Enhanced Primary Care Case Management System

Legislative Report

North Carolina Community Care Networks, Inc.

Quarterly Report

As of October 1, 2010

Contents

Reporting Requirement (Section 10.36(h))

"NCCCN, Inc., shall report quarterly to the Department and to the Office of State Budget and Management (OSBM) on the development of the statewide Enhanced Primary Care Case Management System and its defined goals and deliverables as agreed upon in the contract. Beginning July 1, 2010, NCCCN, Inc., shall submit a quarterly report to the Secretary of Health and Human Services, OSBM, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division on the progress and results of implementing the quantitative, analytical, utilization, quality, cost containment, and access goals and deliverables set out in the contract. NCCCN, Inc., shall conduct its own analysis of the Community Care system to identify any variations from the development plan for the Enhanced Primary Care Case Management System and its defined goals and deliverables set out in the contract between DMA and NCCCN, Inc. Upon identifying any variations, NCCCN shall report the plan to DMA within 30 days after taking any action to implement the plan."

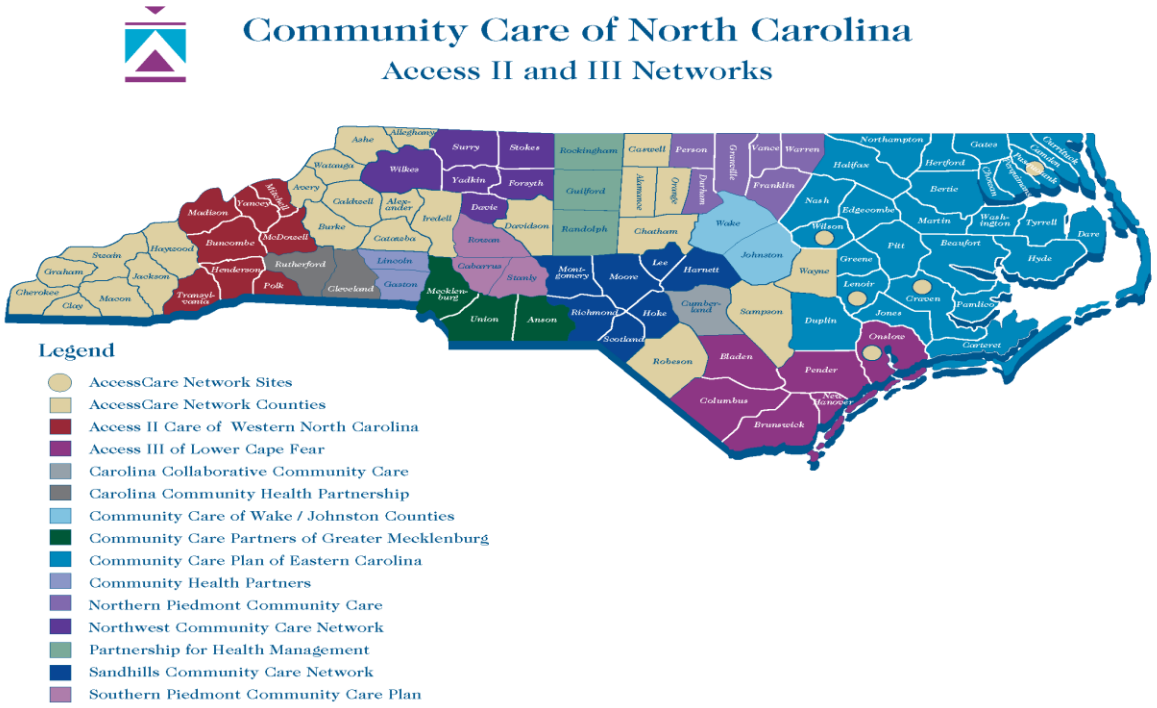
Introduction

The NCCCN Inc. is a not-for-profit administrative entity designed to (a) work with Community Care Networks assisting them to establish, support, and maintain provider-network case management relationships with local providers to develop an organized health care delivery system for Medicaid Network enrollees such that services provided are coordinated across a full continuum of care and (b) develop processes and formal programs to promote population health management principles, community development, quality improvement and cost containment efficiencies, service utilization, budget analytics and forecasting to address the challenges of providing health services to the Medicaid population in the state of North Carolina, including all rural and underserved areas such that cost and quality of care delivery is influenced favorably.

Under the Community Care system approach to health care delivery, certain clinical, disease and case management services are purchased for enrollees and disease and care management support systems are established which implement quality improvement initiatives and test new approaches to population management. Further, the approach is based on a fee-for-service model with an enhanced services case management fee. COMMUNITY CARE Networks coordinate health care services with the Primary Care Providers (PCPs) who function as the enrollees' Medical Homes while achieving budget performance goals and benchmarks.

Pursuant to Session Law 2010-31 §10.36(h) regarding Community Care in North Carolina, the North Carolina Community Care Networks Inc. is submitting this quarterly report to document the results of its efforts with regard to the implementation of a statewide Enhanced Primary Care Case Management System as well as associated goals and objectives. Contractual deliberations between NCCCN, Inc. and the Division of Medical Assistance are being conducted currently and this report includes information with regard to chart review and claims based performance measurements which NCCCN believes with be set forth in the contract when it is executed between DMA and NCCCN, Inc.

The Total and the Aged, Blind and Disabled (ABD) member enrollment in the Community Care Networks as of September, 2010 was 1,039,086 and 192,520, respectively while the total number of practices enrolled in Community Care was 1,433. The overall profile of the Community Care system and its fourteen (14) networks as of September, 2010 is as follows:



Community Care of North Carolina Networks

Access Care: Alamance, Alexander, Alleghany, Ashe, Avery, Burke, Caldwell, Caswell, Catawba, Chatham, Cherokee, Clay, Davidson, Graham, Haywood, Iredell, Jackson, Macon, Orange, Robeson, Sampson, Swain, Watauga, and Wayne.
September 2010 Enrollment: Total - 225,664; ABD – 34,532 277 Practices

Access II Care of Western NC: Buncombe, Henderson, Madison, Mitchell, McDowell, Polk, Transylvania and Yancey
September 2010 Enrollment: Total - 52,626; ABD – 10,967 65 Practices

Access III of Lower Cape Fear: Bladen, Brunswick, Columbus, New Hanover, Onslow and Pender
September 2010 Enrollment: Total - 57,028; ABD – 14,630 136 Practices

Carolina Collaborative Community Care: Cumberland
September 2010 Enrollment: Total - 46,570; ABD – 9,887 79 Practices

Carolina Community Health Partnership: Cleveland and Rutherford
September 2010 Enrollment: Total = 23,794; ABD – 4,115 20 Practices

Community Care Partners of Greater Mecklenburg: Anson, Mecklenburg, Union
September 2010 Enrollment: Total - 118,041; ABD – 17,980 156 Practices

Community Care of Wake and Johnston Counties: Wake, Johnston
September 2010 Enrollment: Total – 77,596; ABD – 10,708 89 Practices

Community Care Plan of Eastern Carolina: Beaufort, Bertie, Camden, Carteret, Chowan, Craven, Currituck, Dare, Duplin, Edgecombe, Gates, Greene, Halifax, Hertford, Hyde, Jones, Lenoir, Martin, Nash, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Washington and Wilson
September 2010 Enrollment: Total - 128,879; ABD – 35,480 212 Practices

Community Health Partners: Gaston and Lincoln
September 2010 Enrollment: Total – 33,051; ABD – 5,764 47 Practices

Northern Piedmont Community Care: Durham, Franklin, Granville, Person, Vance and Warren
September 2010 Enrollment: Total – 49,245; ABD – 9,479 40 Practices

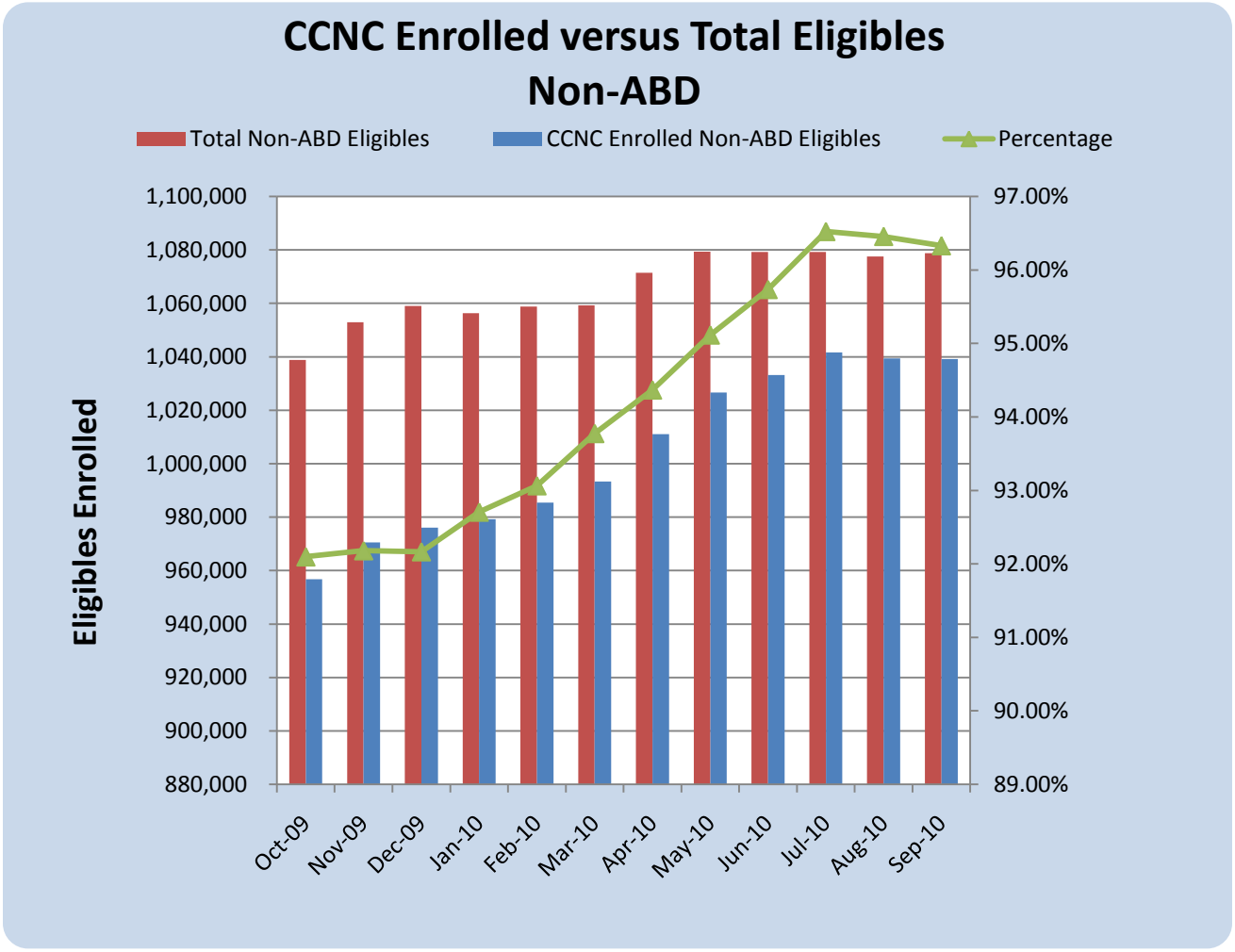
Northwest Community Care Network: Davie, Forsyth, Stokes, Surry, Wilkes, and Yadkin
September 2010 Enrollment: Total – 74,436; ABD – 14,400 108 Practices

Partnership for Health Management: Guilford, Randolph and Rockingham
September 2010 Enrollment: Total – 52,380; ABD – 6,814 50 Practices

