

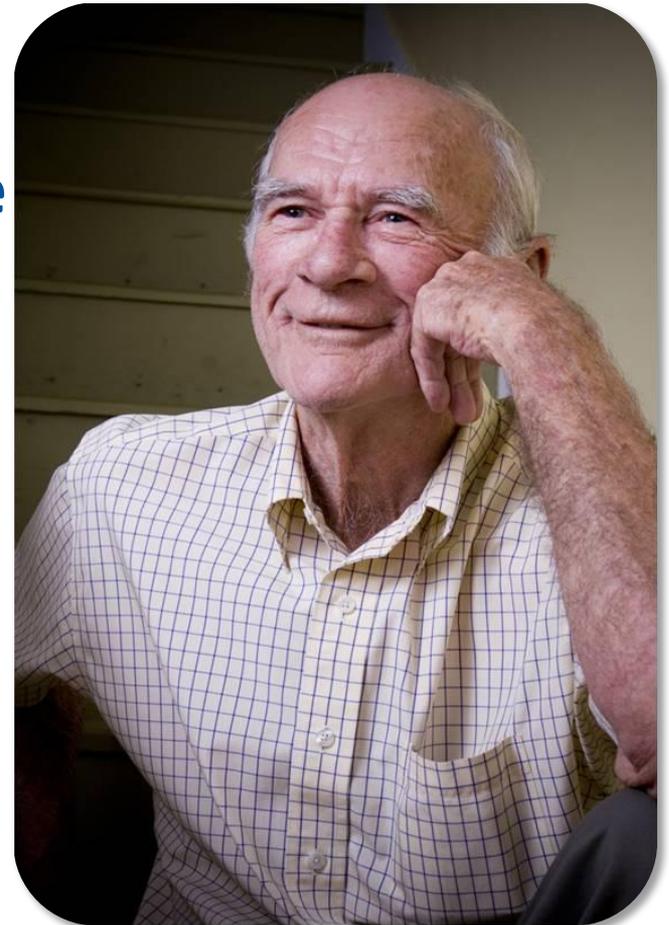


COLORADO
CHOICE TRANSITIONS
YOUR PATH TO INDEPENDENCE

Transition Coordinator & Intensive Case Manager Training

Presented by:
CCT Team

Colorado Department of Health Care
Policy & Financing



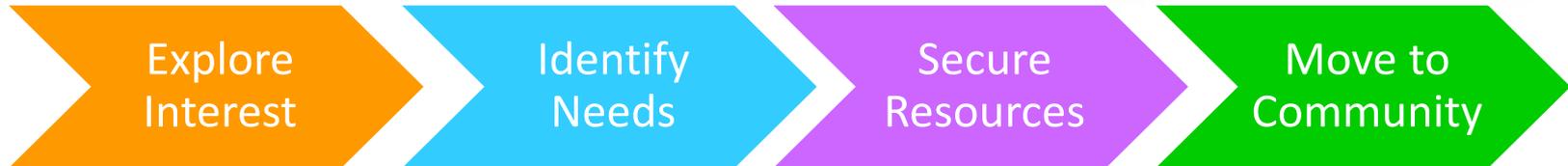
Our Mission:

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



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



Funding & Reform

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



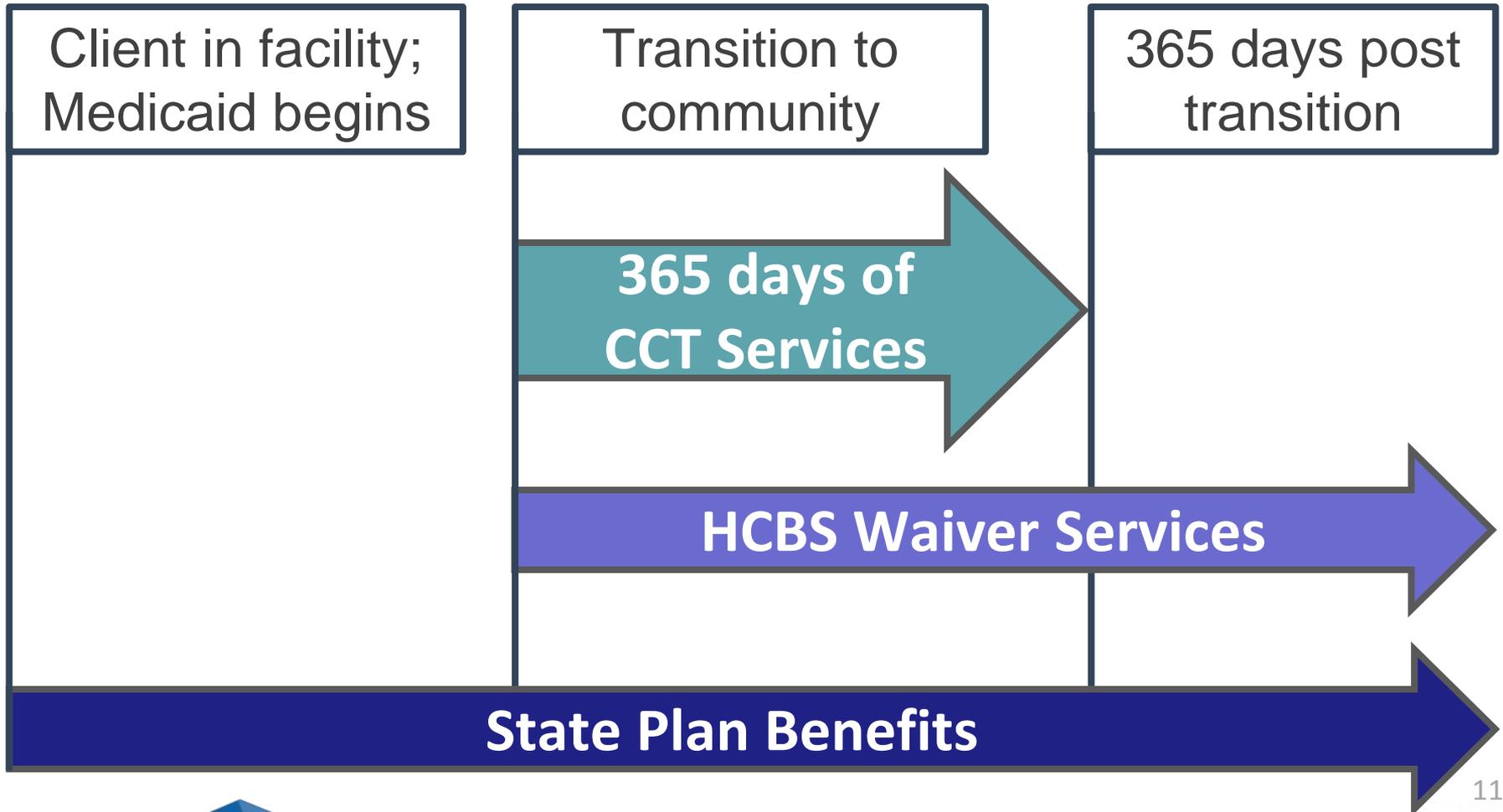
Residence in community-based setting with no more than 4 unrelated individuals



