What is Transitional Care Management?

**CMS Definition:**
Care transitions occur when a patient moves from one health care provider or setting to another.

- Nearly 1 in 5 Medicare patients discharged from a hospital—approximately 2.6 million seniors—are readmitted within 30 days, at a cost of over $26 billion every year.

- Hospitals have traditionally tried to reduce readmissions by focusing efforts on components that they are directly responsible for - the quality of care during the hospitalization and the discharge planning process.

- Identifying key drivers of readmissions and implementing appropriate interventions to address those drivers is necessary for reducing readmissions.
The requirements for TCM services include:

• The services are required during the patient’s transition to the community setting, following certain discharges.

• The healthcare professional accepts and takes responsibility of the patient’s care post-discharge from the facility setting without a gap.

• The patient has medical and/or psychosocial problems that require moderate or high complexity medical decision making.

The 30-day TCM period begins on the date the beneficiary is discharged from the inpatient hospital setting and continues for the next 29 days.
During the 30 days, beginning on the date the beneficiary is discharged from an inpatient setting, you must furnish these three TCM components:

1) AN INTERACTIVE CONTACT
An interactive contact must be made with the beneficiary and/or caregiver, as appropriate, within 2 business days following the beneficiary’s discharge to the community setting. The contact may be via telephone, email, or face-to-face. It can be made by you or clinical staff who have the capacity for prompt interactive communication addressing patient status and needs beyond scheduling follow-up care.
2) **CERTAIN NON-FACE-TO-FACE SERVICES**
Non-face-to-face services must be furnished to the beneficiary, unless determined that they are not medically indicated or needed. Clinical staff under physician or NP direction may provide certain non-face-to-face services.

**NON-FACE-TO-FACE SERVICES provided by physician or NPs:**
- Obtain and review discharge information (for example, discharge summary or continuity of care documents).
- Review need for or follow-up on pending diagnostic tests and treatments
- Interact with other health care professionals who will assume or reassume care of the beneficiary’s system-specific problems.
- Provide education to the beneficiary, family, guardian, and/or caregiver.
- Establish or re-establish referrals and arrange for needed community resources.
- Assist in scheduling required follow-up with community providers and services.
Services Provided by Licensed Clinical Staff Under the Direction of a Physician or NP:

- Communicate with agencies and community services the beneficiary uses.
- Provide education to the beneficiary, family, guardian, and/or caretaker to support self-management, independent living, and activities of daily living.
- Assess and support treatment regimen adherence and medication management.
- Identify available community and health resources.
- Assist the beneficiary and/or family in accessing needed care and services.
3) **A FACE-TO-FACE VISIT**
Physicians or NPs must furnish one face-to-face visit within certain time frames as described by the following two Current Procedural Terminology (CPT) codes:

CPT Code 99495 – Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge).

CPT Code 99496 – Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge)
TCM services are furnished following the patient’s discharge from one of the following inpatient hospital settings:

- 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

Following discharge from one of the above settings, the patient must be returned to his or her community setting, such as:

- His or her home
- His or her domiciliary
- A rest home
- Assisted living
Who Can Bill for Transitional Home Care?

These health care professional may furnish TCM services:
- Physicians (any specialty)

These non-physician practitioners (NPs) who are legally authorized and qualified to provide the services in the State in which they are furnished:
- Certified nurse-midwives (CNMs)
- Clinical nurse specialists (CNSs)
- Nurse practitioners (NPs)
- Physician assistants (PAs)
In addition to TCM services, STHS Transition Home Care’s aim is to provide effective, patient-centered care transitions between settings by:

- Preventing medication errors by medication reconciliation at home
- Making PCP and Specialty Care appointments if needed
- Identifying barriers to care for early intervention - DME, community resources or referral to needed medical services.
- Complete advance care planning if desired.
- Avoid duplication of processes and efforts to utilize resources more effectively.
- Provide patient & caregiver advocacy by supporting patient’s preferences and choices.
STHS Transitional Home Care Staffing

Dr. Hill, Collaborating Physician

Jennifer Ledet, APRN
Emily Pupo, RN
Paula Toups, AVP

Shirley Timmons, APRN
Robyn Malbrough, RN
Beth Monies, Supervisor

Tyesha Rhodes, SW
Transitional Home Care- How YOU Can Help

- Identify patients who meet criteria for Transition Care services:
  - BPCI-a patients
  - Medicare, Managed Medicare and commercial insurance
  - Patients w/ a moderate or high risk for unplanned readmission score
  - Multiple comorbidities
  - Multiple hospital admissions and/ or Emergency Department visits
  - Complex needs to address social determinants of health
  - Complex psychosocial needs

- Place EPIC ambulatory referral for patients who meet criteria for program

- Educate your patients on the STHS Transition Care program and benefits
Now that I’m discharged...

what's next?

Transitional Home Care

Our Transitional Home Care Program is staffed with a highly skilled Nurse Practitioner, Registered Nurse (RN) and Certified RN Case Manager. This team will follow your care for at least 30 days after hospital discharge. The purpose of this program is to ensure that you continue to improve and avoid a return visit to the hospital.

After you leave the hospital:

- Please follow all discharge instructions received while you were in the hospital.
- You will receive a post-discharge phone call from a Case Manager within two business days of discharge.
  - During this phone call, a Nurse Practitioner visit will be scheduled if a visit is indicated.
- You will receive follow up visits and/or telephone calls as needed by a Registered Nurse.
- Our highly experienced team will connect you with vital resources to ensure your medical needs are met throughout your episode of care.

If you have any questions about your discharge plan, please call the St. Tammany Health System Transitional Home Care team at 985-871-5959.

World-Class Health Care. Close to Home.
Thank You!!

STHS Transition Home Care Team
1010 South Polk Street
Suite 2
Covington, LA 70433
(985) 871-5955 (phone)
(985)871-5954 (fax)