

TRANSITIONAL CARE MANAGEMENT RESOURCE GUIDE

NORTH CENTRAL ACCOUNTABLE COMMUNITY OF HEALTH

NCACH TRANSITIONAL CARE MANAGEMENT – RESOURCE GUIDE

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Introduction:

The North Central Accountable Community of Health Transitional Care and Diversion Intervention Workgroup has identified the regional Transitional Care Management Model (adopted by Confluence Health) as the approach we will implement across the region specific to Transitional Care. The attached document provides details on the model and outlines how organizations can engage in developing a regional Transitional Care Management process as part of the Medicaid Transformation Project.

Model Selected:

Transitional Care Management (As adapted by Confluence Health)

Summary of Model:

Prior to discharge, hospital staff organize follow-up services and address patients' financial and psychosocial barriers to receiving needed care, drawing on community resources as needed. The bedside RN and inpatient case manager discuss instructions with the patient. The patient is sent home with written material that has all of this included on it in addition to a patient-specific summary of the visit. That document is called an AVS (After Visit Summary). The AVS summary is also used by the transitional care management RN's (TCM-RN) who make the post discharge hospital follow up phone call.

The TCM-RN makes a 24-48 hour (2 business days) post hospital discharge phone call that affirms that the patient has a follow up appointment with their PCP, medication review, if they have all of their post hospital services arranged i.e.: DME, O2, HH/Hospice, and or caregiver help. Any problems are evaluated and directed to the appropriate resource. Patients are instructed to call their provider for certain symptoms or seek immediate medical attention based on severity of symptoms.

The TCM-RN identifies patients from a daily discharge report excluding discharged to hospice, assisted/skilled nursing facility, patients who left AMA, discharged to another facility, patients receiving hemodialysis, or those that are in another case-managed program. Patients who have a follow-up appointment the day after discharge are not called.

A prompt follow-up visit with their outpatient provider provides follow-up care, ongoing symptom and medication management and continuous access for the 30 day post-discharge period.

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Target Population:

Patients discharged from inpatient hospital care to home or supportive housing.

Target Measures For Transitional Care Models:

- Increase in follow-up post hospitalization physician/mid-level visits all patient's
- Decrease in unnecessary Inpatient Hospital Utilization
- Decrease in unnecessary Outpatient Emergency Department Visits
- Decrease in All-Cause Hospital Readmission Rate (30 Days)

Implementation partners may develop additional measures specific to their region.

Transitional Care Models Reporting Requirements:

1. NCACH will require periodic written and verbal reports from implementation partners. Those reports will include:
 - a. Business plan outlining implementation plans for TCM in their organization
 - b. Target Measures the organization will track and provide to NCACH to help in program evaluation across the region.
 - c. Partners will be required to submit written reports electronically through an online portal.
2. Reporting requirements will be detailed in Memorandums of Understanding between the NCACH and each partner.
3. TCM partners will be expected to share with other hospital partners every other month on progress of implementation, best practices, and other potential issues.

Eligibility:

- Initial Pilot Partners in 2018: Hospitals with an annual Medicaid Discharge of >200 beneficiaries a year or have a current TCM program in place
- Partners who could join in 2019: All other hospital organizations with a Medicaid discharge of <200 beneficiaries a year

Funding Identifications:

Approximate funding to implement the transitional care model for organizations will be \$35,000 over the course of implementation. This funding will cover the cost of staff time to implement the work and the cost to ensure the system is integrated into your organizations.

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What is Transitional Care Management?

- Transitional Care Management (TCM) provides telephone discharge follow-up calls to patients discharged from the hospital setting. A brief review of symptoms, medication changes and follow-up care is discussed during this telephone call. The RN making TCM call then enters telephone note into the electronic medical record and forwards the note to the PCP.
- If a patient meets criteria for TCM, the provider who provides the hospital follow-up appointment with the patient may bill a TCM code which includes reimbursement for non-face-to-face services provided by staff. See criteria below for more information on who qualifies for TCM (Note: Medicaid does not accept billing codes at this time).

