Older or disabled adults moving between different health care settings are particularly vulnerable to receiving fragmented and unsafe care when transitions are poorly coordinated.

CMS requires all Medicare Advantage – Special Needs Plans which includes all MSHO and most SNBC products to develop a process to coordinate care when members move from one care setting to another to avoid potential adverse outcomes.
Care Transitions: Learning Objectives

- Characterize care transitions and understand impact on older and disabled adults.
- Learn methods that support members through transitions.
- Review Minnesota Health Plan’s MSHO and SNBC care transition process and documentation requirements.

Care Transitions

- **Transition:** Movement of a member from one care setting to another as the member’s health status changes.
  - Examples include: moving from home to a hospital as the result of an exacerbation of a chronic condition or moving from the hospital to a rehabilitation facility after surgery.

- **Care Setting:** The provider or place from which the member receives health care and health-related services. In any setting, a designated practitioner has ongoing responsibility for the member’s medical care.
  - Examples include: home, home health care, acute care, nursing facility, rehabilitation facility
Care Transitions

339 Days in the Life of Mrs. B

- Hospital to Home (H2H) and the Medicare QIO Care Transitions Project, CFMC (QIO for Colorado)
- Presentation by Jane Brock, MD, MSPH, Care Transitions Medical Officer, Quality Improvement Services – Colorado Foundation for Medical Care (CFMC)

339 Days in the Life of Mrs. B

- Mrs. B is newly established with an Internal Medicine doctor who will provide regular source of care to the member.
- Initial visit – Mrs. B has diagnoses of Diabetes, Hypertension (high blood pressure), osteoporosis and hypothyroidism.
  - Mrs. B diabetes is poorly controlled and she has stared to experience early numbness
- Set up to see doctor every 2 weeks until diabetes is controlled.
### Mrs. B...

#### DAY 15

| Status                      | Fully Functional  
|                            | Helps with grandchildren  
|                            | Takes care of her husband  
| Providers                  | Internist  
| Medications                | 2 hypertension – 1 time/day  
|                            | 2 diabetes – 2 times/day  
|                            | 1 osteoporosis – once weekly  
|                            | 1 hypothyroidism – 1 time/day  
|                            | Eye drops  
| Payments                   | $180.00  
| Daughter                   | 7  

#### DAY 68

| Status                      | Homebound receiving home health  
|                            | Not feeling well  
| Providers                  | Internist  
|                            | HH Physical Therapist  
|                            | ER Doctor  
|                            | HH Occupational Therapist  
| Medications                | 2 hypertension – 1 time/day  
|                            | 2 diabetes – 2 times/day  
|                            | 1 osteoporosis – once weekly  
|                            | 1 hypothyroidism – 1 time/day  
|                            | Pain medications – every 4-6 hours  
| Payments                   | $3,256 – Emergency Room  
|                            | $476 – Home Health Aide  
|                            | $99 – Primary Care Provider  
| Daughter                   | Daily visits, doing the shopping and transportation to medical appointments, worried about dad  

| Payments                   | $4011  

Daughter, daily visits, doing the shopping and transportation to medical appointments, worried about dad.
### DAY 69

| Status | Hospitalized with Staph Septicemia, dehydration, acute renal failure, congestive heart failure, atrial fibrillation, pneumonia, and diabetes uncontrolled. |

### DAY 82

<table>
<thead>
<tr>
<th>Status</th>
<th>Transferred to Skilled Nursing Facility due to short-term rehab for ADL assistance. Depressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers</td>
<td>Internist</td>
</tr>
<tr>
<td>ER Doctor</td>
<td>SNF Occupational Therapist</td>
</tr>
<tr>
<td>Hospitalist</td>
<td>Hospitalist Physical Therapist</td>
</tr>
<tr>
<td>Cardiologist</td>
<td>Psychologist/Therapist</td>
</tr>
<tr>
<td>Medications</td>
<td>2 hypertension – 1 time/day</td>
</tr>
<tr>
<td></td>
<td>2 antibiotics – 1 time/day</td>
</tr>
<tr>
<td></td>
<td>2 diabetes – 2 times/day</td>
</tr>
<tr>
<td></td>
<td>2 heart failure – 1 time/day</td>
</tr>
<tr>
<td></td>
<td>Antidepressant – 1 time/day</td>
</tr>
<tr>
<td></td>
<td>1 osteoporosis – once weekly</td>
</tr>
<tr>
<td></td>
<td>1 hypothyroidism – 1 time/day</td>
</tr>
<tr>
<td></td>
<td>Pain medications – every 4-6 hrs</td>
</tr>
<tr>
<td>Payments</td>
<td>$47,423 - hospital</td>
</tr>
<tr>
<td></td>
<td>$586 – Emergency Room</td>
</tr>
<tr>
<td>Daughter</td>
<td>Stressed out, unsure her mother is taking her medications correctly, wondering about home health and mom coming home, daily visits to Dad at home, feeling overwhelmed and no light at end of tunnel</td>
</tr>
</tbody>
</table>
### DAY 82 – 182 in the Skilled Nursing Facility

