Care Management/Risk Stratification 201: Developing Complex Care Management Teams in Primary Care

Findings from Community Care of North Carolina

Jennifer Cockerham, RN, BSN, CDE
Senior Vice President of Clinical Programs
Community Care of North Carolina

Tara Robinson, RN, BSN, CCM
Deputy Director, Privacy Officer, QI Coordinator
Community Care of Wake and Johnston Counties

Maine Quality Counts
June 20, 2014
What is Community Care of North Carolina?

- Statewide Primary Care Management Program (PCCM) program established in 1998
- Provide population health management for Medicaid beneficiaries
- Collaborative of local physicians, hospitals, health departments, and departments of social services
- Engage and support primary care providers
- Work with Medical Homes to coordinate a comprehensive approach to chronic illness care
- Reduce preventable utilization (admits, readmits, ED)
- 1,620 Primary Care Practices
- 1.4 million Medicaid Enrollees
- 22,560 uninsured in HealthNet programs
- 25,000 privately insured in pilot programs

Source: CCNC September 2012
How is CCNC Funded?

NC DMA
Contracts with CCNC, Inc.
Pays on a per member enrolled in a CCNC PCP per month basis (PMPM)

NC DHHS

CCNC INC.
Contracts with each local Network
Pays on a per member per month basis (PMPM)

CCNC NETWORK

PCP/MEDICAL HOME
Receive a PMPM from DMA to participate in CCNC PCCM & QI Model
Party to a 3-way contract between CCNC Inc., CCNC Local Network, Practice

1.3 M

Local Partners Grants

$1800
Central Office Clinical Leadership (CCNC, INC.)

- Physician Leadership
- Care Management
- Quality Improvement
- Call Center
- Pharmacy
- Behavioral Health
- Informatics Center
The CCNC program is multi-faceted, with a number of program components that target and support high-utilizer subpopulations.

14 geographically distributed “community networks”

Each Network has:

- Administrative and Operational staff (Network Director, Clinical Director)
- Physician Champions (pediatrics, chronic care, OB, Palliative Care, etc.)
- Nurse and Social Work Care Managers (adults, children, hi-risk pregnancies)
- Pharmacy Team
- Psychiatrist
- Behavioral Health Coordinator
- Quality Improvement Teams
CCNC Supported Medical Home

- Patient
- Hospital
- Pharmacy
- Specialty Providers
- Community Resources
- PCP & Clinic Team
- HH/Rehab/SNF
- Prospective and Retrospective Quality Data
- Care Management Team
Population Management

Population Needs

System Resources
Approach to Population Management

Identify the Right Patients

...At the Right Time

...In the Right Settings

...Provide the Right Care

...With the Right Team
This person would likely benefit from care management; however, under conventional flagging methodology, this person would have been missed.

Under conventional flagging methodology, all of these people might have been flagged; care management would likely have had minimal impact for most of them.

Who should we target for Care Management?
CCNC’s Approach

All individuals within the same Clinical Risk Group (CRG)
CCNC’s Approach

CRG#1

CRG#2

CRG#3

= Expected preventable costs for people within that CRG

= Priority patients for care management using CCNC’s new flagging approach
How do intervene in a timely manner?

- Local Hospital Relationship
- Real-Time ED and Inpatient notifications
- Provider Referrals (PCP, ED, LME, Community Partners)
- Provider Portal
- Call Center Referrals
Getting patients the care they need when, and where they need it

- Team-based Care
- Established presence in each practice
- Care managers know the patients, the community, and the resources that are available
- Care managers connect the dots between patient, physician, specialist, hospital, home health and other community resources
190,000 NC Medicaid recipients are admitted to the hospital every year, and 31,000 have multiple hospital admissions.

- Nearly one in ten admissions represents a readmission within 30 days of a prior discharge.
- Cross-hospital traffic is common: 23% of 30-day readmissions occur in a different facility.

Cross-state traffic: Complex Medicaid patients admitted to UNC from 80 counties.
Challenge = Opportunity
Medication Confusion

Most common drug therapy problems at care transitions (20,673 patients)

- Patient not taking medication prescribed at discharge (4,747 or 23%)
- Status of patient’s chronic medication(s) not addressed at discharge (4,581 or 22%)
- Patient non-adherent to therapy (3,962 or 19%)
- Patient taking medication at a different dose or interval than prescribed (3,879 or 19%)

About 6% of drug therapy problems considered “urgent” - imminent rehospitalization if not resolved

Data based on a representative sample of 20% of patients receiving medication reconciliation/review services
Transitional Care Program

- Core components of CCNC Transitional Care
  - Face-to-face contact
  - Comprehensive medication management
  - Patient/caregiver self-management education, “red flags”
  - Timely outpatient follow-up with informed medical home
  - Collaboration with partners/ resources to maximize reach and avoid duplication of services.

