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POLICY AND PROCEDURE

Policy Number	CM-034
Policy Name	Transitional Care Services
Department Name	Case and Disease Management
Department Officer	Manager, Case and Disease Management
Policy Owner	Director of Social Determinants of Health
Lines of Business	Medi-Cal and Group Care
Effective Date	01/01/2023
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	8/18/2023
Compliance Committee Approval Date	9/19/2023

POLICY STATEMENT

Care transitions are defined as a member transferring from one setting or level of care to another, including, but not limited to: discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home- or community-based settings, Community Supports, post-acute care facilities, or long-term care (LTC) settings.

Under Population Health Management (PHM) and in line with CalAIM, the Alliance is accountable for providing strengthened Transitional Care Services (TCS) beginning on January 1, 2023 and be fully implemented for all members by January 1, 2024 across all settings and delivery systems, ensuring members are supported from discharge planning until they have been successfully connected to all needed services and supports. This is accomplished by ensuring that a single point of contact, herein referred to as a care manager, can assist members throughout their transition and ensure all required services are complete.

The transitional care policies are consistent with the DHCS' Comprehensive Quality Strategy (CQS) and are being measured through quality reporting. This includes ensuring timely follow-up for members with emergency department (ED) visits for mental health issues or SUD. The Alliance will implement future DHCS policy guidance ongoing.

The Alliance implements timely prior authorizations and when informed that members are admitted, discharged or transferred.
The Alliance also ensures that all TCS are complete (including assigning a care manager/single point of contact who will complete all required responsibilities) for all high-

risk members. For Transitional Care Services, high risk members are defined as the following populations:

- Any "high risk" members as identified through the AAH's' RSS mechanisms or through the PHM Service once the statewide RSS and risk tiers are available;
- Any other populations who require assessments, including but not limited to:
  - Those who are in ECM or CCM (TCS must be provided by the ECM or CCM Care Manager); and
  - Those who received LTSS.

By January 1, 2024 the Alliance will ensure all TCS (as required below) are completed for all members.

PROCEDURE

Admission, Discharge, and Transfer (ADT)

The Alliance is responsible for knowing, in a timely manner, when all members have planned admissions, and when they are admitted, discharged, or transferred, and therefore experiencing a transition, through the following mechanisms:

- The Alliance is responsible for ingesting and utilizing ADT feeds when they exist.
- The Alliance enters agreements with ~~facilities to gain access to ADT feeds where their members are admitted.~~all contracted general acute care hospitals and emergency departments, as defined by HSC § 1250 to received ADT notifications from them whenever their members are admitted, discharged or transferred, and request such notification in advance of the ADT Event, when possible.
- The Alliance provides up to date Member rosters to their contracted general acute care facilities, emergency departments, and skilled nursing facilities (together "Participating Facilities") so that such facilities can send notifications to the Alliance whenever one of their members is admitted, discharged or transferred to or from their facility.
  - To meet this expectation, The Alliance receives these ADT notifications from "intermediaries", defined as a health information exchange network, health information organization, or technology vendor that assists a "Participating Facility" in the Exchanged of Health and Social Services Information.
- When ADT feeds are not available (for example, many SNFs do not create ADT data feeds), the Alliance identifies other mechanisms or establishes other data-sharing agreements to know when members are expected to be/are admitted, discharged, or transferred. These can include but are not limited to requirements for notification by admitting facilities and institutions directly or leveraging existing prior authorization requests.

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Prior Authorizations and Timely Discharges

The Alliance will ensure timely prior authorizations and discharges for all members, which includes, but is not limited to, ensuring that prior authorizations required for a member's discharge are processed in a timely manner.

Identification of High- vs. Lower-risk Transitioning Members

"High-risk" transitioning members means all members listed below:

- Those with long-term services and supports (LTSS) needs (as required by federal and state law and waiver).
- Those entering CCM (per NCQA).

