



Scope of Work

Name of Program/Services

Assertive Community Treatment Team (ACTT) with Best Practices

Description of Services

An Assertive Community Treatment (ACT) team consists of a community-based group of medical, behavioral health, and rehabilitation professionals who use a team approach to meet the needs of a beneficiary with severe and persistent mental illness. A beneficiary who is appropriate for ACT does not benefit from receiving services across multiple, disconnected providers, and may become at greater risk of hospitalization, homelessness, substance use, victimization, and incarceration. An ACT team provides person-centered services addressing the breadth of a beneficiary's needs, helping him or her achieve their personal goals. Thus, a fundamental charge of ACT is to be the first-line (and generally sole provider) of all the services that an ACT beneficiary needs. Being the single point of responsibility necessitates a higher frequency and intensity of community-based contacts, and a very low beneficiary-to-staff ratio. Services are flexible; teams offer varying levels of care for all beneficiaries, and appropriately adjust service levels given an individual beneficiary's changing needs over time. The requirements and expectations contained within this scope of work are intended to reinforce Alliance's desire to offer services that will produce the greatest impact to our members.

Required Elements of the Program/Service

- Provider must adhere to the current NC Medicaid Clinical Coverage Policy No. 8A-1 and State-funded ACT service definition.
- Effective no later than 8/10/2020, Provider must use the DLA-20 to complete a face-to-face functional needs assessment for all individuals receiving ACT.
- For individuals new to ACT with an authorization starting on 8/10/2020 or after, the DLA-20 must be completed during the initial 60 calendar days of treatment, every 6 months/180 calendar days thereafter, and at discharge. For individuals already in treatment as of 8/10/2020, the DLA-20 must be completed within 60 calendar days of 8/10/2020, every 6 months/180 calendar days thereafter, and at discharge (The every 6 months can fall in-line with the authorization cycle). This 6-month reassessment will support the process of reevaluating the individual's needs and efficacy of interventions. The reassessment will offer an opportunity for integration of information that is gathered as part of the multiple visits from all service providers.
- ACT is a flexible service provided in an individualized manner. As such, service frequency and intensity will vary across beneficiaries. However, when considering caseload averages, the team must see beneficiaries, on average, 1.5 times per week and for at least 60 minutes per week. For the purpose of ACT program fidelity monitoring, of interest is the median rate of service frequency and the median rate of service intensity. Notwithstanding the foregoing, ACT Teams will have a goal of an increased average of no



less than 2 face to face contacts per week for a combined minimum of 60-84 minutes of face-to-face contact per week, for each individual enrolled in ACT services for more than 90 calendar days. The intent of this increased contact is to ensure longer community tenure, reduced admissions to inpatient/FBC, and retention of housing. Alliance will report on contacts quarterly via Provider Scorecards. Alliance and Provider agree to review the frequency of contacts on a quarterly basis to evaluate the intended outcomes, and Alliance reserves the right to request a plan for increasing frequency of contacts if outcomes are not improving.

- Provider must actively engage in the discharge planning process from DSOHF facilities (e. g., state psychiatric hospitals, ADATCs, etc.) prior to an individual's discharge from the facility. Providers are expected to communicate by phone and meet with individuals and their natural supports, participate in discharge planning meetings, take individuals to explore where they might like to live, etc.
- Alliance encourages providers to offer evidence-based pharmacotherapy, particularly those medications that are on the Medicaid formulary. By March 2021, Provider will develop a plan to be able to offer evidence-based medications for which there is limited availability in the community (e. g., Zyprexa Relprevv).

