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Transitional Care Management



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Agenda

- Definitions
- Why Transitional Care
- TCM Overview
- TCM Model Case Study

Definitions



Definitions and Acronyms

- **Transition Care Management (TCM):**
- **Direct supervision:** 42 CFR 413.65 - the physician or nonphysician practitioner must be immediately available to furnish assistance and direction throughout the performance of the procedure
- **General supervision:** 42 CFR 410.32(b)(3)(i) -the procedure or service is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure

Definitions and Acronyms

- **Personal Supervision:** 410.32(b)(3)(iii) - the physician must be in attendance in the room during the performance of the service or procedure
- **Population Health:** the health outcomes of a group of individuals, including the distribution of such outcomes within the group. These groups are often geographic populations such as nations or communities, but can also be other groups such as employees, ethnic groups, disabled persons, prisoners, or any other defined group.

Definitions and Acronyms

- **Patient-Centered Medical Home (PCMH)** is a care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand.

Definitions and Acronyms

- **Core measures:** National standards of care and treatment processes for common conditions. These processes are proven to reduce complications and lead to better patient outcomes. **Core measure** compliance shows how often a hospital provides each recommended treatment for certain medical conditions.

Why Transitional Care?



Why Transitional Care?

- Reduce re-admissions
- Minimize adverse events
- Lower healthcare costs
- Minimize miscommunication/misunderstanding
- Increase accountability
 - Provider
 - Patient

Vignettes

- An 80-year-old retired school teacher visited the emergency department four times in a month for exacerbations to a mild heart failure condition, twice requiring hospitalization. When provided with discharge instructions, she is able to repeat them back accurately. However, she doesn't follow through with the instructions after returning home because she has not yet been diagnosed with dementia.

The Joint Commission

Vignettes

- A 68-year-old man is readmitted for heart failure only one week after being discharged following treatment for the same condition. He brought all of his pill bottles in a bag; all of the bottles were full, not one was opened. When questioned why he had not taken his medication, he began to cry, explaining he had never learned to read and couldn't read the instructions on the bottles.

The Joint Commission

Vignettes

- After falling at home, a 78-year-old woman received three new prescriptions from her primary care physician because during the exam her blood pressure was 164/90. The doctor instructed her to start taking the new medication for hypertension the same day, and to stop taking her current blood pressure medication the following day. The physician also arranged for a home care nurse to come to her home and check on her in a few days. When asked whether she had any questions about the new medications, she replied that she understood and didn't have any questions.

Vignettes

- Two days later, the home care nurse came to see her. The patient complained of a headache and dizziness, and the nurse noted that she had a blood pressure of 190/96. When the nurse asked what medications she was taking, the patient said she had stopped taking her “old blood pressure medicine, like the doctor told me to.” When the nurse asked about her new medication for hypertension, the patient became upset, and said that she didn’t have them yet. When the nurse asked her why, the woman’s husband said, “because we don’t have the money to get them, that’s why!” The woman was on Medicare, but they did not have enough money for the co-pay amounts for the new medications.

Readmissions

- Medicare said the penalties are expected to total \$528 million, about \$108 million more than last year, because of changes in how readmissions are measured.
- Medicare examined these conditions: heart attacks, heart failure, pneumonia, chronic lung disease, hip and knee replacements and — for the first time this year — coronary artery bypass graft surgery.

Readmissions

- The fines are based on Medicare patients who left the hospital from July 2012 through June 2015. For each hospital, the government calculated how many readmissions it expected, given national rates and the health of each hospital's patients. Hospitals with more unplanned readmissions than expected will receive a reduction in each Medicare case reimbursement for the upcoming fiscal year that runs from Oct. 1, 2016 through September 2017.

Readmissions

- The payment cuts apply to all Medicare patients, not just those with one of the six conditions Medicare measured. The maximum reduction for any hospital is 3 percent, and it does not affect special Medicare payments for hospitals that treat large numbers of low-income patients or train residents.
- 2016 - Forty-nine hospitals received the maximum fine. The average penalty was 0.73 percent of each Medicare payment, up from 0.61 percent 2015 and higher than in any other year, according to the Kaiser Health Network(KHN) analysis.

TCM Overview



TCM Services

- Transitional Care Management Services codes are for a new or established patient whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transition from an inpatient hospital setting, partial hospital, observation status in a hospital or a skilled nursing facility/nursing facility to the patient's community setting.

