Improving care through shared knowledge

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STATEWIDE NETWORK OF MEDICAL HOMES

- 1.4 million Medicaid recipients, including ~400,000 Aged, Blind and Disabled
- All 100 NC counties through 1,800 primary care practices and 90+% of all primary providers

COMMUNITY-BASED

- 14 regional networks (in process of consolidation). Each network staff includes pharmacist, behavioral health provider, care managers, clinical director and network director.
- Includes 501(c)(3) organizations, hospital-owned networks and network associated with a county health department
- Flexibility around local preferences, resources, provider capacity
- Many care managers embedded in medical practices, hospitals and even EDs

PROVIDER-LED TEAMS

- Primary care doctor leads diverse team of health care professionals working at the top of their licenses.
- State pays monthly per-member, per month payments (risk adjusted) to support CCNC and provide flexible resources for medical practices.

Four key principles for "purposeful" data use

1. POPULATION HEALTH NEED DIFFERS FROM ENCOUNTER-BASED CARE

- Two essential elements of data used in population health:
  - Prompts to action; and
  - *Dynamic* care plan

2. INSIGHTS, NOT RECORDS

- 86-page Continuity of Care Documents do not change care delivery or health outcomes
- Don't "transfer records" -- hand off *actionable insights* that inform the team member receiving the information.

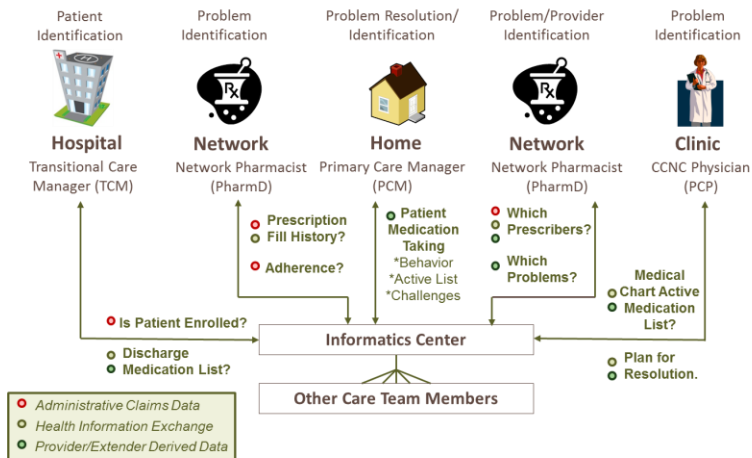
3. KEEP DATA "LIQUID"

- Require data liquidity for care plans from all electronic systems of record
- Pharmacist, urgent care, primary care provider must have some common view

4. "IT TAKES A VILLAGE"

- Standards ideally apply across *all provider types* and settings

It Takes a Village (defining the community system of care)



Integrating data across the continuum of care – 3 examples

1. TRANSITIONAL CARE

- Integrates real-time hospital data with claims-based risk segmentation methods to send real-time alerts to community-based care team.
- Flags when high-risk patients are admitted to the hospital, with intervention guidance (high vs. low-intensity transitional care support, optimal timing of outpatient follow-up appointment)

2. PHARMACeHOME

- Combines medication use info from multiple sources (claims or fill transactions, hospital discharge summary, PCP EMR, brown bag review done by care manager) into single community record
- Automated identification of medication or dosing discrepancies, potential drug therapy problems, adherence, etc.
- Enables a much more robust and efficient medication reconciliation process, integrating community pharmacy, medical home, and community based care managers into a common workflow

Integrating data across the continuum of care – 3 examples

3. PREGNANCY HOME/OB CARE MANAGEMENT

- Universal risk screening tool used during the prenatal visit by several hundred participating practices incorporated into a statewide care management information system
- Risk segmentation for targeted care management support provided by local public health departments
- Medicaid claims + patient risk data +vital statistics (DHHS birth certificate data) used for performance reporting and feedback to practices and stakeholders

Other fruitful efforts

1. DISEASE REGISTRIES

- Making disease registries and other data available at point of care of improves decision-making

2. IMMUNIZATION REGISTRIES

- Effective partnership with state, local entities key to building immunization registries

3. WORKING WITH SMALL PRACTICES

- Supporting independent physicians in attaining Meaningful Use
- Supportive smaller practices with additional resources.

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