

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

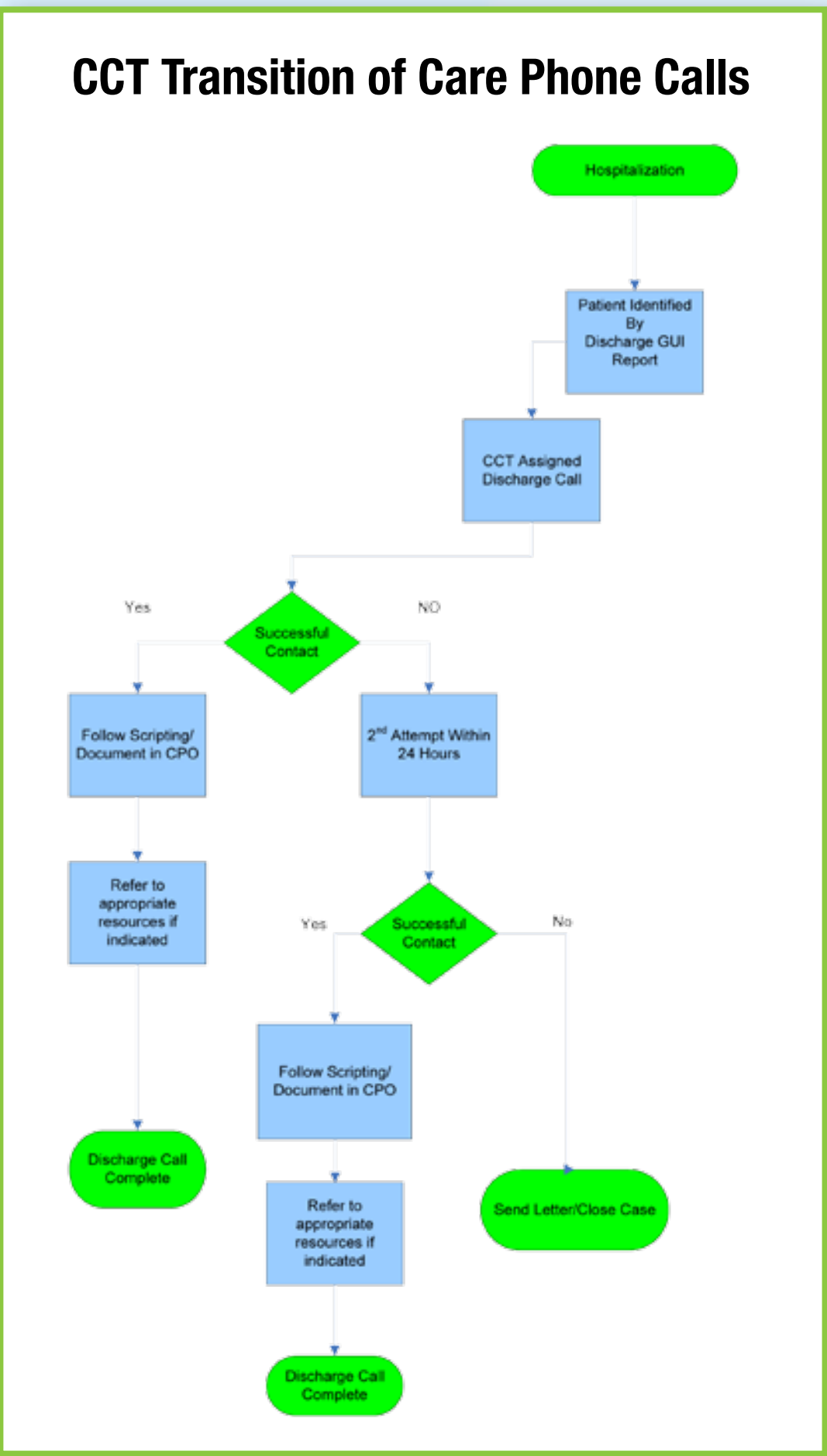
- Complete Transition of Care calls on CCT high-risk patients within 24-48 hours post discharge
- Encourage behavioral changes in patients
- Provide specialty support at patient's primary care practice
- Arrange for care with specialists
 - Nurse Care Manager
 - Social Services
 - Licensed Behavioral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

Process

Identifying “high risk” patients:

1. Algorithm

- Concomitant chronic disease states; poly-pharmacy; abnormal clinical indicators



2. Discharge Reconciliation Tool

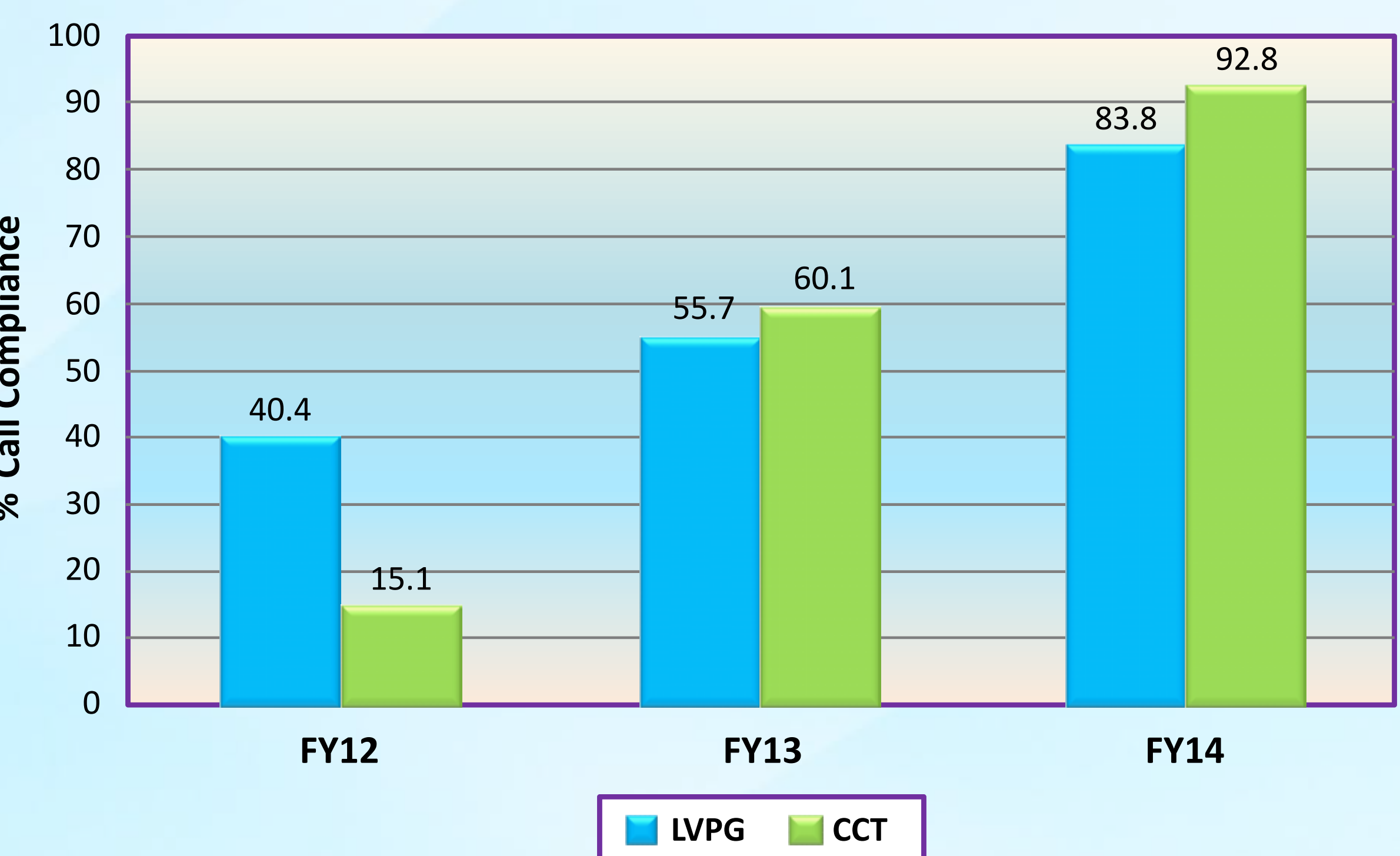
- Ensures high risk patients are offered services they need
- Allows practices to focus on the remainder of patients and work effectively with CCTs

Discharge	Admission	Age	Admission	Discharge Date	Discharge Time	Discharge Location	Discharge Status	CCT Assigned	CCT Assigned Date	CCT Assigned Time	CCT Assigned Location	CCT Assigned Status
1	1	1	1	1	1	1	1	1	1	1	1	1

