Community Care of North Carolina

N.C. Institute of Medicine

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Community Care of North Carolina

CCNC at a glance

- 1.3 million enrolled beneficiaries
- 305,000 Aged, Blind and Disabled included
- 5,000 participating physicians
- 1,600 medical homes
- 100 NC counties of operation
- 14 regional networks

"Joint Principles" of the Patient-Centered Medical Home

- A personal physician who coordinates all care for patients and leads the team.
- Physician-directed medical practice – a coordinated team of professionals who work together to care for patients.
- Whole person orientation – this approach is key to providing comprehensive care.
- Coordinated care that incorporates all components of the complex health care system.
- Quality and safety – medical practices voluntarily engage in quality improvement activities to ensure patient safety is always being met.
- Enhanced access to care – such as through open-access scheduling and communication mechanisms.
- Payment – a system of reimbursement reflective of the true value of coordinated care and innovation.

The Patient Centered Medical Home

Patient-centered | Physician-directed

Culture of Improvement

- Establish baseline performance measures
- Collect and analyze data
- Discuss best practices and improvement
- Conduct regular clinical team meetings

Risk-stratified Care Management

- Understand ways to identify patient's risk status
- Plan out care for chronic conditions and preventive care
- Identify "high-risk" patients
- Use tools to track populations by risk category

Medical Neighborhood

- Manage care transitions and build linkage to community resources
- Coordinate care with specialists and outside facilities
- Evaluate care transition process

Quality Care

Family Medicine

Convenient Access

- Same-day appointments and extended hours
- E-mail communication with patients (E-visits)
- Web portals for Rx refill and appointments
- Translation and Culturally appropriate services

Shared Decision Making

- Understanding the patient's social barriers, goals and priorities
- Create care plans in collaboration with patient/caregiver
- Monitor progress between visits

Patient Experience

- Conduct patient satisfaction surveys on a regular basis
- Establish patient advisory panel and QI activities
- Conduct patient focus groups

Quality Care

Patient-centered Care

Family Medicine

Patients Are More Satisfied with Their Care

Financial Management

- All staff are aware of the most efficient ways to deliver care
- National policies support the investment of resources into primary care practices that are effective and efficient

Culture of Change

- Establish a PCMH leadership team
- Engage all members of the practice in a shared vision
- Provide staff education and training to support patient-centered care

Practice | Environment

- Staffing model supports team-base care
- Define roles for team members
- Include health coach and care coordination functions

Practice Organization

Quality Care

Patient-centered Care

Family Medicine

Technology Infrastructure	Digitally Connected	Evidence-Based Medicine	EHR Reporting Tools
• Patient reminders • Patient notification for new information • Reminders for recommended care or health maintenance • Makes patient registries possible	• Enhances care coordination by improving information flow with other physicians, practices, and providers • Improves patient - physician communication	• Point-of-care learning , alerts and reminders • Clinical decision support (e.g., Epocrates)	• Can quickly pull clinical data for quality analysis • Can enhance business processes • Population health management through patient registries

Practice Organization

Health Information Technology

Quality Care

Patient – centered Care

Family Medicine

Ingredients for Change

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Vision	+	Skills	+	Incentives	+	Resources	+	Action Plan	=	**Change**
		Skills	+	Incentives	+	Resources	+	Action Plan	=	**Confusion**
Vision			+	Incentives	+	Resources	+	Action Plan	=	**Anxiety**
Vision	+	Skills			+	Resources	+	Action Plan	=	**Resistance**
Vision	+	Skills	+	Incentives			+	Action Plan	=	**Frustration**
Vision	+	Skills	+	Incentives	+	Resources			=	**Treadmill**

