Reducing Readmissions Through Care Transitions: Barriers, Billing and Beyond

Andrea Backes, PharmD, BCACP
Gloria Sachdev, BS Pharm, PharmD

Lessons Learned: Implementing Successful Transitions of Care Programs

Andrea Backes, PharmD, BCACP
Care Transitions Pharmacist
Frederick Memorial Hospital

Objectives

- Define the Maryland all-payer model and its impact on Care Transitions programs
- Describe 3 aspects that should be considered when designing a Care Transitions program
- Discuss opportunities for improvement in an established Care Transitions program

3

Maryland All-Payer Model

www.iandrinstitute.org

- Only state with an all-payer system
- Health Services Cost Review Commission (HSCRC)
- Modernized model approved Jan 2014
  - Readmission rates are high compared to national rates
  - Estimated to save Medicare $330 million over the next 5 years
  - Achieve quality improvements including reduction in 30-day RA rate
  - Population health management

4

Frederick Memorial Hospital

- Frederick – one of the fastest growing counties in Maryland
- Payment model = global budget revenue (GBR)
  - Incentivized to decrease expenses per patient
  - Potentially avoidable utilization (PAU)
  - Preventable quality indicators (PQI)
- "Population Health"

www.fmh.org

5

Lesson #1: "It Takes a Village…"

Care Transitions (CT) Team

- RN Navigators (3.0)
- Pharmacists (2.4)
- Community SWs (2.0)
  - Behavioral health
- ED Social Workers (2.3)
- Coordinator (1.0)
- Nurse Practitioner

- Started July 2012
- Preventable readmissions are complex

6

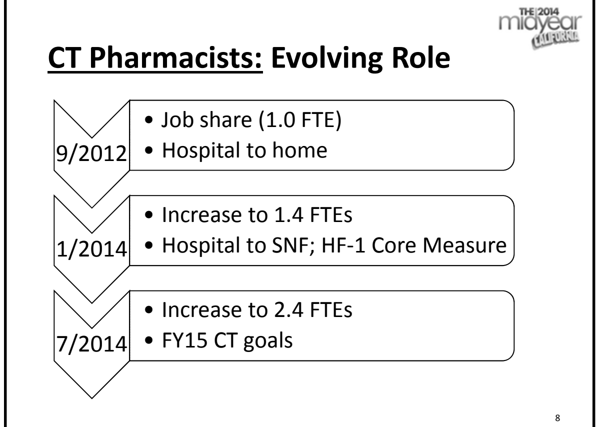
© 2014 American Society of Health-System Pharmacists

CT Team: Roles & Responsibilities

RN Navigator	Social Worker	Coordinator
• Identify high-risk pts • Assess needs • Remove barriers to care • Educate on disease states • Coach on self-management • Find providers • Communicate with providers • F/u phone calls	**ED** • Care plans • Secure f/u care • SNF placement **Community** • Pt advocate (appointments) • Assesses home • SNF/LTC/AL placement • F/u phone calls	• Prioritize referrals • Organize contacts • Secure f/u care • Schedule f/u appts • Reminder calls • Fax records • TransIT app • SafeLink app • Med coupons • Patient assistance applications • F/u phone calls

7

CT Pharmacists: Evolving Role



8

FY15 Care Transitions Goals

1. Achieve a 10% reduction in avoidable admissions for the 419 “high utilizers”
2. Achieve all-cause (intra-hospital) RA rate of 8.4%
3. Achieve all-cause (inter-facility) RA rate of 9.68%
4. Reduce diabetes readmissions by 15%
5. Reduce behavioral health readmissions by 20%

9

CT Team: Opportunities

- Working at the top of our licenses
- Identifying the “highest-risk” patients
  - Shared accountability hospital-wide
- Seven day coverage by all CT disciplines
- Partnering with community organizations
  - Home health care
  - Primary care including PCMHs
  - Community Action Agency
  - WayStation

10

Lesson #2: Bedside Delivery is Essential

- Primary medication non-adherence
  - Any prescription issued to a patient for which no medication is picked up
- Ambulatory care
  - 7% - 24% of prescriptions
- Discharge from hospital
  - 27% of prescriptions within 7 days of discharge
  - Associated with increased 1-year mortality for post-acute myocardial infarction patients

Ekedahl et al. *Pharm World Sci.* 2004;26:26-31. Jackevicius et al. *Circulation.* 2008;117:1028-36
Fischer et al. *J Gen Intern Med.* 2010;25:284-90.

11

Bedside Delivery: Removing Barriers

Patient Perspective

- Lack of transportation
- Difficulty affording medications
- Long wait times at the pharmacy

CT Perspective

- Access to medications
  - Is it in stock?
    - How common is it?
    - Controlled substances
  - Prior authorizations
    - 24-72 hours
  - Non-formulary; preferred alternative?
- Automatic order to CM
  - “Check insurance coverage” for high-cost medications

Kripalani S, et al. *Mayo Clin Proc* 2008;83:529-35.

12

© 2014 American Society of Health-System Pharmacists

Bedside Delivery: Evolving Program

- Monday to Friday (9 – 5:30 pm)
- Daily bed huddles to identify discharges
- Limited read-only access to EHR
- Expert in medication discounts
  - Discount cards (www.goodrx.com)
  - Patient assistance programs
- Expanded to BHU, SDS, & Family Center
  - Delivery of non-medications
  - "On-Call" for ED & ICU
  - Rx for employees
- 48-hr follow-up phone calls
  - If issues, notify CM & CT team

13

Bedside Delivery: Lessons Learned

- Find the "right" person
  - Communication skills
    - Patient
    - Bedside RN
    - Case manager
    - Hospitalist
    - Care Transitions
  - Proactive
  - Understands the purpose
- Not a hospital employee
- Medication deliveries need to be reviewed
  - Right patient
  - Right medication
  - Right medication dosing
  - Completeness of order

