Smart Transitions of Care: Fostering the Team that a Recovering Patient Needs

June 9, 2021
Rules of Engagement

• Audio for the webinar can be accessed in two ways:
  o Through the phone (*Please mute your computer speakers)
  o Or through your computer

• All hyperlinks on the screen are active if you click on them

• Q&A session will be held at the end of the presentation
  o Written questions are encouraged throughout the presentation
    • To submit a question, type it into the Chat Area and send it at any time during the presentation
Upcoming Team Training Events

Webinars
July 14, 2021 | 12:00 – 1:00 PM CT
Register here! “Transforming Care Through Age-Friendly Health Systems”

Online Community Platform
Join Mighty Network to access exclusive content and connect with your peers to share stories, tools, and content.

New: Advancing Care Conference
This brand-new interactive conference experience, that will use cutting-edge design thinking exercises, equip attendees with custom strategies and an actionable plan to tackle their challenges. Conference registration will opening soon! We hope to see you there. Check out our website for more information.
Today’s Presenter

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Smart Transitions of Care: Fostering the Team that a Recovering Patient Needs

Tricia Baird, MD, FAAFP, MBA
JUNE 9, 2021
Today’s Objectives

Participants will…

1. Understand the series of recovery behaviors that patients need to complete in transition from inpatient care to baseline health.

2. Recognize the signals patients give about whole-person needs – clinical + behavioral + social health.

3. Build an incremental program launch, able to refine the team structure and needs based on evolving understanding of the population being served.

4. Articulate differences in clinical care to support Fee-for-Service contracts versus Value-Based contracts.

5. List the unique challenges for patients without a primary medical home or a primary team that shifts due to acute illness.
Improve health, inspire hope and save lives™

31,000+ Team Members

$8.3 Billion Enterprise*

$542 Million Community Benefit*

$30 Million Philanthropy*

2,300 Volunteers

4,700 Physicians and Advanced Practice Providers (Spectrum Health employed and independent)

14 Hospitals

150 Ambulatory Sites

219,000 Virtual Video Visits*

514,000+ Home Health Care Visits*

$100 Million Health Equity Funding (Over next 10 years)

$100 Million Venture Capital Fund

1 Million+ Members Served by our Health Plan

7,000+ Employers Contracted by Priority Health

97% Michigan Primary Care Doctors in Network

*Jan. 1–Dec. 31, 2020
Care Management: Who We Are

Care Coordination - 530 Staff Members Total

- Project Team and Utilization Management – 62 Staff Members
- Inpatient Care Management – 282 Staff Members
- Transition of Care Team *NEW* – 23 Staff Members
- Ambulatory Care Management – 163 Staff Members
Care Management: Our Journey
Risk Contract Attributed Patients

- BCBS Commercial
- BCBS Medicare Advantage
- West Michigan Accountable Care Organization: FFS Medicare
- Priority Health
Care Management Reengineering: Focus Areas

2020

Population Identification:
Who is at highest risk? How do we find them and provide the help needed?

Transitions of Care Coordination (TOCC) Design:
Who is focused on finding the patients who need help this week?

2021

Seamless Transitions of Care:
How do we build this care flow to work for every patient, every time?

Information Sharing / Communication:
How do we communicate with patients in the ways they need? How do we share needed information with all necessary care teams?

Engagement and Intervention:
What problem is the patient trying to solve? How do we partner in that solutioning?
Faster Discharge
How often does this happen?

