SOMOS Your Health, LLC ("MSO")
Department Care Management
Policy Number 101.3

Title
Continuity of Care and Transition of Care

Review Procedure
No less than annually and as needed as determined by ongoing monitoring and evaluation of the Care Management (CM) process that include continuity and transition of care, the Director of Care Management will review and ensure compliance with all applicable state and federal laws and regulations. The policy will be reviewed and approved by the Quality Management (QM) Committee.

REVIEW AND APPROVAL HISTORY						
VERSION	**AUTHOR**	**REVIEWED BY**	**REVIEW DATE**	**APPROVED BY**	**APPROVAL DATE**	**DESCRIPTION OF CHANGE**
1		**Quality Committee**	**Jan. 2024**			

General Statement of Policy
SOMOS Your Health LLC (the "MSO") is a management services organization that has contracted with managed care companies ("MCOs") to provide certain services on the behalf of the MCO. SOMOS will provide available services to patients managed by SOMOS and is not required to provide coverage for benefits not otherwise covered. This policy describes the SOMOS Care Management (CM) Department's policy for providing continuity of care and for SOMOS managed patients to prevent the delay, or interruption, of medically necessary covered services in accordance with 18 CRR-NY 505.16 of the New York Codes, Rules and Regulations, 42 CFR §438.208 of Title 42 of the Code of Federal Regulations and 15.6 of Section 15.6 in the New York Managed Medicaid Contract.

Contacts/Scope
Policy 101.3 is intended to provide guidance on continuity of care and transition of care to healthcare providers, SOMOS CM Department and to current and future eligible SOMOS managed patients. The Chief Medical Officer (CMO) and the Director of Care Management provide oversight of the CM Department's process for continuity of care and transition of care.

This policy applies to all patients that are enrolled with a SOMOS Care Management Program:

Glossary/Definitions
Transition of Care: Movement from one setting to the next or one provider to another

Care Manager: An individual with two (2) years' experience in a substantial number of activities including the performance of assessments and development of care management plans.[1]

Continuity of care: Ensuring patients enrolled in the SOMOS Care Management Program receive consistent, uninterrupted, and coordinated healthcare services, regardless of changes in healthcare providers, settings or levels of care.

Long Term Services and Supports (LTSS): Provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility or other institutional setting.[2]

Personal Care Services: Services ordered by a physician or nurse practitioner that include the provision of some or total assistance with personal hygiene, dressing and feeding and nutritional and environmental support (meal preparation and housekeeping).

Planned Transition: Include elective surgery or a decision to enter a long-term care facility.

Unplanned Transition: Include sudden hospitalizations resulting from emergencies.

Procedures

To ensure that continuity of care is provided according to best practice standards, SOMOS develops and implements written policies and procedures, consistent with best practices and that comply with state and federal law as well as SOMOS's contractual obligations.

The following procedure outlines the criteria and process for continuity of care and transition of care to eligible SOMOS managed patients.

1. Continuity of care
    a. Components
        i. Patient-Centered: Continuity of care prioritizes the individual 's preference, needs, and values in all care transitions and decision making processes.
        ii. Communication and Collaboration: Open, effective, and timely communication will be maintained between all healthcare providers, settings, and levels of care involved in the patient's treatment.
        iii. Comprehensive Assessment and Planning: A thorough assessment of the patient's needs, risks, and goals will be conducted at the outset, followed by the development of a comprehensive, individualized care plan.
    b. Process
        i. Care Transition Planning
            1. A designated care manager will oversee all care transitions, ensuring that patients move smoothly between different levels of care, settings, or providers.

[1] N.Y. Comp, Codes R. & Regs. Tit. 18 § 505.16
[2] 42 CFR § 438.2

2. The care manager will conduct a comprehensive assessment and create a transition plan for patients who are moving between healthcare providers, facilities, or services.

ii. Communication Protocols
1. A standardized communication process will be established to ensure that all pertinent patient information is shared accurately and promptly during care transitions.

iii. Medication Management
1. A medication reconciliation process will be implemented during care transitions to ensure that patients' medication lists are accurate and up-to-date.
2. The care team will educate patients about any changes in their medication regimen and provide clear instructions for proper administration.

iv. Follow-Up and Monitoring
1. A plan for follow-up appointments, tests, and procedures will be established. This plan will be communicated to the and all relevant healthcare providers, as pertinent.
2. Ongoing monitoring and evaluation of the patient's progress will be conducted to ensure that the care plan is effectively implemented and adjusted as needed.

v. Coordination of Services
1. The care manager will serve as the central point of contact for the patient, coordinating services across all healthcare settings and providers involved in the patient's care.
2. Referrals to specialists, ancillary services, and community resources will be facilitated as necessary to support the 's overall well-being.

