CARE TRANSITIONS INTERVENTION MODEL TO REDUCE 30-DAY READMISSIONS:
FOR TRANSITION MANAGEMENT TEAM (PSYCHIATRIC UNITS)

Implementation Toolkit

Last Updated: 11/09/2017
# Implementation Toolkit: Care Transitions Intervention *(Transition Management Teams – Psych)*

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HOW TO USE THIS IMPLEMENTATION TOOLKIT

This toolkit is intended for OneCity Health partners providing Transition Management services on inpatient Psychiatry Units. The toolkit is to be read and used as a reference by all members of the Transition Management Team (TMT), as well as by supervisors and leadership overseeing the Transition Management Program. The fourth section of this toolkit “Administration and Management of the Care Transitions program” is intended for supervisors and program leadership.

There is a separate implementation toolkit for TMTs on inpatient medicine floors.

ONECITY HEALTH SUPPORT DESK

If you have any questions, please contact the OneCity Health support desk:

Phone Number: 646-694-7090

Email: ochsupportdesk@nychhc.org, with the subject line “Care Transitions Question”

Hours of Operation: Monday through Friday from 9am to 5pm ET

SECTION 1: PROJECT OVERVIEW

PROJECT OBJECTIVE

The objective of this project is to provide a 30-day supported transition period for patients at high risk of readmission.

RATIONALE AND RELATIONSHIP TO OTHER PROJECTS

When a patient is discharged from the hospital, the transition from the hospital to the community setting is a critical time when many patients are at significant risk for re-hospitalization. High-risk patients include those who are discharged from psychiatric inpatient units. This risk may be increased by other factors including uncontrolled medical conditions, complex medication regimens, social factors (such as housing instability and food insecurity), systems issues (such as incomplete communication of the hospital course to community providers), health literacy or language barriers, and lack of engagement with the outpatient health care system. Targeted transitional care support can be provided by care managers working one-on-one with the patient to identify the relevant modifiable factors and find appropriate solutions, in order to reduce the risk of readmission.
OVERVIEW OF TRANSITION MANAGEMENT

This project will create dedicated TMTs to help patients at high risk for readmission be able to remain in the community. The success of TMTs will depend in part on their ability to integrate successfully into the existing hospital interdisciplinary team. The core components of Transition Management are as follows:

- **Identifying patients at high risk of readmission** early in the hospital stay. In the psychiatric inpatient setting, risk of readmission will be high for almost all patients. Therefore, all Medicaid and uninsured patients should be assessed by the transition team for care transitions needs. (Please note that this protocol differs from the medical inpatient units, where care teams are expected to identify 10-15% of patients as high risk and requiring assessment).

- **Transition Management** for patients at high risk of readmission, coordinated by a dedicated TMT. The TMT meet with all patients during their hospital stay to assess whether the patient is an appropriate candidate for Transition Management and to create a care transition plan. The TMT engages the patient during the hospitalization and follows assigned patients for 30 days after discharge.

- **Leveraging the OneCity Health partner network to address actionable risk factors.** While successful care transitions begin in the hospital, they fundamentally rely on a rich network of clinical and social service organizations that assist the patient after discharge. The TMT links patients to resources that meet their needs.

TMTs consist of a variety of staff. On Inpatient Psychiatry units, teams may be led by a registered nurse or a licensed social worker. Nurse practitioners, pharmacists, peers, or other team members may be added at the discretion of the agency providing care management services. The team model may be adjusted in the future to require these or any other roles, as the program evolves.

The TMT will be located in the hospital and will complement, but not replace, existing discharge planning work requirements of the hospital staff. The role of the TMT is to bridge patients from the hospital to the community setting; and to continue to interact and follow up with patients and their care team members for a 30-day period. The TMT will not replace or duplicate the work of longitudinal care managers (care managers that follow a patient over time, such as a Health Home Care Manager), but will collaborate with and link to these programs to facilitate services beyond the 30-day transition period.
CENTRALIZED TRANSITION MANAGEMENT PHONE NUMBER

There is a centralized Transition Management phone number that can be used to contact the TMT in any of the 12 hospitals in the OneCity Health network: 844-216-4663. Some ways this number can be used include:

- By hospital staff who want to make a referral or discuss a patient during nights, weekends, holidays, or any other time the Transition Manager is not readily available.
- By a patient who would like to contact their existing Transition Manager
  - The TMT may also use their work-issued cell phones to communicate with patients
- By the TMT from one hospital to contact the TMT from another hospital
  - For example: in the event a patient is readmitted and the two The TMT want to coordinate their care.

The Transition Management Team

The TMT is an interdisciplinary team comprised of the following:

- Registered Nurses (RNs)
- Licensed Social Workers (SWs)
- Nonclinical workers who will serve as Transition Management Assistants (TMAs). The term TMA refers to a job function, not a job title.
- In the future, other members may be added

All teams must have at least one RN, one SW, and one TMA. Teams on medical units must be led by RNs whereas teams that are assigned to Inpatient Psychiatry Units can be led by either the RN or licensed SW.

All licensed clinical team members must have active New York State licenses. All licensed professional members of the TMT will be required to meet Continuing Education requirements established by the NYS Office of the Professions.

There may be additional required trainings that The TMT must attend as a part of the OneCity Health Team. The TMT will also be required to comply with any training and orientation requirements established by the facility (hospital) in which they are based.

Nurse practitioners, pharmacists, peers, or other team members may be added at the discretion of the agency providing care management services. The team model may be adjusted in the future to require these or any other roles, as the program evolves.
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**ROLE OF THE TMT**

The Transition Manager (TM) has a special role in an exciting partnership. The TMT are:

- Employees of the agency that hired them (this is where management structure exists)
- An integrated team member of a particular hospital in the OneCity Health network
- A part of the OneCity Health team, working on the Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions, which is part of a statewide initiative called DSRIP

The role of the TM is to help the patient transition from the hospital to the community setting as seamlessly as possible, and to work with the patient and their caregivers to adhere to the discharge plan, maintain wellness, and address any risk factors that may lead to a readmission.

**What is expected of the TM?**

- Assessment
- Patient Engagement
- Facilitation of discharge
- Education of patient regarding the discharge plan
- Coordination of care in the community
- Advocacy for additional resources
- Evaluation of compliance, safety and wellbeing post discharge.

**HOW DOES TRANSITION MANAGEMENT DIFFER FROM OTHER TYPES OF CARE MANAGEMENT?**

Transition management focuses specifically on the 30-day period after hospital discharge. This is a time period when patients’ needs are most sensitive and when risk of readmission is high. For the purposes of this program, Transition Management is defined at a minimum as (1) the TMT can visit with the patient in the hospital for initial assessment, and (2) the TMT will follow the patient for a period of 30 days post discharge.

Patients who have ongoing (longitudinal) care managers can also benefit from the increased intensity of transition management during this 30-day period, when patients’ needs and intensity of risk are heightened. *Transition management is episodic care management; it supplements, but does not replace, longitudinal care management.* Therefore, patients can be
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in both Care Transitions and the Health Home simultaneously. The role of the Transition Manager is to work with and coordinate with the other resources a patient has and fill in the gaps, not duplicate services, to plan for the patient’s current and future needs.

Other care managers may include:

- Inpatient care managers (with varying degrees of intensity for post-discharge follow-up)
- ED Care Managers.
- Health Home care coordinators
- Care Managers from Managed Care Organizations (MetroPlus, Healthfirst)
- Ambulatory Care Managers
- Care Managers from homeless shelters, residential facilities, transitional housing, or substance abuse treatment programs

SECTION 2: THE CARE TRANSITIONS INTERVENTION

KEY TASKS OF TRANSITION MANAGEMENT TEAMS: OVERVIEW

The TMT is an interdisciplinary team whose members will collaborate to care for their shared patients. Below is an overview of the tasks of the TMT. Some may begin while the patient is hospitalized and continue over the course of the 30-day post discharge follow-up period. In the next section, we will break down standard work in each setting (hospital and community).

1. Visit referred patients in hospital for initial assessment
2. Identify and coordinate with other care management services available to the patient
3. Assist in medication review
4. Provide self-management support
5. Link to community-based resources as needed, e.g., home services, nutrition, social services, caregiver support
6. Ensure ability to obtain medications, medical equipment, and other supplies as prescribed
7. Assist in follow-up with primary care physician and other key providers
8. Call patient after discharge within 24-48 hours
9. Document in all 6 care plan domains outlined in the Care Transitions Implementation Toolkit
10. Make a home visit (or face to face visit) within one week of hospital discharge. Home visits should be conducted by the TMA or Social Worker*. Whenever possible,
particularly for behavioral health patients and other patients considered high risk, a home visit should occur within 72 hours of hospital discharge.

11. Provide at least one contact weekly for the 30 day period (phone or face to face)
12. Update the care plan, at minimum, once per week for the 30-day period.
13. Conduct a case conference within 7 days following any critical events
14. Enter data, create care plan, and track in GSI. All data should be entered in a timely fashion (within 48 hours)

*Due to NYS regulation which precludes RNs from making home visits unless under the direct supervision of licensed homecare agency, the RN on the team will not make home visits. The RN can, however, conduct phone calls and face to face visits at locations other than the patient’s home (e.g. at the clinic).*

**CASELOADS**

It is anticipated that the TMT will carry a caseload 25-30 patients on Inpatient Psychiatry units, versus to 75-100 patients on Medical floors, due to the increased intensity of services anticipated for patients with psychiatric needs.

**TEAM COMMUNICATION AND DIVISION OF RESPONSIBILITIES**

The caseload of 25-30 patients on inpatient Psychiatry floors is expected to be managed jointly by the TMT of three. However, once the patient is discharged from the hospital, it is anticipated that they will have one team member who is their primary point of contact.

The supervisor of the organization providing Transition Management services will advise and coach the team on division of responsibilities based on expertise and licensure, and the patients’ primary needs. For example, while the RN on the team will work with the patient on planning for care of chronic medical conditions and on medication reconciliation; needs that are social or psychosocial in nature, such as housing, behavioral health issues, entitlements, and unsafe home environments, will more typically be addressed by the SW and/or TMA. Home visits (and other face-to-face visits in the community) are the responsibility of the TMA with the support of the SW where necessary. At this time, it is not expected that the RN will be making home visits.

Self-management support for chronic diseases can be provided by either the RN, or the TMA under the direction of the RN. At least one member of the team must attend interdisciplinary rounds every day, and both the RN and the SW should interface with members of their own discipline in the hospital to collaborate around referrals.
Communication amongst the members of the TMT is essential for team coordination. Timely documentation in GSI is also imperative, as it will allow all team members to remain up to date on contacts with shared patients, as well as changes in the care plan and any other issues.

