Northwest Triad Community Alliance
The Carolinas Center for Medical Excellence
(North Carolina)
Community Partners

- Pamela Duncan, PhD, FAPTA, FAHA
- Lynn Watkins, PT, MSPT
- Melissa Smith, BA
- Ron Gaskins, MBA, MPA
- Jeff Williamson, MD, MHS
- Karen Southard, MHA, RN
- Eleanor Everett, LCSW, MSW
Northwest Triad of North Carolina

Community Data
- FFS Beneficiaries: 46,720
- Readmission Rates:
  - All Cause: 18.5%
  - AMI: 18.4%
  - HF: 27.7%
  - PNE: 19.4%
Improving Care Transitions and Reducing Hospital Readmissions In Collaboration With the Stitch Center on Aging and Community Partners
Hospital to Home Program for Older Adults

Bridging the existing gap between the medical and social models

Established 2009
30-Day All Cause Readmissions for Individual Patients

3 Year Individual Readmission Rate Within 30 Days: 12.1%

www.ccmemedicare.org
30-Day Readmission Rate for Hospital to Home Program

3 Year Average: 4.7%
Cost Savings

• Average cost per case when readmitted within 30 days: $9,600 (Medicare estimate per avoided hospitalization used for CCTP application)

• Using 2011 results showing a 11.9 percent 30-day readmission rate among participants, this program provided Medicare savings of $3.7 million over three years.
Person-Centered Hospital Discharge Model Planning Grant 2009

- Provided CMS funding through NC DHHS
- Senior Services was one of three pilot sites in NC to receive funding
- Senior Services and Richard Gottlieb lead initial effort to develop hospital and community partnerships and began dialogues and processes
Community Care of North Carolina

• **Mission:** To provide “care that is patient-focused, doctor-driven, community-based, and cost-effective.”

• **Goals:**
  – Improve the care of the *Medicaid* population while controlling costs.
  – Provide a “medical home” for patients, emphasizing primary care.
  – Create community networks capable of managing recipient care.
  – Build local systems that improve management of chronic illness in both rural and urban settings.
Bringing Together Competing Constituencies to Improve Care Transitions: Which Physicians Can Help?

1. Seek out a physician who values interprofessional teams
2. Critical understanding of comorbidity, Medicare, and systems of care
3. A physician’s expertise and leadership without always having to be THE expert or THE leader
4. Examples: Geriatricians (rare), some general internists, some family practitioners
Northwest Triad Community

FFS Population vs. Readmission Rates

Variation in 30-day readmission rate by ZIP code region
## Focus Group Surveys: Identified Drivers for Readmissions

<table>
<thead>
<tr>
<th>Drivers</th>
<th>Percent of Comments</th>
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<tbody>
<tr>
<td>Communication Across Providers/Settings</td>
<td>35%</td>
</tr>
<tr>
<td>Medication/Medication Reconciliation</td>
<td>35%</td>
</tr>
<tr>
<td>Patient Education/Health Literacy</td>
<td>32%</td>
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<tr>
<td>Financial Issues</td>
<td>25%</td>
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<tr>
<td>Social/Family Issues</td>
<td>21%</td>
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<tr>
<td>Physician Follow-up</td>
<td>21%</td>
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<tr>
<td>Lack of Community Resources</td>
<td>15%</td>
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Application Process Organizational Structure

Executive Steering Committee
Pam Duncan, Lynn Watkins, Karen Southard, Sabrena Lea, Robin Modica

Writing Team

Data Analysis Team

Model Team

Evaluation Team

Financial Model Team

Community Implementation Team
Social Networking Analysis

≥ 30 Transitions
Committees Work

- Committees began meeting right away
- Model team the largest with active weekly participation by multiple partners
  - Shared leadership
  - Dialogue and contributions by all
  - Considered RCA results
  - Outcome was our innovative model design which is leading our community partnership now towards expanded, re-engineered care
An Innovative Model of Team Components

Core Values:
Patient Centered,
Trust building,
Community Engagement

www.ccmemedicare.org
Login name: clcyoungblood  
Password:  
CMIS Passport: B2 A2 A1 G3  
If you don't have CMIS Passport, leave the CMIS Passport fields blank. Passport fields are case sensitive. If * is displayed in CMIS Passport fields, it means your passport is saved.  
Remember my Passport on this computer  
Login to CMIS  
Forgot your password?  

