The Role & Challenges of Hospital Care Coordination in a "POP HEALTH WORLD"

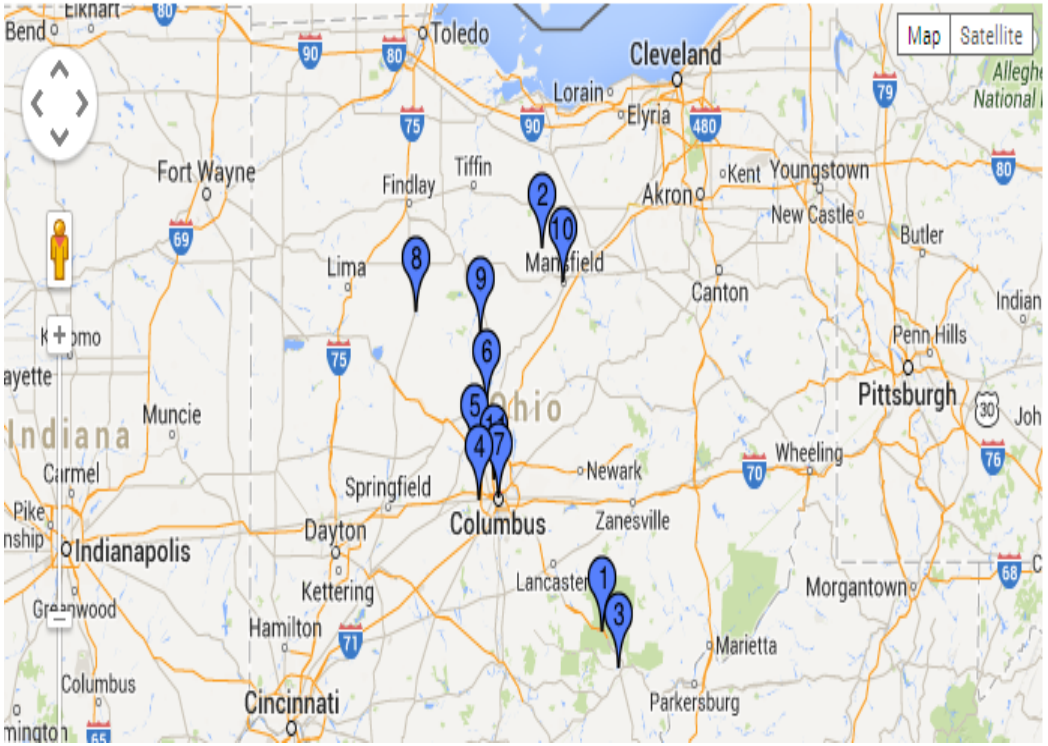
Presented by:

Mary Jane Fellers, RN, BSN, MBA
Senior Director, UM & Care Coordination
OhioHealth
Columbus, Ohio

HIMSS
CENTRAL & SOUTHERN OHIO *Chapter*

OhioHealth
BELIEVE IN *WE*

Hospitals and Locations



Our mission

To improve the health of those we serve.

Fast Facts

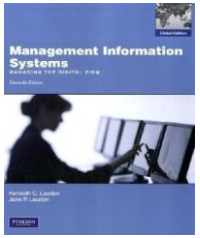
Fact

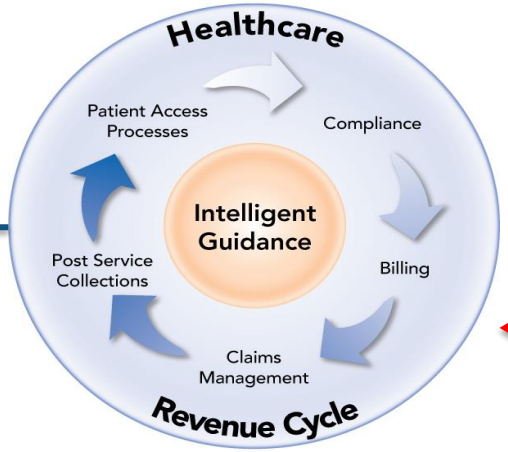
21,000 associates
3,600 physicians
3,500 volunteers
17 hospitals (10 member, 1 managed and 6 affiliated)
50+ambulatory sites
152,000 inpatient admissions + observation stays
493,000 Total ED visits
94,000 hospital surgeries
+2.7 million outpatient visits
Over $2.4 billion in net patient revenue

HIMSS
CENTRAL & SOUTHERN OHIO *Chapter*

So who am I?

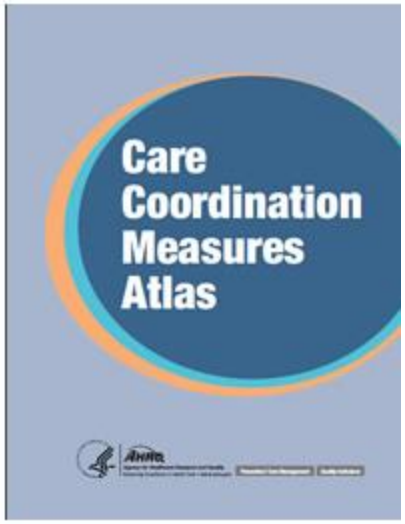
ASK·A·NURSE





Senior Director,
UM & Care Coordination
OhioHealth

HIMSS CENTRAL & SOUTHERN OHIO *Chapter*



Care coordination means different things to different people; no consensus definition has fully evolved. A recent systematic review identified over 40 definitions of the term "care coordination."

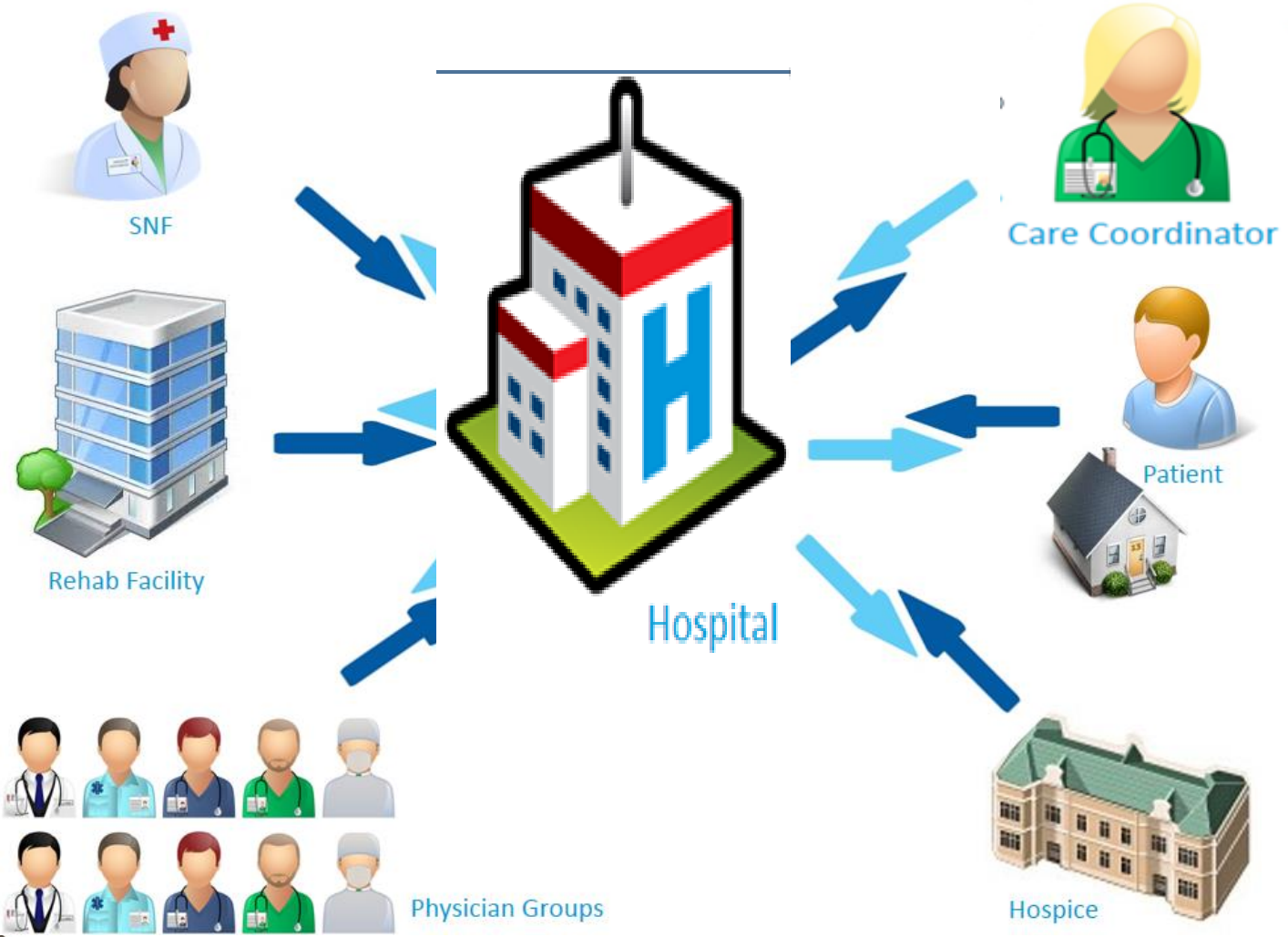
"Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care."

