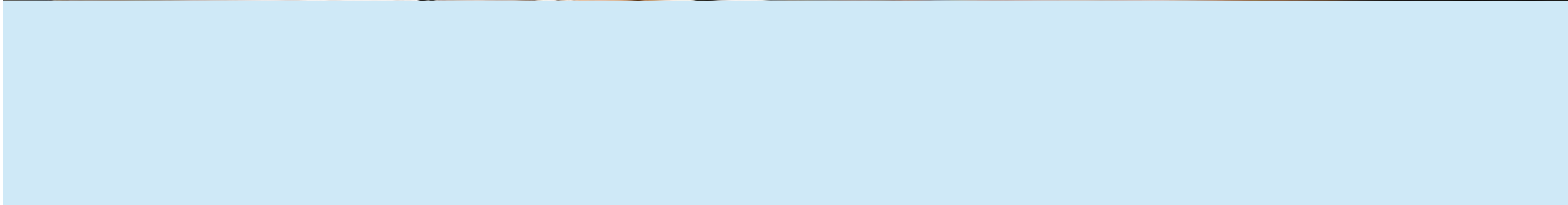
Great Lakes Practice Transformation Network



Transition of Care Management:

Moving Beyond a Hospital's Boundaries to Improve Patient Care Outcomes

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Great Lakes Practice Transformation Network

TCPI Program

- The Transforming Clinical Practice Initiative is designed to help clinicians achieve large-scale health transformation through collaborative and peer-based learning networks
- 29 Practice Transformation Networks awarded
- 10 Support Alignment Networks awarded
- CMS Investment of **$685 million**

Great Lakes Practice Transformation Network

- Offer grant-funded Lean assistance
  - Facilitated Rapid Improvement Events (RIE)
  - Training staff at practice to build internal capacity for future efforts
  - Targeted grant related metrics, but have wide breadth of application

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Rapid Improvement Events

A3 Problem-Solving Process for Rapid Improvement Events (RIEs)

SCOPE	SOLVE	SUSTAIN
1 Clarify the Challenge Problem to solve or reason for taking action, including 1 to 3 metrics that need to improve.	**4 Identify Key Gaps** Description of the roadblocks to reaching the target state expressed in terms of root cause and lean thinking.	**7 Define a Completion Plan** Actions, owners and dates needed to deploy and sustain the solutions.
2 Model the Current State Description of the process to improve, including scope; baseline value for metrics; key attributes to change; and flow diagrams.	**5 Develop Balanced Solutions** How to address the root causes and gaps by adding lean functionality and eliminating waste.	**8 Hardwire Essential Behaviors** Define features and functions that mistake-proof the process and achieve lasting behavior changes.
3 Define the Target State Description of the improved process, including desired values for metrics (numeric goals), key attributes, and future-state flow diagrams.	**6 Run Simple Experiments** Conduct test in the gemba (workplace) that shows via data that solutions achieve 80% target state (numeric goals).	**9 Initiate Daily Improvement** Implement visual control board, data collection and, when needed, a huddle process in the workplace to monitor, stabilize and sustain solutions.

