True Performance Best Practices: All Cause Readmissions
Questions and Answers from April 19, 2018 Session

1. **As part of their transition of care (TOC), do you track or know the percentage of patients that had a Primary Care Provider (PCP) appointment scheduled prior to discharge and kept their appointment?**

   Robyn Lombard, St. Vincent: We have a TOC committee that tracks this. The last report I viewed showed 99% scheduled and I believe the percent that kept their appointment, including reschedules within the 14 days, was close to 97%. The touch points from the Care Manager to remind patients of this appointment has given us this high success rate.

2. **If we attempt to call the patient at least two times with no response, are we able to review/reconcile discharge medications, document that, and still bill the 1111F?**

   Robyn Lombard, St. Vincent: To do an appropriate medication reconciliation, conducted by a nurse or higher, it is important to have this discussion with the patient. Patients are often confused by their medications prior to the hospital and what they currently have at home. If you were unable to reach the patient, the medication reconciliation can also be completed at the time of visit. However the two documented attempts need to be in the chart in order to meet the criteria to bill the TOC visit.

3. **This seems different than what I've been told up until now...so are you saying we have to do BOTH: contact the patient within 2 days of discharge and review their discharge medications and instructions, AND complete the TOC visit?**

   Robyn Lombard, St. Vincent: In order to bill a TOC visit, you have to do both – 1) the medication reconciliation and 2) the visit within the 7-14 days. However, if you don't see the patient in the office, you can still get credit for the medication reconciliation if completed.

4. **Are there examples of a checklist for post discharge follow-up that practices can use?**

   Highmark: A checklist is on page 84 of the STAAR toolkit available from the following link: http://www.ihi.org/Engage/Initiatives/Completed/STAAR/Pages/default.aspx

5. **How do Highmark case managers interact with hospital aligned case managers?**

   Highmark: If our complex case or disease managers are working with a member that is in the hospital, they are able to collaborate with hospital case managers as they deem necessary. Typically our team does not call members until after the patient has been discharged from the hospital, so it is not often that they reach out to the hospital case managers during the hospitalization unless concerns regarding discharge planning arise.

6. **Are there examples of work flow/process to establish accountability between inpatient and outpatient settings for tests, imaging, and home health care?**

   Highmark: Yes, the following are 2 examples of work flow process to establish accountability between hospitals & outpatient settings (PCP offices):

   1) Hospital A (attending physician & nursing staff) conducts a medication reconciliation for every patient before discharge. This is noted in the hospital's EMR discharge summary & transfer record. Owning PCP offices identify daily discharges from Hospital A. (PCP office staff member assigned to check EMR daily). They have access to same EMR. When they identify one of their patients was discharged and had a medication reconciliation, they enter the CPT II code 1111F into the outpatient's chart for compliance with the Star Measure – Medication Reconciliation Post-Discharge.

   2) Hospital B has a daily discharge list. Care Coordination faxes attributed discharged patients to their PCP offices the same day. Two of the offices have high risk care coordinators that reach out to the discharged patient/family that day to make a 7 day follow-up appointment. The care coordinators also make follow-up discharge phone calls within 3-4 days to review medications, to identify any difficulties/ issues the patient may be having and to provide interventions that may prevent readmissions.

7. **We are using our medical assistant (MA) to make hospital follow up calls and schedule appointments. Is the MA able to conduct the post discharge phone call? Also can the follow up appointments and/or calls be scheduled with our clinical pharmacist?**

   Highmark: Medication reconciliations need to be conducted by a prescribing practitioner, clinical pharmacist or registered nurse on the date of discharge through 30 days after discharge (31 total days).