BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY
POLICIES AND PROCEDURES MANUAL

Chapter: 04	**Care and Treatment Services**		
Section: 27	**Core Clinical Services**		
Topic: 01	**Case Management / Supports Coordination Services**		
Page: 1 of 7	**Supersedes:** **Pol: 3-18-04** **Proc: 5-15-15, 8-15-13, 9-30-06, 2-17-04, 7-28-98**	**Approval Date:** **Pol: 10-17-13** **Proc: 12-1-2024**	*Board Chairperson Signature* *Chief Executive Officer Signature*
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Policy

It is the policy of Bay-Arenac Behavioral Health Authority (BABHA) to provide person-centered mental health services to individuals from Bay and Arenac counties with serious mental illness, serious emotional disturbance, developmental disability or co-occurring substance abuse disorder who require coordination of care and provision of services. Assessment, planning, linking, advocacy, coordination and monitoring will be provided based on the Person**-Centered** Planning process. BABHA will support individual empowerment and self-determination.

Purpose

This policy and procedure was developed to define the role of Case Manager and Supports Coordinator entrance criteria for persons in need of case management service; and to define targeted case management service.

Education Applies to

☐ All BABHA Staff
☒ Selected BABHA Staff, as follows: <u>All Clinical and Clinical Management</u>
☐ All Contracted Providers: ☐ Policy Only ☐ Policy and Procedure
☒ Selected Contracted Providers, as follows: Primary Care Providers
  ☐ Policy Only ☒ Policy and Procedure
☐ Other:

Definitions

Primary Case Holder/Care Coordinator/Case Manager/Supports Coordinator (PCH/CSM/SC: The staff person who works with the individual to gain access to and coordinate the services, supports and/or treatment that the individual wants or needs. Responsible for the development, coordination, implementation and oversight of the Person-Centered Planning (PCP) process and the Individual Plan of Service (IPOS).

Procedure

Program Description

BABHA offers Case Management and Services Coordination services to residents of Bay and Arenac Counties. This program provides individuals with the levels of support and supervision they need to be connected to resources in the community and to find services and providers that assist them in achieving their goals. Services are designed to provide comprehensive supports, including supportive counseling, crisis intervention, and a collective and coordinated effort to have all an individual’s supports working together. Hours of operation vary. After hours emergency contact is available 24 hours a day, 7 days a week through BABHA’s Crisis Intervention services. Admission to the program is by referral from BABHA Access Center.

Targeted Case Management/Supports Coordination services are available for children with serious emotional disturbance, adults with serious mental illness, persons with developmental disability, and those with co-occurring substance use disorders who have multiple service needs, have a high level of vulnerability, require access to a continuum of mental health services from the PIHP, and/or are unable to independently access and sustain involvement with needed services.

Targeted Case Management/Supports Coordination is a covered service that assists individuals to design and implement strategies for obtaining services and supports that are goal-oriented, individualized and focused on recovery, wellness, skill acquisition, enhanced quality of life, productivity, independence, community inclusion and resiliency. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services, meaningful activities, and natural supports developed through the Person-Centered Planning process. Targeted case management is provided in a responsive, coordinated, effective and efficient manner, focusing on process and outcomes.

The location of case management activities are by their choice, usually in the community where the person lives or works, but can be in the office as long as the needs of the persons are met. Individuals must be provided a choice of available, qualified case management staff upon initial assignment and on an ongoing basis.

Core Requirements Targeted Case Management and Support Coordination: Providing a comprehensive orientation to services including system navigation.

Assuring that the Person-Centered Planning process takes place and that it results in the Individual Plan of Service (IPOS) that promotes recovery, wellness, skill acquisition, enhanced quality of life, productivity, independence, community inclusion and resiliency. Planning and/or facilitating planning using person centered principles. This function may be delegated to an independent facilitator chosen by the individual.

- Assuring that the person-centered planning process takes place and that it results in the individual plan of service.
- Independent facilitation of the person-centered plan is made available.
- Assuring that the plan of service identifies what services and supports will be provided, who will provide them, and how the case manager will monitor (i.e., interval of face-to-face contacts) the services and supports identified under each goal and objective.
- Overseeing implementation of the individual plan of service, including supporting the beneficiary’s dreams, goals, and desires for optimizing independence; promoting recovery; and assisting in the development and maintenance of natural supports.
- Assuring the participation of the beneficiary on an ongoing basis in discussions related to the beneficiary’s plans, goals, and status.
- Identifying and addressing gaps in service provision and addressing all issues, i.e., housing and employment.
- Coordinating the beneficiary’s services and supports with all providers, making referrals, and advocating for the beneficiary.
- Assisting the beneficiary to access programs that provide financial, medical, and other assistance such as Home Help and Transportation services.
- Assuring coordination with the beneficiary’s primary and other health care providers to ensure continuity of care.
- Coordinating and assisting the beneficiary in crisis intervention and discharge planning, including community supports after hospitalization.
- Facilitating the transition (e.g., from inpatient to community services, school to work, dependent to independent living) process, including arrangements for follow-up services.
- Assisting beneficiaries with crisis planning.
- Identifying the process for after-hours contact.
- Assisting the beneficiary in developing social networks.

