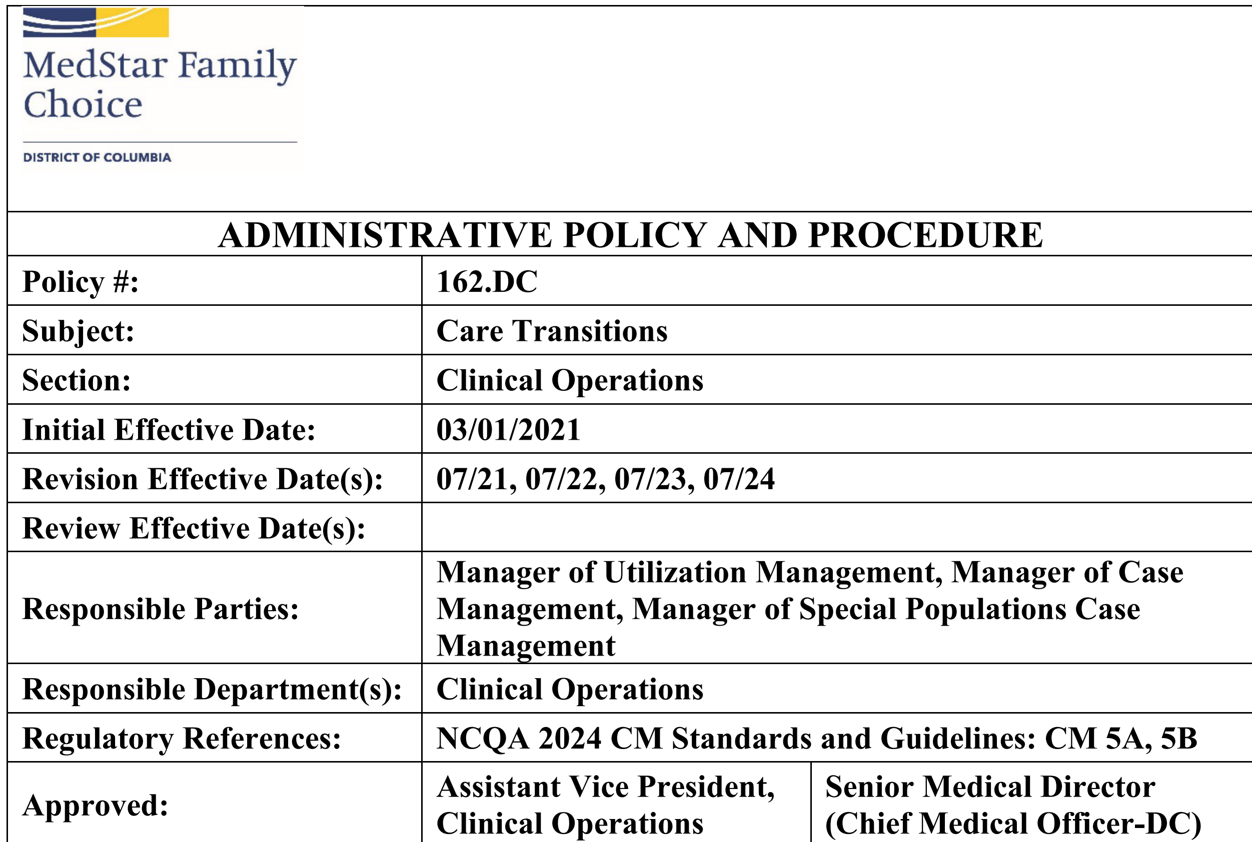

MedStar Family Choice
DISTRICT OF COLUMBIA

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, 07/24**	
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 2024 CM Standards and Guidelines: CM 5A, 5B**	
Approved:	**Assistant Vice President, Clinical Operations**	**Senior Medical Director (Chief Medical Officer-DC)**

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

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

Policy: **MedStar Family Choice 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 that includes acute care facilities, emergency departments, skilled nursing facilities, custodial nursing facilities, rehabilitation facilities, and the home and community.**

Procedure:

A. **Transition from Inpatient, Subacute Rehab (SAR), Skilled Nursing Facility (SNF), Long Term Acute Care (LTAC), Acute Rehab, or Hospice to Home/Community**
   1. MedStar Family Choice DC identify Enrollees who have a transition from Inpatient, Subacute Rehab (SAR), Skilled Nursing Facility (SNF), Long Term Acute Care (LTAC), Acute Rehab, or Hospice to Home/Community through the following methods:

   a. Direct Contact with the Hospital's Discharge Planning Departments
   b. Chesapeake Regional Information System for our Patients (CRISP)
      i. CRISP is the state designated Health Information Exchange (HIE) and Health Data Utility (HDU) that provides near real-time event notification, allowing MedStar Family Choice DC to identify any Enrollee with a transition.
   c. Daily Utilization Management (UM) Inpatient Concurrent Review Process
      i. MedStar Family Choice DC UM RNs review clinical information received from the admitting facility and identify any Enrollee with a transition.
   d. Weekly Census Meetings
      i. Census meetings are conducted weekly and attended by the Director of Clinical Operations, Manager of UM, Managers of Case Management, Medical Directors, UM RNs, and Transition of Care RNs. All Enrollees with current inpatient admissions are clinically reviewed for appropriate utilization of services, discharge planning, as well as identification for complex case management or other case management programs and services.

2. To ensure continuity of care, MedStar Family Choice DC will notify the Enrollee's usual providers such as the primary care physician (PCP) and specialists, home health agency, and/or other treating practitioners within 72 hours of admission to Inpatient, SAR, SNF, LTAC, Acute Rehab, or Hospice and within 72 hours of discharge to home/community.

3. MedStar Family Choice DC will assign a Transition of Care (TOC) Case Manager (CM) responsible for supporting the Enrollee through the transition within 72 hours of admission.

4. The TOC CM will perform a chart review in GuidingCare and review any completed assessments, case management notes, and care plans. After the chart review, the TOC CM will share necessary information e.g. health history, status, and goals that may affect the Enrollee's transition with the hospital discharge team within 72 hours of transition.

5. The TOC CM will communicate the care transition process to the Enrollee and their designated representatives within 72 hours of identifying a transition.

6. The transition status will be tracked using the following methods and documented in the case management system:
   a. MedStar Family Choice DC's Utilization Management (UM) Department will monitor the Enrollee's status throughout the transition by reviewing clinical information received from the admitting facility. If any discharge planning needs are identified, the UM Department will inform the TOC CM.

   b. The TOC CM will work closely with the hospital discharge team to monitor transition status.
   c. The TOC CM will utilize CRISP reports to monitor transition status and identify any discharges.

7. Throughout the transition, the TOC CM will work collaboratively with the hospital discharge team to obtain information on the Enrollee's status, assist with the arrangement of appropriate services for the Enrollee following discharge, and help optimize use of available health insurance benefits. This allows the TOC CM to anticipate needs once the Enrollee transitions home or to the community, providing the Enrollee with a safe, timely, and seamless transition.

8. Within 72 hours of discharge, the Enrollee and their designated representatives will be contacted by the TOC CM or the Enrollee's CM if the Enrollee is already in case management.
   a. If the Enrollee is already in case management, the TOC CM will notify the Enrollee's CM of the discharge and share necessary information about the transition. Within 72 hours of discharge, the CM will contact the Enrollee and their designated representatives. If the Enrollee is unreachable, the CM will make two attempts within 48 hours. During this outreach, the CM will do the following:
      i. Assess if there have been any significant changes to the Enrollee's health status. If there are significant changes, the CM will reassess the Enrollee to determine if additional services and goals are needed.
      ii. Work with the Enrollee and their designated representatives to update the case management plan as needed, ensuring that all changes are communicated with the Enrollee and their designated representatives.
      iii. Ensure that the Enrollee understands the discharge instructions.
      iv. Verify that the Enrollee has follow-up appointments scheduled with their PCP. If the Enrollee does not have a PCP, the CM will assist the Enrollee with selecting a PCP.
      v. Confirm that the Enrollee has all needed services scheduled.
      vi. Review the Enrollee's new and existing medications and document in the case management system.
         a. The CM will perform medication reconciliation and ensure the Enrollee understands why they are taking the medications, how to take them properly, and associated side effects. If the Enrollee is noncompliant, the CM will identify reason for noncompliance and inform the appropriate provider. Additionally, the CM will notify the appropriate provider if any discrepancies are identified and follow up for correction.
   b. If the Enrollee is not in case management, the TOC CM will contact the Enrollee and their designated representatives within 72 hours of

