Trinity Health

Caring for our patients across the continuum

Trinity Health IHA Medical Group

Presented by: Caitlin Valley, MHA

Date: May 19th, 2023

Agenda

Who is Trinity Health IHA Medical Group?

What are Transitions of Care and Why are they Important?

Transitions of Care: A Team Based Care Approach

Post-Acute Care Collaboration

Caring for our patients across the continuum with an emphasis on utilization and health outcomes!

Trinity Health IHA Medical Group

Background & Overview:

- Formed in 1994, joined Trinity Health in 2010
- **Multispecialty medical group** with over **1,000** providers & over **2,200** support staff across **50+** specialties and **150+** locations
- Over **500,000** primary care and pediatric attributed lives.
- Committed to delivering **patient-centered care** with exceptional **quality**, **affordability** and **population health:** Achieved **#1** in the state in BCN Quality, 7 of the last 8 years.

Trinity Health Michigan

Our Trinity Health Michigan team includes:

20,400 Colleagues

6,000+ Physicians and Clinicians

who deliver exceptional, compassionate care with leading-edge technology to all members across Michigan at:

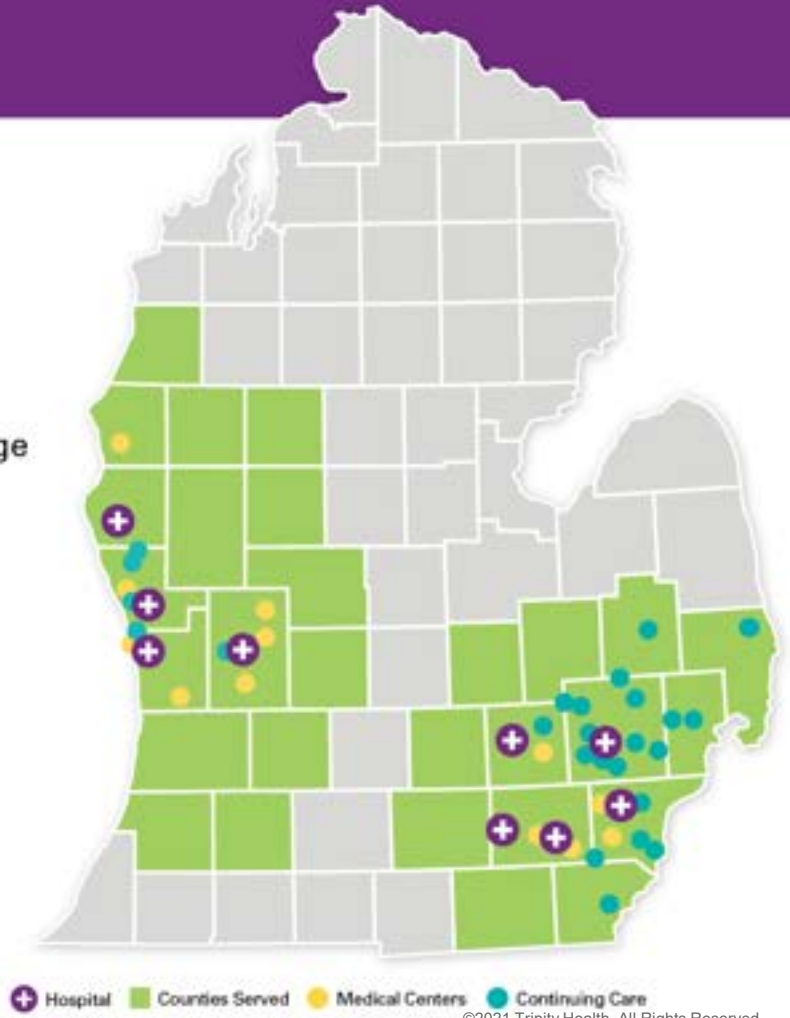
9 Acute Care Hospitals

25 Continuing Care Locations

23 Urgent Care Locations

13 Outpatient Medical Centers

Trinity Health



Our **Mission**

We, Trinity Health, serve together in the spirit of the Gospel as a **compassionate and transforming healing presence** within our communities.

