Healthy at Home Virtual Clinic

Improving Transitional Care

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CMO Utilization Management & Clinical Documentation Integrity

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University Hospitals

About University Hospitals

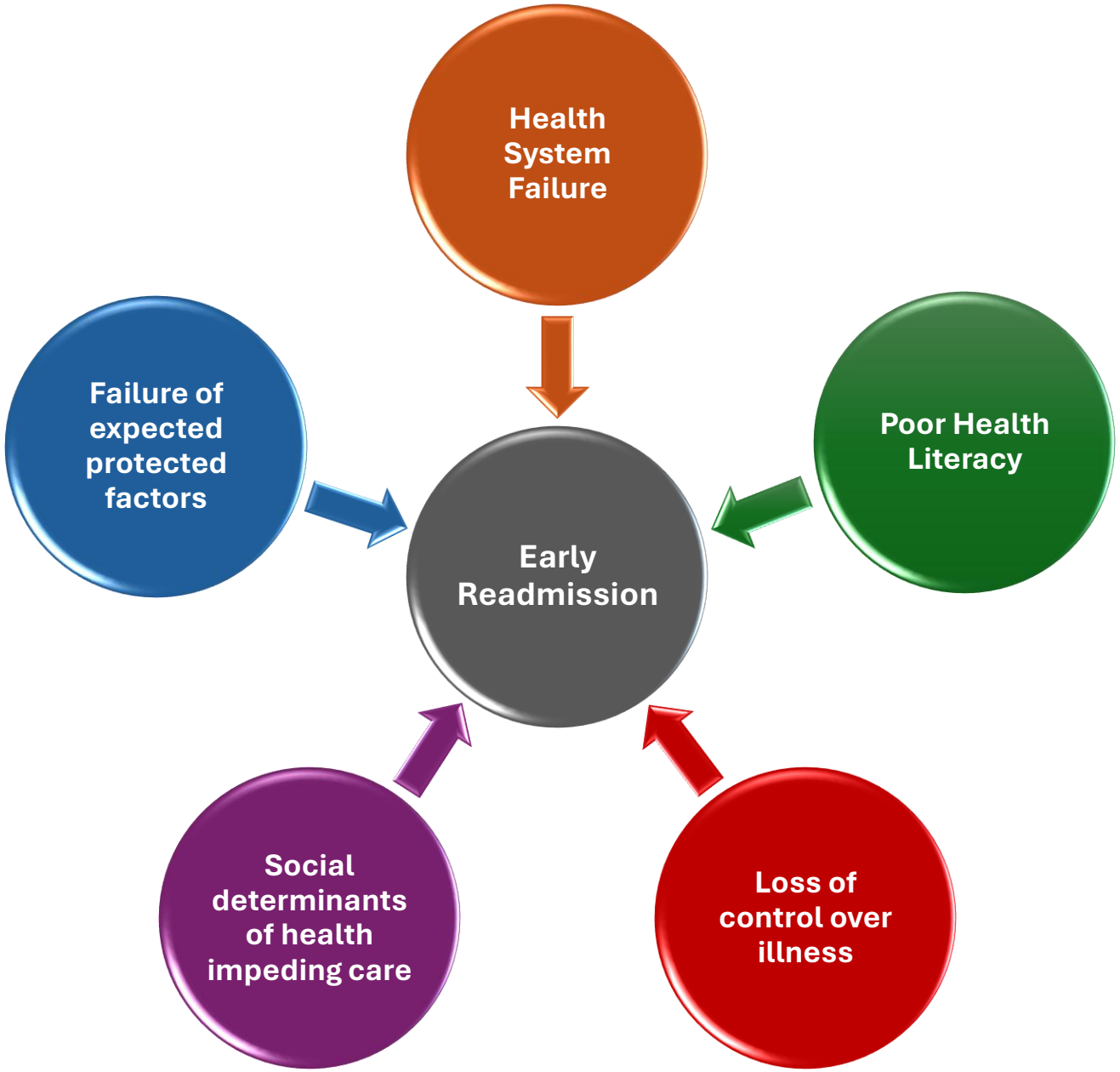
- Founded May 14, 1866
- Located in Northeast Ohio
- Eighteen hospital system
- Forty health centers
- Serving over 1 million patients

The Problem

Approximately 20% of Medicare beneficiaries are readmitted within 30 days of discharge, and these readmissions have been estimated to cost the American public more that $15 billion per year *(nih.gov)*

