# Transitions of Care (TOC) Training

# What is a “Transition of Care”?

Member’s movement from one care setting to another setting due to changes in the member’s health status.

Examples: member moves from home to a hospital as the result of an exacerbation of a chronic condition; member moves from hospital to a skilled nursing facility.

# What is a “Care Setting”?

- The place where the member receives health care and health-related services
- Examples: member’s home; hospital; skilled nursing facility; rehabilitation facility
- “Usual care setting”
- “Receiving care setting”


# Importance of TOC Coordination

- Older adults moving between health care settings are vulnerable to:
  - 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.
  - 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 the key to preventing problems during transitions.**

# TOC & Health Plan Collaboration

1

Minnesota Health Plans worked together in a collaborative effort to streamline processes that make TOC simpler for care coordinators:

- Core requirements are consistent across plans.
- Common data elements across plans.

2

To simplify the requirement to track the care transition process, the health plans have created a form called the *Individual Care Transition Log.*

3

Use of this form is required whenever a TOC has occurred.

4

Complete a log entry for each TOC.

# Example of  Care Transition

Member has a total of **three** transitions and each one would have its own entry on the Individual Care Transitions Log.

- Member leaves home and is admitted to a hospital. (one transition).
- Member is discharged from a hospital to a skilled nursing facility. (one transition).
- Member returns home. (one transition).

# Providing Support

- Care Coordinators (CCs) act as a consistent person to support the member throughout the transition, and to help prevent transitions:
  - Educate to avoid unnecessary ER visits and hospitalizations.
  - Look for risks (falls, lack of preventive care, poor chronic care disease management) and take action.
  - Identify to 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.
  - Setting up crucial follow up appointments with primary care or specialists upon hospital discharge.

# Identifying Transitions

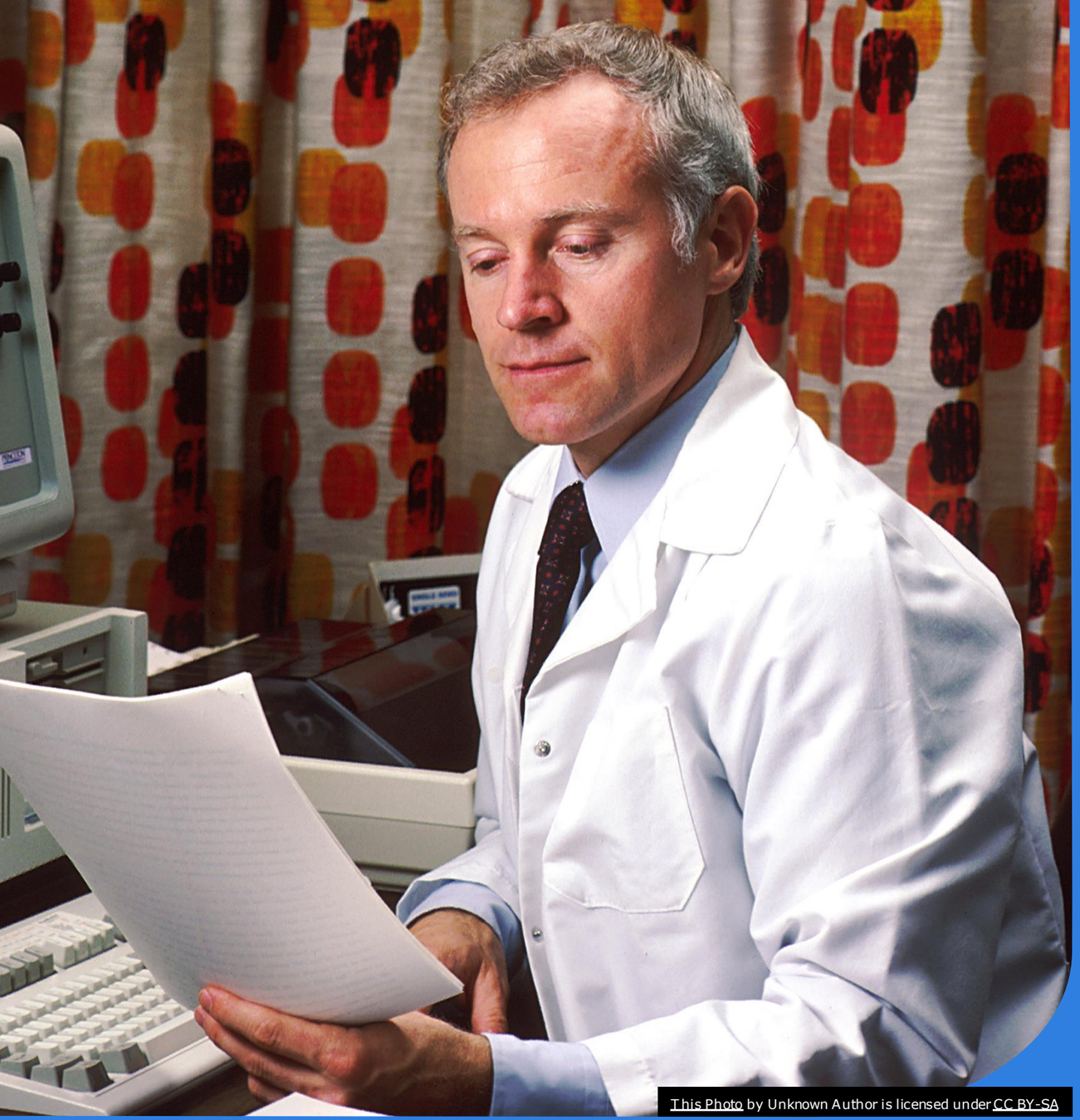
| | |
|---|---|
| Daily Authorization Report | Hospitalizations.<br>Planned procedures requiring prior authorization.<br>Monthly MSHO Hospital and ER readmission report. |
| Discussion with Members | Talk about outpatient procedures that might. require care plan changes, TOC management. |
| TOC Brochure | Review brochure with members/responsible party, make them aware of their role in transitions. |

