Behavioral Health and Intellectual/Developmental Disability Tailored Plan
Tailored Care Management Provider Manual: Community Inclusion Addendum

This addendum to the Tailored Care Management Provider Manual addresses in-reach and transition requirements for Advanced Medical Home Plus (AMH+) practice and Care Management Agency (CMA)-based Care Managers providing Tailored Care Management. The Department recognizes that some Behavioral Health and Intellectual/Development Disability (I/DD) Tailored Plan members will benefit from in-reach and transition services and has established requirements for these services that are customized to the needs of different Behavioral Health I/DD Tailored Plan populations. When Behavioral Health I/DD Tailored Plans launch, AMH+ practices and CMAs will be responsible for providing in-reach and transition services for certain assigned members, while specialized Behavioral Health I/DD Tailored Plan-based staff will be responsible for providing these services for other members, as described in the table below.

AMH+ and CMA-Based Care Managers Responsible for Providing In-Reach and Transition Services	***Behavioral Health I/DD Tailored Plan-Based Staff Responsible for Providing In-Reach and Transition Services***
• *Children and youth admitted to a state psychiatric hospital, psychiatric residential treatment facility (PRTF), or Residential Treatment Levels II/Program Type, III, and IV as defined in the Department's Clinical Coverage Policy 8-D-2 ("Residential Treatment Levels"); and* • *Adult members admitted to a state psychiatric hospital or an Adult Care Home (ACH) who are eligible for Tailored Care Management and who are **not** transitioning to supportive housing.*	• *Members admitted to a state developmental center; and* • *All members who are transitioning to supportive housing from a state psychiatric hospital or an ACH through the Transition to Community Living Initiative (TCLI).*

For more information about the Behavioral Health I/DD Tailored Plan-based specialized staff and the members they are responsible for providing in-reach and transition services to, see Section V.B.3.h.v. "Table 1. In-Reach and Transition Staffing Requirements" in the Behavioral Health I/DD Tailored Plan Request for Applications (RFA). Additional information on TCLI in-reach and transition services is available in the TCLI In-Reach and Transition Manual.

Community Inclusion Activities

The Department is committed to providing all individuals with serious mental illness, serious emotional disturbance, or intellectual or developmental disabilities the opportunity to live in their communities and to meaningfully participate in community life to the greatest extent possible. To this end, as part of their role in providing care management, AMH+ practices and CMAs will be required to provide supports to assigned Behavioral Health I/DD 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, AMH+

practices and CMAs will be required to provide pre- and post-transition supports needed to ensure their assigned members can live safely and to thrive in their communities.[1]

This addendum describes the specific in-reach and transition activities that AMH+ practice and CMA-based Care Managers delivering the Tailored Care Management model will be required to perform for assigned members admitted to and residing in an institutional or other congregate setting, including an ACH. In-reach activities comprise identifying and engaging individuals in institutional or other congregate settings whose service needs could potentially be met in home or community-based settings. Transition activities consist of developing and executing a person-centered plan for an individual to move from an institutional or other congregate setting to a home or community-based setting. AMH+ practices and CMAs will assume primary responsibility for in-reach and/or transition activities for assigned members who are part of the following populations:[2]

- Children and youth admitted to a state psychiatric hospital, psychiatric residential treatment facility (PRTF), or Residential Treatment Levels II/Program Type, III, and IV as defined in the Department's Clinical Coverage Policy 8-D-2 ("Residential Treatment Levels"); and
- 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.

In-Reach Activities

AMH+ practices and CMAs will be 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 will be responsible for identifying and engaging such members and conducting the following in-reach activities:

- Provide age and developmentally appropriate education and ensure that the member and their family and/or guardians are fully informed about the available community-based options; this may include accompany them on visits to community-based services;
- Identify and attempt to address barriers to relocation to a community setting;
- Provide the member and their family and/or guardians opportunities to meet with other individuals with similar diagnoses and shared lived experience, who are living, working, and receiving services in community settings;
- Ensure that the member and their family and/or guardians who may be eligible for supportive housing are fully informed about the available options; and
- Identify any specific trainings that facility staff may benefit from to support smooth transitions for members to live and work in community settings.

