ACL NWDBC Grant Project

Care Manager Transitions Process Flow: Hospital/SNF/ED to Home

Revised April 21, 2021

1. Care Manager (CM) to check CaMSS daily (and with AAA hospital liaison if applicable) to determine if any Aged & Disabled Waiver (ADW) participants from their panel have been hospitalized, admitted to a skilled nursing facility (SNF), or had an Emergency Department (ED) visit.
2. For ED visit, skip to #3. For hospital or SNF admission, CM to connect with hospital/SNF discharge planning team to communicate as follows:
   1. Patient/resident is being followed by the AAA as ADW participant
   2. Services and supports currently received by participant
   3. Name(s) of service providers and if they also provide home health care services in the event home health care is needed post hospital/SNF discharge
   4. Additional key information that may be helpful to hospital/SNF staff (e.g. goals of care, informal supports)
   5. Discuss possible service plan needs for when participant returns home
   6. Obtain hospital/SNF discharge planner contact information (phone number, email address) for CM follow up communications and coordination of care
   7. Provide CM contact information (phone number, email address) for hospital/SNF follow-up collaboration in transition planning and care coordination
   8. Contact participant/designated representative and/or active family or informal caregivers for coordination of care as appropriate
   9. For SNF admissions, follow up at least weekly with SNF discharge planner
   10. Communicate and coordinate care with health plan care manager as appropriate.
3. Once participant returns home, CM to contact participant/designated representative and/or family or informal caregiver(s) within three (3) days of hospital/SNF discharge or ED visit and review the following:
   1. Participant’s health, functional, nutritional, and social support/caregiver status
   2. Changes in goals of care, functioning or support needs to determine if service plan modifications are appropriate
   3. In-home services and supports to ensure all services have begun or resumed (or continued if ED Visit)
   4. Caregiving arrangements to determine if Structured Family Caregiving service is indicated for activities provided by a caregiver who lives with the participant
   5. Upcoming appointments to ensure participant has transportation
   6. New and existing medications to identify any discrepancies needing clarification
   7. Care coordination needs to determine if Integrated Healthcare Coordination service is indicated to integrate medical and social services and manage chronic conditions in collaboration with physicians
   8. Communicate and coordinate care with health plan care manager as appropriate.
4. CM to document in CaMSS all transition and care coordination activities (see documentation guidelines for transitions from hospital/SNF to home)

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Care Manager Transitions CaMSS Documentation: Hospital/SNF/ED to Home

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**Cases**

**Activities**

**Activity Type**

Enter the following:

* Note

**Subject**

Enter the following:

* Transition

**Description**

Include each of the following in the first part of the note:

* Hospital/SNF Admission or ED Visit Date
* Reason(s) for Admission or ED Visit
* Hospital/SNF/ED Discharge Date
* Date Notified

Provide a description of the activity including:

* Who contacted (e.g., participant, caregiver, hospital staff, etc.)
* Type of contact (e.g., phone, home visit, hospital visit, SNF visit)
* Reason for contact
* Participant’s Transition Goals
* Assessment and plan
* Note if any changes made to service plan
* Medications reviewed
* Action to prevent future transition
* Follow-up plan

**Work Code**

* Monitoring