YES WE CAN!
BUT WE PROBABLY WON'T.
Chattanooga Times Free Press
Bennett

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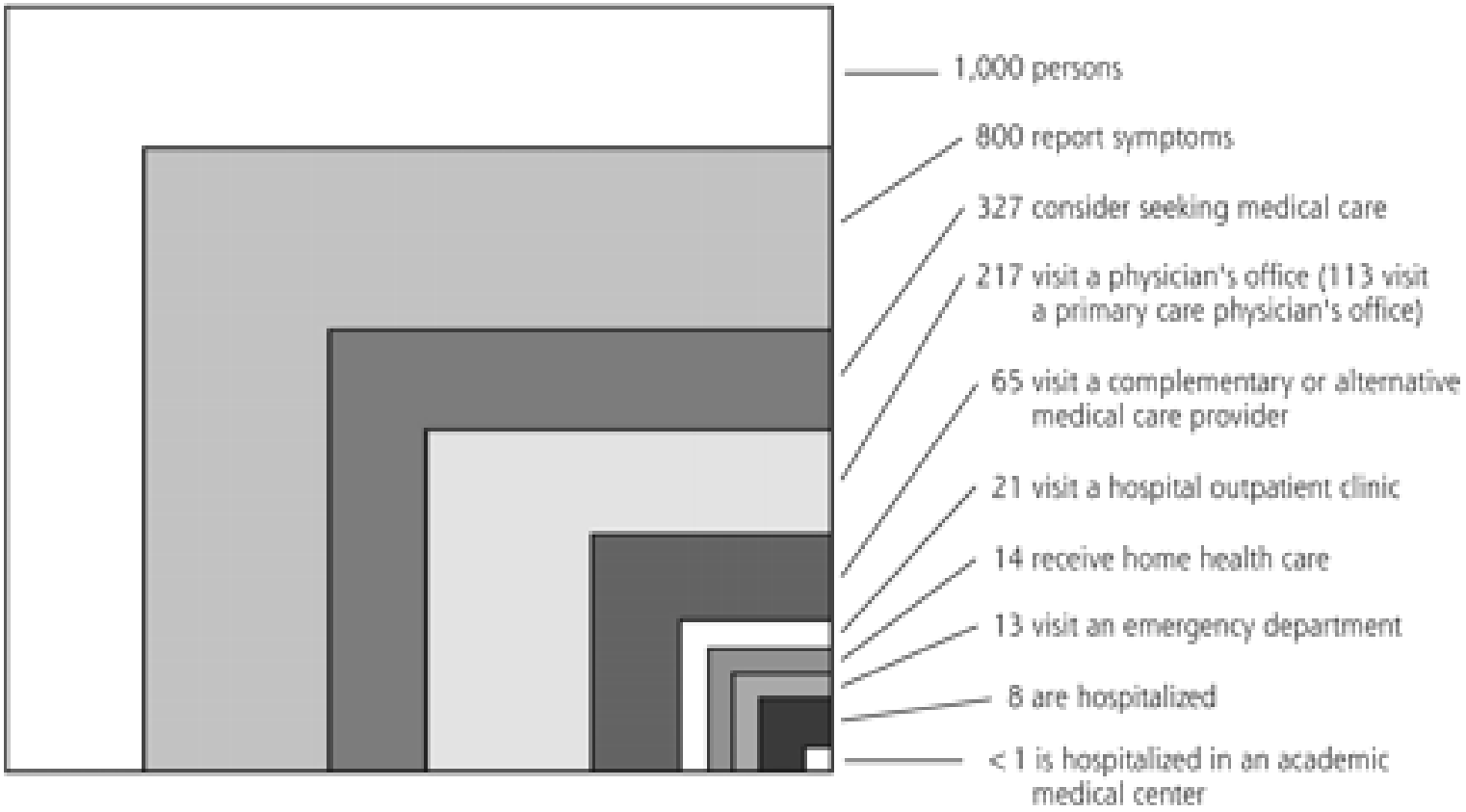
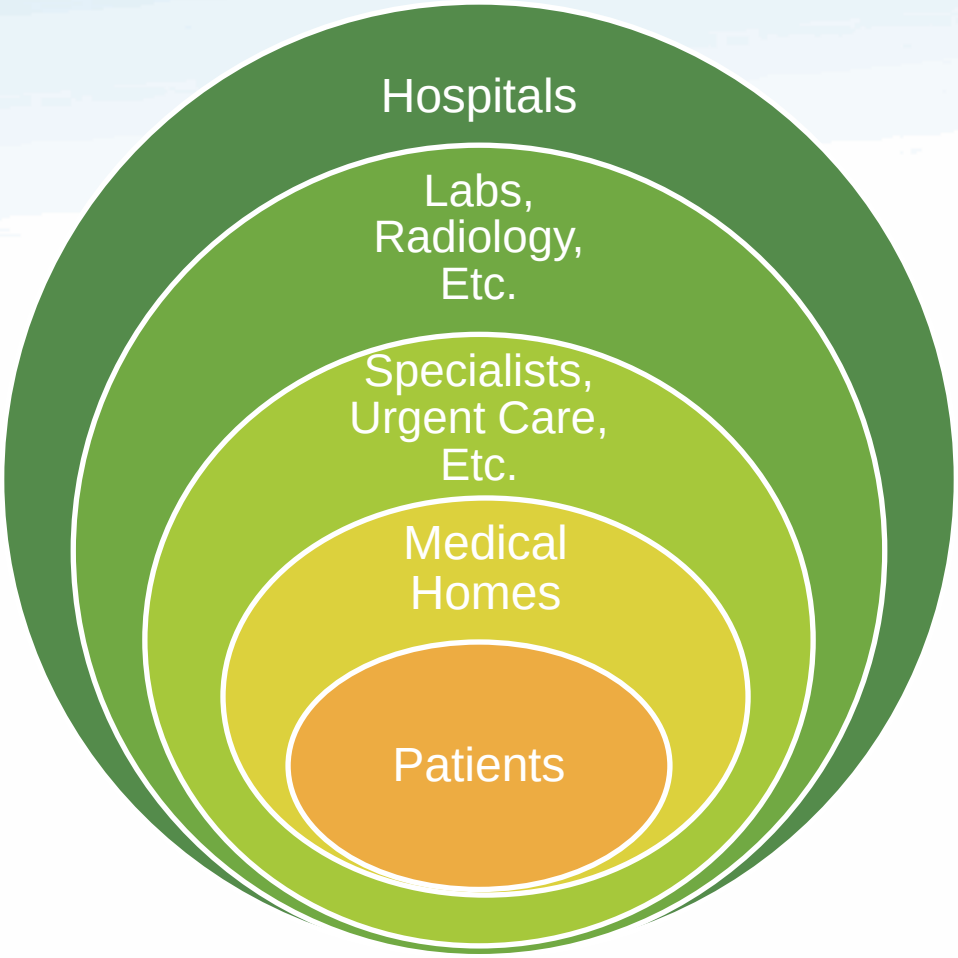


