Clinical Performance Standards:

Behavioral Health Case Management

Updated August 2023

C·B·H
Community Behavioral Health
A DIVISION OF DBHIDS | CBHPHILLY.ORG

Member Services Hotline
888.545.2600
888.436.7482 *(TTY)*

Mental Health
Delegate Hotline
215.685.6440

TABLE OF CONTENTS

1. INTRODUCTION

1.1. Purpose of the Standards

The purpose of the Adult and Children Behavioral Health Case Management Standards is to serve as the practices and procedures that represent the values that underlie the implementation of Behavioral Health Case Management services in Philadelphia County. These standards serve as procedures that align with federal and state regulations, The Department of Behavioral Health and Intellectual disAbilities (DBHIDS) Philadelphia County Standards, and Community Behavioral Health (CBH) guidelines, and serve as the minimum requirements for provision of Case Management services.

The standards are inclusive of all Behavioral Health Case Management services. These levels of care include: Resource Coordination (RC), Intensive Case Management (ICM), Substance Use Intensive Case Management (SU ICM), Blended Case Management (BCM), and Non-Fidelity ACT (NFA) (also referred to as Community Treatment Team or Blended Enhanced Case Management), These apply to all agencies funded by Philadelphia County DBHIDS that provide case management services to adults and children who meet Medical Necessity Criteria established by the State of Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS).

As regulations and guidelines change, notifications of updates will be communicated to the provider network.

1.2. Fundamental Principles of Philadelphia Behavioral Health Case Management

Behavioral Health Case Management in the County of Philadelphia serves individuals who live in the community and who have behavioral health diagnoses. It also serves persons with co-occurring conditions such as substance use disorder, autism spectrum disorder, individuals who experience homelessness, individuals involved in the forensic system, as well as other special populations. Case Management is a voluntary, time-limited service, the purpose of which is to help individuals independently manage their own recovery. The Behavioral Health Case Management Standards use support principles from the following sources: The National Association of Case Management (NACM), Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), and State of Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS).

1.2.1. NACM

The **National Association of Case Management** (NACM) works to professionalize the workforce and provide guidelines and resources to help organizations provide the best Case Management services possible. NACM's definition of Case Management describes the philosophy of the model practiced in Philadelphia County:

> *"NACM defines Case Management as a coordinated approach implemented by professionals for delivering health, substance abuse, mental health, and social services, linking individuals with appropriate services to address specific individual needs and achieve stated goals.*

1.2.2. DBHIDS

Case Management providers are part of the network of providers under the Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS). As part of that network, providers are expected to comply with DBHIDS standards, guidelines, and principles, summarized below. DBHIDS is committed to TEC, which is the lens we use to prioritize our work:

- **TEC: Addressing Trauma, Achieving Equity, Engaging Community**
  - Addressing **T**rauma – transform operations to be trauma-responsive and trauma-mitigating.
  - Achieving **E**quity – transform systems to reduce behavioral health disparities and promote racial equity among Black, Indigenous, and People of Color (BIPOC) by intentionally addressing structural and systemic racism.
  - Engaging **C**ommunity – Shift services to become increasingly community-based, ensuring long-term and sustained impacts of programs.
- **The P.A.C.E. Strategic Plan**
  - DBHIDS' strategic framework is called P.A.C.E. or Prioritizing to Address Our Changing Environment. Developing a strategic plan demonstrates DBHIDS' commitment to promoting recovery, resilience, and self-determination. A clear path forward will help DBHIDS set priorities for delivering services and programs that align with our values and population health approach. These values are equity, equality, excellence, integrity, outcomes, commitment to the whole population, rights to recovery, resilience, and self-determination.
- **Philadelphia DBHIDS Transformation Practice Guidelines for Recovery and Resilience-Oriented Treatment**
  - Designed to help our system deliver services and supports that promote **recovery, resilience**, and **self-determination** in children, youth, adults, and families. They embrace the following framework:

4 Domains			
1: Assertive outreach and initial engagement	2: Screening, assessment, service planning, and delivery	3: Continuing support and early re-intervention	4: Community connection and mobilization

1.2.3. Family Inclusion Standards

The **Family Resource Network (FRN) Family Involvement (FI) Standards** are part of the Philadelphia DBHIDS Practice Guidelines. It is recommended that Behavioral Health Case Management providers make a priority of adopting these standards.

1.2.4. OMHSAS

The Office of Mental Health and Substance Abuse Services (OMHSAS) is a part of the Department of Human Services (DHS) for the Commonwealth of Pennsylvania. It is responsible for the administration, oversight, development, management, regulation, enforcement, and training of licensing programs for all human service programs across the Commonwealth. Case Management in Philadelphia follows the below principles from the OMHSAS-10-03 Blended Case Management Bulletin.

- Adults
  - The **Community Support Program Values and Principles (CSP)** and outlined by OMHSAS, should be followed by all case managers providing services to adults in Philadelphia County.

- Children
  - The **Community Support Program Values and Principles (CASSP)** form the foundation for all children's behavioral health treatment and Case Management services provided in Pennsylvania. They should be followed in providing services to children in Philadelphia County.

1.3. Multi-Level Team Approach

A team approach is used to serve individuals at all levels of service. The success of Philadelphia's Case Management initiative requires three levels of teaming, which are defined below:

- The provider agencies' internal teams of case managers, including supervisors.
  - At the provider agency level, teaming allows the case management staff to serve the individual's needs and concerns holistically. All staff members on a case management team serve all individuals assigned to that team. The team approach expands the number of staff responsible for delivering services to any one person and thus requires that all staff be familiar with each individual's history and current personal goals.
- Provider departments that support the case management team to serve the individual.
  - All relevant departments within the provider agency, including but not limited to administrative, fiscal, data management, and human resources, must work closely and support the case management team in meeting quality of care standards, documenting the services provided, and reporting data.
- Provider agency case management external teams, including DBHIDS, CBH, and the individual's other relevant supports.
  - The provider agencies work collaboratively with the Targeted Case Management Unit (TCMU) of DBHIDS and the Behavioral Health Case Management Unit (BHCMU) of CBH. TCMU and BHCMU assist with technical assistance, utilization management, and help restore communication between various service provider agencies when it falters. Additionally, system advocacy is facilitated across other relevant supports such as (but not limited to) crisis response centers, inpatient facilities (behavioral health or medical), other units from DBHIDS such as the Office of Homeless Services (OHS), Housing and Homeless Services (Formerly Transitions, Integration, and Partnerships Unit), Single County Authority (SCA), Behavioral Health Justice Division (BHJD), schools, Philadelphia Department of Human Services (DHS), families and natural supports, and other community programs, to ensure that individuals receive the most appropriate and least restrictive services and promote and improve continuity of care.

1.4. Quality Improvement Process

Case Management providers cooperate in activities that improve the quality of care and services and individual experience. This includes the collection and evaluation of data and participation in CBH's **Quality Improvement** (QI) activities. Such activities may include, but are not limited to:

- Providing the information requested through Provider Bulletins and Provider Notices
- Adhering to Practice Guidelines and Performance Standards
- Participating in Quality Management activities, including chart reviews, root cause analyses, action plans, quality improvement plans, and the complaint and grievance processes

- Reporting on Performance Metrics requested through the Pay for Performance (P4P), values-based payment (VBP), and the performance evaluation processes
- Engaging in credentialing and re-credentialing activities

1.4.1. NIAC Review

Network Improvement and Accountability Collaborative (NIAC) is the primary mechanism to accomplish site reviews (i.e., monitoring) across various funding streams in the Philadelphia County Behavioral Health System. NIAC promotes the ongoing improvement of behavioral health providers regarding quality of care. NIAC assesses the quality of services delivered by Case Management provider agencies through their scoring instrument, the **Network Inclusion Criteria** (NIC). Therefore, all Behavioral Health Case Management providers are expected to meet the core standards identified in the NIC.

2. BEHAVIORAL HEALTH CASE MANAGEMENT STANDARDS

2.1. Licensing and Agency Requirements

Case Management provider agencies that provide Behavioral Health Case Management services must be able to demonstrate that they are both willing and able to provide committed administrative, fiscal, data management and human resources supports to their Case Management program and its staff.

Case Management programs are expected to provide services to all adults and children who meet the Medical Necessity Criteria and who are Medical Assistance (MA) eligible, uninsured, or underinsured. Individuals must reside in Philadelphia County, and catchment area boundaries do not apply to Case Management services.

