

Adult Mental Health



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CASE MANAGEMENT

Tennessee Department of Mental Health
In Collaboration with the Bureau of TennCare



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Table of Contents

	<i>Page</i>
❖ Acknowledgments	2
❖ Table of Contents	3
❖ Mental Health Case Management (MHCM) – Tennessee	5
❖ Definitions	5
❖ Case Management	6
➤ What Is Case Management?	7
➤ Are There Multiple Case Management Models?	9
❖ Adult Mental Health Case Management (MHCM) – Tennessee	12
➤ What Will Adult Mental Health Case Management (MHCM) Include in Our State?	12
➤ Examples of the Primary Duties of an Adult Mental Health Case Manager and Those Duties That Are Not Considered the Responsibility of a Case Manager	13
▪ Benefit Limitations on Adult MHCM-Tennessee	14
❖ What Is the Criteria for Medical Necessity?	14
❖ Who Will Determine Medical Necessity?	20
❖ What Are the Principles Underlying Adult MHCM-Tennessee?	20
❖ Who Can Receive Adult MHCM-Tennessee Services?	21
❖ Will All Eligible Service Recipients Receive the Same Level of Adult MHCM-Tennessee Services?	22
➤ Level 1 Adult MHCM-Tennessee – Team Intensive Services	22
➤ Level 2a Adult MHCM-Tennessee – Individual Intensive Services	25

	<i>Page</i>
➤ Level 2b Adult MHCM-Tennessee – Individual Supportive Services	29
❖ How Long Will It Take Eligible Service Recipients to Begin Receiving Adult MHCM-Tennessee Services?	33
❖ Adult MHCM-Tennessee Service Delivery Process	34
❖ Case Management Staff/Provider Requirements	35
➤ Case Manager Requirements	35
▪ Level 1 – Adult MHCM-Tennessee – Team Intensive Services	35
▪ Level 2a – Adult MHCM-Tennessee - Individual Intensive Services	35
▪ Level 2b Adult MHCM-Tennessee – Individual Supportive Services	36
➤ Supervisor Requirements	37
❖ Outcomes	38
➤ Level 1 Adult MHCM-Tennessee – Team Intensive Services	38
➤ Level 2a Adult MHCM-Tennessee – Individual Intensive Services	38
➤ Level 2b Adult MHCM-Tennessee – Individual Supportive Services	38
❖ Assessment Tools for Case Managers	41
❖ Research on the Benefits of Case Management	43
➤ Supportive Mental Health Case Management: A Case Study	45
❖ References	46

Mental Health Case Management (MHCM) – Tennessee

All mental health statutes are incorporated within Title 33 of the Tennessee Code Annotated (TCA). Chapter 1, Part 2 specifically designates the Tennessee Department of Mental Health (TDMH) as the State's mental health authority. As such, TDMH has responsibility for system planning, system monitoring and evaluation, setting policy and quality standards, disseminating information to the public, and advocacy for all persons, regardless of age, that have a mental illness or serious emotional disturbance. The Department's mission incorporates planning for and promoting the availability of a comprehensive array of quality prevention, early intervention, treatment, habilitation and rehabilitation services and supports based on the needs and choices of individuals and families served (TDMH Web page). Case management, specifically mental health case management (MHCM), is one of many effective services promoted by TDMH because it strives to connect persons with mental illness to needed resources and services that provide for recovery, self sufficiency, and an overall better quality of life.

Definitions

Behavioral Health Safety Net of TN (BHSN of TN) – An assistance for uninsured service recipients in the State of Tennessee that have been classified in the priority population and require behavioral health services on an outpatient basis. Eligibility is predetermined and must be met for service recipients to qualify for this assistance. Eligibility criteria include Tennessee residency, United States citizenship, income at 100 percent of the federal poverty level, and lack of other insurance or payor source (TDMH, January 2009).

Bureau of TennCare – The division of the Tennessee Department of Finance and Administration that has been designated and approved to administer the TennCare program (CRA, 2011).

Health Maintenance Organization (HMO) – An entity certified by the Tennessee Department of Commerce and Insurance (TDCI) under applicable provisions of TCA Title 56, Chapter 32 (CRA, 2011).

Diagnostic and Statistical Manual of Mental Disorders (DSM) – Published by the American Psychiatric Association, this manual provides common language and standard criteria for the classification of mental disorders. Criteria for a diagnosable mental disorder should be based on the most current revision.

Managed Care Organization (MCO) – an entity licensed to operate as a Health Maintenance Organization (HMO) in the State of Tennessee that has met additional qualifications established by the State for providing or arranging for the provision of covered physical health, long-term care, and behavioral health services to persons enrolled in the TennCare program and for whom it has received prepayment (adapted from CRA, 2011).

Medically Necessary – A requirement for a medical item or service to be paid for by TennCare. Criteria, herein identified as “medical necessity” is delineated in this document.

Provider – An agency or facility approved by TDMH that accepts payment for providing services to an eligible BHSN or TennCare service recipient (TDMH, January 2009).

Families First – Tennessee’s version of the Temporary Aid to Needy Families (TANF) program, a federal-state cash assistance program. Basic rules for administration are set by the federal government, but states have responsibility for developing their programs and income eligibility limits. Benefit levels for the State of Tennessee are set by our state. Such levels vary widely across states (TDHS, 2011).

TennCare – The Medicaid program in the State of Tennessee that operates through the Tennessee Department of Finance and Administration, Bureau of TennCare, as designated by the State and the Centers for Medicare and Medicaid Services (CMS) pursuant to Title XIX of the Social Security Act and the Section 1115 Research and Demonstration waiver granted to the State of Tennessee (CRA, 2011).

Tennessee Department of Commerce and Insurance (TDCI) – The state agency with the statutory authority to regulate, among other entities, health maintenance organizations and insurance companies (CRA, 2011).

Tennessee Department of Finance and Administration – In addition to being the single state Medicaid agency, this state agency oversees all state spending and acts as the chief corporate office of the state (CRA, 2011).

Veteran’s Administration Benefits – The Department of Veterans’ Affairs provides a definition of Disabled Veterans with a Mental Illness. The disability has to be within the purview of the VA’s definition of mental disability, which is based on the DSM-IV-TR criteria. If determined eligible, benefits are available.

Case Management

Case management is tool that has been used across varied disciplines, in varied settings, by varied professionals. In the world of behavioral health, case management is used to coordinate service delivery for persons with mental illness while ensuring continuity and integration of services (DHHS, 1999). It has emerged as an important intervention in the

field because it maintains a consistent and primary focus on client self-determination and quality of care while fostering the careful shepherding of health care dollars (CMSA, 2010).

After deinstitutionalization, thousands of mentally ill individuals were moved from the state psychiatric hospitals into the community for service. Increasingly persons with mental illness were never even admitted to the state hospitals and the community mental health systems became more complex and extremely difficult to navigate. Case management became a remedy to the confusion that was created by the multiple care providers in various settings. The intervention was further designed to ensure accessibility, accountability, and continuity of care for persons with long-term disabling mental disorders (Encyclopedia of Mental Disorders, 2011).

What Is Case Management?

There are as many definitions of case management as there are groups or organizations that provide or certify the service. For example, CMS defines case management as “services that assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services”, as added by the Deficit Reduction Act of 2005 (CMS, 2007). The National Association of Social Workers (NASW) provides a definition for case management that is more profession specific and reads: “Case management is a method of providing services whereby a professional social worker assesses 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”. The National Association of State Mental Health Program Directors (NASMHPD) has defined case management as “a range of services provided to assist and support patients in developing their skills to gain access to needed medical, behavioral health, housing, employment, social, educational, and other services essential to meeting basic human services; linkages and training for patient served in the use of basic community resources; and monitoring of overall service delivery” (NASMHPD, 2011).

One of the most succinct yet comprehensive definitions of case management is provided by the Case Management Society of America (CMSA). CMSA defines case management as “**a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s and family’s comprehensive health needs through communication and available resources to promote quality cost-effective outcomes**” (CMSA, 2010, p. 6). Thus, the focus includes not only individuals, but their natural supports. Case management is an activity that assists individuals in gaining access to necessary medical, behavioral, social, and other services that are appropriate to their needs. The service is not only individualized, but it is empowering, comprehensive, person centered, strengths-based, and outcome-focused (North Carolina Division of Medical Assistance, Mental Health, 2010).

Everybody benefits when individuals with mental health issues reach their optimal level of wellness and functional capability. Case management is one of the means through which

such persons can achieve wellness as well as optimum functioning. Case management service delivery can be individually based or handled by a team. It is provided by individuals known as “case managers”, especially on the individual service-delivery level.

As with most strategies, there are guiding or clarifying principles. CMSA has identified 12 principles that guide the practice of case management:

Case managers:

1. Connect with community resources.
2. Assist in the navigation of the health care system to achieve successful care, especially during transitions.
3. Promote optimal safety for the consumers they serve.
4. Promote the utilization of evidence-based care.
5. Promote quality outcomes and the measurement of those outcomes.
6. Promote the integration of behavioral change principles and science.
7. Use a holistic, comprehensive approach.
8. Use a collaborative, client-centric partnership approach.
9. Practice cultural competence, with respect for and awareness of diversity. Accommodation for diversity, gender, ethnicity, race, life stage, disability, and sexual orientation should be build into the case management process. The five (5) elements associated with becoming culturally competent include: valuing diversity; understanding the dynamics of cultural interaction; incorporating cultural knowledge; making/taking a cultural self assessment; and adapting practices to the diversity present in a particular setting (Why Case Management, 2000).
10. Facilitate self-care and self-determination through the tenets of shared decision-making, advocacy, and education, whenever possible.
11. Maintain competence in practice and pursue professional excellence.
12. Maintain and support compliance with federal, state, local, organizational, and other relevant rules and regulations (CMSA, 2010).

