CASE MANAGEMENT PRACTICE TIERS

Prepared for:
Jackson County Community Mental Health Fund

Resource Development Institute

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Table of Contents

Executive Summary ... 1

Introduction ... 2

Case Management Overview ... 2

  Case Management Definition ... 2

  Quality Case Management ... 4

    Client/Provider Relationship ... 4

    Activities/Functions ... 4

    Fidelity to Evidence-Based and Best Practice Approaches/Perspectives ... 7

    Client and Agency Case Management Outcomes ... 8

Focus Group Results ... 8

  Focus Group Content ... 9

    How Agencies Define Case Management ... 9

    Approach or Service Model Used at Agency ... 14

    Agency Follow-up with Clients Who Do Not Return ... 15

    Transition Planning in Case Management ... 16

Discussion ... 16

  Tiered Case Management Service Structure ... 17

Bibliography ... 19

Executive Summary

Resource Development Institute, under contract with the Jackson County Community Mental Health Fund, developed a Case Management Practice Tier framework to inform the fund's mental health case management funding.

Project results include recommendations to better identify the quality of the activities the Levy is funding as well as a framework to better "fit" reimbursement rates to the depth, or value, of the funded activities.

It is recommended that:

1. The Jackson County Community Mental Health Fund adopt case management practice tiers to guide the selection of agencies for mental health case management funding. The proposed tier structure highlights the importance of:
    a. Full programs (including assessment, case planning, case management, and evaluation);
    b. Staff competence (identified by: license, credential, certificate, or degree; annual performance reviews with feedback to case managers about their success implementing the agency's case management model, and by the maintenance of stable client relationships over time with one specific case manager); and
    c. Quality service provision (as seen by the use of validated assessment tools, evidence-based practices, a multidisciplinary/team approach, and the use of data to determine needed change in service provision at both the client and agency levels).
2. The Fund collect additional data during, or prior to, the application process including:
    a. How the agency's case management model fits the agency's client demographics;
    b. The client assessment tool to be used, and if the tool is validated;
    c. How measurable client outcomes are linked to treatment plans;
    d. How implementation fidelity data are collected through proposed staff training and individual coaching, as well as the frequency and duration of proposed training activities;
    e. The agency's case manager turn-over rate the previous year;
    f. Planned case manager retention activities; and
    g. The average caseload for agency case managers the previous year.
3. Site visits to funded agencies include gathering documentation of implementation fidelity. How do the agencies know they are "doing" their service model correctly?
4. The Fund use case management practice tiers to guide mental health grant expenditures and reimbursement rates. Linking Levy-defined high quality case management to reimbursement rates will increase the fit between the *amount* of Jackson County Community Mental Health Fund fiscal support for case management services and the *activities* which are funded.

Introduction

Resource Development Institute, under contract with the Jackson County Community Mental Health Fund, developed a Case Management Service Tier framework and supporting recommendations to inform the Board's mental health case management funding.

Project work included a review of the literature through online academic databases to develop a definition of case management, and to identify what tasks fall under the umbrella of quality case management. Sources from the Internet were used, as necessary. Additional literature was identified to support discussion of the fidelity of program implementation.

Focus groups were held to collect data regarding: how case management is defined at the agencies, what agency/department approach or case management model is used, how agencies follow up with clients who don't return for services, and what role transition planning has in the care provided at the agencies.

Six focus groups were held (three for agency administrators and three for staff). Thirty-one people participated in the focus groups with an additional two participating via personal phone calls. Seventeen agencies were represented. Participating agency administrators were identified by the Community Mental Health Fund. The administrators referred agency staff to participate.

Case Management Overview

Case Management Definition

Multiple definitions of case management exist, specific to a certain extent to the population served (ex: people who are homeless or who are being dismissed from a hospital) or for the professions of the service providers (ex: social workers or nurses).

Scott and Dixon note that case management programs in the field of mental health vary according to four dimensions:

- Locus of the decision-making responsibility (client-centered versus case manager-centered),
- Theory of cost effectiveness (improved patient functioning versus active cost management),
- Organization of patient care (team versus individual case manager), and
- Case manager's role in patient/client care (referral/linkage versus direct service provision).

Information synthesized from a review of literature garnered five models of case management in the mental health field, presented below.

