

Healthy at Home Virtual Clinic

Improving Transitional Care

Anthony Muni, MD

CMO Utilization Management & Clinical Documentation Integrity

Medical Director Healthy at Home Virtual Clinic

Anthony.muni@uhhospitals.org



About University Hospitals

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

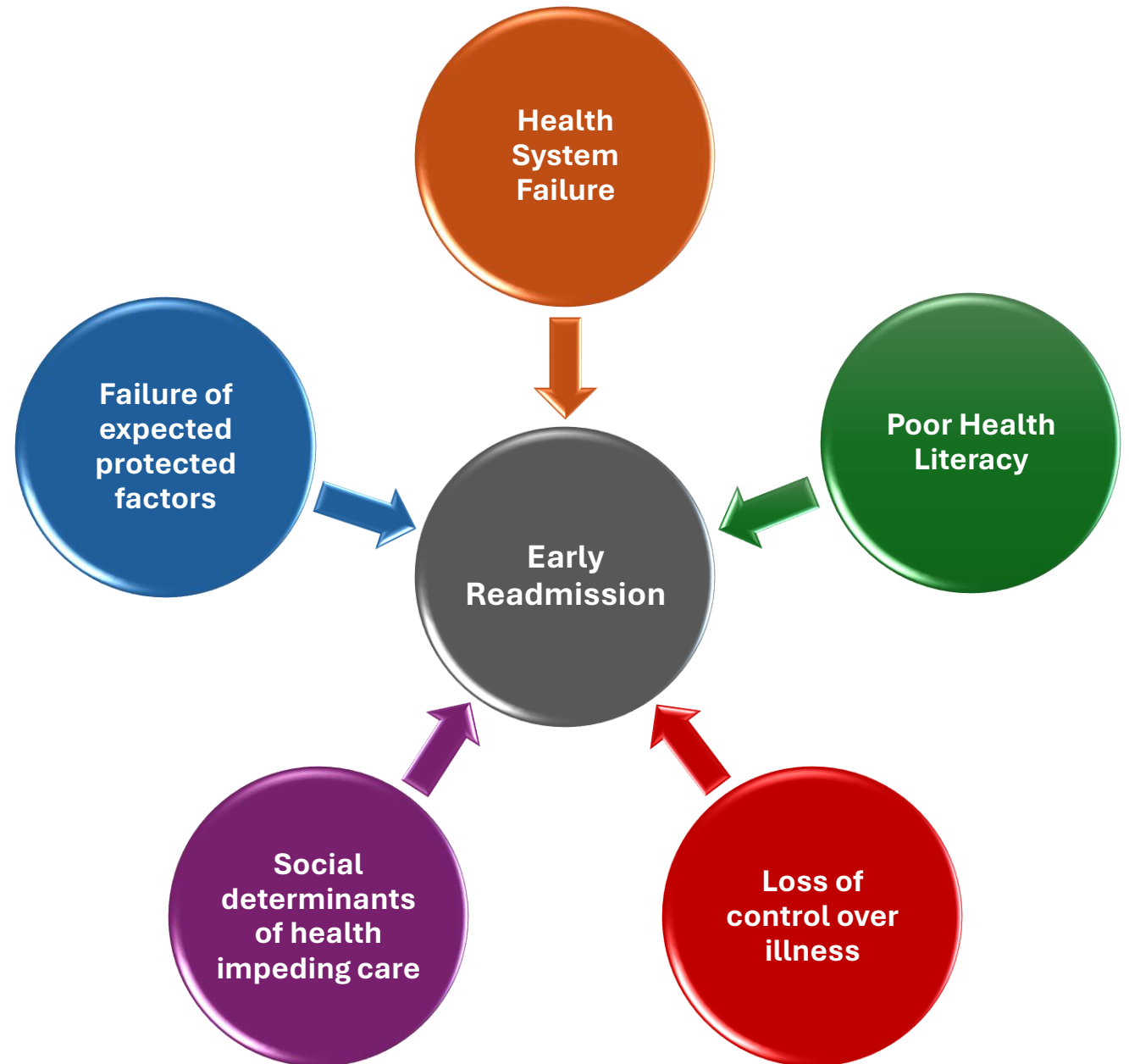


