# 2022

# STRONGER

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Temple University Health System

UC San Diego Health

# Virtual and Bridge Clinic Approaches That Improve Care Transitions and Reduce Readmissions

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# Learning Objectives

- Discuss the role of a transitions clinic in identifying systemic care lapses to inform broader quality initiatives.

- Describe how to care for patients across the continuum of care from inpatient to outpatient and, specifically, how to prevent readmissions in an urban area with high socioeconomic barriers.

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# Virtual Clinic Improves Care Transitions and Reduces Readmissions

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# What is VToC?

| | | |
|---|---|---|
| **Patient Identification Process** | EMR decision support: BPA alert (LACE+ score*, d/c home) | MA referral screening: Smart phone, no PCP appt within 7 days, patient consent |

Hospital Admission

Discharged from hospital

VToC Referral

VToC Visit

VToC Scheduled

PCP/Specialist Follow-up

Multidisciplinary handoff / access triage

**Care Team**: PCP, Specialist, Referring Hospitalist, VToC Physician & VToC Medical Assistant

VTOC: Virtual Transitions of Care

*The LACE+ Index predicts risk of mortality or urgent readmission within 30 days of discharge from the hospital

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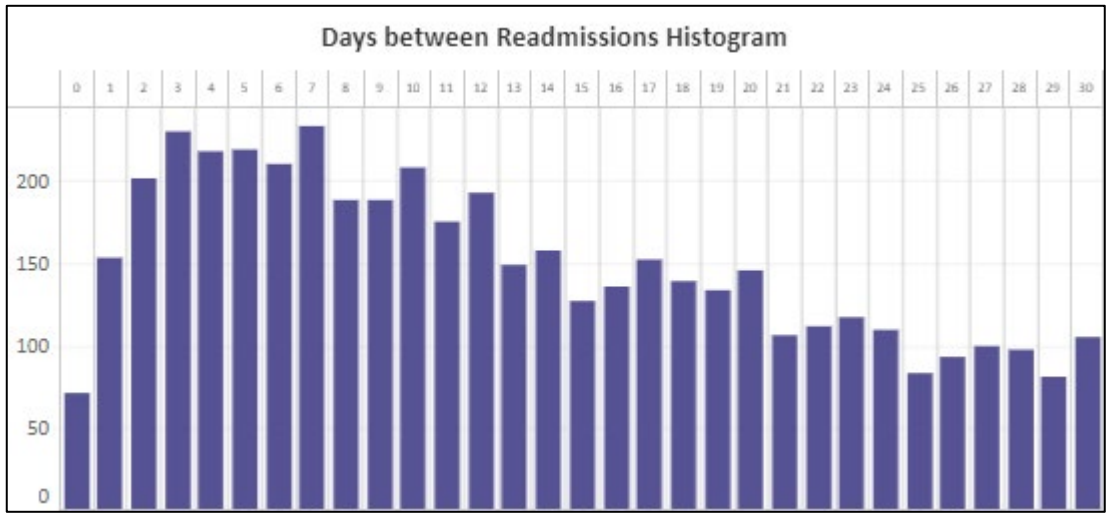
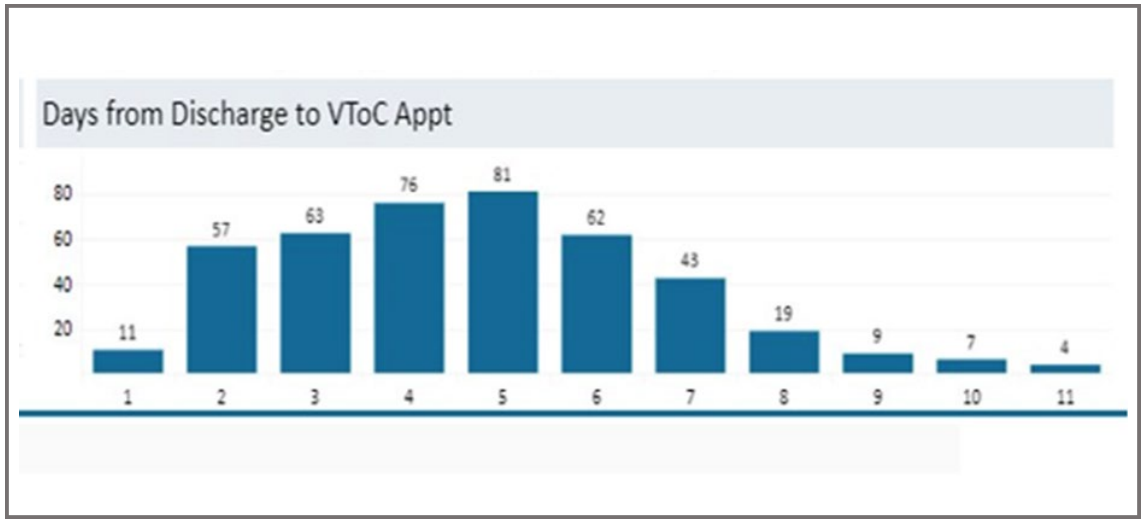
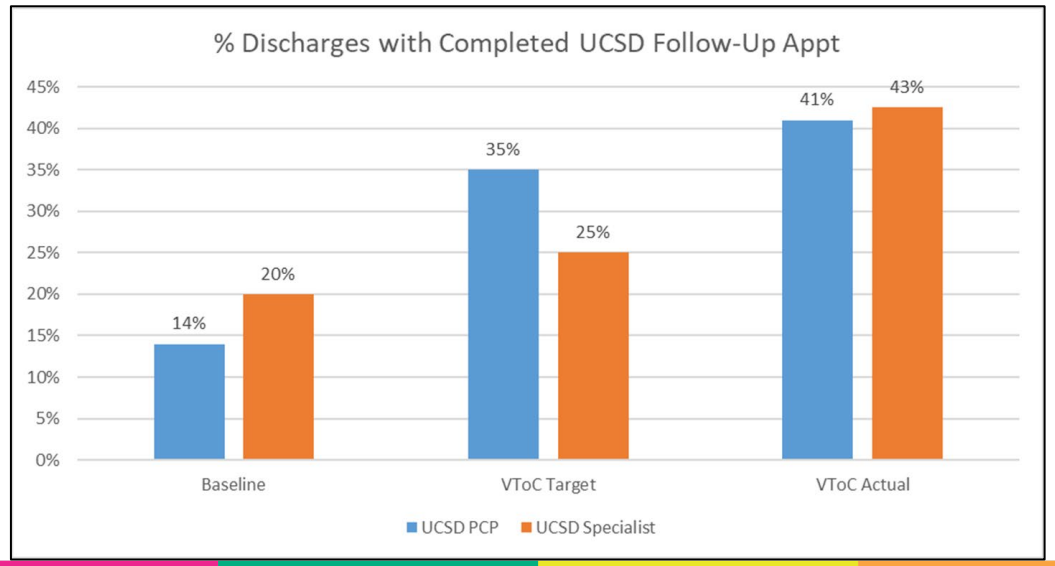
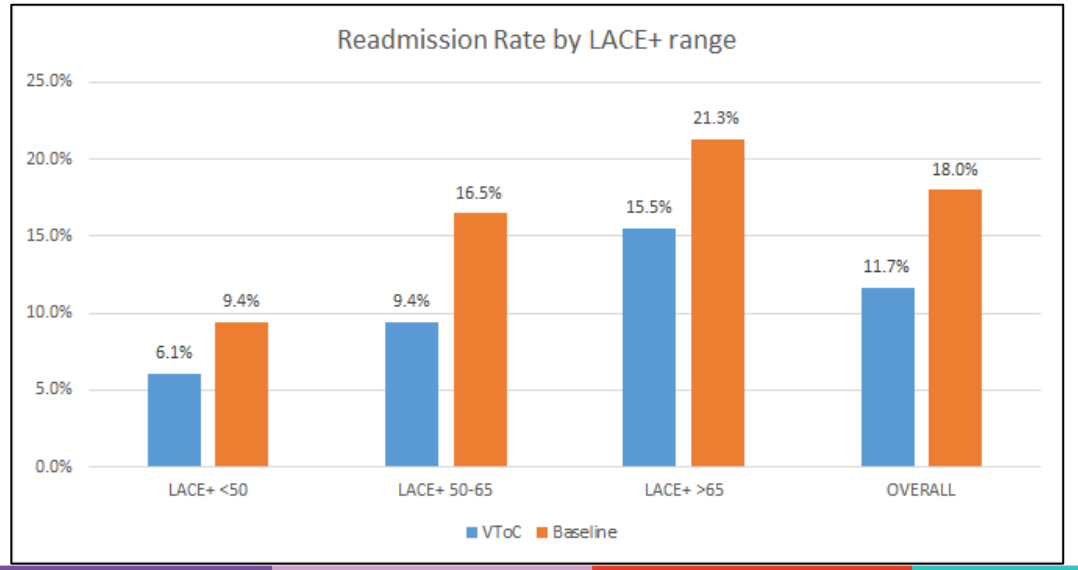
# VToC improves access and reduces readmissions

