ECMC's Comprehensive Transition of Care Program

Addressing health disparities to decrease avoidable readmissions and improve health outcomes

Amanda Farrell, RN, Population Health Clinical Data Analyst
Nicole Jurek, MS, Physician Assistant

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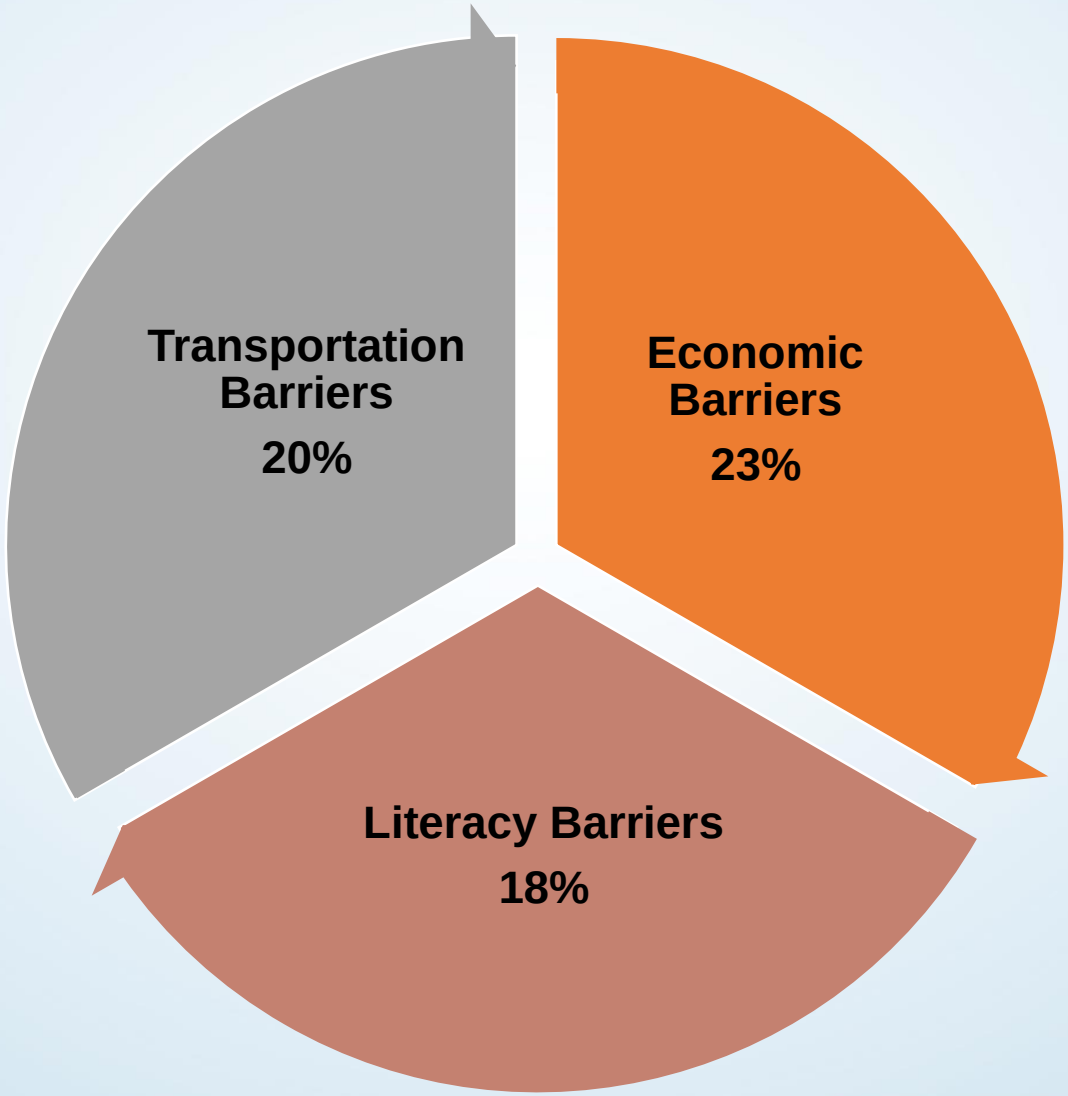
Background


