Status Active PolicyStat ID 10449072

Origination	06/2017	Owner	Vicky Politowski
Last Approved	03/2022	Policy Area	Integrated Health Care
Effective	03/2022	References	NCQA QI8
Last Revised	03/2022		
Next Review	03/2023		

Complex Case Management

POLICY

It is the policy of Detroit Wayne Integrated Health Network (DWIHN) to promote effective Complex Case Management (CCM) services for members (adults, children and youth) with multiple behavioral health and/or medical needs that require a wide variety of resources to manage and improve quality of life. Services are provided in a collaborative manner and assess, plan, implement and coordinate care to assist members in regaining optimum health and/or improved functional capability in a safe, supportive environment and in a cost-effective manner – utilizing appropriate providers within appropriate time frames.

PURPOSE

The purpose of this policy is:

1. To improve the health status and quality of life of members with multiple medical, behavioral, and/or substance use disorders (SUD).
2. To decrease inpatient admissions, Emergency Department (ED) visits and to improve participation in outpatient behavioral/physical health services to avoid any gaps in treatment.
3. To improve member self-management skills by increasing adherence to evidence-based practices delivered by service providers – i.e. peer advocates, Clubhouses, available wellness resources (myStrength), etc.
4. To provide intensive, personalized case management services to include goal-setting and implementation utilizing person-centered principles.

APPLICATION

1. The following groups are required to implement and adhere to this policy: DWIHN Board,

DWIHN Staff, Contractual Staff, Clinically Responsible Service Provider (CRSP) and their subcontractors, Specialty Providers, Crisis Services Vendors, Credentialing Verification Organization (CVO)

2. This policy serves the following populations: Adults, Children, Individuals with Intellectual and/or Developmental Disabilities (I/DD), Serious Mental Illness (SMI), Serious Emotional Disturbance (SED), Substance Use Disorder (SUD), Autism
3. This policy impacts the following **contracts/service lines**: MI-HEALTH LINK, Medicaid, SUD, Autism, Grants, General Fund.

KEYWORDS

1. Access Center
2. Biopsychosocial Assessment
3. Care Connect 360 (CC360)
4. Complex Case Management (CCM)
5. Consent to Share Information
6. Co-Occurring Disorders (also known as Co-occurring Issues or Conditions)
7. Coordination of Care
8. Cultural Competence
9. Health Risk Assessment (HRA)
10. Integrated Health Care
11. Integrated Plan of Service (IPOS)
12. Level of Care Utilization System (LOCUS)
13. Medicaid Health Plan (MHP)
14. myStrength
15. Pre-Paid Inpatient Health Plan (PIHP)
16. Primary Health Care

STANDARDS

1. At least annually, Detroit Wayne Integrated Health Network (DWIHN) performs an assessment of the characteristics and needs of the entire population including adults, children/youth and relevant subpopulations. The assessment will include, but is not limited to, the following characteristics – age, gender, race/ethnicity, language preference, primary and co-morbid conditions, i.e. medical and/or behavioral health categories (SED, SMI, I/DD, SUD, Autism). (NCQA QI8 element A)
2. As a result of the population assessment and consideration of relevant characteristics, the Director of Integrated Care, in collaboration with the Chief Medical Officer, will use this information to: (NCQA QI8 element A)
    a. Assess and revise the Complex Case Management (CCM) program on an annual

basis;

b. Review and update the CCM resources (e.g. staffing ratios, clinical qualifications, job training, external/community resource needs and contacts, etc.) to address member needs, as necessary;

c. Review and update the CCM processes, services offered to members, and goals of CCM program;

d. Assess members' CCM needs and adjust procedures to facilitate linking enrollee/ members with CCM services that meet their needs.

3. Enrollee/Members will be identified for the DWIHN Complex Case Management Program (CCM) based on the following criteria (NCQA QI8 element A)

    a. The services geared towards adults aged 18 years and older will meet the following criteria:

        1. High frequency of Emergency Department usage;
        2. Multiple chronic medical/behavioral health conditions – i.e., congestive heart failure, chronic obstructive pulmonary disease, bipolar disorder, schizophrenia, major depression, and SUD concerns;
        3. Multiple psychiatric and/or medical inpatient admissions;
        4. Gaps in service – no PCP visit within one year; for those with behavioral health concerns, limited outpatient psychiatric follow-up and adherence to medications.

    b. Children/youth will meet the following criteria in order to be considered for CCM services. They will:

        1. Be diagnosed with Serious Emotional Disturbance (SED) or Intellectual/ Developmental Disability (I/DD);
        2. Range between the ages of 2 – 21 years (those enrollee/members in this cohort that are aged 18 – 21 are typically specially designated as youth with learning disabilities, court ward status, I/DD, etc);
        3. Have increased ED visits as well as multiple behavioral/physical health admissions and/or
        4. Have gaps in service and/or care; and
        5. Be diagnosed with asthma or other chronic health issues.

    c. Enrollee/members considered for participation in CCM services will be identified from service claims information, Vital Data, encounters, and utilization management data obtained through MHWIN, Care Connect 360, hospital discharge data, and other available electronic databases. Complex Case Managers also may make referrals for members in the program to appropriate resources based on member assessment or need. DWIHN's Complex Case Management program integrated with the following areas/services to assist member engagement in their health and well-being. (NCQA QI8 element D)

        1. Referrals can be made by DWIHN Utilization Management, Care

Coordinator and other internal staff; and externally by the multiple service providers within and outside of the DWIHN network.

