Today’s Agenda

- Introductory Thoughts / CHS
- Our Approach
- Results
- Dialogue
Carolinas HealthCare System
CHS Journey

1980s → 1990s → 2000s → 2010s

Charlotte Memorial Hospital
Dickson Tower
Physician Network Expansion
AnMed
Levine Cancer Institute

Levine Children’s Hospital
CMC-University
CMC-NE
CMC-Fort Mill

STANDARD & POOR’S

Davidson Clinic (1985)

Carolinas HealthCare System

ROPERS ST FRANCIS HEALTHCARE

Sanger Heart & Vascular Institute

CMC-NE
Commitment to the Community

Mission Statement
The mission of the Carolinas HealthCare System is to create and operate a comprehensive system to provide health care and related services, including education and research opportunities, for the benefit of the people it serves.

Vision Statement
Carolinas HealthCare System will be recognized nationally as a leader in the transformation of healthcare delivery and chosen for the quality and value of services we provide.

Levine Children’s Hospital
Med-1 Mobile Hospital
MedCenter Air
Carolinas HealthCare System

- Second largest public healthcare system in the nation
- Largest non-profit healthcare system in the Southeast
- Strong Physician Network and Clinical Service Lines
- Total Enterprise 2014 net operating revenue: $8.6 billion
- Primary Enterprise AA-rated since 1983
Breadth of CHS

**Continuum of Care**
- Nursing Homes
- Rehabilitation Hospitals
- Hospitals
- Emergency Care Centers
- Ambulatory Surgery Centers
- Hospice & Palliative Care
- Behavioral Health
- Urgent Care Centers
- Health Clinics
- Primary Care Practices
- Home Health
- LiveWELL Carolinas
- Specialty Care Practices

**Summary of System**
- 60,000 employees
- 39 hospitals
- Over 900 care locations
- Nearly 7,500 licensed beds
- 11 long-term care facilities
- 12 home health agencies
- 12 hospice providers
- 8 freestanding EDs
- One of 5 academic medical centers in the state of North Carolina

**Key Statistics – 2014**
- 11.5 million patient encounters
- Over 7.2 million physician visits
- 262,000 inpatient discharges
- 636,000 adjusted discharges
- 1,514,000 ED visits
CHS Experience

Carolinatas HealthCare System affiliates and physician networks in NC, SC and GA.
Physician Services at CHS

- **First practice in 1988**
- **Over 600 locations across North Carolina, South Carolina and Northern Georgia**
  - **CHS Medical Group**
  - **Levine Cancer Institute**
  - **Regional Physician Network** (Scotland, Columbus, New Hanover, Cleveland, Wilkes, St. Luke’s and Anson)
  - **Regional Hospital Groups** (Roper, Cone Health, AnMed, Murphy, MedWest, Blue Ridge, Stanly)

*Total CHS ‘System’ Physicians: 2,317*
Research and Education

- 385 faculty physicians
- 377 residents and fellows
  - 16 Medical Residency Programs
  - 12 Fellowship Programs
- UNC-Chapel Hill School of Medicine Charlotte Campus
- 3 Schools of Nursing and Allied Health
- Approximately $17 million in grants for research from external, federal and state organizations
  - National Institute of Health
  - Department of Defense
  - Department of Education
  - Duke Endowment
  - A-O Foundation
  - NC DHHS, Division of Public Health
Clinical System-ness

Branded Clinical Programs

- Levine Cancer Institute
- Carolinas Hospitalist Group
- Sanger Heart and Vascular Institute
- Neurosciences Institute
- Remote Critical Care Services
- Carolinas Stroke Network
- Carolinas Trauma Network

Levine Cancer Institute is focused on delivering care at the community level

Remote ICU monitoring center will enable consistent, high quality care across the System
Quality & Safety Operations Councils (QSOC™)

- System-wide collaboratives focusing on specific functions or service lines
- Teams prioritize what is important
- Learn from each other
- Tap resources / other experts within our System
- Share best practices
- Enables spread and rapid replication
- Builds high reliability
- Network with “like” peers

Blue = Goal-oriented team
Orange = Networking team
Yellow = Informational team
Tactics: 2008-15

