

Tailored Care Management 106:

*Transitional Care Management and
Community Inclusion Activities*

November 5, 2021

Tailored Care Management Webinar Series

Today's webinar is a part of a series to help develop a shared understanding of the Tailored Care Management model across the North Carolina provider community and any anyone else who is interested.

Date <i>Fridays 12 -1 PM</i>	Topic
October 1, 2021	Introduction to Tailored Care Management
October 8, 2021	Becoming an AMH+/CMA
October 15, 2021	Health IT Requirements and Data Sharing
October 22, 2021	Partnering with a Clinically Integrated Network and Other Partners
October 29, 2021	Delivery of Tailored Care Management
November 5, 2021	Transitional Care Management Community Inclusion Activities
November 19, 2021	Conflict-Free Care Management and Additional Care Coordination Functions for Members Enrolled in the Innovations or TBI Waiver
December 3, 2021	Billing
December 10, 2021	Oversight and Quality Measurement/Improvement

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- Time permitting, we will be holding a Q&A session at the conclusion of today's presentation.
 - You may ask a question at any time throughout the presentation, using the Q&A text box
 - Q&A Text Box is located at the lower right-hand side of the screen
 - Simply type in your question and click send

For additional questions on Tailored Care Management, please email:
Medicaid.TailoredCareMgmt@dhhs.nc.gov

- A recording of today's presentation and the slide deck will be available at the below website.

For more information on Tailored Care Management, please visit:
<https://medicaid.ncdhhs.gov/transformation/tailored-care-management>

Presenters

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NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

Agenda

- **Recap: Tailored Care Management Model**
- **Transitional Care Management**
 - Overview of Requirements
 - Process for Identifying Individuals in Transition
 - Example Scenarios
- **Community Inclusion Activities**
 - Diversion
 - In-Reach and Transition
 - Example Scenarios
- **Question & Answer**

Recap: Tailored Care Management Model Overview

What is Tailored Care Management?

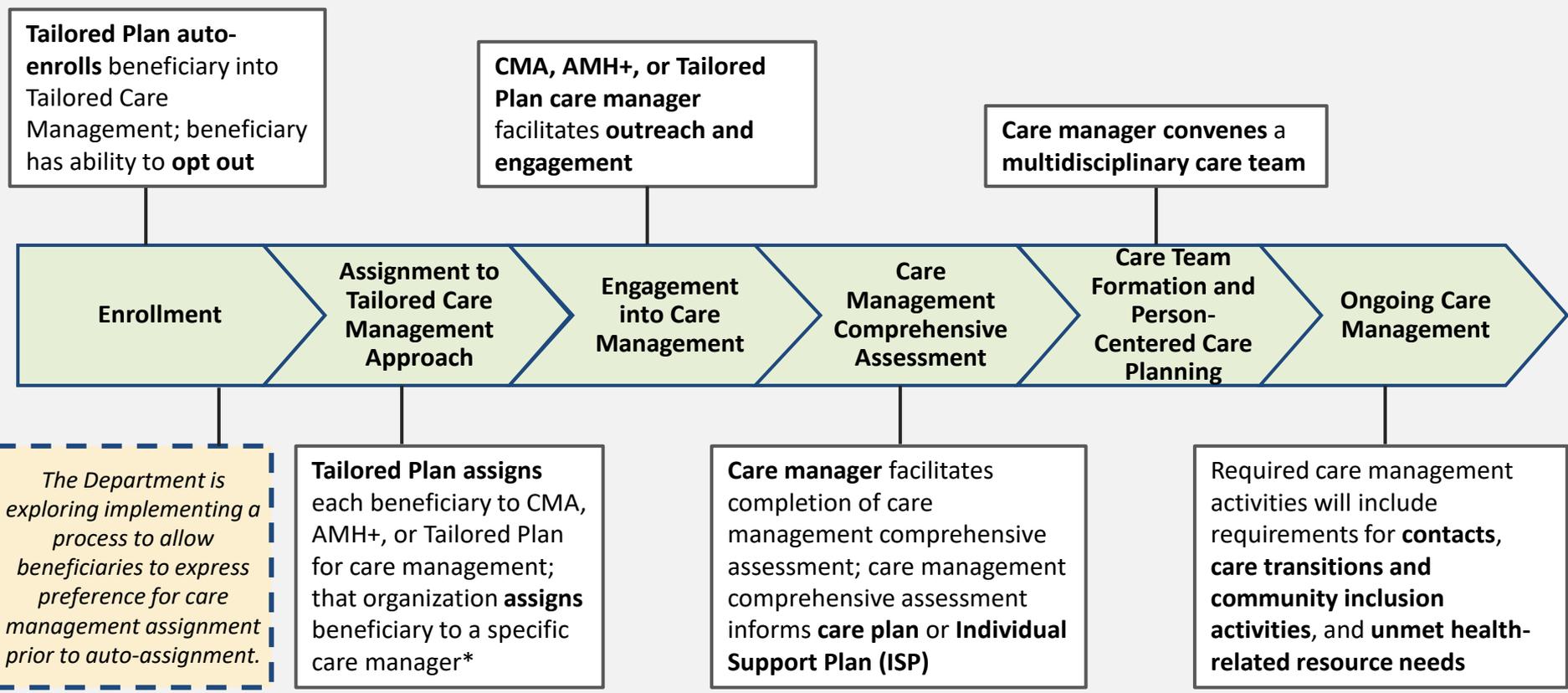
Key Features of Tailored Care Management

