Maine Quality Counts presents…

QC Provider Lunch & Learn

Promoting Safe & Effective Transitions of Care: The Critical Role of Primary Care Practices

December 3, 2013 (12PM – 1PM)
Today’s Speakers

**Rhonda Selvin, APRN, CNP,** is Associate Medical Director for Practice Transformation for Maine Quality Counts. She is a family nurse practitioner who has practiced for several years in primary care settings, most recently at Wiscasset Family Medicine. Rhonda currently serves as President of the Maine Nurse Practitioners Association and is a graduate of the Hanley Health Leadership Development (HLD) program.

**Debra McGill, RN,** is the Population Health Manager for Maine Medical Partners. Under the guidance of the MMP Quality Program, Debra has developed a successful Care Transition Program using several components of the Dartmouth Institute’s Clinical Microsystem approach to quality improvement.
1. Identify key changes, role of primary care in improving safe and effective transitions of care
2. Introduce “Primary Care Roadmap for Change”
3. Identify, share challenges & best practices
4. Review CMS Transitional Care Management (TCM) codes
Maine PCMH Pilot
Practice Core Expectations

1. Demonstrated provider leadership
2. Team-based approach
3. Population risk-stratification and management
4. Practice-integrated care management
5. Enhanced access to care
6. Behavioral-physical health integration
7. Inclusion of patients & families
8. Connection to community
9. **Commitment to waste reduction**
10. Patient-centered HIT
Defining the Problem

- PCMH Pilot/MAPCP demo ask practices to commit to reducing waste, identifying ways to improve care and reduce avoidable costs
- *In Maine, ~1 in 6 Medicare patients rehospitalized within 30 days of discharge*
- Care transitions = key improvement opportunity!
- In addition to hospital-based efforts to improve discharge processes, **primary care practices play critical role** in improving transitions
Exploring Solutions:
Primary Care Roadmap for Change

- Summarizes key roles for primary care practices to promote safe and effective care transitions and reduce avoidable readmissions

- Developed by Maine PCMH Pilot from review of current best practices in improving transitions, reducing avoidable readmissions, including consensus and expert opinion
  - IHI
  - QIO efforts
  - Project RED, BOOST
  - Health system initiatives to improve care transitions

- Current practices assessed via PCMH practice survey (Sept)

- Introduced to multi-stakeholder group – Oct 3 meeting

- Further refined to reflect group input
Primary Care Roadmap: 7 Key Changes

1. Reduce readmissions by preventing avoidable admissions
   - Identify patients at high risk for hospital admission/readmission and use evidence-based strategies to reduce avoidable admissions – e.g.
     - Patients with HF, COPD, dementia
     - Polypharmacy
     - Frail elders
   - Use proven care management strategies to provide addnl support
   - Identify at-risk patients using all available information sources – e.g. HealthInfoNet, MAPCP RTI Portal, MaineCare HH Utiliz Rpts
Primary Care Roadmap: 7 Key Changes

2. Develop reliable systems for timely, two-way communications re: patients admitted/ discharged from hospital, Skilled Nursing/Rehab facilities
   - Ensure systems for practice to regularly provide patient information to ED and hospital-based physicians
   - Establish reliable systems with local hospitals, SNF, and rehab facilities to ensure routine notification of patients at time of admission and discharge (e.g. via EMR, fax, or other secure messaging notice)
   - Use HIN notification function to receive automated alerts when your patients are admitted/discharged
   - Whenever possible, use telephonic report (“warm hand-off”) to practice staff for admitted/discharged pts, including meds
3. Conduct telephonic outreach to all patients within 24-48 hrs of discharge, including medication reconciliation

- Develop reliable systems for conducting telephone outreach to patients within 24-48 hours of discharge
- Use standard phone protocols or scripts for staff to assess readmission risk and post-discharge needs
- Conduct medication reconciliation using standard protocols
- Schedule post-discharge follow up visit
- (Note: can use Medicare reimbursement for non-visit based services through CMS “Transitional Care Management” codes*)

4. Provide patient-centered, timely access to follow-up care (i.e. office visit within 3-7 days)

- Educate front-office practice staff on need to be receptive to recently discharged patients and families
- Ensure practice scheduling systems provide adequate access to accommodate timely post-discharge follow up visits
- Conduct follow-up office visit with patient and family member, ideally within 3-7 days of discharge (adjusted for risk level)
- (Note: CMS Transitional Care Management codes require in-person post-discharge visit within 14 days)
4. Provide patient-centered, timely access to follow-up care (cont’d)

