SCOPE OF WORK

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 for up to 90 calendar days before discharge. 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, proving pre-tenancy support services, and linking individuals to a community-based behavioral health provider and community resources for after care.

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 Health for members identified as TCL eligible and meeting the requirements of this SOW. Provider must adhere to the current Alliance alternative service definition for Assertive Engagement, as well as all requirements included in this scope of work if transition to a tenancy provider has not occurred.

- Attend and/or facilitate frequent transition meetings to include, individual, guardian, transition staff, state psychiatric hospital (SPH) staff or adult care home (ACH) staff, and natural supports
- Meet with individual while still residing in ACH/SPH, or other setting, to obtain records (i.e., mental health, physical, substance use) and use assertive engagement skills when necessary
- Assist with the development and update of an individualized Person-Centered Plan (PCP)
- Meet with individuals as many times as requested, or as necessary, to help them explore options, respond to questions, and provide additional resources
- Be designed to develop a meaningful engagement with the individual who was not connected to or who was disengaged from community-based services that are available to meet their clinical needs.
- Be flexible and individualized to meet the needs of each individual.
- Increase and strengthen individual’s networks of community and natural supports, as well as their use of these supports for crisis prevention and intervention.
- Include active participation in transition teams held in the state psychiatric hospital either onsite or through telemedicine.
- Include assistance during the pre-transition period, including applying for (or restarting) entitlements.
- Include gathering and utilizing various biopsychosocial assessments, treatment team recommendations, and other assessment data in the development of a Person-Centered Plan (PCP).
- Include connection with the individual the day of discharge and ensure agreed upon transition plan actions to link individual to their ongoing services and supports regardless of discharge setting.
- 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) with assistance from team members, and all referrals are made as soon as possible
- Arrange community visits to view housing options based on individual’s preferences, completes applications, meets landlord, etc.
Arranges outings for housing selection, lease signing, utility activation, and purchasing of furniture, housewares, groceries, etc.

Participates and provides support 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

Attends all transition meetings:
  - 1st and 2nd Transition Team meeting
  - Day of transition into the community at individual’s house or Bridge Housing

Meet with individual regularly to address and skill build in all life domains for successful community living

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. In rare instances, with prior approval by Alliance TCL staff, Assertive Engagement can be provided for up to (30) calendar days post discharge for specific circumstances such as individuals moving out of the Alliance catchment area or not transitioning to CST or ACT services.

Assertive Engagement in an ACH will have intensified supports and increased member engagement in order to transition the member into the community within 90 days. 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 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.

Collaboration

- Provider will receive and contact referrals made by TCL staff and communicate directly with Alliance TCL team for assigned individuals.
• 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**
• Individuals will seamlessly transition and receive services from the associated CST or ACT team (or other services if not engaging in CST or ACT post discharge) within (7) calendar days of discharge (unless the individual moves out of Alliance catchment upon discharge).

**Finance**
Provider must submit all billing into the Alliance Claims System (ACS) for reimbursement.

**TCL Assertive Engagement – code YA341, $25.91/unit (one unit=15 minutes)**
• Daily: 32 units (8 hours)
• Monthly: 128 units (32 hours)
• Maximum units per individual: 384 units (96 hours)

**NOTE:**
• Individuals with Medicaid are eligible to receive this service under this scope of work
• Assertive engagement and CST or ACT cannot be billed within the same 30-day period.
• Assertive engagement cannot be billed beyond a four-month period.

**Start Date: April 1, 2022**