Abstract – North Carolina's Alternative Non-Emergency Provider Program

North Carolina Medicaid proposes to engage its community-based medical home and care management system (Community Care) in implementing the alternative non-emergency provider program. Community Care is a statewide community-based infrastructure that has substantially improved the quality and cost-effectiveness of care for Medicaid recipients. Through Community Care, North Carolina has partnered with community providers to build regional networks that are organized and operated by community physicians, hospitals, health departments and other community organizations to improve the management of care and care outcomes for the State's Medicaid recipients. There are currently fourteen (14) Community Care Networks with 1,250 primary care practices that serve as medical homes for 760,000 Medicaid recipients.

With support from CMS, North Carolina will provide incentives and support to forty (40) large Community Care practices, which are willing to become alternative non-emergency providers ("advanced medical homes") in the communities they serve. By the end of year four (4), the project expects to directly affect 175,000 Medicaid recipients a year. We also expect to have at least two (2) non-emergency provider sites in each of the fourteen (14) Community Care networks. We also expect that a majority of the provider sites will be in rural areas and that each site will work closely with its community hospital in implementing the program. By creating the non-emergency providers within the Community Care medical home infrastructure – creating the "advanced medical homes" with after hours and weekend coverage – we can assure that continuity and coordination of preventive, primary and chronic health care needs are met. When beneficiaries use other "non-emergent providers", such as urgent care centers, communication with and follow-up by their primary care provider rarely occurs. North Carolina's approach would ensure and reinforce the medical home concept and reduce the fragmentation and lack of coordination inherent in the current system.

North Carolina is extremely well positioned to successfully carry out the alternative non-emergency provider initiative. It has the medial home and care management infrastructure combined with a Medicaid payment policy that encourages primary care providers to establish evening and weekend hours for patients with non-emergency conditions. The support being requested from the Centers for Medicare and Medicaid (CMS) will be the catalyst to make it happen.

North Carolina's CMS Proposal for Establishment of Alternative Non-Emergency Services Providers

Statement of Project / Need:

Medicaid beneficiaries have traditionally used the Emergency Department (ED) as a vehicle for non-emergent care. Similar to other State's experiences, the Medicaid population has found the ED to be an accessible site for obtaining care. Transportation barriers are eased during evening hours and treatment is provided regardless of insurance status. According to Kaiser State Health Facts, North Carolina's emergency room visit rate per 100 population in 2005 was 43.6 compared to the national average of 38.7. North Carolina had the 15th highest rate. Although ready access to the hospital emergency room is vital for patients with emergency needs, it is an inappropriate (and costly) site of care for non-emergency care needs, particularly patients with chronic disease and in need of follow-up. In an attempt to create better and more appropriate access to primary care for the Medicaid population, North Carolina embarked on a major policy initiative to create "medical homes" for Medicaid beneficiaries – beginning in 1991 with a traditional primary care case management program and continuing in 1998 with the implementation of a model that linked the medical homes with community-based care management support systems to create a statewide infrastructure (Community Care of North Carolina).

North Carolina has strong history of inter-agency collaboration and partnership. The Division of Medical Assistance (Medicaid Agency) partners with the North Carolina Office of Rural Health and Community Care to administer and provider oversight and supervision to the Community Care Program. The Community Care Program is North Carolina's approach to improving the quality and managing the cost of most Medicaid beneficiaries through an enhanced primary care case management program. These funds will be used contractually with select Community Care networks/practices to implement the program and staffing will be contracted by the North Carolina Foundation for Advanced Health Programs, Inc. – a private non-profit organization that has partnered and supported Community Care initiatives since its inception.

