

## **Transition Management Services (TMS)**

**Revised 12/15/19**

### **Service Definition and Required Components**

Transition Management Services (TMS) is a service provided to individuals participating in the Transition to Community Living Initiative (TCLI). TMS is a rehabilitation service intended to increase and restore an individual's ability to live successfully in the community by maintaining tenancy. TMS focuses on increasing the individual's ability to live as independently as possible, managing the illness, and reestablishing his or her community roles related to the following life domains: emotional, social, safety, housing, medical and health, educational, vocational, and legal. TMS provides structured rehabilitative interventions as listed below.

#### **A. Assessment**

- Identify the individual's housing preferences, and transition and housing retention barriers related to successful tenancy.
- Assess needed social and independent living skills to support capacity to live independently and maintain housing using a functional assessment tool
- Identify resources to cover expenses such as security deposit, moving costs, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses.

#### **B. Individual Housing & Tenancy Sustaining Services**

- Assist with the housing application and search process including locating available rental units, identifying landlord partners, completing applications, identifying resources to cover application fees, completing applications for eligible housing programs, and transporting the individual during the housing search process.
- Ensure that the living environment is safe and ready for move-in.
- Assist in arranging for and supporting the details of the move such as utility connection, purchase housing items to set up apartment (bedroom, kitchen, livingroom, bathroom), and arrange transportation to move items to apartment.
- Provide early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations.
- Assist the individual in understanding the role, rights and responsibilities of the tenant and landlord.
- Restore skills to develop key relationships with landlords/property managers with a goal of fostering successful tenancy.
- Assist in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action.
- Restore the individual's connection to community resources to prevent eviction when housing is, or may potentially become jeopardized.
- Assist with the housing recertification process.
- Establish or restore the individual's ability to comply with lease agreement and manage his or her household.
- Act as primary contact for landlord to address any tenancy issues.

**C. Money Management and Entitlements**

- Assist the individual in gaining access to obtain birth certificates, request social security cards, facilitate credit repair, and criminal record corrections.
- Assist in accessing financial entitlements such as SSI/SSDI, Medicaid, Special Assistance In-Home, food stamps, Veteran benefits, and payeeship (as needed) including assisting with applications for these entitlements and/or identifying and referring the individual to local community agencies that can assist in applying for financial entitlements.
- Assist the individual to improve ability to budget his or her money and pay bills. Monitor financial needs monthly or more frequently if needed.
- Assist the individual with utility management to prevent high utility bills and utility arrears.
- Manage Special Assistance In-home Benefit and provide updated information to the department of social services where the Special Assistance In-home and Medicaid originated.-

**D. Activities of Daily Living**

Assist the individual to restore or improve his or her ability to:

- Perform self-care management
- Maintain personal safety
- Meal plan, grocery shop, cook, use kitchen appliances and properly store food safely
- Purchase and care for clothes
- Maintain and clean apartment
- Use different modes of transportation

**E. Personal Health, Wellness and Recovery**

Assist the individual to restore or improve his or her ability to:

- Manage medications
- Access and use pharmacy services; and appropriately store medications
- Manage personal health needs
- Assist individual with navigating health services system
- Maintain nutrition and physical activities
- Identify and participate in self-help groups
- Develop a personal crisis management plan, including suicide prevention or psychiatric advance directive using Wellness Recovery Action Plans (WRAP), Whole Health Action Management (WHAM) and/or psychiatric advanced directives (PAD)
- Develop a relapse prevention plan, including identification/recognition of early warning signs and rapid intervention strategies.

**F. Promote Community Integration**

Assist the individual to restore or improve his or her ability to:

- Socialize, communicate and develop friendships
- Identify his or her interests and lifestyle choices
- Identify where to pursue those interests plan a leisure-time schedule
- Develop social skills for spending leisure time with others, e.g., how to make a date, how to host a get-together, dining in a restaurant, going to a movie or bowling

- Use resources (e.g., phone, computer, or newspaper) to learn what is happening in the community in terms of entertainment or recreational activities/events.

Link to employment, educational and volunteer programs if identified as a goal by the individual. The TMS shall develop relationships with agencies that provide housing services, i.e., Housing Authority, permanent supportive housing providers, rapid re-housing providers, HUD-VASH, NC Housing Finance Agency, and relationships with local landlords to increase access to appropriate, safe, and affordable housing.