- Human Factors
- PACS Quality MAP
- CHS PSOs
- Continuum Goals
- CANOPY CPOE
- OPPE/FPPE
- Shared Baselines
- Sharing Days
- TeamSTEPPS
- Advanced Analytics
- Aligned Incentives
- Clinical Optimization
- Unified Goals
- QSOC™
- PELC
- Enterprise-wide Metrics
- Health Literacy
- Quality Division
- CMOs
- Boards On Board
- Patient Stories
- “Safers”
- Patient Stories
- Lean
- Clinical Optimization
- MDI
- Process Mapping
- NQF Leadership
- NSQIP™
- Medical Staff Application Module
- Clinical Breakthroughs
- Enhance Quality Reputation Nationally
- TJC-DSC Program Strategy
- Premier QualityAdvisor™
- Premier Physician Focus™
- HEN/LEAPT
- Transparencies
- Global Trigger Tool
- Care Model Redesign
- Clinical Optimization
- Simulation
- Service Line
- Lean
- Clinical Optimization
- MDI
- Care Model Redesign
- Global Trigger Tool
Carolinas PSO Approach and Expected Results

Data in and protected → Aggregation and Analysis → Data-driven Solutions

- Hospital
- Pharmacy
- Physician Groups
- Ambulatory Care
- SNF
- Home Health
- FQHC
- Durable Medical Equipment
- Long Term Care Facility

New Knowledge

Comparative Reports

Collaborative Learning

Carolinas HealthCare System
CHS Is A Leading Health System

DATA POINTS
1: OVERALL
2: Mortality*
3: Complications*
4: Patient Safety*
5: Core Measures
6: ALOS*
7: HCAHPS

QUINTILES
- Green: 80 TO 100
- Yellow: 60 TO 80
- Orange: 40 TO 60
- Red: 20 TO 40
- Black: 0 TO 20

PROFILED HEALTH SYSTEM
2012 Comparison group: n = 110
2008 - 2012 Comparison group: n = 110

* Rate of Improvement 2009 - 2012

©2014 Truven Health Analytics Inc.
CHS has been recognized nationally for delivery of high quality medical care and exceptional customer service.
Our Approach
Fundamental: The Transition from Volume to Value

VOLUME
- uncoordinated
- Silo work
- fee for service
- volume-based
- reactive
- cost containment
- team accountability
- information technology
- standardization
- innovation
- transparency
- engaged physicians
- safe
- improved quality
- team-based care
- transparency
- care coordination
- patient-centric
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True North Aspiration

To provide and manage care that achieves value and health for populations
Clinical Integration Call Series

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<th>Presentations</th>
<th>Topics</th>
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<tr>
<td>2012 Perspective Survey: Service Lines</td>
<td><strong>75 presentations on over</strong></td>
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<tr>
<td>2014 Maturity Model Criteria</td>
<td><strong>50 different topics</strong></td>
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<td>ACP (CAP) Update</td>
<td>since January 2012</td>
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<td>Advanced Illness Management Program (AIM)</td>
<td><strong>January 2012</strong></td>
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<td>Advisory Board - Care Management/&quot;Graduation&quot;</td>
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<td>CI Self-Assessment Results</td>
<td><strong>CHS Care Management</strong></td>
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<td>CIN Legal Aspects - Hogan Marren</td>
<td><strong>CHS Chronic Disease Management for COPD</strong></td>
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<td>Clinical Integration Q&amp;A</td>
<td><strong>CHS Chronic Disease Management Model (CDMM)</strong></td>
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<td>Clinical Optimization</td>
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<td>CMS Readmission Reduction Program</td>
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<td>Critical Care</td>
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<td>Diabetes Work</td>
<td><strong>CIN Legal Aspects - Hogan Marren</strong></td>
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**HEN/LEAPT**

**Hospitalists**

**Integrated Systems of Care Strategic Priority**

**ISOC Assessment/ Service Line Commentary, Learnings, Scorecard**

**LCH NICN Innovation Project**

**LCI update**

**Medical Bundled Payment Analysis**

**Medicare Spending Per Beneficiary**

**MHR- NC exchanges**

**NC Medicaid Mental Health/LME Update**

**Neuro ISOC Update**

**New Payment Models**

**Patient First Update**

**Pediatric ED Readiness Assessment**

**Peds Asthma**

**PQRS**

**Primary Palliative Care**

**Readmissions**

**RSF - CIN/Boeing**

**Sterile Outsourcing**

**Succeeding in the New Health Care Ecosystem (Advisory Board)**

**The CHS Approach to Clinical Integration**

**Triad HealthCare Network - Care Management**

**Triad HealthCare Network (THN)**

**True North Metrics Metrics**

**Update on Medicare Bundled Payments for Care Improvement**

**Value Based Purchasing (VBP)**
Population Health Analytics

We are using “big data” in a big way.
**CHS Care Management**

**Nurse Care Manager**
- Care plan development
- Medication adjustments
- Coaching, goal setting, motivational interviewing, behavior modification.