| Status            | Receiving daily physical therapy  
|                   | Excellent wound care  
|                   | Has visits from Primary Care Provider (Internist)  
|                   | Diabetes control improved  
|                   | Neuropathy continues.  
|                   | Ambulation potential not returned to baseline.  
| Daughter          | Stressed out  
|                   | Daily visits to Dad at home  
|                   | Daily visits to Mom at nursing home  
|                   | Feels guilty about noticing that nursing home made her life easier  
|                   | Committed to getting mom home  
|                   | Thinking about getting a part-time job because coming up short each month to pay bills.  

### DAY 182

| Status | Home – needs assist with ambulation and transfers, abrasions well healed, diabetes in good control, depressed – doesn’t like new diet  
|--------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------  
| Providers | Internist | HH Physical Therapist | SNF PT  
|          | ER Doctor | HH Occupational Therapist | SNF OT  
|          | Hospitalist | Hospitalist Physical Therapist |  
|          | Cardiologist | Psychologist/Therapist |  
| Medications | 2 hypertension – 1 time/day  
|           | 2 diabetes – 2 times/day  
|           | 2 heart failure - 1 time/day  
|           | 1 osteoporosis – once weekly  
|           | 1 hypothyroidism – 1 time/day  
|           | Antidepressant – 1 time/day  
| Payments | $34,495 – Skilled Nursing Facility  
|         | $99 – Primary Care Provider (Internist)  
| Daughter | Stressed out, committed to getting her mother “back to normal”,  

Mrs. B...
### DAY 183

**Status**
- Home
- Nauseated and poor appetite
- Unsure what to eat – doesn’t feel like eating anyway
- Can’t find her teeth
- Husband is vague and needs help with basic decisions
- Daughter visited 2 times today even though she has started a new part-time job.
- Daughter intends to call Primary Care Provider to schedule home health again.

### DAY 184

**Status**
- Readmitted to the hospital
- Dehydration, congestive heart failure, atrial fibrillation, diabetes

**Providers**
- Internist
- ER Doctor (2)
- Hospitalist (2)
- Cardiologist
- HH Physical Therapist
- HH Occupational Therapist
- Hospitalist Physical Therapist (2)
- Psychologist/Therapist

**Medications**
- 2 hypertension – 1 time/day
- 2 diabetes – 2 times/day
- 2 heart failure – 1 time/day
- 1 osteoporosis – once weekly
- 1 hypothyroidism – 1 time/day
- Antidepressant – 1 time/day

**Payments**
- $24,281 – hospital
- $110,895

**Daughter**
- Stressed out, daily visits to dad – looking for day care program, feels guilty about readmission, committed to getting her mom “back to normal, working part-time.”
### Mrs. B...

#### DAY 191 to 337

<table>
<thead>
<tr>
<th>Status</th>
</tr>
</thead>
</table>
| Admitted to Inpatient Rehabilitation for intensive physical and occupational therapy.  
Discharged to nursing home.  
Progressive renal failure and heart failure with intermittent atrial fibrillation.  
Daughter visits often but is unable to make it daily  
Dad in daily day care – daughter is considering nursing home. |

### Mrs. B...

#### DAY 338

<table>
<thead>
<tr>
<th>Status</th>
</tr>
</thead>
</table>
| Readmitted to the hospital  
Acute renal failure, decompensated congestive heart failure, acute respiratory failure, acidosis |
### DAY 339

<table>
<thead>
<tr>
<th>Status</th>
<th>Deceased</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers</td>
<td>Internist</td>
</tr>
<tr>
<td></td>
<td>ER Doctor (2)</td>
</tr>
<tr>
<td></td>
<td>Hospitalist (2)</td>
</tr>
<tr>
<td></td>
<td>Cardiologist</td>
</tr>
<tr>
<td>Medications</td>
<td>None</td>
</tr>
<tr>
<td>Payments</td>
<td>$133,966</td>
</tr>
<tr>
<td>Daughter</td>
<td>Grieving</td>
</tr>
<tr>
<td></td>
<td>Worried about dad</td>
</tr>
<tr>
<td></td>
<td>Worried about personal finances</td>
</tr>
</tbody>
</table>

- **What went wrong?**
  - Reactive care – chronic disease care in acute care settings.
  - Fragmented care with discharge.
  - No assistance with navigating the health care system. Member and family had to “fend for themselves”.
Mr. T...

