Clinical Safety & Effectiveness
Cohort # 24
Team #7

Capturing Transition of Care Appointments

UT Health San Antonio
Quality & Lifelong Learning

University Health System

UNIVERSITY OF TEXAS
MD ANDERSON
CANCER CENTER
Making Cancer History®

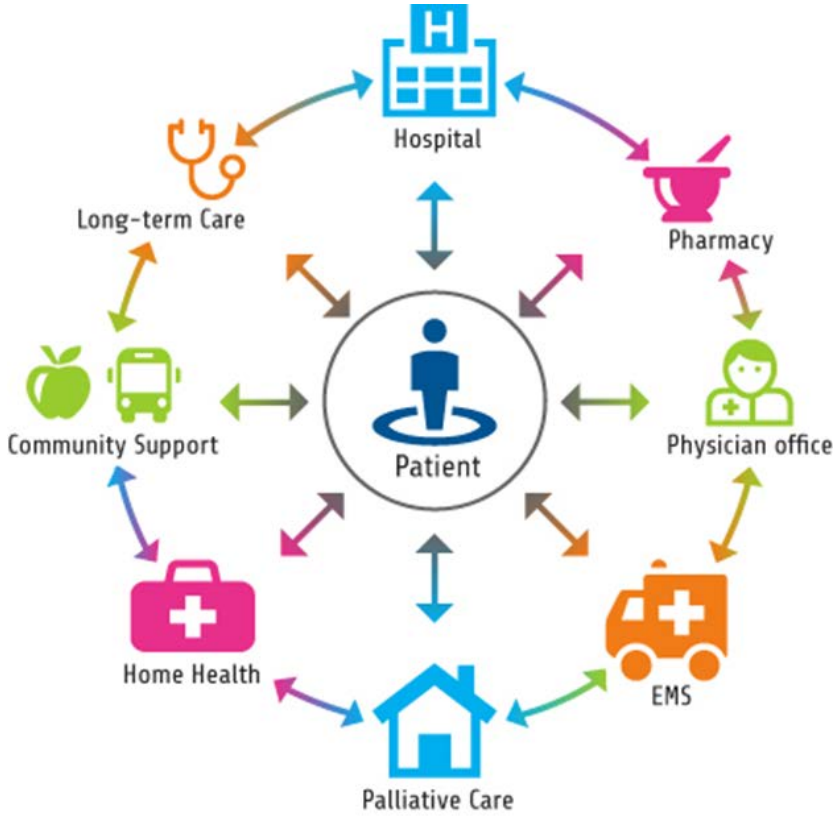
TEAM

- CSE Participants
  - Cynthia Castillo, MD (MARC PCC Internal Medicine)
  - Henneth Corado, MD (MARC PCC Internal Medicine)
  - 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)**
  - **Luci Leykum (Division Chief, Hospital and Medical Services, Sponsor)**
  - **Chandana Tripathy, MD (UT MARC Medical Director, Sponsor)**
  - **Ramon Cancino, MD (UT PCC Director, Sponsor)**
  - Jack Badawy, MD (UHS Internal Medicine Hospitalist, facilitator)
  - 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)
  - Joevoni Villareal (Manager, Patient Access Services)

