TYPE 2 DIABETES FACT SHEET: CARE COORDINATION

While improvements have been made in the number of patients achieving A1C goals, only 50% of patients achieved a goal of <7% in 2007-2010.[1] Effective coordination of care may impact the delivery of optimal care for patients with type 2 diabetes (T2D). The American Diabetes Association (ADA) has recommended strategies to help ensure continuity of care for patients with T2D.[2]

ADA RECOMMENDED STRATEGIES[2]

- Align care with components of the Chronic Care Model to ensure productive healthcare professional–patient interactions.
- Care systems should support team-based care, community involvement, patient registries, and decision support tools.
- Treatment decisions should be timely and follow evidence-based guidelines that are tailored to individual patient needs.
- A patient-centered communication style that addresses patient preferences, literacy and numeracy, and cultural barriers, should be employed.

Successful transition from inpatient to outpatient care is critical for the management of T2D[3]

- Understand the patient's daily life, including the living situation postdischarge
- Identify comorbidities before and at time of hospitalization
- Set goals for therapy and select antihyperglycemia regimen
- Provide nutritional counseling and recommendations for physical activity

People with diabetes are at high risk of complications at the time of discharge[2]

- Discharge planning should begin upon admission[2,4]

The Agency for Healthcare Research and Quality recommends the following for discharge plans[5]:

- **Medication reconciliation**
  - Ensure the safety of any new prescription and that no chronic medication was stopped.
- **Structure discharge communication**
  - Communicate medication changes, tests, and follow-up needs to outpatient physicians.
  - Transmit discharge summaries to primary physician.
  - Schedule outpatient follow-up prior to discharge to help ensure patients keep appointments.

Ongoing patient engagement is vital to effective care coordination

Throughout the continuum of diabetes care, opportunities exist to provide effective care coordination and maintain patient engagement. Since hospitalization can be common in patients with diabetes, the efficient

transfer of care from the inpatient to outpatient setting may help to maintain appropriate diabetes care.

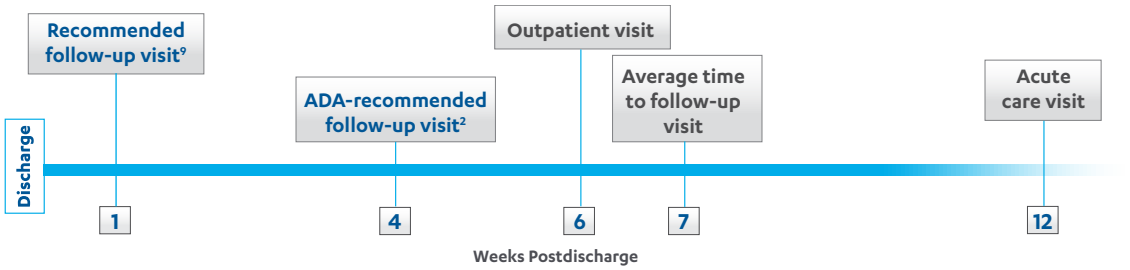
The continuum of diabetes care

- Effective inpatient care can improve hospital outcomes in diabetes[6-8]
- Improved outcomes can reduce health service utilization and hospitalizations[7]
- Integrated outpatient care works with a goal of achieving good glycemic control[7]
- Patients who are lost to follow-up have more severe hyperglycemia and are at greater risk of complications[8]

Postdischarge follow-up presents opportunities to improve care coordination

- Healthcare reform provisions promote patient follow-up visits to an appropriate physician within the first week following hospital discharge[9]
- The ADA recommends a follow-up visit with a primary care provider, an endocrinologist, or a diabetes educator within one month of discharge[2]

The length of time between discharge and recommended follow-up visit vs actual follow-up visit for patients with diabetes discharged from a municipal hospital*[9]



*A retrospective analysis conducted in 2001 of records for 658 patients from one municipal hospital to examine the pattern of immediate postdischarge visits and patient characteristics.