CPT 2017

TCM Services

- The requirements for TCM services include:
 - The services are required during the beneficiary's transition to the community setting following particular kinds of discharges
 - The health care professional accepts care of the beneficiary post-discharge from the facility setting without a gap
 - The health care professional takes responsibility for the beneficiary's care
 - The beneficiary has medical and/or psychosocial problems that require moderate or high complexity medical decision making
- The 30-day TCM period begins on the date the beneficiary is discharged from the inpatient hospital setting and continues for the next 29 days.

TCM Services

- Physicians (any specialty)
- These non-physician practitioners per state and scope of practice:
 - Certified nurse-midwives (CNMs)
 - Clinical nurse specialists (CNSs)
 - Nurse practitioners (NPs)
 - Physician assistants (PAs)

TCM Services

- Service settings:
 - Inpatient Acute Care Hospital
 - Inpatient Psychiatric Hospital
 - Long Term Care Hospital
 - Skilled Nursing Facility
 - Inpatient Rehabilitation Facility
 - Hospital outpatient observation or partial hospitalization
 - Partial hospitalization at a Community Mental Health Center

TCM Services

- Discharge disposition should be:
 - Home
 - Domiciliary
 - Rest home
 - Assisted living
- Face-to-Face – requires direct supervision
- Non-face-to-face - general supervision
- The practitioner must order services, maintain contact with auxiliary personnel, and retain professional responsibility for the services.

What about staffing considerations?



Interactive Contact

- There must be contact made with the patient and/or the patient care giver:
 - Within 2 business days of DC
 - Telephone
 - Email
 - Face-to-face

Interactive Contact

- For Medicare purposes, attempts to communicate should:
 - Continue after the first two attempts in the required 2 business days **until they are successful.**
 - If two or more separate attempts are made in a timely manner and documented but are unsuccessful, and if all other TCM criteria are met, you may report the service.

Interactive Contact

- Communication with the patient/patient family
 - Regarding aspects of care
 - Education
 - Support
 - Daily living needs
- Medication reconciliation and support treatment regimen adherence
- Coordination of care of one or more disciplines and/or community services.

Non-Face-to-Face Services

- As medically necessary, the following non-face-to-face services should be provided by the **physician or NPP**:
 - Obtain and review discharge information
 - Review need for or follow-up on pending diagnostic tests and treatments
 - Interact with other health care professionals
 - Other specialties
 - All medical conditions

Non-Face-to-Face Services

- As medically necessary, the following non-face-to-face services should be provided by the **physician or NPP**:
 - Provide education to the beneficiary, family, guardian, and/or caregiver
 - Referrals and/or arrangements for needed community resources
 - Assist in scheduling required follow-up with community providers and services

Non-Face-to-Face Services

- **Services Provided by Clinical Staff Under the Direction of a Physician or NPP**
- Clinical staff under your direction may provide these services, subject to the supervision, applicable State law, and other rules discussed above:
 - Communicate with agencies and community services the beneficiary uses
 - Provide education to the beneficiary, family, guardian, and/or caretaker to support self-management, independent living, and activities of daily living

Non-Face-to-Face Services

- **Services Provided by Clinical Staff Under the Direction of a Physician or NPP**
- Clinical staff under your direction may provide these services, subject to the supervision, applicable State law, and other rules discussed above:
 - Assess and support treatment regimen adherence and medication management
 - Identify available community and health resources
 - Assist the beneficiary and/or family in accessing needed care and services

Face-to-Face

- CPT Code 99495 - Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)
- CPT Code 99496 – Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge)
- Based on Medical decision making
- * Medication reconciliation must be furnished no later than the face-to-face service is provided.

Face-to-Face - Documentation

- At a minimum, you must document this information in the beneficiary's medical record:
 - Date the beneficiary was discharged
 - Date you made an interactive contact with the beneficiary and/or caregiver
 - Date you furnished the face-to-face visit
 - The complexity of medical decision making (moderate or high)

Face-to-Face - Documentation

- **Medical Decision Making**
- Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option, which is determined by considering these factors:
 - The number of possible diagnoses and/or the number of management options that must be considered
 - The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed
 - The risk of significant complications, morbidity, and/or mortality as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options

BILLING TCM SERVICES

- Only one health care professional may report TCM services.
- Report services once per beneficiary during the TCM period.
- The same health care professional may:
 - Discharge the beneficiary from the hospital
 - Report hospital or observation discharge services, and
 - Bill TCM services.
- Report reasonable and necessary evaluation and management (E/M) services (other than the required face-to-face visit) to manage the beneficiary's clinical issues separately.