- Those entering ECM.
- Children with Special Health Care Needs (CSHCN).
- Pregnant individuals.
- Seniors and persons with disabilities who meet the definition of "high risk" as established in existing APL requirements, namely:
    - Members who have been authorized to receive:
        - IHSS greater than, or equal to, 195 hours per month;
        - Community-Based Adult Services (CBAS), and/or
        - Multipurpose Senior Services Program (MSSP) Services.
    - Members who:
        - Have been on oxygen within the past 90 days;
        - Are residing in an acute hospital setting;
        - Have been hospitalized within the last 90 days or have had three or more hospitalizations within the past year;
        - Have had three or more emergency room visits in the past year in combination with other evidence of high utilization of services (e.g., multiple prescriptions consistent with the diagnosis of chronic diseases);
        - Have a behavioral health diagnosis or developmental disability in addition to one or more chronic medical diagnoses or a social circumstance of concern (e.g., homelessness);
        - Have end-stage renal disease, acquired immunodeficiency syndrome (AIDS), and/or a recent organ transplant;
        - Have cancer and are currently being treated;
        - Are pregnant;
        - Have been prescribed antipsychotic medication within the past 90 days;
        - Have been prescribed 15 or more prescriptions in the past 90 days;
        - Have a self-report of a deteriorating condition; and
        - Have other conditions as determined by the MCP, based on local resources.

In addition to these groups, and in recognition of high risk of poor outcomes in transition for Alliance members enrolled in multiple payors, those transitioning from SNFs, and those at high risk who are potentially not captured by the above categories, the Alliance also considers the following members "high-risk" for the purposes of TCS:

- Any member who has been served by county SMHS and/or DMC or DMC-ODS (if known) within the last 12 months, or any member who has been identified as having a specialty mental health need or substance use disorder by the MCP or discharging facility
- Any member transitioning to or from a SNF
- Any member that is identified as high risk by the discharging facility and thus is referred or recommended by the facility for high-risk TCS.

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Alliance Oversight of Facility Discharge Planning Process

TCS requirements build on, rather than supplant, existing requirements on facilities. Hospitals must provide patient-centered discharge planning under their Conditions of Participation (CoPs) for Medicare and Medicaid programs set forth in federal regulation; national Joint Commission accreditation standards; and state statutory requirements; and certain similar requirements apply to SNFs.

The Alliance is accountable for providing all TCS in collaboration and partnership with discharging facilities, including ensuring hospitals provide discharge planning as required by federal and state requirements. The Alliance ensures discharging facilities complete a discharge planning process that:

- Engages members, and/or members' parents, legal guardians, or Authorized Representative, as appropriate, when being discharged from a hospital, institution or facility.
- Focuses on the member's goals and treatment preferences during the discharge process, and that these goals and preferences are documented in the medical record.
- Uses a consistent assessment process and/or assessment tools to identify members hwo are likely to suffer adverse health consequences upon discharge without adequate discharge planning, in alignment with hospitals' current processes. Hospitals are currently already required to identify these members and complete a discharge planning evaluation on a timely basis, including identifying the need and availability of appropriate post-hospital services and documenting this information in the medical record for establishing a discharge plan.
    - For high-risk members, the Alliance ensures the discharging facility shares this information the Alliance's assigned care manager and that the discharging facilities have processes in place to refer members to ECM or Community Supports as needed.
    - For members not already classified as high-risk by the Alliance, the ~~dischd~~discharging facility must have processes in place to leverage the assessment to identify members who may benefit from high-risk TCS services. This process must include referrals to the Alliance for:
        - Any member who has a specialty mental health need or substance use disorder.
        - Any member who is eligible for an ECM Population of Focus
        - Any member whom the clinical team feels is high-risk and may benefit from more intensive transitional care support upon discharge.
- Ensures appropriate arrangements for post-discharge care are made, including needed services, transfers, and referrals, in alignment with facilities' current requirements.
- Ensures members and their caregivers are informed of the continuing health care requirements through discharge instructions and that this information must be provided in a culturally and linguistically appropriate manner.
    - This must include a medication reconciliation upon discharge that includes education and counseling about the member's medications.
- Coordinates care with:
    - The member's designated family caregiver(s). The Alliance ensures they are notified of the member's discharge or transfer to another facility.
    - Post-discharge providers. The Alliance ensures they are notified and receive necessary clinical information, including a discharge summary in the medical record that outlines the care, treatment, and services provided, the patient's condition and disposition at discharge, information provided to the patient and family, and provisions for follow-up care.

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Once a member has been identified as being admitted, including SNFs, the Alliance identifies the care manager, who is the single point of contact responsible for ensuring completion of all transitional care management services in a culturally and linguistically appropriate manner for the duration of the transition, including follow-up after discharge.

