CommunityConnect

My Recovery. My Story.

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Background

In 2017, the Department of Human Services and the Department of Corrections and Rehabilitation collaborated to establish a community-based behavioral health program, Free Through Recovery. The program was designed to increase access to recovery support servicesfor individuals engaged with the criminal justice system and who have behavioral health concerns.

Stakeholders in the North Dakota Behavioral Health System Study 2018 reported that North Dakota's current behavioral health system is "primarily crisis oriented and pays inadequate attention to rehabilitative and community-based services." The study identified a recommended(4.1) to ensure access to needed recovery support services, including providing funds to supportthe implementation of a "Free Through Recovery" program separate from the criminal justice system. During the 2019 North Dakota legislative session, Senate Bill 2012 passed which created a new section in ND Century Code and provided funding to implement such program (see ND Century Code excerpt below).

50-06-41.2. Community behavioral health program.

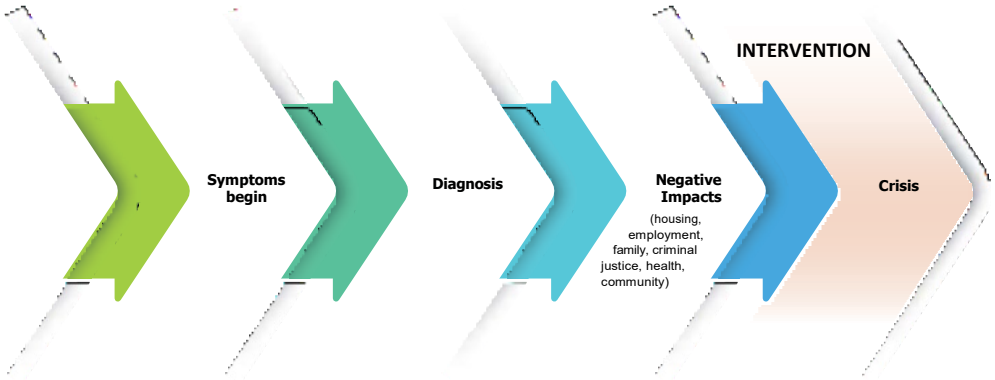
1. The department of human services shall establish and implement a community behavioral health program to provide comprehensive community-based services for individuals who have serious behavioral health conditions.
2. In developing the program, the department shall:
   a. Establish a referral and evaluation process for access to the program.
   b. Establish eligibility criteria that includes consideration of behavioral health condition severity.
   c. Establish discharge criteria and processes.
   d. Develop program oversight and evaluation processes that include outcome and provider reporting metrics.
   e. Establish a system through which the department:

i. Contracts with and pays behavioral health service providers.
ii. Supervises, supports, and monitors referral caseloads and the provision of services by contract behavioral health service providers.
iii. Requires contract behavioral health service providers to accept eligible referrals and to provide individualized care delivered through integrated multidisciplinary care teams.
iv. Provides payments to contract behavioral health service providers on a per-month per-referral basis based on a pay-for-performance model that includes consideration of identified outcomes and the level of services required.

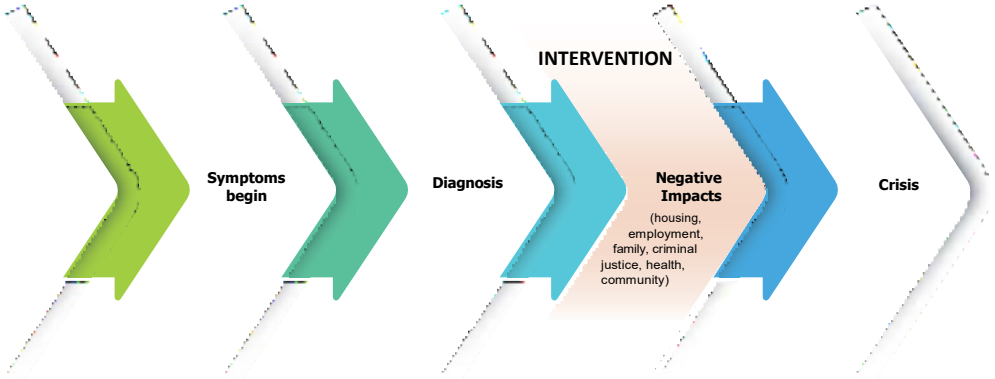
Program Mission and Goals

The unfortunate reality is that we typically become aware of an individual's needs at the time of a crisis. Many of the current interventions focus on immediate crisis relief and are generally reactionary.

The current systems assisting individuals are often disjointed, there are no clear steps or responsibility, the individual's current services do not meet their needs, and there is a separation in services for recipients. Without supportive community-based services, this type of system can lead to criminal justice involvement, utilization of emergency services, foster care placements, unemployment, and homelessness.



Community Connect will connect and assist individuals in navigating appropriate services to address their needs and goals, preventing individuals from becoming further involved in other systems such as, child welfare and criminal justice systems. Providing cross-sector partnership across government agencies and community-based providers to assist with responding more proactively to meet the needs of individuals in communities before they reach a higher level of risk or need.



Community Connect will provide community-based behavioral health services designed to assist individuals with meeting their needs and goals through the provision of care coordination, recovery services and peer support services.

SERVICES

Care Coordination

Care Coordinators provide a source of connection, support, and motivation for long-and short-term goals while creatively problem-solving barriers.

Peer Support

A supportive relationship with a peer who has similar lived experience, and who serves as an advocate mentor, and who offers sound advice and resources.

Recovery Services

Recovery looks differently for everyone. A provider can assist with access to nourishment assistance programs, supportive housing, educational opportunities, meaningful employment, leisure activities and wellness, family and community social supports, parenting education, spiritual engagement, and any other individualized resources needed to help lead a healthy and fulfilling life.

Click here to apply for Community Connect

Mission

To provide quality, community-based behavioral health services that promote collaboration and partnership to meet the individual needs of every person served

Principles

To provide targeted, collaborative partnership services to develop relevant, culturally appropriate care plans that address underlying needs, build on strengths, and draw from community supports.

A strengths-based, trauma-informed approach to addressing the needs of individuals.

The North Dakota Behavioral Division is committed to the principles outlined below. These principles are not comprehensive. Other values and best practices may guide the development and implementation of this program.

Data Driven

Measure Relevant Practices and Processes: Outcome measures will be identified, tracked, and reported for use in determining the overall success of the program at assisting participants in improved behavioral health functional status. Data will be used to determine which specific aspects of the program correlate to the success of its participants.

Recovery-Oriented

Engage Ongoing Support in the Community: The program emphasizes the importance of access to a full continuum of behavioral healthcare, beyond traditional treatment strategies. To that end, recovery-based services such as peer support, recovery coaching, physical healthcare, and housing and employment support are engaged.

Transparent

Provide Measurement Feedback: Data will be provided to stakeholders at various levels to guide their participation and practices relevant to the program. Feedback will be provided to inform decision-making and improve practices related to the program.

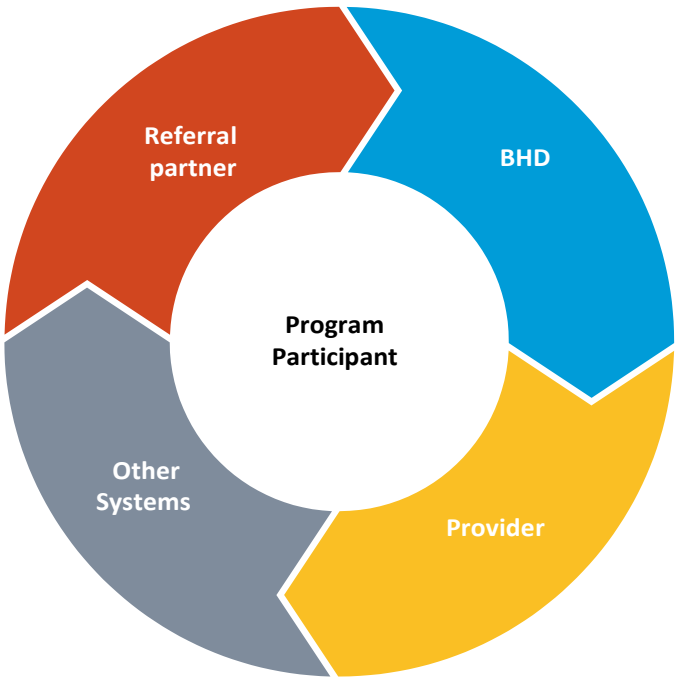
Trauma-Informed

A strengths-based service delivery approach that is grounded in an understanding of the responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors. This approach creates opportunities for survivors to rebuild a sense of control and empowerment.

