



# Use of Health IT and HIE in Section 2703 Medicaid Health Homes: What Types of Health IT Can Medicaid/CHIP Agencies Support to Build a Health Home Infrastructure for Medicaid Providers and Beneficiaries?

Presented by:

**Mary Pat Farkas**, Health Insurance Specialist, Division of Integrated Health Systems, Disabled and Elderly Health, Programs Group Center for Medicaid, CHIP and Survey & Certification, Centers for Medicare & Medicaid Services

**Denise Levis Hewson, RN, BSN, MSPH**, Director of Clinical Programs and Quality Improvement, Community Care of North Carolina

Moderated by:

**Linda Dimitropoulos, PhD**, Director, Center for the Advancement of Health IT, RTI International

September 29, 2011,  
2:00 p.m.–3:00 p.m. EST

Funded by the Agency for Healthcare Research  
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\* Please note all participants were placed on mute as  
they joined the session.

# Overview

Welcome—Linda Dimitropoulos, RTI

- Before we begin
- Introduction
- Use of health IT and HIE in Section 2703 Medicaid health homes:  
What types of health IT can Medicaid/CHIP agencies support to build a health home infrastructure for Medicaid providers and beneficiaries?

Presented by:

- Mary Pat Farkas, Centers for Medicare & Medicaid Services
- Denise Levis Hewson, RN, BSN, MSPH, Community Care of North Carolina
- Questions and Answers—Linda Dimitropoulos
- Closing Remarks—Linda Dimitropoulos

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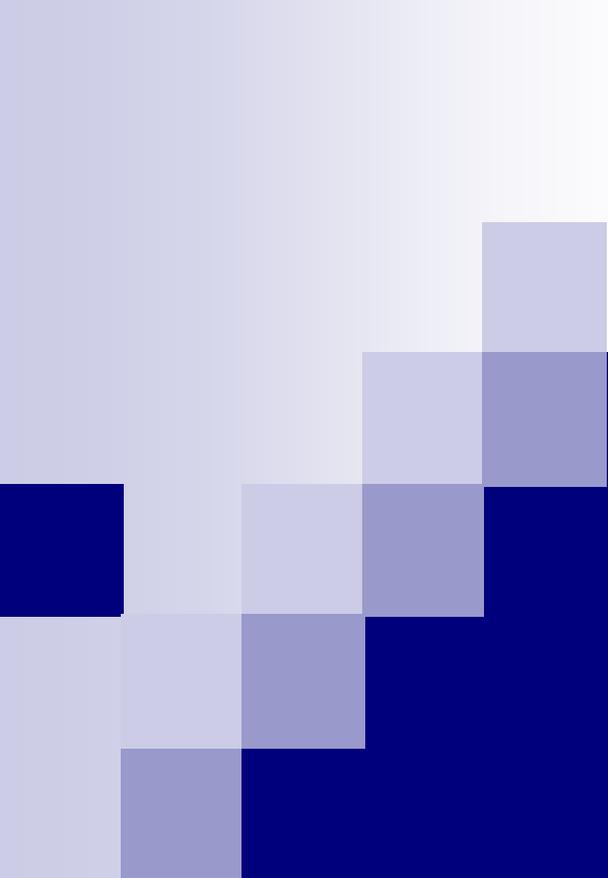


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- As always, thank you!



# Section 2703: State Option to Provide Health Homes for Enrollees with Chronic Conditions

Presented by:

**Mary Pat Farkas**, Technical Director

Division of Integrated Health Systems

Disabled and Elderly Health Programs Group

Center for Medicaid, CHIP, and Survey & Certification

Centers for Medicare & Medicaid Services

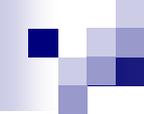
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# Background

- A goal of implementing Section 2703 is to expand the traditional and existing medical home models to build linkages to community and social supports, and to enhance the coordination of medical, behavioral, and long-term care.
- Health home is a new Medicaid State plan option that provides a comprehensive system of care coordination for Medicaid individuals with chronic conditions.
- Health home providers will coordinate all primary, acute, behavioral health, and long-term services and supports to treat the “whole person.”

# General Information

- Section 2703 adds section 1945 to the Social Security Act to allow States to elect this option under the Medicaid State plan.
- The provision offers States additional Federal support to enhance the integration and coordination of primary, acute, behavioral health, and long-term care services and supports for Medicaid enrollees with chronic conditions.
- The effective date of the provision is January 1, 2011.
- States can access Title XIX funding using their pre-Recovery act Federal Medical Assistance Percentages (FMAP) rate methodology to engage in planning activities aimed at developing and submitting a State Plan Amendment.
- Waiver of comparability 1902(a)(10)(B)
- Waiver of Statewideness 1902(a)(1)



# Eligibility Criteria

- Medicaid eligible individual having:
  - two or more chronic conditions,
  - one condition and the risk of developing another,
  - or at least one serious and persistent mental health condition.

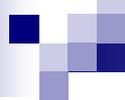
# Chronic Conditions in 2703

- The chronic conditions listed in statute include:
  - mental health condition,
  - substance abuse disorder,
  - asthma,
  - diabetes,
  - heart disease, and
  - being overweight (as evidenced by a BMI of  $> 25$ ).
- Through Secretarial authority, States may add other chronic conditions in their State Plan Amendment for review and approval by CMS.



# Health Home Services

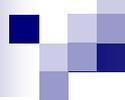
- Comprehensive care management,
- Care coordination,
- Health promotion,
- Comprehensive transitional care from inpatient to other settings,
- Individual and family support,
- Referral to community and social support services, and
- Use of health information technology, as feasible and appropriate.



# Health Home Provider Types

There are three distinct types of health home providers that can provide health home services:

- designated providers,
- a team of health care professionals, and
- a health team.



# Health Home Providers

As noted in the November 16, 2010, SMD letter, health home providers are expected to address several functions including, but not limited to:

- providing quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services;
- coordinating and providing access to high-quality health care services informed by evidence-based guidelines;
- coordinating and providing access to mental health and substance abuse services;
- coordinating and providing access to long-term care supports and services.

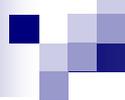


# Enhanced Federal Match

- There is an increased Federal matching percentage for the health home services of 90% for the first 8 fiscal quarters that a State Plan Amendment is in effect.
- The 90% match does not apply to other Medicaid services a beneficiary may receive.

# Enhanced Federal Match, cont.

- A State could receive 8 quarters of 90% FMAP for health home services provided to individuals with chronic conditions, and a separate 8 quarters of enhanced FMAP for health home services provided to another population implemented at a later date.
- Additional periods of enhanced FMAP would be for new individuals served through either a geographic expansion of an existing health home program, or implementation of a completely separate health home program designed for individuals with different chronic conditions.
- It is important to note that States will not be able to receive more than one 8-quarter period of enhanced FMAP for each health home enrollee.



# Reporting Requirements

## Provider Reporting

- Designated providers of health home services are required to report quality measures to the State as a condition for receiving payment.

## State Reporting

- States are required to collect utilization, expenditure, and quality data for an interim survey and an independent evaluation.

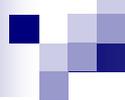
## Reports to Congress

- Survey of States & Interim Report to Congress 2014
- Independent Evaluation & Report to Congress 2017

# Current Health Home SPAs

As of 9-7-2011:

- Three States have submitted health home State Plan Amendments (SPAs):
  - Missouri (one SPA on clock)
  - Rhode Island (two SPAs on clock)
  - Oregon
- Draft proposals under review from six States.
- Thirteen States with approved health home planning requests:
  - Arizona, West Virginia, Mississippi, Arkansas, Nevada, New Jersey, New Mexico, North Carolina, California, Washington, Idaho, Alabama, Wisconsin



# Next Steps

- CMS is providing technical assistance to States interested in submitting a State Plan Amendment.
- CMS will be engaging in rapid learning activities to prepare for the release of well-informed regulations.
- CMS will continue to collaborate with Federal partners, including SAMHSA, ASPE, HRSA, and AHRQ, to ensure an evidence-based approach and consistency in implementing and evaluating the provision.

