

2025 Learning Collaborative

Building Effective Networks for Transitions of Care



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Building Effective Networks for Transitions of Care

Session Objectives

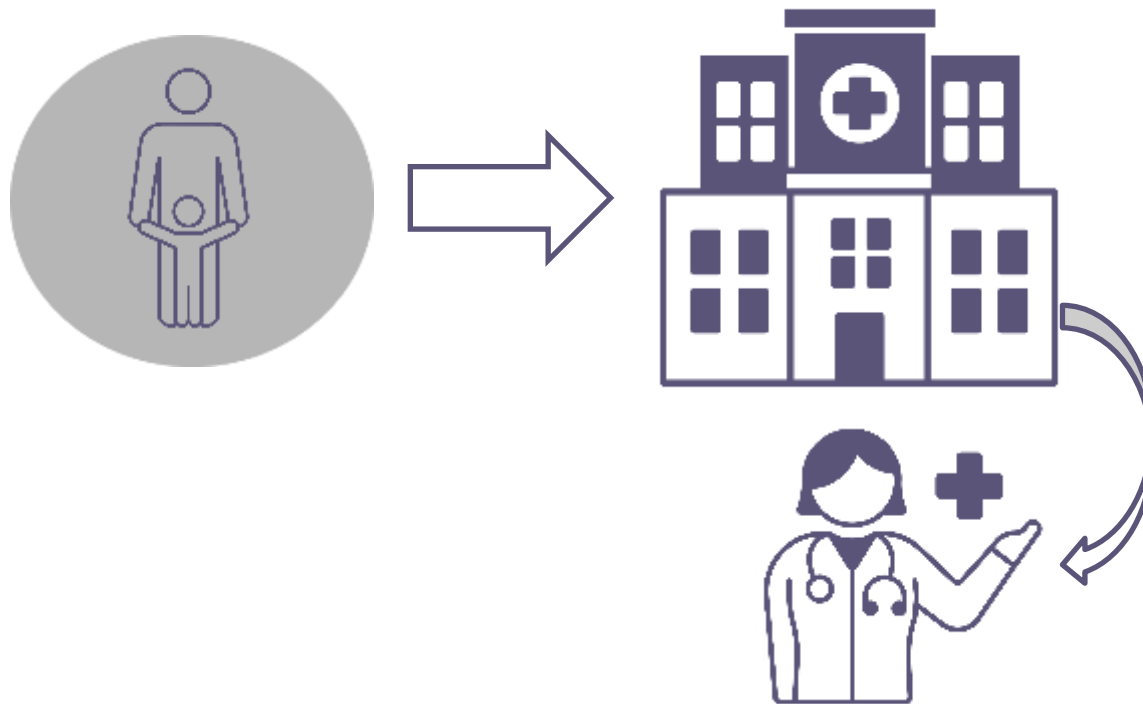
- Define key barriers to effectively link people leaving the hospital to ongoing care.
- Describe effective strategies to address key barriers to transitions of care.
- Interpret strategies to effectively share data across diverse organizations.

