AHA Team Training

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

June 9, 2021

American Hospital Association™
Advancing Health in America

AHA CENTER FOR HEALTH INNOVATION

Rules of Engagement

- **Audio for the webinar can be accessed in two ways:**
  - Through the phone (*Please mute your computer speakers)
  - 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**
  - 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.

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Today's Presenter

Tricia Baird, MD, FAAFP, MBA
VP, Care Coordination
Spectrum Health West Michigan

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

Tricia Baird, MD, FAAFP, MBA

JUNE 9, 2021

Spectrum Health

Today's Objectives

Participants will…

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**.

Improve health, inspire hope and save lives™

Spectrum Health

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

Priority Health

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

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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

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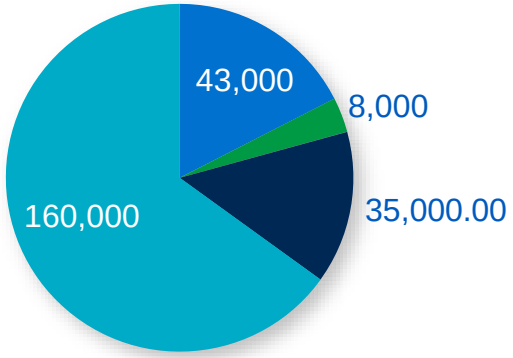
Care Management: Our Journey
Risk Contract Attributed Patients



Care Management Reengineering: Focus Areas

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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?

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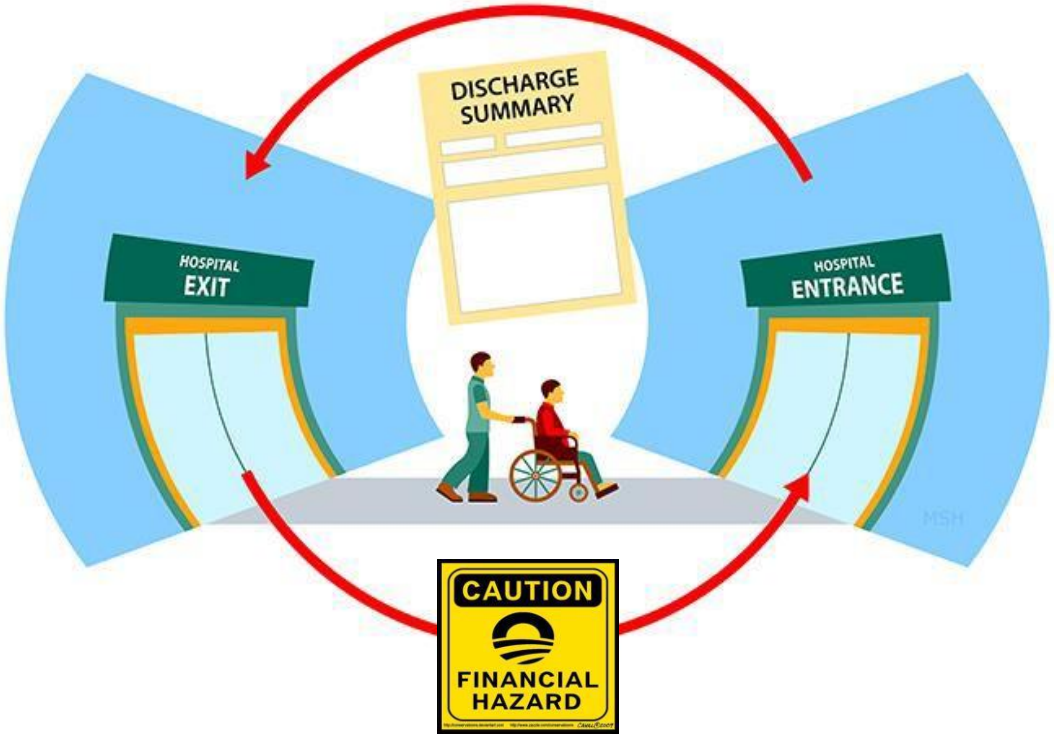
Faster Discharge



