

Community Care of North Carolina



Presented by:

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Chronic Care Coordinator

WHO WE ARE:

- ❖ **The CCNC program is sponsored by the Office of the Secretary, the Division of Medical Assistance and the N.C. Foundation for Advanced Health Programs, Inc.**
- ❖ **Program direction is provided by the Office of Rural Health and Community Care.**

HISTORY OF CCNC

- 1990's – Carolina Access = Medicaid Managed Care
- 1998 – Access II & III – to help providers better manage Medicaid recipients
- Dr. David Bruton, DHHS Secretary, James Bernstein, Director ORDRHD, Denise Levis, Jeffrey Simms, Tork Wade
- Local Physician and Community Leadership
- Primary Care Case Manager Model
- 9 pilot areas (Buncombe, Gaston, Cleveland, Durham, Guilford, Pitt, Surry, Cabarrus)
- Total enrollment 1998 – 119,198

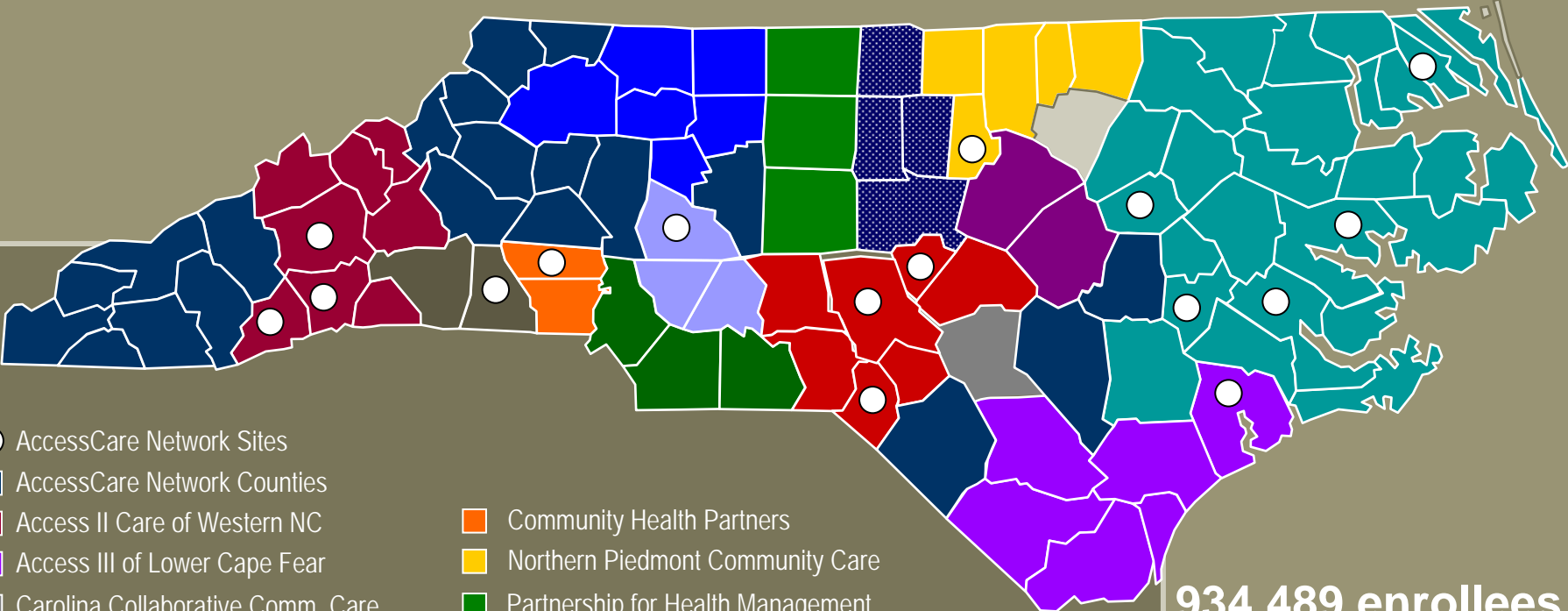
Basic Operating Premise

- Regardless of who manages Medicaid, North Carolina's physicians, hospitals, health departments and other safety net providers will be serving the patients.
- 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.
- Our care systems must become as adept at caring for patients with chronic illness as they are treating patients with acute illness.

