CCME

2021 External Quality Review

ABSOLUTE TOTAL CARE MEDICARE-MEDICAID PROGRAM

Submitted: February 24, 2022

Prepared on behalf of the
South Carolina Department
of Health and Human Services

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EXECUTIVE SUMMARY

At the request of the South Carolina Department of Health and Human Services (SCDHHS), The Carolinas Center for Medical Excellence (CCME) conducted an External Quality Review (EQR) of Absolute Total Care's Healthy Connections Prime Program. Absolute Total Care is a Coordinated and Integrated Care Organization (CICO) serving Medicare-Medicaid (MMP), Dual-eligible Special Needs Plan (DSNP) and Medicare Advantage Prescription Drug Plan (MAPD) members. This review focused on the following areas:

- Provider Network Adequacy
- Evaluation of Over/Under Utilization
- Care Transitions

The goals and objectives of the review are to:

- Determine if Absolute Total Care (ATC) is following service delivery as mandated in the CCO contract with SCDHHS and in the federal regulations
- Evaluate the status of deficiencies identified during the 2020 annual external quality review and any ongoing quality improvements taken to remedy those deficiencies
- Provide feedback for potential areas of further improvement
- Validate that contracted health care services are being delivered and are of good quality

The review consisted of two segments. The first was a desk review of materials and documents received from ATC and reviewed in the offices of CCME. These items focused on administrative functions, committee minutes, member, and provider demographics, over-and under-utilization data, and care transitions.

The second segment was an onsite review conducted virtually on January 26th and 27th. The onsite visit focused on areas not covered in the desk review and areas requiring further clarification.

Findings

An overview of the findings for each section follows and is detailed in the tabular spreadsheet (Attachment 2). CCME classifies areas of review as meeting a standard "Met," acceptable but needing improvement "Partially Met," or failing a standard "Not Met." The status of any deficiencies identified during the 2020 EQR and ATC's response to those deficiencies are included in the applicable sections.

Network Adequacy

ATC is required by the SCDHHS contract to maintain a network of Home and Community Based Services (HCBS) providers sufficient to provide all enrollees with access to a full range of covered services in each geographic area. SCDHHS established a minimum of at least two providers for each service in each county except Anderson, Charleston, Florence, Greenville, Richland, and Spartanburg. For these larger counties, a minimum of three providers for each service was established. The HCBS services include:

- Adult Day Health
- Case Management
- Home Delivered Meals
- Personal Emergency Response System (PERS)
- Personal Care
- Respite
- Telemonitoring

CCME requested a complete list of all contracted HCBS providers currently in ATC's network. The minimum number of required providers for each county was calculated and compared to the number of current providers for the seven different services. There were 41 counties documented as having members. Of the 287 services across 41 counties, 287 met the minimum requirements resulting in a validation score of 100%, which is sustained from last year's rate of 100%. Refer to *Table 1: HCBS Provider Adequacy Results* for a detailed breakdown by county and service.

TABLE 1: HCBS Provider Adequacy Results

County	Unique Providers	Minimum Required	Score
Abbeville			
Adult Day Health	4	2	Met
Case Management	3	2	Met
Home Delivered Meals	4	2	Met
PERS	16	2	Met
Personal Care	24	2	Met
Respite	7	2	Met
Telemonitoring	3	2	Met
Allendale			
Adult Day Health	2	2	Met
Case Management	5	2	Met
Home Delivered Meals	2	2	Met
PERS	15	2	Met

County	Unique Providers	Minimum Required	Score
Personal Care	14	2	Met
Respite	4	2	Met
Telemonitoring	3	2	Met
Anderson			
Adult Day Health	4	3	Met
Case Management	3	3	Met
Home Delivered Meals	3	3	Met
PERS	17	3	Met
Personal Care	32	3	Met
Respite	7	3	Met
Telemonitoring	3	3	Met
Bamberg			
Adult Day Health	4	2	Met
Case Management	5	2	Met
Home Delivered Meals	3	2	Met
PERS	17	2	Met
Personal Care	17	2	Met
Respite	5	2	Met
Telemonitoring	4	2	Met
Barnwell			
Adult Day Health	4	2	Met
Case Management	5	2	Met
Home Delivered Meals	4	2	Met
PERS	17	2	Met
Personal Care	18	2	Met
Respite	5	2	Met
Telemonitoring	4	2	Met
Beaufort			
Adult Day Health	3	2	Met
Case Management	4	2	Met
Home Delivered Meals	3	2	Met
PERS	16	2	Met
Personal Care	16	2	Met
Respite	4	2	Met

