APPENDIX C: CARE MANAGEMENT PROGRAM ANALYSIS

Description and Background
The NCCCN Care Management program is one of the foundational tenets of NCCCN and is referenced in the contract with DMA under Appendix A: Duties of the Networks (1.11, 1.12, 1.19, 1.21, 1.25).

NCCCN Care Management (CM) is a set of interventions and activities that address the health care of a population to promote quality, cost-effective care. NCCCN Care Management programs apply systems and information to improve care and assist patients to become engaged in a collaborative process designed to manage medical, social, and behavioral health conditions more effectively and improve outcomes. NCCCN views the term “care management” as an umbrella term to include case management, care coordination and targeted care management.

The NCCCN Care Management model is evidence-based and built on frameworks, standards of practice and quality guidelines from nationally recognized models and industry leaders, including:

- Chronic Care Model\(^{31}\)
- Case Management Society of America (CMSA)
- Commission for Case Manager Certification (CCMC)
- National Committee for Quality Assurance (NCQA)

Goals of NCCCN Care Management
- Maintain a model that focuses on patient engagement, empowerment, and education
- Using an interdisciplinary team, meet the needs of chronically ill members by reducing their vulnerability and changing the trajectory of the course of their chronic illness
- Work with medical homes to promote treatment regimens that are aligned with evidence-based guidelines
- Help medical homes design workflows that are patient-centered and focus on facilitation of behavior change and self-care while addressing emotional and social issues as well.
- Reduce fragmented care and facilitate communication across settings and providers

In order to effectively and efficiently meet the complex needs of high-risk patients and to provide the optimal benefit, NCCCN’s care management program is operated as a team approach under the oversight of the Primary Care Manager and in collaboration with the Primary Care Physician (PCP). The Primary Care Manager (PCM) may be a registered nurse (RN), social worker (Bachelors or Masters prepared), or Certified Case Manager (CCM), and coordinates and oversees the delivery of care management services to each patient on their case load. Since PCMs from various disciplines are utilized, the needs of individual patients are aligned with the specific scope of practice, education and expertise of the PCM (e.g., RNs manage more medically complex patients while social workers may work with patients with behavioral health and/or psychosocial conditions). In addition to RNs and Social Workers, the interdisciplinary team may also include pharmacists, pharmacy assistants, nutritionists, experts in behavioral health, palliative care, community resources, care management assistants, etc. The staffing model is designed to enable an efficient workflow and allow professionals to work at the top of their license.

\(^{31}\) http://www.improvingchroniccare.org/index.php?p=The_Chronic_CareModel&s=2
Care Management program staff at the Central Office support the networks by providing key oversight on process development and refinement, staff development, educational resources, training, analytics, reporting, and other needs as they arise. Similar to how care management is deployed at the local level, the Care Management program is very much a team-based program.

Also included in the care management program is the NCCCN Call Center, which is housed at the Central Office. The Call Center consists of a nurse manager, three nurse health coaches and four health educators.

Data Driven Care Management
NCCCN works dynamically with the Networks, using claims data and analytics, to stratify the population by risks and identify members who will benefit the most from care management. This process defines the priority populations and determines where and how to target resources to deploy the most cost-efficient model and yield optimal outcomes.

Over time, NCCCN has greatly refined our ability to identify the most “impactable” patients. Our ability to combine the methods above with program evaluation findings and national evidence enables implementation of an automated process in which care managers can see which patients are highest priority for outreach.

Targeting the Right Patients at the Right Time

Transitional Care Priority
The NCCCN Transitional Care Program is a sophisticated approach to finding impactable patients at a highly impactable moment – transitioning from one setting of care to another. The Transitional Care Priority Indicator identifies non-Dual patients at risk for a failed transition after a hospital stay. This indicator is generated using a data model that includes medication information, utilization history, presence of multiple chronic conditions (including behavioral health diagnoses), and/or criteria defining high risk children.

Real-time Admission/Discharge/Transfer (ADT) data from approximately 60 NC hospitals enables care managers to intervene with Transitional Care Priority patients at the time of their discharge in order to prevent costly readmissions.