- This requirement applies to high-risk members starting on January 1, 2023, including members with long-term services and supports (LTSS) needs, those entering CCM, those entering ECM, Children with Special Health Care Needs (CSHCN), Pregnant individuals, and Seniors and persons with disabilities (SPD). This requirement applies to all members starting on January 1, 2024.
- For members enrolled in CCM or ECM, the Alliance ensures that the member's assigned ECM Lead Care Manager or CCM care manager is the care manager who must provide all TCS.
- "Longitudinal support" means that a single relationship must span the whole transition. For members not enrolled in ECM or CCM, this single point of contact ("care manager") does not need to be employed by the plan and can be provided by contracted entities (e.g. the primary care practice, an Accountable Care Organization or, the hospital). The Alliance ensures that a single point of contact is assigned until needs are met and that all TCS can be completed.
- Working with a care manager is optional for members. The Alliance ensures that the member is offered the direct assistance of the care manager, but members may choose to have limited or no contact with the care manager. In these cases, at a minimum, the Alliance ensures that discharging facilities comply with federal and state discharge planning requirements (listed above) and that the care manager assists in all care coordination among the discharging facility, the PCP, or any other identified follow-up providers, and the follow-up is complete.

Communication of Assignment to the Care Manager

The Alliance communicates both with the responsible care manager (or contracted care manager) and with the facility, including SNFs where the patient is admitted (referred to as the "discharging facility") in a timely manner so that the care manager can participate in discharge planning and support access to available services. This requirement applies to high-risk members starting on January 1, 2023, and to all members starting on January 1, 2024.

For members receiving TCS, their assigned care managers (including ECM and CCM) are notified within 24 hours of admission, transfer or discharge when an ADT feed is available or within 24 hours of the Alliance being aware of any planned admissions, or of any admissions, discharges or transfers for instances where no ADT feed exists (such as for SNF admissions).

However, this notification time frame will not apply if the care manager responsible for TCS is notified of the admission, discharge, or transfer through an ADT feed directly.

The Alliance notifies the identified responsible care manager of the assignment and of the member's admission status, including the location of admission, and ensure that the discharging facility has the name and contact information, including phone number, of the identified care manager in the discharge planning document. The member must be given the care manager's contact information as part of the discharge planning document, as described below.

Care Manager Responsibilities

The care manager responsible for TCS is responsible for coordinating and verifying that members receive all appropriate TCS, regardless of setting and including, but not limited to,

inpatient facilities, discharging facilities, and community-based organizations. Hospital and nursing home staff who help with discharge plans should work with, but do not supplant the need for, a care manager unless the responsibility for TCS is fully contracted out.
The care manager is also responsible for ensuring collaboration, communication, and coordination with members and their families/support persons/guardians, hospitals, EDs, LTSS, physicians (including the member's PCP), nurses, social workers, discharge planners, and service providers to facilitate safe and successful transitions. While the care manager does not need to perform all activities directly, they must ensure all transitional care management activities occur, including the discharge risk assessment, discharge planning documentation, and necessary post-discharge services and follow-ups, noted below. Based on the phased implementation timeline, the care manager is responsible for completing all required responsibilities outlined below for high-risk members starting on January 1, 2023, and for all members starting on January 1, 2024.

The Alliance and the assigned care managers ensure Member transitions to and from a SNF are timely and do not delay or interrupt any Medically Necessary services or care, and that all required transitional care activities are completed.

Discharge Risk Assessment and Discharge Planning
A core responsibility of the care manager is to coordinate with discharging facilities to ensure the care manager fully understands the potential needs and the needed follow-up plans for the member and to ensure the member participates in the care plan and receives and understands information about their needed care. ~~ensure that a discharge risk assessment is complete and that a discharge planning document is created and shared with appropriate parties.~~ To do this, the care manager must complete the following:

- Risk Assessment:
  - The care manager must assess the member's risk for adverse outcomes to inform needed TCS. This must include, reviewing information the discharging facility's assessment(s) and discharge planning process (e.g., the discharge summary). The care manager may supplement this risk assessment as needed through member engagement. During this process the care manager must also identify members who may be newly eligible for ongoing care management (ECM/CCM) and/or Community Supports and make appropriate referrals.
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- Discharge Instructions:
  - Care managers must receive and review a copy of the discharging facility's discharge instructions given to the member, including medication reconciliation completed upon discharge by the discharging facility.
  - After discharge, upon member engagement, care manager must review the discharge instructions with the member and ensure that member can have any questions answered.
  - A best practice (not required) is for the care manager to work with the facility to ensure that the care manager's name and contact information are integrated into the discharge documents.
- Discharge Summary and Clinical Information Sharing:
  - Care managers must receive and review a copy of the discharging facility's discharge summary once it is complete.
  - Care managers must ensure all follow-up providers have access to the needed clinical information from the discharging facility, including the discharge summary.

