TRANSITIONS TO COMMUNITY LIVING (TCL)

In-Reach/Transition and Diversion Manual

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

TABLE OF CONTENTS

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 the individual 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 with the support of Employment and Independence for People with disabilities (EIPD) and Individual Placement & Support.
- ✓ 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-Tailored Plans (LME/MCO-TPs) will prioritize In-Reach to Adult Care Homes (ACHs) determined to be an Institution for Mental Disease (IMD). [1]

Priority Population

The priority population for In-Reach includes the following categories per page five of the NC Settlement Agreement[2]:

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] When TP is noted in the manual it is referencing both TP and LME/MCO.
[2] 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 the Settlement Agreement, such as group homes and shelters.

Each TP 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 TP based on Medicaid County or residential county. On occasion, the Department of Health and Human Services (DHHS) may email a list of individuals to each TP that is based on claims/encounters, 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 TP 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 TP 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[3] (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 the TP 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 TP remains responsible for ensuring required activities are completed.

It is the responsibility of the TP 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 TP 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 would first internally connect with the registered nurse care managers for consultation and/or pre-transition medical

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

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[4]
- 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 a 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.

TP Oversight

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

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

Each TP 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 TP are required to attend the training. Additional training in engagement skills and supports may be necessary and be guided by the TP staff needs assessment.

[4] 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
    - Teir 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.

On May 13, 2022, DHHS provided guidance on *Clarification of Transitions to Community Living In-Reach Function* to clarify expectations related to in-reach functions. Procedures were required to be in place on or before May 13, 2022.

The guidance provided a framework on how TPs will provide in-reach to ensure individuals are engaged frequently and fully educated about benefits of supported housing. Effective immediately, the following expectations for In-Reach are:

1. Letters are never to be used for In-Reach contact.
    - Introductory letters to individuals and legal guardians to introduce TCL and the role of the In-Reach Specialist may still be captured in the TCL Database.
    - These letters are not considered an In-Reach contact.
2. Phone calls
    - Phone calls are permitted for introductions, scheduling visits and informal conversations, but are not considered an In-Reach contact.

The spirit of In-Reach is based on building relationships through communication and engagement. The following activities are not considered In-Reach:

- Leaving voice mails
- Talking only to facility staff or providers to do "check ins"
- Making appointments or referrals for the individual

- Staffing meetings with supervisors or teams when the individual or guardian is not present
- Talking with natural supports that are not legal guardians
- Making an attempted phone call
- Making an attempted on-site/face-to-face visit
- Completing paperwork when the individual or legal guardian is not present

The Settlement Agreement defines In-Reach as "frequent education efforts targeted to individuals in adult care homes and State psychiatric hospitals. In-Reach includes providing information about the benefits of supported 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." In-Reach requires face-to-face interaction, so peers can engage with each individual and establish rapport.

Materials

Each TP 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 TP, with information on individuals who are residing in ACHs who appear to meet the eligibility requirements for the DOJ Settlement Agreement.
2. The TCL Staff are responsible for reviewing the individuals listed and validate their diagnosis (SMI and/or SPMI), county of Medicaid eligibility and note anything that could disqualify an individual such as a 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 needing services provided in a Skilled Nursing Facility (SNF).
3. DHHS will be notified if the TP staff identify that the individual is not eligible for consideration.
4. Once the TP 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 TP is available at: https://www.ncdhhs.gov/attachment-d-2025march6docx/open

b. TP 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/idm-tool-individual-form-b/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 TP is available at: https://www.ncdhhs.gov/attachment-e-2025march6docx/open
    - The Letter to Guardian from the TP is available at: https://www.ncdhhs.gov/attachment-f-2025march6docx/open
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 TP 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.
    a) 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 TP staff will address through client rights protocols.
    b) 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.
    c) 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

16. If the individual expresses an interest in receiving behavioral health services or supported employment, the TP 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.
17. 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

18. 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 TP based on Medicaid County or residential county.
3. TP staff will review referrals provided in addition to information within the TP 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 TP 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. TP staff coordinates the In-Reach process with the designated hospital Social Worker, including validating contact information for legal guardians as applicable.
6. TP In-Reach staff will gather information to prepare for the initial visit.
7. In-Reach starts when TP 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 TP 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, TP 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 TP 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 TP 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.

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 TPs, 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 TPs ensure eligible individuals can participate fully in the IDM process. If there are concerns with public guardians refusing to allow in-reach visits or discuss PSH, please submit a ticket in Medicaid Help Center (MHC) so the issue is filed as a barrier.

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/

IDM AND INFORMED CHOICE

1. Individual and guardian engagement occurs frequently and face-to-face.
2. In-reach assessment includes reassessments at a minimum quarterly so informed decision can be made about moving to an integrated community setting.
3. Each TP submits completed IDM tools to DHHS TCL, and the IDM Review team completes a minimum of two reviews for quality assurance and to ensure the individual made an informed choice about PSH.
4. In-Reach continues until the next reassessment period if the review team determines informed choice is not clear.
5. If the review team determines an informed choice has been made, the status is changed in TCLD from Not Housed In-Reach to Not Housed Informed Choice In-Reach.
6. During Not Housed Informed Choice In-Reach, reassessments change to face-to-face "check-ins" but are only made every 6 months (180-days).
7. Definition of "quick check-in" - The visit/contact will be a brief touch base conversation regarding the individual's status and any unmet needs they may have. The IRS should not ask the individual about transitioning into the community unless the individual raises that as an issue of interest. The visit/contact should be more like "how are you doing, wanted to check in and see if you need anything, has anything changed since we last spoke?"
8. If the individual mentions transitioning, the IRS can then discuss it or schedule a follow-up visit/contact to do that.
9. For individuals with guardians (family, DSS, or agency) you must do the check-in with the guardian. If the guardian allows you to see the individual, please do the face-to-face visit/contact with them also. ALL face-to-face visits/contacts must be documented in TCLD within 3 business days.
10. If during the 6-month check-ins, you verify the individual is no longer TCL eligible, please document the reason in TCLD and notify DHHS so a review is conducted to determine if the individual TCLD status can be changed.
11. Each LME/MCO is responsible for making sure individuals on the informed choice list are seen for check-ins every 6 months.
12. DHHS will conduct random reviews to monitor for compliance.

In-Reach Services: Priority 5- NOT DIVERTED

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 TP 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. TPs should send the ACHs introductory letters and contact 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 directly 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 TP 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 TP 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 TPs use, to allow timely access to training for new employees as well as refresher training for existing staff. It is available in the HELP section when you login to TCLD. The current **TCLD USER GUIDE** version 4 is available for use.

