Service Name: High Utilizer Management

Service Definition

The High Utilization Management (HUM) program provides support to individuals who experience challenges and barriers in accessing and remaining enrolled in desired community-based services and supports. Using a data-driven process, the HUM program identifies and provides assertive linkage, referral, and short-term care coordination for individuals with behavioral health challenges who have a demonstrated history of high crisis service utilization. The program offers support, education, and navigation to assist at-risk individuals who could benefit from the removal of barriers to accessing community-based treatment. Utilizing a recovery-oriented approach, HUM services offer care coordination in identifying and gaining access to required services and supports, as well as medical, social, educational, developmental, and other services and supports, regardless of the funding source for the services to which access is sought. The HUM program includes assertive engagement and time-limited follow up to individuals to support and encourage a consistent and ongoing connection with appropriate community resources. Objectives for the programs are to:

a. Determine the factors related to an individual's high utilization of crisis services (e.g., homelessness, inadequate discharge planning, engagement challenges, cultural factors, etc.).
b. Use case management to educate, connect to services, and advocate for the individual.
c. Utilize a person-centered approach to tailor supports to meet the unique needs of the individual served.
d. Reduce the individual's re-admission rate into inpatient settings.
e. Act as a navigator for an individual who has not been able to engage successfully in services beyond a crisis.
f. Reduce the number of people with elevated acute behavioral needs to improve access to care.
g. Elevate identified gaps in resources to regional community collaboratives in order to address these gaps and develop solutions with community partners.

This service supports effective engagement as defined by one or more of the following outcomes:

1. Individual's linkage to the appropriate service(s) and support(s);
2. Completion of an initial evaluation/behavioral health assessment;
3. Completion of a psychiatric evaluation;
4. Authorization for services;
5. Completion of two (2) face-to-face follow up appointments; and/or
6. Individual reports feeling sufficiently supported and connected to desired services.

Admission Criteria

Individuals with a primary substance use, mental health, or co-occurring diagnosis who have been admitted to a crisis setting (CSU, BHCC, State contracted Community-Based Inpatient Psychiatric facility, or PRTF) meeting one of the following frequency rates:

1. A 30-day readmission; or
2. Two (2) admissions within a 12-month period;

AND/OR

3. Other crisis utilization indicators, as evidenced by the following:
    a. Three (3) mobile crisis dispatches within 90 days or;
    b. Four (4) or more mobile crisis dispatches within nine (9) months; or
    c. Two (2) or more presentations at an Emergency Department within 90-days; and/or
    d. 30 consecutive days or more in a CSU or State contracted Community-Based Inpatient Psychiatric bed.

Continuing Stay Criteria

Individual remains disconnected from behavioral health community-based services and supports.

Discharge Criteria

1. Individual has solidified recovery support networks to assist in maintenance of recovery; and
2. Individual reports feeling sufficiently supported and connected to an appropriate level of services and supports.
3. Documented multiple attempts (e.g., a minimum of four attempts over the first two weeks, a minimum of six attempts over the first month, and/or a minimum of eight attempts over a two-month period) to locate and make contact with an individual. The individual may be removed from the caseload due to drop out/unsuccessful engagement after 90-days.

Service Exclusions

1. This service may not duplicate any discharge planning efforts which are part of the expectation for hospitals, BHCCs, CSUs, and PRTFs.
2. The HUM program is not available to any individual who has an authorization for and is actively engaged in services (as evidenced by face-to- face contact within the past 30-days) with IC3, CME, or IFI.

Clinical Exclusions

1. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition co-occurring with the diagnosis of:
    a. Intellectual/Developmental Disabilities; and/or
    b. Autism; and/or
    c. Neurocognitive Disorder; and/or
    d. Traumatic Brain Injury.
2. Individual does not present with medical necessity and functional limitations to substantiate eligibility for a behavioral health service.

Required Components

1. Provider organization must agree to promote HUM activities as an integrated service within the agency's continuum/system of care in order to promote engagement and successful ongoing connection.
2. Each HUM Navigator will have access to, and/or receive a report generated daily of:
    a. Individuals assigned to their agency; and
    b. DBHDD hospital recidivism, specific to the individuals assigned to their agency.

