APPENDIX H
NEW MODELS OF CARE IN NORTH CAROLINA

The ACA includes funding to test new models of delivering and financing health services, with the goal of improving quality and patient outcomes and reducing the costs of health services. The ACA included $5 million in federal fiscal year (FFY) 2010, and $10 billion for FFY 2011-2019 to develop and evaluate new delivery and payment models through the new Centers for Medicare and Medicaid Innovation (Innovation Center), within the Center for Medicare and Medicaid Services (CMS).[1] All Innovation Center demonstrations are specific to Medicare, Medicaid, and CHIP. However, the ACA also includes other innovations that could be supported and/or tested with broader populations.

The following includes a short description of some of the new innovations that may be tested as part of the ACA. They are grouped into themes, including patient-centered medical homes, transition care models, accountable care organizations, all-payer payment models, coordination of care for dual eligibles, medication management, geriatric care, telehealth/telemonitoring, and use of health information technology, shared decision-making, malpractice reform, and nursing home culture change. This Appendix also includes a short description of some of the existing North Carolina initiatives that are similar to the models that may be tested through the ACA, along with contact information for each of the North Carolina initiatives.

The following is not an exhaustive list of all the examples of ongoing innovations in North Carolina. The demonstrations listed are matched as closely with New Models of Care provisions in the ACA as possible. Innovations not mentioned in the ACA or innovations addressing other provisions in the ACA, such as quality, are not included here. In addition, the NCIOM may be unaware of other innovative practices in the state. Thus, this list of innovations should be viewed as some of the initiatives currently underway in North Carolina.

PATIENT-CENTERED MEDICAL HOMES (PCMH)

Description of ACA Provisions

- *Health homes for people with chronic illnesses*.[2]
  A health home is a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual with chronic conditions to provide health home services. Health home services include comprehensive care management, care coordination and health promotion, transitional care, patient and family support, and referrals to community and social services. Note: This is a state option specific to Medicaid, not a demonstration program. States that agree to the terms are eligible for an enhanced federal match (90%) for payments to health homes for eight fiscal year (FY) quarters beginning once they have an approved state plan amendment. Eligible individuals include Medicaid enrollees with two chronic conditions, one chronic condition with a risk of a second chronic condition, or one serious and persistent mental illness.

- *Primary care payment and practice reform*.[3]
  This Innovation Center demonstration is intended to test broad payment and practice reform

in primary care including patient-centered medical homes for high-need individuals, women, and models that transition primary care practices away from fee-for-service (FFS) to more comprehensive payment or salary-based payment.

- *Optimal use of health professional credentials*.[4]
  This Innovation Center demonstration is intended to promote greater efficiencies and timely access to outpatient services through models that do not require a physician or other health professional to provide services or be involved in establishing the plan of care. Services must be provided by a health professional who has the authority to furnish the service under existing state law.

- *Community-based interdisciplinary, interprofessional health teams to support patient-centered medical homes*.[5]
  The health teams established by this section must be from a state, state-designated, or tribal entity and must establish a plan for financial stability after three years. This demonstration is not specific to Medicare or Medicaid, but entities must agree to provide services to Medicaid eligibles with chronic conditions. Health teams shall create contractual agreements with primary care providers to support services; collaborate with providers and area resources to coordinate prevention efforts, disease management, and transitions of care; and implement and maintain health information technology to facilitate coordination of care. Providers shall provide care plans for each patient, provide health teams with access to patient medical records, and meet regularly with the health teams to ensure integration of care.

North Carolina Initiatives

- *Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration*
  This demonstration, operated by CMS and HRSA, aims to improve care for Medicare beneficiaries through the use of more coordinated, team-based care. Participating FQHCs must achieve Level 3 patient-centered medical home status. FQHCs will be paid a monthly care management fee for each eligible Medicare beneficiary. The following 18 FQHCs in North Carolina are participating: Apex Family Medicine, Colerain Primary Care, First Choice Community Health Centers at Anderson Creek Medical Center, First Choice Community Centers at Angier Medical Center, First Choice Community Health Centers at Benhaven Medical Center, Gaston Family Health Services-Bessemer City Health Care Center, James Bernstein Community Health Center, Julian T. Pierce Health Center, Maxton Medical Center, Metropolitan Community Health Service, Inc., OIC Family Medical Center, PHS – Charles Drew Community Health Center, PHS Prospect Hill Community Health Center, Rock Quarry Family Medicine, Rural Health Group at Norlina, Rural Health Group at Twin County, Rural Health Group at Whitakers, and Snow Hill Medical Center.[6]

  Contact: Rebecca Whitaker, MSPH, Director of Health Policy and Governmental Affairs, North Carolina Community Health Center Association, whitakerr@ncchca.org.

- *Community Care of North Carolina (CCNC).*
  North Carolina is nationally known for the work it has done through CCNC in creating patient-centered medical homes for the Medicaid population. CCNC has led to improved health outcomes and reduced health care costs, particularly as costs relate to patients with

chronic or complex health problems. The program is funded through the Division of Medical Assistance (DMA) within North Carolina Department of Health and Human Services (NCDHHS), and the North Carolina Foundation for Advanced Health Programs, Inc. CCNC is a community-based approach that involves primary care providers, federally qualified health centers, and other safety net organizations, hospitals, social services, local health departments, and other community resources that work together to provide care coordination and high quality care for the enrolled population. There are 14 regional community health networks across North Carolina providing services to more than 1.2 million Medicaid and NC Health Choice beneficiaries. Providers in the network are responsible for delivering, coordinating, and managing the care of enrollees and receive a per-member-per-month (PMPM) payment from the state. CCNC also offers clinical improvement initiatives including specific disease management programs (eg, diabetes disease management), medication management programs, chronic care and transitional care programs, and emergency room initiatives. CCNC has been expanded to include a more comprehensive team-based approach, embedding care managers, pharmacists, psychiatrists or other behavioral health professionals, and nutritionists in the networks and in some of the larger patient practices. The team focuses on care for people with chronic or complex health conditions, working to improve the quality of care provided as well as patient self-management skills.[7]

Contact: Torlen Wade, Executive Director, NCCCN, Inc., twade@n3cn.org; Denise Levis Hewson, RN, BSN, MSPH, Director of Clinical Programs and Quality Improvement, NCCCN, dlevis@n3cn.org.

- *CCNC Pregnancy Home.*
  CCNC's Pregnancy Home initiative aims to improve the quality of perinatal care by increasing healthy birth outcomes and thereby reducing Medicaid expenditures. The initiative is modeled after CCNC's primary care case management program. The goal is to reduce the low birth weight rate by 5% per year in the first two years and to achieve a primary c-section rate at or below 20%. Medicaid providers who choose to become a Pregnancy Medical Home must ensure there are no elective deliveries before 39 weeks, administer progesterone ("17P" project) to reduce premature births, decrease primary cesarean section rates, perform a standardized high-risk screening on all initial visits, integrate care with the pregnancy care manager from the local health department, and agree to open chart audits. All qualified Medicaid providers that provide prenatal care are eligible to become a Pregnancy Medical Home. Participating providers receive incentives such as exemption from prior approval for obstetric ultrasounds, a $50 incentive for each risk screening form, a $150 incentive for each post-partum visit, and an increased reimbursement rate for a vaginal delivery.

  Women who are determined to be at risk of poor birth outcome, specifically preterm birth (based on the screening), will be assigned a pregnancy care manager from the local health department. Priority patients include those with a history of preterm birth or low birth weight, chronic disease that might complicate the pregnancy, multifetal gestation, fetal complications, tobacco use, substance abuse, unsafe living environment, unanticipated

hospital utilization, two or more missed prenatal visits without rescheduling, or when a provider requests care management assessment.

Contact: Kate Berrien, RN, BSN, MS, Pregnancy Home Project Coordinator, North Carolina Community Care Networks, Inc., kberrien@n3cn.org.

