ST PETER'S HEALTH PARTNERS	**Effective Date:** March 1, 2023

Category: **D. Critical Events and Incidents**

Title: **1. Care Transitions**

Applies to:

☐ St. Peter's Health Partners (SPHP)

☐ All SPHP Component Corporations **OR** ☐ Only the following Component Corporations: (Click here for a list)
☐ _____

☐ All SPHP Affiliates **OR** only the following Affiliates: (Click here for a list)
☒ **All Capital Region Health Connections Care Management Agencies**

☐ St. Peter's Health Partners Medical Associates (SPHPMA)

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PURPOSE

To ensure that Members receive thorough and timely follow-up and appropriate services when transitioning out of an inpatient facility, hospital or incarceration setting with the aim of reducing the likelihood of re-admission and increasing overall Member well-being and stability.

POLICY STATEMENTS

Care Transitions refers to the movement of patients from one setting of care to another as their needs change. This can include discharges from facilities or releases from incarceration. Essentially, Members are moving from a facility in which their care is largely managed by the

facility, and those structures and supports will no longer be in place when the Member is discharged or released back to his or her community. The Health Home program seeks to assist in these Care Transitions to help prevent the Member from being re-admitted to the facility from which they were released, thus reducing re-admissions, re-presentations to an Emergency Department or re-incarceration. Providing timely and thorough supports at time of a Care Transition are critical to the success of Members in transition. Care Transitions may include the following activities.

- Education on the reason for the hospitalization
- Education on the use of the Emergency Department (vs a PCP or Urgent Care)
- Reminders on coping skills or social supports to utilize
- Reviewing discharge paperwork, including instruction for post-discharge
- Attending follow-up appointments with providers
- Obtaining medications post-discharge
- Informing the Care Team of the event and any needed follow-ups
- Updating the Member's Plan of Care with new information and needs

SCOPE OF AUTHORITY / COMPETENCY

All Care Management Agencies that comprise the Capital Region Health Connections Health Home program.

DEFINITIONS

***Care Transitions*:** A set of actions designed to provide coordination and continuity of care as Members move from one level of care or placement to another within the community.

***DOH 5055*:** Health Home Patient Information Sharing Consent Form; the State produced form for capturing consent for other providers as well as natural supports

PROCEDURE

A. Care Transitions

1. Care Transitions must be provided when a Member is transitioning from one level of care to another, or a Member presents to the Emergency Department (ED).

2. The purpose of Care Transitions is to assist the Member post-event to help reduce the likelihood that a Member will re-present to an ED, be re-hospitalized or re-admitted to the facility (rehab, nursing home, incarceration, etc.) and to ensure the

Member has access to outpatient treatment providers to effectively manage their condition(s) in a more appropriate setting.

3. A thorough Care Transition may include the following activities, as defined by New York State:
   a. Follow up with hospitals/ER upon notification of a Member's admission and/or discharge to/from an ER, hospital/residential/rehabilitative setting.
   b. Facilitate discharge planning from an ER, hospital/residential/rehabilitative setting to ensure a safe transition/discharge that ensures care needs are in place.
   c. Notify/consult with treating clinicians, schedule follow up appointments, and assist with medication reconciliation.
   d. Link Member with community supports to ensure that needed services are provided.
   e. Follow-up post discharge with Member/family to ensure Member Plan of Care needs/goals are met.

B. Care Transition Follow-ups and Communications

1. When staff are notified of an event requiring a Care Transition, the Care Coordinator must follow-up with the Member as soon as possible, but no more than two (2) business days following receipt of the alert.

2. If the Care Coordinator is unable to connect with the Member, progressive and persistent attempts are expected to include outreach to participants of the Member's Care Team and the Member's MCO, with consent to determine the cause of the event and what next steps may be needed to support the Member.

3. Coordination and collaboration are key to a successful Care Transition. Care Coordinators must communicate Member transitions with consented providers as appropriate, including the Member's MCO. Appropriate providers are those who are participants of the Member's Care Team and those who may provide care or support following the transition.

4. Care Coordinators must share, or document attempts to share, known information regarding the admission / presentation / discharge with appropriate and consented providers and work with them to provide services to alleviate the cause of the event or reduce the likelihood of the re-admission / re-presentation.

5. Depending on the critical event, it may be appropriate for the Care Coordinator (or other CMA staff) to call a Case Conference with the Member's consented care team with the goal of addressing the critical event and minimizing the likelihood that such

an event will occur again. (See Policy I2. Contacts and Communication: Case Conferences)

6. Depending on the nature of what prompted the admission / ED presentation, updates to the Plan of Care may be warranted. For example, if a Member received a new diagnosis, has new providers recommended or multiple follow-up steps, those will likely warrant a Plan of Care Amendment so that no critical needs are left unmet.

7. If the event was a suicide attempt or Member death, it may be reportable to Capital Region Health Connections as a Reportable Incident. For more on the definitions of Reportable Incidents, see Policy D2. Incidents and Complaints.

8. Because a thorough and complete Care Transition will require communication with the Member and consented providers as well as assisting with needs post-discharge to ideally prevent re-admission, Care Transitions will occur over multiple days or weeks, possibly months. Care Transitions should never be viewed as simply a phone call to the Member within two (2) business days to determine what caused to event.

To assist Care Coordinators in providing thorough Care Transitions, several tools and resources are available on the Health Home website. This includes the following resources.

Care Transitions Guide for Members
Care Transitions Guide for Providers
Education on the Use of the ER
Care Transitions Training Video and Case Vignettes

C. Discharge Planning and Summaries

1. When a Member is discharged from a structured setting (may include hospital, inpatient setting, incarceration, etc.) the Care Coordinator must make and document efforts to obtain the discharge summary from the discharging entity and assist the Member in following the discharge instructions. This may include participating in discharge planning, scheduling appointments with providers for follow-up, linking the Member with needed providers for follow-up or scheduling a Case Conference. (See Policy I2. Contacts and Communication: Case Conferences)

2. Whenever possible, Care Coordinators should make efforts to engage in the discharge planning process with facility staff. This may include participating in discharge meetings and contributing to the development of the plan.

3. Any unsuccessful efforts to participate in discharge planning or obtaining documentation must be documented in the Member's chart in CareManager.

4. Once obtained, discharge summaries must be thoroughly reviewed with Member to ensure follow-up needs are understood by the Member and the Care Coordinator should provide assistance with scheduling or attending any follow-ups, as needed. Discharge summaries must be uploaded to the Member's chart in CareManager. Some discharges may also warrant being added to the Member's HML assessment as well.

D. Care Transitions for High Utilizers

1. It is recognized that some Members present to Emergency Departments (ED) often, sometimes daily or more frequently. In those situations, Care Transitions will focus less on each individual presentation and need to obtain discharge summaries for each, but rather should focus on the larger issue causing the repeat presentations.

2. Addressing these situations will always require a case conference with other providers or engaging the Lead Health Home for assistance on a complex case.

3. In some situations, it may be appropriate to include an Objective on the Member's Plan of Care focused on reducing ED usage.

REFERENCES

New York State Department of Health (October 5, 2015). Health Home Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations.
(https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_mco_cm_standards.pdf)

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