



## North Carolina Department of Health and Human Services

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### **LME-MCO Communication Bulletin #J201**

Date: June 2, 2016

To: LME-MCOs

From: Mabel McGlothlen, LME-MCO System Management Section Chief, DMH/DD/SAS and Kathy Nichols, Behavioral Health Manager, Community Based Services Section, DMA

Subject: Role Clarification of Possible Transition Team Participation

This bulletin clarifies operational roles of staff in the positions of Assertive Community Treatment (ACT) providers, Regional Housing Coordinator, Transitions to Community Living Initiative (TCLI) Transition Coordinator, and Transition Management (Tenancy Support) worker. In an effort to prevent duplication of efforts, this bulletin identifies how these roles work collaboratively assisting individuals transitioning to community housing.

#### **Assertive Community Treatment (ACT) provider [LME/MCO Contracted Provider]:**

ACT services are highly intensive, clinical and non-clinical supports provided by an interdisciplinary team of mental health professionals. These services are intended for individuals with severe and persistent mental illness (schizophrenia, schizoaffective disorder, bipolar disorder) that have complex needs across multiple life domains that cannot be adequately met in lower levels of community care and these illness more often cause long term psychiatric disability. Beneficiaries with other psychiatric illnesses are eligible dependent on the level of long term disability.

Individuals that receive ACT services are unable to receive Transition Management Services (formerly known as Tenancy Support Team services). At least one ACT staff on every ACT team shall successfully complete the DHHS approved Tenancy Supports Training. All ACT teams are to actively provide tenancy support services to ensure that individuals are able to maintain independent housing in the community of their choice.

When an individual receiving ACT services has been identified by a TCLI Transition Coordinator as part of the priority population, the ACT team should begin making arrangements for the individual to move into the community. These services can include, but are not limited to, housing search, establishment of utilities, attainment of housing resources (furniture, furnishing, etc.), and benefit coordination. ACT staff should

maintain regular communication with the Transition Coordinator so he or she is aware of the consumer's status throughout the transition process.

During the transition period, ACT staff takes lead responsibility for physically assisting the consumer into the community-based housing unit. This includes coordination of the relocation from the institution/previous dwelling to the unit, assisting with unpacking and settling into the new living space, and an orientation to the operation of the unit's features (HVAC, stove, mailbox, etc.).

During the post transition period, ACT staff assists with on-going support of the consumer. This can include orientation to the new community and its resources, maintaining a regular schedule of visits to the unit based on what has been identified in the consumer's Person-Centered Plan (PCP), and implementing an intense skill training model to assist the consumer with managing and maintaining his or her new environment, with the plan to gradually decrease service intensity as the individual demonstrates increased independence and community integration.

### **Regional Housing Coordinators [DAAS]:**

The North Carolina Division of Aging and Adult Services (DAAS) currently has a Regional Housing Coordinator assigned to each of the nine identified geographic catchment areas across North Carolina. The role of the Regional Housing Coordinator is to manage and provide assistance with the Targeted Unit program.

The Targeted Unit program works as follows, in exchange for low income housing tax credits, property owners are required to set aside at least 10 percent of the property's units for persons with disabilities. This creates high quality, professionally managed assessable and affordable housing units that are integrated into the community.

Regional Housing Coordinators should be considered a resource for Transition Coordinators and Tenancy Supports staff when searching for housing in the community, and it is important that Transition Coordinators form and nurture a relationship with the Regional Housing Coordinators in their areas. The services of the Regional Housing Coordinator should work collaboratively with other members of the transition team to review available housing resources for the individuals being assisted through TCLI.

Regional Housing Coordinators can assist the transition process by monitoring the Targeted Unit program for available units, assisting with reasonable accommodation requests, and networking with the Housing Finance Agency for possible additional funds to assist with the removal of barriers to housing for the consumer.

Information is available at <http://www.ncdhhs.gov/assistance/low-income-services/programs-to-find-maintain-housing>. Questions concerning the Targeted Unit program can be directed to Ellen Blackman at 919-855-4992 or [ellen.blackman@dhhs.nc.gov](mailto:ellen.blackman@dhhs.nc.gov).

### **TCLI Transition Coordinator [LME/MCO]:**

Each LME-MCO has been provided funding to set up a team of Transition Coordinators through the per member per month (PMPM) payment and based on Medicaid population numbers. The role of the Transition Coordinator is to be the primary contact person to a consumer that has expressed a desire to participate in TCLI.

In such a role, they are also the lead of the consumer's Transition Team. After consulting with the consumer on the make-up of the team, the Transition Coordinator reaches out to family, friends, and providers to manage transition activities.

The Transition Coordinator should be actively identifying transition needs of the consumer, and in response enlisting the services of a qualified provider to meet those needs. It is not the intended role of the Transition

Coordinator to perform the actual tasks required of the transition under normal circumstances or to serve as a case manager. The Transition Coordinator should have a strong understanding of the service providers in his or her network to allow necessary contracts to be developed to bring services and resources into the consumer's PCP. The Transition Coordinator should also collaborate with staff in other units/departments of the LME/MCO (such as Housing, Provider Network, etc.) to assist with identifying appropriate resources to address the transition needs of the consumer or to address any barriers related to the consumer's transition.

The Transition Coordinator should have oversight of the transition process at all levels, and adjust services and supports based on the consumer's response to community-based living. The Transition Coordinator should ensure appropriate services in place to allow transfer of coordination of care to community providers within the identified time frame of 90 days post transition.

**Transition Management (Tenancy Support Services) Worker [LME/MCO Contracted Provider]:**

Transition Management Services (formerly known as Tenancy Support Services) are identified as non-clinical supports provided by a provider agency to assist the consumer through the three stages of moving or of moving and living in the community. Those stages are pre-transition, the transition, and post transition.

During the pre-transition period, staff working in Transition Management Supports should be brought into the service array for the consumer by the TCLI Transition Coordinator. Taking direction from the consumer, the Transition Management Supports staff will begin making arrangements for the move to the community. These services can include, but are not limited to, housing search, establishment of utilities, attainment of housing resources (furniture, furnishing, etc.), and benefit coordination. Transition Management Supports staff should maintain regular communication with the Transition Coordinator so he or she is aware of the consumer's status throughout the transition process.

During the transition period, Transition Management Supports staff take lead responsibility for physically assisting the consumer into the community-based housing unit. This includes coordination of the relocation from the institution/previous dwelling to the unit, assisting with unpacking and settling into the new living space, and an orientation to the operation of the unit's features (HVAC, stove, mailbox, etc.).

During the post transition period, Transition Management Supports staff assist with on-going support of the consumer. This can include orientation to the new community and its resources, maintaining a regular schedule of visits to the unit based on what has been identified in the consumer's PCP, and implementing an intense skill training model to assist the consumer with managing and maintaining his or her new environment, with the plan to gradually decrease service intensity as the individual demonstrates increased independence and community integration. Transition Management Support staff also must develop and maintain strong communication with any and all other community providers and/or supports to ensure the consumer is receiving coordinated and effective services.

DHHS appreciates your participation in making these services available and supporting the individuals in community based housing. If you have questions, please contact Ken Edminster at 919-715-2774 or [ken.edminster@dhhs.nc.gov](mailto:ken.edminster@dhhs.nc.gov).

*Previous bulletins can be accessed at: <http://jtcommunicationbulletins.ncdhhs.gov/>*

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