Each network has:

- Clinical Director
  - A physician who is well known in the community
  - Works with network physicians to build compliance with care improvement objectives
  - Provides oversight for quality improvement in practices
  - Serves on the State Clinical Directors Committee
- Network Director to manage daily operations
- Care Managers to help coordinate services for enrollees/practices – many embedded in local practices
- Pharmacists for Med management of high cost patients
- Psychiatrists & Behavioral Health Coordinators for mental health integration
- Palliative Care - Physician Champions, Palliative Care Coordinators, Community Resources
Challenge = Opportunity
Medicaid Admissions / Readmissions

- 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.

MULTIPLE factors contribute to MULTIPLE problems

**Multiple Prescriptions**
- Patients with 4 or more chronic conditions fill an average of 40-50 prescriptions each year

**Multiple Providers**
- More than Half of People with Serious Chronic Conditions have Three or More Different Physicians
- Medicare recipients with 5 or more Chronic conditions see an average of 12 physicians annually

**Multiple Facilities**
- Cross-hospital traffic is common: 23% of 30-day readmissions occur in a different facility.

**Multiple Medical Records & Documents**
- Limited access to information
- Systems that don’t communicate
- Conflicting Med lists
- Discharge Instructions that are hard to understand/not person-centered
CCNC Care Management Model

Time to First Readmission for Patients Receiving Transitional Care Versus Usual Care
Lighter shaded lines represent time from initial discharge to second and third readmissions
Example of an ACRG with a HIGH risk of readmission that benefited from transitional care.

Return on Investment

Patients needing transitional care to avert 1 hospital admission in the coming year:
- Complex, chronic patients = 6
- Healthier Patients = 133
Real-time notification of hospital admission. Priority flagging based on overall risk profile using historical claims.

### Core components of CCNC Transitional Care

- Face-to-face contact encounters
- Enhanced assessment of post-discharge needs
- Interdisciplinary Communication & Collaboration
- Comprehensive medication management
- Enhanced communication at discharge
- Timely outpatient follow-up with informed medical home
- Preparation for provider visits
- Engage Community Resources & Providers
- Patient/caregiver self-management education, "red flags"
- Patient Activation/Patient Coaching
- Enhanced teaching and learning
- Person-centered goal setting and care plan development
- Self management coaching
- Motivational Interviewing, Teach-Back, Adult Learning Principles
- Local flexibility, many local innovations
Each dot represents the home address of a client who received transitional care services between July 2011 and June 2012. As of December 2012, we are providing transitional care management for approximately 4500 patients per month.
4 Key Ingredients

1. Accountability
2. Relationships
3. Coordinated Care
4. Communication

More information?

www.communitycarenc.org

Thank You!
North Carolina Care Transitions – Challenges and Opportunities
Karen Southard, RN, MHA
Program Manager, Patient Safety and Care Transitions
March 1, 2013
www.ccmedicare.org

For the Nation
Partnership for Patients – Care Transitions

“Safe, effective, and efficient care transitions require thoughtful collaboration among health care providers, hospitals, nursing homes and other facilities, social service providers, patient caregivers, and patients themselves.”

Partnership for Patients

www.ccmedicare.org
Top Diagnosis for Admission and Readmission

- Diabetes
- COPD
- Heart Failure

Quarterly ED Visits/Observation Stays
Annual Post-Acute Care Setting Readmissions
(January 1, 2011 - December 31, 2011)

Care Transitions Communities in NC

North Carolina
Drivers of Readmission

- Lack of coordinated care among providers
- Lack of integrated electronic medical records
- Lack of medication management
- Lack of patient engagement
- Lack of advanced care planning
- Social isolation
- Poverty

www.ccmedicare.org
North Carolina

The Faces of Disparity

It Takes a Community

But it Begins with a Leader

To engage and motivate the patient and family to make goals for care

To assess, treat, and follow up with the patient

Coordinate effective services to enhance the quality of the patient’s care

Interventions at Work

• Utilizing EMS to provide transition follow up
• Clinical pharmacy in the hospital and community
• Schedule appt and follow-up phone calls post-discharge to physician and patient
• Expanding EHR reach to community partners
• Area on Aging working with Care Transitions teams in some hospitals

