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Housing Support Providers Training

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Agenda

- Housing Support – Authorization Process
- DBHDD Service Definition
- Billable Services
- Documentation Requirements
- Encounter/Claims Submissions
- Questions/Answers
- Resources

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Chapter

01

Housing Support – Authorization Process

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“HSUP” GHV Housing Supports Authorization

Level of Service	Type of Service	Type of Care Code	Type of Care Description	Service Class Code	Service Groups Available	Service Description	Initial Auth		Concurrent Auth		Max Daily Units	Place of Service
							Max Auth Length	Max Units Auth'd	Max Auth Length	Max Units Auth'd		
BFHV	HV	HV	Georgia Housing Voucher[1]	GHV	20515	Housing Voucher	See note[1]	See note[1]	See note[1]	See note[1]	See note[1]	See note[1]
Outpt	MH, SU, MHSU	HSUP	GHV Housing Supports	BHA	10101	BH Assmt & Service Plan Development	180	8	275	8	8	11, 12, 53, 99
				CMS	21302	Case Management	180	140	275	140	24	11, 12, 53, 99
				PSI	20306	Peer Support – Adult - Individual	180	520	275	520	48	11, 12, 53, 99
				PSR	10151	Psychosocial Rehabilitation - Individual	180	300	275	300	48	11, 12, 53, 99
				ADS	10152	Addictive Disease Support Services	180	100	275	100	48	11, 12, 53, 99
				CIN	10110	Crisis Intervention	180	64	275	64	16	11, 12, 53, 99
				CT1	21202	Community Transition Planning	180	32	275	32	24	11, 12, 53, 99
				CL4	20514	Community Residential Rehabilitation 4	180	36	275	36	8	11, 12, 53, 99

“HSUP” GHV Housing Supports Authorization

- Housing Supports providers must submit/receive an authorization from the Georgia Collaborative to bill DBHDD services
- The HSUP authorization allows providers to bill services for housing-related services
- Once an HSUP authorization is received, the provider can bill all the services on the previous slide (per contract/DBHDD Provider Manual)
- The billable services will be reviewed throughout this training

Chapter

02

DBHDD Service Definition

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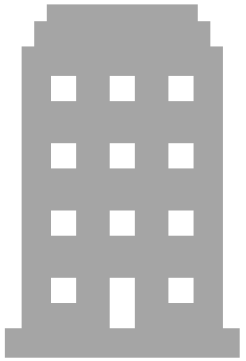
Housing Support – Service Definition

All GHVP-enrolled individuals are required to engage in the Housing Support program to promote community integration, coordination of desired services, and long-term housing stability



The Housing Support program (HSP) is a required element of the program for all individuals entering the Georgia Housing Voucher Program (GHVP) or renewing their lease under GHVP, as of April 1, 2022

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Housing Support – Service Definition

The Housing Support program is comprised of multiple supports designed to assist individuals living in permanent supportive and/or subsidized housing to promote ongoing housing stability and provide a foundation for recovery

- Assistance with housing search, leasing, and move-in processes;
- Purchase of initial household furnishing, deposits, household goods for the one-time move-in needs;
- Safety and wellness checks and housing safety inspections;
- Developing a Housing Stability Support Plan as an adjunct to an individual's IRP;
- Early intervention to mitigate factors impacting housing stability (e.g., late rent payment, lease violations, tenant/landlord or property owner conflicts);
- Education on the roles, responsibilities, and rights of tenant(s) and the landlord/property owner; and
- Assistance with the annual housing recertification and inspection process.

All individuals enrolled in the Housing Support program shall receive any of the following supports, according to their needs and preferences:

1. Completion of supportive housing referral and application processes;

2. Landlord engagement, recruitment, and enrollment;

3. Coaching on relationship-building with landlords/ property owners, managers, and neighbors, and assisting in dispute resolution; and

4. Linking with community resources to prevent eviction.

HOUSING STABILITY IS MEASURED BY:

- Ongoing housing
- Decreased number of hospitalizations/ER visits/incarcerations
- Decreased frequency and duration of crisis episodes
- Increased and/or stable participation in maintenance of personal housing stability and wellness

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The Housing Support staff will serve as the first point of contact for landlords/ property owners for any issues arising with an individual in supportive housing, and will provide linkage to:

- Community
- General entitlements
- Psychiatric, substance use disorder, medical services, crisis prevention, and intervention services.

