

ATTACHMENT D – BLENDED CASE MANAGEMENT GUIDELINES

These guidelines establish the standards for the provision of mental health Blended Case Management (BCM) under provisions of the approved Medicaid State Plan. Any requests for the waiver of provisions in this bulletin shall be sent to the OMHSAS field office for consideration. Any waiver request that diminishes the effectiveness of the program, violates the purposes of the program, or adversely affects consumers' health and welfare will not be approved by OMHSAS. Also, waiver requests that are inconsistent with consumer rights or federal, state, or local laws and regulations will not be granted by OMHSAS.

SECTION I: GENERAL PROVISIONS

Consumer Eligibility

Any individual who qualifies for Intensive Case Management (ICM) or Resource Coordination (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, as outlined below, will be the minimum eligibility requirement for blended case management.

A. Adults who have a serious mental illness as defined by meeting the criteria for Diagnosis, Treatment History, and Functioning Level:

1. **Diagnosis:** Diagnosis within DSM IV R (or succeeding revisions thereafter), excluding those with a principal diagnosis of mental retardation, psychoactive substance abuse, organic brain syndrome or a V-Code.
2. **Treatment History:** Shall be established when **one** of the following criteria is met:
 - i. Six or more days of psychiatric inpatient treatment in the past twelve months;
 - ii. Met standards for involuntary treatment within the past twelve months;
 - iii. Currently receiving or in need of mental health services and receiving or in need of services from two or more human service agencies or public systems such as Drug and Alcohol, Vocational Rehabilitation, Criminal Justice, etc;
 - iv. At least 3 missed community mental health service appointments, or two or more face-to-face encounters with crisis intervention/emergency services personnel within the past twelve months, or documentation that the consumer has not maintained his/her medication regimen for a period of at least 30 days.
3. **Functioning Level:** Global Assessment of Functioning Scale (as defined in DSM IV R or revisions thereafter) ratings of 60 and below.

- B.** Adults who were receiving resource coordination, intensive case management, or blended case management services as children and were recommended by the provider and approved by the County Administrator or his/her designee, or the Behavior Health Managed Care Organization, as applicable, as needing blended case management services beyond the date of transition from child to adult.
- C.** Children who have a mental illness or serious emotional disturbance as defined by meeting the criteria for Diagnosis, Treatment History and Functioning Level:
1. **Diagnosis:** Diagnosis within DSM IV R (or succeeding revisions thereafter) excluding those with a principal diagnosis of mental retardation, psychoactive substance abuse, organic brain syndrome or a V-Code.
 2. **Treatment History:** Shall be established when one of the following criteria is met:
 - i. Six or more days of psychiatric inpatient treatment in the past twelve months;
 - ii. Without blended case management services would result in placement in a community inpatient unit, state mental hospital or other out-of-home placement, including foster homes or juvenile court placements;
 - iii. Currently receiving or in need of mental health services and receiving or in need of services from two or more human service agencies or public systems such as Education, Child Welfare, Juvenile Justice, etc.
 3. **Functioning Level:** Global Assessment of Functioning Scale (as defined in DSM IVR or revisions thereafter) ratings of 70 and below.
- D.** An adult, child or adolescent who currently receives Intensive Case Management or Resource Coordination services.
- E.** An adult, child or adolescent who needs to receive blended case management services, but does not meet the requirements identified above, may be eligible for Blended Case Management upon review and recommendation by the County Administrator or his/her designee, or the Behavioral Health Managed Care Organization, as applicable.

Discharge Process

Blended case management may be terminated for one of the following reasons:

- A.** Determination by the consumer or the parent of a child receiving the service that blended case management is no longer needed or wanted, and with written concurrence by the county administrator or the Behavioral Health Managed Care Organization that blended case management is no longer necessary or appropriate for the adult or child receiving the services;

- B. Determination by the blended case manager in consultation with his supervisor or the director of blended case management, and with written concurrence by the county administrator or the Behavioral Health Managed Care Organization that blended case management is no longer necessary or appropriate for the adult or child receiving the services;
- C. The consumer or the child moves out of the geographical jurisdiction of the county/provider.

