Title:	Case Support	**Code:**	YP215
Type:	State Benefit Plan	**Group Code:**	N/A
Effective Date:	03-10-20	**Units:**	1 unit= 15 minutes

Service Description

Case Support is designed to augment member care by allowing providers to complete tasks, which have otherwise not been completed by providers because there was no reimbursement method for these activities, or providers have completed but this is not sustainable without funding to support. It allows providers to coordinate with all agencies who may be involved in the member's care. This service will be solely for uninsured members that have no other funding stream (Medicaid, private insurance) and may assist these members in applying to access those benefits. These services will be limited to those providers that serve as a safety net provider in the local community for the indigent population and will be utilized to assist member not only in linkage to appropriate MH/SU/IDD services, but medical services, community services, and other needed supports. This service will also be used to fill in treatment gaps when members are unable to receive their typical site-based programming activities or face-to-face services, but those providers are still able to provide supports to the members through telephonic or tele-health methods.

Population to Be Served

Case Support is an indirect, periodic service where the case support staff arranges, coordinates, and monitors services on behalf of the recipient. This service may be provided with and/or on behalf of a recipient of MH/SU/IDD services, ages 5 and up, who are uninsured and have no other funding stream (Medicaid, private insurance).

Entrance Process

Identification of a member's need for Case Support would be identified at the time of the provider assessment or presentation to a walk-in clinic/open access or may be identified by providers having to suspend typical operations due to the pandemic. This service should be part of the individual's treatment plan and have a valid service order prior to service initiation, but when utilized for the pandemic this may be completed retroactively. Screening should occur prior to service initiation that members does not have any other active services that would duplicate interventions and determine the treatment modalities for safe delivery of the service for the member and provider.

Service Order Requirement
Service orders can be completed by fully licensed clinicians or for IDD-Qualified professionals

Admission Criteria
The recipient is eligible for this service when:
A. The individual meets State Benefit Plan eligibility criteria
AND
B. There is a DSM-5 diagnosis present, or the person has a condition that may be defined as a developmental disability as defined in GS 122C-3 (12a).
AND

Utilization Management

Continued Stay Criteria:
The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's service plan or the recipient continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

A. Recipient has achieved initial service plan goals and additional goals are indicated.
B. Recipient is making satisfactory progress toward meeting goals.
C. Recipient is making some progress, but the service plan (specific interventions) need to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.
D. Recipient is not making progress; the service plan must be modified to identify more effective interventions.
E. Recipient is regressing; the service plan must be modified to identify more effective interventions.
F. Recipient has not been linked to other more appropriate behavioral health services.

Discharge Criteria:
Consumer's level of functioning has improved with respect to the goals outlined in the service plan, or no longer benefits from this service. The decision should be based on one of the following:

1. Consumer is not making progress, or is regressing, and all realistic treatment options within this modality have been exhausted.
2. Consumer has moved to a bundle service were case support activities are included.

Covered Services include:

Case Support includes face-to-face and telephone time in contact with the member, collateral, and other agency personnel. This service can also be delivered via tele-health. The frequency and amount of this service is based on the individual's needs. The activities must be directly related to support to the member and not strictly for administrative activities such as scheduling clinic appointments, appointment reminders, forwarding messages to staff, phone calls for cancellation of appointments, etc.

- Staff Travel Time is not covered under this service
- Preparation or completion of documentation such as service notes, time sheets, etc. is not covered under this

service
- Structured services including Evaluations, Outpatient Treatment/ Habilitation or After-hours services are to be reported to the appropriate service type.
- This service is not utilized for members that have enhanced services in place that are actively still being delivered, or services that are expected to provide case support activities.

Eligibility Criteria

Case Support is an indirect, periodic service where the case support staff arranges, coordinates, and monitors services on behalf of the recipient. This service may be provided with and/or on behalf of a recipient of MH/SU/IDD services, ages 5 and up, who are uninsured and have no other funding stream (Medicaid, private insurance).

Service Exclusions

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This service should not be provided to members linked with enhanced services when these are actively being provided. Specifically, if members are actively receiving Assertive Community Treatment (ACTT), Community Support Team (CST), Substance Abuse Intensive Outpatient (SAIOP), Substance Abuse Comprehensive Treatment (SACOT), Intensive In-Home Services(IIHS), Multi-Systemic Therapy (MST), High Fidelity Wraparound Services (HFW) or other services that already have case support activities included.

Documentation Requirements:
Documentation required for this service should be maintained in the provider's medical record for the individual and a full-service note is required for all dates of service. This should include a note of the activities preformed, amount of time spent, agencies contacted, if applicable, and signature and credentials of the individual providing the service.

Service Limitations:
Twenty (20) units per day (5 hours) is the daily service maximum. Using the maximum hours should be time limited while connecting an individual to a more intensive service. The service may be delivered up to daily for members that need specific daily support due to social isolation due to the pandemic; who require daily check in for medication reminders, etc. Documentation should clearly support the reason for this frequency, with typical units of 1-2 daily.

Treatment Program Philosophy, Goals, and Objectives

Case Support includes activities with and/or on behalf of a recipient of MH/SU/IDD services including:

- Case support activities performed by an individual at a provider agency for members that do not have other services in place that would be responsible for these case support activities. The service is designed to meet some of the broad healthcare needs, educational, vocational, residential, financial, social and other non-treatment needs of the individual. The service includes the arrangement, linkage or integration of multiple
- service and providers involved in the member's care. This includes making referrals to enhanced service providers and following up to ensure services are initiated.

Interventions include strategies and actions for the purposes of coordination treatment and assisting the member in connection to community supports. These are typically associated with members receiving services through the walk-

in clinic or advanced access provider or may be provided as a follow up after acute crisis episode when enhanced services are not clinically indicated but some time-limited periodic support is needed to ensure successful stabilization after these treatment episodes.

The following strategies and actions may occur in addition to the above treatment intervention:

- Activate referrals and connections to other providers
- Initiate bed finding/placement activities
- Assist in connection to housing resource
- Monitor individual's safety, medical and psychiatric status (beyond time spent in the clinical activities)
- Provide food, hydration, and comfort items for those individuals where this is needed to stabilize
- Peer Support Specialist services to educate on WRAP plans, Advanced Directives, etc.
- Provide community resource information
- Assist in benefit coordination, inclusive of assisting member to complete paperwork to apply for benefits
- Assist in applying for patient assistance programs for medication or
- Assist in coordination with physical health providers including linkage and referral to these providers
- Identify natural supports
- Monitor as needed based on first evaluations where transfer to more intensive services in needed and is being coordinated.

Expected Outcomes

The expected outcome of this service is to support consultation with other agencies and professionals who are assessing and addressing the identified cognitive and behavioral deficits of the recipient and to facilitate referrals to appropriate treatment services on a short-term basis.
Agencies will evaluate this service as part of overall satisfaction surveys. Utilization of this service will also be monitored to ensure that this is not utilized as a replacement for other more appropriate basis and that this is not used on a long-term basis but as a time limited support for activities that are not otherwise included in other services but help address behavioral health needs and other social determinant of health needs.

Staffing Requirements

- Case Support must be delivered by practitioners employed by a mental health/substance abuse provider organization that meet the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G.
- Provider must be approved be the LME/MCO to deliver this service
- Persons who meet the requirements specified for professional or paraprofessional status for the appropriate disability population or qualified professional or paraprofessional status for the appropriate disability population according to 10 NCAC 14V.
- Supervision is provided according to supervision requirements specified in 10 NCAC 14V and according to licensure/certification requirements of the appropriate discipline.
- Staff will receive training based on the functions they are preforming as part of this service. For Paraprofessional staff performing case support functions, the agency will have an outlined training plan for these staff, including de-escalation training for additional support by clinical staff when indicated.

Targeted Length of Service
Length of stay is dependent upon COVID-19 period.