Community Care is a collaborative through which the state has partnered with community providers to build regional networks, organized and operated by community physicians, hospitals, health departments and other organizations, to improve the quality, efficiency and cost-effectiveness of care for the state's Medicaid population. It is an enhanced primary care case management model with fourteen (14) community care networks, with more than 3,500 physicians, serving over 760,000 Medicaid enrollees. The state provides a per member per month fee to the primary care providers ("medical homes") and to the network to implement population management solutions. The community care networks use population management tools, such as: providing an enrollee with a medical home, implementing evidence-based practice guidelines, providing targeted care and disease management, coordinating the delivery of care, helping physician practices improve how they manage patients with chronic health care needs, and getting community providers to work together in managing enrollee care. Community Care has demonstrated success in helping participating practices collect and adopt evidence-based practice guidelines for asthma, diabetes, congestive heart failure, depression and chronic obstructive pulmonary disease. The networks have integrated targeted care management initiatives to help physicians manage and care for the most frail and costly patients. Case managers, hired locally by the networks, work closely with primary care physicians and patients / families to implement care and disease management interventions. Community Care produces and distributes reports to physicians and practices that highlight their effectiveness in meeting performance measures and goals and offers tools to improve outcomes. As North Carolina's Medicaid primary delivery system, Community Care has demonstrated that if you engage those community providers who care for the patients and provide them with a system and support, community-based health is effective in improving quality of care and helping preserve limited health care resources.

The importance to North Carolina of having a statewide provider network in place cannot be overstated. Not only is the Community Care system achieving documented improvements in the quality, utilization and cost-effectiveness of care for Medicaid, it also has given North Carolina a community-based

infrastructure that can be used to tackle a range of problems. By providing a structure for community providers to work together, by providing tools and supports for networks to design and develop programs, and by providing resources to implement programs, North Carolina has created a system that, if nurtured, can continue to grow and respond to state and local health care needs. Expanding upon this infrastructure to implement the alternative non-emergency provider initiative is a natural progression in the development of "advanced medical homes" that will drive an appropriate and accessible health care delivery system at the community level.

Project Justification: *Phase One* – Community Care will identify 20 community practices, at least one in each of the 14 Community Care networks, that are willing to become alternative non-emergency providers (Advanced Medical Homes) in the communities in which they are located. To participate in this non-emergency services provider initiative, a practice must be:

- A physician practice, community health center, rural health center, health department, hospital clinic, or similar health care provider that is a participating "medical home" provider in Community Care.
- A practice that can provide clinically appropriate services for the diagnosis and treatment of non-emergency conditions.
- A practice that is willing to pursue designation as a Community Care Advanced Medical Home. This designation would require a practice to put in place the supports and processes that are needed to become an effective alternative non-emergency provider including:
    - An "open access" and/or triage system to accommodate timely ("same day") access for patients seeking care for non-emergency conditions.
    - Extended hours (evening/weekends).
    - Disease, care and case management support for patients with chronic conditions.

- Patient education that re-enforces the use of the “medical home” for non-emergency conditions.
- 24 hour nurse advice line.
- Engage and support patients in the self management of their chronic condition(s).
- Collect and review utilization/cost data.
- Work with their community hospital in developing / implementing the alternative non-emergency provider program.
- Participate in the “Advanced Medical Home” collaborative.
- Be willing to accept new Medicaid Community Care enrollees.

As with other Community Care clinical and care improvement initiatives, the goal of the “Advanced Medical Home” initiative is to test interventions and to spread successful intervention across networks and practices. The goal is to build successful provider-led care improvements that can be sustained and spread. Thus in phase one it is important that the initial cohort of “advanced medical home” participants not only represent a cross section of practices by region, rural/urban, practice type and size, but also be able to provide leadership in spreading effective interventions. We will also seek to pilot community-wide interventions where community providers join together to establish a collaborative alternative non-emergency provider site to serve enrollees from sponsoring practices.

For practices participating in the “advanced medical home” project, Community Care, and its participating networks will provide the following support:

- A start-up grant to enable participating practices to put in place the extended hours and other supports needed and to help offset the start-up costs incurred during the ramp-up period and before increased utilization (and revenue) can cover the added expenses.
- Notifying/educating Community Care enrollees in phase one communities on the availability of the “advanced medical home.”

