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



UC San Diego Health

Sarah Horman, MD

Hospitalist, Medical Director Virtual Transitions of Care Clinic

Eric Lundin

Project Manager & Organizational Consultant
UC San Diego Health, San Diego, CA

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**Claire Raab, MD**

CEO Temple Faculty Practice

**Dharmini Shah Pandya, MD**

Medical Director MVP Clinic

**Steven R. Carson, MHA, BSN, RN**

SVP Population Health

Temple University Hospital, Philadelphia, PA

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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 and Bridge Clinic Approaches That Improve Care Transitions and Reduce Readmissions

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# Virtual Clinic Improves Care Transitions and Reduces Readmissions

**Sarah Horman, MD**

Hospitalist, Medical Director Virtual Transitions of Care Clinic

**Eric Lundin**

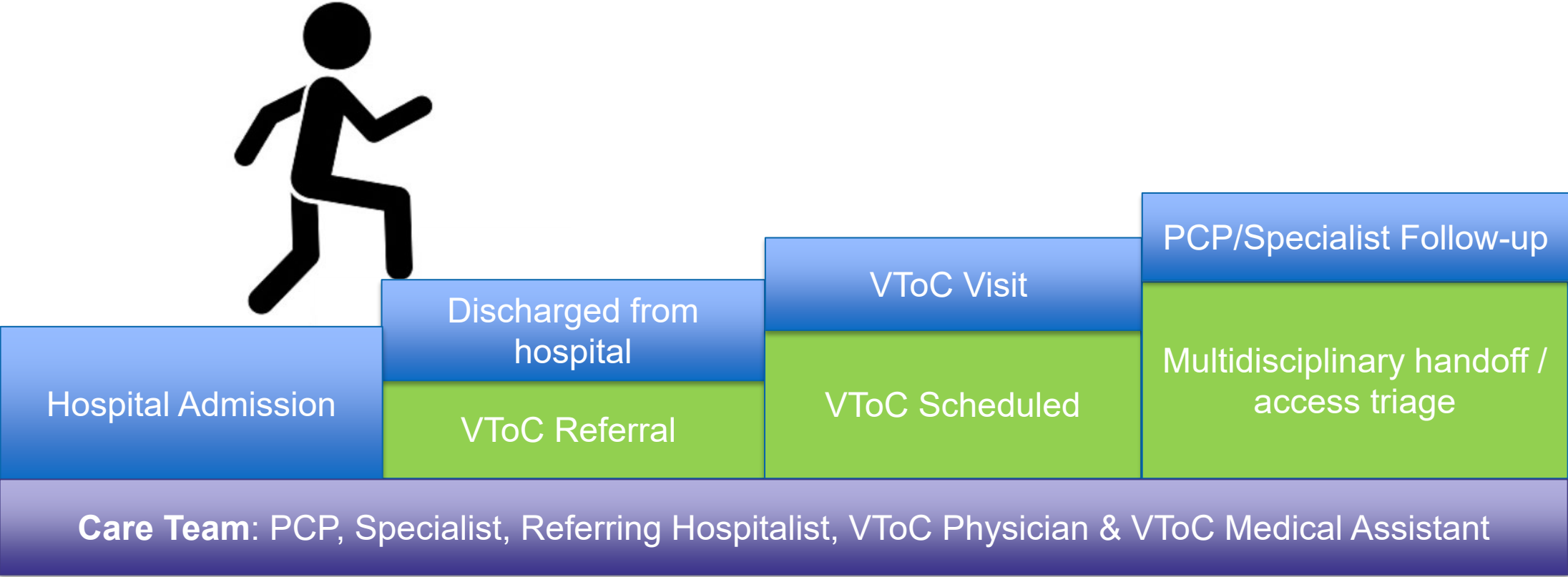
Project Manager & Organizational Consultant

