CCNC Care Management

Community Care of North Carolina (CCNC) is a statewide population management and care coordination infrastructure founded on the primary care medical home model. CCNC incorporates leadership by local clinicians, a strong emphasis on care coordination, disease and care management, medication management and quality improvement to improve the cost-effectiveness and quality of care for Medicaid enrollees with chronic illness. CCNC’s central office, 14 regional networks, and locally-based care managers work together with CCNC-affiliated primary care physician practices (primary care medical homes) to coordinate services and to connect patients with a broad range of integrated services (medical, behavioral, social) to meet the recipients individual needs, thereby improving outcomes and reducing costs. Direct services to patients include care management and coordination between physical health, behavioral health, and other social services and close management of transitions between care settings.

Community Care Networks are responsible for the delivery of targeted care management services that will improve quality of care while containing costs. CCNC’s Primary Care Case Management (PCCM) model is based on guidelines published by the Case Management Society of America (CMSA) and designed on the basis of the Chronic Care Model. 

Care Management (CM) is a collaborative set of interventions and activities that addresses the health care and preventive service needs of a population to promote quality, cost effective care. Care management is outcome-focused and monitors the population and service delivery system using data. Care management programs apply systems and information to improve care and assist recipients and their system to become engaged in a collaborative process designed to manage medical/social/behavioral health conditions more effectively.

When an individual reaches the optimum level of wellness and functional capability, everyone benefits: the individuals being served, their support systems, the health care delivery systems and the various reimbursement sources. Care management serves as a means for achieving client wellness and autonomy through advocacy, communication, education, identification and use of community resources. (Adapted from CMSA, 2010).

CCNC Care Managers are vital participants in the care team who empower patients to understand and access quality, coordinated, effective health care. The Care Managers in each CCNC network and certain partnering agencies provide a variety of services in the form of population management, medical home support, and direct care management, all driven by data in effort to target the right recipients, at the most impactful time, with the right interventions and provided by the right care team, to facilitate optimal outcomes tailored to the unique needs of the patient and/or population being targeted.
The Functions of Care Management Include:

- Access to and systematic use of data to include IC Reports, Provider Portal, Pharmacy Home, CMIS, to target recipients and providers for outreach, education, and intervention
- Monitoring system access to care, services, and treatment including linkage to medical home
- Addressing the total individual, inclusive of medical, psychosocial, behavioral, and spiritual needs.
- Involvement of the recipient and their support systems (i.e. caregiver, family, etc.) in the decision-making process
- Use of a patient-centric, collaborative partnership approach to assist the recipient with improved self-care
- Utilization of proven processes to measure a recipient’s understanding and acceptance of the proposed plans, his/her willingness to change, and his/her support to maintain health behavior change
- Expanding the interdisciplinary team in planning care for individuals
- Communicating and coordinating with all providers and members of the care team, in an effort to minimize fragmented care
- Navigating transitions of care
- Monitoring quality and effectiveness of interventions to the population by setting both long term and short term specific, measurable goals.
- Advocating for recipients and supporting providers to ensure delivery of appropriate, evidence based care
- Supporting the medical home through education and outreach to recipients & providers
- Facilitating Quality Improvement activities that educate, support, and monitor providers regarding evidence based care for best practice/National Standards of Care

(Adapted from CMSA, 2010)

The Population We Serve
The CCNC program serves 1.3 million of North Carolina’s approximately 1.8 million Medicaid beneficiaries. Roughly 80 percent of the CCNC population is children with relatively few medical needs, while the adult population includes many individuals with complex clinical and behavioral health needs, including approximately 300,000 aged, blind or disabled (ABD) beneficiaries. Forty-one percent of ABD beneficiaries have at least one type of mental illness, developmental disability or substance abuse issue. CCNC analytics team has the ability to risk-stratifies patients by severity of illness and past utilization, to identify higher risk patients who will benefit from more intense care management than those who are reached through disease management and/or population management.

Priority populations:
- In-patients who need transitional care
- High-risk/high-cost patients are the priority of CCNC, based on a risk-adjustment methodology that prioritizes people who have spent more in hospital costs (admit/ED/readmit, including behavioral health) than expected for their clinical risk group.
- Patients referred by providers or ED
COMPONENTS OF CARE MANAGEMENT

- **Patient identification and comprehensive assessment**: Identify patients through direct referrals, by mining administrative claims data (risk stratification tools, frequent hospital and emergency room admissions), through screenings and assessments, and through chart reviews that identify gaps in care.

- **Developing an individualized care plan**: The health care team — including the care manager, primary care provider, patient and family/caregiver — agree on goals in a care plan.

- **Care coordination**: The care manager ensures the patient’s care plan is implemented, communicating and coordinating across providers and delivery settings.

- **Reassessment and monitoring**: Monitor the patient’s progress toward goal achievement on an ongoing basis, adjusting care plans as needed.

Care Managers are expected to utilize data to identify recipients to target for direct CM activity based on defined CCNC Priority Populations (focuses exclusively on high utilizers within the broader CCNC population). In effort to meet recipients’ comprehensive health needs through communication, interventions, and available resources to promote quality cost effective care, CMs are to implement a collaborative process of:

- Assessment
- Facilitation
- Education
- Evaluation
- Planning
- Coordination of care
- Advocacy
- Evaluation

The care management plan includes an assessment of the patient’s progress toward overcoming barriers to care and meeting patient centered goals, as well as condition/disease-specific outcomes that lead toward enhanced self-management. The care management process includes reassessment and adjusting the care plan and its goals on an ongoing basis.

