THE WAKE COUNTY PHYSICIAN Magazine

Celebrating medicine, the arts, intellect, ideas and curiosity.

This issue of Wake County Physician Magazine is underwritten by Rex Healthcare
community care of wake and johnston counties

Our Local Community Care of North Carolina Network

By Elizabeth Cuervo Tilson, MD, MPH Medical Director, CCWJC

Every once in a while, a really good thing comes along. Good patient care wins out. Physicians are put in charge of health care. Government gets it right. In North Carolina's case, that right thing is Community Care of North Carolina (CCNC). It is why CCNC has won Harvard University's Innovations of Government Award, why other states are looking to North Carolina for leadership in health care transformation, and why CCNC is credited with more than $1 billion of Medicaid costs savings between 2007-2009.

Before I explain what CCNC is, let me explain what it is not. CCNC is not an out-of-state private managed care company with profit margins to achieve and shareholders to please. CCNC is not trying to dictate and limit patient care or increase administrative hoops and barriers. CCNC is not Medicaid coming to audit charts, find deficiencies, imply you deliver bad care, and deny payment. CCNC is not blaming you for patients who are hard to manage. CCNC is not carving out high risk patients and services from its book of accountable business.

So what is CCNC? Simply put, CCNC is a state-wide provider-led primary care medical home and care coordination system that has been growing for the past 10 years. It is a private-public partnership that is operationalized through 14 networks covering all 100 NC counties. It rests on the framework of Carolina Access Medicaid; a program in which Medicaid recipients are linked to a primary care medical home. On that framework, CCNC activities are added to further increase access to high quality, cost-effective, and coordinated care. By helping providers take care of patients, we have shown that we can improve health, reduce emergency department (ED) visits and hospitals admissions, and save money.

Statewide, more than 1360 primary care practices and more than 1.3 million patients are part of CCNC. Community Health Choice recipients, are part of our CCWJC network.

The major goals of the network are to: 1) provide quality improvement (QI) resources to primary care homes to better manage their patients; 2) connect primary care practices and patients with other segments of the health care system to create functioning local systems of care; 3) give providers the information they need to care for patients in a cost-effective way; and 4) utilize local multi-disciplinary care management teams to provide support for high risk patients. Funds for network activities are provided up front by Medicaid in a per member per month model. No fee-for-service payment is made to the networks. Payments to network providers include standard fee-for-service payments and an additional per member per month payment to support care management of their patient population and engagement with CCWJC quality initiatives.

Seventy-one staff members comprise the CCWJC multi-disciplinary team and include five physicians (a Medical Director, an Associate Medical Director, two Network Psychiatrists, and a Net-
work Obstetrician), RN Care Managers, Social Work Care Managers, Pharmacists, Pharmacy Technicians, Patient Coordinators, and QI, Provider Services, and Information Technology specialists.

The team works with providers and patients to support key network initiatives. These include chronic disease management, transitional care, pharmacy management including medication reconciliation for poly-pharmacy patients, integration of physical health and behavioral health, palliative care, chronic pain management, and preventative care.

Care managers identify high risk patients through a robust health information system populated with claims data (Informatics Center) and real time referrals from hospital inpatient units, ED and provider referrals. Care managers can help patients overcome barriers to care, e.g. transportation, and provide intense patient education and self-management resources, e.g. pill-boxes to increase medication compliance and pill box covers to reduce asthma triggers. Care managers can facilitate smooth transitions between healthcare settings, e.g. ensuring outpatient follow up care happens after a hospitalization and discharge information is shared. They promote a strong connection with the primary care medical home, help to coordinate services across the different aspects of the local health care system, e.g. behavioral health and specialists, and connect patients to community resources. Nurse care managers draw on the expertise of the multi-disciplinary team to best meet the holistic needs of the patients.

Some care managers are embedded in local hospitals and practices serving large Medicaid populations. Other community-based care managers accompany patients to practice visits, do telephonic care management, and make home visits. As such, CCWJC care management activities can extend the reach and effectiveness of providers and practice or agency-based case management services.*

Beyond care management, resources and data feedback are provided to the practices to support QI initiatives. A key resource is the Provider Portal, a part of the Informatics Center that allows providers access to patient level data. Providers can access information on recent ED, hospital, specialist, and mental health visits, radiological studies, and medication fills and costs that can help guide management of individual patients. In addition, practices can access population level reports that identify high risk patients for whom outreach and more intensive management may be warranted.

CCWJC’s approach is working. Quality metrics for the statewide program are in the top 10% of national HEDIS

* SS is a 51 year old woman with a history of a transient ischemic attack, hypertension, hydrocephalus with shunt and revisions, cerebral aneurysm with coil repair, myocardial infarction, anemia and depression. Her fragmented care resulted in seven ED visits and three hospital admissions in one year. Multi-disciplinary care management, inclusive of home visits, began via a CCWJC Nurse and Social Worker. The coordination of her care, re-establishment of links to her primary care and behavioral health providers, and provision of intensive patient support and education to promote self-management improved her health and health care. In the year after care management began, she had no ED visits and only one admission. Better control of her chronic diseases allowed her to return to school for her GED and enter the workforce.

