Effective Post-Discharge Transitional Care Management (TCM)

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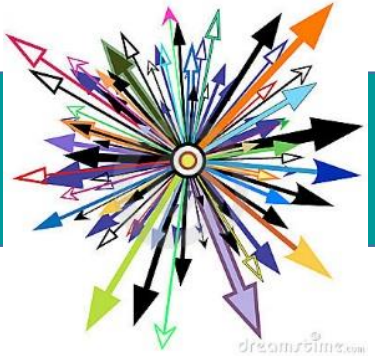
30 YEARS OF SERVING CONNECTICUT PHYSICIANS

Webinar Objectives



- Explore the challenges and opportunities of post-discharge transitional care management
- Identify opportunities for transitional care management reimbursement
- Review tools and techniques for effective transitional care management
- Understand the role of home health care in managing post-discharge care transitions

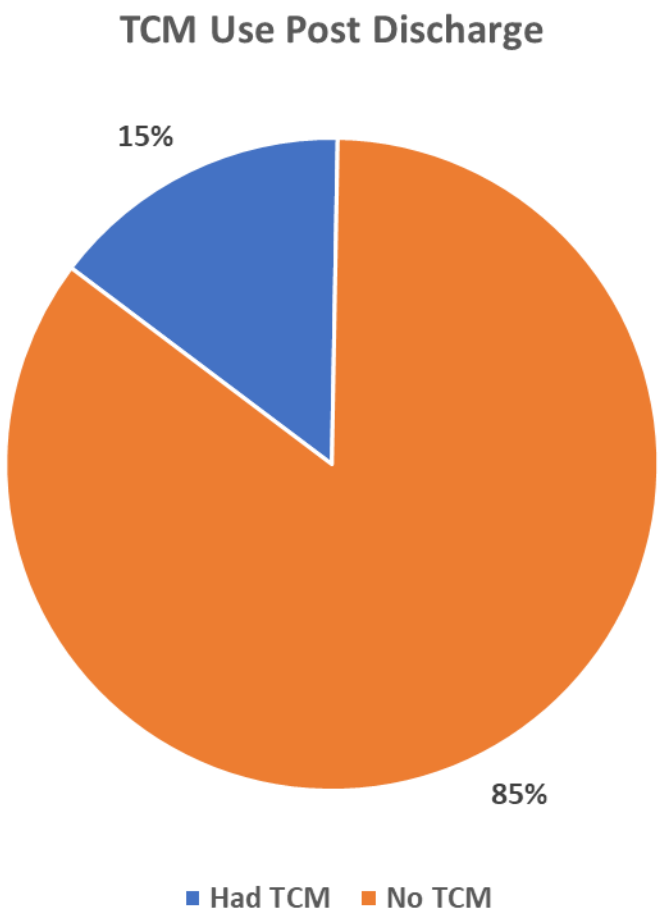
Transitional Care Management Defined

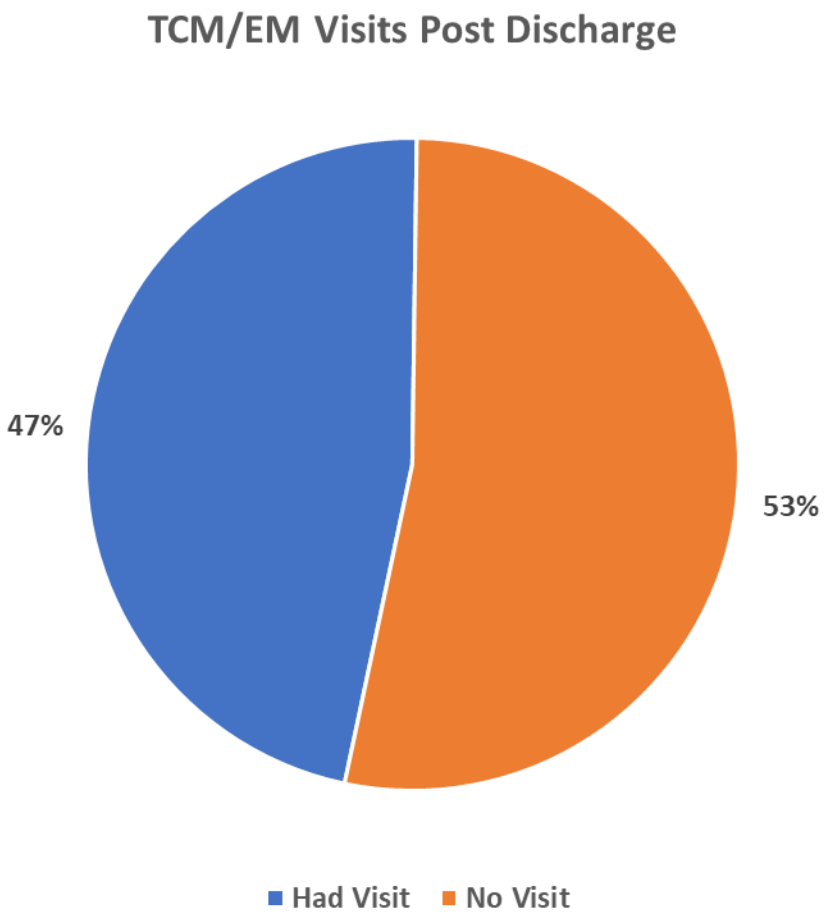
The essence of transitional care management is that a health care provider takes charge of the patient's care from the instant he or she has been discharged through the 30th day post discharge. A key goal for TCM management is to reduce readmissions and improve outcomes.

