UPMC LIFE CHANGING MEDICINE

Creating a Transition of Care Dashboard: Improving Acute Care Discharge Follow-up in Central PA

Andrew Eckert, DO, Medical Director, Population Health

Nicole Holmes, MSN, RN, Ambulatory Director, Clinical Call Services

UPMC Central PA Medical Group

BACKGROUND

- Transitional Care Management (TCM) or Transition of Care (TOC) is a billable encounter type designed for primary care doctors and specialists to improve the care they provide to patients who have been discharged from hospitals or other facilities.
- UPMC Central PA uses a variety of people and processes to facilitate TCM, including hospital scheduling, an ambulatory TOC team that contacts patients within 2 days of discharge, individual primary care office staff and provider compensation incentives.
- Despite these efforts, TCM scheduling and appointment completion has been inconsistent, payor contract goals have not been met, and providers have not had a complete picture of their patient discharge data.
- Leadership within UPMC Central PA Medical Group was charged with creating a solution to improve provider engagement and ensure consistent, accurate, and actionable internal discharge data.

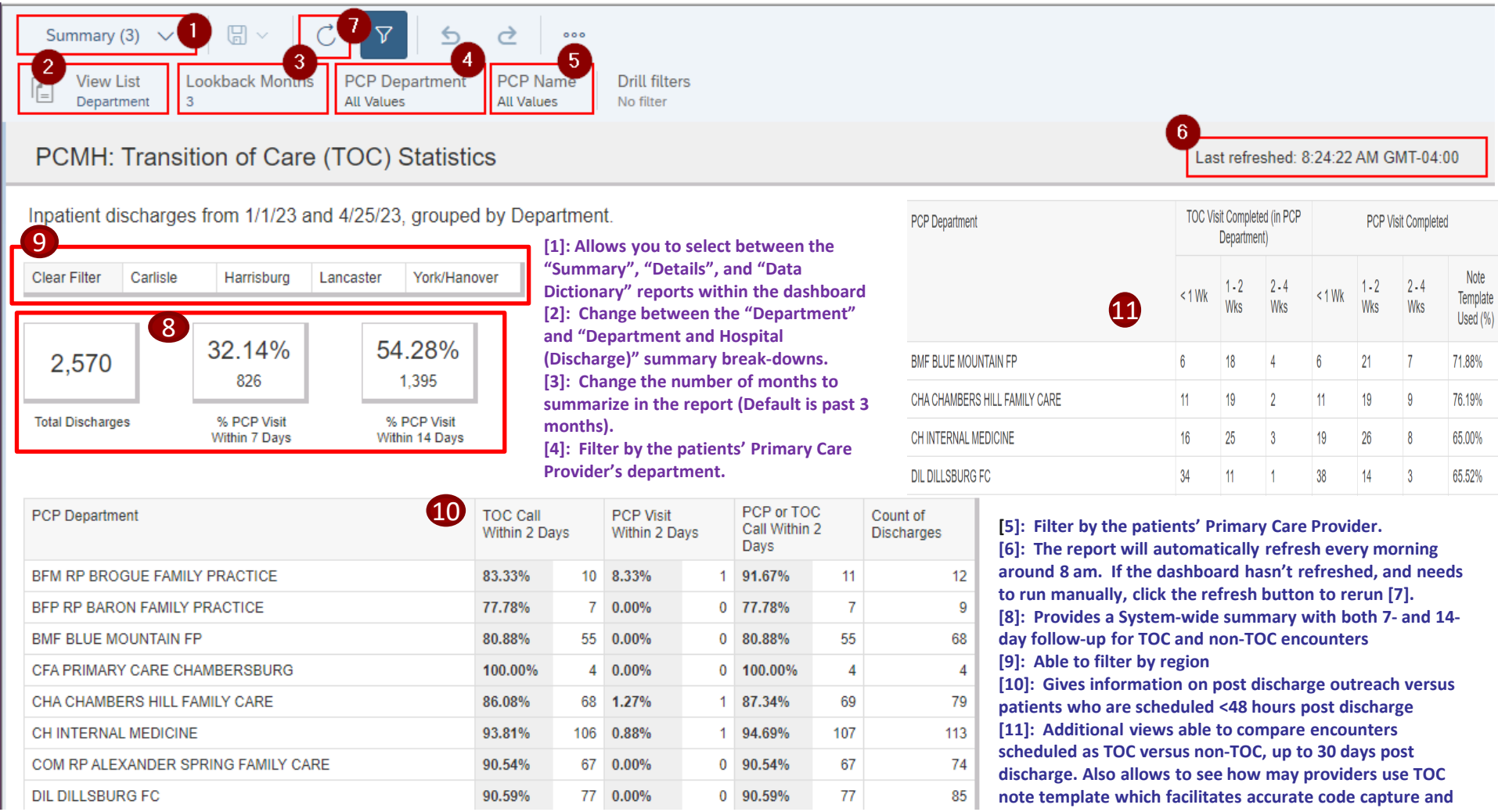
OBJECTIVE

- Primary objective was to create a single data platform that could be accessed by all service line leaders and eventually individual providers.
  - A dashboard provided the most concise format.
    - The dashboard had to:
      - Include all primary care practices
      - Include discharges from all 7 Central PA hospitals
      - Include information on post discharge patient contact
      - Exclude discharges that didn't require TCM
      - Include patient NO-SHOWS
      - Provide current, filterable, and patient-level data

APPROACH

- Formed a workgroup with stakeholders from the medical group, and IT
- Set goals for data definitions, including exclusion and inclusion criteria
- Three major data goals defined by the group:
  - % completion rate of TOC outreach call
  - # of patients seen at given intervals of 2, 7, and 14-, and 30-days post discharge
  - % usage of medical group TOC note template
- Based on the report requirements, we discussed the business process/workflow behind each of the metrics
- We used the workflows to identify discrete data elements in Epic for reporting.
- Once the dashboard was developed, we performed manual validation of the metrics to a review of patient charts.
- If there were discrepancies, we amended the metric data lineage until the dashboard aligned with original requirements.

RESULTS



[1]: Allows you to select between the "Summary", "Details", and "Data Dictionary" reports within the dashboard