**FACILITY ORIENTATION FOR THE TMT**

As the TMT begin work at one of the OneCity Health hospital facilities, you can expect:

- An orientation to the inpatient units, patient population, staffing structures, and logistical issues related to onboarding (employee badge, desk/workspace)
- A staff member (or members) to be assigned as ‘buddies’ to orient the TMT and be available for questions about the hospital
- Facilitated introductions to hospital staff
- Assistance in obtaining view-only access to the hospital’s Electronic Medical Record (EMR) as requested. The TMT will not document in the hospital EMR. All documentation will take place in GSI.

Transition Management Teams will be required to attend hospital-based Human Resource (HR) Trainings for new employees, which may only be offered monthly or bimonthly. Once the partner is notified of the hospitals in which they will be providing services, the partner should provide an HR point-person to coordinate these activities with hospital HR staff.

**HOW WILL ONECITY HEALTH MONITOR THE CARE TRANSITIONS PROGRAM?**

OneCity Health will collect data to assess the success of this program, based on documentation by the TMT in GSI Health Care Management software, and by the GSI reports mentioned in the previous section. It is imperative that all data is entered **within two calendar days**. If there is a weekend/long weekend/holiday, the documentation must be entered on the first day the Transition Manager returns to work. This includes referrals, assessments, and any in-person or telephonic contacts (attempted or successful). The TMT supervisor must arrange for cross coverage during staff vacations and/or extended periods of absence. Staff with excessive absences or lateness should be terminated.

As will be detailed in later steps, all information that should be seen by the care team should be documented in the patient’s care plan and subsequent care plan updates. Progress notes can be used in addition to, but should not replace, care plan documentation.

**Differences between Transition Management in the Medical and Psychiatric Setting**
There are important differences in OneCity Health’s Transition Management model on medical units and psychiatry units. The chart below summarizes some of the major differences in care between the two settings.

<table>
<thead>
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<th>Medical setting</th>
<th>Psychiatric setting</th>
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<td>A subset of patients are referred by the clinical team for transitions assessment</td>
<td>All psychiatric inpatients are assessed by the TMT</td>
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<tr>
<td>RN is team leader</td>
<td>Either RN or SW is team leader</td>
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<tr>
<td>Caseload is anticipated to be 75-100</td>
<td>Caseload is anticipated to be 25-30 because of more intense patient needs</td>
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<td>Inpatient and ED transitions initiatives will be designed and implemented separately, with less intensive services in the ED setting. As programs evolve, ED patients with higher intensity needs may be referred to the more intensive 30-day model.</td>
<td>Intensity of need is similar in inpatient and Comprehensive Psychiatric Emergency Program (CPEP) settings, so more intensive model is anticipated to apply in both settings as more TMTs are deployed.</td>
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**Standard Work in Hospital**

In their first few weeks at their new facility, it is important for TMTs to learn about and deeply understand current processes and workflows around discharge planning, and the best way for Transition Management to strengthen these existing resources in a way that will benefit patients and be helpful to hospital staff without being redundant to existing services. The work of the TMT should not duplicate that of existing care coordinators, discharge planners, or care managers. The hospital team will continue to coordinate standard discharge planning responsibilities, such as creating discharge plans, prescribing medications, and ordering homecare and other services as needed.

The role of the Transition Manager in the hospital can be thought of as preparation for the 30 days post discharge. TMTs should be talking to the patient and their caregivers to understand resources and gaps in carrying out the hospital’s discharge plan. If there are services or needs
that the Transition Manager feels would benefit the patient that are not being addressed, the TMT can and should communicate it to the hospital team.

**DAILY ACTIVITIES**

As members of the hospital team, the TMT should seek guidance from their facility colleagues (the DSRIP facility lead and point person on their unit) regarding their daily schedule. The hospital team will provide the TMT with a list of meetings and other unit based activities that the team is *expected and required to attend*. If the team has any concerns about this schedule, they should raise the issue with their supervisor, who can discuss with the facility. The TMT must comply with all hospital and unit policies and procedures. For example, the inpatient Psych unit may be a locked unit governed by specific protocols to which the TMT, as well as any other staff, must adhere.

**EARLY ENROLLMENT**

The facility team is instructed to refer patients as early in the hospital stay as possible (and at least two days prior to discharge) so that the Transition Manager has time to assess the patient and help plan for their safe discharge while there is time to coordinate and communicate with the hospital team on the floor. The earlier that the TMT begins getting services in place for the patient, the better chance they will have a safe transition when they leave the hospital. For the Inpatient Psychiatry population, the stability of patient’s diagnosis and behaviors should guide the timing of the initial interaction.

**INITIAL ASSESSMENT AND INITIATION OF CARE PLAN**

All referrals to the TMT must be entered in GSI. An initial assessment must be completed for all referrals. The initial assessment can help the TMT assess the patient’s appropriateness for the program. *Please note that the term assessment refers to the initial evaluation in GSI, as opposed to a nursing assessment.* Patients that are not enrolled will be changed to inactive status.

There are six domains that must be addressed on all care plans when the initial care plan is created. By the end of the 30 day period, any of the domains with open issues must be addressed and resolved. The six required domains are:

a) Medication Reconciliation  
b) Caregiver Stress  
c) Self-Education  
d) Adherence to appointments  
e) Social Support and Services  
f) Medical (Diagnosis)
The TMT can prioritize; not every domain needs to be addressed at every encounter, as long as they are all resolved by the end of the 30 day period. All issues should be closed by the time the patient graduates. If there are still goals that are not met, the Transition Manager should have referred the patient to ongoing services that will address these needs.

See Appendix C for a more complete guide of required documentation in each of the domains.

COLLABORATION WITH THE CARE TEAM

It is imperative that one or more members of the Transition Management team attend interdisciplinary rounds every day to update the hospital team regarding which patients were enrolled and which declined services. At rounds, the TMT should:

- Clarify discharge dates with team
- Collaborate with case manager/designee regarding discharge plan
- Give updates on patients that were previously discharged and are currently being followed in the community. Update should include if the discharge plan developed for the patient was appropriate (i.e. if home care services are meeting the patient’s needs.)
- Be an active participant

Other daily check-ins between the TMT and hospital staff should also occur regularly. In the hospital, it is expected that the TMT spends as much time as possible on the unit interacting with hospital staff. Staying available on the units gives the team the best opportunity to interact with clinicians and accept new referrals.

ASSESSING PATIENTS FOR TRANSITION MANAGEMENT

All patients being discharged from an inpatient psychiatry unit should be assessed by the TMT for the 30-day Care Transitions Intervention Program. Therefore, the inpatient team does not need to refer each patient to Transition Management. TMTs should evaluate all patients and identify any who are not good candidates.

Other criteria that may increase risk, and that are used for screening in medical units, may include:

- Prior hospitalization in last 90 days;
- High risk of medical decompensation in absence of close short-term follow-up;
- Social support insufficient to meet follow-up needs, or high caregiver stress; or
- Significant recent decline in ADL

In addition to morning rounds, a member of the TMT may have a structured daily “check in” with a particular member of the hospital team, such as the head nurse.
This program is for Medicaid patients and the uninsured. It is important that the Transition Manager check the patient’s insurance before they are enrolled to make sure they qualify. There are a number of reasons why, upon initial assessment, the Transition Manager may not enroll the patient. These include:

- Patient refuses.
- Patient is going to a skilled nursing facility (SNF), rehab, or long term care facility.
- All of patient’s needs are met by family members or other care management resources already in place, or patient is otherwise not a good fit for the program based on referral criteria (or other reason).
  - This is partly a subjective decision. In this case, the Transition Manager should always communicate with the patient’s physician to discuss the case.
- Patient will be leaving NYC area within the 30-day period post-discharge.

All eligible patients must be entered in GSI prior to assessment. It is the responsibility of the Transition Manager to work to increase patient acceptance of the services offered. Some patients will not “warm-up” to the Transition Manager immediately, and might require repeated contacts. Some patients may be more likely to accept services if the Transition Manager presents it while they are alone, and others may be more likely to accept when their family, caregivers, or other members of their care team are present. The Transition Manager should try to get to know the patient and understand what they need or want to achieve. The primary goal of some patients may be to stay healthy or get help getting to their doctor’s appointments. A homeless patient may be most interested in help with housing or meals. By “meeting the patient where they are” and explaining how Transition Management can help them achieve what is most important to them, the team can be more successful in increasing acceptance rate of the services offered.

**MEDICATION MANAGEMENT**

Medication management and education is an important role of the RN on the TMT. The RN should compile a medication list by source (i.e. chart, list provided by patient, patient/caregiver interview) while the patient is still in the hospital, and work to rectify the lists from various sources. If caregiver is available, the RN should have them bring the medications to the hospital. The RN should review medications with patient and caregivers and ensure that patient/caregiver understands the purpose of and how to take each medication. The Transition Manager should communicate any issues or gaps to the physician and RN on the inpatient team. The RN should also inquire about any over the counter medications, herbs, vitamins, creams, and eye drops that the patient may be using.
The RN on the team should ask the patient if he/she understands use, frequency, side-effects of medications, as well as asking the patient where their prescription is filled and who picks up their medications. The team should identify barriers to obtaining medication and develop solutions to address them, involving the hospital team where necessary. The RN may wish to provide targeted nutritional counseling for patients whose psychiatric medications increase risk of metabolic disease. This should all be documented in the medication reconciliation domain of the care plan.

The RN on the team should identify patients who do not display medication adherence or have one of the indicated chronic diseases (Asthma/COPD, CHF, Diabetes, Hypertension, Schizophrenia, Bipolar disorder and Depression). The RN should refer patients who meet this criteria to a Pharmacist, participating in the Care Management Medication Adherence program, to perform a post discharge medication reconciliation and a 3 month follow-up assessment of medication adherence.

The Pharmacist should contact the patient within 3 days of discharge to conduct a medication reconciliation and counsel patient on importance of medication adherence. The Pharmacist should distribute the updated medication reconciliation section of the care plan to the patient and RN on the TMT within 7 days of discharge. The Pharmacist should conduct a 3 month assessment of medication adherence and counsel patient on importance of medication adherence.

Please see the documentation guide in Appendix C for how the Medication Reconciliation Section of the Care Plan, as well as other sections of the care plan, should be completed.

**ASSESS PATIENTS TO IDENTIFY RISKS IMPEDING ADHERENCE TO MEDICAL TREATMENT PLANS AND DEVELOP SOLUTIONS**

The TMT should use the time while the patient is in the hospital to begin assessing their support system, identifying any barriers to keeping appointments (such as transportation arrangements), and identifying ways to address these barriers, as well as identifying any additional self-management education needs.

