Policy Title:	**Transition of Care**
Department:	**Markets Growth & Retention**
Business Unit:	**Director, Medicaid SNP Member Solutions & Innovation**
Approved By:	**Director of SPP Products**
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PRODUCTS AFFECTED

- Minnesota Senior Health Options (MSHO) – Medica DUAL Solution®
- Minnesota Senior Care Plus (MSC+) – Medica Choice Care℠ MSC+
- Special Needs BasicCare (SNBC) – Medica AccessAbility Solution®
- Integrated Special Needs BasicCare (I-SNBC) – Medica AccessAbility Solution Enhanced®

DEFINITIONS

Care Coordination: The assignment of an individual who assesses the need for and coordinates the provision of all Medicare and Medicaid health and long-term care services for Members and who assesses the need for and coordinates services to a member among different health and social service professionals and across settings of care.

Care Plan/Support Plan: The document developed in consultation with the member, the member's treating physician, health care or support professional, or other appropriate individuals, and where appropriate, the member's family, caregiver, or representative. The Care Plan/Support Plan, taking into account the extent of and need for any family or other supports for the member, identifies the necessary health (including behavioral health), housing support, rehabilitation, and other services to be furnished to the member. Upon launch of the revised MnCHOICES application, the Care Plan will be referred to as the Support Plan and must be completed in MnCHOICES for all members other than MSHO and MSC+ members who reside in an institutional setting.

Care Setting: The provider or place from which the member receives health care and health-related services. Settings include:

- Home
- Acute Care Hospital
- Inpatient Psychiatric Hospital
- Swing Bed Care
- Transitional Care Unit
- Residential Services
- Skilled Nursing Facility
- Custodial Nursing Facility
- Inpatient Rehabilitation Facility
- Outpatient/Ambulatory Care/Surgery Centers

- Mental Health or Substance Use Disorder Residential Treatment

Delegate: A County/Tribal Nation, Agency, or Care System contracted with Medica to provide Care Coordination to Medica members enrolled in the MSHO and MSC+ products. For purposes of this Policy, the term Delegate also includes internal Medica staff that provide Care Coordination services to members.

Engagement Coordinator (EC): A non-clinical employee of Medica that provides outreach efforts to MSC+ and SNBC members on their caseload that have refused Care Coordination or are unable to be reached with the goal of successfully engaging members. Upon engagement and acceptance of ongoing Care Coordination, the EC will transition the member to a CC to begin the Care Coordination process.

Nursing Facility Level of Care (NF LOC): Standard to allow entry to nursing facilities and the home and community-based waivers for individuals demonstrating one or more of the following characteristics: a high need for assistance in four or more activities of daily living (ADL); a high need for assistance in one ADL that requires 24 hour staff availability; a need for daily clinical monitoring; significant difficulty with cognition or behavior; qualifying nursing facility stay of 90 days; or living alone and risk factors are present.

Planned Transition:
A scheduled transition of care. Planned transitions include elective surgery, planned move to a SNF, etc.

Preadmission Screening (PAS): The PAS identifies the person's need for Nursing Facility Level of Care (NFLOC) through a screening of the person's health status, independence in activities of daily living, and the availability of supports and services that could meet the person's needs either in an NF or in the community.

Transition: Movement of a member from one care setting to another as the member's health status changes. This includes outpatient procedures that may impact the ability of the member/responsible party to manage usual activities of daily living.

Unplanned Transition:
An unscheduled transition of care. Unplanned transitions include an unscheduled hospitalization, an unscheduled move to a SNF, etc.

PURPOSE:
To assure that all Delegates that provide Care Coordination for Medica members have a policy and/or procedure addressing implementation of a care transitions process that ensures planned and unplanned transitions between care settings are well managed and smooth with a consistent person supporting the member and/or designated representative or guardians.

Transitions of care are considered an additional opportunity to engage with members and ensure that the care plan/support plan continues to meet the member's needs. The goal of the transitions process is to reduce incidents related to fragmented or unsafe care by having a CC assist the member in planning and preparations for transitions, coordinating follow-up care, identifying barriers, and facilitating communication with all involved parties. In addition, the CC will assist in determining the criteria for eligibility for NF LOC and interventions that can be initiated if a member no longer meets NF LOC.

POLICY:

Delegates that provide Care Coordination for Medica members are required to implement the care transitions process described in this policy upon notification that a member has experienced a transition. The Care Coordinator (CC) serves as the primary point of contact for managing and coordinating delivery of care during a transition.

MSC+ and SNBC members assigned to Medica's internal Care Coordination team who have declined or have been unable to be reached to participate in Care Coordination services may be managed by an Engagement Coordinator. Following notification of a Transition, a specialized TOC team, including a Transition of Care, Care Coordinator (TOC CC) handles all transition of care services for these members and serves as the primary point of contact for managing and coordinating delivery of care during transitions. If the member indicates they are interested in working with a Care Coordinator, they will be transitioned to a Care Coordinator for ongoing assignment and Care Coordination.

