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Managing Care Transitions in Medicaid: Spotlight on Community Care of North Carolina

EXECUTIVE SUMMARY

This second of three case studies examining key operational aspects of coordinated care initiatives in Medicaid focuses on Community Care of North Carolina's (CCNC) **Transitional Care Program (TCP)**. CCNC is a medical home program that serves 83% of all North Carolina Medicaid beneficiaries. Individuals are enrolled in a practice that participates as a medical home in their community. Regional networks provide practice support to improve care management, with training, data, and tools provided by the central CCNC office, and hire care management staff, who are assigned to the medical home practices. The TCP, which is an enhancement of CCNC, identifies high-risk CCNC enrollees when they are admitted to a hospital, and plans, coordinates, and arranges their transition back to the community. The idea is that robust discharge and transition planning for patients with complex needs can reduce their risk of emergency department use and readmission. The TCP has three main elements. CCNC's *Informatics Center* provides the regional networks and medical home practices with real-time data on Medicaid inpatient admissions and the characteristics and utilization history of the patients. The networks receive additional funding to hire hospital-based *"embedded" care managers* to coordinate transition planning with the CCNC care managers who staff the medical home practices. *Training and tools* support the embedded care managers.

KEY THEMES

- **The CCNC infrastructure provided the foundation for the TCP.** Implementation of the TCP was relatively rapid because much of the infrastructure was already in place, including medical home practices and regional networks supported by data analytics and training. The state added a new cadre of hospital-based care managers, expanded central office functions and financing for data and information capability, and developed new models of care and training to support the system.

- **Obtaining timely hospital data is critical, but challenging.** CCNC worked with the state hospital association to get hospitals to provide real-time feeds of admissions data to the Informatics Center. Regional networks must make agreements with individual hospitals that do not participate in the Informatics Center exchange to obtain their Medicaid admissions data, which are often transferred through paper records that are hard to manipulate and sort. Diagnostic information on admissions records may not be complete or accurate.

- **A strength of the TCP is the blend of common program features and local customization.** While CCNC guidance and training on key aspects of the transitional care model apply statewide, regional flexibility is also built in. Care managers are hired locally by the regional networks, which can adapt the program and innovate based on local conditions. CCNC's convening function facilitates sharing of lessons across regions.

- **The TCP enjoys strong support.** Care managers view the TCP as an integral part of CCNC. In addition, the TCP has catalyzed interaction among community groups that share its goals. Hospitals, individual practices, and community organizations that serve the same patients work closely with regional network staff to manage transitions.

LOOKING AHEAD

A recent evaluation shows that the TCP has had considerable success in reducing readmissions among beneficiaries who receive transitional care. As policymakers seek effective approaches to delivering coordinated care, especially for Medicaid beneficiaries and others with high needs and costs, North Carolina's TCP demonstrates that a robust network of primary care practices that operate as medical homes, supported by health information technology, care managers, and care management tools, can expand the reach of patient-centered care beyond the walls of the doctor's office and the hospital into the community, reducing hospitalizations for high-risk individuals.

INTRODUCTION

In recent years, a growing number of states have undertaken major delivery system reforms in Medicaid, seeking to improve care coordination and health outcomes for Medicaid beneficiaries and reduce spending growth in the program. To help inform the development of such initiatives in other places, the Kaiser Commission on Medicaid and the Uninsured (KCMU) worked with Mathematica Policy Research (Mathematica) to examine key operational features of coordinated care initiatives in Medicaid in three states – Colorado, North Carolina, and Rhode Island.

This issue brief focuses on Community Care of North Carolina (CCNC) – specifically, on the Transitional Care Program, which is designed to reduce hospital readmissions by supporting the transition of high-need Medicaid beneficiaries who are being discharged from the hospital back to the community. The information and perspectives presented here are based on a review of CCNC and Transitional Care Program documents, one-hour telephone interviews with program managers at the state level, and key staff in two of the 14 CCNC regional networks across the state.

