Piedmont ATHENS REGIONAL

GRADUATE MEDICAL EDUCATION

How to Show Your Residents' Value to Your Institution Through Education in Transitions of Care

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Disclaimer- We have no disclosures

However…….

We are offering you a triple treat

- Resident Education in SBP and PBLI
- Institutional Cost avoidance/ cost savings
- Educational Portfolio enhancement

Objectives

- Discuss a Transition of Care (TOC) implementation process
- Identify methods and tools to institute a TOC Curriculum & Clinic
    - TOC curriculum
    - TOC clinic schedule
    - TOC note templates
    - Script for phone calls
    - Resident and faculty responsibilities
- Recognize and evaluate the ACGME sub-competencies of SBP and PBLI
- Share common barriers to successful implementation

Why Should you Implement TOC ?

- Readmissions cost $26 billion every year
- $12 billion is spent on avoidable readmissions
- Information is not always transmitted to the primary care physician
- Lack of access to primary care for many discharged patients
- Important to teach residents care coordination

Value of TOC to Graduate Medical Education(GME)

- Helps build resident patient panels
- ***Shows GME's value to the institution***
- Education for residents in safe transitions of care and QI
- Inter-professional education and team work
- **Improves patient safety**
- Provides faculty and resident Scholarly activity

Essential Elements to Consider

- If you are planning on developing TOC practice we suggest:

- Create a team
- Do a SWOT analysis
- Prepare your Elevator pitch for the C-suite
- Set up the Clinic carefully
- Potential barriers to be prepared for or to avoid

Sample-SWOT Analysis

S Strengths

- Scripts to-go
- Community care clinic
- Emergency Dept. Home Health Care & PCP referrals
- Multi-Disciplinary Rounds
- Projected Day of Discharge (PDOD)
- Discharge Packet
- 24-hr Patient Follow-up calls
- Cerner: Lighthouse Tool, PCP Identification at admission, Workflow process

W Weaknesses

- Care Coordination of existing TOC projects
- Communication lapses: Interdisciplinary & departmental silos
- Accountability – clear designation of roles and responsibilities
- Execution and sustainability of projects
- Too many initatives competing for same resources – unable to execute.
- Quality of patient prep for D/C and quality of patient education and information packets

O Opportunities

- Care Coordination across disciplines
- Relational Coordination and communication
- Transitions of Care Committee: meet quarterly and include multi-discpilinary team members
- Four top goals identified:

1. Provide patient with effective education prior to discharge
2. Peform medication reconciliation prior to discharge
3. Schedule outpatient follow-up appt. prior to discharge
4. Provide community physician with discharge summary within 48hrs of discharge

T Threats

- Organizational drift to other strategic priorities
- Inadequate resources
- Lack of accountability and expectation for completion of initiatives
- Communication breakdowns/silos
- Organizational culture
- Team spiritedness
- Hand-off of project to new leadership, Succession Plan

TOC Implementation Process

Education & Clinic Set up

Clinic Notification via EMR or Hotline

Phone call within 2 days

TOC visit

Faculty Development and Engagement

- Brainstorm in a small group to assess the ideal yet achievable process for your program

Key Elements

- Who will lead the project
- Faculty responsible for the curriculum
- Funding and resources for initial clinic set up
- Documentation requirements for phone calls and TOC visits
- Billing for TOC visits
- Creation appropriate of templates

TOC Curricular Components

- Goals and Objectives
- Responsible faculty
- Supervision requirements
- Educational Components
  - SBP, PBLI, PC, ICS
- Evaluation Tools
  - TOC milestones

ACGME Milestones 2.0
How to evaluate your residents in TOC?

- **System Based Practice**
  - SBP1: Patient Safety and Quality Improvement
    - Contributes to local quality improvement initiatives
  - SBP2: System Navigation for Patient-Centered Care
    - Uses local resources effectively to meet the needs of a population and community
  - SBP3: Physician Role in the Health Care Systems
    - Engages with patients in shared decision making, informed by each patient's payment models
- **Practice Based Learning and Improvement**
  - PBLI1: Evidence-Based and Informed Practice
    - Locates and applies the best available evidence integrated with patient preference, to the care of complex patients