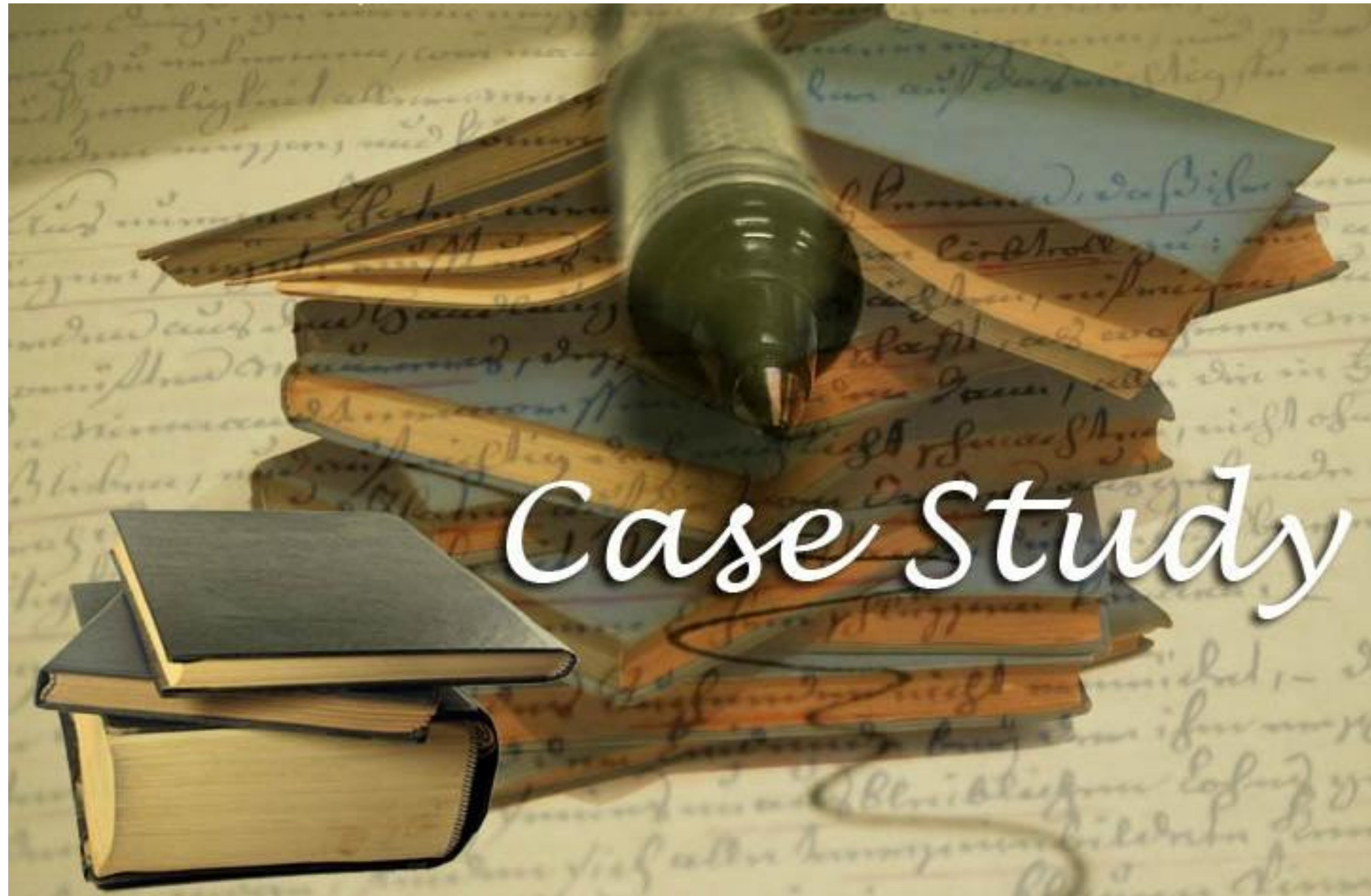
BILLING TCM SERVICES

- The face-to-face visit may not take place on the same day you report discharge day management services.
- Do not bill TCM services which fall within a post-operative global period
 - (TCM services cannot be paid if any of the 30-day TCM period falls within a global period for a procedure code billed by the same practitioner).