County	Unique Providers	Minimum Required	Score
Telemonitoring	4	2	Met
Berkeley			
Adult Day Health	4	2	Met
Case Management	6	2	Met
Home Delivered Meals	3	2	Met
PERS	16	2	Met
Personal Care	19	2	Met
Respite	6	2	Met
Telemonitoring	4	2	Met
Calhoun			
Adult Day Health	5	2	Met
Case Management	4	2	Met
Home Delivered Meals	4	2	Met
PERS	17	2	Met
Personal Care	19	2	Met
Respite	3	2	Met
Telemonitoring	4	2	Met
Charleston			
Adult Day Health	6	3	Met
Case Management	6	3	Met
Home Delivered Meals	4	3	Met
PERS	16	3	Met
Personal Care	22	3	Met
Respite	7	3	Met
Telemonitoring	4	3	Met
Cherokee			
Adult Day Health	3	2	Met
Case Management	4	2	Met
Home Delivered Meals	2	2	Met
PERS	16	2	Met
Personal Care	18	2	Met
Respite	5	2	Met
Telemonitoring	4	2	Met
Chester			

County	Unique Providers	Minimum Required	Score
Adult Day Health	6	2	Met
Case Management	3	2	Met
Home Delivered Meals	3	2	Met
PERS	16	2	Met
Personal Care	23	2	Met
Respite	9	2	Met
Telemonitoring	3	2	Met
Chesterfield			
Adult Day Health	2	2	Met
Case Management	3	2	Met
Home Delivered Meals	5	2	Met
PERS	16	2	Met
Personal Care	18	2	Met
Respite	5	2	Met
Telemonitoring	3	2	Met
Clarendon			
Adult Day Health	4	2	Met
Case Management	6	2	Met
Home Delivered Meals	3	2	Met
PERS	17	2	Met
Personal Care	18	2	Met
Respite	5	2	Met
Telemonitoring	3	2	Met
Colleton			
Adult Day Health	5	2	Met
Case Management	5	2	Met
Home Delivered Meals	4	2	Met
PERS	16	2	Met
Personal Care	19	2	Met
Respite	6	2	Met
Telemonitoring	4	2	Met
Darlington			
Adult Day Health	2	2	Met
Case Management	5	2	Met

County	Unique Providers	Minimum Required	Score
Home Delivered Meals	2	2	Met
PERS	16	2	Met
Personal Care	21	2	Met
Respite	5	2	Met
Telemonitoring	2	2	Met
Dillon			
Adult Day Health	2	2	Met
Case Management	4	2	Met
Home Delivered Meals	3	2	Met
PERS	19	2	Met
Personal Care	17	2	Met
Respite	4	2	Met
Telemonitoring	3	2	Met
Dorchester			
Adult Day Health	3	2	Met
Case Management	5	2	Met
Home Delivered Meals	3	2	Met
PERS	15	2	Met
Personal Care	20	2	Met
Respite	7	2	Met
Telemonitoring	3	2	Met
Edgefield			
Adult Day Health	3	2	Met
Case Management	3	2	Met
Home Delivered Meals	3	2	Met
PERS	16	2	Met
Personal Care	16	2	Met
Respite	5	2	Met
Telemonitoring	2	2	Met
Fairfield			
Adult Day Health	5	2	Met
Case Management	4	2	Met
Home Delivered Meals	4	2	Met
PERS	17	2	Met