### **Provider Requirements**

The provider requirements are as follows:

- a. Meet the provider qualification policies, procedures, and standards established by the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS);
- b. Fulfill the requirements of 10A NCAC 27G;
- c. Demonstrate compliance with these standards by being certified by the Local Management Entities-Managed Care Organizations (LME-MCO); and
- d. Become established as a legally constituted entity capable of meeting all of the requirements of the Provider Certification, LME-MCO Enrollment Agreement, Communication Bulletins, and service implementation standards.
- e. Comply with all applicable federal and state requirements. This includes the North Carolina Department of Health and Human Services statutes, rules, policies, and communication bulletins, and other published instructions.

The TMS provider shall ensure all staff, whether office-based or home-based, is located within 45 miles/45 minutes for rural areas and 30 miles/30 minutes for urban areas of persons to be served. The LME-MCO may grant an exception to requirement.

### **Staffing Requirements**

TMS services are provided by a team of four individuals (six individuals if using two staff to fill the NC Certified Peer Support Specialist) consisting of the following staff:

- One full-time dedicated Qualified Professional serving as the Team Leader,  
AND
- One full-time dedicated Qualified Professional or Associate Professional  
AND
- One FTE NC Certified Peer Support Specialist (NCCPSS) (may be filled by two part-time individuals),  
AND
- An additional FTE NCCPSS (may be filled by two part-time individuals) or one full-time Paraprofessional.

TMS Staff shall have at least two years of experience working with adults with mental health and/or substance use disorders.

Providers are encouraged to use a Licensed Occupational Therapist meeting QP status to fill the QP position. Occupational therapy in community mental health has shown to increase an individual's ability to live as independently as possible in the community while engaging in meaningful and productive life roles.

Oversite of the Team shall be provided by a licensed professional who has the knowledge, skills, and abilities required by the population served. Clinical and administrative supervision of TMS staff is covered as an indirect cost and therefore, should not be billed separately. It is anticipated that the licensed professional will spend approximately six hours a month working with the Team.

The Qualified and Associate Professionals shall meet the requirements according to 10A NCAC 27G .0104. A Paraprofessional shall meet the requirements specified for Paraprofessional status according to 10A NCAC 27G .0104. TMS staff shall have the knowledge, skills, and abilities to successfully provide TMS to adults with mental illness and substance use disorders. The NCCPSS professional's life experience with mental illness or substance abuse and behavioral health services provides expertise that professional training cannot replicate. To ensure that the experience of the peer specialist is commensurate with those served by TMS, for this position, the individual must have "lived experience" and a personal recovery story specific to primary mental illness or substance use disorders.

TMS staff shall complete the DHHS approved Tenancy Support training prior to the delivery of TS Services. In addition, TMS staff shall complete the following training within 90 days of hire:

- Crisis Interventions and Supports
- Recovery principles
- Motivational Interviewing
- Person-Centered thinking
- Trauma-informed Care
- Basic Mental Health and Substance Use 101

### **Service Type and Setting**

TS is a direct and indirect periodic rehabilitative service in which TMS members help the individual successfully transition to community living. TMS shall provide services where they live prior to the transition, in their new home, and other community settings.

### **Program Requirements**

The TMS staff works together as an organized, coordinated unit under the direct supervision of the Team Leader who in addition to carrying a caseload, ensures the team implements all featured aspects of the service definition. All TMS members shall know all individuals served by the team, but not all team members necessarily work closely with all individuals. It is expected that the 90% of individuals shall see at least two team members in a given month except when the individual is receiving only one contact per month.

The Team meets at least weekly, facilitated by the Team Leader, to ensure that the planned TS interventions are provided. The team meetings are usually held face-to-face. Conference calls or webinars may be used if the team member's office is in different locations. However, one team meeting per month must be held face-to-face. The Team Leader monitors the delivery of

TMS services to ensure the interventions provided effectively help the individual obtain and maintain his or her housing.

The licensed professional shall facilitate at minimum, monthly face-to-face meetings with TMS to review each individual's progress and interventions provided and provide consultation as needed.