BILLING TCM SERVICES

- When you report CPT codes 99495 and 99496 for Medicare payment, you may not also report these codes during the TCM service period:
 - **Care Plan Oversight Services**
 - Home health or hospice supervision: HCPCS codes G0181 and G0182
 - End-Stage Renal Disease services: CPT codes 90951–90970
 - Chronic Care Management (CCM) services (CCM and TCM service periods cannot overlap)
 - Prolonged E/M Services Without Direct Patient Contact (CPT codes 99358 and 99359)
 - Other services excluded by CPT reporting rules

TCM Model Case Study



Case Study

As the landscape of healthcare changed, the way we conducted business would need to evolve. We had identified:

- How we maximize reimbursement rates for our commercial and high level of Medicare/Medicaid participants thru a quality-based program?
- How we would prepare the Health System for population health and participation into a clinically integrated network?
- How we would manage the healthcare expenses of our employees and other area companies through plan design and narrow networks.

Transitional Care in Rural NC

- Structure
 - Independent hospital (One of a few left in NC)
 - Local Board of Trustees
 - Not for profit
- Service Area
 - 40 miles North of Raleigh
 - Granville (City) Population: 51,341
 - Total Service Area Population: 150,013

How did Transitional Care Evolve?

- Reimbursement guidelines based on:
 - ACA
 - Managed Care
 - Capitated Models
 - CMS Quality & Pay for Performance
- The new environment of healthcare: Pay for performance, based on quality and outcome.

How did Transitional Care Evolve?

The Realization?

1. Ultimately, we are responsible for the decisions our patients make.
2. If we get our patients out of the hospital and back to their Primary Care Provider (PCP), good things will happen.

Building the Model

In order to be successful, the Transitional Care Program required:

- Board of Trustee Buy-in
- Medical Staff Led with Identified Physician Champions
- Rethinking the traditional Case Management model
- Inclusion and Participation from all Involved Areas:
 - Transitional Care (Case Management)
 - Hospitalists
 - Emergency Medicine
 - Primary Care (employed & community physicians)
 - Local Home Health Agencies and other Community Partners
 - Long Term Care

Building the Model

In order to be successful, the Transitional Care Program required:

- Establish the goal to come together as a medical community and support the concept of the medical home as the anchor of the program.
- Working with patients to make better decisions leading to improved quality of life.

Timeline

A program born from Primary Care and Quality:

2012

- The Board and Medical Staff approve the creation of a service line dedicated to managing patients' continuum of care.
- Primary Care Service Line (PCSL) develops discharge education and pathways
- PCSL identifies CMS core measures
- Evolving methodology for identifying measures
- Initial focus on Diabetes; additional diagnosis are introduced to the program:
CHF, COPD, PNA
- Care coordination begins upon admission

Timeline

A program born from Primary Care and Quality:

2013

- PCSL incorporates home visits: complete medication reconciliation
- Care management protocols developed
- Diabetic patients to be scheduled for eye exams
- ED readmit flag

Timeline

2014

- PCSL develops into “Community Transitional Care”
- Patients to follow up with PCP within 14 days; appointments made while patient is still in the hospital. PCP follow up confirmation
- Focus on readmissions (added as a metric) and medication reconciliation
- Works to identify additional internal resources to support program
- Community Alternative program (CAP) and EMS identified as support resource for home visits and safety checks
- EMS and CAP begin visiting homes

Timeline

2015

- EMS increases home visits: Implements Mobile Integrated Health Program
- Facility commits Primary Care Practices to reserve 7 slots per day to schedule transitional care patients
- Focus on reduced readmissions, improves PCP follow up to 7 days and home visits within 3 days for high-risk diagnosis patients
- Reevaluate definition of high-risk diagnosis

Success Stories

- **Readmission for new onset of Diabetes**
 - Was not taking Medications as prescribed due to cost.
 - Transitional Care Coordinator (TCC) identified issues with patient's insurance coverage, worked with patient and pharmacy to correct insurance error, significantly decreasing patient's monthly co-pay
 - Decreased the cost from more than \$200.00 per month to \$20.00 per month.
 - EMS followed up with a home visit to review medications
- **The Outcome**
 - Patient following up with PCP
 - Patient now compliant with medications.
 - No new readmissions

Success Stories

- **New Onset of Diabetes & did not have a PCP**
 - Due to the nature, and timing, of the diagnosis, the patient was identified as a readmission risk
- **The Outcome**
 - TCC identified an accepting Primary Care Physician
 - Provided additional education on monitoring blood glucose levels and a glucometer at discharge.
 - Conducted a home visit to confirm patient's compliance and understanding of medical condition.
 - Eye doctor appointment made as part of protocol revealing incidental need for corrective lenses.
 - Six month follow up demonstrate patient managing diabetes.
 - No new readmissions and followed up with his PCP.

