STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Health Home Learning Collaborative

Transitions in Care

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This training is a collaborative effort between the Managed Care Organizations and Iowa Medicaid

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AGENDA

Introductions

Learning Objectives

Types of Transitions of Care

Discharge Planning

Transition Planning

Questions

Learning Objectives

Identify the Member's suitability for transition

Illustrate process of transitioning the Member into the most appropriate setting

Outline means for providing support throughout and after the transition

Transitioning & the Health Plan

- Most Integrated
- Least Restrictive
- Safest
- Environment to allow maximum independence

Types of Transitions

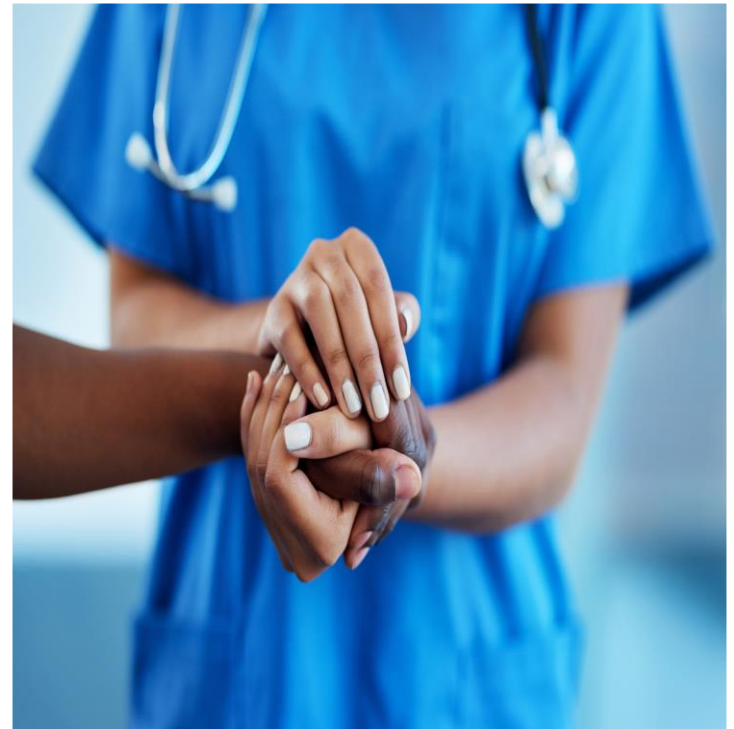
Hospital Admission

If Member was in Community:

- Inform Providers
- Complete CIR (Critical Incident Report)
- Discuss discharge plan

If Member was in a Nursing Facility:

- Contact MCO CBCM
- Determine the bed level



Hospital Discharge

Returning Home vs. Transitioning into Facility Living

- What are your biggest challenges/Concerns?
- What would be helpful to make this as successful as possible?

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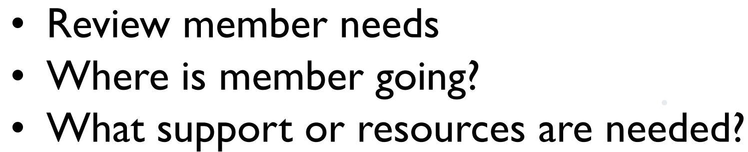
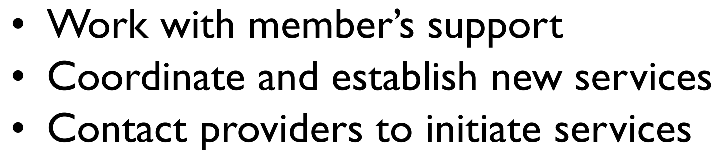
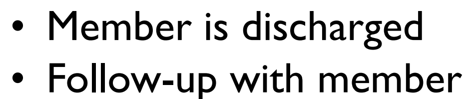
Hospital Discharge Planning







Facility Transitions

❶ Level of care available in alternate setting

❷ Minimal risk for readmission

❸ Expressed interest and consent

What are your biggest challenges/concerns?
What would be helpful to make this as successful as possible?