- Tabulating and analyzing claims paid data on Medicaid patients linked to participating "phase one" practices. Analysis will be shared with participating networks and practices.
- Telephone follow-up with patients who continue to use the hospital emergency room for non-emergency conditions. The goal of the telephone follow-up will be to both emphasize the importance of the "medical home" and to determine reasons why it wasn't used.
- Sponsor "advanced medical home" meetings to enable participating practices to learn from each other, for the project to refine strategies and initiatives, and to provide medical policy feedback to the Division of Medical Assistance (Medicaid agency).

Phase One Participants

Although there is not time within the application process to secure formal commitments from practices to participate in Phase One, we believe, based on discussions with networks, that the following Community Care networks and practices will be strong candidates. *[# of Medicaid Enrollees / # of SCHIP Enrollees]*

Access Care Network

- Mt View Pediatrics (Burke County) – rural [4,725 / 326]
- Goldsboro Pediatrics (Wayne County) – urban [11,991 / 1,079]
- Sandhills Pediatrics (Moore County) – rural [4,127 / 352]
- Washington Pediatrics (Beaufort County) – rural [3,367 / 308]
- Thomasville Pediatrics (Davidson County) – urban [6953 / 555]
- Sandhills Pediatrics (Moore County) – rural [4,127 / 353]
- Eastern Carolina Pediatrics (Wilson County) – urban [6,088 / 468]
- Coastal Children's Clinic (Craven County) – rural [3,542 /389]
- Catawba Pediatrics (Catawba County) – urban [4,688 / 280]
- Burlington Pediatrics (Alamance County) – urban [2,940 / 307]
- Clinton Medical Group (Sampson Cty) – rural [4,261 / 290]
- Lumberton Children's Clinic (Robeson County) – rural [8,959 / 492]
- Purcell Clinic (Scotland County) – rural [3,815 / 169]
- Lexington Pediatrics (Davidson County) – urban [3,740 / 303]
- Purcell Clinic (Scotland County) – rural [3,815 / 169]
- Piedmont Healthcare (Iredell County) – rural [4,670 / 205]
- Jacksonville Children's Clinic (Onslow County) – urban [4,253 / 327]
- Coastal Pediatrics (Pasquotank County) – rural [3,610 / 286]
- Boone Pediatrics (Watauga County) – rural [2,133 / 303]
- Henderson Pediatrics (Henderson County) – rural [3,483 / 351]

Access II Care of Western North Carolina

- Buncombe County Health Department (Buncombe County) – urban [2,699 / 115]
- Blue Ridge Community Health Services (Henderson County) – rural [1,557 / 78]
- MAHEC Family Health Center (Buncombe County) – urban [1,889 / 81]
- Henderson Family Medicine (Henderson County) – urban [608 / 15]
- Hot Springs Health Program (Madison County) – rural [1,862 /88]
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Carolina Community Health Partnership

- CLECO (Cleveland County) – rural [1,737 / 11]
- Rutherford Pediatrics (Rutherford County) – rural [3,315 / 203]
- Shelby Children's Clinic Pediatrics (Cleveland County) – rural [6,911 / 355]
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Community Health Partners

- Gaston Family Health Services (Gaston County) – urban [1,785 / 17]
- Lincoln Pediatrics (Lincoln County) – rural [1,929 / 115]
- Gaston County Health Department (Gaston County) – urban [2,272 / 61]
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Community Care Partners of Greater Mecklenburg

- CMC Medical Clinics (Mecklenburg County) – urban [16,258 / 306]
- Anson County CHC (Anson County) – rural [586 / 39]
- Metrolina Comprehensive Health Center (Mecklenburg County) – urban [6,104 / 123]
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Southern Piedmont Community Care Plan