discharge. If the Enrollee is unreachable, the TOC CM will make two attempts within 48 hours. ring this outreach, the TOC CM will do the following:

i. Ensure that the Enrollee understands the discharge instructions.
ii. Verify that the Enrollee has follow-up appointments scheduled with their PCP. If the Enrollee does not have a PCP, the CM will assist the Enrollee with selecting a PCP.
iii. Confirm that the Enrollee has all needed services scheduled.
iv. Review the Enrollee's new and existing medications and document in the case management system.
    a. The TOC CM will perform medication reconciliation and ensure the Enrollee understands why they are taking the medications, how to take them properly, and associated side effects. If the Enrollee is noncompliant, the TOC CM will identify reason for noncompliance and inform the appropriate provider. Additionally, the TOC CM will notify the appropriate provider if any discrepancies are identified and follow up for correction.
v. Refer the Enrollee to complex case management or other case management programs and services if the Enrollee requires additional support. The assigned CM will assess the Enrollee and work with the Enrollee to create an individualized case management plan that addresses the Enrollee's needs.

B. Transition from Inpatient to Subacute Rehab (SAR), Skilled Nursing Facility (SNF), Long Term Acute Care (LTAC), Acute Rehab, or Hospice

1. MedStar Family Choice DC identify Enrollees who have a transition from Inpatient to SAR, SNF, LTAC, Acute Rehab, or Hospice through the following methods:
    a. Direct Contact with the Hospital's Discharge Planning Departments
    b. Chesapeake Regional Information System for our Patients (CRISP)
        i. CRISP is the state designated Health Information Exchange (HIE) and Health Data Utility (HDU) that provides near real-time event notification, allowing MedStar Family Choice DC to identify any Enrollee with a transition.
    c. Daily Utilization Management (UM) Inpatient Concurrent Review Process
        i. MedStar Family Choice DC UM RNs review clinical information received from the admitting facility and identify any Enrollee with a transition.
    d. Weekly Census Meetings
        i. Census meetings are conducted weekly and attended by the Director of Clinical Operations, Manager of UM, Managers of Case Management, Medical Directors, UM RNs, and Transition of Care RNs. All Enrollees with current inpatient admissions are clinically reviewed for appropriate utilization of services,

discharge planning, as well as identification for complex case management or other case management programs and services.

2. To ensure continuity of care, MedStar Family Choice DC will notify the Enrollee's usual providers such as the primary care physician (PCP) and specialists, home health agency, and/or other treating practitioners within 72 hours of admission to Inpatient and within 72 hours of discharge to SAR, SNF, LTAC, Acute Rehab, or Hospice.

3. Once it has been determined that the Enrollee will transition from the Inpatient setting to skilled nursing facilities, custodial nursing facilities, or rehabilitation facilities, MedStar Family Choice DC will assign a Post-Acute RN to support the Enrollee through the transition within 72 hours. Additionally, MedStar Family Choice DC will provide the hospital discharge planning team with the list of in-network facilities that have the capability of providing the needed care. The name and number of the Post-Acute RN will also be included.

4. The Post-Acute RN will perform a chart review in GuidingCare and share necessary information e.g. health history, status, and goals that may affect the Enrollee's transition with the hospital discharge team within 72 hours of identifying a transition.

5. The Post-Acute RN will communicate the care transition process to the Enrollee and their designated representatives within 72 hours of identifying a transition.

6. The transition status will be tracked using the following methods and documented in the case management system:
    a. The Post-Acute RN will monitor the Enrollee's transition status by reviewing clinical information received from the admitting facility.
    b. The Post-Acute RN will work closely with the hospital discharge team to monitor transition status.
    c. The Post-Acute RN will utilize CRISP reports to monitor transition status and identify any discharges.

