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# Inpatient to Outpatient Transitions of Care

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# Objectives

- Define transition of care (TOC)
- Summarize the impact of poor care transitions
- Explain the requirements for billing for Transitional Care Management (TCM) programs
- Interpret outcomes from TCM programs conducted at Akron General Medical Center

**“The scenario in which a patient moves from one care setting to another”**

# Cost of poor care transitions

**34,500 patients discharged and readmitted on the same day in 1996-1997**

**Cost = \$226 million**

# Cost of poor care transitions

**20% of Medicare hospitalizations followed by readmission within 30 days in 2003-2004**

**~50% had no physician visit before readmission**

# Cost of poor care transitions

**19% of Medicare discharges followed by adverse event within 30 days**

**66% were drug-related**

# Cost of poor care transitions

Potential for cost savings by preventing unplanned readmissions

**\$17.4 billion**

# Cost of poor care transitions

**A decrease in diabetes medication adherence results in a 58% increase in hospitalizations**

**...and an 81% increase in all-cause mortality**



# What can we do?

- Improve care transitions!
  - Time-consuming
  - Labor-intensive
  - May require significant resources
- Billing codes for Transitional Care Management programs developed



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# Transitional Care Management (TCM) requirements

# Who qualifies?

- Patients discharged from inpatient facility...
  - Inpatient acute care/psych hospital
  - SNF, ECF, rehab, LTAC
  - Partial hospitalization/Observation
- ...to a community setting
  - Home
  - Assisted living

# Components of a TCM visit

- Interactive contact
  - Within 2 business days of leaving facility
  - Phone, electronic, face-to-face
- Non face-to-face services
- Face-to-face visit
  - Time span depends on acuity
  - 99495 vs. 99496

# Interactive contact

- May be initiated by any member of staff
  - May require provider involvement
- At least 2 additional attempts in first 2 days
  - Must directly exchange information
  - May not bill if attempts not made
- Assess need for non face-to-face services

# Non face-to-face services

- Review discharge information
- Follow up on needed tests/procedures
- Provide education to patient/caregiver
- Establish referrals/community services
- Schedule follow-up with other providers
- Assess treatment adherence

# Face-to-face visit

- Requires documentation:
  - Date of facility discharge
  - Date of interactive contact
  - Date of face-to-face visit
- Medical complexity
  - Moderate = 99495
  - High = 99496

# 99495 vs. 99496

	99495	99496
Medical complexity	Moderate	High
Time from D/C to visit	14 days	7 days
Approx. charge	\$160	\$230