The Transition Manager should plan for how exacerbation/decompensation of behavioral health issues or medical disease once home will be handled. The team should make sure patient and caregiver(s) know who to call if he/she has a problem. The Transition Manager will also have a phone number for someone in the hospital whom they can contact with issues or concerns once the patient is discharged.
Transition Management is a new, and very much needed service in all the hospitals in the OneCity Health Performing Provider System (PPS). Members of the hospital staff have already been oriented to the Transition Management program. Still, a necessary part of the Transition Manager’s job, especially in the beginning weeks and months, is to “market” Transition Management Services so that hospital staff learn about the program, what it offers, and how to refer. Relationship building with hospital staff is key to program success and getting referrals.

In order to integrate as seamlessly as possible, The TMT should:

- Take the initiative to introduce themselves to new staff members on the inpatient units.
- Talk about what TMTs do for patients that is different than existing programs.
- Explain how Transition Management is different than other Care Management Services
- Be friendly, professional, and energetic

**OBTAINING CONSENTS**

Please refer to the documents entitled “Consent and Information Sharing Documentation Workflow for OneCity Health (Delivery System Reform Incentive Payment [DSRIP] Program)” and the “Summary of Documents Governing Sharing, Privacy and Confidentiality of Protected Health Information” forms for additional information and workflows regarding consents.

**Standard Work in the Community**

Some of the items outlined as standard work in the community may begin while the patient is still in the hospital. The earlier the TMT can begin the process of scheduling appointments with other providers and making referrals to needed programs or services, the better chance the patient will have a smooth transition when they leave the hospital. OneCity Health has an extensive partner network to provide for patient needs in the community. See the OneCity Health website for links to several different resources regarding the hundreds of partners that are part of the OneCity Health Performing Provider System.

**IDENTIFY AND COLLABORATE WITH MEMBERS OF A PATIENT’S CARE TEAM**

The TMT must identify the crucial members of a patient’s care team and enter it into GSI. **It is essential that every patient discharged from the inpatient Psychiatry Unit has both a Primary Care Physician (PCP) and a Psychiatrist (or other Behavioral Health provider) assigned (and entered) in GSI.** If the patient does not have a PCP, or a Psychiatrist/Behavioral Health Specialist, the TMT must refer the patient. Medical follow-up is important as well as Behavioral
Health follow-up, because many patients discharged from psychiatric units are readmitted for medical problems.

- The PCP name and the Psychiatrist name should be entered in the Care Team app.
- The upcoming PCP appointment should be documented in the Patient Profile Section of the Care Plan in GSI.

Patients’ care teams will have different structures based on their unique needs and diagnoses. Other members of the care team include: Home Health aides, social workers, care managers, nutritionists, case managers, parole officers, pharmacists and others; essentially any other team member who participates in the patient’s care. All the members of the patient’s care team should be noted in GSI.

**ENSURE PATIENT KEEPS PCP AND BEHAVIORAL HEALTH APPOINTMENTS**

The TMT should encourage, and coordinate as needed, timely patient follow-up appointment(s) with PCP, psychiatrist, and specialists soon after discharge and ensure patient can keep these appointments. **All patients should have a Behavioral Health appointment within 7 days of discharge.** Patients should also have a PCP appointment if clinically necessary. Even if they do not need a PCP appointment immediately, the Transition Manager should work with the patient to establish a primary care relationship if one does not already exist.

*Scheduling of PCP and Behavioral Health appointments are program metrics that will be monitored by OneCity Health.* The Transition Manager should assist with scheduling and, if necessary, arrange for needed transportation or accompany the patient to the appointment as needed.

**LINKING PATIENT TO A PCP OR PSYCHIATRIST**

Whenever possible, patients that have an existing provider should have a follow-up appointment made with that provider. Selection of a PCP for a patient who does not have one is dependent on their insurance. The Transition Manager should contact the patient’s managed care company. Patients who are uninsured can get primary care at a Federally Qualified Health Center (FQHC). The TMT should utilize the OneCity Health partner list and the Health Information Tool for Empowerment (HITE) website to find Primary Care or Behavioral Health clinics in their patient’s service areas. (Search HITE for Healthcare and Medicine, and limit to the patient’s zip code and “Primary Care.”) See Appendix F for more information on the HITE website and other ways it can be used to link patients to free and low cost services. 

If the patient has a Health Home Care Manager, the Transition Manager should ensure that the Health Home Care Manager is aware of, and attends, the appointment with the patient as needed.

**PCP AND BEHAVIORAL HEALTH PROVIDER NOTIFICATION**

An additional program requirement is for the Transition Manager to provide a copy of the patient’s care plan to the Primary Care and Behavioral Health Physician. It is up to the supervisor or manager to determine the appropriate method to ensure this communication occurs (via secure email, fax, etc.) Physicians that have GSI access will be able to view the patient’s care plan once they are added to the care team.

The Transition Manager should:

- Collaborate with PCP/Behavioral Health Provider/Care Team in order to facilitate implementation of a patient-centered plan and goals.
- Collaborate with network specialists (pharmacy, Behavioral Health, palliative care, social services, etc.) to provide interdisciplinary care management as needed.
- Conduct case conference, as needed, with PCP/Behavioral Health Provider/Care Team, and after critical events such as an ED visit or an in-patient admission, eviction, domestic violence, etc. A case conference can occur in-person, via telephone, via secure messaging.

**FACE-TO-FACE ENCOUNTERS**

All patients should have at least one home (or face-to-face) visit from the TMT during the first seven days post discharge. Whenever possible, this visit should occur at the patient’s home.

Home visits will be conducted by the Transition Management Assistant and/or the SW where necessary. Due to NYS regulation which precludes RNs from making home visits unless under the direct supervision of licensed homecare agency, the RN on the team will not make home visits. The RN can, however, conduct phone calls and face to face visits at locations other than the patient’s home (e.g. at the clinic).

All visits, attempted or completed, must be documented in GSI as encounters. Behavioral Health patients, and other patients identified as high-risk by the RN or SW should receive a home visit within 24-48 hours of discharge. It is strongly recommended that the home visit is made within the first 72 hours after discharge for all patients whenever possible. A face-to-face visit can also happen at a clinic, shelter, or other location if it is not possible to visit the patient in the home (for example, if the Transition Manager does not feel safe visiting the patient’s home, or if the patient refuses).
If a visit is unable to be made because the patient could not be contacted, or for any other reason, this must be documented in the patient’s care plan.

Additional face-to-face encounters should be conducted as needed.

There are times when it may be more appropriate to have a face-to-face encounter with the patient at the provider’s office. The patient should be instructed to bring all their medication bottles with them to facilitate the medication reconciliation process.

At face-to-face visits, the TMT should provide self-management support for chronic diseases or other medical conditions.

### ASSESS THE PATIENT’S HOME ENVIRONMENT

The TMA or Social Worker should assess the safety of the patient’s home environment on the first home visit. Where needed, the Transition Manager should arrange for house cleaning, exterminator, decluttering, or advocacy with landlord, and refer to and collaborate with housing providers as needed.

### EVALUATE HOSPITAL DISCHARGE PLAN

Throughout the 30-day period, the Transition Manager should evaluate the hospital discharge plan and whether the patient’s needs are being met. Were medications filled during the 30-day transition period? Did community-based or home-based services occur as planned, and were these services adequate? The TMT should identify any reasons why the patient is not taking medications and consult with RN, Pharmacist or PCP. If necessary, the team should conduct a case conference to discuss.

### ASSESS ADEQUACY OF SERVICES AND REFER AS NEEDED

Beginning in the hospital and continuing throughout the 30-day period, the TMT should address social determinants of health such as:

- Homelessness
- Food insecurity
- Employment
- Social Support and Services

As needed, the patient should be linked to community based services and support such as:

- Housing providers
- Caregiver support
The Transition Manager should also assist in follow-up with mental health and or/substance abuse providers, and should ensure that the patient is connected to other care management programs that may meet their needs and for which they are eligible, such as Health Home. New York State’s Health Home eligibility criteria are as follows:

- Medicaid eligible/active Medicaid; and
- Two (2) or more chronic conditions; or
- One (1) single qualifying condition of either HIV/AIDS or a Serious Mental Illness (SMI)
  - Any patient that meets these criteria should be referred.

The Health Home At-Risk program accepts all Medicaid and uninsured patients who have care management needs (such as a single chronic disease, and appear to have declining health and increasing health care needs) but who do not qualify for Health Home. Patients should be referred to Health Home and Health Home At-Risk as early in the 30-day period as possible, but the TMT should continue following the patient for the 30 days post discharge.

FOLLOW-UP CALLS AND CONTACT

All patients must be contacted, at a minimum, once weekly by the Transition Manager. During follow up phone calls, the TMT should assess for potential barriers to the patient attending the appointment and assist with planning and transportation to facilitate completion of appointment. The patient’s PCP must be documented in GSI and added as a member of the patient’s care team. Both attempted and successful phone calls are required to be documented. OneCity Health will track whether contacts are made once per week (ie: one contact each in:

- Days 1-7
- Days 8-15
- Days 15-22
- Days 23-30

ALERTS AND CASE CONFERENCES

The Transition Manager will receive alerts via GSI for any patient that has an ED visit or inpatient admission during the 30 days in the program. When possible, a member of the TMT
Implementation Toolkit: Care Transitions Intervention (Transition Management Teams – Psych)

should meet the patient in the ED, or within 48-72 hours post discharge to evaluate their current status and reason for readmission.

Case conferences must be conducted within 7 days of ED visits or inpatient admissions, and must include either the PCP or at least one member of the inpatient care team. A case conference is defined as follows:

- Must focus on the needs of a patient, with the goal of improving the patient’s health or well-being
- Must have bidirectional communication
- May be done via any secure communication medium (e.g. in person, phone, secure email)
- A member of a clinical treating team must be included, and other individuals and organizations should be included as appropriate
- Should be initiated for events including (but not limited to) ED visit, hospitalization, worsening of medical status
- Content should include Situation (patient issue); Background; Assessment; Results (plan and timeline)

All case conferences must be documented in GSI in progress notes (Case Conference type must be selected). If documented elsewhere, the case conference will not be counted in reporting.

For those patients already connected to Health Home, the Health Home Care Manager will also receive the alert. The Transition Manager should coordinate with the Health Home Care manager regarding meeting the patient in the ED/ hospital.

Addressing Homelessness in the Care Transitions program

Homeless patients are eligible for the Transition Management program. The homeless are a high-risk population in great need of extra supports to transition safely from the hospital. Some special considerations for the TMT when working with the homeless population are detailed below. As the program grows in experience and in numbers, best practices for working with the homeless will be collected and shared across the PPS.

