Home and Community-Based Services Expansion: Jail and Emergency Department Diversion

As Required By

The 2016-17 General Appropriations Act,
H.B. 1, 84th Texas Legislature, Regular Session, 2015
(Article II, Department of State Health Services, Rider 61b)

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Executive Summary

Many individuals with a diagnosis of serious mental illness (SMI)[1] have complex needs, which may lead to repeated arrests or emergency department (ED) visits. The frequency of arrests and ED visits could be minimized if these individuals had access to a home and community based program that closely coordinated needed services and community resources.

In response to legislative direction in the 83rd Regular Session of the Texas Legislature, the Department of State Health Services (DSHS) and Health and Human Services Commission (HHSC), the single state Medicaid agency, worked collaboratively to seek a Medicaid state plan amendment (SPA) under the Social Security Act §1915(i) to obtain federal financial participation for the Home and Community Based Services-Adult Mental Health (HCBS–AMH) program. DSHS, as one of five state agencies in the State's Health and Human Services enterprise (HHSC), operates under the authority and oversight of HHSC, the single state Medicaid agency. DSHS, a Medicaid operating agency, will administer the HCBS-AMH program under an executive directive by HHSC. The HCBS-AMH program is designed for adults (18 years old and older) with SMI and a history of extended inpatient psychiatric stays. DSHS, in collaboration with HHSC obtained federal approval for the HCBS-AMH SPA on October 13, 2015.

The General Appropriations Act, H.B. 1, 84th Texas Legislature, Regular Session, 2015 (Article II, DSHS, Rider 61b), requires DSHS to develop an HCBS program to divert populations with SMI from jails and EDs into community treatment programs. DSHS plans to request federal approval of additional populations into the HCBS–AMH program to include jail diversion and ED diversion.

Based on data analysis and forecasting projections, DSHS anticipates serving approximately 300 individuals in the HCBS-AMH jail diversion expansion program with an anticipated cost in state general revenue of $4.8 million ($9.5 million all funds) over the biennium. DSHS anticipates serving an additional 300 individuals in the HCBS-AMH ED expansion program with an anticipated cost in state general revenue of $4.7 million ($9 million all funds) over the biennium. These projected budgets assume general revenue will be utilized for fiscal year 2016 until the Center for Medicare and Medicaid Services (CMS) approves an amendment to the HCBS-AMH SPA. CMS approval of an amendment to include theses expansion populations is anticipated to take seven to nine months.

[1] Serious mental illness among people ages 18 and older is defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services as having, at any time during the past year, a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities.

Introduction

The 83rd Texas Legislature required Department of State Health Services (DSHS) to establish a Home and Community Based Services program for adults with serious mental illness (SMI) and a history of extended inpatient psychiatric hospital stays. The Legislature further directed Health and Human Services Commission (HHSC) and DSHS to seek a Medicaid state plan amendment (SPA) under §1915(i) of the Social Security Act. DSHS operates and administers Home and Community-Based Services – Adult Mental Health (HCBS-AMH) under executive directive and oversight by HHSC, the single state Medicaid agency. HCBS-AMH provides individualized services to support long-term recovery from mental illness, and is designed for individuals who have resided in a mental health facility long term. [2]

Each HCBS-AMH participant is assigned a "recovery manager" that supports the individual in all aspects of their recovery process, including assisting the individual in gaining access to needed services and other resources, making informed choices according to individual needs, resolving issues impeding recovery, and developing strategies/resources to promote recovery. In accordance with federal regulations, HCBS-AMH services must be provided in home and community based settings of the individual's choice, which may include individual homes, apartments, assisted living settings, and small community based residences. Services are designed to address unmet needs associated with SMI that may contribute to frequent or prolonged psychiatric hospitalization. Appendix 1 provides a description of the services available through HCBS-AMH.

