
2024 VIZIENT CONNECTIONS SUMMIT
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Seamless Transitions: Enhancing Patient Outcomes, Reducing Readmissions, and Improving Care Delivery

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Learning Objectives

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- Explain how to design sustainable interventions that enhance patient outcomes, reduce readmissions and improve healthcare delivery.
- Outline the steps to develop and implement individualized care plans that integrate medical, social and behavioral health interventions.

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UC Davis Health Overview

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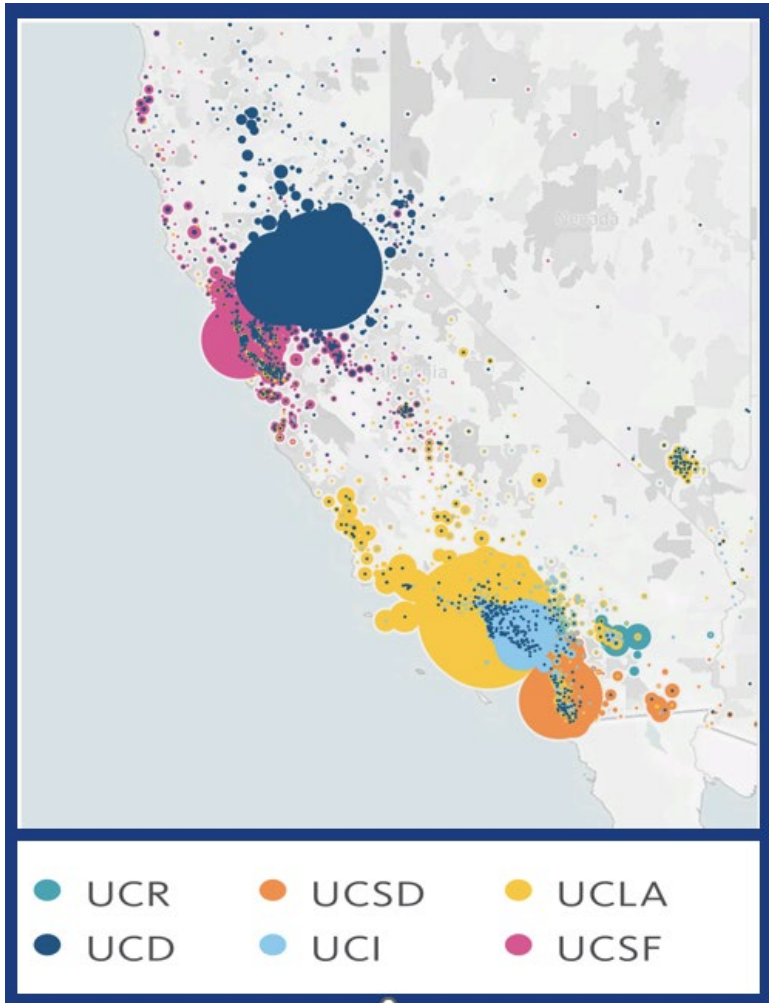
- Level 1 trauma center
- 646-bed multispecialty academic medical center
- 80,000+ ED visits and 32,000+ admissions
- Ranked Sacramento’s #1 hospital by U.S. News & World Report, and among the nation's best in multiple specialties.



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Transitions of Care Program - 2015

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- Create the burning platform - Leadership sponsorship/buy-in
- Partnership with key stakeholders, create common vision
- Identify key leaders and develop KPIs
- Formed 5 work groups [now all programs under Transitions of Care (TOC)]
  - Multi-visit patient (MVP) efforts, individualized care plans
  - Medication Reconciliation – TOC Pharmacist / Techs
  - Post discharge calls / contacts and triage / follow up
  - Community Network with SNFs
  - Expand Ambulatory alternatives to ED and Inpatient care
  - Care Coordination | Post Discharge/Transitional Care Clinic