Depending on case manager requirements for a state or managed care organization (MCO), for example, case manager roles could be varied. **Individuals hired as case managers in the delivery of Adult MHCM-Tennessee services, however, will not have blurred or overlapping roles.** They will not diagnose or provide mental health treatment, for example. Adult MHCM-Tennessee case managers will only deliver case management services.

As originally designed, case management was not a time-limited service. The intent was that service would be ongoing, ensuring that service recipients have whatever they need whenever they need it and for as long as they need it (Encyclopedia of Mental Disorders, 2011). However, the idea of recovery suggests that people can and do get better. They can function independently. They can attain their goals. They can be compliant with their medications. They can hold down a full-time job. They can monitor their own blood sugar. They can secure and maintain housing. Being able to be self-determined and self-reliant ring through the mental health recovery definition from the Substance Abuse and Mental Health Services Administration (SAMHSA): “Mental health recovery is a journey of healing

and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential” (SAMHSA, 2004).

With the aid of case management, consumers should be able to accomplish the following goals:

1. Increase their retention in and completion of treatment in order to move them toward recovery and self sufficiency.
2. Increase their access to essential services such as psychiatric care, primary health care, stable and secure living arrangements, positive support networks, vocational and/or educational training, and employment (Adapted from Pennsylvania Department of Health, 2003).

Are There Multiple Case Management Models?

A review of the literature typically yields two models of case management. They are assertive community treatment (ACT) and intensive case management. Another commonly referenced model is that of clinical case management (CCM). In this model, the case manager performs case management activities in addition to functioning as the primary therapist/clinician. In CCM, case managers are expected to possess necessary education and skills to operate as therapists (Mueser, Bond, Drake, & Resnick, 1998). Then there is the blended case management model. It has been promoted recently by some states in their efforts to help eligible individuals with mental illness gain access to needed medical, educational, social, and other services with minimal complexity (Pennsylvania Department of Public Welfare, 2009).

The Assertive Community Treatment (ACT) model was first implemented at Mendota State Hospital in Madison, WI, inside an inpatient research unit in the late 1960s. The underlying philosophy was to create and provide a “hospital without walls.” The model typically involves a multidisciplinary team of 10-12 professions that include case managers as well as medical and other mental health professionals. This team has responsibility for a caseload of around 10 consumers with mental health issues 365 days a year, seven (7) days a week, 24 hours a day (DHHS, 1999). An emphasis is placed on helping the consumer to manage his/her own illness and, with assistance as necessary, conduct activities of daily living (Encyclopedia of Mental Disorders, 2011).

ACT involves a team approach to delivering effective and comprehensive services to adults diagnosed with severe mental illness and who have needs that have not been well met by more traditional approaches to delivering services. Among the ACT principles are:

- 1) Engagement of individuals in treatment and monitoring;
- 2) The provision of a flexible and comprehensive range of treatment and services;
- 3) Sharing of responsibility between individuals and team members served by the team;
- 4) Targeted services for a specific group of individuals with severe mental illness;

- 5) Individualized treatment, rehabilitation and support services;
- 6) Treatment, rehabilitation and support services are provided directly by the ACT team;
- 7) There are small staff to individual ratios (approx. 1 to 10);
- 8) Interventions occur in community settings rather than in clinic settings or hospitals;
- 9) Services are available twenty-four (24) hour a day; AND
- 10) There is no arbitrary time limit on receiving services (CRA, 2011).

The research base supporting ACT is overwhelmingly strong, with reports of control of psychiatric symptoms, increased housing stability, reduced hospitalizations and homelessness, reduced inappropriate hospitalizations, and improved quality of life (Encyclopedia of Mental Disorders, 2011).

The Program of Assertive and Community Treatment (PACT) was developed by Stein and Test in the 1970s (Mueser, Bond, Drake, & Resnick, 1998). It contains the elements of ACT as a service delivery model for providing comprehensive community-based treatment to adults with mental illness. It incorporates the use of a multidisciplinary team of mental health professionals organized as an accountable, mobile mental health agency or group of providers. Services are provided in the consumer's own home or in an agreed upon location in the consumer's community. PACT staff are similar to staff the consumer would encounter had he/she been hospitalized. They function interchangeably as a team to provide the treatment, support services, and rehabilitation that persons with severe and/or persistent mental illnesses need to live successfully in the community (CRA, 2011)

PACT takes the services provided in the hospital "home", at least to the community. This strategy was conceptualized when former psychiatric hospital patients began to lose ground after the round-the-clock care of the hospital was no longer available to the consumer following discharge. In 1972, researchers moved the hospital-treatment staff into the community for the real test. In PACT, the consumer does not have the requirement of adapting to or following prescriptive rules of a treatment program (NAMI, 2011).

Unlike ACT and PACT, Intensive Case Management (ICM) is individually based and generally targeted to those with the greatest needs. For example, individuals with a history of multiple hospitalizations or who are both homeless and severely mentally ill would be assigned to ICM. It is more likely that ICM case managers will schedule or connect clients with services rather than provide them directly themselves. ICMs are strengths based and empower consumers to fully participate in all treatment decisions (Encyclopedia of Mental Disorders, 2011). These strengths-based models operationalize recovery principles while simultaneously helping people reclaim, recover, and transform their lives through the identification and sustaining of a range of resources for thriving in the community (AMHD, 2008).

Clinical case management (CCM) models tend to show their greatest effect after consumers have been hospitalized. Undergoing CCM versus ACT tends to get the consumer out of the hospital sooner. Experts agree, however, that high-quality CCM and ACT should be

essential features of any mental health service system (Encyclopedia of Mental Disorders, 2011).

Blended case management has been promoted as a case management model in which individuals with mental illness are not required to change case managers when the intensity of their service needs changes. Piloted in the state of Pennsylvania, for example, the model does not alter the case management services being delivered, but there are changes in the manner in which such services are delivered. It allows the case manager, who is referred to as the “blended case manager”, to make adjustments to service intensity based on the consumer’s needs. In Pennsylvania, this pilot project was initiated by the Office of mental Health and Substance Abuse Services in July 2003. Project results demonstrated that blended case management:

- Increased continuity of care at both the individual and systems levels;
- Decreased disruption in service, thus allowing consumers and their families to focus more on goals;
- Allows services to be consumer driven;
- Gives the consumer as well as the case manager a greater sense of accomplishment because of the opportunity to maintain a working relationship through transitions; AND
- Provides flexibility, particularly for individuals coming out of facilities (Pennsylvania Department of Welfare, 2003).

Case management models can be categorized in many different ways. Moreover, many of the same activities can be found across models. For example, most models provide services for the consumer in the community rather than in the office. The common goal across case management models is to help consumers survive, thrive, and optimize their adjustment in the community (Mueser, Bond, Drake, & Resnick, 1998).

Adult Mental Health Case Management (MHCM) – Tennessee

What Will Adult Mental Health Case Management (MHCM) Include in Our State?

Adult mental health case management (MHCM) is a comprehensive service that aims to enhance treatment effectiveness and outcomes with the goal of maximizing recovery and resilience options and natural supports for the adult service recipient. It is consumer focused, consumer-centered, and strength-based, with services provided in an appropriate, timely, coordinated, effective, and efficient fashion. MHCM for adults comprises activities performed by a single mental health case manager or a team to support clinical services. The mental health case managers assist in ensuring that the service recipient has access to services.

Case management is defined as those services that are necessary to coordinate an optimum life style for the targeted consumers. As designed, it will help consumers access clinical and other services that prevent deterioration in their current mental status and promote their recovery toward independent living. Case management will also serve to aid the consumer in receiving treatment in the least intensive level of care. At least 51 percent of contacts need to be face-to-face.

Like other kinds of case management, MHCM for adults requires that the mental health case manager and the service recipient and/or family have a strong, productive relationship. This relationship could include accepting the individual/family as a responsible partner in identifying and obtaining the necessary services and resources. MHCM for adults should be delivered in community settings that are accessible and comfortable to the individual and/or his/her family. Further, the service should be provided in a culturally competent manner and be outcome driven. MHCM for adults should be also available 24 hours a day, 7 days a week. The service itself is not time limited, as service recipients/families will work through case management at their own pace. However, the intent of MHCM, as provided for adults, is to empower the individual in improving and maintaining a wholesome quality of life. MHCM can be delivered for adults through individual or team approaches. In our state, adult MHCM will be known as Adult MHCM-Tennessee.

Examples of the Primary Duties of an Adult Mental Health Case Manager and Those Duties That Are Not Considered the Responsibility of a Case Manager. Case Managers may assist in a referral to aid the consumer in obtaining non-case management services.

