MedStar Family Choice DISTRICT OF COLUMBIA		
ADMINISTRATIVE POLICY AND PROCEDURE		
Policy #:	**162.DC**	
Subject:	**Care Transitions**	
Section:	**Clinical Operations**	
Initial Effective Date:	**03/01/2021**	
Revision Effective Date(s):	**07/21, 07/22, 07/23**	
Review Effective Date(s):		
Responsible Parties:	**Manager of Utilization Management, Manager of Case Management, Manager of Special Populations Case Management**	
Responsible Department(s):	**Clinical Operations**	
Regulatory References:	**NCQA 2023: CM 5A**	
Approved:	**Sharon Henry, RN Director, Clinical Operations**	**Raymond K. Tu, MD Sr. Medical Director (CMO)**

Purpose: **To define a process for arranging and managing Enrollees' transition to alternative levels of care.**

Scope: **MedStar Family Choice District of Columbia (MFC-DC)**

Policy: **MFC-DC care management staff will facilitate safe transitions of care, identify problems that can cause unplanned transitions and prevent unplanned transitions, when possible, to care settings to include acute care facilities, emergency departments, skilled nursing facilities, custodial nursing facilities, rehabilitation facilities, the home and community.**

Procedure:

A. MFC-DC will identify Enrollees who require transitions between settings during the daily utilization management (UM) inpatient concurrent review process, Weekly Census Meetings, Chesapeake Regional Information System for our Patients (CRISP) reports, and direct contact with the hospitals' discharge planning departments. Hospital discharge planners/ case managers are encouraged to discuss length of stay and anticipated care needs with the Enrollee, their representative or family on admission.

B. For all transitions, the MFC-DC assigned case manager will notify the Enrollee's usual provider, case manager, primary care physicians (PCP)/ specialist, home health agency, and/or other treating practitioners within 72 hours of transition to ensure continuation of care.

C. Unplanned Transition (Home/Community to Emergency Room/Inpatient)
   1. MFC-DC's Utilization Management (UM) Department will:
      a. Monitor the Enrollee's status throughout the unplanned transition, on receipt of clinical information from the admitting facility through discharge.
      b. Provide appropriate authorization for the stay within 72 hours of receipt of clinical information.
      c. Communicate any identified discharge planning needs to the assigned MFC-DC Case Manager, the Post-Acute Care Registered Nurse (RN), or designee.
   2. MFC-DC's assigned Case Manager (CM) will:
      a. Communicate the care transition process to Enrollees and their designated representatives within five (5) days of notification of the admission from the UM Department, CRISP report and or the Transition Care Referral.
      b. Outreach to the Enrollee/caregiver, hospital social worker/discharge planner, and/or MFC-DC UM department to obtain information on the Enrollee's status to identify any discharge planning needs. MFC-DC's CM will collaborate with the hospital discharge team on identified discharge needs.
      c. Discuss any changes to the case management plan with the Enrollee and their designated representatives and will be fully available to facilitate and assist with timely and safe transition to the next level of appropriate care of setting. Also, inform the interdisciplinary team members of any change, as appropriate.
         i. The CM also receives the daily hospital assignment and will contact the UM Department to track the Enrollee's transition status.
   3. If the discharge plan is to a lower level of care other than home/community, the Post-Acute Care RN will:
      a. Discuss the discharge plan with the hospital social worker/discharge planner, and/or MFC-DC UM department to obtain information on the Enrollee's status to identify the discharge planning needs.
      b. Collaborate with the hospital discharge team on identified discharge needs.

D. Transition Inpatient to Subacute rehab (SAR), Skilled Nursing Facility (SNF***)***, Long Term Acute Care (LTAC), Acute Rehab, and Hospice:
   1. MFC-DC's Post-Acute Registered Nurse (RN) or designee will be responsible for supporting the Enrollee through the transition to skilled nursing facilities, custodial nursing facilities, and rehabilitation facilities based on stability for discharge and bed availability. The Post-Acute RN will collaborate with the hospital discharge planner to identify and discuss alternative transitions for difficult to place Enrollees or plan for discharge home with community-based services and/ or home health care services. The Post-Acute RN will assist with coordinating services with MFC-DC's in-network agencies/providers for outpatient services such as home health care, physical therapist

(PT), occupational therapists (OT), speech language pathologist (SLP), wound care, additional test, and community-based services.

