


Community Care of North Carolina



NATIONAL ORGANIZATION OF STATE OFFICES OF RURAL HEALTH

Mobile, Alabama --- August 2009

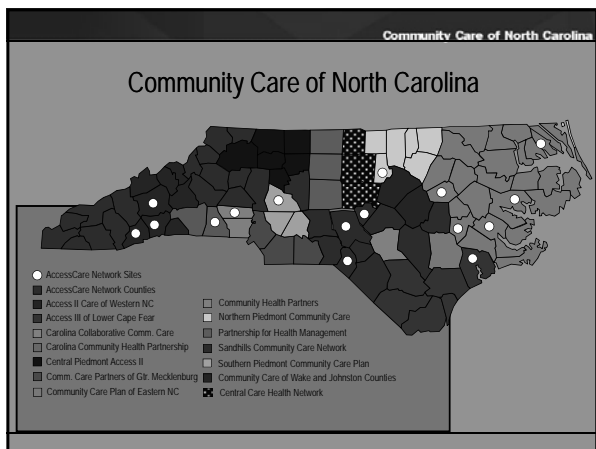
Chris Collins
Deputy Director - Office of Rural Health and Community Care
Assistant Director - Managed Care Division of Medical Assistance
North Carolina Department of Health and Human Service

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Improve the care of the Medicaid population while controlling costs.
Regardless of who manages Medicaid, North Carolina's physicians, hospitals, health departments and other safety net providers will be serving the patients and making the clinical decisions.

Develop the infrastructure needed to improve chronic illness
Our primary care systems must become as adept at caring for patients with chronic illness as they are treating patients with acute illness.

Develop Community Networks capable of managing recipient care
Through Community Care, DHHS is partnering with North Carolina's safety net providers to build the needed improvements in care for Medicaid and other low-income populations.



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Collectively our **14 Networks** have more than **3,500 physicians and 950,000** plus enrollees.

CCNC Networks are non-profit organized health care arrangements. Comprised of safety net providers that include Primary Care Providers, Hospitals, Health Departments, Department of Social Services and other members as identified by the community such as Mental Health.

Each CCNC Network has a physician champion that represents the local network at State level meetings. Community safety net providers participate in local steering and medical management committees and govern the Network.

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Focuses on improved quality, utilization and cost effectiveness of chronic illness care through disease, case and utilization management.

Implementing best practices quality improvement processes

- Implementing Targeted Disease Management
- Implement Chronic Care
- Implement Pharmacy Home
- Build accountability through monitoring & reporting

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Services remain FFS

Primary Care Practices are funded an additional \$1.00 PM/PM for providing the Medicaid patient a medical home with 24/7 access and coordination of specialty care.

Receive an additional \$1.50 upon joining the network and committing to the implementation of CCNC goals and initiatives.

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Networks are funded \$3.00 PM/PM

Network funds are used to support the local staffing such as: medical directors, case managers, pharmacist, quality improvement specialist... and for other key infrastructure including statewide case management information system, quality improvement tools, training and technical support.

Statewide approximately 250 case managers

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Patient Identification

Real time data / referrals

- Hospitals
- Primary Care Providers
- Specialist
- Members of the care team

Identify high risk and high cost through claims analysis

Provider audits - State AHEC and / or local Network audits

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Managing Clinical Care

Clinical Directors Group

- Select targeted diseases/care processes
- Review evidenced-based practice guidelines
- Define the program
- Establish program measures

Local Medical Mgmt. Comm.

- Implement state-level initiatives
- Develop local improvement initiatives

PRACTICE A **PRACTICE B** **PRACTICE C**

Care Managers and CCNC quality improvement staff support clinical management activities

ASTHMA
DIABETES
PHARMACY
HIGH-RISK & -COST
ED
HEART FAILURE

GASTRO-ENTERITIS	FEVER
OTITIS MEDIA	DEPRESSION
CHILD DEVELOPMENT	LOW BIRTH WEIGHT
ADHD	CAP-C
CHRONIC CARE	MENTAL HEALTH
DIABETES DISPARITIES	DENTAL VARNISHING
OBESITY	

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Case Management Process

- Comprehensive Assessment
- Develop Individualized Care Plan
- Care Coordination
- Re-Assessment / Monitoring
- Outcomes
- Evaluation

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..... Chronic Care... identify and engage the population

- Move away from single disease focus towards “triads” and “dyads”
Diabetes and CV disease
- Train CC Case Manager
Improve comfort level with multiple chronic conditions
- Prioritize interventions
Unstable patients
- HTN/CVD/Post MI data
Demands a statewide QI program
- Audit Process Revisions
Consider changing to fewer measures across multiple chronic diseases

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Interventions to Improve Health Outcomes

- Chronic Care Case Management
- Hospital Transitions
- Pharmacy Home
- Mental Health Integration
- Disease Management
- Self Management Support


For ABD (Aged, Blind and Disabled) Aid category funding increased.

- Primary Care Providers' PM/PM increased to \$5.00
- Networks' PM/PM increased to \$8.00

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Global Lessons Learned

- Not at top down approach
- Community ownership
- Can't do it alone – must partner
- Incentives must be aligned
- Must develop systems that change behavior
- Have to be able to measure change
- Change takes time and reinforcement



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System level - Lessons Learned

- Moving to large scale population approach requires significant infrastructure investment and integration.
 - Funding / IT / Case Management / Data
- Must have key partners that are willing to engage and change
 - Providers / DMA / Legislators / Foundations
- Once built the infrastructure can leverage additional resources.
 - Internally: Health Check Coordinators, Managed Care Consultants, Other DHHS case managers....
 - Network: Case management, Pharmacy, Quality Improvement
 - Practice: Champions, Therapist, Nutritionist
 - Community: Smart Start / Hospitals / LME (Mental Health) / AHEC

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Patient level - Lessons Learned

Traditional focus on identification, linkage, disease management, and education.


Additional attention on communication, transitions and self management.

Care management is moving from managing a single condition to assisting the whole person who may have multiple complex medical, behavioral and social needs.

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"Community Care of North Carolina" in the news...

October 2007: Community Care of North Carolina wins the 2007 Annie E. Casey Innovations in American Government Award given by Kennedy School of Government at Harvard University



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Independent Analysis

FY 2003
60 million compared to FY02 AFDC
203 million compared to FFS AFDC

FY 2004
124 million compared to FY03 AFDC
225 million compared to FFS AFDC

FY 2005 and 2006
231 million AFDC

FT 2007
135 to 149 million AFDC

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Independent Analysis

FY 2008 ABD pilot

- Changes in care management for SFY 2008 versus SFY 2007 appear to have increased SFY 2008 costs under the Community Care/ACCESS program by a relatively modest \$6 million.
- All care management initiatives to date, including the changes referenced above, appear to have reduced SFY 2008 costs under the Community Care/ACCESS program by \$400 million.