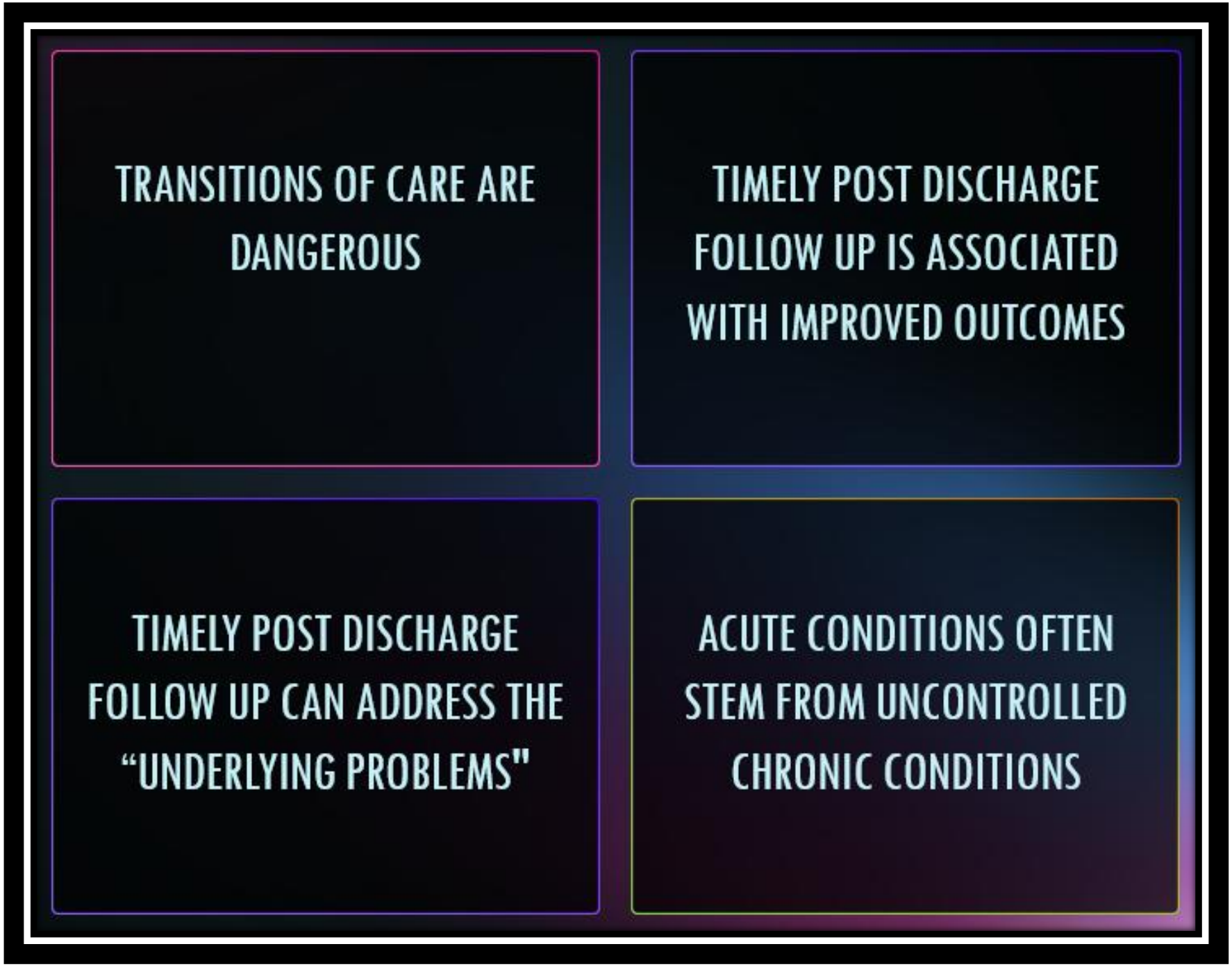
Medicare Payment Advisory Commission estimated that 12% of readmission are potentially avoidable

The Underlying Problem



Rubin, D. (2014)

Transitions of Care



Transitional Care Clinics in the Literature

Brigham

Significant reduction in ED visits and hospitalization in 3 months before and after interventions

Univ. of Florida

Significant reduction 90 days readmission but not 30 or 60 days for those pt referred to transitional clinic vs PCP

Northwestern

Significant reduction 90- and 180-days readmission but not 30 days for those pt referred to transitional clinic vs PCP

Rush

Significant reduction in 30 days readmission for those patients attending a transitional care visit. Nonsignificant for PCP arm. Significant reduction for all pt if visit < 14 days vs > 14 days

