

Albuquerque/Bernalillo County BH Task Force
Case Management Subgroup

EXECUTIVE SUMMARY

The Albuquerque and Bernalillo County area have a complex array of behavioral health and social services, with a great many different funding streams contributing to services. Unfortunately, it is quite challenging for citizens and individuals in need to penetrate this complex system, and connect with the right services, at the right time, in the right situation. Because funding for most services is based on eligibility, or limited to certain programs or categories of need, it is very frustrating and challenging for most individuals to be able to effectively access the appropriate services and benefit from them.

Case Management is a general term used to describe an array of overlapping services, all of which provide general paraprofessional assistance to individuals in accessing and connecting with services, programs, supports, and benefits. Case managers often act as “navigators” to help people in need to find their way through our complex system, connecting people in need to the right services and resources, and helping them to obtain or meet categories of eligibility, such as obtaining Medicaid, etc. Case Managers help in a holistic manner, assisting people in addressing both social, as well as medical/behavioral health issues. Thus, Case Managers help people to obtain psychiatric assessment and treatment, but also help them to fill critical social needs such as housing, employment, education, childcare or social activities.

In a highly fragmented, “siloesd” system of care, such as exists in the Albuquerque/Bernalillo County area, case managers/navigators are a critical and necessary stopgap intervention to assist people in need to access necessary services. Unfortunately, while our area has a wide array of programs and services which include Case Management, these programs are equally siloesd, with category and eligibility restrictions. Such services are often short-term in nature, and extremely specific and limited to certain issues or areas, and there is not a high level of community awareness that these programs exist. Even within systems such as UNM or the Medicaid-provider system, there is little internal communication or coordination between various overlapping case management services. Medicaid/State funding of Case management services within the Albuquerque/Bernalillo area is extremely limited, to restricted providers who serve a limited group of clients.

Increased access to Medicaid for adults has not yet resulted in a significant change in access to services such as case management, or expansion in capacity of services which are available. Despite attention towards integration of mental and physical health, there has been little on the ground work to support Case Managers and other paraprofessionals in addressing medical needs along with behavioral health.

Recommendations:

▪ Immediate Local Actions:

- Increase city and county funding of case management services, based on determination of need, rather than eligibility. Program strategies such as the UNM Pathways Program and the UNM Fast Track programs offer models which could be replicated and expanded, and may better serve the community if they were more widely available and marketed.
- Support a systemwide Albuquerque-area BH resource database/list, which is maintained and kept up to date;
- Support a low –level referral/coordination system, ie, a 311 information system to provide basic service contact information to callers;

▪ Mid-Range Local Actions:

- Support development of a “one-stop shop” or Central BH Hub/clearinghouse of BH coordination within the City/County;
- Support the efforts of Community Engagement Teams (CET) to assist individuals in connecting with services prior to emergency;
- Create a City/County statutory body, entity, or committee which is tasked with monitoring and monitoring the effectiveness of the local behavioral health system of care;
- Encourage MCO’s to add Case Management as a Value-Added Service (VAS) in the interim period to State restoring it to Fee Schedule;
- Encourage CNM to develop and implement a “Community Health Worker” certification program which integrates behavioral health Case Management;
- Support enhanced rates for services provided in a language other than English;
- Identify ways in which Community Health Workers can be reimbursed through local and State funds.

▪ Long-range State Initiatives requiring advocacy to state legislature and HSD/BHSD for:

- Resume provision of Targeted Case Management as a Medicaid-billed service to provide short-term assistance to clients in accessing and engaging in services;
- Expand provision of Medicaid- and BHSD-funded CCSS, either through expansion of CSA system, or allowing non-CSA providers to apply for CCSS.
- Support of access services such as Community Engagement Teams, Crisis Stabilization Unit and other non-emergent means by which consumers may access and engage services;
- Incorporate Community Health Workers and Case Management services/needs into State plans for Health Home and BH/Medical integration.
- CCSS services may need to be redefined at a State level to focus on provision of Section 2703 ACA services, including care management, individual care coordination and health promotion, transitional services, consumer and family advocacy, and linkage to community resources.
- Investigate technology that may be used to offer greater appointment access and support, and explore methods of reimbursement for such services.

Consumer/Community Comment

We had our son go to a private psychologist from 16 - 18. She tested him and was not able to make a diagnosis but a list of issues. We thought that we had a "bad kid". We sent him to live with an uncle to get him away from his "friends" and finish high school out of state. While on a trip after graduation he had a manic attack where within a week he was in an outpatient psychiatric hospital in Sacramento, Ca. After an all day analysis with 3 doctors, he was diagnosed Bi-Polar. He now sees a private psychiatrist. The doctors and psychologists were not much help with finding family support. We researched online and found DBSA and NAMI. Both groups have bent over backwards to help with information and direction. We have been surprised at the lack of knowledge from the professionals on how to help the family, who helps direct services for the family member. The focus is on the patient who may not have the foresight that they need help. HIPAA is a disaster in terms of helping the patient. People with mental illness need help from family and friends to assist with medication and patient care. They do this in the dark once the patient turns 18.