Transportation Barriers
20%
Economic Barriers
23%
Literacy Barriers
18%

Patient and Caregiver Risks Throughout Transitions

- Lack of patient and caregiver involvement
- Poor continuity of care
- Inadequate preparation
- Gaps in services
- Absent or inadequate communication
- Limited collaboration
- Multiple health and social challenges
- Complex and conflicting treatment regimes

Comprehensive Transition of Care

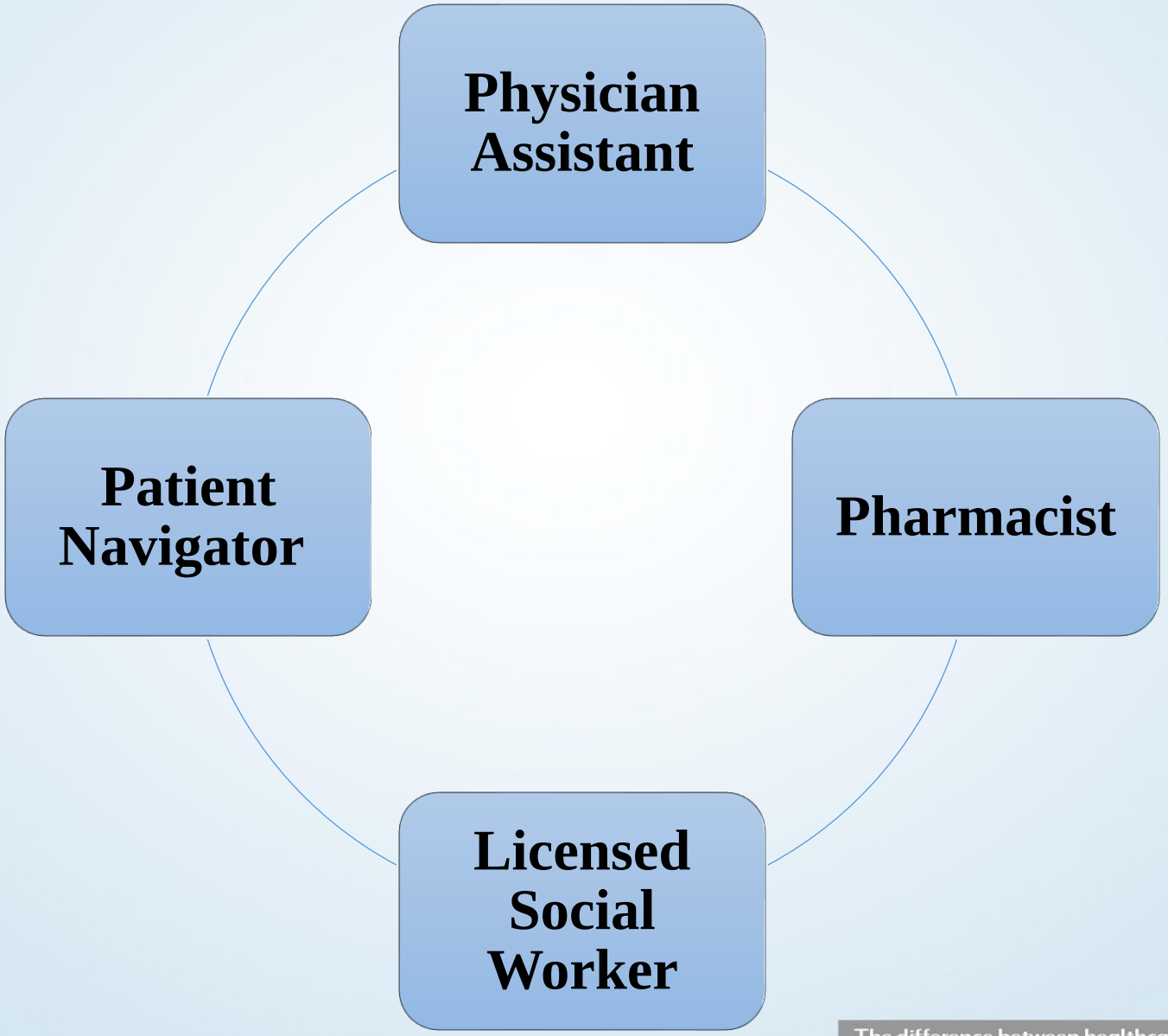
Problem: Hospital readmissions represent a significant cost to the healthcare system and are a burden to patients.