County	Unique Providers	Minimum Required	Score
Personal Care	27	2	Met
Respite	8	2	Met
Telemonitoring	3	2	Met
Florence			
Adult Day Health	3	3	Met
Case Management	5	3	Met
Home Delivered Meals	4	3	Met
PERS	19	3	Met
Personal Care	24	3	Met
Respite	5	3	Met
Telemonitoring	3	3	Met
Georgetown			
Adult Day Health	4	2	Met
Case Management	6	2	Met
Home Delivered Meals	3	2	Met
PERS	17	2	Met
Personal Care	20	2	Met
Respite	5	2	Met
Telemonitoring	3	2	Met
Greenville			
Adult Day Health	5	3	Met
Case Management	4	3	Met
Home Delivered Meals	4	3	Met
PERS	18	3	Met
Personal Care	33	3	Met
Respite	11	3	Met
Telemonitoring	5	3	Met
Greenwood			
Adult Day Health	4	2	Met
Case Management	6	2	Met
Home Delivered Meals	3	2	Met
PERS	16	2	Met
Personal Care	26	2	Met
Respite	8	2	Met

County	Unique Providers	Minimum Required	Score
Telemonitoring	2	2	Met
Hampton			
Adult Day Health	3	2	Met
Case Management	5	2	Met
Home Delivered Meals	3	2	Met
PERS	16	2	Met
Personal Care	14	2	Met
Respite	3	2	Met
Telemonitoring	4	2	Met
Horry			
Adult Day Health	3	2	Met
Case Management	7	2	Met
Home Delivered Meals	2	2	Met
PERS	17	2	Met
Personal Care	19	2	Met
Respite	4	2	Met
Telemonitoring	2	2	Met
Jasper			
Adult Day Health	3	2	Met
Case Management	4	2	Met
Home Delivered Meals	3	2	Met
PERS	16	2	Met
Personal Care	16	2	Met
Respite	5	2	Met
Telemonitoring	4	2	Met
Kershaw			
Adult Day Health	5	2	Met
Case Management	5	2	Met
Home Delivered Meals	3	2	Met
PERS	18	2	Met
Personal Care	28	2	Met
Respite	10	2	Met
Telemonitoring	3	2	Met
Laurens			

County	Unique Providers	Minimum Required	Score
Adult Day Health	4	2	Met
Case Management	6	2	Met
Home Delivered Meals	4	2	Met
PERS	17	2	Met
Personal Care	33	2	Met
Respite	10	2	Met
Telemonitoring	4	2	Met
Lee			
Adult Day Health	5	2	Met
Case Management	5	2	Met
Home Delivered Meals	3	2	Met
PERS	17	2	Met
Personal Care	17	2	Met
Respite	6	2	Met
Telemonitoring	3	2	Met
Lexington			
Adult Day Health	7	2	Met
Case Management	6	2	Met
Home Delivered Meals	3	2	Met
PERS	17	2	Met
Personal Care	35	2	Met
Respite	9	2	Met
Telemonitoring	4	2	Met
Marion			
Adult Day Health	3	2	Met
Case Management	6	2	Met
Home Delivered Meals	3	2	Met
PERS	18	2	Met
Personal Care	22	2	Met
Respite	4	2	Met
Telemonitoring	3	2	Met
Marlboro			
Adult Day Health	2	2	Met
Case Management	3	2	Met

County	Unique Providers	Minimum Required	Score
Home Delivered Meals	3	2	Met
PERS	17	2	Met
Personal Care	19	2	Met
Respite	5	2	Met
Telemonitoring	3	2	Met
McCormick			
Adult Day Health	3	2	Met
Case Management	3	2	Met
Home Delivered Meals	4	2	Met
PERS	17	2	Met
Personal Care	18	2	Met
Respite	5	2	Met
Telemonitoring	3	2	Met
Newberry			
Adult Day Health	10	2	Met
Case Management	6	2	Met
Home Delivered Meals	5	2	Met
PERS	17	2	Met
Personal Care	27	2	Met
Respite	7	2	Met
Telemonitoring	3	2	Met
Orangeburg			
Adult Day Health	7	2	Met
Case Management	7	2	Met
Home Delivered Meals	3	2	Met
PERS	17	2	Met
Personal Care	25	2	Met
Respite	8	2	Met
Telemonitoring	4	2	Met
Pickens			
Adult Day Health	3	2	Met
Case Management	3	2	Met
Home Delivered Meals	3	2	Met
PERS	17	2	Met