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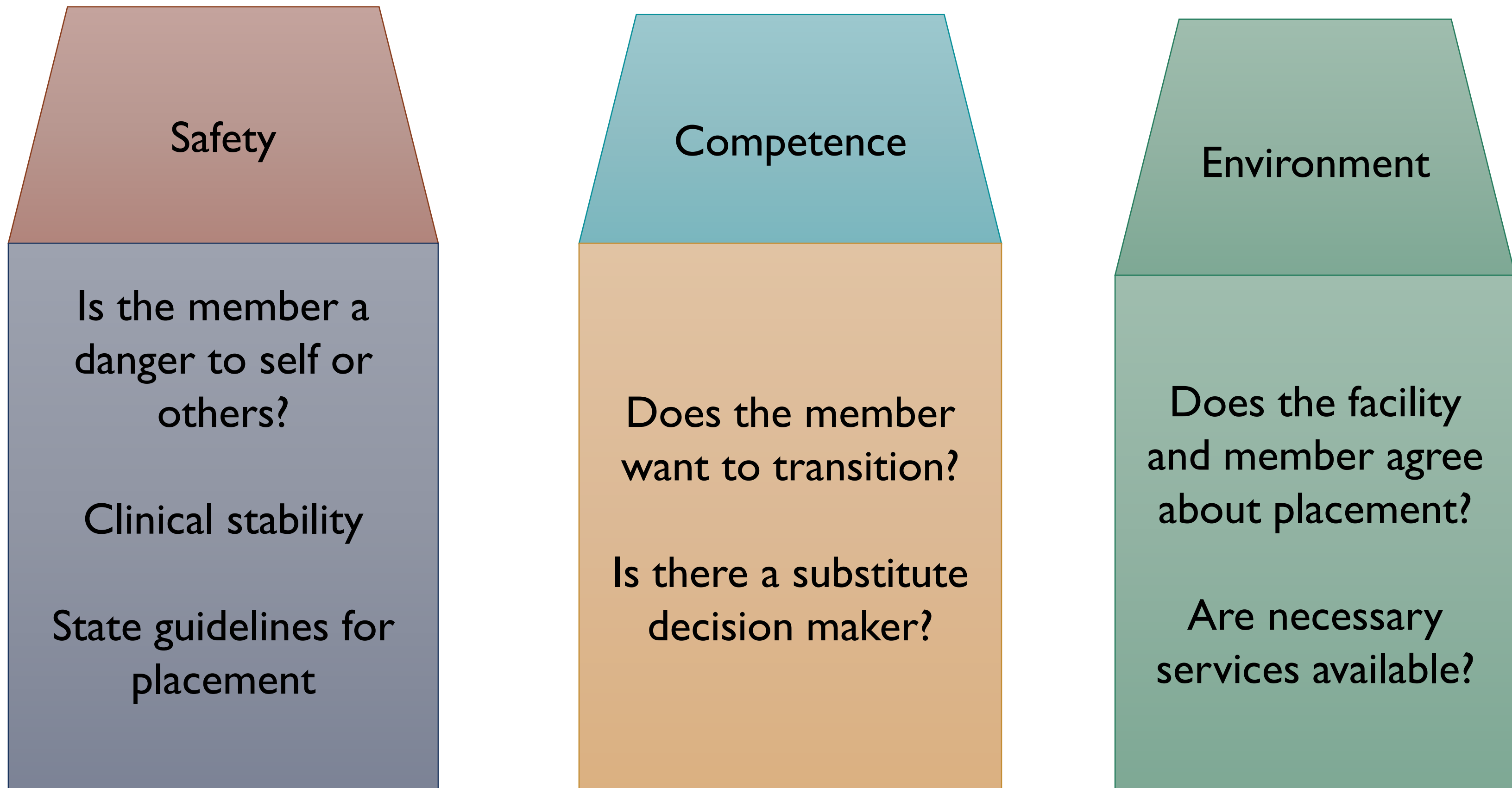
Transitioning from a Facility

Transitioning into Another Facility



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Identify Suitability

- Coordinate arrangements for transition:
  - Needs
  - Mental capacity
  - Identify level of care required
- Review Process
- Find available housing
  - Isolate housing option
  - Availability and barriers

Transitioning from Jail

Partner with diversion programs

Online Tools

- Iowa Courts Online
  Some Juvenile Records are here (JVJV)

- Department of Corrections
  Search Status

- ➢ What are your biggest challenges?
- ➢ What are gaps that make this difficult?

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HH to HH Transfer

Original Health Home

- Schedule a warm transfer meeting with the new health home, member, provider(s), etc.
- Provide the new health home with:
  - Current PCSP/PCCP (word)
  - Current CASH (word)
  - Other important documents
  - Date you will discharge member
  - Complete HH Notification

New Health Home

- Participate in the warm transfer meeting
- Review documentation provided by original health home
- Obtain necessary ROIs to complete intake paperwork
- Update PCSP/PCCP and CASH within 30 days of enrollment to HH
- Complete HH Notification Form

COMMUNICATION

- What makes this challenging?
- What works and doesn't work?

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Discharge Planning

Discharge Team Meeting

Purpose

- Discuss best options for transition/discharge
- Determine Member's ability to transition into applicable setting
- Set up services needed
- Modify/develop a PSCP
- Should begin at the date of admission

Discharge Team

- Member
- Health Home RN/Care Coordinator
- Support system (Family, guardians, providers, etc.)

