FY27 PROGRAM DESCRIPTION
HAMHDS: CASE MANAGEMENT AND ASSESSMENT
CARF: CASE MANAGEMENT/SERVICES COORDINATION

PHILOSOPHY OF PROGRAM
This service is based on the belief that those who are affected by major mental illnesses can and do lead meaningful and productive lives. Mental illness is a brain disease. Management of the illness can result in a decrease/elimination of symptoms and certainly a decrease in the impact of symptoms on the individual. Recovery is the goal. Establishing meaningful roles in the community, via work, school, church and participation in other community activities is a significant aspect of recovery, as is individual choice and individual empowerment. The service seeks to assist all individuals with reaching their maximum potential. Integral to the success of all interventions is the development of a positive relationship between the case manager and the individual. The case manager works with other internal programs such as: psychiatric services, vocational services, residential services, agency peer counselors and the psychosocial program to provide and coordinate services. Case management also works with external entities such as, social services, primary care physicians, medical specialists, private mental health providers, family members and local hospitals, to assure individual needs are consistently met.

DESCRIPTION OF SERVICES
The Case Management and Assessment Unit (CM&A) is a program within Adult Recovery Services, a division of Henrico Mental Health and Developmental Services. The CM&A unit provides case management for individuals who meet specific admission criteria. In addition, the CM&A Unit is the receiving program for referrals made to the ARS department via intra-agency units (e.g. Outpatient Teams, Youth and Family teams, Jail services, etc) and the receiving unit of the vast majority of intakes deemed appropriate for ARS services via the agency's Same Day Access Unit.

The goal of case management is to coordinate all treatment services received by an individual. In addition, case managers work to link individuals they serve with services and opportunities in the community that will assist in meeting basic needs and provide life-enriching opportunities. Services are individualized and may look different from individual to individual based on need. Frequency of contact is based on individual need. Most services are provided face-to face, but the location of the service varies depending on the individual's needs and circumstances. Services may be provided in the office, in the individuals' homes, or in the community. Additional contact is maintained with individuals via telephone and, in rare circumstances may occur via telehealth via a HIPPA compliant telehealth platform.

Case Management services include:
Monitoring of symptoms, medication management and coordination of psychiatric and medical care
Linking to community resources such as Social Security, SNAP benefits, other DSS resources, and Housing opportunities.
Linking to needed services such as individual therapy, psychosocial rehabilitation, and mental health skill-building services and monitoring an individual's participation and progress in these services.
Assisting with community integration
Addressing activities of daily living and linking with appropriate services
Linking to educational and support groups in the agency and the community such as Family psycho-education groups, Illness Management and Recovery groups (IMR), Action Planning for Prevention and Recovery (APPR) groups and individual advocacy groups.

Coordination of services with other agencies such as: courts, probation and parole, community corrections, social services, the Department of Rehabilitative Services, etc.
Education and supportive counseling
Outreach

Specific admission criteria include:
18 years or older
Diagnosed with Schizophrenia, Psychoses, Bipolar, Major Depression with and without psychosis
May have Cluster A and Borderline Personality Disorder if all other criteria apply
Symptoms must not be caused solely by developmental delay, dementia, brain injury, alcohol/drug abuse, intoxication or withdrawal
Individual must exhibit severe and recurrent disability from mental illness
Individual must meet at least two of the following criteria on a continuing or intermittent basis:
Individual is unemployed, is employed in a sheltered setting or supportive work situation, has markedly limited or reduced employment skills or has a poor employment history
Individual requires public assistance to remain in the community and may be unable to procure such assistance without help
Individual has difficulty establishing or maintaining a personal social support system
Individual requires assistance with basic living skills
Individual exhibits inappropriate behavior that often results in intervention by mental health professionals or the judicial system

All case managers address substance use disorders should individuals present with those issues and address it's impacts individuals' mental health and overall wellness. Co-occurring MH/SUD services are based upon the belief that both disorders are primary and should be treated simultaneously. Substance use and abuse often leads to medication non-compliance or medication ineffectiveness and mental health instability. Therefore, these services focus on harm reduction although the ultimate goal is obtaining and maintaining long-term abstinence.

Evidenced based Psycho Education groups are facilitated by team clinicians, which incorporate education and support for families and individuals. These groups are based on evidence that increasing education, awareness, and an informed support network assists the individual in their recovery process.

Peer support is available on all the CM&A teams. Peer support affords individuals the opportunity to establish mutually supportive relationships with a peer who has experienced similar mental health challenges. Peer specialists also provide outreach and mentoring to agency individuals and assist them with accessing needed resources in the community. Peer support specialists facilitate a number of support groups on a number of topics within the agency and also facilitate Action Planning for Prevention and Recovery (APPR) groups to agency individuals.

Individuals living with the symptoms of Borderline Personality Disorder and individuals with other diagnoses which interfere with relationships may be referred to Dialectical Behavior Therapy (DBT) by a community therapeutic provider to address the symptoms associated with those disorders. Clinicians within the CM&A unit also periodically provide DBT skills groups for individuals that would benefit from learning these valuable skills but continue to need agency case management services.

Case management is provided in each of the three main offices (Woodman, East Center, Providence Forge) and within our Mental health support homes. It is also provided in the individuals' home, the hospital, other parts of the community, and as appropriate, via telehealth.

Initial requests and/or requests to change an individual's case manager will be given serious consideration. Every attempt will be made to honor reasonable requests that ensure effective service delivery within available resources, unless otherwise clinically indicated.

The CM&A Program utilizes the World Health Organization Disability Assessment 2.0 (WHODAS) at intake and every 6 months, which is a self-report tool that is used as a measurement of the individual's progress in services with the agency. These assessments are done in person with the individual and results are shared with the person served and documented in the agency electronic record. Staff are trained at agency hire on the use and administration of this assessment tool.

Every effort is made to accommodate individuals with concurrent physical disabilities and other special needs. Interpreters are utilized for the hearing impaired when necessary, and volunteer or paid interpreters are sought for individuals whose primary language is not English and who have difficulty communicating in English and the provider of the service does not speak the primary language of the individual.

The hours for the CM&A program are generally Monday-Friday 8:30am-5:00pm. In addition, the office is open several evenings a week for individuals who need late appointments. The emergency services program is available 24 hours a day, seven days a week for individuals experiencing crises. The emergency services program contacts the primary case manager or supervisor (when indicated) following an individual's contact.

The organization does not use Artificial Intelligence (AI) in service delivery or for health data analysis and processing. The CM&A program does not provide services via a mobile unit, but does have agency vehicles for staff to use for community visits and for linkage to services outside of the agency.

CONTRACT SERVICES

The Case Management and Assessment teams do not utilize contract services in the provision of the case management service. Teams do work closely with the Daily Planet for primary care services with individuals that choose to receive their medical services through this agency. The Daily Planet utilizes office space at our 2 main sites several days week to see individuals for their primary health care needs. The agency also works closely with Westwood Pharmacy staff, that are housed at both main offices to fill prescriptions for individuals that choose to use Westwood as their pharmacy provider.

Prescriber Services

Psychiatric services for CM&A individuals are provided by psychiatrists, nurse practitioners, and physician assistants employed by the Henrico Area Mental Health. These prescribers provide psychiatric coverage for individuals seen in the West, East, and Providence Forge offices, provided the individual chooses to have their psychiatric care within the agency.

Should an individual receiving CM&A services require hospitalization, inpatient services will be provided by one of the hospitals having an agreement with the agency's Emergency Services Program.

STAFFING

All staff have appropriate education, experience and training in the area of mental health case management. Case managers must have a bachelor's degree in a human service field (Psychology,

Social Work, Counseling, and Nursing) and be eligible or certified by the Virginia Department of Health Professionals as a Qualified Mental Health Professional for Adults (QMHP-A). Individuals with previous experience in case management are preferred. Nurses must be licensed to practice as a registered nurse in the Commonwealth of Virginia. Nurses with previous community mental health adult experience are preferred. Clinicians, clinical supervisors, and the program manager must have a master's degree in a human service field and be licensed or licensed eligible.

Staff in the east office consists of a clinical supervisor, five full-time case managers, two clinicians, an intensive case manager, and part time peer recovery specialist. One of the clinicians on the team, serves as the agency's NGRI coordinator, who is responsible for assisting individuals that are deemed Not Guilty by Reason of Insanity (NGRI) through the gradual release process from a state facility and follow their Conditional Release Plans once discharged back to the community. The intensive case manager provides services to individuals who have intensive needs that do not reach the level of Assertive Community Treatment (ACT) services. The team also works closely with a psychiatric nurse located on site that administers prescribed injections and assists individuals with needed labs.

There are two case management teams in the west office. The West 1 team consists of a clinical supervisor, one clinician, two part-time peer recovery specialists, five full time and an intensive case manager who provides services to individuals who have intensive needs, but do not need the level of intensity of ACT services. The West 2 team consists of a clinical supervisor, one clinician, one part-time and one full time peer recovery specialist, four case managers, one intensive case manager and one Outreach case manager that works across the 3 main case management teams to help engage individuals that may have difficulty connecting with the agency for services or need additional support to maintain their community placement and engagement in mental health services. All case managers are required to successfully complete the state certification modules for case management.

Both the east and west offices have pharmacy technicians employed by our contracted onsite pharmacy at our East End office, who work in the drug dispensary and assist with ordering, logging in and out, and safe storage of medication received from outside pharmacies and patient assistance programs.