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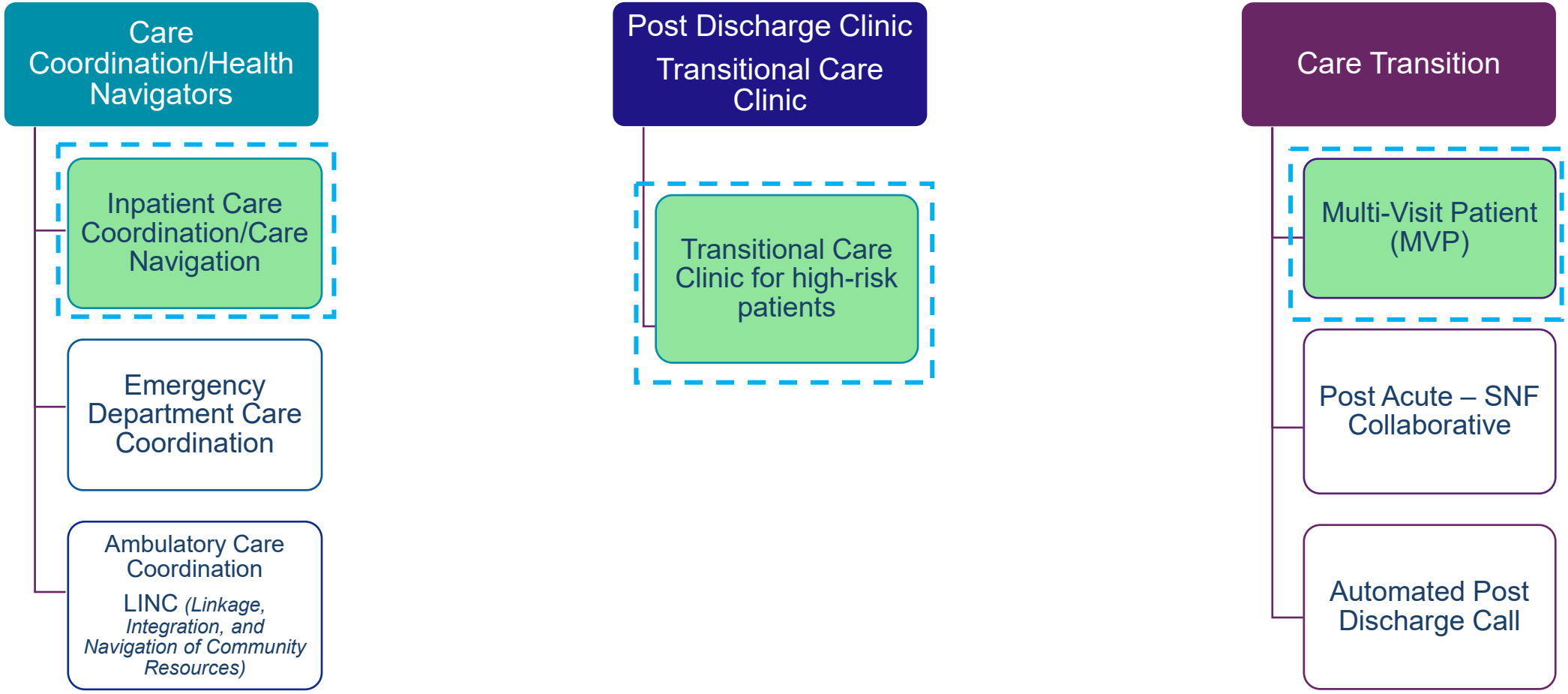
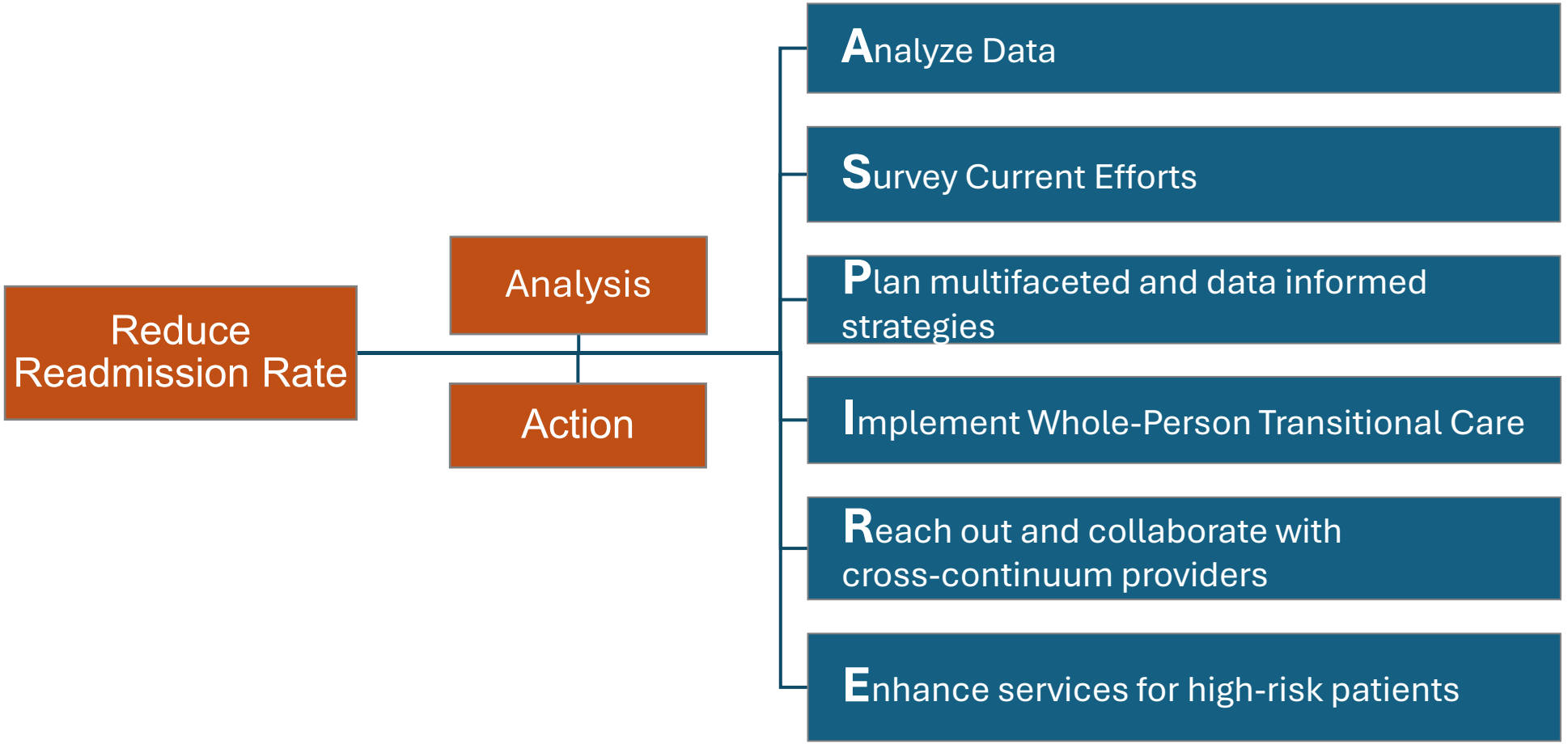
Transitions of Care/Care Coordination Domains



Strategy and Framework to Reducing MVP Utilization

ASPIRE: Collaborative Healthcare Strategies Model by Dr. Amy Boutwell MD, MPP



Boutwell A, Mohta NS, Williams MV. Why Health Systems and Providers Care About the Readmissions Journey. NEJM Catalyst. 2020;1(2). doi:10.1056/CAT.20.0044.

Analyze Data

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2019: MVP Patients' Impact on Hospital Utilization and Readmission

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Frequent Inpatients

4+ Inpatient Encounters within Previous 12 Months

Frequent Patient	Total Patients	% of Total Patients.	Total Encounters	% of Total Encounters.	30-Day Readmit	% of Total 30-Day Readmit.	Avg. LOS
No	23,753	96.58%	28,591	86.18%	1,930	51.49%	5.67
Yes	840	3.42%	4,583	13.82%	1,818	48.51%	7.74

Hospitalization Usage: Frequently Hospitalized Patients vs Non-Frequently Hospitalized Patients

Frequent Patients. (hover for associated diagnoses)

*Use slidebar filter in menu bar at right to adjust total visits within 12 months.

Data showed: **48.5% of total 30-day readmissions and 13.8% of all encounters are attributed to 3.42% MVP patients (~840 patients)**

