

Community Care of North Carolina in 2013

L. Allen Dobson, Jr., Denise Levis Hewson, Torlen L. Wade

Community Care of North Carolina has transformed the delivery of health care to the Medicaid population through its physician-led integrated system of networks and medical homes that are improving the quality and containing the costs of care delivered to the state's most vulnerable and needy citizens.

Over the past year, much attention has been focused on Medicaid at both the state and national levels. For most states, Medicaid represents both an opportunity and a challenge. As enrollments increase, states grapple to develop a strategy that will bring both quality and efficiency to a public program that represents an ever increasing part of state budgets. The national Medicaid dialogue explores such concepts as patient-centered medical homes, health homes, accountable care organizations, payment reform, and care coordination.

In 2013, Community Care of North Carolina (CCNC) will reach its 15th year of operation as a statewide system of medical homes and local-community not-for-profit networks of physicians, hospitals, social service agencies, and other community provider organizations. These networks have been organized by North Carolina providers in order to better serve Medicaid patients in the state. CCNC networks and the Office of Rural Health and Community Care's HealthNet program for the uninsured work together closely at the community level. CCNC's web-based informatics center and care management information system support both programs, so meaningful information can follow uninsured individuals across providers and payers as they move in and out of Medicaid. CCNC is currently serving approximately 1.4 million citizens (including 144,000 Health Choice for Children enrollees and 90,000 uninsured residents) through 14 regional nonprofit networks of 1,600 medical homes and 5,500 physicians. CCNC has become a national model of a private-public partnership between a state and its health care providers—a partnership that uses a patient-centric population-management approach and is physician-led and community-based. The principles of CCNC are arguably the same ones that are being employed across the country to improve patient-centered care, improve health outcomes, and reduce costs.

Over the past 5 years, CCNC has demonstrated both significant improvements in quality and reductions in Medicaid expenditures. CCNC outperforms Medicaid managed care

plans on the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) quality measures for asthma, diabetes, hypertension, and cardiovascular disease [1]. Between 2007–2010, North Carolina had the lowest average annual growth in Medicaid spending of any state in the country [2].

CCNC, which links each patient to a primary care practice, actively seeks to engage the highest-cost and highest-risk individuals to participate in the program. These are the patients for whom CCNC's population-management interventions will have the greatest impact. Sustainable savings come primarily from learning to deliver care in smarter, more coordinated ways that are patient-centric and community-based. Providing high-quality team-based care to the right patient at the right time, in the most appropriate setting, continues to result in positive outcomes.

What Makes CCNC Different?

CCNC is led by local physicians who provide care to North Carolina's Medicaid recipients, along with other health providers in the community. This bottom-up governance has been the key to getting buy-in at the practice level. With this buy-in, CCNC has begun to make significant changes in the way that the community-based health care delivery system functions. CCNC is built on a foundation of every patient having a "medical home." This approach identifies a primary care physician, nurse practitioner, or physician assistant who assumes responsibility for delivering and overseeing the care for a panel of patients over the long term.

The 14 local CCNC networks across the state provide wraparound support to primary care practitioners and their Medicaid patients. More than 800 care managers, 30 medical directors, 20 clinical pharmacists, and 10 local psychiatrists provide support that covers all urban and rural areas of the state. In addition, the networks hire nonlicensed personnel to support health care teams and population management efforts. These are local people managing local patients—and driving improvements in the system. The physicians are engaged in creating standardized expecta-

Electronically published March 18, 2013.

Address correspondence to Dr. L. Allen Dobson, Jr., North Carolina Community Care Networks, Inc., 2300 Rexwoods Dr., Raleigh, NC 27607 (adobson@n3cn.org).

N C Med J. 2013;74(suppl):S12-S15. ©2013 by the North Carolina Institute of Medicine and The Duke Endowment. All rights reserved. 0029-2559/2013/74S02

tions regarding the implementation of evidence-based best practices. They lead local teams and decide how to collaborate to get the best results.