Medical Neighborhoods



Focus on complex patients driving utilization

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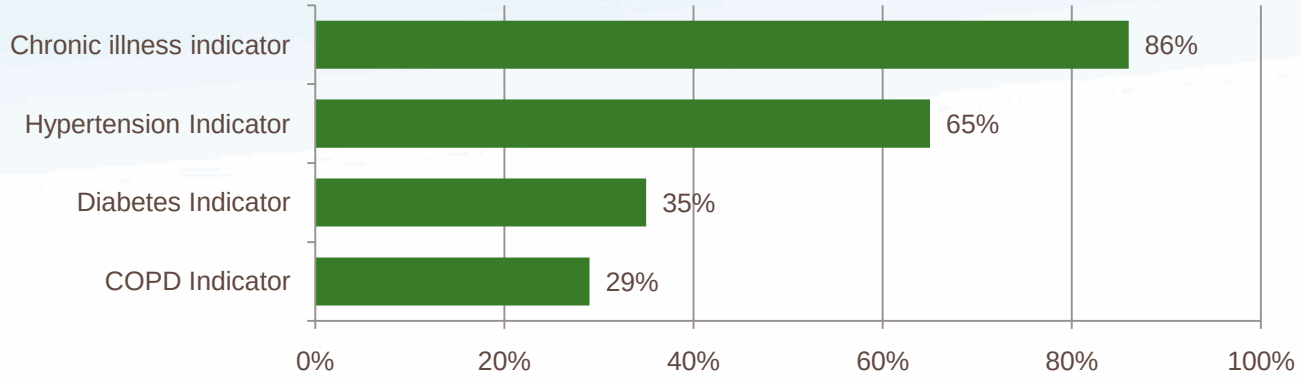
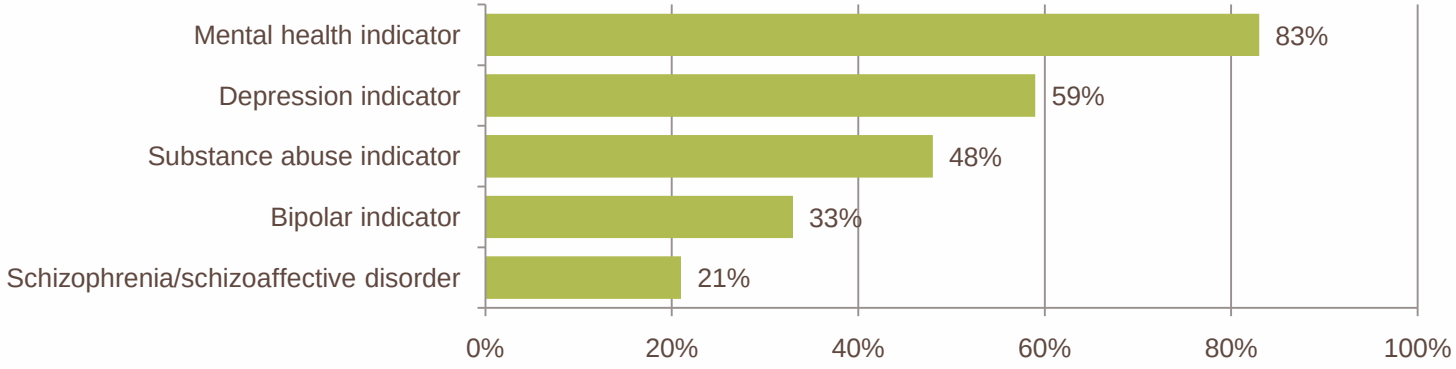
Prevalence of Chronic Illness

