

Statement of

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Chairman

North Carolina Community Care Networks, Inc

On behalf of

Community Care of North Carolina

and the

North Carolina Department of Health and Human Services

Committee on Health, Education, Labor, and Pensions

United States Senate

“State Initiatives that Improve Health and Control Costs”

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Senator Kennedy, Senator Enzi and other distinguished members of the committee; thank you for the invitation to be here today and to share with you the work of Community Care of North Carolina. I am Dr. Allen Dobson, Chairman of the Board of Directors for North Carolina Community Care Networks, Inc., the statewide umbrella organization representing all our local Community Care networks, and former Assistant Secretary and Medicaid Director for the North Carolina Department of Health and Human Services.

Community Care of North Carolina (Community Care) is a public-private partnership between the State of North Carolina and 14 not for profit networks that are comprised of the majority of local healthcare providers; primary care physicians, hospitals, health departments, social service agencies and safety net organizations. Together this partnership delivers the key components of a medical home and community based care management to Medicaid and SCHIP recipients and to other low-income adults and children of our state. Our Community Care networks now include over 3500 primary care physicians in 1200 medical homes covering all 100 counties of North Carolina and manage over 875,000 patients.

Community Care delivers improved quality and cost savings to our State through three critical elements. First, primary care physicians serve as “true medical homes” for patients-where the patients are known, care is coordinated and quality care is the first priority. Second, local networks serve as “virtual” integrated healthcare systems that link the medical home and patients to the rest of the local providers and support agencies. These networks, by leveraging existing community resources

and relationships, provide the needed physician leadership and local collaboration to create local solutions for improving care management and quality to meet statewide goals. This network system provides a flexible structure that is adaptable to rural as well as to urban areas of our State. Third, the State funds the medical home through an additional monthly fee and also funds the network to provide additional local resources such as case managers/ care coordinators, clinical pharmacists, part time medical directors and the local quality improvement infrastructure to work with and support the local medical homes. This assures optimal supports are provided to patients and that improvement goals are achieved.

Community Care has demonstrated quality improvement, cost saving and phenomenal growth. Community Care physicians, both locally and through a statewide medical directors group, develop and agree upon quality measures and desired outcomes whether for local initiatives or statewide projects. The results are monitored and reported to networks and practices. Many networks have shown significant improvements in asthma care that have resulted in a 35% decrease in hospitalizations, as well as improvement in diabetes care. North Carolina has seen improvement in preventable dental caries in small children by training primary care doctors to screening for dental disease and apply fluoride varnish. Other networks have seen a marked increase in preventive visits for Medicaid children. Network medical directors meet regularly with state officials to plan and pilot care improvement strategies. Significant cost savings have also been documented by both the Sheps Center at University of North Carolina at Chapel Hill and Mercer Human Resources Consulting Group. Statistically reliable cost comparisons have

shown savings exceeding \$ 100 million per year since 2003. In short, North Carolina has successfully managed the cost of its Medicaid program through this clinical management strategy rather than just payment reduction and regulatory controls.

Community Care is now the centerpiece healthcare strategy in North Carolina. It is enthusiastically accepted by both patients and providers. The legislature has mandated the expansion into SCHIP and also the aged blind and disabled.

Community Care is now seeking a Medicare demonstration waiver to serve citizens eligible for both Medicare and Medicaid as well as at risk Medicare recipients.

Community care is also the platform for a major State initiative that will unite public and private payors in adopting and measuring physician-led quality care for 5 key diseases and is helping North Carolina address such important health issues as health disparities, prevention, the uninsured, childhood obesity and child development.

We believe Community Care can serve as an important national model for healthcare reform. Community Care's local infrastructure will work in both urban and rural as well as public and private settings. The path forward for the US healthcare system can clearly be informed by the important work of some of our best and most integrated healthcare systems. However the majority of the nations healthcare is still provided in communities where there is no "system" at all.

Lessons learned in Community Care can provide a road map to organizing all local

communities regardless of size in order to focus on quality, costs and improvement in the health of its citizens.

There are a number of lessons from Community Care I would like to restate. These are 1) primary care physicians and the medical home are essential to providing improved access to care and prevention 2) public-private partnerships that develop and strengthen local healthcare systems are important 3) providers are best motivated when the focus is on quality, population health and how care is delivered locally 4) a shared responsibility and shared incentives are important 5) the program must have flexibility that allows communities to organize themselves based on their unique characteristics and resources 6) strong physician leadership is needed 7) to create meaningful and lasting improvement you have to engage the physicians and other community providers who care for our patients 8) a portion of the saving must be reinvested to further develop local systems and programs.

In summary, while improving Health IT, payment reform, and expansion of health insurance coverage, are important, what is essential is a sustained effort in organizing the healthcare delivery system to achieve needed access, quality and efficiency goals. Community Care thus provides an important example of how states can provide leadership and new models that may provide a valuable alternative for Congress to consider.

Appendix 1:

Examples of Community Care Initiatives

Asthma

Diabetes

Pharmacy Management (PAL, Nursing Home Polypharmacy)

Dental Screening and Fluoride Varnish

Emergency Department Utilization Management

Case Management of High Cost-High Risk

Congestive Heart Failure (CHF)

“Assuring Better Child Development” (ABCD)

ADD/ADHD

NC HealthNet/Coordinated care for the uninsured

Gastroenteritis (GE)

Otitis Media (OM)

Projects with Public Health (Low Birth Weight, open access & diabetes self management)

Diabetes Disparities

Medical Home/ED Communications

Aged, Blind and Disabled (ABD) care management

Depression Screening and Treatment

Mental Health Integration

Mental Health Provider Co-Location

E-Rx

Partner with AHEC to support Improving Performance in Practice Initiative

Medical Group Visits

Dually Eligible Recipients