Efforts to improve care and to reduce unnecessary expenditures are owned by those who directly care for patients—physicians, nurse practitioners, and physician assistants, with support from care managers and other members of the care team. CCNC care managers know the patients, the community, and the resources that are available locally. Care managers “on the ground” connect the dots between the patient, the primary care practitioner, specialists, hospitals, providers of home health assistance, and other community resources. This wraparound support emphasizes the various responsibilities that health care professionals and organizations have to their patient population. Those responsibilities include informing enrollees about their health, sharing resources and expertise, addressing medical and social needs, and providing and coordinating needed health care services. Managing a population involves more than just the delivery of physical health care services; providers are also required to address social, mental health, and community issues that may impact health and medical care. Simply put, population management recognizes the social and environmental factors that affect an individual's health status.

The state of North Carolina and CCNC identify clinical priorities based on the incidence of a condition, the cost of the care that is available for it, and its amenability to specific health interventions. CCNC's informatics center provides quality and care management data to networks and practices. Physicians get regular performance and patient-specific feedback that helps to drive improvements in the care they deliver. An essential component has been stratifying the CCNC population to identify (and track) those patients who will benefit the most from population-management interventions. As part of its population-management approach, CCNC does the following things: it works to ensure that every patient has a medical home and understands the value of a medical home; it analyzes the health care needs and experiences of the enrolled population, and it defines subsets of the population that may need and benefit from population-management support and interventions (care and disease management); it develops local care-management initiatives and supports, and it utilizes and organizes community resources to best serve the population; it tracks and evaluates program performance and adjusts program initiatives accordingly; it ensures that patients receive appropriate preventive screenings; and it supports healthy lifestyles and provides self-management coaching.

Over the years, CCNC has, with its partners, implemented integrated care management strategies that address the following issues: chronic diseases and how best to care for them, evidence-based best practice guidelines, pharmacy management, emergency department utilization, prevention and health promotion, transitional support, palliative care, and high-cost or high-risk patients, including

high-risk obstetrics patients. The challenge for a successful population-management approach is how to determine which subsets of the population will benefit from the targeted interventions. Identifying those who will benefit most from the program's services is an ongoing process. CCNC's population-management approach builds on its patient self-management component through member education and care-management support. When implemented successfully, this approach equips individuals with chronic conditions with the ability to manage them more effectively, gradually lowering the percentage of high-risk and high-cost patients in the population and reducing the demands on the care system.

An Example of Effective Collaboration: Transitional Care

Recently CCNC, working with its partner physicians and hospitals, identified an opportunity to reduce unnecessary readmissions. Successful pilot projects and research studies have demonstrated that readmissions can be reduced with targeted interventions that improve the care processes [3, 4]. In North Carolina, 190,000 Medicaid recipients are admitted to the hospital every year, and 31,000 of those recipients have multiple hospital admissions. Nearly 1 out of every 10 admissions is followed by a readmission within 30 days of discharge. An additional complicating factor is the frequency of cross-hospital traffic: In 23% of cases of readmission within 30 days of discharge, the patient's second admission is to a different facility.

In 2008, CCNC implemented a statewide rollout of a population-based transitional care initiative designed to provide support for enrollees as they transition from one setting to another. The initiative primarily targeted transitions from the hospital to the community. Working with partner hospitals, CCNC identified and implemented several key components of a model for such transitions. Networks were advised to take the following steps: embed care managers in large hospitals with a high volume of Medicaid admissions and discharges; provide comprehensive medication management for patients following their discharge from the hospital; provide patients and their families with face-to-face self-management coaching before discharge from the hospital, or in the home or clinic post discharge; make follow-up appointments for the patient with the appropriate medical home and/or specialist; improve communication with the health care team that is responsible for the patient during hospitalization; and ask for documentation of discharge planning. In addition, CCNC began compiling data on transitional care and provided informatics support to networks to help them collect such data.

