Case Management - Non-Medical, targeting Substance Use Disorders	Pg
Service Category Definition - State Services	**1**
NMCM-SUD Chart Review - The Resource Group This service was not reviewed in 2020. No historical data due to it being a newly funded service category. The review will be completed in 2022.	**6**
How a Case Manager Helps with the Treatment Process **- Sunrisehouse.com, June 2019**	**7**
Comprehensive Case Management for Substance Use Disorder Treatment - SAHMSA, 2021	**11**

Local Service Category:	**Care Coordination (Non-Medical Case Management) Targeting Substance Use Disorder**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions (**TRG Only**):	Maximum 10% of budget for Administrative Cost. Direct medical costs and Substance Abuse Treatment/Counseling cannot be billed under this contract.
DSHS Service Category Definition:	**Care Coordination** is a continuum of services that allow people living with HIV to be served in a holistic method. Services that are a part of the Care Coordination Continuum include case management, (both medical and non-medical, outreach services, referral for health care, and health education/risk reduction. **Non-Medical Case Management (N-MCM)** model is responsive to the immediate needs of a person living with HIV (PLWH) and includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, entitlements, housing, and other needed services. **Non-Medical Case Management Services (N-MCM)** provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. N-MCM services may also include assisting eligible persons living with HIV (PLWH) to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication (e.g., face-to-face, phone contact, and any other forms of communication) as deemed appropriate by the Texas DSHS HIV Care Services Group Ryan White Part B program. Limitation: Non-Medical Case Management services do not involve coordination and follow up of medical treatments.
Local Service Category Definition:	***Non-Medical Case Management:*** The purpose of Non-Medical Case Management targeting Substance Use Disorders (SUD) is to assist PLWHs with the procurement of needed services so that the problems associated with living with HIV are mitigated. N-MCM targeting SUD is intended to serve eligible people living with HIV in the Houston EMA/HSDA who are also facing the challenges of substance use disorder. Non-Medical Case Management is a working agreement between a PLWH and a Non-Medical Case Manager for an indeterminate period, based on PLWH need, during which information, referrals and Non-Medical Case Management is provided on an as- needed basis and assists PLWHs who do not require the intensity of Medical Case Management. Non-Medical Case Management is both office-based and field based. N-MCMs are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWH may be identified, including substance use disorder treatment/counseling and/or recovery support personnel. Such incoming referral coordination includes meeting prospective PLWHs at the referring provider location in order to develop rapport with and ensuring sufficient support is available. Non-Medical Case Management also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those PLWHs who have not returned

	for scheduled appointments with the provider nor have provided updated information about their current Primary Medical Care provider (in the situation where PLWH may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Non-Medical Case Management extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWH who are not currently accessing primary medical care services.
Target Population (age, gender, geographic, race, ethnicity, etc.):	**Non-Medical Case Management targeting SUD** is intended to serve eligible people living with HIV in the Houston EMA/HSDA, especially those underserved or unserved population groups who are also facing the challenges of substance use disorder. The target populations should also include individuals who misuse prescription medication or who use illegal substances or recreational drugs and are also: – Transgender, – Men who have sex with men (MSM), – Women or – Incarcerated/recently released from incarceration.
Services to be Provided:	**Goals:** The primary goal for N-MCM targeting SUD is to improve the health status of PLWHs who use substances by promoting linkages between community-based substance use disorder treatment programs, health clinics and other social service providers. N-MCM targeting SUD shall have a planned and coordinated approach to ensure that PLWHs have access to all available health and social services necessary to obtain an optimum level of functioning. N-MCM targeting SUD shall focus on behavior change, risk and harm reduction, retention in HIV care, and lowering risk of HIV transmission. The expectation is that each Non-Medical Case Management Full Time Equivalent (FTE) targeting SUD can serve approximately 80 PLWHs per year. **Purpose:** To promote Human Immunodeficiency Virus (HIV) disease management and recovery from substance use disorder by providing comprehensive Non-Medical Case Management and support for PWLH who are also dealing with substance use disorder and providing support to their families and significant others. **N-MCM targeting SUD** assists PLWHs with the procurement of needed services so that the problems associated with living with HIV are mitigated. **N-MCM targeting SUD** is a working agreement between a person living with HIV and a Non-Medical Case Manager (N-MCM) for an indeterminate period, based on identified need, during which information, referrals and Non-Medical Case Management is provided on an as- needed basis. The purpose of **N-MCM targeting SUD** is to assist PLWHs who do not require the intensity of *Clinical or Medical Case Management*. **N-MCM targeting SUD** is community-based (i.e. both office- and field-based). This Non-Medical Case Management targets PLWHs who are also dealing with the challenges of substance use disorder. N-MCMs also provide "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Efforts may include coordination with other case management providers to ensure the specialized needs of PLWHs who are dealing with substance use disorder are thoroughly addressed. For this population, this is not a