The TMS staff shall make a referral to the LME/MCO for mental health or substance abuse services if the individual experiences psychiatric or substance abuse symptoms that interfere with his/her ability to be housed or to maintain housing. The TMS staff shall collaborate with the LME-MCO and any mental health, substance abuse, or IPS-Supported Employment service providers identified to provide services to the individual.

The case load is comprised of individuals who require services ranging from a minimal to an intensive nature. TMS maintains an individual-to-staff ratio of 12:1 with a team maximum of 48 individuals. Sixteen additional individuals may be allowed if teams find the majority of the required 48 individuals are only requiring minimal services. These additional individuals must only require the minimum of one face-to-face per month. Initial team case load shall be titrated with no more than 12 individuals enrolled per month until maximum case load is established. The Qualified Professional shall complete a DHHS approved Independent Living Skills Assessment and develop and write the PCP identifying the specific skill building interventions for each life domain based on the individual's strengths, using a person-centered approach. All TMS members participate in the initial development, implementation and on-going revisions of the Person Centered Plan (PCP). The Qualified Professional develops the Crisis Plan to include a Housing Support Crisis Plan that identifies prevention and early intervention services when housing is jeopardized. The plan shall address the interventions and support for the following potential housing crises:

- apartment fire and property damage
- natural disasters such as flooding, hurricanes, tornado
- electronic power failure,
- appliances malfunction or do not turn on
- altercation with neighbors or other issues with neighbors
- uninvited guests who will not leave
- instances involving the landlord
- any instance that could result in eviction from apartment

The Certified Peer Support Specialist shall support wellness management strategies which includes delivered manualized interventions such as, Wellness Recovery Action Planning or Illness Management and Recovery.

As part of the PCP Crisis Plan, the TMS provider shall coordinate "first responder" coverage and crisis response with the LME-MCO. TMS is not the first responder addressing a psychiatric crisis but shall provide crisis support to the individual by the initiation of WRAP or other crisis support plan. TMS shall make immediate telephone contact with the individual and a face-to-face within 90 minutes after a crisis has occurred. TS shall contact the landlord if necessary to address any tenancy issues that may have occurred during the crisis. The Qualified Professional shall coordinate with the individual to review, update and modify his or her Crisis

Plan and Housing Support Crisis Plan after each crisis occurrence, and at minimum every three months, for the first year to reflect current needs and address existing or recurring housing retention barriers.

TMS services are provided 24/7 to meet the individual's housing goals and assist the individual in housing crisis as identified in the Housing Support Crisis Plan. The team members shall be able to provide multiple contacts based on assessed needs and identified on the PCP. The TMS initial contacts with the individual are intended to begin building a relationship and provide housing transition services. It is expected that TMS contacts with the individual will increase during the transition to his or her apartment. Therefore, it is expected the individual's need for service will be titrated, as skills improve to a minimum of one face-to-face contact per month, for as long as the individual is a member of TCLI. If at any time the individual's service needs increase or he/she is in threat of eviction or have lost his/her housing, TMS contacts shall increase.

Program services are primarily delivered face-to-face with the individual in community locations and outside the agency's facility. Ancillary contacts are expected with the landlord at least monthly to discuss housing issues that may arise. TMS is a community-based service, therefore contacts with individuals are physically face-to-face. Telemedicine/telepsychiatry are not reimbursable for TMS.

TMS shall provide the majority of services in the community with at least 90% of the team's total face-to-face service contacts provided to the individuals in the community (non-office-based or non-facility-based settings).

Units are billed in 15-minute increments.

### **Utilization Management**

Individuals identified as meeting the clinical criteria for Transition to Community Living and accepts a housing slot is eligible for TMS. TMS Prior Authorization by the LME-MCO is required. The TMS provider shall submit to the LME-MCO the initial 30-day PCP identifying the interventions to assist in identifying and obtaining housing. TMS It is expected that the amount, duration, and frequency of TMS service will be highest initially in order for the TMS to complete housing assessments to obtain housing and at the time the individual actually moves into housing and begins to demonstrate independent living skills. It is expected that the TMS will regularly review the impact of services on the individual's ability to live successfully in the community. Service intensity will be titrated down as the individual demonstrates continued improvement in targeted life domains. A maximum of 60 units of TMS services can be provided in one-week. Additional units may be requested from the LME-MCO as needed.