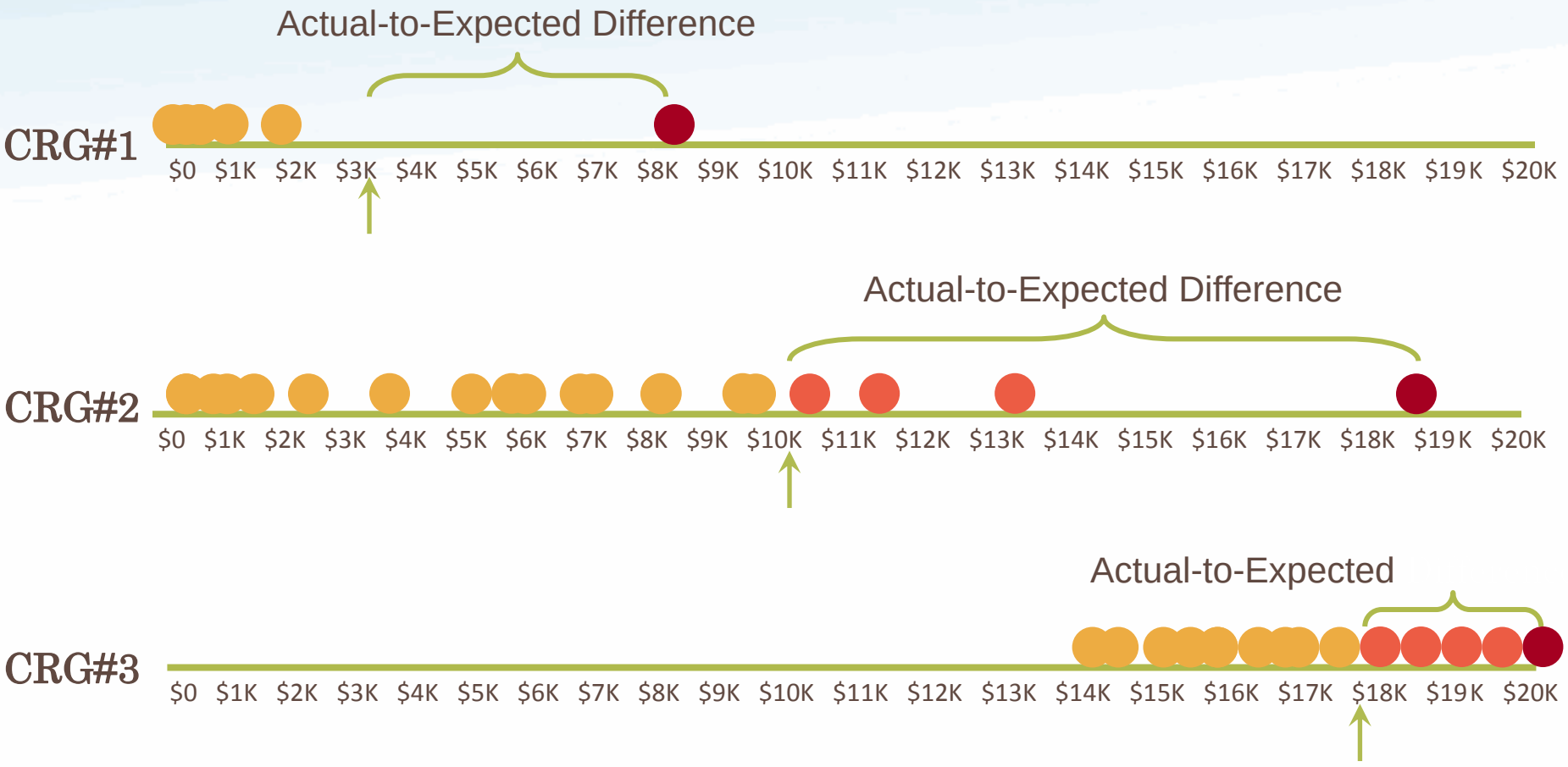


Prevalence of Mental Health Issues



Analysis of 1,394 NC Medicaid recipients with 20 or more ED visits in State Fiscal Year 2011.

Prioritizing the Population



↑ = Expected Hospital Costs for Specific Clinical Risk Groups

Challenge = Opportunity
Medication Confusion

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Most common drug therapy problems at care transitions
(20,673 patients)

- Patient not taking medication prescribed at discharge (4,747 or 23%)
- Status of patient's chronic medication(s) not addressed at discharge (4,581 or 22%)
- Patient non-adherent to therapy (3,962 or 19%)
- Patient taking medication at a different dose or interval than prescribed (3,879 or 19%)

About 6% of drug therapy problems considered "urgent" - imminent rehospitalization if not resolved)

Consolidated Medication List

Prescription Fill History Current Regimen Con Opti

Fill Date	Drug Description	Class	AI	Prescriber
12/12/12	LISINOPRIL TAB 20MG	HYPOTENSIVES ...	0.36	JAN MAREE PI ...
12/11/12	ACCU-CHEK TES AVIVA PL	DIAGNOSTICS		RICHARD ANTH ...
12/09/12	OMEPRAZOLE CAP 40MG	ANTI-ULCER/O ...		JAN MAREE PI ...
12/06/12	METFORMIN TAB 1000MG	DIABETIC THE ...	0.93	JAN MAREE PI ...
12/04/12	NICOTINE DIS 14MG/24H	CNS STIMULAN ...		JAN MAREE PI ...
