# Transition of Care

# Successful Completion of Transition of Care Module

- View the “Transition of Care” recorded webinar,
- Complete the Transition of Care case study, and
- Complete the Transition of Care Module evaluation.

- Types of certificates available upon success completion of Transitions of Care Module
  - Certificate of Completion
  - Nursing Continuing Education Contact Hour

*Note:  this activity provides - 0.5 BCBSM PDCM Learning Credit

# Disclosure

- There is no conflict of interest for anyone with the ability to control content for this activity.
- Participants who successfully complete the entire Transition of Care online module, and submit the required course evaluation, will earn 0.5 Nursing CE contact hour.
- This nursing continuing professional development activity was approved by the Ohio Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. (OBN-001-91)
- ONA Activity 2020-0000000365
- Expiration date for eLearning module "Transition of Care" Nursing CE contact hour is 5/12/22.

# Disclaimer

Each physician organization and/or practice is solely responsible for all medical care and services delivered to its patients and all decisions related to such medical care and services. Neither MICMT or the Regents of the University of Michigan shall be responsible for any delivery of medical care or other services to any patient, or any decisions, acts or omissions of persons in connection with the delivery of medical care or other services to any patient.

# Objectives

Identify Key Elements of Transitions of Care

Identify Role of the Physician Office Care Team Members in Providing Transition of Care Services

MICMT

# Definition of Transition of Care (TOC)

**A set of actions** designed to ensure the coordination and continuity of health care as patients transfer from hospital to home.

. . .TOC services are provided after a patient is discharged from one of these inpatient settings

- Inpatient acute care hospital
- Hospital outpatient observation
- Skilled nursing facility (SNF)
- And other in patient settings

https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf;jsessionid=15B79538FFD509D36F09E059C4CD6BB2?sequence=1

# Why is TOC Important?

**20%** of patients experience an adverse event (66% drug related).

"US health care spending **increased 4.6%** to reach $3.6 trillion in 2018, a faster growth rate than the rate of 4.2% in 2017 but the same rate as in 2016." (Health Affairs, January 2019)

**20%** of Medicare patients are re-admitted within 30 days of discharge.

Analysis conducted by the Medicare Payment Advisory Committee (MedPAC) US data

Reference: Schall M, Coleman E, Rutherford P, Taylor J. How-to Guide: Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Re-hospitalizations. Cambridge, MA: Institute for Healthcare Improvement; June 2013. Available at www.IHI.org.

https://healthinsight.org/outpatient-clinicians/strengthening-primary-care/transitional-care-management

National Health Care Spending In 2017," *Health Affairs,* January 2019

# Transitions Between Hospitals and Primary care are Recognized as High-Risk Scenarios for Patient Safety

The impacts of problems at time of transition from hospital to home include:

- emotional and physical pain and suffering for service users, care givers and families
- increase in morbidity (temporary or permanent injury or disability)
- increase in adverse events
- preventable readmissions to hospital
- delays in receiving appropriate treatment and community support
- additional primary care or emergency department visits
- increase in mortality
- patient and provider dissatisfaction with care coordination
- additional or duplicated tests or tests lost to follow-up



https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf;jsessionid=15B79538FFD509D36F09E059C4CD6BB2?sequence=1

# Goals for a Positive Transition of Care

Patient receives the continuity of care they need to keep condition stable and recognize warning signs and actions to take