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

In accordance with the DOJ Settlement, the TP must demonstrate compliance with and reporting of individual outcomes from In-Reach services to include (a) lack of response to written communication from the TP by individual or guardian; (b) refusal of an individual to meet with TP staff; and (c) refusal by a guardian for the individual to participate in the In-Reach process. All TP 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, North Carolina's Adult Care Home Bill of Rights outlines the rights of individuals residing in an ACH to include 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, NCDHHS Division of Health Service Regulation (DHSR) monitors complaints regarding ACHs. In the event TP In-Reach staff is denied access to an ACH or to the individual for the purposes of completing In-Reach activities, TP 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/ombudsman-contact-list-county-1/open
- 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 a TP has concerns regarding the care and services provided to an individual living at an ACH, the TP will file a complaint with the DHSR Complaint Intake Unit. The TP 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/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 TP has concerns regarding the care and services provided to an individual in a state-operated facility, the TP 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 NCDHHS. 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 TP In-Reach Activities

Each TP has a customer service department. All concerns or complaints about activities related to TP 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. TP 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 TP 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 TP 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 all essential services and supports 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 a 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 TP. 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 resources to address 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.

TP Oversight

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

DHHS funds 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.

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

On December 10, 2015, DHHS provided guidance on *New Procedures for In-Reach and Transitions Across Different TPs* to clarify expectations related to the delivery of Behavioral Health services and supports. The procedures were required to be in place on or before January 4, 2016.

It is the intent of North Carolina to provide access to the array and intensity of behavioral health services and supports necessary to enable individuals with Severe Mental Illness (SMI) in or at risk of entry into an Adult Care Home (ACH) to successfully transition to and live in community-based settings.

TPs are responsible for completing in-reach and transition coordination activities for individuals with SMI who reside in ACHs, including linking individuals who choose to remain living in an ACH to services if the individual expresses an interest.

On occasion, an individual with SMI may live outside of the responsible TPs catchment area or an individual with an approved housing slot may request to move to a county outside of the responsible TPs catchment area. These situations require collaboration between two or more TPs to facilitate the individual's smooth transition to the community and/or connection to services.

To promote collaboration between TPs and to ensure behavioral health services and necessary supports are implemented in a timely manner, the attached In-Reach and Transitioning Individuals between TPs Procedure was developed by a work group of TPs TCL Transition Coordinators in collaboration with DHHS.

The state requested each TP implement the In-reach and Transitioning Consumers between TPs Procedure on or before January 4, 2016. The implementation of these procedures will help facilitate community transitions and/or connection to services for those individuals living outside of the responsible TPs catchment area, as well as assist with streamlining the number of TPs completing in-reach and transition coordination activities per ACH.

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

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

Each TP is expected to create procedures documenting the method by which transition activities will be completed and documented. The procedures developed by the TP 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 TP 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 a TP assigns a TCL housing slot number, the TP 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 TP and others.
7. The Transition Coordinator in partnership with the assigned TP 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 prevent 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, 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, ACHs, and other entities or providers that the individual maybe working with, 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 required forms to establish the relationship with the Housing staff, 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 TPs. All individuals must receive 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, instead, the TCL RN/OT Evaluator Team) 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 ask 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 TP'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 TP must ensure appropriate behavioral health, physical health, and other needed services are in place for individuals prior to transitioning them into the community.
26. Once 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.

28. The Transition Coordinator will ensure that the post-transition follow along guidelines are followed with the intensity of interventions being individualized for each individual.
29. 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 as to 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 (their Local Barriers Committee representative, then if not resolved, elevate barriers by emailing the State Barriers Lead and make an entry into the TCL side of the Medicaid Help Center.
6. The Transition Coordinator could begin to discuss and/or explore expungement[5] 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 health, 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 TP 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 providers and respect preferences for location of service, access to transportation, etc.
5. The authorization process will also be explained, including the PCP process. 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.
6. The Transition Coordinator will modify provider roles and expectations based on whether the individual will receive enhanced services or basic services.
7. The Transition Coordinator will educate the enhanced services provider about the TCL process and inclusion of all 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.
8. The Transition Coordinator will ensure that the individual obtains needed services, including in the ACH or other facility, to ensure services are in place, and that provider and natural support relationships are established, and roles are clearly defined and set to begin the day of the individual's community transition.
9. 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 TP staff that also includes tenancy crisis planning.
10. TCL functions remain the sole responsibility of TCL Staff. Tailored Care managers [6]are not responsible for TCL functions. This means that TCL Staff retain responsibility of supporting TCL participants in their transition from an Adult Care Home (ACH) or a State Psychiatric Hospital into permanent supportive housing or TCL Bridge Housing. Tailored Care managers assigned TCL participants are expected to attend Transition Team meetings convened by TCL Staff as a part of the participant's Transition Team and coordinate with the TCL

[5] 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: https://www.nccourts.gov/documents/forms/application-for-certificate-of-verification-of-prior-expunction-or-discharge

[6] A Tailored Care Manager may be with the tailored plan or with a provider agency contracted with the plan.

participant's providers and TCL Staff on care management functions. The Tailored Care manager continues to be responsible for delivering whole-person care management to the TCL participant. The Tailored Care manager is also responsible for providing non-housing-related care management functions during a TCL participant's transition to supportive housing, including care coordination of health care needs and non-housing, health-related resource needs. More information about the role of a Tailored Care Manager for a member in TCL can be found here: https://medicaid.ncdhhs.gov/documents/providers/playbook/tcm-provider-manual-20240209/download?attachment

11. TP 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).
12. 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 make a referral to their Registered Nurse/Occupational Therapy Evaluator Team (RN/OT Evaluator Team) when there are physical health and/or significant functional health concerns noted in the CCA or other member records. The RN/OT Evaluator Team performs the following:
    a. The RN/OT Evaluator Team, perform an in-person, initial physical health and functional assessment of the TCL member, review the member's records and collateral information available from other sources, and develop recommendations for services and supports needed to support the member in community-based housing.
    b. Provide the member's behavioral health services provider maintaining the member's Person-Centered Plan a copy of the physical health and functional assessment and the RN/OT Evaluator Team's recommendations for services and supports needed to support the member in community-based housing in the next transition team meeting.
    c. The RN/OT Evaluator Team will perform a housing walkthrough to assess the TCL member's need for physical and functional health accommodations in the member's chosen housing to further inform and implement the RN/OT Evaluator Team's assessment recommendations. This walkthrough shall be done before transition, except to the extent when that is not possible due to housing occupancy restrictions, the walkthrough will be performed within three (3) Business Days after the member's transition.
    d. After the RN/OT Evaluator Team 's walkthrough of the member's community-based housing, consult face-to-face (preferably in person, or using Telehealth instead) with the TCL member and the TCL member's behavioral health service providers to include the medical, self-care, functional skill development recommendations and reasonable accommodations recommendations pertaining to the TCL member's housing in the member's person-centered plan, and present any recommended specialty care services to the TCL member and to their attending ordering provider. If the ordering provider and the TCL member approve the recommendation, the ordering provider will make the appropriate referral.

e. During the ninety (90) days post-transition period, verify that the TCL member's chosen physical health, behavioral health and specialty services are effective, and shall reassess as needed to make additional recommendations.