Population health Plethora of definitions….

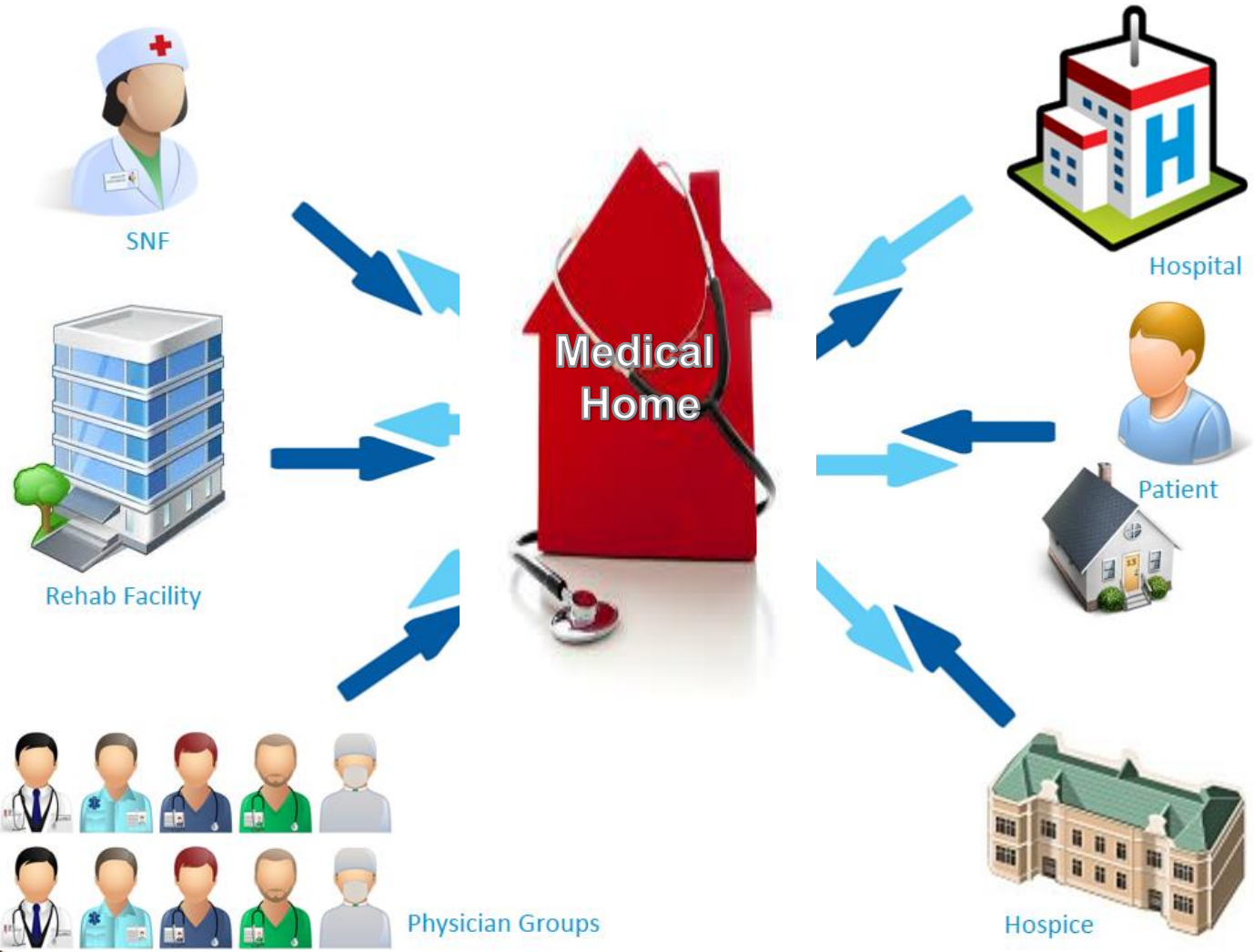
From Wikipedia, the free encyclopedia

Population health has been defined as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group".[1] It is an approach to health that aims to improve the health of an entire human population. *This concept does not refer to animal or plant populations.* A priority considered important in achieving this aim is to reduce health inequities or disparities among different population groups due to, among other factors, the social determinants of health, SDOH. The SDOH include all the factors: social, environmental, cultural and physical the different populations are born into, grow up and function with throughout their lifetimes which potentially have a measurable impact on the health of human populations.[2] The Population Health concept represents a change in the focus from the individual-level, characteristic of most mainstream medicine. It also seeks to complement the classic efforts of public health agencies by addressing a broader range of factors shown to impact the health of different populations. The World Health Organization's Commission on Social Determinants of Health, reported in 2008, that the SDOH factors were responsible for the bulk of diseases and injuries and these were the major causes of health inequities in all countries.[3] In the US, SDOH were estimated to account for 70% of avoidable mortality.[4] From a population health perspective, health has been defined not simply as a state free from disease but as "the capacity of people to adapt to, respond to, or control life's challenges and changes".[5] The World Health Organization (WHO) defined health in its broader sense in 1946 as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[6][7]

Moving on: Hospital Care Coordination



"Medical Home" now the key player!



The Care Coordination Puzzle

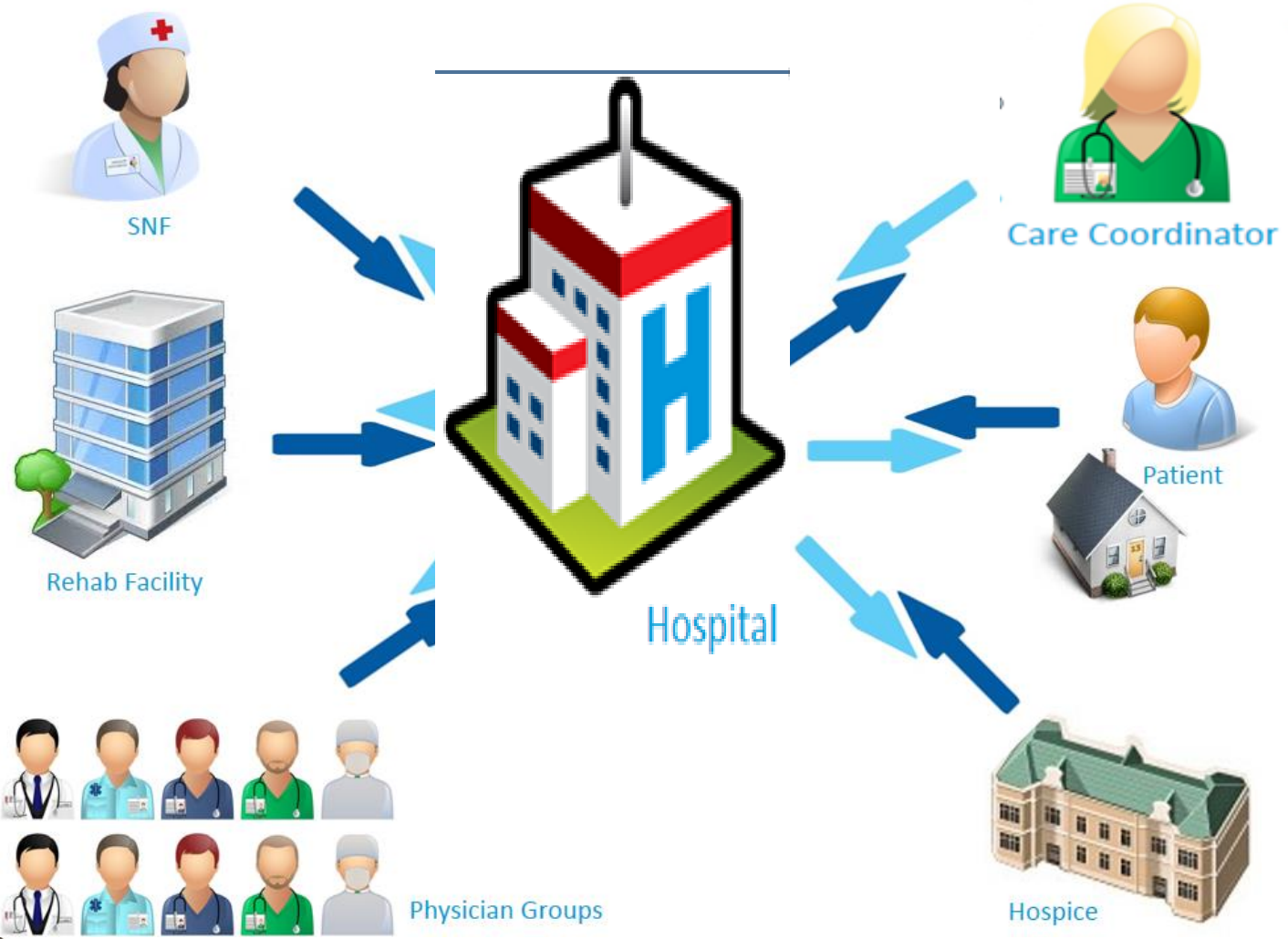
"As healthcare reform leads to a change from the fee-for-service payment model to value-based, quality-focused care, hospitals around the country must solve the care coordination puzzle.

