



Transitional Care Management

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MEMORIAL COMMUNITY HEALTH

Memorial Community Health

- ▶ 13 Bed Critical Access Hospital
- ▶ Outpatient services
- ▶ Specialty clinics
- ▶ 3 Family Medicine Clinics
- ▶ Independent/Assisted Living
- ▶ Long term Nursing facility
- ▶ 4 MD's, 3 APRN's, and 1 PA



Objectives

- ▶ Discuss Strategies to implement a Transitional Care Management Program (TCM)
- ▶ Review how to build efficiencies for success
- ▶ Discuss how to use your TCM program to improve quality outcomes for patients who are hospitalized

What is Transitional Care Management

- ▶ Supporting a patient's transition from the hospital to a community setting
- ▶ Intended to reduce potentially preventable readmissions and medical errors during the 30 days following discharge from the acute care setting

Goals of TCM

- ▶ Support patients transition to a community setting
- ▶ Keep them out of the hospital
- ▶ Reduce potentially preventable medical errors
- ▶ Improved patient and family engagement
- ▶ Improved outcomes
- ▶ Increased revenue

TCM Service Requirements

- ▶ The 30 day TCM period begins on a patients discharge date and continues for the next 29 days
 - ▶ Discharges may occur from
 - ▶ Inpatient acute hospital
 - ▶ Inpatient psychiatric hospital
 - ▶ Inpatient rehab facility
 - ▶ Long-term care hospital
 - ▶ Skilled Nursing facility
 - ▶ Hospital outpatient observation
 - ▶ Partial hospitalization at a community mental health center
 - ▶ After discharge patient must return to their community setting
 - ▶ Home, assisted living, group home, nursing facility

Who can provide TCM?

- ▶ Physicians
- ▶ Mid-level practitioners
 - ▶ CNS
 - ▶ NP
 - ▶ PA
 - ▶ NMP

TCM Components

- ▶ When a patient is discharged from an approved discharge setting, you must provide at least these components
 - ▶ Interactive Patient Contact
 - ▶ Face to Face Follow up Visit
 - ▶ Medication Reconciliation

Interactive Patient Contact

- ▶ Must be within 2 business days after discharge from hospital
- ▶ Can be done by medical staff or clinical staff under direct supervision
- ▶ This person must be able clinical staff who can address patient status and needs beyond scheduling follow up care
- ▶ Can be done by phone, face to face, or email
- ▶ Can report service if you make 2 or more unsuccessful separate contact attempts in a timely manner (and meet other components) and you have continued to try to reach the patient until successful

Face To Face Visit

- ▶ Face to Face Visit – must have 1 of the following:
 - ▶ CPT Code 99495 — Transitional Care Management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; Medical decision making of at least moderate complexity during the service period; Face-to-face visit, within 14 calendar days of discharge
 - ▶ CPT Code 99496 — Transitional Care Management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; Medical decision making of high complexity during the service period; Face-to-face visit, within 7 calendar days of discharge
 - ▶ CMS booklet does say you can provide them via telehealth – our clinic has not done this yet

Complexity Grid/Medical Decision Making

Type of Decision Making	Diagnoses & Management Options Possible	Data Amount & Complexity	Significant Complications, Morbidity, & Mortality Risk
Straightforward	Minimal	Minimal or None	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

Medication Reconciliation

- ▶ Medication Reconciliation must be done on or before the face to face visit date
- ▶ This can be done by the provider or nursing staff at the visit.
- ▶ Also a best practice to go over the medicine changes with the patient on the initial phone call.