Health outcomes are consistent with patient's wishes

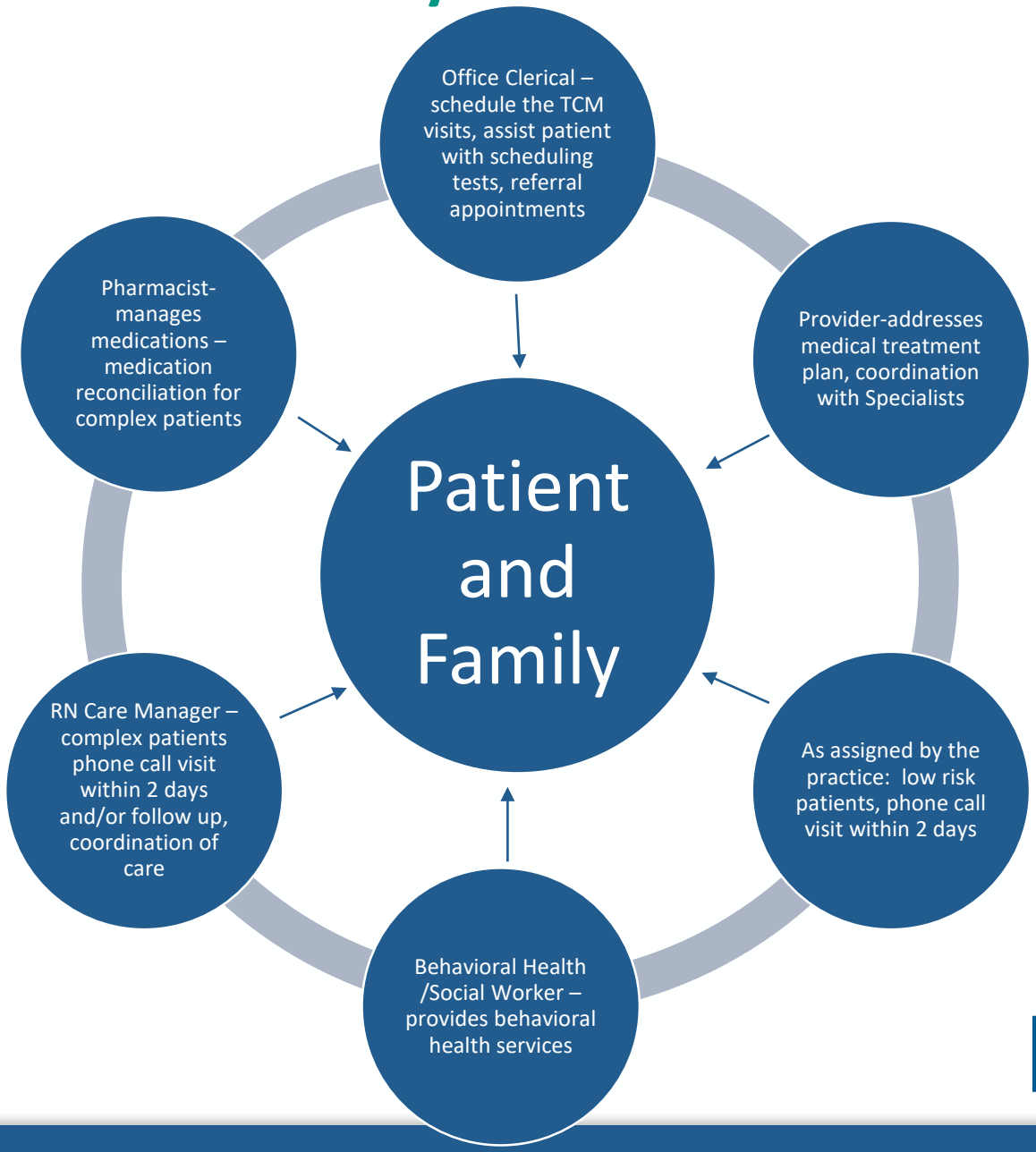
Avoid hospital readmission

Patient and family's experience and satisfaction with care received.

Providers have the information they need to understand and bridge care.

Nielsen GA, Bartely A, Coleman E, Resar R, Rutherford P, Souw D, Taylor J. *Transforming Care at the Bedside How-to Guide: Creating an Ideal Transition Home for Patients with Heart Failure.* Cambridge, MA: Institute for Healthcare Improvement; 2008. Available at http://www.ihi.org

# Transition of Care in the Physician Office



# 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 high complexity; 14 calendar days moderate complexity)
- 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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# SDOH – Address during the follow up phone call within 2 days of Discharge, on going

- Patient activity level and functional status
- Availability of appropriate transportation
- Suitability of the patient's home (e.g. cleanliness, stairways, location)
- Patient cognitive status
- Availability of support from care givers/family
- Ability to obtain medications and health care and social services

https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf;jsessionid=15B79538FFD509D36F09E059C4CD6BB2?sequence=1

# Medication Reconciliation - Definition

Medication reconciliation—it is a process of comparing the medications a patient is taking (or should be taking) with newly ordered medications. The comparison addresses duplications, omissions, and interactions, and the need to continue current medications. The types of information that clinicians use to reconcile medications include (among others) medication name, dose, frequency, route, and purpose.  NPSG 2020

**Performing medication reconciliation** at every transition point can **reduce adverse drug events** and **prevent hospital admissions.**

https://www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/2020/npsg_chapter_ahc_jul2020.pdf
https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf?sequence=1

# Medication Reconciliation

- Obtain and/or update information on the medications the patient is currently taking
- Define the types of medication information (for example, name, dose, route, frequency, purpose) to be collected in different settings.
- Compare the medication information the patient brought with the medications ordered for the patient in order to identify and resolve discrepancies.
- Provide the patient (or family as needed) with written information on the medications the patient should be taking at the end of the visit.
- Explain the new list to the patient and communicate with health care professionals.



https://www.jointcommission.org/standards/national-patient-safety-goals/ambulatory-health-care-2020-national-patient-safety-goals/

# Patients have a *Key* Role in Medication Reconciliation

Educate Patients about:

- Bringing a medication list to the physician office visits.
  - May include bringing a bag of all medications they are taking
- Updating their own list when medications are discontinued, doses are changed, or new medications (including OTC medications) are added.
- Carrying their medication information at all times in case of an emergency.

