Care Transitions Breakout Session

May 8th, 2024

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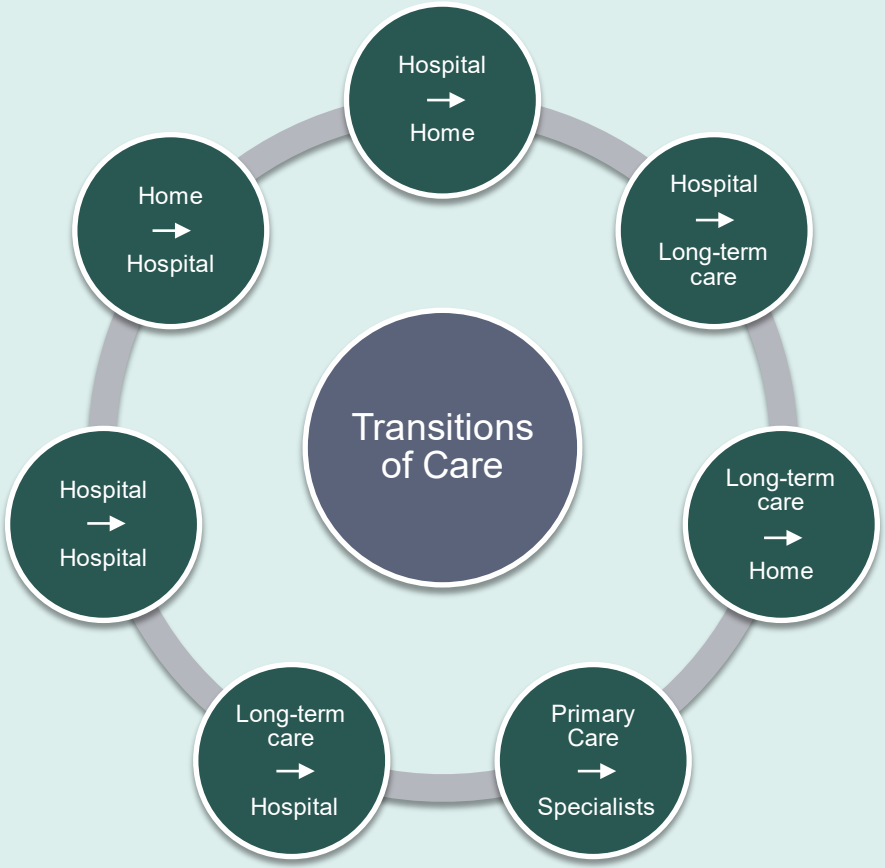
Importance of Care Transitions



