Policy:	MA.6030
Title:	**Transition of Care**
Department:	Medical Management
Section:	Case Management
CEO Approval:	*/s/ Michael Hunn 01/29/2024*
Effective Date:	05/01/2010
Revised Date:	01/01/2024
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the process for managing Members at risk for planned and unplanned transitions across the care continuum.

II. POLICY

A. CalOptima Health shall maintain a Transition of Care program that is focused on identifying Members at risk for transitions and facilitating the movement of Members between care settings. This shall include, but is not limited to:

1. Hospitals;
2. Ambulatory Surgical Centers;
3. Emergency Departments;
4. Long Term Acute Care (LTAC) Facilities;
5. Skilled Nursing Facilities (SNF);
6. Custodial Care/Other Long-Term Care (LTC) Facilities;
7. Recuperative Care/Shelter/Temporary Housing;
8. Behavioral Health Specialty Care and Settings;
9. Specialty Care Providers and Clinics;
10. Assisted Living/Board and Care Facilities;
11. Street Medicine;
12. Home Health Care/Home Based Primary Care; and
13. Home and Community-Based Services/Long Term Services and Supports (LTSS).

B. CalOptima Health and a Health Network shall identify individuals to serve as liaisons for the LTSS Provider community to help facilitate member care transitions, their contact information shall be provided in materials for Providers and Members.

C. The LTSS liaison shall be included in the Interdisciplinary Care Team (ICT), as appropriate for members accessing those services.

D. The LTSS liaison shall be trained by CalOptima Health or a Health Network to identify and understand including the following:

1. Medicare and Medi-Cal LTSS;

2. Home and community based services; and

3. Long-term institutional care including payment and coverage rules.

E. CalOptima Health and a Health Network shall implement specific evidence-based interventions to prevent readmissions and ensure safe and coordinated care across the care continuum. CalOptima Health shall ensure Members are in the least restrictive setting that meets their health care needs.

F. The Transition of Care process is the responsibility of CalOptima Health for Members assigned to CalOptima Health Community Network (CHCN), or for members assigned to the delegated Health Network and is the responsibility of the assigned Primary Care Provider (PCP). CalOptima Health and the Health Network must follow CalOptima Health OneCare Transition of Care policies, although the Health Network may implement its own unique strategies for identifying, managing and reporting on care transitions.

G. The CalOptima Health OneCare Transition of Care program is aligned with the delegated delivery system and designed to ensure that unplanned and planned transitions are identified.

H. Transitions may be managed by an ICT that is trained to manage the specific Member's needs and ensure consistency across the network. The responsibility for communicating information among the teams, the PCP, and Member or Member's Authorized Representative lies with CalOptima Health for Members assigned to CHCN, or the HN for Members assigned to the Health Network.

I. CalOptima Health and its associated Health Networks have the responsibility for managing the Transition of Care for OneCare Members. This includes but is not limited to:

1. Identification of Members at risk of planned and unplanned transitions;

2. Management of Members through planned and unplanned transitions;

3. Communication with Practitioners and Providers, as well as the Member or the Member's Authorized Representative;

4. Reduction of unplanned transitions;

5. Ensuring Members are at the least restrictive level of care; and

6. Analyzing, tracking and trending data for process improvement.

J. CalOptima Health, shall provide ongoing oversight of the CHCN and Health Network to ensure compliance with statutory, regulatory, contractual, and CalOptima Health policy requirements. This

shall include, but is not limited to, oversight of the structures, processes, and outcomes of the Health Network operations, in accordance with CalOptima Health Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Managing and Supporting Members Through Transitions

1. CalOptima Health or a Health Network will identify a planned transition of a OneCare Member from the Member's usual care setting to a hospital, and from the hospital to the next setting, by monitoring OneCare Members through the provision of utilization management, ongoing risk stratification, and case management.

2. For planned and unplanned transitions from the Member's usual setting of care to the hospital, and from the hospital to the next setting, CalOptima Health or a Health Network will facilitate effective transfer of the Member's care plan between the sending setting and the receiving setting within two (2) business days of notification that a transition has occurred. Transfer of the care plan may occur in a variety of ways, including, but not limited to, facsimile, mailing, or secure email of electronic Medical Record transfer to the next setting or PCP, or face-to-face giving of the hard copy to the Member.

3. For planned and unplanned transitions from any setting to any other setting, CalOptima Health or the Health Network will do the following:

   a. Notify the Member's PCP when the Member experiences a transition within two (2) business days;

   b. Communicate with the Member or responsible person about the care transition process and changes in the Member's health status and plan of care within two (2) business days; and

   c. Assign each Member who experiences a transition to a Case Manager to support the Member through the transition process within two (2) business days.

