Community Care of North Carolina

Cost Savings Strategies

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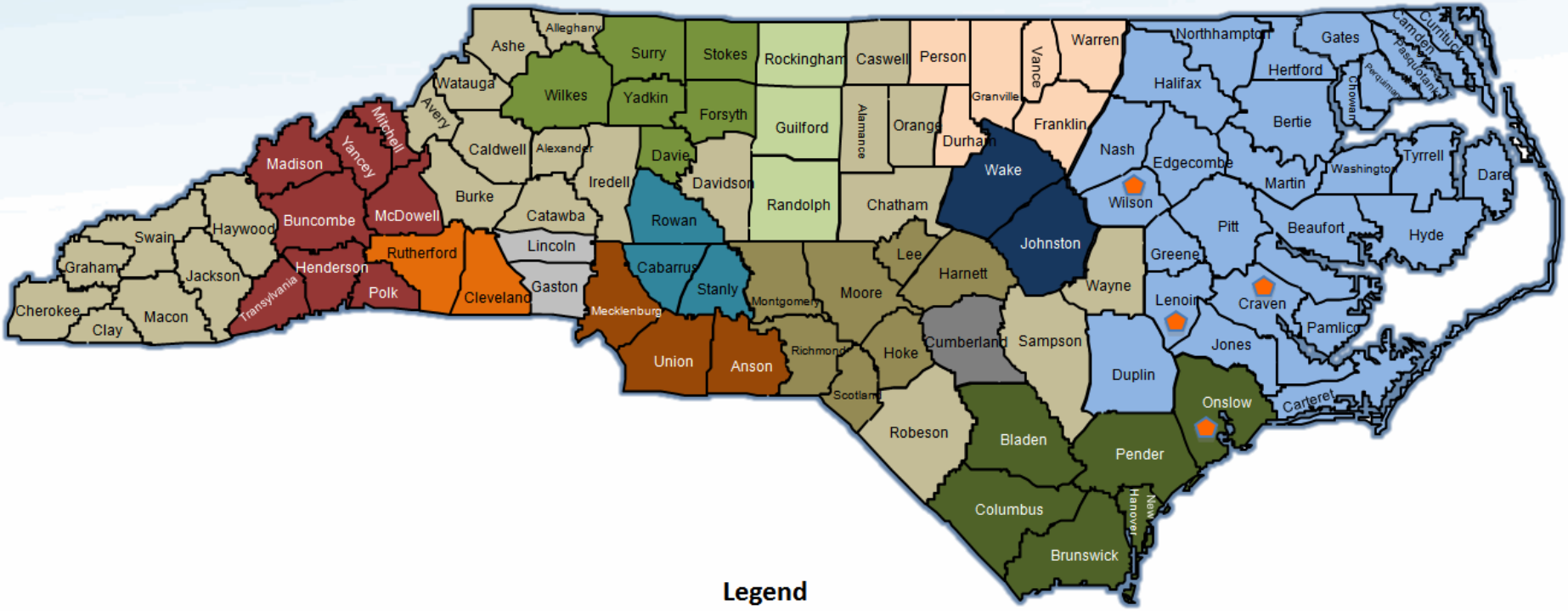
Community Care of North Carolina

Community Care Networks

Community Care of North Carolina



Legend

- AccessCare Network Sites
- AccessCare Network Counties
- Community Care of Western North Carolina
- Community Care of the Lower Cape Fear
- Carolina Collaborative Community Care
- Community Care of Wake and Johnston Counties
- Community Care Partners of Greater Mecklenburg
- Carolina Community Health Partnership
- Community Care Plan of Eastern Carolina
- Community Health Partners
- Northern Piedmont Community Care
- Northwest Community Care
- Partnership for Health Management
- Community Care of the Sandhills
- Community Care of Southern Piedmont

Key interventions for quality and cost

- **Medical Homes** -- linking each patient to a primary care physician.
- **Evidence-based programs and protocols** developed and implemented by Community Care physicians.
- **Improve processes for patients with chronic illnesses by** supporting physicians and practices – "PCMH," medical management and transition support.
- **Sharing "best practices"** and spreading those practices through CCNC networks across the State.
- **Providing Care Management** to patients with complex medical and behavioral health issues.

