TRANSITIONS TO COMMUNITY LIVING (TCL)

In-Reach/Transition and Diversion Manual

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

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IN-REACH FUNCTION

In-Reach is an engagement, education and support effort designed to accurately and fully inform adults who have a serious mental illness (SMI) or a serious and persistent mental illness (SPMI) about community-based mental health services (including Individual Placement and Support- Supported employment (IPS-SE)) and supportive housing options. This includes, but is not limited to, the availability of tenancy support services and rental assistance.

In-Reach is ongoing with the goal of educating individuals about all services that may be beneficial to him/her as well as community-based options:

- ✓ The choice to transition to supportive housing
- ✓ The choice to choose from an array of services and supports available to those living in supportive housing, including rental subsidy and tenancy supports
- ✓ The choice to remain in the adult care home (ACH) and the services that can be offered to support the individual in that setting
- ✓ The choice to receive information about Medicaid, Special Assistance, and services under the North Carolina State Plan for Medical Assistance or the state-funded service array for which the individual is eligible
- ✓ The choice to consider employment through Supported Employment (SE) or the Division of Vocational Rehabilitation Services (DVRS)
- ✓ The choice to request and receive, information on community activities and resources that match their interests and needs (social, recreational, educational, faith based, health and wellness, etc.) and the choice about which they want to participate in and/or use.
- ✓ The choice to request and receive from the In-Reach staff, opportunities to actively engage with other individuals who are living, working, and receiving services in the community

In-Reach staff should utilize community inclusion and integration activities to actively engage individuals with peers in the community. This should occur as early as possible to ensure individuals can make an informed choice about where they want to live, work, and learn.

Local Management Entity-Managed Care Organizations (LME/MCOs) will prioritize In-Reach to Adult Care Homes (ACHs) determined to be an Institution for Mental Disease (IMD).

Priority Population

The priority population for In-Reach includes the following categories per page five of the NC Settlement Agreement[1]:

1. Individuals with SMI who reside in ACHs determined by the state to be an IMD
2. Individuals with SPMI who are residing in ACHs licensed for at least 50 beds and in which 25 percent or more of the resident population have a mental illness
3. Individuals with SPMI who are residing in ACHs licensed for between 20 and 49 beds and in which 40 percent or more of the resident population have a mental illness
4. Individuals with SPMI who are or will be discharged from a State Psychiatric Hospital (SPH) and who are homeless or have unstable housing

[1] https://www.ncdhhs.gov/nc-settlement-olmstead/open

5. Individuals diverted from entry into ACHs pursuant to the pre-admission screening and diversion provisions established by the State

Note: Any individual residing in an IMD as of August 23, 2012, is considered first priority regardless of where they are currently living. This may result in providing In-Reach to an area not previously defined in Settlement Agreement, such as group homes and shelters.

Each LME/MCO receives information on those who are identified as ***potentially*** eligible for one of the Priority Populations in the following ways:

- *Priority 1, 2 and 3*: individual referrals are submitted through the Referral Screening Verification Process (RSVP) and electronically sent to the LME/MCO based on Medicaid County or residential county, and on occasions the Department of Health and Human Services (DHHS) may email a list of individuals to each LME/MCO that is based on claims, which means that it can include people who aren't eligible, as well as exclude individuals who are eligible. If the individual is found to be TCL eligible, the individual is entered into the TCL database and In-Reach begins.
- *Priority 4*: individual referrals are submitted through the RSVP and electronically sent to the LME/MCO based on Medicaid County or residential county
- *Priority 5*: individuals who were identified through the RSVP, who were not diverted from an ACH are automatically eligible for on-going In-Reach (outreach) services

These individuals also are considered a member of the Special Healthcare Population being served by the LME/MCO Care Coordination and are expected to be followed by care coordination, after the 90-day transition period has ended.

ADMINISTRATIVE COMPONENTS OF IN-REACH:

Required Skills, Experience and Education

In-Reach staff must be a North Carolina Certified Peer Support Specialist[2] (CPSS). Eligibility requirements for a CPSS are: 18 years or older; have lived experiences in recovery from a significant mental health or substance use disorder; have been in recovery for at least one year; and have a minimum of a high school diploma/GED. Requires years of experience working with the Mental Health (MH) and Substance Use (SU) population (CPSS must be certified within six months of hire). CPSS are individuals who provide support to others who can benefit from their lived experiences.

If an LME/MCO has limited availability of a qualified CPSS in their catchment area, efforts to build capacity, train, and recruit CPSSs must be documented and continuous. The peer support specialist position may be contracted out, but the LME/MCO remains responsible for ensuring required activities are completed.

It is the responsibility of the LME/MCO to ensure In-Reach staff are knowledgeable about all community-based resources and services, such as: Medicaid and Special Assistance benefits, available clinical services, community supports, supportive housing; SE; and other means of community participation. If an individual and/or guardian has questions about their rights under the Americans with Disabilities Act (ADA) or the *Olmstead Decision*, the In-Reach Specialist should refer them to the appropriate LME/MCO staff.

Since a large portion of the Transitions to Community Living (TCL) population have physical health concerns, In-Reach staff should be knowledgeable about and/or know how to link individuals to appropriate medical services. They

[2] http://pss.unc.edu/index.php

would first internally connect with the registered nurse care managers for consultation and/or pre-transition medical assessment. Medical assessment results of the care needed in a person's housing and/or in the community would then be included in transition planning and as needed in the individual's Person-Centered Plan (PCP).

In-Reach staff receive training in the following skill set, prior to working independently with individuals:

- Assertive Engagement
- Motivational Interviewing[3]
- Active Listening Skills
- Other relevant methods of Engagement

All In-Reach Specialists take Intentional Peer Support training – equipping them with a solid foundation on what is expected as a Peer Support Specialist.

Motivational interviewing is an introductory and intermediate training facilitated by SA trainer certified by the Motivational Interviewing Network of Trainers (MINT). This gives the In-Reach Specialists great tools to engage with individuals in the early stages of change around moving.

Additional training suggestions for In-Reach Specialists, include but are not limited to:

1. *Stage of Change Treatment* - helps identify the skills and tools to use with individuals based on their presenting stage of change.
2. *Brief Strengths Based Case Management for Substance Abuse* - although the primary focus has been on adults with substance use and adults with HIV, the focus is linking and connecting with care. The five guiding principles are:
    - Encourage identification and use of strengths, abilities, and assets.
    - Recognize & support client control over goal setting and the search for resources.
    - Establish an effective working relationship.
    - View the community as a resource and identify informal sources of support.
    - Conduct case management as an active, community-based activity.

LME/MCO Oversight

LME/MCOs are the entity responsible for coordinating and overseeing the completion of In-Reach and Transition plan activities, including documenting in accordance with DHHS approved guidelines.

Each LME/MCO validates the Medicaid County of origin for each individual referred for activities under the Settlement Agreement. The LME/MCO assumes primary responsibility for In-Reach and Transition for individuals whose Medicaid originates in counties in their catchment area (home LME/MCO). This does not preclude LME/MCOs collaborating to meet the needs of individuals who reside in another LME/MCO catchment area (host LME/MCO) or those who wish to transfer to another area.

Each LME/MCO must create procedures documenting the method by which initial and ongoing In- Reach and Transition activities will be completed and documented. These procedures must be consistent with the requirements and directives provided by DHHS. Procedures related to In-Reach should be made available upon request.

DHHS will sponsor ongoing training regarding In-Reach and Transition activities. Staff from the LME/MCO are required to attend the training. Additional training in engagement skills and supports may be necessary and be guided by the LME/MCO staff needs assessment.

[3] http://www.motivationalinterviewing.org/

Expectations of In-Reach Function

Good communication skills are key to setting the tone for successful In-Reach activities. Examples include:

- *Building Trust* – Prior to the meeting to gather information, attempts should be made to make the individual feel at ease. This can be accomplished by talking to the individual about:
    - everyday activities, social conversations, looking through family pictures, etc.
    - natural supports who would like to be a part of the continuum of support; and
    - their strengths and what they want to do.
- *Establishing Rapport* – Active listening skills can lead to good rapport and engagement. This includes paraphrasing what has been heard, gently encouraging the individual to continue talking and validating the individual's feelings.
- *Communication* – Person-centered dialogue is central to learning more about the individual's values, strengths, preferences, and concerns. It is an effective method to gather accurate information about the individual and the supports that may be needed for a successful transition to the community. Person-centered interaction supports informed choice and decision-support processes, which may include:
    - Taking the individual into the community to see what supportive housing is like (visiting/talking to individuals that live in the community, observing individuals on the job as they work, visiting places in the community they want to live, etc.);
    - Listening to the individual express his/her preferences, values, service needs, and circumstances;
    - Engaging in conversation for a mutual exchange of information and possible options that are tailored around the stated needs and preferences;
    - Providing support that leads the individual to make informed choices about long-term services and supports;
    - Connecting the individual when it is his/her choice, to public/private services and/or informal supports, and
    - Following-up with the individual with the ultimate goal to support the individual to live in their community of choice.

Materials

Each LME/MCO must keep up-to-date materials for dissemination to interested individuals and have a section of the agency website dedicated to TCL. This includes, at minimum, a brief description of TCL, the process overview, and local contact information.

STEP BY STEP PROCEDURES FOR IN-REACH:

Adult Care Home: Priority 1, Priority 2, and Priority 3

In-Reach services will follow an individual in the Department of Justice (DOJ) Special Healthcare population throughout their involvement in the TCL, whether the person transitions into supportive housing or remains in an ACH.

In-Reach includes providing information about the benefits of supportive housing, facilitating visits in such settings, and offering opportunities to meet with other individuals with disabilities who are living, working, and receiving services in integrated settings, with their families and with community providers.

The following process will be followed for all individuals identified by DHHS as Priority 1, Priority 2, or Priority 3.

1. Referrals are submitted through the RSVP for each LME/MCO, with information on individuals who are residing in ACHs who appear to meet the eligibility requirements for the DOJ Settlement Agreement.
2. The LME/MCO TCL staff are responsible for reviewing the individuals listed and validate their diagnosis (SMI and/or SPMI), county (home county based on Medicaid) and note anything that could disqualify an individual such as a primary diagnosis of Major Neurocognitive Disorder, Alzheimer's Disease, or a sole diagnosis of Intellectual Developmental Disability (I/DD), Traumatic Brain Injury (TBI), or medical fragility that necessitates a person being in a Skilled Nursing Facility (SNF).
3. DHHS will be notified if the LME/MCO staff identify that the individual is not eligible for consideration.
4. Once the LME/MCO identifies the facility, communication will occur with the facilities listed, as well as consumers/guardians/legal guardians as follows:
    a. A letter will be sent, following the DHHS approved format, to the owners of facilities selected based on review of the prioritization of recipients. All letters will be sent by certified/tracked mail and time-stamped fax confirmation.
        - The Letter to ACH from the LME/MCO is available at: https://www.ncdhhs.gov/attachment-d-2021june30docx/open
    b. LME/MCO In-Reach staff will contact the owner/administrator via telephone after confirmation that they have received the letter to arrange a time to meet (preferably face-to-face) or talk by phone at the convenience of the facility.
5. The following will occur during the call/face-to-face meeting:
    a. Discuss the letter;
    b. Educate the facility owner/administrator about the In-Reach process, helping them understand the comprehensiveness of the process that fully informs individuals on their options for living arrangements (remain in ACH, moving into supportive housing, exploring other residential options) and the services/supports that may be available to support the individuals wherever they choose to live;
    c. Share and review forms used in the In-Reach process, which include The In-Reach/Transition to Community Living Tool (Revision November 2017); Guidance documents; and Informed Decision-Making Tool (IDM tool)
        - The In-Reach TCL Tool is available at: https://www.ncdhhs.gov/documents/files/attachment-b-reach-tcl-tool-revnov2017/open
        - The In-Reach TCL Tool Guidance Document is available at: https://www.ncdhhs.gov/documents/files/reachtcltool-guidance-document-revnov2017/open
        - The In-Reach TCL Tool Conversational Guidance Document is available at: https://www.ncdhhs.gov/documents/files/reachtcltool-conversational-guidance-document-revnov2017/open
        - The IDM Tool is available at: https://www.ncdhhs.gov/media/13096/download?attachment
    d. Answer questions about In-Reach activities;
    e. Advise the owner/administrator that the names of individuals already identified as potentially eligible will be shared once individuals have been notified;
    f. Inform them that for individuals who have a legal guardian, contact will be made with that person prior to contacting the individual;
    g. Advise the facility owner/administrator that they can ask that a resident individual be reviewed to determine eligibility for TCL; and
    h. Solicit input from the facility owner/administrator on scheduling visits for individuals and/or guardians (point of contact, best days/times, as not to interfere with programs and activities in the ACH or other activities/appointments of individuals, times to avoid)

6. In-Reach staff will send a letter to individuals identified in the ACH (as reflected by the RSVP, following the DHHS approved format. The letter will detail the In-Reach process and offer times for face-to-face meetings. It will also include contact information for the In-Reach staff to ensure meetings are scheduled during times that are convenient to the individual, guardian, and facility.
    - The Letter to Individual from the LME/MCO is available at: https://www.ncdhhs.gov/attachment-e-2021june30docx
    - The Letter to Guardian from the LME/MCO is available at: https://www.ncdhhs.gov/attachment-f-2021june30docx
7. Once confirmed that the letter(s) have been received, the In-Reach Specialist will contact individuals and/or their guardians as applicable to confirm appointments. They will also be informed that the individual may invite others to the face-to-face meeting if they choose. Written consent will be obtained from the individual or legal guardian before allowing others to participate.
8. In-Reach staff will make direct contact with the administrator of the facility and/or their designee to confirm the scheduled time for In-Reach activities. Meetings will usually occur at the facility but can be held in any location requested by the individual.
9. Prior to the initial face-to-face meeting, In-Reach staff should gather information to prepare for the visit
10. During the initial visit, the In-Reach Specialist will establish rapport with the individual, provide basic information about TCL and respond to any questions. At the end of the initial visit, the individual should be provided with contact information to reach the In-Reach Specialist.
11. The In-Reach Specialist may introduce the DHHS In-Reach/Transition to Community Living Tool (Revision November 2017) to gather information and guide the conversation during the initial visit. The tool is a resource for the individual/guardian and others, in identifying needs; preferences; interests; what is important to; and important for the individual. The goal is to gather as much information as possible throughout the process.
12. In exploring interests and needs of the individual, the LME/MCO In-Reach Specialist should ask about:
    a. Past living situations (independent living, family, hospital, group home, ACH, SNF, boarding homes, friends, shelters etc.)
        1) Where the individual lived prior to the ACH?
        2) Why the individual/guardian chose the current setting?
        3) Whether anyone helped the individual learn about other options?
        4) What did the individual do with their time? What did a typical day/week look like?
        5) What roles did the individual have? (mother, father, friend, co-worker, student, employee)
    b. Current living situation to include supports:
        1) Medical services
        2) Personal Assistance
        3) Any type of special therapies (Occupational Therapy (OT), Physical Therapy (PT))
        4) Behavioral health services to include medication management
        5) Employment
        6) Community participation activities and transportation (How they spend their time?)
        7) Do they have contact with outside friends or family?
13. The In-Reach Specialist will meet with the individual as many times as needed to engage with them and as requested to help them explore options; respond to questions and provide additional resources as requested. Release of information (ROI) forms to receive additional information may be explained and signatures received.

14. The In-Reach Specialist will inform the individual of what life on an everyday basis might be like as well as educate the individual and/or legal guardian on services and supports that are available to assist the individual to transition to a community setting, to include but not be limited to:
    a. A description of the individual's ideal living situation
    b. A description of what the individual would like to do with their time
    c. The individual's strengths
    d. Supported employment opportunities
    e. Housing and geographic location preferences
    f. Concerns or fears the individual may have about living in supportive housing
    g. Local supportive living options
    h. Costs
    i. Consumer-directed options
    j. Transportation

    ** Note: many of these topics are also discussed in the context of supporting someone who chooses not to move.

IF INDIVIDUAL IS NOT INTERESTED IN SUPPORTIVE HOUSING

15. If the individual indicates that he/she is not interested in supportive housing, this will be documented in Transitions to Community Living Database (TCLD) and on the IDM tool. The In-Reach Specialist will explore and address all concerns of any individual who declines the opportunity for supportive housing or is unsure about moving.
16. For those with a legal guardian, any decisions about supportive housing or services and supports should include the individual's preferences to the extent possible. If this is not occurring, the LME/MCO staff will address through client rights protocols.
17. The individual and/or guardian, as appropriate, and facility staff will be informed that follow-up In-Reach (face-to-face) will occur as often as is needed to engage but at a minimum of every 90 days. The In-Reach Specialist will confirm that the individual, guardian, and facility have contact information for the In-Reach staff in case they have questions or desire a visit before the next scheduled contact.
18. Throughout the In-Reach process, In-Reach staff will continue to educate the individual/ guardian/facility on resources in the community (including supportive housing, supported employment), benefits and financial aspects of living in the community, Medicaid, and Special Assistance funds, as well as services covered under the North Carolina State Plan for Medical Assistance, Medicaid 1915 (b)(c) waiver and the state-funded service array.

*During In-Reach, a great opportunity to educate the individual and/or guardian on the resources in the community is to take the individual into the community to see what supportive housing is like. For example, visiting/talking to individuals that live in the community; observing individuals as they interact in the community; and/or visiting places in the community they say they may want to live, work, or learn.

IF INDIVIDUAL ONLY EXPRESSES INTEREST IN SERVICES

19. If the individual expresses an interest in receiving behavioral health services or supported employment, the LME/MCO should implement care coordination activities and link the individual to services and assessments indicated. In-Reach should make IPS referrals when individuals say they are interested in supported employment.
20. If the individual indicates prior to discharge that he/she is only discharging to another setting (i.e., MH group home, move-in with family or friends, etc.) for temporary housing, In- Reach will continue to occur as often as requested but at a minimum of every 90 days.

IF AN INDIVIDUAL EXPRESSES INTEREST IN SUPPORTIVE HOUSING

21. If the individual indicates that he/she is interested in supportive housing, the process for requesting a Housing Slot in TCLD will be followed. If a person agrees to transition into the community, a housing slot should be obtained within 10 calendar days.

State Psychiatric Hospitals: Priority 4

1. Priority 4 individuals are those with SPMI who are or will be discharged from a SPH and who are homeless or have unstable housing.
2. SPH staff will submit RSVP referrals for individuals who are potentially eligible for In-Reach for the LME/MCO based on Medicaid County or residential county.
3. LME/MCO staff will review referrals provided in addition to information within the LME/MCO system daily.
4. SPH staff will consult with the individuals and/or legal guardians and provide an overview of TCL. They will also inform the LME/MCO staff of interests, concerns, or resistance. The SPH staff will provide an overview of TCL to the people they think are eligible. This work is ongoing, as people are frequently entering and leaving the state hospitals.
5. LME/MCO staff coordinates the In-Reach process with the designated hospital Social Worker, including validating contact information for legal guardians as applicable.
6. LME/MCO In-Reach staff will gather information to prepare for the initial visit.
7. In-Reach starts when LME/MCO In-Reach staff make the first documented contact with the individual or guardian. Initial contact may be in person, by phone or letter to the individual or guardian (if they have a guardian) and should be made prior to the individual leaving the hospital. A face-to-face visit is the preferred method of contact.
8. Subsequent meetings will be coordinated with the SPH Social Worker (if the individual is still in the SPH) and will include the individual, legal guardian (if applicable) and others that the individual may choose to have involved.
9. The In-Reach Specialist will make frequent face-to-face contacts to establish rapport with the individual and provide basic information to them about TCL and respond to any questions.
10. The In-Reach Specialist will utilize the *In-Reach-Transition to Community Living Tool (Revision November 2017)* and guidance documents to assist in the process of obtaining information.
11. In exploring interests and needs of the individual, the LME/MCO In-Reach Specialist should ask about:
    a. Where the individual lived prior to State Psychiatric Hospitalization?
    b. Past living situations (independent living, family, hospital, group home, ACH, Skilled Nursing Facility (SNF), boarding homes, friends, shelters etc.)
    c. What did the individual do with their time? What did a typical day/week look like?
    d. What life roles did the individual have? (mother, father, friend, co-worker, student, employer)
    e. What the individual would like to do with their time?
    f. What are the services and activities the individual participates in at the hospital, to include any type of specialized therapies to address physical problems (OT, PT) or co-occurring diagnoses (such as Substance Abuse Services)?
12. The In-Reach Specialist will talk with the individual as many times as requested by the individual, or as needed, to help explore their options, respond to questions, and provide additional resources. Release of information forms to receive additional information may be explained and signatures received; for example, if additional medical records are needed to facilitate a referral to a therapy like OT, the Specialist will obtain the records to facilitate the referral after receiving signed consent.
13. The In-Reach Specialist will educate the individual/legal guardian about services and supports that are available to help the individual become involved in their community. This includes, but is not limited to:

a. A description of the individual's ideal living situation
b. A description of what the individual would like to do with their time
c. The individual's strengths
d. SE opportunities
e. Housing and geographic location preferences
f. Concerns or fears the individual may have about living in supportive housing
g. Local supportive living options
h. Costs
i. Consumer-directed options
j. Transportation

14. If the individual indicates that he/she is not interested in supportive housing, this will be documented. The In-Reach Specialist will explore and address all concerns of any individual who declines the opportunity for supportive housing or is unsure about moving, in TCLD and on the IDM tool.
15. For those with a legal guardian, any decisions about supportive housing or services and supports should include the individual's preferences to the extent possible. If this does not occur, LME/MCO staff will address through client rights protocols.
16. The individual/guardian, as appropriate, and SPH staff will be informed that follow-up In-Reach will occur as much as requested but at a minimum of every 90 days, whether the individual is still in the SPH or is discharged to another setting, such as an ACH.
17. If the individual continues placement in the SPH, the LME/MCO staff (hospital liaison/Lead Transition Coordinator/Community Transition Coordinator/Care Coordinator, etc.) will continue to network with the SPH Social Worker and other staff and will participate in ongoing treatment team meetings to include development of the Continuing Care Plan at discharge.

IF THE INDIVIDUAL STATES, THEY ARE NOT INTERESTED IN SUPPORTIVE HOUSING

18. The In-Reach Specialist will confirm that the individual, guardian, and facility have contact information for the In-Reach staff in case they have questions or desire a visit before the next scheduled contact.
19. Throughout the In-Reach process, staff will continue to educate the individual/ guardian/ facility on resources in the community (including supportive housing, supported employment), benefits and financial aspects of living in the community, Medicaid, and Special Assistance funds as well as services covered under the North Carolina State Plan for Medical Assistance, Medicaid 1915 (b)(c) waiver and the state-funded service array.
20. When the individual is discharged, the SPH Social Worker will communicate discharge placement and services to the In-Reach Specialist directly or through the LME/MCO staff (Hospital Liaison/Transition Coordinator, etc.). If the individual indicates, living in a .5600 licensed group home or their own place, is a permanent housing plan and choice, In-Reach does not continue after discharge. The informed choice should be clearly documented on the IDM tool.

IF AN INDIVIDUAL EXPRESSES INTEREST IN ONLY SERVICES

21. If the individual expresses an interest in receiving behavioral health services or SE and is not already linked to either, the Hospital Liaison/Lead Transition Coordinator and Social Worker should coordinate with the transition team to ensure services are available upon discharge.
22. If the individual indicates prior to discharge that he/she is only discharging to another setting (i.e., MH group home, moving in with family or friends, etc.) for temporary housing purposes, In-Reach will continue to occur as frequently as requested but at a minimum of every 90 days.

IF AN INDIVIDUAL STATES INTEREST IN SUPPORTIVE HOUSING

23. If the individual indicates that he/she is interested in supportive housing, a Housing Slot will be requested. The In-Reach process might have additional steps to complete. If so, the transition tasks can begin and should not be held up for the completion of any part of In-Reach.

Informed Decision-Making (IDM) (See IDM workflow in appendix)

The IDM tool was first implemented on September 1, 2020, and revised in June 2021. The tool was developed to support a core principle, derived from the *Olmstead* decision: that a person doesn't oppose transition to the community and that their agreement to receiving services in the community is based on an informed choice. The IDM tool helps guide conversations about community living between TCL participants and In-Reach staff. The tool assists its user in covering such topics as community living options, available resources, and services, as well as barriers/objections that interfere with community living, and individualized strategies to address barriers/objections. The process of engagement, done correctly, is imperative to establishing a rapport with an individual, forming a relationship, and getting to know them before initiating a discussion of community living using the IDM tool.

IDM AND GUARDIANSHIP

When a DSS or agency is the guardian for individuals residing in ACHs and SPHs, or being considered for admission into an ACH, TCL encourages them to partner with the LME/MCOs, educating staff on supporting transition; what is required for transitions to succeed; supportive housing; and the process for guardians making an informed decision concerning a ward's participation in TCL. The DHHS respects DSS and agency guardians' need to balance the individual's goals and rights under the Americans with Disabilities Act (ADA) and *Olmstead* with the guardian's concerns for the safety and welfare of the ward. The collaboration between public guardians' and the LME/MCOs ensure eligible individuals can participate fully in the IDM process.

We know any advocate and/or professional provider wants to ensure that an individual has been fully educated regarding their choices. DHHS works with NC Housing Finance Agency (NCHFA) to develop an online training module, that allows participants to gain a better understanding of the importance of informed decision making and how to use the IDM tool.

The IDM Online Training Module is available at:
https://www.nchfa.com/sites/default/files/informed-decision-making-process-and-tools/

In-Reach Services: Priority 5- DIVERSION

1. Individuals not diverted from ACH placement are automatically referred for In-Reach services.
2. The In-Reach Specialist will contact individuals and/or their guardians within seven business days of admission into the ACH to educate them about TCL and the In-Reach process.
3. The In-Reach Specialist will follow the procedures outlined in the step-by-step procedures for In-Reach: ACH: Priority 1, Priority 2, Priority 3 (above)

Other Administrative/Programmatic Guidelines

In Reach tracking for the initiation of In-Reach is based on the TCL determination date and/or verified date of admission into the ACH. The In-Reach tracking for frequency of In-Reach contacts/visits begin (the date LME/MCO staff enter a face-to-face contact/visit into TCLD) based on the following activities:

- ACH In-Reach officially starts after the first face-to face contact/visit is made and documented in TCLD. LME/MCOs should send the ACHs introductory letters and make contact with the individual or the guardian (if they have a guardian.) Letters are never to be used for In-Reach contacts.

- Introductory letters to individuals and legal guardians to introduce TCL and the role of the In-Reach Specialist may still be captured in TCLD in the notes section. Introductory letters are not considered an In-Reach contact.
- Phone calls are permitted for introductions, scheduling visits and informal conversations, but are not considered an In-Reach contact.

For individuals submitted through the RSVP or direct entered into TCLD (who are *potentially eligible)*: if a letter is sent and later it is determined the person is not eligible (could be primary diagnosis of Dementia or no SMI/SPMI), they should still be entered into TCLD.

Once it is determined an individual meets the minimum criteria for the settlement, their information should be entered into TCLD. Once an In-Reach visit has been recorded in TCLD, the number of days since the last visit will be highlighted. **Regardless of the method of contact, documentation is required in TCLD.**

When the interest list for housing slots exceeds twice the number of housing slots required to be filled in the current and subsequent fiscal year, DHHS may temporarily suspend In- Reach efforts.

Documenting In-Reach Activities

Staff completing In-Reach and transition activities for LME/MCO must utilize the In- Reach/Transition to Community Living Tool (Revision November 2017) and any updated versions approved by DHHS. This document outlines key elements to support the In-Reach and transition process of the individual.

The LME/MCO shall document all In-Reach activities in accordance with DHHS guidelines that include data entry into the web-based system in effect at a point in time (currently TCLD). Data entry must occur in a timely manner to ensure system data reflects real-time activities with individuals. Timely documentation is daily but no less than by the 10th of the following month. An on-line training module was developed for LME/MCOs use, to allow timely access to training for new employees as well as refresher training for existing staff. It is available on the state **TCL WEB PAGE**[4]. The current **TCLD USER GUIDE**[5] is available for use.

The TCLD User Guide is available at:
https://files.nc.gov/ncdhhs/documents/files/TCLD%20UserGuide.pdf?pBIm6s8ZUiPwYKNgq_Swdgkm9PxP3LJA

The LME/MCO shall also document direct activities with individuals being served through established procedures within the respective LME/MCO that could include case notes.

In accordance with the DOJ Settlement, the LME/MCO must demonstrate compliance with and reporting of individual outcomes from In-Reach services to include (a) lack of response to written communication from the LME/MCO by individual or guardian; (b) refusal of an individual to meet with LME/MCO staff; and (c) refusal by a guardian for the individual to participate in the In-Reach process. All LME/MCO documentation shall be made available to the state upon request.

Individual's Rights and Reporting Concerns

The rights of individuals living in adult care homes are protected by state law. In accordance with law, the North Carolina's Adult Care Home Bill of Rights outlines the rights of individuals residing in an ACH to include

[4] http://www.ncdhhs.gov/mhddsas/providers/dojsettlement/index.htm

[5] https://www.socialserve.com/waitlist/Help.html?ch=NC&waitlist_id=11&back_ref=waitlist%3B11

an individual's right to associate and communicate privately and without restriction with people and groups of his or her choice. The right for them to participate in In-Reach services is covered here.

The Long-Term Care Ombudsmen serve as advocates for individuals living in ACHs throughout North Carolina. In addition, NC DHHS Division of Health Service Regulation (DHSR) monitors complaints regarding ACHs. In the event an LME/MCO In-Reach staff is denied access to an ACH or to the individual for the purposes of completing In-Reach activities, LME/MCO staff will contact the regional Long-Term Care Ombudsman and the DHSR Complaint Intake Unit.

- The name and contact information for the regional Long-Term Care Ombudsman can be found at https://www.ncdhhs.gov/ombud/contact
- The DHSR Complaint Intake Unit can be reached at 800-624-3004 or 919-855-4500. Additional information is available at: https://info.ncdhhs.gov/dhsr/ciu/index.html

If an LME/MCO has concerns regarding the care and services provided to an individual living at an ACH, the LME/MCO will file a complaint with the DHSR Complaint Intake Unit. The LME/MCO should also discuss any concerns with the facility.

The instructions for Filing an Adult Care Home/Family Care Home complaint are available at: https://info.ncdhhs.gov/dhsr/ciu/filecomplaint.html

Article 6 of North Carolina General Statutes Chapter 108A, the "Duty to report; content to report; immunity" requires that: any person having reasonable cause to believe that a disabled adult needs protective services shall report such information. When you suspect mistreatment of an older adult or an adult with a disability, NC law requires you to contact Adult Protective Services (APS) at the Department of Social Services (DSS) in the county where the adult is living. Contact information for County DSS offices can be found at https://www.ncdhhs.gov/local-dss-directory-992022/download?attachment

Individuals living in state-operated facilities are afforded all state and federal civil rights, including rights under: Article 3 of North Carolina General Statutes Chapter 122C, the Individuals with Disabilities Education Act (IDEA), The ADA, The Rehabilitation Act, the Civil Rights of Institutionalized Persons Act, and Title VI of the Civil Rights Act. Health Insurance Portability and Accountability Act (HIPAA) confidentiality protections also apply.

Consumer Advocates are in state-operated healthcare facilities and are available to individuals and their families, 24 hours a day, 7 days a week. Anyone receiving services in a state-operated facility has a right to express a concern or grievance without fear of retribution. Concerns or grievances can also be brought forward by a guardian, or anyone authorized to speak on behalf of the individual receiving services.

Consumer Advocates also conduct timely investigations when there are reports or suspicions of rights violations, such as abuse, neglect, or exploitation. In the event the LME/MCO has concerns regarding the care and services provided to an individual in a state-operated facility, the LME/MCO may file a complaint with the Consumer Advocate for that facility. A link to find the Advocate for each facility can be found at https://www.ncdhhs.gov/divisions/state-operated-healthcare-facilities/facilities

Each facility has a Human Rights Committee appointed by the Secretary of DHHS. These committees also work to protect the rights of the people being served by the facility. The facility advocates support the mission of these Human Rights Committees by providing information regarding many aspects of the facilities' programs for the committee to review. The Consumer Advocates are also available to follow-up on any matters of concern to the Human Rights Committees.

Each state is required by the federal government to be part of the federal Protection and Advocacy (P&A) system. Disability Rights North Carolina (DRNC) is a private non-profit organization that was designated by the Governor in 2007 as the P&A for North Carolina. DRNC can be contacted at 877-235-4210 or info@disabilityrightsnc.org

Reporting Complaints about LME/MCO In-Reach Activities

Each LME/MCO has a customer service department. All concerns or complaints about activities related to LME/MCO In-Reach efforts should be shared with the customer service department. In addition, concerns or complaints can be made to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) Customer Service and Community Rights Team at 800-662-7030. LME/MCO In-Reach staff should provide individuals and facility administrators contact information for the customer service department along with information on how to share any concerns or complaints related to LME/MCO In-Reach efforts.

Transition Coordination Function:

Transition, by definition, is a process of changing, movement, development, or evolution from one state to another. The function of transition in TCL is to assist individuals identified through the In-Reach or diversion process who voiced a desire to explore other possible community-based supportive-living opportunities.

The primary purpose of transition coordination is to support a person transitioning from facility services in securing appropriate community-based housing and clinical services. This includes the LME/MCO assigning a Transition Coordinator who assumes primary responsibility for coordinating and managing the transition process. The goal is that the individual transitions into supported housing, with all domains addressed and that all essential services and supports are in place, within 90 days from the initial transition planning meeting.

During this process, the Transition Coordinator:

- Maintains a commitment to person-centered transition practices congruent with the philosophy of recovery.
- Ensures transition planning is based on the principle that with sufficient services and supports, people with SMI or SPMI can live in an integrated setting.
- Models respectful, positive, “can do” attitude throughout the process.
- Focuses on the collaboration of all partners and facilitation of services and resources.
- Facilitates a comprehensive planning process to give individuals with disabilities the opportunity to live in housing of their choice, with an array of services and supports that help them keep their housing, such as tenancy supports, conflict resolution and crisis response.
- Sees individual and their “family/friend/community network of supports” as central to the transition process
- Assists individuals in receiving support to become fully participating members of the community, including assistance with socialization and gainful employment.

Core responsibilities include, but are not limited to:

- Leading the transition process
- Acquisition of all services selected by the individual

- Transition planning of transition steps and tasking and monitoring the progress of transition team members
- The transition and the solutions and people to solve transition barriers
- Follow along of the service provision, and the individual's community integration
- Reporting requirements

Administrative Components of Transition:

Required Skills, Experience and Education

Staff functioning as a Transition Coordinator should be employed by the LME/MCO. The individual in this role must meet minimum qualifications of a Qualified Professional (QP) in accordance with APSM 30-1:10A NCAC 27.G (19): Staff Qualifications.

The Transition Coordinator must have a good understanding of person-centered thinking and planning and developing a transition planning team for the individual transitioning to supportive housing. Knowledge of and experience with the following is critical:

- Housing
- Behavioral Health resources (including linkage and referral)
- Physical health and wellness needs (complex care)
- Financial supports, entitlements, and the acquisition of social determinants of health
- Employment, vocational resources, and education opportunities
- Community resources (faith-based, recreational and leisure, social, advocacy, support groups, volunteer opportunities)
- Benefits counseling
- Adaptive equipment needs
- Crisis planning such as psychiatric, medical, tenancy, and interpersonal
- Person-specific risk mitigation strategies including recovery action planning
- Cultural and linguistic needs of the individual

Included in knowledge and experience with the key domains is the ability to identify resources/people applicable to each individual and incorporating them into the Transition Team.

LME/MCO Oversight

LME/MCOs have been identified by DHHS as the entity responsible for coordinating and overseeing the completion of the transition activities. LME/MCOs are responsible for documenting the completion of transition activities for applicable individuals whom Medicaid originates in a county for which the LME/MCO is responsible and for non-Medicaid individuals who reside in the LME/MCO catchment area. Transition coordination must be completed by LME/MCO staff knowledgeable about community services and supports, including supportive housing.

DHHS and NC Housing and Finance Agency (NCHFA) created and fund the Bridge Housing which increases opportunities for individuals identified as needing housing through TCL. Individuals waiting for a full transition to permanent supportive housing and are in immediate need of interim housing should be evaluated for eligibility.

LME/MCOs shall collaborate to achieve efficiencies for individuals whose Medicaid originates in a county covered by one LME/MCO but who resides in another LME/MCO's catchment area.

On December 10, 2015*, Joint Communication Bulletin#172-New Procedures for In-Reach and Transitions Across Different LME/MCOs* was released to clarify expectations related to the delivery of Behavioral Health services and supports. The bulletin outlined procedures to be in place on or before January 4, 2016.

The desk reference below is meant to provide a framework on how LME/MCOs will collaborate to ensure an individual's needs are met in various situations:

The In-Reach and Transitioning Individuals between LME/MCOs is available at:
https://www.ncdhhs.gov/documents/files/tcli-reach-and-transitioning-individuals-between-lme-mcos/open

Each LME/MCO is expected to create procedures documenting the method by which transition activities will be completed and documented. The procedures developed by the LME/MCO must be consistent with the requirements and directives provided by the state. Procedures related to transition should be made available to the state upon request.

The state may provide ongoing training regarding transition activities. Staff from the LME/MCO are required to attend the state-sponsored training.

Step by Step Procedures for ACH Transition Planning: (see flowchart in Appendix)

1. Once an individual agrees to supportive housing and transition, a housing slot must be obtained within 10 days, triggering the change in TCLD to Transition Planning.
2. Once an LME/MCO assigns a TCL housing slot#, the LME/MCO assigns a Transition Coordinator who will serve as the point person for the transition. *Note: Best practice is to involve a Transition Coordinator during the In-Reach process, once the individual has said "yes" to transition. This person may partner with the In-Reach Specialist in requesting the housing slot.*
3. If the individual does not have a current Comprehensive Clinical Assessment (CCA), the Transition Coordinator will partner with the individual/guardian and may partner with care coordination staff to obtain the CCA as quickly as possible, but no later than 30 calendar days from housing slot assignment.
4. The Transition Coordinator is responsible for convening a Transition Team that will be the hub of planning activities until the transition to supportive housing occurs, but also remains as a resource during the follow-along and post-transition process.
5. Within 10 calendar days of the housing slot assignment, the In-Reach Specialist facilitates a "soft transition" meeting between the Individual, the legal guardian (if applicable), natural supports, and Transition Coordinator (if they have not met before). The In-Reach Specialist will introduce the individual to the Transition Coordinator and share any information he/she has that will facilitate the warm hand off to the Transition Coordinator. A "warm hand off" is best practice and should be used as often as possible.
6. During the initial face-to face meeting, the Transition Coordinator becomes acquainted with the individual and begins outlining the transition process. If key documents were not obtained during the In-Reach process or Housing Slot assignment process, the Transition Coordinator will begin collecting what will be needed and explain the guidelines for information to be shared with the LME/MCO and others.
7. The Transition Coordinator in partnership with the assigned LME/MCO Care Coordinator, is

responsible for ensuring that the comprehensive Person-Centered Planning (PCP) is inclusive of all clinical services, supports and goals, and that these are or will be in place and are being provided **prior to** the move-in. The PCP must also include other services and supports to address goals related to: Other Health Needs (complex care), Housing, Employment, Community Participation, Financial Supports and Community Resources, and any other support/goal identified in the planning meetings. If a PCP already exists, it will be updated to include all necessary elements. This is essential during the transition phase because provision of services is delayed by providers when they refuse to accept hospital plans.

8. The PCP meeting may take place simultaneously with the initial Transition Planning meeting. If the meetings are not simultaneous, the PCP meeting should be scheduled at the beginning of the process, allowing the PCP to be submitted in a timely manner. This is important to preventing delays in the transition.
9. The Transition Coordinator will work with the individual to identify key people to be included in their initial Transition Planning /PCP meeting. The individual will also be educated on others who have core roles in transition (i.e., providers, DSS, housing specialist, care coordinator, medical provider, Housing Subsidy Administrator, SE, advocacy groups, etc.). Release of Information (ROI) forms will be signed to allow the Transition Coordinator to contact others and to confirm that the individual has consented to their involvement.
10. *It is Important to obtain an ROI for communication with DSS, ACH and the Housing Subsidy Administrator, if possible, during initial meeting. If this is not appropriate to obtain these in the "soft transition" meeting, the ROIs will be done in the first formal Transition Planning meeting.*
11. The Transition Coordinator will schedule the first Transition Planning/PCP meeting within 10 calendar days at a time and location that is convenient to the individual and family/guardian, ACH, hospital, or other setting where the individual may be residing.
12. The Transition Coordinator will be responsible for notifying all individuals/agencies who are invited.
13. During the initial Transition Planning meeting, the individual will be given an opportunity to ask questions or voice concerns that they may have.
14. The Transition Coordinator will outline steps in the transition process and begin to identify any barriers that could impact a transition to supportive housing within 90 days, per settlement requirements.
15. Information from the **In-Reach/Transition to Community Living Tool** (Revision November 2017) that details individual functioning across multiple domains, will be shared to facilitate the conversation on how to plan and support the individual in community housing.
16. The **In-Reach/Transition to Community Living Tool** (Revision November 2017) and PCP should be in alignment with their assessment of the individual's needs and appropriate care.
17. Tasks to be accomplished will be outlined with timeframes and assignments of team members who will take the lead in coordinating each aspect of care. This will include tasks for the individual as well. All tasks are to be documented in the recipient chart and TCLD.
18. The Transition Coordinator will continue completing the **In-Reach/Transition to Community Living Tool** (Revision November 2017) that was utilized during the In-Reach process.
    a. The Transition Coordinator will emphasize throughout the meeting that there are tasks and activities involved in the transition process, noting that each transition is individualized, and the team will be flexible to meet the needs and preferences of each individual.
19. The Transition Coordinator will present key forms to establish the relationship with the Housing Subsidy Administrator, including the N.C. Supportive Housing Program Tenant Application and Confidentiality Release form and a Referral for Transition Management Services (TMS). These forms will be completed during the meeting or within a week of the meeting.
20. Other forms that are completed during the housing search process may be introduced.
21. TMS is a service contracted to the behavioral health providers by the LME/MCOs. All individuals must be receiving TMS unless they have an Assertive Community Treatment (ACT) or a Community Support

Team (CST) provider where in either case ACT or CST will provide the TMS services for the individual.

22. The Transition Coordinator and team will review what was addressed in the meeting, prioritize tasks to be completed and schedule the next planning meeting. When possible, the team will develop a schedule for ongoing meetings that will include all relevant stakeholders, adding new team members as tasks are addressed (i.e. inclusion of DSS to address Special Assistance-In Home, medical provider for those with medical conditions that may require special attention, Community Care of North Carolina (CCNC) Care Manager to help individual become linked to a new medical home (if their physician has been an employee of the facility) and to discuss medication/pharmacy care issues, etc. If a team member is not able to attend in person, the Transition Coordinator will facilitate their involvement telephonically.
23. During transition planning, the Transition Coordinator should be preparing the individual to co-facilitate their meetings and brainstorming with them prior to the meetings next steps that will occur. They should also be asking the individual who they would like to have support them in the process.
24. Transition planning meetings will occur as scheduled to address all areas needed for successful transition to supportive housing within 90 days. The Transition Coordinator will address barriers with the team, and if they cannot be resolved, refer to the LME/MCO's Local Barriers Committee. In cases where there are systemic barriers that cannot be solved locally, the Transition Team should refer those barriers to DHHS for emergent assistance and possible referral to the State Barriers Committee.
25. The LME/MCO must ensure appropriate behavioral, physical health, and other needed services are in place for individuals prior to transitioning them into the community.
26. The Transition Coordinator assures that the PCP is complete, and the individual's housing has passed Housing Quality Standards (HQS), the transition process can continue to the lease signing phase. The PCP, CCA, HQS Inspection, and any additional assessment material are subject to review by designated DHHS staff.
27. The Transition Coordinator will ensure that guidelines related to administration of the Quality of Life (QoL) survey to the individual are met.
    a. The Pre-Transition QoL Survey assesses the individual's experiences in the current living arrangement, prior to transitioning to supportive housing in the community. The survey should be conducted face-to-face, ideally in the early stages of transition planning after the individual has said "yes" to supportive housing. Pre-Transition surveys must be conducted no later than the day prior to the individual's transition date, i.e., before the effective date of the individual's lease, to be considered timely*. For example, if an individual says "yes" to transition on March 1 and transitions with a lease effective date of May 10, the survey ideally would be conducted in March or April and must be conducted by May 9 to be considered timely.* Pre-Transition surveys should not be re-administered to individuals who have left housing for a period of time and are being rehoused.
    b. Follow-up surveys should also be conducted face-to-face with the individual. Calculated due dates for 11-Month and 24-Month follow-up surveys are 335 and 730 days after the individual's transition date. To be considered timely, follow-up surveys must be conducted between 30 days before and 30 days after their calculated due dates. *For example, a survey with a calculated due date of September 15 is considered timely if it is conducted between August 16 and October 15.* If an individual leaves housing before a follow-up survey due date and is subsequently rehoused, the follow-up survey due date is extended by the number of days the individual was not housed. Follow-up surveys should not be conducted with individuals who are not in housing.
    c. Survey links:
        - Pre-Transition Quality of Life Survey: https://surveymax.dhhs.state.nc.us/TakeSurvey.aspx?SurveyID=72LLnp2K
        - 11/24-Month Follow-up Quality of Life Survey: https://surveymax.dhhs.state.nc.us/TakeSurvey.aspx?SurveyID=72LM352K
28. The Transition Coordinator will provide justification to DHHS when transition extends beyond 90 days

and next steps.

29. The Transition Coordinator will ensure that the post-transition follow along guidelines are followed with the intensity of interventions being individualized for each individual.
30. Discuss the need to ensure the TCLD information is maintained in a timely manner.

The following, outlines procedures in key areas. The Transition Team will prioritize tasks based on each individual.

Procedures – Vital Documents:

1. The Transition Coordinator is responsible for ensuring vital documents needed to facilitate the transition process are available. These include but are not limited to:
    a. Birth certificate, Social Security Card or letter from Social Security Administration, Driver's license or government issued or approved ID card, confirmation of custody/guardianship
        i. Legal documents confirming that another person is the legal guardian
        ii. Copies of power of attorney paperwork if there is another person responsible for certain decisions for the individual (financial, medical, emergency, etc.)
    b. Criminal background check
        i. Review to determine if there are items that could limit access to housing in some areas or may lead to denial by a property manager
        ii. Evaluate need for a Request for Reasonable Accommodations
    c. Credit history
        i. Review to determine type of debts, when they were incurred, correlation with person's disability and attempts to remedy the issues in the past
        ii. Evaluate need for Request for Reasonable Accommodations
    d. Validation of payee status (self or other, including ACH)
    e. Verification of income and other financial resources
2. The Transition Coordinator will determine if any of these were obtained during the In-Reach process and secure copies of them for use in the transition process.
3. If documents have not been obtained or are not available, guidelines outlined in the In-Reach/Transition to Community Living Tool (Revision November 2017) will be utilized.
4. The Transition Coordinator will present information and needs to the Transition Team, where a decision will be made on who will be responsible for obtaining needed documents. A time frame to receive them will be established by the team and monitored by the Transition Coordinator.
5. Should there be barriers that cannot be overcome by the team in obtaining needed documents and information, the Transition Coordinator will inform DHHS and seek guidance/assistance via email to the Community Mailbox or telephone consultation, depending on urgency.
6. The Transition Coordinator could begin to discuss and/or explore expungement[6] of criminal records, if applicable.

Procedures – Behavioral Health Linkage and Referral:

1. Following completion of a Comprehensive Clinical Assessment (CCA), the Care Coordinator/Transition Coordinator will educate the individual/legal guardian on the behavioral, physical health, and other recommended services including how these services will be part of the of resources to support the individual in residing in supportive housing.
2. The Transition Coordinator will update the Transition Team on recommendations.
3. TCL staff will meet with the individual/legal guardian and provide a list of available providers in the LME/MCO provider network. The list will include the provider who completed the CCA, if this is within their continuum of services.
4. The Transition Coordinator will emphasize consumer choice in selecting provider and respect

preferences for location of service, access to transportation, etc.

5. The authorization process will also be explained, including the PCP process.

[6] General Statues related to Expunction of Records in North Carolina: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/ByArticle/Chapter_15A/Article_5.pdf
Application to initiate expunction in North Carolina: http://www.nccourts.org/forms/documents/1202.pdf

6. The TCL staff will assist the individual/guardian in contacting their selected provider and have Release of Information (ROI) forms completed allowing the provider to become part of the Transition Team. This will include ensuring an appointment to start services with the provider is confirmed in a timely manner, based on urgency of need.
7. The Transition Coordinator will modify provider roles and expectations based on whether the individual will receive enhanced services or basic services.
8. The Transition Coordinator will educate the enhanced services provider about the TCL process and inclusion of all services, not just enhanced services, and goals into the PCP. The Transition Coordinator will serve as the link to ensure the provider has access to all information needed. Goals related to developing skills needed to support housing, employment/education, and community activity will be included along with the Transition Team member responsible.
9. The Transition Coordinator will emphasize the need for services to begin as soon as possible, including in the ACH or other facility, to ensure services are in place, and that provider and natural support relationships established, and roles are clearly defined and set to begin the day of the individual's community transition.
10. The Transition Coordinator will facilitate discussion on elements for crisis plan, disaster plan and emergency plan during transition planning meetings. These will be included in the PCP developed by the enhanced services provider or LME/MCO staff that also includes tenancy crisis planning.
11. LME/MCO staff will provide information to the basic services provider on their role in the transition process and partner to include information from their treatment plan in the comprehensive PCP.
12. LME/MCO staff will be responsible for completing the PCP in the following circumstances:
    a. The CCA supports basic services, including medication management only (the Care Coordinator will incorporate outpatient services strategies and goals into the PCP);
    b. The CCA indicates current services (medication management with primary care physician) need to continue with other community supported services; or
    c. The individual refuses any behavioral health services (plan will address housing goals, life goals, natural and community services and supports).
13. The Transition Coordinator/Care Coordinator will ensure that the PCP is reviewed as part of ongoing team meetings and updated as the individual's needs change.

Procedures – Other Health Needs:

1. The Transition Coordinator will review the **In-Reach/Transition to Community Living Tool** (Revision November 2017) to identify the medical home of the individual (if other than the ACH), other specialty providers (chronic medical conditions, specialized treatments, and therapies such as personal care, home health, and companion care) and pharmacy when an individual's treatment requires medications.
2. The Transition Coordinator will meet with the individual/guardian to obtain ROI forms to consult with CCNC (when applicable). The Transition Coordinator will also obtain records from CCNC and medical providers, if records have not been received.
3. Information will be shared with the Transition Team. Goals and interventions needed to address health and wellness issues will be identified and included in the PCP.

4. The Transition Coordinator will consult with the individual/guardian, ACH, and existing medical providers to determine any existing appointments and future appointments during the transition period and after move-in to ensure there is no lapse in services. As needed, transportation to appointment will be arranged or provided by TCL staff.

5. When applicable, the Transition Coordinator will check the CCNC Informatics Database to determine if there is a CCNC Care Manager and primary care provider assigned. If one is assigned, the Transition Coordinator will contact the CCNC Care Manager and primary care provider. Most individuals in an ACH have a physician employed by the ACH as their primary provider. Many do not have an identified Care Manager unless there are complex-health related concerns.
6. When applicable, the Transition Coordinator will work with their internal RN and OT Care Managers or CCNC and the individual/guardian to facilitate assignment of any type of physical health provider and medical home.
7. A ROI will be signed allowing information to be exchanged with the primary and other physical health providers. The Transition Coordinator will ensure any special needs identified in the transition planning meetings are addressed.
8. The Transition Coordinator will facilitate completion of paperwork with the primary care physician and other physical health providers for access to ADA transportation if not in place.
9. The Transition Coordinator will work with the ACH physician or the individual's primary care physician for assessments and service orders on health services that need to be in place prior to move-in, including home health and personal care, durable medical equipment, etc. The physician will also be consulted on prescriptions for medications to ensure there is no lapse in the individual having medication during the transition. If physician does not do this, the Transition Coordinator will consult with their internal RN Care Managers or CCNC and/or the new primary care provider.
10. The Transition Coordinator will work with the individual/guardian on selection of a pharmacy if needed. Consideration will be given to pharmacies near the apartment of the individual, preferably one that delivers medications.
11. If the individual has no special health care needs, the Transition Coordinator will ensure that the Transition Planning meetings address information on health and wellness (routine visual, dental, and/or health exams). As appropriate, goals to address concerns in these areas will be identified and addressed by the appropriate Transition Team member.

Procedures – Housing:

1. The Transition Coordinator shall work with the LME/MCO Housing Specialist when an individual is assigned a TCL Housing Slot. Information obtained during In-Reach on preliminary preferences for housing and special circumstances will be shared. The Housing Specialist will be asked to participate in transition planning meetings as needed. Additional expectations include, but are not limited to:
    - Ensuring choice among multiple units in the community
    - Ensuring in-person, onsite tours of potential housing
    - Directly assisting the individual to find housing in the community
    - Frequently performing housing searches (TCL recipients get priority for Target/Key units)
    - Collaborating with their Regional Housing Coordinators
    - Ensuring to at least try to move into a Target/Key unit and keep the housing affordable

    ***Reminder**: Subsidy amounts that exceed 120% fair market rent require waiver approval by DHHS.
2. The Transition Coordinator will identify the target date for move-in (within 90 days of initial transition planning meeting) and outline target dates for completion of activities related to housing.

Specific dates will be detailed in the Transition Planning process for each individual.

3. When working with the Housing Specialist, Housing Specialists will share information on property managers who do not accept subsidies, those whose rent exceeds fair market value, complexes that may not meet standards based on inspections, the percentage of residents with disabilities etc., and have this available for planning meetings.

4. When necessary, reasonable accommodation should be requested.
5. The Transition Coordinator will ensure each step identified below has a projected completion date and an identified Transition Team member who is the point person. The Transition Coordinator will monitor all tasks to ensure they are completed in a timely manner and share information in Transition Planning meetings.
    a. Identification of potential barriers to housing (criminal background, credit history, lack of available housing in preferred area, chronic medical conditions)
    b. Identification of preferred geographic location (including in county, out of county) and other important factors (proximity to stores, laundromat, family and social network, transportation, etc.)
    c. Individual selection of units to visit and prioritization of choices
    d. Arranging visits to units selected to include people individual wishes to have accompany him/her on visits
    e. Individual selection of preferred apartment
    f. Coordinating a meeting with landlord to review and complete Tenant Application including Request for Reasonable Accommodations, if applicable
    g. Securing funding for application fees (identified method of payment accepted and amount)
    h. Identifying turn-around time on approval of Tenant Application
    i. Confirming deposit and due date
    j. Enter household income and unit information in Community Living Integration & Verification (CLIVe) this is the subsidy payment/reimbursement system run by NCHFA upload:
    i. Request for Lease (RFL) for TCLV or Lease Notice – other Community Housing form for non-TCLV
    ii. Tenant Household Composition and Income Summary
    iii. TCL Certification of Informed Housing Choice
    iv. Waiver Requests, if applicable
    k. For individuals utilizing Transitions to Community Living Voucher (TCLV) - coordination of unit inspection; upload inspection reports and inspection invoice (if third party contractor is used) in CLIVe
    l. Assisting individual in submitting at least two weeks' notice to ACH or other facility of discharge date
    m. Scheduling lease signing date
    n. Accompanying individual/guardian to landlord's office to review and sign lease
    o. Enter security deposit, lease, and HAP information in CLIVe and upload executed lease and Housing Assistance Payment (HAP) contracts
    p. Establishing needed utilities (including funding for utility deposits and confirming method of payment accepted- if targeted unit consultation with state for payment of security deposit)
    q. Packing belongings and furnishings in preparation for the move-in
    r. Confirming move in day arrangements, including who will transport individual, transport and/or deliver items
    s. Assisting individual in setting up apartment
6. The Transition Coordinator will ensure that an inventory of the individual's belongings and what will be needed to transition to their own apartments is done.
7. The Transition Coordinator is responsible for oversight and management of the one-time Transition Year Stability Resources (TYSR) funds ($2,000). These funds are available to assist an individual in safely and adequately meeting his/her transition related expenses during the first year. The funds

must be utilized in accordance with DHHS approved guidelines. If additional transition funds are needed, the Transition Coordinator should access any funds within the LME/MCO and in rare cases make requests for additional funds from DHHS. B3 funds can also be utilized.

8. The Transition Coordinator will document the team member(s) responsible for accompanying the individual to purchase items and track the status of items identified in the inventory to make sure all needs are addressed.
9. Issues will be shared with the Transition Team with people identified to ensure everything is completed prior to transition.
10. The Transition Coordinator will follow procedures adopted by the respective LME/MCO for purchasing items and processing of TYSR requests to DHHS for reimbursement. The Housing Funds Guidelines Manual is available at: https://files.nc.gov/ncdhhs/documents/files/HousingFundsGuidelinesManual.pdf?7J4uxGZL27hFY.sPOFpcnoHR.FiV6BUT
11. The Transition Coordinator will submit a waiver request to DHHS for items outside of the DHHS TYSR fund guidelines, noting the justification for the purchase. Approval of the waiver request must be received before TYSR funds are used. DHHS will not reimburse the LME/MCO for items purchased prior to approval of a waiver request.
12. Purchasing items with the individual throughout the transition process is encouraged to ensure that they are available on move-in day (except for fresh groceries).

Procedures-Financial Supports:

1. The Transition Coordinator will ensure financial supports needed for the individual are addressed with the Transition Team and in the PCP.
2. The Transition Coordinator will address payee issues, including transfer of the ACH as payee to another representative payee (including the individual in selection of representative payee agency). The Transition Team will also assess whether the individual, who is his/her own payee but has received supports to manage their finances from the facility, may need a temporary payee to support their transition.
3. A Transition Team member will be identified to assist the individual in establishing a bank account if they do not have one.
4. The Transition Coordinator will assign a team member to assist the individual in transfer of benefits with the Social Security Office to decrease any delays in benefits received.
5. The Transition Coordinator will follow all guidelines adopted by the Division of Aging and Adult Services (DAAS) to establish and address changes to Medicaid and Special Assistance-In home benefits (initial application or change to Special Assistance/In-Home (SA-IH) for the TCL population. This will include completing the DHHS Economic Assistance Worksheet and providing monthly payment tracking information for each individual). The Transition Coordinator will assure that changes in the individual's situation are reported to the DSS.
    a. For individuals who choose to move outside of their current home Medicaid County, the Transition Coordinator will coordinate efforts between the two DSS agencies and the receiving LME/MCO (transfer of Medicaid and other support funding).
6. The Transition Coordinator will follow guidelines to request Community Living Assistance (CLA) funding to cover lapse in receipt of SA-IH benefits while the transition process occurs using the DHHS Economic Assistance Worksheet.
7. The Transition Coordinator will work with the individual/guardian to identify any outstanding debts and develop strategies to address these.
8. If the individual's credit history negatively impacts their ability to secure housing, strategies will be developed with the individual and Transition Team to address. Request for Reasonable Accommodations will be completed as indicated.
9. A Transition Team member will be assigned to work with the individual on developing a budget to follow once

living in their own apartment. Goals related to money management will be included in PCP as appropriate.
10. The Transition Team will continue educating the individual on the options for Supported Employment, including the impact on benefits and advantages to employment.

Procedures-Community Resources:

1. The Transition Coordinator will review the interests, Important to and Important for, and community resources information available from meetings with the individual/guardian and the **In-Reach/Transition to Community Living Tool** (Revision November 2017). Current involvement and the desire to continue participating in activities will be emphasized.
2. The Transition Coordinator will meet with the individual/guardian to review this information and obtain information on other interests and resources available including, but not limited to, faith based, social, recreational, volunteer, leisure, educational, advocacy oriented, support groups, employment and vocational interests that are important to be considered in transition planning. The availability of continuing existing transportation for current activities will be explored and options to consider if this is not possible (funding for bus passes, taxi services, gas for family/friends etc.).
3. A Transition Team member will work with the individual/guardian to assess community resources available in all areas identified by the individual and facilitate linkage between the individual and the community resources/supports.
4. The Transition Coordinator and or transition team member will address potential volunteer and employment opportunities during planning meetings and facilitate involvement of the In-Reach Specialist and possibly Supported Employment provider to continue to explore interests and options.
5. The Transition Coordinator and or transition team member will include any mentoring, coaching and support strategies to assist individual in using public transportation and becoming integrated into the community in transition planning and plan development.
6. A listing of other available transportation resources (family, friends) will be confirmed. If the individual chooses personal transportation, the Transition Coordinator will assist the individual obtaining the appropriate medical assessments, licenses, and plans to obtain the means of individual transportation.
7. Community Integration goals and supports will be included in the PCP.

Procedures-Final Transition Meeting:

1. The Transition Coordinator will convene a final meeting of the transition team at least two weeks prior to the anticipated move-in. Once the PCP is complete, the lease signing process can continue. This date will be included on the schedule of meetings developed by the Transition Coordinator in the early transition planning meetings.
2. The Transition Coordinator should ensure that all team members are invited to/reminded of the meeting with sufficient notice (suggested a minimum of seven business days) to participate (face-to-face or telephonically if unable to attend in person).
3. New team members who have been identified will be included in the final transition meeting.
4. The Transition Coordinator will review with the transition team: the planning process, the strategies, goals and supports identified and approved in the PCP and identify if there are any tasks not completed. The individual and/or guardian will be asked to share their perspective and ideas on past and present concerns about moving into housing.
5. The Transition Coordinator will review the status of activities outlined in Housing Procedures to confirm roles, responsibilities, and any tasks to be completed in the final two weeks before move-in. The team will also identify others who wish to support the individual during the move to supportive housing. With the consent of the individual, the Transition Coordinator will add others to the move-in team and

detail their roles.

6. The Transition Coordinator will ensure that plans to address crises (disaster, emergency, behavioral health crisis, medical crisis) are current with details, responsible people, and current phone numbers. The team will identify a member of the move-in team to ensure key telephone numbers are posted in the apartment on the day of the move-in and easily viewed and accessible to the individual.
7. The Transition Coordinator will confirm completion and submission of the Pre-Transition QoL survey.
8. The Transition Coordinator will plan for check-ins, face-to-face and telephonically, with the individual in the interim between the final planning meeting and the move-in date. The Transition Coordinator and others identified will offer support and encouragement but also address any last-minute transition issues, including access to staff and financial resources.

Procedures-Follow Along (90 days post transition) and Post Follow Along:

1. Transition duties assigned during the Follow Along period (90 days post transition) will be detailed by the Transition Coordinator in the transition planning meetings with the transition team. During transition planning, the frequency of Follow Along is routinely discussed to ensure that a person's housing, clinical activity needs, and issues related to health and safety are identified and addressed on a timeline. Transition planning plays a vital role in assisting the individual to maintain housing and critical services. A schedule of contacts will be developed and provided to the individual but may be more frequent based on individual needs.
2. The minimum frequency of visits as defined by the settlement includes:
    - First month: weekly in-person contact with individual
    - Second month: every other week in-person contact with individual
    - Third month: monthly contact in person

    *However, there is an expectation that the frequency of visits will be customized according to the individual's level of need. The Transition Coordinator also assures that all providers' contacts are of sufficient frequency, duration, intensity, and type necessary for the initial and all other subsequent phases of the individual's transition and community tenure. If provider services are insufficient, the Transition Coordinator should work to resolve the problem with the provider(s), the LME/MCO Provider Network, Program Integrity, or other LME/MCO departments.
3. Follow Along tasks will be completed by the Transition Coordinator and/or Care Coordinator. These activities do not duplicate the role of TMS, enhanced services providers or other resources and supports identified in the PCP.
4. The Transition Coordinator will convene the Transition Team to address any areas noted during the Follow Along period. If areas of concern are identified, the Transition Team may decide it's necessary to revise services and supports identified in the PCP. The revisions to the PCP could result in new services/supports or more intensive supports from existing providers.
5. The LME/MCO will define who conducts ongoing monitoring of the individual for as long as he/she remains in TCL and include this information in their TCL procedures. This will include conducting the QoL survey at 11- and 24-months' post transition.

