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Origination	11/2021	Owner	Ebony Reynolds: Clinical Officer
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Case Management Network Procedure

PROCEDURE PURPOSE

In accordance with Detroit Wayne Integrated Health Network (DWIHN) Care Coordination Policy, the Case Management Network Procedure provides guidance to support individuals served with a diagnosis of SMI, SUD, I/DD and or SED, to achieve wellness and autonomy by meeting their comprehensive needs. This includes their natural supports and involves a collaborative process of assessment, treatment planning, facilitation, monitoring and evaluation through advocacy, coordination of care, health education and identification of available resources to promote safety, quality of care and cost effective outcomes.

EXPECTED OUTCOME

Efficient and effective coordination of member behavioral and physical health care with a focus on all aspects of a member's life, including behavioral health, medical, housing, education, employment, transportation and other social determinants of health that are essential to meet the members individualized needs that will:

1. Improve overall health care status and quality of life
2. Increase community engagement and integration
3. Improve self- management skills and self advocacy
4. Promote self-sufficiency, resilience and functional capability
5. Improve capacity for self-determination and autonomy
6. Encourage stronger relationships with natural supports
7. Establish continuity and coordination between behavioral and physical health care to achieve best outcomes

PROCEDURE

Clinically Responsible Case Manager/Supports Coordinator shall:

1. Facilitate appropriate access to care and services with a coordinated plan for informal and formal supports, and comply with the principles of person-centered planning as outlined in the Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual, The Behavioral Health and Developmental Disabilities Administration (BHDDA) and Person-Centered Planning Policy.
2. Be free from conflict of interest, meaning when one who has an interest in or is employed by a provider of Home and Community-Based Services (HCBS) for a person served can not be involved in case management/case coordination or development of a person-centered plan of service, except when MDHHS demonstrates that the entity is the only willing and qualified entity available to complete these functions and also provide HCBS. See CFR 441.301(c)(1)(vi)
3. Assess the total needs of individual served, including strengths, which is inclusive of medical, psychosocial, behavioral, social supports system, living situation, finances, family history legal, religious and cultural factors, as well as coping mechanisms to create a diagnostic image of an individual's condition and factors contributing to it, to achieve optimal outcomes.
4. Establish and coordinate an Individual Plan of Service (IPOS) and assist with making short and long term goals, employing a strength based approach to developing a course of action through the person centered planning process.
5. Assist with developing a Safety and/or Crisis Plan with member and his/her advocates (as part of the assessment process), if applicable. (Please refer to the **Crisis Plan Policy**)
6. Advocate and link members to necessary medical, behavioral health professionals and other resources and support services, i.e. housing, vocational training, employment, financial assistance, social services, etc.
7. Coordinate and monitor member's use of needed services.
8. Educate member on how to connect to resources as well as rehabilitation and support services independently, in order to meet his/her basic needs and improve overall quality of life.
9. Encourage involvement of individuals served, including their caregiver/natural supports in the decision making process.
10. Use available evidence-based guidelines in daily practice to best aid members served to re-integrate into their community with an emphasis on healthy self-reliance.
11. Improve outcomes through use of and adherence to standardized tools and proven processes to measure members understanding and acceptance of proposed plans.
12. Promote use of peer support services, such as peer support specialists/peer mentors/ recovery coaches to assist member with goal attainment through shared life experiences and communicating member concerns to other professionals from the member's perspective.
13. Ensure reasonable accommodations are made to address the needs of special populations

served. These may include and are not limited to translators, interpreters, staff with specific training in certain culturally competent areas.

14. Be appropriately trained and licensed and/or registered in the State of Michigan to provide services at the level authorized, and act within the scope of practice as defined by his/her license.
15. Demonstrate knowledge of financing systems, health care services and health care delivery systems, human dynamics as well as clinical standards and outcomes.
16. Have a caseload size and composition that is realistically manageable to complete core requirements (listed below) and applicable to the target population to achieve best outcomes. Factors to consider when determining caseload size and complexity: member needs and response difficulty, intervention type, frequency of contacts, geographical distribution of members and travel time, administrative work, clinical practice setting, legal and regulatory requirements, and case manager competency.

Clinically Responsible Case Manager/ Supports Coordinator Core Requirements/Responsibilities

1. Assure the person-centered planning process takes place and that it results in the Individual Plan of Service (IPOS).
2. Assure the IPOS identifies what services and supports will be provided, who will provide them, and how the case manager / supports coordinator will monitor (i.e., interval of face-to-face contacts) the services and supports identified under each goal and objective. (Please refer to the IPOS Individual Plan of Service / Person Centered Plan)
3. Oversee the implementation of the IPOS, including supporting the member's dreams, goals, and desires for optimizing independence; promoting recovery; and assisting in the development and maintenance of natural and community supports.
4. Ensure member participation in plan development and on an ongoing basis in discussions about his/her plans, goals, and status.
5. Routinely monitor member progress to ensure he/she is receiving authorized services compliant with his/her IPOS, which are delivered in an environment that addresses their health and safety needs, and satisfaction with the service, as well as evaluate the impact of services on member goals and quality of life, including identifying and addressing gaps in service provision and amending the IPOS as needed.
6. Ensure the frequency of face to face contacts and other contacts are specified in the IPOS of member served, and that the frequency and scope of Case Manager and Supports Coordinator contacts or monitoring activities reflect the intensity of the individual's health and safety needs as identified in their IPOS.
7. Coordination of member's services and supports with all providers, making referrals, and advocating for the member.
8. Assist member with accessing programs that provide needed services, i.e. financial, medical, and other assistance, such as support groups, parenting classes, Home Help and Transportation services. DWIHN's funds should be used as the payer of last resort, e.g. Medicaid Insurance. All first and third party insurance benefits should be utilized to the fullest

