Community Care of North Carolina

L. Allen Dobson, Jr., MD
Super Utilizer Summit
February 11 & 12, 2013
- 1,620 participating primary care practices
- 1.25 million Medicaid and 140,000 HealthChoice enrollees
  - 22,560 uninsured in HealthNet programs
  - 25,000 privately insured in pilot programs

Source: CCNC September 2012
Each network has:

- Clinical Director
  - A physician who is well known in the community
  - Works with network physicians to build compliance with care improvement objectives
  - Provides oversight for quality improvement in practices
  - Serves on the State Clinical Directors Committee

- Network Director to manage daily operations

- Care Managers to help coordinate services for enrollees/practices – many embedded in local practices

- Pharmacists for Med management of high cost patients

- Psychiatrists for mental health integration

- OB champions, QI specialists, etc.
<table>
<thead>
<tr>
<th>Name</th>
<th>Billing Provider</th>
<th>Date Of Admission</th>
<th>Discharge Date</th>
<th>Readmit 30 Days</th>
<th>Primary Diagnosis</th>
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<td>NEW HANOVER REGIONAL MEDICAL</td>
<td>08-27-2012</td>
<td>09-04-2012</td>
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<td>09-12-2012</td>
<td>09-14-2012</td>
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<td>10-01-2011</td>
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<td>UNC HOSPITALS</td>
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<td>UNC HOSPITALS</td>
<td>06-03-2012</td>
<td>08-28-2012</td>
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<td>Phlebitis Intracran Sinus</td>
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</table>
Challenge = Opportunity
Emergency Department Overuse

- Local emergency room “high-flyers”
- Small number of people driving high percentage of ER costs.
Complex patients drive ER usage*

Prevalence of Chronic Illness

- Chronic illness indicator: 86%
- Hypertension indicator: 65%
- Diabetes indicator: 35%
- COPD indicator: 29%

Prevalence of Mental Health Issues

- Mental health indicator: 83%
- Depression indicator: 59%
- Substance abuse indicator: 48%
- Bipolar indicator: 33%
- Schizophrenia/schizoaffective disorder: 21%

* Analysis of 1,394 NC Medicaid recipients with 20 or more ED visits in State Fiscal Year 2011.
Challenge = Opportunity
Medication Confusion

Most common drug therapy problems at care transitions (20,673 patients)

- Patient not taking medication prescribed at discharge (4,747 or 23%)
- Status of patient’s chronic medication(s) not addressed at discharge (4,581 or 22%)
- Patient non-adherent to therapy (3,962 or 19%)
- Patient taking medication at a different dose or interval than prescribed (3,879 or 19%)

About 6% of drug therapy problems considered “urgent” - imminent rehospitalization if not resolved

Data based on a representative sample of 20% of patients receiving medication reconciliation/review services
Transitional Care Program

- Core components of CCNC Transitional Care
  - Face-to-face contact
  - Comprehensive medication management
  - Patient/caregiver self-management education, “red flags”
  - Timely outpatient follow-up with informed medical home
  - Collaboration with partners/ resources to maximize reach and avoid duplication of services.

- Local flexibility, many local innovations
- Automatic notification of hospital admissions via Informatics Center started 12/10
- 56 hospitals now participating (2/3 of discharges)
Real-time notification of hospital admission. Priority flagging based on overall risk profile using historical claims.
**Patient Example:** 58 year old man with severe diabetes, kidney disease and Hepatitis C; recently hospitalized with aspiration pneumonitis/acute respiratory failure; re-hospitalized with colitis and hepatic coma.

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**Inpatient Visits - 4**

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<tr>
<th>Admit Date</th>
<th>Discharge Date</th>
<th>Diagnosis 1</th>
<th>Diagnosis 2</th>
<th>Diagnosis 3</th>
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<td>DIABETES WITH RENAL MANIFESTATIONS, TYPE II (NON-INSULIN-DEP)</td>
<td>CLOSTRIDIUM DIFF PSEUDO</td>
<td>CHRONIC HEP C W/O HEPATIC COMA</td>
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<td>FOOD/VOMIT PNEUMONITIS</td>
<td>ACUTE RESPIRATORY FAILURE</td>
<td>ENCEPHALOPATHY UNSPECIFIED</td>
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<td>CHRONIC KIDNEY DISEASE STAGE III (MODERATE)</td>
<td>DIABETES WITH NEUROLOGICAL MANIFESTATIONS, TYPE II(NON-INSULIN-DEP)</td>
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**Emergency Department Visits - 2**

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<th>Admit Hour</th>
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<tr>
<td></td>
<td>Monday</td>
<td></td>
<td>DIAB W MANIF NEC ADULT</td>
<td>HEADACHE</td>
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<td></td>
<td>Saturday</td>
<td></td>
<td>NAUSEA WITH VOMITING</td>
<td>DIABETES UNCOMPL ADULT</td>
<td>DURHAM REGIONALHOSPITAL</td>
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Medication Review
What is he supposed to be taking? What is he really taking?

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<tr>
<th>Fill Date</th>
<th>Drug Description</th>
<th>Qty</th>
<th>Days</th>
<th>Paid</th>
<th>Class</th>
<th>DOC</th>
<th>Gap</th>
<th>AI</th>
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<td>4/30/12</td>
<td>LANTUS INJ SOLOSTAR</td>
<td>10</td>
<td>30</td>
<td>$221</td>
<td>DIABETIC THE ...</td>
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<td>ANTI-DRASSETI</td>
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20 medicines in patient’s possession based on prescription fill history. Additional 10 (unmatched) medicines listed on hospital discharge summary.
Transitional Care Team in Action

- RN care manager and health educator visit diabetics patient’s home 2 days after discharge
  - Note chaotic household; patient “completely confused” about hospital events; unaware that blood sugar had been >1000 at admission; seemed very “absent-minded”
  - CM decide to accompany patient to f/u PCP visit

- Follow-up home visit by H Ed. and registered dietician
  - Instruct brother-in-law on “red flags” and use of glucometer
  - Provide bus pass to endocrinology appointment

- Network pharmacist consultation
  - Clarify active med list
  - Correspond with endocrinologist to recommend simplifying insulin regimen for better manageability, switch to pen due to visual impairment
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; ACRG3 = 65-66)

Example of an ACRG with a HIGH risk of readmission that benefited from transitional care.
Each dot represents the home address of a client who received transitional care services between July 2011 and June 2012. As of December 2012, we are providing transitional care management for approximately 4500 patients per month.
Return on Investment

Patients needing transitional care to avert 1 hospital admission in the coming year:

- Complex, chronic patients = 6
  - Non-mental health discharges = 5.6
  - Mental health discharges = 7.2
- Healthier patients = 133

CCNC’s Transitional Care Program significantly reduces future hospital admissions – especially for the most complex chronic patients.

Providing Transitional Care to 2300 “priority” patients every month prevents 4600 re-hospitalizations per year.
...identification of individuals who are incuring preventable hospital costs and are most likely to benefit from care management outreach.
Prioritizing the Population

Actual-to-Expected Difference

CRG#1

CRG#2

CRG#3

$0 $1K $2K $3K $4K $5K $6K $7K $8K $9K $10K $11K $12K $13K $14K $15K $16K $17K $18K $19K $20K

Actual-to-Expected Difference

= Expected Hospital Costs for Specific Clinical Risk Groups
Care Management Interventions for High Risk Patients

- Medical home linkage
- Medication reconciliation
- Goal setting and care plan development
- Health education
- Self management coaching
- Motivational interviewing
- Preparation for provider visits
- Linkage to community resources
More information?

www.communitycarenc.org

adobson@n3nc.org

Thank You!