Options for Reimbursement

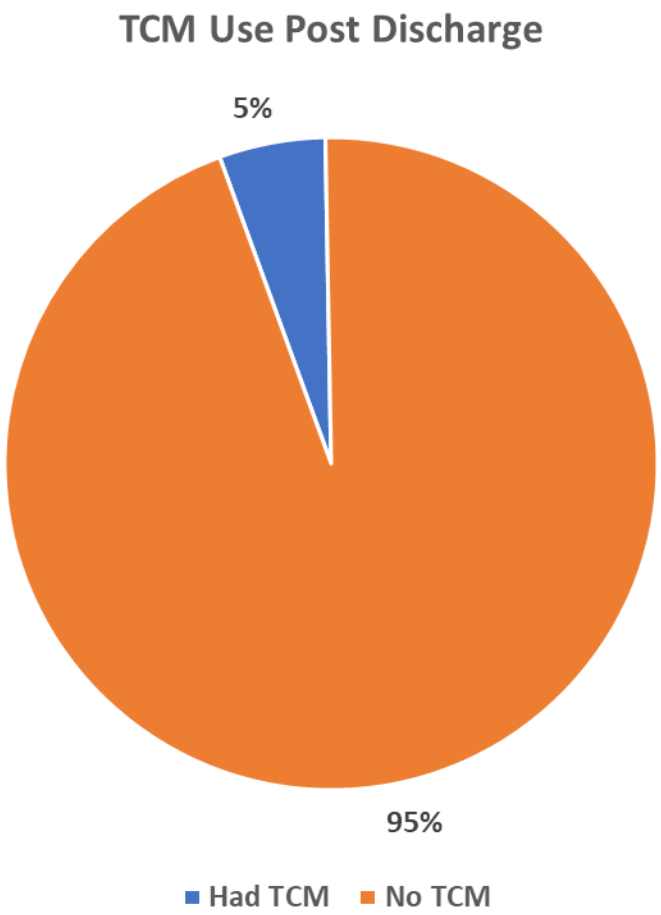
- **Transitional care management (TCM)** (codes 99495-99496)
  - Documentation of follow-up call (that reaches the patient) within 2 business days of discharge.
  - Documentation of face-to-face visit within 7-14 days of discharge. Acuity of patient determines when the patient should be seen, and which code to bill under.
  - Medication reconciliation is completed at or before this face to face visit.
- Follow up visit with **E&M coding**
- **Medication reconciliation coding** (CPT category 2 code: 1111F)
- Codes for **home care certificatio**n (G0170 and G0180)