UC San Diego Health, San Diego, CA



# What is VToC?

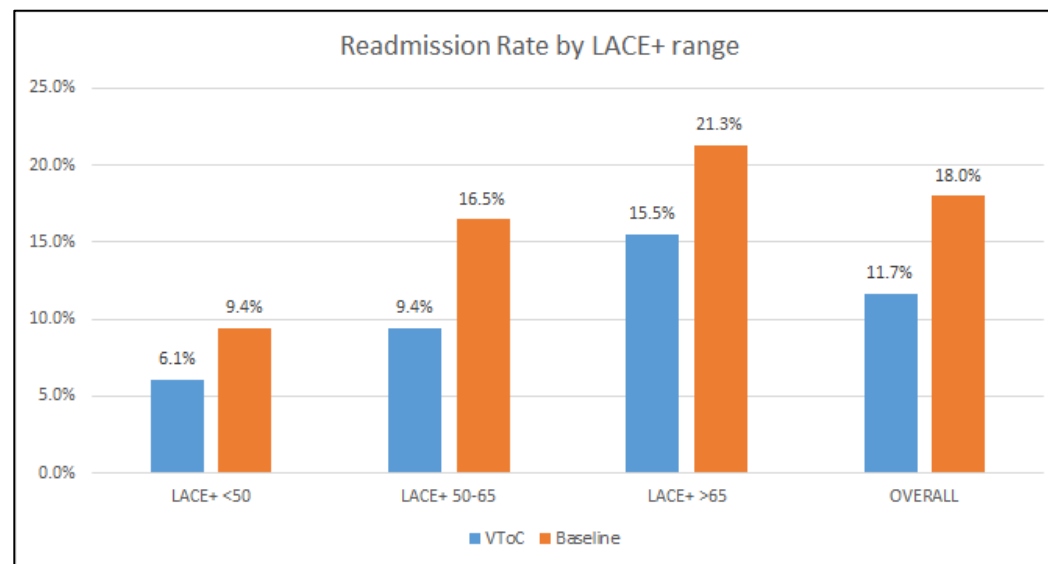
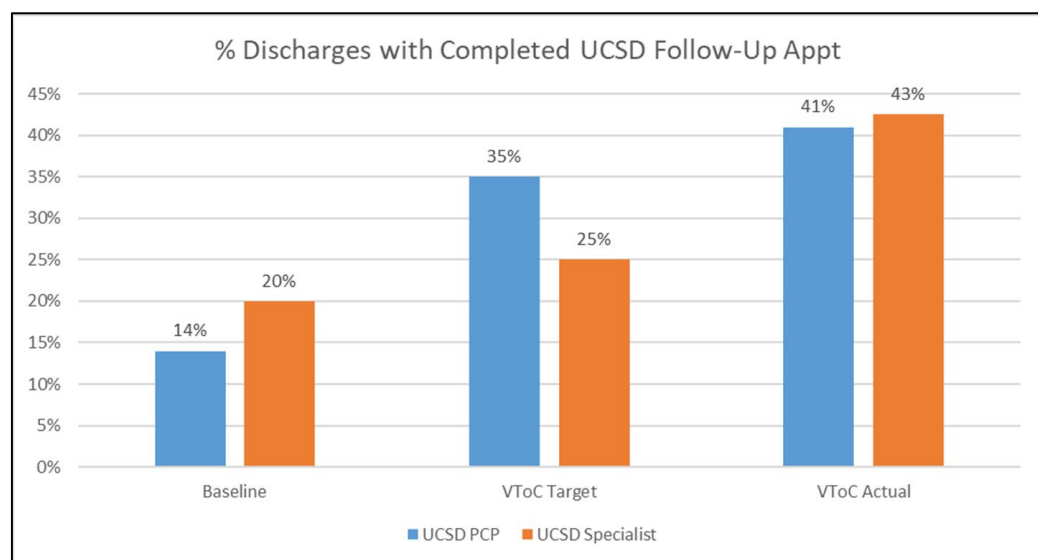
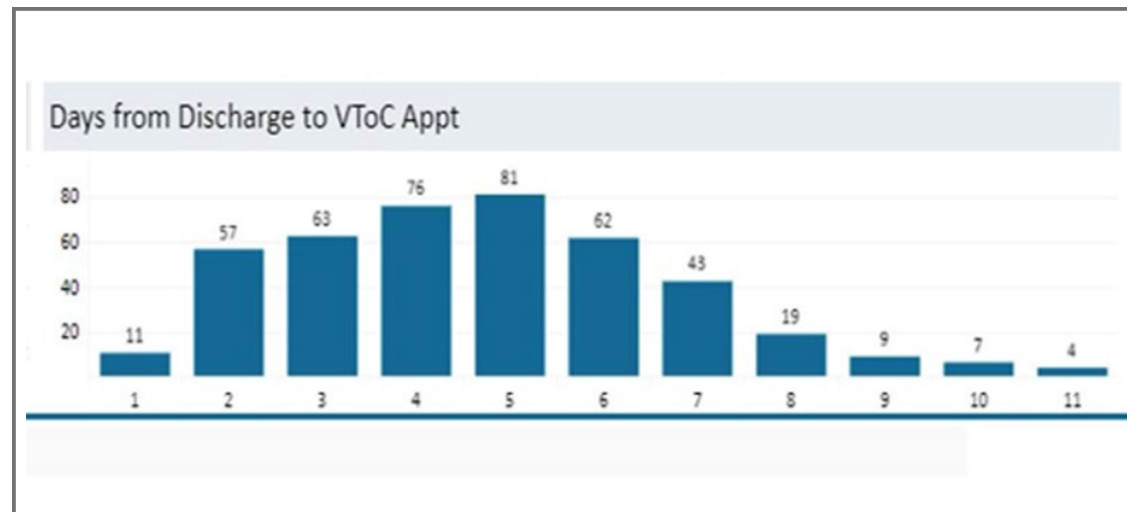
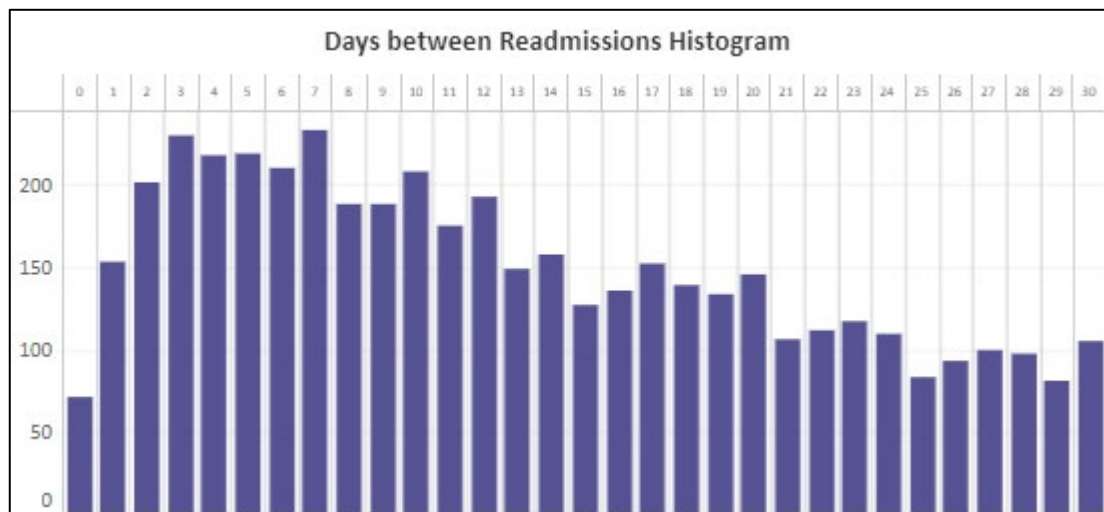
|                                       |                                                                |                                                                                         |
|---------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------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