If a consumer declines or refuses services despite the case manager's persistent and caring attempts to engage that individual, discharge from BCM or transfer to a lower level of care should not occur automatically. In such situations, a thorough review of the circumstances, the clinical situation, the risk factors, and strategies to reengage the individual shall be reviewed and documented before discharge is considered.

Consumers cannot be terminated from services for non-compliance or non-participatory behavior that results from a mental illness or emotional disorder. All consumers discharged from blended case management shall have an after-care plan developed with family/consumer input that will continue to support recovery.

Building a Blended Case Load

OMHSAS recommends that existing ICM and RC programs transition gradually to BCM 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 the ICM and RC caseloads 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.

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 Case Management shall not exceed 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.

Ensuring correct level of service is delivered

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 case management 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 the Combined Strengths Assessment Scale (CSAS) in place of the Environmental Matrix (EM) may continue to use the CSAS instead of EM.

Supervision

Supervision is critical to the success of the blended case management model. The 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. 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 shall devote 1/9th of available hours per week to supervising each blended case manager.

On-Call

Individuals receiving blended case management services are 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 shall 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.

Relationship to Other Parts of the System

- A. The intensive case manager or supervisor shall be present when an involuntary commitment of a consumer is being considered to ensure that all appropriate alternatives to hospitalization are reviewed.
- B. Enrolled providers shall establish formal and informal links with other service providers as needed to carry out BCM activities. Written agreements shall be made with frequently used external providers/agencies including the county MH/MR program, psychiatric inpatient facilities, partial hospitalization programs, psychiatric clinics, residential programs, drug and alcohol programs, social and vocational programs and other agencies as needed. The providers shall have agreements with the county mental health crisis intervention services to contact the on-call case manager when contacted by a consumer or a parent, if the consumer is a child receiving BCM services.

For children and their families, linkages shall also be established with child welfare, education, juvenile justice, and other child serving systems.

Provider Participation

Providers of Blended Case Management (BCM) services are required to enroll in Pennsylvania's Medical Assistance Program as a BCM provider. Refer to Attachment C for additional information concerning Provider Enrollment. Upon enrollment into the Pennsylvania Medical Assistance Program as a provider of Blended Case Management services, providers are bound by the General Provisions (Chapter 1101); MA Program Payment Policies (Chapter 1150), and the specific criteria outlined in this bulletin

SECTION II: RESPONSIBILITIES

Responsibilities of County Administrators

County Mental Health Administrators, in partnership with their Behavioral Health Managed Care Organization(s), are responsible for identifying the need for blended case management services and for developing a program and fiscal plan to address that need. County Administrators and Managed Care Organizations are required to monitor the compliance of providers of case management services under their jurisdiction with the provisions of these guidelines, as well as to provide fiscal and program reports to the Department. Administrators shall certify if state funds are available for matching Medicaid compensable services and, if applicable, ensure that sufficient state funds are available for non-Medicaid compensable services.

Responsibilities of Providers

Providers shall adhere to requirements set forth in these guidelines and submit reports as required by the Department and the County Administrator or Behavioral Health Managed Care Organization. Providers shall assist consumers or the parents, if the consumer is a child, in accessing appropriate mental health services and in obtaining and maintaining culturally appropriate basic living needs and skills. Services shall be provided within the context of the consumer's and the family's culture. Providers shall provide services in accordance with a written, consumer-specific, service plan which is goal and outcome oriented. The initial plan shall be developed within 30 days of admission to blended case management, and shall be reviewed and updated at least every 6 months. Outcomes shall be reported to the Department via the *Consolidated Community Reporting Performance Outcome Management System (CCR POMS)* or any other reporting system that the Department may establish in the future. Providers shall deliver services as needed in the place where the consumer resides or needs the service. Services may also be provided at the Blended Case Manager's office when off-site interventions would not be more appropriate.