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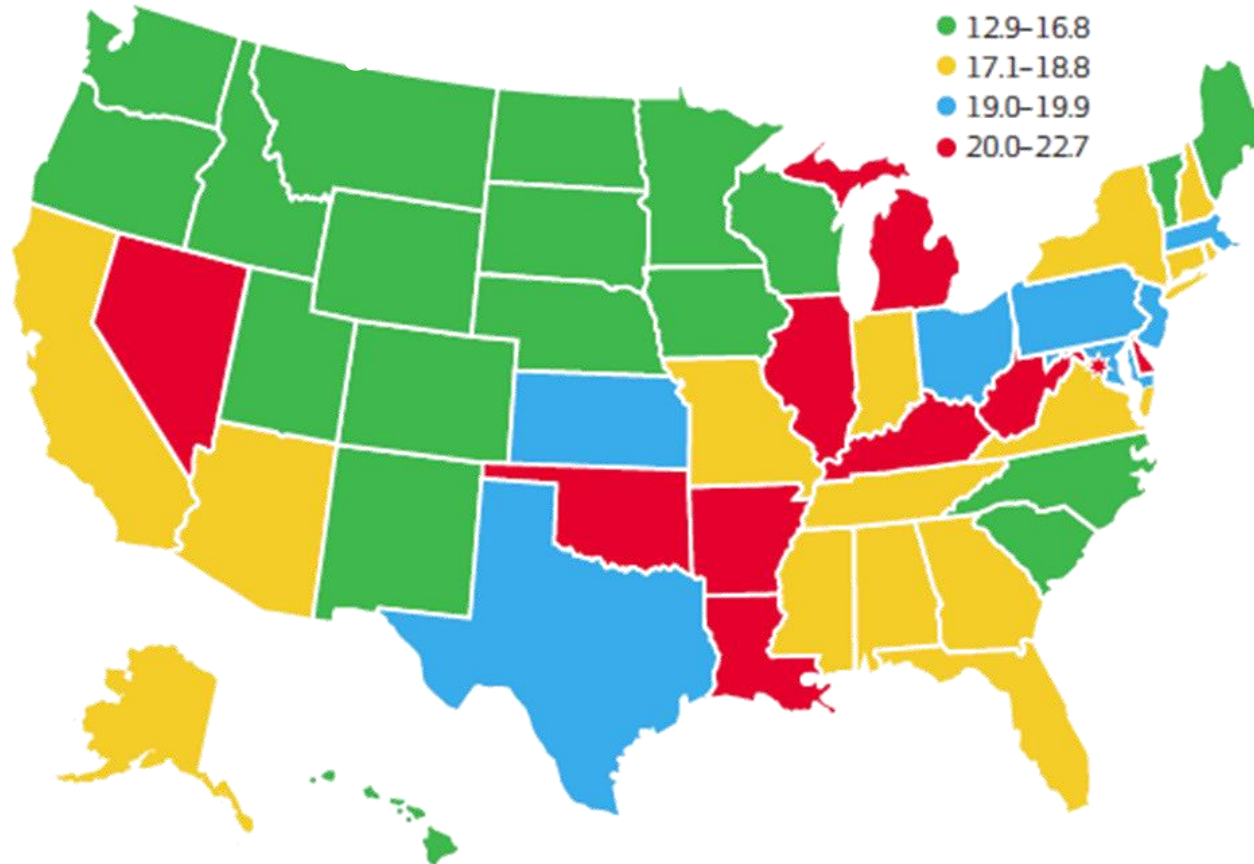
# Practice examples at Akron General Medical Center