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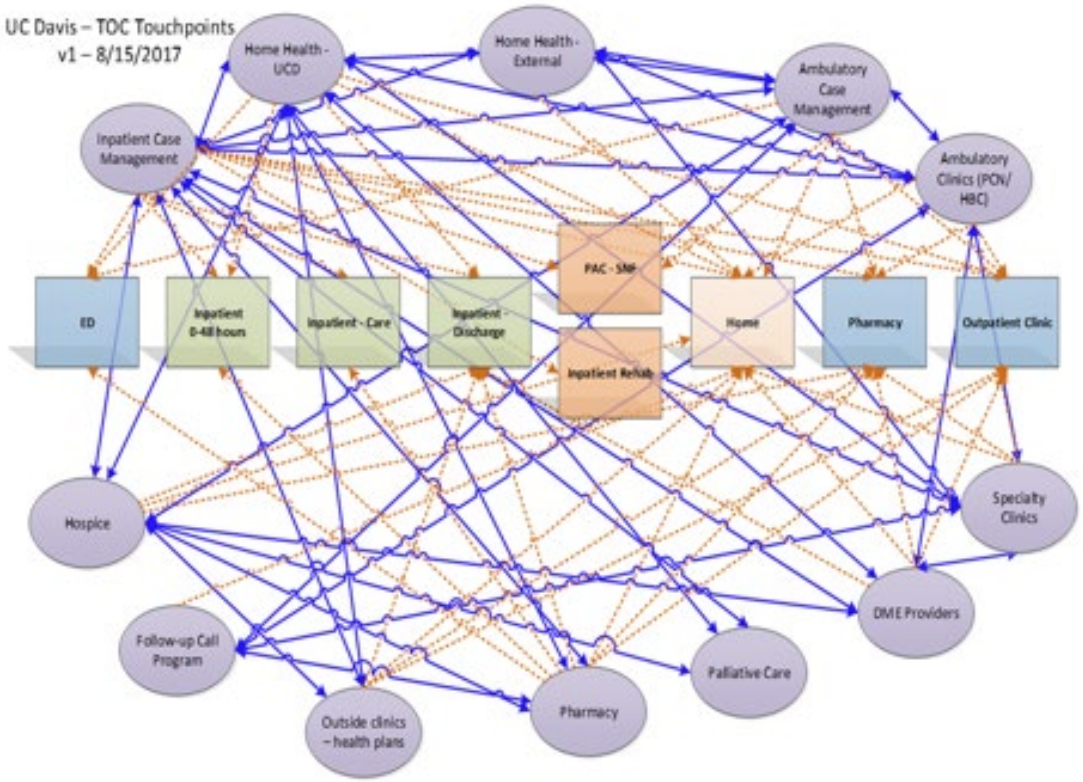
Survey Current Efforts



Common Themes:

1. **Multiple Departments-** insufficient concerted efforts to address readmitted patients in real time
2. **Taxonomy-** transparency in job titles, tasks and scope across departments
3. **Ambiguous Role Definition-** identified contact person for staff and providers to reach out to for patient care coordination
4. **Lack of Standardization-** in practice, scope, communication, documentation and overall workflow
5. **Alignment and Communication-** lack of accountability and standards resulting in process inefficiencies

Plan Multifaceted and Data Informed Strategies

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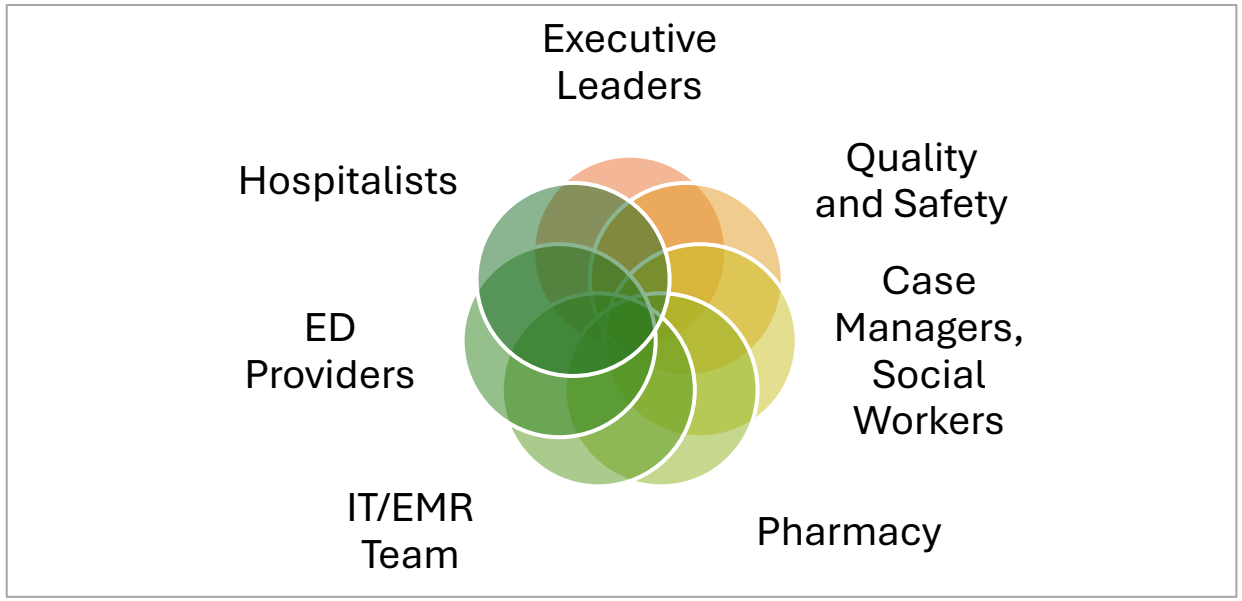
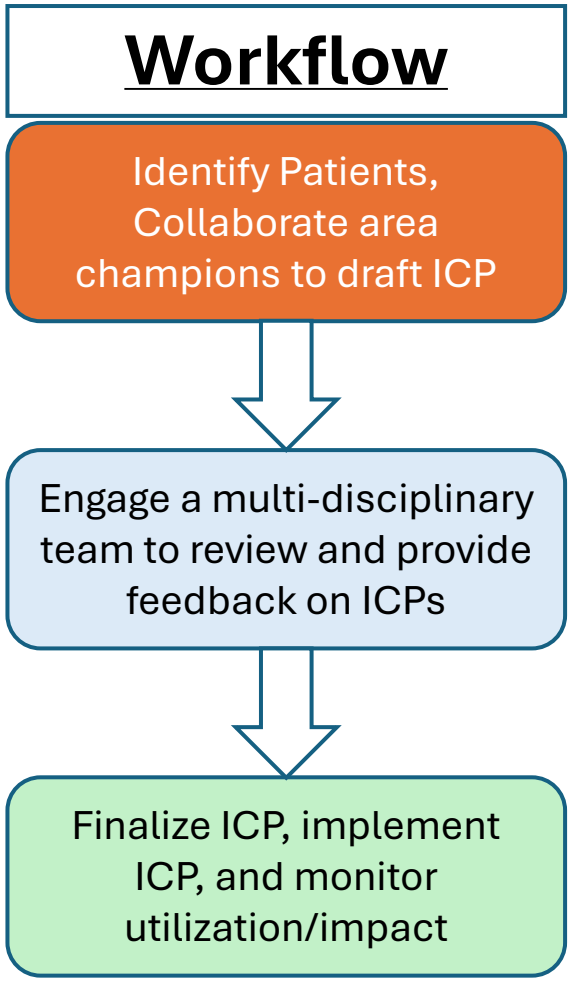
- Create committee, engagement and collaboration with stakeholders – multi disciplinary work group
- Established Workflow for ICP development





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Implement Whole Transitional Care

