Transitional Care Management

Presented by:
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February 4, 2026

Transitional Care Management (TCM)

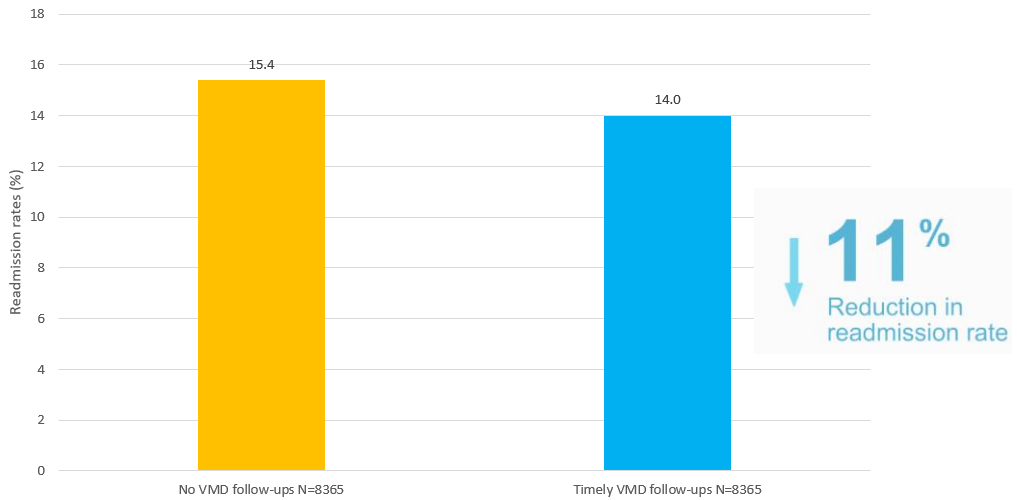
*Involves the **coordination** of healthcare needs during a patient's **movement between care settings**—most commonly from hospitalization back to the patient's home setting. This includes support **during the inpatient stay**, **active discharge planning**, and **post-discharge follow-up** to ensure continuity of care, minimize complications, and **reduce the risk of readmission**. TCM is particularly **critical** for patients with complex medical needs, multiple chronic conditions, or a high risk of rehospitalization.*

Transitional Care has proven to improve:

- **Reduce hospital readmissions**: by ensuring patients receive timely follow-up, medication support and disease education
- **Improved medication safety and adherence:** preventing adverse drug events through accurate medication reconciliation and patient education. This is especially important for older adults with polypharmacy where medication errors are common
- **Better chronic disease management:** ensuring prompt follow-up and continuity of care, TCM supports better control of chronic diseases, reducing exacerbations and complications. This also leads to higher treatment adherence and improved health outcomes long-term
- **Higher patient satisfaction:** Patients report greater confidence in their care and feel more supported during vulnerable periods, contributing to better overall satisfaction and trust in the healthcare system.

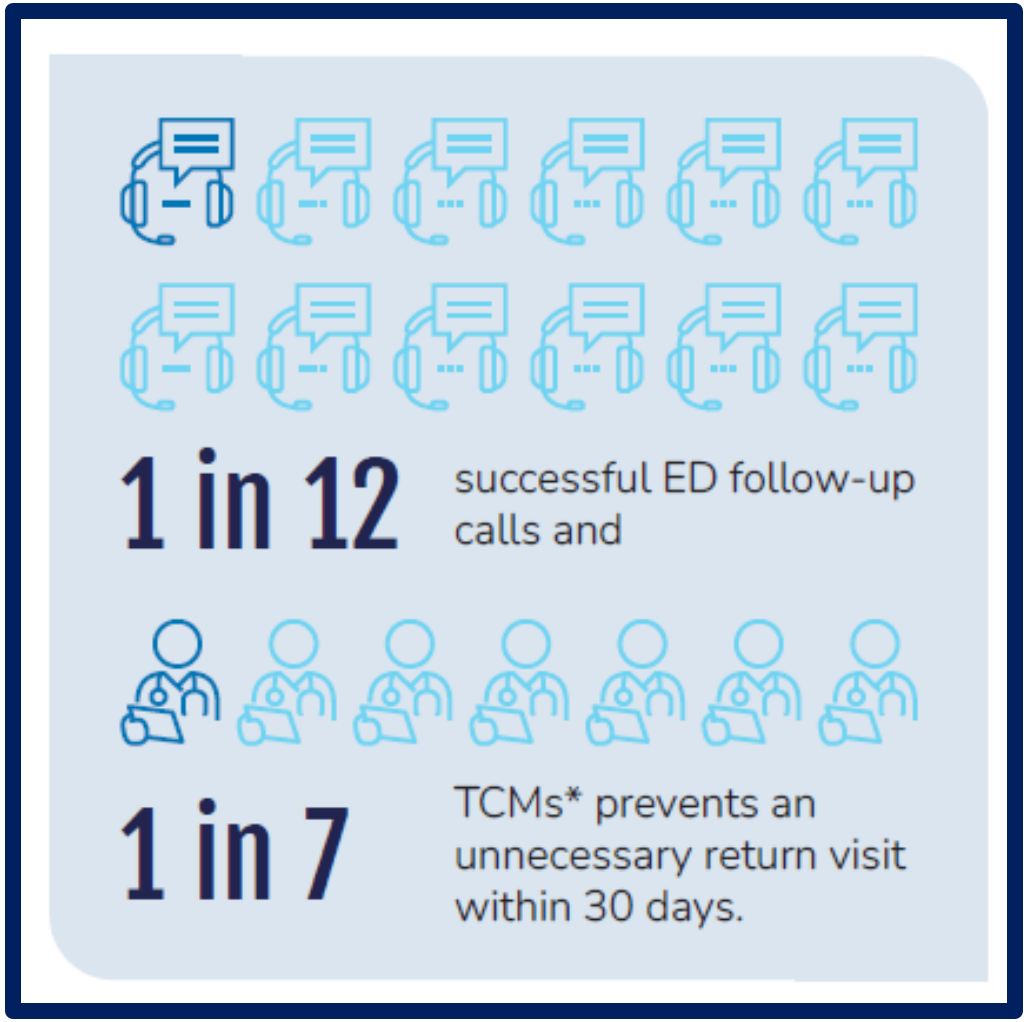
Internal and external analyses have shown the impact timely follow-up visits has on reducing readmissions