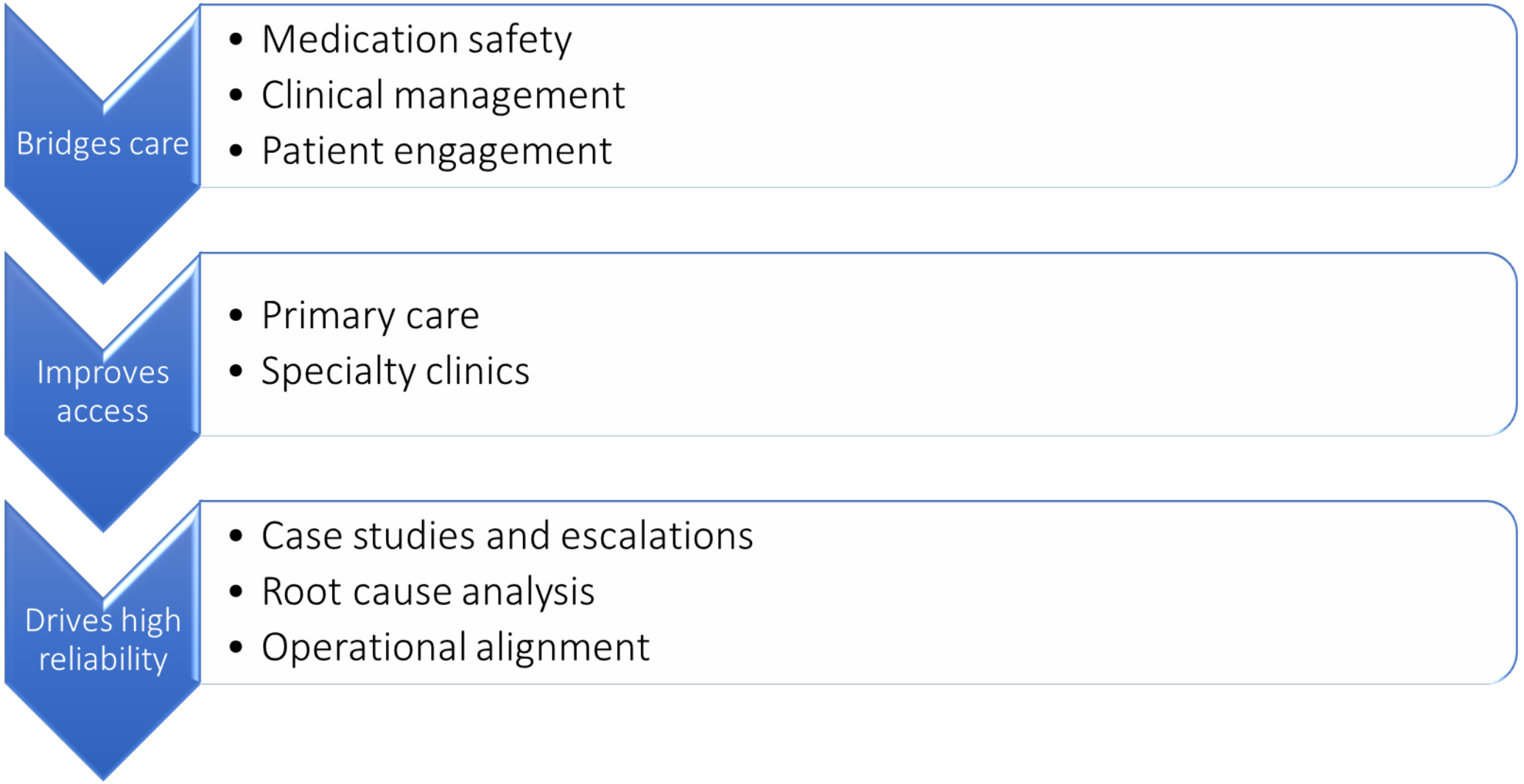


# Lessons Learned



# Key Takeaways

- Understand readmission risk factors (at patient and system level)
- Align inpatient and outpatient transition of care goals and operations
- Track qualitative and quantitative metrics to assess effort vs. impact

# Appendix

| Characteristic | VToC patients | Benchmark population |
|---|---|---|
| Age - yr | *Avg +/-* | *Avg +/-* |
| Mean | 62 | 59 |
| Median | 62 | 59 |
| Range | 19 - 98 | 16 - 103 |
| Sex - no (%) | | |
| Male | 164 (49%) | 721 (56%) |
| Female | 172 (51%) | 577 (44%) |
| Race -- no (%) | | |
| White | 176 (52%) | 701 (54%) |
| Asian | 34 (10%) | 82 (6%) |
| Black | 36 (11%) | 111 (8%) |
| Other | 92 (27%) | 382 (30%) |
| Ethnicity - no (%) | | |
| Hispanic | 68 (23%) | 259 (20%) |
| Non Hispanic | 218 (75%) | 947 (73%) |
| Unavailable | 3 (1%) | 78 (6%) |
| LACE distribution | | |
| <50 | 33 (11%) | 380 (30%) |
| 50-65 | 139 (46%) | 512 (39%) |
| >65 | 129 (43%) | 383 (31%) |
| Mean | 57 | 55 |
| Median | 57 | 57 |
| | | |

**Benchmark**: Patients dicharged by Hospital Medicine service to Home Routine between 9.1.21 and 12.31.21

# Temple University Hospital

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# Showcasing Our MVPs *Multi-Visit Patients*