From admission to discharge and beyond, hospitals now take a more active role in improving patient engagement, patient navigation, physician engagement, medical monitoring technology and working with pharmacists and other specialists to align all the pieces to create more affordable, quality healthcare.

One of the most important aspects of care coordination is a team-based approach between hospitals and post-acute care facilities to reduce readmissions and improve patient satisfaction ,while emphasizing preventive healthcare,"

Janet Comrey, R.N., a senior consultant for population health at Geisinger Healthcare in Danville, Pennsylvania in interview with Fierce HealthCare.

Hospital Care Coordination



5 PIECES OF THE CARE COORDINATION PUZZLE

Physician Engagement

Patient Engagement

Pharmacy & Specialist Consults

Remote Monitori

Challenge #1: How do we know if the 5 puzzle pieces are applied?

You can have all the systems in the world….

but if you can't EXECUTE a strategy… you're

Where /how do I know if the patient navigator has the patient on their list? How does a patient get on their list?

How do I know if the pharmacist has been consulted? And if they
have …how do I know if they've seen the patient ..and what they have done?

Remote monitoring … who does that?... How do I know if its been done?

Patient Engagement??? - Teachback?? How do I know if this has been done? And even more if patient was 'engaged?'

And do I have the resources to do this for everyone??

Note that there are other risk assessments in the environment and this is just one example.

Ottawa Hospital Research Institute
LACE Index Scoring Tool for Risk Assessment of Death and Readmission

Step 1. Length of Stay

Length of stay (including day of admission and discharge): _____ days

Length of stay (days)	Score (circle as appropriate)
1	1
2	2
3	3
4-6	4
7-13	5
14 or more	7

→ L

Step 2. Acuity of Admission

Was the patient admitted to hospital via the emergency department?
If yes, enter "3" in Box A, otherwise enter "0" in Box A

A

Step 3. Comorbidities

Condition (definitions and notes on reverse)	Score (circle as appropriate)
Previous myocardial infarction	+1
Cerebrovascular disease	+1
Peripheral vascular disease	+1
Diabetes without complications	+1
Congestive heart failure	+2
Diabetes with end organ damage	+2
Chronic pulmonary disease	+2
Mild liver disease	+2
Any tumor (including lymphoma or leukemia)	+2
Dementia	+3
Connective tissue disease	+3
AIDS	+4
Moderate or severe liver disease	+4
Metastatic solid tumor	+6
TOTAL	

If the TOTAL score is between 0 and 3 enter the score into Box C. If the score is 4 or higher, enter 5 into Box C

C

Step 4. Emergency department visits

How many times has the patient visited an emergency department in the six months prior to admission (not including the emergency department visit immediately preceding the current admission)? _____
Enter this number or 4 (whichever is smaller) in Box E

E

Add numbers in Box L, Box A, Box C, Box E to generate LACE score and enter into box below. If the patient has a LACE score that is greater than or equal to 10, the patient can be referred to the virtual ward. (Note: A *virtual ward* uses the systems and staffing of hospital care, but without the physical building: staff provide preventative care for patients in their own homes. If your hospital does not support a virtual ward, proceed to treat patient as a high risk individual.)

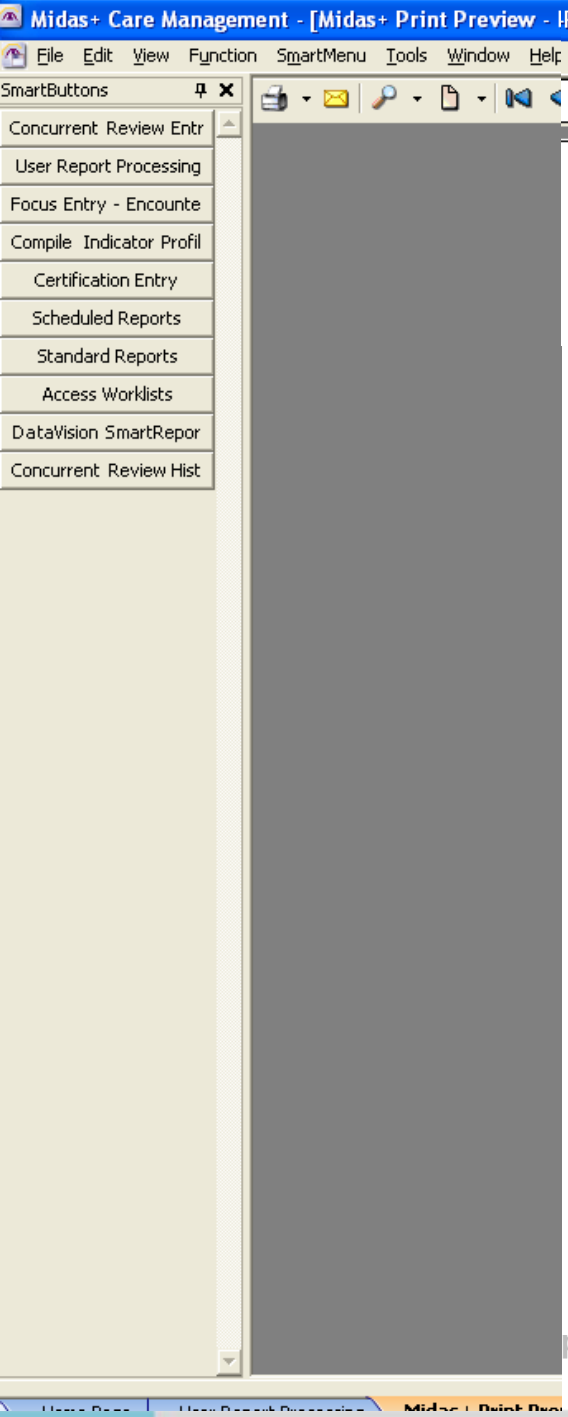
LACE

Shared with permission from Carl van Walraven (lead author) on July 3, 2012.

