CCNC Informatics: Fueling Better Outcomes for Patients and Populations

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Duke Community and Family Medicine Grand Rounds
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Community Care of North Carolina (CCNC) Mission

Focused on controlling costs and improving health outcomes for the most vulnerable populations
CCNC Footprint in North Carolina

- 5,000 primary care providers
- 1,800 Practices
- 90% of PCPs in NC

All 100 NC Counties

- 1.4 million Medicaid Patients
  - 300,000 Aged, Blind, Disabled
  - 150,000 Dually Eligible

14 Networks

Each network averages:
- 1.4 Medical Directors, 1.0 Psychiatrist
- 42.8 Local Care Managers
- 1.8 Pharmacists
- Multiple disciplines: RN, LCSW, RD, …
Impact through Scale, Efficiency, Community-Based Infrastructure

>32,000 Individuals received CCNC Transitional Care Support in 2015

Targeted from among 146,000 patients with 190,000 hospitalizations
Out of 1.4 million enrolled in Medicaid primary care medical home program

- Community-based multidisciplinary care team
- Connecting the dots with PCMH and other providers
- Comprehensive medication management
- Goal setting and care plan
- Education and self-management support
- Linkage to community resources
Typical patient identified as high priority for Transitional Care Management

58 year old man with severe diabetes, kidney disease and Hepatitis C

- Earlier in the year:
  - Two ED visits at Duke and Durham Regional;
  - Two UNC hospitalizations with uncontrolled DM and hyperosmolarity coma

- Recently hospitalized at Duke with hepatic encephalopathy and aspiration pneumonitis/ acute respiratory failure

- Re-hospitalized at UNC with c diff colitis and hepatic coma

- Primary care provider is in a Duke-affiliated practice
Medication Review

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 visited patient’s home 2 days after discharge
  - Noted chaotic household; patient was “completely confused” about hospital events; unaware blood sugar had been >1000 at admission; “absent-minded”
  - CM worked with patient & family to develop a person-centered plan of care
- Follow-up PCP visit
  - CM accompanied patient to medical home
- Team-based care
  - Follow-up home visit by health educator and registered dietician
  - Patient/family education on “red flags” and use of glucometer
  - Nutritional assessment – baseline habits and knowledge
  - Provided bus pass to endocrinology appointment
- Network pharmacist consultation
  - Clarified active med list
  - Corresponded with patient’s endocrinologist to simplify insulin regimen for better manageability, and switch to pen due to visual impairment
Early Findings from the CCNC Transitional Care Program

• 20% reduction in readmissions for patients with multiple chronic conditions in the transitional care program

• Benefit persists far beyond the first 30 days

• For every six interventions, one hospital readmission avoided – strong ROI
Time to First Readmission for Patients Receiving Transitional Care vs. 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)

Survival Function

Proportion still out of the hospital

Months since discharge from the hospital

NNT=3
Incremental Savings Achieved From Transitional Care, by Clinical Risk Strata

Size of circle represents number of Medicaid discharges, excluding newborn/delivery.
Digging Deeper

How important is early outpatient follow-up after hospital discharge?

• A majority of patients do not meaningfully benefit from early follow-up

• Efforts should focus on assuring that highest risk patients receive follow-up within 7 days
## Key Insight: Current Outpatient Visit Resources are Mis-matched

### Opportunity Analysis for Patients Receiving 7-day Follow-up

<table>
<thead>
<tr>
<th>Risk Strata Grouping</th>
<th>Recommended Follow-up Period</th>
<th>Did the patient receive follow-up within 7 days of discharge?</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>0</td>
<td>30 days</td>
<td>16,082</td>
<td>10,242</td>
</tr>
<tr>
<td>1</td>
<td>21 days</td>
<td>9,834</td>
<td>4,237</td>
</tr>
<tr>
<td>2</td>
<td>14 days</td>
<td>9,099</td>
<td>4,151</td>
</tr>
<tr>
<td>3</td>
<td>7 days</td>
<td>11,515</td>
<td>5,510</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>46,530</td>
<td>24,140</td>
</tr>
</tbody>
</table>

For every patient getting a 7-day follow-up who doesn’t need it, there is a patient who would have benefitted from 7-day follow-up who did not get it.
Digging Deeper

Is the Home Visit Really Necessary?