Case Management agencies must have an effective continuum of care as demonstrated by linkages to an array of behavioral health services, drug and alcohol services, specialized services, and informal community services, as evidenced by Memoranda of Understanding (MOU), referral agreements, and other documented care coordination.

To be eligible for payment for services, agencies must comply with all applicable Pennsylvania laws, including Title 55, General Provisions 1101, and Chapters 1247, as well as all associated MA Bulletins and OMHSAS Bulletins, licensing requirements, and any contractual agreements made with DBHIDS and CBH.

Finally, agencies must meet the standards defined in this document.

Throughout this document, provider agencies will be referred to as “agencies” or “providers” interchangeably.

2.1.1. Individual Involvement in Agency Policy and Planning

Case Management agencies should have procedures in place to ensure individuals are involved in their Case Management care. This care includes their specific behavioral health services and the Case Management activities driven by their goals. This can include:

1. An advisory committee of individuals receiving Case Management services and/or family members will be established and can be inclusive of a larger agency wide committee.

2. An internal individual satisfaction survey of the case management agency and its services that is conducted annually.

2.1.2. Training Requirements of Case Managers

All case managers, supervisors, and other applicable staff must complete the required initial and ongoing trainings, as outlined below.

1. All case managers must receive an orientation by their agency within three months of hire. The orientation must include, but is not limited to, reviews of agency policies and procedures, as well as how to complete case management service documentation.

2. Each agency will have a training plan that details the training needs of individual case managers and other case management staff. This training plan should include sessions on understanding wellness and recovery, and how it pertains to the individuals they serve and themselves. The training plan must document the topics together and include the number of training hours completed.

3. Case managers and supervisors are also required to complete CBH trainings as outlined in the Manual for Review of Provider Personnel Files (MRPPF), which is found in section 8.3 of the **CBH Provider Manual**.

4. All new case managers and supervisors must successfully complete the Philadelphia DBHIDS Case Management Orientation through the Behavioral Health Training & Education Network (BHTEN). The Basic Case Management Orientation is an asynchronous, self-paced training through the **DBHIDS Learning Hub** (LMS). There is a separate orientation for adult case managers and children case managers. All assignments and evaluations must be completed to generate a certificate of completion. Case Management Orientation should be completed within 6 months of being hired. Case Management Orientation does not need to be completed again if a case manager changes workplace agencies.

5. All directors and supervisors must complete the DBHIDS TCM Supervisory Training when made available.

6. All case managers, supervisors, and directors are required to attend training sessions that pertain to major system changes (i.e., alterations of medical necessity criteria or goal planning, etc.).

7. Case managers who serve in a specialty position are required to attend training sessions in specialty areas. For example, an SUD specialist should attend DDAP trainings, or a forensic specialist should attend forensic specific trainings.

8. Case managers of programs that have a specialty are required to attend training sessions in their specialty area. This program includes specialty areas in forensics, substance use disorder, housing first and autism.

    - SUD ICM case managers are required to take the DDAP-required core trainings, which are available through BHTEN.

9. All case management supervisors and directors will attend the monthly provider meeting planned by the TCMU and will relay information to their direct care case management staff and other pertinent people in their agency.

10. Each case manager and supervisor must complete a minimum of 30 hours of continuing education in relevant topics each year. The 30 hours of continuing education can be external or internal to the agency if it is structured, job-related, and curriculum/syllabus is documented. Providers are responsible for keeping

documentation of all training sessions by way of certificates of completion, training sign-in sheets, etc. These hours should include all trainings required by the **NIAC NIC**.

2.1.3. Agency Data Management and Service Reporting

2.1.3.1. Information Reporting for Internal Agency Management of Service

Provider agencies must have an integrated data management system to ensure the provision and monitoring of Case Management services. Each agency must have the management information system capability to generate specific service compliance reports as required for the agency's case management team purposes, as well as county and state reporting requirements. The director/supervisor must know how to review and use these internal data reports to manage the provision of Case Management services and to improve the quality of service. Service information reporting is based on data fields displayed on the service documentation form.

1. The service documentation form will be completed at the time of service and submitted for timely data entry.

2. The agency must have the ability to run reports that use data taken directly from the service documentation.

2.1.3.2. Information Reporting for External County Monitoring of Service

2.1.3.2.1. WebFocus

Currently, the Enterprise Data Services (EDS) WebFocus Data System, commonly referred to as WebFocus, is the DBHIDS Data Management System that provides a database of everyone who has been authorized for Case Management services. WebFocus contains information about the current status of individuals, along with their service history. It serves as a registry for case management provider staff and as a tool for caseload management and reports. Additionally, inpatient and incarceration alerts are documented in this database. All providers are responsible for maintaining up-to-date information in WebFocus.

Below are the categories of data to be reported in WebFocus by agencies that provide Case Management services:

- Admission Information (Section 2.3)
- Caseload Management (Section 2.3.3)
- Re-Authorization Information (Section 2.1)
- Discharge Information (Section 2.9)
- Staff Registration and staff updates (Section 2.2.2.1)

The agency will review and amend its WebFocus Caseload on a monthly basis.

2.1.3.2.2. Additional Reporting

1. Providers shall submit any reports as required by OMHSAS, the County Administrator (DBHIDS), or the Behavioral Health Managed Care Organization (CBH).

2. When MA benefits are activated for any individual receiving Case Management services through county funding, the agency will submit the *CBH Case Management Service Request Form* to CBH Operations Supports Services (OSS). When MA benefits are terminated for individuals receiving Case Management services and CBH funding, the agency will submit the *TCM County Funded Service Request Form* to the County DBHIDS TCM Unit.

- Agencies should check MA eligibility at least monthly and submit relevant service request forms within 30 days.

2.1.4. BHCM Program Quality Management and Supervision

1. The provider agency will conduct quarterly chart reviews with a minimum sample of ten charts selected at random from the caseload at each service level for adults and children (Blended, ICM, SUD ICM, RC, and NFA). The reviewer must have an appropriate level of clinical expertise and preferably is employed by the agency in a position other than the BHCM program (e.g., Quality Management).

2. The supervisor will hold team meetings, 3-5 days a week, to discuss current individual issues and to assign tasks to the team.

3. The supervisor will conduct scheduled supervision of each case manager bi-weekly. Supervision may be more frequent depending upon the performance of the case manager, the activity of the caseload, and the supervisors' administrative judgment. Supervision logs will be maintained by each supervisor which should contain the staff supervised, date and length of supervision, and the topic of each supervision session. Directors are responsible for ensuring that adequate supervision occurs.

4. The supervisor will perform quarterly reviews of individual charts, progress notes, and goal plans with each individual case manager.

2.2. Staffing Requirements of Behavioral Health Case Managers

2.2.1. Agency Composition of Case Management Staff

2.2.1.1. Children

The children's Case Management teams provide one level of service: *Blended Case Management (BCM).* BCM teams provide the continuum of ICM and RC services with the assistance of a part-time consulting psychiatrist.

2.2.1.2. Adults

The adult Case Management teams provide four levels of service:

- Resource Coordination (RC):
  - Shelter-based Case Management team, with access to a part-time consulting psychiatrist.
  - Prevention and Recovery Services (PARS), a short-term, rapid response team of case managers with a part-time consulting psychiatrist, which provides quick engagement, stabilization, and referrals to treatment and community supports.
- Intensive Case Management (ICM): Provide intensive recovery support through teams of case managers with the assistance of a consulting psychiatrist. These teams currently only serve the homeless population and individuals who have a primary substance use disorder (SUD ICM).
- Blended Case Management (BCM): Provide the continuum of ICM and RC services with the assistance of a part time consulting psychiatrist.
- Non-Fidelity ACT or Blended Enhanced Case Management (also referred to as CTT or TCM): The adult Blended Enhanced model supplies the intensity of Case Management and high frequency of individual contact, which can vary in accordance with the individual's changing needs, without altering the team of case

managers. These programs also have a full-time psychiatrist (with limited treating capabilities), nurse, and SUD specialist.

1. Agency staff composition will conform to the guidelines established by these standards. Agencies contracted to provide Case Management services will establish a separate unit to deliver those services**.**

   The unit will be comprised of the following:

   - An identified case management director.
   - One full-time supervisor for up to seven case managers.
   - Designated administrative support personnel for daily entry of case management service documents, daily monitoring of WebFocus activity, and to complete all other clerical needs of the unit.

2.2.1.3. Roles of the Case Management Team Members

It is the expectation that, along with the individual served, each case management team includes at least one supervisor, up to seven case managers, and a psychiatrist (consulting or treating).