READMISSION RATES IN MATCHED GROUPS: NO VMD FOLLOW-UPS* VS 7-DAY VMD FOLLOW-UPS



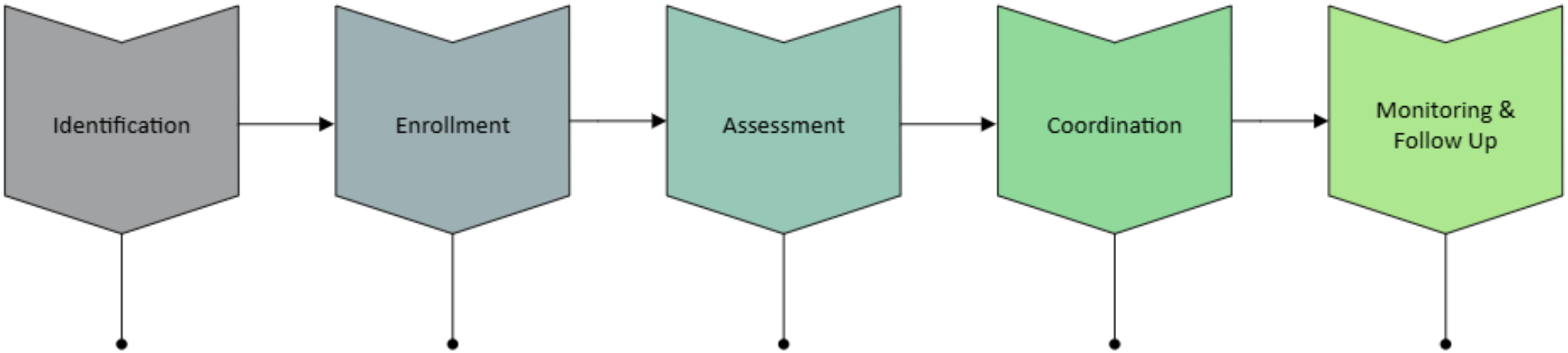
Patient, market, payer, stay, and hospital-level factors are matched.

1. Internal analysis controlled for a variety of factors and showed that having a timely follow-up visit decreased the odds of readmission by 11%.



*Aledade white paper: Transitional Care Management: How ACOs are Getting Patients Into the Doctor's Office and Out of the Hospital

5 Key Components of Transition Care Management Program



Timely identification of utilization events is critical to reducing avoidable readmissions, supporting smooth transitions of care and achieving value-based care goals

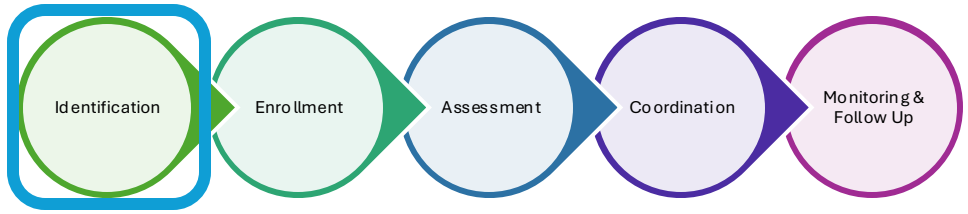
Every patient deserves a safe, seamless and compassionate transition across the care continuum. Our program begins at the point of admission ensuring support through early engagement

A well-executed assessment transforms care from reactive to proactive—shifting the focus from managing an isolated hospitalization to supporting the whole person

By establishing communication prior to discharge, we enable timely interventions that support a safe and coordinated transition. Care Management plays a central role in bridging the gap between inpatient and outpatient care

Frequent connections during both admission and post-discharge periods ensures tight continuity of care and early intervention for any changing healthcare needs while supporting safe transitions of care for our patients

Identification



The Transitional Care Management (TCM) Program encompasses the full continuum of a patient's journey **starting the moment a patient is admitted** through 30 days after discharge to their home setting.

Timely identification of utilization events is critical to reducing avoidable readmissions, supporting smooth transitions of care and achieving value-based care goals.

Both Admission, Discharge and Transfer **(ADT) alerts** and **key relationships with local facilities** enable prompt notification when a patient enters or exists a facility.

Data sources –

Healthcare technology companies: such as Bamboo, deliver encounter notifications when patients are Admitted, Discharged or Transferred (ADT)

Health Information Exchanges (HIE): Admission, Discharge and Transfer (ADT) alerts enable prompt notification when a patient enters or exists a facility

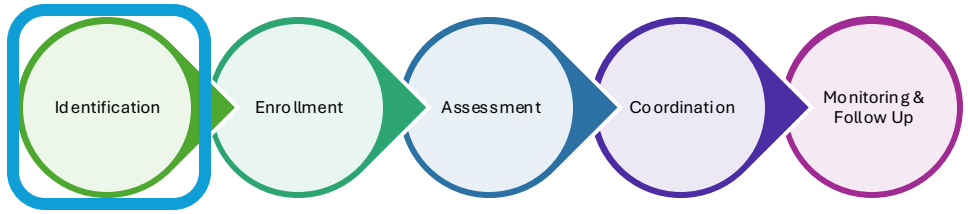
Payer data feeds: census data from value-based care payer partners provide supplemental information on hospital utilizations

