

## EXPERT Q&A: HOW TO “REACH BEYOND THE FOUR WALLS” OF THE HOSPITAL



One of the most important pieces of cultivating loyal patients is going beyond the status quo of caring for people only within the timespan of their hospital, ED, or urgent care encounters. In this Expert Q&A, **SCP Health's Vice President of Program Management, Patient Engagement, Marsha S. Masten, RN, BSN**, shares her perspective on what the evolving consumerist patient is looking for—and how hospitals, health systems, and providers can shift their approach to start “meeting patients where they are.”

**Q: Why is engaging people in their daily lives (as opposed to only during their episodes of care) becoming an increasingly important priority for healthcare providers and organizations?**

**A:** In the past, patients would come into a healthcare facility, receive their evaluation and treatment, and be provided post-discharge directions for how to care for themselves after leaving the facility. At this point, they were no longer under the provider's immediate oversight.

Now, the extreme complexity of America's healthcare system is making it increasingly difficult for patients to navigate to the right place, receive treatment at a reasonable price, and correctly follow post-discharge directions. Our community members are flooded with questions like:

- Who do I contact about how I'm feeling?
- Where I am eligible to get care?
- What will I be charged for immediately and what charges will there be for any potential ongoing treatment—and is it worth it?
- How do I pick up my prescribed medications?
- What do I do if something goes wrong?

Sometimes, the process is so complicated that patients would decide not to see a doctor at all. Sometimes, they come in, but don't understand and/or don't have the resources to follow post-discharge instructions, so they end up back in the health system. Patients need support—and as healthcare leaders and providers, we can make a difference for them.

Patients are going to spend much more time outside your facilities than they do inside, so you need to meet them where they are.

**Q: How do you do that?**

**A:** It's asking about meal availability; its coordinating transportation; it's setting up appointments; it's just following up, demonstrating commitment, and being a clear resource.

If we want patients to trust us, come back to us, recommend us to their friends, share their positive experiences at our facility with their family, and rely on us as a long-term partner in sickness and in health, then we have to be where they are and be there for them. If we don't, patients in our community will suffer—and we'll be spending time helping people in the short-term, only to watch it all fall apart once they leave our facility.

Everybody is a patient; so build a reputation as the place patients want to go and the provider they want to see.

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**Q: Is there still work to be done in order for America's health care system to "meet the patients where they are?"**

**A:** Patients want a connected system; in fact, we all want a connected system. I've never talked to or worked for anyone that isn't working to make healthcare easier for the patient to access, use, and rely on. But the reality is, we haven't gotten it completely right yet.

We have at least two extremely strong opportunities for patients and providers to interact in a much more meaningful way—and keep our population healthier for longer:

1. **One source of truth.** In all of our minds, we intuitively know that if our PCP, the clinician treating us in the ED, the pharmacist filling our medication, and the home health nurse visiting us once a week were all looking at one comprehensive, longitudinal view of our health journey, life would be easier. Instead, the patient is often put in the middle, running down old records, looking for a fax machine, trying to locate scans or remember medications, etc. We need to push toward one source of truth, or patients will continue to suffer from stress and distrust of our ability to communicate between providers and sites of care.
2. **A quarterback.** Initially, the PCP was thought to be the hub for coordinating patient care across the continuum, but many patients don't have PCPs or their PCPs aren't kept in the loop about their care—making it impossible for them to fill this role. PCPs usually don't have the resources or hours to play quarterback either. A trend we are seeing across the industry is leaning on clinical coordinators (most often nurses) to help manage a patient's journey through doctors, hospitals, labs,

clinics, home visits, and more. Ideally, that coordinator would be able to follow up periodically with a patient for years to come, always referencing the one source of truth to know the patient's social and financial situation, risk factors, recurring challenges, and much more. We'd be able to get ahead of issues rather than play catch-up—ultimately keeping patients well longer.

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**Q: Talking about the future inspires hope and motivation, but it can also be overwhelming to think about all that would have to happen to get healthcare to that ideal state. So, what's step one? Where do we begin?**

**A:** We start by simply asking, “What can we do differently right now, beginning today?”

We can't go back and change the past, but we can shift what we do now. As we've discussed, **reality hits once patients are discharged**, and they often default back into the patterns that sent them to our hospital, urgent care, or ED in the first place. So that's where we begin.

