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Transitional Care Management: Practical Processes for Your Practice

Helping patients safely bridge the gap from acute care to ambulatory care is good for patients and practices too.

Transitional care management (TCM) addresses the safe handoff of a patient from one setting of care to another. Most often this handoff involves a patient moving from an acute, inpatient setting to an outpatient care environment.[1] Patients with chronic conditions, organ system failure, or frailty are at greatest risk during this period. Common causes of patient readmission include communication failures, procedural errors, and unimplemented care plans.[2]

During transitions of care, primary care physicians (PCPs) often encounter care gaps that are beyond their control due to factors such as inaccessible patient records, unclear discharge care plans, or limited effort by others to engage the primary care team or the

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patient and his or her caregivers.

Well-defined protocols can promote coordinated care and safe transitions, but they take time and effort to implement. Recognizing this, the Centers for Medicare & Medicaid Services in 2013 began offering payment to ambulatory care practices for TCM services, which includes contacting patients within 48 hours of their discharge, scheduling an office visit to occur within 7 to 14 days, and discussing the care plan with the patient or caregivers. (See "Transitional care management code requirements.")

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This article describes the process improvements that our practice used to enhance TCM, which led to reduced patient readmissions, improved patient and family experiences, and increased reimbursement.

WHAT LED US TO IMPROVE TCM?

Our all-geriatric medicine practice of five physicians, four nurse practitioners, a clinical pharmacist, a physician assistant, a practice manager, three licensed vocational nurses, a receptionist, a scheduler, two benefit coordinators, and six medical assistants serves a panel of 2,400 patients across 15 counties in south Texas. These patients may be admitted to or discharged from 15 hospitals within five health care systems.

Our practice experienced two significant problems related to transitions of care. One, many of our patients did not attend scheduled office visits after being discharged from the hospital and soon went to the emergency department or were readmitted. Two, our inability to access area hospitals' electronic health record (EHR) systems impeded continuity of care.

In team meetings, we systematically devised a process for addressing these problems. Using process improvement tools (e.g., Pareto charts and root cause analyses) to critique our existing TCM process, we developed insights that led us to make changes in four areas:

1. Education. We realized that many of our patients did not understand the importance of TCM. For patients and their families, we developed materials that emphasized how TCM benefits patients' long-term outcomes and explained why they should inform the practice when the patient goes to the hospital or other acute/post-acute facility, share the primary care physician's contact information with the acute/post-acute facility team, contact the practice the day the patient is discharged, and come to the practice for a visit within 7 to 14 days after discharge. We displayed posters detailing TCM services in patient waiting areas and examination rooms, sent out secure email messages via our patient portal, and distributed colorful flyers to our acute/post-acute facility partners to give to patients upon discharge.

2. Collaboration. We worked with the Office of Professional Services at each of our acute/post-acute facility partners to obtain access to patient discharge summaries and other electronic records for our care managers and key office staff. We have true EHR compatibility with one health system, but with the other systems, designated people in our practice have at least read-only access to patient records. We also met with each facility's hospitalist team to establish collaborative processes for communicating patient discharge needs and summaries. We then met with emergency department physicians to educate them about TCM and the importance of identifying and contacting the patient's primary

KEY POINTS

- Transitional care management (TCM) seeks to ensure that patient care doesn't suffer when the patient transfers from one care setting to another, such as from hospital to home.
- Improving transitional care management involves improving communication between the patient or caregivers, the primary care practice, and the practice's acute/post-acute facility partners.
- Effective, efficient TCM depends on a detailed protocol that instructs physicians and staff how to identify patients needing TCM services, schedule them for appointments within 14 days of discharge, and make sure their medication and other needs are covered.

care team. We gave them the names and contact information for each of our PCPs as well as a back-up telephone number for the practice in case they couldn't contact a PCP. Magnetic cards with TCM information and PCP names and contact information were also distributed to the teams in each facility. During conversations with these partners, we reminded them that Medicare levies financial penalties for excessive patient readmissions and that reducing those readmissions should be everyone's goal.

3. Workflow and protocol. We developed a staff training curriculum that covered the importance of TCM to patients and the practice, as well as how to document and code for TCM services. We emphasized that "discharge" as it relates to TCM may refer to discharge from an inpatient setting such as an acute care hospital, rehabilitation hospital, long-term acute hospital, or skilled nursing facility, even if the stay was just for observation, as well as from a partial hospital program, such as those treating mental health or substance abuse disorders, where the patient spends the day at the treatment center and the night at home. Discharge from these settings may necessitate the handoff of medical crisis management, a change in therapy, or management of a new diagnosis, and the practice must provide medication reconciliation and new or ongoing specialist consultation.

We also created a TCM protocol that established a workflow and assigned roles and responsibilities to all team members in our practice. We trained our staff and clinicians during regularly scheduled team meetings to use the protocol and reinforced its proper use in daily huddles. Here's how it works:

• We designate a TCM patient coordinator each day from a pool of staff members who have been trained to address TCM needs. This person could be a care manager or, in our case, a licensed vocational nurse or registered nurse.

