**Project 2C: Transitional Care**

**Project Objective:** Improve transitional care services to reduce avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place.

**Target Population:** Medicaid beneficiaries in transition from intensive settings of care or institutional settings, including beneficiaries discharged from acute care to home or to supportive housing, and beneficiaries with SMI discharged from inpatient care, or client returning to the community from prison or jail.

**Evidence-based Approaches for Care Management and Transitional Care:**

1. Interventions to Reduce Acute Care Transfers, INTERACT™4.0, [https://interact.fau.edu/](https://interact.fau.edu/) - a quality improvement program that focuses on the management of acute change in resident condition.
3. The Care Transitions Intervention® (CTI®), [http://caretransitions.org/](http://caretransitions.org/) - a multi-disciplinary approach toward system redesign incorporating physical, behavioral, and social health needs and perspectives. *Note: The Care Transitions Intervention® is also known as the Skill Transfer Model™, the Coleman Transitions Intervention Model®, and the Coleman Model®.*
4. Care Transitions Interventions in Mental Health, [http://www.integration.samhsa.gov/Care_transition_interventions_in_mental_health.pdf](http://www.integration.samhsa.gov/Care_transition_interventions_in_mental_health.pdf) - provides a set of components of effective transitional care that can be adapted for managing transitions among persons with serious mental illness (SMI).

**Evidence-informed Approaches to Transitional Care for People with Health and Behavioral Health Needs Leaving Incarceration**

Despite the relative dearth of specific, outcomes-focused research on effective integrated health and behavioral health programs for people leaving incarceration, considerable evidence on effective integrated care models, prison/jail reentry, and transitional programming has paved the way for increased understanding of critical components of an integrated transitional care approach. Refer to the following:

Reference the “Project Implementation Guidelines” for additional details on the project’s core components, including Domain 1 strategies and evidence-based approaches, to guide the development of project implementation plans and quality improvement plans.

**Project Stages**

**Stage 1 – Planning**

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Proof of Completion</th>
<th>Timeline (complete no later than)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assess current state capacity to effectively deliver care transition services</td>
<td>Completed current state assessment</td>
<td>DY 2, Q2</td>
</tr>
<tr>
<td>• Identify how strategies for Domain I focus areas – Systems for Population Health Management, Workforce, Value-based Payment – will support project</td>
<td>Completed Financial Sustainability, Workforce, and Systems for Population Health Management strategies, as defined in Domain 1, reflective of support for Project 2C efforts</td>
<td>DY 2, Q2</td>
</tr>
<tr>
<td>• Select target population and evidence-based approach informed by regional health needs</td>
<td>Definition of target population and evidence based approach(s)</td>
<td>DY 2, Q2</td>
</tr>
</tbody>
</table>
| • Identify, recruit, and secure formal commitments for participation from implementation partners via a written agreement specific to the role each organization and/or provider will perform in the selected approach  
  o For projects targeting people transitioning from incarceration: identify and secure formal partnerships with relevant criminal justice agencies (including but not limited to correctional health, local releasing and community supervision authorities), | Identified implementation partners and binding letters of intent | DY 2, Q2 |
health care and behavioral health care service providers, and reentry-involved community-based organizations, including state and local reentry councils.

- Develop project implementation plan, which must include:
  - Implementation timeline
  - Description of selected evidence-based approach, target population, justification for how approach is responsive to specific needs in the region
  - If applicable, explanation of how the standard pathways selected in Project 2B align with the target population and evidence-based approach selected in this project;
  - Explanation of how the project aligns with or enhances related initiatives, and avoids duplication of efforts, consider Health Home and other care management or case management services, including those provided through the Department of Corrections
  - Roles and responsibilities of implementation partners
  - Description of service delivery mode, which may include home-based and/or telehealth options
  - Describe strategies for ensuring long-term project sustainability

