Transitions of Care (TOC)

Care Coordination 101 Supplemental Training

Why is Supporting Members in a TOC Important?

A transition of care is when a member moves between health care settings. For example, from home to the hospital or hospital to a nursing home. Moving between health care settings increases vulnerability:

- 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
- Risk of readmissions to hospital

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 key to a safe return home!

MN Encounter Alert Service (MN EAS)

In partnership with DHS, the Encounter Alert Service (EAS) allows providers (including care coordinators) serving Medical Assistance and Mn Care enrollees throughout the state to receive alerts, for individuals who have been admitted to, discharged, or transferred from, an EAS-participating hospital, emergency department, long-term care facility, or other provider organization in real time.

Care coordinators access MN EAS on business days to receive notification of assigned member's admissions and discharges. MN EAS also provide ER notifications and some SNF admissions.

Transition of Care Focus Areas

TOC logs, as required* (Documentation)

Notifying the PCP of transition within 1 business day of notification (phone/fax/EMR)

Sharing Support Plan with the receiving setting within 1 business day of notification

Communication with the member/representative within 1 business day of notification

4 Pillars of Optimal Transition & Support Plan Updates

*Use of TOC log is required for MSHO and Connect + Medicare members

Communicating with Receiving Setting

State your role, how you can help with support, resources, supplemental benefits and as important

What you know about the member's current services or lack of services.

Share a verbal summary of the persons support plan.

Document the details

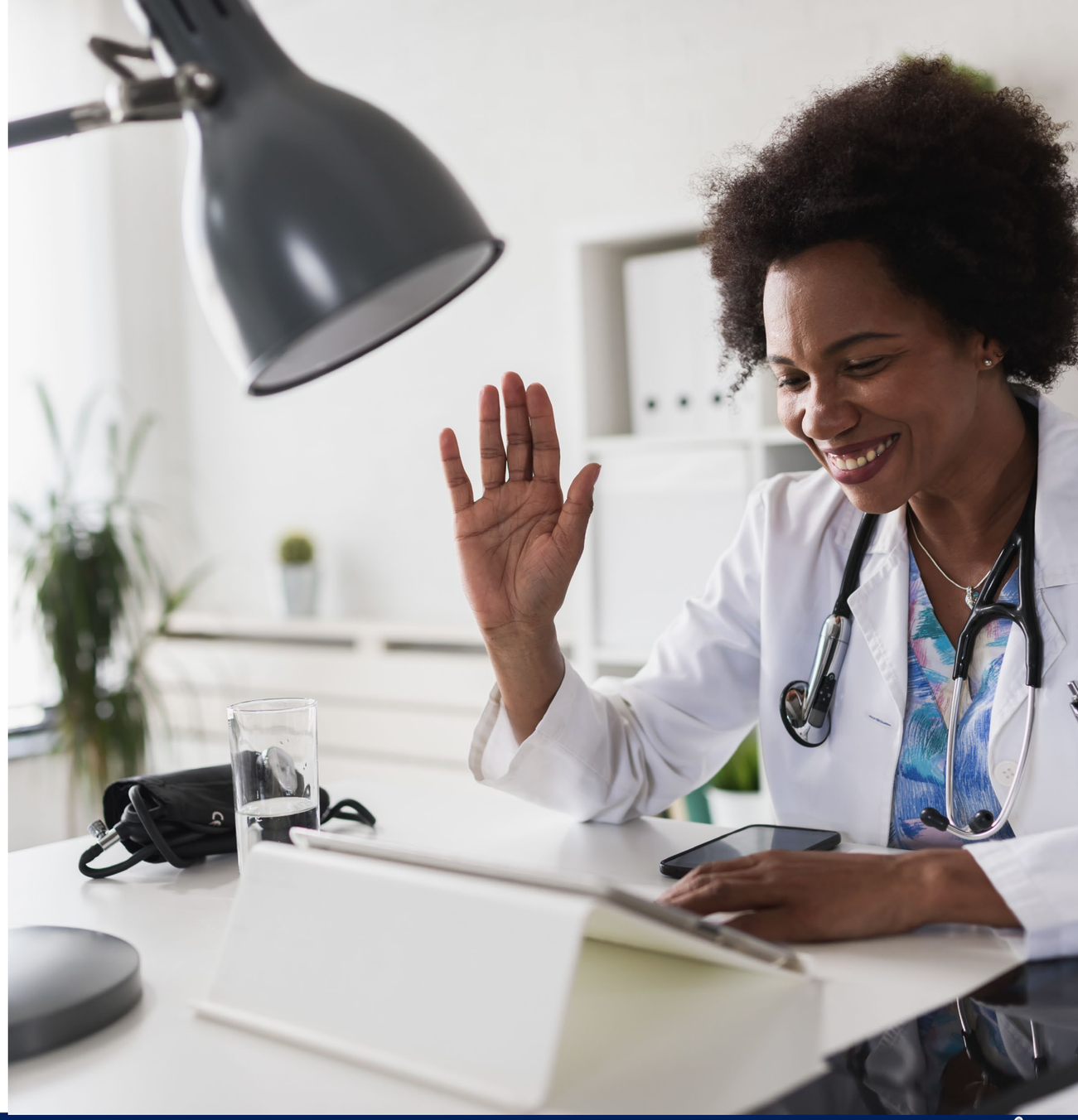
Who did you speak with?