Person-Centered Care

Participants have control over their services, including the amount, duration, and scope of services, as well as choice of providers. Person-centered care is respectful and responsive to the cultural, linguistic, social, and environmental needs of the individual.

Program Overview



Referral Partner

A referral partner will access the application for eligibility. These referral partners will include but are not limited to, human service zones, private behavioral health providers, human service centers, early intervention providers, courts, justice system and education providers. The application for eligibility is not limited to any specific group or person.

An individual that's interested in the services provided by Community Connect could also complete the application for eligibility on their own or with the help of a friend or family member.

Behavioral Health Division (BHD)

North Dakota Behavioral Health Division will be responsible for admissions, discharges, contracting with providing agencies, behavioral health best practices, outcomes, payments, and overall program administration

Providers

Private agencies within North Dakota will enter into an agreement with the North Dakota Behavioral Health Division to provide care coordination and access to recovery services including peer support.

Other Systems

Community Connect services will include cross-sector partnership and collaboration with other systems including but not limited to, tribal communities, human service zones, division of juvenile services, public and private behavioral health providers, children and family services, educational institutions, and courts.

Individual Eligibility

To meet the criteria for Community Connect an individual must meet the following criteria:

- 18 years of age or older
- Resides in North Dakota
- Have a Mental Health or Substance Use Disorder diagnosis impacting their functionality in multiple domains including housing, employment, parenting, physical health, and/or community connections.

Applications for eligibility will be prioritized based on the severity of impact from the identified behavioral health conditions and additional priority will be given to:

- Parents and caregivers
- Parents and caregivers with child protection services involvement
- Pregnant women
- Individuals that utilize emergency and detox centers
- Individuals who are homeless or at risk of homelessness

To apply for Community Connect please access the application at behavioralhealth.nd.gov/community-connect

Referral

A referral partner will access the application for eligibility online. These referral partners include but are not limited to, human service zones, private behavioral health providers, human service centers, early intervention providers, courts, justice system and educational providers. An individual that is interested in the services provided in Community Connect can also complete the eligibility application on their own. The application is accessibleto any individual in the community, access is not restricted to any certain individuals or groups.

Once an application for eligibility is submitted it will be reviewed by the Behavioral Health Division, if approved the applicant will be notified. If denied, the applicant will be notified and connected to additional community-based resources.

Becoming a Provider

The strength of the behavioral health workforce in North Dakota comes from wide range of providers, consisting of large, statewide organizations, to one-person shops, all serving the community. Providers represent every area of service, culture, gender, faith, etc. and work together to support participant's choice and the many different roads to recovery.

Provider Requirements

Providers must at a minimum:

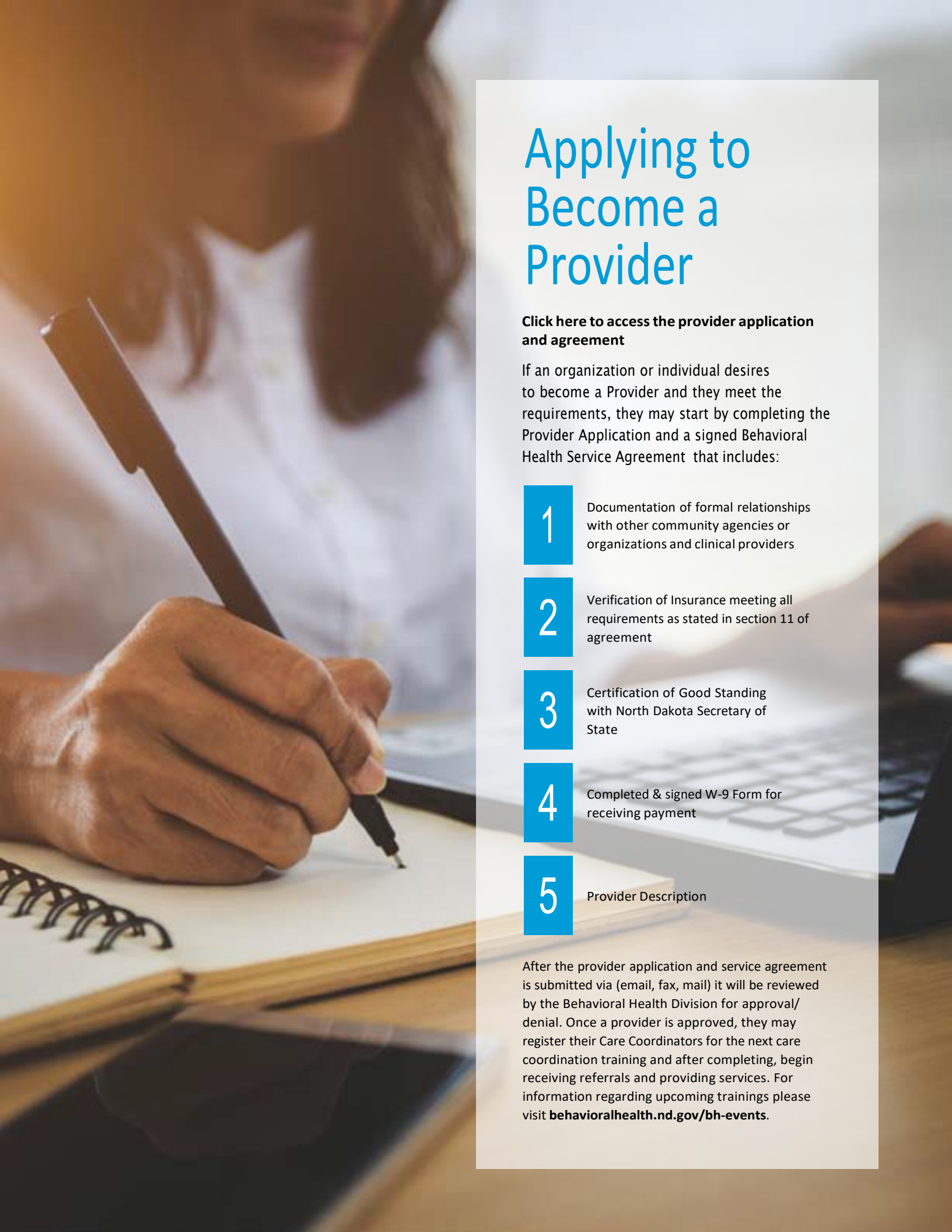
- Accept all referrals provided by BHD unless the Provider is at program capacity.
- Ensure that each participant is assigned a Care Coordinator.
- Hold an "intake" meeting with each participant within three days of referral.
- Provide a comprehensive, collaborative care plan with each participant within 10 days of referral. Please note this care plan must be reviewed and updated monthly.
- Submit care plans, outcomes and case note documentation by the 5th of each month for all program participants.
- Match participants to a peer support specialist based on demographics, personality, and lived experience.
- Demonstrate experience providing services to individuals with complex needs including mental illness, substance use disorders.
- Establish and maintain formal relationships with community providers to ensure participants have timely access to a full continuum of behavioral healthcare.
- Submit documentation confirming formal collaboration with community agencies.

Additionally, providers must:

- Participate in meetings, trainings, and technical assistance as requested by the Behavioral Health Division.
- Share information regarding the maximum number of clients the provider can effectively serve.
- Collect and share data regarding program participants, services and outcomes related to employment, financial, housing, criminal justice involvement, parenting, engagement, and discharge, etc.
- Engage in regular performance and progress assessments and meetings.
- Receive skill training and coaching from BHD.
- Ensure participants have access to 24-hour crisis intervention services.

