FACT SHEET

Care Transitions (CT)

What

Care Transitions refers to the movement of a member from one care setting to another as the member's health status changes. In 2009, the management of Care Transitions became a CMS requirement for all Medicare Special Needs Plans (SNP).

SCAN has a short-term telephonic Care Transitions process with specific intervention strategies designed to ensure smooth transitions between care levels and prevent unnecessary readmissions. A Care Transitions Coach (Registered Nurse or Social Worker) assists the member/advocate in taking an active role in the discharge planning process.

Why

Care Transitions is an evidence-based intervention that reduces readmissions, improves member self-management, and increases adherence to the medical treatment plan.

How

The SCAN Care Transitions Program focuses on five key elements:

- Medication reconciliation
- How and when to respond to warning signs/ symptoms
- Ensuring post-discharge MD follow up visits occur
- A Personal Health Record (PHR) to convey information across settings
- Advanced care planning to assist in end of life discussion and decision making

When

The program starts within one business day of notification of hospital admission or prior to admission, if known. The coach works with the member/advocate and health care providers as the member moves from each level of care to the next. At case closure, the coach evaluates the member's ongoing needs and refers the member to another case management program, internally, at the medical group or in the community, as applicable.

Provider Organization Role in Care Transitions

SCAN encourages Provider Groups to assist with Care Transitions and to coordinate with SCAN to develop and implement programs and processes that will help to ensure safe and smooth care transitions and prevent unnecessary readmissions.

When a planned or unplanned transition occurs, SCAN encourages Provider Groups to provide each member who experiences a transition with a consistent person or unit within the organization responsible for supporting the member through transitions between any points in the system and to implement the following procedures:

Provider discharging/sending member

- Identify that the transition is going to happen and communicate with the member or member's advocate about the care transition process and how their health status and plan of care will be impacted.
- Notify the member's usual practitioner and SCAN by phone or by fax of the transition from a hospital or SNF within 1 business day of notification of transition.
- Communicate with the receiving facility by sending the member's plan of care within 1 business day of transition notification. Information to be exchanged should include but is not limited to"
    - Medical status
    - Current medication list
    - Functional status
    - Cognitive status
    - Self-care skills
    - Social support
    - Living arrangements
    - Language/literacy/health beliefs
    - Advance directives
    - Durable medical equipment needs

Provider receiving member

- Confirm receipt of plan of care and other information with sending provider
- Review all information from sending provider
- Contact sending provider with questions or concerns regarding transition or member status prior to receiving the member
- Share member information with appropriate staff in receiving care setting
- Use information from sending provider in development of plan of care for your setting

Resource Links:

Care Transitions	http://www..org http://caretransitions.org
Advance Directives	http://www.agingwithdignity.org

Please send completed referral form via e-mail to CMReferral@scanhealthplan.com. Please use file encryption that is password protected or fax form to (562) 989-5212. For questions regarding case management enrollment please contact our referral coordinator at (562) 308-4373.