Background

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

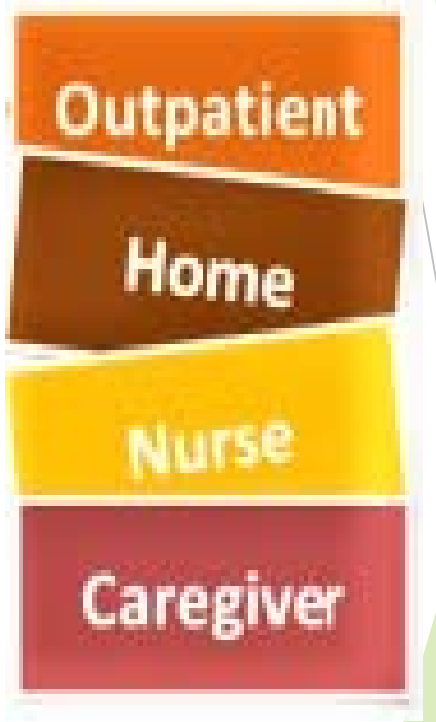


Importance of Transition of Care Appointments

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

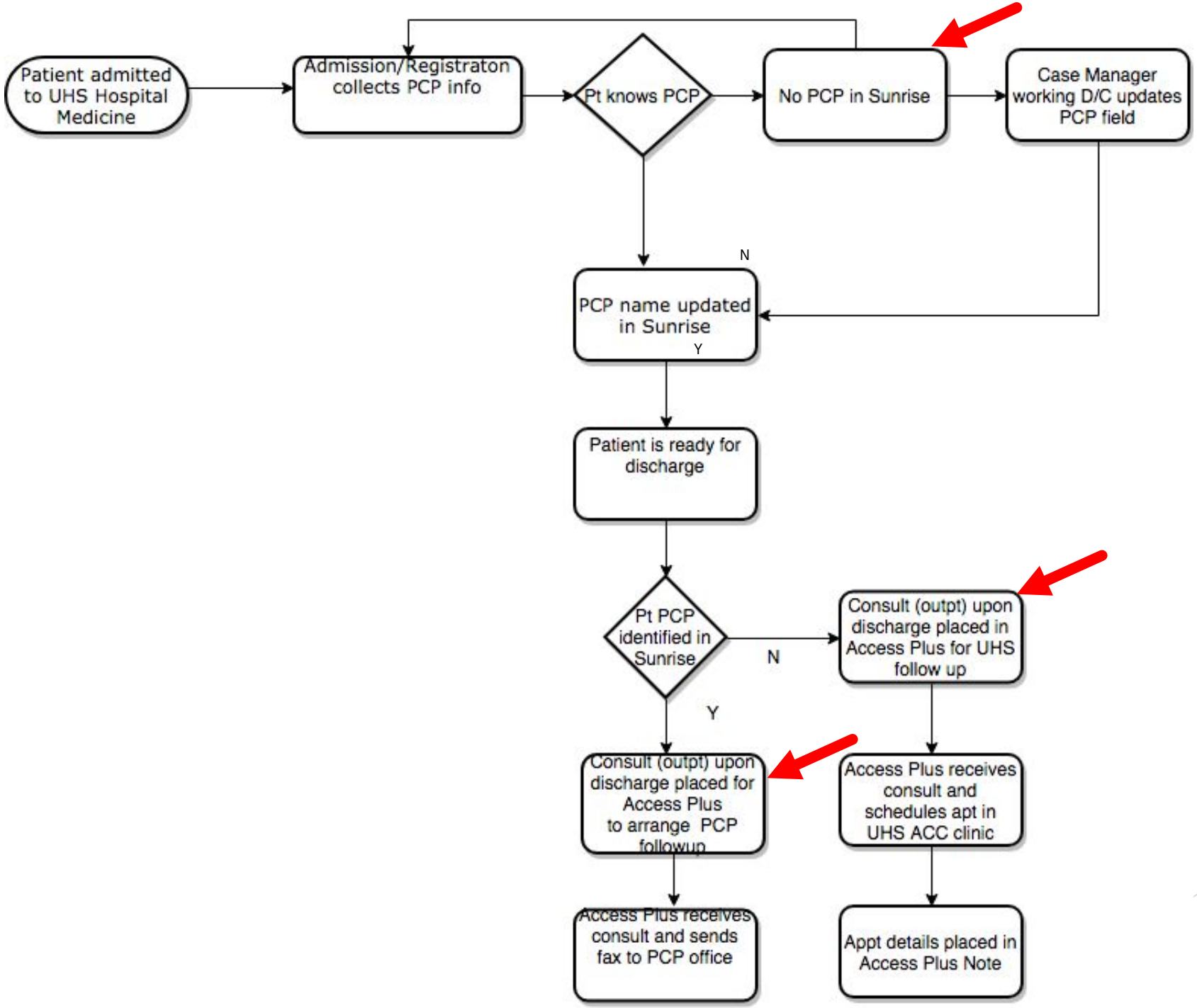
Transitional Care Management Criteria

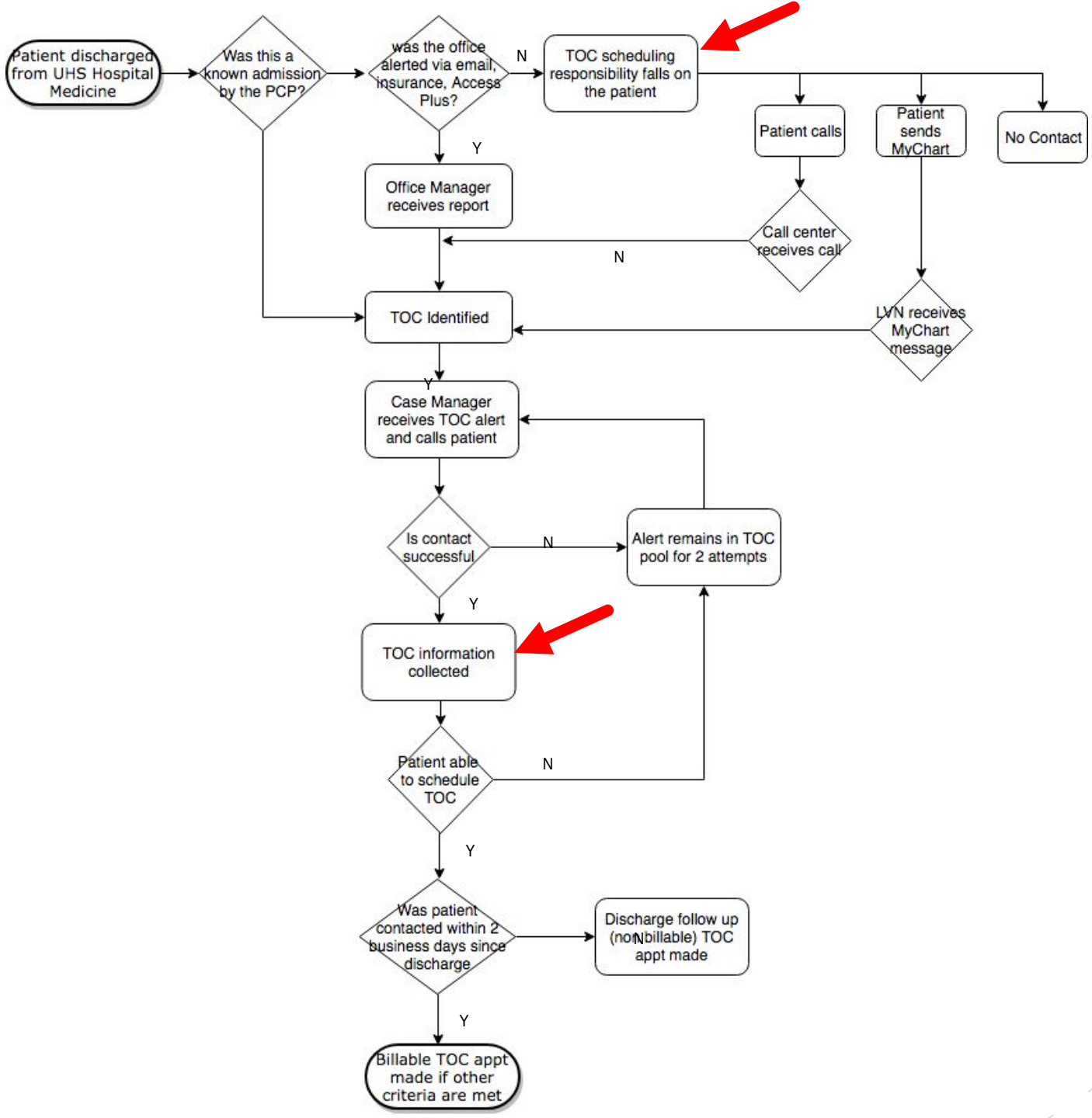
1. Interactive communication with the patient or caregiver within 2 business days after discharge
   - Phone, email or face to face
   - By provider or other clinic staff
   - At least 2 attempts
2. Certain non face to face services
   - Examples: review discharge documents, follow-up or review need for diagnostic tests, patient education, referrals, etc
3. Face to face visit within 14 days

