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

- 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/
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 ..... 

- 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
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.