- Home Visits significantly reduce odds of hospital readmissions, compared to less intensive forms transitional care support (OR 0.52; 95% CI 0.48-0.57)

- Benefit is greatest for higher risk patients
  - Among highest risk, the incremental benefit amounted to 37 additional admissions averted over 6 months for every 100 patients who received a home visit
Where we took it from there…

*Impactability Scores* as opposed to Risk Scores

- **Risk Scores** are designed to predict events/outcomes in the absence of intervention. The dependent variable in the predictive models are typically events (e.g., hospital utilization) or costs.

- **Impactability Scores** are designed to identify members who will benefit the most from a given intervention. The dependent variable in the predictive models are the estimated savings from care management interventions, based on rigorous, controlled real-world evaluations.

*Evidence-based Care Guidance*

- What interventions make the most difference…. FOR which patients? BY whom? WHEN?
Specific data-driven care guidance:

- Home visit priority
- Timing of outpatient f/u
- Risk of drug therapy problems (interaction, duplication, adherence)
- End-of-life planning (mortality risk)
- Children in foster care system
- Chronic pain/opiate misuse
- Behavioral health comorbidity
The Sweet Spot: Optimizing ROI requires a focus on impactability

“Impactability” predicts how much change can be expected through care management intervention.

“Risk” predicts where a person is expected to be in the future.
The Pitfall of Targeting Highest Cost/ Highest Risk

Historically, care management efforts have been targeted at the highest risk.

Total Enrolled Population

○ = Total costs for an individual
This person would likely benefit from care management, but would have been missed under conventional methodology.

= Potentially preventable hospital costs for an individual
1.8 Million Medicaid Recipients

Predictable Savings Opportunity of $3200 over 6 months

Impactability Score

LOW -----> HIGH

Total Cost of Care

LOW -----> HIGH

$0K $20K $40K $60K $80K $100K $120K $140K $160K $180K $200K

$0K 100 200 300 400 500 600 700 800 900 1000

Care Management Impactability Score
Savings Impact by Targeting Strategy
(Pre-post trend for comparison vs. intervention group)

Change in Total Spend Relative to Prior 6 Months

- Impactability: -$705
- Inpatient Super-users: -$742
- ED Super-users: -$563
- Any Prior IP or ED Visit: -$262

In each case, the darker shaded bar represents the change in spend PMPM in the 6-month follow-up period for those receiving care management, while the lighter shaded bar represents the change in spend for the comparison group.

Regression to the mean
The same investment in care management yields VERY different results depending on who you choose to manage.
Inpatient Admission Trends among NC Medicaid Beneficiaries with Multiple Chronic Conditions, 2008-FY2014

This means >8,000 fewer inpatient admissions in SFY2014 compared to 2008 performance.
Continued Success: Current CCNC Performance Relative to 2012 NC Medicaid Benchmarks

- Total Spend: 3% below expected
- Admissions: 26% below expected
- ED Visits: 6% below expected
- Readmissions: 48% below expected
The Bigger Picture: 
*Putting Data to Good Use for Population Health Management*

**Program Administration**
- Contractual/regulatory reporting of cost, utilization, and quality outcomes
- Network management, identification of improvement opportunities through analysis of cost and quality variation

**Planning and Implementation**
- Targeted Interventions and Quality Improvement Initiatives
- Public Health and Community Partnerships
- Targeted care management strategies to maximize ROI
- Tracking of process and outcome metrics for rapid-cycle tests of change

**Direct Patient Care**
- Primary care panel management, patient registries
- Identification of patient care gaps
- Decision support/workflow management for between-visit team-based care
NC Medicaid Admissions CY2015

Hospital Use Dashboard: Inpatient Visits

Inpatient Visits by Billing Provider Name

- Select a category from the above dropdown.
- Select Billing Provider Name to See Patient Details. Hover over one of the three horizontal axes to find the sorting option. Red reference lines represent the group.

