CHAPTER 37E

OUTPATIENT SERVICE STANDARDS

Authority

N.J.S.A. 30:9A–10

Source and Effective Date

R.1995 d.481, effective September 18, 1995.
See: 26 N.J.R. 3608(a), 27 N.J.R. 3603(a).

Executive Order No. 66(1978) Expiration Date

Chapter 37E, Outpatient Service Standards, expires on September 18, 2000.

SUBCHAPTER 1. GENERAL PROVISIONS

SUBCHAPTER 2. PROGRAM OPERATION

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10:37E–1.1 Scope and purpose

(a) The rules in this chapter shall apply to all Division funded outpatient services (OP).

(b) The purpose of OP services is to support, enhance and encourage the emotional development and the development of clients life skills in order to maximize their individual functioning. These services are designed to preserve or improve current functioning, strengths and resources. In OP services clients and staff work together to plan and implement effective treatment.

10:37E–1.2 Definitions

The words and terms in this chapter shall have the following meanings unless the context clearly indicates otherwise.

"Affiliated psychiatric emergency service" means a psychiatric emergency service which has a written, Division approved affiliation agreement with a designated screening center to provide screening services within the area served by the designated screening center.

"Division" means the Division of Mental Health and Hospitals in the Department of Human Services.

"Medication monitoring" means medication services provided under supervision of a licensed physician, or by a certified nurse practitioner/ clinical nurse specialist and his or her collaborating physician, to evaluate, prescribe or administer, and monitor the client's use of psychotropic medications including anti-parkinsonian medications.

"Outpatient services" means mental health services provided in a community setting to clients who possess a psychiatric diagnosis, including clients who are seriously and persistently mentally ill but excluding substance abuse and developmental disability unless accompanied by treatable symptoms of mental illness. Periodic therapy, counseling, and supportive services are generally provided onsite at the provider agency for relatively brief sessions (between 30 minutes and two hours). Services may be provided individually, in group, or in family sessions.

"Provider agency (PA)" means a public or private organization which has a contract with the Division to provide OP services.

"Psychoeducation services" means a mutual exchange of information and education between the professional and client or the professional and family members in order to increase the likelihood of family and community support to the client and to reduce the probability of client decompensation. Information may address etiology and symptoms characteristic of the client's mental illness, effects of medication, coping skills, daily living skills community resources and supports, and similar mental health service-related matters.

SUBCHAPTER 2. PROGRAM OPERATION

10:37E–2.1 Written policies and procedures

(a) PA shall develop and implement written policies and procedures to ensure that the provider complies with the rules in this chapter.

1. The PA shall have a written policy and procedure manual which is reviewed at least annually as evidenced by a written review date.

2. The PA shall have written policies and procedures that reflect the operational standards and practices of the PA.

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10:37E–2.2 Population/admission priorities

(a) The PA shall have written policies and procedures describing its admission criteria and practices. First priority for admissions into OP services shall be given to persons with severe and persistent mental illness in accordance with target populations, as defined in N.J.A.C. 10:37–5.2.

1. The PA shall have written and implemented policies and procedures regarding admission criteria requiring that clients referred directly from emergency services by a screening or affiliated psychiatric emergency service for medication follow-up be seen within seven calendar days of referral and that clients referred from inpatient settings for medication monitoring services be seen within fourteen calendar days of referral.

2. The PA shall have written and implemented policies which establish time frames and procedures for completion of the admission process for clients needing services other than medication monitoring.

3. The PA shall have written policies and procedures which specify the information to be obtained and the records to be maintained on all applicants or referrals for admission, the procedure for accepting referrals from outside organizations, self referrals and other sources, the statistical data to be recorded at the intake process, and the procedures to be followed, including alternative services, when an applicant is found ineligible for admission.

4. The PA shall have written and implemented policies and procedures that require every client receive an initial face-to-face assessment by professional staff or by a student in a recognized training program who is supervised by a member of the professional staff assuming responsibility for the work.

5. The PA shall have written and implemented policies and procedures requiring that applicants for service fully understand the program characteristics and their rights and responsibilities, including the nature and goals of the treatment program, the hours during which services are available, the treatment costs to be borne by the client, if any, and any other information deemed pertinent by the PA. Documentation of this communication shall be maintained in the clinical record.

10:37E–2.3 Services to be provided

(a) The OP program shall provide a range of services which address the individual needs of clients and shall include, at a minimum, the following:

1. Assessment and evaluation;

2. Referral, linkage and follow-up services;

3. Individual, group, and family therapy;

4. Psychiatric evaluation, medication services and medication monitoring; and

5. Psychoeducational services.

(b) Progress notes shall be completed after each OP session and shall be entered chronologically in the client record to document service provision.

(c) Progress notes shall generally relate the treatment provided to the goals and objectives contained in the written service plan and, at a minimum, shall address the following:

1. All face-to-face and other pertinent contacts;

2. Amount of time it took to deliver the service;

3. Clinical course of treatment including rationale for service provided;

4. Significant changes in the client's condition or situation, if any; and

5. Current status and response to treatment.

(d) The PA shall develop and implement policies and procedures to ensure effective provision of medication monitoring services.

1. Methods for service coordination and communication between PAs and other service providers serving mutual clients receiving medication shall be developed and implemented consistent with confidentiality rules in N.J.A.C. 10:37–6.59 to ensure that all providers of service are aware of the medication prescribed, potential side effects, and other medication monitoring concerns.