[2]: Change between the "Department" and "Department and Hospital (Discharge)" summary break-downs.
[3]: Change the number of months to summarize in the report (Default is past 3 months).
[4]: Filter by the patients' Primary Care Provider's department.

PCP Department	TOC Visit Completed (in PCP Department)			PCP Visit Completed			
11	< 1 Wk	1 - 2 Wks	2 - 4 Wks	< 1 Wk	1 - 2 Wks	2 - 4 Wks	Note Template Used (%)
BMF BLUE MOUNTAIN FP	6	18	4	6	21	7	71.88%
CHA CHAMBERS HILL FAMILY CARE	11	19	2	11	19	9	76.19%
CH INTERNAL MEDICINE	16	25	3	19	26	8	65.00%
DIL DILLSBURG FC	34	11	1	38	14	3	65.52%

PCP Department 10	TOC Call Within 2 Days		PCP Visit Within 2 Days		PCP or TOC Call Within 2 Days		Count of Discharges
BFM RP BROGUE FAMILY PRACTICE	83.33%	10	8.33%	1	91.67%	11	12
BFP RP BARON FAMILY PRACTICE	77.78%	7	0.00%	0	77.78%	7	9
BMF BLUE MOUNTAIN FP	80.88%	55	0.00%	0	80.88%	55	68
CFA PRIMARY CARE CHAMBERSBURG	100.00%	4	0.00%	0	100.00%	4	4
CHA CHAMBERS HILL FAMILY CARE	86.08%	68	1.27%	1	87.34%	69	79
CH INTERNAL MEDICINE	93.81%	106	0.88%	1	94.69%	107	113
COM RP ALEXANDER SPRING FAMILY CARE	90.54%	67	0.00%	0	90.54%	67	74
DIL DILLSBURG FC	90.59%	77	0.00%	0	90.59%	77	85

[5]: Filter by the patients' Primary Care Provider.
[6]: The report will automatically refresh every morning around 8 am. If the dashboard hasn't refreshed, and needs to run manually, click the refresh button to rerun [7].
[8]: Provides a System-wide summary with both 7- and 14-day follow-up for TOC and non-TOC encounters
[9]: Able to filter by region
[10]: Gives information on post discharge outreach versus patients who are scheduled <48 hours post discharge
[11]: Additional views able to compare encounters scheduled as TOC versus non-TOC, up to 30 days post discharge. Also allows to see how may providers use TOC note template which facilitates accurate code capture and submission

UPMC LIFE CHANGING MEDICINE

DISCUSSION

- First and foremost, dashboard allowed us to verify previously observed trends of TOC visit completion rate.
- Roughly 30% of patients are seen by a provider in the PCP's practice within 7 days of discharge; 50% within 14 days.
- The data also allowed us to verify that one office not utilizing our central TOC outreach team had a significantly lower outreach rate, and lower TOC appointment completion. FTE was approved to support the addition of that office to use our central TOC outreach team.
- Key limitation in the dashboard is lack of external data. Many patients in central PA, particularly in certain counties, do not use UPMC facilities for acute care. While this decreases data for some practices, we felt the dashboard was valuable to highlight how to improve our internal workflows.