Building the Case for Value-Based Primary Care for High-Risk Patients
Jennifer Houlihan, MSP
Director of CIN Strategy, Integration and Population Health
About Wake Forest Baptist Health

• $2B a year, single clinical enterprise inclusive of North Carolina Baptist Hospital and Wake Forest University School of Medicine.

• 885 bed hospital & medical school on main Winston-Salem campus

• Wake Forest Baptist also operates:
  • 2 community hospitals – located in Davie and Davidson Counties
  • 11 emergency departments across the region
  • 25 primary care and 114 specialty care clinics
  • 17 dialysis centers across the region
  • A freestanding imaging and endoscopy center
Multiple Cross Continuum Programs Rooted in Population Health

**Navigators**
Inpatient and ambulatory navigators managing high risk (high cost + high utilization) patients with primary care and hospitalists. Expand integration with Medicaid, Behavioral Health Partners, Other Payers, and Develop Community Health Worker Taskforce.

**Home Health**
Develop cross continuum collaboration through improved communication, evidenced base care management/coordination, and data sharing with Home Health partners- Wake Forest Baptist Health CARE at HOME – a joint venture with Kindred Healthcare.

**Skilled Nursing**
Develop Skilled Nursing Transition Team with selected SNF partners to better manage patients- Incorporate CMS funded INTERACT training and quality initiatives with Carolina’s Center for Medical Excellence + small co-management subset of beds per facility.

**Palliative Care**
Increase the number of palliative care consults, development of outpatient referrals for palliative care and conversion of appropriate inpatient to hospice services Moved from #117 to #10 UHC Mortality Index since 2011.

**Primary Care**
Establish Care Plus- Management of high risk patient population to ensure patient-centered, coordinated care and rapid medical response for patients with acute medical, mental and functional decline. Expanding model to other Wake Forest PCP clinics.
Population Health Approach

Primary Care/Acute Care/Injury
Prevention/Virtual Primary Care
Wellness Program

Care Support/Chronic Disease Care Pathways

Disease Management

Care Plus

Personalized Primary Care
Navigators and Patient Care Advocates

Wellness

Top 50%

Top 20-30%

Top 10%

Bottom 50%
CarePlus Program Overview:
Top 10% Risk Category

• **Pilot Project Overview:** A primary care based medical home model for frequent inpatient and ED utilizers attributed to two primary care practices (both are internal medicine resident teaching clinics) traditionally serving high numbers of Medicaid and dually-eligible patients.

• **Partnership:** Project funded by Wake Forest Baptist Medical Center, Northwest Community Care Network and CenterPoint (the local Mental Health MCO)

• **Start Date:** Enrollment began August 2013; official program kick-off October 2013

• **Total Enrollment (as of Aug 2015):** 220
Program Summary

Admission Criteria

- Established patient of DHP/ OPD
- More than three ED visits or admissions in the past 12 months
- Forsyth County, NC (Winston-Salem’s county)
- Exclude Sickle cell, HIV, Dialysis unless DHP PCP
- Patient have multiple (3+) co-morbidities

Services Provided

- Weekly multidisciplinary care coordination meetings
- Longer, more frequent visits
- Home visits
- Comprehensive needs assessment to look at food/ housing/ transportation
- Resources to assist with medication, transportation, food pantry
- Population management including outreach to patients who miss primary care and subspecialty appointments
## Care Plus Team

<table>
<thead>
<tr>
<th>Role</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician/Medical Director</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Clinic Based RN</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Licensed Clinical Social Worker</td>
<td>1 FTE (paid by CenterPoint/NWCCNC)</td>
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<tr>
<td>Patient Services Rep/CMA</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Community Health Worker</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Community Based Medicaid RN</td>
<td>1 FTE (paid by NWCCNC)</td>
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<tr>
<td>Psychologist (part time- 2x week)</td>
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</tr>
<tr>
<td>Chaplain Resident</td>
<td>(1 x week)</td>
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Collaboration with Consulting Psychiatrist, PharmD, Palliative Care, Home Health
# Managing Medical Complexity in the Context of Psychosocial Challenges

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Employment</td>
<td>95% Unemployed</td>
</tr>
<tr>
<td>Education</td>
<td>31% Not Completed High School</td>
</tr>
<tr>
<td>Socioeconomic</td>
<td>90% Qualify for Food Stamps</td>
</tr>
<tr>
<td>Mental Health Screen</td>
<td>41% Moderate or More Severe Depression</td>
</tr>
<tr>
<td>Substance Use</td>
<td>37% (Primarily alcohol, cocaine)</td>
</tr>
<tr>
<td>Cognitive Function</td>
<td>64% Cognitive Impairment (22% Severe)</td>
</tr>
</tbody>
</table>
Top 5 Chronic Dx:
1) Diabetes
2) Hypertension
3) COPD
4) Congestive Heart Failure
5) Depression
## Care Plus Findings

<table>
<thead>
<tr>
<th>Inpatient Days</th>
<th>Inpatient Admissions</th>
<th>30 Day Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Change from Pre to Post</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N=220 patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-47%</td>
<td>-50%</td>
<td>-42%</td>
</tr>
</tbody>
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Wake Forest Baptist Medical Center
Conclusions

- Impact utilization for panel of 220 patients- 50% reduction in admissions and 42% reduction in 30 day readmissions

- Population management model experience for highest risk patients-preparation for Medicaid reform and expansion of risk contracts- pay for performance

- Requires team based approach; LCSW/social worker and community health worker roles are imperative

- Significant team stress due to complexity of patient population contributing to staff turnover

- More patients currently eligible than CarePlus team can handle; current waitlist of 40+ patients

- Opportunity to refine the eligibility criteria to strategically focus resources to best and highest use
Next Steps

• Diversify patient cohorts enrolling in the program

• Continued refinement of eligibility criteria to target population with largest impact potential

• Incorporate learners to CarePlus model

• Further analysis to determine PMPY reductions for attributed patients in Wake Forest’s Medicare Shared Savings Program

• Further collaboration with Psychiatry

• Scale program to other primary care clinics in Wake Forest system
Capitalizing on Institutional Clinical Imperatives to Advance a Career as a Geriatrics Educator

Franklin Watkins, MD
Medical Director, Transitional and Supportive Care
Interim Director, Palliative Medicine
All Politics is Local…

- Know your institution’s clinical problem areas
  - Wake’s were 30-day readmissions and mortality
  - This was the sweet spot for geriatrics
- Come to the table with potential options for solutions
  - Transitional and Supportive Care Program
  - Shared Service Line led by Geriatrics
Undergraduate Medical Education

• LCME Hot Topics directly related to Transitional Care
  • Community health
  • End-of-life care
  • Health disparities
  • Health care financing
  • Health care systems
  • Patient safety
  • Population-based medicine
  • Interprofessional education
Graduate Medical Education

• Many residency programs are implementing IHI and other quality improvement curricula
• Systems errors are ripe territory for resident- and fellow-driven projects
• Aligning these projects to institutional priorities provides opportunity for financial support, visibility, and sustainability
Play Outside Your Sandbox!!

• Funding is limited
  • GACAs are gone and GWEPs are funded
  • Consider for-profit companies, post-acute partners, other payers, and venture capitalists as potential sources of funding

• Geriatrics capacity is limited
  • Find others doing similar work and be willing to cede control to them when needed
  • Use geriatrics principles for non-traditional populations
  • Your biggest champions might come from unexpected places