



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.

A Validated Care Management Approach that Generates a Two- to Three- Fold Higher ROI

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.

Most Important Predictors of CCNC’s Impactability Score™

- Medication adherence
- Utilization unexplained by disease burden

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.

Removing the Barriers to Care Improves the Impact of Care

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

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| 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 | |

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 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 as high as \$6,000 annually.

We Deliver Better Care Management Because We Know North Carolina

With a statewide infrastructure that includes Care Managers in all six Medicaid regions and across all of North Carolina's 100 counties, CCNC knows this state's patient population better than any single system of care.

CCNC is best positioned to achieve better health outcomes for high-risk, impactable patients while also reducing costs.

We understand North Carolina's unique communities and their challenges. 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:

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Data and additional resources:

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