

Community Care of North Carolina

2011 Overview

March 16th, 2011



Community Care
of North Carolina

Medicaid challenges



- Lowering reimbursement reduces access and increases ER use
- Reducing eligibility or benefits limited by federal “maintenance of effort”; raises burden of uninsured on community and providers
- The highest cost patients are also the hardest to manage (disabled, mentally ill, etc.) — Community Care has proven ability to address this challenge
- Utilization control and clinical management only successful strategies to reining in costs overall

Community Care Provides NC with:

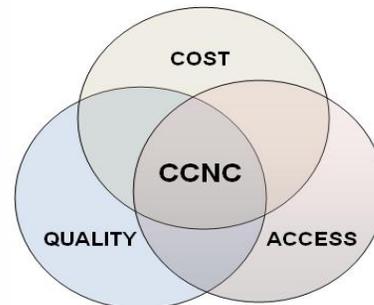


- Statewide medical home & care management system in place to address quality, utilization and cost
- 100 percent of all Medicaid savings remain in state
- A private sector Medicaid management solution that improves access and quality of care
- Medicaid savings that are achieved in partnership with – rather than in opposition to – doctors, hospitals and other providers.

Key Tenets of Community Care



- Public-private partnership
- “Managed not regulated”
- Community Care is a clinical partnership, not just a financing mechanism
- Community-based, physician-led medical homes
- Cut costs by delivering greater quality and efficiency
- Providers who are expected to improve care must have ownership of the improvement process



Community Care: “How it works”



- Primary care medical home available to 1.1 million individuals in all 100 counties.
- Provides 4,500 local primary care physicians with resources to better manage Medicaid population
- Links local community providers (health systems, hospitals, health departments and other community providers) to primary care physicians
- Every network provides local care managers (600), pharmacists (26), psychiatrists (14) and medical directors (20) to improve local health care delivery

How it Works



- The state identifies priorities and provides financial support through an enhanced PMPM payment to community networks
- Networks pilot potential solutions and monitor implementation (physician led)
- Networks voluntarily share best practice solutions and best practices are spread to other networks
- The state provides the networks access to data
- Cost savings/ effectiveness are evaluated by the state and third-party consultants (Mercer, Treo Solutions).

Community Care Networks



Community Care
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-  AccessCare Network Sites
-  AccessCare Network Counties
-  Community Care of Western North Carolina
-  Community Care of the Lower Cape Fear
-  Carolina Collaborative Community Care
-  Community Care of Wake and Johnston Counties
-  Community Care Partners of Greater Mecklenburg
-  Carolina Community Health Partnership

Legend

-  Community Care Plan of Eastern Carolina
-  Community Health Partners
-  Northern Piedmont Community Care
-  Northwest Community Care
-  Partnership for Health Management
-  Community Care of the Sandhills
-  Community Care of Southern Piedmont

CCS's Care Management Model



- Established presence in each practice
- Care managers know the patients, the community, and the resources that are available
- Care managers connect the dots between patient, physician, specialist, hospital, home health and other community resources
- **GETTING PATIENTS THE CARE THEY NEED WHEN THEY NEED IT**





Transition In Care

- **Hospital Partnerships**
- **Hospital Liaisons**
- **Communication/CMIS/Referrals between networks**
- **Home Visit/Face to face encounters/72 hours**
- **Medication Reconciliation**
- **Transition Care Summary (TCS)**
- **Goal: Provider has the TCS when patient is seen for the post hospital visit**

Medication Reconciliation



Are you aware of your patient's medications?

Obtain a complete list of the patient's current medications upon admission, and compare it to any admission, transfer, and/or discharge orders.

Medication reconciliation involves the following four steps:

1. Upon admission, obtain and document a complete list of the patient's medications, including over-the-counter drugs, vitamins, and herbs.
2. Make sure the medications and doses are appropriate.
3. Compare new medications with the list and document changes in orders.
4. Provide a copy of the reconciled list to the patient and the next provider of care at transfer or discharge.



Reconciling patient medications is a requirement of The Joint Commission's National Patient Safety Goal 8.

