Alternative or "in Lieu of" Service Description Family Navigator

Service Name and Description:

Service Name:

Family Navigator

Description:

Trillium Health Resources ("Trillium") experiences a large number of referrals of individuals deemed to be at significant risk of placement in Intermediate Care Facilities for Individuals with Intellectual Disability (ICF-IID) or state facilities due to complex needs and a lack of Medicaid funding services for individuals with Intellectual Development Disability (I/DD) and/or Traumatic Brain Injury (TBI). Medicaid beneficiaries' and their families often have a difficult time accessing or navigating healthcare and other systems because they are not designed to best support this population's unique needs. Family Navigators can assist members and families to navigate these challenging times and to understand the changes in systems through lived experience. NC already offers this for adults who experience Mental Health and Substance use disorders using a Peer support model. Family Navigator is the equivalent for Medicaid beneficiaries who experience I/DD or TBI.

Trillium has identified a gap in access to care for this population who has complex needs. Family Navigator can provide outreach and promote member engagement to reduce the need for crisis services and stop the cycle of admission and re-admissions to Emergency Departments and to higher levels of care or out of home services in ICF-IID or other residential or institutional restrictive settings.

Family Navigator is a way of working with children, adolescents and/or adults with an I/DD or TBI diagnosis and who are experiencing challenges navigating the systems that can provide support for the health and well-being of this population. Family Navigator is a critical element of the habilitation model as it allows flexibility to meet member's particular needs in their own environment or current location (i.e. home, hospitals, jail, shelters, streets, etc.) using a variety of methods.

It is designed as a short-term outreach and engagement service targeted to populations or specific member circumstances that prevent the individual from fully participating in needed care for intellectual or developmental disability or traumatic brain injury.

Trillium has found through review of available data that the majority of members in need of Family Navigator services are existing members who are waiting for funding for Innovations Waiver services or who reside in institutional setting or who are unable to

navigate systems to gain adequate access to medical, educational, vocational, behavioral, nutritional or other entitlements without the lived experience of a Family Navigator to support and assist them.

Trillium is aware that these members have a higher than average potential to go into crisis and long term care settings as a result of not receiving an adequate level of services and supports despite having Medicaid. These members will likely experience one or more of the following:

1. Present at a local Emergency department with a high level of needs with no other services available resulting in ED boarding for extended periods of time.
2. Create a disruption in the home setting without adequate supports, for children this often leads to foster care placement.
3. Contact crisis services such as NC START, mobile crisis or Emergency Services (911) for assistance on an ongoing basis.
4. Be placed under an IVC or admitted to an inpatient hospital setting either at a community-based hospital or a state psychiatric hospital, and have nowhere to return if discharged.
5. Adults often end up living in adult care homes, nursing homes or family care homes at a very young age due to lack of services and support.

Selected providers will be able to utilize the Family Navigator service as a strategy to provide outreach and engage and retain members, in an effort to prevent the repeated use of hospital or other crisis services, and out of home needs,

Expected Outcomes of Family Navigator:

Members are expected to achieve one or more of the following outcomes:

- Members become engaged and involved through increased effective access to all community systems for support (i.e. Access to healthcare, access to education, access to vocational services, access to benefits, etc.)
- Members develop and/or maintain meaningful engagement in services that is to say services meet the persons needs
- Member's use of hospital services (inpatient/ ED) is avoided or reduced in frequency and duration
- Member's use crisis services (mobile crisis) is avoided or less frequent
- Members need for out of home residential or treatment services is avoided
- Members access to medical services and annual physical and dental exams are increased

Unit of Service:

Per unit/15 minute interval

Information about Population to be Served:

Population	Age Ranges	Characteristics
I/DD	3-64 years of age	Member diagnosed with intellectual/developmental disability or traumatic brain injury. Member is unable to access care as a result of challenges navigation complex systems.

Treatment Program Philosophy, Goals and Objectives:

Philosophy:

Definition: I/DD Family Navigators (I/DD/FNs) provide or assist a family, caregiver, or self-advocate with an array of formal and informal services and supports provided to individual or families who are experiencing social, medical, health care, emotional, developmental, physical, intellectual, and/or behavioral challenges in their home, school, living arrangement, and/or community. I/DD/FNs provide a structured, strength-based relationship between a FN and the family, caregiver, or member for the benefit of the member.