BUILDING EFFECTIVE NETWORKS FOR TRANSITIONS OF CARE

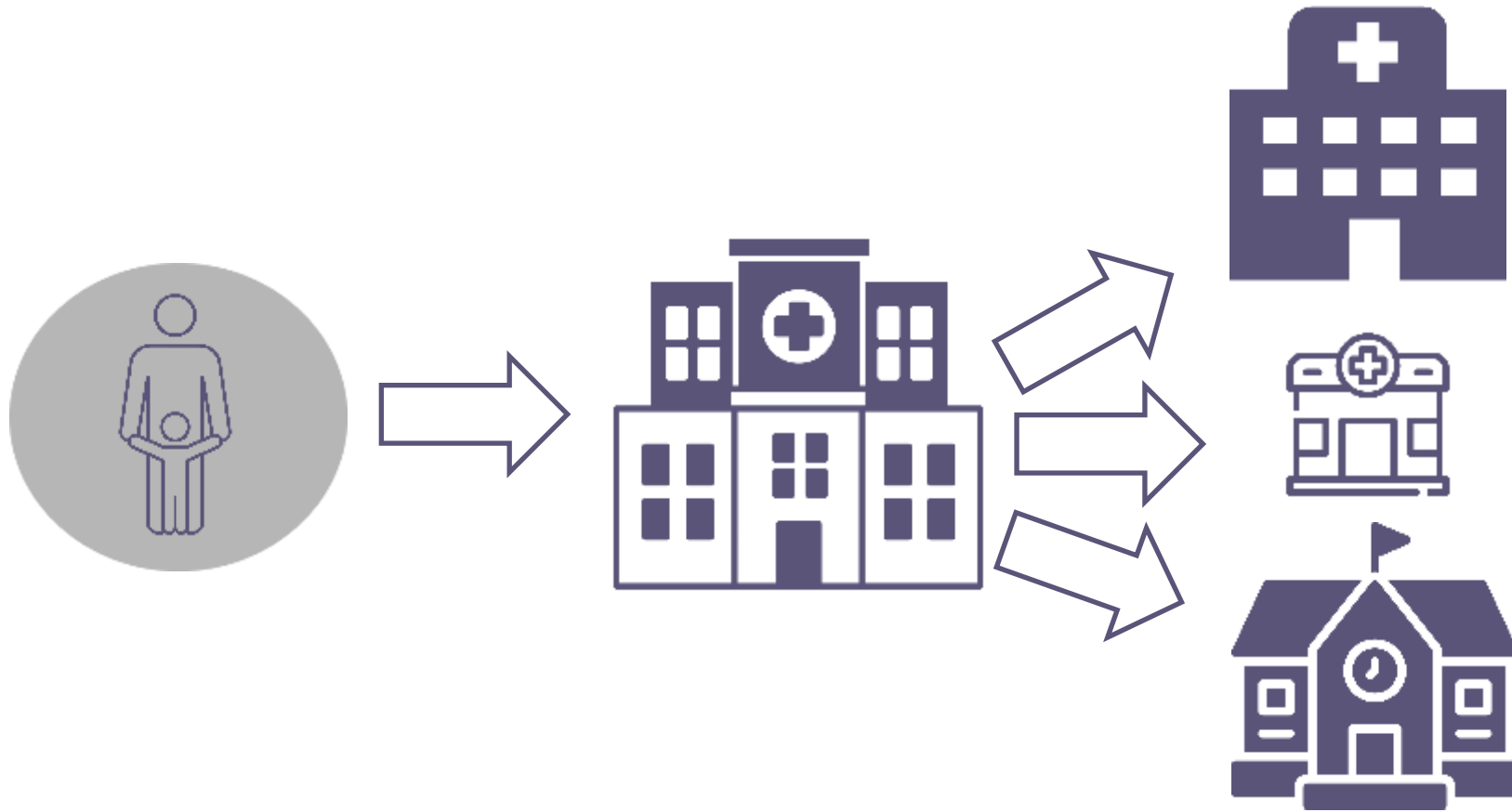
Transitions of Care



Transitions of Care



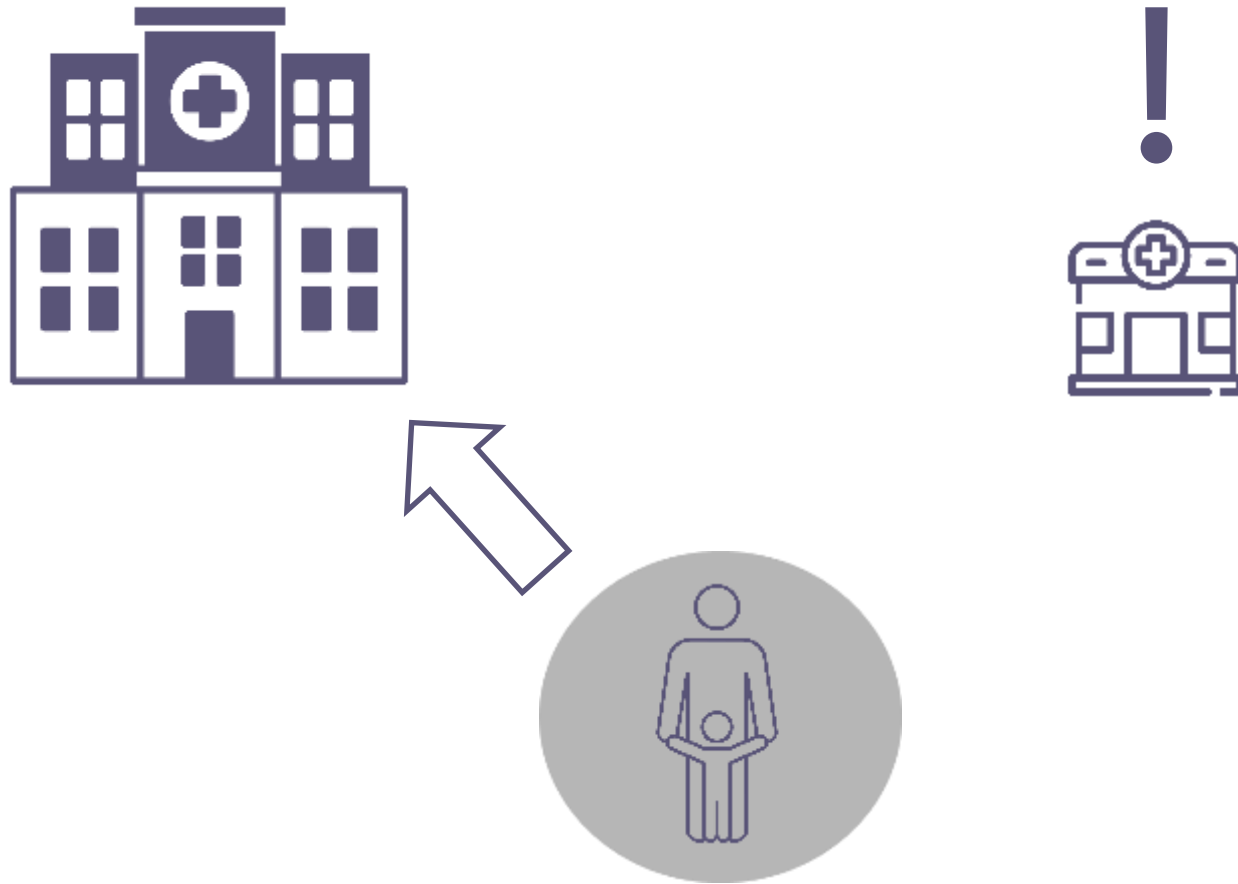
Transitions of Care



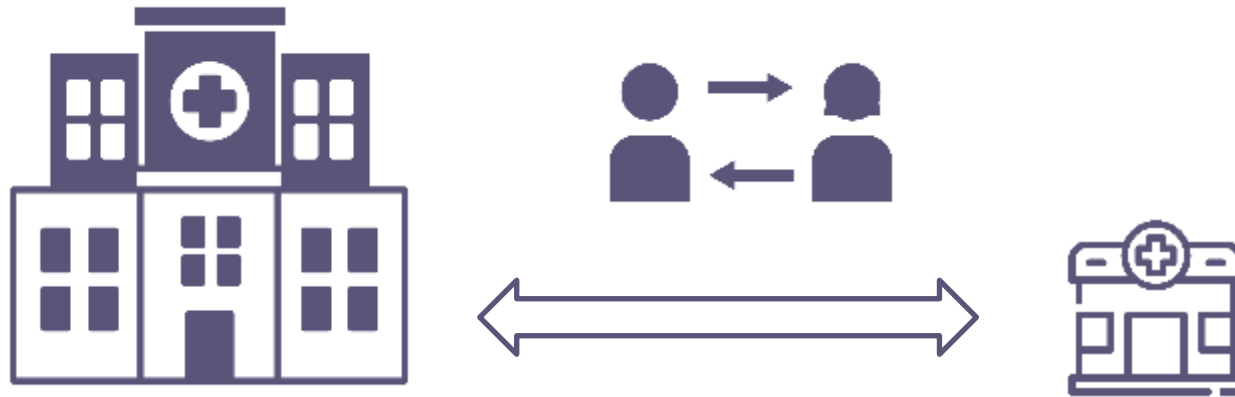
Transitions of Care



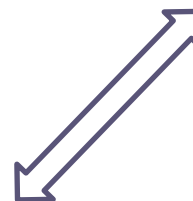
Transitions of Care



Transitions of Care



Transitions of Care



Transitions of Care Quality Improvement

Hospital-facing improvements

Community provider-facing improvements

Patient-facing improvements



Summa Behavioral Health

Working Effectively in a County System to Strengthen the Continuum of
Care and Improve Patient Outcomes