Providers are also required to demonstrate the following:

- Assessment of the participant's needs.
- Development of warm, empathic, and helpful professional relationships with participants.
- Cross-sector partnership and collaboration with other systems including but not limited to, tribal social services, zone social service, division of juvenile services, public and private behavioral health providers, children and family services, educational institutions, and courts.
- Timely completion of requested documentation, data, reports, and plans.
- Identification and reporting of gaps between needed and available community-based support services, as well as development of creative plans to fill identified gaps, to positively impact participant needs and outcomes.



Applying to Become a Provider

Click here to access the provider application and agreement

If an organization or individual desires to become a Provider and they meet the requirements, they may start by completing the Provider Application and a signed Behavioral Health Service Agreement that includes:

1. Documentation of formal relationships with other community agencies or organizations and clinical providers
2. Verification of Insurance meeting all requirements as stated in section 11 of agreement
3. Certification of Good Standing with North Dakota Secretary of State
4. Completed & signed W-9 Form for receiving payment
5. Provider Description

After the provider application and service agreement is submitted via (email, fax, mail) it will be reviewed by the Behavioral Health Division for approval/ denial. Once a provider is approved, they may register their Care Coordinators for the next care coordination training and after completing, begin receiving referrals and providing services. For information regarding upcoming trainings please visit **behavioralhealth.nd.gov/bh-events**.

Care Coordination

What is Care Coordination

Care Coordinators provide a source of connection and support for the program participants. Assisting the participants with achieving motivation for long-and short-term goals while creatively problem-solving barriers. Each provider is responsible to ensure that every program participant is matched to a Care Coordinator.

Qualifications

A Care Coordinator should have a bachelor's degree in a field closely related to the positions responsibility or have 4 years of experience in a human service setting providing direct services to individuals.

How to become a Care Coordinator

- Be hired by a Provider
- Complete training approved by the North Dakota Behavioral Health Division

Expectations of a Care Coordinator

- To offer an intake meeting with each participant within three (3) business days of referral.
- To create a comprehensive, collaborative care plan with each participant within ten (10) business days of referral, and to update this care plan each month.
- To be a source of cross-sector partnership and collaboration-working with public and private providers to collaborate in partnership regarding participants care.
- To provide participants with comprehensive, individualized care coordination services.
- To provide access to recovery support services, including peer support.
- To ensure that the participant has the opportunity for contact with either their care coordinator or peer support specialist as required per documented level.
- The same person should not provide care coordination and peer support services to a participant.
- Submit care plans, outcomes and case note documentation by the 5th of each month for all program participants.
- Care Coordinators are responsible to ensure that all contact, attempted contact, and work carried out on behalf of the participant supporting the person-centered care is documented in a case note.
- To participate in meetings, trainings, and technical assistance as requested by the Behavioral Health Division.
- Understand and comply with job duty differences between the Care Coordinator and a Peer Support Specialist.

Care Coordination Services

- Every participant should be provided with face-to-face care coordination.
- Tele-behavioral health/ video options for care coordination is supported in the following instances:

In addition to face-to-face to increase contacts;

- The Care Coordinator should reside in the same region in North Dakota as the program participant they are serving, unless this has been pre-approved by the BHD Admin and was a participant choice.
- Tele-behavioral health/ video options for care coordination can be used as an addition to face-to-face contact.

Case Notes

The following guidance will outline the expectations of Case Notes, provide the timelines, and provide a description of each section of the Case Notes

WHAT ARE CASE NOTES?

- Case Notes are the designated place that all contact, attempted contact, or work that the provider completes on behalf of the participant should be documented.
- Case Notes allow the BHD Administrator to reconcile, vet outcomes, and verify provider payment.

CASE NOTE EXPECTATIONS

- Care Coordinators are responsible to ensure that all contact, attempted contact, and work being done on behalf of the participant supporting the person-centered care is documented in a case note.
- Case Note documentation should be objective and include facts, avoid opinions, bias, assumptions, and slang terms, unless copyingverbatim what a participant states.
- If the Care Coordinator documents in a note that there is a plan to meet and then no documentation following that note that mentions the face-to-face meeting or what occurred, this creates a gap. This type of gap in documentation creates questions when reviewing case notes and should be avoided.
- Case Note topics should include, but are not limited to:
  - Housing
  - Employment
  - Recovery
  - Criminal Justice Involvement
  - Parenting
  - Barriers or needs and plan to address
  - Successes
  - Referrals; including documentation of cross sector-partnership and collaboration
  - Care Plan development and updates

DEADLINES

Case Notes should be completed in a timely manner, as quickly as possible following contact or attempted contact by the Care Coordinator or Peer Support Specialist. It is required that all case note documentation for the reporting period is completed and sent to the BHD at comconnect@nd.gov by no later than the5th of each month. If the case note documentation does not include information to support contact or attempted contact as required in each level the provider may be ineligible for payment. Please see the level guidance for further information regarding contact expectations.

The Case Note documentation is due by the 5th of each month and should include all contact or attempted contact from the reporting period, which is the prior month. For example, submitting documentation on 10/5/20, this documentation would cover all contact or attempted contact from 9/1/20-9/30/20.

Case note Section	Expectation
Participant Name	First and Last Name of the program participant
ID#	ID# provided upon referral
Level	Select the highest level that the participant was in during the reporting month
Provider	The program Provider
Month/Year	The month and year of the reporting period documented
Care Coordinator Name	Assigned provider Care Coordinator
Peer Support Name	Assigned Peer Support, if offered and declined please type declined and reason
Date of contact	This is the date that the contact or attempted contact occurred, not the date you are completing the documentation
Contact Duration	This is the length of your contact, please include minutes or hours
Types of Contact	**Face to Face** The Care Coordinator has a physical meeting with the program participant. **Phone Call** The Care Coordinator has a phone conversation with the program participant **Text Message** The Care Coordinator has a text message conversation with the program participant **Web-Based video** The Care Coordinator has a web-based video meeting with the program participant **Incidental Contact** The Care Coordinator has contact with the participant that was not planned and this does not meet criteria for weekly engagement **Peer Support** The Peer Support specialist has a meeting with the participant **Email** The Care Coordinator engages in email correspondence with the program participant **Mail** The Care Coordinator engaged in mail correspondence with the program participant **Attempted Contact** The Care Coordinator or Peer Support Specialist attempted to engage in contact with the program participant and was not successful in this contact. This contact attempt can be made via a phone call or text. **No Show** There was a meeting scheduled and the program participant did not show up. **Treatment Staff** **Care Team** If you have any contact with BHD or any other agency that you have a release of information signed to regarding the program participants care, needs or staffing
Notes	FORMAT: • Review Care Plan • Note any new risks, concerns, challenges or barriers and the plan to address • Summarize referrals or plan to address participant's needs, collaboration with other agencies/providers. • Outcomes • Plan for next meeting

I would like to print and write in the case note documentation and scan to the BHD Admin each month, can I do this?

No, BHD will not accept handwritten documentation. This documentation must be typed and saved as a pdf and sent in an email attachment by the fifth of each month.

Case Notes

The Case Notes should be updated after every contact or attempted contact with the program participant.

Case Notes must be completed and sent each month with monthly outcomes and care plan documentation.

Types of contact include: *face to face, phone call, text message, web-based video, incidental contact, peer support, email, mail, attempted contact, no show, treatment staff, care team.*

Participant Name _____ ID# _____

Level _____ Provider _____ Region _____

Month _____ Year _____

Care Coordinator Name _____ Peer Support Name _____

Case Notes #1

Date of contact _____ Contact type _____ Contact duration _____

Notes

Care Plan Guidance

The following guidance will outline the expectations of a Care Plan, provide the timelines, and provide a description of each section of the Care Plan.

What is a Care Plan?

- The Care Plan is a guide or blueprint to outline a participant's needs, strengths, and goals.
- A Care Plan guides the participant towards reaching their goals and assists care coordinators and peer support specialists to monitor progress and adjust plan when needed.