	duplication of service but rather a set of agreed upon coordinated activities that clearly delineate the unique and separate roles of N-MCMs and medical case managers who work jointly and collaboratively with the PLWH's knowledge and consent to partialize and prioritize goals in order to effectively achieve those goals. N-MCMs should provide activities that enhance the motivation of PLWHs on N-MCM's caseload to reduce their risks of overdose and how risk-reduction activities may be impacted by substance use and sexual behaviors. N-MCMs shall use motivational interviewing techniques and the Transtheoretical Model of Change, (DiClemente and Prochaska - Stages of Change). N-MCMs should promote and encourage entry into substance use disorder services and make referrals, if appropriate, for PLWHs who are in need of formal substance use disorder treatment or other recovery support services. However, N-MCMs shall ensure that PLWHs are not required to participate in substance use disorder treatment services as a condition for receiving services. For those PLWH in treatment, N-MCMs should address ongoing services and support for discharge, overdose prevention, and aftercare planning during and following substance use disorder treatment and medically-related hospitalizations. N-MCMs should ensure that appropriate harm- and risk-reduction information, methods and tools are used in their work with the PLWH. Information, methods and tools shall be based on the latest scientific research and best practices related to reducing sexual risk and HIV transmission risks. Methods and tools must include, but are not limited to, a variety of effective condoms and other safer sex tools as well as substance abuse risk-reduction tools, information, discussion and referral about Pre- Exposure Prophylactics (PrEP) for PLWH's sexual or drug using partners and overdose prevention. N-MCMs should make information and materials on overdose prevention available to appropriate PLWHs as a part of harm- and risk-reduction. Those PLWHs who choose to access primary medical care from a non-Ryan White source, including private physicians, may receive ongoing Non-Medical Case Management services from provider**.**
Service Unit Definition(s) (**TRG Only**):	One unit of service is defined as 15 minutes of direct services or coordination of care on behalf of PLWH.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA Services*.
Eligibility for Services:	PLWHs dealing with challenges of substance use/abuse and dependence. Resident of the Houston HSDA.
Agency Requirements (**TRG Only**):	These services will comply with the TRG's published **Non-Medical Case Management Targeting Substance Use Disorder** Standards of Care and policies and procedures as published and/or revised, including linkage to the CPCDMS data system as well as DSHS Universal Standards and Non-Medical Case Management Standards of Care. **Non-Medical Case Management targeted SUD** must be planned and delivered in coordination with local HIV treatment/prevention/outreach programs to avoid duplication of services and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

	Subrecipients must document established linkages with agencies that serve PLWH or serve individuals who are members of high-risk population groups (e.g., men who have sex with men, injection drug users, sex-industry workers, youth who are sentenced under the juvenile justice system, inmates of state and local jails and prisons). Contractor must have formal collaborative, referral or Point of Entry (POE) agreements with Ryan White funded HIV primary care providers.
Staff Requirements:	Minimum Qualifications: **Non-Medical Case Management Workers** must have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing services to PLWH may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Non-Medical Case Management Workers must have a minimum of one (1) year work experience with PLWHA and/or substance use disorders. Supervision: The Non-Medical Case Management Worker must function within the clinical infrastructure of the applicant agency and receive ongoing supervision that meets or exceeds TRG's published **Non-Medical Case Management Targeting Substance Use Disorder** Standards of Care.
Special Requirements (**TRG Only**):	Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Universal Standards and non-Medical Case Management Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service. Contractor must be licensed in Texas to directly provide substance use treatment/counseling. Non-medical Case Management services can be delivered via telehealth and must follow applicable federal and State of Texas privacy laws.