7. The Post-Acute RN will work collaboratively with the hospital discharge planning team on the discharge plan.
    a. The hospital CM and/or the facility liaison will submit clinical information to the Post-Acute RN, who will review the information and request additional information as needed based on the Enrollee's discharge needs.
        i. The Post-Acute RN uses InterQual and American Society of Addictive Medicine (ASAM) criteria, along with information from the hospital to assure medical necessity and the appropriate level of care.
        ii. 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 of receipt of the facility request to ensure safe and timely transitions.

b. The Post-Acute RN reviewer can approve an Enrollee's continued stay up to 90 days, when the following conditions are met:
   i. Enrollee is still receiving one or more disciplines of PT, OT or SLP and progressing toward goals.
   ii. 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.
   iii. 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.
   iv. Enrollee needs additional teaching on their disease state and/or medication management due to cognitive issues.
   v. Medical management that is needed cannot be safely completed in a home setting due to the frequency or complexity of care.
   vi. 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.
   vii. 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:
   viii. 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
   ix. 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
   x. 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.

c. 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.

d. The Post-Acute RN will assist with coordinating services with MedStar Family Choice DC 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.
e. 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 if the Enrollee requires care that is not available at an in-network facility.

8. Once the Enrollee no longer meets the criteria for post-acute care, the expectation is that the Enrollee will be discharged to home or the community. The Post-Acute Care RN will inform the TOC CM, who will collaborate with the facility Social Worker or discharge planner for a safe discharge.

9. Within 72 hours of discharge to home, the Enrollee and their designated representatives will be contacted by the assigned TOC CM or the Enrollee's CM if the Enrollee is already in case management.
    a. If the Enrollee is already in case management, the TOC CM will notify the Enrollee's CM of the discharge and share necessary information about the transition. Within 72 hours of discharge, the CM will contact the Enrollee and their designated representatives. If the Enrollee is unreachable, the CM will make two attempts within 48 hours. During this outreach, the CM will do the following:
        i. Assess if there have been any significant changes to the Enrollee's health status. If there are significant changes, the CM will reassess the Enrollee to determine if additional services and goals are needed.
        ii. Work with the Enrollee and their designated representatives to update the case management plan as needed, ensuring that all changes are communicated with the Enrollee and their designated representatives.
        iii. Ensure that the Enrollee understands the discharge instructions.
        iv. Verify that the Enrollee has follow-up appointments scheduled with their PCP. If the Enrollee does not have a PCP, the CM will assist the Enrollee with selecting a PCP.
        v. Confirm that the Enrollee has all needed services scheduled.
        vi. Review the Enrollee's new and existing medications and document in the case management system.
            a. The CM will perform medication reconciliation and ensure the Enrollee understands why they are taking the medications, how to take them properly, and associated side effects. If the Enrollee is noncompliant, the CM will

identify reason for noncompliance and inform the appropriate provider. Additionally, the CM will notify the appropriate provider if any discrepancies are identified and follow up for correction.

b. If the Enrollee is not in case management, the TOC CM will contact the Enrollee and their designated representatives within 72 hours of discharge. If the Enrollee is unreachable, the TOC CM will make two attempts within 48 hours. During this outreach, the TOC CM will do the following:
    i. Ensure that the Enrollee understands the discharge instructions.
    ii. Verify that the Enrollee has follow-up appointments scheduled with their PCP. If the Enrollee does not have a PCP, the CM will assist the Enrollee with selecting a PCP.
    iii. Confirm that the Enrollee has all needed services scheduled.
    iv. Review the Enrollee's new and existing medications and document in the case management system.
        a. The TOC CM will perform medication reconciliation and ensure the Enrollee understands why they are taking the medications, how to take them properly, and associated side effects. If the Enrollee is noncompliant, the TOC CM will identify reason for noncompliance and inform the appropriate provider. Additionally, the TOC CM will notify the appropriate provider if any discrepancies are identified and follow up for correction.
    v. Refer the Enrollee to complex case management or other case management programs and services if the Enrollee requires additional support. The assigned CM will assess the Enrollee and work with the Enrollee to create an individualized case management plan that addresses the Enrollee's needs.

C. Transition from Emergency Department (ED) to Home/Community

1. The Emergent Care Program offers care coordination services for Enrollees who exhibit a pattern of frequent ED utilization. The 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. Enrollee outreach is done by the Emergent Care coordinator. The Emergent Care Coordinator is non-licensed and operates the program under the guidance of the Manager of Case Management.

2. MedStar Family Choice DC uses a predictive modeling software to identify Enrollees who are high-risk for return ED visits. Once identified, Enrollees are assigned to the Emergent Care Program for outreach.

3. MedStar Family Choice DC uses CRISP reports to identify Enrollees who utilized the ED. Within 48 hours of discharge from the ED, the Emergent Care coordinator will outreach the Enrollee. The Emergent Care coordinator must make at least two attempts within 48 hours.

