Creating Opportunities
Case Management Workgroup Report
March 2011

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Executive Summary

For over thirty years in Virginia, case management has been a primary service in the publicly funded system of services for citizens with mental illness and those with intellectual disabilities. Case management is the core service that Virginians with behavioral health disorders and intellectual and developmental disabilities receive to help navigate and make the best use of our publicly funded system of services. It is the one service that is of critical importance to all dimensions of the services system, yet this service lacks specified coursework and preparation. Strengthening the case manager's role is essential to assuring effective and accountable services, and all case managers must develop the knowledge and expertise needed to identify and strengthen individuals' natural support systems.

A case management workgroup was established by the Commissioner of the Department of Behavioral Health and Development Services (DBHDS) in June, 2010, to address the issues identified above by completing the following tasks:

1. Identify a set of core competencies for case managers, including principles of self-determination and person-centered planning for all who are served, and recovery for those with behavioral health disorders, to ensure objectivity.

    - The workgroup recommends that, in addition the definitions found in DBHDS and DMAS regulations, DBHDS and CSBs should uniformly adopt the following service definitions of care coordination, basic case management, and targeted case management:

        Care Coordination: *The management and brokering of services for individuals to ensure that needs are met, covered services are not duplicated by the care-providing organization(s), and resources are used most cost effectively. It primarily involves gate-keeping functions, such as approving care plans and authorizing services, utilization management, providing follow-up, and promoting continuity of care.*

        Basic Case Management: *Basic case management means assessing the needs, wants, strengths and preferences of individuals seeking services and supports; creating a viable plan to assist in referring to, accessing, and utilizing needed services and supports; actively monitoring the delivery of services and their outcomes; supporting and assisting to address unmet needs; and collaborating and coordinating with others to ensure effectiveness and avoid duplicative services.*

        Targeted Case Management[1]*, as it has developed and is provided in the public behavioral health and developmental services system, includes the elements of Basic Case Management and a full range of care and support that individuals with more severe*

[1] As used by the federal Center for Medicaid and Medicare Services (CMS), "targeted" case management refers to case management that is restricted to specific beneficiary groups (e.g., individuals with serious mental illness).

disabilities require in order to live successfully in the community. These services include but are not limited to: supportive counseling; crisis intervention; direct assistance with limited activities of daily living; coaching; intake and discharge planning; relationship building; teaching decision making; self-advocacy, and wellness planning; educating regarding the need for medications, primary care, and therapy; promoting continuity of care among various health systems and providers; providing family education and support and generally overcoming barriers for accessing appropriate care.

- ❖ The workgroup recommends that DBHDS and Community Services Boards (CSBs) uniformly adopt the following case management competencies:

  General Competencies- *Cultural and Linguistic Competence, Safety, Ethics, and Use of Technology*

  Case Management-Specific Competencies- *Job Knowledge, Assessment Skills, Service Planning and Service Access, Advocacy, Interpersonal and Team Skills, Judgment and Analytical Ability, Adaptability, and Organizational Skills.*

2. Outline a plan to establish a core curriculum that will provide case managers with the foundational knowledge that is needed to fulfill their roles as case managers, as well as including specialized competencies to address disability-specific issues.

   - ❖ The workgroup identified and defined in this report an outline of training topics designed to address both basic and disability-specific case management competencies. The workgroup recommends that DBHDS and CSBs establish a case management curriculum committee to work with a curriculum development expert to assess existing training modules identified in this report for their suitability in addressing case management competencies.

3. Identify efficient and effective methods to deliver training on a statewide and local basis.

   - ❖ The workgroup recommends that the case management curriculum committee established by DBHDS and CSBs also identify and develop additional curriculum and testing needed to address the core and disability-specific competencies.

4. Assess the potential value of a certification program for case managers in Virginia.

   - ❖ The workgroup expressed its consensus for the intent to establish consistency around the state through a formal recognition of the competencies each case manager holds. At the same time, the cost for and administration of training, testing, and credentialing case managers were identified as significant challenges that require further consideration.

   - ❖ The workgroup recommends that the case management curriculum committee develop training completion timeframes, testing, and other requirements that would define a uniform case management certification with basic and advanced disability-specific levels. DBHDS should then identify an accrediting body and certification process that would apply to case managers in the behavioral health and developmental services systems statewide..

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I. Background and Process

For over thirty years in Virginia, case management has been a primary service in the publicly funded system of services for citizens with mental illness and those with intellectual disabilities. As the Commonwealth has moved from institutions as the main service delivery system to supporting the vast majority of individuals with these disabilities in the community, it is case management that has assured that individuals receive the services they need and the individualized support that is required to successfully become integrated in the community and minimize the crises that lead to the most restrictive and expensive treatment modalities.

The term "case management" is used to cover a broad array of services, from temporary to intermittent activities performed by clinicians and others in coordinating behavioral health care, to long-term wraparound direct services provided by specified case managers. Similarly, the preferred term for such long-term comprehensive services for individuals with an intellectual disability is "support coordination" and in children's mental health services, it is called "care coordination" or "service coordination." In further confusion, managed care entities and insurance companies use the term "case management" in describing activities that are often limited to assessing the need for and authorizing access to medical or behavioral health care (e.g., care coordination in a managed care environment).

For the purposes of this paper, case management will refer to the service as it is provided in the public behavioral health and developmental services system, which includes a full range of direct care and supports that individuals with more severe disabilities often require to successfully live in the community. The term "care coordination" will refer to the basic case management activities of assessing, planning for, referring to, coordinating with, and following up on services.

Case management (support coordination/service coordination) is the core service that Virginians with behavioral health disorders and intellectual and developmental disabilities receive to help navigate and make the best use of our publicly funded system of services. It is the one service that is of critical importance to all dimensions of the services system, yet this service lacks specified coursework and preparation. Strengthening the case manager's role is essential to assuring effective and accountable services, and all case managers must develop the knowledge and expertise needed to identify and strengthen individuals' natural support systems.

The Office of Inspector General's (OIG) 2006 *Review of Community Services Board Mental Health Case Management Services for Adults* and its 2007 *Review of Community Services Board Mental Retardation Case Management Services for Adults* found that case managers receive little training in topics specifically related to case management and few, if any, new case managers enter employment at CSBs with formal training or professional preparation to be a case manager. The absence of appropriate workforce development for case managers and inconsistent standards for what is expected of this role

has resulted in a very wide variety of case management experiences for individuals and families throughout Virginia and a limited ability to assess competency and measure outcomes.

Creating Opportunities Case Management Workgroup

A case management workgroup was established by the Commissioner of DBHDS in June, 2010, to address the issues identified above by completing the following tasks:

1. Identify a set of core competencies for case managers, including principles of self-determination and person-centered planning for all who are served, and recovery for those with behavioral health disorders, to ensure objectivity.
2. Outline a plan to establish a core curriculum that will provide case managers with the foundational knowledge that is needed to fulfill their roles as case managers, as well as including specialized competencies to address disability-specific issues.
3. Identify efficient and effective methods to deliver training on a statewide and local basis.
4. Assess the potential value of a certification program for Case Managers in Virginia.