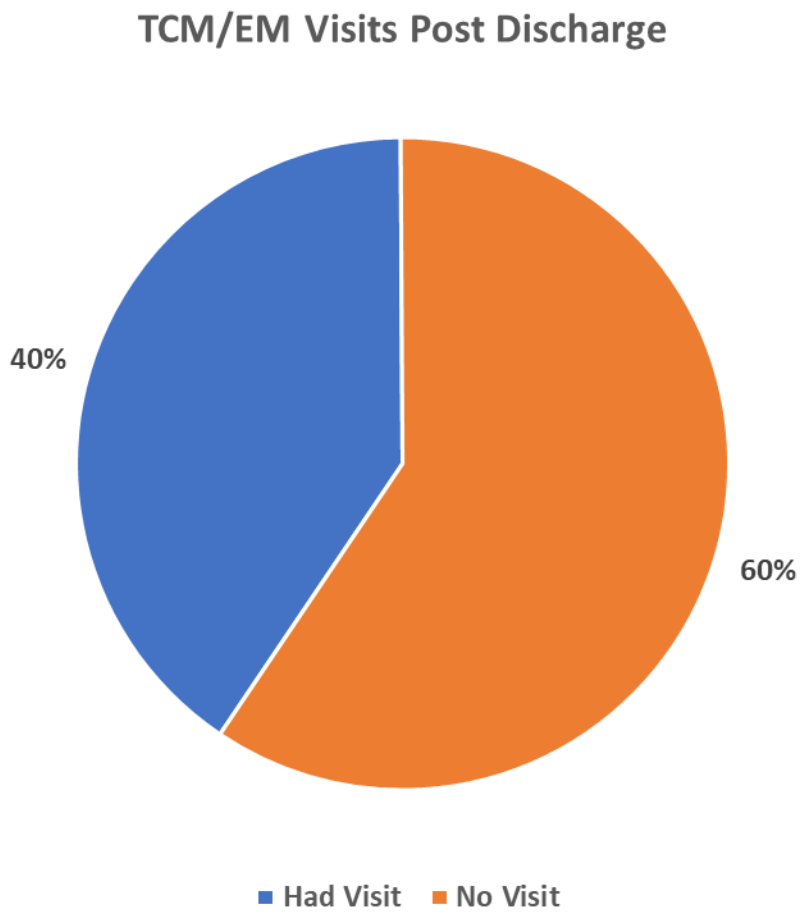
CSMS-IPA Medicare Advantage Transitions of Care (CCI & WellCare) 2019





CSMS-IPA Commercial Transitions of Care (CCI & Cigna) 2019





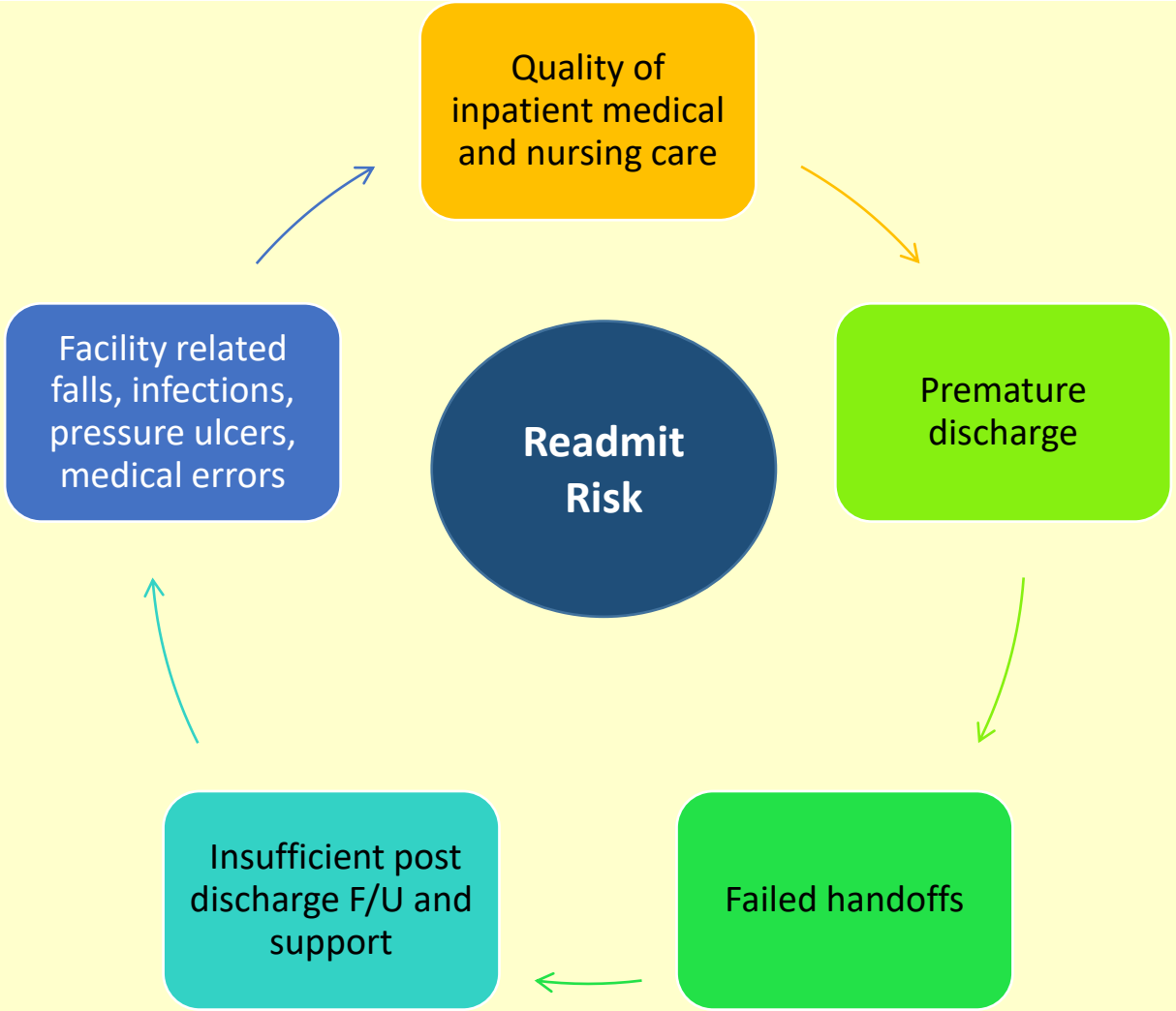
Why Transitional Care Management?

