Community Care
OF NORTH CAROLINA
Community Care of Wake/Johnston Counties

Transitional Care Management
1/24/2018

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Complex Care Management Core Components

- Review of Patient Records
- Reinforcement of Provider Plan of Care
- Initial and Comprehensive Health Assessment
- Goal Setting & Patient-Centered Care Plan
- Patient Education (Healthwise) and Tools
- Practice Visits/Home Visits
- Community Resource Referrals – addressing Social Determinants of Health
- Transitional Care
- Medication Reconciliation/Pharmacy Support

Transitional Care – Inpatient Setting

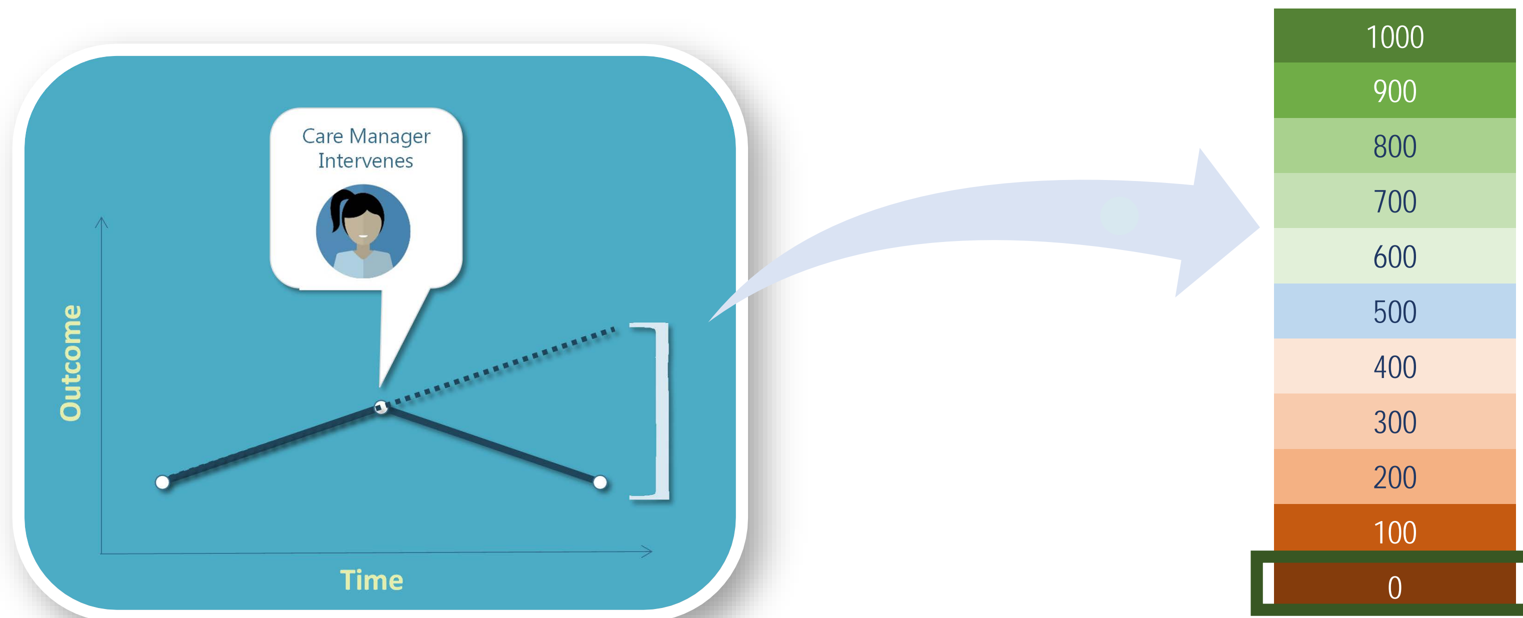
- Core Components:
  - RN CM reviews hospital census to identify patients for engagement
  - Assess priority by reviewing Transitional Care Impactability Score
  - CM referrals/ floor rounds
  - Face-to-Face patient engagement in the hospital
  - Bedside scheduling of home visits
  - Inpatient medication reconciliation
  - Link to Community Pharmacy Enhanced Services Network (CPESN)
  - Congestive Heart Failure/Advanced Practice Paramedics (CHF/APP) program
  - Address Social Determinants of Health