3. HUM Navigators will maintain a short-term, rolling case load of individuals with whom active connection and reconnection services are being coordinated.
4. The HUM program is expected to engage a high percentage of individuals into services with few dropouts. In the event that a HUM Navigator has documented multiple attempts (e.g., a minimum of four attempts over the first two weeks, a minimum of six attempts over the first month, and/or a minimum of eight attempts over a two-month period) to locate and make contact with an individual, and has demonstrated a diligent search, the individual may be removed from the caseload due to drop out/unsuccessful engagement after 90-days.
5. HUM Navigators work as part of the known or developing care coordination team/network.
6. HUM Navigators may use flexible funds up to $500 per HUM program-enrolled individual for the following allowable expenses:
    a. Transportation – Round-trip bus or car fare for individuals to attend behavioral health, medical provider, or housing appointments.
    b. Medication – One (1) time allowance for direct purchase of [60 to 90-day supply] prescription medication from retail pharmacies other than the provider's pharmacy.
    c. Personal items – One (1) time purchase of necessary personal care items (e.g., basic clothing, grooming/hygiene items).
    d. Food - Light meal that is engagement-related with HUM navigator; maximum of $8.00 per meal.
    e. Requisite benefits-related documentation - Obtaining birth certificate, state identification, etc.

HUM Navigators will use specified leveling in order to prioritize individuals based on the color coding below to identify barrier levels:

Green – lowest level – mild barriers. Individual may have had previous service authorizations and/or an established connection to a provider; individual is known to the system, but not continuously and consistently engaging in community services that support stability; individual may have inadequate/inappropriate level of care; and/or individual may have refused services.

Yellow – mid level – moderate barriers. Individual may or may not have been authorized and/or engaged previously with provider, but is currently neither authorized for services nor connected, individual may have had inadequate/inappropriate level of care; individual may have refused services. Circumstances may include change in payor, financial limitations, location.

Red – highest level – severe barriers. No current or previous authorization; individual may be homeless or have other unsafe/unstable housing, may present with medical complexity and/or co-occurring I/DD, involvement with criminal justice system or DFCS; individual may have inappropriate level of care; may have refused services.

<u>Staffing Requirements</u>

1. The practitioner who provides this service will be referred to in this definition as a HUM Navigator.
2. A full-time HUM Navigator must be hired in accordance with Department determined criteria, and in collaboration with the Department's High Utilization Management Coordinator (HUMC).
3. The following practitioners may provide HUM program services:

- Practitioner Level 2: Psychologist, APRN, PA
- Practitioner Level 3: LCSW, LPC, LMFT, RN
- Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAADC, CAC-II, GCADC (II, III); CPS, PP, CPRP or Addiction Counselor Trainee/Counselor in Training with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology
- Practitioner Level 5: CPS; PP; CPRP; or, when an individual served has a co-occurring mental illness and substance use disorder: CAC-I, GCADC-I, or Addiction Counselor Trainee/Counselor in Training with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above.

4. Staff-to-consumer ratio for each HUM navigator shall be maintained at a minimum caseload of one HUM navigator serving 50 individuals (1:50). This is based on a rolling census of eligible individuals identified in the Beacon system and/or by other enrolled providers who may serve as referral sources. Of these individuals, those who become connected to services will be discharged and no longer counted in the ratio.

<u>Clinical Operations</u>

1. It is not expected that HUM Navigators participate in or deliver clinical services.
2. HUM Navigator service delivery may include (with appropriate consent) coordination with family and significant others and with other systems/supports (e.g., work, school, religious entities, law enforcement, aging agencies, etc.) when appropriate for services and supports.
3. HUM Navigators must have the ability to deliver engagement services in various environments, such as inpatient, residential, homes, homeless shelters, or street locations.
4. HUM Navigators must incorporate assertive engagement techniques to identify, locate, engage, and retain the most difficult to engage individuals who have a history of cycling in and out of intensive services.
5. HUM Navigators must demonstrate the implementation of well thought out engagement strategies, including the use of street and shelter outreach approaches and collateral contacts with family, friends, probation or parole officers.
6. Using assertive engagement skills, the HUM Navigator will function to perform and report on the following 30-60-90 Day Activities:
   <u>Within 30 days (Rapid Intensive Engagement)</u>
   - have had face-to-face contact with individual
   - collaborate to identify most urgent needs
   - collaborate to identify barriers to access treatment/supports, prioritize services
   - report on progress

   <u>Within 60 days (Focused Resource Engagement)</u>

   - connection to appropriate resources, services (as evidenced by attendance to appointments)

- convening appropriate parties, treatment providers, natural supports, stakeholders to identify and resolve barriers

Within 90 days (Active Monitoring Engagement)

- Integration into appropriate level of services, supports and other resources.
- Monitor access and continued engagement in identified services/supports.
- Transition out of HUM program

HUM Navigators must:

1. Use case management strategies to educate and connect to services and advocate for individuals.
2. Utilize a person-centered approach to meet the needs of each unique person.
3. Engage individuals who have not been successfully engaged into services beyond a crisis.
4. Use conventional and unconventional methods of engagement to determine barriers to ongoing community-based care.
5. Use a standardized comprehensive needs assessment tool.

The HUM program must:

1. Use available data to identify and assign a level of priority (see Required Components) to eligible individuals;
2. Utilize methods, materials, settings, and outside resources appropriate to the developmental and cognitive levels, capabilities, age, gender, and culture of participants;
3. Utilize methods, materials, approaches, activities, settings and outside resources appropriate for, and targeted to individuals with Substance Use Disorders and co-occurring mental illness;
4. Elevate identified gaps in resources to the regional community collaboratives/local interagency planning team chairs to address and develop solutions with community partners;
5. Reduce the number of people with elevated acute BH needs to improve access to care;
6. Increase utilization and participation in programming that promotes stability, wellness and recovery; and/or
7. Reduce the re-admission rates of individuals being re-admitted into BHCC, CSU, Private Hospital, PRTF levels of care.

Service Accessibility

1. There must be documented evidence that service hours of operation are flexible and include outreach and engagement during evenings and weekends.
2. Demographic information collected shall include a preliminary determination of hearing-impairment status to determine the appropriateness of a referral to the Office of Deaf Services.
3. HUM Navigators are expected to assertively engage with individuals in settings to include: Hospitals, BHCCs, CSUs, PRTFs, and other community settings.
4. Parents/families/legal guardians are considered to be necessary supports for youth served in the HUM service. However, if the individual served is 18 years of age or older, they may choose not to have parents/families engaged.

Documentation Requirements

- 30/60/90-day reporting of progress Date of admission and discharge from HUM program Discharge Disposition:
    - Still receiving services;
    - Completed receiving services;
    - Refused services;
    - Left catchment area;
    - Incarcerated; or
    - Other dispositions.
- Date of first and last HUM Navigator contact
- Unique identifier for each individual, which will follow them across multiple engagements
- ID of HUM Provider (T1, T2+), perhaps Federal ID #?
- Region
- County (where individual intends to reside while receiving services)
- Urban vs. Rural (based on county)
- Initial priority level coming into HUM (Red, Yellow, Green)
- Number and type of Crisis contacts - What factors placed them on the HUM list?
    - ER
    - IP Stay (State contracted beds)
    - BHCC/CSU
    - PRTF
    - Mobile Crisis
- Initial Barriers to engagement in community treatment (select as many as apply):
    - Homelessness
    - Transportation
    - Inadequate DC planning
    - Cultural factors
    - Lack of understanding of value of OP services
    - Unavailability of services in community
    - Lack of knowledge in how to access state services
    - Prior negative experience with community services
    - Other
- List of barriers that were successfully removed by the HUM Navigator/service.

<u>Billing & Reporting Requirements</u>

1. Compliance with monthly programmatic reporting as required by the Department's HUM Coordinator.
2. Each HUM navigator must submit per unit encounters for all individuals served.
3. Post 90-Day Review - The HUM Navigator will provide a monthly programmatic report to DBHDD of the caseload outcomes for individuals served in the HUM program.

<u>Additional Medicaid Requirements</u>

None