blue california
Promise Health Plan

Policy Title: Post-Acute Discharge and Transitional Care Planning		POLICY #: 90.2.8 Line of business: CMC	
Department Name: Utilization Management	**Original Date** 7/13	**Effective Date** 6/19	**Revision Date** 12/18
Department Head: Sr. Director, UM		**Date: 3/21**	
Medical Services/P&T Committee: (If Applicable) PHP CMO		**Date: 3/21**	

PURPOSE

To ensure that the post-acute discharge is accomplished appropriately and that care transitions occur effectively and safely, as evidenced by the identification and development of a discharge plan based on the individualized patient needs to promote an individualized, effective and safe transition between health care settings for Medicare Medicaid Plan (MMP) members.

Post-acute discharge planning is an interdisciplinary integrated approach that includes Person-Centered planning to actively engage the member in his or her health treatment and LTSS planning and service delivery process, with an emphasis on identifying the strengths, capacities, preferences, needs and desired outcomes of the individual. The plan of care developed focuses on assisting him or her achieve personally-defined outcomes in the most inclusive community setting.

POLICY

Blue Shield of California Promise (Blue Shield Promise) will incorporate appropriate use of LTSS, including IHSS, CBAS, MSSP, nursing facilities, home and community based services (HCBS) Plan benefits, and Community Based Organization (CBO) services, behavioral health partners, and alcohol and substance abuse service providers in planning post-acute discharge planning.

The Utilization Management (UM) Case Managers will perform transitional and discharge planning needs under the following circumstances:

a. Acute Admission
b. Skilled Nursing Facility (SNF) admission or discharge to the community
c. Long Term Care to the Community
d. Acute Psychiatric
e. Non-institutional (Residence, B&C, Assisted Living)
f. PCP request for community placement
g. Rehabilitation Facility Care

PROCEDURE

Multiple modalities are utilized to assess the member's clinical and psychosocial status for discharge/transitional care needs:

1. Physician Plan of Care – This involves the active problem, clinical findings the patients past medical history, and treatment plan.
2. Surgical Procedures – Indication of a complex outcome of the surgery, co-morbidity's unexpected complications, wound management, drains, tubes, equipment, etc
3. Respiratory Management – O2 therapy, respiratory treatments, O2 saturation's etc.
4. Medication Regime – Pain management, ABT Therapy, anticoagulation therapy, associated labs, adverse reactions, insulin management, or medication teaching.
5. Physical Medicine Therapies – (Physical Therapy, Occupational Therapy, Speech Therapy)
6. Social Needs – Environmental considerations such as, patient's support system, transportation access, meals and nutrition, and other current living circumstances.
7. Level of Care Required –
    a. SNF
    b. Acute Rehab – physical
    c. Sub-Acute
    d. TCU
    e. Home Health
    f. Psychiatric placement or services
    g. Alcohol and substance abuse rehab
    h. Community residential
8. Patient Goals – for self-directed care
9. Patient's/Family skill level regarding needs maintaining care in the home.
10. Educational and instructional needs for patient/caregiver regarding disease process and or skilled and ADL care and other modalities to improve health status
11. Patient's activity prior to hospitalization

Blue Shield Promise shall ensure the provision of discharge planning/transitional care when an MMP member has a change in condition that requires assessment of an alternate setting and/or additional support services to optimally maintain their health care needs.

Discharge/Transitional Care Planning Settings:
Based on the needs of the member to include medical, psychological environmental, support system, social needs, and self-directed determinations of the member and/or caregiver, discharge planning will evaluate the most appropriate setting to meet the member's needs. Setting options may include but are not limited to the following:

a. Return to previous living condition
b. Residential care facility for the elderly – RCFE
c. Skilled Nursing Facility
d. Behavioral Health Center – Alzheimer's Unit – extended psychiatric care
e. Hospice placement
f. Rehab for alcohol and substance abuse

Discharge Planning/Transitional Care Planning Support Services

1. When deemed that the patient is to return home the following support systems will be considered to optimally and/or restore the member:
    a. Palliative Care
    b. Home Health
    c. Rehabilitation Care (PT, OT, ST, RT)
    d. CBAS programs
    e. IHSS
    f. MSSP
    g. Other LTSS community – based services

2. When the member has identified an actual or potential alcohol or substance problem, the case shall be referred to Case Management to coordinate referral to the local Alcohol and Other Drugs Program (AODP) for appropriate services, including outpatient heroin detoxification providers for available service site.
    a. Blue Shield Promise will ensure the provision of primary care and other covered services unrelated to the alcohol or substance abuse problem during the Member's treatment.
3. For those members with a psychiatric diagnosis in need of placement or outpatient mental health services, arrangements will be made by the Blue Shield Promise case manager to refer to the mental health provider for determination of medical necessity. This may include referrals to the local Medi-Cal Mental Health Plan for Medi-Cal benefits and to a Medicare rendering provider the management of a Medicare psychiatric benefit. Other appropriate community resources will be contacted as necessary to assist the member to locate available mental health services.
    a. Blue Shield Promise will ensure the provision of primary care and other covered services unrelated to the psychiatric condition during the Member's treatment.
4. When the member requires placement in a skilled nursing facility the Blue Shield Promise case manager will develop specific care coordination provisions for the member. The case manager will perform concurrent review pertaining to nursing facility utilization and work with the care transitions team to develop care transition plans to move the plans to move the patient back into the community to the extent possible. Such transition care planning shall include assessment of the need for Home-and Community Based Services, and involve Members, family, legal representatives, PCPs, nursing facility personnel, behavioral health representatives, and other health care and LTSS community-based providers.
5. For members returning to community residential living, the case manager will coordinate and collaborate with county agencies for IHSS and behavioral health services, MSSP providers and CBAS centers, CBOs, such as Area Agencies on Aging, Independent Living Centers, etc., as appropriate regarding discharge planning.
    a. For members who are being discharged from the hospital that are at risk for placement in a SNF the case manager will arrange an expedited MSSP assessment and eligibility determination to offer these comprehensive services for optimal community transition.

REFERENCES

- UM P&P 10.2.100.20 Discharge Planning
- CMS-CA Duals Demonstration Memorandum of Understanding