The workgroup met for the first time on 6/24/10. Membership included representatives from CSBs, the Department of Medical Assistance Services (DMAS), DBHDS, family and consumer groups, and private providers, serving individuals with behavioral health disorders (BH), intellectual disability (ID), developmental disabilities (DD), or substance use disorders (SA) covering the spectrum from children to adults:

Case Management Workgroup Members	
Name	**Organization**
Chanda Braggs	DBHDS Licensing
Tim Capoldo	Norfolk CSB
Judy Carter	Alexandria CSB
Kathy Drumwright (co-convener)	Virginia Beach CSB executive director
Pamela Fisher	DBHDS Child and Family Services
Yvonne Goodman	DMAS
Sally Hall	Rappahannock Area CSB
Catherine Hancock	DMAS
Tracy Harris	DMAS
Toni Johnson	Richmond BHA
Cindy Kemp	Arlington CSB executive director
Steven King	DD Case Manager
Noreen Lewis	Self-Advocate
Janet Lung	DBHDS Child and Family Services
Jim Martinez	DBHDS Behavioral Health Services
Nancy Mercer	ARC of Northern Va
Bonnie Neighbour	VOCAL
Sandy O'Dell	Planning District One CSB
Lee Price	DBHDS Developmental Services

Case Management Workgroup Members	
Name	**Organization**
Lisa Poe	Richmond Residential Services
Beth Rafferty	Richmond BHA
Mellie Randall	DBHDS Behavioral Health Services
Gail Rheinheimer	DBHDS Developmental Services
Les Saltzberg	DBHDS Licensing
Renae Sands	Hanover CSB
Michael Shank (co-convener)	DBHDS Behavioral Health Services
Deborah Smith	Crossroads CSB
Stacie Turner	Blue Ridge CSB

The committee began its work with a review of existing services and practices throughout the CSB community, looking at current case management responsibilities, caseload sizes, and educational levels of staff. The following are brief descriptions of case management models employed by the organizations that are represented by committee members:

Disability Group	Workgroup Member Organizations' Case Management Model Descriptions
ID	Two levels: 1. Broker model with a ratio of 1:50 provided by staff with mixed roles 2. Broker model with a ratio of 1:20-25 provided by dedicated staff.
ID	Two levels for caseloads mix of ID Waiver and State Plan Option service recipients: 1. Higher level for individuals with ID and DSM Axis I disorders with a ratio of 1:35 and 2. Regular level for those with ID and no Axis 1 disorder with a targeted ratio up to 1:45
ID	Dedicated team with Waiver and non-Waiver recipients in a ratio of 1:30-35 in entirely field-based workplace (with virtual web-based office work).
ID	Broker model designed to serve caseloads of approximately 30+
ID	Broker model with 17 case managers (plus 5 for children) with caseloads of approximately 42
DD	Private DD-Waiver case management practice serving 45 individuals from Suffolk to Galax with monthly 1-1.5 hour face to face visits and 100-hour work weeks.
BH	Three levels: 1. Broker model with a ratio of 1:50 provided by staff with mixed roles; 2. BH Intensive model with a ratio of 1:20-35 3. Assertive Community Treatment (PACT)
BH	Dedicated case managers to a mixed caseload ratio of 1:35 (SA=1:30-35) in individuals' homes, service centers, or CM offices
BH	Provided by mixed-role staff (i.e., clinician/case managers) to a MH/SA caseload in a ratio of 1:35-40 with emergency services, and therapy also provided as needed
MH	Three levels: 1. Caseloads of 1:55 for level 1 (low),

	2. Caseloads of 1:31 3. Caseloads of 1:23 for level 3 (high). Levels of care assigned based on a standardized evaluations and individuals and staff move among levels as needs change, (usually once a year for approximatley 15% of the caseload).
MH	Two levels: 1. 'Comprehensive recovery teams' serve a total of 200-250 individuals with SMI 2. A less intensive level provided by case managers working in outpatient, clubhouse, or residential services.
MH	Case managers team up with licensed clinicians,
SA (HIV)	Office-based broker model services provided by a team of three case managers, one clinical, and one outreach worker with caseloads of 45 (average range = 30-50),

The workgroup first identified a sample of case managers' current general duties and areas of concern as described below:

Sample Case Management Functions, Roles, and Concerns	
Assessing needs and strengths	Housing, employment, health care, entitlements, legal, criminal justice
Assistive technology	Identify cultural issues
Benefits counseling	Individual services/supports planning
Coaching (e.g., travel companion)	Knowing how to bill for services
Community education / Ambassadors	Knowing the resources
Connection with Peer organizations	Liaison between Training Center and State Hospital
Coordination / collaboration	Linking to services
Coordination of med management	Modifying / revising service plans
Crisis intervention	Monitoring delivery of services
Customer satisfaction	Relationship building
Discharge (and intake) planning	Relationships with community resources/natural supports
Documentation	Safety monitoring / Quality monitoring
Educate / advocate with other providers about services	Self-awareness (aware of biases)
Education re meds / PCP / therapy	Skill training
Empowering (not enabling)	Supportive counseling
Enhancing community integration / inclusion	Teaching about abuse / neglect / Human Rights
Evaluations	Teaching decision making / self-advocacy
Family support and education	Timeliness

Sample Case Management Functions, Roles, and Concerns	
Good listening skills	Travel training
Good people-person skills	Wellness planning / advance directives / WRAP
Guardianship / authorized representatives	Work incentives / personal support trusts
Helping consumers learn self advocacy	Working with client's preferences

The workgroup then looked at material from other states to determine whether case management issues that have been identified in Virginia were being addressed and whether there would be an opportunity to utilize such material here. Members reviewed a list of core competencies from Maine and those outlined in the Alaskan Core Competencies report, by the Annapolis Coalition on Workforce Development, as they align with the above list of case management functions, roles, and concerns. (DBHDS obtained permission from the authors to use this report in the course of this work.)

Competencies for case management developed in Texas, Florida, Kentucky, and Utah were also reviewed and, to the extent appropriate, incorporated into this work: The workgroup also utilized material from the Center for Medicare and Medicaid Services (CMS), The Center for Healthcare Strategies, the Workforce Development Committee of the Commission on Mental Health Law Reform, and the VACSB Human Resources Workgroup. After reviewing these materials, the workgroup adopted the list of core competencies described below in Section II.

The recommendations of the workgroup include a definition of case management that reflects the current realities and new CMS requirements, activities with individuals that are critical to success in the community, general core competencies, and disability-specific core competencies. The workgroup also identified existing training materials that address core competencies by disability, and noted existing gaps where curriculum development is needed.

II. Case Management Description and Core Competency Definitions

The Workgroup agreed to the following service descriptions of care coordination, basic case management, targeted case management as it is provided today, and core competency definitions:

> ***Care Coordination:*** *The management and brokering of services for individuals to ensure that needs are met, covered services are not duplicated by the care-providing organization(s), and resources are used most cost effectively. It primarily involves gate-keeping functions, such as approving care plans and authorizing services, utilization management, providing follow-up, and promoting continuity of care.*
>
> ***Basic Case Management:*** *Basic case management means assessing the needs, wants, strengths and preferences of individuals seeking services and supports; creating a viable plan to assist in referring to, accessing, and utilizing needed services and supports; actively monitoring the delivery of services and their outcomes; supporting and assisting to address unmet needs; and collaborating and coordinating with others to ensure effectiveness and avoid duplicative services.*

> ***Targeted Case Management****, as it has developed and is provided in the public behavioral health and developmental services system, includes the elements of Basic Case Management and a full range of care and support that individuals with more severe disabilities require in order to live successfully in the community. These services include but are not limited to: supportive counseling; crisis intervention; direct assistance with limited activities of daily living; coaching; intake and discharge planning; relationship building; teaching decision making; self-advocacy, and wellness planning; educating regarding the need for medications, primary care, and therapy; promoting continuity of care among various health systems and providers; providing family education and support and generally overcoming barriers for accessing appropriate care..*

Targeted Case Management is a one-to-one service that, in CSBs, has served all populations with serious mental illness, substance use disorders, and intellectual disabilities since the establishment of CSBs in the Code of Virginia. It is the constant clinical service that assures continuity of care through the professional development of a dynamic service plan which changes as the needs of the client change.

Many of the case manager's typical clients are individuals who need a high degree of direct assistance, in addition to the referrals, prompts, and follow up calls common to case management in other systems. It is through a therapeutic relationship with their case manager that many individuals are motivated to work on objectives that support their life goals; and when any crises may occur, the case manager is often the best person to help resolve their urgent needs and avoid more costly emergency services or even hospitalization.

The intensity and frequency of need for direct assistance varies by individual and different case mix strategies are utilized by CSBs to ensure effective and flexible deployment of case management staffing resources. Virginia's monthly Medicaid rate for mental health and developmental services case management financially supports the flexibility needed to be responsive to changing individual needs, however reimbursement rates may need to be changed to much shorter units of time (e.g., hourly or less) in response to requests by the federal Center for Medicaid and Medicare Services (CMS).

CMS has also ruled that case management may not include direct services beyond assessment, planning, referring, monitoring, and follow up. DMAS has provided guidance in this regard to clarify that "supportive counseling and education to better enable a person to access or benefit from services such as medical, housing, medication management, or symptom management is permitted" if it is related to the care plan and is not a treatment service. Any changes to the monthly reimbursement rate must be made carefully to account for the level of direct services beyond the CMS limitations as they are now provided by case managers. (See Appendix 2 for case examples)

Required Core Competencies:

DBHDS and DMAS regulations identify knowledge, skills, and abilities that case managers must possess, but they do not describe them in much detail (see Appendix 3). To successfully provide the general level of services and supports required of all case managers, the following competencies are needed.