Our **Vision**

As a mission-driven innovative health organization, we will become **the national leader in improving the health of our communities and each person we serve**. We will be the **most trusted health partner for life**.

Our **Core Values**

Reverence

Commitment to Those Who are Poor

Safety

Justice

Stewardship

Integrity

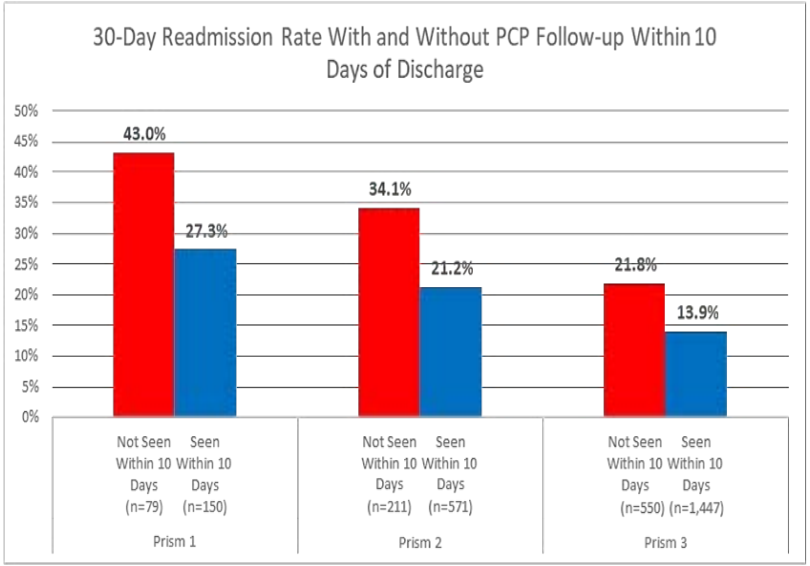
What are Transitions of Care and Why are they important?

Trinity Health

Background

- CMS defines **a transition of care (TOC)** as the movement of a patient from one setting to another.
- TOC increases the risk of adverse events.
- One of the key measures for TOC includes 30-day readmission rates.
- Reducing hospital readmissions is a national healthcare priority.
- Hospital readmissions are a major source of healthcare expenditures and are associated with poor outcomes*.
- Re-hospitalized patients use 60% of hospital's resources*.

We know that the largest contribution to readmission reduction was seen in the first 10 days of hospital discharge.



Risk Stratification

- Trinity Health IHA Medical Group utilizes the **Epic Risk of Admission or ED Visit** as the risk stratification tool for prioritizing care team interventions.
- The Epic Risk of Admission or ED Visit score is based on a cognitive computing model that:
  - Allows care managers and other clinicians to see which patients have the highest risk of visiting the ED or being admitted to the hospital before those patients end up there.
  - Integrated the model into regular workflows to identify and reach out to at-risk patients
  - Chronicles-based logistic regression model consisting of 18 features.
    - Demographics and General Information
    - Diagnosis
    - Utilization
  - High Risk = Scores greater than or equal to 40%
    - Approximately 5% of the population is high risk

Transitions of Care:
A Team Based Care Approach

Trinity Health

Transitions of Care

HOSPITAL DISCHARGE

Hospital colleagues discussing the importance of HFU appt and scheduling appt prior to discharge.

POST-DISCHARGE PHONE CALL

Reinforce discharge instructions, monitor current symptoms, completed post-discharge medication reconciliation.

HOSPITAL FOLLOW-UP VISIT

Seen by a Primary Care Provider within 10 days of hospital discharge.

CONTINUED MANAGEMENT

Continued weekly outreach for 4 weeks after discharge

Transitional Support Call Center

- Hospital Nurses making post-discharge follow-up phone calls typically between 2-5 days after hospital discharge.
- Call focuses on:
  - Discharge Instructions
  - Medication Compliance
  - DME/Supplies/Home Care
  - Scheduled Follow-up Appointment(s)
  - When to contact PCP or Specialist
  - Patient Experience with hospital stay

- Transition between hospital and primary care
- Connecting with Ambulatory Care Manger with on-going concerns.
- Connecting patients with PCP if they do not already have one or want to switch providers.