2.2.1.3.1. Individual (All Levels)

The individual authorized for Case Management services is a full and equal partner of the case management team, working collaboratively with the other members of the team. The individual's lived experience, point of view, choices, and voice are critical elements in the development and implementation of the person-centered case management service plan.

2.2.1.3.2. Case Manager (All Levels)

Case managers are responsible for assisting individuals in making full use of natural community supports, in addition to all available behavioral health services, which will enable the individual to live a stable, healthy, and safe life in the community of their choice. This will be accomplished by assessing the individual’s needs, developing a goal plan with the individual, linking the individual to agreed-upon services, and ongoing monitoring of these services and supports.

2.2.1.3.3. Supervisor (All Levels)

The supervisor has both an administrative and leadership role and does not carry an assigned caseload but may have direct caseload responsibilities on an as-needed basis. The supervisor provides a broad knowledge of behavioral health diagnoses as well as of the resources available in the Behavioral Health System. Administratively, the supervisor is familiar with the policies and procedures of the agency and makes sure that these are carried out. The supervisor provides supervision to case managers, ensuring the completion of all case manager-related tasks.

2.2.1.3.4. Psychiatrist (All levels)

In the Blended Generic model (including ICM and RC/PARS) the psychiatrist is part-time and serves as a consultant to the team. In the Blended Enhanced model, the psychiatrist is full-time and has limited treatment capabilities. Under both models, they are available to all staff, individuals, and families to offer valuable information on the course of treatment, primary effects and side effects of medications, medical complications, and other best practices.

2.2.1.3.5. Nurse (Blended Enhanced only)

The nurse provides support to the entire program and therefore does not carry a specific caseload. The nurse brings a medical perspective to the team and educates case management staff, individuals, and families. The nurse will link individuals to appropriate medical resources and provide information to assist in that linkage.

2.2.1.3.6. Substance Use Disorder Specialist (Blended Enhanced only)

The SUD specialist should have knowledge of substance use treatment modalities, including but not limited to supports such as 12-step programs and Alcoholics Anonymous (AA)/Narcotics Anonymous (NA), substance use outpatient and inpatient programs and how to link individuals to these supports. The SUD specialist does not carry a caseload but works with case managers and individuals to teach skills that will support the recovery journey.

2.2.1.3.7. Director (All levels)

The director provides both an administrative and leadership role and is the liaison to the regulatory stakeholders. The director does not carry an assigned caseload but may have direct caseload responsibilities on an as-needed basis. The director provides a broad knowledge of behavioral health diagnoses, as well as of the resources available in the Behavioral Health System. Administratively, the director is the person most familiar with the policies and procedures of the agency and the Behavioral Health Case Management Standards and are responsible for monitoring the case management program for the agency. They provide direction, set goals, and monitor the outcomes of the program. The director is also responsible for monitoring the ongoing quality improvement initiatives for the program.

2.2.2. Professional Qualifications of Case Managers

1. Case management directors and supervisors of individual case managers must meet the qualifications of mental health professionals.

   To qualify as a mental health professional, an individual must possess one of the following:

   - A master's degree in social work, psychology, rehabilitation, activity therapies, counseling, or education, and three years of mental health direct care experience
   - A bachelor's degree in sociology, social work, psychology, gerontology, anthropology, political science, history, criminal justice, theology, counseling, education, or be a registered nurse and five years of mental health direct care experience, two years of which include supervisory experience. Individuals using these criteria must receive a written waiver from the DBHIDS prior to hiring
   - A bachelor's degree in nursing and three years of behavioral health direct care experience

2. Case managers who are not mental health professionals (as defined above) must be directly supervised by a mental health professional. Also, case managers who are not mental health professionals must possess one of the following:

   - Bachelor's degree with major coursework in sociology, social work, psychology, gerontology, anthropology, other related social sciences, criminal justice, theology, nursing, counseling, or education
   - Registered Nurse
   - A high school diploma, plus a minimum of 12 college credit hours in sociology, social welfare, psychology, gerontology, or other social science, plus two years of mental health direct care experience

- Individuals using these criteria must receive a written waiver from the DBHIDS prior to hiring. If received, the waiver is specific to the case management agency and cannot be transferred by the employee to a different provider agency.

2.2.2.1. Agency Registration of Case Managers

1. The agency will complete a staff registration and/or termination in WebFocus for the following reasons:
    - New hire
    - Resignation or termination
    - Change in job status
    - Addition of educational credentials, e.g., master's degree, Certified Addiction Counselor (CAC), Registered Nurse (RN)
    - Completion of the state-required orientation training from BHTEN
    - Legal change of name

2.2.3. Duties and Responsibilities of Case Managers

Case managers are responsible for assisting individuals to make full use of their natural community supports and all available behavioral health services, which will enable individuals to live stable, healthy, and safe lives in the community of their choice.

Per OMHSAS-10-03 Bulletin-Blended Case Management, Case Management activities include:

- Linking with Services: Assisting the individual in locating and obtaining services specified in the treatment plan, service plan, or both, including arranging for the individual to be established with the appropriate service provider.
- Monitoring of Service Delivery: There shall be an ongoing review and written record of the individual's receipt of, and participation in, services. Contact with the individual shall be made on a regular basis, based on the Environmental Matrix, to determine their opinion on progress, satisfaction with the service or provider, and needed revisions to the treatment plan. Contact with the individual's therapist shall be made on a regular basis to determine if the individual is progressing on issues identified in the treatment plan and if specific services continue to be necessary 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 individual is making. Regular contacts shall be made with other public agencies serving the individual and with parents/guardians if the member is a child.
- Gaining Access to Services: Assertive and creative attempts are required to help the individual 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 individual'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 individual is required regarding unmet needs and plans for the future.
- Problem Resolution: Active efforts to assist the individual 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 individual's biological family and/or family of choice (not family counseling or therapy), natural supports and friends, with the individual's permission, cooperation, and written consent, to build an informal support network.
- Use of Community Resources: Assistance to persons in identifying, accessing, and learning to use community resources to meet an individual's daily living needs shall be provided as needed by making referrals to appropriate service providers.

2.3. Authorization and Admission Requirements

2.3.1. Individual Eligibility

For an individual to qualify for Behavioral Health Case Management, they must meet the appropriate Medical Necessity Criteria (MNC). MNC is outlined under CBH Medical Necessity Criteria for Community Treatment Teams (aka NFA and BE), CBH Targeted Case Management MNC (applies to BCM, RC and ICM), and DDAP Substance Use Case Management Medical Necessity Criteria from the DDAP Case Management and Clinical Services Manual (applies to SUD ICM). MNC is in Appendix 3.3.

2.3.2. Referrals and Authorization of Individuals

1. Referrals need to include the following information to determine MNC (OMHSAS-10-03):
    - Identifying information, to include the individual's name, address, date of birth, social security number, and third-party resources
    - Referral form to include date, source, and reason for referral to case management and DSM-V (or subsequent revision) diagnosis
    - Verification of eligibility to receive Case Management, such as past treatment records, psychiatric or psychological evaluations, letters summarizing treatment history, Individual Education Plan (IEP), and the like
    - Individual or parent/guardian signature (for children under the age of 14)
2. When a provider receives a referral, they must complete an initial Environmental Matrix (2.7.3) to determine that a prospective individual meets the medical necessity criteria for their program.
3. Within five calendar days of receiving a referral, the agency will notify the referral source of the following:
    - Member has been admitted into the program, or
    - Member is not admitted to the program and the reason why (e.g., capacity challenges, does not meet MNC), or
    - Information is missing from the referral form; therefore, additional information is needed
        - If a referral does not have complete information, contact the referral source, and request missing information be submitted within two (2) business days.
            - A determination should be made within three (3) business days of receiving the missing information.

- If a referral source is not responsive to follow up, after two (2) business days, the referral process will be discontinued.

The agency should maintain documentation of all communication, including date, time, and mode of communication (i.e., telephonic, face to face, electronic).

4. If the member is admitted into the program and has active MA, the agency will submit an authorization request to CBH. If the member does not have active MA, the agency will submit an authorization request to the County DBHIDS TCM Unit.

    - The agency will determine the authorization date. The authorization date should follow CBH policy.

2.3.3. DBHIDS WebFocus Registration and Case Management Assignment

Upon acceptance of a referral, the agency will ensure that a TCM Intake is completed in WebFocus. The agency will open the individual in WebFocus and will assign the individual to the caseload of a case management team. This should occur within five (5) business days of the authorization date.