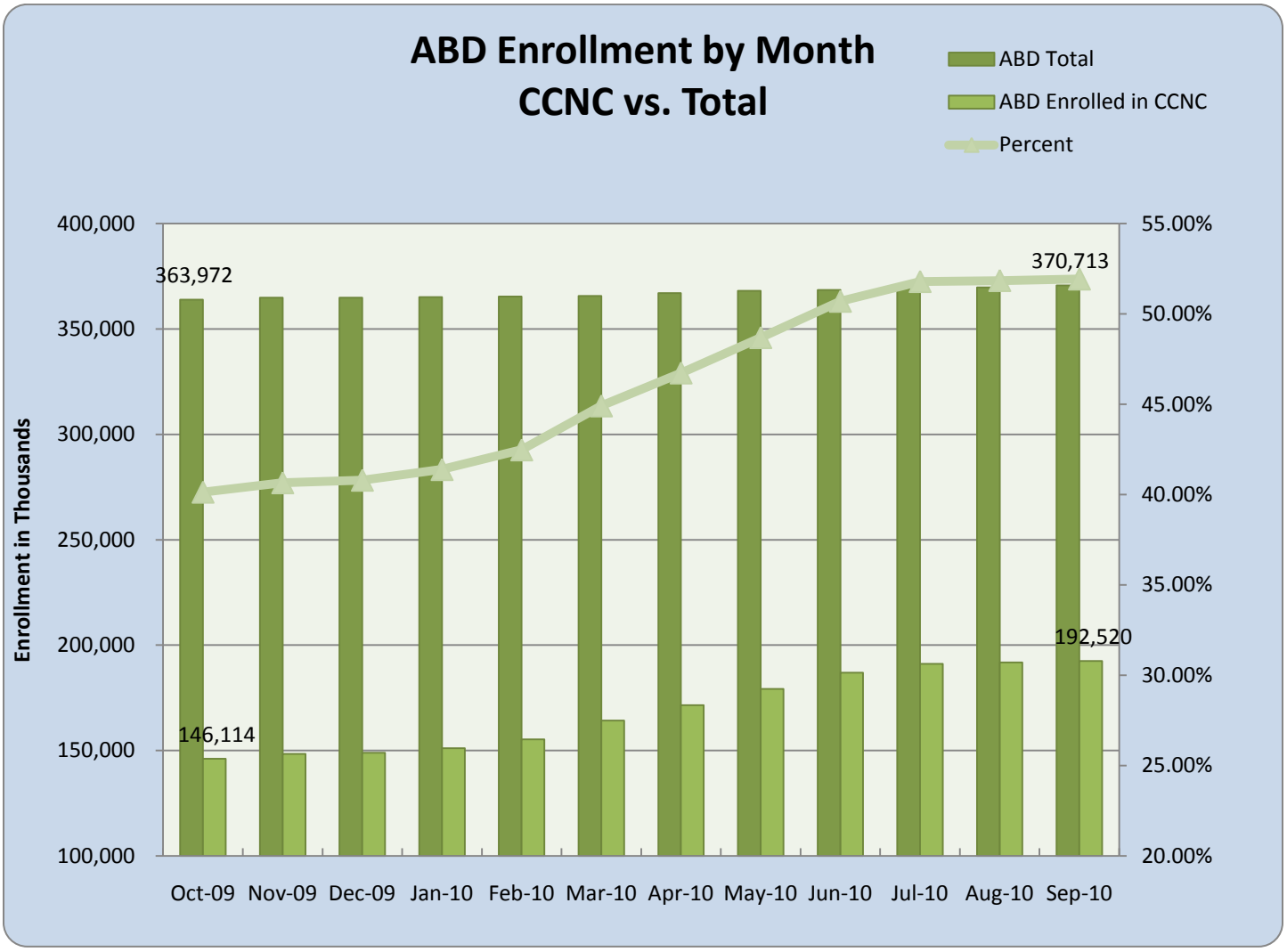
Sandhills Community Care Network: Harnett, Hoke, Lee, Montgomery, Moore, Richmond and Scotland
September 2010 Enrollment: Total - 54,074; ABD – 10,061 89 Practices

Southern Piedmont Community Care Plan: Cabarrus, Rowan and Stanly
September 2010 Enrollment: Total – 45,702; ABD – 7,703 65 Practices

The past twelve months has witnessed a steady increase in Community Care system enrolled members, both Total and in the ABD category. For program categories other than ABD (non-ABD), Community Care membership versus Medicaid Totals increased from 92% to 96%, 1,039K vs. 1,079K at the end of September, 2010. This growth in enrolled membership is depicted visually as follows:



For the ABD program category, Community Care membership versus total ABDs in the Medicaid program increased from 40% to 52%, 193K vs. 371K at the end of September, 2010 and the growth is depicted visually as follows:



Initiatives – Programs – Activities – Overall Status

The following table identifies major initiatives, programs or activities in which NCCCN, Inc. is engaged currently as well as a brief indication of status.

North Carolina Community Care Networks Incorporated Initiatives – Programs - Activities	
Activity and Description	10/01/ 2010 Status Overview
Case Management Information System – A web based, secure, case management software package launched in 2001 with subsequent enhanced releases. The CMIS contains demographic and claims data on more than two million Medicaid recipients (more than one million enrolled currently). Processes follow the nursing care management model such that care managers and Network staff maintain a single care plan that stays with the patient when the patient changes location within the state. The CMIS includes standardized health assessment and screening tools, disease management and coaching modules, and workflow management features.	The CMIS application has over 650 active users statewide. There has been a steady increase in the number of patients whose records have been accessed in CMIS (for review, assessment, or task documentation), from approximately 50,000 per month during early 2009, to over 73,000 during July 2010. Enhancements to the CMIS application over the past year include: • More robust screening and assessment tools to better target care management efforts • Bulk task capacity was added to allow for population-level interventions (for example, to send a flu shot reminder to all patients with diabetes) • A new secure messaging feature allows care managers to communicate patient health information securely to primary care providers or others involved in the patient's care outside of the CMIS system • Enhanced report-designing capacity allows network managers to more closely monitor the caseload and activities of the care management workforce.
Provider Portal Application – Utilizing a web portal, providers treating patients in various settings can access a Medicaid patient's health record, Medicaid claims history, and clinical care alerts including information generated outside of the provider's local clinic or health system to obtain a "total" perspective. In addition, contact information for the patient's case manager, pharmacist, mental health	See report commentary below.

therapy provider, durable medical equipment supplier, home health or personal care service provider is readily available.	
Pharmacy Home Application – Involves the process of gathering and organizing drug use information from multiple sources (patient, medical chart, prescription history, discharge instructions) and sharing this data with providers to identify and resolve urgent & emergent duplications, interactions, possible adverse events, poor adherence or other suboptimal drug-taking behaviors.	Pharmacy Home has been enhanced to include more care alerts which involve both medical and pharmacy utilization data. Additionally, a multilingual health literacy tool that presents drug information both in writing and via video demos has been added to the feature list. Upcoming releases are to include a medication module which will impute medication lists from multiple sources and settings (hospital, office, home, pharmacy).
Network Pharmacist Program – Each Network has a pharmacist responsible for overseeing pharmacy related projects and initiatives. Medication responsibilities include education and support of case management, new program development and outreach to pharmacy providers. They are responsible also for coordinating efforts related to cost-effective prescribing.	Network Pharmacists have been involved in education, outreach and troubleshooting support resulting from changes to the Preferred Drug List that recently affected over 50 drug classes. Having built out their own team of Clinical Pharmacists, they are now focused on reaching out and engaging Clinical Pharmacist Partners, who would benefit from Community Care pharmacy programs, such as medication reconciliation and using Community Care managers as an integral part of their practice.
Clinical Pharmacy Program (Pharmacy Home Project) – An application developed during 2007 where Network pharmacists, care managers and PCPs readily can access prescription fill history, monitor care alerts related to medication omissions, interaction potential, therapeutic recommendations, and perform medication reconciliation activities. The application provides a patient level profile and medication history for point-of-care activities and population based reports. Prospective use of the application includes identification of care gaps, problem alerts and care plan development while retrospective use includes quality improvement and program evaluation.	See report commentary below.
Electronic Prescribing Adoption Program – Focus is to provide customized, practice-specific support (regardless of type of practice or where the practice resides on the continuum of adoption) to increase the rate of electronic prescribing. The program supports practices regardless of participation in a Network.	The E-Prescribing Adoption Program is transitioning from its initial goals of education, outreach and adoption regardless of the medical record medium used to a more inclusive health information technology adoption program supported by the AHEC Regional Extension Center. E-prescribing efforts now are supported as one piece, the e-prescription piece, in a broader Regional Extension Center program to move to use of electronic health records.

Asthma Disease Management Initiative – Involves building capacity for the routine assessment of asthma and the education of patients, family and school personnel, reducing unintended variation in care delivery and establish consistency, and report outcomes and process measures to all providers and staff regularly.	All networks and participating practices have implemented evidence based best practice guidelines for patients with asthma. In 2009, approximately 70% of patients with Asthma are getting continued care visits with their primary care provider. The asthma inpatient rate per 1000 in 2009 was 1.5 which is below the national average for a commercial population.
Diabetes Quality Improvement Initiative – Core elements of the initiative include establishing criteria for diabetes diagnosis and best practice standards, identifying and implementing diabetes teams, defining and developing diabetes resources and tools, enhancing partnerships with community resources, and developing materials and tools for provider education and buy-in.	All networks and participating practices have implemented evidence based best practice guidelines for patients with diabetes. In 2009, over 90% of patients with diabetes had the appropriate testing of glucose levels (HbA1c) and over 80 % had an annual nephropathy screening.
Congestive Heart Failure Initiative – Core elements of the initiative involve the identification of the heart failure population, improving quality of care in the Community Care system practices, measuring improvement and developing an effective case management model	All networks and participating practices have implemented evidence based best practice guidelines for patients with congestive heart failure (CHF). In 2009, over 90% of patients with heart failure were on the appropriate Beta Blocker medication and over 87% were on the appropriate ACE/ARB medication. Most importantly, the 30 day re-admission rate for heart failure patients decreased from 26.6% in 2008 to 18.6% in 2009.
Behavioral Health Integration Initiative - A plan that supports the integration of behavioral health services, including mental health and substance abuse, into the 1,400 primary care practices of the fourteen Community Care Networks across North Carolina. The initiative aims at integrating care to consumers in their medical homes across the state.	See report commentary below.
Chronic Care Project – Focuses on the ABD population to effect comprehensive care management. It is a multi-project program. Project workgroups involving Network personnel include Screening Assessment and Care Planning, Polypharmacy, Pediatric Chronic Care, Hypertension/Coronary Artery Disease, Mental Health, Data and Evaluation, the Care Management Information System (CMIS), and Self Management of Chronic Illnesses. Networks aim to reorganize delivery of care in ways that enhance appropriate access, increase service delivery options, improve efficiencies in the identification, assessment	All networks have implemented the following care management initiatives and processes in the chronic care program: • Transitional support – including embedding close to 50 care managers in practices with high volume Medicaid members and close to 50 care managers in hospitals with high volume Medicaid admissions. The hospital based care managers are working as part of the discharge planning team and beginning to assess, educate and support the patients in their transition out of the hospital setting.

and care planning processes, reduce the rate of institutionalization and reduce unnecessary inefficiencies and expenses inherent in the current system.	• Medication reconciliation – is being performed in the homes of all high risk patients within 5 business days from hospital discharge. • Behavioral health integration – described in the box above but critical in managing those patients with co-morbid mental health conditions. Health Care Team – practices are implementing patient centered care planning as part of a health care team when managing the highest risk and cost patients.
Section 646 Project – The project goal is to improve the quality of care delivered to Medicare/Medicaid (dual eligible)as well as Medicare only beneficiaries by using the Community Care system model to address gaps in care, quality and efficiency. Improvements in both clinical and non-clinical processes are combined with payment reimbursement changes to introduce financial incentives to facilitate improved healthcare.	Begun on January 1, 2010, eight Networks with more than 200 practices and 900 providers are participating in twenty-six counties. Dual eligibles seen in one of the participating practices on a qualifying visit constitute the program population. Networks interact with the practice to provide support in identify and assist in the care management of these duals. Using Medicare claims data to be obtained from CMS to develop population risk stratifications, NCCCN will identify patients who would benefit from specific disease management interventions. Any saving from Year 1 and 2 of the demonstration will be used in Year 3 to fund the care management of the Medicare only population.

Quarterly Reported Performance Measures and Improvement Targets

Since its beginning in 1998, the Community Care system has used performance measurement and feedback to help meet its goals of improving the quality of care for Medicaid recipients while controlling costs. Quality measurement is intended to stimulate or facilitate quality improvement efforts in Community Care practices and local Networks as well as to evaluate the performance of the program as a whole. Under the direction of Network Clinical Directors, this measurement and feedback process has evolved over time to meet the changing needs of the Community Care program and it is expected that this evolutionary process will continue to address issues such as:

-Continued expansion of the Community Care system's enrolled population and increasing focus on the ABD population who suffer frequently from multiple chronic condition,

-Development of additional quality initiatives,

-Changes in evidence based clinical practice guidelines,

-Decisions rendered by the Community Care system's Quality Measurement and Performance workgroup whose Network representatives meet periodically to review and improve performance measures. The workgroup's goals are to develop performance measures with:

-clinical importance based on disease prevalence and potential for improvement,

-scientific soundness (the strength of the evidence underlying the clinical practice recommendation and evidence the measure improves care based on its reliability, validity and comprehensibility), and

-feasibility of implementing the performance measure

Presently, there are two sets of quality of care measures, based respectively on review of patient charts and review of Medicaid claims data. In addition, NCCCN, Inc. has focused attention on e-prescribing activity.

<u>Patient Chart Review</u>

Chart reviews are performed on an annual cycle for patients with medical conditions involving asthma, diabetes, ischemic vascular disease and heart failure. Chart review measures pertain to:

-Appropriate asthma management

-Diabetes glycemic control and foot-care

-Management of blood pressure, cholesterol, and tobacco use

-Appropriate use of aspirin
-Assessment of LV function in heart failure

The Community Care system continues to contract with Area Health Education Centers to perform independent and random chart reviews using an electronic data abstraction tool. Practice-level results with patient-level details are available to the Networks via a **secure** internet reporting service on a next day basis.

Providing credible and provider friendly reports, accompanied with benchmarks and peer comparisons is crucial in motivating providers to improve processes that will enable them to provide "best" health care in a cost effective manner. Monthly, quarterly and annual performance measures regarding clinical processes, cost, utilization and quality continue to be available to Networks and practices as feedback. These quality metrics are critical to the ability to implement locally the systemic changes needed to improve quality and care outcomes in practices. Network Clinical Directors are instrumental in engaging community providers and motivating them to implement Community Care quality initiatives.

Because the chart review activity is conducted on an annual cycle, there is no change to report for these performance measures compared to the information submitted with the July 1, 2010 quarterly report. For completeness however, the measures reported in that quarterly report are included in this quarterly report as Attachment A. It is anticipated that the 2010 cycle will be completed during December, 2010, and results should be available for inclusion in NCCCN's quarterly report to be submitted for January 1, 2011.

