blue california
Promise Health Plan

POLICY & PROCEDURE
Medical Services

Policy Title: Managing Care Transitions		
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Department Head: Date:		**Medical Services/P&T Committee: Date:**
P&P Committee: Date:		**Department(s): Population Health**

PURPOSE:

The purpose of this policy is to establish a collaborative, multidisciplinary approach to manage member transitions from one setting to another, i.e. Hospital to Skilled Nursing Facility or home and vice versa. The Blue Shield Promise Case Management Department utilizes a team approach to focus on the care transition process. The Blue Shield Promise Case Management Department will monitor outcomes and assess effectiveness in an effort to identify opportunities for continual improvement.

POLICY:

Blue Shield Promise Health Plan is committed to providing safe transitions for our members who may be older or disabled. This population is at risk for poor outcomes when transitions of care are inadequately coordinated. The Case Management Team will focus on promoting continuity of care with the application of a member specific care plan and an integrated approach with healthcare professionals in the process of coordinating, monitoring and communicating the needs of the member. This shall be achieved by utilizing the skills of a multidisciplinary team of practitioners including: physicians, case managers, social workers, pharmacists and other trained in the management of members with complex care needs.

DEFINITIONS:

Care Setting: The provider or place from which the member receives health care and health-related services. Settings include: home, 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. The organization sets parameters for the types of information that should be communicated between settings in a care plan. The care plan should

be tailored to each individual and take patient health status into consideration. The care plan may contain, and is not limited to, both medical and non-medical information.

Receiving Setting: The setting responsible for the member's care after a transition.

Sending Setting: The setting responsible for the member's care before a transition.

Transition: Movement of a member from one care setting to another as the member's health status changes.

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

Transitional Process: the period from identifying a member who is at risk from 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.

PROCEDURE:

Care Transitions are monitored and overseen by the Case Management Team which includes the Director of Case Management, Care Transition Specialist, Inpatient Case Manager, Care Transition Nurses, Disease Management Nurse and the Complex Case Management Nurse. The Director of Medical Services and the Chief Medical Officer provide a consulting and supervisory function within the team.

I. Managing Planned and Unplanned

a. Planned transitions from the member's usual setting of care to the hospital will be identified through reports that identify all inpatient admissions that have been authorized prospectively by Blue Shield Promise Utilization Management Department. Reports will be generated daily, identifying future planned transitions. These members or responsible party will be mailed a letter that explains the Care Transition process and provides them with contract information in case they have any questions.

b. For planned and unplanned transitions from member's usual setting of care to the hospital, Blue Shield Promise will retrieve the Individualized Care Plan generated through the HRA SNP MOC process and fax it to the hospital within one (1) day of notification of the transition. Planned transitions from the hospital to the next setting (usual setting of care or skilled nursing facility) will be identified by the Blue Shield Promise Inpatient Case Manager through the daily concurrent review process that takes place with the hospital case manager. Post discharge orders/care plan will be requested from the hospital and faxed to the receiving setting within one (1) business day of notification of the transition.

c. For planned and unplanned transitions, from any setting to another setting, excluding the home setting, the Inpatient Case Manager will ensure that sending setting's care plan is shared with receiving's setting via fax within one (1) business day of the notification of the transition.

d. For planned and unplanned transitions, from any setting to another setting, the Inpatient Case Manager will ensure that the patient's Primary Care Physician is notified of the transition via fax within three (3) business days of the notification of the transition.

When the member is being transitioned to a care setting, other than the usual setting of care, (includes the home setting), the Inpatient Case Manager will ensure that the sending setting's care plan is shared with the receiving's setting via fax within one (1) business day of the notification of the transition.

When the member is being transitioned to the usual setting of care, the Inpatient Case Manager in conjunction with the sending setting's discharge planner will communicate with the member or responsible party the discharge care plan. The Care Transition Specialist will call the member or responsible party within two (2) business days of the transition, to perform a scripted telephonic assessment, (see sample Care Transition Assessment attached) that will contain both medical and non-medical questions. Based on the member's or responsible party's responses, a Care Plan will be developed. This Care Plan will be mailed to the member or responsible party, the PCP and any other relevant health professional involved in the member's care within two (2) business days of its completion.

II. Supporting Members through Transition:

a. For planned and unplanned transitions from any setting to any other setting the Care Transition Team will communicate with the member or responsible party about the Care Transition Process and about changes to the member health status and plan of care. All members meeting the above criteria will be provided with a name and phone number of a Care Transition Specialist who is responsible for supporting the member through the transition process. A member of the Care Transition Team will accomplish the above communications with either the member or responsible party within two (2) business days of the transition.

III. Identifying Unplanned Transitions:

a. The Blue Shield Promise UM/Case Management team has established procedures for working with network facilities to identify members who experience unplanned transitions such as hospitalizations through the Emergency Department or admissions to Long Term Care Facilities.

i. In network acute care facilities are expected to send hospital admissions information to Blue Shield Promise Health Plan by faxing the hospital face sheet and clinical information to the UM Department within one (1) business day of admission.
ii. In network long-term facilities are expected to send report of admission to Blue Shield Promise Health Plan by faxing the facility's face sheet and clinical information to the UM Department within one business day of admission.

