

Transition Coordination Introduction & Referral Process

Presented By Nora Brahe

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Our Mission

Improving health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.

Session 1 Objectives

Increase knowledge regarding:

- Targeted Case Management - Transition Coordination (TCM-TC) Services
- Transition Coordinator (TC) Responsibilities
- Community Living Options Process
- Multiple roles and responsibilities for entities involved with the transition process

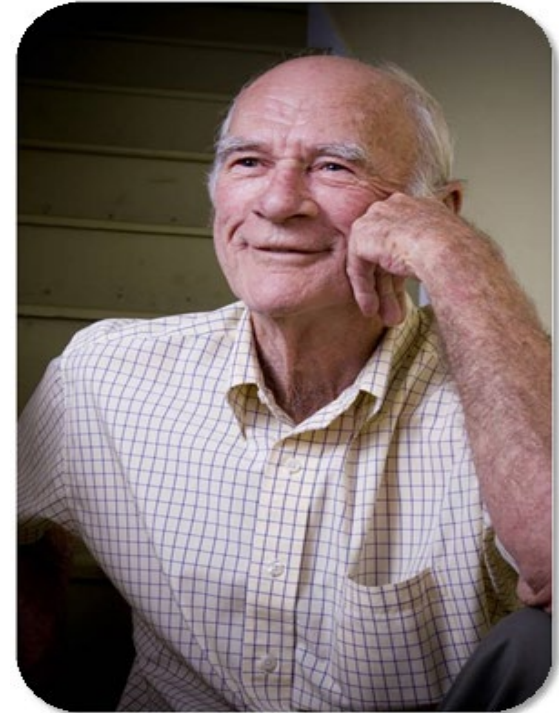
Key Principles of Transition Coordination

Every person has the right to make an informed choice about where to live and how to receive care

Any person can live independently in the community with the appropriate level of supports and services

Targeted Case Management- Transition Coordination (TCM-TC) Services

- Provided through a Transition Coordination Agency (TCA)
- State Medicaid Plan Benefit
- Reimbursed as Targeted Case Management



Assists individuals who have chosen to pursue the option of transitioning to a community-based living arrangement



TC Provides Pre- and Post Transition Support

- Facilitation of team process to make transition recommendation
- Management of housing process
- Coordination for discharge planning
- Post-discharge monitoring

Transition coordination requires multiple skills and experience



Five Person-Centered Planning Competency Domains

1. Strengths Based, Culturally Informed, Whole Person-Focused
2. Cultivating Connections Inside the System and Out
3. Rights, Choice, and Control
4. Partnership, Teamwork, Communication, and Facilitation
5. Documentation, Implementation, and Monitoring

National Center of Advancing Person-Centered Practices and Systems (NCAPPS)

