CHAPTER 37C

CLINICAL CASE MANAGEMENT

Authority

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CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. PURPOSE, SCOPE AND DEFINITIONS

10:37C-1.1 Scope and purpose
10:37C-1.2 Definitions

SUBCHAPTER 2. PROGRAM OPERATION

10:37C-2.1 Written policies and procedures
10:37C-2.2 Population priorities
10:37C-2.3 Service requirements
10:37C-2.4 Staff requirements, qualifications and duties
10:37C-2.5 Service coordination
10:37C-2.6 Records

SUBCHAPTER 1. PURPOSE, SCOPE AND DEFINITIONS

10:37C-1.1 Scope and purpose

(a) The rules in this chapter shall apply to all Division–Funded clinical case management (CCM) services.

(b) The purpose of CCM services is to assist clients 18 years of age or older in gaining access to needed medical, social, educational, and other services. Within the continuum of community mental health case management, CCM services have the capability to offer the most comprehensive range of services to enrolled clients and provide varying degrees of service intensity based on the clients' changing needs. These rules provide a description of the clients for whom the services are targeted, services to be provided, the requirements and responsibilities of the PAs and their staff, and the procedures required to provide the services.

10:37C-1.2 Definitions

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

"Advocacy" means the ongoing process of assisting the client in receiving all benefits to which he or she is entitled by working toward the removal of barriers to receiving needed services.

"Assessment" means the ongoing process of identifying and reviewing a client's strengths, deficits, and needs based upon input from the client, significant others, family members and health professionals. The assessment process continues throughout the entire length of service and the assessments are updated periodically based upon the availability of client information.

"Clinical case management" (CCM) means the provision of individualized clinical support services for a client who needs consistent contact to help that client maintain stability and to assist the client in accessing or receiving needed services. Provided primarily offsite, CCM services include, but are not limited to, assessment, service planning, service coordination, service linkage, ongoing monitoring, ongoing support services and advocacy.

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

"Ongoing monitoring" means the ongoing review of the client's status and needs and the routine follow-up with the client's service providers to assess if services are provided as planned and if they meet the client's needs.

"Ongoing support services" means the provision of face-to-face individualized clinical support services for a client who needs such contact.

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

"Risk assessment" means an assessment that concludes with the assignment of a risk category.

"Risk category" means the three levels of CCM involvement, based upon assessed risk of hospitalization, functional level and willingness or ability to access needed services. The three risk categories are: high-risk, or intensive case management; at-risk, or supportive case management; and low-risk, or maintenance level case management.

"Service coordination" means communication among multiple service providers regarding services offered to clients, and the use of communicated information in CCM service planning.

"Service linkage" means the referral to and enrollment with other appropriate service providers to address the needs identified in the assessment.

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"Service planning" means the process of organizing the outcomes of the assessment in collaboration with the client, significant others, potential service providers, including providers of medication monitoring, and others as designated, to formulate a written service plan that addresses the client's needs, planned services to address these needs, and plans to motivate the client to utilize services. The service planning process shall continue throughout the client's receipt of CCM services.

"Wait for service" means the wait experienced by clients who have been screened by the CCM program and meet admission criteria but are not immediately admitted.

SUBCHAPTER 2. PROGRAM OPERATION

10:37C–2.1 Written policies and procedures

(a) The PA shall develop and implement written policies and procedures to ensure that the services provided comply with the rules in this chapter.

1. The PA shall have written and implemented policies and procedures which support the concept of offsite, community-based service provision and intensive outreach to clients in their own environment.

2. The PA shall have written and implemented policies and procedures requiring the assessment of risk and methods of identifying risk. Such assessment shall be used to prioritize and plan CCM services. Such policies and procedures shall have been approved by the Division.

3. The PA shall have written and implemented policies and procedures regarding the use of mental health and other community services by clients appropriate for such services. Particular emphasis shall be placed, in this regard, on liaison services, screening center services and short term care facility services.

4. The PA shall have written policies and procedures to monitor the CCM services provided and describe how these are integrated with the overall agency QA plan.

5. The PA shall have written policies and procedures to assure that there is client input into all aspects of the program and that there is individualized client goal setting. Policies should emphasize accommodating client preferences, whenever possible and shall acknowledge the client's right to refuse repeated offers of initial service.

6. The PA shall have written policies and procedures to monitor each client's wait for service and the prioritization of clients for service.