- Cabarrus Family Medicine (Cabarrus County) – urban [1,227 / 53]
- Cabarrus County Public Health Authority (Cabarrus County) – urban [2,184 / 96]
- Albemarle Pediatrics (Stanly County) – rural [2,221 / 165]
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Central Piedmont Access II

- Downtown Health Plaza (Forsyth County) – urban [10,595 / 391]
- Surry County Health Center (Surry County) – rural [1,138 / 131]
- Wilkes Pediatrics (Wilkes County) – rural [2,860 / 265]
- Forsyth Pediatric Group (Forsyth County) – urban [6,648 / 493]
- Aegis (Forsyth County) – urban [7,436 / 461]
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Partnership for Health Management

- Health Serve (Guilford County) – urban [1,080 / 11]
- Randolph Medical Associates (Randolph County) – rural [3,535 / 234]
- Guilford Child Health (Guilford County) – urban [Wendover = 6,384 / 221; Highpoint = 2,804 / 90; Devon = 1,729 / 30]
- Rockingham County Health Department (Rockingham County) – rural [1,641 / 71]

Access Care – UNC

- Piedmont Health Services (Orange, Chatham, Alamance Counties) – rural [Alamance = 2,091/116; Chatham = 1,427/98; Orange = 731/49]
- UNC Family Medicine (Orange County) – urban [1,185 / 55]

Community Care of Wake/Johnston Counties

- Wake Community Health Center (Wake County) – urban [5,936 / 300]
- Growing Child Pediatrics (Wake County) – urban [5,698 / 334]
- Benson Area Medical Center (Johnston County) – rural [797 / 30]
- Johnston County Health Department (Johnston County) – rural [1,713 / 95]

Northern Piedmont Community Care

- Lincoln Community Health Center (Durham County) – urban [6,567 / 172]
- Duke Pediatrics (Durham County) – urban [4,771 / 261]
- Henderson Pediatrics (Vance County) – rural [4,028 / 201]
- Oxford Family Medicine (Granville County) – rural [1003 / 62]
- Vance Family Medicine (Vance County) – rural [2,892 / 174]
- Duke Family Medicine (Durham County) – urban [2,463 / 91]

Carolina Collaborative Community Care

- Melrose Pediatrics (Cumberland County) – urban [3,816 / 203]
- Highland Valley Pediatrics (Cumberland County) – urban [2,615 / 158]
- Cumberland Count Health Department (Cumberland County) – urban [2,404 / 87]
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Sandhills Community Care Network

- First Health (Moore, Richmond, Hoke and Montgomery Counties – rural [2,283 / 162]
- ABC Pediatrics (Harnett County) – rural [4,268 / 408]
- Hoke County Health Department (Hoke County) – rural [688 / 21]
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Community Care Plan of Eastern North Carolina

- Tarboro Clinic (Edgecombe County) – rural [5,312 / 208]
- Roanoke / Amaranth CHC (Northampton & Halifax Counties) – rural [1,797 / 92]
- ECU Medical Clinics (Pitt County) – urban [11,288 / 365]
- Kinston Community Health Center (Lenoir County) – rural [2,635 / 87]
- Roanoke / Chowan CHC (Hertford County) – rural [402 / 2]
- Rocky Mount OTC Family Medicine (Edgecombe County) – rural [4,009 / 115]
- Boice Willis Clinic (Nash County) – urban [6,022 / 401]
- Goshen Medical Center (Duplin County) – rural [3,524 / 239]

Access III of Lower Cape Fear

- New Hanover CHC (New Hanover County) – urban [967 / 21]
- Black River Health Services (Pender County) – rural [235 / 17]

- Knox Clinic (New Hanover County) – urban [3,250 / 182]
- Bladen Medical Associates (Bladen County) – rural [3,114 / 204]
- Children's Clinic (New Hanover County) – urban [3,360 / 302]
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These 77 Community Care practices, with more than 65% located in rural counties, provide the broad geographic coverage that is being sought during phase one. This potential participation list also provides a good cross section by practice type, specialty and size. More than 300,000 Medicaid recipients (and 16,500 SCHIP recipients) are enrolled with these practices.

