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

Presented by:

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Senior Director, UM & Care Coordination
OhioHealth
Columbus, Ohio
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
So who am I?

Senior Director,
UM & Care Coordination
OhioHealth
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 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

- SNF
- Rehab Facility
- Physician Groups
- Care Coordinator
- Patient
- Hospice
5 PIECES OF THE CARE COORDINATION PUZZLE

Physician Engagement

Patient Engagement

Pharmacy & Specialist Consults

Remote Monitoring

Patient Navigators

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 it's 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??
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

<table>
<thead>
<tr>
<th>Length of stay (days)</th>
<th>Score (circle as appropriate)</th>
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</thead>
<tbody>
<tr>
<td>1</td>
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<td>7-13</td>
<td>5</td>
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<tr>
<td>14 or more</td>
<td>7</td>
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</tbody>
</table>

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.

Step 3. Comorbidities

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

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.

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.

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
<table>
<thead>
<tr>
<th>Risk Score</th>
<th>Interventions</th>
</tr>
</thead>
</table>
| Low Risk    | • Multidisciplinary Discharge Planning Rounds (3 times/wk)  
              • PCP referral and/or Urgent Care Center Referral; Investigate “ZONE” instructions and ‘call back’ number. |
| Mild Risk   | • Multidisciplinary Discharge Planning Rounds (3 times/wk)  
              • Social work referral – psychosocial assessment |
| Moderate Risk| • 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   | • 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 |
Hospital Process Metrics

Follow up phone call
Teachback
Pharmacy Consult (Mod/High Risk only)
Home Health Referral (coaching or visit)
Follow up phone call.
RE Admissions 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 Apt Scheduled:
- [ ] Yes
- [ ] No

Transitional Care in Lieu of Follow-up Apt Scheduled:

Date Follow-up Appointment Scheduled:
- 5/9/2014

Follow-up Phone Call Attempted:
- [ ] Yes
- [ ] No

Transitional Care in Lieu of Follow-up Phone Call:

Date of Phone Call - 1st Attempt:
- 5/11/2014

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

Follow up on 6/9/14 @ 1:00 P.M.

Added to Focus/Worklist Manually:
- [ ]

Enter a brief reason that the PT had to manually be added to the Focus/Worklist CM estimated risk category:

- [ ] CHF
- [ ] High
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<thead>
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<th>Dublin Methodist Hospital: COPD Scorecard</th>
<th>FY2014</th>
<th>FY14 TD</th>
<th>Target</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
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<td><strong>Funnel of Work</strong></td>
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<td><strong>30 Day All-Cause Readmission (same facility)</strong></td>
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<td># Readmissions numerator (hospital all cause) DV</td>
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<td># Discharges denominator (primary dx) DV</td>
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<td>Cases with Complete Focus Study</td>
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<td>Follow up Appointment with same pod</td>
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<td>% Follow up Appointment with same pod</td>
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<td>Home Health Referral</td>
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<td>% Qualifying cases with Home Health Referral</td>
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<td>Follow up Phone Calls</td>
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<td>% Qualifying cases with Followup phone cells completed within condition specific time from discharge</td>
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<td>Readmission Case Interview</td>
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<td>% Qualifying Readmissions with Interview Completed</td>
<td>90.0%</td>
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*Grey cells are preliminary.*
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?

_It’s 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?

Starts with Hospital Visit

With referral at discharge to

Possible the payer is calling patient as well

Which of these players 'owns' the patient's care coordination after discharge?

Patient call back after discharge

But also potential for....

Hospital RN

AND VERY POSSIBLE THE PAYER IS CALLING PATIENT AS WELL
Patient arrives at Hospital

ADT or Creighton Report to “PO”**

“PO” notifies Central UR: “this one is ours”

PO notifies Central UR:

Central UR “tags” member in MIDAS with Identified “PO”

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.

