

## Brief History of the NCCC

In January 1991, Altcare, a joint venture between the Wilder Foundation and General Mills, established the National Chronic Care Consortium (NCCC). The NCCC was a 13-year national collaborative of leading health systems dedicated to the transformation of chronic illness care. The NCCC enabled participating organizations to use the best of their collective talent to establish Geriatric Care Networks (GCNs). GCNs were defined as person-centered, system-oriented alliances of primary, acute and long-term care providers working together to improve *total* cost and quality performance in serving chronically-ill persons. The group involved outside research, technical and policy experts to supplement internal capabilities.

The specific form of each GCN varied from member to member; but all members shared a common vision and followed a common set of guiding principles. Most NCCC activity was funded by a combination of member dues, fees for services provided and foundation grants.

NCCC members assumed current operating methods of caring for persons who were frail, disabled and with complex medical conditions—healthcare’s most vulnerable, high-cost and fast-growing care segments—were fundamentally flawed. Fixing the problem required realigning the relationship among providers that served a common group of chronically-ill persons. NCCC founders assumed that if one could bring together many of the nation’s leading health and long-term care system executives to identify and establish “real-world solutions” to chronic illness care, under prevailing market conditions, overall costs would go down, quality would go up, and others would follow.

NCCC membership included acute-care systems, such as Johns Hopkins Medical Center, Sutter Health System, Intermountain Healthcare and Henry Ford Health System. It involved health plans such as Group Health Cooperative, Highmark Blue Cross/Blue Shield, SCAN and UCare of Minnesota. It involved long-term care system, such as Village Care of New York, the Visiting Nurse Services of New York, Wesley Woods Geriatric Center, Metropolitan Jewish Health System, and Wisconsin Partnership Program at Community Living Alliance. The VA was also an active member. (A complete list of organizations involved in the NCCC follows on next page.)

The Consortium’s work was organized primarily around a series of time-limited, task-oriented work groups. These “working sessions” involved people with significant operational experience and expertise in the administration, financing and delivery of chronic illness care. Those involved worked across sites and disciplines to establish new tools and methods for managing programs, money, information and care...across time, place and profession. The group also established multi-site demonstrations for targeted explorations and advanced various legislative and regulatory initiatives.

The NCCC assumed the integration of Medicare and Medicaid was central to improving total quality and cost performance for high-risk populations. As a result, the NCCC provided consultation to the State of Minnesota in advancing M/SHO, one of the nation’s first state Medicare/Medicaid integration demonstration initiatives. The NCCC also provided consultation to other State Medicaid agencies for similar purposes, and developed an array of products for use by states involved in the RWJF Medicare/Medicaid Integration Demonstration Initiative.

Unfortunately, good will only go so far. Members faced a barrage of ongoing financial, cultural and regulatory impediments that rewarded targeting the healthy rather than the sick and reinforced silo-based behavior. As a result, in 2003, management terminated NCCC operations and established the National Health Policy Group to explore options for changing financial and regulatory structures, consistent with the NCCC mission. Working with and through members of the Medicare Payment Coalition for High-risk Beneficiaries, established through the NCCC, initial efforts were made to advance risk-adjusted financing. The group later advanced Special Needs Plan legislation and other related efforts to further advance payment methods, performance measurement and the integration of Medicare and Medicaid.

## Founding Membership Criteria (September 1990)

In establishing the NCCC, Altcare sought participation from the nation's leading acute- and long-term care systems to serve as the nucleus of a national collaborative. Fourteen organizations became founding members. Others were added through invitation, based on the following criteria:

1. National recognition as leading-edge provider.
2. CEO or COO commitment to implementing GNC vision.
3. Internal geriatric/chronic care leadership in key senior management role.
4. The existence of a continuum of primary, acute- and long-term care services.
5. Case management capability in place.
6. Already in process of establishing key elements of the shared vision.
7. Commitment of \$10,000 per year for two years to support NCCC activity.
8. Sees NCCC as important "value added" resource in developing local initiative.
9. Has something to contribute to other NCCC members.
10. Has developed a two-year commitment to progress in indicating important momentum in furthering the goals and ideals of the shared vision.

## Shared Vision of Geriatric Care Network Capabilities

All members of the NCCC shared a commitment to establish locally-based networks of geriatric care (GNCs). Each GCN was organized differently and carried their own unique identity, with all geriatric care networks containing the following attributes.

