CCNC and Long Term Services and Supports

November 12, 2014

Whole Person Supports Workgroup

Community Care of North Carolina

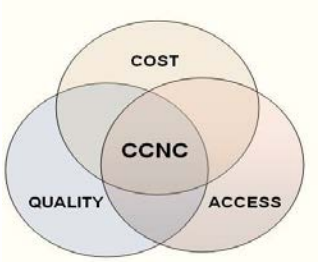
Agenda

- **Overview of CCNC**
  - Care Management and Practice Support
  - Infrastructure in place
- **CCNC Initiatives with LTSS Populations**
  - Care Management Assessments for Support Services
  - Skilled Nursing Facilities
  - Adult Care Homes
  - Dual Eligible 646 Quality Demonstration
- **Future Considerations**

What is CCNC?

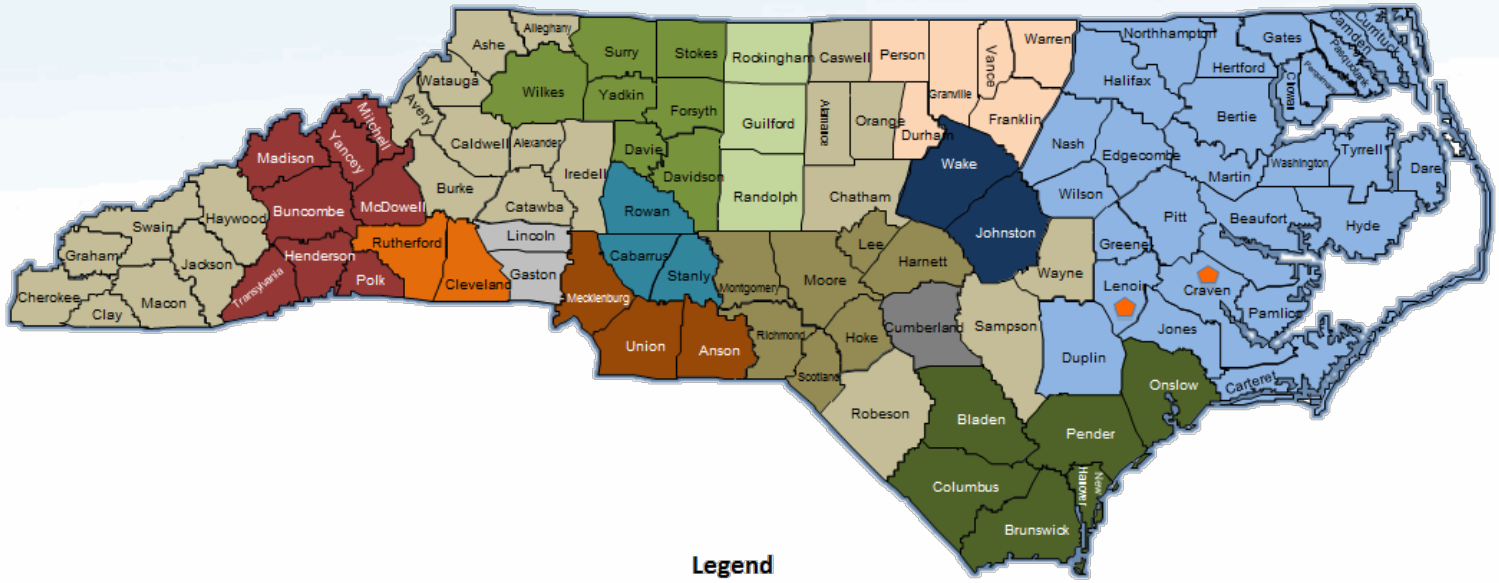
Community Care of North Carolina

- Community-based, physician-led medical homes coordinate care across health systems
- Managed through **14** local, non-profit networks, ~**1,800** practices & **6,000+** providers
- Population Health Approach: Case management and medical home capacity building
- Goal: **Ensure patients receive optimal care, avoid unnecessary utilization and reduce costs**
- Health informatics target at-risk beneficiaries and high-impact care settings
- Use of data to drive performance and standardization across networks
- Medicaid savings achieved in partnership with doctors, hospitals and other providers
- Able to demonstrate improved quality and health outcomes and cost containment = **value based model**



