Adult Care Home Resident Discharge Team Procedures

House Bill 677 (Session Law 2011-272)

Division of Aging and Adult Services

Division of Mental Health/Developmental Disabilities/Substance Abuse Services

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Appendices

Adult Care Home Resident Discharge Team Procedures

I. Statement of Purpose

Purpose of House Bill 677 (Session Law 2011-272)
An act to provide adult care homes with greater flexibility in the transfer and discharge of residents and to enact appeal rights for adult care home residents and adult care homes with respect to discharge decisions and to create Adult Care Homes Resident Discharge Teams (ACH-RDT) within every county which contains an adult care home licensed under Chapter 131D of the General Statutes. The legislation can be found at: http://www.ncga.state.nc.us/Sessions/2011/Bills/House/PDF/H677v7.pdf. Flow charts outlining the overall statutory provisions are available in Appendix A and B of these procedures.

Target Population
Persons eligible to be served through the utilization of the ACH-RDT are individuals:

- Residing in a 131D licensed Adult Care Home (ACH) or Family Care home (FCH) and
- Who have received a notice of discharge, and at the time of discharge, the destination is unknown, or is not appropriate, and
- For whom placement assistance is needed and for whom the ACH/FCH has requested assistance.

II. Adult Care Home Resident Discharge Team Requirements

Department of Social Services Establishes a Team
Each department of social services (DSS) in a county with a licensed adult care home must establish an ACH-RDT. An ACH-RDT must include at least one member of the DSS and one member of a Local Management Entity (LME).

Information about LMEs can be found at:
http://www.ncdhhs.gov/mhddsas/lmeonbluebyname.htm

Information about DSSs can be found at:
http://www.ncdhhs.gov/dss/local/docs/directory.pdf.

Upon request of the resident/consumer or the resident/consumer's legal representative, the Regional Long Term Care Ombudsman shall serve as a member of an ACH-RDT. Information about Regional Long term Care Ombudsmen can be found at http://www.ncdhhs.gov/aging/ombud/ombstaff.pdf.

An ACH-RDT will explore an array of options/housing settings and utilize the expertise of its members to locate an appropriate placement for the resident/consumer. Other individuals that the DSS and LME deem necessary to carry out the function of an ACH-RDT may be asked to participate. These other members should be knowledgeable about ACH/FCHs, placement options, and community services and resources. An ACH-RDT should consist of members who are able to meet on short notice. Each community is unique and may have agencies and individuals who can play an important role on an ACH-RDT. In some instances it may be appropriate to access housing specialists to work with an ACH-RDT.

The county in which the ACH/FCH is located (where the resident/consumer resides) has the responsibility for convening an ACH-RDT even if Special Assistance or Medicaid funding originates from another county. In a situation where the Special Assistance or Medicaid funding originates from another county, both DSSs and the LMEs are expected to work together to ensure the safe and orderly transfer or discharge of the resident/consumer when needed.

Use of Multi-Disciplinary Teams as ACH-RDTs
Some counties have already established Multi-Disciplinary Teams (MDTs) that include the LME and other individuals and organizations. These teams or a subset of the MDTs may be used as an ACH-RDT since they are already composed of the required members and are collaborating on many issues related to services for consumers. As with a newly established ACH-RDT, the MDT must be flexible and available to meet on short notice and carry out all statutorily mandated provisions for an ACH-RDT.

DSS Participation on an ACH-RDT
The DSS is to identify one person who will be the primary point of contact for an ACH-RDT. This is the person the ACH/FCH contacts when there is a request to convene an ACH-RDT. The DSS is to provide the contact information to each of its ACH/FCHs and the LME responsible for the county in which the resident/consumer resides.

- DSS is to identify an alternate team member(s) who can serve on an ACH-RDT in the event that the primary DSS team member is unable to participate.
- The DSS is to contact other members to serve on an ACH-RDT as determined by the DSS and LME. These members may vary based on the needs of the resident/consumer.

LME Participation on an ACH-RDT

When there is a need to convene an ACH-RDT, the DSS will call the LME (where the ACH/FCH is located) Screening, Triage and Referral (STR) toll free number during business hours to notify the LME of the discharge and request an LME staff be identified to serve on an ACH-RDT. Each LME's toll free number can be found on the Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SA) website at:http://www.ncdhhs.gov/mhddsas/lmeonbluebyname.htm.

Since an ACH-RDT must convene within 2-3 business days, the LME is required to respond to the DSS contact and identify an LME staff to serve on an ACH-RDT within one business day from the receipt of the call. The "host" LME (where the ACH/FCH is located) may be required to consult with the "home" LME (LME where the Medicaid originates that may be managing the care of the resident/consumer). The LME may (at its discretion) identify a specific staff(s) to respond to all ACH-RDT participation requests made by a DSS and to serve as a standing member, but it is not a requirement.

