# 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

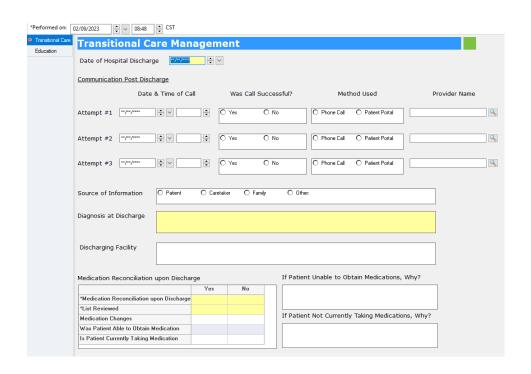
- Medication Reconciliation must be done on or before the face to face visit date
- This can be done by the provider or nursing staff at the visit.
- Also a best practice to go over the medicine changes with the patient on the initial phone call.

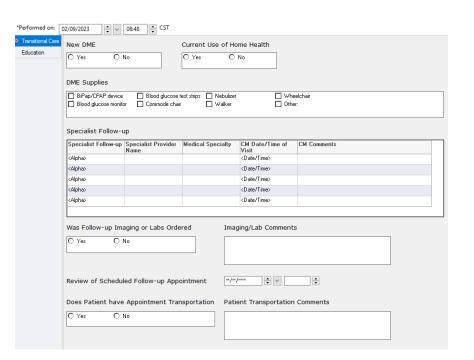
### TCM Components

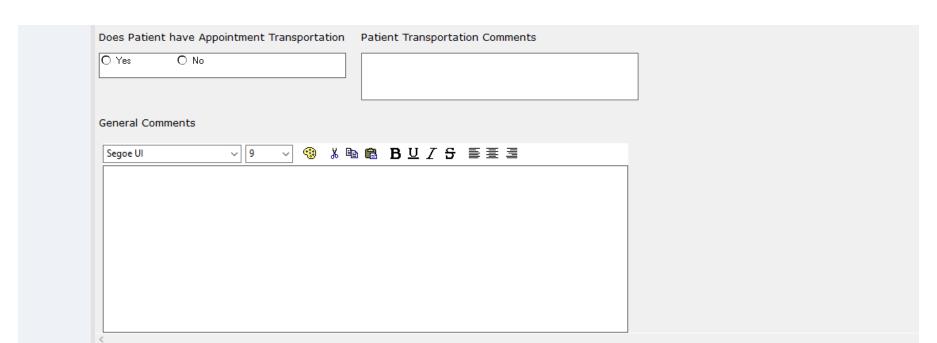
- ▶ If you have met all requirements and the patient has been out of the hospital for 30 days then you can bill for TCM
- Our clinic holds the charge for 30 days to be sure the patient hasn't been readmitted if patient is readmitted then a normal office visit is billed

#### 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)







# 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 Elliquis 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-caremanagement

# Questions?

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