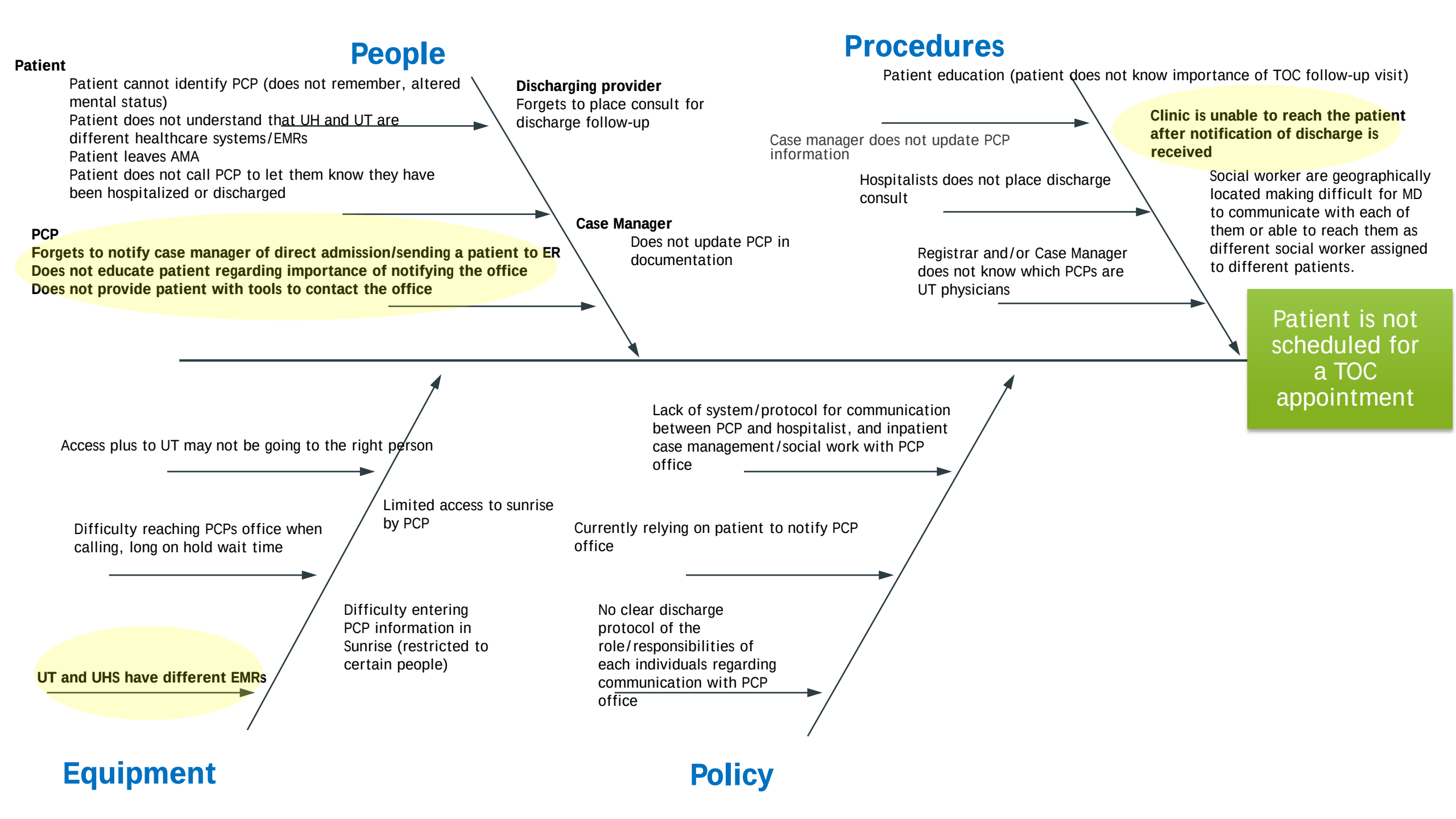
TOC appointment rate at the MARC PCC office is <50%

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


Patient admitted to UHS Hospital Medicine
Admission/Registraton collects PCP info
Pt knows PCP
No PCP in Sunrise
Case Manager working D/C updates PCP field
N
PCP name updated in Sunrise
Y
Patient is ready for discharge
Pt PCP identified in Sunrise
N
Consult (outpt) upon discharge placed in Access Plus for UHS follow up
Y
Consult (outpt) upon discharge placed for Access Plus to arrange PCP followup
Access Plus receives consult and schedules apt in UHS ACC clinic
Access Plus receives consult and sends fax to PCP office
Appt details placed in Access Plus Note


Patient discharged from UHS Hospital Medicine
Was this a known admission by the PCP?
was the office alerted via email, insurance, Access Plus?
N
TOC scheduling responsibility falls on the patient
Patient calls
Patient sends MyChart
No Contact
Y
Office Manager receives report
Call center receives call
N
TOC Identified
LVN receives MyChart message
Y
Case Manager receives TOC alert and calls patient
Is contact successful
N
Alert remains in TOC pool for 2 attempts
Y
TOC information collected
Patient able to schedule TOC
N
Y
Was patient contacted within 2 business days since discharge
Discharge follow up (non-billable) TOC appt made
N
Y
Billable TOC appt made if other criteria are met

