What is Community Care of Wake & Johnston Counties (CCWJC)?

- CCWJC is the Community Care of North Carolina (CCNC) network for Wake and Johnston Counties serving Carolina Access (CA) Medicaid patients

- CCWJC is the 4th largest CCNC network in North Carolina

- CCWJC serves approximately 115,000 recipients including more than 16,000 aged, blind, and disabled (ABD) people and 16,000 Health Choice recipients.
Community Care of Wake & Johnston Counties

A non-profit partnership between

- Primary Care Providers
- Hospitals
- County Health Departments
- County Departments of Social Services
- Mental Health Agencies
- Wake AHEC – Improving Performance In Practice (IPIP) / Regional Extension Center (REC)
- County School System
- Other Community Programs
The medical home ..... 

Built on the Medical Home model, Community Care matches each patient with a primary care provider to manage and coordinate care across providers and settings.

We support the medical home by...

- Promoting and supporting best practices
- Providing Care Management services to high risk patients
- Offering individual/population management data and care alerts through Community Care’s Provider Portal
- Supporting quality improvement efforts by providing practice-specific data and resources
Family-Centered Regional Partnership Approach

- Community Resources
- Multidisciplinary support
- QI Support
- Primary Care Home
- Patient

Family-Centered Regional Partnership Approach
Community Care of Wake & Johnston Counties

We are charged by Medicaid with:

- Improving health care outcomes
- Reducing care costs

We do this by:

- Implementing best practice guidelines in evidenced-based medicine and health information technology
- Promoting medical home concept with care management services
- Supporting high-risk chronically ill patients through disease management initiatives to include:
  - asthma, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) and diabetes
CCNC Priorities

- Reduce Emergency Department visit rates
- Reduce hospitalization rates
- Reduce 30-day hospital readmissions rates
- Reduce overall cost of care
- Reduce prescription drug costs
- Increase knowledge and practice of evidence-based chronic disease management
- Increase in Well Child Visit rates
- Identify and provide care management to high cost/high risk patients
How We Help Primary Care Practices & Providers

Care Management

- Nurse and Social Work Care Managers work with patients to reinforce providers’ plan of care

Quality Improvement

- We promote best practice guidelines and evidence-based management of chronic diseases through tools, resources and education to providers and staff.

Increased Reimbursement

- Management Fees paid to practice
Once a patient has been assigned for care management, a CCWJC care manager may retrieve information to assist with:

**Program Goals:**

- Implementation of best practice guidelines, achievement of improved clinical outcomes (ex. reduction in HbA1c in patients with diabetes)
- Improve patient self-management of chronic medical conditions
- Improve medication adherence and compliance
- Assist with transition from hospital to home, assisted living facility or other place of residence.
- Decrease non-emergent hospital and ED usage
- Reduce hospital re-admissions

How can care management help your practice?

- Refer high risk/chronically ill patients for services.
- Care Managers will provide education, support, tools, and assistance with medication management.
- Care Managers will assist with primary care and specialist coordination, encourage linkage with a PCP, and provide education about the importance and appropriate use of a primary care home.
Community Care of Wake and Johnston Counties (CCWJC)

Adult Care Management Referral Form

Date: ____________________  Referral Source/Agency: ____________________

Patient Name: ____________________ Male/Female (circle one)

DOB: ____________________ Medicaid ID Number: ____________________

Patient informed of referral? Yes/No (circle one)

Physical Address: ____________________ County: ____________________

Primary Language: English  ______  Spanish  ______  Other (specify): ____________________

Person Referring: ____________________ (MD, RN, SW, Other) please circle

Phone: ____________________  Fax: ____________________

Reason for Referral:

☐ Asthma (please specify):

☐ Repetitive Use of ED Services/Multiple Hospitalizations:

☐ CHF (please specify):

☐ Diabetes (please specify):

☐ Social Concerns/Family Support (please specify):

☐ Mental Health Concerns:

☐ Financial/Housing/Community Resource Needs:

☐ Transportation Needs:

☐ Chronic/Complex Medical Condition(s) Requiring Care Management

☐ Needs assistance in following plan of care for chronic illness (please specify):


Community Care of Wake and Johnston Counties (CCWJC)

Care Coordination for Children (CC4C)

Pediatric Care Management Referral Form – fax completed form to (919) 510-9162

Date: ____________________  Patient Name: ____________________  DOB: ____________________

Male/Female (circle one)  Parent/Guardian informed of referral: Yes/No (circle one)

