UIC UNIVERSITY OF ILLINOIS AT CHICAGO Institute for Health Care Innovation
COLLEGE OF NURSING

Money Follows the Person Pathways to Community Living

Pre-Transition Processes

Division of Developmental Disabilities

Pathways To Community Living

Last Revised: March 2015

Goals of Collaborative Care Management

- Improve individual/guardian/family participation in health care decisions and management.
- Improve individual/family ability at self-management of health conditions, medication adherence, and participation in health promotion activities.
- Improve communication among/between individuals, families, providers, and care managers.

Goals of Collaborative Care Management

- Improve the coordination and delivery of quality care across the continuum of care.
- Improve individual/family health status, satisfaction, and quality of life.
- Improve the delivery of cost effective care in the least restrictive environment.

Collaborative Care Management Process

Enrollment of individual.

Assessment of individual.

Risk Identification involves identifying known risks based on findings from the assessment.

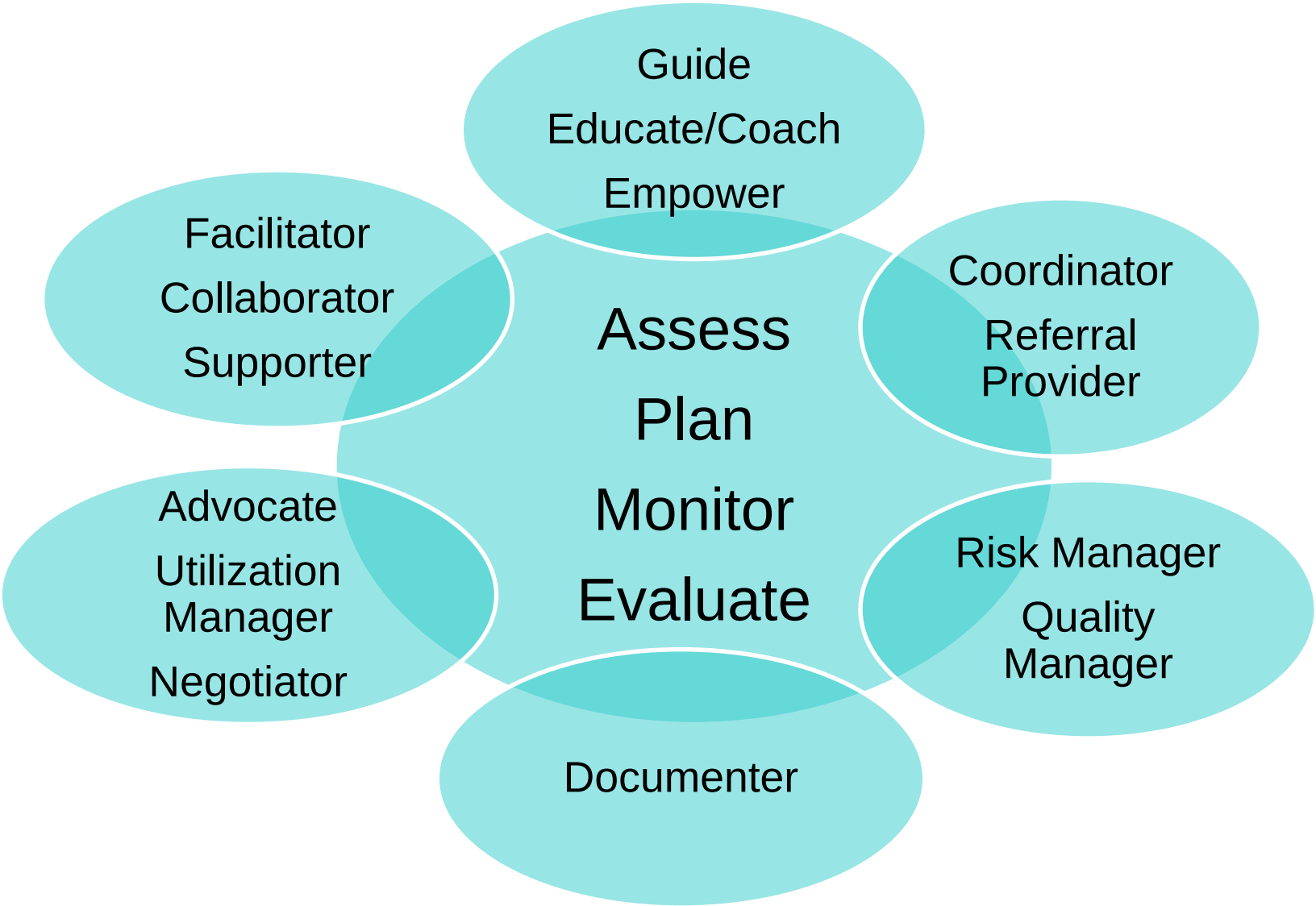
Mitigation Planning with individual, providers, family members, and/or guardian.

Collaborative Care Management Process

<u>Implementation of the Mitigation Plan</u> (Person Centered Plan/Individual Support Plan) involves the act of mitigating identified risks by following the recommended mitigation plan.

