Substance Use Disorder (SUD) Care Coordination
Performance Improvement Project (PIP)

QI & UM

November 2022

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WHAT ARE PIPs?

- **Program Improvement Projects (PIP):**
  - As a Medi-Cal funded Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS), we are required by Federal regulation and State contract to have various active PIPs at any given time.
  - A PIP is a project designed to address an identified problem and achieve significant improvement, sustained over time, in health outcomes and client satisfaction.
  - A PIP may be designed to change behavior at a client, provider, and/or system level.

SUD Treatment Outcomes

- **Definition of Progress**
  - Made Progress
    - Comp Tx/Rcvr Plan Goals/No Ref
      Comp Tx/Rcvr Plan Goals/Ref
    - Left w/Satis Prog/No Ref
      Left w/Satis Prog/Ref
  - No Progress
    - Left w/Unsatis Prog/No Ref
    - Left w/Unsatis Prog/Ref

❖ Excludes Death & Incarceration

SUD Treatment Outcomes— Discharge Status by Modality

- Almost 50% of the clients receiving services in Residential settings are discharged without making any progress.

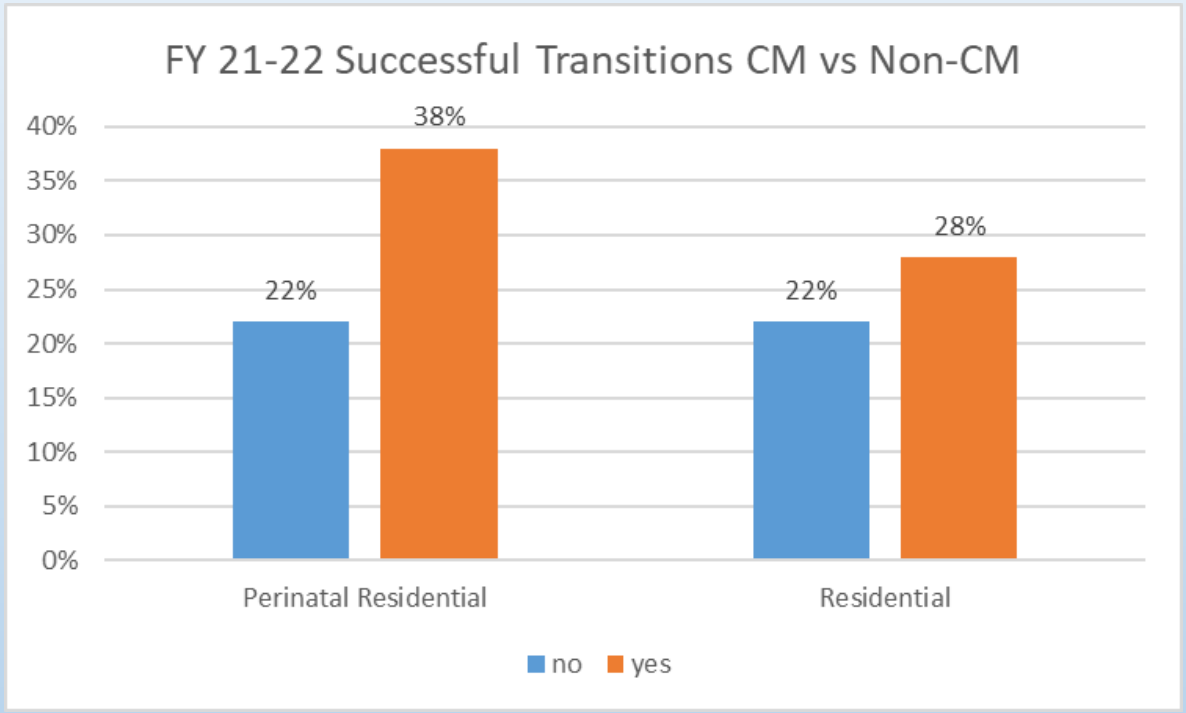
Modality	Treatment Outcomes	Percent
Intensive Outpatient	Made Progress	56%
	No Progress	44%
Opioid Maintenance	Made Progress	39%
	No Progress	61%
Outpatient Services	Made Progress	73%
	No Progress	27%
Perinatal Residential	Made Progress	51%
	No Progress	49%
Recovery Support Services	Made Progress	79%
	No Progress	21%
Residential	Made Progress	52%
	No Progress	48%