- *North Carolina Community Care Networks, Inc. (NCCCN) 646 Demonstration.*
  Section 646 of the Medicare Modernization Act (MMA) created a five-year demonstration program to improve safety, effectiveness, efficiency, patient-centeredness, and timeliness of care for Medicare enrollees. NCCCN is one of two organizations currently receiving funding to test new models to achieve these goals. Eight of the 14 networks in NCCCN are participating in the demonstration, which began on January 1, 2010, and will end on May 31, 2014. NCCCN builds on CCNC's patient-centered medical home model by including dual-eligibles and Medicare-only beneficiaries. The program assigns beneficiaries to a primary care physician, provides community-based care coordination services, expands case management information systems, and uses a performance measurement and an incentive program to encourage improvements in care and reductions in cost.[8,9]

  The program is being implemented in 26 counties: Bertie, Buncombe, Cabarrus, Chatham, Chowan, Edgecombe, Gates, Greene, Hertford, Hoke, Lincoln, Madison, Mecklenburg, Mitchell, Montgomery, Moore, New Hanover, Orange, Pasquotank, Pender, Perquimans, Pitt, Sampson, Stanly, Union, and Yancey.[10]

  Contact: Angela Floyd, NCCCN, afloyd@n3cn.org.

- *CHIPRA Grant Demonstrations.*
  These grants were awarded to establish and evaluate a national quality system for children's health care that encompasses care provided through the Medicaid program and the Children's Health Insurance Program (CHIP). This grant is funded by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). The CHIPRA statute mandates the experimentation and evaluation of several promising ideas to improve the quality of children's health care.[11] North Carolina was one of 18 states that received CHIPRA grant funds.

  North Carolina's CHIPRA grant is focused on three primary areas. The first is a statewide initiative to collect and report pediatric quality measures to CMS and to report these measures on a quarterly basis to the networks and practices to drive quality improvement. CMS has identified 24 measures. To date, the practices are reporting on 13 of the 24 measures and have plans to report on 23 of the 24 measures by the end of 2012. In addition, the state has voluntarily added five measures which it is collecting. As part of this statewide initiative, CCNC is working with DMA to develop and distribute an Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) report card at the network and practice level which will report on rates of well-child (EPSDT) screens for children under age 21, as well as developmental, autism, vision, and hearing screens, Body Mass Index (BMI) measurement, and lead testing. CCNC has also hired 14 part-time Quality Improvement (QI) specialists through this grant. They are housed in the 14 CCNC networks to support primary

care practices throughout the state. The second component is focused in seven of the 14 CCNC networks. It is focused on strengthening the medical home for children, particularly for children and youth with special needs. This initiative began in 11 practices, and is providing learning collaboratives to help practices with community linkages and referrals, maternal depression screening, child and adolescent mental health risk factors and screenings, and developmental and autism screenings for children birth through age five. This work is supported through the NC Center for Excellence for Integrated Care and four full-time QI specialists. Finally, the third component focuses on developing and evaluating a pediatric electronic health record (EHR) model. Rather than work with a specific vendor to develop a software package, North Carolina's initiative is focusing on evaluating a set of best practice standards for effectiveness and improving quality child health care. Any EHR vendor can participate, and those that do will be more competitive, as national certification for meaningful use will be based on the model that North Carolina is helping develop.

Contact: Stacy Warren, Project Coordinator-CHIPRA, stacy.warren@dhhs.nc.gov.

- *North Carolina's Health Home State Plan Amendment (SPA).*[12]
  The ACA gives states the option of creating "health homes" for Medicaid recipients with chronic health problems. States receive 90% enhanced Federal Medical Assistance Percentage (FMAP) rates for the health home services for up to eight fiscal quarters. DMA's SPA has been approved by CMS.[13] North Carolina's health home will strengthen the coordination between primary care providers and those who are meeting the needs of people with mental health or substance use disorders, or those with intellectual and developmental disabilities.

  Contact: Debbie Pittard, Debbie.pittard@dhhs.nc.gov

- *BCBSNC and UNC-CH Medical Home.*[14]
  Blue Cross and Blue Shield of North Carolina (BCBSNC), in partnership with the University of North Carolina-Chapel Hill (UNC-CH), designed a PCMH facility, Carolina Advanced Health, which is located in Orange County. The facility is part of a three-year pilot program. The home will serve 5,000 BCBSNC patients with a focus on the chronic care population with coronary artery disease, hypertension, hyperlipidemia (high cholesterol), diabetes, chronic obstructive pulmonary disease (COPD), chronic heart failure or asthma. The facility includes a pharmacy, a lab, a range of providers, extended hours, and state-of-the-art information technology. The model includes integrating administration with medical practice and a team-based care approach. Evaluation of the model will include patient satisfaction, carrier satisfaction, and clinical metrics.[15]

  Contact: Don Bradley, MD, Senior Vice President and Chief Medical Officer, BCBSNC, don.bradley@bcbsnc.com.

- *State Health Plan Maternity Case Management Incentive Program.*
  The State Health Plan implemented a two-year maternity care incentive pilot program to incentivize pregnant women to engage in care management in the first trimester. Women will receive telephone nurse support and education to support healthy birth outcomes and identify

high-risk conditions. Active participants will have their hospital inpatient copayment waived at time of delivery. The goal is to decrease pregnancy-related complications, preterm deliveries, low birth weight babies, and neonatal intensive care unit admissions.

Contact: Anne Rogers, RN, BSN, MPH, Director of Integrated Health Management, State Health Plan, Anne.Rogers@shpnc.org.

- *WellPath Models to Improve Quality and Value.*
  WellPath has entered into new agreements with health systems and medical group practices designed to improve the quality and value of services provided and enhance patient outcomes. WellPath believes that health care professionals are in the best position to redesign the health care delivery system to enhance quality, outcomes, and efficiency. As a result, WellPath has focused on designing and implementing collaborative approaches to support redesign efforts to remove barriers and financial disincentives that make it difficult for provider groups to achieve these goals. Some of the key elements include:

  - Support for patient-centered medical homes. For example, WellPath has worked with the provider organizations to change provider compensation to support necessary but previously non-revenue producing activities and to more closely align with evidence-based quality measures.
  - Support for provider-led system redesign by aligning benefit plan design and compensation systems for the purpose of meeting the comprehensive needs of the patient/members and providing increased affordability.
  - Comprehensive information sharing between WellPath and the provider organizations to support quality, improved health outcomes, and greater efficiency.

  Two of these arrangements will be operational early in 2012 to serve individuals within Medicare Advantage plans, small group and large group employer plans, and individual plans. Approaches for self-funded employers are anticipated to be available later in 2012.

  Contact: Peter Chauncey, FACHE, Executive Vice President and Chief Operating Officer, WellPath, A Coventry Health Care Plan. PWChauncey@cvty.com.

- *North Carolina Health Care Facilities Association's "Journey to National Best" demonstration of the effectiveness of nurse practitioners in skilled nursing care facilities*.
  One of the initial efforts as part of the *Journey to National Best* (described more fully in Nursing Home Culture Change), supported by NC DHHS, has been a carefully evaluated demonstration of the utility and effectiveness of nurse practitioners in skilled nursing care facilities. This project, implemented in a single facility in North Wilkesboro, NC, showed the impact of an on-site nurse practitioner, as evidenced by lower rates of re-hospitalization, lower medication errors, and higher levels of patient satisfaction. Efforts are underway to negotiate with federal Medicare fiduciary agents and DMA to work out procedures for payment for these services (as has been the case with NPs in primary care) when the NP is an employee of the nursing facility, but supervised by multiple physicians responsible for individual patient care. Although some North Carolina nursing homes already employ nurse practitioners and have reported similar results, widespread adoption of this innovation awaits

resolution of these payment arrangements with Title 18 and 19 authorities.[16]

- *FutureCareNC Oral Hygiene Demonstration.*
  FutureCareNC, the nonprofit research and educational foundation of the North Carolina Health Care Facilities Association, is sponsoring an oral hygiene demonstration in partnership with a multi-disciplinary team from UNC-Chapel Hill for participating facilities in 2010 and 2011. This project focuses on oral care procedures to improve oral and nutritional outcomes as well as training for promoting oral care with resistive individuals. Dedicated oral health aides have been trained to provide routine, daily oral health care for patients unable to provide these services for themselves. Projects employing similar approaches in other states have demonstrated both improved hygiene and health outcomes, as well as increased dietary intake and positive self-esteem of patients. Early results from the North Carolina demonstration projects have shown similar results.

