SCOPE OF WORK TEMPLATE

Name of Program/Services

T1019 U4 22 Z1—Individual Support TCL (Medicaid b3 service)

Description of Services

Individual Support is an action-oriented service for persons with Serious and Persistent Mental Illness (SPMI) or Serious Mental Illness (SMI) as documented in the PASRR manual Appendix C and meet clinical criteria for Transitions to Community Living. The intent of the service is to teach and assist individuals in carrying out Instrumental Activities of Daily Living (IADLs), such as preparing meals, managing medicines, grocery shopping and managing money, so they can live independently in the community**.** Under this scope of work, Individual Support TCL is specific to providing ongoing IADL skill attainment and support for individuals who are residing in stable housing and no longer meet criteria for a more intensive tenancy support service such as ACT, CST or TMS. As individual's gain IADL skills, it is expected that this service will fade or decrease over time as the individual becomes capable of performing some of these activities more independently. Individual Support is not used for housing search.

Required Elements of the Program/Service

Individual Support is a mental health service and is delivered by mental health providers. Providers must meet the provider qualification policies, procedures and standards established by the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), the requirements of 10A N.C.A.C 27G and NC G.S. 122C, and any competencies specified by the NC Division of Medical Assistance (DMA). Providers of Individual Support will comply with the Individual Support b3 Service Definition posted at https://www.alliancehealthplan.org/providers/mhsa/.

Individual Support is intended to be part of a provider's continuum of tenancy support services, which includes Community Support Team (CST) and/or Assertive Community Treatment Team (ACTT).

A. Individual Housing & Tenancy Sustaining Services (not an exhaustive list)
    - 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.

B. Money Management and Entitlements (not an exhaustive list)
  - Assist in accessing financial entitlements such as SSI/SSDI, Medicaid, Special Assistance In-Home, food stamps, Veteran benefits, and payee-ship (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 overdue utility bills.
  - Manage Special Assistance In-Home benefit and provide updated information to the Department of Social Services where the Special Assistance In-Home benefit and Medicaid originated.

C. Activities of Daily Living (not an exhaustive list)—Assist individual to restore or improve ability to:
  - Perform self-care management
  - Maintain personal safety
  - Meal plan, grocery shop, cook, use kitchen appliances, and store food safely
  - Purchase and care for clothing
  - Maintain and clean apartment

D. Personal Health, Wellness, and Recovery (not an exhaustive list)—Assist individual to restore or improve ability to:
  - Manage medications
  - Access and use pharmacy services and appropriately store medications
  - Manage personal health needs
  - Assist individual with navigating mental and physical health services systems
  - Maintain nutrition and physical activities
  - Identify and participate in self-help groups
  - Assist individual to access free online resources for depression, anxiety, symptom management, etc.
  - Assist individual with acquisition and use of technologies to remain in touch with service providers, natural supports, etc.

E. Promote Community Integration (not an exhaustive list)—Assist individual to restore or improve ability to:
  - Socialize, communicate, and develop friendships
  - Identify his or her interests and lifestyle choices
  - Identify where to pursue those interests and 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, newspaper) to learn what is happening in the community in terms of entertainment or recreational activities/events

Identify employment and/or education goals and refer to Individual Placement and Supports- Supported Employment (IPS-SE) services; **Individual Support is not an employment service, all individuals interested in employment should be referred to an IPS-SE provider who can provide benefits counseling and employment services.*

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

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 (TCL)

- Develop Integrated PCP for housing
- Communicate with Alliance staff
- Assist with discharges from hospitals and other crisis centers (e. g., move, transportation, etc.)
- Complete and submit a Monthly Tenancy Checklist to Alliance
- 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 annual inspection of units
- Assist with shopping for items needed to maintain community living
- Participate in separation conversations/meetings
- Assist members when they separate from housing (e. g., move out furniture, secure storage, work with natural supports, etc.)
- Actively explore and pursue Community Inclusion opportunities with emphasis on referrals to IPS-Supported Employment
- Complete and submit re-housing plans
- 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
- Notify TCL staff when referring member to additional services or discharging from services
- Identify and refer for assessment for higher levels of service as medically appropriate
- Assist with applying for mainstream vouchers
- Provide notification to TCL Team of any application denials, lease violations, rehouses, notices to vacates, or unexpected absences from unit

Staffing Requirements
Individual Support staff must meet requirements as specified in 10A N.C.A.C. 27G 0104, and supervision of staff must be provided according to the supervision requirements specified in 10A N.C.A.C. 27G 0204.

Individual Support service is provided by qualified providers with the capacity and adequate workforce to offer this service to eligible Medicaid beneficiaries. The provider must have the ability to offer this service at any time of the day, including evening times or weekends, as needed by the beneficiary and specified in the beneficiary's service plan or PCP.
Individual Support staff must be supervised by a full-time Qualified Professional (QP) who meets the requirements according to 10A NCAC 27G .0104.

Individual Supports is provided by Paraprofessional staff who meet the requirements according to 10A NACA 27g .104.

The maximum program staff ratios are as follows: QP to Paraprofessional staff is 1:8; and Paraprofessional staff to beneficiary is 1:15.