**Health Advocate**
- Navigation/Coordination
- Pro-active outreach
- Facilitate referrals
- Coaching in support of care plan

**Behavioral Health Provider**
- Diagnosis
- Treatment
- Communication
- Education
- Navigation
- Coaching

**Pharm D**
- Injectable Med Titrations
- Med Adherence / Rec
- Poly Pharmacy, cost effective regimens

**STANDARDIZED APPROACH**

- PERFORMANCE REPORTS
- PROTOCOLS FOR CARE
- MED PROTOCOLS
- STANDARD SERVICES
- FULL CONTINUUM DOCUMENTATION
**Integration Maturity Model**

### 2013 Original Criteria

1. CHS **Clinical Integration Priority Tool** used
2. One and three -year **cross continuum/geographies plans**
3. Specialty “**Principle Coordinator of Care**” criteria developed
4. **Integration** with palliative care, home health, etc.
5. **Service line** work influencing primary care, continuing care and/or acute care is created & distributed
6. Method to **stratify patients** is developed & deployed
7. CHS **Chronic Disease Management** Model (CDMM) is utilized to address key conditions and chronic populations within the service line
8. Navigator/Coordinator connected to the medical home
9. Action plan for **readmission reduction** is in place
10. An **action plan** is in place to address one or all of the following: high drug costs **utilization**; unnecessary lab **testing**; testing in higher cost settings; **avoidable** ED **visits**
11. **Goals** are articulated in all three dimensions of **value**
12. Cross continuum **value dashboards** are developed
13. **Care coordination** models, clinical pathways, transitions developed & executed

### 2015 Criteria

14. **Physician leaders** fully engaged in strategic discussions and work through physician colleagues to achieve results
15. Physicians ensure **compliance** with cross continuum care pathways/protocols
16. **Team-based** care models are developed
17. **Access** leverage
18. Action plan positively impacting our **employee population** is developed/executed
Advancing Integration, Driving Transformation, Creating Value

- Integrated Practice Units (IPU)
- Expand Heart Failure Network
- Care Coordination of ACS Patients (CMC-Pineville)
- Readmission plan to include all CV diagnoses
- Develop cross-continuum protocols/pathways for 2 CV specific procedures
- Cardiovascular Program Summit
- Care Model Clinical Care Team Redesign
- Care Model Access Standards
- Skill Optimization - Health Advocate Role Development
- CPOE
- Patient Portal Adoption
- Virtual visits/ consults/eVisits
- Cross Continuum Care Management
- CIN development
- CHS/CNSA spine alignment: Care model clinical care strategies
- Primary Palliative Care
- Advanced Care Team (AIM) deployment
- Deployment of Referral Portal Online (RPO) within high opportunity Emergency Departments
- Redesign of ED intake to enable appropriate access for unscheduled care
- Oncology-ED Program
- Care coordination and alignment with CHS care management and CCNC
- CHS Pediatric Emergency Care Readiness Initiative
- ACEP “Choose Wisely” Campaign
- CHS/CNSA spine alignment: Take care of the patient, not the plan
- Care coordination and alignment with CHS care management and CCNC
- Onco-dermatology program
- Expansion of navigator network
- Cancer Palliative Care Expansion
- Sr. Oncology Program Expansion
- Cardio-oncology
- Survivorship Programs
- ED Psych Hold Reduction
- Expanded Access
- BH Primary Care Integration
- Readmission reduction – pre-op, IP, post-surgery collaboration
- Capture OC home care referrals to Healthy @ Home
- Care coordination with Sports Med & Injury Care (SMIC)
- Improve ortho surgery care coordination (CHS leakage)
- Redesign of ED intake to enable appropriate access for unscheduled care
- Onco-dermatology program
- Expansion of navigator network
- Cancer Palliative Care Expansion
- Sr. Oncology Program Expansion
- Cardio-oncology
- Survivorship Programs

Across Carolinas HealthCare System...
Maturity Model

Average Improvement

- **38%** 2013 to 2014
- **24%** 2014 to 2015
- **72%** Improvement 2013 to 2015
HEN & LEAPT

Carolinias HealthCare System HEN
TOTAL MONTHLY HARM PER 1,000 DISCHARGES

Harm per 1,000 discharges

Jan-12, Feb-12, Mar-12, Apr-12, May-12, Jun-12, Jul-12, Aug-12, Sep-12, Oct-12, Nov-12, Dec-12, Jan-13, Feb-13, Mar-13, Apr-13, May-13, Jun-13, Jul-13, Aug-13, Sep-13, Oct-13, Nov-13, Dec-13, Jan-14, Feb-14, Mar-14, Apr-14, May-14, Jun-14, Jul-14, Aug-14
Depression: PRE - POST

