Transitional Care Management (TCM)

The Challenge

When patients transition from one care setting to another, it is especially critical. Appropriate care and support after discharge, communication with all involved, medication reconciliation and management, coordination of care, and patient and family engagement are just some of the challenges that can result in unnecessary hospital visits.

The Idea

Transitional Care Management (TCM) is a set of services and processes designed to ensure a smooth and coordinated transition and proper care for patients moving from one healthcare setting to another, including from a hospital to a home. One of its primary goals is to lower rates of hospital readmissions. TCM is important for patients with complex medical or psychosocial needs. Within two business days of discharge, a patient or their caregiver is contacted followed by a face-to-face visit within seven to 14 days. During the 30 days after hospitalization, TCM services include care coordination, medication management, scheduling follow-up appointments and addressing any complications or concerns. Proper documentation and billing ensure appropriate reimbursement for the providers involved.

Impact

In addition to increased reimbursement and cost-savings, providers implementing TCM see their patients visiting the hospital less frequently, with more engagement, better medication management and overall improved satisfaction.

Studies have shown that TCM reduces post-discharge readmissions and mortality. Additionally, the extra support allows patients to experience better health outcomes, faster recoveries and improved chronic condition management. Because of closer monitoring and streamlined communication, patient satisfaction improves, medication errors are reduced and potential problems are identified earlier.

Steps for Implementation

1. Obtain leadership support.
2. Identify a champion.
3. Develop a plan and form your care/delivery team.
4. Identify processes for identifying and engaging patients.
5. Enroll your patients.

6. Deliver TCM and engage patients.
7. Code, bill and receive reimbursement.
8. Continually evaluate successes.

Tips for Success

- Start with one staff member and one patient to test your processes.
- Begin engagement with the patient and family as early as possible during the hospital stay to help plan a smoother transition.
- Use clear communication with the patient, family and all providers.
- Know when to involve an interpreter and use plain language.
- Use various learning tools to accompany your conversation (pictures, large print, videos) (ensure that materials are no higher than a fifth-grade level)
- Use the teach-back method to confirm understanding.
- Meet regularly as a team to review patient engagement processes, billing and reimbursement to determine improvement opportunities.

Resources

MLN908628 – Transitional Care Management Services (cms.gov)

References:

1. Transitional Care Management: Practical Processes for Your Practice | AAFPAbout Chronic Diseases | CDC
2. Transitional Care Management Quality Improvement Methods That Reduced Readmissions in a Rural, Primary Care System | American Board of Family Medicine (jabfm.org)
3. How Medicare's Chronic Care Management Works (verywellhealth.com)

Put new ideas to work in your community:

TCM is one of several care transition interventions highlighted in HQI's Ideas That Work series. To explore other strategies for strengthening care coordination activities in your community, check out our YouTube Playlist and the HQIN Resource Center.

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