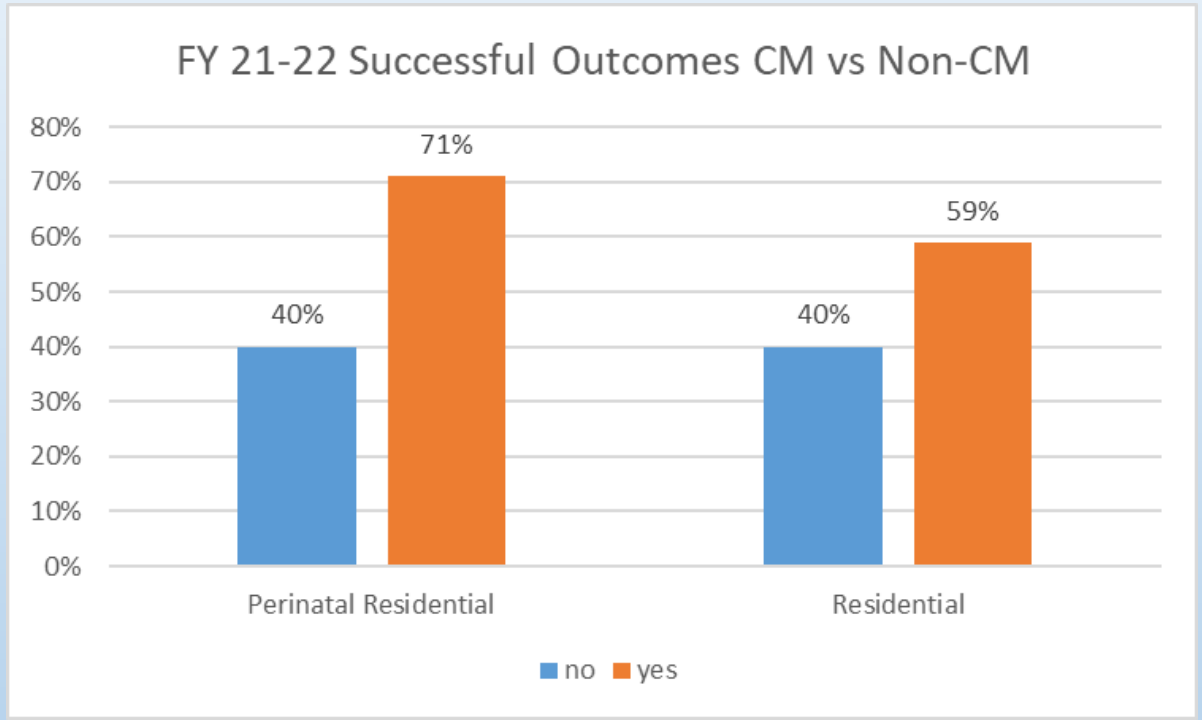
SUD Treatment Outcomes— Discharge Status by Modality

- Clients discharging from Residential services only successfully transition to the next level of care 27% of the time.

Modality	Transitions in 30 Days	Percent
Perinatal Residential	No	74%
	Yes	26%
Residential	No	74%
	Yes	26%
Residential Withdrawal Management	No	71%
	Yes	29%
Sobering	No	89%
	Yes	11%

Care Coordination/ Case Management Improves Outcomes





NOTE: Care coordination and case management will be used synonymously throughout this presentation.

Substance Abuse & Mental Health Services Administration (SAMSHA) Definition of Case Management

SAMSHA General Definition: Coordinated, individualized approach that links clients with appropriate services to address their specific needs and help them achieve their stated goals.