Prescriber coverage is provided by 4 psychiatrists, 2 nurse practitioners, and a physician assistant. These practitioners provide psychiatric assessments and medication management services to individuals. The physicians and the nurse practitioners are available for staff consultation as well as direct service to individuals. On occasion, a prescriber may do a home visit accompanied by the case manager, should the individual's needs dictate such. Psychiatric nurses provide nursing services, including injections, medication and health education, and venipuncture services. They also assist the physician in monitoring lab work. These staff report ultimately to the agency medical director.

All case managers, except the intensive case managers, carry a case load of 40-50 individuals (ideally) for whom they provide primary case management services. Clinicians generally carry 30-40 individuals. The intensive case managers carry a case load of approximately 15-20 individuals for whom they have primary case management responsibilities. They are also available to assist individuals, not on their caseloads, when the primary case manager sees a temporary need for additional, more intensive, services. The primary case manager maintains responsibility for the services to these individuals. The supervisors carry a variable case load, depending on the current need. The preferred case load size for supervisors is no more than 5 individuals.

Clinicians in the unit co-facilitate groups (including Dialectal Behavior Therapy, Illness Management and Recovery, Mindfulness-Oriented Recovery Enhancement, and other Co-Occurring Substance Use and Mental Health treatment groups), provide short term individual therapy to individuals with an identified need, provide crisis intervention services, clinical coverage for team supervisor, and carry a case load of individuals for case management. All staff will provide supportive counseling to individuals on their case load.

The East and West teams meet weekly separately at their respective locations. Periodically, the 3 case management teams will meet jointly to discuss issues relevant across teams. During the weekly team meetings, new intakes are presented, assignments are made, peer supervision and collaboration with agency prescribers occurs, program planning occurs, and any concerns are addressed.

The staffing pattern varies as individuals are added to and removed from the program. Adequate staffing is maintained is ensure individuals are safe while participating in the program and to assist as needed during evacuations.

See agency organization chart.

PROGRAM GOALS

Assist individuals to reach their maximum level of functioning through the use of medication, support and rehabilitation services
To demonstrate that the initiation of case management services reduces the rate of hospitalization for our individuals.
To ensure individuals requesting services are seen for ongoing case management services within 7 days of their same day access intake.
To ensure that individuals are connected with primary care physicians and receive annual physicals to diagnose and address any medical needs, promote wellness and encourage preventative screenings which aids the individual's overall health and wellbeing.
To provide individuals services that they believe to be helpful and valuable.
To measure agency prescribers' and Collaborative Service providers' satisfaction with case managers/clinicians within CM&A.

PROGRAM OBJECTIVES

Annually, objectives are developed to measure the effectiveness, efficiency, service access, individual and stakeholder satisfaction within the program. These measures consider three important factors: quality, customer value and financial performance. Specific performance improvement objectives are:
At least 80% of newly opened individuals will demonstrate a reduction in hospitalization rate from their baseline period (measured from 3 months prior to initiation of service to 3 months after initiation of service) as compared with their hospitalization rate from months 4-9, post treatment initiation.
At least 55% of agency case management individuals will receive an annual health physical to identify and treat any medical conditions.
Non-crisis individuals will be seen for ongoing case management services within 7 days of their initial attempt to access services.
90% of individual responses will be one of the two highest ratings to questions on the satisfaction survey

90% of agency prescribers and ARS Collaborative Services providers' responses will be one of the two highest ratings to question on satisfaction surveys rating case managers and clinicians within CM&A.

FEES

The identified payors/funding sources are as follows: Medicaid MCO's, Medicare, Commercial Insurance, Self-pay, State funds, Federal MH Block Grant funds, County funds.

Individuals complete a financial at admission and at every change in insurance/income or every 5 years whichever comes first. Services are provided based on a sliding scale. If a individual feels that they are unable to pay the fee assessed, a financial appeal can be completed. No one is turned away from services due to inability to pay. The charge per month for case management is $367.31. The majority payer source is Medicaid.

PROCEDURES FOR REFFERAL, SCREENING, ADMISSION AND RE-ADMISISON

CM&A serves as the entry point for all seriously mentally ill adults (age 18 +) who require long term services and who live in HAMHDS' catchment area. This area includes the counties of Henrico, Charles City and New Kent. Services are not provided to individuals whose symptoms are solely related to substance use (e.g., abuse, dependence, intoxication or withdrawal), dementia, or traumatic head injury. Individuals with diagnosis of schizophrenia, schizoaffective disorder, other psychotic disorders, and bipolar disorder are eligible for services. Individuals with major depression, borderline personality disorder, schizoid personality, schizotypal personality, and paranoid personality disorder may be eligible for services. Determinations in these instances are made based on history of hospitalization, need for support to remain in the community, level of disability and lack of internal or external resources.