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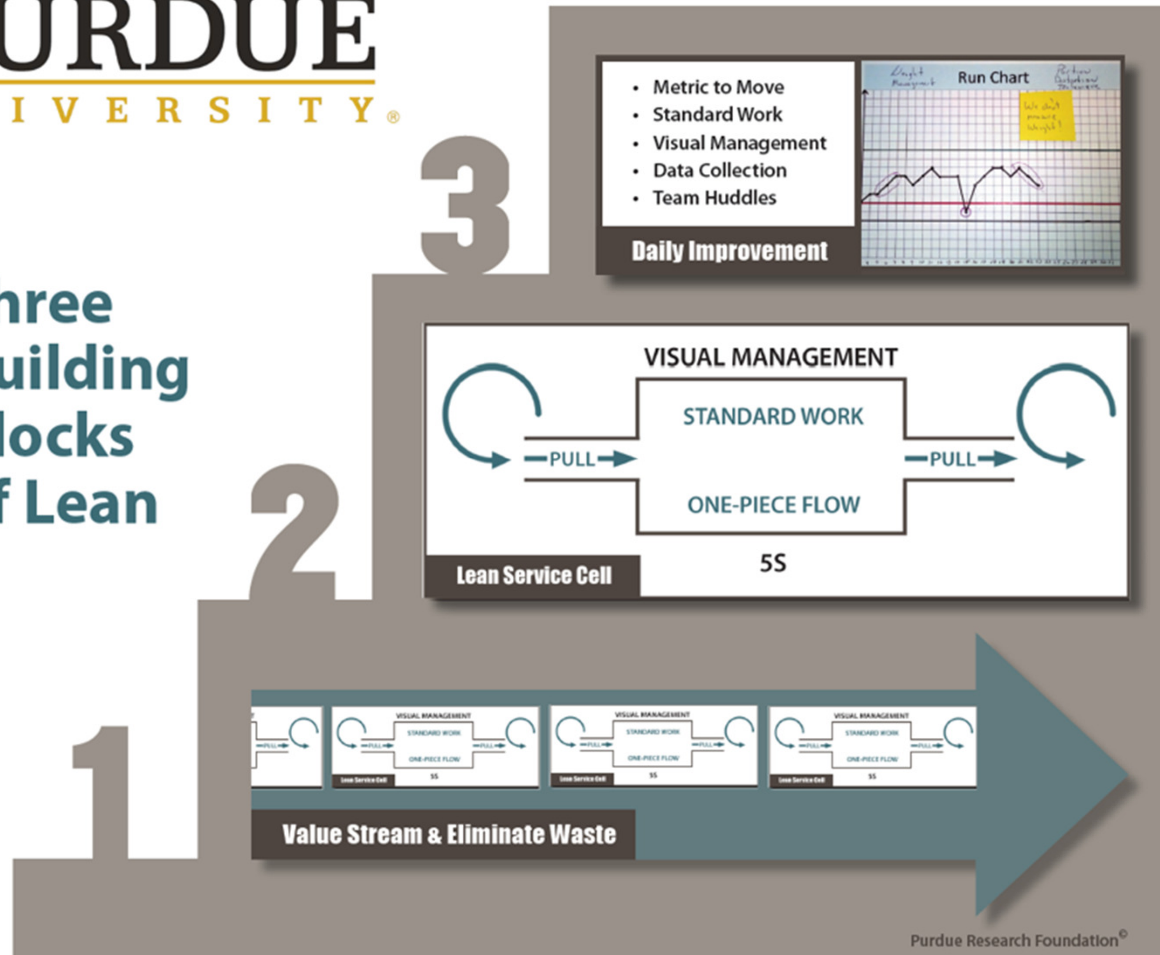
LEAN Model



LEAN FIRST

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Understanding Transitional Care Management

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About TCM

- Transitional Care Management services are intended to help Medicare Fee-For-Service patients transition successfully from a hospital stay back to a community setting
- Can be billed by traditional practices, RHCs, FQHCs
- Payment, based on complexity of patient, ranges from $165 to $230 in an ambulatory setting

