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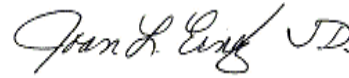
NUMBER:

OMHSAS-09-02

SUBJECT:

Blended Case Management (BCM)

BY:



Joan L. Erney, J.D.
Deputy Secretary

Office of Mental Health and Substance Abuse Services

SCOPE:

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

PURPOSE:

The purpose of this bulletin is to establish blended case management as a stand-alone service. This bulletin transmits the information necessary for the provision and reimbursement of blended case management services, and applies to adult as well as children's services. The issuance of this bulletin shall render the previous bulletin on Blended Case Management, OMHSAS-06-06, 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 blended case management. Most of the program standards delineated in this bulletin are already being followed by all the providers of blended case management. Additional guidelines have been added in order to strengthen blended case management services. The intent of this bulletin is to consolidate those standards and guidelines, and also to eliminate the need for waivers to provide blended case management as previously required in the now obsolete Blended Case Management Bulletin OMHSAS-06-06.

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

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Office of Mental Health and Substance Abuse Services, Bureau of Policy and Program Development,
P.O. Box 2675, Harrisburg, PA 17105. General Office Number 717-772-7990

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 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), 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-06-06, obsolete.

ATTACHMENT A – DEFINITIONS

The following words and terms, when used in this bulletin, have the following meanings, unless the context clearly indicates otherwise:

Blended Case Management (BCM): The model of Targeted Mental Health Case Management as described in this bulletin.

Case: A consumer and members of the consumer's family if the consumer is a child).

Child: A person 17 years of age or younger or 21 years of age or younger if enrolled in special education.

Consumer: A person who receives case management services. The term does not include a family member who receives services.

County Administrator: The MH/MR administrator who has jurisdiction in the geographic area.

Department: The Department of Public Welfare of the Commonwealth of Pennsylvania.

Emotional Disturbance/Disorder: A child's inability to function in the home, school or community, resulting in the child requiring multiple medical, social, educational or other supports.

Environmental Matrix: A scale which evaluates the functional level of consumers on the activities identified as Blended Case Management activities.

Enrolled Provider: A county MH/MR program or private agency which has been approved by the Department and enrolled by the Office of Mental Health and Substance Abuse Services in PROMISE for claims processing and/or reporting of services rendered.

Family: Parents, as defined in this section, siblings and other relatives living in the home.

Global Assessment of Functioning (GAF) Scale: A procedure for measuring the overall severity of psychiatric disturbance which is contained in DSM-IV-R (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Revised) or revisions thereafter, published by the American Psychiatric Association.

Intensive Case Manager: A staff person qualified and designated to provide Intensive Case Management under 55 PA Code §5221.21

Intensive Case Management (ICM): The services described in 55 PA Code §5221 which are designed to assist targeted adults with serious and persistent mental illness and targeted children with a serious mental illness or emotional disorder and their families, to gain access to needed resources such as medical, social, educational and other services.

MH/MR: Mental Health/Mental Retardation.

Mental Health Direct Care Experience: Working directly with adult or children mental health service consumers, 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.

Mental Illness: The existence of a mental disability subject to DSM IV-R (or revisions thereafter) diagnoses, excluding mental retardation or substance abuse as the primary diagnosis, diagnosed by a licensed physician or psychologist.

Parent: The biological or adoptive mother or father or the legal guardian of the child or a responsible relative or caretaker with whom the child regularly resides.

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

Resource Coordination (RC): The services described in OMHSAS Bulletin OMH-93-09, which are designed to assist targeted adults with serious mental illness and targeted children with a serious mental illness or emotional disorder and their families, to gain access to needed resources, such as medical, social, educational and other services.

Resource Coordinator: A staff person qualified and designated to provide Resource Coordination

Supervisor: A person who is qualified and designated to supervise case managers.

Targeted Population: Adults with serious mental illness and children with serious mental illness or emotional disorders who are deemed eligible to receive Blended Case Management as identified by the county administrator or the Behavioral Health Managed Care Organization as applicable.

ATTACHMENT B - FISCAL ISSUES

The guidelines outlined in this bulletin establish criteria for payment for blended case management services under provisions of 55 PA Code §4300 (the County MH/MR Fiscal Manual). Providers who serve eligible fee-for-service recipients shall bill the Medical Assistance Program via PROMISe™ for eligible services. Payment for a 15 minute unit of service will be made by a department established fee. Billable services include the activities listed in *Attachment D Section V: Blended Case Management Activities*. Activities such as staff meetings, attending training, and completing paperwork are not billable as units of service. Providers who serve eligible HealthChoices recipients will work with the Behavioral Health Managed Care Organization (BH-MCO) with whom they have contracted to receive payment for services rendered.

The maximum number of units that may be billed during a 15 minute period shall equal the number of staff persons involved or the number of consumers being served, whichever is smaller. For payment for services rendered to Fee-For-Service recipients, the reimbursement rate for blended case management will be the same as the rate for Intensive Case Management (ICM) as determined by the Department. For payment for services rendered to HealthChoices recipients, the rates are determined by the BH-MCO with which the provider has contracted.