Parent/Guardian’s Name & Phone #: ____________________

Physical Address: ____________________ County: ____________________

Primary Language: English  ______  Spanish  ______  Other (specify): ____________________

Referral Source/Person: ____________________ (MD, RN, SW, Other) please circle

Agency ____________________  Phone: ____________________  Fax: ____________________

*For children 0-5 yrs, refer directly to GDSA if concern is primarily developmental*

☐ Medicaid ID: ____________________  ☐ Uninsured  ☐ Private Insurance

☐ Asthma  ______  ☐ Diabetes

☐ Repetitive Use of ED Services/Multiple Hospitalizations  ☐ Needs Medical Home

☐ Child in Foster Care Program  ☐ Child w/Mental Health Concern

☐ Child with Special Healthcare Needs (chronic (> 12 mo) physical, behavioral, or emotional condition) (Please specify)

☐ Child who is exposed to toxic stress (circle one: current domestic/family violence, healthcare needs, neglect, unsafe/unstable environment, homelessness in shelter, parent/guardian with substance abuse or mental health condition, parental rights terminated in the past)

☐ Other (Please specify): ____________________

Referrals for Children aged 5-9 years (Must have Carolina Access Medicaid)

☐ Medicaid ID: ____________________  ☐ Asthma  ______

☐ Diabetes  ______  ☐ Transportation Needs

☐ Repetitive Use of ED Services/Multiple Hospitalizations

☐ Child with Special Healthcare Needs (chronic (> 12 mo) physical, behavioral, or emotional condition) (Please specify)

☐ Child w/Mental Health Concern

☐ Other (Please specify):

For Care Manager’s Use Only:

Date: ____________________  Accepted into Care Management

Other Interventions: ____________________

Rev. 7.6.11
Chronic and Transitional Care Management

CCWJC care managers work to dissolve the fragmentation that occurs between providers, hospitals, and home by:

- Targeting care management services to help patients avoid unnecessary emergency room visits, hospitalizations, and re-admissions
- Assisting patients with hospital transition to ensure proper usage of medications, services, and equipment
- Linking the patient back to their medical home after a hospital discharge
- Reconciling medications to determine discrepancies, compliance and adherence
- Coordinating care with the medical home and other community agencies and supportive services
How We Help Primary Care Practices & Providers

Quality Improvement

- Provider Portal access with practice level reports for population management, hospital/ED utilization and quarterly metrics
  - Medicaid claims data for patients such as visit and medication history
- Patient education and disease management tools and resources
- Support for various QI efforts by providing practice level data
  - Annual CCNC Chart Review data feedback
  - Quarterly claims based data feedback
  - Practice specific risk adjusted trending reports on ED, inpatient, readmission, and cost data (Key Performance Indicators)
### Adult Quality Improvement Considerations

**Community Care of Wake & Johnston Counties**

#### Patient Information
- **Name:**
- **Date of Birth:**
- **Practice Name:**
- **MID #:**
- **Last Office Visit:**
- **Reason for chart review:**
  - [ ] Pre-existing appointment
  - [ ] CCNC Chart Review
  - [ ] Other

#### Diabetes
- **Per ADA 2010 Guidelines:**
  - **Hemoglobin A1C:** Yes, last date: ; last value: 
  - **Blood Pressure:** Yes, last date: ; last value: ; No
  - **ACEI or ARB therapy:** Yes, last date: ; last value: ; No
  - **Lipid Profile or Direct LDL:** Yes, last date: ; last value: ; No

#### Heart Failure
- **Per ACC/AHA Guidelines:**
  - **Documentation of Left Ventricular Failure:** Yes, last date: ; last value: ; No
  - **Beta Blocker therapy:** Yes, last date: ; last value: ; No
  - **ACEI or ARB therapy:** Yes, last date: ; last value: ; No
  - **Written Asthma Management Plan:** Yes, last date: ; last value: ; No

#### Ischemic Vascular Disease / Cardiovascular Disease
- **Per ACC/AHA Guidelines:**
  - **Blood Pressure:** Yes, last date: ; last value: ; No
  - **Lipid Profile or Direct LDL:** Yes, last date: ; last value: ; No
  - **Aspirin Use:** Yes, last date: ; last value: ; No