OhioHealth

LACE Index Intervention Algorithm

	Risk Score	Interventions
Low Risk	**0-4**	• **Multidisciplinary Discharge Planning Rounds (3 times/wk)** • PCP referral and/or Urgent Care Center Referral; Investigate "ZONE" instructions and 'call back' number.
Mild Risk	**5-9**	• **Multidisciplinary Discharge Planning Rounds (3 times/wk)** • **Social work referral – psychosocial assessment**
Moderate Risk	**10-13**	• **Multidisciplinary Discharge Planning Rounds (3 times/wk)** • **Social work referral – psychosocial assessment** • **Referral to Pharmacy for medication review, recommendation, patient education** • **Home Health referral** • **Follow up appointment** • **Follow-up phone call within 48 hours post discharge**
High Risk	**14 or Higher**	• **Multidisciplinary Discharge Planning Rounds (3 times/wk)** • **Social work referral – psychosocial assessment** • **Referral to Pharmacy for medication review, recommendation, patient education** • **Home Health referral** • **Follow up appointment** • **Follow-up phone call within 48 hours post discharge** • **Interdisciplinary care conference with physician, nurses, social worker, case manager, patient, and family**



1 of 1 Close Current Printer: \\vmoprintamb01.ds.ohnet\PR7806

OhioHealth

FS-READMISSION CM CASES MANUALLY ADDED w/ EST RISK SCORE

Encounter... Discharge Date Between "6/1/2014" and "6/10/2014" AND LACE CATEGORY... Name IsEntered

Focus ID No	D/C Date	Account No	Patient Name	Reviewer Name	CM Est Risk Category	Reason for Addition to Worklist
14-1328728	06/05/2014		1234 Patient X	MATHIAS,CONNIE	HIGH	CHF
14-1485768	06/09/2014		1235 patient Y	ARENSTEIN,DIANN	HIGH	ICU admit for CHF
14-1519438	06/10/2014		2134 Patient Z	ARENSTEIN,DIANN	HIGH	new dx CHF
14-1255767	06/03/2014		1234 Patient A	SHROFF,KARA	MODERATE	drug abuse, renal CA.
14-1447360	06/03/2014		1235 patient B	HOLCOMB,ELIZAB	MODERATE	
14-1510638	06/06/2014		2134 Patient C	THOMAS,MARY E.	MODERATE	Both CM, HFNN and physician felt higher risk than s

Hospital Process Metrics

Follow up phone call
Teachback
Pharmacy Consult (Mod/High Risk only)
Home Health Referral (coaching or visit)
Follow up phone call.

pter logo

Focus: READMISSIONS CM **Date:** 5/20/2014 Focus ID: 14-1328728

Save | Save & Print | Documents | Files | Qualifying Criteria | Close

READMISSIONS | TELEPHONE SCRIPT

READMISSIONS CM FOCUS

NAME OF REVIEWER: MATHIAS,CONNIE B.

THIS ENCOUNTER IS A READMISSION WITHIN 30 DAYS--CHECK IF "YES":

DIAGNOSIS: CHF

DISPOSITION: HOME

HOME HEALTH/HEALTH COACH REFERRAL? (•) Yes ( ) No

FOLLOW-UP APPT SCHEDULED? (•) Yes ( ) No

TRANSITIONAL CARE IN LIEU OF FOLLOW-UP APPT SCHEDULED:

DATE FOLLOW-UP APPOINTMENT SCHEDULED 6/9/2014

FOLLOW-UP PHONE CALL ATTEMPTED? (•) Yes ( ) No

TRANSITIONAL CARE IN LIEU OF FOLLOWUP PHONE CALL:

DATE OF PHONE CALL - 1st ATTEMPT 6/11/2014

DID YOU TALK TO PATIENT? YES

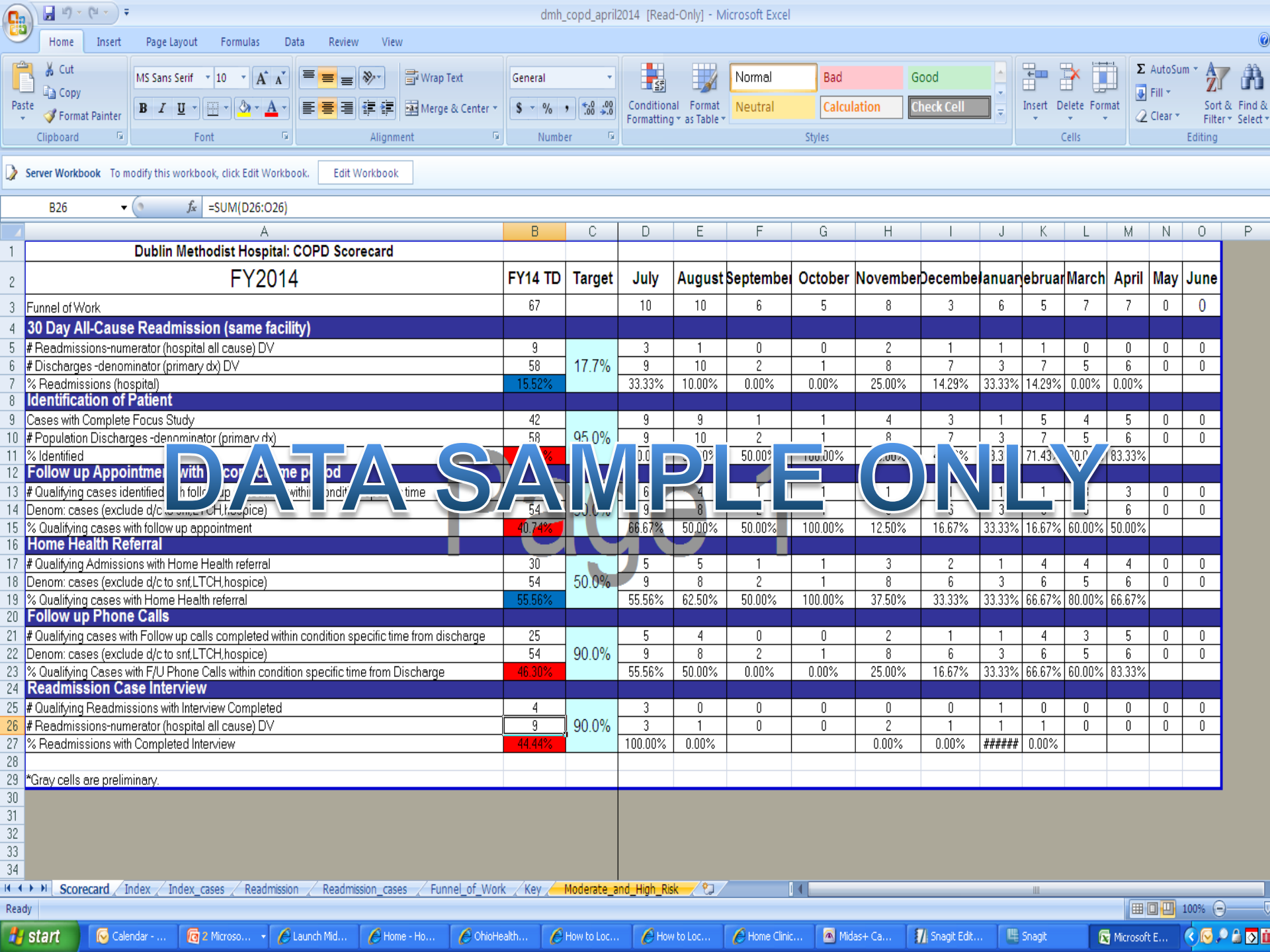
COMMENTS:

5/20/14 lace 4.ab
5/21/14 lace 5.ab
5/22/14 lace 6,ab
5/23/14 lace 7.ab
5/27/14 lace 8.ab
6/2/14 lace 10.ab
6/5/14 Follow up on 6/9/14 @ 1:00.cwl

ADDED TO FOCUS/WORKLIST MANUALLY: ☑

ENTER A BRIEF REASON THAT THE PT HAD TO MANUALLY BE ADDED TO THE FOCUS/WORKLIST: CHF

CM ESTIMATED RISK CATEGORY: HIGH



dmh_copd_april2014 [Read-Only] - Microsoft Excel

Home | Insert | Page Layout | Formulas | Data | Review | View

Server Workbook To modify this workbook, click Edit Workbook. Edit Workbook

B26 =SUM(D26:O26)