There are many activities that will be covered under Adult MHCM-Tennessee. However, there are also a number of services that might be beneficial to consumers but may not be covered under case management for the purposes of this manual. Items in the following table provide examples of the Primary Duties of an Adult Mental Health Case Manager and those duties that are not considered the responsibility of a Case Manager. Case Managers may assist in a referral to aid the consumer in obtaining non-case management services. **It should be noted that the lists are not designed to be all inclusive.**

Primary Duties of an Adult Mental Health Case Manager	Services that an Adult Mental Health Case Manager Cannot Directly Provide but May Initiate a Referral to Obtain
Coordinating and arranging needed services that have been identified in the service plan.	Teaching, tutoring, training, instructing, or educating the consumer, except in so far as the activity is specifically designed to assist the consumer or his/her informal supports to independently obtain needed services for the consumer.
Developing, implementing, monitoring and documenting a written, individualized, and coordinated case management service plan. The plan shall include documentation of contacts, the consumer's progress and changing needs in compliance with all MCO requirements.	Directly assisting with personal care or activities of daily living such as bathing, eating, etc.
Assisting the consumer and their support system to address issues related to implementation of the service plan.	Providing direct delivery of an underlying clinical, social, educational, or other service to which the consumer has been referred.
Developing goals in collaboration with the consumer that foster recovery.	Transporting the consumer when the sole purpose of the service is simply to transport the consumer.
Providing referrals or other related activities to help the consumer obtain all medically necessary covered services and other supports to foster recovery.	Spending time transporting the consumer's family members.
Performing activities with the consumer that assist in establishing and/or maintaining eligibility for state and federal assistance programs.	Providing services for or on behalf of other family members that do not directly assist the client to access needed services.

Primary Duties of an Adult Mental Health Case Manager <i>(continued)</i>	Services that an Adult Mental Health Case Manager Cannot Directly Provide but May Initiate a Referral to Obtain <i>(continued)</i>
Assisting with scheduling medical/behavioral services and transportation as needed.	Providing day care services for the consumer.
Educating the consumer and/or his/her informal supports about the value of early intervention services and treatment programs.	Performing routine courier services such as shopping.
	Providing legal advocacy.
	Administering medications.
	Providing outreach activities to potential clients.

Benefit Limitations on Adult MHCM-Tennessee

The Contractor Risk Agreements (CRAs) include an MCO Behavioral Health Benefits Chart that clarifies type of service along with any limitations on benefits. As noted in the chart below, Adult MHCM-Tennessee will be limited by the fact that medical necessity is a requirement.

MCO Behavioral Health Benefits Chart

SERVICE	BENEFIT LIMIT
Mental Health Case Management (MHCM)	As medically necessary.
Source: CRA, 2011	

What Is the Criteria for Medical Necessity?

The medical necessity standard set forth at TCA Section 71-5-144 and in associated rules govern the delivery of all medical items and services to all enrollees or classes of TennCare beneficiaries. Hence, medical necessity is an essential requirement in the delivery of Adult Mental Health Case Management- (MHCM-) Tennessee services. Criteria for medical necessity is covered in T.C.A. §§4-5-202, 4-5-209, 71-5-105, 71-5-109, Executive Order No. 23. The rule related to medical necessity is found in Chapter 1200-13-16-.05 and presented below in its entirety.

Medical Necessity Criteria

- 1) To be medical necessary, a medical item or service must satisfy each of the following criteria.
 - a) It must be recommended by a licensed physician who is treating the enrollee or other licensed healthcare provider practicing within the scope of his/her license who is treating the enrollee;
 - b) It must be required in order to diagnose or treat an enrollee's medical condition;
 - c) It must be safe and effective;
 - d) It must not be experimental or investigational; AND
 - e) It must be the least costly alternative course of diagnosis or treatment that is adequate for the enrollee's medical condition.

- 2) The convenience of an enrollee, his/her family or caregiver, or a provider, shall not be justification in determining that a medical item or service is medically necessary.

- 3) Services required for diagnosis of an enrollee's medical condition.
 - a) May include screening services, as appropriate, provided that all the other medical necessity criteria are satisfied.
 - b) "Appropriateness" of screening services requires they meet **ONE** of the following three categories:
 - i) Services required to achieve compliance with federal regulatory or statutory mandates under the EPSDT program; OR
 - ii) Newborn testing for genetic/ metabolic defects as set forth in Tennessee Code Annotated, Section 68-5-401; OR
 - iii) Pap smears, mammograms, colorectal cancer screenings, prostate cancer screenings, and screening for sexually transmitted diseases, including HIV, and tuberculosis, in accordance with nationally accepted clinical guidelines adopted by the Bureau of TennCare.
 - c) Other screening services are "appropriate" only if they satisfy **EACH** of the following criteria, unless specifically provided for herein:
 - i) The Bureau of TennCare, an MCO, or a state agency that performs the functions of an MCO determines that the screening services are cost effective; AND
 - ii) Screening via these services must have a significant probability of detecting the disease; AND
 - iii) The disease for which the screening is conducted must have a significant detrimental effect on the health status of the affected person; AND
 - iv) Tests must be reasonably priced for purchase; AND
 - v) Evidence-based treatment methods must be available for treating the disease at the disease stage that the screening is designed to detect; AND
 - vi) Treatment in the asymptomatic phase must yield a therapeutic outcome.
 - d) Services required for diagnosis of an enrollee's medical condition comprise diagnostic services mandated by EPSDT requirements.

Medical Necessity Criteria (continued)

- 4) Services required in the treatment of an enrollee's medical condition. Treatment may only consist of the following, provided that all other elements of medical necessity are satisfied:
 - a) Medical care essential in the treatment of a diagnosed medical condition, symptoms of a diagnosed medical condition, or the effects of a diagnosed medical condition and which, if not provided, would have a demonstrable and significant adverse impact on length or quality of life.
 - b) Medical care essential in the treatment of significant side effects of another medically necessary treatment (*e.g.*, nausea medications for side effects of chemotherapy).
 - c) Essential medical care, based on an individualized determination of a particular patient's medical condition, to avoid the onset of significant health problems or complications that, with reasonable medical probability, will arise from that medical condition in the absence of such care.
 - d) Home health services.
 - i) Home health aide services are necessary in the treatment of an enrollee's medical condition only if such services:
 - (1) Are of a type that the enrollee cannot perform for himself/herself; AND
 - (2) Are of a type for which there is no caregiver able to provide the services; AND
 - (3) Consist of hands-on care of the enrollee.
 - ii) All other home health services are necessary in the treatment of an enrollee's medical condition only if they are ordered by the treating physician, pursuant to a plan of care, and meet the requirements described at subparagraph (a), (b), or (c) immediately above or (f) immediately below. Services that do not meet these requirements, such as cleaning services, general child care services, or the preparation of meals, are not required in the treatment of an enrollee's medical condition and will not be provided. Because children typically have non-medical care needs that must be met, to the extent that home-health services or private-duty nursing services are provided to a person under 18 years of age, a responsible adult (someone other than the health care provider) must be present at all times in the home when home health or private duty nursing services are provided, unless all of the following criteria are met:
 - (1) The child is non-ambulatory; AND
 - (2) The child has extremely limited ability or no ability to interact with caregivers; AND
 - (3) The child shall not reasonably be expected to have needs that fall outside the scope of medically necessary, TennCare covered benefits (*e.g.* the child has no need for meal preparation or general supervision) during the time the private duty nurse or home health provider is in the home without the presence of another responsible adult; AND
 - (4) No other children shall be present in the home during the time the private duty nurse or home health provider is present in the home without the presence of another responsible adult.

Medical Necessity Criteria (continued)

- e) Private Duty Nursing services are separate services from home health services. When private duty nurses are authorized by the MCO to provide home health aide services pursuant to rule 1200-13-13-.04(7)(f) or 1200-13-14-.04(8)(f), it is mandatory that the services meet the requirements described at Part 1 immediately above.
- f) Home health services may not be denied on any of the following grounds:
 - i) Because such services are medically necessary on a long term basis or are required for the treatment of a chronic condition;
 - ii) Because such services are deemed to be custodial care;
 - iii) Because the enrollee is not homebound;
 - iv) Because private insurance utilization guidelines, including but not limited to those published by Milliman & Robertson or developed in-house by TennCare MCOs, do not authorize such health care as referenced above;
 - v) Because the enrollee does not meet coverage criteria for Medicare or some other health insurance program, other than TennCare;
 - vi) Because the home health care that is needed does not require or involve a skilled nursing service;
 - vii) Because the care that is required involves assistance with activities of daily living;
 - viii) Because the home health service that is needed involves home health aide services; OR
 - ix) Because the enrollee meets the criteria for receiving Medicaid nursing facility services.
- g) Personal Care Services.
 - i) Personal care services are necessary to treat an enrollee's medical condition only if such services are ordered by the treating physician pursuant to a plan of care to address a medical condition identified as a result of an EPSDT screening. Personal care services must be supervised by a registered nurse and delivered by a home health aide. In addition the services must:
 - (1) Be of a type that the enrollee cannot perform for himself or herself; AND
 - (2) Be of a type for which there is no caregiver able to provide the services; AND
 - (3) Consist of hands-on care of the enrollee.
 - ii) Services that do not meet these requirements, such as general child care services, cleaning services or preparation of meals, are not required to treat an enrollee's medical condition and will not be provided. For this reason, to the extent that personal care services are provided to a person under 18 years of age, a responsible adult (other than the home health aide) must be present at all times during provision of personal care services.
- h) The following preventive services:
 - i) Prenatal and maternity care delivered in accordance with standards endorsed by the American College of Obstetrics and Gynecology;
 - ii) Family planning services;
 - iii) Age-appropriate childhood immunizations delivered according to guidelines developed by the Advisory Committee on Immunization Practices;

