



## SCOPE OF WORK

### **Name of Program/Services:**

Enhanced Residential Services for Children with Complex Needs- Children with I/DD and co-occurring MH diagnosis (Residential Services – Complex Needs)

### **Description of Services:**

The members being served through Enhanced Residential Services – Complex Needs benefit from a multi-disciplinary approach tailored for individuals with co-occurring disorders by staff who are trained to treat people diagnosed with intellectual and developmental disorders (I/DD), mental health conditions, and who exhibit severe behaviors.

### **Required Elements of the Program/Service:**

This service is supported by a team of treatment professionals with expertise in working with individuals with behavioral challenges and co-occurring disorders. This team includes a minimum of a minimum of one psychologist and one licensed clinician who are routinely involved and readily accessible for the development of behavioral intervention plans and during crisis events to provide support for assessment and de-escalation.

Families/caregivers/guardians are expected to be actively engaged in the treatment program and coached on strategies and interventions that could be replicated in non-residential settings, such as the members' own homes. The focus is on strategic planning across systems, with the ongoing development of a strong natural support structure to reduce the need for paid supports. This strategy is specifically identified in the person-centered plan (PCP).

This program requires planned visits home where the caregivers are expected to accommodate the youth in the family/caregiver home for regular therapeutic leave in addition to Thanksgiving, Christmas, and other holidays to ensure the individual is continuing those natural relationships as reunification is the ultimate goal once treatment gains indicate the child and family are ready for a step down. Exceptions to this must be agreed upon and documented in the PCP. All therapeutic leave has specific goals and interventions reviewed with the child and caregiver prior to the leave and staff will debrief with the caregivers and child after they return to the program.

At a minimum, providers are required to have access to qualified professionals, licensed clinical staff, psychologists and medication prescribers. Based on the members' individual needs, other services (such as nursing services, speech therapy, occupational therapy, and physical therapy)



also may be utilized as adjuncts to treatment. The level of involvement of these additional services will be based on the comprehensive clinical assessment, neuropsychological/psychological, and psychiatric assessments of the members and adjusted throughout treatment. Routine nursing may be a standard part of the Residential program, if indicated based on the population served.

### **Staffing Requirements**

- A minimum of one qualified professional and either an associate professional or a paraprofessional with two years of experience with the population served is available at all times
- Two awake staff present anytime there are two or more individuals in the home, including sleep hours.
- A licensed clinician is always available for crisis response and serves as the first responder. This clinician assesses whether de-escalation and recommendation of strategies/interventions can be done via phone or face-to-face intervention. This clinician can request assistance from the doctoral-level psychologist, if needed.
- A doctoral-level psychologist must be involved in the programming and consultation and available for crisis response via telephone at a minimum within 45 minutes with face-to-face follow up within 24 hours, as necessary.
- Psychiatric involvement – All members are expected to receive a full psychiatric assessment, preferably by a child and adolescent psychiatrist for members under 18, by an MD or DO. These services can be billed separately, but the residential provider is responsible for coordinating and ensuring this assessment occurs. Any exceptions based on clinical needs of the member must be documented and coordinated with the care coordinator.
- Training in a standardized program for working with individuals with dual diagnosis is required within six months of operations. The provider will specify the specific training elements, hours required and accepted training platforms for documentation of training



completion (e.g., training modules through College of Direct Support or similar programming).