TCM RIE at Harrison County Hospital

Cynthia Lee, ASA

Physician Practices Manager

Rose Higazy, MSN, RN

Medical-Surgical Nurse Manager

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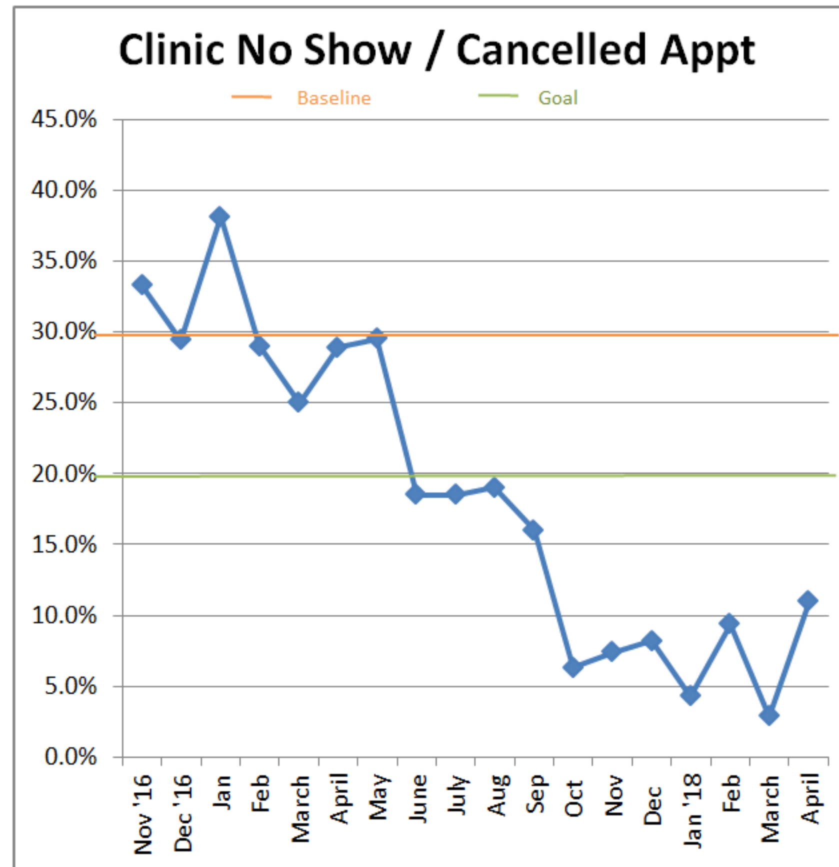
Reason for the Change
“We Have a Problem”

Statement of Project: Prior to implementation of new process, the No-Show/ Cancellation rate was 30% within the hospital owned practices.

Clinic No Show / Cancelled Appt	
Nov '16	33.3%
Dec '16	29.4%
Jan	38.1%
Feb	29.0%
March	25.0%
April	28.9%
May	29.5%
June	18.5%
July	18.5%
Aug	19.0%
Sep	16.0%
Oct	6.3%
Nov	7.4%
Dec	8.2%
Jan '18	4.3%
Feb	9.4%
March	2.9%
April	11.0%



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Harrison County Hospital & Physician Practices

13 Hospital Owned Physician Practices

HCH is a Critical Access Hospital with:

- 4 ICU Beds / 8 TCU Beds
- 22 Medical/Surgical Beds
- 7 OB/Nursery
- 12 ED Rooms, 2 Hallway Beds
- 2 Hospitalists & 2 NP's

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Analysis of Workflow
Common Barriers

	PRESENT STATE	GOAL
Continuity of Care	• 30% of patients not coming to f/u appointments.	• Facilitate ease of patient f/u • Secondary capture of post-hospitalization TCM charges
Communication Gap	• Computerized documentation only at discharge from hospital • Volume of papers the patients did not read	• Establish morning huddle • SBAR – TCM tool to patient and MD office
Process Flow	• No flag that patient was post-hospital visit • No standard work process • Variances in multiple offices	• Created TCM form at discharge • Developed visual management • Trained all staff
Teamwork	• Silos • Limited understanding of work outside of own practice area	• Collaboration • Communication • Continuity

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Standard of Work

Transition of Care Management
Hand-off Document

Patient Name: ____________________

Inpatient → Access Center → Circle Provider: Albertson, Bodney, Bonacum, Clunie, Connerly, Gonzaba, J.Grossman, Gunter, Kline, Lemmel, McCarty, McCollum, Melton, Murphy, Pierce, Sauer, Wheatley

