



Improving Care, Saving Money

- Community Care was established in 1998 as a partnership between North Carolina and 14 provider networks across the state covering all 100 counties.
- In 2007, CCNC was incorporated as a 501(c)(3) to create a Central Office that supports clinical and quality program implementation and makes possible a robust Informatics Center.
- CCNC is a private sector, community-based approach to managed care that is led by local physician champions.
- Approximately 5,000 physicians and other health care providers work closely with CCNC networks as do public health departments and all of the state's hospitals.
- Community Care serves more than 1.3 million North Carolinians, including more than 90,000 uninsured residents.
- Community Care is an award-winning program recognized in 2007 with the Annie E. Casey Innovations Award from Harvard University.

The Results: Savings and Quality Care

- A 2011 study by national consulting firm Milliman, Inc. estimated that CCNC saved North Carolina Medicaid nearly a **billion** dollars from 2007 to 2010.
- Earlier studies by Treo Solutions and Mercer also identified significant program savings.
- From 2008 through 2012, North Carolina was one of only two states to show a year to year decrease in its total expenditure for Medicaid (NASBO, 2012).
- CCNC has improved the quality of care for chronic conditions, consistently achieving both year-over-year improvement and above-average HEDIS scores compared to corporate Medicaid managed care organizations.

Community Care by the Numbers:

- Total CCNC enrollment = 1.3 million, including more than 90,000 uninsured.
- CCNC serves more than 981,000 children and 400,000 Aged, Blind and Disabled (ABD).
- Approximately 41% of the ABD population has co-morbid behavioral health conditions.
- CCNC's statewide network includes more than 1,600 medical homes and 5,000 primary care providers.
- Four of five North Carolina primary care physicians participate in CCNC programs.
- 14 CCNC networks have approximately 800 care managers, 30 medical directors, 14 network directors, 18 clinical pharmacists, 10 local psychiatrists.

What Makes Community Care Special?

- CCNC provides patient-centered medical homes in all 100 North Carolina counties.
- Nonprofit, private-sector approach to care that keeps overhead low and savings in North Carolina.
- Every patient has access to a patient-centered medical home and a primary care physician who assumes responsibility for his or her care.
- Efforts to improve care and save money are owned and led by clinicians directly caring for patients.
- Palliative care programs that help patients determine what care they need and what setting will provide the best quality of life possible.
- Effective transitional care programs that connect patients with on-the-ground care managers familiar with local health care resources.
- Targeted care programs include Pregnancy Medical Home, Chronic Pain Initiative and Care Coordination for Children (CC4C).
- CCNC's Informatics Center provides regular quality and care management data to networks and practices to drive improvement.
- Health departments, departments of social services, local hospitals, mental health organizations and area health education centers are key partners.
- Care managers know their patients and the community resources available to assist them.

Community Care Key Activities:

- Use health data analytics to identify and intervene with “highly impactable” patients.
- Manage transitions between care settings, especially hospital discharges.
- Coordinate home health and doctor visits after a hospital stay, including medication reconciliation.
- Manage high-risk and high-cost patients with two or more chronic conditions to prevent expensive complications and avoidable hospital readmissions.
- Avoid duplication of services by coordinating care for patients working with multiple agencies and/or multiple health care providers.
- Direct patients to community resources that help them get well and stay well.

Community Care and Behavioral Health:

- Primary care medical homes screen patients for depression, mental health or substance abuse issues and collaborate with behavioral health service providers.
- Strong focus on patients with co-morbid medical and behavioral health conditions.
- Community Care networks connect patients to local mental health agencies and/or providers.
- Community Care networks review quality-of-care issues with service providers to ensure appropriate care and follow up.
- In select practices, primary care and behavioral health providers are being co-located to support integrated care.

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