Megan Recker, LISWS MBA
System Director, Behavioral Health

A Brief History

The Downside of Disruption

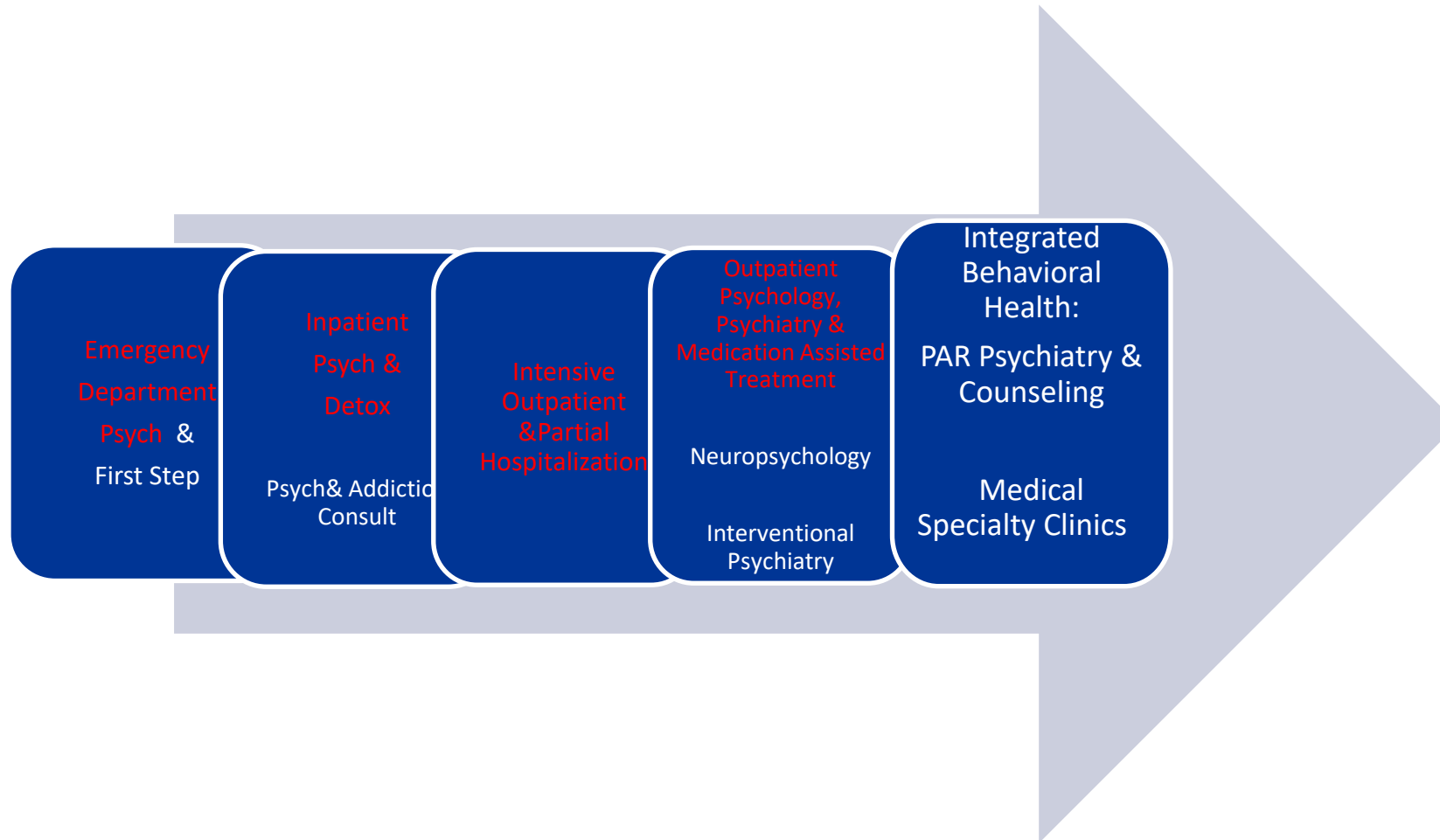
Brief (Recent) History:

- STH IP, IOP
- 2015/2016:
 - Launched Primary Care Behavioral Health integration in collaboration with an out-of-county Community Mental Health agency.
 - Launched First Step with an out-of-county Community Mental Health agency.
- 2018: Expanded collaboration to the ED, embedding clinicians in the Summa Akron City ED.
- 2020: Opened Psychiatric unit in the Akron City ED

Downside

Later, Summa would realize that 2015 was pivotal in alienating them from the community system.

Summa Behavioral Health Service Continuum



Payer Mix and Disposition Snapshot

- Emergency Department: ~ 60% Medicaid
- Hospital IP & OP Programs: ~70% medicaid
- SHMG OP: ~40% Medicaid
- 10%-20% of ED patients are dispositioned to the County Crisis Center
- 60%-70% of IP patients are discharged to community agencies

2021: A Reckoning

The Paradox of Behavioral Health

Summa approaches ADM to partner on system-wide initiative only to reckon with loss of trust from the community, resulting from:

- Partnering out of county
- Misperceptions about hospital infrastructure
- Policy changes that positioned the hospital as a competitor

Rebuilding Bridges

Lessons Learned

Initiatives

- Agency and Hospital Leadership Council
- Community Shared Clients Working Group
- Navigator program across Summit DD and Community Mental Health agencies.

Lessons

- Understand the system at a macro level; develop knowledge of service delivery, funding streams, incentives and institutional relationships, to affect change at the micro level.
- Impact of perceived power differential between the ADM Board and Community agencies.
- Work at the provider level versus the executive leadership level.