The LME is also required to establish written internal procedures which clearly describe the steps that the LME will take to ensure that the DSS request is addressed within the required one business day time frame after receipt of the call. In addition, the written internal procedures should include, but not be limited to the following information:

- Procedure to document and track the DSS request
- Procedure to identify staff to serve on an ACH-RDT
- Procedure to notify the DSS contact person of the LME staff to who serve on an ACH-RDT
- Procedure to coordinate the completion of a comprehensive clinical assessment, if it is determined by the LME that a comprehensive clinical assessment is needed to determine any unmet mh/dd/sa needs
- Procedure to contact the "home" LME (LME where the Medicaid originates) that may be managing the care of the resident/consumer (in the event that the LME takes the lead role for the discharge destination)
- Procedure to document the discharge destination, connection to benefits, services, etc. (in the event that the LME takes the lead role for the discharge destination)
- Procedure to notify the DSS about the final discharge destination (in the event that the LME takes the lead role for the discharge destination)

A description of Statewide Crisis Services in North Carolina for mental health, substance abuse, and intellectual/developmental disabilities issues is available in Appendix C of these procedures.

Lead Role within an ACH-RDT

At the time that an ACH-RDT is established, the members will discuss the expectations of the lead role based on the situation with the resident/consumer involved in the discharge. Although one entity will be designated as lead, it is expected that all members will work together to identify resources to ensure the safe and orderly transfer or discharge of residents/consumers and establish who will take the lead to assist the ACH/FCH in locating placement.

- LMEs shall take the lead role for the discharge destination for those residents/consumers whose primary unmet needs are related to mental health, developmental disabilities, or substance abuse and who meet the criteria for the target population established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. Information about target populations is available in Appendix D of these procedures.

- DSSs shall take the lead role for the discharge destination for those residents/consumers whose primary unmet needs are related to health, including Alzheimer's disease and other forms of dementia, welfare, abuse, or neglect.

Involving Housing Resources on an ACH-RDT

When housing options are needed for the safe and orderly discharge of a resident/consumer, it may be appropriate to include housing specialists on an ACH-RDT for assistance with immediate housing needs. An ACH-RDT may benefit from developing an ongoing relationship with entities that develop affordable housing.

Public Housing Agencies (PHAs) operate Public Housing developments and administer the Section 8 Housing Choice Voucher Program. Contact information for NC PHAs can be found at: www.hud.gov/offices/pih/pha/contacts/states/nc.cfm.

Twenty-three cities in NC directly receive Community Development Block Grant (CDBG) Program and HOME Investments Partnerships Program funds from the US Department of Housing and Urban Development. These funds may be used to develop affordable housing. Direct entitlement cities include: Asheville, Burlington, Cary, Chapel Hill, Charlotte, Concord, Durham, Fayetteville, Gastonia, Goldsboro, Greensboro, Greenville, Hickory, High Point, Jacksonville, Kannapolis, Lenoir, Morganton, Raleigh, Rocky Mount, Salisbury, Wilmington, and Winston-Salem. Contact local city governments to identify which government agencies administer CDBG and HOME funds and which local partners CDBG/HOME administrators recommend for potential partnership.

All county governments have departments that address housing-related issues, but names of these departments vary. Look for departments that include words like neighborhood development, community development, economic development, and/or housing development.

LME Housing Specialists have developed partnerships with entities that finance, develop and operate affordable housing and supportive housing for persons with disabilities and often participate in or chair local housing committees, local affordable housing coalitions, 10 Year Plan to End Homelessness committees, and local Continuums of Care, which are responsible for applying for homeless program funding from the US Department of Housing and Urban Development. LME Housing Specialists can help the DSSs identify private housing developers and operators and other partners that have special interest in housing for persons with special needs in local communities.

In addition to the above resources, http://www.NCHousingSearch.org is a free searchable registry for finding affordable rental housing and housing with accessible features across North Carolina. The site lists numerous rental units throughout the state and allows for customized searches to meet certain specifications. The site provides a free communication tool for property owners and managers to list available properties and maintain up-to-date vacancy information.

III. Process for ACH/FCH to Request an ACH-RDT

Overall Responsibilities of the ACH/FCH

It is expected that the ACH/FCH will understand and follow the requirements of House Bill 677 (Session Law 2011-145). The ACH/FCH retains responsibility for the resident/consumer until the discharge is completed. The discharge still must occur in a safe and orderly manner in accordance with the North Carolina General Statutes and adult care home licensure rules. The adult care home licensure rules can be found at: http://www.ncga.state.nc.us/gascripts/statutes/statutelookup.pl?statute=131D

Reasons for Initiating a Discharge

An ACH/FCH may initiate discharge of a resident/consumer based on any of the following reasons as stated in North Carolina General Statutes 131D-4.8 Discharge of Residents; Appeals. The General Statute can be found at: http://www.ncga.state.nc.us/Sessions/2011/Bills/House/PDF/H677v7.pdf

