Subject: Complex Case Management Procedure	**Accountability:** Clinical Practices	**Effective Date:** 12/31/2016	Pages: 3
Overarching Policy: SWMBH MHL 12.7 Complex Case Management Policy		Last Reviewed Date: 6/13/18	Past Reviewed Dates: 1/4/17 4/25/17
LINE OF BUSINESS: ☐ Specialty Waiver (B/C) ☐ 1115 Waiver ☐ Healthy Michigan ☐ SUD Medicaid ☐ SUD Block Grant ☒ MI Health Link ☐ Other:_____	**APPLICATION:** ☒ SWMBH Staff and Ops ☐ Participant CMHSPs ☐ SUD Providers ☐ MH / DD providers ☐ Other:_____	Last Revised Date: 6/13/18	Past Revised Dates: 1/4/17 4/25/17
Approved : B.b. Rau Date: 6/19/18		Required Reviewer: Medical Director	

I. Purpose

To define the execution of Southwest Michigan Behavioral Health's (SWMBH) Complex Case Management program in adherence to the Complex Case Management Policy 12.7, while supporting and enhancing the overall goal of improving care under the standards of best practice driving quality based outcomes.

II. Scope

SWMBH's Complex Case Management (CCM) program includes identifying members within an eight county region, who meet the enrollment criteria for participation in the CCM Program. This procedure intends to operationalize the methods for then assessing the member's physical and behavioral health needs, identifying and developing member centered goals, evaluating existing needs and barriers to meeting those goals, and identifying and coordinating with community resources to address them. Followed by periodic reassessments and updates to the Case Management Plan.

III. Procedural Steps

A. Upon identification of a member who meets the enrollment criteria for the CCM Program and agreement to participate, the Managed Care Information System (MCIS) will be used for SWMBH's Complex Case Manager to assess and document the following information.

B. Obtain member signature on enrollment documents as follows:

1. State of Michigan Behavioral Health Consent form
    a. If member refused to sign a consent form after confirming his/her understanding of its usefulness, plan to discuss the use of this form again at your next CCM visit.
2. Email communication form
    a. This form is optional, but if signed gives the CCM permission to use email communication for the purposes of confirmation of scheduled appointments and sending educational materials.
3. WHO DAS baseline assessment.
    a. Complete the baseline assessment and explain the use of this assessment will be re-administered at set intervals and at the conclusion of CCM.

C. Complete the CCM assessment to include all National Council for Quality Assurance (NCQA) CCM assessment items listed below.
   1. Assess members' health status, including condition-specific issues, comorbidities, self-reported health status, and presenting diagnosis.
   2. Document clinical history and medications, to include disease onset, acute phases, inpatient stays, treatment history, current and past medications
   3. Assess and document activities of daily living, including but not limited to eating, bathing and mobility.
   4. Assess Behavioral Health status, including cognitive functions by:
      a. Assessing the ability to communicate and understand instructions
      b. Assessing the ability to process information about an illness.
      c. Assessing mental health conditions
      d. Assessing for substance use disorders.
   5. Assess psychosocial status including:
      a. Beliefs about the condition or treatment
      b. Perceived barriers to meeting treatment requirements
      c. Access to transportation
      d. Financial barriers to obtaining treatment.
   6. Assess life-planning activities, such as a will, advance directives and healthcare powers of attorney. Life planning needs will be addressed as follows:
      a. Confirm member receipt of the advance directive brochure in the welcome packet.
      b. Members can also request mailed information at any time.
   7. Evaluate cultural and linguistic needs, preferences or limitations. All identified needs will be addressed.
   8. Evaluate visual and hearing needs, preferences or limitations. All identified needs will be addressed.
   9. Evaluate caregiver resources and family involvement. All identified needs will be addressed.
   10. Evaluate available benefits and determination whether the available resources will be adequate to fulfill the treatment plan.
   11. Evaluate the need for available community resources, including but not limited to:
      a. Community Mental Health
      b. Employee Assistance Program
      c. Disease Management
      d. Wellness organizations
      e. Palliative care programs
      f. Other national or community resources
   12. Development of an individualized case management plan, including:
      a. Prioritized patient-centered goals
      b. Time frame for reevaluation
      c. Resources to be utilized, including appropriate level of care
      d. Planning care transitions and transfer of care to other agencies.
      e. Collaborative approaches with family, partners and friends, including level of involvement.
      f. Specified time frames for reevaluations.
   13. Identify barriers to receipt of care, compliance with the case management plan or with meeting goals.
   14. Facilitate the need for resource referrals and follow up on adherence to referrals.
      a. Referral facilitation may be completed by:
         i. Warm referral, Case Manager makes the referral call with the member

ii. Coached referral, Case Manager provides information and instruction to member.

15. Develop a communication schedule and follow up as needed in the following areas:
    a. Counseling
    b. Disease Management
    c. For additional referral to health resources
    d. For additional Member education as needed
    e. Self-management support
    f. Or, determining when follow-up is not appropriate
16. Develop members' self-management plan. This will be communicated verbally and in writing as needed or requested by member.
17. Assess members' progress with the Case Management Plan.
    a. Identify barriers to care.
    b. Identify barriers to meeting treatment goals.
    c. Adjusting the care plan as needed.

D. Withdrawal from Complex Case Management

1. Upon member identification for the Complex Case Management program, participation can be withdrawn in one of the following ways:
    a. Refused offer to participate in the Complex Case Management program.
    b. Voluntarily withdraws from Complex Case Management participation prior to completion.
    c. Inability for member to verbalize needs or participate in person-centered planning.
    d. Inability for Case Manger to reach or engage member for the Complex Case Management program. Unable to contact member following a minimum of three documented attempts within a two week period, and within the first 30 days of eligibility through at least two of the following mechanisms:
        i. Telephone
        ii. Regular mail
        iii. Email
        iv. Fax
2. Upon completion of the CCM program, the Complex Case Management event can be closed if the following criteria are met, or per review and approval of a SWMBH physician:
    a. Stable for three months, no chronic emergency department (ED) or inpatient (IP) visits
    b. Active and/or stable with behavioral health (BH) care, or discharged from BH treatment.
    c. Active with Primary Care Physician.

IV. Resources

None

V. Definitions

1. Integrated Healthcare Specialist: Registered Nurse (RN), Licensed Master Social Work (LMSW).
2. Care Manager II or Care Manager III: Licensed Master Social Work (LMSW), Limited License Psychologist (LLP), Licensed Professional Counselor (LPC), or Registered Nurse (RN) is required.

VI. References

None

VII. Attachments

None