

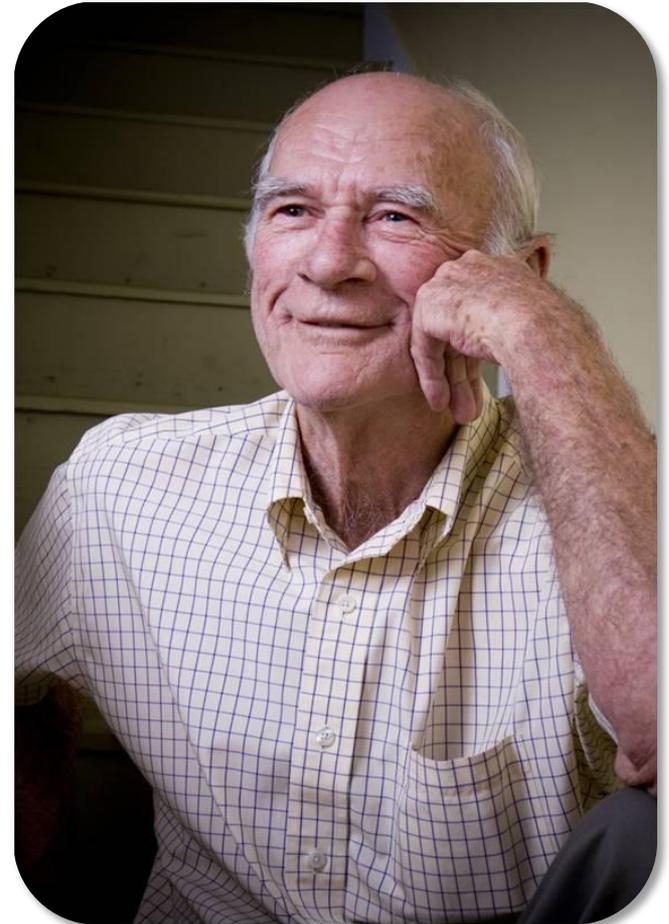


COLORADO  
**CHOICE** TRANSITIONS  
YOUR PATH TO INDEPENDENCE

# Welcome

Presented by:

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Policy & Financing



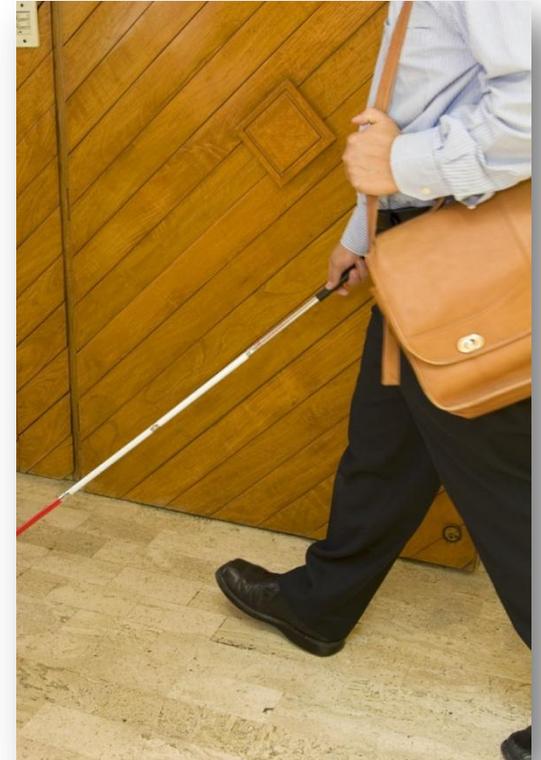
*Our Mission:*

**Improving** health care access  
and outcomes for the **people**  
we serve while demonstrating sound  
stewardship of financial **resources**



# Purpose

- Learn the process involved in transitioning a client from a nursing facility to the community through the Community Transition Services Program



# Community Transition Services (CTS)

- Services provided by a Transition Coordinator to help an individual relocate to the community
- Provided through the HCBS-EBD waiver and the Colorado Choice Transitions program



# What's the difference?

## HCBS – EBD

- Clients must meet HCBS EBD waiver eligibility criteria
- Informed Consent Form not required
- No length of stay requirement
- TC rate = \$850.00
- Household Set up = \$1150
- Housing options do not have to meet CCT “Qualified Housing” criteria
- Will not receive CCT services after discharge