Blended Case Management services provided to consumers residing in inpatient settings are not eligible for Medicaid reimbursement except under the circumstances outlined in OMHSAS Policy Clarifications TCM – 01 dated February 26, 2007, and ICM-04/RC-01/FBMHS-09 dated November 6, 1995. Justified non-Medicaid reimbursable services provided to consumers in inpatient facilities may be billed to the County for reimbursement from state funds.

The Centers for Medicare and Medicaid Services (CMS) requires OMHSAS to affirm the availability of state funds prior to submitting invoices to Medical Assistance for federal reimbursement. This requirement will remain in effect and will continue to be the responsibility of the county. All documentation to support the reimbursement of services should be maintained at the provider level.

Effective July 2003, OMHSAS has enforced a Department established fee for each service. Providers who render services to Medicaid eligible consumers will receive reimbursement of the federal share per the department established fee through PROMISe™. For more billing related information, please refer to The PROMISe™ Provider Handbook and Billing Guides available at:

<http://www.dpw.state.pa.us/PartnersProviders/PROMISe/003675041.htm>.

ATTACHMENT C – PROVIDER ENROLLMENT

All Blended Case Management providers shall be licensed/approved by the Office of Mental Health and Substance Abuse Services (OMHSAS) to provide blended case management (BCM) services. OMHSAS-approved/licensed providers of BCM services shall be enrolled into Pennsylvania's Medical Assistance (MA) Program to receive payment for BCM services rendered to eligible recipients. Enrollment in the MA Program includes meeting the conditions of these guidelines and enrolling in PROMISe™ as a BCM provider prior to billing for services. When in conflict, these guidelines shall prevail over requirements established in other bulletins.

New BCM providers shall apply for a PROMISe™ service location number. This is accomplished by completing a PROMISe™ Provider Enrollment Base Application. For any new provider, or for a provider expanding services to include BCM, the county must notify the Department in writing of their intent to support the program under county funding, MA fee-for-service funding, and/or HealthChoices funding. Existing BCM providers do not have to take any additional steps to remain enrolled as BCM providers.

Procedure to Enroll in PROMISe as a Blended Case Management Provider

The PROMISe™ provider enrollment application can be found at: <http://www.dpw.state.pa.us/omap/promise/enroll/omappromiseenroll.asp>. The provider shall complete all the required enrollment documents for Provider Type 21, Case Manager, and list each location that will be performing blended case management services. Providers should also review the “Requirements/Additional Information/Forms” section for Provider Type 21 to ensure the application is complete when submitted. Required documentation is listed in the checklist below:

- ✓ Completed and signed Pennsylvania PROMISe™ Provider Enrollment Base Application
- ✓ Case Management Addendum for Blended Case Management
- ✓ TIN Label or document from the IRS which includes the TIN
- ✓ Signed DPW Provider Agreement for Outpatient Providers
- ✓ Copy of OMHSAS Site Survey Approval for Blended Case Management
- ✓ Letter from County indicating Financial Support for Blended Case Management

Mail the completed PROMISe enrollment application and accompanying documentation to:

DPW/OMHSAS
Provider Systems and Database Management Unit
DGS Annex Complex
Bldg #31, Shamrock Hall, 2nd Fl.
PO Box 2675
Harrisburg, PA 17105-2675

Provider will receive a letter informing them of their enrollment into PROMISe™ as a provider of Blended Case Management services.

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. Bachelor's degree in sociology, social work, psychology, gerontology, anthropology, nursing, other related social sciences, criminal justice, theology, counseling, or education, and have two years mental health direct care experience; or
- B. Registered nurse with three 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 the 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, if the consumer (or family, if the consumer is a child) does not consent to termination.
 - 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

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.

APPENDIX A

PENNSYLVANIA CASE MANAGEMENT SERVICES FOR CHILDREN AND ADOLESCENTS WITH SEVERE EMOTIONAL DISTURBANCE/DISORDERS AND THEIR FAMILIES

A. Core Values for the System of Care

1. The system of care should be child-centered, with the needs of the child and family dictating the types and mix of services provided;
2. The system of care should be community-based, with the focus of services as well as management and decision –making responsibility resting at the community level.

B. Principles of Services for Children & Adolescents in Pennsylvania

1. Children and adolescents deserve to live and grow in nurturing families;
2. Children and adolescents' needs for security and permanency in family relationships should pervade all planning;
3. The family setting should be the first focus for treatment for the child or adolescent. Out-of-home placement should be the last alternative. Young children should not need to be in a State hospital to receive appropriate mental health treatment;
4. Communities should develop a rich array of services for children and their families so that alternatives to out-of-home placement are available, such as home-based services, parent support groups, day treatment facilities, crisis centers and respite care;
5. Parents and the child should participate fully in service planning decisions;
6. The uniqueness and dignity of the child or adolescent and his/her family should govern service decisions. Individualized service plans should reflect the child or adolescent's developmental needs which include family, emotional, intellectual, physical and social factors. The older adolescent's right to risk should be considered. Children and adolescents should not need to be labeled in order to receive necessary services;
7. The community service systems which are involved with the child and family should participate and share placement, program, funding and discharge responsibilities;
8. The primary responsibility for the child or adolescent should remain with the family and community. Pre-placement planning should include a discharge plan;
9. Case management should be provided to each child and family to ensure that multiple services are delivered in a coordinated, time-limited and therapeutic manner which meets the needs of the child and family;
10. Each child should have an advocate.