General Competencies- These are required competencies for all staff working with consumers needing behavioral health and/or developmental services, including case managers:

- **Cultural and Linguistic Competence**- The ability to interact and communicate with individuals from a variety of cultural contexts, including language, gender, sexual orientation, ethnicity, geographic origin, spiritual traditions, and other differences.
- **Safety-** Understanding and practice of general safety procedures in the community and office environments.
- **Ethics**- The ability to understand and apply appropriate boundaries in working with individuals, protecting confidentiality, and adhering to corporate compliance.
- **Use of Technology-** The ability to use agency computer systems, maintain electronic records, and utilize other electronic technology.

Case Management-Specific Competencies

Job **Knowledge**- Foundational information on case management, case management models, and individuals served, specialty areas specific to disability, appropriate terminology, documentation, policies, rules and regulations on case management, and licensure and funding (Medicaid, etc.) requirements.

Assessment Skills- The ability to identify needs, strengths, capacity, and competency, use of evaluation tools and outcome measurements, ability to gather and summarize information, and assist in identifying personal values, goals and priorities.

Service Planning and Service Access- The ability to individualize care and supports through ISP development, facilitate service acquisition, service planning and team meetings, intake and discharge planning, linking and coordination, specialty areas by disability, including recovery principles and person centered planning, wellness recovery plans (WRAP, etc.) and person-centered support plans, and advanced directives, etc.

Advocacy- The ability to act in the individual's best interest, including the provision of family support and education, knowledge and use of community resources, and promoting the development of other needed services and supports.

Interpersonal and Team Skills- Advanced abilities in communication, listening, and problem solving, establishing rapport, and effectively working with internal and external teams of services and supports providers.

Judgment and Analytical Ability- The ability to identify critical issues, act appropriately in high risk situations, assess and reassess appropriate crisis responses, and assist individuals in utilizing creative approaches to problem solving

Adaptability- The ability to flexibly assume various roles of counselor, advocate, and service broker, and adjust to change to meet the individual's needs in the changing healthcare environment.

Organizational Skills- The ability to independently manage an often large caseload and prioritize both direct service and accountability for recipient records and other related tasks and activities.

III. Case Management Training Needs

The workgroup developed a list of subjects that case managers would need to be familiar with in order to meet these expectations. The following table describes the training topics identified by the committee to address the core competencies as they relate to basic and disability-specific case management:

Competencies Required for Case Management	Related Training Topics		
	Basic Case Management	**Behavioral Health Case Management**	**Developmental Services Case Management**
Job Knowledge- Foundational information on case management, case management models, and recipients, specialty areas specific to disability, appropriate terminology, documentation, policies, rules and regulations on case management, and licensure and funding (Medicaid, etc.) requirements.	Why case management is needed, how it differs from other professional roles, and the level of commitment needed to effectively fulfill the role Case management models – targeted, intensive, and higher-level Roles and responsibilities in community-based and home-based work Ethical boundaries in working with clients in the field Risk assessment and crisis response Person centered philosophy and approaches Laws governing interrelated public and private systems – e.g., CJ, schools, CSA Core services taxonomy and related terminology	Mental illness Substance abuse – the nature of use, abuse, and addiction Emotional disturbance in children Clinical use of self and fostering treatment relationships Human development and brain diseases Bio-psychosocial philosophy and approaches Integrated co-occurring philosophy and approaches Recovery vs. Illness models – historical context and orientation Recovery facilitation and support Peer-run services and peer specialists roles and functions Family systems theory and practice Family dynamics, support, and psychoeducation Gender differences and the Relational Model of Treatment	Evolution and current values of ID/DD services Introduction to ID/DD characteristics, causes, and misconceptions Understanding Medicaid Waivers Knowing ID/DD resources available in the community
Assessment Skills- The ability to identify needs, strengths, capacity, and competency, use of evaluation tools and	Interviewing skills - How to elicit information and encourage "Telling the story" /gathering information through	Bio-psychosocial approaches (including sexual and spiritual aspects) Client-driven assessment	Supports Intensity Scale Level of Functioning Personal profile Assuring

outcome measurements, ability to gather and summarize information, and assist in identifying personal values, goals and priorities.	conversations Quarterly reviews and reassessment requirements Evaluation and outcome identification processes	approaches Risk assessments	eligibility/reviewing psychological evaluations Identify warning signs, stressors and supports needed
Service Planning and Service Access- The ability to individualize care and supports through ISP development, facilitate service acquisition, service planning and team meetings, intake and discharge planning, linking and coordination, specialty areas by disability including recovery principles and person centered planning, wellness recovery plans (WRAP, etc.) and person-centered support plans, and advanced directives, etc.	Identifying and differentiating goals, objectives, strategies, and interventions Person-centered thinking and practices How to collaboratively design a service plan Intake and discharge requirements Resource knowledge and application Non-service related supports including work, education, and housing Cross-systems planning Linking and coordinating of services and supports Monitoring service delivery	Recovery-oriented practices WRAP for children	Person-centered Individual Support Plan
Advocacy- The ability to act in the individual's best interest, including the provision of family support and education, knowledge and use of community resources, and promoting the development of other needed services and supports	Effective approaches to advocate for the individual's best interest fulfill the role of educator with all key stakeholders Self-advocacy Empowering/engaging individuals/families Internal agency advocacy Enhancing community integration		

	Understanding and communicating human rights		
Interpersonal and Team Skills- Advanced abilities in communication, listening, and problem solving, establishing rapport, and effectively working with internal and external teams of services and supports providers.	Listens effectively Communicates effectively Builds positive relationships Collaborates Analytical thinking Group work – models and stages of development Team and group facilitation Creativity – how to develop and use natural supports, not just programs Anticipatory Guidance – playing out possible scenarios Meeting the person where they are Transitions – to other case managers, termination of services, etc.	Strength-based philosophy and approaches	
Judgment and Analytical Ability- The ability to identify critical issues, act appropriately in high risk situations, assess and reassess appropriate crisis responses, and assist clients in utilizing creative approaches to problem solving	Predicting possible issues that may arise How to help clients implement crisis plans When and how to seek supervision		
Adaptability- The ability to flexibly assume various roles of counselor, advocate, and service broker, and adjust to change to meet the individual's			

needs in the changing healthcare environment.			
Organizational Skills- The ability to independently manage an often large caseload and prioritize both direct service and accountability for recipient records and other related tasks and activities.	Time management Writing skills Triage and prioritization Meeting regulatory and legal requirements Effective use of supervision		
Other	Knowledge and understanding of medication, physical disabilities, medical conditions and medical care, medical terminology, and interactions with medical staff		IDOLS (ID on-line system) Using Medicall and ARS Access to associated websites – CMS, DMAS, DBHDS

IV. Existing Training to Address Competency Development

Members then discussed current training and existing curricula, researched e-learning resources between meetings, and began to collect information on costs to users for access to the online training modules available through NetSmart, Trilogy, and other online training providers[2].

There are a number of CSBs currently using these e-learning tools that pay a monthly cost per user for its employees. Members noted that it would be helpful to know how many CSBs are using which online training vendors, and they affirmed the desire to have a core curriculum that would be standard across the state. In order to make these resources available state-wide, there would need to be a budget developed to address initial and ongoing costs; which was beyond the initial scope of this workgroup.

NetSmart's online content was described by Richmond BHA staff as having a good recovery focus, affirming the value of case management, and a focus on hope. It includes the following 6 modules specific to case management, but was considered to be too heavy on the history of MH and SA services, a little condescending to the user, and all adult MH oriented.

Trilogy eLearning Case Management Courses	Credits
Case Management, 01 Introduction	2
Case Management, 02 Models and Functions of Case Management: What Case Managers Do	2
Case Management, 03 - Who are consumers of Case Management Services?	2
Case Management, 04 - Mood Disorders	2
Case Management, 05 - The Recovery Perspective	2
Case Management, 06 - Listening, Communicating and Problem-Solving	2

Other courses include topics such as confidentiality, psychopharmacology, ethics, cultural diversity, communication, assessment, networking, advocacy, crisis intervention, Wellness Recovery Action Plans (WRAP), and person-centered planning.