Opportunities in care coordination can improve diabetes care and reduce costs.[2,10,11] *Effective transitions of care and ongoing patient engagement can reduce risk at hospital discharge and improve patient self-management.*[2,12]

References: 1. Casagrande SS, Fradkin JE, Saydah SH, et al. The prevalence of meeting A1C, blood pressure, and LDL goals among people with diabetes, 1988-2010. *Diabetes Care*. 2013;36(8):2271-2279. **2.** American Diabetes Association. Standards of medical care in diabetes—2017. *Diabetes Care*. 2017;40(suppl 1):S1-S135. **3.** Peterson G. Transitioning from inpatient to outpatient therapy in patients with in-hospital hyperglycemia. *Hosp Pract*. 2011;39(4):87-95. **4.** Moghissi ES, Korytkowski MT, DiNardo M, et al. American Association of Clinical Endocrinologists and American Diabetes Association consensus statement on inpatient glycemic control. *Diabetes Care*. 2009;32(6):1119-1131. **5.** Agency for Healthcare Research and Quality. Adverse events after hospital discharge. http://psnet.ahrq.gov/primer.aspx?primerID=11. Accessed January 10, 2017. **6.** Van den Berghe G, Wouters P, et al. Intensive insulin therapy in critically ill patients. *N Engl J Med*. 2001;345(19):1359-1367. **7.** Wagner EH, Sandhu N, Newton KM, et al. Effect of improved glycemic control on health care costs and utilization. *JAMA*. 2001;285(2):182-189. **8.** Graber AL, Davidson P, Brown AW, et al. Dropout and relapse during diabetes care. *Diabetes Care*. 1992;15(11):1477-1483. **9.** California Healthcare Foundation. Issue brief. The post-hospital follow-up visit: A physician checklist to reduce readmissions. October 2010. **10.** National Committee for Quality Assurance. Standards for Patient-Centered Medical Home (PCMH) 2011. February 1, 2011:1-28. **11.** Muhlestein D, Croshaw A, Merrill T, Peña C. Growth and dispersion of accountable care organizations: June 2012 update. Center for Accountable Care Intelligence. June 2012. **12.** Shah M, Norwood CA, Farias S, Ibrahim S, Chong PH, Fogelfeld L. Diabetes transitional care from inpatient to outpatient setting: pharmacist discharge counseling. *J Pharm Pract*. 2012;26(2):120-124.

CASE MANAGER'S CODING GUIDE FOR CARE COORDINATION SERVICES

Care coordination is a key part of the National Quality Strategy to improve the effectiveness, safety, and efficiency of the healthcare system.[1] To that end, the Centers for Medicare & Medicaid Services (CMS) supports both transitional care and complex care coordination with specific CPT® codes.[2]

The Transitional Care Management (TCM) services codes

Healthcare professionals (HCPs) who provide moderate- or high-complexity medical decision-making to patients transitioning to the community from an inpatient setting can be reimbursed under **CPT codes 99495** and **99496**. An HCP who accepts care of the patient postdischarge without a gap and takes responsibility for care may use these codes for billing.[3]

Who is eligible for TCM services?

Patients who require TCM services during their transition to the community setting and who have medical and/or psychosocial problems that require moderate- or high-complexity medical decision-making.

What is the time frame for providing services?

Starting on the date the patient is discharged from a hospital, services may be provided for up to 30 days.

Which code should be used?

CPT code 99495

TCM services with *moderate* medical decision complexity. A face-to-face visit must take place *within 14 days of discharge*.

CPT code 99496

TCM services with *high* medical decision complexity. A face-to-face visit must take place *within 7 days of discharge*.

What services must be provided?

The following 3 components *must* be provided within the 30 days after discharge:

- An interactive contact by telephone, e-mail, or face-to-face within 2 business days*
- A face-to-face visit
- Certain non–face-to-face services

Who can provide services?

Physicians and nonphysician practitioners (NPPs) including:

- Certified nurse-midwives
- Clinical nurse specialists
- Nurse practitioners
- Physician assistants
- Licensed clinical staff under the direction of a physician or NPP may provide some face-to-face services, including communication, education, assessment of treatment adherence, identification of community resources, and assisting in accessing needed care and services

*Medicare requires that attempts to communicate continue after the first 2 attempts, until the patient and/or caregiver is reached directly.[3]

What documentation is required?

- At a minimum, the following information must be documented in the medical record:
  - discharge date
  - date of interactive contact
  - date of face-to-face visit
  - complexity of medical decision-making

Other information

- The face-to-face visit is part of the TCM service and is not billed separately
- Only 1 HCP may report TCM services
- Services may only be reported once per beneficiary during the 30-day period
- When you report CPT codes 99495 and 99496, you may not also report care plan oversight services (HCPCS codes G0181 and G0182) and End-Stage Renal Disease services (CPT codes 90951 to 90970)

The Chronic Care Management (CCM) Services Codes[2]

HCPs who treat patients with chronic conditions can be reimbursed for complex care coordination services

- Covered services include: developing and maintaining a comprehensive care plan, facilitating access to care and services, assessing and supporting patient compliance with treatment plan and medication adherence, patient/caregiver education, identifying resources, communicating with home health agencies, communicating aspects of care with patients and caregivers, and collecting health outcomes data and registry documentation. Regulatory requirements for billing CCM services are different from the rules for Evaluation and Management (E/M) and other services.