14

Bedside Delivery by Month

	May-14	Jun-14	Jul-14	Aug-14
# of Pts Offered Bedside Delivery	309	829	1021	1056
# of Pts Accepted Bedside Delivery	80	85	109	117
# of Pts Who Used Bedside Delivery	60	64	91	99
# of Rx Processed via Bedside Delivery	244	242	345	398

15

Bedside Delivery: Opportunities

- Offer weekend service
- Deliver medications to patients' homes
- Accept all insurances (ex: Amerigroup)
- Prioritize high-risk patients (ex: cath lab)
- Provide 24-hour supply of meds to pts transitioned to SNFs
- Partner with community pharmacists for shared accountability (ex: access to EHR)
- Follow-up with pts at 30 days for chronic meds that need refills

16

Lesson #3: Don't forget about SNF pts

- MedPAC - 23.5% of all hospital discharges to SNFs were readmitted w/in 30 days in 2006
  - Total cost = $4.34 billion/year
  - 78% of admissions - potentially avoidable
- 22.1% of pts visited the ED or were readmitted within 30 days of discharge from SNF to home
- SNF value-based purchasing program is on the horizon

Mor et al. *Health Aff* 2010;29:57-64. Toles et al. *J Am Geriatr Soc* 2014;62:79-85.
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/SNF-VBP-RTC.pdf

17

SNFs: Evolving CT Program

Pilot (Started Jan 2014)
- Citizens
- Northampton Manor
- Vindobona

Other Facilities
- Golden Living
- Glade Valley
- College View
- St. Joseph's/St. Catherine's
- Buckinghams Choice
- Homewood

Criteria
- NOT long-term care
- Identified as high-risk for readmission
  - High-utilizer
  - Concerns from CM and/or other providers
- Seen by CT RN for disease state education
- Seen by CT pharmacist for medication review

18

© 2014 American Society of Health-System Pharmacists

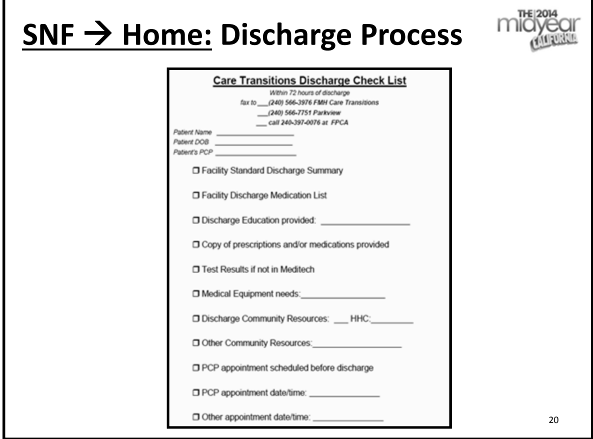
Hospital → SNF: Medication Reconciliation

- One study identified at least one medication discrepancy in 71.4% of SNF admissions
- Discharge med rec is not mandatory at FMH
  - Dictation of discharge summary - unsigned
  - Meditech medication list - not updated
- Access to SNF medication lists within 48 hrs
  - Fax or obtain access to electronic records

Tjia et al. *J Gen Intern Med* 2009;24:630-5.

19

SNF → Home: Discharge Process


Care Transitions Discharge Check List
Within 72 hours of discharge
fax to ___(240) 566-3976 FMH Care Transitions
___(240) 566-7751 Parkview
___ call 240-397-0076 at FPCA

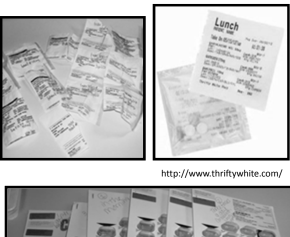
Patient Name ________________
Patient DOB ________________
Patient's PCP ________________

❒ Facility Standard Discharge Summary
❒ Facility Discharge Medication List
❒ Discharge Education provided: ________________
❒ Copy of prescriptions and/or medications provided
❒ Test Results if not in Meditech
❒ Medical Equipment needs:________________
❒ Discharge Community Resources: ___ HHC:________
❒ Other Community Resources:________________
❒ PCP appointment scheduled before discharge
❒ PCP appointment date/time: ______________
❒ Other appointment date/time: ______________

20

SNF → Home: Medications

- Variability in Rx that are given at discharge
  - All Rx provided
  - No CII Rx
  - No Rx at all
- Variability in remaining medications given at discharge
  - None
  - Bulk meds
  - All



http://www.thriftywhite.com/

SNF → Home: Discharge Med Lists

Medication List

Prescription Medications:
Bumex 2mg by mouth daily for CHF. (9am)
Losartan 25mg by mouth daily. (9am)
Celexa 40mg by mouth daily. (9am)
Potassium Chloride 40 meQ by mouth daily. (9am)
Exalgo 8mg ER 1 tab by mouth daily for pain. (9am)
Toprol XL 25mg by mouth daily for CHF. (9am)
Advair Diskus 500-50mcg inhaler 1 puff twice daily. (9am, 9pm)
Neurontin 300mg capsule – take 2 capsules by mouth twice daily at 9am and 2pm. (9am, 2pm)
Neurontin 300mg capsule – take 3 capsules by mouth at bedtime. (9pm)
Crestor 40mg by mouth at bedtime. (9pm)
Requip 0.5mg by mouth at bedtime for RLS. (9pm)
Zantac 150mg by mouth daily at bedtime. (9pm)
Coumadin 2mg at bedtime on Sunday, Tuesday, Thursday and Saturday. (9pm)
Coumadin 2.5mg at bedtime on Monday, Wednesday and Friday. (9pm)
Ventolin HFA inhaler 2 puffs every 6 hours as needed for wheezing.

