Functions/Responsibilities of Transitional Care Management

What is Transitional Care Management?

Per the North Carolina Department of Health and Human Services (NC DHHS) 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, emergency department visits, or adverse outcomes for members who are transitioning between clinical settings.

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Requirements of Transitional Care Management

Tailored Care Management organizations are responsible for carrying out the core functions of transitional care management, performing in-reach and transition activities for special populations, and implementing diversion activities to prevent at-risk members from being admitted to institutional settings.

1. Core transitional care management functions:
   - Ensure that a care manager is assigned to manage the transition.
     - The care manager assumes coordination responsibility for transition planning.
     - The 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.
   - Conduct outreach to the member’s service providers and family/community supports.
   - Obtain a copy of the discharge plan and review the discharge plan with the member and facility staff.
   - Facilitate clinical warm handoffs.
   - Refer and assist members in accessing needed social services and supports identified as part of the transitional care management process, including access to housing.
   - Assist the member in obtaining needed medications prior to discharge, ensure an appropriate care team member conducts medication reconciliation/management and support medication adherence.
   - Develop a 90-day post-discharge transition plan (90-day PDTP) before discharge from residential or inpatient settings, in consultation with the member, facility staff and the member’s care team, that outlines how the member will maintain or access needed services and supports, transition to the new care setting, and integrate into their community. Note that a 90-day PDTP is not required for all emergency department visits but may be developed according to the care manager’s discretion.
     - 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.
   - Facilitate arrangements for and scheduling of transportation, in-home services, and follow-up outpatient visits with appropriate providers within a maximum of seven calendar days, unless required within a shorter time frame.
   - Ensure that the assigned care manager follows 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 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 days of the discharge/transition based on the results of the care management comprehensive assessment.

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.
- Instances where a member is transitioning out of foster care.
2. **In-reach and transition for special populations:**

All members residing in the following settings are eligible for in-reach and transition services:

- State psychiatric hospitals
- Adult care homes (ACHs) (members with SMI only).
- State developmental centers.
- Psychiatric residential treatment facilities (PRTFs)
- Residential Treatment Level II/Program Type, Level III, and Level IV as defined in NC Clinical Coverage Policy 8-D-2

For these populations, Tailored Care Management organizations must carry out the following functions:

- Provide supports to assigned Tailored Plan members admitted to and residing in institutional and select other congregate settings to prepare them for and help them transition to a less restrictive setting, if the member chooses to do so.
- Following a transition from one of these settings, provide pre- and post-transition supports needed to ensure their assigned members can live safely and to thrive in their communities.
- Assume primary responsibility for in-reach and/or transition activities for assigned members who are part of the following populations:
  - Children and youth admitted to a state psychiatric hospital, PRTF, or Residential Treatment Level II/Program Type, Level III, and Level IV as defined in Clinical Coverage Policy 8-D-2.
  - Adult members admitted to a state psychiatric hospital or an ACH who are eligible for Tailored Care Management and who are not transitioning to supportive housing.
- Document all in-reach and transition activities in the member’s record and make available for review upon request.

**In-Reach Activities**

In-reach activities identify and engage individuals in institutional or other congregate settings whose service needs could potentially be met in home or community-based settings. For members newly admitted to one of these facilities, in-reach activities begin within seven days of admission.

Tailored Care Management organizations are responsible for in-reach activities for assigned members under 18 admitted to or residing in a state psychiatric hospital and members admitted to or residing in a PRTF or congregate child residential treatment settings who may be able to have their needs safely met in a community setting. Care Managers are responsible for identifying and engaging such members and conducting the following in-reach activities:

- Provide age and developmentally appropriate education, including linkages to peer support services when appropriate and available, and ensure the member and the member’s family members and/or guardians are accurately and fully informed about community-based options available.
- Facilitate and accompany the member and their family members and/or guardians on visits to community-based services.
- Identify and attempt to address barriers to relocation to a community setting.
- To the maximum extent possible, explore and address the concerns of the member and/or their family members or guardians who decline the opportunity to transition or are ambivalent about transitioning despite qualifying for supportive housing or other community services. Arrange for peer-to-peer meetings when appropriate to address concerns. For members who decline the opportunity to transition, the organization must:
  - Continue to engage the member and/or their family members or guardians about the opportunity to transition to a more integrated setting.
  - Clearly document that the member’s decision to not transition was based on informed choice. Documentation must describe steps taken to fully inform the member of available community services, including supportive housing.

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• Provide the member and/or the member’s family members or guardians opportunities to meet with other individuals with SMI, SED, I/DD or TBI (as relevant to the member) who are living, working, and receiving services in integrated settings. This may include accompanying them on visits to community-based settings.

• Identify any specific training that facility staff may benefit from to support smooth transitions, such as the type and availability of community services and supports that allow individuals with SMI, SED, I/DD or TBI to live in their home/community.

• Providing information on the opportunity and process for opting back in to all members who have previously opted out of Tailored Care Management.