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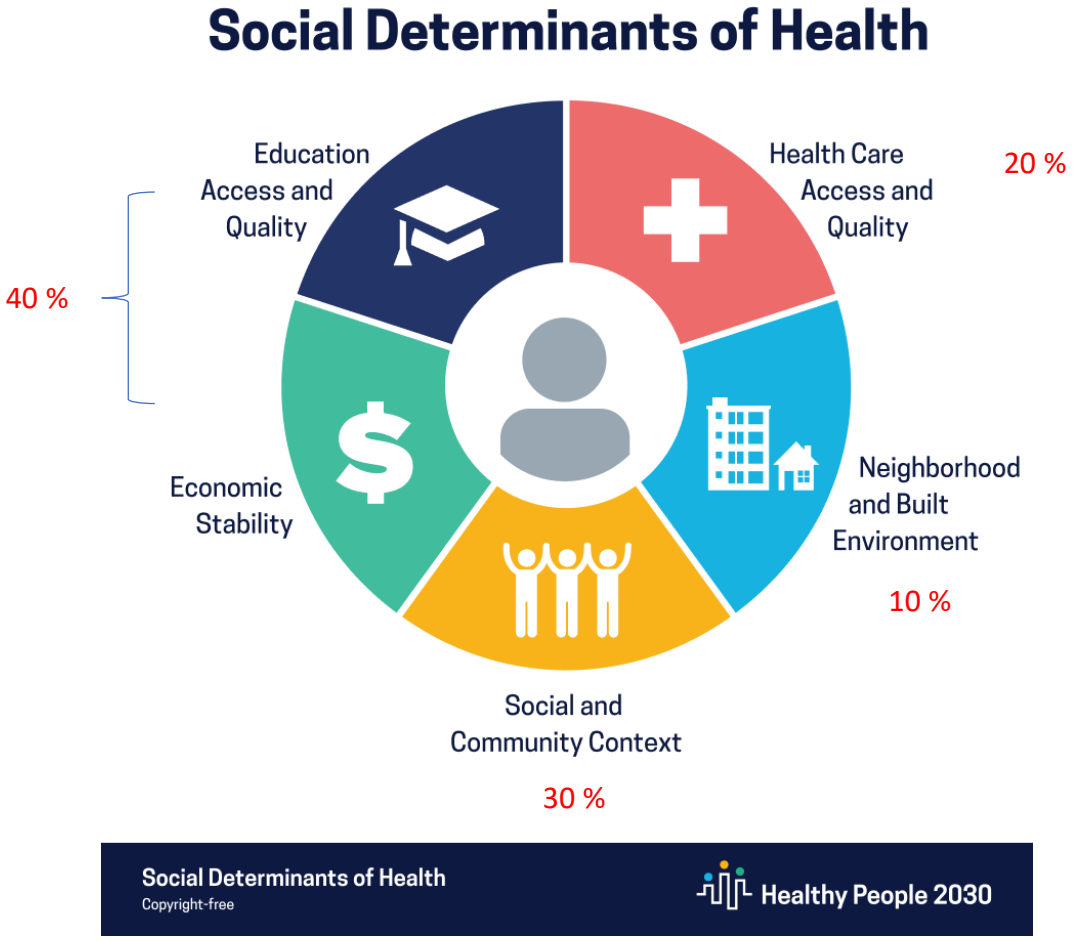
