WEBVTT

1
00:00:31.560 --> 00:00:38.010
Jeff Shoate: hello, and welcome to today's webinar my name is Jeff and i'll be in the background answering any technical questions.

2
00:00:38.520 --> 00:00:44.550
Jeff Shoate: If you experienced difficulties during this session, please type your question into the Q amp a section and a producer will respond.

3
00:00:45.390 --> 00:00:57.870
Jeff Shoate: will be holding the Q amp a session during today's webinar we encourage you to submit written questions at any time, using the Q amp a pound located at the bottom of your zoom webinar viewer please type your questions in the text field and click send.

4
00:00:58.920 --> 00:01:14.730
Jeff Shoate: Should you wish to abuse closed captioning during this program please click CC at the bottom of your zoom window to enable or hide subtitles during today's event all participants will remain in listen only mode with that we will get started in, and we hope you enjoyed today's presentation.

5
00:01:15.870 --> 00:01:27.720
Jeff Shoate: I now like to introduce you introduce your first speaker for today crystal hinton associate director of population health North Carolina medicaid quality and population health crystal you now have the floor.

6
00:01:29.370 --> 00:01:45.150
Krystal Hilton: Thank you Jeff good afternoon everyone and welcome to the sixth installment of our tailor care management, one on one series today, we are in segment 106 looking at transitional care management and Community inclusion activities.

7
00:01:46.560 --> 00:01:54.810
Krystal Hilton: We would like to share that, in addition to our focus of today, we have several upcoming to round out our series.

8
00:01:55.050 --> 00:02:04.410
Krystal Hilton: which will be looking at conflict manage conflict free care management and additional care coordination functions as it relates for innovations or tbi waiver.

9
00:02:04.770 --> 00:02:10.140

Krystal Hilton: Billing and, later on, rounding out with oversight and quality measurement and improvement activities.

10
00:02:10.680 --> 00:02:20.520
Krystal Hilton: We are in, in addition to that, we are actively working to schedule a data specifications session, which will be a deeper dive and we're looking at as a.

11
00:02:21.210 --> 00:02:31.890
Krystal Hilton: level series, so please be on the lookout for that information as to when that will be scheduled and please be sure to have your data personnel as a part of that participation for the day.

12
00:02:33.060 --> 00:02:33.870
Krystal Hilton: Next slide.

13
00:02:35.640 --> 00:02:50.370
Krystal Hilton: As Jeff said, we are planning time permitting to hold a question answer session at the conclusion of the presentation, so please do add your questions to the the Q amp a text box at the bottom of the screen.

14
00:02:51.600 --> 00:03:03.870
Krystal Hilton: And just hits in, and we will be able to get those questions so just in case we run out of time which we have done, unfortunately, we will still have your questions and be able to respond to them at a later time frame.

15
00:03:04.500 --> 00:03:13.740
Krystal Hilton: Also, if you do have additional questions, please feel feel free to send those through the care that Taylor care management email address which you see on the screen.

16
00:03:14.250 --> 00:03:24.810
Krystal Hilton: And if you would like to get a recording as well as the slide deck of today's presentation, it will be posted on the Taylor care management website that you can see here.

17
00:03:25.950 --> 00:03:34.110
Krystal Hilton: Another late breaking piece of information that I would like to share is that over the last couple weeks we've been sharing that we were working to.

18
00:03:34.380 --> 00:03:40.860

Krystal Hilton: update and build out the Taylor care management website, so we have been able to get that completed, as of today, actually.

19
00:03:41.160 --> 00:03:50.490
Krystal Hilton: So we have some new additions to that website some real organization, as well as we have published in for additional information and guidance related to capacity building Program.

20
00:03:50.970 --> 00:04:03.210
Krystal Hilton: As well as the data specifications documents are also published on the tail of care management website, so please feel free to preview peruse that website to get those additional pieces of information.

21
00:04:04.650 --> 00:04:05.370
Krystal Hilton: Next slide please.

22
00:04:07.530 --> 00:04:18.390
Krystal Hilton: Okay, so joining me today during this presentation will be Dr Keith McCoy, who is the deputy CMO for behavioral health and idd Community systems.

23
00:04:19.620 --> 00:04:30.840
Krystal Hilton: In the chief medical officer for behavioral health and idd and Glen rock who's a senior program manager within population health of our quality and population health.

24
00:04:32.130 --> 00:04:32.670
Krystal Hilton: Next slide.

25
00:04:35.790 --> 00:04:41.520
Krystal Hilton: i'm going to start off with just a little bit of a recap, to let you know what our focus areas offer today so we'll be.

26
00:04:42.360 --> 00:05:02.430
Krystal Hilton: doing a quick review of the Taylor care management model spinning a lengthy discussion on transition transitional care management, looking at the requirements process for identifying individuals in transition and walking through several scenarios then we'll also be having a nice discussion.

27
00:05:03.480 --> 00:05:10.740
Krystal Hilton: Regarding Community inclusion activities, the version in reaching transition and also providing example scenarios.

28
00:05:11.220 --> 00:05:29.640
Krystal Hilton: And, as I shared that time permitting we'll be having a question answer session, but please do not hesitate to put questions within the chat and we will be able to respond to those if not doing a question and answer session at a later time and get those responses to you next slide.

29
00:05:31.290 --> 00:05:31.620
Okay.

30
00:05:32.670 --> 00:05:33.420
Krystal Hilton: And the next slide.

31
00:05:36.360 --> 00:05:38.550
Krystal Hilton: Okay i'm briefly going to walk through.

32
00:05:39.870 --> 00:05:47.940
Krystal Hilton: The kind of a recap of of what is Taylor career management we've shared before and we know you're very familiar, but we just want to kind of anchor.

33
00:05:48.210 --> 00:05:58.590
Krystal Hilton: To help lead into our conversation today, so the key features of Taylor care management is that, where Taylor care management is the primary care management model for Taylor plans.

34
00:05:59.070 --> 00:06:06.930
Krystal Hilton: All tailored plan Members are eligible for telecare mid management, and this includes individuals that are enrolled in the.

35
00:06:07.950 --> 00:06:10.410
Krystal Hilton: seat innovations and tbi waivers.

36
00:06:11.550 --> 00:06:17.670
Krystal Hilton: Individuals enrolled in medicaid and REC also have access to take care management.

37
00:06:18.690 --> 00:06:27.900
Krystal Hilton: If they are otherwise eligible for tailored plan unless they will belong to a delay group or excluded from managed care.

38
00:06:29.670 --> 00:06:36.930

Krystal Hilton: Another key feature is that Taylor care management is able to be delivered through one of the approaches.

39
00:06:37.260 --> 00:06:49.410
Krystal Hilton: And that is where services can be delivered with an advanced medical home plus practice a care management agency or it will be plant based care management directly via the tailor plants.

40
00:06:50.700 --> 00:07:09.120
Krystal Hilton: Care management should be provider based and perform at the sight of care to the maximum soon as possible and all providers must be certified as an AMA plus practice or a cma care Management Agency in order to perform care management services.

41
00:07:11.070 --> 00:07:17.670
Krystal Hilton: Taylor care management, Members will have a single care manager, who is equipped and.

42
00:07:19.050 --> 00:07:33.120
Krystal Hilton: is equipped to manage all of their needs and that will cross the physical health behavioral health idd tbi pharmacy long term services and supports areas, as well as working to address unmet health related resource needs.