Evaluating the patient’s social needs (e.g., transportation, shelter, food) and personal preferences (e.g., values and areas of interest such as religious affiliations, social and vocational goals) can drive activities, supports and case management services. Understanding these areas can help to create individualized, person-centered case management plans.

The care management team identifies and addresses all obstacles to a patient receiving or participating in a care management plan. An analysis of potential barriers can include issues such as language or literacy; lack of or limited access to reliable transportation; a patient’s lack of understanding of a condition; a patient’s lack of motivation; financial or insurance issues; cultural or spiritual beliefs; visual or hearing impairment; and psychological impairment.

Self-management plans are activities undertaken by patients to help manage their condition, and are based on instructions or materials provided to them or to their caregivers. In medium or heavy care management, development and communication of the self-management plan refers to the instructions or materials provided to patients or their caregivers to help them manage their condition. These activities are designed to shift the focus in patient care from patients receiving care from a
practitioner or care team, to patients providing care for themselves, where appropriate. Self-management activities are components of the patients’ care plan.

**UTILIZE A TEAM APPROACH**

Utilization of an interdisciplinary team including network resources, community resources, and the care team at the medical home, especially involvement of the Primary Care Provider (PCP) provides the optimal benefit for the patient. The team will utilize all appropriate staff/network resources to ensure the care management needs of the patient are met:

- Primary Care Managers (RNs, BSWs, MSWs)
- CM Support (social workers, LPNs, Behavioral Health Specialists, Palliative Care Coordinators, Dietitians, other clinical professionals)
- Pharmacist and pharmacy assistants
- Non-licensed staff to support the care managers in their outreach and education efforts.
- Non-clinical personnel to provide administrative help (e.g., reminding patients about appointments and ensuring that follow-up visits to specialists are kept).

In addition to the above, each network has a medical director, psychiatrist, and other physician champions/consultants who are available for team conferences and problem solving care plans for difficult to manage patients.

The team at the Medical Home is also a key player on the CM team. Care managers provide timely information to the PCP about the hospitalization, social and environmental concerns about the involvement of other services and providers. They communicate with PCP on patient goals, plans, education, adherence. Care managers also work with clients to prepare them for provider encounters—for example, encouraging them to ask questions when instructions are not clear (and to bring a list of questions to the visit), to gather their medications in advance of the visit, and to bring a personal health record with them. CCNC care managers sometimes accompany patients to physician visits when such assistance is requested. Network care managers and QI Teams are also responsible for helping physician practices identify patients with high risk conditions or needs, assisting providers with disease management education and follow-up, helping patients coordinate their care or access needed services, and collecting performance data.

Local, community resources are also an integral part of the CM team approach. Care managers are familiar with local community organizations and state agencies that can help to meet their clients’ needs, and facilitate these connections when appropriate. Mental health agencies, faith-based organizations, Area Agencies on Aging, disability centers, and other community or regional organizations are often engaged by network staff to provide additional local support to clients as necessary.

**TRANSITIONAL CARE**

Of North Carolina’s approximately 150 hospitals, 56 provide CCNC with twice-a-day ADT (admission/discharge/transfer) feeds detailing clinical encounters with program participants, while many others provide access to hospital information systems. Many participating hospitals also host embedded CCNC care managers. These elements of real-time access enable CMs to
interact with patients and provide transitional care interventions in a timely manner which is critical in facilitating successful transition between care setting and preventing re-admissions

**KEY COMPONENTS OF THE CCNC TRANSITIONAL CARE MODEL**
- Face-to-Face Patient Encounters
- CCNC Medication Management
- Patient Self-Management Notebook / Patient Education
- Follow-Up Calls and Contact
- Post-discharge Follow-Up with PCP or specialist in a timely manner

Hospitalized patients are identified as “Transitional Care Priority” if they fall into disease and severity clusters that have been found to benefit from transitional care. Transitional care priority clients receive additional support following an inpatient stay through the CCNC Transitional Care program. CCNC Care Managers are embedded in large hospitals and routinely round at smaller ones, to visit patients at the bedside, interact with the hospital team, and coordinate discharge planning. Local care managers perform post-discharge home visits to perform medication reconciliation (with a full review of the client’s medications by a network pharmacist when necessary), educate patient and family on “red flags” that could signal complications and appropriate actions to take, and subsequent follow-up activities aiming to ensure that the client is following discharge instructions and seeing their primary care provider soon after hospital discharge

**DOCUMENTATION IN CCNC CASE MANAGEMENT INFORMATION SYSTEM (CMIS)**
- CMIS is a secure, web-based system for the management of its enrollees that is a user-built, patient-centric, electronic record of care management activities.
- CMIS contains standardized health assessments, care plans, screening tools, disease management, health coaching modules, and workflow management features
- ALL care management activities (tasks), interventions, tasks, progress toward goals, etc., are documented in CMIS.
- CMIS enables the CM to assess, plan, implement, and evaluate patient care management