2. Additional referrals can be made by medical health plans, hospital discharge planners, court systems, and self-referral via family or the member themselves.
3. The Disease Management Program that the member has their medical insurance coverage through can provide continued educational materials to members who may have chronic conditions or health concerns to keep members engaged in their health management.
4. DWIHN provides continued access to their online self-management and wellness program myStrength to members. Complex Case Managers assist members with getting connected during program enrollment.
5. DWIHN's Utilization Management department collaborates with Complex Case Management by assisting with referrals and updating Complex Case Managers on inpatient stays, members with complex diagnosis, crisis events, or multiple/frequent hospitalizations.
6. DWIHN Complex Case Managers work with staff at Clinical Responsible Service Provider (CRSP) organizations to coordinate care and strengthen members relationship with current care team which includes sharing plan of care, attending some meetings with care team, and frequent contact with Case Manager/Supports Coordinator.
7. DWIHN Complex Case Managers may work together with Palliative Care teams and/or End of Life Services as needed to assist with the Transition of Care.
8. DWIHN Complex Case Managers connect members to Community Resources to meet needs such as food banks, financial assistance, transportation, housing and additional supports services such as home care assistance.

4. A Complex Case Management (CCM) assessment will be completed for each member involved in CCM. Within the CCM assessment will be embedded the WHO-DAS and PHQ-9/PHQ-A; both are evidenced-based tools that will provide measurable outcomes throughout an enrollee/member's participation in the program. (NCQA QI8 element G and H)
    a. WHO-DAS measures quality of life and covers six domains of functioning including cognition, mobility, self-care, getting along with others, life activities and participation.
    b. The PHQ-9/PHQ-A is used for screening, diagnosing, monitoring and measuring the severity of depression.
    c. The assessment shall also include the following information for the member: current health status, clinical history, current medications, including schedules and dosages, ability to perform activities of daily living, current behavioral health status, social determinants of health, life planning, cultural and linguistic needs, visual and hearing needs, caregiver resources, available benefits, and community resources.

5. A Plan of Care will be developed utilizing person-centered practices and will include the needs identified in the CCM assessment.
    a. It will include measurable goals, expectation of completion date, strengths, the enrollee/member's priorities and any barriers to success.
    b. The Plan of Care shall prioritize goals, include time frames for achieving goals, resources needed to achieve goals, and identify barriers to achieving goals. (NCQA QI8 element I)
6. All communications, assessments and plans of care will be located within the DWIHN electronic record.
7. Complex Case Management (CCM) services will be delivered within the philosophical principles of integrated care. Some examples include:
    a. Referral to Medical Health Plan Disease Management programs that will provide educational materials to enrollee/members to keep them engaged in the management of their medical/behavioral health condition.
    b. Wellness and self-management programs such as smoking cessation, personal action toward health (PATH), Wellness Recovery Action Plan (WRAP), and Whole Health Action Management (WHAM) and the online myStrength tools are further options to support members in working towards their goals.
8. Criteria for discontinuing Complex Case Management (CCM) services include enrollee/member:
    a. Having reached maximum benefit from CCM services and is able to safely return to outpatient service providers;
    b. Having met or partially met the majority of identified short-term goals;
    c. Declines further services;
    d. Unable to reach member after 3 or more outreach contacts;
    e. Enrollee/member requires a higher level of care – i.e, enrollee/member: is inpatient with an anticipated length of stay greater than 30 days; is incarcerated for longer than 30 days, requires hospice services, etc.
9. The effectiveness of Complex Case Management Services (CCM) will be reviewed using the following parameters:(NCQA QI element J)
    a. Decreased gaps in services related to physical and behavioral health care;
    b. Increased adherence to medications as evidenced by pharmacy claims;
    c. Decreased ED visits, inpatient psychiatric and/or physical health admissions;
    d. Improved scores of the PHQ-9/PHQ-A and WHO-DAS tools embedded in the CCM Assessment;
    e. Satisfaction surveys completed by the member/guardian;

QUALITY ASSURANCE/IMPROVEMENT

DWIHN shall review and monitor contractor adherence to this policy as one element in its network

management program, risk management program, and Quality Assessment/Performance Improvement Program (QAPIP) Work-plan.

The quality improvement programs of Network Providers must include measures for both the monitoring of and the continuous improvement of the programs or processes described in this policy.

COMPLIANCE WITH ALL APPLICABLE LAWS

DWIHN staff, contractors, and subcontractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended.

LEGAL AUTHORITY AND REFERENCES

1. Michigan Department of Health and Human Services Medicaid Provider Manual (in effect, and as as amended)
2. Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program (PIHP/CMHSP contracts in effect, and as amended)

RELATED POLICIES

1. Assessment Policy
2. **Complex Case Management Procedure**
3. Eligibility and Screening Policy
4. Referral, Coordination and Integration of Care Policy

CLINICAL POLICY

YES

INTERNAL/EXTERNAL POLICY

EXTERNAL

Attachments

CCM Periodic Review of Outcomes and Program Effectiveness

Approval Signatures

Step Description	Approver	Date

Final Approval	Melissa Moody: Chief Clinical Officer	03/2022
Stakeholder Feedback	Allison Smith: Project Manager, PMP	03/2022
Director Committee Review	Yolanda Turner: Legal Counsel	03/2022