CCNC INFRASTRUCTURE

- Joins other community providers (hospitals, health departments and departments of social services with physicians
- Creates community networks that assume responsibility for managing recipient care.
- Locally operated, Non-profit organizations
- Networks receive \$3.00 pm/pm for straight Medicaid – \$8 pm/pm for ABD
- PCPs receive \$2.50 pm/pm for straight Medicaid –\$5 pm/pm for ABD

Community Care of North Carolina



- 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
- Northwest Community Care Network
- Comm. Care Partners of Gr. 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

934,489 enrollees
4000 providers
1340 practices

PRIMARY GOALS

- Improve the care of the Medicaid population while controlling costs
- Develop community networks capable of managing recipient care
- Develop systems needed to improve chronic illness

PRIMARY FOCUS

- Improve quality
- Improve utilization
- Cost effective chronic illness care

Managing High Risk Patients

- Identify high cost/high risk through claims and report analysis
- Improved access to care
- Improved quality of care by implementing best practice guidelines
- Targeted care management
- Coordinate resources
- Set expectations

Build Accountability

- Chart audits
- Practice profiles
- PAL scorecard
- Progress toward goals & benchmarks



- ◀ HOME
- ▶ NEXT
- ◀ LAST

Implementing Disease Management

- Evidence-based guidelines
- Clinical directors set performance standards
- Local provider buy-in obtained
- Improve the care management process
- Local & state level technical assistance
- Pilot initiatives



Initiatives

- **State-Wide**

Asthma

Diabetes

Heart Failure

Hypertension

COPD

ED Utilization

Medical Home

Pharmacy

CV Risk Reduction

CHRONIC CARE

- ***Pilots - Polypharmacy, Mental Health Integration, Chronic Pain, Childhood Obesity, Stroke Prevention, Diabetes Disparities***

Chronic Care Population

- **Approx. 125,600 Aged, Blind, or Disabled (ABD) recipients enrolled in CCNC networks**
- **Approx. 30% of Medicaid population**
- **Consume around 70% of total Medicaid expenditures**
- **ABD recipients are 4.5 times more expensive than non-ABD**
- **Recipients have 3 or more co-morbid conditions**
- **41% had ED visit over 6 month period of time**
- **17% had at least 1 hospitalization in 6 months**

3 Areas Impacting High Cost:

Chronic Disease Prevalence

ED and Inpatient Utilization

Readmissions within 30 days

- **The NC General Assembly directed DHHS to expand the scope of CCNC's Care Management Model to target Medicaid & dually-eligible recipients with multiple chronic conditions**
- **This year the General Assembly, charged DHHS (and CCNC) to save \$29 million in FY 2009 (July 08 thru June 09) in the ABD population**

Identification of High Risk Patients

- Real-time ED and hospital data
- PCP & other community provider referral
- ABD data report – patients meeting priority and/or screening criteria
- Patients with 2 or more chronic conditions (including Mental Health diagnoses) and/or defined as unstable by evidence of 2 or more of the following:
 - ≥ 1 Inpatient admit within the past 6 months
 - ≥ 3 or more ED visits within the past 6 months
 - ≥ 8 Rxs over the past month or 24 over 3 mos
 - ≥ 3 or more Outpatient Providers over 6 months
 - No PCP visit within the past year
 - ≥ 2 ADL deficits requiring hands-on assistance
- Care Manager embedded in practice
- Case ID for emerging patients or patients with less complex disease management needs

Targeted Care Management Services for Recipients

- Telephonic, Home Visits, PCP Visits
- Strengthen link to Medical Home
- Facilitate self-management
- Disease Management, prevention, risk reduction
- Coordinate services
- Identify and link with community resources
- Transitional Care

COMPONENTS AND GOALS OF TRANSITIONAL CARE

	Medication Management	Self Management Notebook	Follow-Up	Red Flags
GOALS	Patient/CG know about medications and have a medication management system in place; include Med Rec	Maintain a Self-Management Notebook (SMN) to facilitate communication and ensure continuity	Patient schedules and completes follow-up visit with the PCP/ Specialist	knowledge about symptoms that indicate their conditions are getting worse and what to do