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	**Dublin Methodist Hospital: COPD Scorecard**														
2	FY2014	FY14 TD	Target	July	August	September	October	November	December	January	February	March	April	May	June
3	Funnel of Work	67		10	10	6	5	8	3	6	5	7	7	0	0
4	**30 Day All-Cause Readmission (same facility)**														
5	# Readmissions-numerator (hospital all cause) DV	9		3	1	0	0	2	1	1	1	0	0	0	0
6	# Discharges -denominator (primary dx) DV	58	17.7%	9	10	2	1	8	7	3	7	5	6	0	0
7	% Readmissions (hospital)	15.52%		33.33%	10.00%	0.00%	0.00%	25.00%	14.29%	33.33%	14.29%	0.00%	0.00%		
8	**Identification of Patient**														
9	Cases with Complete Focus Study	42		9	9	1	1	4	3	1	5	4	5	0	0
10	# Population Discharges -denominator (primary dx)	58	95.0%	9	10	2	1	8	7	3	7	5	6	0	0
11	% Identified	[illegible]%		0.0	[illegible]0%	50.00%	100.00%	[illegible]00%	[illegible]%	33.3	71.43	[illegible]0.0	83.33%		
12	**Follow up Appointment with [illegible] Time period**														
13	# Qualifying cases identified [illegible] follow up [illegible] within [illegible] condition specific time	[illegible]		6	4	1	1	1	[illegible]	1	1	[illegible]	3	0	0
14	Denom: cases (exclude d/c to snf,LTCH,hospice)	54	[illegible]0.0%	9	8	[illegible]	[illegible]	[illegible]	[illegible]	3	[illegible]	[illegible]	6	0	0
15	% Qualifying cases with follow up appointment	40.74%		66.67%	50.00%	50.00%	100.00%	12.50%	16.67%	33.33%	16.67%	60.00%	50.00%		
16	**Home Health Referral**														
17	# Qualifying Admissions with Home Health referral	30		5	5	1	1	3	2	1	4	4	4	0	0
18	Denom: cases (exclude d/c to snf,LTCH,hospice)	54	50.0%	9	8	2	1	8	6	3	6	5	6	0	0
19	% Qualifying cases with Home Health referral	55.56%		55.56%	62.50%	50.00%	100.00%	37.50%	33.33%	33.33%	66.67%	80.00%	66.67%		
20	**Follow up Phone Calls**														
21	# Qualifying cases with Follow up calls completed within condition specific time from discharge	25		5	4	0	0	2	1	1	4	3	5	0	0
22	Denom: cases (exclude d/c to snf,LTCH,hospice)	54	90.0%	9	8	2	1	8	6	3	6	5	6	0	0
23	% Qualifying Cases with F/U Phone Calls within condition specific time from Discharge	46.30%		55.56%	50.00%	0.00%	0.00%	25.00%	16.67%	33.33%	66.67%	60.00%	83.33%		
24	**Readmission Case Interview**														
25	# Qualifying Readmissions with Interview Completed	4		3	0	0	0	0	0	1	0	0	0	0	0
26	# Readmissions-numerator (hospital all cause) DV	9	90.0%	3	1	0	0	2	1	1	1	0	0	0	0
27	% Readmissions with Completed Interview	44.44%		100.00%	0.00%			0.00%	0.00%	######	0.00%				
28															
29	*Gray cells are preliminary.														

Scorecard | Index | Index_cases | Readmission | Readmission_cases | Funnel_of_Work | Key | Moderate_and_High_Risk

Ready 100%

Sometimes ..its the little things that can throw a screw in the works

EXAMPLE: Post Acute Referral important..but who do I make it to?

Who's your primary physician Mr. Smith?

Its Dr. Stan Bush 

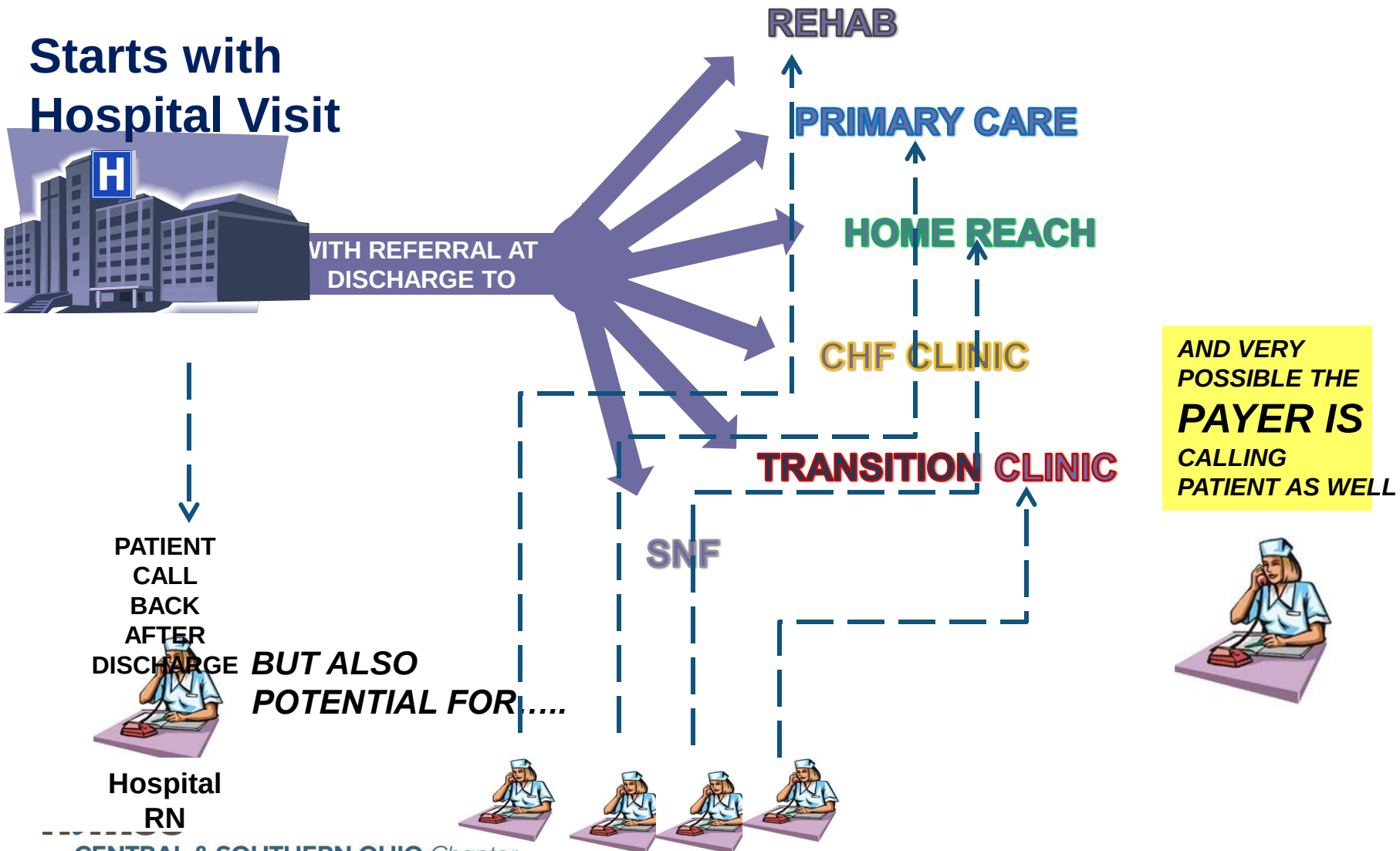
Well I see at your last admission it was Dr. Dave Lubdub?

Oh no, He's my cardiologist. 

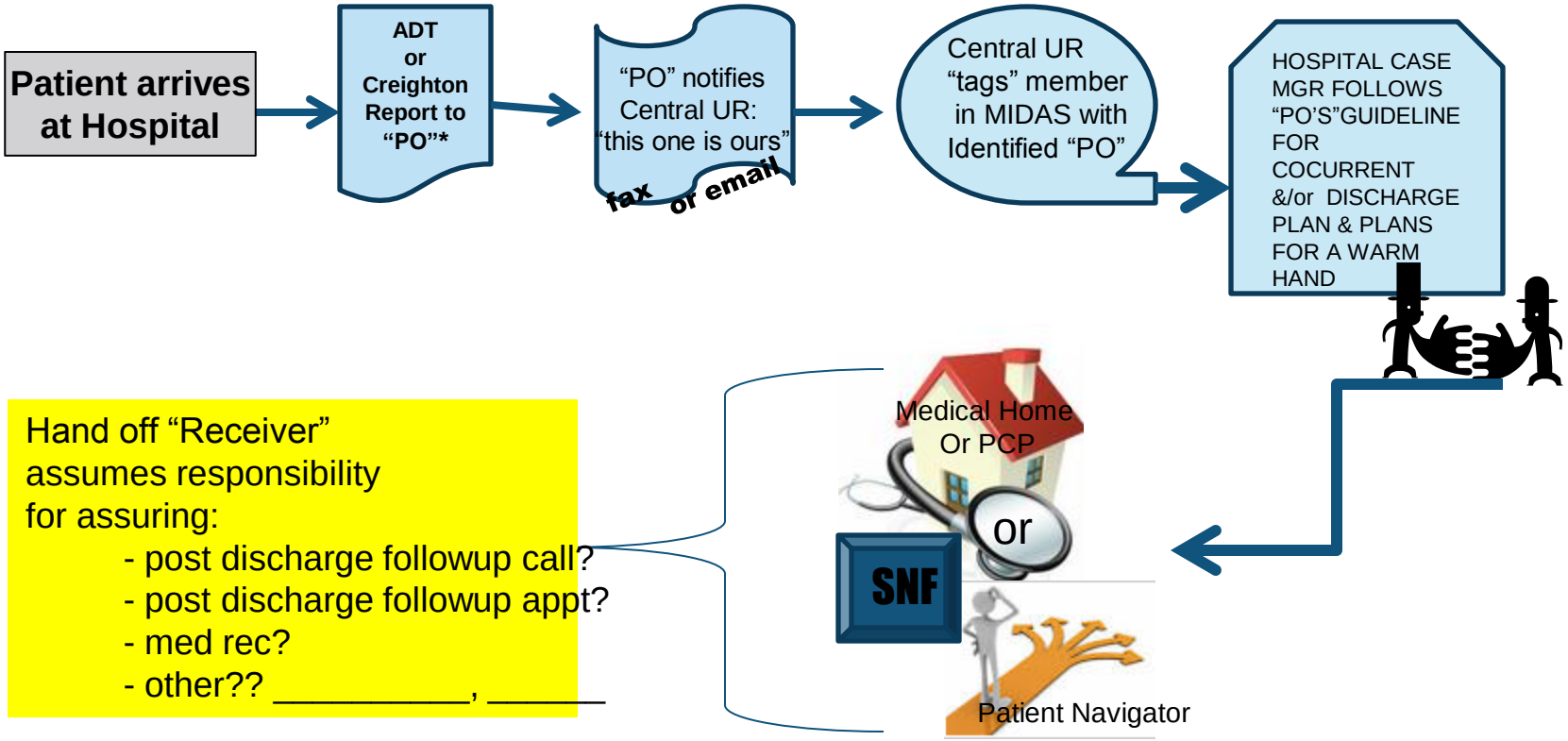
So Dr. Stan Bush is your primary care physician and that's who you see on a regular basis?

