Transition of Care

Care Coordination Training Module #7

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Transition of Care

Transitions are a time when members are often very vulnerable. The Care Coordinator has an important role in ensuring that the member has a smooth transition. This may include communication and follow up regarding services that need to be implemented, ensuring everyone on the Interdisciplinary Care Team (ICT) is aware of any changes, or ensuring appropriate follow up occurs.

The Care Coordinator role is critical to the success of the member upon their return to usual care setting.

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Care Settings

Each time the member changes care settings, it is a new transition. Care settings may include:

- Home
- Acute Care/Hospital
- Inpatient Psychiatric Hospital
- Swing Bed
- Transitional Care Unit
- Nursing Facility (skilled or custodial)
- Inpatient Rehabilitation Facility
- Mental Health or Substance Use Disorder Residential Treatment

Importance of TOC Care Coordination

The Care Coordinator is tasked with ensuring that the member is successful during all transitions and upon the return to their usual care setting.

Care Coordinators help to ensure success by:

Ease member concerns of discharge

Help with adjustments to new care settings

Meet new needs

Reduce unsafe environment

Ensure the member understands changes

Reduce hospital readmissions

Reduce ED visits

Provide a consistent person to support the member through transition

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Without Care Coordination Support

Members are at risk of:

- Fragmented care
- Lack of follow up care
- Lack of ICT collaboration
- Unsafe care due to changes
- Unnecessary hospital readmission
- Lower quality of care/satisfaction
- Lack of member-focused care
- Unsafe medication management

Planned transitions

Care Coordinators still need to complete TOC process.

Reach out to member ahead of time to check in and plan.

Share essential information/communicate with facility as soon as able.

Prior to Discharge

- Determine from discharge planner if any new services or equipment are needed.
- Determine who is arranging for services.
- Confirm where member will go. What is best phone number to reach them?

Stressors Upon Discharge:

Understanding of orders and changes

Transportation

Scheduling follow up appts

Picking up prescriptions

Arranging home care

Arranging DME delivery

Return home: groceries, mail, heat/ac etc.

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Documentation Requirements

Transition Log **(Only REQUIRED for MSHO & ISNBC members)**

CC Notification Date

Documentation must be present to show:

- Admission/discharge dates
- Communication with the receiving care setting
- Communication with PCP
- Communication with the member/responsible party
- Return to usual setting conversations occurred
    - Verification follow-up appointment
    - Verification discharge instructions were received and understood
    - Verification of medication review completion
    - Verification member is able to manage medications or medication management system is in place
    - Verification of member's ability to verbalize warning signs and symptoms to watch for and how to respond
    - Verification of adequate food, housing, and transportation
    - Verification of safety in the home
    - Address concerns regarding: vulnerability, abuse, or neglect

Update the member's care plan and share with the member and their Interdisciplinary Care Team.

FAQs

What should a Care Coordinator do when they learn about a hospital admission when the member has already discharged home?

MSHO/ISNBC: CC will need to contact the member and complete **BOTH** transition logs and PCP notification.

MSC+/SNBC: CC will need to ensure all documentation requirements are met for **BOTH** transitions and PCP notification.

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

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FAQs

What if the Care Coordinator learns about the transition several weeks after it occurred?

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.

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FAQs

What should a Care Coordinator do when they cannot reach the member post-hospitalization?

Document your contact attempts, which can include a letter as well and complete BOTH transition logs (MSHO & ISNBC) and PCP notification.

Care Plan/Support Plan can be updated with information on reason for admission and dates.

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Case study- Notification

The first step of the transition process is CC notification of transition. This may occur through the CC receiving the Daily Admission Report via email from Medica, an internal EMR alert, a call from the member/their family/guardian, or communication from providers.

Within 1 business day of this notification, Care Coordinators must complete the first transition log or appropriate documentation.

CCs must have contact with the member or their responsible party, the receiving setting, and the PCP at a minimum.

TRANSITIONS OF CARE (TOC) LOG

TOC tasks should be completed by the CC within one (1) business day of notification of each transition.