#### Preventive Services
- **Per Medicaid and USPSTF Recommendations:**
  - **Height:**
  - **Weight:**
  - **BMI:**
  - **Daily aspirin therapy:** Yes, last date: ; last value: ; No
  - **Blood pressure status determined:** Yes, last date: ; last value: ; No
  - **Influenza Vaccine (annually), adult 50+ or high risk:** Yes, last date: ; last value: ; No
  - **Pneumococcal Vaccine, 65+ or high risk:** Yes, last date: ; last value: ; No
  - **Mammography within past 2 years (ages 40-69):** Yes, last date: ; last value: ; No
  - **Colonoscopy or fecal occult blood test:** Yes, last date: ; last value: ; No

#### Comments:
- **Chart Review Date:**
- **Phone:**
- **Care Manager:**

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### Pediatric Quality Improvement Considerations

**Community Care of Wake & Johnston Counties**

#### Patient Information
- **Name:**
- **Date of Birth:**
- **Practice Name:**
- **MID #:**
- **Last Office Visit:**
- **Reason for chart review:**
  - [ ] Pre-existing appointment
  - [ ] CCNC Chart Review
  - [ ] Other

#### Asthma
- **Per NIH Guidelines:**
  - **Assessment of environmental triggers:** Yes, last date: ; last value: ; No
  - **Maintenance asthma medication for patient with poor asthma control (e.g. frequent asthma ED visits, exacerbations, steroid pulses or bi-agonist rescue):** Yes, last date: ; last value: ; No
  - **Written Asthma Management Plan (annually):** Yes, last date: ; last value: ; No

#### Diabetes
- **Per 2010 ADA Guidelines:**
  - **Hemoglobin A1C:** Yes, last date: ; last value: ; No
  - **Lipid Profile or Direct LDL:** Yes, last date: ; last value: ; No
  - **Blood Pressure:** Yes, last date: ; last value: ; No
  - **Nephropathy detection or management (age ≥ 10):** Yes, last date: ; last value: ; No

#### Preventive Services
- **Per Medicaid policy:**
  - **Well child visit (annually):** Yes, last date: ; last value: ; No
  - **Blood Pressure:** Yes, last date: ; last value: ; No
  - **Influenza Vaccine (annually, 6 months – 18 years):** Yes, last date: ; last value: ; No
  - **Tobacco use determined (age ≥ 10):** Yes, last date: ; last value: ; No

#### Comments:
- **Chart Review Date:**
- **Phone:**
- **Care Manager:**

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**Quality Improvement**
COMMUNITY CARE OF NORTH CAROLINA
Quality Measurement and Feedback Initiative
Practice Report with Prior Year 6/23/2012

Community Care of Wake and Johnston Counties
WAKE County

Sample 2012: Patients enrolled with Carolina Access at least 11 months during CY 2011 or identified as a 6-49 demonstration patient.
Chart Review Date: 4/12/2012
Charts Reviewed: 116

Look back period of one year from most recent office visit date.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Eligible Patients</th>
<th>Random Sample Patients</th>
<th>Confirmed</th>
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<tbody>
<tr>
<td>DIABETES</td>
<td>10</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>ASTHMA</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>ISCHEMIC VASCULAR DISEASE</td>
<td>7</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>HYPERTENSION</td>
<td>13</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>HEART FAILURE</td>
<td>3</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**DIABETES**

- **ATC Control**: 100.0% * 79.0% 
- **BP Control**: 0.0% * 16.7% 
- **LDL Cholesterol**: 0.0% * 80.0% 

*Among patients ages 5-75 (n=12), for patients with no measurement in prior year, ATC assumed to be > 9.0 and LDL assumed to be > 140.

**ASTHMA**

- **Continued care visit with**
- **Assessment of triggers**: 100.0% * NA 
- **Action plan**: 0.0% * NA 
- **Appropriate Pharmacological**: 0.0% * NA

* Among patients ages 5-49 (n=10).

**PREVENTION AND MANAGEMENT OF CARDIOVASCULAR DISEASES**

- **BP Control < 140/90**
- **Aspirin use**: 25.0% * 60.0% 
- **Lipid testing**: 100.0% * 100.0% 

*Among patients ages 18-75 with HTN (n=15).

**HEART FAILURE**

- **LVF documented in PCP chart**: 100.0% * 100.0% 
- **Beta Blocker use**: 2011 | 2012 | 2011 | 2012 |

* Among patients ages ≥ 18 (n=1).