- For patients with precarious housing situations early and sustained contact is pivotal to a safe transition from hospital to the community. It is important for the TMT to know where the patient will go after discharge and the best way to get in contact with them. If the patient has no phone, the TMT should still make every effort to make a face-to-face contact with the patient within the first 48 hours’ post discharge, whether it is in a
shelter or even on the street. For homeless patients, it is important for the TMT to gather information (while the patient is in the hospital) about their likely patterns, what services they have used before, and where they are most likely to be located after discharge.

- The TMT should refer the patient to the Health Home and to DHS (the Department of Homeless Services) as early as possible. Warm hand-off and a face-to-face connection with the patient’s DHS worker is important.
- It is important for the Transition Manager to support a homeless patient in having their medical needs met. Typically, a home care agency can visit any patient who has an address (even if that address is a shelter). The TMT should remain in regular communication with a patient’s homecare nurse if they have one.
- Certain subgroups of homeless patients may have particular services available to them, including LGBTQ and veterans, and the Transition Manager should research all available options.
- Linkage to primary care is essential for homeless patients, as it is for all patients. Health Care for the Homeless has clinics in shelters which might best meet the needs of some patients.
- If the patient is unwilling or unable to go to a shelter, consider a drop-in center. Many drop in centers are open 24 hours a day, 7 days per week.
- If the patient was in a shelter prior to hospitalization, work on connecting the patient back to the same shelter as early in their hospitalization as possible. Carefully consider a patient’s transportation needs to get back to the shelter. The Transition Manager should work with the patient to plan for how they will get back to the shelter.

Please refer to Appendix I for the most up to date resource list for homeless patients. This list will also be updated over time.
SECTION 3: WORKFLOW AND DOCUMENTATION PROTOCOLS

DSRIP 30-DAY TRANSITION MANAGEMENT TEAM (TMT) SERVICE: Patient Identification, Referral and Assessment

1. Start
2. Customize criteria for patient identification (optional)
3. Identify Patients for Referral to TMT (node of 2 days pre-discharge)
4. Multidisciplinary bedside rounds
5. Discharge planning conferences
6. Other multidisciplinary team meetings
7. Other (i.e., readmission reports may be reviewed by TMT; however, the inpatient care team must approve patient referrals)

Initial Patient Care Team

- Inpatient Care Team
- Patient identified for TMT service
- Assessment for TMT Service
- Does patient have any care management connectivity, i.e., health plan, PCCP, Health Home, Assertive Community Treatment, etc?

Transitions Management Team

- Does existing care management connectivity meet requirements of 30-day TMT service?
  - Yes
    - Leverage/consult with staff of other care management services as needed
  - No
    - Patient accepted to TMT service
    - Patient followed for 30 days post-discharge by EMPT

- TNC
### Implementation Toolkit: Care Transitions Intervention (Transition Management Teams – Psych)

#### DSRIP 30-DAY TRANSITION MANAGEMENT TEAM (TMT) SERVICE:
**Roles, Responsibilities and Oversight**

<table>
<thead>
<tr>
<th>Role</th>
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<tr>
<td>Inpatient Care Team</td>
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<tr>
<td><strong>Care Team Collaboration</strong></td>
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</table>
| Care Team Collaboration | Customize criteria for identifying patients for referral to TMT  
  - Identify patients for referral to TMT  
  - Include TMT in multidisciplinary activities  
  - Support warm introduction of TMT as necessary, to patient and/or caregiver  
  - Review documented transitions management activities via GSI Health Care Management system as needed (read only access to be provided to identified care team members)  
  - Document referral for TMT service in EMR note  |
| **Staff Supervision and Support:** |  |
| Designate a nursing leader to serve as point of contact for TMT RN and/or SW and OneCity Health partner representative  
  - Contact DSRIP Facility Lead with any concerns; (s)he will address with OneCity Health; OneCity Health will address with partner representative  |

| TMT: RN and/or SW |  |
| **Care Team Collaboration** |  |
| Care Team Collaboration | Actively respond and participate in multidisciplinary activities  
  - Actively respond to warm introduction to patient and/or caregiver or other staff or patient and/or caregiver engagement activities  
  - Review EMR as necessary to obtain information on referred and/or accepted patients (read-only access to be provided)  |
| **Assessment for Transition Management Service** |  |
| Assess referred patients to determine if there is any current care management service being provided  
  - Determine which care management service is most appropriate for patient  
  - Liaise with staff of other care management service(s) as needed to avoid neglect and duplication of services  |
| **Transition Management Service** |  |
| Transition Management Service | Conduct comprehensive assessment  
  - Finalize transitions management plan  
  - Ensure execution of Transition Management Plan  
  - A. Patient and/or caregiver education on TMT service  
  - B. Establishment of home care services: ensure services are setup before/after discharge  
  - C. Medication reconciliation: independently and/or in consultation with pharmacist or treating physician (RN only)  
  - D. Primary care connectivity: schedule appointment, provide discharge plan  
  - E. Post-discharge contact: conduct initial call within 72 hours of discharge  
  - F. Short/long-term connectivity to care management: screening and linkage for Health Home or Health Home At-Risk services  
  - Complete required documentation via GSI Health Care Management system  |
| **Staff Supervision and Support:** |  |
| Supervise Transition Management Assistants  |

| TMT: Transition Management Assistant |  |
| **Care Team Collaboration** |  |
| Care Team Collaboration | Actively respond and participate in multidisciplinary activities  
  - Actively respond to warm introduction to patient and/or caregiver or other staff or patient and/or caregiver engagement activities  
  - Review EMR as necessary to obtain information on referred and/or accepted patients (read-only access to be provided)  |
| **Support for Execution of Transition Management Plan** |  |
| Support for Execution of Transition Management Plan | Conduct follow-up calls and home/other face-to-face visits to patients  
  - Escort patients to appointments as needed  
  - Complete required documentation via GSI Health Care Management system  |

| DSRIP Facility Lead |  |
| **Collaboration** |  |
| Collaboration | Actively respond issues/concerns raised by unit leadership  
  - Advise and work with OneCity Health to address issues/concerns  
  - Facilitate facility-specific onboarding including training/education, workspace, identification, etc.  |

| OneCity Health |  |
| **Training** |  |
| Training | Provide support for training (including GSI Health Transitions Management Module) and onboarding of TMTs  |
| **Relationship Management** |  |
| Relationship Management | Contract with OneCity Health partners to provide TMT service  
  - Manage relationship with OneCity Health Partner and facility (with input from DSRIP Facility Lead)  |

| Partner |  |
| **Training and Operational Support** |  |
| Training and Operational Support | Provide training and onboarding of TMTs  
  - Ensure TMT members have appropriate equipment and supplies  |
| **Relationship Management** |  |
| Relationship Management | Interface with OneCity Health and facility (via DSRIP Facility Lead) with guidance from OneCity Health  |
Documentation in GSI

The team member who completed the assessment or encounter should be the one who enters in GSI. It is important that program activities are updated in “real time,” or within no more than 48 hours.

GSI will be adapted based on feedback received from the TMTs and facility teams and workgroups.

Below is a list of workflow and documentation protocols. Because the operational workflow and documentation rules are so intertwined, this toolkit combines both into one section.

1. Registering Patients: All patients should be entered in GSI prior to evaluation/initial assessment. This allows the program to capture all referrals, and thereby monitor referral patterns.

2. The Transition Manager should complete the Initial Assessment. Once evaluated change status to
   a) “Enrolled” if the patient is a good candidate for, and accepts, the program and is still in the hospital. Once the patient is discharged from the hospital, change the status to “assigned” so that it is clear that they are being followed in the community. The important distinction between “enrolled” and “assigned” will provide useful information to the TMT and the hospital team regarding how many patients are being followed in the community.
      i. The Transition Manager must document the patient’s insurance status (Medicaid or uninsured, and include their CIN Medicaid ID number if they have one.)
   b) Change the status to “inactive” if the patient is not enrolled after initial assessment for example, if patient refuses or if the Transition Manager performs the initial assessment and determines that the patient is not appropriate for program. The Transition Manager should first discuss the referral with the clinician before changing the status to inactive and deciding not to enroll.

3. Start Date of Care Plan: The Start Date is the day the initial assessment is completed (typically at bed side), but the 30 days starts counting down on the day after hospital discharge. For example, if a patient is discharged on Monday, Day 1 of the 30-day period is Tuesday.

4. Start Date of Goals: Anticipated (day you and patient think they will start working toward goal) and actual. This may be the same date, or it may be two different dates.
5. There are **six domains that must be addressed on all care plans**. *These domains must be addressed when the care plan is initiated. Any open issues must be addressed at subsequent care plan updates, and resolved by the end of the 30-day period.*
   
   - g) Medication Reconciliation
   - h) Caregiver Stress
   - i) Self-Education
   - j) Adherence to appointments.
   - k) Social Support and Services
   - l) Medical (Diagnosis)

Any others domains can be used as needed. The user can always use “n/a” or “no issues noted at this time” as appropriate. See Appendix C for more information on documentation requirements for each of the domains

6. **Care Plan: Frequency of Update:** The Care Plan must be updated at **least** every seven days post discharge or more as appropriate.
a) All contacts (phone calls, home visits) – successful or unsuccessful – must be documented

b) It is expected that the patient will be contacted at least once per week and/or that the Transition Manager will speak with the patient’s other Care Manager at least once per week if they have one (e.g., their Health Home Coordinator)

c) All data must be entered within 48 hours of assessment/contact.

d) Please note that issues should be recorded and updated in the care plan. Progress notes can be used, but should not replace documentation within the care plan itself.

e) While all encounters should be entered, when the Transition Manager updates an issue from a previous encounter, it is important that they do not link it to a new encounter (as this will overwrite the original entry).