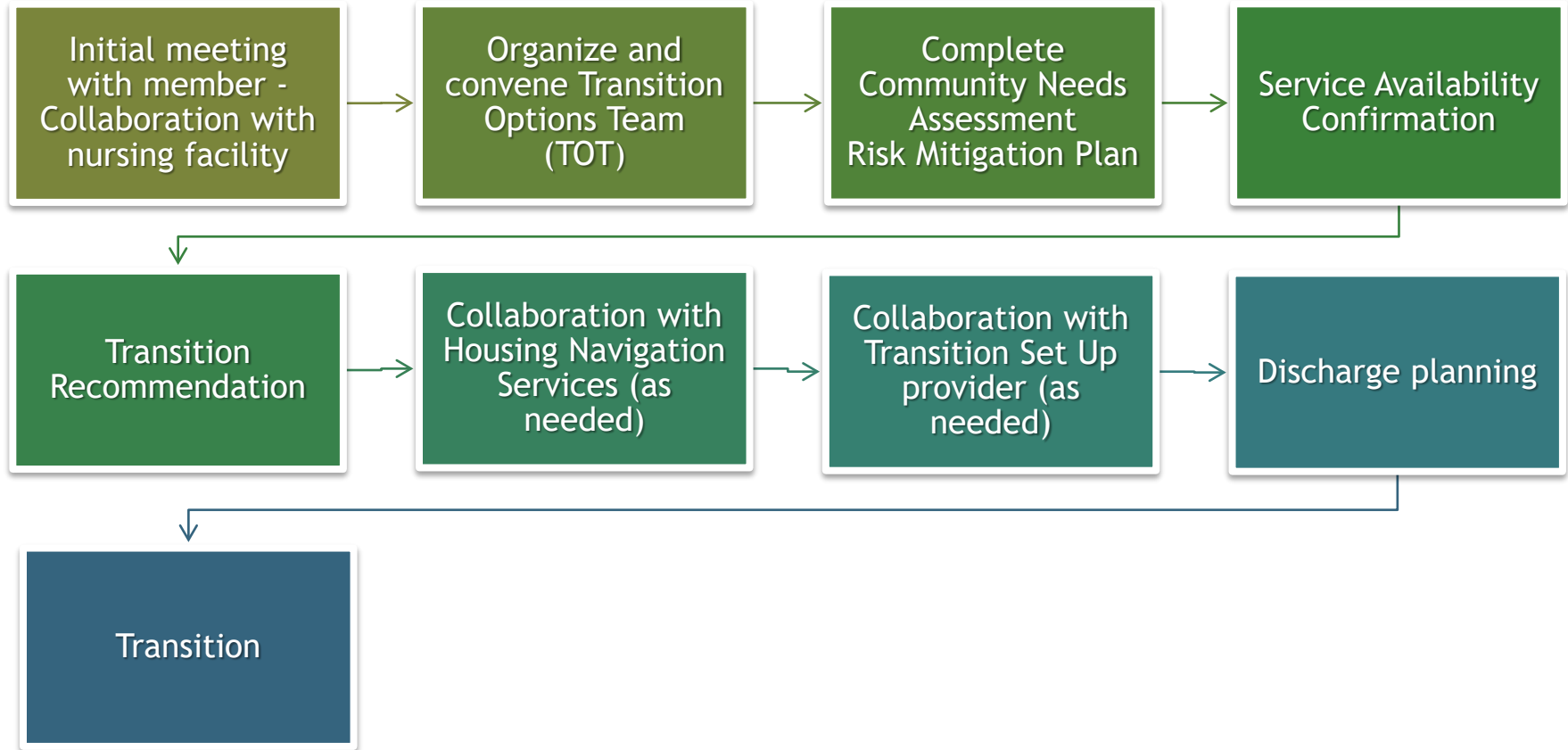
Transition Coordinator Skills

- Knowledge/experience with population
- Interview and assessment
- Intervention & interpersonal communication
- Knowledge of community resources
- Meeting facilitation
- Organization
- Time management
- Collaboration

Transition Coordination Responsibilities

- Advocate for member
- Document service provision and transition process
- Organize and facilitate Transition Options Team process
- Maintain communication
- Conduct activities to assist member to secure a community living arrangement
- Coordinate facility discharge
- Provide post-discharge monitoring

Community Living Options Process



There are multiple entities involved in the transition process.

Each has specific roles & responsibilities.





Questions?



