8.519.27 Targeted Case Management – Transition Services (TCM-TS)

8.519.27.A Definitions

1. Case management agency means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the state department to provide case management services for home and community-based services waivers pursuant to section CRS 25.5.-10-209.5 and CRS 25.5-6-106. The case management agency shall provide case management services pursuant to a provider participation agreement with the state department.

2. Community risk level means the potential for a client living in a community-based arrangement to require emergency services, to be admitted to a hospital, nursing or intermediate care facility, be evicted from their home or be involved with law enforcement due to identified risk factors.

3. Post-transition monitoring means targeted case management activities that occur after a client has successfully transitioned into community and is a recipient of home-and community-based services.

4. Pre-transition coordination means targeted case management activities that occur before a client has transitioned into community to prepare with the client for success in community living and integration, including establishing home and community-based services.

5. Risk factors means factors that include but are not limited to health, safety, environmental, substance abuse, community integration, service interruption, inadequate support systems and substance abuse that may contribute to an individual's community risk level.

6. Risk mitigation plan means the document that records the risk mitigation planning process. Risk mitigation plans are used to conduct post-discharge monitoring of effectiveness of risk prevention strategies; to document identification of additional risk factors, and to revise risk incident response plans.

7. Risk mitigation planning means the process of identifying risk factors, developing options and actions to enhance opportunities and prevent adverse consequences that would result if risk is not managed and identifying planned actions to take in response to an adverse consequence should a risk be realized.

8. Service plan means the written document that specifies identified and needed services, to include Medicaid and non-Medicaid services regardless of funding source, to assist a client to remain safely in the community and developed in accordance with the department rules.

9. Targeted case management - transition services (TCM-TS) means support provided to a client who is transitioning from a nursing facility, intermediate care facility or regional center and includes the following activities: comprehensive assessment for transition, development and periodic revision of a service plan, referral and related activities, and monitoring and follow up activities.

10. Transition assessment means the process of capturing a comprehensive understanding of the client's health conditions, functional needs, transition needs, behavioral concerns, social and

cultural considerations, educational interests, risks and other areas important to community integration and transition to a home and community-based setting.

11. Transition case manager (TC) - means an individual who meets all the case management qualifications and performs the case management functions pursuant to 10 CCR 2505-10, section 8.519 and conducts activities listed under pre-transition coordination and post-transition monitoring.

12. Transition options team (TOT) means the group of people involved in supporting and implementing the transition, to include the person receiving services, the transition case manager, the family, guardian or authorized representative, and others chosen and designated by the individual receiving services as being valuable to participate in the transition process.

13. Transition period means the period of time in which the member receives TCM-TS for the purpose of successful integration into community living. A transition period is complete when the member has successfully established community residence and is no longer in need of TCM-TS based on the risk mitigation plan.

14. Transition plan means the written document that identifies person-centered goals, assessed needs, and the choices and preference of services and supports to address the identified goals and needs; appropriate services and additional community supports; outlines the process and identifies responsibilities of transition options team members; details a risk mitigation plan; and establishes a timeline that will support an individual in transitioning to a community setting of their choosing.

15. Transition service planning means development of a service plan, risk mitigation plan and transition plan in coordination with the transition options team.

8.519.27.B Functions of case management agencies offering transition services

Pending federal approval, case management agencies offering TCM-TS must comply with all requirements of a case management agency pursuant to 10 CCR 2505-10, section 8.519 and shall establish agency procedures sufficient to execute TCM-TS according to the provisions of these rules and regulations. Such procedures shall include, but are not limited to:

1. Assessment of community needs and risk factors.
2. The authorization of services and supports.
3. Service and support coordination.
4. Monitoring and service plan review:
    a. The case manager shall ensure that clients receive services in accordance with their service plan, transition plan and risk mitigation plan and monitor the quality of the services and supports provided to clients.
    b. Monitoring shall occur no less than weekly in the first three months post-transition and at least twice monthly the remainder of the transition period unless otherwise documented in the risk mitigation plan, including the reason why the frequency was changed.
    c. The level of monitoring shall meet the need based on the client's community risk level as documented in the risk mitigation plan and be based on the client's preference. Monitoring may include:
        i. Face-to-face in the client's residence.

ii. Face-to face in community.
iii. By telephone or electronic communication.