Apartment with individual lease

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

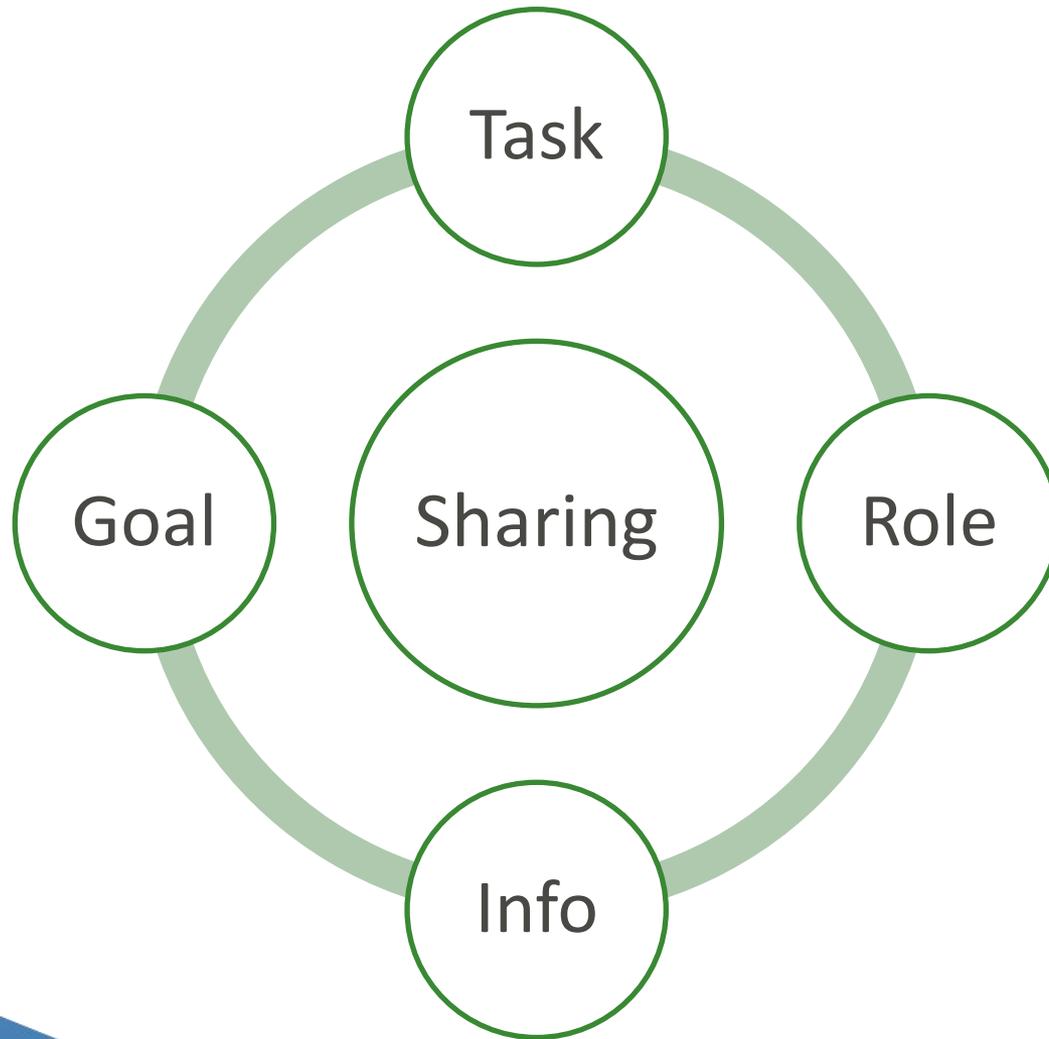
CCT Eligibility Span



System Collaboration



Elements of Positive Interdependence



Regional Transition Committee (RTC)

Develop Regional Transition Strategy

Sustain
community
living

Promote &
support
transitions

Problem
identification &
resolution

Process
evaluation

Ongoing
communication
& collaboration

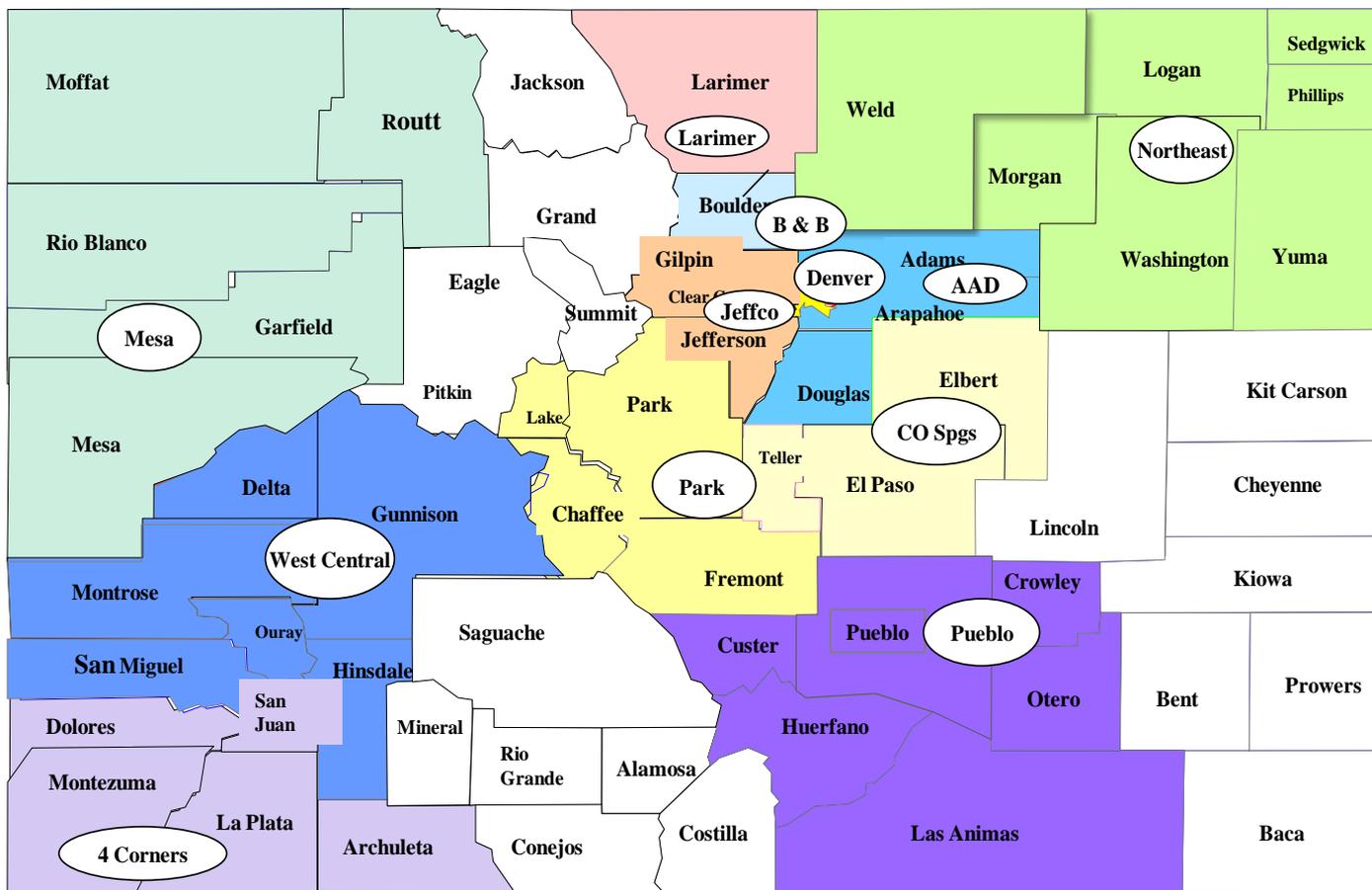


RTC Members

- 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



Regional Transition Committees



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

Explain client responsibilities

Facilitating meetings

Assist with paperwork

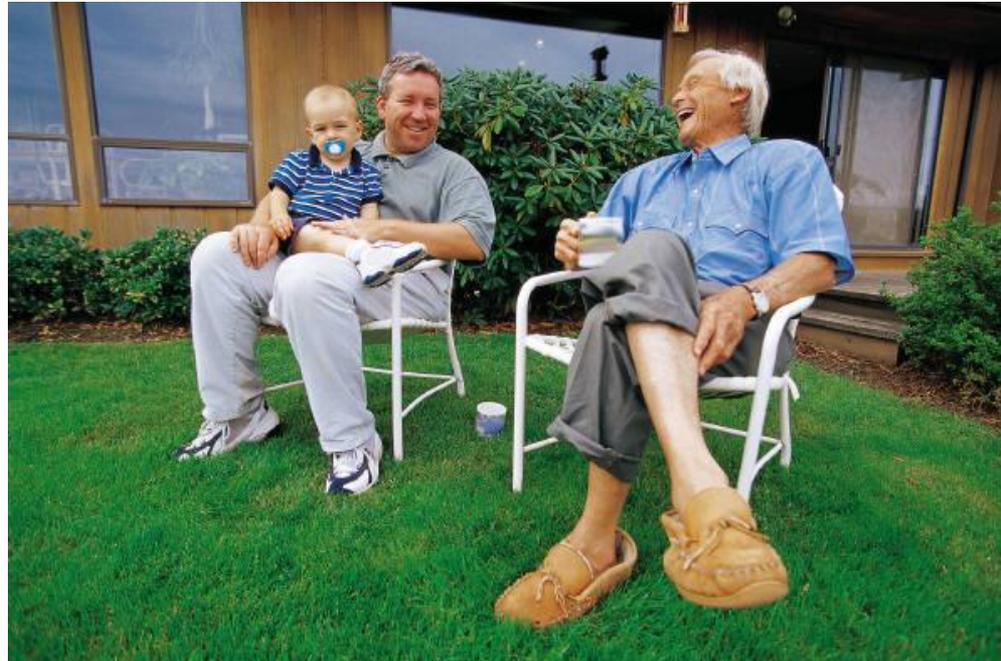


