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Optimizing Transitional Care Management

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Optimizing Transitional Care Management: Improving Quality of Care with Pre-Visit Planning Checklist

St. Albans Primary Care | St. Albans, VT

Mary Kate LoPiccolo | *September 2016*

Preceptor: Toby Sadkin, MD

Community Mentor: Heidi Luneau, RN

Problem

In 2013, under the leadership of the Centers for Medicare & Medicaid Services, Transitional Care Management (TCM) billing codes were created in an effort to promote primary care follow-up, reduce medical errors upon discharge, and minimize preventable 30-day readmissions. These codes require the following:

- *Communication* with the patient or caregiver within 2 days of discharge
- *Face-to-face visit* within 7 days of discharge for high complexity cases and within 14 days for moderate complexity cases ³

At first glance, the requirements seem simple. However, during my time in St. Albans, I gradually realized the complexity and immense time commitment involved in successful care transitions. At a minimum, the primary care team must:

- Obtain, review, and follow up on pending tests, treatments, and/or referrals included in the discharge summary
- Reconcile patient medication lists from before and after discharge and assess patient compliance
- Educate the patient or caregiver regarding self-management
- Help the patient access community health resources or additional health services they might need
- Answer any other patient questions regarding their diagnosis, rehabilitation, and prognosis

In talking to providers, nurses, and community care coordinators, I found that there was a need for a streamlined process to ensure that each TCM visit was adequately planned and prepared for. In reviewing the practice's system for preparing for TCM visits, incomplete discharge summaries, poorly communicated medication reconciliations and care management plans, inadequate coordination of follow-up, and general misunderstanding of the requirements for the TCM visit were identified as areas for improvement.

Public Health Costs

Impact on the Healthcare System

- Almost 15.6% of Medicare patients are readmitted within 30 days of discharge as of 2015.¹ VT's rate of 30-day readmission is on par with the national average.²
- An estimated \$26 billion is spent each year on readmissions for Medicare patients alone. \$17 billion were spent on readmissions that could have been prevented with improved transitions of care.^{6,8}
- TCM visits are key to helping reduce these costs; studies show interventions directed at increasing outpatient follow-up were the most successful in reducing readmission rates.

Impact on Primary Care Providers

- Inadequate communication between the PCP and hospital, poor follow-up with the discharged patient, and lack of thorough preparation can lead to failure to satisfy TCM billing requirements in addition to confusion, error, inefficiency, and incomplete care on the day of the TCM visit.
- Satisfactory TCM can strengthen the provider-patient relationship that is at the core of the Patient-Centered Medical Home, the up-and-coming model for improving quality of patient care and minimizing health care expenditures.

Impact on Patient Care

- Over 50% of patients experience 1 medical error (in drug reconciliation or diagnostic follow-up upon discharge). Medication errors are the most common cause of adverse events after discharge.^{4,8}
- Patients are often discharged only to realize that they did not have an adequate understanding of their diagnoses or discharge instructions, were unable to care for themselves, or were unsure of who to turn to for follow-up. Successful TCM visits can address patient concerns, encourage self-management, and coordinate comprehensive treatment.

Community Perspective

Toby Sadkin, MD, is a family medicine physician and practice manager at St. Albans Primary Care. In addition, she is the Executive Committee chair at Primary Health Care Partners, the largest physician-owned primary care organization in Vermont. Dr. Sadkin sees, on average, about 3 TCM visits per week and relies on her office staff, medical assistants, and nurses to collect the majority of the pieces necessary for a TCM visit. In explaining the utility of this proposed intervention, she stated...

“The transition of care (TCM) visit is meant to help patients achieve a successful transition from an inpatient stay back to home. In our office, we have tried to incorporate preparation for TCM visits into our pre-visit planning protocol, but we have been finding that there is much variability in the completeness of this pre-visit planning and preparation. Lacking the necessary information at the time of the TCM visit significantly impacts the usefulness of the visit. Standardizing our TCM pre-visit planning will reduce the variability we have been struggling with and will ensure that the TCM visit is both efficient and meaningful.”