<table>
<thead>
<tr>
<th>Stage 2 – Implementation</th>
<th>Proof of Completion</th>
<th>Timeline (complete no later than)</th>
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</thead>
<tbody>
<tr>
<td>Milestone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop guidelines, policies, procedures and protocols as necessary to support consistent implementation of the model / approach</td>
<td>Adopted guidelines, policies, procedures and/or procedures</td>
<td>DY 3, Q1</td>
</tr>
<tr>
<td>Develop Quality Improvement Plan (QIP), which must include ACH-defined strategies, measures, and targets to support the selected model / approach</td>
<td>Completed and approved QIP, reporting on QIP measures</td>
<td>DY 3, Q2</td>
</tr>
<tr>
<td>Implement project, including the following core components across each approach selected:</td>
<td>Estimated number of partners implementing each selected model / approach</td>
<td>DY 3, Q4</td>
</tr>
<tr>
<td>o Ensure implementation addresses the core components of each selected approach</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Establish guidelines, policies, protocols and/or procedures as necessary to support consistent implementation of the model
- Incorporate activities that increase the availability of POLST forms across communities/agencies (http://polst.org/), where appropriate.
- Ensure each participating provider and/or organization is provided with, or has secured, the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner.
- Implement robust bi-directional communication strategies, ensure care team members, including client and family/caregivers, have access to the care plan.
- Establish mechanisms for coordinating care management and transitional care plans with related community-based services and supports such as those provided through supported housing programs.
- Develop systems to monitor and track performance
- Establish a performance-based payment model to incentivize progress and improvement.

<table>
<thead>
<tr>
<th>Stage 3 – Scale &amp; Sustain</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone</strong></td>
</tr>
<tr>
<td>Increase scope and scale, expand to serve additional high-risk populations, and add partners to spread approach to additional communities</td>
</tr>
<tr>
<td>Employ continuous quality improvement methods to refine the model, updating model and adopted guidelines, policies and procedures as required</td>
</tr>
<tr>
<td>Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion</td>
</tr>
<tr>
<td>Identify and document the adoption by partnering providers of payment models that support transitional care and the transition to value based payment for services.</td>
</tr>
</tbody>
</table>

**Project Metrics**
<table>
<thead>
<tr>
<th>Year</th>
<th>Metric Type</th>
<th>Metric</th>
<th>Report Timing</th>
</tr>
</thead>
</table>
| **DY 3 – 2019** | **P4R – ACH Reported** | • Report against QIP metrics  
• Number of partners trained by selected model / approach: projected vs. actual and cumulative  
• Number of partners participating and number implementing each selected model / approach  
• % partnering provider organizations sharing information (via HIE) to better coordinate care | Semi-Annual |
| **DY 4 – 2020** | **P4R – ACH Reported** | • Report against QIP metrics  
• Number of partners trained by selected model / approach: projected vs. actual and cumulative  
• Number of partners participating and number implementing each selected model / approach  
• % partnering provider organizations sharing information (via HIE) to better coordinate care | Semi-Annual |
| **DY 5 – 2021** | **P4R – ACH Reported** | • Report against QIP metrics  
• Number of partners trained by selected model / approach: projected vs. actual and cumulative  
• Number of partners participating and number implementing each selected model / approach | Semi-Annual |
% partnering provider organizations sharing information (via HIE) to better coordinate care  
VBP arrangement with payments / metrics to support adopted model  

<table>
<thead>
<tr>
<th>P4P – State Reported</th>
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</thead>
<tbody>
<tr>
<td>Follow-up After Discharge from ED for Mental Health,</td>
</tr>
<tr>
<td>Follow-up After Discharge from ED for Alcohol or Other Drug Dependence</td>
</tr>
<tr>
<td>Follow-up After Hospitalization for Mental Illness</td>
</tr>
<tr>
<td>Inpatient Hospital Utilization</td>
</tr>
<tr>
<td>Outpatient Emergency Department Visits per 1000 member months</td>
</tr>
<tr>
<td>Percent Homeless (Narrow Definition)</td>
</tr>
<tr>
<td>Plan All-Cause Readmission Rate (30 Days)</td>
</tr>
<tr>
<td>Annual</td>
</tr>
</tbody>
</table>

**Project Implementation Guidelines:** This section provides additional details on the project’s core components and should be referenced to guide the development of project implementation plans and quality improvement plans.