- 46 year old male admitted to the hospital with cellulitis. He has a history of hypertension for which he takes medication. He was treated with antibiotics in the hospital for the cellulitis. It was also noticed that he had persistently high blood pressure and the decision was made to increase his blood pressure medication. His blood pressure responded appropriately to the new dose.

- On the day of discharge he was given a prescription for clindamycin, motrin, and a new prescription for Lisinopril with the new dosage.

- He went home, got the new prescription filled and took them as instructed on his discharge papers and as well as what was written on the medication bottles. But also continued to take her old dose of Lisinopril as well.

- Patient started to have problems of feeling light headed, family brought him back to Emergency Room and he was readmitted to the hospital with acute renal failure.

Care Transitions

- Older or disabled adults moving between health care settings are particularly vulnerable to:
  - Fragmented care due to lack of follow-up
  - Health care providers not communicating.
  - Unsafe care due to changes with medication regimes or lack of medications and self-management concerns.

Care Coordinators are the key to prevent problems during transitions.
CareTransitions: Health Plan Collaboration

- Minnesota Health Plans created a care transition process with the goal of reducing incidents related to fragmented or unsafe care and to reduce readmissions for the same condition.

- Health Plans worked together in a collaborative effort to streamline processes. Core requirements to be consistent.
  - One set of requirements
  - Identified common data elements

Goals

- Health Plans agreed that the goals of care transition management are to use care coordination to:
  - reduce incidents related to fragmented or unsafe care
  - reduce readmissions for the same condition

- Without care coordination, such care transitions often result in poor quality care and risks to member’s health and safety
Care Coordination Requirements

- Proactive care coordination to prevent transitions.
  - avoid unnecessary ER and hospitalizations
  - look for risks (falls, lack of preventive care, poor chronic care disease management) and take action
  - work with Health Plans to identify high risk members (Health Plan processes vary)

- Provide a consistent person to support member throughout the transition

Care Coordination Requirements

- Identify planned transitions – reach out to the member prior to the admission or day of the admission.

- Share essential information with the receiving setting within 1 business day of the notification of the admission.

- Communicate within 1 business day of notification with providers, member and/or responsible party about the transition process and about changes in the member’s health status and care needs.
Care Coordination Requirements

Communication with Primary Care Provider

- Contact within 1 business day of notification of the transitions.
  - Verbally, fax, or flag in an electronic system.
  - Contact the clinic – Primary Care Provider and/or Specialty Care Provider.
    - Notify of admission - if not involved.

Communication with Receiving Setting

- Contact within 1 business day of notification or the transitions.
  - Unit or Discharge planner, Social Worker, etc…
  - Verbally, fax, flag in an electronic system

- Contact to share:
  - Services that are currently being received and who provides them (i.e. home care services)
  - Primary Care Provider and/or Specialty Care Provider contact information, resource for current medications, chronics conditions, current treatments, etc…
Care Coordination Requirements

- Communicating with the Receiving Setting is NOT a utilization review function and does not constitute authorization of the hospital stay.

- Communicate with discharge planner so they know what services are being provided (i.e. home care, EW, CADI, etc...). Determine from discharge planner if any new services and/or equipment might be needed and assist to coordinate with best possible Provider.

- Determine who is arranging for services upon discharge.

Communication with the Member and/or Responsible Party

- Contact within 1 business day of notification or the transitions.
  - Talk with member and/or responsible party (face-to-face, telephonic):
    - what happened;
    - changes in health status;
    - what might occur while in hospital/nursing home; and
    - discharge plans leading to or delaying discharge.
Care Coordination Requirements

Communication with the Member and/or Responsible Party

- Work with member and/or family, reassure you’ll contact when they go home, reassure that you’ll be available to support them.
  - Offer Care Coordinator’s phone number for contact.

---

Reach out to the member after the return to usual setting to assess needs and prevent readmissions.

