Transforming

Frequently Asked Questions 002

To: All Enrollees, Stakeholders, and Providers

From: Cham Trowell, UM Director

Date: June 22, 2016

Subject: Questions and Answers to Clinical Communication Bulletin # 007

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1. There was no mention or reference to IDD Supervised Living, which is another Arc-legacy program. BCDC provides this service at our Supervised Apartment Living Program location on Tarboro Street in Washington---this is a less restrictive service than Group Living-Moderate (which we provide in our two IDD 5-bed Group Home locations). We do not have a vacancy now, but in the future is this service open to new admissions?
   - *Yes, this is not a change. This service is open if a bed is available in this setting due to the legacy funding.*
2. I work inpatient psych at CarolinaEast Medical Center. We have a 3-way bed contract with Trillium. I have been getting auths for these beds thru Provider Direct. Today's bulletin said the providers WITH contracts need to call the phone number for authorizations (bottom of page 2). Would you please clarify if the process has changed?
   - *The process has not changed. You can still request through provider direct.*
3. Community Support Team benefit is available to individuals stepping down from ACTT. It then reads that the benefit is now open to new state funded admissions for people who meet the eligibility criteria without any insurance.
   - *Step down from ACTT is a first priority population. Others may also qualify depending on need.*
4. State funded FBC has been 8 days unmanaged. According to this, it is now 7 days? (Medicaid remains the same as 8 days unmanaged)
   - *112 units or 8 days unmanaged. No change*
5. Why can Personal Assistance only be provided in the home? What about Community involvement?
   - *It can be provided in the community as well.*
6. Personal Assistance plans are denied if we discuss any goals regarding medications, can you tell us why this is?
   - *Trillium wants to be sure people get the right services. Personal Care is the more appropriate service to address Medication related goals.*
7. What about individuals under the age of 21?
   - *This service may be offered to individuals who are transitioning from high school but not school aged children.*

8. How can we incorporate a true Person Centered Plan with such restrictions on the service definition?
   - *Need more detail.*
9. Why is it that an individual can only have one service- not both (Long Term Vocational Support and Personal Assistance)?
   - *Benefit plan decision.*
10. In regards to the Communication Bulletin 007, I wanted to know if consumers who meet the criteria for Personal Assistance and have Medicaid can they receive Personal Assistance?
    - *If they are also have state funds benefit plan and are not eligible for or receiving Medicaid personal care. Most adults should first be denied Medicaid Personal Care before pursuing state funded Personal Assistance.*
11. We do monthly schedules for each ACTT recipient. Does UM want schedules for each month in the service authorization period downloaded with the ACTT recipient's PCP?
    - *Yes*

May 1 - 7, 2016

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	1 Sunday	2 Monday	3 Tuesday	4 Wednesday	5 Thursday	6 Friday	7 Saturday
		ACTT Goals 1&2--Wellness check, Med/sx monitoring (RN&QP)		annual physical			
9 am	ACTT Goals 1&2: phone med/sx monitoring		ACTT Goals 1&2: phone med/sx monitoring (QP)	ACTT goal 3&4: triggers and ADLs (PSS)	ACTT goals 1&2: phone wellness check (QP)	ACTT Goals 2&3: Limit setting, problem visitors, processiing triggers, improving relationships (TL)	nephew's soccer game
10 00	church	WELL class@Wellness City					ACTT goals 1&2: phone med/sx monitoring
11 00				coping skills@Wellness City			meet friends for coffee
12 pm		AA meeting	AA meeting	AA meeting	AA meeting	AA meeting	
1 00			Circle of Support class@Wellness City	ACTT Goals 1&2: Assess, med review, relaxation skills (MD&TL)	AA bowling league		AA Annual picnic
2 00					ACTT Goal 5: job search (QP or AP)		
3 00			ACTT Goals 1&2: phone med/sx monitoring (PSS)			ACTT goals 1&2: phone med/sx monitoring	
4 00	ACTT goals 1&2: phone med/sx monitoring	ACTT Goals 3&4: Recovery and ADLs: (PSS&LCAS)					ACTT goals 1&2: Phone med/sx monitoring
5 00				church			
6 00			niece's play			sharing with sponsor	
7 00	AA Meeting						AA meeting

Tasks: 0 Active tasks, 0 Completed tasks

12. I do not see the TST program listed in the provider manual under the benefit plan or the rate schedule. We are billing YM120. I looked under Clinical Communication 007 and nothing there either.
    - *This is a contract specific service. It is no authorization required with an allocated amount of funding for this service. This service is only available for persons in the AMTCLI benefit plan and providers*
13. Where can I find UM guidelines for TST (Tenancy Support Team)?