Essential (E-Learning) has a larger library (see Appendix 1) and does more regular updates to topics such as person-centered planning, predicting violence, WRAP (10 courses), mental illness 101, recovery, suicide prevention and risk reduction, personal safety, family dynamics, CM service basics, and consumer-directed care.

Members felt that E-Learning seemed to meet MH/SA needs, but not necessarily the training needs of case managers serving children or individuals with ID. The workgroup also felt that CM training should reference other courses such as human rights and College of Direct Supports. It was pointed out that

[2] Netsmart University's Trilogy Network of Care eLearning, and Essential Learning (E-Learning) are online learning resources for behavioral health, developmental disability, and human service organizations with hosted Learning Management Systems (LMS) that enables organizations to create, deliver, manage, and track a variety of training options.

Trilogy has modules on Intellectual Disabilities in the Department's Learning Management System, and that CARF also has related courses.

The next steps in planning to establish a core curriculum to provide case managers with the foundational knowledge needed to fulfill their roles will be to determine the gaps to be filled with other existing modules in the Netsmart and Essential Learning online libraries and through additional curriculum development. The following table identifies existing training modules available through Trilogy and E-Learning LMS hosted by the VACSB and other DBHDS on-line resources that will partially address the core competencies identified for behavioral health and intellectual and developmental disability case managers.

Case Management Competencies	Existing Training Resources: Basic Case Management	Existing Training Resources: Behavioral Health Case Management	Existing Training Resources: Developmental Services Case Management
Job Knowledge- Foundational information on case management, case management models, and recipients, specialty areas specific to disability, appropriate terminology, documentation, policies, rules and regulations on case management, and licensure and funding (Medicaid, etc.) requirements.	10 Case Management Modules (Trilogy/Netsmart) Case Management Basics (Essential Learning)	WRAP Training; Understanding Recovery (Essential Learning)	ID Staff Orientation Workbook Handout: "Just the Facts" (DBHDS) ID Targeted CM (TCM) Training Modules
Assessment Skills- The ability to identify needs, strengths, capacity, and competency, use of evaluation tools and outcome measurements, ability to gather and summarize information, and assist in identifying personal values, goals and priorities.			2-day PCT Training (DBHDS available through Partnership for People with Disabilities) Person-Centered Individual Support Plan (PC ISP) Module 1 SIS Interviewer Training SIS Provider and Family Trainings
Service Planning and Service Access- The ability to individualize care and supports through ISP development, facilitate service acquisition, service planning and team meetings, intake and discharge planning, linking and coordination, specialty areas by disability including recovery principles and person centered planning, wellness recovery plans (WRAP, etc.) and person-centered support plans, and advanced directives, etc.	Treatment Planning and Documentation (Trilogy/Netsmart) Documenting the Treatment Planning Process; Guidelines for Documentation (Essential Learning)	WRAP Training; Clinical Documentation (Trilogy/Netsmart)	ID Targeted CM (TCM) Training Modules LOF Guidance document Developmental Milestones PC ISP Modules ID CM Transfer Protocol Onsite Monitoring Tool

Advocacy- The ability to act in the individual's best interest, including the provision of family support and education, knowledge and use of community resources, and promoting the development of other needed services and supports	Human Rights - State of Virginia and HIPAA Series (Trilogy/Netsmart) Client/Patient Rights; Confidentiality & HIPAA; HIPAA Privacy Rule (Essential Learning)		Partnership for People with Disabilities website PCT Community Connections Training DBHDS Office of Human Rights Training
Interpersonal and Team Skills- Advanced abilities in communication, listening, and problem solving, establishing rapport, and effectively working with internal and external teams of services and supports providers.	Effective Communication (Trilogy/Netsmart) Effective Teams; Teamwork: The Fundamentals; Customer Relations (Essential Learning)		
Judgment and Analytical Ability- The ability to identify critical issues, act appropriately in high risk situations, assess and reassess appropriate crisis responses, and assist clients in utilizing creative approaches to problem solving	Effective Decision Making Strategies; Crisis Intervention and Risk Assessment (Trilogy/Netsmart) Crisis Management (Essential Learning)		
Adaptability- The ability to flexibly assume various roles of counselor, advocate, and service broker, and adjust to change to meet the individual's needs in the changing healthcare environment.	Management of Change (Trilogy/Netsmart)		
Organizational Skills- The ability to independently manage an often large caseload and prioritize both direct service and accountability for recipient records and other related tasks and activities.	Time Management (Trilogy/Netsmart) Time Management (Essential Learning)		

Other The ability to communicate and interact with people across cultures, working in a safe manner both in the office and in the community, acting in an ethical manner and maintaining professional boundaries, effective use of technology (e.g. electronic calendar, email, computer forms, and other agency computer systems)	Cultural Diversity - A Primer; Understanding and Valuing Diversity; OSHA Series; Stress Management On and Off the Job; OSHA BBP; Ethics – Boundaries; Ethics Series; Workplace Ethics; Corporate Compliance: Understanding your Role (Trilogy/Netsmart) Cultural Diversity; Emergency Preparedness; Personal Safety in the Community; BBP; Corporate Compliance and Ethics (Essential Learning)	Cultural Issues in MH Treatment; Law, Ethics, & Confidentiality in Behavioral Health Care; Therapeutic Boundaries (Essential Learning)	ODS IDOLS training DMAS Website

V. Training Gaps and Required Curriculum Development

Much of the existing training resources are geared towards adult services. The following child and family related training topics may require the creation of new courses, and care should be taken to ensure that they align with Early Intervention training.

Gaps/Curriculum Development Needed for Children's Case Management

1. Comprehensive Services Act (CSA)
    - CSA as a System of Care
    - Terminology
    - Requirements
2. Medicaid Requirements and Children's Medicaid Reimbursable Services
3. Guiding Principles of Early Intervention
4. The Early Intervention Process
5. Overview of IDEA (Individuals with Disabilities Education Act)
6. Overview of Systems of Care
7. Working with Families
    - Role of the Family
    - Family Systems Theory and Principles of Family Functioning
    - Empowerment of the Family
11. Stages of Child and Adolescent Development
12. Assessment-Use of the Child and Adolescent Needs and Strengths (CANS)
13. Common Mental Health Diagnoses of Children
14. Child and Adolescent Medication Management
15. Trauma Informed Care (Abuse, Neglect, Medical Trauma, Domestic Abuse, etc)
16. Understanding and Managing Behavior
17. Skill Development for Children and Adolescents
    - Social Skills
    - Educational/Vocational Training
    - Independent Living Skills
    - Teen Parenting
18. Natural Learning Environments
19. Service Transitions (including from early intervention services to child services and from child/adolescent services to adult services)
20. Financial Matters related to Early Intervention/Part C Services
21. Intensive Care Coordination
    a. ICC Guidelines Overview
    b. Principles of Wraparound
    c. Phases and Activities of the Wraparound Process

VI. Case Management Certification:

The committee reviewed the potential value of a certification program for case management in Virginia and expressed its consensus for the intent to establish consistency around the state through a formal recognition of the competencies each case manager holds. At the same time, the cost for and

administration of training, testing, and credentialing case managers were identified as significant challenges.

The committee suggested that any case management certification be tiered for the basic and disability-specific levels of competency and trainings should be appropriate to each level (e.g., not all disability-specific training should be provided online). Individuals should be allowed to work and gain experience as case managers for a limited period of time (e.g., 6 months) prior to completing training and passing exams, based on standard curricula, to become certified. Existing case managers should be allowed to waive training as long as they successfully pass the exams.

Committee members believe other staff would be interested and appropriate for the training and testing, but recommended that certification requirements be limited to those working as case managers (i.e., not including staff that may perform case management activities in other job roles).