Reminder – when a member is in the hospital or facility it is important that discharge plans are being discussed upon admission.

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Transition Planning

Key Components in Transition Planning

Successful transitioning planning involves

- Member & family involvement
- Utilize Person Centered Principles and Processes
- Provide Choice and Quality of Life
- Life Options & Alternatives
- Provision of Adequate Services in Community Settings

Transition Support

- Remain calm
- Listen to what they are saying
- Meet them where they are at
- Identify things you can do to easy their fears
- Focus on the members strengths

Key Elements of Successful Transition Planning

- Involves member, legal representatives & others of member choosing
- Follow person centered principles and processes
- Allows for expression of choice and quality of life
- Life options and alternatives
- Provides adequate services in community setting
  - Housing
  - Medical
  - Behavioral Health
  - Personal Assistance
  - Durable Medical Equipment / Assistive Devices
  - Public Safety

Key Elements of Successful Transition Planning cont.

- Transportation
- Education
- Employment
- Money Management
- Social, Leisure, Community, Family Support
- Environmental Modifications
- Legal
- Rights Restrictions
- Staff and Caregiver Training

  https://hhs.iowa.gov/sites/default/files/Transition%20Guidebook_Web.C.pdf

Transition Plan Consists of

A document to provide communication to the entire team should consist of at least:

- Date/Time of Move
- New Address
- Main Point of Contact
- Who will help prepare
- Items to purchase
- Support for the member
- Community Resources
- Personal Belongings
- Transportation
- Medications
- Adaptive Equipment
- Medical Equipment
- Medical Appointments
- Back up Plans
- Safety/Crisis Plan

Preparing for Transition

A team meeting is important to hold to finalize the move and develop/modify the PCSP

- PCSP/PCCP will need to identify
- New Address/phone #
- New Providers
- Risks – any newly identified
- Changes in safety/crisis plan
- Back-up plans to services
- Goals

Person Centered Service Plan

Person Centered Service Plan

Strengths

Goals & Desired Outcomes

Recreation/Social Activities

HCBS Services

Financial/Budgeting

Education/ Vocational/Employment

Housing

Transportation

Mental & Physical Health Needs/Supports

- Needs/Diagnosis
- Treatment Options/Availability
- Therapies/Treatments
- Physicians/Specialist
- Medications/Management

Sociological Needs

- Natural Supports
- Friends/family
- Church/Faith

After Transition

- Contact member and guardian or legal representative within 5 days of transition
- Contact provider w/in 5 days of transition
- Follow-up with legal representative w/in 30 days
- 30 – 45 days after transition team meeting

Child to Adult Brainstorming Differences

- Talk with member of things that might come up when a child turns 18. For example, they can now go to jail for behaviors they have.
- Talk about habilitation services as an option (this should begin no later than age 16). Can start sooner if member/family is interested.
- Talk about next steps or needs
  - Guardianship/Power of Attorney Needs
  - Further education and supports they may need
  - Applying for Social Security
  - Where will they live, cost, etc.
  - Service needs/supports available

Resources

- Referral tracker – spreadsheet attached to tracker referrals made and results
- How to Request Waiver when Member leaves Facility – document to step out process depending on discharge date
- Transition Guidebook – attachment
- Waiver Application for those currently on Medicaid

Resources

- Waiver Information Packets – https://dhs.iowa.gov/ime/members/Medicaid-a-to-z/hcbs/waivers

THE SEVEN HCBS WAIVERS

1. Health and Disability (HD) Waiver
   HD Waiver Information Packet: In English / En Espanol
2. AIDS/HIV (AH) Waiver
   AH Waiver Information Packet: In English / En Espanol
3. Elderly (E) Waiver
   E Waiver Information Packet: In English / En Espanol
4. Intellectual Disability (ID) Waiver
   ID Waiver Information Packet: In English / En Espanol
5. Brain Injury (BI) Waiver
   BI Waiver Information Packet: In English / En Espanol
6. Physical Disability (PD) Waiver
   PD Waiver Information Packet: In English / En Espanol
7. Children's Mental Health (CMH) Waiver
   CMH Waiver Information Packet: In English / En Espanol

If you wish to learn more about the HCBS Waiver Program, please read the HCBS Waiver Program brochure, "**Are Home and Community Based Services Right for You?**"

Resources

- Habitation Packet Information: https://hhs.iowa.gov/sites/default/files/Comm531.pdf?020420222149

- PMIC Article on how to support families when their child is hospitalized/inpatient https://childmind.org/article/bringing-child-home-psychiatric-hospitalization/

Questions