For members newly admitted to one of these facilities, in-reach must begin within seven days of admission. Not all members will be able or willing to continue with the in-reach process or begin transition planning. For those members, Care Managers will be required to make best efforts to address member concerns and arrange for peer-to-peer meetings, when appropriate; and continue to engage

[1] In addition to the in-reach and transition activities described in this addendum, Care Managers will be responsible for providing diversion interventions to members who are at risk of requiring care in an institutional setting or ACH. For additional information, see Section 4.8 "Transitional Care Management" in the Tailored Care Management Provider Manual.

[2] Behavioral Health I/DD Tailored Plan-based Care Managers will be responsible for performing in-reach and transition activities for members assigned to Behavioral Health I/DD Tailored Plans for Tailored Care Management.

the member and their family and/or guardians on a regular basis about the opportunity to transition to a more integrated setting.

Transition Activities

AMH+ practices and CMAs will be responsible for transition activities for assigned members under age 21 residing in a state psychiatric hospital and all members residing in an ACH who are *not* transitioning to supportive housing, and assigned members in a PRTF or Residential Treatment Levels II/Program Type, III, and IV. The goal of the required transition activities is to facilitate the transition of a member receiving services in an institutional or other select congregate setting (including an ACH) to a community setting, while ensuring access to appropriate services and supports. Care Managers will be responsible for planning for effective and timely transition of members to the community and performing the following transition activities:

- Collaborate with the appropriate individuals, specialists, and providers needed to facilitate a smooth transition to the community, including but not limited to, facility providers and discharge planners, the member's community-based primary care provider (PCP), education specialists, and other community providers and specialists as relevant to the member's needs;
- Assist the member with selecting a community-based PCP and other clinical and behavioral health specialists prior to discharge and actively engage them in the transition planning process;
- Arrange for individualized supports and services that are needed to be in place upon discharge;
- Collaborate with the member and their family and/or guardians to identify and schedule post-discharge appointments for the critical services necessary to address the member's specific needs, such as complex behavioral health, primary care and medical needs;
- Work to identify any specific training needs by receiving providers and/or agencies to ensure a seamless transition for the member;
- Address any barriers to discharge planning to the most integrated setting possible, such as transportation, housing, and training for family members and/or guardians prior to discharge;
- Work with the facility providers to arrange for any post-discharge services, when applicable;
- Review the discharge plan with the member and their family and/or guardians and facility staff and assist the member in obtaining needed prescription on the day of discharge; and
- Convene and engage the member's Child and Family Team through the entire transition process.

In-Reach and Transition Training Requirements

In addition to the comprehensive training requirements for Care Managers providing Tailored Care Management outlined in Section V.7. "Training" of the Tailored Care Management Provider Manual, Care Managers also will complete a separate curriculum on the domains that are critical to ensuring the health and well-being of members receiving in-reach and transition services, including:

- The array of available community services and supports;
- Engagement methods, including assertive engagement and active listening skills;
- Motivating and working with a member's family and/or guardians and facility staff, including linguistic and cultural needs;
- Developing an interdisciplinary transition plan; and
- Components of the permanent supportive housing model.

Additional Support for Care Managers

Behavioral Health I/DD Tailored Plan-based staff will be available to support and provide consultation to AMH+ practice or CMA-based Care Managers providing in-reach and transition activities to their assigned members. Care Managers will have guidance from Behavioral Health I/DD Tailored Plan-based staff for supporting individuals with the most complex needs, such as members with co-occurring disorders or a history of aggression and/or serious self-harm. A Behavioral Health I/DD Tailored Plan-based transition supervisor, along with a member of the Behavioral Health I/DD Tailored Plan clinical leadership, will be required to participate in case discussions and transition planning for members with the most complex needs.