Transitional Care – Community Setting

- Core Components:
  - Face to Face contact (goal within 7 days of discharge)
  - Review and support Discharge Instructions/Plan of Care
  - Comprehensive medication management with med reconciliation
  - Patient/caregiver self-management education “red flags”
  - Timely outpatient follow-up with informed Health Home
  - Link back to specialist, home health, BH system
  - Connect with community resources to address social determinants of health

Transitional Care (TC) Impactability Score™

Score	How Defined?	What it means?
Transitional Care Impactability Score™	A score from **0-1,000 reflecting likely cost saving, per month** (over **6 months** following discharge) in which the patient received transitional care management); CCNC **prioritizes patients with a TC Impactability Score above 200** who are **being discharged from the hospital.**	Clinical characteristics and utilization patterns indicate a **high likelihood of benefitting from transitional care management following inpatient discharge**. Prioritizing patients with a score of 200-1,000 flags less than 1% of the Medicaid population, but for these patients, we are confident that we can expect an average savings of $1,200 - $6,000 per patient receiving care management.



Transitional Care and Pharmacy Integration

- Augment Transitional Care Management Services
  - Assist with Patient follow up and confirmation of receipt of discharge meds
  - Preliminary medication assessment 24 post discharge
  - Comprehensive medication review within 15 days post discharge
  - Patient-centered pharmacy care plans within 15 days of post discharge
  - Provider follow-up post discharge regarding drug related concerns or recommendations for med optimization
  - Collaboration with CPESN pharmacies to coordinate care post discharge

    (38 CPESN pharmacies in CCWJC network)
- Network Pharmacy Program Manager, Clinical Pharmacists, Pharmacy Program Assistants

Hospital and PCP Collaborations

- 4 Hospitals- WakeMed, Johnston Health, Duke Raleigh, & Rex
- State Operated Behavioral Health Inpatient facilities-
  - 3 regional Network hubs receiving MCO specific admission & discharge reports (CCWJC, CCPGM, & CCPEC)
  - CCWJC receives Alliance BH specific admission & discharge information
  - CCWJC- Central Regional Hospital & Cherry Hospital
- High Utilizer Meetings– WakeMed & Advance Community Health
- Collaboration with WakeMed Pediatric Endocrine on high-risk pediatric diabetic patients

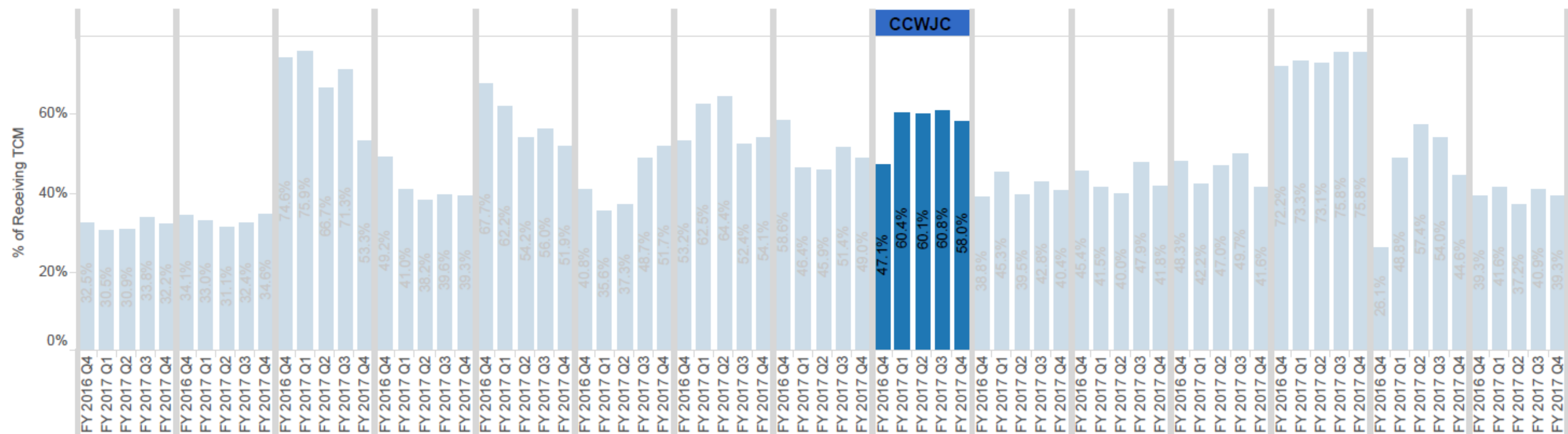
So, how are we doing?