Ph: (812) 734-3100 F/U Appt Date/Time: ____________________

Fx: (812) 738-3155 If discharged after hours fax to access center and they will call patient to set up an appointment. If non-staff physician use yellow sheet. Fax: 812-738-3155

INPATIENT (Nurse/Ward Clerk to complete)

Discharge Diagnoses (Top 3): Primary: ____________________

Secondary: ____________________

Tertiary: ____________________

Date of Discharge: ____________________

Designated Caregiver Name: ____________________ Phone: ____________________

Medication Considerations & F/U: ____________________

Diet: ____________________

Tobacco engagement: ☐ No interest ☐ Interest (☐ Gave packet ☐ Gave prescription ☐ Other__________)

New Equipment: Walker / Life Vest / O2 / Nebulizer / Glucose Meter / Other: ____________________

Vendor: ____________________

Functional Limitations: Mobility / Incontinence / Confusion: ____________________

Skin Breakdown: Location: ____________________ Stage: ____________________

Pending Test Results: ____________________

Specialty Provider Referrals Specialty: ____________________

Provider Name: ____________________ Appt. Date: ____________________

Signature: ____________________ Date: ____________________

Medication list is attached to this paper. Please take both forms to your doctor appointment.

FOR OFFICE USE ONLY

ACCESS CENTER (Information Access Center will be asking)

Appointment made during business hours? ☐ Yes ☐ No

If no, then appointment date/time: ____________________

Qualify for TCM: ☐ Yes ☐ No. If No, reason:

☐ Doesn't have Medicare/Medicare Replacement insurance.

☐ No communication documented. ☐ Scheduled 2 weeks past discharge date.

☐ Re-admit within 30 days ☐ Other:

Signature: ____________________ Date: ____________________

ORIGINAL: To ICU Medical Records Drawer – "TCM" Folder COPY: To Patient

Transition of Care Management
Hand-off Document

Patient Name: ____________________

Non- staff Physician: Name: ____________________ Phone Number: ____________________

Follow Up Appointment Date/Time: ____________________

INPATIENT (Nurse/Ward Clerk to complete)

Discharge Diagnoses (Top 3): Primary: ____________________

Secondary: ____________________

Tertiary: ____________________

Date of Discharge: ____________________

Designated Caregiver Name: ____________________ Phone: ____________________

Medication Considerations & F/U: ____________________

Diet: ____________________

Tobacco engagement: ☐ No interest ☐ Interest (☐ Gave packet ☐ Gave prescription ☐ Other__________)

New Equipment: Walker / Life Vest / O2 / Nebulizer / Glucose Meter / Other: ____________________

Vendor: ____________________

Functional Limitations: Mobility / Incontinence / Confusion: ____________________

Skin Breakdown: Location: ____________________ Stage: ____________________

Pending Test Results: ____________________

Specialty Provider Referrals Specialty: ____________________

Provider Name: ____________________ Appt. Date: ____________________

Signature: ____________________ Date: ____________________

Medication list is attached to this paper. Please take both forms to your doctor appointment.

Yellow copy to patient. Copy to Medical Records – Goes to chart not Access Center