2.4. Engagement Process

Agency engagement of an individual entails the formation of a partnership with that individual. Engagement begins with the case management team's explanation of Case Management services and how it will benefit the individual. The pace of the engagement process will vary—engagement usually develops through short, repetitive contacts with individuals by the case management team. Initial engagement is best taken place in settings where the individual is most accessible and comfortable.

1. Within five calendar days of the authorization start date of a new individual to Case Management services, a member of the case management team will make initial, face-to-face contact with that person to initiate engagement.

2. Within 30 calendar days of the authorization of an individual to Case Management services, the individual will either read or be read the documents listed below. They (or a parent/legal guardian, if under age 14) will then sign and date the documents, including but not limited to:

    - Consent for treatment/service
    - Individual Bill of Rights and Responsibilities
    - Agency conflict of interest
    - Agency grievance procedure
    - Notification of HIPAA Guidelines
    - Release of information forms

3. Within 30 calendar days of the authorization of an individual to Case Management services, the following documentation will be completed with the individual and/or legal guardian:

    - Environmental Matrix (EM) Score (Standard 2.7.3)
    - Individual strengths using the Strength Assessment Domains (Standard 2.7.1)
    - Personal Goal Plan/Service Plan of the individual (Standard 2.7.2)

- » FACE Sheet (Standard 2.7.4)

4. Within 90 calendar days of the authorization of an individual to Case Management services, the following documentation will be completed with the individual and/or legal guardian:

   - » Wellness Management Plan (Standard 2.7.5)

2.5. Linkage of Resources to Individuals

2.5.1. Linkage Activities

1. Appropriate and timely linkage of services is essential to achieve the best individual outcomes. Linkage may involve any or all the following protocols:

   - » The case management team supports individuals to gain access to available behavioral health treatment and rehabilitation services and facilities.
   - » The case management team supports the individual to link to educational/vocational services.
   - » The case management team supports the individual by linking them with the natural supports available to the individual through family, friends, and neighbors.
   - » The case management team supports the individual to link them with local community resources/stakeholders.

2. The case management team plays the primary role in coordinating the individual's Personal Goal Plan/Service Plan among all providers/supports (i.e., residential staff, family, therapist, psychiatrist, vocational counselor, etc.). The case management team schedules and leads the linkage meetings.

3. If necessary, the case management team will support the individual to secure transportation to the place of their treatment or service (by means of SEPTA, Paratransit, taxi, family member, etc.).

   - » Case manager travel time and time spent transporting or escorting individuals should not be billed as a unit of service. (OMHSAS-13-01)

4. Documentation of all referrals and linkages to all types of services and supports will be maintained in the individual's record.

2.5.2. Monitoring Resource Linkage

The case management team monitors to assess: 1) the continued need of services used by the individual and 2) their satisfaction with those services. If any changes are needed the case management team will collaborate with the individual to make those changes.

2.5.3. Documentation of Services Provided

The documentation of services provided to individuals must conform to county and state reporting requirements. According to these guidelines and regulations, agency staff will document all individual service contacts as well as movement, growth, program transfers, linkage meetings, case conferences, and summarize the progression of the person through the behavioral health system.

1. Case managers must complete accurate documentation of all services that they provide to the individual on the team caseload and any related information. Information should be entered into the individual's record daily.

2. The individual's record shall indicate their progress and responses at each visit and any changes in diagnosis, treatment, or services.

3. Service documentation must reflect the Personal Goal Plan/Service Plan of the individual.

4. Records shall be retained for seven (7) years, or age 22 when the individual is a minor. Records must be readily available for review by local, state, and federal officials. Records shall be made available during the same day as requested, in accordance with HIPAA regulations, at the provider's place of business. Upon written request, records shall be forwarded without charge and in a timely manner to the Department of Public Welfare or DBHIDS.

5. The Unit of Service (UOS) for billing purposes shall be ¼ hour of service (15 minutes). Billable services include the activities listed in Section 2.2.3-Duties and Responsibilities of Case Managers. Multiple contacts cannot be combined to claim as a UOS (example: three distinct contacts, each lasting 5 minutes cannot be combined to bill as one unit of service. Additionally, time spent on activities that do not constitute actual contacts are not Medicaid reimbursable (example: leaving a voice mail message or just waiting for an individual). A change in the location of services will necessitate writing a new service document.

6. State verification of participant eligibility for Case Management services requires the case management team to schedule and document the following evaluation and examination of each assigned individual:

    - An annual psychiatric or psychological evaluation
    - An annual physical examination (or the attempt to assist the individual in obtaining one)
        - Agencies should utilize a form documenting that they offered assistance with obtaining physical examination and if an individual accepts or denies help.
    - Assessments must be done on an annual basis by a medical professional, per regulations. These can be copies of assessments/evaluations done by other providers/services. If assessments cannot be completed by another provider/services, it remains the responsibility of the case manager to do the scheduling and follow-up on these assessments.

2.6. Coordination of Care

Coordination of services to ensure the continuity of care for an individual is a critical task of Case Management. The individual and case management team plans a variety of services and supports needed to promote the individual's independence and inclusion in the community. The individual and the case management team coordinate the services of community-based organizations, treatment, and primary care supports, as well as housing services, by advocating on behalf of the individual. The continuity of care process depends upon the collaboration of the individual and the case management team and these service providers.

1. The case management team will meet with the individual, their family members, and/or significant others (when appropriate) and the treatment provider within 48 hours of receiving notification of the individual's admission to either a behavioral health or substance use inpatient facility to:

    - reassess the individual's needs
    - advocate the individual's choices (as desired)
    - document appropriate modifications of the Personal Goal Plan/Service Plan
    - provide pertinent information about the individual that is requested by the provider

Telehealth and telephone contact may be acceptable, in lieu of face to face contacts, if the case management team is unable to access the treatment provider due to health and safety issues. Case managers should document denial of in-person access, who issued denial and reason given by the facility.

The case management team should also document when a treatment provider declines to provide information about an individual or access to the individual. Case managers should document denial of in-person access, who issued denial and reason given by the facility.

2. The case management team will meet with the individual at least twice during the first seven days of behavioral health or substance use inpatient care, and once every seven days thereafter, until discharge.

3. The case management team will be involved with the treatment planning of assigned individuals who are receiving behavioral health or substance use inpatient care, as well as assisting with planning their discharge.

4. The case management team will contact both the individual and medical provider within 24 hours of receiving notification of the individual's admission to a medical hospital. The case management team will:

    - Reassess the individual's needs
    - Advocate for the individual's choices (as desired)
    - Provide pertinent information about the individual that is requested by the provider

5. A member of the case management team shall be present when an involuntary commitment of an individual is being considered, to ensure that all appropriate alternatives to hospitalization are reviewed.

6. During the course of an individual's outpatient treatment or rehabilitation, the case management team will play a primary role in the coordination of the person's treatment or rehabilitation as it relates to the personal goal plan/service plan.

7. The case management team will inform an individual of their freedom to choose the services and resources that they need from available providers.

    The case management team should document all outreach attempts if they are unable to establish contact with the individual.

    For psychiatric and medical facilities, the services provided by the case manager must not duplicate or replace the institution's responsibility to provide discharge planning, continuity of care, or any other responsibilities of the inpatient setting (OMHSAS-10-03 Attachment B-Fiscal Issues).

2.7. Assessment of Individual

2.7.1. Strengths, Interests and Needs

The purpose of assessing an individual's strengths and interests is to assist them in developing an effective goal plan reflecting their unique needs. An assessment of individual strengths and interests must incorporate Community Support Programs (CSP), Recovery Principles or CASSP Principles, values, and life domains (see Appendix 3.3).

1. When the case management team engages a new individual, an initial assessment will be completed within 30 days of authorization, and include an individual's strengths, needs and interests. An assessment of the individual's basic needs must be given initial priority.

2. The Strengths Assessment must be based on a careful consideration of the cultural context of the individual's life.

3. The Strengths Assessment will be amended or revised no less than every six months from the date of the previous assessment. The assessment must be amended or revised whenever substantial changes impact the individual's strengths and needs.

2.7.2. Person Goal Plan/Service Plan

The Service Plan (Children) or Personal Goal Plan (PGP) (Adults) is a strength- based, individualized, person-centered plan that serves as a compass for the individual's recovery and an essential reference tool for documenting the provision of case management services. The plan is driven by the individual's strengths, interests, and needs, as identified in their Strengths Assessment (Standard 2.7.1). The plan identifies the role of the individual, case management team, service providers and other informal or natural supports in helping the individual meet their goals. The plan uses specific goals and action steps which may be long-term or short-term. The case management team will advocate in assertive and creative ways to assist the individual with accessing resources and services identified in the plan.