Collaboration with facilities –

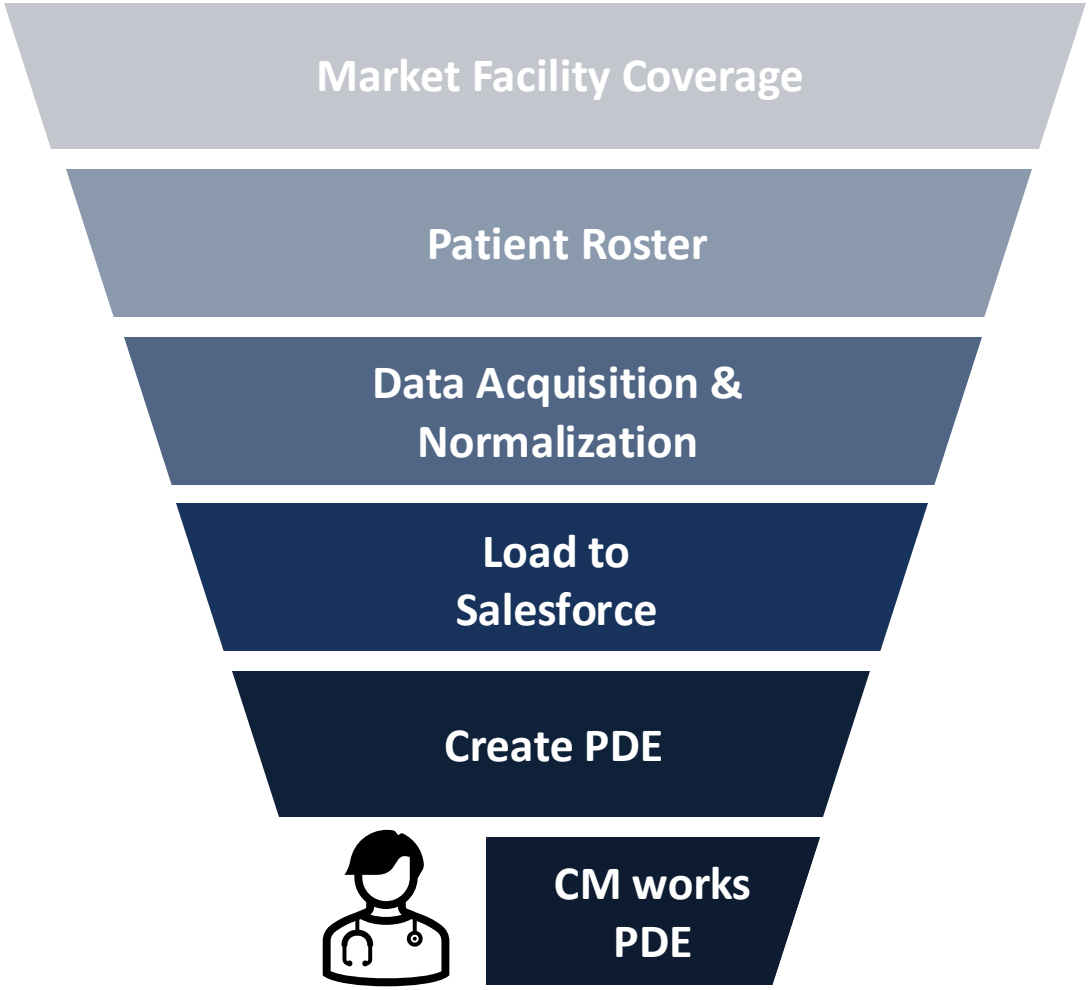
Partnership with hospitals and hospitalist groups: shared accountability for clinical outcomes, patient experience and cost efficiency. Collaboration ensures alignment on key performance indicators such as length of stay and readmission rates

Improved discharge readiness: proactive and timely interventions for barriers to discharge through joint discharge planning. Arrange for timely follow up post-discharge for improved health outcomes

Identification – ADT Pipeline



Village Patient Discharged



Market Facility Coverage: A mix of strategic contracts with HIEs, Paid Vendors, Direct Facility Sourcing & Payers to cover the highest percentage of our patient's utilization events in each market

Patient Roster: We tell our sources who to send us alerts for (and who to charge for, PMPM) by patient roster. Typical logic is all living, non-Commercial, who are attributed to a Village provider.

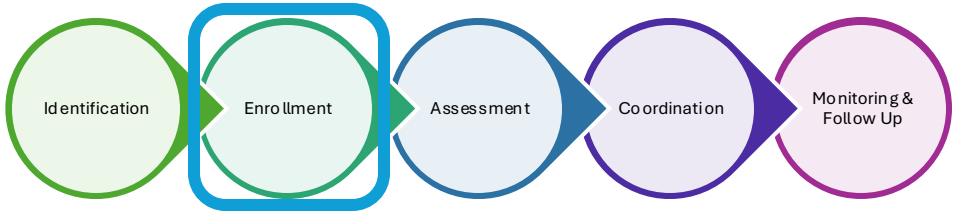
Data Normalization: Load ADT alerts to Snowflake. Normalize to standard format, map values like Utilization Type (Observation Sub Type) and combine all market sources into single picture of ADT data.

Load to Salesforce: Load alerts from Snowflake to Salesforce via Mulesoft jobs running every few hours. Alerts populate in Salesforce as EHR Observations

Create PDE: Cam PDE Flow with lots of logic based on Alert Data and Patient Demographics decide if we want to create a PDE based off of the EHR Observation. Not all Observations create PDEs.

CM works PDE: PDEs get assigned to Care Manager to work in Cam.

