NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

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LME/MCO Joint Communication Bulletin # J442

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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 Adult Care Homes**

This bulletin outlines expectations of the Discharge and Transition process for Transitions to Community Living (TCL). These procedures are designed to assist with transitioning individuals from Adult Care Homes (ACH) into permanent supportive housing in compliance with the requirements of the TCL Settlement Agreement with the US Department of Justice (DOJ) dated Aug. 23, 2012 (Settlement Agreement).

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 re-assessments. 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 (See TCL In-Reach/Transition and Diversion Manual, Pg. 17 for a definition of "soft transition") include 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 translate 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 requests 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. 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).

If you have any questions, please contact Tamara Smith, PhD at 984-236-5153 or tamara.smith@dhhs.nc.gov.

Previous bulletins can be accessed at: www.ncdhhs.gov/divisions/mhddsas/joint-communication-bulletins

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