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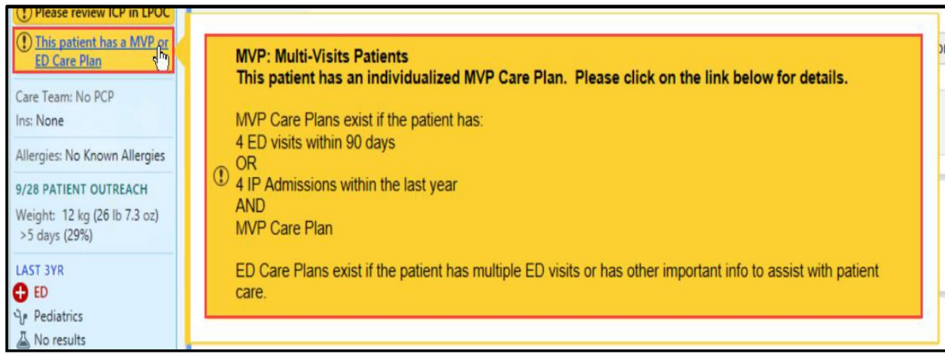
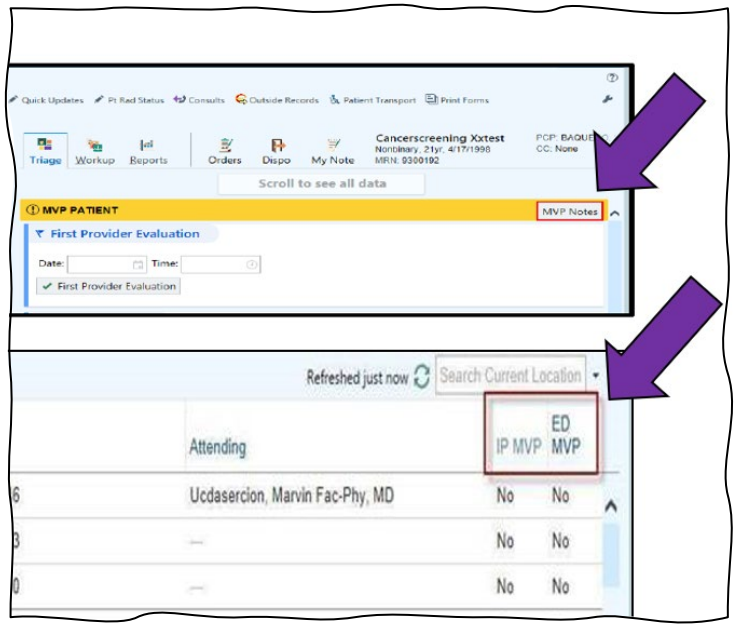
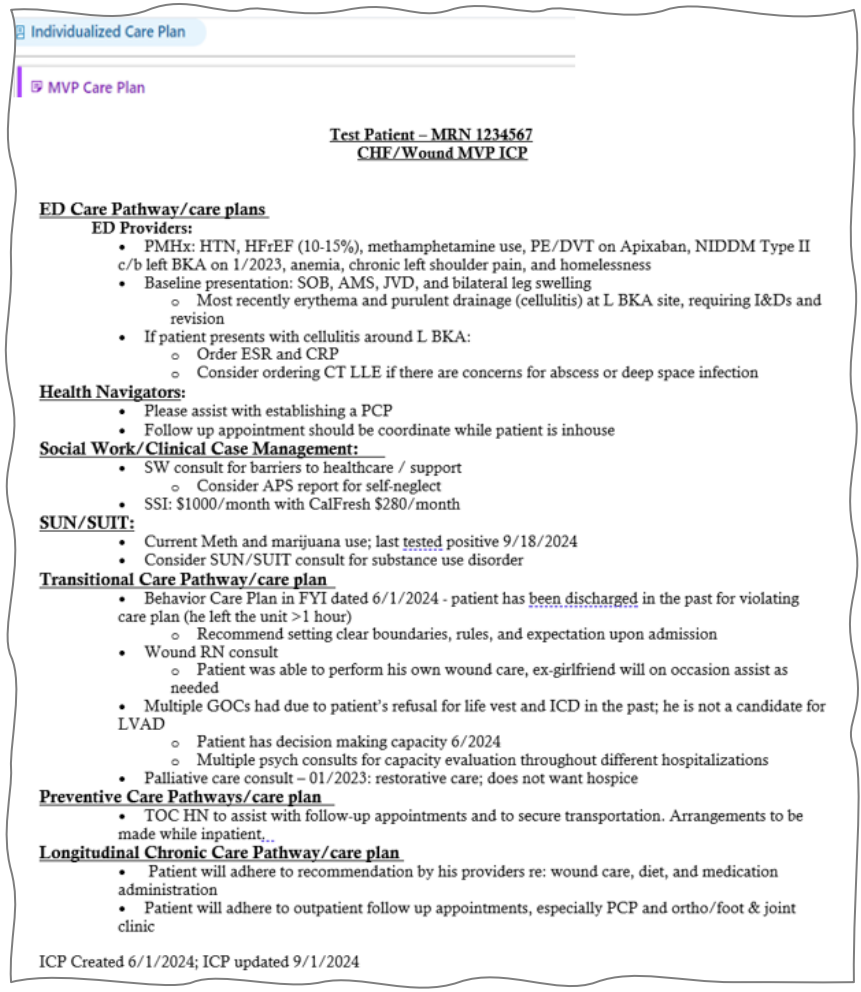
EMR Enhancement: Quick identification of MVP in ED or IP & link to Individualized Care Plans







Individualized Care Plan

MVP Care Plan

Test Patient – MRN 1234567
CHF/Wound MVP ICP

ED Care Pathway/care plans

ED Providers:

- PMHx: HTN, HFrEF (10-15%), methamphetamine use, PE/DVT on Apixaban, NIDDM Type II c/b left BKA on 1/2023, anemia, chronic left shoulder pain, and homelessness
- Baseline presentation: SOB, AMS, JVD, and bilateral leg swelling
  - Most recently erythema and purulent drainage (cellulitis) at L BKA site, requiring I&Ds and revision
- If patient presents with cellulitis around L BKA:
  - Order ESR and CRP
  - Consider ordering CT LLE if there are concerns for abscess or deep space infection

Health Navigators:

- Please assist with establishing a PCP
- Follow up appointment should be coordinate while patient is inhouse

Social Work/Clinical Case Management:

- SW consult for barriers to healthcare / support
  - Consider APS report for self-neglect
- SSI: $1000/month with CalFresh $280/month

SUN/SUIT:

- Current Meth and marijuana use; last tested positive 9/18/2024
- Consider SUN/SUIT consult for substance use disorder

Transitional Care Pathway/care plan

- Behavior Care Plan in FYI dated 6/1/2024 - patient has been discharged in the past for violating care plan (he left the unit >1 hour)
  - Recommend setting clear boundaries, rules, and expectation upon admission
- Wound RN consult
  - Patient was able to perform his own wound care, ex-girlfriend will on occasion assist as needed
- Multiple GOCs had due to patient's refusal for life vest and ICD in the past; he is not a candidate for LVAD
  - Patient has decision making capacity 6/2024
  - Multiple psych consults for capacity evaluation throughout different hospitalizations
- Palliative care consult – 01/2023: restorative care; does not want hospice

Preventive Care Pathways/care plan

- TOC HN to assist with follow-up appointments and to secure transportation. Arrangements to be made while inpatient,..

