

10/18/2012

The Draft Summary of In-Reach and Transition Expectations within DOJ Settlement/DHHS Guidance

**DRAFT FOR DISCUSSION PURPOSES ONLY
NOT CONSIDERED OPERATIVE OR FINAL**

Reflecting Advisory Committee questions up through 10/1/2012

I. IMPORTANT IMPLEMENTATION DEADLINES:

- No later than November 23rd, 2012 the State will work with LME/PIHP to develop requirements and materials for in-reach and transition coordinator and teams to provide training for those transition coordinators and teams. (Settlement, pg.15 E3c, DHHS Guidance)
- In-reach Begins: No later than 2/23/2013 (Settlement, pg. 15, E13b, DHHS Guidance)

II. IMPORTANT CONTRACTUAL UPDATES/ INFORMATION

- DHHS will enter into contract with MCOs: (DHHS Guidance)
 - Transition Coordinator will be housed within MCO
 - Transition coordinator responsible for coordinating in-reach
 - use of peer supports for in-reach
 - Contracts with MCOs will be amended to integrate in-reach function into care coordination responsibilities
- 1915(b) will be amended to add “institutionalized individuals under this agreement” to the State’s definition of special needs populations. (DHHS Guidance).
- North Carolina will obtain additional CMS authority for Medicaid funding under the 1915(b)(3) authority for Transition Year Stability Resources (TSYR). As such, TYSR will be managed by the LME-PIHP.

III. IN-REACH, KEY ELEMENTS

- State will implement procedures to ensure residents individuals are “accurately and fully informed about all community-based options” (Settlement, pg. 11, E1)
- In-Reach=Options counseling and arranging options view/visit community options.
- Practices must promote informed decision making (both in understanding community options available and understanding that person may choose to remain where he is). (Settlement, pg.11, E1 and DHHS Guidance)
- Strong use of mental health peer support specialists in In-Reach (DHHS Guidance)
- Initially, targeting in-reach into ACHs/IMDs (Settlement, pg 12, E2)
- Regularly, not less than quarterly (Settlement, pg. 12, E2)

Comment [DU1]: How will transition coordination function be funded? Particularly before next SFY 2014?

Comment [DU2]: With expansion, does this impact CCNC's role?

Comment [DU3]: Need more discussion about how TC and Peer Support will interface during In-reach.

Comment [DU4]: How is the State defining “institutionalized?”

Comment [DU5]: Does this mean that start up funding comes from (b)(3) savings?

Comment [DU6]: Need to consider what role guardian has in authorizing in-reach discussions. See Settlement pg 3 II B for some guidance

Comment [DU7R6]: What if person who has guardianship has regained, through treatment, ability to make own decisions.

Comment [DU8]: How does In-Reach look if person has already left the facility?

Comment [DU9]: What if resident wants representative with him/her to hear information? What ... [1]

Comment [DU10]: Will In-reach/options counseling include information about Sal ... [2]

Comment [DU11]: Will options counseling including information about being at risk of losing ... [3]

Comment [DU12]: Will DAAS Options Counseling curriculum be folded into the training?

Comment [DU13]: What if person chooses to remain in psych hospital?

Comment [DU14]: Is use of peer support a requirement or recommendation?

Comment [DU15]: How do we ensure that peer supports are qualified to do in-reach job ... [4]

Comment [DU16]: Do peer supports have to fit into traditional service definition?

Comment [DU17]: Is this based on where enrollees are located or ACHs physically located in ... [5]

Comment [DU18]: Does this mean quarterly to facility or quarterly to individual?

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- In-Reach Activities (Settlement, pg 12, E2):
 - Benefits/financial aspects of clinically appropriate community-based settings, including supported housing
 - Accompany on housing visits
 - Address concerns of ACH residents re: supportive housing
 - Link to peer support specialists

Comment [DU19]: This is a really important element of ensuring informed decision-making. Consider transportation considerations. Lots of folks won't transport individuals in personal cars because of perceived liability or cost. This "facilitated transport" will be essential for these visits.

Comment [DU20]: How will this link to housing specialists happen?

Comment [DU21]: Would make sense for peer support specialists to do in-reach? DHHS: yes, that is intent if/when possible.

