

Managed Care, Value Based Care and Health Care

CareSouth Carolina – our story

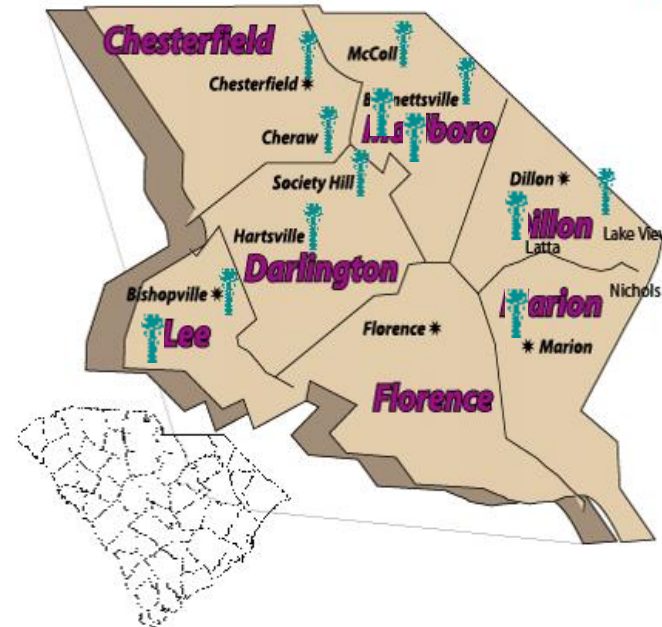


CareSouth Carolina: Who and Where are we?

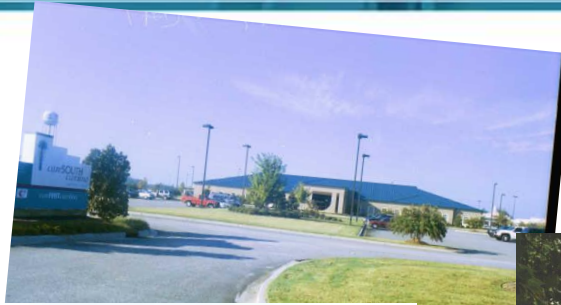
- FQHC in SC Pee Dee area since 1980 as Society Hill Family Center with 4 staff, including me!
- Our mission is to improve health and wellbeing equitably for everyone.
- Serving ~ 50,000 people via
 - 14 physical locations: Big and small, over 2,656 square miles
 - 3 medical, 2 dental mobile vans
 - 5 Mobys – sprinter vans for outreach, vaccination, testing, and in home care
 - Telehealth and telecommunication
 - 59 schools with services including medical, dental and behavioral health services.
 - With 625 Staff



Counties Served:
Chesterfield • Darlington
Dillon • Lee • Marlboro



The CareSouth Carolina Fixed Sites



The THREE CareSouth Carolina Strategies in the Pee Dee of SC to Address Transportation and other SDoH Barriers



BRING PEOPLE IN FOR FULL CARE



TAKE SELECTED SERVICE TO THE PEOPLE



TAKE FULL SERVICE TO PEOPLE



What do we do: Services and Programs

- **Family practice with 9 physicians, 28 NPs ,**
- **Geriatric care for two nursing homes**
- **Pediatric care with 1 physician and 3 NPs**
- **Women's care including pre-post natal and gynecological care with 1.5 OB-GYNs,**
- **Infectious disease services: Ryan White HIV/AIDS program with 200-240 patients, Hep C treatment program with 1 infectious disease physician and 1 NP**
- **Infusion services with 2 NPs**
- **Chiropractic services in two locations with 1 chiropractor**
- **Dental services – in offices, transportable and mobile in schools with four dentists and five hygienists**
- **With SDoH barriers addressed by a staff of 35: CHWs, Patient Advocates, outreach**
 - **2 food pantries, 3 community gardens, eligibility assistance and resource help**
- **Pharmacy services in 9 on-site pharmacies – 5 with a drive thru; home delivered program for high risk patients and families along with mail order for elderly**
- **All coming together in a Value Based Care Model**



