CORPORATE POLICY & PROCEDURE

	Policy Name: Transitional Care for Acute Care
Department: Umpqua Health - Transitional Care	Policy Number: TC1
Version: 2	Creation Date: 11/02/2017
Revised Date: 5/24/19	Review Date:

Line of Business: ☐ All

☒ Umpqua Health Alliance	☐ Umpqua Health Management
☐ Umpqua Health - Harvard	☐ Physician eHealth Services
☐ Umpqua Health - Newton Creek	☐ Umpqua Health Network
☐ UHA Community Activities	☐ ACE Network
☐ Professional Coding and Billing Services	

Signature: F Douglas Carr, MD

Approved By: F. Douglas Carr, MD, Chief Medical Officer Date: 7/23/19

POLICY STATEMENT

Umpqua Health Alliance (UHA), through its Transitional Care Program, is committed to delivering enhanced coordination of care between patients, providers and care settings by utilizing Transitional Care staff and community resources to ensure members who have been discharged from acute care or long term care setting have an effective transition to home or the next care setting.

PURPOSE

The purpose of this policy is to reduce unnecessary acute care (i.e. hospital readmissions), while increasing the quality of care provided to our UHA and ATRIO members; to meet the cost management goals of the plans and avoid potential financial stressors within the acute care/health plan partnership.

RESPONSIBILITY

Umpqua Health - Transitional Care

DEFINITIONS

LACE Score: Identifies patients that are at risk for readmission or death within thirty days of discharge. It incorporates the following four parameters.

- L stands for the length of stay of the index admission.
- A stands for the acuity of the admission.
- C stands for co-morbidities.
- E stands for the number of emergency department visits in the last six months.

Department	Standard Operating Procedure Title	SOP Number	Effective Date	Version Number
N/A	N/A	N/A	N/A	N/A

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UHA Transitional Care Program: Refers to the entity tasked with empowering members to develop a reliable approach to medication management, medical care follow-up, establishment of a personal health record and awareness of warning signs that their condition may be worsening.

PROCEDURES

1. Determination of program eligibility will be made by the following actions:
    a. Interaction with the hospitalists, hospital discharge planners/case managers on a routine basis.
    b. Assessment of members for the potential need of transitional care services.
2. Members being discharged to non-facility which does not provide medical management ("home") would be eligible for transitional care services if they meet the qualifying criteria listed below:
    a. LACE score calculation at 9 or higher.
    b. Implied referral related to lack of access to the Primary Care Provider (PCP) within 72 hours of discharge; and/or
    c. Direct referral from PCP or direct referral from hospital discharge planners/case workers.
3. In collaboration with the hospital care coordination staff and discharge planners, Transitional Care staff will perform the following:
    a. Offer all eligible members transitional care services.
    b. Anticipate the care elements necessary for the optimization of the discharge plan.
4. Transitional care services are initiated during the hospitalization, or shortly after discharge, and can continue up to four weeks depending on the needs of the patient.
    a. Follow-up care is coordinated with the PCP and/or case management.
5. Provided services will be face to face or by phone depending on the circumstances. In the majority of cases the first visit will be face to face and subsequent visits will be delivered in the manner deemed to be most effective.
6. The service will include:
    a. Performing medication reconciliation;
    b. Developing a reliable approach to medication management;
    c. Designing and/or reinforcing the plan for medical care follow up;
    d. Teaching how to establish a personal health record;
    e. Teaching about warning signs that their condition may be worsening;
    f. Members are encouraged, within all aspects of the integrated and coordinated health care delivery system, to use wellness and prevention resources and to make healthy lifestyle choices; and

g. Working with Umpqua Health's internal and community partners to facilitate follow up treatment.

7. Transitional care services will be documented in Umpqua One Chart and sent to PCP and/or specialist via electronic medical record (EMR) routing or fax when needed.