VII. Recommendations:

The committee makes the following recommendations to the Department to define case management and its core competencies and plan for training and certification of case managers in Virginia's behavioral health and developmental services system:

1. Definitions:
In addition the definitions found in DBHDS and DMAS regulations; DBHDS and CSBs should uniformly adopt the following service definitions of care coordination, basic case management, and targeted case management:

> ***Care Coordination:*** *The management and brokering of services for individuals to ensure that needs are met, covered services are not duplicated by the care-providing organization(s), and resources are used most cost effectively. It primarily involves gate-keeping functions, such as approving care plans and authorizing services, utilization management, providing follow-up, and promoting continuity of care.*
>
> ***Basic Case Management:*** *Basic case management means assessing the needs, wants, strengths and preferences of individuals seeking services and supports; creating a viable plan to assist in referring to, accessing, and utilizing needed services and supports; actively monitoring the delivery of services and their outcomes; supporting and assisting to address unmet needs; and collaborating and coordinating with others to ensure effectiveness and avoid duplicative services.*
>
> ***Targeted Case Management****, as it has developed and is provided in the public behavioral health and developmental services system, includes the elements of Basic Case Management and a full range of care and support that individuals with more severe disabilities require in order to live successfully in the community. These services include but are not limited to: supportive counseling; crisis intervention; direct assistance with limited activities of daily living; coaching; intake and discharge planning; relationship building; teaching decision making; self-advocacy, and wellness planning; educating regarding the need for medications, primary care, and*

therapy; promoting continuity of care among various health systems and providers; providing family education and support and generally overcoming barriers for accessing appropriate care.

Case management in the public behavioral health and developmental services system means not only addressing needed behavioral health and developmental services, but also accessing and assisting to use any medical, nutritional, social, educational, vocational and employment, housing, economic assistance, transportation, leisure and recreational, legal, and advocacy service or support that the individual needs to function in a community setting.

2. Core competencies required for case management:

DBHDS and CSBs should uniformly adopt the following case management competencies:

General Competencies- These are required competencies for all staff working with consumers needing behavioral health and/or developmental services, including case managers:

- **Cultural and Linguistic Competence**- The ability to interact and communicate with individuals from a variety of cultural contexts, including language, gender, sexual orientation, ethnicity, geographic origin, spiritual traditions, and other differences.
- **Safety-** Understanding and practice of general safety procedures in the community and office environments.
- **Ethics**- The ability to understand and apply appropriate boundaries in working with individuals, protecting confidentiality, and adhering to corporate compliance.
- **Use of Technology**- The ability to use agency computer systems, maintain electronic records, and utilize other electronic technology.

Job **Knowledge**- Foundational information on case management, case management models, and individuals served, specialty areas specific to disability, appropriate terminology, documentation, policies, rules and regulations on case management, and licensure and funding (Medicaid, etc.) requirements.

Assessment Skills- The ability to identify needs, strengths, capacity, and competency, use of evaluation tools and outcome measurements, ability to gather and summarize information, and assist in identifying personal values, goals and priorities.

Service Planning and Service Access- The ability to individualize care and supports through ISP development, facilitate service acquisition, service planning and team meetings, intake and discharge planning, linking and coordination, specialty areas by disability, including recovery principles and person centered planning, wellness recovery plans (WRAP, etc.) and person-centered support plans, and advanced directives, etc.

Advocacy- The ability to act in the individual's best interest, including the provision of family support and education, knowledge and use of community resources, and promoting the development of other needed services and supports.

Interpersonal and Team Skills- Advanced abilities in communication, listening, and problem solving, establishing rapport, and effectively working with internal and external teams of services and supports providers.

Judgment and Analytical Ability- The ability to identify critical issues, act appropriately in high risk situations, assess and reassess appropriate crisis responses, and assist individuals in utilizing creative approaches to problem solving

Adaptability- The ability to flexibly assume various roles of counselor, advocate, and service broker, and adjust to change to meet the individual's needs in the changing healthcare environment.

Organizational Skills- The ability to independently manage a diverse caseload, and prioritize both direct service, accountability for recipient records, and other related tasks and activities.

3. Case management training curriculum:

DBHDS and CSBs should establish a case management curriculum committee to work with a curriculum expert to assess existing training modules identified in this report for their suitability in addressing case management competencies and should identify and develop additional curriculum and testing needed to address the core and disability-specific competencies.

4. Case management certification:

The case management curriculum committee should develop recommendations to DBHDS for training completion timeframes, testing, and other requirements that would define a uniform case management certification with basic and advanced disability-specific levels. DBHDS should identify an accrediting body and certification process that would apply to case managers in the behavioral health and developmental services systems statewide.

Appendix 1: Essential E-Learning Courses

Essential E-Learning Course Library	Number of Courses	Training Hours
Addiction Or Substance Use – General	1	1.50
Addiction Or Substance Use Conditions	3	7.50
Addiction Or Substance Use Interventions	9	21.50
Behavioral Health Interpretation	4	6.00
Clinical Supervision	7	20.50
Corrections - Offender Management - Safety And Security	1	3.50
Crisis Or Emergency Management	4	10.50
Dental Health	2	2.00
Developmental Disabilities Habilitation	1	2.50
Disaster Response	1	6.00
E-Learning	1	0.00
Employee Development	6	10.50
Employment	2	7.50
Ethics Or Rights Or Client Care	5	11.00
Health And Safety	4	12.00
Integrating Physical And Behavioral Health	2	8.00
Laws Or Regulations	5	11.50
Leadership	1	1.50
Lifespan Development	5	11.00
Management Or Supervision	1	2.00
Medication	3	8.50
Mental Health – General	42	83.50
Mental Health Conditions	23	55.00
Mental Health Interventions	35	71.00
Mental Health Rehabilitation & Recovery	35	65.50
Military Service Related	4	11.50
Performance Improvement	1	4.00
Physical Health – General	2	9.00
Physical Health Conditions	1	1.50
Treatment Or Service Documentation	4	14.50
Treatment Or Service Planning	1	1.00
Working With Families Or Caregivers	2	4.50
TOTALS	**218 courses**	**486 hours**

Essential Learning Clinical Courses in Development Disabilities	Training Hours
An Advocacy Toolkit	1
Assessment of Treatment of Criminal Offenders with ID	1.5
Autism Spectrum Disorders: Separating the Data from the Myths	1
Behavior Development for People with DD	2
Behavioral Phenotypes in Genomic Syndromes	1.5
CBT for Adult Asperger Syndrome	3

Essential Learning Clinical Courses in Development Disabilities	**Training Hours**
CBT for People with Developmental Disabilities	3
Community Networks of Specialized Care for Indiv with Dual Diagnosis parts 1 and 2	2.5
Diagnosis and Treatment of PTSD and Interpersonal Trauma: The DM/ID Criteria and IBT	2
Diagnostic Systems for Use with People with ID Parts 1 and 2	3.0
Dialectic Behavioral Therapy for Special Populations	1.5
Ecobehavioral Approaches for Individuals with IDD	1
Effective Behavior Support for Individuals with HFA and Asperger's	1
Evaluation of Community Protection Program for Offenders with DD	2
FASD: Why Isn't this Person Responding to Treatment	2
Human Sexuality for Students with Special Needs	2
Identifying And Preventing Child Abuse And Neglect	2
Identifying and Preventing Dependent Adult Abuse and Neglect	2.5
Least Restraints: A Journey	1
Measuring Happy: Using the MTR Assessment	1.25
Medical Problems and Adverse Drug Events in People with ID/MI	1.5
Medical Problems and Adverse Drug Events in Psychiatric Inpatients with ID	1.5
Mental Wellness: A Critical Element in the New DD Service	1
Multi-Disciplinary Consultation for Patients with ID and MH	1.25
Neurological Develop. & Environ: Challenges & Opportunities	1
Person First Treatment: Using the Supportive Relationship to Promote Change	1
Perspectives in Dual Diagnosis: History & Future	1
Practical Implications of Genetic Diagnoses for People with DD	1.5
Preventing Toxic Threats to Neurodevelopment	1
Program for IDD in a Forensic Mental Hospital	1.5
Psychological Assessment of ASD	1.5
Psychopathology in Children and Adolescents with DD	3
Psychopharmacology and Behavioral Treatments	2.5
Psychopharmacology of Children with Intellectual & Developmental Disabilities	3
Psychotherapy for Persons with Developmental Disabilities	3
Sleep & Mental Health: Disorders Not Recognized & Not Treated	4
The Autistic Learning Disabilities Approach	2
The NADD Competency-Based Dual Diagnosis Certification Program Parts 1 and 2	2
The Playground, the Promise & the Perils of Psychopharmacology in DD	2
The Power of Strength-Based Educational Strategies in DD	1.5
The Right Way: A Philosophical Approach to Services for Persons with DD	2
Trauma and People with Intellectual Disabilities	1.5
Treatment of Behavioral Health Problems for Individuals with ASD	3
Ways to Support Individuals with Autism	2
What Exactly is OCD for People with IDD	1
Totals: 45 Courses	**83 hours**

Appendix 2: Case Examples

The following are actual examples that briefly describe case management activities with individuals.