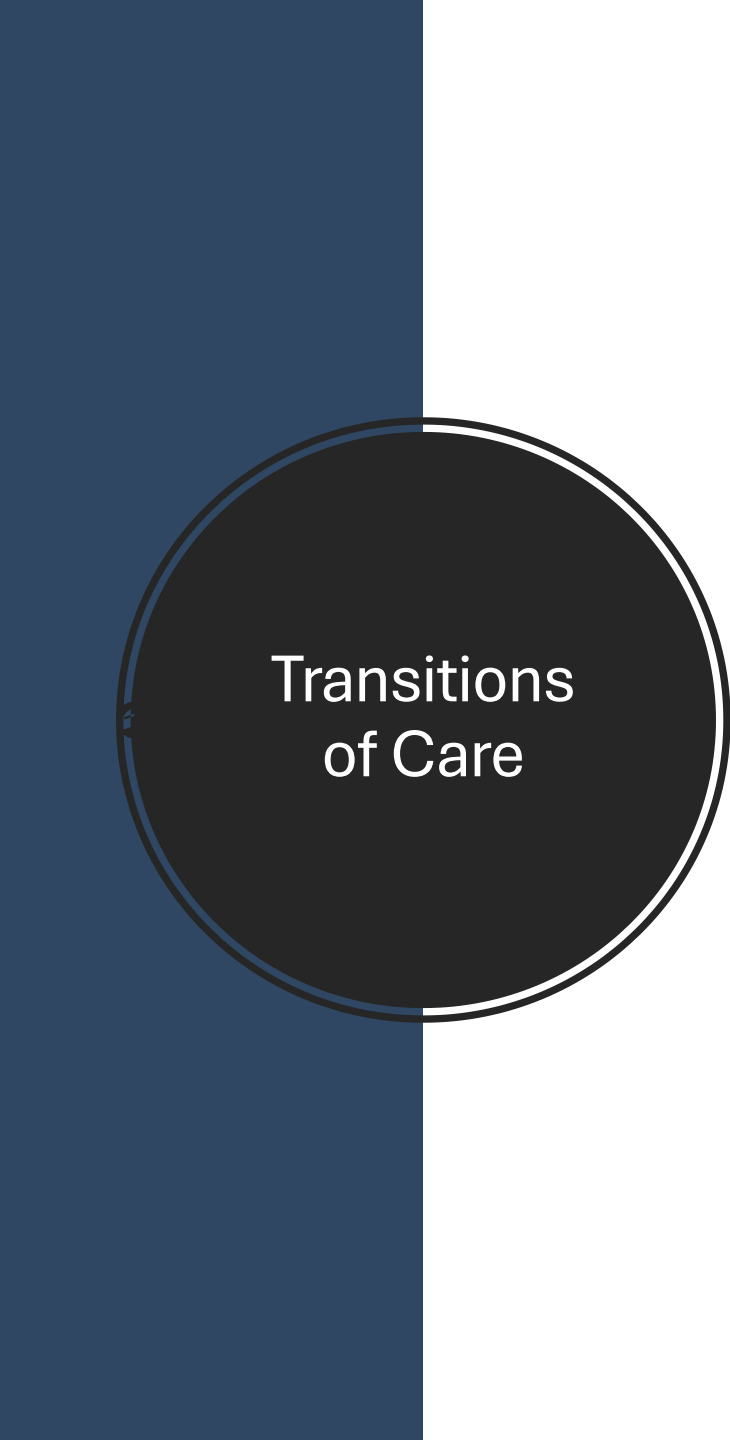
The Problem

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

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

The Underlying Problem





Transitions
of Care

TRANSITIONS OF CARE ARE
DANGEROUS

TIMELY POST DISCHARGE
FOLLOW UP IS ASSOCIATED
WITH IMPROVED OUTCOMES

TIMELY POST DISCHARGE
FOLLOW UP CAN ADDRESS THE
"UNDERLYING PROBLEMS"