• For members who may be eligible for supportive housing:
  ◦ Ensure that the member and their family members and/or guardians are accurately and fully informed about all available supportive housing options.
  ◦ Facilitate and accompany the member and their family members and/or guardians on visits to supportive housing settings.

For members who are not able or willing to continue with the in-reach process or begin transition planning, care managers must make best efforts to address member concerns, arrange for peer-to-peer meetings (when appropriate), and continue best efforts to engage those members.

Transition Activities

Transition activities consist of facilitating the relocation of a member receiving services at an institutional or other congregate setting to a home or community-based setting, while ensuring access to appropriate services and supports. This includes the development execution of a care plan or individual support plan to ensure the member receives the appropriate level of services and supports that the member requires.

Tailored Care Management organizations are responsible for transition activities for assigned members who are:

• Under the age of 21 who are residing in a state psychiatric hospital.
• Residing in an ACH and are not transitioning to supportive housing.
• Residing in a PRTF or in Residential Treatment Level II/Program Type, Level III, or Level IV.

Care managers are required to plan for effective and timely transition of members to the community and perform the following transition activities:

• Collaborate with the following individuals, specialists, and provider types as applicable depending on the member’s needs, participating in all transition meetings either by phone or in person, to ensure effective and timely discharge and smooth transition to the community:
  ◦ The member and/or the member’s family or guardian.
  ◦ Facility providers.
  ◦ Facility discharge planners.
  ◦ The member’s care manager.
  ◦ The member’s community-based PCP once selected.
  ◦ Peer support specialist or other individuals determined to have appropriate shared lived experience.
  ◦ Educational specialists.
  ◦ Other community providers and specialists as appropriate in the transition planning process, including physical health providers, BH providers, and I/DD and/or TBI providers.

• Engage the member’s community primary care physician (PCP) and other providers as appropriate so that they are actively engaged in the transition planning process prior to member’s discharge.

• Assist the member before discharge (by phone or in person) in selecting a qualified community PCP and clinical specialists as needed, including assisting the member and/or their family members or guardians in developing interview questions to ask potential community providers when they are selecting providers.
• Collaborate with the member and/or the member’s family members or guardians, peer support specialists when available, facility providers, and other relevant community service providers to:
  ◦ Make arrangements for individualized supports and services needed to be in place upon discharge.
  ◦ Identify and prioritize the most critical services necessary to address the member’s specific needs, including complex BH, primary care and medical needs, prior to discharge.
  ◦ Schedule post-discharge appointments for critical services to occur in a timely manner based upon the member’s identified needs and no later than seven calendar days following discharge.

• When applicable, collaborate with the facility to make a referral to NC START or other applicable crisis prevention services prior to discharge.

• Assist the member and/or the member’s family members or guardians in initiating selected community service options including but not limited to behavioral health services.

• Work with receiving providers and/or agencies, if applicable, to identify if any specific training is needed by the receiving providers and/or agencies to ensure a seamless transition.

• Address any identified barriers to discharge planning to the least restrictive and most integrated setting possible, including but not limited to:
  ◦ Network adequacy issues.
  ◦ Transportation.
  ◦ Housing assessment (including for risk of interpersonal violence).
  ◦ Resource identification.
  ◦ Referrals to qualified providers and care manager
  ◦ Training of family or guardians and natural supports prior to the member’s discharge.

• Before discharge, explore and secure appropriate and available funding options and work through any potential funding needs with community providers such as managing spend downs, if needed.

• When applicable, work cooperatively with the facility provider to develop the necessary discharge service orders for post-discharge services required to meet the member’s individual needs. Within three business days of receipt of discharge service orders from the facility provider, make best efforts to secure authorization and/or denial of services requested to begin upon discharge.
  ◦ If services included in the discharge service order are not authorized or a community provider is not available, submit to the facility provider a written request for any necessary revisions to the discharge service order and/or identify alternative community providers within three business days of receipt of discharge service order. Promptly provide additional information necessary to support the revised service order prior to the member’s discharge.
  ◦ Make best efforts to ensure that the information contained in the discharge service order, the 90-day transition plan and the discharge summary are made available to the community providers who will be serving the member after discharge.
  ◦ Ensure the discharge service order, the transition plan and the discharge summary are made available to the organization providing Tailored Care Management if the member is eligible for Tailored Care Management

• For members residing in a state psychiatric facility whose Medicaid eligibility is in suspended status, work with NCDHHS to ensure Medicaid eligibility is active upon or soon after discharge.

• For members transitioning into an Innovations Waiver slot, ensure level of care assessment and the ISP are completed prior to discharge in accordance with Innovations Waiver requirements.

• For members residing in state developmental centers: If needed, request an extension of memorandum of agreement in writing to the DSOHF developmental center director before the discharge date outlining the reasons for the extension and anticipated length of extension needed.

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• On the day of discharge:

1. Obtain a copy of the discharge plan and review the discharge plan with the member and/or the member’s family members or guardians and facility staff.

