UCare CT/CT+ MED and MSC+/MSHO

Care Coordination and Long-Term Services and Supports

Title: Transition of Care: Care Coordination Guidelines

Purpose: To provide guidance and instruction to care coordinators around the appropriate and required actions when members experience a change in care settings.

Summary: A member's movement from one care setting to another setting due to changes in the member's health status is called a Transition of Care (TOC). Example: a member is admitted to a hospital from their home as the result of an exacerbation of a chronic condition; then, the member moves from the hospital to a skilled nursing facility for ongoing care. Each move is one TOC.

Reference: Transition of Care (TOC) Scenarios | Transitions of Care recorded training

On an annual basis, care coordinators provide engaged members the Transition of Care Member Handout to assist in educating members about the TOC process. Care coordinators (CCs) act as a consistent person to support the member throughout the transition process. Care coordinators:

- Educate to avoid unnecessary ER visits and hospitalizations
- Look for risks (falls, lack of preventive care, poor chronic care disease management, social determinants of health and vulnerable adult concerns) and take action
- Share with hospital discharge planners the support and services the member currently has, assisting with discharge planning
- Identify when a member may need assistance to manage their medications
    - Refer to Medication Therapy Management as applicable
- Set up crucial follow-up appointments with primary care or specialists upon hospital discharge
- Utilize UCare supplemental benefits to aid in the reduction of readmission
    - Refer to LSS Healthy Transitions | Additional and Supplemental Benefits | ILOS & Post Discharge Meals

Definitions

Communication with the member/responsible party: During each transition, care coordinators offer assistance with the transition process. The process includes identifying members' risks, communicating and helping the member plan and prepare for transitions, and following up care after discharge.

- Communication should include an update of known medication changes, durable medical equipment (DME) products and service needs resulting from a change in the member's health status.
- Provide education related to the prevention of readmission and future unplanned care transitions
- Discussions can include, but are not limited to, reducing fall risk, improving medication management, addressing food insecurity, additional services, advance care planning, etc.

Notification Date: The date the delegate agency and/or care coordinator was informed of the transition.

Receiving Setting: Care coordinators share the support plan, including CC contact information, with the receiving setting. This includes home when home care services are in place, assisted living, hospital, SNF, TCU/rehabilitation facility, mental health, substance use disorder residential treatment and other applicable case managers (Behavioral Health Home, Targeted Case Manager or waiver case manager). If the transition is a return to the usual care setting with no services, care coordinators would document accordingly.

- Care Coordination Talking Points (Connect/Connect + Med | MSC+ MSHO) are available for care coordinators to reference and help explain the role of care coordination during admissions and discharges. This document can also be shared with receiving settings as needed.

Sharing the Support Plan: The support plan may include the support plan or a summary of the relevant support plan information, the hospital/SNF discharge instructions, or other relevant information. The support plan summary

and/or relevant information, which includes current services, informal supports, advance directives, medication regimen, CC contact information, etc., may be communicated via phone, fax, secure e-mail or in person**.**

- Collaboration with Behavioral Health Home Case Managers, Targeted Case Managers and community disability waiver case managers is a requirement during TOC.
- Release of Information (ROI): A release of information is required to share substance use disorder and treatment with a member's providers. If an ROI is not available for TOC communications, document the facts in the member record/TOC log.

Transition Date: The date the member moved from one care setting to another. If the date is not known, the care coordinator documents "unknown" for this item.

Transition Type: Planned transitions include elective surgery, planned move to a Skilled Nursing Facility (SNF), etc. Unplanned transitions include an unscheduled hospitalization after an emergency room visit, an unscheduled move to an SNF, etc**.**

Usual Care Setting: Most often, the usual care setting is where the member calls "home" and the location the care coordinator indicates on the TOC log in the "admission from". 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).

Four Pillars of Optimal Transition

When a member returns to their usual care setting, it is an essential time for care coordinator intervention, support and education. Timely intervention is often the key to preventing an unnecessary readmission, which helps improve the quality of life for members. Four-pillar answers might not be the end of the conversation on the topic, especially when the initial answer is "no." Care coordinators ensure education, support, resources and assistance are provided to move the "no" answer to "yes".

I. Does the member have a follow-up appointment with a primary care physician, specialist, or mental health provider within 15 days of discharge (medical) or 7 days (mental health)?
   a. *If no, assist with scheduling and ensuring that primary care is established.*

II. Can the member manage their medications, or is there a system in place to manage medications?
   a. *If no, consider assisting with arranging support.*

III. Does the member have a copy of & understand their discharge instructions?
   a. *If no, offer to assist in obtaining and contacting the PCP with questions.*

IV. Can the member verbalize warning signs and symptoms to watch for and how to respond?
   a. *If no, offer to review discharge instructions with the member.*

Additional Follow-Up Topics for Discussion

Care coordinators address social determinants of health and other risks/vulnerabilities as part of the post-discharge conversation.