- Average 5.1 discrepancies per patient
- Most Common Discrepancies
 - **Unconfirmed Discontinuation** – patient continuing to take medications not prescribed for them at discharge (can potentially lead to additional problems such as therapeutic duplications, otherwise unknown drug interactions and worsening of health status)
 - **Medication Adherence** – patient not taking medication prescribed at discharge or patient non-adherent with chronic medications that would prevent them from going back into the hospital
 - **Medication Dose/Frequency/Duration** – patient medication instructions at discharge and on home assessment do not match (patients may be over/under dosing themselves on medications)

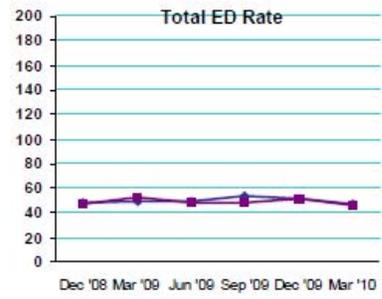
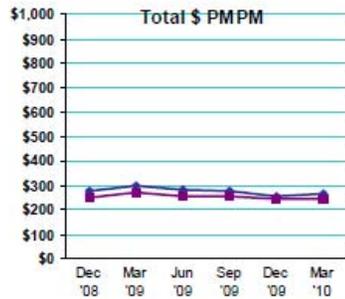
YourPractice Profile

Community Care Peer Review Summary

ACCESS II & III

Name:
Managed Care Provider Type: Community Care of North Carolina
Administrative Entity: Sandhills Community Care Network
PCP Number:
Address1:
Address2:

Time Period: Quarter ending Mar, 10
Peer Group:
Avg. Monthly Enrollment: 4684
Eligibility 0 - 21: 4674
Eligibility > 21: 10



Utilization	PCP Qtr End 9/09		PCP Qtr End 12/09		PCP Qtr End 3/10		Peer	
	Rate	PMPM	Rate	PMPM	Rate	PMPM	Rate	PMPM
PCP	583	\$47	655	\$50	671	\$49	393	\$25
Specialist	101	\$14	84	\$12	90	\$12	115	\$14
Hospital Inpatient	2	\$11	3	\$10	3	\$11	3	\$14
Hospital Outpatient	116	\$28	94	\$23	102	\$21	120	\$23
Pharmacy	821	\$59	860	\$61	756	\$62	560	\$46
ED Total	54	\$15	51	\$14	47	\$13	46	\$13
ED Non emergent	32	\$8	29	\$7	30	\$7	29	\$7
Labs	70	\$3	51	\$2	56	\$2	26	\$1
X-Rays	1	\$1	2	\$1	1	\$1	1	\$1
Out-patient Mental Health	105	\$39	73	\$24	89	\$28	159	\$41

Disease Management	PCP Qtr End 9/09	PCP Qtr End 12/09	PCP Qtr End 3/10	Peer
Asthma				
Case Count	301	313	325	-
Case Rate	6.74%	6.75%	6.90%	-
ED Asthma Visits	5	3	0	N/A
IP Asthma Visits	1	1	1	N/A
Diabetes				
Case Count	17	14	15	-
Case Rate	0.38%	0.30%	0.32%	-
Eye Exam (15 mo reviewed)	70.59%	57.14%	53.33%	50.90%

Pharmacy



- Preferred Drug List (PDL)
- Controlled Substance Reporting Site
- Promotion of generic prescribing
- Consultation to providers
- Clinical Pharmacist - MRH, SMH, SRH and PMC
- E-prescribing



Focused Initiatives



- Chronic Care Program (ABD population)
- HealthNet of the Sandhills
- 646 Medicare Demonstration Project
- Behavioral Health Initiative
- Pregnancy Medical Home
- Care Coordination for Children (CC4C)
- HealthCheck
- Assuring Better Child Development (ABCD)
- CHF – Telehealth
- Hypertension - Telephonic Care Management
- Patient Centered Medical Home (PCMH)
- SCCN Health Information Exchange (HIE)
- Palliative Care



Community Care's Informatics Center



- Care Management Information System (CMIS)
- Pharmacy Home
- Quality Measurement and Feedback Chart Review System
- Informatics Center Reports on prevalence, high-opportunity patients, ED use, performance indicators
- Provider Portal

Provider portal in action

<https://portal.n3cn.org/>



Provider Portal

Welcome to the Community Care of North Carolina Provider Portal!

The Provider Portal application is provided to improve patient care and care coordination for NC Medicaid recipients. Providers in primary care practices, hospitals, and other settings may use this secure portal to access care team contact information, visit history, and pharmacy claims history for their Medicaid-enrolled patients. Population management and quality reporting is also available for CCNC practices.

[Video: Using Provider Portal at point of care - 3 cases in 6 minutes](#)

For more information about Community Care of North Carolina, please visit the [CCNC website](#)

To inquire about access to the Provider Portal or if you need assistance, please contact your [local CCNC network](#)

Forgot password? [Click here](#)

First time logging in? [Click here](#)

Pre-register a new user? [Click here](#)

[Video: Provider Portal pre-registration](#)

This application is designed to work best with a minimum screen resolution of 1024 X 768 and Internet Explorer version 6.x or higher.