FY 2023 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**			Date: **06/09/2022**
Recommendations:	Approved: Y:_____ No: ______ Approved With Changes:______	If approved with changes list changes below:	
1.			
2.			
3.			

Step in Process: **Steering Committee**			Date: **06/02/2022**
Recommendations:	Approved: Y:_____ No: ______ Approved With Changes:______	If approved with changes list changes below:	
1.			
2.			
3.			

Step in Process: **Quality Improvement Committee**			Date: **05/03/2022**
Recommendations:	Approved: Y:_ ___ No: ______ Approved With Changes: _______	If approved with changes list changes below:	
1.			
2.			
3.			

Step in Process: **HTBMTN Workgroup #2**		Date: **04/19/2022**
Recommendations:	Financial Eligibility:	
1.		
2.		
3.		

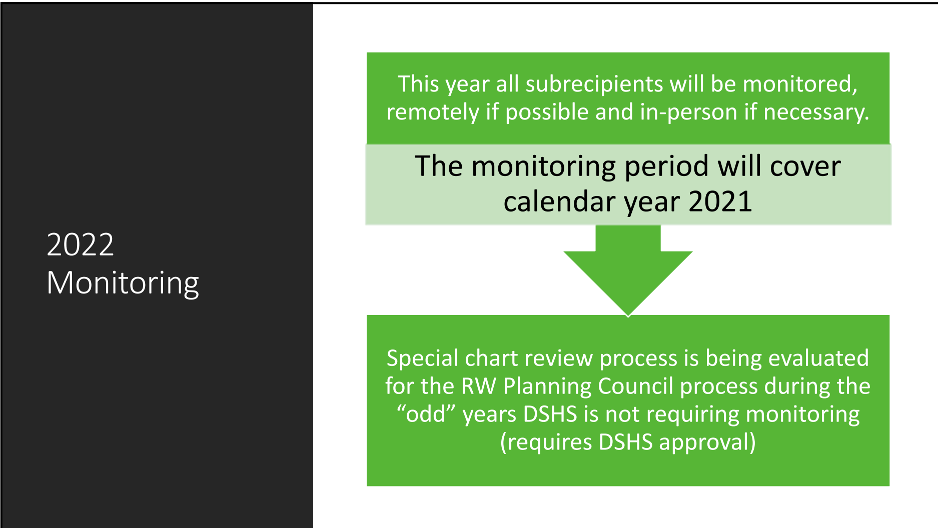
Modified Monitoring Process

Effective March 13, 2020 TRG enacted emergency response procedures due to COVID-19 pandemic. All monitoring was deferred/suspended in 2020 per DSHS and HRSA guidance.

In 2020, DSHS launched a burden reduction plan to reduce administrative burden by 50% for AA's and Subrecipients.

- This model requires subrecipient monitoring every other year (even years only).
- Per DSHS guidance, TRG is not required to complete monitoring in odd years
- In 2020, subrecipients that didn't have the ability to complete a remote review, were exempted from the 2020 Standards of Care chart review monitoring due to the COVID-19 State of Emergency.

2022 Monitoring



NOT REVIEWED IN 2020. NO HISTORICAL DATA DUE TO IT BEING A NEWLY FUNDED SERVICE CATEGORY. REVIEW WILL BE COMPLETED IN 2022.

Non-Medical Case Management-SUD

How a Case Manager Helps with the Treatment Process

Written by: Editorial Staff Last updated on June 25, 2019

A case manager is an advocate who takes on clients with complex issues and finds integrated treatment options beyond just detox and rehabilitation. Although case management has roots in social work, the position does not involve training to become a social worker and instead involves working across multiple disciplines to help clients get services they need to maintain a healthy lifestyle. The job has become increasingly popular since the 1980s, especially for those overcoming addiction or substance abuse.