  Contact: Craig Souza, President, North Carolina Health Care Facilities Association (NCHCFA), craigs@nchcfa.org.

TRANSITIONS OF CARE

Description of ACA Provisions

- *Community-based care transitions program*.[17]
  The ACA appropriated $500 million (FFYs 2011-2015) to CMS to support collaborative partnerships between hospitals and community-based organizations that provide improved care transition services to high risk Medicare beneficiaries. The initiative focuses on high risk traditional fee-for-service Medicare beneficiaries with chronic illnesses, including cognitive impairment, depression, and history of multiple readmissions. This demonstration began on January 1, 2011.

North Carolina Initiatives

- *NCCCN's 646 Demonstration.*
  NCCCN, a community-based organization, coordinates patient care among providers, including hospitals, to improve overall quality of care for Medicare beneficiaries and dual-eligibles. One performance measure for quality involves transition of care. For more details on the 646 Demonstration, please see North Carolina initiatives under Patient-Centered Medical Homes.[18]

ACCOUNTABLE CARE ORGANIZATIONS (ACOS)

Description of ACA Provisions

- *Medicaid global payment system demonstration project*.[19]
  The US Department of Health and Human Services (HHS) Secretary, in conjunction with the newly established Innovation Center, shall establish the Medicaid Global Payment System Demonstration Project. This project, to be tested in no more than five states, will adjust state payments to an eligible safety net hospital from fee-for-service to monthly capitated payments for years FY2010 through FY2012. The

Innovation Center will test and evaluate patient outcomes and costs resulting from this model. Funds for this project have been authorized but not appropriated.

- *Pediatric ACO demonstration in Medicaid*.[20]
  Allows pediatric medical providers that meet specified requirements to be recognized as an accountable care organization (ACO) for purposes of receiving incentive payments. This demonstration is specifically for Medicaid and CHIP and lasts from January 1, 2012 to December 31, 2016. Money has been authorized but not appropriated.

- *Medicare shared savings program*.[21]
  Establishes a shared-savings program for Medicare providers no later than January 12, 2012. Providers meeting eligibility requirements determined by the Secretary can coordinate care for Medicare beneficiaries through an ACO. ACOs that meet quality requirements set by the Secretary can receive these capitation payments. ACOs are required to report measurement data as determined by the Secretary. This section was amended to allow for other methods of making payments such as partial capitation models. North Carolina Medicare Shared Savings ACO participants announced in April and July 2012 are listed below. CMS is expected to announce the next round of participants on January 1, 2013 which is likely to expand North Carolina's list of Medicare Shared Savings Program ACOs.[2223]

  Start Date: July 1, 2012

  Cornerstone Health Care, PA
  1701 Westchester Drive, Suite 850
  High Point, NC 27262
  Andrew Weniger, CPA
  andrew.weniger@cornerstonehealthcare.com

  Meridian Holdings, Inc.
  4477 West 118th Street, Suite 304
  Hawthorne, CA 90250
  Anthony C. Dike, MD, FACP
  323-295-5062

  Triad Healthcare Network, LLC
  1200 N. Elm St.
  Greensboro, NC 27403
  Steve Neorr
  855-484-6669

  Start Date: April 1, 2012

  Accountable Care Coalition of Caldwell County, LLC
  321 Mulberry Street, SW
  Lenoir, NC 28645
  Jim Korry

713-770-1121

Accountable Care Coalition of Eastern North Carolina, LLC
1315 South Glenburnie Road, Suite A-3
New Bern, NC 28562
Jim Korry
713-770-1121

Coastal Carolina Quality Care, Inc.
1020 Medical Park Avenue
New Bern, NC 28562
Carrie Hagan, MBA, CPC, CHCC
chagan@cchealthcare.com

North Carolina Initiatives

- *NCCCN 646 Demonstration.*
  The 646 Demonstration is a shared-savings ACO program, which offers the potential to share savings with CCNC networks. If NCCCN is able to show improved health outcomes and lower health care costs, then it can share in the savings with CMS. For more details on the 646 Demonstration, please see North Carolina initiatives under Patient-Centered Medical Homes.[24]

- *CCNC.*
  While CCNC does not currently share savings with the state or federal government, CCNC could potentially meet the requirements for a Medicaid pediatric ACO. Providers participating in a CCNC network receive PMPM payments from the state. For more details on CCNC, please see North Carolina initiatives under Patient-Centered Medical Homes.

- *Forsyth Medical Group Physician Group Practice Demonstration.*
  Forsyth Medical Group, located in Winston-Salem, was one of 10 sites selected for the CMS Physician Group Practice demonstration for Medicare beneficiaries. The five-year demonstration began in 2005. The demonstration was designed to improve coordination of Medicare hospital, physician, and outpatient services; promote quality and cost effectiveness; and reward physicians for positive patient outcomes. Providers receive incentive payments based on Physician Quality Reporting Initiative (PQRI) measures in diabetes, congestive heart failure, coronary artery disease, and preventive care. Each practice was allowed to design its own care programs in order to meet the quality measures.

  Forsyth Medical Group developed the COMPASS Disease Management Program and the Safe Med programs as a part of the demonstration. The demonstration program uses COMPASS Disease Management Navigators and Safe Med Pharmacists to identify patients at the time of hospital discharge who are at high risk for readmission and/or adverse events such as those with high- risk diseases and/or multiple/high-risk prescriptions. At-risk patients are identified at discharge and contacted for an assessment to determine their understanding and ability to follow discharge instructions and medication regime. Patients are also assessed for their understanding of their disease process and offered self-management tools and

coaching. The patients are directed back to their primary care provider for follow-up care. Another part of the program uses physician-led teams to promote programs and educate patients to improve quality and outcomes. All practices in the nationwide demonstration have met benchmark performance on at least 29 of 32 measures. Novant met 100% of the quality outcome measures for project year (PY) one and PY2. In PY3 and PY4 the group met 96% for the minimum quality targets. The data for PY5 is in the process of being analyzed.[25,26]

Currently, the CMS is allowing ACOs to apply for participation in this demonstration until the Medicaid Shared Savings Program begins on January 1, 2012.[27]

Contact: Nan Holland, RN, MPH, CPHRM, Senior Director, Clinical Excellence, Novant Medical Group, nlholland@novanthealth.org.

- *PACE Model.*
  The Program of All-Inclusive Care for the Elderly (PACE) model is designed to care for the frail elderly who want to receive long-term care services in their own community instead of in a nursing home. Patients receive adult day-center services and in-home services such as transportation, nutrition counseling, social services, case management, primary care, specialized therapies, and nursing care through the program. To receive PACE benefits, an individual must be 55 years of age or older, eligible for Medicaid under the state's criteria for nursing facility level of care, reside in a PACE-approved area, and be safely served in the community. Medicaid pays PACE a monthly fee for each recipient, allowing PACE to provide all services patients need without the limitations of fee-for-service systems. Medicare covers some of the costs for dual eligibles in addition to the Medicaid payments. Only nonprofit and public entities can have PACE models. All programs are monitored on an ongoing basis by the state and CMS to ensure compliance.

  There are currently four PACE models in North Carolina: Elderhaus, Inc. in Wilmington and Piedmont Health SeniorCare in Burlington, PACE of the Triad, Greensboro, LIFE (Living Independently For Seniors) at St. Joseph of the Pines in Fayetteville, and PACE at Home in Newton. Other PACE models are in development in Durham, Hickory, Statesville, Greenville, and Asheville.

  In general, PACE models in North Carolina have seen a majority of patients improve or maintain performance in activities of daily living and cognitive functions.[28]

  Contact: Jennifer Barton, RN, North Carolina Division of Medical Assistance, jennifer.barton@dhhs.nc.gov.