Other Administrative/Programmatic Guidelines

Documenting Transition Activities

Staff completing Transition activities for the LME/MCO must utilize the **In-Reach/Transition to Community Living Tool** (Revision November 2017) and any updated versions approved by DHHS. This document outlines

key elements to support the In-Reach and transition process of the individual.

The LME/MCO shall document all transition activities in accordance with DHHS guidelines that include data entry into the web-based system in effect at a point in time (currently *TCLD*). Data entry should occur daily to ensure system data reflects real-time activities with individuals. An on-line training module has been developed for LME/MCOs use, allowing timely access to training for new employees and refresher training for existing staff. It is available on the state **TCL WEB PAGE**. The current **TCLD USER GUIDE** is available for use. Data must be entered by the date indicated by the state to meet settlement and legislative reporting requirements. DHHS will keep LME/MCO staff apprised of deadlines should they change.

Transition Timeline and Overview

1. Person says "YES" to supportive housing (day 1)
2. Assign Housing Slot within 10 days
3. Housing Slot assigned in TCLD
4. Within 10 calendar days of 3 (Housing Slot Assigned) warm hand-off between the In- Reach Worker and Transition Coordinator. Within 10 calendar days of warm hand-off, there should be the first Transition Planning / PCP Meeting
5. Additional Transition Meeting as necessary
6. Within 30 calendar days of conditional housing slot assignment, the PCP is completed
7. Resolve any issues with PCP
8. Services begin once PCP is approved by Utilization Review.
9. Begin financial worksheet.
10. Once property is located, arrange for a Housing Quality Standard inspection.
11. Once inspection is passed **AND**, lease may be signed
12. Secure household items
13. Identify move-in date
14. No more than 100 days from 3 (Housing Slot Assigned) – move-in (services must be in place, inspection must have been completed and passed, financials must be complete, lease must be executed)
    **The goal is within 90 days from the first Transition Planning meeting, the individual will move.*

TRANSITION COORDINATION IN A STATE PSYCHIATRIC HOSPITAL

The transition guidelines vary in part when an individual in Category 4 is transitioning from one of the three State Psychiatric Hospitals (SPHs) into Permanent Supportive Housing (PSH) or Bridge Housing through TCL. Differences include transition team members, inpatient commitment, and treatment considerations, at times incapable to proceed legal status, and the division of labor between tasks to be completed by SPH staff and LME/MCO staff inside the SPH and transition tasks needed to be performed but others outside the SPH in the community of the person's choice. Each LME/MCO staff should follow the division of those roles and tasks as outlined in the LME/MCO and Division of State Operated Healthcare Facilities (DSOHF) contract. These guidelines are written in agreement with those contractual requirements.

SPH Transition Steps and Guidelines

1. Upon admission the SPH Social Worker (SW) reviews adult admissions when indicated fills out TCL checklist and gives checklist to onsite LME/MCO Lead Transition Coordination (LTC) staff and/or sends

checklist to LME/MCO TCL staff for review within three days of admission

2. LME/MCO TCL internal staff and LME/MCO onsite LTC coordinate such that individuals meeting Settlement Agreement Category 4 criteria as outlined in the SW's checklist who meet TCL criteria are assigned in-reach within seven days of admission. Though there must be no in-reach waitlist, LTC and SW coordination and timing of in-reach visits are necessary to assure that the recently admitted person to the SPH is psychiatrically stable enough to participate in the in-reach process
3. LTC and/or LME/MCO staff will check within their electronic medical record if the individual has an existing community behavioral health provider. The LME/MCO would then contact and involve the individual's provider in the in-reach or transition process or would offer the individual an Assertive Engagement (AE) provider to engage the person in services outside the SPH and to participate in discharge and transition planning and perform in-community pre-transition tasks
4. The SW will obtain for the IRS and LTC all relevant SPH psychiatric assessments, social histories, physical health testing results and treatment needs, psychiatric occupational and psychological testing, and assist in obtaining or reengaging all entitlements needed for discharge and transition
5. The SW would inform the In-reach Specialist (IRS) of the person's guardianship status and if applicable, in-reach would begin with fully informing the guardian of the TCL services and supports for community transition.
6. If the individual without a guardian or one with a guardian chooses not to transition with TCL, the IRS would be re-in-reached as needed and in extended cases of refusing TCL would assist the individual and/or their guardian with completion of the Informed Decision-Making Tool (IDM). Barriers to TCL transition noted on the IDM and solutions would be reviewed with the individual and/or their guardian
7. If the individual and/or guardian chooses TCL transition, the IRS immediately notifies the SW, LTC, and LME/MCO TCL staff. The IRS then completes the In-Reach and Transition Tool with the individual while simultaneously the LTC and TCL staff assign the transition coordinator
8. While the In-reach and Transition Tool is being completed, the SW obtains vital documents needed for transition, the LTC and/or assigned community TC notifies the community provider/AE provider to complete pre-transition tasks, and the IRS introduces the TC to the individual and SW as to their upcoming role in the transition process
9. The TC will assure that the In-reach and Transition Tool information as to what is important to and important for the individual is written into and followed through on the person's SPH Continuing Care Plan and the community treatment Person Centered Plan
10. The shared LME/MCO and SPH section of the SPH chart must have the in-reach and transition process steps and status recorded on the "TCL Progress Note" kept for SPH, DHHS, and DOJ review
11. The assigned LME/MCO TC would request a housing slot from DHHS and arrange with coordination from the SW and LTC the first TCL Transition Team. Transition teams are meetings held at the SPH and apart from the individual's SPH treatment team. Transition teams are chaired by the individual in conjunction with their TC, are attended by relevant SPH staff, community provider(s) or AE, natural supports, and anyone else deemed necessary for TCL transition by the individual. Transition teams will outline the steps to the unique transition circumstances, needs, and chosen locations of the individual. The TC will actively assure that SPH treatment team recommended behavioral health, physical health, and specialized therapies are reviewed with the individual and/or guardian and obtained
12. The TC will inform the individual of housing options, and if possible, given the individual's SPH length of stay, arrange with the SW for community visitation of housing, services, and meetings with other individuals who already transitioned in the person's chosen community
13. The TC will also provide or find providers who will explore employment, education, and community activity options with the individual. If the individual wants to explore the feasibility of employment and education, the TC will connect the individual with supported employment to explore those options and to perform benefits counseling

14. Once housing is chosen, the TC will lead the leasing efforts and coordinate with the provider/AE lease signing, pre-move-in purchases, utility connection, pharmacy arrangement, housing accommodations, and if needed, physical health provision and durable medical equipment available day-of discharge

15. If the length of SPH stay is does not afford enough time for the individual to step into their PSH at the time of discharge, the TC will connect the individual, their natural supports, and their community service provider(s) with the LME/MCOs Bridge Housing
16. If the individual is at the SPH under an Incapable to Proceed (ITP) order, and though choosing TCL transition must first return to a county detention facility to resolve their ITP status, the LTC and TC will coordinate with the individual, SW, when available the SPH Forensic Coordinator, community provider/AE and other transition team members as to who will be responsible for pre-discharge and post-discharge connections with detention facility staff and the individual to as best as possible maintain treatment and contact in detention, and transition the person into their chosen PSH or maintain a stable transition into Bridge Housing at detention center release

DIVERSION FUNCTION

Diversion is the provision of evidence-based practices that prevent individuals with SMI/SPMI from entering into an ACH. DHHS developed and implemented a tool to ensure that when any individual is being considered for admission to an adult care home, there is a determination, by an independent screener, of whether the individual has SMI. The tool also connects any individual with SMI to the appropriate PIHP and/or LME/MCO for a prompt determination of eligibility for mental health services.

Once an individual is determined to be eligible for mental health services, the LME/MCO will work with the individual to develop and implement a community integration plan. The individual shall be given the opportunity to participate as fully as possible in this process. The development and implementation of the community integration plan shall be consistent with the discharge planning provisions in Section III(E) of the settlement agreement.

If the individual, after being fully informed of the available alternatives to entry into an ACH, chooses to transition into an ACH, the LME/MCO TCL staff will document the steps taken to show that the decision is an informed one on the IDM tool. The LME/MCO TCL staff will set forth and implement individualized strategies to address concerns and objections to placement in an integrated setting and will monitor individuals choosing to reside in ACHs and continue to provide In-Reach and transition planning services.

Pre-Admission Screening

On November 1, 2018, DHHS implemented the Referral Screening Verification Process (RSVP) as the tool for screening individuals being considered for admission to adult care homes. Prior to November 1, 2018, the state utilized the ACH Pre-Admission Screening and Resident Review (PASRR) to screen individuals seeking admission to ACHs. In addition, as of November 1, 2018, individuals admitted to an ACH licensed under G. S. 131D-2.4 will not receive Personal Care Services (PCS) prior approval without verification of a RSVP Referral ID number (#). For additional information on the requirement for billing PCS, see the Division of Medical Assistance Revised Clinical Coverage Policy 3L – Personal Care Services. (https://medicaid.ncdhhs.gov/media/9893/open)

The following procedures address the RSVP as well as the Diversion process, for individuals who are being

considered for admission to ACHs.

Step by Step Procedures for Pre-Admission Screening

THE RSVP PROCESS OVERVIEW

The RSVP is a two-step process for referring and screening all Medicaid-eligible individuals who are being considered for admission to a licensed Adult Care Home (ACH), Family Care Home (FCH), or Assisted Living Facility (ALF). The first step is the referral process where a referral is submitted for an individual who is being considered for admission to an ACH, FCH, or ALF and who is also Medicaid Eligible. Once the referral is submitted, the screening process begins. For all referrals that indicate a Behavioral Health Diagnosis, the referrals are sent to a LME/MCO contracted by DHHS to complete a screening to determine if an individual meets diagnosis and Medicaid/financial eligibility criteria for TCL. For all referrals submitted with a medical diagnosis only indicated, the referrals are submitted to DMH/DD/SAS for screening to determine if the individual may need to be further screened by an LME/MCO for TCL.

RSVP INFORMATION: WHAT I NEED TO KNOW

Who Needs to Submit an RSVP Referral?

- ALL Medicaid-eligible individuals being considered for admission to an Adult Care Home licensed under G.S. 131D-2.4, must be screened through the RSVP.
- All Medicaid-eligible individuals being considered for admission to an ACH or residing in an ACH who are requesting Personal Care Services (PCS). *Beneficiaries will not be assessed for PCS without a RSVP Referral ID#.*
- If the ACH admission was before November 1, 2018, no RSVP is required, until there is a change in medical status or the individual moves to another facility. If an individual was admitted to an ACH as private pay after November 1, 2018, and then becomes Medicaid-eligible, an RSVP is required in order for the ACH to receive an authorization to provide Personal Care Services.

Who Does Not Need an RSVP Referral?

- Individuals NOT being considered for admission to an ACH
- Individuals who are NOT Medicaid eligible.
- Individuals that have already been referred and screened through RSVP and that are currently participating in Transitions to Community Living. *If in question, contact your local LME-MCO to verify.*
- Individuals who have had a previous RSVP and the individual enters a medical or non-DHSR licensed psychiatric hospital, an acute or sub-acute rehabilitation facility, or a long-term acute care hospital for medical or psychiatric treatment, and who returns to the same ACH after treatment. These individuals do not need an additional RSVP unless there has been a significant change in psychiatric or medical status for those with SMI/SPMI.
- Individuals who have requested to transfer from one ACH to another **AND** already have an existing RSVP Referral ID #, can transfer if they are medically and psychiatrically stable.

Who May Submit an RSVP Referral?

- Individuals, family members, advocates, providers, community hospitals, state operated facilities, Standard Plans, and LME/MCO staff can ALL submit a referral using RSVP.
- If a staff member within an ACH believes they have a resident who may benefit from transitioning from the ACH to supportive housing or needs mental health services, he or she should contact the individual's designated LME/MCO that covers that individual's Medicaid administrative county, to

inquire about TCL for the individual.

Who May Not Submit an RSVP Referral?

- Any person who does not have consent from the individual or the individual's legal guardian.

When MUST an RSVP Referral Be Submitted?

- Prior to the admission of Medicaid-eligible individuals into an Adult Care Home (ACH) licensed under G.S. 131D-2.4 or prior to the receipt of an authorization for Personal Care Services for individuals residing in a licensed ACH.
- When an individual covered by private insurance or under private pay status that was admitted to an ACH on or after November 1, 2018, subsequently becomes Medicaid-eligible.
- When an individual admitted into an ACH before November 1, 2018, has a "status change," moves to another facility, or requires Personal Care Services and does not have an existing RSVP Referral ID #.

What Type of Documents May Be Requested After an RSVP Referral is Submitted?