# Additional Information

- Health homes mailbox for any questions or comments—[healthhomes@cms.hhs.gov](mailto:healthhomes@cms.hhs.gov)
- 11/16/10 Health Homes State Medicaid Director Letter—<http://www.cms.gov/SMDL/SMD/list.asp>
- 12/23/10 CMCS informational bulletin on Web-based submission process for health home SPAs; contact health homes mailbox.



# Community Care of NC— Approach to Medical Home and Population Management

Presented by:

**Denise Levis Hewson, RN, BSN, MSPH**

Director of Clinical Programs and Quality  
Improvement

Community Care of North Carolina

Funded by the Agency for Healthcare  
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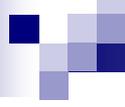


# Our Vision and Key Principles

- Develop a better health care system for NC starting with public payers.
- Strong primary care is foundational to a high-performing health care system.
- Additional resources are needed to help primary care manage populations.
- Timely data are essential to success.
- Must build better local health care systems (public-private partnership).
- Physician leadership is critical.
- Improve the quality of the care provided and cost will come down.
- A risk model is not essential to success—shared accountability is!

# Primary Goals of Community Care

- Improve the care of the enrolled population while controlling costs.
- Provide a “medical home” for patients, emphasizing primary care.
- Provide community networks capable of managing recipient care.
- Have local systems that improve management of chronic illness in both rural and urban settings.



# Community Care: How it Works

- Primary care medical home available to 1.1 million individuals in all 100 counties.
- Provides 4,500 local primary care physicians (94% of all NC primary care physicians—PCPs) with resources to better manage Medicaid population.
- Links local community providers (health systems, hospitals, health departments, and other community providers) to PCPs.
- Every network provides local care managers (600), pharmacists (26), psychiatrists (14), and medical directors (20) to improve local health care delivery.

# How it Works, cont'd.

- State identifies priorities and provides financial support through enhanced per-member/per-month (PM/PM) payments to community networks.
- Networks pilot potential solutions and monitor implementation (physician-led).
- Networks voluntarily share best practice solutions and best practices are spread to other networks.
- State provides the networks (Community Care of NC—CCNC) access to data.
- Cost-savings/effectiveness are evaluated by the State and third-party consultants (Mercer, Treo Solutions).

# Community Care Introduced Four Elements to Support Medical Home

- Provider networks
- Population management:
  - evidence-based programs,
  - high-risk case management, and
  - population stratification.
- Care management/clinical support:
  - medical director,
  - clinical pharmacists,
  - targeted clinical leadership—psychiatrists, palliative care, ob,
  - care managers.
- Data and feedback

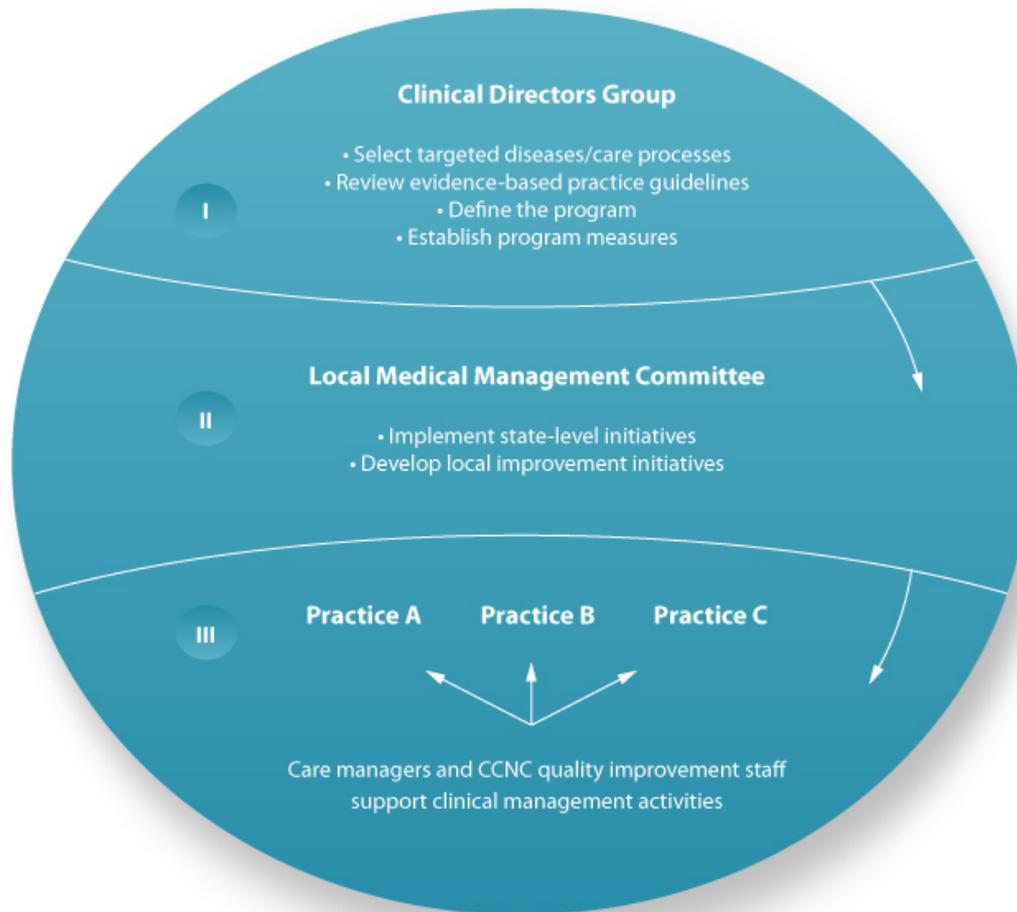
# Community Care Networks

- Are nonprofit organizations.
- Seek to incorporate all providers, including safety net providers.
- Have medical management committee oversight.
- Receive a PM/PM from State for most enrollees.
- Hire care management staff to work with enrollees and PCPs.
- Participating PCPs receive a PM/PM to provide a medical home and participate in disease management and quality improvement.

# Each CCNC Network Has:

- A clinical director who
  - is a physician well known in the community,
  - works with network physicians to build compliance with CCNC care improvement objectives,
  - provides oversight for quality improvement in practices, and
  - serves on the State clinical directors committee.
- A network director who manages daily operations.
- Care managers to help coordinate services for enrollees/practices.
- A PharmD to assist with medication management of high-cost patients.
- Psychiatrist to assist in mental health integration.
- Palliative care and pregnancy home coordinators.

# Managing Clinical Care (Spreading Best Practices)



# Current Statewide Disease and Care Management Initiatives

- Asthma (1998—first initiative)
- Diabetes (began in 2000)
- Dental screening and fluoride varnish (piloted in 2000)
- Pharmacy management
  - Prescription Advantage List (PAL)—2003
  - Nursing home poly-pharmacy (piloted for the State 2002–2003)
  - Pharmacy home (2007)
  - E-prescribing (2008)
  - Medication reconciliation (July 2009)
- Emergency department utilization management (began with pediatrics 2004/adults 2006 )

# Current Statewide Disease and Care Management Initiatives cont'd.

- Case management of high-cost, high-risk patients (2004 in concert with rollout of initiatives)
- Congestive heart failure (pilot 2005; rollout 2007)
- Chronic care program—including aged, blind and disabled
  - Pilot in 9 networks 2005–2007
  - Began Statewide implementation 2008–2009
- Behavioral health integration (began fall 2010)
- Palliative care (began fall 2010)
- Pregnancy home and care coordination for children with special needs (began April 2011)

# Population Management Components

- Outreach/education/enrollment/communication
- Screening/assessment/care plan
- Risk stratification/identify target population
- Patient-centered medical home—evidence-based best practices, and team-based care
- Targeted disease and care management interventions and best practices
- Pharmacy management
- Behavioral health integration
- Transitional care
- Self-management of chronic conditions

# Practices Want Help to “De-fragment” Care

- Patient admitted and discharged from hospital without communication to medical home:
  - Need effective and timely communication with hospitalists/discharge planners.
  - Need to ensure follow-up with PCP and/or specialist, medication reconciliation.
- See multiple specialists without effective communication to medical home.
- Multiple prescribers.
- Information systems do not talk with each other.

