IHI's 15th Annual International Summit on Improving Patient Care in the Office Practice and the Community

Mini Course on Transitions of Care

Washington D. C.

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Care Transitions

In SETMA's Model of Care -- Care Transition involves:

1. Evaluation at admission with Hospital Plan of Care produced and given to the patient -- transition issues "lives alone," barriers , DME, residential care, or other needs. The Plan of Care includes: why hospitalized, what will be done, consolations, procedures, tests, estimated length of stay and potential for readmission.
2. Fulfillment of PCPI Transitions of Care Quality Metric Set
3. Post Hospital Follow-up Coaching

   A 12-30 minute call made by members of SETMA's Care Coordination Department
4. Plan of Care and Treatment Plan
5. Follow-up visit with primary provider

Care Transitions & Hospital Readmission

- In SETMA's experience, there are fifteen steps required to address care coordination and hospital readmissions, as a function of a quality care initiative which is sustainable.

- The steps and the solution for each are as follows.

Care Transitions & Hospital Readmission

1. January,1999, SETMA began using the EHR to document patient encounters.

   May, 1999, SETMA modified the goal to electronic patient management (EPM) in order to leverage the power of electronics to improve treatment outcomes.

   October, 1999, SETMA began using the EMR in the hospital for hospital H&Ps, creating continuity-of-care processes, based on healthcare data being electronically created and being available at all points of care.

Care Transitions & Hospital Readmission

2. In 2000, realizing that excellent care in the 21st Century was going to be team-based, SETMA formed a hospital service team, which provides 24-hour-a-day, seven-day a week, in-house coverage for all of our patients.

Care Transitions & Hospital Readmission

3. In 2001, SETMA began using the EHR to produce hospital discharge summaries which further advanced continuity-of-patient-care and established the groundwork both for care transitions and for effectively addressing preventable readmissions.

   At this point, medication reconciliation could take place in the: clinic, hospital, nursing home, home health and emergency department.

Care Transitions & Hospital Readmission

4. In 2003, SETMA designed hospital-admission-order sets, based on national standards of care, which created a consistency of treatment plans and eliminated delay in the initiation of excellent care.

Care Transitions & Hospital Readmission

5. Also, in 2003, SETMA began using the EHR in all thirty-two nursing homes we staff. Because our patients' care is managed in the same electronic data base, whether in the ambulatory setting, hospice, home health, physical therapy, hospital, emergency department, or nursing home, there is a continuity-of-care which is data and information driven.

Care Transitions & Hospital Readmission

6. In 2004, SETMA designed an electronic, **Inpatient Medical Record Census** (IMRC); deployed on SETMA's intranet and HIPPA compliant, the IMRC allows searchable-data recording of:
   a) date of admission to the hospital
   b) place of admission
   c) date and time of completion of the History and Physical
   d) date of discharge
   e) date and time of completion of the Hospital Care summary and post-hospital plan of care and treatment plan.
   f) Posting of questions from business office which need research by hospital care team.

Care Transitions & Hospital Readmission

7. In 2007, SETMA's partners realized that many of our patients, even those with insurance, cannot afford all of their health care. This resulted in the creation of **The SETMA Foundation**.

   SETMA partners have given over $2,500,000 to the Foundation which pays for medications, surgeries and other care, such as dental, for our patients who cannot afford it.

Care Transitions & Hospital Readmission

8. In June, 2009, the Physician Consortium for Performance Improvement (PCPI) published the first national quality measurement set on Care Transitions; the same month, SETMA deployed the measures in our EHR. ***Since then, of the over 21,000 discharges from the hospital, 98.7% have had the Hospital Care Summary completed at the time the patient left the hospital***.

Care Transitions & Hospital Readmission

9. October, 2009, SETMA adapted a Business Intelligence tool to create an audit of hospitalized patients to examine differences between patients who are re-admitted and those who are not.

   The audit looks at: gender, ethnicity, socio-economic issues, social isolation, morbidities and co-morbidities, lengths of stays, age, timing of follow-up after discharge, whether a follow-up call was received and other issues.

   These measures look for leverage points for "making a change, which will make a difference in readmissions"

Care Transitions & Hospital Readmission

10. November, 2009, SETMA began publicly reporting performance on over 300 quality metrics by provider name at www.jameslhollymd.com. Disease management plans-of-care documents for diabetes, hypertension, and cholesterol, include the provider performance on that patient's care, as judged by these quality metrics.

Care Transitions & Hospital Readmission

11. In July, 2010, pursuant to **becoming** a NCQA, Tier 3 PC-MH, SETMA created a Department of Care Coordination, tasked with:
    - Post Hospital follow-up calling
    - Completing SETMA Foundation Referrals
    - Patient counseling for barriers to care
    - Establishing continuity of care
    - Engaging patients in their own care
    - Alerting providers to patients' special needs
    - Another level of mediation reconciliation

Care Transitions & Hospital Readmission

12. September, 2010, at a National Quality Forum workshop on Care Transitions, SETMA realized that the term "discharge summary" was outdated. We changed the name to "**Hospital Care Summary and Post Hospital Plan-of-Care and Treatment-Plan**," long and perhaps awkward, this name, is functional, focusing on the unique elements of Care Transition which contribute to the foundation for a sustainable plan for addressing preventable readmissions to the hospital.

Care Transitions & Hospital Readmission

13. In 2010, SETMA deployed both a secure web portal and a health information exchange to allow the seamless exchange of information between the hospitals , nursing homes, home health agencies, hospices, and SETMA. The HIE has been expanded to a multi-county project including all healthcare providers and agencies, which will ultimately be the key to preventing readmission to the hospital.

