Passport Advantage
Provider Manual
Section 12.0
Transitions of Care

Table of Contents

12.0 Transitions of Care

A care transition is defined as member movement from their usual care setting to another due to a change in health status. Transitions can be planned, such as a scheduled surgery, or unplanned due to an exacerbation of a member's medical condition, such as an inpatient admission for Diabetes. Passport Advantage staff actively manage each care transition from notification until the member is stable in the lowest possible care setting in order to prevent fragmented and potentially unsafe care.

As part of Passport Advantage's Model of Care (MOC) requirements an individualized plan of care (ICP) is developed for every member. An ongoing analysis of member level data is conducted to identify any changes in member health status and to proactively identify members, who may be at risk for an unplanned transition in order to update their plan of care, add interventions designed to minimize barriers, facilitate communication between all providers involved in the member's care, coordinate any changes that need to be made in the treatment plan to hopefully avoid the transition all together.

Passport Advantage may also become aware of care transitions through the Utilization Management (UM) process, or request for authorization, especially for planned services. The UM staff initiates discharge planning upon notification of an admission. This discharge planning includes identification of resources available to support the member's plan-of-care, organization of those resources, as needed, authorization of the resources, as needed, all in coordination with the facility staff to ensure that the member receives the services necessary for effective transition through the continuum of care and a timely discharge.

As part of transition interventions, Passport Advantage staff:

- Updates the ICP
- Notifies the member's PCP, or usual provider, if they are not directly involved in the transition of care
- Facilitates communication between all providers involved in the member's care
- Facilitates communication between the providers involved in the member's care and the member and/or caregiver(s)
- Provides the member and/or caregiver(s) with a consistent single point-of-contact who can assist them through the transition process
- Coordinates the sharing of the member's ICP plan between the care settings within one business day of notification of the transition
- Identifies potential problems that can arise during the transition process and to take steps to prevent, minimize or mitigate those problems
- Coordinates services for members at high risk of experiencing another transition, such as readmission
- Educates the member and/or caregiver(s) regarding how to prevent unplanned transitions
- Coordinates approval for necessary services
- Conducts member follow-up post discharge to assess transition status, including medication reconciliation. All Members will receive at least two (2) discharge follow-up

call attempts within four (4) business days of notification.

- Distributes the ICP to the member and/or caregiver, and external ICT participants, including PCP, as relevant.