ACUTE CONDITIONS OFTEN
STEM FROM UNCONTROLLED
CHRONIC CONDITIONS

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

EASY ACCESS

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

ON DEMAND PROVIDERS

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

SOCIOECONOMIC SUPPORT

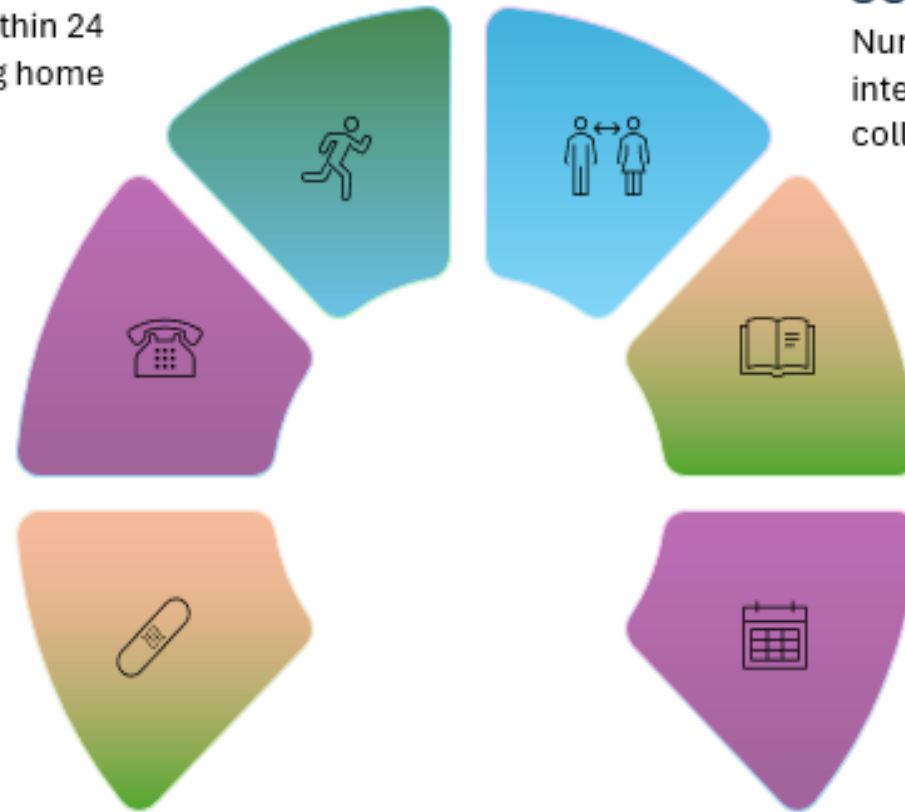
Nurses trained in SDOH interventions and tight collaboration with CHW/SW

