Transition Coordinator & Intensive Case Manager Training

Presented by:
CCT Team
Colorado Department of Health Care Policy & Financing
Our Mission:

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

• Understand Colorado Choice Transitions (CCT)
• Guide a client through a successful transition to the community

Explore Interest
Identify Needs
Secure Resources
Move to Community
Overview

- Colorado’s Money Follows the Person (MFP) initiative, CCT, facilitates transition of people from Long-Term Care (LTC) facilities to community living
- $22M grant for 5 years from Centers for Medicare and Medicaid Services (CMS)
History of Money
Follows the Person

- MFP born of Supreme Court’s landmark decision *Olmstead v. L.C*, 527 U.S. 581 in 1999
- Authorized in Deficit Reduction Act of 2005
- Expanded through the Affordable Care Act
CMS Goals for CCT

• Increase HCBS
• Eliminate barriers to client’s choices for community living
• Ensure continuous quality assurance
Colorado’s CCT Goals

• Transition 490 people by 2016
• Increase investments in HCBS
• Streamline access to LTSS
• Increase housing options
• Expand consumer direction
• Expand array of LTSS
Increased Federal reimbursement for CCT services

25 ¢ of each dollar received dedicated to rebalancing fund
CCT Eligibility

- Meet long-term care Medicaid eligibility requirements
- Currently residing in long-term care facility (minimum 90 consecutive days)
- Move into qualified housing
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
CCT Eligibility Span

Client in facility; Medicaid begins

Transition to community

365 days post transition

365 days of CCT Services

HCBS Waiver Services

State Plan Benefits
System Collaboration
Elements of Positive Interdependence

- Task
- Goal
- Sharing
- Role
- Info
Regional Transition Committee (RTC)

Develop Regional Transition Strategy

- Sustain community living
- Promote & support transitions
- Problem identification & resolution
- Process evaluation
- Ongoing communication & collaboration
RTC Members

• Transition Coordinators
• Service Providers
• Nursing Facilities
• Mental Health Centers
• Community Centered Boards (CCBs)
• Single Entry Points (SEPs)
• Housing Authorities
• Area Agencies on Aging (AAAs)
• Ombudsmen
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 at least one waiver
- 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
How Are They The Same?

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

Explore Interest
Identify Needs
Secure Resources
Move to Community
Providing Options

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Referrals

• Referrals for transition services can come from any source:
  – The resident
  – NF social worker
  – Family and/or friends

• TCs follow same procedure for all types of referrals
Minimum Data Set (MDS) Assessment

- MDS assessment is required for all nursing facility residents
  - Upon admission
  - Quarterly
  - Upon significant change in condition

Are you interested in speaking to someone about the possibility of returning to the community

- Yes
- No
- Not sure
MDS Q Referral to Transition Coordinator Agency

“Are you interested in speaking to someone about the possibility of returning to the community?”

**YES**

More information regarding community living options & transition process is given

**Does not** commit a resident to leave NF at a specific time
Role of Local Contact Agency

- Meet with resident within 10 days of referral
- NF staff consultation regarding referral
- Provide information about community living options, transition process & TC role
- Answers resident’s questions and helps explore transition options
- Residents asked if they want to explore transition
  - If yes, referral to TC is made
Roles & Responsibilities
Transition Coordinator
Relationship Building & Transition Coordination

- Explain transition process & procedures
- Assist with paperwork
- Support client decision-making
- Explain client responsibilities
- Facilitating meetings
- Encourage client participation & self-assessment
- Clarify client’s personal goals
Identify Needs

Explore Interest  Identify Needs  Secure Resources  Move to Community
Transition Assessment

• Assessment
  – Self-reflection guide
  – Assessment areas completed by experts
  – Reflecting full range of clients needs, preferences, desires
  – Must include type, scope, amount, duration & frequency

• Continually assess client’s strengths, challenges, commitment, abilities, motivation

• Transition options team determines if assessment is accurate & complete
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
• Identifies available services
• Addresses unmet need
• Includes Transition Options Team agreement
Final Review of Transition Plan

- Team reviews Transition Plan
  - Ensure assessed needs, preferences, desires are met
  - Risk mitigation plans in place
  - Services and Supports arranged
- Team determines Transition/Discharge Date
Secure Resources

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Role Play Exercise

Identify your client’s needs and create a transition plan
Discharge Requirements

• All supports & services have been arranged
• Health, welfare and safety of client ensured
• Qualified providers are available
• Transition Options Team is in agreement
Establish Discharge Date

- Collaboration between ICM & TC
- CCT Service Plan
- Household Set Up
- Community Integration Activities
Moving Plan

- Set moving date & plan
- Obtain physician orders
- Facility discharge plan
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
CCT Authorization & Reimbursement

Complete client’s Authorization & Reimbursement worksheet
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
ICM/TC Monitoring

- Services & supports are in place
- Check health, welfare, & safety

Explore Interest  Identify Needs  Secure Resources  Move to Community
Good Documentation

- Reports significant service provision issues
- Monitors client safety, health and welfare
- Allows review of work and track changes
- Is accurate, timely and complete

- Provides continuity for others who work with the individual
- Identifies opportunities for quality improvement
- Provides evidence required by the state to meet federal assurance
Risk Management

Potential for realization of unwanted, adverse consequences to human life, health, property or the environment.