Care Transitions & Hospital Readmission

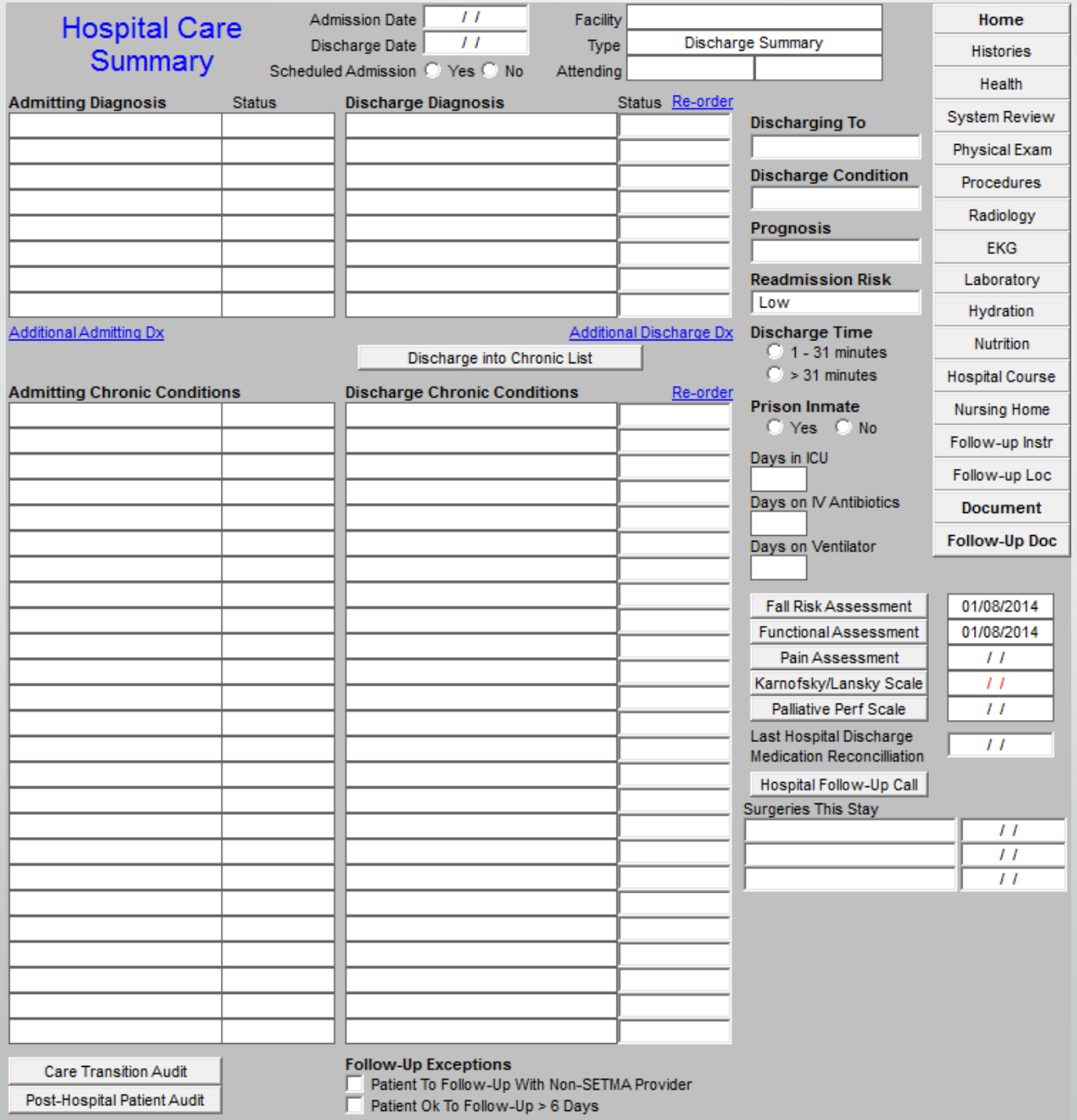
14. Since 1997, SETMA has partnered with a Medicare Advantage home health agency, with other home health agencies and with free-standing hospices to provide compassionate, competent care for our patients in settings other than hospital inpatient to reduce readmissions of our most vulnerable patients while providing excellent care to them.

Care Transitions & Hospital Readmission

15. As a Patient-Centered Medical Home, SETMA makes certain that the Hospital Care Summary and Post Hospital Plan of Care and Treatment is transmitted to the next site of care as the "baton," (see below). With these care coordination, continuity of care and patient-support functions, SETMA believes that we are ready to make a major effort to decrease preventable readmissions to the hospital.

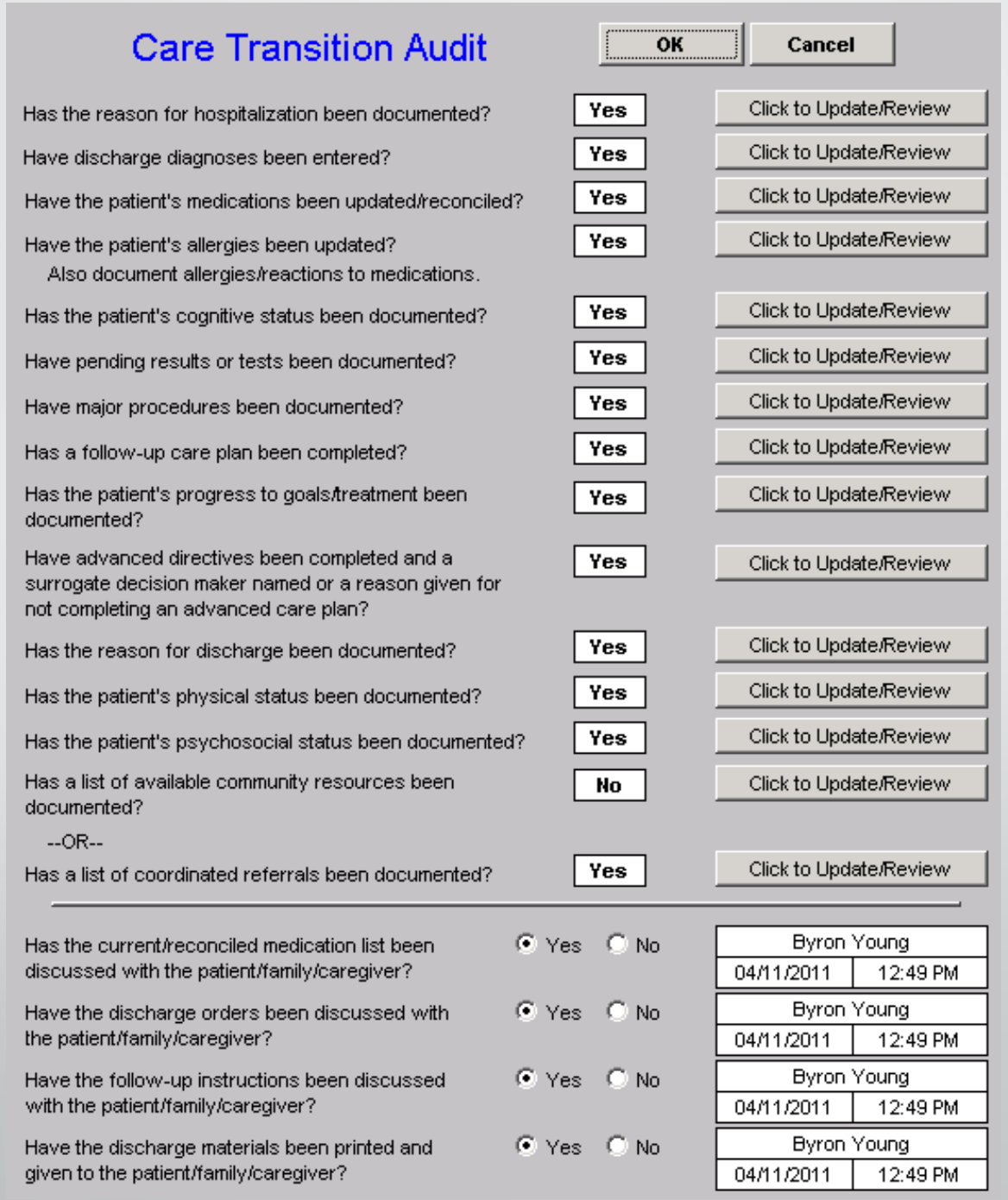
Hospital Care Summary

- SETMA's Hospital Care Summary is a suite of templates with which the transition of care document Is created. (A full tutorial of these templates can be found on our website at www.jameslhollymd.com under "Electronic Patient Tools" at "Hospital Based Tools.")
- The following is a screen shot of the Master Discharge Template entitled "Hospital Care Summary". This screen shot is from the record of a real patient whose identify has been removed.