If you are using Mozilla Firefox browser, please add IE (Internet Explorer) Tab. [Click here for instructions](#)

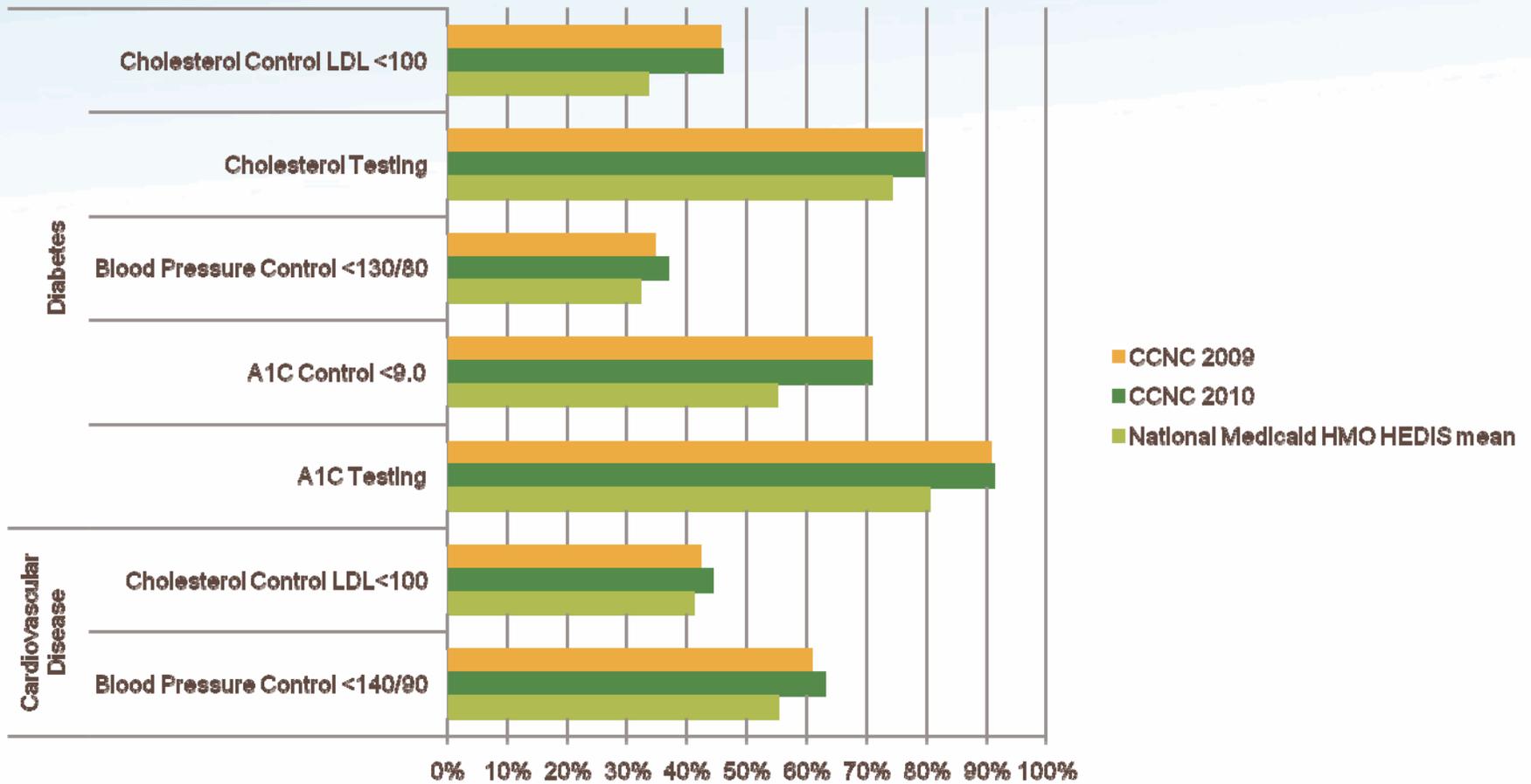
North Carolina Drugs of Choice information is now available. [Click here for NC DOC list](#)