22

SNF → Home: Discharge Med Lists

Date: Jul 7, 2014
Time: 09:35:14 ET

Order Summary Report

Order Status: Active Active Orders As Of: 07/07/2014

Resident: Location: Admission: 04/13/2014

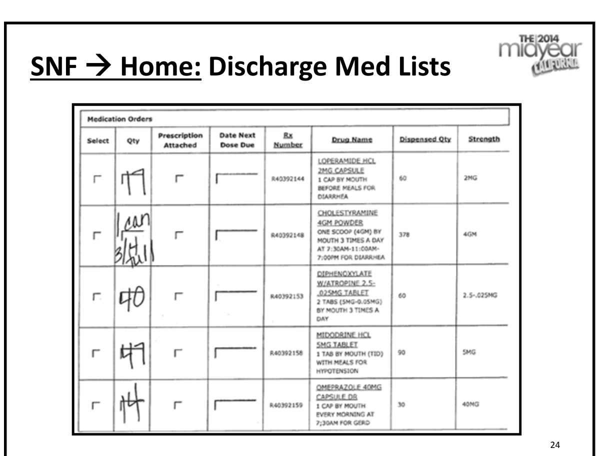
Order Summary	Communication Method	Order Status	Order Date	Start Date	End Date
Weekly Weights	Prescriber Written	Active	05/26/2014		

Pharmacy

Order Summary	Communication Method	Order Status	Order Date	Start Date	End Date
Advair Diskus Aerosol Powder Breath Activated 250-50 MCG/DOSE (Fluticasone-Salmeterol) 1 inhalation inhale orally two times a day related to CHRONIC AIRWAY OBSTRUCTION NEC (496)	Phone	Active	05/11/2014	05/12/2014	
Albuterol Sulfate Nebulization Solution 0.63 MG/3ML 2.5 mEq inhale orally via nebulizer every 6 hours as needed for for breathing treatment related to CHRONIC AIRWAY OBSTRUCTION NEC (496)	Phone	Active	05/13/2014	05/13/2014	
Ambien Tablet 5 MG (Zolpidem Tartrate) Give 1 tablet by mouth as needed for sleep Give at HS PRN for inability to sleep	Prescriber Written	Active	06/06/2014	06/06/2014	
Amiodarone HCl Tablet 200 MG Give 200 mg by mouth one time a day related to ESSENTIAL HYPERTENSION (401) hold if SBP less than 110 or hr60	Prescriber Written	Active	05/20/2014	05/20/2014	
AmLODIPine Besylate Tablet 10 MG Give 10 mg by mouth one time a day related to ESSENTIAL HYPERTENSION (401) hold for SBP less than 100	Phone	Active	05/11/2014	05/12/2014	
Aranesp (Albumin Free) Solution 60 MCG/ML (Darbepoetin Alfa-Polysorbate) Inject 60 mcg subcutaneously at bedtime every Sat related to	Phone	Active	05/19/2014	05/24/2014	

23

SNF → Home: Discharge Med Lists

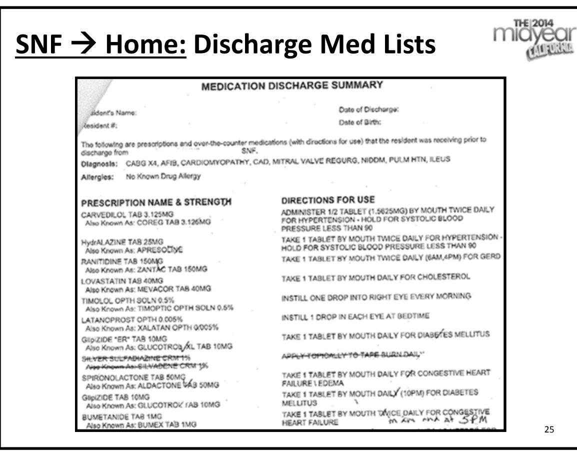

Medication Orders

Select	Qty	Prescription Attached	Date Next Dose Due	Rx Number	Drug Name	Dispensed Qty	Strength
⌜	17	⌜		R40392144	LOPERAMIDE HCL 2MG CAPSULE 1 CAP BY MOUTH BEFORE MEALS FOR DIARRHEA	60	2MG
⌜	1 can 3/4 full	⌜		R40392148	CHOLESTYRAMINE 4GM POWDER ONE SCOOP (4GM) BY MOUTH 3 TIMES A DAY AT 7:30AM-11:00AM-7:00PM FOR DIARRHEA	378	4GM
⌜	40	⌜		R40392153	DIPHENOXYLATE W/ATROPINE 2.5-.025MG TABLET 2 TABS (5MG-0.05MG) BY MOUTH 3 TIMES A DAY	60	2.5-.025MG
⌜	47	⌜		R40392158	MIDODRINE HCL 5MG TABLET 1 TAB BY MOUTH (TID) WITH MEALS FOR HYPOTENSION	90	5MG
⌜	14	⌜		R40392159	OMEPRAZOLE 40MG CAPSULE DR 1 CAP BY MOUTH EVERY MORNING AT 7;30AM FOR GERD	30	40MG

24

© 2014 American Society of Health-System Pharmacists

SNF → Home: Discharge Med Lists



MEDICATION DISCHARGE SUMMARY

Resident's Name: Date of Discharge:
Resident #: Date of Birth:

The following are prescriptions and over-the-counter medications (with directions for use) that the resident was receiving prior to discharge from SNF.