- Telephonic or face-to-face contact
  - Medication changes/new prescriptions filled
  - DME/Supplies
  - Follow-up appointments, transportation, services
  - Changes in functional needs (bathing, eating, dressing, transfers, etc…)
  - Understanding of what to do if condition changes or gets worse.
Health Plan Requirements

- The Health Plan is required by Centers for Medicare and Medicaid Services (CMS) to:
  - Conduct an analysis of the transitions designed to identify and address barriers that might result in unplanned transitions.
  - Audit to ensure that management of care transitions is occurring.

Health Plan Requirements

- Aggregate analysis required by CMS such as:
  - Hospital Readmissions
  - ER visits
  - % of membership experiencing transitions
  - % by types of transitions: hospital, skilled nursing facility
  - % of planned vs unplanned

- Audit process may include:
  - Desk audits, claims reviews, additional data collected during care plan EW audits.
To simplify the requirement to track the care transition process, the health plans have created a form called the Individual Transition Log.

Use of this form will be required whenever a care transition has occurred.

- If the same data can be pulled from an electronic record then the form does not need to be used. Discuss with contracted Health Plan.
- PrimeWest and IMCare are using different forms with same care transition content.
## Individual Transition Log

### Individual Care Transitions Log

<table>
<thead>
<tr>
<th>Name:</th>
<th>PNI #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCO ID:</td>
<td>MCO Name:</td>
</tr>
<tr>
<td>Agency/Country/Care System:</td>
<td></td>
</tr>
</tbody>
</table>

## Individual Transition Log

### Transition

<table>
<thead>
<tr>
<th>Date</th>
<th>Notification Date</th>
<th>Notification by</th>
<th>Transition Date</th>
<th>Transition From</th>
<th>Transition To</th>
<th>Category</th>
<th>Notes</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Transition Description:**
- Planned Transition
- Unplanned Transition

**Comments:**
- [ ] Informs Member/Medicaid
- [ ] Informs MH/Single
- [ ] Health Plan/Provider
- [ ] Other

**Communication from CC/CM:**
- [ ] DCC
- [ ] Other

- [ ] Date Completed
- [ ] Other

- [ ] Date Completed
## Individual Transition Log - Examples

### Table 1

<table>
<thead>
<tr>
<th>Date</th>
<th>Transition Description</th>
<th>Transition Type</th>
<th>Transition Location</th>
<th>Communication From CCM/CM</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/01/13</td>
<td>Planned Transition</td>
<td>Home</td>
<td>Home</td>
<td>Member was discharged from the hospital and transferred to home on 04/01/13 for rehabilitation services.</td>
<td>Details about discharge and transition services provided.</td>
</tr>
</tbody>
</table>

### Table 2

<table>
<thead>
<tr>
<th>Date</th>
<th>Transition Description</th>
<th>Transition Type</th>
<th>Transition Location</th>
<th>Communication From CCM/CM</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/01/13</td>
<td>Planned Transition</td>
<td>Home</td>
<td>Home</td>
<td>Member was discharged from the hospital and transferred to home on 04/01/13 for rehabilitation services.</td>
<td>Details about discharge and transition services provided.</td>
</tr>
</tbody>
</table>

### Table 3

<table>
<thead>
<tr>
<th>Date</th>
<th>Transition Description</th>
<th>Transition Type</th>
<th>Transition Location</th>
<th>Communication From CCM/CM</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/01/13</td>
<td>Planned Transition</td>
<td>Home</td>
<td>Home</td>
<td>Member was discharged from the hospital and transferred to home on 04/01/13 for rehabilitation services.</td>
<td>Details about discharge and transition services provided.</td>
</tr>
</tbody>
</table>
Individual Transition Log - Examples

### INDIVIDUAL CARE TRANSITIONS LOG

<table>
<thead>
<tr>
<th>Name:</th>
<th>EXAMPLE #3 - Ms. T</th>
</tr>
</thead>
<tbody>
<tr>
<td>PM#:</td>
<td>099999999</td>
</tr>
<tr>
<td>MCO ID:</td>
<td>099999999</td>
</tr>
<tr>
<td>MCO Name:</td>
<td>Blue Earth County</td>
</tr>
<tr>
<td>Agency/County/Care System:</td>
<td>Blue Earth County</td>
</tr>
</tbody>
</table>

#### Transition Log: Example 3

<table>
<thead>
<tr>
<th>Date</th>
<th>Practice Name</th>
<th>Transition Type</th>
<th>Transition From</th>
<th>Transition To</th>
<th>Communication Method</th>
<th>Communication Notes</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/09/23</td>
<td>Medical Practice A</td>
<td>Referral</td>
<td>Home</td>
<td>Hospital</td>
<td>Email</td>
<td>Notified member of medical condition</td>
<td>03/09/23</td>
</tr>
</tbody>
</table>