~~This discharge risk assessment and discharge planning document may be completed by the discharging facility (and, at a minimum, should be informed by discharging providers). The assigned care manager ensures that it is complete and accurately coordinated, shared with appropriate parties as listed below, and that the member does not receive two different discharge documents from discharging facility and from the care manager. Details on the discharge risk assessment and discharge planning document are below:~~

- ~~A discharge risk assessment is completed prior to discharge to assess a member's risk of re-institutionalization, re-hospitalization, destabilization of a mental health condition, and/or SUD relapse. As part of this discharge risk assessment done prior to discharge, care managers must ensure that members are assessed to determine if they are newly eligible for ongoing care management services such as ECM or CCM.~~

- ~~Care managers ensure a discharge planning document is created and shared with the member, member's parents or authorized representatives, and the treating providers, including the PCP, the discharging facility, and the receiving facility or provider in order to facilitate communication and information sharing of the member's specific discharge plan.~~

- ~~The discharge planning document uses language that is culturally, linguistically, and literacy-level appropriate, and includes:~~

- ~~pre-admission status,~~

- ~~predischarge support needs,~~

- ~~discharge location, barriers to post-discharge plans,~~

~~Information regarding available care and resources after discharge~~

- ~~This discharge planning document also includes the care manager's name and contact information and a description of TCS.~~

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Necessary Post-Discharge Services and Follow-Ups

Knowing that immediately post-discharge is an especially vulnerable time for high-risk members, support and follow-up post-discharge are critical aspects for the care manager responsible for TCS, including tasks in the Alliance contract and as described below:

- Member Outreach:
  - The identified care manager is responsible for contacting the member within 7 days of discharge (may be sooner) and supporting the member in all needed TCS care identified at discharge, as well as any new needs identified through engagement with the member or their care providers.
- Ensuring needed post-discharge services are provided and follow-ups are completed, including (but not limited to) by assisting with making follow up provider appointments, to occur within 7 days post-discharge; connecting to the PCP (if different); and arranging transportation.

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- SUD and mental health treatment initiation or continuation for those who have an identified SUD or Mental health condition.
- Medication reconciliation, post discharge:
- Care manager must ensure this is complete after individual is discharged. This can be done by the follow-up provider, such as the PCP, or by the care manager if they hold an appropriate license, or by another team member on the care manager's team that has appropriate license, in a manner that is consistent with California's licensing and scope of practice requirements, as well as applicable federal and state regulations.
- Completion of referrals to social service organizations, and referrals to necessary at-home services (DME, home health, etc.).
- Connection to community supports as needed.
- For members who are transferred to/from nursing facilities, ensure completion of care coordination tasks in the contract including:
    - Ensure outpatient appointments are scheduled prior to discharge;
    - Verify that Members arrive safely and have their medical needs met;
    - Follow-up with Members to ensure all TCS needs and requirements have been met.

~~The Alliance and their assigned care managers ensure needed post-discharge services are provided, and follow-ups are scheduled, including but not limited to follow-up provider appointments, SUD and mental health treatment initiation, medication reconciliation, referrals to social service organizations, and referrals to necessary at-home services.~~

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End of TCS

TCS for high-risk members extends until the member has been connected to all the needed services, including but not limited to all that are identified in the discharge risk assessment or discharge planning document. TCS for high-risk members should always extend at least 30 days post-discharge. If the MCP has delegated TCS, the MCP must ensure that the delegate follows and coordinates services for the member until all aforementioned activities are completed. For those who have ongoing unmet needs, eligibility for ECM or CCM and/or Community Supports should be reconsidered.

For members who may not respond to the MCP's outreach attempts or did not attend scheduled follow-up ambulatory visits, the MCP must make reasonable effort to ensure members are engaged and that the follow-up ambulatory visits are completed. For example, the care manager must ensure the members know that TCS support is available for at least 30 days or use CHWs to conduct outreach and attempt to engage the members in person.