Types of Treatment Case Managers

- Broker/generalist
- Strengths-based perspective
- Assertive community treatment
- Clinical/rehabilitation

What Case Managers Do

- Screening and assessment
- Brokering for resources
- Developing case plans
- Determining eligibility for benefits
- Evaluating Progress

Case managers are involved in multiple therapeutic and medical disciplines, including helping ex-convicts, people with chronic or mental illnesses, homeless and formerly homeless individuals, and those overcoming addiction. The position requires advocating for all kinds of assistance, including help with prescription medications, routine doctors' appointments, housing, job retraining, and more. Case managers typically work with multiple clients at once through an organization like a hospital or charity; however, case managers tend to focus on one discipline, such as substance abuse.

It is important for case managers to have some core competencies. These include:

- Understanding models of addiction and substance abuse, especially as these relate to finding treatment and other resources
- Describe these philosophies and scientific approaches to their client to help focus treatment
- Recognize the importance of family, social networks, and community on the treatment and recovery plan
- Maintain working knowledge of treatment options, including government, insurance, and more
- Understand diverse cultures to incorporate cultural differences as a way of supporting treatment rather than working against it
- Appreciate and promote an interdisciplinary approach to addiction treatment

There are a few types of case managers, and each has basic expectations for how their job will be performed.

Case Management Models

There are four basic types of case managers. These are:

- ***Broker/generalist***: This type of case manager links their clients with appropriate services as rapidly as possible. The case manager provides few direct services beyond initial assessment; however, once the level of need has been determined, this type of case manager can get referrals to a variety of agencies, including drug testing services, work training, and housing. This type of case management is often found in settings involving a high volume of clients, such as probation court or hospitals.

- ***Strengths-based perspective***: This form of case management develops a longer-term relationship between the client and the case manager. The two work together to develop a treatment plan based on what the individual believes are their strengths and focuses on getting treatment that involves building on those strengths. That could include non-institutional treatments, such as complementary medicine or spiritual direction.

- ***Assertive community treatment***: This style involves case managers meeting clients in their "natural settings," often at home or nearby. The management system focuses on daily living needs, like prescription medications, housing, income, and help for children. Individuals meet with

their case managers on a frequent, regular basis, and the relationship is developed with the aim of the two maintaining a long-term commitment to managing the individual's substance use disorder and any co-occurring mental health issues.

- ***Clinical/rehabilitation*:** In this type of case management, the individual works with a case manager who provides integrated clinical treatments in addition to managing resources; these treatments can include therapy, counseling, skills development, intervention, and more. This is another long-term type of case management since the relationship between therapist/case manager and client is integral to the healing process.

What Case Managers Can Do

Regardless of the model used to manage their clients, a case manager is expected to provide six primary types of assistance, especially in a substance abuse rehabilitation setting. These are:

- ***Screening and assessment*:** This is the initial assessment of a new client. It involves determining their condition, strengths, treatment needs, and ultimate goals.
- ***Brokering for resources*:** The case manager will take information gathered during their assessment and begin contacting services through the Department of Health, Social Security Administration, insurance, community partners, child welfare organizations, and vocational rehabilitation as needed.
- ***Developing case plans*:** The primary goal of case management, whether the relationship is short-term or long-term, is to help the client find the resources they need to become and remain healthy and self-sufficient. The case plan is essentially a roadmap, created by the case manager with extensive input from the client. In most case management models, the client must agree with the plan. Each step of the plan shows how the individual will use resources to overcome addiction, find work and housing, and maintain sobriety.
- ***Determining eligibility for benefits*:** Once the plan has been agreed to, the case manager helps the client fill out paperwork to apply for benefits. These could be social security or disability benefits, Medicare or Medicaid, insurance coverage, food stamps, or charity help. In some cases, this could also be contacting support groups, churches, or nonmedical treatment services.
- ***Evaluating progress*:** The case manager either maintains contact with the client to receive updates on progress, gathers progress reports from outside

services like rehabilitation and therapists, or both. By using milestones to track the client's progress, the case manager can determine how effective the treatment plan is and whether it should be re-evaluated.

- ***Recording case progress*:** Leaving a paper trail helps to track an individual's progress on a long-term basis. If the person leaves the case manager's care but then returns for support later, their original plan, level of completion, and overall effectiveness will remain on record for future reference. This can help with the development of a new plan, or it may involve a return to the original plan.

When Is a Case Manager Needed?

