***Policies and Procedures for Transitions to Community Living Designated Providers***
*10/6/23*

The purpose of this document is to outline the roles and responsibilities of Advanced Medical Home (AMH+) practices and Care Management Agencies (CMAs) serving Medicaid beneficiaries assigned to them for Tailored Care Management who are also Transitions to Community Living (TCL) participants. The document also includes a list of required policies and procedures for AMH+ practices and CMAs seeking designation to provide Tailored Care Management to TCL participants.

**Key Topics Communicated in This Guidance**

1. Background on TCL settlement and TCL designation process for Tailored Care Management providers
2. Overview of roles and responsibilities for Tailored Care Management care managers serving TCL participants
3. Roles and responsibilities for LME/MCO TCL staff and Tailored Care Management care managers as TCL participants transition to supportive housing
4. Roles and responsibilities for diversion and in-reach for TCL participants
5. Detailed guidance for LME/MCOs and Tailored Care Management providers regarding policies and procedures to serve TCL participants

## Background

North Carolina's Department of Health and Human Services (the Department) believes TCL participants will benefit from the longitudinal, whole-person care management provided through Tailored Care Management.[1] As such, participants in TCL are able to access Tailored Care Management in addition to the TCL supports provided by the LME/MCOs.

To ensure TCL participants have a choice of obtaining Tailored Care Management from an LME/MCO, AMH+ practice, or CMA, the Department is establishing a designation process to allow TCL participants to choose to obtain Tailored Care Management (but not the TCL functions of transition, in-reach, diversion, and complex care) from an AMH+ practice or CMA. The Department will work with the National Committee for Quality Assurance (NCQA) to establish a designation process for already certified AMH+ practices or CMAs and Round 3 Tailored Care Management provider applicants to become designated as qualified to serve TCL participants, similar to the way AMH+ practices or CMAs can be designated as qualified to provide Tailored Care Management services to children, individuals with I/DD, or Innovations/TBI waiver enrollees.

AMH+s/CMAs that apply for this designation must develop a policy and procedures for providing Tailored Care Management to TCL participants, which will be assessed by NCQA. See pages 5-7 for the required components that must be addressed in the policies and procedures. Additionally, providers that receive designation will need to work closely with the LME/MCO in their region to coordinate with the LME/MCO's TCL team.

[1] A recovery-oriented transition into community living is a combination of an individual's choice of services and the supports they receive for their housing, supported employment/education, and community activity/integration choices.

North Carolina must continue to comply with the terms of the ongoing Olmstead settlement. To meet those terms and to best serve the needs of TCL participants, TCL functions for individuals receiving Tailored Care Management will continue as they do today. LME/MCO TCL staff will continue to work exclusively with the TCL population, including those receiving Tailored Care Management, and will be solely responsible for performing TCL in-reach, diversion, transition, and complex care functions for those individuals. Tailored Care Management care managers will not be responsible for TCL functions for the TCL population.

**Overview of Tailored Care Management Care Manager Roles and Responsibilities**

The Tailored Care Management care manager will continue to be responsible for delivering whole-person care management to the TCL participant. More specifically, the Tailored Care Management care manager will be responsible for the following for TCL participants, in coordination with LME/MCO-based TCL staff:

- 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;
- Completing the care management comprehensive assessments and developing the care plan/Individual Support Plan (ISP) (with input from the TCL Transition Coordinator and the In-Reach (IR)/TCL Tool populated by LME/MCO TCL staff);
- Conducting Care Team meetings, as needed, and consulting with the multidisciplinary Tailored Care Management Care Team;
- Providing health promotion services;
- Developing and deploying prevention and population health programs (e.g., preventive screenings, addressing broader physical health needs);
- Ensuring medication reconciliation/monitoring occurs; and
- Conducting ongoing monitoring of 1915(i) services (if applicable).

TCL functions will remain the sole responsibility of LME/MCO TCL staff and Tailored Care Management care managers will be responsible for providing Tailored Care Management services (see below for more detail).

At the end of the follow-along period (no sooner than 90 days after move-in), the LME/MCO Transition Coordinator will convene the TCL participant's full Transition Team, including the Tailored Care Management care manager, to identify a participant's ongoing and unmet needs–including those related to employment and community integration–and update Transition Team staff roles and responsibilities and the participant's ISP or care plan accordingly. Based on established LME/MCO criteria and standards, the LME/MCO Transition Coordinator will determine at this time if the participant is ready for the Tailored Care Management care manager and Care Team to take the lead in supporting the TCL participant in the community. TCL staff will remain on the participant's Care Team and available for support as needed.

