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OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES BULLETIN

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SUBJECT: Blended Case Management (BCM) - Revised

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SCOPE:

Behavioral Health Managed Care Organizations
County Mental Health/Mental Retardation Administrators
Mental Health Targeted Case Management Providers

PURPOSE:

This bulletin revises the earlier OMHSAS Blended Case Management (BCM) bulletin OMHSAS-09-02 to reflect updated information regarding **supervisory qualifications** *(Attachment D, Section III-Requirements, Staff Requirements)* and **documentation of discharge information** *(Attachment D, Section III-Requirements, Case Record Requirements, Documentation of Services, Discharge Information*) for BCM services. This bulletin applies to adult as well as children's services and retains all the requirements outlined in OMHSAS-09-02 barring the revisions indicated above. The issuance of this bulletin shall render the previous bulletin on BCM, OMHSAS-09-02, obsolete.

All counties, mental health case management providers, and Behavioral Health Managed Care Organizations (BHMCO) shall use the guidelines and standards in this bulletin for developing, administering, and monitoring BCM.

BACKGROUND:

Since its inception in 1988, Targeted Case Management (TCM) has been separated into two distinct programs, namely, Intensive Case Management (ICM), and Resource Coordination (RC). 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. However, this system design also requires a change in case managers when the consumer

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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, this model allows the consumer to keep the same "blended case manager" even when there is a change in the level of service needs. 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. In essence, the blended case manager would provide ICM or RC level of service as needed, 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.

The purpose of this pilot project was: a) to measure consumer, family, youth, and case manager satisfaction, and; b) to assess the level of impact the blended case management model may have on the consumer. OMHSAS, as well, as individual pilot programs, conducted surveys with consumers, youth, family members and case managers. Analyses of these surveys confirmed positive results indicating that consumers, youth, families and case managers were satisfied with blended case management services. To assess the level of impact the blended model had on the consumer, the Environmental Matrix (EM) scores were collected for individuals in the various pilot programs. Analyses of data from the EM scores indicated 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.

This model has proven to accomplish the following:

- It increases the continuity of care at both the individual as well as the systems level, and decreases disruption in service, thereby allowing consumers and families to focus more on goals;

  It provides flexibility, particularly for those coming out of facilities or placements;

  It gives the consumer and the case manager a greater sense of accomplishment because they are able to maintain a working relationship throughout transitions;

  It allows services to be consumer driven.

DISCUSSION:

Since the completion of the pilots in December 2004, many county MH/MR programs and providers have implemented the blended model of case management. Given the positive results of these blended case management programs, OMHSAS recommends that county MH/MR programs and their case management providers develop plans for conversion of their ICM and RC caseloads to BCM model. New case management providers may choose to enroll as blended case management providers from the outset; they are not required to enroll

as an ICM or RC provider to be eligible to enroll as a BCM provider. Existing BCM providers do not have to take any additional steps to remain enrolled as BCM providers. The approval process for BCM (both new and existing) will follow the established protocols for review and approval of TCM programs.

The following attachments to this bulletin establish the standards and guidelines for BCM services:

Attachment A contains the definitions of the terms used in this bulletin;

Attachment B describes fiscal issues associated with the provision of BCM;

Attachment C describes the procedures that will enable providers to enroll in PROMISe™ (Provider Reimbursement and Operations Management Information System), which is the claims processing and management information system implemented by the Pennsylvania Department of Public Welfare; and

Attachment D provides the standards and guidelines for the provision of BCM.

The bulletin also contains the following three appendices:

Appendix A provides additional guidelines for the provision of blended case management services to children and adolescents with serious emotional disturbance and their families.

Appendix B contains Pennsylvania's Community Support Program Values and Principles which are the guiding principles that emphasize client self-determination, individualized and flexible services, normalized services and service settings, and service coordination.

Appendix C contains the Recovery Principles which are the fundamental elements and guiding principles of mental health recovery that serve as guideposts for recovery-oriented services.

OBSOLETE BULLETIN: The issuance of this bulletin shall render the previous bulletin on Blended Case Management, OMHSAS-09-02, obsolete.