Care Plan Expectations

- People are experts in their own lives and the Care Coordinator's role is to guide and encourage the person to make their own choices while being informed.
- It is essential that the care plan is developed in a collaborative manner with the participant, Care Coordinator, and Peer Support Specialist.
- In developing the Care Plan, the Care Coordinator has the opportunity to discuss with the participant what they want to accomplish and to assist with identifying their strengths and needs.
- Care Coordinators shall become knowledgeable in the principles of person-centered care and utilize motivational interviewing skills to assist the participant in developing their Care Plan.
- All updates to the Care Plan must be completed with the participant.
- Goals are to be identified by the participant based on what they want to achieve. Goals should not be based on what the Care Coordinator wants the individual to do. Goals can be placed in quotes to indicate the participants' words.
- When a participant completes a goal, it is the Care Coordinator's responsibility to guide and assist them in developing their next goal.

Deadlines

- Within 10 days of the participant's referral to the program, a Care Coordinator is required to develop the care plan with the participant.
- By the 5th of every month, the Care Coordinator is required to submit an updated Care Plan to BHD.

Care Plan Section	Expectation
Date Plan Initiated	This is the date the plan is initially started; this date will not change.
Date Last Updated	This is the date of last review/ update with participant, this date should change during each reporting period.
Reason for Referral	Describe the participants needs and desires to live a purposeful and fulfilled life.
Strengths	Identify several strengths in collaboration with the participant.
Goal	The participants identified goal, use quotes to identify the participants words.
Outcome	Select from the outcome areas relating to the participant's goal: • Housing • Recovery/Social Support • Employment/Financial • Criminal Justice • Other
Date Created	The date the participant identified and developed the goal to include the month, date, and year. This date should not change once it is created.
Action Steps	• Action steps are the movements or progress that the participant takes or plans to take to reach their goal. • Must use SMART principles (Specific, Measurable, Attainable, Relevant, and Time Specific). See SMART principles guidance • Action steps will be on-going, and participants may work on multiple goals that involve multiple action steps simultaneously.
Start Date	This is the date that the participant agrees they will start on the action step.
Completed Date	This is the date that the participant completes the action step identified.
Comments	Comments detailing information on the progress or lack of progress towards action steps may be provided here. There is no requirement for a comment to be included, though it c an be a useful tool for the care coordinator if needed.

CARE PLAN

Each reporting period/month the care plan must be updated or reviewed and sent with monthly outcomes and case notes documentation.

Participant Name ID#

Care Coordinator Provider Region

Date Plan Initiated Date last Updated/Reviewed

Reason for Referral to Community Connect

Strengths

Goal #1

Date created

Outcome

Action Steps	Start Date	Completed Date
1.		
2.		
3.		
4.		
5.		

Comments

Goal #2

Date created

Outcome

Action Steps	Start Date	Completed Date
1.		
2.		
3.		
4.		
5.		

Comments

What if the Care Coordinator does not have contact with the participant during the reporting period?

If the Care Coordinator does not meet with the participant during the reporting period, this will be reflected in the case notes and the care plan will not be updated. The care plan document should still be sent on the fifth of the month with the case note and outcome documents.

Can the assigned Peer Support Specialist update the care plan?

The care plan development and updating is the responsibility of the Care Coordinator. However, the care plan should be developed and maintained with the input of the participant and all members of the care team, including the Peer Support Specialist.

Can I print and write in the Care Plan?

You can print and write in the Care Plan document, however the documentation that is sent monthly needs to be typed, saved, and emailed as an attachment. BHD will not accept handwritten documentation.

Peer Support

Peer Support Specialists bring hope by sharing their experiences and promoting a sense of belonging. A Peer Support Specialist is an individual who uses the individual's lived experience and skills learned through formal training to deliver services to promote mind-body recovery and resiliency.

Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.

- Health: Choices that support one's overall well-being
- Home: A safe and stable place to live
- Purpose: Meaningful daily activities, such as job, school, or volunteering
- Community: Relationships and social networks that provide support, friendship, and love

Peer support is effective:

- Improves quality of life
- Improves whole health, including conditions like diabetes
- Improves engagement and satisfaction with services and support
- Decreases hospitalizations and inpatient stays
- Reduces health care costs.

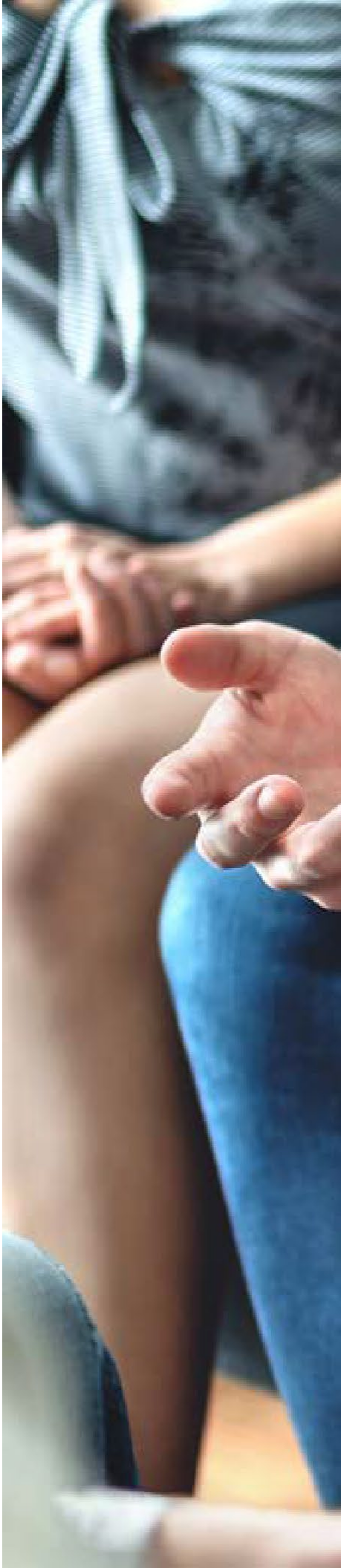
Peer Support is an evidence-based practice, is endorsed by the Behavioral Health Division, and has shown to help with the recovery process through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.

Expectations of a Provider

- Follow the requirements identified in the provider agreement.
  - To match every participant with a peer support specialist based on demographics, personality, and lived experience.
  - Participants that do not want a peer support specialist must opt out of peer support, and care coordinators must document the reason given by the participant.
  - The same person should not provide care coordination and peer support services to a participant.
  - A provider may not hire or enter into a peer support services contract with a current participant they are serving.
  - Document all peer support contact before the end of each monthly reporting period.
- Hire or contract with a Certified Peer Support Specialist I or II.
- Understand and comply with job duty differences between the Care Coordinator and a Peer Support Specialist.

Peer Support Services

- Every participant should be provided with face-to-face peer support as available.
- Tele-behavioral health/video options for peer support is supported in the following instances:
  - In addition to face-to-face to increase contacts
  - In rural areas, where face-to-face peer support is not available, telehealth/video options may be used



Differences Between a Care Coordinator and Peer Support Specialist

Care Coordinator	Peer Support Specialist
Engage participant in services	Establish positive rapport
Establish positive rapport	Serve as pro-social model
Develop a care plan with participant	Share their lived experience and recovery story to instill hope, foster trust, and build mutuality
Assist participant in accessing services to address their needs	Provide support focused on advocacy, coaching, and mentoring
Cross-sector partnership and collaboration. Working with public and private providers to collaborate in partnership, regarding participants care.	Offer insight to the participants care team

Ways to Hire a Peer Support Specialist

- Follow your established agency practices on hiring, no different than any other position.
- Request a list of all Certified Peer Support Specialists in North Dakota and reach out to individuals. To request a list, email peersupport@nd.gov.
- Subcontract with a community agency or individual to provide peer support. This option is only approved if the written subcontract acknowledges the expectations of the Memorandum of Understanding signed between the Provider and the Behavioral Health Division.