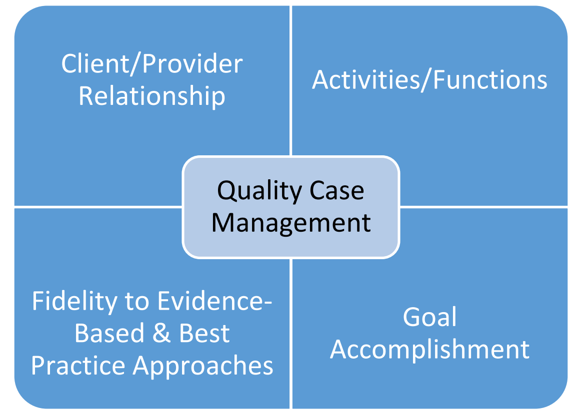
Types of Case Management				
Types	**Characteristics**			
	Distinguishing Characteristic	**Coordination or Service Provision**	**Responsibility**	**CM Service Intensity**
Rehabilitation	Consumer-driven goals for concrete skills	Coordination	Case worker	Low
Broker/Generalist	Coordination: referral linkage	Coordination	Case worker	Moderate
Intensive*	Comprehensive	Coordination/ service provision	Team	High
Critical Time Intervention* (as in Crisis Intervention or Discharge Planning)	Specialized for quick-turnaround transitions	Coordination	Case worker	NA
Clinical	Case manager as therapist	Service provision	Case worker	NA
*Case managers may/may not provide direct therapy services, depending on composition of the multidisciplinary team				

After consultation with Jackson County Community Mental Health Board Staff two types of client case management services were set aside since they are billed as separate services.

1. Critical Time interventions were set aside. Instances in which a client with an established, or developing, professional relationship with a case manager may need a time-sensitive referral are incorporated in the Broker/Generalist model.
2. Clinical interventions were set aside. Clinical providers bill their services as therapy units rather than case management.

Quality Case Management

An important indicator of quality case management is the nature of the consumer-provider relationship. This carries through to activities/functions, fidelity to evidence-based and best practice approaches/perspectives employed, and the accomplishment of client goals and agency case management goals.



Client/Provider Relationship

"Frequently, when individuals are involved in multiple public systems it is important for a single point of contact to coordinate care and engage all the system partners in service planning and delivery" (SAMHSA, 2015). In these instances, the functions of case management are "characterized by a closer involvement between case manager and client" (Vanderplasschen, 2007, p. 82). This relationship is deemed so important that the Minnesota Department of Human Services Legislative Report on *Minnesota Case Management Reform* consistently includes as the first item on lists of case management activities, "Working relationship between the case manager and person" (2014, p. 15).

