Section: **Clinical Practices**	Policy Name: **Complex Case Management**	Policy Number: **12.20**
Owner: **Director of Quality Management and Clinical Outcomes**	Reviewed By: **Alena Lacey, MA, LPC**	Total Pages: **4**
Required By: ☐ **BBA** ☐ **MDHHS** ☐ **NCQA** ☒ **Other (please specify):** _____	Final Approval By: *Alena Lacey*	Date Approved: Jun 28, 2024
Application: ☒ **SWMBH Staff/Ops** ☒ **Participant CMHSPs** ☐ **SUD Providers** ☒ **MH/IDD Providers** ☐ **Other (please specify):** _____	Line of Business: ☒ **Medicaid** ☐ **Healthy Michigan** ☐ **SUD Block Grant** ☐ **SUD Medicaid** ☐ **MI Health Link** ☐ **Other (please specify):** _____	Effective Date: **10/30/2020**

Policy: The overall goal of Complex Case Management (CCM) is to help members regain optimum health or improved functional capability in the right setting and in a cost-effective manner while supporting and enhancing the overall goal of improving care under the standards of best practice driving quality-based outcomes. It involves comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a case management plan with patient-centered goals, monitoring and follow-up.

Purpose: To organize and coordinate services for members with multiple or complex conditions helping members obtain access to care and services and coordinating care by identifying and coordinating member's needs.

Scope: Integrated Health Care and Utilization Management may be affected by this policy.

Responsibilities: Integrated Healthcare Specialist or Care Manager II or III will fulfill the policy as written.

Definitions:

A. Integrated Healthcare Specialist: Registered Nurse (RN), Licensed Master Social Work (LMSW).
B. Care Manager II or Care Manager III: Licensed Master Social Work (LMSW), Limited License Psychologist (LLP), Licensed Professional Counselor (LPC), or Registered Nurse (RN) is required.

Standards and Guidelines:

A. The organization completes population assessment annually to review and update activities, resources and program offerings based on population needs.
    1. Assesses characteristics and needs, including social determinants of health, of member population.
    2. Identifies and assesses the needs of relevant member subpopulations.
    3. Assesses the needs of individuals with disabilities.
    4. Assesses the needs of individuals with serious and persistent mental illness.
B. The organization collects data from existing databases and proactive data mining is conducted utilizing programmed reports. Some data access is collected in collaboration with demonstration partners.
C. The organization uses data at its disposal to identify members with multiple or complex conditions without discrimination. The organization also has a process for facilitating the receipt of referrals via email, fax or phone. Points of data include:
    1. Claims or encounter data
    2. Hospital discharge documentation (including being used to assess for eligibility and any member needs upon discharge)
    3. Pharmacy data (including but not limited to being assessed in CC360 and used to identify any medication concerns and identify if medications are filled regularly)
    4. Utilization management documentation, hospital reviews and authorization documentation
    5. Verbal report and data provided by the member or caregiver
    6. Data and documentation provided by behavioral and medical health providers upon collaboration.
D. CCM is an opt-out program; all eligible members have the right to participate or to decline participation.
E. SWMBH uses multiple avenues for program referral including managed care program referrals (ICOs, MHPs, HIDE-SNP/DSNP), discharge planner referral (including SWMBH UM who communicate and assist with discharge planning), member and caregiver and practitioner referrals
F. CCM documentation system includes automated features that provide accurate date, time and user ID. Automated features also include prompts and reminders for follow up assessments.
G. CCM systems are supported by evidence-based clinical guidelines or algorithms with automatic documentation and automated prompts for follow up.
H. CCM process documentation and details are included in Southwest Michigan Behavioral Health's (SWMBH) Complex Case Management procedure 12.19.1.
I. Each CCM file will be documented according to NCQA standards.
J. SWMBH will evaluate member experience with the CCM program minimally on an annual basis.
K. SWMBH will evaluate the effectiveness of the CCM program annually.

Effectiveness Criteria:

A. Inpatient admission utilization 6 months prior to CCM, during CCM and 6 months post CCM will be analyzed.
B. Emergency Room utilization 6 months prior to CCM, during CCM and 6 months post CCM will be analyzed.

References:
National Council Quality Assurance Standards – QI 8 Complex Case Management

Michigan Center for Clinical Systems Improvement Complex Care Management Guidelines https://www.miccsi.org/wp-content/uploads/2016/01/Complex-CM-Guideline-Final-Version-pdf.pdf

Michigan Center for Clinical Systems Improvement Care Management Toolkit https://www.miccsi.org/wp-content/uploads/2016/01/Mi-CCSI-S-Vos-Care-Mgmt-Guidelines-Toolkit-Final-version-2-2016.pdf

Relias Here's How Complex Case Management Can Work https://www.reliasmedia.com/articles/142399-heres-how-complex-case-management-can-work

Attachments: None

Revision History

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
Initial	5/16/2015		unknown	unknown
1	11/15/2016		Unknown	unknown
2	5/21/20		Made edits to reflect 2020 NCQA standards	Sarah Green
3	10/30/20	Throughout document	Made edits to the CCM process to reflect updates after annual population assessment and review of the program	Sarah Green
4	04/19/2024		Re-labeled the policy and moved to Clinical Practices Section	Alena Lacey