10:37C–2.2 Population priorities

(a) The PA shall give priority to providing services to clients most in need of the services because they suffer from a serious mental illness, pose a risk to their own welfare in the absence of such services and exhibit two of the following criteria:

1. The client has repeated admissions to inpatient services. Priority will be given to persons with two or more admissions to inpatient psychiatric services within a 12 month period, or two or more uses of emergency/screening services within a 30 day period;

2. The client participates in mental health services, but is not receiving additional services which meet the individual's multiple needs, and requires extensive service coordination (for example, individuals who are dually diagnosed as mentally ill and chemical abusing or children involved with DYFS and school systems);

3. The client has a recent history of being a danger to self or others within a time period of three months;

4. The client has a history of resistance or non-compliance in use of medication, resulting in a pattern of decompensation and hospitalization;

5. The client is in another service system and in need of assessment and possible treatment prior to linkage to case management (for example, residential, drug and alcohol programs, or shelters for homeless); or

6. The client resides with family, in a boarding home, or other residential setting and is not receiving needed mental health services.

(b) The PA's discharge criteria shall include at least one of the following:

1. The client has been successfully engaged in needed mental health and non-mental health services; or

2. The client is low risk and has remained at the same low risk status for six months and has had no record of crisis services use, hospitalization or involvement with the criminal justice system for the previous six months; on an exceptional basis, where there is clinical justification for continued services to a client who meets this termination criteria, the PA shall clearly document the reasons in the client record; or

3. Agreement between the client and the PA that CCM services are no longer of benefit to the client; or

4. The client refuses repeated offers of service; or

5. The client leaves the county or service area and the PA makes attempts to engage the client with the receiving county or appropriate PA; or

6. The client cannot be located after repeated efforts by the PA to do so.

10:37C–2.3 Service requirements

(a) The PA shall provide services that assist clients to reach and maintain their individual optimal level of functioning in the community.

1. The PA shall provide the following concrete services to enrolled clients: assessment, support, service planning, service monitoring, risk assessment, support to family or significant others, coordination and integration of services in the client's support system, client and system advocacy, service linkage and education.

2. The intake and initial assessment process shall identify the factors that result in the client's admission to or the rationale for nonadmission to the CCM services.

3. Face-to-face clinical support contacts shall be provided primarily offsite, at the client's location, including, but not limited to, hospitals, homes, boarding homes, shelters, jails, neighborhood restaurants and streets, based on functional level and risk of hospitalization of the client. Such support shall be available on a crisis basis as needed.

4. A preliminary service plan shall be entered in each client's record within 10 working days of their admission to CCM services which provides a basis for clinical intervention. The initial risk assessment shall be completed within 30 days of a client's admission to CCM services.

5. The service plan addressing the client's functional level, resources, skills and supports shall be completed and implemented within three months of the first community contact. Based on a comprehensive assessment, the service plan shall document specific strategies to engage the client and proposed clinical interventions.

6. The comprehensive assessment, which shall address the following aspects of the client's life: physical health, finances, family, legal, functional skills, mental health and non-mental health needs, client's choices and goals, reason for referral, client's natural support system, overall resources and previous history, and when available, information from current and prior service providers. The assessment process shall continue throughout the entire length of service. New information pertaining to the assessment shall be documented in the clinical record as it occurs.

7. Service plans shall be updated every 90 days during the first year of service and every six months thereafter.

8. The intensity of service shall be based on the client's assessed risk status and needs. The PA shall develop and implement procedures so that the assigned status reflects the client's current condition.

9. The service planning process shall address client relationships with family, significant others and pertinent service providers.

10. Record documentation shall reflect that the efforts or referrals of the PA link clients to mental health or non-mental health programs as appropriate.

11. The PA shall maintain contact and follow-up with other service providers as permitted by N.J.A.C. 10:37–6.79 and as needed to effect linkage and to make adjustments in service provision that may be indicated by such information.

12. The PA shall assist the client in receiving all concrete services and benefits to which he or she is entitled.

13. The PA shall advocate for enrolled clients within the mental health and non-mental health systems to enhance access to existing services.

10:37C–2.4 Staff requirements, qualifications and duties

(a) The PA shall employ sufficient numbers of qualified staff to provide required services.

(b) The PA shall develop a written description and rationale for the PA's caseload size. The rationale shall include consideration of geographic and service area variables, program design, nature of referrals, type of population, age, and outcome expectations.

(c) The CCM supervisor shall have a master's degree, or the equivalent, in social work, psychology, counseling or a related field; three years postgraduate work experience in a related field; and supervisory experience. A bachelor's degree in a related field plus three years experience as a clinical case manager may be substituted for the above requirements provided such an individual is actively enrolled in a master's degree granting program in social work, psychology, counseling or a related field.