**Guidance for Project-Specific Domain 1 Strategies**

- **Population Health Management/HIT:** Current level of adoption of EHRs and other systems that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes, and information to enable population health management and quality improvement processes; provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.

- **Workforce:** Capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs such as:
  - Shortage of Mental Health Providers, Substance Use Disorder Providers, Social Workers, Nurse Practitioners, Primary Care Providers, Care Coordinators and Care Managers
  - Opportunities for use of telehealth and integration into work streams
  - Workflow changes to support integration of new screening and care processes, care integration, communication
  - Cultural and linguistic competency, health literacy deficiencies

- **Financial Sustainability:** Alignment between current payment structures and guideline-concordant physical and behavioral care, inclusive of clinical and community-based; incorporate current state (baseline) and anticipated future state of VBP arrangements to support integrated
care efforts into the regional VBP transition plan. Assess timeline or status for adoption of fully integrated managed care contracts.
Development of model benefit(s) to cover integrated care models.

### Guidance for Evidence-Based Approaches

#### Evidence-based Approaches for Care Management and Transitional Care

#### Interventions to Reduce Acute Care Transfers, INTERACT™4.0

The skilled nursing facility (SNF) and the project implementation team will utilize INTERACT™4.0 toolkit and resources and implement the following core components:

- Educate leadership in the INTERACT™ principles.
- Identify a facility champion who can engage other staff and serve as a coach.
- Develop care pathways and other clinical tools for monitoring patients that lead to early identification of potential instability and allow intervention to avoid hospital transfer.
- Provide all staff with education and training to fill their role in the INTERACT™ model.
- Educate patients and families and provide support that facilitates their active participation in care planning.
- Establish enhanced communication with acute care hospitals, relying on technology where appropriate.
- Establish quality improvement process, including root cause analysis of transfers and identification and testing of interventions.
- Demonstrate cultural competence and client engagement in the design and implementation of the project.

#### Transitional Care Model (TCM)

Implement the essential elements of the TCM model:

- Use of advanced knowledge and skills by a transitional care nurse (TCN) to deliver and coordinate care of high risk older adults within and across all health care settings. The TCN is primary coordinator of care throughout potential or actual episodes of acute illness;
- Comprehensive, holistic assessment of each older adult’s priority needs, goals and preferences;
- Collaboration with older adults, family caregivers and team members in implementation of a streamlined, evidenced-based plan of care designed to promote positive health and cost outcomes;
- Regular home visits by the TCN with available, ongoing telephone support (seven days per week) through an average of two months;
Continuity of health care between hospital, post-acute and primary care clinicians facilitated by the TCN accompanying patients to visits to prevent or follow-up on an acute illness care management;

- Active engagement of patients and family caregivers with a focus on meeting their goals;
- Emphasis on patients’ early identification and response to health care risks and symptoms to achieve longer term positive outcomes and avoid adverse and untoward events that lead to acute care service use (e.g., emergency department visits, re-hospitalizations);
- Multidisciplinary approach that includes the patient, family caregivers and health care providers as members of a team;
- Strong collaboration and communication between older adults, family caregivers and health care team members across episodes of acute care and in planning for future transitions (e.g., palliative care); and
- Ongoing investment in optimizing transitional care via performance monitoring and improvement.

### Care Transitions Intervention®

**Implementation guidance:**

- A meeting with a Transitions Coach® in the hospital (where possible, as this is desirable but not essential) to discuss concerns and to engage patients and their family caregivers.
- Set up the Transitions Coach® in home follow-up visit and accompanying phone calls designed to increase self-management skills, personal goal attainment and provide continuity across the transition.