- The discharge is necessary to protect the welfare of the resident and the adult care home cannot meet the needs of the resident, as documented by the resident's physician, physician assistant, or nurse practitioner.
- The health of the resident has improved sufficiently so that the resident is no longer in need of the services provided by the adult care home, as documented by the resident's physician, physician assistant, or nurse practitioner.
- The safety of the resident or other individuals in the adult care home is endangered.
- The health of the resident or other individuals in the adult care home is endangered, as documented by a physician, physician assistant, or nurse practitioner.
- The resident has failed to pay the costs of services and accommodations by the payment due date specified in the resident's contract with the adult care home, after receiving written notice of warning of discharge for failure to pay.
- The discharge is mandated under this Article, Article 3 of this Chapter 131D, or rules adopted by the Medical Care Commission.

Request by ACH/FCH to Convene an ACH-RDT

A request to convene an ACH-RDT can only be made by an ACH/FCH. The ACH/FCH should identify staff responsible for initiating these requests and to serve as the ACH/FCH point of contact for the DSS.

When the ACH/FCH is aware that a resident/consumer may need to be discharged, the ACH/FCH must take the necessary steps to find an appropriate destination prior to issuing the notice of discharge. If, at the time the discharge notice is issued, the destination is unknown, or the destination is not appropriate, the ACH/FCH must request an ACH-RDT be convened to assist with finding an appropriate placement. The ACH/FCH is not solely responsible for securing an appropriate discharge destination. The ACH/FCH should request the assistance of an ACH-RDT at the time a discharge notice is given, if the destination is unknown or is not appropriate.

The ACH/FCH may have identified a discharge destination at the time the discharge notice was issued. However, there will be circumstances when sometime during the 30-day discharge timeframe, the discharge destination is no longer available. As a result, a request by the ACH/FCH for an ACH-RDT to be convened may come at any time during the 30 day timeframe.

Confidentiality and Consent for Release of Information Requirement
Meetings of an ACH-RDT are not subject to the provision of Article 33C of Chapter 143 of the General Statutes (public access to the meetings or information shared in these meetings). All information and records acquired by an ACH-RDT are confidential unless all parties give written consent to the release of that information.

Consent for Release of Information:
The ACH/FCH must obtain and provide to an ACH-RDT, a written "consent for the release of information" signed by the resident or the resident's legal representative in order for the resident/consumer's personal/medical information to be shared with an ACH-RDT. A Consent for the Release of Information to an Adult Care Home Resident Discharge Team form is available in Appendix E of these procedures.

ACH-RDT Confidentiality Statement:
Each ACH-RDT team member must sign a confidentiality statement to assure that all information made available to him/her as a team member remains confidential unless the resident/consumer or the resident/consumer's legal representative gives written consent that it can be shared. A Statement of Confidentiality form is available in Appendix F of these procedures.

Information Provided by the ACH/FCH to an ACH-RDT
The ACH/FCH is to provide the following information for use by an ACH-RDT. The information is to be provided to the DSS point of contact prior to the initial meeting of an ACH-RDT.

- The Adult Care Home Notice of Discharge with the Adult Care Home Hearing Request Form;
- Name of Medicaid (Home) county;
- A copy of the resident/consumer's most current FL-2;
- A copy of the resident/consumer's most current assessment and care plan;
- A copy of the resident/consumer's most current physician's orders;
- A list of the resident/consumer's current medications;
- A copy of the resident/consumer's vaccinations and TB screening;
- A list of all destination locations contacted that were unable to admit the resident/consumer and the reasons they were not appropriate; and
- Information about the resident/consumer's legal representative, including contact information and relationship along with the signed "Consent for the Release of Information" document.

IV. Process When DSS Receives Request for an ACH-RDT

Timeframes for Convening an ACH-RDT
The DSS point of contact is to convene the ACH-RDT within 24 to 72 hours (2-3 business days) upon receipt of a request from an ACH/FCH. The request must come from the ACH/FCH at the time the resident receives a discharge notice, if the destination is unknown or not appropriate for the resident/consumer.

A request from the ACH/FCH may come during the 30 day timeframe after the notice is issued, if the ACH/FCH determines that the discharge destination is no longer available, is inappropriate or changes to unknown. When a request is made for an ACH-RDT to convene sometime after the resident/consumer received a discharge notice, an ACH-RDT is to act quickly to explore resources for an appropriate placement before the end of the 30 day discharge period when at all possible.

If the health or safety or the resident/consumer or others in the facility is endangered and the ACH/FCH intends to discharge the resident/consumer as soon as practicable rather than issuing a 30 day discharge notice, the DSS will need to convene an ACH-RDT immediately to assist the ACH/FCH with placement options.

An ACH-RDT is not a crisis team, and it is not the intent for the team to meet after business hours or during weekends.

If an ACH-RDT is unable to locate an appropriate placement or the resident/consumer refuses the recommended placement, the ACH/FCH may choose to discharge the resident/consumer. The discharge must be in a safe and orderly manner in accordance with the adult care home licensure rules. The adult care home licensure rules can be found at: http://www.ncga.state.nc.us/gascripts/statutes/statutelookup.pl?statute=131D.

Initial Face-to-Face Meeting of an ACH-RDT
The DSS point of contact should share the resident/consumer information received from the ACH/FCH with the LME staff identified to serve on an ACH-RDT as soon as possible after receiving the request to convene an ACH-RDT. The DSS must verify that the resident/consumer or the resident/consumer's legal representative has signed a consent for the release of information and the LME has signed a confidentiality statement prior to releasing the information and setting up face-to-face meetings. The DSS must verify that other ACH-RDT members have also signed a confidentiality statement prior to their participation in any meetings.

In some situations, prior to the face-to-face meeting with the resident/consumer, an ACH-RDT may elect to have a preliminary meeting to discuss the request. Convening a preliminary meeting is at the discretion of an ACH-RDT.

The initial face-to-face meeting is held at the ACH/FCH and is to include all members of an ACH-RDT (includes DSS and LME staff) and the resident/consumer in order to allow the resident/consumer, the resident/consumer's legal representative, and staff (if possible) to participate in the meeting. If the resident/consumer has an established service

provider, the service provider may also participate in the meeting and serve as a resource for an ACH-RDT.

Subsequent Meetings of an ACH-RDT

Subsequent ACH-RDT meetings may be held off-site at a location determined by the ACH-RDT. Telephonic participation in subsequent meetings is permissible to ensure an ACH-RDT accomplishes its work in a timely manner. The frequency and extent of additional meetings will be determined by the ACH-RDT based on the needs of the resident/consumer.

V. Residents/Consumers Special Circumstances and Rights

Residents/Consumers with Diminished Capacity
Upon arrival at any ACH/FCH, an individual must be identified to receive a discharge notice on behalf of the resident/consumer. An ACH/FCH shall notify a resident/consumer, the resident/consumer's legal representative, and the individual identified to receive a discharge notice of its intent to initiate the discharge of the resident/consumer.

The legal representative and the individual identified to receive a discharge notice may be able to assist a resident/consumer with diminished capacity to ensure that the resident/consumer understands his/her options and to assist in completing necessary documents for the purpose of the transfer or discharge. These individuals may also be a resource to an ACH-RDT to assist with placement options. The Regional Long Term Ombudsman may also assist in protecting the rights of the resident/consumer in the discharge process when requested by the resident/consumer or the resident/consumer's legal representative.

Residents/Consumers with Guardians
Legal guardians remain responsible for the placement of their wards. Prior to discharge of a ward, the ACH/FCH should already be working with the guardian or the guardian's representative to affect a transfer or discharge of a resident/consumer, if needed. If placement cannot be located, the ACH/FCH may request the DSS to convene an ACH-RDT to assist with placement.

Resident/Consumers' Rights
The ACH/FCH shall notify a resident/consumer, the resident/consumer's legal representative, and the individual identified to receive a discharge notice of its intent to initiate the discharge of the resident in writing, at least 30 days before the resident is discharged, except in situations where the health or safety of the resident/consumer or others in the home is endangered. The resident/consumer has the right to appeal the discharge.

Resident/Consumer Appeals the Discharge by the ACH/FCH
When a resident/consumer or the resident/consumer's legal representative elects to appeal a discharge initiated by the ACH/FCH, the appeal shall be made to the Hearing Unit. The Hearing Unit is the chief hearing officer within the Division of Medical Assistance designated to preside over hearings regarding the transfer and discharge of ACH/FCH residents/consumers, and the chief hearing officer's staff. The Hearing Unit shall decide all appeals pertaining to the discharge of ACH/FCH residents/consumers. The decision of the Hearing Unit is the final agency decision. Any person aggrieved by a decision of the Hearing Unit pertaining to an ACH/FCH resident/consumer discharge is entitled to immediate judicial review of the decision in Wake County Superior Court or in the county where the person resides.

Role of the ACH-RDT and ACH/FCH in an Appeal of a Discharge
The DSS may receive a request to convene an ACH-RDT from the ACH/FCH for a resident/consumer who has appealed his/her discharge. The role of an ACH-RDT remains the same. An ACH-RDT shall provide the Hearing Unit with the transfer or discharge location at or before the discharge hearing.

If a discharge is under appeal to the Hearing Unit, the resident/consumer shall remain in the ACH/FCH and shall not be subject to discharge until issuance of the decision of the Hearing Unit with the following exceptions:

- The discharge is necessary for the resident/consumer's welfare and his/her needs cannot be met in the facility as documented by the resident/consumer's physician, physician assistant, or nurse practitioner;
- The safety of other individuals in the facility is endangered;
- The health of other individuals in the facility is endangered as documented by a physician, physician assistant, or nurse practitioner.

The appeal process described above pertains to the discharge from the ACH/FCH, not the placement plan arranged by the ACH-RDT.

The ACH/FCH may appeal the decision of the Hearing Unit. The ACH/FCH appeal of the Hearing Unit decision will be heard by the Superior Court in the county where the ACH/FCH is located.

VI. Ongoing ACH-RDT Activities

Documentation Requirements
An ACH-RDT is expected to maintain documentation regarding the placement of each resident/consumer where assistance was requested by the ACH/FCH. The documentation should include, but is not limited to, information about the request to convene the ACH-RDT, the meeting date(s), actions taken, outcomes and members present.

- When a request to convene an ACH-RDT is received from the ACH/FCH, the ACH/FCH is to provide the documentation listed on page 6. of this guidance entitled "Information Provided by the ACH/FCH to the ACH-RDT." The DSS is to retain this documentation in their records for the activities of an ACH-RDT.

- The DSS is to maintain a Referral Log. The DSS may choose to complete more detailed records in addition to the Referral Log. The Referral Log can be found at: http://www.ncdhhs.gov/aging/adultsvcs/referral_log.xls

- The DSS is to maintain a Meeting Log. The DSS may choose to complete more detailed records in addition to the Meeting Log. The Meeting Log can be found at: http://www.ncdhhs.gov/aging/adultsvcs/meetingllog.xls

- If the LME takes the lead to locate an appropriate discharge destination, the LME will communicate to the DSS point of contact the resident/consumer's discharge destination and connections made to service providers as well as natural and community supports, if applicable. The DSS will incorporate this information into their records for the activities of the ACH-RDT.

Reporting/Coding/Billing/ACH-RDT Activities
ACH-RDT activities may include arranging team meetings, attending team meetings, consulting with or providing consultation to other agencies, opening services to further address the needs of the resident/consumer, and/or determining and arranging options for placement. Agencies involved in the above activities will determine the most appropriate mechanism to report, code and bill for the time involved.

DSSs have several options to use when taking the lead within an ACH-RDT for locating the placement destination for a specific resident/consumer as listed below.

- Adult Care Home Case Management Services when the resident/consumer is already receiving this service
- At Risk Case Management Services when the resident/consumer meets the target population and other eligibility requirements
- Adult Placement Services
- Guardianship Services when the DSS is the legal guardian for the resident/consumer

Adult Care Home Resident Discharge Team - House Bill 677

http://www.ncga.state.nc.us/Sessions/2011/Bills/House/PDF/H677v7.pdf

Appendix A

Adult Care Home/Family Care Home (ACH/FCH) initiates discharge of a resident/consumer

ACH/FCH may discharge for the following reasons:
(1) To protect the welfare of the resident; the ach cannot meet their needs
(2) Resident has improve sufficiently as not to need the services of the ach/fch
(3) The safety of the resident or other individuals in the ach/fch is endangered
(4) The health of the resident or other individuals in the ach/fch is endangered
(5) The resident has failed to pay for services for accommodations after written warning
(6) The discharge mandated under Article 3 of this Chapter or rules adopted by the Medical Care Commission (MCC)

ACH/FCH unable to locate a discharge destination after working with the resident/consumer to locate a placement destination

Resident/consumer is given at least a 30 day written notice of discharge to ensure orderly transfer or discharge

If the health or safety of the resident or others in the home is endangered, the ACH/FCH may discharge the resident as soon as practicable vs. issuing a 30 notice. The discharge must still be safe and orderly in accordance with the adult care licensure

Resident or resident's legal guardian appeals the discharge

ACH/FCH makes a request to the DSS to convene a Adult Care Home Resident Discharge Team for assistance to identify a discharge destination

ACH/FCH will provide:
-Copy of Discharge Notice
-Name of Medicaid (Home) County
-Current FL-2
-Current assessment and care plan
-Current physician orders
-Current medications
-Vaccinations and TB screening
-Information on efforts to locate alternate housing-Legal Representative contact information

Resident is allowed to remain in ACH/FCH until resolution of Appeal unless:
(1) The discharge is necessary for the resident's welfare; resident's needs cannot be met in facility.
(2) The safety of other individuals in the facility is endangered;
(3) The health of other individuals in the facility is endangered as documented by a physician, physician assistant, or nurse practitioner.

DSS convenes Adult Care Home Resident Discharge Team within 2 to 3 business days

The Adult Care Home Resident Discharge Team consists of at least a member from the LME and a member from the DSS. Other members may include the regional long term care ombudsman if requested, housing specialists, community based service providers, and others necessary to carry out the function of the Adult Care Home Resident Discharge Team

The Hearing Unit will decide all appeals and issue a final agency decision

The Adult Care Home Resident Discharge Team determines the lead agency (DSS or "Host" LME), then utilizes all of the knowledge and expertise of its members to offer an appropriate placement for the resident

County DSS completes Referral Log

The ACH/FCH may appeal the decision of the Hearing Unit to Superior Court within 30 days (county where the resident lives)

If resident is MH, DD or SA and has unmet needs and meets criteria for target population, LME takes the lead

The Decision of the Hearing Unit remains in effect pending review of Superior Court

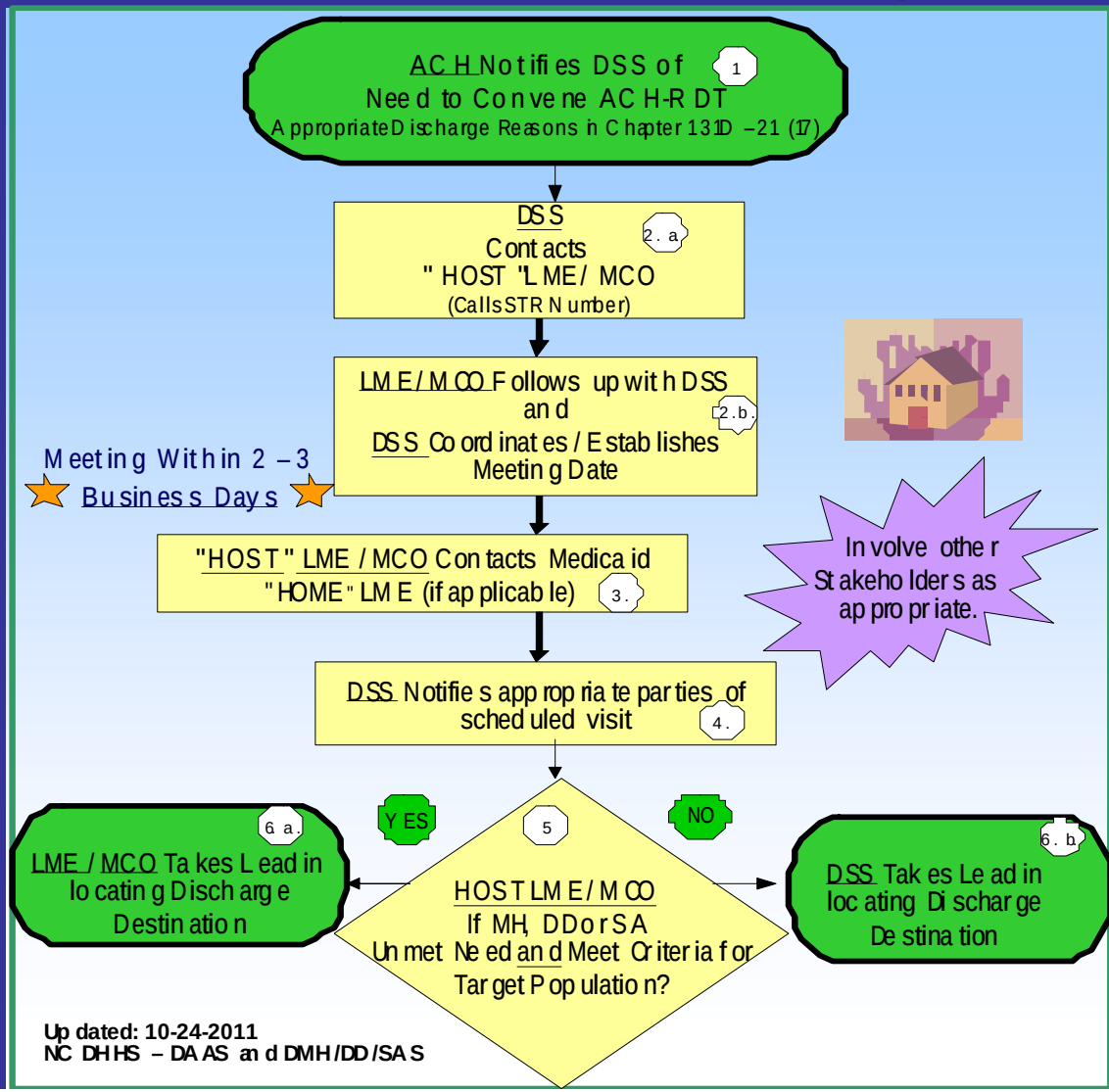
If the Resident Discharge Team is unable to locate an appropriate placement, or if the resident refuses placement, the ACH/FCH may exercise its right to discharge the resident as long as it is in a safe and orderly manner

County DSS completes Meeting Log

Superior Court renders final decision

Notes documents placement attempts

Adult Care Home Resident Discharge Team (ACH-RDT) Flowchart :



DETAILS:

1. ACH RDT: Notifies local Department of Social Services (DSS) of the need to convene the ACH-RDT upon *Notice of Discharge* provided to resident/legal representative, & if "destination is unknown", ACH will provide at minimum the following discharge information:
   - Name of Medicaid "Home" County
   - Legal Representative's contact information (if applicable)
   - Copy of Notice of Discharge & documentation on reason for discharge
   - Documentation on efforts made to locate alternative discharge destination;

   In Addition To:
   - A copy of the resident's most current FL 2;
   - A copy of the resident's most current assessment care plan, and Incident Report if applicable;
   - A copy of the resident's current physician orders;
   - A list of the resident's current medications, MAR;
   - A record of the resident's vaccinations and TB screening
2. DSS: Initiates contact to the Screening, Triage and Referral (STR) number (during regular business hours) to notify the "Host" LME/ MCO (where the resident physically resides) of the need to convene the ACH-RDT. DSS point person will provide their contact information.

   LME/ MCO will follow up with DSS within one business day. DSS provides all discharge information, and leads coordination to establish meeting date.
3. "HOST" LME or MCO: Initiates immediate contact to the "Home" LME/ MCO (if applicable) to inform of the need to convene the ACH-RDT and provide discharge information. DSS, LME/ MCO will connect with other community partners as appropriate throughout process.
4. DSS: Notifies ACH, Client/legal representative, and if appropriate *MH/SA Service Provider* of scheduled visit.
5. &6. "HOST" LME or MCO: Establishes if resident has a MH, DD or SA unmet need and meet criteria for *target population*
   - If resident has a MH, DD or SA unmet need, and meets target population, LME/ MCO takes lead to locate appropriate discharge destination.
   - If resident does NOT have a MH, DD or SA unmet need and does Not meet target population, DSS takes lead to locate appropriate D/C destination.

Appendix B

Statewide Crisis Services

Any individual may receive crisis and emergency services in North Carolina for mental health, substance abuse, and intellectual/developmental disabilities issues. Regardless of where the individual is in the state, they can call the 24-hour access/crisis telephone line in the county in which they reside at any time. A trained person answering the telephone will connect the individual with services to address their situation. The individual may receive crisis services regardless of the ability to pay.

Based on the situation the individual will be connected with one or more of the following crisis services:

Mobile Crisis Team
Mobile Crisis Management services are available at all times, 24/7/365 for individual who may need support to prevent a crisis or are experiencing a crisis related to mental health, substance abuse, or intellectual/developmental disabilities. Mobile Crisis teams provide services in locations such as the home, school, workplace, or other places. Before contacting the local Mobile Crisis Management provider, it is recommended that the individual first contact the Local Management Entity (LME) or the mental health, substance abuse, or developmental disabilities service provider, if assigned one.

NC START (Systemic, Therapeutic, Assessment, Respite, and Treatment)

NC START provides prevention and intervention services to adults with intellectual and/or developmental disabilities (IDD) and complex behavioral health needs. They provide crisis response and respite for the individual in crisis and ongoing training, consultation, and support to family members and providers. The first priority of NC START services is to provide person centered supports that enable the individual to remain in the home or community placement during and after a crisis.

Although providing services in the home for persons in crisis, and training, consultation, and support to family members and providers is priority, short term emergency respite may be available in crisis situations that cannot be addressed in the home or current placement. Short term planned respite is also available to NC START consumers who live at home with their family and are unable to access traditional respite due to behavioral needs.

Although NC START may contact directly, it is recommended that you contact the LME access/crisis line first.

Walk-In Crisis and Psychiatric Aftercare
An adult, adolescent, or family in crisis can receive immediate care at a Walk-In Crisis and Psychiatric Aftercare site. The care may include an assessment and diagnosis for mental illness, substance abuse, and intellectual/developmental disability issues as well as planning

and referral for future treatment. Other services may include medication management, outpatient treatment, and short-term follow-up care. Psychiatric aftercare may also assist consumers returning to the community from a state psychiatric hospital or alcohol and drug abuse treatment center until they are established with a local clinical provider.

Facility-Based Crisis (Professional Treatment Services in Facility-Based Crisis Program)
Facility-Based Crisis provides an alternative to hospitalization for adults who have a mental illness, substance abuse disorder or intellectual/developmental disability and are in crisis. Services are provided in a 24-hour residential facility and include short-term intensive evaluation, and treatment intervention or behavioral management to stabilize acute or crisis situations. Before contacting the local Mobile Crisis Management provider, it is recommended that the individual first contact the Local Management Entity (LME) or the mental health, substance abuse, or developmental disabilities service provider, if assigned one.

Additional Crisis Services information is found at
http://www.ncdhhs.gov/mhddsas/crisis_services/index.htm.

Appendix D

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
Summary of Target Populations
HB677 Procedures

Adult Mental Health Target Populations

Adult with Mental Illness (AMI) Eligibility Criteria.

Adult, ages 18 and over, who meets diagnostic criteria,* and who as a result of a Mental Illness exhibits functioning which is so impaired as to interfere substantially with his/her capacity to remain in the community. In these persons their disability limits their functional capacities for activities of daily living such as interpersonal relations, homemaking, self-care, employment, and recreation.

Level of functioning criteria includes:

- Any client who has or has ever had a GAF score of 50 or below OR
- Current client who never had a GAF assessment when admitted

AND

- Who without continued treatment and supports would likely decompensate and again meet
- the level of functioning criteria (GAF score of 50 or below) OR
- Current client who when admitted met level of functioning criteria but as a result of effective

  treatment does not currently meet level of functioning criteria

AND

- Who without continued treatment and supports would likely decompensate and again meet the level of functioning criteria (GAF score of 50 or below) OR
- New client who does not currently meet GAF criteria and no previous GAF score is available, and who has a history of:
  - two or more psychiatric hospitalizations; OR
  - two or more arrests; OR
  - homelessness as defined by:
    1) lacks a fixed, regular and adequate night-time residence OR
    2) has a primary night-time residence that is:
       (a) temporary shelter or
       (b) temporary residence for individuals who would otherwise be institutionalized or

(c) place not designed/used as a regular sleeping accommodation for human beings.

NOTE: It should be noted that an individual can remain in the target population even though his/her level of functioning might improve beyond the initial GAF score of 50.

This population should include any clients who are currently homeless or who are at imminent risk of homelessness as defined by:

- due to be evicted or discharged from a stay of 30 days or less from a treatment facility

AND

- lacking resources to obtain and/or maintain housing.

This population should also include any clients who have been assessed as having special communication needs because of deafness or hearing loss and having a Mental Health diagnosis.

* Diagnostic Criteria: Severe mental illness diagnosis such as Schizophrenia, Major Depression, Bipolar, Anxiety Disorders, and Personality Disorders.

Adults Substance Abuse Target Population

Adult Substance Abuse Treatment Engagement and Recovery (ASTER)

Adults who are ages 18 and over with a primary alcohol or drug abuse disorder and who require substance abuse assessment, treatment initiation, engagement, treatment and/or continuity of treatment services and supports for relapse prevention and recovery stability.

Developmental Disabilities Target Populations

Adult with Developmental Disability (ADSN)

Adult, age 18 and over, who is:

- Screened eligible as Developmentally Disabled in accordance with the current functional definition in GS 122C-3(12a) OR
- Meets the State definition of Developmentally Disabled and having a co-occurring diagnosis of Mental Illness OR
- A confirmed Thomas S. class members and was receiving MR/MI funded services at the dissolution of the Thomas S. lawsuit.

These individuals must have a Developmental Disability Assessment based on NC SNAP 1 through 5.

Eligibility Determination for this population group should be completed annually in conjunction with the Person Centered Plan process.

Developmental Disability means a severe, chronic disability of a person which:

- Is attributable to a mental or physical impairment or combination of mental and physical impairments;
- Is manifested before the person attains age 22, unless the disability is caused by a traumatic head injury and is manifested after age 22;
- Is likely to continue indefinitely;
- Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, capacity for independent living, learning, mobility, self-direction and economic self-sufficiency; and
- Reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are of a lifelong or extended duration and are individually planned and coordinated.

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Appendix E

Informed Consent for Release of Information for Adult Care Home Resident Discharge Team

_____
Resident/Consumer Name

I give permission for _____ (Adult Care Home/Family Care Home name) to obtain information from or release the following information about me to the Adult Care Home Resident Discharge Team to assist in finding an appropriate living arrangement for me.

Information to be shared

☐ A copy of the Discharge Notice with the Hearing Request Form from the adult care home or family care home;

☐ A copy of the most current FL-2;

☐ A copy of the most current assessment and care plan;

☐ A copy of the most current physician's orders;

☐ A list of the current medications;

☐ A copy of the vaccinations and TB screening;

☐ A list of all destination locations contacted that were unable to admit me; and

☐ Information about my legal representative, including contact information and relationship..

- I understand the contents to be released or obtained, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information.
- I understand that this consent is voluntary and is valid for one year.
- I understand that I may withdraw this consent at any time except to the extent that information has already been released or obtained.
- If other specific information is needed or information needs to be released or obtained by another agency not listed above, I understand that I will be asked to sign another consent form.

_____ _____

Signature Date

STATEMENT OF CONFIDENTIALITY FOR ADULT CARE HOME RESIDENT DISCHARGE TEAM MEMBERS

I, _____, as a member of the Adult Care Home Resident Discharge Team, and an employee of _____, may have access to or be exposed to confidential information about residents of adult care homes or family care homes. I understand and agree that I am not to share confidential information to any unauthorized person verbally, in writing, electronically, or in any other manner without the consent of the resident or his/her legal representative, and then, only as appropriate.

_____	_____	_____
Signature	Title	Date