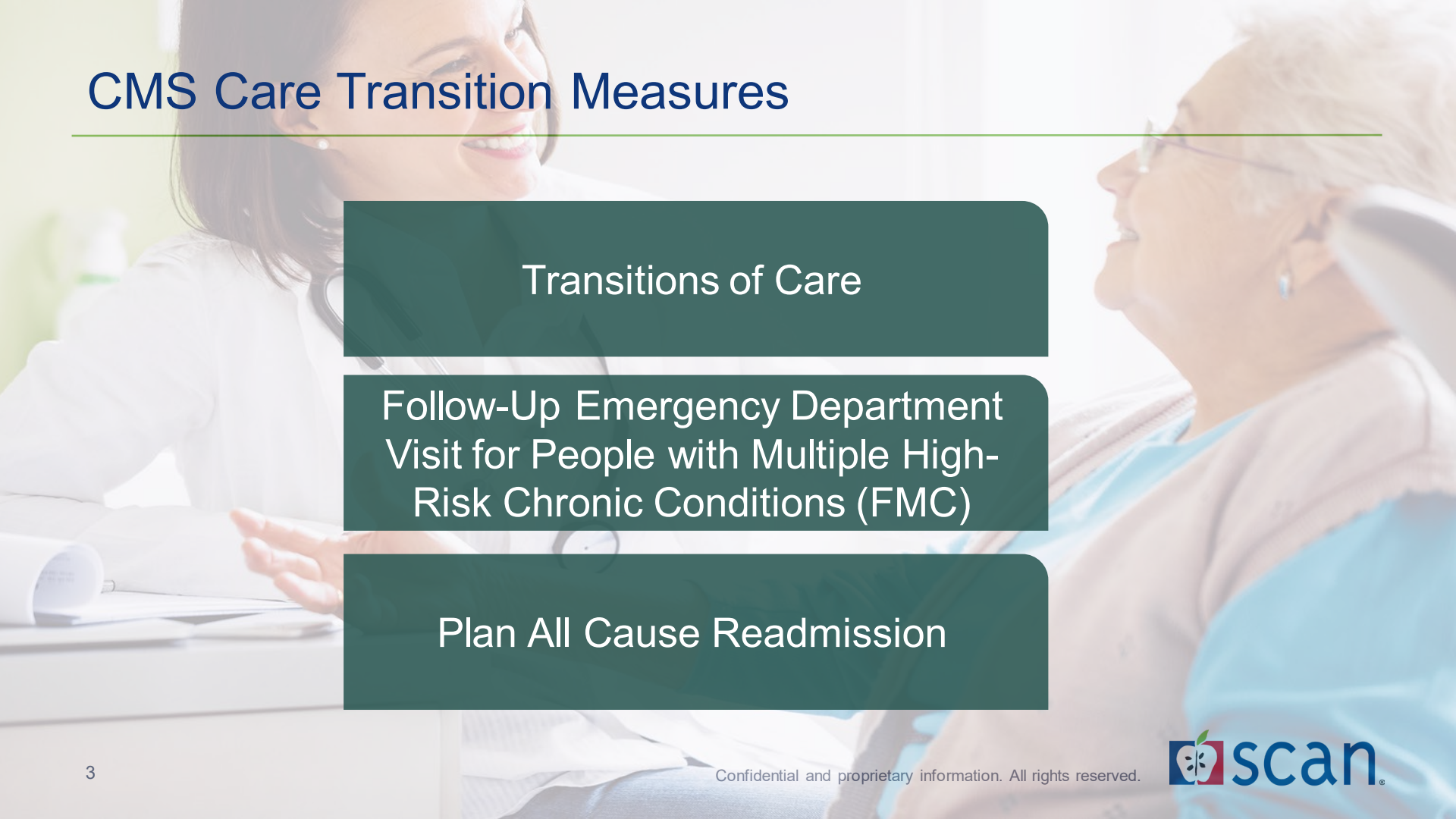
Readmissions from post-acute care providers to acute care, amount to more than **$26 billion** annually and affect almost **20% of beneficiaries**

Patients who experience Transitions of Care experienced:

- Fewer rehospitalizations
- Lower total Medicare Parts A & B spending
- Almost one-third of an additional healthy day at home

ThoroughCare, C. T. (2023, August 22). *Transitional Care Management: Using Tech for safety and cost control*. https://www.thoroughcare.net/blog/transitional-care-management-data-safety-cost-control

CMS Care Transition Measures



Transitions of Care

Follow-Up Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)

Plan All Cause Readmission

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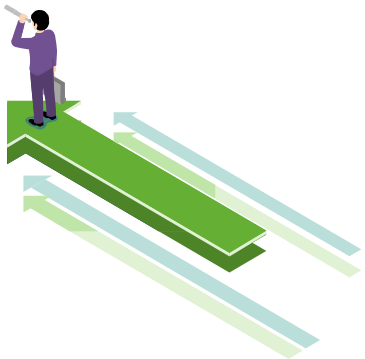
Care Transition Worksheet

Please identify 2 processes or objectives for each measure that can be applied to drive performance improvement

Transitions of Care

Follow-Up after ED Visit

Plan All Cause Readmission



Transitions of Care

Four-Part Measure

Transitions of Care

4-Part Measure

1. **Notification of Inpatient Admission**
2. **Receipt of Discharge Information**
3. **Patient Engagement after Inpatient Discharge**
4. **Medication Reconciliation Post Discharge**