- Encourage patients to bring in medications (“brown bag”) to visit
- Assess patient understanding and needs and establish (or update) care plan, including plans for self-management goals, warning signs, and follow up care
- Use plain language and teach-back methods to assure that patient and family have a clear understanding of care plan
- Consider use of patient navigators or advocates to support patients through high-risk time periods
- Facilitate coordination of care with other members of care team (e.g. specialists, home care)
5. Connect with community resources to optimize patient & family/caregiver supports

- Routinely assess social service needs for patients following discharge; use community resources (e.g. Area Agencies on Aging) to conduct in-home assessment of service needs for high-risk patients

- Establish links with community partners to arrange and provide needed home-based services - e.g.
  - Home care providers, Area Agencies on Aging, Emergency Medical Services, parish nursing programs

- For patients with history of frequent ED or hospital use, consider referral to local Community Care Team
Primary Care Roadmap: 7 Key Changes

6. Facilitate patient and family-centered discussions regarding end of life care
   - Encourage advance planning for patients with dementia and others not able to self-advocate
   - Encourage compassionate discussions about end of life decisions with patients and families
   - Promote use of advance directives with all patients; encourage use of Physician Orders for Life-Sustaining Therapies (POLST)*

*POLST: http://mainehospicecouncil.org/polst/
7. Build personal relationships across your medical neighborhood!

- Value of collaborative relationships – esp. across silos!
- Build multidisciplinary care transition teams within community - include primary care, patients and families, Skilled Nursing and Rehab facility staff, Area Agencies on Aging, and others
- Find ways to re-build relationships and ongoing communication between hospital and community-based providers – e.g.
  - Medical neighborhood “block parties”, medical staff meetings, breakfast meetings
Primary Care Roadmap

- Challenges?
- Successes?
- Best practice sharing!

Promoting Safe and Effective Transitions of Care: The Critical Role of Primary Care Practices

INTRODUCTION: In Maine, approximately 1 in 6 Medicare patients are rehospitalized within 30 days of discharge. The Robert Wood Johnson Foundation has termed this the “revolving door syndrome,” and is working to promote a new approach to care. While many hospitals are working to improve their discharge process with initial promising results, we recognize that primary care practices play a critical role in addressing this problem and improving care. This “Roadmap” summarizes key roles for primary care practices to promote safe and effective care transitions and reduce avoidable readmission, and emphasizes the need for rapid and complete flow of information from all involved.

Key Changes:
1. Reduce readmissions by preventing avoidable admissions: Identify patients at high risk for hospital admission/readmission and use evidence-based strategies to reduce avoidable admissions.
   - Prospective identify and track patients with diagnoses that put them at high risk for admission – e.g., heart failure, COPD, dementia, polypharmacy, co-occurring mental health/substance abuse
   - Use protocol-driven care management strategies to improve self-management, home monitoring
   - Provide after-hours options for care (e.g., telephonic support, evening & weekend hours)
   - Use provider knowledge, primary care management, and all available data to identify practice patients who are at high risk for admission, or have been recently and/or frequently hospitalized (e.g., HealthinfoNet, MAAPRI Portal, MaineCare HH Utilization Reports). Review admission data monthly.

2. Develop reliable systems for timely, two-way communications about patients admitted or discharged from hospital, Skilled Nursing/Rehab facilities: Ensure that systems are in place to accurately provide patient information to Emergency Department and hospital-based physicians, and to reliably receive information on patients discharged from hospitals, Skilled Nursing Facilities (SNF), and/or rehab facilities.
   - Establish reliable systems with local hospital, SNF, and rehab facilities to ensure that your practice is routinely notified regarding patients from your practice at time of admission and discharge (e.g., EMR, fax, or other secure messaging notice)
   - Enroll your practice with HealthinfoNet (HIN), and use HIN notification function to receive automated alerts when your patients are admitted/discharged from any HIN-participating facility statewide (soon to include all Maine hospitals)
   - Whenever possible, establish system for facilities to provide telephonic report (“warm hand-off”) to practice staff on admitted and discharged patients
   - Establish systems to ensure that your practice receives clear discharge information on all patients, including list of patient medications at time of facility discharge

3. Conduct telephonic outreach to all patients within 24-48 hrs of discharge, including medication reconciliation: Many patients following hospital discharge are unclear about their medications, symptoms self-monitoring, and/or plans for home care or follow-up care; providing timely phone follow up to high-risk patients can identify problems early and provide needed education and support.
   - Develop reliable systems for conducting telephone outreach to patients within 24-48 hours of discharge

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The Role of Primary Care in Safe Patient Transitions

Debra McGill, RN
Population Health Manager
Maine Medical Partners
Maine Medical Partners

