CPC
Comprehensive Primary Care

Capturing the Opportunities in Transitions of Care

September 23:
Finding Your Ideal Workflow for Transitions of Care

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- **Moderator:** Rose Langdon, MBA, RN (TMF)
- **Panelists:**
  - Rachel Wallis, MPH (TMF)
  - Russell Kohl, MD, FAAFP (TMF)
  - Connie Sixkiller (Warren Clinic Jenks)
  - Pratheep Arora, MD (Summit Medical Clinic)
  - Verda Weston (Utica Park)

Participation Pointers

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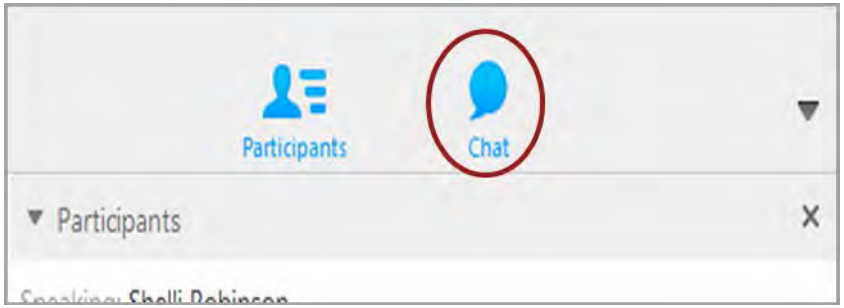
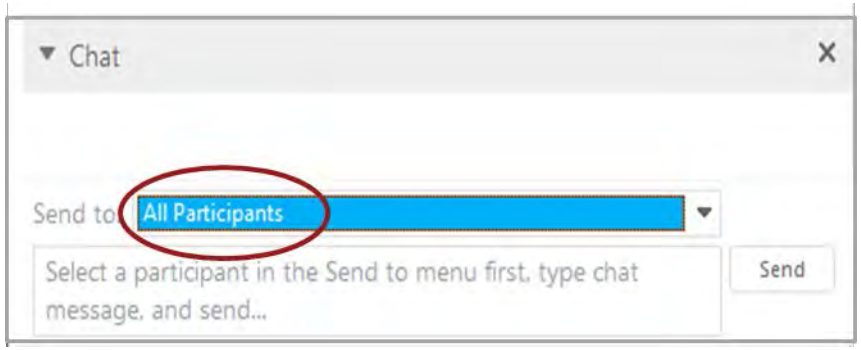
Active Learning Tips:

- Please open your Chat

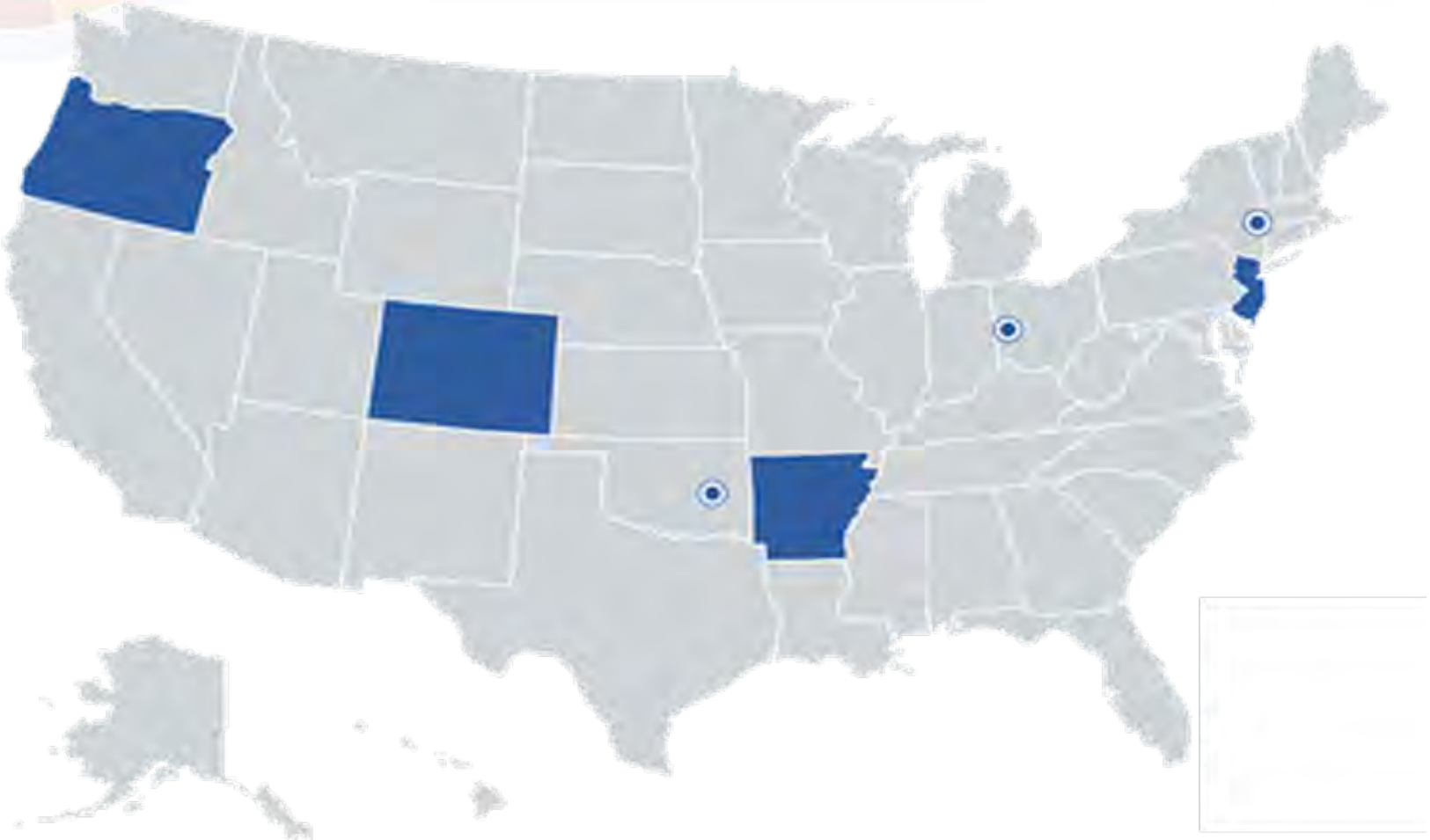


- Set the "Send to" to **All Participants**



- Raise your hand to share verbally

Click the arrow on the annotation toolbar, then point to your location.



Source: Centers for Medicare & Medicaid Services

What is your role in the practice?

- Physician
- Nurse
- IT Specialist
- PA-C or ANP
- Care Mgr/ Coord
- Practice Manager
- Quality Specialist
- Admin.
- Other

Today's Discussion

- Share case examples that are informing your work.
- Present specific changes and new ideal workflow examples.
- Brainstorm most appropriate measures and ways to document/track changes made.
- Plan for first test of change.

