Community Care of North Carolina

Statewide program for managing Carolina Access recipients

Key Goals

- Improve access to, quality of, and coordination of care for Carolina Access Medicaid patients.

- By doing so, decrease the cost of care.

Key Visions

- Public-private partnership
- The primary care medical home is key for success
- Community-based, provider-led
- Quality and system oriented
- Managing care via population management strategies

Basic Operating Premise

- Regardless of who manages Medicaid, physicians, hospitals, health departments, and other safety net providers will be serving the patients
- Ownership of the improvement process must be vested in those who have to make it work
- Providers who care for patients must work together
- The State should partner with and support community providers who are willing to build the care systems that are needed
- Focus on quality improvement
- Information and feedback are key
- System changes can be applied to other populations of patients

How this is Operationalized

Community Care of North Carolina

- Rests on framework of Carolina Access Medicaid
  - Patients are linked to a primary care medical home
- Creates local networks that:
  - Join primary care homes with other segments of the local health care system (e.g. hospitals, health departments, mental health agencies, social services)
  - Are capable of creating systems of care
  - Are responsible for managing recipient care
  - Supports a patient-centered medical home
- 14 local Networks across all 100 counties with more than 4500 Primary Care Physicians (1360 medical homes)
- Over one million Medicaid enrollees

CCNC Network Map: http://www.communitycarenc.com/

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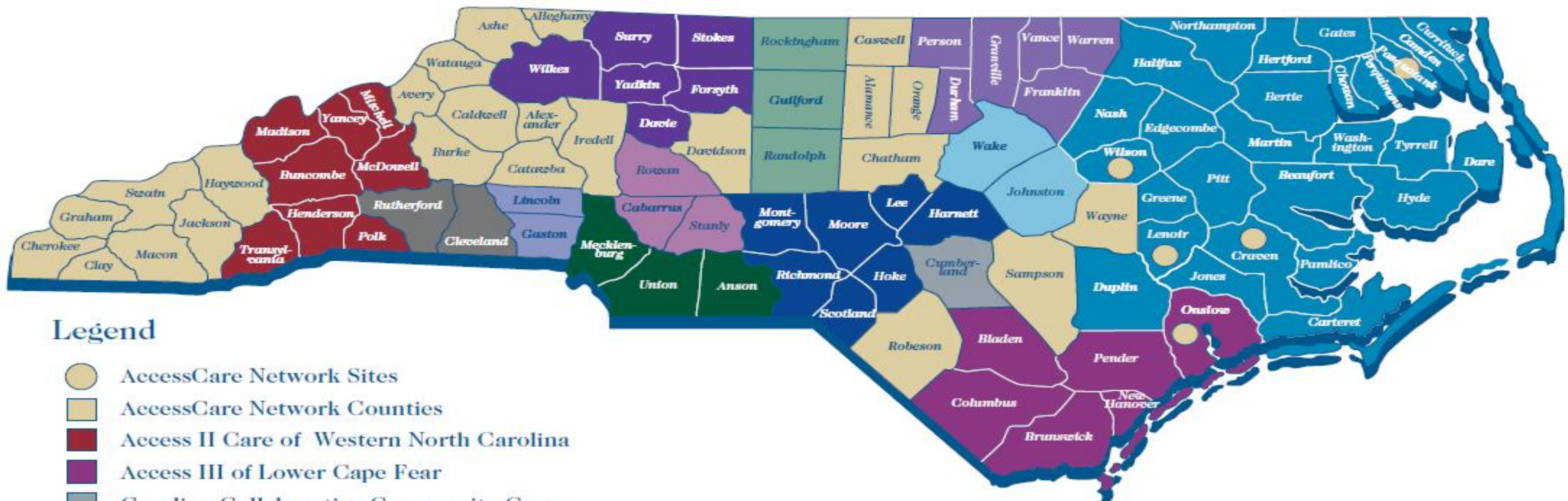
Access II and III Networks