ALL-PAYER PAYMENT REFORM

Description of ACA Provisions

- *Allowing states to test and evaluate systems of all-payer payment reform.*[29]
  States can test and evaluate payment reform systems for the medical care of all residents in the state including dual eligibles. This demonstration is a part of the new Innovation Center.

North Carolina Initiatives

- *North Carolina Multi-payer Demonstration in seven rural counties.*
  North Carolina was one of the first eight states awarded a demonstration grant under the new Innovation Center. The demonstration is to test a multi-payer partnership between NC DHHS, CCNC, BCBSNC, and the State Health Plan. The demonstration will allow individuals in seven rural North Carolina counties (Ashe, Avery, Bladen, Columbus, Granville, Transylvania and Watauga) who are enrolled in Medicare, BCBS, or the State Health Plan to enroll in Community Care networks. Community Care medical homes in these seven counties currently serve over 112,000 Medicaid beneficiaries. The program is expected to expand the number of patients served to over 128,000 Medicare beneficiaries and over 121,000 privately insured or State Health Plan recipients.[30] Medicare will support this initiative by paying per member per month payments to primary care practices and CCNC networks to pay for care management and quality improvement activities.

  Contact: Torlen Wade, Executive Officer, NCCCN, Inc., twade@n3cn.org.

CO-LOCATION MODELS

Description of ACA Provisions

- *Co-location of primary and specialty care in community-based mental and behavioral health settings.*[31]
  Grants will be awarded to qualified community mental health programs to implement co-location of mental health and primary care services for special populations. Awards will be used for providing on-site primary care services in community-based mental health settings, paying for medically necessary referrals to specialty care, implementing information technology, and making facility modifications. No more than 15% of the grant money can be used for information technology and facility modifications. This section provides $50 million for FY2010 and then money as needed until FY2014. This demonstration is not specific to Medicare or Medicaid.

North Carolina Initiatives

- *CCNC Co-Location Pilot Program.*
  CCNC's co-location of mental health and primary care pilot program targets practices with high Medicaid enrollment (2,000 or more). The program aims to build practice infrastructure, increase the number of primary care providers who use evidence-based screening tools to identify patients with mental health needs, and increase the number of mental health patients with access to primary care services. Twelve CCNC networks participate in the program. Early evaluations show the program has improved functioning and increased screenings for Medicaid beneficiaries. Significant cost savings have also been identified due to early intervention for behavioral health problems. Medicare and DMA have created new coding to help sustain and expand this model.[32]

  Contact: Torlen Wade, Executive Director, NCCCN, Inc., twade@n3cn.org.

- *Foundation for Advanced Health Program's Center of Excellence for Integrated Care.*

The North Carolina Foundation for Advanced Health Programs (NCFAHP) was initially funded by the North Carolina Health and Wellness Trust Fund and DMA to create a Center of Excellence for Integrated Care. The work is now supported by other contracts and foundations, including funding from the federal CHIPRA Quality demonstration grant, Kate B. Reynolds Charitable Trust, and a contract with the Governor's Institute on Substance Abuse. The Center works to improve patient outcomes through integrating mental health, substance abuse services, and primary medical care. It provides trainings, learning collaboratives, and technical assistance to primary care and behavioral health providers, health departments, Local Management Entities (LMEs), and Critical Access Behavioral Health Agencies (CABHA) to help them implement integrated care models to better serve patients with underlying medical problems, mental health conditions, substance abuse disorders, and/or certain intellectual or developmental disabilities. The Center currently has funding to support integrative practices in primary care and mental health and substance abuse settings in seven of the 14 CCNC networks, including 27 primary care practices. The Center provides training, technical assistance, and learning collaboratives around integrated care processes; brief intervention and referral into treatment for substance abuse disorder, depression, and other forms of mental illness; identification and support for children with autism spectrum disorder; maternal depression; and childhood obesity.

Contact: Regina S. Dickens, Program Director, NC Center of Excellence for Integrated Care, regina.dickens@ncfahp.org; Maggie Sauer, President and CEO, North Carolina Foundation for Advanced Health Programs, Maggie.sauer@ncfahp.org.

COORDINATION OF DUAL ELIGIBLES

Description of ACA Provisions

- *Integrated care for dual eligibles.*[33]
  States are allowed to test and evaluate fully integrated care for dual eligible individuals, including management and oversight of all funds with respect to these individuals. This demonstration is a part of the Innovation Center.

North Carolina Initiatives

- *NCCCN 646 Demonstration (Medicare Shared Savings Program).*
  The 646 Demonstration is a five-year program that coordinates care for Medicare/Medicaid dual eligibles. For more details on the 646 Demonstration, please see North Carolina initiatives under Patient-Centered Medical Homes.

- *CCNC Medicaid Payment for dual eligibles.*
  Medicaid pays CCNC a per-member-per-month payment for all dual eligibles. An increased PMPM payment is given to primary care providers and CCNC for all aged, blind, and disabled beneficiaries, including dual eligibles. This increase was to fund behavioral health integration, embedded care managers in large hospitals and practices, and network privacy and security officers. A portion of the payments are given to NCCCN to fund centralized clinical leadership and the Informatics Center.[34,35] For more details on CCNC, please see North Carolina initiatives under Patient-Centered Medical Homes.

- *PACE Pilots.*
  When an individual enrolled in PACE is eligible for both Medicaid and Medicare, then both Medicaid and Medicare provide PACE with monthly capitation payments.[36] For a more detailed description of the PACE model, please see North Carolina initiatives under Accountable Care Organizations (ACOs).

MEDICATION MANAGEMENT

Description of ACA Provisions

- *Using medication therapy management services such as those described in Section 935 of the Public Health Service Act*.[37]
  This demonstration, which is a part of the Innovation Center, provides medication therapy management (MTM) by licensed pharmacists to treat chronic disease while improving quality and reducing cost. Targeted individuals include those taking four or more medications, taking any high-risk medications, having two or more chronic diseases, or having had a transition of care.

- *Medication management for people with multiple medications and/or chronic diseases*.[38]
  This demonstration is similar to the one above but it is not specific to Medicare or Medicaid. The HHS Secretary shall establish grants or contracts to provide medication management for people with four or more medications, high-risk medications, and/or chronic diseases to improve quality of care and reduce overall costs. The demonstration will be funded by Section 931 of the Public Health Service Act (PHSA), which authorizes $75 million for FY2010-2014.

North Carolina Initiatives

- *Health and Wellness Trust Fund's ChecKmeds NC***.**
  The ChecKmeds NC program, launched in 2007, uses a network of nearly 500 retail and community pharmacists to provide medication reviews to Medicare beneficiaries 65 and older who have a Medicare-approved drug plan. The program targets drug effectiveness, safety, adherence, and cost-effectiveness. Pharmacists under contract with the third party administrator, Outcomes Pharmaceutical Health Care, provide patient education and coordinate patient care among multiple providers. Some of the pharmacists also provide assistance with how to maximize Medicare-approved drug benefits; however, ChecKmeds does not reimburse for this service. When the Health and Wellness Trust Fund lost its funding, the ChecKmeds NC program was moved to the North Carolina Office of Rural Health and Community Care. The program is funded through mid-2012.[39]

  Contact: Ginny Klarman, Community Development Specialist, North Carolina Office of Rural Health and Community Care, ginny.klarman@dhhs.nc.gov.

- *CCNC Pharmacy Management Initiative: The Pharmacy Home Project.*
  The Pharmacy Home uses the Medication Reconciliation PLUS process to coordinate care among multiple providers. This process collects patient data from administrative claims, medical records, case managers, patients, and physicians. The data is then put into a virtual database, which can be accessed by CCNC case managers, pharmacists, and primary care

physicians. The system is used to identify potential adverse events due to drug interactions as well as poor medication adherence.