Phase One will last two years. Phase Two, which will run during years three and four of the project, will focus on the spread of the "advanced medical home" intervention. An additional 20 practices will be brought into the project. We expect to directly affect 175,000 Medicaid recipients a year by the end of Phase II. The project will not end after Phase II. As with all Community Care program-wide clinical and quality initiatives, the goal will be to spread the successful interventions and program elements to all networks and counties in North Carolina.

Project Goals and Outcomes: As a result of this project, North Carolina would expect the following goals and outcomes:

- A decrease in the non-emergency hospital emergency department (ED) visit rate in the targeted counties.
- An increase in visits to advanced medical homes.
- An increase in after-hours billings from the advanced medical homes.
- An increase in the number of practices that have implemented "open access" or "same day visits" or other strategies to improve access to non-emergent care.
- An increase in the number of Medicaid recipients linked to an advanced medical home.

This grant would provide the Community Care networks and the participating practices with the support needed to build the infrastructure to support the "advanced medical home" and be able to deliver appropriate non-emergent care to Medicaid beneficiaries. The above goals will be measured on a regular basis and shared with network and practice staff to drive additional system changes and /or enhancements.

Estimate of Impact to Beneficiaries: Based on the projected designation and participation of 40 alternative non-emergency providers, we expect that 175,000 Medicaid recipients will be directly affected by the project each year. The project target area will be one half of North Carolina's 100 counties and will include counties in each of the 14 Community Care networks (see attached Community Care Network map). This approach will ensure that the project will achieve the type of participation (across region, geography, rural/urban, practice type) that can spur the spread of the alternative non-emergency provider model.

Description of Magnitude of the Impact to Medicaid: The two major components of North Carolina's Alternative non-emergency provider initiative (advanced medical home) are to encourage participating practices to establish extended clinic hours (evenings and weekends) and to create, through "open access" and triage systems, reductions in appointment delays and office waiting times that make for easier and more timely access to primary care services. We do have studies and data, which confirm that these two approaches whether alone or together, have a significant impact on emergency room utilization. In North Carolina communities, where an alternative non-emergency provider already exists, North Carolina Medicaid has seen significantly lower emergency room utilization rates. For example, in nine counties where, at least, one major Medicaid practice already offers good evening and weekend office hours for their patients, non-emergency room visits are substantially lower than the statewide average. For FY 2007, statewide non-emergency utilization in hospital emergency rooms was 36.2 visits / 1000 compared to 29.25 visits / 1000 in the nine counties. The per member per month cost for non-emergent emergency room visits was also substantially lower in the nine counties. For FY 2007, statewide per member per month (pmpm) non-emergency hospital ER costs were $6.45 pmpm compared to $5.13 pmpm (or 21% lower) in the nine counties.

Based on the experience of the nine counties, we project that by the end of phase one, North Carolina's target project area will divert approximately 16,000 non-emergent ED visits annually to an alternative non-emergency provider practice. By the end of phase two, the deferred number of non-emergency room visits will reach 32,000 annually. This annual reduction in hospital non-emergency room visits will translate, by the end of phase two, into an annual reduction in Medicaid payments in excess of $8 million.

Description of Sustainability of the Project: The NC Division of Medical Assistance has made a big step in recognizing the importance of establishing alternative non-emergency providers by establishing a special after hours payment that is paid in addition to the fee for the office visit ($16 / $30). This payment will be available to primary care practices willing to establish evening and weekend hours for patients with non-emergency conditions.

