

PROJECT ABSTRACT

Project Title: Community Care of North Carolina's Physician Transformation Network

Applicant: Community Care of North Carolina, Inc.

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Community Care of North Carolina, Incorporated, (CCNC, Inc.) proposes to develop and implement a network of clinicians engaged in practice transformation that will be able to achieve the triple aims – improved quality, improved satisfaction and lowered costs. CCNC is an enhanced primary care case management (PCCM) program providing 1,800 medical homes with 6,000 primary care providers serving over 1.5 million Medicaid, dual eligible, CHIP, Medicare and commercial members through a statewide community-based medical home and population health infrastructure. Our culture is one of continuous quality improvement and we will devote our most experienced leadership staff to work diligently with CMMI leadership, technical support staff and community stakeholders to successfully implement a model that will deliver the desired goals and objectives articulated in the request for proposal. Our statewide network of primary care medical homes includes all North Carolina safety net providers, including Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), and Health Departments (HDs). CCNC's statewide network of medical homes will serve as the foundation for our practice transformation work. To strengthen our ability to work with the many small, rural, independent and safety net providers in our network, we are working with those providers to establish a Clinically Integrated Network (CIN) where participating physicians will work collaboratively to improve the quality and efficiency of patient care. The CIN will be able to participate in new payment models, such as Accountable Care Organizations. Behavioral health specialists will be included to focus on whole patient care. The physicians and practices will be supported by a population health management infrastructure (CCNC) to serve as a health care delivery solution for "all" systems by demonstrating *value* and *quality* of patient care across conditions, providers, settings and time, while helping providers remain independent; demonstrate their ability to achieve quality and cost metrics; and to compete successfully in value based reform efforts both in the public and private sector. This model of whole person care will improve healthcare outcomes for Medicaid, dual eligible Medicare/Medicaid, Medicare and CHIP beneficiaries while addressing the range of physical and behavioral health needs for patients through this reformed health care model. The transformation paradigm will be comprised of 3,000 clinicians by the end of the fourth year and will be led with the support of a Program Director, QI Project Manager, primary care and specialists, Physician Champions and Liaisons, Program Managers, Transformation Coaches, Behavioral Health Integration Specialists, Pharmacists and Quality/Data Analysts as well as support from the Quality Improvement Organizations and CMMI staff and technical contractors. CCNC is requesting \$18,580,523 over a four year period to implement the five phases of transformation within physician and specialty practices, with over 50 % representing clinicians serving in rural, safety-net and underserved communities.