Purpose, Setting and Types of Family Navigator Services

Purpose: The purpose of this service is to support the individuals with Intellectual or Developmental Disabilities or Traumatic Brain Injury or families who are caring for an individual with an Intellectual/Developmental Disability or TBI, so they can achieve their full potential and are able to live successfully in their community.

Setting: Family Navigator services can be provided in an individual or group setting (in person or via telephone or through advanced telehealth technology).

Services: The Family Navigator has 3 major areas with a number of functions within each area that can be delivered: Family/Self Advocacy, Outreach and Information and Community Connections and Natural Supports.

The following represents those functional areas and services that are to be provided under this service definition:

Family/Self Advocate Skills	1. Assist member/Families during life transitions by educating them about systems, processes and resources and how to navigate them.

	2. Support, when needed communication between families and/or member and health care providers to insure that needs are adequately met in a timely fashion. 3. Provide resources for members and their families to reduce isolation and feelings of stigma, blame and hopelessness. 4. Assist member/families to identify and contact service providers with expertise and who are skilled at working with those with I/DD. 5. Assist member/family with preparing for meetings and accompany them when needed
Outreach and Information	1. Provide outreach and education to member/family about various funding sources available to them. 2. Answer "Warm Line" calls that members/ families can make for information. 3. Provide resource materials and directories to help member/families identify relevant services and resources. 4. Perform outreach and engage with member/families to ensure the information provided is meeting their needs and progress is being made. 5. Inform member/families about the grievance and appeals process for specific agencies. 6. Perform outreach in the community to raise awareness, reduce stigma and engage member/families in services.
Community Connections and Natural Supports	1. Facilitate meetings and connections with member/families to promote self-care, strengthen social connections and decrease isolation. 2. Assist member/families with identifying, connecting and/or reconnecting to natural supports to participate and integrate into the community. 3. Facilitate connection between members and family members and others with similar life experiences. 4. Network and collaborate with the community to create resource to meet unmet needs. 5. Help families and/or self-advocates identify and get involved in leisure and recreational activities in their community.

Family Navigator Provider Requirements

Provider Requirements:

Provider Agencies approved and contracted with the PHP

To be eligible to bill for the service related to this policy, the provider(s) shall:

a. meet Medicaid, State Funded or NCHC qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Direct care providers shall meet the competencies and supervision requirements as specified in 10A NCAC 27G .0202 and .0204.

Family Navigator Service Provider Qualifications and Exclusions

Qualifications: The Family Navigator Service will be delivered by Family Navigators. To be eligible as a Family Navigator, the applicant must:

- have personal experience providing care to a loved one with I/DD or TBI or be a person with lived experience with Intellectual or Developmental Disability or TBI.
- have a high school diploma or GED
- complete the approved training for the Family Navigator Role from an authorized training source
- provide services based on their training and their unique qualifications to work with individuals or families.

Exclusions: Family Navigators would not be eligible under the following conditions:

- the applicant cannot work for the same agency/organization from whom they are currently receiving care/services
- the applicant cannot provide services to self, their child(ren) and/or a family member
- the applicant cannot be currently receiving Family Navigator services

I/DD/Family Navigator Service Supervisor Qualifications

Provider Qualifications: Supervisors of Family Navigators must be a Qualified Professional with documentable lived experience as a family member of a person with I/DD or TBI or a QP with experience with I/DD Maximum program staff ratios: –QP to FN: 1:8 –FN to beneficiary: 1:25 –

Eligible Population:

The member is eligible for this service when all of the following criteria are met:

a. There is an intellectual or developmental disability or TBI diagnosis present;
b. The member has impaired role functioning that adversely affects at least two of the following:
    1. Employment;
    2. Management of financial affairs;
    3. Ability to procure needed public support services;
    4. Community engagement; or
    5. Activities of daily living.
c. The member's level of functioning may indicate a need for support if the member has unmet needs related to system navigation and gaining access to care and supports to build the skills and experience needed to maintain personal care, meal preparation, housing, or to access social, vocational and recreational opportunities in the community.

Exclusions:

- The member would not be eligible if they currently reside in an Intermediate Care Family for individuals with Intellectual Disabilities.
- The member would not be eligible if they are currently on the Innovations Waiver.

Utilization Management

Entrance Process

An assessment of needs that demonstrates medical necessity shall be completed prior to provision of this service. This service is episodic in nature to provide support navigation related to specific identified needs. This service is not intended to be ongoing. If a substantially equivalent assessment is available, reflects the current level of functioning, and contains all the required elements as outlined in community practice standards as well as in all applicable federal and state requirements, it may be utilized as a part of the current comprehensive clinical assessment. Relevant diagnostic information shall be obtained and be included in the PCP. A support needs matrix or SIS evaluation is a sufficient assessment for this service.

