Continuing Care Clinic

MyMichigan Medical Group
Practice Overview

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MyMichigan Medical Group

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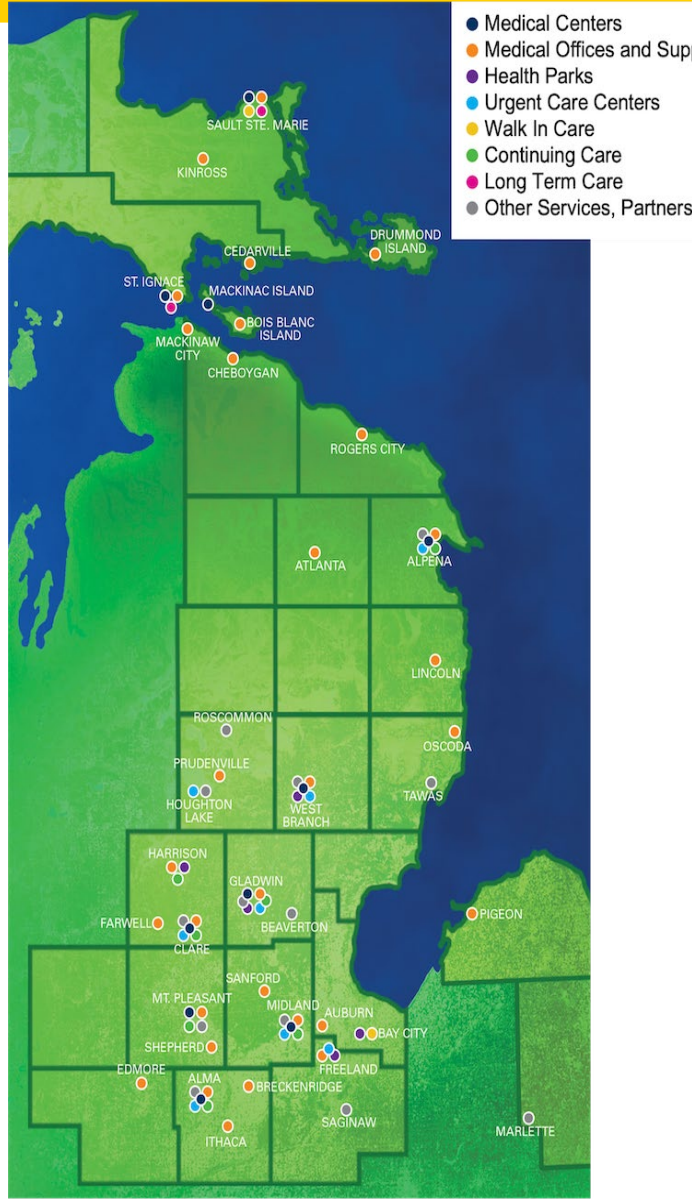
MyMichigan Health

MyMichigan Health
UNIVERSITY OF MICHIGAN HEALTH

MyMichigan Health

- Serving 981,000 people in a 25-county region
- Medical Centers in Alma, Alpena, Clare, Gladwin, Midland, Mt. Pleasant, Sault St. Marie and West Branch
- Affiliations with Medical Centers in St. Ignace and Mackinac Island
- 789 hospital beds and 51 long-term care beds at 9 hospitals
- 10,600+ employees, volunteers and physicians and other personnel
- 900+ associated physicians and advance practice providers
- 750+ volunteers systemwide
- 80+ specialties and sub-specialties
- Major employer in most of our communities
- $128M+ in community benefits in FY23



Readmissions and Transitions of Care

- Unplanned readmissions among hospitalized patients pose a significant burden on patients, families, and health systems
- Impacted by several factors:
  - SDOH gaps
  - Patient unable to mange symptoms or illness – relapse of symptoms
  - New medication routines
  - insufficient post-discharge follow up[1]
- Post-discharge follow up with a primary care provider (PCP) is an essential, yet often missed, component of returning to wellness

Readmissions and Transitions of Care

- Recovery following discharge – healing at home
- Transitions of care barriers:
  - Primary Care Access
    - Patients may not receive post discharge care in an appropriate timeframe (typically 7-14 days) due to lack of PCP support or availability
- Internal data showed that patients are typically readmitted between 12-13 days post-discharge
- Hospital follow up for patients within 7 days can impact readmission and mortality rates[2]

Continuing Care Clinic Services

- Bridging the gap
  - Provide timely follow-up after hospital discharge, ED, or Urgent Care presentation – within 7 days for Pneumonia/Sepsis
  - Assistance in establishing with an MyMichigan Medical Group (MMG) PCP and bridging patient care to that appointment
  - Patient centered care: Connecting Continuing Care Clinic (CCC) patients with resources to address social determinates of health gaps, medication needs and disease management education
  - Goals of Care Discussions
  - One hour appointment time slots

Locations of Clinics: Midland and Alma

Midland Continuing Care Clinic
555 W. Wackerly Street, Suite 600
Midland, MI 48640

