



CCNC Transitional Care

Active handoffs and shared data lead to coordinated care and better outcomes

Why Transitional Care?

A 62-year-old man with a developmental disability is discharged from a North Carolina hospital after a two-month stay for multiple medical conditions and a nonhealing wound. Team meetings coordinated discharge plans and follow up care: home health, palliative care, medical supplies, appointments with multiple specialists, and in-home care.*

Yet when a CCNC care manager visits the patient two days after discharge, she finds the home health agency has not done dressing changes, he has no wound care supplies, in-home personal care has not yet begun, and pain medication has been denied at the pharmacy.

Despite the best efforts of the hospital team and Medicaid coverage for needed follow-up, this patient was on a fast track to readmission. Quickly, the CCNC care manager established a plan for services needed across settings and providers, incorporating Social Determinants of Health (transportation, social support, nutrition, etc.). For patients of this complexity, the home visit is a critical tool for timely identification of problems and ultimately improving health outcomes.

*See NCMJ Vol. 73, No. 1

CCNC's Singular Focus

- Patients are assigned a Transitional Care Impactability Score™ to identify those most likely to benefit from an intensive transitional care intervention following a hospital discharge
- Research shows patients with multiple chronic conditions need a different level of management intervention
- Targeting this population with specific interventions pays off for patients, providers, and payers

Preventing Readmissions

- The key statistic is the “number needed to treat” (NNT) to prevent one inpatient admission in the coming year. For the patient population with a low Transitional Care Impactability Score™, CCNC must intervene with **133 patients to prevent one readmission.**
- But for the population with a high Transitional Care Impactability Score™, CCNC needs to intervene with only **6 patients to prevent one readmission.**

This focus creates an extremely efficient allocation of care management resources.

NNT 133 vs NNT 6

The CCNC Difference

- CCNC’s “on the ground” care managers keep the primary care medical home informed of what’s happening and coordinate a broad spectrum of community-based care.
- In hospitals with a high volume of Medicaid patients, embedded care managers meet with the patient while still in the hospital.
- For priority patients, we provide timely face-to-face home visits and follow-up with multiple providers. Interventions improve the likelihood of a successful transition to home and greatly reduce the risk of readmission to the hospital.

Patients with multiple chronic conditions who receive a CCNC home visit are on average *half as likely* to have a 30-day readmission compared to those receiving less intense forms of transitional care

Core Components of CCNC Transitional Care



Face-to-Face Patient Encounters

- Support to patients with complex medical and behavioral health needs
- Timely in-home visits to priority patients provide a wealth of information and opportunities to improve care
- Identification of barriers and Social Determinants of Health



Medication Management

- Comprehensive review and reconciliation of lists, including admission and discharge medication, medications listed in the PCP record, fill history from claims data, patient/family interviews and “brown bag” review



Patient and Family Education

- Summarize goals, medications and treatment needs using CCNC Self-Management Notebook and motivational interviewing



Cultivation of Local, Cross-Agency Partnerships

- Help to bridge the gap between primary care and specialists, Departments of Social Services, inpatient and rehabilitation facilities, and community resources



Data Support and Information Exchange

- Target outreach using Transitional Care Impactability™ scoring
- Identify patients most likely to be helped by intensive care management
- Thrice-daily ADT reports from 85% of NC hospitals provide “real time” data
- Clinical information shared across the care team – multiple locations, licenses and organizations

Transitional Care Gets Results

27%↓

Reduction in inpatient admissions

48%↓

Reduction in potentially preventable readmissions

\$128M↓

2017 savings for CCNC beneficiaries compared to unenrolled population

For more information about Transitional Care, contact:

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More information on the web at:

<http://ccnc.care/transitionalcare>

Accountability

Collaboration

Excellence

Innovation