Alliance Health

Provider Practice Transformation Academy

Transitions for Members in State Facilities

What are the Tailored Care Management requirements for members transitioning out of state facilities?

Transitional care management (assisting members through a transition from one clinical setting to another) is a key part of Tailored Care Management (TCM). It is intended to prevent unplanned or unnecessary readmissions, ED visits, or adverse outcomes for members who are transitioning between clinical settings. The North Carolina Department of Health and Human Services (NCDHHS) has outlined certain requirements of transitional care management when members are transitioning out of state facilities.

What are the North Carolina state facilities?

State psychiatric hospitals:

- Cherry State Psychiatric Hospital
- Broughton State Psychiatric Hospital
- Central Regional Hospital (CRH)

Alcohol and drug abuse treatment centers (ADATC):

- RJ Blackley
- Walter B Jones
- Julian F. Keith

Developmental centers:

- Murdoch
- J. Iverson Riddle
- Caswell

Neuro-medical treatment centers:

- Black Mountain
- O'Berry
- Longleaf

Whitaker Psychiatric Residential Treatment Facility (PRTF)

Wright School

Continued

Why are state facilities different?

These facilities are primarily state-funded only and are minimally funded by Medicaid. Typically, when a member is admitted to a state facility, the member's Medicaid will be suspended until the member has been discharged back into the community.

How will Alliance help with member transitions from state facilities?

Alliance has integrated health consultants (IHCs) who serve as liaisons to state facilities and help coordinate all discharges and transitions back into the community. The IHCs are responsible for coordinating the overall discharge/transition process, which includes notifications to the CMA/AMH+ providers when their assigned members are admitted to a facility, and to hospitals to inform them of the member's assigned CMA/AMH+ (when applicable).

What does this mean for provider-led Tailored Care Management agencies?

If a member is assigned to a CMA/AMH+ and is subsequently admitted to a state facility, the member will transition to an Alliance IHC for care management. In this situation, the CMA/AMH+ will need to complete the Transitions of Care Warm Handoff Summary and submit that form to Alliance's transitional support team at TransitionalSupport@AllianceHealthPlan.org. When the form is received, the assigned Alliance IHC will schedule a meeting with the CMA/AMH+ for discussion.

Upon discharge from the facility:

- If the Medicaid is suspended, the member will be assigned to Alliance for Tailored Care Management, and the Alliance TCM staff will work to transition the member back to the previously assigned CMA/AMH+ once Medicaid is reinstated.
- If the Medicaid is active, the Alliance IHC will reach out to the CMA/AMH+ to transition the member back to the community.

The IHC will stay in contact with the previously assigned CMA/AMH+ throughout the member's stay in the facility, will keep the CMA/AMH+ updated on progress towards discharge, and will facilitate a warm handoff to the CMA/AMH+ upon discharge. The CMA/AMH+ may attend the member's discharge meeting if desired to help facilitate transition back into the community.

The Alliance IHC/care manager will remain available to the CMA/AMH+ care manager for consultation for 90 days following the warm handoff.

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
- Transitions of Care Warm Handoff Summary: AllianceHealthPlan.org/document-library/74142/