

The Role of Community Care in Improving the Quality of Care

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The Community Care of North Carolina program has built community health networks that are organized and operated to support primary care providers and the medical home. Since its inception in 1998, Community Care has been marketed as a quality improvement program intended to improve the quality of care to all enrolled Medicaid recipients.

One prominent physician leader arguing for the expansion of the original CCNC concept would often say: “quality health care will cost less.” Community Care has developed quality improvement and care management initiatives that have been able to achieve both quality and cost objectives. The CCNC program follows a simple process: assess the needs and severity of the enrolled population in order to target care and disease management initiatives where they are most beneficial. In identifying core initiatives, the physicians look at quality and utilization data and take the lead in choosing quality and care management initiatives where there are opportunities for improving health processes and outcomes. They then help define the performance measures they are expected to achieve. This approach is key to obtaining local physician input and buy-in, and in spreading the initiative to peers.

Each network has at least one designated clinical director who takes the lead in championing quality improvement (QI) initiatives throughout their network. Over the past 10 years, the clinical directors have met regularly to review and assess meaningful data and information about their enrolled population, to share best practices, and to collectively choose initiatives, performance measures, and goals. An example: in August of 2008, nine clinical directors from the first nine pilot networks met with Community Care leadership and reviewed utilization data on their enrolled Medicaid population. They quickly chose asthma as the first disease management initiative since it was the number one reason for hospital admissions and emergency department visit. Each network has regular medical management committee meetings that are chaired by their clinical director, with clinical representation from participating practices. In networks that cover a large geographic area, the

clinical directors may choose different strategies to engage their community providers and in some instances this may require going to all the practices for face-to-face time with participating physicians. These local meetings provide a forum to obtain provider input and buy-in and to implement a process for spreading quality improvement initiatives to all

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participating practices. Both the clinical director’s meetings and the local medical management committee meetings serve as catalysts for this model of improvement.

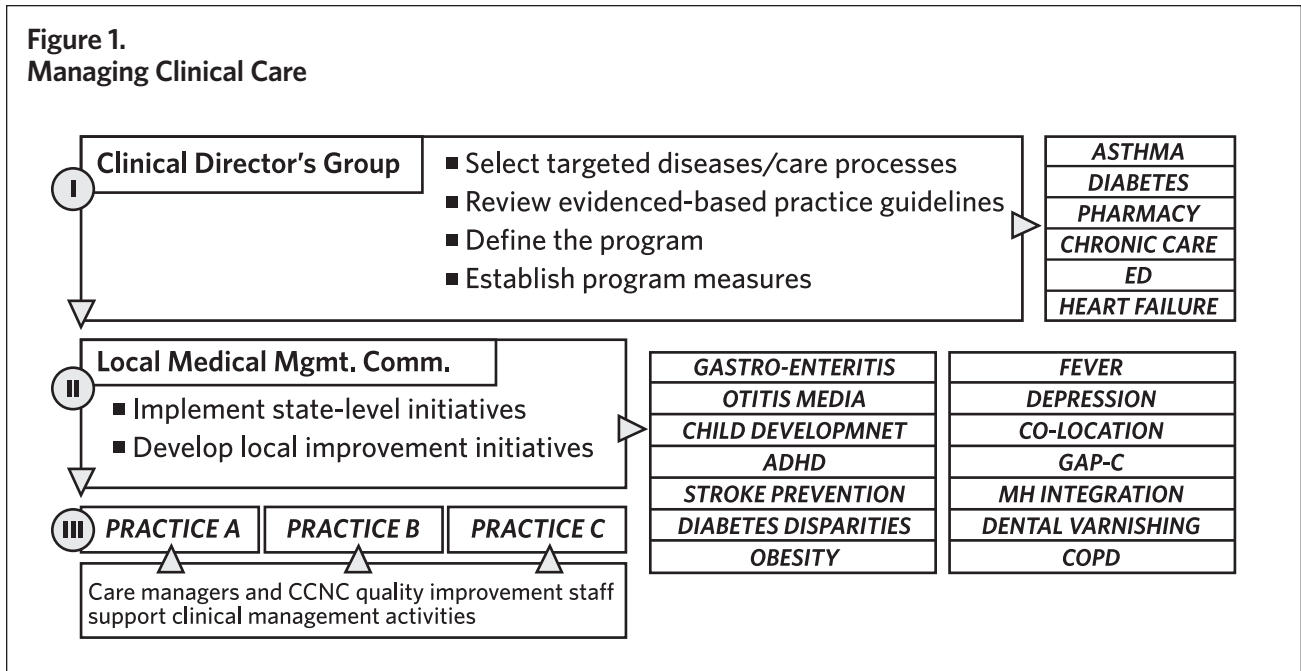
The flow chart in Figure 1 depicts the clinical directors group at the top where they are responsible for selecting initiatives, determining the needed program components, and defining the performance measures.