Hand off “Receiver” assumes responsibility for assuring:
- post discharge followup call?
- post discharge followup appt?
- med rec?
- other?? __________, ______

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

<table>
<thead>
<tr>
<th>Cert. Category</th>
<th>Criterion</th>
<th>Description</th>
<th>Req. Summary Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Coordination</td>
<td>Transition of Care</td>
<td>when transitioning a patient to another care setting, the EP or EMR should provide a summary of care record</td>
<td>Transition of Care/Referral Summary</td>
</tr>
<tr>
<td>Data Portability</td>
<td>170.314(b)(3) &amp; (4)</td>
<td>when a patient transitions from provider or setting to another, a medication reconciliation should be performed</td>
<td>Export Summary</td>
</tr>
<tr>
<td>View/Download/Transmit</td>
<td>170.314(e)(1)</td>
<td>patients must be able to view &amp; download their own medical info &amp; also be able to transmit that info to a 3rd party</td>
<td>Ambulatory or Inpatient Summary</td>
</tr>
<tr>
<td>Clinical Summary</td>
<td>170.314(e)(2)</td>
<td>provide clinical summaries for patients for each office visit</td>
<td>Clinical Summary</td>
</tr>
</tbody>
</table>

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[HiMSS Central & Southern Ohio Chapter](http://www.HIMSS.org)
Prospective Payment System

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

Hospital Medicare Payment at Risk, Year by Year

- Value-Based Purchasing:
  - Oct 2010: 1%
  - Oct 2011: 2%
- 30-Day Readmissions:
  - Oct 2012: 1%
  - Oct 2013: 2%
  - Oct 2014: 3%
- Hospital-Acquired Conditions:
  - Oct 2015: 1%

TOTAL: 2% in 2010, 3% in 2011, 5% in 2012, 6% in 2013

Source: Sg2 Analysis, 2011.
...But no one interacts with the Interact

Interventions to Reduce Acute Care Transfers

What is INTERACT?

INTERACT is an acronym for ‘Interventions to Reduce Acute Care Transfers’. The interventions are 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 improvement program?

The overall goal of the INTERACT program is to reduce the frequency of transfers to acute care, thereby reducing the frequency of transfers due to physical or emotional stress, and result in numerous complications of hospitalization.

In the plans for health care reform, Medicare may financially reward facilities with lower rates of acute care transfers. In order for this to be possible, we must be able to identify changes in patient status, and communicate this to facilities on a timely basis.

What are the INTERACT tools and who should use them?

There are three basic types of tools: 1) Communication tools; 2) Care Pathways 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.
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
Cons: Physicians may have up to 30 days to dictate/sign.
<table>
<thead>
<tr>
<th><strong>Patient Name/DOB:</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital:</strong></td>
<td></td>
</tr>
</tbody>
</table>
| Admission date/discharge date -  
  • LOS  
  • Prior hospitalizations |  |
| Principle Diagnosis: |  |
| Co-morbidities/other dx: |  |
| Patient self care potential/physical 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

### Patient 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.

“But I don’t want to be in Observation Status... my doctor said I could be admitted and then go to a nursing home”...
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

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 service.
   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 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 aids (cane, walker, rollator) that are currently being used or have been tried to assist the patient’s functional impairments/limitations.
      B1g. Describe the reason mobility aids 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’s medical condition(s) over time and provide supporting documentation (test results, X-ray reports, etc.) 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
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 list). The written order must occur within 6 months of the encounter.

Written Order Requirements: Order Prior to Delivery

1. The beneficiary's name
2. Detailed description of DME ordered
3. The prescribing practitioner's National Provider Identifier (NPI) - Must be noted above the Practitioner's signature.
4. The date of the order and the start date, if start date is different from the order date
5. The signature of the ordering Practitioner
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.

ACO Model requires a “safe transition” to care... How safe is it if I can’t supply the SUPPLY needed for discharge?

The FINE PRINT: Therapy notes can support the medical necessity, but cannot 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 6 months 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.
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?
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?