Adult Behavioral Health Case Management Examples

Case #1: S. is a 26 year old man who, along with his parents, requested services at Hanover CSB when they moved from northern Virginia in 2006. He has a diagnosis of schizoaffective disorder with a history of paranoid delusions, isolation and 2 psychiatric hospitalizations. S. was assigned a case manager (CM) to help him access community supports and supportive counseling, and a psychiatrist for medication. When he did not keep appointments, his CM went to his home in an attempt to monitor medication and try to engage him in services.

Assertive outreach and face-to-face interventions by Case Managers help engage individuals in therapeutic services and avoid more critical problems.

Unfortunately, she found that S. had already become quite delusional and threatening, and observed drawings in his apartment identifying with Cho, of the Virginia Tech. shootings. She witnessed an altercation with his landlord, who had already notified law enforcement and the CM conducted a preadmission screening to facilitate an involuntary hospitalization. S.'s CM went to his commitment hearing and collaborated with hospital treatment providers to ensure continuity of care and helped his family join the Hanover Family Support Group.

While at CSH, S. indicated his preference for a male and within 2 days of discharge S. was transitioned to a new male CM. He was discharged to a small private adult home where his medication and meals could be monitored and he would be less likely to isolate and become preoccupied with his thoughts. His new case manager was assertive in visiting S. at the home to show support for S. and advocate for the supervision he needed to stay out of the hospital. The CM drove him to Raft House, a psychosocial rehabilitation clubhouse, hoping he would join and work on appropriate coping and communication skills there. He frequently visits S. in that setting to collaborate with staff and transports him to his psychiatrist appointments to ensure that all three are on the same page.

Case Managers transport and accompany clients to appointments to ensure that service providers' interactions are meaningful and effective.

The CM further gained S.'s trust by letting him move at his own pace and by being open with him about the need for collaboration with family, residential staff, and CSB treatment providers to prevent a relapse. Supportive counseling like this with his CM focuses on understanding his illness and preventing and managing symptoms. They discuss effective ways to express thoughts and angry feelings, with his interactions with peers at home and clubhouse and his family providing real life practice experiences. The CM supported S.'s goals to become physically healthy by helping him obtain a YMCA membership. Although S. periodically experiences increased symptoms and "crises" his CM has helped with de-escalation to avoid another hospitalization

Case #2: Client is a 54 year old African American man with diagnoses of Schizophrenia, Paranoid Type, Cocaine Dependence, and Alcohol Dependence. He has been in our care at Virginia Beach MHSA

intermittently for well over 20 years, having had his first psychotic episode in the early 1980s. His history includes early years of verbal and physical abuse by nuclear and extended family members, multiple hospitalizations at the local and state levels, incarcerations in local jail, and periods of homelessness. He has been unable to negotiate relationships or live with others successfully and his mother has a outstanding Restraining Order against because of a violent psychotic episode. Many unsuccessful attempts were made to keep him engaged in outpatient treatment for medication management, housing, and case management.

During the past 8 – 10 yrs., he was jailed on at least 2 occasions and disappeared on a few other occasions after losing his housing for becoming aggressive. Client has been more active and consistent with treatment after his release from Central State Hospital and jail in January 2009. The case manager worked intensively with the state hospital staff and correctional center staff as he was transferred between the two facilities and appeared with him in court. where his sentence was ultimately suspended. The case manager then helped with his release from jail into a hotel for a temporary stay while they found him a single unit in permanent housing. As he began to rely on our interest and assistance, he accepted short term Mental Health Support Services and very occasional day program participation at Beach House. Two episodes of "misunderstanding" with another tenant at his apartment complex were negotiated by his Case Manager with the management there to ensure that he maintains his housing.

Case Managers provide more than just access to services; they help secure and maintain the community supports needed to avoid relapse and pursue recovery.

He remained stable enough to stay out of hospitals and jails, tried to avoid abuse of crack and alcohol, and has had no "dirty" urine screens throughout this time. He has gradually come to show a useful level of trust to key members of his treatment team: his prescriber, nurse, case manager, and Beach House worker. He has begun to work at least an hour here and there at the Beach House over the past 3 – 5 months. Client takes his medication at a dramatically increased rate – approaching 100% of the time. His Case Manager has worked to find other adequate, housing for him when he was evicted from his single unit apartment in May (he had failed to provide key info on the original application, an oversight he was unaware of). This eviction occasioned several months of transience and homelessness, resulting in increased agitation, paranoia, verbal aggressiveness, poor grooming and hygiene. He re-stabilized when temporary housing was located for him and he is currently awaiting placement in permanent housing with MHSA/CDC. This client has developed substantially from one of whom many staff were afraid, to a level of recovery that is allowing him to be housed by us, avoid drug and alcohol abuse, participate in programs, and permit us to help him more than ever in the past.

Case #3: Client is a 56 year old unmarried Caucasian woman who initiated services with MHSA in February 2010 after a one-week voluntary hospitalization at a local psychiatric facility. She was referred for Case Management follow up by that facility and local Adult Protective Services (APS). Client elected to continue psychiatric medication care with the attending psychiatrist she had seen during inpatient. Client's presentation with the Case Manager for the first several visits was one of extreme emotional fragility, tearfulness, and reticence to talk. She appeared to lack functional and social skills. Her adult caretaker son, who accompanied client to all visits, agreed to obtain assistance for his mother primarily because of APS insistence.

By report of client and her son, client's history included 6 or 7 inpatient stays and consistent outpatient care in the Marion, VA area. She has a diagnosis of Schizoaffective Disorder, and shows symptoms of severe depression, suicidality, and paranoid tendencies when destabilizing. Son has been her caretaker and representative payee for many years and client followed him to Virginia Beach in early 2010. Both lived with a military retiree, whom the son met at his church, and client had no other social or personal support system except for the son and housemate.

When Case Manager was eventually able to meet with client in the absence of client's son, she reported that she wanted to obtain a mammogram, get her eyes and teeth checked, and develop social connections and activities. When CM attempted to proceed with arranging the eye appointment, however, son refused to "allow" client to accept the support of CM.

CM continued to meet with client and link with other service providers weekly to coordinate appointments, assess stability, and monitor progress. CM learned from APS that client had been physically abused by son on a few occasions since their move to Virginia Beach and pursued alternate arrangements with APS instead of continuing to reside with son and continuing to allow him to be her payee. Shortly thereafter son abruptly left the area, having made no housing or care arrangements for client. Client's housemate/landlord gave her three days to vacate his premises then, which required CM to immediately find emergency housing and request assistance from client's prescribing private psychiatrist to have the payee-ship reassigned.

Case Managers often complement Adult Protective Services to help meet the ongoing needs of individuals with disabilities when their families cannot.

CM found temporary housing for client, was able to have a new payee appointed and helped get into Adult Foster Care housing through local Department of Social Services. Case Manager helped client integrate into her new residence and continues to actively link with the AFC provider. Although initially somewhat depressed and tearful upon relocating, client has re-stabilized and is succeeding in that environment. Frequent contact with her by CM during this transition was required to assist and reassure her.

CM coordinated appointments with client's Primary Medical provider to obtain MRI and CT Scans, which led to surgery for abdominal hematoma. Several non-malignant lesions were also found on her brain, for which continued testing and medical monitoring are planned.

In late July, CM coordinated closely with our Community Based Crisis Stabilization (CBCS) where CBCS staff intervened with client to teach client new skills for controlling her thoughts and emotions. Client's successful completion of the CBCS and her engagement with the support services of the private National Counseling Group led to her referral to our Psychosocial Rehabilitation program, "Beach House." Client now attends 5 days each week and has begun to develop social connections and participate in activities with her peers.

In conclusion, CM continues to link weekly with the Adult Foster Care Coordinator, the home care provider, National Counseling Group, and client's Psychosocial program staff. Client has begun to enjoy more stable emotions, interact some with others, and to be medically improved. Perhaps most

exciting, client is able to recognize and verbalize the positive changes and progress she has made over the past 8 months.

