Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

Implementing Phone Calls in Transitional Care Management

TAP TO GO BACK TO KIOSK MENU

Jaya Kanduri MD, Ryan Eid MD, Andrew Silapaswan MD MPH, Niloo Latifi MD,
Robert Stuver MD, Tara Skorupa MD, Tarsha Soares RN , Candace Reynolds RN, Rebecca Glassman MD, Molly Brett MD, Kelly Graham MD,
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Problem

- The post-hospital discharge transitional care period is a vulnerable time for patients, prone to adverse events, and costly
- There is a 19.6% 30-day rehospitalization rate among Medicare fee-for-service patients
- $44 billion per year is spent on 30-day rehospitalizations
- Post-discharge, patients may not be connected to care despite inpatient efforts
- At HCA, 55% of Medicare patients discharged home have a PCP appointment scheduled within 14 days and only 44% are seen within 14 days of discharge
- The Transitional Care Management (TCM) protocol can help identify acute issues in Medicare patients within 48 hours post-discharge, ensure outpatient follow up is established within 7-14 days after discharge, and help improve transitions in care
- There is also a mortality benefit associated with TCM post-discharge visits

Goals

- Develop and implement a TCM protocol including phone calls made within 48 hours after discharge
- Increase post-discharge follow-up for medicare patients using phone communication
- Identify acute symptoms, medication errors and barriers to care prior to in-office visit
- Increase post-discharge office visits to facilitate coordination of care and to address ongoing active and chronic medical conditions

Multidisciplinary Team

- Residents: Jaya Kanduri MD, Ryan Eid MD, Andrew Silapaswan MD MPH, Niloo Latifi MD, Robert Stuver MD, and Tara Skorupa MD
- Attendings: Rebecca Glassman MD, Molly Brett MD, Kelly Graham MD
- Clinical Nurses: Tarsha Soares RN , Candace Reynolds RN

Interventions

Identify Health Care Associates (HCA) Medicare patients discharged from BIDMC to home

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Call patients within 2 business days of discharge

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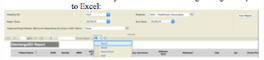
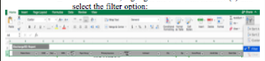
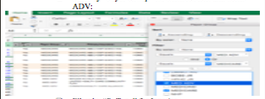
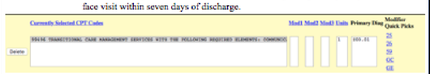
Facilitate office visit within 7-14 days based on medical complexity

Protocol

TCM Protocol for Nursing

BEFORE PHONE CALL	PHONE CALL	AFTER PHONE CALL
❑ Obtain daily list of HCA Medicare patients discharged from BIDMC to home from Performance Manager ❑ Select "Discharge and ED" under Registry Reports ❑ Select the day before w/ the following settings & export to Excel:  ❑ Once in Excel, highlight the row with headers (4) and select the filter option:  ❑ Filter by "Payer Group" for MEDICARE and MED ADV:  ❑ Filter by "Pt Type" for Inpatient ❑ Filter by "Disposition ADT" for HOME and HOME WITH SERVICES ❑ Print finalized list for the day, as well as list of patients not reached the day prior ❑ Review discharge summary &/or worksheet ❑ Discharge diagnoses ❑ Transitional issues ❑ Procedures performed ❑ New/stopped/revised medications ❑ Need for follow up services ❑ Determine if follow-up already scheduled with designated PCP/NP	❑ Make telephone contact with patient and/or caregiver within 2 business days following discharge to home (encounter may not occur on same day as discharge). This includes business days Monday-Friday 8AM-5PM (nights, weekends, and holidays do not count toward two-day allowance) ❑ Telephone content ❑ Review how patient is feeling including red flag signs/symptoms ❑ Ask patient if they stopped medications, picked up new medications, and/or are taking new dose ❑ Triage to CRS if issues with transportation ❑ Triage to pharmacy if issues with medications ❑ Tell patient to bring in all medications for next visit ❑ Ask if patient is able to keep appointment, and if not, what are their barriers ❑ Review when patient is scheduled for PCP follow-up and re-schedule to within 7 vs. 14 days after discharge if needed based on complexity of medical decision-making ❑ Prioritize follow-up with PCP first, if unavailable then NP if already being co-managed, then with resident in same suite as PCP ❑ Update new/stopped/revised medications in OMR	❑ Use "TCM Phone Visit" macro to document phone call in OMR ❑ If unable to reach patient, document missed attempt and attempt to contact at least twice within 2 business days as two separate OMR notes ❑ Include "TCM" in comments section under reason for visit for follow-up appointment