Housing Support providers **are expected** to bill any of the following DBHDD behavioral health services associated with the "HSUP" GHV Housing Supports authorization, *as necessary*:

- Behavioral Health Assessment (BHA)
- Service Plan Development
- Case Management (CM)
- MH and/or SUD Peer Supports (PS)
- Psychosocial Rehabilitation – Individual (PSR-I)
- Addictive Disease Support Services (ADSS)
- Crisis Intervention
- *Community Residential Rehabilitation (CRR-IV)
- *Community Transition Planning (CTP)

**If approved per contract*

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Housing Support providers are **NOT allowed** to bill the following DBHDD behavioral health services:

Community Residential Rehabilitation Levels 1-3 (unless individual has a voucher for subsidized housing and is seeking a transition out of a residential program into permanent housing).

Addictive Disease Residential Programs are excluded, as supports are already a part of those programs and they typically do not serve individuals living with SPMI.

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Required Components

The Housing Support program must be provided through a team approach (as evidenced in documentation).

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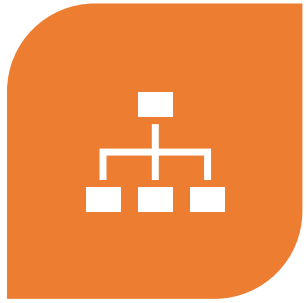
Focuses on building and maintaining a positive relationship with the individual, facilitating needed independent living supports, and working toward recovery goals.

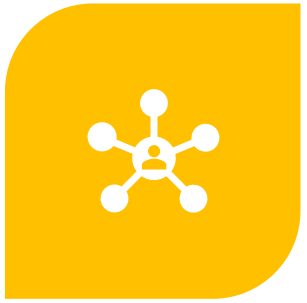
Staffing Requirements

Housing Support providers must, at a minimum, have the following positions on staff:



One (1) FTE Program Director dedicated to the program (licensed: LCSW, LPC, or LMFT).

At least one (1) FTE clinically licensed professional providing clinical support and oversight of care across the team's caseload. This position may also be the Program Director/Manager, if appropriate, based on the agency's average caseload size.

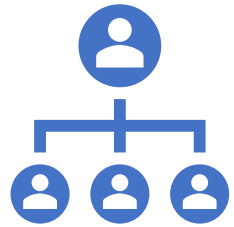


At least one (1) FTE Housing Specialist/Case Manager (practitioners who can provide Case Management services as defined in the BH Provider Manual) who is responsible for providing all the supports described herein.

Staffing Requirements

Peer Support is a critical component of recovery. Individuals being served by a Housing Support provider must have access to a CPS-MH that can provide Peer Support services. There must be documented engagement by the staff team with a CPS-MH. The hiring of Certified Peer Specialists or individuals who can earn their Certification within 12 months for any position shall be prioritized.

Housing Support must maintain an average (i.e. across all Housing Support staff members) maximum ratio of 25 individuals per staff member; however, a ratio of 20 individuals per staff member is recommended.



Provider must adhere to the Staffing Requirements section of the Service Definition/Requirements for the specific DBHDD service being provided, as well as to all other staffing/professional requirements found elsewhere in the DBHDD's Provider Manual for Community Based Behavioral Health Providers.

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Required Components

The Housing Support program must include a variety of interventions to assist the individual in developing:

- Recovery orientation and skills to work toward their personal recovery goals related to their ability to live independently.
- Illness self-monitoring and self-management of symptoms.
- Strategies and supportive interventions for developing positive relationships/avoiding conflicts with neighbors and property owner.
- Relapse prevention strategies and plans.
- All interventions are billable with corresponding documentation in a progress note.

Required tasks include checking on and documenting the following monthly:

- Individual wellness, need for additional supports or connection to other community resources;
- Household wellness, health and safety of the housing unit;
- Community integration and relationships with property/neighbors;
- Household financial stability.