The Pennsylvania Child and Adolescent Service System Program (CASSP)

The following guidelines form the foundation for blended case management services for children and their families:

1. The major thrust of the case management service shall be the commitment to permanency planning for each child and adolescent with severe emotional problems;
2. The relationship of the case manager with the family shall be one of a partnership, embodying the concept of “parents and professionals as partners”;
3. The process of providing case management services to children and adolescents and their families shall be based on the developmental needs and phases of the children and adolescents as they progress to adulthood;
4. The case manager will first utilize the normalizing community services as resources in serving the child and family rather than “specialty services”;
5. The case management services shall be delivered in the context of a systems approach, recognizing that case management services shall be integrated with the other child-serving agencies and systems serving the child;
6. The case manager needs to view the family as the primary care giver and recognize the family as the primary resource in the care and treatment of their children;
7. The role of the case manager most often will be that of teacher and consultant to the family.

APPENDIX B

COMMUNITY SUPPORT PROGRAM VALUES AND PRINCIPLES

The Community Support Program (CSP) of Pennsylvania is a coalition of mental health consumers, family members and professionals working to help adults with serious mental illnesses and co-occurring disorders live successfully in the community. The statewide coalition links CSP nationally with regional and local CSP's throughout the State. The following is a list of their core values and principles.

Services should be consumer-centered. Services should be based on and responsive to the needs of the client rather than the needs of the system or the needs of providers.

Services should empower clients. Services should incorporate consumer self-help approaches and should be provided in a manner that allows clients to retain the greatest possible control over their own lives. As much as possible, clients should set their own goals and decide what services they will receive. Clients also should be actively involved in all aspects of planning and delivering services.

Services should be racially and culturally appropriate. Services should be available, accessible and acceptable to members of racial and ethnic minority groups and women.

Services should be flexible. Services should be built upon the assets and strengths of clients in order to help them maintain a sense of identity, dignity and self-esteem.

Services should be normalized and incorporate natural supports. Services should be offered in the least restrictive, most natural setting possible. Clients should be encouraged to use the natural supports in the community and should be integrated into the normal living, working, learning and leisure time activities of the community.

Services should meet special needs. Services should be adapted to meet the needs of subgroups of severely mentally ill persons such as elderly individuals in the community or institutions; young adults and youth in transition to adulthood; mentally ill individuals with substance abuse problems, mental retardation, or hearing impairments; mentally ill persons who are homeless; and mentally ill persons who are inappropriately placed within the correctional system.

Services systems should be accountable. Service providers should be accountable to the users of the services and monitored by the state to assure quality of care and continued relevance to client needs. Primary consumers and families should be involved in planning, implementing, monitoring and evaluating services.

Services should be coordinated. In order to develop community support systems, services should be coordinated through mandates or written agreements that require ongoing communication and linkages between participating agencies and between the various levels of government. In order to be effective, coordination must occur at the client, community and state levels. In addition, mechanisms should be in place to ensure continuity of care and coordination between hospital and other community services.

APPENDIX C

RECOVERY PRINCIPLES

Self-direction: Consumers lead, control, exercise choice over, and determine their own path of recovery by maximizing autonomy, self-agency, and independence.

Individualized and Person-Centered: There are multiple pathways to recovery based on the individual person's unique consumer needs, preferences, experiences – including past trauma, and cultural backgrounds in all of its diverse representations. Individuals also identify recovery as being an on-going journey, an “end result” as well as an overall paradigm for achieving optimal mental health.

Empowerment: Consumers have the authority to exercise choices and make decisions that impact their lives and are educated and supported in so doing.

Holistic: Recovery encompasses the varied aspects of an individual's life including mind, body, spirit, and community including such factors as housing, employment, education, mental health and healthcare services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person.

Non-Linear: Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from these experiences.

Strengths-Based: Recovery focuses on valuing and building on the multiple strengths, resiliency, coping abilities, inherent worth, and capabilities of individuals.

Peer Support: The invaluable role of mutual support wherein consumers encourage other consumers in recovery while providing a sense of belongingness, supportive relationships, valued roles and community is recognized and promoted.

Respect: Community, systems, and societal acceptance and appreciation of consumers - including the protection of consumer rights and the elimination of discrimination and stigma – are crucial in achieving recovery. Self-acceptance and regaining one's belief in one's self is also vital, as is respect for others.

Responsibility: Consumers have personal responsibility for their own self-care and journeys of recovery. This involves taking steps towards one's goals that may require great courage.

Hope: Recovery provides the essential and motivating message that people can and do overcome the barriers and obstacles that confront them.