1. A member of the case management team assists the individual in completing an initial plan within 30 days of authorization for Case Management services.

2. A member of the case management team reviews the plan at least every 30 days with the individual, and progress is noted in service documentation.

3. The plan must be signed by the individual or family member/guardian if under the age of 14. The plan will also include the signatures of other parties involved, including the case manager and case manager supervisor, and include an indication of agreement or disagreement. If the requisite signatures cannot be obtained, then attempts to obtain them must be documented on the plan and the related service documentation.

4. The plan: identifies specific goals, objectives and action steps, responsible persons, time frames for completion and the case manger's role in relating to the individual and involved others.

5. The goals are reflective of each individual's areas of need for service as established in the six areas of the Environmental Matrix along with an individual's strengths and needs.

6. Goals should be **S**pecific to the individual, **M**easurable, **A**chievable, **R**ealistic, and **T**ime-specific (SMART Goals).

7. The action steps reflect the coordination of different people, programs, and services, including natural support systems and community involvement of family, friends, informal social networks, employers, landlords, and other supports. This coordination is used in a manner that results in the achievement of the defined goal.

8. Each plan must accurately reflect the individual services to be provided to the person. Therefore, the documentation of service must be consistent with the plan.

9. Plans should be reviewed and/or updated at the following times:

    - Upon completion of a goal.
    - Upon admission to a treatment facility, correctional facility, or Juvenile Justice Services.

- Prior to discharge from a treatment facility, correctional facility, or Juvenile Justice Services.
- Upon request of the individual.
- When a major life change or alteration of the individual's needs or desires warrants an update.

10. The case management team is responsible for collaborating with other service providers (with permission from the individual) to promote efficient service coordination driven by the participant's goal plan and ensuring that all providers involved are working toward unified goals.

2.7.3. Environmental Matrix

The Environmental Matrix (EM) is a scale that determines the need for Case Management services and evaluates the functional level of individuals on six (6) identified activities. The scale is used by provider agencies at the time of referral for Case Management services to determine a provisional score. A new EM should be completed within 30 days of authorization to case management services.

- The Environmental Matrix (EM) is critical in ensuring the correct level of service is provided. Providers are required to comply with OMHSAS regulations, which indicate that the EM be completed every six months at a minimum, when there is a significant change in life domains, or whenever there is a change in level of service.

  Please Note: Substance Use Disorder Intensive Case Management is not required to complete an environmental matrix.

2.7.4. FACE Sheet

The Factual and Clinical Elements (FACE) Sheet contains information and specific instructions vital to persons providing crisis services to an individual. When utilized in conjunction with the Wellness Management Plan (Section 2.7.5), the FACE Sheet provides critical crisis information, as well as important information for linking to services and accessing services for individuals.

A FACE Sheet contains:

- Individual's address, phone number, social security number, and birth date
- Medication regimen
- Psychiatric and medical diagnoses
- Medical status (including allergies)
- Treating psychiatrist's name and office telephone number
- Financial and insurance information
- Emergency contact person(s)
- Wellness Management Plan (see Section 2.7.5 below)

An initial FACE sheet must be completed within 30 days of authorization. Upon completion of the initial FACE Sheet:

- Relevant updates from the team meetings will be added to the FACE Sheet within 24 hours.
- FACE Sheets will be reviewed monthly by the supervisor.

2.7.5. Wellness Management Plan

The Wellness Management Plan is a section of the FACE Sheet which contains critical crisis information. Information on the FACE Sheet is expanded into a Wellness Management Plan which contains individualized, specific instructions/interventions aimed at de-escalating a crisis and promoting stabilization. Examples of types of interventions could include linking to certain services, specific approaches that have been successful with the individual in the past, or triggers that tend to escalate a crisis (e.g., person is more aggressive towards male staff). The development of an Advance Directive may be included in the process.

- Wellness Management Plan must be completed within 90 days of Case Management authorization.
- The case management team and individual will develop and update the individual's Wellness Management Plan. The Wellness Management Plan:
  - identifies triggers and ways to manage them
  - outlines the individual's warning signs of a behavioral health crisis
  - specifies the individual's choices of appropriate interventions and supports
  - identifies support people who may provide those supports

2.7.6. Documentation of Additional Assessments and Evaluations

The following assessments and evaluations can be obtained from other providers and are considered part of the case management record.

2.7.6.1. Trauma History

Case Management should be trauma-informed; therefore, Case Management providers should include capturing an individual's trauma history as part of their initial assessment, and on-going assessment process, using an evidence-based trauma screening tool. Follow-up care should be provided if an individual has a trauma history.

2.7.6.2. Additional Assessments

Providers should develop internal assessments that also capture the following information, which should be maintained in an individual's record:

- Medical history, taken within the past 12 months, or documentation of the case manager's efforts to assist the individual in obtaining a physical examination.
- Summaries of hospitalizations, incarcerations or other out-of-home placements while enrolled in Case Management, including the place and date of admission, reason for admission, length of stay, and discharge plan.
- Children only: IEP, school testing - for example, psychological evaluations – guidance counselor reports, and the like, or documentation of the case manager's efforts to obtain the information if not in the record.

2.7.6.3. NIAC Assessments

Case management providers are required to include any assessments required by the **NIAC NIC** that align with the DBHIDS Practice Guidelines.

2.8. Provision of Behavioral Health Case Management

In keeping with the CSP principles, Best Practice Principles, and Recovery Principles/CASSP Principles, each agency emphasizes the team approach to Case Management. All case management staff members are expected to serve everyone on the team caseload. A team approach requires that all staff become familiar with each individual's history and current personal goals.

2.8.1. Individual Involvement in Case Management Services

Case Management services should be person-centered, and collaborative in nature. The case management team will include the individual and or responsible family in the planning of their services and in the selection of their service provider(s).

2.8.2. Availability of Case Management Staff

Case Management provides 24-hour availability, 365 days a year for those individuals who have the greatest need for either continuing service or crisis intervention service. Philadelphia County expects Case Management agencies to develop flexible, multi-shift schedules seven (7) days a week, including evening hours, in order to meet this requirement.

2.8.3. Staffing Hours

- The provider shall have a written policy showing how 24-hour, 7 day per week coverage for Case Management services is provided. This should include the agency's on-call policy. The Case Management agency should also have a procedure in place to ensure that staff members on call have access to relevant individual information, including strategies for addressing crisis or emergency situations. (OMHSAS-10-03)
- The agency must have a written staffing policy that specifies coverage of RC services provided to individuals during business hours.
- Non-Fidelity ACT/Blended Enhanced Teams are expected to provide staffing for 12 hours a day, Monday through Friday, and eight hours a day on Saturday and Sunday.
- Blended Teams, Intensive Case Management Teams and Substance Use Intensive Case Management Teams are expected to provide 10 hours a day of coverage Monday through Friday and 6 hours on Saturday and Sunday.
- RC Teams are expected to provide 10 hours of coverage a day. No weekend hours are required for Resource Coordinators.

2.8.4. Availability of Case Management Staff in a Crisis

Individuals who experience a crisis need access to link to crisis intervention and Case Management support 24 hours a day, 7 days a week. Case management teams coordinate linkages of crisis intervention services and provide necessary information for the resolution of a crisis.

Please Note: *Case managers or supervisors should NOT be the first point of contact in crisis situations that require either immediate medical attention or police intervention.*

1. A member of the case management team shall be present when an involuntary commitment of an individual is being considered, to ensure that all appropriate alternatives to hospitalization are reviewed, as documented in the Wellness Management Plan (Section 2.7.5). The case management team shall abide by the current state and county guidelines regarding their role in a 302 petition. If the case manager or supervisor is not present at 302, documentation as to why should be in the individuals record (OMHSAS-10-03).

2. When the case manager or on-call staff is called by the CRC, the doctor has already made the decision to hospitalize, and CBH has approved the admission, the case manager/on-call staff need not go immediately, but they must see the individual in the hospital within 24 hours of the CRC admission. When the CM does not go to the CRC because the person is being hospitalized, that information must be documented in the chart.

2.8.4.1. During On-Call Hours

1. Case management supervisors or responsible designees are the point of contact for any case management individual-related crisis calls. The designee must 1) meet the qualifications of a mental health professional (Section 2.2.2); 2) must have demonstrated clinical experience and knowledge of triage in emergency situations; and 3) must be knowledgeable about each person on the agency caseload.

