THE TIME IS NOW FOR TCM

Prioritize Discharge Planning for Transitional Care Management

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TELEHEALTH

White Paper

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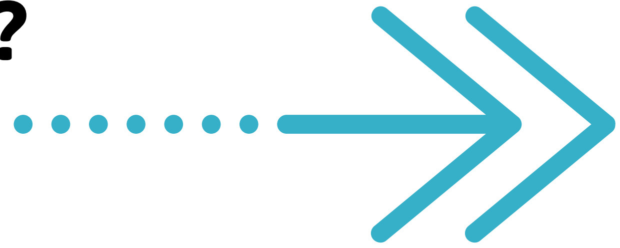
WHAT IS TRANSITIONAL CARE MANAGEMENT?

And how is it represented?



TCM allows primary care providers and specialists to furnish continued and improved care for patients who have been recently discharged from a hospital or another facility as qualified by the Centers of Medicaid and Medicare Services (CMS).

Through TCM, members of the care team review discharge information

As well as the need for follow-up tests or treatments

And further educate the beneficiary & their family members, if needed

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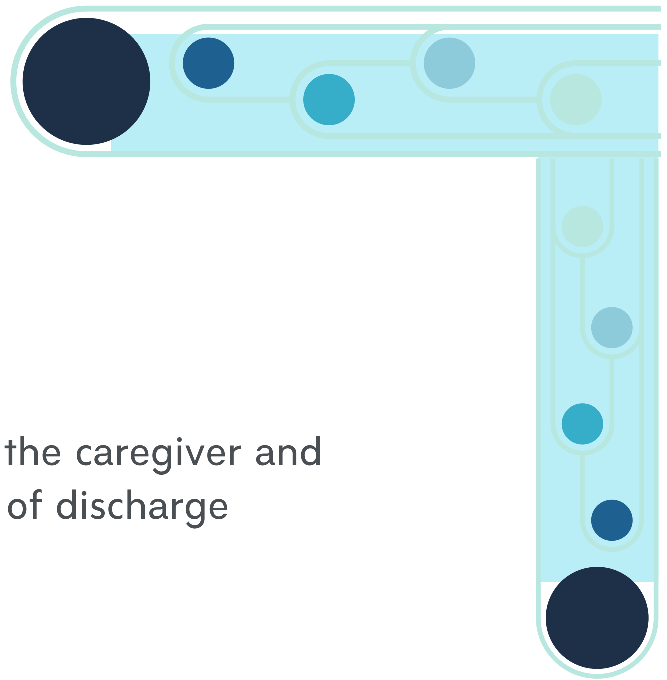
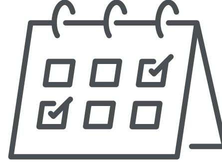
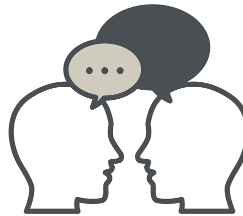
Characteristics of TCM





1 Contact that must be made between the caregiver and beneficiary within two business days of discharge



2 Occasional face-to-face visits that must be conducted under direct supervision within 7-14 business days of discharge

3 Non-face-to-face methods of communication, conducted under general supervision, that are used to monitor the patient or provide education

4 Help with moderate or high complexity medical decision-making for patients with mental or psychosocial issues

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A Growing Trend

In 2013, there were 476,307 Medicare claims of TCM services billed nationwide.

In 2018, there were 1,358,697 Medicare claims of TCM services billed nationwide.

The total number of billed TCM services nationwide from 2013 to 2018 was 5,354,427.[1]

Effectiveness of TCM

A randomized clinical trial that observed older adults with heart failure returning to their homes after being discharged, showed readmission rates improved for those receiving TCM and saw fewer all-cause rehospitalizations than those who did not.[2]

P-value of .026, meaning that there is a 2.6 percent chance these results are due to pure chance.

When observed after one year of being discharged, per-patient cost savings were on average

$4,845.20

In another program launched by the University of Pennsylvania Health System called the Transitional Care Program, the rehospitalization rate for high-risk patients 30 days after being enrolled was half that of the national average for Medicare beneficiaries with 4+ conditions.

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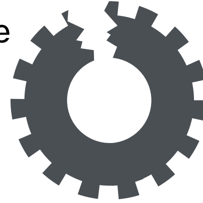
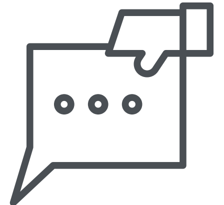
TCM MISTAKES TO AVOID

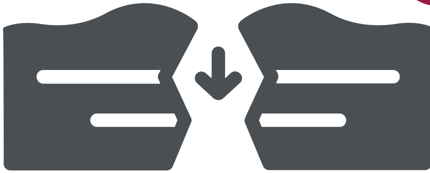
Poor management - Transitional care can often be poorly managed, especially for adults with multiple chronic conditions, or MCCs.