Prior authorization is not required

Medicaid funded services may cover up to 60 days for the initial authorization.

This service is limited to 40 units per month.

Service Orders

This service can be ordered by a Qualified Professional

Continued Stay Criteria

The member is eligible to continue this service if:

a. The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the member's PCP; or the member continues to be at risk based on current clinical assessment, and history, or the tenuous nature of the functional gains;

AND

ANY of the following applies:

a. The member has achieved current PCP goals, and additional goals are indicated as evidenced by documented symptoms;
b. The member is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service shall be effective in addressing the goals outlined in the PCP;
c. The member is making some progress, but the specific interventions in the PCP need to be modified so that greater gains, which are consistent with the member's pre-morbid level of functioning, are possible; or
d. The member fails to make progress, demonstrates regression, or both in meeting goals through the interventions outlined in the PCP. The member's diagnosis should be reassessed to identify any unrecognized co-occurring disorders, and treatment recommendations shall be revised based on the findings. This includes the consideration of alternative or additional services.

Discharge Criteria

The member meets the criteria for discharge if any one of the following applies:

a. The member's level of functioning has improved with respect to the goals outlined in the PCP
b. The member has achieved positive life outcomes that support stable and ongoing supports and is no longer in need of FN services;
c. The member is not making progress or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services;
d. The member or legally responsible person no longer wishes to receive FN services

Documentation Requirements

Refer to NC Medicaid Clinical Coverage Policies and the DMHDDSAS Records Management and Documentation Manual for a complete listing of documentation requirements.

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 the following:

a. Member's name;
b. Medicaid identification number;
c. Service provided (for example, FN);
d. Date of service;
e. Place of service;
f. Type of contact (face-to-face, telephone call, collateral);
g. Purpose of the contact;
h. Description of the provider's interventions;
i. Amount of time spent performing the interventions;
j. Description of the effectiveness of the interventions in meeting the member's specified goals as outlined in the PCP; and
k. Signature and credentials of the staff member(s) providing the service

A documented discharge plan shall be discussed with the member and included in the service record and in the last note for the last date of service.

Service Exclusions

This service in part of a care team. Care Teams are comprised of several different professionals that work with the member. Under managed care part of the Care Team role includes the development of the ISP, completing or gathering evaluations inclusive of the re-evaluation of the level of care, monitoring the implementation of the ISP, choosing service providers, coordination of benefits and monitoring the health and safety of the member consistent with 42 CFR 438.208(c) this is not a part of the Family Navigator role. The creation and the facilitation of the Individual Support Plan or Person Centered Plan is the responsibility of the Care Coordinator on the Care Team. The Family Navigator can assist the member with preparing for the meeting and understanding the process.

- Members cannot receive Community Guide or Community Navigator at the same time as Family Navigator.
- Members cannot currently reside in an Intermediate Care Facility for Individuals with Intellectual Disabilities.
- Members cannot be on the Innovations Waiver.

- Family Navigator will not duplicate the roles of Tailored Care Management

Anticipated Units of Service per Person and Team Caseload:

Service is designed to meet the needs of the member. Maximum per month is 40 units per month.

Describe why this service is needed and is different than any State Plan or alternative service already defined. If implemented in other states, describe successful outcomes.

Family Navigator is a central component in to maintain continuity of care for individuals with I/DD. Research has shown in other populations a:

- decrease in hospitalization
- reduction in number of days in hospital
- Reduction in admission to institutional or other out of home placements
- Significant improvement in coping skills and quality of life

People who experience and I/DD and TBI also present unique and individualized challenges. People who experience I/DD or TBI are stigmatized and marginalized in our culture and many individuals find it difficult to get help. Barriers to care often prevent access to medically necessary clinically appropriate care resulting in poor health outcomes. The lack of services and supports leads deterioration of an individual's health and well-being. Delays and disruptions in services and supports can also result in individuals having more complex and often more expensive care needs.

Description of Monitoring Activities:

- State facility and community ICF-IID bed day utilization will be avoided or reduced
- Member access to services in the community is increased or maintained
- Member continuity of care is maintained during the disaster event. To include assistance with hospitalization and visitation support and guidance during times of quarantine
- Crisis services contacts will be avoided or reduced