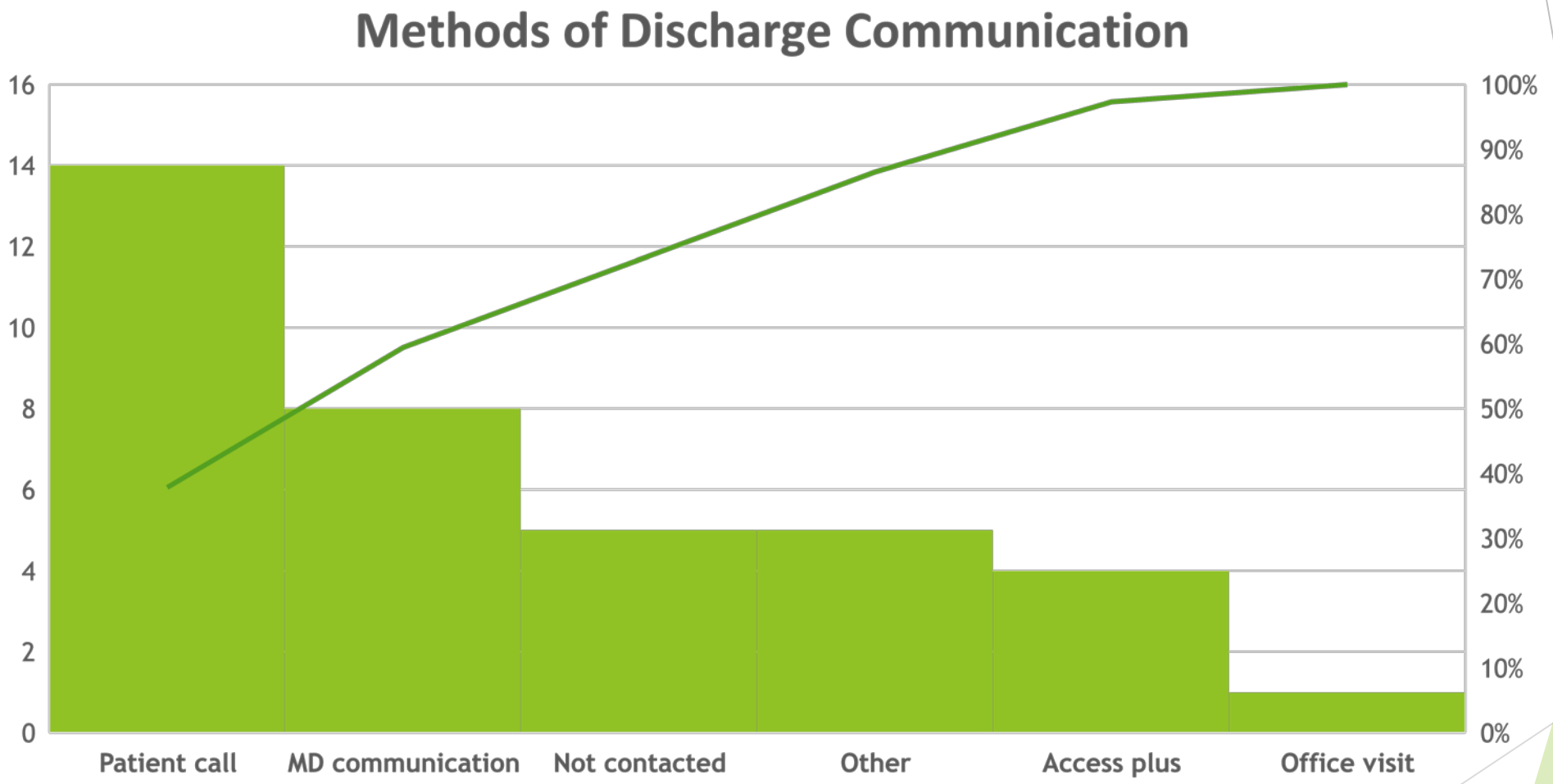

People
Patient
Patient cannot identify PCP (does not remember, altered mental status)
Patient does not understand that UH and UT are different healthcare systems/EMRs
Patient leaves AMA
Patient does not call PCP to let them know they have been hospitalized or discharged
PCP
Forgets to notify case manager 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 education (patient does not know importance of TOC follow-up visit)
Case manager does not update PCP information
Clinic is unable to reach the patient after notification of discharge is received
Hospitalists does not place discharge consult
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.
Registrar and/or Case Manager does not know which PCPs are UT physicians
Patient is not scheduled for a TOC appointment
Access plus to UT may not be going to the right person
Difficulty reaching PCPs office when calling, long on hold wait time
UT and UHS have different EMRs
Limited access to sunrise by PCP
Difficulty entering PCP information in Sunrise (restricted to certain people)
Equipment
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
Policy