It is anticipated that the project's proposed payments to support the establishment and ramp up of the alternative non-emergency provider sites will be sufficient until patient volume combined with the enhanced after-hours payments generate the revenue needed to sustain the alternative non-emergency provider services. The proposed patient support and education center, which will emphasize the importance of the alternative non-emergency provider / enhanced medical home, will be sustained through cost-containment funds provided by NC's General Assembly. Once the center can document the Medicaid savings generated from its work greatly exceeds center costs, cost-containment funds can be used to support its operation.

Evaluation Plan: Community Care will tabulate (from the Medicaid Claims Paid File) and analyze, on a quarterly basis, changes in utilization and cost which result from project implementation. This analysis will be done at the county-level and will capture utilization and cost information on services provided by the alternative non-emergency providers and by the hospital emergency rooms. This information will be reviewed with the participating providers (and networks) to guide improvements in performance.

The Division of Medical Assistance's actuarial contractor (currently Mercer Human Resources Consulting), which is already charged by the NC General Assembly to evaluate the Community Care Program and its initiatives, will include in their evaluation work an annual assessment of the alternative non-emergency provider (Advanced Medical Homes) initiative.

Description of Project Implementation Readiness:. North Carolina is extremely well positioned to successfully carry out the alternative non-emergency provider initiative. Through its Community Care Program, North Carolina Medicaid has in place the state-wide infrastructure that cannot only implement the project, but that also provides the framework for rapid spread.

Key Milestones – Year One: 01/01/08 – 12/31/08

Date	Key Milestones	Responsible Organization(s)
Nov – Dec 07	Mailings to and meetings with interested networks and practices regarding this project – listing criteria for participation and process to apply.	CCNC
Dec 07	Advertise and interview project staff.	CCNC
Jan 08	All key project staff identified, hired and oriented.	CCNC
Jan 08	Develop participation contracts and list of deliverables for pilot sites.	Project Coord.(PC)
Jan 08	Identify initial 20 pilot practice sites to implement advanced medical homes.	CCNC
Feb 08 - Mar	Develop and disseminate toolkits to include useful resources, such as: open-access; after-hours billing and coding; community marketing material; educational brochures on non-emergent condition, etc.	Project Staff
Mar 08	Meeting with all participating (20) advanced medical homes – provide technical assistance, guidance and monitoring.	Project Staff
April 08	Create baseline data reports.	Project/ Data Staff
April – May 08 & Ongoing	Provide targeted technical assistance and support to project sites.	CCNC/Project /Data Staff
June 08	Produce and disseminate first quarterly report on performance measures – non-emergent ED utilization and advance medical home utilization rates.	Project /Data Staff
July 08	Meeting with all participating (20) advanced medical homes – provide technical assistance, guidance and monitoring and begin to share "lessons learned" and best practices in the field by participating practices.	Project/ Practice Staff
July 08 & Oct 08	Produce and disseminate quarterly reports on performance measures – non-emergency ED utilization and advance medical home utilization.	Project/Practice Staff
October 08	Meeting with participating (20) advanced medical homes.	Project /Practice Staff
December 08	Review preliminary year one results from claims analysis and implement a dissemination / education strategy for all participating practices.	CCNC/Project/Data Staff

Key Milestones – Year Two: 01/01/09 – 12/31/09

Jan 09	Create first annual summary report on performance measures, including utilization, cost and access.	Project/ Data Staff

Ongoing Monthly	Provide targeted technical assistance and support to project sites.	CCNC/Project/Data Staff
April 09	Produce and disseminate quarterly report on performance measures – non-emergent ED utilization and advance medical home utilization rates.	Project /Data Staff
July 09	Meeting with all participating (20) advanced medical homes – provide technical assistance, guidance and monitoring and begin to share "lessons learned" and best practices in the field by participating practices.	Project/ Practice Staff
July 09 & Oct 09	Produce and disseminate quarterly reports on performance measures – non-emergency ED utilization and advance medical home utilization.	Project/Practice Staff
December 09	Review preliminary year two results from claims analysis and implement a dissemination / education strategy for all participating practices.	CCNC/Project/Data Staff
December 09	Identify and communicate with 20 new practices participating in initiative. Obtain contracts with new practice sites.	CCNC/Project Staff