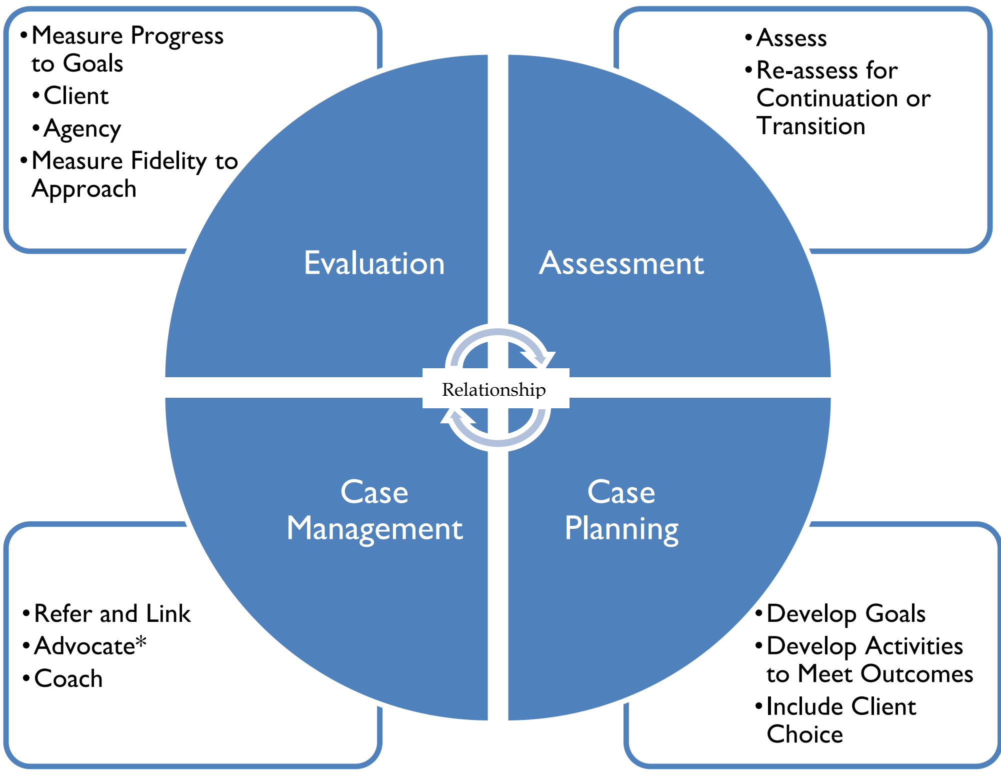
Activities/Functions

SAMHSA presents case management best practice guidelines in *Comprehensive Case Management for Substance Abuse Treatment*: *Treatment Improvement Protocol* 27, noting that, "case management is a set of social service *functions* that helps clients access the resources they need" (SAMHSA, 2015, p. 3). This corresponds with the National Association of Social Workers' definition that case management is "a process to plan, seek, advocate for, and monitor services from different social services or health care organizations and staff on behalf of a client. The process enables social workers in an organization, or in different organizations, to coordinate their efforts to serve a given client through professional teamwork, thus expanding the range of needed services offered" (NASW, 2013, p. 13).

Multiple frameworks for these services exist in the literature. The number of, and specific stages of service provision, vary - often linked to a model of case management included. However, in all frameworks the stages of services are dynamic and can be recurrent as clients and case managers meet outcomes and re-goal. The following four-stage framework presents case

management services as an integral part of *multidisciplinary coordinated care* for clients receiving mental health services through the Broker/Generalist, Intensive, or Rehabilitation models. Case management is one of the four stages of multidisciplinary coordinated care and includes referring and linking clients to services, advocating for clients, and coaching clients. Also presented is the central importance of the client/case manager relationship. Client intake occurs prior to the following stages (screen, complete benefit/financial forms, pre-diagnose) and is not included as part of multidisciplinary coordinated care.

Multidisciplinary Coordinated Care



* fitting the services to the client, rather than the client to the services

Multiple tasks can occur in each stage of multidisciplinary coordinated care (including case management) with variation in the intensity, duration, and frequency of activities. Sample activities from the literature, by stage, follow.

Activities and Stages of Multidisciplinary Coordinated Care	
Stages	**Activities**
Assess/Reassess	Gather pre-assessment information from agency records and staff
	Gather information from outside sources (including caregivers)
	Interview client
	Complete valid assessment tool
Case Planning	Identify outcomes
	Identify activities to meet outcomes
	Partner with client in decision-making (face-to-face)
	Plan for Transition
	Consult with families/caregivers
	Review completed care plan
Case Management	Link/broker/refer for social or other client services
	Advocate for social or other client services
	Responsive documentation
	Maintain/expand client social networks/develop informal resources
	Psycho-educate/coach in life skills
	Transport
	Conduct medication screen
	Provide medication assistance
	Provide instrumental assistance
	Provide crisis intervention
	Monitor/follow-up on social or other service provision
	Transition/terminate
Evaluation	Evaluate progress toward client goals and adjust services, as needed
	Evaluate progress toward agency case management goals and adjust services, as needed
	Examine case management fidelity to agency-adopted approach and adjust practice, as needed
All Stages	Engage and maintain professional relationship with client

The previous discussions highlight the concept that case management is a "set of social service *functions"* (SAMHSA, 2015, p. 3) with "a single point of contact to coordinate care and engage all the system partners in service planning and delivery". By definition, case management is discrete from formal programs or program components run by agencies. Many formal programs are integral to a client's and agency's success but are direct interventions rather than case management. Case management and multidisciplinary coordinated care also are

differentiated from administrative activities, training, and therapeutic interventions. Examples of programs and activities which are *not* case management or multidisciplinary coordinated care follow.

