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Standardization of Transition Care Management (TCM) Workflow in a Safety Net Hospital Increases Percentage of Completed TCM, Increases Revenue and Decreases Hospital Readmission

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Abstract The Centers for Medicare and Medicaid Services (CMS) in 2013 began offering payment to ambulatory practices for the transitional care management (TCM) service to address readmission rates. The adoption of a successful TCM model is needed to improve patient outcomes and lower readmission rates. At UF Health Jacksonville, we formed a dedicated TCM team whose role was exclusive to the completion of the TCM non-face-to-face process (NF2F). The team elected to utilize the Define, Measure, Analyze, Improve, and Control (DMAIC) model as the process improvement methodology to guide the project. UF Health Jacksonville has eliminated many of the barriers facing Academic Center Safety-net Hospitals as it relates to readmissions by implementing this approach. After the implementation of the dashboard and all of the improvements, there was an immediate return on investment increase of 81.06 percent exceeding the projected goal of 75 percent and decrease in readmission rate to as low as 5 percent.

Keywords: *Transition Care Management, hospital readmission, revenue*

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1. Introduction

Academic Center Safety-net Hospitals traditionally serve patients with lower socioeconomic resources, which can contribute to high readmission rates. The Value-based program established by the Centers for Medicare and Medicaid Services (CMS) in 2013 began offering payment to ambulatory practices for the TCM service to address readmission rates; however, it puts safety-net healthcare centers at a disadvantage due to having higher readmissions and poor patient experiences [1]. The disadvantage continues due to a high volume of vulnerable populations served.

The adoption of a successful TCM model is needed to improve patient outcomes and lower readmission rates. TCM addresses the safe handoff of a patient from one setting of care to another. Most often this handoff involves a patient moving from an acute inpatient setting to an outpatient care environment [2,3]. TCM includes management and coordination of care during a patient's transition from the hospital to home. A review of the literature revealed poorer outcomes for safety-net hospitals when implementing a TCM model. [1] Factors identified that contribute to poor outcomes relate to staff availability and access to post discharge care. Ohuabunwa et al., [4], reviews utilizing alternative staff for a safety-net healthcare system to be successful at cost-effective TCM in order to promote adoption of a TCM model.

The objective of this research was to develop a standardized, streamline approach to complete TCM's thereby improving patient care, decreasing hospital readmission rates, and increasing reimbursement from payers.

The Academic Center Safety-net Hospital of UF Health Jacksonville (UFHJ) is affiliated with 33 Family Medicine and General Internal Medicine primary care clinics. UFHJ has developed and implemented a TCM model that includes utilization of central care team in adjunct with the primary care practices. The TCM team, consist of two registered nurses, who complete NF2F visits with discharged patients within 48 hours of discharge. This model includes the use of a certified integrated electronic medical record (EMR) system providing reports of the

patients' inpatient status. All practices have access to the EMR, which increases the continuity and coordination of care. After the TCM Team completes the NF2F visit, a face-to-face (F2F) TCM visit is scheduled. A TCM Smartphrase template was created for providers to utilize during TCM appointments. This template supplies the provider with the critical information in order for them to easily complete the note. This TCM model addresses the concerns of staffing and post discharge care. CMS guidelines require a 48-hour NF2F visit conducted by a licensed person for reimbursement. This warm hand off to the primary care provider increases adherence to complete the note for a F2F TCM visit and promotes positive patient experiences influencing a 30-day hospital readmission [5].

UF Health Jacksonville has eliminated many of the barriers facing Academic Center Safety-net Hospital as it relates to readmissions. Utilizing a centralized care team to facilitate the TCM process and improving the post-discharged patient experience, contributed to barrier elimination. The EMR enhances UF Health Jacksonville TCM model by providing real time population health data. This TCM model has demonstrated a return on investment (ROI) for the model implementation and a decrease in the organizations readmission by six percent in a twelve month period.

2. Method and Results

The UFHJ performance improvement TCM team was established in September 2020 after discovering noticeable opportunities for improvement. The team was initially devised using a multidisciplinary approach comprised of primary care providers, pharmacists, care associates, managed care members, clinic nurses, one care coordination administrator and one informatics analyst support. This approach created inconsistencies in availability and predictability that lead to the decision to form a dedicated TCM team whose role was exclusive to the completion of the TCM NF2F process. Next, the team elected to utilize the Define, Measure, Analyze, Improve, and Control (DMAIC) model as the process improvement methodology to guide the project. During the *Define* phase, the team developed a project charter that defined the scope, problem statement, and business rationale. The project goal was to increase the percentage of successfully completed NF2F TCM from 42.30 percent to 75 percent for patients discharged from UF Health that were eligible for TCM reimbursement based on established guidelines.