Member Name: Bonnie Johnson		**Care Coordinator: Ashley Heehn**	**MCO/Health Plan Member ID#: 01234567**
Product: MSHO		**Agency/County/Care System: Medica**	
Transition #1			
Notification Date: 9/22/2023	**Transition Date:** 9/20/2023	**Transition From: (Type of care setting)** Home **Is this the member's usual care setting?** ☒Yes ☐ No	**Transition To: (Type of care setting)** Hospital
Transition Type: ☐Planned ☒ Unplanned		**Reason for Admission/Comments:** Fall, Hip Fracture	
Contact member/responsible party to offer assistance with transition: 9/22/2023 **Shared CC contact info, care plan with receiving setting—Date completed: 9/22/2023** **Name and title of receiving setting contact: Sarah, unit social worker.**			
Notified PCP of transition—Date completed: 9/22/2023 Name of PCP: Dr. Bernard Method of PCP contact: ☒Fax ☐Phone ☐ EMR ☐ Secure e-mail **(OR)** ☐Member's PCP was the Admitting Physician **Comments: CC contacted Essentia Health St. Mary's by phone and was transferred to 8W where member is presently admitted. CC spoke to unit RN Amy and unit social worker Sarah. They reported member had a fall in her home which resulted in a hip fracture. She had surgery upon admission and will likely d/c to a TCU early next week. CC spoke to member who reported she understand plan to d/c to TCU and reported her pain has been well controlled.**			

Case Study- PCP Notification

FAX

CARE TRANSITION – PROVIDER NOTIFICATION

DATE:	9/22/23		
TO:	Dr. Bernard	FROM:	Ashley Heehn, CC/CM
COMPANY:	Essentia West Duluth Clinic	COMPANY:	Medica
FAX:	218-786-0000	FAX:	952-992-0000
PHONE:	218-786-0001	PHONE:	952-992-0001
SUBJECT:	Care Transition Notification		

MESSAGE:

As your patient's/client's care coordinator/care manager, **I was notified** on 9/22/23 that your

Patient/Client Name: **Bonnie Johnson** DOB: **10/31/1950**

☒ was **hospitalized/admitted** to **Essentia St. Mary's** on **9/20/22**.

☐ was **returned to their usual care setting/home** on .

As your patient's/client's care coordinator/care manager; I will be assisting the member during the transition of care process and manage activities such as:

- Support the member through the transition process.
- Provide follow-up care and coordinate needed services or equipment.
- Facilitate communication between the member and the provider.

Please contact me if you have any questions about this member's/client's care transition.

Thank you.

Comments: It was reported that Bonnie had a fall in her home which resulted in a hip fracture. She had surgery and will likely transfer to a TCU early next week.

PCP notification can be done via:

- Phone
- EMR (for appropriate care systems)
- Fax
- CCs can document if the PCP was the admitting physician.

Case Study-Second Transition

The CC should continue to follow the member as they experience any change in care setting. It is common for members to transition from a hospital to a rehab unit or TCU before returning to their usual care setting. Remember to again complete required documentation or the second TOC log as appropriate.

Transition #2 *Complete additional tasks below, if this transition is a return to usual care setting.

Notification Date: 9/25/2023 Transition To: (Type of care setting)* TCU

Transition Date: 9/25/2023 Transition Type: ☒Planned ☐ Unplanned

Contact member/responsible party to offer assistance with transition: 9/25/2023

Notified PCP—Date completed: 9/25/2023 Name of PCP: Dr. Bernard

Shared CC contact info, care plan/services with receiving setting or, if applicable, home care agency—Date completed: 9/25/2023

Name and Title of receiving setting contact Katie, TCU RN Manager

Comments: CC received call from hospital social worker confirming member will d/c today to TCU. CC spoke to member to discuss the move. CC contacted TCU and spoke to RN Manager. It is anticipated to be a short-term stay, less than 30 days. She will notify CC of planned care conferences.