7. Tracking PCP and Behavioral Health provider information
   a) The patient’s PCP and Behavioral Health provider must be added to the Patient’s Care Team via the Care Team App
   b) the upcoming PCP or Behavioral Health appointment should be documented in the Patient Profile Section of the Care Plan in GSI

8. Close Current Care Plan if:
   a) Patient is readmitted: If the patient returns to the hospital during the 30-day transition period, close the care plan. A new plan will be initiated for the patient’s second discharge (and a new 30-day period will begin).
      i. This holds whether patient is readmitted to the same facility or a different facility. A new care manager may be assigned even in the same facility (based on the unit the patient is discharged from and readmitted to).
      ii. The initial care manager should communicate with the new care manager (ideally by phone for warm hand off, or secure message in GSI), and the first care manager should be listed as a collaborator in this case.
      iii. If the patient is readmitted during the 30 days to another hospital in the PPS network (another NYC Health + Hospitals facility or SUNY Downstate) that does not yet have Transition Management Services, and the Transition Manager has the capacity to continue following the patient, they should discuss with their supervisor. This situation will be evaluated on a case-by-case basis.

   b) Patient is deceased: Close care plan if patient expires at any point during the 30-day period

   c) Patient declines services once enrolled: If patient refuses services and after motivational interviewing determines that they do not need/want a Transition Manager, case is closed

   d) Patient is transferred to another unit in the hospital that is covered by a different TMT: If there is more than one team in the hospital and the patient is initially
evaluated on one unit and gets sent to a unit that is covered by a different TMT (in the same hospital stay), the initial care plan should be closed and a new care plan created by the new Transition Manager (i.e.: if the patient is initially on the Medicine Unit and gets sent to Psych Unit (or reverse)). If there is only one transition team in the hospital, the same TM should continue following the patient. Additionally, if the Transition Manager feels they have already established a strong relationship with the patient and prefer to keep following them, they should discuss with their supervisor, and this can also be evaluated on a case by case basis.

e) **Patient is sent to ICU or is unconscious:** Close current care plan. A new care plan will be initiated once the patient is back on a regular Medicine floor and preparing for discharge

f) **Patient referred meets criteria but length of hospital stay is >7 days:** If after a patient is evaluated they have still not been discharged 7 days later, the Transition Manager has the option of changing the status to inactive and initiating a new care plan once the patient is ready for discharge.

g) **Patient is incarcerated**

h) **Patient is transferred to a Nursing Home or SNF:** At this time, The TMT will not follow patients in SNFs/nursing homes/long term care facilities.

i. If there is team capacity and it is anticipated that the patient will only be at the facility for 7-10 days, following the patient at the SNF/nursing home is at the discretion of the TMT

Please note: If the patient has an ED visit without an admission during the 30-day period, there is no interruption of Transition Management services.

9. **There is no early graduation.**

a) If a patient meets all goals, they continue to receive a light touch – one phone call per week – until the 30 days is up

b) For patients that are lost to follow up (unable to be reached by phone for two weeks, after voicemails have been left), the Transition Manager should attempt a home visit. If unsuccessful, the Transition Manager should follow the “Unable to Reach” policy.

c) The Care Plan should not be closed if the patient is referred to Health Home or has another care manager

i. The role of the Transition Manager is to liaise with the other care services the patient may be receiving

10. **Definitions for status of goals**

a) **Deferred:** Patient accepted a goal initially, but then it becomes clear that they are not willing or able to work on this goal in the 30-day period, but may come back to it later (i.e.: Patient wants to lose weight to improve diabetes status, but will do so later when they recover from an injury and can be more active)
b) Abandoned: Patient accepted goal initially but then decides they do not want to pursue it anymore (i.e.: Patient wanted to quit smoking and then decided they don’t want to work towards this goal at this time)

c) Declined: Patient was never interested in pursuing that particular goal

d) Achieved: Goal was set and met in time frame

e) Suggestion: Transition Manager suggested goal, but patient has not yet committed to it- can be revisited

11. Client priority: Patient determines: high, medium, low priority

12. Definitions for Clinician Priority:

   a) Urgent:
      i. Issues that if left unaddressed, patient will most likely return to the ED or be readmitted; or
      ii. An exacerbation of a condition that needs attention within 24 hours; or
      iii. A newly identified social issue that is impacting the patient’s ability to self-manage, or impacting their immediate safety

   b) High: Typically related to the original reasons for admission, medication reconciliation issues, long term social issues that could trigger returning to the ED

   c) Medium: Showing improvement, but needs ongoing weekly monitoring to meet goal

   d) Low: Stabilized, maintenance stage. Just needs occasional ongoing reinforcement
13. Short term goals: are typically those that can be achieved in 30 days

14. Long term goals: will likely require longer than 30 days

15. Example of Strengths and Resources include family support, social and community support, existing care management programs, understanding of disease

16. Examples of challenges include: Lack of knowledge or understanding of disease, no care giver support
17. The End of the 30 Day Period: At the end of the 30-Day Period, it is expected that some of the patient’s needs will be met, while other issues may not yet be resolved. During the 30-day Transition Management period, the Transition Manager will have created a team in the community that can assist the patient with ongoing needs and help them work towards the goals identified during the 30-day period. There should be a warm hand off of any open issues on the care plan to another member of the patient’s care team at the end of the 30-day period. The status in GSI Health should be changed to “inactive”. At this point
  a) If the patient successfully completed the 30-day program, the inactive reason code of “closure” should be used. This code should be used for all patients who successfully complete the program, and should only be used for patients who are followed until 30 days.
  b) Each goal should be completed, and a comment reflecting whether the goal was successful or not should be included. For any issues that are still outstanding, the Transition Manager should document the referrals or handoffs to other programs should be documented in the care plan.

SUPPORT FOR THE TRANSITION MANAGEMENT PROGRAM

OneCity Health will have regular meetings with all partners providing Transition Management Services to discuss program implementation and share best practices across sites and partners.

1. Any technical questions relating to GSI Health documentation should be directed to the GSI Health Help Desk

- Telephone Number: **1-888-594-4612**
- Email Address: **Help@GSIHEALTH.com**
- Hours of Operation: **Monday through Friday 7am to 10pm ET**

1. On TMTs, patient-specific and other clinical questions and concerns should be escalated through the team structure accordingly (Transition Assistant to RN or SW, and up to
Program Director/lead as necessary). As mentioned previously, TMTs will be given a Facility contact for operational and logistical questions related to the specific hospital in which they are based.

2. Programmatic Questions can be directed to the OneCity Health Help Desk: Telephone Number: 646-694-7090, Email Address: ochsupportdesk@nychhc.org, with the subject line “Care Transitions Question”. Hours of Operation: Monday through Friday 9am to 5pm ET

SECTION 4: ADMINISTRATION AND MANAGEMENT OF THE CARE TRANSITIONS PROJECT

This section of the toolkit is intended to be used by the supervisory leadership of the Transition Management Partner.

RECRUITING, SCREENING AND ONBOARDING

The OneCity Health partner organization providing Transition Management services is responsible for recruiting, screening, and hiring Transition Management staff that meet all the requirements outlined in the OneCity Health TMT job descriptions, as well as maintaining high quality provision of services that meet all of the requirements outlined in this toolkit and in the accompanying Standard Operating Procedures (SOPs).

The job functions for each team member are outlined in subsequent sections of this toolkit below.

OneCity Health will work with the organization that provides Transition Management services in order to match TMTs to inpatient facilities. Based on this matching process, OneCity Health will provide guidance around the number of teams needed, hospital locations, language needs, and types of hospital units in which the TMT will provide services. These factors may influence staffing qualifications. Please use the staffing template below. Resumes/ CVs or a narrative of the new hire’s experience may be requested by either OneCity Health or the hospital in which he/she will be working.

The DSRIP Facility Lead at the hospital in which the TMT will be working will identify a staff member from their Human Resources (HR) department who can work with HR from the care management organization regarding requirements for new staff. These include, but may not be limited to:

- Name, Address, Telephone number, and birth date of new employee
Implementation Toolkit: Care Transitions Intervention (TMTs – Psychiatry)

- Official start date at the hospital facility
- Copy of license and/or certifications
- Copy of PPD, influenza vaccine record, and HIPAA acknowledgment form
- Date when orientation was completed

TRAINING

It is also the responsibility of the partner providing Transition Management services to ensure that staff are provided with the necessary clinical orientation and administrative operational support. Staff training needs may include, but are not limited to the list below. The partner may be asked to share documentation that staff have been trained according to topics on the list below, or to share the curriculum for training in the below topics during the orientation period.

A core curriculum of care management skills includes the following.

1. Engaging patients in care management
2. Care management standard processes and documentation
3. Care plan development/goal setting
4. Conducting effective case conferences
5. Navigating community resources (including for uninsured)
6. Overview of insurance
7. Health advocacy
8. Advocacy for the homeless/applying for housing resources
9. Documentation and communication in GSI Health software
10. Transitions in care
11. Self-management and health coaching
12. Medication list comparison
13. Overview of chronic medical conditions
14. Overview of serious mental illness
15. Trauma-informed care
16. Crisis management
17. Harm reduction
18. Managing patients with Behavioral Health issues/substance abuse issues
19. Ethics, cultural competency, and health disparities
20. Motivational Interviewing

Certain trainings, including motivational interviewing, care coordination, care planning and documentation will be required before the team begins accepting referrals. OneCity Health is
Implementation Toolkit: Care Transitions Intervention (*TMTs – Psychiatry*)

developing an integrated training strategy for care management, and will keep partners apprised as centralized resources are made available to partners.

**SUPPLIES**

The organization providing Transition Management Services must provide cell phones and laptops for their staff. Basic office supplies, printers, desk tops, and landline phones will be provided by the hospital.

**IT Checklist for GSI: Currently supported**

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Please review these GSI system requirements with your organization’s IT Department.

**HR Checklist**

The OneCity Health Contracted Partner will be expected to provide the following:

- HR contact (to liaise with HR contact for the acute care facility)
- Demographics: name, address, telephone number, date of birth
- Start date at the assigned facility
- Copies of: license and/or certifications, completed training (as needed), Tuberculosis skin test (PPD Mantoux), flu shot, and HIPAA acknowledgment form
- Other facility-specific requirements as needed

**Quality Control and Management Expectations**

Management and oversight of the TMT falls under the purview of the organization that is contracted to provide Transition Management Services, **not within OneCity Health or in the hospital where the TMT are providing services**. There is a DSRIP lead at each facility to support integration into the hospital clinical team, but there will not be an onsite supervisor. It is the responsibility of the partner providing Transition Management services to perform ongoing monitoring of the TMT, conduct regular performance evaluations, ensure that the TMTs are high performing and meeting the expectations outlined in this toolkit, and conduct corrective action where needed.

Performance monitoring requirements include, but are not limited to:

- **Attendance.** TMT members must discuss and coordinate **pre-planned** time off with their supervisor and colleagues so that sufficient coverage is maintained five days per week. TMT members must notify their supervisor of any **unplanned** absences or lateness, and the supervisor must convey this information back to the facility.

- **Schedules and location of TMT staff:** TMT supervisors should discuss and guide the team on division of responsibilities and work (for example, who on the team attends rounds). Staff should notify their supervisor when they will not be in their standard location on the floor due to offsite work such as home visits or accompanying the patient to an appointment. The supervisor should ensure that at least one member of the team attends rounds daily.
• **Performance standards**: Supervisors must review their team’s documentation in GSI on a regular basis. Additionally, they should conduct a minimum of 15 chart reviews per month using the chart review tool located in Appendix D; ensuring that documentation is complete, timely, and correctly identifying and capturing issues. The Transitions Management supervisor must provide corrective action, coaching, and instruction where needed. The Project Implementation guide that accompanies the contract clearly outlines required activities, and should be used in conjunction with this toolkit to ensure that all project requirements are being met.