CCNC Networks

Community Care of North Carolina

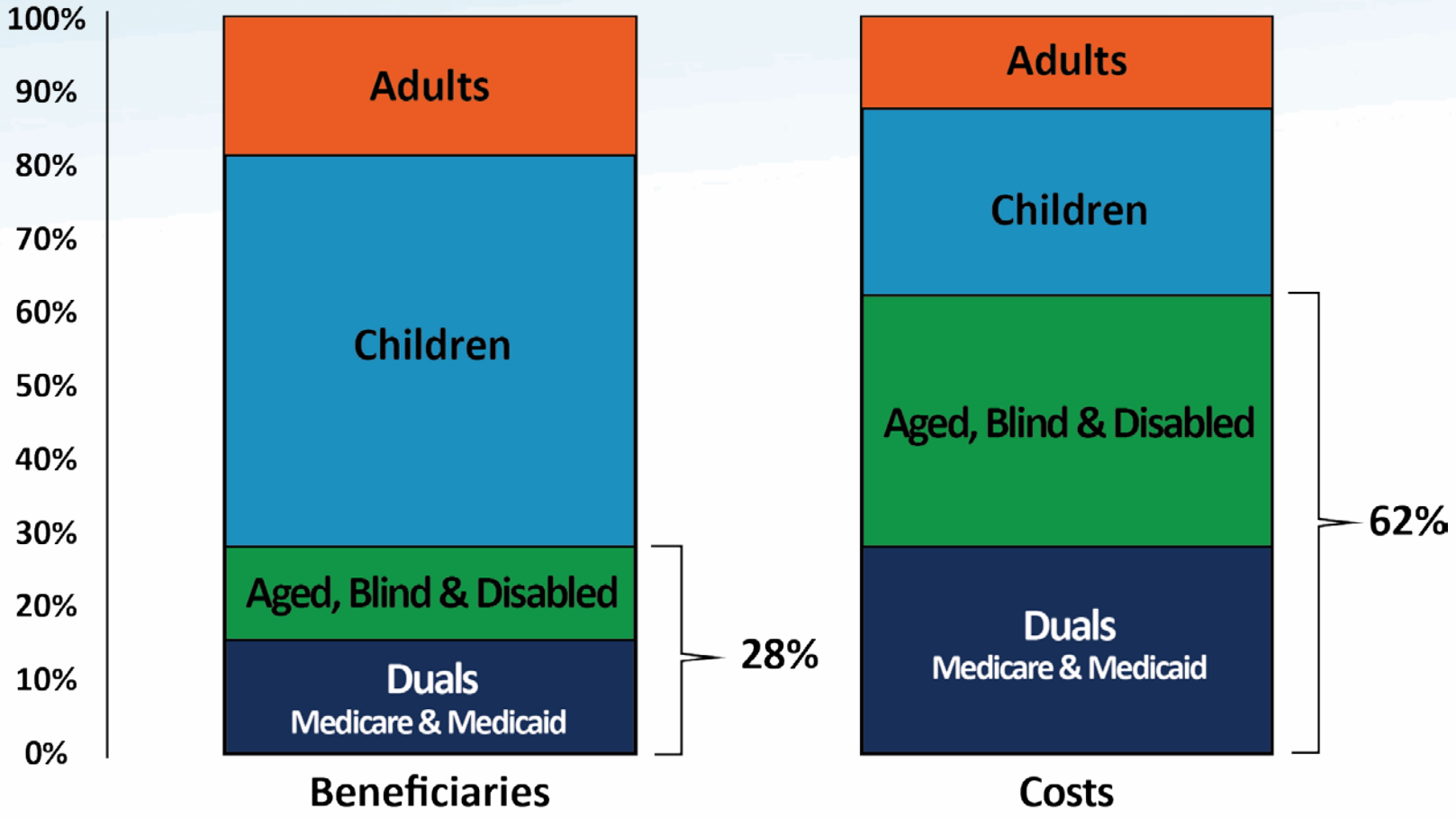


Legend

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

Source: CCNC March 2013

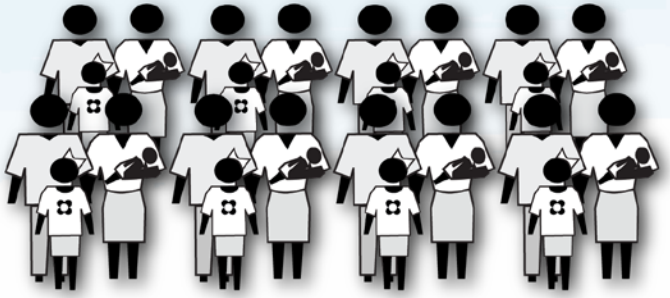
Where are the Opportunities?