Learning from Cases

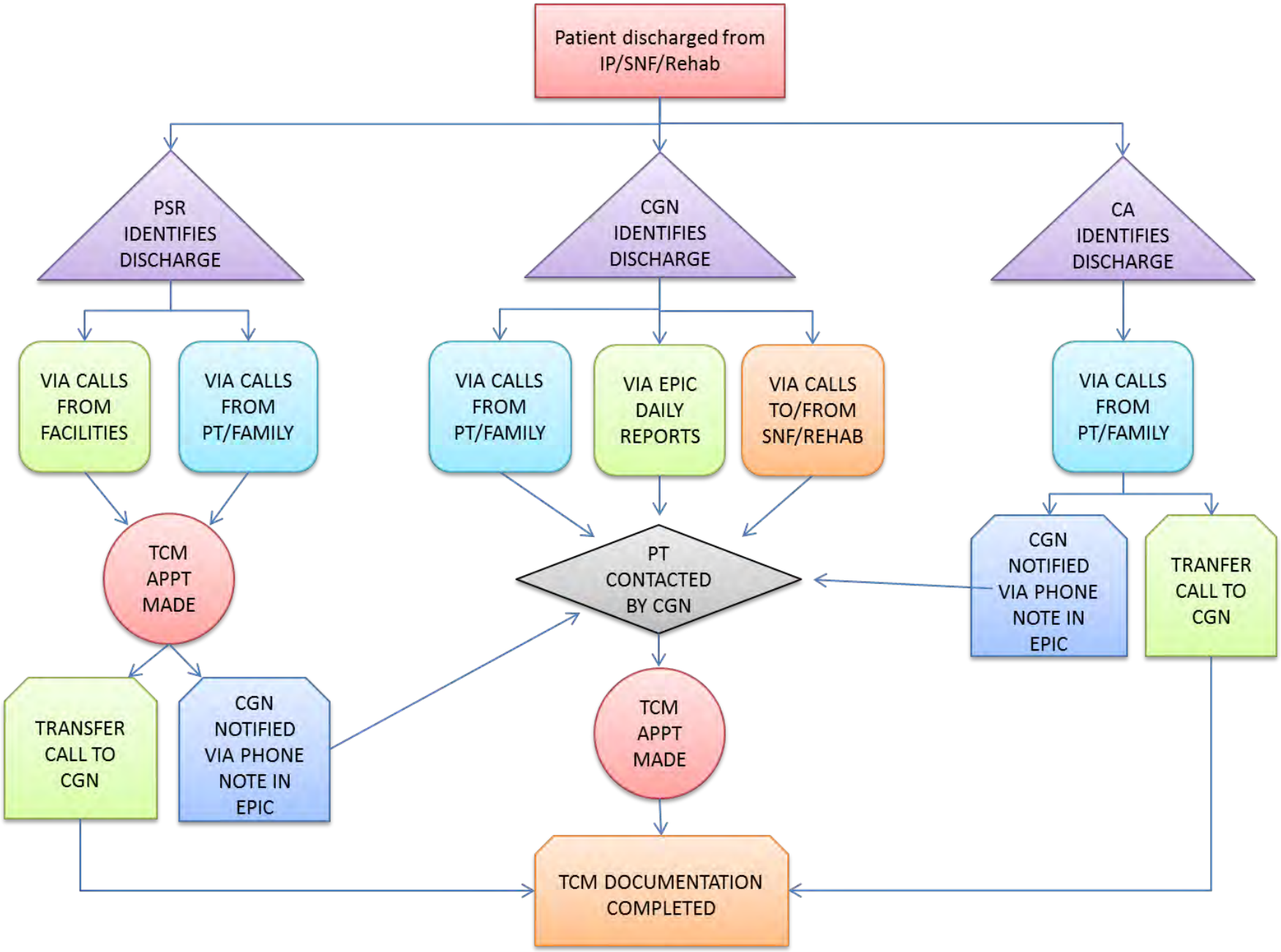
- Case examples of excellent TOC

- Case examples of challenging TOC

Worksheet: Warren Clinic Jenks

Task	Current State: How	Current State: Who	Improvement Opportunity?	Future State: How	Future State: Who
Notification of Discharge	Report run daily from our EHR, EPIC if in our facility, by patient self-report if at another facility, or by discharge coordinator at SNF or rehab	Care Guidance Nurse runs report. Patients may self-report or may be notified by discharge coordinator at SNF or rehab.	Improve in office communication of discharges. Improved communication with discharge coordinator at SNF or rehab. System to identify admissions other area hospitals.	Post workflow for benefit of float personnel. Standardize communication process between front office and CGN. Increase use of warm handoff from front office to CGN.	team
Protocol for call attempts:	2 attempts minimum. Contact via patient portal acceptable. All attempts are documented.	Care Guidance Nurse	Yes	Encourage enrollment in patient portal access to increase ability to contact patients.	team