12/01/12	BACLOFEN TAB 10MG	MUSCLE RELAX ...		BRANDON RYA ...
11/30/12	BENZTROPINE TAB 1MG	ANTIPARKINSO ...		BRETT A GURK ...
11/21/12	METOPROL TAR TAB 50MG	CARDIOVASCUL ...	1.01	JAN MAREE PI ...
11/18/12	NAPROXEN TAB 500MG	ANTIARTHRITI ...		BRANDON RYA ...
11/15/12	QUETIAPINE TAB 400MG	ANARACTICS - ...	0.75	BRETT A GURK ...
11/15/12	DIVALPROEX TAB 500MG ER	ANTICONVULSA ...	1.09	BRETT A GURK ...
11/15/12	PERPHENAZINE TAB 8MG	ANARACTICS - ...		BRETT A GURK ...
11/11/12	METHOCARBAM TAB 500MG	MUSCLE RELAX ...		ERIC RAYBUR ...
11/07/12	VENLAFAXINE CAP 150MG ER	PSYCHOSTIMUL ...	1.05	BRETT A GURK ...
11/06/12	NABUMETONE TAB 500MG	ANTIARTHRITI ...		KYRA F WILLI ...
11/01/12	CYCLOBENZAPR TAB 10MG	MUSCLE RELAX ...		JAN MAREE PI ...
10/18/12	PENICILLN VK TAB 500MG	PENICILLINS		WILLIAM E RI ...
10/18/12	CHANTIX PAK 0.5& 1MG	CNS STIMULAN ...	1 Fill	JAN MAREE PI ...
10/02/12	NICOTINE DIS 21MG/24H	CNS STIMULAN ...		JAN MAREE PI ...
9/24/12	METAXALONE TAB 800MG	MUSCLE RELAX ...		KYRA F WILLI ...
9/11/12	ACCU-CHEK MIS MLTICLIX	MEDICAL SUPP ...		RICHARD ANTH ...
7/18/12	ADVAIR DISKU AER 250/50	BRONCHIAL DI ...	0.63	RICHARD ANTH ...
6/22/12	GABAPENTIN CAP 300MG	ANTICONVULSA ...	1.09	BRETT A GURK ...
1/18/12	METFORMIN TAB 500MG ER	DIABETIC THE ...	0.93	RICHARD ANTH ...
1/16/12	JANUVIA TAB 100MG	DIABETIC THE ...	1 Fill	CLAUDE ROOF ...

