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Novant Health Stroke Bridge Clinic

Integrated Post-Acute Care

2020

Agenda

- How Covid-19 Challenged us to adapt for our stroke patients
- Overview of Integrated Pilot
  - Stroke Bridge Clinic/ Home Health/ Technology
- Review of Pilot Details

The **Evolution** of Post-Acute Care

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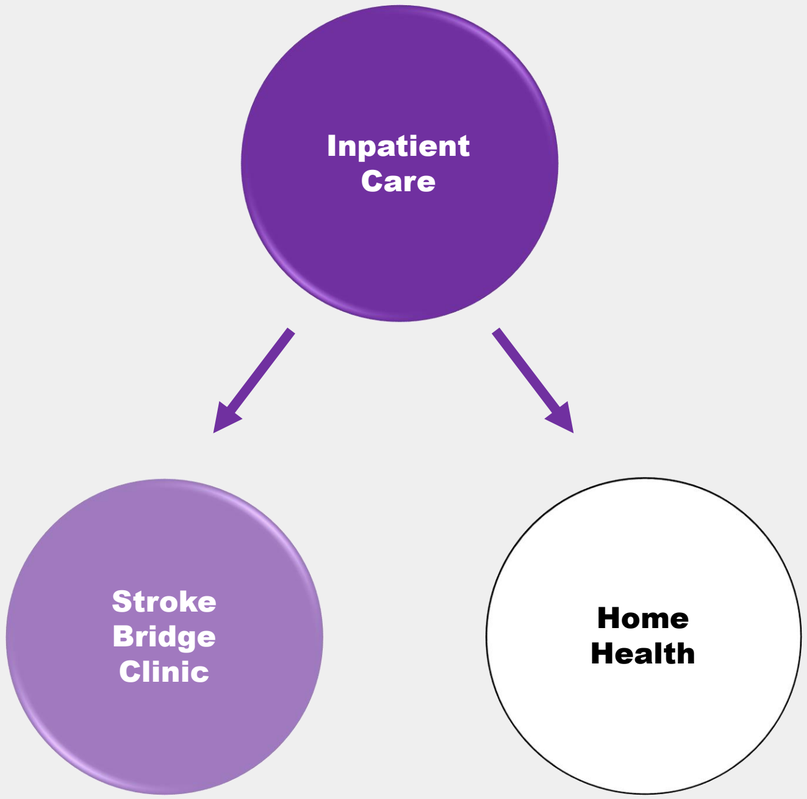
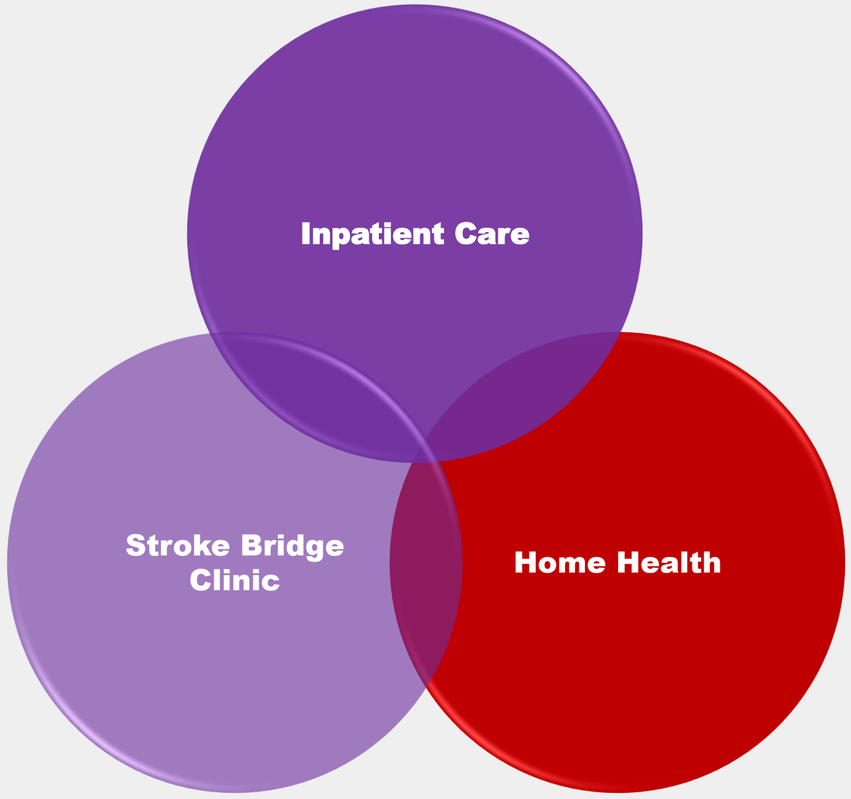
Move from …