#### Comments:
- Notified member of medical condition
- Planned to call the member the next day
- Called member to confirm they understood the information
- Member did not return call

### INDIVIDUAL CARE TRANSITIONS LOG

<table>
<thead>
<tr>
<th>Name:</th>
<th>EXAMPLE #4 - Mrs. J</th>
</tr>
</thead>
<tbody>
<tr>
<td>PM#:</td>
<td>099999999</td>
</tr>
<tr>
<td>MCO ID:</td>
<td>099999999</td>
</tr>
<tr>
<td>MCO Name:</td>
<td>Blue Earth County</td>
</tr>
<tr>
<td>Agency/County/Care System:</td>
<td>Blue Earth County</td>
</tr>
</tbody>
</table>

#### Transition Log: Example 4

<table>
<thead>
<tr>
<th>Date</th>
<th>Practice Name</th>
<th>Transition Type</th>
<th>Transition From</th>
<th>Transition To</th>
<th>Communication Method</th>
<th>Communication Notes</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/10/23</td>
<td>Medical Practice B</td>
<td>Referral</td>
<td>Home</td>
<td>Hospital</td>
<td>Email</td>
<td>Notified member of hospital stay</td>
<td>04/10/23</td>
</tr>
</tbody>
</table>

#### Comments:
- Notified member of hospital stay
- Planned to call the member the next day
- Called member to confirm they understood the information
- Member did not return call

---

*Note: The above example logs are for demonstration purposes only and do not reflect any actual patient information.*
Individual Transition Log

- Care Systems/Counties to develop internal process to collect & record data.
  - One log per member – record whether the transition was planned or unplanned.
  - Multiple transitions can be recorded on one log for the member.
  - Extract from an electronic system – must contain all the elements from the Individual Transition Log.

---

Example of PrimeWest Health Transition Form
### Individual Transition Log - PrimeWest

#### Transition of Care Update to PrimeWest Health

<table>
<thead>
<tr>
<th>Option</th>
<th>Date of transition</th>
<th>Date form completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge and new admission</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**County case manager (CCM) RN name**

<table>
<thead>
<tr>
<th>Member name</th>
<th>Member P#</th>
<th>Date of birth (mm/dd/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**County of residence**

- If other: please indicate county

**Reason for transition**

- Planned
- Unplanned

**From current setting of care**

- (choose one)
  - Skilled bed
  - Mental health inpatient
  - Jail
  - SNF
  - LT SNF
  - AFC

**Where member transitioned to**

- (choose one)
  - Skilled bed
  - Mental health inpatient
  - Jail
  - SNF
  - LT SNF
  - AFC

**SNF (Required if SNF selected from box above right)**

<table>
<thead>
<tr>
<th>Name of facility</th>
<th>If other: please indicate facility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Reason for ST SNF admission**

- (choose one)
  - SNF new admission
  - ST SNF return to facility
  - LT SNF new admission
  - LT SNF return to facility

### Individual Transition Log - PrimeWest

**Yes.** Care plan/transfer form/discharge papers/elements of care plan were provided to receiving facility or sent home with member within 24 hours of transition.

**If not completed within 24 hours, please indicate why.**

**PCP notified of transition within 2 business days of admission or discharge or PCP is the admitting or discharging physician.**

- Yes
- No (please indicate why)

**Comments, discharge concerns, or, if hospital admission, reason for admission**

### Notes

- PrimeWest Health’s name for the Special Needs RiskCare (SNRC) program
- **PrimeWest Health’s name for the Minnesota Senior Health Options (MSHO) program**

---

PW_2009_215R 05_11
The Care Coordination is the key to preventing and managing care transitions by:

- Facilitating communication to improve member’s health and safety
- Develop relationships with members, local practitioners, hospitals, nursing facilities, etc...
- Monitoring those at higher risk to prevent unplanned care transitions.
Care Transitions – Summary

- Care coordinators need to document care transitions and supporting activities.
  - Individual Transition Log, contact notes, etc…
  - Support audit activities for the Health Plan
  - Provides “proof” to CMS of the care transition activities by Care Coordinators.

Questions/Ideas?
Thank You!

- Blue Plus
- Health Partners
- IMCare
- Medica
- MHP
- Prime West
- South Country Health Alliance
- UCare