Medical Necessity Criteria (continued)

- iv) Health education services for TennCare-eligible children under age 21 in accordance with 42 U.S.C. Section 1396d;
 - v) Other preventive services that are required to achieve compliance with federal statutory or regulatory mandates under the EPSDT program; OR
 - vi) Other preventive services that have been endorsed by the Bureau of TennCare or a particular MCO as representing a cost effective approach to meeting the medically necessary health care needs of an individual enrollee or group of enrollees.
- 5) Safe and effective.
- a) To qualify as being safe and effective, the type, scope, frequency, intensity, and duration of a medical item or service must be consistent with the symptoms or confirmed diagnosis and treatment of the particular medical condition. The type, scope, frequency, intensity, and duration of a medical item or service must not be in excess of the enrollee's needs.
 - b) The reasonably anticipated medical benefits of the item or service must outweigh the reasonably anticipated medical risks based on:
 - i) The enrollee's condition; AND
 - ii) The weight of medical evidence as ranked in the hierarchy of evidence in rule 1200-13-16-.01(22) and as applied in rule 1200-13-16-.06(6) and (7).
- 6) Not experimental or investigational.
- a) A medical item or service is not experimental or investigational if the weight of medical evidence supports the safety and efficacy of the medical item or service in question as ranked in the hierarchy of evidence in rule 1200-13-16-.01(22) and as applied in rule 1200-13-16-.06(6) and (7). This standard is not satisfied by a provider's subjective clinical judgment on the safety and effectiveness of a medical item or service or by a reasonable medical or clinical hypothesis based on an extrapolation from use in diagnosing or treating another condition. However, extrapolation from one population group to another (e.g. from adults to children) may be appropriate. For example, extrapolation may be appropriate when the item or service has been proven effective, but not yet tested in the population group in question.
 - b) Subject to the provisions set forth in subparagraph (c) immediately below, use of a drug or biological product that has not been approved for marketing under a new drug application or abbreviated new drug application by the United States Food and Drug Administration (FDA) is deemed experimental.
 - c) Use of a drug or biological product that has been approved for marketing by the FDA but is proposed to be used for other than the FDA-approved purpose (*i.e.*, off-label use) is experimental and not medically necessary unless the off-label use is shown to be widespread and all other medical necessity criteria as set forth in rule 1200-13-16-.05(1)(a), (b), (c) and (e) are satisfied.
 - d) Items or services provided or performed for research purposes are experimental and not medically necessary. Evidence of such research purposes may include

Medical Necessity Criteria (continued)

- e) written protocols in which evaluation of the safety and efficacy of the service is a stated objective or when the ability to perform the service is contingent upon approval from an Institutional Review Board, or a similar body.
 - f) Unless a proposed diagnosis or treatment independently satisfies the criteria for “not experimental or investigational”, and satisfies all other medical necessity criteria, the fact that an experimental/investigational treatment is the only available treatment for a particular medical condition or that the patient has tried other more conventional therapies without success does not qualify the service for coverage.
- 7) The least costly alternative course of diagnosis or treatment that is adequate for the medical condition of the enrollee.
- a) Where there are less costly alternative courses of diagnosis or treatment that are adequate for the medical condition of the enrollee, more costly alternative courses of diagnosis or treatment are not medically necessary, even if the less costly alternative is a non-covered service under TennCare.
 - b) Where there are less costly alternative settings in which a course of diagnosis or treatment can be provided that is adequate for the medical condition of the enrollee, the provision of services in a setting more costly to TennCare is not medically necessary.
 - c) If a medical item or service can be safely provided to a person in an outpatient setting for the same or lesser cost than providing the same item or service in an inpatient setting, the provision of such medical item or service in an inpatient setting is not medically necessary and TennCare shall not provide payment for that inpatient service.
 - d) An alternative course of diagnosis or treatment may include observation, lifestyle, or behavioral changes or, where appropriate, no treatment at all when such alternative is adequate for the medical condition of the enrollee.
 - e) The following is a non-exhaustive illustrative set of circumstances that could fit within the provisions of rule 1200-13-16-.05(7)(d). These examples may or may not be appropriate, depending on an individualized medical assessment of a patient’s unique circumstances:
 - i) Rest, fluids and over-the-counter medication for symptomatic relief might be recommended for a viral respiratory infection, as opposed to a prescription for an antibiotic;
 - ii) Rest, ice packs and/or heat for acute, uncomplicated, mechanical low back pain along with over-the-counter pain medicine, as opposed to x-rays and a prescription for analgesics;
 - iii) Clear liquids and advance diet as tolerated for uncomplicated, acute gastroenteritis, as opposed to prescription antidiarrheals.
- 8) The Bureau of TennCare may make limited special exceptions to the medical necessity requirements described at rule 1200-13-16-.05(1) for particular items or services, such as long term care, or such as may be required for compliance with federal law.

Medical Necessity Criteria (continued)

- 9) Transportation services that meet the requirements described at rule 1200-13-13-.04 and 1200-13-14-.04 shall be deemed to be medically necessary if provided in connection with medically necessary items or services (T.C.A. §§4-5-202, 4-5-209, 71-5-105, 71-5-109, Executive Order No. 23.).

Who Will Determine Medical Necessity?

The Managed Care Organization (MCO) may establish procedures for the determination of medical necessity. Medical necessity determinations shall be made on a case by case basis and in accordance with the definition of medical necessity defined in TCA 71-5-144 and TennCare rules and regulations. However, this requirement shall not limit the MCO's ability to use medically appropriate cost-effective, alternative services in accordance with Section 2.6.5 in the Contract Risk Agreement (CRA).

The Bureau of TennCare has ultimate responsibility in the determination of medical necessity. On occasion, the Bureau may establish or endorse medical necessity guidelines that shall guide determinations of medical necessity for specific services or items across all MCOs and State agencies performing the function of MCOs. Such guidelines shall be established with input from all healthcare providers, be evidence based, and take into account all criteria of the statutory definition of medical necessity. The approved guidelines will be disseminated to the MCOs and the provider community and a continuous medical review process will be set in motion to ensure the responsiveness of the approved guidelines to advances in medical technology and knowledge (CRA, 2011).

What Are the Principles Underlying Adult MHCM-Tennessee?

The MCO's case management program for adults will be promoted as Adult MHCM-Tennessee. This service will be guided by the following principles:

- Case managers shall only deliver case management services.
- Eligible service recipients shall be assigned to a single case manager, unless they are being served by a team, i.e., a multidisciplinary group of behavioral health providers. In the event of the latter, the service recipients shall be managed by a single team.
- Services shall be rendered in a manner that exemplifies the principle of recovery, acknowledging that people with mental illness **CAN** and **DO** recover (Sherman & Ryan, 1998).
- Eligible service recipients shall have the right to refuse Adult MHCM-Tennessee services.

Who Can Receive Adult MHCM-Tennessee Services?

Admission to Adult MHCM-Tennessee will be based on medical necessity. Services must assist consumers in overcoming barriers, caused by the mental health condition, that are preventing the attainment of goals. The following key components should be addressed in determining eligibility for Adult MHCM-Tennessee services.

The service recipient:

- Has a diagnosable mental illness that impairs the his/her ability to function within the community;
- Is actively participating in treatment at an outpatient setting or Is reasonably expected to participate in outpatient treatment as a result of referral and/or education;
- Needs assistance utilizing or accessing behavioral health, medical, and/or community-based services to function in the community as necessary for recovery, including services related to:
 - Employment or public assistance.
 - Housing.
 - Childcare.
 - Money management.
 - Transportation.
 - Education.
 - Legal matters (Adapted from U.S. Behavioral Health-CA, 2011).

Will All Eligible Service Recipients Receive the Same Level of Adult MHCM-Tennessee Services?

Adult MHCM-Tennessee will be provided as three (3) different levels of case management. One level will be team-based and the remaining two (2) levels will be delivered through an individual approach. Two levels are intensive and one (1) level is supportive. MCOs will be expected to ensure delivery of Adult MHCM-Tennessee according to the standards set forth by medical necessity guidelines, the CRA, and MCO level-specific guidelines. **Peer support, i.e., Certified Peer Specialists, might be used as an adjunct to the case manager, where available, in the least restrictive level. At no time, however, should peer support in the form of Certified Peer Specialists or any other form become a substitute for case managers in the delivery of case management services.**

Key components for each level of Adult MHCM-Tennessee services are described below.

The following charts outlining the service criteria are provided only as guidelines to assist MCOs and case manager providers in determining the appropriate level of care needed.