- Local flexibility to meet local needs
What is the incremental impact of transitional care on readmission rates?
Today’s Take Home Points

- Transitional Care **significantly** reduces future hospital admissions.
- This is **especially** true for the most complex chronic patients.
Real-time notification of hospital admission. Priority flagging based on overall risk profile using historical claims.
Transitional Care Results

- 20% reduction in readmissions for patients in transitional care program.
- 12-month readmission rates consistently lower for participants within each level of clinical severity.
- For every six interventions, one hospital readmission avoided – strong ROI
- CCNC achieved significant cost savings for the non-elderly disabled population
  - $184 million during 5 year period
- The savings were even more pronounced for the sickest patients – those with multiple chronic conditions
- Significant reductions in acute inpatient and ED utilization and increased physician visits
Quality comes first…

...savings ensue

Higher is better!

What does this mean in absolute numbers?

- Cholesterol Control LDL < 100
  - CCNC 2009: 50%
  - CCNC 2012: 60%
  - National Medicaid HMO HEDIS Mean 2011: 50%

- Blood Pressure Control < 140/90
  - CCNC 2009: 70%
  - CCNC 2012: 80%
  - National Medicaid HMO HEDIS Mean 2011: 70%

- A1C Control < 8.0
  - CCNC 2009: 60%
  - CCNC 2012: 70%
  - National Medicaid HMO HEDIS Mean 2011: 60%

- Nephropathy Screening
  - CCNC 2009: 80%
  - CCNC 2012: 85%
  - National Medicaid HMO HEDIS Mean 2011: 80%

- Cholesterol Control LDL < 100
  - CCNC 2009: 40%
  - CCNC 2012: 50%
  - National Medicaid HMO HEDIS Mean 2011: 40%

- Blood Pressure Control < 140/90
  - CCNC 2009: 60%
  - CCNC 2012: 70%
  - National Medicaid HMO HEDIS Mean 2011: 60%

>10,000 more patients with good diabetes control

>11,000 more patients with good BP control
Right Service
Right Time
Right Setting

Care Management Support
- Transitional Care
- Medication Reconciliation
- Disease Management
- High Risk-Impactable
- High Risk Pregnancy
- Special Needs Children
- Care Alerts

Services
- Community-Based Supports
- Chronic Pain
- Behavioral Health Integration
- Practice Profile
- Informatics
- Patient Portal
- NC HIE
- Call Center

Quality Improvement
- PCMH Recognition
- Disease Registry/Population Management
- Practice QI Process Development
- Developmental Screenings
- Practice Level Data & Analysis
Family-Centered Regional Partnership Approach
Key Initiatives

Chronic Disease

- Asthma, Diabetes, Congestive Heart Failure, Cardiovascular Disease, Obesity

Transitional Care

- See the patient bedside and follow-up within 72 hours of discharge, conduct medication reconciliation and get the patient re-established with the primary care medical home.

Palliative Care

- Supporting providers and patients to build awareness around resources for end-of-life care needs, advance directives, palliative care and hospice.
**Key Initiatives**

**Pregnancy Medical Home**
- Improving the quality of maternity care and outcomes for mothers and babies

**Health Check Coordination**
- Ensuring children fully utilize the medical home for preventive health and sick care services

**Care Coordination for Children**
- Targeting high-risk, high cost children ages birth to five years for care management services
Key Initiatives

Child Health Accountable Care Collaborative (CHACC) – Specialty Care Management

- Focus on NC Medicaid children with complex, chronic medical conditions

Living Healthy

- Improving the self-efficacy and self-management of patients with chronic diseases through Stanford University’s evidence-based workshops
  - Chronic Disease (CDMSP)
  - Diabetes Self-Management (DSMP)
  - Chronic Pain (CPSMP)
**Aged, Blind & Disabled Population**

Referrals:
- PCP
- Self
- Hospital/NF
- Assisted Living
- Aging Agency
  - Aging Agency
  - Aging Hotline
  - Community
  - DMA
  - DSS

**Target Population Defined**

**Individual Assessment Occurs**

**Individual Needs Defined**
(Directs Initial Patient Program Assignment)

**Target Population:**
- High Cost/High Risk
- Referrals (PCP, Self, Others)
- Polypharmacy
- Discharges (Hospitals, Nursing Homes)
- Need PCP Linkage
- Benefit From Case Management

**Disease Management Program**
- CCNC Case Management
- Pharmacy Management
- Mental/Social Referrals
- Interdisciplinary Team Review

**Sub Group Assigned**
- A Chronic Care Case Manager

Assist With PCP Reviews
- Periodic Assessments
- Periodic Review By Interdisciplinary Team:
  - Track Follow Up
  - Amend Care Plan
  - Link With PCP
  - Screenings & Prevention

**Web-Based Care Plan**
- Multi-Agency Access
- Integrates Care Needs
- Documents Referrals
- PCP/Medical Home Established
- Collaborate With Community Partners
- Family Care Giver Involvement
Network Staffing

