



COMMUNITY CARE OF NORTH CAROLINA

# Community Care At a Glance

Leadership Works • Partnership Works • Innovation Works ◀

## ▶ Overview

*Under the Community Care program (formerly known as Access), North Carolina is building community health networks that are organized and operated by community physicians, hospitals, health departments and departments of social services.*

*By establishing provider networks, the program is putting in place the local systems that are needed to achieve long-term quality, cost, access and utilization objectives in the management of care for Medicaid recipients.*

*Fourteen networks with more than 1,380 practices across North Carolina are working with their local health departments, hospitals, and social service agencies to better manage the care of 970,558 Medicaid & NCHC Enrollees.*

## ▶ Approach

How does the Community Care approach differ from other efforts? Community Care of North Carolina:

- Works directly with those community providers who have traditionally cared for North Carolina's low-income residents.
- Builds private and public partnerships where community providers can work together to cooperatively plan for meeting patient needs and where existing resources can be used most efficiently.
- Conveys responsibility for managing the care of a specific Medicaid population to a community network.
- Places responsibility for performance (and improvement) in the hands of those who actually deliver the care.
- Ensures that all funds are kept local and go to providing care.
- Puts in place the local networks that can manage all Medicaid patients and Medicaid services, and can address larger community health issues.

## ▶ Savings

A recent actuarial study from Mercer Human Resource Consulting Group found, when comparing what the access model would have cost in SFY07, without any concerted efforts to control costs, the program saved approximately \$147 million.

## ▶ Network

Access Care (150 provider sites including UNC)

Access II Care of Western NC (Buncombe, Henderson, Madison, Mitchell, McDowell, Polk, Transylvania and Yancey)

Access III of Lower Cape Fear (Bladen, Brunswick, Columbus, New Hanover, Onslow and Pender)

Carolina Collaborative Community Care (Cumberland)

Carolina Community Health Partnership (Cleveland and Rutherford)

Northwest Community Care (Davie, Forsyth, Stokes, Surry, Wilkes, and Yadkin)

Community Care Partners of Greater Mecklenburg (Anson, Mecklenburg, Union)

Community Care of Wake and Johnston Counties (Wake, Johnston)

Community Care Plan of Eastern Carolina (Beaufort, Bertie, Camden, Carteret, Chowan, Craven, Currituck, Dare, Duplin, Edgecombe, Gates, Greene, Halifax, Hertford, Hyde, Jones, Lenoir, Martin, Nash, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Washington and Wilson)

Community Health Partners (Gaston and Lincoln)

Northern Piedmont Community Care (Durham, Franklin, Granville, Person, Vance and Warren)

Partnership for Health Management (Guilford, Randolph and Rockingham)

Sandhills Community Care Network (Harnett, Hoke, Lee, Montgomery, Moore, Richmond and Scotland)

Southern Piedmont Community Care Plan (Cabarrus, Rowan and Stanly)

## ► Community Care Networks

- Non-Profit Organization Comprised of Safety Net Providers
- Steering and Medical Management Committees
- Receive \$3.00 PMPM from the State
- Manage Care of Medicaid Enrollees
- Hire Case Managers/Medical Management Staff

## ► Key Elements

Community networks are putting into place the management tools that programs need to achieve improved performance:

- Implementing Best Practices
- Implementing Disease Management
- Managing High-Risk Patients
- Managing High-Cost Services
- Building Accountability

## ► Clinical Improvement Initiatives

Physician leaders from participating networks come together to design and develop clinical improvement initiatives:

- Asthma Disease Management
- Congestive Heart Failure Disease Management
- Diabetes Disease Management
- Emergency Room Initiatives
- Pharmacy Management Initiatives
- Case Management of High Risk / High Cost Patients

## ► Pilot Initiatives

- Aged, Blind, Disabled/Chronic Care
- Health Choice
- COPD
- Special Needs Children

## ► Performance and Results

### Asthma Disease Management 2000-2005

- All practices adopted best practice guidelines from National Institute Health with expansion to 700 additional practices from 2002-2004.
- 28% increase in flu vaccines
- Over 90% of staged asthma patients on appropriate preventive medication.
- The Sheps Center Report estimated the asthma disease management program saved \$3.5 million from 2000-2002 from lower inpatient admissions and emergency department visits.

### Diabetes Disease Management 2000-2004

- 10% increase in referrals for eye exams.
- 62% increase in flu vaccines.
- Continued Care visits are at 94%. Improved 7% since baseline.
- BP at every cc visit at 96%. Improved 8% since baseline.
- Foot exams are at 71%. Improved 18% since baseline.
- Lipid testing is at 77%. Improved 11% from 2004-2005.
- All practices adopted best practice guidelines from American Diabetes Association.
- The Sheps Center Report estimated the diabetes disease management program saved \$2.1 million from 2000-2002.

### Emergency Department Initiative 2001 – 2002

- Care management follow-up, outreach and education on all enrollees with 3 or more visits to the ED in a six month period of time
- 30% lower per member per month cost
- 13% lower ED rate

### Pharmacy Management Initiatives

#### Prescription Advantage List (PAL)

- 22% lower expenditures in PAL Pilot (\$640,000 actual savings from February – March 2003)
- Rolled out statewide November 2003
- In 2004, cost savings from over-the-counter (OTC) prescribing estimated at \$1.7 million

#### Nursing Home Polypharmacy

- Patients Reviewed – 9,208
- Recommendations Made – 8,559 (74% implemented)
- Physician / pharmacist team review drug regime and make recommendations to change prescriptions
- \$6 million in cumulative savings since November 2002 (savings of \$9 million estimated for 2004)

### Case Management of High Cost/ High Risk

- Care management follow-up, outreach and education on recipients with \$25,000 or more in Medicaid expenditures in six months period of time.
- Defining process to use DxCG predictive modeling to target individuals at greatest risk based on historical utilization and diagnoses.