Best Practices for Supported Employment

- Vocational Specialist on the ACT team will provide evidence-based supported employment, also known as the Dartmouth Individual Placement and Support (IPS) model per Clinical Coverage Policy No. 8A-1 and the State-funded ACT service definition.
- The role of the vocational specialist will be protected. The team lead and other team members will determine who will assist with non-vocational and non-educational needs.
- Anyone who expresses any level of interest in employment or education shall be provided that assistance.
- Per the IPS model, there is a zero-exclusion criterion, meaning that individuals are not disqualified from engaging in employment simply because of perceived readiness factors, such as active substance use, criminal background issues, active mental health symptoms, treatment or medication non-adherence, or personal presentation. Individuals are not required to participate in pre-vocational training or other job readiness models. Teams assist individuals in addressing barriers to employment through behavioral health integration.
- The ACT Team will follow the 8 practice principles of IPS (www.ipsworks.org).
 1. Focus on Competitive Employment
 2. Eligibility Based on Client Choice (Zero-Exclusion)
 3. Integration of Rehabilitation and Mental Health Services
 4. Attention to Individual Preferences



5. Personalized Benefits Counseling
 6. Rapid Job Search
 7. Systematic Job Development
 8. Time Unlimited and Individualized Support
- The ACT Team will implement the critical elements of IPS (www.ipsworks.org).
 1. Development of the career and educational profile (profile can be found at <https://ipsworks.org/index.php/library/>)
 2. Ongoing benefits counseling
 3. Behavioral health integration
 4. Addressing barriers to employment
 5. Rapid job search and systematic job development
 6. Disclosure
 7. Job accommodations and assistive technology
 8. Follow-along supports

Best Practices for Permanent Supportive Housing

- Choice of housing
- Functional separation of housing and services
- Decent, safe, and affordable housing
- Housing integration
- Access to housing
- Flexible, voluntary, and recovery focused services
- Active outreach and engagement
- Helping people find and acquire housing
- Connecting people to benefits and community-based services
- Providing direct supports for housing retention

Ensuring persons are living in safe, decent, and affordable housing is essential to treatment retention and success. When a person is facing eviction or living in homelessness or substandard housing, it is imperative that every effort to avoid eviction or rapidly re-house a person be made. This active housing intervention could require daily efforts to locate suitable housing and assist the person with applications and other requirements of leasing.

Examples of searching for stable housing can include:

- Online apartment searches through Social Serve, Apartment Finders, etc.
- Knowledge of local affordable housing properties and outreach to property managers for vacancies. This includes the search for Targeted/Key units.
- Accessing ILI funding to assist with move-in costs or eviction prevention
- Preparing for mitigation of housing barriers through reasonable accommodation requests



- Asking for technical assistance from Alliance’s housing team and following up on leads
- Maintaining a list of potential landlords in private rental markets
- Accessing boarding houses as temporary living options to avoid or exit homelessness
- Advocating with landlords to comply with Fair Housing and to make necessary repairs to units to avoid having to move when conditions are substandard
- Placing persons on the Housing Choice and Public Housing waiting list with the local Housing Authorities

It is expected that the team will document the intensity of their efforts (e.g., frequency, duration, etc.) on the PCP and in the Service Authorization Request (SAR). It is also the expectation that when a person is living in homelessness or in unsafe conditions, the ACT team will prioritize actively addressing housing needs and engage in intensive efforts to quickly resolve the situation.

Highlights and examples of Skills Development, Symptom Management and Recovery training and support, and Coordinating and Managing Services for Members identified as being engaged in the Transitions to Community Living Initiative (TCLI)

- Support and assistance in obtaining vital documents for applications
- Develop Integrated PCP for housing
- Attend Soft Transition meeting from TCL In-Reach Phase to Transition Phase
- Communicate with TCL In-Reach staff, Transition Coordinators, and Care Coordinators
- Assist with discharges from hospitals and other crisis centers (e. g., move, transportation, etc.)
- Complete and submit a Monthly Tenancy Checklist to TCLI Supervisor
- Assist with completing and obtaining signatures on TCL Voucher Forms
- Assist with and ensure completion of recertification documentation for rental assistance
- Assist with preparing for and scheduling of annual inspection of units
- Attend and provide supports during lease-signing and move-in
- Ensure member is able to inhabit their new home/unit/transitional housing upon move in
- Assist with shopping for items needed to maintain community living
- Provide a higher level of support during the initial move-in period. During the first week following move-in, there will be increased face-to-face and/or phone contacts with individuals, natural supports, and/or landlords, recognizing that frequency may vary depending on an individual’s needs.
- Participate in separation conversations/meetings
- Assist members when they separate from housing (e. g., move out furniture, secure storage, work with natural supports, etc.) This might include directly assisting or helping member arrange for tasks to be completed.
- Actively explore and pursue Community Inclusion opportunities with emphasis on IPS-Supported Employment