OVERVIEW OF COMMUNITY CARE OF NORTH CAROLINA

Community Care of North Carolina is North Carolina's widely recognized statewide, community-based Medicaid medical home and care management system. Expanded and enhanced over the last 25 years from an original pilot in a single rural county, CCNC now serves some 1.3 million Medicaid beneficiaries, or 83 percent of all beneficiaries in the state.[1] Beneficiaries are enrolled in one of approximately 1,800 participating primary care or group practices statewide that serves as a medical home in their community. Fourteen regional Community Care networks are funded by the state to support the practices as well as coordination with the other local health and social service providers. The regional networks are supported, in turn, by a central, statewide CCNC office that provides them with training, data, and tools to help them work with practices to improve care management and outcomes. State Medicaid funds for care management flow through the central CCNC office to the regional networks, which each hire their own care management staff, including a clinical director, care managers who are assigned to specific practices or are shared across several of them, a pharmacist, a psychiatrist, a behavioral health coordinator, a palliative care coordinator, and other clinical experts and support staff. Each individual practice also receives an enhanced per member, per month fee from the state directly to support their practice's medical home efforts, to include care management and quality improvement activities.

THE TRANSITIONAL CARE PROGRAM

In 2008, the state legislature expanded CCNC to include aged and disabled Medicaid beneficiaries (excluding those who are also enrolled in Medicare, known as "dual eligible" beneficiaries). This population has a high prevalence of multiple chronic physical and mental health conditions as well as an array of socioeconomic disadvantages that make them high-risk for gaps in coordination of their care and for multiple hospitalizations. While these individuals make up only one-quarter of North Carolina Medicaid beneficiaries, they account for more than 40% of all Medicaid inpatient admissions, two-thirds of all potentially preventable hospitalizations, and 80% of total Medicaid costs.[2]

Recognizing the need to ensure coordination and continuity of care in the community for aged and disabled beneficiaries, CCNC decided to strengthen its care management model for this population as well as for those with multiple chronic conditions who were already enrolled in CCNC. The newly created Transitional Care Program (TCP) identifies high-risk CCNC members at the time they are admitted to a hospital, and plans for, coordinates, and arranges their transition from the hospital back to the community. The idea is that robust discharge and transition planning, supported by both a care manager workforce dedicated to this activity, and data analytics and data sharing, can reduce the risk of emergency department (ED) use and hospital readmission for Medicaid patients with complex needs, improve health outcomes, and reduce costs.[3] The transitional care program is now statewide. In 2013, it handled approximately 30,000 discharges.

The TCP is not freestanding; it is an overlay on the existing CCNC infrastructure, involving additional capacity and resources aimed specifically at managing the fragile transition of high-need Medicaid beneficiaries from the inpatient hospital setting back to the community. The main elements of the program are:

- Centralized health information technology that provides the Community Care networks and practices with real-time data on Medicaid admissions to North Carolina hospitals, along with background on the characteristics and utilization history of each patient;
- Additional funding for the regional networks to hire hospital-based, "embedded" care managers to coordinate the discharge and care management of high-risk beneficiaries returning to the community with the care managers already staffing CCNC practices; and
- Guidance on care management for embedded care managers, including training and tools to carry out specific functions of their job.

HEALTH INFORMATION TECHNOLOGY

The TCP is supported by real-time (twice daily) data feeds from North Carolina hospitals that show new Medicaid admissions and the associated diagnoses. The CCNC Informatics Center combines this information with data it already has on these hospitalized patients from the Medicaid claims data warehouse it maintains. These additional data show the risk status of the patient, the conditions for which he or she is being treated, and the individual's historical utilization of services. Based on this information, it is possible to identify the newly hospitalized Medicaid beneficiaries who meet the criteria for transitional care, which include a history of multiple ED and inpatient visits, multiple medications, lack of contact with a primary care provider, specified medical conditions, and high costs. Hospital-based care managers (discussed next) receive a real-time report when a Medicaid beneficiary in their regional network is admitted to their hospital as an inpatient. The care managers use the risk information (so called "flags") to identify the Medicaid patients who have priority for their services. The patient data are also made available to CCNC medical home practices and community-based providers in the region through the CCNC data portal.