Outcomes

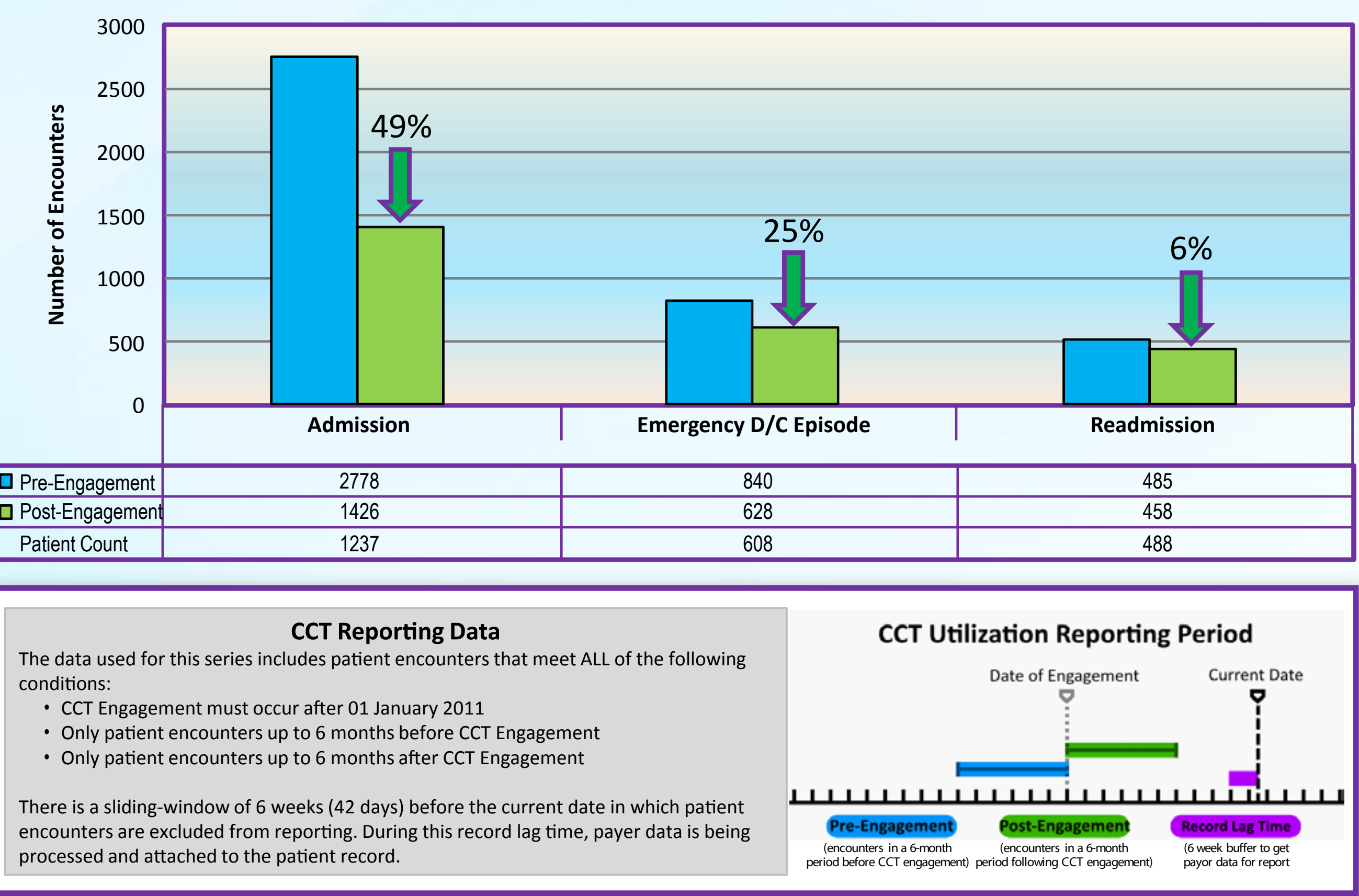
Reconciliation of CCT discharges results in decreased admissions, readmissions, and ER utilization of high risk patients in CCT practices.

Transition of Care Call Compliance CCT vs. LVPG



CCT Utilization Data

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



REFERENCES:

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).

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