North Carolina Programs Addressing Cost and Quality

Chapter 3

In order to most effectively increase access to quality health care the state needs to address all three elements of the so-called "Iron Triangle"—access, cost, and quality. Achieving desirable levels of any two elements is possible by sacrificing the third dimension. For example, a highly accessible, low-cost system is possible if it has low quality. Other aspects of the health care system fit into this framework. For example, more effective prevention strategies can lower cost and improve quality. Increases in practitioner supply can lead to increases in access (i.e. more availability) and quality (i.e. greater ability of practitioners to manage their patient panels). The charge to the Health Access Study Group specifically addressed access, however, the Study Group acknowledged that it is important to consider the other two elements as well.

Although there are many effective programs in North Carolina aimed at improving quality and/or reducing cost, there are two particularly innovative programs in North Carolina addressing cost containment and quality improvement: Community Care of North Carolina (formerly Access II and III) and the North Carolina Healthcare Quality Alliance (previously known as the Governor's Quality Initiative). Community Care of North Carolina has been operating for ten years and provides a managed care, medical home model for Medicaid recipients. The North Carolina Healthcare Quality Alliance is still in the design phase and aims to provide standard health care quality measures throughout the state.

In January 2009, Community Care of North Carolina managed the care of more than 874,000 Medicaid enrollees and more than 95,000 children on NC Health Choice.

Community Care of North Carolina (CCNC)

Community Care of North Carolina (CCNC) was initiated in July 1998 as a Medicaid managed care demonstration program designed to reduce health care costs and increase access and quality for the state's Medicaid population.[a] The program creates networks of community providers, such as physicians, hospitals, health departments, and social services to manage the care of the enrolled Medicaid population. There are currently 14 networks in North Carolina. (See Figure 3.1.) These networks are responsible for managing the care of approximately 80% of the state's Medicaid population. In January 2009, CCNC managed the care of more than 874,000 Medicaid enrollees and more than 95,000 children on NC Health Choice.[b]

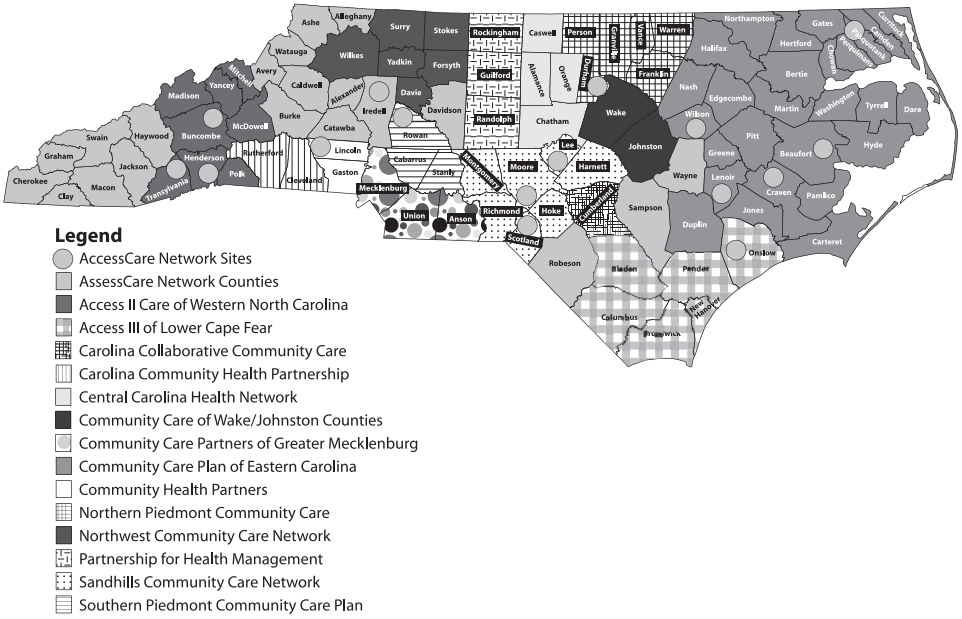
Each network has a CCNC program director, medical director, and case/disease managers. The network medical directors participate in a statewide clinical directors group that aims to identify and adopt statewide quality improvement initiatives. Current statewide disease and care management initiatives include asthma,

a Community Care of North Carolina is sponsored by the Office of the Secretary, Division of Medical Assistance (Medicaid), and the North Carolina Foundation for Advanced Health Programs, Inc. Administration of the program is through the Office of Research, Demonstrations, and Rural Health Development. Additional grant funding for start-up and pilots was obtained from the Kate B. Reynolds Health Care Trust, the Commonwealth Fund, and the Center for Health Care Strategies.