2. Transition of Care Process, as administered by sub-delegate
   a. Sources of identification and referral of patients for transition of care services may include:
      i. Hospital Discharge Reports
      ii. Daily Inpatient Census Reports
      iii. Other Care Coordination programs
      iv. Referrals from the Utilization Management team
      v. Hospital Case Managers/Discharge Planners or Social Workers
   b. A Care Manager is assigned the referral and will reach out to the patient or the patient's designated representative to inform them of the person responsible for supporting them during their transition.
   c. The Care Manager will be assigned the referral and will develop a transition of care plan that will include:
      i. Notifying the patient's usual care providers (Primary Care Provider or Specialists) responsible for the patient's care.

ii. Notify the patient or the patient's designated representative the person responsible for supporting their transition. Patients and their designated representatives will be educated about the transition process. Any changes to the care plan are communicated to the patient or the patient's designated representative.
iii. Collaborating and communicating with the appropriate members of the healthcare team (e.g., Utilization Management team, Hospital CM's/Discharge planners, receiving facility/setting) involved with the patient's transition to facilitate a continuity of care across settings and to resume or initiate services, including LTSS.
iv. The status of the patient's transition. The transition of care plan will include:
    1. The current location of the patient
        a. If the patient has intensive medical or behavioral health needs, ensure sufficient time is provided to fully implement the discharge plan including assurance of informal and formal support at the lower level of care.
    2. Planned date of discharge/transfer
    3. Planned setting for discharge/transfer
        a. Care Manager will arrange for covered services as medically necessary for the patient's care.
        b. When safe discharge cannot be arranged solely due to a patient's lack of housing, Care Manager will work collaboratively with the facility to explore all options and referrals available considering the patient's specific circumstances, including coordination with housing providers, homeless services, as applicable.
    4. Contact information for staff who coordinate care at the current setting (e.g., Hospital CM/Discharge Planner/Social Worker)
v. Medication reconciliation of new and existing medications during a transition between settings and for informing providers about discrepancies between the medication list and documented medications.

3. Transition of Care Process, as administered by SOMOS Care Management
    a. Sources of identification and referral of patients for transition of care services may include:
        i. Hospital Discharge Reports
        ii. Daily Inpatient Census Reports
        iii. Other Care Coordination program
    b. A Care Manager will be assigned the referral and will reach out to the patient or the patient's designated representative, post-discharge.
    c. The Care Manager will complete a program specific assessment and create a plan of care.

d. The Care Manager will follow-up with the patient as necessary to ensure that they are receiving any post-hospitalization care and provide assistance to patients for obtaining appointments, medications, and any other needs as necessary.

Monitoring and Oversight

The overall continuity of care process is monitored and evaluated on a continuous basis to ensure compliance with all applicable state and federal laws and regulations. Progress and outcomes of continuity of care services received are reviewed and discussed in the QM Committee on a quarterly basis. Program quality is monitored through monthly case audits on randomly selected cases to ensure compliance to program guidelines. In the event non-compliance is discovered, immediate investigation of the root cause commences and is reported to the Director of Care Management and Chief Medical Officer and shared with the QM Committee. Audit findings are used to share with the individual and is used as a training and guidance for the CM staff.

Documentation/Attachments

Checklists or monitoring tools—If the SOP is overseen with a checklist or some other tool, reference it in the SOP and/or attach it. This may include an ongoing monitoring tool as well as an annual audit tool.

Governance

18 CRR-NY 505.16 (c)(3)(iv) and (b)(4)(iv) of the New York Codes, Rules and Regulations
42 CFR §438.208 (b)(1)(2) - Title 42 of the Code of Federal Regulations
10.37 Discharge Planning in the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract
15.6 Service Continuation of Section 15 in the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract
21.10 Provider Status Changes in the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract
PHL § 4403(6)(e) - New York Public Health Law
2020 NCQA CM Standards: CM 5, Element A, Factors 1-7
2022 NCQA HPA Standards: LTSS 3, Element A, Factors 1-7
SOMOS Provider Manual updated April 30, 2021

Whom Do I Contact with Further Questions?

Chief Executive Officer
Chief Compliance Officer
General Counsel