CORPORATE POLICY & PROCEDURE

	Policy Name: CE29 - Transitional Care for Acute Care
Department: Health Plan Operations	Policy Number: CE29
Version: 1	Creation Date: 06/23/2022
Revised Date:	
Line of Business: ☐ All ☒ Umpqua Health Alliance ☐ Umpqua Health Management ☐ Umpqua Health - Newton Creek ☐ Umpqua Health Network	
Approved By: Quality Improvement Committee, Nancy Rickenbach (Chief Operating Officer) Date: 01/23/2023	

POLICY STATEMENT

Umpqua Health Alliance's (UHA) Transitional Care Program, through its policy CE18 – Integrated Care Coordination and in accordance with Oregon Administrative Rules (OAR) 410-141-3865 and 410-141-3860, is committed to delivering enhanced coordination of care between members, and care settings by utilizing Transitional Care staff and community resources to ensure members who have been discharged from an acute care setting including Acute Inpatient Hospital Psychiatric Care, or post hospital extended care (PHEC) admission, have an effective transition home or to the next care setting as indicated in CE22.

PURPOSE

The purpose of Umpqua Health Alliance - Transitional Care is to facilitate transition planning, to take an active role in discharge planning, and to reduce unnecessary hospital readmissions; while increasing the quality of care provided to our UHA members and Dual Special Needs Plan (DSNP) dual eligible members; to meet the cost management goals of the plans and avoid potential financial stressors within the hospital/health plan partnership.

RESPONSIBILITY

Health Plan Operations

DEFINITIONS

Care Coordination: A series of actions contributing to a patient-centered, high-value high-quality system. Care coordination is defined as the organized coordination of member's health care services and support activities between two or more participants deemed responsible for the member's health outcomes and the role of care coordinator. Organizing the delivery of care and resources involves a team-based approach focused on the needs and strengths of the individual member. The care coordinator ensure that participants involved in in a member's care facilitate the appropriate delivery of health care services and supports. Successful care coordination requires the exchange of information among participants responsible for meeting the needs of the member, explicit assignments for the functions of specific staff members, and addresses interrelated medical, social cultural, developmental, behavioral, educational, spiritual and financial needs in order to achieve optimal health and wellness outcomes. Successful care coordination is achieved when the health care team, including the member and family/caregiver, supported by the integration of all necessary information and resources, choose and implements the most appropriate course of action at any point in the continuum of care to achieve optimal outcomes for the members.

Care Coordinator: A single, consistent individual who is familiar with a member's history,

strengths, needs and support system; follow a member through transitions in levels of care, providers, involved systems and legal status; takes a system wide view to ensure services are unduplicated and consistent with identified strengths and needs; and who fulfills care coordination standards as identified in the Coordinated Care Organization (CCO) Contract.

Case Management Services: Services provided to ensure that CCO members obtain health services necessary to maintain physical, mental, and emotional development and oral health. Case management services include a comprehensive, ongoing assessment of medical, mental health, substance use disorder or dental needs plus the development and implementation of a plan to obtain or make referrals for needed medical, mental, chemical dependency, or dental services, referring members to community services and supports that may include referrals to Allied Agencies.

Collective Medical is the largest real-time care collaboration network in the United States. Collective unifies a member's entire care team—including hospitals, primary and specialty, post-acute care, behavioral health providers, community service organizations, and health plans to collaborate for better member outcomes.

Integrated Care Coordination: Integrated person-centered care and services that assure that physical, behavioral, and oral health services are consistently provided to members in all age groups and all covered populations when medically appropriate and consistent with the needs identified in the community health assessment (CHA) and community health improvement plan (CHP) as defined in OAR 410-141-3860.

LACE Score: Identifies members that are at risk for readmission or death within thirty days of discharge. It incorporates the following four parameters.

- L stands for the length of stay of the index admission.
- A stands for the acuity of the admission.
- C stands for co-morbidities.
- E stands for the number of emergency department visits in the last six months.

