A Statewide Transitional Care Program for Medicaid Recipients

Community Care of North Carolina

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BACKGROUND

Community Care of North Carolina (CCNC) is 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.

CCNC is comprised of 14 regional networks, supporting >1.4 million Medicaid beneficiaries and >1,800 primary care practices statewide, to assure patient access to a primary care medical home and community-level infrastructure for care coordination and quality improvement support.

OBJECTIVES AND TARGET POPULATION

The goal of this program was to improve care transitions for NC Medicaid recipients discharged to home after hospitalization. Primary objectives:

- ✓ Improve patient outcomes and patient experience
- ✓ Reduce hospital readmissions
- ✓ Reduce Medicaid spending

When the initiative was first launched in 2008, the target population was 128,000 Medicaid aged, blind, or disabled enrollees.

By 2010, the focus had shifted to include all **Medicaid recipients with multiple chronic conditions**, regardless of eligibility category. This population was similar in size, but accounted for a larger proportion (>85%) of hospital readmissions.

INTERVENTION

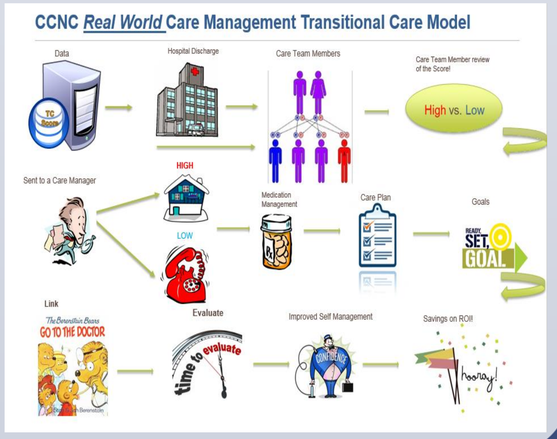
Key components of the CCNC Transitional Care Model:

Information Systems

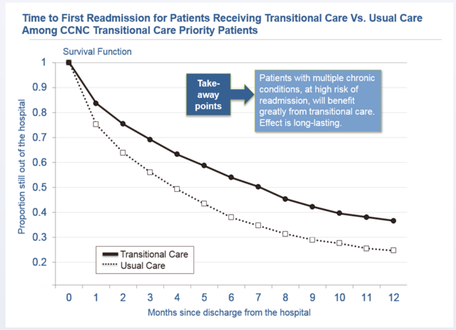
- ✓ Establishing real-time data notification when Medicaid patients are admitted to the hospital
- ✓ Use of historical claims data to flag patients at risk (initially based on disease burden, number of medications, and utilization history)
- ✓ Care Management Information System and PharmaceHome medication management platform used statewide.

Local Care Team

- ✓ Timely, face-to-face follow-up after hospital discharge
- ✓ Comprehensive medication management
- ✓ Patient and family education; self-management support; individualized care plan
- ✓ Multidisciplinary care team approach with collaboration among nurse care managers, network pharmacists, behavioral health coordinators, palliative care coordinators, and other disciplines (SW, RD) as needed
- ✓ Coordinated linkage back to community services and the primary care medical home



EARLY LEARNINGS

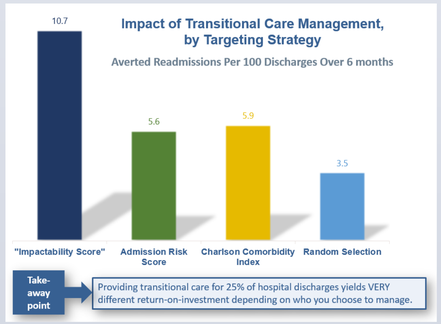


- ✓ Transitional Care support reduced readmissions by 20% among patients with multiple chronic conditions; with sustained effects. For every 6 patients, one readmission was averted over the coming year. (NNT=6)
- ✓ The impact varied across the population: For highest risk patients, the NNT=3; for low risk patients, NNT=133.
- ✓ Home visits reduced odds of hospital readmissions by approximately half compared to less intensive forms transitional care support, but certain patients are much more likely to benefit than others.
- ✓ Securing early follow-up appointments for certain higher risk patients decreased readmission rates by up to 20 percent; but a majority of patients did not benefit meaningfully from early outpatient follow-up

REFINEMENT OF THE MODEL

CCNC operationalized these learnings into the creation of a "Transitional Care Impactability Score,™" which predicts achievable savings through transitional care. When compared to more common targeting strategies, this approach yields nearly twice as much savings.

Additional indicators drive care team interventions related to medication management, home visits, palliative care, involvement of behavioral health or chronic pain expertise, and the urgency of outpatient follow-up.