2. MFC-DC will provide the acute inpatient hospital's discharge planning department with the list of in-network facilities which have the capability of providing the needed care. The name and number of the MFC-DC's Post-Acute RN will also be included.

3. Hospital CM and/or the facility liaison will submit clinical information to the Post-Acute RN's attention. The Post-acute RN will request additional information based on the Enrollee's discharge needs.

4. MFC-DC uses InterQual and American Society of Addictive Medicine (ASAM) criteria, along with information from the hospital (including discharge screens) to assure medical necessity and the appropriate level of care.

5. The Post-Acute RN will work collaboratively with the hospital discharge planning team on the discharge plan and communicate necessary information, such as the level of care, initial length of stay and authorizations. The Post-Acute RN will also communicate authorization details to the accepting facility to facilitate seamless and timely admission based on the timeframe requested by the facility. Out-of-network facilities may be considered in the following circumstances:
    a. The Enrollee requires care that is not available at an in-network facility.

6. If the Enrollee meets Post-Acute InterQual or ASAM Criteria, the Post-Acute RN will negotiate the appropriate level of care, assign an initial length of stay based on the Enrollee's condition and create the authorization in the clinical software system. Authorizations for facility transitions will be provided within 24 hours, not to exceed 72 hours of receipt of the facility request to ensure safe and timely transitions.

7. The Post-Acute RN reviewer can approve an Enrollee's continued stay up to 90 days, when the following conditions are met:
    a. Enrollee is still receiving one or more disciplines of PT, OT or SLP and progressing toward goals.
    b. Enrollee is receiving intravenous (IV) antibiotic therapy and their condition or social situation does not allow them to receive this service safely in a home setting.
    c. Enrollee is receiving wound care and the Enrollee cannot be taught, is not physically capable to administer care, does not have adequate support at home, or the wound care cannot be provided through home care due to the frequency or complexity of care.
    d. Enrollee needs additional teaching on their disease state and/or medication management due to cognitive issues.
    e. Medical management that is needed cannot be safely completed in a home setting due to the frequency or complexity of care.

f. Enrollee can no longer care for self and there are no family members or willing family members to care for Enrollee. The plan would be to reside in the SAR/SNF as a long-term care resident.
g. Enrollee is determined to be: Above custodial care and not requiring skilled nursing services or rehabilitation services may be determined medically eligible for a SAR/SNF if they require, on a regular basis, health-related services above the level of room and board. These services are described as follows:
    i. Care of an individual who requires hands-on assistance to adequately and safely perform two or more activities of daily living (ADLs) as a result of a current medical condition or disability; or
    ii. Supervision of an individual's performance of two or more ADLs for an individual with cognitive deficits, as indicated by a score of 15 or less on the Folstein Mini-Mental Status Evaluation, and who is in need of assistance with at least three instrumental activities of daily living (IADLs); or
    iii. Supervision of an individual's performance of two or more ADLs combined with the need for supervision/redirection for an individual exhibiting at least two of the following behavior problems: wandering several times a day, hallucinations/delusions at least weekly, aggressive/abusive behavior several times a week, disruptive/socially inappropriate behavior several times a week, and/or self-injurious behavior several times a month.

Once these conditions are no longer met, the expectation is that the Enrollee will be discharged to home/ community. The Post-Acute Care RN will collaborate with the facility Social Worker or discharge planner for a safe discharge.

E. Transition Inpatient, SAR, SNF, Long Term Acute Care (LTAC), Acute Rehab, and Hospice to Home/Community:

1. MFC-DC's assigned RN Case Manager will work closely with the Utilization Management Department, Post-Acute Care RN, facility's Social Workers and/or discharge planners to monitor and track the Enrollee's status and to identify any discharge planning needs to ensure a successful transition to the home environment /community. The CM will notify the Enrollee's PCP and other providers of the transitions, as necessary.