High Risk Inpatients – 18%

Rising Risk Inpatients – 22%

Low Risk Inpatients – 60%
Patient Perspective:
All the teams who may call the patient after discharge

- ED Team (patient satisfaction scores)
- Registration Staff (Billing information)
- Primary Care Team (follow up visit)
- Inpatient Nursing Unit (HCAPS)
- Specialty Teams (follow up visits)
- Hospital Billing (payment arrangements)
- Payer Care Management (cost containment)
- Office-based Care Management (care coordination)
- Payer billing (payment of monthly premium, denial of care notices)
- Community Based Organizations (Social Determinants of Health issues)
- Home Care/Physical Therapy Follow-up
- Pharmacy (pick up medications)
Reality: Whole Person Coordination is Challenging

- Not all patients have a Primary Care Provider.
- Some patients will center to a Specialty Team as their medical home.
- Social Determinants of Health are a core part of Whole Person Coordination.
Working in silos causes everyone to compete for patient's time.
Work Together on Transition Plan: What problem are we trying to solve?
Goals for Transition Support

• **Timely** – Identify the patients who need help, when patients and their families are still trying to craft solutions.

• **Targeted** – Reach out to those who need help, in the format they desire.
  – Low Risk patients: texts, self-service, ability to self-escalate
  – Rising Risk: some outreach to queue key behaviors, but also support to activate their own plan and some reminders of key behaviors and key actions in their transition.
  – High Risk: whole person support, proactive outreach, team members including RN, MSW, CHW. One source of contact who never says, “That’s not my job,” rather, “I don’t know, let’s find out together.”

• **Actionable** – Working with people whose struggles are solvable.
Making a strong case to the recovering person that we are a valuable member of THEIR recovery team.
How do we efficiently and effectively address all the factors for health?

Social and Economic Factors (40%)
- Employment
- Food Insecurity
- Education
- Housing Instability
- Poverty

Health Behaviors (30%)
- Discrimination
- Loneliness
- Health Literacy
- Alcohol, Drug & Tobacco Use
- Diet & Exercise

Environmental Factors (10%)
- Quality of Housing
- Physical Environment

Clinical Care (20%)
- Access to Care
- Quality of Care
Top Transition Needs

- Transportation
- Medication
- Food
- Utilities
- Housing
- Disease Monitoring Equipment
IMPLEMENTING SIGNIFY HEALTH, A CLOSE-THE-LOOP SOLUTION THAT ALLOWS US TO SECURELY COMMUNICATE BETWEEN PROVIDERS AND CBOS TO FACILITATE INDIVIDUAL SOCIAL HEALTH SOLUTIONS.

IT IS SECURE AND ASYNCHRONOUS, ELIMINATING THE NEED FOR VOICEMAILS AND MISSED CONNECTIONS AMONG COLLABORATIVE TEAMS.

THE DATA IS COLLECTED IN A STRUCTURED FORMAT, ALLOWING US TO MAP HOTSPOTS OF NEED ACROSS PAYER POPULATIONS AND GEOGRAPHIC AREAS.
ED Visit Text Follow-up

Spectrum Health would like to check in after your ED visit. Click here to chat: https://clinic-staging.conversahealth.com/ll/Z07x7e5bqjCDg9T15m7o11UATvN53a1oh1P5MRM5544

**Provide**
- Provide automated virtual support after an ED visit
- Escalate to RN CM support as needed

**Reduce**
- Reduce avoidable ED return visits

**Identify**
- Proactively identify patients who have clinical or social determinant barriers that put them at risk of ED readmission or other care overutilization

**Help**
- Help patients feel connected to their care team to assist them in adhering to their follow up plans
Growing Partnerships

G.R.A.C.E. Network

(Gather Resources and Align Community Efforts)
Technology | The Gift and Challenge of Virtual Care
Patient Story
Patient Story
Patient Story
Summary

Understand the series of recovery behaviors that patients need to complete in transition from inpatient care to baseline health.

Recognize the signals patients give about whole-person needs – clinical + behavioral + social health.

Build an incremental program launch, able to refine the team structure and needs based on evolving understanding of the population being served.

Articulate differences in clinical care to support Fee-for-Service contracts versus Value-Based contracts.

List the unique challenges for patients without a primary medical home or a primary team that shifts due to acute illness.
Thank you
Questions? Stay in Touch!

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