- **Tailored Care Management is the primary care management model for Tailored Plans.**
 - All Tailored Plan Members are eligible for Tailored Care Management*, including individuals enrolled in the 1915(c) Innovations and TBI waivers.
 - Individuals enrolled in NC Medicaid Direct (e.g., dual eligibles) will also have access to Tailored Care Management, if they otherwise would be eligible for a Tailored Plan if not for belonging to a group delayed or excluded from managed care.

- **Tailored Plan members will be assigned to one of three approaches for obtaining Tailored Care Management: an Advanced Medical Home Plus (AMH+) practice, Care Management Agency (CMA), or a plan-based care manager.**
 - The Department strongly believes that care management should be provider-based and performed at the site of care (i.e., at an AMH+/CMA) to the maximum extent possible.
 - Providers must be certified as an AMH+ practice or CMA to perform Tailored Care Management.

- **Under Tailored Care Management, members will have a single care manager who will be equipped to manage all of their needs, spanning physical health, BH, I/DD, TBI, pharmacy, long-term services and supports (LTSS), and unmet health-related resource needs.**

Tailored Care Management Process Flow



 **Today's Focus:**
Care Transitions and Community Inclusion

NOTE: Members can change the organization they are assigned to for Tailored Care Management and/or change care managers twice per year without cause and anytime with cause (see [provider manual](#) for description of what qualifies as cause).

*Innovations and TBI waiver beneficiaries will have the choice of keeping their current care coordinators if the care coordinators meet all of the care manager requirements to serve Tailored Plan beneficiaries and federal requirements for conflict-free case management.

Transitional Care Management

Types of Transitions

AMH+ practices, CMAs, and Tailored Plans delivering Tailored Care Management must conduct *transitional care management* during the following transitions from a clinical or residential setting, as well as life transitions.

Clinical or Residential Transitions

- Transitioning out of hospital [inpatient or emergency department (ED) visit] to the community
- Transitioning out of residential setting to the community
- Transitioning between clinical and/or residential settings

Life Transitions

- Transitioning out of school-related services
- Life changes with employment, retirement, or other life events
- Loss of or change in primary caregiver
- Transitioning out of foster care

Care managers are also responsible for care management when a person is hospitalized or in a residential setting (e.g., visiting the member, reviewing the discharge plan with the member) to prepare the member for successful transition.

Reassessments and Care Plan/ISP Updates

The following transitions or “triggering events” will prompt reassessments and/or care plan/ISP updates.

- Inpatient hospitalization
- Two ED visits since the last care management comprehensive assessment or reassessment
- Involuntary treatment episode
- Other change in circumstances requiring increased or decreased need for care (e.g., transition into or out of an institution; loss of a family/friend caregiver)
- Becoming pregnant and/or giving birth
- Loss of housing
- Foster care involvement
- Use of behavioral health crisis services
- Arrest or other justice system involvement

Transitional Care Management Functions

Organizations providing Tailored Care Management must manage care transitions for members by making best efforts to conduct the following activities.