# Practices Want Help in Managing Patients with Multiple Comorbidities

- Medication reconciliation
- Personal health record:
  - medication list,
  - problems,
  - specialists, and
  - action plan.
- Help in linking with mental health:
  - Who is the MH provider and how can we communicate with them?



# Practices Want Help to Improve Quality

- Outreach to patients with gaps in care.
- Prepare patient for visit; synchronize patient, information, and visit.
- Activate patients to self-manage their disease.
- Feed data back to the practice and help benchmark against other practices.
- Help educate and follow up with the highest-risk patients.

# Community Care of NC—Now in 2011

- Focused on improved quality, utilization, and cost effectiveness of chronic illness care.
- 14 networks with more than 4,500 PCPs (1,360 medical homes).
- Over one million Medicaid enrollees.
- Actively engaging other payers and providers:
  - 646 quality demonstration ~ 44,000 duals (1/3 of State),
  - Multipayer demonstration in 4 networks (includes Medicaid, Medicare, BCBS, and State Health Plan), and
  - Commercial and self-insured employers.

# Community Care's Informatics Center

- Care Management Information System (CMIS)
- Pharmacy home
- Quality measurement and feedback chart review system
- Informatics Center reports on prevalence, high-opportunity patients, ED use, performance indicators
- Provider portal

# Informatics Center Functions

NCCCN Inc. Informatics Center - Windows Internet Explorer

https://ic.n3cn.org/Menu.aspx

NCCCN Inc. Informatics Center

Information Support for Patient-Centered Care

Community Care of North Carolina

Home | Links | Contact Us | Sign Out | Training

Features  
Applications  
My Profile  
Change Password  
Sign Out

12/21/2009 **Access to IC Report Site**  
Click the link to access IC Report Site. You may also bookmark the site and access it directly: <https://icreports.n3cn.org>

12/21/2009 **Access to Pharmacy Home**  
Click the link to access Pharmacy Home. You may also bookmark the site and access it directly: <https://ph.n3cn.org>

12/21/2009 **Welcome To Informatics Center**

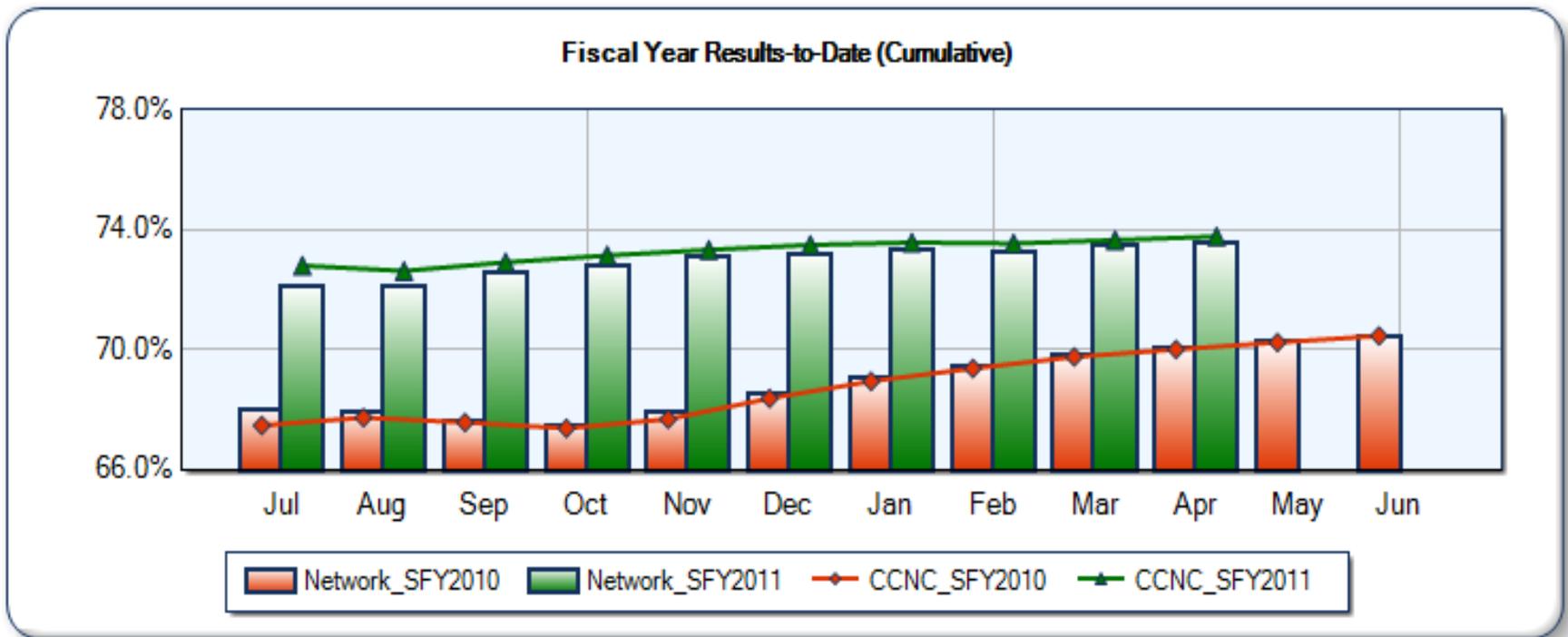
Community Care Informatics Center Functions

- Patient care and care coordination
  - Needs assessment, intervention planning,
  - Risk stratification / patient identification for targeted care management,
  - Care alerts for population management and clinical decision support,
  - Communication of key information for patient care /care coordination,
  - Workflow management and care team communications:
    - CMIS
    - Pharmacy home
    - Provider portal
- Practice- and community-based quality improvement
- Performance measurement and program evaluation

# Coupling Performance Measurement with Actionable Information

Examples of key performance indicators (tracked over time and in comparison to Statewide program performance)

Generic medications as percentage of all fills, all Medicaid nonduals



# ...Coupled with Proactive Assistance to Providers and Patients in Making Good Medication Choices

Pharmacy Home Report Center  
 Home > My Network Reports - AccessCare > Gretchen > 2009 PA and Generics Effort > ACE-ARB-Renin Inhibitors > Branded ACE ARB or Renin Inhibitor users -in regimen- by practice

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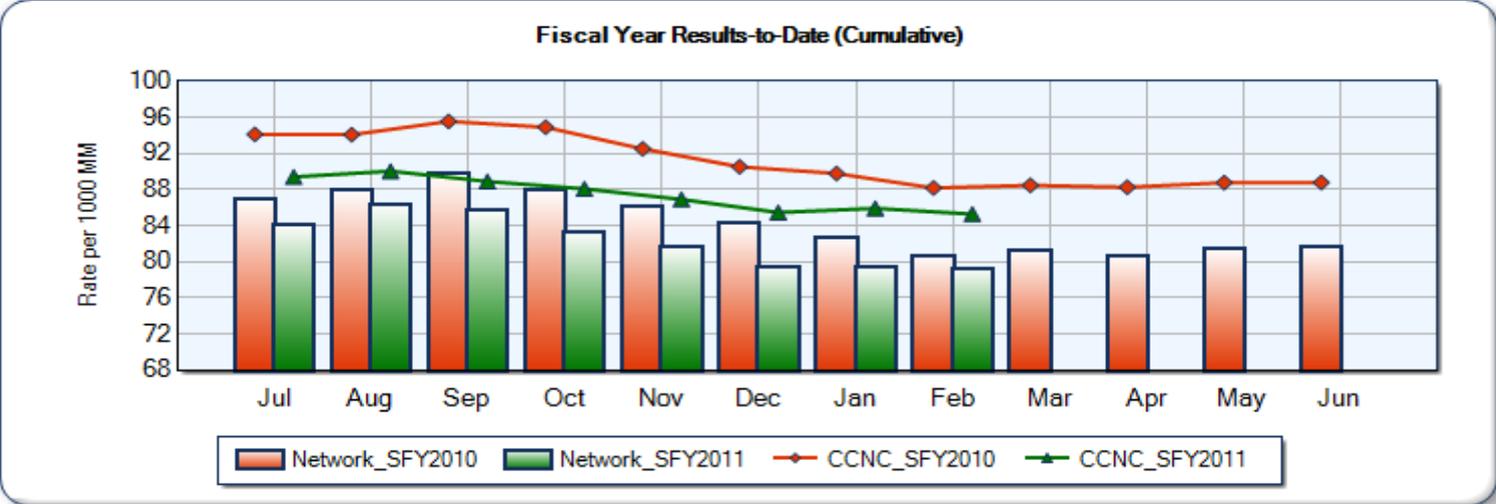
Patients using Branded ACEs, ARBs, or Renin Inhibitors by Practice  
 ("In-Regimen" use with latest in class and use within last year)