- CAROLINAS MEDICAL CENTER
- DUKE UNIVERSITY HOSPITAL
- MOSES H CONE MEMORIAL HOSPITAL OPER
- VIDANT RADIOSURGERY
- CUMBERLAND COUNTY HOSPITAL SYSTEM
- WAKEMED
- MISSION HOSPITAL INC
- UNIVERSITY OF NC HOSPITALS AT CHAPE
- FORSYTH MEMORIAL HOSPITAL, INC
- NORTH CAROLINA BAPTIST HOSPITAL
- NEW HANOVER REGIONAL MEDICAL CENTER
- THE PRESBYTERIAN HOSPITAL
- THE CHARLOTTE MECKLENBURG HOSPITAL
- No Billing Provider
- SOUTHEASTERN REGIONAL MEDICAL CENTRE
- GASTON MEMORIAL HOSPITAL INCORPORAT
- FIRSTHEALTH OF THE CAROLINAS, INC.
- HIGH POINT REGIONAL HEALTH
- NASH HOSPITAL INC.

Visits 0K 5K 10K

Paid Amount $0K $40,000K

Avg. Paid $0K $50K $10K
Inpatient Visits– Drilling Down to specific DRGs

Box Chart of Visits and Average Medicaid Costs by Billing Provider
- The size of the box represents the number of inpatient visits by Billing Provider.
- The color shade represents the average cost per visit.

Visits by Diagnosis
Select a Major Diagnosis Category to drill down the list.

Major Diagnostic Category
- Newborns and Other Neonates with Significant Problems
- Pregnancy, Childbirth, and the Puerperium
- Disease and Disorders of the Respiratory System
- Disease and Disorders of the Circulatory System
- Mental Illness and Behavioral and Developmental Disorders
- Disease and Disorders of the Digestive System
- Infectious and Parasitic Diseases (Systemic and Unspecified Sites)
- Diseases and Disorders of the Musculoskeletal System

Count of patients returned: 385

Community Care of North Carolina – Improving care through shared knowledge
Hospitalizations for Durham Co. Medicaid recipients in Past Year

**Hospital Use Dashboard: Inpatient Visits**

- Count of patients returned: 4,125
- Count of visits returned: 5,182

**Inpatient Visits by Billing Provider Name**
- Select a category from the above dropdown.
- Select Billing Provider Name to See Patient Details. Hover over one of the three horizontal axes to filter.

<table>
<thead>
<tr>
<th>Billing Provider Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>DUKE UNIVERSITY HOSPITAL</td>
</tr>
<tr>
<td>UNIVERSITY OF NC HOSPITALS AT CHAPE</td>
</tr>
<tr>
<td>WAKEMED</td>
</tr>
<tr>
<td>SBH-RALEIGH, LLC DBA STRATEGIC BEHAVIORAL CEN.</td>
</tr>
<tr>
<td>UNC HOSPITAL</td>
</tr>
<tr>
<td>CENTRAL REGIONAL HOSPITAL</td>
</tr>
<tr>
<td>HOLLY HILL HOSPITAL, LLC</td>
</tr>
<tr>
<td>DUKE UNIVERSITY HEALTH SYSTEM - MED INST</td>
</tr>
<tr>
<td>REX HOSPITAL INC</td>
</tr>
<tr>
<td>NORTH CAROLINA SPECIALTY HOSPITALS</td>
</tr>
<tr>
<td>DUKE UNIVERSITY HEALTH SYSTEM - DURHAM REGIO.</td>
</tr>
<tr>
<td>MOSES H CONE MEMORIAL HOSPITAL OPER</td>
</tr>
<tr>
<td>BRYNN MARR HOSPITAL, INC.</td>
</tr>
<tr>
<td>GRANVILLE HEALTH SYSTEM</td>
</tr>
<tr>
<td>KEYSSTONE WSNC, LLC DBA OLD VINEYARD BEHAVIOR</td>
</tr>
<tr>
<td>NORTH CAROLINA BAPTIST HOSPITAL</td>
</tr>
<tr>
<td>CAROLINAS MEDICAL CENTER</td>
</tr>
<tr>
<td>PERSON MEMORIAL HOSPITAL</td>
</tr>
</tbody>
</table>