Transitional Care Management Interactive Outreach

- Care Team Navigator making post-discharge follow-up phone calls within 2 business days after hospital discharge for high-risk patients.
  - Schedule Follow-up appointment within 10 days of discharge. Triage if needed to be seen sooner.
    - Address any Transportation Issues
    - Address any barriers to attending HFU appointment
  - Review any new or worsening symptoms.
  - Medication reconciliation – current medications reconciled against the discharge list of medications.
    - Refer to Clinical Pharmacist for patients with 10 or more medications for a comprehensive medication review visit
  - Refer to Ambulatory Care Manager in PCP office for weekly follow up x4 weeks.

The Role of Social Determinants of Health in Transitions of Care

- SDOH account for up to 80% of health outcomes.
- Currently, we screen for Social Influencers of Health Needs (SIOH) at all Medicare Wellness visits, Physicals, and **TOC visits**.
- Provide confidential navigation and problem solving related to:
  - Difficulty paying bills
  - Childcare
  - Caring for family members
  - Placing loved ones in extended care
  - Transportation Difficulties
  - Other community resources

Comprehensive Medication Review

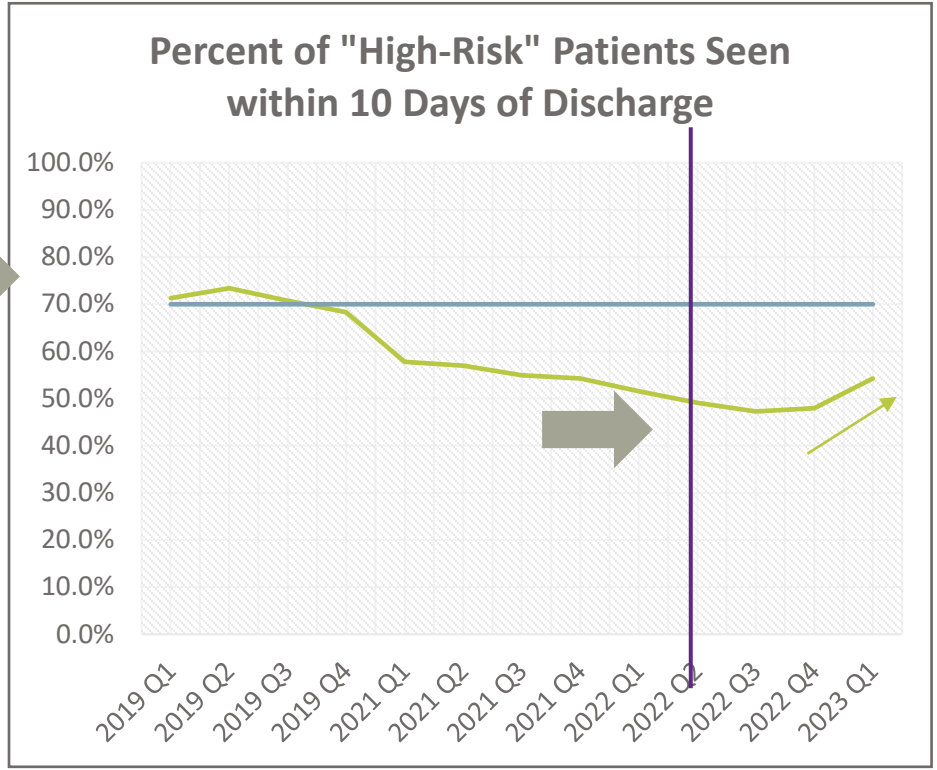
- Clinical Pharmacist calls/videos patient and completes a comprehensive medication review.
  - Critically evaluates drug therapy for safety, efficacy and evidence-based medicine practices.
  - Changes regimen made to improve medication therapies and disease state management.
  - Focus on avoiding or resolving drug interactions, optimizing or altering therapies, reducing pill burden and cost to patient, improving disease state management.

- 10 to 30% of hospital admissions and ED Visits are drug related[1]
- Post-discharge adverse drug events occur in up to 19% of patients[3].
  - At least one-third of these events are preventable
- Decrease in readmissions when pharmacists are involved in the TOC process.