The CCNC Informatics Center collaborated with North Carolina hospitals to develop the centralized data exchange on admissions because Medicaid claims data are not timely enough for the TCP's purposes, and the alternative of having each regional network collect information individually from each of its hospitals would have been burdensome. The collaborative effort initially included a subset of hospitals that were already

reporting real-time ED data for public health surveillance purposes through a common vendor, facilitated by the North Carolina Hospital Association.

By 2013, close to 60 hospitals, accounting for more than two-thirds of all Medicaid discharges statewide, were participating in the centralized data exchange on admissions, including major medical centers and referral regions. The regional networks are responsible for obtaining information from hospitals that do not participate in the centralized exchange through the Informatics Center. Non-participating hospitals tend to be small and their data are often transferred through paper records.

EMBEDDED CARE MANAGERS

The monthly per member fee that the regional networks receive for each patient gives the networks funding to hire care managers, who are embedded in high-volume hospitals and share responsibility for lower-volume hospitals. Large hospitals can have multiple care managers to handle the system's volume. Embedded care managers work closely with both hospital staff and community-based health and social service providers. They review new hospital admissions to identify any Medicaid beneficiaries who meet CCNC priority criteria, have a targeted chronic condition, or are appropriate candidates for intensive care management. These patients receive visits from the embedded care manager at least once before they are discharged from the hospital, as well as a home visit, ideally within three business days of their discharge, with a focus on medication reconciliation. Embedded care managers also ensure that a follow-up physician visit is scheduled prior to discharge and verify later that it occurred. Further, care managers can do whatever seems necessary or important to enhance the care of their Medicaid patients, tailoring their efforts to individuals' needs and preferences.

Because CCNC, including the Informatics Center, operates on a statewide basis, high-risk Medicaid patients who are admitted to hospitals outside their regional network still receive transitional care planning for their return to their local community. The TCP also provides limited services for non-high-risk patients, for example, ensuring that a follow-up appointment is scheduled with their provider before they are discharged.

CARE MANAGEMENT TRAINING AND TOOLS

Care management in the TCP follows a standardized, statewide plan that emphasizes team work with patients and their providers; patient self-management, including motivational interviewing and patient education about "red flags" that may warrant a doctor visit post-discharge; medication management; and medical care follow-up (see Appendix). The goal is to meet patients' care goals and preferences while planning post-hospital care that limits or prevents the need for ED use or re-hospitalization. The hospital-based care managers work with patients for up to four weeks from the time of their admission, and coordinate their transition to community-based care management services for longer-term follow-up when appropriate.

The central CCNC office trains care managers on care management processes and specific techniques and tools (e.g., motivational interviewing), but the regional networks have flexibility to apply them in ways that accommodate local needs and conditions. To illustrate, one regional network has a team of 20 care managers, three or four of whom are embedded in the larger hospitals in the eight-county region served by the network. An embedded care manager reviews the daily feed of data on Medicaid admissions and available claims-based information on each patient's prior use and risk status. The care manager makes bedside visits to the patients

who are high-priority for attention. If a patient has not previously received care management in the community, the care manager introduces the model and explains how it works in the practice in which the patient is enrolled, tells the patient who the care manager in the community is, and walks through what will happen when the patient leaves the hospital. In the case of patients with specified triggers (e.g., a history of readmission), the care manager seeks to identify problems that might have contributed, such as lack of transportation or lack of money for medication, and arrange assistance designed to avoid similar problems following the patient's discharge from the hospital. The embedded care manager is in communication with the community-based care manager and together they coordinate the patient's follow-up care.

KEY THEMES

The existing CCNC infrastructure provided the foundation for the TCP.

North Carolina could implement the TCP in CCNC relatively rapidly because much of the infrastructure required to support it was already in place. Medical home practices and regional networks already had the support of data analytics, training, and program guidance provided centrally by CCNC. The regional networks already supported the practices with patient information based on claims history, practice-based care managers, specialized personnel, such as pharmacists and psychiatrists, and linkages to other providers in the community. The TCP could be implemented by funding CCNC to add some new components to this infrastructure – a new cadre of hospital-based care managers; expanded central office functions and financing to build out CCNC's existing information support (i.e., combining real-time feeds of admission data and related risk-assessment information); development of new models of care; and training necessary to support the system. In states lacking such a foundation, it would be necessary to develop an infrastructure along the lines of CCNC's before a comparable program of transitional care could be implemented.