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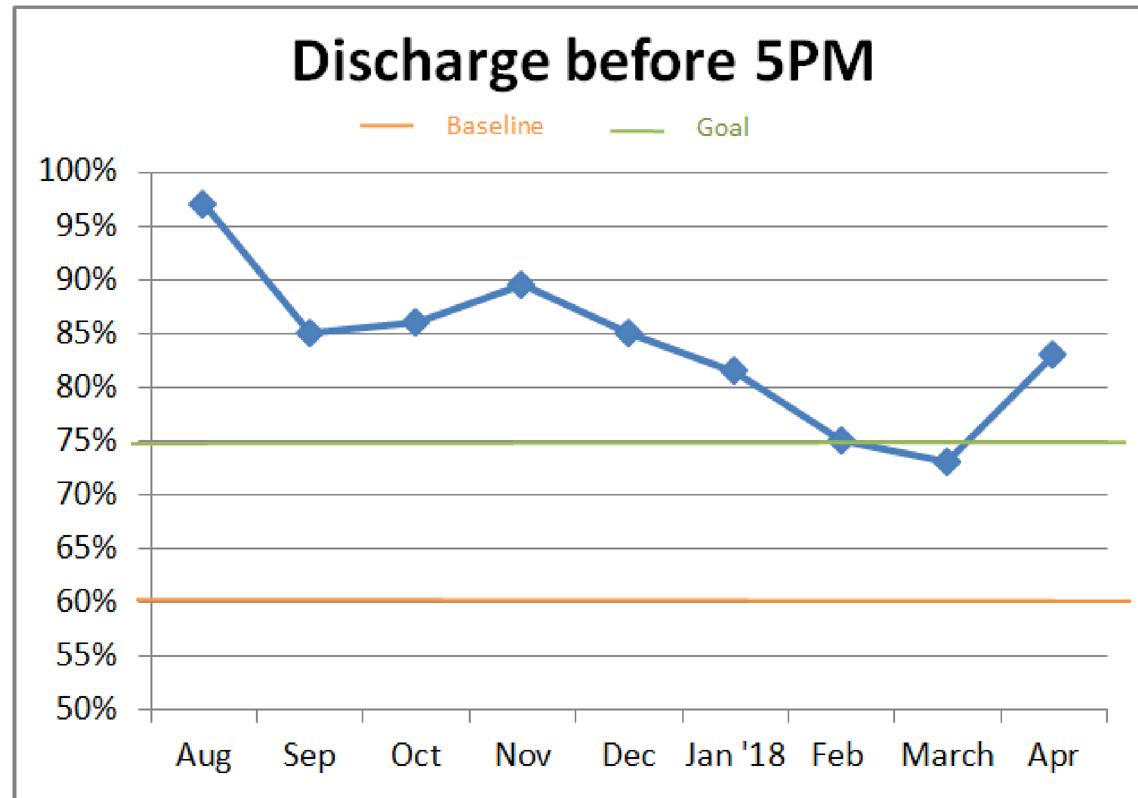
Metric Measurements

- Huddle – Attendance
- Amount D/C'd & those D/C'd before 5p
- Appts made within 48 hrs
- No-shows / Cancellations
- Coding – If TCM qualified
- Outliers – Patients <u>not</u> D/C'd by 5p
- Readmission rate within 30 days

Leading Metric

Metric: % of patients discharged from the hospital before 5:00 pm each day.

Discharge before 5PM	
Aug	97%
Sep	85%
Oct	86%
Nov	89.5%
Dec	85%
Jan '18	81.4%
Feb	75%
March	73%
Apr	83%