'Right-sizing' our Interventions to Maximize ROI

TC Intervention	TC Impactability Score Criteria	Equivalent Savings Estimate Per Patient
High-Intensity	500-1,000	$3,000 - $6,000
Low-Intensity	200-499	$1,200 - $2,999

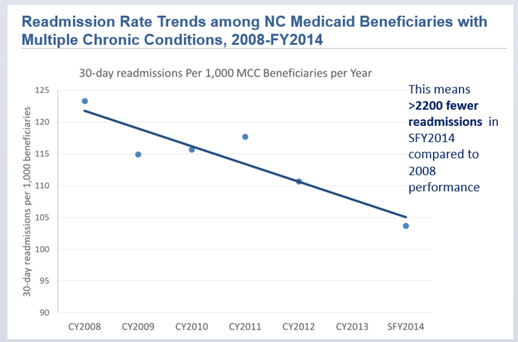
- **High-Intensity Transitional Care:**
  - Home visit
  - Comprehensive medication review
  - Outpatient follow-up within 7 days
  - End-of-life planning (if high predicted mortality risk)
  - Individualized Care Plan
- **Low-Intensity Transitional Care:**
  - Telephonic or face-to-face contact without home visit
  - Medication reconciliation
  - Outpatient follow-up within recommended time-frame
  - Individualized Care Plan

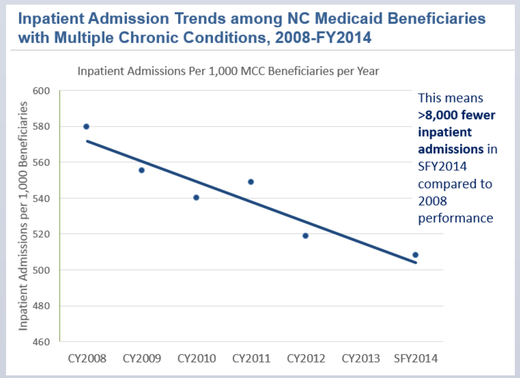
TODAY

- ✓ 87 hospitals, representing 80% of NC Medicaid admissions, provide real-time notification of admissions, discharges, and transfers.
- ✓ Every Medicaid recipient is assigned a "Transitional Care Impactability Score" as a first-pass screening mechanism to optimize resource allocation.
- ✓ CCNC provides transitional care support to >2,600 Medicaid recipients every month. Approximately 1/3 of those receive high intensity support including a home visit.
- ✓ Care Management processes designed to maximize efficiencies and effectiveness have been standardized across the state. All CCNC networks achieved NCQA intensive case management accreditation in 2015.

OUTCOMES

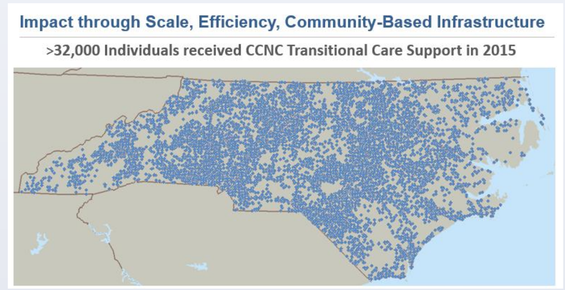
- ✓ Among NC Medicaid beneficiaries with multiple chronic or catastrophic conditions, readmission rates and overall inpatient utilization rates have fallen by 16% and 10%, respectively, since the program began in 2008.





OUTCOMES, cont.

- ✓ A 2015 evaluation commissioned by the NC Office of the State Auditor concluded that CCNC's overall management model has yielded a 9 percent reduction in total Medicaid costs ($312 per member per year), with much of that savings driven by a reduction in inpatient utilization.
- ✓ Improvements in targeting strategies, data systems, and care team processes have led to an increase in numbers of patients served year-over-year, despite state budget cuts.



REFERENCES

Jackson, CT., DuBard, CA. (October 2015). *Identifying Highest Yield Transitional Care Opportunities*. CCNC Data Brief, No. 5, Community Care of North Carolina, Inc.: Raleigh, NC.

Jackson et al. Incremental Benefit of a Home Visit Following Discharge for Patients with Multiple Chronic Conditions Receiving Transitional Care. *Population Health Management*. 2015 Oct.

DuBard et al. Conflicting Readmission Rate Trends in a High Risk Population: Implications for Performance Measurement. *Population Health Management.* Oct 2015, 18(5)

Jackson et al. Readmission Patterns and Effectiveness of Transitional Care Among Medicaid Patients with Schizophrenia and Medical Comorbidity. *NC Med Journal.* 2015 Sept; 76(4)

Jackson et al. Timeliness of Outpatient Follow-up: an Evidence Based Approach for Post-Discharge Planning. *Annals of Family Medicine.* March/April 2015

Jackson et al. Transitional Care Cut Hospital Readmissions For North Carolina Medicaid Patients With Complex Chronic Conditions. *Health Affairs*. 2013(32)

DuBard et al. Collaborative Accountability for Care Transitions: the Community Care of North Carolina Transitions Program. *NC Med Journal*. 2012 Jan-Feb

ACKNOWLEDGEMENTS

Jennifer Cockerham, RN, BSN, CDE
Sherry Hedrick, RN, BSN, MPH
Carlos Jackson, PhD
Barbara Matthews, RN, BSN, MBA, CMAC
Trista Pfeiffenberger, PharmD, MS
Troy Trygstad, PharmD, PhD, MBA
Avera White, RN, MSN, CCM
Ginger Wilder, RN, BSN, CCM
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