43
00:07:34.440 --> 00:07:35.010
Krystal Hilton: Next slide.

44
00:07:39.090 --> 00:07:39.390
Okay.

45
00:07:40.890 --> 00:07:55.650
Krystal Hilton: Before you, we have a pretty voluminous slide but i'll give you the the endpoint first today we're going to be focusing on care transitions and Community inclusion as we, as I did share on the car and the onset.

46
00:07:56.280 --> 00:08:01.680
Krystal Hilton: But we did want to do just a brief walkthrough of the Taylor care management process flow.

47
00:08:02.850 --> 00:08:14.280
Krystal Hilton: So we start with auto enrollment of beneficiaries entertainment care management and the beneficiary has that opportunity to actually opt out of tailored care management.

48
00:08:15.690 --> 00:08:16.230
Krystal Hilton: The.

49
00:08:17.250 --> 00:08:20.940
Krystal Hilton: wants the tailored plan has then.

50
00:08:21.960 --> 00:08:36.240
Krystal Hilton: auto enrolled a beneficiary, then they assign beneficiaries to a cma am H plus or tailored plan for care management as appropriate to take care of that beneficiaries needs.

51
00:08:37.020 --> 00:08:47.850
Krystal Hilton: The actual Taylor care management provider, that the beneficiaries assigned to would then assign a specific care manager to work directly with the beneficiary.

52
00:08:48.960 --> 00:09:05.760
Krystal Hilton: That Taylor care manager will then reach out and begin engagement with the beneficiary and that entails the completion of a comprehensive assessment, which leads to the development of care plan or the individual support playing.

53
00:09:06.960 --> 00:09:19.260
Krystal Hilton: With the creation of those care plans and in or individual support plan the care manager convenes a multi multi disciplinary care team, with the focus of that providing an IT person centered.

54
00:09:20.100 --> 00:09:40.800
Krystal Hilton: Care planning and then we initiate ongoing care management, and this would involve the appropriate of completing the appropriate contacts care transitions looking at Community inclusion activities and undress and addressing on met health related resource needs.

55
00:09:42.150 --> 00:09:55.890
Krystal Hilton: One thing of note, would like to share that Members enrolled in Taylor care management are able to make changes or to actually change the tailored care Management Organization up to two times a year.

56
00:09:56.310 --> 00:10:12.330
Krystal Hilton: Without calls just because they're just not feeling that is working for them and they're able to change it anytime with calls,

please note that defined with cause requirements are listed within the Taylor care management program manual.

57
00:10:14.130 --> 00:10:14.940
Krystal Hilton: Next slide.

58
00:10:17.730 --> 00:10:27.900
Krystal Hilton: Okay, so now, I will be turning it over to winch rot who will work with us smooth transitions do care transitions going.

59
00:10:34.890 --> 00:10:36.150
Gwendolyn Sherrod: Good afternoon.

60
00:10:38.250 --> 00:10:42.300
Gwendolyn Sherrod: I will be discussing transitions of care.

61
00:10:43.590 --> 00:10:56.910
Gwendolyn Sherrod: So we're going to start with types of transitions a major plus practices cma and Taylor plans delivering Taylor care management must conduct transitional care management.

62
00:10:58.050 --> 00:11:04.740
Gwendolyn Sherrod: not to be confused with trends with transitions of care during the during the.

63
00:11:06.240 --> 00:11:18.570
Gwendolyn Sherrod: During the following transitions from a clinical or residential setting as well as life transitions clinical or residential transitions are where a.

64
00:11:20.250 --> 00:11:38.370
Gwendolyn Sherrod: A beneficiary is transitioning out of the hospital Inpatient or emergency department visits to the Community, they would also be transitioning out of residential settings in back into the Community or transitioning between clinical and or residential setting.

65
00:11:39.570 --> 00:11:51.180
Gwendolyn Sherrod: they're also life transitions were the beneficiary may be transitioning out of the school related services they may have life changes with.

66
00:11:52.200 --> 00:12:06.030

Gwendolyn Sherrod: Employment or retirement or other life events they're also maybe loss of or change in their primary caregiver and, lastly, they may be transitioning out of foster care.

67
00:12:08.760 --> 00:12:27.150
Gwendolyn Sherrod: Care managers are also responsible for care management, when a person is hospitalized or in a residential setting, for example, visiting the Member reviewing the discharge plan with the Member to prepare the Member for successful transition next slide.

68
00:12:34.080 --> 00:12:46.980
Gwendolyn Sherrod: Re assessments and care plan or ISP updates the following transitions or, as we call triggering events will prompt reassessments and or care plan is for ISP updates.

69
00:12:48.600 --> 00:12:57.900
Gwendolyn Sherrod: The Member could have an Inpatient hospitalization to ED visits, since the last care management comprehensive assessment or reassessment.

70
00:12:58.620 --> 00:13:14.880
Gwendolyn Sherrod: And involuntary treatment episode other changes in circumstances requiring increased or decreased me for care for example transitioning into or out of an institution loss of a family friend or caregiver.

71
00:13:16.710 --> 00:13:31.260
Gwendolyn Sherrod: becoming pregnant and or giving birth loss of housing foster care involvement use the behavioral health crisis services a wrist or other judicial system involvement.

72
00:13:32.310 --> 00:13:33.030
Gwendolyn Sherrod: Next slide.

73
00:13:39.120 --> 00:13:54.030
Gwendolyn Sherrod: So transitional care management functions organizations, providing Taylor career management must managed care transitions for Members by making this efforts to conduct the following activities.

74
00:13:55.980 --> 00:14:08.940
Gwendolyn Sherrod: First, they must assign a care manager to manage the transition and have the care manager or care team Member visit the Member during the institution during an institutional stay and on discharge day.

75

00:14:10.230 --> 00:14:20.400
Gwendolyn Sherrod: They must conduct outreach to the Members providers review the discharge plan with a member and facility staff and facilitate clinical handoffs.

76
00:14:21.720 --> 00:14:32.400
Gwendolyn Sherrod: assist the Member in obtaining medications prior to discharge and with medication reconciliation and medication management and medication adherence.

77
00:14:34.200 --> 00:14:51.870
Gwendolyn Sherrod: They must also create communicate and or educate the Member the caregivers and providers about and implement a 90 day transition plan outlining how the Member will maintain and access needed services and supports.

78
00:14:52.920 --> 00:14:59.790
Gwendolyn Sherrod: And how they will transition to the new care setting and how they will integrate into his or her community.

79
00:15:01.440 --> 00:15:10.350
Gwendolyn Sherrod: They must also facilitate arrangements for transportation in home services and follow up outpatient visits within seven days.

80
00:15:11.730 --> 00:15:22.050
Gwendolyn Sherrod: They must follow up with a member within 48 hours of discharge and arrange to visit the Member in their new care setting after discharge or transition.

81
00:15:23.400 --> 00:15:32.520
Gwendolyn Sherrod: They must conduct a care management comprehensive assessment within 30 days of the discharge or transition or update the current assessment.

82
00:15:34.170 --> 00:15:41.070
Gwendolyn Sherrod: They must update the Members care plan or ISP within 90 days of the discharge or transition.

83
00:15:42.480 --> 00:15:43.590
Gwendolyn Sherrod: Next slide please.

84
00:15:49.170 --> 00:15:52.830
Gwendolyn Sherrod: Identifying individuals in transition.