What information was provided/received?

Create a follow-up plan.

PCP Communication

- The PCP communication must be completed via phone call, fax or EMR within 1 business day of notification of change in care settings.
    - Exception: if the PCP is the admitting physician – document accordingly.
- Sharing updates about the patient's condition is an important part of the care coordinator role.
- With significant changes, use your professional judgement if the support plan is reshared.



Communication with Member/Representative

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

Two actionable attempts or more per CC judgement.

Discussion should include:

- Care transition process
- Changes to member's health status
- Changes to Support Plan
- Services/supports needed
- Education about how to prevent unplanned transitions/re-hospitalizations
- How to reach CC
- **Upon return to usual care setting**: 4 Pillars to Optimal Transition Management

To Learn More:
TOC Member Handout

Four Pillars for Optimal Transition
Required upon return to usual setting

Pillar 1. Follow- Up Appointment

- Ideally w/in 15 days of discharge or 7 days for mental health

- **ASK:** When is your follow up appointment?
- How are you getting to your appointment?
- Can I assist with making an appointment?
- Stress the importance of keeping the appointment and address barriers.

- *Reference: TOC Instructions on Care Mgt and CC Home Page*

Pillar 2. Medication Self Management

- Determine if the member has a good understanding of medication regimen?

- **ASK:** Do you have all of your current medications?
- What changes were made to your medications?
- How do you remember to take them?
- Do you need help with setting up or taking medications?
- Consider a referral to SNV/HHA or MTM if eligible

Pillar 3. Knowledge of Warning Signs

- Is the member aware of the symptoms that indicate problems with healing or recovery?

- **ASK:** What are the warning signs that might tell you that you are having a problem?
- What should you do if symptoms appear?
- Who do you call if you have questions?
- Do you have those numbers readily available?
- Consider this a possible lead in question to Pillar 4!

Pillar 4. Personal Health Record

- Determine if the member utilizes a PHR

- **ASK: Did you receive a copy of your discharge summary? Let's review together…**
- Remember to bring discharge instructions to f/u appointments.
- Attempt to obtain DC Summary if member does not have a copy (as able).
- Offer to assist with creating or providing a personal health record for tracking health information (IE: Med list, Vaccine hx, BP results, etc.).

Document, Document, Document

Member outreach at every transition** (2 or more attempts to reach member).

Include names of those who you spoke with (SW, RN, SNF staff) and the content!

All areas of the TOC log are to be addressed or marked with “NA” if not applicable.

Document directly on the TOC Log.*

*(MSC+ and UCare Connect is not required to use the TOC LOG and may opt to document in case notes)

**If notification of discharged is received after 15 days of the transition to usual care setting, the TOC log is not required. Use clinical judgement when following up with members to support their health and safety and document in the member’s case notes.

Questions?

Clinical Liaisons

- MSC_MSHO_Clinicalliaison@ucare.org
- SNBCClinicalLiaison@ucare.org