Resident Education

- Large group discussion (TBL) with residents, administration and faculty
- Noon conference to educate both faculty and residents about the importance and process of TOC
- Include TOC in ambulatory didactic sessions quarterly
- Include a TOC station in OSCEs
- Chart simulated recall is an option
- Develop a Direct observation tool to evaluate residents

- Link to our curriculum Transitions of Care Curriculum.docx

Creation of a TOC Clinic Team

- Teaching Faculty as coordinator
- Lead resident
- Residents
- RN Clinical Manager(Optional)
- Pharmacist
- Social Worker
- Financial Counselor

TOC Clinic Essentials

- Staff: Faculty and residents
- Clinic RN responsible for TOC project
- Clinic 5 days/week decide if TOC will be held in all sessions
- 30-60 minute visit slots
- Additional support – MA's, Pharmacy and Social Work
- Insurance status of patients
- Patient characteristics
  - New to clinic
  - Established patient
  - Unable to see their PCP in 14 days- one time TOC visit

Clinic Schedule and other Issues

- Regular TOC team meetings with all stakeholders
- TOC nurse adds TOC patients to the residents' schedule
- TOC visits scheduled as 30-60 minutes slots
- Resident may become PCP after the TOC visit if the patient is unassigned
- TOC lead resident and faculty are on-call to trouble shoot issues
- **Did we say IRB approval to study re-admission rates and cost savings?**
- **TOC QI faculty and resident team planning and responsibilities**

The Process

Education

Clinic Notification via EMR or Hotline

Phone call within 2 days

TOC visit

Clinic Notification via a hotline or EHR

1. Find a central number Or

2. Create a list in your electronic health record(EHR)

3. Designate a responsible person

- Link (Step by step: Creating your own TOC list on Cerner or EPIC)..\Desktop\toc\EMR TOC lists (1).docx
- RN job Description ..\Desktop\toc\Transition Of Care RN job description.docx

The TOC Process

Education

Clinic Notification via EMR or Hotline

Phone call within 2 days

TOC visit

Phone Call

- **Designated person calls within 48 hours** of discharge
  - Focused history and symptom review
  - Medication reconciliation
  - Identify possible socioeconomic barriers- eg. transportation
  - Education using **Ask Me 3** eg. CHF, diet
  - Answers questions

  - Link to our 48-hour phone call template

..\Desktop\toc\TOC call template.docx

The Process

Education

Clinic Notification via EMR or Hotline

Phone call within 2 days

TOC visit

Anatomy of a TOC visit

Financial counselor review

Medication reconciliation

Physician visit

Pharmacy and social work involvement

Plan for follow up

Resident completes note using TOC template

Faculty bills for TOC visit- Level 1 or 2

TOC team collects data for ongoing QI project

Link to our TOC visit template
..\Desktop\toc\TOC visit Template.docx

Strategies to evaluate a TOC Visit

- Directly observe the TOC visit with the resident
- Link to the direct observation tool : DOT to evaluate residents.doc
- Chart simulated call on the note
- Multi-source evaluation of resident performance
  - Pharmacist
  - Financial counselor or social worker
  - TOC clinic RN
  - Patient

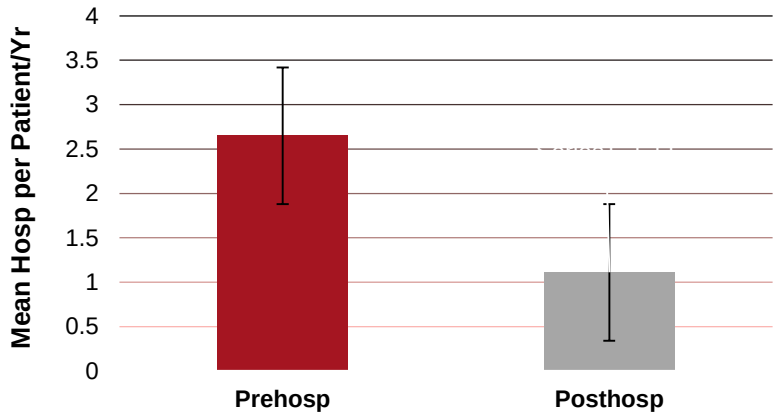
Lesson One – Keep Ongoing Measurements

Sample Results of a TOC QI Project

- Retrospective chart review of patients seen- 41/300 charts
- Population- adults >18 seen in the TOC clinic
  - ≥3 clinic visits
  - Initial visit within 1 month of hospitalization or ED visit
  - Documented referral from hospital, urgent care or ED
- Intervention
  - Transition of Care Visit
- Comparator
  - Mean #s of hospitalizations, 30dR, and ED use per patient
  - 6 months before and after the index visit
- Outcomes
  - Hospitalizations, 30dR and ED visits improved
  - **Cost savings $ 920,436**