CCNC has been collecting information on the number and type of medication-related problems that are identified during the Medication Reconciliation PLUS program. The 18-month results through October 2011 indicate that CCNC staff identified 19,022 medication-related problems in 6,927 patients.[40] On average, there were 2.7 problems found per patient reviewed, including patients not taking their prescribed discharge medication (23% of problems identified); poor adherence to medications for chronic conditions (18%); or problems with the medication dose/frequency or duration (19%). Of these problems, 6% were deemed urgent (potentially leading to imminent hospitalization). Identifying these potential events allows the patient's providers to intervene before the events occur. This intervention reduces hospitalizations and re-hospitalizations.[41]

Contact: Troy Trygstad, PharmD, MBA, PhD, Director, Network Pharmacist Program, CCNC, troy@t2email.com.

- *North Carolina State Health Plan Medication Adherence Pilot Project***.**
  The State Health Plan also has a medication adherence pilot project.[42] Under this initiative, started in December 2009, all State Health Plan retirees using diabetes or cardiovascular medications were eligible for a reduction in their copayment. Retirees were targeted due to the high prevalence of these diseases among the retiree population and the potential to improve adherence through reduced cost sharing. By October 2011, approximately 26,000 retirees had participated in the program. Medco, the Plan's Pharmacy Benefit Manager, determined that the program saved members more than $1 million in co-payments, and reduced costs to the State Health Plan by more than $2.3 million. In addition, the medication adherence rate improved by more than 14% for oral diabetes and cholesterol medications, and by more than 19% for blood pressure medications.

  Contact: Sally Morton, PharmD, Clinical Pharmacist, State Health Plan. Sally.Morton@shpnc.org.

- *Senior PharmAssist.*
  The mission of Senior PharmAssist is to "promote healthier living for Durham seniors by helping them obtain and better manage needed medications, and by providing health education, Medicare insurance counseling, community referral and advocacy."[43] The nonprofit program is funded primarily through private donations, with some small government contracts and earned income. This program assists seniors in Durham with medication management, medication access, and tailored health education and community referral that helps seniors remain in their homes. In addition, Senior PharmAssist helps Medicare beneficiaries select appropriate Medicare health and prescription drug plans as Durham County's Senior Health Insurance Information Program (SHIIP) coordinating site.

  The program is evaluated based on medication adherence, health services utilization, functional capability, and satisfaction. Data is collected every six months. After two years, the evaluations have shown a 51% reduction in the rate of any hospitalizations and a 27%

reduction in the rate of any emergency department use.[44]

Senior PharmAssist conducted an evaluation of their SHIIP counseling assistance with stand-alone Part D plan selection for 2010 benefits. Two-thirds of the seniors needed to switch drug plans for a mean savings of $522 (median of $343).[45] The 2011 findings were very similar and have been accepted for publication. These savings do not yet reflect the staff's recommendations for generic or therapeutic substitutions, clinical interventions, or referrals for other subsidies that could help reduce health care or pharmacy costs.

Currently, the program is working to expand its services further through providers in Durham, North Carolina, with a focus on decreasing hospital readmissions for Medicare beneficiaries. Senior PharmAssist has helped other communities begin similar programs and has a newly revised implementation guide. The program is also currently contemplating applying for grants related to the ACA.

Contact: Gina Upchurch, RPh, MPH, Executive Director, Senior PharmAssist, gina@seniorpharmassist.org.

GERIATRIC CARE

Description of ACA Provisions

- *Geriatric assessments and care plans*.[46]
  This Innovation Center initiative will test the use of geriatric assessments and care plans to coordinate care for people with multiple chronic conditions and an inability to perform two or more activities of daily living or a cognitive impairment.

- *Independence at Home Demonstration Program*.[47]
  This demonstration will test a payment-incentive service delivery model with eligible home-based primary care teams who serve eligible Medicare beneficiaries. No more than 10,000 beneficiaries will be served by the demonstration. The Secretary will determine quality and performance standards that the project teams must meet. Payments will be based on a target-spending standard based on the amount the Secretary estimates will be saved annually through the program. Incentive payments will be made to project teams if actual annual expenditures are less than the estimated spending target set by the Secretary. Five million dollars for each fiscal year 2010 through 2015 was appropriated for the demonstration. The demonstration is scheduled to begin no later than January 1, 2012. Agreements with practice teams will last no more than three years.

North Carolina Initiatives

- *Doctors Making Housecalls, LLC*
  Doctors Making Housecalls is a medical practice with 23 board-certified clinicians operating in the Triangle Region of North Carolina. Doctors Making Housecalls provides home-based clinical services to patients who are unable to leave the house, or prefer to receive care in their home. The practice specializes in treating older patients with more complex conditions. Doctors Making Housecalls is equipped with sophisticated technology which allows their

clinicians to perform many tests and procedures normally received in a physician's office in-home.[48]

Contact: 4220 Apex Highway, Suite 200, Durham, North Carolina 27713, (919) 932-5700.

- *Just for Us (JFU).*
  Just for Us is a collaboration of Duke University Health System and Lincoln Community Health Center (LCHC), a federally qualified health center. LCHC patients receive primary care in their home from the JFU-Duke care team. JFU is managed by Duke Community Health. LCHC's aging or disabled patient must be age 30 or older and have an access to care impediment. The care team is comprised of a physician, physician assistant, nurse practitioner, occupational therapist, social worker, community health worker, and phlebotomist. JFU currently serves 350 residents in 14 housing complexes.[49,50] An evaluation of the program two years after its implementation shows that it has substantially reduced emergency room use, inpatient hospital care costs, and improved quality indicators.[51]

  Contact: Frederick S. Johnson, MBA. Assistant Professor, Deputy Director, Division of Community Health, Department of Community and Family Medicine, Duke University Medical Center, johns427@mc.duke.edu.

- *CCNC home visits.*
  As part of CCNC's care-management program, care managers visit patients' homes to provide medication reconciliation, falls prevention assessments, chronic care assessments, home environment assessments, and/or patient education. Patients are given a severity screening and those categorized as "high risk" are given priority for home visitation. Outcome measures of the program include hospital admissions, readmissions, emergency department visits, and follow-up appointments with primary care providers. Home visits are covered in the PMPM payment to CCNC.[52]

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TELEHEALTH/TELEMONITORING AND HEALTH INFORMATION TECHNOLOGY

Description of ACA Provisions.

- *Supporting care coordination of chronically-ill individuals with health information technology*.[53]
  The Innovation Center is authorized to test care coordination for chronically-ill individuals at high risk of hospitalization through a health information technology-enabled provider network that includes care coordinators, a chronic disease registry, and home telehealth technology.

- *Facilitate inpatient care of hospitalized individuals*.[54]
  The Innovation Center is also authorized to test the use of electronic monitoring by specialists based at integrated health systems to improve services to patients at local

community hospitals.

- *Using telehealth services in medically underserved areas and facilities of the Indian Health Service*.[55]
  Another potential initiative of the Innovation Center will be to use telehealth to treat behavioral health issues and stroke and to improve the capacity of non-medical providers to provide health services for people with chronic complex conditions.

North Carolina Initiatives

- *Roanoke-Chowan Telehealth Network Grant.*
  Roanoke-Chowan Community Health Center (RCCHC) received a grant from the North Carolina Health and Wellness Trust Fund in 2006 to establish a daily remote monitoring and chronic care management program. Phase I of the program began in September 2006 and targeted high risk patients with diabetes, cardiovascular disease (CVD), and hypertension. Patients are given monitoring equipment, including a scale, blood pressure/pulse monitor, blood glucose monitor, and a pulse oximeter to monitor their health status daily. Data from these devices, along with other information about a patient's health status and functioning, is sent via a phone line or Internet daily to a secure server. RCCHC RNs monitor data daily, contact the patient via phone and conduct a nursing assessment and education for any patient with abnormal readings. When the RN determines a potential need for a change in medical regimen, the RN informs the patient's primary care provider via the EHR. This program allows health professionals to intervene early if a patient's health begins to trend downward. An external evaluation showed a statistically significant reduction in hospital charges for patients who participated in this initiative. Patients in the program demonstrated a statistically significant reduction in diastolic blood pressure and have learned better self-management skills. During 2007-2009, additional funding was obtained by Kate B. Reynolds Charitable Trust, the Obici Foundation, Pitt County Foundation, and Roanoke Chowan Community Benefit to expand RCCHC's remote monitoring program and implement post-discharge remote monitoring and chronic care management for diabetes patients at Roanoke Chowan Hospital. Funding received by East Carolina University (ECU) School of Cardiology implemented remote monitoring for RCCHC/ECU cardiovascular disease (CVD) patients and funding received by Piedmont Health Services implemented remote monitoring for CVD patients.