County	Unique Providers	Minimum Required	Score
Personal Care	31	2	Met
Respite	10	2	Met
Telemonitoring	4	2	Met
Richland			
Adult Day Health	8	3	Met
Case Management	6	3	Met
Home Delivered Meals	4	3	Met
PERS	17	3	Met
Personal Care	40	3	Met
Respite	11	3	Met
Telemonitoring	4	3	Met
Saluda			
Adult Day Health	3	2	Met
Case Management	3	2	Met
Home Delivered Meals	4	2	Met
PERS	17	2	Met
Personal Care	23	2	Met
Respite	6	2	Met
Telemonitoring	3	2	Met
Spartanburg			
Adult Day Health	6	3	Met
Case Management	5	3	Met
Home Delivered Meals	3	3	Met
PERS	17	3	Met
Personal Care	32	3	Met
Respite	12	3	Met
Telemonitoring	5	3	Met
Union			
Adult Day Health	7	2	Met
Case Management	6	2	Met
Home Delivered Meals	3	2	Met
PERS	16	2	Met
Personal Care	25	2	Met
Respite	9	2	Met

County	Unique Providers	Minimum Required	Score
Telemonitoring	4	2	Met
Williamsburg			
Adult Day Health	4	2	Met
Case Management	7	2	Met
Home Delivered Meals	4	2	Met
PERS	17	2	Met
Personal Care	19	2	Met
Respite	5	2	Met
Telemonitoring	3	2	Met
Total that Met Minimum (sum of all services across 41 counties with minimum required providers met)	287		
Total Required (sum all of services across 41 counties: (41 counties, 7 services for each county)	287		
Percentage MET	100%		
VALIDATION DECISION	Met		

Validation Decision Categories: Met = 91% or higher; Partially Met = 51% -90%; Not Met = ≤50%

Plans are also required to have a network of behavioral health (BH) providers to ensure a choice of at least two (2) providers located within no more than fifty (50) miles from any enrollee unless the plan has a SCDHHS-approved alternative time standard. All network providers must serve the target population (i.e., adults aged 65 and older) and at least one of the BH providers used to meet the two (2) providers per fifty (50) mile requirement must be a Community Mental Health Center (CMHC).

Information on BH providers was submitted in the desk materials. The requirements as set forth by the State were compared to submitted information. The Geo Access report provided by Quest Analytics showed that 99.7% of members had access to a psychiatrist and 14 members out of 4,734 did not have access, 99.9% of members have access to a psychologist with 1 member out of 4,734 without access, 99.9% of members have access to a social worker with 1 member showing no access, and 99.9% of members with access to a CMHC (using a requirement of one in 50 miles).

Evaluation of Over/Under Utilization

Over-and under-utilization focuses on five key indicators: 30-day hospital readmission rates for any potentially avoidable hospitalization, length of stay for hospitalizations,

length of stay in nursing homes, emergency room utilization, and the number and percentage of enrollees receiving mental health services.

The files submitted contained reports on utilization in the five required services, as well as other services. The 30-day readmission rate was below the expected utilization at 13.11% (goal is <14.5%). The Length of Stay – Inpatient rate was well above the goal rate of 6.5 at 14.3 (Q1 and Q2 were extremely high values). The penetration rate for behavioral health services was at 1.4% for the last measurement in October 2021. The Skilled Nursing Facility length of stay and ER utilization trending was not included in the desk materials but was submitted after the onsite.

Care Transitions

The Healthy Connections Prime Care Management Program Description 2021 provides an overview of the program's purpose, scope, structure, goals, and objectives. Related policies, such as Policy SC.MMP.CM.24, Discharge Planning and Outreach, and SC.MMP.UM.02, Care Transitions, provide additional information and guide staff in conducting transition of care (TOC) activities for members transitioning between care settings.