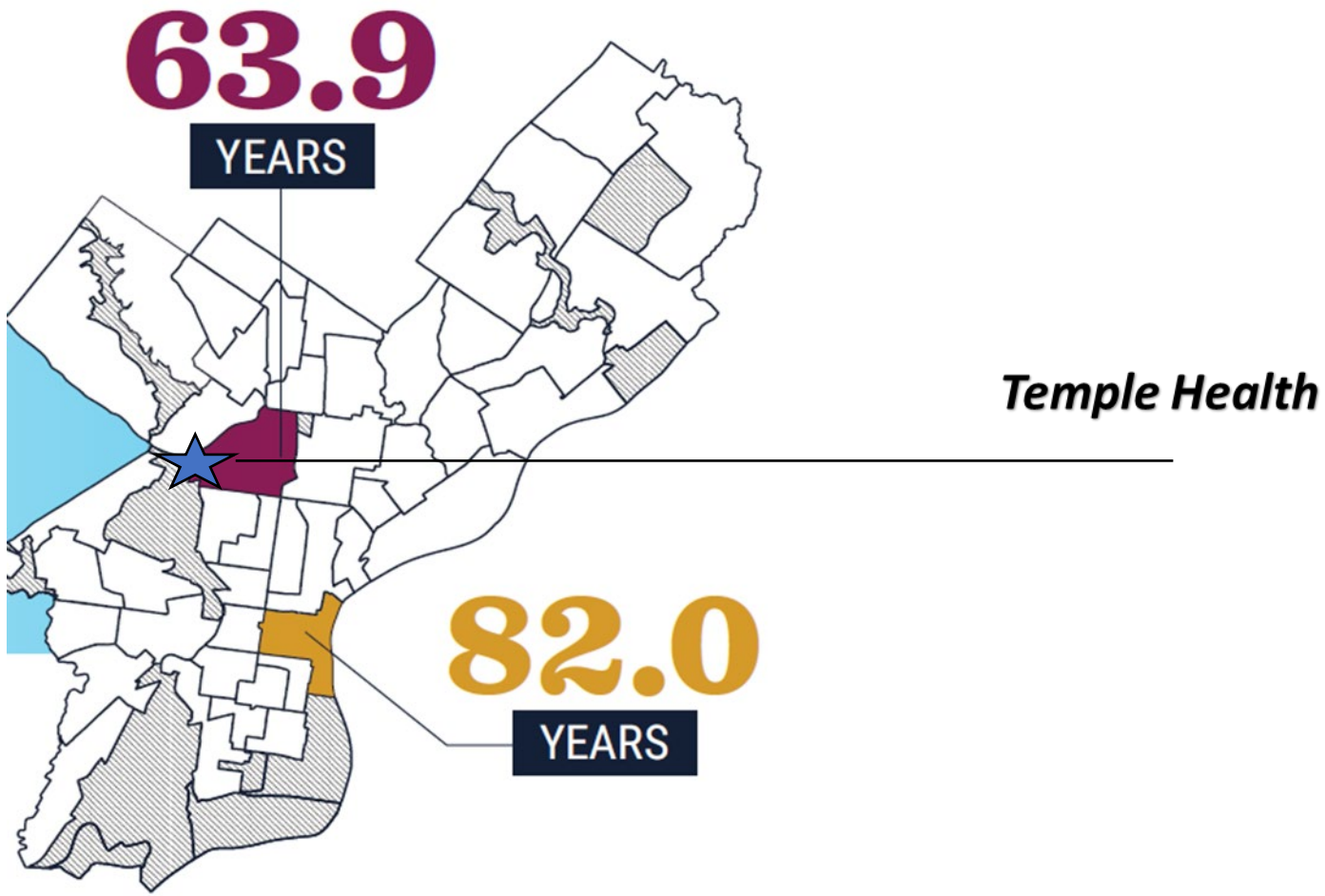
# Social Determinants of Health Influences Outcomes

