CCNC Care Management

Lowering Costs and Improving Care for Patients with Complex Needs

When the needs of patients are great, but resources are limited, how can an organization focus its Care Management efforts in the most effective and efficient way?

Community Care of North Carolina's award-winning approach relies on Impactability Scores™ to identify the patients who will benefit most from intensive Care Management interventions. This ensures a financially sustainable Care Management program specifically designed for patients with complex needs and multiple chronic conditions.

An Approach to Care Management Validated by Peer–Reviewed Publications and National Experts

CCNC's approach to Care Management has been studied and validated by industry experts. Using data from more than 20,000 patients, CCNC determined where intervention had the greatest impact and constructed a predictive model that identifies the "impactable" patients most likely to benefit from intensive Care Management interventions.

Medication adherence and historical utilization that was unexplained by disease burden proved to be the most important predictors of an Impactability Score™. Compared to traditional targeting strategies, CCNC's Impactability Score™ generates a two- to three-fold higher return on investment.

An Impactability Score™ is not a risk prediction or risk stratification model. Thus, it does not have to replace other risk models. Rather, a patient's Impactability Score™ identifies clinical opportunities where there is strong evidence of high return-on-investment from an intensive and complex Care Management intervention. CCNC's community-based, face-to-face model, is based on over 20 years of real experience with the North Carolinians who need it the most.

Knowing Impactability Scores™ helps to maximize the cost-benefit of our interventions by making sure high-yield clinical opportunities are not missed.

When We Remove the Barriers to Care, We Improve the Impact of Care

Social and environmental barriers can prevent many high-risk patients from getting the care they need. These barriers can include:

Lack of an adequate social support system	Lack of adequate transportation
Unstable housing	Substance use
Unmet nutritional needs	Trauma or abuse
Illiteracy or low health literacy	

Accountability | Collaboration | Excellence | Innovation

Community Care OF NORTH CAROLINA

ACCREDITED NCQA CASE MANAGEMENT 3 YEARS

Our community-based CCNC Care Managers engage patients with multiple chronic conditions to identify and address barriers that impact their healthcare outcomes.

An individualized care plan is developed with each patient, with the goal improving healthcare outcomes and reducing avoidable hospital admissions and readmissions.

Benefits Provided by CCNC's Targeted Care Management Include:

- Stronger return-on-investment for patient intervention and more efficient allocation of Care Management resources
- Connecting the dots with PCMH and other providers to improve communication and continuity within a patient's network of care
- Providing comprehensive medication management that improves adherence
- Delivering patient education and self-management support to create greater independence
- Linking patients to local community resources to help improve social determinants of health

Bring Better Care Management to Those in Your Community Who Need It Most

Patients with complex needs often do not have all of their needs identified, much less met. Crucial opportunities to improve health can be missed, leading to more extensive and expensive care than necessary. By relying on CCNC to help manage these risks, you can achieve higher-quality, better coordinated care that is better for the patient and cuts your costs, too.

Patients with high Impactability Scores™ represent less than 1% of North Carolina's Medicaid population — but the savings per patient can be has high as $6,000 annually.

By Knowing North Carolina, We Know How to Deliver Better Care Management

With a statewide infrastructure that includes regional affiliates and Care Managers across all of North Carolina's 100 counties, CCNC knows this state's patient population better than any single system of care. This positions us to help you meet your goal of achieving better health outcomes for high-risk patients with complex needs while also reducing costs. The challenges in local communities are specific and unique. To solve them, you need a partner who understands the nuances of those challenges — and who has proven solutions built to meet them. That's CCNC.

For more information about how you can bring the benefits of CCNC's Care Management to your organization, contact:

Jamie Philyaw, MSW, CCM
Vice President of Care Management
jphilyaw@communitycarenc.org

Data and additional resources:

- Population Health peer-reviewed article http://ccnc.care/pophealth
- CCNC Data Briefs http://ccnc.care/databriefs