NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

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LME/MCO Joint Communication Bulletin # J441

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TO: Local Management Entities-Managed Care Organizations (LME-MCOs)

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SUBJECT: **Clarification of Transitions to Community Living Discharge & Transition Process from State Psychiatric Hospitals**

This bulletin outlines requirements for the Transitions to Community Living (TCL) in-reach (IR), transition, and discharge process for individuals in State Psychiatric Hospitals (SPHs). These procedures are designed to assist with transitioning individuals from SPHs into permanent supportive housing or TCL Bridge Housing in compliance with the requirements of the TCL Settlement Agreement with the US Department of Justice (DOJ), dated Aug. 23, 2012.

- Within seven days of an adult admission, the SPH screens for TCL eligibility using the DHHS approved TCL eligibility checklist and submits an in-reach referral using RSVP. If applicable, the SPH refers the individual for TCL, and the LME/MCO verifies eligibility. The Lead Transition Coordinator (LTC) arranges onsite in-reach and transition planning meetings coordinated with the individual and SPH social worker.

- Any LME/MCO staff routinely performing onsite in-reach and/or discharge and transition planning activities must complete an SPH orientation process. The purpose of this orientation is to ensure safety procedures and rules are followed and to provide a streamlined check-in process that includes badge access to patient care units to facilitate working with SPH patients.

- The LME/MCO Transition Coordinator (TC) at the SPH, often referred to as a Hospital Liaison or as an LTC, must comply with the discharge and transition process outlined in the LME/MCO and Division of

State Operated Healthcare Facility Settlement Contract (DSOHF) and DOJ Settlement Agreement (SA), 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." The LTC working onsite at the SPH shares the lead in discussions and tasks regarding transition planning and tasks in the community with the community-based TC, LME/MCO staff, and providers.

- The LTC must connect the individual to their pre-admission community behavioral health provider, or if admitted without an active provider, connect them to a new provider while at the SPH. Pre-discharge, providers will be expected to perform duties with the individual and their transition team including, but not limited to, building rapport with the individual, attending onsite transition teams, and completing collateral transition tasks as assigned by the transition team. Collateral tasks include but are not limited to assisting SPH Social Workers with obtaining vital documents, presenting housing choices, pre-lease landlord brokering, pharmacy planning, employment and benefits counseling exploration, natural support connection, community visitation with transitioned individuals, and community activity engagement as per IR/TCL tool preferences.

- In most cases, multiple in-reach meetings are essential to build a trusting relationship necessary for an authentic and complete in-reach process. If during any point in the in-reach process the individual says "YES" to transition, the LME/MCO shall assign a housing slot in the Transitions to Community Living Database (TCLD), and a TC shall begin pre-transition tasks. In these cases, the IR will perform a warm introduction of the TC to the individual or legal guardian and explain the ongoing overlapping in-reach and transition process. In addition, in-reach will include community visits for individuals to meet with people already transitioning into the community as per the Settlement Agreement.

- Transition teams shall occur at the SPH, face-to-face with the individual. A transition team must be comprised of the individual and when applicable their guardian, facilitated by their LTC or TC, and regularly attended by the SPH social worker, and community providers. The transition team may include ad hoc attendees approved by the individual such as other LME/MCO, SPH, or provider staff, or natural supports. Transition teams cannot occur during SPH multidisciplinary treatment teams. Although the LTC attends SPH treatment teams, the individual's TC must attend when the individual's discharge is on the SPH treatment team agenda. The LTC and TC treatment team attendance is to inform them of TCL transition team progress, and the SPH treatment team will inform the transition team of an individual's clinical status and impending discharge dates.

- Information that must be reviewed and verified in soft transition meetings (see TCL In-Reach/Transition and Diversion Manual, Pg. 17 for definition of soft transition; https://www.ncdhhs.gov/tcl-manual-ir-transition-and-diversionrev-11-14-2022pdf/open) includes but is not limited to the individual's housing preferences, predominant and co-occurring treatment needs, skills and talents, desired activities, employment/education, relationship development, transportation, etc. Information shall be described in detail that translate into tenancy support, social determinants of health (SDOH) supports, supported employment/education, recovery-oriented clinical interventions, and community activity engagement. The transition team plan must 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 SPH's Continuing Care Plan and the individual's Person-Centered Plan (PCP).

- With the attending psychiatrist's approval and in collaboration with the SPH social worker, the TC will arrange and have LME/MCO TCL staff accompany the individual on pre-discharge community visits with others who have transitioned through TCL, review housing options, prepare for or attend lease signings, explore community activities, and participate in other community transition preparatory activities.

- When personal barriers occur during in-reach that would hinder transition (complex behavioral, medical and/or functional, legal-criminal, financial, social/familial, occupational, inadequate accommodation, etc.) or systemic barriers (facility staff, service providers/provision, managed care, entitlements, funding, housing stock/access, employment limitations, community isolation, etc.), the TC will 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 In-Reach Specialist (IRS) and TC to report them to the Local Barriers Committee (LBC). If the LBC is unable to mitigate or remediate a barrier that could be systemic, the barrier must referred to the State Barriers Committee.

If you have any questions, please contact Brad Owen, at 919-609-1908 or brad.owen@dhhs.nc.gov.

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