Hospital Care Summary
Admission Date
Discharge Date
Scheduled Admission Yes No
Facility
Type
Discharge Summary
Attending
Admitting Diagnosis
Status
Discharge Diagnosis
Status
Re-order
Additional Admitting Dx
Additional Discharge Dx
Discharge into Chronic List
Admitting Chronic Conditions
Discharge Chronic Conditions
Re-order
Care Transition Audit
Post-Hospital Patient Audit
Follow-Up Exceptions
Patient To Follow-Up With Non-SETMA Provider
Patient Ok To Follow-Up > 6 Days
Discharging To
Discharge Condition
Prognosis
Readmission Risk
Low
Discharge Time
1 - 31 minutes
> 31 minutes
Prison Inmate
Yes No
Days in ICU
Days on IV Antibiotics
Days on Ventilator
Fall Risk Assessment
01/08/2014
Functional Assessment
01/08/2014
Pain Assessment
Karnofsky/Lansky Scale
Palliative Perf Scale
Last Hospital Discharge Medication Reconcilliation
Hospital Follow-Up Call
Surgeries This Stay
Home
Histories
Health
System Review
Physical Exam
Procedures
Radiology
EKG
Laboratory
Hydration
Nutrition
Hospital Course
Nursing Home
Follow-up Instr
Follow-up Loc
Document
Follow-Up Doc

Care Transition Audit

- At the bottom of this template, there is a button Entitled "Care Transition Audit." Once the suite of Templates associated with the Hospital Care Summary has been completed, the provider depresses this button and the system automatically aggregates the data which has been documented and displays which of the 18-data points have been completed and which have not.


Care Transition Audit
OK
Cancel
Has the reason for hospitalization been documented?
Yes
Click to Update/Review
Have discharge diagnoses been entered?
Yes
Click to Update/Review
Have the patient's medications been updated/reconciled?
Yes
Click to Update/Review
Have the patient's allergies been updated?
Also document allergies/reactions to medications.
Yes
Click to Update/Review
Has the patient's cognitive status been documented?
Yes
Click to Update/Review
Have pending results or tests been documented?
Yes
Click to Update/Review
Have major procedures been documented?
Yes
Click to Update/Review
Has a follow-up care plan been completed?
Yes
Click to Update/Review
Has the patient's progress to goals/treatment been documented?
Yes
Click to Update/Review
Have advanced directives been completed and a surrogate decision maker named or a reason given for not completing an advanced care plan?
Yes
Click to Update/Review
Has the reason for discharge been documented?
Yes
Click to Update/Review
Has the patient's physical status been documented?
Yes
Click to Update/Review
Has the patient's psychosocial status been documented?
Yes
Click to Update/Review
Has a list of available community resources been documented?
No
Click to Update/Review
--OR--
Has a list of coordinated referrals been documented?
Yes
Click to Update/Review
Has the current/reconciled medication list been discussed with the patient/family/caregiver?
Yes
No
Byron Young
04/11/2011
12:49 PM
Have the discharge orders been discussed with the patient/family/caregiver?
Yes
No
Byron Young
04/11/2011
12:49 PM
Have the follow-up instructions been discussed with the patient/family/caregiver?
Yes
No
Byron Young
04/11/2011
12:49 PM
Have the discharge materials been printed and given to the patient/family/caregiver?
Yes
No
Byron Young
04/11/2011
12:49 PM

Care Transition Audit

- The elements in black have been completed; any in red have not. If an element is incomplete, the provider simply clicks the button entitled "Click to update/Review." The missing information can then be added. This fulfills one of SETMA's principles of EHR design which is "We want to make it easier to do it right than not to do it at all."

Care Transition Audit

- Quarterly and annually, SETMA audits each provider's performance on these measures and publishes that audit on our website under "Public Reporting," along with over 200 other quality metrics which we track routinely.
- The following is the care transition audit results by provider name for 2013.

Care Transition Audit (Section A)

Discharge Date(s): 01/01/2013 through 12/31/2013

Provider	Reason for Hospitalization	Discharge Diagnoses	Medications Updated Reconciled	Documentation of Allergies	Cognitive Status	Pending Test Results	Major Procedures	Follow-Up Care Plan	Progress to Goals Response to Treatment
Anwar	99.2%	99.2%	95.4%	96.5%	96.9%	97.5%	97.3%	96.5%	97.5%
Aziz	98.1%	98.8%	96.7%	97.7%	98.1%	98.1%	97.7%	97.9%	97.9%
Cox	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Deiparine, C	98.6%	99.7%	97.9%	99.0%	99.3%	98.3%	98.9%	98.3%	98.6%
Duncan	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Foster	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	100.0%	75.0%	75.0%
George	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Halbert	98.4%	99.4%	99.1%	99.4%	100.0%	99.1%	97.8%	98.8%	98.8%
Holly	98.8%	99.4%	96.5%	98.2%	98.8%	97.7%	98.4%	97.7%	98.8%
LaBorde	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Le	95.9%	99.8%	94.2%	97.1%	98.1%	95.5%	97.5%	94.4%	95.7%
Leifeste	98.0%	99.9%	97.2%	98.7%	98.9%	97.5%	98.3%	97.9%	98.0%
Murphy	99.5%	99.0%	99.0%	98.5%	99.5%	99.5%	99.0%	99.0%	99.0%
Palang	99.4%	99.4%	98.7%	98.7%	99.7%	99.4%	98.4%	98.4%	99.1%
Qureshi	96.8%	99.8%	94.9%	98.1%	98.1%	96.2%	97.0%	95.3%	96.4%
Shepherd	99.4%	100.0%	96.1%	98.1%	98.1%	96.8%	98.7%	98.1%	96.8%
Thomas	98.7%	99.9%	94.5%	96.4%	96.4%	98.5%	97.7%	96.5%	97.4%
SETMA Totals :	98.3%	99.6%	96.5%	98.0%	98.4%	97.8%	98.0%	97.3%	97.8%

Care Transition Audit (Section B)