# Identifying Transitions, cont.

- Utilize the MSHO/Connect + Medicare Hospital & ER Readmission monthly report
  - Sent by the second week of the month.
  - Shows hospital admissions, readmissions, ER visits over the previous 6 months.
  - Utilize this report as a tool to assist in identifying members who may benefit from:
    - A Disease Management Program
      - If a member has multiple ED visits for CHF, Asthma, Diabetes.
    - Educate members on how to prevent multiple ED visits. Options for urgent care, primary care, nurse line services.
    - A way to identify members that may need additional support.

# CC Communication With Receiving (non-usual) Care Setting

- For transitions to settings other than member's usual care setting, the CC is required to
- Identify an appropriate contact within the unit/floor such as a discharge planner or social worker
- Communicate the following with the receiving setting within 1 business day of notification of the transition:
    - CC contact information.
    - **Current care plan or summary,** hospital/SNF discharge instructions, and services (home care, etc).
    - Current meds, chronic conditions, current treatments, etc.
    - Service providers
        - Usual provider and/or specialty care provider contact information;
    - Other relevant information.
- Communication may be done via phone, fax, or flag in an electronic system.



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# PCP Contact

- The CC is required to notify PCP of admission, if PCP was not admitting physician.
    - By fax, phone, or flag in an electronic system.
    - Within 1 business day of notification of the transition.
    - If PCP is admitting physician, no additional notification is required. Note on the log.

# CC Communication for Transitions Back to Usual Setting or “New” Usual Setting

- For transitions back to their usual care setting, or “new” usual care setting (i.e. – a community member moves to permanent nursing home), the CC is required to:
  - Communicate with receiving setting:
    - CC contact information.
    - Current care plan and services, providers, etc.
    - Information about the transition.
    - Relevant information – current services, informal supports, medications, advance directives, etc.
  - Notify PCP of transition.
  - Communicate with Member/Responsible Party.

# Communication with Member/Resp. Party Upon Return to Usual Setting

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

Outreach may be telephonic or face-to-face.

Discussion should include:

- Care transition process
- Changes to member's health status
- Changes to care plan
- Educate about how to prevent unplanned transitions/re-hospitalizations
- Provide contact info
- 4 Pillars to Optimal Transition Management. –Follow up appointments, medication management, ability to verbalize warning signs, personal health record (discharge summary).

# 4 Pillars to Optimal Transitions

| 1. Medication Self-Management. | 2. Patient Centered Health Record- across providers and settings. | 3. Follow-Up. | 4. Red Flags. |
|---|---|---|---|
| • Medication changes/new prescriptions filled. | • Discharge instructions, care plan, etc. | • Follow-up appointments, transportation, services, DME, supplies, etc.<br>• Changes in functional needs (bathing, eating, dressing, transfers, etc.) | • Understanding if condition changes or gets worse. |

# Transition of Care Log and Tasks

**TOC tasks are identified on the TOC log.**

**All TOC tasks should be completed by the CC within 1 business day of notification of each transition.**

**Auditing shows issue of logs not being completed.**

Missing elements.

If something doesn't apply, mark N/A.