2. The current location of the Enrollee, the planned discharge/ transfer date, the receiving settings, will be documented in the clinical software system.

3. MFC-DC's assigned RN Case Manager will:
    a. Communicate the care transition process to the Enrollee and their designated representatives within three (3) business days of notification of the discharge from the

Transition Care Referral, UM Department/ Post-Acute Care RN, and /or the daily CRISP report.

b. Outreach to the Enrollee/caregiver, social worker/discharge planner, and/or MFC-DC UM department to obtain information on the Enrollee's status to identify any discharge planning needs and collaborate with the care coordination/ discharge team on identified discharge needs.

4. In order to improve the quality-of-care management services for transition from acute hospital or post-acute care setting to home, the assigned CM will work with the Enrollee, family/caregiver, PCP and other members of the multidisciplinary team to assist with arrangement of appropriate services for the Enrollee following discharge from the clinical setting and help optimize use of available benefits.
   a. Collaborate with the Enrollee, family, providers as needed to reassess the care plan within two (2) business days after notification of discharge from facility, to identify factors that may lead to readmissions and barriers that may impact engagement. The CM will modify the existing care plan as needed emphasizing improving health outcomes through effective resource management, care coordination activities, and management of chronic conditions, medication management and gaps in care closure. The CM will monitor and evaluate effectiveness of the case management plan at least monthly and modify as necessary.
   b. Document medications with the Enrollee and their designated representatives which involves building a complete list of Enrollee's medications (new and existing), checking them for accuracy, reconciling and documenting any changes. When a medication discrepancy is identified, communicate the identified discrepancy to the appropriate provider and follow up for correction.
   c. Ensure access to services appropriate to their health needs and will verify the Enrollee's scheduled services and follow-up appointments are made with their PCP.
   d. Assist the Enrollee with selecting a PCP if they do not have one. Provides Enrollee assistance in helping with identified psychosocial needs/issues such as caregiver issues, community resource referrals, emergency needs, financial assistance, housing arrangements and/or long-term care planning.
   e. Maintain contact and collaboration with the Enrollee and /or representative for engagement and ongoing case management follow ups to ensure that all proper services are in place and the discharge plan is being adhered to.

F. Transition Emergency Department (ED) to Home/Community
   1. The Emergent Care Program will offer care coordination services for those Enrollees who exhibit a pattern of frequent ED utilization. The Emergent Care program is designed to reduce the likelihood of return ED encounters for services that could otherwise be provided by a PCP or urgent care center.
      a. The Emergent Care Coordinator, who is non-licensed, facilitates the program under the guidance of the Manager of Case Management.
      b. Enrollees are identified for the Emergent Care program by the clinical software Stratification Manager, a predictive model software, that identifies Enrollees who are high-risk for return ED visits.

c. Once identified, a program is automatically generated within the clinical software system for Enrollees to be outreached.
d. Services provided by the Emergent Care Coordinator will include but not limited to:
    i. Educating Enrollees on alternatives to use of ED services for care that can be provided elsewhere.
    ii. Assisting with scheduling a follow-up appointment with their PCP or specialist.
    iii. Establishing care with a PCP.
    iv. Medication fulfillment.
    v. Providing transportation assistance when needed.
    vi. Verifying and or assisting Enrollees with access to a hard copy of their insurance card to avoid being denied the opportunity to schedule an appointment with a practitioner.
e. The Emergent Care Coordinator will refer Enrollees participating in the Emergent Care Program. who are found to require additional assistance upon program completion for follow-up by the assigned RN CM. Enrollees may also be offered in-home primary care interventions to address immediate needs, barrier analysis related to accessing care outside the ED, and assistance to re-connect care with a PCP.

Summary of Changes:	**07/23:** • Regulatory References: Updated NCQA to 2023 • Formatting changes throughout the document **07/22:** • Responsible Parties: Removed associates' names; added titles. • Approver: Removed Dr. Patryce Toye, added Dr. Raymond Tu. • Changed 'enrollee' to 'Enrollee' throughout the document. • Corrected grammatical errors where applicable throughout the document. **07/21:** • Updated Responsible Parties. **03/21:** • New policy.