Longitudinal Chronic Care Pathway/care plan

- Patient will adhere to recommendation by his providers re: wound care, diet, and medication administration
- Patient will adhere to outpatient follow up appointments, especially PCP and ortho/foot & joint clinic

ICP Created 6/1/2024; ICP updated 9/1/2024

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Implement Whole Transitional Care

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Multi Visit Patients Daily Intervention Bundle

Standard Bundle	Enhance Bundle	Enhance Plus Bundle
• MVP RN Navigators perform in-depth chart review to identify cause/care gap resulting in hospitalization • MVP RN Navigators document findings and recommendations in EMR • MVP RN Navigators will notify care team re: recommendations (via Email, Secure/Team Chat) • For UCD MVP – Linkage/warm handoff to UCD ACM • For Non-UCD MVP – Linkage/warm handoff to Plan ACM, ECM	• MVP RN Navigators perform in-depth chart review to identify cause/care gap resulting in hospitalization • MVP RN Navigators document findings and recommendations in EMR • MVP RN Navigators will notify care team re: recommendations (via Email, Secure/Team Chat) • For UCD MVP – Linkage/warm handoff to UCD ACM • For Non-UCD MVP – Linkage/warm handoff to Plan ACM, ECM	• MVP RN Navigators perform in-depth chart review to identify cause/care gap resulting in hospitalization • MVP RN Navigators document findings and recommendations in EMR • MVP RN Navigators will notify care team re: recommendations (via Email, Secure/Team Chat) • For UCD MVP – Linkage/warm handoff to UCD ACM • For Non-UCD MVP – Linkage/warm handoff to Plan ACM, ECM
	• MVP RN Navigator performs bedside interviews – admission day + 1 • MVP RN navigator directly collaborate with inpatient Discharge Planner • MVP Care Coordinator assigned with specific tasks to coordinate follow up PCP/Specialty appointments, provide transportation assistance if warranted • MVP RN Navigator– Follow up on all pending recommendations/referrals – admission day + 3	• MVP RN Navigator performs bedside interviews – admission day + 1 • MVP RN navigator directly collaborate with inpatient Discharge Planner • MVP Care Coordinator assigned with specific tasks to coordinate follow up PCP/Specialty appointments, provide transportation assistance if warranted • MVP RN Navigator– Follow up on all recommendations/referrals – admission day + 3
		• When appropriate, facilitate care conferences with MVP stakeholders, IP providers, O/P providers (i.e. Specialty Clinics), and/or insurance Complex Case Managers • MVP RN Navigators perform f/up calls (case by case) • Complete/close pending care coordination/gaps

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Reach Out and Collaborate with Cross-continuum Providers

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Tenet for Success in Individualized Care Plan Development

- **Daily Chart Reviews:** Perform comprehensive daily chart reviews for every readmitted patient.
- **Partnerships:** Collaborate with ED providers, hospitalists, specialists, case managers, social services, and dialysis centers.
- **MVP RN Roles:** Provide support for discharging complex patients without duplicating work; act as a liaison for cross-continuum providers.

Enhanced Services for High-risk Patients

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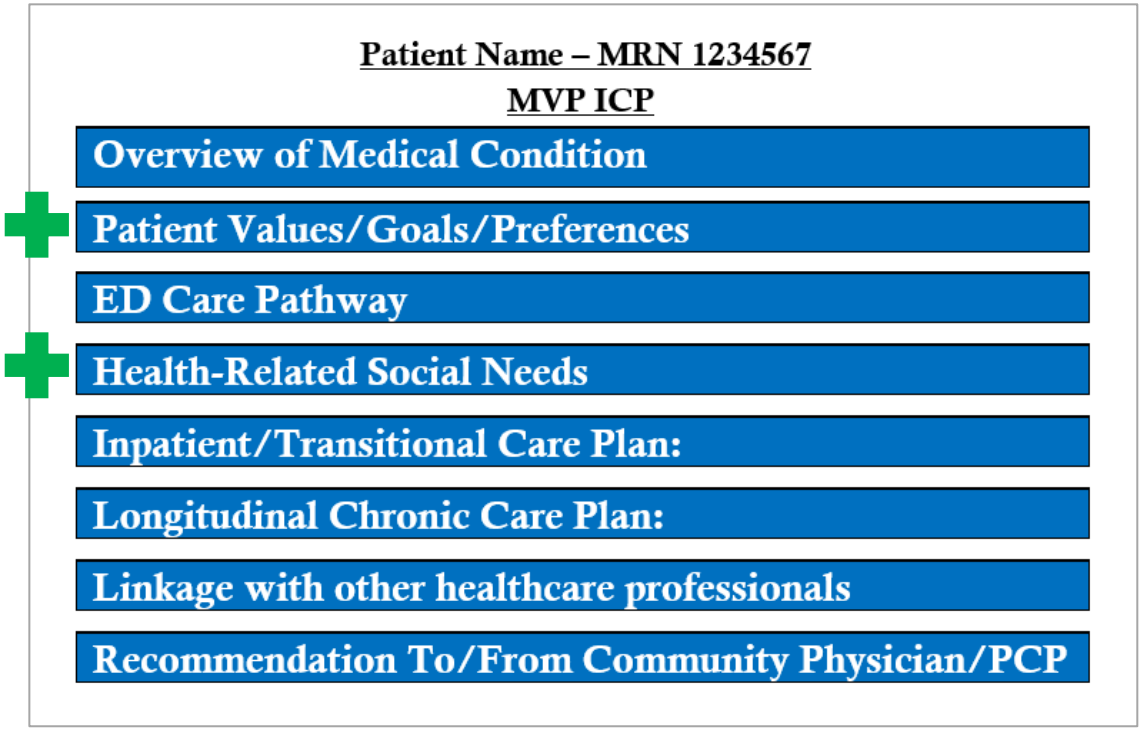
- **Daily Recommendations:** Record daily care recommendations in the EMR, with follow-up calls and Home Care Services initiated within 24-48 hours.
- **Collaborative Care Plans:** Collaborate with multidisciplinary teams, BEST, and DEI champions to create inclusive, culturally sensitive care plans that incorporate patients' values and goals, ensuring equitable healthcare access.



