Community Engagement for Health

J. Lloyd Michener, MD
Professor and Chair
Department of Community and Family Medicine
Duke School of Medicine
Director, Duke Center for Community Research

Community Engagement Health Conference
Medical College of Wisconsin
October 26, 2010

Durham

- Hypertension Patients
- Simulated Patients 06-07
- ED Yes
- ED No
A Journey

1. Community: Walltown, Lyon Park Neighborhood Clinics
2. Seniors: Just For Us
3. Medicaid
4. Durham Health Innovations
5. A hint at the future

Walltown and Lyon Park Clinics

Duke-Durham Neighborhood Partnership

- Population: African-American, new Latino population, low-income, transient, uninsured
- High ED use, high-risk health behaviors, substance abuse, depression/anxiety
- 37% of patients surveyed would have gone to ED
- High patient satisfaction – 4.7/5.0
Just For Us

• 350 patients since 2000
• Average age 70, multiple chronic conditions
• 44% have mental illness
• All are home-bound
• 84% African-American; many with low to no family support
• Low literacy or illiterate

Annual Income $7,000  ➔  25% Rent ➔ $5,250/Year

Outcomes

• Ambulance costs  ➔  49%
• ER costs  ➔  41%
• Inpatient costs  ➔  68%
• Prescription costs  ➔  25%
• Home health costs  ➔  52%

All patients with hypertension 79% ≤ 140/90
Diabetics with hypertension 84% ≤ 140/90
Community Care of North Carolina

- 42,000 Medicaid patients, 34 primary care sites
- Durham (DCHN), Vance, Granville, Warren, Person, Franklin Counties
- Latino population
  - Teams of community health workers, DSS social workers, nurses work with patients at home
    - Patient education & support, system navigation, self-management skill training
  - Electronic links among practices, hospitals, DSS, Health Depts., & care teams
  - $2.50 pmpm
  - $2.50 to Network
  - additional $2.50/$3.00 pmpm for high acuity enrollees

Outcomes

<table>
<thead>
<tr>
<th>Category of Service</th>
<th>SFY05 Projected Benchmark PMPM</th>
<th>Actual SFY05 PMPM</th>
<th>Projected vs. Actual</th>
<th>Estimated Savings from Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>$44.06</td>
<td>$23.76</td>
<td>54%</td>
<td>$158,801,272</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$21.99</td>
<td>$18.16</td>
<td>83%</td>
<td>$29,276,397</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$13.64</td>
<td>$11.10</td>
<td>82%</td>
<td>$19,824,757</td>
</tr>
<tr>
<td>Primary Care, Specialist</td>
<td>$54.82</td>
<td>$49.20</td>
<td>90%</td>
<td>$43,962,817</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>$28.05</td>
<td>$29.46</td>
<td>105%</td>
<td>$(11,034,819)</td>
</tr>
<tr>
<td>Other</td>
<td>$27.59</td>
<td>$29.07</td>
<td>105%</td>
<td>$(11,615,111)</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>$190.06</strong></td>
<td><strong>$160.76</strong></td>
<td><strong>83%</strong></td>
<td><strong>$229,215,312</strong></td>
</tr>
</tbody>
</table>

DUHS Principles of Community Engagement

• Proposed projects should be based on a need identified by the community that is beneficial to the community.

• Scope and time frame of project should be clear to the community. Partners must be willing to commit time and resources to the project.

• Partners must trust each other and build mutual respect while learning from each other’s perspectives.

http://www.cdc.gov/phppo/pce

DUHS Principles of Community Engagement (cont’d)

• A diverse range of community members and agencies need to participate to ensure that proposed activities meet the needs of a diverse population. All participants are considered experts.

• A safe environment must exist for all participants of all backgrounds to share ideas without fear of ridicule or criticism. No blaming or judgments. Keep lines of communication open.

• Partners must be good stewards of project data and include the community in outcome reporting and evaluation, potential programmatic intervention, education opportunities, and future program planning activities.

http://www.cdc.gov/phppo/pce/
Community Members, Practitioners, and Researchers Engaged in Care Redesign
Over 500 people, 100 community groups

- Life stage
  - Maternal/Fetal Health
  - Adolescent Health
  - Seniors’ Health
- “Hard medical”
  - Cardiovascular
  - Cancer screening/survivors
  - Asthma/COPD
- Behaviors
  - Substance abuse/pain management
- Medical/behavioral
  - Obesity
  - Diabetes
  - STDs

result: Care that is …

Closed
To home, neighborhood, school, workplace…

Connected
Individuals to health providers Health providers to each other

Accountable
Measurable performance with consequences

It is a fundamental redesign – not a substitution model, not a “lesser” model
**DHI Goals**

Identify and classify patients’ health risks according to health status, environmental issues and social/economic factors;

Use information technology to help clinicians offer personalized treatments and seamless patient care;

Create a "web" of healthcare options, including Care Management/Care Coordination

Establish clear metrics and accountability

Establish a community-wide living laboratory for health improvement
Medical Home Version 2

PA/NP Micro Clinic

Home Care

Office

Specialists Hospital

Care Management

Medical Home Version 3
DUKE CONNECTED CARE™
Locate clinicians and services as needed to provide and coordinate care
Center for Medicare and Medicaid Innovation

“The purpose of the CMI is to test innovative payment and service delivery models to reduce program expenditures...while preserving or enhancing the quality of care. . . “

Budget neutral not required initially

Secretary may waive requirements “as may be necessary”

Funding: $5 m in “FY2010”; $10b in FYs “2011-2019”

HIZ Update - Goals

- Reduce the rate of increase in health care costs while maintaining or improving quality
- Redesign the role of specialists in the care of patient populations
- Design new clinical processes and technologies to support delivery of effective care
- Develop a new cultural paradigm to achieve patient- and population focused care
- Maximize the use of EHRs to improve patient and population health.
- And translate care delivery changes into educational reforms
HIZ Update – Payment Model

- Tier 1 – Comprehensive Payment
  - AMC assumes risk for a population; payment is bundled by payor based on AHC experience; AHC shares in upside and downside
  - Could include medical homes; expanded bundled episode payments, up to comprehensive payment for all covered services

- Tier 2 – Shared Accountability Payment
  - Inpatient and outpatient prospective payment systems and Medicare physician fee schedules are reduced,
  - Accountability payments for total performance added

- National Learning Community
  - Akin to CTSA

HIZs Included in the CMI

“Establishing comprehensive payment to Healthcare Innovation Zones, consisting of groups of providers that include a teaching hospital, physicians, and other clinical entities that, through their structure, operations, and joint-activities deliver a full spectrum of integrated and comprehensive health care services to applicable individuals while also incorporating innovative methods for the clinical training of future health care professionals”
New Reporting Requirements for Tax-Exempt Hospitals

Community health needs assessment and implementation strategy every three years

Adopt, implement and publicize financial assistance policy and emergency medical care policy

Limit changes to no more than amounts generally billed to insured patients

No extraordinary collection actions before determining if individual eligible for assistance

If more than 1 hospital, each hospital must meet requirements

$50,000 penalty for failure to meet
HEALTHIER WISCONSIN PARTNERSHIP PROGRAM

Improving Wisconsin’s health through community-academic partnerships

**Impact and Development Awards**

- 109 Projects
- $22.4M

Through community-academic partnerships:

- Address leading health risks and priorities
- Focus on specific populations
- Prevent causes of death and disability
- Build capacity and enhance systems

**Goal:**

Healthy Communities

Engaged Community Members, Clinicians and Researchers

Duke Medicine