<u>Medicaid Claims Review</u>

Medicaid claims data is reviewed to develop a set of quality of care measures which pertain to:

-Medication therapy for patients with asthma, heart failure and those in a post myocardial infarction status
-Adult preventive services (breast, cervical, colorectal cancer screening)
-Pediatric preventive services (dental care and well-child exams)

Claims data derived measures are reported quarterly at the Network and practice levels as well as by County. Measures include:

-Preventable Readmissions As a Percent of Total Admissions (Non-Duals)
- Inpatient Admissions per 1000 Member Months, Enrolled Non-Dual ABDs
-ED Rate per 1000 Member Months, Enrolled ABD, Any Diagnosis
- Generic Medications as Percent of all Fills, All Medicaid Non-Duals

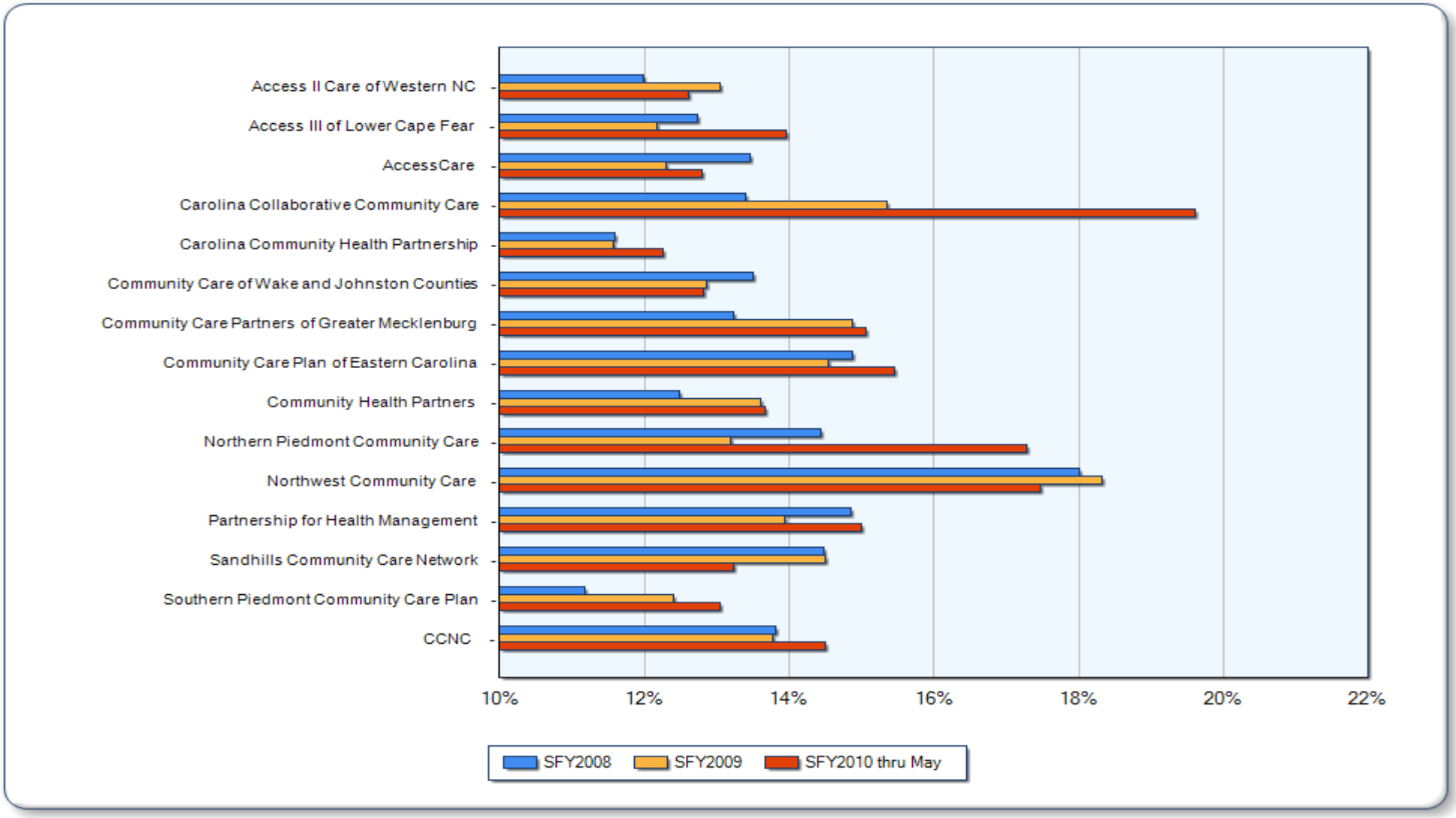
Preventable Readmissions as a Percent of Total Admissions, Enrolled Non-Duals

Network	Network Name	SFY2008			SFY2009			SFY2010 thru May			SFY2010 GOAL
		Inpatient Visits	30 Day Readmits	% Readmits	Inpatient Visits	30 Day Readmits	% Readmits	Inpatient Visits	30 Day Readmits	% Readmits	(5% Reduction)
6701007	Access II Care of Western NC	2,276	273	12.0%	2,439	318	13.0%	2,631	332	12.6%	11.4%
6702004	Access III of Lower Cape Fear	3,615	460	12.7%	3,465	422	12.2%	3,637	508	14.0%	12.1%
6701006	Access Care	11,806	1,590	13.5%	11,774	1,448	12.3%	10,315	1,320	12.8%	12.8%
6701013	Carolina Collaborative Community Care	2,725	365	13.4%	2,207	339	15.4%	2,285	448	19.6%	12.7%
6701010	Carolina Community Health Partnership	1,226	142	11.6%	1,261	146	11.6%	1,158	142	12.3%	11.0%
6701011	Community Care of Wake and Johnston Counties	2,623	354	13.5%	2,824	363	12.9%	2,911	373	12.8%	12.8%
6701009	Community Care Partners of Greater Mecklenburg	5,806	768	13.2%	6,034	898	14.9%	6,117	921	15.1%	12.6%
6702000	Community Care Plan of Eastern Carolina	7,793	1,159	14.9%	7,162	1,042	14.5%	7,409	1,145	15.5%	14.1%
6701003	Community Health Partners	2,033	254	12.5%	2,167	295	13.6%	2,223	304	13.7%	11.9%
6702007	Northern Piedmont Community Care	2,395	346	14.4%	2,182	288	13.2%	2,194	379	17.3%	13.7%
6702006	Northwest Community Care	3,708	668	18.0%	3,713	680	18.3%	3,865	675	17.5%	17.1%
6701012	Partnership for Health Management	1,711	254	14.8%	1,924	268	13.9%	2,160	324	15.0%	14.1%
6702005	Sandhills Community Care Network	2,644	383	14.5%	2,950	428	14.5%	3,149	417	13.2%	13.8%
6702003	Southern Piedmont Community Care Plan	2,095	234	11.2%	2,186	271	12.4%	1,947	254	13.0%	10.6%
	Community Care System	**52,456**	**7,250**	**13.8%**	**52,288**	**7,206**	**13.8%**	**52,001**	**7,542**	**14.5%**	**13.1%**

Preventable Readmissions Definition
Criteria: Non Dual recipients enrolled with Community Care and same network at time of admission and readmission. Same-day transfers, long term care admissions, rehabilitation, state mental hospital, hospice admissions, and observation stays are not considered hospital admissions. Admissions are excluded from both the numerator and denominator if either the initial or readmission DRG indicates: malignancy, trauma, obstetrical, burn, and newborn. Admissions with no discharge date are excluded.

Target: 5% reduction from network's baseline rate (SFY 08) by end of year 1 (SFY 10)
16% reduction from baseline rate by end of year 2 (SFY 11) and maintain 16% reduction from baseline rate in year 3 (SFY 12)

Preventable Readmissions as Percent of Total Admissions, Enrolled Non-Duals

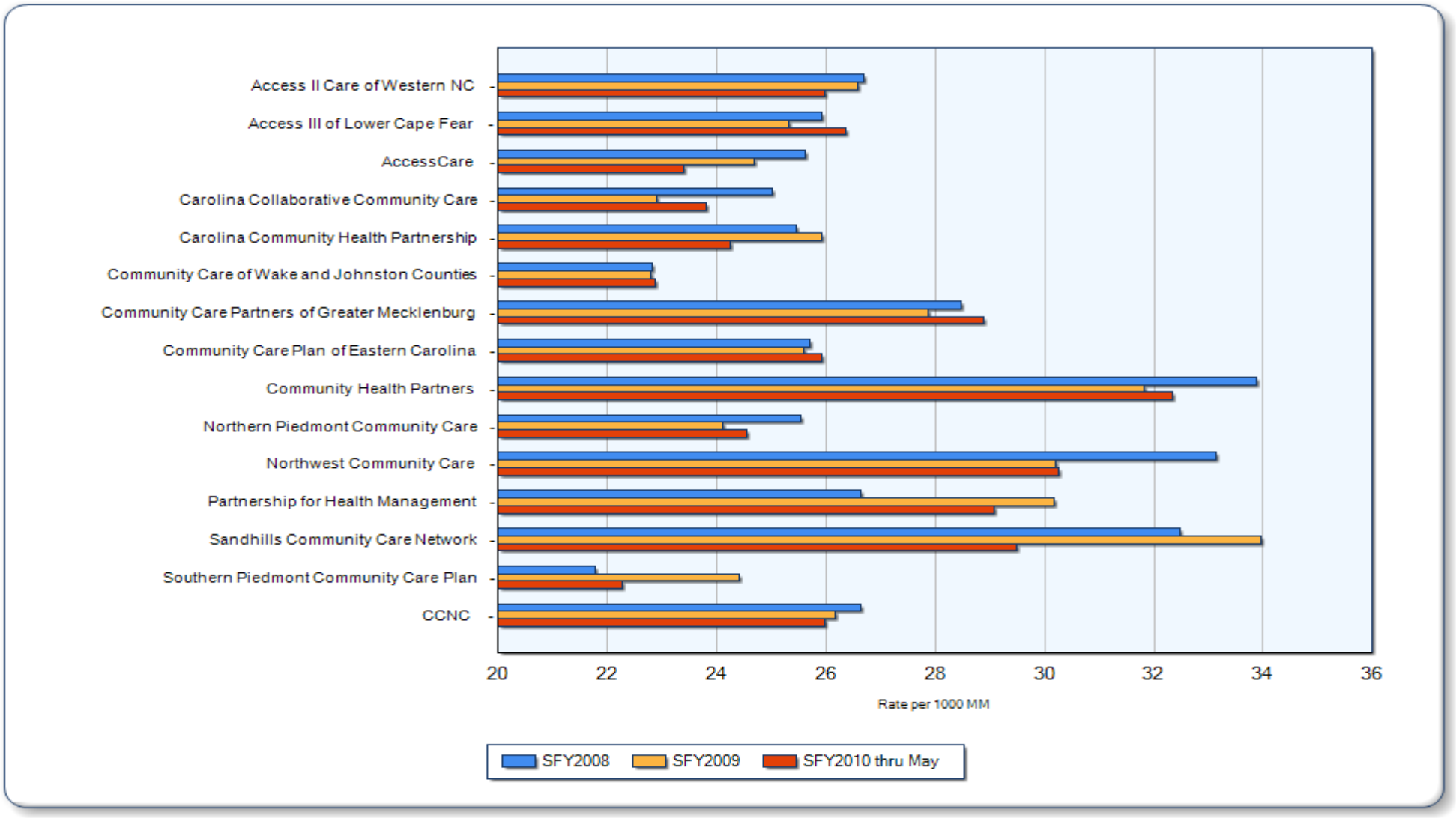


Inpatient Admissions per 1000 Member Months, Enrolled Non-Dual ABDs

Network	Network Name	SFY2008			SFY2009			SFY2010 thru May			SFY2010 GOAL
		Member Months	Inpatient Visits	Rate Per 1000 MM	Member Months	Inpatient Visits	Rate Per 1000 MM	Member Months	Inpatient Visits	Rate Per 1000 MM	(2% Reduction)
6701007	Access II Care of Western NC	44,009	1,174	26.7	49,018	1,303	26.6	56,207	1,460	26.0	26.1
6702004	Access III of Lower Cape Fear	78,208	2,028	25.9	82,387	2,086	25.3	86,137	2,270	26.4	25.4
6701006	Access Care	225,211	5,768	25.6	233,722	5,767	24.7	228,488	5,343	23.4	25.1
6701013	Carolina Collaborative Community Care	62,554	1,564	25.0	67,514	1,546	22.9	65,219	1,553	23.8	24.5
6701010	Carolina Community Health Partnership	26,513	675	25.5	27,612	716	25.9	27,360	663	24.2	25.0
6701011	Community Care of Wake and Johnston Counties	63,160	1,442	22.8	70,352	1,603	22.8	71,436	1,634	22.9	22.4
6701009	Community Care Partners of Greater Mecklenburg	95,521	2,719	28.5	116,255	3,239	27.9	111,654	3,224	28.9	27.9
6702000	Community Care Plan of Eastern Carolina	183,607	4,719	25.7	191,936	4,911	25.6	201,383	5,219	25.9	25.2
6701003	Community Health Partners	28,870	978	33.9	31,626	1,006	31.8	33,992	1,099	32.3	33.2
6702007	Northern Piedmont Community Care	54,653	1,396	25.5	57,761	1,392	24.1	59,877	1,470	24.6	25.0
6702006	Northwest Community Care	69,260	2,295	33.1	77,323	2,336	30.2	84,244	2,549	30.3	32.5
6701012	Partnership for Health Management	31,756	846	26.6	34,615	1,044	30.2	41,862	1,217	29.1	26.1
6702005	Sandhills Community Care Network	42,704	1,387	32.5	46,836	1,590	33.9	57,508	1,695	29.5	31.8
6702003	Southern Piedmont Community Care Plan	40,883	890	21.8	47,160	1,151	24.4	47,022	1,047	22.3	21.3
	Community Care System	**1,046,909**	**27,881**	**26.6**	**1,134,117**	**29,690**	**26.2**	**1,172,389**	**30,443**	**26.0**	**26.1**

Admissions per 1000 MM Definition
Criteria: Non-Dual ABD recipients enrolled with the Community Care system. Excludes admissions to skilled nursing and long-term care facilities.