For more information on Peer Support, including information on peer support certification, training, and frequently-asked-questions, please go to www.behavioralhealth.nd.gov/addiction/peer-support.

Behavioral Health Division does not endorse any peer.

The Behavioral Health Division does not regulate or determine wages of peer support specialists.

The agency does not have authority to contract for or incur obligations on behalf of the Behavioral Health Division.

Recovery Services

Some important things to keep in mind:

- Recovery looks different for everyone.
- Involvement from supportive family members can result in successful recovery. Encourage participants to include support people in appointments, meetings, and events.
- Empower participants by facilitating consumer choice as much as possible. Be supportive if they have concerns about a certain provider and help them problem solve.
- Connection and community engagement are keys to success. Consider helping participants access support groups, spiritual or religious organizations and activities, volunteer opportunities, and positive community events.
- Identify strengths and positive attributes of the individual on an ongoing basis. Acknowledge these strengths often and use them as a guide for recovery. Remember to identify specific things the participant is doing well and reinforce them through praise or other means.
- Make a genuine effort to get to know the person and be curious about their insights. Learn who they are aside from their diagnoses. Actively listen and meet in locations where the individual feels safe and comfortable.
- Be willing to self-disclose when appropriate, things about yourself, within your personal and ethical boundaries, to facilitate connection and rapport.
- Gather information about the person's goals outside of the realm of "treatment", such as education, recreational, relational, spiritual, and financial goals.

Providers should become familiar with local and statewide resources available for participants. Here are some organizations and websites that may be beneficial to utilize:

Recovery Talk is a free, anonymous, and confidential phone line available 24/7 for recovery support with a Peer Support Specialist.

1.844.44.TALK2

behavioralhealth.nd.gov/24-7recoverytalk

FirstLink is a free, confidential service available to anyone 24/7/365 for listening and support, referrals to resources/help and crisis intervention. FirstLink answers the 211 help line, the National Suicide Prevention Lifeline and communicates via Text line 898-211. FirstLink provides these services across the entire state of North Dakota and parts of Minnesota. Website: myfirstlink.org

The Behavioral Health Division (BHD) works with partners within the Department of Human Services and the state behavioral health system to improve access to services, address behavioral health workforce needs, develop policies, and ensure quality services are available for those with behavioral health needs. For resources on addiction, mental health, and prevention, please go to behavioralhealth.nd.gov

The North Dakota Department of Human Services (DHS) provides services that help vulnerable North Dakotans of all ages to maintain or enhance their quality of life, which may be threatened by lack of financial resources, emotional crises, disabling conditions, or an inability to protect themselves. Website: nd.gov/dhs/

DHS operates eight regional human service centers. Each serves a designated multi-county area, providing counseling and mental health services, substance abuse treatment, disability services and other human services. For contact information and other resources, go to nd.gov/dhs/info/pubs/docs/hsc-contact-info.pdf

Facebook pages to follow: Free Through Recovery Providers, Behavioral Health Division, Parents Lead, North Dakota Peer Support Specialists.

Reimbursement Rates and Level Guidance

The following guidance will outline reimbursement rates and levels, provide a description of the rates of reimbursement and levels to assist each provider with implementation and ongoing guidance.

What are levels?

- The purpose of levels is to provide person-centered services that provide support for participants by adjusting the level of services according to their goals and needs, allowing participants to maintain long-term connections with their chosen provider.

Process

- All participants referred will start at level 3
- The Care Coordinator will assist with the development of the Care Plan, identifying goals and barriers, and connecting a participant to a Peer Support Specialist (if chosen), before staffing for a change from level 3
- A participant change in level should also be discussed with the participant, remaining person-centered is imperative. If a participant has had numerous months of positive outcomes and there is a natural decline in the number of needs and engagement by the provider a change in level should be discussed with the participant first and then BHD.
- Participants may step down one level at a time, unless deemed necessary by the Care Team
- To change levels the Care Coordinator will staff the requested change and justification with the BHD Case Lead
- When approved, the Care Coordinator will document the level change within the Case Notes

Description

Level 3 (Entry level for all participants)

Objectives: The Care Coordinator should focus on building rapport, referring for peer support, developing a care plan, assessing on-going needs and progress, making referrals to community-based services and resources, and providing cross-sector partnership and collaboration with all providers involved in providing care to the participant.

Engagement

- The Care Coordinator and/or Peer Support Specialist **will provide** the opportunity to engage face-to-face weekly with the participant during each reporting period.
  - This may be once a week or several times a week, depending on the needs/barriers of the participant
  - If you have incidental contact with the participant in the community, for example at a meeting or grocery store this is incidental contact, not face to face engagement and doesn't meet criteria for weekly face-to-face engagement.
- In order to enter outcomes the Care Coordinator must engage(face-to-face) with the participant at least once during the reporting period.

Reimbursement

- **Ineligible: $0**
  The provider has not met the engagement standards outlined, there is no documentation to support that weekly engagement(face-to-face) during the reporting period was offered by the Care Coordinator or Peer Support Specialist during the reporting period.
- **CC Diligence/No Engagement: $200**
  There is case note documentation indicating that the participant had "at least" weekly opportunities to engage (face-to-face) during the reporting period with the Care Coordinator and/or Peer Support Specialist. If the provider is not able to engage the participant, there must be supporting documentation demonstrating that the BHD Case Lead was engaged to assist with a strategy for engagement
- **Engagement Pay: $400**
  There is case note documentation indicating that the Care Coordinator and/or Peer Support Specialist engaged (face-to-face) at least weekly during the reporting period, and the participant has less than 3 positive outcomes.
- **Outcome Pay: $480**
  There is case note documentation indicating that the Care Coordinator and/or Peer Support Specialist engaged (face-to-face) at least weekly during the reporting period, and the participant has 3 or more positive outcomes.

# of Levels

Level 2: Engagement with Community Resources

Objectives: To connect the participant to long-term community-based services and support in order to assist with maintaining positive outcomes

Engagement

- The Care Coordinator will engage (face-to-face) with the participant at least once a month during the reporting period.
  - During this meeting the provider must assess the effectiveness of the care plan, identify new objectives/ goals and further develop the care plan to meet the needs of each participant
  - Care should be transitioning from resolving immediate/urgent needs towards long-term stability and connection
  - The Peer Support Specialist can continue to engage with the participant.
- If a participant is struggling to maintain positive outcomes the Care Coordinator and/or Peer Support Specialist can work with the participant to determine if level 3 needs to be considered.
- In order to enter outcomes, the Care Coordinator must engage(face-to-face) with the participant at least once during the reporting period.

Reimbursement

- **Ineligible: $0**
  The provider has not met the engagement standards outlined, there is no documentation indicating that monthly engagement (face-to-face) during the reporting period was offered by the Care Coordinator.
- **CC Diligence/No Engagement: $150**
  There is case note documentation indicating that the participant had opportunities for engagement (face-to-face)during the reporting period. A one-time attempt at engagement during the reporting period, does not meet diligence criteria. If the provider is not able to engage with the participant, there must be supporting documentation demonstrating that the BHD Case Lead was engaged to assist with a strategy for engagement.
- **Engagement Pay: $200**
  There is case note documentation indicating that the Care Coordinator engaged (face to face) at least once during the reporting period, and the participant has less than 3 positive outcomes.

  If outcomes indicate that a higher level may be beneficial, a higher level of care should be discussed with the participant and staffed with the Care Team.
- **Outcome Pay: $280**
  There is case note documentation indicating that the Care Coordinator engaged (face to face) at least once during the reporting period, and the participant has 3 or more positive outcomes.

Level 1: Extended Recovery Support

Objectives: The Care Coordinator and/ or Peer Support Specialist must be accessible to the participant in order to quickly respond to changes in the participant's needs and care plan.