For members with multiple care transitions within a 30-day period, the MCP must ensure the same care manager is assigned to support them through all these transitions. If the second transition is within 7 days of the first transition, then the care manager must ensure the follow up visit is completed within 7-days post discharge after the last transition. The care manager must also provide TCS support for at least 30 days after the last transition. These members should be considered for ECM/CCM and/or Community Supports eligibility.
~~TCS will end once the member has been connected to all the needed services, including but not limited to all that are identified in the discharge risk assessment or discharge planning document. If the Alliance has delegated TCS, the Alliance ensures that the delegate follows and coordinates services for the member until all aforementioned activities are completed. For those who have ongoing unmet needs, eligibility for ECM or CCM should be reconsidered.~~

~~If the member is enrolled in ECM or CCM, and if the care manager responsible for TCS will not continue as their ECM or CCM Lead Care Manager, the member should be connected to their new care manager through a referral.~~

Minimum TCS Elements and Processes for Lower-Risk Members

Lower-risk members in transition are defined as those not included in the high-risk definition above. The Alliance ensures that:

- The member has access to a specialized TCS team for a period of at least 30 days from the discharge: and
- Ambulatory follow-up occurs.

Dedicated Team/Phone Number for Member Contact and Support
The Alliance ensures that it has a dedicated team and phone number to support the transitioning members telephonically when they request help. The required features of this dedicated support service are as follows:

- Minimum Requirements for the Dedicated TCS Team:
    - First point of member contact may be a trained customer service representative or similar unlicensed team member. However, the team must consist of additional staff and support to provide an escalation pathway to allow the member to reach care management/clinical staff, who can address any of their issues that require licensed care providers. This may include nurse care managers or physicians.
    - The team is able to access discharge planning documents, if needed, to assist members with questions regarding care at the discharging facility, including medication changes.
    - The team must is to provide assistance for any TCS need, including (but not limited to) help with access to ambulatory care, appointment scheduling, referrals/handoffs to needed social services or community-based resources, including arranging NEMT.
    - The team must is to place and coordinate referrals to longer term care management programs (ECM/CCM) and/or Community Supports at any point during the transition.
- Minimum Requirements for the Phone Line:
    - The Alliance offers, at minimum, dedicated telephonic support services for members experiencing a transition of care. The Alliance leverages existing member support telephone services to meet this requirement.
    - During business hours, the Alliance ensures that members are able to connect with a live team dedicated to TCS.
    - Outside of business hours, the Alliance ensures that:
        - Members are referred to emergency services if needed;
        - Members can leave a message;
        - Messages are shared with the dedicated TCS team. A TCS team staff responds to members within 1 business day after the initial phone call.
- Member Communication of TCS Support:
    - The Alliance ensures lower risk members in transition receive direct communication about the dedicated TCS team and phone line and how to access it. The Alliance makes best efforts to ensure members receive this information no later than 24 hours after plans are notified of the discharge.

Necessary Post-Discharge Services and Follow-Ups for Lower-Risk Members
In addition to the dedicated call line, the Alliance ensures that each lower-risk member in transition completes a follow-up ambulatory visit with a physician or advanced practice provider (with prescribing authority) within 30 days of discharge for necessary post-discharge care and services, such as medication reconciliation post-discharge, which is a critical TCS requirement. In addition, for any members who have open preventive services care gaps or have not had a PCP visit within 12 months, the Alliance ensures that each lower-risk member has PCP follow up in addition to any other non-PCP ambulatory visits that may be needed.

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End of TCS for Lower-Risk Members
The Alliance continues to offer TCS support through a dedicated telephonic team for at least 30 days post-discharge. In addition to accepting referrals to longer term care management at any point during the transition, the Alliance uses data including any information from admission, to identify newly qualified members for outreach and enrollment into ECM/CCM and/or Community Supports.

Guidance for Members Enrolled with Multiple Payors
Given that the Alliance is responsible for coordinating whole-person care, even for services or benefits carved-out of Medi-Cal managed care, the Alliance or its contracted care manager is responsible for ensuring transitional care coordination for its members as outlined above. This also applies in instances where the Alliance is not the primary source of coverage for the triggering service (e.g., hospitalization for a Medicare FFS dual-eligible member, or an inpatient psychiatric admission covered by a County MHP).
For all members enrolled with multiple payors undergoing any transition, the Alliance is informed when their members are admitted, discharged, or transferred; the Alliance notifies existing Medi-Cal care managers (ECM or CCM) of admissions, discharges, and transfers; and the Alliance conducts prior authorizations and coordinates, in a timely manner, for any Medi-Cal covered benefits where Medi-Cal is the primary payor. However, there are specific modifications to the assignment of a care manager and care manager responsibilities as follows:

- Requirements for Members Dual-Eligible for Medi-Cal and Medicare in Medicare Medi-Cal Plans or Dual-Eligible Special Needs Plans (D-SNPs):
    - For admissions, transfers and discharges involving dually eligible members enrolled in Medicare Medi-Cal Plans (MMPs), or members enrolled in any other D-SNP, the MMP/ D-SNP is responsible for coordinating the delivery of all benefits covered by both Medicare and Medi-Cal, including services delivered via Medi-Cal Managed Care and Medi-Cal FFS. Thus, the Alliance is not responsible for assigning a transitional care manager or any transitional care manager responsibilities for dually eligible beneficiaries enrolled in MMPs or D-SNPs. However, if a member has an existing ECM or CCM care manager, the Alliance is responsible for notifying that care manager of the admission, discharge or transfer.
    - For admissions, transfers and discharges involving AAH members dually eligible for Medi-Cal and Medicare enrolled in Medicare FFS or MA plans (except D-SNPs), the Alliance remains responsible for ensuring all transitional care requirements are complete, including assigning or delegating a care manager or having a dedicated TCS team/phone number.

- Requirements for When County MHPs or DMC-ODS Are the Primary Payors:

- For members who are admitted for an acute psychiatric hospital, psychiatric health facility, adult residential, or crisis residential stay, where the county MHP is the primary payor, and for members who are admitted for residential SUD treatment, including residential withdrawal management, where DMC-ODS is the primary payor, MHPs or DMC-ODS are primarily responsible for coordination of care with the member upon discharge. However, MHPs and DMC-ODS have limited access/ability to coordinate across the Alliance or physical health care needs, therefore:
    - In addition to the core AAH responsibilities noted above, the Alliance assigns or contracts with a care manager to coordinate with behavioral health or county care coordinators, ensure physical health follow-up needs are met, and assess for additional care management needs or services such as CCM, ECM, or Community Supports.
    - The Alliance has MOUs with required entities, including Alameda County Behavioral Health Services, to facilitate care coordination and ensure non-duplication of services. In 2024, AAH will be implementing the expanded MOU requirements to include additional entities, including local alcohol and SUD treatment services.

- Additional Requirements for Inpatient Medical Admission with Transfer to Inpatient Psychiatry or Residential Rehab:
    - For members who are admitted initially for a medical admission and transferred or discharged to a behavioral health facility, including a SUD psychiatric or a residential rehab facility (including intra-hospital transfers to a psychiatric-distinct unit of a hospital):
        - The Alliance is responsible for all TCS during the transfer/discharge to the behavioral health facility.
        - TCS for this transfer/discharge end once the member is admitted to the behavioral health facility and connected to all needed services, including care coordination. In these instances, this likely will be after the member arrives at the behavioral health facility, medication reconciliation has occurred, and all information sharing between institutions is complete.
        - After the member's treatment at the behavioral health facility is complete and the member is ready to be discharged or transferred, the Alliance follows the same transitional care requirements as either psychiatric admission or residential SUD treatment facility admission listed above.

Scope

This Policy and Procedure addresses referrals into Case Management for Transitional Care Services as well as referrals from CM to other Health Plan, practitioner, community, and other services as dictated by the needs of the member.

Referral Screening

1. CM staff will:
    a. Receive referrals from:

i. Admission, Discharge, and Transfer (ADT) reports,
ii. Inpatient Utilization Management and other departments
iii. Phone, fax or email

b. Log the referral in the Clinical Information System with relevant information such as the referral source, urgency of referral (if appropriate), and any corresponding details.

c. Review direct referrals received via the Clinical Information System Provider Portal to ensure appropriate program is selected to address the identified concerns:
    i. Care coordination concerns
    ii. Complex medical care concerns
    iii. Disease Management, Asthma, Diabetes, COPD
    iv. Managed Long Term Services – CBAS, Custodial Care
    v. Behavioral Health Referral

2. After the Referral is created as outlined above, the CM staff will begin the screening process.
3. Referral screening consists of the following
    a. Determination of current eligibility of the member.
    b. Delegate medical group affiliation
    c. If eligible, the CM Staff will review existing programs the member is enrolled in, including CCM.
    d. Referrals will be processed within 24 – 72 hours (1 business day).

If at any time, the Manager of CM or designee or referral source believes that the case is of an urgent nature, priority will be given to the case to be completed as soon as possible.