Measures the percentage of discharges that had all 4 care transition actions completed

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Transitions of Care (Continued)

1 Notification of Inpatient Admission

- Within 2 days after admission
- Notification via phone, email, fax, HIE, ADT feed or shared EMR

2 Receipt of Discharge Information

- Within 2 days after discharge
- Discharge information including discharge instructions, procedures or treatment provided, discharge diagnoses, Medication list and **testing results, pending tests, or "no tests pending"**

Tips:

- Proof of timely, automated receipt of notice of inpatient admission and discharge in PCP EMR and signed off
- When using a shared EMR system, documentation of a "received date" in the EMR is not required to meet criteria. Evidence that the information was filed in the EMR and is accessible to the PCP or ongoing care provider on the day of discharge through 2 days after the discharge meets criteria
- SCAN faxes automatic out of area admission and discharge notifications to PCPs

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Transitions of Care (Continued)

3 Patient Engagement after Inpatient Discharge

- Within 30 days after discharge
- Patient engagement via office visits, visits to the home, telehealth, or transitional care management services

4 Medication Reconciliation Post Discharge

- Within 30 days after discharge
- Medication reconciliation is defined as medication reconciliation between 1) the last medication list in the outpatient record prior to the inpatient admission and 2) the discharge medication list
- MRP can be completed by RN, clinical pharmacist, MD, NP, and PA
- A visit is **not required** to complete MRP
- In order to satisfy this measure, document & code properly: 1111F, 99495 or 99496.

Tip: During the post discharge visit, review discharge instructions and reconcile inpatient and outpatient medications

Follow-Up Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)

Follow-Up After ED Visit for People with Multiple High-Risk Chronic Conditions

What Does it Measure?

The percentage of emergency department visits for members with multiple high-risk chronic conditions who had a follow-up service within 7-days of the emergency department visit.

Tip: Excludes ED visits that resulted in an inpatient stay

Follow-Up After ED Visit for People with Multiple High-Risk Chronic Conditions

Denominator: Eligible members have 2+ conditions prior to the emergency department visit

- COPD and Asthma
- Alzheimer's Disease and related disorders
- Chronic Kidney Disease
- Depression
- Heart Failure
- Acute Myocardial Infarction
- Atrial Fibrillation
- Stroke and Transient Ischemic Attack

Tip: SCAN provides a list of all patients who could be in the denominator

Follow-Up After ED Visit for People with Multiple High-Risk Chronic Conditions

Numerator: Follow-up service within 7 days of emergency department visit

- Outpatient visit
- Telephone or telehealth visit
- Transitional care management services
- Case management
- Complex Care Management
- Outpatient or telehealth behavioral health visit
- Intensive outpatient encounter or partial hospitalization
- Community mental health center visit
- Electroconvulsive therapy
- An observation visit

Plan All Cause Readmission

Plan All Cause Readmission

What it Measures	Exclusions	Key Changes
The number of acute inpatient or observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission	• Nonacute inpatient stays • Hospice patients * *Other exclusion may apply*	The measure now includes observation discharges

Call to Action

- Ensure that chronic conditions are accurately evaluated and coded, as this is a case mix adjusted measure
- Ensure all hospitalization data with all diagnosis are submitted

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Meet our Panel

Grenda Lee, LCSW
Senior Director, Care Transitions at Providence

Grenda is a leader focusing on implementing, evaluating, and refining the Care Management strategy across the Providence health system with the goal of knowing and understanding the populations that we serve in California.

Dr. Richard Lam
Medical Director Home Visits, Transitions of Care at Alta Med

Dr. Lam oversees the Clinician Home Visit Program, Transitions of Care Program, and Enhance Care Management Program.

Dr. Madhavi Koka
Regional Chief Medical Officer of L.A. South at Optum

Dr. Koka oversees Clinical Performance, Quality, Access and Utilization for members in South LA county.