Criteria for TCM

- It is recommended that only Primary Care bill for TCM services, as whoever bills this code has to be willing to be responsible for all of the patient's medical conditions as well as psychosocial needs for 30 days post discharge
- No call is needed to be placed by TCM staff if the patient is seen by their provider for a hospital follow up office visit within 2 business days of discharge. The provider may bill for TCM without a call being made in this circumstance. TCM monitors the patient via the EMR to confirm they attend the appt. If they do not attend, the TCM call is made to the patient.
- Moderate risk patients must be seen by provider within 14 days (high risk patients should be seen within 7 days) of discharge for a **hospital f/u visit** (day of discharge is day #1 and this includes weekends.)

The patient would NOT qualify for TCM billing reimbursement if any one of the following is present:

- Patients receiving hemodialysis
- OB Patients
- Patients discharged to skilled nursing (Assisted living and AFH **DO** qualify for TCM)
- Patients discharged on hospice
- Pediatric patients
- Patients within a post-operative global period, if not medically necessary

NOTE: If a patient is re-admitted to the hospital before follow up appointment, no call will be made. A TCM attempt will be made at subsequent discharge from the hospital. TCM staff will attempt to call patients who don't qualify for TCM call, such as surgical bundle patients or patients with a f/u within 2 days of discharge, if time permits.

Hospital Discharge Follow Up: (TCM WORKFLOW)

1. A daily report of hospital discharges will be sent to the TCM staff. All patients will receive a TCM call within 2 business days of discharge with the exception of patients listed in number 4 below.
2. After review of available hospital & EMR documentation, the Hospital Discharge Follow Up call will be made using the TCM template and entered into the EMR using the category of TCM (code 402) in the **Telephone Call** note.
 - a. The note will be routed to the Provider that will be seeing the patient for the hospital follow up visit along with the following message: The TCM call has been completed, the hospital follow up visit may qualify for a “moderate complexity visit code of 99495” or a “high complexity visit code of 99496”.
3. The TCM tool will prompt the reviewer to confirm or coordinate a follow up visit with the PCP. A patient with moderate medical decision complexity needs a follow up appointment with the PCP within 14 days of discharge, and a patient with high medical decision complexity needs an appointment with the PCP within 7 days of discharge. A follow up visit can be made with an MD, Physician Assistant or a Nurse Practitioner.
4. TCM will not call patients who are:
 - a. Discharged to a SNF, Assisted Living, Acute Inpatient Rehab, or another transfer to an Acute Inpatient Facility
 - b. Home with Hospice
 - c. Jail
 - d. If the patient leaves AMA
 - e. Observation status patients
 - f. Patients who have expired
 - g. Mother/baby
 - h. Patient who are seen by the provider’s office within two business days of discharge and a note reflecting this will be made in the EPIC record.
 - i. If the discharge documentation is unavailable. This will be documented in the medical record.

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RISK LEVEL	Presenting Problems	Diagnostic Procedures	Management Options Selected
<p>High Risk</p> <p>Requires any ONE of these elements in ANY of the three categories listed</p>	<ul style="list-style-type: none"> • One or more chronic illness, with severe exacerbation or progression • Acute or chronic illness or injury, which poses a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolism, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness, with potential threat to self or others, peritonitis, ARF • An abrupt change in neurological status, e.g., seizure, TIA, weakness, sensory loss 	<ul style="list-style-type: none"> • Cardiovascular imaging, with contrast, with identified risk factors • Cardiac EP studies • Diagnostic endoscopies, with identified risk factors • Discography 	<ul style="list-style-type: none"> • Elective major surgery (open, percutaneous, endoscopic), with identified risk factors • Emergency major surgery (open, percutaneous, endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate, or to de-escalate care because of poor prognosis

5. Every attempt will be made to initiate the initial follow up call with patient contact within two (2) business days of patient's discharge date.
6. Any problems or concerns that arise during the TCM initial follow up call will be directed to the discharging provider or PCP for follow up via EMR for internal PCP and for external PCP print your note and fax it to the appropriate office.