Patient

Community
Practitioner

Supportive
Services
Seasonally Adjusted Quarterly Admissions per 1,000

- National
- State
- Coalition

Impact of Coalition work on North Carolina Admissions

- Community Resident Admissions
- Non-Resident Admissions

45.7%
54.3%

Impact of Coalition work on North Carolina Readmissions

- Community Resident Readmissions
- Non-Resident Readmissions

46.8%
53.2%
QIO Support to the Community Through Learning and Action Events

Beginning April 2013
Beginning early Summer 2013

www.ccmemedicare.org
• NC) 800-682-2650
• (SC) 800-922-3089

This material was prepared by The Carolinas Center for Medical Excellence (CCME), the Medicare Quality Improvement Organization for North and South Carolina, and commissioned for use by the Centers for Medicare & Medicaid Services, an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.

Karen Southard, RN, MHA
ksouthard@thecarolinastrcenter.org
919-461-5663

The Carolinas Center for Medical Excellence
North Carolina Virginia Hospital Engagement Network (NoCVA) and North Carolina Alliance for Effective Care Transitions (NC ACT)

Patient Protection and Affordable Care Act

Partnership For Patients
- Launched on April 12, 2011
- Purpose: to improve the quality, safety and affordability of healthcare
- Combines the efforts of key public and private stakeholders
- 7700 organizations have pledged
- Aligns with NQS priorities
  - Making care safer by reducing the harm caused in the delivery of care
Partnership Goals

- By the end of 2013, preventable hospital-acquired conditions would **decrease by 40%** compared to 2010.
- By the end of 2013, preventable complications during a transition from one care setting to another would be decreased such that all hospital readmissions would be **reduced by 20%** compared to 2010.

Hospital-acquired Conditions

- Central line associated blood stream infection
- Catheter associated urinary tract infection
- Surgical site infection
- Pressure ulcers
- Injuries from falls and immobility
- Adverse drug events
- Obstetrical adverse events (Early Elective Deliveries)
- Venous thromboembolism
- Ventilator-associated pneumonia

Who Has Pledged?
The Hospital Engagement Network (HEN)

- Part of a network of resources to support hospitals with PFP
- 27 HENs
- Conduct training programs in all core events
- Provide technical assistance
- Monitor and track improvement
- Funding for 2 years
- Hospitals pledge to join only one HEN

HENs Operating in North Carolina

- NoCVA (83 hospitals)
- Carolinas Healthcare System (21 hospitals)
- Premier (8 hospitals)
- Lifepoint (2 hospitals)

NC Readmissions
All Cause, All Payer, 30 Day
NC VA HEN (NoCVA)  
“Two States, One Purpose”  
• A partnership between North Carolina and Virginia Hospital Associations  
• Sharing of resources to improve the successful attainment of the PfP goals  
• Subcontractors and Partners  
  o Healthcare Team Training  
  o Carolinas Center for Medical Excellence  
  o 31 Partners

Preventing Avoidable Readmissions Collaborative  
• Mission: To improve transitions in care and reduce avoidable hospital readmissions.  
• Goals:  
  o Reduce readmission rates by 20%  
  o Increase medication reconciliation at discharge to 95%  
  o 10% improvement or national 25th percentile in scores on four HCAHPS dimensions

Collaborative Methods  
• Complete an assessment of five recent readmissions  
• Conduct observations of patient admission, patient education, and patient discharge  
• Develop value stream process maps of the discharge process  
• Develop value stream process maps of medication reconciliation at discharge  
• Develop targets for improvement in 4 areas:  
  o Enhanced assessment of patient post-hospital needs  
  o Effective teaching and enhanced patient learning  
  o Ensuring post-hospital care follow-up  
  o Providing real-time handover communications  
• Participate in community engagement readiness assessment  
• Identify and connect with community organizations, services and practices
NC NoCVA Readmissions Collaborative Readmission Rates

NC ACT

- Statewide partnership and collaboration committed to improving the transition of care
- Stakeholder group representing continuum of care
- Person centered quality services and supports when North Carolinians transition from one healthcare setting to another

NC ACT

Includes all stakeholders to:
- connect services and resources
- identify best practices and needs, and
- educate the public, providers and decision makers on person centered quality services and supports for optimal healthcare transitions
NC ACT website

www.NCACT.org