



Performance Standards

Targeted Case Management

Performance Standards are intended to provide a foundation and serve as a tool to promote continuous quality improvement and progression toward best practice performances, to increase the consistency of service delivery and to improve outcomes for members

Disclaimer: These Performance Standards should not be interpreted as regulations. Entities providing services as part of the HealthChoices program must first be enrolled in the Pennsylvania Medical Assistance program as the appropriate provider type. Providers must then comply with all applicable Pennsylvania laws, including Title 55, General Provisions 1101, licensing program requirements and any contractual agreements made with Community Care Behavioral Health Organization in order to be eligible for payment for services.

**TARGETED CASE MANAGEMENT (TCM)
(INTENSIVE CASE MANAGEMENT (ICM) AND RESOURCE COORDINATION
(RC)/BLENDED CASE MANAGEMENT (BCM))**

PERFORMANCE STANDARDS

Targeted Case Management (TCM) services include a range of Medical Assistance (MA) funded activities for persons with psychiatric disabilities that have resulted in significant levels of functional impairment. These services are provided in a manner consistent with the principles articulated by the Community Support Program (CSP) and the Child and Adolescent Service System Program (CASSP). The primary focus includes the following:

- Assessment, development, and implementation of a strengths based service plan.
- Development and maintenance of community based linkages.
- Participation, in a leadership role, as a part of the treatment team, to coordinate services and ensure continuity of care.
- Crisis intervention including assessment for diversion from the most restrictive levels of care.
- Advocacy for member and/or family choice of services and active participation in the member's recovery process through education and training.
- Utilization of recovery principles throughout the treatment process with efforts towards member self-management of the illness.

These standards represent an effort to build on the work of the Department of Public Welfare (DPW), the CSP and CASSP program, with input from member and family stakeholders and providers to increase the consistency of service delivery and to improve outcome. As with all performance standards developed with Community Care, these standards are intended to define the parameters of a reasonable standard of care. To that end, these should NOT be interpreted as regulations, or as means to require or prohibit specific interventions for specific individuals. All individuals receiving services should have a strength based service plan developed to address the individual's strengths and needs.

It is anticipated that these standards may form a foundation for the eventual development of TCM services for persons with addiction disorders. Additional review will be needed.

ACCESS STANDARDS

Member/family should be able to have a choice of providers:

- A Members may have a preference on the desirability of TCM services that are integrated with treatment and other behavioral health services (some members prefer "conflict-free" case management that is provided independently of their treatment programs; others prefer to have the services from one provider).

- The provider has an obligation to provide information to the member to ensure that the member/family has the opportunity to make an informed choice about the provider of TCM services.
- Member/family should have an assessment of need within the time frame designated for the urgency of the referral (the service is designed to meet the needs of persons with serious mental illness, or serious emotional disturbance (SED) in the case of children and adolescents, who generally have relatively immediate case management needs). providers will respond to “inquiries” regarding the suitability of a potential referral:
- Face-to-face assessment.
- Emergent - should occur within 24 hours under specific circumstances, such as an imminent change in environmental status, e.g., discharge from inpatient care (both community and state hospital), release from jail/prison, imminent homelessness, and significant family disruption. A Community Care care manager, following an assessment of the situation, makes notification of emergent referrals to the TCM provider. This would most often occur with unplanned discharges from inpatient or diversion and acute stabilization levels of care (this should not be confused with mobile or other crisis services).
- Urgent – Should occur within 72 hours under circumstances where the need is reasonably apparent but there is not imminent risk of danger to the member or community. A Community Care care manager, following assessment of the situation, makes notification of urgent referrals to the TCM provider. This may occur in instances when a member was discharged against medical advice (AMA) from inpatient or another residential level of care.
- Routine – Should occur within seven days of receiving the completed referral packet, e.g., a referral is made for an individual who is scheduled for discharge from institutional care in two months would not normally suggest that the above timeframes are relevant; it is expected that services would be in place at the time of the discharge/release.
- “Referral” means receipt of a completed (as defined by DPW and county standards) referral packet.
- The initial activity includes a screening to assess general appropriateness, including member choice, availability, general need, and eligibility.