The TCM team gathered for the *Measure* phase and completed a process map. This map outlined 79 steps. The completion of the steps identified a five minute per patient verification process where the care associates screened each patient to determine who was eligible for TCM completion. As the group moved into the *Analyze* phase, the group determined multiple points of concern. For example, the criteria for an "eligible patient" needed to be defined. Next, the process to identify eligible patients required refinement. Additionally, a standardize practice needed to be established to update and review the criteria annually. Furthermore, a design to regulate the completion of TCM encounters and the required documentation needed to be developed. Lastly, a method to monitor and report progress on the TCM encounters was considered paramount in discovering potential missed opportunities.

During the *Improve* phase, the team solicited help from the IT analysts and began collaboration on an innovative TCM dashboard. The dashboard identified and solved numerous problems such as accidental deletions of patients and duplication of workflow efforts. A pre-screen function allowed all discharges from UF Health to be filtered to only list patients eligible for a TCM reimbursement. By having all of that information completed via EPIC, this process saved approximately two hours per day for the care associates and reduced the process map from 79 steps down to only 10 steps. The dashboard development outlined a succinct workflow that tracked each phase of the process. The TCM team begins the process by selecting a newly discharged patient. This patient will be contacted for medication reconciliation and assessed for signs of decline or the new onset of a condition. The ultimate goal is to schedule a TCM appointment with the patient's primary care provider. If the aforementioned steps could not be completed by the TCM team, the steps are then managed on the dashboard to be revisited and addressed within a pre-calculated due date. By having this integration, the administrator can prevent missed deadlines, redistribute workflow, track appointment outcomes, and initiate rescheduling for no-show appointments to maximize prevention of lost revenue.

The documentation exploration process presented more concerns as the lack of continuity was discovered. The group incorporated the use of Episodes of Care within EPIC to allow for all required information to be placed in a documentation template. This template extracted all components necessary for billing reimbursement. Remarkably, the template connects the admission, NF2F, and primary care provider documentation in one location. The most impressive aspect of the Episodes of Care function is the free-flow feature that was designed to reduce the primary care provider documentation time by transferring the hospital visit and NF2F notations into the primary care provider's documentation with the use of an EPIC SmartPhrase.

After the implementation of the dashboard and all of the improvements, there was an immediate ROI increase of 81.06 percent. This increase exceeded the project's goal of increasing from 42.30 percent to 76.59 percent. The group continued to make modifications to the dashboard to ensure accuracy in patient screening and workflow efficiency resulting in an overall success rate high of 86.01 percent in August 2021.The completed F2F TCM percentage increased once providers were made aware of the implementations and were educated on the steps required. Meetings were held with individual clinics and providers to introduce and review the process for successful completion and documentation of TCM. TCM workflow steps included: proper reason for visit type on the provider's schedule as TCM; utilization of Smartphrase with all required documentation for billing; education on the use of Episodes of Care to close the F2F visit.

3. Barriers to Providing TCM Services

Transitional care management visits are associated with a reduction in hospital readmission at 90 days by 60 percent. [6] TCM visits also have a high reimbursement rate and high *relative value unit (RVU)* relative to traditional primary care visit reimbursements. However, Medicare billing for these services remains low. In a cohort study of almost 19 million eligible Medicare discharges, "During the first three years in which transitional care management services were covered, the percentage of billed services ranged from 3.10 percent in 2013 to 5.50 percent in 2014 and to 7 percent in 2015." [7] The use of this service in primary care practices continues to remain low leading to a need for consideration of what barriers may exist that make participation in TCM services difficult for primary care physicians In order to compliantly bill for a TCM service, the physician must first be aware that the patient was hospitalized as an inpatient. This requires reliance on outside reports or communications that may not always be forthcoming. The existence of multiple hospital systems with different electronic records and reporting systems creates one barrier that involves the use of multiple staff resources to overcome. Once notification of a hospital admission is received, appropriate staff resources must be designated to manage the follow through to determine the actual patient discharge date and appropriate patient contacts for follow up.

The second requirement is for the physician or qualified non-physician provider to contact the patient for a NF2F visit within 48 hours of discharge and to schedule the patient within a 7 or 14 day window. The person designated to call the patient must be notified and have the time to make this call and document it appropriately. If the right level of complexity is not billed within the right scheduling window, the charge will be rejected. High complexity must be within 7 days and moderate complexity within 14 days. However, there is confusion and debate over what qualifies as moderate or high complexity. In addition, there may also be difficulty scheduling the patient in the defined time frame due to patient transport issues or physician scheduling issues. In a small office, the physician may be the only person who meets the level of professional qualification to perform the follow up calls, which takes away from clinic visit time and creates a burden on the physician. In larger organizations, this barrier can be overcome with use of non-physician providers' including pharmacists, licensed clinical social workers (LCSW), licensed practical nurses, and dieticians; however, commonly these resources are not available. For some physicians, the time spent doing a NF2F visit is time away from the clinic. Further, if the patient has their questions answered over the phone, they may not come to the follow up F2F visit creating a missed billing opportunity and loss of precious time.