Change between the FIRST and LAST PHQ-9 score (n=331)

Average PHQ-9 before health coaching = 16.7 (± 4.3)

49% decrease in PHQ-9 score

Average PHQ-9 after health coaching = 8.7 (± 7.0)

Average PHQ-9 score decrease = 8.0 (± 7.5)*

p < .0001**

Median PHQ9 = 16*

Median PHQ9 = 7*

*Captures change within the same patient (pre-post analysis using paired t-test procedure)

**p-value <.05 indicates statistically significant change
Symptom Severity: Pre & Post

- As a result of health coaching patients’ move from the higher severity categories to the lower or no depression categories
- 73% of the patients improved by one severity level after health coaching (A3 metric)
HgB A1C

<table>
<thead>
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<th>Mean (± Standard Deviation)</th>
<th>Mean change</th>
<th>p-value*</th>
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<tr>
<td>Baseline</td>
<td>8.6 (±2.4)</td>
<td>↓0.8 (±1.8)</td>
<td>p=.0002</td>
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<tr>
<td>6 months</td>
<td>7.7 (±1.9)</td>
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*p-value <.05 indicates statistically significant change (statistical significance doesn’t always indicate clinical significance)
6% (26 patients) had at least one IP admission 6 months before program enrollment compared to 5% (23 patients) post (p=.001)

Only 5 patients PRE and 7 patients POST had > 2 admissions.

Overall length of IP stay decreased from 159 to 115 days (within person comparison p=.41)

There was a minor decrease in overall billed charges (within person comparison was not possible due to small numbers of patients (n=7) with both PRE and POST charges)
Advanced Illness Management
Pre/Post Utilizations (N=296)
9/14/15

Number of Utilizations
(ED Visits nd Hospitalizations)

<table>
<thead>
<tr>
<th></th>
<th>Pre-SOC</th>
<th>Post-SOC</th>
<th>Reduction</th>
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<tr>
<td>ED</td>
<td>280</td>
<td>186</td>
<td>34%</td>
</tr>
<tr>
<td>Hospital - Index</td>
<td>309</td>
<td>108</td>
<td>65%</td>
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<tr>
<td>Hospital - 30-day Readmit</td>
<td>99</td>
<td>52</td>
<td>47%</td>
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<tr>
<td>Hospital - OBS</td>
<td>88</td>
<td>42</td>
<td>52%</td>
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<tr>
<td><strong>Total</strong></td>
<td></td>
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<td><strong>50%</strong></td>
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Average LOS = 133.2 days
CHS Virtual Care Progress

Year-to-Date Telem medicine Comparison

January – September 2015

- Infectious Disease
- LCH Infectious Disease
- NICU Transport
- Behavioral Health Expansion
- TelePsych Expansion
- LCI – Palliative Care
- SHVI Primary Care Integration
- TeleStroke
- Transition Clinic

Other Activity
- Playbook / Standardization
- IS platform standardization
- Scheduled Virtual Visit platform Development
- LCH PICU – Virtual Rounding at JGCH given touchstone award for 2015 Quality and Patient Experience Day
- Telemedicine in Sleep Medicine – Dr. Jaspal Singh leading national sleep association in development of national TeleSleep Medicine standards
Metrics 2010 – 2014 Progress

Ambulatory Appropriate Care (QCC)

Baseline: 82%
Target: 85%
Stretch: 88%
Actual: 85.7%

Clinical Decision Support

Data Reporting

Medical Assistant Standard Work

Baseline: 82%
Target: 85%
Stretch: 88%
Actual: 85.7%

50.0%
55.0%
60.0%
65.0%
70.0%
75.0%
80.0%
85.0%
90.0%
Progress: Patient’s perspective

- 12,150 Telemedicine Encounters
- 60,000 Diabetic patients in managed care
- 27,000+ People identified at risk for prediabetes or diabetes in one year
- 175 Home health transfers to acute care have been avoided
- 1,600 Cancer patients enrolled in clinical trials
- 9,800 Patient safety events avoided over three year partnership for patients program
- 1000+ Readmissions have been avoided
- 28,094 More patients were discharged from emergency departments in fewer than 180 minutes
- 141,100 Patients enrolled to use our online patient portal
- 27,000+ People identified at risk for prediabetes or diabetes in one year
- 500+ Emergency virtual behavioral health consults conducted monthly
- More than 1,500 Patients treated through Virtual Visit
- 500+ More patients were discharged from emergency departments in fewer than 180 minutes
Questions?