Bridging the Gap: Improving Transitions of Care

Victor Catania MD
Lehigh Valley Health Network, Victor.Catania@lvhn.org

Grant M. Greenberg M.D., M.H.S.A., M.A.
Lehigh Valley Health Network, grant.greenberg@lvhn.org

Deborah Bren DO
Lehigh Valley Health Network, deborah.bren@lvhn.org

Published In/Presented At

Catania, V. Greenberg, G. M., Bren, D. (2018, December 6-9). *Bridging the Gap: Improving Transitions of Care.* Poster Presented at: Conference on Practice Improvement - Society of Teachers of Family Medicine, Tampa, FL.

Bridging the Gap: Improving Transitions of Care

Victor Catania, MD; Grant Greenberg, MD; Deborah Bren, DO

Lehigh Valley Health Network, Allentown, Pa.

BACKGROUND

Transition of care management in family medicine outpatient settings represents an opportunity to improve outcomes and reduce hospital costs. The time between a patient discharge from an inpatient facility until they are seen by their primary care provider represents a delicate shift in their health and status. Within our region comprising of 12 clinicians and 9 offices, at baseline fewer than 10% (N=500) of hospital discharges annually received a transition of care appointment within 14 days. To improve these rates, we introduced a dedicated LPN to provide care coordination across all 9 satellite offices. This LPN has access to a daily discharge census report and follows a pre-approved transition of care script to ensure that the patient is contacted within 48 hours of discharge and all necessary CMS documentation components are completed before scheduling the patient directly with their primary care provider. This intervention should yield both improved health care value by increasing TOC visit rates, yielding lower readmission rates, and netting incremental outpatient revenue.

METHOD AND OUTCOMES

The creation of a dedicated care coordination role shared across a number of offices allows for a significant increase in the number of transition of care appointments without a prohibitive increase in staffing cost. Within our division, this was accomplished with the identification of an LPN that stated a preference for this line of work and had buy in with respect to the need for transitions of care. Within our health care network, there is a combination of physician portal and electronic health record which generated a centralized in-patient census that our dedicated support could utilize to identify patients admitted and who their primary care provider was as well. This allowed for rapid identification without investing in additional resources as this generated as part of the in-patient work flow. Additionally, with this staff member identified a network generated discharge list could be sent to them to allow for rapid identification of these patients for early contact. We developed a scripted template within our EHR for this staff member to follow. This ensured that we hit the exact metrics required for generating this charge and created replicability with our process. Every patient contact was the same, which ensured a consistent patient experience as well as a consistent clinical experience. Having this template within the EHR also removed the need to generate additional notes or create paperwork to be sent to the primary care provider. These electronic notes were automatically routed to the provider for review. Each participating provider identified in their schedule when they would want to see post-hospital discharges. This, coupled with empowering our LPN to make appointments, created a seamless encounter for the patient where they had an outreach moment and then at the same time transitioned back to their primary care provider for a hospital follow-up. This rapidly improved the turn around times for these appointments, from an average of 16 days to 5.5 days. From a provider standpoint, a template was generated and instruction on use was provided. This reduced the burden in making providers remember what needed to be asked to satisfy billing requirements and also reinforced the concept of a consistent experience across all clinical sites. Additional, reinforcing instruction was provided at the two-week mark for practices as they “went live” to ensure key concepts and billing were met. To date, two-thirds of clinical sites are utilizing this work flow with the rest scheduled to come online before the end of the calendar year.

Ultimately, this allowed practices to be proactive in reaching their patients within 48 and often within 24 hours from discharge- allowing for a timely appointment. More importantly, it provides an additional layer of support to talk to the patient to ensure they understand their diagnoses, discharge instructions, and provides an opportunity to reconcile medications. The creation of these visits also improves practice revenue; on average generating an additional $35-$40 per visit compared to traditional 99213/99214 appointments. The additional work from a provider standpoint was found to be negligible with the standardization of a transition template that was integrated in to the electronic medical record. The downstream effects of reducing readmissions to the network’s hospital, particularly within a 90-day window, cannot be overstated.

Lehigh Valley Health Network

LVHN.org