Patients need to be **fully engaged** and **empowered** to advocate for themselves in the medication reconciliation process.

Gleason KM, Brake H, Agramonte V, Perfetti C. Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation. (Prepared by the Island Peer Review Organization, Inc., under Contract No. HHSA2902009000 13C.) AHRQ Publication No. 11(12)- 0059. Rockville, MD: Agency for Healthcare Research and Quality. Revised August 2012.

# Transition of Care

## Billing Codes for Practices Delivering TOC Services

# Reimbursement for TOC services - 99495 and 99496

- Reimbursement for services provided to patients whose medical and/or psychosocial problems require ***moderate*** or ***high*** complexity medical decision making during transitions.

- Terminology:  TOC services = for coding/billing this is referred to as Transitional Care Management (TCM).

- CPT guidance may vary from payer reporting guidelines, so it is important to check each payer's policies.

# Considerations for TCM Billing

Select the appropriate code for TCM billing:

**Moderate Complexity TCM**
- CPT code: 99495
- The visit must be completed within 14 calendar days of discharge

**High Complexity TCM**
- CPT code: 99496
- The visit must be completed within 7 calendar days of discharge

- TCM code selection based on patient's complexity level, determined by the provider
- Billed once per patient within 30 days after discharge
- May only be reported by one medical provider

**Availability of Telemedicine visits**

- TCM code 99495 or 99496 may be applied to a telemedicine TCM visit

# 99495 Transitional Care Management Services

- 99495 TCM with moderate medical decision complexity with a face-to-face visit within 14 calendar days of discharge.
- 99495 required elements:

**Communication** (direct contact, telephone, electronic) with the patient and/or caregiver within two 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.

# 99496 Transitional Care Management Services

- 99496 TCM with high medical decision complexity with a face-to-face visit within seven calendar days of discharge.
- 99496 required elements:

**Communication** (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge.

**Medical decision making** of **high** complexity during the service period.

**Face-to-face visit** within **seven calendar days** of discharge.

# TCM Outreach Visit to Patients within Two Business Days

**The TCM outreach visit within 2 business days of patient discharge***

- Based on the patient' needs, this phone/electronic visit includes:
- Caregiver education to family or patient, addressing independent living and self-management
- Communication with patient and all caregivers and professionals regarding care
- Determining which community and health resources would benefit the patient
- Providing communication with home health and other patient utilized services
- Support for treatment and medication adherence
- The facilitation of services and care

*CMS requires 2 attempts within 2 business days of patient discharge and to continue.

# In Summary

Identified Key Elements of Transitions of Care

Identified Role of the Physician Office Team Members in Providing Transitions of Care Services

# Next Steps to Complete the TOC Module

After viewing this recorded webinar:

- Complete the Transition of Care case study,
- Access the TOC Module evaluation on the www.micmt-care.org website:
  - Complete the Transition of Care evaluation and select the certificate type you would like to receive.
  - The certificate will be generated and in your MICMT dashboard once you complete the above steps.

# References


- Gleason KM, Brake H, Agramonte V, Perfetti C. Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation. (Prepared by the Island Peer Review Organization, Inc., under Contract No. HHSA2902009000 13C.) AHRQ Publication No. 11(12)- 0059. Rockville, MD: Agency for Healthcare Research and Quality. Revised August 2012.
- The Joint Commission. (2020). National patient safety goals. Retrieved from https://www.jointcommission.org/standards/national-patient-safety-goals/ambulatory-health-care-2020-national-patient-safety-goals/
- Schnipper, J. L., & Labonville, S. (2016). Medication reconciliation in ambulatory care: A work in progress. American Journal of Health-System Pharmacy, 73(22), 1813-1814. doi:10.2146/ajhp160672
- Guide to Reducing Disparities in Readmissions. https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/OMH_Readmissions_Guide.pdf
- Transitions of Care: Technical Series on Safer Primary Care. Geneva: World Health Organization; 2016. License: CC BY-NC-SA 3.0 IGO.

# Resources/Toolkits

Schall M, Coleman E, Rutherford P, Taylor J. How-to Guide: Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Re-hospitalizations. Cambridge, MA: Institute for Healthcare Improvement; June 2013. Available at www.IHI.org.

Nielsen GA, Bartely A, Coleman E, Resar R, Rutherford P, Souw D, Taylor J. *Transforming Care at the Bedside How-to Guide: Creating an Ideal Transition Home for Patients with Heart Failure.* Cambridge, MA: Institute for Healthcare Improvement; 2008. Available at http://www.ihi.org

Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation, 2012. Retrieved from: https://www.ahrq.gov/sites/default/files/publications/files/match.pdf

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