2. On-call staff respond within 15 minutes (or less) of receiving a call or message.

3. During a crisis response call, the on-call staff provides current clinical information from the FACE Sheet to the service performing the crisis intervention. This service includes but is not limited to the CRC or Mobile Emergency Team (MET).

4. The FACE Sheet must be kept in the case management team's 24-hour Crisis and Emergency Logbook or be accessible via an electronic device. Since FACE Sheets contain critical information, its timely update is important, and the on-call staff must have access to the most current information. (Section 2.7.4)

5. When the on-call staff receives a notification of an individual experiencing a crisis, face-to-face contact must be established within 1 hour or less from the point of initial contact. Situations that might require face-to-face contact include (but are not limited to) CRC visits, MET team, involuntary commitment, and medical emergencies.

Documentation of weather or other emergency circumstances that may delay response time is required. Additionally, when face to face is not able to occur, there should also be documentation citing why. In these circumstances, on-call staff are expected to maintain communication with the individual and follow the individual's Wellness Management Plan

2.8.5. Frequency of Contact

Frequency of contact must be based on individual need for service, as determined by the individual's Environmental Matrix. Continuous assessment of the individuals' needs is the basis of determining the frequency of contact and type of service. The standards of frequency of contact are the minimum expectations. Every case management team must contact the individual as often as needed to serve the individual's behavioral health needs. The following are minimum requirements:

1. The Blended Enhanced/Non-Fidelity ACT Team, services individuals with an EM score of 4.0-4.9, and should have at least one face to face contact every 7 calendar days.

2. Adult Blended Case Management Teams, Intensive Case Management Teams, and Substance Use Intensive Case Management Teams service individuals with an EM score of 2.1-3.9 and must have at least one face-to-face contact every 14 calendar days.

   Please Note: *Though SUD ICM does not complete the Environmental Matrix, they will follow this intensity of care.*

3. Childrens Blended Case Management teams service individuals with an EM score of 1.5-5. Individuals with an EM score of 4-5 must have at least one face-to-face contact every 14 calendar days. Individuals with an EM score of 1.5-3.9 must have at least one face-to-face contact every 30 calendar days.

4. The RC Team services individuals with EM scores of 1.5-2 and must have at least one face-to-face contact every 30 calendar days.

EM Scores below 1.5 do not require case management services. An individual with an EM score below 1.5 and currently receiving Case Management can graduate from Case Management because the services are no longer required (Section 2.9). A new referral with a score below 1.5 does not qualify for Case Management and the referral source should connect the individual to other community supports and/or resources.

If the individual 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. (OMHSAS-10-03).

2.8.6. Type, Location, and Duration of Case Management

Effective provision of Case Management service at any level requires a recovery-oriented and person-centered approach. As such, most services to an individual should be provided via face-to-face contact. Development of the relationship between the case management team members and individuals is most effective when face-to-face contacts frequently occur in the person's natural environment, including their residence and community setting, rather than at the case management office.

1. Within each level of Case Management services, at least 75% of the agency's aggregate face-to-face contacts with individuals over a period of 30 days must occur in the community and/or at the individual's residence.

2. A minimum of one face-to-face contact with the individual must occur in the individual's residence every 30 days for individuals receiving NFA, BCM, ICM and SUD ICM.

3. A minimum of one face-to-face contact with the individual must occur in the individual's residence every 60 days for individuals receiving RC.

4. A minimum of one face-to-face contact of at least 30 minutes (excluding travel time) should occur every 30 days for all levels of care.

2.9. Discharge Planning

Discharge is a planned decision that begins at the initial engagement stage of service delivery and is a part of the ongoing service planning process. At the point that discharge is in sight, which is individually driven based on the Service Plan/PGP, a separate and distinct discharge goal plan should be written with the individual with discharge planning as the goal, and the process of disengagement will begin at that time. The individual must agree to a change in the level of care, and this change should be communicated to all relevant agencies/providers involved in the member's care.

Disengagement is the lessening of supports from the Case Management provider and an increase of the individual's independent or natural supports that should be used more frequently. This process must be initiated with the knowledge of both the individual and their supports that are in place. The discharge goal plan should identify and include those supports that are/will be involved with the individual after Case Management services end. Those supports may include family and/or significant others, informal community services, formal behavioral health treatment providers, and residential resources.

All discharges of individuals from Case Management services must meet the medical necessity discharge criteria and are subject to retrospective review by CBH and TCMU. Discharges should be seen as an outcome that results from completion of the stated goals on the goal plan.

2.9.1. Reasons for Discharge

Reasons for discharge from case management services include:

- Inability to contact the individual (unable to locate),
- An individual and/or legal guardian decides services are no longer desired or required. That decision must be made by:
  - legal guardian of an individual age 13 or younger, or
  - individual aged 14-17 and legal guardian, or
  - individual aged 18 or older
- Planned discharges (examples include individual is moving out of county; they have completed their Case Management goals; long-term adult/juvenile justice placement; long-term residential treatment facility; long term nursing home; transition to family-based services, etc.)
- Death of individual
- Transfers: When an individual may need to transition to another Case Management agency or to another Case Management level of care.

The following steps apply for all discharges from Case Management service:

- The case management director or supervisor of the team must approve any discharge. All discharges must meet discharge criteria for Medical Necessity Criteria and BHCM Standards.
  - This includes a discharge goal plan that reflects the acknowledgement of the individual and their support system in attendance at the planning and linking meeting. This documentation should be kept in the individual's record.
- The case management director or supervisor of the team will submit a closure into WebFocus.
  - Discharge packet should also be uploaded into WebFocus.

2.9.1.1. When Unable to Contact the Individual

- Prior to discharging an individual from Case Management services, it is the responsibility of the case management team and/or agency to implement the standardized procedures when an individual cannot be located. These actions include, but are not limited to the following, and should be documented in the individual's record/discharge summary:
  - Contact family, friends, emergency contacts and/or significant people (if signed consent form is in individuals record).
  - Conduct outreach to places that the individual has been known to frequent.
  - Contact CBH (215-413-3100) to determine if the individual has been admitted to a community inpatient hospital unit or any other CBH-noted activity.
  - Notify the DBHIDS Acute Services Delegates (215-685-6440) to determine if the individual has been seen at a CRC, or to file a Missing Person's Report.
  - Notify the Police and file a Missing Person's Report (after 24 hours, when appropriate).

- Check Pennsylvania Unified Judicial System at ujsportal.pacourts.us.
- Check Homeless System by calling Homeless Services (215-685-5400) and/or checking Homeless Cafes.
- Call Outreach Coordination Center (215 232-1984).
- Call the Medical Examiner's Office (215-685-7457).
- Contact all other supports and other systems of care involved with the individual such as: TSC, MPRS, CPS, Therapist, CUA/DHS worker, and school.
- Send a letter to the individual/family regarding pending discharge and make a final home visit attempt.

- When the case management team is unable to locate a formerly active individual for 30 days from the last contact, the assigned case management team should begin the above procedure. After 60 days without contact, if the case management team is still unable to locate the individual, the case management director or supervisor may submit the discharge. Supportive documentation, e.g., service documentation that describes ongoing attempts made to locate the individual should be in the individual's record/discharge summary.
- If the case management team is unable to locate a newly authorized individual at the end of 30 days from the authorization date, the case management director or supervisor may submit a discharge. Supportive documentation, e.g., service documentation that describes ongoing attempts made to locate the individual should be in the individual's record/discharge summary.

2.9.1.2. When Individual/Legal Guardian Decides Services Are No Longer Required

Case Management is a voluntary service, and an individual may express (verbally or in writing) a desire to leave the service at any time. Any verbal requests made need to be documented by the case management team. Nonetheless, a case manager should make continued efforts to engage by scheduling a linkage meeting with the individual to discuss aftercare planning. Case managers should notify other systems of care involved with the individual that the individual is being discharged. Supportive documentation should be in the individual's record/discharge summary.

2.9.1.3. Planned Discharges

Individuals who, for various reasons, may need to transition from Case Management services. Reasons may include individual is moving out of county; completion of case management goals; long-term adult/juvenile justice placement; long-term residential treatment facility; long term nursing home; transition to family-based services, etc. A linkage meeting should occur and must include the individual and their support services team to discuss the proposed change and develop an aftercare plan prior to requesting discharge. Supportive documentation should be in the individual's record/discharge summary.