**Ensure you are completing the log for each transition that occurs.**

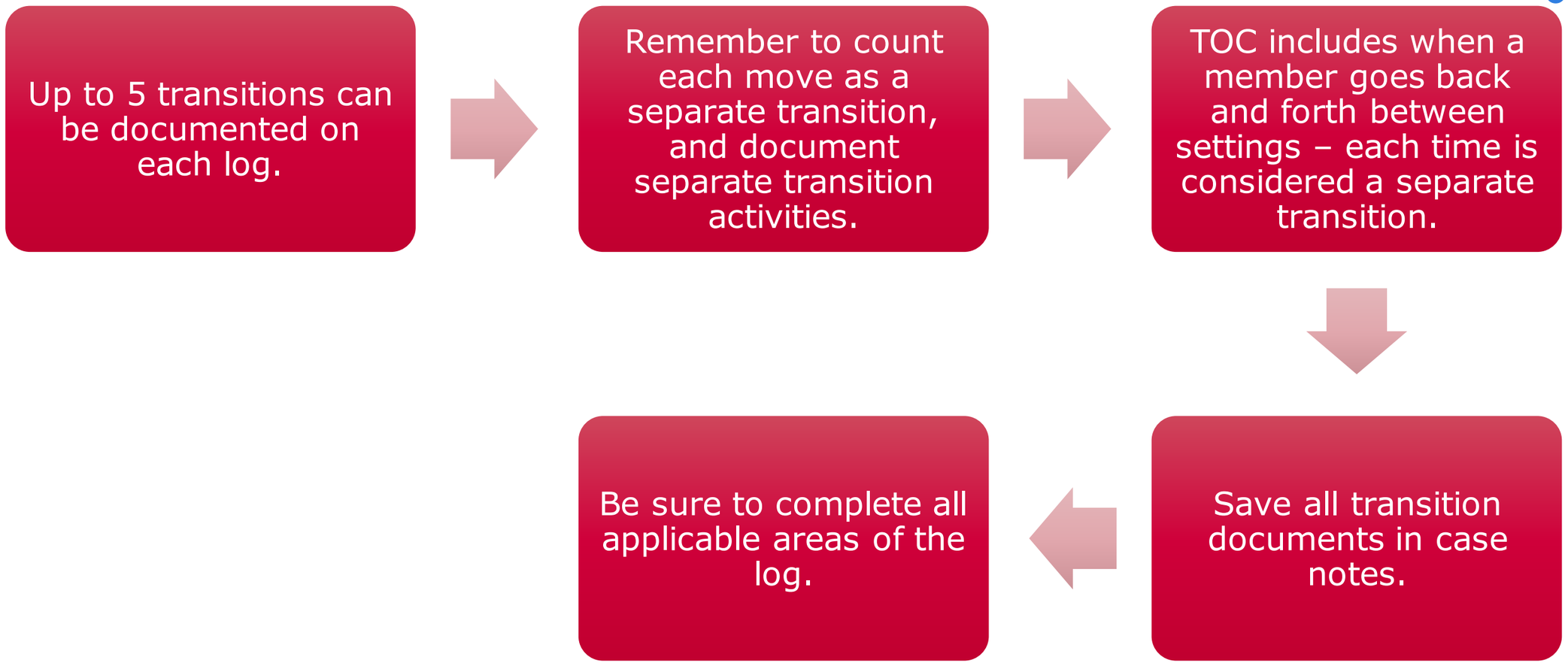
# Late Notice on Transitions

If CC finds out about the transition 15 or more days after the transition after the member has returned to their usual setting, **no TOC log is required.**

The CC is still required to follow up with the member/rep to:

- Discuss the TOC process
- Discuss changes to the member's health status and POC
- Provide education about how to prevent TOCs
- Discuss 4 Pillars of Optimal Transitions
  - Document this discussion in case notes.
  - Case Notes may be audited, so ensure this documentation is present in case notes, since no log is required.

# Additional Notes



# Summary

- The Care Coordinator is the key to preventing and managing care transitions by:
  - Educating members about prevention and avoidance of care transitions.
  - Facilitating communication to improve member’s health and safety.
  - Developing relationships with members, local practitioners, hospitals, nursing facilities, etc.
  - Monitoring members at higher risk to prevent unplanned care transitions.
  - Ensure member has follow up appointments scheduled, primary care, specialty.

# Updates to the TOC Log

UCare has updated the TOC log in the following ways:

- Added additional transitions boxes so that you do not need to use as many additional logs
- Added a question around if the discharge summary has been reviewed with the member.
- Added areas to include information about conversations with the ICT
- Added information about mental health follow up within 7 days of an inpatient mental health stay

# TOC Log Sample-DRAFT

**TRANSITIONS OF CARE (TOC) LOG**

TOC tasks should be completed by the CC within one (1) business day of notification of each transition. Follow up contact with member is required after return to their usual care setting. Note: If CC finds out about the transitions fifteen (15) days or more after the member has returned to their usual care setting, no TOC log is needed. However, the CC should check in with the member to discuss the transition process, any changes needed to the support plan and document it in a case note.

| **Member Name:** | **MCO Name:** | **MCO/Health Plan Member ID#:** |
|---|---|---|
| **Product:** | **Care Coordinator Contact:** | **Agency/County/Care System:** |