Interest Lists

- In-reach/MCO: submit list of interested folks to State. (DHHS Guidance)
- State may temporarily suspend in-reach if interest list exceeds housing supply (Settlement, pg 12 E2)

IV. DISCHARGE AND TRANSITION PLANNING

The State will provide each individual with SMI in, or later admitted to, an adult care home, or State psychiatric hospital operated by the Department of Health and Human Services, with effective transition/discharge planning and a written transition/discharge plan.

The goal of this planning is to assist the individual in developing a plan to achieve outcomes that promote the individual's growth, well being and independence, based on the individual's strengths, needs, goals and preferences, in the most integrated setting appropriate in all domains of the individual's life (including community living, activities, employment, education, recreation, healthcare and relationships).(DHHS Guidance)

1. OVERARCHING EXPECTATIONS and REQUIREMENTS RELATED TO TRANSITION PLANNING (DHHS Guidance, Settlement Specifics Noted)

- MCO TC responsible for entire planning process, even if discharging out of state psych hospitals. (Settlement, pg.13, E5)
 - State psych hospitals will continue using discharge planning protocols
- Transition and discharge planning for an individual will be completed within 90 days of assignment to a transition team.
- Discharge of an individual will occur within 90 days of assignment to a transition team provided that a Housing Slot is then available. If a Housing Slot is not available for an individual within 90 days of assignment to the transition team, the transition team will maintain contact and work with the individual on an ongoing basis until the individual transitions to community-based housing. (Settlement, pg 15, E13c).

Comment [DU22]: Who is responsible for ensuring individual has access to supports and services if they choose to remain in ACH/facility?

Comment [DU23]: Does this mean plan is submitted within 90 days or Approved within 90 days?

Comment [DU24]: These two 90 day requirements may be a bit confusing. Difficult to complete transition planning w/o housing identified. Much of planning (i.e. service identification, community logistics re: transportation, banking, etc. are determined by housing location.

Comment [DU25]: If I choose to move to a place where a housing slot is not available, is my place on the priority list held?

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- Using MFP and other relevant transition planning methods (DHHS Guidance)
 - State ensures Transition Coordinators are trained (Settlement, pg 14, E0 Including facilitating person centered **planning**)
- 2. TRANSITION FLOW and RELEVANT TIMELINES**
- Interest List Sent to **State**
 - State reviews/screens and assigns to **MCO**
 - Determines Medicaid eligibility
 - MCO assigns TC:
 - Transition Planning Occurs
 - See Transition Coordinator Functions
 - See Required Team Composition
 - See Transition Planning Tool
 - See Initial Planning Meeting Expectations
 - Transition occurs.
 - Follow Along
- 3. REQUIRED TRANSITION TEAM COMPOSITION**
- See Team members (Settlement, pg 12, E4, supplemented by DHHS Guidance).
 - Individual
 - Guardian
 - Persons knowledgeable of resources,
 - Housing Specialists
 - MCO care coordinator
 - Professionals, including MH and physical health clinical professionals
 - Cultural competence
 - Peer specialists
 - Other relevant folks, with consent of person.
 - ACH will assign a point of contact for transition
 - Community **Providers**
- 4. SPECIFIC CONTENT of TRANSITION PLAN**
- Description of Written Plan that Results from Discharge Planning (Settlement pg 13, E8).
 - Identifies the individual's strengths, preferences, needs (clinical and support), and desired outcomes;
 - 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

Comment [DU26]: We certainly have different tools/curricula in mind, but is there a specific person centered planning approach (MAPS? PATH? ELP?) that DHHS is wanting to use? Or is this referring to ISP/PCP

Comment [DU27]: Assuming by LME/MCOs?

Comment [DU28]: Is DDHS- level person assigning 1) MCO that will do TC or 2) each individual team member? I would urge the first option. 2nd too complex/not appropriate (in my opinion).

Comment [DU29]: hasn't already been set up, we may want to set this up so that each MCO has a "point of contact" at state level for review/approval." Transitions=ambiguity and it helps to build direct relationships with clearly identified individual to expedite process. Especially good if same MCO that is doing in-reach will also be doing on-going coordination. Want any "authorization" to be as fast as possible.