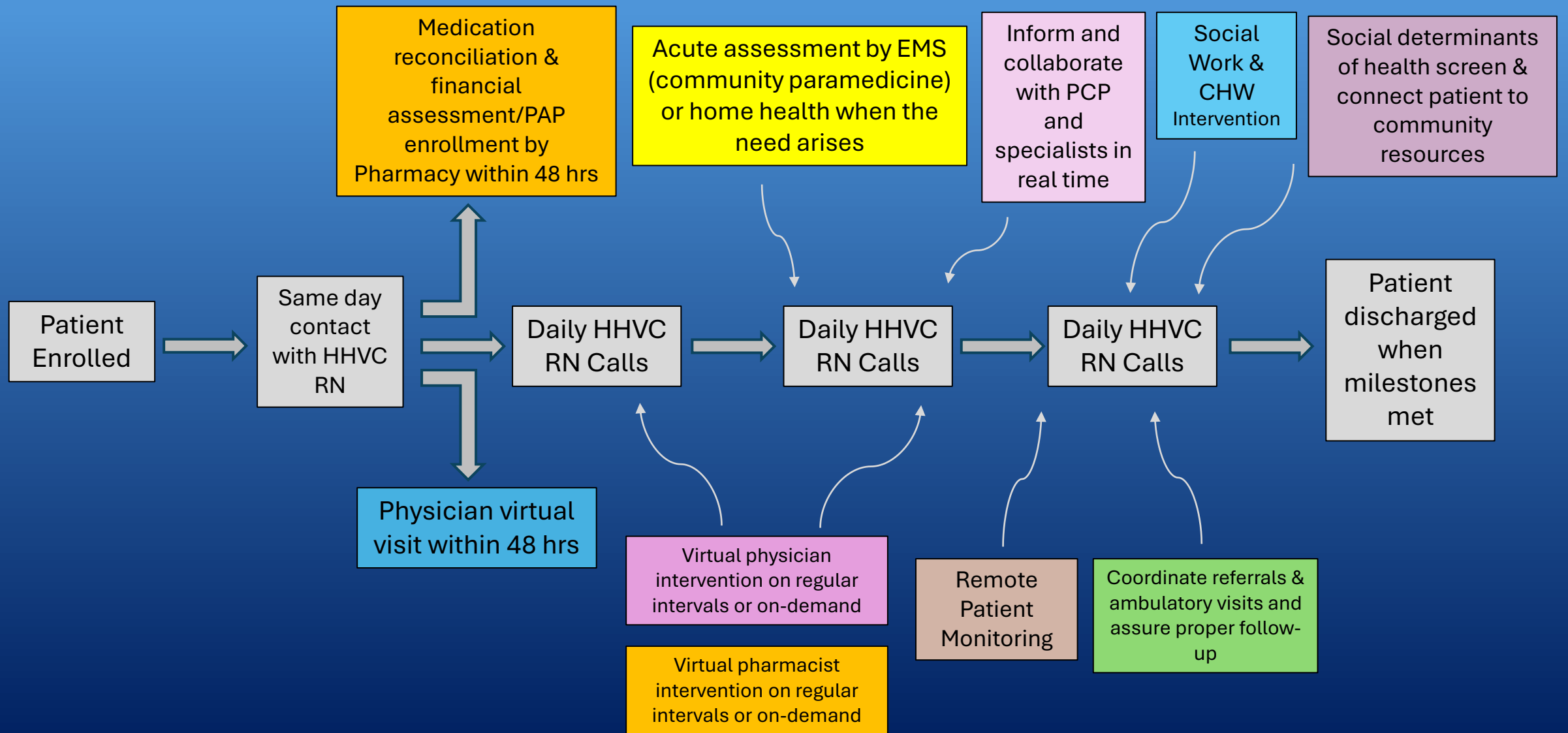
GUIDELINE DIRECTED CARE

Implement evidence-based guidelines

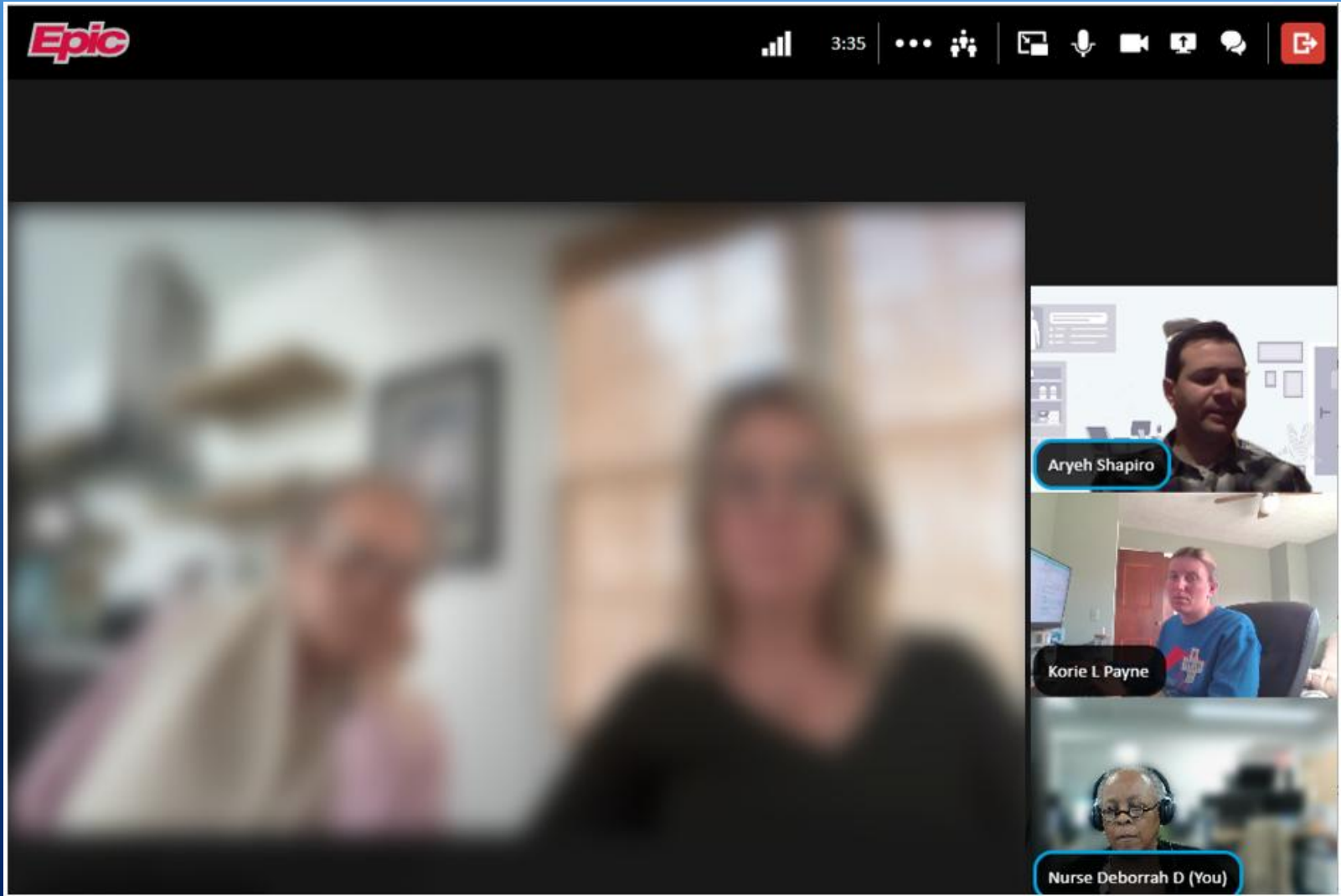
LONGITUDINAL CARE

Intensive and frequent outreach for a month or more





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