Inpatient Admissions per 1000 MM, Enrolled Non-Dual ABD

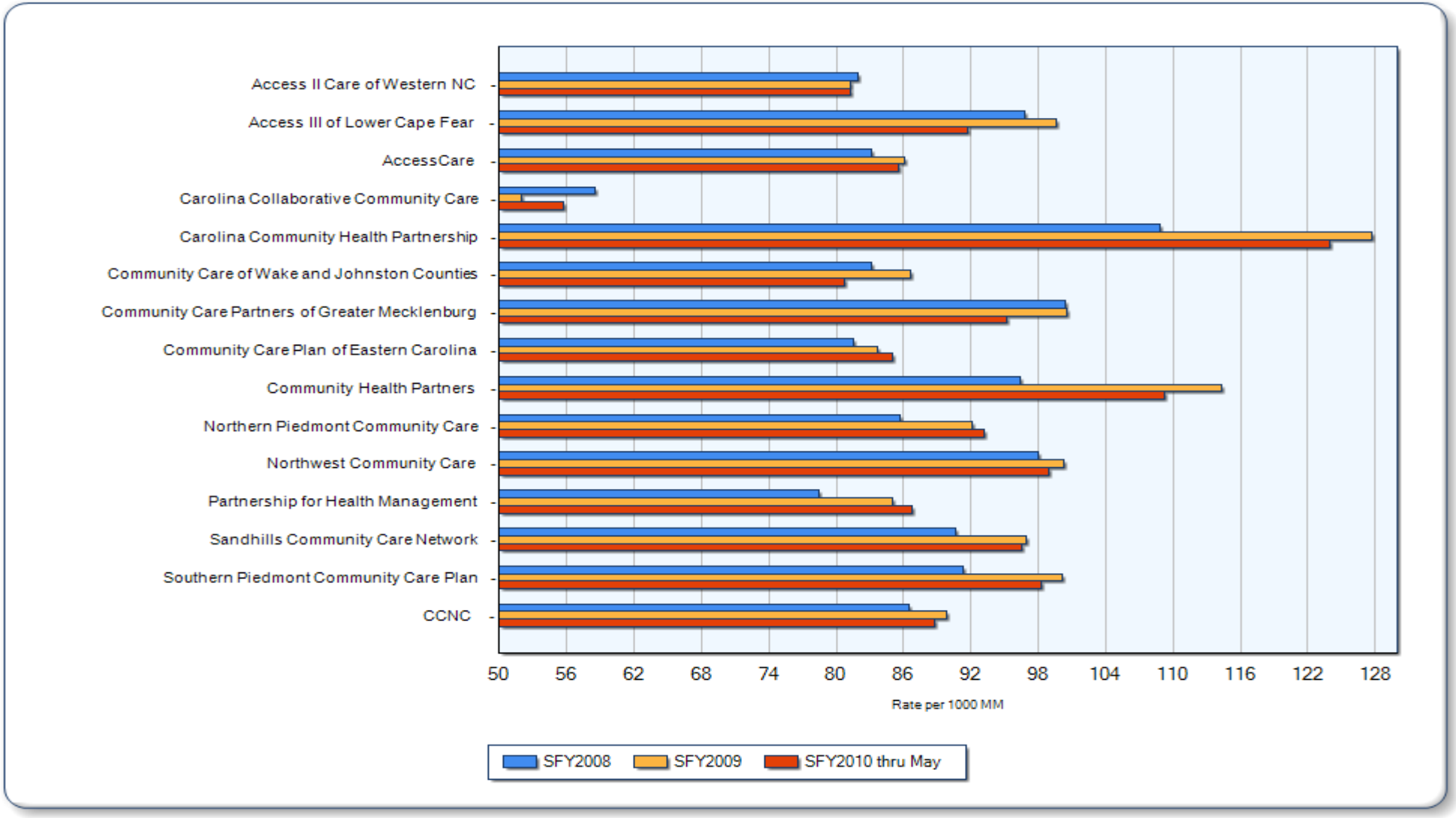


ED Rate Per 1000 MM, Enrolled ABD

Network	Network Name	SFY2008			SFY2009			SFY2010 thru May			SFY2010 GOAL
		Member Months	ED Visits	Rate Per 1000 MM	Member Months	ED Visits	Rate Per 1000 MM	Member Months	ED Visits	Rate Per 1000 MM	(5% Reduction)
6701007	Access II Care of Western NC	66,721	5,466	81.9	75,787	6,154	81.2	91,064	7,405	81.3	77.8
6702004	Access III of Lower Cape Fear	106,872	10,345	96.8	112,114	11,164	99.6	124,507	11,424	91.8	92.0
6701006	Access Care	300,122	24,969	83.2	312,733	26,931	86.1	312,483	26,729	85.5	79.0
6701013	Carolina Collaborative Community Care	77,151	4,518	58.6	84,636	4,403	52.0	83,828	4,675	55.8	55.6
6701010	Carolina Community Health Partnership	31,936	3,474	108.8	33,497	4,278	127.7	34,044	4,221	124.0	103.3
6701011	Community Care of Wake and Johnston Counties	77,476	6,443	83.2	86,627	7,507	86.7	88,739	7,169	80.8	79.0
6701009	Community Care Partners of Greater Mecklenburg	123,199	12,367	100.4	150,729	15,158	100.6	160,022	15,235	95.2	95.4
6702000	Community Care Plan of Eastern Carolina	294,492	24,019	81.6	309,751	25,935	83.7	329,050	27,967	85.0	77.5
6701003	Community Health Partners	37,187	3,583	96.4	40,705	4,651	114.3	46,810	5,114	109.3	91.5
6702007	Northern Piedmont Community Care	74,061	6,341	85.6	79,402	7,312	92.1	82,662	7,706	93.2	81.3
6702006	Northwest Community Care	96,547	9,455	97.9	109,973	11,020	100.2	122,983	12,169	98.9	93.0
6701012	Partnership for Health Management	42,630	3,342	78.4	46,151	3,925	85.0	55,718	4,834	86.8	74.5
6702005	Sandhills Community Care Network	58,228	5,281	90.7	63,974	6,203	97.0	80,371	7,756	96.5	86.2
6702003	Southern Piedmont Community Care Plan	57,063	5,210	91.3	66,557	6,668	100.2	72,162	7,095	98.3	86.7
	Community Care System	**1,443,685**	**124,813**	**86.5**	**1,572,636**	**141,309**	**89.9**	**1,684,443**	**149,499**	**88.8**	**82.1**

ED Rate Per 1000 MM Definition
Criteria: Community Care enrolled ABD recipients with an emergency department visit.

ED Rate per 1000 MM, Enrolled ABD



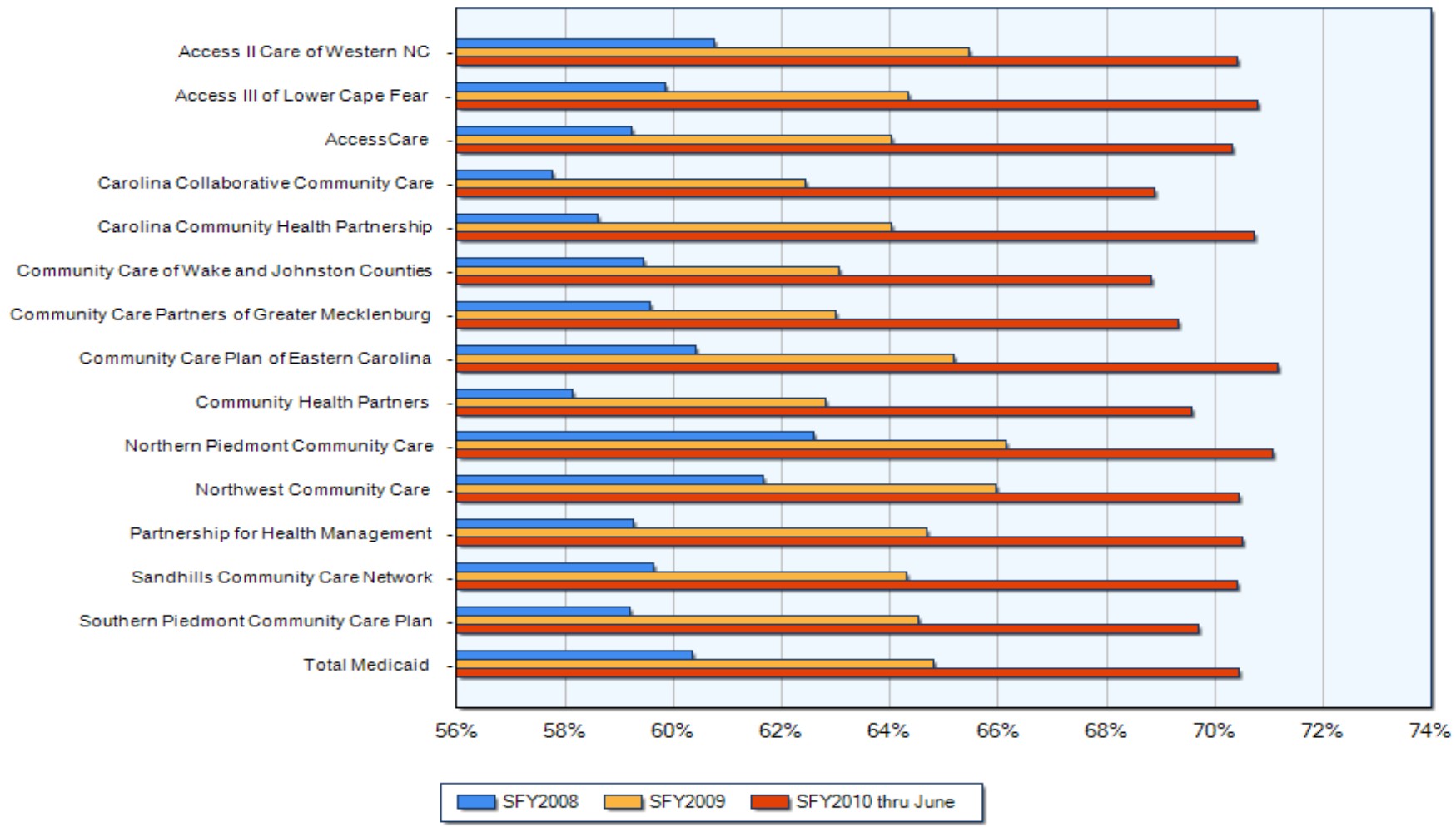
Generic Medications as Percent of all Fills, All Medicaid Non-Duals

Network	Network Name	SFY2008			SFY2009			SFY2010 thru June			SFY2010 GOAL
		Total Fills	Generic Meds	% Generic	Total Fills	Generic Meds	% Generic	Total Fills	Generic Meds	% Generic	(3.1% Point Increase)
0	No Network	4,425,747	2,722,279	61.5%	4,248,856	2,802,186	66.0%	3,795,108	2,697,224	71.1%	64.6%
6701007	Access II Care of Western NC	410,853	249,643	60.8%	456,209	298,579	65.4%	552,484	389,016	70.4%	63.9%
6702004	Access III of Lower Cape Fear	589,977	353,097	59.8%	652,656	419,811	64.3%	741,267	524,783	70.8%	62.9%
6701006	AccessCare	2,137,618	1,266,070	59.2%	2,295,413	1,469,506	64.0%	2,384,608	1,676,554	70.3%	62.3%
6701013	Carolina Collaborative Community Care	387,812	223,976	57.8%	421,864	263,412	62.4%	455,919	314,036	68.9%	60.9%
6701010	Carolina Community Health Partnership	257,307	150,793	58.6%	281,523	180,238	64.0%	308,078	217,865	70.7%	61.7%
6701011	Community Care of Wake and Johnston Counties	441,679	262,553	59.4%	519,301	327,517	63.1%	578,734	398,316	68.8%	62.5%
6701009	Community Care Partners of Greater Mecklenburg	735,834	438,309	59.6%	891,471	561,529	63.0%	973,156	674,702	69.3%	62.7%
6702000	Community Care Plan of Eastern Carolina	1,101,490	665,292	60.4%	1,218,278	794,136	65.2%	1,387,235	987,266	71.2%	63.5%
6701003	Community Health Partners	336,231	195,455	58.1%	373,661	234,650	62.8%	419,705	292,040	69.6%	61.2%
6702007	Northern Piedmont Community Care	339,105	212,247	62.6%	376,632	249,094	66.1%	420,276	298,671	71.1%	65.7%
6702006	Northwest Community Care	545,249	336,132	61.6%	647,749	427,136	65.9%	771,117	543,180	70.4%	64.7%
6701012	Partnership for Health Management	267,739	158,656	59.3%	313,922	203,060	64.7%	402,594	283,796	70.5%	62.4%
6702005	Sandhills Community Care Network	397,220	236,898	59.6%	458,176	294,623	64.3%	567,393	399,593	70.4%	62.7%
6702003	Southern Piedmont Community Care Plan	366,236	216,860	59.2%	433,062	279,368	64.5%	491,631	342,670	69.7%	62.3%
	Total Community Care System	**12,740,097**	**7,688,260**	**60.3%**	**13,588,773**	**8,804,845**	**64.8%**	**14,249,305**	**10,039,712**	**70.5%**	**63.4%**

Generic Medications Definition
Criteria: Percent of generic medication fills. Non-Dual Medicaid enrollees (CAI, CAII and FFS).