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Case Study-Second Transition

FAX

CARE TRANSITION – PROVIDER NOTIFICATION

DATE:	9/25/23		
TO:	**Dr. Bernard**	FROM:	**Ashley Heehn, CC/CM**
COMPANY:	**Essentia West Duluth Clinic**	COMPANY:	Medica
FAX:	**218-786-0000**	FAX:	**952-992-0000**
PHONE:	**218-786-0001**	PHONE:	**952-992-0001**
SUBJECT:	**Care Transition Notification**		

MESSAGE:

As your patient's/client's care coordinator/care manager, **I was notified** on 9/25/23 that your

Patient/Client Name: **Bonnie Johnson** DOB: **10/31/1950**

☒ was **hospitalized/admitted** to **North Shore Estates** on **9/25/22**.

☐ was **returned to their usual care setting/home** on .

As your patient's/client's care coordinator/care manager; I will be assisting the member during the transition of care process and manage activities such as:

- Support the member through the transition process.
- Provide follow-up care and coordinate needed services or equipment.
- Facilitate communication between the member and the provider.

Please contact me if you have any questions about this member's/client's care transition.

Thank you.

Comments: Bonnie was admitted to North Shore Estates TCU today. It is anticipated to be a short-term stay, less than 30 days.

PCP notification is required for each transition.

Be sure to continue to document all contacts with member, the facility, and other members of the ICT in your case notes.

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Case Study- Return Home

Upon the member's return to usual care setting, CC's must again complete all required documentation or TOC log.

Transition #4 (if applicable) *Complete additional tasks below, if this transition is a return to usual care setting.

Notification Date: 10/16/2023 **Transition To: (Type of care setting)* Home**
Transition Date: 10/16/2023 **Transition Type:** ☒Planned ☐ Unplanned
Notified PCP—Date completed: 10/16/2023 Name of PCP: Dr. Bernard
Contact member/responsible party to offer assistance with transition: 10/16/2023
Shared CC contact info, care plan/services with receiving setting or, if applicable, home care agency—Date completed: 10/16/2023
Name and Title of receiving setting contact John, Home Care Coordinator

Comments: CC confirmed with TCU SW that member discharged home this morning. Member's DME was ordered and is to be delivered to her home today. Member's daughter is staying with her at her apartment this week to ensure a smooth return home. Senior Friends will be providing PT/OT/RN visits as ordered. Member has a follow up appointment scheduled on Friday which her daughter intends to drive her to.

Case Study Return Home

FAX

CARE TRANSITION – PROVIDER NOTIFICATION

DATE:	10/16/23		
TO:	Dr. Bernard	FROM:	Ashley Heehn, CC/CM
COMPANY:	Essentia West Duluth Clinic	COMPANY:	Medica
FAX:	218-786-0000	FAX:	952-992-0000
PHONE:	218-786-0001	PHONE:	952-992-0001
SUBJECT:	Care Transition Notification		

MESSAGE:

As your patient's/client's care coordinator/care manager, **I was notified** on 10/16/23 that your

Patient/Client Name: **Bonnie Johnson** DOB: **10/31/1950**

☐ was **hospitalized/admitted** to on .

☒ was **returned to their usual care setting/home** on **10/16/23**.

As your patient's/client's care coordinator/care manager; I will be assisting the member during the transition of care process and manage activities such as:

- Support the member through the transition process.
- Provide follow-up care and coordinate needed services or equipment.
- Facilitate communication between the member and the provider.

Please contact me if you have any questions about this member's/client's care transition.

Thank you.

Comments: Bonnie returned home on 10/16/23. She has PT/OT/RN visits in place at this time. Follow up appointment scheduled on 10/20/23.

Case Study- Return Home

RETURN TO USUAL CARE SETTING *Complete tasks below when the member is discharging TO their usual care setting.

For situations where the Care Coordinator is notified of the discharge prior to the date of discharge, the Care Coordinator must follow up with the member or designated representative to confirm that discharge actually occurred and discuss required TOC tasks as outlined in the TOC Instructions. (This includes situations where it may be a 'new' usual care setting for the member. (i.e., a community member who decides upon permanent nursing home placement following hospitalization and rehab).