Adult Developmental Services Case Management Examples

Case #4: Individual is 32 years old man with Profound Intellectual Disability and Autism. He is does not talk and communicates mostly by gesturing. His mother has mild intellectual disability and his father has numerous physical health problems. In addition, the family also had two other children to care for and they were ill equipped to provide the support he required to stay in the family home. Since the age of 9, he has resided at Southwestern Virginia Training Center. Due to health problems in recent years, his family had been unable to make the three hour trip to visit him at the training center.

They became increasingly interested in trying to find supports for him in his home community, but did not want him to go to a nursing facility, where they worried that the care and support he would receive would not be equal to the care he was receiving at SWVTC. The case manager kept a close watch for providers in the area that could meet his needs. When the case manager learned of a new 4 bed Congregate Residential Support provider opening just a mile from his family home, the case manager immediately began educating the family about the opportunity. The case manager arranged tours for the family to see the home and to meet and discuss supports with the staff.

The case manager met with the family several times to thoroughly explain how Money Follows the Person (MFP) slots worked. The case manager set up meetings and worked closely with training center staff to problem-solve concerns about community living, such as if it was a safety risk for him to go up and down stairs or if the kitchen not being locked at the group home could lead to behavior issues. There were not a lot of stairs at the training center so nobody was sure how this would affect him. Also, he loves to eat and snack so it was a concern that with an unlocked kitchen he would not be able to fight the impulse to eat.

The case manager arranged a series of visits for him and training center staff to come to the group home to visit and to provide training to the new providers. The case manager wanted to ensure the new providers were familiar with how he communicated his needs and preferences to help make the transition as smooth as possible. He has been at the group home since September 1st and is doing well. His family has been able to visit several times, and he is getting to know his parents and siblings again. He has also being introduced to his nieces and nephews for the first time. The case manager continues to maintain contact with the individual, the provider, and the family to make sure supports are being provided and that his needs and preferences are met.

Case Managers facilitate successful transitions from institutions into the community by working with all of the individual's supporters and service providers.

Case #5: Pl is a 35 year old man identified by his treatment team at SEVTC and the Case Manager as one of the residents of SEVTC who could live successfully in the community. Several meetings were held to determine the type of community placement that would best meet his needs. There was a staff person at SEVTC that he had a relationship with and had told other people that he wanted to live with her.

She became a Licensed Sponsored Residential Provider and the CM then worked with his cousin, who is his Authorized Representative, to explain what living in the community would mean for him. The CM placed many phone calls to the cousin who lives out of state to explain how living in the community would benefit PL. After months of phone calls and talking, a visit was arranged by the CM for the cousin to come to Virginia and see the proposed placement and approve a trial visit with the provider.

The CM coordinated the transitional meeting at the training center and made the arrangements for the trial visit. The team meeting is a key component of the ID Case Management system. Because this man attended a day support program in the community while at the training center, he could continue in that program. So the program representative was at the meeting, as was staff from the cottage. The medical staff were represented as well as the new Sponsored Residential Provider.

The trial visit went well and the placement has been successful. Since discharge from the training center he continues to participate in the day program, he has hosted his birthday party at his new home having friends from his day program and others from the community that he has met. One of the things he always wanted was a pierced ear which he now has and on his birthday he was pictured drinking a beer, another of his wishes.

The CM will have one more meeting with his new provider, the Day Support program staff and the new CM from his new community. Since everything has gone well these first 90 days, his case will be transferred to the CSB in his new community so that the new CSB Case Manager can begin to follow his life and support needs.

Child/Adolescent Behavioral Health Case Management Examples

Case #6: JD is a 16 year old 10th grade student who is currently in foster care. He was originally referred for services three years earlier by his mother due to "anger problems" that escalated to physical violence in the home. JD was placed in foster care after his mother's death; his older sister was 18 years of age, had a baby and was unable to care appropriately for him.

JD had been recently expelled from school due to bringing a knife and participating in a "riot." JD's original diagnosis was oppositional defiant disorder. JD was assigned a therapist and later CM joined the treatment team. JD has historically been unable to establish a positive relationship with male figures in his life. He has never had a relationship with his father and every other male figure in his life has been inappropriate (substance abuse or in/out of jail/prison and sexual abuse by a male teacher). CM, a male, was able to develop a strong relationship with JD through building trust, being non-judgmental, and providing support when needed. He partnered with JD's therapist and together they wrapped services around the child.

Case Managers, for many individuals, are their primary therapeutic relationship upon which other meaningful and productive relationships can grow.

JD entered services looking unkempt and at times dirty. The CM took him to get a haircut and helped him with proper hygiene and self care. JD would share feelings and thoughts toward other family members, friends, and classmates with the case manager; JS knew that this information would be kept

confidential. Furthermore, the CM and his therapist attended his graduation from 8th grade, since he had no family that could attend.

After a while, JD hesitantly informed CM that he was bi-sexual. He was initially hesitant to share this information with the CM for fear that it would change the nature of relationship. The CM assured JD that their relationship would not change due to JD's sexual orientation. This was a huge source of relief for JD and, feeling confident in their relationship, JD has become open and honest about drug use (primarily marijuana) with his therapist and CM. The CM has also built a relationship with JD's sister, who was estranged from him for a long time. She now contacts case manager CM when JD reveals to her issues that may be better addressed with him.

Appendix 3: Regulatory Requirements

Case Management Regulatory Requirements

DBHDS Requirements	DMAS Requirements			
Qualifications of case management employees or contractors.	**Mental Health Case Management**	**Substance Abuse Case Management**	**Targeted MR/ID Case Management**	**Developmental Disability Case Management (Support Coordination)**
	The mental health case management provider must be a Community Services Board member and licensed by DBHDS. The provider must be licensed as a provider of Case Management Services by DBHDS. Providers may bill Medicaid for mental health case management only when the services are provided by qualified mental health case managers.	The enrolled provider must be licensed by DBHDS as a provider of substance abuse case management services.	MR/ID Targeted Case Management providers must be licensed by DBHDS as a provider of case management services and operate a 24-hour emergency services system available for individuals. Providers may bill for Medicaid mental retardation case management only when the services are provided by qualified mental retardation case managers.	Providers must have a current DMAS Participation Agreement to provide Support Coordination services.
Knowledge				
Qualifications of case management employees or contractors.	**Mental Health Case Management**	**Substance Abuse Case Management**	**Targeted MR/ID Case Management**	**Developmental Disability Case Management (Support Coordination)**
A. Employees or contractors providing case management services shall have knowledge of: 1. Services and systems available in the community including primary health care,	Persons providing case management services must have knowledge of: • Services, systems, and programs available in the community including primary health care, support services, eligibility criteria and intake processes, generic community resources, and	(See education/experience requirements below)	The incumbent must have at entry level the following knowledge, skills and abilities. These must be documented or observable in the application form or supporting documentation or in the interview (with appropriate documentation).	For Support Coordination services to qualify as reimbursable services under Medicaid reimbursement, the individual employed as a Support Coordinator must have, at entry level, qualifications that are

support services, eligibility criteria and intake processes and generic community resources; 2. The nature of serious mental illness, mental retardation and/or substance abuse depending on the population served, including clinical and developmental issues; 3. Different types of assessments, including functional assessment, and their uses in service planning; 4. Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning and service coordination; 5. Types of mental health, mental retardation and substance abuse programs available in the locality; 6. The service planning process and major components of a service plan; 7. The use of medications in the care or treatment of the population served; and 8. All applicable federal	mental health, mental retardation, and substance abuse treatment programs; • The nature of serious mental illness, mental retardation, and substance abuse depending on the population served, including clinical and developmental issues; • Different types of assessments, including functional assessments, and their uses in service planning; • Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning, and service coordination; • The service planning process and major components of a service plan; • The use of medications in the care or treatment of the population served; and • All applicable federal and state laws, regulations, and local ordinances.		a. Knowledge of: (1) The definition, causes and program philosophy of mental retardation (2) Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning and service coordination (3) Different types of assessments and their uses in program planning (4) Consumers' rights (5) Local community resources and service delivery systems, including support services, eligibility criteria and intake process, termination criteria and procedures and generic community resources (6) Types of mental retardation programs and services (7) Effective oral, written and interpersonal communication principles and techniques (8) General principles of record documentation (9) The service planning process and the major components of a service plan	documented or observable to include: A.Knowledge of: 1. The definition, causes, and program philosophy of developmental disabilities; 2. Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning, and consumer-directed (CD) service facilitation; 3. Different types of assessments, including functional assessment, and their uses in service planning; 4. Human rights; 5. Local community resources and service delivery systems, including support services (e.g., housing, financial, social welfare, dental, educational, transportation, communications, recreation, vocational, legal/advocacy), eligibility criteria and intake processes, termination criteria and procedures, and generic community resources