  North Carolina Health and Wellness Trust Fund Phase II Health Disparities funding, received in July 2009, is targeting Medicaid and dual eligible patients with CVD in five additional Community Health Centers (Bertie Rural Health, Greene County Health Services, Kinston Community Health, Commwell Community Health and Cabarrus Community Health Center). In September 2010, RCCHC received a three-year HRSA Telehealth Network Grant and has expanded or will expand the pilot to North Carolina community health centers (First Choice Community Health Center, Piedmont Health Services, Robeson Community Health Center, Wake Health Systems), a rural hospital (Chowan Hospital), and Pitt County Memorial Hospital East Carolina Heart Institute. RCCHC is currently monitoring and managing patients in 14 North Carolina counties from Ahoskie.[56]

Contacts: Kim Schwartz, MA, CEO, Roanoke-Chowan Community Health Center, kschwartz@pcmh.com; Bonnie Britton, MSN, RNC, Telehealth Administrator, University Health Systems of Eastern Carolina. Bonnie.Britton@uhseast.com.

- *East Carolina University Telepsychiatry.*
  The ECU telemedicine program has been in continuous operation since its inception in 1992, making it one of the longest running clinical telemedicine operations in the world. The Telemedicine Center provides clinical telehealth services and support, conducts telehealth research, consults and oversees new and existing statewide telehealth networks and openly educates health care providers and the public on the utility of telehealth. Currently, ECU's telemedicine network consists of various sites across the state delivering direct patient care from multiple physician-read stations within the medical campus. The Telemedicine Center provides the necessary functions for conducting clinical telemedicine transactions, including scheduling, network operations, troubleshooting, training, and administrative support to those sites receiving medical services from ECU Physicians and other local health care providers.

  The telepsychiatry network includes sites in 13 Eastern North Carolina counties (Northampton, Gates, Hertford, Bertie, Edgecombe, Nash, Wilson, Pitt, Greene, Beaufort, Craven, Pamlico, and Jones). Three full-time equivalent psychiatrists provide services to patients through videoconferencing and face-to-face services. The psychiatrists also provide consultation and support for other clinical providers for complicated cases and coordinate with the mobile crisis teams in the 13 counties.[57]

  Contact: Sy Saeed, MD, MS, DFAPA, MAC*Psych*, Professor and Chairman, Department of Psychiatric Medicine, Brody School of Medicine at East Carolina University, Chief of Psychiatry, Pitt County Memorial Hospital, saeeds@ecu.edu.

- *Duke Telepsychiatry.*
  For the past six years, the Durham Child Development and Behavioral Health Clinic in the Department of Pediatrics, formerly the Community Guidance Clinic, has had a telepsychiatry program for children with Axis I diagnoses in three Durham public schools. Child psychiatry fellows offer on-site mental health services and staff enrichment each Tuesday morning in order to continue a child's education in a public school in a therapeutic environment. A maximum of 48 students are served through the program, 24 students from K-5th grade and 24 from 6th-12th grade. Duke faculty supervise the visits and provide consultation via telepsychiatry to each school while the fellows are with the children, teachers, counselors, case managers, and family members. The Department of Pediatrics charges Durham Public Schools for each hour the fellows are on site, billing semiannually. New grant funding has allowed Duke to begin a consultation service to two pediatric clinics through Southern Regional Area Health Education Center (AHEC).

  Contact: Richard E. D'Alli, MD, Med, ScM, Associate Professor of Psychiatry and Behavioral Sciences, Associate Professor of Pediatrics, Department of Pediatrics, Duke

University Medical Center, dalli003@mc.duke.edu

- *Foundation for Advanced Health Program Telehealth Grants.*
  A three-year grant to the North Carolina Foundation for Advanced Health Programs from The Duke Endowment, with matching funds from Medicaid, (totaling $434,000) funded three CCNC networks to test a telehealth program for congestive heart failure. Two of the networks (4C and Sandhills) completed the program. The program supplied telemonitoring equipment to patients at home in conjunction with patient self-management education. The goal was to improve outcomes in Medicaid patients by targeting transitions from acute illness to clinical stability. Case managers and network physicians identified patients to include in the program through hospital discharges and outpatient visits. The telemonitoring equipment transmitted data including weight, blood pressure, oxygen saturation, and clinical status daily to a CCNC nurse case manager. Patients who developed acute problems were managed according to CCNC heart failure protocols. An evaluation, available at the end of March 2011, will be based on patient hospitalization rates, re-hospitalization rates within 12 months, total cost per-member-per-month excluding drug costs, change in heart failure quality of life scores, change in self-management self-efficacy scores, patient satisfaction, and adherence rates.[58]

  Contact: Susan Yaggy, President and CEO, North Carolina Foundation for Advanced Health Programs, susan.yaggy@ncfahp.org.

- *CHIPRA Grant Demonstrations.*
  North Carolina's grant initiative was designed to test the use of new and existing measures of quality for children; provider-based models to improve the delivery of care; and demonstrate the impact of model pediatric EHRs on quality of health, quality and cost. The grant period of performance will be 60 months, from FY 2010 through FY 2015.[59]

  For more details on the CHIPRA Grant Demonstrations, please see North Carolina initiatives under Patient-centered Medical Homes.

  Contact: Stacy Warren, Project Coordinator-CHIPRA, stacy.warren@dhhs.nc.gov.

- *Beacon Grant.*
  The Southern Piedmont Community Care Plan (SPCCP) in Concord was one of 15 communities awarded over $15 million to model a demonstration in HIT. The grant is a part of the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Three counties (Cabarrus, Rowan and Stanly) are participating in the grant and make up the Southern Piedmont Beacon Community. SPCCP will use the grant to improve community-level care coordination in high-risk populations such as diabetics, asthmatics, patients with congestive heart failure, and patients transitioning to medical homes. Objectives of the innovation include increasing EHR penetration (especially in free clinics, health departments, FQHC's and small practices), increasing provider and patient access to health data, reducing rates of duplicate testing, reducing readmission rates, improving chronic disease care, and increasing quality in pharmacotherapy. The Community will work closely with regional technology extension centers, the state, and the National Health Information Technology

Research Center to share experiences with HIT to future organizations implementing the technology. Evaluation will be based on cost, health and outcome measures in high-risk patients.[60] SPCCP will use a Health Record Bank that will allow patients to participate in their care and care managers to access information needed for coordination.[61]

Contact: Cindy Oakes, RN, BSN, Director, Southern Piedmont Community Care Plan, cindy.oakes@carolinashealthcare.org.

- *CCNC Pharmacy Management Initiative: The Pharmacy Home Project.*
  The Pharmacy Home will be expanding to include additional data and capabilities and will be expanded for use by all users of the Health Information Exchange (HIE), including providers who are not part of the CCNC system. North Carolina was just awarded an additional $1.7 million for the HIE to build a system to manage medication information from the HIE and other sources. This system will be built by CCNC on the Pharmacy Home model. The project will be piloted in 10 North Carolina counties: Ashe, Avery, Bladen, Cabarrus, Columbus, Granville, Rowan, Stanly, Transylvania and Watauga. All North Carolina counties will have access to the system by late 2012.[62]

  For more details on CCNC's Pharmacy Home Project, please see North Carolina initiatives under Medication Management.

  Contact: Troy Trygstad, PharmD, MBA, PhD, Director, Network Pharmacist Program, CCNC, troy@t2email.com.