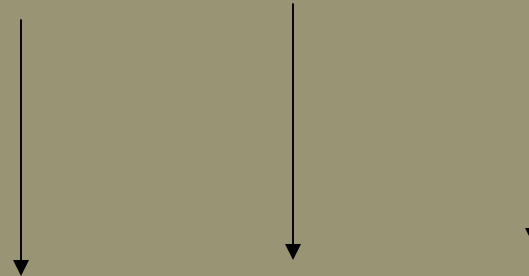
Modified Coleman guidelines

Chronic Care Model

INFORMED
ACTIVATED
PATIENT

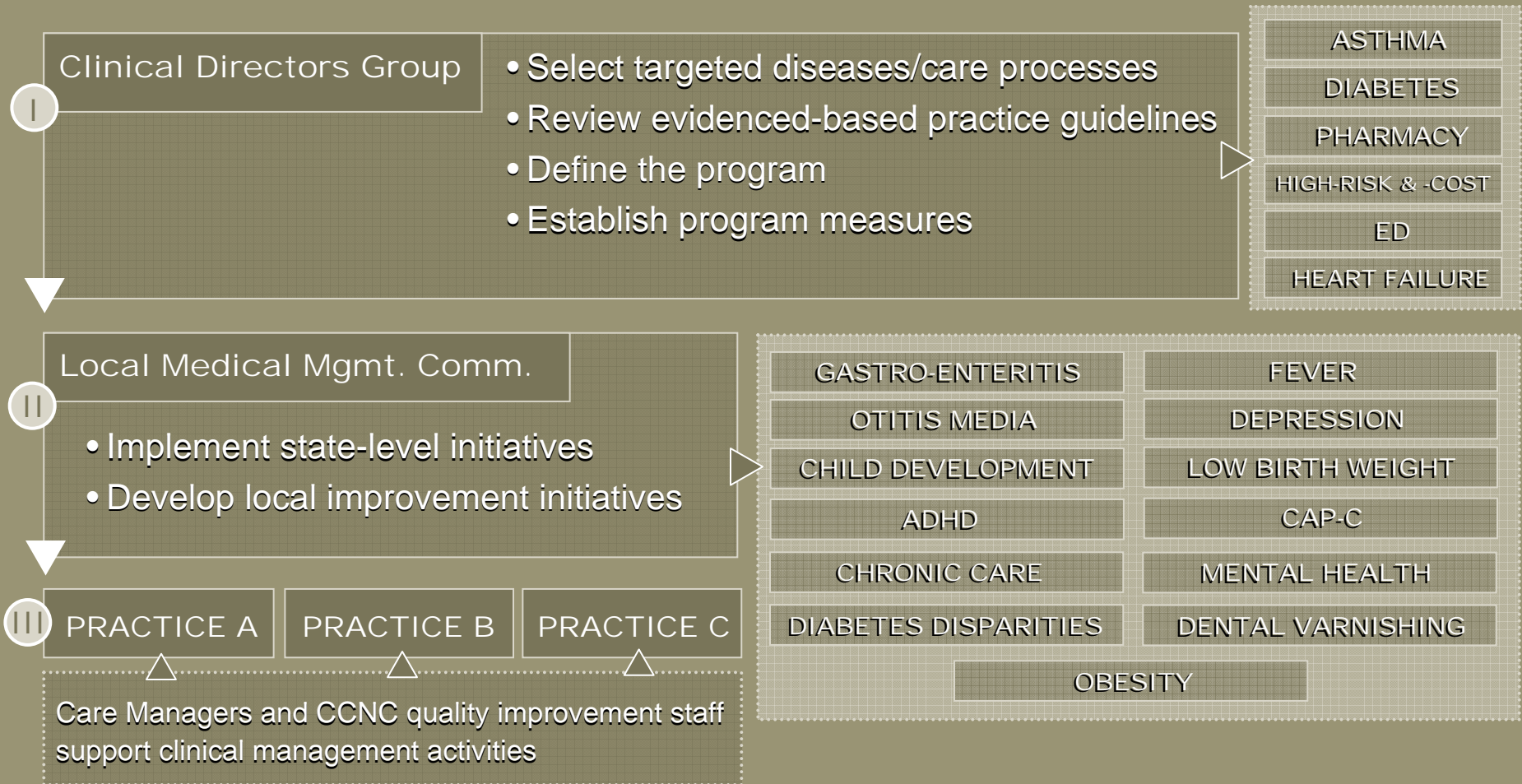


PREPARED
PROACTIVE
TEAM



IMPROVED OUTCOMES

Managing Clinical Care



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)

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.

**CCNC received the 2007
Annie E. Casey Innovations
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Kennedy School of
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