Training Module 3

CCT Transition Process

Last Rev. 5-12-16

Objectives

By the end of this module, the audience should be able to:

- List the five phases of the CCT transition process
- Provide a brief description of each phase of a CCT transition
- Discuss the responsibilities of the Lead Organization's (LO) Transition Coordinators (TC) and Registered Nurses (RN) in the CCT transition process

5 Phases

The CCT transition process is comprised of five phases:

- Phase 1: Outreach and Targeting
- Phase 2: Information Gathering & Enrollment
- Phase 3: Implementation
- Phase 4: Transition to Community Living
- Phase 5: Follow-Up

Phase One

OUTREACH AND TARGETING

Outreach & Targeting

- Develop relationships with area long-term care inpatient facilities
- It is recommended (but not required) to establish relationships with Managed Care Plans (MCP) in the area
- Respond to inpatient facility referrals of people who want more information about community integration (identified in MDS, Section Q)

Building Relationships with Inpatient Facilities

- Facility administrators should be aware of the CCT demonstration, but facility staff may not know about CCT
- CCT LOs should always call ahead to:
  - Provide information about the CCT program
  - Explain how Medi-Cal eligible members may benefit from the CCT program
  - Inform staff about when you plan to arrive and how long you plan to stay at the facility

Facility Information Sheet

- Maintain a file for each facility with which you work
- Ensure the information in the facility's file is kept current, and includes, but is not limited to:
  - Facility's location
  - Staff names, titles, and contact information
  - Other facilities owned by the same company
  - Any other helpful information

About Inpatient Facility Discharge Staff

- All Medi-Cal certified inpatient facilities must have designated staff responsible for discharge planning
- Discharge planners should be included in the CCT transition planning team and process
  - It is recommended to leave a copy of the Initial-Transition and Care Plan (I-TCP) with the facility's discharge planner to added to the member's chart
- It is prudent to become familiar with facility resources – create relationships!
- Collaboration and cooperation is essential

Phase Two

INFORMATION GATHERING AND ENROLLMENT

Information Gathering

- LO staff conducts an initial interview with the member to gauge interest in CCT
- Eligible Medi-Cal members interested in transitioning to the community must agree to the terms of the demonstration, and sign the following CCT forms:
  - CCT Enrollee and Participant Rights and Responsibilities Consent form
  - Authorization for Release of Protected Health Information (PHI)
- It is recommended that LO submit Enrollee Information Form (EIF) at this point to notify state CCT staff they are working with the member

Supporting Documentation

- TC collects records necessary to conduct local-level review of patient history, eligibility, durable power of attorney (DPA), etc.
- TC begins the assessment tool
- RN completes the clinical portion of the assessment tool to identify the health and safety needs to be addressed in the I-TCP

Initial Transition & Care Plan (I-TCP) Development

- TC meets with the member to gather information on their preferences, and service and care needs for community living
- TC determines if transition to community living is possible based on the services available to meet the member's identified preferences and needs in his/her chosen location

Transition & Care Planning Team

- Plan Development Team Members:
  - Eligible Medi-Cal member / CCT Enrollee
  - CCT LO's TC and staff/contracted RN
  - member's legal representative (if applicable)
  - member's friends and family (as requested by the individual)
  - Facility discharge planner
  - Assigned MCP case manager (as appropriate)

I-TCP Resources

- Resources for Developing the I-TCP:
  - Person-Centered Planning Techniques
  - Information within the member's completed CCT Assessment Tool, facility face sheet, and medications list

Transition & Care Planning

Long-Term Services & Support Plan

(Putting the pieces together)

Health Care Services

- Plan of Treatment
- Nursing Care Services
- Nutrition Services
- Allied Health, Other Therapies
- Durable Medical Equipment & Supplies

Supportive Services

- Family & Friends
- Personal Attendants
- Emergency Backup
- Housing
- Transportation

Social Services

- Peer Support
- Recreation, Cultural, & Spiritual Connections

Environmental Services

- Home & Vehicle Modifications
- Assistive Technology
- Household Set-up

Education / Training Services

- Independent Living Skills & Life Skills Development
- Caregiver Training & Management
- Emergency Planning