Schedule F/U Visit:	CGN or front office may schedule. Appt is designated as TCM visit and discharge date noted. If scheduled by front office CGN is notified.	Care Guidance Nurse or front office staff	Yes	Post workflow for benefit of float personnel. Standardize communication process between front office and CGN. Increase use of warm handoff from front office to CGN.	team

Workflow: Warren Clinic Jenks



Checklist: Warren Clinic Jenks

Transitional Care Management Documentation Checklist

Patient Name _____ **Date of Discharge** _____

- ☐ **Phone call or personal visit within 2 business days**
- ☐ **Face-to-face office visit** date _____
- ☐ **Within 7 calendar days**, **99496** high complexity of medical decision making (**Post TCM01 on this date)**
- ☐ **Within 14 calendar days**, **99495** moderate complexity of medical decision making (**Post TCM01 on this date)**
- ☐ Review of discharge summary documented
- ☐ Reconciliation of medications documented
- ☐ Review need for or follow-up on pending diagnostic tests and treatments
- ☐ Referrals made to providers of care and community resources documented
- ☐ Patient and/or family education to support self-management, independent living and activities of daily living documented
- ☐ Transitional Care Management Code **99495 or 99496** billed 30th day after discharge

Date to bill _____

Diving Deeper:
Areas of opportunity

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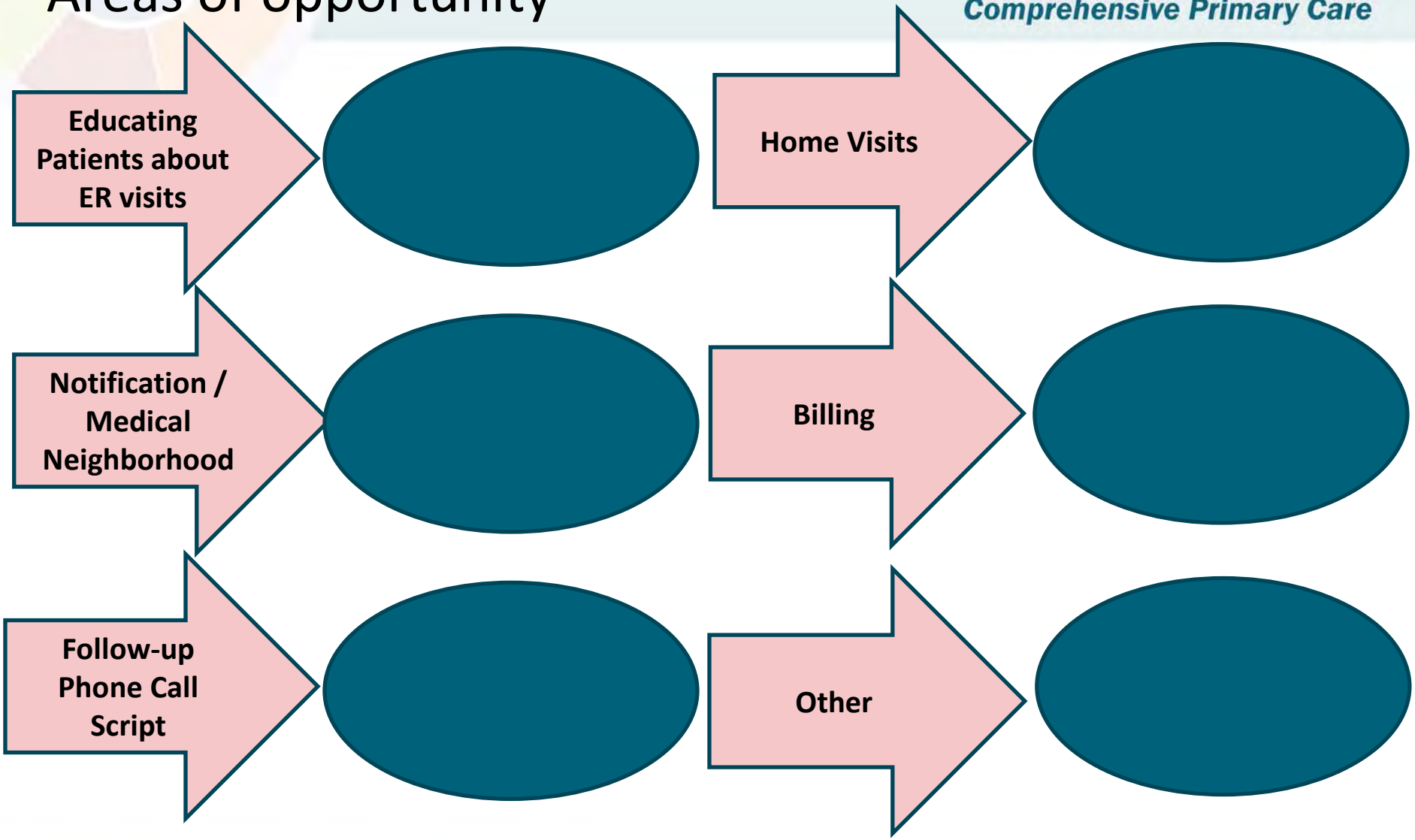

