Service Name	Care Transition Coordination and Support
Service Number	TBD
Service Category	Access
Service Definition	The Care Transition (CT) program is intended to provide proactive discharge planning, extensive coaching, and post discharge supports by a Community Health Worker (CHW) or other health care professional. This coaching is intended to support adults age 60 or older discharging from a medical care institution to the place they consider to be home preventing re-institutionalization. CT supports include intake, assessment, a development of service(s) plan, person centered planning, services arranging, primary care follow-up, medical transportation coordination, red flag warning education, medication review and weekly follow up.
Unit of Service	Each 15 min (.25 hours) for CT activities provided for an individual.

Minimum Standards

1. Each program shall have a written eligibility criteria and intake process.
    a. Age 60 and over.
    b. AAAs may develop written criteria to further target low-income individuals, however participation may not be denied because individuals do not meet low-income criteria. Eligibility to participate is not based on a person's level of income.
    c. Participant is not receiving medical care institution transition services and support from another state or federally funded program.
    d. Participants must be admitted to a medical care facility or be within 3 business days of status post discharge from a medical care facility.
    e. Participant cannot be enrolled in the MI Choice Program or MI Health Link Program.
2. Participants are contacted and have their initial assessment completed within 3 business days of discharge from a medical care institution.
3. A coordination of services mechanism must be used to verify duplication of care transition services, and thus prevention of duplicate payments.
4. Each program shall maintain National Aging Program Information System (NAPIS) registration for each program participant. The intake process shall be initiated within one week after an individual becomes active in the program.

5. Each participant shall receive an initial assessment. Assessors shall attempt to acquire each item of information listed below but must recognize and accept the participant's right to refuse to provide requested items:
    a. Basic Information (may be completed by the participant)
        1. Individual's name, address, and phone number
        2. Name, Address, and phone number of person to contact in case of emergency
        3. Gender
        4. Participant Sexual Orientation
        5. Age and date of birth
        6. Race and/or ethnicity
        7. Is the participant Multi-Racial?
        8. Is the participant Hispanic?
        9. Living arrangements
        10. Type of housing
        11. Does the participant speak a language other than English at home?
    b. Health History
        1. History of illnesses, injuries, and health problems
        2. Allergies to medicine, food, etc.
        3. List of current prescription and over-the-counter medications
        4. Orders by physician(s)
        5. Names of current physicians
        6. Diagnosis
        7. Reason for most recent hospitalization
6. The program shall operate within the following basic levels of service:
    a. **Person-Centered Planning:** Discuss goal setting and participant objectives to identify personal needs and wishes, designing a pathway to services that will support a healthy recovery.
    b. **Service Arranging:** Program staff shall provide information, assistance, supports, services options, linkages, and service plan strategies for participants.
    c. Follow-Up
        1. Primary Care Follow Up: Cueing of 7-day primary care follow up
        2. Medical transportation coordination
        3. Weekly phone call follow-up/check-in for at least 30 days to ensure service plans are implemented as established and service needs are being met.
    d. Red Flag warning
        1. Confirm patient is knowledgeable about indications that their condition is worsening and how to respond.

e. **<u>Outcome Measures Reporting requirements include:</u>**
    1. Was the participant readmitted to the hospital within 30 days?
    2. If the participant was readmitted, provide readmittance diagnosis and how the AAA followed up.
    3. Was a medication review of current and new medications completed with a health professional?
    4. Did the participant follow up with their primary care physician within 7 days?
    5. What Long Term Supports and Services were received?
    6. Was medical transportation provided?
    7. Type of medical institution (hospital, nursing facility, clinic, etc.).
    8. Each provider must obtain the views of recipients about the quality of services received using the Care Transition participant feedback survey.

7. **Recommendation:**
    a. Medication consultation/management: Assure patient is knowledgeable about medications and has a medication management system to assure medications are taken as prescribed.