Engagement

- The Care Coordinator will engage (via phone call) with the participant once a reporting period to connect and assess collaboratively the need for continuing in level 1 or a higher level.
  - During the engagement the Care Plan must be reviewed, along with assessing each outcome area.
  - The Care Coordinator must ensure that the participant is aware of the ability to request a higher level at any time, if their needs change.
- The Care Coordinator will remain available to the participant, if the needs of the participant change, a higher level of care can be staffed with the Care Team.
- The Peer Support Specialist can continue to engage with the participant.
- There is no option for CC Diligence/No Engagement reimbursement, if the Care Coordinator does not connect with the participant, they are not eligible for reimbursement.
- The minimum standard for engagement is a video/phone call, however the Care Coordinator can engage(face-to-face) if desired.
- In order to enter outcomes and be eligible for reimbursement the Care Coordinator must engage (via video/ phone) with the participant at least once during the reporting period.

Reimbursement

- **Ineligible: $0**
  The provider has not met the engagement standards outlined, there is no documentation indicating that engagement (via video/ phone call) was offered by the Care Coordinator.
- **Engagement Pay: $100**
  There is case note documentation supporting that the Care Coordinator had engagement (via video/phone call) at least once during the reporting period, and the participant has less than 3 positive outcomes

  If outcomes indicate that a higher level may be beneficial, a higher level of care should be discussed with the participant and staffed with the Care Team.
- **Outcome Pay: $180**
  There is case note documentation supporting that the Care Coordinator had engagement (via video/phone call) at least once during the reporting period, and the participant has 3 or more positive outcomes

What if the Care Coordinator and/or Peer Support Specialist cannot engage with a participant for two reporting periods in a row?

If the provider cannot engage with the participant for two reporting periods, the provider and the BHD Case Lead will staff the case to determine next steps. After the two months of CC Diligence/No Engagement the provider will be ineligible for payment and discharge/ transition will be discussed.

What is the reporting period?

The reporting period is the duration of time specified to provide and document services provided to participants. The information that is documented will be assessed in the outcomes the following month. In the program the reporting period is a month, if the participant is referred on 10/15, the reporting period would be 10/15-10/31, the next reporting period is 11/1-11/30. For example, all documentation of services provided from 10/1/20-10/31/20 will be reported by 11/5/20.

What if I forget to document my attempted contacts with the participant?

All attempts at engagement must be documented in case notes, if not the provider would become ineligible for payment.

What if the Care Coordinator and Peer Support are attempting to contact the participant but the participant is not returning calls or texts and we cannot meet?

The Care Coordinator should reach out to the BHD Case Lead for assistance in engaging the participant, this information must be documented. If after 60 days of attempted contact the participant cannot be engaged, the Care Coordinator should staff a discharge request with the BHD Case Lead.

What happens if a participant changes levels during the middle of a reporting period? Can a participant change level during the middle of a reporting period?

Yes, an individual can change levels during a reporting period. The provider will be reimbursed at the highest level of service that the participant received during the reporting period.

Does the participant have to stay on each level for a certain amount of time?

No, levels are determined based on the participants needs, and goals and barriers identified on their care plan.

Reporting Monthly Outcomes and Provider Payment

The following guidance will outline the expectations of Monthly Outcomes, provide the timelines, and provide a description of each section of the Monthly Outcomes document.

What are outcomes?

- Outcomes identify participant results, in the areas of housing, employment/ financial, recovery/social supports, and criminal justice involvement
- Outcomes determine payment
- Outcomes will be used to measure the effectiveness of the services provided

Outcome expectations

- Providers will be responsible to provide data on whether each participant has achieved identified outcomes on a monthly basis.
- Case Note and Care Plan documentation should support the data reported in the Monthly Outcomes.
- The Care Coordinator is responsible to answer each outcome with yes, no, or NA. The Care Coordinator comments are required to be filled out and must include comments that supports the outcome answer
- Outcome documentation should be objective and include facts, avoid opinions, bias, assumptions, and slang terms
- Failure to complete outcomes will result in the provider being ineligible for payment

Engagement

- Providers ensure each participant has the opportunity for a contact with either their Care Coordinator or Peer Support Specialist as expected in each level. Case note documentation must reflect that these contacts occurred or were offered
- If a participant does not appear for an appointment or does not want to meet this documentation should be included in case notes
- If the Care Coordinator or Peer Support Specialist has not had contact with the participant during the reporting period, the Monthly Outcomes must be answered NA
- If the Care Coordinator and/or Peer Support Specialist is attempting contact as outlined in the level, the provider is still eligible for payment (CC diligence/engagement), however should answer the outcomes NA
  - The corresponding monthly case note documentation must demonstrate attempted contacts

Timelines

- Monthly outcomes are required for each program participant.
- The Care Coordinator may submit monthly outcome documentation from the first to fifth of each month, the outcomes must be submitted by no later than the fifth of each month for the reporting period.
- The reporting period for the monthly outcome documentation is the month prior. For example, the outcome documentation is submitted on 10/5/20, the reporting period is 9/1/20-9/30/20.

Monthly Outcomes Sections	Expectation
Participant Name	First and Last Name of the program participant.
ID#	ID# provided by BHD
Level	Select the participants highest identified level during the outcome period. Please refer to the level guidance for questions regarding levels.
Care Coordinator	Identified Provider Care Coordinator
Month	This is the month of the reporting period that the outcomes were collected from. For example, monthly outcomes are sent to the BHD Admin on 10/5/20 for the reporting period of 9/1/20-9/30/20, the month is September.
Year	The corresponding year of the reporting period that the outcomes were collected from.
Housing	The participant will get credit for this outcome if they meet at least one of the following: • The participant lives independently. • The participant is living with a safe friend or family. • The participant is living in a halfway house, temporary shelter, etc. *If the Care Coordinator can say yes to any of these the housing outcome should be answered "Yes". If the Care Coordinator has not had contact with the participant during the reporting period, the outcome should be answered "NA".*
Recovery/Social Supports	The participant will get credit for this outcome if they meet at least one of the following: • The participant is engaged with or taking steps to engage their support network. • The participant is engaging in strategies to avoid more serious/problematic substances (harm reduction strategies). • The participant relapsed but is honest with provider and continues to work towards recovery (harm reduction strategies). • The participant is refraining from using non-prescribed, mood altering substances. • The participant is demonstrating an effort to improve mental health functioning and/or reporting a decrease in symptoms. *If the Care Coordinator can say yes to any of these the recovery/social support outcome should be answered "Yes". If the Care Coordinator has not had contact with the participant during the reporting period, the outcome should be answered "NA".*
Employment/Financial	The participant will get credit for this outcome if they meet at least one of the following: • The participant is employed. • The participant is actively job hunting. • The participant can meet their needs from their economic resources. • The participant is enrolled in school or workforce training. • The participant has been approved and is receiving disability. • The participant is enrolled in a treatment program that does not allow them to work. *If the Care Coordinator can say yes to any of these the employment/financial outcome should be answered "Yes". If the Care Coordinator has not had contact with the participant during the reporting period, the outcome should be answered "NA".*
Criminal Justice Involvement	The participant will get credit for this outcome if they meet at least one of the following: • If the participant is on state or federal supervision, they had no violations resulting in the revocation of their supervision. • The participant has not been arrested for a new offense. *If the Care Coordinator can say yes to any of these the criminal justice outcome should be answered "Yes". If the Care Coordinator has not had contact with the participant during the reporting period, the outcome should be answered "NA".*

Care Coordinator Comments	The Care Coordinator must include a comment indicating how they answered the outcome. The comment should support the outcome answer.
Administrator Comments	The BHD Administrator will determine the outcome answer after review of the case note, care plan and outcome documentation. The BHD Administrator will include a comment to support the outcome and leave feedback for the Care Coordinator, if applicable.

Pay Status

The assigned BHD administrator will select the pay status and total payment to provider. Upon completion of outcomes the BHD administrator will complete a payment sheet and submit to the Provider to verify/discuss. The above described outcomes will be used to form the basis of awarding outcome pay. The BHD Administrator will submit payment sheets to fiscal by the 15th of each month.