2.9.1.4. Death of an Individual

In case of the death of an individual, an incident report should be submitted to CBH and TCMU, 24 hours after the Case Management agency has been notified of the death. The case management team may work on behalf of the deceased for up to 15 days past the date of death, county funding can be billed for these 15 days. This activity may include funeral arrangements and coordination with family members and other supports.

2.9.1.5. Transfers

A transfer occurs when a case management team requests that an individual be transferred to a higher or lower level of care of Case Management or transitioned to another Case Management provider agency for the same level of care.

The following steps apply for transfers:

- In collaboration with the individual, the current Case Management provider agency will determine what type of transfer to make (higher level of care, lower level of care or lateral transfer), identify a new Case Management provider, and submit a discharge packet to the provider through WebFocus. If ACT level of care is needed, the ACT referral should be completed.
    - The current Case Management provider should continue to provide services until transfer has been accepted by a new provider agency.
- The new provider agency must respond to a transfer request within five (5) calendar days. The new provider should follow the same steps outlined in Standard 2.3.2.
    - If the new provider agency does not accept the transfer request, then the current provider agency continues to serve the individual and can make a transfer request to a different provider agency.
- The original case management team and new case management team will discuss and agree upon the effective discharge/authorization date.
- The original case management team will arrange a transfer meeting with the individual and the new case management team within five (5) calendar days of discharge/new authorization date.
- The new team must make face-to-face contact with the individual within five (5) calendar days of authorization.
- For up to a 30-day period following a transfer, the former case management team and new case management team will work together to ensure continuity of care.

2.9.2. Discharge Documentation

A discharge must be made with the knowledge of the individual/family and their support network. The discharge documentation should be in the individual's record, and the packet should be uploaded into WebFocus at the time a discharge is submitted. If the discharge is not submitted or was submitted incorrectly in WebFocus, the case management authorization will remain active.

Discharge Documentation Packet will include:

1. Discharge service plan which contains the signature of the individual, the family or caregiver/guardian if the individual is a child, and other service providers, if obtainable
2. Discharge Summary which contains the following:
    - A reason for admission to Case Management
    - The services provided and continuing service needs
    - The goals obtained, the goals not completed and why
    - Diagnosis and medication at discharge
    - Reason for discharge
        - If reason for discharge is unable to be locate; discharge documentation should include all outreach attempts as listed in section 2.9.1.1.
        - If reason for discharge is death of individual, the discharge summary should include date and cause of death from incident report
3. A recommended aftercare plan including:

- Information of all identified resources that an individual has been linked to at the time of discharge; information should include type/relationship of resource, name, and contact information
- Names of primary supports (family, extended family, and/or significant people) that have been identified that will ensure continued success once discharge takes place

4. Signature of the case management director or supervisor, who has reviewed and approved discharge

2.10. Renewed Authorization of Services

Review of individuals for renewed Case Management service is an annual process in which the individual's need for continuing service is assessed. Continued stay criteria is outlined in each level of care's medical necessity criteria (BCM, NFA and SUD ICM) found on CBH's website and in Appendix 3.3. Annually, provider agencies must complete and submit a re-authorization lead sheet, which renews service authorization for each individual on an agency's active caseload list.

Retrospective reviews of caseloads will occur by CBH and TCMU to ensure that caseloads continue to meet MNC and continued stay criteria. This will be facilitated and measured by the Case Management Key Performance Indicators (KPIs) as outlined by CBH. If KPIs change, notifications of updates will be communicated to the provider network. Continued technical assistance will be provided to ensure a cohesive and systematic approach to improving the quality-of-service provision for people served throughout the Behavioral Health Case Management system in Philadelphia.

1. Each agency is assigned an annual schedule for its submission of the re-authorization lead sheet. The lead sheet contains an agency's entire caseload of current individuals served. The case management director or supervisor must report the Medical Assistance (MA) eligibility of every individual on the lead sheet. Failure to submit an annual lead sheet by the predetermined due date can delay authorization of renewed service for individuals and impact billing of services. Additionally, lead sheets that are submitted late may result in a gap of service authorization, in which the provider will not be able to bill for services rendered.

2. The case management director or supervisor will provide a copy of the completed lead sheet to:
   - The Targeted Case Management Unit at DBHIDS
   - The OSS unit or BHCMU at CBH
   - The appropriate internal departments as outlined by the agency policy.

3. APPENDICES

3.1. Index of Acronyms

AA/NA	Alcoholics Anonymous/Narcotics Anonymous
ACT	Assertive Community Treatment
BCM	Blended Case Management
BH	Behavioral Health
BHCM	Behavioral Health Case Management
BHCMU	Behavioral Health Case Management Unit of CBH
BHJD	Behavioral Health Justice Division
BHS	Behavioral Health System
BHTEN	Behavioral Health Education & Training Network
CAC	Certified Addictions Counselor
CBH	Community Behavioral Health
CEU	Continuing Education Units
CM	Case Management
CQI	Continuous Quality Improvement
CRC	Crisis Response Center
CSP	Community Support Program
CST	Consumer Satisfaction Team
DBHIDS	Philadelphia Department of Behavioral Health and Intellectual disAbility Services
DHS	Philadelphia Department of Human Services
EM	Environmental Matrix
EDS	Enterprise Data Services
EVS	Eligibility Verification System
FACE	Factual And Clinical Elements (Sheet)
FIR	Forensic Intensive Recovery

FRN	Family Resource Network
HIPAA	Health Insurance Portability and Accountability Act
ICM	Intensive Case Management
DBH	Department of Behavioral Health
MA	Medical Assistance
MET	Mobile Emergency Team
MIS	Management Information System
MNC	Medical Necessity Criteria
MOU	Memoranda of Understanding
NACM	National Association of Case Managers
NIAC	Network Improvement and Accountability Collaborative
NFA	Non-Fidelity ACT
OMHSAS	Office of Mental Health and Substance Abuse Services
OHS	Office of Homeless Services
PARS	Prevention And Recovery Services
PGP	Personal Goal Plan
RC	Resource Coordinator/Resource Coordination
RN	Registered Nurse
SUD	Substance Use Disorder
SU ICM	Substance Use Intensive Case Management
TCMU	Target Case Management Unit, part of the Department of Behavioral Health

3.2. Glossary of Terms

Advance Directive	Allows an individual receiving behavioral health services to specify their treatment preferences before a disabling crisis occurs. In an advance directive, a person may specify 1) specific treatments they would like to receive or avoid and/or 2) a proxy to make treatment decisions for them should they become incapacitated. Advance directives are recognized by state in Pennsylvania and will be honored by most treatment providers.

Base Service Unit (BSU)	The Philadelphia BSU system is comprised of 13 federally mandated community mental health centers located in specified catchment areas. It is a geographically based model intended to facilitate data collection and tracking of individuals based upon their area of residence. Historically, the BSU system has also been used as a 'safety net' where people with no insurance are directed and expected to receive services.
Behavioral Health System (BHS) *AKA DBHIDS*	Consists of the Department of Behavioral Health (DBH), which includes the Single County Authority, Community Behavioral Health (CBH), and Intellectual disAbilities Services (IDS).
Behavioral Health Division	Provides administrative, fiscal, program planning and monitoring for a comprehensive array of behavioral health services such as social and psychiatric rehabilitation, individual and group counseling, family support, residential support, outreach, recovery support, consumer-directed service, Case Management, vocational rehabilitation, administrative management, outpatient services, residential and supportive independent living supports. It is a division of DBHIDS.
Behavioral Health Training & Education Network (BHTEN)	The Philadelphia Behavioral Health System-funded training facility specifically designated as a training resource for Philadelphia County behavioral health staff.
Blended Enhanced Case Management Model *AKA NFA or CTT*	An Intensive Case Management model in which the intensity of Case Management and frequency of individual contact vary in accordance with the individual's changing needs without altering the team of case managers. The model also enhances delivery of service through the addition of a full-time consulting/treating psychiatrist, a nurse, and a SUD specialist to the case management team.
Collateral Contact	A type of service provision by a case manager involving a telephone contact or meeting with a person other than the individual served. Examples would include meetings or telephone conversations with the individual's family, landlord, or staff at a provider agency.
Community Behavioral Health (CBH)	A non-profit corporation contracted by the City of Philadelphia to provide mental health and substance use services for Philadelphia County Medicaid recipients. It is a division of DBHIDS.
Continuous Quality Improvement (CQI)	A management process that is used to improve outcomes via a data-driven team approach. CQI uses data and a team of staff to identify problems, analyze their cause(s), implement change, and continuously measure improvement to see if the changes are effective.
Co-Occurring Disorder	The coexistence of both a mental health and a substance use disorder.
Crisis Plan	Part of the FACE sheet, which contains demographic and other information about an individual that may be vital to persons providing crisis service, such as a hospital or Crisis Response Center. The crisis plan, developed with the individual, identifies individualized, specific instructions/interventions aimed at de-escalating the crisis and promoting stabilization. This information should be completed within the first 30 days of service and is expanded as experience allows.
Crisis and Emergency Logbook	Maintained by each case management team. It contains vital information for all individuals served by the team that can be shared with persons providing emergency/crisis services when the chart is unavailable. The logbook is always available to the supervisor or their designee for the provision of 24/7 case management service. Included in the logbook are current FACE sheets, Wellness Management plans, and a 24-Hour Crisis Tracking Form. The logbook may be in electronic form.
Crisis Tracking Form	A 24-hour tracking form used to record crisis and emergency contacts and staff interventions (e.g., CRC visits).