VTOC: Virtual Transitions of Care

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

# VToC improves access and reduces readmissions



# Lessons Learned

Bridges care

- Medication safety
- Clinical management
- Patient engagement

Improves  
access

- Primary care
- Specialty clinics

Drives high  
reliability

- Case studies and escalations
- Root cause analysis
- Operational alignment

# 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 discharged by Hospital Medicine service to Home Routine between 9.1.21 and 12.31.21 |               |                      |

# Temple University Hospital

2022

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# Showcasing Our MVPs *Multi-Visit Patients*

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CEO Temple Faculty Practice

**Dharmini Shah Pandya, MD**

Medical Director MVP Clinic

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SVP Population Health

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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

## Social Determinants of Health



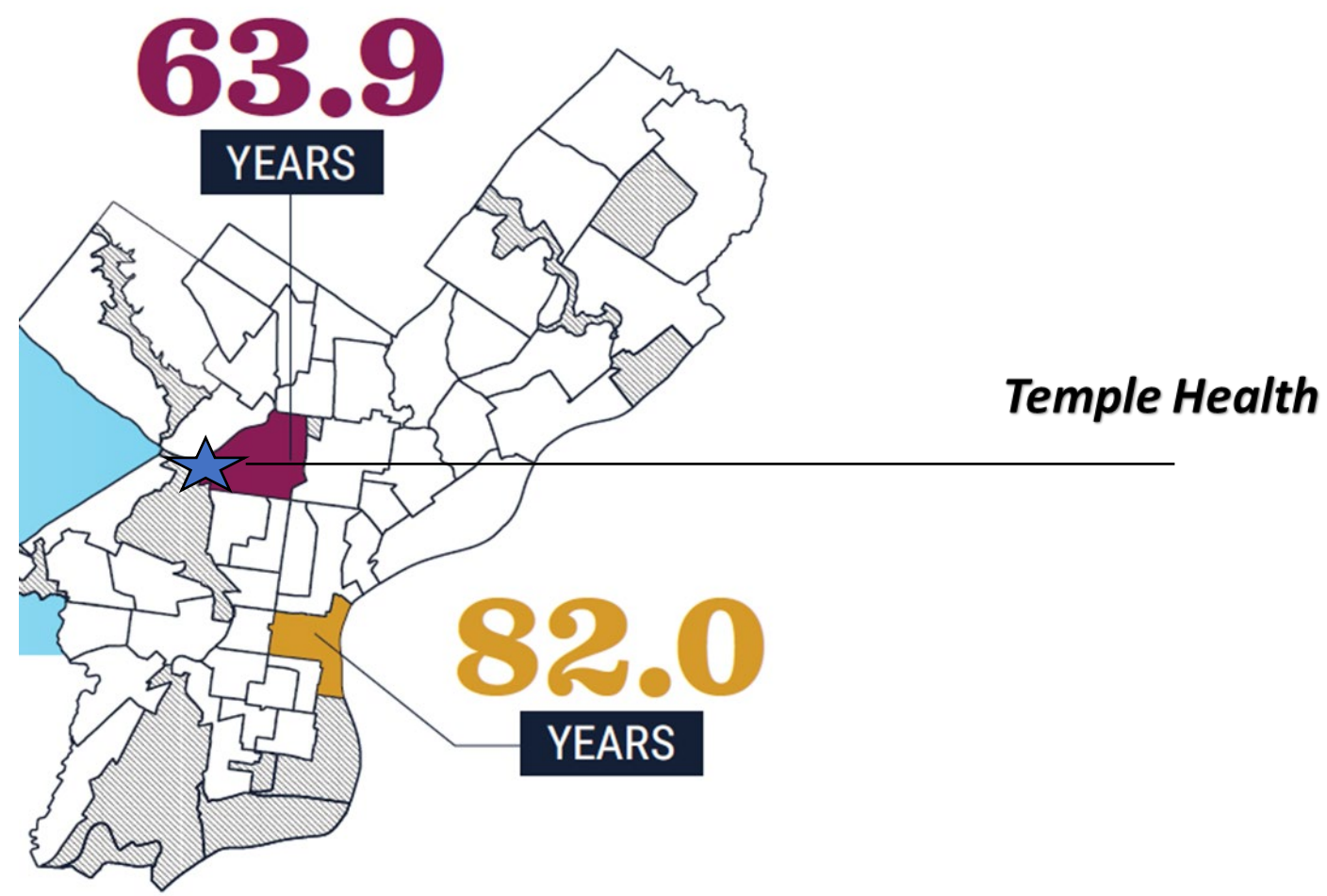
Social Determinants of Health  
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Healthy People 2030