4. For all transitions, CalOptima Health and the Health Network will conduct an analysis of the aggregate performance of all aspects of the care transition program annually to identify areas for improvement. Analysis will be conducted using appropriate and representative samples from the population of transitions. The annual analysis will include a report of data collected, quantitative and qualitative analysis, and the identification of opportunities for improvement.

B. Identifying Unplanned Transitions

1. CalOptima Health, CHCN or Health Network shall identify Members at risk for transitions by reviewing the following reports for facilities within the network:

   a. Reports of hospital admissions within one (1) business day of admission; and

   b. Reports of admissions to long-term care facilities within one (1) business day of admission.

C. Reducing Transitions

1. CalOptima Health, CHCN and the Health Network will identify Members at risk for transitions to minimize unplanned transitions and maintain Members in the least restrictive setting possible:

a. CalOptima Health and Health Network will review its inpatient census daily to identify and manage Members in transitions (planned and un-planned).

b. CalOptima Health and Health Network will review its inpatient bed day utilization data, including readmissions within thirty (30) calendar days, on a monthly basis, to identify trends and areas for improvement in the managing transitions and care coordination.

c. CalOptima Health and Health Network is responsible for sharing the transition information with the PCP.

2. CalOptima Health and the Health Network will coordinate care and services for Members at high risk for transition.

   a. The Health Network will place the Members in Case Management based on their Care Management Level (CML), pursuant to CalOptima Health Policy MA.6009: Care Management and Coordination Process.

3. CalOptima Health and the Health Networks will provide Member education and communication to minimize transitions, as follows:

   a. Through the CalOptima Health/OneCare Website, scheduled mailings, face-to-face interactions and Member materials, such as the Evidence of Coverage (EOC), which is sent to Members annually.

   b. Empowering Members by providing them with information about their benefits and available programs designed to support them in the management of their health. Information provided includes, but is not limited to:

      i. Recommended health screenings;

      ii. Disease specific self-care information;

      iii. Recommended monitoring of chronic conditions;

      iv. Access to the MTM program;

      v. Dedicated PCP;

      vi. Information on availability of Case Management;

      vii. Benefits (Medicare, Medi-Cal and OneCare's benefits); and

      viii. Community-based programs for support.

4. At least annually, CalOptima Health's Case Management Department shall monitor its overall process for reducing transitions by analyzing admission rates for the entire population and determining actions to take to reduce potentially avoidable or unplanned transitions. Analysis includes patterns of both planned and unplanned admissions, readmissions, emergency department (ED) visits, repeat ED visits, and admissions to both participating and non-participating facilities. Results of the analysis will be reported to the Quality Improvement Health Equity Committee (QIHEC).

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy GG.1619: Delegation Oversight.
B. CalOptima Health Policy HH.2003: Health Network and Delegated Entity Reporting
C. CalOptima Health Policy MA.6009: Care Management and Coordination Process
D. Department of Health Care Services CalAIM Dual Eligible Special Needs Plans Policy Guide, CY24
E. HEDIS® Technical Specifications, Volume 2

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2010	MA.6030	Transition of Care	OneCare
Revised	06/17.2010	MA.6030	Transition of Care	OneCare
Revised	11/01/2011	MA.6030	Transition of Care	OneCare
Revised	10/01/2012	MA.6030	Transition of Care	OneCare
Revised	06/01/2016	MA.6030	Transition of Care	OneCare
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Revised	10/01/2017	MA.6030	Transition of Care	OneCare
Revised	08/01/2018	MA.6030	Transition of Care	OneCare
Revised	02/01/2020	MA.6030	Transition of Care	OneCare
Revised	09/01/2021	MA.6030	Transition of Care	OneCare
Revised	12/31/2022	MA.6030	Transition of Care	OneCare
Revised	01/01/2024	MA.6030	Transition of Care	OneCare

IX. GLOSSARY

Term	Definition
Authorized Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Health Policy HH.3009: Access by Member's Personal Representative.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Interdisciplinary Care Team (ICT)	A team comprised of the Primary Care Provider and Care Coordinator, and other providers at the discretion of the Member, that works with the Member to develop, implement, and maintain the Individual Care Plan (ICP).
Long Term Care	A variety of services that help Members with health or personal needs and Activities of Daily Living over a period of time. Long Term Care (LTC) may be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.
Long Term Services and Supports (LTSS)	A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. LTSS includes all of the following: 1. Community-Based Adult Services (CBAS); 2. Multipurpose Senior Services Program (MSSP) services; 3. Skilled Nursing Facility services and subacute care services; and 4. In-Home Supportive Services (IHSS).
Member	A beneficiary enrolled in the CalOptima Health OneCare program.
Primary Care Provider (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a specialty care provider or clinic.
Provider	Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.