- For members already established with psychiatric providers, all efforts should be made to maintain continuity with these practitioners whenever possible. The residential provider is expected to have a psychiatrist or other physician with extensive behavioral health experience/training with the population being served (e.g., developmental pediatrician) employed with the company who can provide consultation as necessary and who can assist with interfacing with the community psychiatrist, if different.
- Training in a standardized program for working with individuals with dual diagnosis is required within six months of operations. The provider will specify the specific training elements, hours required and accepted training platforms for documentation of training completion (e.g., training modules through College of Direct Support or similar
- Staff should be NADD certified or in the process of becoming NADD certified.
- At a minimum, providers are required to have access to qualified professionals, licensed clinical staff, psychologists and medication prescribers. Based on the members' individual needs, other services (such as nursing services, speech therapy, occupational therapy and physical therapy) also may be utilized as adjuncts to treatment. The level of involvement of these additional services will be based on the comprehensive clinical assessment, neuropsychological/psychological, and psychiatric assessments of the members and adjusted throughout treatment. Routine nursing may be a standard part of the Residential program, if indicated based on the population served.
- A psychiatrist or other physician with behavioral health expertise within the provider organization must be available for consultation, and in close coordination of clinical services with outpatient psychiatric care. Modalities and interventions are individualized based on the unique needs of the members, and behavioral plans will be developed and implemented for all members.
- A doctoral-level psychologist must be involved in the programming and consultation and available for crisis response via telephone at licensed clinician request with face-to-face follow up within 24 hours, as necessary.



- Within the first 30 days of admission in this program the youth will have been assessed by a psychiatrist who specializes in autism. For example, Duke Center for Autism or Carolina Institute for Developmental Disabilities
- Within the first 30 days of admission in this program the youth must be evaluated by a pediatrician, or nurse practitioner to address all physical health concerns. When indicated, a copy of the medical treatment plan is shared (with consent) with the residential provider and is documented within the individual's medical record.
- Within 90 days of admission into this program the youth is referred for a functional behavior assessment and weekly therapy with a board-certified behavior analyst for ABA services
- Within 60 days the youth is referred for outpatient therapy to address trauma, social skills, soothing/coping skills using a modified trauma focused cognitive behavioral therapy, dialectical behavioral therapy, eye movement desensitization reprocessing or biofeedback model.
- The staff assigned to this program must be NADD credentialed direct support staff.

**Collaboration:**

Monthly child and family teams must include the child, caregivers and residential staff at minimum, with input and preferably attendance by outpatient service providers.

Residential staff must coordinate with ABA provider(s) and staff.

Residential staff must collaborate with schools, healthcare professionals, juvenile justice and child welfare as indicated.

- Documentation and collaboration between behavioral health, physical health and allied health professionals such as occupational therapy, speech therapy, applied behavior analytic services should be evidenced in the youth's medical records.

**Documentation Requirements:**

- The minimum service documentation requirements for services provided in a residential setting are contained within Clinical Coverage Policy 8 D-2.



- The person-centered plan clearly documents the need for the individualized enhanced services described in this scope of work.
- Documentation of initial training and regular supervision as outlined required in the person-centered plan.

### Objectives

- Enable learning, resiliency and living in the community at the least restrictive level of care.
- Provide active treatment and therapeutic MH/Behavioral interventions that develops the necessary skills to live as independently as possible in the community.
- Gain additional family and caregiver personal skills that are addressing co-occurring disorders affecting community functioning.
- Provide support so that level of functioning is restored or developed so that individual can reach highest level of functional capacity.
- Enable discovery and effective use of the intrinsic strengths necessary for sustaining the changes made and enabling stability
- Generalize acquired skills to environments outside of the milieu.

### Goals:

- Reduction in behaviors or challenges warranting this level of care
- Improvement in skill development
- Reduction in crisis episodes
- Reduction of mental health symptoms
- Demonstrated ability to transition back to the family setting or less restrictive setting home within six months
- Evidence of improvement on standard outcome measures utilized at routine treatment intervals, at completion of treatment and during follow up care whenever possible
- Objective improvement in school or work as indicated in progress notes, employee reviews, treatment team meetings, etc.



- Evidence of improved coordination with physical health stakeholders to promote wellness, stability and whole person care.
- Demonstrated school success  
Observable indicators the youth is making gains as a contributing community member

**Expected Outcomes:**

At discharge (for youth who received at least 60 days of service):

- 80% of youth move to a permanent or less restrictive setting or planned residential program.

Six months post discharge (for youth who received at least 60 days of service):

- 80% of youth have remained stable in a permanent, planned or less restrictive setting.
- Out-of-home placement: Less than 10% of youth have been placed in a higher level of residential treatment services, and less than 5% have had a psychiatric hospitalization.

**Entrance Criteria and Target Population**

Children and adults (ages 13 through 17) are eligible for this service when **ALL** the following criteria are met:

Must meet all Level III Residential criteria as outlined in Clinical Coverage Policy 8 D-2.

And

Has a co-occurring diagnosis of autism spectrum disorder (as determined by psychological assessment).

And

member meets the functional eligibility requirements for the NC Innovations 1915(c) waiver program **but not enrolled** in the NC Innovations.



Functional eligibility for the NC Innovations waiver means the member meets ICF/IID (intermediate care facility for individuals with intellectual Disabilities) level of care criteria as summarized below:

- Has been diagnosed with an intellectual disability prior to the age of 18 OR
  - Has been diagnosed with a related condition prior to the age of 22 that is likely to continue indefinitely (such as a developmental disability or a traumatic brain injury)
- AND
- Has substantial limitations in three of six major life activity areas (self-care, understanding and use of language, learning, mobility, self-direction, capacity for independent living)
  - AND
  - Requires active treatment to enable the member to function as independently as possible and prevent or delay loss of optimal functional status. Active treatment is defined as a “continuous program that includes aggressive, consistent implementation of specialized and generic training, treatment, health services, and related services.”

### **Continued Stay Criteria**

The member is eligible to continue this service if the desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the member’s PCP; or the member continues to be at risk for out-of-home placement, based on current clinical assessment, history and the tenuous nature of the functional gains.

**AND**

One of the following applies:

- The member has achieved current PCP goals, and additional goals are indicated as evidenced by documented symptoms;
- The member is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the PCP;



- The member is making some progress, but the specific interventions in the PCP need to be modified so that greater gains, which are consistent with the beneficiary's premorbid level of functioning, are possible; OR
- The member fails to make progress, or demonstrates regression, in meeting goals through the interventions outlined in the PCP. The member's diagnoses should be reassessed to identify any unrecognized co-occurring disorders, and interventions or treatment recommendations shall be revised based on the findings. This includes consideration of alternative or additional services.

### **Discharge Criteria**

The beneficiary shall be discharged from this level of care if any one of the following is true:

a. The level of functioning has improved with respect to the goals outlined in the service plan and the beneficiary can reasonably be expected to maintain these gains at a lower level of treatment.

OR

b. The beneficiary no longer benefits from service as evidenced by absence of progress toward service plan goals and more appropriate service(s) is available.

OR

c. Discharge or step-down services can be considered when in a less restrictive environment the safety of the beneficiary around sexual behavior and the safety of the community can reasonably be assured. \*Note: Any denial, reduction, suspension or termination of services requires notification to the beneficiary or legal guardian about their appeal rights.

Prior to discharge, Alliance Health care management is involved in the discharge planning. 90 days prior to discharge, referral to care management is completed by the provider.





**Prior to discharge, the care management entity shall be involved in the discharge planning.**

**Service Exclusions**

This service is intended to be a comprehensive service, without the need for additional services until the member is within 60 days of discharge to allow for transition to the planned post discharge services.

The following services when clinically appropriate will be allowed to be authorized during the same period as approved by the utilization management team as required, but must be included in the plan, and coordination occurring.

- Outpatient services  
This includes psychiatry and psychological testing.
- Day treatment
- Research-based mental health treatment

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

Provider shall follow health's benefit plans, which can be found at [www.alliancehealthplan.org](http://www.alliancehealthplan.org) and submit service authorization requests through the Alliance ACS provider portal. The CCA, PCP and any available assessments and/or behavior plans are submitted with authorization requests. All re-authorization request for services must include the updated PCP and any other new assessments or behavior plans. Provider will bill UCR using code H0019 HQ 22.