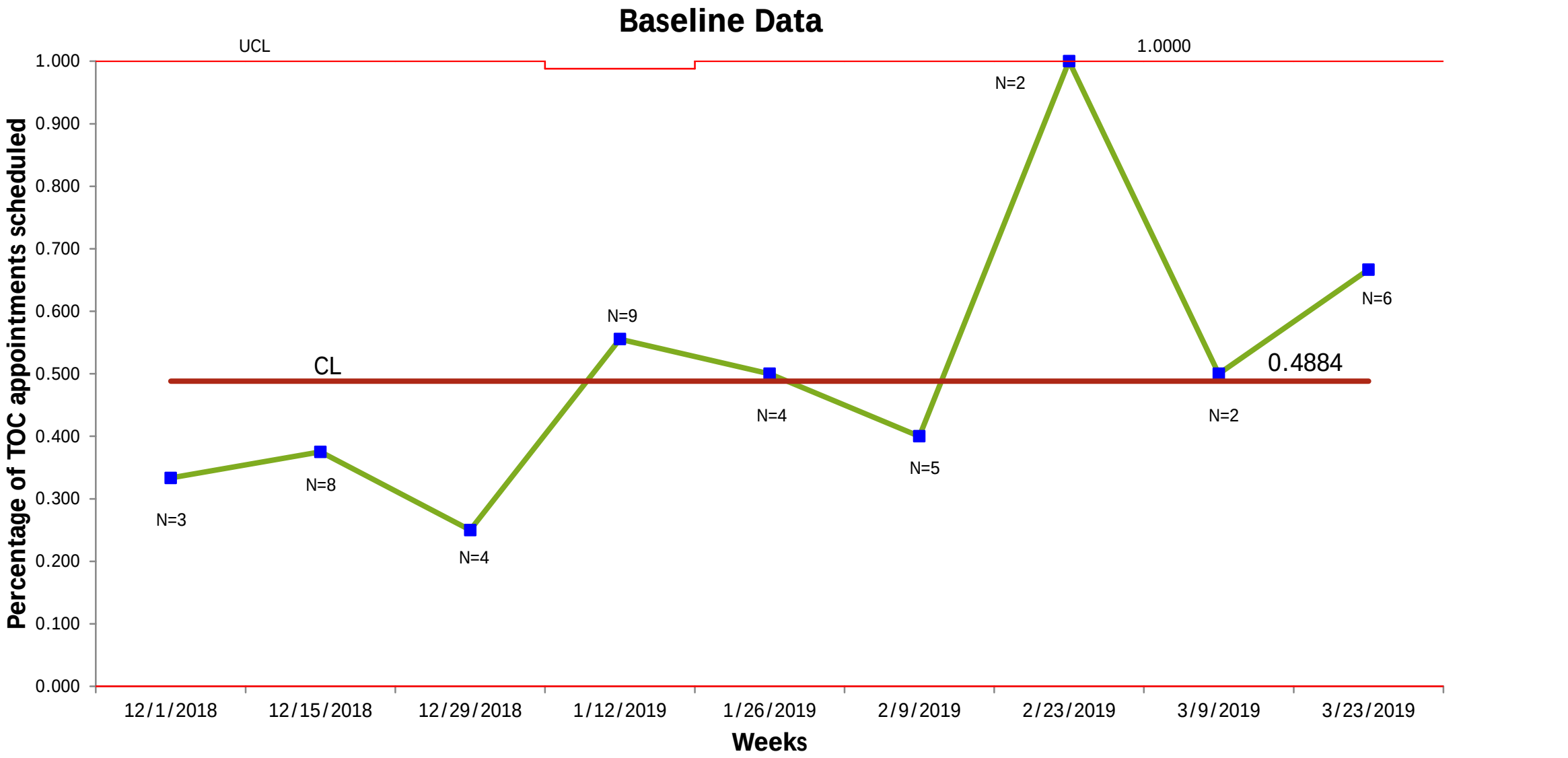
Process for Data Collection

- 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

Driver Diagram

Goal	Primary Drivers	Interventions	Responsible
To increase the percentage of TOC appointments scheduled at MARC PCC	**Improve notification of discharged patients from UHS to MARC PCC**	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	1) Melanie Roller / Bhugra 2) IT / Melanie Roller / Bhugra 3) MARC Clinic Manager, Case Manager, Corado, Castillo 4) Patricia Reyes/MARC case managers
	Improve outreach to patients	**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	1) Clinic Manager, Case manager 2) Case manager, medical director, LVNs
	Correctly identify PCP during admission	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	MARC Clinic Manager, Johnson, MARC internists
	Improve PCP access	1) Designate one provider per week for TOC only visits 2) Generate more MD only slots which can be utilized for TOCs	Clinic manager


Methods of Discharge Communication
16
14
12
10
8
6
4
2
0
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Patient call
MD communication
Not contacted
Other
Access plus
Office visit