(d) The CCM supervisor shall be responsible for the following:

1. Service availability through regular staff scheduling or provision of on-call or other back-up services, as appropriate;

2. Adequate levels of clinical staff supervision, skill development, and support;

3. Organization of the CCM staff to assure continuity of services, range of available staff skills, including skills with mentally ill chemical abusers, and sufficient staff backup;

4. Development and appropriate documentation of the various CCM functions;

5. Active participation in the Quality Assurance activities;

6. Identifying system resource gaps in service delivery;

7. Active participation in the area's System Review Committee;

8. Appropriate completion of and monitoring of affiliation agreements with other mental health, social and health service providers;

9. Participation of the PA in the local mental health, health, and human services planning activities, and identification of resource gaps in these areas;

10. Documentation of staff training and development activities; and

11. All other activities necessary to access or directly provide client support services.

(e) The clinical case managers shall have a master's degree in social work, psychology, counseling, or a related field with clinical training; or a bachelor's degree in a related field and two years relevant experiences, (two additional years of relevant experience may be substituted for a bachelor's degree) or an associate's degree in a direct care field (including, but not limited to, psychosocial rehabilitation or nursing of the seriously mentally ill) and two years of relevant experience.

(f) The duties of the clinical case manager shall include the following:

1. Responsibility to establish and maintain the ongoing therapeutic relationship;

2. Provision of intensive community-based services to maximize the client's access to services and ability to function adequately and integrate into the community;

3. Development and implementation of a treatment plan and completion of other documentation as required;

4. Facilitation of access to appropriate services, including transportation to services, and activities as necessary and application for and receipt of all applicable public entitlements;

5. Facilitation of the client's service linkage in the community mental health and non-mental health systems through provision of ongoing individualized clinical support and monitoring;

6. Coordination and integration of services from multiple providers until the client is discharged from the CCM services. This responsibility may include coordination of meetings of the client's service providers in the community;

7. Monitoring of service delivery to meet a client's changing needs and advocacy as necessary;

8. Identification of client resource gaps and problems of service delivery; and

9. Provision of direct service support to the client's natural support system, including family, friends, employers and self-help groups.

10:37C–2.5 Service coordination

(a) The PA shall coordinate CCM services with other community mental health and non-mental health programs.

1. The PA shall develop written affiliation agreements where necessary to facilitate access to services.

2. The PA shall provide service coordination for all clients served. Evidence of service coordination shall be reflected in the clinical record.

3. PA staff shall participate in the System Review Committee meetings and activities and so document.

4. The PA shall define and refer problems which are systemic and cannot be resolved at the agency level to the System Review Committee by an identified process.

10:37C–2.6 Records

(a) The PA shall maintain individual records in an up-to-date organized manner. The records shall contain all relevant client information and shall be maintained to preserve confidentiality. The records shall contain the following:

1. An intake summary;

2. An assessment;

3. A service plan; and

4. Progress notes.

(b) Services shall be related to documented client needs and stated through clear goals, objectives and interventions.

(c) The service plan shall:

1. Relate to the comprehensive assessments;

2. Contain goals and timeframed and measurable objectives, which shall be stated in behavioral and measurable terms;

3. Delineate specific interventions to implement objectives and reach goals;

4. Be based on the client's expressed goals;

5. Identify and address all resource needs of the client as contained in the assessments;

6. Be completed and implemented within three months of the first community contact;

7. Reflect changes in service provision and be updated every three months for the first year and every six months thereafter;

8. Identify the staff person or other party responsible for implementation of interventions; and

9. Be properly authenticated with a signature, date, and title of the clinical case manager, and approved and signed by the CCM supervisor.

(d) Attempts shall be made to have the client sign the service plan to indicate client's involvement in the development or revision of the service plan. If the client is unwilling to participate or if such participation is clinically contra-indicated, it shall be so documented.

(e) When the client consents, the service plan shall include family involvement, or if clinically contra-indicated, family non-involvement.

(f) Progress notes shall reflect the client's course of treatment, as follows:

1. A summary of services shall be documented for each face-to-face contact;

2. Progress notes shall make reference to the service plan and reflect client's status, interventions provided, client's response to interventions, and change in service provision;

3. Progress notes shall reflect any significant event that impacts on the client's status or service provision;

4. Progress notes shall reflect collateral contacts and communication with persons other than the client on behalf of the client which impact on the client's status or service provision; and

5. Progress notes shall be properly authenticated with a signature, date and title at the end of each entry.

(g) A discharge summary shall be completed for all clients, as follows:

1. The discharge summary shall be completed within 15 working days of discharge.

2. The discharge summary shall include the following:

i. Presenting problem at admission;

ii. Client's status and diagnosis at discharge;

iii. Client's clinical course of treatment;

iv. Client's response to treatment, including where possible client's self assessment of progress and further program needs;

v. Medication prescribed at discharge, including dosage, frequency, prescribing physician and adverse reactions, if known; and

vi. Recommendations, plans or linkages for further services.