NCCCN Priority
The NCCCN Priority Indicator identifies high-risk/high-cost patients who are in need of intensive care management services. This indicator is based on sophisticated predictive models that flag Dual and non-Dual patients who are at high risk for a hospitalization in the next 12 months, or generating potentially preventable spending above what would be expected for their clinical disease profile, and are highly likely to benefit from care management.
Table 7: Volume of Priority Patients for Care Management

<table>
<thead>
<tr>
<th></th>
<th>Monthly Average of Priority Patients</th>
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</thead>
<tbody>
<tr>
<td>Transitional Care Priority</td>
<td>128,233</td>
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<tr>
<td>(non-Dual)</td>
<td></td>
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<tr>
<td></td>
<td>(of whom 53,868 are discharged from the hospital)</td>
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<tr>
<td>NCCCN Priority</td>
<td>29,833</td>
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</tbody>
</table>

Real-time Referrals
Because meeting the needs of NCCCN providers and community partners is a priority, patients identified with potential care management needs at the point of care are included as part of our priority population.

Other Priority Care Management Initiatives
- Working with beneficiaries with high ED utilization
- Utilizing the NCCCN Call Center to outreach to new enrollees and patients with non-emergent ED visits as well as offering health coaching to appropriate patients
- Palliative Care coordinators work to enhance the quality and access to care at the end of life through integration of palliative care with transitional care services.

Implementing Care Management
Utilizing Motivational Interviewing (MI) techniques and other evidence-based resources, care team members work diligently to engage beneficiaries and their families/support systems in care management. Once the recipient has agreed to participate, the following process is set in motion in a patient-centered, coordinated fashion:

1. Initial Assessment – process of gathering data from all relevant sources (patient, medical home, clinical, claims, etc.) in order to identify all important problems and barriers (existing and potential) that keep the patient from better health and lead to unplanned hospitalizations.
2. Planning – process of using the assessment data to work with the patient and the care team to prioritize problems, identify goals, and develop a patient-centered plan of care (written document shared with the patient and team).
3. Implementation – tasks and interventions carried out by the care team in order to meet the goals of the plan of care and improve patient outcomes. This includes coordination of care activities and communication with the medical home, community resources, specialty providers, and any other service the patient may be receiving.
4. Evaluation – process of ongoing monitoring and adjusting of goals, tasks, and interventions to ensure barriers are being identified and addressed and patient needs are being met.

Priority Interventions
- Face – to – face encounters
- Medication management
- Patient education
Timely follow-up care, including post-discharge appointments with primary care providers and specialists

NCCCN Care Managers are community-based, and embedded in hospitals and practices where needed. Roughly 112 FTE care managers are physically located within 149 PCP practices with large Medicaid populations across the state, and are fully dedicated to managing that practice’s NCCCN population. In addition, approximately 56 FTE care managers are embedded in 49 high volume hospitals across the state, which allows for timely engagement with transitional care patients prior to their discharge.

Interacting with patients and their families/support systems, face-to-face in their home, community, and/or in the medical home is preferred. This is optimal for patient engagement, establishing an effective relationship to promote behavior change, and performing a comprehensive assessment. Frequent contact using a combination of face-to-face encounters and telephonic follow-up is necessary for effective intense care management. Once the goals of intensive care management have been achieved, Health Coaching is available for patients interested in continuing to improve self-care and reduce risk factors in an effort to prevent complications and better manage their chronic illness.

Medication errors and adherence issues are known causes of frequent ED use, hospitalization and readmissions. Network pharmacists and pharmacy techs are critical members of the care team in the performance of medication reconciliation, comprehensive medication reviews, resolution of drug therapy problems, closing the gaps on adherence issues, and other medication-related interventions.

Patient engagement, empowerment and education is the foundational framework of NCCCN Care Management. A variety of trainings, materials, and evidence-based techniques are available to ensure patient education is delivered in a manner that is culturally appropriate and easily understandable by the patient, their families and support systems.

Timely follow-up care after hospitalization with the PCP or specialists is important to reduce the risk of readmission. NCCCN evaluation findings indicate that some patients need this follow up sooner than others in order to prevent readmission. Reports are available to the care team that flag those who need a follow-up visit within 7, 14, and 21 days post discharge. This enables the care manager to prioritize activities and work with practices to ensure those at highest risk are seen quickly after discharge.

In addition to the care managers at the local level, the NCCCN Call Center supports the care management program by providing ED follow-up calls, new enrollee education, and health coaching. Beneficiaries who have been to the ED for a non-emergent visit are contacted by Call Center staff and educated about their medical home benefit and other local resources, as well as reeducating them on appropriate use of the emergency department. Call Center staff also reach out to new enrollees to review how to use their benefits from Medicaid and NCCCN. They use this opportunity to discuss the role of the PCP and medical home, appropriate use of the ED, obtaining access to specialists and urgent care when necessary and other benefits available to them. Another role of the Call Center is to provide health coaching to patients who are referred by care managers. The Health Coach Nurses work with patients to improve their chronic diseases such as diabetes and discuss topics such as weight loss, tobacco cessation, nutrition and exercise.