I am the father of a 27 year-old son diagnosed with schizophrenia. Our son is unable to admit to needing or seeking help to make his life peaceful and meaningful, and is anxious about issues involved with initiating help. He has been living with us for almost a year, and we are at a loss as to effectively find needed resources, while our inquiries to help are hindered by the current system for patient protection and insurance issues. We ourselves are not clear on the actions it would take to get the help we need to help our son and our family to deal with his mental health. We are currently in the NAMI "Family to Family" program that has helped us to understand the disease and some of the resources available, and we have gotten some insight through contact with mental health resources and community meetings. I've made many calls to services, but can't seem to get a definitive path to begin help, especially since our son is protected under HIPAA, and unless we take more drastic measures than persuasion, he is resistant to seek help.

Unless he is a direct threat to himself or others, our hands are tied to call law enforcement, which feels extreme, and I'm afraid may cause more harm than good. I feel that we need to categorize community services and develop a pathway to them. We also need to have a more robust non-crisis intervention resource to help families like mine that can work with families to get those that need help, be able to get it—difficult, but necessary. Our son has looked for help, but has been lost in the process. Develop one-stop shops; that allow easy application for Medicaid, and easy entrance to the system—keep it consistent and advertise it with flyers, banners, and the web.

Isolated Social Needs-Based Programs and Funding Sources



Coordinated Programs with Centralized Funding Source



Medicaid:

Prior to 2007, Case Management was a Medicaid service. CMS reportedly was concerned about the abuse of Case Management, and the service being used in open-ended, non medical-necessity situations. Around 2007, HSD amended State Plan Amendment, removing Case Management as a service, and replacing it with Comprehensive Community Support Services.

(Targeted Case Management is still on NM Fee schedule/State Plan Amendment, but is limited to the activities of CYFD for children in foster care)

Case Managers typically assisted clients in accessing benefits and resources, coordinating therapy appointments, enroll in educational and/or vocational programs, helped clients apply for SSI, welfare, coordinated housing services, etc. Because many of these needed services weren't explicitly related to medical/mental health conditions and didn't fit well into current medical model billing, there were concerns that Case Management was more of a "social service" than a medical one.

There were concerns at the time that Case Management services were not focused on client's strengths, or on recovery/resiliency. Goal of CCSS was to "teach client to do for themselves," rather than doing for client. There was/is an implicit assumption that some Medicaid/State-funded clients lack initiative or skills to achieve and access services, as opposed to

acknowledging the institutional and systemic barriers. CCSS focuses back on the client's deficits, rather than the system's.

CCSS was implemented and restricted, in terms of units/amounts per client, and per agencies authorized to perform service, limited to Core Service Agencies (CSA). Many agencies which could provide Case Management were unable to provide CCSS after the change. Despite significant reductions in out-of-home care and increased Medicaid enrollment, there hasn't been an increase in CCSS capacity, but instead, a reduction.

Core Service Agency (CSA) is a statewide initiative, which limits certain services (including CCSS) to specific agencies, and creates access standards for agency. Many State (non-Medicaid) BH funds are limited to CSA. Initially intended to create a youth "CMHC," the project's scope was extended to the adult system, and to create a "clinical home," which followed clients and ensured coordinated care. CSA was named in regulations and Centennial plan, but no regulations are promulgated for CSA, no current CSA requirements are in place, and access standards are not currently enforced. Per contract, MCO's are limited from naming new CSA's until after 2nd year of Centennial. It is unclear as to how much the CSA system is currently meeting goals and needs.

CCSS is limited to SED/SDMI categories, restricting the service to individuals who meet criteria of serious mental illness. CCSS is available under CYFD and DOH (BHSD) funding, to some individuals who are not Medicaid-eligible, though the CCSS rules are identical to those of Medicaid. Under CYFD-funding, CCSS may be provided to some individuals who meet "at-risk" category.

CCSS allows/includes peer support services, though the extent or full use of this capacity remains low and under-developed.

Comprehensive Community Support Workers (CSWs) are not case managers. CCSS activities specifically address independent living, learning, working, and social and recreational efforts. They embody particular core values:

- Individuals and families are the experts (on their own lives).
- Personal choice should be supported.
- CSW's are collaborators, not directors.
- CSW's demonstrate respect.
- CSW's assist in identifying strengths.
- CSW's assist in identifying solutions to barriers that negatively impact the achievement of previously identified goals.

Comprehensive Community Support Workers (CSWs) may perform the following services and activities:

- Help the client define what recovery means to them individually and set appropriate and attainable goals.