Comment [DU30]: Is there any additional guidance about which Community Providers should be there. **TF: will re-read guidance to flesh out.**

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of whether those services and supports are currently available;

- o Includes a list of specific providers that can or are secured to 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;
- o Documents the barriers preventing the individual from transitioning to a more integrated setting and a plan for addressing those barriers;
- o Such barriers shall not include the individual's disability or the severity of the disability.
- o For individuals with a history of re-admission or crises, the factors that led to re-admission or crises shall be identified and addressed.
- o Sets forth the date the transition can occur, as well as the timeframes for completion of needed steps to effect the transition; and
- o Prompts the development and implementation of needed actions to occur before, during, and after the transition

5. **SPECIFIC FUNCTIONS OF TRANSITION COORDINATOR**

- **Transition Coordinator assures discharge planning (DHHS Guidance for all, Settlement, pg. 13 E5 for psych hospitals specifically)**
 - o Begins at admission
 - o Person CAN transition with sufficient supports into integrated settings.
 - o Results in written plan
 - o Person-centered, self-directed options

Comment [DU31]: DHHS Guidance indicates TC is responsible for this.

Comment [DU32]: How will this be possible if MCO doesn't know about person until quarterly In-Reach?

Comment [DU33]: Admission to what?

The Transition Coordinator Roles (DHHS Guidance)

The Transition Coordinator is the lead for ensuring that any individual who wishes to move to a more integrated setting from the adult care home is provided with necessary services and supports.

The Transition Coordinator:

- serves as a guide to a person who is interested in transitioning into his or her community with supports;
- models respectful, positive, "can do" attitude throughout the process;
- is honest about what the challenges may be, but works to overcome those challenges;

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- sees the person and her family as central individuals in the transition process, taking on responsibilities in the transition work;
- is willing to be flexible to meet the specific transition needs of the person involved; and
- should be a person who genuinely enjoys the process of supporting a person to return to his home and community and the efforts involved in supporting a person to build a community-based life
- cannot be a provider of community or institutional services.
- Has been identified as a Transition Coordinator by MCO and has received state-endorsed training on transition philosophy, methods and practices.

Transition Coordinators invite others involved in the transition process to:

- keep the individual's wishes, rights and well-being at the center of the effort;
- work towards the goal of supporting a person to transition into his/her home and community;
- collaborate to develop creative, person-centered solutions to challenges;
- respect the contribution of all members;
- acknowledge that respectful disagreement is sometimes inevitable and provides an opportunity for learning;
- create a sense of "collective accountability," with each member (including the person transitioning and family members) committing to being responsive and flexible throughout the process;

Transition Coordinators will:

- Have ongoing, respectful communication with the transitioning individual, his/her supports, facility and community provider staff throughout the transition process;
- Work with the individual and the individual's family and supports to develop a thoughtful, organized transition plan that addresses his/her community-based support needs;
- Coordinate with the individual, his/her family and supports to identify and secure the community resources necessary to transition. This includes but is not limited to: housing, medical care, financial management (setting up a bank account, etc.) and other community supports that are needed for community living;
- Coordinate Transition Year Stability Resources (TYSR) requests;
- Conduct the initial Quality of Life Survey
- Maintaining regular follow up with the individual for at least three months after the transition

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- Work with the individual's care coordinator to notify of any critical incidents impacting the individual.

6. SPECIFICS OF PLANNING PROCESS/STRUCTURE
Planning Structure

- Initial planning meeting (DHHS Guidance)
 - Identify need for transition services
 - Housing navigator
 - Support/service needs
 - Including linking to Housing
 - Including to Community Based MH Services
 - Care coordinator "who is a qualified professional clinically responsible for ensuring that all elements and components of the plan are arranged for the recipient in a coordinated manner."
 - Including linking to Supported Employment Services (

Comment [DU34]: Needs clarification TF: will do.

7. SPECIFIC FUNCTIONS OF STATE TEAM

- DHHS will create a State Level Transition Team (Settlement, pg 14, E9)
 - Help local teams with trouble shooting
 - ID and address barriers
 - Ensure TCs are adequately trained, including on person-centered planning.
 - Quality Assurance Oversight (DHHS guidance).