Notes:
- Rates based on small numbers are unstable and should be interpreted with caution. *Indicates < 10 patients in the denominator.
- N/A indicates that no patients were eligible for this measure. "Appropriate Pharmacological Therapy" not measured prior to 2011.
- Footnotes refer to 2012 rules and sample size.
- COPE chart reviews for the 6-49 demonstration are not included in this report. Refer to patient snapshots for these results.
- Data used in preparation of this information is from protected data sources. Use of this information is intended only for quality improvement activities.
### Total Medicaid Cost PMPM

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<td>PMPM</td>
<td>Risk Adj Index</td>
<td>PMPM</td>
<td>Risk Adj Index</td>
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<tr>
<td>All Enrolled</td>
<td>$31,253</td>
<td>1.018</td>
<td>$304,277</td>
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<tr>
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<td>1.073</td>
<td>$1,271,052</td>
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<tr>
<td>Non-ADO</td>
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<td>0.981</td>
<td>$299,599</td>
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<tr>
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<td>$923,548</td>
<td>0.970</td>
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<td>CHIS</td>
<td>$239,444</td>
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<td>$225,253</td>
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### Emergency Department Visits

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<tbody>
<tr>
<td></td>
<td>ED Rate per 1000 MM</td>
<td>Risk Adj Index</td>
<td>ED Rate per 1000 MM</td>
<td>Risk Adj Index</td>
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<tr>
<td>All Enrolled</td>
<td>69.70</td>
<td>0.989</td>
<td>58.52</td>
<td>0.954</td>
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<tr>
<td>ADO</td>
<td>52.35</td>
<td>0.918</td>
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<tr>
<td>Non-ADO</td>
<td>67.55</td>
<td>0.906</td>
<td>70.65</td>
<td>0.950</td>
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<tr>
<td>ANUE</td>
<td>114.22</td>
<td>0.969</td>
<td>108.07</td>
<td>0.970</td>
</tr>
<tr>
<td>CHIS</td>
<td>92.34</td>
<td>0.996</td>
<td>70.58</td>
<td>0.971</td>
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### Inpatient Admissions

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<tbody>
<tr>
<td></td>
<td>IP Rate per 1000 MM</td>
<td>Risk Adj Index</td>
<td>IP Rate per 1000 MM</td>
<td>Risk Adj Index</td>
</tr>
<tr>
<td>All Enrolled</td>
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<td>0.603</td>
<td>4.29</td>
<td>0.608</td>
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<tr>
<td>ADO</td>
<td>20.33</td>
<td>0.982</td>
<td>20.34</td>
<td>0.834</td>
</tr>
<tr>
<td>Non-ADO</td>
<td>2.01</td>
<td>0.504</td>
<td>2.01</td>
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<tr>
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<td>16.31</td>
<td>0.941</td>
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<td>CHIS</td>
<td>2.44</td>
<td>0.846</td>
<td>2.50</td>
<td>0.856</td>
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### Potentially Preventable Readmissions

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<td>PPR Rate per 1000 MM</td>
<td>Risk Adj Index</td>
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<td>Risk Adj Index</td>
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<tr>
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<td>0.790</td>
<td>2.02</td>
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<tr>
<td>Non-ADO</td>
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<td>0.970</td>
<td>0.12</td>
<td>0.814</td>
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<tr>
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<td>0.870</td>
<td>1.37</td>
<td>0.819</td>
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<tr>
<td>CHIS</td>
<td>0.11</td>
<td>0.833</td>
<td>0.13</td>
<td>0.830</td>
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</table>
Provider Reimbursement

- **Providers in Network**
  - $2.50 PMPM for all CA Medicaid
  - Vs. $1 for CA or $0 straight Medicaid for non-Network
  - $5.00 PMPM for ABD—NEW REIMBURSEMENT

For XXXXX Practice

XXX CA patients x $2.50 X 12 = $ XXXXX.XX

XXX ABD patients x $5.00 x12 = $XXXXXX.XX

(Based on CA July 2012 enrollment) $ XXXXX.XX per year
Additional Programs & Initiatives

- Pregnancy Medical Home
- Chronic Pain
- Palliative Care
- Children’s Health Insurance Program Reauthorization Act (CHIPRA)
- Smoking Cessation
- Congestive Health Failure
- First In Health
- Active Health
Provider Services Contacts

Anne Morton, Provider Services Manager  
amorton@wakedocs.org  Ph 919-528-5665  Fax 919-528-3396

C. Lucas, Provider Services Specialist  
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Ashley Aull, Provider Services Representative  
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Jaimica Wilkins, Provider Services Liaison  
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