Enrollment



Enrollment Philosophy

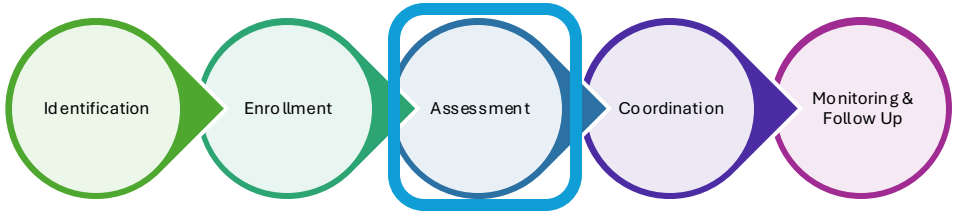
At Village, we believe every patient deserves a safe, seamless and compassionate transition across the care continuum. Our program begins at the point of admission, ensuring patients receive coordinated support through early engagement with patients, caregivers and hospital staff. Our philosophy is grounded in the commitment to empower patients and their caregivers with the knowledge, resources, and support they need to navigate their health journey confidently. Our interdisciplinary team ensures each patient feels respected and treated as a person – not just a case.

Enrollment Process

We prioritize timely and multi-modal outreach to all admitted patients. During an admission, there are often numerous individuals coming in and out of the facility room, which can lead to confusion for patients and caregivers. It is imperative that our team members have a clear introduction of who they are and the purpose of their outreach.

- All admitted and discharged patients will receive outreach the same day of notification, not to exceed 24-48 hours
- Diligent outreach attempts will be conducted to engage patients
  - Including face to face visits with patients admitted to facilities, as clinically appropriate
  - Communication with hospital staff is prioritized to assist with high-risk admissions

Assessment – During Admission



Admission Assessment Philosophy:

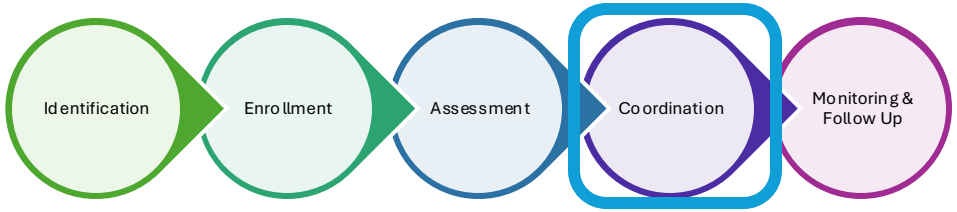
We believe that a well-executed admission assessment transforms care from reactive to proactive—shifting the focus from managing an isolated hospitalization to supporting the whole person. Our team conducts focused assessments early in the admission to identify medical complexity, social determinants of health, caregiver support, and potential discharge barriers. This approach enables the development of a personalized transition plan that promotes care continuity, reduces readmission risk, and supports improved health outcomes.

Admission Assessment Process:

Discharge planning begins the day the patient is admitted and is focused on 4 key priorities

- Early identification of discharge barriers, including unmet social needs, limited support systems, and complex medical needs
- Review of risk factors for readmission such as clinical severity, ready access to urgent clinical care, medication concerns, fall risk and infection indicators
- Strengthened communication with patient, caregiver, hospital teams and primary care provider to ensure nothing is missed as the patient moves between care settings
- Enhanced patient engagement and trust by building rapport and helping them feel seen and heard. This improves adherence to care plans and follow up needs

Coordination – During Admission



Admission workflow – Initiating Post-Discharge Planning Early

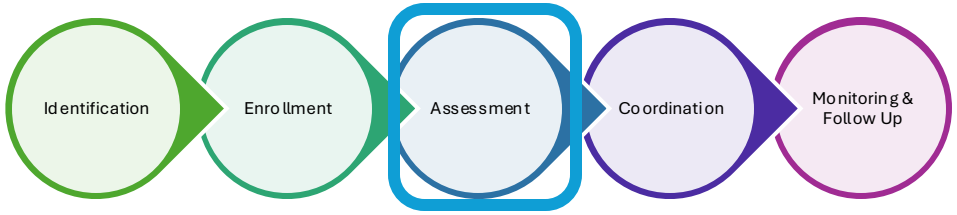
Early engagement with patient's, caregivers, and facility staff is a vital component of our Care Management strategy. By establishing communication prior to discharge, we enable timely, proactive interventions that support safe and coordinated transitions.

- Key elements of this process include:
  - Partnering with the patients, caregivers and hospital teams within 24-48 hours of admission.
  - Completing the Care Management *Admission Essentials*, which involve:
    - Reinforcing "Call Us First" messaging
    - Highlighting the importance of timely PCP follow-up and appointment scheduling
    - Reviewing and encouraging Advance Care Planning documentation

Coordination of care includes:

- Care Team Member is responsible for applying early interventions to mitigate risk factors for readmission (e.g., fall risk, infection, medication concerns) and setting up resources for unmet social needs that may delay both discharge and timely post-discharge follow up
- Any patients requiring home health, post-acute admissions, or specialist referrals will be given our Preferred Provider Network partners

Assessment – Post-Discharge



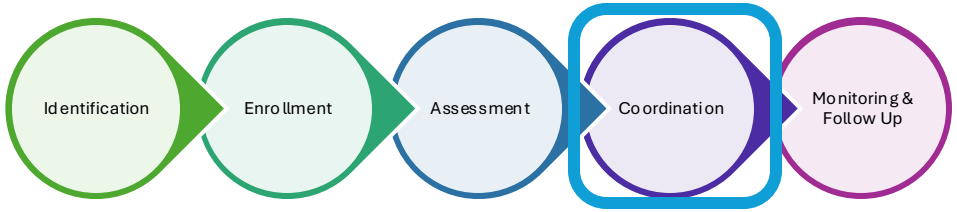
Post-Discharge Assessment Philosophy:
We believe that following discharge, timely outreach from the Care Management team helps a patient feel supported and not forgotten. By reinforcing the care plan, confirming follow-up appointments, and addressing new concerns, we build trust and empower patients to take an active role in their recovery. This continued connection promotes confidence, reduces anxiety surrounding complex care transitions, and strengthens continuity of care during a vulnerable time.