Level 1 Adult MHCM-Tennessee – Team Intensive Services

<p>Introduction</p>	<p>Level 1 encompasses the most intensive level of Adult MHCM-Tennessee. Services for this level are designed for persons of exceptionally high-need and/or high-risk that have a mental illness. Level 1 services also include an interdisciplinary team. Individuals receiving this level of service are likely disconnected psychiatrically and/or medically from community-based services. They typically show more severe psychiatric impairment such as a diagnosis of chronic, severe psychosis, and may be characterized by a pattern of excessively high service use or needs.</p> <p>Adult MHCM-Tennessee currently recognizes three (3) team approaches that might be utilized in the delivery of Level 1 services: ACT, CTT, and PACT (CRA, MCO Amendment M-E-W 10 & 7, 2011; CRA, TennCare Select Amendment 27, 2011).</p>
<p>Admission Criteria</p>	<p>Admission to Level 1 Adult MHCM-Tennessee will be based on medical necessity. At a minimum, admission criteria should include the following key components.</p> <p style="padding-left: 40px;">The service recipient:</p> <ul style="list-style-type: none"> ○ Has a diagnosable mental illness that impairs the his/her ability to function within the community; ○ Is actively participating in treatment at an outpatient setting or is reasonably expected to participate in outpatient treatment as a result of referral and/or education; ○ Needs assistance utilizing or accessing behavioral health, medical, and/or community-based services to function in the community as necessary for recovery, including services related but not limited to: <ul style="list-style-type: none"> ○ Employment or public assistance. ○ Housing. ○ Childcare. ○ Money management. ○ Transportation. ○ Education. ○ Legal matters (Adapted from U.S. Behavioral Health-CA, 2011).

Level 1 Adult MHCM-Tennessee – Team Intensive Services (continued)

<p>Admission Criteria (continued)</p>	<p>In addition, persons admitted to Level 1 Adult MHCM-Tennessee would need to meet at least TWO (2) of the following conditions.</p> <p>The service recipient has:</p> <ul style="list-style-type: none"> ○ Demonstrated extremely poor and/or erratic functioning in the community and could not be effectively served through less intensive community-based services. ○ Been a nonparticipant in traditional community-based treatment. ○ Been hospitalized for at least one (1) psychiatric admission. ○ Had at least three (3) emergency psychiatric presentations either through a crisis stabilization unit (CSU) or other alternative level of care while residing in the community. ○ Had regular contact with the legal system. ○ Experienced homelessness or is at very high risk of losing community tenure. ○ Demonstrated consistent patterns of high service use or needs. ○ No family, friends, significant others, or other identifiable natural supports to provide necessary assistance in accessing and/or utilizing services and/or skills that are geared toward recovery.
<p>Step-Down Criteria</p>	<p>Level 1 service recipients transitioning to the next level of care might exhibit the following:</p> <ul style="list-style-type: none"> ○ Along with his/her team, involvement in the decision that the team approach of case management services is no longer needed. ○ Participation in treatment (behavioral health and/or medical). Behavioral health treatment may be pharmacological, psychosocial, or a combination of the two. ○ No hospitalizations. ○ No involvement with law enforcement or the criminal justice system involving extended incarceration. ○ Demonstration of some ability to identify and/or communicate with family, friends, or significant others for informal support in the management of their illness and/or other needs and services that will increase the likelihood of community tenure and move them toward recovery. ○ Demonstrated progress in access to or engagement of community-based services. <p><i>*The service recipient could transition to Level 2a or Level 2b.</i></p>

Level 1 Adult MHCM-Tennessee – Team Intensive Services (continued)

<p>Continuation Criteria</p>	<p>Components of continued stay for the service recipient in Level 1 would include the following:</p> <ul style="list-style-type: none"> ○ Still meets admission criteria. ○ Short-term and/or long-term goals have not been achieved and the team, including the service recipient, recommends continuation. ○ Continues to need or request significant assistance from others to obtain any meaningful information regarding his/her own mental health status and/or personal goals and objectives. ○ A disconnect with community-based services, including psychiatric and medical, continues to exist. ○ Has experienced relapses in the community.
<p>Discharge Criteria</p>	<p>Discharge for Level 1 service recipients would consider the following components:</p> <ul style="list-style-type: none"> ○ At least 70% of the short-term goals necessary for transition to a lower level of care (Level 2a or 2b) were met. ○ Along with his/her team, there was mutual agreement to terminate this level of Adult MHCM-Tennessee service. ○ Demonstration of little to no progress in meeting targeted goals for some extended period of time, despite documented attempts to engage him/her in services. ○ Refusal to participate in coordination of services through the medical home for some extended time period. ○ Movement out of the service area. ○ Loss of community tenure through long-term incarceration or the need for skilled-nursing care, for example. ○ Death.
<p>Maximum Caseload Size</p>	
<p>Adult CTT</p>	<p>20 individuals:1 team 20 individuals:1 case manager</p>
<p>ACT/PACT</p>	<p>100 individuals:1 team 15 individuals:1 case manager</p>
<p>Minimum Face-to-Face Contacts</p>	
<p>Adult CTT, ACT, or PACT</p>	<p>One (1) contact per week</p>

Level 2a Adult MHCM-Tennessee – Individual Intensive Services

Introduction	<p>Level 2a involves an <i>intensive</i> level of Adult MHCM-Tennessee services that is supplied through the individual approach. Services at this level are geared toward persons with diagnosable mental illnesses who have not successfully engaged in community-based mental health and/or medical services. Individuals receiving this level of service typically fail to keep appointments and often have failed to schedule any appointments. Thus, consumers of Level 2a are extremely inconsistent in their access to and utilization of community-based services. That is why prospective consumers are most likely heavy users of high-end services such as emergency departments. Consumers of Level 2a further lack natural supports. If identifiable, access to and/or engagement of those supports is extremely unpredictable, at best.</p> <p>A single case manager provides individual Level 2a Adult MHCM-Tennessee services, in contrast to the team-approach of Level 1a. The case manager’s sole responsibility is to provide case management services for the consumer which involves client contact, monitoring, and coordination of necessary services that aid the service recipient in moving toward recovery. The case manager does not and will not provide direct clinical services or services for the consumer outside of those activities approved as case management services (CRA, MCO Amendment M-E-W 10 & 7, 2011; CRA, TennCare Select Amendment 27, 2011).</p>
Admission Criteria	<p>Admission to Level 2a Adult MHCM-Tennessee will be based on medical necessity. At a minimum, admission criteria should include the following key components.</p> <p style="text-align: center;">The service recipient:</p> <ul style="list-style-type: none">○ Has a diagnosable mental illness that impairs the his/her ability to function within the community;○ Is actively participating in treatment at an outpatient setting or is reasonably expected to participate in outpatient treatment as a result of referral and/or education;○ Needs assistance utilizing or accessing behavioral health, medical, and/or community-based services to function in the community as necessary for recovery, including services related but not limited to:

***Level 2a Adult MHCM-Tennessee – Individual Intensive Services
(continued)***

Admission Criteria (continued)	<ul style="list-style-type: none"> ○ Employment or public assistance. ○ Housing. ○ Childcare. ○ Money management. ○ Transportation. ○ Education. ○ Legal matters (Adapted from U.S. Behavioral Health-CA, 2011). <p>In addition, persons admitted to Level 2a Adult MHCM-Tennessee would need to meet at least TWO (2) of the following conditions.</p> <p>The service recipient has:</p> <ul style="list-style-type: none"> ○ Demonstrated extreme inconsistency or failure in scheduling or keeping appointments at an outpatient facility in order to stabilize symptoms of his/her mental and/or physical illness within the last six (6) months. ○ Demonstrated extreme inconsistency in his/her adherence to prescribed behavioral health or medical treatment within the last six (6) months. Behavioral health treatment can be pharmacological and/or psychosocial. ○ Been hospitalized for at least one (1) psychiatric admission within the last six (6) months. ○ Had at least two (2) emergency psychiatric presentations either through a crisis stabilization unit (CSU) or other alternative level of care within the last six (6) months. ○ Failed to identify and/or communicate with natural supports to assist with access or utilization of needed medical, educational, social, or other services within the last six (6) months. ○ Demonstrated moderate to high contact with law enforcement or the criminal justice system within the last six (6) months. ○ Demonstrated an inability or unwillingness to keep or hold a job due to his/her mental illness within the last six (6) months. ○ Failed to obtain or maintain stable living arrangements within the last six (6) months. ○ Demonstrated an inability or unwillingness to manage his/her finances within the last six (6) months.
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Level 2a Adult MHCM-Tennessee – Individual Intensive Services
(continued)

Step-Down Criteria	<p>Appropriate monitoring by case managers is expected prior to any transition in case management services.</p> <p>Level 2a service recipients transitioning to the next level of care might exhibit the following:</p> <ul style="list-style-type: none"> ○ High percentage of short-term and/or long-term goals and objectives met. ○ Increased number of medical (behavioral and/or physical health) appointments scheduled and kept within the last six (6) months. ○ Increased access to and/or engagement in community-based services, including those connected to the medical home within the last six (6) months. ○ Improved participation in behavioral health and/or medical treatment, where behavioral health treatment can be psychosocial, pharmacological, or a combination of the two, within the last six (6) months. ○ Reduced psychiatric symptoms within the last six (6) months. ○ Reduced hospitalizations within the last six (6) months. ○ Increased identification and/or communication with a support network within the last six (6) months. ○ Reduced utilization of high-end emergency options, including emergency departments, for psychiatric needs within the last six (6) months. ○ Reduced contact with law enforcement and/or the criminal justice system within the last six (6) months. ○ Improved stability in living arrangements within the last six (6) months. ○ Increased identification and/or utilization of various transportation options for accessing essential services within the last six (6) months. ○ Has made application for or obtained employment (full or part-time) within the last six (6) months. ○ Has made application for or obtained financial assistance in the form of Families First, VA benefits, or disability benefits, e.g., within the last six (6) months. ○ Has developed and/or utilized a plan to better manage their finances within the last six (6) months.
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Level 2a Adult MHCM-Tennessee – Individual Intensive Services
(continued)