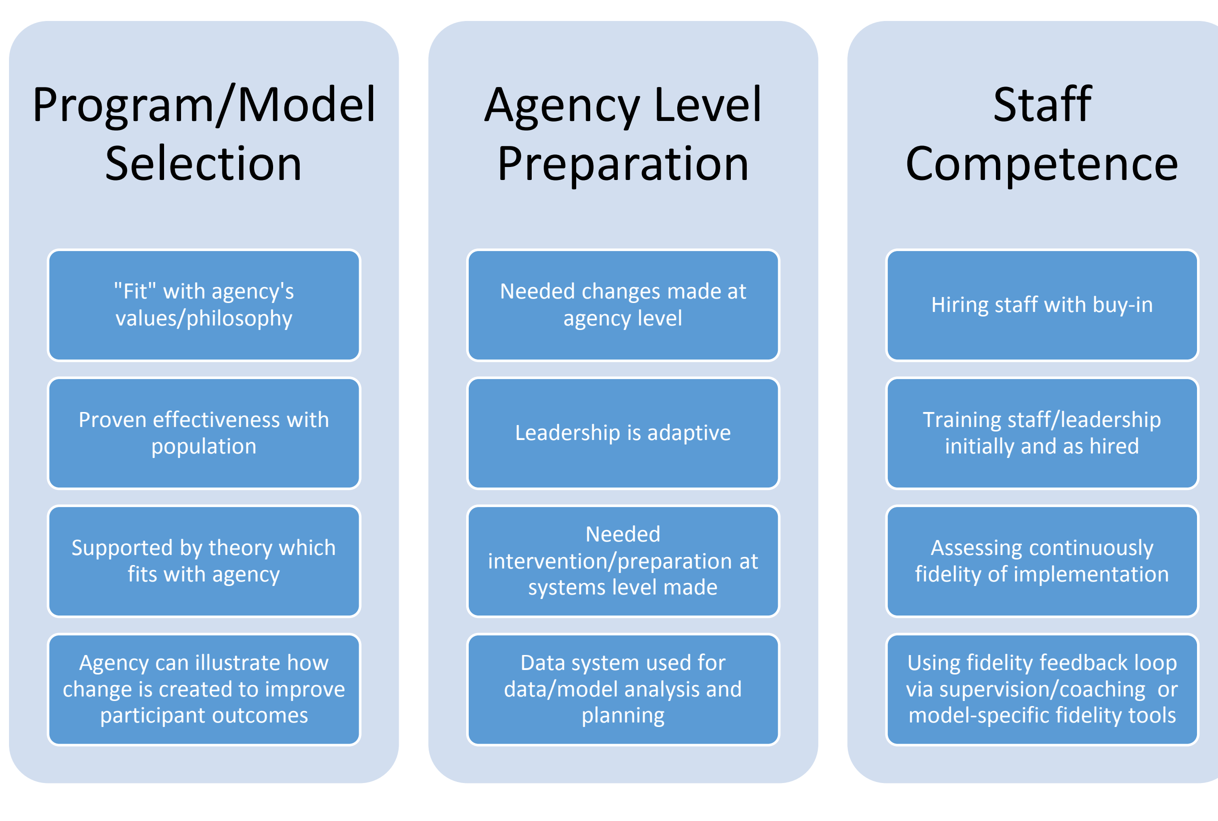
Non-Case Management/Multidisciplinary Coordinated Care Examples	
Types	**Examples**
Formal Programs	Psycho-educational groups
	Peer support groups
	Peer mentoring programs
	School behavior-management programs (Ex: Behavior Intervention Support Team –BIST)
Administrative Activities	Attendance at general team meetings
	Agency documentation review
	Professional development/training
	Internal/external communication (phone/email)
	Team documentation completion/filing
Therapeutic Interventions	Direct therapy Crisis intervention
Physician Extender	Advanced practice RN providing vital signs to physician contributing to care plan

Fidelity to Evidence-Based and Best Practice Approaches/Perspectives

Implementing a new program with fidelity can take two to four years and includes multiple steps, many of which happen prior to staff interacting with clients via the program model. These steps include selecting a model that: is a "fit" with the agency's values and philosophy, has proven effectiveness with the population to be served, is supported by a clear human behavior or organizational development theory, and has a theory of change (or logic model) which illustrates how change is created to improve client outcomes.

