Managing High-Risk Patients: Community Care Team Outcomes

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Managing High Risk Patients: Community Care Team (CCT) Transition of Care Call Outcomes

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MISSION - *"Promote health behavior change in the community by providing comprehensive integrated care to support primary care practices and address physical, socioeconomic and psychosocial needs of high risk population identified through use of a risk stratification model."*

Background

Triple Aim: Better health for populations. Better care of individuals. Better Cost.

Lehigh Valley Health Network implemented a multifactorial model of care transitions as a vital strategy for improving quality and reducing costs, decreasing avoidable hospital admissions, readmissions and emergency department visits. Integral to the success of this care transition process was the implementation of **Community Care Teams (CCT).**

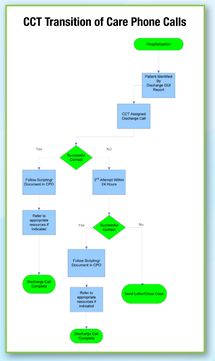
Goals

- Complete Transition of Care calls on CCT high-risk patients within 24-48 hours post discharge
- Encourage behavioral changes in patients
- Provide specialty support at patient's primary care practice
- Arrange for care with specialists
  - Nurse Care Manager
  - Social Services
  - Licensed Behavioral Health Specialist
  - Clinical Pharmacist

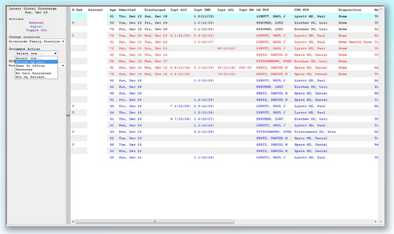
Process

Identifying "high risk" patients:

1. **Algorithm**
   - Concomitant chronic disease states; poly-pharmacy; abnormal clinical indicators



2. **Discharge Reconciliation Tool**
   - Ensures high risk patients are offered services they need
   - Allows practices to focus on the remainder of patients and work effectively with CCTs

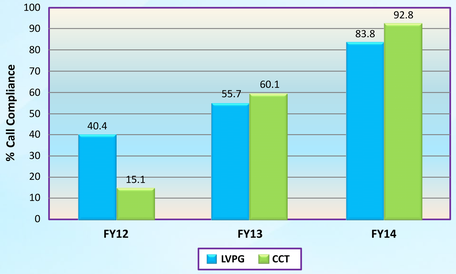


Outcomes

Reconciliation of CCT discharges results in decreased admissions, readmissions, and ER utilization of high risk patients in CCT practices.

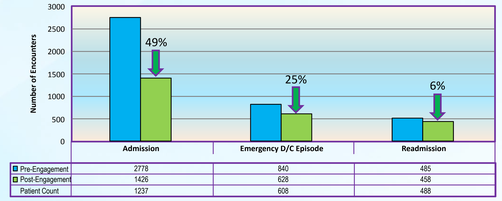
Transition of Care Call Compliance

CCT vs. LVPG



CCT Utilization Data

All Practices 6 Months Pre-Post Intervention
July 2012 - December 2014



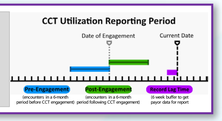
	Admission	Emergency D/C Episode	Readmission
Pre-Engagement	2778	840	485
Post-Engagement	1426	628	458
Patient Count	1237	608	488

CCT Reporting Data

The data used for this series includes patient encounters that meet ALL of the following conditions:

- CCT Engagement must occur after 01 January 2011
- Only patient encounters up to 6 months before CCT Engagement
- Only patient encounters up to 6 months after CCT Engagement

There is a sliding-window of 6 weeks (42 days) before the current date in which patient encounters are excluded from reporting. During this record lag time, payer data is being processed and attached to the patient record.



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1. Foltz, C., Lawrence, S., Biery, N., Gratz, N., Paxton, H. & Swavely, D. (2014). Supporting Primary Care Patient-Centered Medical Homes with Community Care Teams: Findings from a Pilot Study. *Journal of Clinical Outcomes Management, 21*(8).