The following documents and information may be requested by LME/MCOs to complete the screening:

- Clinical documentation from within the past 12 months to verify qualifying Serious Mental Illness (SMI)/Serious and Persistent Mental Illness (SPMI)
- Completed NC Medicaid Adult Care Home FL-2 https://medicaid.ncdhhs.gov/media/6549/download

Where Can I Submit an RSVP Referral?

- Option #1: https://www.myhousingsearch.com/nc/rsvp
- Option #2: Paper version can be mailed or faxed to the following locations. To ONLY be used if internet access is not available:

  Mailing Address: Attention Mental Health Section – RSVP
  Mail Service Center 3001
  Raleigh, NC 27699-3001
  FAX#: 919-508-0953
- If paper version is submitted, there will be a delay in receiving the Referral ID #. DHHS staff will enter the paper referral into RSVP within 24 business hours of receipt of the mailed or faxed referral. It is the responsibility of the referral to contact DHHS at TCLD.Support@dhhs.nc.gov, to obtain the RSVP Referral ID #

Where Can I Access Additional Information About RSVP?

The following links contain information regarding RSVP:

- RSVP Referral Weblink: https://www.socialserve.com/pre_screening/ncdrst/DiversionScreeningTool.html
- RSVP FAQ: https://www.ncdhhs.gov/media/10500/download
- NC Medicaid Clinical Coverage Policy 3L – Personal Care Services: https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/community-based-services-clinical-coverage-policies
- DHHS - TCL Webpage: https://www.ncdhhs.gov/about/department-initiatives/transitions-community-living-initiative

Who Do I Contact to Get Help with Submitting an RSVP Referral?

DMH/DD/SAS will provide technical assistance.

- RSVP technical asistance or Medical only RSVP submission inquiries can be submitted through TCLD.Support@dhhs.nc.gov
- For RSVP Behavioral Health (Mental Health, Substance Abuse, TBI and IDD) referrals already submitted please contact the LME/MCO that is listed on the printed final submission page

RSVP PROCESS WORKFLOW

Non-Behavioral Health Workflow – electronic and/or paper referrals routed to DMH/DD/SAS

- If there is no potential Behavioral Health diagnosis indicated on the RSVP, the RSVP is routed to DMH/DD/SAS.
- Medical documentation must be faxed to the contact number provided on the final submission page. Once the medical documentation has been submitted, individual can move forward with ACH admission.
- The RSVP Referral ID # will be assigned to the individual seeking admission and can be found on the final submission page of the RSVP.
- DMH/DD/SAS will review the RSVP along with the medical documentation to be submitted. If the RSVP is found to have information indicating a potential behavioral health diagnosis, the RSVP will be forward to LME/MCO for determination of TCL

Behavioral Health Workflow – electronic and/or paper referrals routed to LME/MCO for determination of TCL eligibility

- If there is a potential Behavioral Health diagnosis indicated on the RSVP, the RSVP is routed to the designated LME/MCO
- LME/MCO staff begin the screening process by reviewing the RSVP to determine whether the RSVP was submitted as an appropriate Pop Cat 5 referral to allow an individual to be diverted from entry into an ACH. If the referral was submitted by an ACH with an admission date on or prior to the RSVP submission date the individual is not eligible for diversion and will need to be direct entered into TCLD by the LME/MCO so in-reach can begin and will be coded as DOJ Pop Cat 1-3. If the referral was submitted by a State Psychiatric Hospital (SPH) the individual is not eligible for diversion and will be coded as DOJ Pop Cat 4 and moved through to TCLD so that in-reach can begin. (See Behavioral Health RSVP Workflow Addendums)
- Once the proper DOJ Pop Cat has been determined as DOJ Pop Cat 5 based on the location of the individual at the time of the referral, then the pre-screening process begins by contacting the individual/guardian and determining if the individual is being considered for admission to an adult care home. This is the next step in the determination as to whether the RSVP will continue as a valid Pop Cat 5 referral for Diversion.
- If it is determined that the individual is NOT being considered for ACH admission, LME/MCO staff should code the RSVP accordingly, which will allow the system to administratively withdraw the referral because it does not meet the criteria for DOJ POP Cat 5, “being considered for admission to an ACH” thus making the referral invalid. The referral source should also be contacted to inform them of the invalid referral and educate the referral source about the TCL criteria for DOJ Pop Cat 5.
- If it is determined that the individual is being considered for admission to an ACH based on direct interviews with the individual/guardian AND there is medical/clinical documentation to verify that individual has a need for assistance with activities of daily living (ADLs), then the RSVP is coded as “Being Considered for ACH Admission” and moved through to the screening process.
- During the screening process, staff will verify that the individual has a qualifying SMI/SPMI diagnosis AND that the individual is Medicaid or financially eligible based on criteria set forth in the settlement agreement and JCB#281 Medicaid and Eligibility for TCL Housing Slots. In order to verify and confirm that the individual has a qualifying SMI/SPMI diagnosis, staff should obtain, and review approved

clinical documentation (Comprehensive Clinical Assessment (CCA) Diagnostic Assessment (DA), or other DHHS approved document) dated within the past 12 months that verifies there is a qualifying SMI/SPMI diagnosis.

- *Important Clarification – per JCB#419 Transitions to Community Living (TCL) Eligibility with Co-Occurring Diagnoses and Change in TCL Terminology*
  https://www.ncdhhs.gov/media/15612/download?attachment
  The following clarifications provide further guidance to facilitate determinations of TCL eligibility:
  1. The presence of the SPMI and/or SMI fulfills TCL's mental illness eligibility criteria; therefore, the designation of these diagnoses as primary or secondary is not relevant to TCL eligibility.
  2. An individual with co-occurring SPMI and/or SMI and an IDD diagnosis is TCL eligible.
  3. Aggressive, sexual, and/or criminal behaviors resulting from an SPMI/SMI do not by themselves exclude a person from TCL.
  4. Substance Use Disorders (SUD) with accompanying SPMI and/or SMI do not exclude an individual from TCL eligibility including if they are receiving Medication Assisted Treatment, such as methadone, suboxone, naltrexone, or similar SUD treatments.
  5. Alzheimer's disease, dementia, or acquired brain injury are the only medical diagnoses mentioned in the Settlement Agreement that if present in the individual's diagnostic array would cause a person to be ineligible for TCL.
  6. *Important Clarification per JCB#426 - Clarification Regarding Transitions to Community Living (TCL) Eligibility for Individuals with Co-Occurring Neurocognitive and/or Acquired Brain Injury Diagnoses* https://www.ncdhhs.gov/media/16896/download?attachment
     The following clarifications provide further guidance to facilitate determinations of TCL eligibility for individuals with a co-occurring diagnosis of Acquired Brain Injury:
     a. An individual is TCL eligible if diagnosed with an SPMI and/or an SMI and a co-occurring neurocognitive disorder and/or other medical condition.
     b. An individual is TCL eligible if diagnosed with an SPMI and/or SMI and co-occurring ABI where it is clinically determined that the ABI is secondary to the SPMI and/or SMI.
     c. An individual is not TCL eligible if, at the time of application to TCL, the individual has been diagnosed with Alzheimer's Disease and/or dementia, even if the person is also diagnosed with an SPMI and/or SMI.
     d. An individual is not TCL eligible if diagnosed with an ABI and a co-occurring SPMI and/or SMI where their ABI is clinically determined to be the primary source of the SPMI and/or SMI.
- If the individual has been confirmed to have a qualifying SMI/SPMI diagnosis AND they are also Medicaid or financially eligible based on criteria, staff should begin the community integration planning process and begin conversations with the individual about permanent supportive housing options and community-based services and supports. Once all information has been verified and documented, the RSVP is then coded as SMI/SPMI eligible and Medicaid/Financially eligible, and the individual is determined to be TCL Eligible (Ready for Transitions to Community Living Database (TCLD)).
- The referral is then moved through to TCLD so a Diversion Outreach staff can be assigned, and outreach activities can begin. Outreach contacts/visits with the individual/guardian should be person centered and the frequency based on the needs of the individual. All outreach contacts should be detailed in the notes and documented under the Diversion Screening tab under Outreach Contacts.

ADMINISTRATIVE COMPONENTS OF DIVERSION

a. **Required Skills, Experiences and Education**
Diversion outreach is an engagement, education and support effort designed to fully inform adults with SMI or SPMI about community-based services and supports and permanent supportive housing options. Diversion outreach is frequent and on-going with the goal of educating individuals about all services and supports that may be beneficial. Diversion outreach staff should utilize community inclusion and integration activities as early as possible to actively engage individuals with peers in their community. Community integration activities assist individuals in making an informed choice about where they want to live, work, and learn.

Diversion Outreach activities can be performed by

- Licensed clinicians
- Registered Nurses
- Qualified Professionals (QP)
- Certified Peer Support Specialists (CPSS)
- Any other staff designated by the LME/MCO

DHHS will sponsor ongoing training regarding Outreach activities. Staff from the LME/MCO are required to attend the trainings. Additional training in engagement skills and supports may be necessary and be guided by the LME/MCO staff needs assessment.

b. **LME/MCO Oversight**
LME/MCOs are the entity responsible for coordinating and overseeing the completion of Diversion (outreach) activities, including documenting in accordance with the DHHS approved guidelines. Each LME/MCO validates the Medicaid County of origin for each individual referred for activities under the Settlement Agreement. The LME/MCO assumes primary responsibility for Diversion (Outreach) for individuals whose Medicaid originates in counties in their catchment area (home LME/MCO). This does not preclude LME/MCOs collaborating to meet the needs of individuals who reside in another LME/MCO catchment area (host LME/MCO) or those who wish to transfer to another area.

Each LME/MCO must create procedures documenting the method by which initial and ongoing Outreach activities will be completed and documented. These procedures must be consistent with the requirements and directives provided by DHHS. Procedures related to outreach should be made available upon request.

c. **Expectations of Outreach Function**
Contact the individual/guardian to arrange a time to meet (preferably face-to-face) or talk by phone as soon as the individual has been determined as TCL eligible through a RSVP screening.

- Schedule a face-to-face visit that works best for the individual/guardian in order to engage individuals and guardians to build trust, determine if there is immediate needs/imminent risk, establish rapport and identify strengths and preferences.
- Educate about permanent supportive housing, including Bridge housing, and available community-based services and supports (i.e., enhanced services, Individual Placement and Support (IPS)) and make additional referrals as needed.

- Utilize recommended tools (i.e., TCL Diversion Tool, Community Integration Planning (CIP) Guidance Document, and IDM tool.
- Meet with individual/guardian as many times as requested, or as necessary, to help them explore options, respond to questions, and provide additional resources.
- Provide opportunities to meet individuals in the community with disabilities who are living, working, and receiving services, along with meeting their family, other natural supports, and providers.
- Refer to TCL transition staff as soon as the individual says yes to transitioning to permanent supportive housing, in order to stay in the community. Refer to the LME/MCO Registered Nurse (RN), Occupational Therapist, and/or Physical Therapist, especially individuals with complex physical health needs
- Participate in the initial transition meeting with Transition Coordinator, individual, guardian, and any other stakeholders
- Work with Transition Coordinator to refer to services and supports and any other community resources
- Communicate with any providers involved regarding individual's status in the TCL process, once there are valid consents for Release of Information (ROI) in place
- Provide any assistance during the pre-transition, transition, and post-transition process, as needed
- If an individual declines permanent supportive housing or is undecided about permanent supportive housing, the informed decision (choice) should be clearly documented. Additionally, designated LME/MCO staff (Transition Team) should be notified to assist with identifying barriers and documenting the strategies/steps to address all barrier when necessary.
- If the individual/guardian after being fully informed of all the available housing options, prior to entry into an adult care home, then chooses to transition into an adult care home, the Diversion staff must address the following:
    a. Document steps taken to show that the decision is an informed one.
    **DHHS recommends using the IDM tool unless staff have clear documentation of this step on another DHHS approved document, and that documentation can appropriately be utilized for DOJ Pop Cat 5 individuals "choosing" to enter an ACH and leave an integrated setting (community).*
    b. Set forth and implement individualized strategies to address concerns and objections to placement in an integrated setting in the community.
    c. Continue to monitor individual's choosing to reside in an ACH setting and continue to provide In-Reach and Transition Planning.
- If the individual ultimately moves into an ACH during the diversion process, outreach ends, and In-Reach functions MUST then begin.