Providers shall contact the consumer or the parents, if the consumer is a child or adolescent, as often as necessary. Face-to-face contact with a child or adolescent consumer shall be made at least once a month and face-to-face contact with an adult consumer shall be made at least every two months. Minimal contact should not be the standard and should reflect a lower level of service delivery for individuals who are stabilized and who would normally have been transferred to a lower level of case management service. Many will need contact weekly or

more frequently consistent with the standards set forth in the ICM regulations. If the consumer cannot be contacted face-to-face, the attempt to contact shall be documented. In situations where numerous attempts have been made, the case manager should utilize assertive and creative means to contact the consumer, including utilizing family and natural supports. The provider shall establish protocols to ensure that the blended case management staff attend orientation, state mandated core case manager training, and ongoing training sessions. Providers shall ensure that the principles established by the *Pennsylvania Child and Adolescent Service System Program* (CASSP) are followed in providing services for consumers who are children or adolescents and their families, and that *Recovery* as well as *Community Support Program* (CSP) principles are followed in providing services for adult consumers.

SECTION III: REQUIREMENTS

Staff Requirements

The following minimum requirements shall be met by supervisors of blended case management services:

- A.** A master's degree in social work, psychology, rehabilitation, activity therapies, counseling or education and 3 years mental health direct care experience; or
- B.** A bachelor's degree in sociology, social work, psychology, gerontology, anthropology, history, criminal justice, theology, counseling, education, or be a registered nurse, and 5 years mental health direct care experience, 2 of which shall include supervisory experience; or
- C.** A bachelor's degree in nursing and 3 years mental health direct care experience.

A blended case management staff person shall meet one of the following criteria:

- A.** Bachelor's degree with major course work in sociology, social welfare, psychology, gerontology, anthropology, other related social sciences, criminal justice, theology, nursing, counseling, or education; or
- B.** Registered nurse; or
- C.** A high school diploma and 12 semester credit hours in sociology, social welfare, psychology, gerontology, or other social science and two years experience in direct contact with mental health consumers; or
- D.** A high school diploma and five years of mental health direct care experience in public or private human services with employment as a case management staff person prior to April 1, 1989.

Mental health direct care experience is working directly with mental health service consumers (adults, children or adolescents) providing services involving casework or case management, individual or group therapy, crisis intervention, early intervention, vocational training, residential care, or social rehabilitation in a mental health facility or in a facility or program that is publicly

funded to provide services to mental health consumers, or in a nursing home, a juvenile justice agency, or a children and adolescent service agency.

Blended case managers shall be employed as full-time staff unless an exception is granted by the Office of Mental Health and Substance Abuse Services. When a part-time case manager has been approved, the case manager may not provide any service other than BCM service to any individual on his/her caseload. The maximum size of the caseload managed by the part-time case manager shall be proportionate to the hours worked.

Recordkeeping Requirements

Records shall be maintained which verify compliance with the requirements of these guidelines, and shall be retained for a minimum of seven years. Site survey reports, employee schedules, payroll records, job descriptions, documents verifying employee qualifications and training, policies and protocols, fees or charges, records of supervision and training, letters of agreement with referral sources and service agencies, and a grievance and appeals process are examples of records that shall be kept to verify compliance with these guidelines.

- A. Blended case management records shall be identified and maintained apart from other service records using forms required by the Department.
- B. Records shall be maintained for a minimum of 7 years.
- C. Written procedures and records shall be kept in accordance with Chapters 1101 and 4300 of the Pennsylvania Code (relating to general provisions; and county mental health and mental retardation fiscal manual).
- D. Changes in a consumer's progress, including admission and termination, shall be documented detailing cause and projected effect in the case record. For example, a meeting with a teacher shall indicate why the meeting was arranged and what the case manager hopes to accomplish in serving the consumer.

Case Records Requirements

To satisfy the recordkeeping requirements in §§ 5221.31(4) and 5221.41 (relating to responsibilities of providers; and recordkeeping), blended case management records should contain, at a minimum, the following:

- A. **Intake Information.** The following shall be included:
 - 1. Identifying information to include the consumer's name, address, date of birth, social security number, and third part resources;
 - 2. Referral Form, to include date, source and reason for referral to Blended Case Management, and DSM IV (or subsequent revision) diagnosis;
 - 3. Verification of eligibility to receive blended case management, such as past treatment records, psychiatric or psychological evaluation, letter summarizing treatment history, Individual Education Plan (IEP), and the like.