1. Burton, J. Implementing a Successful Transitions Program While Avoiding Common Pitfalls. CJHP. January/February 2015. Pgs 7-14.
2. Jencks SF, et al. Rehospitalizations among patients in the Medicare program. N Engl J Med 2009;360(14):1418-28.
3. Spiegel B, et al. Cost-Effectiveness of Pharmacist Postdischarge Follow-Up to Prevent Medication-Related Admissions. J of Accountable Care 2018; 6(2): e1-e8.

Hospital Follow-up Appointments with PCP

- One primary focus for TH for reducing readmissions is increasing the proportion of patients with HFU appointments.
- Patients identified as high risk need to follow up with a Primary Care Provider within ten days of discharge.
  - PCP → APP → Other PCP
- Hospital follow-up rates have fluctuated greatly since the COVID-19 pandemic.



Barriers to Scheduling Hospital Follow-up Appointments

- Online Scheduling Options Not Available
- No Virtual Visits
- Transportation Issues
- Primary Care Access
- Copays or No Insurance
- Lack of education re: importance of HFU appt
- Pt has too many follow-up appts

Overcoming those barriers…

Patient Education

- Hospital colleagues discussing the importance of HFU appt and providing patient education

Transportation Resources

- Research and Collate transportation resources by region.
- Exploring contract with Lyft for Transportation

Creative Scheduling

- Telehealth services
- Shorter appointment length
- Developed Scheduling Guidelines to override certain blocks

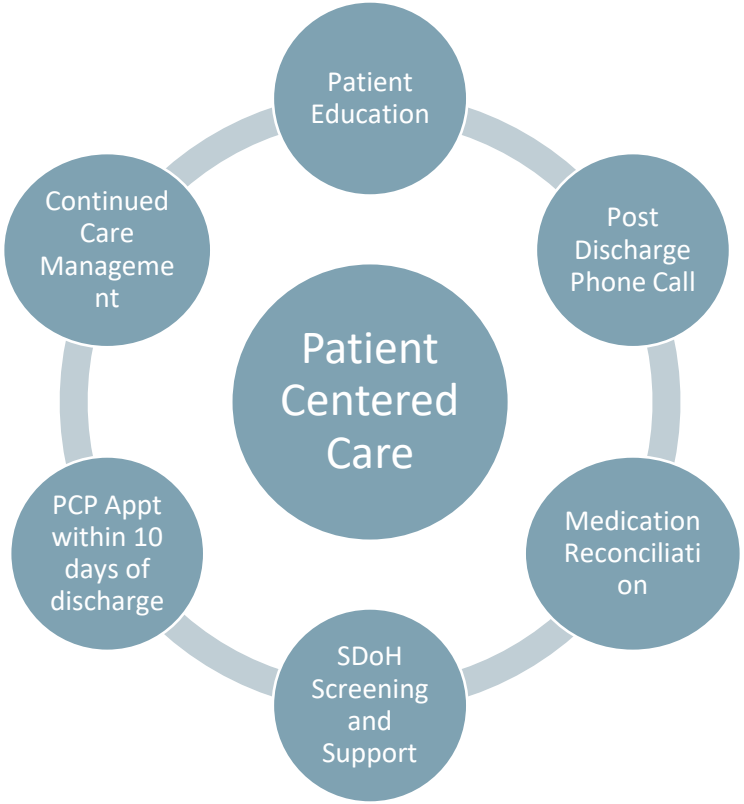
Our family caring for yours, at our house or yours.

Trinity Health
IHA Medical Group

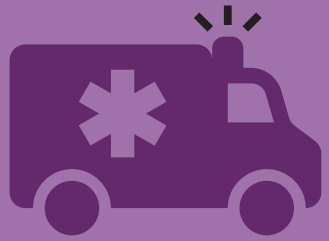
- Patients' chronic health issues may go unmanaged due to not being able to come to their provider's office.
- High-risk patients with barriers to coming into the practice are offered a Transitions of Care Home Visit.
  - Nurse Practitioner Visit covering:
    - Medication Reconciliation
    - Vital Signs
    - Review Discharge Instructions and Care Plan
    - Home Assessment – Family Support System, Safety, etc.
    - Order any follow-up labs, imaging, or diagnostic testing
    - Discuss Advanced Care Planning