2. The PA shall ensure that clients receive information and instructions about the medication prescribed including, at a minimum, dosage, administration, contraindications, potential adverse reactions, and any relevant health education.

10:37E–2.4 Service planning

(a) Each client shall be provided OP services according to a written service plan contained in the clinical record.

1. Service plans shall be based upon the findings and treatment recommendations of a comprehensive mental health assessment. The comprehensive mental health assessment shall identify the client's needs and strengths and shall address, at a minimum, the following information about the client:

i. Current emotional and behavioral functioning;

ii. Previous emotional, behavioral, and substance abuse problems and treatment;

iii. Medication history, including medication dosage, frequency and side effects;

iv. Previous and current physical health problems, and observation of physical appearance as it may relate to the client's mental condition;

v. Abuse, neglect, and domestic violence history;

vi. Family situation, including the constellation of the family group; the current living situation; and social, ethnic, cultural, emotional, and health factors;

vii. Educational and work history;

viii. Identification of the community resources currently utilized by the client;

ix. Evaluation of the developmental age factors of the client in programs serving minors;

x. Psychological assessments, when clinically indicated; and

xi. Evaluations of any language, self-care, and other areas of functioning which relate to the client's mental condition.

2. The professional staff shall fully consider the client's preferences when formulating the service plan and shall ensure that the client participates in the development of his or her treatment plan. Level of participation shall be documented in the client record. Exceptions shall be documented, with specific reasons, as to the client's non-participation. If a client does not participate, the specific reasons for the non-participation shall be documented.

3. Service plans shall be developed by appropriately licensed or credentialed professionals. For clients who are receiving medications, a physician shall participate in the development of the service plan, meet with the client regularly and review and approve the client's service plan.

4. The service plan shall contain goals, timeframes, measurable objectives that relate to the goals and specific criteria for termination or reduction of services. Service plans for clients receiving solely medication monitoring services need only address the reason for medication monitoring. For all clients receiving medication, the service plan shall identify the medication, dosage, and frequency of administration and indicate frequency of clinic appointments.

5. The service plan shall specify the following:

i. Anticipated staff interventions necessary to meet the client's needs;

ii. Frequency of service provided; and

iii. Any referrals for needed services that are not provided directly by the agency.

6. The service plan shall document any involvement of the family and significant others, and be in accordance with the legal requirements for client consent to family involvement.

7. The service plan shall be completed by the fifth session or within 60 days of the first face-to-face visit, whichever occurs first, except when documented that clinical circumstances dictate that a different time frame is in the client's best interests.

8. The service plan shall be reviewed at significant decision points in each client's course of treatment and the review shall be documented in either the progress notes or treatment plan revision. Significant decision points shall include, but need not be limited to, the transfer or discharge of a client, changes in medication, and any significant change in the client's condition or situation, including, at a minimum, adverse reactions to medications.

9. The clinician and client shall review the service plan together at least every three months for the first year of treatment and at least every six months thereafter. The clinician's supervisor shall review the plan after each review by the client and clinician. For those clients who require only medication monitoring services, the service plan shall be updated by the physician and client, if appropriate, every six months.

10:37E–2.5 Termination of services

(a) The OP program shall establish and implement policies and procedures to address the termination of services to clients.

1. When it is determined that termination of services to a client is clinically appropriate, professional staff shall assess further client needs and make appropriate referrals and linkages.

2. Individuals shall not be terminated due to non-attendance without prior specific efforts to engage the client which shall be documented in the client's clinical record.

3. A termination summary shall be documented in the client record within 30 days following termination. This shall include, at a minimum, the following:

i. Primary presenting problem;

ii. Significant findings;

iii. Treatment provided and response to treatment;

iv. Clinical condition at termination;

v. The recommendations and arrangements for further treatment, including prescribed medications, dosage and possible side effects and any referrals made; and

vi. The individual's final multi-axial diagnoses, as derived from the most recent edition of the Diagnostic and Statistical Manual, published by the American Psychological Association, 750 First St. NE, Washington, DC, 20002–4242, tel. 202–336–5500.

10:37E–2.6 Staffing requirements

(a) The PA shall employ staff who are licensed, when required, appropriately credentialed and sufficiently trained to provide OP services.

1. No counseling or therapy services requiring professional training, licensure or certification shall be provided by any staff member not appropriately trained, licensed or certified to provide such services. Unless licensure or certification provisions permit otherwise, counseling or therapy services shall be provided by individuals with at least a masters degree in a recognized mental health discipline.

(b) The OP Program Director shall manage OP operations and provide OP staff clinical supervision. This individual shall possess, at a minimum, an earned masters degree in a human services field, and five years experience in mental health services with two years supervisory experience.

10:37E–2.7 Utilization review

(a) In addition to meeting the quality assurance requirements as promulgated in N.J.A.C. 10:37–9, the PA shall also monitor and evaluate utilization of OP resources.

(b) At a minimum, the following data shall be routinely collected and analyzed:

1. Wait for service data:

i. The length of time from referral to intake interview from a designated screening center or a psychiatric emergency service with a written affiliation agreement with a designated screening center for medication monitoring; referrals from inpatient settings for medication monitoring; and referrals from other sources;

ii. The length of time from intake interview to initiation of ongoing therapy, categorized by referrals for medication monitoring and referrals from inpatient settings for medication monitoring; and referrals from all other sources;

iii. Monthly number of clients on the waiting list.

2. Caseload size per therapist; and

3. Percentage of direct service time and indirect service time spent by each therapist each month.