B. Assessments and Evaluations. The following assessments and evaluations shall be made:

1. Medical history, taken within the past 12 months, or documentation of the blended case manager's efforts to assist the consumer in obtaining a physical examination;
2. Assessment of the consumer's strengths, needs, and interests;
3. Summaries of hospitalizations, incarcerations or other out-of-home placements while enrolled in blended case management, including the place and date of admission, reason for admission, length of stay, and discharge plan;
4. Children only: IEP, school testing - for example, psychological evaluations – guidance counselor reports, and the like, or documentation of the blended case manager's efforts to obtain the information if not in the record;
5. Outcome information required for annual Consolidated Community Reporting Performance Outcome Management System reporting—that is, consumer level of functioning, independence of living, and vocational/educational status.

The following applies to clauses 1, 3, and 4 above:

- a. If the blended case management provider is part of a multiple service agency which maintains the assessments and evaluations in clauses (1), (3) and (4) in another file, the information other than that required to establish eligibility for blended case management does not need to be duplicated for the blended case management record;
- b. These reports are considered to be part of the blended case management record, and shall be made available if the blended case management record is requested.

C. Written Service Plan. The plan shall:

1. Be developed within 1 month of registration with input from the consumer and reviewed at least every 6 months;
2. Reflect documented assessment of the consumer's strengths and needs;
3. Be signed by the consumer, the family if the consumer is a child, the blended case manager, the blended case management supervisor and others as determined appropriate by the consumer and the blended case manager. If the signatures cannot be obtained, attempts to obtain them should be documented;
4. Identify specific measurable goals, outcomes, and objectives. The service plan shall also identify responsible persons, time frames for completion and the Blended Case Manager's role in relation to the consumer and others involved.

D. Documentation of Services. The following shall be included:

1. Case Notes. The case notes shall:

- a. Be legible;
- b. Verify the necessity for the contact and reflect the goals and objectives of the blended case management service plan;
- c. Include the date, time and circumstance of contacts, regardless of whether or not a billable service was provided;
- d. Identify the consumer by name or case number on both sides of each page on which there is writing on both sides. The consumer's name and case number should appear together earlier in the file;
- e. Be dated and signed by the individual providing the service.

2. Documentation of Referral for Other Services.

- a. Signed Encounter forms.

3. Discharge Information. The following shall be included:

- a. A termination summary, including a reason for admission to blended case management, the services provided, the goals attained, the goals not completed and why, and a reason for closure. The summary shall:
 - i. Contain the signature of the consumer, the family if the consumer is a child, and involved others, if obtainable.
 - ii. Contain the signature of the county administrator/designee or the authorized representative of the Behavioral Health Managed Care Organization (as applicable) whether the consumer (or family, if the consumer is a child) consents to termination or not.
 - iii. Contain the signature of the county administrator/designee or the authorized representative of the Behavioral Health Managed Care Organization (as applicable) if the consumer requests termination but is at risk.
- b. A recommended after-care plan.

Quality Assurance and Utilization Review

The quality and appropriateness of services shall be monitored at the agency and county levels. Monitoring shall occur according to an annual quality assurance/utilization review plan, to be developed by each provider of blended case management services, and to be reviewed and approved by the County MH/MR Administrator/designee or the Behavioral Health Managed Care Organization as applicable. The plan shall address the implementation of concurrent utilization review, peer review, consumer and family member satisfaction surveys, and self-evaluation of compliance with standards set forth in this chapter. Services are subject to reviews by federal and state authorities as well as by agents of the county.

Conflict of Interest

When an agency that provides blended case management also provides other mental health treatment, rehabilitation or support services, the responsible county administrator shall ensure that the provider agency:

1. Does not restrict the freedom of choice of the consumer, or parent, if the consumer is a child, of needed services and provider agencies when needed services, including case management, are available;
2. Fully discloses the fact that the agency is or may be performing other direct services which could be obtained at another agency if the consumer so desires;
3. Provides each consumer and parent, if the consumer is a child, a listing of mental health treatment, rehabilitation and support services available within a reasonable proximity to the consumer's home where needed services could be obtained and if the consumer or parent, if the consumer is a child, so desires, the blended case manager assists the consumer or parent in obtaining those services;
4. Documents that the information in this section has been reviewed and understood by the consumer or parent, if the consumer is a child.