CCNC approach tailored to needs of the population

Local Network: Community Care of Wake/Johnston

- 155 primary care sites
- Wake Faculty Practices



- 103,000 Medicaid
- 5th largest network in population

Wake & Johnston Numbers

- 2 Medical Directors
- 39 Local Case Managers
- 3 PharmDs
- 1 Palliative Care Coordinator
- 2 Psychiatrists
- 1 Obstetrician

Embedded:

WakeMed

- 11 FTEs dedicated to WakeMed
- 9 Registered Nurses/SW
- 2 Patient Coordinators

…Provide the Right Care

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CCNC Care Management Team

- 600 Complex Care Managers (RN, BSW, MSW)
- 300 OB Care Managers
- 300 High Risk Pediatric Care managers
- 60 Pharmacists

Care Management Model

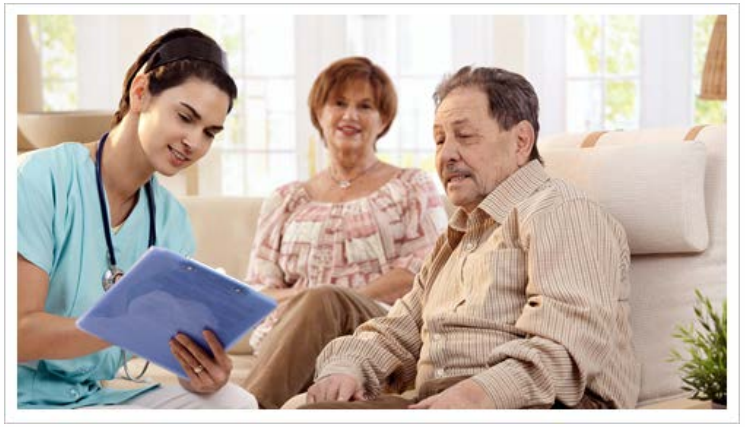
- Patient engagement through motivational interviewing
- Assessment, care planning, goal setting based on NCQA framework
- Interdisciplinary team linked by informatics platform
- Integration with medical home and other care settings

CCNC Structure and Capacity

- **Significant reorganization in 2013 to improve accountability and performance**
- **Consolidating networks in 2014/15 to improve standardization, quality, and efficiency**
  - Complex care management accreditation
  - Broadening service offerings to practices
  - Modernizing informatics platform (e.g. cloud based, mobile)
- **CCNC as Convener of Medical Neighborhood**
  - Collaboration with BH Providers and LME-MCOs
  - Home Health and Hospice
  - Duals Demonstration Stakeholders
  - Adult Care Homes Workgroup
  - Connectivity with SNFs through NC HIE

Care Management Approach

- **Assessment, Goal Setting, Care Planning**
  - Care Managers perform comprehensive assessment of beneficiaries including:
    - Physical and Behavioral Health
    - Medication reconciliation
    - Functional and Cognitive Status
    - Support Services Needs
    - Palliative Care Needs
    - Health Literacy
    - Caregiver Support
    - Housing and Transportation Needs



Care Management Approach

- **Patient-centered care**
  - Care managers implement patient-centered care plans to meet specific needs of individual
  - Work with patient to develop personal goals
  - Utilize motivational interviewing
  - Connect patients to full range of home and community-based services to meet social and health needs of individual
  - Collaborate with community-based providers and case managers

Care Management: Analytics and Workflow

- **Targeted approach:**
  - Analytics team identifies most ‘impactable’ patient population
    - Readmission risk
    - Above expected hospital costs
    - ED super utilizers
    - Risk for drug therapy problems
    - Dually-eligible population
    - Complex, chronic conditions
    - Patients with behavioral health conditions