- Complete and submit re-housing plans for individuals engaged in TCLI who have separated from housing and are being re-housed. Plan should include details about what is being addressed and/or what has changed since previous housing situation to help the individual be successful after moving into new housing situation. Submit plans to tjhayes@alliancehealthplan.org. Assist with completion of FL-2 and applying for Special Assistance (SA) In-home
- Assist with applying/recertification for Disability and Medicaid
- Monitor SA In-Home and CLA funding utilization
- Utilize, to the extent possible, B3 Medicaid One Time Transitional Costs service
- Notify TCL staff when referring member to additional services or discharging from services
- Assist with applying for mainstream vouchers
- Provide notification to TCL Team of any application denials, lease violations, rehouses, notice to vacates, or unexpected absences from unit

Required Additional Trainings

Who	Training	Trainers
Team Lead and all non-licensed team members within 90 days of hire	Harm Reduction (at least 3 hours)	as arranged for by provider or Alliance
Each ACT team lead and housing specialist: Existing team leads and housing specialists should complete this training by 12/31/2020. For newly hired team leads and housing specialists, training must be completed within 90 days of hire.	15 hour Permanent Supportive Housing Training	As arranged for by Alliance
ACT Housing specialist and other	All trainings offered or required by	Alliance may arrange for these trainings or



team members whose roles actively support housing tenure	Alliance, either in-person or online, that are related to housing, Fair Housing, tenancy support, and/or Transitions to Community Living	notify providers of available trainings in the community.
All ACT Team members	Initial DLA-20 Training, including completion of Train the Trainer for specified agency staff	As arranged for by Alliance at no cost to providers

Collaboration

- Provider will participate in monthly ACT Learning Collaborative
- Provider will participate in ACT related calls scheduled by Alliance upon reasonable notice to Provider
- Provider will attend case review meetings with Alliance’s TCLI staff as requested upon reasonable notice to Provider
- Provider will collaborate with other service providers and community stakeholders for the purpose of coordinating an individual’s care and supports
- Provider will work diligently with agencies and representatives to share best practices, identify barriers, and work toward solutions collaboratively with the goal of better outcomes for members.

Performance Monitoring

Assertive Community Treatment Team services will be monitored by Alliance and reported to providers quarterly via Provider Scorecards. Provider Scorecards include the following indicators, reported in aggregate, for all individuals served during the reporting period:

QUALITY INDICATORS	MEASUREMENT	REPORTING FREQUENCY
Level of Functioning / DLA-20	Percent improvement based on change scores at each re-assessment	Every 6 months
Employment	<ul style="list-style-type: none"> • Percent employed (NCTOPPs) Goal: Increase the number of employed individuals	Every 6 months



Crisis Utilization	<ul style="list-style-type: none"> • Percent with inpatient/FBC admissions (claims) • Average length of stay per admission (claims) • Community tenure / LOS between admissions (claims) <p>Goal: Decrease in the average length of stay per admission and increase in community tenure between admissions.</p>	Quarterly
Monthly Contacts / Encounter Billing	Median number of encounters billed per individual, per month following the 4 paid contacts. (claims)	Quarterly

Additional Quality Indicators

1. For individuals engaged in TCL, housing retention will be monitored through the TCL Housing Database.
2. PCP Reviews will be conducted throughout the year based on a randomized sample of individuals actively receiving services. Providers will receive review results including individualized feedback and overall trends. Issues identified during these reviews may result in a request of a formal corrective action plan. Failure to successfully implement a plan and correct issues may result in imposition of sanctions. PCP reviews are evaluated based on the following elements:
 - All elements of the PCP, in accordance with the NC DHHS PCP Instruction Manual, are completed in a manner that is person-centered and individualized to the identified needs in an individual’s CCA, service authorization request, and DLA-20 functional assessment.
 - PCPs are updated and goals continued, revised or discontinued from previous PCPs. Goal updates should include a brief description of progress towards goal.
 - Comprehensive Crisis Plans are updated following an inpatient/FBC admission; updated Comprehensive Crisis Plans should be uploaded to Alpha.
 - PCP reflects Employment Specialist services unless the individual has consistently refused or has an age or disability related medical condition that even with adaptations/equipment makes it difficult to work. This should be documented in either the CCA or PCP.
 - For individuals engaged in TCL, the PCP includes at least one housing goal relevant to the individuals’ tenancy phase, with specific objectives, tasks including who is responsible for each task. The housing goal(s) have been updated to reflect the individual’s changing needs to transition to the community and is updated through each tenancy phase.
 - If an individual has a substance use diagnosis, PCP has goals and interventions that are reflective of the individual's Stage of Change and documents the individual's desire regarding addressing their substance use.



- If an individual is receiving multiple services, either from the same provider or from more than one provider agency, all services should be included in one cohesive PCP to reflect an integrated care plan.
- 3. NCTOPPs: Alliance will actively monitor NC TOPPS data related to the following domains. Results will be shared during ACT collaborative every 6 months and sent to Providers (issues in these areas will trigger focused monitoring and corrective action):
 - a. Employment
 - b. Routine health/dental care
 - c. Participation in positive activities
 - d. Family support
 - e. Quality of life
- 4. Sample Chart Reviews: Alliance will implement a sample chart review monitoring process to examine the nature of provider contacts when the average number of contacts is lower than required, issues are identified through NC-TOPPS review, or repeated administration of the DLA-20 indicates a lack of progress. For individuals engaged in TCL, housing separation may also trigger a chart review.
- 5. Alliance may perform additional analysis throughout the year utilizing data from approved authorizations, claims, survey results, provider reports and other means to verify fidelity, efficacy, quality and satisfaction with services being provided.

Documentation Requirements (added 4/29/2021)

Documentation Requirements: There must be written documentation that the provider is implementing the program requirements as listed within the scope of work. Note that these documentation requirements may be further defined in the future but not without 30 days' notice.

Reporting Requirements and Monitoring

Effective July 10, 2020, Providers must submit an ACT Team Roster for each ACT team to PNDProviderReports@alliancehealthplan.org. Please include ACT Team Rosters in the subject line of the email. Roster template will be provided by Alliance. Rosters will be due the 10th of the month following the end of the quarter (July 10th, October 10th, January 10th, and April 10th). If there were no changes during the reporting period, Providers shall notify Alliance of this via email to PNDProviderReports@alliancehealthplan.org. When there have been no changes, a roster is not required.

Effective 8/10/2020, Provider must submit completed DLA-20s to Alliance via upload to Clinical Documents in Alpha. Document should be named "DLA-20 MM/DD/YYYY" (date is the date on which the DLA-20 was completed). Please note that guidelines regarding submitting DLA-20s to Alliance may change. Guidelines for when to complete the DLA-20 are noted above under "Required Elements of the Program/Service."



Effective January 10, 2021, Provider must submit Employment and Educational Data to PNDProviderReports@alliancehealthplan.org. ACT Team Roster template will be revised to include this data. Rosters will be due the 10th of the month following the end of the quarter (July 10th, October 10th, January 10th, and April 10th).

Effective April 29, 2021, Provider will submit results of all external fidelity monitoring, within 10 days of receiving the written report, to Alliance's Provider Network Evaluation unit to PNDProviderReports@alliancehealthplan.org.