GENERAL APPROPRIATENESS FOR SERVICES

Individuals who receive services must meet the eligibility criteria established by the Departments of Public Welfare and/or Health. In addition:

- “Generally necessary”, e.g., within the bounds of eligibility criteria, there are individuals for whom TCM *would* normally be expected to be necessary - this should not be interpreted to mean that the service is required.
- Individuals with multiple inpatient stays and a lack of successful treatment connection in community settings. For children/adolescents, this includes multiple RTF admissions as well.
- Individuals with unstable living environments.

- Individuals with co-morbid conditions, such as addictive disorder or medical illness or condition.
- Individuals with serious and persistent mental illness who have a record of forensic involvement, particularly when the forensic involvement is a direct result of the individual's mental illness.
- Individuals who have significant responsibility for the care of dependents as well as themselves.
- For children and adolescents:
 - Those involved in help-seeking from multiple systems (CYF, JPO, school special education).
 - Children whose parents have a serious behavioral health diagnosis.

Difficulties responding within access standards because of parental involvement or non-responsiveness should be documented.

- “Generally not necessary”, e.g., within the bounds of DPW eligibility criteria, there are individuals for whom TCM services would not *normally* be expected to be necessary -bear in mind this should not be interpreted to mean that any one individual is not able to receive the service; merely that it isn't *normally* necessary or useful under these circumstances. This refers to new members, not to those who are already engaged in TCM services prior to placement.
- Individuals with secure and stable housing and environmental supports in place, such as a skilled nursing facility.
- Individuals already receiving similar services.

For individuals currently receiving services in a long term setting, the TCM is responsible for communication with the treatment team regarding TCM involvement. In all cases, the TCM must be involved in the discharge planning. TCM documentation should indicate the frequency and goals of involvement.

ENGAGEMENT/RE-ENGAGEMENT

This area should be a part of the crisis/relapse planning process with the member in order to identify appropriate boundaries and accepted interventions. It is understood that because of the nature of the illnesses, individuals who may be appropriate may not be immediately agreeable to the provision of service. While we recognize that this is a voluntary service, it is incumbent on providers and others concerned about the welfare and needs of vulnerable populations make and document a significant effort to engage the member in services.

Benchmark expectations have been established

They include:

- At least three attempts to make planned face-to-face contact with the member who has been previously unreachable by any other means. These planned contacts would be considered a HealthChoices billable contact to Community Care.
- At least two additional attempts to make telephone contact with the member.

- At least one follow-up letter via certified mail or mail confirmation:
- This should include service alternatives for the member as well as directions on how to contact the provider if the member's interests change. The appropriate telephone crisis service number must also be provided.
- Contact with the Community Care care manager to request notification if member's location is determined through a request for service.
- Contact with the forensic liaison, if this resource is available, to determine if the member has been incarcerated.
- Provide assistance to the family or significant other in determining if a safety issue exists and law enforcement needs to be notified.
- This activity should occur over no less than 45 days (60 days for children and adolescents).

ASSESSMENTS

The strengths based assessment process must be a collaborative process between the TCM, member, and family and must reflect cultural competence and acceptance of member choices.

Environmental Matrix Score will be used to determine MNC and will guide the TCM in determining, with the member and family, the frequency and intensity of TCM services. Assessments and re-assessments will include the following domains:

- Assessment of skills in activities of daily living.
- Assessment of housing needs/assets/food/clothing/basic needs.
- Assessment of behavioral health treatment needs.
- Assessment of vocational/educational goals/supports/needs.
- Leisure/recreational/social supports.
- Peer and family supports.
- Cultural/spiritual supports/issues.
- Medical supports/Dental/Specialist.
- PCP involvement.
- Active access to medical care for any on-going issues.
- Access to Special Needs Units at the physical health managed care organization (PH-MCO) serving the member (when the member is enrolled in HealthChoices).
- Financial issues.
- Legal/forensic issues.
- MISA Screening.
- Crisis/relapse plan- this should include identification of patterns of decompensation for inclusion in the plan.
- Safety Issues.
- Additionally, for children and adolescents:
 - Education.
 - Primary contact with school.
 - Social/human services providers.
 - Safety issues, including housing.