Key Milestones – Year Three: 01/01/010 – 12/31/10

January 10	Create annual summary report for first set of 20 practices.	Project/Data Staff
Jan 10 - Mar	Develop and disseminate toolkits to include useful resources, such as: open-access; after-hours billing and coding; community marketing material; educational brochures on non-emergent condition, etc. (20 new practices).	Project Staff
Mar 10	Meeting with all new participating (20) advanced medical homes – provide technical assistance, guidance and monitoring.	Project Staff
Mar 10	Create baseline data reports for new sites.	Project/ Data Staff
Ongoing & Monthly	Provide targeted technical assistance and support to all project sites.	Project /Data Staff
April 10	Produce and disseminate quarterly report on performance measures to all practice sites– non-emergent ED utilization and advance medical home utilization rates	Project /Data Staff
July 10	Meeting with all new participating (20) advanced medical homes – provide technical assistance, guidance and monitoring and begin to share "lessons learned" and best practices in the field by participating practices.	Project/ Practice Staff
July 10 & October 10	Produce and disseminate quarterly reports on performance measures – non-emergency ED utilization and advance medical home utilization.	Project/Practice Staff
December 10	Review preliminary year three results for first set of 20 practices and year one results for second set of 20 practices	Project /Practice Staff

Key Milestones – Year Two: 01/01/11 – 12/31/11

Jan 11	Create first annual summary report on performance measures, including utilization, cost and access for 2nd set of 20 practices; and annual summary report for 1st set of 20 practices.	Project/ Data Staff
Ongoing Monthly	Provide targeted technical assistance and support to project sites.	CCNC/Project/Data Staff
April 11	Produce and disseminate quarterly report on performance measures – non-emergent ED utilization and advance medical home utilization rates.	Project /Data Staff
July 11	Meeting with all participating (20) advanced medical homes – provide technical assistance, guidance and monitoring and begin to share "lessons learned" and best practices in the field by participating practices.	Project/ Practice Staff
July 11 & Oct 11	Produce and disseminate quarterly reports on performance measures – non-emergency ED utilization and advance medical home utilization.	Project/Practice Staff
December 11	Review preliminary results from claims analysis and implement a dissemination / education strategy for all participating practices.	CCNC/Project/Data Staff

December 11	Create final report and analyses on project initiative and impact on non-emergent services provided. Develop replication plan for other networks and practices.	CCNC/Project Staff

Three main components, in particular, of Community Care are essential to the successful implementation of the alternative non-emergency provider initiative:

- *Medical Homes* – The Community Care program has 1,250 primary care practices that serve as medical homes for 750,000 Medicaid recipients. From these medical homes will come the providers who will step forward to become alternative non-emergency providers or as we have characterized this model – Advanced Medical Homes.
- *Community Systems* – Community Care's 14 networks are owned and operated by community physicians, hospitals, health departments and other community health organizations. These collaborations are important in implementing, promoting and replicating the program.
- *Decision-making* – Community Care's clinical and care management programs are designed, endorsed and implemented by a state-wide "Clinical Director's Group", which is comprised of physicians and other medical leaders from the 14 networks. This group will champion the implementation of the alternative non-emergency provider program.

These structural pieces combined with NC Medicaid's newly adopted incentives to encourage expanded primary care access, make North Carolina particularly ready to implement this program. By creating non-emergency providers within the Community Care medical home infrastructure – creating "advanced medical homes" with after hours and weekend coverage – we can assure that continuity and coordination of preventive, primary and chronic healthcare needs are met. North Carolina's approach would ensure, reinforce and support the medical home concept and reduce the fragmentation, high cost and lack of coordination inherent in the current system. The support being requested from CMS will be the catalyst to make it happen.