- High-risk patients

Question: What happens to underserved/high-risk patients when they get discharged from the hospital, and will improved health care outside the hospital reduce readmissions?

- Comprehensive Transition of Care

Transition of Care Team



Transition of Care & Complex Care Management

- **Clinical Care Team**: Physician assistant, pharmacist, social worker, patient navigator
    - **Key interventions:**
        - Screening for high-risk status upon admission
        - Integration of clinical care team to bridge gap between inpatient (acute & behavioral health), outpatient & community
        - Transition of care clinical intervention and coordination for patients discharged from acute and behavioral health admissions to ensure patients do not get readmitted or lost-to-care post-discharge
        - Enhanced medication management, reconciliation, and adherence counseling
        - Social determinant of health screenings and assistance in addressing barriers to care post-discharge
        - Telehealth and remote patient monitoring to improve accessibility to care

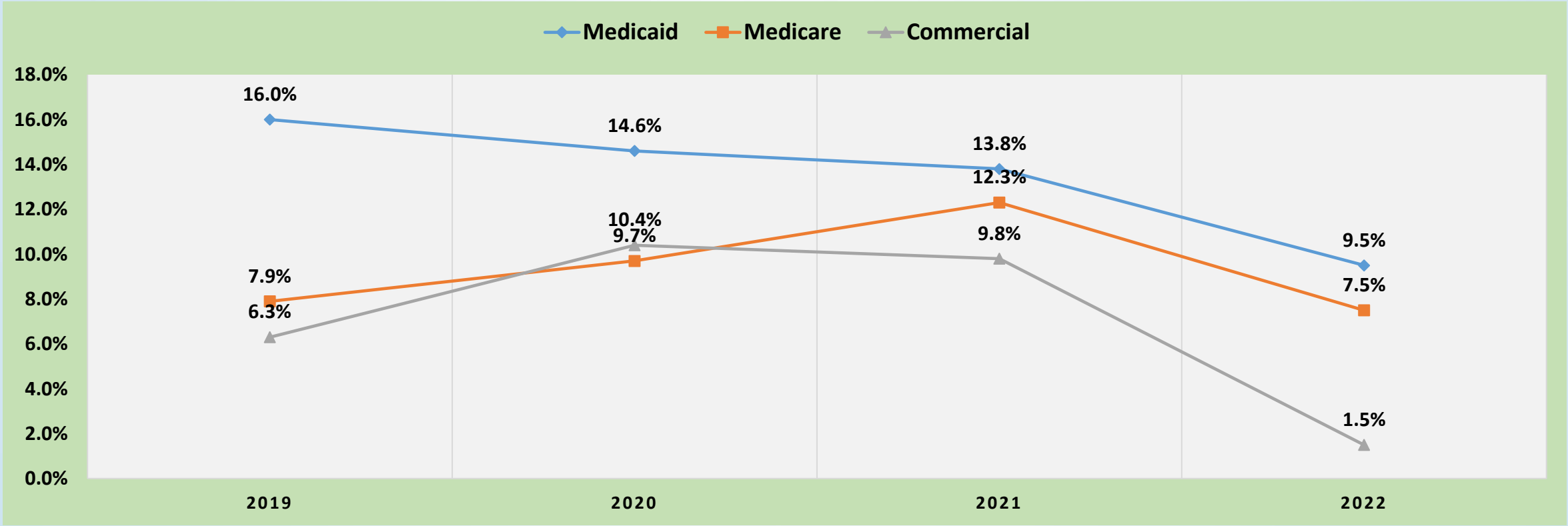
Patient Vignettes

- 75-year-old male who presented to the ER with dyspnea on exertion and found to be COVID positive. PMH is significant for A. fib with pacemaker, BMI of approximately 32, and CAD.