TCM Components

- ▶ If you have met all requirements and the patient has been out of the hospital for 30 days then you can bill for TCM
- ▶ Our clinic holds the charge for 30 days to be sure the patient hasn't been readmitted if patient is readmitted then a normal office visit is billed

Documentation

- ▶ At a minimum, document this information in the patient's medical record:
 - Patient discharge date
 - Patient or caregiver first interactive contact date
 - Face-to-face visit date
 - Medical complexity decision making (moderate or high)

*Performed on: 02/09/2023 08:48 CST

Transitional Care Management

Date of Hospital Discharge

Communication Post Discharge

Attempt #	Date & Time of Call	Was Call Successful?	Method Used	Provider Name
Attempt #1	<input type="text"/> <input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Phone Call <input type="radio"/> Patient Portal	<input type="text"/>
Attempt #2	<input type="text"/> <input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Phone Call <input type="radio"/> Patient Portal	<input type="text"/>
Attempt #3	<input type="text"/> <input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Phone Call <input type="radio"/> Patient Portal	<input type="text"/>

Source of Information Patient Caretaker Family Other

Diagnosis at Discharge

Discharging Facility

Medication Reconciliation upon Discharge

	Yes	No
*Medication Reconciliation upon Discharge		
*List Reviewed		
Medication Changes		
Was Patient Able to Obtain Medication		
Is Patient Currently Taking Medication		

If Patient Unable to Obtain Medications, Why?

If Patient Not Currently Taking Medications, Why?

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Transitional Care Management

New DME

Yes No

Current Use of Home Health

Yes No

DME Supplies

BiPAP/CPAP device Blood glucose test strips Nebulizer Wheelchair
 Blood glucose monitor Conmode chair Walker Other:

Specialist Follow-up

Specialist Follow-up	Specialist Provider Name	Medical Specialty	CM Date/Time of Visit	CM Comments
<Alpha>			<Date/Time>	
<Alpha>			<Date/Time>	
<Alpha>			<Date/Time>	
<Alpha>			<Date/Time>	
<Alpha>			<Date/Time>	

Was Follow-up Imaging or Labs Ordered

Yes No

Imaging/Lab Comments

Review of Scheduled Follow-up Appointment

Does Patient have Appointment Transportation

Yes No

Patient Transportation Comments

Does Patient have Appointment Transportation

Yes No

Patient Transportation Comments

General Comments

Segoe UI 9

Strategies for starting a program

- ▶ Get all of the right players involved
- ▶ Start small – grow it as you have success
- ▶ Educate medical staff and clinical staff
- ▶ Be flexible
- ▶ Make adjustments when needed
- ▶ Use your resources
 - ▶ Phone a friend
 - ▶ ACO resources

How does this relate to quality?

- ▶ Helps us to address Readmissions
- ▶ Another set of eyes on the chart/patient
 - ▶ Identify gaps/problems
 - ▶ Look for missing quality items
 - ▶ Do they have hypertension – is it controlled? Are they on medications?
 - ▶ Do they have CHF – are the required D/C items done?
- ▶ Most importantly – it helps make sure our patients are doing well at home and are safe

Success Stories

- ▶ Patient discharged home with DX of PE's. Script for Eliquis sent home. Patient was unable to fill medication due to cost. Nurse discovered at discharge phone call – was able to assist patient to get co-pay card and some samples to give time for her to get signed up for patient assistance.
- ▶ New onset diabetic discharged with script for meter, strips, insulin. Patient could only afford meter and strips. Insulin script was a non-formulary medication on patients insurance and was roughly \$800 for a script. - staff was able to work with pharmacy to find most affordable insulin with patients insurance company.
- ▶ Patient admitted for hypoglycemic episodes. During discharge call nurse found patient was going high and low often. Let MD know – we were able to get patient set up for a CGM trial to wear for 10 days to gather data for the patients follow up visit.

Resources

- ▶ TCM CMS Booklet

- ▶ <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/transitional-care-management-services-fact-sheet-icn908628.pdf>

- ▶ TCM Frequently Asked Questions

- ▶ <https://edit.cms.gov/files/document/billing-faqs-transitional-care-management-2016.pdf>

- ▶ Rural Health Information Hub

- ▶ <https://www.ruralhealthinfo.org/care-management/transitional-care-management>

Questions?

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