## CCT

- Must meet eligibility criteria for one of waivers
- Must sign CCT Informed Consent Form
- Must be LTC resident for 90 days not including rehab
- TC rate = \$2000
- Household Set Up = \$1500
- Must move into “Qualified Housing”
- Will receive CCT services after discharge



# Qualified Housing



Home owned or leased by individual or individual's family member



Residence in community-based setting with no more than 4 unrelated individuals



Apartment with individual lease

- Living, sleeping, bathing & cooking areas
- Lockable access and egress
- Services not condition of tenancy

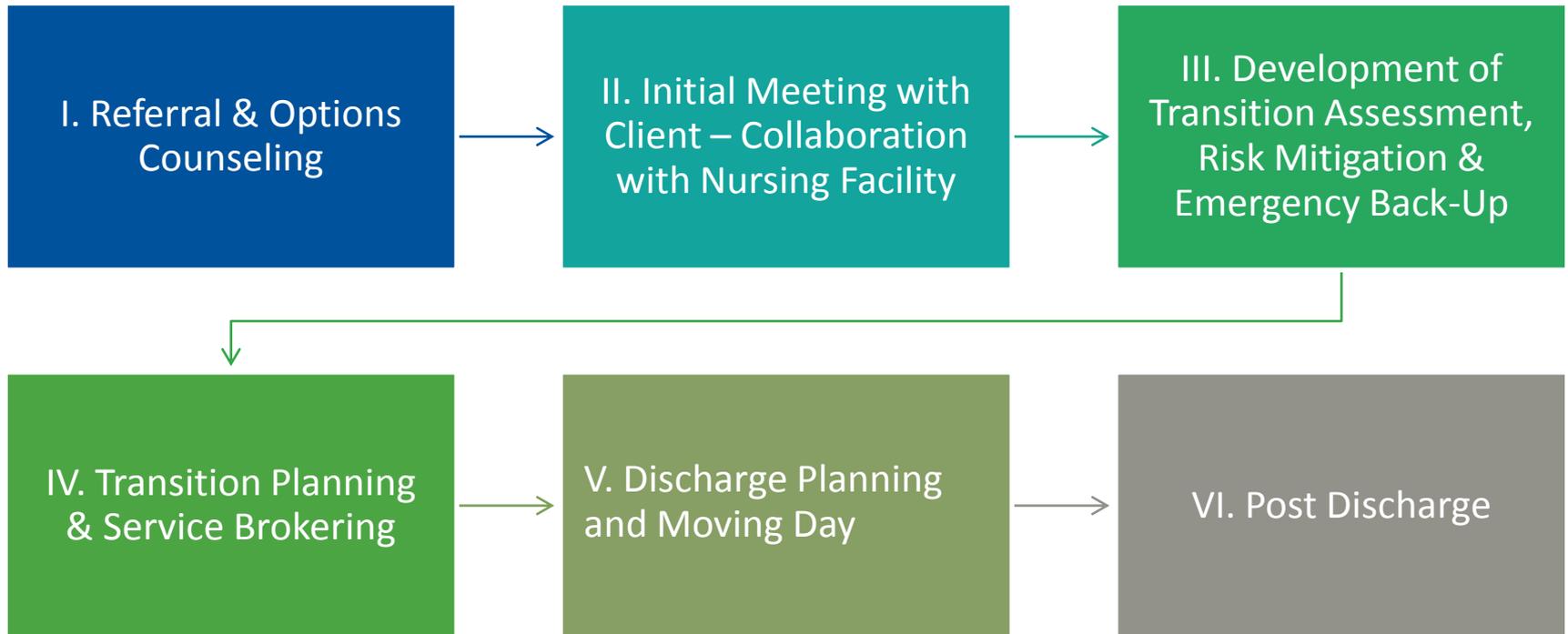


# How Are They The Same?

- Transition Coordinator Roles & Responsibilities
- Community Living Process Transition Model
- Documentation
- Reporting
- BUS
- Billing & Reimbursement Procedures



# Community Living Options Process



# Community Living Options Process Check List

Purpose:

- ✓ Assist with tracking progress
- ✓ Coordinate activities
- ✓ Clarify roles & responsibilities
- ✓ Establishes typical transition sequence



## Acronyms :

ARCH – Adult Resources for Care and Help

CCT – Colorado Choice Transitions

CM – Case Manager

CTS – Community Transition Services

EBD – Elderly, Blind, People with Disabilities

HCBS – Home & Community-Based Services

ICM – Intensive Case Manager (CCT only)