TCM interventions can:

- Reduce readmissions
- Lower the cost of care *
- Reduce mortality *
- Improve clinical outcomes
- Improve patient and family satisfaction (and reduce stress)

* JAMA Intern Med. 2018;178(9):1165-1171. doi:10.1001/jamainternmed.2018.2572

Health Care Factors that Influence Readmissions



Transitional care management can/should address these issues.

Patient Factors that Impact Readmissions

Deficits in these areas should also be addressed during transitional care management

Frail Adults and the “Vulnerable Period”

- First 24-48 hours post discharge
- “Post-hospital syndrome” *
- Stress, anxiety, depression
- May be some confusion
- Exhaustion
- May be malnourished
- Heightened fall risk
- Pt and family are overwhelmed

* Krumholtz, H. NEJM, 2013

Poll: Your Top Post-Discharge Challenge

- ❑ Lack of timely discharge notification
- ❑ Inadequate information from acute care facility
- ❑ Patients making and keeping post-discharge appointments
- ❑ Getting reimbursed for transitional care management
- ❑ Medication reconciliation

Key Elements of Good Transitional Care Management

- Identify practice patient discharges
- Review discharge documents
- Make post discharge call to patient/caregiver
- Close pressing gaps in care
- Perform post-discharge follow up visit
- **Reconcile medications**
- Make referrals and coordinate care
- Provide patient and family education

Post-Discharge Visit Best Practices

Checklist for Post-Hospital Follow-Up Visits

Prior to the Visit

- ☐ Review discharge summary.
- ☐ Clarify outstanding questions with sending physician.
- ☐ Reminder call to patient or family caregiver to:
  - ☐ Stress importance of the visit and address any barriers.
  - ☐ Remind to bring medication lists and all prescribed and over-the-counter preparations.
  - ☐ Provide instructions for seeking emergency and non-emergency after-hours care.
- ☐ Coordinate care with home health care nurses and case managers if appropriate.

During the Visit

- ☐ Ask the patient to explain:
  - ☐ His/her goals for visit.
  - ☐ What factors contributed to hospital admission or ED visit.
  - ☐ What medications he/she is taking and on what schedule.
- ☐ Perform medication reconciliation with attention to the pre-hospital regimen.
- ☐ Determine the need to:
  - ☐ Adjust medications or dosages;
  - ☐ Follow up on test results;
  - ☐ Do monitoring or testing;
  - ☐ Discuss advance directives;
  - ☐ Discuss specific future treatments (POLST).
- ☐ Instruct patient in self-management; have patient repeat back.
- ☐ Explain warning signs and how to respond; have patient repeat back.
- ☐ Provide instructions for seeking emergency and non-emergency after-hours care.

At the Conclusion of the Visit

- ☐ Print reconciled, dated, medication list and provide a copy to the patient, family caregiver, home health care nurse, and case manager (if appropriate).
- ☐ Communicate revisions to the care plan to family caregivers, health care nurses, and case managers (if appropriate). Consider skilled home health care or other supportive services.
- ☐ Ensure that the next appointment is made, as appropriate.

The Post Hospital Follow-Up Visit A Physician Checklist to Reduce Readmissions California Health Foundation, 2010

Medication Reconciliation - THE KEY TCM Strategy

According to the Joint Commission:

Medication reconciliation is the process of comparing a patient's **medication orders** to all of the **medications that the patient has been taking**.