Discharge Date(s): 01/01/2013 through 12/31/2013

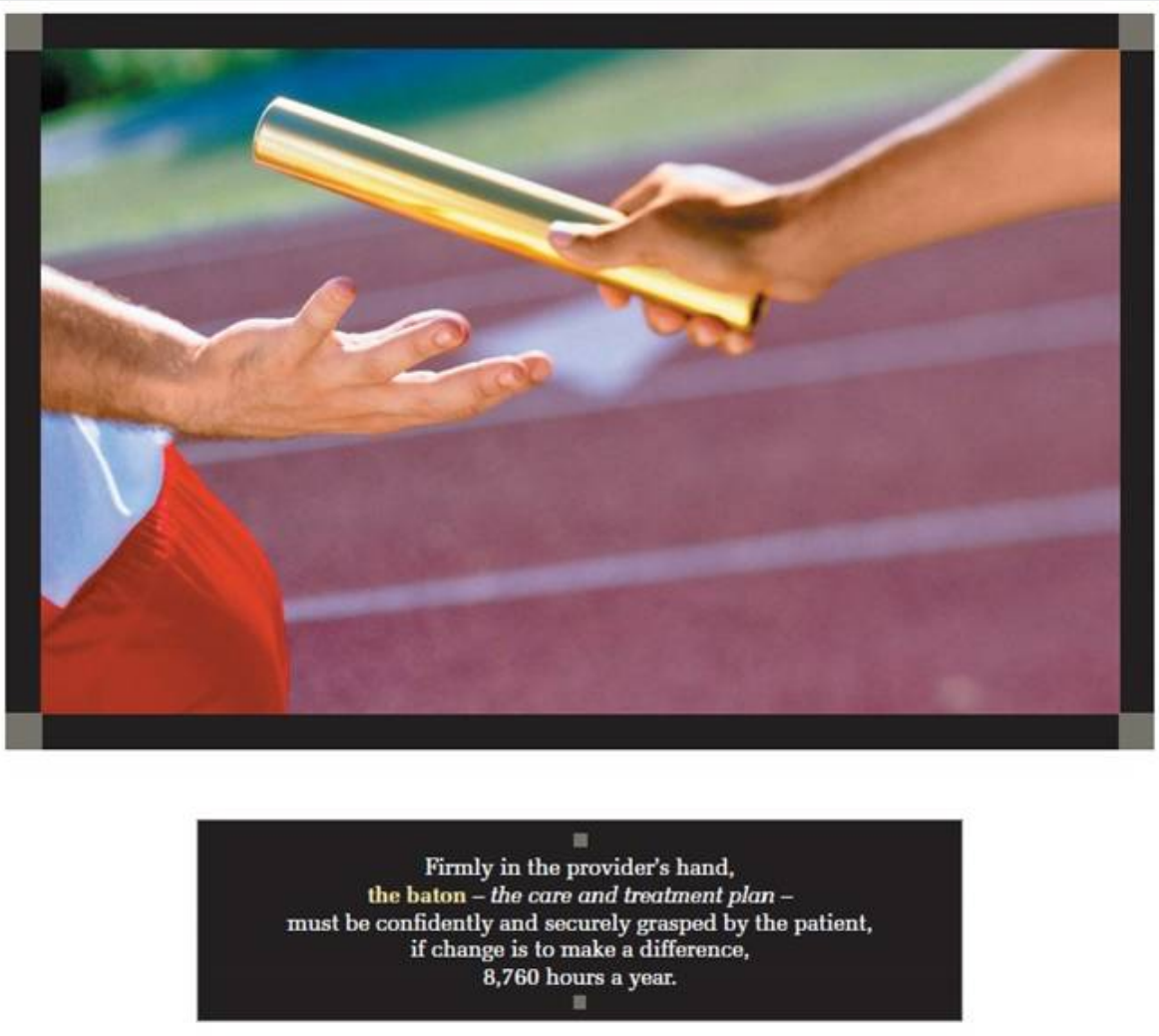
Provider	Advanced Directives	Reason for Discharge	Physical Status	Psychosocial Status	Community Resources Coordinated Referrals	Medication List	Discharge Orders	Follow-Up Instructions	Discharge Materials
Anwar	93.4%	99.0%	97.1%	96.9%	94.4%	93.6%	93.6%	93.6%	91.3%
Aziz	95.6%	98.5%	98.1%	98.3%	96.7%	96.5%	96.5%	96.5%	95.6%
Cox	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	25.0%
Deiparine, C	97.1%	98.6%	99.2%	98.8%	96.4%	96.1%	96.1%	96.1%	94.9%
Duncan	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Foster	75.0%	75.0%	100.0%	75.0%	75.0%	75.0%	75.0%	75.0%	50.0%
George	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Halbert	97.2%	98.8%	100.0%	99.7%	98.8%	98.4%	98.4%	98.4%	95.0%
Holly	96.3%	98.8%	98.8%	98.1%	95.3%	94.9%	94.9%	94.9%	94.0%
LaBorde	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%
Le	92.2%	95.1%	98.6%	96.3%	92.6%	92.0%	92.0%	92.0%	90.1%
Leifeste	96.4%	97.9%	98.9%	98.5%	96.8%	95.9%	95.9%	95.9%	90.5%
Murphy	97.4%	99.5%	99.5%	99.0%	99.0%	98.5%	98.5%	98.5%	98.0%
Palang	98.4%	99.4%	99.7%	99.4%	98.7%	98.4%	98.4%	98.1%	95.9%
Qureshi	93.8%	96.8%	98.1%	96.6%	93.4%	93.4%	93.4%	93.4%	91.0%
Shepherd	96.1%	99.4%	98.1%	98.1%	96.8%	96.1%	95.5%	95.5%	88.4%
Thomas	93.8%	98.1%	96.4%	95.9%	94.7%	93.3%	91.8%	91.8%	87.1%
SETMA Totals :	95.5%	98.1%	98.4%	97.8%	95.8%	95.2%	95.0%	95.0%	92.2%

Hospital Care Summary

- Once the Care Transition issues are completed, The Hospital Care-Summary-and-Post- Hospital-Plan-of Care-and Treatment-Plan document is generated and printed. It is given to the patient and/or to the patient's family, and to the hospital.

The Baton

- The following picture is a portrayal of the "plan of care and treatment plan" which is like the "baton" in a relay race.



The Baton

- "The Baton" is the instrument through which responsibility for a patient's health care is transferred to the patient or family. Framed copies of this picture hang in the public areas of all SETMA clinics and a poster of it hangs in every examination room. The poster declares:

Firmly in the provider's hand --The baton -- the care and treatment plan Must be confidently and securely grasped by the patient, If change is to make a difference 8,760 hours a year.

The Baton

The poster illustrates:

1. That the healthcare-team relationship, which exists between the patient and the healthcare provider, is key to the success of the outcome of quality healthcare.
2. That the plan of care and treatment plan, the "baton," is the engine through which the knowledge and power of the healthcare team is transmitted and sustained.
3. That the means of transfer of the "baton," which has been developed by the healthcare team, is a coordinated effort between the provider and the patient.

The Baton

4. That typically the healthcare provider knows and understands the patient's healthcare plan of care and the treatment plan, but without its transfer to the patient, the provider's knowledge is useless to the patient.

5. That the imperative for the plan – the "baton" – is that it must be transferred from the provider to the patient, **if change in the life of the patient is going to make a difference in the patient's health.**