Supporting Medical Homes

- **CCNC-Enrolled Primary Care Practices**
  - Link at risk beneficiaries with Medical Home
  - Utilize evidence-based practices to manage complex chronic conditions
    - Care alerts
    - Population management tools
    - Provider portal

  - Refer patients to care managers, pharmacists, psychiatrists, palliative care coordinators and others to address specific needs
  - Participate in continuous quality improvement

Transitional Care

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- **Care managers are embedded in hospitals and practices across the State**
- **Support patient transitions back to home or community setting**
- **Proven success at preventing hospital readmissions**
- **CMS Transitional Care Program for Medicare beneficiaries**
- **Target patients at high risk for readmission – high disease burden, complex conditions, medically-fragile children**

Statewide Informatics Platform

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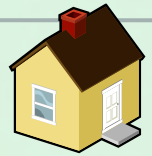
- **Community Care Record**

  (CMIS, PHARMACeHOME, Provider Portal)

  - Care record for care managers, pharmacists, providers, community service providers
  - Secure messaging
- **Analytics and Reporting**
  - Identify beneficiaries with above expected costs or gaps in care
- **Clinical Applications**
  - Integrating claims with EMR clinical data through HIE

Convening the Medical Neighborhood

Hospital



Community Resources

PCP & Clinic Team

Pharmacy

PATIENT

Prospective and Retrospective Quality Data

Specialty Providers

Behavioral Health

LTSS Providers

CCNC and Medicare/Medicaid Beneficiaries

- **Medicare Health Care Quality Demonstration – "646 Project"**
  - 52,000 dually-eligible beneficiaries
  - Met targets for 23 of 25 quality metrics
  - Statistically significant savings for enrolled subgroup
    - Total savings achieved for CCNC-enrolled cohort were sizeable at **greater than $18 million** in year two ($654 pmpy)
    - Statistically significant cost savings for patients with vascular disease and end-stage renal disease, as well as disabled beneficiaries
    - Other savings noted for beneficiaries with cancer, congestive heart failure, diabetes, myocardial infarction and stroke
    - Statistically significant reduction in ED utilization

LTSS Initiatives and Special Projects

- **Duals Demonstration Planning Process**
- **Adult Care Homes**
- **Care Management Evaluations for Support Services**
- **Nursing Facility Residents**

Adult Care Homes

- **Project REACH (Reaching out to Enhance the health of residents of Adult Care Homes)**
- **AccessCare Network**
  - Alamance, Caswell, Chatham and Orange counties
- **Improving health outcomes of Medicaid and Dually-eligible residents of ACHs**
- **46 ACHs linked to Medical Homes**
- **Care management driven model provides primary care services to residents**
  - REACH LINK: Care coordination outreach initiative
  - REACH Group Home medical visits

Support Services Evaluation Pilot

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- **Five networks performing patient evaluations for support services, including Personal Care Services (PCS) and high-cost medical equipment**
- **Performed by RN or OT care managers at request of PCP prior to completing PCS Referral/Attestation Form**
- **Home visit with patient completed to determine:**
  - Ability to independently perform Activities of Daily Living (ADLs)
  - Availability of family support
  - Most appropriate services to meet patient's needs
  - Medical equipment needs
  - Duration of patient's need

