Transitions of Care (TOC)
What is a “Transition of Care”? 

• Member’s movement from one care setting to another setting due to changes in the member’s health status.

• Examples: member moves from home to a hospital as the result of an exacerbation of a chronic condition; member moves from hospital to a skilled nursing facility.
What is a “Care Setting”? 

- The place where the member receives health care and health-related services

- Examples: member’s home; hospital; skilled nursing facility; rehabilitation facility

- “Usual care setting”

- “Receiving care setting”
Importance of TOC Coordination

• Older adults moving between health care settings are vulnerable to:
  − Fragmented care due to lack of follow-up.
  − Health care providers not communicating.
  − Unsafe care due to changes with medication regimes or lack of medications, and self-management concerns.

• CMS requires all Medicare Advantage-Special Needs Plans to develop a process to coordinate care when members move from one care setting to another to avoid potential adverse outcomes.

  Care Coordinators are the key to preventing problems during transitions.
TOC & Health Plan Collaboration

• Minnesota Health Plans worked together in a collaborative effort to streamline processes that make TOC simpler for care coordinators:
  – Core requirements are consistent across plans.
  – Common data elements across plans.
• To simplify the requirement to track the care transition process, the health plans have created a form called the *Individual Care Transition Log*.
• Use of this form is required whenever a TOC has occurred.
• Complete a log entry for each TOC.
Example of Care Transition

- Member has a total of **three** transitions and each one would have its own entry on the Individual Care Transitions Log.
  - Member leaves home and is admitted to a hospital. (one transition).
  - Member is discharged from a hospital to a skilled nursing facility. (one transition).
  - Member returns home. (one transition).
Providing Proactive Support

- Care Coordinators (CCs) act as a consistent person to support the member throughout the transition, and to help prevent transitions:
  - Educate to avoid unnecessary ER visits and hospitalizations.
  - Look for risks (falls, lack of preventive care, poor chronic care disease management) and take action.
  - Work with health plans to identify high risk members.
Identifying Transitions

- Daily Authorization Report
  - Hospitalizations.
  - Planned procedures requiring prior authorization.

- Discussion with Members
  - Talk about outpatient procedures that might require care plan changes, TOC management.

- TOC Brochure
  - Review brochure with members/responsible party, make them aware of their role in transitions.
CC Communication With Receiving (non-usual) Care Setting

- For transitions to settings other than member’s usual care setting, the CC is required to
- Identify an appropriate contact within the unit/floor such as a discharge planner or social worker
- Communicate the following with the receiving setting within 1 business day of notification of the transition:
  - CC contact information.
  - **Current care plan or summary**, hospital/SNF discharge instructions, and services (home care, etc).
  - Current meds, chronic conditions, current treatments, etc.
  - Service providers
    - Usual provider and/or specialty care provider contact information;
  - Other relevant information.
- Communication may be done via phone, fax, or flag in an electronic system.
The CC is required to notify PCP of admission, if PCP was not admitting physician.

- By fax, phone, or flag in an electronic system.
- Within 1 business day of notification of the transition.

- If PCP is admitting physician, no additional notification is required.
CC Communication for Transitions Back to Usual Setting or “New” Usual Setting

- For transitions back to their usual care setting, or “new” usual care setting (i.e. – a community member moves to permanent nursing home), the CC is required to:
  - Communicate with receiving setting:
    - CC contact information.
    - Current care plan and services, providers, etc.
    - Information about the transition.
    - Relevant information – current services, informal supports, medications, advance directives, etc.
  - Notify PCP of transition.
  - Communicate with Member/Responsible Party.
Communication with Member/Resp. Party Upon Return to Usual Setting

• Reach out to the member, **upon return to their usual setting**, within **1 business day of notification** of the transition, to assess needs and prevent readmissions.

• Outreach may be telephonic or face-to-face.

• Discussion should include:
  – Care transition process
  – Changes to member’s health status
  – Changes to care plan
  – Educate about how to prevent unplanned transitions/re-hospitalizations
  – Provide contact info
  – Reassure member
  – 4 Pillars to Optimal Transition Management.

• Update the Care Plan
4 Pillars to Optimal Transitions

   - Medication changes/new prescriptions filled.

2. Patient Centered Health Record- across providers and settings.
   - Discharge instructions, care plan, etc.

3. Follow-Up.
   - Follow-up appointments, transportation, services, DME, supplies, etc.
   - Changes in functional needs (bathing, eating, dressing, transfers, etc.)

4. Red Flags.
   - Understanding if condition changes or gets worse.
TOC Handouts

- Individual Care Transition Log.
- Individual Care Transition Log Instructions.
- Care Transition Notifications to PCP.

All handouts are located on the UCare website.
Transition of Care Log and Tasks

- TOC tasks are identified on the TOC log.
- All TOC tasks should be completed by the CC within 1 business day of notification of each transition.
Late Notice on Transitions

• If CC finds out about the transition 15 or more days after the transition after the member has returned to their usual setting, no TOC log is required.

• The CC is still required to follow up with the member/rep to:
  – Discuss the TOC process
  – Discuss changes to the member’s health status and POC
  – Provide education about how to prevent TOCs
  – Discuss 4 Pillars of Optimal Transitions
    • Document this discussion in case notes.
    • Case Notes may be audited, so ensure this documentation is present in case notes, since no log is required.
Up to 3 transitions can be documented on each log.
Remember to count each move as a separate transition, and document separate transition activities.
TOC includes when a member goes back and forth between settings – each time is considered a separate transition.
Save all transition documents in case notes.
Be sure to complete all applicable areas of the log.
Care Coordination Summary

• The Care Coordinator is the key to preventing and managing care transitions by:
  – Educating members about prevention and avoidance of transitions of care.
  – Facilitating communication to improve member’s health and safety.
  – Developing relationships with members, local practitioners, hospitals, nursing facilities, etc.
  – Monitoring members at higher risk to prevent unplanned care transitions.
Thank you for your participation in this training!!

Please direct questions to the Clinical Liaisons via email at clinicalliaison@ucare.org,

Or by phone at 612-294-5045.