Maine’s largest multi-specialty medical group

Maine Medical Center, the State’s largest tertiary care center

Part of MaineHealth, Maine’s largest healthcare system

MMP employs a team of more than 300 physicians and 1,500 employees
• Revolving Door Syndrome
• Transitions are a time of risk for patients
• Primary Care Providers play a key role
MMP Care Transition Program implemented in 2010

Program Design has always included:

• Telephone contact to patient within 24-72 hours
• Early provider follow-up
Medication Reconciliation

• Review hospital discharge instructions & discharge summary
• Review PCP EMR
• Ask the patient “what are you ACTUALLY taking?”
Ensure Early Follow-Up
– Schedule if no appointment made
– Change what was scheduled
– Confirm what was scheduled
Intensive Telephone Intervention

- Confirm ordered services have been initiated
- Identify lack of resources
- Make referrals as necessary
  - Home Health Care
  - Community Services
  - Med Access
Many of our patients require an intervention beyond what is standardly expected

- F/U home care
- F/U provider
- F/U community resource

More likely to readmit
Impact on Readmissions

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<thead>
<tr>
<th>Study Group</th>
<th>Readmission Rate</th>
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<tbody>
<tr>
<td>Phone Call</td>
<td>12.9%</td>
</tr>
<tr>
<td>No Phone</td>
<td>20.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
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</thead>
<tbody>
<tr>
<td>No Phone</td>
<td>20.0%</td>
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</table>
New CPT Codes Introduced

• CMS approved the following new CPT codes in 2013:
  – 99495
  – 99496
• Designed to provide reimbursement for post-hospital transitional care management
• Can be billed by only one provider
Implementing Use of the Codes

1. Assembled a multidisciplinary team
   - PCP
   - Application Support
   - EPIC Report Writer
   - Coding & Compliance
   - Billing
   - Care Transition
   - Operations Specialist
Implementing Use of the Codes

2. Reviewed current process for performing Care Transition Intervention

3. Identified opportunities within existing processes
   - TCM Episode
   - Visit Reason
   - Spreadsheet for Charge Entry Specialists
Process

• Patient identified as discharged from inpatient or observation status
• Care transition telephone intervention completed
• Schedule early follow-up
• Open episode in EPIC
• Charge entry monitors TCM Worksheet
# Checklist for Charge Entry Specialist When Determining TCM Eligibility

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Must Meet?</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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</thead>
<tbody>
<tr>
<td>1. Patient was discharged from an inpatient or observation status</td>
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<tr>
<td>2. Patient received a completed telephone intervention by an MMP Care Transition nurse or designee within 2 business days of hospital discharge</td>
<td>No, if #2 below met</td>
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<tr>
<td>3. If no completed telephone intervention by an MMP Care Transition Nurse or designee, 2 attempts were made to reach the patient by telephone within 2 business days of hospital discharge</td>
<td>Yes, if #1 above not met</td>
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<tr>
<td>4. A Transitional Care Episode was opened in the patient's EPIC record</td>
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<tr>
<td>5. The telephone encounter or 2 attempted telephone calls are linked to the Transitional Care Episode</td>
<td>No</td>
<td></td>
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<tr>
<td>6. The patient had a hospital follow-up visit with a provider within 14 calendar days of hospital discharge</td>
<td></td>
<td>Yes</td>
<td></td>
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<tr>
<td>7. The hospital follow-up visit was linked to the Transitional Care Episode in the patient's EPIC record</td>
<td>No</td>
<td></td>
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<tr>
<td>8. The patient was not re-hospitalized in the 29 days following the Transitional Care Episode start date (ER visits are ok)</td>
<td>Yes</td>
<td></td>
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<tr>
<td>9. Patient is alive on the 30th day following hospital discharge?</td>
<td></td>
<td>Yes</td>
<td></td>
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**Action:**

- To Care Transition for clarification
- To provider for code review
- Charge ok to bill
Readmission During TCM Episode

• If a patient is re-hospitalized during an open TCM Episode, the TCM codes cannot be used.

• You may start a new TCM Episode upon subsequent discharge of patient.
Coding & Compliance Highlights

With minor exceptions, any additional services during the 29 days are separately billable.

Exceptions include:

• Anticoagulation management
• Care plan management
Successes

• Easy to operationalize
• Providers becoming more familiar with the use of the codes
• Encourages cross continuum communication and collaboration
• Already had successful submission & reimbursement
Challenges

• Catching 99212-99215 codes before they drop
• MAs remembering to link the visit to the episode to cue the provider to use the 99495 or 99496 code
• Tracking re-admissions within the episode
• Varying levels of understanding of process by staff & providers
Next Steps

• Focused education to providers and staff to address identified gaps
• Coding & compliance audits
• Collaboration with the central billing office
• Work with MaineHealth to negotiate with Anthem to recognize TCM codes
Questions?
Contact Information

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