CCME reviewed 36 files for members who were readmitted within 30 days of a hospital discharge and noted an overall improvement in the frequency of interdisciplinary care team meetings. Files reflected staff make multiple attempts to contact members after discharge, including attempting to get additional or alternate contact information from providers, facilities, etc. Overall, the files included documentation of clinical and non-clinical barriers and support.

Issues identified through the file review included:

- Lack of documentation of interaction with facility Case Managers or Discharge Planners was noted for six files.
- Lack of documentation of collaboration with the PCP was noted for seven files.
- Untimely – or no – attempts to contact members/caregivers within 72-hours of discharge in five files.
- Lack documentation of a full assessment post discharge was noted for 13 files. It was noted that Policy SC.CM.24, Discharge Planning and Outreach – MMP, indicates "A subsequent HRA and ICT meeting is scheduled if hospitalization resulted from change in condition or functional status" and that if "admission resulted in minor changes in health condition" the Care Coordinator may update only applicable components of the health risk assessment specific to the condition in a clearly documented outreach note. However, the *CICO Three-Way Contract, Section 2.6.3.9.4* requires the CICO to conduct a reassessment and ICP update upon any of the following trigger events:

hospital admission, care setting transition, change in functional status, loss of caregiver, changes in or additions of a diagnosis, and if requested by the member of the multidisciplinary team.

- In some file notes, the admission and discharge date fields were not completed, making it difficult to associate the note to a particular admission event.

Four of the five issues identified in the files reviewed for the current EQR (2021) were repeat findings from the previous EQR (2020). See *Table 2: Previous Care Transitions Quality Improvement Items*, for ATC's response to the previous year's findings.

Table 2: Previous Care Transitions Quality Improvement Items

Standard	EQR Comments
III. Care Transitions	
1. The CICO conducts appropriate care transition functions, as defined by the CICO 3-Way Contract, Section 2.5 and 2.6, to minimize unnecessary complications related to care setting transitions.	CCME reviewed 32 files for members who were readmitted within 30 days of discharge from a hospital. CCME noted an overall improvement in notifications of admissions and discharges between Utilization Management and Care Management staff, and between ATC and the healthcare facilities. The following recurring documentation issues were identified: •16 files (50%) did not reflect a reassessment was conducted after a change in the member's status. •14 files (44%) did not have clinical follow-up within 72 hours of the member's transition. •10 files (31%) did not reflect outreach to the PCP. •10 files (31%) did not reflect contact with the facility's discharge planner. •7 files (22%) did not reflect Medication Monitoring and Adherence was assessed. During the virtual onsite, ATC acknowledged the identified issues and noted opportunities were missed. Improvement strategies, such as transitioning all TOC staff into one team, retraining staff, and continuing collaboration with Provider Relations staff were established to address areas of low performance. *Quality Improvement Plan: In order to comply with requirements in the CICO 3-Way Contract, Section 2.6.9.7, ensure members are reassessed after a change in status and clinical follow-up is conducted within 72-hours of transition. Continue to implement and evaluate improvement processes that address communication barriers between the health plan and facilities, and between internal departments (CM, UM, etc.). Ensure files contain documentation of all communication with the PCP's office and documentation of medication monitoring.*
ATC Response: 1. Communication between internal/external departments, health plan and facilities: • ATC's UM team will identify readmissions and send notification tasks to the TOC team to initiate the TOC process. Immediate implementation.	

Standard	EQR Comments

• ATC's TOC team will send tasks to primary CM alerting of readmission and discharge. Immediate implementation.
• See below for auditing #6.
 	
2. Files contain documentation of PCP notification:
• The TOC team will ensure timely outreach by:
  • Review of tasks from UM team and initiate outreach to facility discharge planner and member's PCP within outlined timelines.
  • Notify member's PCP of discharge within outlined timelines.
  • Implement above processes immediately.
  • See below for auditing #6.
 	