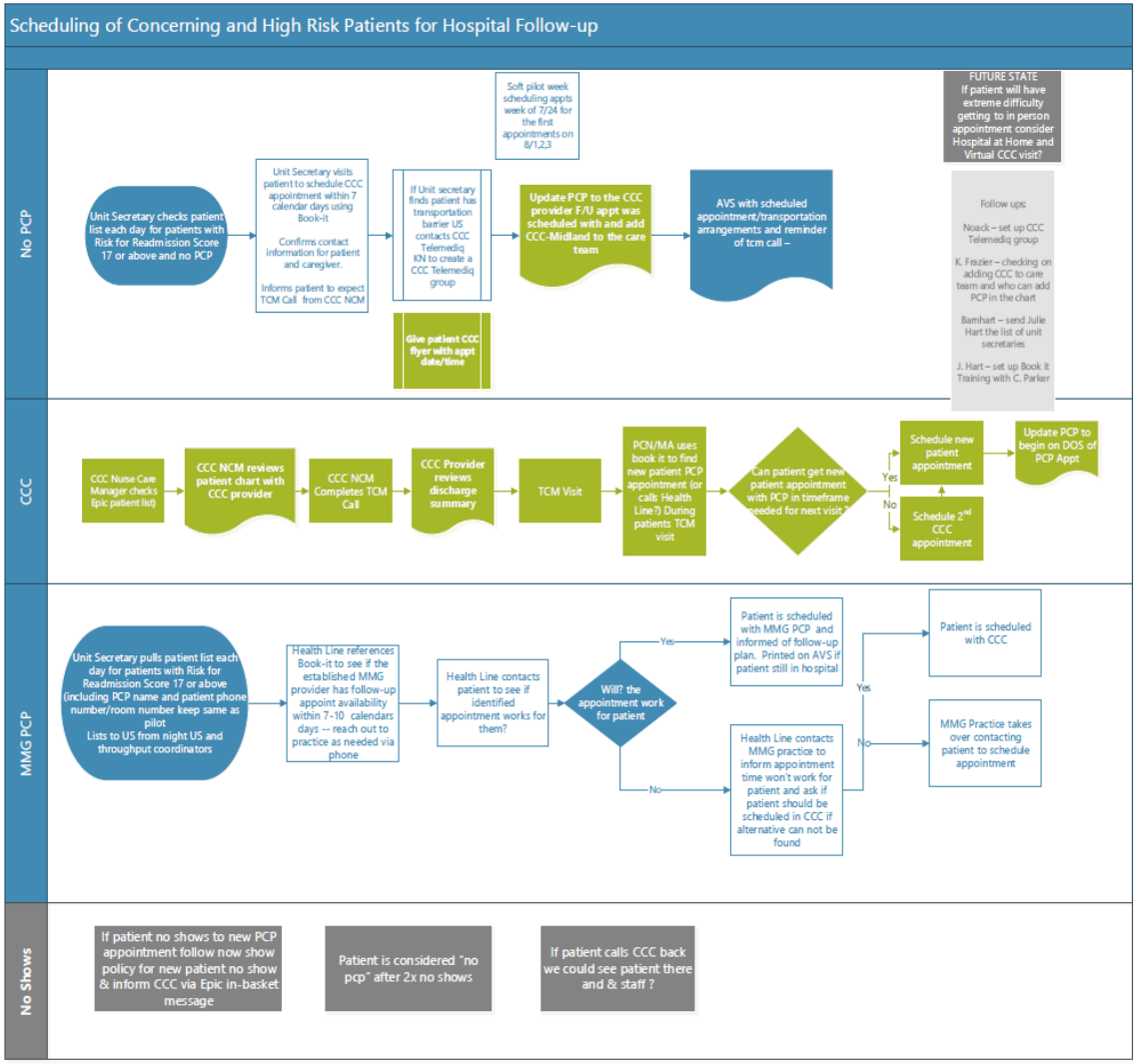
Alma Continuing Care Clinic
160 E. Warwick Drive
Alma, MI 48801

Continuing Care Clinic Staff

- Lindsey Pulcer, NP – Midland
- Justine Thompson, PA – Midland
- Lynnsilee Alvera NP – Alma
- Dr. Shannon Martin – Supervising Physician
- Patient Care Navigator – Midland
- Ambulatory Pharmacist for Medication Management
- Nurse Care Manager and MSW – ACP, patient education and assistance with SDOH
- Community Health Worker – Alma

Workflow

- What version are we on again?