Heidi Luneau, RN, is the Community Care Coordinator at St. Albans Primary Care. She serves as the primary connection for patients who are trying to navigate the complexities of the health care system and obtain the community resources best suited to their health needs. When patients under the care of St. Albans PC are hospitalized at the nearby Northwestern Medical Center, Heidi will make an effort to visit with them and directly communicate with the nurses in charge of the patient’s discharge. Heidi identified areas of “poor organization and follow-through,” particularly in pre-visit planning. We examined the established workflow by assessing preparedness for 2 real TCM visits (see next slide, “Overview of Original TCM Visit Preparation”). Several gaps were found particularly in obtaining diagnostic test results for provider review, identifying the need for referral, and performing medication reconciliation prior to PCP follow-up.

“As a patient, the healthcare system seems incredibly complex and intimidating, particularly in the setting of an unexpected hospitalization. The TCM visit serves as a heartfelt reminder that they are not alone—their primary care ‘home’ will support them along each step of the process and welcome them back with open arms once they leave the hospital. Improving this visit is a step toward ensuring that patients continue to feel completely at home in our care.”

Intervention and Methodology

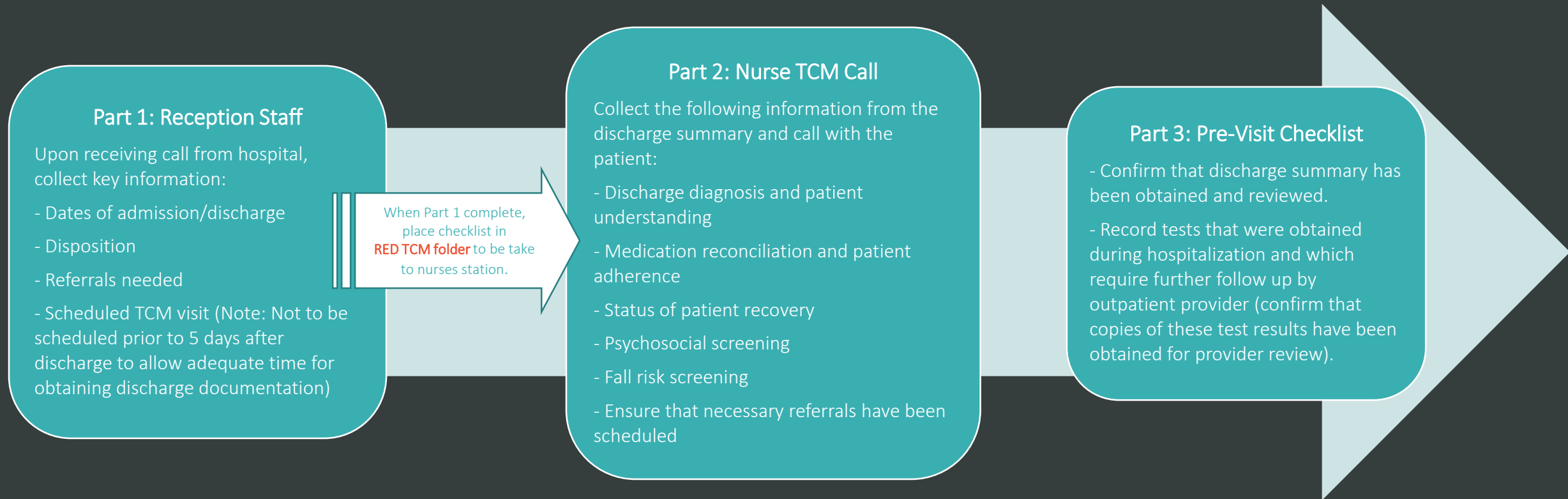
Overview of Original TCM Visit Preparation