 **Assign a care manager to manage the transition** and have care manager/care team member **visit the member** during institution stay and on discharge day

 **Conduct outreach to the member's providers, review discharge plan** with the member and facility staff, and **facilitate clinical handoffs**

 **Assist the member in obtaining medications** prior to discharge and with medication reconciliation/management and medication adherence

 **Create, communicate/educate** member and caregivers/providers about, and **implement a 90-day transition plan** outlining how the member will maintain/access needed services and supports, transition to the new care setting, and integrate into his or her community

 **Facilitate arrangements for transportation, in-home services, and follow-up outpatient visits** within seven days

 **Follow up with the member within 48 hours of discharge** and 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 or ISP within 90 days** of the discharge/transition

Identifying Individuals in Transition

The care team must access admission, discharge, transfer (ADT) data that correctly identifies when members are admitted, discharged, or transferred to or from an ED or a hospital in real time or near-real time.

Organizations providing care management must implement a systematic, clinically appropriate process with designated staffing for responding to certain high-risk ADT alerts, including:



Real-time response to notifications of ED visits – e.g., contacting the ED to arrange rapid follow-up.



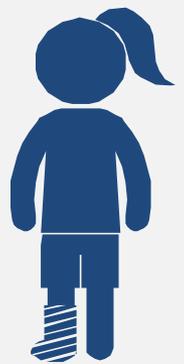
Same-day or next-day outreach for designated high-risk subsets of the population.



Additional outreach within several days after the alert to address outpatient needs or prevent future problems for other individuals who have been discharged from a hospital or an ED.

Example Scenario 1

Member is enrolled in a Tailored Plan and selects AMH+ practice as her care management provider.



Member

- Individual with very low income, eligible for Medicaid
- History of opioid use disorder, not on medication-assisted treatment
- Stable, now in outpatient SUD care after SAIOP, but at risk for relapse

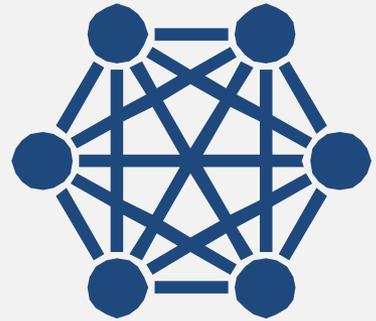


Scenario

- Injured in car crash
- Discharged from ED with nonoperative fracture
- At risk of untreated pain or relapse due to self-medication

Example Scenario 1 – *continued*

AMH+ practice has partnered with a CIN/Other Partner to support care management for HIT requirements, including access to ADT alerts.