Diagnosis: CABG X4, AFIB, CARDIOMYOPATHY, CAD, MITRAL VALVE REGURG, NIDDM, PULM HTN, ILEUS

Allergies: No Known Drug Allergy

PRESCRIPTION NAME & STRENGTH	DIRECTIONS FOR USE
CARVEDILOL TAB 3.125MG Also Known As: COREG TAB 3.125MG	ADMINISTER 1/2 TABLET (1.5625MG) BY MOUTH TWICE DAILY FOR HYPERTENSION - HOLD FOR SYSTOLIC BLOOD PRESSURE LESS THAN 90
HydrALAZINE TAB 25MG Also Known As: APRESOLINE	TAKE 1 TABLET BY MOUTH TWICE DAILY FOR HYPERTENSION - HOLD FOR SYSTOLIC BLOOD PRESSURE LESS THAN 90
RANITIDINE TAB 150MG Also Known As: ZANTAC TAB 150MG	TAKE 1 TABLET BY MOUTH TWICE DAILY (6AM,4PM) FOR GERD
LOVASTATIN TAB 40MG Also Known As: MEVACOR TAB 40MG	TAKE 1 TABLET BY MOUTH DAILY FOR CHOLESTEROL
TIMOLOL OPTH SOLN 0.5% Also Known As: TIMOPTIC OPTH SOLN 0.5%	INSTILL ONE DROP INTO RIGHT EYE EVERY MORNING
LATANOPROST OPTH 0.005% Also Known As: XALATAN OPTH 0.005%	INSTILL 1 DROP IN EACH EYE AT BEDTIME
GlipiZIDE "ER" TAB 10MG Also Known As: GLUCOTROL XL TAB 10MG	TAKE 1 TABLET BY MOUTH DAILY FOR DIABETES MELLITUS
~~SILVER SULFADIAZINE CRM 1% Also Known As: SILVADENE CRM 1%~~	~~APPLY TOPICALLY TO TAPE BURN DAILY~~
SPIRONOLACTONE TAB 50MG Also Known As: ALDACTONE TAB 50MG	TAKE 1 TABLET BY MOUTH DAILY FOR CONGESTIVE HEART FAILURE \ EDEMA
GlipiZIDE TAB 10MG Also Known As: GLUCOTROL TAB 10MG	TAKE 1 TABLET BY MOUTH DAILY (10PM) FOR DIABETES MELLITUS
BUMETANIDE TAB 1MG Also Known As: BUMEX TAB 1MG	TAKE 1 TABLET BY MOUTH TWICE DAILY FOR CONGESTIVE HEART FAILURE [illegible] at 5PM

25

SNF → Home

- 100% of SNF pts were discharged home with more medications than upon their initial admission to hospital
- Decipher discharge med list
- Variability of prescriptions and medications provided
- Drop off and pick up Rx at pharmacy and hope for no issues
- Figure out routine for med management
- Medication education
- Evaluate for home visit

Sinvani et al. *J Am Med Dir Assoc* 2013;14:668-72.

26

Home-Based Medication Management

- Mixed impact on readmissions
- Pharmacist-RN team
- Dovetail Health
  - Pharmacist-led
  - Access to RN
- Johns Hopkins
  - Access to social worker
- Timing matters
  - # of days post-discharge
  - Prior to HHC & PCP

Triller et al. *AJHP* 2007;64:2244-9.
Stewart et al. *J Am Geriatr Soc* 1998;46:174-80.
Novak et al. *Consult Pharm* 2012;27:174-9.
Pherson et al. *AJHP* 2014;71:1577-83.

27

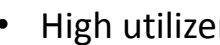
Home Visits: Factors to Consider

- Lives alone and/or no social support
- Previous medication-related hospitalization
- Inadequate functional health literacy
- Multiple medication changes at discharge
- Number of medications at discharge
- Safety concerns at the home
- Difficulty coming to FMH clinic
- Utilization of home care services
- **TIME** (90 to 120 minutes per visit)

Pherson et al. *AJHP* 2014;71:1577-83.

28

SNF → Home: Patient Case



- High utilizer
- Homebound; continuous 02
- Transportation concerns
- Minimal social support
- Low functional health literacy
- Sees multiple providers (8)
- Takes > 20 medications
- Weekly pillbox fills
- Ongoing medication education

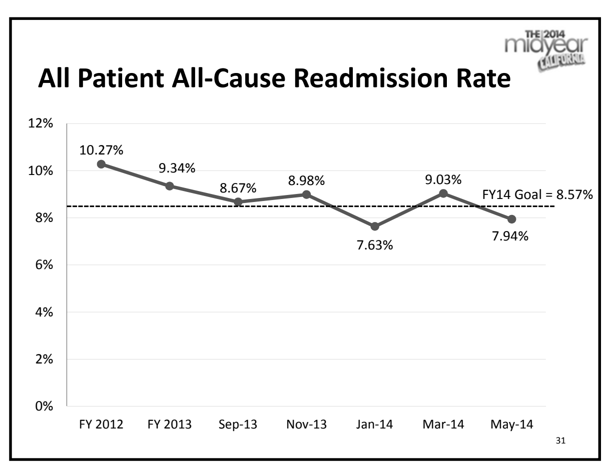
29

SNFs: Opportunities

- Electronic discharge med rec for all SNF pts
- Collaborate with consultant pharmacists at SNFs
  - Hand-offs: hospital → SNF → home
  - Continued medication education
  - Investigate medication costs
- Timely notification of discharges from SNF to home
- Implementation of Bedside Delivery service at SNFs
  - Provision of remaining bulk meds
- Creation of patient-friendly discharge medication lists

30

© 2014 American Society of Health-System Pharmacists

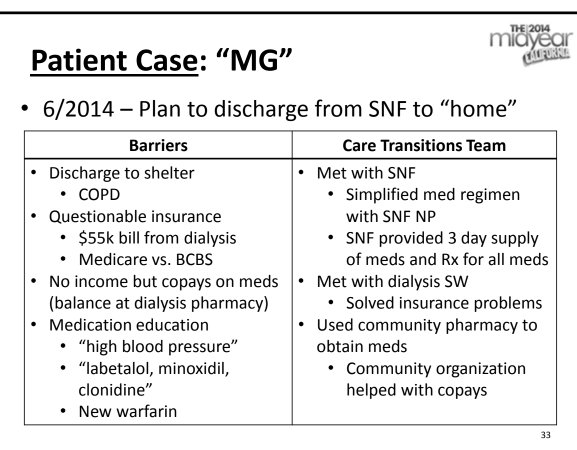


Patient Case: "MG"

