

A Generalist's View of Community Care of North Carolina

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Community Care of North Carolina (CCNC) and the ongoing efforts of the Division of Medical Assistance to provide for the citizens of North Carolina through the system that has evolved to date is the most practical and well thought-out public collaborative that I have been a party to in my almost 27 years of general internal medicine practice. The local, regional, and national acclaim it has received also bears testament to this fact.

The success of the statewide effort is due to the organization's understanding of the essential elements of a patient-centered system for delivering care. This fundamental understanding is what attracted me most to this effort. The limitations of small primary care practices are not a secret. The prohibition of cost makes it all but impossible for a small practice to hire a multidisciplinary team to include a quality improvement officer, practice case manager, social worker, mental health worker, pharmacist, information technology expert, and diversity coach.

CCNC recognized that health care is delivered where patients live and work and therefore focused on a model

that could meet the needs of a patient-centered practice where the patient and the provider are in the community. With the collective will of the state legislature, the input of the providers of primary care, and a strong and responsive central office leadership team, I found an organization that was resourceful, resilient, innovative, and willing to extend itself to community providers. This support includes expertise and resources both technical and financial. Both are much needed.

CCNC's track record for improving quality along with both patient and provider satisfaction has been proven to me. Like so many of us in private practice, CCNC also wrestles with the fiscal constraints and realities encountered in the provision of health care in North Carolina. It has not, however, lost sight of the goal of very good, cost-effective, and value conscious health care. I will continue to participate and encourage others to do so as well.

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of the private practices, the medical school practice joined the night clinic and actually provided space and manpower for the expansion. In its first year, the after hours clinic led to a 17% decrease in pediatric emergency room utilization with a rough estimate of cost-savings to North Carolina Medicaid of \$400,000 per year. In smaller towns with fewer pediatricians, this model will not be easy to replicate.

Telephone triage by trained nurses using evidence-based protocols also helped provide information to our parents when a child became sick or injured. Some networks financially supported these triage lines by funding a portion of the cost for the practice based on the numbers of North Carolina Medicaid patients in the practice.

Our network also looked at ancillary services for our Medicaid patients. North Carolina Medicaid requires that the primary care physician authorize these services, a task that we are not well prepared to do. Requests for payment for physical therapy, occupational therapy, and speech therapy were reviewed by a knowledgeable physician who recommended authorization or discontinuance to the pediatrician in the medical home. While we all felt this was a valuable service, the grant from the state funding this position was not renewed.

As pharmacy costs escalated, we developed a voluntary drug formulary called the prescription advantage list (PAL). For the first time, practicing physicians could know which drugs were more costly for their Medicaid patients. This was especially important for pediatric practices where there are no co-pays for prescriptions.

Carolina Access Becomes Community Care of North Carolina

In the year 2000, a new Governor and a new Secretary of North Carolina's Department of Health and Human Services arrived. By this time, internal audits of Carolina Access could show cost savings in the tens of millions of dollars. The new Secretary mandated that Carolina Access III become a statewide program, now called Community Care of North Carolina.

With CCNC, we realized that we have a truly unique asset in health care: a network of primary care medical homes statewide that can serve as a template for statewide innovation. We also have a strong partnership with our state leaders who are responsible for the North Carolina Medicaid program. The effectiveness of this partnership is exemplified by the over the counter (OTC) prescription program developed within a three month period of time when Prilosec and Claritin became available OTC. The doctor could now write a script for those OTC drugs for a Medicaid patient. Again, the state saved millions. We also exposed a weak link in our primary care based system; some specialists were not informed and continued to prescribe the more costly brand name products.

What about caring for children with special health care needs? These complex kids were a strong driver in the development of the pediatric medical home concept because of the fragmentation of care between PCPs and multiple specialists. A grant funded Improving Pediatric Access through Collaborative Care (IMPACC), a program that used