

	MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES BULLETIN COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF PUBLIC WELFARE		
	NUMBER: OMHSAS-06-06	ISSUE DATE: 12-08-06	EFFECTIVE DATE: 12-01-06
SUBJECT: BLENDED CASE MANAGEMENT	BY :  Joan L. Erney, J.D. Deputy Secretary for Office of Mental Health and Substance Abuse Services		

SCOPE:

County Mental Health/Mental Retardation Administrators
 Mental Health Targeted Case Management Providers

PURPOSE:

The purpose of this bulletin is to stipulate the standards for blended case management, and also to outline the procedure to apply for blended case management program. The standards and procedures mentioned in this bulletin are already being followed by all the concerned parties. The intent of this bulletin is to consolidate those standards and guidelines into a single, formal document. This bulletin applies to adult as well as children's targeted case management services.

All field offices, counties, and case management providers shall use the guidelines, standards, and procedures in this bulletin for developing, administering, and monitoring blended case management until final regulations are published and codified.

BACKGROUND:

Since its inception in 1988, Targeted Case Management has been separated into two distinct programs, Intensive Case Management (ICM) - available in all County MH/MR programs, and Resource Coordination (RC) which is available in most County MH/MR programs. Although both of these programs provide the same type of service, the intensity at which the service is provided is different. The two tiered system guarantees many benefits by ensuring that those with the most significant needs are seen at more frequent intervals. Unfortunately this same system design also means a change in case managers when the individual requires a change in the level of case management service.

In July 2003 a pilot project was initiated by the Office of Mental Health & Substance Abuse Services (OMHSAS) to test a case management model in which individuals are not required to change case managers (from ICM to RC or vice-versa) when the intensity of their service needs changes. Referred to as the Blended Case Management Model (BCM), an individual is able to keep the same "blended case manager" despite a change in level of service. This model does not change the case management services being delivered, but it does change the manner in which these services are delivered. It was theorized that by permitting the blended case manager to adjust service intensity based on consumer needs, there would be improved continuity of care and enhanced support for recovery/resiliency concepts, not just for the individual receiving

services but also for the service providers. In essence, the blended case manager would provide both ICM and RC level of service, essentially eliminating the distinction between RC and ICM in terms of service delivery. Nine case management agencies in five County MH/MR offices participated in this pilot project.

Purpose of the Blended Case Management Pilot

The pilot project, initiated in July 2003 and concluded on December 6, 2004, was necessary for two primary reasons:

1. **To measure consumer, family, youth, and case manager satisfaction**

Blended case managers are essentially targeted case managers performing the same activities as Intensive Case Managers and Resource Coordinators; however, as mentioned above, the difference is the way in which these services are delivered. This model broadens the window of service fluctuation and therefore increases certain case management responsibilities such as monitoring, balancing, and flexibility. With these increased demands came the need to ensure that all individuals involved were satisfied with the delivery and receipt of blended case management services. Of particular concern was the need to ensure that individuals with significant needs received proper level of service. In an effort to ascertain this, four types of OMHSAS surveys were collected in the following manner: at the start of blended services (7/03), at six months (1/04), and at twelve months (7/04) from individuals receiving services, youth and family members, and case managers involved in the pilot. In addition, individual pilot programs also collected their own satisfaction results, most with the assistance of their local Consumer Satisfaction Teams. When analyzed by the OMHSAS Management and Information Systems (MIS), both the OMHSAS and local surveys yielded positive results indicating that consumers, youth, families, and case managers were satisfied with blended case management services.

2. **To assess the level of impact the blended case management model may have on the consumer**

Environmental Matrix (EM) scores were collected for individuals in the pilot initially, and at the sixth and twelfth month. Also, the Environmental Matrix was required each time there was a change in service level. The EM scores provided some indication as to whether or not those receiving blended case management demonstrated an increase or a decrease in stability and functioning. EM scores also provided indications regarding the number of times individuals would have changed case managers had they not been part of the pilot project. Data collected from EM scores were analyzed by the OMHSAS MIS Department, with the results indicating that most individuals remained stable or improved. The results also demonstrated that had the blended model not been in place, individuals would have had to change case managers a number of times.

DISCUSSION:

Opportunities for Offering Blended Case Management

Since the conclusion of the pilot projects, many other county MH/MR programs and providers have implemented blended model of case management. Given the positive results of these blended case management programs, the OMHSAS would like to encourage other county MH/MR programs and their case management providers to implement blended case management. In order to do so the OMHSAS is recommending that interested county MH/MR programs complete the following in collaboration with their interested case management programs:

1. **Review the Operational Toolkit (Attachment A):** The Operation Toolkit is a reference for developing a blended case management program. Its design is based on lessons learned from the pilot projects, projects which yielded positive satisfaction results. These lessons are relevant and important for consumer, youth, family and case manager satisfaction as well as the overall success of a blended case management program.

2. Complete and Submit the Blended Case Management Waiver Application which contains the Waiver Request and Safeguards Questionnaire (Attachment B): This application contains a waiver request and safeguard questionnaire. **The waiver request is for waiver of certain ICM and RC requirements in order to implement blended case management. Beyond what is waived, programs must continue to follow all the requirements in the existing ICM regulation Chapter 55 PA Code 5221, and RC bulletin OMH-93-09. Any existing or future policy clarifications on ICM and RC services, with the exception of the requirements specifically waived for blended case management, will be valid for blended case management also.** Responses to the safeguard questions should demonstrate that county MH/MR programs and their interested providers have reviewed the toolkit.
3. Follow the procedure outlined in **Attachment C** when applying for new blended case management programs.
4. Waivers are granted for a year, after which the County MH/MR has to apply for an extension using an Extension Application (**Attachment D**). The procedure outlined in Attachment C does not apply to extension applications.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

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