Target: 3.1% increase from Network's baseline rate (SFY 08) by end of year 1 (SFY 10) or 80%, whichever is lower
8.8% increase from baseline rate by end of year 2 (SFY 11) or 80%, whichever is lower and maintain performance level in Year 3 (SFY 12)

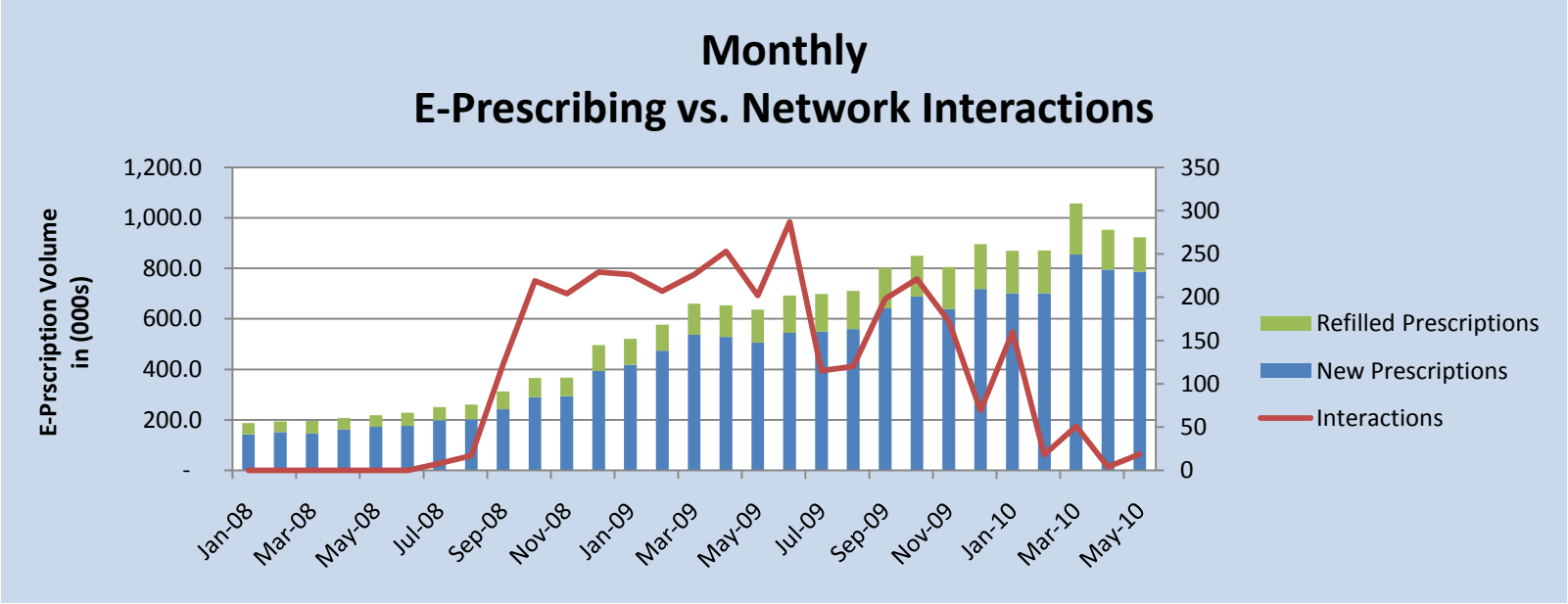
Generic Medications as Percent of all Fills, All Medicaid Non-Duals



Prescribing Activity – E-Prescribing and Prescription Costs

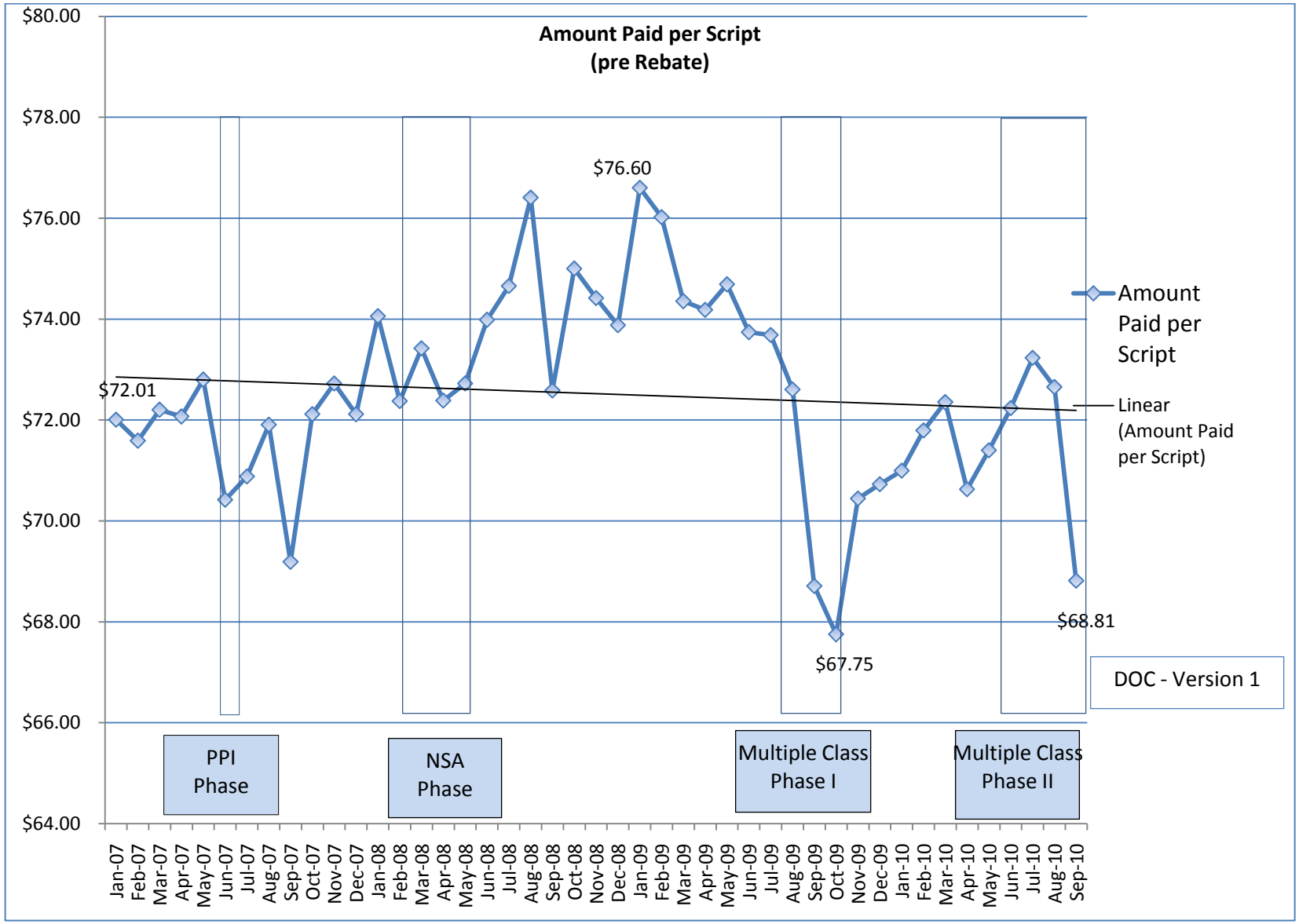
NCCCN, Inc. in concert with Network personnel is actively engaged with providers, encouraging them to increase their e-prescribing activity. E- prescribing data is obtained from Surescripts Incorporated, a commercial network of retail pharmacies. The first chart below shows the volume of e-prescribing versus Network initiated interactions with providers. The positive correlation between interactions and e-prescribing volume is apparent. The following table shows the percentage of providers in which at least one practiconer has made use of e-prescribing technology during the past month is tracked. A second graph shows the cost of prescriptions, on a pre-rebate basis.

E-Prescribing



% of CCNC PC Practices with at Least 1 Active Prescriber												
	2007				2008				2009			
Network	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Access II Care of Western North Carolina	9%	11%	9%	14%	19%	20%	23%	33%	34%	42%	41%	42%
Access III of Lower Cape Fear	8%	10%	11%	11%	12%	12%	14%	24%	22%	29%	28%	32%
AccessCare	12%	14%	16%	18%	19%	21%	27%	36%	38%	43%	44%	49%
Carolina Collaborative Community Care	8%	10%	10%	11%	11%	12%	14%	33%	38%	51%	47%	45%
Carolina Community Health Partnership	10%	10%	10%	10%	10%	15%	15%	15%	30%	45%	40%	55%
Community Care Partners of Greater Mecklenburg	3%	5%	5%	3%	6%	9%	16%	19%	22%	23%	24%	26%
Community Care Plan of Eastern Carolina	10%	11%	12%	12%	14%	16%	19%	25%	28%	30%	33%	34%
Community Care of Wake / Johnston Counties	13%	12%	13%	14%	13%	14%	19%	27%	26%	28%	27%	28%
Community Health Partners	7%	7%	7%	7%	7%	7%	14%	25%	27%	32%	39%	30%
Northern Piedmont Community Care	28%	25%	25%	25%	25%	33%	36%	47%	61%	61%	61%	69%
Northwest Community Care	7%	7%	7%	8%	8%	7%	9%	28%	25%	26%	34%	37%
Partnership for Health Management	23%	23%	21%	21%	21%	21%	30%	40%	40%	37%	42%	51%
Sandhills Community Care Network	12%	14%	18%	22%	24%	25%	25%	32%	35%	38%	41%	39%
Southern Piedmont Community Care	6%	6%	4%	4%	6%	34%	43%	43%	46%	54%	52%	57%
Total Community Care Systems	**10%**	**11%**	**12%**	**13%**	**14%**	**17%**	**21%**	**30%**	**32%**	**36%**	**37%**	**40%**
							Program Activity					

Prescription Costs



		Length of Effort
PPI Phase:	Launched Proton Pump Inhibitor (PPI) of Drug Utilization Management in June, 2007.	1 Month
NSA Phase:	Launched Non-Sedating Anti-histamine (NSA) of Drug Utilization Management in February, 2008.	4 Months
Multi-Drug -1	Launched First Multi-Drug Class Phase of Drug Utilization Management in July, 2009.	3 Months
Multi-Drug – 2	Launched Second Multi-Drug Class Phase of Drug Utilization Management in September, 2009.	7 Months
Drug of Choice -1	Released Drugs of Choice (DOC) List – Version 1 on September 15, 2010.	On-going

Provider Portal

NCCCN, Inc. released its Informatics Center Provider Portal web-based application on schedule during August, 2010. The application, built with the medical provider in mind, offers elements of the Informatics Center's Case Management and Pharmacy Home systems in addition to utilizing key elements of the Reports Site.

Through a secure web portal, providers treating patients in the primary care medical home, hospital, emergency room, or mental health system can access a Medicaid patient's health record which includes patient information, care team contact information, visit history, pharmacy claims history, and clinical care alerts. Importantly, the use of Medicaid claims data provides key information typically unavailable from provider charts and data or the information generated outside of the provider's local clinic or health system such as hospitalizations, ED visits, primary care and specialty visits, laboratory and imaging activities. Contact information for the patient's case manager, pharmacist, mental health therapy provider, durable medical equipment supplier, home health or personal care service provider is readily available.

Providers can discern whether prior prescriptions were ever filled, and what medications have been prescribed for the patient by others. Built-in clinical alerts appear if the claims history indicates a patient may be overdue for recommended care such as a diabetes eye exam or a mammography.

The Provider Portal also contains key resources for assisting providers in managing Medicaid patients, such as a compendium of low-literacy patient education materials and practice tools for risk assessment and disease management. Through a seamless link into a licensed service maintained by an outside partner, providers can retrieve medication information for patients in multiple languages, in either video or print format. Medical home providers directly may access population management reports and quality metrics for their own patient population through a seamless link into the Informatics Center Reports Site.

An overview introductory presentation of the Provider Portal and its capabilities which was used in the rollout of the application and which continues to be used in on-going Network and provider training is included at Attachment B.

Behavioral Health Integration Initiative

In February 2010, the Division of Medical Assistance (DMA) approved a proposal regarding the integration of behavioral health services into North Carolina's Community Care Network, the **Community Care Accelerated Implementation Proposal**. This Behavioral Health Integration Initiative speaks to a unique plan that supports the integration of behavioral health services, including mental health and substance abuse, into the 1,400 primary care practices of the Community Care System and its Networks across North Carolina, and the initiative fits well into the vision of the national health care reform plan by bringing integrated care to consumers in their medical homes across the state. As a result, North Carolina with integrated care in its Community Care medical homes will be well positioned for the future increase in Medicaid consumers expected by 2014.

To focus and direct the implementation of this plan at the State Level, a lead psychiatrist was hired by the North Carolina Community Care Network Inc. (NCCCN). In addition, the local Networks have moved forward in hiring psychiatrists and behavioral health co-coordinators to establish an appropriate workforce in order to implement the proposal at the Network and local levels. Funding for these additional resources was secured by an increase in the per member per month payment made by the Medicaid Program to the Networks.
The strength of the Community Care program has always been the initiative exhibited by local providers in recognizing each Network's unique needs enabling them to develop a local response supported and guided by local leadership. This local decision making approach was utilized to hire ten (10) full-time equivalent psychiatrists and fourteen (14) behavioral health coordinators to serve the fourteen (14) Networks. Ultimately, each Network will have access to its own dedicated psychiatrist as well as a mental health coordinator to oversee the implementation of the Behavioral Health Integration Initiative at the local level.
The goals of the initiative have been defined as an improvement in performance measures such that the mental health and substance abuse populations experience:

- A reduction in psychiatric admissions of 1.2%,
- An increase in the number of primary care providers adopting evidence based pathways for depression, Attention Deficit Hyperactive Disorder (ADHD), and substance use, and
- An increase in the number of co-located behavioral health and primary care providers in practices.