85
00:15:54.120 --> 00:16:07.410
Gwendolyn Sherrod: The care team must assess admission discharge and transfer commonly known as adt data that correctly identifies when Members are admitted discharged or transferred to or from.

86
00:16:07.890 --> 00:16:17.010
Gwendolyn Sherrod: An emergency department or hospital in real time or near real time organizations, providing care management must implement a.

87
00:16:17.820 --> 00:16:39.240
Gwendolyn Sherrod: Systematic and clinically appropriate process with designated staffing for responding to certain high risk adt alerts so we're asking that the providers have a way to receive this adt information and have identified staff to be able to respond to the information.

88
00:16:41.250 --> 00:16:48.570
Gwendolyn Sherrod: So we were we're looking to the providers and organizations, providing care management to.

89
00:16:49.650 --> 00:16:59.250
Gwendolyn Sherrod: have real time response to the notifications of ED ED visits, for example, contacting the ED to arrange rapid follow up.

90
00:17:00.150 --> 00:17:07.440
Gwendolyn Sherrod: same day or next day outreach for designated high risk subsets of your of the patient population.

91
00:17:08.340 --> 00:17:20.610
Gwendolyn Sherrod: Additional outreach within several days after the alert to address the outpatient needs or prevent future problems for other individuals who have been discharged from the hospital or from an ED.

92
00:17:22.410 --> 00:17:23.100
Gwendolyn Sherrod: Next slide.

93
00:17:28.410 --> 00:17:31.770
Gwendolyn Sherrod: example scenario one.

94
00:17:34.590 --> 00:17:45.300
Gwendolyn Sherrod: The Member is enrolled we have we have a Member here she's enrolled in a tailor plan and selects an H plus practice as her career management provider.

95
00:17:46.620 --> 00:17:58.530
Gwendolyn Sherrod: So the Member, so we can talk about the Member the Member is an individual with low income eligible for medicaid history of opioid use disorder, not on medication assisted treatment.

96
00:17:59.220 --> 00:18:19.590
Gwendolyn Sherrod: She stable she's now in an outpatient substance use disorder care after say up but but but is at risk for relapse so she's she's been enough substance abuse intensive outpatient program known as a up but she's she's now.

97
00:18:21.690 --> 00:18:38.550
Gwendolyn Sherrod: But she's at risk for relapse so the scenario is she's injured in a car crash she's discharged from the ED with a non approval fracture and she's at risk of untreated pain or relapse do self medication.

98
00:18:39.600 --> 00:18:40.320
Gwendolyn Sherrod: Next slide.

99
00:18:45.330 --> 00:18:58.050
Gwendolyn Sherrod: So the AMA plus practice is partnered with a ci and other partner to support care management for the health information technology requirements, including access to the adt alerts.

100
00:18:59.160 --> 00:19:13.110
Gwendolyn Sherrod: So the a mix plus practice conducts care because that's care planning has the care management has care management staff in house and leads the transition of care management.

101
00:19:15.690 --> 00:19:19.530
Gwendolyn Sherrod: team with assistance from the CIA and other partner.

102
00:19:20.610 --> 00:19:36.480
Gwendolyn Sherrod: The CIA and other partner aggregates, the data from the Taylor clan receives the high risk adt alert and delivers panel specific information that may be incorporated into the AMA plus practice workflows.

103
00:19:38.490 --> 00:19:39.180
Gwendolyn Sherrod: Next slide.

104
00:19:41.910 --> 00:19:58.620

Gwendolyn Sherrod: So let's continue on with our scenario after the after the ED discharge the mx plus practice engages in transitional care management to ensure that the Member has good pain relief and avoids relapse.

105
00:20:00.180 --> 00:20:17.340
Gwendolyn Sherrod: So let's take it by the by by the numbers, so we have the member of the middle and number one the ED admission after the she has an ad admission after the motor vehicle collision so we follow the arrow down she goes to the hospital.

106
00:20:19.110 --> 00:20:27.510
Gwendolyn Sherrod: There is an adt data there's at data and there's an alert sent out that alert would go to the ci and other partner.

107
00:20:29.790 --> 00:20:34.530
Gwendolyn Sherrod: The adt alert and the patient information is sent to the AMA to plus practice.

108
00:20:36.180 --> 00:20:52.110
Gwendolyn Sherrod: And then we go to number for the care manager care manager reaches out to the Member to assess her knees and support her in safe pain management approaches and connects with the care team to ensure the Members needs are met.

109
00:20:54.150 --> 00:21:00.660
Gwendolyn Sherrod: Across the primary care behavioral health supports physical therapy and other needed specialist.

110
00:21:01.980 --> 00:21:02.970
Gwendolyn Sherrod: Next slide please.

111
00:21:07.170 --> 00:21:14.520
Gwendolyn Sherrod: So i'm going to pass this over to Dr McCoy to go over examples scenario number two.

112
00:21:16.980 --> 00:21:26.370
Keith McCoy: Thank you, Graham um so this scenario just gets into a little bit more of a situation where someone might have a chronic illness.

113
00:21:27.390 --> 00:21:30.960
Keith McCoy: And how that may differ from someone who goes through an acute.

114
00:21:32.070 --> 00:21:45.450
Keith McCoy: Transition so in this situation, we have an individual with bipolar disorder and long term use of lithium isn't magic as a medication and lithium can certainly have an impact on someone's kidney function.

115
00:21:45.870 --> 00:21:57.480
Keith McCoy: So this individual is hospitalized due to uranium associated with kidney dysfunction low blood pressure, unstable vital signs mental status changes which can all be associated with.

116
00:21:58.710 --> 00:22:03.450
Keith McCoy: challenges of the intersection between with them and the system.

117
00:22:04.230 --> 00:22:20.730
Keith McCoy: This individual then requires a short term transition to a skilled nursing facility for rehabilitation due to the conditioning associated with the level of severity of the physical issue and then ultimately is going to need to ship back home with dialysis next one.

118
00:22:24.030 --> 00:22:37.080
Keith McCoy: So in this situation there's going to be a similar scenario where the care management entity learned through an adt alert that someone has ended up in hospital that adt alert maybe.

119
00:22:39.480 --> 00:22:53.340
Keith McCoy: moderated in order to get to the cna by the CIA or other partner and, in this situation, the care manager is with a care management agency which is primarily a behavioral health or ID agency.

120
00:22:54.150 --> 00:23:07.530
Keith McCoy: Here in the care manager again reaches out to the Member to assess the needs to support the transition to the sniff and again from the Smith, because this individual one know that they are going to transition back to this difference to the Community which won't come through an http.

121
00:23:08.850 --> 00:23:17.250
Keith McCoy: For placement back into the Community, so this is a whole scenario where the care manager needs to be on top of who's taking care of what.

122
00:23:18.390 --> 00:23:22.890
Keith McCoy: Those have social workers and so that hospital social worker may be taking care of.

123
00:23:23.490 --> 00:23:31.200
Keith McCoy: The lead on the sniff referrals but that social worker may need to understand other critical elements of this person's care.

124
00:23:31.770 --> 00:23:40.200
Keith McCoy: This individual may need to stay at a sniff that's closer to their behavioral health team this individual may be out of Community support team, for example.

125
00:23:40.800 --> 00:23:52.470
Keith McCoy: They have pretty unstable bipolar disorder and recently had to come off lithium so that they may need to transition medications they would need to be coordination with.

126
00:23:52.950 --> 00:24:01.710
Keith McCoy: The individual psychiatrist or other prescriber to make sure that a safe alternative medication regimen is implemented is monitored.

127
00:24:02.430 --> 00:24:18.720
Keith McCoy: Both for implementation and for effect i'm ensuring that behavioral health resources and services continue during this transition befallen the hospital, while the sniff and also transitioning into the Community.

128
00:24:19.710 --> 00:24:34.560
Keith McCoy: If this person needs to be at a sniff that is close to other caregivers you know that's the sort of information that I care manager would be critical to help communicate with the hospital case manager, who may be coordinating some of this new referral, for example.

129
00:24:35.700 --> 00:24:36.600
Keith McCoy: Next slide.

130
00:24:39.390 --> 00:24:47.610
Keith McCoy: So now we're going to go into Community inclusion and Community inclusion has been very intentional.

131
00:24:48.630 --> 00:24:58.680
Keith McCoy: Of the Taylor plan design the state, and I appreciate Jamie Schreiber joining us today we have questions about transitions to community living.

132
00:24:59.340 --> 00:25:03.480

Keith McCoy: Resources services programming that we have in North Carolina.

133
00:25:04.470 --> 00:25:12.030
Keith McCoy: We have learned a lot through the process of opening individuals with serious mental illness and serious and persistent mental illness.

134
00:25:12.390 --> 00:25:21.630
Keith McCoy: Transition out of institutions like state psychiatric hospitals and adult care homes and we're wanting based on this lessons learned to try to weave in.

135
00:25:21.990 --> 00:25:27.060
Keith McCoy: resources to help people be as integrated and included in their communities as possible.

136
00:25:27.690 --> 00:25:36.390
Keith McCoy: So you'll see that we've taken some of the model that we have in transitions to community living and tried to replicate that as relevant and appropriate.

137
00:25:36.870 --> 00:25:42.510
Keith McCoy: For other populations, such as children with emotional sitcom serious emotional disturbance.

138
00:25:42.840 --> 00:25:54.510
Keith McCoy: and individuals with intellectual and developmental disabilities, to give them the best opportunity to live in their communities and meaningfully participate in Community life to the greatest extent possible.

139
00:25:55.230 --> 00:26:02.400
Keith McCoy: Community inclusion services, aims to help members remain in their communities or prepare them for transition to the Community.

140
00:26:03.060 --> 00:26:08.940
Keith McCoy: And again, this is a key part of tailored care management model for Members who need these services.

141
00:26:09.540 --> 00:26:22.560
Keith McCoy: host transition supports provided to ensure a Member can live safely and thrive in their community such as post discharge meetings to address any issues are also part of the tailored campaigns.

142
00:26:24.000 --> 00:26:30.870
Keith McCoy: We recognize that in REACH and transition services requires special knowledge and have also at places.

143
00:26:32.430 --> 00:26:45.930
Keith McCoy: included additional staff that will go above and beyond tailored care management in the tailored plans to support and provide consultation to tailored care manager staff who are providing some services next slide.

144
00:26:48.750 --> 00:26:57.960
Keith McCoy: So there are three real pillars of Community inclusion when it comes to the functions that need to occur for.

145
00:26:58.770 --> 00:27:06.240
Keith McCoy: Community inclusion services are a set of services designed to prevent Members from entering into institutional settings unnecessarily.

146
00:27:06.630 --> 00:27:14.220
Keith McCoy: Or to ensure timely and successful transitions of Members already in institutional settings back to Community settings.

147
00:27:14.790 --> 00:27:27.180
Keith McCoy: And some of the settings we're going to talk about may not technically be institutions from the definition of like a State psychiatric hospital all right take facility and I cf and adult care home.

148
00:27:27.660 --> 00:27:36.270
Keith McCoy: And, nevertheless, we want to think about congregate settings We certainly understand through the pandemic that Connor gets settings bring their own risks.

149
00:27:36.810 --> 00:27:47.490
Keith McCoy: They also bring safety sometimes but they tend to decrease someone's ability to fully participate in their community in a way that you are I would.

150
00:27:48.210 --> 00:27:58.410
Keith McCoy: Living more independently, so the three pillars are diversion, which is the process of identifying members living in the Community who are at risk, require care.

151

00:27:58.860 --> 00:28:11.100
Keith McCoy: In an institutional setting and providing additional, more intensive supports in order to prevent further deterioration of their condition that could result in place and institutional setting or other congregants.

152
00:28:12.720 --> 00:28:24.780
Keith McCoy: The second pillar is in REACH, this is the process of identifying and engaging members and institutional settings who service needs can potentially be met in a home or community based second.

153
00:28:25.440 --> 00:28:37.500
Keith McCoy: And then the last pillar is transition which is developing and executing a person centered plan for a Member to move from an institutional setting to a home or community based saying next slide.

154
00:28:40.350 --> 00:28:41.760
Keith McCoy: we're going to talk about the version.

155
00:28:42.180 --> 00:28:53.280
Keith McCoy: So there are certain Members who are eligible to receive diversion services and care managers will provide diversion interventions to their members who are at risk of requiring care in an institutional setting.

156
00:28:53.670 --> 00:28:57.720
Keith McCoy: or an adult care home based on several eligibility criteria.

157
00:28:58.290 --> 00:29:08.070
Keith McCoy: So the first eligibility criteria is if a Member has recently transitioned from an institutional or correctional setting within the previous six months or is seeking.

158
00:29:08.640 --> 00:29:17.940
Keith McCoy: Entry into an institutional setting and then some additional criteria for those who have an intellectual developmental disability or traumatic brain injury.

159
00:29:18.390 --> 00:29:27.600
Keith McCoy: If they had a caregiver who may be unable to provide required interventions do too fragile health, such as a caregiver he was hospitalized and the previous 12.

160
00:29:28.080 --> 00:29:47.070

Keith McCoy: months is diagnosed with a terminal illness or has poorly managed chronic health issue work when a parent or guardian dies where if a child or youth with ID or tbi has co-occurring complex behavioral health needs separate them at risk of out of home placement next time.

161
00:29:51.060 --> 00:29:56.520
Keith McCoy: So there are various divergent activities that are conducted by care managers.

162
00:29:57.030 --> 00:30:11.940
Keith McCoy: The first is to identify Members who would be eligible for diversion services to screen and assess those numbers for eligibility for Community based services or other entitlement programs that will help them continue to live in a Community setting.

163
00:30:12.570 --> 00:30:23.430
Keith McCoy: to educate that Member and or their guardian on the choice to remain in the Community and to let them know and educate them on the services available to support the decision to stay in the Community.

164
00:30:24.300 --> 00:30:34.650
Keith McCoy: To facilitate referral and linkages to Community based and other support services to determine if the Member is eligible for supportive housing if supportive housing is needed.

165
00:30:35.490 --> 00:30:47.400
Keith McCoy: to consult with medical staff either based at Taylor plan at the age practice or the cna to assess that means that the Member may have, and how those might be addressed in the Community side.

166
00:30:48.600 --> 00:31:05.970
Keith McCoy: And for those who choose to remain in the Community to develop a Community integration of course tip the documents, the decision that was made, based on an informed choice and to integrate that Community integration plan as an addendum to the Members care plan or is.

167
00:31:07.320 --> 00:31:22.350
Keith McCoy: For those who choose not to remain in a Community a care manager, we need to clearly document, but the decision was made, based on an informed choice and described steps taken to fully informed the number of available communities or services, including support house.

