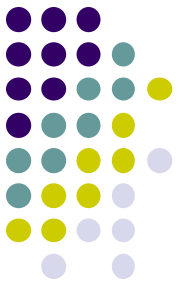
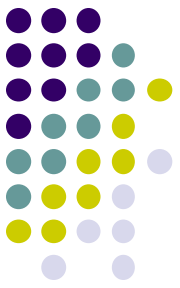


CASE MANAGEMENT

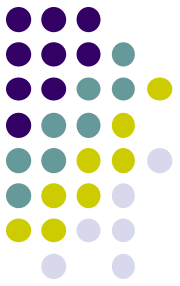


CCQC: Is it possible to do this alone?



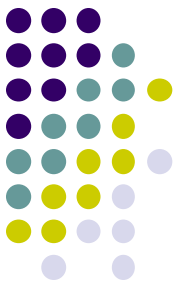
- Training programs can get to be very expensive especially when all of the costs – actual and opportunity costs – are included
- Resource limitations force too many providers to use ineffective on the job training programs which can range from inconsistent to very scary
- Standardized training tools are critical but they must be updated to keep interest and freshness of the material – trainers get bored too.

Behavioral Health Risk



- Centers around two primary issues
 - 1) are we providing covered services that are medically necessary
 - 2) are we documenting these services so that an auditor realizes this

Brief Background



- Case management considered high risk by
OIG and CMS
- Costs high, value uncertain
- Mostly abuse by states
- Resulted in a change to the definition of
case management by Congress in the
Deficit Reduction Act

Brief Background



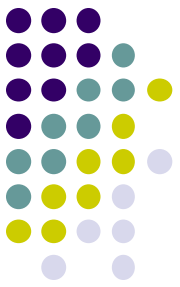
- Remaining advice is a State Medicaid Director's letter, the DRA definition, and the post-moratorium CMS –all in your handouts
- Colorado intends to submit a SPA for TCM – right now providers operating under current definition which is clinic based
 - HCPF has informed CMS that providers are currently doing community based CM

Medical Necessity



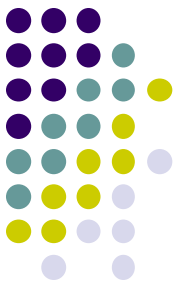
- The payers perspective
 - 1) Definition is controlled by the payer
 - 2) Multi-dimensional decision-making but big question is, is it necessary?
 - 3) CM or not?
 - 4) Cost-effectiveness

Documentation



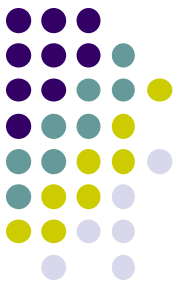
“Without complete clinical record documentation, including a description of what took place in a therapy session, the medication prescribed, the individual’s interaction with group members, his or her progress compared to the treatment plan goals, and future plans of treatment, the appropriateness of the individual’s level of care is unclear.

Documentation



- Furthermore, inadequate documentation of individual therapies and treatment provides little guidance to physicians and therapists to direct future treatment. In this regard, the lack of required documentation precludes reviewers from determining whether those services are needed.”

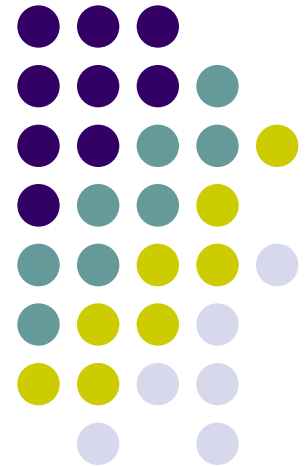
Case Management

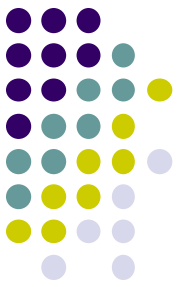


- Remembering always :
 - Documentation is not a means of gaming the system; of just making sure you are using the right words
 - Documentation is an accurate depiction of a covered service that actually took place with some analysis of the intervention's impact on the progress of the individual towards their own goals.
- This training is designed to spend the bulk of the time helping trainees figure out what Case Managers are supposed to do. Not just how to document services.

The Real Basic Rules

Medicaid and Medicare





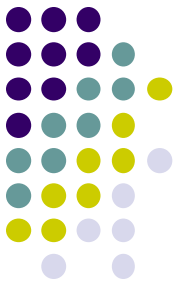
Medicaid

- Primary payer of community-based mental health services, including case management
- Joint payment by both the federal government and the state -so they both have a say as to how services are provided
- Highly regulated industry

CURRENT ENVIRONMENT: Enforcement and Oversight



The government understands that it needs to bend the cost curve in health care and so it looks for savings in efficiencies, implementation of better models AND the reduction of fraud, abuse and waste in the system.



Colorado CMHCs Get Paid

- We get a set amount each month for each Individual assigned to us as a member to provide all of their mental health needs.
- The amount we get paid in this set amount is dependent on the health care status of the individual.
- We track the services we provide by submitting encounters to the Behavioral Health Organizations which are responsible for managing the Medicaid mental health dollars for the state.
- For the purposes of compliance encounters and claims are the same thing.



With Medicaid: Rule #1



- Everything that is therapeutic is not billable
 - Remember Medicaid is like any other insurance – it only pays for covered services
 - Therefore understanding the definition of case management services is critical

With Medicaid: Rule #2



- To become a Medicaid provider you must meet certain criteria:
 - We must be a licensed CMHC to be a Medicaid Provider – the conditions for this license are contained in the Department of Behavioral Health regulations.
 - Each time we submit an encounter we certify that we meet all regulatory requirements

With Medicaid: Rule #3: Medicaid and Medicare are both highly regulated and now a highly enforced business environment.

- Medicare works under a model of care that requires that a mental health professional orders care, oversees implementation, and ensures the plan is effective and being followed
- In Colorado, the treatment plan –no matter who actually writes it – must be signed by a licensed professional.
- Colorado is committed to recovery/resiliency based treatment – we must learn to use Medicaid's rules in such a way that these models of service delivery are supported.

What Does This Mean for Provider Organizations?

- We must build structures that gives providers the information they need to safely provide services
- We have a compliance program and compliance officer to help answer questions and to investigate potential problems.



"Make sure everything is done ethically. Within reason, of course."

What Does This Mean for Individual Providers?



- You must remember that your name is going on every encounter/bill.
- Try to remember that the rules (e.g. documentation) are usually put into place to help you.
- You must not bill for services you do not think meet requirements
- You need to follow the rules

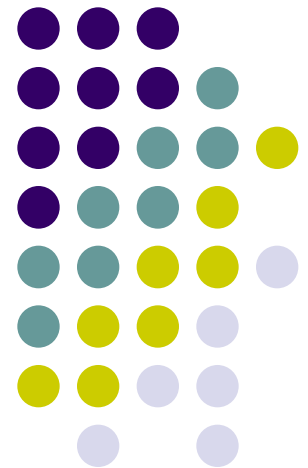
Risk of Non-Compliance



- Loss of Medicaid funding
- Reduction in reimbursement rates
- Significant paybacks
- Exclusion: Loss of eligibility to participate in the Medicare/Medicaid programs, both as an agency or as individual providers
- Personal risk to professional license

**Not Just Fraud,
Abuse and Waste**

**But also Improper
Payments**



IMPROPER BILLING PRACTICES

“Up-coding” - *submitting a bill with a service code that is at higher cost than the actual service*

provided , e.g. providing CM and coding it as therapy

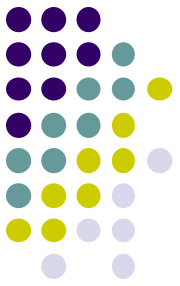
No clinical note (or an inadequate note) - *lack of substantiation for the delivered service*

Cloned documentation: *where every note looks virtually the same for the individual or across a CM caseload.*

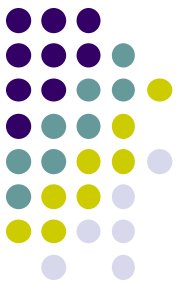
Delivering more treatment than is medically necessary- *knowingly providing more service than is warranted for the client’s needs – e.g. to meet productivity you see clients for longer periods of time.*



CASE MANAGEMENT SERVICES



What is CM? It is “care coordination”.



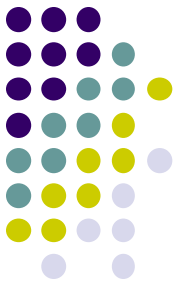
- “Care coordination” is a client-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which an individual’s needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an identified care coordinator following evidence-based standards of care.

State Medicaid Manual



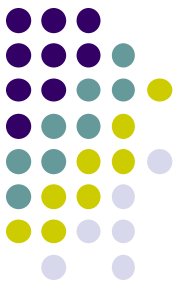
Chapter 4: 4302 A: Case management is an activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual.

What is CM? The New Federal Definition in the DRA.



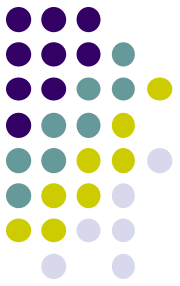
- Services that consist of one or more of 4 buckets of activities:
 - CM assessment
 - CM plan or integration of CM interventions into a treatment plan
 - Referral and related activities
 - Evaluation and Monitoring of the plan

New Federal Definition is Congruent with the Definition of Effective Care Coordination



- “Care coordination” is a client-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which an (1) individual’s needs and preferences are assessed, (2) a comprehensive care plan is developed, and (3) services are managed and (4) monitored by an identified care coordinator following evidence-based standards of care.

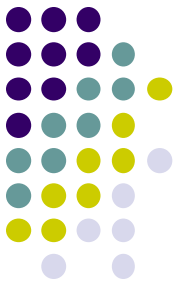
CASE MANAGEMENT



In Colorado, there are
really 3 types of
Case Management



Clinic Based Case Management

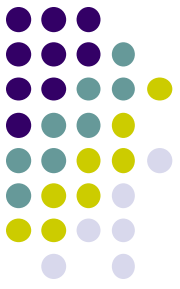


Case management services are provided by the Individual's clinician.

- Facility based
- Usually for ad hoc needs or concentration on one or two systems.
- Usually more of a brokerage system – lots of phone work

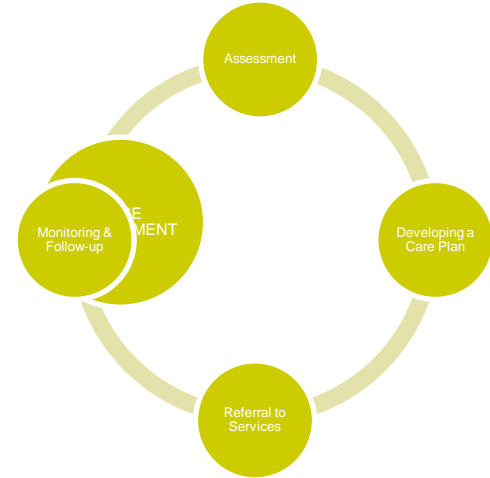


Community-Based Case Management



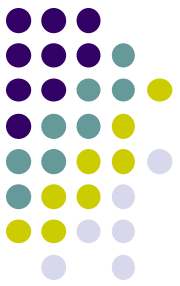
- Usually high need for assistance with multiple systems
- Individual has few supports
- Often significant functional problems – social and cognitive deficits that make linking difficult
- Often need for both community-based work and aggressive outreach along with phone work for coordination of care