2. Assist the member in obtaining needed medications and ensure an appropriate care team member or facility staff conducts medication reconciliation and/or medication management and supports medication adherence.

• Ensure effective and timely discharge and transition to appropriate community providers, in accordance with applicable laws, program requirements, and applicable policies and protocols established by the state for the distinct member population served.

Additional required activities for members who may be eligible for supportive housing:

• Collaborate with the BH I/DD Tailored Plan’s housing specialist to make arrangements for individualized supports and services needed to be in place upon discharge.

• Assist the member and/or the member’s family members or guardians in initiating housing-related services and supports including locating and securing housing, ensuring the home environment is safe and move-in ready, and other ongoing tenancy supports that enable the member to maintain housing.

• Ensure the transition is completed within 90 days of receiving a housing slot.

Additional required activities for members residing in a PRTF or Residential Treatment Level II/Program Type, Level III, or Level IV, and members under age 18 residing in a state psychiatric hospital:

• Convene the member’s child and family team and work with team, including the member’s care manager, if applicable, to add new team members as needed to ensure an effective and timely transition.

• Engage the member’s child and family team through the entire transition planning process.

• Ensure PRTF family peer partner is included in transition planning for members in a PRTF, when applicable.

• Provide the member and their family or guardian linkages to relevant state agencies and systems that support the development and well-being of children, including local school systems and child welfare systems.

• Provide the member and the member’s family or guardian with linkages to community-based services and supports that address unmet health related resource needs, including:
  ◦ Disability benefits.
  ◦ Food and income supports.
  ◦ Transportation.
  ◦ Education.
  ◦ Services for justice-involved populations.

• Collaborate with the member and their family or guardian and all relevant service providers to ensure needed individualized supports and services—including any school related services, recreational and pro-social activities, supervision plans, and family supports—are in place upon discharge.

• Work with the member and their family or guardian to assess and prepare the member’s home so that it provides the member with a safe and appropriate community setting.

• Identify and address any barriers to active engagement of a member’s family or guardian in transition planning.

• Educate and train the member and the member’s family or guardians on resource availability, and how to independently access resources to maintain self-sufficiency in caring for the member in the community.

• If the member has no permanent family or guardian, work with supervising care manager to request that a Department of Social Services (DSS) guardian locate a permanent placement for the member and escalate to DSS supervising staff if permanent placement is not being pursued.
3. **Diversion from Institutional Settings**

Tailored Care Management organizations are required to identify members who are at risk of requiring care in an ACH or an institutional setting (such as an ICF-IID, psychiatric hospital, or PRTF) and perform diversion activities in a timely manner.

Members who meet at least one of the following criteria are eligible for diversion activities:

- Have transitioned from an institutional or correctional setting, or an ACH for adult members within the previous six months; or
- Are seeking entry into an institutional setting or ACH; or
- Meet one of the following additional criteria for members with I/DD or TBI:
  - Member has an aging caregiver who may be unable to provide the recipient their required interventions.
  - Member’s caregiver is in fragile health, which may include but is not limited to member caregivers who have been hospitalized in the previous 12 to 18 months, diagnosed with a terminal illness, or have an ongoing health issue that is not managed well (e.g., diabetes, heart condition, etc.).
  - Member with two parents or guardians if one of those parents/guardians dies.
  - Any other indications that a member’s caregiver may be unable to provide the member their required interventions.
  - Member is a child or youth with complex BH needs.

Diversion activities must include:

- Screening and assessing the member for eligibility for community-based services.
- Educating the member on the choice to remain in the community and the services that would be available.
- Facilitating referrals and linkages to community support services for assistance.
- Determining whether the member is eligible for supported housing, if needed.
- For those who choose to remain in the community:
  - Developing a community integration plan (CIP) that clearly documents that the member’s decision to remain in the community was based on informed choice, and the degree to which the member’s decision has been implemented.
  - Integrating the member’s CIP as an addendum in the member’s care plan or ISP.
  - For members with a CIP, refer and provide linkages to services and supports for which they are eligible, including supportive housing.
Transitions for members not engaged in Tailored Care Management

If a member who is not already engaged in Tailored Care Management is transitioning out of a facility (such as state hospitals, ADATCs, developmental centers, etc.), Alliance will assign those members to Tailored Care Management to a care management organization, based on member choice, prior to discharge. Alliance's transitional support team will serve as liaisons to state facilities to assist with coordinating all discharges and will provide a warm handoff to the assigned care management organization upon discharge/transition.

- The newly assigned care manager providing Tailored Care Management must meet with the member and/or the member’s family members or guardians prior to discharge.
- Alliance's transitional support team will remain a part of the member’s care team following the warm handoff until 90 days post-discharge. During this time, the integrated healthcare consultant is available to the care manager providing Tailored Care Management for consultation.

References:

- RFA Section V.B.3.ii (xi) (p. 140-142)
- RFA Section V.B.3.viii (i - iv) (p. 170-175)
- Tailored Care Management Provider Manual, Section V, 4.8
- NC Clinical Coverage Policy 8-D-2