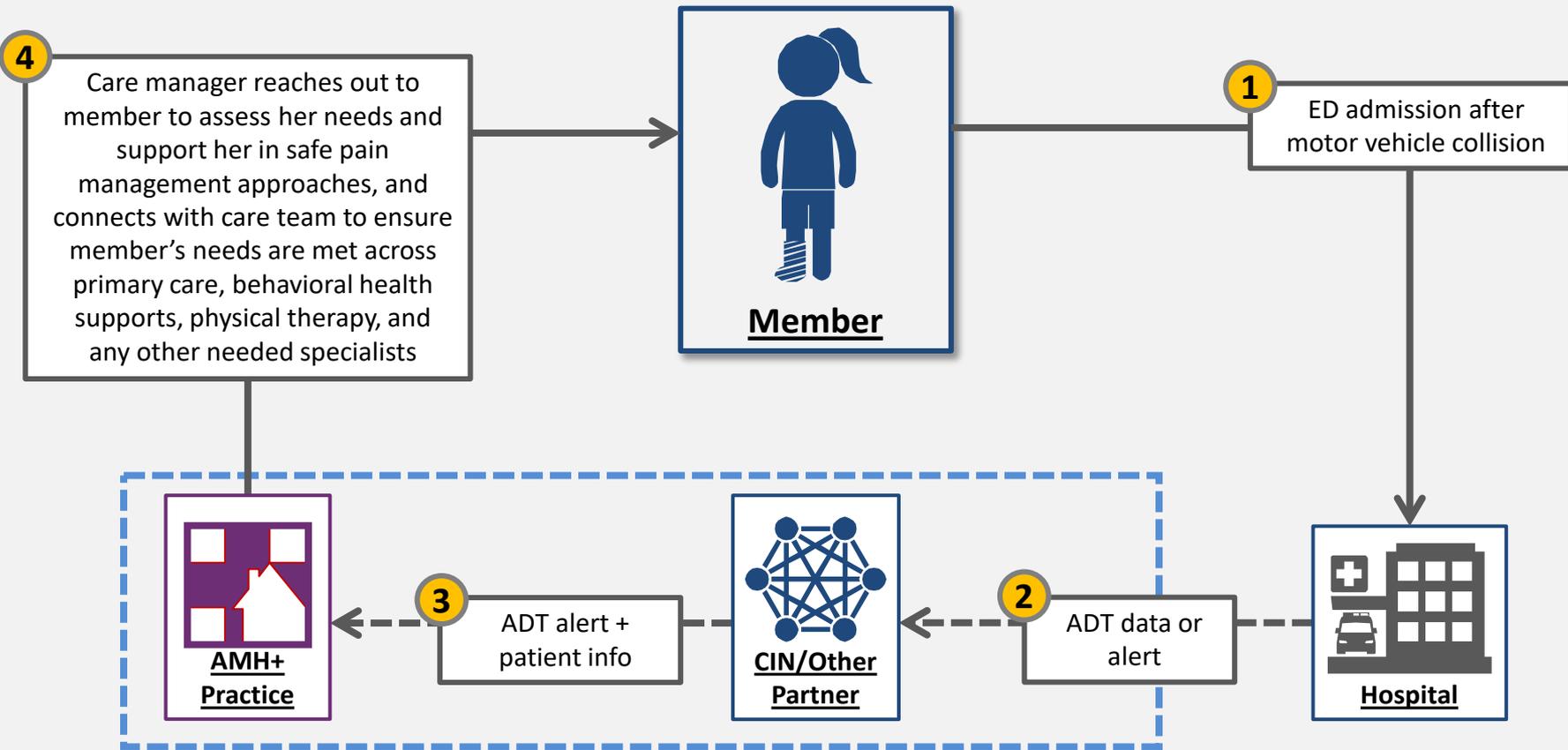


- AMH+ Practice**
- Conducts care planning
 - Has care management staff in-house
 - Leads transitional care management with assistance from CIN/Other Partner

- CIN/Other Partner**
- Aggregates data from Tailored Plan
 - Receives high-risk ADT alerts
 - Delivers panel-specific information that may be incorporated into AMH+ practice workflows

Example Scenario 1 – *continued*

After ED discharge, AMH+ practice engages in transitional care management to ensure member has good pain relief and avoids relapse.



Example Scenario 2

Member is enrolled in a Tailored Plan and selects a CMA as his care management provider.



Member

- Individual with bipolar disorder and long-term use of lithium medication, as well as kidney disease