PROCEDURE:

1. Upon notification of a planned or unplanned transition, the CC will initiate transition of care activities. This includes completion of the Transition of Care Log for all members.
    a. In the event, the Delegate was notified of a planned or unplanned transition 15 days or more after the member has returned to their usual care setting
        i. A Transition of Care Log is not required.
        ii. The CC must attempt to verify through a conversation with the member and/or responsible party or guardian that the member has returned to their baseline with no changes in care needs or newly identified risks.
        iii. The CC must attempt to provide member education; including information on the role the CC can play in future transitions.
        iv. The CC must document these discussions in the member's case notes and update the member care plan/support plan to reflect the transition.
    b. The CC will attempt to communicate directly with the member and/or designated representative or guardian during each phase of a transition.
        i. Communication may contain, but is not limited to:
            1. Explanation of the CC's role in the transition process
            2. How the CC can be contacted
            3. Assistance with discharge planning and follow-up care after the transition
            4. Review of medication changes, durable medical equipment (DME) products required, services needed, etc.
            5. Education on strategies to help prevent readmissions
    c. The CC will communicate with the receiving care setting, if the member has not yet been discharged, and/or home care agency, if applicable. This communication should occur within (1) business day of notice of a transition and may occur via mail, fax, secure email, phone, or EMR.
        i. Communication may contain elements of the member's care plan/support plan, which may include medical and non-medical information such as
            1. Current problem list
            2. Medication regimens
            3. Advance directives
            4. Physical and cognitive function
            5. Contact information for providers, practitioners, and informal supports

6. Current services in place
7. Possible plans for discharge, including collaboration with discharging staff and county social services to ensure the member's needs are met by Medicaid services, managed long term services, and supports, and informal supports

ii. Outreach to the receiving care setting to share information is not required if the member has discharged from the receiving care setting.

d. The CC will notify the member's Primary Care Physician (PCP), if the PCP is known, of all transitions within one (1) business day of notification, including the return to usual setting.
   i. Notification may occur via mail, fax, phone, EMR, or secure email. The Delegate must be able to provide the content of the notification to the health plan upon request (example: copy of PCP notification fax, snapshot of EMR, documentation of telephonic discussion)
   ii. If the PCP is the admitting physician, the CC is not required to make notification, but will document this on the Transition of Care Log or in the member's record.
   iii. If the PCP is not known, the CC will attempt to determine who the PCP is.
e. If the transition is related to behavioral health or substance use, the member may also be managed for utilization by an MBH UM Care Advocate.
   i. If the CC is contacted by an MBH UM Care Advocate, the CC will respond timely for efficient coordination both during the hospitalization and for coordination of care post discharge.
   ii. If the CC is made aware of a psychiatric or substance use hospitalization and would like direction or support, the CC may call the MBH case consultation line @ 1-800-848-8327 and ask to speak to the Clinical Program Manager/Supervisor
   iii. In these instances, the CC may complete referrals to the members county of residence to ensure members have the support (i.e.: CADI, TCM, or ARMHS) they need to maintain stability post-discharge.
   iv. MSHO members may be referred for MBH Case Management for members with specific behavioral health conditions that exceed the capacity of the care coordinator to support. In these instances, the Medica Care Coordinator and MBH Case Manager work together (co-manage) to support the interest and health of the member.
f. Upon return to the member's usual care setting (which may be a "new" usual care setting for the member), the CC will attempt to reach the member and/or designated representative or guardian to discuss the care transition process, changes to the member's health status, and any necessary care plan/support plan updates. This includes determining if changes in the member's health status/needs require a new assessment. At this time, the CC also will provide education about transitions with the goal of fostering self-management strategies that will help the member prevent unplanned transitions/readmissions in the future.
   i. The CC will facilitate conversations with the member and/or designated representative or guardian on key factors shown to be important in reducing preventable readmissions, such as:
      1. Verification that the member has appropriate follow-up appointment(s) scheduled with their PCP or specialist
         a. Medical: Visit within fifteen (15) days of discharge
         b. Mental Health: Outpatient mental health appointment with a mental health professional within seven (7) days of discharge from a behavioral health hospitalization
      2. Verification discharge instructions were received and understood

3. Verification of medication review completion by PCP, pharmacist, home care agency/nursing facility/residential services facility, or Medication Therapy Management Services (MTMS)
4. Verification member can manage medications or medication management system is in place
5. Verification of member's ability to verbalize warning signs and symptoms to watch for and how to respond
6. Verification of adequate food, housing, and transportation
7. Verification of safety in the home
8. Addressing concerns regarding vulnerability, abuse, or neglect

g. The CC will summarize the hospitalization including the reason for admission and potential changes in care needs on the Transition of Care Log.
h. The CC will update the care plan/support plan as necessary with transitions, newly identified risks, need for services or changes in interventions needed to ensure health and well-being.

2. If the transition leads to a change in the member's NF LOC or current services, the CC will work with the member and/or designated representative or guardian, discharging staff, and/or county social services as applicable to ensure the member's needs are being met by Medicare services, Medicaid services, community services, and/or other informal services and supports.

3. If the transition leads to an admission to a Skilled Nursing Facility, the CC will collaborate with the Senior Linkage Line and other social service staff to ensure that the Pre Admission Screening (PAS) process is completed and determine of NF LOC criteria has been met.

4. The CC will adjust the member's follow-up plan after a transition based on their professional judgement and identified member needs.

5. All outreach attempts to the member and/or designated representative or guardian, discharging staff, receiving facility, county social services, and/or providers will be documented in the member's record.

6. Medica will monitor the management of transitions through an annual audit of transition of care activities performed by CCs.

CROSS-REFERENCES:
MSHO Model of Care
SNBC Model of Care
Preadmission Screening for Nursing Facility Admission Policies and Procedures
Transition Log
Transition Log Instructions
Notification of Care Transition Fax

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