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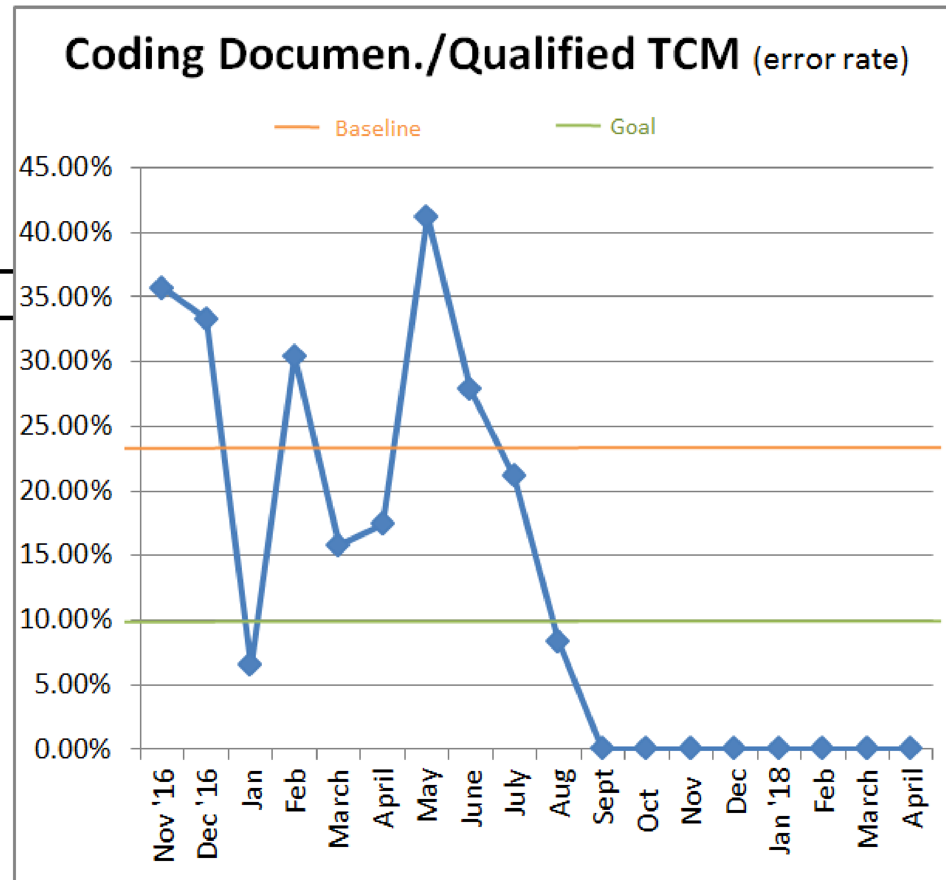
Lagging Metric

Metric: % of charges correlated to TCM charge (post-hospital follow-up visit charge)

Coding Documentation/Qualified TCM	
Nov '16	35.70%
Dec '16	33.30%
Jan	6.50%
Feb	30.40%
March	15.80%
April	17.40%
May	41.2%
June	27.8%
July	21.1%
Aug	8.3%
Sept	0%
Oct	0%
Nov	0%
Dec	0%
Jan '18	0%
Feb	0%
March	0%
April	0%



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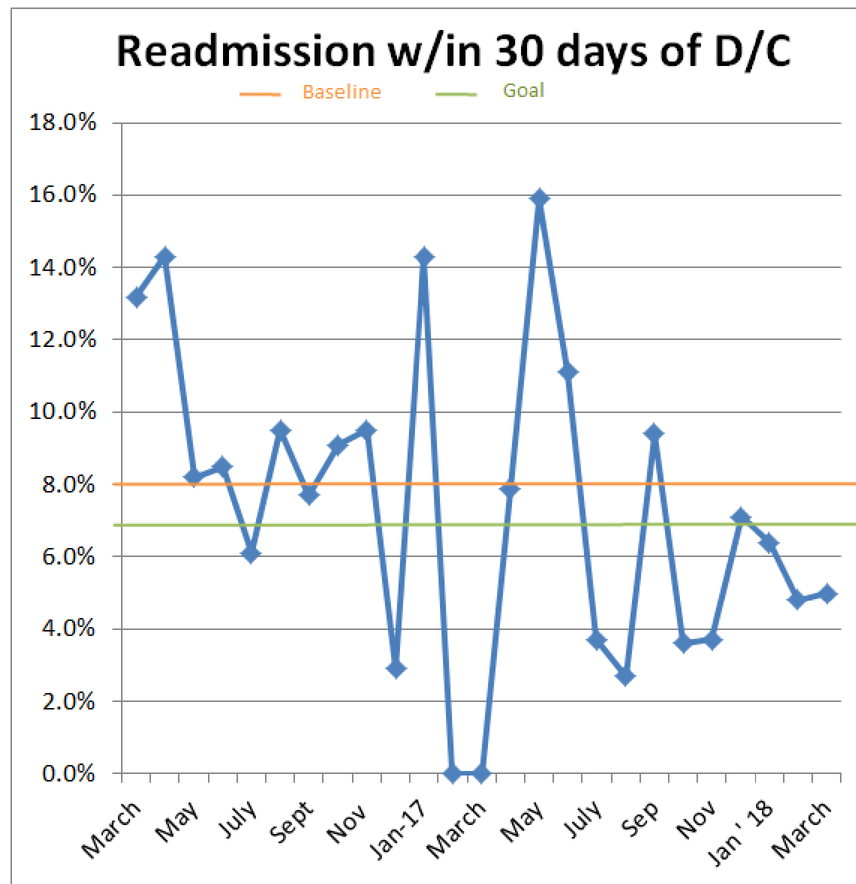
Lagging Metric