INTENSIVE CASE MANAGEMENT



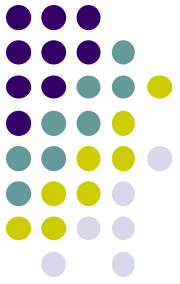
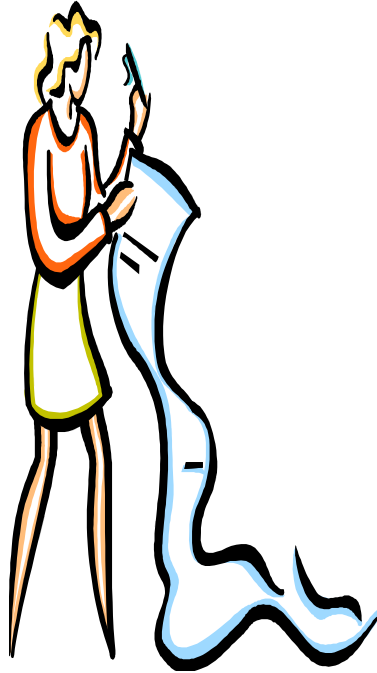
ICM is defined as “community-based services averaging **more than one (1) hour per week**, provided to children and youth with serious emotional disturbances (SEDs) and adults with serious mental illnesses (SMIs) who are at risk of hospitalization, incarceration and/or homelessness due to multiple needs and impaired level of functioning (LOF). ICM Services are designed to provide adequate supports to ensure community living.”

A form of community-based case management services. Decision to bill/encounter for this is a week by week decision, i.e. Individuals are not enrolled in intensive case management.

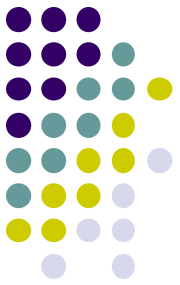


Goal of all Types of CM

- Greater independence on the part of individuals and families in accessing and linking to appropriate services and supports.
- CM always focus on working themselves out of a job with each individual on their caseload.
- CM always looking for other less formal supports, e.g family, social services, etc. that will replace the mental health system.



OTHER IMPORTANT CM RULES



PROVIDER CHOICE

The client must have a choice in where he/she receives their case management services. We cannot require clients receive their CM services from us.

- Help the individual to choose one CM if they have more than one. If not, coordinate so that you are not both addressing the same issues.



Do not duplicate other CM services!

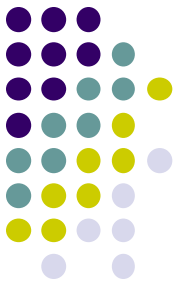
- Where there are others involved try to focus on the mental health CM needs of the person.
- Where there are others involved: Medicaid is always the payer of last resort.

COLLATERAL CONTACTS AND CASE MANAGEMENT ...



- Case management may include contacts with collateral contacts or family members when necessary to manage the care of the client (e.g., to help access services, identify needs and supports, and provide useful feedback to case managers).
- Contacts with others can be either face to face or via phone
- Family members may also be involved in all components of case management—for example, when they provide feedback or alert the case manager to changes in the individual’s condition or needs that results in a change in the treatment plan.
- However, CM services cannot be provided for the family if they do not have their own diagnosis and CM plan. This is called “exclusive benefit” .

THE CASE MANAGEMENT CODE CANNOT BE USED FOR ...

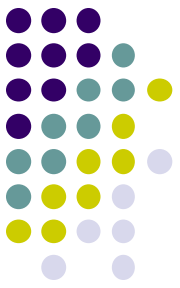


The direct delivery of a service to which the consumer has been referred. For example, you cannot provide skill building service and call it case management.

Does not include time spent transporting the consumer to required services or time spent waiting while the consumer attends a scheduled appointment.

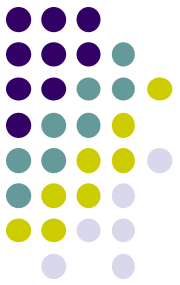


CM Code **Cannot** be Used for



- Any treatment interventions or skill building
- Social or recreational activities or supervision of them
- Running errands
- Clinical or administrative supervision
- Documentation
- Service record reviews

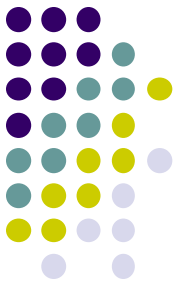




Case managers are not...

- Mother or father
- Big brother or sister
- Taxi or chauffeur
- “Gofer” or “Do for person”
- Friend or companion
- Date, escort
- Accountant, bookkeeper or loan agent
- Police Officer

Some examples of Non-CM Activities

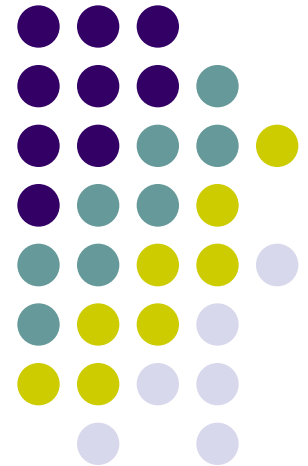


- Attending a meeting or going to court with a client
UNLESS you are testifying or negotiating with the judge/parole officer for changes so that additional tx can be provided.
- Working on a budget with a client
- Delivering meds to the client's home
- Sitting in on the psychiatrist's appointment
- Leaving messages, writing no-show letters
- Refilling prescriptions
- Activities to do with jury duty notices

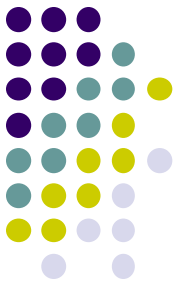


So, What is CM?

I know what I cannot do, but what
can I do?



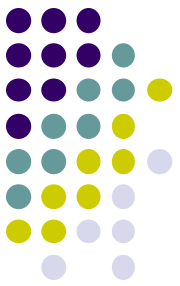
ELEMENTS OF CASE MANAGEMENT



FIRST: A comprehensive assessment to determine the need for medical, educational, social or other services. This includes

- Assessing the individual's strengths and preferences
- Taking client history
- Identifying needs and completing related documentation
- Gathering information from other sources such as family members, medical providers, social workers, educators, or others to form a complete assessment of the eligible individual's needs.



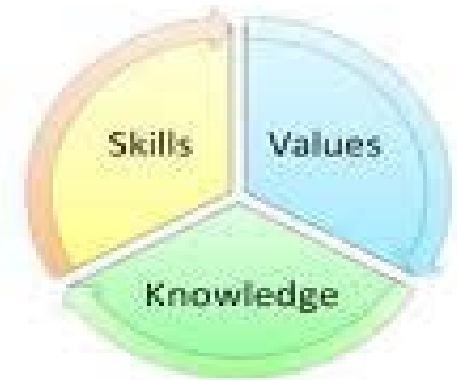


CM ASSESSMENT

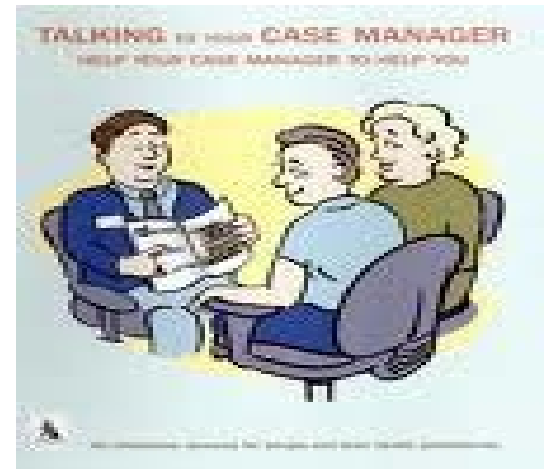
Determines the Individual's needs using multiple sources including their own story.

The case management assessment

- Is an organized review of needs
- Determines priorities.
- Asks:
 - What kind of impact is the issue having?
 - How have they been dealing with this?
 - Anyone else helping them?
 - Anyone else available?
 - Do they need help?
 - What kind?



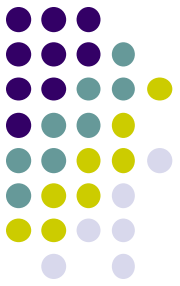
What are Assessment Activities that Can be Encountered?



Assessment

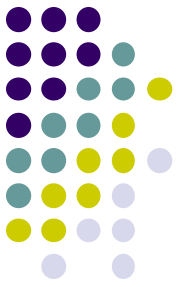
- Meeting with client/family members
- Completing assessment tool
- Gathering authorizations to get information from other providers
- Reviewing biopsychosocial with client and family to familiarize yourself and to ask questions
- SEE HANDOUT

Case Management Assessment



- Two examples: (remember this is not required – but a clinical assessment is usually not specific enough for CM needs)
 - Pennsylvania
 - Pennsylvania Lite

Case Management Assessment Script for Case Managers

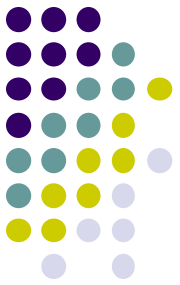


Ask the following questions for each life domain:

1. In the past 30 days has your situation/ability/functioning with or in (list domain) made it difficult for you to participate in mental health/ substance abuse treatment, job/job training, school, or seeing your medical doctors?
2. If yes, how much? (A little, somewhat, a great deal)
3. If yes, can you describe the current situation and what type of help you think you need?
4. Is anyone else helping you with this?
5. Were they helpful and are you still working with them?



ELEMENTS OF CASE MANAGEMENT

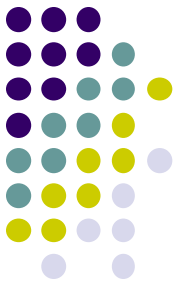


SECOND: The *development of a specific plan of care*

(based on information collected through the assessment process)

- The plan lists the recovery goals and actions necessary to address the medical, social, educational and other services the individual needs.
- The Individual should be an active participant (remember they are more likely to engage if active participant) -this is true for adults and children both
- The CM plan should address the same goals and objectives as the treatment plan – you should all work towards the same recovery goals.

Planning: What Needs to Be Considered



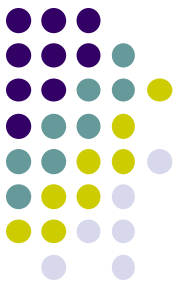
- Person-centered planning is a process—not an event. *(Stay with the Individual – they don't know or trust you or the system in the early days.)*
- Who do you need to link to – in what order – with what effort?
- What types and kinds of coordination will be needed?
- When and how will you assess the effectiveness of the plan?



Do We Need to Have a Separate CM Plan?



- NO – with an integrated treatment/CM plan, CM will usually show up as interventions.
- E.g. Goal: I would like to be able to reconcile with my family.
 - Objective: Jim will make one call to each family member and talk for 5 minutes about a non-controversial subject.
 - CM: link to therapist to assist individual with developing social/conversational skills; coping with anxiety, anger management.
 - CM link to AA for community based recovery support



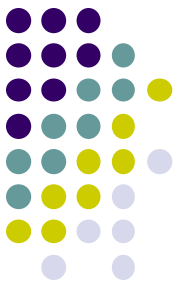
CM Planning: What You Can do

Developing the initial plan includes covered activities such as: SEE HANDOUT

- Coordinating planning meetings;
- Making sure the individual understands the planning process and is included in planning;
- Helping the individual prioritize their needs and identify strengths and the skills and supports they need as a result;
- On-going evaluation, with the individual and your supervisor together, of the effectiveness of the plan.
- Writing the plan if the client is present – concurrent documentation



ELEMENTS OF CASE MANAGEMENT



THIRD: Referral/Linkage and related activities to help individuals obtain needed services.

This includes activities that :

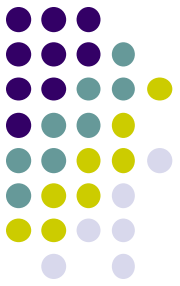
- Plan for linkage and referral activities
- Do the actual referral and linkage



Linkage... TWO PARTS



- Linkage Strategy: Planning for implementation of the various parts of the plan: timelines, appointments, priorities, etc.
- Linkage Implementation of the plan: Assistance with accessing services and supports.



“Case management referral activity is completed once the referral and linkage have been made.” From the Interim Final Rule

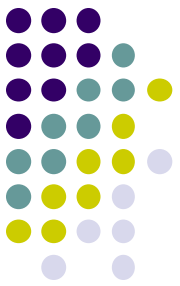
- Referral: process of directing someone to a service or support
- Linkage: Need to ask the question could this person independently access the service on their own?
 - Linkage means something more; not just the referral but the ability to use and manage the referral.

Referral and Linkage

- Making and Keeping Appointments –its not easy
 - Pay attention to the secretary
 - Understand what has been said or written
 - Think about other appointments you have made so as to avoid a schedule conflict
 - Remember to write down the appointment
 - Remember to look at the calendar on the designated day.
 - Plan how you will get to the appointment
 - Organize yourself to make sure you are there on time.
 - You may even want to make notes about the things you will need to discuss at the appointment



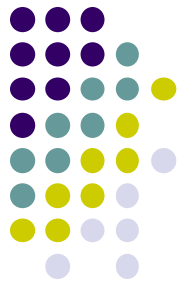
Referral and Linkage



- Making and Keeping Appointments
 - Very important: you must also be emotionally ready and willing to keep the appointment
 - You must be able and comfortable expressing your issues and concerns to the provider
 - You must be able to remember changes, homework, advice and counseling, additional activities you must undertake (e.g. lab work)

This sequence can be overwhelming. You are trying to intervene where necessary, to provide supports where needed, and to back off where the Individual can do by themselves or with supports other than you.

ELEMENTS OF CASE MANAGEMENT



FOURTH: Monitoring and follow-up activities

including

- Activities and contacts that are necessary to ensure that the care plan is effectively implemented and is adequately addressing the person's needs.
- Follow-up may be with the individual's family members or service providers, or other entities or individuals.

ELEMENTS OF CASE MANAGEMENT



FOURTH: Monitoring and follow-up activities including

- Monitoring/Coordination of Care may involve either face-to-face or telephone contact. The activities can be conducted as often as necessary (including at least one annual meeting) to help determine whether:
 - services are being furnished in accordance to the individual's plan;
 - the services in the care plan are adequate; and
 - there are changes in the eligible individual's needs or status.
- If so, necessary adjustments can be made in the care plan and service arrangements with providers.

Monitoring Implementation



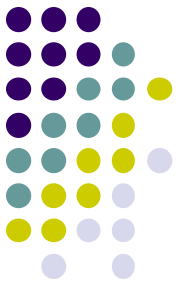
You are not monitoring the client.

You are monitoring the implementation and effectiveness of the plan.

- *Is this active treatment?*
- *Is it the appropriate treatment?*
- *Does the client agree the overall plan is effective for them?*
 - **Is the consumer getting the services in the plan?**
 - **If not, why not?**
 - **If yes, are they satisfied with the provider(s)/services?**
 - **Are providers doing as expected?**
 - **Are they coordinating their respective roles?**



Consultation with Collaterals



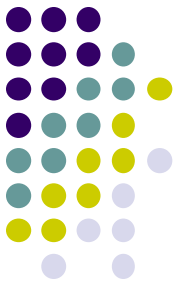
- Request for an opinion or advice related to treatment, treatment options, etc from a member of the treatment team for a specific Individual. *Currently internal consultations cannot be encountered. Clinical supervision is not covered.*
- *Request for an opinion or advice related to the treatment, treatment options, etc. from a professional who is not a member of the treatment team but who either knows the client or has access to the medical records in order to render a professional opinion on treatment.*
- Meeting with your clinical supervisor to discuss treatment options, progress, prognosis ONLY when the client or a collateral is present.

SUMMING UP



The CM service must consist of one of the 4 buckets of activities and

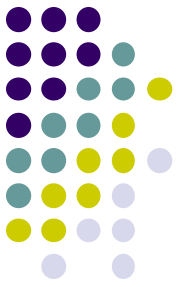
- **Services must be medically necessary**
- **Individual must be unable to access the services and supports on their own – consider always natural supports**
- **Must have an impact on client's recovery or recovery goals – watch for significance**
- **Requires vigilance in determining if plan is being implemented – active treatment concept**



Case Management Services

WHY DO I NEED TO KNOW ABOUT MEDICAL NECESSITY?

CM Services Must be Medically Necessary



- AND

THE MEDICAL, MENTAL HEALTH, AND
SUBSTANCE ABUSE SERVICES YOU LINK
THE INDIVIDUAL TO MUST BE
MEDICALLY NECESSARY AS WELL OR
THE INDIVIDUAL'S MEDICAID BENEFIT
WILL NOT COVER THE SERVICE

COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING –MEDICAL NECESSITY

“Medical necessity means that a covered service shall be deemed a medical necessity or medically necessary if, in a manner consistent with accepted standards of medical practice, it:

1. Is found to be an equally effective treatment among other less conservative or more costly treatment options, and

COLORADO HCPF CONTINUED

2. Meets at least one of the following criteria:
 - a. The service will, or is reasonably expected to prevent or diagnose the onset of an illness, condition, primary disability, or secondary disability.

 - b. The service will, or is reasonably expected to cure, correct, reduce or ameliorate the physical, mental cognitive or developmental effects of an illness, injury or disability.

COLORADO HCPF CONTINUED

c. The service will, or is reasonably expected to reduce or ameliorate the pain or suffering caused by an illness, injury or disability.

d. The service will, or is reasonably expected to assist the individual to achieve or maintain maximum functional capacity in performing Activities of Daily Living.

Medical necessity may also be a course of treatment that includes mere observation or no treatment at all.”

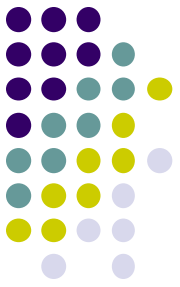
MEDICAL NECESSITY: An Operational Definition



- The member has a mental health/substance abuse condition/illness that has produced a current problem in functional status, including current signs and symptoms that interfere with functionality, that can be helped by providing the services listed on the treatment/CM plan.



Operational Definition of Medical Necessity



Help can be focused on the:

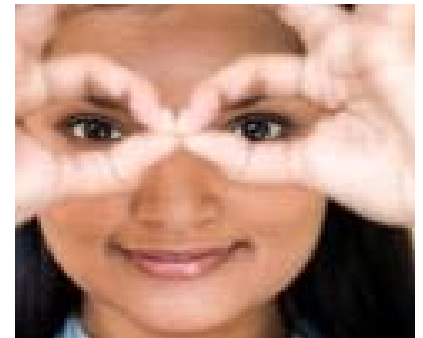
- Reduction or better management of signs and symptoms;
- betterment of a functional status;
- prevention of a worsening or maintenance of functional status;
- development of age appropriate functioning in a child where mental illness has prevented age appropriate functioning;
- or the prevention of new morbidities where they are threatened by the individual's mental illness.

What are they looking for and where do they look?

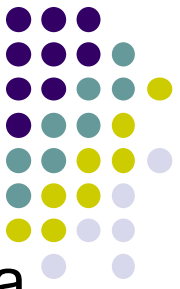


Medical Necessity and CM

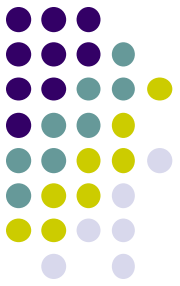
1. It treats a mental health condition/illness or functional deficits that are the result of the mental illness.
2. It has been ordered or prescribed—credentials critical.
3. The service should be generally accepted as effective for the mental illness being treated.
4. The individual must be willing to participate in treatment
5. The individual must be able to benefit from the service being provided.
6. There must be active treatment.



What makes a CM service medically necessary? ?

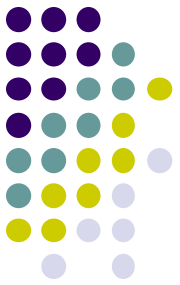


- The individual meets the diagnostic and clinical criteria for case management
- The service is ordered in the individual's treatment plan or a separate case plan
- You provide a service that meets the definition of medical necessity –one of the 4 buckets allowed in CM
- The Individual wants to receive CM services from you
- The Individual is unable to link to services on their own but with your help can become more independent in locating and using services and supports
- The case management activities are being provided according to the plan including the necessary linkages and referrals.



***Doing Case Management
well means.....***

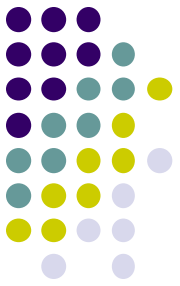
Elements of Case Management



Four Buckets of Allowed Services

Are the Documents There?

vs. What do they say?



- Is there a comprehensive CM assessment
- Is there a current and appropriately signed treatment plan with CM interventions
- Is there a complete and accurate note



CONTENT STANDARDS

- Is the service CM?
- Are the services individualized? Is it a clone? Copy and paste?
- Is there a current assessment that provides evidence of eligibility for CM services?
- IF the treatment isn't working is the strategy changing?

WHAT IS THE GOLDEN THREAD?



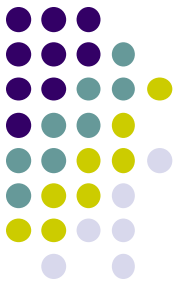
- The golden thread begins with the CM assessment (identified needs), then pulls through the treatment plan (interventions and goals) to ongoing progress notes (client efforts, services provided, progress made).
- It is golden because, if accurately followed through, the documentation that supports each decision, intervention, or client progress note contributes to a complete record of client care that is error-free and ready for reimbursement.

The Golden Thread

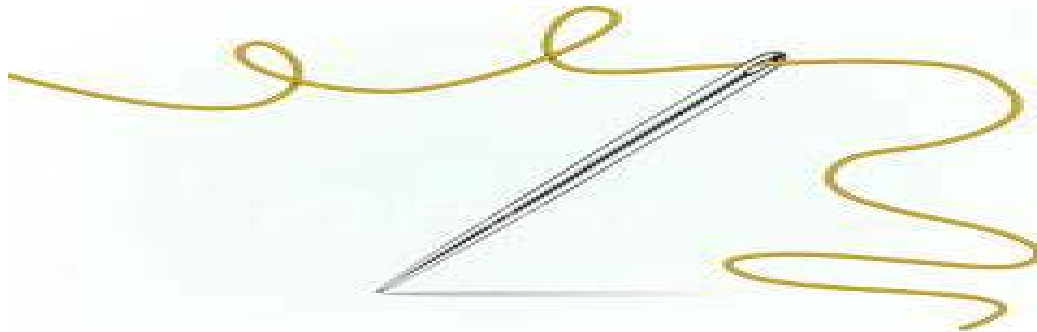


- Each piece of documentation must flow logically from one to another so that someone reviewing the record can see the logic.
- The assessment must lead to the treatment plan and be coherent and cohesive and establish medical necessity.
- The progress notes must flow from the treatment plan and document the services provided and the individual's response to treatment.
- The progress notes lead to the treatment plan review and update, which leads to the progress notes, etc.

Documentation Linkage - a “Reflection” of the Golden Thread



- **Assessing with the Client** → **Completing the Assessment Form**
- **Planning with the Client** → **Completing the Service Plan**
- **Working with the Client** → **Writing Progress Notes**

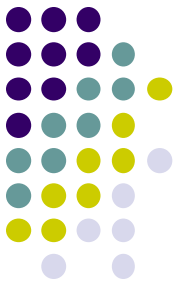


It's Not All About Paperwork !



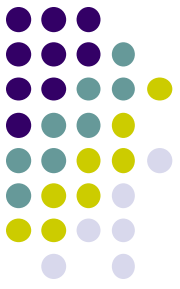
- Documentation should just be an accurate retrospective account of what we do in an abbreviated form.
- If what we do makes sense and is billable then documenting it should not be a painful process.
- We should not need to *Bend our Documentation* to meet compliance standards.
- Documentation should be intuitive and support our work.

Learning to Think Like a CM: The Client



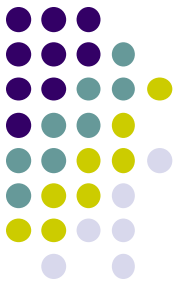
Client currently experiencing auditory hallucinations that she responds to frequently resulting in eviction from apartment and 2 subsequent hospitalizations. Current situation began 3 months ago when client stopped taking medications. Client moved in with brother, currently on meds but not stable and family (other treatment team members) are concerned about client's compliance as client admits to frequent lapses in past. Client unable to attend day programming and difficulty with social isolation as a result. Client seeing psychiatrist bi-weekly to stabilize medications. Brother wants Client out as soon as possible but will provide some supports.

Assessment:



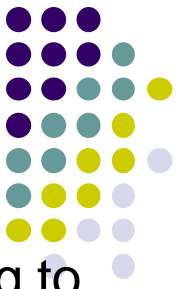
1. Client not stabilized on meds so currently still symptomatic – *continued linkage to psychiatry; client teaching; family provide supports; higher level of care?*
2. Client not consistently medication compliant – *research other resources; client teaching*
3. Client socially isolated – not good as it adds to her paranoia and bizarre behavior – *research local supports; family resources; other activities*
4. Unstable living situation jeopardizing community placement – *housing plan needed*

Thinking CM Interventions by Reviewing Objectives



- Treatment Objectives for Medical Services:
 - Client will stabilize on medications that will reduce symptoms so that he can attend day treatment to reduce isolation and work on recovery goal.
 - Client will work with Rx Team (ID them) to recognize and then minimize side effects from the medication that make compliance more difficult. As measured by....
 - Client will work with Rx Team to be able to connect the use of medications with reduction in symptoms that risk his community placement. As measured by...
 - Family members (ID) and client will be able to identify meds, their purpose and major side effects. As measured by....

CM Interventions:



- Client will continue to see MD bi-weekly
 - CM to meet with client bi-weekly for ½ hour prior to MD meeting to ID questions
 - CM will engage family to accompany client to medication appointments.
 - CM will ID any med changes and ensure scripts filled and family notified
- Client and family will meet with nurse weekly for one hour for medication education.
 - CM will coordinate appointments and arrange transportation if necessary
- Client will see current primary care doctor to make sure he/she knows about psych meds and to screen for any contraindicating co-morbidities.
 - CM will assist family/client to set up appointment.
 - CM will accompany client to appt in order to advocate for appropriate follow-up appointments and to assist client in explaining current medications.
 - CM will coordinate correspondence and communication between psychiatrist and primary care MD,

CASE MANAGEMENT PROGRESS NOTE *

- Which goal/objective is being addressed from the service plan
- Start and end time/duration
- Type of CM activity and specific functions :

Assessment

Service plan development

Referral

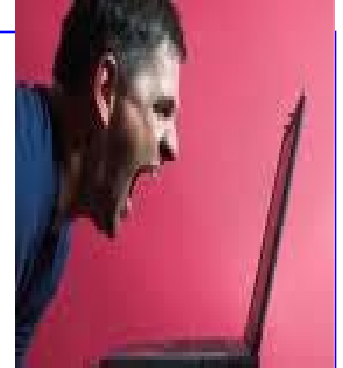
Monitoring and follow-up



* From Colorado Coding Manual

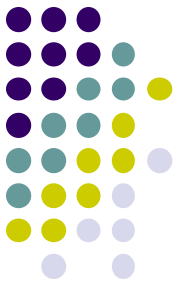
CASE MANAGEMENT PROGRESS NOTE *

- Each contact with and on behalf of consumer
 - Nature and extent of service
 - Date and place of service delivery
 - Mode of contact (telephone/face-to-face)
 - Issues addressed (adult living skills, family, income/support, legal, medication, educational, housing, interpersonal, medical/dental, vocational, other basic resources) - FROM A CASE MANAGEMENT PERSPECTIVE ONLY
 - Consumer's response
 - Progress toward service plan goals and objectives
- Case Manager's dated signature, degree, title/position



* From Colorado Coding Manual

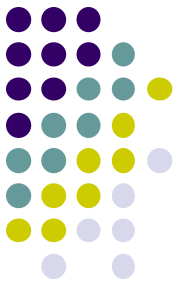
CM Progress Notes



- A good progress note for any service is the only way auditors can judge what you did and whether it meets definitions.
- A legitimate CM service may be denied if the note does not justify the service provided and link back to the treatment plan.



The Rules Documentation



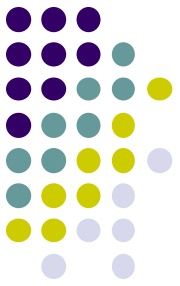
- Legibility
- No white out or cross outs without an explanation
- Timeliness
- Accuracy: dates, times, signatures
- Must relate to a service ordered on the treatment plan
- Must relate to a focus or issue listed for that service on the treatment plan
- Must describe what you did with the client
- **Handout on Medicare documentation.**

GIPP-one type



- Goal/Objective—what goal from the service plan was addressed today?
- Intervention—what action was taken by the CM clinician? What technique used? Action words!
- Progress—what was the impact of this activity? Client's progress or lack of it toward goals, possible barriers to progress
- Plan what will be next session's activity? Does tx plan need to be changed? For clinicians providing CM, is the dx still applicable.

EXAMPLE: GIPP CM NOTE



Assessment and Linkage

G: “I want to stay in my own apartment and pay my own rent”

I: Assisted client to complete paperwork to apply for SSI.

P: Client was able to answer most questions but may need to contact parents to complete some questions. We will need to locate copy of birth certificate.

P: Client will ask parents for birth certificate. If not available, I will research how to get new copy. I may contact parents to complete SSI application.



DAP NOTES: DATA- ASSESSMENT- PLAN

Goal: Janie wants to stay in her apartment.