Encourage client participation & self-assessment

Support client decision-making

Clarify client's personal goals

Identify Needs



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Transition Options Team



Advocate

Plan

Assess

Review



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

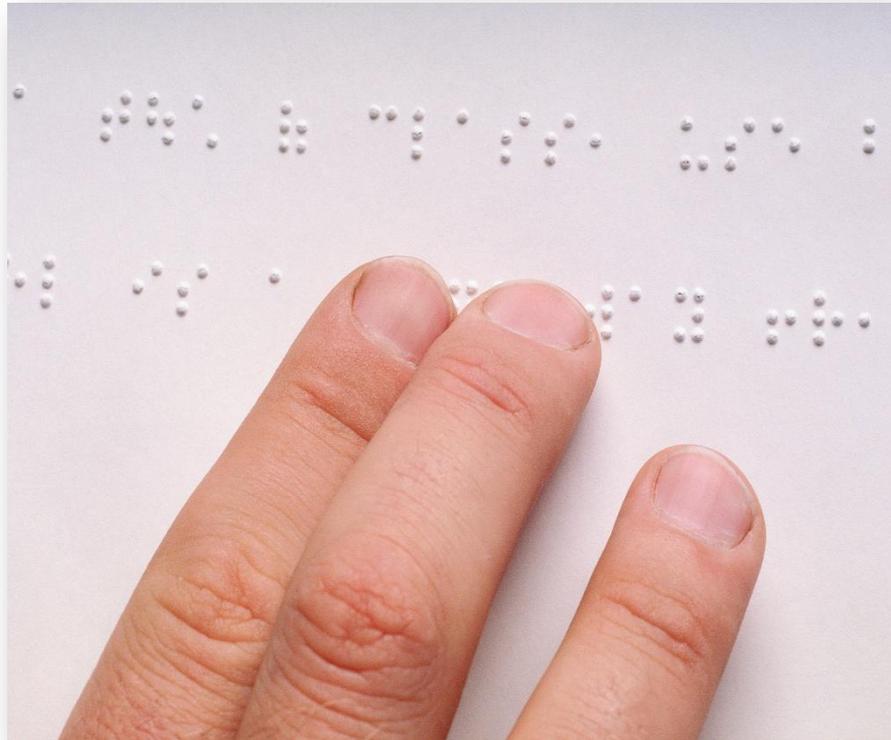


Final Review of Transition Plan

- 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



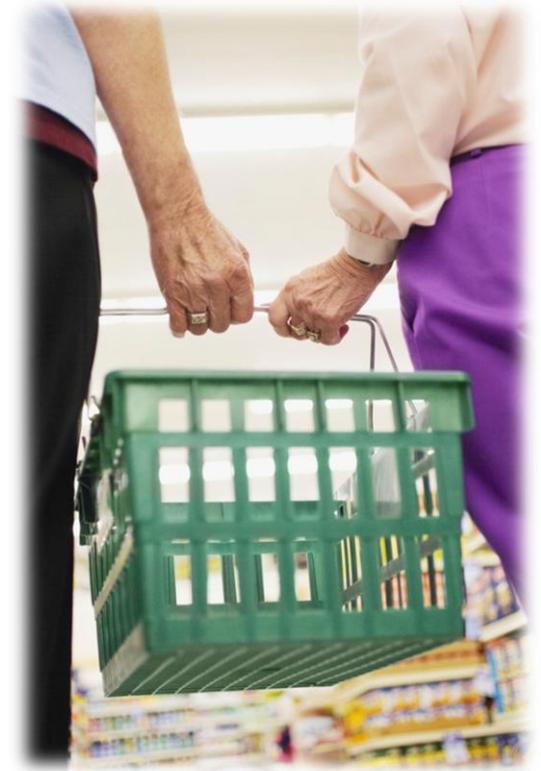