1. An **integrated continuum** of prevention, acute care, specialized short-term care, transitional care and long-term care (community and residential) services, with providers following a **common** set of **care protocols** and **quality measures**.
2. **Person-centeredness** including self-help assistance, family caregiver support and simplified access to the full array of continuum of care from any point within the network.
3. **Condition-responsive, centralized care management**, where primary care physicians and other allied professionals work together to optimize total quality and cost performance as a person's care needs evolve over time and across care settings.
4. **Disability prevention orientation**, where all CCN providers seek to prevent, delay or reduce the effects of disease and disability throughout a condition's natural progression.
5. **Simplified, client-centered procedures**, where clients are given access to the spectrum of chronic care services from any point they contract within the care network.
6. **Specialized and centralized organizational capabilities in chronic care** including for: (a) strategic planning; (b) financial management; (c) information management; (d) in-service training and education; (e) research and development; (f) marketing management; (g) quality assurance; and (h) health direction.
7. **Systems-management capability** where provider/payer contracting arrangements include: (a) pooled, capitated, risk-sharing, population-based financing; (b) incentives for primary, acute and long-term care providers who serve the same persons to collectively prevent, delay or minimize disease and disability progression across time, place and profession; and (c) outcome-based accountability methods.

The initial Geriatric Care Network (GCN) concept was later changed to a Chronic Care Network (CCN) concept to reflect the importance of applying these attributes to transformation of chronic care for persons of all age groups.

## Member Organizations Involved in NCCC between January 1001 and July 2003

Aging in America, Inc.  
Albert Einstein Healthcare Network  
Allina Health System  
Amherst H. Wilder Foundation/Health East/Bethesda Lutheran Hospital  
Area Agency on Aging, #10B  
Baycrest Centre for Geriatric Care  
Baylor Health Care System\*  
Benjamin Rose Institute and the University Hospital of Cleveland\*  
Beverly Hospital\*  
Beth Abraham Family of Health Services\*  
Blue Cross & Blue Shield of Minnesota  
Carle Foundation Hospital-Health Systems Research Center  
Carondelet Health Network  
Catholic Healthcare West  
Catholic Health Initiatives  
Centura Health  
Community Health Partnership, Inc.  
Covenant Health Systems  
Crozer-Keystone Health System  
Evangelical Health Systems/Park Side Senior Services  
Fairview Health Services/Ebenezer\*  
Florida/Puerto Rico Network of the U.S. Dept. of Veterans Affairs VISN 08  
Group Health Cooperative  
HealthEast  
Lutheran Hospital of Indiana/Lutheran Homes and Social Services\*  
Lutheran General/Parkside Senior Services  
Lutheran Health Care Systems (Mesa Lutheran)\*  
Hebrew Home and Hospital  
Henry Ford Health System  
Highmark Blue Cross Blue Shield  
Huntington Memorial Hospital/Visiting Nurse Association of LA  
Inglis Innovative Services  
Institute on Aging  
InterMountain Health Care\*  
Johns Hopkins Health System  
Lancaster General Hospital  
Loretto  
Lutheran Health System

Madlyn and Leonard Abramson Center for Jewish Life  
Masonicare  
Mercy Medical Center-North Iowa Center  
MetroHealth System  
Metropolitan Jewish Health System  
Minnesota Senior Health Options  
Motion Picture and Television Fund  
Northeast Health Health System  
Northeast Health Systems/Beverly Hospital  
Philadelphia Geriatric Center/Albert Einstein Medical Center\*  
Presbyterian SeniorCare  
Providence Health Partners  
Rochester General Hospital and Park Ridge Health System\*  
Saint Mary Medical Center  
Saint Michael's Hospital  
Saint Vincent Hospital and Health Center  
SCAN  
Scripps  
Sentara Health System  
Sierra Health Services  
State of Washington, Aging and Disability Services Administration  
Summa Health System  
Sutter Health  
The Eddy  
Total Longterm Care, Inc.  
UCare Minnesota  
Unity Health Systems  
University of California-San Francisco  
University Hospitals Health System  
Upstate New York Network of the U.S. Dept. of Veterans Affairs VISN 02  
ViaHealth  
Village Care of New York, Inc.  
Visiting Nurse Service of New York  
Volunteers of America National Services  
VNA Foundation  
Wesley Woods Geriatric Center  
Willow Valley Retirement Communities  
Wisconsin Partnership Program at Community Living Alliance

## Principal Management/Staff Leadership

Verne Johnson, VP General Mills  
Co-founder and President and CEO from 1991 to December 1993  
Rich Bringewatt Co-founder, Creator of NCCC strategy, and President and CEO from December 1993 to July 2003  
John Selstad, Senior Vice President (Collaborator in developing GCN strategy and staff lead on ACN demonstration)

Deborah Paone, Vice President  
(Staff lead in developing SASI tool, providing M/SNO consultation and various other NCCC products)  
Valerie Wilbur, Policy Consultant (Lead on developing NCCC policy initiative)  
Laura Hines Iverson, Project Director  
Mary Bany, Project Manager (Website)  
Joyce Ann Wainio (Project leadership)