168
00:31:23.490 --> 00:31:33.210
Keith McCoy: And to refer those Members who choose to enter into a congress or institutional setting or adult care home for enrich services next one.

169
00:31:36.060 --> 00:31:51.090
Keith McCoy: So next we're going to talk about enrich and transition members eligible to receive and reach and transition services include individuals who are currently in a state psychiatric hospital individuals who are in an adult care home.

170
00:31:52.470 --> 00:31:58.200
Keith McCoy: This excludes family care homes individuals who reside in a state developmental Center.

171
00:31:58.890 --> 00:32:14.610
Keith McCoy: Individuals who are in congregate child residential settings such as pure tx where a residential treatment levels two programs type three and four, and again, these are defined and political coverage policies 81 and 82.

172
00:32:15.480 --> 00:32:22.860
Keith McCoy: and individuals who are residing intermediate care facilities for individuals with intellectual disabilities next time.

173
00:32:27.060 --> 00:32:43.710
Keith McCoy: So this is a little complicated and try not to let it be overwhelming we've got a while to help people really understand the ins and outs of who is responsible for what particular task when it comes to diversion in rage and transition.

174
00:32:44.310 --> 00:32:47.460
Keith McCoy: This is particularly focused on in reaching transition.

175
00:32:48.090 --> 00:32:57.660
Keith McCoy: And members will receive and reach and transition services from either the mx plus or CA or from staff base at a tailored plan that could be a tailored care manager based at a talent.

176
00:32:58.320 --> 00:33:05.400
Keith McCoy: For specialty staff that are available to everybody when those staff are located at the time, we will go through the items.

177
00:33:06.030 --> 00:33:19.380
Keith McCoy: And who is responsible for which pieces may depend on the age of the Member the setting that they're in and whether or not they're moving to permanent supportive housing upon discharge, those are sort of different roles, based on again.

178
00:33:19.800 --> 00:33:24.900
Keith McCoy: Age setting and whether or not permanent supportive housing just part of their discharge plan.

179
00:33:26.400 --> 00:33:32.580
Keith McCoy: So for individuals who are getting their tailored career management through the H plus or the cma.

180
00:33:33.300 --> 00:33:42.750
Keith McCoy: The care manager that tailored care manager, is responsible for in recent transition for the following populations, there was.

181
00:33:43.290 --> 00:33:58.680
Keith McCoy: suitable for in REACH for Members under the age of 18 who are in a state psychiatric hospital all Members who are in appear tf and all Members who are in residential treatment level to program type Level three and level four.

182
00:33:59.760 --> 00:34:04.560
Keith McCoy: They are responsible for transition for Members in a state psychiatric hospital.

183
00:34:04.890 --> 00:34:13.140
Keith McCoy: noting that Members age 21 and older and a State psychiatric hospital are not eligible for Taylor can management.

184
00:34:13.380 --> 00:34:22.380
Keith McCoy: because their medicaid will be placed on hold or discontinue depending on how long they're in their due to the State psychiatric hospitals being high, and these are institutions from.

185
00:34:24.120 --> 00:34:27.090
Keith McCoy: which have an exclusion for medicaid eligibility.

186
00:34:29.070 --> 00:34:34.380
Keith McCoy: So, again transition from Members that are in state psychiatric hospitals to continue to have active medicaid.

187
00:34:35.160 --> 00:34:46.950
Keith McCoy: For those who are residing in adult care homes again for those who are impure Ts or these congregate residential treatment settings for youth level to program type three and four.

188

00:34:47.760 --> 00:34:59.760
Keith McCoy: Who are not transitioning to permanent supportive housing permanent supportive housing is a very specialized skill and we have some additional resources for those who are transitioning who are going to be doing so with permanent supportive housing.

189
00:35:00.600 --> 00:35:12.210
Keith McCoy: The other positions listed here are positions that reside within the Taylor plane so in REACH specialists are a special role that's dedicated within the tailored plan.

190
00:35:12.720 --> 00:35:19.980
Keith McCoy: For in REACH for Members who are in the state developmental centers, this is a new role but that's being developed with the tailor points.

191
00:35:20.790 --> 00:35:27.450
Keith McCoy: We have certified peer support specialists who are responsible for in reach two adults and a State psychiatric hospital.

192
00:35:27.930 --> 00:35:33.990
Keith McCoy: or an adult care home, these are currently roles that are in the transition to community living.

193
00:35:34.590 --> 00:35:41.910
Keith McCoy: structure that we have in North Carolina for adults with serious mental illness or serious and persistent mental illness.

194
00:35:42.270 --> 00:35:56.430
Keith McCoy: These are specialized trained certified peer support specialists who are really good and skilled and engaging individuals with seo or SEM I are in state psychiatric hospitals or adult care homes.

195
00:35:58.110 --> 00:36:04.680
Keith McCoy: To help them understand what their Community live in options are and it's, a role that we want to protect and keep in the future.

196
00:36:05.370 --> 00:36:12.210
Keith McCoy: The next role is the transition coordinator and one of these is currently in the transitions to community living.

197
00:36:13.200 --> 00:36:22.500
Keith McCoy: Programming that we have four Members transitioning to permanent supportive housing, from whatever location that they're in typically and a ch er state psychiatric hospital.

198
00:36:23.280 --> 00:36:32.010
Keith McCoy: We also have a new role for transition from Members who are transitioning out of the developmental Center into the Community so that will be a tailored plan install.

199
00:36:33.270 --> 00:36:39.930
Keith McCoy: Please note that individuals in ic s and the State developmental centers are pricey Apps are not eligible for.

200
00:36:40.680 --> 00:36:47.490
Keith McCoy: tailored care management and that's fine, but the care manager wouldn't be an option for these individuals, while they're in the settings.

201
00:36:47.820 --> 00:36:58.110
Keith McCoy: federal rules define the role and scope of ice ax and there are some angel care management requirements or ice is that or duplicative of tailored care management.

202
00:36:58.620 --> 00:37:08.580
Keith McCoy: That said, we still feel like it's very important for there to be roles that focus on informing individuals and their caregivers of options other than ice ax and other than.

203
00:37:09.810 --> 00:37:16.620
Keith McCoy: State developmental centers and helping them understand those options and if they're interested helping them transition into the Community.

204
00:37:17.340 --> 00:37:32.610
Keith McCoy: Once someone transitions into the Community, they would an out of an ICM they would then be eligible for our care management and Taylor care manager manager would work with and have things handed off to them by that transition coordinator once someone is in the Community.

205
00:37:33.750 --> 00:37:37.740
Keith McCoy: For individuals that are 21 and older in the state psychiatric.

206
00:37:38.220 --> 00:37:43.230
Keith McCoy: Are not transitioning into permanent supportive housing so again, these are people while they're in the hospital.

207

00:37:43.560 --> 00:37:48.270
Keith McCoy: Who don't have active medicaid, and so they won't be eligible for talent management at that time.

208
00:37:48.540 --> 00:37:59.340
Keith McCoy: They are specialized the soft admission to discharge managers that will help with those transitions once someone moves back into the Community and their medicaid becomes active again because they're no longer in D.

209
00:37:59.700 --> 00:38:12.480
Keith McCoy: tailored career management would that be eligible again and then that admission to discharge manager would help hand things off to that Community telecommuting telecommunication and there's one last role for in REACH and transition to Members and community.