- For each of the above domains, the TCM obtains the following information:
 - What is working for the member?
 - What has been successful in the past?
 - What services are being utilized?
 - What else might be needed?
 - Does anything need to be corrected or adjusted to better meet the member's needs?
 - Are there service needs with family members or significant others that may affect the member's recovery?

SERVICE PLANNING ELEMENTS

At Intake: In an effort to formulate an initial service plan and to coordinate treatment and support services, the member record will contain one of the following:

- A copy of the member's treatment plan or documentation that reasonable efforts have been made to obtain the treatment plan.
- Documentation evidencing communication between the case manager and the treatment team that is of sufficient substance to promote continuity and coordination.

Ongoing Planning: To maintain continuity and coordination, the member record will contain:

- Treatment plans that are relevant to the service period and updated as the treatment plan changes or documentation that reasonable efforts have been made to obtain the treatment plan, **OR**
- Documentation evidencing substantive communication between the case manager and the following members of the clinical treatment team. If permitted by the member, this contact should occur no less than once every two months.
 - Member
 - Family
 - Residential provider
 - Psychiatrist
 - Outpatient provider

In addition:

- Other mental health service provider representatives such as psychiatric rehabilitation and diversion and acute stabilization as ad hoc team members of the team
- Other service system providers currently delivering services to the member such as CYF, Juvenile Justice, Aging, Education/Vocational as appropriate

All service providers should have a working knowledge of the treatment plan for each service being delivered to the member. This sharing of information must be supported by documentation in the member chart along with appropriate Releases of Information.

Changes in the member's Status

Any change in the member's status should be communicated immediately to other members of the treatment team. Such changes will include, but not be limited to:

- Use of crisis/on-call.
- Risk of homelessness.
- Change in clinical presentation.
- Use of emergency room.
- Arrest.
- Inpatient hospitalization.
- Significant change in support network.
- Inability of TCM to locate/contact member

The case manager will coordinate the revision/update of the service plan process to incorporate modifications that may be necessary.

The service plan should:

- Be based on recovery principles and should identify strategies for TCM involvement in the recovery process.
- Be developed with the fullest possible participation of the member and significant others, as appropriate and agreed to by the member.
- Address identified strengths and needs of the member.
- Include measurable goals and objectives, and time frames for addressing them - these should be related to the member identified goals and objectives.
- When appropriate, include a contingency plan to address anticipated problems should they arise. For example, if a member historically experiences an exacerbation of symptoms in the spring of the year, the service plan should include a plan that anticipates that this may recur in the coming spring.
- Note other services and supports being used by the member (including peer supports, family supports, and community supports).
- Include specifics regarding the member's access to medical and dental resources - this should include access strategies (that is, the member has a PCP and the member knows how to successfully access the PCP). This should also include strategies for contact with the Special Needs Unit of the member's PH-MCO for assistance with any special health care needs, as appropriate.
- Include a plan or strategy for working with the member to provide education regarding the member's management and monitoring of his/her illness. This may involve provision of reading materials, referral for or linkage to peer support, educational efforts by the TCM or any other intervention that the member sees as pertinent and relevant.
- Include a crisis/relapse plan that is shared with the member and/or family and is readily available to on-call staff to guide crisis resolution.
- Document family involvement as appropriate.
- Document leisure/recreational/social supports.
- Include documentation of a discussion with the member regarding transition from this level of care.

- Include the signature of the member indicating active participation in and his/her agreement with the plan.
- Additionally, for children and adolescents, the service plan should:
 - Document summer plans.
 - Document plans for transition events (life benchmarks, such as school change).

Upon completion of the service plan, the document should be shared and reviewed with the treatment team, including the member/family.