CPT CODES[2]

Code 99487 – Covers first hour of clinical staff time directed by a physician or other qualified HCP with no face-to-face time

Code 99489 – Covers each additional 30 minutes of complex chronic care coordination

Code 99490 – Covers at least 20 minutes of clinical staff time to support a beneficiary with ≥2 chronic conditions through non–face-to-face care management services

Codes 99487 or **99489** – Can be reported only once per month by the physician or HCP for the first 31 to 75 minutes of service

The above codes overlap existing evaluation and management (E/M) CPT codes. When using the above codes, do not use the codes for care plan oversight services (CPT codes 99339, 99340, 99374-99380), prolonged services without direct patient contact (99358, 99359), anticoagulant management (99358, 99364), medical team conferences (99366-99368), education and training (98960-98962, 99071, 99078), telephone services (98966-98968, 99441-99443), end-stage renal disease services (90951-90970), online medical evaluation services (98969, 99444), preparation of special reports (99080), analysis of data (99090, 99091), medication therapy management services (99605-99607), or transitional care management services (99495, 99496).[2]

References: 1. US Department of Health and Human Services. National Strategy for Quality Improvement in Health Care. 2015 Annual Report to Congress. http://www.ahrq.gov/workingforquality/reports/annual-reports/nqs2015annlrpt.pdf. Accessed October 10, 2017. **2.** Pershing Yoakley & Associates (PYA). Coding and documentation of transitional and chronic care management services. http://www.pyapc.com/coding-documentation-transitional-chronic-care-management-services/. Accessed October 11, 2017. **3.** Centers for Medicare & Medicaid Services. Medicare Learning Network. Transitional care management services. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf. Accessed October 10, 2017.

CARE COORDINATION RESOURCE LIST

Here is a selection of resources to help you implement or enhance care coordination efforts in your organization.

NTOCC
National Transitions of Care Coalition
www.ntocc.org

NTOCC is a not-for-profit organization that is dedicated to filling the gaps that occur when patients leave one care setting and move to another. NTOCC has developed tools and resources to help stakeholders—healthcare professionals, consumers, and policymakers—address the challenges of meeting the needs of patients transitioning between care settings. For more information, go to: **http://www.ntocc.org/Home.aspx**

The **Transitions of Care (TOC) Compendium** is an extensive collection of resources including white papers, articles, and website links, arranged by care strategy and by care setting. There is no charge to access the Compendium, which can be found at: **http://www.ntocc.org/Toolbox**

Other resources offered by NTOCC include:

- Transitions of Care Evaluation Software℠, a free web-based tool designed to facilitate data entry, analysis and report generation
- TOC Summits, one-day events that bring together healthcare professionals, patient and caregiver advocates, thought leaders, and partner representatives. Subscribers receive notifications of upcoming summits
- Virtual events, including webinars and software demonstrations
- Latest news

Individuals can join to receive updates on NTOCC activities and tools. Organizations can support the work of NTOCC by becoming Associate Members. There is no charge for membership.

Healthcare Information and Management Systems Society (HIMSS)
www.himss.org

HIMSS is a global, cause-based, not-for-profit organization that is working to optimize health engagements and care outcomes using information technology. HIMSS has produced a Continuity of Care (COC) Guide for Ambulatory Medical Practices and numerous COC resources, including several for people with type 2 diabetes.

The COC Guide can be found at:
http://www.himss.org/ResourceLibrary/ResourceDetail.aspx?ItemNumber=10535

Improving Chronic Illness Care (ICIC)
www.improvingchroniccare.org

This organization is dedicated to improving the health of chronically ill people by helping health systems, particularly those serving low-income populations, improve their care through the implementation of the Chronic Care Model. They offer information and resources, including a Care Coordination Toolkit and Model, as described below.

Reducing Care Fragmentation: A Toolkit for Coordinating Care

This is a set of resources designed for clinics, practices, and health systems that are focused on improving care coordination by transforming the way they manage patient referrals and transitions. The toolkit was created to ease the challenges of providing coordinated care.