# Akron General Medical Center

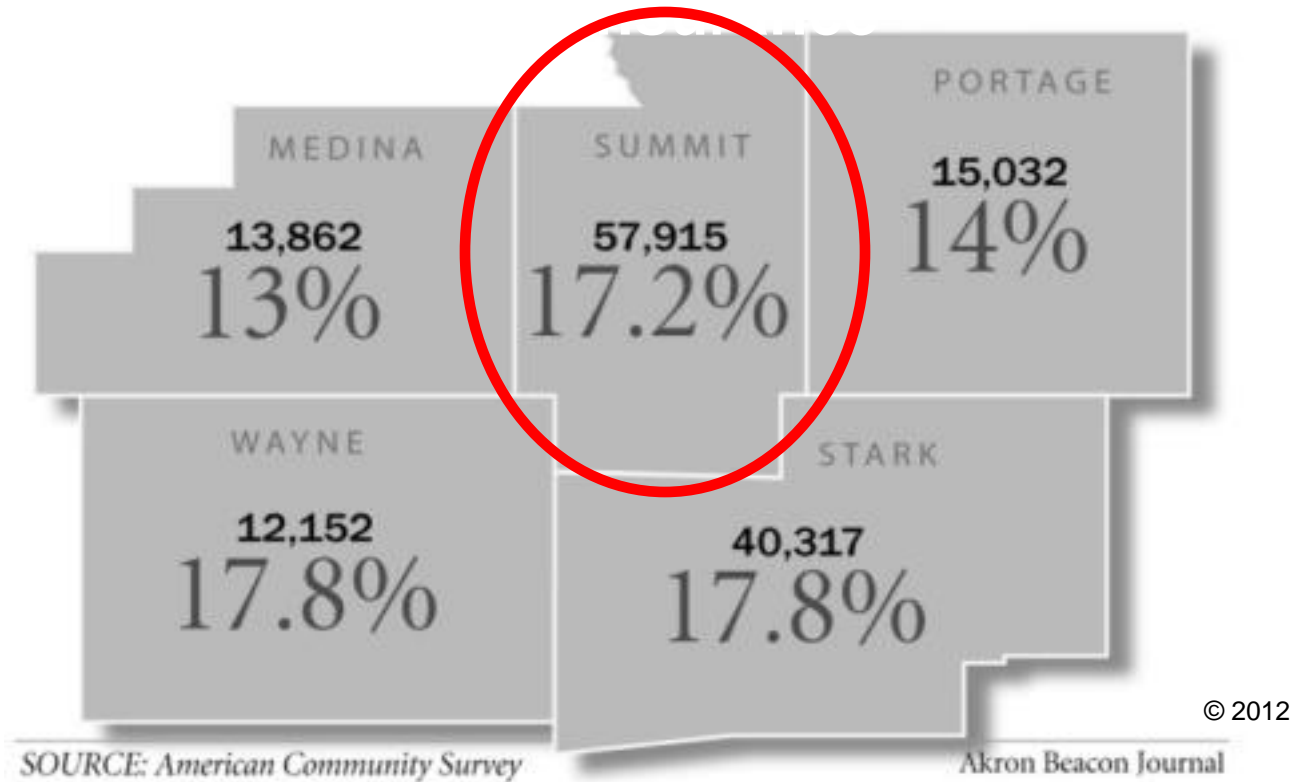
- 511 adult-bed teaching hospital
  - Affiliated with Northeast Ohio Medical University
- Significant proportion of admissions for underserved patients



# Hospital readmissions



# Local Ohioans uninsured





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# Diabetes Management Team

# Identified metrics

- Decrease LOS by at least 0.5 days
  - No glucose requirements for discharge
- Achieve better glycemic control
  - Improved control earlier during admission
- Reduce rate of DM-related admissions by 25%

# Team organization

Endocrinologist

Pharmacotherapy specialist

Diabetes educators (RN, CDE)

Registered dietitians

# Team functions

- Comprehensive patient assessment
- Survival skill education
  - Advanced education (i.e., carb counting)
- Medication management
  - Inpatient insulin pump management
- Daily follow-up
- Follow-up at transitional care clinic
  - “Bridge” clinic



# Typical “Bridge” patients

- New-onset DM
- Patients new to insulin
- No PCP prior to admission
- Anticipated follow-up with endo
- Anticipated change in treatment post-D/C
  - Cardiac surgery
  - Steroids tapered as outpatient

# “Bridge” clinic

- Review of discharge medication list
- Goals of therapy reviewed
- Education/Literature provided
- Medication changes made (if needed)
  - Collaborative practice agreement
- Follow-up plan established
- All information sent to primary care

# Diabetes Transitional Care Clinic

## Progress Note

Patient name: \_\_\_\_\_

DOB: \_\_\_\_\_

Date: \_\_\_\_\_

Primary care physician: \_\_\_\_\_

Last eye exam: \_\_\_\_\_

BG: \_\_\_\_\_ Last Ate: \_\_\_\_\_

Last podiatry exam: \_\_\_\_\_

Most recent HbA1c: \_\_\_\_\_

Self-Management issues addressed:

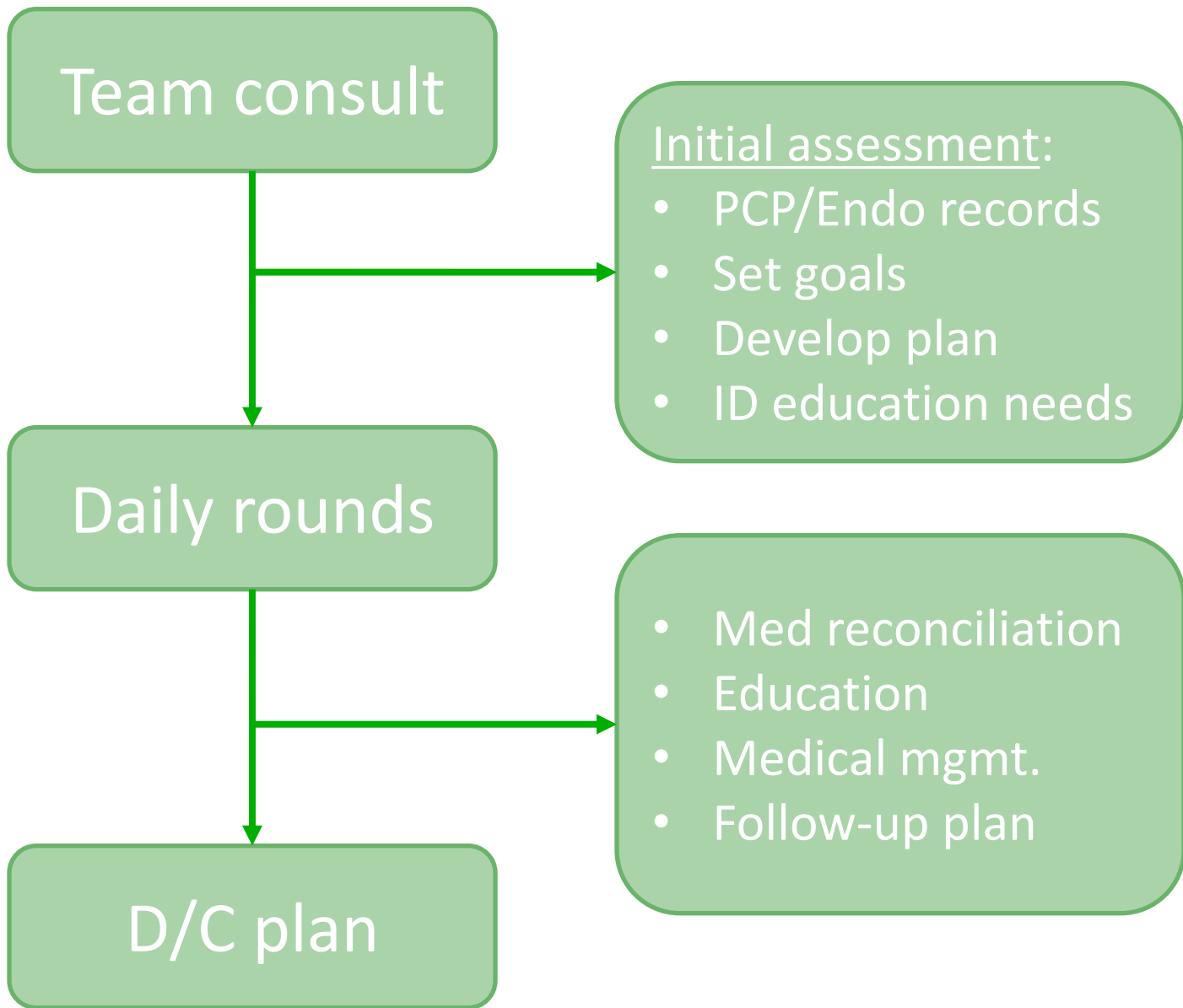
- |  |  |
|--|--|
| <input type="checkbox"/> Glucometer use                      | <input type="checkbox"/> Diet/Meal plan                              |
| <input type="checkbox"/> Insulin self-administration         | <input type="checkbox"/> Use of CHO/insulin ratio (if applicable)    |
| <input type="checkbox"/> Hypoglycemia plan                   | <input type="checkbox"/> Use of correctional insulin (if applicable) |
| <input type="checkbox"/> Understanding of medication regimen | <input type="checkbox"/> _____                                       |