Consideration is also given early in the program selection process to agency-level preparation: what changes and "adaptiveness" are needed at the administrative level, what interventions are needed to occur at the systems level, and are the data collection and analysis systems ready to support decision-making about the new model. Additional fidelity steps, in a sense, set staff up for success using the model. These steps focus on staff competence and highlight: selecting staff, initially training all staff and leadership, continuing assessment of staff's program implementation with fidelity, and ongoing supervision/coaching in the model or the use of model-specific fidelity tools. The following diagram presents these three types of fidelity components, applicable to funded programming.

Fidelity Components, by Type



Client and Agency Case Management Outcomes

In addition to examining program fidelity as a window into the quality of program implementation, client and agency case management (population) outcomes must also be examined (Bertram, et al., 2011). Are individual *client* outcomes improving as expected? Are *agency*-level outcomes as predicted? Feedback loops to case management staff regarding the completion of client goals set the stage for re-goaling, transitioning to other levels of services, or discussing the impact of program fidelity (or lack of fidelity) on client outcomes.

Focus Group Results

Jackson County Community Mental Health Board Staff identified agencies for participation in focus groups. A stratified selection was made to include agencies of various sizes and across a wide variety of populations served. Email addresses for agency administrators were provided by Levy staff. Agency administrators were asked to forward the participation request to agency staff.

Thirty-three people provided information regarding case management at their agencies (22 administrators and 11 agency staff). Representatives from the following agencies participated:

Comprehensive Mental Health
Cornerstones of Care: Pathways
Empowerment Project: JVS/UMKC
Jewish Vocational Services
KC Care Clinic
Mattie Rhodes
MOCSA
Newhouse
Reconciliation Services
ReDiscover
reStart
Rose Brooks
Salvation Army Children's Center
Sheffield Place
Spofford
The Children's Place of Kansas City
Truman Medical Center

Focus Group Content

Focus group discussion included content from four areas: 1) how case management is defined at the agencies, 2) what approach or service model is employed at the agencies, 3) how the agencies follow-up with clients who do not return for services, and 4) what role transition planning has in the provision of case management.

How Agencies Define Case Management

When describing case management at their agencies, focus group participants shared: what tasks they see included in case management; how agencies foster an ongoing, trusted relationship between a client and one identified provider who works with the client over time; if their agencies have different levels of case management services and staffing; and if there are case management services which remain unbillable.

Tasks Included in Case Management

Please note that agencies were not asked what services they provide in each *stage* of multidisciplinary coordinated care or case management discussed earlier. Rather, they were asked to share what activities are undertaken as case management at their agencies. One agency administrator from a domestic violence shelter noted, "I hate the term *case management*. I feel it doesn't do survivors service". The administrator prefers the terms *service coordination* or *person-centered care*.

Assessment Tools

The following assessment tools were identified by agency administrators as validated tools employed, with the exception of biopsychosocial assessment identified by agency staff.

Assessment Tools
Behavior and Symptoms Identification Scale (Basis 24)
Biopsychosocial Assessment
Daily Living Activities Functional Assessment (DLA)
Devereux Student Strengths Assessment (DESSA)
Hopkins Symptoms Checklist (HSCL)
SLV MS
Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT), transitioned to Family-Service Prioritization Decision Assistance Tool (F-SPDAT)
WHO Disability Assessment Schedule (WHODAS)

Case Planning

Three administrators included discussion of case planning as part of case management. Staff members from two additional agencies also discussed case planning activities.

Link/Broker/Refer

Most participants noted that they made referrals and linkages for mental health treatment and for housing. One agency in particular noted that efforts to link clients to housing were based on the Housing First model and that the agency also concentrated on Rapid Re-Housing. (For scale, six participants referred for *Mental Health Treatment* and five referred for *Housing*.)

Advocate

Many focus group respondents noted that they advocated for clients through *Legal Support/Assistance* (for scale, 7 respondents). This included: going to court with the clients, helping with orders of protection, attending meetings with attorneys, and general legal support. One agency staff member noted specifically working to obtain birth certificates for clients who are foreign born (refugees). Three agencies noted they provide translation services.