NYITCOM - AK

Significant reduction 30 days readmissions for transitional clinic patient vs usual care

SUNY Downstate

Significant reduction in 7- and 30-day readmission for those patients attending a transitional care visit vs those who did not

Limitations of Transitional Care Clinics in the Literature

BANKING HOURS

SINGLE VISIT

FOCUS ON PATIENTS WITHOUT PCPS

BRICK AND MORTAR

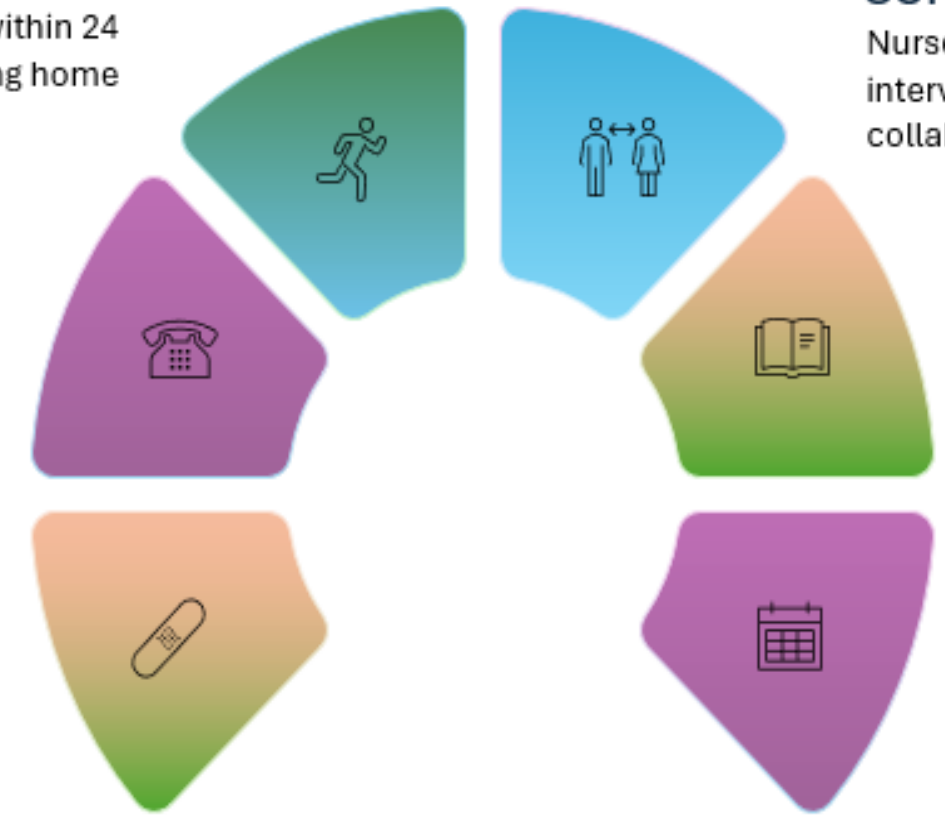
How is University Hospitals Different

RAPID FOLLOW UP

Outreach occurs within 24 hours of returning home

SOCIOECOMOMIC SUPPORT

Nurses trained in SDOH interventions and tight collaboration with CHW/SW