In an evaluation of CCNC's transitional care program, patients who received transitional care were statistically significantly less likely than were patients not receiving such care to return to the hospital during the year following discharge. The greatest impact was observed among

patients with complex chronic conditions; for every 1,000 such patients receiving transitional care, an estimated 174 readmissions were prevented within the next year. Findings were relevant even when the analysis controlled for demographic, clinical, and hospital characteristics (CCNC, unpublished data). CCNC, working closely with North Carolina's hospitals, has successfully implemented a robust statewide transitional care program targeting patients with complex chronic conditions.

Strategic Priorities for 2013

For 2013, CCNC's goals are to continue to focus on the state's priorities of improving the outcomes of care while lowering the cost of care. CCNC will now work on expanding clinical management into other areas of the program, increasing provider accountability, reducing variability in care, expanding its networks in order to serve larger populations, enhancing shared informatics resources, and creating budget predictability for the state. In collaboration with the North Carolina Department of Health and Human Services (DHHS), the Division of Medical Assistance (DMA), and CCNC's provider partners, CCNC will be conducting several major initiatives in 2013.

First, CCNC will enter into a new contract with DMA that moves responsibility for program operation and performance from the 14 networks to the central organization. The primary goals of this shift in responsibility are to strengthen consistency in performance across networks and medical homes and to better position CCNC to respond to and meet state priorities. As part of this transition, a smaller, network-balanced CCNC board governance structure has been created to enhance accountability and enable swifter informed decision-making.

In addition, CCNC will work with DHHS and DMA leaders to bring other parts of the Medicaid program under CCNC's clinical management, beginning with those services that have the greatest potential for program savings. And CCNC will work with its health partners, with long-term care and community-based service providers, and with DMA to launch a "dual-eligible" initiative to integrate care for people who are eligible for both Medicare and Medicaid. This initiative, with support from the Centers for Medicare and Medicaid Services, will enable North Carolina to integrate Medicare and Medicaid services and financing in an attempt to improve the care outcomes of more than 200,000 dually eligible beneficiaries. CCNC will also work with state leaders to develop a closer alignment between the clinical services, care management, and analytics of Medicaid and those of the State Health Plan of North Carolina and other state-sponsored health programs. Significant efficiencies, and a greater impact, can be achieved if CCNC assets are utilized and if providers are actively engaged across multiple programs.

CCNC will work with its partners and with state leaders to identify and implement new payment models that promote the achievement of outcome and cost-containment goals by

providers and networks. These models may include budgets, shared savings, and incentive payments or outcome-based payments to primary care physicians and other providers.

CCNC will seek out and enroll specialists who want to work with CCNC and its partners to improve care, quality, and outcomes for the Medicaid population. The organization will also continue to build effective partnerships with local management entities and managed care organizations—and with behavioral health providers, long-term care and home care providers, and community-based providers—to improve the coordination and outcomes of care for Medicaid patients with complex medical, behavioral, and social conditions.

And because meaningful data and analytics are the lifeblood of the care improvement process, CCNC will continue to work with SAS Institute, Treo Solutions, and key academic partners to build the strongest informatics support possible for its providers and networks.

Lessons Learned and Final Comments

CCNC is in continuous quality improvement mode, working with engaged providers and consumers to identify barriers and solutions to health care at the local level. Six lessons have emerged from our experience.

First, it is important to avoid a top-down approach. Those who are expected to be the ones to improve should be given ownership of the quality improvement process. Improving care and care outcomes is a community development initiative in which the opportunity for improvement rests squarely on the ability to engage community providers. Unless those who are expected to improve the processes of care feel ownership for the program, the prospects for lasting advancements are lessened.

Second, you cannot do it alone—you must have partners. If improving care for chronic illness is the focus, then building community partnerships is instrumental to success. Patients with multiple medical and social problems typically require care support, and they also require care plans that coordinate care between providers. This level of performance calls for community providers to work together in a way that rarely happens in most local care systems. Partners must be willing to develop the structures, processes, and resources that can help achieve meaningful and sustainable coordination and integration in the delivery and management of care.