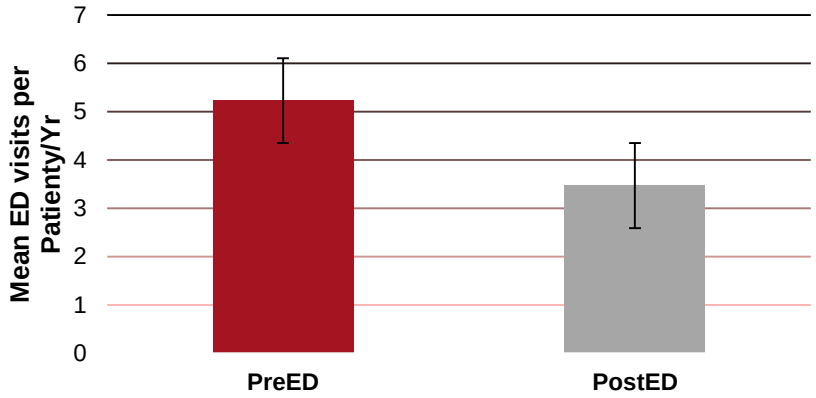
Results

Mean Hospitalizations per Patient/Yr



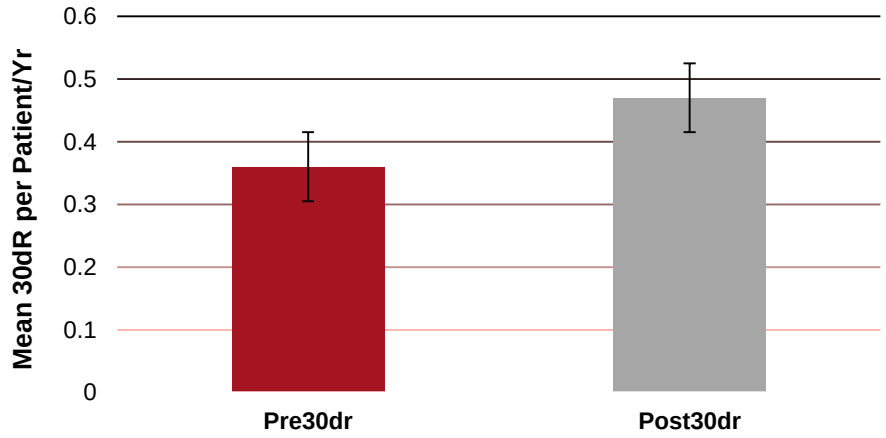
△ 1.54 (0.70 – 2.38)
(p<0.001)

Mean ED Visits per Patient/Yr



△ 1.76 (0.35 – 3.88)
(p< 0.0010)

Mean 30 day Readmission per Patient/Yr



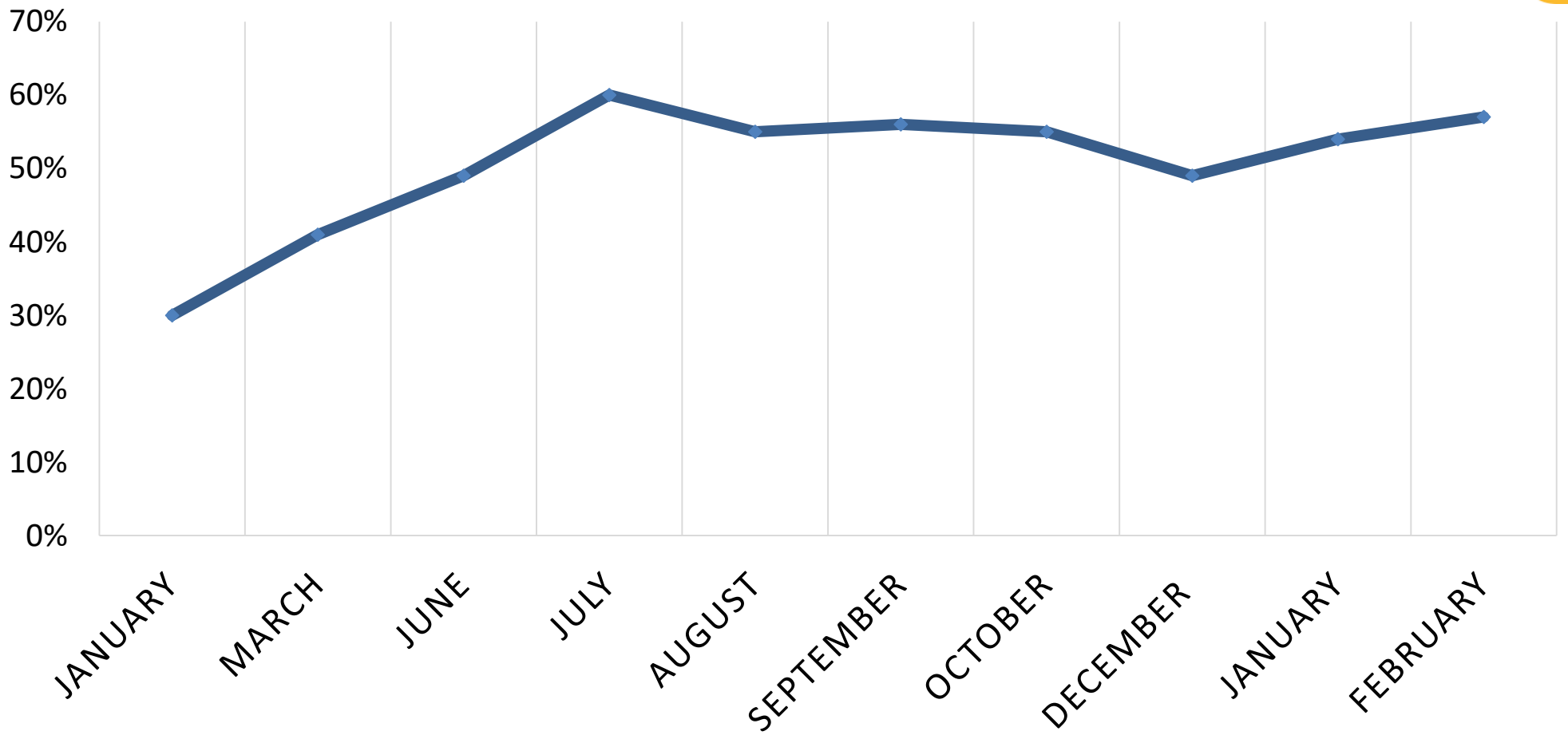
△ -0.10 (-0.44 – 0.22)
(p=0.509)

Cost Saving Analysis

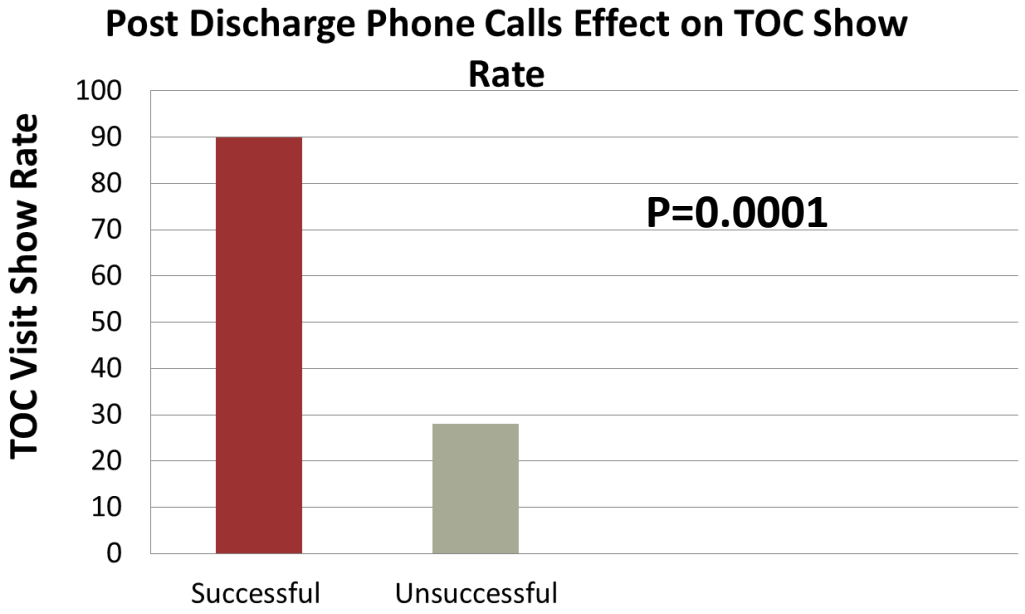
- -**1.54** (mean hospitalization per patient/yr) x 41 patients x $12,100*=$763,994
- **-1.76** (mean ED visits per patient/yr) x 41 x $2168**= $156,442
- Total estimated savings= **$920,436** for the 41 patients included