The third requirement to bill for a TCM visit is the F2F visit. Primary components of the F2F visit include verifying medications and coordinating follow up testing and referrals. If hospital records are unavailable, discharge summaries are not completed, or the patient is unable to provide an accurate history, the usefulness of this visit is challenged. Weekend discharges sometimes have longer processing times leading to delays in information reaching the PCP office.

These three stages of the TCM visit present barriers that encourage creative strategies to overcome. For example, larger organizations have the opportunity to designate care coordinators capable of tracking hospitalizations/discharges and can perform the NF2F component of care. The interdisciplinary approach to medical care has become the new status quo in today's practice leading to the creation of new positions that utilize RNs and LCSWs to assist with new standards. Given the benefits of TCM to patient care, the evidence shows that the changed approach is clearly worth the effort.

4. Discussion

The TCM goal is to provide a smooth transition of patients from one setting of care to another. This transition frequently involves patients being discharged from an inpatient setting to an outpatient environment. Successful completion of TCMs has the potential to improve patient outcomes, decrease readmissions, and increase revenue.

The negative impact of readmissions include adverse medical and financial outcomes to patients, cost to the hospital, loss of star rating from insurance vendors, poor quality reviews from patients, and increased workload of the hospital staff. As Medicare Merit-based Incentive Payment System (MIPS) and other payors shift its criteria with an emphasis on cost, readmission rates become increasingly important to control.

In order to achieve the smooth transition and to properly bill for this essential service, several steps must be completed and documented. For TCMs to be successful, a team approach is important.

In this process, the central stakeholder is the patient, who should be made aware of the discharge plan and the implemented transition of care. Other stakeholders include hospital administration, discharge team, appointment team, information technology team, care associates, clinic staff, and health care provider. The hospital administration must provide financial resources to have the personnel available to complete the tasks necessary to successfully complete TCMs. The discharge team will give the patient clear understandable information including the anticipated follow up and obtain updated patient contact information.

After discharge or transfer, the care associates can perform the NF2F visit to insure that the patient's immediate discharge needs are met and document most of the information needed for the F2F visit. The NF2F visit must occur within 48 business hours of discharge and must be performed by a licensed professional. This visit can be performed in person or virtually. The NF2F guidelines can be satisfied when two or more unsuccessful attempts to reach the patient are documented. This process attempts to insure that discharge medications are sent to pharmacy and filled. Next, the patient's understanding of medication administration is verified. Additionally, if home health services are needed, this service will be established or confirmed. Finally, follow-up appointments are set.

The NF2F is followed up by a F2F visit within 7-14 days depending on the level of complexity. The TCM

team should communicate to the patient that a F2F visit is scheduled for the purpose of completing a TCM appointment within insurance guidelines. The TCM team completes the NF2F documentation and the patient's primary provider performs the F2F visit to monitor the patient's improvement since discharge. Billing personnel must wait for 30 calendar days after discharge to submit the claim to ensure the patient is not readmitted. If patients are readmitted, the original NF2F documentation is voided and new NF2F documentation is created to reflect the most current discharge. If possible, the preexisting appointment can be utilized to capture the TCM visit.

The TCM process becomes challenging when the following barriers occur: missed 48-hour window to contact patients for the NF2F completion; EMR documentation is not completed; patient is discharged from a non UF Health hospital; discharge documentation is not completed; or the patient's contact information is invalid. In addition, clinic staff may not use the correct billing type to alert the provider that a TCM should be performed or did not schedule the patient in the time required for the F2F visit. These barriers can be mitigated by educating the clinic staff on the importance of proper visit type use and scheduling within TCM 14-day guidelines. This process may require overbooking the patient or dedicating slots to the schedule for TCM appointments.

TCMs may not be part of the medical care team's routine. However, provider and staff education should be conducted to streamline these visits. If portions of the documentation are missed, then the TCM visit cannot be charged. The reimbursement for TCMs vary from one insurance company to another with some reimbursements being significantly higher than the charge for an office visit. Some insurers like Medicaid do not reimburse for TCM management.

5. Conclusion

Standardization and streamlining the TCM workflow has significantly decreased the readmission rate from 12.60 percent to 5 percent at UF Health Jacksonville. This is despite the challenges of being a safety-net hospital with a population that is frequently of low economic income and having several needs of the social determinants of health.

Safety-net hospitals are uniquely positioned given their razor thin operational bottom line and lack of financial and social resources for many of the population they serve. TCMs help to improve the quality of care to this underserved population and can have positive financial impact on hospitals. Critical to this new TCM process is the buy-in of key stakeholders. Their buy-in aids the development of the TCM process and helps to insure successful implementation of this vital service.

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