Inpatient to Outpatient Transitions of Care

John M. Moorman, PharmD, BCPS
Pharmacotherapy Specialist, Endocrinology
Akron General Medical Center

Associate Professor, Pharmacy Practice
Northeast Ohio Medical University
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
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
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<thead>
<tr>
<th>Medical complexity</th>
<th>99495</th>
<th>99496</th>
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<tbody>
<tr>
<td>Time from D/C to visit</td>
<td>14 days</td>
<td>7 days</td>
</tr>
<tr>
<td>Approx. charge</td>
<td>$160</td>
<td>$230</td>
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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

“Improving Care Transitions,” Health Affairs, September 13, 2012, Available at http://www.healthaffairs.org/healthpolicybriefs
Local Ohioans uninsured

The percentage of persons aged 18 to 64 without health insurance

SOURCE: American Community Survey
Akron Beacon Journal

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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:

☐ Glucometer use  ☐ Diet/Meal plan
☐ Insulin self-administration  ☐ Use of CHO/insulin ratio (if applicable)
☐ Hypoglycemia plan  ☐ Use of correctional insulin (if applicable)
☐ Understanding of medication regimen  ☐ ___________________________
Team consult

Initial assessment:
- PCP/Endo records
- Set goals
- Develop plan
- ID education needs

Daily rounds

- Med reconciliation
- Education
- Medical mgmt.
- Follow-up plan

D/C plan
D/C plan

Determine need for follow-up:
- PCP/Endo appt. made?
- ECF/LTC at D/C?

“Bridge” clinic

Plan sent to PCP:
- Med changes
- Further Ed?

Follow-up for long-term DM mgmt.
established

Establish PCP if none
F/U plan given to pt.
“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
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
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

References (cont.)