Metric: 30 day readmission rate

Readmission w/in 30 days of D/C	
March	13.2%
April	14.3%
May	8.2%
June	8.5%
July	6.1%
Aug	9.5%
Sept	7.7%
Oct	9.1%
Nov	9.5%
Dec	2.9%
Jan-17	14.3%
Feb	0.0%
March	0.0%
April	7.9%
May	15.9%
June	11.1%
July	3.7%
Aug	2.7%
Sep	9.4%
Oct	3.6%
Nov	3.7%
Dec	7.1%
Jan ' 18	6.4%
Feb	4.8%
March	5%



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Pilot Project

3 Months Implementation

- Aug, Sept, Oct 2017

Scope: 2 Hospitalists, 1 NP
5 Clinics
13 providers consisting of:
(Internal Medicine)

- MD
- NP
- PA

Included: Patients on 3 Inpatient/OBS units

- ICU
- TCU
- Med/Surg

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Results & Evaluation

HCAHPS Summary Report

Harrison County Hospital

Surveys Returned: July 2017 - September 2017

					All DB N = 2228	Small PG DB N = 726	All PG DB N = 2228	HCH Peer Group N = 20
		Your Top Box Score						
Domains and Questions	**n**	**Previous % Apr-Jun**	**Current % Jul-Sep**		**Percentile Rank**	**Percentile Rank**	**Percentile Rank**	**Percentile Rank**
Care Transitions	79	53.3%	63.0%	▲	90	82	90	99
Hosp staff took pref into account	76	44.6%	57.9%	▲	91	82	91	95
Good understanding managing health	79	50.5%	60.8%	▲	83	77	83	95
Understood purpose of taking meds	79	64.9%	70.3%	▲	90	81	90	95

Harrison County Hospital

Surveys Returned: October 2017 - December 2017

					All DB N = 2213	Small PG DB N = 790	All PG DB N = 2213	HCH Peer Group N = 20
		Your Top Box Score						
Domains and Questions	**n**	**Previous % Jul-Sep**	**Current % Oct-Dec**		**Percentile Rank**	**Percentile Rank**	**Percentile Rank**	**Percentile Rank**
Care Transitions	57	63.0%	65.0%	▲	93	87	93	99
Hosp staff took pref into account	56	57.9%	57.1%	▼	90	82	90	95
Good understanding managing health	57	60.8%	61.4%	▲	84	78	84	95
Understood purpose of taking meds	53	70.3%	76.3%	▲	97	93	97	99

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Results & Evaluation

- Financial Impact
  - Increased RVU's from 79.16 to 111.68
  - Increased revenue for clinics by $4,896
- Appointments Kept
  - Baseline 30% No-show
  - Present Performance Aug – April 9%
- % Readmits
  - Monitoring readmission rate for changes

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Other Outcomes of Process Change

- Decreased staffing issues during the day and at change of shift
- Decreased rework; Eliminated waste
- Increased patient engagement at time of discharge and follow-up
- Decreased barriers within organization and strengthened communication
- Decreased coding deficiencies to 0%
- Provided a process for implementation at other hospitals and clinic practices.

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Summary

- Transitional Care Management (TCM) is a billing code that supports the Quadruple Aim
  - Better Care
  - Better Health
  - Lower Cost
  - Better Provider Work Life
- A well-defined process eases the transition

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Questions for the Presenters

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