



## Community Care of North Carolina

Serving our most vulnerable citizens  
with a strong health care partnership

## Community Care of North Carolina stands on a single principle: the best health care delivery system is rooted in the communities it serves.

Driven by that belief, we are working to change health care in our state. At the heart of our effort is a partnership that's directed by doctors, focused on patients and beneficial to providers, payers, patients and taxpayers alike.

### WHAT WE DO

Community Care brings together regional networks of health care providers, hospitals, health departments, social service agencies and other community organizations. We create medical homes, matching each patient with a primary care provider who leads an interdisciplinary care team – professionals who coordinate seamless medical services for better outcomes. CCNC's 14 networks include more than 1,500 practices and serve more than a million Medicaid and Medicare recipients, NC Health Choice enrollees and private sector employees.

### SHARING OUR SUCCESS

#### Why is the medical home model so effective?

- It puts the patient at the center of care
- It empowers the patient team to make critical care decisions
- It personalizes care, encouraging patient follow-through
- It streamlines care and curbs waste
- It focuses on keeping patients healthy

A Mercer actuarial study examining the TANF portion of CCNC's population – children and adults with dependent children, excluding the Aged, Blind or Disabled (ABD) – found that CCNC saved the state approximately \$160 million in FY 2008.

Treo Solutions found that between 2007 and 2009 patient cost per member per month for the CCNC-enrolled ABD Medicaid population decreased from \$397 to \$391 – even though CCNC had assumed responsibility for more high-risk patients with complex medical conditions. Costs for the Medicaid population not enrolled in CCNC were higher than expected (15% in 2008 and 16% in 2009). Treo Solutions estimate of CCNC's ABD savings between 2007 and 2009 alone: **nearly \$1.5 billion.**

**In North Carolina, physician-driven, patient-centered care is happening. And it is benefiting more than 5,000 providers, 1.1 million patients and 9 million taxpayers.**

### THE COMMUNITY CARE DIFFERENCE

#### Community Care's fresh approach:

- Foster communication and collaboration through public-private partnerships
- Work directly with community health professionals who serve low-income residents
- Empower networks to develop local solutions to regional and community health issues
- Put responsibility for performance and improvement in the hands of those who deliver the care
- Achieves savings by a focus on quality – CCNC's HEDIS scores are in the top 10% nationally, compared to managed care organizations.

**For more information contact your local Community Care of North Carolina network representative at:**

#### **Community Care of North Carolina**

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**Want to learn more? Ready to get involved? Visit [www.communitycarenc.org](http://www.communitycarenc.org) or contact us at the number above.**

## HOW WE WORK

To help providers improve the quality and consistency of care, our community networks:

- Develop and implement best practices
- Develop and implement disease management programs
- Manage high-risk patients
- Manage high-cost services
- Build accountability
- Support patients in managing chronic conditions

The Community Care central office supports local community networks and primary care practices:

- Organize steering committees and workgroups on key initiatives
- Provide clinical and management support
- Access to population data through the Informatics Center and the Provider Portal
- Share best practices and innovative solutions among networks

Though Community Care, physician leaders from participating networks come together to design and develop clinical improvement pilots. The most successful initiatives are then rolled out statewide.

### Here's a sample of what we've accomplished and current areas of focus:

**ASTHMA** – Increased flu vaccinations, got 90% of staged asthma patients on preventive medication; saved \$3.5 million in two years by reducing inpatient admissions and emergency room visits.

**DIABETES** – Increased eye exam referrals; improved rates of care – continued care visits by 10%, foot exams by 18% and lipid testing by 11%. Saved \$2.1 million in two years.

**EMERGENCY DEPARTMENTS** – Care management outreach and education for enrollees with three or more visits to the ED in six months decreased emergency department use by 13% and per-member per-month cost by 30%.

Want to learn more? Ready to get involved? Visit [www.communitycarenc.org](http://www.communitycarenc.org).

### ADDITIONAL PROGRAMS AND INITIATIVES

- Telehealth
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Electronic Prescribing
- Special Needs Children
- Obesity and Stroke Prevention
- Multi-payer Initiative (MAPCP)
- Pregnancy Medical Home
- Medicare 646 Waiver
- Children's Health Insurance Program Reauthorization Act (CHIPRA)
- Care Coordination for Children (CC4C)
- First in Health – medical homes for private sector employees

health status.

by targeting those with high inpatient and ED use relative to people with a similar approach highlights patients who may benefit most from care management outreach “potentially preventable” hospital costs given their clinical profile. Clinical risk group modeling methodology that identifies individuals with higher than expected

### FOCUS ON MOST IMPACTABLE

– Targeting individuals based on predictive and unnecessary testing and emergency department visits.

### CHRONIC PAIN INITIATIVE

– Identifying patients with substance abuse issues and referring them to appropriate behavioral care. Reduces misuse of opiates, overdoses and unnecessary testing and emergency department visits.

dedicated to integration at local level.

### BEHAVIORAL INTEGRATION

– Statewide effort to break down silos by integrating behavioral health services, including mental health and substance abuse, into 1,500 participating practices. Psychiatrist and mental health coordinator at each network is

dedicated to integration at local level.

### CHRONIC CARE PROGRAM

– Implemented program of transitional support, include medication reconciliation for all high-risk patients. Embedded care managers in hospitals (55) and primary care practices (120).

home polypharmacy initiative.

### PHARMACY MANAGEMENT

– Implemented pharmacy homes, network pharmacists to support medical reconciliation; Piloted doctor- and patient-friendly approach to preferred drug list (PDL) that lowered costs by 22%; conducted nursing