**Transition Communication Actions from Care Management Contact**

**Transition #1**

| **Notification Date:** | **Transition Date:** | **Transition From: (Type of care setting)** | **Transition To: (Type of care setting)** |
|---|---|---|---|
| | | | |

**Is this the member's usual care setting?** ☐ **Yes** ☐ **No**

**Transition Type:** ☐ **Planned** ☐ **Unplanned**

**Reason for Admission/Comments:**

**Notes from conversation with the member, provider, discharging and receiving facility (as applicable):**

**Shared CC contact info, support plan/services with receiving setting—Date completed:**

**Notified PCP of transition—Date completed:** via ☐ Fax ☐ Phone ☐ EMR ☐ Secure e-mail **(OR)** ☐ Member's PCP was the Admitting Physician

**Transition #2**

**Notification Date:**
**Transition To: (Type of care setting) ***
**Transition Date:** **Transition Type:** ☐ **Planned** ☐ **Unplanned**
**Notified PCP—Date completed:** via ☐ Fax ☐ Phone ☐ EMR ☐ Secure e-mail
**Shared CC contact info, support plan/services with receiving setting or, if applicable, home care agency—Date completed:**
***Complete additional tasks below if this transition is a return to usual care setting.**
**Comments:**

**Notes from conversation with the member, provider, discharging and receiving facility (as applicable):**

**Transition #3 (if applicable)**

**Notification Date:**
**Transition To: (Type of care setting) ***
**Transition Date:** **Transition Type:** ☐ **Planned** ☐ **Unplanned**
**Notified PCP—Date completed:** via ☐ Fax ☐ Phone ☐ EMR ☐ Secure e-mail
**Shared CC contact info, support plan/services with receiving setting or, if applicable, home care agency—Date completed:**
***Complete additional tasks below if this transition is a return to usual care setting.**
**Comments:**

**Notes from conversation with the member, provider, discharging and receiving facility (as applicable):**

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# TOC Log Sample-DRAFT

**Transition #4 (if applicable)**

**Notification Date:**
**Transition To: (Type of care setting) ***
**Transition Date:** _____ **Transition Type:** ☐ **Planned** ☐ **Unplanned**
**Notified PCP—Date completed:** ____ via ☐ Fax ☐ Phone ☐ EMR ☐ Secure e-mail
**Shared CC contact info, support plan/services with receiving setting or, if applicable, home care agency—Date completed:** ____
***Complete additional tasks below if this transition is a return to usual care setting.**
**Comments:**

**Notes from conversation with the member, provider, discharging and receiving facility (as applicable):**

**Transition #5 (if applicable)**

**Notification Date:**
**Transition To: (Type of care setting) ***
**Transition Date:** _____ **Transition Type:** ☐ **Planned** ☐ **Unplanned**
**Notified PCP—Date completed:** ____ via ☐ Fax ☐ Phone ☐ EMR ☐ Secure e-mail
**Shared CC contact info, support plan/services with receiving setting or, if applicable, home care agency—Date completed:** ____
***Complete additional tasks below if this transition is a return to usual care setting.**
**Comments:**

**Notes from conversation with the member, provider, discharging and receiving facility (as applicable):**

***Complete tasks below when the member is discharging TO their usual care setting within one (1) business day of notification.** 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 or designated representative to confirm that discharge actually occurred and discuss required TOC tasks as outlined in the TOC Instructions. (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 following hospitalization and rehab).*

**Date completed:** **Communicated with member or their designated representative about the following: care transition process; about changes to the member's health status; support plan updates; education about transitions and how to prevent unplanned transitions/readmissions**
**Four Pillars for Optimal Transition:**
*Check "Yes" - if the member, family member and/or SNF/facility staff manages the following: If "No" provide explanation in the comments section.*
☐ Yes ☐ No Does the member have a **follow-up appointment** scheduled with primary care or specialist? *(Mental health hospitalizations—the appt. should be w/in 7 days)*
For mental health hospitalizations: ☐ Yes ☐ No Does the member have a **follow-up appointment** scheduled with a mental health practitioner within 7 days of discharge?
☐ Yes ☐ No Can the member **manage their medications or** is there a system in place to manage medications *(e.g. home care set-up)*?
☐ Yes ☐ No Can the member verbalize **warning signs and symptoms to watch for** and how to respond?
☐ Yes ☐ No Does the member use a **Personal Health Care Record**? *Check "Yes" if visit summary, discharge summary, and/or healthcare summary are being used as a PHR.*

☐ Yes ☐ No **Have you updated the member's support plan?** *If "No" provide explanation in comments.*
☐ Yes ☐ No **Have you reviewed the discharge summary with the member?** *If "No" provide explanation in comments.*
**Comments:**

**Notes from conversation with the member, provider, discharging and receiving facility (as applicable):**

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