Texas received federal approval of the HCBS-AMH SPA from Centers for Medicare and Medicaid Services (CMS) on October 13, 2015. DSHS continues implementation efforts of this program including provider recruitment and program outreach and education. These implementation efforts and experience of developing the existing HCBS-AMH program can be leveraged and has informed plans to expand HCBS to divert people with SMI from jails and avoidable ED visits.

The General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, Department of State Health Services, Rider 61b), requires DSHS to expand HCBS to divert populations from jails and EDs into community treatment programs. Prior to implementation, DSHS is required to submit a report of the projected program to the Governor's Office and Legislative Budget Board, with information including: an estimate of the total population to be served; projected costs, including average monthly cost per recipient; and potential cost-sharing opportunities with local entities that benefit from lower jail and ED admissions.

This report describes the plan developed by DSHS, in collaboration with HHSC, to expand HCBS to individuals with SMI and repeated arrests and avoidable ED visits. Each targeted population, jail diversion and ED diversion, has specialized needs and considerations for expansion of HCBS that are identified in this report.

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[2] The Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services defines recovery as: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

HCBS-AMH Jail Diversion Expansion Program

Needs of the Jail Diversion Population

An estimated 14 percent of men and 24 percent of women in jails have SMI, such as bipolar disorder or schizophrenia. National data indicates individuals with SMI enter the criminal justice system for minor crimes because there are insufficient resources for mental health care, and remain incarcerated longer than those without mental illness.[3] A report by the Texas Criminal Justice Coalition notes a general sentiment that inmates with mental health needs spend twice as long in jails compared to inmates with non-mental health issues for the same offense.[4]

The Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services has identified the following barriers that jeopardize recovery and increase re-arrests for individuals with SMI:

- Lack of health care
- Limited job skills and education
- Lack of stable housing
- Poor connection with community behavioral health providers[5]

HCBS-AMH Jail Diversion Expansion: Program Design

Barriers identified by SAMHSA for individuals with SMI and repeated arrests can be addressed by the services and individualized supports offered in the current HCBS-AMH program design. The General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, Department of State Health Services, Rider 61b), identified the need to divert individuals with repeated arrests into community treatment programs. Therefore, DSHS plans to amend the current HCBS-AMH SPA to expand HCBS-AMH services to divert individuals with repeated arrests combined with multiple psychiatric crises (i.e. inpatient psychiatric hospitalizations and/or crisis episodes requiring outpatient mental health treatment) into community based treatment. HCBS jail diversion services will be provided to individuals enrolled in Medicaid.

HCBS-AMH Jail Diversion Expansion: Estimated Population

DSHS analyzed data of fiscal years 2012-2015 to identify the needs of individuals with SMI served in the community. During fiscal years 2012-2015, 91 percent of these individuals were not admitted to the state hospital or arrested. Of the approximately nine percent who were hospitalized or arrested, over two thirds were hospitalized (72 percent) or arrested (67 percent) only once.[6] For the proposed HCBS-AMH jail diversion expansion program, individuals that

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[3] Substance Abuse and Mental Health Services Administration (SAMHSA). Criminal and Juvenile Justice. SAMHSA. http://www.samhsa.gov/criminal-juvenile-justice. Updated June 15 2015. Accessed October 9 2015.

[4] Texas Criminal Justice Coalition. Costly Confinement & Sensible Solutions: Jail Overcrowding in Texas. Texas Criminal Justice Coalition. http://www.texascjc.org/sites/default/files/publications/Costly%20Confinement%20Sensible%20Solutions%20Report%20%28Oct%202010%29.pdf. Published 2010. Accessed October 9 2015.

[5] Substance Abuse and Mental Health Services Administration (SAMHSA). Criminal and Juvenile Justice. SAMHSA. http://www.samhsa.gov/criminal-juvenile-justice. Updated June 15 2015. Accessed October 9 2015.

[6] Department of State Health Services, Division of Mental Health and Substance Abuse Services, Office of Decision Support, September 2015.

have been arrested and in crisis only once were excluded from the target population as they do not demonstrate as high of a need for the intensity of services.

