Community Integration Plus (CIS+) Responsibilities

(Appendix A)

Updates to this document are inserted as shaded text and voided text from the previous version is stricken.

This document describes the benefits and responsibilities associated with Housing Navigation ~~Supports~~ and Medical Respite. Health Plans have primary responsibility for the implementation of these activities but may opt to delegate the activities defined below to their contracted CIS+ Providers. If a Health Plan chooses to delegate the identified activities to a contracted provider, MQD expects that implementation efforts between Health Plans and CIS+ Providers are coordinated and collaborative. CIS+ services will be furnished only to the extent it is reasonable and necessary as clearly identified through an enrollee's person-centered service plan, when the enrollee is eligible for the service, and when the services cannot be obtained from other sources. The CIS+ program is voluntary for members.

Housing Navigation ~~Supports~~	
Service	**Responsibilities**
Pre-Tenancy Supports	i. Engaging members and obtaining consent from them to participate in CIS+ via multiple modalities, including via mail, text, phone, email, street-level engagement, and in person meetings where the member lives, seeks care or other social services. ii. Connecting individuals to settings or programs where identified basic needs can be immediately met, such as access to shower, laundry, shelter, and food. iii. Working with the member to provide information necessary for and to conduct a housing needs assessment to: identify the member's preferences related to housing (e.g., type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the individual); and provide assistance in budgeting for housing and living expenses. iv. Providing members who may have needs for medical, peer, social, educational, legal, and other related services with information and logistical support. Activities include but are not limited to assisting members with connecting to services, helping members find and apply for necessary supports to meet their needs, assisting with filling out applications and submitting appropriate documentation to obtain sources of income necessary for community living and establishing credit, supporting understanding and meeting obligations of tenancy, and other referral activities. v. Developing an individualized care plan based upon the housing needs assessment. Identifying and establishing short and long-term measurable goal(s) and establishing how goals will be achieved and how concerns will be addressed. Examples of short-term goals could include: identifying housing needs and preferences; assistance with move in arrangements, support from service coordinator to ensure the housing unit is safe, meets the member's needs and ready for move in; support from

	service coordinator in acquiring necessary documentation for housing application and move in; assisting with housing search and completing housing applications; assistance from service coordinator during any housing interviews with landlords or property managers for emotional or behavioral support; requests for reasonable accommodations or appeals after housing application denials). vi. Participating in care plan meetings at enrollment, redetermination and/or revision plan meetings, as needed. vii. Providing supports and interventions per the person-centered plan. viii. Assisting in obtaining identification/ documentation (e.g., Social Security card, birth certificate, prior rental history) needed to apply for and receive benefits and other supports. ix. Assisting members with connecting to social services and the Coordinated Entry System homeless and housing service providers, to help with finding and applying for independent housing necessary to support the member to meet their medical care needs. x. Coordinating and linking the recipient to services and service providers including primary care and health homes; substance use treatment providers; mental health providers; medical, vision, nutritional and dental providers; vocational, education, employment and volunteer supports; hospitals and emergency rooms; probation and parole; crisis services; end of life planning; and other support groups and natural supports. xi. Conducting a needs assessment identifying the member's preferences related to housing (e.g., type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the individual); providing assistance in budgeting for housing and living expenses; assistance in connecting the individual with social services to assist with filling out applications and submitting appropriate documentation in order to obtain sources of income necessary for community living and establishing credit, and in understanding and meeting obligations of tenancy.
Tenancy Sustaining Services	i. Service planning support and participating in care plan meetings at enrollment, redetermination, and/or revision plan meetings, as needed. This should include the development of a crisis plan or eviction prevention plan, created with the member, that includes the early identification of behaviors that could jeopardize tenancy (for example: noise violations, late rent payments, violent or threatening behaviors, guests overstaying guest policy) ii. Entitlement assistance including assisting members in obtaining, maintaining, or renewing documentation, navigating and monitoring application/renewal process, and coordinating with the