Tenancy Support Team (TST)

November 1, 2015

Service Definition and Required Components

Tenancy Support Team (TST) is a service provided to individuals participating in the Transition to Community Living Initiative (TCLI). TST is a rehabilitation service intended to increase and restore an individual's ability to live successfully in the community by maintaining tenancy. TST focuses on increasing the individual's ability to live as independently as possible, managing the illness and reestablishing his or her community roles related to the following life domains: emotional, social, safety, housing, medical and health, educational, vocational, and legal. TST provides structured rehabilitative interventions as listed below.

A. **Assessment**
   - Identify the individual's housing preferences, and transition and housing retention barriers related to successful tenancy, using the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services approved Housing History/Housing Supports Need Assessment.
   - Assess needed social and independent living skills to support capacity to live independently and maintain housing.
   - Assist with the housing application and search process including locating available rental units, identifying landlord partners, completing applications, identifying resources to cover application fees, completing applications for eligible housing programs, and transporting the individual during the housing search process.
   - Identify resources to cover expenses such as security deposit, moving costs, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses.

B. **Individual Housing & Tenancy Sustaining Services**
   - Ensure that the living environment is safe and ready for move-in.
   - Assist in arranging for and supporting the details of the move such as utility connection, purchase housing items to set up apartment (bedroom, kitchen, Livingroom, bathroom), and arrange transportation to move items to apartment.
   - 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.

C. **Money Management and Entitlements**

- Assist the individual in gaining access to obtain birth certificates, request social security cards, facilitate credit repair, and criminal record corrections.
- Assist in accessing financial entitlements such as SSI/SSDI, Medicaid, Special Assistance, food stamps, Veteran benefits, and payeeship (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.
- Assist the individual with utility management to prevent high utility bills and utility arrears.

D. **Activities of Daily Living**

Assist the individual to restore or improve his or her ability to:

- Perform self-care management
- Maintain personal safety
- Meal plan, grocery shop, cook, use kitchen appliances and properly store food safely
- Purchase and care for clothes
- Maintain and clean apartment
- Use different modes of transportation

E. **Personal Health, Wellness and Recovery**

Assist the individual to restore or improve his or her ability to:

- Manage medications
- Access and use pharmacy services; and appropriately store medications
- Manage personal health needs
- Assist individual with navigating health services system
- Maintain nutrition and physical activities
- Identify and participate in self-help groups
- Develop a personal crisis management plan, including suicide prevention or psychiatric advance directive using Wellness Recovery Action Plans (WRAP), Whole Health Action Management (WHAM) and/or psychiatric advanced directives (PAD)
- Develop a relapse prevention plan, including identification/recognition of early warning signs and rapid intervention strategies.

F. **Promote Community Integration**

Assist the individual to restore or improve his or her ability to:

- Socialize, communicate and develop friendships
- Identify his or her interests and lifestyle choices
- Identify where to pursue those interests 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, or newspaper) to learn what is happening in the community in terms of entertainment or recreational activities/events.

Link to employment, educational and volunteer programs if identified as a goal by the individual. The TST shall develop relationships with agencies that provide housing services, i.e., Housing Authority, permanent supportive housing providers, rapid re-housing providers, HUD-VASH, NC Housing Finance Agency, and relationships with local landlords to increase access to appropriate, safe, and affordable housing.

Provider Requirements

The provider requirements are as follows:

a. Meet the provider qualification policies, procedures, and standards established by the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS);
b. Fulfill the requirements of 10A NCAC 27G;
c. Demonstrate compliance with these standards by being certified by the Local Management Entities-Managed Care Organizations (LME-MCO); and
d. Become established as a legally constituted entity capable of meeting all of the requirements of the Provider Certification, LME-MCO Enrollment Agreement, Communication Bulletins, and service implementation standards.
e. Comply with all applicable federal and state requirements. This includes the North Carolina Department of Health and Human Services statutes, rules, policies, and communication bulletins, and other published instructions.

The TST provider shall ensure all staff, whether office-based or home-based, is located within 45 miles/45 minutes for rural areas and 30 miles/30 minutes for urban areas of persons to be served. The LME-MCO may grant an exception to requirement.

Staffing Requirements

TST services are provided by a team of four individuals (six individuals if using two staff to fill the NC Certified Peer Support Specialist) consisting of the following staff:

- One full-time dedicated Qualified Professional serving as the Team Leader,

AND

- One full-time dedicated Qualified Professional or Associate Professional

AND

- One FTE NC Certified Peer Support Specialist (NCCPSS) (may be filled by two part-time individuals),

AND

- An additional FTE NCCPSS (may be filled by two part-time individuals) or one full-time Paraprofessional.

TST Staff shall have at least two years of experience working with adults with mental health and/or substance use disorders.

Oversite of the Team shall be provided by a licensed professional who has the knowledge, skills, and abilities required by the population served. Clinical and administrative supervision of TST staff is covered as an indirect cost and therefore, should not be billed separately. It is anticipated that the licensed professional will spend approximately six hours a month working with the Team.

The Qualified and Associate Professionals shall meet the requirements according to 10A NCAC 27G .0104. A Paraprofessional shall meet the requirements specified for Paraprofessional status according to 10A NCAC 27G .0104. TST staff shall have the knowledge, skills, and abilities to successfully provide TST to adults with mental illness and substance use disorders.

The NCCPSS professional's life experience with mental illness or substance abuse and behavioral health services provides expertise that professional training cannot replicate. To ensure that the experience of the peer specialist is commensurate with those served by TST, for this position, the individual must have "lived experience" and a personal recovery story specific to primary mental illness or substance use disorders.

TST staff shall complete the DHHS approved Tenancy Support training prior to the delivery of TS Services. In addition, TST staff shall complete the following training within 90 days of hire:

- Crisis Interventions and Supports
- Recovery principles
- Motivational Interviewing
- Person-Centered thinking
- Trauma-informed Care
- Basic Mental Health and Substance Use 101

Service Type and Setting
TS is a direct and indirect periodic rehabilitative service in which TST members help the individual successfully transition to community living. TST shall provide services where they live prior to the transition, in the home where the individual lives, and other community settings.

Program Requirements
The TST works under the direct supervision of the Team Leader **who in** addition to carrying a caseload, ensures the team implements all featured aspects of the service definition. All TST members shall know all individuals served by the team, but not all team members necessarily work closely with all individuals. It is expected that the 90% of individuals shall see at least two team members in a given month.

All TST members participate in the initial development, implementation and on-going revisions of the Person Centered Plan (PCP). The Qualified Professional shall develop and write the PCP based on the individual's strengths, using a person-centered approach. In addition to a Crisis Plan, the Qualified Professional shall develop a Housing Support Crisis Plan that includes prevention and early intervention services when housing is jeopardized. The plan shall address issues such as loss of electricity/water, fire, natural disasters, and non-payment of rent or utilities. The Qualified Professional shall coordinate with the individual to review, update and modify his or her housing support and crisis plan after each crisis occurrence, and at minimum every three months, for the first year to reflect current needs and address existing or recurring housing retention barriers.

As part of the PCP Crisis Plan, the TS provider shall coordinate "first responder" coverage and crisis response with the LME-MCO. TST is not the first responder addressing a psychiatric crisis but shall provide crisis support to the individual by the initiation of WRAP or other crisis support plan. TST shall make immediate telephone contact with the individual and a face-to-face within 90 minutes after a crisis has occurred and contact the landlord if necessary to address any tenancy issues that may have occurred during the crisis.

The Team meets at least weekly, facilitated by the Team Leader, to ensure that the planned TS interventions are provided. The team meetings are usually held face-to-face. Conference calls or webinars may be used if the team member's office is in different locations. However, one team meeting per month must be held face-to-face. The Team Leader monitors the delivery of TST services to ensure the interventions provided effectively help the individual obtain and maintain his or her housing.

The licensed professional shall facilitate at minimum, monthly face-to-face meetings with TST to review each individual's progress and interventions provided and provide consultation as needed.

The TST staff shall make a referral to the LME/MCO for mental health or substance abuse services if the individual experiences psychiatric or substance abuse symptoms that interfere with his/her ability to be housed or to maintain housing. The TST staff shall collaborate with the LME-MCO and any mental health, substance abuse, or IPS-Supported Employment service providers identified to provide services to the individual.

The case load is comprised of individuals who require services ranging from a minimal to an intensive nature. TST maintains an individual-to-staff ratio of 12:1 with a team maximum of 48 individuals. Sixteen additional individuals may be allowed if teams find the majority of the required 48 individuals are only requiring minimal services. These additional individuals must only require the minimum of one face-to-face per month. Initial team case load shall be titrated with no more than 12 individuals enrolled per month until maximum case load is established.