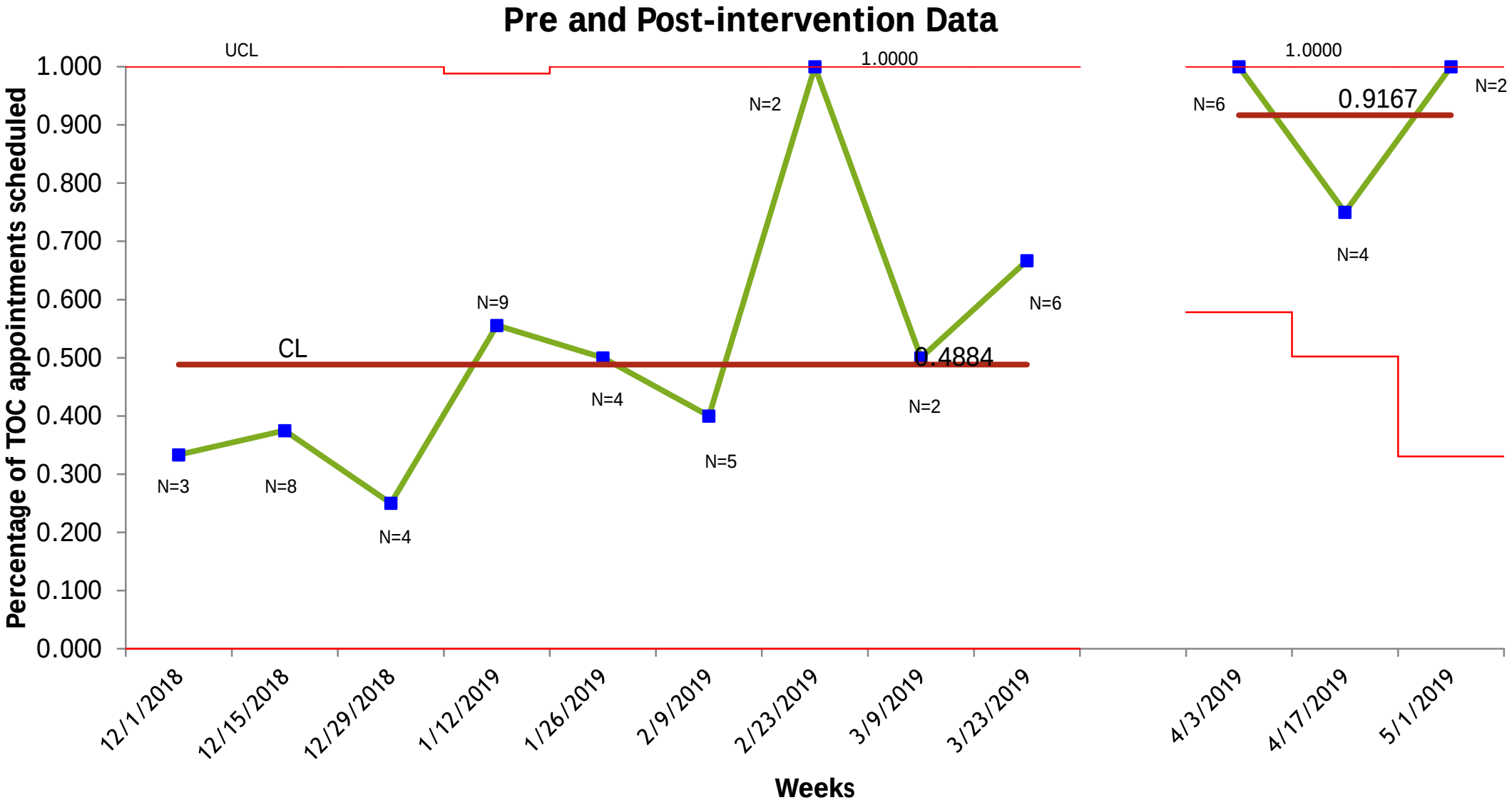


N=total number of discharges in the 2 week period

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



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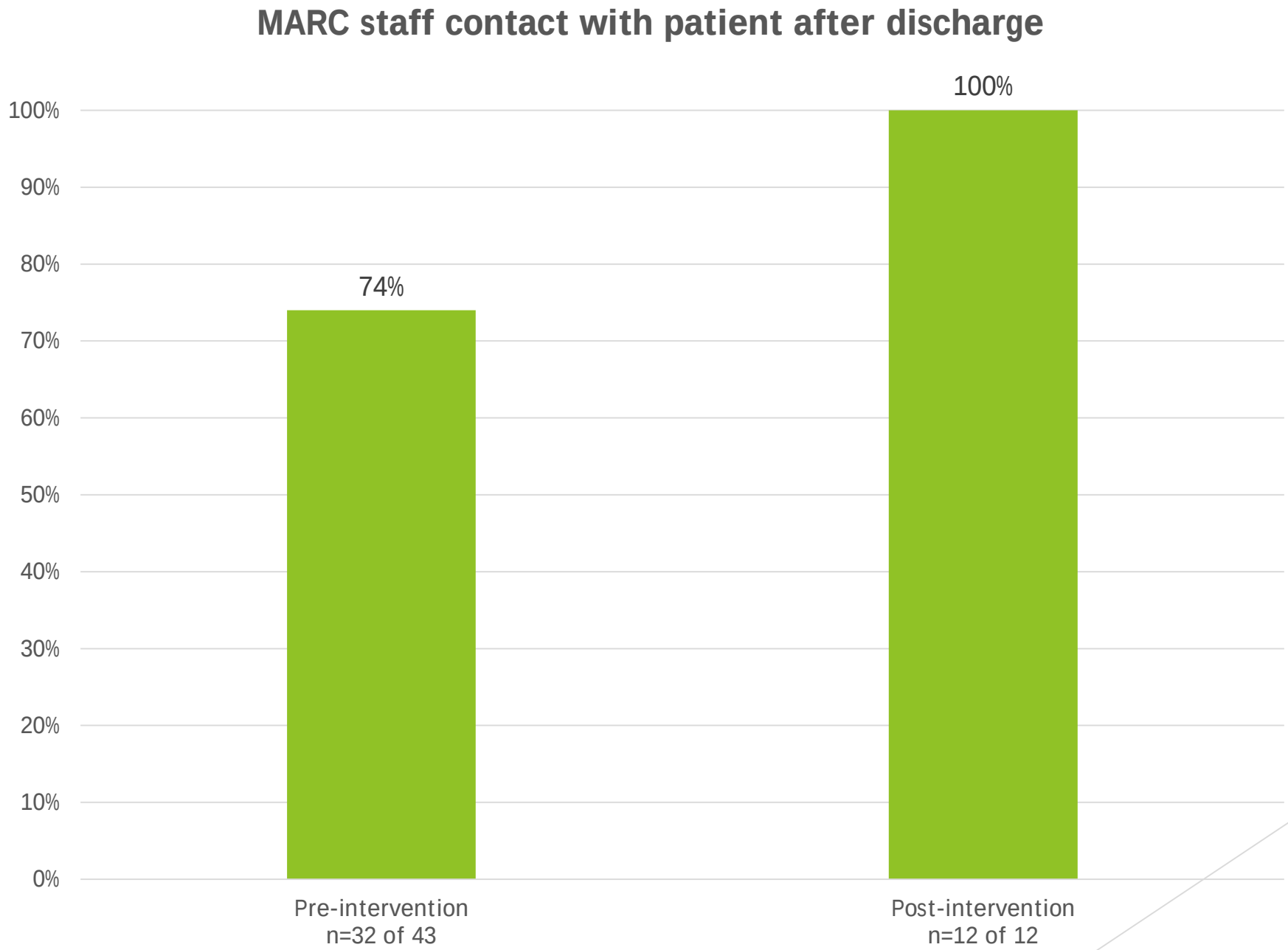
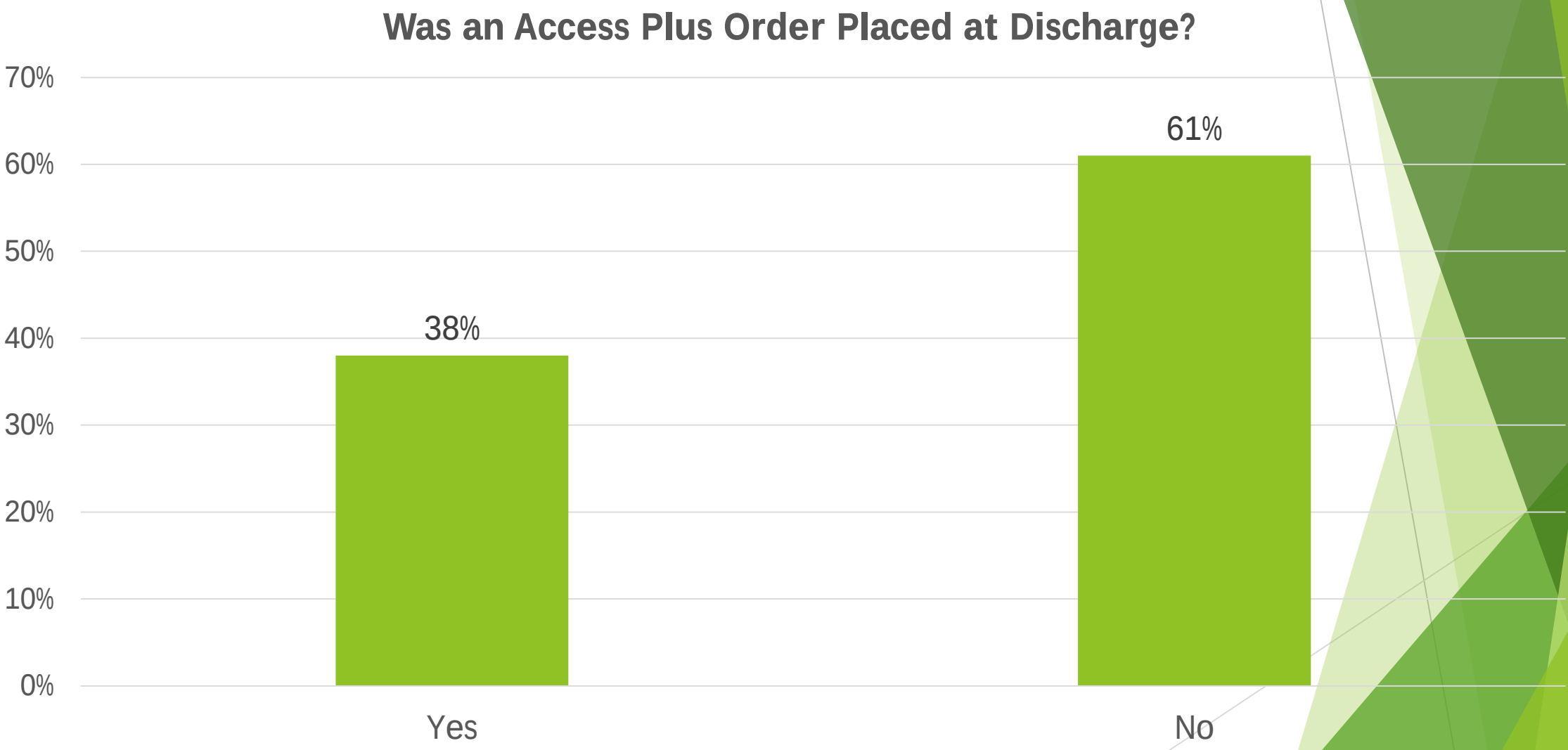
