Hope Network
Behavioral Health– East

Program Description – Case Management/Supports Coordination

Mission Statement

In Christian service, Hope Network empowers people to overcome challenges and achieve their highest level of independence.

Program Goal

The primary goal of Case Management and Supports Coordination Programs are to provide goal-oriented and individualized supports focusing on improved person served self-sufficiency and community inclusion. The amount, scope, and expected duration of services are outlined in each person's treatment plan.

Program Description / Program Philosophy

Case Management and Supports Coordination Programs provide goal-oriented and individualized supports focusing on improving the person served self-sufficiency and community integration through assessment, planning, linkage, advocacy, coordination, monitoring activities, including but not limited to needed psychiatric, mental, physical and substance use services, financial assistance, housing, employment, education, benefits/entitlements, natural supports, and crisis interventions to adult individuals with psychiatric, developmental, or co-occurring disabilities.

Caseloads vary and depend on the level of severity of persons served needs. Generally, the case manager to person served ratio is 1:50. Hope Network will make efforts to match workforce members demographic characteristics to those of the persons we serve. Workforce members are culturally and linguistically competent relative to the current person's served caseload. Workforce members promote recovery and/or well-being, provide services consistent with the needs of persons served, implement and monitor the treatment plan, and react to service provisions as persons served needs change.

Generally, bachelor or master level workforce member who have a degree in a human service area. Workforce members work with the persons served to achieve maximum levels of functional potential and increased social connectedness based on the person's served needs and wants. A qualified mental health professional supervises Case Managers and Service Coordinators. Medical consultation is provided by the Medical Director or medical workforce member assigned to the program.

Days & Hours of Services

Generally, the Case Management and Supports Coordination office hours are Monday-Friday, between 8:00 a.m. and 5:00 p.m. Critical after hour situations are to be directed to emergency services unless otherwise stated in the person's served treatment plan.

Service Locations

Case Management and Supports Coordination services are provided primarily to individuals in independent living situations, individuals in unlicensed, supported settings, and persons served in 24-hour licensed, specialized adult foster care facilities.

Frequency of Services

Services are individually tailored to meet the needs of the person served. The amount, scope, and expected duration of services are outlined in each person's served individual treatment plan. Case

Management and Supports Coordination Services are provided in a responsive, coordinated, effective, and efficient manner focusing on process and outcomes.

Target Population

- Adults and children with serious mental illness
- Adults and children with developmental disabilities
- Adults and children with co-occurring disorders
- Adults and children with multiple service needs
- Adults and children with a high level of vulnerability and/or are unable to independently access and sustain involvement with needed services

Credentialing & Training

- Workforce member will be trained in First Aid, CPR, OSHA, Recipient Rights, Trauma Informed Care, Crisis Intervention, Zero Suicide initiative techniques, HIPAA, LEP, Cultural Competency, Compliance and Integrity, related issues.
- Continuing education/orientation will include at least an additional 14 continuing education hours annually, covering:
    - Assessment and referral
    - Person-Centered planning and self-determination
    - Treatment and service
    - Relapse and recovery
    - Medication administration, monitoring, and education
    - Addiction counseling and prevention
    - Crisis management and intervention
    - Clinical documentation
    - Co-Occurring Disorders
    - Other areas as needed to provide high quality services
- On-going professional and clinical supervision
- On-going access to a medical professional, fully licensed bachelors level qualified mental health professional, and addictions specialist

Service Approach/Modality

- Person Centered Planning
- Self Determination
- Illness Management and Recovery
- Integrated Dual Diagnosis Treatment
- Multidisciplinary Team
- Secondary interventions for non-IDDT responders
- Relapse Prevention
- Family Psycho-Education
- Motivational Interviewing Approach / “Stages of Change”
- Community Inclusion
- Other services adequate to meet Medicaid regulations for this service.

Services Provided

- Assessment
- Psychiatric evaluation
- Treatment planning
- Service reviews
- Pharmacological
- Medication management and support
- Outreach
- Substance use/addiction education services and referrals for services

- Family psycho-education
- Community linkage/service coordination
    - Entitlements/benefits
    - Psychiatric care
    - Medical care
    - Substance use services
    - Shelter/housing
    - Social support networks
    - Educational
    - Transportation
    - Vocational/employment
- Skill development related to community living, social skills and supports
- Community/natural supports
- Coordination of care with primary care physician and health plan
- Transition services
- 30-Day post service follow-up
- Arranges for crisis intervention services

Service Outcomes

- Support, recovery, or a better quality of life
- Integrated Dual Disorder Treatment (IDDT)
    - Reduces
        - Relapse of substance abuse and mental illness
        - Hospitalization
        - Arrest
        - Incarceration
        - Duplication of services
        - Service Costs
        - Utilization of high-cost services
    - Increases
        - Continuity of care
        - Person served quality of life outcomes
        - Stable housing
        - Independent Living
- Greater self-determination
- Reduction of symptoms or needs
- Restoration or improvement in levels of functioning
- Community integration
- Greater use of natural supports

Program Access

Persons served are referred to Case Management and Support Coordination services through the local CMH. An individual may also contact Hope Network and engage in services independently if they have an ability to privately pay for the services available. If the person served qualifies for case management services, an assessment will be completed within seven days of the referral.

Admission and Readmission Criteria

- Current mental illness or developmental diagnosis as reflected in the recent version of the DSM or ICD and at least one of the following manifestations:
    1. Prominent disturbance of thought processes, perception, affect, memory, consciousness, and somatic functioning with or without co-occurring substance disorder
    2. Disruption of self-care and independent functioning
    3. Difficulty with managing medication without ongoing support
    4. Risk to self or others
    5. Socially disruptive behavior that puts them at high risk for arrest and inappropriate incarceration or those exiting a jail or prison

6. Frequent users of inpatient psychiatric hospital services, crisis services, crisis residential, or homeless shelters

The referring agency, insurance provider, and Hope Network Behavioral Health – East workforce members work together in making access, referral, transition, and/or discharge decisions.

The referring agency manages admission priorities and any wait lists for services.

Exclusionary Criteria

A. Person served is in an institution or ICF/MR and is not expected to be discharged within the next 180 days.
B. Person served is enrolled in the PSR clubhouse and receives case management as a "bundled" service. Persons served are eligible to receive case management services either from the PSR Clubhouse Program or as a separate Targeted Case Management Service (outside the Clubhouse), but not both.
C. Person served has a mental illness but does not meet the criteria for severity of illness/intensity of service to be admitted for Targeted Case Management.
D. Person served is enrolled in ACT.

Transition/Discharge Criteria

- Achieves/obtains treatment goals
- Ability to maintain adequate physical, mental, and emotional health and stability
- Moves outside of geographic area of the Case Manager/ Supports Coordinator's responsibility
- When the person served requests termination of services
- Requires higher level of care
- When the Case Manager/Supports Coordinator cannot locate the person served

When services are denied, individuals will be informed as to the reason for the service denial. Recommendations for alternative services will be summarized with the individual. Where appropriate, service denials and/or service recommendations will be communicated to the referring agency.

When services are transitioned and/or discharged, persons served will be provided a transition/discharge summary and a copy of the summary will be provided to the persons served designated representative and responsible agency.

When services are denied, reduced, and/or suspended, persons served will be provided due process notices including but not limited to adequate notice, advanced notice, Office of Recipient Rights Complaint Form, and/or internal grievance procedures and associated forms.

Payer Sources/Fees

- Generally, this service is paid for by Medicare and/or Medicaid. This service provision may be covered by commercial insurance. The insurance card/number will indicate the reimbursement source.

Funding Source

These programs are generally funded through various contracts with Community Mental Health agencies and individual contribution; which is based upon the individual's ability to pay. Persons served may be private pay.