**PCP NOTIFICATION**

An additional program requirement is for the Transition Manager to provide a copy of the patient’s care plan to the primary care physician and/or Behavioral Health physician. It is up to the supervisor or manager to determine the appropriate method to ensure this communication occurs (via secure email, fax, etc.).

**CHART REVIEW**

The supervisor of the team must conduct a minimum of 15 chart reviews per team per month to ensure the quality of team activities and integrity of data. The chart review tool in Appendix D of this toolkit is provided as a guide. Corrective action, performance appraisal, and mentoring should occur as appropriate.

**CASE CONFERENCES**

Weekly case conferences for each TMT are also mandatory. (See Appendix E for Case Conference Guide).

Any readmission within the 30-day period must have a complete case conference review to determine reason for readmission and any mitigating factors and/or improvements that could have impacted the outcome. A case conference is defined as follows:

• Must focus on the needs of a patient, with the goal of improving the patient’s health or well-being
• Must have bidirectional communication
• May be done via any secure communication medium (e.g. in person, phone, secure email)
• A member of a clinical treating team must be included, and other individuals and organizations should be included as appropriate
• Should be initiated for events including, but not limited to, ED visit, hospitalization, worsening of medical status
• Content should include Situation (patient issue); Background; Assessment; Results (plan and timeline).

**Reporting Requirements**

The supervisors/managers of the TMT will be required to attend training on GSI Reporting in Population Health Manager. The partner will be responsible for running a number of reports in GSI that track process and outcome measures, for purposes of performance management of the TMTs. Some reports will be generated by OneCity Health, and the partner will be responsible for reviewing and process improvement only. Other reports may be required to be manually run by the partner. Some of these reports must be submitted to OneCity Health in order for payment to occur.

**POLICIES AND PROCEDURES**

OneCity Health has developed a number of policies and procedures to be used by community partners providing Transition Management services. These include:

- Oversight, Support, and Supervision of TMT
- EMS Activation Policy
- HIPPA ID Verification Policy
- Unable to Reach/Engage Process for Participants in Active Transition Management

**Standard Operating Procedures (SOPs)** will be distributed to all partners as an addendum to this toolkit. These SOPs, along with the guidelines for case conferences, chart review template, checklists for standard work in the hospital and community, and job descriptions, provide guidance for program implementation that will standardize the Transition Management program across the PPS.

*It is up to the partner to dictate particular activities of the various members of the TMT to ensure that these activities are aligned with any regulatory requirements that otherwise govern the agency.*

**APPENDICES**

*Please be sure to refer closely to the GSI User Training Manual and the SOPs.*
APPENDIX A: TMT JOB FUNCTIONS

This section refers to functional roles, not job titles.

Transitional Care Manager - (Registered Nurse): Duties and Responsibilities

1. Receive list of identified high risk admitted patients eligible for care transitions program.
2. Attends interdisciplinary rounds with the in-patient unit team.
3. Meet eligible patients soon after admission to initiate engagement and enrollment; collaborate with hospital care team to review patient status; and ensure processes are in place for patient to have a safe, timely discharge.
4. Complete assessment of patient to determine what care, services and follow up are needed to ensure a safe discharge and transition from hospital to home. Determine if a home visit is required within 24-48 hours of discharge.
5. Reconcile discharge medications and if possible obtain names of medications patient is currently taking at home. The RN reviews medications with patient and caregiver and ensures that they understand the indication for use, frequency and dosage. RN should consider targeted nutritional counseling for patients whose psychiatric medications increase the risk of metabolic disease.
6. Assess primary verbal and written language and health literacy to determine best way to communicate health information.
7. Plan for how exacerbation/decompensation of disease once home will be handled. Make sure patient and caregiver(s) know who to call if he/she has a problem.
8. Make sure patient has follow up appointment with PCP and other specialists as indicated.
9. Initiate care plan prior to discharge and revises as needed throughout the 30-day period in collaboration with the patient/family and members of the care team.
10. Ensure that a phone call is made to patient within 24- 48 hours after discharge to ask if patient has filled medications, understands and is taking them, is aware of signs and symptoms of decompensation, ordered services are in place.
11. Coordinate with home health care agency field nurse. If patient is not receiving this service assess if home visit is needed within first 24- 48 hours after discharge for home safety issues, medication concerns, signs and symptoms of disease decompensation or other concerns.
12. Call patients to remind them about upcoming appointments and follow up after appointments.
13. Communicate with health care providers as needed.
14. Conduct case conference after critical events such as ED visit, inpatient admission, eviction, etc.
15. Identify long term care management needs and makes appropriate referrals such as to Health Home, other home and community based services, or managed long-term care program prior to the end of the 30-day period.

16. Document all encounters in GSI as per protocol.

17. Direct and supervise other team members such as Community Liaison.

Transition Management Assistant: Duties and Responsibilities

- Greet patients and engage them in Transition Management program and participate in obtaining nonclinical information for the assessment of need.
- Assist with the implementation of the discharge plan and report barriers to effective service utilization.
- Ensure access to treatment services after discharge.
- Visit patient in home at a minimum of once during the 30-day transition period.
- Assist team in setting up discharge plan while patient is hospitalized and follows up at least weekly with patient for 30 days after discharge.
- Monitor participant adherence with clinical services (appointments, treatment, medication, etc.)
- Work with team leader (Transitional Care Manager) and other team members to report concerns and problems she/he has identified which are barriers to care, make recommendations and seeks advice as needed.
- Follow up on identified problems, issues, complaints.
- Document information in designated electronic record as per protocol.
- Participate in program meetings and in services.

Transition Care Social Worker: Duties and Responsibilities

- Participate in transition care planning while patient is hospitalized, identifies medical, behavioral and social needs and makes appropriate referrals.
- Attend daily rounds with the interdisciplinary team, contributes patient information and barriers to discharge, is an active participant.
- Prior to discharge from the hospital, initiate care plan with identified issues and goals/interventions.
- Determine, along with team members, which patients will require a home visit within 24-48 hrs.
- Conduct at least one face to face visit during the 30-day period. Additional visits as needed to meet the needs of the patient.
- Ensure patient understands medication regimen in collaboration with RN Team Leader.
- Follow patient for 30 days after discharge via follow up calls and/or home visits to:
  - Assess psycho social barriers to Health care and makes appropriate referrals.
Implementation Toolkit: Care Transitions Intervention (TMTs – Psychiatry)

- Ensure patient obtained medications, received durable medical equipment as ordered as well as other supplies.
- Continue to follow up on all referrals made to ensure services are implemented i.e. home care services, Health home care manager, etc.
- Initiate case conferences with Behavioral Health continuity provider, PCP/designee, and other members of the care team.
- Provide support and information on the social and emotional effect of patient’s disease on patient and caregiver(s).

- Attend in services, trainings and meetings as required.
- Serve as a resource for the team.
- Keep current on entitlements, services, programs, community and other resources.

APPENDIX B: INITIAL ASSESSMENT GUIDANCE TOOL

The tool below is to be used by Transition Manager with the Initial Assessment Tool in GSI.

**Medical**
- Do you have a primary care doctor? What is the doctor’s name and contact information?
- When was the last time you saw Dr. PCP? Date?
- Why did you see Dr. PCP?
- Was the visit for preventative care? (Ex: vaccination, PAP/Mammo/CBE (for women), or colon cancer screening)
- Was the visit for a chronic disease, like diabetes, high blood pressure, asthma?
- Are you taking medications?
- If so, what medications are you taking?
- Tell me when you’re taking your medications? (Ex: once a day, three times a day, in the morning, at night)
- Did Dr. PCP ask you to follow up with another provider? (Ex: gastroenterologist for colonoscopy)?
- Did Dr. PCP ask you to get lab work done? By when?

**Mental Health**
- Are you seeing a therapist and/or psychiatrist?
- What is the name of your therapist and/or psychiatrist?
- When was the last time you saw Dr. Therapist or Psychiatrist? Date?
- Why did you see Dr. Therapist or Psychiatrist?
- Are you taking medications?
- What medications are you taking?
- Tell me when you’re taking your medications (Ex: once a day, three times a day, in the morning, at night)
- Has Dr. Therapist or Psychiatrist referred you to another provider?
Have you visited that provider?
Did Dr. Psychiatrist ask you to get lab work done? By when

Substance Use

The purpose of this section is to understand whether or not an individual’s well-being is at risk of being compromised by the use of substances (drugs, alcohol). It is important to understand that certain types of substance use could require immediate medical intervention if/when a person chooses to cease use of that substance. For example, withdrawal from alcohol or benzodiazepines (e.g. Xanax) can have fatal indications without the appropriate medical supervision. Additionally, comorbid use of substances can also place an individual at risk of medical complications (e.g. concurrent alcohol and benzodiazepine use).

It is common for persons using drugs and/or alcohol to be protective of this information as a result of the perceived stigma associated with substance abuse, an individual’s readiness (or lack) to cease use, or a lack of information about the dangers of substance use. For these and other reasons, it is important to ask questions in as non-invasive of a manner as possible. Open-ended questions typically provide more qualitative answers than do close-ended questions; it is advisable to reframe questions in this manner as often as possible.

For example, asking a person “Do you use drugs?” allows for an easy “No.” response. Conversely, asking, “When was the last time you used any drugs, including alcohol?” encourages a more open response.

By beginning the exploration of a person’s substance use patterns with these open ended questions, you will create room to ask more direct questions. Helpful questions to ask in this setting include:

- Which substances have you ever used or tried (including drugs/alcohol)?
- When was the last time you consumed any drugs, including alcohol (date of last use)?
- Have you ever attempted to cut back or stop use all together?
- What sorts of things have you done to try to quit using? If affirmative answer:
  - Have you ever gone to a counselor for assistance in efforts to stop using?
  - Have you ever gone to a hospital or other medical clinic for help?
  - Have you gone to an inpatient or residential facility for help?
  - When was the last time/location of (whatever modality was indicated)?
- Are you interested in learning more about the different types of resources that are available to help you learn how to better control your substance use?

Housing

- Tell me a little about your current housing situation? Where are you living?
Implementation Toolkit: Care Transitions Intervention (TMTs – Psychiatry)

**I have a place to live.**
- Do you have your own bedroom? Where do you sleep?
- How many people sleep in the bedroom or room that you are in?
- How many people sleep in the apartment or house that you live in?
- How long have you been living there?
- How long can you continue to stay where you are now?

**I owe back rent where I am living.**
- How much do you currently owe?
- What is your monthly rent?
- Has your landlord sent you anything about the money you owe?

If yes, ask them to bring any paperwork relating to their back rent the next time you meet? This should be done quickly, if back rent is excessive possibly within 48 hours.

Landlords will sometimes send eviction notices with a specific date to vacate the apartment that they print and deliver themselves but unless the notice received is from the NYC Housing Courts or from the Marshall, it is not an actual eviction notice.