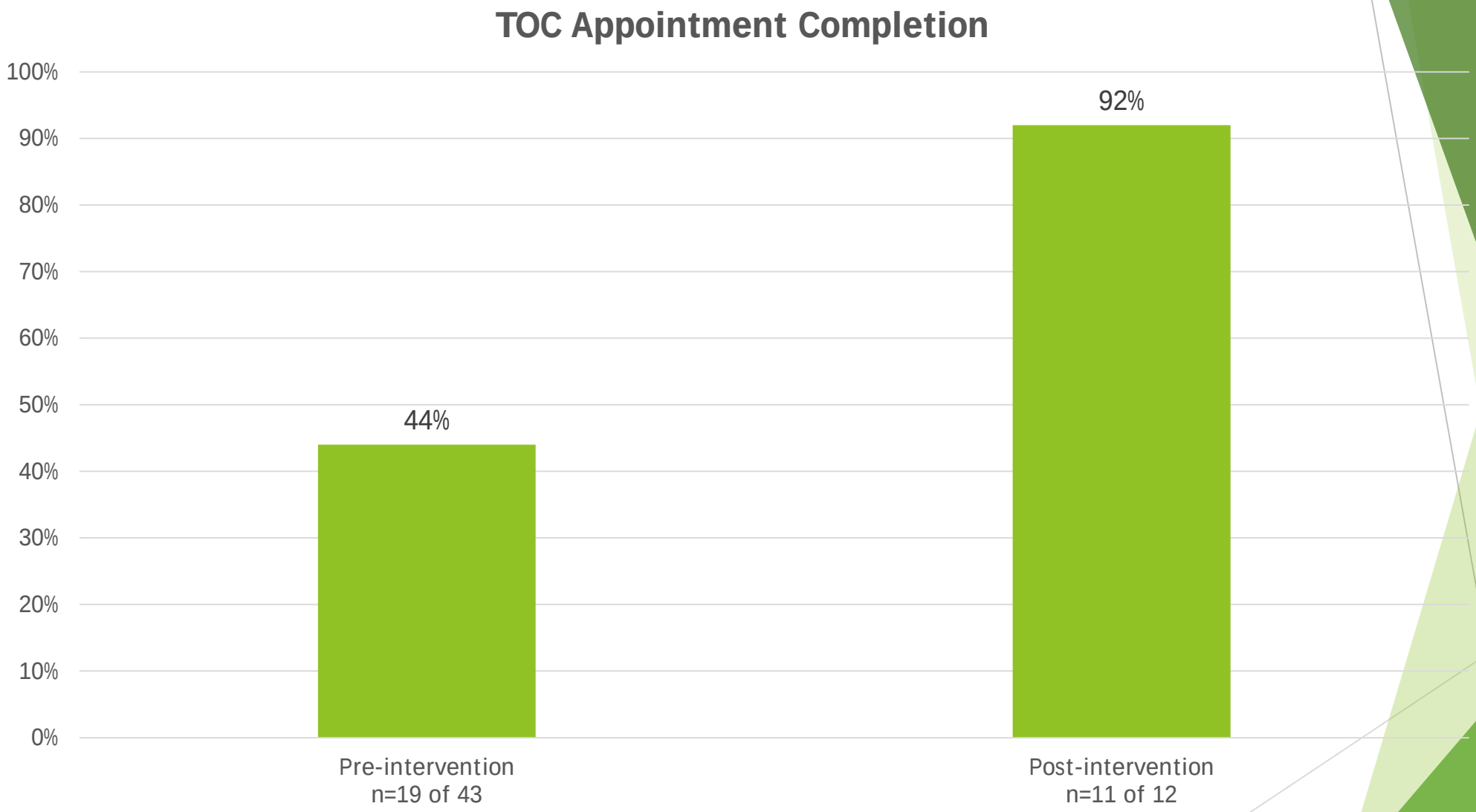

MARC staff contact with patient after discharge
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
74%
100%
Pre-intervention
n=32 of 43
Post-intervention
n=12 of 12


Was an Access Plus Order Placed at Discharge?
70%
60%
50%
40%
30%
20%
10%
0%
38%
61%
Yes
No


