

Community Care of North Carolina



Communities Connect

"Putting the Pieces Together..."

Access to Care through Medical Homes

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What is Needed to Improve Chronic Illness Care

According to Ed Wagner, MD, author of the Chronic Care Model, fundamental system changes are needed to meet the needs of patients with chronic illnesses:

- A medical home that can provide a “continuous healing relationship”
- Use of care team
- Effective evidence-based treatment
- Support for patient self-management
- Systematic follow-up and planned encounters
- More intensive management for high risk patients and for those not meeting goals
- Coordination across settings and professionals
- Registries



New NCQA Standards for “Patient-Centered Medical Homes”

Standards to Address:

- Access and Communication
- Patient Tracking and Registry Functions
- Case Management
- Patient Self-Management Support
- Electronic Prescribing
- Test Tracking
- Referral Tracking
- Performance Reporting & Improvement
- Advanced Electronic Communications



North Carolina's Approach



First - Background

- NC is mainly a rural state not well suited for traditional managed care
- NC is dominated by small practices and loosely organized medical systems
- The county system remains very strong
- Since early 1990's, NC has had in place across the state, a PCCM program for Medicaid recipients
- In 1998 NC started to build and support community level networks to support medical homes in chronic illness care



Primary Goals

- Improve the care of the Medicaid population while controlling costs
- Develop Community Networks capable of managing recipient care
- Develop the systems needed to improve chronic illness
- Fully develop the Medical Home



Key Visions

- “Managed not regulated”
- CCNC is a clinical program not a financing mechanism
- Public-private partnership
- The medical home is key for success
- Community-based, physician led
- Quality and system oriented
- Economizing through raising quality rather than lowering fees



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- Joins other community providers (hospitals, health departments and departments of social services) with primary care physicians
- Designated primary care medical home
- Creates community networks that assume responsibility for managing recipient care



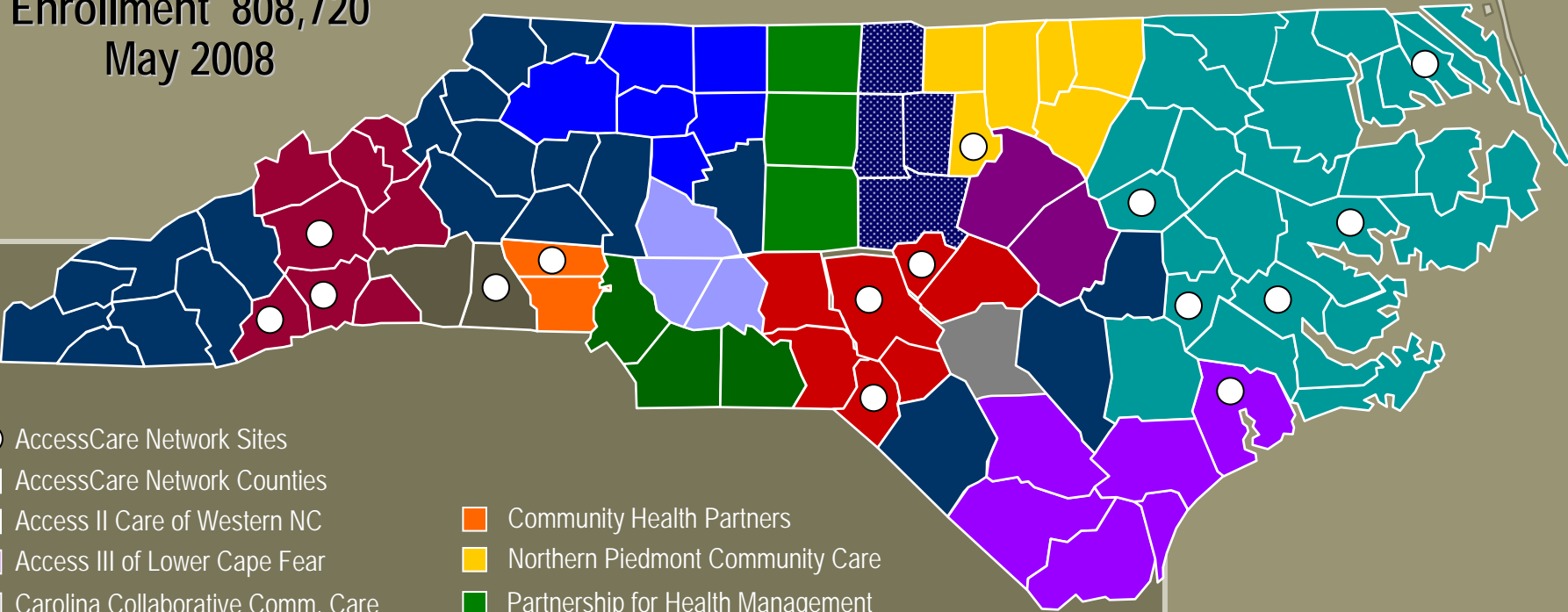
Community Care of North Carolina – *Now in 2008*

