

Summary of the California Community Transitions (CCT) Transition Process

The CCT transition process is broken into five stages to simplify program administration and the billing process. Each stage of the process builds upon the ones that come before; and therefore, must be completed in the following order:

I. OUTREACH AND TARGETING

- A. CCT Lead Organizations (LO) identify local Medicaid-certified nursing facilities
- B. LOs meet and develop relationships with facility administrators, and educate facility staff about the CCT demonstration
- C. LOs identify, develop relationships with, and educate potential CCT participants
- D. LOs also establish relationships with the Managed Care Plans in the service area

Anticipated Outcomes:

- Increased recognition of, and knowledge about, CCT
- Stronger on-going business relationships between institutional care providers, HCBS organizations, and Managed Care Plans
- Growth of sustainable network of HCBS providers

II. INFORMATION GATHERING AND ENROLLMENT

- A. CCT LO Transition Coordinators (TC) conduct initial interview(s) with individuals who indicate they want more information on returning to live and receive services in the community
- B. If an individual expresses interest in transitioning, the TC provides him/her with a copy of the CCT information packet and thoroughly walks the individual through the contents
 1. The CCT Information Packet must include, but is not limited to, the following documents:
 - Authorization for Release of PHI
 - CCT Rights, Responsibilities, & Consent
 - Notice of Privacy Practices
 - Your Hearing Rights

2. The CCT Information Packet may also include:
 - Home Set-Up Resource
 - Independent Housing Disclosure
 - 24/7 Backup Plan
 - Initial Transition and Care Plan
 - Final Transition and Care Plan
 - Other documents included by the CCT LO
- C. In order to continue to work with, and on behalf of, the individual pursuing a transition to community-living, the TC must obtain signed consent from the individual (and/or, if applicable, the individual's Legal Representative)
- D. With the consent of the individual (or the individual's Legal Authority), the TC collects necessary records¹ and the LO's Registered Nurse (RN) completes the CCT Assessment and determines availability of services in the community for successful transition to community living
- E. Using Person-Centered Planning techniques and the information within the individual's completed CCT Assessment Tool, facility face sheet, and medications list, the CCT LO works with the individual, the individual's legal representative (if applicable), friends and family (as requested by the individual), facility discharge planner, and the assigned managed care case manager (as appropriate) to develop the Initial Transition and Care Plan (ITCP) based on the individual's preferences.
- F. The ITCP includes initial information pertaining to:
 - Health Care Services
 - Education/Training
 - Supportive Services
 - Social Services
 - Financial Services
 - Environmental Services
 - Other Services
- G. Upon completion of the ITCP, the TC submits the initial 20 hour Treatment Authorization Request (TAR) with attachments² to the assigned DHCS Nurse Evaluator (NE) for adjudication
- H. DHCS NE adjudicates the initial TAR

¹ Necessary records include: Medical file face sheet, medication list and schedule, and other documentation necessary to inform the development of a comprehensive Initial Transition Care Plan

² Attachments to the initial TAR include: the individual's CCT Assessment Tool, face sheet, meds sheet, and the ITCP. Before the initial TAR is submitted to DHCS, the TC must submit the CCT New Enrollee Information Form to the central CCT mailbox.

1. If the ITCP fulfills the individual's identified preference(s), need(s), and risk(s), the 20 hour TAR is approved, the resident is enrolled, and the LO continues to work with the individual
2. DHCS will immediately process the approval of the 100 hour pre-transition TAR.
3. If the ITCP does not meet the individual's identified preference(s), need(s), and risk(s), the DHCS NE notifies the LO that the plan must be revised to meet them
 - a) The 20 hour TAR is still billable for actual hours spend for enrollment

Anticipated Outcome(s):

- Individuals enrolled in CCT will be provided comprehensive transition planning services that meet their preference(s), and address their need(s) and risk(s)

III. IMPLEMENTATION

- A. Once the individual is enrolled in CCT, the transition team begins working with the participant to implement the ITCP by securing the necessary long term services and supports (LTSS) prior to discharge from the facility
- B. Appropriate medical and social supports are key to a successful transition, and the transition team works to identify current Medi-Cal managed care plan (if applicable), or options for enrollment, secure appropriate and available HCBS waiver, program, project, and/or demonstration services, community physician, housing, in home supportive services (IHSS), etc. to meet identified needs and preferences

Anticipated Outcome(s):

- Comprehensive transition and care plan is prepared, as directed by the CCT participant
- Robust and on-going communication between members of the transition team and the CCT participant/representative/family

IV. TRANSITION TO COMMUNITY LIVING

- A. When all of the HCBS LTSS are in place, the LO:
 1. Connects with the participant's community physician and schedules an appointment to ensure continuity of care
 2. Secure community physician's signature on the CCT Final Transition and Care Plan (FTCP) to indicate there will be no gaps in care post-transition to the community
 3. Submits the home set-up TAR for review and approval
 4. Conducts the Quality of Life (QoL) Survey (Baseline)
 5. Attaches the CCT FTCP to the Post-Transition TAR for review and approval

- B. On the day of discharge:
1. The TC must be with the CCT participant to assist with discharge
 2. Services must be in place, including: household set-up, delivery and set-up of equipment, financial arrangements, health care, and other services as needed
 3. Waiver and/or personal care services may still be in process, in which case, the LO shall provide “gap” services
 4. The participant must sign the Day of Transition Report to indicate all services and supports are in place and adhere to the FTCP as planned

Anticipated Outcome(s):

- The comprehensive supports and services provided to the participant in the community maintain, if not improve, the individual’s quality of life

V. FOLLOW-UP

- A. Post-Transition, CCT Los continue to collaborate with the participant and other service providers to:
1. Ensure the ongoing safety and sustainability of the transition
 2. Address any needs and/or concerns that may come up during the 365-day demonstration period, and prior to the completion of demonstration
 3. Remind the participant that the last day of the CCT demonstration is day 365, and that existing services will continue as long as the individual remains eligible for HCB Medi-Cal services
- B. Follow-up visits and/or phone calls are required at specific points of the 365-day demonstration period based on the qualified housing arrangement and services they receive
- C. In the twelfth (12th) month of the 365-day demonstration period, the LO will conduct the second QoL survey (1st follow up)
- D. Finally, in the twenty-third (23rd) month after the date of transition, the LO will visit the individual to conduct the third QoL survey (2nd follow up)

Anticipated Outcome(s):

- Safe and sustainable home or community-based living