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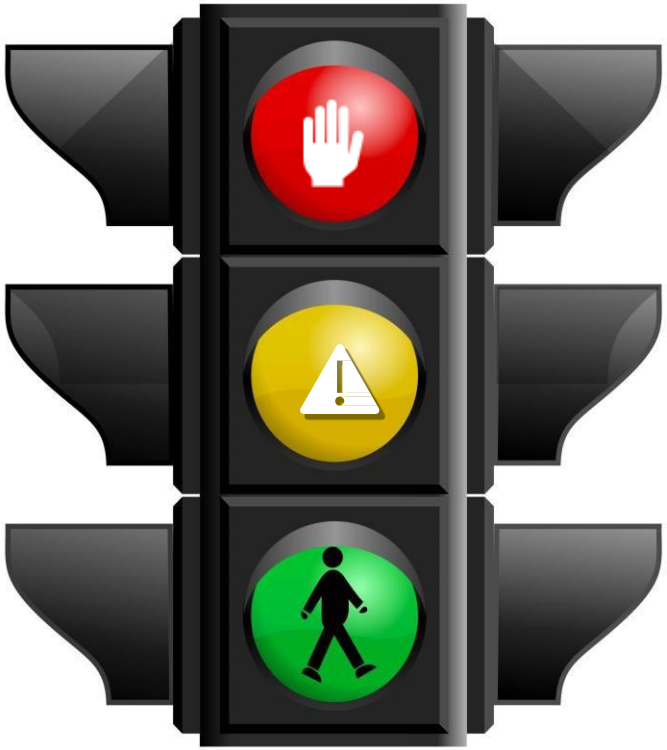
How often does this happen?

3x

2x

1x



High Risk Inpatients – 18%

Rising Risk Inpatients – 22%

Low Risk Inpatients – 60%

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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)

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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.

Competing for Patient's Time

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Working in silos causes everyone to compete for patient's time.

Work Together on Transition Plan: What problem are we trying to solve?

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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.

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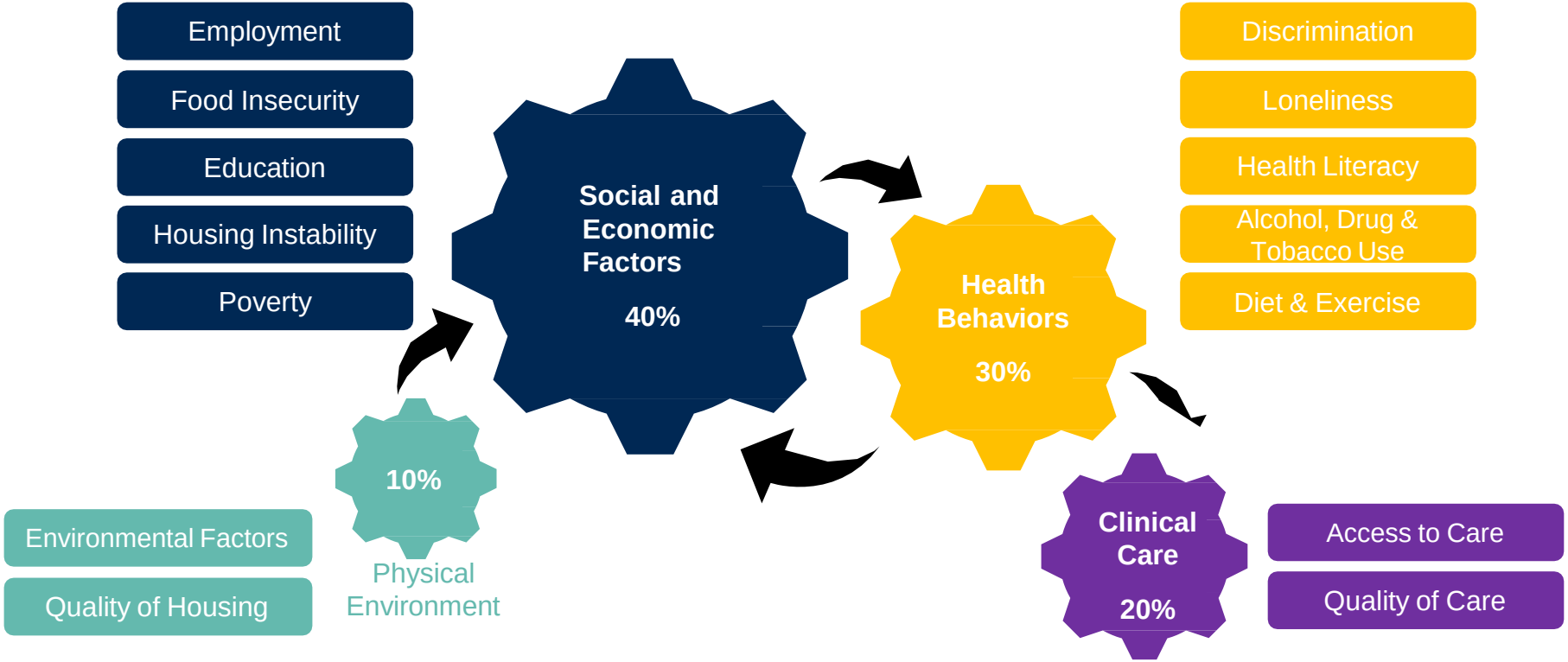
How do we efficiently and effectively address all the factors for health?