Oh no.. I usually see my pulmonologist for my COPD ..that's Dr. Wheezer. 

So again…who owns the patient?



POTENTIAL SOLUTION? ATTRIBUTION WORKFLOW



*PO = "patient owner" – the entity that has this member 'tagged' in their system as an 'attributed member' to follow either while in hospital or post discharge.

Challenge #2: Lack of standardized "handoff"

Industry Standards:

Meaningful Use – Stage II Care Coordination

Interact

Interim Electronic:

Discharge instructions

Discharge summary

Others: "Warm Handoff"

2014 Edition EHR Certification Criteria: Categories & Criteria

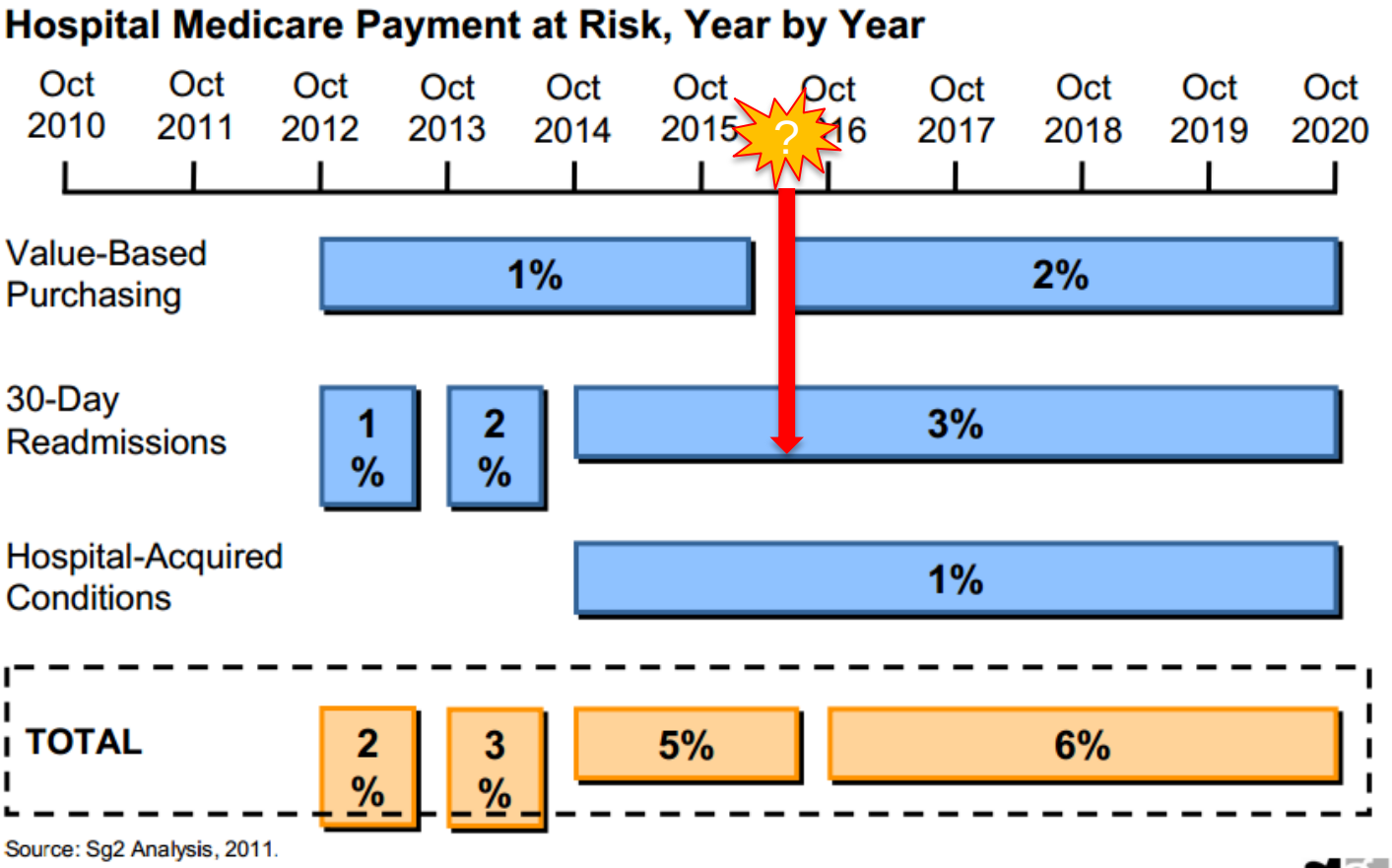
Putting the I in HealthIT
www.HealthIT.gov

Cert. Category	Criterion	Description	Req. Summary Type
Care Coordination *170.314(b)*	Transition of Care *170.314(b)(1)&(2)*	when transitioning a patient to another care setting, the EP or EH/CAH should provide a summary care record	Transition of Care/Referral Summary
	Data Portability *170.314(b)(7)*	when a patient transitions from provider or setting to another, a medication reconciliation should be preformed	Export Summary
Patient Engagement *170.314(e)*	View/Download/Transmit *170.314(e)(1)*	patients must be able to view & download their own medical info & also be able to transmit that info to a 3rd party	Ambulatory or Inpatient Summary
	Clinical Summary *170.314(e)(2)*	provide clinical summaries for patients for each office visit	Clinical Summary

DELAYED

Prospective Payment System

HOSPITAL REIMBURSEMENTRISK HERE NOW – NOT WHEN STAGE 2 MEANINGFUL USE FINALLY ARRIVES



Source: Sg2 Analysis, 2011.

INTERACT

Interventions to Reduce Acute Care Transfers

Home ◆ About INTERACT ◆ INTERACT Tools ◆ Educational Resources ◆ Links to Other Resources ◆ Project Team ◆ Contact Us

What is INTERACT?

INTERACT is an acronym for "**Inter**ventions to **R**educe **A**cute **C**are **T**ransfers". The interventions is a quality improvement program designed to improve the identification, evaluation, and communication about changes in resident status.

INTERACT was first designed in a project supported by the Centers for Medicare and Medicaid Services (CMS). The current quality improvement project is supported by a grant from the Commonwealth Fund, and will involve a total of 30 nursing homes in the states of Florida, New York and Massachusetts. Many nursing homes across the country are using INTERACT.

What is the purpose of the INTERACT quality improvemer

The overall goal of the INTERACT program is to reduce the frequency of transfers to
physically difficult for residents, and result in numerous complications of hospitaliz

In the plans for health care reform, Medicare may financially reward facilities with lo
identification, evaluation, and communication about changes in resident status, some, but not all acute care transfers can be avoided.

What are the INTERACT tools and who should use them?

There are three basic types of tools: 1) Communication tools; 2) Care Paths or Clinical tools; and 3) Advance Care Planning tools.

The specific tools are designed for use by selected members of the care team. However, in order for the INTERACT II project to be successful, all members of the care team should be aware of all of the tools and their uses.

How are the INTERACT tools used in every day work in your facility?