Required Components: Contacts

New referrals should receive a first contact attempt within 2 business days.

Services must be provided at a time that accommodates individuals' needs, which may include during evenings, weekends, and holidays.

Contact must be made a **minimum of once a week while an individual is searching for housing**.

Once in subsidized housing, Housing Support teams must provide scheduled visits to an individual's home to provide supports and establish a relationship of trust.

- Contact must be made **a minimum of once a week during the first three months** to ensure individuals remain stabilized.

The minimum contacts **are** billable services (Case Management or PSR-I).

Required Components – Contacts

After the first three months of being housed, then contact frequency may decline but must continue to be made a minimum of twice each month, one of which must be in the individual's residence and the required tasks on the previous slide.

Half of Housing Support contacts must be face-to-face, and the other half may be either face-to-face or telephone contact depending on the individual's support needs and documented preferences.

A staff person must be available 24/7 to respond to emergency calls.

Required Components – Contacts

Individuals who have established a documented and substantial level of stability and independence with managing their residence and personal health needs, as evidenced by no mental/physical health crisis events nor eviction-risk events in the last 6 months, may receive a reduced level of contact in the form of at least one face-to-face (in-person) visit monthly.

- Individual preferences must still be taken into account.
- The service provider cannot reduce frequency if the individual wishes to maintain the baseline requirement of contact frequency (twice each month/once at the residence).
- Individuals with this level of stability must receive assistance in determining eligibility and applying for a transition to the Housing Choice Voucher program, utilizing the preferential access granted to individuals belonging to the settlement target population.

Required Components

Individuals being supported through Housing Supports who report zero income must receive assessment for employment supports and should receive appropriate referral to employment resources and/or federal benefits such as SSI/SSDI through the SOAR program in tandem with their housing referral.

Individuals receiving housing supports who continue to report no income must receive assistance with pursuing employment and benefit options.

Households must receive assistance with establishing and maintaining household food security. This includes applying for mainstream food benefits, e.g. SNAP, WIC, and meeting recurring requirements to maintain those benefits, as well as understanding how to access and utilize local food bank programs (find information onhttps://feedinggeorgia.org/).

Mainstream benefits in Georgia can be applied for and maintained through the Georgia Gateway portal (https://gateway.ga.gov/)

Households must receive assistance with applying to federal subsidy programs that reduce the cost of phone and internet access, such as the Lifeline Program(https://www.lifelinesupport.org/) or Assistance Connectivity Program(https://www.affordableconnectivity.gov/).

Required Components

Provider must support eligible individuals with application and transition to federally funded Housing Choice Voucher (HCV) program with the use of the preferential access for individuals belonging to the settlement target population (i.e. GHVP eligibility criteria).

Individuals can utilize Bridge Funding to support a transition to HCV if needed and funds are available.

DBHDD services provided via the Housing Support service must adhere to all DBHDD service definitions and requirements for each service provided.

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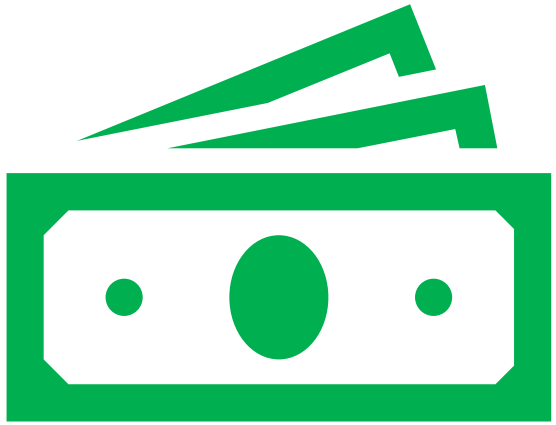
Chapter

03

Billable Services



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As a reminder, Housing Support providers **are expected** to bill the following services, as clinically necessary:

- Behavioral Health Assessment (BHA) H0031
- Service Plan Development H0032
- Case Management (CM)
- Psychosocial Rehabilitation – Individual (PSR-I)
- Addictive Disease Support Services (ADSS)
- MH and/or SUD Peer Supports (PS)
- Crisis Intervention
- *Community Residential Rehabilitation (CRR-IV)
- *Community Transition Planning (CTP)

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Verified Diagnosis

- Specific to an individual's diagnosis, Housing Support program providers must collect the necessary clinical documentation from a collaborating core/specialty provider, as per the requirements in Part II, Section III. Documentation, 3. Diagnosis, item H. sub-item iii in the DBHDD Provider Manual.
- A description of the DBHDD requirements for a diagnosis are contained on the next slides.