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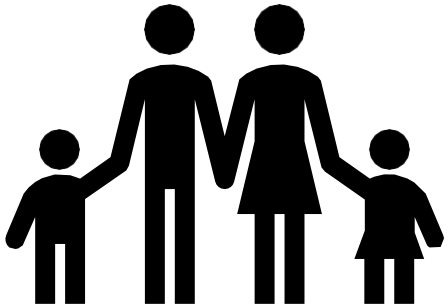
Top Transition Needs



- Transportation
- Medication
- Food
- Utilities
- Housing
- Disease Monitoring Equipment

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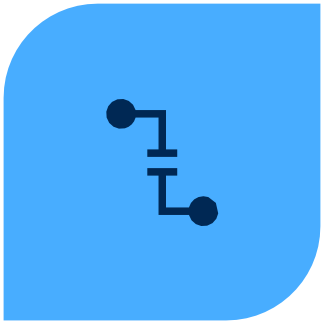
SDoH Platform

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.

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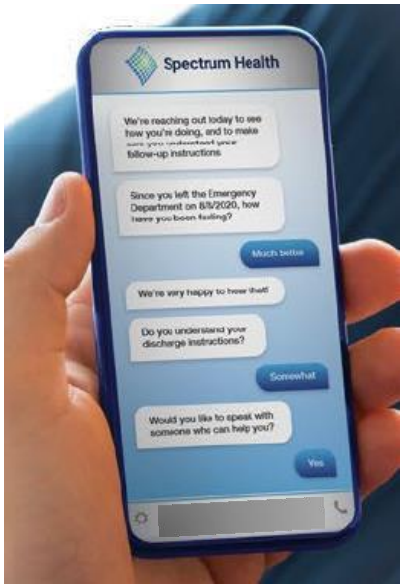
ED Visit Text Follow-up



Spectrum Health would like to check in after your ED visit. Click here to chat: https://clinic-staging.conversahealth.com/l/ZO7x7e5bqjCDg9Tt5m7o11UATyN53a1oh1P5MRM5544

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

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Growing Partnerships

truenorth community services

G.R.A.C.E. Network

(Gather Resources and Align Community Efforts)

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Technology | The Gift and Challenge of Virtual Care

Patient Story

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Patient Story

Patient Story

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Summary

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Thank you

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Questions? Stay in Touch!

www.aha.org/teamtraining

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