Data: Janie indicates she is having difficulty making ends meet and may lose apartment. She is unable to find a job. She reports she is experiencing increased symptoms of depression including sleeping more, not eating, and difficulty concentrating and agreed to plan listed below. .

Assessment: Janie needs an earlier to appointment with MD to discuss compliance with medications and efficacy. She and MD should discuss use of a Rep Payee. She may need to consider help in developing budget and managing her money.

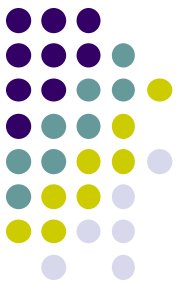
Plan:

Get appt with MD this week, email her with Janie's issues, f/up with Janie/MD after appt to see what f/up needed. Referral to Voc Rehab if Janie agrees. Research application process for next meeting. Referral to skill building for managing budget .Discuss with Janie when we meet next week if she is better able to concentrate.

Begin discussions about housing alternatives if Janie cannot pay rent.



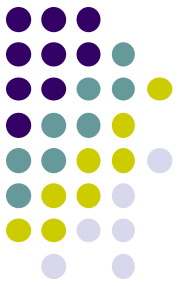
Documentation: Watch out for...



- There is adequate content for time billed (can't have one sentence for a 3 hour service)
- The client is responding to the treatment: are they participating and are they benefiting?
- Is an appropriate treatment strategy being implemented?



Every Progress Note is a bill for services. Decide if you'd pay for the service!



- Would you pay for what you read in a progress note?
- We get paid to provide skilled interventions that address assessed BH needs and help a person reach personal recovery and treatment goals.
- We don't get paid to “see clients” or for “conversations” for checking up on them, monitoring their symptoms, etc.

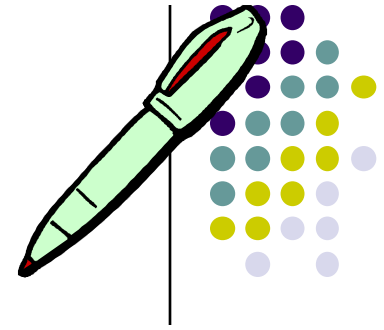


Would you pay for this ?



- **Goal: I want to stay in my own house; Objectives: Consumer will determine housing choice. Consumer will develop a plan for obtaining permanent housing.**
- Reason for visit: Develop housing plan post transfer from shelter
- Consumer in crisis bed and is homeless with no entitlements. Educated consumer about options for housing if SSI is denied. Explored consumer's preferences. Consumer stated she would prefer SRO but is open to other options. Agreed we will follow-up by end of week to complete SSI application and discuss level of help needed to locate housing.

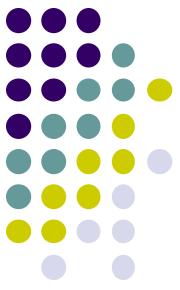
Would You Pay for This?



Goal: I want to go back to work. Objective: Client will be able to manage symptoms and reapply for admission to PSR program part-time

Reason for visit: to check in with client about symptoms

Met briefly with consumer. She reports that she is stable and taking her medications as prescribed. She agreed to a follow-up appointment with me next week. She reported no difficulties at this time. Does not appear to be responding to hallucinations. Speech fluent, coherent. Reports no side effects.

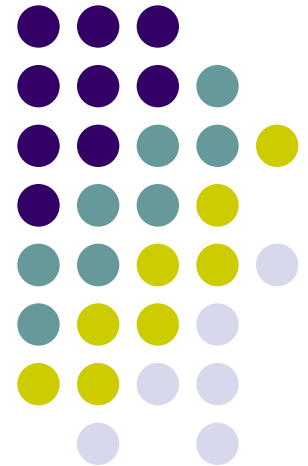


Would You Pay for This?

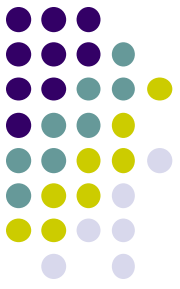
- **Goal: I want to go back to my own apartment**
Objectives: Client will take first step to being medication compliant: she will take all meds for one week with prompting from brother
- Reason for visit: Prep for MD Appointment
- Met with brother and client to prepare for meeting with MD tomorrow. Completed pre-appointment checklist and I will fax to MD. Will call tomorrow to remind about appointment. Brother will transport. Both said they felt comfortable about what they need to accomplish. Brother appeared to be less anxious about acting as advocate. We will talk by phone tomorrow to follow-up on outcome.

SUMMARY

CASE MANAGEMENT
SERVICES



What Makes TCM Effective? ⁽¹⁾



- Outreach and education to individuals , their families and referral sources – not many people know what targeted case management is and its purpose
- Developing a trusting relationship
- Respecting the individual's autonomy
- Prioritizing the individual's self determined needs – assisting them in generating their own solutions



What Works?

- Assistance in obtaining resources – note not just services
 - No overlaps, no misses
 - Quickly and diligently
 - Concrete and active
- Individualized Resource Development
- Appropriate caseloads

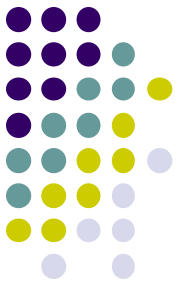


What Works?

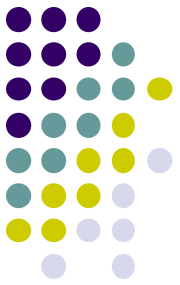
- “ACT- like” or CST approaches
 - Team
 - Multi-disciplinary
 - Access to specialists
 - Long term if necessary – appeal of denials may be necessary
- Focus on specific and realistic targets

(1) Morse, Gary Ph.D., A Review of Case Management for People Who Are Homeless: Implications for Practice, Policy and Research

What do you have to be able to do well?



- Engage and motivate
- Understand community resources: barriers and opportunities
- Identify and engage natural supports not just organizational supports
- Be able to use out of the box activities to ensure coordination of the treatment and support team involved with the client
- Support and encourage independence
- Celebrate discharge



Thanks for being