Expanded Clinical Criteria

- Expanded target population:
  - Those lacking a PCP and Dx with Chronic conditions
  - High ED Utilizers/lacking a PCP and/or those requiring timely follow up – unassigned population
  - MMG patients unable to establish care with a new PCP within a timely fashion/already scheduled with delay
  - Clinical judgement of hospitalist medicine care team to prioritize patients
  - Utilization of Telehub locations to support rural geographies
- Perception of what transitions of care means

Data Review

- Initial data is promising, although limited
  - Providing value to rising risk population
    - Decreased readmission rate
  - All cause readmission rates at CCC are lower
  - Pneumonia Mortality rates have decreased but more data is needed

- Key Performance Indicators
  - Lead time:
    - Hospital follow up – 7 days
    - New patient – 7 days
    - ED Follow up – 4 days
    - Established Patient – 17 days

Patients Perspective

- "I was really lost for a-while with so many appointments, being sick, medications and had no idea where to start. Justine was wonderful, she scheduled half of the appointments and gave me a place to start. Her and her staff were amazing."
- "When you are in the hospital for a longer stay, when get out you are so focused on healing but it's confusing with all the appointments and medications. The clinic really can help people transition successfully by giving them a place to start."
- "This clinic is needed for people like me. I have a lot of things going on and when we came up here, they had a wait of 8 months to see a doctor! They helped me get into see a doctor sooner…and got me better"
- "I can't tell you what I would have done without them"

The Evolution of the CCC

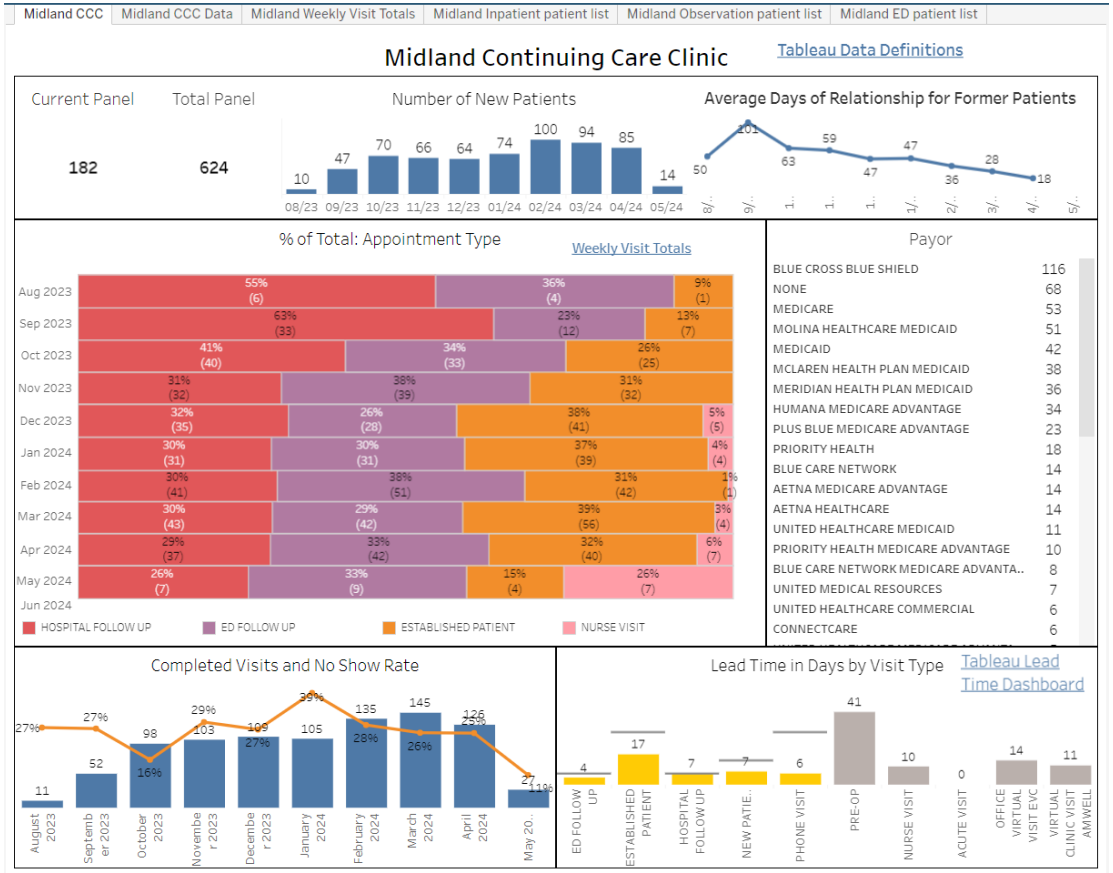
- What is on the horizon?
  - Expanded coverage via Telehub clinics
  - The potential for partnerships with additional service lines

Thank You

- Questions

Appendix:

- Dashboard



References

1. Rasmussen LF, Grode L, Barat I, Gregersen M. Prevalence of factors contributing to unplanned hospital readmission of older medical patients when assessed by patients, their significant others and healthcare professionals: a cross-sectional survey. Eur Geriatr Med. 2023 Aug;14(4):823-835. doi: 10.1007/s41999-023-00799-6. Epub 2023 May 24. PMID: 37222865; PMCID: PMC10206346.

2. Saxena, F. E., Bierman, A. S., Glazier, R. H., Wang, X., Guan, J., Lee, D. S., & Stukel, T. A. (2022). Association of early physician follow-up with readmission among patients hospitalized for acute myocardial infarction, congestive heart failure, or chronic obstructive pulmonary disease. *JAMA Network Open*, *5*(7), e2222056. https://doi.org/10.1001/jamanetworkopen.2022.22056