Clinical Safety & Effectiveness
Cohort # 24
Team #7
Capturing Transition of Care Appointments
TEAM

- **CSE Participants**
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  - Priyanka Bhugra, MD (UHS Internal Medicine Hospitalist)
  - Mary Catherine Johnson, MD (UT Health Internal Medicine Chief Resident)

- **Team Members**
  - Jan Patterson, MD (Facilitator and CSE Course Director)
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  - Chandana Tripathy, MD (UT MARC Medical Director, Sponsor)
  - Ramon Cancino, MD (UT PCC Director, Sponsor)
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  - Linda McFarlin, RN (MARC clinic manager)
  - Tamara Heflin, RN (UT Health Care Coordinator)
  - Shemica Parrish, LVN (MARC case manager)
  - Melanie Roller, RN (Care Coordination Manager of Hospital Services)
  - Patrician Reyes (Operation Manager, Access Plus)
  - Carmen Sanchez (UHS Director of Clinical and Business Analytics)
  - Florence Hernandez (Senior Administrative Assistant, Access Plus)
  - Joveoni Villareal (Manager, Patient Access Services)
Background

- Transition of care refers the safe handoff of a patient from one setting of care to another.
Importance of Transition of Care Appointments

- Decrease health care expenditure
  - Reducing readmission rates
  - Length of stay
  - Unplanned ER visits

- Improve patient safety and decreasing adverse events
  - Medication Management
  - Disease management

- Increase revenue

UT Health is becoming an ACO
Transitional Care Management Criteria

1. Interactive communication with the patient or caregiver within 2 business days after discharge
   - Phone, email or face to face
   - By provider or other clinic staff
   - At least 2 attempts

2. Certain non face to face services
   - Examples: review discharge documents, follow-up or review need for diagnostic tests, patient education, referrals, etc

3. Face to face visit within 14 days

TOC appointment rate at the MARC PCC office is <50%
AIM Statement

Improve the percentage of patients scheduled for Transition of Care appointments for Internal Medicine primary care patients at the MARC clinic who are discharged from UHS Internal Medicine inpatient services from 49% to 75% from April 2019 to June 2019
People

Patient
- Patient cannot identify PCP (does not remember, altered mental status)
- Patient does not understand that UH and UT are different healthcare systems/EMRs
- Patient leaves AMA
- Patient does not call PCP to let them know they have been hospitalized or discharged

PCP
- Forgets to notify case manager of direct admission/sending a patient to ER
- Does not educate patient regarding importance of notifying the office
- Does not provide patient with tools to contact the office

Discharging provider
- Forgets to place consult for discharge follow-up

Case Manager
- Does not update PCP in documentation

Procedures

Patient
- Patient education (patient does not know importance of TOC follow-up visit)

Case manager does not update PCP information

Registrar and/or Case Manager does not know which PCPs are UT physicians

Hospitalists does not place discharge consult

Clinic is unable to reach the patient after notification of discharge is received

Social worker are geographically located making difficult for MD to communicate with each of them or able to reach them as different social worker assigned to different patients.

Policy

Lack of system/protocol for communication between PCP and hospitalist, and inpatient case management/social work with PCP office

Currently relying on patient to notify PCP office

No clear discharge protocol of the role/responsibilities of each individuals regarding communication with PCP office

Equipment

UT and UHS have different EMRs

Access plus to UT may not be going to the right person

Difficulty reaching PCPs office when calling, long on hold wait time

Limited access to sunrise by PCP

Difficulty entering PCP information in Sunrise (restricted to certain people)
Process for Data Collection

- Identify MARC clinic patient discharges from UHS by:
  - MARC clinic report
  - UHS MIDAS report

- Retrospective data was collected and analyzed from December 1, 2018 to April 2, 2019