DSHS assumes that individuals identified for the jail diversion expansion program will require a similar service array as the current HCBS-AMH program, but at a lower rate of utilization to live successfully in the community. Appendix 1 provides information about the HCBS service array. This assumption is based on DSHS calls with mental health professionals working with individuals with SMI and repeated arrests, analysis of existing mental health services utilization data, and a literature review of services for identified individuals in the jail diversion target group. In addition, DSHS hosted stakeholder meetings to gather feedback from mental health professionals, advocacy groups, family members, potential HCBS-AMH participants, and managed care organizations that have experience with services and supports for adults with SMI and repeated arrests.

Stakeholders verified that the services and supports offered through HCBS-AMH program are comprehensive and needed to successfully support individuals with SMI combined with repeated arrests. Stakeholders expressed a need for the State to increase communication and education with the criminal justice system for this expansion to be successful. In response to stakeholder input, DSHS initiated communication with criminal justice stakeholders in communities with interested HCBS-AMH providers. DSHS will continue to communicate with criminal justice staff across the state to provide education regarding eligibility, referral and enrollment, and services and supports offered in HCBS-AMH.

In maintaining consistency with the current HCBS-AMH program, the jail diversion expansion program will target individuals with serious and persistent needs for these intensive services. For individuals with SMI, DSHS defines serious needs as individuals who have a combination of arrests and psychiatric hospitalizations within the same year. For individuals with SMI, DSHS defines persistent needs as individuals who have a combination of arrests and psychiatric hospitalizations within the same year for multiple years.

In order to determine the estimated number to be served, DSHS analyzed characteristics of individuals with SMI who have been both arrested and hospitalized in a state hospital in the same fiscal year. Table 1 shows between fiscal year 2012 and 2015, the majority of individuals with serious and persistent needs have experienced only one year in which they were both arrested and hospitalized. In addition, these individuals with only one year of serious and persistent needs are the least likely to have Medicaid. This table demonstrates that those individuals with higher numbers of arrests and psychiatric hospitalizations are more likely to have Medicaid. Based on this data, DSHS plans to target individuals with two or more years in which they had both an arrest and psychiatric inpatient hospitalization in the same year. Overall, the number of individuals meeting these criteria represents less than three percent of the individuals with SMI served in the community by a local mental health authority (LMHA). This high needs population could benefit from the comprehensive and intensive services that can be offered through HCBS-AMH.[7]

[7] Department of State Health Services, Division of Mental Health and Substance Abuse Services, Office of Decision Support, September 2015.

Table 1. Characteristics of Jail Diversion Target Population

Number of Years with Both Arrests and Psychiatric Hospitalizations	Number of Individuals with Both Arrests and Psychiatric Hospitalizations	Percent with Medicaid	Average Number of Arrests During the Past Three Years	Average Number of Psychiatric Hospitalizations During the Past Three Years
1	4,653	39%	2.2	1.5
2	541	55%	4.5	3.6
3	93	68%	7.5	6.4

Note: This data represents a total of 4,653 non-duplicated individuals with both arrests and psychiatric hospitals between fiscal year 2012 and 2015. The number of individuals with multiple years of combination of arrests and psychiatric hospitalizations (541 with 2 years, 93 with 3 years) are duplicated counts.

Source: Department of State Health Services, Division of Mental Health and Substance Abuse Services, Office of Decision Support, September 2015.

HCBS-AMH Jail Diversion Expansion: Projected Budget

The projected budget and anticipated utilization assumes the following:

- DSHS anticipates serving approximately 300 non-duplicated individuals over the biennium. This projection is based on the data showing 55 percent of the individuals that meet the jail diversion target criteria are Medicaid eligible (see Table 1). Additionally, individuals who meet the target criteria must also to meet the functional level of need for the program. [8].
- DSHS calculated the projected jail diversion budget using services identified for the jail diversion population from the HCBS-AMH service array, utilization data that includes current rates for services in the HCBS-AMH program, and HHSC forecasting report.[9]
- Based on the above calculations DSHS estimates $2,409 as the average monthly cost per person enrolled in HCBS-AMH jail diversion expansion. This estimate is consistent with other home and community based programs within the five state agencies in the State's Health and Human Services enterprise.
- Based on available funds, DSHS estimates the ability to serve approximately 120 non-duplicated individuals in fiscal year 2016 and enroll approximately 180 additional non-duplicated individuals in fiscal year 2017.
- The projected budget includes anticipated ramp up in both fiscal years to reach the estimated number served. DSHS anticipates a six month ramp up to serve 120 individuals in fiscal year 2016 and a four-month ramp-up to serve all 300 individuals in fiscal year 2017.

[8] Functional level of need refers to the level of functional impairment associated with the individual's mental health needs. The level of functional impairment must rise to the level that it requires HCBS-AMH services for an individual to be eligible for the program.

[9] Forecasting is the process of making predictions about the future based on past and present data and analysis of trends. A common example is the estimation of some variable of interest at some specified future date, for example, future years client enrollment or service cost based on the last several years of data. Forecasting typically involves statistical methods, ranging from simple averages, to complex time series models. The Office of System Forecasting is a division of HHSC responsible for the caseload and cost forecasting functions for many health and human services programs, including Medicaid.

The projected budget identified in Table 2 assumes general revenue will be utilized for fiscal year 2016 until CMS approves an amendment to the HCBS-AMH SPA.[10] CMS approval of an amendment to include the jail diversion population to the HCBS-AMH SPA is anticipated to take seven to nine months.

Table 2. Budget for Jail Diversion Expansion

Fiscal Year	Estimated New Enrollment	State Funds	Federal Funds	Annual Total
FY 2016	120	$1,135,275	$0	$1,135,275
FY 2017	180	$3,619,777	$4,741,916	$8,361,693
Biennial Total	**300**	**$4,755,052**	**$4,741,916**	**$9,496,968**

Source: Health and Human Services Commission, Division of Medicaid, Office of System Forecasting, November 2015.

HCBS-AMH Jail Diversion Expansion: Potential Local Cost-Sharing Opportunities
DSHS will engage community stakeholders and local resources in the jail diversion expansion program. Starting in November 2015, DSHS began holding meetings with community stakeholders including healthcare providers, LMHAs, housing providers, local governments, and criminal justice and judicial systems to discuss the HCBS-AMH jail diversion expansion program and to identify cost-sharing opportunities.

Specifically, DSHS plans to leverage local affordable and permanent supported housing resources because affordable, community-integrated housing is a key component of any HCBS program. Gaining access to affordable housing is currently a barrier for individuals with SMI and repeated arrests. The factors that lead to this barrier include lack of housing stock and housing providers. Additionally, landlords are frequently unwilling to amend screening criteria that excludes individuals due to criminal background and/or credit and rental histories. Educating local entities about the supports and resources available to individuals enrolled in HCBS-AMH will aid local entities in understanding the need to leverage financial resources and relationships with housing providers to address this problem.

HCBS-AMH Emergency Department Diversion Expansion

Needs of the Emergency Department Diversion Population
Individuals with psychiatric disorders are more likely to use EDs on multiple occasions and have multiple hospitalizations, compared to individuals without psychiatric disorders.[11] For mental health and substance use ED visits, mood disorders are the most common (42.7 percent), followed by anxiety disorders (26.1 percent), and alcohol-related conditions (22.9 percent). The

[10] Health and Human Services Commission, Division of Medicaid, Office of System Forecasting, September 2015.
[11] The American College of Emergency Physicians (ACEP). ACEP Psychiatric And Substance Abuse Survey 2008. ACEP. http://www.acep.org/uploadedFiles/ACEP/newsroom/NewsMediaResources/StatisticsData/Psychiatric%20Boarding%20Summary.pdf. Published April 2008. Accessed October 9 2015.

remaining common conditions included drug-related conditions, schizophrenia and other psychoses, and intentional self-harm.[12] Hospital readmission is also more likely if an individual has a major mental health or substance use condition as a secondary diagnosis, even for medical and surgical admissions.

