Case Study: Transition of Care for Complex Patient v3

Directions: *Read the Transition of Care (TOC) case study below.*

Following the case study, review each question and take a few minutes to write down your response.

Tips:

- *Think about the Transition of Care key elements and action steps the health care team members take to conduct evidence based interventions. (included below)*
- *Keep in mind the members of the health care team: Primary care practice, Specialist(s) practice, and the clinical-community linkages that may exist or new ones that may be beneficial, and the patient/family.*

You review the morning's Admission Discharge and Transfer (ADT) patient list. Mr. Lawson is a 68-year-old male, on the ADT list, who was just discharged from the hospital for an exacerbation of Congestive Obstructive Pulmonary Disease (COPD) and extreme fatigue. You have access to Mr. Lawson's EHR for his most recent hospital admission and his providers including his Pulmonologist, and primary care physician. Per your physician office protocol, you schedule a transition of care phone call to Mr. Lawson.

Background

Mr. Lawson has a history of COPD, smoking and uncontrolled HTN. During his recent hospitalization a routine chest X-ray revealed a large mass in his left lower lung. He was discharged with home oxygen, new prescriptions and an oncology consult. His PCP office visit notes reveal that he is retired and lives at home with his wife, who does not work and suffers from her own health needs. He stated at his last office visit that he receives monthly social security but that his pension was cut off a few months ago. His immediate relatives live out of state.

Transition of care phone call – within 2 days of hospital discharge

As a care management team member in the Pulmonologist office, you conduct a post-discharge phone call to Mr. Lawson within 2 days of his hospital discharge. Mr. Lawson admits he really has not been taking care of himself which led to the hospitalization secondary to not taking his medications and his continued smoking. He states that the diagnosis of the lung mass scares him and doesn't know what he is going to do. He goes on to tell the care management team member that he is the caregiver of his grandchildren ages 5 and 9, ever since his daughter passed away three months ago. His daughter was living with them at the time and provided financial assistance. He struggles to make ends meet since his pension from the steel worker union stopped and now he only receives $800 per month in social security. This has led him to make choices between filling his prescriptions, paying the heating bill, or buying groceries. His wife also receives $700 in social security per month, however they still have trouble making ends meet. He is fearful of losing his home and concerned about who will take care of the grandchildren when he and his wife are no longer here. He currently has Medicare however he did not sign up for part B or prescription coverage and does not know how he is going to pay for the new prescriptions. The Pulmonologist care team member asks Mr. Lawson "Who do you speak with the most at you PCP office?" Mr. Lawson replies, he speaks with Thomas. Mr. Lawson is open to care management services.

Next steps:

- Contact Thomas at the PCP office to coordinate care. Your office works closely with the PCP office and there is agreement that the TOC will be provided by your Pulmonologist's practice.
- Confirm that Mr. Lawson has a return visit within 7 days with the Pulmonologist.

Pulmonologist Office visit - within 7 days of hospital discharge

A few days later Mr. Lawson attends his visit with the Pulmonologist. You are able to meet with Mr. Lawson in the clinic. He was late for the appointment stating he has unreliable personal transportation and at times has to rely on neighbors to get around. During the visit he opens up more about his health and what is going on in his life. He begins to talk about the lung mass that was found and that he has yet to tell his wife for fear of causing her more distress and anxiety. The hospital did not give him much information except to follow up with an oncologist. Mr. Lawson admits he doesn't read very well and was very confused about the discharge instructions he was sent home with. Furthermore, there has been the threat of child protective services getting involved and he is fearful he might lose his grandchildren. He is trying to do his best, to keep things together for his family.

Case Study – TOC

1. How will you coordinate care with Mr. Lawson's PCP practice?

2. What are the key elements for conducting TOC to address with Mr. Lawson? (*see Transition Care Management – Key Elements below pg. 3)*

3. Who is on the health care team and what interventions can they address?

4. What community resources may be of value?

TCM Elements

KEY - Identify who is the LEAD

Call patient within 2 days of discharge

- Obtain and Review discharge information
- Confirm LEAD: office visit scheduled with PCP or Specialist (7 calendar days complex, 14 calendar days moderate)
- LEAD: communicate with appropriate PCP/Specialist team members
- LEAD: Identify if patient has urgent needs prior to F2F visit: ex. SDOH, clinical needs – connect patient with appropriate PCP team member to address SDOH

Visit Prep (Same day as provider visit or prior to)

- Complete medication reconciliation
- Discuss patient's goals and concerns
- Provide relevant education
- Conduct screenings
- Coordinate Specialists, Primary care, community resources, other care plan needs.

TCM Visit

- Address medical treatment plan
- Assess for complications
- Review need for and/or follow up on pending tests/treatments
- Interact/coordinate with Specialists
- Educate patient/caregiver
- Discuss patient's goals and concerns
- Discuss care team member support opportunities

Follow Up Support

- Regularly check in with high risk / moderate risk patients to review care plan, self-management goals, and any patient concerns.
- Goal is to avoid readmission.

Bill

- Bill the TCM if the practice is assured that there have been no readmissions within 30 days.
- 99495 = Visit completed within 14 days.
- 99496 = Visit completed within 7 days.

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