## National Policy and Research Advisors Involved in NCCC Activity

Stanford A. Alliker, Levindale Hebrew Geriatric  
Center for Health Care Strategies, Inc.  
Stuart H. Altman, PhD, Brandeis University  
Drew Altman, PhD, Henry J. Kaiser Family Foundation  
James Ahearn, National Multiple Sclerosis Society  
Jerry Anderson, Johns Hopkins University  
Tom Ault, Health Policy Alternatives  
Robert Applebaum, Scripps Gerontology Center  
Howard Bedlin, NCOA  
Larry G. Branch, PhD, Boston University Social of  
Medicine  
Robert Berenson, Urban Institute  
Chad Boulton, MD, Johns Hopkins Bloomberg School of  
Public Health  
Elaine M. Brody, Private Consultant  
Virginia Burggaraf, American Nurses Association  
James Callahan, PhD, The Heller School, Brandeis  
University  
Robert Clarke, Deloitte  
Eric Coleman, University of Colorado Health Sciences  
Center  
Janet Corrigan, Institute of Medicine  
Senator David Durenberger, U.S. Congress  
Connie Evashwick, PhD, San Diego University at Long  
Beach  
Peter Fox, PDF Incorporated  
Robert Freidland, Center on a Aging Society  
Linda Fried, MD, Johns Hopkins University  
James Firman, United Seniors Health Cooperative  
Sheldon Goldberg, American Association of Homes for  
the Aging  
Jeff Goldsmith, PhD, Health Futures, Inc.  
Leonard Gruenberg, PhD President, The Long Term  
Care Data Institute  
Jay Greenberg, ScD, Long Term Care Group  
Mitch Greenlick, PhD, Kaiser Permanente  
Keith Halleland, President Halleland Health Consulting  
George Halvorson, Kaiser Permanente  
Robert L. Kane, MD, University of Minnesota School of  
Public Health  
David Knutson, Park Nicollet Institute  
Andrew Kramer, University of Colorado  
Richard Kronick, PhD, University of California at  
San Diego  
David Lansky, The Foundation for Accountability  
Richard Lieberman, Health Data Services  
David Lyon, The Rand Corporation  
Gerald McManis, Independent Consultant  
Mary Jane Milano, American Hospital Association  
Margaret McAdam, PhD, Biegel Institute for Health  
Policy  
Steve McConnell, Alzheimer's Association  
Mark R. Meiners, PhD, University of Maryland  
Dick Neu, The Rand Corporation  
Dwayne Oberlander, Gransmakers in Health  
Greg Pawlson, MD, MPH, The George Washington  
University Medical Center  
John Rother, AARP  
Barbara Schneider, Independent Consultant.  
Joanne G. Schwartzberg, American Medical Association  
Stephen M. Shortell, University of California-Berkley  
Knight Steel, MD, Boston University Medical Center  
Elliot Stern, Miami Jewish Homes & Hospital for the  
Aged  
Fernando Torress-Gil, UCLA American Society on  
Aging  
Stanley S. Wallack, President LifePlans, Inc.  
Edwin L Walker, Administration on Aging  
Jon Wander, Reden and Anders  
Joshua M. Wiener, PhD, The Brookings Institution  
Gail Warden, Henry Ford Health System  
Fairview Partners—Minneapolis, MN  
Gail Warden, Henry Ford Health System  
Josh Winner, Brookings Institute  
T. Franklin Williams, MD, ScD, National Institute on  
Aging  
Nancy Wilson, Baylor University  
Mryl Weinberg, National Health Council  
Karen Williams National Pharmaceutical Council  
Rick Zawadski, OnLok

## Foundations that Provided Financial Support to Various NCCC Initiatives

Flinn Foundation  
General Mills Foundation  
The Commonwealth Fund  
John A Hartford Foundation

Pew Charitable Trust  
Retirement Research Foundation  
Robert Wood Johnson Foundation

## Founding Members of the Medicare Payment Coalition for High-risk Beneficiaries

The MPC for High-risk Beneficiaries was established in 2000 to evaluate the adequacy of various risk-adjustment methodologies under consideration by CMS, with special focus on the adequacy of these methods for plans targeting frail elder and other high-risk beneficiaries. The group also advocated for development of clinical guidelines for specialized managed care, modification of performance criteria and demonstration of added value among specialized managed care programs. After advancing SNP legislation (passed by Congress in June 2003) the group evolved into the SNP Alliance.

The following organizations were founding members of the MPC:

Community Health Partnership—Eau Claire, WI  
Community Living Alliance—Milwaukee, WI  
Elder Care of Dane County—Madison, WI  
Elder Health—Baltimore, MD  
Elderplan—New York, NY

EverCare—Minneapolis, MN (national market)  
Fairview Partners—Minneapolis, MN  
Geriatric—San Diego, CA (national market)  
Inglis Innovative Services—Philadelphia, PA  
SCAN—Long Beach, CA