EASY ACCESS

Virtual appointments and 24/7 nurse line. Able to serve a wide geography

GUIDELINE DIRECTED CARE

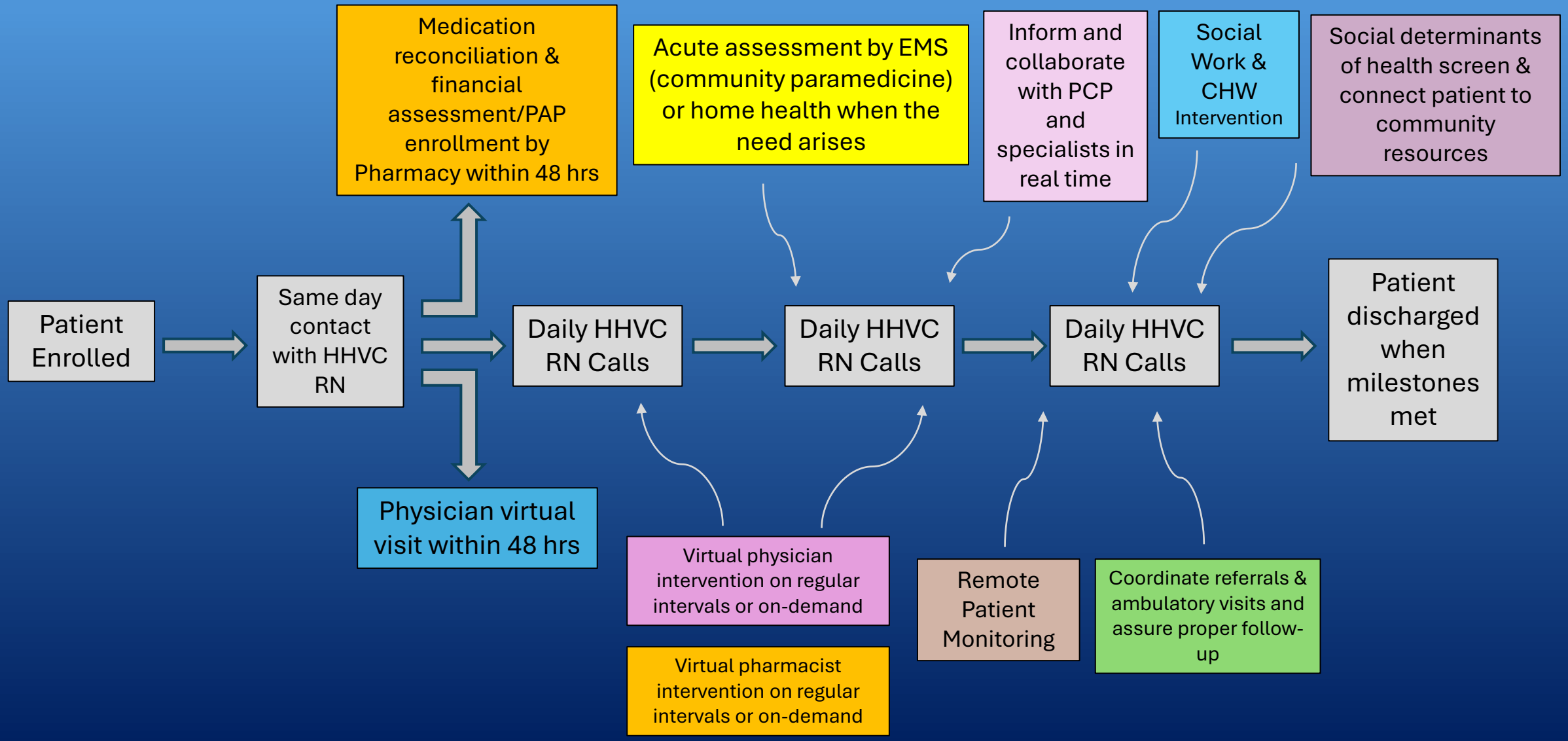
Implement evidence-based guidelines

ON DEMAND PROVIDERS

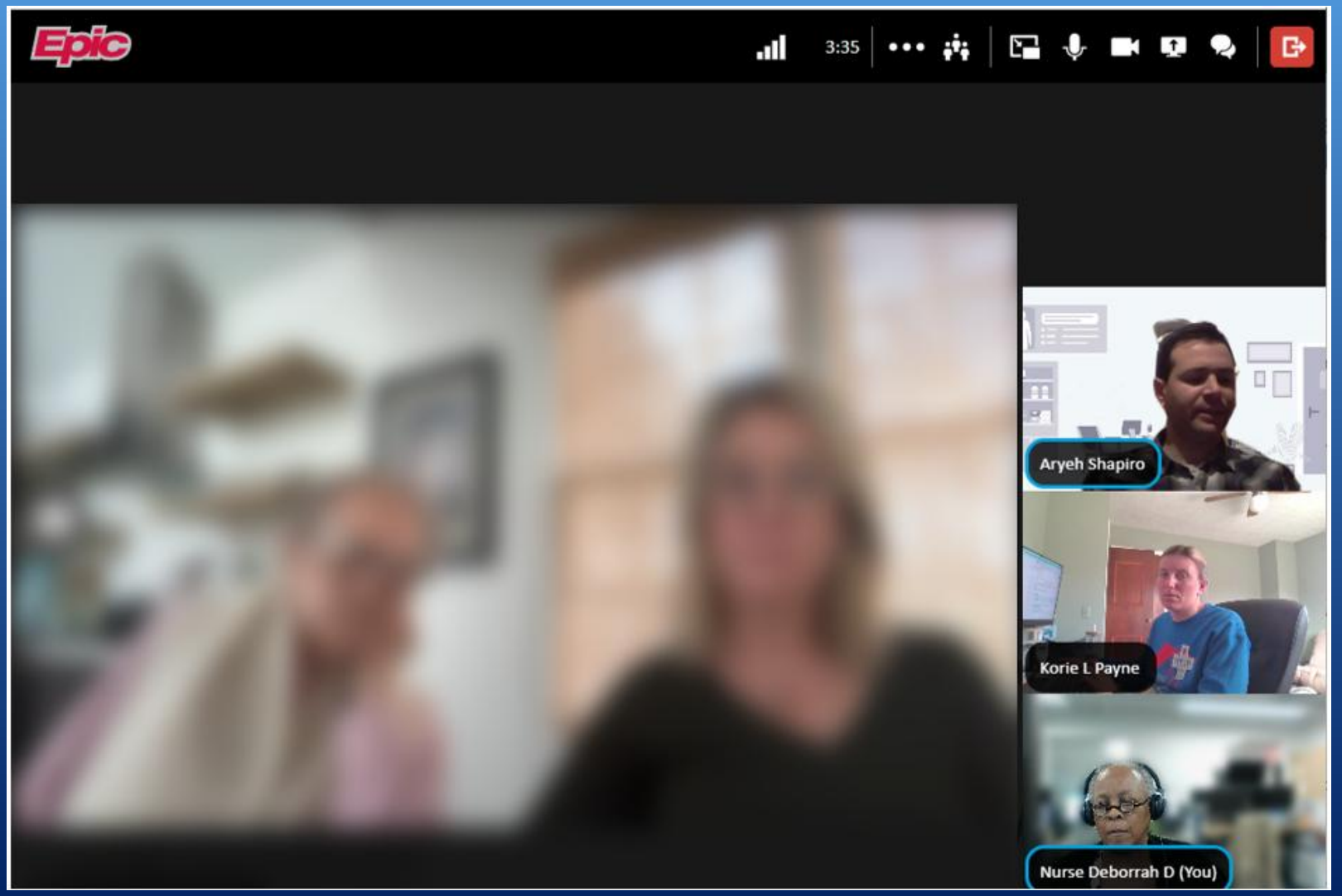
Daily physicians, APPs and pharmacist to intervene outside of scheduled appointments

LONGITUDINAL CARE

Intensive and frequent outreach for a month or more


Medication reconciliation & financial assessment/PAP enrollment by Pharmacy within 48 hrs
Acute assessment by EMS (community paramedicine) or home health when the need arises
Inform and collaborate with PCP and specialists in real time
Social Work & CHW Intervention
Social determinants of health screen & connect patient to community resources
Patient Enrolled
Same day contact with HHVC RN
Daily HHVC RN Calls
Daily HHVC RN Calls
Daily HHVC RN Calls
Patient discharged when milestones met
Physician virtual visit within 48 hrs
Virtual physician intervention on regular intervals or on-demand
Virtual pharmacist intervention on regular intervals or on-demand
Remote Patient Monitoring
Coordinate referrals & ambulatory visits and assure proper follow-up