TA – Transitions Administrator

TC – Transition Coordinator

TCA – Transition Coordination Agency



# I. Referral & Options Counseling

## Players

- ARCH – Pueblo, Weld, Larimer
- TC – all other counties
- Referral Sources

## Tasks

- Receive referral
- Meet with client
- Communicate with nursing facility

## Documents

- Transition Referral Information Form
- CCT Informed Consent Form



# Referral & Options Counseling

- Referrals can come from any source
- Not all referrals will result in a transition
- Same procedure is followed for all types of referrals



- In ***Pueblo, Larimer*** and ***Mesa*** counties the Adult Resources for Care and Help (ARCH) will receive and respond to referrals
- In all other counties referrals will be made to TCAs
- Nursing facilities will have list of ARCHs and TCAs



## I. Referral & Options Counseling

Receive referral via phone or secure e-mail – complete top half of *Transition Referral Information Form*

Schedule options information meeting with client.

Meet with client and provide information regarding:

- Community based services
- Housing
- Transition services options (Medicaid CTS/HCBS-EBD or CTS/CCT)
- Transition process and coordinator

Complete bottom half of *Transition Referral Information Form*. Request client to sign form.

If client has chosen CTS/CCT – explain *CCT Informed Consent Form* to client and request their signature. (CCT Only)

Obtain copy of doctor's admitting orders to determine rehab status.

Provide client with Transition Coordinator Agency (TCA) choices. Refer to TCA chosen by client.

Inform nursing facility of client choice.

Give nursing facility a copy of signed *Transition Referral Information Form*.

Submit *CCT Informed Consent Form* to HCPF CCT Transition Administrator (TA).

Inform nursing facility of client choice.



# Transition Options

- Medicaid & HCBS eligible – Community Transition Services through CCT or HCBS-EBD
- Medicaid – transition without CTS
- Non-Medicaid – CTS not an option



## If client chooses CTS

Assist client to choose TCA

Provide CCT service & eligibility information



## If Client chooses CCT



## Confirm eligibility criteria

Complete CCT Informed Consent Form

Obtain doctor's admitting orders to verify rehab status



## II. Initial Meeting with Client – Collaboration with Nursing Facility

### Players

- TC
- ICM or CM

### Tasks

- Meet with client
- Refer client case management agency
- Collaborate with nursing facility
- Determine initial functional eligibility status

### Documents

- CTS Authorization for Release of Information
- Self- Reflection Guide - client completes with assistance as needed (optional)



## II. Initial Meeting with Client – Collaboration with Nursing Facility

Contact nursing facility to inform of TC assignment and coordinate meeting with client.	TC
Contact client and schedule first meeting.	TC
Meet with client and complete the following: <ul style="list-style-type: none"> <li><input type="checkbox"/> Explain <b>Authorization for Release of Information Form</b> and request client signature.</li> <li><input type="checkbox"/> Discuss client desires, preferences and concerns.</li> <li><input type="checkbox"/> Explain transition process and transition options team and client’s role and responsibility.</li> <li><input type="checkbox"/> Identify Transition Options Team members.</li> <li><input type="checkbox"/> Give client copy of <b>Self-Reflection Guide</b> and explain its purpose.</li> </ul>	TC
Consult with nursing facility to schedule a time and place for the first transition options team meeting.	TC
Refer client to the appropriate case management agency.	TC
Inform assigned Intensive Case Manager (ICM) or HCBS-EBD CM about the transition options team and first meeting.	TC
Request an initial screening for functional eligibility by phone from ICM or HCBS-EBD CM.	TC
Conduct initial screening for functional eligibility and inform TC of preliminary finding.	ICM or CM



# III. Development of Transition Assessment, Risk Mitigation & Emergency Back-Up

## Players

- TC
- Client
- Transition Options Team

## Tasks

- Complete, review and approve Transition Assessment & Community Needs Inventory
- First Transition Options Team Meeting
- Completion of Transition Assessment
- Risk Factors Identified
- Risk Mitigation Plans developed
- Emergency Back Up plan started

## Documents

- Plan for Community Living Guide ( client completes with assistance as needed (optional)
- Risk Mitigation Plan
- Participant Risk Agreement
- Emergency Back Up Plan