- 60 yo AA male with ESRD (2/2 HTN) on IHD

Hospitalizations	Hospital → Discharge Disposition
9/16/13 – 9/18/14	FMH → home
12/23/13 – 12/24/14	FMH (chest pain) → transferred to JHH
12/14/14 – 1/8/14	JHH → SNF
1/13/14 – 1/22/14	St. Joseph Medical Center (afib) → ?
1/29/14 – ?	JHH ?
2/8/14 – 2/11/14	MedStar Franklin Square Hospital Center → ?
3/10/14 – 3/11/14	FMH observation → home
4/4/14 – 4/13/14	FMH (shortness of breath) → SNF
4/22/14 – 4/25/14	FMH (atrial fibrillation) → SNF
4/26/14 – 5/11/14	FMH (SOB) → SNF

32

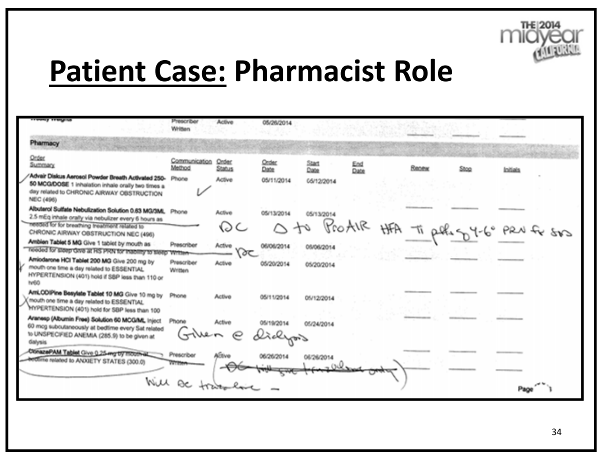

Patient Case: "MG"

- 6/2014 – Plan to discharge from SNF to "home"

Barriers	Care Transitions Team

• Discharge to shelter
  • COPD
• Questionable insurance
  • $55k bill from dialysis
  • Medicare vs. BCBS
• No income but copays on meds (balance at dialysis pharmacy)
• Medication education
  • "high blood pressure"
  • "labetalol, minoxidil, clonidine"
  • New warfarin
	• Met with SNF
	  • Simplified med regimen with SNF NP
	  • SNF provided 3 day supply of meds and Rx for all meds
	• Met with dialysis SW
	  • Solved insurance problems
	• Used community pharmacy to obtain meds
	  • Community organization helped with copays

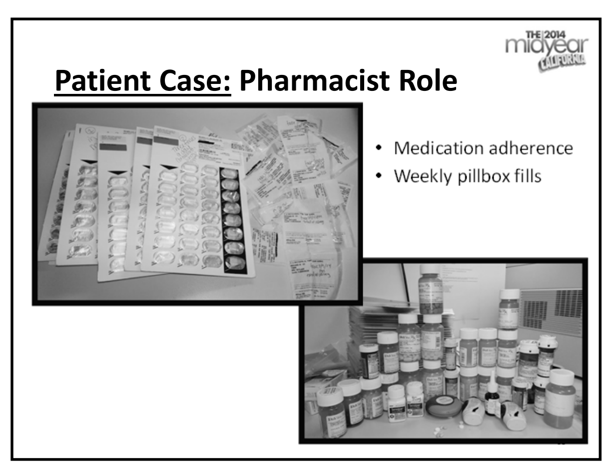
33


Patient Case: Pharmacist Role

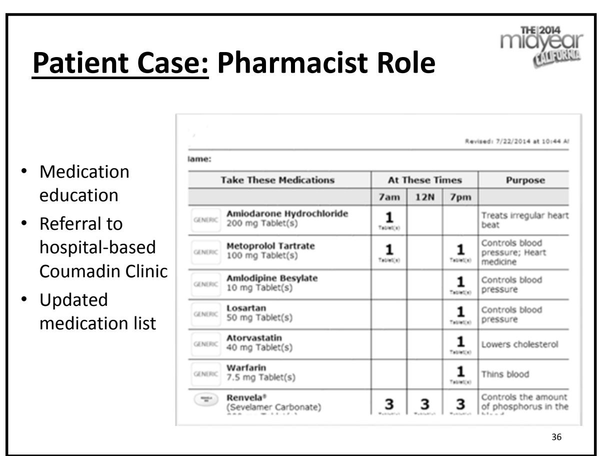
Pharmacy

Order Summary	Communication Method	Order Status	Order Date	Start Date	End Date	Renew	Stop	Initials
Advair Diskus Aerosol Powder Breath Activated 250-50 MCG/DOSE 1 inhalation inhale orally two times a day related to CHRONIC AIRWAY OBSTRUCTION NEC (496)	Phone	Active	05/11/2014	05/12/2014				
Albuterol Sulfate Nebulization Solution 0.63 MG/3ML 2.5 mEq inhale orally via nebulizer every 6 hours as needed for for breathing treatment related to CHRONIC AIRWAY OBSTRUCTION NEC (496)	Phone	Active	05/13/2014	05/13/2014				
Ambien Tablet 5 MG Give 1 tablet by mouth as needed for sleep Give at HS PRN for inability to sleep	Prescriber Written	Active	06/06/2014	06/06/2014				
Amiodarone HCl Tablet 200 MG Give 200 mg by mouth one time a day related to ESSENTIAL HYPERTENSION (401) hold if SBP less than 110 or hr60	Prescriber Written	Active	05/20/2014	05/20/2014				
AmLODIPine Besylate Tablet 10 MG Give 10 mg by mouth one time a day related to ESSENTIAL HYPERTENSION (401) hold for SBP less than 100	Phone	Active	05/11/2014	05/12/2014				
Aranesp (Albumin Free) Solution 60 MCG/ML Inject 60 mcg subcutaneously at bedtime every Sat related to UNSPECIFIED ANEMIA (285.9) to be given at dialysis	Phone	Active	05/19/2014	05/24/2014				
ClonazePAM Tablet Give 0.25 mg by mouth at bedtime related to ANXIETY STATES (300.0)	Prescriber Written	Active	06/26/2014	06/26/2014				