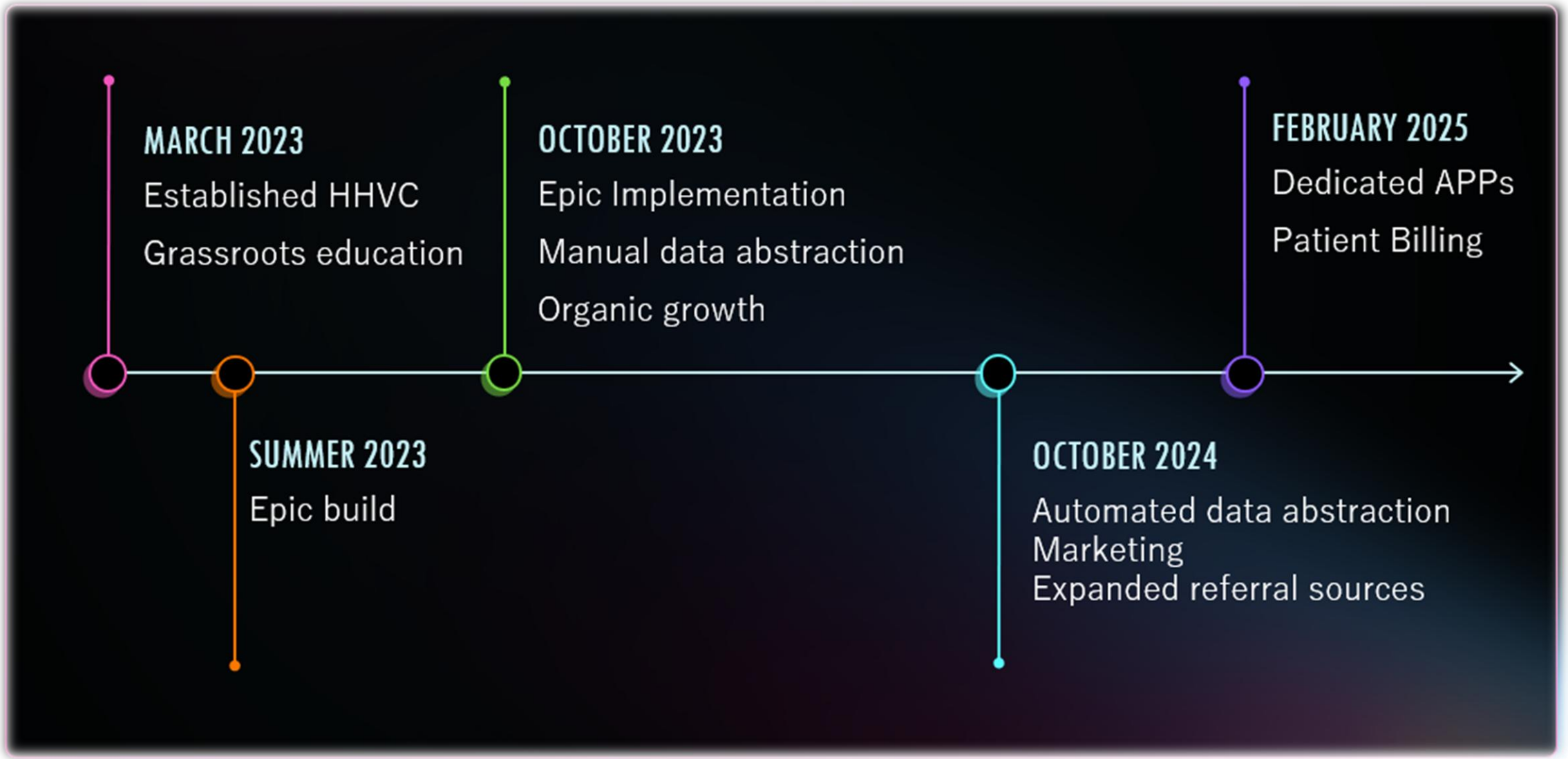
Video Visits
or
Telephonic



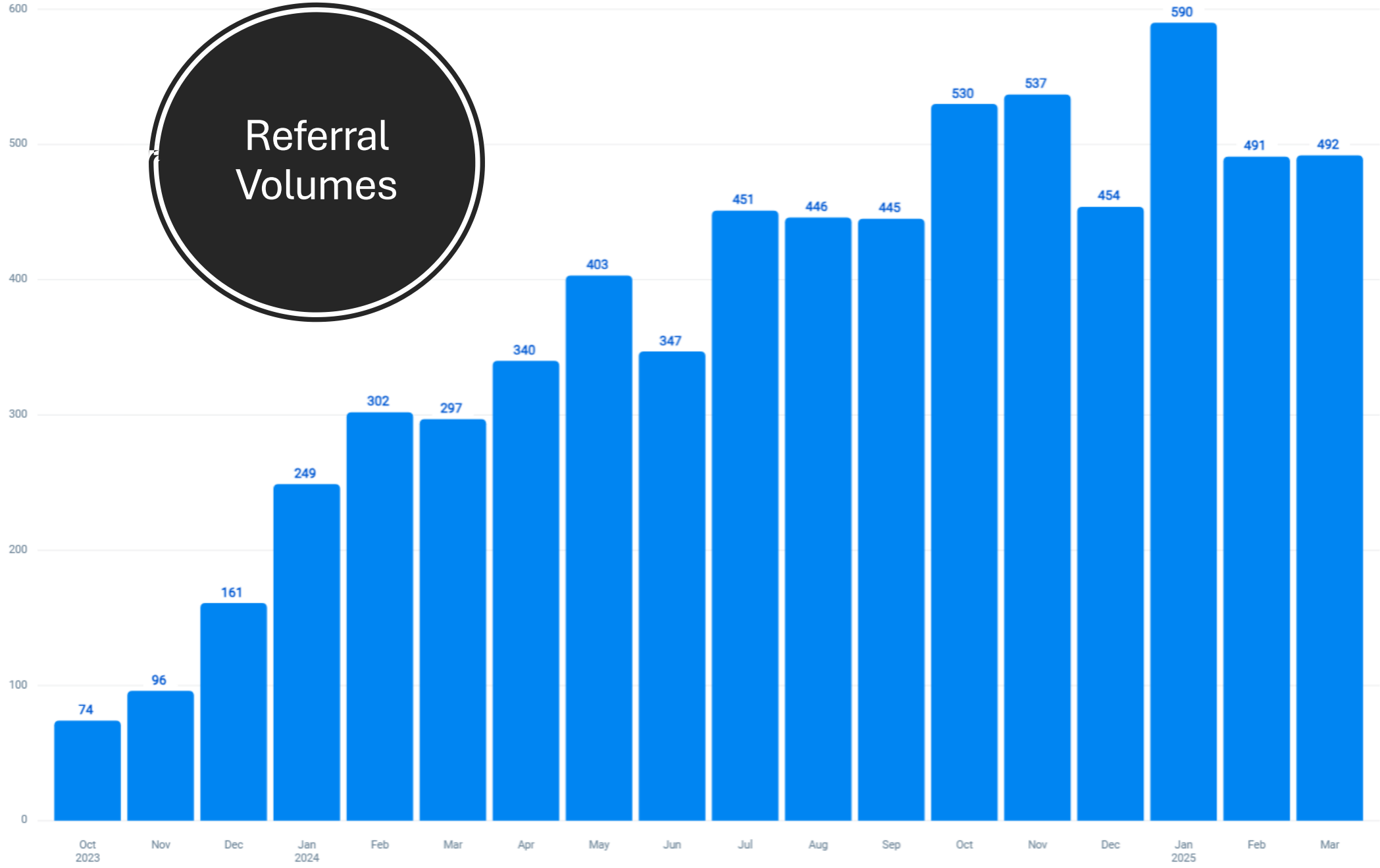
Patient Criteria for Enrollment

- Focus on CHF, COPD and DM
- No geographic limitations
- No insurance limitations
- Diverse referral source
- Exclusion: primary psychiatric and pain management

Care Plans and Pathways


MARCH 2023
Established HHVC
Grassroots education
SUMMER 2023
Epic build
OCTOBER 2023
Epic Implementation
Manual data abstraction
Organic growth
OCTOBER 2024
Automated data abstraction
Marketing
Expanded referral sources
FEBRUARY 2025
Dedicated APPs
Patient Billing

Referral Volumes



Referral Volumes by Source

Ordering User	2025 Jan	2025 Feb	2025 Mar
STILL, KITTY L	14	71	28
NJOKU, TARA	14	21	18
SHAH, ROHIT M	17	21	6
SCHECHTMAN, JEFFREY L	15	15	12
WEST, GRETA	25	10	2
BOLAN, KATHLEEN	21	4	11
NAVARATNARAJAH, NISHANTHIKA N	21	8	7
BURTON, SAMANTHA	14	12	9
SCOTT, MELANIE	1	8	18
KACZMARCZYK, SHARON	8	14	4
ROZHON, CHRISTA A	7	8	6
LEWIS, CLAUDIA B	6	2	11
NGUYEN, DANG-KHOA Q	10	7	2

Referred By Location	2025 Jan	2025 Feb	2025 Mar
ELY Medical Center	117	81	76
CMC Medical Center	152	113	124
AHU Medical Center	65	59	91
PAR Medical Center	61	103	64
GEA Medical Center	38	24	31
STJ Medical Center	42	34	33
UHHS Service Area	42	34	30
POR Medical Center	35	22	10
WES Medical Center	35	28	35
TRI Medical Center	4	13	10
SAM Medical Center	20	3	3
SCC Seidman Cancer Center	6	5	9
CON Medical Center	0	3	3

Readmission rates

↓17%

30-day readmission for MED-HIGH risk LACE+

↓13%

30-day readmissions

↓10%

30-day readmission for HIGH-risk LACE+

Comparison groups: enrolled in program vs declined program
October 2023 – October 2024