Getting Client Set Up

- 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



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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

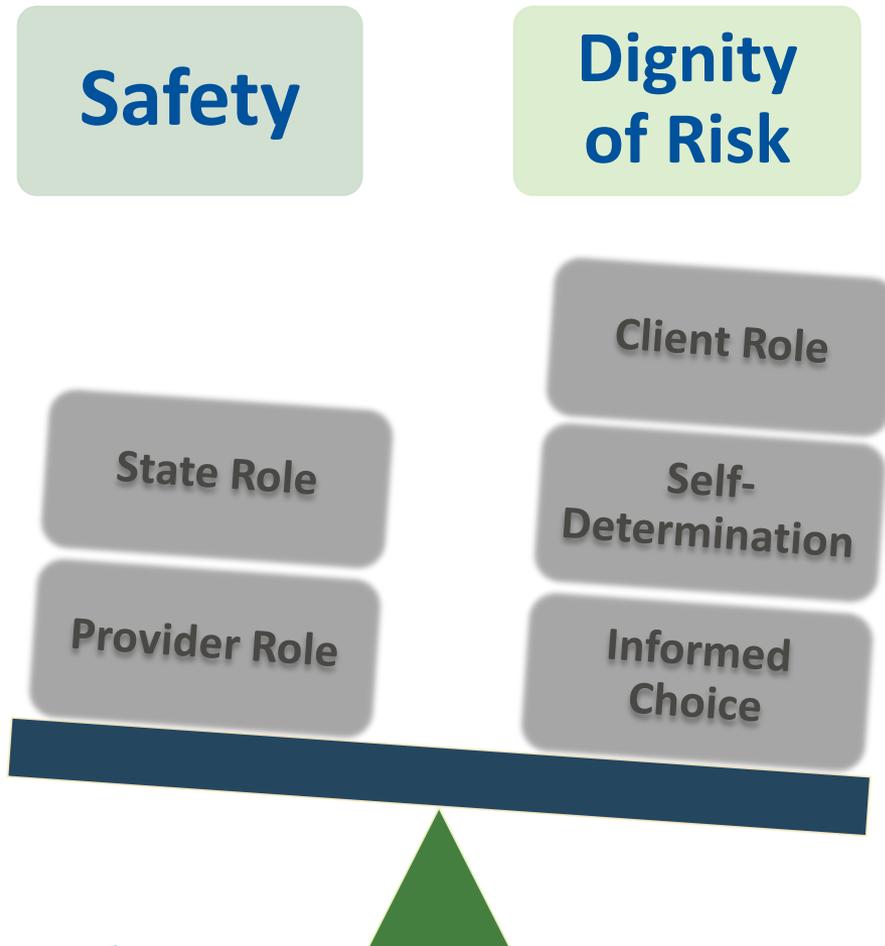


Critical Elements of Risk Management

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



The Balancing Act



Risk Assessment

Identification of:

- Risks associated with daily life in the community
 - Health
 - Behavior
 - Personal safety
- Risk preparedness