HCBS-AMH Emergency Department Diversion: Program Design

Case management, individualized care plans, and peers are integral services and supports for improving clinical and social outcomes, decreasing cost, and decreasing overall number of ED visits among frequent ED users.[13, 14, 15] The services and supports available through the current HCBS-AMH program (detailed in Appendix 1) are aligned with these integral services and supports. A few key services likely to be utilized by the ED diversion population include recovery management, long-term nursing services, housing supports, and peer support. The current HCBS-AMH program supports individualized service coordination through "recovery managers" who ensure a flexible array of services will be tailored to meet the needs of this population. The General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, Department of State Health Services, Rider 61b), identified the need to divert individuals with repeated ED visits into community based treatment. DSHS plans to amend the current HCBS-AMH SPA to expand HCBS-AMH services to meet this legislative direction. HCBS ED diversion services will be provided to individuals enrolled in Medicaid.

In addition, DSHS has begun to seek stakeholder input to inform program design specific to this population and establish specific program characteristics required for successful program expansion. Development of HCBS-AMH ED diversion will be informed by stakeholders, such as managed care organizations (MCOs) and local entities that might partner in the project. An HCBS ED diversion workgroup comprised of DSHS and HHSC began meeting in early September 2015. The workgroup is seeking Medicaid MCO stakeholder feedback for individuals with SMI that are ED high utilizers to meet the needs of the ED diversion expansion population.

HCBS-AMH Emergency Department Diversion: Estimated Population

DSHS analyzed data between fiscal years 2012 and 2014 to identify the needs of individuals with SMI and repeated ED visits. During this three year period, 14,741 individuals with SMI were identified as having an average of 1.61 ED visits related to a mental health diagnosis and 3.86 overall ED visits. DSHS further analyzed the 14,741 individuals and identified

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[12] Owens P.L., Mutter R., Stocks C. *Mental Health and Substance Abuse-Related Emergency Department Visits among Adults, 2007*. HCUP Statistical Brief #92. Agency for Healthcare Research and Quality, Rockville, MD. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb92.pdf. Published July 2010. Accessed October 9, 2015.

[13] American College of Emergency Physicians (ACEP). Care of the Psychiatric Patient in the Emergency Department – A Review of the Literature. ACEP. http://www.acep.org/uploadedFiles/ACEP/Clinical_and_Practice_Management/Resources/Mental_Health_and_Substance_Abuse/Psychiatric%20Patient%20Care%20in%20the%20ED%202014.pdf. Published October 2014. Accessed October 9 2015.

[14] Kumar, G. S., & Klein, R. Effectiveness of case management strategies in reducing emergency department visits in frequent user patient populations: a systematic review. *The Journal of Emergency Medicine*. 2013; *44*: 717-729.

[15] Emergency Nurses Association (ENA). White Paper: Care of the psychiatric patient in the emergency department. https://www.ena.org/practice-research/research/Documents/WhitePaperCareofPsych.pdf. ENA. Published February 2013. Accessed October 9 2015.

833 individuals who had a substantially higher average number of mental health ED visits (11.57 compared to 1.61) and number of overall ED visits (26.9 compared to 3.86).

Table 3 demonstrates the correlation between the numbers of years an individual seeks mental health treatment from an ED to an increase in the average number of total ED visits. This suggests that the comprehensive and intensive intervention of HCBS-AMH services is best targeted toward the population who demonstrates a persistent need. Based on this data, DSHS will target the ED diversion expansion program to individuals with a diagnosis of SMI who have a high incidence of ED visits each year during the three years prior to enrollment into the program. In addition, DSHS will continue to refine projections for the needs-based criteria required for an amendment to the HCBS-AMH SPA to include the ED diversion population.