DELIVERY OF SERVICES

- Regular contact with the member's treatment team.
- Advocate and facilitate member and/or family involvement with the treatment team.
- Facilitate timely treatment team contact with the county and Community Care if there is a clinical disagreement, funding issues, or complex service needs - the TCM role is to ensure that services are coordinated and delivered in a coherent and consistent manner.
- Regular contact with the member's treatment providers and support system (including peers).
- Reassessment of the member's needs and strengths:
- Is focused on recovery principles in the member's development, beyond the immediate need.
- Immediate access to and support during a period of crisis in order to assess the member for appropriate intervention and diversion from inpatient level of care if indicated. To the extent possible (for example, when safety issues are not paramount), these services should be delivered **before** the individual presents at a hospital.
- Presence at the emergency room during an assessment for inpatient admission. On-site presence in the emergency room (ER) is required by regulation for a 302.
- On-site presence is preferred for any assessment for inpatient hospitalization, psychiatric or drug and alcohol.
- Communication with the inpatient treatment team within a minimum of 24 hours of notification, to begin discharge planning, from inpatient.
- Attends all state hospital diversion meetings - the TCM must be involved in discharge planning (if the hospital does not permit/facilitate the participation, this should be documented in the case record, and the care manager should be alerted).
- Ensures that the member attends the first follow up appointment following transition from one level of care to another.
- Contacts Community Care when there is anticipation of a lack of consensus around discharge planning.
- The program should have a means on ensuring that the individuals providing services, especially off-hours, have ready access to pertinent, current information about the member.
- If the TCM has not been notified of a member's presence in the ER for admission to inpatient level of care or by the inpatient unit within 24 hours of the member's

admission, or the TCM experiences any other obstacles to involvement in discharge planning, the TCM should notify a Community Care care manager to file a Significant Member Incident Report.

“INTENSIVE” Versus “EXTENDED” TRACKS OF TCM

It is understood that TCM services may be provided in a particularly intensive mode, when rapid response is required, and that they may also be provided over an extended period of time to support a person in recovery.

“Intensive”

- Generally for a period of up to 30 days during which intensive interventions are appropriate.
- Range of services is expected to be from two to 16 hours a week during this period:
 - Generally, an individual requiring less intervention should probably not be on this track.
 - Conversely, if someone requires more than this, serious consideration should be given to the appropriateness of the level of care.
- Specific activities include:
 - Provision of supports to the member.
 - Assessment of the need for changes in the service or treatment plan.
 - Short term stabilization plan.
 - Linkage to immediately needed services, and/or re-establishment of linkages (respite, crisis intervention, housing, etc.).
 - Documentation of activities and plans may be contained in the progress notes rather than necessarily being noted in a revised or amended treatment plan.

“Extended”

- Because this is a service that is targeted to persons with serious and persistent mental illness, long term services are expected.
- The member should receive at least two face-to-face contacts a month from the TCM - this is more than required by regulation.
- For resource coordination, the person should have a least one contact per month - this is more than required by regulation.
- Normally, an individual would not require contact more than three times a week in this track - more intensive intervention suggests a “move” to the short term track. This does not mean a change of assigned case management staff.

Changes to the frequency and intensity of TCM services should be documented in the member record. Triggers for these changes may include:

- An increased or decrease of on-call use.
- Increased involvement in Criminal/Juvenile Justice System.
- Missed treatment appointment.
- Involvement with Children/Youth and Families.
- Hospitalization.
- Increased ER visits.

- Multiple system involvement.
- Medication issues or concerns.
- Medical complications.
- Identification of substance abuse issues.

These triggers would identify an increased level of need by the member that may include:

- Increased number and intensity of TCM contacts.
- Increased communication with the treatment team.
- Increased need for community support.
- Increased need for referrals or linkages to other supports.

TRANSITION PLANNING FOR ALTERNATIVE SERVICES

- Transition planning from this level of care should be introduced at the initial service plan development.
- This transition plan should identify for the member a provisional plan for follow up services after transition from TCM.
- Planned Transition – the transition planning process, when planned, begins formally at the time that a determination by the member and provider that the period of service has come to a conclusion. This could occur over a period of months, or over a much shorter period. The process should include:
 - A plan for continuing treatment services and support services.
 - Connections to peer and other natural supports should be documented.
 - Specifics of treatment services should be noted.
 - Arrangements for case management services should be noted.
 - Face-to-face, direct linkage to the “succeeding” provider(s) should be made with the approval of the member.
 - The crisis/relapse plan should be provided to the member/family/significant other and documented. This should include information on the telephone and mobile crisis services.
 - Information about how to reconnect with the TCM if the need arises in the future.
- Additionally, for children and adolescents:
 - Specific plans with the school district, principal, pupil personnel, and teacher(s).
 - Family involvement in the discharge planning process with specific instruction regarding treatment and other resource availability.
 - Unplanned discharge (the member withdraws from service).
 - Re-engagement efforts (outlined above in the “Engagement” section) will be made.
 - The care manager at Community Care will be notified.
 - Options for alternative services or alternative providers and supports are developed and offered to the member, including peer and family support.
 - The individual’s significant others and treatment team are notified (within the bounds of informed consent).
 - Assessment and documentation of success in achieving and sustaining the individual’s goals and objectives and of the individual’s status.

