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Community Care OF NORTH CAROLINA

FOR IMMEDIATE RELEASE

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TRANSITIONAL CARE EFFORTS CONTINUE TO DRIVE DOWN NORTH CAROLINA MEDICAID HOSPITAL VISITS, COSTS

North Carolina Community Care Networks Provide Complex Care Management to Patients with Multiple Chronic Conditions

RALEIGH, N.C. (August 26, 2015) – By targeting highest-risk patients and working with them to better manage their health and utilize primary care services, North Carolina Community Care Networks (NCCCN), the physician-led nonprofit that helps manage care for 1.4 million Medicaid recipients, has cut the rates of inpatient admissions and readmissions by 10% over the last six years for the Medicaid population with complex, chronic conditions.

Between 2008 and 2014, hospital admission rates for Medicaid recipients with multiple chronic conditions have declined by 10.3% among those enrolled in NCCCN medical homes, while rising over twice that rate (28.7%) for those not in a medical home (see graphs next page). In 2014, there were 932 admissions for every 1000 high risk Medicaid recipients not enrolled in a NCCCN medical home, compared to 471 admissions per 1000 in a NCCCN medical home. Every avoided hospitalization results in significant savings to the Medicaid program.

This is a statewide effort funded under NCCCN's contract with the NC Department of Health and Human Services to identify and address Medicaid patients in greatest need. NCCCN calls this program "Transitional Care" and targets patients with multiple, complex chronic conditions that are at high risk for repeat hospitalizations, That's because patients with numerous chronic conditions, such as diabetes, hypertension, chronic obstructive pulmonary disease (COPD) and cardiovascular disease, require more intense care management, closer monitoring of their medication use, and better coordination of multiple health and community services.

"We have refined how we identify patients with whom to intervene," said C. Annette DuBard, MD, MPH, Senior VP for Informatics and Evaluation. "This helps us to allocate a workforce of care managers and other clinical resources in an efficient way that maximizes the benefit to the patient through better health outcomes and lower use of high-cost medical services."

Key elements to NCCCN's transitional care program include:

- Utilizing real-time data exchange with NC hospitals for timely notification of Medicaid patients admitted to the hospital;
- Embedding nurse care managers and pharmacists in hospitals and primary care practices to work directly with the patient's physicians and coordinate care across settings;
- Visiting high-risk patients' homes within three days of discharge to review medications, establish a comprehensive care plan, counsel patients and caregivers about identification of warning signs and management of chronic conditions, and communicate with providers to resolve any identified concerns;
- Identifying other patients at high risk of hospital readmission most likely to benefit from care management; and
- Cultivating relationships with community agencies and local resources to coordinate care and avoid duplication of services.

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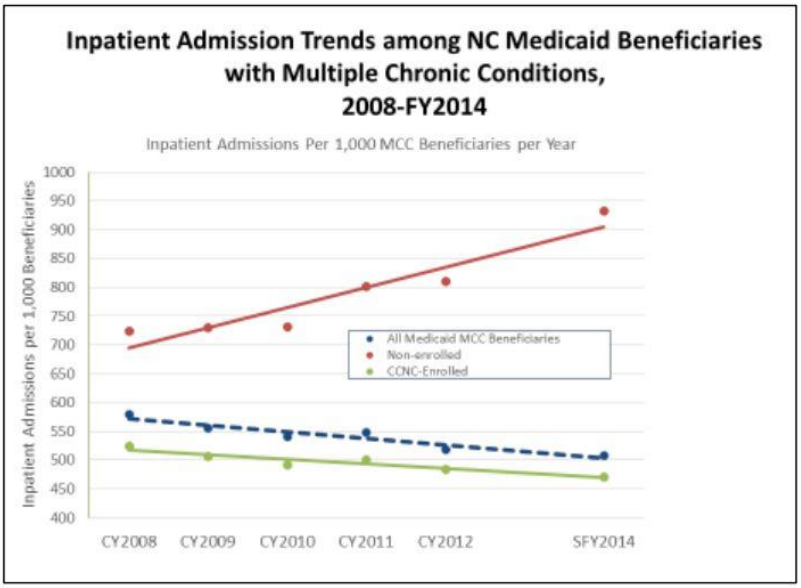
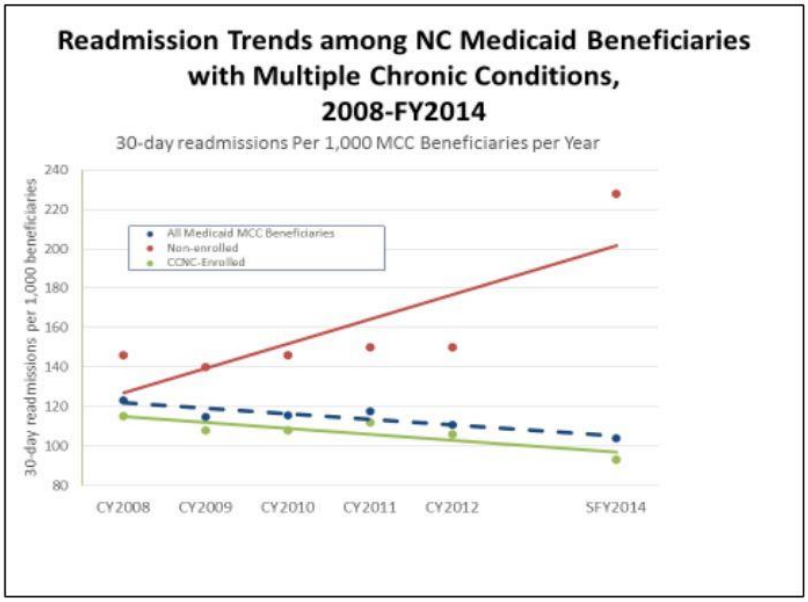
And, in a study recently published in the Annals of Family Medicine, Dr. DuBard's team found that the timeliness of follow-up can make a significant difference in specific patient populations. The study noted that the 25% of patients with the highest risk for readmission were far less likely to be readmitted if they received a home visit or other follow-up within one week of discharge.

"Our research shows that timing is critical," said Dr. DuBard. "In addition to choosing the right patient and the right intervention, our work also has to be done at the right time. There are windows in care delivery that offer opportunities to significantly improve the trajectory of the patient's health. Seizing these opportunities can make a tremendous difference for patients and their caregivers, and help to keep people out of expensive inpatient settings.





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About North Carolina Community Care Networks

NCCCN is a community-based, public-private partnership that takes a population management approach to improving health care and containing costs for North Carolina's most vulnerable populations. NCCCN creates "medical homes" in all 100 counties for Medicaid beneficiaries, individuals that are eligible for both Medicare and Medicaid, privately-insured employees and uninsured people. To learn how NCCCN saves North Carolina millions of dollars every year, visit www.CCNCcares.com. For more information, visit our website, www.communitycarenc.org.

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