b Collins C. Deputy Director, Office of Rural Health and Community Care, Acting Assistant Director, Division of Medical Assistance. Oral communication regarding Community Care of North Carolina. January 12, 2009.

diabetes, pharmacy management, dental screening and fluoride varnish, emergency department utilization management, case management of high-cost, high-risk populations, and congestive heart failure.[1] The CCNC medical directors identify statewide guidelines and priorities. Additionally, local networks are able to identify additional priorities for their region.

Figure 3.1
Community Care of North Carolina Networks



Source: Steiner, B. et al. Community Care of North Carolina: improving care through community health networks. *Ann Fam Med.* 2008;6:361-367.

More than half of all primary care practices in the state, nearly 1,200, are practicing in Community Care of North Carolina.

CCNC has four primary goals: 1) improving access to care by linking each Medicaid recipient to a primary care medical home; 2) improving the quality of care provided to Medicaid recipients, particularly those with chronic illnesses or complex health problems; 3) helping Medicaid recipients with chronic illnesses learn to manage their own health problems; and 4) reducing the costs of the Medicaid program. The CCNC program has succeeded in each of these goals.

Each patient in the CCNC program is linked to a primary care practice, which serves as the medical home for the patient. The practice provides comprehensive primary care and refers patients to other care when needed. Providers who agree to serve as the medical home receive a per member per month (pmpm) management fee to help coordinate the care provided to Medicaid recipients. More than half of all primary care practices in the state, nearly 1,200, are participating in CCNC.[2]

The 14 networks also receive a small pmpm payment to hire staff—typically nurses or social workers—to provide care or disease management to people with chronic illnesses. The work of the care/disease management staff varies, depending on the needs of the network and individual practices. However, typically, the staff works

in collaboration with the providers and Medicaid recipients to help the Medicaid recipients manage their chronic illnesses. In addition, they help practices improve the quality of care provided to individuals with certain health conditions. For example, they might work with a practice to ensure that the providers develop asthma action plans for all of their patients with asthma, or that the providers refer patients with diabetes for an annual eye exam.

Several evaluations, both external and internal, of cost-containment and quality improvement efforts in the CCNC program have shown positive results. Mercer Human Resources Consulting Group reported that CCNC produced a cost savings of between $161 million and $300 million in fiscal year 2006 depending on the assumptions built into the evaluation model.[c,2] Savings resulted from reduced utilization of emergency departments, outpatient care, and pharmacy. The Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill found that CCNC's asthma management program produced a cost-savings of $3.5 million, and that the diabetes management program saved $2.1 million.[3] Internal analyses have also shown positive cost and quality improvements for the asthma management program and improvement in use of evidence-based practices in the diabetes program.[3] For example, an asthma initiative reduced hospital admission rates by 40%, and a diabetes initiative improved the quality of care by 15%. CCNC has been recognized as a national leader in developing a medical home model of care and in improving the care provided to Medicaid recipients. In 2007, CCNC won the Annie E. Casey Innovations in American Government award from the Kennedy School of Government at Harvard University.

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Initially, enrollment in CCNC was limited to Medicaid-eligible children, parents of dependent children, and pregnant women. However, in the last few years CCNC has also been expanded to cover children who receive NC Health Choice and is in the process of expanding to include Medicaid-eligible adults who are disabled or elderly (65 or older). In addition, the program has continued to evolve to further improve care provided to the Medicaid population. For example, some of the practices are involved in mental health co-location efforts (where a mental health practitioner is located in a primary care practice, or visa versa). CCNC has also instituted ePrescribe (an electronic prescribing system), partnered with the North Carolina Area Health Education Centers (AHEC) for the Improving Performance in Practice Initiative, and participated in the Health Net and Care+Share Health Alliance Initiatives (described in Chapter 7). Additionally, CCNC has applied for a Medicaid 646 demonstration waiver for a five year demonstration to manage the care of dual-eligibles (both Medicaid and Medicare eligible), which constitute a large number of Medicaid recipients not currently covered by CCNC. The demonstration would gradually increase the number of dual-eligibles covered until eventually covering 217,808 people by the fifth year.[1] A large amount of the cost-savings from the waiver will be used to provide access to care for low-income uninsured.

c Analysis compared actual costs (model 1) of the program to projected costs (model 2) using historical data from fiscal years 2000-2002.