- A daily MIDAS report was generated to collect prospective data
<table>
<thead>
<tr>
<th>Goal</th>
<th>Primary Drivers</th>
<th>Interventions</th>
<th>Responsible</th>
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<tbody>
<tr>
<td>To increase the percentage of TOC appointments scheduled at MARC PCC</td>
<td>Improve notification of discharged patients from UHS to MARC PCC</td>
<td>1) Generate a MIDAS report from UHS admissions data to identify MARC patients 2) Run the daily report to obtain discharge data 3) Create a system with Access Plus in which AP will utilize the central PCC email to alert the MARC clinic of discharges when the provider places an order for consult outpatient upon discharge</td>
<td>1) Melanie Roller / Bhugra 2) IT / Melanie Roller / Bhugra 3) MARC Clinic Manager, Case Manager, Corado, Castillo 4) Patricia Reyes/MARC case managers</td>
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<td>Improve outreach to patients</td>
<td>1) Use daily MIDAS report to generate an EPIC encounter to start attempts to reach the patient 2) Train schedulers to create an EPIC encounter when notified of recent discharge so that the patients is appropriately triaged to receive TOC contact and appointment</td>
<td>1) Clinic Manager, Case manager 2) Case manager, medical director, LVNs</td>
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<td>Correctly identify PCP during admission</td>
<td>1) Patient education - provide cards with PCP name to be presented on hospital visit 2) Increase visibility of current MARC internists for proper association with patients</td>
<td>MARC Clinic Manager, Johnson, MARC internists</td>
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<td>Improve PCP access</td>
<td>1) Designate one provider per week for TOC only visits 2) Generate more MD only slots which can be utilized for TOCs</td>
<td>Clinic manager</td>
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</table>
Methods of Discharge Communication
Baseline Data

Percentage of TOC appointments scheduled

N = total number of discharges in the 2 week period
List of Prioritized Interventions

1. MIDAS Report
   - Generate a MIDAS report from UHS admissions data to identify MARC patients
   - Grant access to MARC clinic manager to use the MIDAS report
   - Run the daily report to obtain admissions/discharge data

2. Access Plus
   - Create a communication system between UHS Access Plus and the MARC clinic in which Access Plus will send discharge alerts to the PCC email when inpatient providers place a Sunrise consult for PCP follow-up
   - MARC clinic staff will be responsible for calling the patient, scheduling the TOC appointment and providing feedback to Access Plus on the appointment specifics
Percentage of TOC appointments scheduled

Pre and Post-intervention Data

N=total number of discharges in the 2 week period
MARC staff contact with patient after discharge

Pre-intervention:
n=32 of 43
74%

Post-intervention:
n=12 of 12
100%
Was an Access Plus Order Placed at Discharge?

- Yes: 38%
- No: 61%
Pre-intervention: 44% completion of 19 out of 43 appointments.

Post-intervention: 92% completion of 11 out of 12 appointments.
Return on Investment

<table>
<thead>
<tr>
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<th>TOC visits completed (%)</th>
<th>Annual TOC visits completed</th>
<th>Realized annual charges</th>
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<tbody>
<tr>
<td>Pre-intervention</td>
<td>44</td>
<td>56</td>
<td>9,968</td>
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<tr>
<td>Post-intervention</td>
<td>92</td>
<td>117</td>
<td>20,843</td>
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<tr>
<td><strong>Net Revenue</strong></td>
<td></td>
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<td><strong>10,875</strong></td>
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# Readmission Expenditure

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<tr>
<th>Readmission Rate</th>
<th>Annual Readmissions</th>
<th>Readmission Cost</th>
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<tbody>
<tr>
<td>Current Study population</td>
<td>25%</td>
<td>28</td>
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<tr>
<td>Post-Intervention</td>
<td>15%</td>
<td>16</td>
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<td>Cost Avoidance</td>
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# Hospital Readmissions Reduction Program Penalties

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<tr>
<th>Program Year</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tr>
<td>Fiscal Year</td>
<td>2013</td>
<td>2014</td>
<td>2015</td>
<td>2016</td>
<td>2017</td>
<td>2018</td>
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<tr>
<td>Dates of Performance Measurement</td>
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<td>Conditions for Original Hospitalization</td>
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<td>Heart Attack (AMI)</td>
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<td>Heart Failure (HF)</td>
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<td>Pneumonia</td>
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<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
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<td>Hip/Knee Arthroplasty (THA/TKA)</td>
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<tr>
<td>Coronary Artery Bypass Grafting (CABG)</td>
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<tr>
<td>Maximum Penalty</td>
<td>1%</td>
<td>2%</td>
<td>3%</td>
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<td>3%</td>
<td><strong>3%</strong></td>
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Next Step

- Continue tracking admissions and discharges for Clinic patients
- Provider education regarding discharge orders to Access Plus
- Patient education regarding PCP and TOC visits
- Involve other UT Clinics and sites
Lessons Learned

- Improve PCP identification at hospital admission
- Discharge planning and structured order sets
- Effective communication between care providers
- Shared Electronic Health Record system

Improving Transition of Care
Thank You