extent. (Please refer to the Ability to Pay Policy and SUD Ability to Pay Policy)

9. Ensure coordination with member's primary and other health care providers to assure continuity of care.
10. Coordinate and assist member in crisis intervention and discharge planning, including community supports after hospitalization.
11. Facilitate the transition process from, (e.g. inpatient to community services, school to work, dependent to independent living), including arrangements for follow-up services.

Documentation Requirements

1. The member's electronic medical record should contain sufficient information that documents in an accurate, clear and concise manner, the provision of case management/supports coordination. Case management / supports coordination service documentation must include: the nature of the service, the goal being addressed with behaviorally specific and measurable objectives, the date and the location of contacts between the case manager and the member, including whether the contacts were face-to-face.
2. The case manager / supports coordinator should document the member's supports and services on the approved standardized IPOS resulting from the person centered planning process, and obtain the date, start/end time and signature of the member, and or legal representative on the IPOS signifying their agreement to the plan. Assure all provided supports and services are documented, and the role of the case manager/supports coordinator is accurately reflected in the member's clinical record and consistent with his/her IPOS.
3. Case manager / supports coordinator will ensure the member's IPOS, in coordination with any additional plans of the member (e.g. nursing, occupational therapy, physical therapy, behavior support plans, vocational /skill building plans) are present and located in the Member's record and at the service site, and accessible to staff responsible for delivering the supports and services.
4. Case manager / supports coordinator should document the review of services at intervals as defined in the IPOS, but not less than annually. The plan shall be kept current and modified when indicated (reflecting the intensity and / or changes of the member's health and welfare needs).
5. Case manager / supports coordinator will retain evidence in the member's record the coordination of care efforts with primary and acute physical health services, behavioral health care, natural or community, supports, including allies.
6. Case manager / supports coordinator will provide training to aides / direct care staff supporting the member and document that each staff is trained on the individual's IPOS, prior to delivery of service utilizing DWIHN's approved IPOS Training Log.
7. Case management / supports coordination shall not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services.
8. Case manager / supports coordinator are prohibited from exercising the agency's authority to authorize or deny the provision of services.
9. Case management / supports coordination shall not duplicate services that are the

responsibility of another program.

Credentialing Requirements

1. Targeted case management and supports coordination services staff must meet qualifications as defined by MDHHS Medicaid Provider Manual, MI-Health Link, PIHP/CMHSP Provider Qualifications per Medicaid Services & HCPCS/CPT Codes, and DWIHN Credentialing / Re-Credentialing policy https://www.dwihn.org/policies-credentialing-recredentialing.pdf.
2. A primary case manager or supports coordinator must be a qualified mental health or intellectual disability professional (QMHP or QIDP) or, if the case manager has only a bachelor's degree but without the specialized training or experience, they must be supervised by a QMHP or QIDP who possess the training or experience. Services to a child with serious emotional disturbance must be provided by a QMHP who is also a child mental health professional. Services to children with developmental disabilities must be provided by a QIDP. **(See MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services, Section on Staff Qualifications).**
3. Services for children must be provided by a Child Mental Health Professional (CMHP) for children diagnosed with Serious Emotional Disturbances (SED).
    a. Services to children ages 7-21 with SED must be provided by a CMHP trained in CAFAS. Individuals over age 18 that are served by a SED children provider, will continue with CAFAS until age 21. If the child transitions from SED to SMI after age 18, LOCUS will need to be completed and CAFAS scoring should cease.
    b. Services to children ages 4-6 with SED must be provided by a CMHP trained in PECFAS.
    c. Services to children ages 1 month-47 months with SED must be provided by a CMHP trained in DECA.
4. Services for the Home and Community-Based Habilitation Waiver and Children's Waiver programs must be provided by a QIDP.
5. Support Coordination services provided by a Supports Coordinator Assistant or Supports and Services Broker must meet the MDHHS Medicaid Provider Manual, including being selected by the member and supervised by a qualified supports coordinator or targeted case manager. Case Management/Supports Coordination services may be provided by a variety of provider types with different licensure and/or certification levels. However, not every procedure code may be reported by every provider type.