5. Any safeguards necessary to prevent conflict of interest between case management and direct service provision.
6. Denial and discontinuation of TCM-TS.

8.519.27.C Functions of transition case managers

Pending federal approval, transition case managers must perform all of the case management functions pursuant to 10 CCR 2505-10, section 8.519 and must also perform all the following activities:

1. Coordination of the transition options team (TOT): members of the TOT are convened to work in a cooperative and supportive manner to develop and implement the transition plan, and to serve in an advocacy role to the individual. Responsibilities of team members are to:
    a. Contribute to an assessment which identifies preferences, needs and any risk factors the resident may have in a home or community-based setting
    b. Participate in the development of a risk mitigation plan to address identified risk factors
    c. Assist in the identification of supports and services that will be required to address the individual's needs, preferences and risk factors.
    d. Conduct service brokering to determine if the identified necessary supports and services are available at the frequency needed.
    e. Participate in a team decision regarding feasibility of transition.
    f. Contribute to a transition plan if transition is determined to be feasible.
2. Pre-transition coordination includes:
    a. Facilitate completion of transition assessment, risk mitigation and transition plans.
    b. Complete, as needed, housing voucher application, including assistance to obtain necessary documents.
    c. Collaborate, as needed, with housing navigation services to obtain a voucher and locate housing.
    d. Create a transition budget.
    e. Facilitate a community-based living arrangement.
    f. Coordinate any medication, home modification and/or durable medical equipment needs with the nursing facility prior to discharge to ensure that all components of transition plan are in place prior to a discharge.
    g. Assist client in preparing for discharge, including being present on day of discharge.
    h. Meet with client at new home on the day of discharge to ensure that services are in place and the household set-up is complete.
3. Post-transition monitoring includes:
    a. Provide support services to aid in sustaining community-based living.
    b. Provide in-person monitoring based on the client's community risk level.
    c. Respond to risk incidents.
    d. Revise risk mitigation plan as needed.
    e. Assess need for independent living skills training.
    f. Problem-solve community integration issues.
    g. Support community integration activities.
    h. Monitor service provision.
    i. Complete client satisfaction survey to evaluate the client's experience of following:
        i. Service planning.
        ii. Transition plan implementation.
        iii. Transition coordination process.

iv. Level and adequacy of services provided.
v. Overall client satisfaction.

8.519.27.D Training

Pending federal approval, transition case managers must meet all of the case management training requirements pursuant to 10 CCR 2505-10, section 8.519 and must also attend the following mandatory annual training provided by the department. Transition case managers must complete and document the following training within 120 days of hire date prior to providing transition case management services independently:

1. Community needs and risk factor assessment.
2. Service plan development and revision.
3. Risk mitigation plan development, monitoring and revision
4. Referral for services.
5. Monitoring services.
6. Case documentation.
7. Person-centered approaches to planning and practice.
8. Housing voucher application and housing navigation services.

8.760 TARGETED CASE MANAGEMENT SERVICES

8.763 TARGETED CASE MANAGEMENT - TRANSITION SERVICES (TCM-TS)

Targeted case management - transition services (TCM-TS) means support provided to a client who is transitioning from a nursing facility, intermediate care facility or regional center and includes the following activities: comprehensive assessment for transition, development and periodic revision of a service plan, referral and related activities, and monitoring and follow up activities.

8.763.A Eligibility

To be eligible for TCM-TS, clients must be Medicaid recipients who are eligible for Home and Community Based Services, reside in nursing facility, intermediate care facility or regional center, and are willing to participate and have expressed interest in moving to a home and community-based setting. Excluded are children under the age of 18.

8.763.B Services

Pending federal approval, TCM-TS are provided pursuant to 10 CCR 2505-10, section 8.519.27.