Post-Hospital Extended Care (PHEC): Extended care services provided to an individual after transfer from a hospital in which the individual was an inpatient for not less than 3 consecutive days before discharge from the hospital in connection with such transfer

Transitional Care Program: Refers to the entity tasked with empowering members to develop a reliable approach to medication management, medical care follow-up, establishment of a personal health record and awareness of warning signs that their condition(s) may be worsening.

PROCEDURES

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Determination of Program Eligibility

1. UHA primary and DSNP members who meet the following criteria:
    a. Acute care admission to Mercy Medical Center (MMC)
    b. Acute care admission to out-of-network hospital via internal referral or notice of transfer from MMC.
    c. Transfer from inpatient setting to PHEC, or other setting
    d. Discharge from PHEC or Skilled Nursing Facility (SNF) admission.
    e. Discharge from inpatient admission from any setting listed prior.
2. Care coordinators shall promote continuity of care and recovery management through:
    a. Episodes of care, regardless of the member's location;
    b. Monitoring of conditions and ongoing recovery and stabilization;
    c. Adoption of condition management and a whole person approach to single or multiple chronic conditions based on the goals and needs identified by the individual, including avoidance and minimization of acute events and chronic condition exacerbations; and
    d. Engaging members, and their family and caregivers as appropriate.
    e. For FBDE members, engagement of member Medicare providers and, when applicable, member Medicare Advantage or DSNP care coordination team, in order to reduce duplication, share assessments, coordinate NEMT, address member language or disability access needs, coordinate referrals, and ensure effective transitions of care.

Integrated Care Discharge Planning

1. In accordance with OAR 410-141-3865, UHA facilitates transition planning for members by designating integrated care coordinators to:
    a. Take an active role in discharge planning from a condition-specific facility, including acute care at local inpatient facilities, or behavior rehabilitation services facilities, face to face whenever possible, and in collaboration with hospital discharge care coordination.
    b. To assure monitoring of transitions in care settings or between levels of care so that members receive comprehensive transitional care and improve member's experience of care and outcomes; particularly for transitions between hospitals and long-term care.
        i. UHA ensures providers and subcontractors receive information on the processes for members accessing care coordination, this is done through UHA's Integrated Care Coordinators populating records in the Integrated Care Registry, documenting discharge planning, and assessments and outcomes in the member's case file.
    c. Integrated Care Coordinators interact with members in acute care:
        i. Within one business day of admission;

ii. Two times per week while the member is acute care.
iii. To ensure that an effective discharge plan is in place for members prior to discharge date.

Integrated Care Coordination of Transitional Care Program Services

1. UHA is committed to supporting its members by use of integrated care coordination by a designated UHA Case Management Coordinator (CMC). UHA has outlined how it will develop, implement, and participate in activities supporting a continuum of care in its policy CE18 – Integrated Care Coordination.
2. To assure monitoring of transitions in care settings or between levels of care so that members receive comprehensive transitional care and improve members' experience of care and outcomes, particularly for transitions between hospitals and long-term care.
    a. UHA ensures providers and subcontractors receive information on the processes for members accessing care coordination, this is done through UHA's Integrated Care Staff and Transitional Care staff populating records in the respective registries; documenting discharge planning, assessments, and outcomes in the member's case file, and uploading transitional care assessments into member's case file in the hospital event notification (HEN) system.
3. In collaboration with the UHA's Integrated Care Coordination discharge planner, Transitional Care nurses will perform the following for members with a LACE score of 9 or greater:
    a. Engage all eligible members in the transitional care program upon discharge from acute care or PHEC setting or notification of discharge from out-of-network hospital prior authorization,
    b. Anticipate the care elements necessary for the optimization of the discharge plan.
    c. Transitional Care Program services will be face to face or by phone depending on the circumstances. Transitional Care Staff interact with members no less than two times per week within the week of discharge.
    d. In the majority of cases the first visit will be face to face and subsequent visits will be delivered in the manner deemed to be most effective.
    e. The Transitional Care Program services will include:
        i. Performing medication reconciliation;
        ii. Teaching how to establish a personal health record;
        iii. Developing a reliable approach to medication management;
        iv. Designing and/or reinforcing the plan for medical care follow up;
        v. Teaching about chronic health conditions and warning signs that the condition may be worsening;