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Overall Improvement in Readmission Rates

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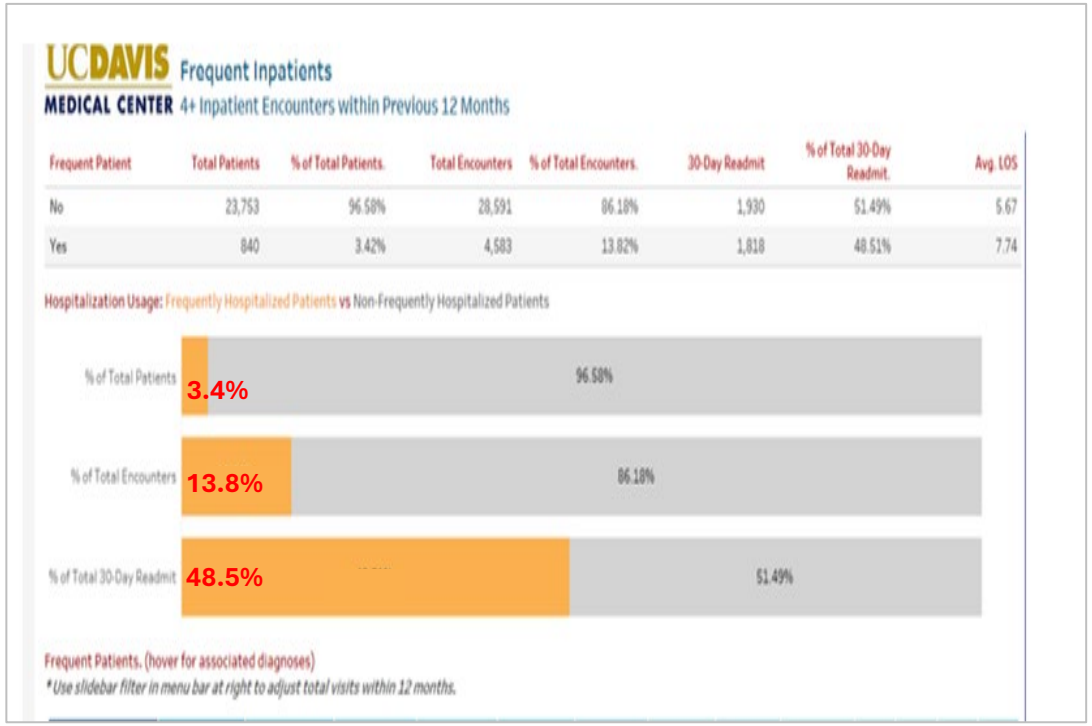
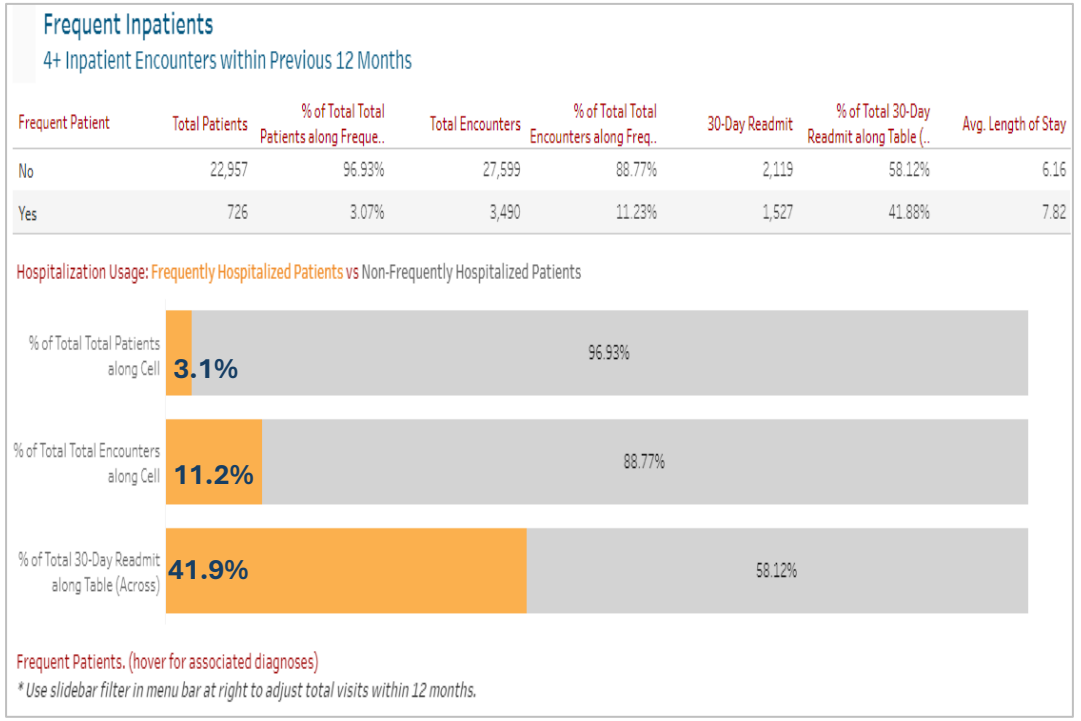
2019: MVP Patients' Impact on Hospital Utilization and Readmission

Data showed: 48.5% of total readmission rate is attributed to 3.42% MVP patients (~840 patients)



2024: MVP Patients' Impact on Hospital Utilization and Readmission

Data showed: **41.9% total readmission rate is attributed to 3.1% MVP patients (~726 patients)** as of **July 2024**



6.6% drop in overall MVP patients' impact on 30-day readmission

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As of July 2024 – 163 Patients with **Active** ICP

Over 235+ ICPs created in last 5 years

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Multi-Visit Patient Individualized Care Plan Analysis

An Operational Excellence / Transition of Care Partnership

Patients were identified by having an Individualized Care Plan (ICP) on file in the UCDH EHR. Individu… scanning the table that stores clinical notes, and collecting the patient MRN's having a note type … Associated Emergency, Observation and Inaptient encounters were also obtained.

1 Active ICPs as of 7/2024

163 patients **5,946** encounters **21,400** patient days

2 Total # of Enc by 163 MVP pts

3 Total # of Enc by 163 MVP pts

Once patients with Individualize… Davis Health Emergency Roo… Indivisdualized Care Plan. *The …*

…onducted to determine if ICP patients returned to the UC …r if there was no change since establishing an

Today-ICP Created / PRE: ICP Created Date - (Today-ICP Created)

Less Visits | More Visits

4 70% had less visits post ICP

70%	4%	26%
(114) patients	(7) patients	(42) patients

For patients who expereinced *Less Encounters*, the median reduction in encounters was