<u>Monitoring and Evaluation</u> of the mitigation plan, occurrence of physician visits, occurrence of critical incidents: hospitalizations, emergency room visits, and adjustments to mitigation plan.

Roles of an MFP Transition Coordinator



Case Study

Brady is a 50-year old, Caucasian male who currently resides at the ICFDD, Shining Star. Brady lived at home with his parents until they passed away 27 years ago and his brother/guardian, Bill, was unable to provide him with the necessary, community supports and services. Brady has never attempted to live on his own or in a CILA. Brady's diagnoses include profound intellectual disability, dysphagia, GERD, and generalized seizure disorder.

First Contact

- Connect with individual and/or guardian about participating in MFP/Pathways.
- Describe the MFP/Pathways program and the type of housing, services and supports available to the individual as part of the program. Available at: http://www.mfp.illinois.gov/
- Provide individual and/or guardian with transition coordinator's (PAS/ISC) contact information.

Enrollment & Informed Consent

- May need to schedule additional meetings or calls with individual and/or guardian until he/she feels comfortable enough to enroll.
- Transition coordinator (PAS/ISC) reviews MFP informed consent with individual and/or guardian.
- Individual or guardian signs informed consent indicating that he/she understands the rights, responsibilities, benefits, and risks involved in program participation.
- If the individual has more than one guardian either one or both guardians sign the informed consent.

* For those residing in SODC's, this conversation occurs with SODC staff.

Enrollment & Informed Consent

- Have the individual or guardian sign two copies of the informed consent: one goes to the individual or guardian and the other one goes to the transition coordinator.
- The date of signature is considered the date of enrollment in the MFP/Pathways program.
- Transition coordinator **faxes** a copy of the MFP Informed Consent to BTS, 217-558-1509

Enrollment & Informed Consent

- *Document individual's enrollment in the CRM WebApp database and upload the MFP Informed Consent **at least one day prior to transition** for MFP eligibility.
- Informed consent includes a statement about sharing information with UIC, which allows UIC to obtain additional documentation from other providers on the individual's care.

*SODC residents: BTS will complete case contact, enrollment documentation and upload the informed consent

Case Study 1st scenario

Brady's Guardian, Bill, is interested in moving Brady closer to his home. He is hopeful Brady could live in a small home with others whom Brady has established friendships. Bill contacts the ISC agent for Brady and asks if this is possible. The ISC Agent works with Bill to complete a packet of information that will be sent to the Community Providers of Bill's choice as Guardian. The ISC Agent will explain MFP involvement to Bill and ask him if he would like Brady to participate in this program when he moves to a Qualified Community Setting.

Case Study 1st scenario, cont.

When Bill signs and returns an MFP Informed Consent to the ISC Agent, an MFP Referral will be entered into the HFS Website for Brady by the ISC Agent, who will also be his MFP Transition Coordinator. When this case appears on the MFP caseload in the CRM database, the ISC Agent/Transition Coordinator will enter a case contact to document the first contact with Bill regarding the possible move to a smaller community setting, and will upload the signed MFP Informed Consent.

NOTE: The MFP Referral Website is open to the public and at any time, Bill could also enter an MFP referral for Brady.

Case Study 2nd scenario

ISC Agent met with Brady and his Guardian (Bill) at Shining Star Developmental Center. ISC Agent explained the MFP/Pathways program to Guardian. Bill said he would consider enrolling Brady into the MFP/Pathways program, but wanted to spend more time thinking about it before enrollment. ISC Agent sets up a meeting to discuss enrollment in two weeks. During those two weeks ISC Agent worked with Bill to compile a packet of information that will be sent to Community Providers of Bill's choice as Guardian for Brady. Two weeks later, Bill signs and returns an MFP Informed Consent for Brady's participation in MFP.

Case Study 2nd scenario, cont.

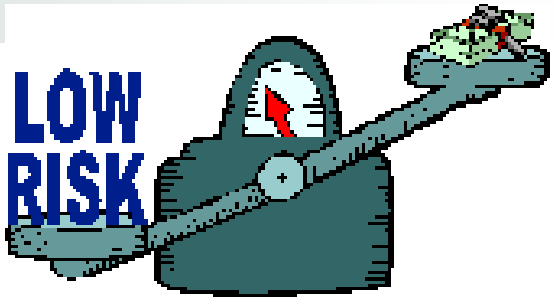
The ISC Agent will enter an MFP Referral for Brady into the HFS Website, and will also serve as his MFP Transition Coordinator.

As in the 1st scenario, when the case appears on the MFP caseload in the CRM database, the ISC Agent/Transition Coordinator will enter a case contact to document the date of first contact with Bill regarding movement to a smaller community setting, and will upload the signed MFP Informed Consent.