<p>Continuation Criteria</p>	<p>Components of continued stay for the service recipient in Level 2a would include the following:</p> <ul style="list-style-type: none"> ○ Still meets admission criteria. ○ Short-term goals not yet achieved. ○ Improved attitude regarding participation in his/her behavioral and/or physical health, but still needs moderate to high levels of assistance. ○ Is hospitalized and/or continues to seek out and use emergency-level services through mobile crisis or an emergency department, e.g. ○ Continues to need or request a high level of assistance from others to obtain any meaningful information regarding his/her mental health status and/or personal goals and objectives.
<p>Discharge Criteria</p>	<p>Discharge for Level 2a service recipients would consider the following components:</p> <ul style="list-style-type: none"> ○ At least 80% of the short-term goals necessary for transition to a lower level of care (Level 2b) were met. ○ Demonstration of little to no progress in meeting targeted goals for some extended period of time, despite documented attempts to engage him/her in services. ○ Refusal to participate in coordination of services through the medical home for some extended time period. ○ Movement out of the service area. ○ Loss of community tenure through long-term incarceration or the need for skilled-nursing care, e.g. ○ Death.
<p>Maximum Caseload Size</p>	<p>25 individuals:1 case manager <i>(Source: CRA, MCO Amendment M-E-W 10 & 7, 2011; CRA, TennCare Select Amendment 27, 2011)</i></p>
<p>Minimum Face-to-Face Contacts</p>	<p>Three (3) contacts per month <i>(Source: CRA, MCO Amendment M-E-W 10 & 7, 2011; CRA, TennCare Select Amendment 27, 2011)</i></p>

Level 2b Adult MHCM-Tennessee – Individual Supportive Services

Introduction	<p>Level 2b Adult MHCM-Tennessee involves a less intensive level of case management service than Level 2a. It is more supportive in nature, designed for the consumer that requires assistance to maintain and/or improve his/her level of functioning but is not deemed to be high risk for hospitalization or homelessness, e.g. Individuals receiving this level of service have a diagnosable mental illness and are inconsistent in following through with treatment regimens, whether behavioral or physical health, pharmacological or psychosocial. They demonstrate inconsistency in making and/or keeping appointments and do not have a good informal support system. Prospective consumers may be low to moderate users of emergency services, but they still have high needs or requests for assistance in accessing or utilizing services.</p> <p>A single case manager provides individual Level 2b Adult MHCM-Tennessee services. The case manager’s sole responsibility is to provide case management services for the consumer which involves client contact, monitoring, and coordination of necessary services that aid the service recipient in moving toward recovery. The case manager does not and will not provide direct clinical services or services for the consumer outside of those activities approved as case management services.</p> <p><i>Where available, peer support might be used as an adjunct to the case manager in monitoring the service recipient prior to discharge from Level 2b Adult MHCM-Tennessee. However, at no time should peer support in the form of Certified Peer Specialists or any other form become a substitute for case managers in the delivery of case management services (CRA, MCO Amendment M-E-W 10 & 7, 2011; CRA, TennCare Select Amendment 27, 2011).</i></p>
Admission Criteria	<p>Admission to Level 2b Adult MHCM-Tennessee will be based on medical necessity. At a minimum, admission criteria should include the following key components.</p> <p>The service recipient:</p> <ul style="list-style-type: none">○ Has a diagnosable mental illness that impairs the his/her ability to function within the community;

***Level 2b Adult MHCM-Tennessee – Individual Supportive Services
(continued)***

Admission Criteria (continued)	<ul style="list-style-type: none"> ○ Is actively participating in treatment at an outpatient setting or is reasonably expected to participate in outpatient treatment as a result of referral and/or education; ○ Needs assistance utilizing or accessing behavioral health, medical, and/or community-based services to function in the community as necessary for recovery, including services related but not limited to: <ul style="list-style-type: none"> ○ Employment or public assistance. ○ Housing. ○ Childcare. ○ Money management. ○ Transportation. ○ Education. ○ Legal matters (Adapted from U.S. Behavioral Health-CA, 2011). <p>In addition, persons admitted to Level 2b Adult MHCM-Tennessee would need to meet at least ONE (1) of the following.</p> <p>The service recipient:</p> <ul style="list-style-type: none"> ○ Has not fully completed all goals set for himself/herself within the last six (6) months. ○ Has demonstrated low to moderate difficulty in making/keeping medical appointments (behavioral and/or physical health) within the last six (6) months. ○ Has demonstrated a need for at least moderate assistance with linkages to necessary resources and services within the last six (6) months. ○ Has demonstrated a need for assistance with coordinating services around the medical home within the last six (6) months. ○ Has demonstrated a need for at least moderate assistance in communicating with natural supports within the last six (6) months. ○ May exhibit increased psychiatric symptoms within the last six (6) months. ○ May have experienced a hospitalization within the last six (6) months. ○ May have had contact with law enforcement or the criminal justice system within the last six (6) months.
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***Level 2b Adult MHCM-Tennessee – Individual Supportive Services
(continued)***

<p>Admission Criteria (continued)</p>	<ul style="list-style-type: none"> ○ May have at least one (1) emergency psychiatric presentation either through a crisis stabilization unit (CSU) or other alternative level of care within the last six (6) months. ○ May have not had gainful employment, full or part-time, within the last six (6) months. ○ May have not applied for and/or begun receiving financial entitlements within the last six (6) months. ○ May not be able to handle his/her finances without assistance within the last six (6) months. ○ May not have had stable living arrangements within the last six (6) months. ○ May have experienced difficulty confirming transportation options within the last six (6) months.
<p>Continuation Criteria</p>	<p>Components of continued stay for the service recipient in Level 2b would include the following:</p> <ul style="list-style-type: none"> ○ Still meets admission criteria. ○ Short-term goals not yet achieved. ○ Slight decline in making/keeping behavioral and/or physical health appointments. ○ Medium to high inconsistency of involvement from natural supports. ○ Continues to need or request at least moderate level of assistance from others to obtain any meaningful information regarding his/her mental health status and/or personal goals and objectives.
<p>Step-Up Criteria</p>	<p>Service recipients should be closely monitored, especially in advance of discharge to determine if their level of functioning is deteriorating and/or their needs for assistance are increasing.</p> <ul style="list-style-type: none"> ○ Monitoring contacts and service follow-ups show that current functioning is below baseline for this level.
<p>Discharge Criteria</p>	<p>The discharge plan should allow for step down to access other traditional outpatient services in the community.</p>

***Level 2b Adult MHCM-Tennessee – Individual Supportive Services
(continued)***

Discharge Criteria (continued)	<p>Discharge for Level 2b service recipients would consider the following components:</p> <ul style="list-style-type: none"> ○ At least 90% of the treatment/service goals met. ○ Refusal to engage in or continue engagement in services. ○ Demonstration of little to no progress in meeting targeted goals for some extended period of time, despite documented attempts to engage them in services. ○ Refusal to participate in coordination of services through the medical home for some extended time period. ○ Movement out of the service area. ○ Loss of community tenure through long-term incarceration or the need for skilled-nursing care, e.g. ○ Death.
Maximum Caseload Size	35 individuals:1 case manager
Minimum Face-to-Face Contacts	Two (2) contacts per month <i>(Source: CRA, MCO Amendment M-E-W 10 & 7, 2011; CRA, TennCare Select Amendment 27, 2011)</i>

How Long Will It Take Eligible Service Recipients to Begin Receiving Adult MHCM-Tennessee Services?

Access to Behavioral Health Services Chart

Service Type	Geographic Access Requirement	Maximum Time for Admission/ Appointment
Mental Health Case Management	Not subject to geographic access standards	Within 7 calendar days
<i>Source: CRA, 2011</i>		

At the very least, providers must schedule Adult MHCM-Tennessee services for eligible service recipients within seven (7) calendar days, regardless of the source of referral (CRA, 2011; Magellan, 2006). In addition, the MCOs shall ensure that Adult MHCM-Tennessee, as implemented by providers, incorporates the following service components.

Crisis Facilitation

Crisis facilitation is the process of accessing and coordinating services for a service recipient in a crisis situation to ensure the necessary services are rendered during and following the crisis episode. It should be provided in situations that require immediate attention and/or resolution for a specific individual or other person(s) in relation to a specific individual. Most crisis facilitation activities will involve face-to-face contact with the service recipient (CRA, 2011).

Assessment of Daily Functioning

This component deals with the ongoing monitoring of how a service recipient is coping with life on a day-to-day basis for the purpose of determining what services are needed to maintain community placement and improve the level of functioning. Most assessments of daily functioning occur during face-to-face contact with the service recipient in his/her natural environment (CRA, 2011).

Assessment/Referral/Coordination

This component includes assessment of the needs of the service recipient for the purpose of referral and coordination of services that will improve functioning and/or maintain stability in the individual's natural environment (CRA, 2011).

Mental Health Liaison

This individual is used to provide services to persons that are not yet assigned to a mental health case management. It serves as a short-term solution to service referral and continuing care until other mental health services are initiated (CRA, 2011)

Adult MHCM-Tennessee Service Delivery Process

1. Eligible service recipients discharged from psychiatric inpatient hospitals and psychiatric residential treatment facilities should be referred to Community Mental Health Centers (CMHCs) for an evaluation of the need for Adult MHCM-Tennessee services. The eligible service recipient has the right to refuse services.
2. The MCOs will ensure that CMHCs providing case management services will do so in accordance with appropriate caseload and face-to-face contacts as established in the Contract Risk Agreement (CRA).
3. The MCO shall review the cases of eligible service recipients referred by primary care physicians or otherwise identified to the MCO as potentially in need of Adult MHCM-Tennessee services and shall contact and offer such services to all eligible service recipients who meet medical necessity criteria. The eligible service recipient has the right to refuse services.
4. The MCO shall require its providers to collect and submit individual encounter records for each MHCM visit, regardless of the method of payment by the MCO. The MCO shall identify and separately report “Level 1”, “Level 2a”, and “Level 2b” Adult MHCM-Tennessee encounters. Monitoring visits and activities should additionally be documented and reported.
5. The MCO shall require mental health case managers to involve the service recipient, the service recipient’s family or parent(s), or legally appointed representative, primary care physician, care coordinator for CHOICES members, as well as other agency representatives, if appropriate and authorized by the service recipient as required, in Adult MHCM-Tennessee activities (CRA, 2011).

Case Management Staff/Provider Requirements

Case Manager Requirements

Level 1 – Adult MHCM-Tennessee – Team Intensive Services

Case managers working with service recipients assigned to this level of Adult MHCM-Tennessee will be part of a team and employed by or under contract with a TennCare-enrolled MHCM provider agency. They will provide services through programs designated as Adult CTT, ACT, or PACT. At the time of this writing, there are two (2) PACT programs and multiple CTT programs in the state.

Level 2a – Adult MHCM-Tennessee – Individual Intensive Services

Case managers working with service recipients admitted to Level 2a of Adult MHCM-Tennessee will be employed by or under contract with a TennCare-enrolled MHCM provider agency. They may further provide Adult MHCM-Tennessee services to service recipients at any level, as well as when service recipients move between levels. As a result, they must meet the following requirements:

- Have, at a minimum, a bachelor's degree or be licensed as a Registered Nurse;
- Only perform case management activities and refrain from diagnosing or providing mental health treatment;
- Ensure that at least 51 percent of all Adult MHCM-Tennessee services take place in the service recipient's home or some appropriate place in the community;
- Document all Adult MHCM-Tennessee services in the service recipient's treatment plan;
- Have supervision by an appropriate supervisor for a minimum of one (1) year;
- Monitor and review case needs at appropriate points of service, allowing for step down from Level 2a services for service recipients if applicable;
- Complete case management training as indicated in the Specialized Training Requirements for Behavioral Health Staff;
When assigned to individuals with co-occurring disorders, the case manager should:
- Have experience and skills necessary to meet the needs of these individuals.

Level 2b Adult MHCM-Tennessee – Individual Supportive Services

Case managers working with service recipients admitted to Level 2b of Adult MHCM-Tennessee will be employed by or under contract with a TennCare-enrolled MHCM provider agency. They may further provide Adult MHCM-Tennessee services to service recipients at any level, as well as when service recipients move between levels. As a result, they must meet the following requirements:

- Have, at a minimum, a bachelor's degree or be licensed as a Registered Nurse;
- Only perform case management activities and refrain from diagnosing or providing mental health treatment;
- Ensure that at least 51 percent of all Adult MHCM-Tennessee services take place in the service recipient's home or some appropriate place in the community;
- Document all Adult MHCM-Tennessee services in the service recipient's treatment plan;
- Have supervision by an appropriate supervisor for a minimum of one (1) year;
- Monitor and review case needs at appropriate points of service, allowing for step down from Level 2b services, i.e., discharge, for service recipients if applicable. (This review may also imply step up from Level 2b to a higher level.);
- Complete case management training as indicated in the Specialized Training Requirements for Behavioral Health Staff;
When assigned to individuals with co-occurring disorders, the case manager should:
- Have experience and skills necessary to meet the needs of these individuals.

Where available, peer support might be used as an adjunct to the case manager in monitoring the service recipient prior to discharge. In those instances, peer support might be provided by Certified Peer Specialists. These individuals have self-identified as having or receiving a mental health or co-occurring disorder diagnosis and completed training recognized by TDMH on how to assist others in regaining control over their lives based on the principles of recovery and resiliency. At minimum, Certified Peer Specialists must meet the following requirements:

- Be 18 years of age or older;
- Have a high school education, as demonstrated by a high school diploma or General Equivalency Degree (GED);
- Have a primary mental illness diagnosis. If there is a co-occurring disorder, the primary diagnosis must still be a mental disorder; a single, primary diagnosis of substance use disorder will not meet certification requirements;
- Self-identify as an individual who has received or is receiving mental health or co-occurring services as part of his or her personal recovery process;
- Demonstrated a minimum of 12 consecutive months in self-directed recovery in the last two years. Self-directed recovery includes experience in advocacy, leadership, and peer support;

- Provide documentation of successful completion of one of the four evidence-based or best-practice Peer Specialist Training Programs recognized by the Tennessee Certified Peer Specialist program. (See reference for program listings.);
- Successfully demonstrated mastery of designated competencies as required by an evidence-based or best-practice Peer Specialist Training Program;
- Have a minimum of 75 hours volunteer or paid work with adults diagnosed with mental or co-occurring disorders in designated roles (TDMH, April 2010);
- Complete case management training as indicated in the Specialized Training Requirements for Behavioral Health Staff.

At no time should peer support in the form of Certified Peer Specialists or any other form become a substitute for case managers in the delivery of case management services.

Supervisor Requirements

Supervisors will be employed by or under contract with a TennCare-enrolled MHCM provider agency. They must meet the following requirements:

- Have a master 's degree in behavioral/social services-related health field from an accredited institution;
- Have at least one (1) year of experience performing case management or working with high-need and/or high-risk individuals having a mental illness; OR
- Have a master 's degree in a non-behavioral health field from an accredited institution;
- Have at least two (2) years of experience working with chronically mentally ill, one (1) of which involved doing case management; AND
- Will maintain no more than a 1:30 supervisory ratio with mental health case managers;
- Complete case management training as indicated in the Specialized Training Requirements for Behavioral Health Staff.

***Note:** Only in the event of staff absence or position vacancy should the supervisor provide MHCM services.

Outcomes

The following are provided only as examples to assist MCOs and case manager providers in monitoring case management services.

Level 1 Adult MHCM-Tennessee – Team Intensive Services

Following receipt of Level 1 Adult MHCM-Tennessee – Team Intensive Services, service recipients could be expected to attain the following outcomes:

- Ability to identify and/or communicate satisfaction with services, with support
- Ability to identify family, friends, and/or significant others as natural supports in recovery
- Able to participate in more traditional community-based services for treatment and other areas of need
- Decreased level or delivery of service needed
- Decreased need for crisis services
- No Decreased need to access hospitalization
- No Decreased or limited involvement with law enforcement
- Illness management and recovery
- Demonstrating Improvements in progress in prescribed adhering to prescribed treatment(s), whether pharmacological or psychosocial
- Increased ability to carry out activities of daily living such as shopping, doing laundry, using transportation
- Met at least 70% of short-term goals
- More normalized social functioning
- Symptom reduction
- Temporary housing in the community

Level 2a Adult MHCM-Tennessee – Individual Intensive Services

Following receipt of Level 2a Adult MHCM-Tennessee – Individual Intensive Services, service recipients could be expected to attain the following outcomes:

- Ability to recognize movement toward recovery
- Able to coordinate services independently or with minimal support from family, friends, and/or significant others
- Able to identify family, friends, and/or significant others as natural supports
- Can coordinate services with ongoing assistance from natural supports
- Can make application for financial entitlements and/or employment with support
- Decreased level of service needed
- Decreased on-call use
- Decreased or limited involvement with law enforcement

Level 2a Adult MHCM-Tennessee – Individual Intensive Services

(continued)

- Decreased use of emergency options for healthcare needs
- Illness management and recovery
- Improved ability to manage own money
- Improved housing stability in the community
- Improved support system
- Increased employment skills
- Increased engagement in prescribed treatment(s), with moderate to high-level support
- Met at least 80% of short-term goals
- Reduced hospitalization
- Reductions in serious involvement with law enforcement
- Starting to identify when symptoms start to escalate
- Symptoms and/or side effects reduced somewhat

Level 2b Adult MHCM-Tennessee – Individual Supportive Services

Following receipt of Level 2b Adult MHCM-Tennessee – Individual Supportive Services, service recipients could be expected to attain the following outcomes:

- Ability to communicate what recovery looks and feels like
- Able to coordinate services independently or with minimal support from family, friends, and/or significant others
- Able to recognize when symptoms start to escalate and/or seek appropriate outpatient treatment
- Active and independent connection to essential resources (i.e., Families First or VA benefits, employment, food banks)
- Consistent independent engagement in prescribed treatment (i.e., making/keeping treatment own appointments, taking medications, engagement in psychosocial activities)
- Decreased level of services needed
- Decreased on-call use
- Decreased use of emergency options for healthcare needs
- Few, if any, symptoms or side effects
- Functional support system
- Increased employment skills, with or without minimal support
- Increased engagement in prescribed treatment, with or without minimal support
- Increased housing stability in the community
- Increased money management skills
- Managing own finances
- Meet criteria for discharge
- Met short-term goals and at least 90% of long-term goals

Level 2b Adult MHCM-Tennessee – Individual Supportive Services
(continued)

- No hospitalization
- No serious involvement with law enforcement
- Regular coordination of services with medical home
- Satisfaction with services

Assessment Tools for Case Managers

It is expected that case managers will utilize tools to determine the needs of the service recipient for referral and coordination of services. **While no specific tool has been designated**, three (3) instruments for use in the identification and monitoring of individual service needs are being shared. They include the Adult Needs and Strengths Assessment (ANSA), Daily Living Activities-20 (DLA-20), and the Level of Care Utilization Scale (LOCUS) 2010. A brief description and contact information for each instrument follow.