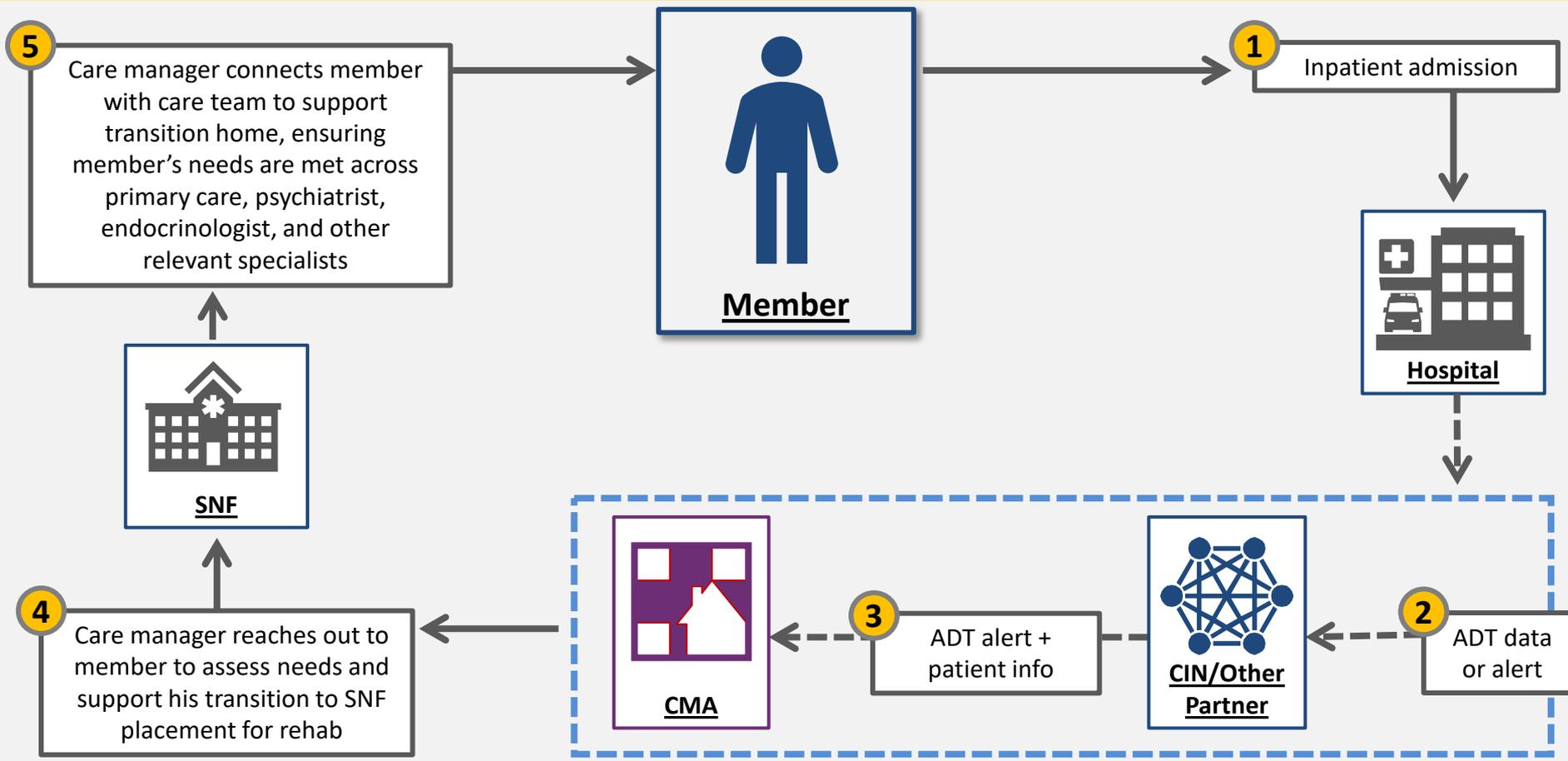


Scenario

- Hospitalized due to uremia (caused by kidney dysfunction), low blood pressure, and mental status changes
- Requires transition to short-term skilled nursing facility (SNF) for rehab and transition back home with dialysis

Example Scenario 2 – *continued*

After hospital discharge, CMA engages in transitional care management to ensure member's care is coordinated across transitions to the SNF and back home.



Community Inclusion Activities

Community Inclusion and Tailored Care Management

The Department is committed to providing all individuals with serious mental illness, serious emotional disturbance, and intellectual or developmental disabilities the opportunity to live in their communities and to meaningfully participate in community life to the greatest extent possible.

- ✓ Community inclusion services, which aim to help members remain in their communities or prepare them for and transition to the community, is a key part of the Tailored Care Management model for members who need these services.
- ✓ Post-transition supports provided to ensure a member can live safely and to thrive in their community—such as post-discharge meetings to address any issues—are also a part of the Tailored Care Management model.
- ✓ Recognizing that in-reach and transition services require specialized knowledge, Tailored Plan staff will be available to support and provide consultation to care managers providing these services.

What Is “Community Inclusion”?

Community inclusion services are a set of services designed to prevent members from entering institutional settings unnecessarily or to ensure timely and successful transitions of members already in institutional settings back to community-based settings.

Diversion

The process of identifying members living in the community who are at risk of requiring care in an institutional setting, and providing additional, more intensive supports in order to prevent further deterioration of their condition that could result in placement in an institutional setting.

In-Reach

The process of identifying and engaging members in institutional settings whose service needs could potentially be met in a home or community-based setting.