Assessment

- All assessments currently required by DDD for Waiver Funded Services will be uploaded to the individual's MFP caseload by the ISC Agent/Transition Coordinator. These currently include:
  - Ligas Transition Plan (if Ligas class member),
  - Current medication list
  - HRST,
  - SAMA,
  - Evaluation from specialty providers (i.e. psychological, psychiatric, PT, OT),
  - Individual Service Plan,
  - Behavior Plan,
  - ICAP,
  - Psycho-Social.

Risk Identification



- UIC will complete the MFP Risk Inventory based on the assessment findings uploaded to the individual's caseload in the CRM database.

- The following informational slide shows how this Inventory is developed by UIC

MFP Risk Identification/Inventory

I. Physical Health
II. Behavioral & Emotional Health
III. Substance Abuse
IV. Self-Harm or Harm to Others
V. Cognition
VI. Medication, Laboratory, and Utilization
VII. Functional
VIII. Environment
IX. Interpersonal & Social Supports
X. Engagement, Self-Management, Recovery

Risk Domains are broad categories in the MFP risk inventory. Questions are grouped within ten domains.

Medicaid Claims Review

- Medicaid Claims Data is generated by the State of Illinois Healthcare and Family Services Data Warehouse.
- Claims Data includes two or more years of any Medicaid claims submitted for hospitalizations, emergency room visits, institutionalization admissions/discharges, medical and psychiatric diagnoses, medications, and diagnostic procedures.
- Claims are uploaded to the WebApp by UIC staff after an Informed Consent is uploaded.

Mitigation Planning

- Mitigation planning involves developing strategies for implementation to reduce identified risks.
- SODC Individual Service Plan and Behavior Intervention Plan (as applicable) or Ligas Transition Plan and any Behavior Intervention Plan serves as the mitigation plan.
- The Mitigation plan is shared with UIC, sending ISC/TC, receiving ISC/TC, CILA provider, Guardian, and BTS representative.

UIC Case Review

- UIC completes a Case Review after the required assessment materials are uploaded to the CRM database.

- Case Review Domains include: demographics; social history; risk stratification; institutional admissions; hospitalizations/ER visits; medical, substance abuse, psychiatric, and developmental disability history.

- UIC shares case review with the sending ISC/TC, receiving ISC/TC, CILA provider, Guardian, and BTS representative prior to the transition plan meeting.

Transition Plan Meeting

- The purpose of the transition plan meeting is to review and discuss the individual's service plan including the individual's health needs, environmental needs, vocational skills, cultural considerations, past residential services, strengths and abilities, likes and dislikes, guardian's considerations, provider's considerations, and miscellaneous administrative work.
- Transition plan **meeting should occur within 2 weeks** of anticipated transition date, but MUST OCCUR PRIOR TO moving to community home. (All assessment materials must be uploaded to the CRM database prior to this 2-week time frame.)
- Staff required to participate in this meeting include: Sending and Receiving ISC/TC; CILA provider; SODC staff and Receiving BTS rep.(if SODC resident); ICFDD staff; UIC staff. Guardian may participate if desired.
- The 24-hour back-up plan is completed at the transition plan meeting.

Case Study – Transition Plan Meeting

- ISC/TC learned at the pre-transition staffing that Brady was hospitalized last week related to having a grand mal seizure.
- His Depakote was adjusted to account for a non-therapeutic level.
- UIC updated medication list: (Depakote 500 mg take 2 tablets in the morning and 1 tablet in the evening) in the MFP care management system.

Transition Planning

- Use the MFP transition checklist to determine if items are arranged/purchased/coordinated for the individual.
- Examples of tasks on the Transition Checklist include:
  - Obtain birth certificate.
  - Determine staff ratio.
  - Determine who will provide services.
  - List all identified providers on 24-hour back up plan.
  - Schedule appointment with primary care provider in the community.
  - Identify any specialty provider(s) and schedule appointment.
  - Collaborate with SODC or ICF/DD to have medication ready on the day of transition.

After the Transition Plan Meeting

- If revisions are needed to any MFP documents/forms after the Transition Meeting, UIC will accomplish this task.
- The Quality of Life Survey will be completed within 30 days prior to transition.
- Anyone administering a Quality of Life Survey (QoL) must be trained by HFS staff prior to any survey completion.

Quality of Life Surveys (Q o Ls)

- QoLs are completed at 3 intervals: prior to transition; at the 11th month after transition; at the 24th month after transition.
- If SODC resident-SODC completes Initial Survey and receiving ISC/TC completes 11 and 24 month Surveys.
- If private ICFDD resident- Sending ISC/TC completes the Initial Survey and Receiving ISC/TC completes 11 and 24 month Surveys.

MFP CRM Webapp Process- Pre-Transition ANE Check

- A new process of checking for history of ANE (abuse, neglect and exploitation) has been implemented in April 2016 to occur on all MFP participants enrolled with Informed Consent & in the Pre-Transition stage in CRM.
- The ANE check is completed by staff at IDoAs BEAM unit.
- The case cannot move into the Transition Stage to document transition to the community until the ANE check has been completed.
- Contact HFS.MFP@Illinois.gov with questions