Community Care of North Carolina

Community Care of Wake & Johnston Counties (CCWJC)

NCIOM Annual Meeting – August 25th, 2009

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Access II and III Networks

Legend

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

December 2008 Enrollment >850,000

PUS Access II III 6-2007

Community Care of Wake & Johnston Counties (CCWJC)

- One of 14 Networks of Community Care of North Carolina (CCWJC)
- Serve Carolina Access II Medicaid population for Wake & Johnston Counties
- Goal: Increase Quality of Care while Containing Cost
- Targets: Link to Primary Care Physicians (PCP); Decrease non-urgent ED utilization; Prevent Hospital Re-admission; Promote Self-Management Skills

Case Management Services

- Link patients to and provide updates for PCP's (e.g. hospital admission, ED visits, medication reconciliation, CM interventions)
- Assist patients with navigation through health-care system
- Provide disease education and resources (e.g. DM, CHF, Asthma)
- Promote self-management for chronic diseases
- Provide medication reconciliation (hospital discharge, in home meds and PCP's records); Utilize PharmD on staff, provide to PCP, work with local pharmacies
- Link with community resources, i.e. transportation, Mental Health, specialists, food/utilities

Barriers/Challenges with Population

- Limited access to primary care
- Understanding the importance of utilizing primary care provider versus ED for primary care
- Non-receptivity to home visits or follow up
- Inconsistent phone numbers and frequent address changes due to unstable housing
- Unreliable transportation

Patient Successes

- Medication Reconciliation: Hospital CM and primary CM performed medication reconciliation and identified discrepancy between discharge instructions, summary, prescriptions and home meds; CM worked with PCP to reconcile
- Spanish Liaison: Staff identified pt at PCP practice in need of CM services and referred to CM. CM and PCP worked together with pt to link to specialists
- Social: CM work with SW to provide assistance for basic necessities and then assist with managing medical needs.

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Thank You