Discussions among stakeholders are being held to clarify these goals to include community and state hospitals' metrics in the measure of reduced psychiatric admissions. Further, it is hoped that these discussions also will (a) expand upon pathways for evidence based care to develop validated screening tools for early identification and treatment as a prevention/early intervention model; and (b) include the bi-directional co-location model of care which will support co-location of specialists at behavioral health as well as at primary care practices.
At the present time, ten of the fourteen Networks have hired a psychiatrist for the position of Network Psychiatrist. The remaining four Networks are interviewing actively and recruiting for

the position. Twelve of the fourteen Networks have hired a full-time behavioral health coordinator, the remaining two interviewing candidates. It is expected that staffing will be complete in all Networks during the next reporting period.

A successful and productive orientation meeting was held on September 22 for the Network teams attended by more than 50 individuals from around the state, and all Networks were represented. At the meeting, attendees were introduced to new administrative and clinical tools for all types of stakeholders available through the recently operationalized web-based Provider Portal. The availability of data to better understand our behavioral health population was discussed, and it was noted that the level of information to manage the quality of care is unprecedented in behavioral health. Examples of population management (polypharmacy, high risk cases, etc) as well as the need for individual case management identified through risk screens in the data system were demonstrated. The use of data now available will enhance the quality of care, and decrease cost of care as these systems are put into practice. Discussions of the educational programs to be taught by the Network psychiatrists to better inform primary care providers in the treatment of depression, utilization of generics, and appropriate doses were held. This educational/technical assistance role will be an important function performed by Network psychiatrists at the local level.

A survey conducted earlier in July with providers and the Networks' leadership indicated the main priority for the Behavioral Health Initiative should be the training of primary care providers in treating depression, guiding patients with pain management issues, and treating ADHD in children and patients with substance use issues. Models of care for these conditions will be defined and introduced at educational trainings and "lunch and learn" programs at the offices of the Community Care primary care providers. Future quarterly reports from NCCCN will address this identification of specific models of care, progress in training stakeholder on the use of such models, and how success will be measured in the implementation of these best practice models.

Future training for the Network psychiatrists will focus on enhancing their knowledge and skill in working with available data from the Pharmacy Home, Case Management Information, and Medicaid Claims Systems. Utilization of data in these systems will help identify practices and providers as well as individual cases that will receive intervention from case management and/or psychiatric input in an effort to improve the quality of care. Examples of these efforts and interventions will be presented in the next report.
The integration of behavioral health and primary care begins to address some of the issues currently faced in medical care as well as respond to emerging issues, such as an increased Medicaid population, and additional stresses placed on an already overburdened workforce that will occur as a result of health care reform. As the number of Medicaid consumers increases by 2014, the delivery model of care must be prepared to respond. The Behavioral Health Integration Initiative is part of the larger effort to provide effectively integrated care to increased numbers of Medicaid patient/consumers.

From the broadest perspective, we can no longer support a silo system of care that ignores the reality that patients frequently possess mental and physical co-morbidity factors. We need to move beyond a health care delivery system that splits the mind and body, and we must address workforce issues by combining and co-locating resources in primary care and behavioral health care. Increased emphasis must be placed on educating and training providers in best practice models, and coordinating all health care where our patient/ consumers are being served. This will mean education and cross training in both the primary care setting and in the behavioral health specialty Network. The Community Care Networks can become the medical home and central point of care for our patient/consumers with mild to moderate behavioral health issues in the primary care system while our severe and persistent mentally ill patient/consumers will continue to be served in our specialty behavioral health system. The vision is consistent with that of national health care reform as evidenced by current studies and funding at the national level. With this Behavioral Health Integration initiative in place, North Carolina will be well positioned to take advantage of the rapid pace of national health care reform.

Attachment A
Annual QMAF Performance Measures

CCNC Quality and Performance "Scorecard" Measures

Annual Quality Measures CY2009

Diabetes

	QMAF Chart Review														
	HbA1c testing			Lipid Profile			Diabetes A1C Control <9.0			Diabetes LDL Cholesterol Control <130			Diabetes Foot Exam		
Network	Num	Den	**Results**	Num	Den	**Results**	Num	Den	**Results**	Num	Den	**Results**	Num	Den	**Results**
Access II Care of Western NC	278	312	89.1%	219	302	72.5%	222	302	73.5%	180	302	59.6%	252	302	83.4%
Access III of Lower Cape Fear	480	548	87.6%	424	537	79.0%	377	537	70.2%	331	537	61.6%	414	537	77.1%
AccessCare	1,192	1,330	89.6%	984	1,258	78.2%	906	1,258	72.0%	790	1,258	62.8%	877	1,258	69.7%
Carolina Collaborative Community Care	298	329	90.6%	270	319	84.6%	230	319	72.1%	207	319	64.9%	248	319	77.7%
Carolina Community Health Partnership	194	209	92.8%	172	201	85.6%	146	201	72.6%	128	201	63.7%	153	201	76.1%
Community Care of Wake / Johnston Counties	282	309	91.3%	227	291	78.0%	188	291	64.6%	173	291	59.5%	174	291	59.8%
Community Care Partners of Gr. Mecklenburg	590	649	90.9%	510	632	80.7%	423	632	66.9%	400	632	63.3%	417	632	66.0%
Community Care Plan of Eastern Carolina	1,412	1,528	92.4%	1,158	1,493	77.6%	1,083	1,493	72.5%	946	1,493	63.4%	982	1,493	65.8%
Community Health Partners	181	195	92.8%	146	187	78.1%	146	187	78.1%	114	187	61.0%	128	187	68.5%
Northern Piedmont Community Care	275	310	88.7%	232	291	79.7%	195	291	67.0%	189	291	65.0%	234	291	80.4%
Northwest Community Care	414	447	92.6%	343	422	81.3%	306	422	72.5%	264	422	62.6%	364	422	86.3%
Partnership for Health Management	162	184	88.0%	121	174	69.5%	108	174	62.1%	91	174	52.3%	109	174	62.6%
Sandhills Community Care Network	272	303	89.8%	241	296	81.4%	200	296	67.6%	183	296	61.8%	219	296	74.0%
Southern Piedmont Community Care Plan	263	282	93.3%	236	266	88.7%	199	266	74.8%	182	266	68.4%	179	266	67.3%
CCNC	**6,293**	**6,935**	**90.7%**	**5,283**	**6,669**	**79.2%**	**4,729**	**6,669**	**70.9%**	**4,178**	**6,669**	**62.6%**	**4,750**	**6,669**	**71.2%**
Hedis mean						76%			52%						
HEDIS 90th %ile						86%			68%						
NCQA goal						80%			85%			63%			80%

CCNC Quality and Performance "Scorecard" Measures

Annual Quality Measures CY2009

Diabetes

	QMAF Claims																	
	Diabetes Eye Exam						Diabetes Cholesterol Screening						Diabetes Nephropathy Screening					
Network	Num	Den	**CY 2008 Results**	Num	Den	**CY 2009 Results**	Num	Den	**CY 2008 Results**	Num	Den	**CY 2009 Results**	Num	Den	**CY 2008 Results**	Num	Den	**CY 2009 Results**
Access II Care of Western NC	226	449	50%	251	485	52%	285	430	66%	298	455	65%	354	449	79%	380	485	78%
Access III of Lower Cape Fear	480	882	54%	553	1,009	55%	678	855	79%	766	973	79%	747	882	85%	846	1,009	84%
AccessCare	1,181	2,271	52%	1,204	2,269	53%	1,539	2,132	72%	1,560	2,128	73%	1,839	2,271	81%	1,829	2,269	81%
Carolina Collaborative Community Care	326	586	56%	357	604	59%	452	560	81%	458	576	80%	497	587	85%	522	605	86%
Carolina Community Health Partnership	204	355	57%	229	379	60%	261	341	77%	308	362	85%	288	355	81%	307	379	81%
Community Care of Wake / Johnston Counties	280	582	48%	270	578	47%	366	553	66%	391	547	71%	478	583	82%	480	579	83%
Community Care Partners of Gr. Mecklenburg	560	1,190	47%	668	1,303	51%	865	1,142	76%	965	1,241	78%	1,034	1,190	87%	1,120	1,303	86%
Community Care Plan of Eastern Carolina	1,159	2,104	55%	1,278	2,317	55%	1,464	2,018	73%	1,679	2,228	75%	1,726	2,105	82%	1,931	2,318	83%
Community Health Partners	172	358	48%	207	390	53%	275	347	79%	303	377	80%	307	358	86%	329	390	84%
Northern Piedmont Community Care	306	590	52%	335	633	53%	405	556	73%	435	593	73%	496	590	84%	534	633	84%
Northwest Community Care	390	753	52%	461	845	55%	487	712	68%	579	801	72%	629	753	84%	669	845	79%
Partnership for Health Management	153	320	48%	177	365	48%	198	306	65%	242	345	70%	261	320	82%	288	365	79%
Sandhills Community Care Network	334	576	58%	358	675	53%	391	560	70%	463	644	72%	477	576	83%	555	679	82%
Southern Piedmont Community Care Plan	205	399	51%	277	510	54%	306	375	82%	379	475	80%	343	399	86%	426	510	84%
CCNC	**5,976**	**11,415**	**52%**	**6,625**	**12,362**	**54%**	**7,972**	**10,887**	**73%**	**8,826**	**11,745**	**75%**	**9,476**	**11,418**	**83%**	**10,216**	**12,366**	**83%**

CCNC Quality and Performance "Scorecard" Measures

Annual Quality Measures CY2009

Asthma

	QMAF Chart Review			QMAF Claims											
	Asthma Continued Care Visit with Assessment of Symptoms			Asthma Inpatient Rate per 1000 MM						Asthma ED Rate per 1000 MM					
Network	Num	Den	**Results**	IP Visits	MM	**CY 2008 Results**	IP Visits	MM	**CY 2009 Results**	IP Visits	MM	**CY 2008 Results**	ED Visits	MM	**CY 2009 Results**
Access II Care of Western NC	178	301	59.1%	8	8,494	0.9	1	11,554	0.1	40	8,494	4.7	44	11,554	3.8
Access III of Lower Cape Fear	226	399	56.6%	17	11,238	1.5	30	12,989	2.3	95	11,238	8.5	140	12,989	10.8
AccessCare	1,333	1,907	69.9%	56	60,092	0.9	73	61,616	1.2	450	60,092	7.5	526	61,616	8.5
Carolina Collaborative Community Care	279	341	81.8%	21	9,808	2.1	12	11,559	1.0	197	9,808	20.1	202	11,559	17.5
Carolina Community Health Partnership	160	216	74.1%	1	5,711	0.2	2	6,433	0.3	33	5,711	5.8	58	6,433	9.0
Community Care of Wake and Johnston Counties	243	413	58.8%	32	11,696	2.7	28	13,964	2.0	169	11,696	14.4	180	13,964	12.9
Community Care Partners of Greater Mecklenburg	347	560	62.0%	36	18,013	2.0	57	21,753	2.6	227	18,013	12.6	250	21,753	11.5
Community Care Plan of Eastern Carolina	677	963	70.3%	31	27,417	1.1	57	30,888	1.8	364	27,417	13.3	479	30,888	15.5
Community Health Partners	108	184	58.7%	8	5,912	1.4	13	7,115	1.8	57	5,912	9.6	70	7,115	9.8
Northern Piedmont Community Care	185	268	69.0%	10	8,788	1.1	20	10,128	2.0	118	8,788	13.4	117	10,128	11.6
Northwest Community Care	302	369	81.8%	23	14,317	1.6	8	16,956	0.5	180	14,317	12.6	195	16,956	11.5
Partnership for Health Management	241	279	86.4%	16	8,455	1.9	19	10,790	1.8	81	8,455	9.6	91	10,790	8.4
Sandhills Community Care Network	220	304	72.4%	13	8,374	1.6	18	13,214	1.4	92	8,374	11.0	116	13,214	8.8
Southern Piedmont Community Care Plan	143	233	61.4%	14	7,374	1.9	9	9,010	1.0	72	7,374	9.8	88	9,010	9.8
CCNC	**4,642**	**6,737**	**68.9%**	**286**	**205,689**	**1.4**	**347**	**237,969**	**1.5**	**2,175**	**205,689**	**10.6**	**2,556**	**237,969**	**10.7**

CCNC Quality and Performance "Scorecard" Measures

Annual Quality Measures CY2009

Asthma

	QMAF CLAIMS					
	Asthma Beta Agonist Overuse					
Network	Num	Den	**CY 2008 Results**	Num	Den	**CY 2009 Results**
Access II Care of Western NC	8	728	1.1%	13	995	1.3%
Access III of Lower Cape Fear	8	969	0.8%	11	1,103	1.0%
AccessCare	59	5,029	1.2%	57	5,161	1.1%
Carolina Collaborative Community Care	11	820	1.3%	14	968	1.4%
Carolina Community Health Partnership	9	483	1.9%	7	547	1.3%
Community Care of Wake and Johnston Counties	12	1,024	1.2%	14	1,170	1.2%
Community Care Partners of Greater Mecklenburg	20	1,515	1.3%	22	1,830	1.2%
Community Care Plan of Eastern Carolina	32	2,300	1.4%	37	2,583	1.4%
Community Health Partners	3	494	0.6%	13	595	2.2%
Northern Piedmont Community Care	21	740	2.8%	15	857	1.8%
Northwest Community Care	20	1,212	1.7%	21	1,442	1.5%
Partnership for Health Management	6	714	0.8%	6	954	0.6%
Sandhills Community Care Network	10	713	1.4%	10	1,106	0.9%
Southern Piedmont Community Care Plan	10	623	1.6%	16	763	2.1%
CCNC	**229**	**17,364**	**1.3%**	**256**	**20,074**	**1.3%**