Consumer Satisfaction Team (CST)	Has an established relationship with DBHIDS to monitor the paradigm of care of community-based services and to ensure an individual's satisfaction with those services. CST holds accountability meetings to address concerns/issues voiced by individuals and family members regarding behavioral health services.
Equity	The centering of creating opportunities and changes to a space or system so that marginalization doesn't unjustly predict one's success. Equity ultimately improves outcomes for all.
Environmental Matrix	A scale that evaluates the functional level of individuals on six (6) identified activities and determines the need for case management services, along with the frequency of contact and type of service.
Factual And Clinical Elements (FACE) Sheet	Contains an individual's current demographic information (name, address, phone, etc.), medical, psychiatric, financial, and insurance information, and specific instructions vital to persons providing crisis service to an individual (such as hospital staff). When utilized in conjunction with the Wellness Management Plan, the FACE Sheet provides critical crisis information, as well as important information for linking services to and accessing services for individuals.
Face to Face Contact	An in-person provision of case management services to an individual by a case manager.
Family and Significant People/Natural Supports	Significant people, including everyone other than treatment staff, who may be important (in a positive or negative way) to a participants' recovery and treatment. Examples of natural supports include religious organizations, recreation centers, family, spouses/partners, roommates, friends, and other community members such as landlords, neighbors, and educational programs.
Housing and Homeless Services	AKA Transitions, Integration, and Partnerships (TIP) Unit, Housing and Homeless Services manages DBHIDS resources focused on ending homelessness and increasing opportunities for Community Inclusion for persons with significant behavioral health challenges. Housing and Homeless Services falls under the Behavioral Health Division of DBHIDS.
Medical Necessity Criteria	Factors used to determine a person's need for case management services. These criteria are based on the person's mental health diagnosis, level of functioning, mental health treatment history, and the Environmental Matrix score.
Linkage Meetings	Regular meetings of members of the individual's support team (e.g. residential staff, family members, other supports), and should include the individual when possible. The purpose of the meeting is to discuss the individual's progress with the objectives contained in the service and any other new relevant issues and concerns regarding the individual's well-being.
Mobile Emergency Team (MET)	A service that provides city-wide psychiatric crisis prevention and intervention in non-traditional settings. The MET is available 24 hours a day, seven days a week. Intervention is provided in individuals' homes, when necessary, with the MET often becoming a mediator and support system for families in times of crisis. The MET works with the police department in mental health emergencies, providing clinical assessments, psychiatric consults, and 302 commitment applications, or acts as petitioner in 302 commitments when appropriate. This service is accessed through the Mental Health Delegates of the Acute Services Office who can be reached at (215) 685-6440.
Recovery	The process of pursuing a fulfilling and contributing life regardless of the difficulties one has faced. It involves not only the restoration but continued enhancement of a positive identity and personally meaningful connections and roles in one's community. Recovery is facilitated by relationships and environments that provide hope, empowerment, choices, and opportunities that promote people reaching their full potential as individuals and community members.

Resilience	A protective process which enables us to cope effectively when we are faced with significant adversities. It is a dynamic process that can change across time, developmental stage, and life domain. All children, youth, adults, families, and communities have the capacity to demonstrate resilience.
Service Documentation	The case managers' case notes, which document each encounter with an individual or collateral contact. The case notes shall verify the necessity for the contact and reflect the goals and objectives of the case management service plan. They should be legible; include the date, time and circumstance of contacts, regardless of whether or not a billable service was provided; identify the individual by name or agency identification number; and be dated and signed by the agency provider team member providing the service.
Service Documentation Form	An agency-designed form that includes state-required information used to document daily contact notes and billing information.
Service Plan/Personal Goal Plan	A strengths-based, individualized plan that serves as a roadmap for, and documents the provision of, case management services. The service plan is an expression of the individual's needs and desires identified in their Strengths Assessment.
Single County Authority (SCA)	The SCA plans, funds, and monitors substance abuse prevention, intervention, treatment, and recovery support services in Philadelphia. Through a network of treatment providers, the Philadelphia SCA guides recovery-oriented drug and alcohol treatment for people enrolled in Medicaid, as well as people who are uninsured and underinsured. The SCA falls under the Behavioral Health Division of DBHIDS.
Strengths Assessment	An evaluation of an individuals' strengths, needs, and interests used to develop an effective goal plan. The strengths, needs, and interests of an individual are assessed in all the Community Support Program (CSP) individual life domains and incorporate CSP principles and values.
Targeted Case Management Unit (TCMU)	A unit that is dedicated to the oversight of Case Management services in Philadelphia County. The unit is a primary support to the providers of Case Management services for the individual and liaisons regularly with CBH and other DBH units to ensure quality of services to the individual. TCMU falls under the Behavioral Health Division of DBHIDS.
Targeted Case Management Providers Meetings	Mandatory meetings involving all Behavioral Health Case Management service providers planned, announced, and conducted by the TCM Unit. These meetings are convened monthly, to provide system-wide training and/or to communicate major system changes.
Team Approach	Occurs when all members of the case management team share in the responsibility of providing services for the entire team's caseload even though a primary case manager may be assigned.
Trauma	Either a single or collection of distressing experiences which result in challenges managing ones' spiritual, mental, and emotional well-being.
Trauma-Informed Care	Recognizes the presence of trauma symptoms and acknowledges the role trauma may play in an individual's life and promotes environments of healing and recovery.
Trauma-Informed Assessment and Interventions	Agencies possess the capability to both assess and treat people who have faced generational, lived, and/or current traumatic experience. Assessment includes methods to determine the complexity, chronicity, and degree of impact on the individual and the family. The assessment process is respectful and patient, using cues from the individual in determining the pacing of the interview. Conceptual clarity and clinical supervision are paramount in the treatment of trauma.

Wellness Management Plan	An expansion of the Crisis Plan that includes relapse and crisis prevention interventions developed over time (in the initial 90 days) with the person being served by Case Management. The Wellness Management Plan identifies triggers, warning signs, special problems/needs, and interventions/supports that have been developed with the person being served when they are in a period of stability. The plan is further developed as experience allows. The Wellness Management Plan may include (informal) Advance Directives.

3.3. Resources

- **Blended Enhanced Medical Necessity Criteria** (also called Community Treatment Teams or Non-Fidelity ACT teams)
- **CBH Provider Manual**
- **Child and Adolescent Service System Program (CASSP) Principles**
- **Community Support Program Values and Principles**
- **DBHIDS Practice Guidelines**
- **DDAP Case Management and Clinical Services Manual**
- **Family Inclusion Standards**
- **NACM Case Management Practice Standards and NACM Code of Ethics**
- **NIAC Network Inclusion Criteria (NIC)**
- **OMHSAS -10-03 Blended Case Management, Revised**
- **OMHSAS-10-03 Attachment B: Fiscal Issues**
- **OMHSAS-10-03 Attachment D: Blended Case Management Guidelines**
- **OMHSAS-12-03 Mental Health Targeted Case Management(TCM) Documentation Requirements**
- **OMHSAS-13-01 Targeted Case Management (TCM) Travel and Transportation Guidelines**
- **OMHSAS Chapter 1101. General Provisions**
- **OMHSAS Chapters 1247. Target Case Management Services**
- **PA Department of Human Services Title 55**
- **P.A.C.E. Strategic Plan**
- **Recovery Principles**
- **Targeted Case Management Medical Necessity Criteria** (used for BCM, RC and ICM LOC)
- **TEC: Addressing Trauma, Achieving Equity, Engaging Community**