Poor communication



In a detailed study, researchers at the University of Calgary surveyed almost 25,000 patients a year after discharge and found that those who reported being consistently left out of their care decisions had a 34 percent higher chance of readmission than patients who were actively involved in care decisions. Additionally, patients who were not informed through written communication about symptoms or health problems to watch for after being discharged had a 24 percent higher chance of readmission.[4]



Gaps in care can lead to worsened conditions for patients compared to their previous state of health.

Physician burnout can be a cause of poor surveillance of electronic health record (EHR) inboxes.

Lack of either physician-prompted or intrinsic patient motivation can lead to pitfalls in continuing care.

As an example, according to one study conducted by Kaiser Permanente Southern California, out of 224,000 kidney patients treated by 7,000 different providers, 58 percent of those patients did not receive needed follow-up care.[3]

Recurring readmission rates are a substantial metric to watch, as the average cost of readmission in 2016 due to any diagnosis was $14,400.

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TRANSITIONAL CARE MANAGEMENT CHECKLIST

Screening: Checking for characteristics that would put a patient at-risk such as age, recent health complications, medical history or presence of chronic conditions

Staffing: Utilizing experienced and well-trained staff, who use multimodal approaches, in-person training and webinar content training, to provide patient-centered care

Maintaining relationships

- Holding virtual or in-person visits, and regularly calling the patient
    - VCS is a billable service, even for FQHCs and RHCs, designed for this purpose
- Maximizing time-sensitive visits and encouraging positive and effective communication between patients and their care teams

Engaging patients and caregivers

- Considering the whole care plan and ensure everyone is involved in care management
- Identifying, documenting, and updating patient health goals as needed
- Respecting patient autonomy while still recommending step-by-step changes
- Providing clarifications regarding care

Assessing and managing risks and symptoms

- Considering all environmental, cultural, and medical factors possibly affecting the patient, such as mental health, substance use history, SDOH, and language barriers
- Considering all patient symptoms, including pain, fatigue, and shortness of breath
- Focusing on patient education and promoting patient self-management
- Coaching and modeling care for patients
- Teaching patients ways to exercise to prevent worsening of health
- Counseling patients on dosage organization systems, co-pay assistance resources and refill plans
- Providing emotional support and encouraging good emotional health to spark long-term behavior changes that will benefit the patient

Collaboration

- Using teamwork to enhance care for the patient
- Using technology and multidisciplinary approaches to care

Promoting continuity: Maintaining the same clinician for the entirety of the patient's journey to foster a strong relationship

Fostering coordination

- Encouraging communication between the patient and the hospital or discharge facility
- Providing referrals for health and community-based services
- Giving effort into making transitions seamless for patients[2]

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Partnering to build a better future for your patients.

With strong communication and effort from providers and the care team, TCM can help discharged patients avoid readmission and worsening health conditions. Following a discharge planning model such as the one outlined above can help patients see more sustainable health outcomes. Finding a partner can help ease the transition into this new workflow. **The time to implement TCM is now, and we will be here to help whenever you feel ready.**

Certintell is a care management company that enables safety-net providers to make a lasting impact on the health of underserved patients through telehealth. We do this by using our in-depth expertise in health care and health information technology to anticipate — and meet — the needs of health care payers, providers and patients.

Closing the Care Gap™

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SOURCES

[1] Marcotte, Leah M., et al. “Trends in Utilization of Transitional Care Management in the United States.” JAMA Network Open, vol. 3, no. 1, American Medical Association, Jan. 2020, pp. e1919571–e1919571. jamanetwork.com, doi:10.1001/jamanetworkopen.2019.19571.

[2] Hirschman, Karen, et al. “Continuity of Care: The Transitional Care Model.” The Online Journal of Issues in Nursing, vol. 20, no. 3, Sept. 2015, doi:10.3912/OJIN.Vol20No03Man01.

[3] Heath, Sara. “Care Gaps Emerge for Patients Not Receiving Key Follow-Up Care.” PatientEngagementHIT, 19 July 2019. patientengagementhit.com, https://patientengagementhit.com/news/care-gaps-emerge-for-patients-not-receiving-key-follow-up-care.

[4] Kemp, Kyle A., et al. “Lack of Patient Involvement in Care Decisions and Not Receiving Written Discharge Instructions Are Associated with Unplanned Readmissions up to One Year.” Patient Experience Journal, vol. 4, no. 2, July 2017, pp. 13–22. DOI.org (Crossref), doi:10.35680/2372-0247.1205.

[5] Bailey, Molly, et al. “Characteristics of 30-Day All-Cause Hospital Readmissions, 2010-2016 #248.” Health Cost and Utilization Project, 6 Feb. 2019, https://www.hcup-us.ahrq.gov/reports/statbriefs/sb248-Hospital-Readmissions-2010-2016.jsp.