3. Clinical follow-up within 72 hrs. of discharge is conducted:
• ATC's TOC team will review inpatient daily census and discharge reports to identify discharges as soon as possible and engage in clinical follow up with the 72 hr. outreach guidelines.
• See below for auditing #6.
 	
4. Files contain documentation of medication reconciliation post-discharge:
• Primary CM will review discharge notification task sent by TOC team and complete member reassessment and medication reconciliation within 30 days of discharge to home/permanent placement.
• Implement immediately.
• See below for auditing #6
 	
5. Members reassessed after a change in Status:
• Primary CM will receive task/email from TOC team informing of discharge to home.
• Primary CM will outreach to member and complete reassessment.
• Update Care plan and notes.
• Implement above immediately.
• See below for auditing #6
 	
6. MMP and TOC Managers will review cases weekly for timeliness of TOC process and reassessment.
If deficiencies are found:
• Managers will retrain individuals and teams, immediately.
• Coaching/performance improvement plans will be developed for individuals with reoccurring deficiencies per human resources policies and procedures.	

From December 2020 to November 2021, 1,225 MMP members experienced a transition of care. Of the 1,225 members, 154 (13%) transitioned to a higher level of care. CCME could not identify documentation that ATC analyzed or reviewed the 154 transitions to a higher level of care to identify barriers, improvement opportunities, or any actions taken to improve outcomes.

Conclusions

CCME's review confirmed ATC meets minimum requirements for its network of HCBS providers and that 99.7% to 99.9% of members have the required access to behavioral health providers (psychiatrists, psychologists, social workers, and CMHCs).

Over-and under-utilization documentation and onsite discussion confirmed ATC monitors and analyzes utilization data for the required indicators to identify trends and opportunities for improvement.

Processes and requirements for Care Transitions activities are documented in policies and program descriptions. Policy SC.CM.24, Discharge Planning and Outreach – MMP, does not appear to follow contractual requirements for post-discharge assessments.

A review of care transitions files for members who were readmitted within 30 days of a hospital discharge revealed several issues. Four of the five file review issues identified in the current EQR were repeat findings from the previous EQR.

Documentation that ATC analyzes or reviews transitions that resulted in a higher level of care to identify barriers or improvement opportunities could not be identified.

ATTACHMENTS

Attachment 1: Tabular Spreadsheet

A. Attachment 1: Tabular Spreadsheet

CCME CICO Data Collection Tool

Plan Name:	**Absolute Total Care**
Collection Date:	**2021**

STANDARD	SCORE			COMMENTS
	Met	Partially Met	Not Met	
I. Provider Network Adequacy				
1. The CICO maintains a network of Home and Community Based Services (HCBS) providers in each geographic area that is sufficient to provide all enrollees with access to a full range of covered services.	X			CCME requested a complete list of all contracted HCBS providers currently in ATC's network. The minimum number of required providers for each county was calculated and compared to the number of current providers for the seven different services. There were 41 counties documented as having members. Of the 287 services across 41 counties, there were 287 that met the minimum requirements resulting in a validation score of 100%, which is sustained from last year's rate of 100%.
2. The CICO maintains a network of behavioral health (BH) providers in each geographic area that is sufficient to provide all enrollees with access to a full range of covered services.	X			Information on BH providers was submitted in the desk materials. The requirements, as set forth by the State, were compared to submitted information. The Geo Access report provided by Quest Analytics showed that 99.7% of members had access to a psychiatrist and 14 members out of 4,734 did not have access, 99.9% of members have access to a psychologist with 1 member out of 4,734 without access, 99.9% of members have access to a social worker with 1 member showing no access, and 99.9% of members have access to a CMHC (using a requirement of 1 in 50 miles).
II. Evaluation of Over/Under Utilization				