TST services are provided 24/7 to meet the individual's housing goals and assist the individual in housing crisis such as power failure, broken water pipe, or broken appliances. The team members shall be able to provide multiple contacts based on assessed needs and identified on the PCP. The TST initial contacts with the individual are intended to begin building a relationship and provide housing transition services. It is expected that TST contacts with the individual will increase during the transition to his or her apartment. Therefore, it is expected the individual's need for service will be titrated, as skills improve to minimum of one face-to-face contact per month, for as long as the individual is a member of TCLI. If at any time the individuals service needs increase or he/she is in threat of eviction or have lost his/her housing, TST contacts shall increase.

Program services are primarily delivered face-to-face with the individual in community locations and outside the agency's facility. Ancillary contacts are expected with the landlord at least monthly to discuss housing issues that may arise. TST is a community-based service; therefore contacts with individuals are physically face-to-face. Telemedicine/tele psychiatry is not reimbursable for TST.

TST shall provide the majority of services in the community with at least 90% of the team's total face-to-face service contacts provided to the individuals in the community (non-office-based or non-facility-based settings).

Units are billed in 15-minute increments.

Utilization Management

An approved DHHS housing slot serves as the evidence of need for TST services. Prior Authorization by the LME-MCO is required. The amount, duration, and frequency of TST service must be included in the individual's PCP and submitted to the LME-MCO. It is expected that the amount, duration, and frequency of TST service will be highest initially in order for the TST to complete housing assessments and obtain housing at the time the individual moves into housing. It is expected that the TST will regularly review the impact of

services on the individual's ability to live successfully in the community. Service intensity will be titrated down as the individual demonstrates continued improvement in targeted life domains. A maximum of 60 units of TST services can be provided in one-week. Additional units may be requested from the LME-MCO as needed.

Eligibility Criteria
Eligibility for TST is based on whether or not the individual meets the clinical criteria for TCLI and accepts a housing slot. Individuals receiving ACT services are not eligible for TST.

Entrance Process
Individuals identified as a member of TCLI are offered the opportunity to receive a housing slot. Upon acceptance, the Transition Coordinator identifies a TST provider who requests TST services from the LME-MCO. TST staff is members of the Transition Team and shall be included planning meetings.

Continued Service Criteria
The individual is participating in TCLI.

Discharge Criteria
The individual shall be discharged from TST when no longer enrolled in TCLI (i.e. returns to ACH, voluntarily requests to leave program, or death) or in the event the individual receives ACT services.

Documentation Requirements
More than one intervention, activity, or goal may be reported in one service note, if applicable. For this service, one of the documentation requirements is a full service note for each contact or intervention for each date of service, written and signed by the person(s) who provided the service that includes all of the following:

a. Individual's name;
b. Date of service provision;
c. Name of service provided;
d. Type of contact;
e. Place of service;
f. Purpose of the contact as it relates to the goal(s) on the PCP;
g. Description of the intervention provided. Documentation of the intervention must accurately reflect treatment for the duration of time indicated;
h. Duration of service: Amount of time spent performing the intervention;
i. Assessment of the effectiveness of the intervention and the individual's progress towards the individual's goal;
j. Signature and credentials or job title of the staff member who provided the service; and
k. Individual's name and record number identified on each note page.

Expected Outcomes
Expected outcomes include, but are not limited to, the following:

- Achieved recovery goals identified in the PCP;
- Continued community tenure;
- Improved personal, social, and community living skills;
- Increased access to necessary services in all life domains;
- Improved functioning in community roles;
- Re-established or restored network of healthy natural supports and community contacts;
- Re-established or restored independent living abilities.

Service Exclusions and Limitations

An individual may receive TST from only one TST provider organization during any active authorization period. Family members or legally responsible individuals of the individual are not eligible to provide this service. TST shall not be provided in conjunction with ACT Team Services.

The following are not billable under this service:

- Transportation for the individual or family. Services provided in the car are considered transportation;
- Any habilitation activities;
- Time spent doing, attending or participating in recreational activities unless tied to specific planned social skill assistance;
- Clinical and administrative supervision of TST staff is covered as an indirect cost and included in the rate, therefore, should not be billed separately;
- Services provided to individuals under age 18;
- Covered services that have not been rendered;
- Services provided to teach academic subjects or as a substitute for educational personnel, including a: teacher, teacher's aide or an academic tutor;
- Services not identified on the individual's PCP;
- Services provided without prior authorization by the LME- MCO.