CCNC Quality and Performance "Scorecard" Measures

Annual Quality Measures CY2009

	Hypertension BP control < 140/90			Smoking Status and Cessation Advice*		
Network	Num	Den	**Results**	Num	Den	**Results**
Access II Care of Western NC	196	303	64.7%	440	497	88.5%
Access III of Lower Cape Fear	385	604	63.7%	722	856	84.4%
AccessCare	802	1,353	59.3%	1,679	2,050	81.9%
Carolina Collaborative Community Care	248	397	62.5%	469	533	88.0%
Carolina Community Health Partnership	121	163	74.2%	228	296	77.0%
Community Care of Wake and Johnston Counties	211	359	58.8%	386	502	76.9%
Community Care Partners of Greater Mecklenburg	371	648	57.3%	810	997	81.2%
Community Care Plan of Eastern Carolina	1,012	1,700	59.5%	1,820	2,373	76.7%
Community Health Partners	120	188	63.8%	210	278	75.5%
Northern Piedmont Community Care	185	332	55.7%	323	468	69.0%
Northwest Community Care	260	397	65.5%	602	699	86.1%
Partnership for Health Management	98	158	62.0%	207	278	74.5%
Sandhills Community Care Network	215	362	59.4%	435	526	82.7%
Southern Piedmont Community Care Plan	167	264	63.3%	293	406	72.2%
CCNC	**4,391**	**7,228**	**60.7%**	**8,624**	**10,759**	**80.2%**
Hedis mean			53%			
HEDIS 90th %ile			65%			
NCQA goal			75%			80%

*Results from Chart Review Prevention And Management of Cardiovascular Disease

CCNC Quality and Performance "Scorecard" Measures
Annual Quality Measures CY2009
Ischemic Vascular Disease (IVD)

	QMAF Chart Review								
	Use of Antiplatelet Therapy			Lipid Profile			LDL cholesterol control <100		
Network	Num	Den	**Results**	Num	Den	**Results**	Num	Den	**Results**
Access II Care of Western NC	171	194	88.1%	135	194	69.6%	86	194	44.3%
Access III of Lower Cape Fear	253	330	76.7%	243	330	73.6%	133	330	40.3%
AccessCare	690	832	82.9%	592	832	71.2%	323	832	38.8%
Carolina Collaborative Community Care	197	241	81.7%	198	241	82.2%	101	241	41.9%
Carolina Community Health Partnership	81	100	81.0%	79	100	79.0%	38	100	38.0%
Community Care of Wake and Johnston Counties	158	196	80.6%	144	196	73.5%	92	196	46.9%
Community Care Partners of Greater Mecklenburg	222	302	73.5%	219	302	72.5%	124	302	41.1%
Community Care Plan of Eastern Carolina	654	879	74.4%	621	879	70.7%	377	879	42.9%
Community Health Partners	85	99	85.9%	75	99	75.8%	47	99	47.5%
Northern Piedmont Community Care	133	149	89.3%	113	149	75.8%	70	149	47.0%
Northwest Community Care	264	317	83.3%	244	317	77.0%	146	317	46.1%
Partnership for Health Management	84	106	79.3%	65	106	61.3%	44	106	41.5%
Sandhills Community Care Network	155	195	79.5%	141	195	72.3%	85	195	43.6%
Southern Piedmont Community Care Plan	107	141	75.9%	103	141	73.1%	62	141	44.0%
CCNC	**3,254**	**4,081**	**79.7%**	**2,972**	**4,081**	**72.8%**	**1,728**	**4,081**	**42.3%**

CCNC Quality and Performance "Scorecard" Measures
Annual Quality Measures CY2009
Heart Failure

	QMAF Chart Review								
	Heart Failure LVEF Documented in PCP Chart			Heart Failure ACE/ARB Use			Heart Failure Beta Blocker Use		
Network	Num	Den	**Results**	Num	Den	**Results**	Num	Den	**Results**
Access II Care of Western NC	33	40	82.5%	10	10	100.0%	10	10	100.0%
Access III of Lower Cape Fear	75	89	84.3%	22	27	81.5%	21	27	77.8%
AccessCare	116	148	78.4%	39	45	86.7%	41	45	91.1%
Carolina Collaborative Community Care	43	51	84.3%	16	18	88.9%	17	18	94.4%
Carolina Community Health Partnership	17	21	81.0%	6	7	85.7%	7	7	100.0%
Community Care of Wake / Johnston Counties	37	42	88.1%	4	6	66.7%	4	6	66.7%
Community Care Partners of Gr. Mecklenburg	82	101	81.2%	39	41	95.1%	39	41	95.1%
Community Care Plan of Eastern Carolina	156	194	80.4%	35	41	85.4%	38	41	92.7%
Community Health Partners	15	20	75.0%	6	7	85.7%	7	7	100.0%
Northern Piedmont Community Care	37	40	92.5%	6	8	75.0%	6	8	75.0%
Northwest Community Care	43	52	82.7%	11	12	91.7%	11	12	91.7%
Partnership for Health Management	23	27	85.2%	9	10	90.0%	9	10	90.0%
Sandhills Community Care Network	42	53	79.3%	10	12	83.3%	12	12	100.0%
Southern Piedmont Community Care Plan	23	28	82.1%	6	6	100.0%	4	6	66.7%
CCNC	**742**	**906**	**81.9%**	**219**	**250**	**87.6%**	**226**	**250**	**90.4%**

CCNC Quality and Performance "Scorecard" Measures
Annual Quality Measures CY2009
Heart Failure

	QMAF Claims																	
	Heart Failure Inpatient Rate per 1000 MM						Heart Failure 30 day Readmission Percent						Heart Failure LVF Assessment Percent					
Network	IP Visits	MM	CY 2008 Results	IP Visits	MM	CY 2009 Results	Num	Den	CY 2008 Results	Num	Den	CY 2009 Results	Num	Den	CY 2008 Results	Num	Den	CY 2009 Results
Access II Care of Western NC	14	726	19.3	9	709	12.7	1	14	7.1%	0	9	0.0%	59	64	92.2%	57	63	90.5%
Access III of Lower Cape Fear	39	1,789	21.8	57	1,946	29.3	5	39	12.8%	9	57	15.8%	139	152	91.4%	154	167	92.5%
AccessCare	149	3,711	40.2	105	3,340	31.4	65	149	43.6%	25	105	23.8%	309	326	94.8%	273	284	96.1%
Carolina Collaborative Community Care	36	1,055	34.1	78	1,334	58.5	7	36	19.4%	20	78	25.6%	87	92	94.6%	106	113	93.8%
Carolina Community Health Partnership	20	510	39.2	17	483	35.2	5	20	25.0%	2	17	11.8%	42	45	93.3%	41	44	93.2%
Community Care of Wake / Johnston Counties	36	1,088	33.1	49	1,178	41.6	10	36	27.8%	6	49	12.2%	99	100	99.0%	96	100	96.0%
Community Care Partners of Gr. Mecklenburg	92	2,488	37.0	83	2,252	36.9	14	92	15.2%	14	83	16.9%	205	212	96.7%	182	192	94.8%
Community Care Plan of Eastern Carolina	134	3,742	35.8	116	3,922	29.6	33	134	24.6%	20	116	17.2%	308	320	96.3%	317	332	95.5%
Community Health Partners	17	590	28.8	22	608	36.2	5	17	29.4%	2	22	9.1%	52	52	100.0%	53	54	98.1%
Northern Piedmont Community Care	55	1,303	42.2	64	1,324	48.3	11	55	20.0%	14	64	21.9%	105	112	93.8%	98	113	86.7%
Northwest Community Care	67	1,195	56.1	38	1,345	28.3	24	67	35.8%	3	38	7.9%	101	105	96.2%	112	119	94.1%
Partnership for Health Management	15	479	31.3	24	578	41.5	2	15	13.3%	4	24	16.7%	39	41	95.1%	49	52	94.2%
Sandhills Community Care Network	43	1,120	38.4	57	1,225	46.5	10	43	23.3%	15	57	26.3%	90	99	90.9%	101	108	93.5%
Southern Piedmont Community Care Plan	21	630	33.3	18	639	28.2	4	21	19.0%	3	18	16.7%	52	54	96.3%	50	55	90.9%
CCNC	738	20,426	36.1	737	20,883	35.3	196	738	26.6%	196	737	18.6%	1,687	1,774	95.1%	1,689	1,796	94.0%

Attachment B
Provider Portal

Brief Into to Provider Portal

Provider Portal

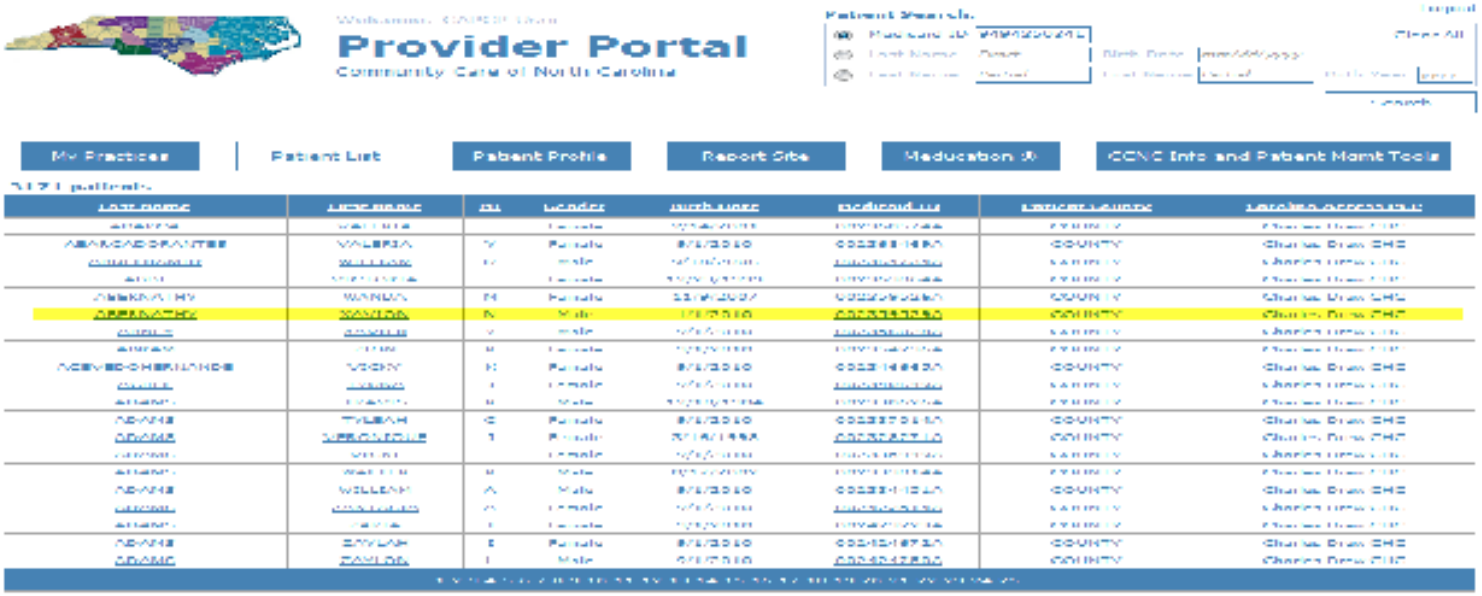
- The Informatics Center Provider Portal was released in August of 2010. This portal was built with the treating provider in mind, offering elements of CMIS, Pharmacy Home, and the Reports Site, tailored to the target user. Through a secure web portal, treating providers in the primary care medical home, hospital, emergency room, or mental health system can access a Medicaid patient health record which includes patient information, care team contact information, visit history, pharmacy claims history, and clinical care alerts. Importantly, the use of Medicaid claims data provides key information typically unavailable within the provider chart or electronic health record. For example, providers are able to see encounter information (hospitalizations, ED visits, primary care and specialist visits, laboratory and imaging) that occurred outside of their local clinic or health system. Contact information for the patient's case manager, pharmacy, mental health therapy provider, durable medical equipment supplier, home health or personal care service provider is readily available. Providers can discern whether prior prescriptions were ever filled, and what medications have been prescribed for the patient by others. Built-in clinical alerts appear if the claims history indicates patient may be overdue for recommended care (e.g. diabetes eye exam, mammography).

- The Provider Portal also contains key resources for assisting providers in the management of Medicaid patients, such as a compendium of low-literacy patient education materials, and practice tools for risk assessment and disease management. Through a seamless link into a licensed service maintained by an outside partner, providers can retrieve medication information for patients in multiple languages, in video or print format. Medical home providers may directly access population management reports and quality metrics for their own patient population through a seamless link into the Informatics Center Reports Site.