34


Patient Case: Pharmacist Role

- Medication adherence
- Weekly pillbox fills


Patient Case: Pharmacist Role

- Medication education
- Referral to hospital-based Coumadin Clinic
- Updated medication list

Revised: 7/22/2014 at 10:44 A

lame:

Take These Medications	At These Times			Purpose
	7am	12N	7pm	
GENERIC Amiodarone Hydrochloride 200 mg Tablet(s)	1 Tablet(s)			Treats irregular heart beat
GENERIC Metoprolol Tartrate 100 mg Tablet(s)	1 Tablet(s)		1 Tablet(s)	Controls blood pressure; Heart medicine
GENERIC Amlodipine Besylate 10 mg Tablet(s)			1 Tablet(s)	Controls blood pressure
GENERIC Losartan 50 mg Tablet(s)			1 Tablet(s)	Controls blood pressure
GENERIC Atorvastatin 40 mg Tablet(s)			1 Tablet(s)	Lowers cholesterol
GENERIC Warfarin 7.5 mg Tablet(s)			1 Tablet(s)	Thins blood
Renvela® (Sevelamer Carbonate)	3	3	3	Controls the amount of phosphorus in the

36

© 2014 American Society of Health-System Pharmacists

Patient Case: Roles of CT team

Nurse Practitioner	• Patient's "PCP" is nephrologist at dialysis
	• Diagnosed humerus fracture, ordered X-ray, placed sling
	  • Set up appt with Mid-Maryland Musculoskeletal Institute (MMI) for f/u
	• Diagnosed ankle sprain and wrapped ankle
	• Communicated plan of care with nephrologist and cardiologist
	  • Ordered medication refills when needed
	• Fed patient so he would take his meds while at Bridge Clinic

Social Worker	• Found a pro-bono lawyer to meet with patient • Helped patient apply for green card • Provided patient w/a phone charger

37

Patient Case: MG's Long-Term Goals

- Keep him out of the emergency room
- Know his medications
  - Fill his own pillboxes
  - Take meds as prescribed
- Help him obtain green card (and citizenship?)
  - Find a job
    - Income
    - Housing
  - Find a purpose

38

Question #1

All of the following statements are true about Maryland EXCEPT:

a. Only state with an all-payer model
b. The Medicare readmission rates are similar to national Medicare readmission rates
c. The HSCRC has set a 6.76% readmission reduction target for 2014

39

Question #2

A "Med to Bed Delivery" service addresses all of the following barriers EXCEPT:

a. Inability to obtain non-formulary medication
b. Long wait times at the pharmacy
c. Discovering the need for a prior authorization
d. Inability to read medication label
e. Lack of transportation to pharmacy

40

Question #3

Opportunities for improving Transitions of Care from Skilled Nursing Facilities to home include:

a. Collaborating with consultant pharmacists
b. Creating a patient-friendly discharge med list
c. Offering a "Med to Bed Delivery" service
d. Communicating with PCPs at discharge
e. All of the above

41

Key Takeaways

- Key Takeaway #1
  - Collaborate with other disciplines to form an effective Care Transitions team.
- Key Takeaway #2
  - Partner with a community pharmacy to offer a medication bedside delivery service.
- Key Takeaway #3
  - Create a standardized discharge checklist for patients transitioning from skilled nursing facilities to home.

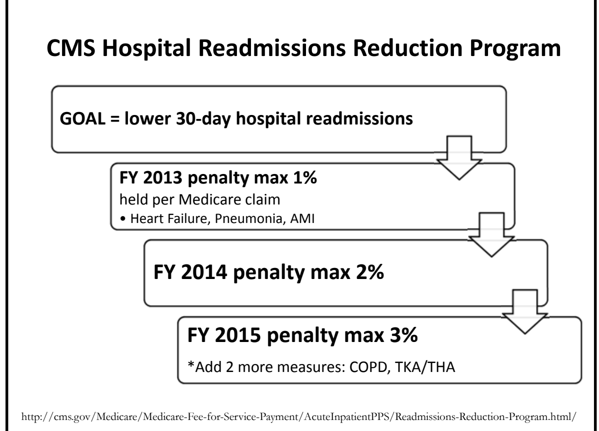
42

© 2014 American Society of Health-System Pharmacists

CPT for TOC, Easy as 1, 2, and 3

Gloria Sachdev, BS Pharm, PharmD
Clinical Assistant Professor, Purdue University College of Pharmacy;
Adjunct Assistant Professor, Indiana University School of Medicine;
President and CEO, Sachdev Clinical Pharmacy, Inc.
December 10, 2014

CMS Hospital Readmissions Reduction Program



http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html/

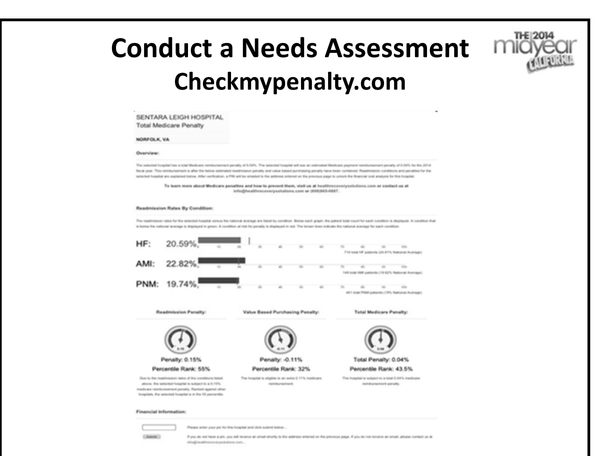
CMS Hospital Readmission Reduction Program

2,610 hospitals will get penalties starting Oct. 1, 2014 to Sept. 30, 2015!

