DMC-ODS Case Management

Santa Cruz County Behavioral Health
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Substance Use Disorder Services / Quality Improvement
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Training Goals & Objectives

Goals

- Define activities related to Case Management service codes for each program (Unplanned and Planned)
- Compare with other possible service codes &
- Best Practice Documentation

Objectives

- ✓ Define DHCS definition of CM code and how this applies to program services (medical necessity driven)
- ✓ Clarify how to determine which code to use based on identified scenarios
- ✓ Identify documentation requirements

“Unplanned” & “Planned” Services

Unplanned: Prior to developed Treatment Plan & unpredictable services

1. Assessment & Reassessments
2. Treatment Planning
3. Crisis Intervention Services
4. CASE MANAGEMENT SERVICES

Planned: Treatment Services identified on Treatment Plan

1. Individual Counseling
2. Group Counseling
3. CASE MANAGEMENT
4. Family Counseling

Client receives unplanned services during assessment phase: from date of admission to the finalization of the signed treatment plan (72 hrs. for WM, 10 days for Residential, 30 days for IOS/OP & 28 days for NTP).

Case Management Services – All LOC

- Case Management is a separate service code available at all levels of care, including Residential. 15 minute increments for F2F or phone. SUD Counselor & LPHA appropriate.
- Start & End time of service applies to CM Services. Staff MUST complete note within 7 calendar days of service, including date of service. Note describes purpose of CM service & how it relates to the client's treatment goals.
- Components of Case Management activities:
  - *Comprehensive assessment and periodic reassessment of client's need for continuous CM services*
  - *Monitoring treatment progress*
  - *Client advocacy and linkage to services*
  - *Monitoring transitional needs to a higher or lower level of SUD care*
  - *Monitoring service delivery to ensure access to services and service delivery system*

DHCS DMC-ODS Case Management (CM)

Care Coordination Services:

"A plan that provides for seamless transitions of care for clients in the DMC-ODS system of care without disruption to services."

Service Coordination:

"Case management services are defined as a service that assist a client to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services."

Case Management is….. Linkage to services

Communication, Coordination, and Referral:

Assisting the client to access needed services through a variety of interventions including:

1. Direct communication with the client and/or individuals within the community in order to facilitate access;

2. Coordination between services and/or appointments (medical appointments, public assistance agencies, housing needs, etc.), and;

3. Facilitating appropriate referrals.

(Services typically include intervention on behalf of the client with other community resources as needed - Social Security office, schools, social services, health departments, PCP office, housing, etc.)

Case Management is…. Monitoring

Monitoring Access:

Activity needed to ensure that the client is accessing identified needed services, and is navigating the service delivery system effectively (keeping appointments, securing need public assistance and housing). Initial access to needed resources needs to be achieved.

Monitoring Progress:

Evaluating whether the identified community resources are meeting the client's needs, and whether the client is progressing toward targeted goals. Monitoring progress centers on making sure the client is continuing to access resources in an effective appropriate manner.

For example: once initial medical appointments and evaluations have been completed is the client following recommended interventions and treatments and progressing toward improved health? If housing has been secured is the client able to maintain or in danger of losing again.

Case Management is….. Placement needs

Placement Services:

Placement coordination services necessary to address the identified substance use disorder condition, including assessing the adequacy and appropriateness of the client's living arrangements. Example: a client moving from a Residential setting to sober living housing.

Services would typically include locating and coordinating the resources necessary to facilitate a successful and appropriate placement in the least restrictive setting and consulting, as required, with the care provider. Activities may also include identification and assistance during times of crisis and need for more intensive placement.

Case Management is NOT….

Providing transportation. (Medi-Cal does not pay for taxi services)

Clerical activities such as scheduling appointments.

On days when client is in an acute psychiatric hospital, PHF, or Jail. Noted Exceptions: day of admission, or for the purpose of coordinating placement of the beneficiary upon discharge.

When CM is being provided by, and reimbursed to, another agency by Medi-Cal (creation of duplicate payments).

For direct delivery of services (rehabilitation, medical, educational, social, other services, etc.).

f) Other activities on DHCS Reasons for Recoupment list.

So what are CM Services?