Subscription Date	Drug Product	Quantity Filled	Units of Measure	Form	Pharmacy Number	Pharmacy Name	Pharmacy Street Address	Pharmacy City	Pharmacy State	Pharmacy Zip	Pharm Phone
1/4/2010	COZAAR 100 MG TABLET	30.00	TAB	TABLET	0015884	GLEN RAVEN PHARMACY INC	1902 W WEBB AVENUE	BURLINGTON	NC	27217	(336) 58
5/10/2010	MICARDIS 40 MG TABLET	30.00	TAB	TABLET	0418365	WAL MART PHARMACY #10-3658	2720 RING RD	GREENSBORO	NC	27405	(336) 3
5/22/2010	EXFORGE 10-320 MG TABLET	30.00	TAB	TABLET	0015495	CVS PHARMACY 7559	2017 W WEBB AVENUE	GLEN RAVEN	NC	27215	(336) 58
6/8/2010	VALTURNA 150-160 MG TABLET	30.00	TAB	TABLET	0015107	MEDICAL VILLAGE APOTHECARY	1610 VAUGHN RD	BURLINGTON	NC	27215	(336) 22
6/8/2010	COZAAR 50 MG TABLET	60.00	TAB	TABLET	0685024	UNIVERSITY OF NC HOSPITALS	101 MANNING DRIVE	CHAPEL HILL	NC	27514	(919) 96
6/15/2010	MICARDIS 40 MG TABLET	30.00	TAB	TABLET	0015024	ASHER MCADAMS DRUG	305 TROLLINGER ST	BURLINGTON	NC	27215	(336) 22
6/20/2010	MICARDIS HCT 40/12.5 MG TAB	30.00	TAB	TABLET	0015743	CVS PHARMACY 4655	401 SOUTH MAIN STREET	GRAHAM	NC	27253	(336) 22
6/22/2010	DIOVAN HCT 160/12.5 MG TAB	30.00	TAB	TABLET	0015743	CVS PHARMACY 4655	401 SOUTH MAIN STREET	GRAHAM	NC	27253	(336) 22
6/23/2010	MICARDIS 80 MG TABLET	30.00	TAB	TABLET	0015495	CVS PHARMACY 7559	2017 W WEBB AVENUE	GLEN RAVEN	NC	27215	(336) 58
7/2/2010	VALTURNA 150-160 MG TABLET	30.00	TAB	TABLET	0015107	MEDICAL VILLAGE APOTHECARY	1610 VAUGHN RD	BURLINGTON	NC	27215	(336) 22
7/7/2010	DIOVAN 320 MG TABLET	31.00	TAB	TABLET	0920359	KERR HEALTH CARE SERVICES LLC	8431 GARVEY DRIVE	RALEIGH	NC	27614	(919) 53
7/10/2010	MICARDIS HCT 40/12.5 MG TAB	30.00	TAB	TABLET	0418365	WAL MART PHARMACY #10-3658	2720 RING RD	GREENSBORO	NC	27405	(336) 3
7/13/2010	BENICAR HCT 40-12.5 MG TAB	30.00	TAB	TABLET	0015495	CVS PHARMACY 7559	2017 W WEBB AVENUE	GLEN RAVEN	NC	27215	(336) 58
8/7/2009	DIOVAN 80 MG TABLET	30.00	TAB	TABLET	0175125	NORTH VILLAGE PHARMACY INC	1493 MAIN STREET	YANCEYVILLE	NC	27379	(910) 66
4/8/2010	COZAAR 100 MG TABLET	31.00	TAB	TABLET	0805739	MEDEXPRESS PHARMACY LTD	1431 W INNESE STREET	SALISBURY	NC	28144	(704) 63
5/14/2010	DIOVAN HCT 320/25 MG TAB	30.00	TAB	TABLET	0175125	NORTH VILLAGE PHARMACY INC	1493 MAIN STREET	YANCEYVILLE	NC	27379	(910) 66
6/15/2010	DIOVAN 80 MG TABLET	60.00	TAB	TABLET	0175125	NORTH VILLAGE PHARMACY INC	1493 MAIN STREET	YANCEYVILLE	NC	27379	(910) 66
6/21/2010	ATACAND 32 MG TABLET	30.00	TAB	TABLET	0495754	COMMONWEALTH PHARMACY INC	117 EXECUTIVE DRIVE	DANVILLE	VA	24541	(804) 75
6/23/2010	DIOVAN 160 MG TABLET	60.00	TAB	TABLET	0175125	NORTH VILLAGE PHARMACY INC	1493 MAIN STREET	YANCEYVILLE	NC	27379	(910) 66

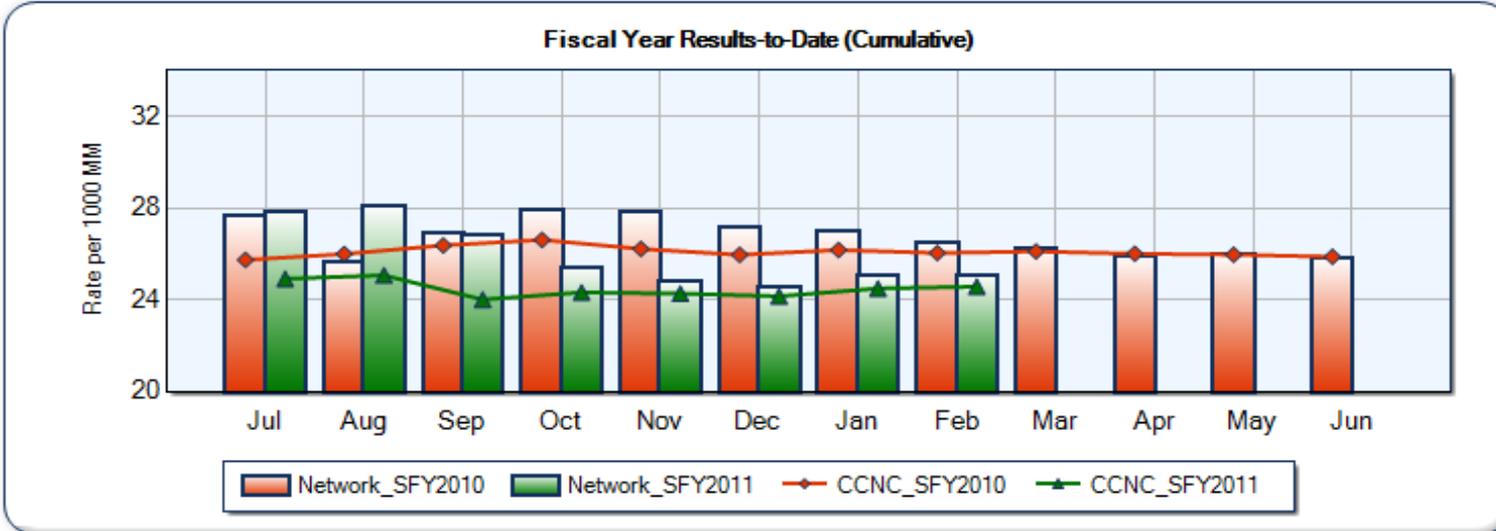
**Community Care of North Carolina**  
 AccessCare  
 MD Easy™ Form for "Instant Approval"