Verified Diagnosis

- Housing Supports team must assure the documentation to support a verified diagnosis is contained in the medical record.
- If utilizing documentation from a collaborating core/specialty provider, all elements from the next slides must be included.

Verified Diagnosis:

- Diagnoses must be verified annually.
- Housing Supports is a specialty service; therefore, the diagnosis must be obtained prior to the first date of service and annually.
- The diagnosis must be provided following a face-to-face (including telemedicine) evaluation by a qualified professional identified in the O.C.G.A Practice Acts.
- Examples of fully licensed staff: LCSW, LPC, Licensed Physician, APRN, etc.

Documentation must include:

- Clearly indicate the diagnosis
- Diagnosing practitioner's printed name and credential
- Signature of practitioner
- Date of diagnosis

Verified Diagnosis:

- A fully-licensed staff from the Housing Supports team can provide the annual, verified diagnosis (LCSW, LPC, etc.)
- Behavioral Health Assessment (H0031) can be billed to obtain the diagnosis from a qualified practitioner

Internal Diagnoses:

- If the diagnosis is obtained from the Housing Supports staff (or the same agency), the following must be included in the medical record:
  - Factors considered and justification used to determine the diagnosis
  - A summary of findings to support the diagnosis
  - A face-to-face clinical assessment (including telemedicine)

Verified Diagnosis

- All information pertaining to the annually-verified diagnosis must be in the medical record for both internal and external diagnoses

Behavioral Health Assessment – H0031

- HSP staff should bill Behavioral Health Assessment when conducting an assessment with the individual
- The purpose of the assessment process is to gather all information needed to determine the individual's problems, strengths, needs, abilities, resources, and preferences

Service Plan Development (H0032)

- All individuals must have a treatment plan/Individual Recovery Plan (IRP) with each service to be delivered by HSP included (Case Management, PSR-I, BHA, SPD, etc.)
- HSP can have a standalone IRP or a combined IRP with outpatient services
- HSP staff should bill Service Plan Development to create an IRP with the individual
- HSP staff must work with the collaborating core/specialty provider to assure duplication of services does not occur

Treatment Plans/IRP and Service Orders

All services must be included on the treatment plan/IRP with interventions for each; services include Housing Supports, PSR-I, Service Plan Development, etc.

Each service must have a service order (CM, ADSS, PSR-I, Service Plan Development, etc.)

Service orders must be dated, signed by an appropriately-licensed staff, to include credential, and printed name

Services must be ordered prior to upon start of services, at least once per year

Orders and IRPs must be current with target dates (not expired)

Who Can Order Services?

Please refer to the chart in the DBHDD Provider Manual

TABLE B: Physicians[1], Physician's Assistants and APRNs[2] may order any service. Please use the chart below to determine other appropriately licensed practitioner(s) authorized to recommend/order specific services.

Ordering Practitioner Guidelines		Licensed Psychologist	LPC, LMFT, LCSW
ices	Addictive Disease Support Services	X	X
	Behavioral Health Assessment & Service Plan Development	X	X
	Behavioral Health Clinical Consult		
	Case Management (adults only)	X	X
	Community Support – Individual (youth only)	X	X
	Community Transition Planning	X	X

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Discharge Plans

- Discharge/transition planning begins at the onset of service delivery
- Includes measurable criteria to be met prior to decreasing the intensity of service or discharge
- Define step-down service/activity or supports to meet individualized needs
- Be measurable and include anticipated step-down service and transition date
- Transition plans can be included on the treatment plan/IRP

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Case Management, PSR-I & ADSS: what is the difference?