Post-Discharge Assessment Process:
Timely outreach to the patient and caregiver is critical to understand a patient's condition, confirm understanding of their discharge summary, and ensure follow-through with PCP and specialist visits. We focus on identifying new or evolving barriers that may impact recovery. This post-discharge assessment allows us to intervene early, reinforce care continuity, and support a safe healing environment at home.

Core elements of the Post-Discharge assessment include:

- Risk factors for readmission including fall risk, new or worsening infection indicators, medication review including adherence concerns and understanding of any new or changing medications
- Social determinants of health challenges, functional & cognitive impairment, caregiver support, and behavioral health concerns
- Follow up and coordination needs including primary care and specialist appointments, DME, and home care services

Coordination – Post-Discharge

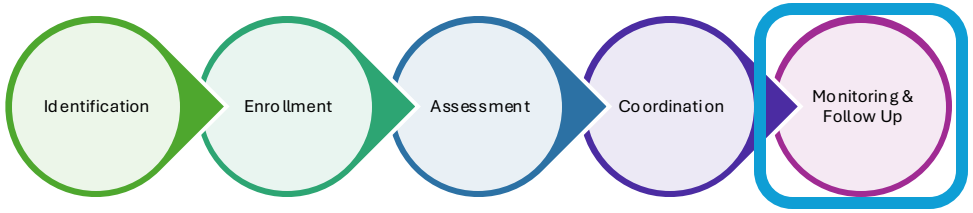


Post-discharge workflow – Ensuring continuity of care

The post-discharge phase is critical to preventing readmissions and promoting recovery. Care Management plays a central role in bridging the gap between hospital discharge and outpatient care by ensuring timely follow up and addressing ongoing needs.

- Key elements of this process include:
  - Outreach within 48 hours of discharge to review the patient's condition, discharge plan and reinforce care needs
    - It is essential that the care team member 'close the loop' on any identified needs during the admission process and confirm the patient's PCP follow up
      - Highest risk patients will be referred directly to Village Medical's Village at Home program.
  - Completing the Care Management *Discharge Essentials*, which involve:
    - Reinforcing "Call Us First" messaging
    - Highlighting the importance of timely PCP follow-up and appointment scheduling
    - Reviewing and encouraging Advance Care Planning documentation
    - Completing clinically relevant assessments and/or surveys that align with the patient's post-discharge needs
      - Establishing a care plan with the patient reflective of these needs

Monitoring & Follow up



Supporting safe recovery, reducing readmissions, and ensuring continuity of care after discharge

After the initial discharge call, patients will be followed closely with a **minimum of weekly outreach**. This will be completed by either the TCM team or the LCM team (if patient had been enrolled in LCM prior to hospitalization). Like the LCM team, the TCM team will utilize **'Tuck-In Call'** and **'Call Us First'** protocols during the post-discharge period to ensure tight continuity of care and early intervention for any changing healthcare needs.

Key elements of this process include:

- Confirm completion of TCM visit with provider
- Address any medication changes or adherence concerns
- Reinforce care plan, and continue working towards goals established during admission/initial discharge calls
- Coordinate specialist visits and community resources
- Provide condition-specific education and self-management support
- Monitor closely for symptom changes and escalate concerns as needed
- Address behavioral health and social determinants of health

At the end of the TCM period, patients will have thorough evaluation and referred to either LCM team or Self-Management care journey

Tuck-In Calls

Tuck-In Calls are proactive, **in-between cycle touches** designed to provide timely, condition-specific support for patients showing signs of clinical decompensation or **requiring closer monitoring**.

When Tuck-In Calls are used

- For patients experiencing **changes in symptoms**, medication adjustments, or worsening chronic conditions
- As part of disease-specific **action plan support** (e.g., CHF, COPD)
- By the **Transitional Care Management** (TCM) team to supplement weekly calls during the 30-day post-discharge period
- To patients with proven **over-utilization of emergency room** visits

Care Team Responsibilities

- Identify patients who may benefit from additional touchpoints based on **clinical indicators**, social needs, or patient-reported concerns
- Document outreach efforts and **escalate concerns** as needed to the broader care team
- Reinforce action plan adherence, assess barriers, and **ensure follow-through** on interventions

Benefits of Tuck-In Calls

- Promotes **early intervention** to prevent avoidable ED visits or hospitalizations
- Strengthens **continuity of care** and patient engagement
- Supports **stabilization** of high-risk patients between standard care cycle intervals
- Enhances responsiveness to **real-time** clinical changes

Call Us First

Every member of the Care Management team is **responsible for educating enrolled patients** and their caregivers on the **importance of contacting the care team first** for any acute health concerns, new symptoms, barriers to care, or other healthcare questions and needs.