SHARED DECISION-MAKING

Description of ACA Provisions

- *Program to facilitate shared decision-making*.[63]
  The ACA authorizes a demonstration to facilitate collaboration between patients, caregivers, or authorized representative and clinicians. A contracted entity will create standards for decision aids—educational tools to help patients, caregivers, and providers understand treatment options and make informed medical care decisions. Grants will be provided to organizations to develop and implement decision aids that meet standards, facilitate informed decision-making, present up-to-date information, explain any lack in clinical evidence for a treatment, and address decision-making across all age groups. The provision also provides grants to develop Shared Decision-Making Resource Centers. These centers will provide technical assistance to providers and develop and share best practices. This demonstration is not specific to Medicare or Medicaid and went into effect immediately. Money has been authorized for FY2010 and each subsequent fiscal year thereafter.

North Carolina Initiatives

- *CCNC Care Management.*
  Case Managers with CCNC coordinate care between patients and providers. A majority of patients can be taught by a case manager how to manage their own conditions and only need one or two follow-ups. However, patients that need more intensive case-management receive regular services. For more details on CCNC, please see North Carolina initiatives under

Patient-Centered Medical Homes.

- *CCNC Palliative Care Initiative.*
  CCNC is proposing a new initiative to train care managers in palliative/end-of-life care to improve health care quality and resource utilization. The initiative aims to teach care managers clinical skills in care planning, cultural competency, and about important documentation tools in end-of-life planning (eg, power of attorney and DNR). The initiative will also create access to palliative care services through information resources, toolkits for care managers, and toolkits for primary care providers. Eight faculty members will develop the curriculum and toolkit for the training sessions. The one-day sessions will include patient communication, care planning, symptom distress screening, and palliative care services.[64]

  Contact: Denise Levis Hewson, RN, BSN, MSPH, Director of Clinical Programs and Quality Improvement, CCNC, dlevis@n3cn.org.

- *Stanford Self-Management Model.*
  The Division of Aging and Adult Services, within the NCDHHS, collaborated with CCNC to bring Stanford University's Chronic Disease Self Management Program to North Carolina. The program is offered through local Area Agencies on Aging and aims to educate patients with chronic conditions on living a healthy life. Participants in the program meet with two certified trainers once a week for six weeks. The curriculum includes exercise and nutrition, medication usage, stress management, communicating with health care providers, emotional health, problem solving, and supporting others. The evidence-based program helps patients feel better and decreases hospitalizations and emergency room use.[65]

  Contact: Denise Levis Hewson, RN, BSN, MSPH, Director of Clinical Programs and Quality Improvement, CCNC, dlevis@n3cn.org.

MALPRACTICE REFORM

Description of ACA Provisions

- *Medical Malpractice*.[66]
  The HHS Secretary is authorized to award $500,000 in demonstration grants to states for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations. This demonstration is not specific to Medicare or Medicaid and is effective for a five-year fiscal period beginning FY 2011.

North Carolina Initiatives

- *NCORHCC and Access II Care system of near miss reporting and improvement tracking in primary care.*
  The North Carolina Office of Rural Health and Community Care (NCORHCC) and Access II Care (a CCNC Network) received a federal grant of $297,710 to conduct a preliminary study to determine the feasibility of creating a near miss reporting and improvement tracking

system in an ambulatory practice network. The near miss reporting and tracking system will be introduced into six diverse practices. The initiative has three components: 1) a standardized orientation for each practice; 2) reporting and collection of near-miss reports from each practice for six months, and 3) ongoing educational and quality improvement efforts aimed at understanding and learning from the near-miss events including ongoing staff prompts and reminders to use the system. Research aspects of the study include: a) evaluation of the implementation of the system in the six study practices; b) analysis of the types of near-miss events reported including their correlates and the validity of seriousness ratings; and c) evaluation of patient and provider reported behaviors regarding the influence of near-miss disclosure. As a result of this preliminary study, the research team expects to gain a better understanding about how to implement a near-miss reporting system in primary care settings; how practices respond to near-miss event reporting (eg, which types of events may be most amenable to improvement); how increased recognition of near-miss events relates to provider awareness and attitudes toward patient safety and practice change; and how provider disclosure might influence patient behavior in terms of seeking legal advice.[67]

Contact: Steven Crane, MD, Assistant Director, Division of Family Medicine, Mountain Area Health Education Center (MAHEC), steve.crane@pardeehospital.org.

NURSING HOME DEMONSTRATIONS

Description of ACA Provisions.

- *Nursing Home Culture Change*.[68]
  The ACA authorized two three-year demonstration projects by March 2011 to develop best practice models for culture change and use of information technology to improve resident care. This demonstration is not specific to Medicare or Medicaid. Funds have been authorized but not appropriated.

North Carolina Initiatives

- *NC NOVA.*
  The North Carolina New Organizational Vision Award (NC NOVA) was created under a Better Jobs, Better Care grant from the Robert Wood Johnson Foundation and The Atlantic Philanthropies to the North Carolina Foundation for Advanced Health Programs. NC NOVA was expanded to be a statewide program effective January 1, 2007, and program activities were integrated into the Department of Health and Human Services. NC NOVA is a voluntary, incentive-based special state licensure program. Any licensed nursing facility, adult care home, or home care agency whose operating license is in good standing may apply for the NC NOVA special licensure designation. NC NOVA encompasses a comprehensive set of workplace interventions to address the retention and recruitment of direct care workers and the quality of care they provide. The criteria for NC NOVA designation apply equitably across nursing homes, adult care homes, and home care agencies. The four domains of NC NOVA include: 1) supportive workplace, which covers six elements: orientation, peer mentoring, coaching supervision, management support, worker empowerment, reward and recognition; 2) training; 3) balanced workloads; and 4) career development. An applicant must demonstrate on paper and in practice, that it meets the established criteria for each domain.

NC NOVA's determination process is separate from the state's regulatory review and licensure process and is conducted by an independent review organization. The NC NOVA special license is issued by the state.

Staff turnover data from all three care settings, nursing home nurse aide wage data, and nursing home occupancy data are used to compare those organizations with NC NOVA to those who do not have the NC NOVA designation as a means to evaluate program impact. Although early in the analysis, NC NOVA designees tend to show a positive impact.[69]

Contact: Jan Moxley, Office of Long-Term Services and Supports, DHHS, jan.moxley@dhhs.nc.gov.

- *North Carolina Coalition for Long-Term Care Enhancement (NCCLTCE).*
  The NCCLTCE, formerly the North Carolina Eden Coalition, offers enhancement grants to nursing homes to support environmental and cultural changes through new health care innovations. The grants are funded by civil money penalty funds through the North Carolina Division of Health Service Regulation. Changes must improve the quality of life for residents of Medicare/Medicaid certified and Medicaid-only certified long-term care nursing facilities with a history of deficiencies.

  Contact: Becky Wertz, Secretary, NCCLTCE, becky.wertz@dhhs.nc.gov.

- *WIN A STEP UP.*
  WIN A STEP UP (Workforce Improvement for Nursing Assistants: Supporting Training, Education, and Payment for Upgrading Performance) aims to increase recruitment and retention of nursing assistants in North Carolina. It is a partnership between the NCDHHS and the UNC-CH Institute on Aging. After a successful pilot, the program was implemented throughout the state. The pilot of the program was funded by a grant from the Kate B. Reynolds Charitable Trust, but currently the program is funded by civil monetary penalty funds. Nursing assistants are given 33 hours of clinical and interpersonal skills training and a pay-raise from their employer after agreeing to continue working for the employer for at least three months after completing the program. There are no legal penalties, however, for breaking the contract.

  Evaluations of the program show improvement in nursing care, team care, and ratings of career rewards. The most significant result of the program has been the reduction in turnover—participating facilities lower turnover rates by 15 percentage points.[70]

  Contact: Thomas Konrad, PhD, Research Scientist, Institute on Aging, University of North Carolina-Chapel Hill, bob_konrad@unc.edu.