IV. Reducing Transitions:

a. The Case Management Team is committed to minimize unplanned transition and prevent avoidable transitions across its member population by:
    i. Utilizing the results of the Health Risk Assessment (HRA) which is performed annually on all SNP members, and within ninety (90) days of enrollment for new members.
    ii. On a monthly basis, a report will be generated that identifies members that have answered a predetermined number of questions in a manner that may indicate a high risk for an unplanned transition. These members will be contacted by phone and assessed as to whether or not they may benefit from home health care or other type of services that may prevent an unplanned transition. These members or responsible parties will also be provided with educational materials that will allow them to remain healthy and safe in the least restrictive setting. The PCP will be informed of these interactions.
    iii. Analyzing the Emergency Room and hospital utilization database at least quarterly and identifying members at risk for changes in health status and referring them in the Blue Shield Promise Complex Case Management Program. The program provides continuous clinical and psychosocial monitoring in an effort to prevent unplanned transitions in care.
    iv. Through the Medication Therapy Management (MTM) Program, identifying members that may be taking medications that place them at risk for unplanned transitions. In such cases, both the prescribing physician, and the member will be contacted in order for medication adjustments to be made. If necessary, Case Management will be provided in order to minimize the member's risk for an unplanned transition.
    v. Members may also be identified as having increased risk for unplanned transitions by notification from a number of sources such as:
        1. Blue Shield Promise Case Managers and Social Workers through direct member interaction
        2. Primary Care Physicians and Specialty Providers
        3. Customer Care Department
        4. Disease Management Department
        5. Member Transportation Requests

Blue Shield Promise Health Plan's approach in coordinating care for members who have been identified for a potential unplanned transition is a multidisciplinary process which includes Case Managers, Social workers, Pharmacist and Physicians. Blue Shield Promise Health Plan utilizes a comprehensive case management software application that is member centric, call CareEnhance Clinical Management Software (CCMS). The program is the central repository for all member specific data which provides an integrated platform for the multidisciplinary team documentation and communication. Information stored in CCMS includes but is not limited to: condition specific assessments, care plans, notes, and medical records. Additionally, CCMS has automated program logic to support processes to promote optimal workflow to the care team to ensure proper follow-up/oversight is conducted with the member or responsible party, physician, care setting and other healthcare providers.

Measurement and Reporting:
Through its Healthcare Informatics Department, Blue Shield Promise will review and analyze data on an annual basis, in order to measure and report the following outcomes:

- Redacted reports identifying all planned transitions and documenting compliance with mailing of the Care Transition informational letter and Care Plan to the member or responsible party, faxing care plans to the receiving setting, PCP and other healthcare professionals
- Redacted reports identifying for all planned and unplanned transitions from any setting to any other setting that communication with the member or responsible party regarding the care transition process and changes to the member's health status and plan of care occurs within a specified timeframe. In addition, the report will identify that each member is assigned a consistent person, or unit that will be responsible for supporting the member through transitions between any points in the system within a specified timeframe.
- Redacted daily admission reports from hospitals and long term care facilities reports
- Redacted reports identifying high risk members using results of the HRA, MTM program and analyzing claims and encounter data
- Reports showing aggregate analysis of transition task performance

45 days to complete HRA based on the following criteria:

If MET tool is included with Member Specific Paid Claims Data File Record Layout and any of the following questions are answered "Yes" then classify as High-Risk.

1. Do you need to see a doctor within the next 60 days?
2. Do you see a doctor regularly for a mental health conditions such as depression, bipolar disorder or schizophrenia?

3. Have you needed help with personal care such as bathing, getting dressed or changing bandages in the last 6 months?
4. Are you using medical equipment or supplies such as a hospital bed, wheelchair, walker, oxygen, or ostomy bags?
5. Do you have a condition that limits your activities or what can you do?
6. Are you pregnant?

Member Specific Paid Claims Data File Record Layout:
If any one of the following diagnosis/claim or encounter is identified then classify as High-Risk

- AIDS Diagnoses
- ESRD Diagnoses
- Behavioral Health Diagnosis with concurrent chronic medical condition
- Recent Organ Transplant
- Cancer currently being treated
- Enrolled in hospice
- Received oxygen within past 90 days
- Hospitalization within last 60 days
- 3 or more hospitalizations in last 12 months
- Emergency Room visit within last 60 days
- 3 or more Emergency Room visits in last 12 months
- SNF admission within last 60 days
- Place of service code 004: homeless shelter
- Any of the following inpatient discharge codes:
    - 2 = Transfer to Transitional Inpatient Care

Pharmacy criteria for Risk Assessment of SPD population:
If any one of the following criteria is met then classify as High-Risk

1. # of prescriptions greater than or equal to 24 per quarter or
2. Paid amount greater than or equal to $600/quarter or
3. Skey HICL (Atypical Antipsychotics) equal to the following:

HICL	Drug Name
24551	Abilify
04834	Clozaril oral
36778	Fanapt Oral
23379	Geodon Vials
21974	Geodon Caps
36479	Invega Inj
34343	Invega Oral
37321	Latuda Oral

25509	Risperdal Consta
08721	Risperdal oral
36576	Saphris SL
14015	Seroquel oral
25800	Symbyax
11814	Zyprexa
36716	Zyprexa Relprevv

REFERENCES/AUTHORITIES: