CSC of Dane County Best Practice Procedure

Member/participant transfer between programs

- The **current entity (MCO or ICA)** Enrollment Department receives a *Long-Term Care Program Member or Participant Request to Transfer and Enroll form F-03397* (https://www.dhs.wisconsin.gov/library/collection/F-03397) from the ADRC. If a person has chosen to transfer to the Partnership program, a *Partnership Supplement F-03398* (https://www.dhs.wisconsin.gov/library/collection/F-03398) is also completed and sent. The ADRC I & A includes an email message with notes containing relevant information. In some MCO instances, this communication could be for same day enrollment in a new entity.

- The **current MCO or ICA** forwards the disenrollment/transfer information to the member/participant's new care team immediately. Receipt of the *Long-Term Care Program Member or Participant Request to Transfer and Enroll form F-03397* triggers preparation of file documentation and transfer of file documents to the receiving entity. This form is sent upon scheduled enrollment into receiving entity and for Family Care, this can be same-day.

- The **MCO or ICA entity receiving the referral** should **call** the current entity identified "point person" (Program Manager or Supervisor) immediately to obtain information about the member/participant in order to facilitate a "warm transfer". Contact list for "point persons" in Dane County is at the end of this document.

    a. A social history
    b. Recent hospitalization or institutional stay information – where, when, duration, reason
    c. Recent police contact information- where, when, duration, reason, outcome
    d. Concerns about providers working with the member/participant
    e. Favorite items/activities/approaches specific to the member/participant
    f. Review of any specific items in the I & A email message
    g. Discuss need for proactive police contact for continuity of care/safety purposes, and make contact if needed
    h. Discuss need for proactive contact with agencies such as Journey, TIES, RSI and make contact if needed

- Documents the **current MCO or ICA should** provide to the **receiving MCO or ICA**:

    a. *LTCFS
    *Note that even if the member/participant does not sign the ROI section of the form, their LTCFS can be transferred under Wis. Stat. § 46.284(7), and the ROI section of the form contains a statement to inform the member/participant of this fact. Once the member/participant completes and signs the F-00221 and the applicable enrollment form, the ADRC will transmit it to the member/participant's new MCO/ICA agency and existing MCO/ICA agency.

    If the current entity still "owns" the LTCFS and there is a delay in releasing it, provide a paper copy to the receiving entity.

    b. Service plan/care plan
    c. Authorizations and names of current service providers
    d. Guardianship documentation (if applicable)
    e. Behavioral Support Plan
    f. Police Plan or Safety Plan (used more with people with IDD)
    g. TIES plan (used more with people with IDD)

h. File of Life (used more with people with dementia)

- ☐ During intake into a new entity, while creating a new care/service plan, obtain from the member/participant and previous providers:

  a. A social history
  b. Recent hospitalization or institutional stay information – where, when, duration, reason
  c. Recent police contact information- where, when, duration, reason, outcome
  d. Concerns about providers working with the member/participant
  e. Favorite items/activities/approaches specific to the member/participant

- ☐ The new ICA or MCO should have the following information on file for each new member/participant before enrollment, or at a minimum within the first 60 days. If a crisis plan is in place, it should be on file and shared with all parties immediately.

  a. LTCFS
  b. Service plan/care plan
  c. Authorizations and names of current service providers
  d. Legal guardian of person and estate (if applicable) or activated health care power of attorney or activated financial power of attorney name, address, phone number, email address
  e. Police Plan or Safety Plan (used more with people with IDD)
  f. TIES plan (used more with people with IDD)
  g. File of Life (used more with people with dementia)
  h. Behavioral support information (or formal Behavioral Support Plan if needed)– triggers, behavioral health and dementia concerns, effective responses
  a. Name, DOB, MA and Medicare numbers
  b. Member/participant current address
  c. Current phone number and email address
  d. Home/residential support contact name, agency, business hours phone number and after hours number
  e. After hours contact name, phone number and description of relationship (could be the same as "m" above)
  f. Informal support(s) name, phone number and address
  g. Current, active diagnosis and medical issues list

NOTE: The ADRC LTCFS notes will contain information, if it was provided, about hospitalizations.

- ☐ Crisis plans and service/care plans should be reviewed with all parties on the team, including service providers, member/participant/family at least annually, and updated accordingly.

Special Considerations for Members/Participants at risk for crisis during transitions:

- **The sending MCO should complete a *Family Care Member County Notification Form F-02558* (*https://www.dhs.wisconsin.gov/forms/f02558.docx*) and submit the form to the receiving County prior to a move when there is an identified need to inform County crisis programs, emergency mental health, or Adult Protective Services. In Dane County, the form can be submitted to the Dane County APS email box: APSMail@countyofdane.com**
- **If there is a police plan from another County, or another jurisdiction within Dane County, it should be updated and shared with law enforcement personnel in the member/participant's new district before the transition.**
- **Advanced planning and communication is essential. If possible, same day enrollments into a new MCO or ICA should be avoided to allow for proper planning and communication among all parties.**