Why "Call Us First" Matters

- Encourages **early identification** and intervention for emerging health issues
- **Reduces unnecessary** emergency department visits and hospitalizations
- Enhances care coordination and **timely access** to appropriate resources
- Builds trust and reinforces the care team as the patient's **first point of contact**

Standard of Care

- Call Us First education is **delivered at enrollment** and **reinforced consistently** during all patient interactions
- Care team members **ensure patients understand** when and how to reach out, and what to expect when they do

Measuring Impact

- Inbound Call Us First calls are **tracked and analyzed** to monitor effectiveness
- Data is captured on:
  - Reason for the call (e.g., symptoms, medication concerns, access issues)
  - Whether the patient was planning to go to the Emergency Department
  - Whether the care team successfully diverted the ED visit
  - What was the disposition of the patient after the phone call
- Regular reporting **helps assess trends**, inform process improvements, and demonstrate the value of early intervention

Key Performance Indicators

Process KPIs

Patient engagement rate

- 60% of admitted patients will have a successful contact during admission (of timely notifications)
- 75% of discharged patients will a successful contact within 2 days of discharge (of timely notifications)
- 55% of patients will have a TCM appointment within 7 days of discharge

Standards of Care

- 90% of contacted/admitted patients complete the *Admission Essentials*
- 90% of engaged patients complete the *Post-Discharge Essentials*
- 50% of patients discharged with COPD exacerbation or new diagnosis will have a COPD Rescue Pack prescribed within the post-discharge period
- 50% of Tier 4 patients discharged will have ACP documentation completed before end of post-discharge period

Operational efficiencies

- 90% of admitted patients are contacted within 48 hours of admission (of timely notifications)
- 90% of discharged patients are contacted within 48 hours of discharge (of timely notifications)
- 95% of discharged patents are contacted timely for 7, 14 and 21 day calls

Outcome KPIs

Reduction in Readmissions

- 30-day Readmission Rate

Increased discharges to home

- Reduction in post-acute admissions

Improved patient satisfaction rates

PCP follow-up visit compliance 2025 Q1-Q3

Market	Discharges Home	7D Follow-Up Completed	% 7D Follow-Up Completed	14D Follow-Up Completed	% 14D Follow-Up Completed
Atlanta*	393	73	19%	120	31%
Austin	330	72	22%	110	33%
Connecticut	1715	522	30%	820	48%
Dallas	244	45	18%	70	29%
Detroit*	206	59	29%	93	45%
ElPaso	499	184	37%	260	52%
Houston*	200	24	12%	36	18%
LasVegas	203	69	34%	91	45%
Orlando	681	253	37%	338	50%
SanAntonio	479	97	20%	199	42%

*Affiliate practices only

Documenting TCMs

Presented by Tonya Cobb, Lead Educator, Clinical Documentation Coding

February 4, 2026

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TCM Documentation Tips

Start the year off strong!

- Reporting Acute Conditions
- Patient Risk Dashboard Reminders
- “Stacking” ICD-10 Codes
- Bold Title Descriptor / ICD-10 Code Mis-matches
- Conflicting Documentation

February 2026

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Acute Conditions

TCM visit will sometimes require reporting acute conditions in the A/P.

Tips

- Only report acute conditions that are still being experienced.
  - ➔ Make sure to specifically note that the condition is still current
  - ➔ Ensure a status and plan are documented.
- Do **NOT** report acute conditions that have resolved.

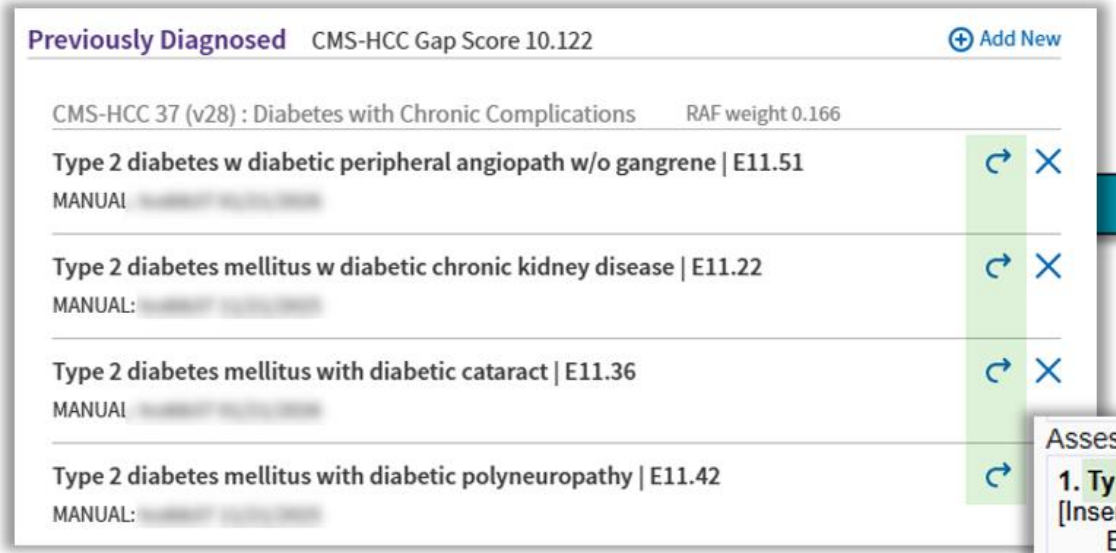
4. Congestive heart failure -
meds reviewed-clinically euvolemic
I50.31: Acute diastolic (congestive) heart failure