3. 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 appointments will be arranged or provided by TCL staff.
4. 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.
5. 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.
6. 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 the 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.
7. 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.
8. 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 TP 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 Assessors
    - 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. Each MCO should ensure, if necessary, that the individual has access to legal services to assist, such as Legal Aid of NC.

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 the 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), which is the subsidy payment/reimbursement system administered by NCHFA. Upload the following into CLIVe:
        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
    t. Ensuring, if needed, that a member of the RN/OT evaluator team completes a timely walk through to suggest any accommodations needed for individual.
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 TP and in rare cases make requests for additional funds from DHHS. 1915(i) Community Transition can also be utilized if the

individual meets the eligibility criteria.

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 TP for purchasing items and processing of TYSR requests to DHHS for reimbursement. The Housing Funds Guidelines Manual is available at: https://www.ncdhhs.gov/ncdhhs-transition-community-living-housing-guidelines/open
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 TP 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 Social Services (DSS) 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.
    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 TP (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.
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 member's community integration interests that shall be in the member's PCP, "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). The Transition Coordinator will make every effort to emphasize that providers' work with the individual focus on the member's chosen work, volunteering, community activities, recovery socialization, family reunification and/or meaningful life skill acquisition.
2. The Transition Coordinator will meet with the individual/guardian and, if applicable, their provider(s) to review the acquisition of needed transportation for current activities such as, but not limited to, funding and/or income utilization for bus passes, taxi services, Uber/Lyft, gas for family/friends. The Transition Coordinator will emphasize to providers and/or natural supports working on a transportation goal to ride with the member and use that time to review the details and skills of using public and private transportation.
3. Transition Coordinator will assist the member in obtaining the appropriate assessments for applying for a driver's license for personal transportation.
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.

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. The Transition Team will address those concerns in the PCP.
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 with the Care Manager if assigned to resolve the problem with the provider(s), the TP Provider Network, Program Integrity, or other TP 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 TP 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.

On February 3, 2023, DHHS provided guidance on Clarification of Transitions to Community Living Discharge & Transition Process from Adult Care Homes to clarify expectations related to discharge and transition planning. The procedures were required to be in place on or before February 3, 2023.

The guidance is meant to assist with transitioning individuals from Adult Care Homes (ACH) into permanent supportive housing.

1. Upon assignment to begin in-reach with an individual, the In-Reach Specialist (IRS) should send the introductory TCL letters to the ACH, individual or legal guardian. IRS should then schedule an in-person visit to the ACH to introduce themselves; educate the facility about TCL; ask about the facility protocols in place for visitors seeing residents (wearing badge, signing in at front desk, etc.); answer any questions about TCL; and address any additional concerns.
2. During each in-reach visit, the IRS will follow all required protocols of the facility, including but not limited to:
    a. Wear identification badges so they are visible and easily seen by staff at the facility.
    b. Be courteous and demonstrate professionalism when interacting with staff at the facility.
    c. Always check-in at reception/front desk and state who you are and who you are there to visit that day.
    d. Ask to speak to the Supervisor in Charge if the ACH Administrator is not onsite when you need to request access to medical records or copies of resident documents. Provide the current, signed release of information (ROI) to staff at the facility when requested.

   e. Provide your contact information when you are asked to do so by the staff at the facility.
   f. Do not smoke outside in the facility's parking lot.
   g. Do not park in handicap parking spaces without a handicap plate or placard.
   h. Always verify guardianship or Power of Attorney (POA) before initiating in-reach and provide in-reach in accordance with the wishes of the guardian or POA. Verification should be made by speaking to the guardian or guardian representative if the individual is served by a public guardian (county department of social services) or guardianship corporation.
   i. In Reach should request a Letter of Appointment when learning that a guardian of the person may be involved. The In Reach should inquire from the guardian his/her preferences of whether they would prefer to be present when visits with the person occur. Powers of Attorney have limited power over the person, while guardians of the person have more authority to make decisions for the person but must act in the best interests of the person.
3. When the IRS cannot address concerns noted by the facility on site, the IRS must notify the IR Supervisor as soon as possible so the facility concerns are documented and addressed in a timely manner. This should be an ongoing process until the individual successfully transitions into the community.
4. IRS should schedule appointments with the individuals and legal guardians prior to arriving at the facility to minimize disruptions in individuals' daily activities and respect the wishes of the individuals or legal guardians.
5. "Frequent engagement" is not the same as the 90-day reassessments. To engage with individuals, IRS must see individuals as frequently as possible, especially when they indicate they are indecisive about their interest in moving.
6. Frequent engagement by the IRS should continue to occur often enough to acquire information to address all the individual's life domains, to record needs and preferences and to establish a relationship with the individual to learn about their interests and concerns. All information must be recorded on the IR/TCL tool, reviewed with the Transition Coordinator (TC) and the transition team in the soft transition meeting to verify information and allow for updates. The LME/MCO TC must comply with the discharge and transition process outlined in the Settlement Agreement Section III E(5) that states, "LME transition coordinator will serve as the lead contact with the individual leading up to transition from an adult care home or State psychiatric hospital, including during the transition team meetings and while administering the required transition process."
7. During frequent engagement, IRS should ask individuals if they would like to have in-reach visits in the community, outside of the facility. DHHS has a strong expectation that IRS are offering individuals a "choice" of where they would like to have in-reach contacts. Locations for in-reach include but are not limited to the library, coffee houses, the park.
8. Information that should be reviewed and verified in soft transition meetings. "Soft transition" includes but is not limited to – the individual's housing preferences, treatment needs, skills and talents, desired activities, employment/education, relationship development, transportation, etc. Information should be described in detail that translates into tenancy support, social determinants of health (SDOH) acquisition, supported employment/education, recovery-oriented clinical interventions, and community activity engagement. The transition team plan should include the paid and natural supports responsible for actualizing these preferences and goals. The TC would assure these preferences and goals are converted into goals and actions on the individual's Person-Centered Plan (PCP) Reminder: Goals and preferences are not interventions.
9. All information obtained during in-reach must be given to providers to ensure the PCP is developed and includes the following as outlined in the Settlement Agreement Section III E(8) that states, The discharge planning process will result in a written discharge plan that accomplishes all of the following:
   a. identifies the individual's strengths, preferences, needs, and desired outcomes;
   b. identifies the specific supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes, regardless of whether

those services and supports are currently available;

c. includes a list of specific providers that can provide the identified supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes;
d. documents any barriers preventing the individual from transitioning to a more integrated setting and sets forth a plan for addressing those barriers;
    i. Such barriers shall not include the individual's disability or the severity of the disability.
    ii. For individuals with a history of re-admission or crises, the factors that led to re-admission or crises shall be identified and addressed.
e. sets forth the date that transition can occur, as well as the timeframes for completion of all needed steps to effect the transition; and
f. prompts development and implementation of needed actions to occur before, during, and after transition.