The INTERACT project champion will assist facility staff in using the tools on a daily basis. The tools have been designed to help staff improve care, but not increase unnecessary paperwork.

...But no one interacts with the Interact

HIMSS
CENTRAL & SOUTHERN OHIO Chapter

...te Care

INTERACT
Version 3.0 Tool

Language: ☐ English ☐ Other _____
Race/Ethnicity: ☐ White ☐ Black ☐ Hispanic ☐ Other _____

B. Family/Caregiver/Proxy Contact
Family/Caregiver Name _____
Tel (_____) _____
Healthcare Proxy/Guardian Name *(if different)* _____
Tel (_____) _____

C. Advance Directives/Goals of Care
☐ Full Code ☐ DNR ☐ DNI (Do Not Intubate)
☐ DNH (Do Not Hospitalize) ☐ No Artificial Feeding ☐ Comfort Care
☐ Hospice Care
☐ Other *(specify)* _____
Were goals of care discussed during this hospitalization? ☐ No ☐ Yes *(specify)*
_____
Patient decision making capacity? ☐ Capable of making decisions ☐ Requires proxy

D. Transferring Hospital Information
Hospital _____
Unit _____
Discharging RN _____
Tel (_____) _____
Discharging MD _____
Tel/Page (_____) _____
Date of Admission to Hospital _____/_____/_____

E. Post-Acute Care Information
Transfered to _____ Tel (_____) _____
Nurse to Nurse verbal report? ☐ No ☐ Yes *(specify to whom)* _____

F. Hospital Physician Care Team Information
Primary Care Physician *(or Hospitalist)* _____ Tel (_____) _____
Specialist _____ Specialty _____ Tel (_____) _____
Specialist _____ Specialty _____ Tel (_____) _____

G. Key Clinical Information
Vital Signs Time Taken _____ Pain Rating _____ ☐ N/A Pain Site _____
Temp _____ BP _____ HR _____ RR _____ O2 Sat _____ Weight _____
Mental Status ☐ Alert ☐ Disoriented, follows commands ☐ Disoriented, cannot follow commands ☐ Not Alert
Diagnoses Primary Discharge Diagnosis _____
Other Medical Diagnoses _____
Mental Health Diagnoses _____

H. High Risk Conditions/Treatment Information *(check all that apply)*
☐ Fall Risk Precautions: _____
☐ Heart Failure: ☐ New diagonsis? ☐ Exacerbation this admission? Date of last echo ____/____/____ ☐ EF_____% Dry Weight *(if known)* _____
☐ Anticoagulated: Reason: ☐ Afib ☐ DVT/PE ☐ Mech. Valve ☐ Post-OP ☐ Low EF ☐ Other _____
Duration _____ Goal INR: ☐ 1.5-2.5 ☐ 2-3 ☐ Other _____
☐ On PPI Indication(s): ☐ In-hospital prophylaxis and can be d/c ☐ Specific Dx

Electronic DI vs. Discharge Summary

Discharge Instructions (the “DI”)

Pros: physician must sign prior to discharge

Cons: limited info – Diagnosis, Procedures, Appointment, Meds

Discharge Summary

Pros: contains the ‘story’ – course of hospital visit/what happened.

Cons: Physicians may have up to 30 days to dictate/sign.

Patient Name/DOB: **Hospital :**	
Admission date/discharge date - • LOS • Prior hospitalizations	
Principle Diagnosis: Co-morbidities/other dx:	
Patient self care potential/physicial limitations Caregiver/relationship/contact info	
Discharge to: • Home • ECF • Home health/palliative • Hospice • Episode of Care	
Specialists consulted in hospital course	

Referrals to specialists, ambulatory services or community services: • scheduled • need to schedule	
Outpatient Tests: • scheduled • need to schedule	
Health Literacy	
Medication Issues • Polypharmacy • High risk medications	
Psychosocial issues/behavioral health issues	
Handoff to: Phone number Date By	

Challenge #3: No "*PING*" back.

Multiple providers cite they will or are following the patient after discharge

- scheduling appointments
- providing transportation
- making call backs, etc..

Hospital doesn't know & since we own the penalty, we don't *let go*.

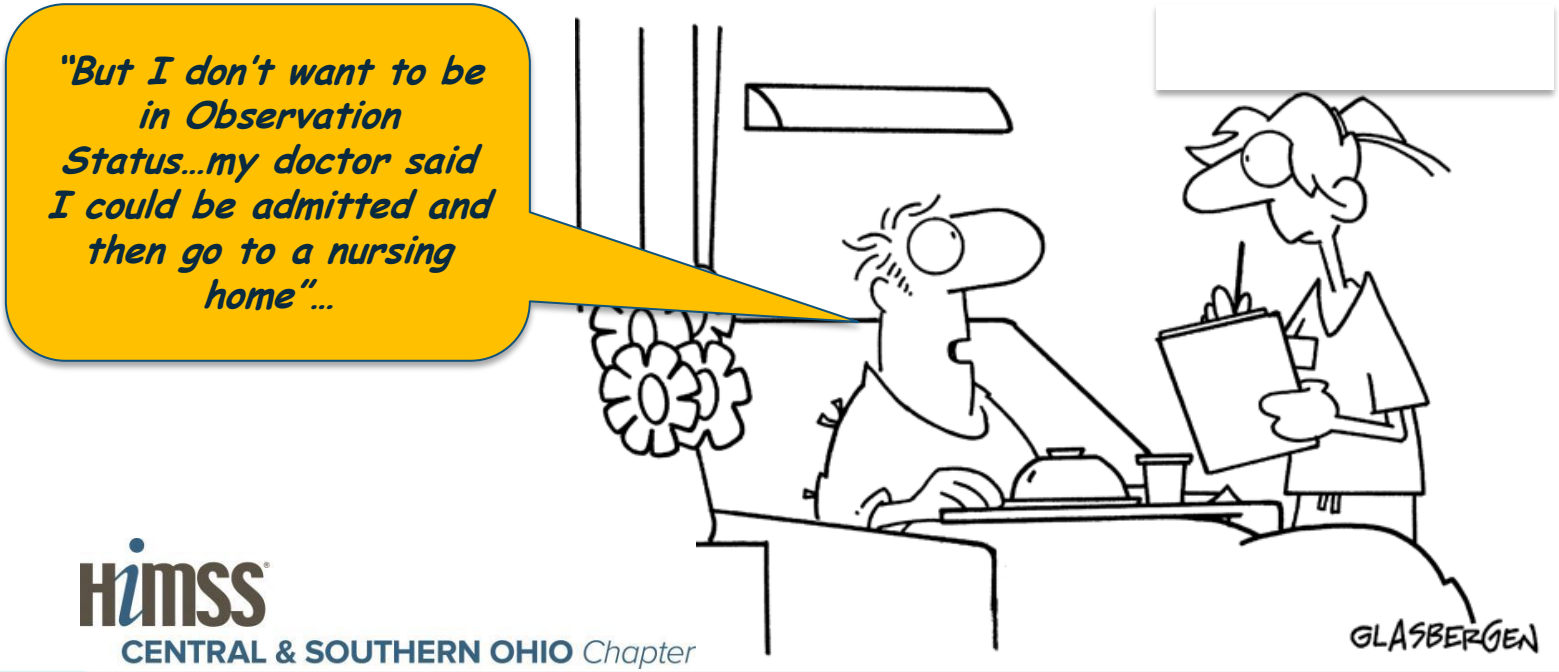
Challenge #4: Complying with Compliance

REIMBURSEMENT IS THERE FOR POP HEALTH…WE ***JUST NEED TO COMPLY*** WITH PAYER REQUIREMENTS TO OBTAIN IT

A few of the rules….

The 3 Day SNF Rule

Currently, when Medicare beneficiaries are discharged to a skilled care facility for rehabilitation, Medicare's coverage only kicks in if beneficiaries have been coded as an in-patient at a hospital for at least three days, known as the three-day stay rule.



Home Health, PT/OT Face-to-Face

Suggested Electronic Clinical Template Elements of a
Progress Note Documenting a
Face-to-Face Examination for Home Health Services
DRAFT v3.1 (02/07/14)

MRADL: Mobility Related Activities of Daily Living[1]

A. Chief Complaint

A1. Indicate that this visit is a face-to-face examination for the purpose of evaluating the patient for a home health services.

A2. Describe, in patient's own words, the symptoms/problems/conditions that limit /impair his/her ability to perform Mobility Related Activities of Daily Living (MRADLs) and/or functional abilities.

B. History of Present Illness

B1. **History of Present Illness** -- Why does the patient now require skilled home health services?