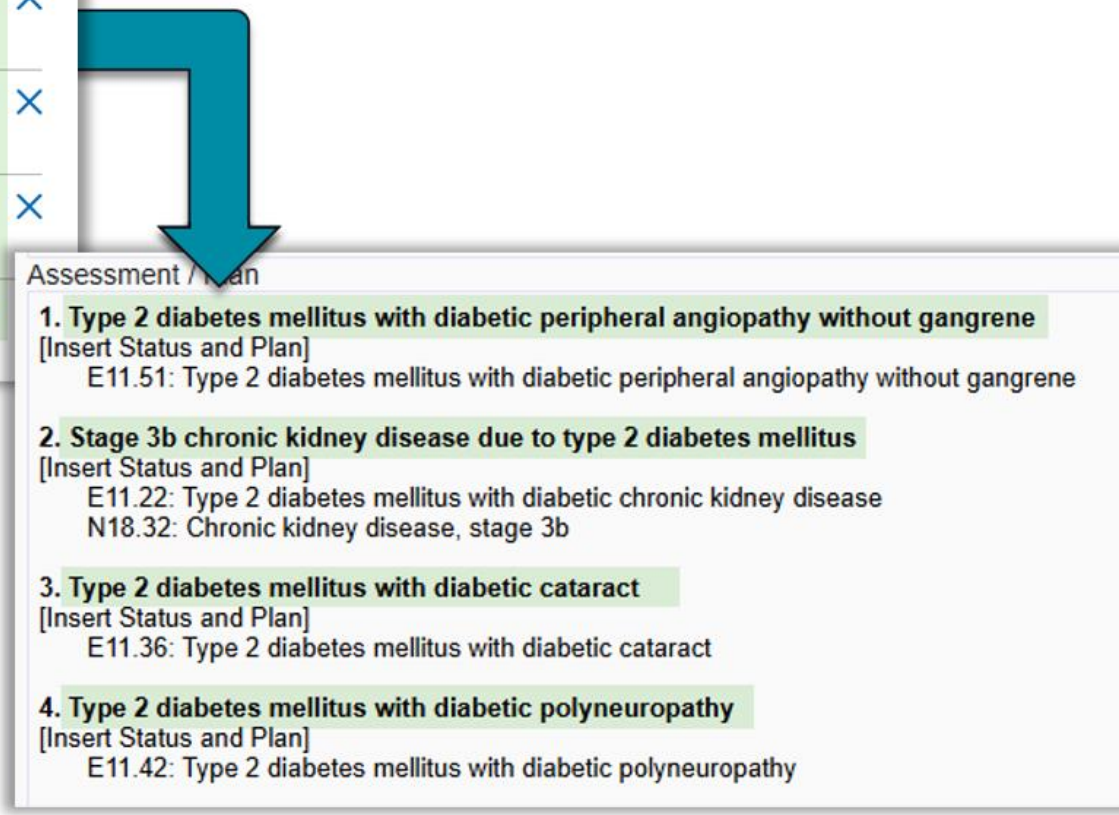
1. Acute diastolic (congestive) heart failure
Recently discharged from hosp. Still experiencing mild acute symptoms but improving. Continue lasix and ordered labs. Follow up in 1 week.
I50.31: Acute diastolic (congestive) heart failure

Acute conditions reported in an outpatient setting are red flags to coders and auditors. It's vital that your documentation supports these conditions as current.

Patient Risk Dashboard (Potential Gaps) - Reminders

Accepting one condition in an HCC category will satisfy the whole category.





If the patient has more than one condition listed in an HCC category, accept ALL conditions that are current for the patient.

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Patient Risk Dashboard (Potential Gaps) - Reminders

RISK REPORT

1

Do not dismiss a diagnosis when ordering testing to rule-in or rule-out a diagnosis. Address the condition on the dashboard once the results have been reviewed.

Chronic kidney disease, stage 4 (severe) | N18.4
Justification: ordering labs
Dismissed by:

Chronic kidney disease, stage 4 (severe) | N18.4
Justification: Reviewed labs. Patient has stage 3b.
Dismissed by:

2

It is best practice to free-type a brief rationale regarding why the condition is being dismissed.

Morbid (severe) obesity due to excess calories | E66.01
Justification: Resolved. Patient lost a significant amount of weight.
Dismissed by:

3

Do not dismiss a diagnosis that was previously addressed. If the previously addressed diagnosis was sufficiently supported and billed, it would not repopulate on the dashboard.

Best practice is to address the diagnosis a second time and document proper support.

Obesity, class 3 | E66.813
Justification: Duplicate
Dismissed by:

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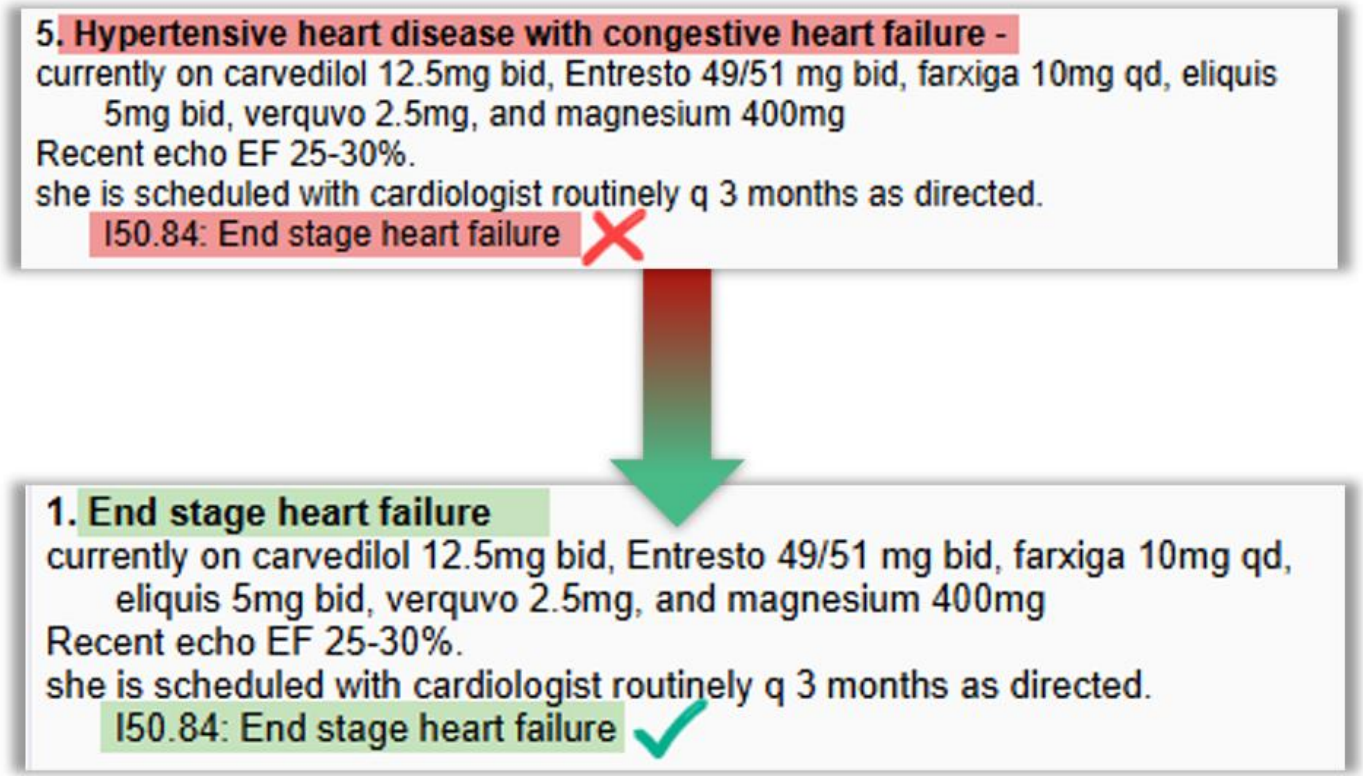
Bold Title Descriptor / ICD-10 Code Mis-matches