vi. Members are encouraged, within all aspects of the integrated and coordinated health care delivery system, to use wellness and prevention resources and to make healthy lifestyle choices;
vii. Working with Umpqua Health's internal and community partners to facilitate follow up treatment;
viii. Completion of a Health Risk Assessment for members that did not complete one upon enrollment, or for a triggering event or have not had one updated in the past year; and completion of a Transitional Care Assessment with care plan;
ix. Internal referral to Intensive Care Coordination, Behavioral Health Care Coordination for members not previously engaged with those services; and
x. Internal and external referrals as needed based on identified needs.

4. In collaboration with the UHA's Integrated Care Coordination discharge planners, Transitional Care Community Health Worker (CHW) can perform Transitional Care services for members with a LACE score of <9. The service will include:
    a. Medication Review;
    b. Discharge instruction review;
    c. CHW assessment;
    d. Completion of a Health Risk Assessment for members that did not complete one upon enrollment, or for a triggering event or have not had one updated in the past year;
    e. Resource coordination for identified needs; and
    f. Internal and external referrals as needed based on identified needs.
5. In accordance with 410-141-3520(5) UHA will document its methods and findings in member's case file, to ensure across the organization, its provider network, and/or any out of network providers that documentation is maintained for its members, including DSNP eligible members, of its coordinated care services and supports among its providers, agencies and community partners, including transitions of care and access to preventive and wellness services. Documentation will be sent to primary care providers (PCP) and/or specialist when needed.
6. In accordance with OAR 410-141-3860(8)(d), UHA's Transitional Care Program implements systems to assure and monitor transitions in care settings or between levels of care so that members receive comprehensive transitional care and improve members' experience of care and outcomes, particularly for transitions between hospitals and long-term care, and ensure providers and subcontractors receive information on the processes for members accessing care coordination.

<u>Post Hospital Extended Care Coordination</u>

1. PHEC is a 20-day benefit that is made available to non-Medicare members who meet Medicare criteria for a post-hospital skilled nursing facility placement (CE18 – Integrated Care Coordination).
2. UHA notifies the member's local Department of Human Services (DHS) Aging and People with Disabilities (ADP) office as soon as the member is admitted to PHEC. Following receipt of the notice, UHA and the member's APD office promptly begins appropriate discharge planning.
    a. In collaboration with APD, UHA's Transitional Care nurses coordinate discharge needs for members admitted to PHEC.
        i. UHA ensures that all a member's post-discharge services and care needs are in place prior to discharge from the PHEC, including but not limited to durable medical equipment (DME), medications, home and community-based services, discharge education or home care instructions, scheduling follow-up care appointments, and provide follow-up care instructions that include reminders to:
            1. Attend already-scheduled appointments with providers for any necessary follow-up care appointments the member may need; or
            2. Schedule follow-up care appointments with providers that the member may need to see; or
            3. Both (1) and (2).
        ii. Upon notification of discharge from PHEC, members receive Transitional Care Program Services as described in section Integrated Care Coordination of Transitional Care Program Services of this policy.
3. UHA provides the PHEC benefit according to the criteria established by Medicare, as cited in the Medicare Coverage of Skilled Nursing Facility Care.
    a. This criteria is available by calling 1-800-MEDICARE or at www.medicare.gov/publications
4. UHA is not responsible for the PHEC benefit unless the member was enrolled with UHA at the time of the hospitalization preceding the PHEC facility placement.

Department	Standard Operating Procedure Title	SOP Number	Effective Date	Version Number
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