CAPCP

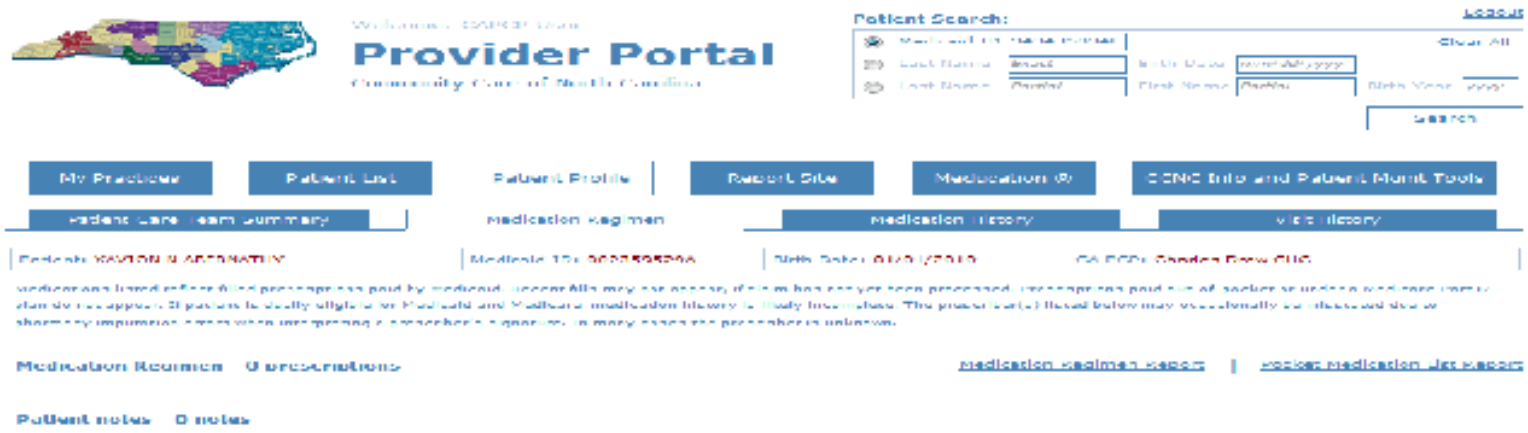
As a Carolina Access Primary Care Provider when you log in you will see a list of your practices.

Patient List



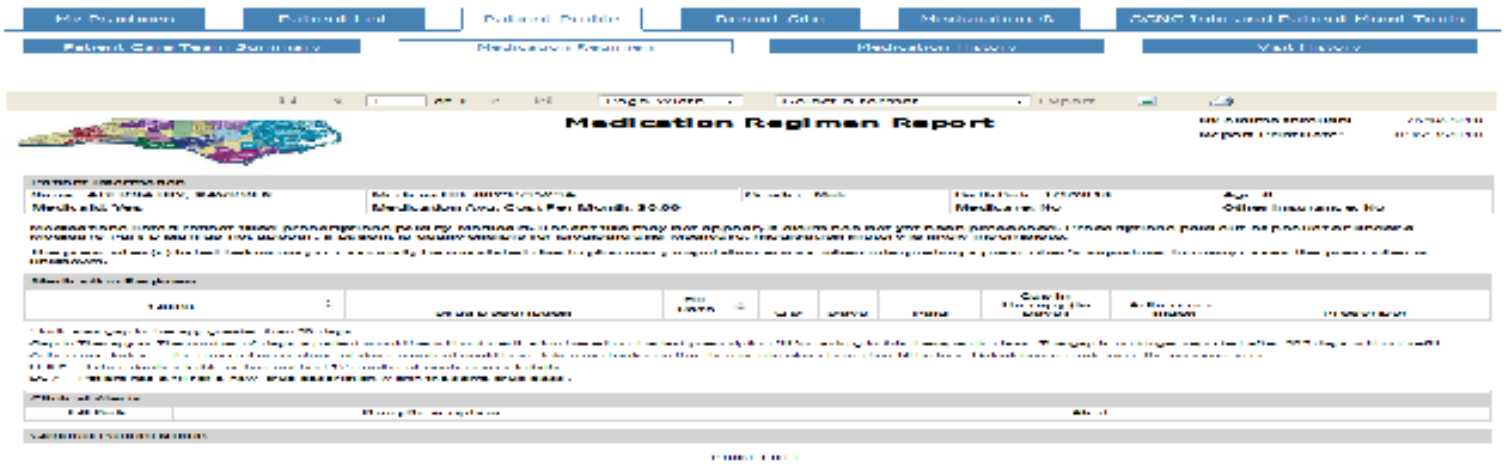
Once you click on your practice name you will be provided a list of patients within that practice.

Medication Regimen



The Medication Regimen will provide each unique drug class prescription fill for that patient.

Medication Regimen Report



This is a report of the regimen that can be printed from here or exported.

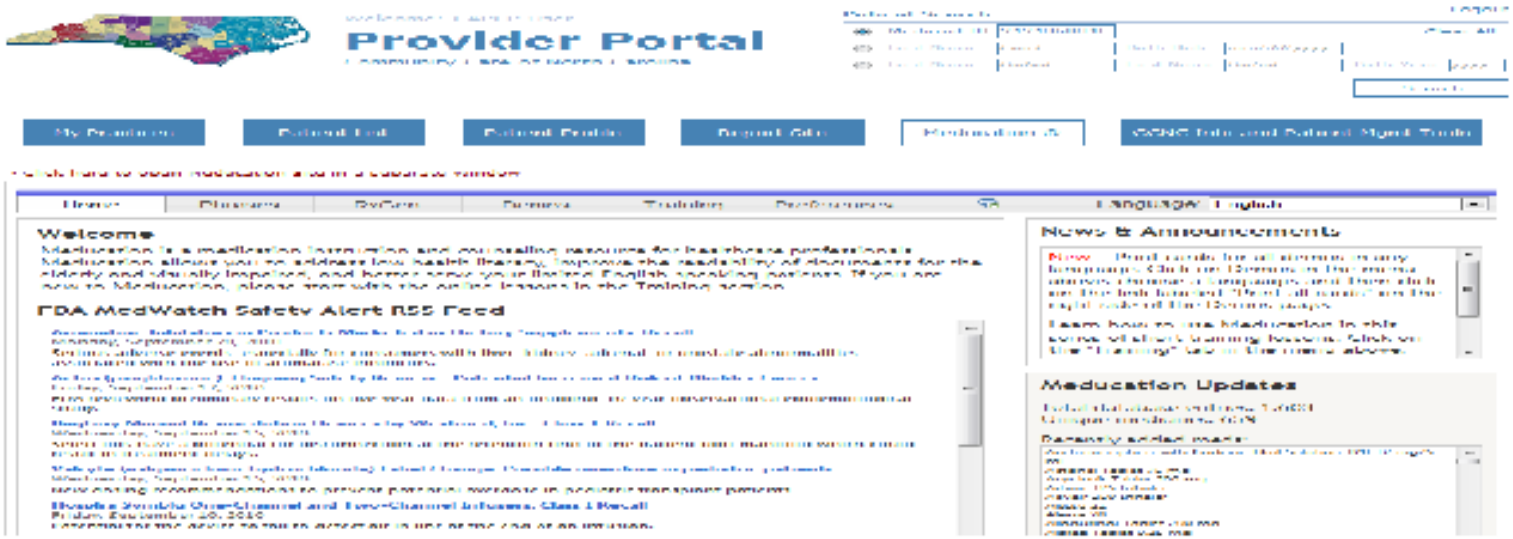
Medication History

Medication history will list all the prescriptions fill for the patient. It defaults to 1 year but can go back as far as 3 years. Please see the yellow box. This is where you can change the date search.

Medication History Report

This is the report that you can print out the entire prescription fill for a patient up to 3 years. This like the regimen can be printed from here or exported out to print

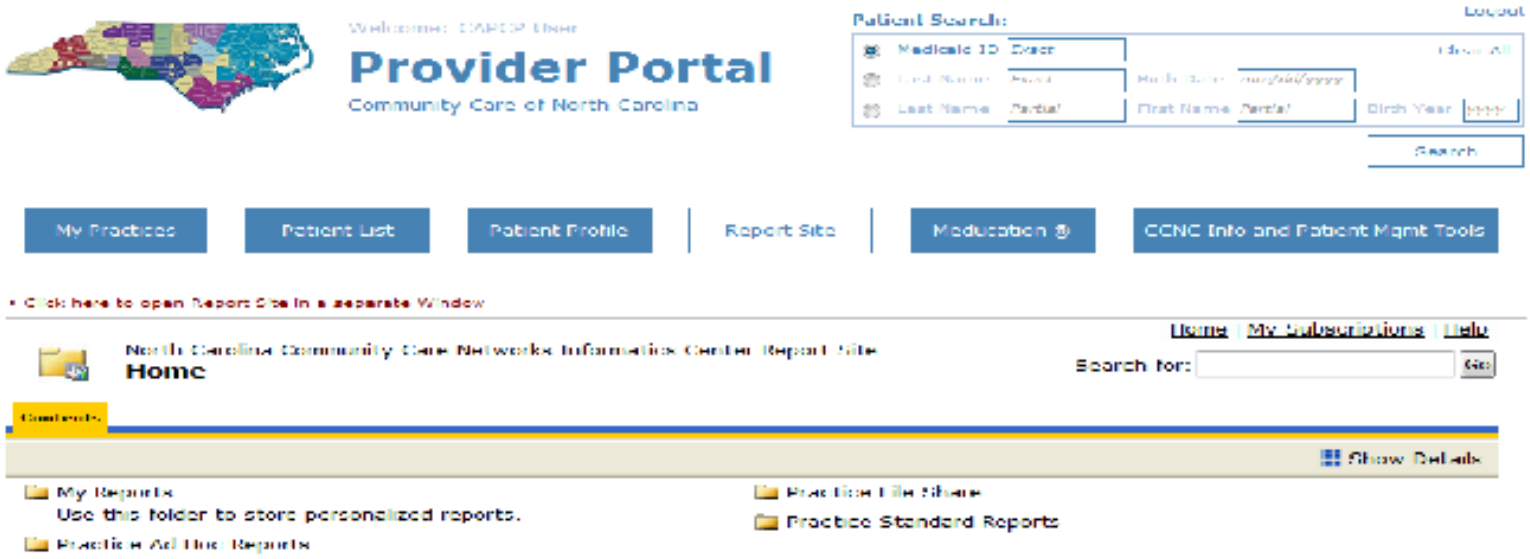
Meducation



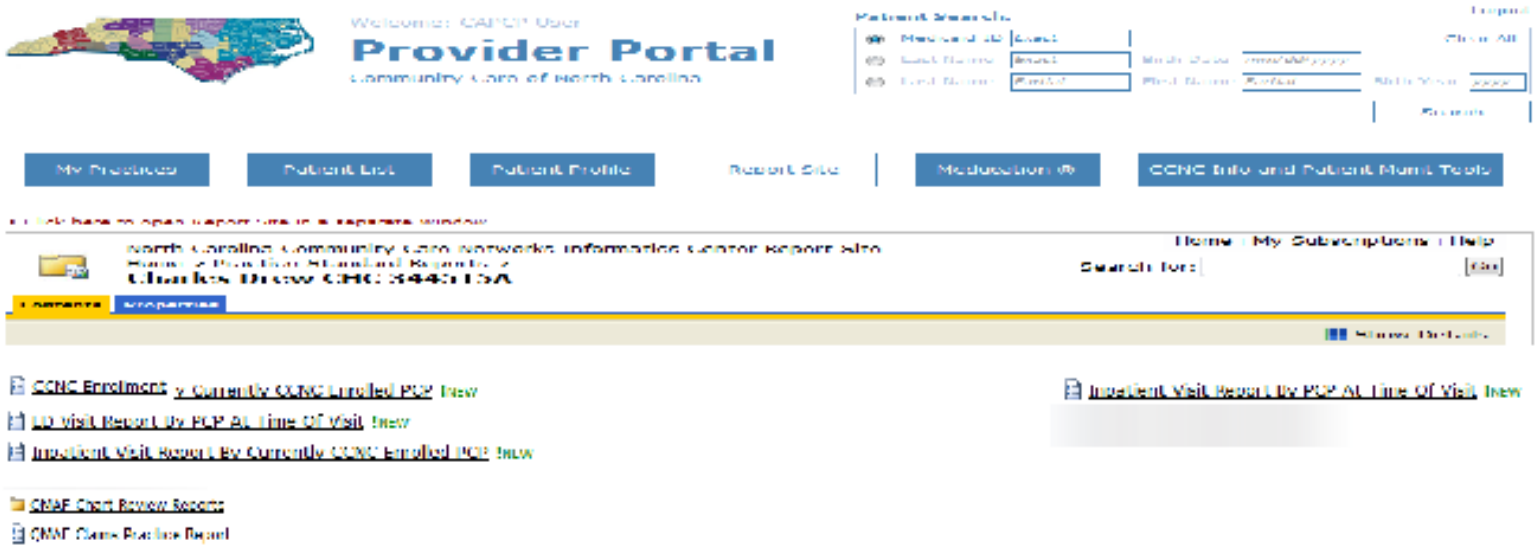
Meducation is a medication instruction and counseling resource for healthcare professionals. Meducation allows you to address low health literacy, improve the readability of documents for the elderly and visually impaired, and better serve your limited English speaking patients. If you are new to Meducation, please start with the online lessons in the Training section.

Patient Management Tools

Report Site


Provider Portal
Community Care of North Carolina
Patient Search:
Logout
Search
My Practices
Patient List
Patient Profile
Report Site
Medication
CCNC Info and Patient Mgmt Tools
Click here to open Report Site in a separate Window
Home
Home | My Subscriptions | Help
Search for:
Go
Show Details
My Reports
Use this folder to store personalized reports.
Practice Standard Reports

Practice Reports



This tab will allow the provider to see their practice information.