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

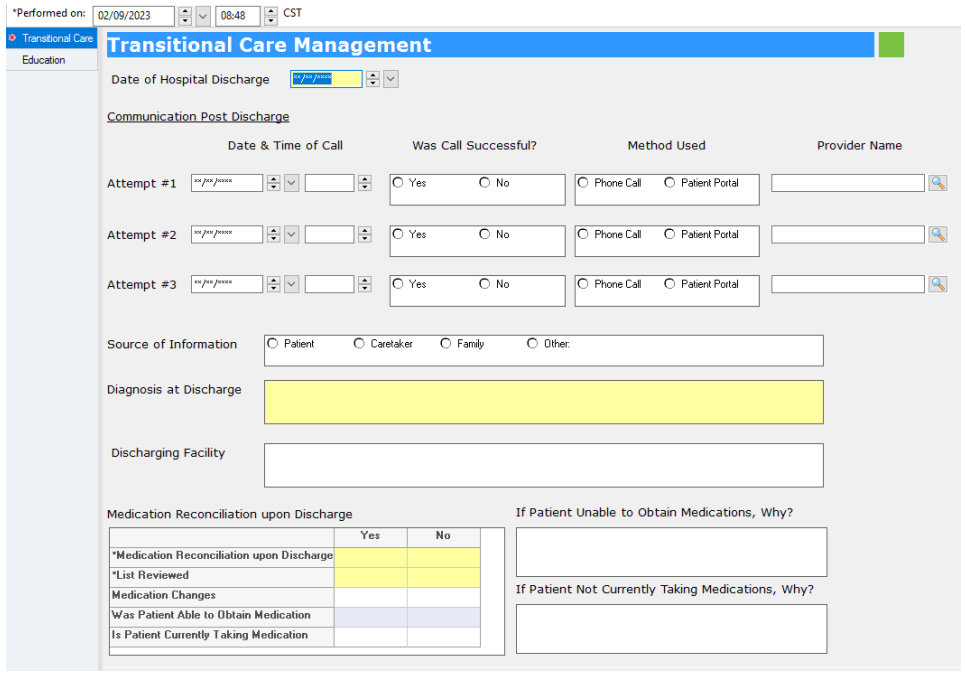
- Medication Reconciliation must be done on or before the face to face visit date
- This can be done by the provider or nursing staff at the visit.
- Also a best practice to go over the medicine changes with the patient on the initial phone call.