STANDARD	SCORE			COMMENTS
	Met	Partially Met	Not Met	
1. The CICO monitors and analyzes utilization data to look for trends or issues that may provide opportunities for quality improvement. Utilization data monitored should include, but not be limited to:				The files submitted in the desk materials contained reports on utilization in the five required services, as well as other services.
1.1 30-day hospital readmission rates for any potentially avoidable hospitalization (enrollees readmitted with a diagnosis of Bacterial Pneumonia, Urinary Tract Infection, CHF, Dehydration, COPD/Asthma, and Skin Ulcers);	X			The 30-day readmission rate was below the expected utilization at 13.11% (goal is <14.5%).
1.2 Length of stay for hospitalizations;	X			The Length of Stay – Inpatient rate was well above the goal rate of 6.5 at 14.3 (Q1 and Q2 were extremely high values).
1.3 Length of stay in nursing homes;	X			
1.4 Emergency room utilization;	X			
1.5 Number and percentage of enrollees receiving mental health services.	X			The penetration rate for behavioral health services was at 1.4% for the last measurement in Oct 2021.
III. Care Transitions				
1. The CICO conducts appropriate care transition functions, as defined by the CICO 3-Way Contract, Section 2.5 and 2.6, to minimize unnecessary complications related to care setting transitions.		X		The Healthy Connections Prime Care Management Program Description 2021 provides an overview of the program's purpose, scope, structure, goals, and objectives. Related policies, such as Policy SC.MMP.CM.24, Discharge Planning and Outreach, and SC.MMP.UM.02, Care Transitions, provide additional information and guide staff in conducting transition of care (TOC) activities for members transitioning between care settings. CCME reviewed 36 files for members who were readmitted within 30 days of a hospital discharge and noted an overall improvement

STANDARD	SCORE			COMMENTS
	Met	Partially Met	Not Met	
				in the frequency of interdisciplinary care team meetings. The files reflected staff make multiple attempts to contact members after discharge, including attempting to get additional or alternate contact information from providers, facilities, etc. Overall, the files included documentation of clinical and non-clinical barriers and support. Issues identified through the file review included: •Lack of documentation of interaction with facility Case Managers or Discharge Planners was noted for six files. •Lack of documentation of collaboration with the PCP was noted for seven files. •Untimely – or no – attempts to contact members/caregivers within 72-hours of discharge in five files. •Lack documentation of completion of a full assessment post discharge was noted for 13 files. It was noted that Policy SC.CM.24, Discharge Planning and Outreach – MMP, indicates "A subsequent HRA and ICT meeting is scheduled if hospitalization resulted from change in condition or functional status" and that if "admission resulted in minor changes in health condition" the Care Coordinator may update only applicable components of the health risk assessment specific to the condition in a clearly documented outreach note. However, the *SC CICO Three-Way Contract, Section 2.6.3.9.4* requires the CICO to conduct a reassessment and ICP update upon any of the following trigger events: hospital admission, care setting transition, change in functional status, loss of caregiver, changes in or additions of a diagnosis, and if requested by the member of the multidisciplinary team.

STANDARD	SCORE			COMMENTS
	Met	Partially Met	Not Met	
				Also, in some notes included in the files, the admission and discharge date fields were not completed, making it difficult to associate the note to a particular admission event. *Quality Improvement Plan: Ensure files include thorough and complete documentation of all required activities, including collaboration with facility Case Managers or Discharge Planners, collaboration with the PCP, a post-discharge TOC assessment within 72-hours of discharge, and completion of a full assessment when there is a hospital admission or other care setting transition. Also, ensure the admission and discharge date fields are entered on case notes to allow the notes to be associated with an admission/transition event, where applicable.*
2. Transitions that result in a move to a higher level of care are analyzed to determine factors that contributed to the change and actions taken by the CICO to improve outcomes.		X		ATC tracks and monitors member transitions resulting in a higher level of care. During the period of December 2020 to November 2021, 1,225 MMP members experienced a transition of care. Of the 1,225 members, 154 (13%) transitioned to a higher level of care. CCME could not identify documentation that ATC analyzed or reviewed the 154 transitions that resulted in a higher level of care to identify barriers or improvement opportunities or any actions taken to improve outcomes. *Quality Improvement Plan: Develop and implement a process to analyze and review member transitions to a higher level of care to identify contributing factors and to implement actions to improve outcomes.*