Data based on a representative sample of 20% of patients receiving medication reconciliation/review services

Transitional Care Program

- Core components of CCNC Transitional Care
  - ✓ Face-to-face contact
  - ✓ Comprehensive medication management
  - ✓ Patient/caregiver self-management education, “red flags”
  - ✓ Timely outpatient follow-up with informed medical home
- Local flexibility, collaborations, and innovations
- Efficiencies through real-time data exchange, risk stratification and alerting of CCNC care management team
  - 56 hospitals now participating (2/3 of discharges)

Geographical Reach of CCNC Transitional Care Interventions

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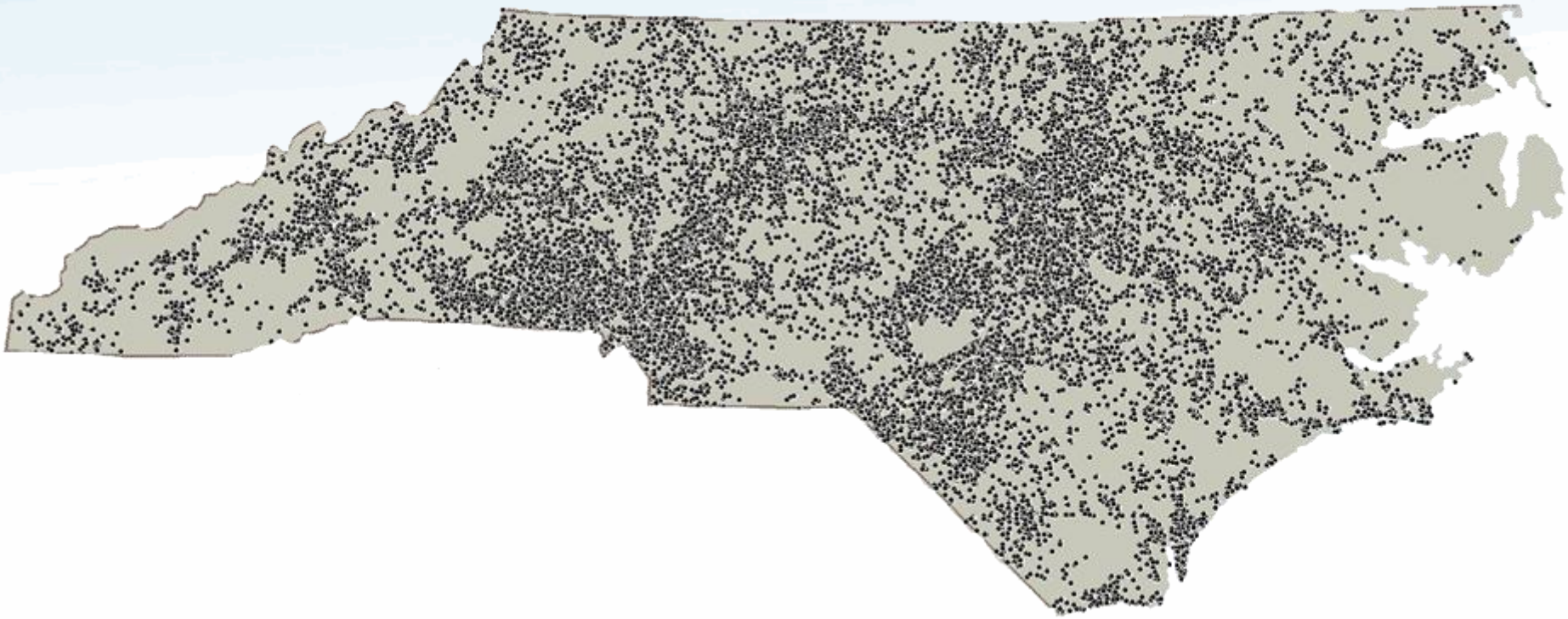

Each dot represents the home address of a client who received transitional care services between July 2011 and June 2012. As of December 2012, we are providing transitional care management for approximately 4500 patients per month.

Transitional Care Results

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- 20% reduction in readmissions for patients in transitional care program.
- 12-month readmission rates consistently lower for participants within each level of clinical severity.
- For every six interventions one hospital readmission avoided – strong ROI

AT THE INTERSECTION OF HEALTH, HEALTH CARE, AND POLICY

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Transitional Care Cut Hospital Readmissions For North Carolina Medicaid Patients With Complex Chronic Conditions

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