- Focuses on improved quality, utilization and cost effectiveness of chronic illness care
- 14 Networks with more than 3500 Primary Care Physicians (1200 medical homes)
- 808,720 enrollees
- Now mandated inclusion of Aged, Blind and Disabled and SCHIP by General Assembly



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Enrollment 808,720
May 2008



- AccessCare Network Sites
- AccessCare Network Counties
- Access II Care of Western NC
- Access III of Lower Cape Fear
- Carolina Collaborative Comm. Care
- Carolina Community Health Partnership
- Central Piedmont Access II
- Comm. Care Partners of Gtr. Mecklenburg
- Community Care Plan of Eastern NC
- Community Health Partners
- Northern Piedmont Community Care
- Partnership for Health Management
- Sandhills Community Care Network
- Southern Piedmont Community Care Plan
- Community Care of Wake and Johnston Counties
- Central Care Health Network

Community Care Networks:

- Non-profit organizations
- Includes all providers including safety net providers
- Medical management committee
- Receive \$3.00 pm/pm from the State
- Hire care managers/medical management staff to work with PCPs
- PCP also get \$2.50 pmpm to serve as medical home and to participate in Disease Management and Quality Improvement
- NC Medicaid pays 95% of Medicare FFS



Each Network Now Has:

- Part-time paid Medical Director – role is oversight of quality efforts, meets with practices and serves on State Clinical Directors Committee
- Clinical Coordinator – oversees the overall network operations
- Care Managers – small practices share/large practices may have their own assigned
- Now all networks have a PharmD to assist with medication management of high cost patients



Key Attributes of Our Medicaid Medical Home

- Provide 24 hour access
- Provide or arrange for hospitalization
- Coordinate and facilitate care for patients
- Collaborate with other community providers
- Participate in disease management/prevention/quality projects
- Serve as single access point for patients



Key Innovations

- Provider networks organized by local providers and are physician led
- Evidenced based guidelines are adopted by consensus rather than dictated by the state
- Medical Homes are given the resources for care coordination and get timely feedback on results
- Inclusion of other safety net providers and human service agencies

“We are about building local systems of care rather than changing how we pay for services”



Current State-wide Disease and Care Management Initiatives

- Asthma
- Diabetes
- Pharmacy Management (PAL, Nursing Home Polypharmacy)
- Dental Screening and Fluoride Varnish
- Emergency Department Utilization Management
- Case Management of High Cost-High Risk
- Congestive Heart Failure (CHF) (2006)



Network Pilot Initiatives

- "Assuring Better Child Development" (ABCD)
- ADD/ADHD
- HealthNet/Coordinated care for the uninsured
- Childhood Obesity
- Telehealth for CHF
- Projects with Public Health (Low Birth Weight, open access & diabetes self management)
- Diabetes Disparities
- Medical Home/ED Communications
- Stroke Prevention



Network Pilot Initiatives

- Aged, Blind and Disabled (ABD)
- Depression Screening and Treatment
- Mental Health Integration
- Mental Health Provider Co-Location
- E-Rx
- Partner with AHEC to support Improving Performance in Practice Initiative
- Medical Group Visits
- Dually Eligible Recipients



Next Steps

- Strengthen the ability of the medical home to manage chronic illness care
- Enhance the ability of practices/networks to support patient self-management
- Improve care planning/coordination across provider settings
- Integrate specialist expertise into care improvement process
- Strengthen communication and performance feedback to clinicians
- Investing in improved Clinical Information System



Take Home Thoughts



Key Points

- Key attributes of CCNC are replicable in other states despite the idiosyncrasies of NC
- Key principles have a role in non government programs
- Many states have rural areas and undeveloped markets that may benefit from local system development
- Operations vary by community – CCNC principles allow local variability

The medical home and community system development are the keys to success!

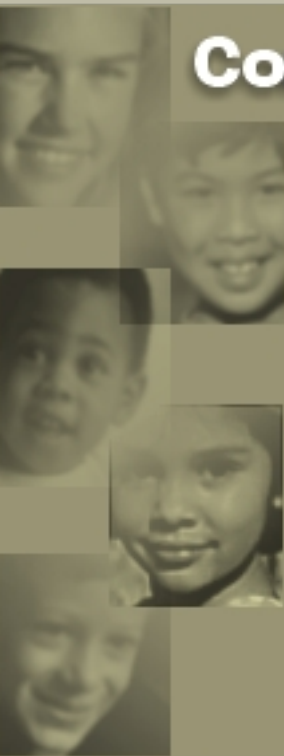


Want to Know More?

www.communitycarenc.com



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Thank You