<b>Practice Information</b>		<b>Request Date</b> 05 / 01 / 2007	
Practice Name: <b>Raleigh Physician's Group</b>		<b>Pharmacy Information</b>	
Practice Address: <b>5120 South St Suite 170</b>		Pharmacy Name: <b>Kerr Drug #1083</b>	
Practice City, State, Zip: <b>Raleigh, NC, 27560</b>		Pharmacy Phone: <b>(919) 555-1212</b> Pharmacy Fax: <b>(919) 555-1000</b>	
Practice Phone: <b>(919) 555-8112</b> Practice Fax: <b>(919) 555-1111</b>			
<b>Patient Information</b>			
Patient Name: _____	Patient DOB: <b>11 Nov 52</b>	Patient Address: <b>123 S. Second, Raleigh, NC, 27566</b>	
Please select <u>one</u> of the following three options and fax to pharmacy.			
<b>1) Please switch patient to (select one):</b>			
<input type="checkbox"/> Omeprazole 20mg Cap Circle one: 1QD 1BID 2QD 2BID Other _____ Dispense # _____ Refill # _____		<input type="checkbox"/> OTC Prilosec 20mg Tab Circle one: 1QD 1BID 2QD 2BID Other _____ Dispense # (circle one): 42 84 126 168 Refill # _____	
<b>2) <input type="checkbox"/> Prescribers: In your own handwriting, please indicate one of the following applicable exemption criteria for override in the space provided below for the medication:</b>			
Originally Prescribed PPI: <b>Aciphex 20mg tab</b>		Quantity: <b>30</b>	
Directions for use & route of administration: _____			
<ul style="list-style-type: none"> <li>• "Failed Omeprazole 40mg for 30 days" (within the last 12 months)</li> <li>• Erosive "Esophagitis grade C" or "Esophagitis grade D" (<b>Esomeprazole (Nexium) only</b>)</li> <li>• "Cannot swallow tablets" or "Cannot swallow capsules"</li> </ul>			
Note: "Dispense as written" or "Brand medically necessary" is only applicable for Prilosec 20mg or 40mg, and can only be used after the above criteria have been documented on the face of the prescription.			
<b>Exemption Criteria (write exactly as shown)</b>		<b>Refill # _____</b>	
(Pharmacist - For exemption criteria, use override code 1 in PA field or 2 in submission clarification field. If patient pregnant or breastfeeding, indicate 2 in the pregnancy indicator field or V22 or V23 in the diagnosis field <b>Override begins June 1, 2007.</b> )			
<b>3) <input type="checkbox"/> On or after June 1, 2007, I will initiate PA process and contact ACS at 866-246-8505 (phone) or 866-246-8507 (fax).</b>			
<b>Prescriber Signature</b> _____		<b>Date</b> _____	
<b>Prescriber Name (please print)</b> _____		<b>DEA</b> _____	
<small>Note: By signing this document and 1) checking the OTC Prilosec/Omeprazole substitution or 2) checking the brand name exemption criteria box above you are consenting to this being a legal prescription and the pharmacy should fill it as such. DMA policy requires documentation of exemption criteria in the patient's chart for auditing purposes if option 2 is selected.</small>			

# ED Rate per 1000MM, Enrolled ABD



# Inpatient Admissions per 1000MM, Enrolled Nondual ABD



# ...Coupled with Tools for Monitoring of ED and IP Visits, Updated with Every Claims Payment Cycle

North Carolina Community Care Networks Informatics Center Report Site (Beta)  
[Home](#) > [Access II Care of WNC Standard Reports](#) > [Patient-Level Utilization Reports](#) >  
**ED Visit Report - Network v2**

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New Subscription ↑

PCP County:  PCP:

Hospital:  Service Month:

Age:  ABD:

Dual Eligibility Status:  Emergent:

Paid Date:  Case Manager:

Case Management Status:

2 of 996 | 100% | Find | Next | Select a format | Export

Document Map x

- ED Visit Report - Network v2
  - Tally by Practice
  - Tally by Patient**
  - Visit Detail

MID	Name	Number of Visits	PCP Number	PCP Name	PCP County	DOB
		33	5908214	Medical Associates of Transylvania Community Hospital	TRANSYLVANIA	
		29	343414A	Health Plus of McDowell HSP	MCDOWELL	
		27	5909193	Brevard Family Practice	TRANSYLVANIA	
		26	344556A	Blue Ridge Community Health Services	HENDERSON	
		24	343414A	Health Plus of McDowell HSP	MCDOWELL	
		24	343414A	Health Plus of McDowell HSP	MCDOWELL	
		24	344556A	Blue Ridge Community Health Services	HENDERSON	
		22	344556A	Blue Ridge Community Health Services	HENDERSON	

# Quality Measurement and Feedback: Quarterly Claims— Derived Quality Measures

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 Home > Access III of Lower Cape Fear Standard Reports > QMAF Reports > Claims Measures Reports >  
**Disease Management and Cancer Screening by Network**

Search for:

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YearQuarter: 2009Q4

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**NETWORK SUMMARY**  
**QMAF CLAIMS DISEASE MANAGEMENT AND CANCER SCREENING BY NETWORK 2009Q4**  
**NON-DUAL PATIENTS**

NETWORK	YEAR QUARTER	ASTHMA			DIABETES				HEART FAILURE			ADULT CANCER SCREENING				
		IP ASTHMA PER 1000 MM	ED ASTHMA PER 1000 MM	BETA AGONIST PERCENT	A1C TESTING	EYE EXAM TESTING	CHOLESTEROL SCREENING	NEPHROPATHY SCREENING	IP CHF RATE PER 1000 MM	IP CHF 30 DAY RE-ADMISSION PERCENT	LVF ASSESSMENT PERCENT	COLON CANCER	CERVICAL CANCER	BREAST CANCER AGES 42 TO 69	BREAST CANCER AGES 42 TO 51	BREAST CANCER AGES 52 TO 69
Access II Care of Western NC	2009Q4	0.1	3.8	1.3 %	83%	52%	66%	78%	12.7	0%	90%	32%	57%	47%	44%	49%
Access III of Lower Cape Fear	2009Q4	2.3	10.8	1.0 %	86%	55%	79%	84%	29.3	16%	92%	42%	61%	49%	46%	51%
AccessCare	2009Q4	1.2	8.5	1.1 %	87%	53%	73%	81%	31.4	24%	96%	38%	59%	47%	44%	50%
Carolina Collaborative Community Care	2009Q4	1.0	17.5	1.4 %	86%	59%	80%	86%	58.5	26%	94%	43%	64%	45%	41%	49%
Carolina Community Health Partnership	2009Q4	0.3	9.0	1.3 %	90%	60%	85%	81%	35.2	12%	93%	36%	53%	38%	39%	37%
Community Care of Wake and Johnston Counties	2009Q4	2.0	12.9	1.2 %	86%	47%	72%	83%	41.6	12%	96%	37%	61%	43%	39%	48%
Community Care Partners of Greater Mecklenburg	2009Q4	2.6	11.5	1.2 %	87%	51%	78%	86%	36.9	17%	95%	36%	64%	41%	38%	44%
Community Care Plan of Eastern Carolina	2009Q4	1.8	15.5	1.4 %	88%	55%	75%	83%	29.6	17%	95%	42%	58%	53%	48%	58%
Community Health Partners	2009Q4	1.8	9.8	2.2 %	90%	53%	80%	84%	36.2	9%	98%	41%	58%	44%	43%	47%
Northern Piedmont Community Care	2009Q4	2.0	11.6	1.8 %	78%	53%	73%	84%	48.3	22%	87%	36%	62%	51%	45%	57%
Northwest Community Care	2009Q4	0.5	11.5	1.5 %	83%	55%	72%	79%	28.3	8%	94%	38%	65%	47%	43%	52%
Partnership for Health Management	2009Q4	1.8	8.4	0.6 %	86%	49%	70%	79%	41.5	17%	94%	35%	60%	51%	49%	53%
Sandhills Community Care Network	2009Q4	1.4	8.8	0.9 %	86%	53%	72%	82%	46.5	26%	94%	40%	58%	50%	47%	53%
Southern Piedmont Community Care Plan	2009Q4	1.0	9.8	2.1 %	87%	54%	80%	84%	28.2	17%	91%	38%	60%	48%	44%	52%
<b>All Networks Total</b>	<b>2009Q4</b>	<b>1.5</b>	<b>10.7</b>	<b>1.3 %</b>	<b>86%</b>	<b>54%</b>	<b>75%</b>	<b>83%</b>	<b>35.3</b>	<b>19%</b>	<b>94%</b>	<b>39%</b>	<b>60%</b>	<b>47%</b>	<b>44%</b>	<b>51%</b>