Discuss with Member/Responsible Party:

Check "Yes" - if the member, family member and/or SNF/facility staff manages the following: If "No" provide explanation in the comments section.

☒ Yes ☐ No Does the member have a follow-up appointment scheduled with primary care or specialist? *Medical transitions-the follow up should be within 15 days of discharge. Mental health hospitalizations—the follow up appointment must be with a mental health provider within 7 days discharge*

☒ Yes ☐ No Has a medication review been completed with member? *If no, refer to PCP, home care nurse, MTM, pharmacist*

☒ Yes ☐ No Can the member manage their medications or is there a system in place to manage medications? *(e.g. home care set-up)*

☒ Yes ☐ No Can the member verbalize warning signs and symptoms to watch for and how to respond?

☒ Yes ☐ No Does the member have a copy of and understand their discharge instructions? *If no, assist to obtain copy of discharge instructions, review discharge instructions, and assist to contact PCP to discuss questions about their recent hospitalization.*

☒ Yes ☐ No Does the member have adequate food, housing and transportation? *If no, add goal and discuss additional supports available to the member*

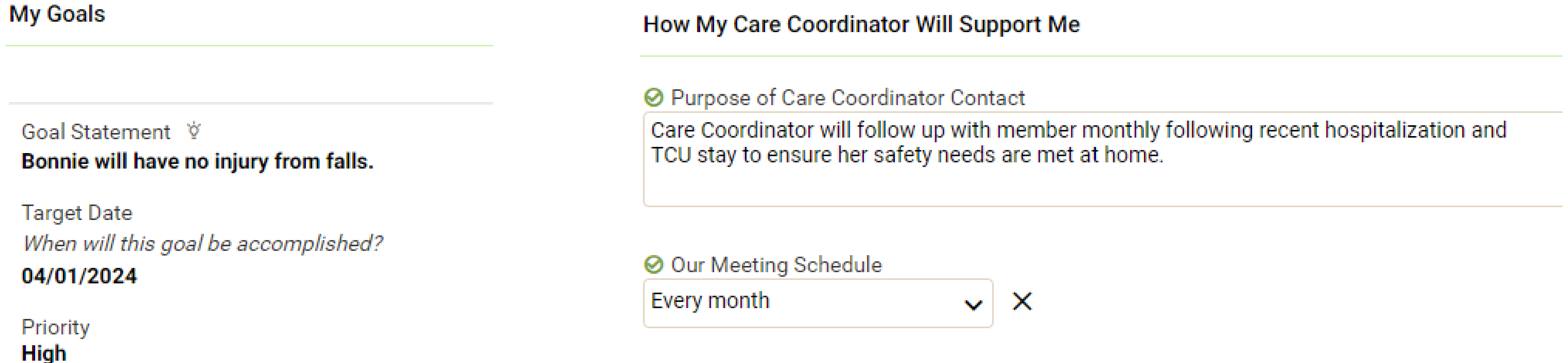
☒ Yes ☐ No Is the member safe in their home? *If no, document needs and support provided*

☐ Yes ☒ No Are there any concerns of vulnerability, abuse, or neglect? *If yes, document concerns and actions taken by Care Coordinator as a mandated reporter*

☒ Yes ☐ No Have you updated the member's care plan? *Add new diagnosis, medications, treatments, goals & interventions, as applicable. If No, provide explanation in comments.*

Comments: **CC spoke to member on 10/16/23 to confirm she made it home. She is happy to sleep in her own bed again. She reported she has a follow up appointment scheduled and appropriate supports in place in her home.**

Case Study-Return Home



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Resources

Refer to the Care Coordinator Hub here: Care Coordination | Medica

Transition of Care

- Notification of Care Transition Fax (DOC)
- Transition of Care Policy (PDF)
- Transition Log (DOC)
- Transition Log Instructions (PDF)
- Transition of Care Hospital Readmission Prevention Resource Guide (PDF)

If you have questions regarding this audit element, please reach out to your auditor or email MedicaSPPRegQuality@Medica.com.

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