Community Care of North Carolina  
Case Management Information System, CMIS, is a secure web application intended for the users of participating CCNC Networks. It integrates components of the CCNC Standardized Plan with accepted care management processes, allowing care managers to build and work with a patient-centric, comprehensive care plan. This system is managed and developed by the Informatics Center of NCCCN, Inc.  
If you are not a user please refrain from attempting to log in to the application.  
Information about Community Care of North Carolina or CMIS can be obtained from 919-745-2425 or awhite@nccn.org. For technical information or support contact 877-850-3766 or CMISsupport@nccn.org.  
Please disable any pop up blockers in your browser. This application is designed to work best with a minimum screen resolution of 1024 x 768 and Internet Explorer version 6.x or higher.  

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Referral Tracking

Sample: HealthNet Referral Tool

Documents referral in Patient’s Task Notes
Reporting

- Built-in Reports
- Ad Hoc Reporting Capabilities
Wake Forest Geriatrics Nursing Home (and Home Health) Outreach

An Example of Improving Care Transitions

1. Personal visits to the nursing and medical director by the geriatrician leader

2. Commitment from hospitals to extend transitional care team “beyond the curb” through:
   - Team interface with NH (and HHA)
   - Post-discharge on-call “response team” available to the NH and familiar w/patient

3. Commitment from NH, HHA providers to:
   - Work with hospital teams to reduce readmission
   - Staff adequately
   - Learn function-based approach to providing care
**Inputs**

- Strong partnership between the hospitals and the community services.
- Senior Services is one of the best organized and funded in the state.
- Previous experience with care transitions model (Hospital to Home).
- Engaged case management team at both hospitals.
- IT infrastructure to develop communication portal exists in the community.

**Outputs**

<table>
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<tr>
<th>Interventions</th>
<th>Processes (implementation, participation)</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital to Home Bridge Program for all hospitals</td>
<td>Rate of eligible patients screened, offered, accepted and completed H2H program (track monthly)</td>
<td>Short- and medium-term outcomes (proximal, intermediary)</td>
</tr>
<tr>
<td>BOOST for High Readmission Hospital, PDSA and then roll out to all hospitals</td>
<td>Number of FFS patients screened for readmission risk and referred to H2H (track monthly)</td>
<td>Long-term outcomes (system-level, utilization)</td>
</tr>
<tr>
<td>Medication Reconciliation at every hand off (standardize check list)</td>
<td>Number of FFS patient discharge checklist completed and sent to care navigator (track monthly)</td>
<td>Demonstrate a positive trend in the number of patients accepted to the care transitions program (track monthly)</td>
</tr>
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<td>ADRC Coordinator at Senior Services to provide options counseling and coordinate discharge services.</td>
<td>Number of patients who have documented medication reconciliation on first home visit (tracked monthly)</td>
<td>Decrease in FFS readmissions by 20% among patients</td>
</tr>
<tr>
<td>Enhance existing community case management web based portal in order to access client information at any time, any point in the care.</td>
<td>Waiting time till service activated per month.</td>
<td>Demonstrate a decrease in the number of patients who are readmitted within 30 days due to an ADE</td>
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<td></td>
<td>Number of times client information is not able to be accessed during care delivery (track monthly)</td>
<td>Demonstrate downward trend in the waiting list for meals on wheels and transportation</td>
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Quality Improvement Organizations

Sharing Knowledge, Improving Health Care.

Centers for Medicare & Medicaid Services

www.ccmemedicare.org
Root Cause Analysis Data Report
Northwest Triad Coalition for Improved Care Transitions

Best Practices
Community SWOT Exercise

Facilitator to Mediator
Lessons Learned

Northwest Triad Community Alliance’s Mission:
Evaluate and improve strategic partnerships to establish a sustainable care transitions program that integrates health care systems with community resources to improve care, health, and reduce costs

Partners:
Hospitals, Community Organizations, Providers, Hospice and Palliative Care, Nursing Homes, Home Health, Medicare Beneficiaries, Northwest Community Care Network, Department of Public Health, Senior Services, Area Agency on Aging, etc.
Mend with Friends

In July 2011, Senior Services received a $50,000 Wal-Mart Foundation /Meals-On-Wheels Association of America Grant to provide rapid nutrition and support services to patients being discharged from local hospitals.