Reducing Readmissions Through Care Transitions: Barriers, Billing and Beyond
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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

Maryland All-Payer Model
• 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

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”

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
CT Team: Roles & Responsibilities

<table>
<thead>
<tr>
<th>RN Navigator</th>
<th>Social Worker</th>
<th>Coordinator</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Identify high-risk pts</td>
<td>ED</td>
<td>• Prioritize referrals</td>
</tr>
<tr>
<td>• Assess needs</td>
<td></td>
<td>• Organize contacts</td>
</tr>
<tr>
<td>• Remove barriers to care</td>
<td></td>
<td>• Secure f/u care</td>
</tr>
<tr>
<td>• Educate on disease states</td>
<td></td>
<td>• Schedule f/u appts</td>
</tr>
<tr>
<td>• Coach on self-management</td>
<td></td>
<td>• Reminder calls</td>
</tr>
<tr>
<td>• Find providers</td>
<td></td>
<td>• Fax records</td>
</tr>
<tr>
<td>• Communicate with providers</td>
<td></td>
<td>• TransIT app</td>
</tr>
<tr>
<td>• F/u phone calls</td>
<td></td>
<td>• SafeLink app</td>
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</tbody>
</table>

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%

CT Pharmacists: Evolving Role
- 9/2012
  - Job share (1.0 FTE)
  - Hospital to home
- 1/2014
  - Increase to 1.4 FTEs
  - Hospital to SNF; HF-1 Core Measure
- 7/2014
  - Increase to 2.4 FTEs
  - FY15 CT goals

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

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

Bedside Delivery: Removing Barriers

<table>
<thead>
<tr>
<th>Patient Perspective</th>
<th>CT Perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lack of transportation</td>
<td>• Access to medications</td>
</tr>
<tr>
<td>• Difficulty affording medications</td>
<td>• Is it in stock?</td>
</tr>
<tr>
<td>• Long wait times at the pharmacy</td>
<td>• How common is it?</td>
</tr>
<tr>
<td></td>
<td>• Controlled substances</td>
</tr>
<tr>
<td></td>
<td>• Prior authorizations</td>
</tr>
<tr>
<td></td>
<td>• 24-72 hours</td>
</tr>
<tr>
<td></td>
<td>• Non-formulary; preferred alternative?</td>
</tr>
<tr>
<td></td>
<td>• Automatic order to CM</td>
</tr>
<tr>
<td></td>
<td>• “Check insurance coverage” for high-cost medications</td>
</tr>
</tbody>
</table>

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

Bedside Delivery by Month

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

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

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

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

Mor et al. Health Aff 2010;29:57-64.
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


SNF → Home: Discharge Process

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

SNF → Home: Discharge Med Lists

- Variability in Rx that are given at discharge
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SNF → Home: Discharge Med Lists

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

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


SNF: 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

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)


SNF → Home: Patient Case

- High utilizer
- Homebound; continuous O2
- Transportation concerns
- Minimal social support
- Low functional health literacy
- Sees multiple providers (8)
- Takes > 20 medications
- Weekly pillbox fills
- Ongoing medication education

Patient Case: “MG”
- 60 yo AA male with ESRD (2/2 HTN) on IHD

Patient Case: Pharmacist Role
- Medication adherence
- Weekly pillbox fills
**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

**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

**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

**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

**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

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

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CMS Hospital Readmissions Reduction Program

GOAL = lower 30-day hospital readmissions

FY 2013 penalty max 1%
• Heart Failure, Pneumonia, AMI
FY 2014 penalty max 2%
FY 2015 penalty max 3%
*Add 2 more measures: COPD, TKA/THA

http://www.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 lose money this year

Conduct a Needs Assessment Checkmypenalty.com

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

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
Billing for Transitional Care Management

BEST Websites

- http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCM5.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

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

<table>
<thead>
<tr>
<th>Type of Decision Making</th>
<th># of possible Options</th>
<th>Amt and/or complexity of DATA to be reviewed</th>
<th>Risk of sig complications morbidity, mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>straightforward</td>
<td>min</td>
<td>min</td>
<td>min</td>
</tr>
<tr>
<td>low</td>
<td>limited</td>
<td>limited</td>
<td>low</td>
</tr>
<tr>
<td>moderate</td>
<td>multiple</td>
<td>moderate</td>
<td>moderate</td>
</tr>
<tr>
<td>high</td>
<td>extensive</td>
<td>extensive</td>
<td>high</td>
</tr>
</tbody>
</table>
Which CPT code to Use

<table>
<thead>
<tr>
<th>Type of Decision Making</th>
<th>Face-to-face within 7 days</th>
<th>Face-to-face within 14 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate Complex</td>
<td>99495</td>
<td>99495</td>
</tr>
<tr>
<td>High Complex</td>
<td>99496</td>
<td>99495</td>
</tr>
</tbody>
</table>

2014 TCM Payment

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

Steps to look Up CMS Payment per CPT Code

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

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.
Q/A: Can you bill TCM if the patient dies prior to the 30th day following discharge?

NO, but practitioners may report any face-to-face visits that occurred under the appropriate evaluation and management (E/M) code.

TCM Minimum Documentation Requirements

- Date the patient was discharged
- Date of interactive contact with the patient and/or caregiver
- The complexity of medical decision making (moderate or high)
- Date of patient face-to-face visit

TCM Worksheet Example by AAFP

[Image of TCM Worksheet]


American College of Physicians

- Initial Communication Post Discharge
- Follow-up Visit

http://www.acponline.org/running_practice/payment_coding/coding/sample_tcm.pdf

Key Takeaways

- **Key Takeaway #1**
  - Conduct a health-system Needs Assessment to determine where the gaps in care are for your service.

- **Key Takeaway #2**
  - TCM services yield a financially sustainable business model, so learn TCM billing rules BEFORE you meet with your billing staff.

- **Key Takeaway #3**
  - Use existing tools to get started. See AAFP and ACP documentation tools and CMS Resource Center.

[Image of Key Takeaways]
References

• CMS Transition of Care Resources

• ASHP-APhA Medication Management in Care Transitions Best Practices published Feb 2013

• 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?

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

- Yes
- No
- I do not know

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