# III. Development of Transition Assessment, Risk Mitigation & Emergency Back –Up

<p>Plan first Transition Options Team meeting:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Contact potential team members</li> <li><input type="checkbox"/> Explain their process and their role</li> <li><input type="checkbox"/> Provide first meeting details (time &amp; location)</li> <li><input type="checkbox"/> Send blank <b><i>Transition Assessment and Community Needs Inventory</i></b> to members. Request completion of area of expertise and/or experience with the client.</li> <li><input type="checkbox"/> Request completed assessment be sent back by a certain date (prior to first meeting)</li> <li><input type="checkbox"/> Give copy of <b><i>Plan for Community Living Guide</i></b> to the client and explain its purpose</li> </ul>	TC
<p>Use the <b><i>Self-Assessment</i></b> and <b><i>Plan for Community Living Guides</i></b> to facilitate a discussion with client to identify his/her needs, preferences, and desires.</p>	TC
<p>Gather assessment information from each team member (including client’s information) and compile onto a master <b><i>Transition Assessment and Community Needs Inventory</i></b>.</p>	TC
<p>Facilitate the first Transition Options Team meeting:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Review completed <b><i>Transition Assessment and Community Needs Inventory</i></b>.</li> <li><input type="checkbox"/> Review client’s completed <b><i>Self-Assessment</i></b> and <b><i>Plan for Community Living Guides</i></b></li> <li><input type="checkbox"/> Revise assessment as needed during the meeting until the team agrees that it is accurate and complete.</li> <li><input type="checkbox"/> Identify risk factors indicated on the <b><i>Transition Assessment</i></b> and <b><i>Community Needs Inventory</i></b>.</li> <li><input type="checkbox"/> Develop <b><i>Risk Mitigation Plans</i></b> to address each identified risk factor.</li> </ul>	TC
<p>If <b><i>Risk Mitigation Plans</i></b> have been developed, obtain client signature on <b><i>Participant Risk Agreement</i></b>.</p>	TC
<p>Begin <b><i>Emergency Back Up Plan</i></b> using the <b><i>Emergency Planning Guide</i></b> and have client sign when complete.</p>	TC



# Transition Assessment

- Assesses client's strengths, challenges, commitment, abilities, motivation
- Each member of the transition team will provide input  
Sections completed by those who have expertise or experience with the client
- Reflects full range of clients needs , preferences, desires
- Must include type, scope, amount, duration & frequency of support & services
- Identifies independent living/community integration goals
- Transition options team determines if assessment is accurate & complete



# Risk Assessment

## Identification of:

- Risks associated with daily life in the community that may negatively impact a client's ability to live in the community

\* Behavioral Health

\* Medication

\* Health and Wellness

\* Nutrition

\* Personal safety

\* Environment

\* Resources



# Risk Mitigation

- Planning to reduce risk of harm
- Strategy identification
- Client involvement
  - Participant Risk Agreement



# Emergency Backup Plan

Emergency Backup Planning:  
One strategy for risk mitigation



# IV. Transition Planning & Service Brokering

## Players

- TC
- Client
- ICM or CM
- Transition Options Team
- TA

## Tasks

- Complete, review & approve Transition Plan
- 2<sup>nd</sup> & 3<sup>rd</sup> Transition Options Team meetings
- Service Brokering
- Establish functional eligibility
- Obtain TA approval for transition
- Complete/submit /approve Authorization Request & Cost Report
- CCT or HCBS-EBD Service Plan completed in BUS

## Documents

- Transition Plan
- Authorization Request and Cost Report



# IV. Transition Planning & Service Brokering

<p>Transfer all identified needs, desires, preferences on the assessment/community inventory forms to the <b>Transition Plan</b> in the Assessed Need column.</p>	<p>TC</p>
<p>Facilitate second Transition Options Team meeting:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Review the <b>Transition Plan</b> and obtain team approval that it includes all supports/services/preferences indicated on the <b>Transition Assessment, Community Needs Inventory</b> and client’s <b>Self-Assessment</b> and <b>Plan for Community Living</b>.</li> <li><input type="checkbox"/> Use the Service Referral Tool to determine appropriate person on the team to determine if supports/services are available as stated on the Transition Plan and to broker services.</li> </ul>	<p>TC</p>
<p>Conduct ULTC 100.2 to determine functional eligibility for HCBS and begin service planning and brokering.</p>	<p>ICM or CM</p>
<p>Submit <b>Transition Assessment, Transition Plan, Risk Mitigation Plan and Participant Agreement</b> to Transitions Administrator (TA) (HCPF) via secure e-mail or fax 303-866-2786</p>	<p>TC</p>
<p>Facilitate third Transition Options Team</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Review Transition Plan to determine if providers have been obtained for all required supports and services</li> <li><input type="checkbox"/> If required supports/services can be obtained, a discharge date can be established based on the date of service initiation</li> <li><input type="checkbox"/> If a provider is not available for a required support or service, develop alternative plan to address that need</li> <li><input type="checkbox"/> Obtain team approval for alternative plan</li> <li><input type="checkbox"/> If team approval cannot be obtained for an alternative plan that will provide for the client’s health, welfare and safety, a transition cannot occur through CTS at this time. A request to review this situation can be made through a transition decision review process.</li> </ul>	<p>TC</p>



