

## Special Needs Plans - Structure & Process Measures

### Planned vs. Unplanned Transitions:

**Unplanned:** Care Coordinators will be responsible for documenting a Transition of Care on the Transition Log when they receive notification that a member has had a Care Transition (Hospitalization, SNF admission).

**Planned:** Care Coordinator will be responsible for documenting a Transition of Care on the Transition Log when member is planning elective surgery (overnight stay) or a decision to enter a long term care facility (move from community to LTC); or member returns to their usual setting.

### SAMPLE TRANSITIONS:

SCENARIO	TRANSITIONS LOG ENTRY NEEDED?
"John" is feeling dizzy and weak. He is taken to the ER for evaluation. He stays several hours while tests are run, but in the end is not admitted to the hospital.	NO: Nothing needed because there was no admission
Same scenario – but he is admitted for "observation" Status.	NO: Not needed because the member was admitted for observation only
"Sue" falls at home and fractures her ankle. She is taken to the ER, and is admitted to the hospital where she has surgery. After surgery, she is transferred to a transitional care unit. She spends 6 weeks at the TCU and is then transferred back home.	YES <b>One for each transition, so this scenario results in 3 logs</b>
"Carl" lives in customized living. He is not happy in his current location, and chooses to move to a different customized living across town.	NO: Although a change in setting/provider the move is not due to a change in health status. Existing Customized Living tools used by Care Coordinator (Customized Living workbook) used in lieu of a transitions log.
"George" lives in the nursing home (custodial care) long term. He decides to change nursing homes so he can be closer to his daughter.	NO: The change/transition is not because of a change in health status
"Ralph" lives in the nursing home (custodial care) long term. His current NF does not have a locked dementia wing. His dementia has worsened and he is no longer appropriate for his current nursing home. He is moved to a new nursing home across town to their dementia specific unit.	Yes: Because the worsening dementia is a change in health status and the change in nursing home is a change in setting/provider.
"Mary" has been living in her own home. She is no longer able to meet her own needs and is moved into a nursing home.	Yes (Planned Transition due to change in condition)
"Floyd" has been living in his home, but decides to move to Customized living at the recommendation of his Care Coordinator and family. He has not had a change in his assessed needs.	No; The CC is coordinating the Customized Living services; member is supported by CC through use of CL tool and by possible reassessment of LTCC. CC best practice is to notify

	PCP of change to CL. Existing Customized Living tools used by Care Coordinator (i.e. Customized Living workbook) used in lieu of a transitions log.
“Frank” has moved from the nursing home to a customized living facility because his needs could be met through a CL setting	No; The CC is coordinating the Customized Living services. Member is supported by CC through use of CL tool and by completing an LTCC. CC best practice is to notify PCP of change to CL setting. Existing Customized Living tools used by Care Coordinator (i.e. Customized Living workbook) used in lieu of a transitions log.
“Bob” has been living in a customized living facility. His condition has improved, and he is planning to move back home to his own apartment in the community.	Yes: This is a change of setting resulting from a change of condition. In the case when someone goes from home to CL no log is needed because the Customized Living tools can be used in lieu of a log. When going from CL to home, these tools are not used, thus a log should be completed.
“Fred” has been living in a Customized Living facility/24 hour customized living facility, and his dementia is worsening, he needs more assistance due to declining cognition. He moves to a secure/locked dementia unit in another area of the same building.	No: While “Fred’s” condition has worsened, he did not move to a different provider, so this is not considered a transition.
“Oscar” has been living in a Customized Living facility/24 hour customized living facility, and his dementia is worsening, he needs more assistance due to declining cognition. He moves to a secure/locked dementia unit located at a different facility.	Yes. This is a change of health condition and change in setting/provider. A transitions log should be completed.

**SNP 4: Care Transitions**  
**DEFINITIONS**

**Transition:** Movement of a member from one care setting to another as the member’s health status changes; for example, moving from home to a hospital as the result of an exacerbation of a chronic condition or moving from the hospital to a rehabilitation facility after surgery.