- Clinical Director
- Network Director
- QI Team
- Care Managers
- Pharmacy Team
- Psychiatrist
- Obstetrician
- Behavioral Health Coordinator
- Palliative Care
- Pregnancy Medical Home Coordinator
- Support Staff
Multi-Disciplinary Approach - Care Management

*Boots on the Ground, The Value Add*

- Embedded care managers in practices with high Medicaid enrollment
- Know the patients, the community, and the resources that are available
- See patients at the bedside in the hospital, in their practice, and in their homes
Multi-Disciplinary Approach - Care Management

- Reinforce providers plan of care and link patients to needed services
- Connect the dots between patient, physician, specialist, hospital, home health and other community resources
- Use common, statewide electronic Care Management Information System (CMIS)
Multi-Disciplinary Approach - Pharmacy

*Providing better health through more efficient and effective drug therapy*

- Medication Reconciliations/Comprehensive Medication Review: reducing discrepancies
  - Promotion of the Preferred Drug List (PDL): reducing prescription drug costs
  - Collaboration with local hospitals, practices, pharmacies: improving patient outcomes
Treating the Whole Patient

- Supporting the integration of behavioral health services, including mental health and substance abuse, into our primary care practices, to better treat the whole patient
- Dedicated Behavioral Health Team to support patient-centered, integrated care
- Cross-training in both primary care considerations and the behavioral health specialty network
Multi-Disciplinary Approach – Behavioral Health Integration

- Coordinating with local Managed Care Organization for integrated care management

- Key initiatives:
  - Antipsychotic use in children and adults
  - Chronic Pain
  - Depression
  - ADHD
  - Substance abuse screening
  - Co-location support
Informatics, Quality and Evaluation

*Improving Quality, Reducing Costs*

- Using Informatics Center data to stratify patient risk and target the highest-risk patients for care management service
- Also used to stratify priority practices and target them for quality improvement interventions
- Training providers on CCNC Provider Portal
- Supporting Evidence-Based Treatment Guidelines for Chronic Diseases
Informatics, Quality and Evaluation

- Providing free educational meetings with Level 1 CME credit
- Helping providers attain Patient Centered Medical Home recognition
- Assisting with practice process and workflow improvement and other strategies to advance accountable care
Community Care of Wake & Johnston Counties

A non-profit partnership between

- Primary Care Providers
- Hospitals
- County Health Departments
- County Departments of Social Services
- Mental Health Agencies
- Wake AHEC – Improving Performance In Practice (IPIP) / Regional Extension Center (REC)
- County School System
- Other Community Programs
Care Management Standardization

- Need for standardization of care management practices identified
  - To determine which interventions are effective
  - To decrease the variability in approach from network to network, case manager to case manager
  - To develop agreed upon definitions, expectations
Care Management Components

- Patient-centered
  - Assessment
  - Care Plan
  - Goals
- Motivational Interviewing
  - Ongoing training
  - Scripting
  - One-on-one observation and feedback
Care Management Process

- **Patient Outreach**
  - CCNC Priority: within 1 month of appearing on a list
  - TC Priority: within 3 business days of becoming aware of discharge
  - Real-time referrals: within 3 business days of receiving the referral
  - Send out-of-Network referrals: within 3 business days of becoming aware of the discharge
Set case status – determined on ability to reach the patient/caregiver and patient’s needs per clinical judgment

- Heavy status – a minimum of 4 tasks per month
- Medium status – a minimum of 1 task per month

Case status review and goal update completed at minimum of every 30 days

Transitional Care – heavy status at minimum of 30 days
Care Management Process

- Within 3 business days of setting case status
  - Gather a minimum of two med lists
  - High-level med review
- Within 15 business days of setting case status
  - Medication reconciliation
- Within 30 business days of setting case status
  - Initial Assessment
Performance Monitoring and Feedback

- Care Management activity reports
  - One-on-one
  - Team-based feedback
- Network benchmarking
- Network-to-Network collaboration
- Core network QI team
Performance Monitoring and Feedback

- Analyze hospital-practice dyads for missed opportunities
  - Identify top dyads for targeting
  - Analyze processes for making timely patient appointments, communicating discharges, reducing no-shows

- Improve communication between hospital-based CM and practice/community based CM for timely appointments
Performance Monitoring and Feedback

- Improve processes for knowing when patients are being discharged and need appointments
  - Implement a process for identifying patients coming out of the hospital
  - Analyze hospital-practice dyads for missed opportunities
- Develop local pilot plans to address care gaps
  - CCWJC-use risk stratified data to identify during inpatient
  - Coordinate while patient is in the hospital
Opportunity Analysis

*Each red dot represents the home address of a patient who should have received follow-up within 7 days but did not
Opportunity Analysis – by Practice

*Each green dot represents the location of a practice – the size corresponds to the size of the missed opportunities.
**Opportunity Analysis – by Hospital**

*Each purple dot represents the location of a hospital – the size corresponds to the size of the missed opportunities*
More information?

www.communitycarenc.org