Independent Approach to Care



To …

Integrated Approach to Care



The **Evolution** is …

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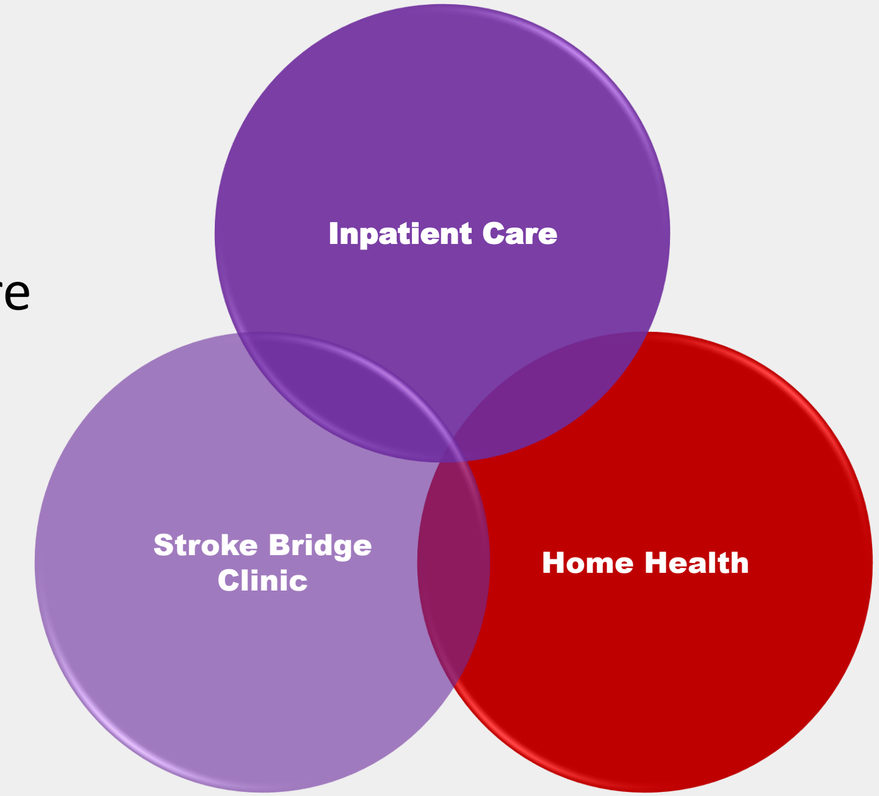
Integrated Post-Acute Care
a new level of care



Utilization of Interactive Technology

Telehealth and Remote Patient Monitoring

- MyChart
- Virtual Zoom Visit
- TytoHome

Exponential Expansion of the Care Team

- Fully coordinated care planning
- Intentional decision-making
- Real-time interventions

Positive Patient Outcomes

- Decreased re-hospitalizations
- Improved functional status
- Increased patient satisfaction

Successful **Integration** leads to **Positive Outcomes**

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Referral Made to BAYADA for Integrated Stroke Post-Acute Care

- Referral made prior to hospital discharge
- BAYADA Transitional Care Navigator coordinates and collaborates with Stroke Bridge Clinic Navigator

Home Health Admission Visit

- Initial admission visit within 48 hours of hospital discharge
- Admitting Nurse notifies *Stroke Bridge Clinic Navigator* and Provider upon completion of admission; communicates significant clinical findings outside of parameters

Stroke Bridge Clinic Virtual Visit w/ Home Health Consultation

- Clinic visit scheduled approximately 7 days after hospital discharge
- Home Health Clinician completes routine patient assessment and provides live report to Provider
- Provider conducts virtual visit with patient; Home Health Clinician assists the provider as needed
- Provider and Home Health Clinician collaborate on patient progress and any plan of care modifications

Patient Experience
With the broad introduction of virtual care, it is important that patients feel confident in the care they receive

Incidence of Missed Visits
Reducing the number of missed visits with health care providers improves compliance and ensures continuity of care for patients

Minimize Avoidable Readmissions
Reducing rates of readmission to acute care settings decreases costs and directly impacts patient satisfaction

Optimize Function
Improvement represents progress in a patient's rehabilitation

Management of Oral Medications
An ability to successfully manage medications promotes disease self-management and reduces risks if adverse events that impact all other metrics

Pilot Planning **Details**

What are we trying to accomplish? Advancing post acute care for our stroke bridge clinic patients by leveraging technology and incorporating virtual video visits with provider during time of home health visit in an integrated approach.

PLAN

Tasks needed for a successful pilot	Responsible Party	Date
Define scope of pilot- *MMC (Union) and PMC (Mecklenburg County)*	**Core Team**	**Complete**
Define workflow for patient selection- *script on offering choice; All stroke patients (Discuss with navigators how to get CM list of patients)*	**Case Management and IP navigators**	**Complete**
Define workflow for scheduling patients with Bayada for home health	**Core Team**	**Complete**
Determine process for coordinating home health visit with video visit at bridge clinic • If they cancel need to determine a way to communicate both sides. • Karen to send My Chart info to Jennifer and determine dummy patient info	**Core Team**	**Complete**
Collect Baseline data	**Tara to send to Karen**	**In progress**
Determine pilot launch date and length of pilot	**6/2 Pilot communication/ education**	**Complete**
Communicate with Key Stakeholders - Notify IP hospitalists- Tara Box - Lisa inform we are doing this pilot - Karen to create SBAR	**Tara/ Lisa/ Karen**	**In progress**
Schedule recurring touch points during pilot and risk escalation points as they arise	**Karen**	**Complete**
Evaluate pilot results		**Week of 7/6**

Study

Input any results from pilot here.