- *North Carolina Health Care Facilities Association's "Journey to National Best".*
  Started in 2005, the *Journey to National Best* is North Carolina Health Care Facilities Association's (NCHCFA) effort to transition skilled nursing homes into facilities of the future. The Journey's goal is to develop strategies to exceed the demands and expectations of

long-term health care consumers and families. To strengthen and transform North Carolina nursing homes, NCHCFA focuses on the issues that are relevant to the lives of residents and the staff who care for them, and works to assure the highest level of health care relevant to the needs of the growing population needing this level of care. The program's mission is a collaborative effort between consumers, policy makers, stakeholders, and providers.

With a grant from The Duke Endowment, FutureCare of North Carolina, the nonprofit research and educational foundation sponsored by the Association, conducted a two-year project "Enhancing the Skills of Nursing Practice in North Carolina Long-Term Care Facilities," 2008-2010. In this project, FutureCareNC launched one of the first projects of its kind in the nation, employing a patient care simulator (PCS) mannequin and a nurse educator in 34 participating nursing homes in North Carolina for 3-5 days per facility. All nursing personnel (at every level: NA, LPN, RN) working in each facility were exposed to clinical modules simulating common patient care situations among older adults. Through these hands-on learning experiences, nursing home staff were exposed to the very best of both nursing education as well as the latest technologies for learning. Emphasis in these sessions was on observational and reporting skills, especially those essential to effective clinical teamwork and individual nursing staff self-efficacy. The experience gained in this initial FutureCareNC project led to a new initiative to use the same technology and approach in addressing the leading categories of medication errors in nursing homes.

For more details on *Journey to National Best*, please see North Carolina initiatives under Patient-Centered Medical Homes.

Contact: Craig Souza, President, North Carolina Health Care Facilities Association (NCHCFA), craigs@nchcfa.org.

HEALTH CARE INNOVATION AWARDS

From clinic to community: achieving health equity in the southern United States
Duke University, in partnership with the University of Michigan National Center for Geospatial Medicine, Durham County Health Department (Durham County, NC), Cabarrus Health Alliance (Cabarrus County, NC), Mississippi Public Health Institute (Quitman County, MS), Marshall University, and Mingo County Diabetes Coalition (Mingo County, WV) plans to use innovation grant funding to reduce death and disability from Type 2 diabetes mellitus among 57,000 underserved, at-risk people in four Southeastern counties.

To support intervention decision making and monitoring, the program will institute an informatics system. Patient-centered care will be coordinated through "local home care teams." Program implementers aim to reduce ED and hospital admissions and the need for amputations, dialysis, and cardiac procedures through preventive care.[71]

Contact: Robert M. Califf, MD, Project Lead, robert.califf@duke.edu.

Building a statewide child health accountable care collaborative: the North Carolina strategy for improving health, improving quality, reducing costs, and enhancing the workforce

North Carolina Community Care Networks, Inc., in conjunction with the Carolinas Medical Center-Charlotte, Duke University Health System, University of North Carolina Hospitals, Vidant Medical Center-East Carolina, and Wake Forest Baptist Health, as well as the children's units at Cape Fear Valley Health, Cone Health, Mission Hospital, New Hanover Regional Medical Center, Presbyterian Healthcare, and WakeMed Hospitals, plan to use innovation grant funding to form a Child Health Accountable Care Collaborative.

The Collaborative aims to improve continuity of care and health care access as well as reduce ED visits, hospitalizations, and pharmacy costs for 50,000 Medicaid and CHIP children with chronic diseases. Care coordination will occur through specialist office "special care managers" and through "parent navigators" (who will work with parents in the home).[72]

Contact:

Regional Integrated Multi-Disciplinary approach to Prevent and Treat Chronic Pain in North Carolina

The Mountain Area Health Education Center plans to use innovation grant funding to pilot "team-based enhanced primary care" for patients with chronic pain. The target population includes over 2,000 people across 16 counties in Western North Carolina. Program implementers expect to improve the health of patients, enhance patient ability to manage pain, and reduce the frequency of outpatient visits.[73]

Contact:

OTHER NORTH CAROLINA NEW MODELS

Value Based Insurance Product Design

Another "new model" that is being tested among private insurers is value based insurance design (VBID). With VBID, insurers encourage enrollees to use services or medications of higher value by reducing or eliminating the out-of-pocket cost sharing (for example, eliminating cost sharing for highly effective medications) or by increasing the cost sharing on services, procedures, or medications that are less useful.[74] VBID products can also be designed to provide financial incentives to enrollees to encourage them to obtain care from high quality, lower-cost health care providers. Unlike traditional Preferred Provider Organization (PPO) insurance products—which have differential cost-sharing arrangements for in-network and out-of-network providers—value based insurance products may have multiple tiers of cost sharing. The amount of the cost sharing may differ depending on the procedure/service and the provider. Thus, a large health care system may be considered a best value provider for open heart surgery, but not for knee or hip replacement. Blue Cross Blue Shield of North Carolina is testing a value-based insurance product design for one large employer group.

Contact: Don Bradley, MD, Senior Vice President, Chief Medical Officer, Blue Cross and Blue Shield of North Carolina. don.bradley@bcbsnc.com

Improving Population Health

In addition to the new models that focus on changes in the health care delivery system and payment methodologies, some communities are testing new models focused on improving overall population health. Population health programs include some of the changes in delivery and payment models discussed previously, but also include community-based efforts to address socioeconomics, transportation, literacy, and other broader societal issues that affect population health. The Durham Health Innovation (DHI) is an example of this broader community-focused health intervention. This is a collaboration between Duke Medicine, Durham County Health Department, Durham Center (Local Management Entity), Durham County Department of Social Services, Durham Public Schools, Durham Housing Authority, Durham Parks and Recreation, City of Durham, Lincoln Community Health Center, and numerous other community agencies and faith-based organizations that are working together to improve the health status of Durham County residents. In 2009, DHI funded 10 planning teams to find ways to reduce death or disabilities from diseases or other health problems prevalent in the community. The planning group selected seven neighborhoods as their pilot sites, focusing on areas in the county that are low-income, more heavily comprised of racial and ethnic minorities, and which have greater health problems. DHI involved the targeted communities in selecting priority interventions. Based on this feedback, DHI decided to develop a neighborhood health navigators program to help link community residents with existing health and social services programs; involve community agencies in providing health information; and engage community organizations, faith-based organizations, neighborhood and community leaders, business owners, and community members to ensure healthy foods in schools and neighborhoods and safe places to exercise. DHI is funded through an institutional commitment of $1 million from Duke University, support from the Clinical and Translational Science Awards which are funded by the National Institutes of Health, and in-kind contributions from numerous community organizations.[75]

Contact: Michelle Lyn, MBA, MHA, Associate Director, Duke Center for Community Research, Chief, Division of Community Health in the Department of Community and Family Medicine, Duke University Medical Center, michelle.lyn@duke.edu.

Medicaid Emergency Psychiatric Demonstration

This demonstration program aims to test whether Medicaid can improve patient care and lower costs by reimbursing private psychiatric hospitals for specific services for which Medicaid has been historically unavailable. North Carolina was one of 12 States to be selected to be part of this demonstration.[76]

Innovation Advisors Program

CMS' Innovation Center has selected "innovation advisors" from across the Country to test new models of care in their own organization and to create partnerships across the United States to share innovations and new delivery models.[77] Four advisors have been selected from North Carolina:

Rob Baird MS
Geriatric Practice Management, Inc.
Asheville, NC

Pamela Duncan PhD, PT, FAPTA, FAHA
Wake Forest Baptist Health
Winston Salem, NC

Suzanne Landis MD, MPH
Mountain Area Health Education Center (MAHEC)
Asheville, NC

Zeev Neuwirth MD, MHCM
Carolinas Healthcare System
Charlotte, NC

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1 Patient Protection and Affordable Care Act, Pub L No. 111-148, § 3021, enacting Sec. 1115A of the Social Security Act, 42 USC 1315a.

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