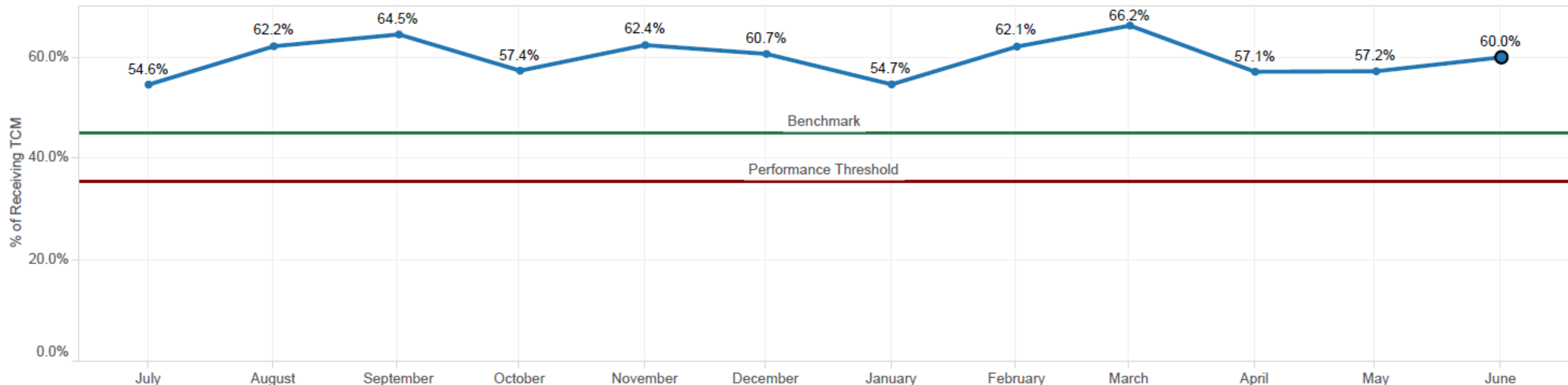
DMA Dashboard- Transitional Care Management Year Ending 6/30/2017 (FY 2017 Qtr. 4)

N3CN Quarterly Report
Year Ending 6/30/2017
Primary Care Case Management

Please click on a network abbreviation to drill to that network's data.
Graph initially shows state-wide rates.

Current Statewide Benchmark
% Receiving Transitional Care Management: **45%**





DMA Dashboards

- Current dashboards used to guide performance and maintain our DMA contract
- CCNC shares dashboard data with DMA quarterly at the organizational level
- CCNC shares network specific dashboards for individual network analysis
- Analysis shared with staff

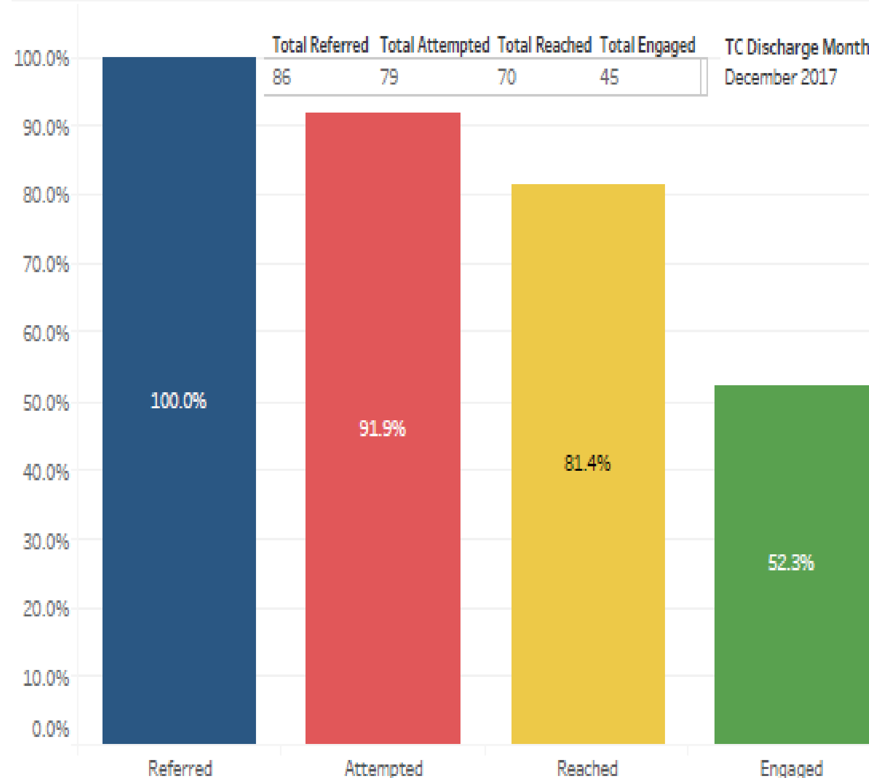
Patient Engagement Dashboards-1st Steps towards Care Management Optimization