COUMADIN/INR
MANAGEMENT

IV ANTIBIOTICS

HEART FAILURE
MANAGEMENT
SYSTEM

MEDICATION
FINANCIAL
ASSISTANCE

BEHAVIORAL
HEALTH

GLUCOSE
MONITORING &
CGM

REMOTE
MONITORING

HOME CARE

PALLIATIVE
CARE

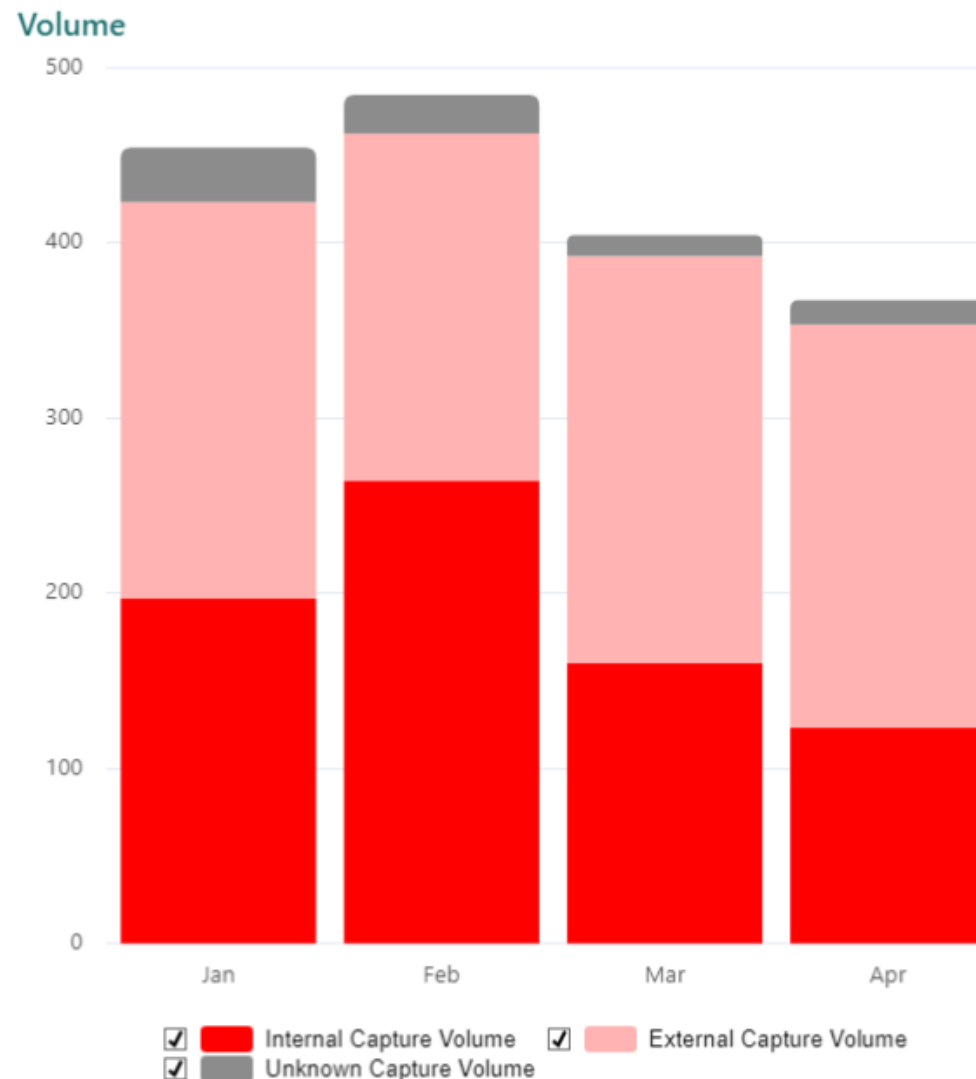
