Community Care of North Carolina: HLC Wellness Frontier Award Winner 2013

Combatting Obesity Through Community Networks

Tom Wroth, MD, MPH
Community-based, physician-led medical homes coordinate care across health systems

Managed through 14 local, non-profit networks, ~1,800 practices & 6,000+ providers

Population Health Approach: Case management and medical home capacity building

Goal: Ensure patients receive optimal care, avoid unnecessary utilization and reduce costs

Health informatics target at-risk beneficiaries and high-impact care settings

Use of data to drive performance and standardization across networks

Medicaid savings achieved in partnership with doctors, hospitals and other providers

Able to demonstrate improved quality and health outcomes and cost containment = value based model
CCNC Medical Home

Stratify population, choose targets
Data to inform decisions & focus efforts
Population mgmt:
Primary Care Foundation

Multi-disciplinary team: RX, Behavioral, Care Manager
CCNC Practice Network: 90% of Primary Care Providers in NC

**Federally Qualified Community Health Centers**

**Other Safety Net (RHC, LHD, other)**

**Independents**

**Established Provider-led ACO’s**

**Large Health System Owned Practices**

**Other Hospital Owned Practices**
CCNC HEDIS Performance Compared to Medicaid Managed Care Benchmarks

Higher is better!

- **Diabetes**
  - Cholesterol Control LDL < 100
    - CCNC: 47%
    - National HEDIS: 35%
  - Blood Pressure Control < 140/90
    - CCNC: 66%
    - National HEDIS: 61%
  - A1C Control < 8.0
    - CCNC: 48%
    - National HEDIS: 61%
  - Nephropathy Screening
    - CCNC: 84%
    - National HEDIS: 78%

- **Cardiovascular Disease**
  - Cholesterol Control LDL < 100
    - CCNC: 47%
    - National HEDIS: 42%
  - Blood Pressure Control < 140/90
    - CCNC: 57%
    - National HEDIS: 64%

>10,000 more North Carolinians with good diabetes control

>11,000 more North Carolinians with good blood pressure control

Higher is better!
Peer-reviewed research

Cuts Program Costs

- Significant savings for 169,667 non-elderly, disabled Medicaid recipients
- $184 million savings in about 5 years
- Higher per-person savings for patients with multiple chronic conditions.

- **White**: 30% (19 Overweight, 11 Obese)
- **African American**: 40% (18 Overweight, 22 Obese)
- **Other Minorities**: 48% (32 Overweight, 17 Obese)
- **Hispanic**: 47% (29 Overweight, 18 Obese)
- **Non-Hispanic**: 33% (19 Overweight, 14 Obese)

BMI category based on percentile (underweight = below 5th percentile, healthy weight = 5th percentile to less than the 85th percentile, overweight = equal to or greater than the 85th, but less than the 95th percentile, obese = equal to or greater than the 95th percentile) for age. Data Source: North Carolina Child Health Assessment and Monitoring Program (CHAMP) Survey Data (2007): State Center for Health Statistics, Raleigh NC.
Percentage of North Carolina Adults Who Are Overweight or Obese

BMI* ≥ 25

Legend
Percent
- 70% - 75%
- 65% - 69%
- 62% - 64%
- 57% - 61%
- 47% - 56%

Source: 2006 Behavioral Risk Factor Surveillance System (BRFSS)

*Body mass index is computed as weight in kilograms divided by height in meters squared (kg/m²).
<table>
<thead>
<tr>
<th>Practices/Communities</th>
<th>People</th>
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<tbody>
<tr>
<td>Identify practices and communities with high prevalence of obesity</td>
<td>Use data to identify individuals who are ‘impactable’</td>
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<tr>
<td>Coach practices on incorporating evidence based care into their workflow</td>
<td>Develop care plan and set patient centered goals</td>
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<tr>
<td>Measure results and provide feedback</td>
<td>Refer patients with obesity to</td>
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<tr>
<td></td>
<td>- Dietician on care management team</td>
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<td></td>
<td>- Community resource or health coach</td>
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Improving Quality: Identifying Practices with Opportunities to Improve

**COMMUNITY CARE OF NORTH CAROLINA**

QMAF Claims Measures Mar 2012
Community Care Plan of Eastern Carolina (6702000)

Diabetes

<table>
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<tr>
<th>Network</th>
<th>Cholesterol Screening Num</th>
<th>Cholesterol Screening Den</th>
<th>A1C Percent</th>
<th>Eye Exam Percent</th>
<th>Cholesterol Screening Percent</th>
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<tr>
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<td>111</td>
<td>82%</td>
<td>46%</td>
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<tr>
<td>BERTIE</td>
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<tr>
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<td>63%*</td>
<td>38%*</td>
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<tr>
<td>DARE</td>
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<td>100%*</td>
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<td>GATES</td>
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<td>HERTFORD</td>
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<td>59%</td>
<td>69%</td>
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<tr>
<td>HYDE</td>
<td>2</td>
<td>3</td>
<td>67%*</td>
<td>33%*</td>
<td>67%*</td>
</tr>
<tr>
<td>JONES</td>
<td>23</td>
<td>41</td>
<td>81%</td>
<td>43%</td>
<td>56%</td>
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A. WHAT ARE YOUR FAMILY HEALTH HABITS?

Please mark the boxes with answers true for most days.

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<table>
<thead>
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<tbody>
<tr>
<td>1. Does your family usually eat more than 4 servings of FRUITS AND VEGETABLES each day?</td>
<td>Yes  No</td>
</tr>
<tr>
<td>2. Do you limit SCREEN TIME (TV, computer, video games, phone) in your family?</td>
<td>Yes  No</td>
</tr>
<tr>
<td>3. Does your family spend time every day in ACTIVE PLAY (fast breathing, sweating)?</td>
<td>Yes  No</td>
</tr>
<tr>
<td>4. Are SODA or sugary drinks (fruit juice, sweet tea sports drinks) available in your home?</td>
<td>Yes  No</td>
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<tbody>
<tr>
<td>5. Are SNACKS like cookies, ice cream, candy or chips available in your home?</td>
<td>Yes  No</td>
</tr>
<tr>
<td>6. Does your family usually eat BREAKFAST?</td>
<td>Yes  No</td>
</tr>
<tr>
<td>7. Do you EAT MEALS TOGETHER as a family?</td>
<td>Yes  No</td>
</tr>
<tr>
<td>8. Do you keep a TV or other SCREENS in the rooms where family SLEEPS?</td>
<td>Yes  No</td>
</tr>
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B. ARE YOU READY TO MAKE CHANGES?

Please circle a number:

- 1: Not yet
- 2: Thinking about it
- 3: Let's go!

C. WHAT WOULD YOU LIKE TO DO?

Please mark one box and write in your goal.

- Eat more fruits and vegetables: ________ servings daily.
- Play (sweat and breathe fast) everyday: ________ minutes.
- Set limits on screen time: ________ hours/day.
- Reduce sugar-sweetened beverage: ________ servings per week.
- Other: ____________________________

D. WHAT MIGHT MAKE IT HARD TO DO THIS?

Please write your answer on the line below:

E. HOW CONFIDENT ARE YOU THAT YOU CAN MAKE CHANGES?

Please circle a number:

- 1: Not confident
- 2: Somewhat confident
- 3: Very confident

Adapted by WNC Healthy Kids and WNC Pediatric Care Collaborative from NCHEC, The Reynolds Foundation, and Eat Smart Move More NC.
CCNC Pediatric Quality Collaborative (26 Practices)
Lessons Learned from North Carolina

- It takes a village
- Patient engagement is the new blockbuster drug
- Cross silo work is essential
- You get what you pay for