Section: **Clinical Practices**	Procedure Name: **Complex Case Management**	Procedure #: **MHL P12.07.01**
Overarching Policy: **Complex Case Management**		
Owner: **Director of Clinical Quality**	Reviewed By: **Moira Kean**	Total Pages: **6**
Required By: ☐ **BBA** ☐ **MDHHS** ☒ **NCQA** ☒ **Other (please specify):** **__MHL_____**	Final Approval By: Moira Kean	Date Approved: Jun 24, 2020
Application: ☐ **SWMBH Staff/Ops** ☐ **Participant CMHSPs** ☐ **SUD Providers** ☐ **MH/IDD Providers** ☐ **Other (please specify):** _____	Line of Business: ☐ **Medicaid** ☐ **Other (please specify):** ☐ **Healthy Michigan** _____ ☐ **SUD Block Grant** ☐ **SUD Medicaid** ☒ **MI Health Link**	Effective Date: **5/21/2020**

Policy: The overall goal of Complex Case Management (CCM) is to help members regain optimum health or improved functional capability in the right setting and in a cost-effective manner while supporting and enhancing the overall goal of improving care under the standards of best practice driving quality-based outcomes. It involves comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a case management plan with patient-centered goals, monitoring and follow-up.

Purpose: To define the execution of Southwest Michigan Behavioral Health's (SWMBH) Complex Case Management program in adherence to the Complex Case Management Policy 12.07, while supporting and enhancing the overall goal of improving care under the standards of best practice driving quality based outcomes.

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 helping members obtain access to care and services and coordinating care by completing a pertinent assessment, identifying barriers, and developing a person-centered plan.

Responsibilities: Integrated Healthcare Specialist or Care Manager II or II will fulfill the policy as written.

Definitions:

A. Integrated Healthcare Specialist: Registered Nurse (RN), Licensed Master Social Work (LMSW).

B. 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.

Procedure:

A. Potential members will be identified by various means, including but not limited to, assessment of members with high behavioral health inpatient and/or emergency department use and referrals from any source (examples: self, provider, SWMBH Utilization Management (UM)).

B. For members who choose to participate, SmartCare will be used for SWMBH's case manager (CM) to assess and document the information detailed in this procedure.

C. Initial Paperwork will be requested and/or completed with the member.

1. Request member signature on State of Michigan Behavioral Health Consent form.
    a. This form is mailed to member upon identification as a potential participant.
    b. If member refuses to sign a consent form after confirming his/her understanding of its usefulness, the CM will discuss the use of this form 1 more time at the next CCM contact.
2. Electronic Communication Consent
    a. This form is mailed to member upon identification as a potential participant.
    b. It is optional.
3. WHO DAS assessment.
    a. Complete the baseline assessment and explain the use of this assessment will be re-administered every three months and upon graduation from the program.
        i. Member may choose to fill out this assessment individually. This may be mailed to member upon request.
        ii. Otherwise, CM may offer to read the questions and complete the assessment verbally.

D. Complete the CCM assessment to include all National Council for Quality Assurance (NCQA) CCM assessment items listed below. The CM will ask both open and closed ended questions to complete the assessment and then will use clinical knowledge to draw and document a conclusion for each section based on the data or information collected.

1. Assess members' health status including condition-specific issues, comorbidities, self-reported health status, and presenting diagnosis or event that led to identification for CCM and current medications.
2. Document clinical history including past hospitalizations and major procedures, significant past illnesses and treatment history and past medications.
3. Assess and document activities of daily living including bathing, dressing, going to the toilet, transferring, feeding and continence.
4. Assess Behavioral Health status:
    a. Cognitive
        i. Ability to communicate and understand instructions
        ii. Ability to process information about an illness.
    b. Mental health conditions
    c. Substance use disorders

