Transition Checklist

This checklist provides a guideline for sharing critical information at points where a member's care is transferred between care settings or care professionals and service providers. It can be used as a standalone checklist or incorporated within an EHR or care management platform. Organizations using the checklist must ensure that information sharing is consistent with member/guardian consent and is in compliance with all state and federal laws including HIPAA.

Initial Care Management Assignment

Upon consent of a member to participate in Tailored Care Management, a TCM Care Manager initiates the Comprehensive Care Management Assessment (CCMA). The Care Manager should make best efforts to share results of the CCMA with member, the member's legally responsible person/guardian (where applicable), the member's primary care, behavioral health, I/DD, and TBI providers (including 1915(i) providers) within 14 days of completion.

Comprehensive Care Management Assessment

- Existing medical records (behavioral health, physical health, dental and other)
- Results from screening tools and level of care determination tools including:
  - **Child and Adolescents Needs and Strengths (CANS) -** a widely-used tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.
  - **American Society of Addiction Medicine (ASAM) Criteria -** a comprehensive set of standards and decision rules that use a holistic, person-centered approach to determining the appropriate level of care and developing treatment plans for patients with addiction and co-occurring conditions.
  - **Supports Intensity Scale (SIS) –** A tool used with individuals in North Carolina's Innovations Waiver program to guide development of Person-Centered Service Plans and to set Individualized Budget Amounts to be used for service. The SIS identifies what help a person with intellectual or developmental disabilities needs to do the same things that others without disabilities do every day, such as assistance needed to shop, prepare meals, work, have friendships, and other daily life activities.
  - **Rancho Los Amigos Levels of Cognitive Functioning Scale –** a tool used with individuals participating in the North Carolina TBI Waiver program to evaluate cognitive and behavioral recovery for persons with traumatic brain injury as part of service and rehabilitation planning.

- **The 1915(i) Assessment Tool –** An assessment conducted with members obtaining or seeking to obtain 1915(i) services. The purpose of the assessment is to see which 1915(i) services eligible Medicaid members need in order to stay in their home and community rather than a facility.
- Existing crisis plans & advance directives
- Current services and providers across all health needs
- Functional needs assessments
- Detailed medication history – a list of all medicines, both over-the-counter medication and medication that has been prescribed, dispensed or administered (and known allergies)

Transitions of Care

A. Provided To The Hospital/Skilled Nursing, Etc

- Demographic information including linguistic and cultural preferences
- Advanced directives
- Relevant medical record information including:
  - Diagnosis, known co-morbidities & chronic conditions
  - Labs and other tests
- A list of all medications, both over-the-counter medication and medication that has been prescribed, dispensed or administered (and known allergies)
- Known history of medication adherence
- Potential for polypharmacy, opioid or substance abuse
- Medication changes by the treating facility/provider
- Needed medications prior to discharge
- Discharge Plan
- Current Care Plan/ISP
- Key provider(s) contact information (PCP, psychiatrist, etc)
- Assigned Care Manager name and contact information

B. Provided To Family/Care-Giver or Community Stakeholders

- 90-day transition plan as an amendment to the member's care plan or ISP that outlines how the member will maintain or access needed services and supports, transition to the new care setting, and integrate into his or her community.
- Diagnosis, co-morbidities, chronic condition
- Medications, known history of adherence

Transition Checklist

- Potential for polypharmacy, opioid or substance abuse
- Appointments
- Cognitive or functional impairments
- Behavioral health issues
- Health-related social needs and social services needed

Service Referrals

Service referral information should be adjusted based on whether the referral is for medical/ behavioral or social needs and whether the receiving organization is a HIPAA covered entity.

- Diagnosis, co-morbidities, chronic condition
- Medications, known history of adherence
- Potential for polypharmacy, opioid or substance abuse
- Scheduled appointments with other healthcare professionals and agencies
- Cognitive or functional impairments
- Behavioral health issues
- Health-related social needs and social services needed