## Temple Community

- 42 % live below 100 % of the federal poverty level.
- 41 % have a behavioral health diagnosis.
- 40 % of adults and 24 % of children are obese.
- 42 % of adults have hypertension, diabetes or cardiovascular disease.
- 22 % are food insecure.
- 4 % skip medications to save money.
- 10 % miss appointments due to transportation.
- Low Acuity ED use rises year over year



# Life Expectancy



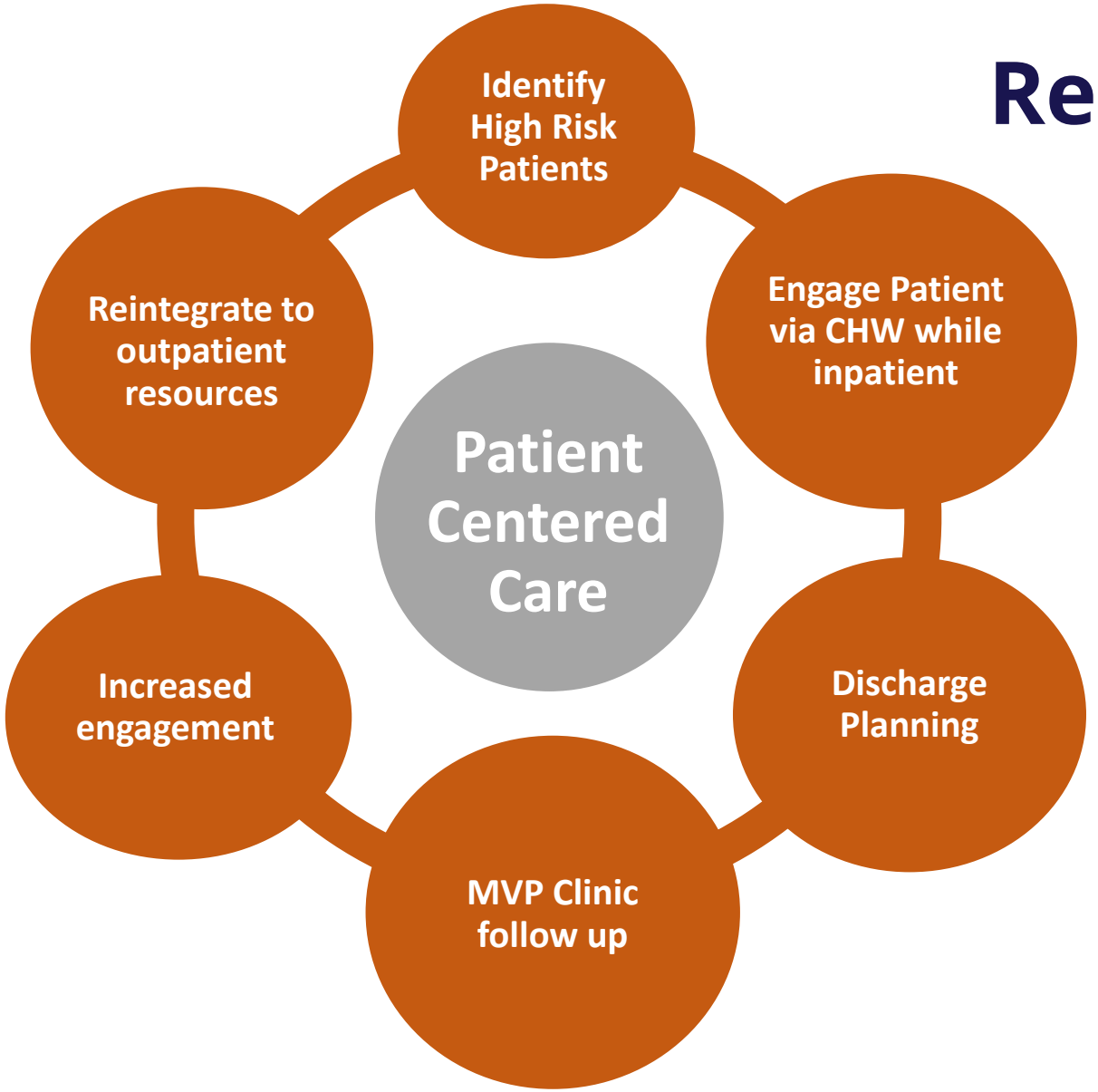
# Formation of a Bridge “Transitional” Clinic