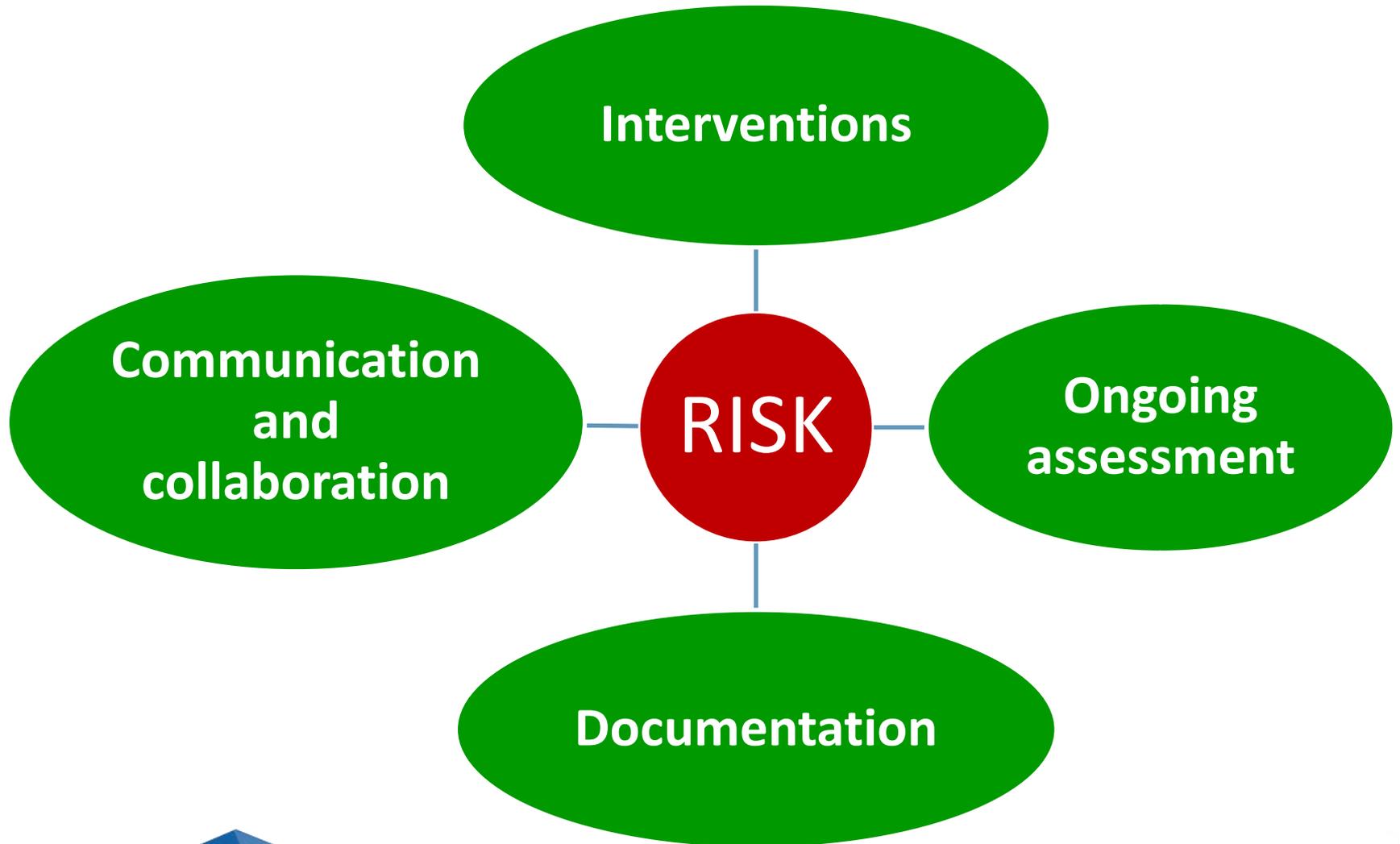


Risk Mitigation

- Planning to reduce risk of harm
- Strategy identification
- Client involvement
 - Risk assumption agreement