- 433 more hospitals penalized FY 2015 than 2014
- Avg. penalty 0.63% FY 2015 vs. 0.38% FY 2014
- 39 hospitals get 3% penalty
- 496 hospitals get 1.00-2.99%

In NJ, every hospital but 1 will loose money this year

Conduct a Needs Assessment
Checkmypenalty.com



Needs Assessment

Terrific website which notes the 3 year (FY 2013, 2014, 2015) penalty trend for every hospital in US

- see link-link
- http://www.kaiserhealthnews.org/Stories/2014/October/02/Medicare-readmissions-penalties-2015.aspx

Transitional Care Management (TCM)

New bundled payment billing codes for 30 days of service post hospital discharge

Implemented January 1, 2013

You may bill other CPT codes for medically necessary visits during this reporting period

© 2014 American Society of Health-System Pharmacists

Billing for Transitional Care Management BEST Websites

- http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf
- http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf
- http://www.aafp.org/dam/AAFP/documents/practice_management/payment/TCM30day.pdf

Providers of TCM services

Physicians (any specialty)

The following non-physician practitioners (NPP) who are legally authorized and qualified to provide the services in the State in which they are furnished

- Certified nurse-midwives
- Clinical nurse specialists
- Nurse practitioners
- Physician assistants

TCM Services are Post Discharge from one of the Following

- Inpatient Acute Care Hospital
- Inpatient Psychiatric Hospital
- Long Term Care Hospital
- Skilled Nursing Facility
- Inpatient Rehabilitation Facility
- Hospital outpatient observation or partial hospitalization
- Partial hospitalization at a Community Mental Health Center

➢ FQHCs and RHCs are NOT paid using TCM billing codes

Service Components to Bill TCM

1. An interactive contact

- **telephone, e-mail, or face-to-face within 2 business days**
- Provided to patient and/or caregiver
- Attempts to communicate should continue after the first two attempts in the required **2 business days** until they are successful.
- It does not count to leave a voicemail or send an e-mail without response from the beneficiary and/or caregiver

Service Components to Bill TCM

2. Certain non-face-to-face services

- Must furnish non-face-to-face services to the beneficiary, unless physician or NPP determine that they are not medically indicated or needed
- May be furnished by **licensed clinical staff under MD or NPP direction (meeting incident to guidelines).**

3. A face-to-face visit

- **Seen within 7 days for moderately complex**
- **Seen within 14 days for highly complex**
- **Medication reconciliation and management** must be furnished no later than the date you furnish the face-to-face visit

Transitional Care Management

2 of the 3 components must be met or exceeded

Type of Decision Making	# of possible Dx or Mgmt Options	Amt and/or complexity of DATA to be reviewed	Risk of sig complications morbidity, mortality
straightforward	min	min	min
low	limited	limited	low
moderate ⇐	multiple	moderate	moderate
high ⇐	extensive	extensive	high

© 2014 American Society of Health-System Pharmacists

Which CPT code to Use

Type of Decision Making	Face-to-face within 7 days	Face-to-face within 14 days
Moderate Complex	99495	99495
High Complex	**99496**	99495

2014 TCM Payment

	CPT 99495 Hospital Outpatient Office	CPT 99495 Physician Office	CPT 99496 Hospital Outpatient Office	CPT 99496 Physician Office
Anaheim, CA	$120.23	$184.81	$173.95	$259.84
Rest of Maryland (except Baltimore/ Surr Cntys)	$113.42	$167.97	$164.10	$237.22
Indiana	$107.19	$155.74	$155.06	$220.13

Steps to look Up CMS Payment per CPT Code

Professional Fee reimbursement Rates (determined annually, varies per region):

1. www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx
2. Select "Accept"
3. Select PRICING INFORMATION, RANGE OF HCPCS CODES
4. Select SPECIFIC LOCALITY
5. Enter HCPC as "99211 - 99215" or any CPT code
6. Select modifier as "ALL MODIFIERS", and select carrier/MAC locality (example, "Indiana")

What is the Pharmacist's Role in TCM

Within 2 business days post-hospitalization patient interactive contact

- Must follow incident to guidelines (except do not need to be face to face)
- Can be by email, phone, or face-to-face

Assist with on-site visit with MD or NPP

- Med Rec must be done at or before on-site visit
- Assess and support treatment regimen adherence and medication management

Assist with follow-up to optimize patient care during entire 30-day post hospitalization period

Q/A: If the patient is readmitted in the 30-day period, can TCM still be reported?

Yes, as long as the services described by the code are furnished by the practitioner during the **30-day period, including the time following the second discharge**.

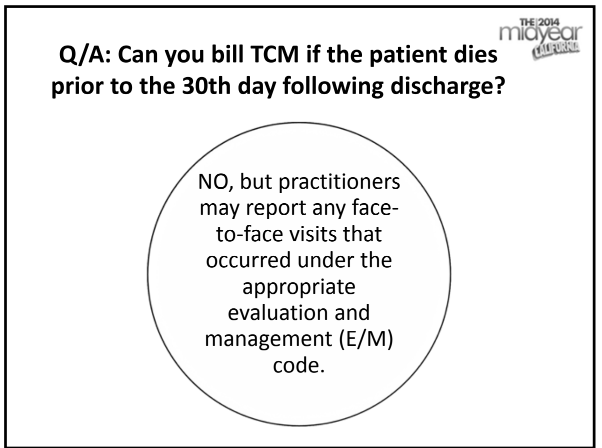
Alternatively, the practitioner can bill for TCM services following the second discharge for a full 30-day period as long as **NO other provider bills the service for the first discharge.**

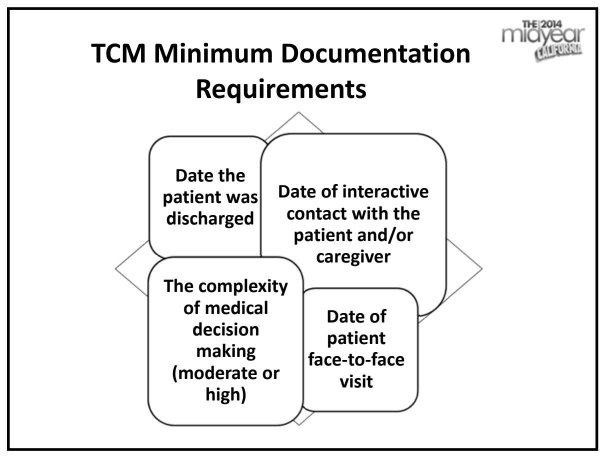
Q/A: If more than one practitioner reports TCM services, how will Medicare determine which practitioner to pay?