TCM Protocol for Provider

BEFORE VISIT	DURING VISIT	AFTER VISIT
❑ Review discharge information and continuity of care documents ❑ Verify there is an initial contact "post-discharge phone note" within 48 hours of discharge in OMR	❑ Use TCM macro note in OMR ❑ Visit content ❑ Transitional issues ❑ Medication reconciliation ❑ Refill medications if needed ❑ Follow up appointments scheduled ❑ Services at home	❑ Determine level of complexity as moderate versus high ❑ Bill Medicare post-discharge follow-up visits meeting moderate or high complexity within 30 days ❑ CPT Code 99495: Covers communication with the patient or caregiver within 2 business days of discharge. Involves medical decision making of at least moderate complexity and a face-to-face visit within 14 days of discharge.  ❑ CPT Code 99496: Covers communication with the patient or caregiver within 2 business days of discharge. Involves medical decision making of high complexity and a face-to-face visit within seven days of discharge. 

➢ **Figure 1. Protocol for contacting patients including screenshots of the computer program used to extract the daily list of discharged Medicare HCA patients from BIDMC, and billing for the TCM visit**

For more information, contact:
Dr. Rebecca Glassman MD

TCM Protocol for Nursing

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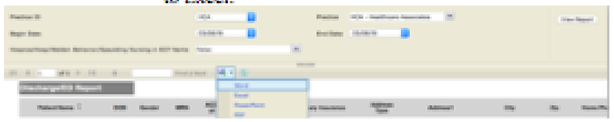
- ❑ Obtain daily list of HCA Medicare patients discharged from BIDMC to home from Performance Manager
  - ❑ Select "Discharge and ED" under Registry Reports
  - ❑ Select the day before w/ the following settings & export to Excel:



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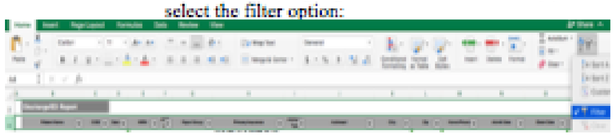
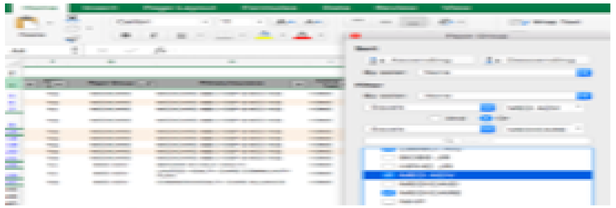


  - ❑ Filter by "Payer Group" for MEDICARE and MED ADV:



  - ❑ Filter by "Pt Type" for Inpatient
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  - ❑ Print finalized list for the day, as well as list of patients not reached the day prior
- ❑ Review discharge summary &/or worksheet
  - ❑ Discharge diagnoses
  - ❑ Transitional issues
  - ❑ Procedures performed
  - ❑ New/stopped/revised medications
  - ❑ Need for follow up services
- ❑ Determine if follow-up already scheduled with designated PCP/NP

PHONE CALL

- ❑ Make telephone contact with patient and/or caregiver within 2 business days following discharge to home (encounter may not occur on same day as discharge). This includes business days Monday-Friday 8AM-5PM (nights, weekends, and holidays do not count toward two-day allowance)
- ❑ Telephone content
  - ❑ Review how patient is feeling including red flag signs/symptoms
  - ❑ Ask patient if they stopped medications, picked up new medications, and/or are taking new dose
  - ❑ Triage to CRS if issues with transportation
  - ❑ Triage to pharmacy if issues with medications
  - ❑ Tell patient to bring in all medications for next visit
  - ❑ Ask if patient is able to keep appointment, and if not what are their barriers
- ❑ Review when patient is scheduled for PCP follow-up and re-schedule to within 7 vs. 14 days after discharge if needed based on complexity of medical decision-making
- ❑ Prioritize follow-up with PCP first, if unavailable then NP if already being co-managed, then with resident in same suite as PCP
- ❑ Update new/stopped/revised medications in OMR

