62nd Annual Greenville Postgraduate Seminar

Spotlight: Primary Care

Wifi: Greenville ONE Center
Login: Conference1
Inspire health. Serve with compassion. Be the difference.
IMPROVING THE HEALTH OF POPULATIONS
Continuum-Based Care

INTEGRATED CARE MODEL

Integrated, standardized workflow management & monitoring

Seamless Patient Experience Across the Continuum

Wellness / Preventive Care
Primary Care / PCMH
Specialty Care
Urgent / Emergent Services
Acute Hospital Care
Care Transitions
Post-Acute Care / Home Care
End-of-Life Care
Integrating the Care Team

- Physicians - Primary Care & Specialists
- Outpatient Clinical Staff
- Digital Health
- Hospitalists / SNFists
- Community - Based Resources
- Traditional & Non-Traditional Care Management
- Behavioral Health
- Home Health & Ambulatory Services
Team-Based Model

- Registered Nurse
- Social Worker
- Health Coach
- Transition of Care
- Community Health
Community Health Engagement

Accountable Communities
Nutrition, Prevention, Physical Fitness, Health Living

Community Resources
Supportive Housing, Social Services, Eligibility Programs

Medical Neighborhoods
Specialists, ER, Urgent Care, Pharmacists, EMS, Fire Department Medical Personnel, Employer Work Sites, Home Health, School Nurses

Care Providers
Physicians, Nurse Practitioners, Home Health, Care Managers, Practice Staff, Family Members
Medical Neighborhoods

- Health system and safety-net collaboration
- Providing access to care within communities
- Community Paramedic and Health Worker Models
- Home Health
- Mobile Health Clinic
- Care Management
- Care Coordination
Patient Hotspotting

Data Driven Process Through:
• Claims and EMR Data Analysis
• Risk Stratification
• Access to Care

Possible Focus Areas:
• ED and EMS Utilization
• Admissions
• Patient Populations
• Chronic Disease Prevalence
• Gaps in Care
Addressing Socioeconomic & Psychosocial Barriers

- Transportation
- Health and Insurance Literacy
- Medication Assistance and Literacy
- Caregiver Education
- Care Navigation
- Trusting Relationships
- Plans of Care
- Connection to Resources
Accountable Communities

- Community-led innovation
  - Community volunteer programs
  - Community resources (faith-based organizations, schools, EMS, police and fire districts)
  - Community Asset Maps

- Patient education and social determinants

- Population health management

- Social service providers
Alignment into Primary Care

- School-based Health Clinics (On Track)
- Mobile Health Clinic
- PASOs
- Community Paramedics
Name: Bill Sampson  
Age: 55  
Insurance Eligibility: Uninsured  
Home Setting: Rents trailer home in rural area  
Medical and Mental Health History: CHF, COPD, Hep C  

**Narrative:** Mr. Sampson presented to the ED with shortness of breath and generalized weakness. During his hospitalization, he was found to be in acute exacerbation of heart failure. He finished the 8th grade and is illiterate. Mr. Sampson has a long history of distrust of the medical system. He has become increasingly withdrawn from family and the few friends that he has. He states that he has not been taking his medications, as he does not have transportation nor the money to pay for them. He also states that he is unable to walk to the closest convenience store for food. He has been discharged back home and this is his first PCP visit.  

**Utilization:** In 12 months prior to the hospitalization, Mr. Sampson has had 14 ED visits, 3 inpatients stays and no PCP visits.
Name: Sara Williams
Age: 28
Insurance Eligibility: Medicaid
Home Setting: Homeless/Moving weekly staying with friends
Medical and Mental Health History: Diabetes insulin dependent; HTN; Depression; PTSD; Anxiety

Narrative: A month ago, Ms. Williams was hospitalized for diabetic ketoacidosis. The inpatient hospital case manager noted that she still does not have an appointment for a PCP, nor does she have her medications filled. Ms. Williams has a history of being a victim of domestic abuse which led her to leave her last relationship 3 years ago making her homeless. She is unemployed, but would like to return to work in light-duty manufacturing. She has no transportation.

Utilization: In past year she has had 9 ED visits with a wide range of non-emergent complaints and 1 hospitalization related to her diabetes.
**Name:** Isabella Rizor  
**Age:** 12  
**Insurance Eligibility:** Uninsured due to legal status  
**Home Setting:** Lives with extended family, mother and father remain out of the country  
**Medical and Mental History:** Depression and anxiety, family planning  

**Narrative:** Ms. Rizor attended Berea Middle School. She was seen by the school-based health clinic (SBHCs) and referred to Family Medicine for a medical home. The school district will not allow the SBHCs to discuss family planning. The NP is also concerned in addition to depression and anxiety that she is suffering from some undiagnosed developmental delays. She is missing school often and grades are poor. Ms. Rizor’s primary language is Spanish. Her travel to the US was a traumatic experience.  

**Utilization:** The SBHC is Ms. Rizor’s first entry to the health system and there are no records of prior care in the US.
NowPow

Addressing Social Determinates of Health
NowPow

A multisided technology platform that drives community level collaborations across the care continuum.

The platform empowers care professionals to:

- Promote awareness of high quality community resources
- Provide data driven referrals
- Track patient engagement and activation
# Community Based Organizations (CBO) Update

<table>
<thead>
<tr>
<th>Contract Signed / Onboarding:</th>
<th>Ongoing Support:</th>
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<tbody>
<tr>
<td>Sexual Trauma Services of the Midlands</td>
<td>Food Share – Columbia/Midlands</td>
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<tr>
<td>Greenville Free Medical Clinic</td>
<td>Wateree Community Action, Inc.</td>
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<td>Transitions Homeless Center</td>
<td>WellPartners</td>
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<tr>
<td>Appalachian COG</td>
<td>Upstate Warrior Solution</td>
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<td>The Cooperative Ministry</td>
<td>The Free Medical Clinic</td>
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<td>PASOs</td>
<td>Triune Mercy Center</td>
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<td>Welvista</td>
<td>Servants for Sight</td>
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<td>Richland County School District One</td>
<td>The Phoenix Center</td>
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<td>Harvest Hope - Greenville</td>
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<td></td>
<td>Harvest Hope - Columbia</td>
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Prisma Health Departments Currently Live

• In-Patient Case Management
• Community Health
• Ambulatory Care Management
• Home Health
## Prisma Health NowPow Data Analytics

<table>
<thead>
<tr>
<th>Prisma Health NowPow</th>
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<tbody>
<tr>
<td># Total Users</td>
<td>404</td>
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<tr>
<td># Screenings Complete</td>
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<td># Searches</td>
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<tr>
<td># Total Referrals</td>
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<td># Referrals Shared</td>
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<tr>
<td># Tracked Referrals Sent</td>
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<tr>
<td>Patients Engaged</td>
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Source: NowPow At-A-Glance Summary Report  
Timeframe: Year-to-Date (01/01/2019-8/13/2019)  
Use: Monitor NowPow Data Analytics Activity
NowPow Discussion

1. How could NowPow help your patients?

2. How could NowPow help your practice workflow?

3. In your practice, which team members should be involved screening for social determinants of health and making referrals through the detail?