

# Post-Transition Coordination Services

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**COLORADO**

Department of Health Care  
Policy & Financing

# 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.



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

## Pre-Transition

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

## Post-Transition

- Supportive services to aid in sustaining community based living for individuals who have transitioned from nursing facilities

# Post-Transition Responsibilities

Monitor provision of basic needs to ensure health, safety and welfare

Home visits based on Community Risk Level

Communicate as needed to CMAs and RAEs



# Post Transition Focus

Community acclimation and integration

Promotion of independent living skills

Monitoring risk mitigation strategies

Responding to risk incidents



# Acclimation: adjusting to a new situation

*There will be a period of acclimation no matter how excited a person is to make a change in their life*

1. Acknowledge that adjustment may be difficult
2. Discuss how the situation will be different
3. Determine what may be most challenging
4. Make a plan to help with challenges

## Use to get perspective about a specific situation

What's Working

What's Not Working  
What can be Improved

What does the member say is working?

What does the member say is not working or could be better

What do others involved with the situation say is working?

What do others involved with the situation say is not working or could be working better?

# Good Day

- What happened that made this a good day?
- What do you look forward to doing?
- Who do you look forward to seeing?
- What gives you energy?
- What makes you happy?
- What could you do that you don't do now to have a good day?

# Bad Day

- What threw your day off?
- Made the day bad for you?
- Made you frustrated? Bored?
- Angry?
- Took the fun out of it?
- Who do you not look forward to seeing?
- What makes you sad? Lonely?
- What don't you like to do?

## Good Day

I get to go somewhere  
I have a puzzle to work on

## Bad Day

I'm alone all day  
I don't have anything to do



## Goal

Make a budget so I have money  
to go to store and buy a puzzle  
twice a month



## Important To

- ★ Having company
- ★ Having puzzles
- ★ Going out



## Ways to support me

Refer to LST for budgeting &  
travel training  
Ask to see my budget  
Admire my puzzles  
Maybe help me with my puzzle

# Effective Monitoring is a Continual Cycle



# Home Visit Objectives

- Confirm that basic needs are being met
- Confirm prevention strategies on RMP are being used and are effective
- Revise strategies as needed
- Review goals identified at last home visit
- Problem-solve challenges
- Add or remove risk factors from RMP as needed
- Celebrate successes
- Assess progress towards skill acquisition

# Home Visit Log Note

- Observation of member and home
- Confirmation that prevention strategies are being implemented and are effective
- Problem-solve/identification of new prevention strategies as needed
- Identification of new risk factors/challenges/problems
- Plan to address challenges/problems
- Identification of goals for upcoming week



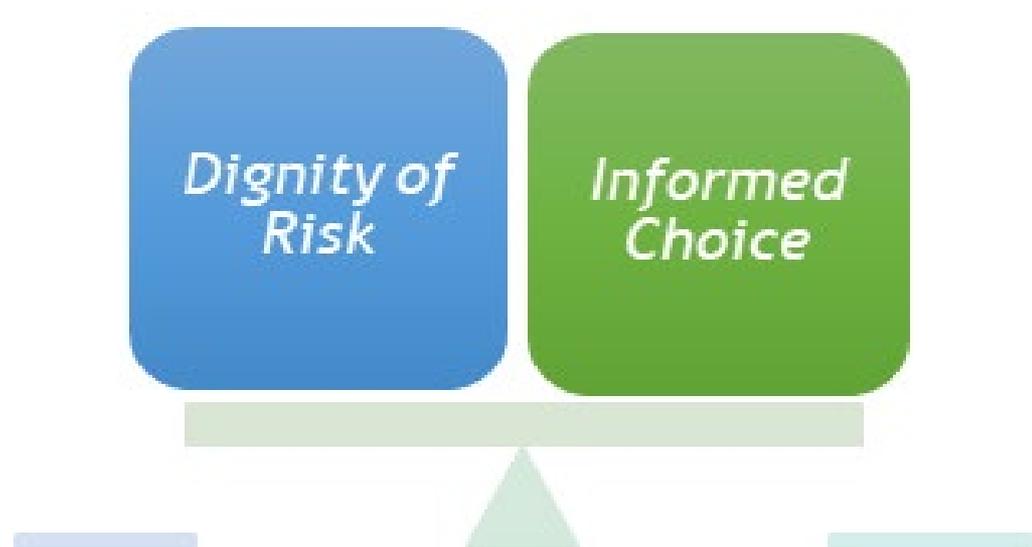


# Risk Mitigation

- Risk mitigation plan must be revised if new risk factors have been identified
- Hard copy is required for member signature
- Living tool that is referenced at each home visit
- BUS plan needs to be revised
- Log note to documentation discussion with members and other involved parties regarding the revision

# Common risks that surface after transition

- Substance misuse
- Complex medical conditions
- Interpersonal relationships
- Housing instability



## Substance Use

- Behavior disturbances
- Lease violations
- Interference with medications
- Financial troubles

## Complex Medical Condition

- Higher level of service provision
- Numerous service providers
- Medical appointments
- Community medical providers

## Regional Accountable Entities

Provide assistance to understand and manage physical and behavioral health benefits, help connect to providers.