**# of Patients w/ Multiple Inpatient Admits**

- 3,400
- 671
- 52
- 2

78 hospitals on this list
Duke ED Visits

ED Visits
- Count of patients returned: 8,113
- Count of visits returned: 10,987
- Emergent
- Non Emergent

Visits by Clinical Category
Select a Clinical Category to drill down to the Clinical Category Level 2.

Clinical Category Level 1
- Injury and poisoning
- Symptoms, signs, and ill-defined
- Diseases of the respiratory system
- Diseases of the nervous system
- Disease of the musculoskeletal system
- Disease of the circulatory system
- Diseases of the digestive system
- Diseases of the genitourinary system
- Complications of pregnancy, childbirth, and the puerperium
- Infectious and parasitic diseases
- Endocrine, nutritional, and metabolic diseases
- Mental illness
- Diseases of the blood and blood-forming organs
- Neoplasms
- Congenital anomalies

Clinical Category Level 2
- Abdominal pain
- FUA
- Nausea/vomiting
- Allergy
- Syncope
- Other care

ED Visits by CA PCP Name
- Select a category from the above dropdown.
- Select CA PCP Name to see patient details.

Number of Visits by Client Zip Code
- Select a zip code type from the dropdown to display.
- Click zip code areas to fill the dashboard.
- Patients or PCPs located in zip codes outside of the list may be missed.

NO PCP
- LINCOLN COMMUNITY HEALTH CENTER: 8,652
- DUKE CHILDREN'S PRIMARY CARE AT ROXBORO ST: 5,611
- DUKE MEDICAL OUTPATIENT CLINIC: 3,902
- DUKE MEDICINE - PEDIATRICS CLINIC: 3,144
- DUKE FAMILY MEDICINE CENTER: 2,656
- DUKE PRIMARY CARE CROASDAILE: 1,416
- ROCK QUARRY RD FAMILY MED: 1,302
- TRIANGLE FAMILY PRACTICE: 1,100
- REGIONAL PEDIATRIC ASSOCIATES: 1,012
- DURHAM FAMILY PRACTICE: 722
- DUKE PRIMARY CARE - KNIGHTDALE: 713
- DURHAM PEDIATRICS: 632
- UNIVERSAL FAMILY MEDICINE: 610
- DUKE PRIMARY CARE - CREEDMORE RD: 606
- SPECTRUM MEDICAL CARE: 562

630 practices on this list
ED Visits by Durham Co residents with SPMI
(Serious and Persistent Mental Illness)
Medicaid Recipients Living in Durham County

Member Scatter Plot of Medicaid Inpatient Visits by Total Medicaid Costs
- Select a utilization measure in the dropdown to the right for vertical axis values.
- Cost categories can be chosen in the right panel for horizontal axis values.
## Medicaid Recipients Living in Durham County

