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Defining Transitional Care

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Everyone in healthcare, it seems, has the heard the term. Some may even practice it in some form or another. But truly, what is it? Is this just another shot in the dark by our government funded healthcare to rein in healthcare spending? Who truly benefits? The patient, the provider, the payer? Is the sole purpose of Transitional Care to prevent readmissions, or is there another, more long term reason transitional care is creating buzz right now?

Transitional Care, at its core is not a new concept. In fact various evidence-based models of Transitional Care have been developed and studied since the mid 1990's, with overall positive short and long-term outcomes. However, it wasn't until just recently, with the unveiling of the Affordable Care Act, that the concept of Transitional Care has been given its due attention.

The Center for Medicare and Medicaid services defines Transitional care as the following "…services provided to a patient whose medical and/ or psychosocial problems require moderate or high-complexity medical decision making during transitions in care from an inpatient setting, partial hospital, observation status in a hospital, or skilled nursing facility/ nursing facility, to the patient's community setting." If you take a deeper look at the definition, the focus should be on one key phrase; "…a patient whose medical and/ or psychosocial problems require moderate or high-complexity medical decision making." The phrase moderate or high complexity medical decision-making is what differentiates Transitional Care from any other post acute in home service.

So what is the goal of transitional care? Well one of the obvious goals is what was stated previously- to prevent readmissions. Hospital Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions, is a catalyst for many hospitals, ACO's and large physician groups with stake in the game, to implement a transitional care program. Whether it be tele-medicine based or creating a brick and mortar "transitional care clinic" and regardless of whether the TC program is executed exactly as CMS envisioned, there is obvious benefit going from zero TC activity to even the most miniscule intervention. Any progress is good progress in the world of Transitional Care. Those that have a Transitional Care program are starting to see lowering of readmission rates, which of course will positively impact the payer. But what about beyond that? What about the benefit to the patient and provider?

No one will disagree that the Transitional Care codes put forth by CMS are complex. More often than not, many providers cannot afford to expend the resources required to provide TC services according to the codes. But let's put that aside for a moment. The intent of the codes is

a good one. The codes require that a face to face visit be conducted by a Nurse practioner or licensed physician. They require this face-to-face visit be within a designated time frame based on the complexity of the patient. Requirements also include timely follow up, interactive contact and medication reconciliation/ management. It doesn't take a lot to derive what the benefit is to the patient; a licensed practioner that can provide clinical oversight, medical management, and continuity of care, without a gap in care, while the patient is at home. This translates into overall better patient outcomes, a greatly improved patient care experience, and overall reduction in healthcare costs. This means less time needed on the part of their physician to track the patient and ensure proper post discharge care.

So when looking at the triangular benefit to the patient, provider, and payer, transitional care, in the way CMS has defined it, makes a lot of sense. So why doesn't everyone do it? This goes back to the earlier statement regarding the complexity of the code and the amount of resources required to provide this level of care. The average reimbursement for Transitional Care is $230. This amount is a global reimbursement for all services rendered in the 30-day period of transitional care- Day 1 being first day post discharge. When you think about the actual cost to the provider for one patient, plus the code limitations associated with transitional care, it is simply not cost effective for the individual provider to provide TC as CMS defines it.

If you do a search on transitional care, you will get over 2.5 million hits. You will find information on the models of TC. You will also find a plethora of software companies looking to provide technological solutions for transitional care management. However, until recently you would not have found a 3rd party group provider that was Medicare approved to provide transitional care services to Medicare beneficiaries. Global Transitional Care is the only 3rd party Transitional Care provider in the country. Based on the Naylor Model of Transitional Care, which was developed at the University of Pennsylvania, GTC is the first organization to be able to exclusively provide transitional care services. It took 4 years of R&D work, working collaboratively with UPENN, and another year and half in infrastructure and protocol development to be able to commercially provide TC services. In the end, GTC has created an innovative way to provide Transitional Care at no charge to the physician or hospital/ inpatient facility. Patients pay a 20% co-pay on TC services in accordance with their Medicare plan.

The story of transitional care is just the beginning. The true impact of TC services remains to be seen. The possibilities are truly endless and it promises to bring about a new era of healthcare delivery that can only improve what we are seeing now by bridging the existing gap in post discharge care.

Rani Kheterpal is the Chief Executive Officer of Global Transitional Care (GTC). GTC is the first Medicare approved, third-party organization dedicated to providing complete, short-term transitional care services. Visit the web site at www.globaltransitionalcare.com.

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