

Cardiac Rehabilitation Referral Strategy

Bridging the Rehabilitation Care Continuum: Spotlight on NYU Langone Health

Subject	Content
Definition/Description	<p>During the past 5 years, NYU Langone Health has established a system-wide integration of a care continuum infrastructure to increase the transitions of cardiovascular patients to the next level of care. The bridging of these services has established a care transitions program to coordinate post hospital discharge patients referral and enrollment to cardiac rehabilitation services.</p>
Key Terms/ Abbreviations	<ul style="list-style-type: none"> • CHHA = certified home health agency • CM = care management • CMS = Centers for Medicare & Medicaid Services • CPT = current procedural terminology • CR = cardiac rehabilitation • CR referral = includes documentation that (1) an order for CR was placed, (2) a discussion took place with the patient of the benefits of CR and the process of enrolling in CR, and (3) patient referral information was communicated to the receiving CR program • EMR = electronic medical record • IRF = inpatient acute rehabilitation facility • PAC PPN = post-acute care preferred provider networks are vetted and contracted agencies and facilities which include CHHAs, IRFs, and SNFs that have an agreement to engage in activities designed to achieve high quality patient care, clinical integration, and selected quality standards. • SNF = skilled subacute nursing facility • TCM = Transitional Care Management services
Background and Purpose	<ul style="list-style-type: none"> • As accountability and affordability drive provider and hospital reimbursement shifts to value, rather than volume, and alternate payment models are negotiated between hospital systems and insurance payer systems, the time is right for CR programs to work more closely with their Departments of CM and Hospital Strategy Development. • The CM Department in your hospital system may be an important bridge to discharge planning and transitions of patients post hospitalization to CR services. CM clinical care coordinators make telephonic outreach to various populations to assist patients transitioning their care from the hospital to

	<p>community. CM coordinators assist in optimizing transitions for care continuum from hospital to inpatient acute or subacute rehabilitation, to homecare services, to outpatient rehabilitation, to primary care, to medical homes, to specialists and to community wellness services.</p> <ul style="list-style-type: none"> • The creation of a PAC PPN such as a hospital PAC agreement with preferred CHHAs, IRFs, and SNFs is to ensure patients transition from the hospital to community receive high quality services have decrease readmissions, and can play a vital role to assure that appropriate patients are referred for cardiac rehabilitation services within this PAC PPN. Relational strategies between a hospital system and PAC PPN are to increase patient experience, improve quality, and reduce readmissions.
<p>Relevant Metric(s)</p>	<ul style="list-style-type: none"> • Metrics include monitoring patient experience and satisfaction of care transitions, readmissions and evaluate the need for post-acute services. • Establish an EMR registry of CR-eligible discharged cardiovascular patients with disposition/destination (home self-care, home with home care services, acute rehabilitation facility and skilled nursing facility) to monitor the transitions of these patients. • Enrollment of referred patients into CR requires that the CR program knows which patients have been referred by a facility and/or provider. The CR program must develop a system to track rate of enrollment from those referred.
<p>Process Description/ Processes Impacted</p>	<p>Partnering with PAC PPN and Department of CM to enhance the CR Care Continuum, to increase the CR referral, enrollment, and adherence:</p> <p>1. PAC PPN Collaboration Identification of your hospital system’s PAC PPN agencies/facilities who are involved in admissions and discharge planning process to establish a system of CR referral upon discharge from these PPN.</p> <ul style="list-style-type: none"> i) Educating the clinicians in the PAC PPN about the value of referring patients to CR in preventing readmissions, and increasing quality of life and impacting comorbidities. ii) Implement provider-provider and clinician-clinician handoffs from hospital to PP agencies and facilities to clarify CR plan of care, improve transitions and communication, and reduce avoidable readmissions iii) Educating PAC PPN staff to schedule an appointment before discharge from the IRF or SNF with the CR Physiatrist or Cardiologist. Establishing an automatic referral systems and reinforcement strategies to encourage patients to enroll and participate. v) Leverage utilization of hospital-based physicians

providing care in SNFs (Cardiologist, Psychiatrists, etc.) to increase within-system referrals and enhance provider communication and follow-up of CR plan of care

2. CMS TCM Services

Since 2016 Medicare has been paying enhanced fees for physicians under the Medicare Physician Fee Schedule under CPT codes 99496 and 99497 for face-to-face care coordination services within 7 or 14 days respectively furnished to Medicare beneficiaries meeting criteria once discharged to the community from an acute care setting to oversee management and coordination of services, as needed, for all medical conditions, psychosocial needs and activity of daily living support for 30 days post discharge to keep patients healthier and reduce preventable hospitalizations

i) The requirements for TCM services include: TCM SERVICES SETTINGS TCM services are furnished following the beneficiary's discharge from one of these inpatient hospital settings:

- Inpatient Acute Care Hospital
- Inpatient Psychiatric Hospital
- Long Term Care Hospital
- Skilled Nursing Facility
- Rehabilitation Facility
- Hospital outpatient observation or partial hospitalization

Following the discharge from one of the above settings, the beneficiary must be returned to his or her community setting, such as:

- His or her home
- His or her domiciliary
- A rest home
- Assisted living

ii) TCM components include:

- Contact must be made within 2 business days following discharge via telephone, email, or face-to-face
- The 30-day TCM period begins on the date the beneficiary is discharged from the inpatient hospital setting and continues for the next 29 days.
- There are medical and/or psychosocial problems that require moderate- or high-complexity medical decision making
- Review discharge information and need for or follow-up on diagnostic tests and treatments
- Coordinate care with other health care professionals
 - Education to the beneficiary, family, guardian
 - Caregiver arrange community resources scheduling follow-up with community providers (importance of including PCP) and services

	<p>iii) One face-to-face visit with provider either 7 or 14 days after hospital discharge:</p> <ol style="list-style-type: none"> 1. CPT Code 99496 – Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge) 2. CPT Code 99495 – Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge) <p>NYU Langone Health established a post-acute rehabilitation TCM program in 2018. Patients discharged from their acute inpatient rehabilitation service are called within 48 hours of discharge and followed with a Rehabilitation Physician with 7 or 14 days for care coordination and to follow up with rehabilitation services (e.g. cardiac rehabilitation). Medical provider follow-up appointments are encouraged and scheduled for patients to primary care providers, specialists and psychiatrists for rehabilitation</p>
<p>Key People/ Departments to Engage</p>	<ul style="list-style-type: none"> • Hospital Strategic Development Administration • Care Management Administration • Rehabilitation Service Line • Cardiovascular Service Line • CR Program’s Medical Director • Find a project champion within your referring providers • Certified Home Health Agency Administrations • Inpatient Rehabilitation Facilities Administrations • Skilled Nursing Facilities Administration • Medical Center Clinical Information Technology
<p>Data Sources</p>	<p>Medical Center Information Technology including EMR</p>
<p>Cost Concerns</p>	<p>This is not costly to the CR program, beyond the time it takes to negotiate with CM for clinical care coordinators who may be already calling these cardiovascular patients to focus on the rehabilitation care continuum to reduce readmissions. Additionally, no cost to understand the PAC PPN System and referring provider’s systems to strategize how to capture eligible patients appropriate for CR services.</p> <p>Once this transitional care CM/CR rehabilitation program is implemented a video can be made to explain to patients this CR continuum. The video may cost a few hundred dollars.</p>
<p>Timeline</p>	<p>This will most likely be a 6 month- to 1-year project, with the first 6 months negotiating with the CM administration to allocate</p>

	<p>resources for telephonic outreach to potential CR patients and preventing readmissions. Strategy should be focus on the first 6 months understanding the issues, adapting systems to establish an EMR registry to track these patients' disposition and destination. Negotiate with cardiology and rehabilitation service lines to have CM staff telephonically track patients for rehabilitation care continuum and collect accurate CR referral data. During the second 6 months, the CM intervention should be implemented and readmissions, emergency department utilization, medication adherence, and physician follow-up appointments with additional CR referral and program data tracked.</p>
<p>Supporting Material</p>	<p>https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf</p>
<p>References</p>	<ol style="list-style-type: none"> 1. Arena R, Williams M, Forman D, Cahalin LP, Coke L, Myers J. Increasing referral and participation rates to outpatient cardiac rehabilitation: The valuable role of healthcare professionals in the inpatient and home health settings. <i>Circulation</i>. 2012;125:1321-1329. 2. Balady GJ, Ades PA, Bittner VA, Franklin BA, Gordon NF, Thomas RJ, Tomaselli GF, Yancy CW. Referral, enrollment, and delivery of cardiac rehabilitation/secondary prevention programs at clinical centers and beyond: a presidential advisory from the American Heart Association. <i>Circulation</i>. 2011;124(25):2951-60 3. King M. Affordability, Accountability, and Accessibility in Health Care Reform: Implications for Cardiovascular and Pulmonary Rehabilitation. <i>J Cardiopulm Rehab Prev</i>. 2013;33:144-152. 4. Pack QR, Mansour M, Barboza JS, Hibner BA, Mahan MG, Ehrman JK, Vanzant MA, Schairer JR, Keteyian SJ. An early appointment to outpatient cardiac rehabilitation at hospital discharge improves attendance at orientation: a randomized, single-blind, controlled trial. <i>Circulation</i>. 2013;127:349-55 5. Riley DL, Krepostman S, Stewart DE, Suskin N, Arthur HM, Grace SL. A mixed method study of continuity of care from cardiac rehabilitation to primary care physicians. <i>Can J Cardiol</i>. 2009;25(6):187-192.

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