

Torlen Wade

While it is commonly known among health leaders that North Carolina has built a statewide medical home and care management system for its Medicaid recipients, there is limited understanding of how North Carolina arrived at where it is today. Community Care of North Carolina (CCNC) did not rise up as a finished vision but rather has evolved over 25 years. Over those 25 years there have been three groups of organizations involved at every step of the way:

- North Carolina Department of Health and Human Services (Office of Rural Health and Community Care and the Division of Medical Assistance)
- North Carolina Foundation for Advanced Health Programs
- Kate B. Reynolds Charitable Trust, The Duke Endowment, Blue Cross Blue Shield of North Carolina Foundation, and other national foundations

Key Development Steps in the Evolution of Community Care

1983-1985

In an effort to improve participation of primary care physicians in Medicaid and to reduce inappropriate use of the emergency room, the North Carolina Foundation for Advanced Health Programs, in partnership with the North Carolina Division of Medical Assistance, submitted a proposal to the Kate B. Reynolds Charitable Trust to pilot North Carolina's first effort at developing "medical homes" for Medicaid recipients. The Foundation received a grant of \$63,566 to work with health organizations in Wilson County to plan and develop the Wilson County Health Plan. Under the Wilson County Health Plan, systems and processes were designed and implemented that would enable Wilson County Medicaid recipients to enroll with primary care providers and group practices who would assume responsibility for providing and coordinating enrollee care.

1986-1988

During the implementation phase of the Wilson County Health Plan, 1,500 Medicaid recipients in Wilson County became members of the plan. During the first year of operation, the average number of hospital days per Medicaid

recipient declined by 58%. The net savings to the state and Wilson County was \$300,000 in that 12-month period. The Kate B. Reynolds Charitable Trust contributed \$49,434 to this implementation phase.

1989-1991

With the success of the Wilson County project and with encouragement and a \$631,000 grant from Kate B. Reynolds, the North Carolina Foundation for Advanced Health Programs again joined with the Division of Medical Assistance to propose spreading the medical home concept to additional North Carolina counties with the goal of building a statewide medical home program.

From 1989-1991, the medical home program, which became known as Carolina Access, secured a federal waiver, developed state support and systems, and expanded the new program to 12 counties (Beaufort, Burke, Durham, Edgecombe, Greene, Henderson, Madison, Moore, Nash, Pitt, Wayne, and Wilson). By May 1993, 45,649 Medicaid recipients had enrolled and 469 primary care physicians were participating in the program.

1992-1997

Based on the success of the 12 county expansion, the Division of Medical Assistance, with support from the General Assembly and the Centers for Medicare and Medicaid Services, began, in 1992, to spread the Carolina Access program statewide. By the end of 1997, Carolina Access was in place in 99 out of 100 North Carolina counties.

1997-1998

In the mid-90s there were serious proposals circulating in Washington, DC that would shift more of the financial responsibilities for the Medicaid program to the states. With this looming prospect, the Secretary of the Department of Health and Human Services asked the Foundation to join with the Division of Medical Assistance and other organizations to plan for North Carolina's next generation Medicaid managed care program. The goal of the effort would be to build on the popular Carolina Access program and to create a medical home model that could better improve the quality and cost-effectiveness of care. In designing the next phase, the Foundation and its partners would work with state and local leaders. The plan developed was to focus on strengthening

Torlen Wade is the executive director of NC Community Care, Inc. He can be reached at [torlen.wade \(at\) ncfahp.org](mailto:torlen.wade@ncfahp.org).

the ability of the primary care physician to improve care and care outcomes by introducing four new elements to Carolina Access:

- Formation of networks
- Introduction of population management tools
- Case management and clinical support
- Data and feedback

Out of this design and development effort emerged the Access II and III programs, which would later become known as Community Care of North Carolina. During phase one, nine networks were formed and program-wide technical assistance and management information system support was put in place. Kate B. Reynolds contributed \$358,000 to the development of the Access II and III programs.

1999-2007

The establishment of Community Care and its medical home and care management system became North Carolina's primary vehicle for improving care and care outcomes for Medicaid recipients. During this time, more than 785,000 Medicaid recipients were enrolled and more than 3,000 primary care physicians were participating.

2007

In addition to shifting the focus of Community Care to patients with chronic illnesses, the program also wanted to focus on prevention. With encouragement and a \$130,900 grant from Kate B. Reynolds, the Community Care Program established a Prevention Workgroup. The workgroup, after reviewing data and considering a number of program options, elected to develop two prevention initiatives: childhood obesity and stroke prevention. Both initiatives received the full endorsement of Community Care's Clinical Directors Group and nine networks requested to participate in one of the prevention initiatives. Core elements, tools, and implementation activities were developed.

2008-2009

A Kate B. Reynolds grant of \$381,000 supported the proposed implementation phase of the prevention program.

2008

CCNC received funding of \$250,000 from the Blue Cross and Blue Shield of North Carolina Foundation to provide technical assistance and incentives to encourage primary care providers to adopt e-prescribing technologies in their practices.

2008-2009

CCNC developed a telehealth monitoring initiative to improve health outcomes in high risk Medicaid recipients with congestive heart failure with the help of \$250,000 in funding from The Duke Endowment.

2006-2009

Community Care, in partnership with the North Carolina Department of Health and Human Services, developed the Integrated, Collaborative, Accessible, Respectful, and Evidence-Based Care Initiative (ICARE) to improve mental health, developmental disabilities, and substance abuse services provided to Medicaid enrollees. This initiative helps increase the capacity of primary care providers to provide evidence-based care, while creating and strengthening linkages between primary care practices and behavioral health practitioners. The Kate B. Reynolds Charitable Trust (\$653,000) and The Duke Endowment (\$2,096,000) provided funding to support training for primary care providers, create linkages to Local Management Entities, and develop collocation models. (ICARE is described more fully in the May/June 2007 issue of the *North Carolina Medical Journal*.)

The Role of National Foundations

CCNC, through the Foundation for Advanced Health Programs, also received support from other national foundations, including the Annie E. Casey Foundation, the Center for Health Care Strategies, and the Commonwealth Fund. Funds from The Commonwealth Fund are being used to help duplicate CCNC models in other states. **NCMJ**