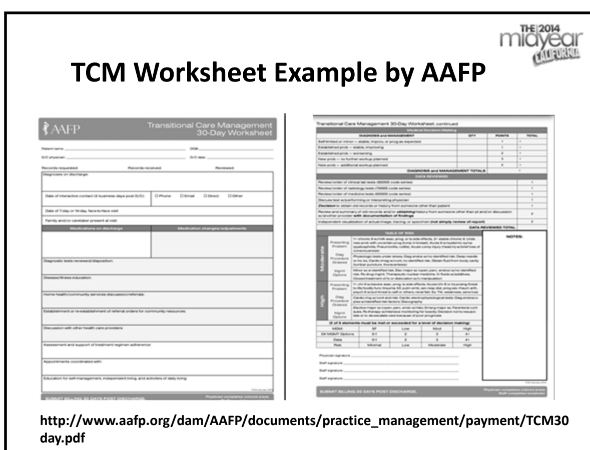
Medicare will only **pay the first** eligible claim submitted during the 30 day period that commences with the day of discharge.

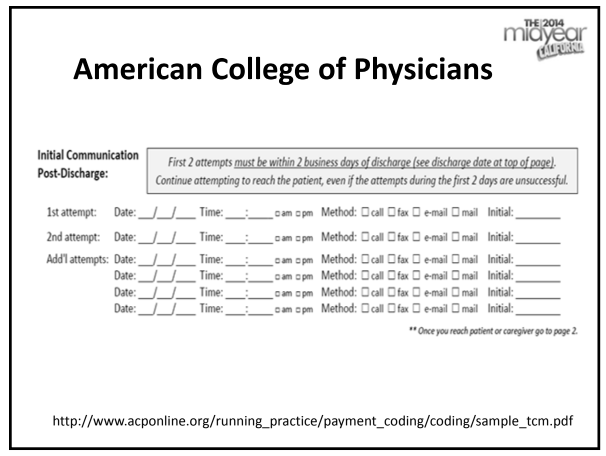
Other practitioners may continue to report other reasonable and necessary services, including other E/M services, to beneficiaries during those 30 days.

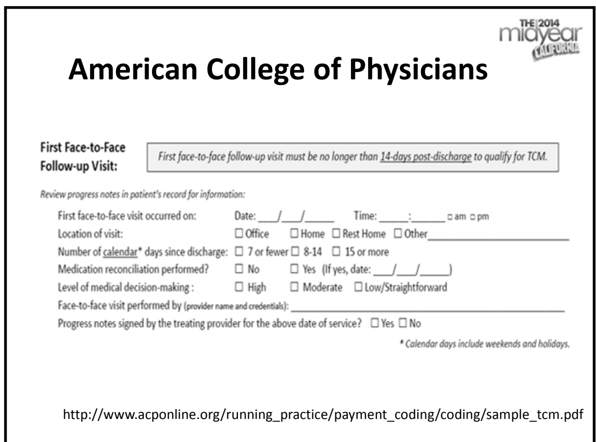
© 2014 American Society of Health-System Pharmacists

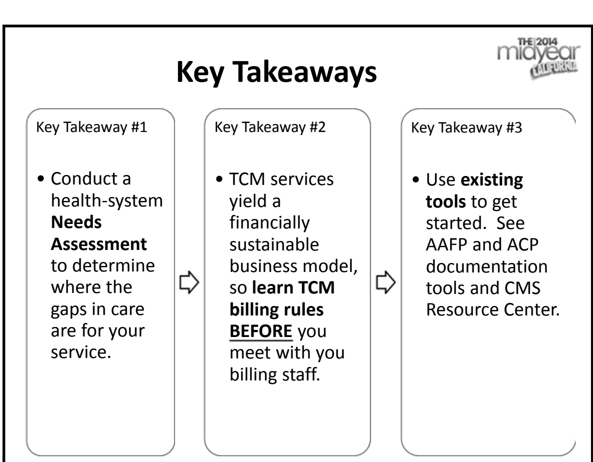












© 2014 American Society of Health-System Pharmacists

References

- CMS Transition of Care Resources
  http://partnershipforpatients.cms.gov/p4p_resources/tsp-preventablereadmissions/toolpreventablereadmissions.html
- ASHP-APhA Medication Management in Care Transitions Best Practices published Feb 2013
  http://www.ashp.org/DocLibrary/Policy/Transitions-of-Care/ASHP-APhA-Report.pdf
- www.ashp.org/menu/News/PharmacyNews/NewsArticle.aspx?id=3885
- www.ashp.org/DocLibrary/MemberCenter/SACP/Spotlight/May-09-2013.pdf

Discussion Time

Poll Everywhere Question

Which statement describes you best?

- A I currently have/practice in a Transitions of Care service.
- B I currently do NOT have/practice in a Transitions of Care service, but WANT to.
- C I currently do NOT have/practice in a Transitions of Care service, and though may have the opportunity, I have NO plans to.
- D I have NO opportunity to have/practice in a Transitions of Care service.

For those who have/practice in a Transitions of Care Service, do you/you organization bill TCM codes for these services?

- A Yes
- B No
- C I do not know

Reducing Readmissions Through Care Transitions: Barriers, Billing and Beyond

Andrea Backes, PharmD, BCACP
Gloria Sachdev, BS Pharm, PharmD

© 2014 American Society of Health-System Pharmacists