PSR-I

Skill development and enhancement

<u>Skills training</u>: social skills, coping skills, budgeting, hygiene, nutrition, household tasks, etc.

Minimum of 2 contacts per month

ADSS

Substance use skill development, supports and enhancement

<u>Skills training</u>: social skills, coping skills, removal of barriers, enhancement of natural supports, relapse prevention, etc.

Minimum of 2 contacts per month

<u>Must have a substance use disorder</u>

Case Management

Linkage and coordination of care

<u>Referral and linkage:</u> physical health, dental, discussion with landlords, food stamps, transportation, etc.

Minimum of 2 contacts per month

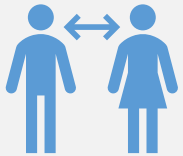
Minimum Monthly Contacts: PSR-I, ADSS & Case Management

Reminder: if minimum monthly requirements are not met in accordance with the DBHDD Provider Manual, the service cannot be billed.

Reminder: Housing supports have a minimum contact requirement, as well.

For example, PSR-I requires a minimum of two contacts per month. If the monthly contacts are not made (or documentation of attempted contacts are not in the record), the service cannot be billed.

If Housing supports does not provide the minimum number of contacts, the service cannot be billed.



If the outpatient and HSP team are with the same provider, Case Management contacts will be looked at from both outpatient and HSP staff to determine whether monthly contacts are met. Both teams can bill Case Management but working on different needs for the individual.

For example, the individual receives both HSP and Case Management from the same provider. The HSP staff are working with the individual on applying for disability. The outpatient staff are working with the individual on obtaining a primary care physician. Both are allowed. However, both the HSP team and the outpatient team should not duplicate services.

Required Components: Housing Supports Contacts

Contact must be made a **minimum of once a week** while an individual is searching for housing.

Once in subsidized housing, contact must be made **a minimum of once a week during the first three months in the individual's home** to ensure individuals remain stabilized.

After three months, frequency may decline, but at contacts must be made a minimum of twice each month (one in the residence).

Individuals who have established a documented and substantial level of stability with managing their residence and personal health needs, in the last 6 months, may receive a reduced level of contact of **at least one face-to-face (in-person) visit monthly**.

Half of Housing Support contacts must be face-to-face, and the other half may be either face-to-face or telephone contact depending on the individual's support needs and documented preferences.

The minimum contacts **are** billable services with proper documentation (Case Management, ADSS or PSR-I).

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Crisis Intervention

Crisis Intervention supports the individual who is experiencing an abrupt and substantial change in behavior.

Interventions are designed to prevent out of community placement or hospitalization.

Crisis services are time-limited and present-focused to address the immediate crisis and develop appropriate links to alternate services.

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Examples of Staff Interventions in a Crisis

- A situational assessment
- Mobilization of natural support systems
- Active listening and empathic responses to help relieve emotional distress
- Verbal and behavioral responses to warning signs of crisis related behavior
- Assistance to and involvement/participation of the individual in active problem-solving planning and interventions
- Facilitation of access to crisis stabilization and other services deemed necessary to effectively manage the crisis

Crisis Intervention services must have a corresponding progress note documenting the crisis, and order for service, staff interventions, the individual's response, and the outcome of the intervention.

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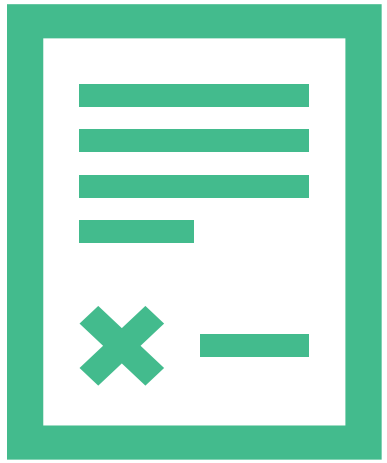
Chapter

04

Documentation Requirements



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Billing/Documentation Requirements

All HSP billed services must have:

- A corresponding authorization (HSUP)
- An order for service by a qualified/credentialed staff for the individual service provided (i.e. CM, ADSS, PSR-I)
- A verified diagnosis
- Interventions on a treatment plan for the service
- A progress note that contains all required elements (next slides)

Progress Notes Requirements

Just like outpatient, all services must have a corresponding progress note

Remember – if it's not documented, it didn't happen

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Progress Notes Requirements

- Time in/out and location of service (in clinic or specific location)
- Complete billing code, with modifier (when applicable)
- Signature and printed name of staff providing the service (or electronic signature, with a time stamp), and staff credential
- Date of entry as to when staff completed the note
- Signed and filed within 7 days of service provided
- Unique documentation; interventions are not duplicated and are about the identified individual; relate back to the IRP
- Staff intervention tied back to the IRP and documentation supports units billed
- Individual's response to intervention and overall progress towards treatment goals

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What code do I use?

The complete billing code must be included on all progress notes

- All progress notes must contain the corresponding HCPCS/CPT code, which must include any designated modifier
- Practitioner modifiers indicate the reimbursement level and are related to the staff member's educational degree and/or license/credential (U3, U4, U5)
- In clinic (U6) vs. out of clinic modifier (U7)
- If making a phone call, the in clinic modifier must be used (U6)

Examples:

- If HSP is billing Case Management, by a U4 practitioner at the individual's residence, the billing code is T1016U4U7.
- If HSP is billing Service Plan Development, by a fully licensed staff in the clinic, the billing code is H0032U3U6.
- All billing by the HSP staff would be submitted under the HSP Authorization (not the outpatient authorization).

Review of HSP Documentation

HSP staff must coordinate with the outpatient/core provider to assure duplication of interventions does not occur.

Both the HSP and outpatient provider CAN provide the same services; however, the interventions cannot be duplicative of each other.

For example, if the HSP staff is assisting the individual with a SNAP application, the outpatient provider should not duplicate this activity.

Claims/encounters submitted from the Housing Supports staff are subject to review from the Georgia Collaborative. This review may occur during a Behavioral Health Quality Review or a Housing Quality Review.

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Non-Billable Activities

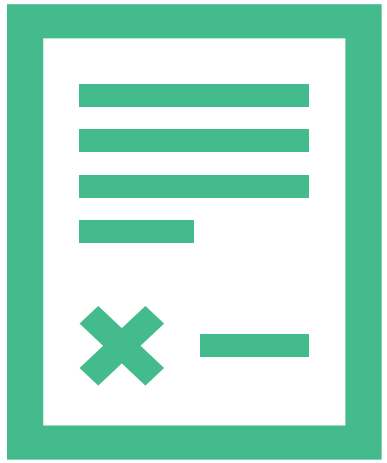
The billable activities of the Housing Support program do not include:

- Transportation
- Food
- Expenses covered under Bridge Funding services
- Generalist engagements/interactions with landlords to build capacity, i.e., landlord interactions must be specific to an individual's IRP to be billable

Chapter

05

Encounter/Claims Submissions



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Billing and Reporting Requirements

The majority of interventions defined herein are billable through the codes through the HSUP authorization:

Level of Service	Type of Service	Type of Care Code	Type of Care Description	Service Class Code	Service Groups Available	Service Description	Initial Auth		Concurrent Auth		Max Daily Units	Place of Service
							Max Auth Length	Max Units Auth'd	Max Auth Length	Max Units Auth'd		
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Chapter

06

Questions & Answers

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Chapter

07

Helpful Resources

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Helpful Resources

- **DBHDD Provider Issue Resolution Form:** https://dbhddapps.dbhdd.ga.gov/DBHDDPIMS/(S(iq03amzaet0yq2etflfist2z))/PIMSCases/PIRF_Ext.aspx
- **DBHDD Provider Manual:** https://dbhdd.georgia.gov/be-connected/community-provider-manuals
- **DBHDD PolicyStat:** https://gadbhdd.policystat.com/
- **Subscribe to the Office of Provider Relations newsletter, send email:** DBHDD.Provider@dbhdd.ga.gov

Thank You

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