- Assist the individual to develop and coordinate a recovery and crisis management plan.
- Assess, support, and recognize symptoms of a potential crisis situation and early signs of relapse.
- Coordinate programs to assist gaining access to rehabilitative, medical, and other services.
- Support clients in identifying strengths and barriers in developing skills necessary for recovery and resiliency.
- Assist in developing interpersonal and functional skills, including adaptations to home, school, and work environments.
- Assist in developing natural supports in the work place, social, and school environments.
- Assist in building symptom management skills, including behavior management, knowledge of medications and their side effects, and development of skills to take medication as prescribed.
- Assist with practical and vocational skills such as financial management, obtaining & maintaining stable housing, and school/employment performance.
- Monitor progress to determine if services meet the individual's needs.

In Bernalillo/Albuquerque, CCSS providers are:

- Adult- UNMH, St. Martin's, Agave. FQHC's (First Choice, First Nations, and AHCH can bill/provide CCSS but are not for the most part). TLS provides some CCSS for clients within their housing. YDI and Open Skies are both authorized to provide CCSS to adults, but are doing so at limited levels, under initial plan of "transition-aged" individuals.
- Child – UNM (CPH), YDI, All-Faiths, Open Skies.

Case Management remains an activity within some Medicaid services, such as Assertive Community Treatment; MultiSystemic Therapy; RTC; Inpatient psychiatric/medical; TFC, etc., where same-day CCSS billing is prohibited and case management services are expected to occur within umbrella service.

Forensics Case Management services at UNM-Psychiatric Center also provides limited case management services to the jail diversion target population who may be referred from Metro Court, District Court or Community Corrections who have not received a Psychiatric assessment within the last 12 months or have a mental health diagnosis but it does not qualify as an SMI. The program mission is as follows:

- To maintain a Jail Diversion program, in order to divert consumers from the criminal justice system and to direct persons in the target population into more appropriate services. Appropriate services may include referral to psychiatric and/or substance abuse treatment, medical services, educational and vocational resources, and other community, state and federal resources.
- To assist the consumer in not only the completion of their legal supervision, but also in their recovery, and the pursuit of their personal, social, educational, and vocational goals. The Forensic Community Support Worker seeks to engage the consumer with mental

health and/or substance abuse problems in the process of recovery through increasing their ability to cope with mental or emotional difficulties that arise, through learning to independently access and maintain treatment and other services, through the development independent living skills as well as the development of natural social supports.

- To coordinate with criminal justice system, including pre-trial services, mental health courts, state probation and parole, to thereby assist the consumer navigating their way through the criminal justice system.
- Currently UNM has 5 CSW's that serve the Jail Diversion population and one CSW who supports the Fast Track program out at MDC. Each case load is approximately 20-30 clients with the average monthly census of 106 clients within the Forensics Case Management department.

Case management is a covered service under Medicaid waivers for Developmental Disability, and Home and Community Based Services.

Care management, care coordination, and other functions still reside within Managed Care, and provide some limited Case management type functions, but focused solely on accessing health services.

Non-Medicaid:

- AMCI reimburses for Case Management under voucher for substance abuse services – limited to 4 hours per voucher. **Case Management:** is a professional helping process whereby adult and/or adolescent clients participating in a program receive non-counseling services appropriate to their needs either at the program or, if necessary, through facilitated referral. Typical case management services include such activities as helping clients to secure access to educational services, employment services, job training programs, health and welfare services and others based on the secondary needs identified in the client's initial assessment at AMCI and supplemented with other needs identified during their time in treatment. Case management services can be provided by a primary counselor, a nurse, or a position employed specifically to be a case manager. (*See Case Management Definition, City Minimum Standard,*). **(Maximum of 16 units per voucher)** Time spent for billing for services is NOT a case management function, nor are providing reports to the court for DWI or criminal justice clients, rescheduling appointments, or other administrative activities, or dispensing medications, or writing progress notes or other documentation.
- Value-Added services from MCO – do not currently include Case Management
- HIS facilities can provide CCSS. Unclear if they do so, or provide Case Management instead under separate funding
- Medicare and commercial insurances don't reimburse for Case Management
- UNM – Pathways and Project Echo: Provide Case Management within these programs, to ???