AFTER PHONE CALL

- ❑ Use "TCM Phone Visit" macro to document phone call in OMR
- ❑ If unable to reach patient, document missed attempt and attempt to contact at least twice within 2 business days as two separate OMR notes
- ❑ Include "TCM" in comments section under reason for visit for follow-up appointment

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TCM Protocol for Provider

BEFORE VISIT

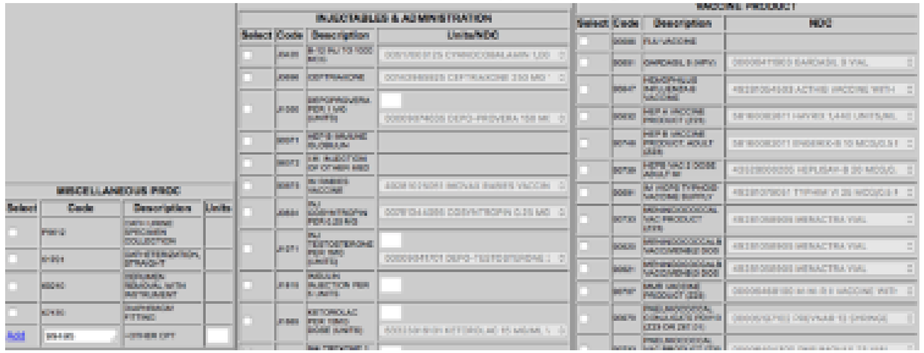
- ❑ Review discharge information and continuity of care documents
- ❑ Verify there is an initial contact "post-discharge phone note" within 48 hours of discharge in OMR

DURING VISIT

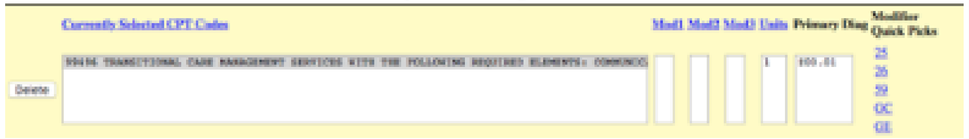
- ❑ Use TCM macro note in OMR
- ❑ Visit content
  - ❑ Transitional issues
  - ❑ Medication reconciliation
  - ❑ Refill medications if needed
  - ❑ Follow up appointments scheduled
  - ❑ Services at home

AFTER VISIT

- ❑ Determine level of complexity as moderate versus high
- ❑ Bill Medicare post-discharge follow-up visits meeting moderate or high complexity within 30 days
  - ❑ CPT Code 99495: Covers communication with the patient or caregiver within 2 business days of discharge. Involves medical decision making of at least moderate complexity and a face-to-face visit within 14 days of discharge.



  - ❑ CPT Code 99496: Covers communication with the patient or caregiver within 2 business days of discharge. Involves medical decision making of high complexity and a face-to-face visit within seven days of discharge.



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Results

Total Patients Contacted During Pilot	60
Number of Patients Discharged Per Day (mean)	4.3

Table 1. Sixty patients were contacted during this pilot with an average of 4.3 patients contacted per day.

Time to Perform Calls

Time to Review Chart, min (mean)	4.3
Time to Update Chart, min (mean)	2.7
Length of Phone Call, min (mean)	8.9
Total Time, min (mean)	22.9

Table 2. Average time to review chart and perform post discharge phone calls

Conclusion/Future Work

- It will require .20 FTE to place 4.3 calls a day
- Post-discharge phone calls have a positive impact on facilitating care in the transitional period for moderate and high complexity patients
- Measure percentage of patients that keep their scheduled follow-up
- Measure 30 day readmission rate among patients contacted
- Implement protocol on a larger scale to include all HCA Medicare eligible discharges

Results

Total Patients Contacted (n=60)	
Reached on first phone call attempt	61.7%
Patients without existing appointment	38.3%
Existing appointment 7-14 days from discharge date	58.1%
Patients unaware of existing appointment	28%
Patients with new appointments made during call	25%
Patients referred to community resource specialist/pharmacists	8.3%
Patients with 30-Day Rehospitalization*	26.7%
High Complexity Patients**	30%

Table 3. Impact of phone calls on facilitating patient care in the post discharge period.
*30-Day rehospitalization refers to patients whose most recent discharge and post-discharge phone call was for a hospitalization that was a 30 day re-admission after previous first hospitalization
**High-complexity according to criteria established by Center for Medicare and Medicaid Services

For more information, contact: