Community Care Alliance of Illinois

POLICY AND PROCEDURE

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Date(s) Reviewed:	Department Approval: [signature] Dr. Connie Zak
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Subject: Transition of care and Continuity of Care

Policy: It is the policy of Community Care Alliance of Illinois to have a process to identify and coordinate care for members who are at risk for a transition from one level of care to another, or who need to transition secondary to insolvency or unexpected closure of a provider site, or PCP termination for any reason. The goal is whenever possible to prevent the unplanned transition. When a transition does occur (both planned and unplanned) interventions are implemented to facilitate a medically safe and effective transition.

Scope: This policy applies to all Community Care Alliance of Illinois lines of business covered

Definitions:

Transition: Movement of a member from one care setting to another as the member's health status changes.

Care Setting: The provider or place from which the member receives health care and health related services. In any setting, a designated practitioner has ongoing responsibility for the member's medical including psychiatric care. Settings may include home, home health care, acute care, skilled nursing facility, custodial nursing facility, or rehabilitation facility.

Procedure:

CCAI will manage transition of care and continuity of care for new members and or members moving from an institutional setting to a community living arrangement

Transition of Care:

1. Identification

1.1 Members at risk for a transition from one level of care to another, or who have other needs such as psychiatric or in Home and Community Based Waiver Programs will be contacted by their Care Coordinator.

1.1.1 The Care Coordinator provides support and assistance to resolve any problems with health care or access to needed services.

1.2 Members of the Care Coordination team meet at least weekly to review aggregate reports to identify those members who are at risk for a transition.

1.2.1 The information analyzed may include the member's Health Risk Assessment, admission and readmission reports, emergency department visits and other episodes of care including provider office visits, medication profiles, lab and radiological studies.

1.2.2 The committee includes but is not limited to the Director of Care Coordination, Care Coordinators, Medical Director and UM specialist.

1.2.3 Appropriate interventions are identified and implemented based upon the individual member circumstance.

1.3. For planned transitions, CCAI is notified through the prior authorization process.

1.3.1 All planned acute and skilled nursing facility admissions require prior approval including transfers to the skilled nursing facility from an acute hospital or from home.

1.4. When a transition occurs, (planned or unplanned) facilities are required to notify CCAI of a member's admission within one working day of the admission.

1.4.1 This is done by the facility submitting to CCAI a hospital face/cover sheet from the member's medical record which contains appropriate patient information for concurrent review.

1.5. Notification of an admission or other transition may also occur through communication with the member or their responsible party, their primary care provider, specialist or ancillary provider.

2. Transition Communication

2.1 When the Community Care Alliance is notified of a member's, CCAI facilitates and supports appropriate communication with the member and their providers throughout the transition process.

2.2 Primary Care Providers (PCP) may be notified of a member's facility admission via CCAI provider portal, fax, secured email, or telephone call.

2.3 For transition from home to a facility the member and/or responsible party are to take with them their Personal Health and medication record. CCAI reminds the member to do this through their telephonic contact and through member newsletters as necessary.

2.4 When a member transitions from one facility to another facility an Inter-facility transfer form will be used to communicate medical information between the sending and receiving facility.

2.4.1 The transfer form will summarize the member's medical issues and medications and acts as a plan of care.

2.4.2 The member's care plan will be sent with the member or is sent directly to the receiving setting within one business day of notification of the transition.

2.4.3 CCAI will delegate the form's completion and transmission to facility personnel and the attending physician responsible for care in the current setting.

2.5. CCAI delegates to the attending physician, hospitalist, and/or the sending setting's discharge planner, the responsibility to communicate with the member or responsible party concerning the care transition process, changes in the member's health status and updates to the plan of care throughout the hospital stay and to summarize the member's health status and plan of care within one day of the transfer.

2.5.1 The member's primary care team is notified of changes to the member's health status or plan of care via the hospital discharge summary.

2.5.2 CCAI Care Coordinators will monitor compliance with this process by following up with the facility and the member after discharge.

2.6. CCAI will be in communication with the facility's discharge planner who is coordinating the transition with the member and/or the responsible party.

2.6.1 In some instances, the receiving facility will do an onsite assessment interview with the member and/or the responsible party prior to the transition and they will communicate with the member at that time as well.

2.7. The member's Care Coordinator will be responsible for supporting a member's transition between any points in the system within one working day if transition is urgent, or within three working days if the transition is not urgent.

2.7.1 The member has direct access to their Health Coordinator by phone and/or through the member services' call center.

2.8. For members transitioned to a skilled or custodial care setting CCAI UM specialist will maintain communication with the receiving facility and while conducting a concurrent review.

2.8.1 Once the member is medically able to be transitioned to a home care setting the skilled or custodial nursing facility completes a discharge plan of care and communicates the plan of care to the member or responsible representative, and to the primary care team assuming the member's care upon discharge.

2.8.2 The information provided includes the member's current health status, treatment summary, medication regimen and any other services the member will require upon discharge.

2.9. For members transitioned to a home care setting the Care Coordinator will contact the member within 72 hours of transition to home to confirm member understands of the plan of treatment and confirms follow-up with primary care provider and/or specialty care appointment has been made. The Care Coordinator will work with the community agencies to insure that long-term

services and supports and community resources are put in place to overcome barriers as necessary.

2.10 The member's consistent point of contact remains the primary care team.

3. Reducing Unplanned Admissions and Emergency Department visits

3.1. Members of the Utilization Management and Care Coordination teams meet twice a week to discuss all members who are currently hospitalized and all ED visits.

3.1.1 The meeting is designed to evaluate the member's level of care, and to identify appropriate interventions necessary to facilitate a smooth transition to the next level of care, and to prevent an unplanned admission/readmission and to prevent ED visits.

3.2. The Care Coordination Team meets as necessary, but not less than monthly to discuss members who have not been hospitalized, who have been in the ED, or may be at high risk for a transition.

3.2.1 These members are identified through referral from primary care providers and specialists, case managers from the emergency departments and other social service agencies, PHC internal staff, family members or responsible care givers, and through the analysis of internal data.

3.3. CCAI will take steps to avoid or minimize hospital admissions and ED visits by tailoring interventions specific to the member's needs. The interventions may include, but are not limited to:

3.3.1 Increased contact by the Case Manager, increased frequency of Interdisciplinary team, increased PCP or specialists' visits.

3.3.2 Long Term Services and Supports Coordinator may arrange for a Home Safety Evaluation/Installation of grab bars as necessary or other long term services and supports as needed.

3.3.3 Assistance with transportation to and from appointments

3.3.4 Referral to appropriate social service organizations

3.3.5 Providing education to the member concerning their diagnosis, warning signs and appropriate actions to take when changes occur.

3.4. When a member is hospitalized their risk stratification is re-determined.

3.4.1 If member is admitted to an Anchor Health Home the care coordinator will visit the member while hospitalized and assist them with completion of their Personal Health Record, provide education regarding the member's condition and warning signs of complications, and will confirm that appropriate documentation has reached all appropriate providers.

3.4.2 The Care Coordinator will communicate with the member or if needed will visit the member in their home within 48 hours post discharge.

3.4.3 The Care Coordinator will again discuss warning signs of complications with the member and or responsible party and conduct a medication review and reconciliation.

3.4.4 The member's compliance with his/her treatment plan will be reviewed as well all follow-up appointments and transportation needs.

3.5 All members identified as to have Home and Community Waiver Services upon enrollment will be contacted by their Long Term Services and Supports Coordinator to transition current waiver services to covered services. The existing service plan will remain in effect for at least a 180 day transitional period unless changed with the input of the member and only after a face to face comprehensive risk assessment is completed.

3.5.1 A member who is receiving a Home and Community Waiver Services and ceases to be eligible for the services but continues to be eligible for HCBS Waiver or equivalent home care services, the member's existing service plan will be transmitted to the applicable State agency with fifteen days after notification of disenrollment.

3.6 All members identified with needing psychiatric support will be referred to a PsycHealth care manager.

3.6.1 The PsycHealth care manager will be added to the interdisciplinary care team and will be part of the team meetings and communications on a regular basis as determined by the team.

4. Monitoring of Transition Quality

4.1. CCAI will meet at least annually to analyze data regarding hospital admissions and readmissions, emergency department visits, long term services and supports, psychiatric care transition communication and member complaints regarding transitions of care and to identify areas for improvement.

4.2. To confirm appropriate communication was done during a transition, CCAI's Facility Quality Improvement Site Reviewer selects a random sample of records for members who have been hospitalized to determine if the PCP was notified of the discharge and provided appropriate clinical information by the hospital or by other means. The results of these audits are reported to the QA/UM Committee annually.

4.3. PHC will meet least annually with contracted hospitals. Topics include the timely and appropriate transmission of information from the emergency department and hospital discharge summaries to the primary care physician and/or specialist, and any operational issues that may impact transitions.

4.4. For Skilled Nursing Facility to home transitions, CCAI will monitor compliance with communication by sending the skilled or custodial facility a letter requesting confirmation that the information has been sent to the primary care physician within one working day of the member's discharge. A Compliance summary is reported CCAI QA/UM committee annually.

Continuity of Care

The care coordinator shall provide coordination of care assistance to prospective members to access a PCP or WHCP or to continue a course of treatment, before the coverage becomes effective. If requested

to provide coordination of care by the prospective members, or if CCAI has knowledge of the need for such assistance. The assigned care coordinator shall attempt to contact the prospective member no later than two (2) business days after CCAI is notified of the request for coordination of care.

1. Eligibility:
   In the event that the out-of –network provider of a new member who is
   - Engaged in an active course of covered treatment that meets clinical criteria/guidelines with an out of network provider.
   - The performance of procedure/surgery that is authorized as part of a document course of treatment and that has been recommended and documented by the provider to occur within ninety (90) days of the effective date of coverage for a newly covered member.
   - Third trimester pregnancy and the immediate postpartum period.
   - Less than six (6) months post-transplant or who are actively listed at a facility for a solid organ or Hematopoietic Stem Cell transplant as (HSCT) determined appropriate after review.

2. Benefit determination
   - Written request (Transition of Care form) must be submitted within ninety (90) days of the enrollment or renewal date or within ninety (90) days from the date of the change in the provider's contract, e.g. discontinuation of the provider's contract for reasons other than quality deficiencies.
   - Transition of care benefits may be authorized for a period up to ninety (90) days from the effective date.
   - The availability of transition of care coverage does not guarantee that a treatment is medically necessary. Nor does it constitute pre-certification of medical services to be provided. Depending on the actual request, a medical necessity determination and formal pre-certification may still be required for a service to be covered.
   - Transition of care request will be forwarded to the UM specialist for review.
   - The UM specialist will consult with the Medical Director, within seventy-two (72) hours, decide on a case by case basis whether a transition period of care provided by the Non-Participating provider is indicated.
   - If the transition of care is approved by the Medical Director, the member will receive the in-network level of coverage for treatment of specific condition by the health care professional for a defined time frame, as determined by CCAI. All other conditions must be care for by an in-network health care professional in order to be covered as in-network level.

3. Coverage determinations communication
   - Verbally for members with pending eligibility when the transition of care request is accompanied by a signed plan enrollment form.
   - Written notice for coverage determination once the member is designated as eligible in the CCMS system

Exceptions: N/A

Change History:
Changed Policy Statement
Added 3.5.1 – for time line clarification