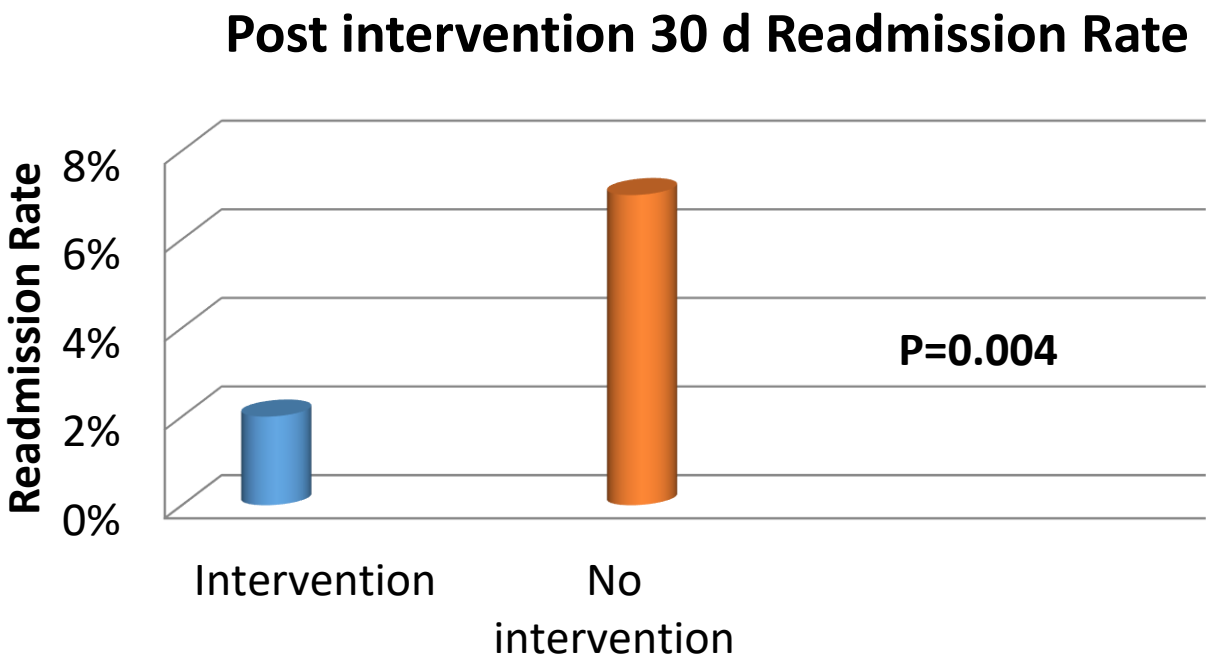
*http://www.theatlantic.com/health/archive/2013/02/how-much-does-it-cost-to-go-to-the-er/273599/
**http://www.hcup-us.ahrq.gov/reports/statbriefs/sb146.pdf

Show Rate in One Year 2017-2018




POST DISCHARGE PHONE CLINIC


Post Discharge Phone Calls Effect on TOC Show Rate
TOC Visit Show Rate
100
90
80
70
60
50
40
30
20
10
0
P=0.0001
Successful
Unsuccessful


Post intervention 30 d Readmission Rate
Readmission Rate
8%
6%
4%
2%
0%
P=0.004
Intervention
No intervention

Objective 4: Barriers and Advice for Adoption

- Demand for the clinic could be much higher than predicted
- Acuity of patients seen is higher than typical ambulatory patients
- Payer-mix is challenging compared to normal clinic
- TOC clinic does not absolve the need for a more continuous process to provide care at the time of discharge

ADVICE

- Adequate staffing is essential
- Continued alignment with healthcare leadership is key
- Clinic performance measures should include cost avoidance
- Clear instructions at the time of discharge is a must
- Build strong relationships within your community- SNFs, Home health, etc.