- Have you gotten a notice from the court or from the Marshall?

  **If yes, follow the steps for eviction below.**

  - Do you get any help with paying your rent each month? Who helps?
  - Have you ever gotten assistance before with paying back rent? When was the last time?
  - Do you want to stay in this apartment?

**I received an eviction notice.**

This requires you to work with the client to resolve immediately.

Work with the client to obtain the eviction notice right away. An eviction can be prevented if immediate action is taken.

Obtain the phone number for the Marshall’s office handling the eviction and call the Marshall.

Let the Marshall know that you have just started working to assist the client and would like time to resolve the arrears. Provide the Marshall with information about any possible financial assistance the client may be eligible for.

- Does the client have an attorney?

  *Need to include additional steps to resolve eviction with court, etc.*

**I do not have any place to sleep tonight.**

  **This requires an immediate referral.**

Provide them with information about NYC Shelters and Drop-in Centers available at NYC.gov.
If the client has HASA, provide them with information about HASA Emergency Placement Unit. If HASA eligible, determine if they have the required documentation to apply for HASA. Include information here about how to apply for HASA.

In some instances, it may be necessary to accompany the client to the appropriate emergency placement unit to assist with obtaining shelter.

**Financial**

The purpose of this section is to understand the member’s financial stability. Financial stability is closely related to many of the other issues that you are addressing in this initial interview so listen for such information throughout the discussion.

Can you tell me a bit about how you support yourself (listen for job, benefits, SSD/SSI, PA, pension, etc.)? These answers will also connect to benefits – so listen for

- Is your income enough so you can make it through the month? If you have to skip bills, which ones do you skip? (Listen for utilities, medication, food, etc.,)
- Do you feel you do a good job managing your money month to month? Could you use some help doing so?
- How much debt do you have? Does it feel like a problem to you?
- Are you able to buy Metrocards to get around to take care things you need to do?

**Entitlements/Benefits**

- Do you have Medicaid/Medicare? Do you know if it is active now? Have you had any issues with your Medicaid or Medicare recently?
- Are you receiving food stamps or other assistance with food?
  - Do you get enough food to eat each day? Have you missed a meal recently? If so, when?
  - How often do you miss a meal?
- Are you getting any cash benefits right now, like through Public Assistance (PA) or through HASA? How much do you get each month? Do you have any other sources of income? Veteran’s benefits?
- Do you get social security income or social security disability income each month? How much do you get?

**Legal**

The purpose of this section is to identify whether the client has any current or pending legal obligations that he/she may require assistance with, or that could play a part in the amount and types of services that the client can engage in.

Helpful questions to ask in this area include:
Implementation Toolkit: Care Transitions Intervention (TMTs – Psychiatry)

➢ Do you have any legal concerns including courts, probation or parole, or ACS monitoring?
  o If yes: Do you have the name and phone number of the person whom you report to?
➢ Do you have current government issued identification?
  o If no: Do you have a birth certificate/social security card?
  o If no: Were you born in the US?

Support Services

This is your opportunity to get a first snapshot of what kinds of services the member has or might need.

Let’s talk for a minute about the things you do during the day and the things that help you to be independent.

➢ How do you spend your time? Do you work? Take classes? Any social clubs or activities? Do you have a church or other organization that you spend time with? Anything like a support group, day program or self-help program?
➢ Do you have any help in your home – an aid?

Notes

The notes section should be utilized to provide qualitative information that corresponds to any of the indicators selected from the various life areas. If any of the life areas has an indicator selected, the writer should explain more about that area in the notes section. For example, if the writer selects “Civil/Criminal” in the “Legal” section, in the notes section, he/she could write, “Ct indicates current NYS Parole supervision, PO Jones 212.543.7754 until approx. March 2016”. This area can also retain any information that is notable or important, including best day/time to contact the client, any special needs, or information that would be important for the person who will follow up with the client to know (e.g. “Ct has 2 large dogs on property”).

APPENDIX C: CARE PLAN DOMAINS DOCUMENTATION GUIDANCE

Medication Reconciliation:

Medication reconciliation is integral to reducing medication errors surrounding hospitalizations.

The responsibility of medication reconciliation is with treatment team. After this is done, the RN on the team should review the medications with the patient while they are in the ED. The RN should compile a medication list by source (i.e. chart, list provided by patient, patient/caregiver interview) while the patient is still in the hospital, and work to rectify the lists from various
Implementation Toolkit: Care Transitions Intervention (TMTs – Psychiatry)

sources. If caregiver is available, the RN should have them bring the medications to the hospital. The RN should review medications with patient and caregivers and ensure that patient/caregiver understands the purpose of and how to take each medication. All of this should be documented in the Medication Reconciliation domain of the care plan. The Transition Manager should communicate any issues or gaps to the physician and RN on the inpatient team.

The RN on the team should ask the patient if he/she understands the use, frequency, and side-effects of medications, as well as asking the patient where their prescription is filled and who picks up their medications. The team should identify barriers to obtaining medication and develop solutions to address them, involving the hospital team where necessary.

Any gaps, remediation, or education should be documented and followed up on in subsequent care plan updates.

**Caregiver Stress:**

A caregiver is anyone who provides help to another person in need, such as an ill spouse or partner, a disabled child, or an aging relative. However, family members who are actively caring for an older adult often don't self-identify as a "caregiver." Recognizing this role can help caregivers receive the support they need.

People who experience caregiver stress can be vulnerable to changes in their own health. Signs of caregiver stress include the following:

- Feeling overwhelmed or constantly worried
- Feeling tired most of the time
- Sleeping too much or too little
- Gaining or losing a lot of weight
- Becoming easily irritated or angry
- Losing interest in activities you used to enjoy
- Feeling sad
- Having frequent headaches, bodily pain or other physical problems
- Abusing alcohol or drugs, including prescription medications

In addition to the negative impact on the individual, a caregiver who is stressed may not be able to care for the patient as well as they should. Any signs of caregiver stress should be documented and discussed with the patient’s care team.
The Transition Manager should consider support groups, engaging other friends and family as needed, and as necessary, speaking to the patient’s doctor about homecare if the caregiver is not able to manage the needs of the patient.

**Self-Education:**

In this care plan domain, the TMT should document any education provided to the patient regarding their condition and its effective treatment, interpreting and reporting symptoms accurately, the importance of adherence to appointments and treatment plan, using medications properly, changing behaviors to improve symptoms or slow disease progression, adjusting to social and economic consequences, coping with emotional consequences, etc.

**Post Discharge Follow Up Appointment:**

In this care plan domain, the Transition Manager should document any follow up appointments and whether the patient was compliant with the schedule. As a reminder, the primary care appointment must also be documented in the Patient Profile section of the care plan.

The Transition Manager should check that the patient or caregiver knows about all follow up appointments (e.g., primary care follows up, lab test, specialist) and their dates, times, and locations; the purpose of the appointments; and that the patient can make it to the appointments. The Transition Manager will need to problem solve with the patient if there are barriers to keeping appointments, such as transportation. The Transition Manager should also ensure that homecare and DME arrived as ordered, and document any gaps in the care plan.

**Social Support and Services**

In this section of the care plan, the Transition Manager should document any community based services to which the patient has been referred, and the outcome of the referral. This includes Health Home, community based organizations, substance abuse treatment programs, food pantries, legal services, etc. If the patient is homeless and referred to DHS or any other homeless services organization, this should be documented in this section of the care plan.
## APPENDIX D: CHART REVIEW TOOL

**Reviewer** | **Date of Review**
--- | ---

**Client Name** | **CIN**

**Assigned CMO** | **Assigned Care Mgr.**

**Enrollment Status** | **Date of Enrollment**

**Program Name** | **Payer Class/Plan**

### Enrollment

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<tr>
<td><strong>Referral date present</strong></td>
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<td><strong>Referral source documented</strong></td>
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### Program Assignment

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<tr>
<td><strong>Member tagged in the 30 Day Transitions Project</strong></td>
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<tr>
<td><strong>Care team completed (PCP, Care Manager minimum)</strong></td>
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### Assessments/ Encounter

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<th>Yes</th>
<th>No</th>
<th>N/A</th>
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<tr>
<td><strong>Initial assessment completed</strong></td>
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<tr>
<td><strong>Encounter present during the first 7 days after discharge</strong></td>
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<tr>
<td><strong>Minimum of 4 encounters in the 30 day period</strong></td>
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### Comprehensive Care Plan

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<tr>
<td><strong>CCP updated every 7 days</strong></td>
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<tr>
<td><strong>CCP addresses 6 domains in 30 Day Transition</strong></td>
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<tr>
<td>1. Medical</td>
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<td>2. Caregiver Stress</td>
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<td>3. Self-education</td>
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<td>4. Post-discharge follow up</td>
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<td>5. Social Service</td>
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<td>6. Diagnosis</td>
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<th></th>
<th>Demonstrates progression (completion &amp; updating) of needs/interventions?</th>
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<tr>
<td><strong>CCP closed:</strong></td>
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<tr>
<td>1. Patient re-admitted</td>
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<td>2. Declined services</td>
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<td>3. Completed 30 day transition period</td>
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### Outreach/Lost to contact after enrollment

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<td>Minimum of three attempts to re-engage patient</td>
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<td>1. Telephonic</td>
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<td>2. Home visit</td>
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<td>3. Contact with provider or collateral</td>
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### Case Conference

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<tr>
<td>Case conference conducted with PCP prior to the end of 30 day period (via secure messaging, phone, in-person, during PCP appointment)</td>
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<tr>
<td>Case conference conducted after critical event i.e. ED visit, in-patient stay, eviction, domestic violence, etc.</td>
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### Comments & Recommendations

|                      |     |    |
APPENDIX E: CASE CONFERENCE GUIDE

What is a Case Conference?

Case conferences must be conducted within 7 days of ED visits or inpatient admissions, and must include either the PCP or at least one member of the inpatient care team. A case conference is defined as follows:

- Must focus on the needs of a patient, with the goal of improving the patient’s health or well-being
- Must have bidirectional communication
- May be done via any secure communication medium (e.g. in person, phone, secure email)
- A member of a clinical treating team must be included, and other individuals and organizations should be included as appropriate
- Should be initiated for events including, but not limited to, ED visit, hospitalization, worsening of medical status
- Content should include Situation (patient issue); Background; Assessment; Results (plan and timeline).

What are some circumstances that could trigger case conference?