Collaborative Wins

- Recognition of Shared Challenges
- Leveraging collective influence
 - Metro
 - Crisis Redesign
 - Unite Us
- Enhanced Transparency
 - Volumes
 - Access
 - Needs
- Expedited problem identification and mobilization of a response
- Inpatient recidivism rates

Challenges

- Real time data sharing
- Consistent, sustainable case management for hospital and medical group programs

The Centers Focus on Transition of Care

COLLEEN PTAK, LISW-S
SENIOR DIRECTOR POPULATION
HEALTH





The Centers

- Circle Health and The Centers for Families & Children Affiliation
- FQHC & Community Health Center
- Serving over 20,000 people a year across the organization
 - Health & Wellness (Behavioral & Physical Health) over 13,000
 - Workforce Development, Youth Residential Care & Family Support Services, approximately 7,000
- Over 500 employees

Transition of Care for Behavioral Health Over the Years

Rapid Access

- In hospital assessments
- Shared staff with CCF
- Transitional Case Manager
- Introduction of Clinisync Notify

Care Coordination

- Daily staff to address notifications
- Time to provide non billable services

Post Hospital Liaison

- Primary responsibility to address hospital notifications
- Monitor both Clinisync Notify & MCO ADT feeds

Successes



Enriched
relationships
with the
hospitals



Meet with
clients while
still inpatient



Increased
receipt of
discharge
paperwork



Improved
utilization of
Clinisync
Notify



Implementation
of transportation
services



Improved
staff
engagement

Pain Points



Notification Issues



Low patient show rate



Conflicting priorities for the patient



Unable to contact the patient

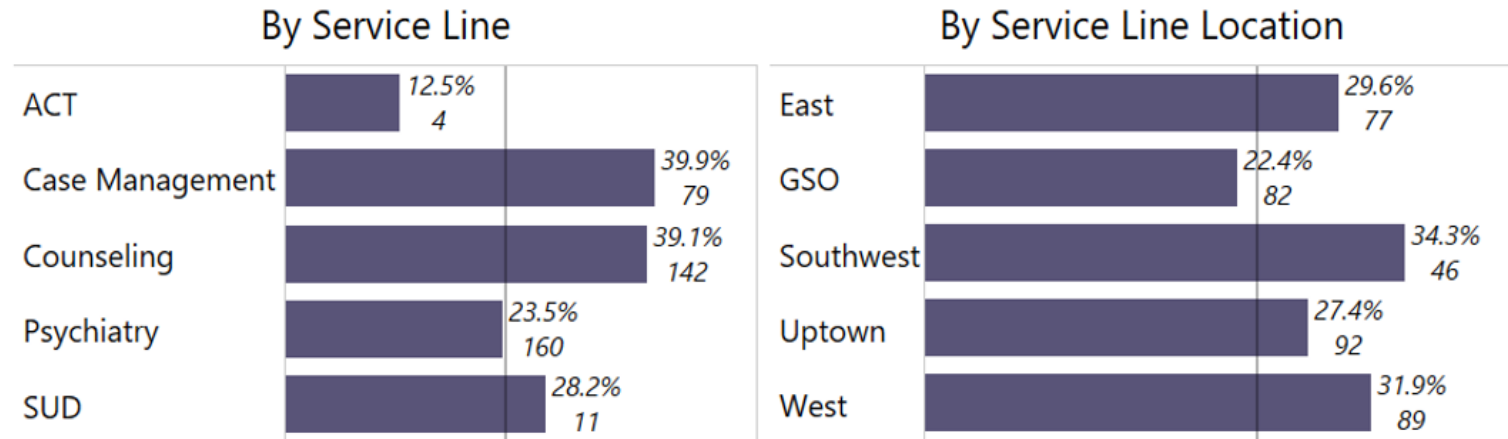
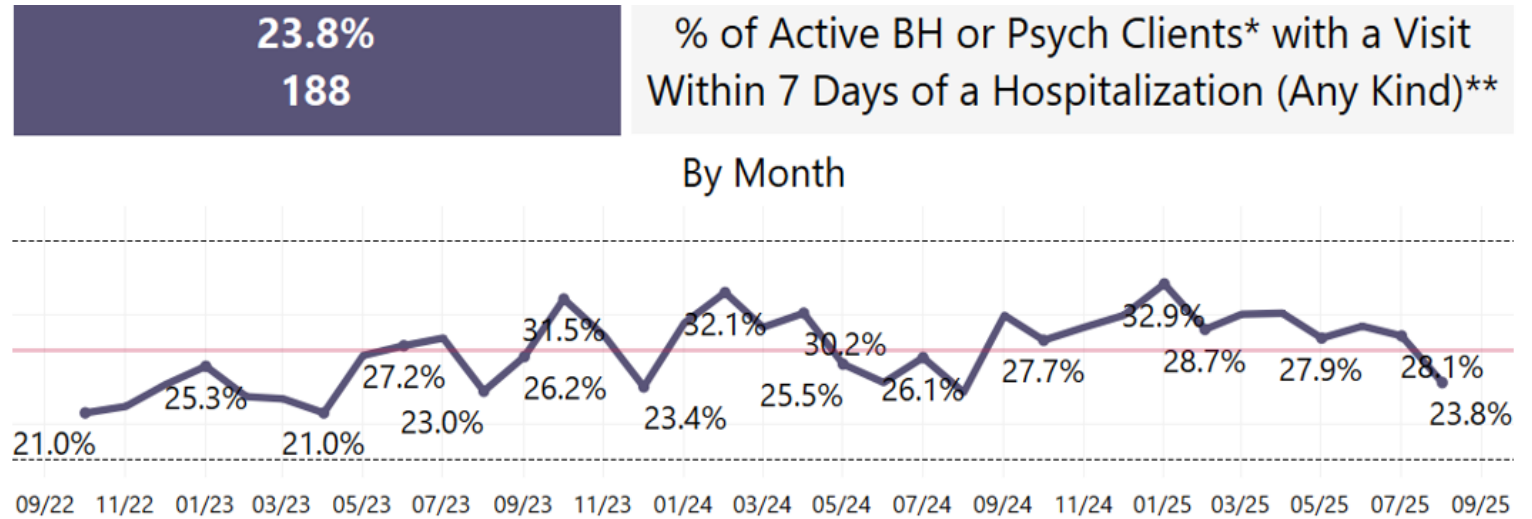


Clinical staff availability within 7 day window



Funding for care coordination/ hospital liaison position

Utilizing Clinisync Notify



* Visit in last 90 days (or in last year for Psych)

** Hospitalization was in past month



How do we increase compliance with hospital follow up appointments?