**Roles and Responsibilities for Transition to Supportive Housing for TCL Participants**

LME/MCO TCL staff will retain the primary responsibility of supporting TCL participants in their transition from an Adult Care Home (ACH) to permanent supportive housing or from a State Psychiatric Hospital into permanent supportive housing or TCL Bridge Housing (LME/MCO responsibilities are detailed in LME/MCO Joint Communication Bulletins #J442 and J441). Tailored Care Management care managers based at AMH+ practices and CMAs who are assigned TCL participants will be a part of the participant's Transition Team and will coordinate with LME/MCO TCL staff during the transition. The below chart outlines the transition-related activities that must always be the primary responsibility of the Transition Coordinator and the Tailored Care Management care manager's responsibilities*.

| Transition Activities that Cannot Be Delegated to the Tailored Care Management Care Manager | Tailored Care Management Care Manager Responsibilities* |
|---|---|
| • Convening the Transition Team<br>• Scheduling and convening transition planning/Person-Centered Plan meetings<br>• Facilitating discussion of a crisis plan, disaster plan, and emergency plan<br>• Leading the Transition Team pre-transition through 90-days (at minimum) post transition, until the Transition Team meets, and the Transition Coordinator determines that lead functions can be transitioned fully to the Tailored Care Management care manager<br>• Planning for and facilitating check-ins between the final transition planning meeting and move-in of the TCL participant at the community-based supported housing<br>• Ensuring that the person's Person-Centered Plan addresses services and supports addressing all housing, employment/education, and community activity/inclusion needs<br>• Ensuring the Complex Care Team completes assessments of the participant and assessments of appropriateness of housing for TCL participants with complex medical needs, and that their recommendations are included in the Person-Centered Plan<br>• Intervening to preserve tenancy and avoid housing separations, and evaluating tenancy issues to extend rehousing tenure<br>• Ensuring housing passes initial and subsequent health and safety inspection, and monitoring that the tenancy support needs delivered by providers are fulfilled<br>• Ensuring financial support needs of the TCL participant are fulfilled | • Coordinating the Comprehensive Clinical Assessment (CCA) and ensuring completion for needed services (e.g., 1915(i))<br>• Working with the clinical provider to ensure the comprehensive Person-Centered Plan is accurate and inclusive of all clinical services, supports, and goals, based on the clinical assessment for services serving the life choices and preferences in the individual's IR/TCL Tool<br>• Ensuring services and supports are in place prior to the move-in<br>• Educating the individual/legal guardian on the behavioral, physical health, and other recommended services, including supported employment<br>• Assessing available community resources and facilitating linkages to them<br>• Connecting participant with primary care/specialty care, and following up on the implementation of health care provider recommendations<br>• Addressing health care and health-related resource needs (not related to housing) noted during the follow-along period and completing follow-along tasks<br>• For TCL participants with a Complex Care Team, following up with health care providers on the implementation of the Complex Care Team's recommendations |

**LME/MCO TCL staff may take the lead role as needed. Responsibility for these tasks should be clearly identified in the TCL participant's Person-Centered Plan.*

During a TCL participant's transition to supportive housing, the individual's Tailored Care Management care manager will stay closely involved in the transition as a member of the Transition Team and will deliver Tailored Care Management services that are not provided through TCL. As part of the Transition Team, the Tailored Care Management care manager should attend all transition planning meetings (in-person, when possible) and participate in discussions as a Transition Team member. The Tailored Care Management care manager may have specific tasks assigned to them by the TCL Transition Coordinator, including assisting individuals to expand their social networks, link to supported employment/education services, find transportation to and engage in chosen community activities, and develop and retain strong relationships with their natural supports, peer support staff, and peer run organizations.

The Tailored Care Management care manager should also assist with identifying health care providers (including but not limited to: primary care, physical health, behavioral health, home health, personal care services, occupational therapy, physical therapy, and speech therapy providers) and connecting/linking TCL participants to those providers as needed; and coordinating with the behavioral health and other types of providers who are responsible for supported employment/education, community integration, and tenancy supports in the follow-along period.

The Tailored Care Management care manager will assume lead responsibility in supporting the TCL participant in the community at the conclusion of the follow-along period (no less than 90 days after move-in), as determined by the Transition Coordinator. Similar to the follow-along period, the Tailored Care Management care manager's responsibilities will continue to include assessing a participant's community engagement/integration (e.g., employment and education), acquisition of services addressing their unmet health-related resource needs including transportation, and connecting participants to community engagement/integration resources. The Tailored Care Management care manager will also be responsible for communicating transition-related concerns to the Transition Coordinator, specifically those related to housing, employment/education, and community activity/integration. LME/MCO TCL staff will remain available for support as needed.

**Roles and Responsibilities for Diversion and In-Reach for TCL Participants**

Diversion and in-reach functions for TCL participants will be performed exclusively by LME/MCO TCL staff. TCL staff may not delegate TCL diversion and in-reach functions to anyone else providing care management to the TCL participant.