- # of patients caregivers involved in video visit
- Survey to care givers and patients

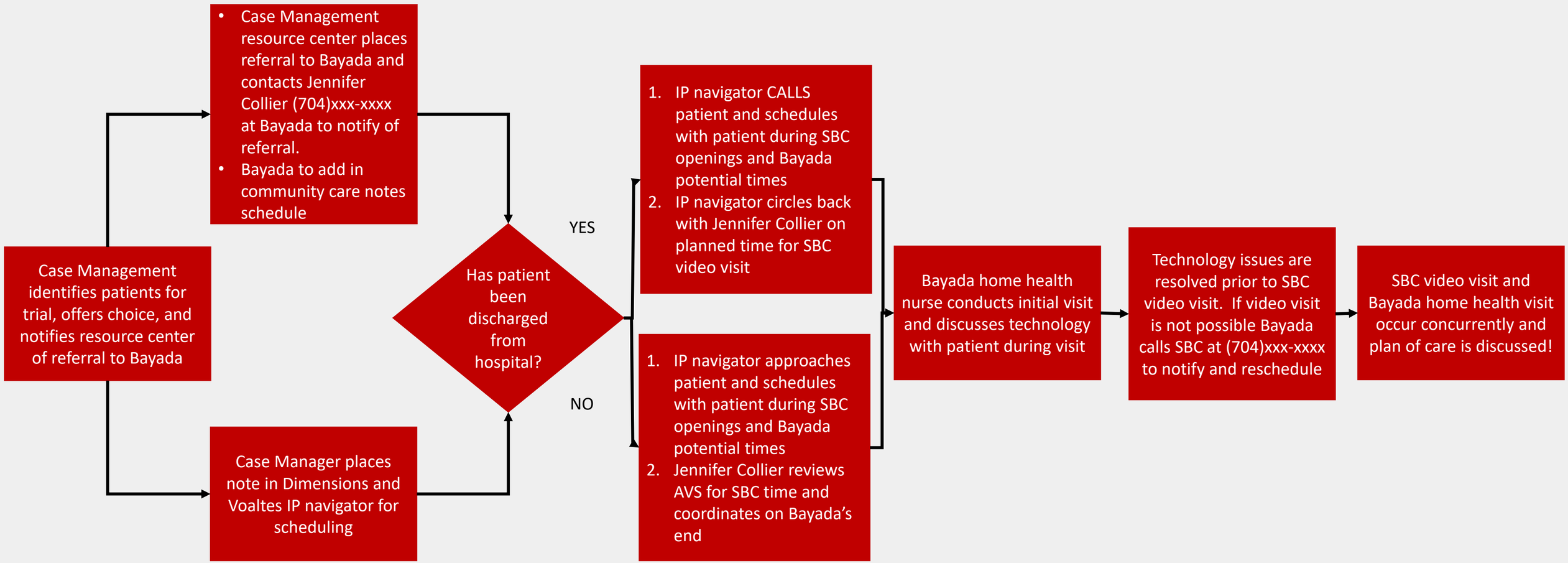
ACT

List any changes to pilot before spread.

DO

Stroke Bridge Clinic Patient Identified → **Scheduled for home health with Bayada** → **SBC visit coordinated with home health visit** → **Simultaneous video visit and home health visit with integrated care coordination** → **Follow up visits coordinated as needed**

Pilot **Workflow**



Pilot **Rollout** Plan

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June 1st- 7th

- Bayada integration with SBC
- Communicate to IP neurologists, OP neurologists, case managers
- Test technology and test dummy patients

June 8th- 14th

- Operation and clinical staff education for CV
- Continued communication and education for Novant Health

June 15th- July 5th

- Schedule 2 patients each week for pilot
- Real-time resolution on any issues that arise
- Weekly touchpoints on pilot success

Week of July 6th

- Continue to schedule patients in pilot
- *Pilot evaluation and study:*
  - Share lessons learned
  - Potential outcomes (if any yet)
  - Progress towards goals
  - Re-evaluate
  - Revise as needed

Reviews from our Patients

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- In the first 3 weeks we saw the following:
  - Two avoided Re-admissions
  - Multiple “great finds” in the home such as – wrong meds patient had reported, wrong doses of meds
  - Positive patient and caregiver feedback
    - 100% of patients preferred this assisted platform over arranging an office visit
    - 100% of patients thought that this enhanced their follow-up care
- Expanded to entire GCM on 8/16/2020
- Anticipate Rowan/Salisbury addition mid-September

Questions