Readmission Rates by DRG

↓ 31 %

COPD

30 Day Readmissions

↓ 20 %

Congestive Heart Failure

30 Day Readmissions

↓ 14 %

Simple Pneumonia

30 Day Readmissions

↓ 18 %

Cellulitis

30 Day Readmissions

↓ 50 %

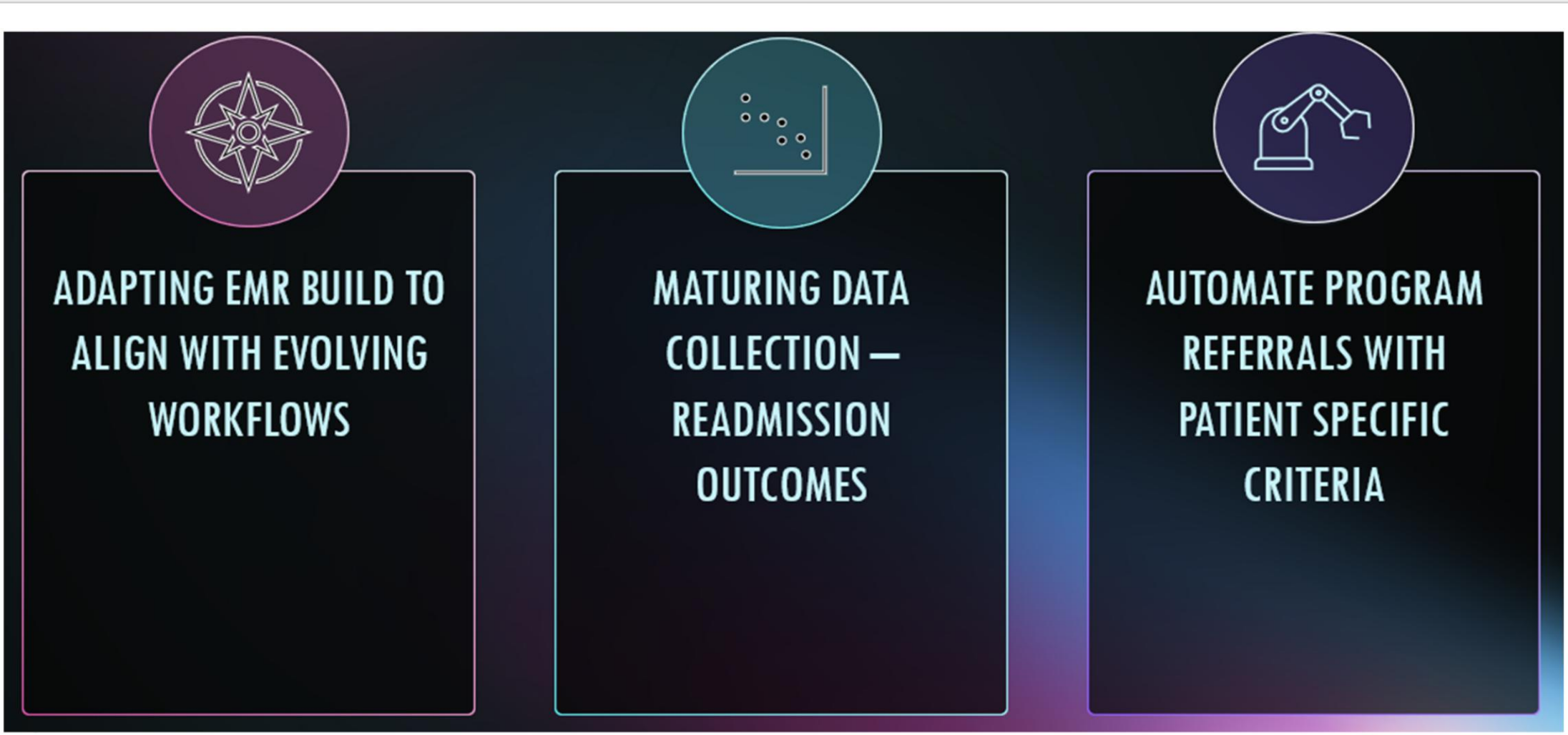
Diabetes (DKA)

30 Day Readmissions

Comparison groups: enrolled in program vs declined program
October 2023 – October 2024

Lessons Learned & Future State

Technology


ADAPTING EMR BUILD TO ALIGN WITH EVOLVING WORKFLOWS
MATURING DATA COLLECTION – READMISSION OUTCOMES
AUTOMATE PROGRAM REFERRALS WITH PATIENT SPECIFIC CRITERIA

Clinical


INCREASE INTERVENTIONS IN ACUTE (BUT NOT EMERGENT) SITUATIONS TO AVOID ED VISITS
COLLABORATE WITH SERVICE LINES TO ENHANCE POST DISCHARGE TRANSITIONS
TAILORED INTERDISCIPLINARY CARE PLAN

Growth


HARDWIRE VIRTUAL CLINIC REFERRAL INTO DISCHARGE PROCESS
EXTEND SERVICES TO APPROPRIATE PATIENTS FROM AMBULATORY PRACTICES AND POST-ACUTE FACILITIES
INCREASE ENROLLMENT CONVERSION PERCENTAGE

References

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