Transitions of Care: Primary Care Perspective

Patrick Noonan, DO

Disclosures

None

Bio

- Outpatient primary care internist at New Pueblo Medicine
- Completed residency at the University of Iowa
- Graduated from Kirksville College of Osteopathic Medicine (KCOM)
  - AT Still University
- Most importantly….

A Bit About New Pueblo

- NCQA Level III recognized PCMH Internal Medicine practice since 2009
  - PCMH- Patient Centered Medical Home
  - HEDIS measures
  - CAHPS survey
- 6 PCPs with patient panels & 1 hospitalist
  - 1-2 Nurse Practitioners and 60+ FTEs
  - 8000 patients
  - 22% Medicare, 12% MA, 66% commercial, no AHCCS
- Recently joined Optum Care

Overview

- Who cares? Why transitions of care are so important
- Where we are right now? Methods and barriers to communication & continuity of care
- It takes a village… Our transition team of patient advocates and our current system of care
- Are you gonna pay for it? Reimbursement programs
- So what can we do to further improve communications through the care continuum?

Importance of Good Transitions

Question

What percentage of hospital readmissions are preventable?

A. 0%

B. 20%

C. 60%

D. 100%

Hospital-Wide (All-Condition) 30-Day Risk-Standardized Readmission Measure

- Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation (YNHHSC/CORE)
- Measures created using Medicare data from 2007-2008, tested on 2009 data for all payers
- Last updated in 2011

Importance of Good Transitions

- Rate of readmission in 2003-2004 was almost 20%
- Cost of readmissions estimated at $17 billion/yr
- Savings if readmissions lowered to top-performing regions was estimated at $1.7 billion/yr
- Most importantly, large ramifications to patients (functional loss, stress, risk of infections, etc)

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/downloads/MMSHospital-WideAll-ConditionReadmissionRate.pdf

Factors That Determined Readmission Risk

- Quality of inpatient care during initial admission
- Communication with patient, family, caregivers, and clinicians caring for them
- Patient education
- Assessment prior to discharge
- Coordination of care after discharge

Factors Associated with Preventable Admissions

1. Premature discharge

2. Lack of discussion about care goals in patients with serious illnesses

3. Failure to relay important information to outpatient health care professionals

4. ER decision to readmit when unnecessary

* Patient functional status was not a factor

Preventability and Causes of Readmissions in a National Cohort of General Medicine Patients; Auerbach, et al. *JAMA Intern Med.* 2016;176(4):484-493. doi:10.1001/jamainternmed.2015.7863; http://archinte.jamanetwork.com/article.aspx?articleid=2498846.

If we narrowed it down to one key feature that would reduce readmissions, what would that be?

COMMUNICATION!!

Flow of Communication

- Patient to emergency physician (ER note)
- Emergency physician to hospitalist
- Patient to hospitalist (H&P)
- Hospitalist to hospitalist (repeat as necessary)
- Hospitalist to Patient (D/C Instructions)
- Hospitalist to outpatient physician team (D/C Summary)

What could possibly go wrong?

Methods and Barriers to Communication

Standard Methods of Communication IP to OP

- Faxed notification of admission (hours-days-week)
- Faxed Hospital H&P (hours-days-week)
- Faxed Discharge Summary (hours-days-weeks)
- Patients call and inform the office of admission
- Patients report the admission at next follow up appt

Question

What is your biggest barrier to communication with inpatient or outpatient settings?

A. Lack of Awareness

B. Lack of Time

C. Lack of Financial Incentive

D. Lack of Access to Systems

Barriers to Communication & Continuity of Care

- PCPs out of the hospitals
  - Hospital medicine became a specialty of its own
  - Change in sense of "ownership" of the patient
- Increased demands on physicians in hospital or office
  - Lack of time (patients, paperwork, etc)
  - Primary Care Quality Paradox
- Different EHRs and lack of access to other systems
- Decrease in physician networking

Our Transition Team and Process

Our Transition Team

- Primary Care Physician
- Hospitalist (and Hospitalist Group)
  - TMC only
- Registered Nurse
- Experienced Medical Assistant and 2 MAs of PCP
- Scheduler
- Pharmacy tech

Ideal system for continuity of care and smooth transitions

- Minimize providers throughout the care continuum
  - Fewer handoffs always better
  - Strong sense of patient "ownership"
  - Good knowledge of the patient's history
- Clear inpatient treatment plan, discharge instructions, and adequate follow up documented in D/C Summary
- Plan and follow up clearly discussed with patient and written out in patient friendly language
- All providers with access to the electronic medical record

Our Hospital System

- One hospitalist admits and cares for our patients M-F
  - TMC only, with residents
- PCPs & hospitalist share night calls and admissions
- Our hospitalist or the hospitalist group round on weekends with residents
- Admission calls go to PCP (or on call provider) first
- PCPs have access to TMC EHR and hospital privileges

Our Transition Process

- Be aware of admissions
  - Monitor faxes for notifications
  - Manually watch the census at local hospitals for our patients
  - Utilize Health Information Exchange (HIE)
    - Soon- real-time admits, discharges, and transfers to PCP
- Know when the discharge happens
  - From the hospital and SNF or acute rehab, if applicable
- Contact the patient and/or caregivers within 1-2 days
- Arrange Post-hospital Visit within 7-14 days

Transition Process cont'd

- SNF discharges are much more difficult to track
  - Tend to be sicker and less functional patients
  - Less contact with facility
  - No access to medical record
  - Medications often adjusted or changed
  - Medication reconciliation not easily available
  - Discharge documentation not required for 30 days

High Risk Patient Pool

- List of patients identified in each PCPs panel that are high risk for complications and admissions
- Contacted every 2-4 weeks if stable (~10-20 min)
  - Current status and care plan
  - Medication reconciliation
  - Specialist follow-up
- High Risk Meeting (transition team) every 2-4 weeks
- Any Post-Hospital Visit done within 7 days of d/c

Reimbursement

Question

How is your practice being reimbursed?