# Family & Friends

Having a social support system will increase an individual's potential for successful community living

*Transition may have significant impact of family relationships*



*Create balance  
between  
Important To and  
Important For  
related to risk  
factors*



# Rebecca's Story

Rebecca is very happy in her apartment. She has a large family - five grandchildren. She loves having her grandchildren visit her. Now that she has her own place, it is important to her to be able to decide who can come to her apartment.

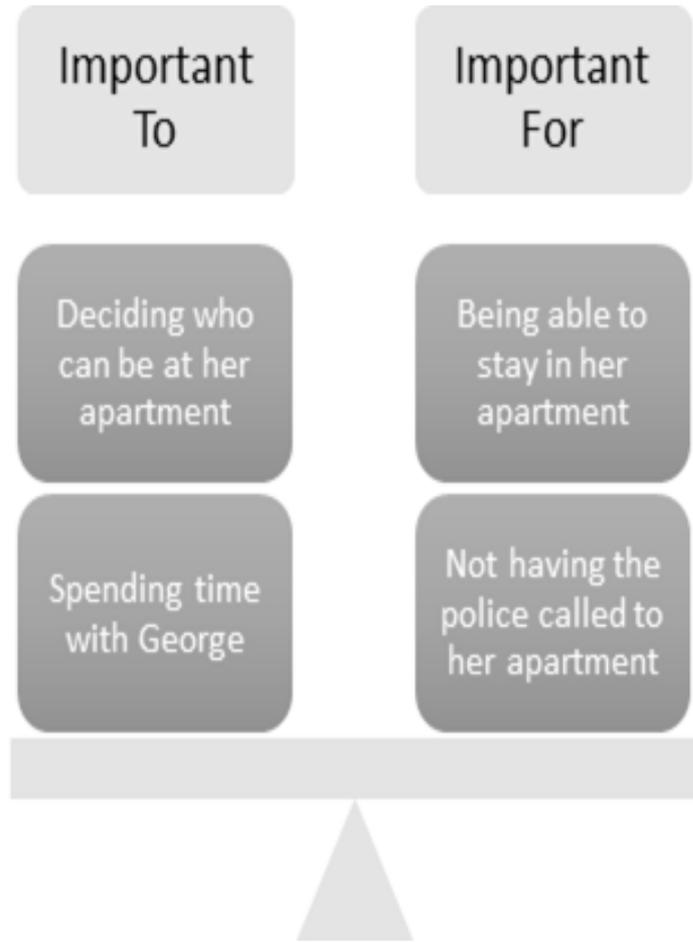
George is Rebecca's 17 year old grandson. George likes to hang out with his grandmother. Sometimes, he doesn't want to leave. He invites his friends over also because he knows his grandmother won't mind.

George and his friends have started a few fights with the other teen-agers who live in the apartment building. The police have been called and citations given.

Rebecca's landlord really likes her and wants her to be able to stay in the apartment. After the last fighting incident, he had to give Rebecca a warning and tell her that George can't stay in her apartment.



# *Rebecca's Important To - Important For*



# Stable housing is essential to community sustainment



- Neighbor relations
- Landlord relations
- Rent payment
- Voucher requirements
- Lease compliance
- Support for risk incidents

# Housing Support Tips

Ensure member has opportunity to learn necessary skills

Introduce member to landlord

Ensure member has and understands a copy of lease and voucher rules

Review lease and voucher requirements on regular basis

Assist member to establish method for paying rent

Establish method to track rent payment



# Post-Transition Support Person-Centered Tools

- Important To - Important For
- Working/Not Working
- Good Day/Bad Day



# Closing TCM-TC Services

- Bridge to long-term Medicaid services
- Services in place to sustain stability in community
- Plan with member how services will end
- Provide written notification to member
- Notify SEP CM and RAE CC - other providers as appropriate
- Complete Transition Summary screen in BUS
- Enter BUS log note

# Over Unit Cap Request

- Unit request form with updated risk mitigation plan submitted
- Explanation for need of additional units
- Description of objectives, outcome and timeline for requested units
- High community risk level substantiated



# Questions?

# Thank You!



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# Contact

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