Case Management/Supports Coordination Privileges and Codes

The following are case management and supports coordination staff/provider qualifications and training requirements with associated procedure codes:

Case Management/Supports Coordination Procedure Codes

Service Description	HCPCS Code	Reporting Code Description from HCPCS and CPT Manuals	Provider/Staff Qualifications & Minimum Training Requirements
Nursing Facility Mental Health Monitoring	T1017/ SE	Targeted Case Management	Mental Health Professional or licensed bachelor's social worker (or limited-licensed bachelor's or master's social worker under the supervision of a fully licensed master's social worker) supervised by a Mental Health Professional or a QIDP or a QMHP. A CMHP is required when delivering services to a child with SED. A QIDP is required when delivering services to a child with DD.
Substance Abuse: Outpatient Care	H2035, H2036	**H2035**: Outpatient alcohol and/or other drug treatment service in which the client participates in accordance with an approved individualized treatment plan. It may include assessment, individual and group counseling, occupational therapy, activity therapies, expressive therapies (art, drama, poetry, music, and movements), referral and information, drug screening urinalysis, medication administration, medical services, case management services, and nutrition counseling – per hour **H2036:** Outpatient alcohol and/or other drug treatment service in which the client participates in accordance with an approved individualized treatment plan. It may include assessment, individual and group counseling, occupational therapy, activity therapies, expressive therapies (art, drama, poetry, music, and movements), referral and information, drug screening urinalysis, medication administration, medical services, case management services, and	Provider agency licensed and accredited as substance abuse treatment program for all "H" and "T" HCPCS Codes: Clinical service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS. Non-clinical services under H2035: Services can be provided by appropriately trained staff when working under the supervision of a SATS or SATP.

Service Description	HCPCS Code	Reporting Code Description from HCPCS and CPT Manuals	Provider/Staff Qualifications & Minimum Training Requirements
		nutrition counseling – per diem	
Supports Coordination	T1017	Case Management	Supports Coordinator, support coordinator assistants, independent services and supports brokers. Assistants or brokers: high school diploma and one-year experience, and supervised by a qualified supports coordinator or case manager.
Targeted Case Management	T1017	Targeted Case Management	QIDP or QMHP: if case manager has only a bachelor's degree without specialized training or experience, they must be supervised by a QMHP or QIDP. Services must be provided by a CMHP or is supervised by a CMHP while the individual is working towards becoming a CMHP to any child beneficiary with SED. Services to children ages 7 through 17 with SED must be provided by a CMHP trained in CAFAS. Services rendered to children ages 4 through 6 with SED must be provided by a CMHP trained in PECFAS. Services rendered to a young child, birth through age 3, must be provided by a CMHP trained in the Devereux Early Childhood Assessment (DECA)
Peer Directed and Operated Support Services (MH or DD)	H0023, H0038, H0046	H0023: Drop-in center H0038: Peer specialist services H0038/HF: Substance Use Disorder Recovery Coach – Substance Abuse: Outpatient Care H0038/TJ: Youth Peer Support Specialist H0046: Peer Mentor – DD Peer Mentor	Drop-in Center Director: An individual in recovery from serious mental illness who is receiving or has received public mental health services. The individual's life experience provides expertise that professional training alone cannot replicate. Peer Specialist: Must be certified by MDHHS if providing services to an individual with SMI. Youth Peer Support Specialist: a

Service Description	HCPCS Code	Reporting Code Description from HCPCS and CPT Manuals	Provider/Staff Qualifications & Minimum Training Requirements
			young adult, ages 18 through age 26, with lived experience who received mental health services as a youth, and is willing and able to self- identify as a person who has or is receiving behavioral health services and is prepared to use that experience in helping others, and has experience receiving services as a youth in complex, child serving systems preferred (behavioral health, child welfare, juvenile justice, special education, etc.), and is employed by PIHP/ CMHSP or its contract providers, and is trained in the Michigan Department of Health and Human Services approved curriculum and ongoing training model Peer Mentor: Must be an individual with developmental disabilities who is trained as a mentor. Peer Support Navigator: Individuals providing Peer support services must be able to demonstrate their experience in relationship to the types of guidance, support and mentoring activities they will provide. Peer support navigators are supervised by licensed Mental Health Professionals working within their scope of practice and applicable state law.

MONITORING STEPS

Data for the Case Management Network Provider Procedure will be reviewed and analyzed to assess progress and identify areas for improvement. Review of outcomes for the effectiveness of this procedure is completed at least annually and is shared with the DWIHN Improving Practices Leadership Team (IPLT) and Quality Improvement Steering Committee (QISC).

Who monitors this procedure:	Ebony Reynolds, LMSW-Clinical Officer

Department: Frequency of monitoring:	Clinical Practice Improvement Annual
Reporting provided to:	Improving Practices Leadership Team (IPLT)/ Quality Improvement Steering Committee (QISC)

Comments: This procedure is associated with the overarching Care Coordination Policy which sets the direction for implementation of these guidelines. Please also refer to the following policies:

1. Credentialing / Re-Credentialing policy
2. Crisis Plan Policy
3. Ability to Pay Policy
4. SUD Ability to Pay Policy
5. IPOS Individual Plan of Service / Person Centered Plan policy
6. Conflict-Free Case Management Policy

Approval Signatures

Step Description	Approver	Date
Policy Admin Review	Allison Smith: Project Manager, PMP	02/2023