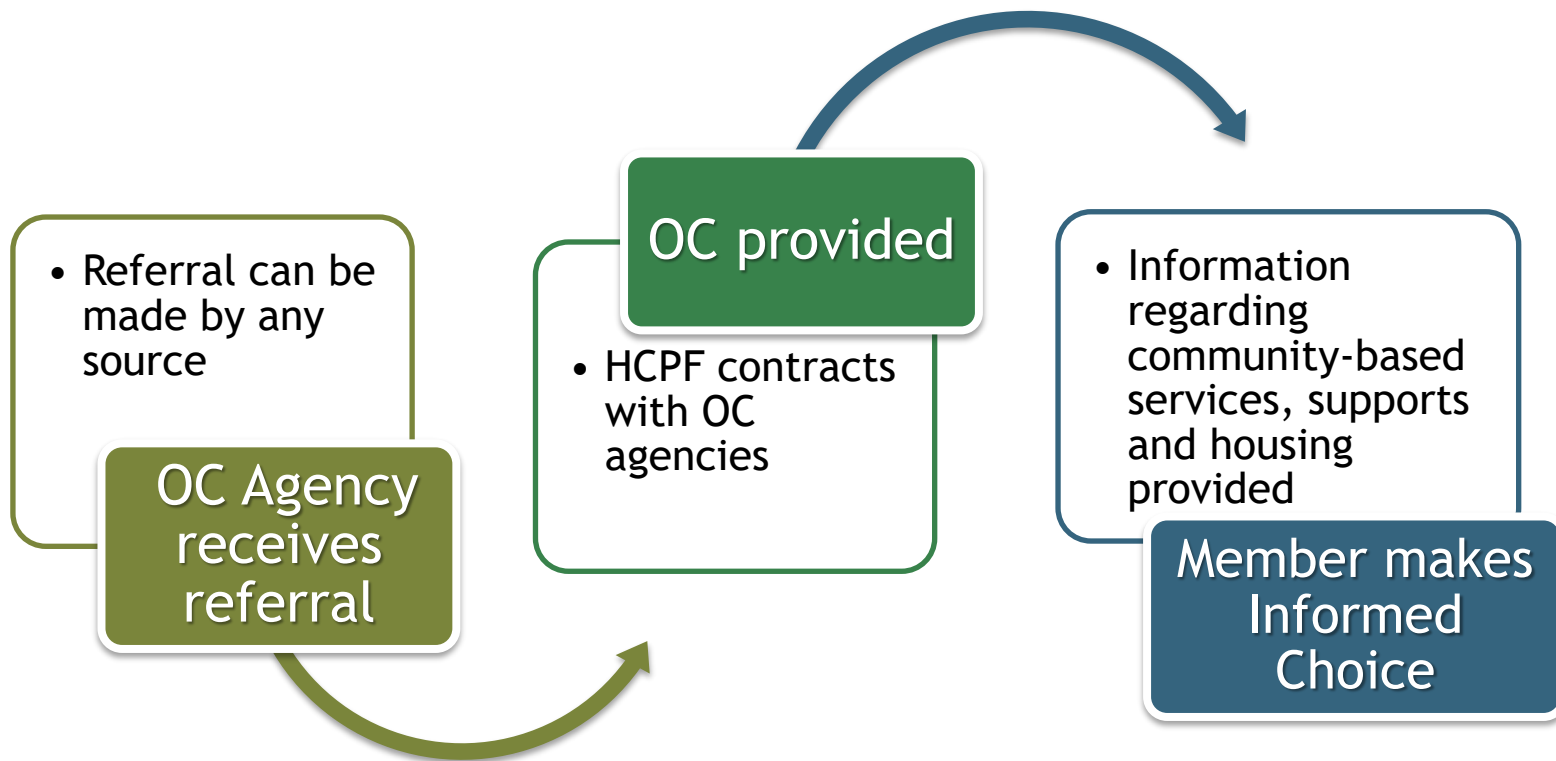
Session 2 Objectives

- Explain Options Counseling process
- Increase knowledge regarding the TCM-TC Services referral process

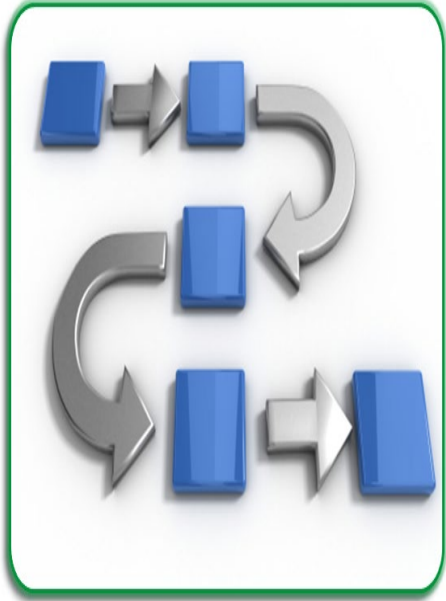
Options Counseling(OC)

Information provided to a nursing facility resident regarding community-based living services, supports and housing options to allow the individual the opportunity to make an informed choice regarding where and how to receive care.

Options Counseling Process



TCM-TC Referral Process



- Member has requested TCM-TC referral during OC meeting
- OC Agency sends referral to TCA
- Referral is accepted within 48-hours
- OC sends finalized TCM-TC referral email

Initiating TCM-TC Services

- Transition Coordinator assigned
- Targeted Case Management - Transition Coordination (TCM-TC) Services Referral Information Form is submitted to Single Entry Point (SEP) or Community Centered Board (CCB)
- Benefits Utilization System (BUS) access obtained
- Transition Process Information Screen is completed in BUS
- Initial meeting with member within 10-days of TCA referral acceptance



Questions?

Contact Information

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THANK YOU!