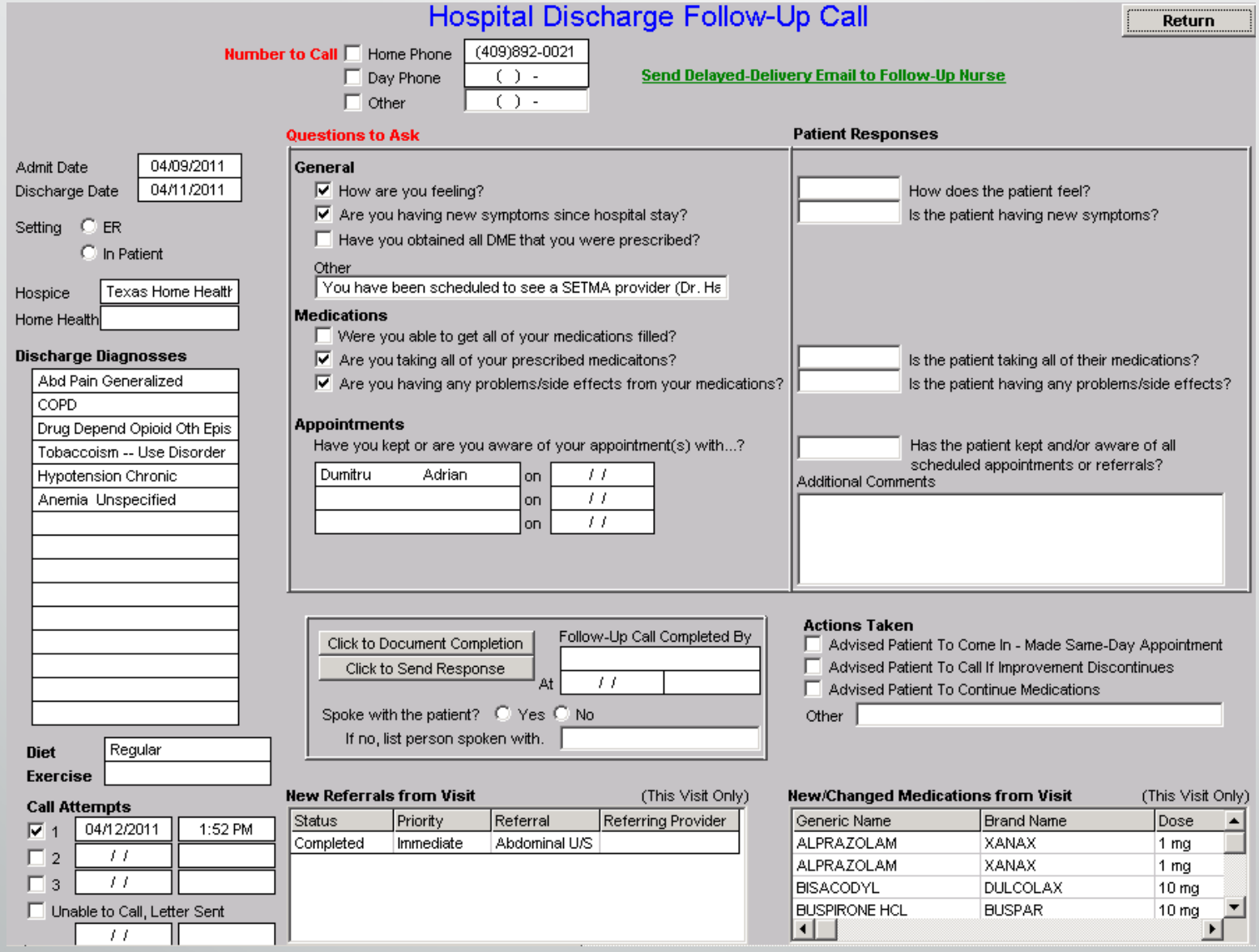
The Baton

6. That this transfer requires that the patient "grasps" the "baton," i.e., that the patient accepts, receives, understands and comprehends the plan, and that the patient is equipped and empowered to carry out the plan successfully.

7. That the patient knows that of the 8,760 hours in the year, he/she will be responsible for "carrying the baton," longer and better than any other member of the healthcare team.

Hospital Follow-Up Call

- After the care transition audit is completed and the document is generated, the provider completes the Hospital-Follow-up-Call document:


Hospital Discharge Follow-Up Call
Return
Number to Call
Home Phone
(409)892-0021
Day Phone
( ) -
Other
( ) -
Send Delayed-Delivery Email to Follow-Up Nurse
Questions to Ask
Patient Responses
Admit Date
04/09/2011
Discharge Date
04/11/2011
Setting
ER
In Patient
Hospice
Texas Home Healt
Home Health
Discharge Diagnosses
Abd Pain Generalized
COPD
Drug Depend Opioid Oth Epis
Tobaccoism -- Use Disorder
Hypotension Chronic
Anemia Unspecified
General
How are you feeling?
Are you having new symptoms since hospital stay?
Have you obtained all DME that you were prescribed?
How does the patient feel?
Is the patient having new symptoms?
Other
You have been scheduled to see a SETMA provider (Dr. Ha
Medications
Were you able to get all of your medications filled?
Are you taking all of your prescribed medicaitons?
Are you having any problems/side effects from your medications?
Is the patient taking all of their medications?
Is the patient having any problems/side effects?
Appointments
Have you kept or are you aware of your appointment(s) with...?
Dumitru Adrian
on
Has the patient kept and/or aware of all scheduled appointments or referrals?
Additional Comments
Click to Document Completion
Click to Send Response
Follow-Up Call Completed By
At
Spoke with the patient?
Yes
No
If no, list person spoken with.
Actions Taken
Advised Patient To Come In - Made Same-Day Appointment
Advised Patient To Call If Improvement Discontinues
Advised Patient To Continue Medications
Other
Diet
Regular
Exercise
Call Attempts
1
04/12/2011
1:52 PM
2
3
Unable to Call, Letter Sent
New Referrals from Visit
(This Visit Only)
Status
Priority
Referral
Referring Provider
Completed
Immediate
Abdominal U/S
New/Changed Medications from Visit
(This Visit Only)
Generic Name
Brand Name
Dose
ALPRAZOLAM
XANAX
1 mg
ALPRAZOLAM
XANAX
1 mg
BISACODYL
DULCOLAX
10 mg
BUSPIRONE HCL
BUSPAR
10 mg

Hospital Follow-Up Call

1. During that preparation of the "baton," the provider checks off the questions which are to be asked the patient in the follow-up call.
2. The call order is sent to the Care Coordination Department electronically. The day following discharge, the patient is called.
3. The call is the beginning of the "coaching" of the patient to help make them successful in the transition from the inpatient setting.

Hospital Follow-Up Call

4. The Care-Coordination, post-hospital call takes 12-30 minutes with each patient and engages the patient in eliminating barriers to care.
5. If appropriate, an additional call is scheduled at an appropriate interval.
6. If after three attempts, the patient is not reached by phone, the box in the lower left-hand corner by "Unable to Call, Letter sent" is checked. Automatically, a letter is created which is sent to the patient asking them to contact SETMA.

Coordinated Care

- The genius and the promise of the Patient-Centered Medical Home are symbolized by the "baton." Its display continually reminds the provider and will inform the patient, that to be successful, the patient's care must be coordinated, and must result in coordinated care.
- In 2011, we expanded the scope of SETMA's Department of Care Coordination, we know that the principal failure-points of coordination are at the "transitions of care," and that the work of the healthcare team – patient and provider – is that together they evaluate, define and execute a plan which is effectively transmitted to the patient.

Follow-Up Visit

The Transition of Care is complete when the patent is seen by the primary care provider in follow-up.

- Many issues are dealt with in this follow-up visit, but one of them is another potential referral to the Care Coordination Department. If the patient has any barriers to care, the provider will complete the following template.
- In this case, with checking three buttons, the need for financial assistance with medications and transportation is communicated to the Care Coordination Department.

SETMA Foundation

- Under the Medical Home model the provider has NOT done his/her job when he/she simply prescribes the care which meets national standards. **Doing the job of Medical Home requires the prescribing of the best care which is available and accessible to the patient, and when that care is less than the best, the provider makes every attempt to find resources to help that patient obtain the care needed.**

SETMA Foundation

- In February 2009, SETMA saw a patient who has a very complex healthcare situation. When seen in the hospital as a new patient, he was angry, bitter and hostile. No amount of cajoling would change the patient's demeanor.
- During his office-based, hospital follow-up, it was discovered that the patient was only taking four of nine medications because of expense; could not afford gas to come to the doctor; was going blind but did not have the money to see an eye specialist; could not afford the co-pays for diabetes education and could not work but did not know how to apply for disability.