Key interventions for quality and cost

- Helping patients and their physicians **manage medications.**
- **Connecting patients with behavioral health issues with the right care** -- and working with the LMEs and CABHAs to manage priority patients.
- **Working with hospitals to improve patient transitions** from hospital to home and reduce re-admission rates.
- **Stratifying the population** to identify the most impactful patients.

Key interventions for quality and cost

- Creating **enriched analytics**, including:
  - CCNC Provider Portal
  - Pharmacy Home
  - Treo Solutions - analysis and targeting
  - Care Management Information System
  - Data for clinical integrity efforts

Other important initiatives

- Clinical integrity – tracking claim outliers and irregularities
- ePrescribe – getting scripts “into the system” to minimize errors and gather data
- Palliative Care – developing pathways of care for chronic, incurable illnesses
- Pregnancy Medical Home – improving prenatal care & reducing pre-term births

Other important initiatives

- Chronic Pain Initiative – Working to reduce substance abuse, accidental overdose and more effective manage chronic pain.
- CC4C – improve outcomes and reduce costs for at-risk children (birth to 5 years old).
- Call Center – Telephone outreach to high-volume, repeat ER patients
- Enrollment – Get all eligible patients into medical homes.

Our process takes time – but it works

- **Asthma (1998 – 1st Initiative)**
- **Diabetes (began in 2000)**
- **Dental Screening and Fluoride Varnish (piloted for the state in 2000)**
- **Pharmacy Management**
  - Prescription Advantage List (PAL) - 2003
  - Nursing Home Poly-pharmacy (piloted for the state 2002 - 2003)
  - Pharmacy Home (2007)
  - E-prescribing (2008)
  - Medication Reconciliation (July 2009)
- **Emergency Department Utilization Management** (Children 2004/ Adults 2006)
- **Case Management of High Cost-High Risk** (began 2004)
- **Congestive Heart Failure** (pilot 2005; roll-out 2007)
- **Chronic Care Program** – including Aged, Blind and Disabled
  - Pilot in 9 networks 2005 – 2007
  - Began statewide implementation 2008 - 2009
- **Behavioral Health Integration** (began fall 2010)
- **Palliative Care** (began fall 2010)
- **Pregnancy Home and Care Coordination for Children** (began April 2011)

Stories of real people

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Northern Piedmont

- Six-year old girl with asthma, severe allergies
- Medical home/care management – Provided asthma education and medication review, home inspection; advocate with landlord to address mold issues; connected to charity for non-fabric furniture; helped patient obtain non-allergy foods from public school; donation of allergy protective pillow and mattress cover, HEPA filters for vacuum and HVAC, plastic containers; educational shopping trip; nutrition and budget education.
- Girl's health greatly improved. Performing better in school. Reduced ED visits and Medicaid costs.

Stories of real people

Community Care of North Carolina

Coastal North Carolina

- Diabetic patient with very high blood sugars -- chronically ill, with frequent ED visits for pain, dizziness, depression, anxiety and GI upset. Overwhelmed and unable to leave her house or even get dressed.
- Outreach program helped her with routine life duties, errands; patient placed as DSS trustee to help manage her resources; nutritional counseling improved her diet; patient also instructed in appropriate pain management.
- Blood sugar now down to acceptable levels. Anxiety, GI upset have abated; pain under control. Patient no longer uses the ED. Care manager calls her “a new person.”

Stories of real people

Eastern North Carolina

- Patient hospitalized in 2008 with diabetes, pulmonary disease and congestive heart failure.
- Two to three hospitalizations a year; on oxygen and multiple medications, and bloated from steroids
- Close interaction with CCNC care manager and medication management, brought diabetes, hypertension under control.
- The patient has not been to a hospital in **two and a half** years.
- She has her life back and once again enjoys activities she had abandoned.

Going forward

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- Moving toward budget accountability with shared savings
- Managing inappropriate utilization
- “High preventables”
- Engaging specialists such as ED physicians and radiologists
- Partnering with provider organizations to manage complex patients

Going forward

- Working on management of duals through an integrated Medicare/Medicaid re-design
- Expanding our work with public and private payers to strengthen the impact of Community Care's quality improvement and cost-containment strategies.
- Strengthening the primary care infrastructure to be prepared for 2014

Questions?

- Thank you for the opportunity to speak to you today.