### Member Demographic and Clinical Characteristics

<table>
<thead>
<tr>
<th>Condition</th>
<th># of patients</th>
<th>% of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD</td>
<td>2,038</td>
<td>5.66%</td>
</tr>
<tr>
<td>Asthma</td>
<td>3,776</td>
<td>10.48%</td>
</tr>
<tr>
<td>Bipolar</td>
<td>741</td>
<td>2.06%</td>
</tr>
<tr>
<td>Cancer</td>
<td>387</td>
<td>1.07%</td>
</tr>
<tr>
<td>CHF</td>
<td>236</td>
<td>0.66%</td>
</tr>
<tr>
<td>Chronic Gi</td>
<td>1,654</td>
<td>4.59%</td>
</tr>
<tr>
<td>Chronic Kidney</td>
<td>543</td>
<td>1.51%</td>
</tr>
<tr>
<td>COPD</td>
<td>562</td>
<td>1.56%</td>
</tr>
<tr>
<td>Dementia</td>
<td>169</td>
<td>0.47%</td>
</tr>
<tr>
<td>Depression</td>
<td>1,726</td>
<td>4.79%</td>
</tr>
<tr>
<td>Depression With Psychotic</td>
<td>232</td>
<td>0.64%</td>
</tr>
<tr>
<td>Developmental Disability</td>
<td>2,013</td>
<td>5.59%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1,769</td>
<td>4.91%</td>
</tr>
<tr>
<td>HIV</td>
<td>203</td>
<td>0.56%</td>
</tr>
<tr>
<td>HTN</td>
<td>3,423</td>
<td>9.50%</td>
</tr>
<tr>
<td>IVD</td>
<td>639</td>
<td>1.77%</td>
</tr>
<tr>
<td>MH</td>
<td>7,896</td>
<td>21.92%</td>
</tr>
<tr>
<td>Neurological</td>
<td>952</td>
<td>2.64%</td>
</tr>
<tr>
<td>Other Psychosis</td>
<td>57</td>
<td>0.16%</td>
</tr>
<tr>
<td>Post-MI</td>
<td>85</td>
<td>0.24%</td>
</tr>
<tr>
<td>Schizophrenia and Schizoaffective</td>
<td>845</td>
<td>2.35%</td>
</tr>
<tr>
<td>Sickle Cell</td>
<td>96</td>
<td>0.27%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Condition</th>
<th># of patients</th>
<th>% of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCNC Priority</td>
<td>125</td>
<td>0.35%</td>
</tr>
<tr>
<td>TC Priority</td>
<td>988</td>
<td>2.74%</td>
</tr>
<tr>
<td>Patients with Inpatient Visit</td>
<td>2,742</td>
<td>7.61%</td>
</tr>
<tr>
<td>Patients with ED Visit</td>
<td>9,589</td>
<td>26.62%</td>
</tr>
<tr>
<td>Patients with Readmission</td>
<td>185</td>
<td>0.51%</td>
</tr>
<tr>
<td>Patients With 3 or More Chronic Conditions</td>
<td>4,024</td>
<td>11.17%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Average Score</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CM Impactability Score</td>
<td>8.12</td>
<td></td>
</tr>
<tr>
<td>TC Impactability Score</td>
<td>14.64</td>
<td></td>
</tr>
<tr>
<td>Risk for admission within the next 12-months</td>
<td>4.33</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Condition</th>
<th># of patients</th>
<th>% of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dual</td>
<td>3,154</td>
<td>8.75%</td>
</tr>
<tr>
<td>Age 0-20</td>
<td>27,287</td>
<td>75.74%</td>
</tr>
<tr>
<td>Female</td>
<td>19,252</td>
<td>53.44%</td>
</tr>
<tr>
<td>Black/African American</td>
<td>19,723</td>
<td>54.75%</td>
</tr>
<tr>
<td>White</td>
<td>11,909</td>
<td>33.06%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>8,390</td>
<td>23.29%</td>
</tr>
<tr>
<td>CAP Patients</td>
<td>408</td>
<td>1.13%</td>
</tr>
<tr>
<td>Living in CA PCP Practice County</td>
<td>31,208</td>
<td>86.63%</td>
</tr>
</tbody>
</table>
Duke Primary Care Patients with Diabetes

Count of patients returned: 21,510

Total and Percentage of Patients
By Category: CA PCP Name / By Subgroup: Diabetes
- Select a subgroup from the dropdown menu to the right to change horizontal axis values, then choose a sorting option to sort bars by total patients or percentage.
- Selections made on bar graph impact both charts below.