SETMA Foundation

He left SETMA with the Foundation providing:

1. All of his medications. The Foundation has continued to do so for the past two years at a cost of $2,200 a quarter.
2. A gas card so that he could afford to come to multiple visits for education and other health needs.
3. Waiver of cost for diabetes education in SETMA's American Diabetes Association accredited Diabetes Self Education and Medical Nutrition Therapy program.
4. Appointment to an experimental, vision-preservation program at no cost.
5. Assistance with applying for disability.

SETMA Foundation

- Are gas cards, disability applications, paying for medications a part of a physician's responsibilities? Absolutely not; but, are they a part of Medical Home? Absolutely! This patient, who was depressed and glum in the hospital, such that no one wanted to go into the patient's room, left the office with help.
- He returned six-weeks later. He had a smile and he had hope. It may be that the biggest result of Medical Home is hope. And, his diabetes was treated to goal for the first time in ten years. He has remained treated to goal for the past two years.

Implementing Medicare Transitional Care Management Services

IHI, Washington D. C.

March 9, 2014

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Transitions of Care Management New Codes Announced

- November 16, 2012
  - CY 2013 Physician Fee Schedule Final Rule published
  - Two new codes introduced for physicians and qualifying nonphysical practitioner care management services for a patient following a discharge from a hospital, SNF, CMHC, outpatient observation or partial hospitalization
- January 30, 2013
  - First payable date of service for Transitional Care Management (TCM) codes
- March 2013
  - SETMA began using TCM codes on eligible patients

Criteria For New Codes

Criteria	99495	99496
Level of Medical Decision Making	Moderate Complexity (99214) or Higher	High Complexity (99215)
Days Since Discharge	Within 14 Days	Within 7 Days
Follow-Up Contact	Within 2 Business Days of Discharge	Within 2 Business Days of Discharge

Potential for Increased Revenue

- TCM codes are billed in place of traditional Evaluation & Management (E&M) codes and offer a higher level of reimbursement.
- In the age of decreasing reimbursement, it is important to be able to access sources of additional reimbursement which are being made available to those providers who can demonstrate their ability to provide excellent care.
- TCM codes are just one example of increase revenue sources available to providers who provide excellent care.

Potential for Increased Revenue

Level of Medical Decision Making	E&M Code Reimbursement	TCM Code Reimbursement	Increase
Moderate Complexity	99214 $101.12	99495 $154.53	$53.41
High Complexity	99215 $135.63	99496 $218.27	$82.64

How To Implement A Sustainable Solution?

- The benefit of increase reimbursement is obvious, but how do you implement a solution which is sustainable and can be time and time again with out placing an additional burden on an already stretched provider?
- The answer…the power of electronics.

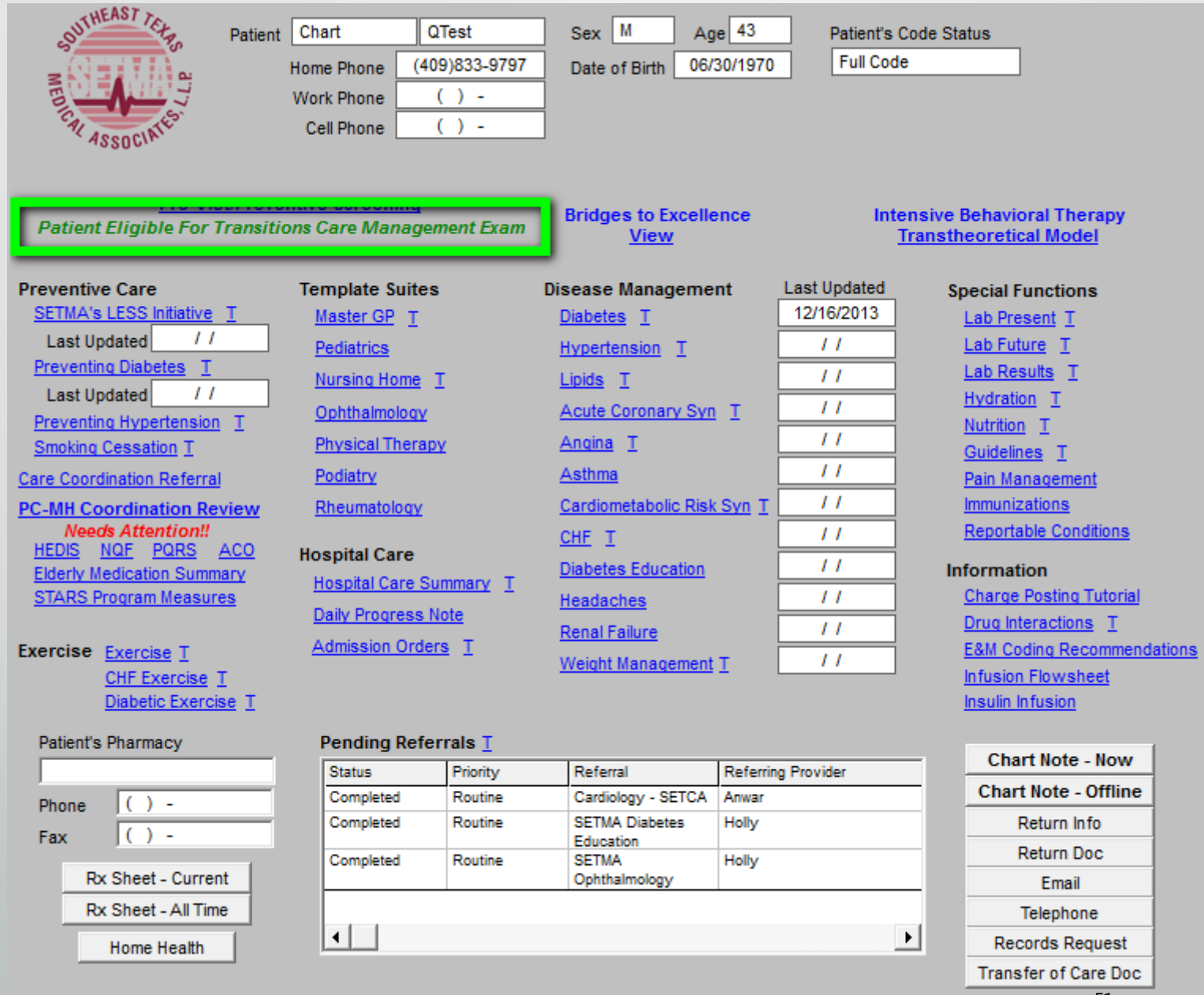
Make It Easier To Do It Right Than Not At All

- Because SETMA uses the same EHR in both inpatient and outpatient settings, all of the information needed to determine a patient's eligibility for the TCM codes is automatically aggregated and calculated in the background.

- All a provider has to do is begin an office visit and if the patient is eligible, they will be alerted on our main AAA_Home template in the EHR.