RB is a 13 year old boy who had poorly controlled insulin dependent diabetes. In one year, the child was hospitalized four times for extended periods and utilized the ED for uncontrolled diabetes six times. The child had been discharged from several physician practices due to non compliance and would go extended lengths of time without seeing a physician or using his insulin. Care management through Community Care provided home and school visits for in-depth educational sessions, referrals to many community resources, including the Wake County EMS Advanced Paramedic Program, and extensive follow up and communication with patient, family, providers and all organizations involved in the patient’s care. The patient is now well linked with a PCP, has improved compliance with medications, improvement in the patient’s psychosocial status, and improved health outcomes. As a result, ED visits and hospitalizations dramatically decreased.

** “Joining CCWJC is the best thing we ever did for our practice” Gayzel Sevilla, Wakefield Pediatric & Adolescent Medicine

"Community Care has been a great help to our practice. Every person who works there is eager to help manage even my most complicated patients. They have gone above and beyond to provide the best medical care while trying to keep costs down. The patients who have been helped by the case managers are grateful. Often they have no idea how to navigate the system and the care managers are a wonderful help with that and getting services set up. I wish all of my patients had access to this resource! In addition, with the guidance of the leaders in Community Care, we physicians are shown better, more cost effective ways of managing our most complicated patients. This is good for everyone.” Dr. Beth Murnane, Sunrise Pediatrics

measure compared to commercial Medicaid HMOs. In addition, three different independent companies have calculated significant cost savings from the program. Mercer calculated more than $700 million in state Medicaid savings from 2006 - 2008. Treo Solutions, adjusting for severity, found that 2009 costs for patients enrolled in CCNC were 7% lower than expected. In comparison, costs for patients not enrolled in CCNC were 16% higher than expected. Milliman, Inc recently calculated a more than $1 billion Medicaid cost savings between 2007-2009 attributable to CCNC.**

We are building on our success in primary care and working to engage specialists and include additional populations. As part of the Pregnancy Medi-
In the following letter to the editor, Dr. Church raises cogent issues concerning the use of generic medications. The article he cites, entitled “Brand vs. Generic: The FDA Approval Process”, from the January 2012 issue of WCPM, was intended as informational and not promotional, providing a better understanding on generic drug approval and the FDA’s stance on generic drug safety.

David Cook, MD

Dr. Cook,

First, I admit that as a contrarian I am biased. To publish a clinical article with no apparent MD input seems to me to be inappropriate. In this case, the most important perspective regarding the relative effectiveness of a drug is the clinical experience of the treating physician over time. Secondly, in this article there was no discussion of the 80-20-20 FDA rule comparing the manufacture of brand drugs compared with generics. Clinicians have long known to avoid generics in critical drugs for certain diagnoses, especially in the case of Dilantin, Synthroid, and others we could mention. Thirdly, the provided references are weak and biased toward a government agency that is both undermanned for the task of evaluating the comparative bioavailability of imported (thereby cheaper) drugs of variable quality, and which has been unduly under pressure from Congress and lobbyists for the generic drug industry. The references also inappropriately include those of the Generic Pharmaceutical Association, an apparent conflict of interest from my perspective.

Sincerely,

C. Franklin Church, MD, FAAFP
Diplomate, ABFP
Past President
NC Academy of Family Physicians
Raleigh, North Carolina

---

With Wake County Human Services and the Johnston County Health Department. Collaboration with ED physicians, pain specialists, and mental health and addiction providers has begun as we develop the Chronic Pain Initiative. Our radiology colleagues are providing leadership to utilize the CCNC framework to advance a Clinical Decision Support system as an alternative to Radiology Prior Approval.

In addition, we are expanding activities to the private sector via the First in Health program. GlaxoSmithKline is the first employer to participate and we are working with Aetna and United to promote and provide medical home support and multi-disciplinary care management to GSK employees.

How does our approach differ from more typical ways of managing Medicaid budgets? Sustainability and scope. Lowering reimbursement rates to providers can reduce access to outpatient care and increase ED utilization and subsequent costs. Reducing eligibility criteria or benefits places the additional burden of uncompensated care on fragile community and provider resources. Shifting financial risk to an external entity without redesigning local health care delivery systems may bring short term budget predictability, but may not bring sustainable cost reductions. Excluding the highest cost patients, who are often the hardest to manage, limits the total Medicaid savings achieved. However, actually helping doctors take care of high-need, high cost patients? That’s something the CCNC model has brought to NC, resulting in better care, decreased hospitalizations and ED visits, and dramatic and sustainable cost reductions.

Want more information? Contact Anne Morton, Provider Services Manager (919)528-5665, amorton@wakedocs.org