Third, scale is important, but so is local flexibility. The ability to have a flexible local network structure and to develop clinical initiatives that can be scaled statewide requires attention to local variations in health care infrastructure and knowledge of how best to leverage local resources to ensure that patients receive consistent care. While each network has flexibility in how they use their local resources, each network is held accountable to achieve the same performance goals. Responsibility for identifying and addressing outlier performance is also shared across all networks.

Fourth, systems and supports for improvement must be

put in place. Although the improvement process is initially dependent on the commitment of physicians and other community providers to improve care and care processes, actual improvement will be minimal unless systems and supports are built. A major emphasis of the CCNC model has been building, through community networks, the local medical, pharmacy, behavioral, and care management support that patients and physicians must have to improve care and care outcomes for patients with chronic illnesses. There is also a growing recognition that physicians need support, whether from care teams within the practice or from community-based care managers and clinicians. New care support structures are needed to improve the management of chronic illness. Much of this support will need to be provided where patients live and where physicians practice.

Fifth, feedback is essential. You can assemble an impressive roster of clinicians committed to improvement and put in place the systems and supports needed to deliver improvements, but if you have not instituted effective ways to measure improvement and to communicate progress to participants, your prospects for success are dim. Reliable and continuous performance data are absolutely essential to driving the care-improvement process. Data are important for measuring progress. Also, timely and meaningful patient utilization data are essential for physicians and networks trying to enhance the delivery, management, and coordination of patient care.

Sixth, it is insufficient to make changes only to Medicaid. One benefit of North Carolina's Medicaid initiative aimed at changing how care is delivered and managed is that when physicians change the processes of care for their Medicaid patients, they usually apply those changes to all of their patients. Thus other insurers and payers benefit from what Medicaid has initiated and financed. The flip side of this is that if physicians receive messages and incentives from insurers and other payers that conflict with the messages and incentives they are receiving from Medicaid, the impact

of any Medicaid changes will be muted.

The reality is that the opportunities for improvements in care and care outcomes will be even greater if the messages, incentives, expectations, supports, and performance reports that physicians receive from multiple payers can be aligned. If physicians were to receive a common set of quality objectives, incentives, collaborative supports, and performance reports regarding the care of most of their patients, the prospects for improvements in care and outcomes could be significantly greater.

Going forward, CCNC will be building the capacity to develop an accountable budget model that provides the state with greater budget predictability for Medicaid. It will also be working with other insurers and payers to create multi-payer projects in which reimbursement, incentives, and care support are aligned. **NCMJ**

L. Allen Dobson, Jr., MD president and CEO, North Carolina Community Care Networks, Inc., Raleigh, North Carolina.

Denise Levis Hewson, RN, BSN, MSPH senior vice president of clinical programs, North Carolina Community Care Networks, Inc., Raleigh, North Carolina.

Torlen L. Wade, MPH executive vice president, North Carolina Community Care Networks, Inc., Raleigh, North Carolina.

Acknowledgments

Potential conflicts of interest. All authors have no relevant conflicts of interest.

References

1. DuBard CA. Improving the quality of care for Medicaid patients with chronic diseases: Community Care of North Carolina. *N C Med J*. In press.
2. Kaiser Family Foundation. Average Annual Growth in Medicaid Spending, FY 1990-FY2010. Statehealthfacts.org Web site. <http://www.statehealthfacts.org/comparetable.jsp?ind=181&cat=4>. Accessed February 11, 2013.
3. Coleman EA, Parry C, Chalmers S, Min SJ. The care transitions intervention: results of a randomized controlled trial. *Arch Intern Med*. 2006;166(17):1822-1828.
4. Naylor MD, Brooten DA, Campbell RL, Maislin G, McCauley KM, Schwartz JS. Transitional care of older adults hospitalized with heart failure: a randomized, controlled trial. *J Am Geriatr Soc*. 2004;52(5):675-684.