1. St. Albans Primary Care is notified that patient has been admitted to the hospital. Community Care Coordinator attempts to communicate with inpatient providers and may visit with the patient in the hospital to begin organizing a successful discharge.
2. St. Albans Primary Care reception desk staff is notified of patient's discharge, and often inpatient providers request a date for outpatient follow-up. This may be within 48 hours of discharge, which often does not allow enough time to collect all discharge documents necessary for follow-up. Reception staff is unaware of the time it takes to prepare for visit, so they will often proceed with scheduling a hasty TCM visit.
3. Nurse TCM call is made to the patient within 48 hours of discharge. Discharge diagnoses, medication reconciliation, patient disposition, and referrals to be made are recorded in a special EHR form, however there is variability in what is actually completed, particularly when the discharge summary has not arrived at the time the call is made.
4. On the day of the patient visit, the medical assistant or nurse usually obtain a copy of the discharge summary for the provider to review. However, at this point, several pieces necessary for a complete and high-quality follow-up may be missing due to variable preparation, often leading to a longer, inefficient visit during which the provider must collect information that has likely been documented before and run the risk of losing time to address patient questions and concerns.

Intervention and Methodology

New TCM Visit Workflow

I made a 3 part checklist that would be passed along from the front office staff, to the TCM call nurse, and ultimately to the medical assistant or nurse responsible for intake on the morning of the TCM visit at different times in the process of preparing for the patient's follow-up. Each part was carefully written and even included sample language to facilitate collection of information from the hospital/patient. Check boxes served as a reminder for task completion, and signature of the individual completing each portion of the form were required to ensure accountability. Each part contains a section for additional notes to clarify information.



Results

My goal is to follow-up with Dr. Sadkin, Heidi Luneau, and Renee, the Nurse Manager, in one month to gauge whether the TCM Checklist has helped streamline the preparation for these visits. I would like to assess whether the new checklist has helped the office staff to effectively collect information from the patients and hospital providers in order to increase the efficiency and value of the visits. I would like to ask for feedback on the Checklist from the staff in order to optimize the workflow and ensure that the key portions of the preparation process are covered. Once the form is at its best, it may be possible to qualify the results through patient surveys after their TCM visit (assessing the quality of the visit as perceived by the patient). Although it may be difficult, perhaps we can quantify the results of the intervention by comparing readmission rates in the few months before the new Checklist was implemented to rates upon successful adopted of the finalized form.

Limitations vs. Effectiveness

- The proposed TCM Checklist is in paper form. Unfortunately, the current EHR system will not allow information to be entered into the Medicare-reimbursed TCM visit form at different times—for example, it is impossible for the information collected during the Nurse TCM Call to directly feed into the TCM visit note (written on the day of the encounter) that is required for billing. Thus, while the information collected through the Checklist will certainly help the provider adequately prepare for a visit with the patient, staff will still be required to spend time transferring the required information from the paper Checklist into the computer note and information in excess of the required fields will not be incorporated into the digital record. The paper form can be scanned into the EHR record for the sake of complete documentation, however this limits the potential for data analysis. The lack of interface between the Checklist and the TCM visit note required for billing presents a particularly challenging hurdle toward providing quality TCM care while maximizing time efficiency.
- However, it is possible that by providing the streamlined Checklist, we will also be educating the office staff and providers on how to adequately prepare for outpatient follow-up. At this point, given the limitations of the EHR for self-populating information into a new TCM visit, having all of the key information in one physical place, rather than separated into several folders within the EHR, may in fact facilitate easier review and ultimate recording. Moreover, the Checklist, completed over a few days, may effortlessly capture the evolution of the patient's discharge and first stages of their recovery.

Next Steps

- I believe that holding an educational meeting, discussing the rationale behind the new Checklist and elaborating on its effective use, would benefit the entire St. Albans Primary Care team. This could also serve as an opportunity for feedback and suggestions to improve the tool.
- It has become clear in my discussions with providers and experiences in a variety of patient interactions that it would be valuable to develop similar checklist-style workflows for ER/Urgent Care follow-ups as well as general Pre-Visit Planning. These checklists will not only continue to further optimize the quality of care and efficiency of the practice, but also reinforce expectations for staff roles in patient care.
- The ultimate goal would be to find a method for the Checklists to be filled out in the EHR and directly feed into the provider's note.

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