Approve <b>Transition Plan, Risk Mitigation and Participant Risk Agreements</b> and inform TC and ICM/CM within 48 business hours.	TA
Provide copies of <b>Transition Plan, Risk Mitigation Plan</b> and <b>Participant Risk Agreement</b> to ICM/CM.	TC
Complete <b>Authorization Request and Cost Report</b> . Submit to CMA.	TC
Approve <b>Authorization Request and Cost Report</b> within 10 business days and notify TC.	ICM or CM
Complete <b>Emergency Back-Up Plan</b> and retain for client records.	ICM or CM
Complete service plan in BUS. <input type="checkbox"/> SEP - Enter summary of Emergency Back-Up Plan and Risk Mitigation Plan in the Contingency Plan Section in the BUS. <input type="checkbox"/> CCB - Enter summary of Emergency Back-Up Plan in the Contingency Section and complete the Risk Mitigation Section in the BUS.	ICM or CM
Give copy of the <b>Planning a Successful Move</b> to the client and explain its purpose.	TC
Establish discharge date when: <input type="checkbox"/> Team agrees that required support/services are available as stated on the <b>Transition Plan</b> and will begin the day of discharge. <input type="checkbox"/> <b>Risk Mitigation Plans</b> are sufficient to address indentified risks.	Transition Options Team



# Transition Plan

- Details how transition will be implemented
- Contains specifics about client needs, desires, and preferences
- Includes every need and risk factor identified on assessments as outlined on the assessment
- Confirms availability of required supports/ services
- Transition Options Team agreement



# Service Plan (CCT or HCBS-EBD)

## Informed by

- Transition assessment/plan
- Client's level of functioning
- Client goals and needs
- Available resources

## Approved by

CTS Transition Administrator  
before transition occurs

## Developed by

- Transition Coordinator
- Discharging facility
- Client or guardian//Family

## Additional Documents

- Risk mitigation Plan
- Emergency Backup Plan

# Discharge Date can be established if:

- All supports & services have been arranged
- Health, welfare and safety of client ensured – Risk Mitigation Plans
- Qualified providers are available as outlined on the Transition Assessment
- Transition Options Team is in agreement



# What happens if support/service is not available?

- Develop an alternative plan to meet the assessed need
- Team & State must approve the plan
- If plan approved – discharge date can be established
- If plan not approved – transition can not occur through CTS at this time



# Authorization Request/Cost Report (AR/CR)

## Transition Coordinator

- Includes copies of cancelled checks & receipts for purchases
- Ensures all expenses requested are on Transition Plan

## Case Manager

- Reviews AR/CR
- Confirms client is in community-based residence
- Notifies TC of approval within 10 business days of receipt of the AR/CR

## Transition Coordinator

- Submits claim to Department's fiscal agent for reimbursement



# V. Discharge Planning and Moving Day

## Players

- ICM or CM
- TC
- Nursing Facility Staff
- TA

## Tasks

- CCT TA notified of discharge date
- Quality of Life Survey completed (CCT only)
- Case management eligibility/enrollment completed
- HCBS “rollover” occurs
- Household set up finalized
- Nursing facility completes discharge plan
- Client moves

## Documents

- Planning a Successful Move Guide client completes with assistance as needed (optional)

## V. Discharge Planning and Moving Day

Arrange HCBS services with client and support network.	ICM or CM
Notify CCT TA of discharge date.	TC
Complete Quality of Life Survey and submit to Department ( <b>CCT Only</b> )	ICM
Issue new certification page and submit to eligibility site.	ICM or CM
Complete CCT or HCBS-EBD PAR. <b>For CCT clients</b> , PARs are submitted to Department for review.	ICM or CM
Obtain physician orders, complete facility specific discharge plan, and submit 5615 to eligibility site.	NF
Confirm that “HCBS Rollover” was completed in CBMS by County Eligibility Staff by day of discharge.	ICM or CM
Using the <i>Planning a Successful Move Guide</i> develop a moving plan with client, support network, ICM or CM and nursing facility staff	TC
Schedule any health and safety assurances that are needed prior to the discharge date.	TC
Purchase, with client, items needed to set up household.	TC
Assist client to set up household.	TC
Facilitate moving plan on day of discharge, ICM or CM is present at facility day of discharge.	TC