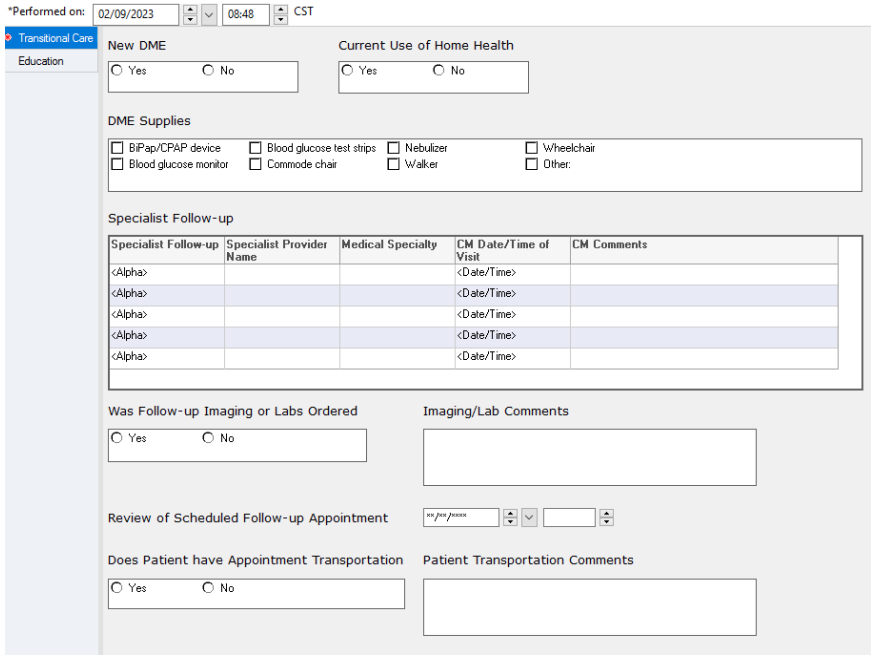
TCM Components

- 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
Education
Transitional Care Management
Date of Hospital Discharge
Communication Post Discharge
Date & Time of Call
Was Call Successful?
Method Used
Provider Name
Attempt #1
Attempt #2
Attempt #3
Yes
No
Phone Call
Patient Portal
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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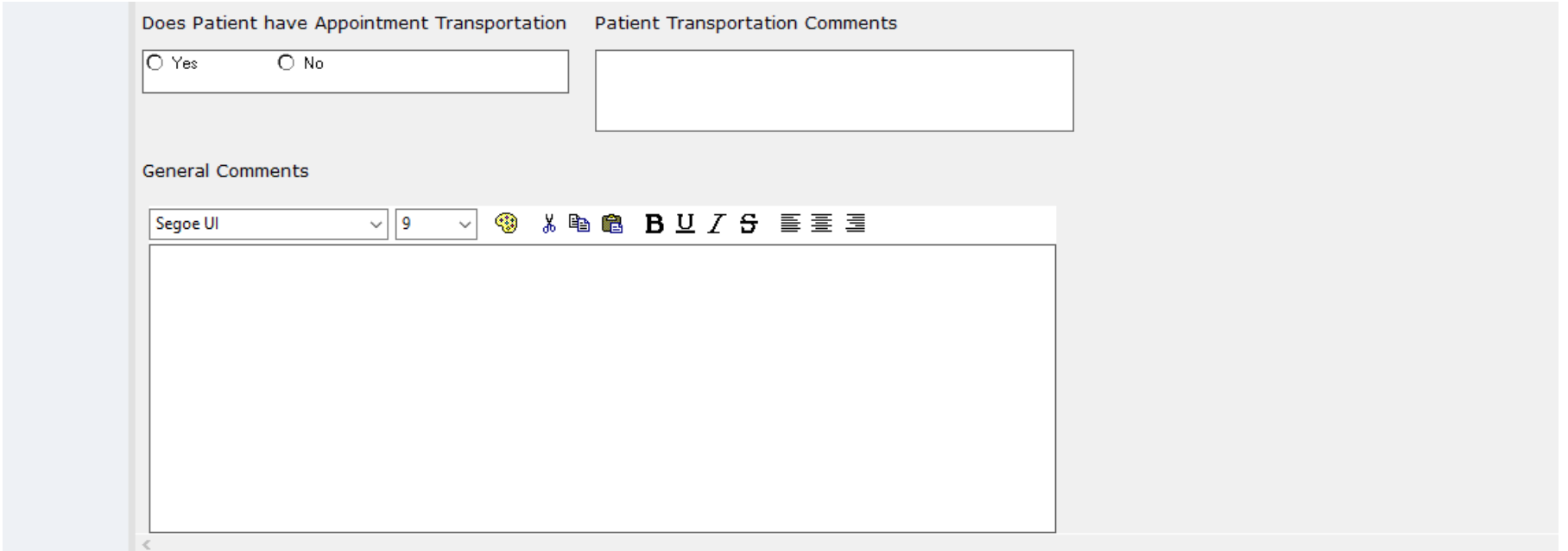
Transitional Care
Education
New DME
Yes
No
Current Use of Home Health
DME Supplies
BiPap/CPAP device
Blood glucose monitor
Blood glucose test strips
Commode chair
Nebulizer
Walker
Wheelchair
Other:
Specialist Follow-up
Specialist Follow-up
Specialist Provider Name
Medical Specialty
CM Date/Time of Visit
CM Comments
<Alpha>
<Date/Time>
Was Follow-up Imaging or Labs Ordered
Imaging/Lab Comments
Review of Scheduled Follow-up Appointment
Does Patient have Appointment Transportation
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 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-care-management

Questions?

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