For compliance reasons, the bold title descriptor must match the description of the ICD-10 code.

All **conditions**, **sites**, **severities**, **complications**, and **other specificities** seen in the ICD-10 code description must be present in the bold title descriptor.



“Stacking” ICD-10 Codes

Don’ts

2. Morbid obesity -
Risks, benefits, and possible adverse effects of medication discussed with the patient who agreed with the plan of care. Patient was instructed regarding appropriate dosing schedule. All questions answered.
Z68.43: Body mass index [BMI] 50.0-59.9, adult
R73.03: Prediabetes
I10: Essential (primary) hypertension

- Zepbound 2.5 mg/0.5 mL subcutaneous pen injector - Inject 0.5 mL every week by subcutaneous route. Qty: (4) 0.5 mL syringe Refills: 0 Pharmacy: WALMART PHARMACY 2718

Do not manually stack multiple ICD-10 codes under a single bold title descriptor. If Athena doesn’t automatically stack the code, it shouldn’t be stacked.

Best practice is to list each diagnosis on separate lines.

Do’s

Assessment / Plan

1. Morbid obesity
[Insert Status and Plan]
E66.01: Morbid (severe) obesity due to excess calories

2. Body mass index [BMI] 50.0-59.9, adult
[Insert Status and Plan]
Z68.43: Body mass index [BMI] 50.0-59.9, adult

- BODY MASS INDEX: CARE INSTRUCTIONS
- LEARNING ABOUT HEALTHY WEIGHT

3. Prediabetes
[Insert Status and Plan]
R73.03: Prediabetes

4. Essential hypertension
[Insert Status and Plan]
I10: Essential (primary) hypertension

Conflicting Documentation

5. End stage renal failure on dialysis - Onset: 11/14/2022 -
11/6/25-Pt anuric. Dialysis is scheduled on T, Th, Sat.. [redacted] is her nephrologist. She is going to check with him for refill of Renavite. Letter written today requesting pt to be excused from work on the days of dialysis.
Z99.2: Dependence on renal dialysis
N18.6: End stage renal disease
N18.5: Chronic kidney disease, stage 5

Assessment / Plan

1. Type 2 diabetes mellitus -
A1c 7.2 ; concern of medication complinance. Given CKD and elevated A1c, will increase Jardiance
E11.69: Type 2 diabetes mellitus with other specified complication
E11.9: Type 2 diabetes mellitus without complications
Z79.4: Long term (current) use of insulin
- metformin 500 mg tablet - Take 1 tablet(s) twice a day by oral route for 30 days.
  Qty: (180) tablet Refills: 3 Pharmacy: CVS/PHARMACY #5910

Avoid conflicting documentation in within the encounter note and the A/P.

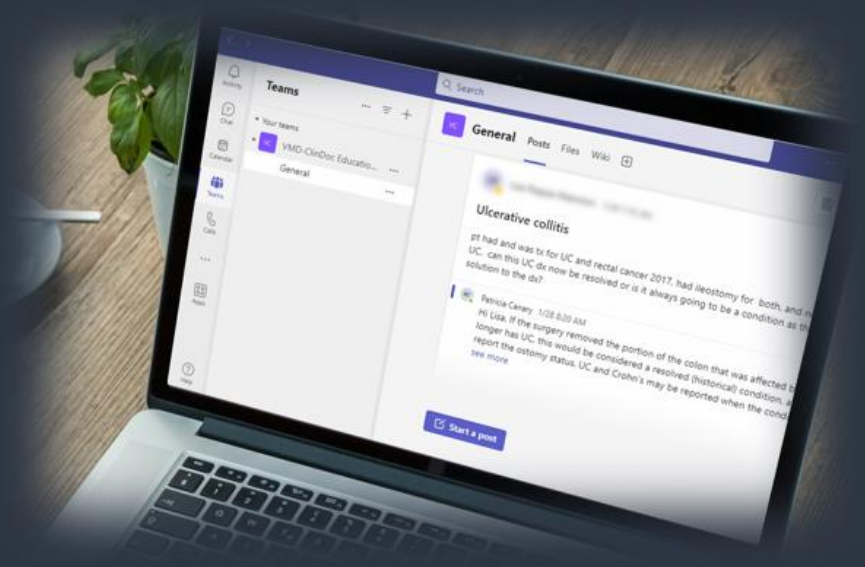
Make sure to read through all the diagnoses in the A/P to ensure documentation is compliant and not conflicting.

Conflicting documentation will result in a query and claim submission will be delayed.

Here to Support You

Contact Us

Who do I contact for **documentation and ICD-10 diagnostic coding** questions?



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