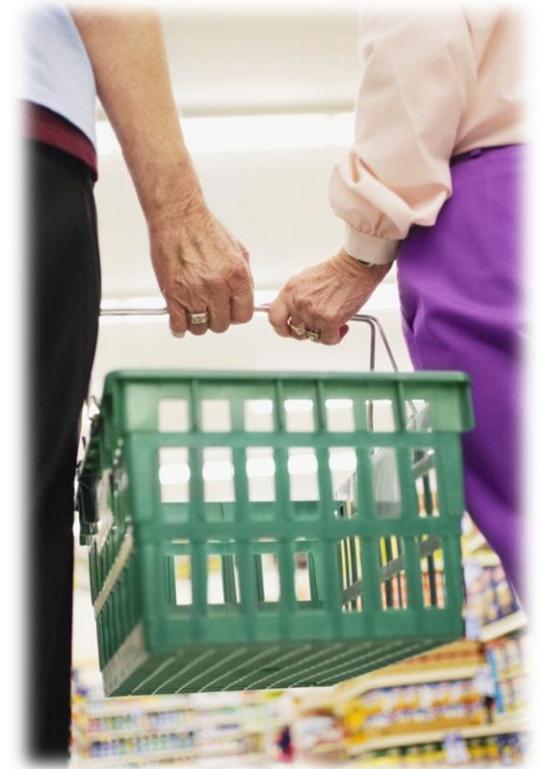
# Getting Client Set Up

- Security deposits
- Utility fees
- Essential household items & furnishings
- Moving expenses
- Health & safety assurances
- Groceries \$100



# Household Set-up Expenses

- Items purchased shall be property of client
- Reimbursement for items listed on transition plan with accompanying receipt
- Will not exceed established amount, unless authorized



# VI. Post Discharge



## Players

- TC
- ICM or CM
- Client
- TCA



## Tasks

- Home Visits
- Joint monitoring for 30 days
- Service plan or risk mitigation plan revised as needed
- Service reimbursement process finalized
- Community Transition Report submitted



## Documents

- Community Transition Report
- Community Transition Services Monthly Referral Log



## VI. Post Discharge

Meet with client at their new home the day of the move. Ensure required supports and services are in place and household set up is complete. <b>For CCT clients, ICM will also meet with client.</b>	TC ICM (CCT Only)
Confirm client has <b>Emergency Back Plan</b> and understands its purpose.	TC
Submit final <b>Authorization Request/Cost Report</b> with cancelled checks and receipts for purchases to case manager.	TC
Review <b>Authorization Request/Cost Report</b> . Confirm client has discharged to community-based residence. Notify TC of approval within 10 days.	ICM or CM
Meet with client in home one week and one month after transition to: <ul style="list-style-type: none"> <li><input type="checkbox"/> Ensure required supports and services are in place.</li> <li><input type="checkbox"/> Ensure <b>Risk Mitigation Plans</b> are being followed.</li> <li><input type="checkbox"/> Determine if changes to supports, services or <b>Risk Mitigation Plans</b> are needed</li> </ul>	TC
<b>For CCT only</b> , conduct 48 hour check-in with client and weekly visits in the first month post-discharge. Joint visits with the TC are encouraged.	ICM
If changes are needed, ICM or CM, TC, client and providers (as needed) meet to establish changes. A new <b>Community Transition Participant Risk Agreement</b> must be completed to encompass any changes to a <b>Risk Mitigation Plan</b> .	Client, TC or ICM and TC
Revise the service plan based on changes.	ICM or CM
File new copies of the <b>Risk Agreement</b> and the <b>Risk Mitigation Plan</b> in the client's file.	ICM or CM
Submit CTS claim to Department's fiscal agency for reimbursement/payment.	TC
Submit <b>Community Transition Report</b> to TA via secure e-mail or fax 303-866-2786.	TC
Close CTS case 30 days after discharge.	TC
List referral and transition on the <b>Community Transition Services Monthly Referral Log</b> .	TC
Submit <b>Community Transition Services Monthly Referral Log</b> to TA by the 5 <sup>th</sup> of each month via secure e-mail or fax 303-866-2786.	TCA 38

