Alliance Health

Provider Practice Transformation Academy

Warm Handoffs and Transitions for Services Excluded from Tailored Care Management

What is a warm handoff?

The North Carolina Department of Health and Human Services (NC DHHS) defines a warm handoff as "time-sensitive, member-specific planning for care managed members or other members identified by either the transferring or receiving entity to ensure continuity of service and care management functions. Warm handoffs require collaborative transition planning between both transferring and receiving entities and as possible, occur prior to transition."

What services are excluded from Tailored Care Management?

Per the NC DHHS BH/IDD Tailored Plan Request for Application, members receiving high-fidelity wraparound (HFW) services, assertive community treatment team (ACTT), or services provided in intermediate care facilities for individuals with intellectual disabilities (ICF-I/DD) are excluded from participation in Tailored Care Management, as Tailored Care Management duplicates the function of those services. However, there is a 30-day period at admission and discharge where the member is eligible to receive both Tailored Care Management and these services as part of the transition of care process. During these periods, Care Management Agencies (CMAs) and Advanced Medical Home + agencies (AMH+s) are required to carry out transitional care management functions when a member is transitioning to or from these services.

Why are warm handoffs needed for transitions to/from these services?

The benefits of warm handoffs include:

- Encourages whole person, integrated care
- Provides continuity of care
- Encourages engagement of family and member; allows them to speak up to team
- Builds relationships
- Provides a safety check
- Provides an opportunity to correct or clarify any information

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How will transitions to/from these services work?

- When a member is entering or has completed the program and is ready to step-down from the service, Alliance Health will assign the member to a care management entity for Tailored Care Management (the exception is if the member opts out of Tailored Care Management). The assignment will be based on the member's previous service claims, so the provider that delivered the service is given preference if that provider is certified as a CMA and has the capacity to serve that member.

- Warm handoffs are required between the agency providing HFW, ACTT or ICF-IDD and the assigned organization providing Tailored Care Management, including Tailored Care Management provided by Tailored Plans. If both the service and Tailored Care Management are provided by the same entity, a warm handoff is still required between the service team and care management team.

- When a member begins receiving HFW, ACTT, or services through an ICF-IID, the member's care manager for Tailored Care Management must share the member's care plan/ISP with the ACTT or ICF-IID case manager/provider, with consent. **The care management team must remain involved in the member's case during the 30-day transition periods.**

How are warm handoffs between Tailored Care Management and HFW, ACTT, or ICF-I/DD conducted?

- Contact the member/guardian upon notice of upcoming transition (within 30 days) to discuss the transition, what it will entail, when it will occur, etc.

- Ensure that the member has chosen the care management organization/service provider to whom the member will be transitioning and obtain authorization to release information to the that organization/provider.

- Contact the receiving care management organization/service provider to find out who the contact person is, how to securely send documentation to them, etc. Engage in transition planning with the organization.

- Send the member's care plan/ISP, along with any other relevant or requested documents, to the receiving care management organization/service provider. *NOTE: if the member is receiving services for SUD, a consent for release of information MUST be obtained for any information can be released. Information should include, but is not limited to:*

  - ☐ Reason for the transition
  - ☐ Current care manager name and contact information
  - ☐ Care management acuity tier
  - ☐ Date of last contact with member
  - ☐ Method of last contact with member (In-person, virtual, telephonic)
  - ☐ Member's language
  - ☐ Member's preferred communication method
  - ☐ Known safety issues
  - ☐ Service(s) the member is currently receiving (including provider and duration in service)
  - ☐ Current medications
  - ☐ Known medication issues
  - ☐ Any ongoing or future appointments the member has scheduled

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- ☐ Known barriers or immediate risks:
  - ☐ Social determinants of health needs
  - ☐ Medically complex/fragile
  - ☐ Non-emergency medical transportation needs
  - ☐ Recent crisis episodes or hospitalizations

- Schedule a meeting with the member/guardian and receiving care management organization/service provider to discuss the transition, including when and how it will occur.
- Continue to support the member through the transition.
- Continue respond to questions, requests from both the member/guardian and the receiving care management organization/service provider until the transition is complete.

Reference:

RFA Section V.B.3.v (v) (p. 163-164)