Seaside Health Plan Policies and Procedures	**Effective Date:** May 17, 2013 **Note: For origination date see History at the end of Policy**
SUBJECT: CARE TRANSITIONS	**Approval Signature:** Barry Smith, MD Chief Medical Officer
Manual: Case Management **Policy/Procedure #** SNP-210 **Section:** Special Needs Population	**Sponsor Signature:** Kimberly Ward, RN Director, Utilization Management
☐ **COMMERCIAL** ☐ **HEALTHY FAMILIES** ☒ **MEDI-CAL** ☒ **MEDICARE**	

AUTHORITY
Medicare Managed Care Manual

POLICY
Seaside Health Plan makes a special effort to coordinate care for Members enrolled in Special Needs Plans, when Members move from one setting to another, such as when they are discharged from a hospital. Without coordination, such transitions often result in poor quality care and risks to patient safety. The Care Transition Process is focused on managing planned and unplanned care setting transitions, identifying unplanned transitions and reducing transitions.

The purpose of this policy is to set forth guidelines for Seaside Health Plan individuals in managing safe care setting transitions, identifying planned and unplanned transitions, and reducing transitions. Activities include but are not limited to, educating the member and responsible parties and coordinating services for members at high risk of problems with transition and to ensure the Members have a consistent person or unit responsible for supporting the Member and managing care transitions.

Seaside Health Plan has a process to track and analyze transitions of care to assure timeliness and appropriateness of services and benefits

Seaside Health Plan disseminates the results of the transitions of care analysis to the interdisciplinary team.

DEFINITION OF TERMS

Planned Transitions*:* A planned transition is an anticipated change in the member's level of care.

Unplanned Transitions: Unplanned transitions are unanticipated changes in the Member's level of care or care setting.

PROCEDURE

Seaside Health Plan manages care transitions, identifies problems that may result in unplanned transitions, where possible prevents unplanned transitions, and educates members on ways to avoid having a transition. Seaside Health Plan makes a special effort to coordinate care as members transition from one level of care to a higher or lower acuity. To achieve this, the following procedures are followed:

I. Identification of Planned and Unplanned Transitions

A. Identifying Planned Transitions

1. Notification that a planned transition is about to happen occurs when requests for authorization of elective inpatient admission/procedure(s) are received from the primary care physician or specialist, or when the provider directs transition to a more or less acute setting.

2. The authorization coordinator enters the pre-service inpatient authorization in the Managed Health Care (MHC) system and provides notification to the Care/Case Management Associate for initiation and coordination of care plan with appropriate individuals within 24 hours or next business day.

3. The Care/Case manager reviews daily elective approved authorizations and weekly open authorization referral report to identify that a planned transition is about to happen. Planned transitions include:

    a. Elective hospital admissions
    b. Elective skilled nursing facility admissions
    c. Elective acute rehabilitation admissions
    d. Elective Long Term Care Admission

B. Identifying Unplanned Transitions

1. The Concurrent Review assistant enters the inpatient admission or Long-Term Care admission in MHC system and provides notification to the Care/Case Management Associate for initiation of the coordination of a plan of care with appropriate individuals with 24 hours or next business day.

2. Seaside Health Plan identifies transitions by reviewing the following for facilities in its network: 1) Reports of hospital admissions within one business day of admission; 2) Reports of admissions to long-term care facilities within one business day of admission by reviewing the daily inpatient census.

3. Care/Case Management associate may be notified of unplanned transitions of care through the following:

a. Non contracted facility notification
b. Daily inpatient census
c. Home Health contracted vendors
d. Pre-service, concurrent, and retrospective review process
e. Health Plans internal associates also notify assigned Care/Case Management associate of new authorization requests as applicable.

II. Management of Care

A. Seaside Health Plan inpatient management review occurs within one business day of notification of admission.

1. The Care Plan is tailored to each individual and takes the member's health status into consideration.

2. The Care/Case Manager develops and/or updates the care plan.

3. Upon completion of an inpatient authorization and/or notification of concurrent admission process, an assessment for discharge planning procedures begins. Seaside Health Plan Care/Case Manager contacts the interdisciplinary care team to assist with the completion of the assessment for appropriate discharge planning and care plan development. IDCT Members are added to team as needed.

III. Transfer of the Care Plan

A. Seaside Health Plan is responsible for providing safe, efficient transitions and appropriate notification to the receiving setting.

1. The transfer of the care plan from one care setting to another must occur within one business day of notification of the transition to ensure that the member's care continues in a safe and effective manner.

2. For planned and unplanned transitions, the Care/Case Manager, in collaboration with the Interdisciplinary Care Team, ensures facilitation of the discharge and transfer process.

   a. Arrangements to a receiving practitioner/provider are made

   b. Availability of a required bed and/or service(s) in receiving the setting are arranged

   c. The individual care plan accompanies the Member to the receiving setting

3. Seaside Health Plan monitors the implementation of the discharge plan to ensure that psychosocial and health needs are met.

4. Post Hospital Discharge Member Calls are placed including but not limited to the following:

a. Care/Case Manager calls the Member upon discharge from the inpatient setting to confirm the discharge plan and to educate and screen the member for additional gaps in care that may benefit or require assistance from Case Management intervention.

b. Medication review ensuring Member has appropriate medication.

c. Call with family or Responsible person provides an opportunity to communicate information related to community services available to assist with ongoing care and service.

