



Functions/Responsibilities of Transitional Care Management, Part I

What is Transitional Care Management?

Per the North Carolina Department of Health and Human Services (NCDHHS) BH/IDD Tailored Plan Request for Application, Tailored Care Management organizations, including Care Management Agencies (CMAs), Advanced Medical Home + practices (AMH+s) and Tailored Plans, are required to carry out transitional care management functions when a member is transitioning from one clinical setting to another. Transitional care management functions are carried out by the member's assigned care manager/care management team.

Why is this Important?

Transitional care management is a key part of Tailored Care Management and is intended to prevent unplanned or unnecessary readmissions, ED visits, or adverse outcomes for members who are transitioning between clinical settings.

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Requirements of Transitional Care Management

A care manager must be assigned to the member to manage transitions. The following are the basic requirements of transitional care management to be provided by the care manager. Additional requirements of transitional care management include in-reach and transition activities for special populations and diversion activities to prevent at-risk members from being admitted to institutional settings.

- Assume coordination responsibility for transition planning.
- Begin discharge planning no later than 7 days after the member's admission to a new service, including convening a discharge team to assist the individual in developing the plan.
 - Care manager or care team member must visit the member during their stay in an institution (e.g., acute, subacute and long term stay facilities) and be present on the day of discharge.
 - For members transitioning from a facility to TCL, ensure that a registered nurse or occupational therapist (RN/OT) conducts medical and functional assessments prior to discharge.
- Conduct outreach to the member's service providers and family/community supports.
- Take the lead on developing a written discharge plan through a person-centered planning process in which the member has a primary role and which is based on the principle of self-determination.
 - The discharge plan must be written into the member's care plan/ISP and must:
 1. Identify the member's strengths, preferences, needs, and desired outcomes.
 2. Identify the specific supports and services that build on the member's strengths and preferences to meet the member's needs and achieve desired outcomes.
 3. Include a pharmacy plan for post-discharge facility medication handling, bridge prescriptions and prescriber, community pharmacy, and those responsible to actively support the individual in obtaining their medications post-transition.
 4. List providers that can provide the identified supports and services that build on the member's strengths and preferences to meet the member's needs and achieve desired outcomes.
 5. Set the date of transition as well as the timeframes for completion of all needed steps to affect the transition.
 - Any barriers preventing the member from being discharged and transitioning into the member's chosen integrated setting must be recorded in the member's care plan/ISP, and care managers must actively seek solutions for addressing those barriers (transition barriers shall not include the member's disability or the severity of the disability).
 - Review the discharge plan with the member and facility staff.
 - Ensure that all services and supports included in discharge plan will be in place and available to the member on the day of discharge, and if they cannot be available, seek to postpone the discharge until all services and supports agreed upon by the discharge and transition team are in place.
 - Ensure effective implementation of the written discharge plan, including without limitation, the provision of all services and supports at the frequency, duration, intensity, and type agreed upon by the member and the transition team in the member's care plan/ISP.
- Facilitate clinical warm handoffs.
- For members with a history of re-admission or crises, the care manager identifies and addresses the factors that led to re-admission or crises and the services, supports, and recovery-oriented interventions in the crisis plan section of the member's care plan/ISP.
- Refer and actively assist members in accessing needed social services and supports identified as part of the transitional care management process, including housing, in their written discharge plan.
- Assist the member in obtaining needed medications prior to discharge, ensure an appropriate care team member conducts medication reconciliation/management and support medication adherence.

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- Assist with scheduling of transportation, in-home services, and follow-up outpatient visits with appropriate providers within a maximum of seven calendar days post-discharge, unless required within a shorter time frame.
- Follow up with the member within 48 hours of discharge.
- Arrange to visit the member in the new care setting after discharge/transition.
- Conduct a care management comprehensive assessment within 30 calendar days of the discharge/transition or update the current assessment.
- Update the member's care plan/ISP in coordination with the member's care team within 90 calendar days of the discharge/transition based on the results of the care management comprehensive assessment.

For individuals who are discharging from residential or inpatient settings, the care manager must also develop a 90 calendar day post-discharge transition plan (90-day PDTP) prior to discharge, in consultation with the member, facility staff and the member's care team. This plan must outline how the member will maintain or access needed services and supports, transition to the new care setting, and integrate into their community. The 90-day PDTP is implemented upon the member's discharge and is added as an amendment to the care plan or ISP.

- To the extent feasible, a care management comprehensive assessment should be conducted to inform the 90-day PDTP.
- For children with complex medical needs, the 90-day PDTP must incorporate any needs for training of parents and other caregivers to care for the child after discharge from an inpatient setting.
- The care management organization must communicate with and provide education to the member and the member's caregivers and providers to promote understanding of the 90-day PDTP.

For individuals with I/DD or TBI, relevant transitional care management activities are conducted in the following life transitions:

- Instances where a member is transitioning out of school-related services.
- Instances where a member experiences life changes such as employment, retirement or other life events.
- Instances where a member has experienced the loss of a primary caregiver or a change of primary caregiver.

References:

- NC DHHS Medicaid Direct Prepaid Inpatient Health Plan Contract, Section IV, G, 10 (p. 170-172)
- First Revised and Restated Request for Application 30-2020-052-DHB BH I/DD Tailored Plan, Section V.B.3.viii (p. 168-170)
- Tailored Care Management Provider Manual, Section V, 4.8