- Planned Transitions include elective surgery or a decision to enter a long-term care facility

**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 care. Settings include:

- Home (the designated practitioner in the home setting is the usual source of care or usual practitioner)
- Home health care
- Acute care
- Skilled nursing facility
- Custodial nursing facility
- Rehabilitation facility.

**Care plan:** A set of information about the patient that facilitates communication, collaboration and continuity of care across settings when members experience transitions. The care plan may contain, and is not limited to, both medical and non-medical information (e.g. a current problem list, medication regimen, allergies, advance directives, baseline physical and cognitive function, contact information for all professional care providers or practitioners and informal care providers).

**Usual setting:** The setting where the member receives care on a regular basis; this may be the member's home or a residential care facility

**Receiving setting:** The setting responsible for the member's care after a transition. For members who transition to home, the receiving setting is the member's usual source of care.

**Sending setting:** The setting responsible for the member's care before a transition. For members who transition from home, the sending setting is the member's usual source of care.

**Transition process:** The period from identifying a member who is at risk for a care transition through the completion of a transition. This process goes beyond the actual movement from one setting to another; it includes planning and preparation for transitions and the follow-up care after transitions are completed.

#### **Intent of SNP 4: Care Transitions**

Organization makes special effort to coordinate care when member moves from one setting to another (ex: dc from hospital).

- Without coordination some transitions (can) result in poor quality care and risks to patient safety.
- Look back period is the 6 months prior to the survey date (report date).
- Older or disabled adults moving between different care settings are vulnerable to unsafe care when transition is poorly coordinated. Problems (can) arise with disease management, medication management, lack of follow up care, **receiving end poorly prepared or poorly informed.**
- Organization conducts transition activities as a part of case management.
- Organization must provide evidence to show how to meet these activities - **TRANSITION LOG!**

### **Element A: Managing Transitions**

Organization facilitates safe transitions by assigning the following tasks and monitoring the systems performance

1. Planned transition will be occurring (elective surgery, dc from hospital to NF)
2. Planned and unplanned transitions sharing sending settings care plan to receiving setting within one business day of notification of the transition
3. Planned and unplanned transitions notify the patients (members) **usual** practitioner (PCP) of the transition

### **Element B: Supporting Member through Transition**

Organization facilitates safe transitions by assigning the following tasks and monitoring the systems performance

1. Planned and unplanned transitions from any setting to another setting, communicate with member or responsible party **about care transition process**  
(example: ... this is what usually happens when going from a hospital to SNF/transitional care....)- **specified timeframe of one business day of notification**
2. Planned and unplanned transitions....communicate to member or responsible party **about changes to the member's health status-plan of care in specified timeframe...**
3. Planned and unplanned transitions .....provide member with consistent person (Care Coordinator) **who will support member through the transition process in specified timeframe**

### **Element C: Analyzing Performance**

1. Organization analyzes its performance annually of its aggregate performance
2. Drawing appropriate samples
3. Quantitative and Qualitative analysis
4. Identify opportunities for improvement

### **Element D: Identifying Unplanned Transitions**

Organization identifies transitions by reviewing the following for facilities in its network

1. Reports of hospital admissions within one business day of admission
2. Reports of admission to long-term care facilities within one day of admission

### **Element E: Analyzing Transitions**

1. Analyzing data at least to ID members at risk of a transition (unplanned) **(Risk Lists)**
2. Analyzing rates of all member admissions to hospitals and ED/ER visits at least annually to ID areas of improvement

### **Element F: Reducing Transitions**

1. Coordinated services for members at high risk of having a transition
2. **Educating members** or responsible parties about transitions and how to prevent unplanned transitions

## **Educating members**

Some examples of educating members include:

- Enrolling a member with congestive heart failure who has several recent visits to the ER in diagnosis-related education classes to reinforce self-management e.g., weight/fluid management.
- Enrolling a member with medication issues into an MTM program to help them better understand the importance of medication adherence and also how and when to take medications safely (proper time of day, with/without food, etc.).
- Working with the member or their responsible party to conduct an in-house risk assessment for falls such as taping down loose rugs, eliminating long electrical cords and installing grab bars in the bathroom, to help the member reduce the risk of falling.
- Distributing educational materials to members which are aimed at reducing future transitions a member may experience for specific chronic conditions.