POLICY: 1.010 TRANSITIONAL CARE

When a significant event is determined, transitional care must be coordinated for Health Home (HH) enrolled patients and documented accordingly.

What is Transitional Care?

Transitional Care (TOC) is the transfer of patient care between providers and/or sites of care. The overarching goal is to transfer the patient back to outpatient services following a significant event, defined as

(1) an emergency room visit;
(2) hospitalization or other inpatient admission (e.g., psychiatric unit, residential treatment facilities, detoxification or rehabilitation programs, skilled nursing facilities, incarceration), or
(3) enrollment into long-term care (e.g., nursing homes, home health care, home care, adult day care, assisted living facilities, alternate level of care, respite care, hospice care).

PROCEDURE:

Transitional Care – ED

1. ACD will notify CMAs whenever a patient has a NYP ED / Inpatient visit and /or any visit obtained from Healthix.
2. Non-NYP ED visits communicated to the NYPHH via MCO or Hospital will be forwarded to CMAs via phone/email.
3. NYPHH receives non-NYP ED notifications from outside providers. (ex. MCOs, Hospitals, Rehabilitation centers, etc.)
4. Upon notification of the patient's ED visit, patient must be contacted *within 2 business days* to discuss the reason(s) for the visit, any change(s) in treatment and any specific care needs that will trigger adjustments to the Care Plan (CP).
5. Communicate with the patient's provider team as soon as possible to review available information regarding the visit and further assess the patient's needs.
6. Upon contacting the patient and communicating with the patient's provider team, update the patient's CP on ACD accordingly to address appropriate transfer back to outpatient preventive services (e.g., linking clients with community supports) and avoid future ED visits.
7. Obtain a summary record from the hospital post-discharge and follow-up with the patient and/or family to assist patient with needs and CP goals. Follow-up ought to include scheduling appointments for outpatient care, verifying patient when to scheduled appointments, outreach and engagement for patients who miss their appointments).
8. Facilitate communication and the transfer of relevant health information between inpatient and outpatient providers.

Transitional Care – Hospitalizations and other Inpatient Admissions

1. ACD will notify CMAs whenever a patient has been admitted into an NYP inpatient setting.
2. Any non-NYP inpatient admission communicated to the NYPHH will be forwarded to CMAs via phone/email.

3. NYPHH receives non-NYP inpatient admission notifications from outside providers. (ex. MCOs, Hospitals, Rehabilitation centers, etc.)
4. The CMA will make best efforts to contact the patient and provider team *immediately*, but *no later than 48 hours after notification of admission* and *immediately,* but *no later than 36 hours after discharge, to* obtain relevant admissions information and engage in the discharge planning process, including:

    a. Determining the reason for admission
    b. Gathering information on the patient's current status
    c. Obtaining a discharge record from the inpatient facility
    d. Conducting medication reconciliation,
    e. Reviewing/scheduling follow-up appointments, verifying the patient when to scheduled follow-up appointments, and assessing and helping to address potential barriers to obtaining follow-up care and treatment compliance.
5. Utilize information gathered from the patient and his/her provider team to update the patient's CP on ACD accordingly to confirm appropriate plans are in place to transfer patient back to outpatient preventive services (e.g., linking clients with community supports).
6. If unable to communicate with the patient and/or the provider team via other modes of contact, make best efforts to conduct a face-to-face encounter with patients hospitalized for any medical reason.
7. Facilitate communication and transfer of relevant health information between inpatient and outpatient providers.
8. Execute reasonable efforts to verify the patient, his or her family and other supports understand the reason for inpatient stay.
9. Adhere to billing guidelines as detailed in section 3.7 of NYS's *Health Home Provider Manual* (see *Appendix F* for more information) for any patients with an extended inpatient stay beyond the first month of admission, but no longer than 180 days. Contact the NYPHH to confirm proper billing guidelines are in place.
10. Cases for active patients with an extended inpatient stay beyond 180 days must be disenrolled from HH.
11. As best practice, execute a "warm handoff" for any patients who must be disenrolled from HH due to an extended inpatient stay beyond 180 days. Patients may re-enroll in HH services following their discharge if appropriate.
12. For patients that become incarcerated, confirm details of the incarceration (e.g., reason for incarceration, length of incarceration, need for legal assistance) and proceed to disenroll the patient from HH if incarceration will extend beyond one month. Once a patient is released from incarceration, the CMA can re-engage and re-enroll the patient into HH.

Transitional Care – Long-Term Care

1. Assess if the patient needs any long-term care services.
2. Continue providing HH services to patients needing long-term care services.
3. Patients requiring long-term care services beyond 120 days may be transitioned into other long term care management programs (e.g., Managed Long Term Care Plan).
4. As best practice, execute a "warm handoff" for any patient being transitioned into a long term care management program.

5. Contact NYPHH to determine whether a patient requiring long-term care services beyond 120 days must be disenrolled from receiving HH services.

Documentation

1. Document pertinent details regarding the patient's ED visit or inpatient stay, including, but not limited to:
    a. Date/s of ED visit or inpatient stay;
    b. Date CMA received notification of the ED visit or inpatient admission;
    c. Who provided the CMA notification of the patient's ED visit or inpatient admission to (e.g., ACD, patient, family member, hospital, other provider, insurance plan);
    d. When the CMA communicated with the patient's care team;
    e. Whether the CMA visited the patient during admission and when; or
    f. First date of face-to-face contact following discharge from ED visit or inpatient stay
2. Update Care Plans as needed and document all services provided to patients during inpatient stays.
3. Document all transitional care activities in the Progress Notes on ACD.

APPENDIX F: Overview of Section 3.7 of the NYS Health Home Provider Manual - Payment for Health Home Members During an Extended Inpatient Stay

- Care management services may continue for HH patients who are admitted for treatment in an inpatient facility, whose discharge is anticipated *within 180 days* (6 months), for the following inpatient settings:

    1. Hospital or other medical facility licensed under article 28 of Public Health Law; or
    2. An inpatient psychiatric unit of a hospital licensed under article 28 of Public Health Law; or
    3. Residential treatment facility for children and youth; or a State operated psychiatric hospital or a free standing psychiatric hospital licensed under article 31 of Mental Hygiene Law; or
    4. Hospital based or freestanding inpatient detoxification programs and chemical dependence inpatient rehabilitation programs, licensed under article 32 of Mental Hygiene Law; or
    5. Chemical dependence residential rehabilitation programs for youth licensed under article 32 of Mental Hygiene law.

- **During the month of admission and/or discharge**, care management services can be billed at the active care management rate, provided at least one of the HH core services is provided for the purposes of discharge planning.
- **During the interim months of admissions**, payment can be sought at the outreach and engagement rate, provided a three month period has lapsed since the CMA last billed for outreach and engagement services.
- **6-month Length of Stay:** Services can be billed throughout a maximum of 6 months. During the first and last month of inpatient admission, care management services can be billed at the Enrollment rate to support transitional care. During the interim months of admission (which is the equivalent of about 4 months of the 6-month stay), outreach services can be billed up to a maximum of three months. one of the four intervening months will, therefore, not be billable.
- **Admissions Exceeding 6-Months**: If the inpatient stay exceed a 6-month period, the patient must be disenrolled from the HH. Upon discharge from inpatient facility, the patient may return to the HH.