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 initiatives 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-disciplinary team members  
- Four top goals identified:  
  1. Provide patient with effective education prior to discharge  
  2. Perform 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

1. Education & Clinic Set up
2. Clinic Notification via EMR or Hotline
3. Phone call within 2 days
4. 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

1. **Education**
2. **Clinic Notification via EMR or Hotline**
3. **Phone call within 2 days**
4. **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

1. Education
2. Clinic Notification via EMR or Hotline
3. Phone call within 2 days
4. 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 30 day Readmission per Patient/Yr**

△ -0.10 (-0.44 – 0.22)  
(p=0.509)

**Mean ED Visits per Patient/Yr**

△ 1.76 (0.35 – 3.88)  
(p< 0.0010)
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.hcup-us.ahrq.gov/reports/statbriefs/sb146.pdf
Show Rate in One Year 2017-2018
Post Discharge Phone Calls Effect on TOC Show Rate

<table>
<thead>
<tr>
<th>Successful</th>
<th>Unsuccessful</th>
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<tr>
<td>100</td>
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P = 0.0001

Post intervention 30 d Readmission Rate

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<th>Intervention</th>
<th>Post intervention 30 d Readmission Rate</th>
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<tbody>
<tr>
<td></td>
<td>P = 0.004</td>
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</table>

<table>
<thead>
<tr>
<th>Readmission Rate</th>
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<tbody>
<tr>
<td>0%</td>
</tr>
<tr>
<td>2%</td>
</tr>
<tr>
<td>4%</td>
</tr>
<tr>
<td>6%</td>
</tr>
<tr>
<td>8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>8%</td>
</tr>
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P = 0.004
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

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Service Description</th>
<th>Office</th>
<th>RVUs*</th>
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<tbody>
<tr>
<td>99487</td>
<td>Complex chronic care management services</td>
<td>$94</td>
<td>2.63</td>
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<tr>
<td>99495</td>
<td><strong>TOC within 14 days</strong>&lt;br&gt;<strong>Moderate complexity during service period; and face-to-face visit within 14 calendar days of discharge</strong></td>
<td>$166</td>
<td>4.64</td>
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<tr>
<td>99496</td>
<td><strong>TOC within 7 days</strong>&lt;br&gt;<strong>High complexity during the service period; and face-to-face visit, within 7 calendar days</strong></td>
<td>$243</td>
<td>6.57</td>
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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](http://www.ahrq.gov)
• Project RED [http://www.bu.edu/fammed/projectred/links.html](http://www.bu.edu/fammed/projectred/links.html)
• 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