5. Assess social determinants of health including economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks that may affect a member's ability to meet case management goals.
    a. Examples include current housing and housing security, access to food markets, exposure to crime, violence and social disorder, residential segregation and other forms of discrimination, access to mass media and emerging technology, and social supports such as access, transportation, financial barriers to obtaining treatment.
6. Confirm member receipt of advance directives brochure sent upon entering the Mi Health Link program and annually thereafter. Assess life-planning activities, such as a wills, living wills or advance directives and health care powers of attorney. Request documentation if the member has advance life-planning documents that are pertinent to the program (e.g. guardianship paperwork or DPOA).
7. Evaluate cultural and linguistic needs, preferences or limitations such as family traditions related to illness death and dying, health literacy and health care treatments discouraged or not allowed for religious or spiritual reasons. 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, e.g. family involvement in and decision making about the care plan. 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.
    a. Examples: community mental health, employee assistance program, disease management, wellness organizations, palliative care programs, other national or community resources
12. Develop an individualized case management plan:
    a. Prioritized patient-centered goals
    b. Time frame for reevaluation of goals
    c. Resources to be utilized, including appropriate level of care.
        i. It is likely that many times the level of care established when doing the LOCUS will not be heavily weighed into the case management plan for CCM – regardless of LOCUS level of care, CCM will provide access to care, coordination of care and other supports.
    d. Planning for continuity of care, including transition of care and transfers
    e. Collaborative approaches to be used including level of family, partners and friends' participation
13. Identify barriers to receiving or participating in a case management plan. e.g. language or literacy level, access to reliable transportation, understanding of a condition, motivation, financial or insurance issues, cultural or spiritual beliefs, visual or hearing impairment, psychological impairment.
    a. Documentation that barriers were assessed will be included, even if none were identified.
14. Facilitate needed referrals to other health organizations when appropriate.
    a. Referral facilitation may be completed by:

i. Warm referral – CM makes the referral call with the member
ii. Coached referral – CM provides information and instruction to member.
iii. Any other method as needed for individual members

15. Develop a communication schedule and follow up as needed in the following areas:
    a. Counseling
    b. Follow-up after referral to a disease management program
    c. Follow-up after referral to a health resource
    d. Member education
    e. Self-management support
    f. Determining when follow-up is not appropriate
16. Work with member to develop his or her self-management plan. This will be communicated verbally. It will be available in writing as needed or requested by member.
17. Assess members' progress with overcoming barriers to care and to meeting treatment goals and assess for and adjust the care plan and goals as appropriate.

E. Completion of CCM Program

1. Active members will be considered "graduates" of CCM based on some or all of the following items:
    a. Self-management goals are complete
    b. Case management goals are complete
    c. Member experiences decrease inpatient and emergency department utilization
    d. Member is active and engaged with healthcare providers.
2. Closure/graduation will be agreed upon by the CM and member prior to completion of the program. The CM will provide the member with a verbal plan for continued disease management (e.g. continuing annual preventive care with PCP and behavioral health medication reviews as ordered). This may be available in writing per participant request.

F. Withdrawal from CCM

1. Participation can be withdrawn in one of these ways:
    a. Member's stated refusal to participate
    b. Member voluntarily withdraws prior to completion.
    c. Member becomes unable to verbalize needs or participate in person-centered planning.
    d. The CM becomes unable to reach or engage member. Attempts to contact the member, within reason, will be made over a two-week period through at least two of the following mechanisms:
        i. Telephone
        ii. Direct mailing
        iii. Email (if member has signed electronic consent)
        iv. Fax (if member has signed electronic consent)

Effectiveness Criteria:

Inpatient and Emergency Room utilization 6months prior to CCM, during CCM and 6 months post CCM will be analyzed.

WHODAS scores at baseline, quarterly and at discharge will be analyzed to assess for functional improvement.
Complex Case Management and Complex Case Management Review documents to be documented in SmartCare at appropriate frequencies.

References: NCQA Standards – QI 8 Complex Case Management

Attachments: None

Revision History

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
1	5/21/20		Made edits to reflect 2020 NCQA standards	Sarah Green

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