Downloadable resources in the Toolkit include:

- Reducing Care Fragmentation: A Toolkit for Coordinating Care
- Executive Summary
- Presentation: Reducing Care Fragmentation: Presentation on Coordinating Care
- Presentation: Key Changes and Resources for Care Coordination (Reducing Care Fragmentation in Primary Care)

The **Toolkit** is located at:
http://www.improvingchroniccare.org/index.php?p=Care_Coordination&s=326

The **Care Coordination Model** is located at:
http://www.improvingchroniccare.org/index.php?p=Care_Coordination_Model&s=353

Agency for Healthcare Research and Quality (AHRQ)
www.ahrq.gov

AHRQ provides a definition and examples of care coordination, along with an explanation of why care coordination is important. You will also find here a selection of downloadable presentations from the AHRQ Annual Conferences, and a collection of resources called "How Can Care Coordination Be Put Into Action?" that includes papers, briefs, manuals, and citations. Some of the resources include:

- Care Coordination Measures Atlas
- Care Coordination Accountability Measures for Primary Care Practice
- The Roles of Patient-Centered Medical Homes and Accountable Care Organizations in Coordinating Patient Care

These resources are located at:
http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html

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AHRQ Health Care Innovations Exchange
www.innovations.ahrq.gov

This is an online information hub for resources and information designed to help solve problems, improve health care quality, and reduce disparities. The Exchange offers evidence-based innovations and quality tools. New innovations and tools are published biweekly. The site includes papers, electronic resources, tools, and practical information about how to implement innovations. A selection of diabetes-related innovations may be found at:
https://innovations.ahrq.gov/narrow-by-subjects/?term=1096

ASSESSING THE TREATMENT BARRIERS FOR PATIENTS WITH TYPE 2 DIABETES

A Care Coordination Tool for Use With Patients

A diagnosis of type 2 diabetes (T2D) can represent a significant challenge for individuals. Very often, a patient may have to reorient his or her life to incorporate a new reality that may involve multiple medications, needle sticks, food restrictions, increased exercise, and multiple visits to healthcare providers (HCPs).[1,2]

Diabetes is largely self-managed: people with diabetes provide close to 95% of their own care.[3] It is important for HCPs to identify any social, psychological, environmental, or cognitive barriers that might interfere with a patient's management of his or her disease or ability to follow the recommended treatment regimen. These could be individual—in the form of social, psychological, environmental, or cognitive barriers—or external barriers resulting from care or facility issues.[1,2,4] Research has shown that personal beliefs, particularly about treatment effectiveness, can act as barriers (or facilitators) to self-management.[5]

TREATMENT BARRIERS THAT PATIENTS WITH T2D FACE

- **Communication barriers**—including literacy problems or patients not understanding what is being said to them, HCPs not having a full understanding of all the patient's circumstances, or if there is a mismatch between the patient's goals and the HCP's goals.[1,6]
- **Personal barriers**—including individual attitudes; financial difficulties; lack of transportation; literacy issues; cultural considerations; self-consciousness or lack of confidence; and depression, which is often associated with nonadherence.[1,4,7]
- **Self-management barriers**—including forgetfulness, not believing their actions have an effect on the course of the disease, fear of pain, not understanding the importance of checking blood glucose levels or maintaining control, and not understanding what to do with the results.[2,7]
- **Care barriers**—including lack of a primary care physician and/or endocrinologist to treat diabetes, not having regular checkups or a monthly medication review, and frequent self-referral to additional specialists who prescribe treatment without the knowledge of the primary care provider.[8]

How to Use This Tool

You may use these questions to help get insight into any barriers or potential barriers to your patient's ability to manage his or her T2D. You may consider performing 2 separate assessments, using the information to adjust or refine your care plan based on the responses you receive.

Patient Barrier Assessment Tool

	Assessment 1	Assessment 2
1. Assess Communication Barriers		
Do you understand what your doctors or other healthcare providers are telling you?		
Are you able to understand the instructions on your medications?		
Do you feel comfortable asking your doctors questions about your disease or treatment?		
Do you feel that your doctors and other healthcare providers understand your concerns and listen to you?		
2. Assess Personal Barriers		
Do you feel that your efforts at managing your type 2 diabetes (for example, diet, exercise, and medication) are helping?		
Do you feel depressed, downhearted, or blue about your illness or anything else? **If yes:** Does depression interfere with testing your blood sugar or taking medicine?		
Does cost prevent you from testing your blood sugar or taking your medication?		
Do you have a meal plan?		
Does your family support your meal plan?		
Do you feel confident that you can stick to your meal plan most of the time? **If no:** Are you often around people who are eating or drinking things you are not supposed to have?		
Does cost ever prevent you from sticking to your meal plan?		
Do you exercise every day? **If no:** What is preventing you from exercising?		
Do you ever run into problems with remembering to exercise?		