- Some City grants include Case Management for people enrolled in program, eg. NM Solutions' Co-Occurring Disorders Programs
- Housing programs such as Supportive Housing, Heading Home have Case Management services embedded within or required.
- Some programs such as DVR, TANF do limited case management
- CYFD provides Case Management often as a part of Child-protective services
- Police and Sheriff's departments have limited case management (CIT, COAST, etc), though many police officers often end up engaging in limited case management
- Jails have Case managers for discharging
- Case managers at MATS
- Community Engagement Teams – was a part of a 2014 legislative bill, and is part of a current NAMI-initiative, to develop and pilot a non-emergency program designed to use peer and professional supports to assist individuals living with mental illness to access services.
- Many therapists do case management as an unreimbursed part of therapy, because their clients are unable to access other supports for case management
- DD waiver case management

UNM Pathways Program, through Health Sciences Center. Operating since 08. Funded by County Mill Levy, serving approx. 450 clients per year. Provides case management/navigation on "pathways"/tracks of need. Strong model which could be expanded and better publicized.

Gaps:

- **Funding:**
 - The majority of Case Management services are provided solely "within-program," based upon category, program-eligibility, or funding limitations.
 - Medicare, commercial insurances don't reimburse for Case Management
 - Medicaid limitations on medical necessity, allegations of fraud, etc., limit provider willingness or availability to expand CCSS services
 - Medicaid restrictions on agencies who can provide CCSS (CSA, CMHC, FQHC, HIS) make more sense in a rural environment, where there are few providers, than in Albuquerque.
 - Unclear overlaps between case management, CCSS, care coordination, and MCO activities confuse clients and providers.
 - Hodge-podge nature of system of funding for Case Management leads to different rules, eligibility, access strategies, service provision strategies, client expectations and experiences, which can be bewildering to clients and citizens.

- There is no association of Case Managers, licensing or certification of case managers, no overarching umbrella over these various entities, services, etc., to ensure best practice, good care, or to facilitate information sharing and resource/referral development for case managers in different programs.
- Peer support services are inconsistently and unclearly supported from a Statewide level, and from varied providers.
- Redundant funding and services – many people interact with numerous case managers in different programs
- Funding/legal limitations restrict use of many technologies such as social media, teleconferencing, etc.
- Clients who would benefit from Case Management to assist in accessing resources and benefits, often have difficulty obtaining case management, or even knowing that it exists;
- Within Albuquerque, Case Management remains quite siloed between Mental Health and Substance Abuse divisions. For example, the AMCI voucher is intended for substance abuse services and case management services are largely focused on this. Medicaid-funded CCSS is predominantly focused on Mental health issues, with some limited co-occurring disorder attention.
- Case managers all develop their own individualized resource lists, recognizing that these lists of services, contacts, processes, benefits, etc., are constantly evolving and changing.
- Siloed system of services and funding hinders integration of medical and BH services/needs
- The strength and successes of Case Management are rarely celebrated or acknowledged. These are folks in the trenches, whose work rarely gets identified or held up, though they usually have far more contact with individual clients, as opposed to therapists and psychiatrists. CM work often results in greater changes to basic needs, strengthening a person's whole life.

Recommendations:

- Needs-Based Provision of Case Management, rather than eligibility (funding stream) based system
- Development of City/County-wide, updated, monitored Resource/Guide list for services, benefits
- Use City 311 system to update resource guide, direct clients to it, and to Case Management resources
 - Could we support a phone number/resource system of its own? “424” = 4BH
- City/County funding of Case Management may be used for Medicaid match, through partnership with HSD.

- Pursue/encourage greater support of Peer Support/Peer Specialist models of CCSS/Case Management
- Support integration of Case management services within Health Home/Patient Centered Medical Home model of integration with Physical and Behavioral Health.
- Delineate “levels” of Case Management services, distinguishing between short-term “quick and dirty” case management, versus longer-term case management/coordination needed to support stability.
- Work with HSD/CMS to restore Targeted Case Management to Fee Schedule
- Work with HSD/BHSD and MCO’s to expand CSA system or open access to CCSS to non-CSA agencies/providers.
- **Pie in the sky – Could an Albuquerque/Bernalillo County Waiver/Carve-out be possible, with blended funding? (similar to Milwaukee Wraparound)**
- **Pie in the sky – Are there technological innovations (Apps, texting, teleconferencing, social media) that could be utilized for Case management/coordination?**
- Clients networking with other clients to share resources using technology could be beneficial. Again, this could go through a 4BH (424)—(for Behavioral Health) number and web service.
- Also, a “for behavioral health” contact could be a repository for all health/social services and resources - behavioral issues are often interwoven with needing jobs, food, shelter, and other BH-related services. Breakdown could be Social Services, Jobs, Behavioral Health, etc.
- Encourage MCO’s to add Case Management as a VAS in the interim period to State restoring it to Fee Schedule.
- Support a “one-stop shop” or Central BH Hub/clearinghouse of BH coordination within the City/County
- Support the efforts of Community Engagement Teams (CET) to assist individuals in connecting with services prior to emergency.
- CCSS services may need to be redefined at a State level to focus on provision of Section 2703 ACA services, including care management, individual care coordination and health promotion, transitional services, consumer and family advocacy, and linkage to community resources.