Alliance Health

Provider Practice Transformation Academy

Functions/Responsibilities of Transitional Care Management, Part II: In-Reach and Transition

What is transitional care management?

Per the North Carolina Department of Health and Human Services (NCDHHS) Behavioral Health I/DD Tailored Plan Request for Application, Tailored Care Management (TCM) organizations, including Care Management Agencies (CMAs), Advanced Medical Home Plus (AMH+) practices 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 transitional care management important?

Transitional care management is a key part of TCM and is intended to prevent unplanned or unnecessary readmissions, ED visits or adverse outcomes for members who are transitioning between clinical settings. In addition to the basic requirements, transitional care management includes in-reach and transition activities for specific populations.

All in-reach and transition activities must be documented and stored in the member's record and made available for review upon request.

What is the difference between in-reach and transition?

"In-reach" is the process of

1. **Identifying** individuals residing in an institutional setting or an adult care home whose service needs could potentially be met in a home or community-based setting.
2. **Engaging** individuals about their desire to transition to a home or community-based setting.
3. **Referring** Individuals for transition, if appropriate.

"Transition" is the process 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.

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For which populations are in-reach activities required to be delivered?

In-reach activities must be coordinated and/or performed by the member's care manager as part of the TCM model for the following populations:

- Members admitted to a Psychiatric Residential Treatment Facility (PRTF)
- Members receiving services in Residential Treatment Level II/Program Type, Level III, and Level IV as defined in NC Clinical Coverage Policy 8-D-2
- Members under the age of 18 who are admitted to a state psychiatric hospital

What are in-reach activities?

In-reach activities consist of identifying and engaging individuals in institutional or other congregate settings whose service needs could potentially be met in home or community-based settings.

Care managers are responsible for performing the following in-reach activities for members receiving services one of the above settings beginning within 7 calendar days of admission and occurring on a regular basis, until the member is referred for transition services.

- 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.
- Engage with the member and the member's family and/or guardians through frequent face-to-face meetings. Frequency of such face-to-face meetings should be determined on a case-by-case basis, but at a bare minimum, no less than twice every 90 days.
- 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 more integrated setting, including barriers related to housing.
- 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, your 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 in the informed decision-making (IDM) tool 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.
        - This tool is used to inform the care plan and should be a part of the members care plan to encompass all aspects of community living.
        - For all members, the IDM tool must be documented and stored in the member's record and made available for review upon request.
        - For Transitions to Community Living (TCL) members, these forms must be sent to Alliance's TCL staff for tracking and submission to the state.
- 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.
- 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.

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

For which populations are transition activities required to be delivered?

Transition activities must be coordinated and/or performed by the member's care manager as part of the TCM model for the following populations:

- Members transitioning from an adult care home (ACH) who are **not** transitioning into supportive housing
- Members transitioning from a PRTF
- Members transitioning from Residential Treatment Level II/Program Type, Level III, and Level IV as defined in the NCDHHS Clinical Coverage Policy 8-D-2
- Members under the age of 21 who are transitioning from a state psychiatric hospital who are not transitioning to supportive housing.

What are 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 and 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.

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:
    1. The member and/or the member's family or guardian
    2. Facility providers
    3. Facility discharge planners
    4. The member's care manager
    5. The member's community-based primary care physician (PCP) once selected
    6. Peer support specialist or other individuals determined to have appropriate shared lived experience
    7. Educational specialists
    8. The registered nurse (RN) or occupational therapist (OT) who has assessed the medical and functional needs of the member being transitioned into housing
    9. Other community providers and specialists as appropriate in the transition planning process, including physical health providers, behavioral health providers, and I/DD and/or TBI providers

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- Engage the member's community PCP and other providers as appropriate so that they are actively engaged in the transition planning process prior to member's discharge.
- Prior to discharge, assist the member (by phone or in person) with 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 behavioral health, primary care and medical needs, before 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 7 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 their family members or guardians in initiating selected community service options, including behavioral health services.
- Work with receiving providers and/or agencies, if applicable, to identify if any specific training is needed by the receiving providers/agencies to ensure a seamless transition.
- Address any identified barriers to discharge planning to the least restrictive and most integrated setting possible, including:
    - 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
- Prior to 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 3 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 3 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 TCM if the member is eligible for TCM.
- 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.

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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. Help the member obtain 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 policies and protocols established by the state for the distinct member population served.

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

- Collaborate with the 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
    - 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 transition activities for members discharging from a PRTF or Residential Treatment Level II/Program Type, Level III, or Level IV, and members under age 18 discharging from 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:
    1. Disability benefits
    2. Food and income supports
    3. Transportation
    4. Education
    5. 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.

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What happens when in-reach/transition and TCM are provided by different agencies/entities?

When a member is receiving both in-reach/transition services and TCM, the in-reach/transition staff and the organization providing TCM must work together to explicitly agree on the delineation of responsibilities, and document that agreement in the care plan or ISP to avoid duplication of services.

References:

- NCDHHS Medicaid Direct Prepaid Inpatient Health Plan Contract, Section IV, G, 10 (p. 209-217)
- First Revised and Restated Request for Application 30-2020-052-DHB BH I/DD Tailored Plan, Section V.B.3.viii (p. 203-211)
- Tailored Care Management Provider Manual, Section V, 4.8
- NC Clinical Coverage Policy 8-D-2