SETMA's Follow-Up Calls

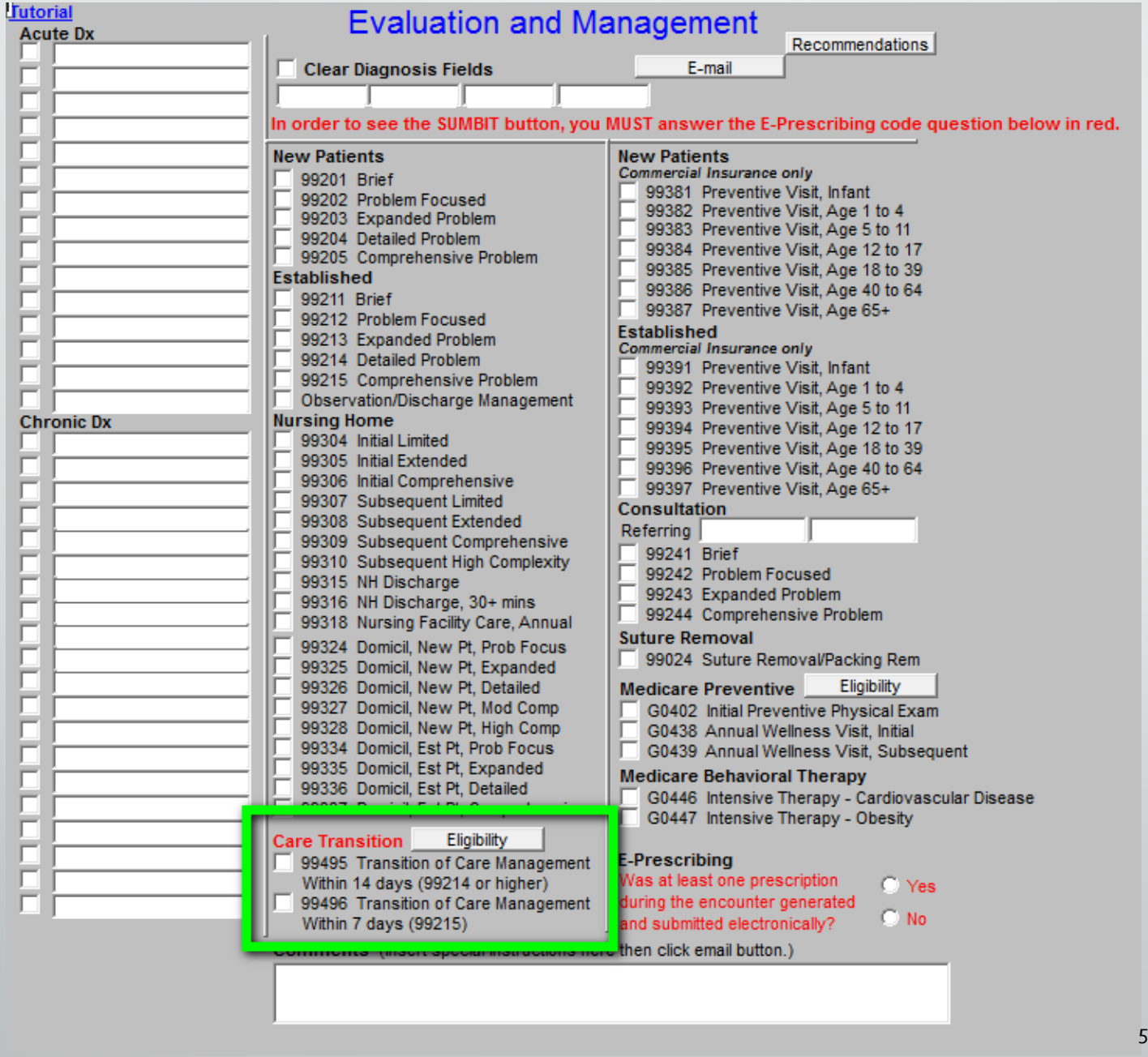
- Every patient that SETMA discharges from the hospital is scheduled to receive a call from our Care Coordination Department.
- SETMA has been calling all patients discharged from the hospital since 2009.
- **We did not have to implement anything new in order to fulfill the follow-up contact requirement of the new TCM codes.**


SOUTHEAST TEXAS MEDICAL ASSOCIATES, L.L.P.
Patient Chart QTest
Sex M Age 43
Patient's Code Status
Home Phone (409)833-9797
Date of Birth 06/30/1970
Full Code
Work Phone ( ) -
Cell Phone ( ) -
Patient Eligible For Transitions Care Management Exam
Bridges to Excellence
View
Intensive Behavioral Therapy
Transtheoretical Model
Preventive Care
SETMA's LESS Initiative T
Last Updated / /
Preventing Diabetes T
Last Updated / /
Preventing Hypertension T
Smoking Cessation T
Care Coordination Referral
PC-MH Coordination Review
Needs Attention!!
HEDIS NQF PQRS ACO
Elderly Medication Summary
STARS Program Measures
Exercise
Exercise T
CHF Exercise T
Diabetic Exercise T
Template Suites
Master GP T
Pediatrics
Nursing Home T
Ophthalmology
Physical Therapy
Podiatry
Rheumatology
Hospital Care
Hospital Care Summary T
Daily Progress Note
Admission Orders T
Disease Management
Last Updated
Diabetes T 12/16/2013
Hypertension T / /
Lipids T / /
Acute Coronary Syn T / /
Angina T / /
Asthma / /
Cardiometabolic Risk Syn T / /
CHF T / /
Diabetes Education / /
Headaches / /
Renal Failure / /
Weight Management T / /
Special Functions
Lab Present T
Lab Future T
Lab Results T
Hydration T
Nutrition T
Guidelines T
Pain Management
Immunizations
Reportable Conditions
Information
Charge Posting Tutorial
Drug Interactions T
E&M Coding Recommendations
Infusion Flowsheet
Insulin Infusion
Patient's Pharmacy
Phone ( ) -
Fax ( ) -
Rx Sheet - Current
Rx Sheet - All Time
Home Health
Pending Referrals T
Status Priority Referral Referring Provider
Completed Routine Cardiology - SETCA Anwar
Completed Routine SETMA Diabetes Education Holly
Completed Routine SETMA Ophthalmology Holly
Chart Note - Now
Chart Note - Offline
Return Info
Return Doc
Email
Telephone
Records Request
Transfer of Care Doc