<table>
<thead>
<tr>
<th>CA PCP Name</th>
<th>Diabetes Count</th>
<th>Percent of CA PCP Name: Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duke Medical Outpatient Clinic</td>
<td>415</td>
<td>23.03%</td>
</tr>
<tr>
<td>Duke Family Medicine Center</td>
<td>171</td>
<td>7.42%</td>
</tr>
<tr>
<td>Duke Primary Care - Knightdale</td>
<td>158</td>
<td>10.35%</td>
</tr>
<tr>
<td>Duke Primary Care Croadaile</td>
<td>123</td>
<td>11.17%</td>
</tr>
<tr>
<td>Duke Primary Care - Creedmore Rd</td>
<td>116</td>
<td>14.05%</td>
</tr>
<tr>
<td>Duke Medicine - Pediatrics Clinic</td>
<td>91</td>
<td>2.25%</td>
</tr>
<tr>
<td>Duke Primary Care - Morrisville</td>
<td>58</td>
<td>9.83%</td>
</tr>
<tr>
<td>Duke Primary Care - Pickett Rd</td>
<td>45</td>
<td>10.07%</td>
</tr>
<tr>
<td>Duke Primary Care - Briar Creek</td>
<td>43</td>
<td>7.56%</td>
</tr>
<tr>
<td>Duke Children's Primary Care at Dolphin St</td>
<td>40</td>
<td>1.87%</td>
</tr>
</tbody>
</table>

Totals and Percentages of Patients by Client Zip Code: Diabetes
- The map displays either total patients or percentage of patients by PCP zip code based on the “Sort by” option chosen in the bar chart above.
- Select a zip code type from the dropdown to display by Client Zip or PCP Zip. Patients or PCPs located outside of NC or in an unknown zip code will not be shown.
Risk-adjusted Cost and Utilization Measures
(Practices located in Durham County)

### KPI Heat Map Table - Inpatient (YE-SEP15)
Adjust the "Minimum Total Member Months" slider to remove results with small sample sizes.

<table>
<thead>
<tr>
<th>Choose Level</th>
<th>Total IP Admits</th>
<th>Total Member Months - IP</th>
<th>Actual IP Rate</th>
<th>Expected IP Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>220</td>
<td>109,767</td>
<td>2.077</td>
<td>2.625</td>
</tr>
<tr>
<td></td>
<td>101</td>
<td>24,064</td>
<td>4.199</td>
<td>5.821</td>
</tr>
<tr>
<td></td>
<td>214</td>
<td>14,288</td>
<td>14.978</td>
<td>19.754</td>
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<td></td>
<td>91</td>
<td>51,123</td>
<td>2.924</td>
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<td></td>
<td>15</td>
<td>5,027</td>
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<td>2.697</td>
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<tr>
<td></td>
<td>53</td>
<td>7,774</td>
<td>6.818</td>
<td>9.606</td>
</tr>
<tr>
<td></td>
<td>35</td>
<td>5,700</td>
<td>8.140</td>
<td>7.500</td>
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<td>37</td>
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<td></td>
<td>12</td>
<td>5,888</td>
<td>2.106</td>
<td>4.135</td>
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<tr>
<td></td>
<td>390</td>
<td>85,751</td>
<td>4.137</td>
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<tr>
<td></td>
<td>54</td>
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<td>2.240</td>
<td>2.600</td>
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<tr>
<td></td>
<td>50</td>
<td>10,818</td>
<td>4.622</td>
<td>6.773</td>
</tr>
<tr>
<td></td>
<td>24</td>
<td>17,526</td>
<td>1.369</td>
<td>2.329</td>
</tr>
</tbody>
</table>

### KPI Heat Map Table - PMPM (YE-SEP15)
Adjust the "Minimum Total Member Months" slider to remove results with small sample sizes.

<table>
<thead>
<tr>
<th>Choose Level</th>
<th>Case Mix Index</th>
<th>Total Cost</th>
<th>Total Member Months</th>
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Cool! But why is DATA to support POPULATION HEALTH MANAGEMENT such a hot topic?