COPD RESCUE
KITS

OXYGEN DME
and WEAN

BRIDGE PCP

Pharmacy and Patient Financial Assistance

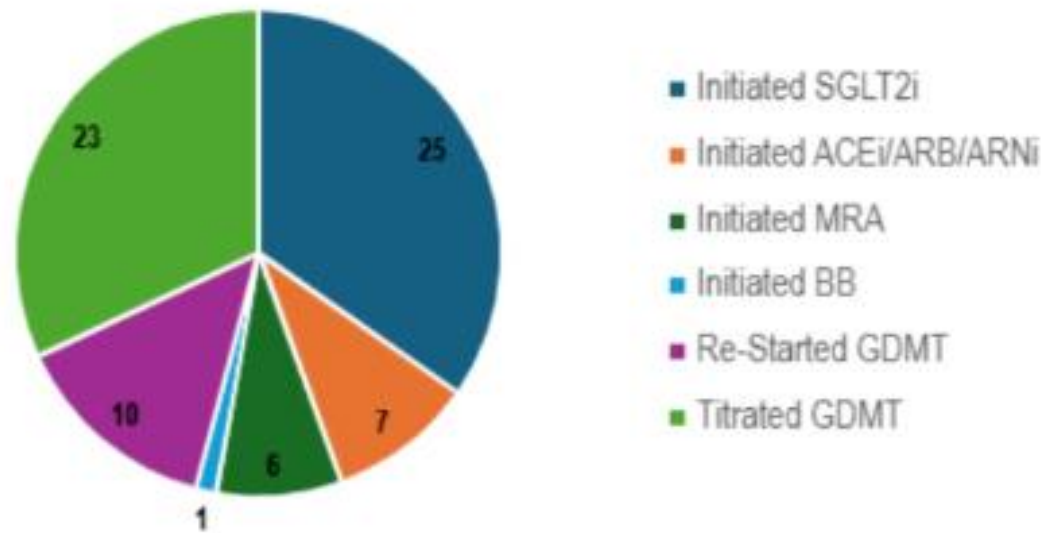
Red represents volume of free brand name medications dispensed through 340b pharmaceutical pricing (Jan – April 2025)