Legend

- AccessCare Network Sites
- AccessCare Network Counties
- Access II Care of Western North Carolina
- Access III of Lower Cape Fear
- Carolina Collaborative Community Care
- Carolina Community Health Partnership
- Community Care of Wake / Johnston Counties
- Community Care Partners of Greater Mecklenburg
- Community Care Plan of Eastern Carolina
- Community Health Partners
- Northern Piedmont Community Care
- Northwest Community Care Network
- Partnership for Health Management
- Sandhills Community Care Network
- Southern Piedmont Community Care Plan

Community Care Networks

- Are non-profit organizations
- Seek to incorporate all providers, including safety net
- Executive Committee (LHD, Hospital, Providers, MH, Social Services)
- Medical Management Committee (Community Providers)
- Receive a per member/per month from the State for population management – no fee for service
- Participating PCPs receive a pm/pm to provide a medical home, participate in Disease Management and Quality Improvement in addition to fee for service

Each CCNC Network Has:

- Clinical Director(s)
- Network Psychiatrist(s)
- Network Director
- Nurse and Social Worker Care Managers
- Care Management Supervisor(s)
- Network Pharmacist (s)
- Informatics System Managers
- Quality improvement coordinator

Current Community Care Resources

- 4,500 primary care physicians
- 450 local care managers
- 30 local medical directors
- 18 clinical pharmacists
- 10 local psychiatrists
- Informatics Center providing quality and care management data to networks and practices
- 28 central staff members supporting clinical program implementation

Key program Asset- Access to data

- **Informatics Center - Medicaid claims data**
  - Utilization (ED, Hospitalizations)
  - Providers (Primary Care, Mental Health, Specialists)
  - Diagnoses
  - Medications
  - Labs
  - Costs
  - Individual and Population Level Care Alerts
- **Real Time data**
  - Hospitalizations, ED visits, Provider referrals

Main Program Activities

- Chronic Disease Management Initiatives (e.g. Asthma, Diabetes)
- Quality Improvement Initiatives
- Hospital Transition Care
- Emergency Department Utilization
- Integration of Physical and Mental Health
- Prevention Initiatives
- Pharmacy Initiatives
- Palliative Care
- Access to Primary Care
- Support of IT Initiatives
- Nurse and Social Worker care management of high cost patients

Care Management Strategies

- Population management strategies
- Use data (claims and real time) to identify, prioritize, and stratify target population
- Dynamic intensity status (Heavy, Medium, Light)

Care Management Goals

- Facilitate self-management of chronic conditions
- Strengthen link to Primary Care Provider
- Coordinate services across providers and sectors

Care Management activities

- Telephonic, Home Visits, Medical appointments
- Provide education about condition, meds, equipment, etc.
- Increase understanding of doctors' plan of care
- Assist in making appointments and with transportation
- Increase awareness of Primary versus Emergency care
- Identify, coordinate, and link with other health providers and community resources
- Transition care after hospitalizations
  - Medication reconciliation
  - Link back to PCP, specialist, home health, mental health

Intersection with Primary Care

A medical home …..

