SCOPE OF WORK TEMPLATE

☒ CONTRACT IS STATE FUNDED

Name of Program Services
TCL Assertive Engagement

Description of Services
Assertive Engagement is a service provided to individuals participating in TCL who are hospitalized in a state psychiatric hospital (e.g., Central Regional Hospital, Cherry Hospital, or Broughton Hospital), residing in an Adult Care Home, incarcerated, residing in bridge housing (where other enhanced services are unavailable), or other congregate care settings to assist with their transition to permanent supportive housing. The purpose of the service is to ensure a seamless transition for individuals to community-based treatment services and stable permanent supportive housing by actively participating in discharge planning and providing pre-tenancy support services.

Required Elements of the Program/Service
No prior authorization is required for the provision of this service. Services are only available for individuals referred by Alliance TCL staff or a State Hospital social worker, who are eligible for ACT or CST, and meet the requirements of this SOW. When referred by a State Hospital social worker, member eligibility must be verified by Alliance TCL staff. Members actively receiving ACT, CST or TMS are not eligible for this service. Provider must adhere to the current Alliance alternative service definition for Assertive Engagement, as well as all requirements included in this scope of work.

- Individuals/guardians and the state psychiatric hospital or adult care home will be contacted within 2-business days of accepting the referral to schedule initial face-to-face meeting with the individual.
- Actively attend and participate in all transition meetings to include, individual, guardian, Alliance transition staff, state psychiatric hospital (SPH) staff or adult care home (ACH) staff, and natural supports, either onsite or through telemedicine.
- Maintain regular contact with member while in the State Psychiatric Hospital or Adult Care Home
    - Minimum of six (6) contacts per month
    - Minimum of one (1) face-to-face contact per week

- Assist individual with obtaining records (i.e., mental health, physical, substance use)
- Assist with obtaining/completing vital records (i.e., NC Identification, birth certificates, Social Security Cards, Proof of Income, FL2s, Level of Care (LOC) recommendations, Comprehensive Clinical Assessment (CCA), psychological evaluations, medication regimen, bridge prescriptions, credit/criminal check)
- Assist with applying for (or restarting) entitlements.
- Utilize all biopsychosocial assessments, treatment team recommendations, and other assessment data in the development of a Person-Centered Plan (PCP).
- Assist individual with exploring community living options and provide additional resources as needed.
- Arrange community visits to view housing options based on individual's preferences, completes applications, meets landlord, etc.
    - When time/distance are prohibitive to in-person visits, coordinated use of audio/visual technology can be used to view housing options.
- Arrange outings for housing selection, lease signing, utility activation, and purchasing of furniture, housewares, groceries, etc.
- Provides in-person support at lease signing and on move-in day including set up, lease review, and initial walk through.
- Assists individuals in receiving support to become fully participating members of the community, including assistance with socialization and gainful employment.
- Be flexible and individualized to meet the needs of each individual.
- Meet with individual regularly to address and skill build in all life domains for successful community living.
- Increase and strengthen individual's networks of community and natural supports, as well as their use of these supports for crisis prevention and intervention.
- Collaborate with LME/MCO to provide updates and progress of individual's treatment.

Provider must have a PCP on file, inclusive of transition goals identified at the SPH/ACH/ Congregate Care location after the first (30) calendar days of Assertive Engagement services. These transition goals are also expected to be continued in the PCP post discharge.

Staff providing Assertive Engagement will work directly with the individual, site location staff, Alliance TCL staff, and other community-based providers towards successful discharge to the community. Assertive Engagement can be provided by existing Clinicians, QPs, APs and/or Peer Support Specialist's on CST or ACT teams. Upon discharge, individuals served will transition fully

onto the Clinician's, QP's, AP's or Peer Support Specialist's respective CST or ACT team to maintain continuity of services.

Assertive Engagement in an ACH will have intensified supports and increased member engagement in order to transition the member into the community. Examples of these increased interventions include but are not limited to the following areas:

- Additional emphasis on Assessment(s) completion and referral for services.
- Barriers to transition should be identified and addressed quickly.
- DME, accommodations, Assistive Technology, and additional care needs for members with complex medial issues should be identified quickly and put in place for transition into the community.
- Identification of ADL support needs and skill building for smooth transition into the community.
- Assistance with linkage to Community Medical Providers and Pharmacies.
- Strong collaboration with Alliance Nurse and OT for additional training and education.
- Coordination and support for accessing community.

Target Population and Eligibility Criteria

Individuals participating in TCL who are hospitalized in a state psychiatric hospital (e.g., Central Regional Hospital, Cherry Hospital, or Broughton Hospital), residing in an Adult Care Home, incarcerated, residing in bridge housing (where other enhanced services are unavailable), or other congregate care settings are eligible for Assertive Engagement under the terms of this scope of work. These individuals will be referred for Assertive Engagement by the Alliance TCL team or a State Psychiatric Hospital Social worker.

Collaboration

- Provider will receive and review referrals made by TCL staff and State Psychiatric Hospital social workers and communicate directly with Alliance TCL team for referred individuals within 2-business days of the referral.
    - o When referred by a State Hospital social worker, member eligibility must be verified by Alliance TCL staff.
- Provider will work in coordination with Alliance TCL staff to complete pre-tenancy activities in the individual's chosen home community.
- Provider will collaborate with other appropriate service providers for the purpose of coordinating an individual's care, as well as collaborate with community stakeholders as outlined in the service definition.

Required Outcomes

• 100% of members will successfully transition into the community with all required services and supports in place as identified by in the transition plan, PCP, and care team.
• Individuals will seamlessly transition into the community and onto the associated CST or ACT team (or other services if not engaging in CST or ACT post discharge) within (7) calendar days of discharge.

Finance

• Provider must submit all billing into the Alliance Claims System (ACS) for reimbursement.
• Individuals must be enrolled in the AMTCL Benefit Plan or claims will deny.
    o Provider must verify individuals have active State insurance with no end date.
        ▪ If State insurance is not active, provider must submit the Enrollment Request through ACS
    o Provider must verify individual has active AMTCL Benefit Plan with no end date.
        ▪ If AMTCL Benefit Plan is not active, provider must submit the Client Update through ACS

TCL Assertive Engagement (YA410, YA352, YA352 GT, YA352 KX) - $3,120/per month

- Minimum of six (6) contacts per month
- Minimum of one (1) face-to-face contact per week
- Only one (1) Assertive Engagement claim will be paid per rolling 30-day period (the 30 days starts with the first claim submission)
- No encounter claims are required at this time.

NOTE:

• Individuals with Medicaid are eligible to receive this service under this scope of work.
• Members actively receiving ACT, CST or TMS are not eligible for this service.
• Assertive engagement and CST or ACT can only be billed within the same 30-day period of a members move-in date.

Start Date: February 16, 2024