– Oxford English Dictionary
Risk Management

• Decisions and activities undertaken to improve a client’s health, safety and environment

• Each risk concerns possibilities of detrimental consequences and likelihoods
Critical Elements of Risk Management

- Risk assessment
- Risk mitigation plan
- Risk monitoring and remediation
  - Interventions
  - Communication and collaboration
  - Ongoing assessment
  - Documentation
The Balancing Act

Safety

Dignity of Risk

State Role

Provider Role

Client Role

Self-Determination

Informed Choice
Risk Assessment

Identification of:

• Risks associated with daily life in the community
  – Health
  – Behavior
  – Personal safety

• Risk preparedness
Risk Mitigation

• Planning to reduce risk of harm
• Strategy identification
• Client involvement
  – Risk assumption agreement
Risk Monitoring & Remediation

- Interventions
- Ongoing assessment
- Documentation
- Communication and collaboration

RISK
Emergency Backup Plan

Emergency Backup Planning: One strategy for risk mitigation
ICM Roles & Responsibilities

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ICM Role in Transition Process

• Joins client’s Transition Options Team
• Reviews client’s universal LTC assessment tool (ULTC 100.2)
• Conducts new ULTC 100.2 if needed
• Participates in transition assessment/planning process
• Completes Service Plan
ICM Responsibilities - Post Transition

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ICM Post Transition Monitoring

• Monitors Client’s
  – Services
  – Health, welfare and safety
  – Quality of Life

• Ongoing assessment of functional status

• Revises the service plan

• Assesses client’s progress on necessary independent living skills acquisition

• Monitor and revise risk mitigation plans
Continuity of Care

Prepare client for transition from CCT program to HCBS waiver program if the client continues to meet the eligibility requirements for a waiver.
CCT Benefits & Services
CCT Benefits & Services

• Promote independent living and choice
• Facilitate a successful transition
• Support stability in the community
Qualified vs Demonstration Services

Qualified Services
• State plan benefits
• Home and Community Based Services (HCBS) Waiver services

Demonstration Services
• CCT services
• Compliment qualified services
Service Plan & Authorization

Explore Interest 
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CCT Service Plan

Informed by
- Transition assessment/plan
- Client’s level of functioning
- Client goals and needs
- Available resources

Developed by ICM with input from
- Transition Coordinator
- Discharging facility
- Client or guardian//Family

Approved by
CCT Transition Administrator
before transition occurs

Additional Documents
- Risk mitigation Plan
- Emergency Backup Plan
Person-Centered Service Planning

- Intensive Case Managers (ICMs) engages and empowers clients in
  - Identifying strengths, capacities, preferences, and needs
  - Achieving personal goals
  - Designing service plan
  - Accessing community services
- Matches transition plan/Plan of Care (POC) to services
- Allows real-time changes in services and supports
Resource Development

- Recruit providers to serve CCT clients
- Identify community resources
- Use service plan as way to identify unmet needs/gaps in services
Prior Authorization Request (PAR) Process

1. Send PAR to Dept
2. CCT Team reviews
3. If DD, DHS reviews also
4. Xerox reviews
5. CCT Team sends PAR letter
Monitoring

Explore Interest -> Identify Needs -> Secure Resources -> Move to Community
Monitoring Activities

- Independent Living Skills
- Goals
- Health, Welfare and Safety
- Risk
- Services and Supports
- Emergency Backup
- Reinstitutionalizations
Readmission Stay < 30 Days

• Readmission:
  – Hospital
  – Nursing Home
  – ICF-IDD

• 365-day demonstration period resumes upon re-entering the community
Re-Enrollment Process

• Reenrollment in CCT is allowed after:
  – Readmission to an institution

• Eligible client:
  – Re-enrolls as new client and meets all CCT eligibility criteria

• A new 365-day demonstration period begins
Post Readmission Review

- Review original transition thoroughly
- Identify and address issues contributing to readmission
- Create risk mitigation plan for identified risk factors
- Draft new Service Plan
- Update information from Transition Assessment/Plan
- Obtain input from client, informal support network, Intensive case manager, transition coordinator and other providers
- Mitigate potential problems for a second transition
Nora Brahe, Transitions Administrator
Kathy Cebuhar, CCT Community Liaison
Tim Cortez, Project Director
Nicole Storm, Project Manager
Web: Colorado.gov/hcpf/CCT
Email: CCT@hcpf.state.co.us