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	Assessment 1	Assessment 2
2. Assess Personal Barriers (cont'd)		
Does your family support you in your efforts to get more exercise?		
Do you smoke? **If yes:** Have you tried to quit?		
Do you understand how to take your medication? Can you repeat the instructions?		
Do you ever forget to take your medication?		
Does your family support you in taking your medication?		
Do you ever run out of your medication?		
Do you check your blood sugar regularly?		
Do you ever feel frustrated about your type 2 diabetes?		
Who helps you the most in caring for your type 2 diabetes (eg, spouse, other family members, HCP, paid helper, no one)?		
3. Assess Self-Management Behaviors and Barriers		
Do you know why it is important to test your blood sugar?		
How serious a disease do you think type 2 diabetes is?		
How important is it to keep your blood sugar close to normal?		
How hard is it for you to keep your blood glucose close to normal?		
Do you think you know enough about type 2 diabetes to manage your health effectively?		
Do you understand how to calculate calories and choose the right foods?		
Have you ever received type 2 diabetes education (for example, attended a series of classes or met with a diabetes educator)?		

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	Assessment 1	Assessment 2
4. Assess Care Barriers		
Do you have a primary care physician? Do you have a diabetes specialist taking care of you?		
Do you schedule appointments with those doctors regularly, and do you keep those appointments?		
Have you seen specialists that your diabetes doctor or primary care doctor doesn't know about?		
Do you take medications that are prescribed by different doctors?		
Do you get prescriptions from more than one pharmacy, including local pharmacies, mail-order pharmacies, or any other place?		
Does your diabetes doctor or primary care doctor know about all the medications you take?		
Does your primary healthcare provider or someone on your care team review your medications with you every month?		
Do you have your eyes and feet checked regularly—at least once a year?		

There may also be **facility barriers**, which can include lack of clarity about which provider is responsible for diabetic control management and lack of care coordination that can result in tests being duplicated, problems being overlooked, and medications with high rates of adverse effects being prescribed. While these factors are not under the control of the patient, these barriers should also be identified and addressed.[6,9,10]

References: 1. Shahady EJ. Barriers to effective diabetes care: how to recognize and overcome. *Consultant 360*. April 24, 2011. http://www.consultant360.com/content/barriers-effective-diabetes-care-how-recognize-and-overcome. Accessed June 29, 2016. **2.** Pun SPY, Coates V, Benzie IFF. Barriers to the self-care of type 2 diabetes from both patients' and providers' perspectives: literature review. *J Nursing Healthcare Chron Illness*. 2009;1(1):4-19. **3.** Pearson ML, Mattke S, Shaw R, Ridgely MS, Wiseman SH. Patient self-management support programs: an evaluation. Final contract report (prepared by RAND Health under Contract No. 282-00-0005). Rockville, MD: Agency for Healthcare Research and Quality. November 2007. AHRQ publication No. 08-0011. **4.** Wen LK, Parchman ML, Shepherd MD. Family support and diet barriers among older Hispanic adults with type 2 diabetes. *Fam Med*. 2004;36(6):423-430. **5.** Glasgow RE, Hampson SE, Strycker LA, Ruggiero L. Personal-model beliefs and social-environmental barriers related to diabetes self-management. *Diab Care*. 1997;20(4):556-561. **6.** Skovlund SE, Peyrot M, on behalf of the DAWN International Advisory Panel. The Diabetes Attitudes, Wishes, and Needs (DAWN) program: a new approach to improving outcomes of diabetes care. *Diab Spectrum*. 2005;18(3):136-142. **7.** Daly JM, Hartz AJ, Xu Y, et al. An assessment of attitudes, behaviors, and outcomes of patients with type 2 diabetes. *J Am Board Fam Med*. 2009;22(3):280-290. **8.** O'Malley AS, Tynan A, Cohen GR, Kemper N, Davis MM. Coordination of care by primary care practices: strategies, lessons and implications. *Research Brief: Findings From HSC*. April 2009:12. http://www.hschange.com/CONTENT/1058/1058.pdf. Accessed June 29, 2016. **9.** Forum of ESRD Networks' Medical Advisory Council (MAC). Assurance of Diabetes Care Coordination Toolkit. 2009. http://www.fmqai.com/library/attachment-library/AssuranceofDiabetesCareCoordinationToolkit.pdf. Accessed June 29, 2016. **10.** Reducing care fragmentation: A toolkit for coordinating care. http://www.improvingchroniccare.org/downloads/reducing_care_fragmentation.pdf. Accessed June 29, 2016.

CarePath | Healthy Engagements

CarePath Healthy Engagements is a comprehensive program designed to help improve the lives of people living with type 2 diabetes and assist those that care for them. CarePathHealthyEngagements.com