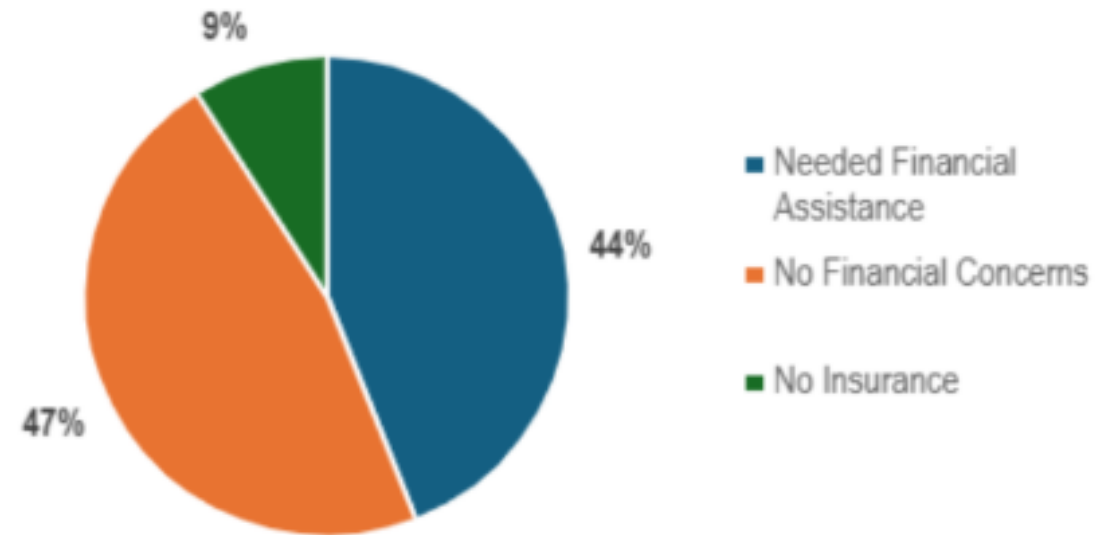
Volume	Jan	Feb	Mar	Apr
Internal Capture Volume	197	264	160	123
External Capture Volume	226	198	232	230