Responsive Documentation

While six agencies noted efforts toward obtaining benefits, three of the responses can be understood as being responsive documentation: 1) *obtaining all entitlements*, 2) *conducting required court record searches*, and 3) *activating Medicaid*. The three remaining agencies noted: *help with benefits, state benefits,* and *Social Security*.

Psycho-educate

Six respondents mentioned psycho-education when discussing their case management. Most noted teaching independent living skills such as shopping, cleaning, and health literacy. One participant reported working with students on behavior management skills.

Instrumental Assistance

Six agencies discussed instrumental assistance (utilities and/or food/food stamps). One administrator noted that "the bottom part of Maslow's Hierarchy" needs to be met prior to therapy.

Activities Which Are Not Case Management

Several activities were mentioned as examples of case management which are direct services rather than case management. These activities are: psycho-educational groups (Recovery and Life Skills groups at Sheffield Place, Social Skills classes at Pathways); peer mentoring (through the UMKC Empowerment Project), and a school behavior management program (Spofford's Reach to Teach).

Fostering Ongoing, Trusted Relationship Between Client and One Provider

In addition to identifying tasks that agencies understand as central to case management, all but two commenting agencies foster an ongoing, trusted relationship between a client and one identified provider who works with the client over time. While the Empowerment Project works with clients on an as-needed basis and the Salvation Army Children's Center has services limited to 30 days, the remaining commenting agencies noted a variety of ways to foster the ongoing supportive professional relationship. Responses follow.

Fostering Ongoing, Trusted Client-Provider Professional Relationship	
Agency	**Example**
Crittenton	Front-line staff develops relationship.
Jewish Vocational Services	Program is "very relationship-driven".
Mattie Rhodes	All domestic violence clients go to one specific case manager.
Newhouse	The therapeutic case manager is the point person and follows clients through time-has a smaller case load and can spend more time with the clients.
Pathways	Can form long-term relationships with clients. Some clients are contacted once a day to discuss their plans for the day.
ReDiscover	Transitions are set up to maintain the same case manager. With some transitions there is turn-over on the team (ex: rehab to maintenance), but the whole team does not turn over.
Sheffield Place	Clients maintain meetings once a week with both the therapist and the case manager.
Spofford Family Residential	The therapist does all of the relationship work (4-6 month timeframe).
Spofford Reach to Teach	There is one staff person in the school so the opportunity is there for long-term relationships.

Varying Levels of Case Management Services and Staffing

Several agencies have varying levels of case management, but not all of the levels are funded through the Jackson County Mental Health Tax Levy Case Management funding.

Varying Levels of Case Management	
Agency	**Levels of Case Management**
Comprehensive Mental Health Services (different specialties, not really levels)	• Rehab • Maintenance
Hope House	• Shelter • Outreach
ReDiscover	• Intensive • Rehab • Outreach
Sheffield Place	• Residential • Aftercare
Spofford	• "Plain case management"-family resilience program • Residential Family Focus-crisis case management • Reach-to-Teach: behavior plan & school-based crisis work

Many participating programs provide team or interdisciplinary services. Their responses follow. (The remaining agencies did not reply.)

Funded Agencies with Team or Interdisciplinary Services	
Agency	**Reported Team Members**
Comprehensive Mental Health Services	Case manager, client advocate, therapist, psychiatrist.
Hope House	Shelter director, advocates, therapists, outreach case manager, court advocates.
Jewish Vocational Services	Case manager, therapist, administrator.
Mattie Rhodes	Client, case manager, therapist, family services.
Newhouse	Case manager, therapist, substance abuse counselor.
Pathways	Case manager, therapist, consulting psychiatrist.
ReDiscover	Case manager, nurse, therapist, psychiatrist, supportive employment.
Rose Brooks	Case manager and therapist.
Sheffield	Case manager and therapist.
Spofford-Family Focus	Case manager and therapist.
Spofford-Reach-to-Teach	Case manager and school student support team
The Children's Place	Very inter-disciplinary
Truman Behavioral Health	Very inter-disciplinary

Unbillable Case Management Services

Staff identified the following case management-type services they understand as not billable:

- Parenting specialist accompanying family to court and Children's Division meetings;
- Intensive engagement-searching for, people who are not yet engaged in services (DMH has a billing code but the agency is overextended);
- ADHD (many hesitate to label students with a mood disorder so there often isn't a diagnosis at all);
- Pre-intake assessments;
- Collateral contacts like landlords-lots more goes on than what is billed for;
- Time to email;
- Research for a case (looking for resources);
- Screening adults for services/risk assessment;
- Initial session with parent prior to beginning therapy with child;
- Community advocacy meetings not linked to a specific client;
- Community collaboration (coordinating client entry into system for housing);
- Crisis department;
- Follow-up home visit if a client is seen in the ER but doesn't return for appointment;
- Staffing;
- Daily phone call to support clients living independently;
- Unplanned visits to housing (lockouts, fire alarms);
- Triage student behavior at school for students not on case load;
- Phone calls to attorneys; and
- Time in car even if talking to client about case.

Overall this list reflects confusion regarding the nature of case management as related to programs, documentation, and billing sources. Levy staff confirmed that a number of these items can be billed when correctly proposed, documented, and supervised.

Approach or Service Model Used at Agency

In the table below, fifty-four responses detailed case management approaches/models employed by the seventeen participating agencies. Thirty-one of the responses speak to case management approaches/ models. However, many reported are not evidence-based. Additionally, respondents from specific agencies discussed many more approaches/models than can concurrently guide quality services.

Identified Case Management Approach or Model	
Number of Responses	**Approach or Model**
18	Trauma-Informed Approaches (Sanctuary Model, Risking Connection)
10	Perspectives/Approaches Framing Case Management (Client/Patient-Centered, Strengths-Based, Empowerment, Person-in-Environment)
1	Stages of Change-Case Management Model
1	Transformational Care-Case Management Model
1	Transition to Independence Process-Case Management Model
17	Therapeutic Approaches, not Case Management Approaches or Models (Narrative Therapy, DBT, EMDR, Freudian, CBT, Devereux Model, Solution-Focused, Positive Behavior Support, Harm Reduction).
5	Techniques Case Managers Could Employ, Not Approaches or Models (Mindfulness, Motivational Interviewing)
1	Cultural Competence

As a follow-up to the information received about case management approaches/models used, agency administrators (not including staff) identified continuing education for staff occurring at their agencies specific to implementing the case management approach/model with fidelity. These include:

- Half-day trainings,
- Yearly refreshers in Trauma-aware,
- The use of an in-house trainer,
- Video training,
- Monthly staff training components,
- Monthly self-supervision,
- Monthly trainings, and
- Use of a training department.

Agency administrators also identified how the delivery of services (fidelity to the model) is monitored, and what feedback loop is used to improve service delivery. Fidelity is monitored through:

- Supervision forms with questions about how the client got to goals and what perspective was used,
- A fidelity check on the "trauma piece",
- Direct observation since the agency is small,
- Small staff can see what is happening in the moment,
- Beginning a 4-year Ph.D.-student-led study of case management effectiveness,
- A detailed approach to supervisor training in trauma-informed care,
- Peer chart reviews, and
- Sanctuary fidelity tools.

Feedback to staff on model/approach implementation is through:

- Informal conversation,
- Daily informal meetings,
- Weekly formal meetings,
- Red flag meetings, and
- On-going coaching by supervisor in trauma-informed care (noted by one agency).

Agency Follow-up with Clients Who Do Not Return

Agencies vary in responses to clients who do not return. Follow-up is often dependent on the level of services.

- Domestic violence shelters are limited in their ability to follow up due to safety reasons. Follow-up contact must be initiated by the client.
- Agencies which provide short-term, or one-time service linkage don't have the expectation that clients will stay in contact.
- For some programs clients must be in services to maintain housing.
- Participating agencies: call, send letters, visit client homes, use contacts in the community, reach parents when dropping off or picking students up from school, and knock on doors in order to follow up.
- Programs serving youth seek out other youth since they tend to stay in contact with each other.