In January 2015, the Department of Health and Human Services announced new goals for value-based payments and APMs in Medicare.

**Medicare Fee-for-Service**

**GOAL 1:** 30%
Medicare payments are tied to quality or value through alternative payment models (categories 3-4) by the end of 2016, and 50% by the end of 2018.

**GOAL 2:** 85%
Medicare fee-for-service payments are tied to quality or value (categories 2-4) by the end of 2016, and 90% by the end of 2018.

“Alternative Payment Model” means providers taking greater financial risk/reward on outcomes and total cost of care.
A single MIPS composite performance score will factor in performance in 4 weighted performance categories:

- Quality
- Resource use
- Clinical practice improvement activities
- Meaningful use of certified EHR technology

MAXIMUM Adjustments:
- 4%
- 5%
- 7%
- 9%

Adjustment to provider’s base rate of Medicare Part B payment:
- 4%
- 5%
- 7%
- 9%

Merit-Based Incentive Payment System (MIPS)

2019 2020 2021 2022 onward

www.cms.gov
What’s the alternative?

Eligible APMs are the **most advanced** APMs that meet the following criteria according to the MACRA law:

- **Base payment on quality measures comparable to those in MIPS**
- **Require use of certified EHR technology**
- **Either (1) bear more than nominal financial risk for monetary losses OR (2) be a medical home model expanded under CMMI authority**

QPs are physicians and practitioners who have a certain % of their patients or payments through an **eligible APM**.

Beginning in 2021, this threshold % may be reached through a **combination** of Medicare and other **non-Medicare payer arrangements**, such as private payers and Medicaid.

QPs:
1. Are **not subject** to MIPS
2. Receive 5% lump sum **bonus payments** for years 2019-2024
3. Receive a **higher fee schedule update** for 2026 and onward

**Major incentives for jumping in to this Accountable Care thing!**

www.cms.gov
Some health systems are getting it...

Can Mount Sinai be serious? The answer is a resounding yes. In fact, we couldn’t be more serious.

Mount Sinai’s number one mission is to keep people out of the hospital. We’re focused on population health management, as opposed to the traditional fee-for-service medicine. So instead of receiving care that’s isolated and intermittent, patients receive care that’s continuous and coordinated, much of it outside of the traditional hospital setting.

Thus the tremendous emphasis on wellness programs designed to help people stop smoking, lose weight and battle obesity, lower their blood pressure and reduce the risk of a heart attack. By being as proactive as possible, patients can better maintain their health and avoid disease.

Our Mobile Acute Care Team will treat patients at home who would otherwise require a hospital admission for certain conditions. The core team involves physicians, nurse practitioners, registered nurses, social workers, community paramedics, care coaches, physical therapists, occupational therapists, speech therapists, and home health aides.

Meanwhile, Mount Sinai’s Preventable Admissions Care Team provides transitional care services to patients at high risk for readmission. After a comprehensive bedside assessment, social workers partner with patients, family caregivers and healthcare providers to identify known risks such as problems with medication management and provide continuing support after discharge.

It’s a sweeping change in the way that health care is delivered. And with the new system comes a new way to measure success. The number of empty beds.

IF OUR BEDS ARE FILLED,
IT MEANS WE’VE FAILED.
Health Care Advisory Board

Strategic guidance in a changing industry

With purchasers demanding more affordable care, how can we lower costs? And how—and where—can you build out population health management at the same time?

Transforming Primary Care

Building a Sustainable Network for Comprehensive Care Delivery

The Expanding Role of Primary Care in the Health System

But wait! I chose family medicine because I want to generate specialist referrals!!
"Why come to me? I'm only a humble doctor. You should see a health-care provider."
METHOD OF EXTINGUISHMENT

Cooling

Be The Spark

FUEL

STARVATION

Starvation

Removal of fuel or removal of combustible material
Thank You!
adubard@n3cn.org
www.communitycarenc.org