Triage and Assignment of TCS case

1. CM staff assignments will be made based on workload, discipline and risk stratification of case.
2. Assignment will be made within 24 hours of admission transfer or discharge when an ADT feed is available, or within 24 hours of the Alliance notification of any planned admissions, or of any admissions, discharges or transfers for instances where no ADT feed exists.
3. The notification timeframe will not apply if the care manager responsible for TCS is notified of the admission, discharge, or transfer through an ADT feed directly.
4. For members enrolled in CCM or ECM, the Alliance will ensure that the member's assigned ECM Lead Care Manager or CCM care manager is the care manager who will provide all TCS.

Outreach

1. The assigned care manager will ensure the discharging facility has the name and contact information, including the phone number of the assigned care manager in the discharge planning document.

2. The assigned care manager will ensure the member is given the care manager's contact information as part of the discharge planning document.
3. The assigned care manager will send a letter to the member and the member's PCP to inform them of the member's facility admission and inform them of the care manager's contact information.

Care Manager Responsibilities

1. Discharge Risk Assessment
    a. The assigned care manager will ensure that the discharge risk assessment is complete.
    b. Will be completed prior to discharge to assess a member's risk of re-institutionalization, re-hospitalization, destabilization of a mental condition, and/or SUD relapse.
    c. The assigned care manager will ensure the member is assessed to determine if they are newly eligible for ongoing care management services, such as ECM or CCM.

2. Discharge Planning Document
    a. The assigned care manager will ensure that the discharge planning document is complete, accurately coordinated, shared with appropriate parties and that the member does not receive two different discharge documents from discharging facility and from the care manager.
    b. The Assigned care manager must ensure that this document is shared with the member, member's parents or authorized representatives, and the treating providers, including the PCP, the discharging facility, and the receiving facility or provider.
    c. The discharge planning document shall use language that is culturally, linguistically, and literacy-level appropriate, and will include:
        i. preadmission status, predischarge support needs, discharge location, barriers to post-discharge plans, and information regarding available care and resources after discharge.
    d. The discharge planning document will also include the care manager's name and contact information and a description of TCS.

3. Necessary Post-Discharge Service and Follow-Ups
    a. Assigned care managers will ensure needed post-discharge services are provided, and follow-ups scheduled, including but not limited to follow-up provider appointments, SUD and mental health treatment initiation, medication reconciliation, referrals to social service organizations, and referrals to necessary services.
    b. Members will be offered the direct assistance of the care manager, but members may choose to have limited to no contact with the care manager. In these cases, at a minimum, the care manager will act as a liaison coordinating care among the discharging facility, the PCP and the Alliance.

End of TCS

a. TCS will end once the member has been connected to all the needed services, including but not limited to all that are identified in the discharge risk assessment or discharge planning document.

b. For delegation, the Alliance will ensure the delegate follows and coordinates services for the members until all activities are completed.
c. For members who have ongoing unmet needs, eligibility for ECM or CCM will be reconsidered.

Referrals to CCM

1. CCM referrals may originate from any source including, but not limited to, self-referral, caregiver, Primary Care Providers or Specialists, discharge planners at medical facilities, health information line referrals, and internal department referrals such as UM, Disease Management and Member Services.
2. For TCS cases opened initially as transitional care, but after the initial or subsequent CM staff interventions is found to be of a higher risk, the CM staff will contact the Department Management or CCM staff to discuss case needs in accordance with CM-001 Policy and Procedure, Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment.

   A CCM Referral Form is at Attachment 1. However, a referral form is not necessary, and all information can be taken by phone or by any other means.
3. Upon receipt of the necessary information for a referral, the CM/DM designated staff shall document the referral in the member's file by entering the information into the referral summary screen in the Clinical Information System. Details on data entry are described in *CM-001 Policy and Procedure, Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment*.

DEFINITIONS

None

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments
Alliance Members
Alliance Delegated Groups
Alliance Directly Contracted Physicians

RELATED POLICIES AND PROCEDURES

CM-001, Policy and Procedure, CCM Identification Screening Enrollment and Assessment
CM Referral Form

REVISION HISTORY

02/21/2023, 9/19/2023

REFERENCES

1. Population Health Management (PHM) Policy Guide
2. CM-001, Policy and Procedure, Complex Case Management Identification, Screening, Enrollment and Assessment

MONITORING

Policy is reviewed at a minimum annually.