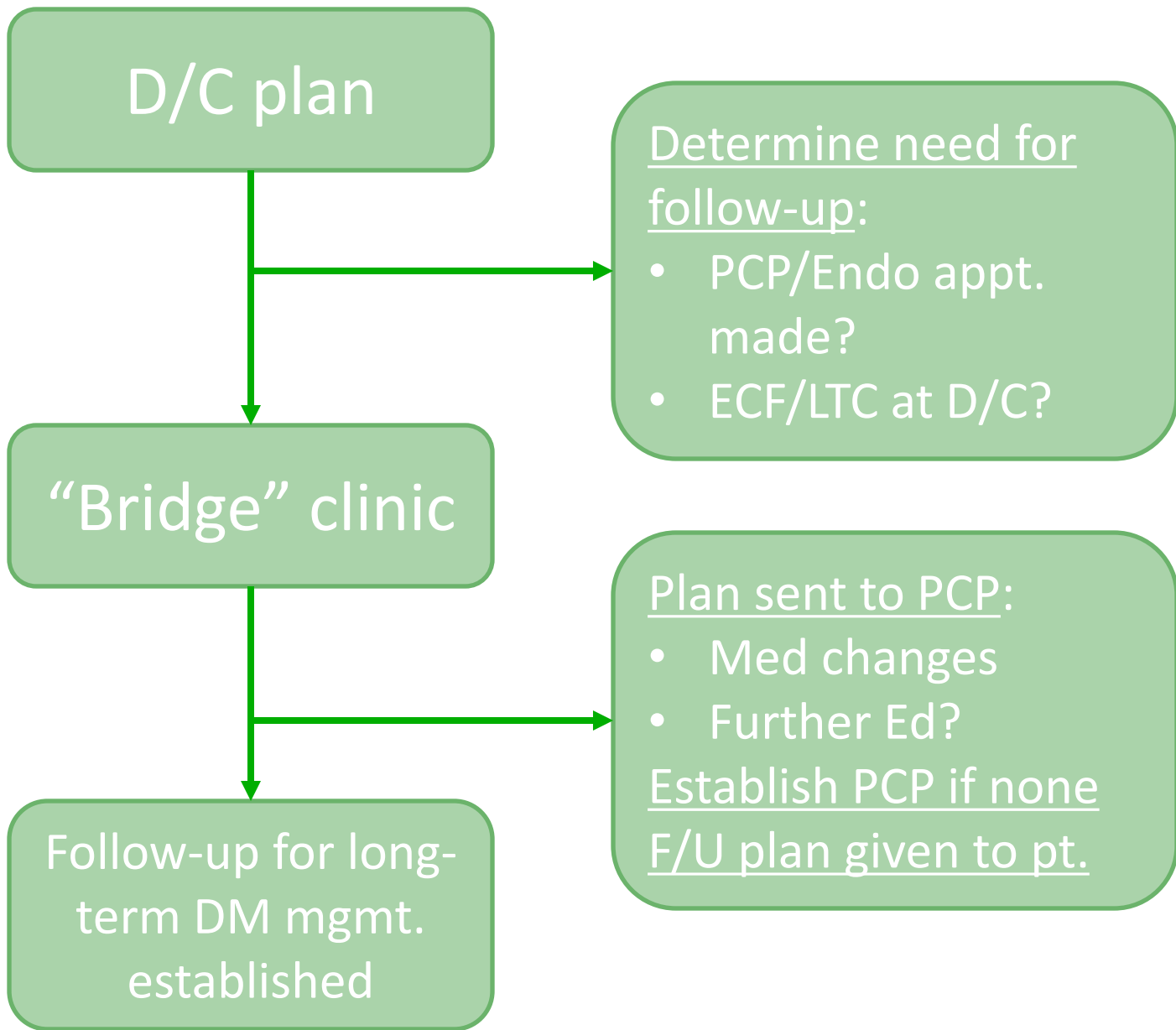
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“It’s snowing still,” said Eeyore gloomily.