IV. Communications

Seaside facilitates safe transitions by conducting or assigning providers tasks and monitoring system performance.

On planned and unplanned transitions from any other setting, providers communicate with the member or responsible party about the care transition process within 2 business days.

On planned and unplanned transitions from any setting to any other setting, providers communicate with the member or responsible party about changes to the member's health status and plan of care within 2 business days.

On planned and unplanned transitions from any setting to any other setting, Seaside provides each member who experiences a transition with a consistent person responsible for supporting the member through transitions between any points in the system within 2 business days.

A. Seaside Health Plan ensures timely and sufficient communication between the Interdisciplinary Care Team through the following processes:

1. The Care/Case Manager, physician, physician office, facility or other assigned staff contacts the member prior to the upcoming hospital admissions and discusses expectations, assesses the member's condition and ability to follow the treatment plan, advises members of probable length of stay and helps anticipate and arrange for services at discharge.

2. The Care/Case Manager works collaboratively with the Interdisciplinary Care Team to systematically identify fragmented care for Members with acute needs and to:

   a. Clarify diagnosis, prognosis, therapies, daily living activities; enforce treatment plans and orders;

   b. Discuss member's course of progress and needs;

   c. Identify plateaus, improvements, regressions and depressions; and

   d. Communicate with the Member and/or responsible party about the care transition process and changes to the member's health status/or and care plan.

3. The Care/Case Manager conducts and facilitates discharge planning upon notification of an admission to a facility. Discharge planning needs are assessed and continuity of care is facilitated through coordination between the facility, interdisciplinary care team and Seaside Health Plan as needed to ensure a timely and safe discharge.

4. When the attending physician has determined that the member no longer requires inpatient stay and authorizes discharge, the discharge and/or care transition process must be communicated to the member and a written discharge plan provided at the time of discharge. The plan must be understandable to the member and/or his or her family/responsible party.

5. The Care/Case Manager informs the member's usual practitioner, verbally or in writing, of the transition of care and documents in the medical record within 5 business days.

V. Reduction of Avoidable and Unplanned Transitions

A. Reducing Unplanned Transition

1. Seaside Health Plan identifies Special Need Plan members at high risk for transitions by various means including referrals to Case Management by internal Health Plan associates, by Member's caregivers, or by self-referral.

2. Reports used by Care/Case Manager to identify Members at risk include but are not limited to:

    a. Daily inpatient census.
    b. Planned admit report.
    c. Monthly readmission report.
    d. ER Daily & monthly utilization report.
    e. Pharmacy and Durable Medical Equipment utilization reports.
    f. Health Plan HRA information.

3. Seaside Health Plan minimizes unplanned transitions and works to maintain members in the least restrictive setting possible by analyzing the above report data at least monthly thru a transition of care analysis team, to identify individual members at risk.

4. The transition of care team may include some or all of the following staff:

    a. Registered Nurse
    b. Licensed Vocational Nurse
    c. UM Medical Director
    d. Utilization Management coordinator
    e. Social Services expert

    The transition of care analysis team will meet monthly to Analyze rates of all member admissions to facilities and ED visits.. Analysis will also be done via ICE Reports quarterly and annually.

B. Coordinating Care

1. Each Member will be assigned a Care/Case Manager who will serve as the member's primary point of contact upon enrollment.
2. Upon identification of member at risk, the Care/Case Manager will:

    a. Contact the member at risk or responsible party to determine if services that would reduce risk; such as home care or DME could reduce the risk of hospitalization. The Care/Case Manager may contact the usual practitioner as needed.

    b. Refer to other care management programs such as disease management, pharmacy, and behavioral health as appropriate.

C. Educating Members

1. During the course of Case Management activities, Seaside Health Plan provides the Special Needs member with educational information regarding how to maintain health and remain in the least restrictive setting and reduce their risk of hospitalizations and other unplanned transitions.

2. Education includes both telephonic and written communication as applicable to individual member's needs.

VI. Analyzing Performance

A. For all transitions, Seaside conducts an annual analysis of its aggregate performance in:

    i. Communicating with the member or responsible party about the care transition process within 2 business days;

    ii. Communicating with the member or responsible part about changes to the member's health status and plan of care within 2 business days;

    iii. Providing each member who experiences a transition a consistent person responsible for supporting the member through transitions between any points in the system within 2 business days.

B. Analysis of performance on managing care transitions are evaluated from population samples and per ICE recommendation performed annually with the following measures:

    iv. Data Elements

        1. Number SNP Hospital Admits:
        2. Number SNP member SNF/LTC Admits
        3. Number SNP Admits through ER
        4. Number ER Visits SNP members
        5. Number of other setting transitions (as required by health plan)

v. Compliance with Timeframes

1. % Care Plan Transitions in 1 business day
2. % Practitioner Notification of Transition within set timeframe
3. % Member/Caregiver communication within set timeframe

vi. Identification of Transitions

1. % SNP Member Hospital admits identified in 1 business day
2. % SNP Member SNF/LTC Facility Admits identified in 1 business day

History: New

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