10. There should be overlapping functions between in-reach and transition planning. In-reach contacts must continue to ensure there is ongoing engagement and completion of the TCL tools after the individual says "YES" to transition. While this occurs, the TC should be introduced to the individual or legal guardian so they know the transition planning process has started and who will be leading transition team meetings.
11. When personal barriers occur during in-reach that would hinder transition (complex behavioral, medical and/or functional, legal-criminal, financial, social/familial, occupational, etc.) or systemic barriers (facility staff, service providers/provision, managed care, entitlements, funding, housing stock/access, employment limitations, community isolation, etc.), the TC should facilitate a meeting with the Local Transition Team at the LME/MCO to address the barriers and develop individualized strategies to avoid delays in transition. When barriers cannot be resolved, it is the responsibility of the IRS and TC to report them to the Local Barriers Committee (LBC). Should the LBC be unable to solve certain systemic barriers, the TC should enact a process of referral to the State Barriers Committee.
12. Barriers and strategies are discussed with the individual or legal guardian during the soft transition meeting. The TC should always include the resident's primary care provider or request documentation with recommendation(s) during the transition planning process, unless the individual or legal guardian has noted a refusal to include them.
13. Once the TC is notified by in-reach the individual said "YES" to transition, IR or the TC should assign a housing slot in Transitions to Community Living Database (TCLD) and initiate Transition Planning (TP).
14. Once the individual says "YES" to transition, the IRS should immediately notify the ACH or SPH of the decision and include them in the Transition Team meetings, if approved by the individual or legal guardian. The IRS should continue to collect vital documents (IDs, Birth certificates, etc.) and engage until the individual is linked to the provider. The IRS or TC should continue to provide updates to the facility staff during the TP phase so they stay abreast of the transition timeline; can provide new information about the individual's health; can ensure all financial obligations are met prior to the transition date, etc.
15. Once the individual says "YES" to transition, the TC should link individuals to a provider before discharge either with their existing provider or through a new provider utilizing assertive engagement. Assertive engagement activities include but are not limited to building rapport with the individual, attending onsite transition teams, and completing collateral transition tasks as requested by the transition team such as assisting with obtaining vital docs, housing choices, pre-lease landlord brokering, pharmacy planning, employment and benefits counseling exploration, social determinants of health and entitlement acquisition or post-discharge resumption, natural support connection, community visitation with transitioned individuals, and community activity engagement as per IR/TCL tool preferences.

16. If health and safety issues arise that delay the transition and the PCP has not been developed yet, that information should be documented in the TCLD and on the IR/TCL tool. Whenever new barriers arise, the transition team should meet again to discuss and document strategies to address each barrier. It is the responsibility of IRS and TCs to refer new barriers to LBCs and to ensure all information is updated on IR/TCL tool for inclusion in PCP.
17. If after being fully educated about TCL and the benefits of permanent supportive housing (PSH) the individual or their legal guardian says "NO" to transition or is hesitant about deciding, the IRS or assigned TCL staff must begin the informed decision-making (IDM) process and complete the IDM tool. The IDM tool is utilized to list and explore all the housing options available, list barriers that prevent the individual from transitioning, and document any strategies utilized to address the barriers identified. If barriers cannot be resolved, they must be referred to the LBC so they can be addressed before the quarterly reassessment period.
18. The purpose of the IDM tool is not to take someone off the in-reach list. The purpose of the IDM tool is to make sure that the IRS has provided sufficient information to the individual and legal guardian so that they can make an informed decision.
19. TCL staff and providers should join the individual or legal guardian at pre-lease reviews/Housing Assistance Payments (HAP) Agreement and actual lease signings to make sure the landlords/property managers and the contract match reasonable expectations of what is the individual's and the landlord's responsibility and that fair housing standards are followed.
20. Post-transition responsibilities include but are not limited to assuring behavioral, medical, functional, tenancy support, supported employment/educational, and community inclusion services are in place on both the day-of transition and thereafter in the frequency, duration, type, and intensity outlined in the individual's pre-transition IR/TCL Tool and detailed in their post-transition PCP.
21. Pursuant to the Settlement Agreement, LME/MCOs may assign IR or TC tasks to providers; however, the LME/MCOs retain responsibility for ensuring that quality supports are provided and discharge and transition procedures are followed in a timely and appropriate manner.

Emergency Situations
When TCL staff are present in the facility and observe or receive reports about problems that involve concerns that impact the health and safety of individuals living in the facility or violations of the Bill of Rights, these concerns must be directed to the State (Division of Health Service Regulation (DHSR) and/or local county Department of Social Services (DSS) Adult Protective Services to make an Adult Protective Services (APS) report, Regional Ombudsman, and SBC).

Other Administrative/Programmatic Guidelines

Documenting Transition Activities

Staff completing Transition activities for the TP 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 TP 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 online training module has been developed for TPs use, allowing timely access to training for new employees and refresher training for existing staff. It is available under the HELP section after you login to TCLD. The current **TCLD USER GUIDE**

version 4 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 TP 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 step 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 is signed.
12. Secure household items.
13. Identify move-in date.
14. No more than 100 days from step 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 TP 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 TP staff should follow the division of those roles and tasks as outlined in the TP 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 TP Lead Transition Coordination (LTC) staff and/or sends checklist to TCL Staff for review within three days of admission.
2. TP TCL internal staff and TP 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 TP staff will check within their electronic medical record if the individual has an existing community behavioral health provider. The TP 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, with or without a guardian, chooses not to transition with TCL, the individual would be reassessed as needed and in extended cases of refusing TCL, the IRS 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 TCL Staff. The IRS then completes the In-Reach and Transition Tool with the individual while simultaneously the TP assigns 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 TP 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 TP TC will request a housing slot from DHHS and arrange the first TCL Transition Team, with coordination from the SW and LTC. Transition teams are meetings held at the SPH and apart from the individual's SPH treatment team. Transition teams are led by the individual, facilitated by 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 utilizing the person-centered framework of the TCL In-Reach Tool. The TC will actively assure that behavioral health, physical health, and specialized therapies that are recommended by the SPH treatment team are reviewed with the individual and/or guardian and appropriate services and supports are in place.
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 develop meaningful activities throughout an individual's week such as but not limited to employment, education, and community activity, recovery-oriented groups, leisure, family reunification, or other options important to the individual. If the individual wants to explore the possibility 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 so everything is available before the day of discharge.

15. If the length of SPH stay 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 TPs Bridge Housing, and consider other temporary housing options.
16. If the individual chooses TCL Transition but is at the SPH under an Incapable to Proceed (ITP) order, and 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. The LTC and TC decides 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 while in detention, and transition the person into their chosen PSH or maintain a stable transition into Bridge Housing upon release from the detention center.

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 TP for a prompt determination of eligibility for mental health services.

Once an individual is determined to be eligible for mental health services, the TP 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 TCL Staff will document the steps taken to show that the decision is an informed one on the IDM tool. The TCL Staff will develop 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). RSVP is 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). As 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/providers/program-specific-clinical-coverage-policies.

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 TP 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 only a medical diagnosis indicated, the referrals are submitted to DMH/DD/SUS for screening to determine if the individual may need to be further screened by a TP for TCL.

RSVP INFORMATION: WHAT I NEED TO KNOW

Who Needs to Submit an RSVP Referral?

- Regardless of diagnosis, ALL Medicaid-eligible individuals who are **being considered for admission to an ACH** [7]under G.S. 131D-2.4, will require the RSVP. This does not include .5600 licensed mental health group homes, ICF/IDD group homes, or unlicensed homes.
- 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 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. This includes individuals being admitted into a long term SNF bed (SNF PASSR required) or into a .5600 MHGH.
- Individuals who are NOT Medicaid eligible.
- Individuals who have previously been referred and screened through RSVP. This would include individuals transferring from one ACH to another ACH, individuals with a history of ACH admissions, individuals with a history of State Psychiatric Hospital (SPH) admissions, individuals living in the community who are actively participating with TCL. *Please contact either your local TP or* TCLD.Support@dhhs.nc.gov *prior to submitting a new RSVP to verify if there is an existing RSVP # that can be utilized.*
- Individuals who have had a previous RSVP and are returning to the same ACH from 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.

[7] For the remainder of the manual, when ACHs is noted, it is referencing ACHs, FCHs, and ALFs.

Who May Submit an RSVP Referral?

- Individuals, family members, advocates, providers, community hospitals, state operated facilities, Standard Plans, and TP 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 TP 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 (verbal or written) 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.[8]
- 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 TPs 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 (not required) 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.myhousingsearch.com/pre_screening/ncdrst/DiversionScreeningTool.html
- RSVP FAQ: https://www.ncdhhs.gov/rsvp-faq-10-1-24/download?attachment

[8] NC Medicaid State Plan Personal Care Services (PCS) Clinical Coverage Policy No: 3L https://medicaid.ncdhhs.gov/3l/open

- DHHS RSVP-Diversion Information Webinar: https://www.youtube.com/watch?v=ttrEg9POe28
- NC Medicaid Clinical Coverage Policy 3L – Personal Care Services: https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies
- DHHS - TCL Webpage: https://www.ncdhhs.gov/about/department-initiatives/transitions-community-living

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

- RSVP Technical Assistance or Medical only RSVP submission inquiries can be submitted through TCLD.Support@dhhs.nc.gov
- DHHS RSVP-Diversion Information Webinar is also available and walks through the RSVP submission process from beginning to end: https://www.youtube.com/watch?v=ttrEg9POe28
- For RSVP Behavioral Health (Mental Health, Substance Abuse, TBI and IDD) referrals already submitted please contact the TP 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 TP for determination of TCL.

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

- If there is a potential Behavioral Health diagnosis indicated on the RSVP, the RSVP is routed to the designated TP
- TP 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 TP 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, TP 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, TP staff will verify that the individual has a qualifying SMI/SPMI diagnosis AND that the individual is Medicaid or financially eligible based on meeting one of the five following criteria Medicaid and Eligibility for TCL Housing Slots:
    A. Is eligible for Medicaid;
    B. Is Special Assistance eligible in an Adult Care Home;
    C. Would be Special Assistance eligible in an Adult Care Home who no longer reside in an Adult Care Home;
    D. Or has a gross income equal to or less than 100 percent of the Federal Poverty Guidelines for a Single Individual.
    E. The state may elect to revise the criteria in this paragraph subject to the approval of the Independent Reviewer.
        - The state revised the criteria by adding: Individuals who are not Medicaid eligible but have a monthly income of $2000 or less.
- 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.
- The Settlement Agreement affirms that the severity of the person's condition does not exempt them from eligibility in Section III.(E)(8)i after spelling out that barriers to transition must be identified, the Settlement Agreement states, "Such barriers shall not include the individual's disability or the severity of the disability." The following clarifications provide further guidance to facilitate determinations of TCL eligibility *Transitions to Community Living (TCL) Eligibility with Co-Occurring Diagnoses and Change in TCL Terminology*:
    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.
    The following clarifications provide further guidance to facilitate determinations of TCL eligibility for individuals with a co-occurring diagnosis of Acquired Brain Injury -*Clarification Regarding Transitions to Community Living (TCL) Eligibility for Individuals with Co-Occurring Neurocognitive and/or Acquired Brain Injury Diagnoses*:
        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 to TCLD so a Diversion Outreach staff member 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. These contacts include contacts made by Transition or any other staff while the individual has an open diversion attempt in process.

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 TP

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

b. **TP Oversight**

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

Each TP 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 TP Registered Nurse (RN) and Occupational Therapist especially individuals with complex physical health needs. See Transition Planning Guidelines below.
- 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. DHHS recommends using the IDM Tool to document the informed choice. Additionally, designated TP staff (Transition Team) should be notified to assist with identifying barriers and documenting the strategies/steps to address all barriers when necessary.
- If the individual/guardian chooses to transition into an adult care home after being fully informed of all the available housing options, prior to entry into an adult care home, then 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 TPs 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://www.ncdhhs.gov/community-integration-planning-guide-04242019-rev-04072021/download?attachment)
   - 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 monthly to the DHHS TCL Review team by the designated TP.

Step by Step Procedures for Diversion Transition Planning:

1. Once an individual agrees to permanent supportive housing and transition, a housing slot number (#) must be obtained within 10 days, and a new transition attempt is initiated in TCLD by the Transition Coordinator.
2. Once a TP assigns a TCL housing slot #, the TP 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 Diversion process, once the individual has said "yes" to transition. This person may partner with the Diversion Staff in requesting the housing slot.*
3. If the individual does not have a current Comprehensive Clinical Assessment (CCA) within the past 12 months, 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 Diversion staff 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 Diversion staff will introduce the individual to the Transition Coordinator and share any information they have 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 Diversion 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 TP-TP and others.
7. The Transition Coordinator, in partnership with the assigned TP-TP 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 prevent 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 about others who have core roles in transition (i.e., providers, DSS, housing specialist, care coordinator, medical provider, 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, ACHs, and other entities or providers that individual may be working with, 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 **Diversion Tool/CIP** 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 **Diversion Tool/CIP** 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 **Diversion Tool/CIP or any other tools** that were utilized during the Diversion 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.
20. The Transition Coordinator will present the required forms to establish the relationship with the Housing staff, 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. Assertive Community Treatment (ACT) or a Community Support Team (CST) will provide the tenancy support services for the individual. TMS is a service contracted to the behavioral health providers by the LME/MCO- TPs. All individuals must receive TMS unless they have an ACT or CST provider.
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, instead, the TCL RN/OT Evaluator Team) 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 ask 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 TP-TP'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 TP must ensure appropriate behavioral health, physical health, and other needed services are in place for individuals prior to transitioning them into the community.
26. Once 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 ideally will be conducted face-to-face and in the early stages of transition planning after the individual has said "yes" to supportive housing. Pre-Transition surveys are considered timely when conducted no later than the day prior to the individual's transition date, i.e., before the effective date of the individual's lease. *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.* Re-administration of the Pre-Transition survey is not required for individuals who have left housing for a period of time and are being rehoused.
    b. Follow-up surveys also ideally will 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 TCL 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 in TCL housing. Follow-up surveys should not be conducted with individuals who are not in TCL housing.
    c. Survey link: https://gcv.microsoft.us/Rx8APs6m6q
28. The Transition Coordinator will ensure that the post-transition follow-along guidelines are followed with the intensity of interventions being individualized for each individual.
29. The Transition Coordinator as well as any other TCL staff working with the individual during the time the individual has an open diversion attempt in process needs to enter TCLD notes to indicate actions taken (discussions w/the individual or guardian, discussions with providers, treatment team meetings, and any actions taken pertaining to the individual's transition or situation. Transition coordinators as well as any other staff working with the individual during the time the individual has an open diversion attempt in process need to enter outreach contacts to indicate dates of contact, type of contact, and the individuals housing slot decision).