This **reconciliation** is done to avoid **medication** errors such as omissions, duplications, dosing errors, or drug interactions.

Medication Reconciliation Issues in TCM

- Complexity that produces errors
- Patients may keep taking drugs "because I paid for them"
- Drug duplication - same drug, different name or appearance
- Lack of effective medication management system
- Patient lacks understanding of medications

- Hospital stops a drug the patient needs
- Patient forgets to take doses
- Polypharmacy - multiple drugs from different providers
- Beers List drugs for seniors
- Long term opioid use

Medication Reconciliation Key Actions

Compare pre-hospital and discharge medication lists

Resolve med access issues

Develop new drug list

Help with med management systems

Educate patient and family

Address opioid use

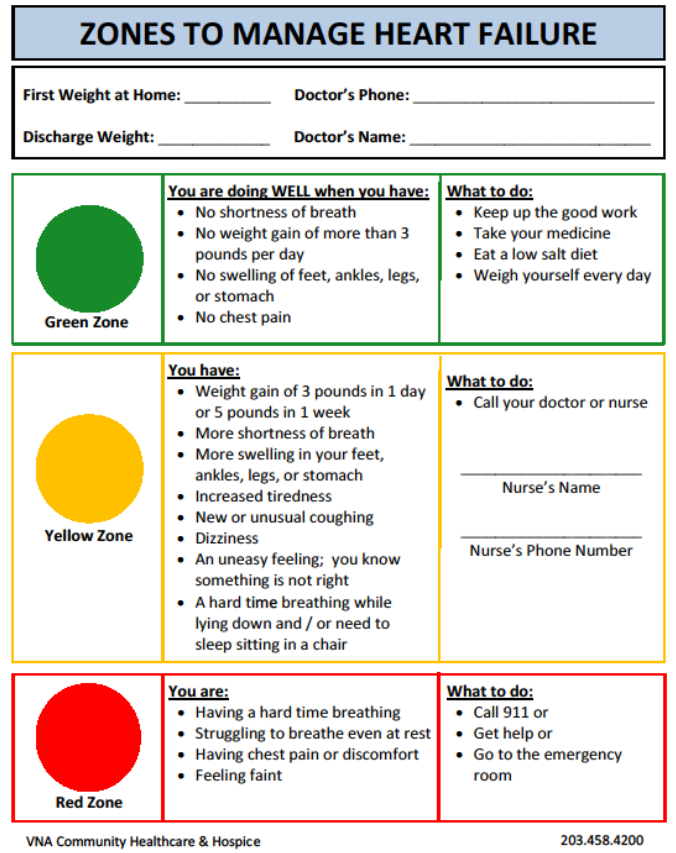
Address polypharmacy

Effective Patient Teaching in TCM

Ask, Tell, Ask

- **ASK** - what the patient already knows
- **TELL** - provide health information in a way that matches the patient's health literacy level
- **ASK** the patient to state in his/her own words what he/she has learned

Provide written instructions with simple visuals.



ZONES TO MANAGE HEART FAILURE

First Weight at Home: _____ Doctor's Phone: _____

Discharge Weight: _____ Doctor's Name: _____

	You are doing WELL when you have:	What to do:
Green Zone	• No shortness of breath • No weight gain of more than 3 pounds per day • No swelling of feet, ankles, legs, or stomach • No chest pain	• Keep up the good work • Take your medicine • Eat a low salt diet • Weigh yourself every day
Yellow Zone	**You have:** • Weight gain of 3 pounds in 1 day or 5 pounds in 1 week • More shortness of breath • More swelling in your feet, ankles, legs, or stomach • Increased tiredness • New or unusual coughing • Dizziness • An uneasy feeling; you know something is not right • A hard time breathing while lying down and / or need to sleep sitting in a chair	**What to do:** • Call your doctor or nurse _____ Nurse's Name _____ Nurse's Phone Number
Red Zone	**You are:** • Having a hard time breathing • Struggling to breathe even at rest • Having chest pain or discomfort • Feeling faint	**What to do:** • Call 911 or • Get help or • Go to the emergency room

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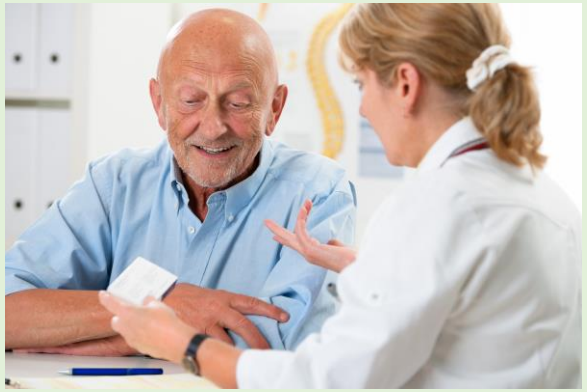
TCM Resources and Tools

