

## **ATTACHMENT A**

### **OPERATIONAL TOOLKIT**

**This toolkit was developed based on experiences and recommendations from the pilot projects as well as from other programs that have implemented the blended case management model.**

#### **1. Consumer Eligibility**

Any individual who qualifies for ICM or RC level of case management, as specified in 55 PA Code 5221 or OMH-93-09 respectively, shall be eligible for blended case management. Eligibility for at least resource coordination will be the minimum eligibility requirement for blended case management.

#### **2. Building a Blended Case Load**

Based on experience from existing blended programs, OMHSAS recommends that new programs start gradually rather than convert their entire program immediately. Existing programs found that “carving out” a blended model case load from existing ICM or RC case loads helped in a seamless transition. This “carve out” process, combined with acceptance of new referrals, was the preferred method by the pilot programs because it seemed to provide the most seamless transition. The implementation of a blended model need not change the referral process for the programs. But it is critical to carefully assess individuals in an effort to determine who may be appropriate for the blended case management model. Certainly a key factor in assessment would be input from the individual as well as the family.

For individuals on an existing case load that may be moving to a blended case load, it is very important to educate consumers and family members about the Blended Case Management model and address their concerns.

#### **3. Case Load Sizes**

The blended model case load size is composed of a mixture of individuals with a high level of need and those with a lower level of need. Development and ongoing management of case loads should be based on the assumption that, at any time, the needs of all individuals on the case load could be very high and intense necessitating the need for significant case management assistance. Based on experience from the pilot projects, OMHSAS has determined that the case load size for blended model be capped at 30. A case manager to whom a blended caseload is assigned shall handle only blended caseload; he/she shall not handle other ICM or RC cases.

#### **4. Ensuring correct level of service is delivered**

Programs found that the Environmental Matrix (EM) is critical in ensuring the correct level of service is provided. OMHSAS requires that EM be completed every six months at a minimum and whenever there is a change in level of service. OMHSAS is requiring that all new programs interested in implementing the blended program complete and include in each chart an environmental matrix to be done at least every (6) months or more often if there is a change in level of service need. A change in the individual's level of care should be communicated to all relevant agencies/providers involved in the member's care. In addition to the EM, OMHSAS also expects the programs to use additional tools/methods to ensure appropriate level of service is provided. These tools/methods include, but are not limited to:

- Consumer/Family input and inputs from other providers involved in the care.
- Number of crisis contacts
- Current or anticipated stressors
- Use of program specific monitoring tools

Counties that have a previously obtained approval from OMHSAS to use Combined Strengths Assessment Scale (CSAS) in place of Environmental Matrix may continue to use CSAS instead of EM.

### **5. Supervision**

Supervision is critical to the success of blended case management model. Blended case management model increases the window of service fluctuation for the case manager. In order to respond to these wide fluctuations of need, a blended case manager will need to possess numerous skills, especially in the areas of flexibility, time management, and service monitoring. The supervisor must keep a watchful eye on the case load mix as well as the case manager's ability to balance multiple priorities and numerous tasks. Key supervision issues include changes in level of service, time management and organizational skills, flexible scheduling, and methods to streamline paperwork. Blended case management may be a "relearning" process for ICM/RC's who transferred into the blended role compared to a "new hire." OMHSAS recognizes that supervision will be a key factor in the implementation of successful blended case management programs. Based on the experience from the pilot projects, OMHSAS has determined that a supervisor shall supervise no more than nine blended case managers. If there are less than nine blended case managers providing blended case management, the supervisor must devote 1/9<sup>th</sup> of available hours per week to supervising each blended case manager.

### **6. On-Call**

Individuals receiving an ICM level of care are entitled to an on-call system per ICM regulation. Since many individuals receiving blended case management may require ICM level of service, consumers in blended caseloads should also be entitled to an on-call system. The provider shall have a written policy showing how 24 hour, 7 day per week coverage for blended case management services is provided. The case management agency must have a procedure in place to ensure that staff members on call have access to relevant consumer information, including strategies for addressing crisis or emergency situations.

### **7. Discharge Process**

Discharge from the blended case management program occurs when the individual no longer requires a targeted case management level of service or other factors that prompt discharge, such as the individual no longer desired the service or moved out of county, etc.. In short, the discharge/termination criteria should be consistent with the discharge/termination criteria for ICM/RC. The pilot programs reported that at the time of discharge, both the individual and the case manager reported a greater sense of accomplishment, perhaps attributable to the consistent relationship and continuity of care. All consumers discharged from blended case must have an after-care plan developed with family/consumer input that will continue to support recovery.

### **8. Overall - Positive Experiences, Hurdles & Recommendations:**

#### **Positive Experiences**

The pilot projects noted that, based on their experiences, this model accomplished the following:

- an increase in continuity of care (individual and systems level).
- flexibility, particularly for those coming out of facilities or placements.
- increased flexibility to the consumer, family and case manager.

Other positive experiences noted include:

- decreased disruption in service
- consumer/family able to focus more on goals without disruption in case management

- greater sense of accomplishment for consumer and case manager when they are able to maintain a working relationship throughout transitions
- service is consumer driven
- access to on-call crisis
- it appears to be a good model for transition age youth particularly given developmental needs
- demands an increased focus on individuals receiving the service since case loads are screened better to assure people are receiving the right level of care.

#### Hurdles

The pilot programs reported the following hurdles encountered during the implementation and management of the blended programs:

- Initially, when building blended case loads, some case managers were reluctant to let go of “their” consumers.
- Blended case managers had to be flexible and adjust to this type of case load management.
- For some, this model included an increase in paperwork such as the use of the matrix.

#### Recommendations/Requirements:

- Convert gradually – do not transfer your entire case management program into a blended program all at once. An exemption may be granted to fully convert to blended model immediately, if the programs are able to demonstrate that such a conversion (immediate) will not undermine consumer interests or quality of service.
- Consider case load size carefully – it should be noted that, in a blended caseload, it is possible that there will be times when all the individuals in the caseload may require ICM level of service. This means that the caseload size of blended case management should not exceed the ICM caseload limit, which is a maximum of 30 consumers per case manager. All blended programs are required to adhere to this caseload limit.
- This model requires the ability to respond to the continual fluctuations of service needs within a wider window of service delivery as well as increased attention and monitoring. Again, it is critical that supervisors keep these issues in mind. Experience from the pilot projects indicated that a supervisory ratio of 1:9 would be optimal for blended models. All blended programs are required to comply with this supervisory ratio.
- Face to face contact every two weeks may no longer be needed, but the consumers should be seen *as often as needed*. But, at a minimum, the frequency of contact must meet at least the requirements specified in the RC bulletin OMH-93-09.
- Provide increased training to blended case managers in the areas of boundaries, time management, working with individuals with complex needs, and the Environmental Matrix (EM).
- It is critical that the county MH/MR program and case management programs work closely together during the conversion process. The county really needs to be involved and consider whether or not the program seems appropriate for a blended model. At least one pilot program felt new case management programs may not be best suited for doing a blended model given the unforeseen hurdles and trials a program encounters just getting a regular CM program off the ground.

#### **9. Billing / Coding:**

• Assignment of New Blended Case Management Codes – New blended case management programs must apply for a new PROMISe service location number, which will be added to their existing provider number. The assignment of this service location number is consistent with PROMISe business rules and is necessary for certain data collection conducted through the OMHSAS.

•Reimbursement Rates - For non-HealthChoices counties, the reimbursement rate for blended case management will be the ICM reimbursement rate of \$12.45. For HealthChoices counties, this rate should be negotiated with the MCO.