Level 3: Full Intensity of Care Coordination Services

Reimbursement for Level 3 Services:

CC Diligence/No engagement = $200 | Engagement Pay = $400 | Outcome Pay = $480 | Ineligible: $0 *The provider did not meet contact expectations and is not eligible for payment.*

Level 2: Engagement with Community Resources

Reimbursement for Level 2 Services:

CC Diligence/No engagement = $150 | Engagement Pay=$200 | Outcome Pay = $280 | Ineligible: $0 *The provider did not meet contact expectations and is not eligible for payment.*

Level 1: Extended Recovery Support

Reimbursement for Level 1 Services:

No contact/Ineligible = $0 | Engagement Pay = $100 | Outcome Pay = $180 | Ineligible: $0 *The provider did not meet contact expectations and is not eligible for payment.*

*Please see Level guidance document for additional questions regarding the levels, reimbursement, or contact/engagement expectations.

MONTHLY OUTCOMES

Monthly outcomes must be sent with case notes and care plan documentation. If the Care Coordinator has not engaged with the participant as required in level guidance please select NA.

Participant Name _____ ID# _____

Please select the highest level of service that the participant received during the reporting period. Providers will be reimbursed at the highest level they provided services at any time during that reporting period.

Level

❑ Level 1 ❑ Level 2 ❑ Level 3

Care Coordinator _____ Provider _____ Region _____

Month _____ Year _____

Housing

A participant will get credit for this outcome if they meet at least one of the following:

- The participant lives independently.
- The participant is living with a safe friend or family.
- The participant is living in a halfway house, temporary shelter, etc.

Care Coordinator Outcomes

❑ Yes ❑ No ❑ NA

Care Coordinator Comments

Administrator Outcomes

❑ Yes ❑ No ❑ NA

Administrator Comments

Recovery/Social Supports

A participant will get credit for this outcome if they meet at least one of the following:

- The participant is engaged with or taking steps to engage their support network.
- The participant is engaging in strategies to avoid more serious/problematic substances (harm reduction strategies).
- The participant is refraining from using non-prescribed, mood altering substances.
- The participant is demonstrating an effort to improve mental health functioning and/or reporting a decrease in symptoms.

Care Coordinator Outcomes

❑ Yes ❑ No ❑ NA

Care Coordinator Comments

Administrator Outcomes

❑ Yes ❑ No ❑ NA

Administrator Comments

Employment/Financial

A participant will get credit for this outcome if they meet at least one of the following:

- The participant is employed.
- The participant is actively job hunting.
- The participant can meet their needs basic needs from their economic resources.
- The participant is enrolled in school or workforce training.
- The participant has been approved and is receiving disability.
- The participant is enrolled in a treatment program that does not allow them to work or earn an income.

Care Coordinator Outcomes

❑ Yes ❑ No ❑ NA

Care Coordinator Comments

Administrator Outcomes

❑ Yes ❑ No ❑ NA

Administrator Comments

Criminal Justice Involvement

A participant will get credit for this outcome if they meet at least one of the following:

- If the participant is on state or federal probation/parole, they had no violation resulting in revocation.
- The participant has not been arrested for a new offense, or incarcerated.

Care Coordinator Outcomes

❑ Yes ❑ No ❑ NA

Care Coordinator Comments

Administrator Outcomes

❑ Yes ❑ No ❑ NA

Administrator Comments

BHD Administrator Use Only

Pay Status

Level 3 Services

❑ Ineligible=$0 ❑ CC Diligence/No engagement=$200 ❑ Engagement Pay=$400 ❑ Outcome Pay=$480

Level 2 Services

❑ Ineligible=$0 ❑ CC Diligence/No Engagement=$150 ❑ Engagement Pay=$200 ❑ Outcome Pay=$280

Level 1 Services

❑ Ineligible=$0 ❑ Engagement Pay=$100 ❑ Outcome Pay=$180

❑ Notes:

Total Payment to Provider

$

Gap Funding Guidance

The following guidance will outline the expectations of a gap funding, provide the timelines, and provide a description of proper utilization and reimbursement.

What is Gap Funding?

- Gap funding was created to help fill a "Gap" when all other resources/funding have been exhausted in the community. The purpose of Gap funding is to help address barriers and should only be considered after all other community resources have been utilized.
- If a participant is facing a financial obstacle that is preventing them from meeting their desired outcomes and goals, gap funding may be considered.

Provider Expectations

- Each provider may have their own internal processes that must align with this guidance and may include steps specific to the provider's internal protocols. Please consult your provider's administration to determine what your provider's protocols are.
- All provider records must be retained for four (4) years including Gap Funding Request Forms, Participant Category Tracker and accompanying receipts.

Step 1: **Determine need**

If a participant is facing a financial obstacle that is preventing them from meeting their desired outcomes and goals, gap funding may be considered.

- The Care Coordinator will work with the participant to determine what options they have to cover the identified expense and what other possible community resources may be utilized. The Care Coordinator will assist the participant in accessing community referrals to meet the need.
- The Care Coordinator will determine if the participant can cover a portion of the request.
- If the Care Coordinator has worked with the participant to exhaust all other options, then gap funding may be utilized.
- The Care Coordinator will work to establish a plan with the participant to cover the expense in the future, if it's a recurring expense.

Step 2: **Determine type of approval**

If the request is on the Gap Funding Category list AND is less than $100 total, prior approval from the Behavioral Health Division is not needed.

- If the request meets one of these categories, the provider may proceed with the purchase.
  - The provider must fill out and retain a copy of the Gap Funding Request Form and an itemized receipt for each purchase.
  - The provider must add this purchase and category to the Participant Category Tracker.

If the request is not on the Gap Funding Categories list, or if it is on the list but will cost more than $100, approval from the Behavioral Health Division is required to be considered for reimbursement.

- If the request falls into this category, the provider must submit via email a Gap Funding Request form to the BHD Administrative Assistant.
  - Allow a minimum of one week for a response from BHD Administrative Assistant regarding approval/denial, or the provider will be notified if more information is needed.
  - If the request is approved, complete the purchase.
  - The provider must retain a copy of the Gap Funding Request Form and an itemized receipt. The itemized receipt should only contain gap funding items purchased.
  - The provider must add this purchase and category to the Participant Category Tracker.

Step 3: **Reimbursement**

The Provider will submit the Participant Category Tracker Form, the Gap Funding Monthly Reimbursement Form, and all matchingreceipts to the BHD Administrative Assistant by the 15th of each month for reimbursement.

All reimbursements must be submitted within 60 days of purchaseotherwise the purchase is not eligible for reimbursement. The provider must add this purchase and category to the Participant Category Tracker.

Please find the Participant Category Tracker and Gap FundingMonthly Reimbursement forms at behavioralhealth.nd.gov/community-connect/providers

Gap Funding Audits

The Behavioral Health Division will conduct periodic audits of gap funding requests and reimbursements. Guidance details what this audit process includes to prepare the provider if selected for an audit.

Providers will be notified by the BHD Administrative Assistant that they have been selected for an audit.

- The provider must submit all Gap Funding Requests Forms and receipts that correlate with the Gap Funding Monthly Reimbursement Forms selected.
- Provider will submit Participant Category Tracker which will be used to verify the number of participant requests.

During the audit, the Division will review the Monthly Reimbursement Form and match all Gap Funding Request Forms and receipts. A provider will "pass" an audit if all expenditures are on the Gap Funding Categories list, or have been approved by the Division, and all purchases are accompanied by a matching receipt. If there are ANY items on the receipt that have not been approved, the entire receipt will be rejected. The provider will be responsible for reimbursing the Behavioral Health Division within 30 days of notification for the entire amount of the rejected receipt.

If the provider does not pass an audit, gap funding services will be suspended for that provider until the discrepancies are reconciled and settled with the Behavioral Health Division. Not passing an audit may result in indefinite suspension of gap funding. Abuses of gap funding or any evidence of fraud may result in discontinuing the MOU with the provider.

Transferring Participants

If a participant transfers from one provider to another, the gap funding history must transfer through the BHD Administrator because it is not covered by the release of information between providers.

- The new provider will enter the history of transferred participant into the new provider's Participant Category Tracker.
- The 12-month period is based on the participant's referral date. The date will not reset upon transfer.