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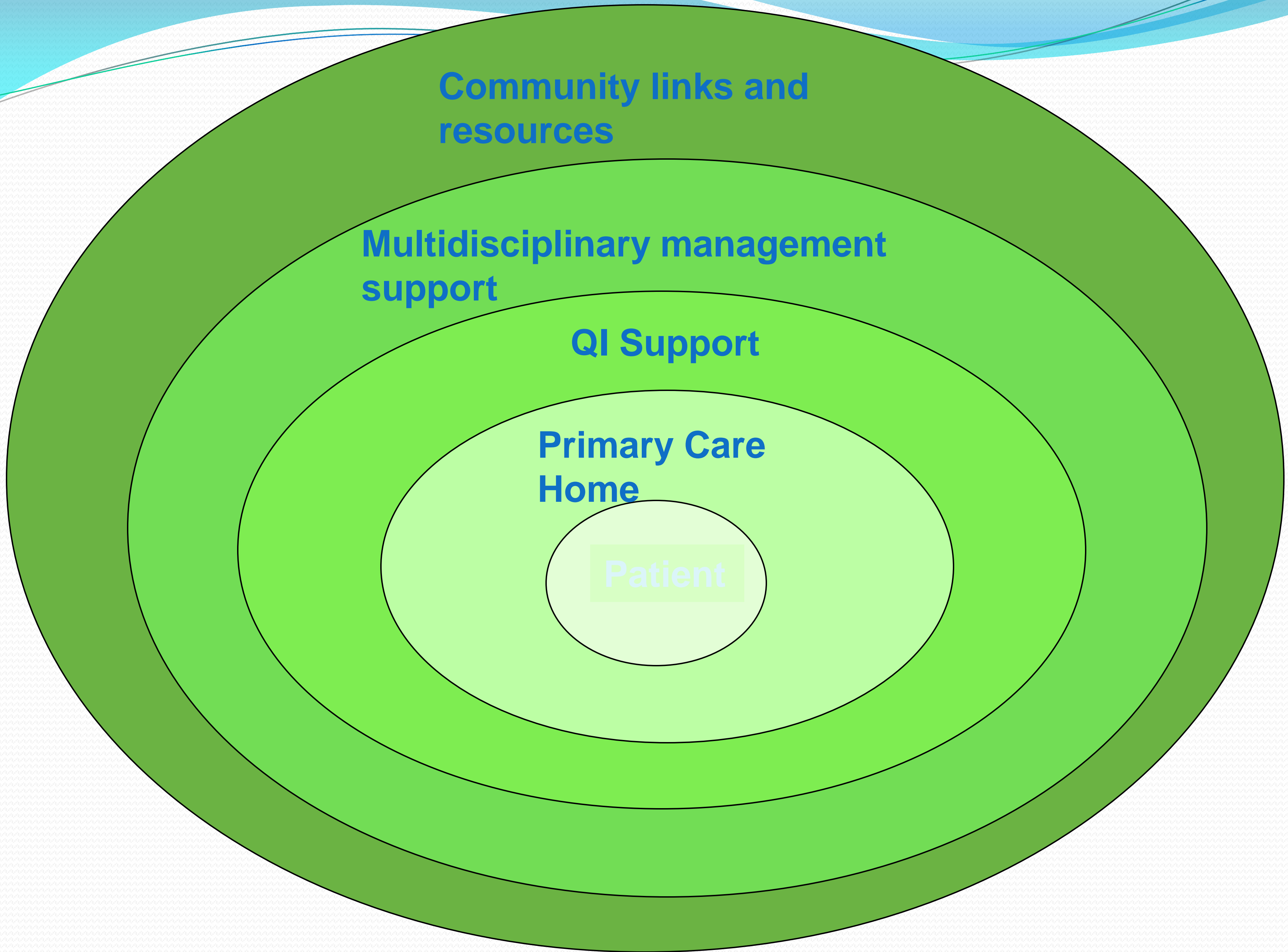
- Assures primary care: preventive, acute and chronic care
- Exists as part of community-based, interdisciplinary, team-based approach to care
- Uses a family-centered partnership
- Exists as care that is: accessible, family/patient-centered, coordinated, compassionate, continuous and culturally effective
- Uses a single point of entry to a system of care that facilitates access to medical and non-medical services
- Conducts quality improvement

Adapted from Source: AAP, National Center for Medical Home Initiatives


Community links and resources
Multidisciplinary management support
QI Support
Primary Care Home
Patient

Benefits of CCNC Model for Providers

- Address patient barriers to adherence
- Support providers' plan of care through patient education
- Help providers implement quality improvement initiatives
- Provide feedback on patient ADL's and home safety concerns

Opportunities to Improve Care

FY 2012

- Pregnancy Home to improve birth outcomes
- Better integration mental health, medical services for Aged, Blind and Disabled patients
- Palliative care initiative

Bringing OB into CCNC networks

- OBs have been eligible to be CCNC primary care providers for 10 years
- Interest in bringing a population management approach to high-risk OB – potential for significant cost savings, improved quality of care and improved outcomes for mothers and babies
- In 2011, a new type of medical home – the "Pregnancy Medical Home" – will be implemented through CCNC networks
- Network OB team (physician champion and nurse coordinator) to support this model