Pharmacy and CHF GDMT

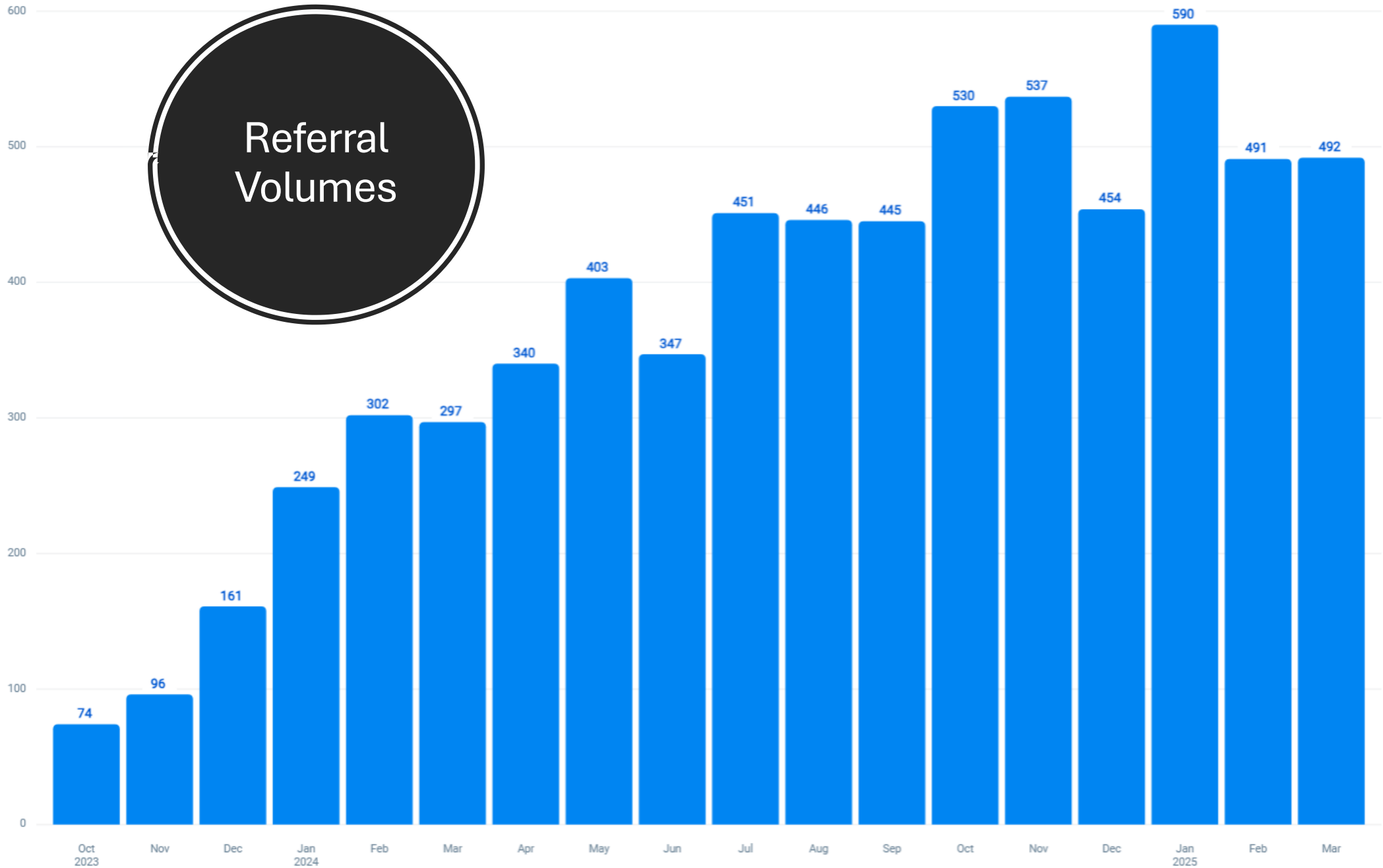
GDMT Intervention



Cost Assessment (N = 117)



Referral Volumes



Referral Volumes by Source

Ordering User	* 2025		
	Jan	Feb	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	Feb	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+

Readmission Rates by DRG

↓ **20%**

Congestive Heart Failure

30 Day Readmissions

↓ **31%**

COPD

30 Day Readmissions

↓ **14%**

Simple Pneumonia

30 Day Readmissions

↓ **18%**

Cellulitis

30 Day Readmissions

↓ **50%**

Diabetes (DKA)

30 Day Readmissions

Lessons Learned & Future State



TECHNOLOGY



CLINICAL

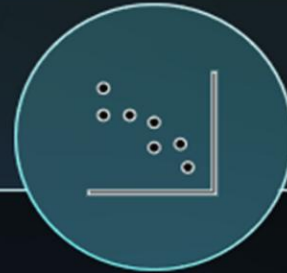


GROWTH

Technology



**ADAPTING EMR BUILD TO
ALIGN WITH EVOLVING
WORKFLOWS**

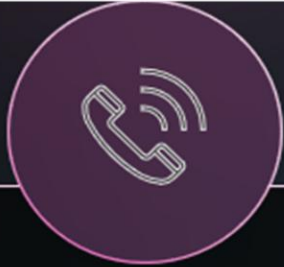


**MATURING DATA
COLLECTION —
READMISSION
OUTCOMES**



**AUTOMATE PROGRAM
REFERRALS WITH
PATIENT SPECIFIC
CRITERIA**

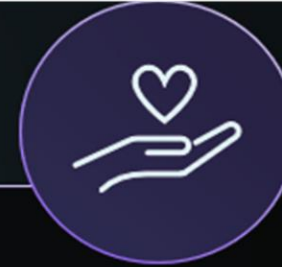
Clinical



**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

1. Rubin, D., et al. Early readmission among patients with diabetes: *Journal of Diabetes and Its Complications*, 28 (2014) 869-873
2. Rotenstein, L., et al. Development of a primary care transitions clinic in an academic medical center: *Journal of General Internal Medicine* (2020) 37(3): 582-9
3. Chakravarthy, V., et al. Efficacy of a transition clinic on hospital readmissions: *The American Journal of Medicine* (2018) 131, 178-184
4. Nall, R., et al. An interprofessional primary care-based transition of care clinic to reduce hospital readmission: *The American Journal of Medicine* (2022) 133:e260-e268
5. Baldino, M., et al. Impact of a novel post-discharge transitions of care clinic on hospitals readmissions: *Journal of the National Medical Association* (2021) 113(2): 133-141
6. Liss, D., et al. Effects of a transitional care practice for a vulnerable population: a pragmatic, randomized comparative effectiveness trial: *Journal of General Internal Medicine* (2019) 34(9): 1758-1765
7. Lee, J., et al. Outcomes of a transitional care clinic to reduce heart failure readmissions at an urban academic medical center: *Int J Clin Res Trials* (2019) 4(2): 1-10