Care Coordination:

1. Outreaching next level of care provider to coordinate a clients transition out of one program and admission into another.
2. Coordinating a transfer to a higher level of care.
3. Monitoring service delivery to ensure client access to service and the service delivery system. (you were informed that client didn't show up for medical appointment)

Service Coordination:

1. Advocating and making a referral to services – medical, mental health, educational, vocational, etc.
2. Following up on the referral to establish services – monitoring access to services
3. Arranging for transportation, clothing voucher, housing based on needs
4. Assist with linking client to new PCP (help with arriving at appointment, filling out paperwork, facilitating communication of needs due to barriers).
5. Monitoring treatment/goal progress and appropriateness of care (weekly ASAM reassessment)

Case Management Service Activities

1. Contacting PCP office or Alliance office to secure a PCP appointment for client to attend to needed physical exam or identified health concern.
2. Link to or coordinate care with MH Counselor or Psychiatrist
3. Coordinate medical appointment needs
4. Coordinate with legal/probation services on treatment status update
5. Outreach SLEs for information on available housing
6. Contacting County Service Coordinator for possible assistance on clothing needs
7. Assessing current level of care and anticipated discharge transfer to another LOC
8. Coordination of access to MAT treatment services
9. Assist in coordinating discharge from hospital/jail or higher level of care
10. Reassessment of ASAM dimensional needs, including CM needs

CM Progress Note details

1. Required Start and End time of service session
2. Duration = Real Time:
   a. Face-to-Face time: service time with client (in-person)
   b. "Other" time:
      1. *Avatar form completion and progress note writing time*
      2. *Case Management time (without client)*
3. Location: Office (in-person), Phone, in community. If not at provider site, ID how confidentiality was maintained.
4. Only if with Client: At least 2 EBPs identified in PN
5. D-I-R-P format – MUST link CM service to Client's TP goal and/or action steps. (**Leaving voicemail or sending an email is not claimable time**.)

CM Progress Note – Example (medical)

Data: Reason for the service & how related to TP, i.e. client doesn't have an established PCP

Intervention: Provide linkage of client to medical care (and assisting with minimizing barriers to the medical service)

Response: Outcome of service(s)

Plan: Follow-up plan and recommendation(s)

D – Staff provided case management service to assist client with establishing a relationship with newly assigned Primary Care Provider (PCP)

I- Staff provided linkage assistance to ensure client arrived at appointment on time and completed new-patient paperwork to accurately report current physical symptoms.

R – Client asked staff to help communicate self-reported needs to medical staff. Staff reminded client to ask for an appointment summary report that also includes any follow-up recommendations by PCP.

P – Staff to follow up with client on receipt of PCP's evaluation and assist with additional medical linkages as indicated on report.

CM Progress Note – Example (housing)

Data: Reason for the service & how related to TP, i.e. client doesn't have an established PCP

Intervention: Provide linkage of client to medical care (and assisting with minimizing barriers to the medical service)

Response: Outcome of service(s)

Plan: Follow-up plan and recommendation(s)

D – Staff provided case management service to assist client connect with housing resources.

I - Staff provided linkage assistance to ensure client contacted the housing authority to begin the Section 8 application process. Client called the housing department with the number provided by staff. With client's permission, staff assisted with communicating the client's need and request for an application.

R – Department staff collected client's needed information and indicated an application will be sent to the provided address within 7 days.

P – Staff to follow up with client on receipt of section 8 application after 7 days and assist with additional housing linkage needs as indicated by client.

CM Progress Note – Example (ASAM reassessment)

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D – Staff provided case management service to monitor clients treatment progress towards goals and action steps.

I - Staff conducted an ASAM reassessment with client regarding current dimensional needs and strengths to determine if there has been significant changes that may require a change in treatment services.

R – Client was forthcoming with current status and identified areas of improvement and continue struggle. ASAM assessment determined that client continues to meet the criteria for current level of care.

P – Staff to follow up with client next week to again review ASAM dimensions and progress in treatment.

Case Management Service Codes: 15 min

1. WM – 3.2 (Janus Detox) = A1780 (A2780 U21)
2. Res 3.5 (Janus) = A1180 (A2180 U21)
3. Residential 3.1 (Encompass SCRR & SPP & Janus 3.1 Main) = A1580 (A2580 U21)
4. IOS (Sobriety Works, Alto N & Alto S) = A1280 (A2280 U21)
5. OP (Sobriety Works, Alto N & Alto S) = A1480 (A2480 U21)
6. OP Youth Services = A2480 U21
7. NTP = A1380 (A2380 U21)

Thank You