Gap Funding Categories List

If the participant's gap funding request does not meet any of the criteria described below, the provider must submit a gap funding request form to the BHD Administrative Assistant for Division approval. If gap funding purchases are made before approval they may be declined for reimbursement.

All gap funding purchases should be included on the Participant Category Tracker.

HOUSING

(Requests are limited to $100 per 12-month period)

- Housing expenses include: rental application fees, utility bill assistance, rent assistance, and security deposit.
- The provider must retain a copy of the application, lease or bill that must include the participant's name. This must be attached to the Gap Funding Request Form as a receipt.

EMPLOYMENT

(Requests are limited to $100 per 12-month period)

- Employment expenses include: work-related attire (boots, shoes, uniforms, clothing), tools or other supplies necessary to gain or sustain employment.

BASIC NEEDS

(Requests are limited to $100 per 12-month period)

- Basic need expenses include: toilet paper, toothpaste, toothbrush, soap, shampoo, conditioner, feminine hygiene products, deodorant, razor and shaving cream, socks, underwear, laundry soap, and fees associated with ordering a birth certificate.

CLINICAL SERVICES

- Clinical expenses include: one clinical assessment per year when other opportunities for funding support have been exhausted.

TRANSPORTATION

(Requests are limited to $100 per 12-month period)

- Transportation expenses include: gas (reimbursement for gas purchased at the pump must include a copy of the receipt as we are unable to provide reimbursement for gas cards), bike, bus fare, Uber, Lyft or taxi (excluding tips or donations), driver's license or state ID fees.

EDUCATION

(Requests are limited to $100 per 12-month period)

- Education expenses include: application fees or textbooks if the education experience is a part of the process for the participant to gain future employment.

COMMUNICATION

(Requests are limited to $100 per 12-month period)

- Communication expenses include: cell phone, cell phone minutes/cards.

FAMILY

(Requests are limited to $100 per 12-month period)

- Family expenses include: school or childcare related expenses for children or dependents, car-seat, diapers, wet wipes, crib/child's bed, child's clothes and/or shoes.

A participants 12-month period starts when they are referred to the program, this 12-month period resets after 12 months and a new 12-month period starts. It is the responsibility of the provider to track and verify that the request falls within the number of requests allowed yearly.

GAP FUNDING REQUEST FORM

Please select the type of gap funding that you are accessing for the participant, complete the following information and retain with receipt. If the request is not on the gap funding category list, or over $100 for a 12-month period send to the Administrative Assistant for approval.

Please note that if a purchase is made that is not on the gap funding category list or exceeds $100 for the 12-month period, without prior approval by BHD staff, the purchase will not be reimbursed.

- ❑ Participant is requesting gap funding that is $100 or less and can be found on the gap funding categories list.
- ❑ The participant is requesting individual gap funding for an item that exceeds $100, or the item is not on the gap funding categories list.

Name of participant:_____ID:_____

Name of provider: _____

Program: ❑ Free Through Recovery ❑ Community Connect

Total Amount Requested: _____

List the community resources, agencies or organizations that you have already tried to access resources and funds from but were denied.

Select or more of the following categories in which the requested funds will help support the participant.

❑ Housing	❑ Transportation	❑ Employment	❑ Clinical Services
❑ Basic Needs	❑ Education	❑ Communication	❑ Family (NA if FTR)

Description of the gap funding request:

Is the participant's care plan completed and up to date? ❑ Yes ❑ No

Briefly describe how this request relates to the participant's goals listed on their care plan?

Participant signature: _____ Date:_____/_____/_____

Provider Care Coordinator signature: _____ Date: _____ /_____/_____

Provider Fiscal Admin signature: _____ Date: _____ /_____/_____

Bottom section for use by Department of Human Services' Behavioral Health Division Administrative staff only

Request: ❑ Approved ❑ Denied

Comments:

Administrator signature:_____ Date:_____/_____/_____

Discharge Guidance

The following guidance will outline the expectations of discharge requests and provide a description of each section of the Request for Discharge or Transfer Providers document.

Expectations of a Provider

- All participants are engaged in this program voluntarily, therefore a participant may choose to opt out of services at any time.
- Once the decision is made by the participant or Care Team to discharge a participant, the Care Coordinator must staff the discharge with the BHD Case Lead.
- After staffing the discharge request with the Case Lead, the Care Coordinator will submit (via email) the Request for Discharge to the BHD Case Lead for approval. Upon review of the request the BHD Case Lead will notify the Care Coordinator of the decision within five business days.
- If a participant is transferring providers due to moving or participant choice the Request for Discharge or Transfer Providers document must be submitted to the BHD Case Lead by the Care Coordinator.
- Until the transfer of providers has been approved the assigned provider should continue to provide care for participants, unless otherwise noted.

Transition

- This program does not have a set length of time for each participant. It's specific to each participant needs.
- If participants are doing well, has multiple months of positive outcomes and feels like they have accomplished their goals, they may be ready to change levels or discharge.
- A conversation should take place between the provider and the participant to start entering a transition phase to ensure the participant has supports and long-term services established in the community.

Discharge Types

- **Stopped participating/no contact** – the participant has stopped communicating with the provider. If at the 60 day mark the participant still has not engaged, despite attempts made by the Care Coordinator, this category type may be used.
- **Participant no longer desires services** – the participant has indicated that they no longer desire services.
- **Completed program/transferred to long-term community services** – the participant is no longer in need of services and has long-term services established in the community.
- **Moved out of ND** – the participant moves out of the state of North Dakota.
- **Incarcerated** – the participant will be or has been incarcerated for over 60 days.
- **Adverse program termination** – participant is removed for reasons such as death, inappropriate or dangerous behavior towards care coordinator, etc.
- **Transfer provider** – the participant transfers from one provider to another.

Request for Discharge or Transfer Providers	Expectation
Participant Name	First and Last Name of the program participant
ID#	ID# provided upon referral
Care Coordinator	Identified Provider Care Coordinator
Date of Request	Month, Date and Year submitted to BHD Case Lead
Discharge Types	Select one discharge type
Stopped Participating/No Contact	Select this discharge type if: • The participant has stopped communicating with the provider • After 60 days of the provider attempting to reach the participant there has been no engagement
Participant no longer wants services	Select this discharge type if: • The participant has indicated that they no longer desire services
Completed program/transferred to long-term community services	Select this discharge type if: • The participant is no longer in need of services and has long-term services established in the community
Moved out of North Dakota	Select this discharge type if: • The participant has moved from the state of North Dakota; if a participant doesn't reside in North Dakota they no longer are eligible for the program
Incarcerated	Select this discharge type if: • The participant will be or has been incarcerated for over 60 days
Adverse program termination	Select this discharge type if: • Participant is discharge for reasons such as death, inappropriate or dangerous behavior, etc.
Transfer Provider	Select this discharge type if: • The participant is transferring providers
Describe the Reason Below:	The Care Coordinator must describe in detail the reason for the discharge request

REQUEST FOR DISCHARGE OR TRANSFER PROVIDERS

Participant Name _____ ID# _____

Care Coordinator _____ Date of Request _____

Discharge Type

Please select one discharge type

❒ Stopped Participating/No Contact - The participant has stopped communicating with the provider. If at the 60 day mark the participant still has not engaged, despite attempts made by the Care Coordinator, this category type may be used.

❒ Participant no longer wants services - The participant has indicated that they no longer desire services.

❒ Completed program/transferred to long-term community services - The participant is no longer in need ofservices and has long-term services established in the community.

❒ Moved out of ND - The participant moves out of the state of North Dakota.

❒ Incarcerated - The participant will be or has been incarcerated for over 60 days.

❒ Adverse program termination - Participant is removed for reasons such as death, inappropriate or dangerousbehavior towards care coordinator, etc.

❒ Transfer provider - The participant transfers from one provider to another or moved regions.

Describe the reason below:

For Behavioral Health Division Use Only:

❒ Approved ❒ Denied

Date of Discharge _____

Final discharge type

Comments

CommunityConnect

My Recovery. My Story.

behavioralhealth.nd.gov/community-connect