Community Care’s clinical directors have established the following guiding principles in selecting a quality improvement initiative:

- There are enough Medicaid enrollees with a disease to obtain a “return on investment.”
- Evidence exists that best practices lead to predictable and improved outcomes.
- Appropriate evidence-based practice guidelines are available.
- Physicians will support the process.
- Patient education and support can improve outcomes.

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Figure 1.
Managing Clinical Care



- Best practices and outcomes are measurable, reliable, and relevant.
- Evidence exists that the quality measures themselves improve care.
- There is room for improvement—a gap exists between best practice and everyday practice.
- Baselines for need and performance can be measured and improvement can be measured longitudinally.

Each network designates clinical champions and QI team leaders to employ the model of rapid cycle quality improvement developed by the Institute for Healthcare Improvement (IHI).¹ This model stresses setting aims, establishing measures, and making system changes that remove barriers and support excellent care. The networks have joined together to do the following:

- Review initial data obtained from claims and chart audits.
- Choose disease management initiatives.
- Develop program expectations.
- Define goals, objectives, and performance measures.
- Identify methods of information collection.
- Create plans for implementation, assessment, and monitoring.
- Share best practices.
- Develop and implement an evaluation strategy for the initiative.

Community Care is designed to support the development of community care systems that can develop programs and processes to manage the care of an enrolled population. The local systems include, but are not limited to, enrollees linked to medical homes, medical and administrative committees that provide direction on care management activities,

dedicated case managers to carry out population management activities in care and disease management, and coordination and collaboration with community resources. The Community Care model aims to integrate the most important elements from the various patient-centered medical home models, including the community-based features in Wagner’s chronic care model.

Community Care has the following disease and care management initiatives in place in every network: asthma, diabetes, and congestive heart failure disease management; high cost and high risk care management; pharmacy management and prescribing initiatives; emergency room utilization; and transitional support and chronic care (managing the comorbid aged, blind, and disabled population). In addition, pilots are underway in several networks to create models of care relevant to the population that can be replicated and spread to other networks. Some of these pilots include, but are not limited to, chronic obstructive pulmonary disease (COPD), mental health integration/co-location, childhood obesity, stroke prevention, diabetes disparities, and depression. The value of networks taking the lead in pilot initiatives cannot be overstated. Local networks are able to understand the needs of their community and their patient population. When possible, grant funds are sought to support pilot initiatives and, as the network is developing and implementing new programs, they are sharing their processes and results with all network leadership. Several initiatives that have begun as pilots are spreading statewide. One such example is the Assuring Better Childhood Development (ABCD) program that began in one network with one clinical champion. It has since spread to almost every network in the program and has been recognized as a national child development model. There is value in one or two networks determining the best strategies to have a positive impact on the target population and then the model

being spread to other networks. All the tools, processes, best practices, and lessons learned assist other networks desiring to adopt these pilot initiatives.

Community Care provides centralized support to the networks and the medical homes by providing the following:

- Clinical expertise and leadership to meet with physicians and practices on targeted QI initiatives. Clinical staff is available to go on-site and meet with physicians, practices, and staff to provide targeted education and technical assistance.
- Provider tool kits are created that summarize best practice guidelines and provide office-based tools for adoption and customization.
- Quarterly practice profiles on utilization, cost, and quality metrics are created and disseminated to all participating practices.
- A web-based case management information system that supports the case manager's effort and contains useful tools, such as uniform screenings and assessments.
- Provider and patient education materials that can be printed and customized for individual practices, such as a medical home brochure with the practice name and contact information.
- Population stratification and gaps in care reports.