Most referrals to the unit come directly from the agency's Same Day Access program. Others are received by referral from another unit (i.e. Outpatient, SUD, Jail Diversion, or Youth and Family). In all cases other than direct admissions from Same Day Access, a referral must be completed by the referring staff. The Case Management and Assessment Program does not have a wait list for services. For individuals coming from Same Day Access, the individual is assigned to a case management staff and given a case management appointment for ongoing services. In all instances, the individual receives an assessment and recommendations are made regarding service needs. In the event that all new second appointment case management slots are filled and the individual is unable to wait for the next available appt, the supervisors will make every effort to offer an earlier appointment. Every effort is made to see the individual for their initial case management appointment within 7 days of their request for services. Most initial evaluations are done in the office, but on occasion they may be done in a hospital setting (i.e. if the individual may be difficulty of engage), in jail, or elsewhere in the community. Individuals in this unit typically remain in services until they move from the area, gain health care coverage and chose to be seen privately, recover or gain skills to the point they no longer need case management services, or discontinue services for some other reason. If an individual is found to not meet program eligibility criteria, the CM&A staff would inform the individual of the reasons for ineligibility and provides options of some alternative services to best meet the individual's needs.

Individuals who have been discharged and return for services must complete the intake process via Same Day Access and have an initial evaluation and screening. Re-admission criteria is the same as initial admission criteria.

ORIENTATION OF INDIVIDUALS TO THE PROGRAM/SERVICE

Individuals receive an orientation to Adult Recovery Services / Case Management at the time of the initial appointment. An overview to the program is completed and any questions regarding services are answered. Also reviewed are the hours of service and an emergency contact number. This information is given to the individual by the person conducting the initial interview. The individual signs the orientation form and is part of the electronic health record. In the event that the individual has an LAR or guardian, that person will receive the same orientation as the individual.

EMERGENCY CLINICAL CONSULTATION

Emergency consultation is available during office hours from the supervisor, the program manager, divisional director, emergency services staff, and the psychiatrist on duty. After hours, emergency clinical consultation is available through ESP. Primary case managers may be contacted at home and are expected to provide consultation to emergency service staff when needed. The Emergency Services Program serves as primary back up for emergency clinical consultation. Emergency services are available on 24 hours a day/7 day a week basis.

TELEHEALTH

Additional contact is maintained with individuals via telephone and, in rare circumstances may occur via tele video via a HIPPA compliant telehealth platform – Webex. Telehealth would only be used when all appropriate agency protocols can be followed and met, and the individual is agreeable to receiving services in this manner.

MEDICATION MANAGEMENT

All case managers and clinicians within the Case Management and Assessment program can assist individuals in the self-administration of prescribed medication. Prior to being able to assist individuals with medications, staff are provided education on medication administration and medication repackaging. Based on individual need, case management staff will assist individuals in filling weekly medication pillboxes to better organize medications and track and increase medication compliance. Medications are stored securely, and any discontinued or expired medications are disposed of properly. CMA program staff are in regular contact with agency prescribers regarding individual's reported concerns regarding medication side-effects and efficacy of medications prescribed.

SECLUSION/RESTRAINTS/EMERGENCY HOLDS

Seclusion and restraint are prohibited and are not used in any agency programs. Brief physical holds are used only by staff trained in Therapeutic Options in an emergency.

TRANSFER/DISCHARGE PROCEDURES

If, at the initial evaluation, it is decided that the individual's needs are not best met in the Adult Recovery Services unit, the referring unit is informed of this decision and asked to maintain their services to the individual. If an individual is open to CM&A, a transfer is completed.
Individuals need to continue to meet the diagnostic criteria to be served by the CM&A unit. In the rare instance that an individual in case management services is found to no longer meet the eligibility criteria (diagnosis, longevity, severity, and lack of resources), a referral may be made to another part of the agency, to a private provider, or the individual might be discharged. An example of this would be an individual who stops using alcohol and no longer shows signs of a serious mental illness.

For individuals transferring to an ACT team, a referral form is completed requesting those services. Once accepted, a program discharge summary must be completed.

In some instances, individuals are discharged when they have reached a level of stability indicating no further need for care (ex. stable on medication and symptom free for some time, living independently without difficulty, able to meet basic needs, etc.) In other instances, discharge occurs when individuals move out of any of the three counties served. Case managers assist individuals with transfers to other CSBs or private providers if needed. Every effort is made to ensure the individual has medication to last until they are seen at the new CSB or private provider. CM&A will continue to work with the individual for up to 60 days after they move from the area, if the new CSB cannot pick them up quickly and if the individual's new housing is close enough to permit service delivery. Once the individual has signed a release of information, any information requested is sent to the new CSB. Other individuals may be discharged when significant outreach efforts have failed to engage them in treatment or when they refuse further treatment.