- "planning and coordinating a package of health and social services that is individualized to meet a particular client's needs" (Moore, 1990, p. 444)
- "[a] process or method for ensuring that consumers are provided with whatever services they need in a coordinated, effective, and efficient manner" (Intagliata, 1981)
- "helping people whose lives are unsatisfying or unproductive due to the presence of many problems which require assistance from several helpers at once" (Ballew and Mink, 1996, p. 3)
- "monitoring, tracking and providing support to a client, throughout the course of his/her treatment and after" (Ogborne and Rush, 1983, p. 136)
- "assisting the patient in re-establishing an awareness of internal resources such as intelligence, competence, and problem solving abilities; establishing and negotiating lines of operation and communication between the patient and external resources; and advocating with those external resources in order to enhance the continuity, accessibility, accountability, and efficiency of those resources" (Rapp et al., 1992, p. 83)
- "assess[ing] the needs of the client and the client's family, when appropriate, and arranges, coordinates, monitors, evaluates, and advocates for a package of multiple services to meet the specific client's complex needs." (National Association of Social Workers, 1992, p. 5)

SUD Care Coordination PIP Overview

GOAL: Improve SUD outcomes in Alameda County residential treatment programs by increasing care coordination services for beneficiaries.

SAMHSA/Multi-County Best Practices and Areas of Focus for Improving Care Coordination:

- Family and support
- Social connection/concerns
- Frequency of Care Coordination contacts
- Transitions in level of care
- Physical health concerns

The Nuts and Bolts –

Billing for Case Management Services

ACBH BILLING CODES FOR CASE MANAGEMENT SERVICES

Level of Care	Billing Code	Service Provided
3.1	112	CM Care Coordination
	113	Service Coordination
3.3	142	CM Care Coordination
	143	Service Coordination
3.5	172	CM Care Coordination
	173	Service Coordination

CM Service	Description of Service
CM-Care Coordination	Coordination of care for clients in DMC-ODS without disruptions to services; this would include any care coordination to transition to a lower level of SUD care.
Service Coordination	Services provided to assist clients to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services

NOTE: Residential Providers cannot bill the daily rate on the client's date of discharge. However, services provided in transitioning the client to a lower level of SUD care or other service coordination activities can be billed on the discharge date.

Case Management Activities

The following reference table may be used as a tool to ensure that core functions of case management and their respective activities are being performed. This table offers some examples of activities that could be covered in sessions, when applicable and are billable. The examples should not be considered an exhaustive list of case management activities.

NOTE: Case management services must be provided by either registered/certified Counselors or LPHAs in order to be billable.

	TOPICS	POTENTIAL BILLABLE ACTIVITES
Connection	Establishing & Maintaining Benefits	Actively help clients to apply for and maintain health and public benefits (e.g., Medi-Cal, Perinatal, Housing, etc.).
	Community Resources	Link clients to community resources and services (e.g., transportation, food and clothing assistance, family planning services, legal assistance, educational services, vocational services, etc.).
Coordination	Transitions in ASAM LOC	Facilitate necessary transitions in ASAM levels of care (e.g., initiating referrals to the next level of care, coordinating with and forwarding necessary documentation to the accepting treatment agency, etc.).
	Health Services	Coordinate care with physical health, community health clinics and providers, and mental health providers to ensure a coordinated approach to whole person health service delivery.
	Social Services	Coordinate activities with State, County and community (e.g., HHS, BHS, Probation, Superior Courts, Housing Providers, etc.) entities.
Communication	Other Health Providers	Communicate face-to-face or by phone with physical health, community health clinics and providers, and mental health providers.
	Service Partners	Communicate face-to-face or by phone with Health and Human Services (HHS) social workers, Behavior Health Services (BHS) Workers, Probation Officers, Housing Providers, etc.
	Advocacy	Advocate for clients with health/social service providers, County and community partners, and others in the best interests of clients.

CASE MANAGEMENT ACTIVITY SCENARIOS

The following reference table may be used as a tool to ensure that core functions of case management and their respective activities are being performed. This table offers some examples of activities that could be covered in sessions, when applicable and are billable. The examples should not be considered an exhaustive list of case management activities.