# Life Expectancy

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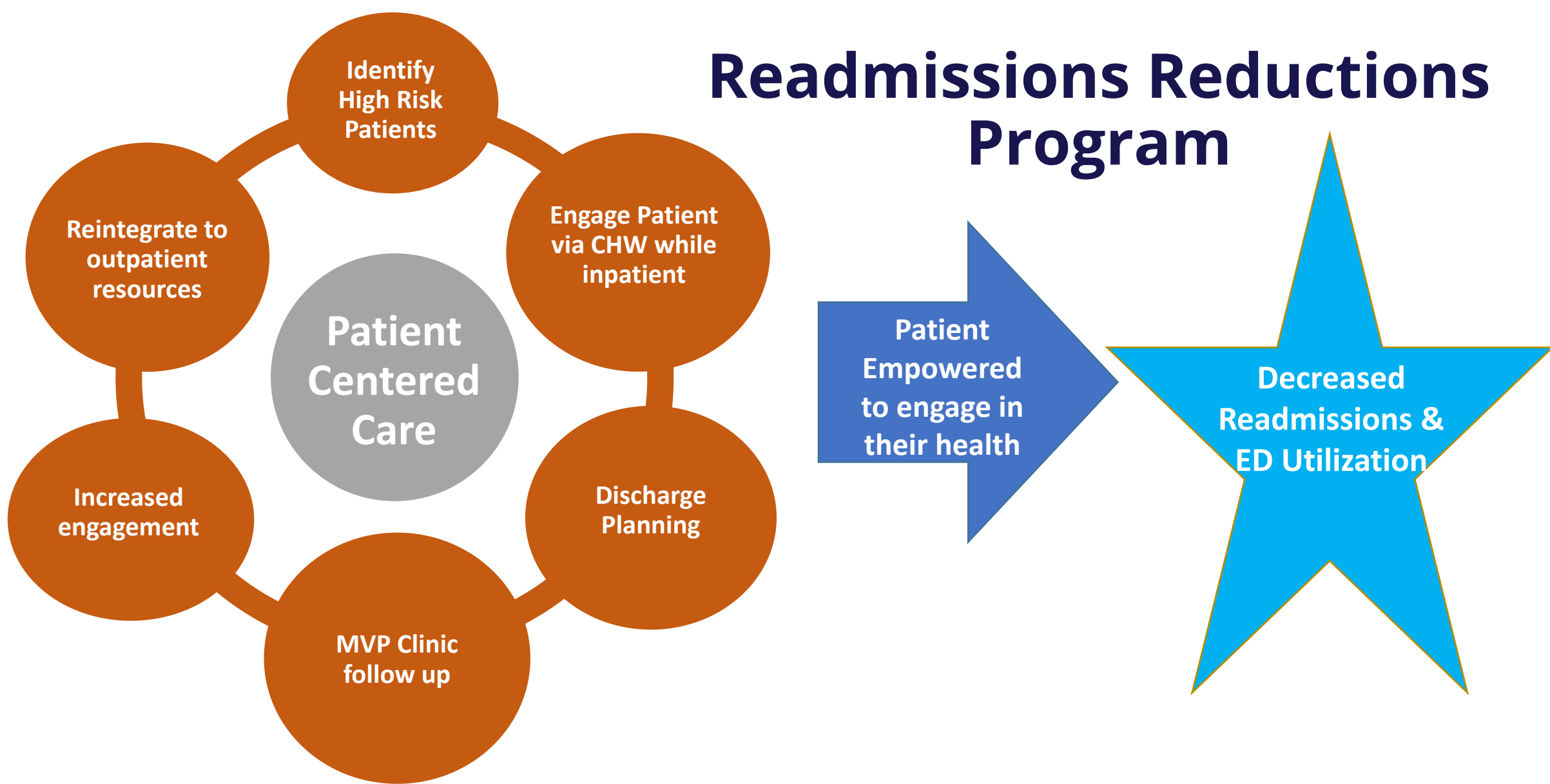
# Formation of a Bridge “Transitional” Clinic

**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



# 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?



UC San Diego Health

## Contact:

Claire Raab MD, [Claire.Raab@tuhs.temple.edu](mailto:Claire.Raab@tuhs.temple.edu)

Steve Carson, [steven.carson@tuhs.temple.edu](mailto:steven.carson@tuhs.temple.edu)

Dharmini Shah Pandya MD, [Dharmini.ShahPandya@tuhs.temple.edu](mailto:Dharmini.ShahPandya@tuhs.temple.edu)

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Sarah Horman, MD, shorman@health.ucsd.edu

Eric Lundin, elundin@health.ucsd.edu