4. Services provided by the Emergent Care Coordinator will include but not limited to:
    a. Educating Enrollees on alternatives to use of ED services for care that can be provided elsewhere.
    b. Assisting with scheduling a follow-up appointment with their PCP or specialist.
    c. Establishing care with a PCP.
    d. Medication fulfillment.
    e. Providing transportation assistance when needed.
    f. Verifying and 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.

5. If an Enrollee is found to require additional assistance upon program completion, the Emergent Care Coordinator will refer the Enrollee to complex case management or other case management programs and services. 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.

D. Reducing Unplanned Transitions for Enrollees

1. Identification of Enrollees at High Risk of an Unplanned Transition
    a. At least monthly, MedStar Family Choice DC uses predictive modeling to assign Enrollees a risk score. Enrollees with high risk scores are assigned for case management outreach.
    b. MedStar Family Choice DC runs a high utilizer report to identify Enrollees with high ED utilization and/or unplanned inpatient admissions. These Enrollees are at risk of another unplanned transition. Once identified, the Enrollees are assigned for case management outreach.
    c. MedStar Family Choice DC uses the Chesapeake Regional Information System for our Patients (CRISP) reports that provide near real-time event notification. This allows the Health Plan to identify and monitor Enrollees with an unplanned transition and provide support once the Enrollees are discharged to prevent another unplanned transition.
    d. MedStar Family Choice DC UM RNs review clinical information received from the admitting facility and identify any Enrollee with an unplanned transition that may require additional support from case management.
    e. Census meetings are conducted weekly and attended by the Director of Clinical Operations, Manager of UM, Managers of Case Management, Medical Directors, UM RNs, and Transition of Care RNs. All Enrollees with current inpatient admissions are clinically reviewed for appropriate

utilization of services, discharge planning, as well as identification for case management programs and services.

f. The Outreach Department calls new Enrollees to welcome them to the health plan. During the welcome call, the Outreach coordinator will work with the Enrollee to complete a Health Risk Assessment. If an Enrollee has multiple risk factors that could result in poor health outcomes and/or an unplanned transition, the Outreach coordinator will refer the Enrollee to case management.

2. Mitigating Risk of Unplanned Transitions
    a. Enrollees at risk of an unplanned transition are identified and enrolled in case management programs and services. These programs and services are built and designed to address the clinical, social, and behavioral health needs. Enrollees receive appropriate intervention based on their health status and identified social determinant of health (SDOH) needs and risks.
    b. The MedStar Family Choice DC Case Manager (CM) will provide the Enrollee with educational materials on how to manage chronic conditions such as Asthma, COPD, Diabetes, Heart Failure, High Cholesterol, and Hypertension.
    c. The CM will coordinate services and assist Enrollees and their caregivers to develop a greater level of independence in self-management of their health conditions.
    d. The CM will assist the Enrollee with finding a PCP and scheduling appointments to promote longitudinal relationships with the PCP and ensure the enrollees receive preventative care.
    e. The CM will promote the 24/7 Nurse Advice Line help enrollees choose the most appropriate care setting for non-emergency care.
    f. The CM will educate the Enrollee on available insurance benefits such as urgent care and telehealth as alternative care routes to the ED.
    g. The CM will perform medication reconciliation to ensure the Enrollee understands why they are taking the medications, how to take them properly, and associated side effects.
    h. For Enrollees with unaddressed SDOH needs,
    i. For Enrollees with homelessness, the CM will assist the Enrollee with access to shelters, Department of Housing and Community Development, crisis facilities, telephonic resources and web-based resources. Attention will be given to connecting Enrollees to practitioners who are nearby for easier access.
    j. MedStar Family Choice DC collaborates with Food & Friends to provide Enrollees with medically-tailored meals and nutritional counseling with a registered nutritionist/dietician.
    k. MedStar Family Choice DC collaborates with STAAR Alert to provide Enrollees at risk of falls with 24/7 monitoring with fall detection.

Summary of Changes	**07/24:** • Removed approver's names from titles. • Changed MedStar name throughout document. • Restructured the policy and renamed sections. • Under Section A, updated the point person to the TOC CM. • Added section D "Reducing Unplanned Transitions for Enrollees". **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.