- TCL diversion functions include:
    - Scheduling visits with participant/guardian to educate about permanent supportive housing options;
    - Providing opportunities to meet individuals in the community, family/natural supports, and providers;
    - Using diversion tool and Community Integration Planning guidance document to assist with participant education; and
    - Documenting decision using Informed Decision-Making tool (or other similar process).
- TCL in-reach functions include:
    - Meeting with facility owner/administrator to discuss in-reach process;
    - Contacting and scheduling meetings with TCL participant/guardian;

- During meetings with participant, exploring interests and needs, options to live in the community, and supports available;
- Providing opportunity to meet peers in the community, family, and providers; and
- Using In-Reach/TCL tool and Informed Decision-Making tool to document process and decisions.

During TCL diversion and in-reach, the Tailored Care Management care manager retains responsibility for all Tailored Care Management functions.

**TCL Designated Provider Policies and Procedures**

As part of the application process to become a TCL designated provider, AMH+ practices and CMAs must develop detailed policies and procedures to coordinate with LME/MCO TCL staff performing TCL functions (i.e., transition, diversion, in-reach, complex care). The policies and procedures should be reflective of the provider's tenancy support values as an agency.

The Department is providing the guidance below on the contents of the policies and procedures to promote standardization across LME/MCO regions and reduce administrative burden for Tailored Care Management providers working with multiple LME/MCOs. The Department expects LME/MCOs and providers to collaborate on these policies and procedures prior to submitting them to NCQA. The Department will also update the requirements in the LME/MCOs' Care Management Policy to reflect this expectation.

The detailed policies and procedures must include the following:

1. A clear description of the procedures for coordinating with LME/MCO TCL diversion, in-reach, transition, and complex care team staff to ensure that TCL participants are obtaining whole-person, coordinated care management, including:
    a. Procedures for coordinating with TCL staff on communications with TCL participants and guardians (if applicable);
    b. Approach for establishing communication channels (e.g., in-person Transition Team meetings, videoconference, phone, email) with TCL staff; and
    c. Timelines for responding to TCL staff requests.

2. A description of processes that will enable the AMH+/CMA to complete required activities and coordinate with LME/MCO TCL staff and transition team, including procedures for:
    a. Tracking activities and providing status updates to TCL staff;
    b. Collecting vital documents (e.g., IDs, birth certificates);
    c. Sharing relevant information from participant's care management comprehensive assessment, care plan, and other screenings/assessments to assist TCL staff;
    d. Identifying, communicating and coordinating with health care providers, including behavioral health providers and other types of providers who are responsible for community integration and tenancy supports;
    e. Educating the individual/legal guardian on the behavioral, physical health, and other recommended services, including supported employment;

f. Addressing problems by communicating barriers to the LME/MCO Local Barriers Committee point of contact where the severity of the individual's condition is not considered a transition barrier, yet their condition warrants more complex service and support wraparound (e.g., complex behavioral, medical, and/or functional, social/familial, occupational barriers), systemic barriers (e.g., service providers/provision gaps, managed care limitations, entitlements, community isolation), and health and safety issues that would hinder or delay transition;
g. Assisting TCL participants to expand their social networks and retain strong relationships with their natural supports, peer support staff, and peer run organizations;
h. Ensuring non-housing services and supports are in place prior to move-in to permanent supportive housing or TCL Bridge Housing; and
i. Adhering to required protocols of Adult Care Homes and State Psychiatric Hospitals when visiting the facility.

3. Plan for Tailored Care Management care manager 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, including:
    a. Approach for assessing a participant's community engagement/integration (e.g., employment and education, community activity attendance, unpaid relationship development, etc.);
    b. Procedures for connecting participants to community engagement/integration resources and the transportation planning needed to attend;
    c. Communication protocols for inviting TCL staff to Tailored Care Management Care Team meetings, requesting TCL staff support, and tracking these requests;
    d. Procedures for communicating with TCL staff if there are any housing-related concerns or a housing separation so TCL staff can manage and evaluate the situation (note that TCL staff remain responsible for the participant's housing after transition); and
    e. Reporting mechanisms to the LME/MCOs on TCL participants post-transition, particularly for early identification of participants who are at risk of a housing separation (i.e., a non-tenancy support behavioral health provider is not involved).

4. Template/mock care plan for participants in TCL beyond all other required components of a care plan for an individual in Tailored Care Management. The care plan for TCL participants should include:
    a. Natural support and if applicable guardian contact information;
    b. TCL staff contact information;
    c. Adult Care Home or State Psychiatric Facility contact information, including details on the care team;
    d. Details and contact information on where the participant transitions to (e.g., permanent supportive housing, bridge housing);
    e. Roles and responsibilities between the care manager and LME/MCO TCL staff;
    f. Participant preferences/goals identified through transition process;
    g. Plan and progress on how member is advancing towards those goals;
    h. Approach to addressing personal support needs or systemic barriers that may impact a successful transition, which will be reported to the LME/MCO Local Barriers Committee point of contact; and

i. Plan for a smooth transition between LME/TCO TCL Transition staff and the AMH+/CMA Tailored Care Management care manager post-follow-along period.