When a person overcoming substance abuse works with a case manager, they are better able to coordinate several outpatient services. This may include detox and outpatient rehabilitation, but it can also include a continuation of care after hospitalization and inpatient rehabilitation. Finding a place in a sober living home, maintaining prescription medications, getting transportation to therapy appointments, and finding support groups are all things a case manager can help with.

While anyone overcoming addiction can benefit from the help a case manager provides, demographics that particularly benefit include adolescents and young adults; older adults and the elderly; those who have relapsed in the past; those diagnosed with co-occurring mental health and substance abuse disorders; and those who have struggled with polydrug abuse.

SAMHSA ADVISORY

Substance Abuse and Mental Health Services Administration

COMPREHENSIVE CASE MANAGEMENT FOR SUBSTANCE USE DISORDER TREATMENT

The definition of case management varies by setting, but in general terms it is a coordinated, individualized approach that links patients[1] with appropriate services to address their specific needs and help them achieve their stated goals. Case management for patients with substance use disorders (SUDs) has been found to be effective because it helps them stay in treatment and recovery. Also, by concurrently addressing other needs, it allows patients to focus on SUD treatment. The types of settings offering SUD case management include specialty treatment programs, federally qualified health centers, rural health centers, community mental health centers, veterans' health programs, and integrated primary care practices.

This *Advisory* is based on the Substance Abuse and Mental Health Services Administration's (SAMHSA) Treatment Improvement Protocol (TIP) 27, *Comprehensive Case Management for Substance Abuse Treatment*. It surveys the underlying principles and models of case management, discusses reasons SUD treatment providers might consider implementing or expanding the use of case management, and lists some case management-related resources and tools.

Key Messages

- Case management is framed around screening to identify a patient's medical, psychosocial, behavioral, and functional needs, and then working directly and/or through community resources to address these needs while the SUD is treated.
- Case management is increasingly used to support treatment engagement and retention while reducing the impact of SUDs on the community.
- The SUD treatment program can select a case management model that matches its treatment approach and best suits its patients and the service setting.
- In any type of case management model employed, all care team members should contribute to and endorse the patient's treatment plan, and effectively communicate with each other as the plan is implemented.

Case Management Overview

The percentage of U.S. SUD treatment programs using case management has risen since 2000, from 66 percent of the 13,418 facilities then in operation to 83 percent of the 15,961 facilities operating in 2019 (SAMHSA, 2020c; SAMHSA, Office of Applied Studies, 2002).

[1]This publication uses only the term "patients" to describe recipients or potential recipients of case management services. In practice, depending on the setting and the context, the terms "clients" or "participants" are also frequently used.

Definitive statements about the overall effectiveness of case management cannot be made, because studies vary in their definitions of the term, methodology, study populations, intervention designs, and outcome measures. However, multiple analyses (Joo & Huber, 2015; Kirk et al., 2013; Penzenstadler et al., 2017; Rapp et al., 2014; Regis et al., 2020) have found positive outcomes for one or more measures, such as treatment adherence, overall functioning, costs, decreases in substance use, reductions in acute care episodes, and increased engagement in nonacute services. A 2019 meta-analysis comparing case management with treatment as usual showed a small yet statistically significant positive effect, which was greater for treatment-related tasks than for personal functioning outcomes such as improved health status and family relations and reductions in substance use and legal involvement (Vanderplasschen et al., 2019).

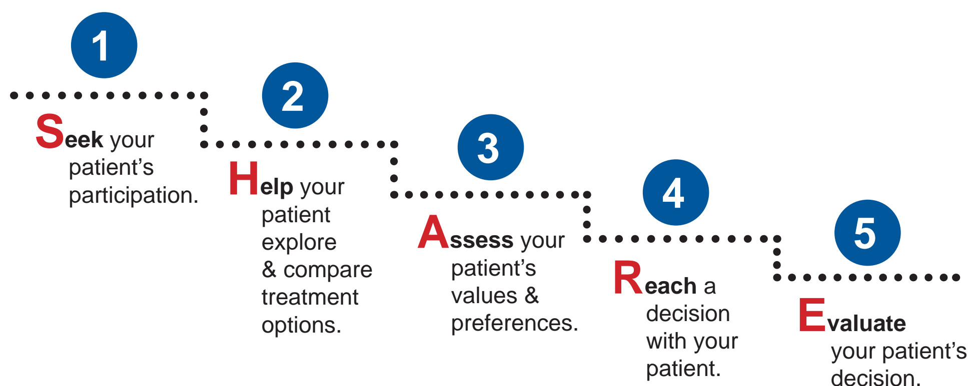
Principles of case management

It offers the patient a single point of contact with the health and social services system. The case manager assumes responsibility for coordinating the care of patients who receive services from multiple agencies. This replaces a haphazard process of referrals with a single, more well structured service.