The following outlines procedures in vital 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 Diversion Tool/CIP 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 -TP 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. 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 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 ensure that the individual obtains needed services 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 transition to PSH.

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 TP staff that also includes tenancy crisis planning.
11. TCL functions remain the sole responsibility of TCL Staff. Tailored Care managers are not responsible for TCL functions. This means that TCL Staff retain responsibility of supporting TCL participants in their transition to permanent supportive housing or TCL Bridge Housing. Tailored Care managers assigned TCL participants are expected to attend Transition Team meetings convened by TCL Staff as a part of the participant's Transition Team and coordinate with the TCL participant's providers and TCL Staff on care management functions. The Tailored Care manager continues to be responsible for delivering whole-person care management to the TCL participant. The Tailored Care manager is also responsible for providing non-housing-related care management functions during a TCL participant's transition to supportive housing, including care coordination of health care needs and non-housing, health-related resource needs. More information about the role of a Tailored Care Manager for a member in TCL can be found here: https://medicaid.ncdhhs.gov/documents/providers/playbook/tcm-provider-manual-20240209/download?attachment
12. TP 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 **Diversion Tool/CIP** to identify the medical home of the individual, 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 make a referral to their Registered Nurse/Occupational Therapy Evaluator Team (RN/OT Evaluator Team) when there are physical health and/or significant functional health concerns noted in the CCA or other member records. The RN/OT Evaluator Team performs the following:
    a. The RN/OT Evaluator Team performs an in-person, initial physical health and functional assessment of the TCL member, reviews the member's records and collateral information available from other sources, and develops recommendations for services and supports needed to support the member in community-based housing.
    b. Provides the member's behavioral health services provider maintaining the member's Person-Centered Plan a copy of the physical health and functional assessment and the RN/OT Evaluator Team's recommendations for services and supports needed to support the member in community-based housing in the next transition team meeting.
    c. The RN/OT Evaluator Team will perform a housing walkthrough to assess the TCL member's need for physical and functional health accommodations in the member's chosen housing to further inform and implement the RN/OT Evaluator Team 's assessment recommendations. This walkthrough shall be done before transition, except to the extent when that is not possible due to housing occupancy restrictions, the walkthrough will be performed within three (3) Business Days after the member's transition.

   d. After the RN/OT Evaluator Team's walkthrough of the member's community-based housing, consult face-to-face (preferably in person, or using Telehealth instead) with the TCL member and the TCL member's behavioral health service providers to include the medical, self-care, functional skill development recommendations and reasonable accommodations recommendations pertaining to the TCL member's housing in the member's person-centered plan, and present any recommended specialty care services to the TCL member and to their attending ordering provider. If the ordering provider and the TCL member approve the recommendation, the ordering provider will make the appropriate referral.
   e. During the ninety (90) days post-transition period, verify that the TCL member's chosen physical health, behavioral health and specialty services are effective, and shall reassess as needed to make additional recommendations.
3. 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.
4. 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.
5. 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.
6. 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.
7. 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.
8. 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 TP 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 Assessors
   - 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. Each TP should ensure, if necessary, that the individual has access to legal services to assist, such as Legal Aid of NC.
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 that the 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
    t. Ensuring if needed that a member of the RN/OT evaluator team completes a timely walk through to suggest any accommodations needed for individual.
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 TP and in rare cases make requests for additional funds from DHHS. 1915(i) funds can also be utilized if the individual is eligible.

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. The Transition Coordinator will follow procedures adopted by the respective TP for purchasing items and processing of TYSR requests to DHHS for reimbursement. The Housing Funds Guidelines Manual is available at: https://www.ncdhhs.gov/ncdhhs-transition-community-living-housing-guidelines/open
10. 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 TP for items purchased prior to approval of a waiver request.
11. 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 Social Services (DSS) 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. 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 TP-TP (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.
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 member's community integration interests that shall be in the member's PCP, "Important To" and "Important For", and community resources information available from meetings with the individual/guardian and the **Diversion Tool/CIP**. The Transition Coordinator will make every effort to emphasize the provider(s') work with the individual focus on the member's chosen work, volunteering, community activities, recovery socialization, family reunification and/or meaningful life skill acquisition.
2. The Transition Coordinator will meet with the individual/guardian, and if applicable, their provider(s) to review the acquisition of needed transportation for current activities such as but not limited to will be explored and options to consider if this is not possible (funding and/or income utilization for bus passes, taxi services, Uber/Lyft, gas for family/friends. The Transition Coordinator will emphasize to providers and/or natural supports working on a transportation goal to ride with the member and use that time to review the details and skills of using public and private transportation.
3. Transition Coordinator will assist the member in obtaining the appropriate assessments for applying for a driver's license for individual transportation. etc.).
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.

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. The Transition Team will address those concerns in the PCP.
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 with the Care Manager if assigned to resolve the problem with the provider(s), the TP Provider Network, Program Integrity, or other TP 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 TP-TP 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.

Procedures-Rehousing :

For all DOJ populations and as noted in the TCM manual, the primary responsibility of the TP Transition Coordinator is to intervene to preserve tenancy and avoid housing separations, and evaluate tenancy issues to extend rehousing tenure. The plan for care managers to assume leadership of the Care Team, upon handoff from the Transition Coordinator and Transition Team at the conclusion of the follow-along period, in supporting the TCL participant in the community, is to follow procedures for communicating with TCL staff if there are any housing-related concerns or a housing separation so the TC is brought back in to manage and evaluate the situation (note that TCL staff remain responsible for the participant's housing after transition).

Other Administrative/Programmatic Guidelines

Documenting Transition Activities

Staff completing Transition activities for the TP must utilize the **Diversion Tool/CIP** or any tools approved by DHHS. These documents outline key elements to support the Diversion and transition process of the individual.

The TP 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 under Outreach Contacts*). Data entry

should occur daily to ensure system data reflects real-time activities with individuals. An online training module has been developed for TPs use, allowing timely access to training for new employees and refresher training for existing staff. It is available under the HELP section after you login to TCLD. The current **TCLD USER GUIDE** version 4 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 TP-TP staff apprised of deadlines should they change.

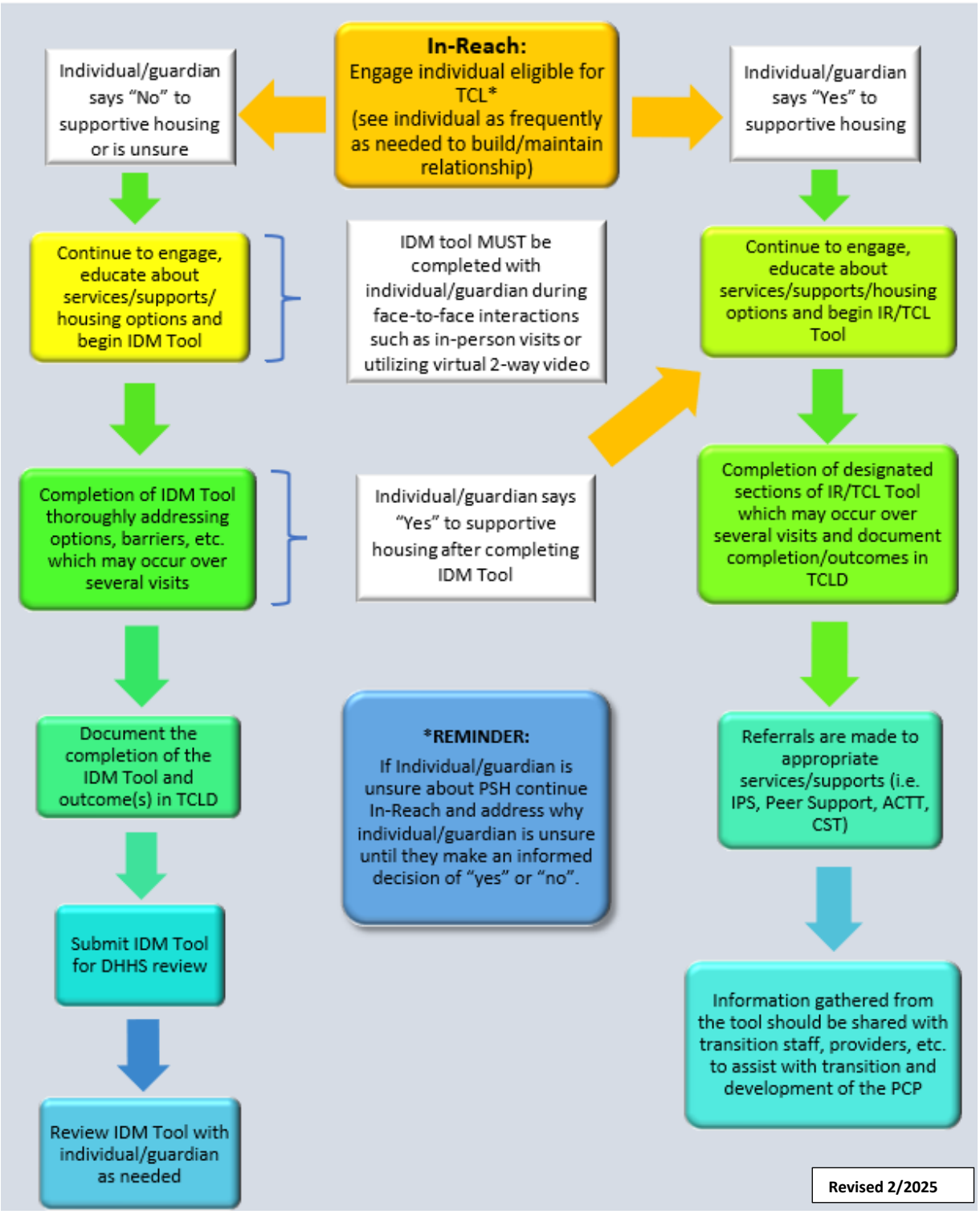
Transition Timeline and Overview

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 step 3 (Housing Slot Assigned) warm hand-off between the Diversion Staff 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.

No more than 100 days from step 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.*