About Behavioral Health

- Long history of integration – twenty six years!
 - CSC provided lead faculty for the HRSA Health Disparities Depression Management Collaborative 2000-2004.
- Staffed, integrated model with 20 counselor staff: 9 LISW-CP, 5 LMSW, 5 LPC, 1 PHD Clinical Psychologist and BH Care Manager
 - All CSC locations have 1-3 staff counselors available on site using the warm handoff model
- Services
 - Cognitive Behavioral therapy, individuals, families and small groups;
 - Both primary and complex mental health disorders; PHQ-9 integrated as a core vital sign
 - Address Alcohol and substance use disorders (more on that later)
 - Clinical Psychology services includes testing and assessments for more severe mental illness.
 - Psychiatry via telehealth with University of SC School of Medicine; three psychiatrists – on a scheduled basis; services available to all ages (pediatric, adolescent, adult and geriatric)
 - Mental Health First Aid – the best tool for community outreach
- Delivery model:
 - In office – by appointment, walk-in or warm hand off
 - By telehealth or telecommunication
 - Mobile vans
 - School Based (thirteen schools) with daily schedules to insure access
 - On site with partner agencies



Substance Use Disorder Services

- **Services**
 - Alcohol addiction treatment and counseling (Vivitrol) – all primary care providers
 - Other addiction services such as tobacco dependency
 - Medication Assisted Therapy for opioid addiction – 18 buprenorphine (Suboxone and Sublocade) providers
 - Tapered model of prevention. Treatment and relapse tx
 - *Mandatory* behavioral health counseling
 - In house drug testing and reference lab for confirmatory metabolic drug testing
 - Range from 500 – 700 patients at any given time
- **Delivery model**
 - In CSC offices
 - Dedicated mobile van – Freedom ROADS
 - On site or mobile van services at all three Department of Alcohol and Substance Abuse Agencies: Trinity, Rubicon and Alpha
- **Rural Opioid Response Consortium: prevention, tx and sustained recovery**
 - Led by CSC
 - Twenty one participants including DAODAS agencies, hospitals, social service agencies, law enforcement, coroner, faith based entities



CareSouth Carolina, Inc.

Population Health & Value Based Care Teams

Medicare MCO Plans

- Care Manager - Coordinate Medicare population efforts
- Wellness RNs - Address annual well visit requirements and care gaps
- Clinical Pharmacist - Address pharmacy related care metrics
- Chronic Care Management - Provide education and care plan oversight for eligible members

Medicaid MCO Plans

- Population Health Manager to coordinate Medicaid population efforts
- Population Health Specialist to work with existing teams and programs within CSC to address needs for a specific Medicaid MCO plan population



Medical Loss Ratio (MLR)



- Management of Referrals
- Management of Transitions of Care
- Active Partnerships with Community Health Providers
- Patient Advocates to address Social Determinates of Health
- Community Outreach Specialists to maintain and develop community partnerships which will benefit the population

Our Tools



GE Centricity



Plan Reports



Clinview



Azara



The CSC Division of VBC

Three teams of 30+ staff (RNs, CMAs, CHWs, etc.)

led by Division Chief
Dr. Jeniqua Duncan

with two dedicated NPs for Medicare AWW, Gaps in care, etc.

CCM program for over 4,000 qualified patients

Remote patient monitoring program for hypertension control

And the Community Outcomes



**New building in Dillon – DHEC (WIC)
CSC (PCMH, Title X FP, Immunization....)**



**McColl – a 27,000 sq ft building and 50+ acres
– including primary care, radiology, lab and
dental services along with and a Wellness Center
with PT, a therapy pool and a state of the art gym.
All donated by the Love Foundation**



**May 2020 -The first testing event
in the Pee Dee: DHEC, CSC,
Nat'l Guard; 506 tested**



And What About Quality?

- Quality Scorecard with 28 measures – HRSA, HEDIS, etc.
- Met 75% or 21 of the measures in 2022
- Highlights:
 - Well Child visits: 82% with -8% disparity for 1014/1243 pts
 - Adolescent well care: 75% with -9% disparity for 3513/4565 pts
 - Controlled hypertension: 64% with 6.3% disparity for 7419/11849 pts
 - Diabetes control: 75% with -0.5% disparity for 4528/6046 pts
 - Diabetic retinal eye exam: 70% with -4.8% disparity for 4233/6030 pts
- Set the 2023 goals significantly higher. In Jan and feb we've met 12!



(Some of..) The keys to success

- TURF is a dirty four letter word for success
 - Give it up, share it,
 - You really can't do it all alone
 - There actually is enough for us all to share grace over
- Don't sweat the small stuff (and it's probably all small stuff)
- Break bread together, reward, recognize and celebrate....
Frequently
- Be nimble, agile: 70,000 Covid tests, 50,000 free at home test kits, 40,000 vaccinations, 12,000 monoclonal antibody infusions (the only ambulatory MAB access in the state)
- The most valuable resource is staff. Turnover kills
- Live the mission, hire for heart



And, most of all.... Beware



Thank you... It's been an honor

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