- **Your IPA representative**
- Payer tools (care management, coaching, social work, community resources, patient education)
- Medication management tools
- Patient access to personal medical information
- Motivational interviewing
- Simple patient education materials and media

- Goals of care conversations (aggressive treatment, palliative, hospice care choices)
- Referrals to other medical or community resources

Poll: Your Most Effective Transitional Care Management Strategy

- ❑ Reading hospital discharge documents
- ❑ Post discharge phone call/visit
- ❑ Medication reconciliation
- ❑ Patient teaching with teach back
- ❑ Community or specialty referrals



Home Health Care as a TCM Tool

Types of Home Health Care

- Skilled, Medicare-certified home health care
- Specialized home care : i.e. IV providers
- Non-medical home care: i.e. homemaker-companion and personal care services
- Hospice home care
- Services provided under Medicare Part B - physical therapy, home psychotherapy

How Home Health Care Helps with TCM

- Can be the provider's "eyes and ears" in the home
- Provides interdisciplinary team care (including RN,PT, OT, ST, SW, Home Health Aides)
- Provides regular monitoring and reporting
- Performs home medical procedures (wound care, drains, etc.)
- Helps patients manage pain and other symptoms
- Intensive patient and family self-care teaching
- Obtains supplies and equipment

What You Hear and What Home Care Clinicians See

- *I am taking all the medications they prescribed at the hospital*
- *I have plenty of help at home - my daughter lives with me*
- *I get around fine with my walker*
- *I know when to call you or 911 for help*

- Patient is also taking meds from before admission because she paid for them
- Daughter, who has COPD and is on O2, lives with the patient and needs help herself
- Patient doesn't like to use walker at home - uses "wall walking"
- Patient delayed going to ER for dyspnea because: "I thought it would go away"

Medicare and MA Home Health Care Requirements

Home Health Care Covered Services

- Nursing *
- Physical therapy *
- Speech therapy*
- Occupational therapy
- Social work
- Home health aide

* One of these 3 “qualifying” disciplines is necessary for Medicare coverage

Home Health Care Requirements

- Patient must be **homebound**
- The patient must require a **qualifying discipline**
- Physician or APRN/PA **signs the Home Care Plan of Care (Medicare form 485)** and **supplemental orders**
- Physician, APRN or PA sees the patient and documents a **“face to face” encounter 60 days before, or 30 days after,** the start of home health care services
- The provider must be **licensed and enrolled in Medicare and PECOS**
- MA plans may use prior authorization

Improving Collaboration with Home Health Care

- Review the plan of care/sign orders (initial and supplemental)
- **Respond to clinician calls**
- Problem solve with clinicians
- Obtain information for chronic care management
- Do joint telehealth visits
- Participate in complex case conferences
- Order social work to help with psychosocial issues and entitlements

“Frequent Flyer” Case Study

Mrs. Ahmed, Age 78

Heart failure, COPD, diabetes

Four day admit for HF decompensation. Second hospital admit in 6 months. Two ER visits for dyspnea.

Care by PCP and 6 specialists

Takes 14 medications

Cognitively intact, but overwhelmed and confused by complex self care regimen

Functionally impaired –uses a walker and has trouble with ADLs.

Son lives nearby and helps “sometimes”

Poll: Which Two Actions Will Help Mrs. Ahmed Most?

- ❑ Post-discharge call - within 2 days
- ❑ Post-discharge visit - in person or telehealth, within 7 days
- ❑ Medication reconciliation
- ❑ Referral to home health care
- ❑ Self care education with teach back

Transitional Care Management and COVID

- The obvious - triage office visits
- Accelerate post-discharge call times
- Reconcile meds - via telehealth, if necessary
- More care in patient teaching
- Check in on chronic patients by phone
- Ask about situation and coping
- Identify and close new gaps in care

References and Resources

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- CT Assn for Healthcare at Home (cthealthcareathome.org)
- American Geriatric Society Beers Criteria for Potentially Inappropriate Medication Use in Older Adults (https://qioprogram.org/sites/default/files/2019BeersCriteria_JAGS.pdf

Conclusion and Questions

- Thank you for your time and attention
- Please feel free to contact me for questions or comments:

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