Community Care uses the performance measures defined by the clinical directors to measure the ability of providers and networks to achieve quality outcomes and processes. The outcome indicators are typically gathered by claims data and the process indicators are gathered by external chart reviews. Community Care has partnered and contracted with Area Health Education Centers (AHECs) to perform randomized chart audits that provide practice-specific feedback and monitoring on process measures, such as performing annual foot exams, lipid management, and HbA1c (glycemic) control for patients with diabetes. A standardized chart audit tool is developed and a random representative sample of charts is identified for review at every medical home. These reviews are collated by AHEC and returned to Community Care's central office where they are distributed and made available to the networks through the Case Management Information System (CMIS). Having this information on CMIS enables networks and care managers to identify patients needing follow-up. For example, they will want to perform outreach and schedule appointments for their patients with diabetes who have not received an annual eye exam. The care managers can proactively identify "gaps in care" and initiate efforts to promote best practice in concert with the medical home.

A critical element to Community Care's success centers on the ability of the networks to locally implement system changes needed at the physician practices. The network clinical directors are instrumental in engaging community providers to implement the quality initiatives. Providing credible and provider-friendly reports of clinical outcomes

are powerful tools, particularly when accompanied with benchmarks and comparisons to peers, helping to motivate providers to improve processes that will enable them to provide best care. The focus is on implementing evidence-based best practices in the medical home.

Currently Community Care uses information obtained from claims, electronic records, and chart reviews to establish baselines and to measure performance. Initial measurements are obtained prior to intervention to serve as the baseline from which to measure improvement. Chart reviews are conducted based on randomized representative samples. The results are broken down by individual practice, by network, and by Community Care as a whole. Practices are compared with like practices such as pediatrics, family practice, and multi-specialty. These summary reports are further broken down by age, utilization of services and cost of services (per member per month cost). In addition, Community Care provides each network with reports that help identify their enrolled Medicaid population (identification and stratification) that might benefit from targeted disease and care management interventions.

As Community Care of North Carolina has gained state and national recognition in its ability to improve quality, utilization, and access, and reduce cost, many leaders from other states and organizations have inquired about our methodology and our ability to engage primary care providers in this effort. Here are some of the lessons learned that we share with other states and programs:

- Community collaboration and local physician leadership is paramount to our model.
- Building a program that places the medical home and the patient's primary care provider in the center of the model is very important. This strong linkage with the medical home is key to our program's success.
- When primary care physicians are invited to partner and participate in identifying, developing, and implementing initiatives, they take that responsibility seriously and are willing to be held accountable to achieve outcomes.
- It is important to invite the primary care physicians to participate early in the process and best to include them in the development phase. The clinical directors can then work with their community physicians, even the late adopters, to implement best practices.
- Solutions to health access and quality issues are local and, if they are led by local clinical champions, the peer pressure is meaningful and will resonate with other community providers.
- Initiatives should be chosen that can demonstrate quality improvement and impact costs.
- Take the time to build confidence at the provider level in the data and reporting processes—build meaningful and provider-friendly reports.
- The primary care physician leaders are your program's best "ambassadors."

- Align with other provider and quality initiatives in the state.
- Recognize that primary care providers need help with some of the barriers in caring for the Medicaid population—such as connecting to local resources, working with the patient and family on social issues, and providing pharmacy support.
- Strength and encouragement is gained when the clinical directors come together and share best practices, strategies, and tools.

Community Care’s approach to quality care helps support two emerging trends—the growing shortage of primary care providers and the increasing prevalence of chronic diseases.

The community-based infrastructure, led by physicians in concert with other key community agencies, will enable North Carolina to implement and disseminate patient-centered care that is culturally appropriate and sensitive to the capacity of the patient’s ability to accept and understand how to care for themselves as well as to navigate the care systems the medical home promotes. As a Medicaid program, CCNC is intended to improve the quality and lower the cost of health care for our most vulnerable citizens; but it is also meant to spread and influence the care of all the people in the state through its practitioners, most of whom care for people with other means to pay or the uninsured. **NCMJ**

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