Case Conference should occur in response to certain triggering events. Situations that other members of the care team should be apprised of- and involved in the response plan for- should precipitate a case conference. Situations that may trigger a case conference in the 30 day-transitions period include but are not limited to:

- An emergency department visit
- An inpatient medical or psychiatric hospitalization
- An arrest
- An eviction or other event resulting in homelessness
- Physical or psychiatric decompensation
- Substance abuse relapse
- Domestic violence incident
- Harm to self or others, or threat of harm to self or others
- Patient is a victim of a crime
- Legal crisis

What should be discussed during a case conference?
Since case conferences occur around specific events, the discussion should be structured around the circumstances of the event. A case conference should address:

- Why/how the event occurred
- The circumstances leading up to the event
- The current status of the patient
- Developing a plan to keep the patient safe
- Developing a plan to prevent a similar event from occurring again

**When should a case conference occur?**

An attempt to initiate/schedule a case conference should be made immediately (within 2 calendar days) upon learning of the event.

**Case Conference Example:** Patient is hospitalized during the 30 day transition period.

Discuss the circumstances that led to the ED visit. The team may consider

1. Was the most recent primary care appointment broken or kept?
2. Was the visit precipitated by any of the following?
   - A medication error or other adverse drug event
   - Uncontrolled pain or psychiatric symptoms
   - Overwhelmed family care givers
   - Homelessness or other housing crisis
   - Substance use
   - Domestic violence
3. Whether the patient has palliative or end-of-life needs
4. Whether the patient has advance directives (DNR, DNI, and MOLST)

Discuss how the ED visit could have been avoided

If the visit could have been avoided, evaluate the 30-day transition plan and make necessary changes. For example, ensure follow-up with PCP, arrange for respite for family caregivers, provide more education for the patient on managing their condition, provide additional medication management services, increase frequency of contact by Transition Manager, and consider referral to the Health Home to ensure the patient is followed after the 30-day transition period is over.

**Follow up:**
• Send a message to the team summarizing the case conference and next steps
• Document the case conference in GSI.

APPENDIX F: HITE RESOURCE GUIDE

Website: [http://www.hitesite.org/](http://www.hitesite.org/)

The Health Information Tool for Empowerment is an online directory offering information on more than 5,000 Health and social services available to low-income, uninsured, and underinsured individuals in the Greater New York area. HITE helps people connect to vital community services quickly and easily. The directory offers information on community services throughout all of New York City and Long Island in the following categories: Optical, Financial, [Health Care & Medicine](#), [Immigrant Support](#), Abuse, School, [Social Services](#), [Transportation](#), and [Wellness & Prevention](#). HITE is a program of the not-for-profit Foundation affiliate of the [Greater New York Hospital Association (GNYHA)](#).

APPENDIX G: ONECITY HEALTH PARTNER LIST

See the [OneCity Health website](#) for links to several different resources regarding the hundreds of partners that are part of the OneCity Health Performing Provider System.

APPENDIX H: RESOURCES FOR WORKING WITH UNINSURED AND UNDOCUMENTED IMMIGRANTS

The target population for the Transition Management program is Medicaid patients and the uninsured, regardless of immigration or documentation status.

In December of 2016, NYC Health + Hospitals issued an “Open Letter to Immigrant New Yorkers” to reassure all immigrants that they can get medical care in any public health care setting without fear. The letter was translated into 13 languages and distributed throughout the City.

The letter, signed by Stanley Brezenoff, Interim President and CEO, NYC Health + Hospitals, and Nisha Agarwal, Commissioner, Mayor’s Office of Immigrant Affairs, promises all immigrants: “The City of New York has a policy to protect immigration status and other confidential information. NYC Health + Hospitals will honor your right to privacy.”

Some undocumented patients may express concerns about giving information, signing consent forms, or accepting home visits. The language from the English letter is displayed below.

The link to the letter translated into all language can be found here. [http://www.nychealthandhospitals.org/immigrant/](http://www.nychealthandhospitals.org/immigrant/)
The TMT may choose to use the letter in its entirety or some of the model language in the letter when talking to their patients.

Open Letter to Immigrant New Yorkers

“Do not be afraid to go to the doctor, the clinic, the hospital, or the emergency room. All immigrants can get medical care in New York City, regardless of immigration status or ability to pay. We want you to seek care in any setting without fear. NYC Health + Hospitals runs the public hospitals and neighborhood health centers in New York City. We respect you and want to help you get the health care you deserve. When you visit our health care facilities, we do not collect information about your immigration status and we never release patient information without authorization by the patient or without being required to do so by law. Our staff will keep it private and confidential. Our health centers and hospitals have a long and proud history of caring for everyone. Our commitment is strong. It has not changed. We promise all immigrants: THE CITY OF NEW YORK HAS A POLICY TO PROTECT IMMIGRATION STATUS AND OTHER CONFIDENTIAL INFORMATION. NYC HEALTH + HOSPITALS WILL HONOR YOUR RIGHT TO PRIVACY. NYC Health + Hospitals public hospitals and health centers are located in neighborhoods all over New York City and provide services in different languages. We provide free interpretation services in 200 languages, 24 hours a day, 7 days a week, and offer translated patient education materials in the top 13 languages preferred by our patients. Our doctors, nurses, and other health care workers care about you. Many of them are immigrants or children of immigrants. They all want to serve you with respect and will work to protect your privacy.

There are different options available to help you get the health care you need. All children and pregnant women can get health insurance -- even if you do not have legal status. NYC Health + Hospitals staff can help you get the insurance you need. NYC Health + Hospitals will help you even if you do not have insurance and cannot pay a lot of money for health care. This is true for all types of health care services, including emergency care, doctor’s visits, medications, long-term care, and hospital stays. To help find out how much you can pay, our staff will ask you for some information about how much you earn and how many people are in your family. You will need to show your home address, some proof of identity, and your date of birth. We want you to get the care you need today, before you get sick, and before it becomes an emergency. NYC Health + Hospitals has also partnered with IDNYC, the City’s municipal identification card available to all which is an accepted form of identification for patients that can be used during the check-in and registration process. Our policy is clear, NYC Health + Hospitals employees cannot give your information to ANYONE else without authorization by the patient or without being required to do so by law. All of our employees know that if they break this promise they
can lose their job. We understand that this is the only way that we can keep your trust. In addition, other City services are available to you, including food, education, legal services, public safety, and more. We encourage immigrant New Yorkers to seek out important City services that are available to them and their families. Call 311 for a list of all public hospitals and health centers, to find out more information about resources like IDNYC, or to send a message to NYC Health + Hospitals or the Mayor’s Office of Immigrant Affairs. It is our mission to empower every New Yorker – without exception – to live the healthiest life possible.”

Signed by: STANLEY BREZENOFF -Interim President and CEO Commissioner NYC Health + Hospitals and NISHA AGARWAL Mayor’s Office of Immigrant Affairs

APPENDIX I: HOMELESSNESS RESOURCES

HOUSING RESOURCES FOR CARE MANAGERS (UPDATED 4/6/2017)

1. General Resources
   b. CIDNY
   c. HITE
2. Eviction Prevention
   a. Homebase locations
   b. Eviction Prevention Legal Services
   c. Mediating conflict with landlords, friends, family and roommates
      i. NY Peace Institute (Manhattan and Brooklyn)
      ii. IMCR: https://www.imcr.org/
         i. Community Mediation Center (Queens)
         ii. NYCID (Staten Island)
3. Understanding, navigating and collaborating with the homeless services system
   a. Coalition for the Homeless Resource Guide
   b. Street outreach
      i. DHS Street Outreach
         1. Godard Riverside (Manhattan)
         2. BronxWorks (Bronx)
         3. Breaking Ground (Brooklyn and Queens)
         4. Project Hospitality (Staten Island)
      ii. BRC (Metropolitan Transit Authority)
      c. Safe Havens (beds for chronically street homeless)
         i. Breaking Ground (The Andrews - Bowery)
         ii. BronxWorks Baretto Street and Pyramid
         iii. BRC (Bowery and Washington Heights)
iv. Urban Pathways (Travelers- Times Sq, and Hegeman St. Brooklyn)
d. Drop-in centers
e. Faith-based shelters
f. DHS Shelter system
   i. Intake points
   ii. Shelter Contact information
   iii. Rules for returning to shelter after an absence
   iv. Single Adults
       1. “official shelter” and resource assessment rules (Title 31 Chapter 3 of Rules of City of NY)
       2. Single adult permanent housing referral criteria (Title 31 Chapter 3 of Rules of City of NY)
v. Families with children
   1. Applying at PATH
vi. Adult Families
g. Domestic Violence Shelter/Housing
   i. Domestic Violence Hotline
   ii. New Destiny Resources
   iii. Project Home
   iv. HASA Emergency Housing
   v. HASA Center Locations

4. Understanding, navigating and collaborating with residential Behavioral Health treatment
   a. OASAS system
      i. Treatment service types
      ii. LOCADOR 3.0
      iii. Bed availability dashboard
   b. OMH system
      i. Program Descriptions
      ii. Locate a program

5. Assisting with housing issues upon discharge (or release) from a health care facility
   a. Emergency Department
      i. How to work with ED “superutilizers”
   b. Inpatient hospital
c. Long term care facility & and Nursing Home
d. Adult Care facilities

6. Assisting with housing issues upon release from a correctional facility
   a. Reentry.net
   b. Fortune Society

7. Supportive Housing placement
   a. Identifying candidates for supportive housing
   b. Mental Health Housing
Implementation Toolkit: Care Transitions Intervention *(TMTs – Psychiatry)*

i. **Supportive Housing Options**
ii. **SMI Criteria**
iii. **NY/NY I and II Eligibility**
iv. **How to Access NY/NY I and II Housing**
v. **SPOA Housing Overview**
vi. **How to Access SPOA Housing**
vii. **Introduction to the Mental Health Report**
viii. **Creating a Psychiatric Summary**
ix. **Creating a Comprehensive Psychosocial**
x. **Preparing Applicants for a Housing Interview**
c. **Guide to Completing the HRA 2010e**
d. **New York / New York III Population Types**
e. **MRT Housing**
f. **HIV/AIDS**
   i. **HASA**
   ii. **Housing Works**
   iii. **Baily House**
   iv. **Fitzgerald House**
   v. **Reality House**
g. **Seniors**
h. **Young Adults**
   i. **National Runaway Safeline**
   ii. **DYCD Programs**
i. **Physical Disabilities**
   i. **Barrier Free Living**
j. **Developmental Disabilities**
k. **Veterans**
   i. **National Call Center**
   ii. **VA Homeless Services**
   iii. **HUD VASH**
      1. **VA Centers in NYC**
   iv. **National Coalition for Homeless Veterans**

l. **Understanding timeframe and likelihood of acceptance**
m. **homelessness definitions**
   i. **NY NY I, II and III Definitions**
   ii. **HUD Definition of Chronically Homeless**

8. **Waiver Programs (community-based alternatives to institutional care)**

**Traumatic Brain Injury Waiver Program**