It is patient centered. Each patient's right to self-determination is emphasized. The case manager is familiar with the patient's experiences and world, and uses this understanding to identify psychosocial stressors and anticipate needs. The case manager works with the patient to set reasonable goals (see box) and helps the patient access the chosen services.

Shared Decision Making

One aspect of patient-centered care is using shared decision making rather than a directive approach with patients. Shared decision making is an emerging best practice that "aims to help people in treatment and recovery have informed, meaningful, and collaborative discussions with providers" (SAMHSA, 2020d) about the behavioral healthcare services they receive. The federal Agency for Healthcare Research and Quality (AHRQ) has developed a five-step process for shared decision making and resources for implementing it.



Adapted from material in the public domain.

It is community based. The case manager helps the patient access and integrate formalized and informal care services, overcome barriers to services, and transition between services. Case managers vary in how much they are directly involved with community services (e.g., whether they make warm handoffs or accompany patients to meetings).

It is equity driven. Typically, the case manager begins by addressing a patient's urgent and tangible needs, such as stable and safe housing, food, child care, or income. The case manager does this work recognizing that when viewed through a social determinants of health (SDOH) lens (see box), some populations disproportionately lack such life-enhancing resources—and that for some patients, access to one or more of these resources may be a prerequisite for focusing on treatment.

Social Determinants of Health

SDOH have been defined as "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks" (U.S. Department of Health and Human Services, n.d.), including risk for substance misuse and related health consequences (Office of the Surgeon General, 2016). Case managers can play a central role in assessing SDOH and in assisting to develop a plan that effectively takes them into account (Fink-Samnick, 2018).

It involves advocacy. The case manager promotes the patient's best interests. This can include educating service providers, negotiating for services, and recommending actions (e.g., using sanctions instead of jail time for patients involved with the justice system). Advocacy can also involve speaking out and acting on behalf of a patient who is refused services (e.g., because of discriminatory attitudes toward people with SUDs) or who requires assistance with meeting basic needs.

It is culturally sensitive and nonstigmatizing. The case manager is knowledgeable and nonjudgmental about the patient's culture. This enables the case manager to effectively connect with the patient and service providers in the patient's community. Another key function of the case manager is to model nonstigmatizing language, attitudes, and actions for other service providers (Volkow, 2020).

It is pragmatic. The case manager may also teach skills helpful to recovery (e.g., assertive communication, collaboration with a team of providers, day-to-day skills for living in the community). These pragmatic skills may be taught explicitly, or simply modeled during interactions between the case manager and client.

Care management versus case management

"Care management" refers to services that help a patient manage one or more chronic diseases, such as diabetes or cardiovascular disease. Case management is usually more limited in scope and time commitment (Ahmed, 2016; Centers for Medicare & Medicaid Services, 2019). For example, a case manager may be involved in a patient's care for only one or a few specific needs, such as transportation to treatment or help in applying for Medicaid (Case Management Society of America, 2020; Treiger, 2020). However, a patient with an SUD may need the kind of sustained help that is more like care management. Assistance from a case manager may be offered along the full continuum of care, and for as long as it benefits the patient.

Models of case management

Variations in the case manager's role are illustrated in the "Models of Case Management" table, which compares four case management models across 11 activities. (See TIP 27, Introduction, pp. 9–11, for descriptions of each model.) Whichever model is used, all members of the care team should contribute to and endorse a shared care plan for the patient, and effectively communicate with each other as the plan is implemented (van Dongen et al., 2016). It is important to note that certification programs exist for case managers, but not all case managers are required to be certified by the relevant authorities (e.g., state Medicaid authorities and/or state mental health authorities).

