### Transitions of Care

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<th>Policy Title:</th>
<th>Transitions of Care</th>
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<tr>
<td>Department:</td>
<td>State and Public Programs</td>
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<td>Business Unit:</td>
<td>Care Coordinated Products</td>
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<td>Approved By:</td>
<td>Director of Dual Eligible and Care System Products</td>
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<td>Approved Date:</td>
<td>9.20.09</td>
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<td>Original Effective Date:</td>
<td>9.20.09</td>
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<tr>
<td>Review Date(s) (no changes):</td>
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<tr>
<td>Revision Dates:</td>
<td>10.2.12, 9.12.13, 10.5.15, 12.12.16</td>
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### PRODUCTS AFFECTED

- Medica DUAL Solution® – for Minnesota Senior Health Options (MSHO) enrollees
- Medica Choice CareSM – for Minnesota Senior Care Plus (MSC+) enrollees
- Medica AccessAbility Solution® – for Special Needs Basic Care (SNBC) enrollees

### DEFINITIONS

**Care Plan:** Medica does not require the use of a specific Care Plan. Any Care Plan that meets the DHS audit protocol requirements and all of the elements of the Community Support Plan (CSP) DHS e-doc form #2925 may be used.

**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
- Skilled Nursing Facility
- Custodial Nursing Facility
- Inpatient Rehabilitation Facility
- Outpatient/Ambulatory Care/Surgery Centers
- Outpatient/Ambulatory Care/Surgery Centers

**Preadmission Screening (PAS):** The PAS identifies the person’s need for Nursing Facility (NF) level of care 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.
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.

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.

Planned Transitions:
When the Care Coordinator (CC) is aware of an upcoming transition, such as a surgery or a move to a different level of care

Unplanned Transitions:
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.

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 Care Coordinators/Case Managers 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. It will also 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 or identified needs. The Care Coordinator serves as the primary contact for member needs.

PROCEDURE:
1. When the MSHO Care Coordinator is made aware of a planned or unplanned member transition, they will initiate a Transition of Care Log.
   a. In the event, the Care Coordinator 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, and the Care Coordinator has verified 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, the Care Coordinator will document this in the members case notes and a Transition of Care Log is not required.

2. Once the MSHO Care Coordinator is made aware of a transition via: internal reports, calls from members and/or their family, reports from receiving care settings, or reports from discharging care settings, the Care Coordinator will communicate with to the receiving care setting. This communication should occur no later than one (1) business day of notification. Outreach to the receiving care setting is not required if the member has already returned to his/her usual setting of care.
   a. Communication may contain, but is not limited to medical and non-medical information
      i. Current problem list
      ii. Medication regimens
      iii. Advance directives
      iv. Baseline physical and cognitive function
      v. Contact information for professional providers, practitioners and informal care providers that are not involved in the transition
      vi. Current services in place

3. The MSHO Care Coordinator will notify the members Primary Care Physician (PCP) of the transition within one (1) business day of notification; if the PCP is the admitting physician, the Care Coordinator is not required to make notification, but will document this in the member’s case notes.

4. Upon return to the members usual care setting (which may include situations where it may be a “new” usual care setting for the member)
   a. The MSHO Care Coordinator will communicate with the member/responsible party about the care transition process, changes to the members health status, plan of care updates, education about transitions and how to prevent unplanned transitions/readmissions
   b. The MSHO Care Coordinator will use the Four Pillars for Optimal Transition questions to facilitate conversations with members regarding:
      i. Follow-up appointment scheduled with PCP or specialist
      ii. Medication management
      iii. Warning signs and symptoms to watch for and how to respond
      iv. Personal Health Care Record

5. When the MSC+ or SNBC Care Coordinator is made aware of a planned or unplanned member transition, they will work closely with members, PCPs, facilities, and caregivers throughout the transition process and document contacts in case notes.

6. If the transition leads to change in NF LOC or current services, the Care Coordinator 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 state MA services, waiver services, or other informal supports.
7. If the transition leads to an admission to a Skilled Nursing Facility, the Care Coordinator will collaborate with the Senior Linkage Line and other social service staff to ensure that the Pre Admission Screening (PAS) process is completed and determines NF LOC criteria have been met.

8. The Care Coordinator will update the Care Plan and Service Agreement with newly identified risks, needs, and/or services after discharge from a care setting whether the member returns to their usual care setting or moves to a new care setting.

9. The Care Coordinator will identify members at high risk of hospitalization through assessments, telephonic consults with members or family, or reports.

10. The Care Coordinators will review identified members on the high risk reports for members identified as at risk of hospitalization through analysis of frailty factors using claims data [John Hopkins ACGs].
   a. Reviews will be completed within 30 days.
   b. If new information is identified, outreach by the Care Coordinator to screen the member is strongly suggested.

11. The Care Coordinator will make adjustments to the follow-up plan based on professional judgement and identified member needs.

12. The Care Coordinator will document all work related to the Transition of Care, for example, attempted care setting contacts, attempted member, family, provider, county social services, and case management systems contacts.

13. Medica will monitor the management of transitions through claims, chart audit data, and reports provided from the Counties, Agencies, and Care Systems annually.

CROSS-REFERENCES:
MSHO Model of Care
DHS Bulletin 14-25-09
DHS Bulletin 14-25-10
DHS Bulletin 14-25-12
DHS Bulletin 14-25-13
DHS Bulletin 15-25-03
Transitions Log
Transition Log Instructions
Notification of Care Transition Fax
Care Transitions Scenarios

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