and state laws, state regulations and local ordinances.				(e.g., churches, clubs, self-help groups); 6. Types of developmental disabilities programs and services; 7. Effective oral, written, and interpersonal communication principles and techniques; 8. General principles of record documentation; and 9. The service planning process and major components of a service plan.
Skills				
Qualifications of case management employees or contractors.	**Mental Health Case Management**	**Substance Abuse Case Management**	**Targeted MR/ID Case Management**	**Developmental Disability Case Management (Support Coordination)**
B. Employees or contractors providing case management services shall have skills in: 1. Identifying and documenting an individual's need for resources, services, and other supports; 2. Using information from assessments, evaluations, observation, and interviews to develop service plans; 3. Identifying and documenting how resources, services and	Persons providing case management services must have skills in: • Identifying and documenting an individual's needs for resources, services, and other supports; • Using information from assessments, evaluations, observation, and interviews to develop ISPs; • Identifying services and resources within the community and establishing service systems to meet the individual's needs and documenting how resources, services, and natural supports, such as family, can be utilized to achieve an individual's personal	(See education/experience requirements below)	b. Skills in: (1) Interviewing (2) Negotiating with consumers and service providers (3) Observing, recording and reporting behaviors (4) Identifying and documenting a consumer's needs for resources, services and other assistance (5) Identifying services within the established service system to meet the consumer's needs (6) Coordinating the provision of services by diverse public and private providers (7) Using information from assessments, evaluations,	B. Skills in: 1. Interviewing; 2. Negotiating with individuals and service providers; 3. Observing, recording, and reporting on an individual's behavior and functional level; 4. Identifying and documenting an individual's need for resources, services, and other supports; 5. Using information from assessments, evaluations, observation, and interviews to develop

natural supports such as family can be utilized to promote achievement of an individual's personal habilitative/rehabilitative and life goals; and 4. Coordinating the provision of services by diverse public and private providers.	habilitative, rehabilitative, and life goals; and • Coordinating the provision of services by public and private providers.		observation and interviews to develop service plans (8) Formulating, writing and implementing individualized consumer service plans to promote goal attainment for individuals with mental retardation; (9) Using assessment tools (10) Identifying community resources and organizations and coordinating resources and activities	service plans; 6. Identifying services within the community and established service system to meet the individual's needs; 7. Formulating, writing, and implementing individualized service plans to promote goal attainment; 8. Coordinating the provision of services by diverse public and private providers; 9. Identifying community resources and organizations and coordinating resources and activities; and 10. Using assessment tools (e.g., level of functioning survey).
Abilities				
Qualifications of case management employees or contractors.	**Mental Health Case Management**	**Substance Abuse Case Management**	**Targeted MR/ID Case Management**	**Developmental Disability Case Management (Support Coordination)**
C. Employees or contractors providing case management services shall have abilities to: 1. Work as team members, maintaining effective inter- and intra-agency working relationships; 2. Work independently performing position	Persons providing case management services must have abilities to: • Work with team members, maintaining effective inter- and intra-agency working relationships; • Work independently, performing position duties under general supervision; and • Engage and sustain ongoing relationships with individuals	(See education/experience requirements below)	c. Abilities to: (1) Demonstrate a positive regard for consumers and their families (e.g. treating consumers as individuals, allowing risk taking, avoiding stereotypes of people with mental retardation, respecting consumers' and families' privacy, believing consumers can grow) (2) Be persistent and remain	C. Ability to: 1. Be persistent and remain objective; 2. Work as a team member, maintaining effective inter- and intra-agency working relationships; 3. Demonstrate a positive regard for individuals and their families (e.g., treating recipients as

duties under general supervision; and 3. Engage and sustain ongoing relationships with individuals receiving services.	receiving services.		objective (3) Work as team member, maintaining effective inter- and intra-agency working relationships (4) Work independently, performing position duties under general supervision (5) Communicate effectively, verbally and in writing (6) Establish and maintain ongoing supportive relationships	individuals, allowing risk-taking, avoiding stereotyping of people with developmental disabilities, respecting individuals' and families' privacy, and believing individuals are valuable members of society); 4. Work independently performing position duties under general supervision; 5. Communicate effectively, verbally, and in writing; and 6. Establish and maintain ongoing supportive relationships.
Other				
Qualifications of case management employees or contractors.	**Mental Health Case Management**	**Substance Abuse Case Management**	**Targeted MR/ID Case Management**	**Developmental Disability Case Management (Support Coordination)**
	The provider must be a DBHDS-licensed case management provider, and case management must be provided by a qualified mental health case manager as defined above. The individual providing case management services is not required to be a member of an organizational unit that provides only case management. The case manager who is not a member of an organized case management unit must possess a job	1. The provider of substance abuse case management services must meet the following criteria: a. The enrolled provider must have the administrative and financial management capacity to meet state and federal requirements; b. The enrolled provider must have the ability to document and maintain individual case records in accordance with state and federal requirements;	A Community Services Board (CSB) Participation Agreement to provide MR/ID Targeted Case Management must be obtained by the CSB or Behavioral Health Authority (BHA) from DMAS. The CSB/BHA may directly operate MR/ID Targeted Case Management Services or may contract with private agencies. If services are contracted, the CSB/BHA remains the responsible provider, and only	Individuals and organizations providing Support Coordination services cannot be a direct service provider for any other DD Waiver service with the exception of CD Service Facilitation. An organization can be a Support Coordination provider and a CD Services Facilitation provider; however, one

	description that describes case management activities as job duties, must provide services as defined for case management, and must comply with service expectations and documentation requirements as required for organized case management units. To qualify as a provider of services through DMAS for Rehabilitative Mental Health Case Management for adults with serious mental illness and children and adolescents with serious emotional disturbance, the provider must meet the following criteria: • The provider must have the administrative and financial management capacity to meet state and federal requirements; • The provider must have the ability to document and maintain individual case records in accordance with state and federal requirements; • The services shall be in accordance with the Virginia Comprehensive State Plan for Mental Health, Mental Retardation, and Substance Abuse Services; and	c. The enrolled provider must be licensed by DBHDS as a provider of substance abuse case management services. 2. Providers may bill Medicaid for substance abuse case management only when the services are provided by a professional or professionals who meet at least one of the following criteria: a. Has at least a bachelor's degree in one of the following fields (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and has at least one year of substance abuse related clinical experience providing direct services to persons with a diagnosis of mental illness or substance abuse; b. Licensure by the Commonwealth as a registered nurse or as a practical nurse with at least one year of clinical experience.	the CSB/BHA may bill DMAS for Medicaid reimbursement. An employee of a CSB/BHA or provider, who providers MR/ID Targeted Case Management services, must possess a combination of MR/ID work experience and relevant education that indicates that he or she has the knowledge, skills, and abilities (KSAs) as established by DBHDS. A person providing MR/ID Targeted Case Management Services is not required to be a member of an organization unit that provides only case management services. The case manager who is not a member of an organized case management unit must possess a job description that describes case management activities as job duties, provide services as defined for MR/ID Targeted Case Management services, and comply with service expectations and documentation requirements as required for organized case management units. A case manager may not be the direct support staff, the immediate supervisor of a direct support staff or the CD services facilitator (SF) to an individual for whom he or she is providing case management services.	individual cannot provide both services to the same DD Waiver recipient. Support coordinators must also have back-up coverage available when the coordinator is absent due to illness, injury, or vacation. Individuals may be employed by an organization that provides Support Coordination services to the support coordinator's spouse, child, or other persons for which the Support Coordinator is the legal guardian. The individual, however, may not be directly involved in the provision of Support Coordination Services to these persons.