A. Fee-for-service only

B. Mostly fee-for-service, some value-based pay

C. Value-based or ACO

D. Other (Direct Patient Care, etc)

Reimbursement

- Transitional Care Management
- Chronic Care Management
- Patient Centered Medical Home (PCMH)
- Value-Based Incentives

Transition Care Management

- Cover the services required to transition the patient to the community setting after discharge
- 30 day TCM period begins on day of discharge and continues for next 29 days
  - Billed after the 30 day period

Transitional Care Management

- CPT Code 99495
  - Contact (face-to-face, phone, email) with the patient or caregiver within 2 business days of discharge
  - Medical decision making of MODERATE complexity
  - Face-to-face visit within 14 days
- CPT Code 99496
  - Contact (face-to-face, phone, email) with the patient or caregiver within 2 business days of discharge
  - Medical decision making of HIGH complexity
  - Face-to-face visit within 7 days

TCM Reimbursement

- CPT Code 99495 (Moderate, visit within 14 days)
  - $111.42
  - 99213 reimburses $76.03
- CPT Code 99496 (High, visit within 7 days)
  - $161.23
  - 99214 reimburses $107.51, 99215 reimburses $145
- First year using these codes, NPM received $100k+

TCM Resources

- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN908628.html
- http://www.aafp.org/dam/AAFP/documents/practice_management/payment/TCMFAQ.pdf

Chronic Care Management

- Non-face-to-face services for Medicare beneficiaries with 2+ chronic conditions
  - "chronic continuous or episodic health conditions that are expected to last at least 12 months, or until death" of pt
  - "place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline"
- Services include care coordination, med mgmt, 24 hr accessibility
- Office visits or other face-to-face encounters billed separately

CCM cont'd

- CCM code can only be billed by physician, advanced practice RN, clinical nurse specialist, or PA
- Must establish, implement, revise, monitor, and manage a comprehensive electronic care plan
  - Certified EHR needed
  - Addressing physical, mental, cognitive, psychosocial, functional, and environmental needs
  - Med rec with adherence/potential interactions
  - List of resources and supports specific to pt

CCM Reimbursement

- CPT code 99490- $43
  - 20+ minutes of clinical staff time per calendar month
- CPT code 99487- $94
  - Complex chronic care management
  - Moderate-high complexity
  - 60 minutes of clinical staff time per calendar month
- CPT code 99489- $47
  - Billed in addition to 99487
  - Each additional 30 minutes per calendar month

CCM Reimbursement

- Initiate services at Initiating Visit (AWV, PE, etc)
  - Use CPT code G0506 add-on ($64)
- Patient's consent for services required
- Does not have to be billed every month
- Copays and deductibles apply
- Cannot be billed with certain other codes
  - Including TCM

CCM Resources

- https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/chronic-care-management.html
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

Patient Centered Medical Home (PCMH)

- Provides roadmap for transformation from volume to value
- It's a journey and not a destination
- Payers provide value incentives based on accreditation
- Pays off in MIPS (MACRA/QPP)
  - Example: Automatic full credit (15%) for Clinical Practice Improvement Activities
    - Determines practice bonus and incentives

Value Based Incentives

- Medicare
  - Merit-based Incentive Payment System (MIPS)
  - Advanced Alternative Payment Models (APMs)
  - Annual Wellness Visit
- Medicare Advantage Plans
  - Gainshare or Profit Sharing (STARS/HEDIS)
  - Annual Care Visit ($75/pt/yr)
- Blue Cross Blue Shield
  - 8% increase in FFS for PCMH
  - $200/pt for chronic disease management
  - Chronic disease incentives ($30-40k)

Other Ways to Improve Communication

- Make the EHR work for us!
  - Improve Health Information Exchange
  - Real-time admit & discharge information
  - Include advanced imaging and procedures to avoid duplication of testing
- Remove quality reporting barriers that do not clearly improve quality of patient care
- Utilize Physician Navigators in hospitals

Improvements Cont'd

- Increase physician networking and camaraderie
  - Work together and have a voice in the legislation
- Decrease physician risk, especially for small groups
  - Use a running 3-5+ year quality scoring system
  - Make the payouts quarterly
  - Allow similar groups to align
  - Reduce the effect of costly outliers that do not illustrate the quality of care, only chance

Conclusions

- Smooth transitions and excellent communication improves the patient experience and outcomes
- It also decreases the cost of healthcare
- As handoffs increase, we have to remember to keep care personalized and communication clear
- It takes a full team of caring healthcare providers
- There are reimbursement programs to cover the additional cost of these important services
- Let's always remember…healthcare is personal!

Thank you!