Coordination Across the Continuum

- Effective coordination begins by ensuring collaboration between the hospital and ambulatory providers and clinicians.
- Educating patients and caregivers on key elements such as diagnosis and the importance of PCP follow-up.
- Multicomponent transitional care models demonstrate improved care quality and reduced utilization.
  - Lower 30-day readmissions
  - Lower 7-day ED visits
  - Improved patient satisfaction



Post-Acute Care Collaboration



Trinity Health

Post-Acute Care Transitional Care Management

- Post-Acute Transitional Care Manager is an integral member of the ambulatory care team.
- Provides complex care management for patients in post-acute setting.
- Currently following all MHP ACO patients discharged from Trinity Health Ann Arbor to Glacier Hills and Evangelical Home – Saline.
- Measuring Success:
  - 30-day Readmission Rates
  - Return to ED Rates
  - SNF Length of Stay
  - Patient Satisfaction
- Following patients from Hospital Discharge → SNF → Home
- Completing a thorough medication reconciliation

Collaboration with Post-Acute Care Partners

- Southeast Michigan Regional Post-Acute Care Collaborative
  - Hospital Partners, Medical Groups, Skilled Nursing Facilities, and Home Health Agencies
  - Trinity Health Skilled Nursing Facility Performance Network – local provider partners committed to providing the high-quality care.
    - Overall CMS Star Rating, Readmission Rate and Participating in Specialty Clinical Programs
  - Disease Management Programs
    - CHF, Sepsis, Stroke, COPD coming in 2023
  - First Fill Program
- Collaboration with Michigan Medicine Post-Acute Division
  - Addressing barriers for Trinity Health patients discharging to Skilled Nursing

Effective Discharge Communication

Redesigned Hospital Discharge Summary to provide needed information to continue care:

- Discharge Diagnosis
- Next site of care
- Code Status at Discharge
- Primary Care Physician
- Post Discharge Follow-up Instructions
  - Labs Pending
  - Incidental Findings
  - Follow-up items for PCP
  - Follow-up Appointments
- Discharge Medications

Trinity Health

IHA Medical Group

IHA Hospital Medicine

@HOSPITALLINE@

Admitting Provider	@ADMPROV@
Discharge Provider	@MD@
Primary Care Physician	@PCP@
Admission Date	@ADMTEXT@
Discharge Date	@TD@

Discharge Information

Discharge Diagnosis	@HPROBLACTRE1@
Discharge Destination	***
Code Status at discharge	@CODE@