- Means to sustain progress and functioning should be identified.

FOR ANY TYPE OF TRANSITION, A MEMBER PRESENTING BACK TO THE TCM PROVIDER SHOULD BE ASSISTED AND THE TRANSITION PLAN RE-ASSESSED FOR POSSIBLE REVISION.

OUTCOME INDICATORS

Each TCM provider should have a policy and procedure in place for outcome measurement. Listed below are outcomes indicators that may be used to evaluate the effectiveness of Targeted Case Management programs. It is not expected that the provider will choose to measure all of the indicators listed below:

- Increased community tenure
- Decreased use of ER/mobile crisis
- Increased adherence to recommended treatment
- Satisfaction of the member with services (Annual Satisfaction Survey)
- Increase in successful diversions from state hospital commitment (measured through documented outcome of the diversion meetings)
- Decreased forensic involvement
- Increased stability in housing of choice
- Successful vocational/educational outcome (defined to mean the member has reached an objective which is satisfactory to the member)
- Increased effectiveness (measured by actual contact with the services and receipt of services)
- Improved quality of life
- Enhanced ability to provide “self case management”
- Increased ability to self-monitor and self-manage the illness and medication regime
- Increased TCM time spent on supporting and reinforcing education and training efforts on member communication with the psychiatrist and other physicians and/or other self-management skills
- Increased TCM time spent on treatment plan review
- Increased TCM time spent on providing feedback to the clinician and/or treatment team on medication issues such as side effects, compliance
- Additional outcomes measures for children and adolescents:
 - Increased school attendance
 - Improved school performance
 - Decreased out-of-home placements
 - Decrease in simultaneous involvement in multiple levels of care

Member Satisfaction

Noted below are recommendations for satisfaction items to be addressed specific to TCM services. These would be assessed in addition to the standard satisfaction measures on an annual basis as required by DPW regulation:

- Were the linkages the TCM staff assisted you with helpful, e.g., was it the right service, did you get the service, did it help you to accomplish your goals?
- If you received different behavioral health services with the assistance of your TCM staff, did the transition go smoothly?
- Did you have adequate access to TCM services outside of usual working hours, e.g., if you needed to use services when your TCM staff was not available, were the services satisfactory?
- Did you understand your right to choose a provider of service? Did you have enough information to make a good choice?
- Did you feel you didn't have referrals or services you needed because your TCM was not able to make referrals to all providers?
- Did the TCM services that you were provided address your specific cultural and value system needs in a respectful manner?

Cultural Competence

- All TCM providers are expected to support the ongoing development of cultural competence within their programs. Supervisors should make cultural competence an ongoing topic of discussion with their teams.
- TCM takes the philosophical approach of identifying strengths and recognizing the uniqueness of each member. Providers should engage in open, respectful communication with members and families about culturally based values and belief systems that need to be considered.
- Providers are expected to maintain documentation of all initiatives to further develop the cultural competence and sensitivity of staff and programs. Cultural competence, from the perspective of the member, is monitored by:
 - Specific requests made by a member, or on behalf of a member
 - Member complaints
 - Member Satisfaction Survey

Supervision

- All TCM programs will adhere to DPW regulations related to supervisory requirements.
- All TCM programs must have a written policy and procedure identifying a model and process for providing regularly scheduled clinical and administrative supervision.
- All TCM programs must keep written documentation of supervision being provided to individual case managers.

Training

- All TCM programs must adhere to DPW regulations regarding training requirements.
- All TCM programs should provide written documentation of individualized training plans and training received for each case manager, updated on an ongoing basis.
- All TCM programs must adhere to Community Care training requirements.