	entitlement agency and/or Coordinated Entry providers. iii. Assistance in accessing supports to preserve the most independent living environment such as individual and family counseling, support groups, and natural supports. iv. Providing supports to assist the member in the development of independent living skills, such as skills coaching, financial counseling, and anger management. v. Providing supports to assist the member in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager. This may include support in creating an eviction prevention plan with the tenant, advocating for a rent repayment plan, or, if eviction proceedings begin, seeking a mutual rescission agreement with the landlord to prevent an eviction on the member's record. vi. Coordinating and linking the member to services and service providers including primary care and health homes; substance use treatment providers; mental health providers; medical, vision, nutritional and dental providers; vocational, education, employment and volunteer supports; hospitals and emergency rooms; probation and parole; crisis services; end of life planning; and other support groups and natural supports. vii. Coordinating with the member to review, update, and modify housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers. viii. Connecting the member to training and resources that will assist the individual in being a good tenant and complying with the terms of their lease, including ongoing support with activities related to household management. ix. Providing members who may have continued or newly identified needs for medical, peer, social, educational, and other related services with information and logistical support. Activities include but are not limited to assisting members with connecting to services, helping members find and apply for necessary supports to meet their needs, and other referral activities. x. Assisting the individual by referring the member to expert community resources to address legal issues impacting housing and thereby adversely impacting health, such as assistance with breaking a lease due to unhealthy living conditions. This service does not include legal representation or payment for legal representation.

Medical Respite	
Service	**Responsibilities**
Short-Term Pre-Procedure Housing	i. Providing short-term housing prior to those who have a planned medical procedure requiring preparation care (e.g., colonoscopy) or who have a planned medical treatment requiring care prior to or following treatment (e.g., chemotherapy treatment). Housing requirements include: a. A private or semi-private[1] sleeping space available to the member 24 hours a day, b. Onsite showering and laundering facilities; c. Clean linens upon admission; d. Secured storage for personal belongings and medications; and e. At least three meals a day provided. ii. When applicable and appropriate, providing clinically oriented recuperative or rehabilitative services and supports. Services are only provided for a clinically appropriate period of time and may include but are not limited to: a. Offering medication support for members who self-manage medication, or managing medication via licensed clinical staff in collaboration with the member; b. Providing at least one wellness check every 24 hours (clinical or non-clinical staff); c. Providing access to non-emergency telemedicine or nurse line; d. Providing and/or coordinating transportation to and from needed health and health related services (e.g., pre-procedure labs, to obtain prescriptions or medical supplies, post operative appointments, etc.) and social services (e.g., appointments related to housing navigation ~~supports~~). When transportation needs exceed what the provider can reasonably accommodate (e.g., inter-island travel or other extensive transportation requirements), the provider should coordinate with the member's Health Plan to arrange and authorize transportation through covered non-emergency medical transportation (NEMT) ~~or non-medical transportation (NMT) benefits~~; and e. Reporting incidents, member concerns, and notable changes in the member's condition to the member's designated medical provider, other respite staff members working the oncoming shift, and other entities such as QI Health Plans, as appropriate. iii. When applicable and appropriate, collaborating with Health Plans to coordinate activities for physical health, behavioral health, and social needs. Such activities may include but are not limited

[1] In the CIS+ Guidance Memo, semi-private is defined as rooms with beds for two (2) to four (4) individuals that affords the member a sleeping space with privacy. ~~Includes appropriate semi-private settings, such as those with dividers for privacy.~~