TOC Appointment Completion
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
44%
92%
Pre-intervention
n=19 of 43
Post-intervention
n=11 of 12

Return on Investment

	TOC visits completed (%)	Annual TOC visits completed	Realized annual charges
Pre-intervention	44	56	9,968
Post-intervention	92	117	20,843
Net Revenue			**10,875**

Readmission Expenditure

	Readmission Rate	Annual Readmissions	Readmission Cost
Current Study population	25%	28	$280,000
Post-Intervention	15%	16	$160,000
Cost Avoidance			**$120,000**

Hospital Readmissions Reduction Program Penalties

Program Year	1	2	3	4	5	6
Fiscal Year	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Dates of Performance Measurement	8-Jun to 11-Jul	9-Jun to 12-Jul	10-Jun to 13-Jul	11-Jun to 14-Jul	12-Jun to 15-Jul	13-Jun to 16-Jul
Conditions for Original Hospitalization	Heart Attack (AMI)	Heart Attack (AMI)	Heart Attack (AMI)	Heart Attack (AMI)	Heart Attack (AMI)	Heart Attack (AMI)
	Heart Failure (HF)	Heart Failure (HF)	Heart Failure (HF)	Heart Failure (HF)	Heart Failure (HF)	Heart Failure (HF)
	Pneumonia	Pneumonia	Pneumonia	Pneumonia	Pneumonia	Pneumonia
			Chronic Obstructive Pulmonary Disease (COPD)	Chronic Obstructive Pulmonary Disease (COPD)	Chronic Obstructive Pulmonary Disease (COPD)	Chronic Obstructive Pulmonary Disease (COPD)
			Hip/Knee Arthroplasty (THA/TKA)	Hip/Knee Arthroplasty (THA/TKA)	Hip/Knee Arthroplasty (THA/TKA)	Hip/Knee Arthroplasty (THA/TKA)
					Coronary Artery Bypass Grafting (CABG)	Coronary Artery Bypass Grafting (CABG)
Maximum Penalty	**1%**	**2%**	**3%**	**3%**	**3%**	**3%**

Next Step

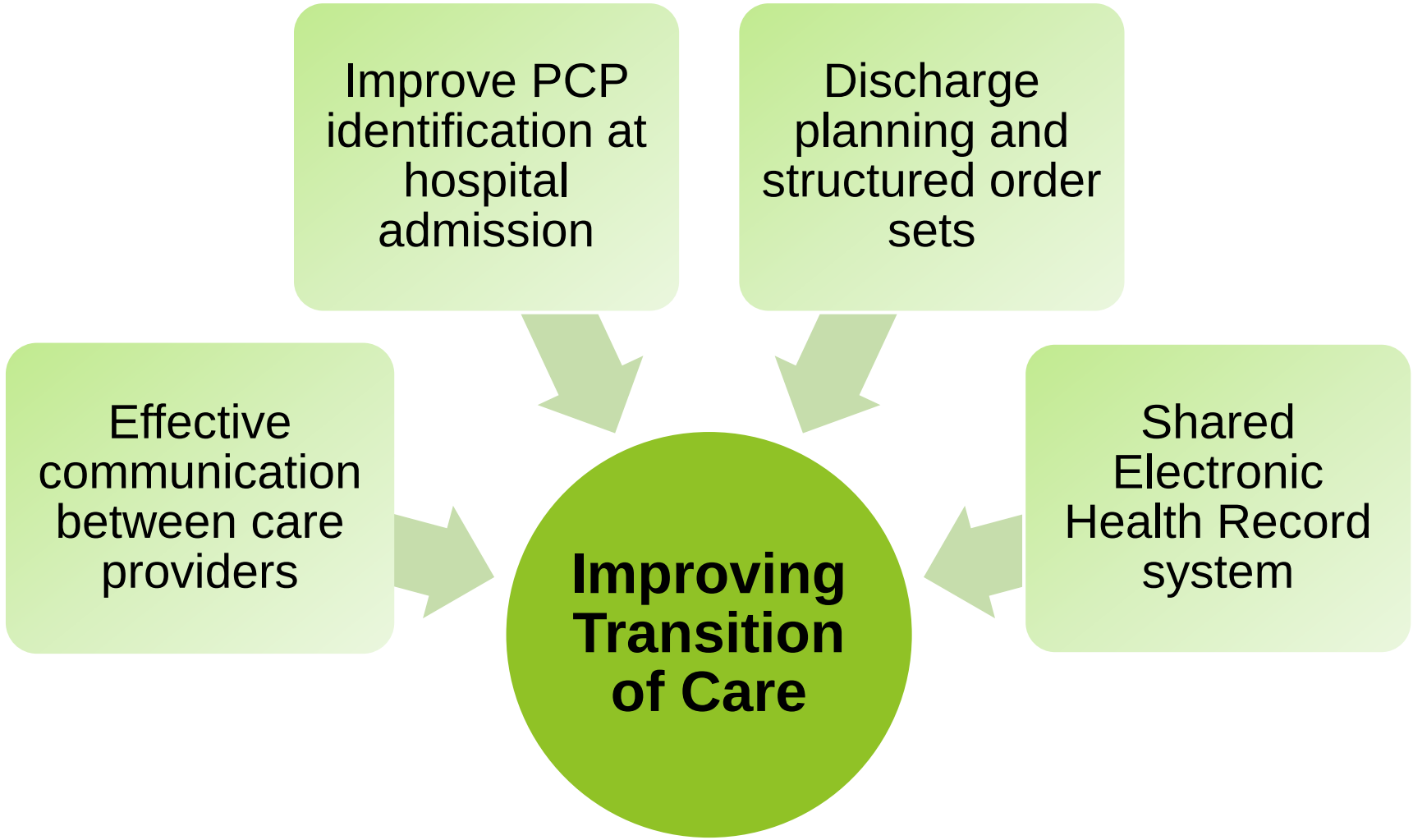
Continue tracking admissions and discharges for Clinic patients

Provider education regarding discharge orders to Access Plus

Patient education regarding PCP and TOC visits

Involve other UT Clinics and sites

Lessons Learned



Thank You

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