**Hospital Administration** initiated the conversation with the hospitalist division to reduce readmissions

**Physicians** voiced that the driver is not just medical in nature and that there needed to be a team approach across the continuum of care

Involved Temple Center for Population Health, who recommended the **Community Health Worker** as a resource

# Readmissions Reductions Program




Patient Empowered to engage in their health

Decreased Readmissions & ED Utilization

# Data-Driven Outcomes

| Patient Counts from 2/27/2020 to 3/31/2022 | | |
|---|---|---|
| **Patients** | **Clinic Visits** | **Avg Charlson Score** |
| 383 | 922 | 7 |

| Utilization Type: Visit Characteristics | Pre-Program Enrollment Raw # | Pre Visit % | Avg Visits per Patient Pre | Post Program Enrollment (Raw #) | Post Visit % | Avg Visits per Patient Post |
|---|---|---|---|---|---|---|
| **Emergency Department** | 319 | 83.30% | **2.2** | 176 | 46.00% | **1.2** |
| **Inpatient** | 298 | 77.80% | **1.6** | 156 | 40.70% | **0.7** |

## Sustained results Noted over 365 days

| Event | Avg Monthly Visits Pre | Avg Monthly Visits Post | Change |
|---|---|---|---|
| **Emergency patient** | 46.4 | 41 | **-12%** |
| **Inpatient** | 90.4 | 59 | **-35%** |
| **Office or clinic** | 261.3 | 347.2 | **+33%** |
| **Urgent care** | 2.2 | 1.7 | **-23%** |

# Lessons Learned

- Meet the patient where they are.
- Access to wrap around services such as transportation, food and community-based organizations is essential.
- Understand the workflow of each entity of your multidisciplinary team and create processes that compliment both groups.
- Leverage data to ensure you are on track, create dashboards that “speak” to multiple audiences.
- Appointment cadence is not the same as a routine transition of care visit. Patients may need to be seen frequently to support outcomes in the initial transition of care phase.

# Key Takeaways

- Partnerships with community health workers and the clinical team can be leveraged to improve patient outcomes
  - There are MULTIPLE layers for readmissions, addressing them through CHWs can help advocate for patients
  - Prioritizing relationships with patients across the continuum of healthcare are key players in improving patient engagement/health literacy
- Alignment of goals with the health system, population health and physician/trainee/provider perspectives allows for increased interests/investment in the program
  - Transitional programs supplement overburdened PCPs, but ensuring communication and shared treatment plans between providers is imperative
  - GME perspective: mission related goal

# Questions?



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