“So it is.”

“And freezing.”

“Is it?”

“Yes,” said Eeyore. “However,” he said, brightening up a little, “we haven’t had an earthquake lately.”

– A. A. Milne

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# Outcomes

- Decrease LOS by at least 0.5 days

Little/No impact, multiple confounders, late consults

- Achieve better glycemic control

Not formally assessed – cardiac surgery?

- Reduce rate of DM-related admissions by 25%

Overall readmission rate = 19%; “Bridge” = 1.6%  
DM-related readmission rate = 8.3%; “Bridge” = 0%

# Diabetes Needs Assessment

- Assessment done early in admission
  - Diabetes Education referral
  - Diabetes Team consult request
- Attempt to:
  - Increase exposure to high-risk patients
  - Barriers identified/addressed earlier
  - Decrease length of stay
    - Avoid “last-hour” consultations



# Pilot test results

- Piloted on three medical floors (~70 beds)
  - 117 patients assessed over 21 days
    - 43 patients missed
  - Average A1c = 7.8%
  - On average, initially seen on adm. day 2
- Almost 40% of patients had Ed/Team referral
  - Decreased LOS by 0.8 days



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# Internal Medicine TOC clinic

# Internal Medicine TOC clinic

- General medicine service
  - No PCP, low access to care
  - Generally high-risk for readmission
- Errors with med list in EMR following D/C
  - Patient confusion
  - Incorrect records
- Want to improve access & correct errors

# TOC clinic structure

- High-risk patients referred upon D/C
- Patient seen by PharmD and IM resident
  - Seen within 7 days of hospital D/C
  - Utilize TOC billing codes (option for -95 and -96)
- Pre-identified roles:
  - PharmD – med rec, counseling, recommendations
  - MD – assess chronic conditions, enact plan
  - CSW – patient assistance program

# References

- Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. *N Engl J Med* 2009;360:1418-28.
- Forster AJ, Murff HJ, Peterson JF, Ghandi TK, Bates DW. The incidence and severity of adverse events affecting patients after discharge from the hospital. *Ann Intern Med* 2003;138:161-7.
- Ho PM, Rumsfeld JS, Masoudi FA, et al. Effect of medication nonadherence on hospitalization and mortality among patients with diabetes mellitus. *Arch Intern Med* 2006;166:1836-41.
- Levetan CS, Salas JR, Wilets IF, Zumoff B. Impact of endocrine and diabetes team consultation on hospital length of stay for patients with diabetes. *Am J Med* 1995;99:22-8.
- Puig J, Supervia A, Marquez MA, et al. Diabetes team consultation: impact on length of stay of diabetic patients admitted to a short-stay unit. *Diabetes Res Clin Pract* 2007;78:211-6.

# References (cont.)

- Koproski J, Pretto Z, Poretsky L. Effects of an intervention by a diabetes team in hospitalized patients with diabetes. *Diabetes Care* 1997;20:1553-5.
- Coleman EA, Parry C, Chalmers S, Min SJ. The care transitions intervention: results of a randomized controlled trial. *Arch Intern Med* 2006;166:1822-8.
- Ip EJ, Shah BM, Yu J, et al. Enhancing diabetes care by adding a pharmacist to the primary care team. *Am J Health Syst Pharm* 2013;70:877-86.
- Fera T, Bluml BM, Ellis WM. Diabetes Ten City Challenge: final economic and clinical results. *J Am Pharm Assoc* 2009;49:383-91.
- Cranor CW, Bunting BA, Christensen DB. The Asheville Project: long-term clinical and economic outcomes of a community pharmacy diabetes care program. *J Am Pharm Assoc* 2003;43:173-84.