- Collection of hospital systems, managed care organizations and community health centers
 - Identified barriers on all sides
 - Suggested possible solutions
 - Explored possible tools & platforms
 - Shared previous practices, successful & unsuccessful



PDSA Ramp Summary

Establish culture that values follow up and evidence-based interventions for follow-up care



Test Cycle 1



Test Cycle 2



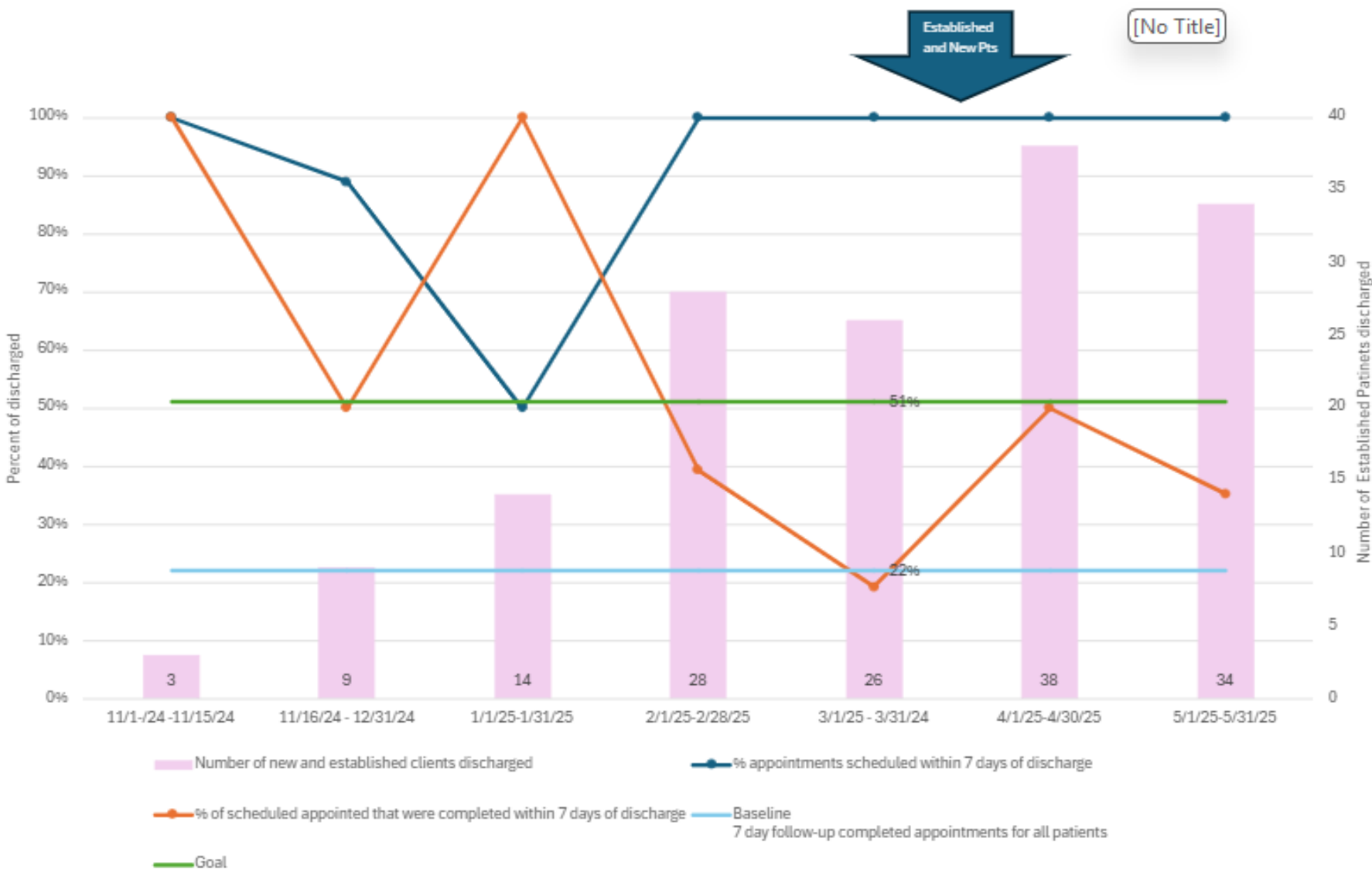
Test Cycle 3



Test Cycle 4

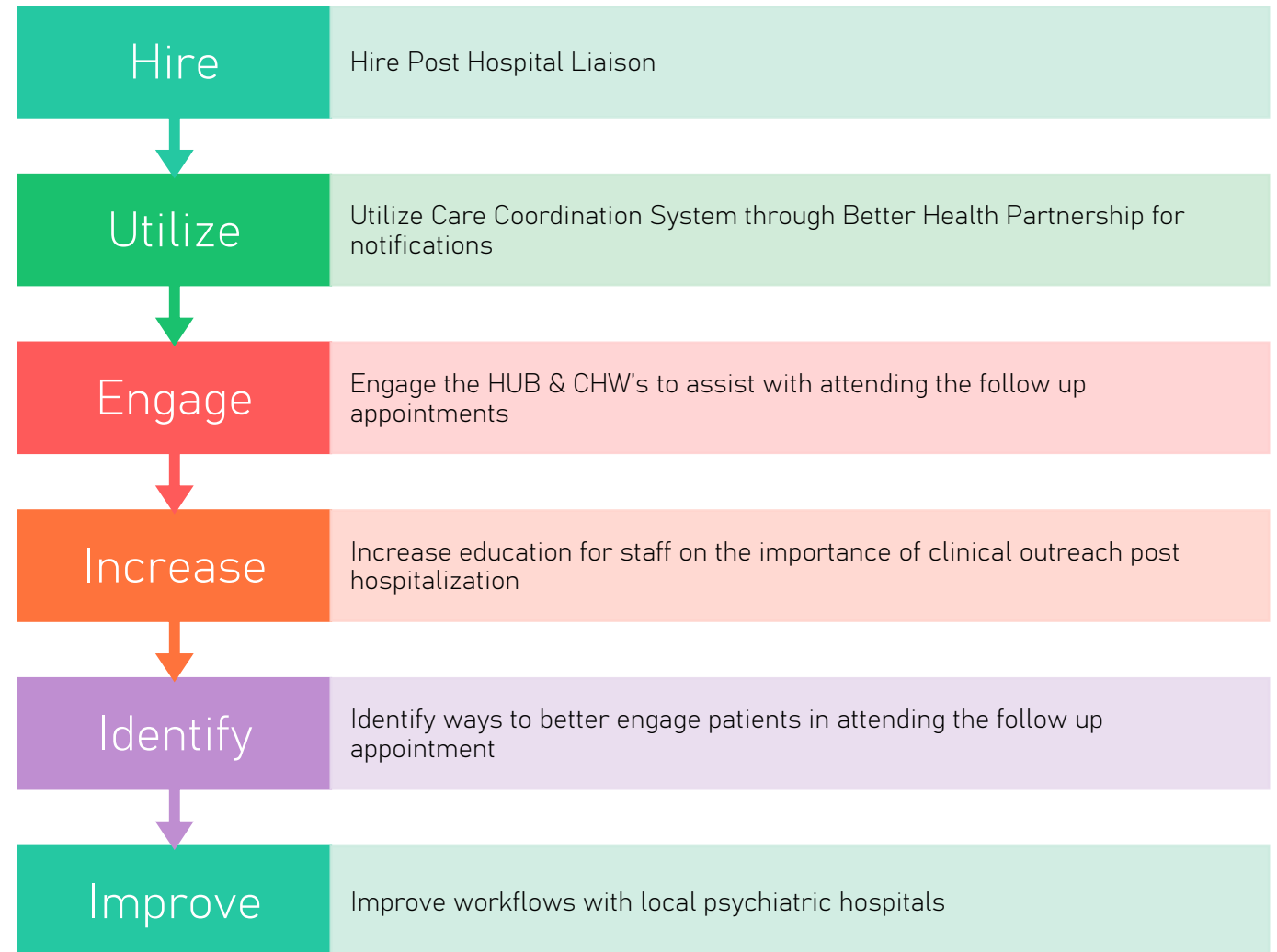
Test Description:	The Centers will coordinate with MetroHealth through email to schedule 7 -day follow-ups for patients of The Centers discharging from Metro BH IP.	Hospital Liaison from The Centers to include information on name and provider type being seen. Re-education to Metro on what email address to send info to	Hospital Liaison will schedule not established Centers patients in their Urgent Care clinic 3-5 days of discharge and follow-up with patient post discharge to enhance engagement	Metro to use designated referral template when making referral for follow-up to The Centers. Metro to also note need for Uber transportation if needed
Prediction:	Having patient's follow-up at their FQHC location will increase adherence to follow-up appointment	Updated workflows will increase scheduled 7 day appointments	Completing 7-day follow-up at the Centers for new patients will increase 7-day attendance and ongoing engagement,	Utilizing the designated form and offering transportation will improve ability to connect patient with follow-up appointment.
Test Population and Location:	Metro IP discharges who receive mental health care at The Centers	Metro IP discharges who receive mental health care at The Centers	MetroHealth IP discharges who will be starting care at The Centers	MetroHealth IP discharges who are new and established with The Centers
Date & Duration (# hours/days/shifts/etc):	11/1/2024-11/15/2024	11/16/2024-12/31/24	2/3/25-2/28/25	4/1/25-4/30/25
Executed by:	Metro IP social work team and Jamara Barnes with the Centers	Metro IP social work team and Jamara Barnes with The Centers	Metro IP social work team and Jamara Barnes with The Centers	Metro IP social work team and Jamara Barnes with The Centers
Test Results:	3 patients discharged from Metro and scheduled at The Centers and 2 attended, and 1 appointment was still future dated	4 additional discharges from Metro. For whole month 7 scheduled 5 attended	58% of patients completed 7 day follow-up appointment in Feb	12 of 26 patients attended appointment in April. 19 of the 26 patients were referred to Jamara for post discharge coordination.

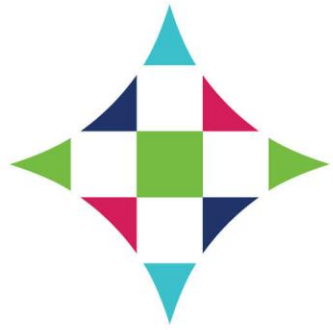
Follow-up within 7 days of discharge for a BH in patient admission



The Centers
Post Hospital
Liaison
Utilizing Metro
Notifications

Future Action Items





Neighborhood Family Practice

COMMUNITY HEALTH CENTERS

Neighborhood Family Practice Emergency Discharge Project

Amber Gravino, Director of Population Health

Thom Thomas, Quality Engineer

Who is Neighborhood Family Practice



- Federally Qualified Health Center founded in 1980
- Service Area spans across 12 neighborhoods on Cleveland's west side
- Serve over 22,000 patients annually
- Primary Care, Behavioral Health, Midwifery, Dental, Podiatry, Pharmacy



Cleveland Clinic Collaboration

Participating in a 12-week Quality Improvement (QI) training aimed at improving emergency discharge follow-up and reducing preventable ED visits.

Neighborhood Family Practice is the first non–Cleveland Clinic entity to join this regional Northeast Ohio collaborative.

NFP formed its own dedicated team and partnered with a Cleveland Clinic QI coach to learn from their internal improvement model.

Through this partnership, NFP is building capacity to develop a sustainable, systemwide quality improvement framework for future initiatives.

