**Policy Title: Managing Care Transitions**

**Department: Utilization Management (UM)**

**Policy Number: UM 120** **Rev. Date(s): 08/01/2018, 05/04/2022**

**Effective Date: 05/01/2015**

| **Product Lines:** | ☐ All/Other | ☑ Gold Coast Medi-Cal | ☐ FFS Medi-Cal |
|---|---|---|---|
| | ☑ Medicare | ☑ Commercial | |
| **Age Limitations:** | ☑ None | ☐ Under 21 | ☐ Other |

## Purpose

To ensure reduction or prevention of planned and unplanned care transitions by identification, management and safe facilitation.

## Policy

AmericasHealth Plan (AHP) will analyze and measure its performance on managing all care transitions as well as identifying and acting on opportunities to improve continuity and coordination of medical care.

**DEFINITIONS**

1. Care Setting: The provider or place from which the member receives health care and health-related services. Settings include: home, home health care, acute care, skilled nursing facility, custodial nursing facility, rehabilitation facility.
2. Transition: Movement of a member from one care setting to another as the members' health status changes.
3. Planned Transitions–include elective surgery or a decision to enter a long-term facility
4. Transitional Process: The period from identifying a member who is at risk for a care transition through the completion of a transition. This process goes beyond the actual movement from one setting to another; it includes planning and preparation for transitions and the follow-up care after transitions are completed.
5. Planned Transition: Pre-arranged or scheduled care such as an elective surgery. It is intended.
6. Unplanned Transition: An unintended event such as an emergency hospitalization or placement into a skilled nursing facility or alternate living arrangement that is unplanned.
7. Care Plan: A set of information about the patient that facilitates communication, collaboration and continuity of care across settings. The organization sets parameters for the types of information that should be communicated between settings in a care plan. The care plan should be tailored to each individual and take patient health status into consideration. The care plan may contain, and is not limited to, both medical and non- medical information.

## Procedures

1. **NOTIFICATION BETWEEN SETTINGS:**
   a. Planned and Unplanned transitions from any setting to any other setting are identified by a notification that is achieved through fax, verbal, or secure e-mail. This information is then populated via a daily census, listing each individual member that has undergone a care transition to an acute hospital, skilled nursing facility, or rehabilitation center. The daily census automatically populates from an authorization report within one business day of notification of the admission.
      i. The UM/Case Management team has established procedures for working with network facilities to identify members who experience unplanned transitions such as

hospitalizations through the Emergency Department or admissions to Long Term Care Facilities.

ii. In network acute care facilities are expected to send hospital admissions information to AmericasHealth Plan by faxing the hospital face sheet and clinical information to the UM Department within one (1) business day of admission.

iii. In network long-term facilities are expected to send report of admission to AmericasHealth Plan by faxing the facility's face sheet and clinical information to the UM Department within one business day of admission.

b. For planned and unplanned transitions from members' usual setting of care to the hospital and transitions from hospital to the next setting, the UM department designated staff (Care Transition Nurse) (CTN) will coordinate sharing, the sending setting's care plan with the receiving setting within one business day of notification of the transition.

c. The member or responsible party will be notified of the transition, changes to the member's health and plan of care within two business days. For planned and unplanned transitions from any setting to any other setting the member's usual practitioner will be notified of the transition within three business days.

## 2. SUPPORTING MEMBERS THROUGH TRANSITION

a. For planned and unplanned transitions from any setting to any other setting, the Care Transition Team shall contact the member or responsible party via phone or in writing within three (3) business days of the transition. The Care Transition Team shall communicate the Care Transition Process and changes to the member's health status and plan of care. The member or responsible party shall be notified by the Care Transition Team, via phone or in writing, of their ability to access their personal health information, including their care plan, to facilitate the coordination of care and communication between providers in other healthcare settings. The Care Transition Specialist shall ask the member, via phone or in writing, whether they would like to access their personal health information. In the event that the member would like access to their personal health information, the Care Transition Specialist shall be responsible for transmitting, via secure methods, the requested information to the member.

b. All members meeting the above criteria will be provided with a name and phone number of a Care Transition Specialist who is responsible for supporting the member through the transition process. A member of the Care Transition Team will accomplish the above communications with either the member or responsible party within three (3) business days of the transition.

c. The member or responsible party shall be provided contact information for CDCR's Health Education Department. The Health Educator will be available to educate the member or responsible party about the member's health status, foster appropriate self-management activities, and answer any questions concerning the member's health during and after the transition of care.

d. The Health Education Department shall maintain contact with the member or the member's caregiver telephonically during transition and post-discharge. The Health Education staff shall offer services, including self-management activities such as goal setting or problem solving, as well as educate the member and/or caregiver to identify signs and symptoms that may signal a change in the member's condition or health status and how to respond to such changes.

## 3. REDUCING TRANSITIONS

a. The Care Transitions Team is committed to minimize unplanned transition and prevent avoidable transitions across its member population by:

i. Readmit Report (weekly)
ii. Catastrophic Report (weekly)
iii. High Risk Report (monthly)
iv. Disease Management Enrollment Report (monthly)
v. Admit utilization report (monthly)

    vi. Transition PCP follow-up appointment reporting for continuity of care (weekly)
    vii. Emergency Room Reporting (weekly)

b. Member Specific Paid Claims Data File Record Layout
c. If any one of the following diagnosis/claim or encounter is identified then classify as High-Risk.
    i. AIDS Diagnoses
    ii. ESRD Diagnoses
    iii. Behavioral Health Diagnosis with concurrent chronic medical condition
    iv. Recent Organ Transplant
    v. Cancer currently being treated
    vi. Hospitalization within last 60 days
    vii. 3 or more hospitalizations in last 12 months
    viii. 3 or more Emergency Room visits in last 12 months
d. Members may also be identified as having increased risk for unplanned transitions by notification from a number of sources such as:
    i. Health Plan/AHP Case Managers and Social Workers through direct member interaction
    ii. Primary Care Physicians and Specialty Providers.
    iii. Member Services Department
    iv. Disease Management Department

**4. ACTION TO PROVIDE IMPROVEMENT IN CARE COORDINATION**

a. By utilizing the monthly data results, the organization ensures unplanned transitions are minimized and works to maintain members in the least restrictive setting possible by performing the following processes.
    i. Conduct quantitative and causal analysis of data to identify continuity of care improvement opportunities.
    ii. Coordinating services for members at high risk of having a transition.
    iii. Educating members or responsible parties about transitions and how to prevent unplanned transitions.
    iv. Analyzing monthly discharge reports.
    v. Monthly Hospital utilization Reports.
    vi. Annual review of Complex Care Program and results from report analysis.
        1. Construct revised program for the following year that reflects the updated identified opportunities for improvement.
b. The interventions identified for improvement will be re-measured for performance determination at least annually.
c. When members who are receiving approved services but whose benefit coverage will end, AHP will inform them about alternatives for continuing care and how to obtain care as appropriate. These services include but not limited to behavioral health care, skilled nursing facility, and home health care.

## Regulatory References

1. National Committee for Quality Assurance (NCQA) Standards and Guidelines
2. CMS Managed Care Manual Chapter 5