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Models of Case Management				
Primary Case Management Activities	**Broker/Generalist**	**Strengths Perspective**	**Assertive Community Treatment**	**Clinical/ Rehabilitation**
Conducts outreach and case finding	Not usually	Depends on agency mission & structure	Depends on agency mission & structure	Depends on agency mission & structure
Provides assessment and ongoing reassessment	Specific to immediate resource acquisition needs	Strengths-based; applicable to any of a patient's life areas	Broad-based; part of a comprehensive (biopsychosocial) assessment	Broad-based; part of a comprehensive (biopsychosocial) assessment
Assists in goal planning	Generally brief; related to acquiring resources, possibly informal	Patient-centered; teaches how to set goals and objectives; goals may include any of a patient's life areas	Comprehensive; goals may include any of a patient's life areas	Comprehensive; goals may include any of a patient's life areas
Makes referrals to needed resources	Initiates contact, or patient may contact on own	Contacts resource or accompanies a patient, or patient may contact on own	Multiple resources, as needed, are integrated into a broad package of case management services	Contacts resource or accompanies a patient, or patient may contact on own
Monitors referrals	Makes follow-up checks	Closely involved in ongoing relationship between patient and resource	Closely involved in ongoing relationship between patient and resource	Closely involved in ongoing relationship between patient and resource
Provides therapeutic services beyond resource acquisition (e.g., therapy, skills teaching)	Provides referral to other sources for these services if requested	Usually limited to answering patient questions about treatment, helping identify strengths and self-help resources	Provides many services within a unified package of treatment/case management services	Provides therapeutic activities central to the model
Helps develop informal support systems	No	Develops informal resources—neighbors, places of worship, family—a key principle of the model	Through implementation of drop-in centers and shelters	Stresses family & mutual-help support via therapeutic activities

continued on next page

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Models of Case Management (continued)				
Primary Case Management Activities	**Broker/Generalist**	**Strengths Perspective**	**Assertive Community Treatment**	**Clinical/ Rehabilitation**
Responds to crises	Responds to crises related to resource needs such as housing	Responds to crises related to mental health and resource needs; active in stabilization and then referral	Responds to crises related to mental health and resource needs; active in stabilization and then referral	Responds to crises related to mental health and resource needs; stabilizes situation, provides further therapeutic intervention
Engages in advocacy on behalf of individual patients	Usually only at level of line staff	Assertively advocates for patients' needs with multiple systems, including agencies, families, legal systems, and legislative bodies	Assertively advocates for patients' needs with multiple systems, including agencies, families, legal systems, and legislative bodies	Assertively advocates for patients' needs with multiple systems, including agencies, families, legal systems, and legislative bodies
Engages in advocacy in support of resource development	Not usually	Usually in the context of specific patient needs	Advocates for needed resources or may create resources	Usually in the context of specific patient needs
Provides direct services related to resource acquisition (e.g., drop-in center, employment counseling)	Provides referral to resources that provide direct services	Helps prepare patient to acquire resources (e.g., by role-playing, accompanying patient to interviews)	Provides many direct services within a unified package of treatment/case management	Provides services that are part of a rehabilitation services plan; offers skill teaching
Adapted from TIP 27, Figure 1-2, pp. 7–8.				

Factors Underlying the Increased Use of Case Management for Patients With SUD

Reasons behind the increasing use of case managers in SUD treatment programs include the following:

Many patients with SUDs have co-occurring mental disorders and comorbid conditions that providers recognize need concurrent treatment. For example, in 2019, an estimated 49 percent of adults with an SUD also suffered a co-occurring mental illness, and of these individuals an estimated 38 percent had a serious mental illness (SAMHSA, 2020b). Common comorbid diseases include cardiovascular disease, hepatitis, and HIV/AIDS (National Institute on Drug Abuse, 2020). The services of a case manager become especially important for patients with an SUD who must navigate complex health systems to obtain treatment for all their psychiatric and medical care needs or who must adhere to

a medication regimen that may involve multiple prescriptions from one or more care providers. In such an instance, the case manager must be familiar with the patient's full medication regimen (National Council for Behavioral Health, 2020).