Risk Monitoring & Remediation



Emergency Backup Plan

Emergency Backup Planning:
One strategy for risk mitigation



ICM Roles & Responsibilities



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



Explore
Interest

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**Move to
Community**

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

Identify
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Move to
Community

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

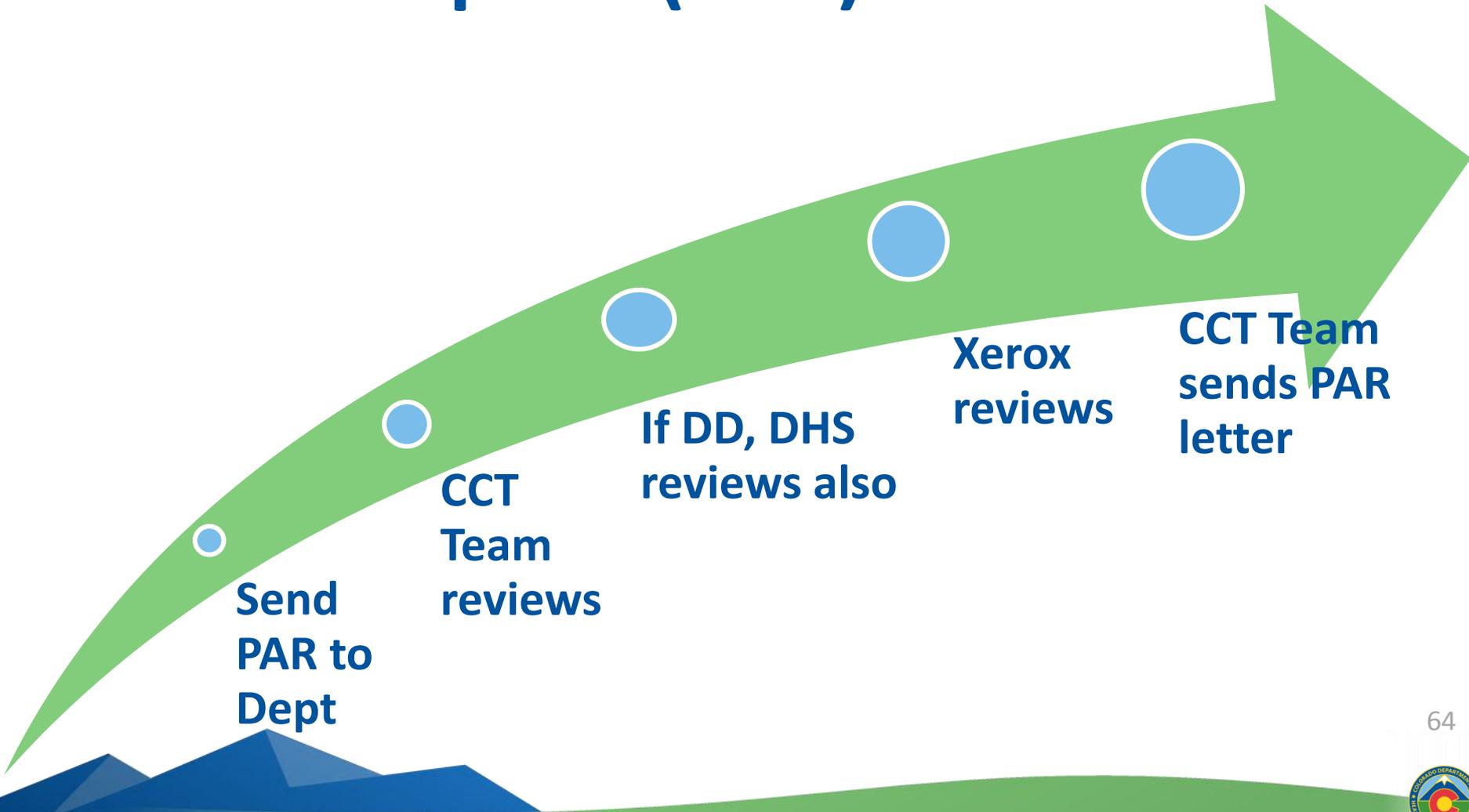


Resource Development

- 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



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





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