210
00:38:14.400 --> 00:38:24.600
Keith McCoy: Or, I see if I ids who are not operated by the state and tailored plans have been tasked with developing their strategy for ensuring in region in transition for those numbers.

211
00:38:24.960 --> 00:38:31.410
Keith McCoy: So I know that's quite complicated, I know that there's a lot of if this than that and how do we get this you know really clear.

212
00:38:31.740 --> 00:38:43.560
Keith McCoy: So we understand that this is something that will all be working on together, and then we'll all be on a learning path to make sure that each of these transitions and roles are clearly defined that everybody knows who's in charge of what part.

213
00:38:43.980 --> 00:38:49.290
Keith McCoy: And that we get this all really ready to go by the time to launch next slide.

214
00:38:53.610 --> 00:39:05.940
Keith McCoy: So in REACH activities conducted by tailored care managers so again, this would be enriched activities for individuals that are in pure etfs for youth that are in congregate child residential care.

215
00:39:07.650 --> 00:39:12.240
Keith McCoy: For individuals who are under the age of 18 who are in a state psychiatric hospital.

216
00:39:13.140 --> 00:39:24.270

Keith McCoy: So enriched activities would include age appropriate education about linkages and community based options, including permanent supportive housing so say someone's getting ready to transition to adulthood.

217
00:39:24.600 --> 00:39:34.470
Keith McCoy: And peer support services when available facilitate and accompany them on visits to understand Community based services that might help them.

218
00:39:34.980 --> 00:39:46.860
Keith McCoy: live in, say, and non congregate or non institutional settings identify and attempts to address barriers or concerns about relocations to more Community integrated sentence to the extent possible.

219
00:39:47.160 --> 00:39:55.800
Keith McCoy: Exploring and addressing concerns of the Member and or their family who decline or ambivalent about transitioning to more Community integrated setting.

220
00:39:56.100 --> 00:40:05.580
Keith McCoy: This may include pure pure meetings appropriate to talk with someone who has already made this transition progressed a lot of experience live anymore Community integrated sentence.

221
00:40:06.030 --> 00:40:12.000
Keith McCoy: To provide the Member and their families with opportunities to meet other individuals with SSI or scd.

222
00:40:12.510 --> 00:40:17.310
Keith McCoy: who are living and working and receiving services and integrated settings to identify training.

223
00:40:17.610 --> 00:40:31.320
Keith McCoy: That facility staff may benefit from to support a smooth transition and to engage and collaborate with stakeholder groups and local agencies that represent individuals receiving in REACH services to provide education and support to facility staff.

224
00:40:32.820 --> 00:40:33.330
Keith McCoy: Excellent.

225
00:40:36.990 --> 00:40:42.210
Keith McCoy: And now we're going to talk about transition activities conducted by tailored care managers.

226
00:40:43.770 --> 00:40:50.760
Keith McCoy: So, this would again be planning the transition for someone who is going to leave appear to congregate child residential level of care.

227
00:40:51.510 --> 00:40:57.060
Keith McCoy: The Youth that's transitioning out of the State psychiatric hospital similar to those things.

228
00:40:57.840 --> 00:41:08.580
Keith McCoy: These also maybe activities after someone has moved from a setting where they don't have Taylor care management into an integrated setting where they can so these may be some things that are handed off.

229
00:41:08.910 --> 00:41:15.570
Keith McCoy: By that transition coordinator to the tailored care manager after say 90 days into the transition back into the Community.

230
00:41:16.140 --> 00:41:22.290
Keith McCoy: So, this would include planning effective timely transition, while ensuring continuity of care.

231
00:41:22.710 --> 00:41:31.110
Keith McCoy: collaborating with ensuring participation of the following in the transition process, so ensuring the Member in the family or the Guardian are participating.

232
00:41:31.350 --> 00:41:38.430
Keith McCoy: Facility providers and discharge planners members of Community based primary care provider once one is selected.

233
00:41:38.790 --> 00:41:49.050
Keith McCoy: peer support specialist or other individuals determined to have shared living experience educational specialist other Community providers are specialists that might be physical or mental health care.

234
00:41:49.890 --> 00:42:00.450
Keith McCoy: This could include lt SS services for children or youth members, ensure that the child and family team is part of this process, including the Members purity of family peer partner when applicable.

235
00:42:01.800 --> 00:42:07.140

Keith McCoy: And then tailored plan clinical leadership will attend to participate in case discussions or transition.

236
00:42:07.710 --> 00:42:18.960
Keith McCoy: planning for Members with complex needs when identified by facility clinical leadership, such as numbers with co occurring disorders, or a history of aggression or serious self next one.

237
00:42:22.680 --> 00:42:28.710
Keith McCoy: Additional activities include helping members select a Community based primary care physician primary care provider.

238
00:42:29.070 --> 00:42:36.600
Keith McCoy: or other clinical specialists, helping to set up appointments for critical services, especially those that need to occur, no later than seven days post discharge.

239
00:42:37.140 --> 00:42:43.590
Keith McCoy: And that includes services to address complex behavioral health means collaborating with the Member their family.

240
00:42:44.220 --> 00:42:46.710
Keith McCoy: Certified peer support specialist when applicable.

241
00:42:47.100 --> 00:43:01.890
Keith McCoy: And facility providers to make arrangements for individualized supports and services that are necessary to be placed upon discharge, and that may also include preparing for any potential crisis and the crisis plan helping them understand what crisis services are available.

242
00:43:02.970 --> 00:43:07.050
Keith McCoy: Additional activities include working with receiving providers.

243
00:43:08.040 --> 00:43:21.840
Keith McCoy: or and or agency, if applicable to identify if any specific training is needed by the receiving provider agency to ensure a seamless transition so folks who are transitioning out of Congress or institutional settings they really have.

244
00:43:22.350 --> 00:43:31.890
Keith McCoy: Specialized means that not every provider would be ready to help them deal with and ensuring that those receiving providers are ready and able to.

245
00:43:33.000 --> 00:43:44.820
Keith McCoy: receive the individual, I have the specialized staff that they need to help them for specialized training that their existing staff needs help support the Member would be an essential part of transitioning to this next one.

246
00:43:47.220 --> 00:43:55.380
Keith McCoy: So the last slide on transition activities by taking care managers, including addressing barriers to discharge planning, this could be.

247
00:43:56.370 --> 00:44:07.110
Keith McCoy: trouble with access for provider or other services transportation issues housing assessment to me that the housing that they're going to save resource identification.

248
00:44:07.680 --> 00:44:15.150
Keith McCoy: referrals to providers or another care manager training and treatment means for families and guardians.

249
00:44:15.990 --> 00:44:29.760
Keith McCoy: And also may include exploring and securing appropriate and available additional funding working through potential funding needs with Community providers such as managing spend nouns if needed prior to discharge next one.

250
00:44:34.290 --> 00:44:46.260
Keith McCoy: So a little bit of a closer look at what this might look like, for example, for a tailored care manager is working with a member and appear tf or congregate level child residential placement level to program three or four.

251
00:44:46.830 --> 00:44:52.200
Keith McCoy: So, remember, maybe in a PR tf or these other congregate levels of residential care.

252
00:44:53.010 --> 00:45:02.430
Keith McCoy: During that time the care managers going to need to be land on lay eyes on the child when they're there and making sure that that setting safe for them and providing enrich services.

253
00:45:02.670 --> 00:45:12.330

Keith McCoy: Helping to educate them about and their families and caregivers as well as the facility, where they are what other options, they may have that are working unity integrated.