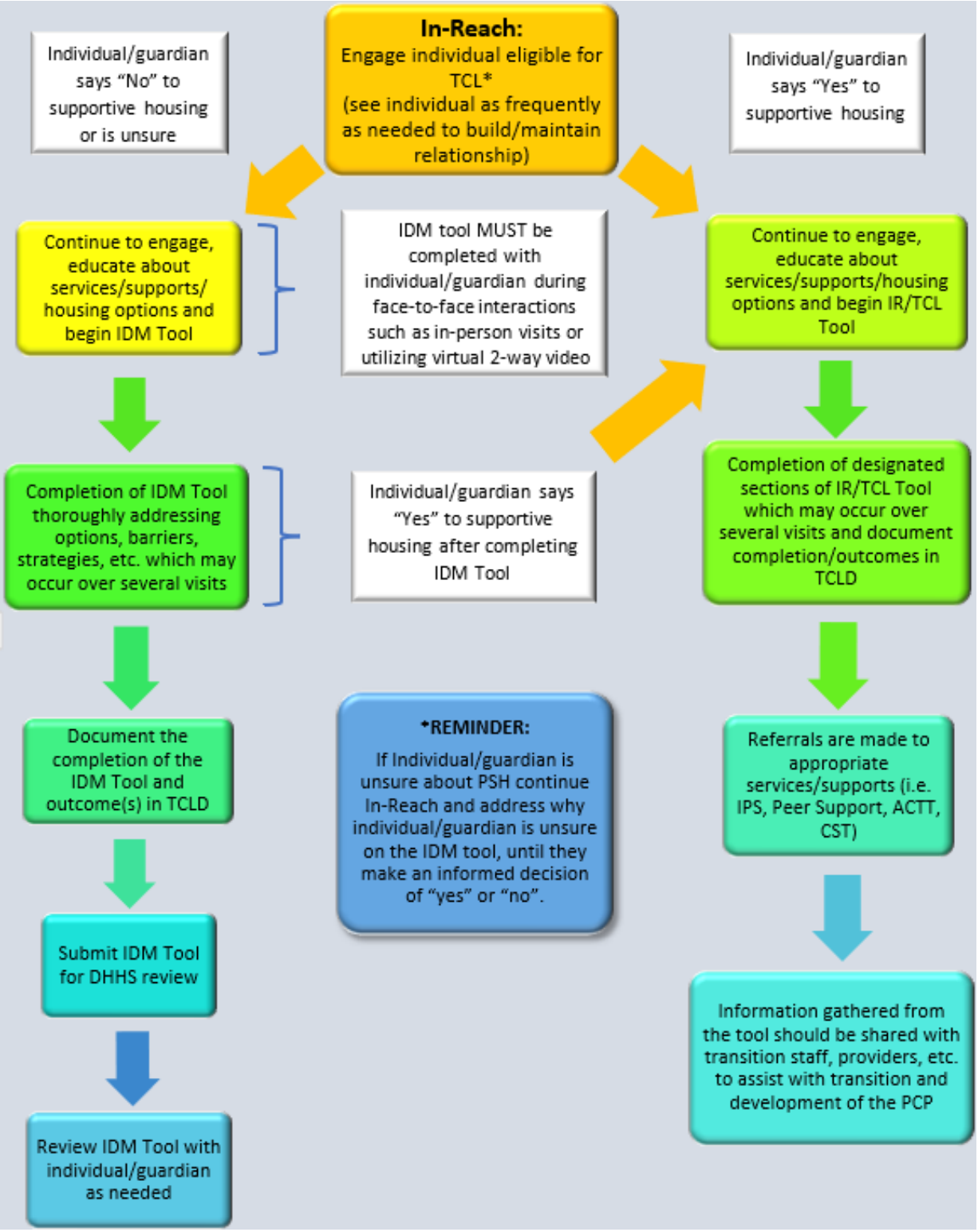
d. **Materials**

1. **Diversion Tool**
    - The Diversion tool is to be started from the first contact with an individual during the diversion process and then follow that individual until they are successfully integrated into the community or choose to no longer participate in TCL. https://www.ncdhhs.gov/media/9526/download
    - The Diversion tool is a resource for the individual/guardian and others, to gather needed demographic information including guardianship, medical and health information, and initiate CIP.

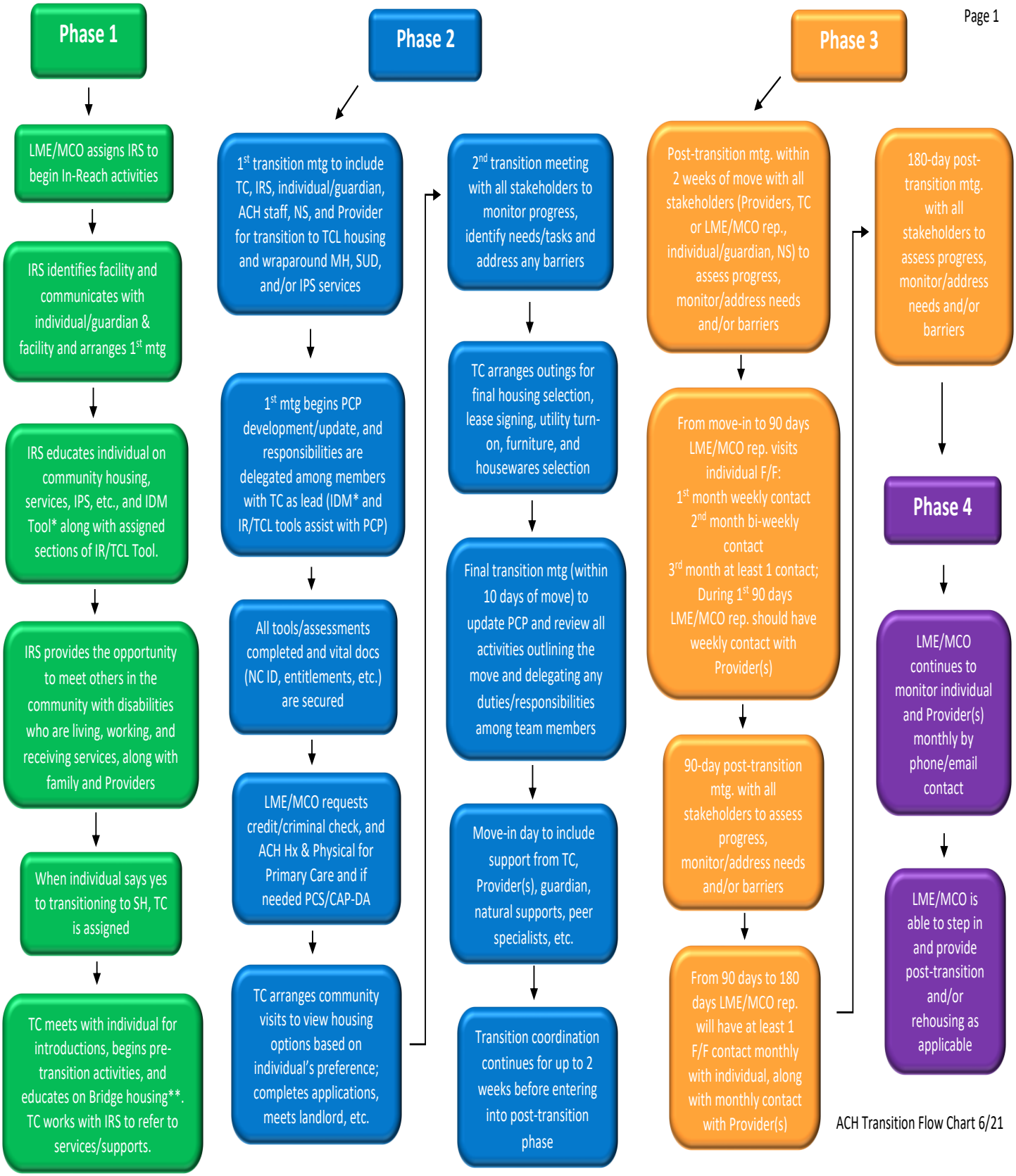
2. **CIP Guidance Document**
    - The purpose of community integration is to ensure that the individual with SMI or SPMI requesting admission to or who is at risk of admission to an ACH, is educated about all the available housing options so they can make an informed choice.
    - The CIP guidance document was developed by DHHS for the LME/MCOs to utilize as a resource for guiding conversations with the individual/guardian and others during the initial outreach contact/visit and ongoing contacts/visits. (https://files.nc.gov/ncdhhs/Community-Integration-Planning-Guide-04242019-rev-04072021.pdf)
    - The CIP guidance document assists with gathering information regarding alternative housing options, community-based services and supports, as well as identifying needs, preferences, and interests of the individual/guardian.
    - The CIP guidance document should be utilized along with the diversion tool and other available resources to assist with developing a community integration plan for the individual.
    - The goal is to gather as much information as possible throughout the TCL process to assist individuals with SMI/SPMI, so they have the appropriate frequency and intensity of services and supports in place that promotes assimilation into the larger community.
3. **IDM Tool**
    - Individuals being screened through RSVP and determined as TCL eligible may choose to enter an ACH and not remain in the community. It is the responsibility of the Screening and/or Diversion staff to ensure discussions regarding all the available housing options and community-based services and supports occur so that the decision made is an informed one.
    - Diversion staff may not need to complete every section of the IDM tool when sections do not apply. Document non applicable (N/A) on the IDM tool in sections that do not apply.
    - The IDM tool helps guide conversations and assists with the informed decision-making process for individuals choosing to transition to an ACH. The IDM tool helps guide conversations and assists with the informed decision-making process for individuals choosing to transition to an ACH. Complete the IDM Online Learning Module to learn more about IDM (See In-Reach section above)
    - As outlined on the IDM tool, decision-making is a continuous process and should take place over time with the individual and their guardian.
    - Engage/re-engage individuals over several face-to-face interactions before completing the tool.
    - Utilization of the tool can enhance participation in decision-making without increasing anxiety and helps align values and choices.
    - All IDM tools completed for DOJ Pop Cat 5 must be submitted to the DMH Diversion Lead and cc: the DMH Community Transitions & Integration (CTI) Team Lead for review.

APPENDIX

In-Reach (IR) Workflow (IR/TCL and IDM Tools)



*Note: Individuals are considered eligible for TCL until they meet the exclusion criteria outlined in the settlement agreement.



ACH Transition Flow Chart 6/21

***IDM tool completed according to guidelines**

****Bridge housing can be utilized during any phase as needed**

ACH Flow Chart Legend:

LME/MCO – Local Management Entity/Managed Care Organization

ACH – Adult Care Home

TCL – Transition to Community Living

IRS – In-Reach Specialist

IPS – Individual Placement and Supports (Supportive Employment)

IDM – Informed Decision-Making

IR/TCL – In-Reach/Transition to Community Living

Mtg – Meeting

TC – Transition Coordinator

NS – Natural Supports

MH – Mental Health

SUD – Substance Use Disorder

PCP – Person Centered Plan

NC ID – North Carolina Identification

Hx – History

PCS – Personal Care Services

CAP/DA – Community Alternatives Program for Disabled Adults

Rep. – Representative

F/F – Face to Face

Transitions to Community Living (TCL) Acronym Glossary

ABI	Acquired Brain Injury
ACH	Adult Care Homes
ACT	Assertive Community Treatment
ADA	Americans with Disabilities Act
ADL	Activities of Daily Living
AE	Assertive Engagement
ALF	Assisted Living Facility
APS	Adult Protective Services
CCA	Comprehensive Clinical Assessment
CCNC	Community Care of North Carolina
CIP	Community Integration Planning
CLA	Community Living Assistance
CLIVe	Community Living Integration & Verification
CPSS	Certified Peer Support Specialist
CST	Community Support Team
CTI	Community Transitions & Integration
DA	Diagnostic Assessment
DAAS	Division of Aging and Adult Services
DHSR	NC DHHS Division of Health Service Regulation
DOJ	Department of Justice
DMH/DD/SAS	Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
DRNC	Disability Rights North Carolina
DSOHF	Division of State Operated Healthcare Facilities
DSS	Department of Social Services
DVRS	Division of Vocational Rehabilitation Services
FCH	Family Care Homes
HIPAA	Health Insurance Portability and Accountability Act
HQS	Housing Quality Standards
I/DD	Intellectual Developmental Disability
IDEA	Individuals with Disabilities Education Act
IDM	Informed Decision-Making
IDMT	Informed Decision-Making Tool
IMD	Institution for Mental Disease
IPS-SE	Individual Placement and Support- Supported Employment
IRS	In Reach Specialist
ITP	Incapable to Proceed
JCB	Joint Communication Bulletin
LTC	Lead Transition Coordination
LME/MCO	Local Management Entity/Managed Care Organization
MH	Mental Health
MINT	Motivational Interviewing Network of Trainers

NCDHHS	North Carolina Department of Health & Human Services
NCHFA	NC Housing Finance Agency
OT	Occupational Therapy
PASSR	Pre-Admission Screening and Resident Review
PCP	Person-Centered Plan
PCS	Personal Care Services
PT	Physical Therapy
QoL	Quality of Life
QP	Qualified Professional
RFL	Request for Lease
RN	Registered Nurse
ROI	Release of information
RSVP	Referral Screening Verification Process
SA-IH	Special Assistance/In-Home
SMI	Serious Mental Illness
SNF	Skilled Nursing Facility
SPH	State Psychiatric Hospital
SPMI	Serious & Persistent Mental Illness
SU	Substance Use
SW	Social Worker
TBI	Traumatic Brain Injury
TC	Transition Coordinator
TCL	Transitions to Community Living
TCLD	Transitions to Community Living Database
TCLV	Transitions to Community Living Voucher
TMS	Transition Management Services
TYSR	Transition Year Stability Resources