Transition

Developing and executing a person-centered plan for a member to move from an institutional setting to a home or community-based setting.

Diversion

Members Who are Eligible to Receive Diversion Services

Care managers will provide diversion interventions to their members who are at risk of requiring care in an institutional setting or an Adult Care Home (ACH), based on the below eligibility criteria.

Eligibility for Diversion Services

- ✓ Member has transitioned from an institutional or correctional setting within the previous 6 months or is seeking entry into an institutional setting.
- ✓ For members with an I/DD or a TBI:
 - Their caregivers may be unable to provide required interventions due to fragile health (e.g., caregiver was hospitalized in the previous 12-18 months, is diagnosed with a terminal illness, has a poorly managed ongoing health issue); or
 - Parent or guardian dies; or
 - Children or youth with an I/DD or a TBI with co-occurring complex behavioral health needs

Diversion Activities Conducted by Care Managers

- ✓ **Identify** members who are eligible to receive diversion services.
- ✓ **Screen and assess** member for eligibility for community-based services and other entitlement programs.
- ✓ **Educate** member **on the choice to remain in the community** and the services available to support that decision.
- ✓ **Facilitate referral and linkages** to community based and other support services.
- ✓ Determine if member is eligible for **supported housing**, if needed.
- ✓ **Consult medical staff** based at Tailored Plan or the AMH+ practices or CMAs to assess the medical needs of the member.
- ✓ For those who choose to remain in the community, develop a **Community Integration Plan (CIP)** that documents the decision was based on informed choice, and **integrate the CIP as an addendum** in the member's **Care Plan or ISP**.
- ✓ For those who choose to not remain in the community, clearly **document the decision was based on informed choice** and describe steps taken to fully inform the member of available community services, including supported housing.
 - Refer members who choose to enter an institutional setting or ACH for in-reach services

In-Reach and Transition

Members Eligible to Receive In-Reach and Transition Services

Members in the below settings are eligible for in-reach and transition services.

Settings for In-Reach and Transition Services

- ✓ State Psychiatric Hospital (SPH)
- ✓ Adult Care Home* (ACH)
- ✓ State Developmental Center
- ✓ Psychiatric Residential Treatment Facility (PRTF) and Residential Treatment Levels II/Program Type, III, and IV**
- ✓ Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)

Staff Responsible for Providing In-Reach and Transition Services

Members will receive in-reach and transition services from either an AMH+ or CMA or from staff based at the Tailored Plan, depending on the age of the member, their setting, and whether they are moving to permanent supportive housing upon discharge.

AMH+/CMA or Tailored Plan Staff?	Role	Responsibilities
AMH+/CMA	Care Manager	<ul style="list-style-type: none"> In-reach for members under age 18 in a state psychiatric hospital and all members in a PRTF, or Residential Treatment Level II/Program Type, III, and IV Transition for members in a state psychiatric hospital,* Adult Care Home, PRTF, or Residential Treatment Level II/Program Type, III, and IV <u>not</u> transitioning to permanent supportive housing
Tailored Plan	In-Reach Specialist	<ul style="list-style-type: none"> In-reach for members in a state developmental center (new role)
	Certified Peer Support Specialist	<ul style="list-style-type: none"> In-reach for adults in a state psychiatric hospitals or Adult Care Home (currently TCL)
	Transition Coordinator	<ul style="list-style-type: none"> Transition for members transitioning to permanent supportive housing (currently TCL) Transition for members in a state developmental center
	DSOHF Admission Through Discharge Manager	<ul style="list-style-type: none"> Transition for adults age 21+ in a state psychiatric hospital <u>not</u> transitioning to permanent supportive housing
	<i>To be determined by the Tailored Plan</i>	<ul style="list-style-type: none"> In-reach and transition for members in ICF-IIDs not operated by the state

*Members age 21+ in a state psychiatric hospital are not eligible for Tailored Care Management due to the institution for mental diseases (IMD) exclusion.

In-Reach Activities Conducted by Care Managers

Candidates for in-reach may include current members newly admitted to a facility or members newly identified as a candidate for in-reach for the AMH+ or CMA by the Tailored Plan. Once a candidate for in-reach is identified, in-reach must begin within 7 days and continue on a regular basis until the member is referred for transition.