Transition Planning in Case Management

Although transitions are individualized and differ by level of service, the majority of focus group participants report that transition is always part of the case plan. Participants noted that:

- Transition planning questions are built in to case management, such as, “What can help you move on?” and “What will it take to not need us”?
- The hand-off or transition is gradual and begins as goals are accomplished.
- The transition can require increased development of informal resources/natural supports.
- Steps toward transition include decreased need for the case manager.
- To prepare for transition, case managers work to connect clients with community health and mental health supports.
- The use of aftercare or outreach for clients who are vulnerable is part of a plan for transition.
- A warm hand-off is part of most transitions.
- Transitions look different if the client is in a domestic violence shelter and returns home. In these instances, the transition details are in the safety plan. It is extremely important that work on the safety plan begins as soon as possible.
- Some agencies noted that their clients don’t plan to use a series of meetings to meet needs. Their clients come and go as they encounter language and cultural barriers.
- With youth, the transition/transfer discussion also begins at intake and is ongoing. For some youth, there is no opportunity to prepare for transition. Some transition planning material can be in a packet of information to hand off when the youth transitions.
- Some transitions are based on outside factors such as court-mandated treatment.

Discussion

Jackson County Community Mental Health Fund data analysis indicates a lack-of-fit between case management funding amounts and the *level* of case management activity, the *number* of case management activities, or the *relationship* between the participant and the case manager. In light of this, the current project was completed to provide recommendations to identify ways in which the costs can become more rational for the funded case management activities.

Focus group results indicate that there is wide variation in the participants’ understanding of case management. This includes lack of understanding of the case management model being used at an agency and identifying therapeutic interventions as case management models. Some respondents had a clear understanding of case management (one administrator simply stated in the middle of a discussion that what was being said was *not* case management, but the course of the conversation did not change).

Additionally, information from agency administrators did not evidence consistent agency emphasis on on-going coaching and individual feedback to staff regarding model implementation. There was little evidence of feedback loops within agencies to improve model implementation.

In order to increase the fit between the *amount* of Jackson County Community Mental Health Fund fiscal support for case management services and the *activities* which are funded, it is recommended that the Fund incentivize clear case management expectations.

Tiered Case Management Service Structure

Jackson County Community Mental Health Fund-defined differential service tiers can be adopted with the anticipation that case management services at agencies applying for funding will have an increased fit with Fund expectations. The following, tiered, case management structure is proposed.

<table>
<tr><th colspan="2">Proposed Case Management Tiers</th></tr>
<tr><td>Tier I
Case Support</td><td>• Episodic activity
• Referral or transaction by person other than high relationship provider may include crisis, screening, referral, etc.
• Referral for benefits application without direct follow-up, includes calendar-driven update</td></tr>
<tr><td>Tier II
Case Management</td><td>• Full case management program includes planning, assessment, and evaluation (see graphic, p. 5)
• Case management model or approach is evidence-based
• Informal fidelity review; Data are collected, reported
• Client benefits enrolled/appealed; active tracking
• Youth have active transition plan; goal review; specific measures, etc.</td></tr>
<tr><td rowspan="2">Tier III
Multidisciplinary
Coordinated Care</td><td>Meets Criteria for Case Management, PLUS must have:
• Documentation that model or approach is EBP; formal fidelity review
• Participant has SMI and/or complex co-morbidities, unstable
• Data collected and utilized to adjust programs/techniques
• Engagement protocol at levels of policy and practice
• Consistent participant-provider relationship. Low turnover for case management positions (turnover formula)</td></tr>
<tr><td>PLUS, must have at least 3 of the following:
• Measures and program adjustments address the espoused outcome(s)
• Provider works with 2+ other disciplines
• Provider has top credential
• Provider meets bilingual certification
• Consistent relationship stable staff (defined by annual percentage for these positions)
• Agency tracks engagement (counts one and done); analysis and utilization of tracking data</td></tr>
</table>

To increase successful transition to the service tier model, the Jackson County Community Mental Health Fund may include the following processes when adopting a tiered structure:

- Obtain feedback from local agency leaders regarding the content of the tiers and perceived fit between individual agencies and the case management tiers;
- “Field test” the tiers by retrospectively using them to examine services, funding, and impact on agencies in previous years; and
- Include agency pre-application meetings prior to, and during, tier roll-out in which details of programming and documentation expectations can be explained.

The Jackson County Community Mental Health Fund is committed to funding, and contributing to, quality mental health service provision. By examining the relationship between quality case management characteristics and previous Levy funding patterns, the Fund continues its thoughtful contribution to practice. There are numerous approaches to elucidating quality case management. The Levy’s focus on identifying a rational relationship between case management activities and funding patterns has valuable applications in the field and warrants continued attention.

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