Assessment
The provider must have the capacity to perform an initial written comprehensive assessment addressing the beneficiary's needs/wants, barriers to needs/wants, supports to address barriers, and health and welfare issues. Assessments must be updated when there is significant change in the condition or circumstances of the beneficiary. The IPOS must also reflect such changes.

Documentation
The beneficiary's record must contain sufficient information to document the provision of case management/supports coordination, including the nature of the service, the date, and the location of contacts between the case manager/supports coordinator and the beneficiary, including whether the contacts were face-to-face. The frequency of face-to-face contacts must be dependent on the intensity of the beneficiary's needs. The case manager/supports coordinator must review services at intervals defined in the individual plan of service. The plan shall be kept current and modified when indicated (reflecting the intensity of the beneficiary's health and welfare needs). A beneficiary or their guardian or authorized representative may request and review the plan at anytime. A formal review of the plan shall not occur less often than annually to review progress toward goals and objectives and to assess beneficiary satisfaction.

Monitoring
The case manager/supports coordinator must determine, on an ongoing basis, if the services and supports identified in the IPOS have been delivered, and if they are adequate to meet the needs/wants of the beneficiary. Frequency and scope (face-to-face and telephone) of case management/supports coordination monitoring activities must reflect the intensity of the beneficiary's health and welfare needs identified in the individual plan of services.

Staff Qualifications
A primary case manager 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 does 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.
Qualifications of supports coordinators are a minimum of a Bachelor's degree in a human services field and one year of experience working with people with developmental disabilities if

supporting that population; or a Bachelor's degree in a human services field and one year of experience with people with mental illness if supporting that population.

<u>Service Modalities and Program Objectives</u>

Service Modality:
A single Client Services Specialist (CSS) is chosen/assigned to persons served. An initial, annual, comprehensive assessment is completed to determine the person's life conditions, strengths, needs, abilities, and preferences. A Person-Centered Planning (PCP) process (per BABHA Agency Manual, Policies and Procedures, C04-S05-T01 - Person Centered Planning) results in an Individual Plan of Service (IPOS) which is completed, specifying amount, scope, and duration of services with the person. The PCP identifies all services and supports provided by BABHA as well as services and supports outside of the CMHSP system. Services are developed in a variety of settings mainly in the community or home of the individuals. Services can be provided in the office setting when identified in the plan.

<u>Population Identification and Mechanisms</u>

<u>Targeted Populations</u> – Targeted Case Management/Support Coordination

Person resides in Bay or Arenac Counties and has been diagnosed with a severe and persistent mental illness, intellectual and/or developmental disability, severe emotional disturbance, and/or a substance use disorder.

<u>Entrance Criteria - Case Management Services</u>:

A. Resident of Bay or Arenac Counties.
B. Meets specialty behavioral health criteria for admission as an adult with serious mental illness, youth with serious emotional disturbance, adult or child with developmental disability, adults or youth with a co-occurring mental health and substance use disorder.
C. Meets medical necessity criteria for specialty mental health services.
D. Is assessed using the Service Selection Guidelines published by the Michigan Department of Health and Human Services (MDHHS) as requiring case management services based on severity of illness criteria.
E. Has functional limitations and multiple service needs.

F. Lacks the capacity to independently access and sustain involvement in needed services.

Referral Process:

A. Referrals for targeted case management or support coordination services are made directly to the program supervisors for case assignment.
B. Intake and assessment process for Outpatient and Case Management services follows BABHA Policy and Procedure, C04-S02-T03.
C. The Person-Centered Planning process is implemented as outlined in BABHA's Agency Manual, Policy and Procedure C04-S05-T01 - Person-Centered Planning and C04-S05-T03 – Case Management/Support Coordination.
D. BABHA's Emergency Services Department provides 24-hour crisis intervention, crisis stabilization, and preadmission screening services for child, adolescent, and adult residents of Bay and Arenac Counties who are experiencing a psychiatric or personal crisis. Trained professional staff are available for telephone and face-to-face contact with persons in crisis on a 24-hour, 7 day a week basis.

Attachments

Case Management/Support Coordination Comprehensive Program Plan

Related Forms

N/A

Related Materials

N/A

References/Legal Authority

1. Michigan Department of Health and Human Services Medicaid Provider Manual.
2. CARF Section 3 - Behavioral Health Core Program Standards, Case Management Service Coordination (CM).

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SUBMISSION FORM

AUTHOR/ REVIEWER	APPROVING BODY/COMMITTEE/ SUPERVISOR	APPROVAL /REVIEW DATE	ACTION (Deletion, New, No Changes, Replacement or Revision)	REASON FOR ACTION - If replacement list policy to be replaced
E. Lamson	E. Lamson	08/24/10	Revision	Reviewed - "Authority" added to BABH - no changes to P/P
K. Withrow M. Swank	PNLT	08/15/13	Revision	Triennial review: Updated with Person First Language and added complete list of eligible populations to both the policy and procedure.
J. Hahn	C. Pinter	05/15/15	Revision	Numbering scheme change from C04-S04-T14; added specialty services language; updated MDCH/MDHHS.
H. Beson J. Hahn	H. Beson J. Hahn	12/1/2024	Revision	Triennial Review. Incorporated Person Centered Planning details. Combined Targeted Case Management and Supports Coordinate per Medicaid Provider Manual. Referred to comprehensive program plan.