8. SPECIAL PRACTICES FOR ACHS DESIGNATED IMDS (SETTLEMENT, Pg. 15, E13(d))

- Within one business day of State notifying ACH of potential IMD status, State will also notify Independent Reviewer, DRNC, applicable MCO and DSS of at-risk determination.
- MCO will connect with resident who wish to transition from ACH to another appropriate setting and link with appropriate MH services.
 - Will be provided in-reach, TC, person-centered planning, discharge and transition planning
- Implementing Care Coordination activities
- "The State will use best efforts to track the location of individuals who move out an adult care home on or after the date of the at-risk notice." If discharge triggered by ACH AND the destination is unknown or inappropriate, "a discharge team will be convened"
- "Upon implementation of this Agreement, any individual identified by the efforts described in Section III (E)(13)(d)(iii) who has moved from an adult care home determined to be at risk of an IMD

Comment [DU35]: BY WHOM?

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determination shall be offered in-reach, person-centered planning, discharge and transition planning, community base services, and housing in accordance with this Agreement. Such individuals shall be considered part of the priority group established by Section III (B)(2)(a).”

* State/LME shall monitor ACHs for compliance with ACH Bill of Rights. (Settlement, pg. 16 E14)

9. SPECIFICS OF FOLLOW ALONG

Key Functional Requirements that Will Need to Be Fleshed Out

* Follow Along Requirements

* DHHS Guidance: follow up for at least three months

*Visits

* Transition Coordinator “case load” requirements (impacted by follow along requirements)

* Role of Transition Coordinator and Care Coordinator after transition.

* Exception practice if transition takes more than 90 days.

* Risk mitigation tools in transition planning process.

Comment [DU36]: Case load requirements will also impact pm/pm administrative payments.

Comment [DU37]: How will these role differ? Up to individual MCO?

See also Settlement, Quality Assurance & Performance Improvement Requirements, outlined in pgs. 17-19.

- Data Tracking
- Quality of Life Survey
- External Quality Review Program

V. QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT MONITORING SYSTEM

“The goal of the state’s [Quality Assurance and Performance Improvement Monitoring System] will be that all mental health and other services and support funded by the State are of good quality and are sufficient to help individuals achieve increased independence, gain greater integration into the community, obtain and maintain stable housing, avoid harms, and decrease the incidence of hospital contacts and institutionalization.” (Settlement, pg. 17, G1)

10. START UP FUNDS

If an individual cannot safely and adequately meet his/her transition-related expenses the person will have access to Transition Year Stability Resources (TYSR). This funding is only available during a person’s transition year and must not be needed as part of a person’s ongoing plan. This service will provide one-time start-up costs such as:

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- Utility and rent deposits
- Appliances
- Essential furnishings
- One-time home preparation: pest eradication, cleaning, allergen control
- Moving expenses
- CONSIDER methods for paying for pre-transition 1:1 staff introductions/training and clinical consultation. These have been the most critical use of start up funds for folks with significant behavioral health needs.

This funding may not be used to cover:

- Ongoing living expenses (such as rent, bill payment)
- Past due balances
- Entertainment items such as televisions, stereos, etc.

Additionally, since TYSR are not available after the first year, there must be clear evidence that the individual's ongoing support needs will be met. All tangible items (furnishings, etc.) acquired using this funding becomes the personal property of the transitioning individual.

Page 1: [1] Comment [DU9] Default User 10/1/2012 7:51:00 PM
What if resident wants representative with him/her to hear information? What if this person is ACH or facility staff?

Page 1: [2] Comment [DU10] Default User 10/1/2012 7:49:00 PM
Will In-reach/options counseling include information about \$al implications of staying and transitioning? (See In-Reach Activities below)

Page 1: [3] Comment [DU11] Default User 10/1/2012 7:49:00 PM
Will options counseling including information about being at risk of losing Medicaid if remain in facility identified as IMD?

Page 1: [4] Comment [DU15] Default User 10/1/2012 7:35:00 PM
How do we ensure that peer supports are qualified to do in-reach job description?

Page 1: [5] Comment [DU17] Default User 10/1/2012 8:17:00 PM
Is this based on where enrollees are located or ACHs physically located in catchment areas? Will need to strengthen "inter region" collaboration practices. Could also be function of DHHS state team: to reassign responsible MCO based on Medicaid or living preference.
HAS ALWAYS made sense for "receiving region" to do TC (know local resources).
Consider issues of travel costs and administrative costs.