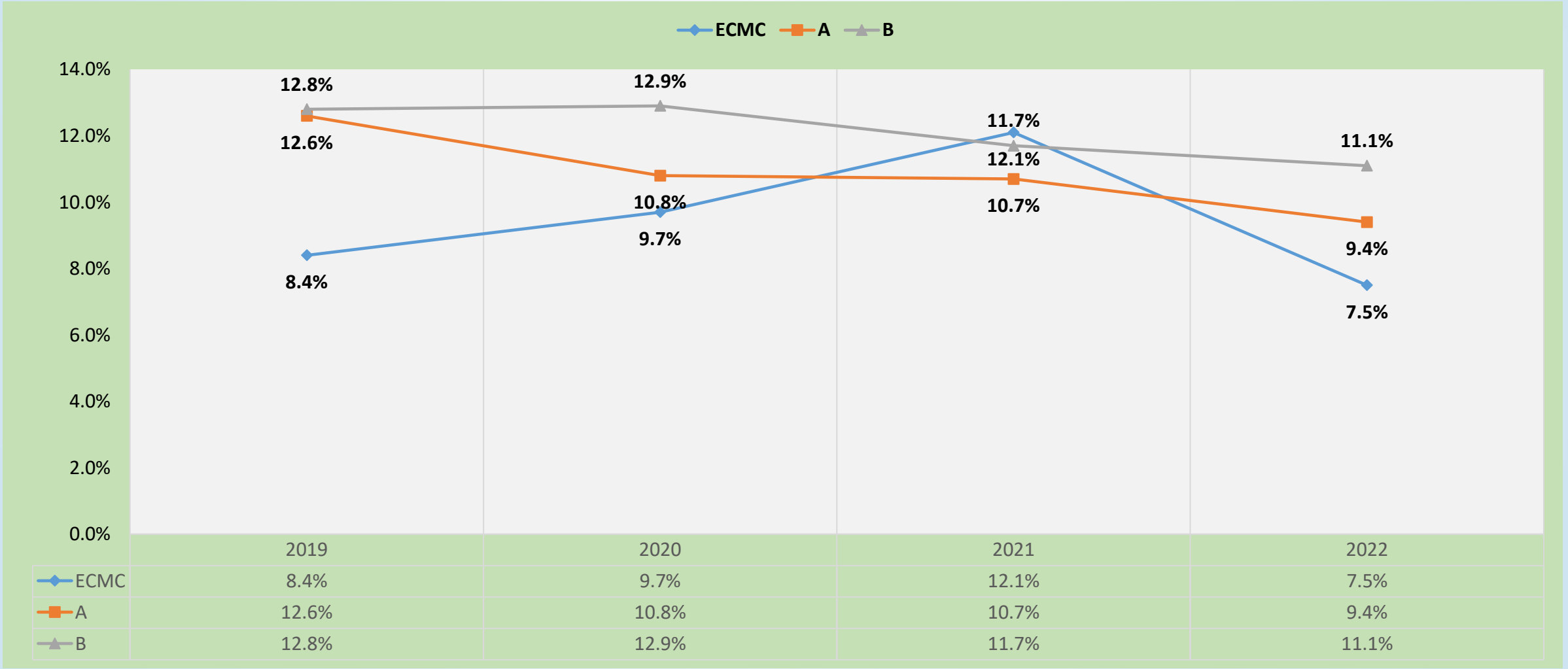
- 35 y/o female with hx of opiate use disorder (heroin), nicotine use disorder and ankle pain s/p ankle surgery. Patient reports she ran out of her Suboxone, Patient is fearful she will relapse and currently c/o nausea, shakiness, restlessness, runny nose, tearing, and hot/cold flashes.

- 59-year-old with past medical history of renal transplant, diabetes, hypertension, atrial fibrillation, and chronic pain who presented with respiratory failure d/t COVID-19.

Transition of Care & Complex Care Management
ECMC Readmission Rates



Transition of Care & Complex Care Management
Community Health System Comparison



	2019	2020	2021	2022
ECMC	8.4%	9.7%	12.1%	7.5%
A	12.6%	10.8%	10.7%	9.4%
B	12.8%	12.9%	11.7%	11.1%

Key Takeaways

1. Addressing a patient's social determinants of health is imperative in setting a sustainable care plan that will prevent hospital readmissions and improve health outcomes.
2. High-risk patients who require assistance navigating the complicated healthcare system benefit from targeted care coordination from a dedicated interdisciplinary team and routine primary care and specialty outpatient follow-up.
3. To impact sustainable results to reduce readmissions, hospitals need to begin to drive the transition of care process at the beginning of the admission, staying involved until hand-offs to primary care, specialty services, and community support agencies are confirmed and completed.

Thank you