B1a. Describe the patient's functional impairments /limitations that require home health services.

B1b. Indicate which type of home health services that the patient now requires: Skilled Nursing, Physical Therapy, Speech Therapy and/or Occupational Health Therapy or continues to need Occupational Health.

B1c. Describe MRADLs which are currently limited by the patient's functional impairments /limitations.

B1d. Indicate

B1e. Describe areas of the home that impair the patient's functional abilities/limitations and/or contribute to their homebound status.

B1f. Describe the mobility aides (cane, walker, rollator) that are currently being used or have been tried t assist the patient's functional impairments /limitations.

B1g. Describe the reason mobility aides are being used or are no longer required.

B1h. Describe the medical condition(s) that contribute to the patient's impairment:

B1hi. Primary diagnosis

B1hii. Secondary diagnoses

B1i. Indicate whether this is a longstanding condition. If it is, describe factors that aggravate the patient' medical condition(s) over time and provide supporting documentation (test results, X-ray reports, et of one or more quantitative characteristics that is associated with the patient's decline.

B1j. Describe prior treatments/services attempted to improve the patient's medical condition(s) (medications, therapies, etc).

C. Past Medical History

C1. **Past Medical History** – What are the medical history factors that contribute to the patient's home bound status?

C1a. List the patient's co-morbid medical conditions and current medication

Add a field to capture: cross-reference to order

Detailed Written Order (DWO)

Beneficiary's name
Date of the face - to - face examination.
Diagnosis
Orders for Discipline and treatments
Goals/Rehabilitation Potential/Discharge Plans
Physician's signature
Date of physician signature

DME REQUIREMENTS

F2F documentation will be required for the following frequently used items . (Actual list several pages long)

1. Wheelchairs
2. Hospital Beds and accessories
3. Portable Oxygen
4. Nebulizer
5. Cpap
6. Bipap
7. Ventilators

What is documentation is needed prior to each delivery:

A F2F encounter must be documented as part of the medical record before the equipment is delivered to the patient. The encounter must have occurred no greater than 6 months prior to the order and delivery date.
A written dispensing order is required prior to the delivery of equipment items that fall under the F2F requirement (see above) the written order must not encounter.

Written Order Require Prior to

ACO Model requires a "safe transition" to care… How safe is it if I can't supply the SUPPLY needed for discharge?

Provider noted **above** the Practitioner's

4. The date of the order and the start date, if start date is different from the date of the order
5. The signature of the ordering Practitioner
6. Date order signed by Practitioner, must be located by signature
6. Ordering Practitioner's printed name (this is not in the regulation, but is always needed if the signature is not legible)

The written dispensing order does not need to be signed by the same practitioner that completed the F2F encounter. The written dispensing order can be signed by a physician, CNP, CNS, PA, or Resident and does not need to be cosigned by physician.

The FINE PRINT: Therapy notes can support the medical necessity, but can not be used in place of the F2F encounter.
If the F2F encounter was completed by physician, CNP, CNS, PA, or Resident, a physician must document the occurrence of the F2F encounter by signing or cosigning the encounter that is documented in medical record.
The requirement of the face-to-face is to document the need for the item that is being ordered. A practitioner can order equipment as long as there is a documented encounter within the last 6 months of the order date that supports the need. If there is no encounter within the last 6months prior to the written order, a new face-to-face encounter will be required for coverage.
•A face-to-face encounter for Oxygen can only be completed 30 days prior to the order. This is different than other F2F equipment, which is 6 months.
•A new face-to-face encounter is required when any of the participating equipment items need replaced.

Transition of Care Billing Codes

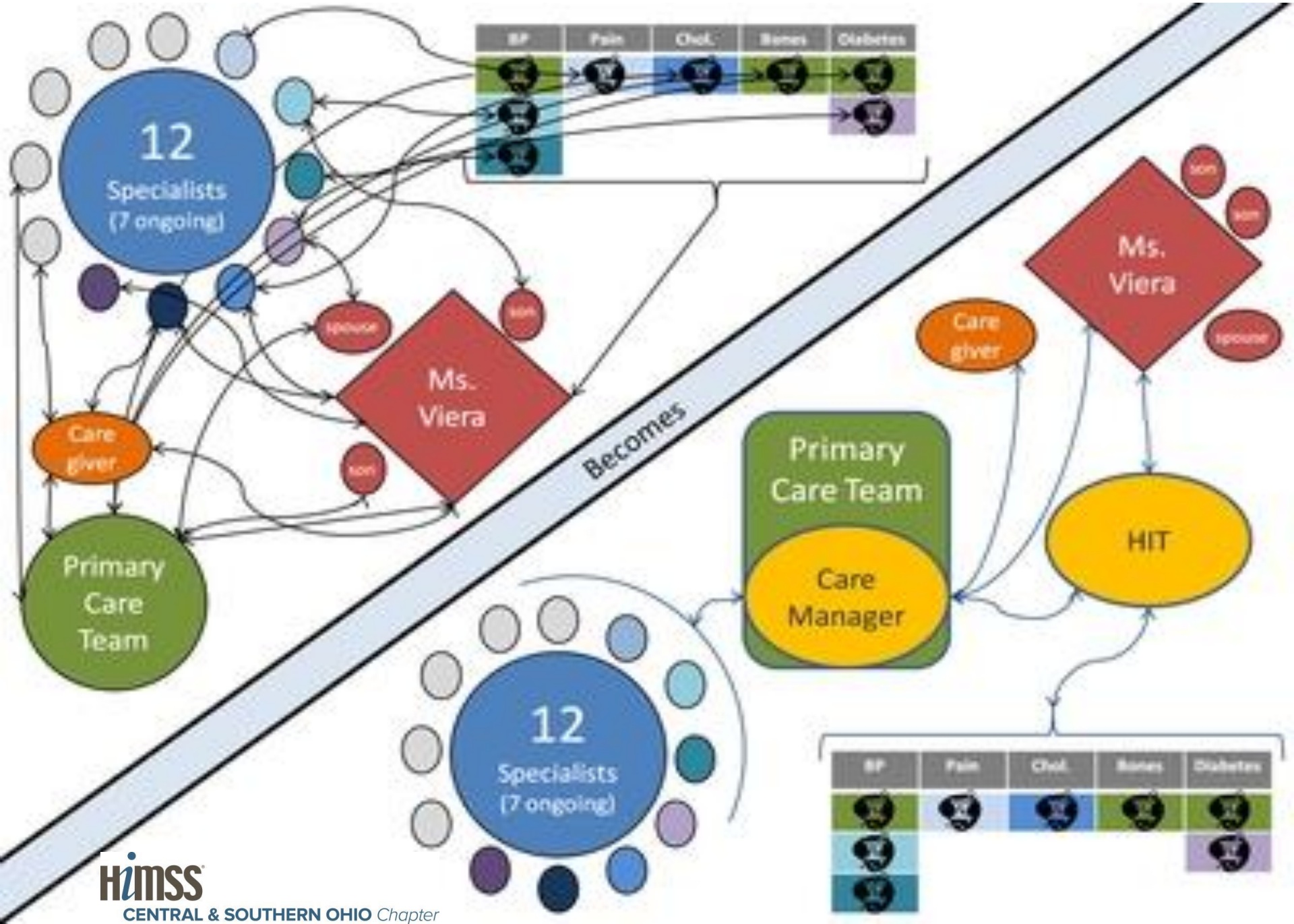
99495: Transitional Care Management Services with the following required elements

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver ***within 2 business days*** of discharge
- Medical decision making of at least ***moderate**** complexity during the service period *Face-to-face visit,* within ***14 calendar days*** of discharge.
- Payment ≈ $135 to $163**.

99465: Transitional Care Management Services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver ***within 2 business days*** of discharge.
- Medical decision making of at least ***high**** complexity during the service period *Face-to-face visit,* within ***7 calendar days*** of discharge.
- Payment ≈ $197 to $230**.

Where do I start?


12
Specialists
(7 ongoing)
Ms.
Viera
Care
giver
Primary
Care
Team
Becomes
Primary
Care Team
Care
Manager
HIT
Ms.
Viera
Care
giver
12
Specialists
(7 ongoing)

Don’t allow the environment to overwhelm..,

Have a thorough understanding of your organizational culture

- From an IT perspective
- From an ACO Model
- From a who’s who in your organization…who are the leaders? The folks who can get things done?

While advancing with strategic steps, there are hundreds of PROCESS steps that can be implemented, that will assure some work is getting done.

But work as a team..have the right people at the table..


Questions?