Financial Services

- Medi-Cal codes
- Money Management
- SSI/SSP Payments

Other Services

- Demonstration Services
- Employment Services
- Supplemental Services

Phase Three

IMPLEMENTATION

DHCS Review

- DHCS Nurse Evaluators (NEs) conduct a clinical record review based on:
  - Assessment tool
  - Comprehensive and personalized I-TCP (I-TCPs are unique for each member and should never be based on a template)
  - Facility face sheet
  - Supporting documentation

Reminder: The EIF is submitted to the CCT inbox, not attached to the TAR

DHCS Review Criteria

- Are all documents complete? Are all required signatures included?
- Is there evidence in the assessment tool &/or supporting documents that indicates the member may need to be evaluated by a physician to determine his/her decision-making capacity?
- Does the information that is provided give a clear picture of the member's LTSS needs?
- Are the LTSS in the I-TCP sufficient to meet the member's health and safety needs in the community?
- Is there a need for clarification of any information?

DHCS NE Adjudication

If the ITCP addresses the needs and preferences of the member, (s)he is enrolled and LO continues to work with the member.

If ITCP does not address the needs and preferences of the member, a notice of action (NOA) is issued for denial of services.

Implementation of ITCP

- Enrollee directs the transition team
- LOs work with the Enrollee, and his/her transition team, to develop a CCT Final Transition and Care Plan that addresses the member's unique preferences, and his/her medical and social needs in the community
- Secure appropriate and available home and community based services (HCBS), housing, in-home support worker(s), etc. to meet the member's identified needs and preferences
- Schedule an intake appointment with the Enrollee's identified community physician

Health Care Consultation

Establishing appropriate home and community-based (HCB) services and supports post transition is critical for a safe and sustainable transition

- Available State Plan and HCBS Waiver services include, but are not limited to the following:
  - Managed Care
  - Program of All-inclusive Care for the Elderly (PACE)
  - Senior Care Action Network (SCAN)
  - Multipurpose Senior Services Program (MSSP)
  - In-Home Supportive Services (IHSS)
  - Nursing Facility/Acute Hospital (NF/AH) Waiver
  - Assisted Living Waiver (ALW)
  - AIDS Waiver
  - Specialty Mental Health Consolidation Program (SMHC)
  - Community-Based Adult Services (CBAS)

Final Transition & Care Plan (F-TCP)

- **Two weeks** prior to transition, LO submits an F-TCP documenting the long-term service and supports (LTSS) that have been put in place prior to enrollee's transition
- F-TCP is attached to the 50 hour post transition TAR
- NE reviews F-TCP and approves post-transition hours

Phase Four

TRANSITION TO COMMUNITY LIVING

Day of Transition

- Services must be in place on the day of transition, including, but not limited to:
  - Home/household set-up;
  - Home modifications;
  - Delivery and set-up of equipment;
  - Financial arrangements; and
  - Personal care services/nursing care services and/or other HCBS
- Waiver and/or personal care services may still be "in process" on the day of transition, and appropriate "gap" services may be provided to the member by the LO **with PRIOR state NE approval**

Day of Transition (continued)

The TC must be with the Participant at his/her home on the day of transition

Day of Transition (continued)

- A CCT Enrollee becomes a Participant the day he/she transitions to the community
- The first day of participation in the 365-day demonstration period begins
- TC reviews the F-TCP with the Participant to ensure all identified services are secured and in place

Phase Five

FOLLOW-UP

Follow-Up

- Collaborate with other service providers to ensure a smooth transition to IHSS social worker, managed care plan case manager, or HCBS case manager
- Review the CCT F-TCP with the participant at regularly scheduled intervals after the day of transition, and address any needs or concerns
- Remind the participant that the CCT demonstration period ends on day 365, and that existing services will continue as long as the person remains eligible for Medi-Cal HCBS
- It is recommended to perform a final review of the F-TCP with the Participant in the 11th month of the demonstration period to ensure all of the Participant's needs have been met

Quality of Life (QOL) Surveys

- TC conducts a QOL survey with the Participant 11 months after the day of transition
- TC conducts the last QOL survey with the Participant 24th months after the day of transition

NOTE: The last day to conduct 11-month and 24-month QOLs for reimbursement is December 31, 2016

Additional Resources

- For more information on the CCT demonstration, please refer to the "Resources for CCT Providers" section of the CCT webpage, available at:

  http://www.dhcs.ca.gov/services/ltc/Pages/CCT.aspx