Programs increasingly recognize that helping patients address basic needs, as determined by a comprehensive SDOH assessment, is essential to treatment (American Public Health Association, 2014). For example, based on needs identified in the comprehensive SDOH assessment, case managers may help patients apply for Medicare, obtain transportation vouchers, or receive housing assistance so that they are better positioned to engage in and benefit from treatment. (See Chapter 5 of TIP 27 for strategies on assisting special needs populations.)

The rate of acute health crises related to drug use continues to increase. Since 1999, U.S. deaths from opioid, other drug, and polysubstance use have trended upward (Centers for Disease Control and Prevention [CDC], 2019), increasing by 10 percent from March 2019 to March 2020 (Ahmad et al., 2020). The numbers of nonfatal overdoses, hospitalizations, and emergency department visits have also increased considerably (AHRQ, 2019, 2020; Vivolo-Kantor et al., 2020; Weiss et al., 2017). For people who enter the health system through emergency services for an SUD-related crisis, case managers can help access follow-up services and care (Sortedahl et al., 2018). For example, a hospital case manager can help coordinate a drug transition plan for a patient with pain seen in the emergency department for prescription opioid overdose. Often, peer recovery support specialists are embedded in these medical settings to help assist with the initial case management needs of patients with an SUD. These specialists have lived experience with recovery and are trained to help patients with SUDs engage in treatment and enter long-term recovery.

Multiple developments in healthcare and behavioral health services are expanding the use of case management (Ahmed, 2016). These include:

- More emphasis on medical and behavioral health integration, which creates a need for coordination of services—a need that case managers can fulfill.
- Greater use of screening, brief intervention, and referral to treatment (SBIRT) tools in care settings, which can involve case managers in implementation, follow-up, and coordination of care.
- Growing adoption of reimbursement for chronic care management and value-based care by Medicare and other insurers; case managers may be involved in monitoring, measuring, and evaluating outcomes achieved by the care team (Tahan et al., 2020).
- The development of health information technology solutions that facilitate care coordination and patient-centered care.
- Increased use of peer recovery support specialists, who can cost effectively extend the services of case managers by guiding people in SUD treatment on their journey through recovery-oriented systems of care (prevention, intervention, treatment, posttreatment).
- Recent changes to the federal regulations governing the confidentiality of SUD patient records that make it easier to use information in such records for case management and care coordination activities (SAMHSA, 2020a).
- The movement of health systems toward a population-based approach to behavioral health care and a systems-wide focus on health equity, cultural competence, and cultural responsiveness. Case managers may participate in community health assessments (CDC, n.d.), and they may also help educate the treatment team about how addressing SDOH can contribute to greater health equity and therefore better health.

Case management services can benefit the individual who needs short-term help in connecting to SUD treatment, or some specific ancillary service that facilitates access to treatment (e.g., transportation, child care). However, case management is especially helpful for people with complex or chronic health and social services needs. Ideally, case management supports the philosophy of "no wrong door." This means that however people enter the healthcare and social services system (whether through the emergency department, a law enforcement encounter, hospitalization, a prevention program, an initial visit to a treatment program, a primary care visit, a shelter stay, or some other entry point), a case manager links them with the range of services they want or need.

Resources

- **Substance Abuse and Mental Health Services Administration (SAMHSA)**
  - Addiction Technology Transfer Center (ATTC) Network Anti-Stigma Toolkit: Guide to Reducing Addiction-Related Stigma
  - Screening, Brief Intervention, and Referral to Treatment (SBIRT) Tools
  - Technical Assistance Publication (TAP) 21, *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice*
  - TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* (see also the Editor's Note on TIP 27)
  - TIP 59, *Improving Cultural Competence*
- **American Case Management Association (ACMA)**
- **Case Management Society of America (CMSA)**
- **Integrated Communities Care Management Toolkit**
- **National Association of Community Health Centers**
  - Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)
- **National Institute on Drug Abuse (NIDA)**
  - Words Matter: Terms to Use and Avoid When Talking About Addiction
- **Pair of ACEs Tree**
- **SIREN (Social Interventions Research & Evaluation Network) Resources**
- **2·1·1 Social Services Database**
- **Think Cultural Health**

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