254
00:45:13.500 --> 00:45:19.410
Keith McCoy: they'll discuss those work with them and deciding what their next steps will be and then based upon that.

255
00:45:19.950 --> 00:45:31.680
Keith McCoy: Help them Member transition back to their home where the care manager provides the transition services coordinating with the Members larger care team, as we have described earlier, and then on later signs.

256
00:45:32.190 --> 00:45:39.930
Keith McCoy: And then, once the Member has transitioned back to their home the care manager continues to provide Taylor Canyon and services next slide.

257
00:45:43.830 --> 00:45:54.240
Keith McCoy: So a little bit of a closer look, about what the role of care managers would be for Member aged 18 or older in a state psychiatric hospital or an adult care.

258
00:45:55.110 --> 00:45:56.460
Keith McCoy: So the care manager will pay.

259
00:45:57.120 --> 00:46:12.780
Keith McCoy: A key leadership role and each members care team and are responsible for coordinating across all the Members needs were not leading in REACH and transition activities, the care managers will collaborate with the Taylor plan in REACH and transition staff.

260
00:46:13.170 --> 00:46:20.100
Keith McCoy: Who will be leading those in REACH and transition activities, so if a Member is in a state psychiatric hospital or adult care home.

261
00:46:20.370 --> 00:46:28.800
Keith McCoy: A peer support specialists based a detailed plan would provide in REACH services, it would be important if someone is actively entailed care management during that time.

262
00:46:29.070 --> 00:46:35.790

Keith McCoy: For that Taylor care manager, to make sure that that happens and ensure that that referral has been made to that enrich specialist.

263
00:46:36.420 --> 00:46:43.620
Keith McCoy: When a Member is transitioning from one State psychiatric hospital or don't care home to support it, housing permanent supportive housing.

264
00:46:44.250 --> 00:46:50.100
Keith McCoy: The plan based transition coordinator, we provide the transition services.

265
00:46:50.550 --> 00:46:56.820
Keith McCoy: If the Member remains eligible for tailored care management, while they're at the state psychiatric hospital, so if they're under age 21.

266
00:46:57.210 --> 00:47:05.280
Keith McCoy: Where if they're an adult care home that's not an IMD where they continue to have active medicaid but tailored care manager remains an important part of the team.

267
00:47:05.580 --> 00:47:14.820
Keith McCoy: Though in REACH and transitions specific services are led by the tailored plan in region transition staff, when the Member has transitioned back to the Community.

268
00:47:15.540 --> 00:47:25.050
Keith McCoy: The care manager that Taylor care manager continues to provide the tailored care management services and a warm handoff to the care manager will take place upon discharge.

269
00:47:25.590 --> 00:47:35.880
Keith McCoy: The tender plan transition coordinator will remain a part of the Members care team until 90 days post discharge to ensure the Member is receiving the transition related services.

270
00:47:36.240 --> 00:47:45.450
Keith McCoy: Other things that go beyond that 90 days will be handed off to that Taylor other transition elements that are needed to be on those 90 days we transition to that tailored care manager.

271
00:47:45.660 --> 00:47:54.990

Keith McCoy: For ongoing supports that trend that Taylor plan transition coordinator will really always be in the back there in the background for helping me then next one.

272
00:47:57.930 --> 00:48:04.350
Keith McCoy: Alright, so we now have some time for questions we understand that there was a lot of dense information.

273
00:48:04.740 --> 00:48:19.200
Keith McCoy: In that and I just want to reiterate that this is an extremely important part of tailored care management and under tailored plan designed to ensure that individuals who are going through healthcare transitions and.

274
00:48:19.530 --> 00:48:34.230
Keith McCoy: Those who may be at risk for already are in institutional or congregate settings have the chance to understand it make choices to be in more Community integrated settings above and beyond what the state is developed the transitions to community living.

275
00:48:35.370 --> 00:48:38.070
Keith McCoy: process that we've had in place for the past decade.

276
00:48:38.550 --> 00:48:44.220
Keith McCoy: we're excited about these resources we understand these handoffs are really important and complicated.

277
00:48:44.430 --> 00:48:50.250
Keith McCoy: But we know that the tailored care management program is going to be essential to helping people achieve.

278
00:48:50.430 --> 00:48:57.630
Keith McCoy: What they want for their lives in the sense that they want to achieve them and we're excited about building these programs over the next few years.

279
00:48:57.930 --> 00:49:12.780
Keith McCoy: Like to help make Community integrated settings more accessible and more reachable for individuals in North Carolina, so we will now help to answer some questions and I don't know if we've got somebody to help us about.

280
00:49:13.830 --> 00:49:24.180
Bryant Torres: This it's Nike thanks so much to you to crystal when for such an informative conversation really appreciate.

281
00:49:25.560 --> 00:49:31.470
Bryant Torres: The knowledge and the in the scenario is very helpful so yeah we have a number of questions that have come in.

282
00:49:33.210 --> 00:49:36.510
Bryant Torres: I think there's a few related to.

283
00:49:37.800 --> 00:49:55.140
Bryant Torres: You know what are the expectation or allowances for virtual or phone engagement, especially considering covert visitation restrictions at Inpatient facilities so any thoughts or guidance on that question.

284
00:49:56.010 --> 00:50:04.800
Keith McCoy: yeah I can provide a little bit of feedback there so we're hoping that we will be out of the public health emergency, by the time that tailored plans launch.

285
00:50:05.640 --> 00:50:20.880
Keith McCoy: But and we've established and in the tailored care management model some minimum contact requirements, some of which have to be in person, we realize continue to assess the degree to which that is safe.

286
00:50:22.260 --> 00:50:25.230
Keith McCoy: As the pandemic continues to unfold.

287
00:50:25.650 --> 00:50:39.900
Keith McCoy: and anticipate that we will make sure that everyone is aware, where it may be appropriate to transition from in person to tell a help sort of face to face but virtual options, but at this point.

288
00:50:40.200 --> 00:50:53.040
Keith McCoy: For what we're planning, we want to plan for a non endemic world, and so we want to make sure that Taylor care management seeds are planning for in person contacts as required.

289
00:50:55.740 --> 00:50:56.310
Keith McCoy: Thank you.

290
00:50:57.630 --> 00:51:00.450
Bryant Torres: So another question.

291
00:51:01.980 --> 00:51:20.910
Bryant Torres: i'm asking how amy provider damage, plus a cma can effectively support me inclusions given that housing is such an issue for a number of individuals so that's a big big issue and big question, but any thoughts or recommendations there.

292
00:51:22.410 --> 00:51:28.560
Keith McCoy: So I may phone a friend, a little bit with with Jamie shaver who's here with us, but to speak about the tailored plan.

293
00:51:28.980 --> 00:51:31.770
Keith McCoy: tethered plans do you have to have housing specialists.

294
00:51:31.980 --> 00:51:46.530
Keith McCoy: And the tailored plans those housing specialist will be working very closely with the tailored career management entities so cna damage classes, as well as tailored plan care managers around Community based housing plans understanding, where their housing grants and.

295
00:51:46.800 --> 00:51:59.280
Keith McCoy: Where there may be vouchers, but through the transitions to community living process that we've had in North Carolina we've really done a lot to develop housing resources and Jamie I don't know if you're available to talk a little bit.

296
00:52:00.180 --> 00:52:09.780
Janie Shivar: shorter short thing Dr McCoy no problem and you're absolutely right on the transitions to community living initiative and the work that we have done, I.