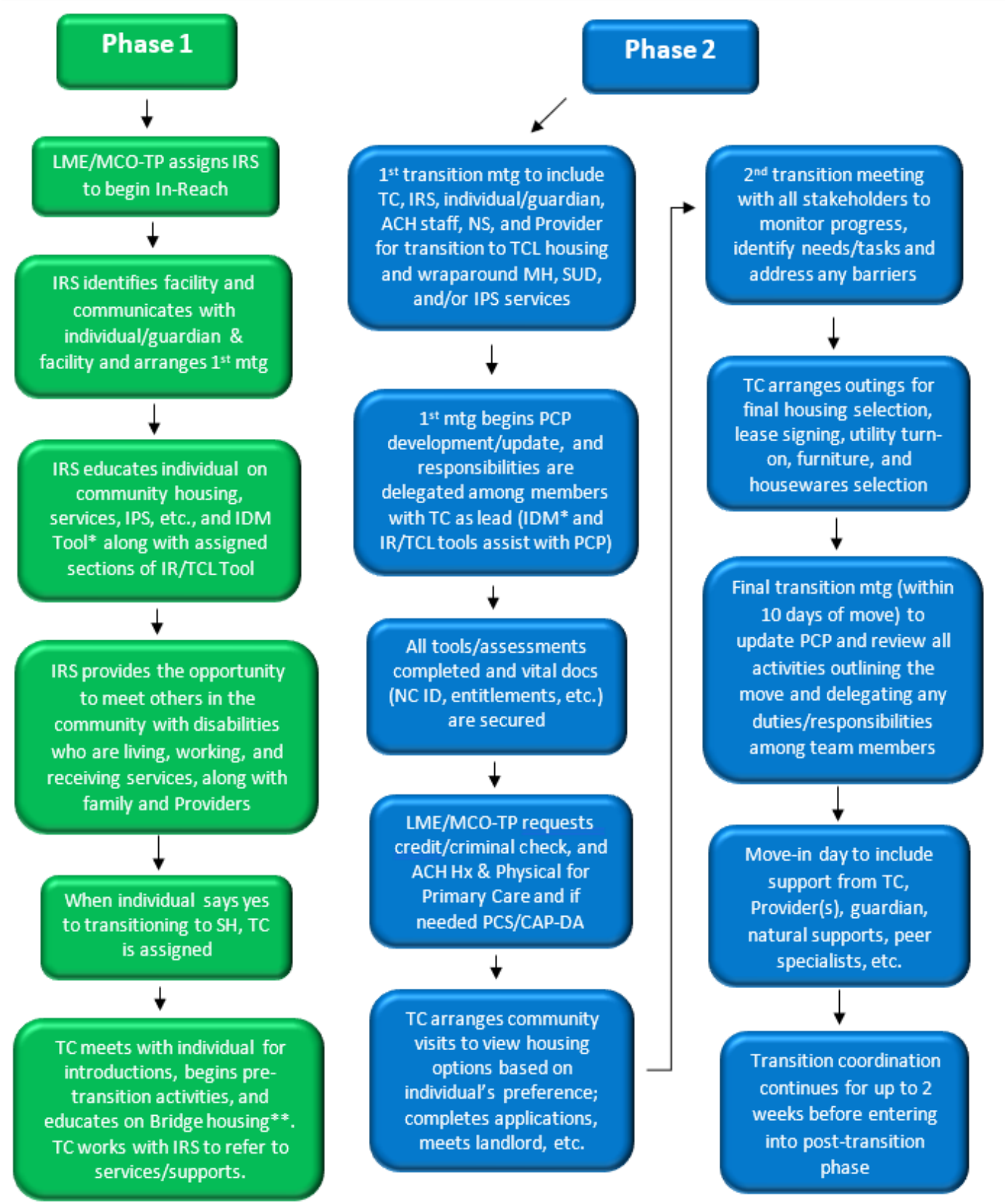
APPENDIX

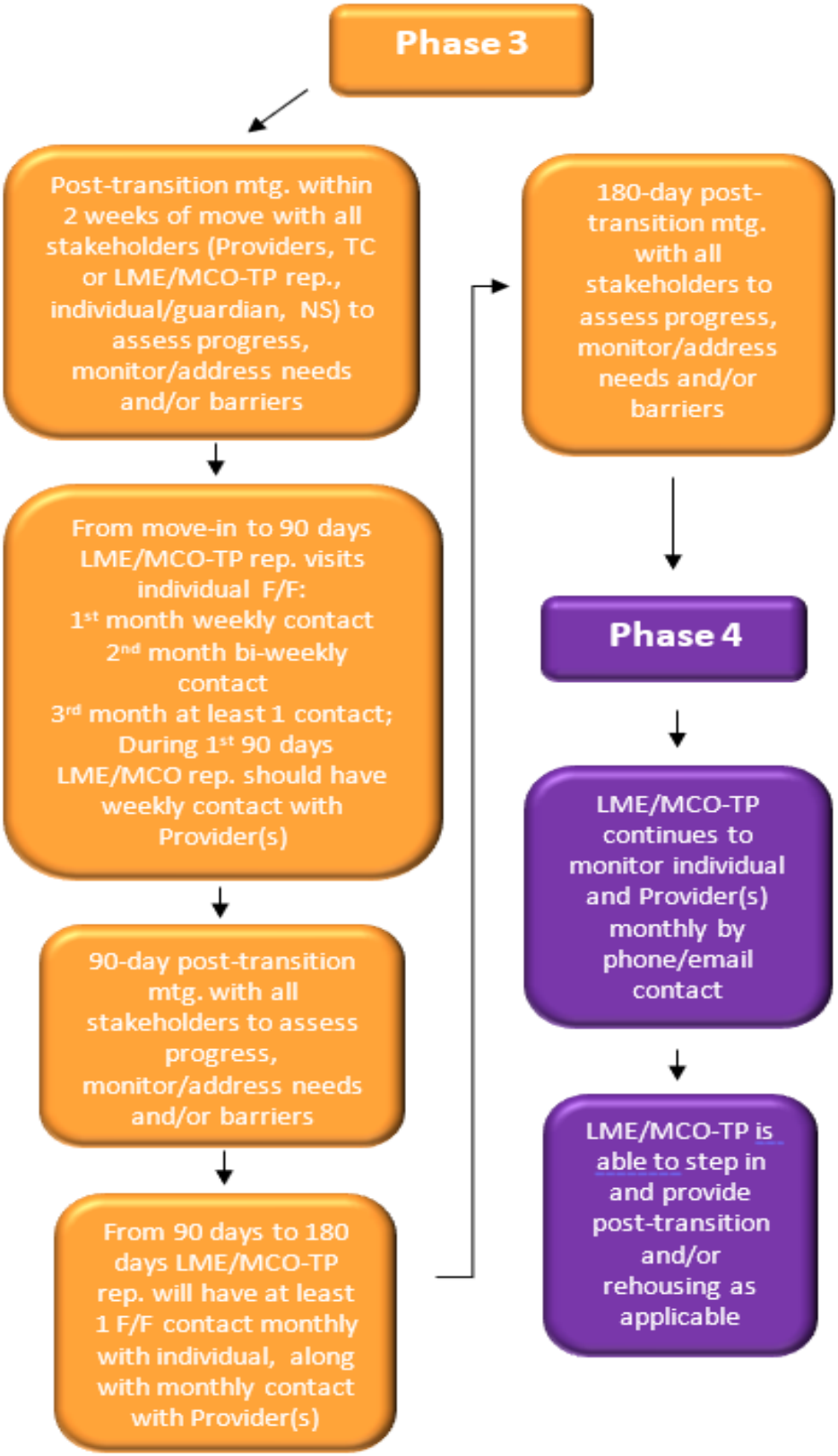
In-Reach (IR) Workflow (IR/TCL and IDM Tools)



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

ACH Transition Workflow




Phase 3
Post-transition mtg. within 2 weeks of move with all stakeholders (Providers, TC or LME/MCO-TP rep., individual/guardian, NS) to assess progress, monitor/address needs and/or barriers
From move-in to 90 days LME/MCO-TP rep. visits individual F/F:
1st month weekly contact
2nd month bi-weekly contact
3rd month at least 1 contact;
During 1st 90 days LME/MCO rep. should have weekly contact with Provider(s)
90-day post-transition mtg. with all stakeholders to assess progress, monitor/address needs and/or barriers
From 90 days to 180 days LME/MCO-TP rep. will have at least 1 F/F contact monthly with individual, along with monthly contact with Provider(s)
180-day post-transition mtg. with all stakeholders to assess progress, monitor/address needs and/or barriers
Phase 4
LME/MCO-TP continues to monitor individual and Provider(s) monthly by phone/email contact
LME/MCO-TP is able to step in and provide post-transition and/or rehousing as applicable

***IDM tool completed according to guidelines**
****Bridge housing can be utilized during any phase as needed**
ACH Transition Workflow Legend:
LME/MCO-TP – Local Management Entity/Managed Care Organization-Tailored Plan
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
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/SUS	Division of Mental Health, Developmental Disabilities, and Substance Use 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
LTC	Lead Transition Coordination
TP	Local Management Entity/Managed Care Organization- Tailored Plan
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