SECTION IV: CONSUMER RIGHTS

Consumer Participation - Consumers have a right to terminate services without prejudice to other mental health services or future services. Consumers shall receive assurances of nondiscrimination, right of appeal and individual civil rights. The Mental Health Procedures Act, 50 P.S. §7101 et seq., provides for an adolescent's right to seek or reject services. Parents shall be involved in service planning for a child, and should be involved in service planning for adolescents over 14 unless the adolescent objects. Consumers cannot be terminated from services for non-compliant or non-participatory behavior that results from a mental illness or emotional disorder.

Notice of Confidentiality - There shall be an assurance of confidentiality to individuals receiving blended case management services as provided by Departmental regulations at 55 PA Code 5100.31-39 and all applicable Federal and State laws. The right to confidentiality shall serve to protect the consumer's dignity and well-being, and not to create a barrier to appropriate treatment and services.

Non-Discrimination – Enrolled providers shall not discriminate against staff or consumers on the basis of age, race, sex, religion, ethnic origin, economic status, sexual preference, or gender identity and shall observe applicable State and Federal statutes and regulations.

Recipient Right of Appeal - Department actions for misutilization or abuse against a staff or consumer receiving blended case management are subject to the right of appeal in accordance with Chapter 275 (relating to appeal and fair hearing and administrative disqualification hearings).

Adults and children who have been terminated from blended case management services over their objections, or the objection of a parent if the child is 13 years of age or younger, shall have the right to appeal the decision in accordance with procedures as outlined in Mental Retardation Bulletin Number 99-86-01 (a joint Mental Health/Mental Retardation Bulletin: Procedures for Review of Service Eligibility and Termination Decisions) effective January 17, 1986 and subsequent revisions of policy. Copies of the bulletin may be obtained from the county administrator.

SECTION V: BLENDED CASE MANAGEMENT ACTIVITIES

Blended case management is a service which will assist eligible individuals with mental illness, including children with a serious mental illness or emotional disorder, in gaining access to needed medical, social, educational and other services.

Activities undertaken by staff providing case management services shall include:

Linking with Services - Assisting the consumer in locating and obtaining services specified in the treatment or services plan, or both, including arranging for the consumer to be established with the appropriate service provider.

Monitoring of Service Delivery - There shall be an ongoing review and written record of the person's receipt of, and participation in, services. Contact with the consumer shall be made on a regular basis to determine his opinion on progress, satisfaction with the service or provider, and needed revisions to the treatment plan. Contact with the consumer's therapist shall be made on a regular basis to determine if the person is progressing on issues identified in the treatment plan and if specific services continue to be needed and appropriate. A process shall be developed for resolution between staff members with levels of appeal to be pursued when there is clinical disagreement on the nature and extent of progress a particular consumer is making. Regular contacts shall be made with other public agencies serving the consumer and with parents, if the consumer is a child.

Gaining Access to Services - Assertive and creative attempts are required to help the person gain resources and services identified in the treatment or service plan, or both. This may include home and community visits and other efforts as needed. It does not preclude the

consumer's therapist from accompanying the case manager on these visits. Home and community shall be defined broadly to include field contacts which may take place on the street, at the person's residence or place of work, psychiatric treatment facilities, rehabilitation programs and other agencies where support or entitlements are available to the recipient.

Assessment and Service Planning - A review of clinical assessment information and a general discussion with the consumer is required regarding unmet needs and plans for the future.

Problem Resolution - Active efforts to assist the person in gaining access to needed services and entitlements. Staff shall have easy access to communicate with the county administrator for the purpose of obtaining assistance in resolving issues which prevent a person from receiving needed treatment, rehabilitation and support services. On a systems level, this may include providing information to help plan modifications to existing services or implement new services to meet identified needs and providing information to help plan modifications for accessing resources.

Informal Support Network Building - Contact with the consumer's family (not family counseling or therapy), and friends with consumer's permission and cooperation to build an informal support network.

Use of Community Resources - Assistance to persons in identifying, accessing and learning to use community resources to meet his daily living needs shall be provided as needed by making referrals to appropriate service providers.