NOTE: Case management services must be provided by either registered/certified Counselors or LPHAs in order to be billable.

BILLABLE	NOT BILLABLE
✓ Linking Clients to housing resources. ✓ Assisting clients with applying for Medi-Cal. ✓ Transferring Medi-Cal benefits for clients ✓ Linking clients to community resources such as food and clothing assistance ✓ Providing warm hand-offs to new LOC.	✓ Providing transportation for clients to scheduled appointments (not considered medically necessary treatment) such as driving client to and from DMV to obtain ID card. ✓ Helping a client move residences. ✓ Driving around looking for a client who went AWOL from the program. ✓ Driving to visit a client in the community and waiting for the client, but the client is a no-show for the appointment. ✓ Waiting for a client in the lobby during a client's doctor appointment.
✓ Identifying a referral agency and scheduling an appointment for a level of care transition (e.g. from IOP or ASAM 2.1.) ✓ Coordinating care to physical and mental health providers to ensure clients are provided appropriate services.	✓ Documenting case mgt activities outside of a progress note for services, including information regarding recent primary care and specialist visits, ED visits, auxiliary treatment services (e.g. dialysis) and any community resources received. Although providers are expected to conduct these activities, time spent documenting these activities are not billable if not a part of a direct documented service.
✓ Time spent communicating with service providers, county workers, judges, etc. either face-to-face or by phone (e.g. meeting with patient and doctor during a primary care visit) or discussing treatment progress with county partners (e.g. Child, Youth and Family Services, Probation Department. ✓ Following up with other agencies regarding scheduled services and/or services received by clients.	✓ Entering data into InSyst/Clinician's Gateway; submitting authorizations, progress notes, etc. ✓ Attempting but not successfully contacting service providers either by phone or face-to-face (e.g., leaving a voice mail message). Providers should only bill for CM if they are successful in communicating with other services providers on the client's behalf. ✓ Providing written reports or communicating via email to health and mental health providers, and county partners (e.g. Child, Youth and Family services, Probation).

Words for Documenting Case Management Services

Advised	Collaborated with	Devised	Followed up	Inquired	Referred
Aided	Communicated	Directed	Furnished	Instructed	Reinforced
Answered	Connected	Discussed	Guided	Linked	Reminded
Arranged	Consulted	Educated	Helped	Offered	Reviewed
Assigned task	Contacted	Encouraged	Helped plan	Planned	Set up
Assisted	Coordinated	Explained	Highlighted	Prepared	Suggested
Attempted	Demonstrated	Explored options	Identified	Provided	Talked about
Checked in	Developed	Facilitated	Informed	Recommended	Worked on

Care Coordination Best Practices & Tips

- Substance abuse clients often arrive in treatment programs with numerous social problems and addressing them in a respectful and timely way makes a difference.

  - Supporting clients in reconnecting with family & friends

  - Assisting in goal planning and following up with the client's progress and future plans

  - Finding and making referrals to other needed services and monitoring the subsequent engagement of the referrals
    - Physical health concerns are one of the number one needed referral.

  - Engaging in advocacy on behalf of individuals to secure additional resources including:
    - Income - GA, CalWorks, employment services
    - Food including CalFresh benefits
    - Phone

- Always come first with a strength based perspective.

SUD PIP Next Steps

- Set up on-going meetings with care coordination staff to:
  - Track success
  - Identify areas that need improvement
  - Remove any barriers encountered
- Provide on-going support for:
  - Case notes
  - Data input
  - Care coordination strategies
- Resources
  - COMPREHENSIVE CASE MANAGEMENT FOR SUBSTANCE USE DISORDEER TREATMENT (samhsa.gov)
  - TIP 27: Comprehensive Case Management for Substance Abuse Treatment (samhsa.gov)

thank you.

Questions and or Feedback?

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alameda county behavioral health

SERVICES FOR MENTAL HEALTH & SUBSTANCE USE DISORDERS