In addition to the direct costs of the TCP, there are other costs states should expect when medical home programs like CCNC are expanded to include the aged and disabled. Expanding CCNC to this population required increased funding to support both the caseload growth and higher per member per month fees paid to medical home practices to reflect the greater needs of aged and disabled individuals for services such as psychiatry and pharmacy services and other support. The inclusion of aged and disabled Medicaid beneficiaries also added to the work of state agencies because it increased the need for coordination and information-sharing among health and social service programs serving the same people.

Obtaining timely hospital data is critical, but challenging.

Timely data on hospitalizations are essential for the transitional care model to work. CCNC worked with the state hospital association to gain hospital agreement to provide the twice-daily feeds of admissions data to the CCNC Informatics Center. CCNC decided to start with hospitals that were already reporting real-time data to a common vendor, as mentioned earlier. This way, the technical challenges were lowered and, with permission, those data could now also be transferred to CCNC.

The regional networks still rely on one-to-one agreements with individual hospitals that are not in the CCNC system to obtain information on their Medicaid admissions; most such information is sent by fax and in printouts. Although data in these formats are much harder than electronic data to manipulate and sort, the networks report that this additional information is useful to them and to the central CCNC Informatics Center.

At the same time, CCNC observed that the automated data received from hospitals are only as useful as the input they reflect. The diagnostic information reported by hospitals at the time of admission may not be complete or accurate. Other information that care managers may want, like patients' room numbers, are not reported on the feeds. CCNC is now assessing what kinds of improvements might enhance the value of the information it receives. Thus, systems like this may be best seen as evolving tools that can benefit from review and improve over time.

A strength of the TCP is the blend of common program features and local customization.

CCNC has articulated guidance and expectations that apply to the TCP statewide. State guidance outlines the minimum intensity of care manager contact with hospitalized patients, the risk factors that should be used to prioritize patients for care management, and the timeframes in which different activities are to take place. Also, all care managers – both practice-based and hospital-based – are trained on the transitional care model and the role of the embedded care managers. Such training builds shared expectations as well as important relationships. For example, hospital- and community-based care managers learn how to work together most efficiently. They also understand how expectations change for a care manager who shifts settings or carries out care management functions in both settings, which sometimes occurs. The statewide training program also fosters relationships among the staff of regional networks across the state. Regional CCNC staff say that, because care managers across the regions know one another and have a common understanding of program expectations, they are better able to serve patients from other regions who may become hospitalized in their region.

But while the TCP is a statewide program, it also builds in regional flexibility. In particular, all hiring of care managers is handled locally by the regional networks, which are also responsible for the formal job description and assignments. Also, regional networks can adapt the program as appropriate to respond to local conditions. For example, in some urban areas, care managers may be able to make home visits to four or five patients quickly if they reside in the same housing complex, whereas care managers in rural areas with longer travel times likely require more time to visit the same number of patients. Similarly, care managers in urban areas with large numbers of hospitalized Medicaid patients may spend all their time on a particular hospital floor working with the discharge staff, whereas, in rural areas, where volume is lower and more dispersed, program efficiency may require that a care manager divide his or her time among the clinic, the hospital, and the patient's home.

Regional networks also have latitude to innovate, and CCNC's convening function facilitates the sharing of lessons learned from their innovations. To illustrate, it is helpful to consider how one region's approach to a universal challenge – the small number of patients whose very high utilization drives a large share of total spending – was scaled up. Staff of this region adopted the strategy of identifying individual high-utilizing patients in the network's largest hospital and having the entire care management team meet. The patient's social worker, practice-based care manager, psychiatric provider, and hospital-based care manager come together in these meetings to discuss the individual's specific circumstances and develop a workable care plan designed to enhance his or her quality of life and prevent ED visits and readmissions. Then, if the patient comes into the hospital, this care plan gets triggered. Because the regional network staff view the intensive meeting strategy as a success, they are now expanding it to other hospitals in the region, and they have also presented it to other regional networks in statewide CCNC sessions. Within the CCNC structure, there is the

opportunity to share experiences more broadly. The capacity for innovation within a common framework appears to be a strength of the program.