Success Stories

- **Dangerous Home Conditions**
 - The Emergency Department initially identified a patient as a high-risk patient due to diagnosis and readmit flag due to previous admission. ED staff then contacted TCC.
 - TCC intervened and identified unsafe living conditions for the patient; not conducive to a healthy home recovery.
 - Because of the home environment, high risk diagnosis, and readmission the patient was identified as a readmission risk.
- **The Outcome**
 - TCC worked with the patient and family to secure placement in a Skilled Nursing Facility, allowing for the correct level of care.
 - No new readmissions and followed up with her PCP.

Program Results

The data supports our success

- **FY 2016 Summary**
 - Reduction in Inpatient Readmissions of patients with high risk Dx
 - \$73,595 (Our Board prepared to accept cuts in Fee for Service vs. Pay for Performance)
 - Reduction in Self Pay Readmissions of patients with high risk Dx
 - \$11,500 (Recognized Savings)

Program Results

The data supports our success

- **FY 2017 Projected Revenue Increase**
 - Increased referrals back to Primary Care Practices
 - 200 patient caseload (200 patients following up with their PCP)
 - PCP office visit TC codes post hospitalization @ \$35.93 per visit = \$7,186
 - Post PCP visit Chronic Care Management \$42.60 (non face to face) each month per patient = \$102,240
 - PCP visits: higher payor reimbursements for RHC clinics

Total Increased Revenue = \$109,426

2015 Data

How we monitored, measured, and adjusted the program

** Prior to FY 2015 – Collected Data at the Department Level*

FY 2015

- **Unassigned Patients from ED requiring follow-up care are discharged with appointment to PCP**
- Baseline: 0% Goal: 80% Final: 79%
- **High Risk Hospital Inpatients seen by PCP within 7 days of Discharge**
- Baseline: 0% Goal: 95% Final: 95%

2015 Data

How we monitored, measured, and adjusted the program

** Prior to FY 2015 –Collected Data at the Department Level*

FY 2015

- **High Risk Hospital Inpatients discharged with f/u visit from a transitional care team member**
- Baseline: 0% Goal: 85% Final: 94%
- **Decrease readmissions for High Risk Dx (HF, PNA,TJR, COPD) as a percent of total available admissions**
- Baseline: 5.1% Goal: 3.5% Final:(1,763 / 42) 2.4%

2016 Data

How we monitored, measured, and adjusted the program

FY 2016

- High Risk ED Patients seen by PCP within 7 days of Discharge
- Baseline: 0% Goal: 80% Final: 86%
- High Risk ED Patients discharged with no primary care received a follow up visit from a Community Paramedic
- Baseline: 0% Goal: 60% Final: 50%
- Decrease readmissions for High Risk Dx (HF, PNA, Joint, COPD) as a percent of total available admissions
- Baseline: 2.4% Goal: 1.4% Final: (1,497 / 15) 1.0%

2017 Forecast

How we monitored, measured, and adjusted the program

FY 2017

- **Transitional Care will reduce the number of 30 day ED bounce backs for those high risk individuals who participate in the Community Paramedic Program**
 - Baseline: 17% Goal: 9%
- **High Risk ED Patients discharged with no primary care will receive a follow up visit from a Community Paramedic**
 - Baseline: 50% Goal: 60%
- **Decrease readmissions for High Risk Dx (HF, PNA, Joint, COPD) as a percent of total available admissions**
 - Baseline: 1.0% Goal: 1.0%

Lessons Learned

Commit to Building your own recipe for Transitional Care

- **You don't know what you don't know and you'll never be ready**
 - This is an evolving program and you must be comfortable with change
 - Your final solution may not exactly reflect the original blueprint of the plan
- **Identify how you will collect and measure data**
 - Remember, this is an evolving program and your measures may need to adjust to reflect change in the program and patient base.
- **Don't underestimate the potential for growth**
 - Our Transitional Care program increased its patient load X3 over 12 months.

Moving Forward

- The Transitional Care Program to expand in 2017
 - Duke Endowment Grant (\$204,600)
 - EMS Mobile Integrated Health Program purchases a dedicated vehicle
 - Transitional Care adds additional FTE
- Chronic Care Managers added to Primary Care Practices to:
 - Provide 1 on 1 telephone conversations to address self-management of care, medication compliance and to ensure all necessary services, resources and equipment is utilized.
 - Establish effective monthly care plan and review problem lists.
 - Monitor patients' physical, mental and social conditions.

Moving Forward

- Further development and integration of the Hospitalist Program
 - Continue to develop care protocols
- Improved documentation and analytics

Questions?



Where do I start? References

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