Data: Summit Medical Clinic

Real-Time Data and Evaluating Progress

- Focused on reducing repeated ER visits
- Discussed during daily huddle
- Tracked on an Excel sheet
  - # of patients calling office before going to ER
  - #of patients calling office to inform of going to ER
  - High ER utilizers having increased knowledge of reasons they should go to the ER versus clinic

Questions/Practice Sharing…

Use the Chat feature or raise your hand to ask questions or share your ideas regarding timely follow-up during TOC.

Status Check

- Have you created a “first-test state” workflow?
- Reviewed specific cases?
- Identified measures to track?

Workflow: Randy Walker

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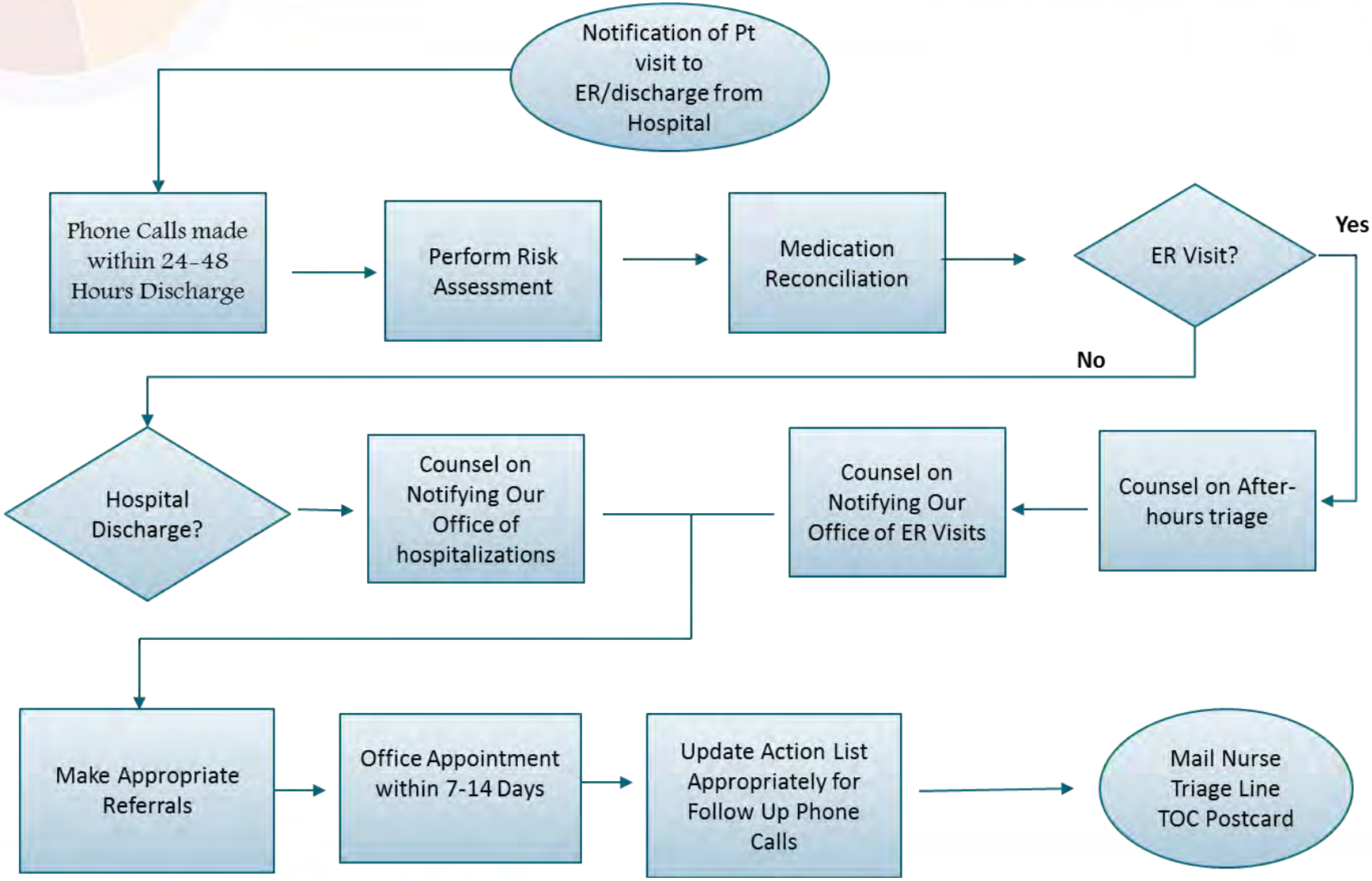
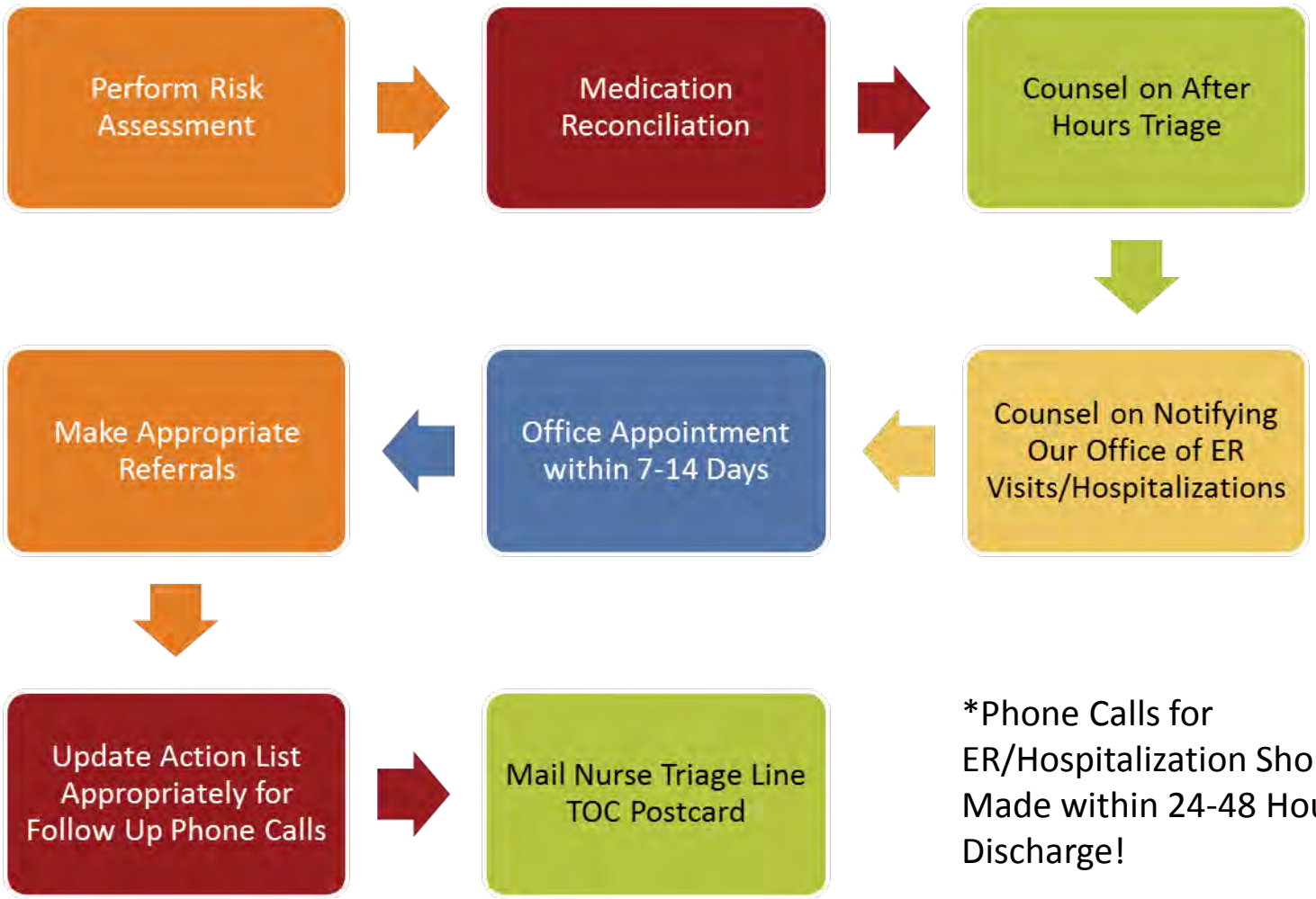