Adult Needs and Strengths Assessment (ANSA)

The Adult Needs and Strengths Assessment (ANSA) is an open domain instrument designed for use in service delivery systems that focus on the mental health of adults and their families. The ANSA addresses six key domains: 1) Life domain functioning; 2) Strengths; 3) Acculturation; 4) Behavioral health needs; 5) Risk behaviors; and 6) Caregiver strengths and needs. It has been around since 1999 and is revised regularly.

The ANSA is free to use, though Melanie Lewis of the Buddin Praed Foundation should be contacted for specific use permission. A copy of the tool can be downloaded from <https://myshare.in.gov/FSSA/pmo/dmha-survey/ATRproviders/Shared%20Documents/INATR%20Forms/ANSA%20Resources/ANSA-Comp4302009.pdf>. A scoring sheet can be obtained from <https://myshare.in.gov/FSSA/pmo/dmha-survey/ATRproviders/Shared%20Documents/INATR%20Forms/ANSA%20Resources/ANSA-ScoreSheet043009.pdf>. Additional information regarding the tool, including training, can be obtained from one of the following individuals.

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Daily Living Activities-20 (DLA-20)

The Daily Living Activities-20 (DLA-20) is a functional assessment. It can be used with a variety of individuals with diverse issues. The DLA-20 identifies functioning on fundamental day-to-day tasks related to a person's overall quality of life using 20 indicators. It was developed in 2001 and copyrighted in 2005.

As long as the DLA-20 is not shortened or altered and used for its validated purposes, programs that register for training will be awarded rights to electronically or manually use the tool. Training is provided through MTM Services. Information about the DLA-20 can be found at <http://www.thenationalcouncil.org/galleries/resources-services%20files/DLA%20Sample.pdf>. You may also use the following email address for contact: Willa.Presmanes@gmail.com.

Level of Care Utilization Scale (LOCUS) 2010

The Level of Care Utilization Scale (LOCUS) 2010 is the latest version of this instrument at the time of this writing. It was designed to: 1) provide a system for assessment of service needs; 2) describe a continuum of service arrays which vary according to scope and amount of available resources; and 3) quantify service need assessment. The LOCUS, like the ANSA, has six dimensions: 1) Risk of harm; 2) Functional status; 3) Medical, addictive and psychiatric co-morbidity; 4) Recovery environment; 5) Treatment and recovery history; and 6) Engagement and recovery status.

This instrument can also be downloaded from the Web. It can be found at http://communitypsychiatry.org/publications/clinical_and_administrative_tools_guidelines/LOCUS2010.pdf. Training is not required but can be arranged through:

Robert Benacci, LOCUS Program Director
Deerfield Behavioral Health
2808 State Street
Erie, PA 16508
814-456-2457 X202
robb@dbhn.com

Research on the Benefits of Case Management

Many studies focusing on mental health case management were published between 1980 and 1998 (Ziguras & Stuart, 2000). The effectiveness of various types of case management, compared to usual treatment (i.e., no case management) or across case management models was the focus of these investigations. Newer studies tend to support previous findings. Snippets below include summary data on the effectiveness of mental health case management.

- Ziguras & Stuart (2000) conducted a meta-analysis of the effectiveness of case management over a span of 20 years. Outcomes for assertive community treatment (ACT) or clinical case management (CCM) were compared to each other or to usual treatment. An analysis of 44 studies revealed the following:
 - Each case management model was more effective than usual treatment in:
 - Family satisfaction with services;
 - Family burden; and
 - Cost of care.
 - The two case management models were equally effective in:
 - Reducing dropout rates;
 - Increasing consumers' contacts with services;
 - Reducing symptoms;
 - Increasing consumers' satisfaction; and
 - Improving social functioning
 - The number of hospital days was reduced for both models, with significantly greater reductions evident for ACT over CCM.
- Clark & Rich (2003) conducted a study comparing the effectiveness of comprehensive housing programs that included case management with specialized case management-only services on achieving positive housing, mental health, and substance use outcomes. All participants were homeless and had been diagnosed as severely mentally ill. The results indicated that participants of low- and medium-symptom severity that received case management only did just as well in housing outcomes as similar participants in the comprehensive housing programs.
- ICM has even been used successfully with low-income women with substance dependence. Compared to their usual care counterparts, ICM consumers demonstrated higher levels of substance abuse treatment initiation, engagement, and retention. They further showed greater abstinence at the end of the 15-month follow-up (Morgenstern et al., 2006).

- Access to case management while residing in the community helped individuals with mental illness live in their communities and stay out of jail. Ventura, Cassel, Jacoby, & Huang (1998) studied the impact of community-based case management on community functioning and recidivism for inmates released from jail. The former inmates were studied for a period three years. Results showed that these individuals were less likely to be re-arrested and stayed in the community longer before any re-arrest than former inmates that did not receive any case management following release to the community.
- Rivera, Sullivan, & Valenti (2007) reaffirmed the value and support of case management from the Schizophrenia Patient Outcomes Research Team (SPORT). They further acknowledged the effectiveness of intensive case management models, specifically ACT and strengths-based, in reducing time spent in hospitals, resulting in longer retention of consumers in treatment, and increasing consumer satisfaction with treatment.
- Meyer and Morrissey (2007) conducted a literature search of the effectiveness of ACT and ICM programs in rural areas. The evidence indicated that ICM programs were effective in those community settings where there is an ample supply of support and treatment services.
- Intensive case management (ICM) that incorporates assertive outreach teams works well in reducing hospital use if consumers are frequent hospital users (Burns, Catty, Dash, Roberts, Lockwood, & Marshall, 2007).
- The New York State Commission on Quality of Care and Advocacy for Persons with Disabilities conducted a study involving select cases in the state's mental health system, in addition to a satisfaction survey of nearly 500 individuals receiving case management services. More than three fourths of persons in both groups reported that their case managers not only did a good job in helping them to obtain essential services, but that their lives were better as a result of the help given by their case manager (New York State Commission, 2008).
- Patients randomly assigned to case management had lower depression scores and increased treatment adherence, compared to control patients. The Patient Health Questionnaire (PHQ)-9 was utilized as the depression measure (Gensichen et al., 2009).

- This study was conducted to evaluate the effectiveness of case management, as well as the feasibility of the Consumers' Family Members (CFM) as service providers. Results showed that the hospitalization rate reduced by 67% and that knowledge and burden of families were improved (Malakouti et al, 2009).
- An ICM program was used with high-risk adults that had chronic mental health conditions. Compared to a control group that met the same criteria, ICM group members demonstrated significantly better outcomes on the following:
 - Inpatient psychiatric costs (lower);
 - Readmissions over a six-month period (lower);
 - Per-member psychiatric emergency department and inpatient substance abuse costs and utilization (lower) (Kolbasovsky, Reich, & Meyerkopf, 2010).

Supportive Mental Health Case Management: A Case Study

The state of New York Office of Mental Health (OMH) implements supportive case management as one of its levels of case management services and has done so since the mid-1990s. As described in a 1995 OMH report, supportive case management was designed to coordinate supports and services for individuals diagnosed with mental illness to help them live successfully in the community.

In general, consumers of OMH's supportive case management programs have some functional disability that requires intervention and/or support to live independently, despite the fact that most are enrolled in community mental health programs (e.g., outpatient programs). The services are individually tailored to the needs, circumstances, and desires of each consumer and provided using a rehabilitation-oriented approach. Among the service provisions are 1) facilitating service delivery, which includes helping consumers make and keep appointments, escorting them to appointments as needed, and arranging mental health, psychiatric rehabilitation and medical services; 2) providing health promotion services and/or arranging for medication education to help the consumer understand the importance of taking medication that has been prescribed; 3) assisting consumers in learning how to use fiscal resources; and 4) assisting and advocating for consumers to gain access to entitlements and other health services (e.g., food stamps, educational services, Medicaid, etc.) (Liberty Resources, Inc., 2011; New York City Department of Health and Mental Hygiene, 2011).

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