The TCP appears to enjoy strong support from the regional networks and care managers as well as community-based organizations.

Care managers view the TCP as an integral part of CCNC. In addition, the TCP has catalyzed interaction among diverse community groups that share its goals. Staff of one regional network stressed that primary care providers cannot plan and implement smooth transitions by themselves – broader participation is key. Hospital staff, individual practices, and community organizations that serve the same patients are all reported to work closely with regional network staff. At the same time, it was noted, it is challenging to develop and carry out transitional care plans in a system with many stakeholders with different concerns, and to establish all the channels of communication needed to make the program work.

CONCLUSION

A recent evaluation of the Transitional Care Program shows that the model has had considerable success. [4] In particular, it documents that Medicaid beneficiaries with complex chronic conditions who received transitional care were 20 percent less likely to experience a readmission during the subsequent year, compared to clinically similar patients who received usual care, and that they were also less likely to have multiple readmissions. As state and federal policymakers seek effective approaches to delivering coordinated care, especially for Medicaid beneficiaries and others with the greatest needs and costs, North Carolina's TCP demonstrates that a robust network of primary care practices that operate as medical homes, supported by health information technology, care managers, and care management tools, can expand the reach of patient-centered care beyond the walls of the doctor's office and the hospital into the community, reducing hospitalizations for high-risk individuals.

APPENDIX: CCNC TRANSITIONAL CARE FUNCTIONS

Face-to-face patient encounters

- Embedded care manager/regional network is notified of all admissions and their risk status.

- Care manager visits high-risk patients at the bedside (at a minimum) and works with the patient, family, and hospital discharge staff to plan for smooth and timely discharge.

- Home visit arranged post-discharge; goal is home visit within 3 days of discharge for high-risk patients.

- Practice-based care manager works with patient at home, office, or community to assess needs and reconcile medications.

Patient education and self-management

- For high-risk patients with particular conditions, care manager provides individualized patient education and a self-management notebook that serves as a personal health record and communication tool.

- Care manager teaches patient and family to identify "red flags," or complications requiring a call to the doctor to avoid an ED visit/readmission.

- Care manager uses motivational interviewing and other education strategies to foster good patient outcomes.

Medication management

- CCNC works to gather, organize, and share information on medication use with community-based providers to identify and resolve issues (i.e., drug duplication, interactions, adverse events, sub-optimal use, etc.)

- Care manager and/or pharmacist reviews medications with patient and/or caregiver at home, in the clinic, or by telephone, helps the patient obtain needed prescription drugs, and educates him or her on proper use. Pharmacist conducts a global review of medication regimen and drug history to identify and address complex topics.

Follow-up calls and contacts

- Case manager works to ensure timely follow-up appointment(s) with primary care provider/specialists following hospital discharge, and addresses barriers to patient follow-through.

- Case manager helps patient prepare questions, a notebook, and other information for the follow-up visit.

- Transitional care follow-up may continue for 30 days. After 30 days, patient may require continued care through general/primary care management.

Source: Authors' summary of information from the CCNC Transitional Care Key Components Sheet and information at http://www.communitycarenc.com/population-management/transitional-support/

ENDNOTES

[1] Community Care of North Carolina: Putting Health Reform Ideas into Practice in Medicaid, Kaiser Commission on Medicaid and the Uninsured, May 2009; and Dobson LA, North Carolina's Community Care of North Carolina, Case Study, National Governors Association (http://statepolicyoptions.nga.org/casestudy/north-carolinas-community-care-north-carolina). For current detail on the program and its elements, see https://www.communitycarenc.org/about-us/

[2] DuBard C, J Cockerham, and C Jackson, "Collaborative Accountability for Care Transitions: The Community Care of North Carolina Transitions Program," North Carolina Medical Journal 73(1), April 5, 2012.

[3] Ibid.

[4] Jackson C, T Trystad, D DeWalt, and C DuBard, "Transitional Care Cut Hospital Readmissions for North Carolina Medicaid Patients with Complex Chronic Conditions," Health Affairs 32(8): 1407-1415, August 2013.