In-Reach Activities

- ✓ Provide age-appropriate **education about and linkages to community-based options**, including permanent supportive housing and peer support services, when available.
- ✓ Facilitate and accompany on **visits to community-based services**
- ✓ Identify and attempt to **address barriers/concerns about relocation** to a more integrated setting
- ✓ To the extent possible, explore and **address concerns of member and/or their family who decline to or are ambivalent about transitioning**; arrange for peer-to-peer meetings when appropriate to address concerns
- ✓ Provide member and their families with **opportunities to meet with other individuals with SMI or SED** (as relevant to the member) who are living, working and receiving services in integrated settings
- ✓ Identify **training that facility staff may benefit from** to support smooth transitions
- ✓ Engage and **collaborate with stakeholder groups and local agencies** that represent individuals receiving in-reach services to provide education and support to facility staff

Transition Activities Conducted by Care Managers* (1 of 3)

Transition Activities

- ✓ Plan **effective, timely transition** while ensuring continuity of care

- ✓ Collaborate with and **ensure participation** of the following in the transition planning process (as appropriate):
 - The member and/or their family or guardian
 - Facility providers and discharge planners
 - The member's community-based primary care provider once selected
 - Peer support specialist or other individuals determined to have shared lived experience
 - Educational specialists
 - Other community providers and specialists, including physical and behavioral health providers
 - *For children or youth members:* the Child and Family Team, including the member's PRTF Family Peer Partner if applicable.
 - Tailored Plan clinical leadership (i.e., clinical Director-level or above) will attend and participate in case discussions and transition planning for members with complex needs identified by facility clinical leadership, such as members with co-occurring disorders or a history of aggression and/or serious self-harm

Transition Activities Conducted by Care Managers* (2 of 3)

Transition Activities

- ✓ Help members **select a community-based PCP and clinical specialists**, and set up appointments for critical services (no later than 7 days post-discharge), including services to address complex behavioral health needs
- ✓ Collaborate with the member, their family, Certified Peer Support Specialists when available and facility providers to **make arrangements for individualized supports and services needed to be in place upon discharge**, including applicable crisis services
- ✓ Work with receiving providers and/or agency if applicable, to identify if any specific **training is needed by the receiving providers/agency** to ensure a seamless transition

Transition Activities Conducted by Care Managers* (3 of 3)

Transition Activities

- ✓ **Address barriers to discharge planning** including but not limited to, access to providers and services, transportation, housing assessment, resource identification, referrals to providers and care manager, and training and treatment needs of family/guardians prior to discharge
 - Settings that the member is transitioning to will be assessed using a checklist provided by the Tailored Plan.

- ✓ Explore and **secure appropriate and available funding options** and work through potential funding needs with community providers such as managing spend downs, if needed, prior to discharge

Closer Look: Role of Care Managers for Members in a PRTF, or Residential Treatment Level II/Program Type, III, and IV

For some members, care managers will be responsible for providing both in-reach and transition services.



Member is in a PRTF, or Residential Treatment Level II/Program Type, III, and IV

The care manager provides in-reach services.



Member is transitioning to back to their home

The care manager provides transition services, coordinating with the member's larger care team, as described on later slides.



Member has transitioned back to their home

Once the member returns to the community, the care manager continues to provide Tailored Care Management services.

Closer Look: Role of Care Managers for Members Aged 18+ in an SPH or ACH

Care managers will play a key leadership role in each member's care team and are responsible for coordinating across all a member's needs. When not leading in-reach and transition activities, care managers will collaborate with Tailored Plan staff leading in-reach and transition services.



Member is in an SPH or ACH

A peer support specialist based at the Tailored Plan provides in-reach services.



Member is transitioning from an SPH or ACH to supportive housing

- A transition coordinator based at the Tailored Plan provides transition services.
- If the member remains eligible for Tailored Care Management while they are in an SPH or ACH, the care manager remains part of the care team, though in-reach and transition is led by the Tailored Plan staff.



Member has transitioned back to the community

- Once a member returns to the community, the care manager continues to provide Tailored Care Management services. The warm handoff to the care manager will take upon discharge.
- The Tailored Plan transition coordinator will remain a part of the member's care team until 90 days post-discharge to ensure the member is receiving needed transition-related services.

Questions?

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