

Introduction

POLICY FORUM: *Community Care of North Carolina*

Health reform is on the minds of most policymakers and virtually every individual involved in the United States health care system. In a way, North Carolina has already reformed its health care delivery system and continues to lead in the development of a coordinated system of care. We have done this with several major initiatives dating back to the 1970s when the state embraced a form of regional communication and training for health care workers in the Area Health Educations Center (AHEC) program. We then developed a mechanism to improve access to care through rural health clinics and increased support for community health centers. In subsequent years, the state regionalized specialty care in perinatal and trauma services. Most recently, we have created a prototype of an “accountable care organization” (ACO) in Community Care of North Carolina (CCNC) which some call a “medical home” system of care. This issue of the *North Carolina Medical Journal* focuses on this last innovation, CCNC; but to understand how it has emerged and why it works, we must first understand its context and background as well as recognize its limitations and its promises.

We can trace North Carolina’s medical home movement back to the 1960s when Jim Bernstein, the founding director of the North Carolina Office of Rural Health, developed a vision for coordinated, community-based primary care in the form of rural health clinics that made use of underutilized nurse practitioners. The clinics were incorporated into networks of practitioners through the Office of Rural Health and the new AHEC system. The training of physicians, nurse practitioners, physician assistants, and other health professionals for these clinics was facilitated by the AHEC that linked professional schools to communities and community practices. North Carolina also tried to incorporate a staff model managed care system to broaden the coordination of care beyond rural and low income populations. At the same time this structure was emerging, we began to hear about a new form of practice, the medical home. The term medical home was initially used by pediatricians, and Dave Tayloe of Goldsboro, now president of the American Academy of Pediatrics, was one of its earliest and most ardent promoters.

All of these elements created fertile ground for a new way for the state to pay for the care of Medicaid recipients using a combination of capitated payment among linked clinics that could depend on community-based support to train clinical staff. The Access projects, which are discussed in detail in this issue of the *Journal*, were the initial result. Systems of care were created based on a coordinating clinical function financed by a small per-enrollee fee. The prior conditions of vision, network, communications, and willingness of practitioners to participate were matched with political will to support this evolutionary change.

That political support became an increasingly important stimulus when the promise of costs savings was tied to the enlargement of the Access program into a statewide Community Care program for all Medicaid patients. The idea of statewide coordinated care was an evolution in the work of Bernstein and others. Their initial task was to create the clinical capacity to ensure access, and the development of rural health clinics and community health center networks did that. Nonetheless, the measures of population health status continued to lag behind those in wealthier, more urban communities. Costs savings and improved care were part of a promise made by Jim Bernstein and his staff that the program would deliver superior care at lower costs—in other words, to be an “accountable care organization,” the very thing we now hear being promised as part of national health reform.

When that promise is made for the nation, we have to caution the architects of reform that the long process of development must include the regional framework that facilitates communication, training, and coordination; that the leaders must have a vision of a systematic approach to medical care; and that

health care professionals have the experience of working together and understanding the various roles and relationships that can make medical homes work. This has been a 40-year process in North Carolina, and the conditions that prevail in this state which have made health reform possible are not found everywhere in the nation.

The CCNC program has received deserved praise but, equally important, it has had to prove its merit and effects in a context of learning of what does and does not work. The tone of the articles in this issue of the *Journal* is largely positive, speaking to the successes of the program. But the program came into being because the outcomes of many prior programs were not advancing toward improvement. CCNC took as its charge the improvement of population health and the realization of population-based health care costs because that was the next step in the process of improving access while ensuring quality. The program must continue to benchmark itself against the best care available and the most optimistic population health improvements, a task that the founders of the system would not shrink from.

The CCNC program is being held up as a model for the nation. However, it should be viewed more as an example of what can be accomplished rather than as a template for change. The elements that were brought together to create the conditions that can make a medical home system work are much broader than just the change in payment—there is an entire mindset that has to be built. The CCNC program enjoyed strong initial success due, in large part, to the efforts of enthusiastic early adopters. Many of the estimates of the cost-savings for the program are based on those early and optimistic results. The bottom line cost-savings are harder to estimate and may not be of the magnitude that are often publicized.

The true test of the medical home in North Carolina is yet to come as it expands to take on more complex and costly patients. These “dual eligible” patients—those people who are eligible for both Medicare and Medicaid—will test the resilience of the network and its participants if the system does receive final permission to fold these people in. We also need to understand how we are affecting the entire life course of care for patients through specialty and long-term care. The unfortunate “hydraulics” of medical costs, where pressure to reduce in one sector only creates expansion in another, is a real concern, and we need to be aware of that potential and be able to understand it if it occurs.

It is difficult to write cautionary words about the CCNC program when it is so popular and so apparently successful. But past success was built by learning both the positive and negative lessons as we moved forward.

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