Neighborhood Family Practice Emergency Room Discharge

- **Institute:** Neighborhood Family Practice
- **Project Leader(s):** Amber Gravino
- **Project Team:** Janet Rodriguez, Hannah Sroka, Andy Shimek
- **Project Sponsor:** Jason Schreiber
- **Coach:** Thom Thomas and Joe Rak
- **Start Date:** February 27th, 2025



Problem Statement

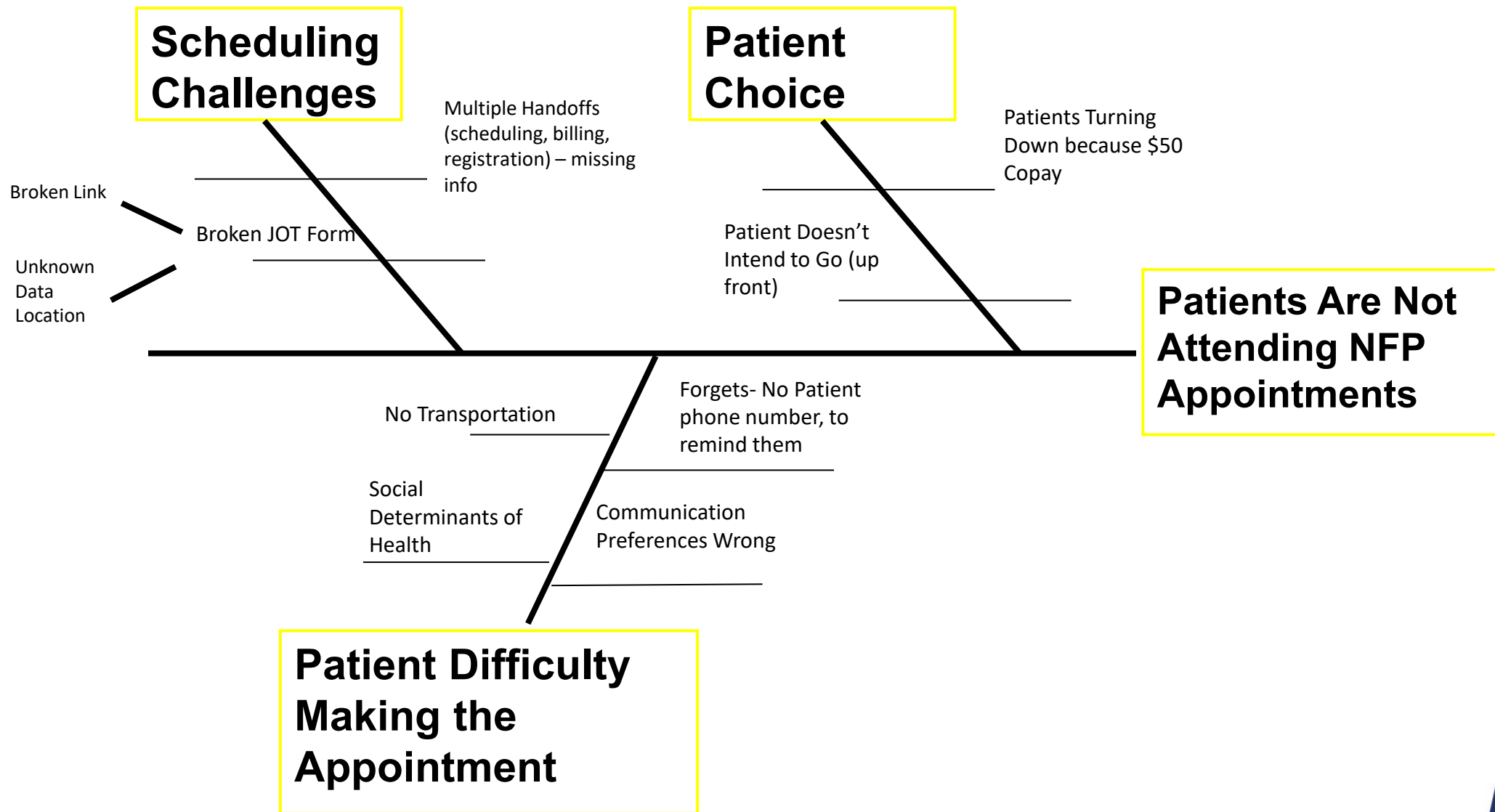
- Neighborhood Family Practice currently offers 7 weekly slots for Cleveland Clinic (CCF) ED follow-up appointments. Cleveland Clinic has requested additional slots; currently only 10% of patients scheduled for these appointments attend resulting in patients returning to the emergency room.

Aim Statement

- Increase the show rate for Cleveland Clinic Emergency Department (ED) follow-up appointments from 10% to 20% within the existing dedicated appointment slots by August 2025. Additionally, we will improve our tracking system to identify and monitor patients scheduled from the emergency room.



Emergency Room Discharge Fishbone Diagram



RECOMMENDATIONS/COUNTERMEASURES

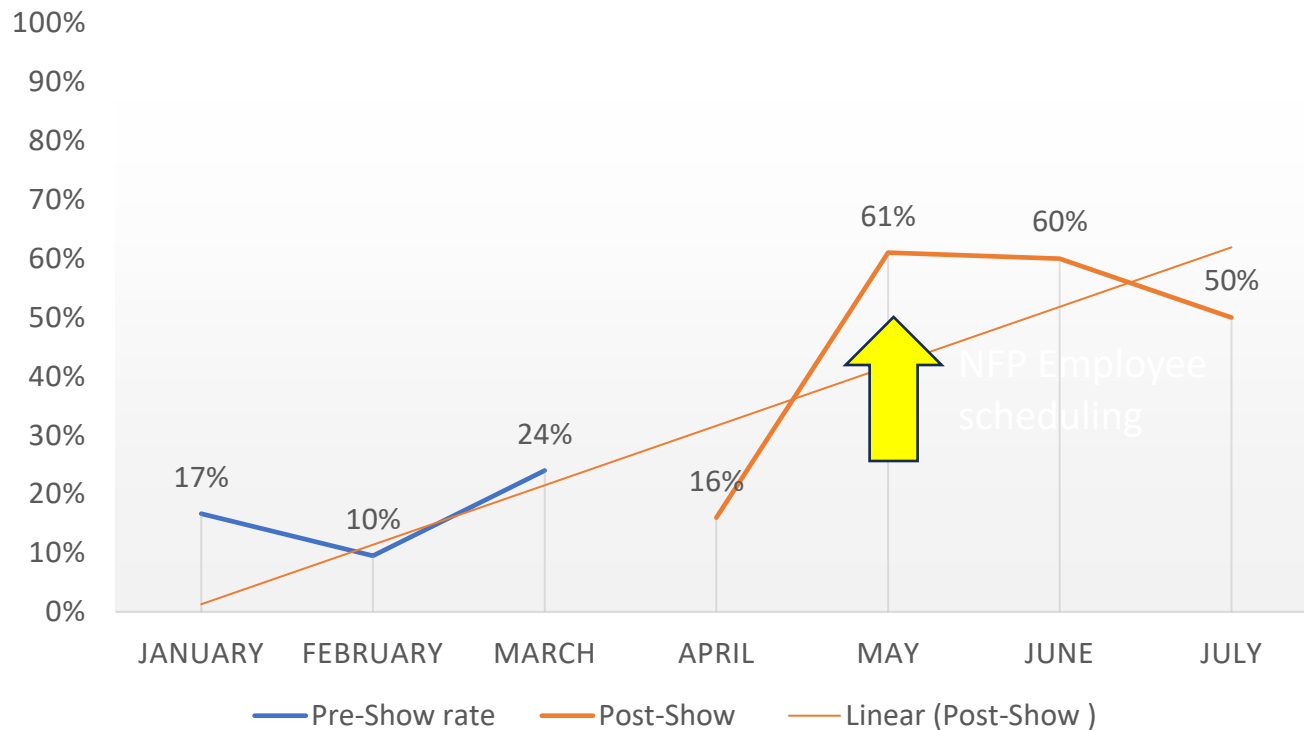
Countermeasures:

- **Presumptive Eligibility Coordination:**
Cleveland Clinic to share presumptive eligibility information with NFP prior to appointments, enabling patients to apply for financial aid in advance and reducing appointment abandonment due to the \$50 copay.
- **Enhanced Patient Tracking:**
Implement a centralized tracking system for patients scheduled through the call center to improve appointment visibility, attendance rates, and workflow efficiency.
- **ED Follow-Up Visit Type Creation:**
Develop a distinct visit type specifically for ED follow-up appointments to ensure accurate scheduling by the call center and facilitate better reporting and tracking.
- **Onsite NFP Support:**
Cleveland Clinic to fund a dedicated NFP staff member to be onsite for real-time scheduling of ED follow-up appointments, improving care continuity and reducing missed visits.



Emergency Room Discharge

SHOW RATE FOR EMERGENCY DISCHARGE PATIENTS TO ESTABLISH
PRIMARY CARE AT NEIGHBORHOOD FAMILY PRACTICE



- Original Appointment Show Rate goal of 20%
- Current Appointment Show Rate of **57%**

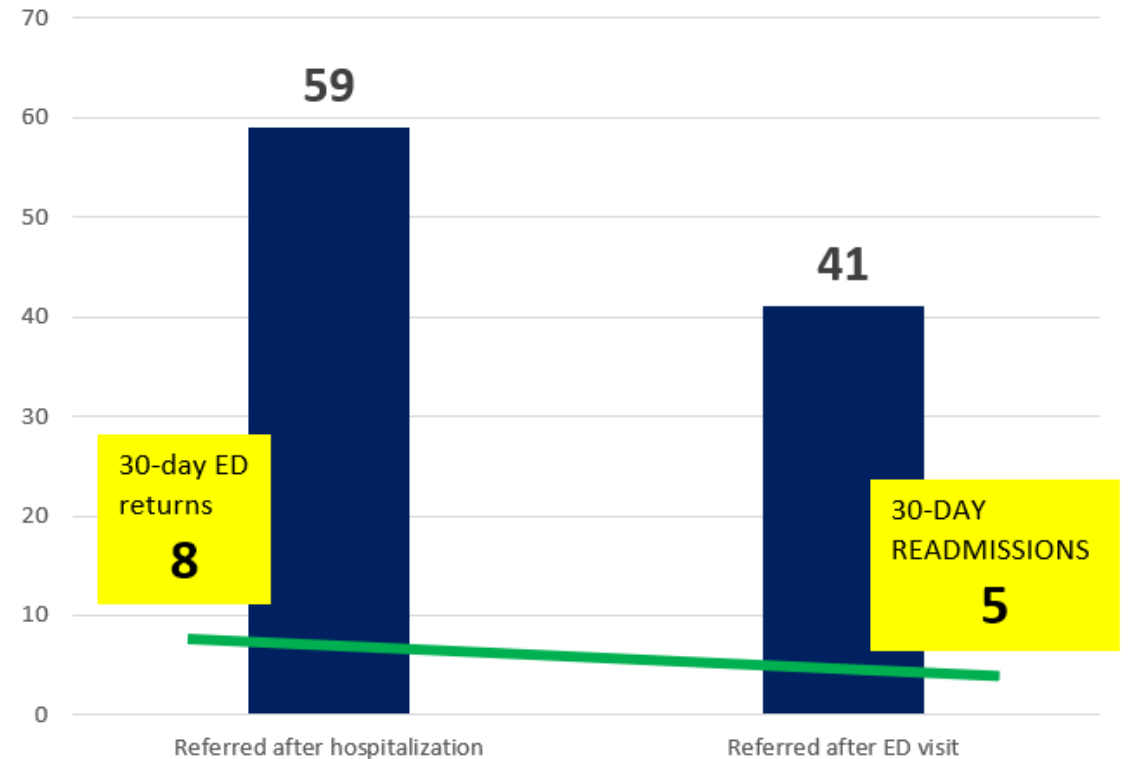


Results

Total patients reviewed post ED and Hospital: **100**

- Patients were selected randomly from the list and had at least **one completed visit at NFP**.
- 59 patients were referred to NFP after been hospitalized and 41 after ED visit.
- Number of returns to ED within 30 days of first ED visit or hospitalization was **8** (8%)
- Number of admissions within 30 days of first ED first ED visit or hospitalization was **5** (5%). Four of the five admission were after a hospital admission, and one was after ED visit.

ED AND HOSPITAL READMISSION RATES 30 DAYS POST VISIT



MARKET HOSPITAL READMISSIONS AVG 17.5%
MARKET AVOIDABLE ER READMISSIONS AVG 10.3%

Benefits Summary

- **Project Benefits:**

- Cost Reduction
 - Appointment confirmation calls by our front were expanded.
- Revenue Improvement
 - Increase in patients attending appointments from ED or hospital
- Reduction of re-admissions from the pts with “kept” appointment

- **Culture of Improvement Benefits:**

- Creating internal continuous improvement program
- Knowledge of continuous improvement across Neighborhood Family Practice
- Patient advocacy
- Patients scheduled by a Neighborhood Family Practice employee from hospital to establish primary care at NFP



Questions?

