Alliance Health

Provider Practice Transformation Academy

90–Day Post Discharge Transition Plan

What is a 90–Day Post Discharge Transition Plan?

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.

As part of transitional care management, NC DHHS requires that organizations providing Tailored Care Management develop a 90-day post discharge transition plan (90-day PDTP) prior to a member's discharge from any residential or inpatient setting, in consultation with the member, facility staff, and the member's care team. The 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.

Why is this important?

The creation and implementation of a 90-day PDTP allows for optimization of outcomes for the member. The success of the plan occurs when the member's interdisciplinary team is aligned with the plan and the plan ensures inclusion of the member and their identified family. Without thoughtful discharge planning, breakdowns in care may occur, creating the need for readmission to residential or institutional settings.

Benefits of 90-Day PDTPs

- Creates continuity of care
- Provides a safety check
- Opportunity to correct or clarify any information
- Allows for evidence-based practices to be included
- Provides time to work on unmet health related needs
- Increases communication and allows for transfer of information about the member

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Requirements of 90-Day Post Discharge Transition Plan

- The plan must be implemented upon the member's discharge from a residential or inpatient setting.
- The plan must be written as an amendment to the care plan or individual service plan (ISP)
- Whenever feasible, the assigned care manager should conduct a care management comprehensive assessment to inform the plan.
- The plan must incorporate any needs for training of parents and other caregivers to care for a child with complex medical needs post-discharge from an inpatient setting.
- The Tailored Care Management organization must communicate with and provide education to the member and the member's caregivers and providers to promote understanding of the plan.

Note that the development of a 90-day PDTP is not required for all emergency department (ED) visits but may be developed according to the care manager's discretion.

References:

RFA Section V.B.3.ii (xi) (p. 140-141)

Tailored Care Management Provider Manual, Section V, 4.8