Community Catalyst

- Nonprofit health care advocacy organization
- Network of advocates in 40+ states
- Building advocacy infrastructure
- Leading broad-based issue campaigns
- Campaign for Better Care
A Crisis in Quality: A Fragmented System

- Chronic Conditions Worsen
- Behavioral Health Needs
- Frequent ER use
- No Help with Non-Medical Services
- Little or No Info upon Discharge
- Frequent Hospital Admissions
- Avoidable Hospital Readmissions

Lack of Accountable, Patient-Centered Care
A Crisis in Quality: Disparate Impact on Certain Populations

- Dually eligible beneficiaries
- Older adults with multiple chronic conditions
- Racial and ethnic minorities
- People living with disabilities
A Crisis in Cost: Impact on Medicare Spending

Two-Thirds of Medicare Spending Is For Beneficiaries With Five Or More Chronic Conditions

- Ninety-six percent of Medicare expenditures involve individuals with multiple chronic conditions.

A Crisis in Cost: Impact on Medicaid Spending

Top 5% of Enrollees Accounted for More than Half of Medicaid Spending, FY 2008

- **5%**
  - Children 0.4%
  - Adults 0.2%
  - Disabled 2.6%
  - Elderly 1.8%

**Enrollees**
Total = 60.6 million

**Expenditures**
Total = $292.2 billion

SOURCE: Centers for Medicare and Medicaid Services, FY MSIS 2008, FY MSIS 2007 for AZ, NC, ND, HI, UT, VT, WI.
A Crisis in Cost: Impact on Spending

Dual Eligibles as a Percent of Medicare and Medicaid Enrollment and Spending, 2006/2007

- Medicare FFS Enrollment, 2006 Total: 36 million
- Medicare FFS Spending, 2006 Total: $299 billion
- Medicaid Enrollment, 2007 Total: 58 million
- Medicaid Spending, 2007 Total: $300 billion

21% of Medicare FFS Enrollment and 15% of Medicaid Enrollment were dual eligibles in 2006/2007.

79% of Medicare FFS Enrollment and 85% of Medicaid Enrollment were monoenrolled in 2006/2007.

64% of Medicare FFS Spending and 60% of Medicaid Spending were dual eligibles in 2006/2007.

NOTES: FFS is fee-for-service. Estimates for Medicare include non-institutionalized and institutionalized beneficiaries, excluding Medicare Advantage enrollees. SOURCE: Medicare spending and enrollment estimates from Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006; Medicaid spending and enrollment estimates from Urban Institute analysis of data from MEPS and CMS Form 64, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2010.
Moving Toward Accountable Care

• Group of providers
• Held accountable for achieving improved health care quality
• Financial incentives to achieve results while lowering the cost of care
Accountable Care Organizations
Lessons From Other States

1. North Carolina
2. New Jersey
3. Massachusetts
North Carolina
Community Care of North Carolina

• Statewide medical home and care management system

• Public-private partnership

• 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
CCNC: How it Works

• Doctors and the networks are paid a per-member, per-month care coordination fee.
  – Networks receive
    • $3.00 pm/pm for most
    • $8.00 pm/pm for Aged, Blind and Disabled populations
  – Primary Care Physicians receive
    • $2.50 pm/pm for most
    • $5.00 pm/pm for Aged, Blind and Disabled populations

• Primary Care Physicians receive fee-for-service Medicaid rates that are near Medicare rates (95%)

• Doctors receive regular reports on the results of their care compared with other doctors in the region and state

• Cost savings/ effectiveness are evaluated by the state and third-party consultants (Mercer, Treo Solutions).
CCNC: How it Works

• Each network has a medical director, a clinical pharmacist and a medical management committee of local doctors who develop best practices.

• Care managers follow up with patients and identify special patient needs.

• Results:
  – Significantly reduced emergency department inpatient admissions
  – Improved monitoring of chronic conditions
  – Reduced projected expenses
CCNC: Savings

- Earlier studies by Mercer, Inc. estimated CCNC savings as:

<table>
<thead>
<tr>
<th>State Fiscal Year</th>
<th>Estimated Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>$77 - $81M</td>
</tr>
<tr>
<td>2006</td>
<td>$154 - $170M</td>
</tr>
<tr>
<td>2007</td>
<td>$135 - $149M</td>
</tr>
<tr>
<td>2008</td>
<td>$156 - $164M</td>
</tr>
<tr>
<td>2009</td>
<td>$186 - $194M</td>
</tr>
</tbody>
</table>

- Shared savings based on meeting quality metrics
CCNC: What’s Next

• Expanded to duals in 2010
  – Medicare 646 Demonstration Program
    • 22 counties
    • Cares for Medicare patients
    • New Duals Demo will build on this

• Beneficiaries are enrolled based on “one touch rule”

• More emphasis on managing multiple chronic conditions
  – Chronic Care Program – including Aged, Blind and Disabled

• Build out Informatics Center and Provider Portal as a shared resource for all communities
New Jersey
The Camden Model
About Camden

- Population 79,000
- Highest crime rate in the US in 2008
- Highest poverty rate in the US in 2006
- 50% African-American; 42% Latino
- Extreme over-use of ERs
  - 50 percent used ER in one year
  - Leading user had 113 visits in one year
## Top 10 ER Diagnoses