North Carolina Healthcare Quality Alliance (NCHQA)

National research has found that patients typically receive only about 50% of recommended care.[4] Additionally, the United States regularly ranks last among seven industrialized nations for the quality of health care delivered to its residents.[5] Furthermore, local variation in practice patterns can be considerable, with practitioners in some areas providing care consistent with evidence-based guidelines, while practitioners in other areas may deviate from guidelines. Evidence-based guidelines can lead to great increases in health, resulting in higher quality and lower cost. For example, some research has found a 50% mortality reduction for adherence to some evidence-based best practices.[6,7] In addition, improvements in diabetes care due to adherence to best-practices can lead to considerable subsequent cost-savings.[6,7]

The United States regularly ranks last among seven industrialized nations for the quality of health care delivered to its residents.

The North Carolina Healthcare Quality Alliance (NCHQA) was created by a group of health care community stakeholders to ensure that individuals in North Carolina receive the highest quality health care. An informal group was formed in 2006 to design the initiative, and they agreed on three broad objectives: 1) align quality measures across payers to reduce the variation in quality measurement faced by providers, 2) measure quality and provide feedback on performance to practices, and 3) support practices through quality improvement process using nationally recognized models.[8]

Align Quality Measures: Often, payers measure practitioner quality slightly differently from other payers, meaning that a patient's insurance partly determines the "best" care a patient should receive. One of the goals of the NCHQA is to align quality measures across payers to reduce the variation in quality measurement faced by providers. The initial set of quality measures will focus on the ambulatory care delivered to patients with at least one of five selected conditions: diabetes, asthma, congestive heart failure, hypertension, and post-myocardial infarction. These conditions were selected because they affect many North Carolinians and there are evidence-based guidelines to improve quality. A group of clinicians from across the state have proposed twenty specific measures across these five conditions; a thirty member Clinical Advisory Group consisting of a diverse group of local health care leaders have endorsed these measures, most of which are endorsed or developed by national organizations (such as the National Committee for Quality Assurance).

Performance Feedback: Measurements will build on the current CCNC system of audits. Practices will be given annual performance reports using data from the audits. Each payer will use claims data to create a list of members with one or more of the five conditions. These lists will be submitted to a third party vendor known as a central data warehouse (CDW). This list will be used for two purposes. First, a random set of charts associated with these patients will be audited by NCHQA to determine the quality of care delivered to a representative set of patients with the particular condition seen at a practice. This model builds on the approach

currently taken by CCNC and other payers. The second purpose of the list is to enable practices to deliver better care to their patients.

Practice support: One of the unique features of the initiative is the support that will be available to participating practices to help them improve quality. Direct support will be provided through the Area Health Education Centers and CCNC networks to redesign practice flow, assist with electronic health record implementation, and provide other supports and resources to practices.[d] The CDW-created lists of patients with specific conditions can be used to support disease registries to enable practices to develop point-of-care reminders to ensure the best available care for their patients. A web-based registry, which will be made available at no cost to all participating practices, is currently in pilot testing.

This initiative is only possible due to the unique partnership of physicians, hospitals, insurers, state government, business, and other organizations committed to improving health care quality in North Carolina. Using uniform evidence-based measures, developing innovative technology, and employing community supports will help improve health outcomes, lower costs, and result in a healthier North Carolina.

d These services include regular reports on quality of care, disease registries and electronic health record consultation, quality collaboratives, free continuing medical education (CME) up to 20 hours per year, support to reach North Carolina Healthcare Quality Alliance standards, staff development and continuing education, free access to the Area Health Education Centers (AHEC) digital library, streamlined and coordinated practice support, and public recognition for participation.

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