• When one of our patients has been or is about to be discharged, the acute/post-acute facility partner alerts the practice using a phone number or email address designated for this purpose. The message typically includes specifics such as how soon the patient needs to be seen. The TCM patient coordinator monitors these messages to identify next steps and has access to the hospital notes and discharge summary for additional details if needed.

• The coordinator contacts the patient, family, or caregiver within 48 hours to verify the patient was discharged and the plan of care. To guide these conversations, we use an EHR template similar to this one in the *FPM* Toolbox (https://www.aafp.org/fpm/2013/0500/fpm20130500p12-rt1.pdf). The coordinator schedules a face-to-face appointment to occur within 72 hours, one week, or two weeks, depending on the patient's needs.

• The practice also receives daily emails from various payers and acute/post-acute facilities listing admitted patients. This facilitates tracking and close follow-up.

• Most TCM visits are performed by our nurse practitioner, who reviews the patients' discharge needs prior to the visit. If the patient does want to see the PCP, we make sure that happens by either overbooking appointments or opening a new slot.

• After the TCM visit, a follow-up visit is scheduled based on patient acuity, either with the nurse practitioner for continuity or the PCP.

• If the patient doesn't come to the TCM visit, the coordinator calls the same day to find out why and reschedule as soon as

TRANSITIONAL CARE MANAGEMENT CODE REQUIREMENTS

The CPT codes for transitional care management require one face-to-face visit, certain non-face-to-face services, and medication reconciliation and management during the 30-day service period.

Code 99495 has the following requirements:

- Communication (direct contact, telephone, or electronic) with the patient or caregiver within two business days of discharge,
- Medical decision making of at least moderate complexity during the service period,
- A face-to-face visit within 14 days of discharge.

Code 99496 has the following requirements:

- Communication (direct contact, telephone, or electronic) with the patient or caregiver within two business days of discharge,
- Medical decision making of high complexity during the service period,
- A face-to-face visit within seven days of discharge.

possible. We try to avoid missed appointments by sending a reminder email or phone call a day before the visit.

4. Technology. We worked with our information technology team to develop TCM templates in our EHR that physicians and staff can use at various steps in the process. For example, during the initial communication with a patient or caregiver after discharge, the template reminds us to ask about updated medication or durable medical equipment, home health needs, pending lab tests, consultations, care goals, how soon the patient needs to be seen, and any tests needed before the TCM visit.

BENEFITS AND COSTS

We piloted our TCM approach with one hospital system in 2013 and evaluated its effectiveness by tracking patient attendance at TCM visits. We then correlated that attendance with patient outcomes. Here's what we found:

- Patient attendance at TCM visits increased from 20 percent in 2014 to 90 percent in 2016. This 90-percent rate has remained consistent. For patients transitioning from rehabilitation facilities, the TCM visit rate improved even more, increasing to around 96 percent. This was due to parallel improvements we made for handling senior care.
- Readmissions decreased from 7 percent in 2013 to 3.2 percent in 2014 and have remained at this level.
- Patients have shared many positive comments about TCM visits. At about the time we began our TCM improvements, we started using patient experience surveys. Our rating is 4.9 out of 5.

These benefits have not been without cost or effort, however. In our experience, practices face at least two potential challenges in implementing a TCM protocol. The first is resistance to change by some patients, staff, and acute/post-acute facility partners. The best way to overcome this is to engage all of these groups while developing the protocol, explain to partners how the protocol benefits them as well as patients, provide in-service training for staff, and recognize individual efforts by patients, practice staff, and partners.

Second, it takes considerable time to create the protocol and implement it. We estimate we spent at least 500 hours in weekly meetings and daily huddles to develop, refine, and sustain our present TCM protocol. By following our example, practices could invest less time. Once the protocol is created, the practice will spend additional time communicating with patients and partners about TCM, obtaining and reviewing patient records, and conducting the face-to-face visits with patients.

Although TCM requires a significant time investment, it will benefit your patients, partners, and practice by improving patient outcomes and experiences, reducing costs, and improving quality of care. These benefits may also help your practice obtain more favorable contracts. We have received value-based contracts from three payers because of our TCM approach.

We did not do a formal cost-benefit analysis, but we believe the positive outcomes of our TCM approach have more than compensated us for the time we invested in establishing it. The reimbursement and work relative value units (wRVUs) generated by TCM codes have certainly been higher than for our regular office visits.

PUTTING IT ALL TOGETHER

Integrating a TCM process into your primary care clinic takes work. You can achieve it by engaging with your acute/post-acute facility partners' leadership and formalizing partnerships with those facilities, leveraging your local health system's strengths and shared resources, writing protocols that define TCM processes, cross-training team members in your practice, and educating patients and caregivers. This effort will achieve a comprehensive TCM program that improves patient outcomes, reduces readmissions, and enhances the quality and safety of patient care. FPM

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