# 5 WAYS TO IMPROVE TRANSITIONAL CARE MANAGEMENT WITH PATIENT NOTIFICATIONS

Once patients are discharged from a hospital or emergency department (ED), the chances they will follow up with their primary care physician on their own decreases. Without timely follow-up, the risk of readmissions or complications increase. This is one of the challenges of a disjointed healthcare system.

The Centers for Medicare and Medicaid Services (CMS) is working to reduce transitional gaps in care by relaxing coding restrictions that formerly disincentivized many physicians from participating in a Transitional Care Management (TCM) program. This is good news since research shows that TCM services can help reduce both mortality and Medicare costs. Now, physicians can bill for TCM along with Chronic Care Management (CCM).

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To receive reimbursement, patients must have an in-person visit or phone/electronic follow up with their primary care physician within seven to 14 days after discharge. To ensure this happens, physicians need to know when one of their patients has been discharged from a hospital or ED. They also need convenient access to complete clinical data about the episode. Receiving notifications about your patient episodes is a perfect example of a tool that can help your practice achieve the goals of a TCM program.

The following graphic outlines 5 ways physician practices can improve their TCM program by implementing a patient notifications solution in their care workflow.

## 5 Ways to Improve Transitional Care Management

- Customize notifications based on the practice and physician preferences and workflow
- Configure real-time notifications for your most urgent cases
- Match data to your specific patient list
- Integrate notifications with your EHR systems
- Include data from out-of-network providers

***"It's crucial for us to know what's going on with our patients. Sometimes it can be hard to find out if a patient went to the hospital, even after the fact. Notifications from CORHIO give us an early heads up on the hospitalizations so we can more quickly follow up with the patient and see how we can help them."***

- Jane Hill, Sr. Business Systems Analyst, InnovAge

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### Customize notifications based on the practice and physician preferences and workflow.

We've all heard about "alarm fatigue" and it's a challenge that can lead to increased stress and burnout. Therefore, it is important that physicians integrate notifications into the care workflow. Having the option of receiving regular batch notifications can be especially helpful in reporting requirements for TCM, value-based care programs and other quality initiatives.

### Configure real-time notifications for urgent cases.

This is especially important for patients with high-risk, acute or chronic conditions such as cardiovascular disease and diabetes. Real-time notifications act as an immediate alert that an episode has occurred. This allows for proactive outreach to the patient to ensure follow-up and post-discharge care plan and medication adherence.

### Match data to your specific patient list.

Receive patient data that is matched to the practice's specific patient file. This enables the data to be quickly acted on and fits into the practice's established processes. Practices that are tracking a portion of their patients who are high risk and part of an ACO management program can be tracked more precisely and efficiently.

### Integrate with your systems.

Collecting patient information from multiple sources typically means faxing, emailing or calling multiple entities, all of which require significant time and effort. Once the information is received, it is all too often incomplete or outdated. Having the information available within the practice's system provides physicians and staff with immediate access to everything they need wherever, whenever, and however they need it.

### Include out-of-network providers.

Some notification solutions are available within a physician's own network, but patients don't always have an in-network provider available when they need immediate care. It's important to choose a solution that pulls data from multiple networks so that physicians can get a full picture of their patients care and are notified no matter where their patient receives care.

## IMPROVING THE CONTINUUM OF CARE

Primary care physicians across Colorado have joined the CORHIO network, giving them immediate access to the most complete, up-to-date patient information right at the point of care. This timely information can be used to improve care management and coordination for patients, prevent hospital readmissions, improve disease management and inform quality improvement. The CORHIO Notifications service also provides clinical data to help physicians pinpoint areas for improving outcomes and containing costs.

To get started, the practices provides CORHIO with a list of patients and CORHIO returns the most current data available from their extensive network of providers.

**To learn more about CORHIO Notifications, visit www.CORHIO.org/Notifications.**

[1]https://www.medicaleconomics.com/view/chronic-care-codes-offer-greater-flexibility-and-payment-2020
[2]https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2687989
[3]https://www.medicaleconomics.com/view/chronic-care-codes-offer-greater-flexibility-and-payment-2020
[4]https://www.beckershospitalreview.com/hospital-management-administration/a-burnout-epidemic-25-notes-on-physician-burnout-in-the-us.html


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