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DHCS Care Coordination Project: Transitions in Care

Background

For Medi-Cal members who have complex health care needs, care transitions from one care setting, or care level, to another are high-risk events that require coordination. High-risk transitions include but are not limited to, moving from an acute medical or psychiatric inpatient hospital facility to a skilled nursing facility (SNF), or from a hospital, SNF, or residential treatment setting, to the community. Through other discussions, the Advisory Committee will address the initial risk assessment and risk stratification of new managed care plan (MCP) members. The enrollment of a new member into an MCP is an event that would justify a new assessment of risk and follow up. Similarly, a transition in care setting or level may also justify a reassessment of risk and specific follow up actions.

Current references to transition in DHCS MCP contracts are general. The primary references are specific to hospital and SNF transition discharge planning for the Seniors and Persons with Disabilities (SPD) population. There are also requirements regarding provision of Managed Long-Term Services and Supports (MLTSS) in conjunction with SNF discharge, and planning prior to discharge from Community-Based Adult Services (CBAS) services. The DHCS Health Home Program (HHP) makes available comprehensive coordination services related to transitions in care for HHP enrolled members, but plans have significant latitude in how this is structured. See the “Additional Information” section below for current contract and legal requirements regarding care transitions across delivery systems.

Framing the Issue

In general, feedback from stakeholders suggest that DHCS should redesign transition coordination requirements as one part of a comprehensive care coordination structure, which will reduce gaps and redundancy by accounting for all scenarios as part of one design process. Stakeholders reinforced that transitions are high-risk because of the coordination required between several entities. The consistent recommendation was that DHCS develop requirements to ensure risk assessment and appropriate follow up transition services are provided for all member care transitions. The following activities were noted as important:

- Plans should coordinate with, hospitals (medical and psychiatric), residential treatment facilities, and SNF facilities coordination on a comprehensive discharge plan that assures continued access to medically necessary covered services which will support the client's recovery and prevent readmission; and
- Plan agreements to incorporate transition language into contracts with hospitals (medical and psychiatric) residential treatment facilities and SNFs to ensure coordination and follow up.

Stakeholders said that finding safe and appropriate placements for members who are ready to transition is frequently a challenge. SNF beds are sometimes difficult to secure, Medi-Cal does not cover placement in certain lower levels of placement (such as a respite/recuperative care placement for homeless members), homeless shelter beds are scarce, and homeless members cannot recuperate appropriately without housing. These challenges are part of this discussion topic, but a portion of these placement issues will be addressed in a later discussion on benefits.

Stakeholders also noted that eligibility transitions present issues, such as transitions on and off Medi-Cal, MCP to MCP, county to county, and FFS to MCP. These issues are not the focus of this discussion document, but will be addressed in a later discussion.

Additional Information

Current Contract and Legal Requirements: The attached document provides relevant transition requirement excerpts from the DHCS MCP, mental health plan (MHP), Drug Medi-Cal Organized Delivery System (DMC-ODS) and Dental boilerplate contracts, the HHP Program Guide, CFR Title 42 § 438.208 (b)(2), DHCS policy letters and the Knox-Keene Act.

Discussion Questions

1. What should be the role of the Plan (MCP, MHP, DMC-ODS) and the hospital (medical or psychiatric), residential treatment or long term care facility in coordinating transitions upon entry and while in the facility, including coverage of all medically necessary services, prescriptions and equipment not included in the negotiated daily rate?
2. Is it recommended to have a standardized risk assessment tool to assess risk for re-institutionalization, re-hospitalization, and SUD relapse? Should such a standard assessment also be used by MHP or DMC-ODS programs?
3. Is the following list of risk assessment information and transition plan activities comprehensive? Do any of the areas present specific issues? And are there any questions about which entity should be responsible for the various activities?
 - Information that supports discharge care needs, medication management, interventions to ensure follow-up appointments are attended, and follow-up

- for self-management of the member's chronic or acute conditions, including information on when to seek medical care and emergency care;
- A written discharge plan, including scheduled follow-up appointments, provided to the member and all treating providers;
 - A systematic follow-up protocol to ensure timely access to follow-up care post discharge and to identify and re-engage Enrollees who do not receive post discharge care;
 - Organized post-discharge services, such as home care services, after treatment services and occupational physical therapy services;
 - Telephonic reinforcement of the discharge plan following Enrollee discharge;
 - Information on what to do if a problem arises following discharge;
 - For members at high risk of re-hospitalization, a visit by the PCP, Specialist, Care Coordinator or Care Manager at the Facility before discharge to coordinate transition;
 - For Enrollees at high risk of re-hospitalization, an in-person assessment by the member's PCP, specialist or care coordinator for post-discharge support. The assessment would include follow-up of: discharge instructions, assessment of environmental safety issues, medication reconciliation, an assessment of support network adequacy and services, and linkage of the member to appropriate referrals;
 - For members who are experiencing homelessness, and are at risk of re-institutionalization, re-hospitalization or SUD relapse, arrangement for homeless care support services, tenancy support services, recuperative care or respite care to ensure a safe transition back into the community.
 - Scheduled follow up outpatient behavioral health and/or primary care visits after discharge;
 - Follow-up to ensure the Enrollee saw his/her provider; and
 - Planning that actively includes the patient and family caregivers and support network in assessing needs.
4. What issues exist regarding the MCP development of discharge planning policies and procedures in collaboration with the hospital in the following areas:
- MCP timely processing all hospital prior authorization requests of all clinic services, such as therapy, home care services, equipment, medical supplies or pharmaceuticals.
 - MCP education of hospital discharge planning staff on clinical services requiring pre-authorization to facilitate timely discharge from the hospital.
 - MCP authorization or care coordination delays that impact discharge from a hospital.
 - Do similar issues exist for MH and DMC-ODS transitions?
5. When the member is discharged to the home or a community residential setting, what should be the Plan's role in coordinating with the facility to ensure the member 1) is discharged to a safe location and 2) that all medically necessary services are available including, but not limited to, home health services, durable

medical equipment and supplies, outpatient rehabilitation services? For applicable beneficiaries, what should be the MHP or DMC-ODS role?

6. How should information be shared between the MCP, PCP, MHP, DMC-ODS, other providers, hospitals, and SNFs regarding medical necessity decisions to authorize care and services, shared care plans, and transition services?
7. What is an appropriate role for the MCP regarding supporting data exchange protocols and tools to support coordination of transitions of care? What about the MHP or DMC-ODS?