Empty cell indicates no patients were eligible for the measure

Community Care of North Carolina Report Date: 4/26/2010

# Coupled with Actionable Information: Care Alerts

North Carolina Community Care Networks Informatics Center Report Site  
[Home](#) > [Go To Practice Standard Reports](#) > [ALAMANCE](#) > [Charles Drew CHC 344515A](#)  
**Care Alerts**

**View** | **Properties** | **History** | **Subscriptions**

New Subscription

Condition:  Alert:   
 Client County:

1 of 1 | 100%

## Care Alerts

344515A - Charles Drew CHC  
 Report Date: 06/23/2011

Report Details

Number of Patients Returned: 20  
 Number Of Records Returned: 20

MID	Patient Name	Condition	Alert
		Diabetes	Consider Eye Exam
		Diabetes	Consider Eye Exam



Welcome: test capcp

# Provider Portal

Community Care of North Carolina

### Patient Search:

[Logout](#)

Medicaid ID:  Clear All  
 Last Name:  Birth Date:   
 Last Name:  First Name:  Birth Year:

- My Practices
- Patient List
- Patient Profile
- Report Site
- Meducation
- CCNC Info and Patient Mgmt Tools

- Patient Care Team Summary
- Medication Regimen
- Medication History
- Visit History

Patient: <input type="text"/>	Medicaid ID: <input type="text"/>	Gender: <b>Female</b>	Birth Date: <input type="text"/>	Age: <input type="text"/>
Address: <input type="text"/>		County: <b>GUILFORD</b>	Phone 1: <input type="text"/>	Phone 2: <input type="text"/>
Months Medicaid-Eligible: <b>12</b>	Medicaid: <b>Yes</b>	Medicare: <b>No</b>	Other Insurance: <b>No</b>	Program Code: <b>SADC</b>

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patient  
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Health

#### Most Recent Service Providers:

Type	Name	Phone	Date Last Billed
Pharmacy	HEALTHKEEPERZ PHARMACY	(910) 522-0002	
Personal Care Services	WE CARE FOR YOUHOME CARE INC	(910) 735-0500	
Enhanced Mental Health Services	SUNSHINE CENTER, INC.	(910) 734-8549	
Mental Health Services	SOUTHEASTERN REG MENTAL HLTH	(910) 738-3261	

#### Most Recent Office Visit Providers:

Billing Provider	Billing Provider Phone	Attending Provider	Attending Provider Specialty	Date Last Billed
LUMBERTON SURGICAL ASSOCS PA	(910) 738-8556	WILLIAMSON,BARRY.E	GENERAL/THORACIC SURGERY, PROCTOLOGY	
SUNSHINE CENTER, INC	(910) 738-7077	PURDY JR,RANDALL.L	PSYCHIATRY	
LUMBERTON INTERNAL MED GRP	(910) 272-8800	MONTILUS,MAC.A	INTERNAL MEDICINE	
SOUTHEASTERN CARDIOLOGY PA	(910) 671-6177	BEKIC,GEORGE.P	CARDIOLOGY	
MOUSER,TIMOTHY.S	(910) 738-4856	MOUSER,TIMOTHY.S	OPHTHALMOLOGY	
CAPE FEAR PODIATRY ASSOCIATES PA	(910) 484-4191	THOMPSON,MATTHEW.J	PODIATRY	



Welcome: test capcp

# Provider Portal

Community Care of North Carolina

### Patient Search:

[Logout](#)

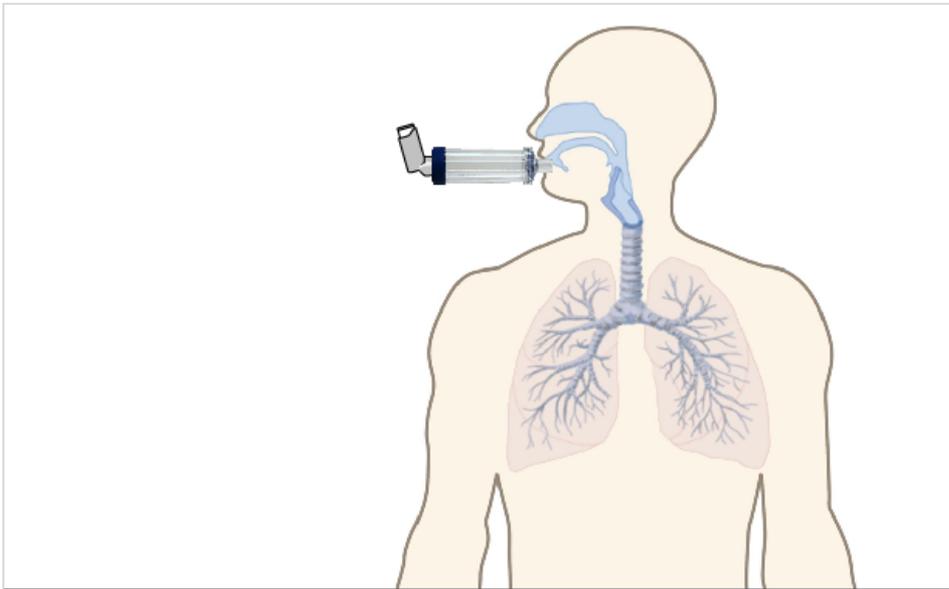
Medicaid ID  Clear All  
 Last Name  Birth Date   
 Last Name  First Name  Birth Year

- My Practices
- Patient List
- Patient Profile
- Report Site
- Medication
- CCNC Info and Patient Mgmt Tools

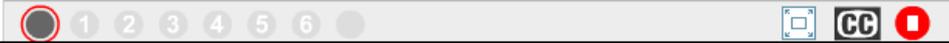
> [Click here to open Medication Site in a separate Window](#)

- Home
- Phrases
- RxGen
- Demos
- Training
- Preferences
- 
- Language:

- Menu
- Player



Select a language:





Welcome: test capcp

# Provider Portal

Community Care of North Carolina

## Patient Search:

[Logout](#)

Medicaid ID  Clear All  
 Last Name  Birth Date   
 Last Name  First Name  Birth Year

- My Practices
- Patient List
- Patient Profile
- Report Site
- Medication
- CCNC Info and Patient Mgmt Tools

> [Click here to open Medication Site in a separate Window](#)

Home
Phrases
RxGen
Demos
Training
Preferences
Language: English v

**Review the medicine instruction. Press Accept to add it to your list of medicines.\***

### Abilify Tablet 10 mg

This medicine is used to improve mood and minimize mood changes.

**How to take medicine**  
Take the medicine by mouth each night at bedtime.

 Morning	 Noon	 Evening	 Bedtime
			1

Take one (1) pill each time.  
You should keep taking this medicine until you are told to stop.

**Instructions**  
Swallow the medicine without crushing or chewing it.  
This medicine may be taken with or without food.  
It is very important that you take the medicine at about the same time every day. It will work best if you do this.  
Keep the medicine at room temperature. Avoid heat and light.

English v

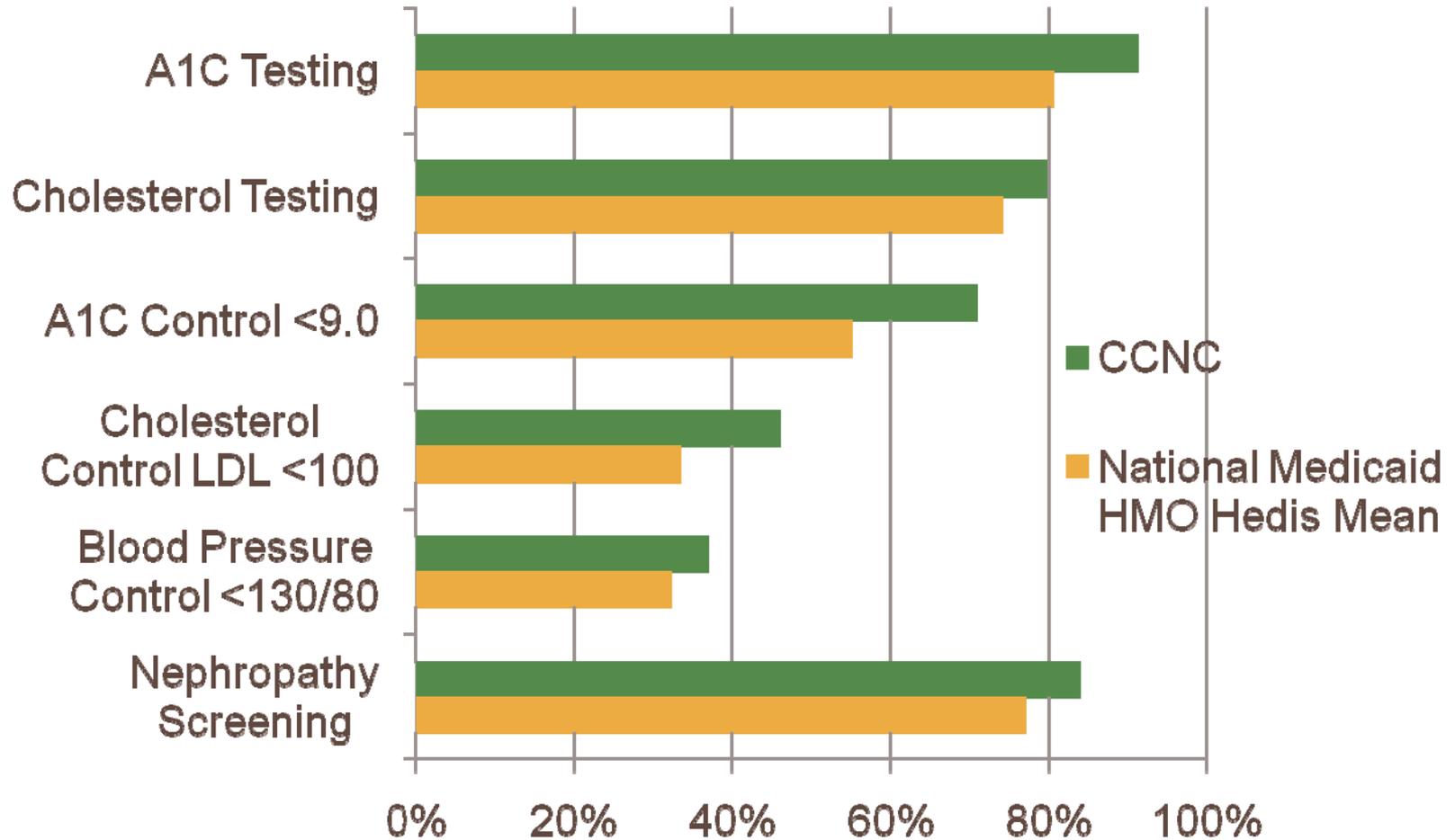
- English
- Spanish
- Arabic
- Cantonese
- French
- Italian
- Korean
- Mandarin (Simplified)
- Mandarin (Traditional)
- Russian

# Systemwide Results

- Community Care is in the top 10% in U.S. in HEDIS for diabetes, asthma, and heart disease compared to commercial managed care.
- Adjusting for severity, costs are 7% lower than expected. Costs for non-Community Care patients are higher than expected by 15% in 2008 and 16% in 2009.
  - For the first 3 months of FY 2011, PM/PM costs are running 6% below FY 2010 figures.
  - For FY 2011, Medicaid expenditures are running below forecast and below prior year (over \$500 million).
  - According to Treo analysis, Community Care's work has meant that more \$1.5 billion in Medicaid costs have been avoided between 2007–2009.

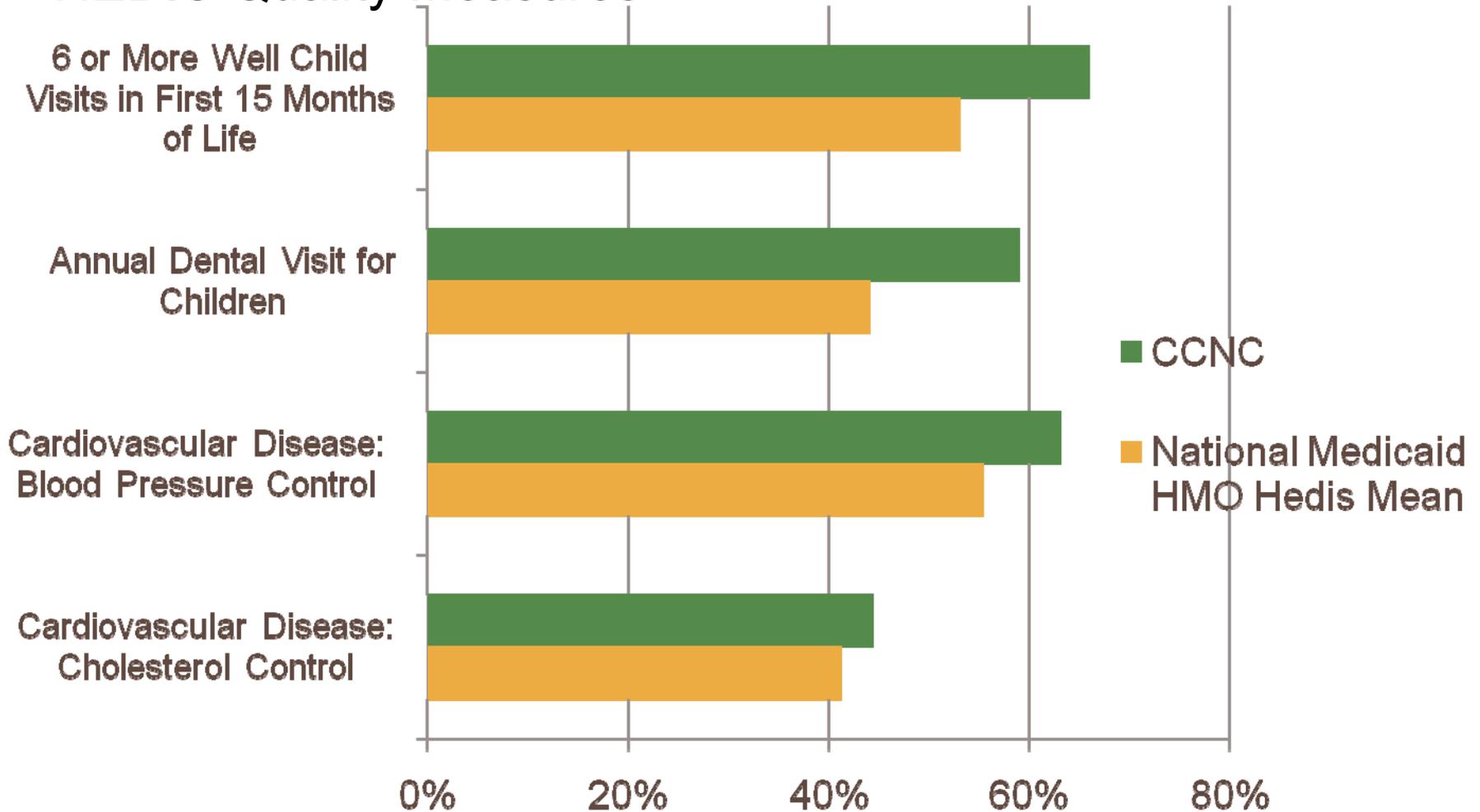
# CCNC Is Outperforming Commercial Managed Care Plans Nationally

## HEDIS Diabetes Quality Measures



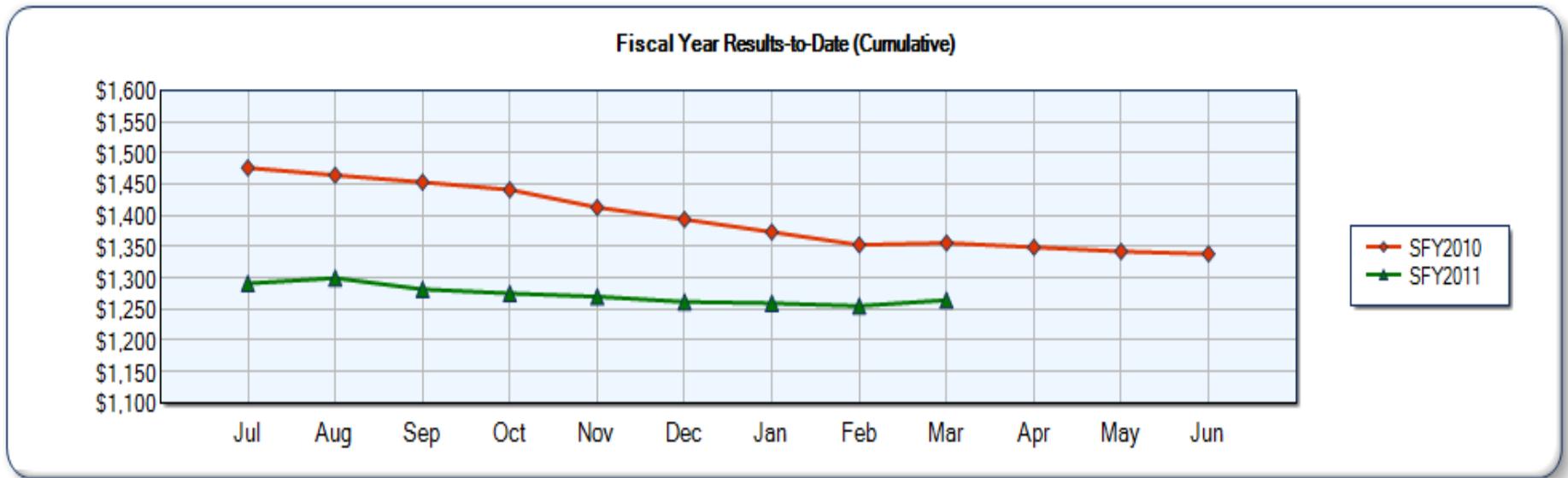
# CCNC Is Outperforming Commercial Managed Care Plans Nationally

## HEDIS Quality Measures



# Lower Spending on Highest-Cost/Highest-Risk Enrollees

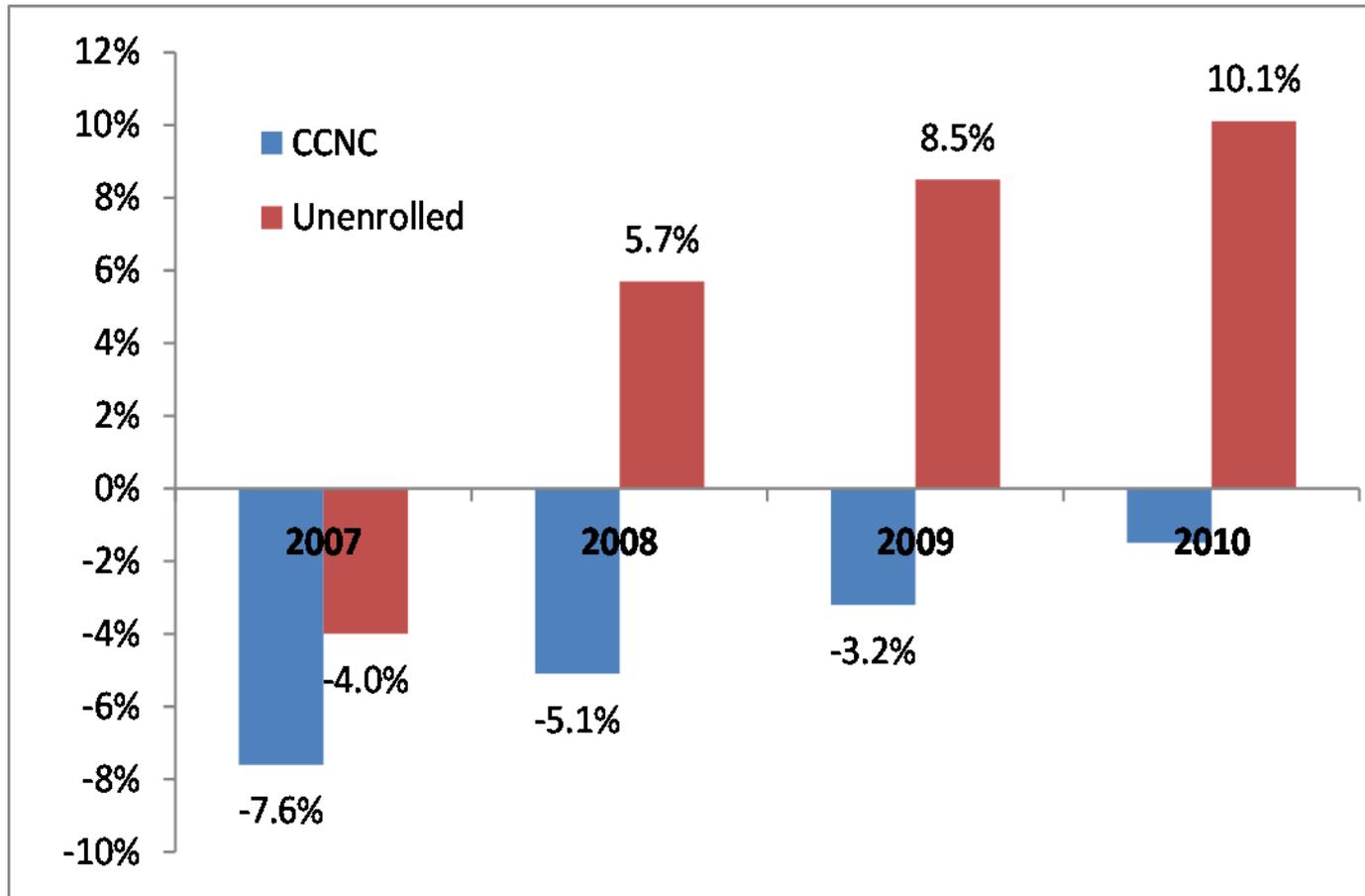
Per Member Per Month Cost for Enrolled (nondual) Aged/Blind/Disabled



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
<b>SFY2010</b>	\$1,476	\$1,464	\$1,453	\$1,441	\$1,413	\$1,394	\$1,374	\$1,353	\$1,356	\$1,350	\$1,343	\$1,339
<b>SFY2011</b>	\$1,291	\$1,300	\$1,281	\$1,274	\$1,269	\$1,261	\$1,259	\$1,254	\$1,264	-	-	-

Fiscal Year Results (Cumulative)

# Actual vs. Expected Costs for Adult ABD CCNC vs. Unenrolled Population 2007–2010



# Next Steps

- Use more robust data systems to support effort.
- Enroll specialists in CCNC.
- Implement Statewide Medicare initiative.
- Build multipayer capacity and support local provider systems (State Health Plan, BCBC, First in Health).
- Test shared savings models (invest in prevention).
- Collaborate with other States.

# Lessons Learned

- Primary care is foundational.
- Data are essential (timely and patient-specific).
- Additional community-based resources to help manage populations needed (best is located in practice).
- Collaborative local networks build local accountability and collaboration.
- Physician leadership is essential.
- Must be flexible: (health care is local) and incremental.
- Make wise choices of initiatives (where you can make a difference—success breeds success).



# More Information?

<http://www.communitycarenc.org>