### **Eligibility Criteria**

An individual is eligible for TMS if they meet the following conditions:

- a. Meets the clinical criteria for Transition to Community Living
- b. Accepts an approved DHHS housing slot

### **Entrance Process**

An individual identified as a member of TCLI is referred to a TMS provider by the Transition Coordinator upon approval for a housing slot for the individual. Prior authorization by the LME-MCO is required. The TMS provider shall submit the initial PCP identifying the interventions to assist in identifying and obtaining housing.

It is expected that TMS shall be provided in conjunction with mental health clinical services such as Community Support Team and Psychosocial Rehabilitation which serves as the clinical home. TMS services shall be included in the PCP developed by the clinical and the Crisis Plan shall include the TMS Housing Support Crisis Plan. In the event an individual does not accept a mental health clinical service, the TMS QP shall remain responsible for the PCP and Crisis Plan.

### **Continued Service Criteria**

The individual is continues participation in TCLI.

### **Discharge Criteria**

The individual shall be discharged from TMS when no longer enrolled in TCLI (i.e. returns to ACH, voluntarily requests to leave program, or death) or in the event the individual receives ACT services.

### **Documentation Requirements**

More than one intervention, activity, or goal may be reported in one service note, if applicable. For this service, one of the documentation requirements is a full service note for each contact or intervention for each date of service, written and signed by the person(s) who provided the service that includes all of the following:

- a. Individual's name;
- b. Date of service provision;
- c. Name of service provided;
- d. Type of contact;
- e. Place of service;
- f. Purpose of the contact as it relates to the goal(s) on the PCP;
- g. Description of the intervention provided. Documentation of the intervention must accurately reflect treatment for the duration of time indicated;
- h. Duration of service: Amount of time spent performing the intervention;
- i. Assessment of the effectiveness of the intervention and the individual's progress towards the individual's goal;
- j. Signature and credentials or job title of the staff member who provided the service; and
- k. Individual's name and record number identified on each note page.

NC Treatment Outcomes and Program Performance System (NC-TOPPS) interviews shall be completed on all individuals receiving TMS.

**Expected Outcomes**

Expected outcomes include, but are not limited to, the following:

- Achieved recovery goals identified in the PCP;
- Continued community tenure;
- Improved personal, social, and community living skills;
- Increased access to necessary services in all life domains;
- Improved functioning in community roles;
- Re-established or restored network of healthy natural supports and community contacts;
- Re-established or restored independent living abilities.

**Service Exclusions and Limitations**

An individual may receive TMS from only one TMS provider organization during any active authorization period. Family members or legally responsible individuals of the individual are not eligible to provide this service. TMS shall not be provided in conjunction with ACT Team Services and Community Support Team.

The following are not billable under this service:

- Transportation for the individual or family. Services provided in the car are considered transportation;
- Any habilitation activities;
- Time spent doing, attending or participating in recreational activities unless tied to specific planned social skill assistance;
- Clinical and administrative supervision of TMS staff is covered as an indirect cost and included in the rate, therefore, should not be billed separately;
- Services provided to individuals under age 18;
- Covered services that have not been rendered;
- Services provided to teach academic subjects or as a substitute for educational personnel, including a: teacher, teacher's aide or an academic tutor;
- Services not identified on the individual's PCP;
- Services provided without prior authorization by the LME- MCO.

**NOTE:** DMH/DD/SAS funds will not reimburse for conversion therapy.

**Policy Implementation and History**

**Original Effective Date:** November 1, 2015

**History:**

<b>Date</b>	<b>Section or subsection Revised</b>	<b>Change</b>
5/23/26	Name Change	Name changed to Transition Management Services.
5/27/16	Staff Requirements	Staff requirements in option to use Occupational Therapist for a QP position.



<b>Date</b>	<b>Section or subsection Revised</b>	<b>Change</b>
5/27/16	Program Requirements	Clarification of person-center plan requirements. Clarification of the independent living skills assessment tool approved by DHHS.
5/27/16	UM and Entrance Process	Clarification person-center plan requirements.
11/1/19	Documentation Requirements	Requirement to complete NC TOPPS interviews
11/1/19	Service Exclusions and Limitations	Excludes service in conjunction with Community Support Team
12/15/19	Service Exclusions and Limitations	<b>Added Note:</b> DMH/DD/SAS will not reimburse for conversion therapy.