More Potential Roadblocks to Avoid

- **System barriers**
  - Lack of strong and sustained leadership
  - Trying to do too much
  - Lack of stakeholder buy in
  - Inter department collaboration- avoid silos
  - Emphasize role and responsibility clarity
- **Provider /Clinic**
  - Resident transitions on account of schedules
  - Variability in care
  - Staff turn over
- **Patient**
  - Low health literacy
  - Socio-economic issues
  - Low Motivation and self efficacy

TOC Coding & Billing

1. Documented 48 hour patient contact

- Direct contact, phone or electronic
- Patient and/or caregiver
- *Waiver if ≥2 separate attempts are made in a timely manner and documented in the medical record, but are unsuccessful*

2. TOC visit

- 7 days----99496+ high complexity decision making(RVU 2.11)
- 14 days---99495+ at least moderate complexity(RVU-3.05)

Must meet documentation requirements:

- Bill one TOC per patient per 30 days
- Only one provider can bill for TOC in a 30 day period
- Can submit bill on date of service no need to hold for 30 days
- Cannot bill for the following-even if requirements are met
  - Minimum level of medical decision making
  - Home health care plan oversight G0181, G0182 (hospice)
  - ESRD services 90951-90970
  - Chronic care management with some exceptions

Billing for TOC visit

CPT Code	Service Description	Office	RVUs*
99487	Complex chronic care management services	$94	2.63
99495 TOC within 14 days	**Moderate complexity** during service period; and face-to-face visit within 14 calendar days of discharge	**$166**	4.64
99496 TOC within 7 days	**High complexity** during the service period; and face-to-face visit, within 7 calendar days	**$243**	6.57

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

Achievements

- Improved show rate and reduced readmissions
- Cost Savings for the institution
- Improved patient safety and satisfaction
- Improved team member satisfaction
- TOC is built into the ambulatory curriculum
- Model can be adapted by programs to improve transitions of care
- Scholarly activity for residents and faculty

Summary

- TOC is a robust learning environment made challenging by high illness acuity
- Need strong leadership- physician champion for sustainability
- Early stakeholder engagement is key
- Keep goals aligned with your institution's strategic goals
- Measure everything you do
- Start small and focus!
- Spread successes all over the institution
- Don’t be afraid to fail

Toolkit

- A summarized article for TOC best practices
- CHRT-Care-Transitions-Best-Practices-and-Evidence-based-Programs-.pdf
- Our TOC curriculum
- Transitions of Care Curriculum.docx
- TOC clinic scheduling rules
- TOC list on EMR (Cerner and Epic) step by step
- EMR TOC lists (1).docx
- TOC RN job description with weekly email template to TOC resident lead
- Transition Of Care RN job description.docx
- Post discharge phone call script
- TOC call template.docx
- TOC visit template
- TOC visit Template.docx
- TOC Direct observation tool for residents' evaluation
- DOT to evaluate residents.doc

Useful Resources

- Geriatric discharge assessment tool: BOOST
- Patient discharge **booklet**: AHRQ www.ahrq.gov
- Project RED http://www.bu.edu/fammed/projectred/links.html
- CMS TOC resources https://partnershipforpatients.cms.gov/p4p_resources/tsp-preventablereadmissions/toolpreventablereadmissions.html
- Forster AJ, Murff HJ, Peterson JF, Gandhi TK, Bates DW. The incidence and severity of adverse events affecting patients after discharge from hospital. Ann Intern Med. 2003;138:161–167
- Jack BW, Chetty VK, Anthony D, et al. A reengineered hospital discharge program to decrease rehospitalization: a randomized trial. Ann Inter Med. 2009;150(3):178–187.
- Effect of a hospitalist-run post-discharge clinic on adverse post-discharge outcomes Robert Burke1, 3, Emily Whitfield2, Allan V. Prochazka2, 3; 1. Hospital Medicine Section