Nursing Facility Residents

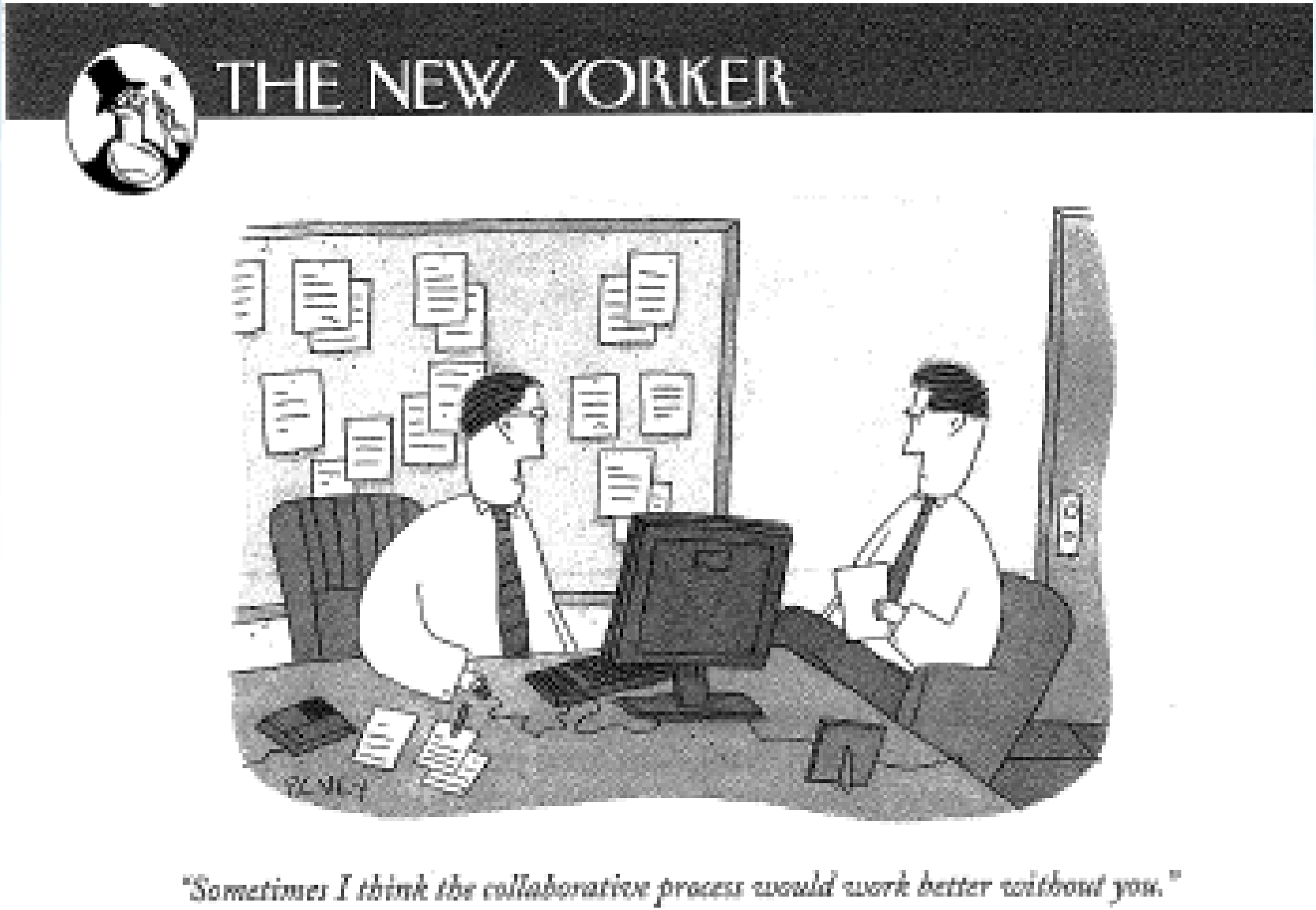
- **Regional project to improve the quality of care and reduce unnecessary hospital admissions and ED visits**
  - 32 Skilled Nursing Facilities
  - Implement INTERACT III
  - Training and support around MOST form and advanced care planning
  - Connecting SNFs and hospital EHR systems
  - Coordinating quarterly SNF leadership forum
  - Coordinating quarterly transition meetings with hospital systems and SNFs

Conclusions:

- **Opportunity to build a clinically driven, accountable system that uses data to assure that beneficiaries receive the right care**
- **Opportunity to coordinate PH, BH, LTSS**
- **Opportunity to use state dollars for LTSS more efficiently while improving outcomes for beneficiaries**
  - Break down program silos
  - Uniformed assessment
  - Whole person care
  - Options counseling and navigation

Conclusions:

- **Build off current care management, medical home, and informatics infrastructure**
  - Build relationships and coordinate with LTSS providers
  - Over 6,000 PCPs and 1800 medical homes
  - Over 600 “boots on the ground” care management staff



"Sometimes I think the collaborative process would work better without you."