System-wide results

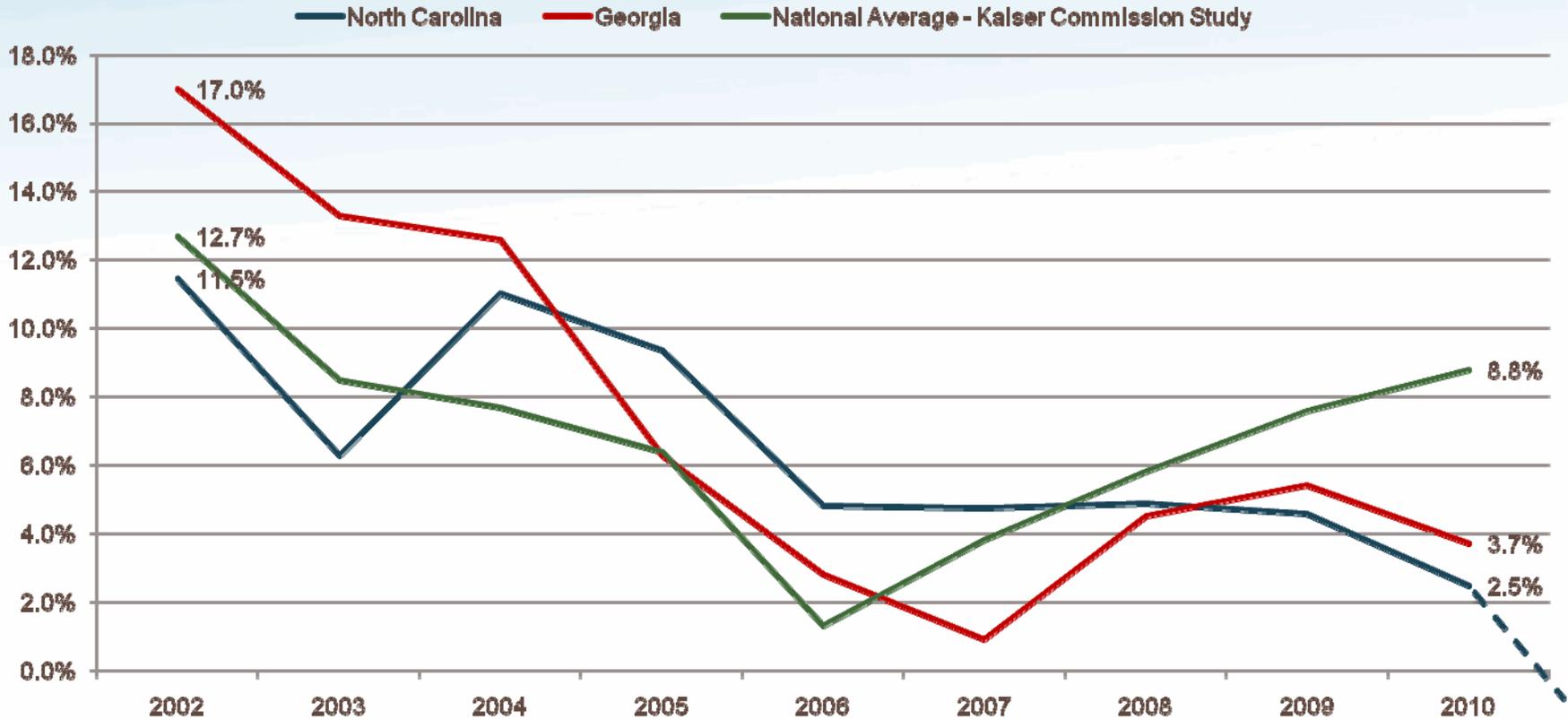


- Community Care is in the top 10 percent in US in HEDIS for diabetes, asthma, heart disease compared to commercial managed care.
- More than \$700 million in state Medicaid savings since 2006.
- Adjusting for severity, costs are 7 % lower than expected. Costs for non-Community Care patients are higher than expected by 15 percent in 2008 and 16 percent in 2009.
- For the first three months of FY 2011, per member per month costs are running 6 percent below FY 2010 figures.
- For FY 2011, Medicaid expenditures are running below forecast and below prior year (over \$500 million).
- According to Treo analysis, Community Care's work has meant that more than \$1 billion in Medicaid costs have been avoided between 2007-2009.

Quality HEDIS Measures



Annual Percent Change in Medicaid Expenditures: 2002-2010



CCNC expands across North Carolina starting in 1998. Between 2002 and 2005 expansion increased from 17 to 93 counties. By 2007, all 100 counties were under the CCNC umbrella organization.

Georgia implements managed care

CCNC implements ABD Program

Building on Success



Other payers and major employers are interested in benefit's of CCNC's approach

- Medicare 646 demo (22 counties) caring for Medicare patients
- Beacon Community (3 counties), all payers
- Multi-payer primary care demo (7 rural counties) Medicare, Medicaid, Blue Cross and Blue Shield of North Carolina, State Employees Health Plan
- New major employer initiative (40,000 patients)

Next Steps for Community Care



- Build out Informatics Center and Provider Portal as a shared resource for all communities
- Add specialists to CCNC
- Develop budget and accountability model for NC Medicaid
- Implement additional multi-payer projects
- Work with NCHA, IHI on best practices for reducing readmissions
- Facilitate Accountable Care Organizations (ACOs)