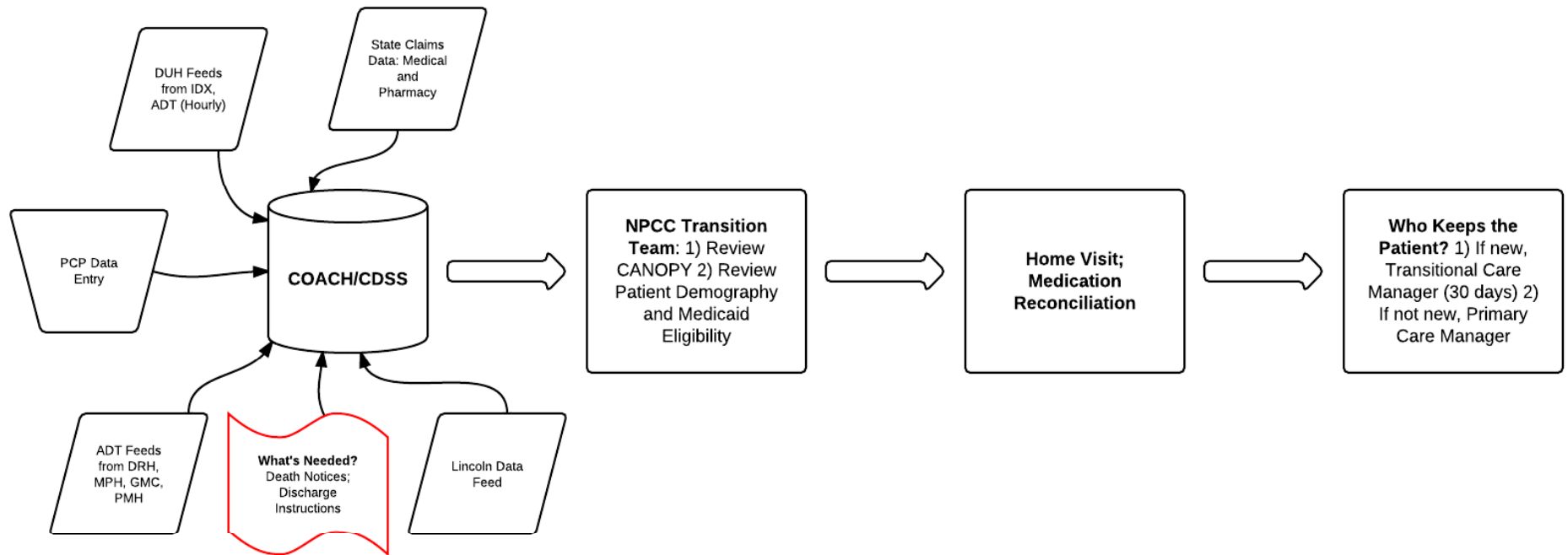
# Our NPCC Care Management Team

	<u>FTE's</u>
➤ Dietitians	3.0
➤ Health Educators	1.5
➤ Community Health Workers	7.5
➤ Nurses (mostly RNs)	6.0
➤ Social Workers	3.0
➤ Pharmacist(2)/Pharm Tech(2)	2.2
➤ Occupational Therapist	0.3
➤ MD Champions(8)	1.0



# 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/>