	to: a. Screening for unmet health or social needs; b. Connecting the individual to community programs, such as substance use programs, and social benefits in collaboration with the Health Plan; c. Coordinating with relevant case management, Health Coordination, or care management entities, including the QI Health Plan, CCS Behavioral Health Plan and/or the Housing Navigation ~~Supports~~ Provider; and d. Participating in person-centered plan meetings at CIS+ redetermination and/or revision plan meetings, as needed.
Short-Term Recuperative Care	i. Providing up to 90 days of short-term residential care to support ongoing medical and psychiatric needs. Housing requirements include: a. A private or semi-private[2] sleeping space available to the member 24 hours a day, b. Onsite showering and laundering facilities; c. Clean linens upon admission; d. Secured storage for personal belongings and medications; and e. At least three meals a day provided with monitoring and supporting of nutrition and diet. ii. Providing clinically oriented recuperative or rehabilitative services and supports. Services may include but are not limited to: a. Providing basic medical clinical services onsite, including monitoring vital signs, conducting assessments, wound care, and other support services; b. Offering medication support for members who self-manage medication, or managing medication via licensed clinical staff in collaboration with the member; c. Ongoing monitoring of the member's condition by clinicians; d. Providing at least one wellness check every 24 hours (clinical or non-clinical staff); e. Providing access to non-emergency telemedicine or nurse line; f. Providing and/or coordinating transportation to and from needed health and health related services (e.g., pre-procedure labs, to obtain prescriptions or medical supplies, post operative appointments, etc.) and social services (e.g., appointments related to housing navigation ~~supports~~). When transportation needs exceed what the provider can reasonably accommodate (e.g., inter-island travel or other extensive transportation requirements), the provider should coordinate with the member's Health Plan to arrange and authorize

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	transportation through covered non-emergency medical transportation (NEMT) ~~or non-medical transportation (NMT) benefits~~; and g. Reporting incidents, member concerns, and notable changes in the member's condition to the member's designated medical provider, other respite staff members working the oncoming shift, and other entities such as QI Health Plans, as appropriate. iii. When applicable and appropriate, supporting collaborating with Health Plans to coordinate activities for physical health, behavioral health, and social needs. Such activities may include but are not limited to: a. Screening for unmet health or social needs; b. Connecting the individual to community programs, such as substance use programs, and social benefits, in collaboration with the Health Plan; c. Coordinating with relevant case management, Health Coordination, or care management entities, including the QI Health Plan, CCS Behavioral Health Plan and/or the Housing Navigation ~~Supports~~ Provider; and d. Participating in person-centered plan meetings at CIS+ redetermination and/or revision plan meetings, as needed.
Short-Term Post-Hospitalization Housing	i. Providing up to six months of short-term housing for individuals who do not have a residence to continue recovery for physical, psychiatric, or substance use conditions following discharge or exit from an institution. Housing requirements include: a. A private or semi-private[3] sleeping space available to the member 24 hours a day, b. Onsite showering and laundering facilities; c. Clean linens upon admission; d. Secured storage for personal belongings and medications; and e. At least three meals a day provided with monitoring and supporting of nutrition and diet. ii. Providing clinically oriented recuperative or rehabilitative services and supports. Services may include but are not limited to: a. Offering medication support for members who self-manage medication, or managing medication via licensed clinical staff in collaboration with the member; b. Providing at least one wellness check every 24 hours (clinical or non-clinical staff); c. Providing access to non-emergency telemedicine or nurse line; d. Providing and/or coordinating transportation to and from needed health and health-related

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	services (e.g., pre-procedure labs, to obtain prescriptions or medical supplies, post operative appointments, etc.) and social services (e.g., appointments related to Housing Navigation ~~Supports~~). When transportation needs exceed what the provider can reasonably accommodate (e.g., inter-island travel or other extensive transportation requirements), the provider should coordinate with the member's Health Plan to arrange and authorize transportation through covered non-emergency medical transportation (NEMT) ~~or non-medical transportation (NMT) benefits~~; and e. Reporting incidents, member concerns, and notable changes in the member's condition to the member's designated medical provider, other respite staff members working the oncoming shift, and other entities such as QI Health Plans, as appropriate. iii. When applicable and appropriate, in collaboration with the Health Plan to coordinate activities for physical health, behavioral health, and social needs. Such activities may include but are not limited to: a. Screening for unmet health or social needs; b. Connecting the individual to community programs, such as substance use programs, and social benefits, in collaboration with the Health Plan; c. Coordinating with relevant case management, Health Coordination, or care management entities, including the QI Health Plan, CCS Behavioral Health Plan and/or the Housing Navigation ~~Supports~~ Provider; and d. Participating in person-centered plan meetings at CIS+ redetermination and/or revision plan meetings, as needed.