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TRANSITIONAL CARE MANAGEMENT DISCHARGE FOLLOW-UP

Discharge Unit/Location: ***

Discharge Date: ***

Discharging Provider: ***

Primary Discharge Diagnosis/Diagnoses: ***

Does the patient have help at home?: ***

Patient status post discharge: ***

Medication Questions or Concerns: ***

Follow-up appointments: ***

Services arranged at discharge (DME, O2, HH/Hospice):

- ***
-

Patient has been instructed to call their provider if:

- ***

Patient has been instructed to seek immediate medical attention for the following symptoms:

- SEVERE CHEST PAIN
- SEVERE SHORTNESS OF BREATH
- FEVER > 101.5 THAT IS NOT RELIEVED BY MEDICATION
- RAPIDLY WORSENING SYMPTOMS

Transitional Care interactive contact is complete.

TRANSITIONAL CARE MANAGEMENT
 Patient Safety Issue Form

Patient Name: <input style="width: 90%;" type="text"/>	EPIC MRN: <input style="width: 90%;" type="text"/>	
Discharge Date: <input style="width: 90%;" type="text"/>	Discharging Provider: <input style="width: 90%;" type="text"/>	
Department: <input style="width: 90%;" type="text" value="Dept/Unit"/>	Length of Stay: <input style="width: 20%;" type="text"/> day(s)	Submitted by: <input style="width: 90%;" type="text" value="Employee"/>
Safety Issue(s): <input style="width: 95%;" type="text" value="AVS Issue - See Notes Below"/>		
Notes: <input style="width: 95%;" type="text"/>		

These are the categories into which the safety issues are placed. They display in a drop down list in the form.

- AVS Issue - See Notes Below
- DISCHARGE DISPOSITION - Incorrect
- DME - Not Ordered
- DME - Other, See Notes Below
- FOLLOW UP - Not Scheduled
- FOLLOW UP - Not Scheduled Correctly
- FOLLOW UP - Other, See Notes Below
- HOME HEALTH - Other, See Notes Below
- HOME HEALTH - Not Notified of Prescription
- HOME HEALTH - Not Notified of Prescription Change
- MED LIST - Conflicting
- MED LIST - Confusing
- MED LIST - Incomplete
- MED LIST - Incorrect
- MED LIST - Other, See Notes Below
- MULTIPLE ISSUES - See Notes Below
- OTHER SAFETY ISSUE - See Notes Below
- PHYSICIAN DISCHARGE SUMMARY - Conflicting
- PHYSICIAN DISCHARGE SUMMARY - Incorrect
- PHYSICIAN DISCHARGE SUMMARY-Other, See Notes
- PRESCRIPTION - Not Given to Patient
- PRESCRIPTION - Not Sent to Pharmacy
- PRESCRIPTION - Prior Auth Issue
- PRESCRIPTION - Other, See Notes Below

Case Management Initial Assessment

Patient main health concern is: ***

How do symptoms interfere with your life? ***

What has helped in the past? ***

Are you able to manage finances, shop, prepare meals, household chores, grooming, and hygiene?
Who helps you with any of this? Do you use adaptive equipment? (Walker, reacher, shower bench,
oxygen) ***

Do you have any vision, hearing, learning or communicating problems? ***

Can you identify strengths and supports in your life? (such as education, employment, family, friends,
children, or spirituality) ***

Who is part of your health care team? (such as social worker, neurology, behavioral health, support
people, cardiology, etc.) ***

Can you tell me about your healthy habits? (exercise, alcohol, drugs, tobacco) How did you establish
this habit? What motivates you to continue to do this? ***

What habits do you need to improve and are you interested on working on them now? If not, why
not? What is interfering with making these changes? On a scale of 1 – 10 how motivated are you in
making a lifestyle change? ***

What can you tell me about your medications? Do you know what you take, including time, dose, and
purpose of medications? Do you have trouble affording your medications? How do you take your
medications? (pharmacy filled medication box, bubble pack, medication box) ***

Do you have any other issues we have not discussed such as advanced care planning, legal issues,
trauma/abuse, financial, preventative screenings, vaccinations, falls, ? ***

Goal: ***

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CH Tiering Tool for Case Management Services Eligibility

Chronic condition is defined as a condition that lasts longer than six months or may recur.

Severe condition is defined as a major, potentially unstable condition that, without optimal care, is likely to worsen or lead to more serious problems resulting in severe illness and/or impairment.

Referral from: ***

Referral regarding: ***

1. List patient's severe or chronic conditions: ***
2. Has patient been admitted to the hospital 2 or more times in the past year? ***
 - A) If yes, how many and length of stay:***
3. Has patient been seen in the ER 2 or more times in the past 6 months? ***
 - A) If yes, how many visits and was patient admitted to the hospital: ***
4. Has patient been seen in the WIC 3 or more times in the past 6 months? ***
 - A) If yes, how many? ***
5. Does the patient take more than 6 prescriptions? ***
 - A) If yes, how many? ***
6. Is the patient advanced in age (over 75 years) and frail? ***
7. Does the patient have cognitive impairment or a mental health diagnosis? ***
8. Are there concerns with the patient/ caregiver's ability to meet patient needs? ***
9. Is the patient using a high level of resources, medications, visits, treatments, phone calls or community resources? ***
10. Is the patient's social support inadequate? ***

Scoring: Each yes is worth one point. Each chronic condition is worth one point up to total of 4.

0 - 3 = Case Management not indicated

4 - 6 = Chart review only

7+ = Active Case Management

Score: ***

Plan/ Case Management Indicated? ***

Type (Active/Chart Review/None)? ***

Additional Review:

Recent Skilled Nursing Facility admission? ***

2 or more missed/canceled appointments in last 3 mos? ***

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Preventative/Health Maintenance up to date? ***

Last PCP visit? ***

Scheduled appointments? ***

Caregiver Authorization on file? ***

Additional Information: ***

Conclusion/Plan of Care: ***

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Pediatric Case Management Initial Assessment

Childs Name: ***

Legal Guardians: ***

Guardian's phone numbers: ***

Primary language of guardian: ***

School child attends: ***

IEP or 504 Plan: ***

Where does child live? ***

Who does child live with? ***

Stable housing? ***

PCP: ***

Main health concerns: ***

Specialists: ***

Dentist name and last visit: ***

OT/PT/ST: ***

DME provider: ***

Vision loss: ***

Hearing Loss: ***

Behavioral Health: past or present ***

Suicide attempts: ***

Medical Equipment: ***

Alcohol, tobacco, substance abuse: ***

Adequate financial sources ***

Guardian disabled? ***

Reliable transportation? ***

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ACES:

Emotional abuse: ***

Emotional neglect: ***

Physical neglect: ***

Physical abuse: ***

Sexual abuse: ***

Household substance abuse: ***

Mother treated violently: ***

Household mental illness: ***

Divorce: ***

Incarceration: ***

Pediatric Tiering Tool for Case Management Services

Referral from: ***

Reason for referral: ***

- 1) Does the patient have a severe or chronic condition? ***
 - If yes, please list: ***
- 2) Has the patient ever been diagnosed with breathing problems? ***
- 3) Two or more inappropriate ER visits in the last 12 months: ***
- 4) Number of WIC visits in last 12 months: ***
- 5) Number of hospitalizations in the last 12 months: ***
- 6) Number of provider visits in the last 12 months: ***
- 7) Does the child take medication regularly? ***
 - If yes, number and names: ***
- 8) Does the child have any cognitive impairment or a mental health diagnosis? ***
- 9) Are there any concerns with the parent/caregiver ability to meet the child's needs? ***
- 10) Is the child/parent/caregiver unable to comply with the treatment plan, including medications? ***
- 11) Is the patient using a high level of resources, medications, visits, treatments, phone calls or community resources? ***

Scoring: Each question is worth one point and each chronic condition is worth one point , up to a total of 4 points.

0-3= Case Management not indicated

4-6= Chart review only

7+= Active Case Management

Score: ***

Plan/ Case Management Indicated? ***

Type: ***

Additional Review:

Missed appointments in the last 12 months? ***

Preventative/ Health Maintenance up-to-date? ***

Specialty clinic visits up-to-date? ***

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Last PCP visit? ***

Scheduled appointments? ***

Additional Information:

Conclusion/ Plan of Care:

If contacted, Case Management services explained to patient/parent?

Patient/Parent accepted or declined?

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Comparison of Transitional Care Management and Case Management Services

Activity	TCM	CM	Frequency
Preparation for transition within a multidisciplinary team	Prior to discharge, hospital staff organize follow-up services and address patients' financial and psychosocial barriers to receiving needed care, drawing on community resources as needed.	The Inpatient RN-CM (IPCM) actively participates in discharge rounds and reports necessary findings to the Outpatient RN-CM (OPCM).	Daily
Identifying patients to participate	Identifies Non-Managed Care Discharged Patients from a daily discharge report excluding discharged to hospice, assisted/skilled nursing facility or patients receiving hemodialysis. Patients who have a follow-up appointment the day after discharge are not called.	Case Managed patient care panels RNCM's manage patients who have one or more of 12 identified chronic conditions, as well as social determinants of health that negatively impact their wellness.	Daily
Individual meeting with patient prior to discharge	Prior to discharge the IPCM and the bedside RN discusses instructions with the patient. The patient is also send home with written material that has all of this included on it. That document is called an AVS (After Visit Summary). The AVS summary is also used by the TCM RN's who make the post discharge hospital follow up phone call.	Prior to discharge the IPCM and the bedside RN discusses instructions with the patient. The patient is also send home with written material that has all of this included on it. That document is called an AVS (After Visit Summary). The AVS summary is also used by the OPCM who makes the post discharge hospital follow up phone call.	One time, prior to discharge
Post discharge phone call	Transitional Care Nurse post discharge phone call affirms that the patient has a follow up appointment with their PCP, medication review, if they have all of their post hospital services arranged i.e.: DME, O2, HH/Hospice, AFH/ALF, and or caregiver help. Any problems identified will be worked on and then directed to the PCP's office.	OPCM post discharge phone call affirms that the patient has a follow up appointment with their PCP, medication review, if they have all of their post hospital services arranged i.e.: DME, O2, HH/Hospice, AFH/ALF, and or caregiver help. Any problems identified will be worked on and then directed to the PCP's office.	CH-TCM: One time, 24-48 hours post-discharge C-TRAC: One time, 48-72 hours post-discharge
Weekly follow-up	N/A	OPCM calls each participant weekly for four weeks	Weekly
Transition to active case management or discharge status	N/A	At the completion of these phone calls the OPCM will assess using the tiering tool to transition the patient to either active case management or discharge status.	At completion of four Weekly follow-up calls

Descriptions of various Care Coordination Services

Transitions of Care Management:

A service provided to all patients who are discharged from the Hospital. This work can either be done with the inpatient or outpatient department. If done in the outpatient, PCP offices can receive discharge lists from local hospitals to notify them when their patients have left their facility.

Clinical Case Management:

Organizations may have two types of Case Management

- Inpatient Case Management evaluate patients while they are hospitalized. Patients are assessed for discharge needs Care plans are put in place to meet those needs. This is an episodic type of care with no ongoing contact with the patient.
- Outpatient Case Management patients are referred from a variety of sources, including ED, providers, inpatient case managers, office staff, etc. Case managers assess and develop an individualized care plan with the patient and their support person/family which will help to facilitate the health and wellbeing of the patient as they continue living in their home. Case Management may follow these patient's for a period of time or indefinitely.

Health Homes:

A program focused on Medicaid patients with a PRISM score of > 1.5. RNs act as care coordinators and the state has a very structured program with strict guidelines and documentation requirements which they follow. Patients have the right to decline to participate, but the goal is to keep the patients out of the ED. The program continues until the patient meets the goals they have set, they decide they no longer want to participate or their insurance changes. Patients typically have multiple co-morbidities and social determinates of care that prevent them from being successful in their healthcare.