8 visits per patient

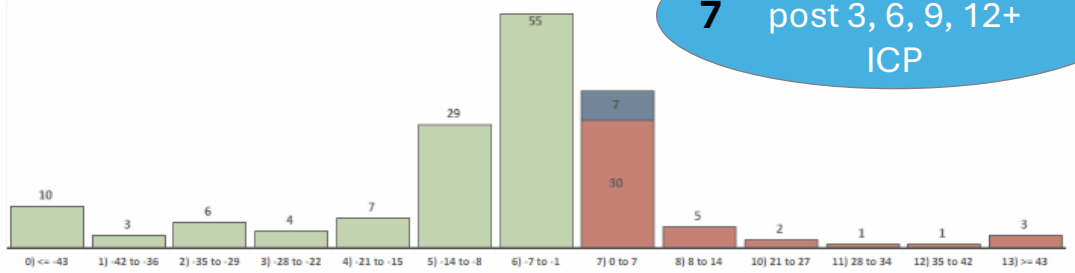
5 Ave 8 visits per MVP post ICP implementation

When taking the patients that experienced less visits and adding up the number of reduced Patient Days compared to the same period prior to ICP creation, the total savings, and Patient Days are:

4,824

6 ~4800 LESS patient days

Distribution of encounters based on gain /reduction post Individualized Care Plan



7 Fewer encounters post 3, 6, 9, 12+ ICP

Cumulative encounter count (Length of Stay) - Pre / Post ICP - 3 Months=0 to 3 months; 6 Months=3 months to 6 months; etc.

Improving Continuum of Care for High-Risk Patients

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- TOC programs success led to funding for Health Navigators in late 2020.
- **With a strong foundation, we aimed to be among the top 5 health systems in Vizient Continuum of Care.**


Establish and schedule PCP appointments


Specialty care appointments


My UCDavisHealth (formerly MyChart) set-up support.


UCDH Post Discharge Clinic


Provide community resources (WIC, IHSS)


Refer patients to UC Davis Health Ambulatory Case Management and payer-based support


Transportation (coverage is based on patient's insurance)


Facilitate provider communication to ensure continuity of care

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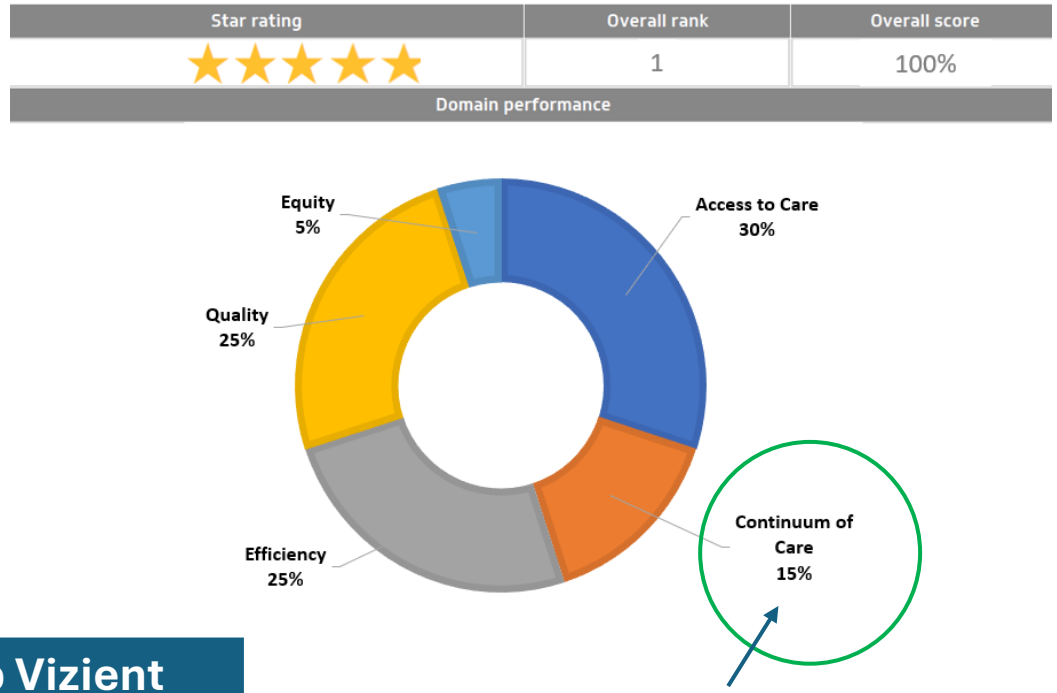
Ambulatory Quality and Accountability Measures

Continuum of Care 15% Weighted	ED utilization (%)	Low acuity ED visits
		Patients with 4 or more ED visits
		Patients 2 or more ED visits in 7 days
	Inpatient Post-discharge follow up within 7 days (%) **Completed visits**	1. Pneumonia
		2. Urinary tract infection
		3. COPD
		4. Heart failure
		5. Diabetes short term complications
		6. Diabetes long term complications
		7. Uncontrolled diabetes
		8. Lower extremity amputation diabetes



Year	Post Discharge Follow up within 7-day	7-Day Follow Up Vizient Ranking
2020	32.8 %	14 (Domain ranking 19)

Source: Vizient Ambulatory Quality and Accountability measures

Strategic Initiatives

- In early-2022, launched a **strategic initiative to improve care continuity** and enhance patient outcomes.
- Focused on ensuring **7-day follow-ups for high-risk patients** with COPD, CHF, UTI, pneumonia, and diabetes (as specified by Vizient/AHRQ).
- Fostered collaboration between **inpatient and outpatient services**.
- Implemented **EMR tools to identify high-risk** patients and schedule follow-ups proactively.
- Developed comprehensive support systems, including free transportation and telehealth options to **address social barriers to care**.
- Initially piloted a Post Discharge Clinic in early 2022, and opened the first full-scale **Post Discharge Clinic in Spring 2023.**

Challenges and Counter Measures for Sustainable Gain

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Early Challenges	Counter Measures
Lack of ownership for 7-day follow-up	TOC team took ownership of identifying and coordinating follow-up
Delays in identifying target population -Prior practice heavily relied on coded data, which was available 3-5 days after discharge)	Created a daily EMR report that leveraged Encounter/Admission primary diagnosis to identify target patients
Fragmented efforts between inpatient and outpatient teams	Partnered with Ambulatory and Clinic leadership to prioritize appointments
No Transitional/Post Discharge Clinic	Piloted NP-led clinic in 2022; opened full-scale Post Discharge Clinic in April 2023
Social barriers such as transportation	Offered free Lyft rides to appointments
Navigators on **hold too long** when coordinating care	Trained navigators to directly schedule patients in EMR (August 2023)