### Care Transitions Interventions in Mental Health

**Set of components of effective transitional care that can be adapted for managing transitions among persons with serious mental illness:**

- Adapt the following components, as proposed by Viggiano et al., of care transitions interventions to focus on points of transition for the SMI population, including discharge from intensive behavioral health care, and discharge from ER for mental health, alcohol, or other drug dependence. ([http://www.integration.samhsa.gov/Care_transition_interventions_in_mental_health.pdf](http://www.integration.samhsa.gov/Care_transition_interventions_in_mental_health.pdf))
- Prospective modeling: employ prospective modeling to identify who is at greatest risk. Consider different patterns of morbid conditions within and among mental illnesses, substance abuse disorders and general medical/surgical conditions that might require modifications.
- Patient and family engagement: create culturally competent engagement strategies to drive authentic inclusion of patient and/or family in treatment/transitional care plan. Adapt engagement strategies for individuals with SMI.
Transition planning: establish an appropriate client specific plan for transition to the next point of care. Consider how to utilize step-down mental health services, such as day treatment and intensive outpatient care. Consider trade-offs between length of stay for stabilization and risk of re-hospitalization. Include assessment of need of primary care planning as well as substance abuse and dual disorders. An assessment and specific plan for housing and other social services should be included.

Information transfer/personal health record: ensure all information is communicated, understood, and managed, and links patients, caregivers, and providers. Establish protocols to ensure privacy and other regulations are followed. Establish pathways for information flow among providers and clinics.

Transition coaches/agents: define transition coach role, tasks, competencies, training, and supervision requirements. Consider the need for mental health providers, such as social workers, to serve as transition agents or to train other personnel in mental health tools and techniques. Consider use of health information technology to augment/assist coaches.

Provider engagement: providers at each level of care should have clear responsibility and plan for implementing all transition procedures/interventions. Communication and hand-off arrangements should be pre-specified in a formal way.

Quality metrics and feedback: gather metrics on follow-up post-hospitalization, re-hospitalization and other feedback on process and outcomes and consumer/family perspective. Utilize metrics in quality improvement and accountability.

Shared accountability: all providers share in expectations for quality as well as rewards/penalties. Accountability mechanisms may include financial mechanisms and public reporting with regard to quality and value. Consumers/families share in accountability as well.

Evidence-informed Approaches to Transitional Care for People with Health and Behavioral Health Needs Leaving Incarceration

For projects targeting people transitioning from incarceration, include in the implementation plan at a minimum:

- Strategy to increase Medicaid enrollment, including:
  - Process for identifying (1) individuals who are covered under Medicaid and whose benefits will not be terminated as a result of incarceration; (2) individuals whose Medicaid eligibility will terminate as a result of incarceration; (3) individuals who will likely be Medicaid eligible at release regardless of current or prior beneficiary status;
  - Process for completing and submitting Medicaid applications for individuals (2) and (3) above, timed appropriately such that their status moves from suspended to active at release; and
  - Agreements in place with relevant criminal justice agencies to ensure individuals (1) above receive community-based, Medicaid-reimbursable care in a timely matter when clinically appropriate (with particular consideration of populations “at risk,” such as the elderly, LGBTQ, chronically ill, those with serious mental illness and/or substance use disorders, and more).

- Strategy for beginning care planning and transition planning prior to release, including:
- A process for conducting in-reach to prison/jails and correctional facilities, which leverages and contemplates resources, strengths, and relationships of all partners;
- A strategy for engaging individuals in transitional care planning as a one component to a larger reentry transition plan; and
- A strategy for ensuring care planning is conducted in a culturally competent manner and contemplates social determinants of health, barriers to accessing services or staying healthy, as well as barriers to meeting conditions of release or staying crime-free.