Policy Title:	**Transition of Care**
Department:	**Government Programs**
Business Unit:	**State Public Programs**
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®
- Special Needs BasicCare (SNBC) Integrated – Medica AccessAbility Solution Enhanced®

DEFINITIONS

Care Plan: Medica does not require the use of a specific Care Plan. Any Care Plan that meet the Department of Human Services (DHS) audit protocol requirements and all of the elements of the Community Support Plan (CSP) DHS e-doc form #2925 may be used. If a delegate plans to use a care plan other than those provided by Medica (Collaborative Care Plan or Medica AccessAbility Solution® / Medica AccessAbility Solution® Enhanced Special Needs BasicCare (SNBC and SNBC SNP) Member Care Plan or Medica Unable to Contact Refusal Care Plan, prior approval is required by the Medica Regulatory Oversight & Improvement Department. Upon implementation of the MnCHOICES online assessment tool, Medica Care Coordinators (CC's) will complete the care plan in the MnCHOICES support plan module.

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

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:
When the Care Coordinator (CC) is aware of an upcoming transition, such as a surgery or a move to a different level 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:
When the Care Coordinator (CC) is notified of a transition by a variety of inputs such as: internal reports, calls from members or their family, reports from receiving facilities, or Medica hospital or SNF admit reports. Unplanned transitions include an unscheduled hospitalization, an unscheduled move to a SNF, etc.

PURPOSE:
To assure that all Care Systems, Agencies, and Counties that provide Care Coordination for Medica members have a policy and/or procedure to clarify the role of CCC's in ensuring that planned and unplanned transitions between care settings are well managed and smooth with a consistent person supporting the member and/or authorized family members or guardians. Transitions of care are considered an additional opportunity to engage with members and ensure that the care plan continues to meet the member's needs. The goal of the CC's efforts is to reduce incidents related to fragmented or unsafe care, by assisting in planning and preparations for transitions, coordinating follow-up care, and facilitating communication with all involved parties. In addition it 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:
Care Systems, Agencies, and Counties that provide Care Coordination for Medica members are required to have procedures in place to guarantee that every Medica member is assigned a Care Coordinator (CC) that will offer to provide Transition of Care services when a member moves from one care setting to another due to a change in health status. The CC serves as the primary point of contact for managing and coordinating delivery of care during transitions. .

Medica MSC+ and SNBC members who have declined to participate in Care Coordination services may be managed by an Engagement Coordinator. The Engagement Coordinator serves as the primary point of contact for these members, until the member is willing to accept and participate in Care Coordination.

PROCEDURE:

1. Upon notification of planned or unplanned transition, the CC will initiate transition of care activities. For MSHO and SNBC Enhanced members, this includes completion of the Transition of Care Log. For MSC+ and SNBC members, the Transition of Care Log is optional, but documentation must be present showing that all steps below (a-h) occurred.
    a. In the event, the CC was notified of a planned or unplanned transition by the member and/or family member 15 days or more after the member has returned to their usual care setting
        i. The CC must verify through a conversation with the member and/or responsible party that the member has returned to their baseline with no changes in care needs or newly identified risks.
        ii. The CC will provide member education; including information on the role the CC can play in future transitions.
        iii. The CC must document these discussions in the member's case notes and update the member care plan to reflect the transition.
        iv. A Transition of Care Log is not required in this instance.
    b. The CC will communicate with the receiving care setting. This communication should occur within (1) business day.
        i. Communication may contain, but is not limited to medical and non-medical information
            1. Current problem list
            2. Medication regimens
            3. Advance directives
            4. Baseline physical and cognitive function
            5. Contact information for professional providers, practitioners and informal supports
            6. Current services in place
            7. Changes in member's needs
            8. Possible plans for discharge, including collaboration with discharging staff and county social services to ensure the members needs are met by Medicaid services, managed long term services and supports, and informal supports
    c. 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 members Primary Care Physician (PCP), if the PCP is known, of the transition within one (1) business day of notification.
        i. Notification may occur via mail, fax, phone, EMR, or secure email.
        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 disorder, the member may also be managed for utilization by a MBH Inpatient Care Advocate.
        i. If the CC is contacted it is important for them to respond timely for efficient coordination both during the hospitalization and for coordination of care post discharge.
        ii. In these instances the CC may need to complete referrals to CADI, TCM, or ARMHS so that the members have the support they need to maintain stability post-discharge.

f. Upon return to the members usual care setting (which may include situations where it may be a "new" usual care setting for the member)
    i. The CC will communicate with the member/responsible party about the care transition process, changes to the member's health status, plan of care updates, and education about transitions and how to prevent unplanned transitions/readmissions in the future.
    ii. The CC will communicate with the PCP, when identified about the discharge.
    iii. The CC will address topics related to Coleman's Four Pillars for Optimal Transition and social determinants of health questions to facilitate conversations with members regarding:
        1. Verification follow-up appointment was scheduled with 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
        4. Verification member is able to 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. Address concerns regarding: vulnerability, abuse, or neglect
g. The CC will summarize hospitalization including the reason for admission and potential changes in care needs.
h. The CC will updated the Care Plan with newly identified risks, needs for services and changes in interventions needed to ensure health and well-being.

2. If the transition leads to change in NF LOC or current services, the CC will work with the member and/or responsible party, discharging staff, and county social services to ensure the member's needs are being met by Medicare services, Medicaid services, Services through formal, informal, and quasiformal Health and Home Based Community Services (HCBS).

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 NF LOC criteria has been met.

4. The CC will identify members at high risk of hospitalization through assessments, telephonic consults with members, responsible party, and/or other Medica reports.

5. The CC will make adjustments to the follow-up plan based on professional judgement and identified member needs.

6. The CC will document all work related to the transition of care.

7. Medica will monitor the management of transitions through claims, chart audit data, and an audit of transition of care activities performed by Care Coordinators.

CROSS-REFERENCES:
MSHO Model of Care
SNBC Model of Care
DHS Bulletin 19-25-03
Transition Log

Notification of Care Transition Fax

Rev. 12/2021