Simple Workflow: Randy Walker



*Phone Calls for ER/Hospitalization Should be Made within 24-48 Hours Discharge!

Before the next session…

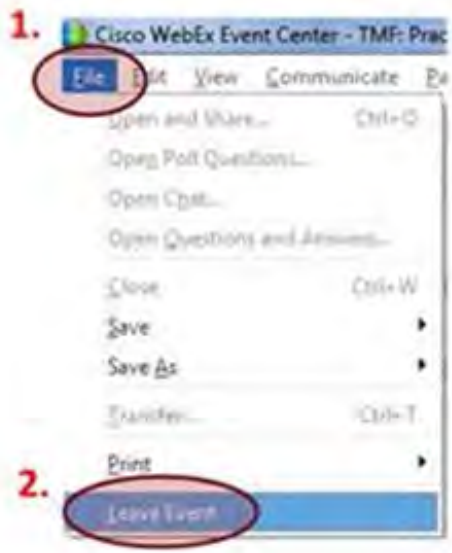
- Review specific strategies and tools that have been shared.
- Plan and initiate your first small test of change.
- Select process measures relevant to the change you will make.
- Share with your peers on CPC Connect.
  - Upload any tools or documents that may be useful to other practices.
  - Post your new ideal state sketch.
  - Post ideas for process measures to track your changes/progress
  - Post your first small test of change results when available.

Next Session

- *Live Session 3 on Oct. 7, 11 a.m. ET*

All attendees, including faculty, MUST complete a survey.

You may add multiple participants on one form if you participated as a group.



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