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>465.9</td>
<td>ACUTE UPPER RESPIRATORY INFECTION (head cold)</td>
<td>12,549</td>
</tr>
<tr>
<td>382.9</td>
<td>OTITIS MEDIA NOS (ear infx)</td>
<td>7,638</td>
</tr>
<tr>
<td>079.99</td>
<td>VIRAL INFECTION NOS</td>
<td>7,577</td>
</tr>
<tr>
<td>462</td>
<td>ACUTE PHARYNGITIS (sore throat)</td>
<td>6,195</td>
</tr>
<tr>
<td>493.92</td>
<td>ASTHMA NOS W/ EXACER</td>
<td>5,393</td>
</tr>
<tr>
<td>558.9</td>
<td>NONINF GASTROENTERI (stomach virus)</td>
<td>5,037</td>
</tr>
<tr>
<td>789.09</td>
<td>ABDOMINAL PAIN-SITE NEC</td>
<td>4,773</td>
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<tr>
<td>780.6</td>
<td>FEVER</td>
<td>4,219</td>
</tr>
<tr>
<td>786.59</td>
<td>CHEST PAIN NEC</td>
<td>3,711</td>
</tr>
<tr>
<td>784.0</td>
<td>HEADACHE</td>
<td>3,248</td>
</tr>
</tbody>
</table>
Inpatient and Emergency Room Visits in Camden, NJ (Jan 2002 - June 2008)

Northgate I Public Housing

Visits Patients Charges Receipts Collected
--- --- --- --- ---
Cooper 3,172 749 $42,144,097 $4,994,658 12%
Lourdes 811 333 $7,848,090 $1,028,611 13%
Virtua 805 331 $1,742,467 $345,092 20%
2005 838 370 $10,834,420 $1,269,373 12%
2006 738 355 $6,867,995 $881,549 13%
2007 790 369 $7,979,262 $901,181 11%
ED 3882 978 $6,150,592 $864,019 14%
Inpatient 906 408 $45,584,781 $5,504,342 12%
Total 4,788 1,070 $55,1,735,374 $6,368,361 12%

Primary Diagnosis
--- -- --- ---
Rank ED Inpatient
1 abdominal pain (789.0) live birth (V356.0)
2 acute URI NOS (465.9) chest pain (786.5)
3 chest pain (786.5) congestive heart failure NOS (428.0)

Source: Cooper, Lourdes, and Virtua Hospital and ER billing data Jan 2002-June 2008

Camden Coalition of Healthcare Providers
CamConnect.org
History of the Camden Model

- **High-need population** lacking access to the right resources
- **Visionary provider leadership**
  - Dr. Jeff Brenner – pushed to gather initial data from local hospitals
  - Camden Coalition of Health Care Providers – participating hospitals, FQHCs, private practices, AND social service providers come together to share data and address diabetes
- Connected with the **community affected by the problem** through Camden Churches Organized for People (PICO affiliate)
- Used existing relationships to build community trust in Northgate II, one of the “hot spots” identified through data
- Met with residents, who identified lack of transportation and office hours as main barriers to care
- Worked with residents to think through solutions
Healthcare Cost Hotspots in Camden, NJ (Jan 2002-June 2008)

High Cost Buildings...
- Northgate II
  - 3,901 visits, 615 patients
  - $83 million in charges ($21,000 per visit)
  - $12 million in receipts
  - 15% collection rate

- Abigail House
  - 1,414 visits, 332 patients
  - $92 million in charges ($65,000 per visit)
  - $15 million in receipts
  - 16% collection rate

Overview of High Cost Hotspots...

Receipts: 37%
Visits: 27%
Patients: 18%
Area: 10%
Blocks: 6%

Map includes only blocks with at least 1 visit

Source: Cooper, Lourdes, and Virtua Hospital and ER billing data
Jan 2002-June 2008

Camden Coalition of Healthcare Providers
www.camdenhealth.org
CamConnect.org
1. Promote collaboration among providers and between providers and the community

2. Build public will for fundamental changes in the delivery of care

3. Directly engage residents in “hot-spot” neighborhoods and populations

4. Train local residents to participate in decision-making over health care resources

Community Engagement Model
Camden Strategies

Solutions:
• Nurse practitioner led clinics in high cost buildings
• More high utilizer outreach teams
• Medical home-based nurse care coordination
• More same day appointments (open access scheduling)

What this has required:
• Analyzing and sharing data among providers
• Creating these “teams” by deliberately building partnerships across traditionally distinct groups of providers (health and social service-oriented)
• Community engagement
• Training providers and community members
Early Successes

- Northgate II
- Replication in Trenton
- Medicaid ACO legislation signed by Governor Chris Christie
- Significant interest from the CMMI in replicating the Camden model
Massachusetts
Senior Care Options

- Dually eligible seniors 65+
- Covers all services reimbursable under Medicare and MassHealth (Medicaid)
- Blended Medicare/Medicaid “Risk Adjusted Premiums”
- Voluntary Enrollment
Commonwealth Care Alliance

- Nonprofit comprehensive care system
- Serves medically complex Medicaid and dual eligible beneficiaries
- 2600+ dual eligible seniors
- 300 Medicaid and dual eligible individuals with Severe Physical Disabilities
- 25 primary care sites
CCA

• Selected hospital, specialist networks
• Substantial investment in primary care
  – Multidisciplinary primary care teams: PCPs, RNs, RNPs, SWs, CHWs
  – Same day episodic care
  – Home visits
  – Comprehensive assessments
  – Care coordination
  – 24/7 availability
  – Electronic medical records
  – Personal care attendants
CCA

- Engage members in meaningful relationships with caregivers; promote active participation in care planning
- Standards re: assessments, care plan development, implementation and monitoring
- Integration of behavioral clinicians directly into primary care
CCA

• Specialized DME management resources ease access to needed equipment and supplies
• Comprehensive system-wide end-of-life planning group
• Member feedback forums; Stanford Model of Chronic Disease Self Management Programs delivered at primary care sites
CCA Results

- Fewer hospitalizations
- Fewer nursing home placements
- Reduced projected costs
Contact Information

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