Brief Hospital Course

***

Problem Oriented Hospital Course

***

Post-Discharge Follow-Up

Labs pending at discharge:
@DCPENDLAB@

Incidental findings:
***

Follow-up items for PCP:
***

Appointments:
@DCFOLLOWUP@

Discharge Medications

@DCMEDSLIST@

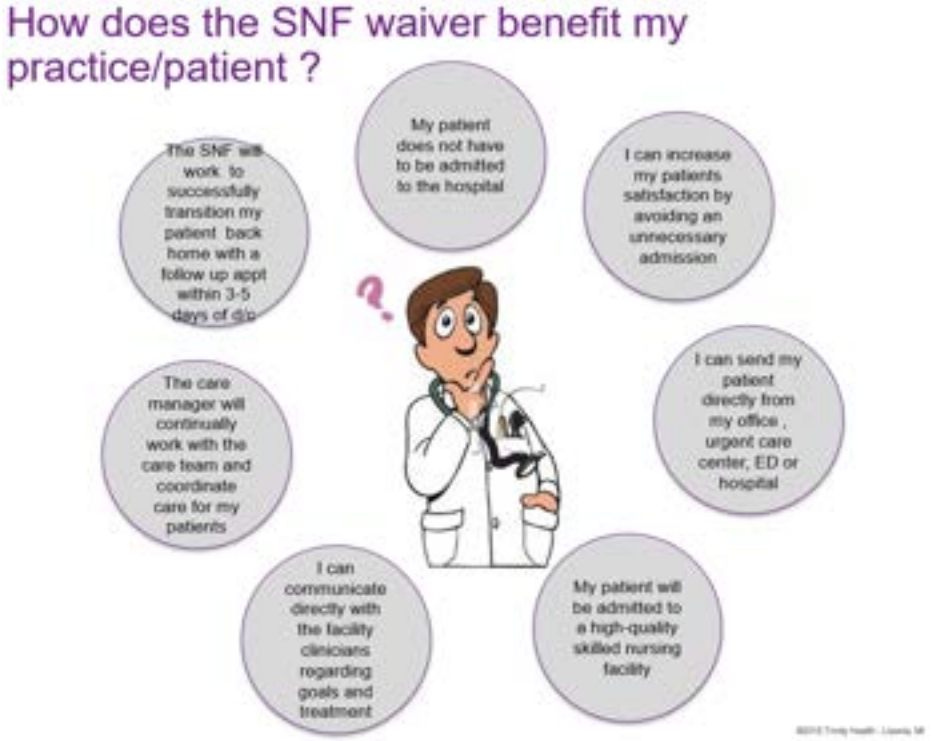
Objective Findings - Day of discharge

@VSSL@

Patient was seen and examined, labs and vitals reviewed. Exam shows ***

CBC	Chemistries
@RESUFAST:WBC,HGB,PLT@	@RESUFAST:NA:1,K:1,CL:1,CO2:1,BUN:1,CREATININE:1,CALCIUM:1,GLUCOSE:1,MG:1@

Participation in MSSP SNF 3-Day Waiver



3DW Requirements

1. Beneficiary Eligibility Requirements
2. Clinical Eligibility Requirements
3. SNF Affiliate Requirements
4. Standard CMS protocol for SNF admission
5. Care Coordination during SNF Episode

Summary

Who is Trinity Health IHA Medical Group?

What are Transitions of Care and Why are they Important?

Transitions of Care: A Team Based Care Approach

Post-Acute Care Collaboration

Caring for our patients across the continuum with an emphasis on utilization and health outcomes!

Sources

- Burton, J. Implementing a Successful Transitions Program While Avoiding Common Pitfalls. CJHP. January/February 2015. Pgs 7-14.
- Hansen, L. O., Young, R. S., Hinami, K., Leung, A., & Williams, M. V. (2011). Interventions to reduce 30-day rehospitalization: A systematic review. *Annals of Internal Medicine*, *155*(8), 520. https://doi.org/10.7326/0003-4819-155-8-201110180-00008
- Jencks SF, et al. Rehospitalizations among patients in the Medicare program. N Engl J Med 2009;360(14):1418-28.
- Koehler, B. E., Richter, K. M., Youngblood, L., Cohen, B. A., Prengler, I. D., Cheng, D., & Masica, A. L. (2009). Reduction of 30-Day postdischarge hospital readmission or emergency department (ED) visit rates in high-risk elderly medical patients through delivery of a targeted care bundle. *Journal of Hospital Medicine*, *4*(4), 211–218. https://doi.org/10.1002/jhm.427
- Kojima, N., Bolano, M., Sorensen, A., Villaflores, C., Croymans, D., Glazier, E. M., & Sarkisian, C. (2022). Cohort design to assess the association between post-hospital primary care physician follow-up visits and hospital readmissions. *Medicine*, *101*(46). https://doi.org/10.1097/md.0000000000031830
- Mansukhani, R. P., Bridgeman, M. B., Candelario, D., & Eckert, L. J. (2015). Exploring Transitional Care: Evidence-Based Strategies for Improving Provider Communication and Reducing Readmissions. *Pharmacy and Therapeutics*, *40*(10), 690–694. PMC4606859
- Saluja, S., Hochman, M., Bourgoin, A., & Maxwell, J. (2019). Primary care: The New Frontier for Reducing Readmissions. *Journal of General Internal Medicine*, *34*(12), 2894–2897. https://doi.org/10.1007/s11606-019-05428-2
- Spiegel B, et al. Cost-Effectiveness of Pharmacist Postdischarge Follow-Up to Prevent Medication-Related Admissions. J of Accountable Care 2018; 6(2): e1-e8.
- Tang, N. (2013). A primary care physician's ideal transitions of care—where's the evidence? *Journal of Hospital* Medicine, 8(8), 472–477. https://doi.org/10.1002/jhm.2060

Trinity Health

Thank you!

Questions / Discussion