- Has a medication review been completed with the member?
  - *If not, consider referring the member to a PCP, home care nurse, MTM, or pharmacist.*
- Does the member have adequate food, housing, and/or transportation?
  - *If no, and if appropriate, add a goal and offer additional supports available to the member.*
- Does the member have concerns with accessibility and/or safety in their home?
  - *If yes, document needs and support offered.*
- Are there concerns of vulnerability, abuse, or neglect?
  - *If yes, document concerns and actions taken by the care coordinator as a mandated reporter.*
- Education provided on preventing readmission.
  - *Consider sharing UCare 24-hour nurse line, Mental Health Hotline, or "Where to go for Care" member handout.*

MN Encounter Alert System powered by PointClickCare

In partnership with DHS, PointClickCare (PCC) allows providers (including care coordinators) serving Medical Assistance enrollees throughout the state to receive alerts for individuals who have been admitted to, discharged, or transferred from a PCC-participating hospital, emergency department, long-term care facility, or other provider organization in real-time. Care coordinators are expected to access PCC on business days to receive notifications of member transitions.

Notification of TOC

Care coordinators may be notified of admissions via:

- Review of PointClickCare on business days
- DAR
- Member/legal representative
- Other: case managers, service providers, etc.

NOTE: 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/responsible party to confirm that discharge actually occurred and discuss required TOC tasks. This includes situations where it may be a 'new' usual care setting for the member.

TOC Log

Connect + Medicare and MSHO care coordinators are required to use the TOC Log to ensure all documentation elements have been addressed. If the TOC log is not used for Connect and MSC+ transitions, the care coordinator is expected to document transition management activities in the member record.

TOC Required Tasks	MSHO & CT + MED	MSC+ & CT
TOC Log (Activity initiated within **one business day** of notification) NOTE: If notification of transition is 15 calendar days or more after discharge to home, the TOC log is not required. Document CC support in member notes.	X	
Follow up with the member/responsible party with each transition (First attempt to reach the member within **one business day** of each notification)	X	
Follow up with the receiving care setting to share the relevant support plan and important member information within **one business day** of notification	X	
TOC notification to PCP via letter/fax/phone call (Within **one business day** of each notification)	X	
Follow up with other members of ICT (BHH and CADI/BI/DD/CAC case manager and other ICT as appropriate)	X	X
Follow up with the member/responsible party upon return to the usual setting (First attempt to reach the member within **one business day** of each notification)	X	X
4 Pillars and Additional Discussion (Completed upon return to usual setting/home) First attempt to reach the member within **one business day** of each notification.	X	
Document all transition management follow-up efforts	X	X

Utilizing Support Staff During TOC

Certain care coordination tasks may be shared with support staff, while a care coordinator must complete other tasks. The table below indicates examples of activities or functions that may be delegated to support staff.

Activity/Task	CC Only Task	Support Staff
Verifying member eligibility in MN-ITS		X
Mailing letters with the assigned CC Name/Contact		X
Member outreach attempts to schedule visits		X
MnCHOICES Assessment/HRA-MCO	X	
MMIS Entry		X
Referrals/authorizations	Assessing the need for referrals	Submit referral/auth forms
Support Plan revisions	X	
Mailing Support Plan		X
TOC Log	Partial: All member contacts and related activities	Partial: Notify PCP, verify admission, prep documents

TOC and the 90-Day Grace/Monitoring Periods

CT + MED and MSHO 90-Day Grace Period: Members remain on the enrollment roster and continue to receive all care coordination tasks, including TOC, while MA is lapsed for up to 90 days.

CT and MSC+ 90-day Monitoring: Members whose MA has lapsed are removed from the enrollment roster and monitored for up to 90 days for assessments/support plans that are due at that time. TOC activity is not completed for CT and MSC+ members in the 90-day monitoring period.

Admission to a Nursing Facility

UCare internal staff complete ALL Nursing Facility (NF) OBRA/Pre-admission Screening and Resident Review (PASRR) activities. Internal UCare staff tasks include:

- Completing and faxing the OBRA Level 1 to the nursing facility
- Making referrals for OBRA Level II if applicable for non-waiver members and members on a DD waiver
- Completing telephone screening (DHS-3427T form) and entering it into MMIS* if applicable
- UCare staff alert care coordinator of PASSR received. CCs review the PASSR and if TOC has not already been initiated, consider this notification of admission.

CC Responsibilities:

- Monitor PointClickCare and the Daily Authorization Report for admissions
- Complete transitions of care activities
- CT+MED and MSHO members complete a TOC log
- Determine if an early assessment due to a change in needs is warranted. An assessment is not required solely based upon admission to a nursing facility.
- If the member is due for an assessment while receiving care in a NF, CC reviews the living status on the enrollment roster (Institutional vs Community) to determine assessment type and requirements.
    - MSC+/MSHO: Living Status, Institutional, complete IHRA and follow Institutional Requirements Grid
    - MSC+/MSHO: Living Status: Community, complete the MnCHOICES MCO Assessment/HRA-MCO and follow MnCHOICES Requirements Grid
    - CT/CT+MED: Living Status, Institutional, complete HRA-MCO and follow CT/CT+Med Requirements Grid

NOTE: If the enrollment roster displays an incorrect Living Status, the CC should complete the correct assessment according to the actual living status and ensure the address is updated accordingly. To update the Enrollment Roster's Living Status from "community" to "institutional" the nursing facility submits the DHS-1503 to the member's county of residence. To change from institutional to community, CC sends the DHS-5181 to notify the county of member address change.

Additional tasks are outlined on the MSC+ and MSHO Requirements grids related to admissions lasting over 30 days including but not limited to:

- Temporarily exiting EW in MMIS on day 31 of admission to a nursing facility
- Communication with the county of financial responsibility using the DHS-5181
- Reopening EW for members returning to the community between 30-120 days
- Reassessments to open EW for members returning to the community after 120 days

Reference: Nursing Facility Coverage Guide