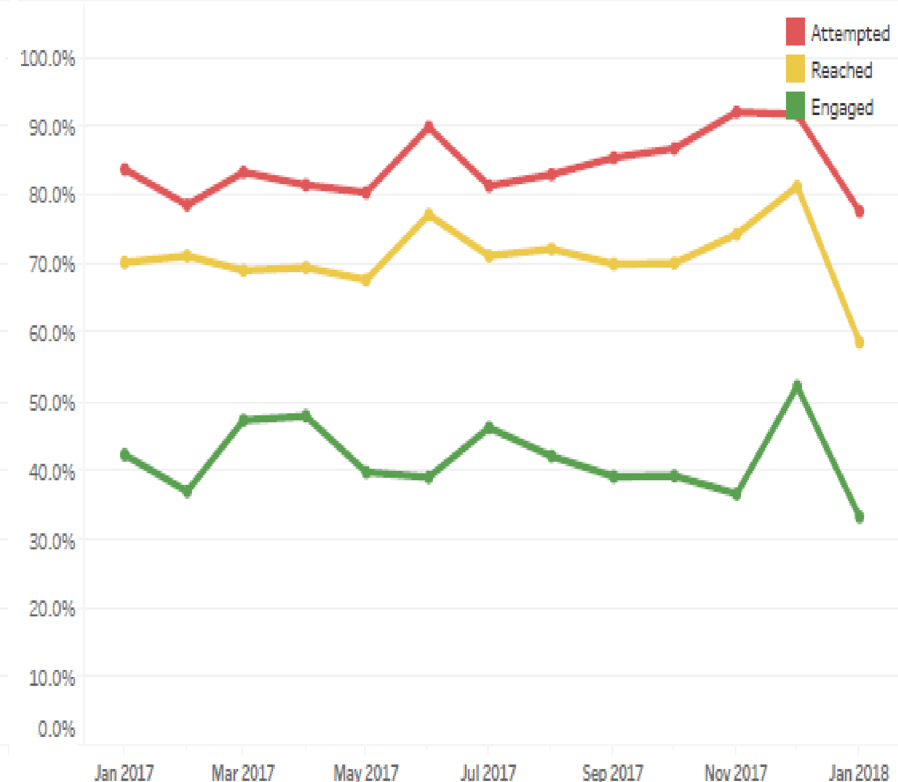
- A tangible product intended to:
  - Equip leadership and staff with necessary information to evaluate and improve organizational, network and individual performance
  - Enhance the organization's ability to obtain contracts and meet the expectations of future customers
  - Provide an automated strategy to drive performance and real-time accountability
  - Focus on Complex CM Priority populations
  - Display attempted, reached, and engaged rates for priority populations over time
  - Offers practical way to identify where patients may fall off and pinpoints areas to improve processes
  - Provide real time list of patients which can be used to prioritize interventions
  - Available to CM Leadership via Care Impact Platform

Patient Engagement Dashboards for NEW TC Priority Discharges (ADT only)

New TC Priority Discharges

Network
All





Opportunities to Improve Patient Engagement

- Enhance staff knowledge, skills, and confidence using engagement techniques and tools
  - January 2018 held Patient Engagement training
    - Identified barriers to engagement and strategies to overcome them
    - Recognized the complexity of a lot of "quarterbacks" involved- Home Health, BH, Hospital CM, etc.
    - Tips on good customer service and Patient Satisfaction
- Engage Staff in identifying trends and areas of improvement for engagement
  - Continue to socialize and bring awareness of Pt. Engagement Dashboards, deferral rates
  - Solicit and share success stories at team meetings; Focus groups to assist with training and engagement of other staff
- Collaboration and Care Coordination with our Hospitals and Clinics- Opportunities to discuss High Utilizers

Questions?

Thank you!

For additional information please contact:

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