Individual Support staff must complete initial training specific to the required components of the **Individual Support** definition within 30-days of employment. This includes:

- CPR/First Aid/seizure management
- Client Rights
- Confidentiality/HIPAA
- Crisis Intervention and Management
- Training specific to the needs of the individual

Staff must complete the following training within 60-days OR by the date of the first available training, if training is not made available within the 60-day timeframe:

- Housing First, Permanent Supportive Housing, Tenancy Support Training
- Basic Tenant's Rights and Responsibilities
- Community resources and services, including pertinent referral criteria
- 2 Day Permanent Supportive Housing Training
- 3 hours of Harm Reduction

- DLA-20 Training

Target Population and Eligibility Criteria

- Adults ages 18 and older with a diagnosis of SPMI or SMI population and a LOCUS level of II or greater.
- Individuals between the ages of 18 and 21 may not live in a Medicaid-funded group residential treatment facility.
- The beneficiary is an individual with an SPMI or SMI diagnosis (as defined in the PASRR manual Appendix C) and has a history of housing instability related to his/her diagnosis.
- Members transitioning to Individual Supports meet clinical criteria for TCL and are stepping-down or stepping-out of Community Support Team (CST), Assertive Community Treatment Team (ACTT), or Transition Management Services (TMS) when clinically appropriate.

Member would be expected to have functional impairments in at least 1 of the following areas:

1. Adaptive skills (communication, problem-solving, or organizational skills)
2. Employment
3. Education
4. Financial management
5. Health management
6. Home establishment and management
7. Meal preparation and cleanup (grocery shopping, cooking, using kitchen appliances, properly storing food)
8. Purchase and care for clothes
9. Safety and emergency maintenance
10. Self-care management
11. Use different modes of transportation

Admission Criteria

See Individual Support (Personal Care) (b)(3) Service Definition posted at https://www.alliancehealthplan.org/wp-content/uploads/Individual-Support-b3.pdf for required utilization management entrance, continuing care, and discharge criteria. This enhanced Individual Support scope of work provides clarification for this service to provide tenancy support to members.

A comprehensive clinical assessment (CCA) is completed by a licensed clinician that meet the criteria included in 10A NCAC 27G. 0104 (12). The CCA demonstrates medical necessity must be completed prior to the provision of this service. If a substantially equivalent assessment is available, reflects the current level of functioning, and contains all the required elements as outlined in community practice standards as well as in all applicable federal and state requirements, it may qualify as a current CCA. Relevant diagnostic information must be obtained and documented in the beneficiary’s Person-Centered Plan (PCP).

Service Exclusions in the Scope of Work for Individual Supports

(In addition to b3 definition exclusions)

- **Individual Support** may not be provided during the same authorization period as ACTT, CST, TMS or Peer Support.
- **Individual Support** may not be provided to children ages 16 up to 21 who reside in a Medicaid funded group residential treatment facility.
- **Individual Support** may not be provided by family members.

Collaboration

- Provider will participate in monthly Learning Collaborative meetings related to tenancy and employment.
- It is expected that provider shall adhere to System of Care values and principles in providing a person centered, strength-based service delivery approach to assist members in achieving their outcomes.
- Provider shall collaborate with Alliance and any other identified partners in implementing this service.
- Provider will collaborate with other provider agencies that are providing services to individuals who receive Individual Supports.
- Provider will attend case review meetings with Alliance's TCLI staff as requested for applicable individuals.
- Provider will work with community resources and organizations to ensure member is aware of ways to fully integrate into his or her community utilizing physical and behavioral health, social, spiritual, financial, transportation, vocational and educational resources.

Documentation Requirements

- A daily full service note or grid that meets the criteria specified in the DMH/DD/SAS Records Management and Documentation manual (APSM 45-2) is required. The DMH/DD/SAS Records Management and Documentation Manual can be found at: https://files.nc.gov/ncdhhs/RMandDM%203rd%20Edition%209-1-16.pdf
- DLA-20, at initiation of services and every 90 days there after

Required Outcomes and Quality Indicators

1. Alliance will track the following data elements to establish baseline performance metrics for FY 2022 (results will be analyzed by Alliance and shared with Providers):
    - Days housed
    - Tenure in current housing
    - Tenure in Individual Support
    - Percent of individuals who achieve/sustain housing, per quarter
    - Number of hospitalizations, per quarter

- Days hospitalized, per quarter
- ED utilization, per quarter
- Percent shared cases with IPS-SE providers
- Percent of individuals with competitive employment

2. Increased ability to function in the major life domains (emotional, social, safety, housing, medical or health, educational, vocational, and legal) as identified and documented on the DLA-20
3. Housing retention will be monitored through the TCL Housing Database. It is expected that housing retention will remain above the state average.
4. Claims data will be utilized to monitor sufficiency of services during transitional periods, e.g., pre-tenancy, post-tenancy, post-rehousing if applicable and at times of crisis services utilization.
5. 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 stated needs in an individual's CCA, service authorization request, DLA-20 assessment.
   - PCPs are updated and goals continued, revised or discontinued from previous PCPs.
   - Comprehensive Crisis Plans are updated following an inpatient/FBC admission; updated Comprehensive Crisis Plans should be uploaded to Alliance ACS Provider Portal.
   - If an individual is receiving services from more than one provider agency all services should be included in one cohesive PCP to reflect an integrated care plan.

Reporting Requirements

Provider must submit all completed DLA-20 assessments to the Alliance ACS Provider Portal with all authorization and re-authorization request for services. Monthly TCL Tenancy Checklist are to be submitted monthly, by the 10th of the month for the previous month, to TenancyChecklist@alliancehealthplan.org. Provider shall include in the subject line of electronic submission the name of the Provider and the specific program for which data is being submitted.

Provider will follow Alliance Health's Benefit Plans, which can be found at www.alliancehealthplan.org and submit service authorization requests through the Alliance ACS provider portal. The CCA, PCP and initial DLA-20 must be submitted with all initial request for services. All re-authorization requests for services must include the updated PCP and DLA-20. For individuals residing in independent housing, documentation of fading plan must be submitted with all request (initial and re-authorization).

Finance

Services rendered will be reimbursed on a fee for service basis for authorized services.