Table 3. Characteristics of ED Diversion Target Population

Number of Years in Which an Individual had an ED Visit Related to a Mental Health Diagnosis	Number of Individuals who had an ED Visit Related to a Mental Health Diagnosis	Percent with Medicaid (Data Based on Medicaid ED Visits)	Annual Average Number of ED Visits Related to a Mental Health Diagnosis ED Visits per Individual	Annual Average Number of Total ED Visits per Individual
1	14,741	100%	1.61	3.86
2	2,862	100%	4.67	12.01
3	833	100%	11.57	26.9

Note: This data analysis includes all DSHS clients who had a Medicaid ED visit. Mental health diagnosis includes International Statistical Classification of Diseases and Related Health Problems (ICD-9) codes 290-319.00. The broad categories of mental health diagnosis include: psychosis (organic psychotic conditions, other disorders including, but not limited to, schizophrenia and episodic mood disorders); neurotic disorders, personality disorders, and other nonpsychotic mental disorders; substance use disorders; and mental disorders diagnosed in childhood.

Source: Department of State Health Services, Division of Mental Health and Substance Abuse Services, Office of Decision Support, November 2015.

HCBS-AMH Emergency Department Diversion: Projected Costs
The projected budget and anticipated utilization assumes the following:

- DSHS anticipates serving approximately 300 non-duplicated individuals over the biennium. This projection is based on data analysis of individuals with high intensity service needs. Individuals who meet the target criteria must also to meet the functional level of need for the program.

- DSHS calculated the projected budget using an estimated $2,136 average monthly cost per person. This calculation is based on identified services and needs of the ED populations, utilization data that includes rates and services in the current HCBS-AMH program, and HHSC forecasting results.[16]
- Based on available funds, DSHS estimates the ability to extend HCBS to approximately 180 non-duplicated participants in fiscal year 2016 and an additional 120 non-duplicated participants in fiscal year 2017.[17]
- The projected budget includes anticipated ramp up in both fiscal years to reach the estimated number served. DSHS anticipates a six month ramp up to serve 180 individuals during fiscal year 2016 and a four month ramp up to serve 300 individuals during fiscal year 2017.

The projected budget included in Table 4 assumes general revenue will be utilized for fiscal year 2016 until CMS approves an amendment to the HCBS-AMH SPA.[18] CMS approval of an amendment to include the ED diversion population to the HCBS-AMH SPA is anticipated to take seven to nine months.

Table 4. Budget for ED Diversion Expansion

Fiscal Year	New Enrollment	State Funds	Federal Funds	Annual Total
FY 2016	180	$1,494,050	$0	$1,494,050
FY 2017	120	$3,239,285	$4,243,470	$7,482,755
Biennial Total	**300**	**$4,733,335**	**$4,243,470**	**$8,976,805**

Source: Health and Human Services Commission, Division of Medicaid, Office of System Forecasting, November 2015.

HCBS-AMH Emergency Department Diversion: Potential Local Cost-Sharing Opportunities

DSHS will collaborate with Medicaid MCOs, community mental health providers, and local government entities to discuss further cost-sharing opportunities. Additionally, participating service providers or housing providers may have housing resources to leverage with the addition of a state-funded ED diversion expansion program.

Conclusion

Many Texas Medicaid clients with SMI and other behavioral health disorders unnecessarily cycle in and out of jails and EDs, in part due to unmet behavioral health needs and a lack of sufficient HCBS to address those needs. DSHS will expand HCBS to individuals with SMI and repeated arrests and avoidable ED visits with the aim of reducing potentially preventable arrests and ED visits. DSHS plans to expand HCBS for the diversion populations by changing the current HCBS-AMH program to include the jail diversion and ED diversion populations. It is

[16] Health and Human Services Commission, Division of Medicaid, Office of System Forecasting, September 2015.
[17] Health and Human Services Commission, Division of Medicaid, Office of System Forecasting, November 2015.
[18] Health and Human Services Commission, Division of Medicaid, Office of System Forecasting, September 2015.

anticipated that the impact of these efforts will begin to address issues of both repeated arrests and avoidable ED visits for adults (18 years old and up) with SMI. Implementation of these programs will likely have an impact at both the state and local levels and ultimately improve the quality of life for many individuals with SMI.

Appendix 1: HCBS-AMH Service Definitions

Adaptive Aids

Specialized equipment and supplies including devices, controls, and appliances that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not otherwise available under the Medicaid State Plan.

Host-Home/Companion Care

Host-Home/Companion Care provides personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene) and functional living tasks; assistance with planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulation and mobility; reinforcement of cognitive training or specialized mental health therapies/activities; assistance with medications based upon the results of an assessment completed by a registered nurse (RN); and supervision of the individual's safety and security. Host home/companion care is provided in a private residence by a host home or companion care provider who lives in and owns or leases the residence.

Assisted Living

Personal care, homemaker, and chore services; medication oversight; and therapeutic, social, and recreational programming provided in a home-like environment in a licensed community setting. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security.

Supervised Living Services

Supervised Living Services fosters recovery and independence by providing individuals with personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene) and functional living tasks; assistance with planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulation and mobility; reinforcement of specialized rehabilitative, habilitative or psychosocial therapies; assistance with medications based upon the results of an RN assessment; and supervision of the individual's safety and security. Supervised living provides residential assistance as needed by individuals who live in residences in which the HCBS-AMH provider holds a property interest and that meet program certification standards.

Supported Home Living

Assists individuals living in the individual's own or family residence which are not provider owned or operated. Direct personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene)and functional living tasks; assistance with planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulation and mobility; reinforcement of behavioral support or specialized therapies activities; assistance with medications and the performance of tasks delegated by a registered nurse; and

supervision as needed to ensure the individual's health and safety; and supervision of the individual's safety and security.

Community Psychiatric Supports and Treatment
Goal directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the individual's Individual Recovery Plan (IRP).

Employment Services
Employment services help people with severe mental illness work at regular jobs of their choosing and to achieve goals meaningful to them, such as increasing their economic security.

Employment Assistance
Helps the individual locate and maintain paid employment in the community and may include activities on behalf of the individual to assist in maintaining employment.

Supported Employment
Provides individualized services to sustain individuals in paid jobs in regular work settings; who, because of disability, require support to be self-employed, work from home, or perform in a work setting at which individuals without disabilities are employed.

Peer Support
Services provided by self-identified consumers who are in recovery from mental illness and/or substance use disorders to help individuals reach their recovery goals. Services promote coping skills, facilitate use of natural resources/supports, and enhance recovery-oriented attributes such as hope and self-efficacy.

Home Delivered Meals
Provides a nutritionally sound meal to individuals, which is delivered to the individual's home.

Minor Home Modifications
Physical adaptations to an individual's home that are necessary to ensure the individual's health, welfare, and safety, or that enable the individual to function with greater independence in the home.

Nursing
HCBS-AMH Nursing cover ongoing chronic conditions such as wound care, medication administration (including training, monitoring, and evaluation of side effects), and supervising delegated tasks.

Recovery Management
Services assisting individuals in gaining access to needed Medicaid State Plan and HCBS-AMH services, as well as medical, social, educational, and other resources, regardless of funding source.

HCBS Psychosocial Rehabilitation Services
Evidence-based or evidence-informed interventions which support the individual's recovery by helping the individual develop, refine and/or maintain the skills needed to function successfully in the community to the fullest extent possible.

Respite Care
Respite is a service that provides temporary relief from care giving to the primary caregiver of an individual during times when the individual's primary caregiver would normally provide care.

Substance Use Disorder services
Assessment and ambulatory group and individual counseling for substance use disorders. Services are specialized to meet the needs of individuals who have experienced extended institutional placement.

Transition Assistance Services (TAS)
Payment of set-up expenses for individuals transitioning from institutions into community settings necessary to enable individuals to establish basic households.

Transportation Services
Transportation is offered in order to enable individuals served to gain access to services, activities, and resources, as specified in the individual recovery plan.