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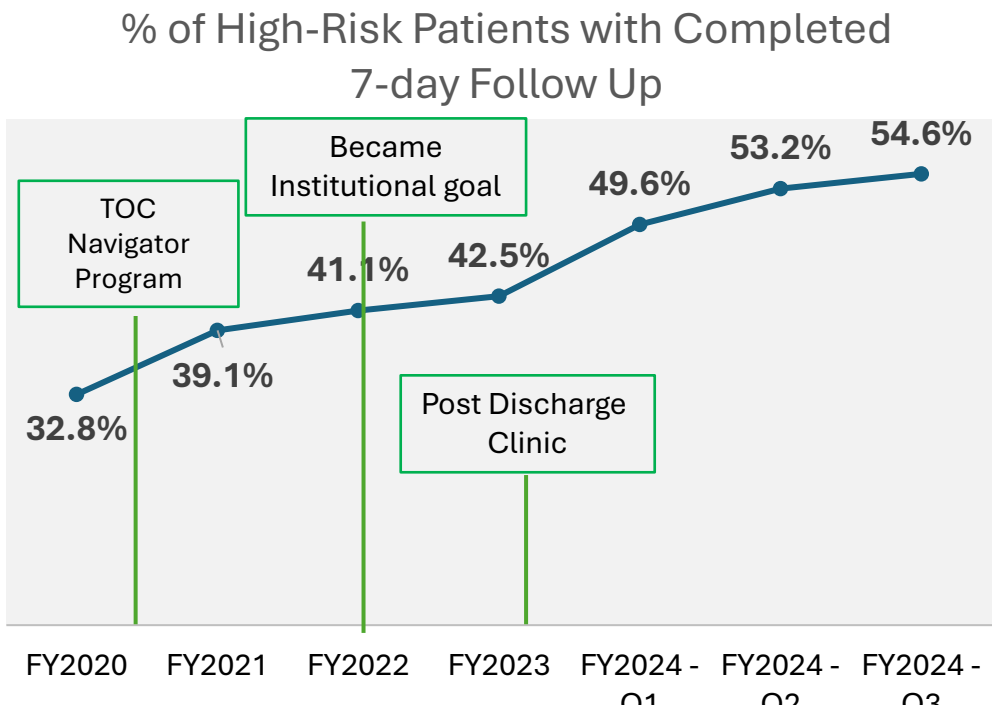
Interventions Timeline

Year	% with 7-day Follow Up Visits	Continuum of Care Domain Ranking	Interventions
FY2020	32.8 %	14 out of 40 health systems (Domain ranking 19)	✓ Implemented Hospital/ED-based Health Navigators to coordinate care before discharge
FY2021	39.13%	7 out of 47 health systems (Domain ranking 13)	✓ Navigators engaged with patients and supported care coordination • **Developed EMR report to identify target population before discharge** • **Partnered with Primary Care Clinic for timely follow-up**
FY2022	41.1%	6 out of 49 health systems (Domain ranking 16)	✓ Navigators engaged with patients and supported care coordination ✓ Refined EMR report for better specificity ✓ Continued partnership with Primary Care Clinic • **Launched NP-led Post Discharge Clinic Pilot (10 slots/week)** • **Partnered with specialty clinics (COPD/HF) for follow-up**
FY2023	42.5%	5 out of 57 health systems (Domain ranking 12)	✓ Navigators engaged with patients and supported care coordination. ✓ Refined EMR report for better specificity ✓ Continued partnerships with Primary Care and specialty clinics • **Opened the first Post Discharge Clinic (Transitional Care Clinic)**
FY2024 (thru March 24)	54.6%	Expected to be top 5 **(Domain ranking thru Q3 : 3)**	• Began NEW effort on reducing 2x visits within 7 days of ED Discharges

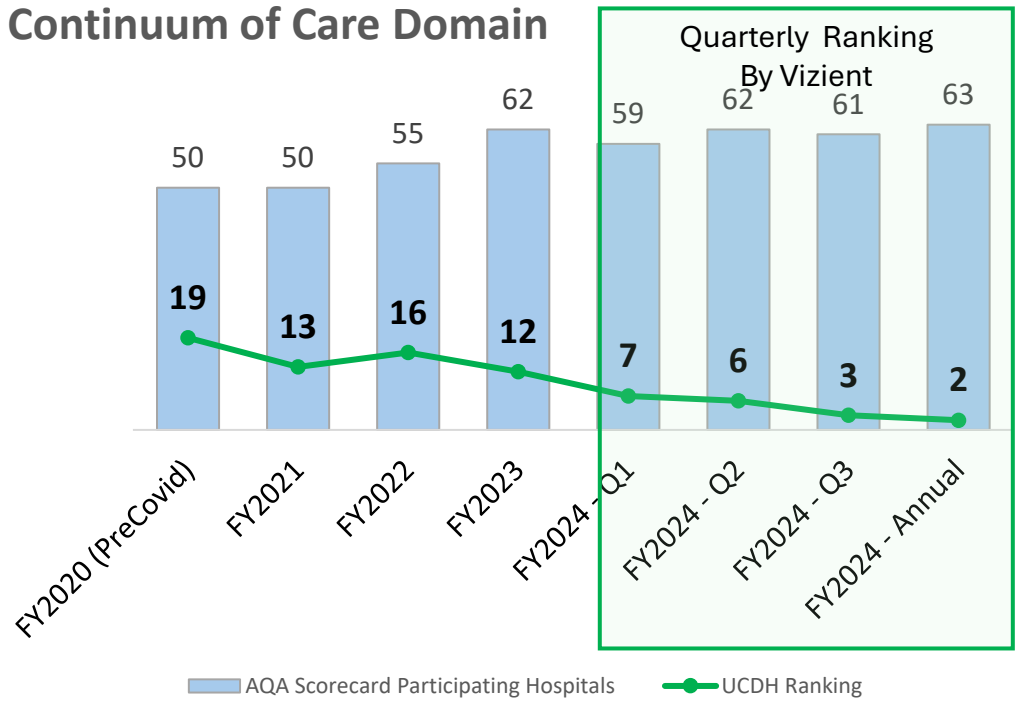
Source: Vizient Ambulatory Quality and Accountability annual scorecard

Outcomes: Ambulatory Quality and Accountability Measures

Published Quarterly by Vizient



AMCs vs. UCDH Ranking



Source: Vizient Ambulatory Quality and Accountability annual scorecard

Lessons Learned

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- **Partnership with IT/EMR:** Developing tools and reports with IT/EMR teams is crucial for a data-driven approach.
- **Executive Leadership Support:** Critical for the success and sustainability of initiatives.
- **Dedicated/Transition of Care Team:** A strong TOC team and dedicated staff are pivotal in enhancing patient outcomes through effective care coordination and managing MVP patients' care plans.
- **Inpatient and Outpatient Collaboration:** Strong partnerships between these services enhance care continuity and patient outcomes.

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Key Takeaways

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- **Improved Patient Outcomes:** Both initiatives led to significant improvements in patient outcomes and reduced readmissions.
- **Comprehensive Patient Care:** Addressing medical, social, and behavioral health needs through individualized care plans ensures comprehensive care.
- **Alignment Across Settings:** Individualized Care Plans for MVPs align care providers across various settings.
- **Sustainable Success:** Continuous evaluation, adjustments, and sustainable support systems are key to long-term program success.

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Questions?

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