297
00:52:10.530 --> 00:52:27.420
Janie Shivar: You know in in that program over the past few years has made tremendous strides and laid a lot of groundwork for on working collaboratively with the North Carolina housing finance agency.

298
00:52:29.340 --> 00:52:40.980
Janie Shivar: federal partners, as well as connecting all of those two local housing agencies in in counties and in regions.

299
00:52:43.110 --> 00:52:55.020
Janie Shivar: Housing writer stephanie Williams, in her predecessors have have just made tremendous strides in this area, and you know really found.

300

00:52:55.620 --> 00:53:09.180
Janie Shivar: been found a lot of creative ways to help support you know expanding available housing options for folks and some of the other things that we have.

301
00:53:09.900 --> 00:53:25.740
Janie Shivar: attended to, as well in that vein are looking at you know some of the barriers that the folks that we serve can often face in getting into housing, such as credit history issues, and you know.

302
00:53:26.610 --> 00:53:33.990
Janie Shivar: Three and working with various partners on getting those kinds of issues resolved so that we can.

303
00:53:35.010 --> 00:53:51.720
Janie Shivar: help to move folks into supported housing on we do see as well that the the Community inclusion component employment is a huge huge issue and really anchoring people.

304
00:53:52.350 --> 00:54:03.390
Janie Shivar: In their community and and having them feel a part of their community, the same way that we all do, working in the Community being engaged in Community activities.

305
00:54:04.230 --> 00:54:17.220
Janie Shivar: is a really crucial component and it's something that we continue to refine up through transitions to community living and we'll also be doing in our larger olmstead work in the coming years as well.

306
00:54:19.980 --> 00:54:23.280
Bryant Torres: hey thanks so much Jamie and Dr McCoy.

307
00:54:24.330 --> 00:54:40.860
Bryant Torres: We have time for maybe one or two more questions so this one here says transitions from hospital services to Community are currently a focus of healthcare organizations and pay organizations.

308
00:54:42.750 --> 00:54:48.570
Bryant Torres: The question is, is the transition plan duplicative in the case of health care transitions.

309
00:54:49.800 --> 00:54:54.750
Bryant Torres: And how can, how will the service be coordinated with health currency to prevent that duplication.

310
00:54:56.550 --> 00:55:02.310
Bryant Torres: So any guidance on roles responsibilities and overlap, or lack thereof.

311
00:55:03.720 --> 00:55:12.780
Keith McCoy: Right so certainly healthcare system it's like hospitals have a lot of incentive to make sure that they've got some cases.

312
00:55:13.800 --> 00:55:17.520
Keith McCoy: it's a case management supports, which is different than peer management.

313
00:55:18.840 --> 00:55:36.510
Keith McCoy: To try to help reduce the likelihood of a readmission to try to make sure there's not a bounce back, and they have their own financial incentive with that and certainly folks are right they've invested and care coordination and case management supports that help will help produce those.

314
00:55:37.680 --> 00:55:39.660
Keith McCoy: For those who are in town of care management.

315
00:55:40.380 --> 00:55:51.660
Keith McCoy: The quarterback really is the tailored campaign manager right but that doesn't mean some roles aren't going to be played by other players who are part of their care team right so while they're in a hospital.

316
00:55:52.020 --> 00:56:02.700
Keith McCoy: Their care team includes that hospital and the hospital case manager that may be the one that's primarily working on referrals to a skilled nursing facility or refer working on referrals to home.

317
00:56:03.630 --> 00:56:09.690
Keith McCoy: But it's up to that tailored care manager, to make sure I know what that case manager at the hospital is doing.

318
00:56:10.020 --> 00:56:23.370
Keith McCoy: I am monitoring, to make sure that it's done in a timely manner i'm making sure that that case manager that that healthcare setting understands all the other needs that the Member that i'm caring for has and are directing.

319
00:56:23.640 --> 00:56:34.770

Keith McCoy: Their efforts in ways that are consistent with what the whole person needs are for this individual that i'm that i'm representing and that we're caring for so.

320
00:56:35.790 --> 00:56:49.020
Keith McCoy: There is always the risk of duplication, that that duplication would be existing if the care manager isn't paying attention to what these other entities are doing and isn't monitoring or ensuring that they're appropriate and then everybody's working in the same direction.

321
00:56:49.380 --> 00:57:03.930
Keith McCoy: So ultimately it's the responsibility of the tired care manager to do those connections be informed about who's who's taking care of what tasks and make sure that that isn't being duplicated or worked against my other tasks and others.

322
00:57:06.360 --> 00:57:20.610
Bryant Torres: Thank you so much right, I think one more, and this, I think this one's for when around at to alert does a cma need to have a contract agreement with a provider to receive alerts.

323
00:57:22.770 --> 00:57:31.710
Gwendolyn Sherrod: Well, the expectation is that organizations, providing Taylor care management will will be required to have access to ATT data.

324
00:57:32.220 --> 00:57:45.780
Gwendolyn Sherrod: That will identify when members of transitioning into and out of emergency departments are hospitals in real time or near real time, so we would.

325
00:57:46.290 --> 00:57:59.340
Gwendolyn Sherrod: Have we have that expectation that you would have some mechanism in place to receive those those that bad information, so it could be that your ehr or.

326
00:58:00.840 --> 00:58:02.430
Gwendolyn Sherrod: Care manager platform.

327
00:58:04.170 --> 00:58:14.940
Gwendolyn Sherrod: can receive that that information or you would contract with another organization or utilize the tailor plans.

328
00:58:17.190 --> 00:58:20.010
Gwendolyn Sherrod: Care management system to be able to.

329
00:58:21.990 --> 00:58:25.710
Gwendolyn Sherrod: receive and in just that that that information so.

330
00:58:27.360 --> 00:58:31.290
Gwendolyn Sherrod: You would have to have that that process in place.

331
00:58:32.910 --> 00:58:37.980
Gwendolyn Sherrod: to receive that information, I mean it's it's critical for.

332
00:58:39.030 --> 00:58:44.130
Gwendolyn Sherrod: The care management, the care manager to receive to be able to receive that information.

333
00:58:46.410 --> 00:59:03.660
Bryant Torres: Thanks so much when Dr mccord janie and crystal we are at time and everyone is probably has another meeting or clients to see so Thank you everyone for joining um any parting thoughts from the north Carolina team.

334
00:59:05.700 --> 00:59:14.760
Keith McCoy: nope Thank you everybody for your participation and know we're all in this together so we'll all get over the finish line together and look forward to additional sessions, thank you.

335
00:59:15.990 --> 00:59:18.390
Krystal Hilton: Thank you all so much have a great afternoon.

336
00:59:19.860 --> 00:59:35.940
Gwendolyn Sherrod: Can I can I reiterate one point that the the recordings and transcripts and slides for these will be posted on the Taylor career management web page, we have also.

337
00:59:37.050 --> 00:59:40.500
Gwendolyn Sherrod: Recently posted information in the.

338
00:59:44.070 --> 00:59:55.140
Gwendolyn Sherrod: on capacity building and as well as the updated data strategy, so all that information is on the Taylor care management website and we look forward to seeing you next week.

339
00:59:56.400 --> 01:00:10.290

Gwendolyn Sherrod: On November 19 when we talk about conflict free care management and additional care coordination functions are members enrolled in the innovations are tbi waiver, so thank you and look forward to seeing you next week.