Make It Easier To Do It Right Than Not At All

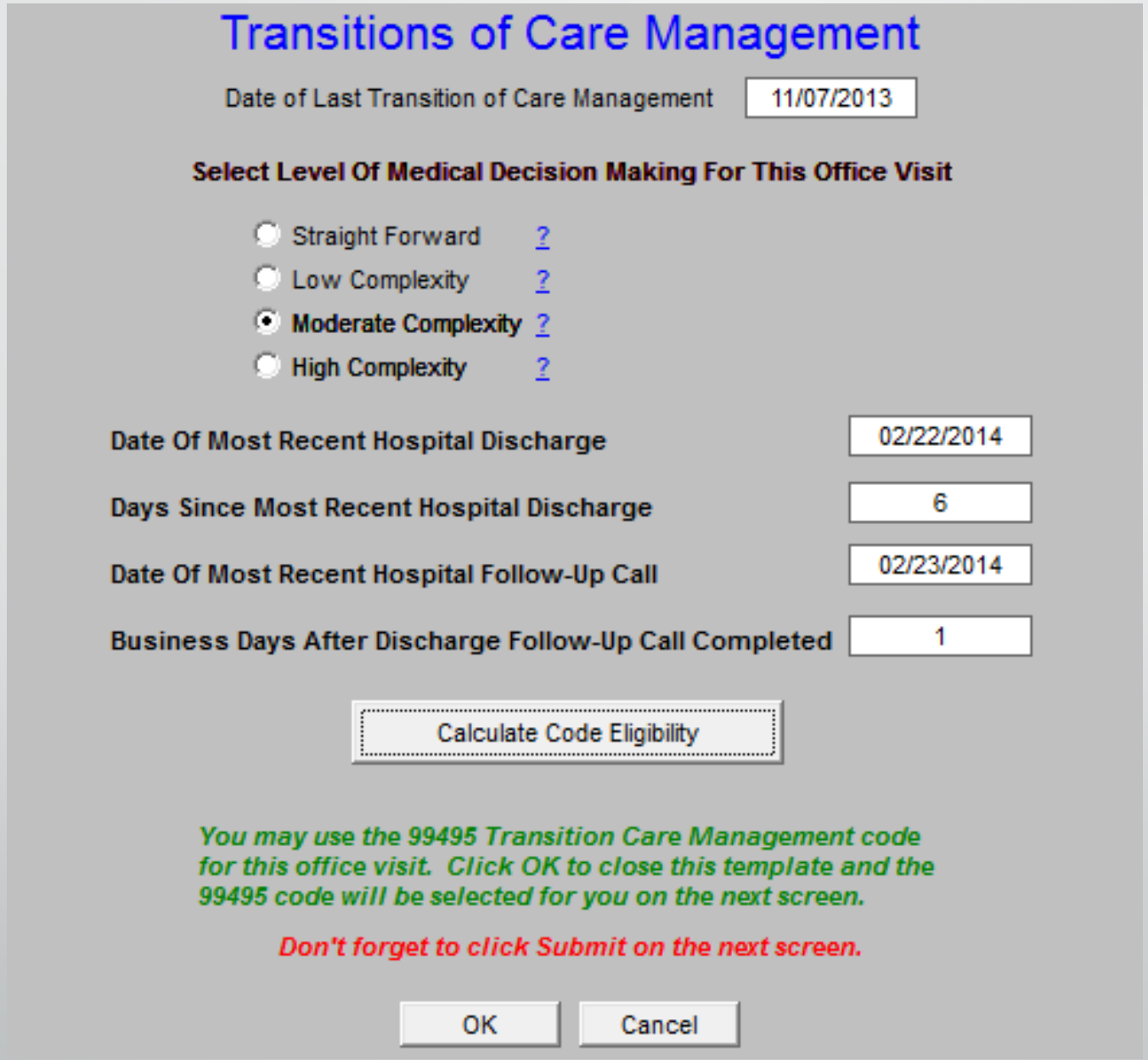
- At the conclusion of the visit, when the provider accesses the billing template, they will again be reminded to bill the TCM code is eligible.

- Again, this requires no extra work on the provider as all of the information has already been aggregated in the background.


Tutorial
Evaluation and Management
Recommendations
E-mail
Clear Diagnosis Fields
In order to see the SUMBIT button, you MUST answer the E-Prescribing code question below in red.
Acute Dx
Chronic Dx
New Patients
99201 Brief
99202 Problem Focused
99203 Expanded Problem
99204 Detailed Problem
99205 Comprehensive Problem
Established
99211 Brief
99212 Problem Focused
99213 Expanded Problem
99214 Detailed Problem
99215 Comprehensive Problem
Observation/Discharge Management
Nursing Home
99304 Initial Limited
99305 Initial Extended
99306 Initial Comprehensive
99307 Subsequent Limited
99308 Subsequent Extended
99309 Subsequent Comprehensive
99310 Subsequent High Complexity
99315 NH Discharge
99316 NH Discharge, 30+ mins
99318 Nursing Facility Care, Annual
99324 Domicil, New Pt, Prob Focus
99325 Domicil, New Pt, Expanded
99326 Domicil, New Pt, Detailed
99327 Domicil, New Pt, Mod Comp
99328 Domicil, New Pt, High Comp
99334 Domicil, Est Pt, Prob Focus
99335 Domicil, Est Pt, Expanded
99336 Domicil, Est Pt, Detailed
Care Transition
Eligibility
99495 Transition of Care Management Within 14 days (99214 or higher)
99496 Transition of Care Management Within 7 days (99215)
New Patients
Commercial Insurance only
99381 Preventive Visit, Infant
99382 Preventive Visit, Age 1 to 4
99383 Preventive Visit, Age 5 to 11
99384 Preventive Visit, Age 12 to 17
99385 Preventive Visit, Age 18 to 39
99386 Preventive Visit, Age 40 to 64
99387 Preventive Visit, Age 65+
Established
Commercial Insurance only
99391 Preventive Visit, Infant
99392 Preventive Visit, Age 1 to 4
99393 Preventive Visit, Age 5 to 11
99394 Preventive Visit, Age 12 to 17
99395 Preventive Visit, Age 18 to 39
99396 Preventive Visit, Age 40 to 64
99397 Preventive Visit, Age 65+
Consultation
Referring
99241 Brief
99242 Problem Focused
99243 Expanded Problem
99244 Comprehensive Problem
Suture Removal
99024 Suture Removal/Packing Rem
Medicare Preventive
Eligibility
G0402 Initial Preventive Physical Exam
G0438 Annual Wellness Visit, Initial
G0439 Annual Wellness Visit, Subsequent
Medicare Behavioral Therapy
G0446 Intensive Therapy - Cardiovascular Disease
G0447 Intensive Therapy - Obesity
E-Prescribing
Was at least one prescription during the encounter generated and submitted electronically?
Yes
No
then click email button.)

Make It Easier To Do It Right Than Not At All

- When the "Care Transition" label is shown in red, the provider clicks the Eligibility button to confirm that all of the criteria have been met to bill a TCM code in place of a traditional E&M code.
- The only thing that the provider must do is select the Level of Medical Decision Making that they feel they performed during the office encounter.
  - 99124 (Moderate Complexity or higher) Level of Medical Decision Making required for TCM code 99495
  - 99125 (High Complexity) Level of Medical Decision Making required for TCM code 99496


Transitions of Care Management
Date of Last Transition of Care Management
11/07/2013
Select Level Of Medical Decision Making For This Office Visit
Straight Forward ?
Low Complexity ?
Moderate Complexity ?
High Complexity ?
Date Of Most Recent Hospital Discharge
02/22/2014
Days Since Most Recent Hospital Discharge
6
Date Of Most Recent Hospital Follow-Up Call
02/23/2014
Business Days After Discharge Follow-Up Call Completed
1
Calculate Code Eligibility
You may use the 99495 Transition Care Management code for this office visit. Click OK to close this template and the 99495 code will be selected for you on the next screen.
Don't forget to click Submit on the next screen.
OK
Cancel

Make It Easier To Do It Right Than Not At All

- The provider simply clicks "Calculate Code Eligibility" and the EHR confirms if all criteria to bill a TCM code have been met.
- If so, the highest eligible TCM code is automatically selected, the provider closes the screen and clicks Submit.
- The work is done!