

Improving Quality Through Transitions of Care

Ron Gaskins, Deputy Network Director
Northwest Community Care Network
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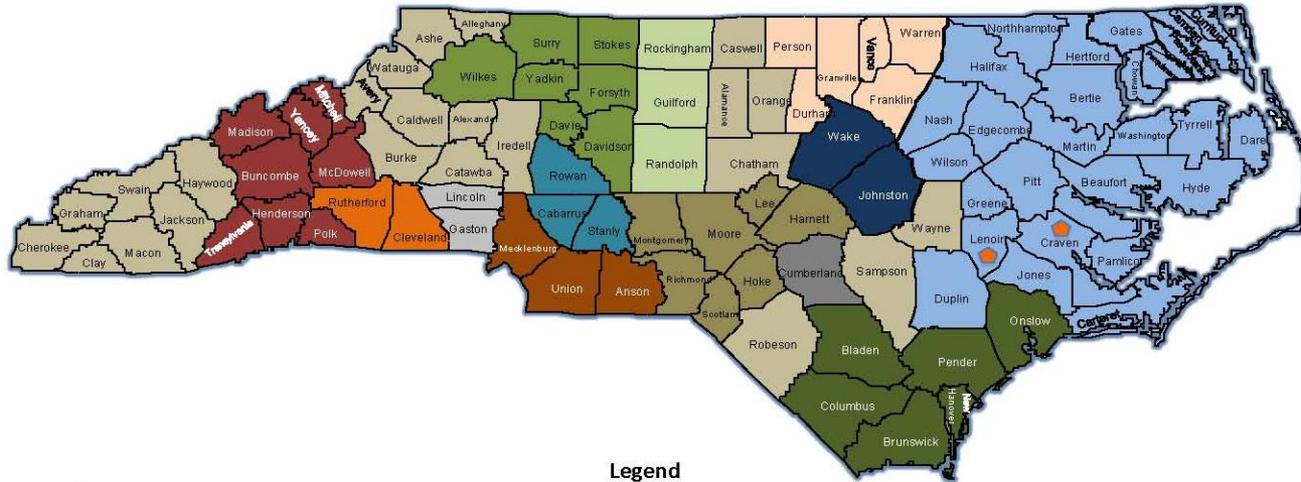
Health Reform

- Affordable Care Act (ACA) is redefining the payment delivery system
 - Fee for service towards fee for value
 - Shared savings, episode based payments, pay for performance
- Accountable Care Organizations (ACO's)
 - Providers who come together voluntarily to give coordinated care to their patients
 - Medicare, Commercial Payers, Medicaid
- Incentivizing for Quality
 - Hospital Value-Based Purchasing Program, Hospital Readmissions Reduction Program
- Financial sustainability requires an organized set of interventions post discharge
 - Transitions of Care

Northwest Community Care Network (NCCN)

- 1 of 14 Networks representing Community Care of North Carolina (CCNC)
- Not-for-profit locally led provider network promoting the “Medical Home” concept
 - Increase access
 - Improve quality
 - Reduce unnecessary expenditures
- Forsyth, Davie, Stokes, Surry, Yadkin, Davidson and Wilkes
- 150 primary care practices & 120,000 Medicaid recipients enrolled
- Targets the high risk patient through resource intense population health strategies

CCNC Networks



- Legend**
- ◆ AccessCare Network Sites
 - AccessCare Network Counties
 - Community Care of Western North Carolina
 - Community Care of the Lower Cape Fear
 - Carolina Collaborative Community Care
 - Community Care of Wake and Johnston Counties
 - Community Care Partners of Greater Mecklenburg
 - Carolina Community Health Partnership
 - Community Care Plan of Eastern Carolina
 - Community Health Partners
 - Northern Piedmont Community Care
 - Northwest Community Care
 - Partnership for Community Care
 - Community Care of the Sandhills
 - Community Care of Southern Piedmont

NCCN Transitional Care

- Implemented in 2008
- Supports Medicaid recipients from hospital to the community
 - Dedicated care manager
 - Centralized web based documentation system (CMIS)
 - Comprehensive medication management
 - Face-to-face self-management education for patients
 - Families timely outpatient follow-up with an informed medical home
 - Data support from robust Informatics Center (e.g. Pharmacy Home, Reports)
- Risk adjusted methodology identifies impactable patients

Child Health Accountable Care Collaborative (CHACC)

- CCNC awarded a 3 year \$9.3 million grant from the CMS Innovations Center
- Improve care for Medicaid children with complex medical conditions between hospitals, primary care providers, and subspecialists
- Built on the CCNC medical neighborhood infrastructure
 - Hospitals (5 academic and 7 tertiary)
 - Primary care
 - Transitional care
 - CMIS
- Projected cost savings of \$24 million

Community-based Care Transitions Program (CCTP)

- Created by Section 3026 of the Affordable Care Act
- Test models of care for improving transitions for high-risk Medicare fee-for-service beneficiaries.
- \$500 million (2011-15) to improve communication between hospitals and community based organizations that will
 - improve care coordination
 - enhance quality for patients
 - reduce avoidable readmissions
- 102 organizations across the country participating as CCTP sites

Actively Navigating Care at Home to Overcome Readmissions (A.N.C.H.O.R)

- Awarded on May 4th, 2012
- Mission: create a sustainable care transitions program that partners our local community-based organizations with our entire healthcare system to reduce hospital readmissions, improve health and reduce costs.
- Northwest Community Care Network will act as the lead CBO
- 2 year project with years 3, 4, & 5 possible if performance targets are met
- Critical performance target....20% reduction in 30-day readmission rates



- October 8th 2012 start date
- Covering Forsyth, Davidson, and Surry counties
- Consortium of community partners:
 - *Northwest Community Care Network, Wake Forest Baptist Health, Forsyth Medical Center, Thomasville Medical Center, Lexington Medical Center, Medical Park Hospital, Hugh Chatham Memorial Hospital, Northern Hospital of Surry County, Kernersville Medical Center, Senior Services of Winston Salem, Davidson County Senior Services, Surry County Senior Services, Piedmont Triad Area Agency on Aging, Gentiva, Advanced Home Care, Right-at-Home Winston Salem*



- Enrolled over 600 patients
- Primary diagnosis of Heart Failure, Pneumonia, Heart Attack, COPD, Diabetes
- 3 Central Components:
 - Transitional Navigators
 - In-Home Care Services
 - ADRC Coordinator at Senior Services
- As of July 2012, 5% reduction in 30 day all cause all hospital readmissions
- Goal of 104 averted readmissions at an annual savings of \$1 million dollars



Questions?

Ron Gaskins, Deputy Network Director

regaskin@nwcommunitycare.org

336-716-8106

www.nwcommunitycare.org