We improve our pre-discharge communication to ensure we're involving the patients' family or caretakers in the conversation; we start calling patients within 24 hours post-discharge to make sure they're doing okay; we train our clinicians to start noting comments the patient makes about social situations or financial stress; we may even find a partner who can help us deploy a care coordination center where nurses are following up with our patients and their various providers, connecting patients with the resources they need (e.g. transportation, a PCP, etc.). This starts to build a longitudinal view of patients' lives as they intersect with the healthcare system.

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**Q: The benefits to the patient are incredibly clear, but what about the facility or health system? Why invest in improving care coordination?**

**A:** There are three key reasons, all of which are somewhat intertwined.

1. **Decreased risk.** Due to the changes in reimbursement, patients are being discharged from the ED now who, just a few years ago, would have been admitted to the hospital for multiple days. Patients are no longer meeting the inpatient criteria, so they are being sent home much sicker than in the past—which is worrisome for hospitals and providers because they are measured, valued, and paid based on metrics like outcomes, readmissions, 30-day post-discharge mortality rates, etc. Beyond that, they can be sued by patients (or families of the patients) if serious complications or bad outcomes experienced post-discharge are perceived as a result of the facility's poor support of the patient.

- 2. Patient satisfaction.** This one is probably pretty obvious. Patients are going to be much more satisfied with their care journey if someone is calling them after they leave the hospital, ED, or urgent care. Patients want to be asked, “how are you doing?” They want someone to talk to after they get home and actually start figuring out who they need to see next, what medications they’re supposed to pick up, and how to tell if they need more care. Taking the time and making the effort to connect with a patient and ask what we can do to help will satisfy the patient—which ultimately translates into exceptional HCAHPS scores, online reviews, and word-of-mouth recommendations.
- 3. Patient engagement and outcomes.** This might feel like a summary of the last two, but it’s slightly different. Following up to ask how a patient is doing might ensure satisfaction, but becoming a patient’s partner as he or she navigates at least the next several months post-discharge creates loyalty and drastically improves the likelihood of good outcomes. Facilities or systems that build a framework in which patients are engaged long-term have the opportunity to change the paradigm. We can educate patients so they know exactly who to call if something goes wrong—hopefully guaranteeing that they call us and not a competitor. We can contact them to eliminate missed appointments, unfilled medications, or unnoted symptoms—likely ensuring that they stay in our network, get the care they need, and stay healthy. At the end of the day, you’ve either lost a patient (to no care or competitor care) or retained a patient—it’s one or the other.

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**Q: Now knowing those incredible benefits to both patients AND facilities/providers, the natural next question is: why isn’t everyone doing this? What’s holding healthcare organizations back from fully diving into care coordination?**

**A:** In some ways, this goes back to the “where do we start?” question discussed earlier. Honestly, this is a top-of-mind issue for everyone leading or providing healthcare. We all want patients to get better and stay better. We all want to get reimbursed fairly. We all want to give the absolute best experience to every person that walks in (and out!) of our doors. But as with everything in life, it’s not as simple as just wanting it.

Mostly what I hear from healthcare organizations is that they’re trying really hard to do as much as they can, but they are running a lot of disconnected efforts and are stretched too thin. I once heard it described as “a circle, but with the pieces all chopped up and floating around.” This situation can be so deflating, and often executives or clinicians find themselves just looking around wondering how they can get better without spending too much money or losing all the work they’ve already done.

So essentially, those are the main barriers to organizations investing in truly coordinated care: financial stress, operational concerns, and the looming task of trying to pull together all the initiatives that are already running into one cohesive solution.

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**Q: Lastly, what approach does SCP Health take to support organizations who want to improve their care coordination processes and programs?**

**A:** The most important thing to understand about SCP Health's approach to care coordination is that our team knows how hard the leaders and clinicians at those organizations work to engage their communities in an affordable and accessible care experience. Our SCP Health team doesn't attempt to discredit or replace those efforts in any way—rather, we aim to first augment the existing initiatives that organizations have put in place and then help find and fill in any remaining holes. Our Care Coordination team is staffed by clinical and non-clinical care coordinators dedicated to serving our partner organizations' communities in the ways they need it most. The support options we offer are customizable, not cookie cutter. **We meet organizations where they are so that they can do the same for their patients.**