

2.50 CASE MANAGEMENT

2.501 Case Management (Adult)

Description of Services: Case management entails the accessing, linking, coordinating, and monitoring of services from myriad systems (e.g., mental health, physical health, social, educational, entitlements, vocational rehabilitation) to enable individuals to live, work, and participate fully in their community. Instrumental to this coordination is the development of a culturally specific individualized care plan which reflects the consumer’s strengths and self-identified goals; obtaining individualized services; facilitating linkages to community-based resources (See Community Support Services); advocating for the consumer’s needs, desires, and rights; and reviewing the progress made (including positive and adverse outcomes).

As an integral part of case management services, discharge / transition services are arranged or coordinated by Care/Case Managers as an individual is preparing for discharge and transition from one level of care to another. These services are designed to support the attainment of consumer-defined goals (e.g., stable living arrangement, quality relationships, employment, vocational training or school attendance). Care/Case Managers may assist with the following:

- During the discharge process, work with discharge planners to ensure that the necessary paperwork is completed, follow-up appointments are made, and the necessary supports are in place;
- Work with individuals to identify sources of prior and current support (e.g., family, friends, colleagues, previous/past providers);
- Consult with providers concerning treatment modalities that assist individuals with reestablishing prior, maintaining current or establishing new community supports and covered services being provided;
- Identify sources of community support for families (e.g., local Alliance for the Mentally Ill, Federation of Families for Children’s Mental Health) and facilitate their involvement with these agencies;
- Identify resources to meet other needs, such as transportation, day care, food, clothing, housing, employment benefits, access to medical care; and
- Provide services on a frequent and regular basis in order to assist individuals in a variety of ways to gain access to needed resources such as vocational, medical, social, educational and other services through natural supports, generic community resources and specialized mental health treatment, rehabilitation and support services.

Criteria

Admission Criteria	<p><i>All of the following criteria are necessary for admission to this level of care:</i></p> <ol style="list-style-type: none"> 1. Individual has a DSM-IV TR Axis I diagnosis or a treatable behavioral condition related to an Axis II diagnosis; 2. Individual requires assistance in obtaining and coordinating treatment, rehabilitation and social services without which individual would likely require a more intensive level of care 3. Individual has a history of multiple treatment episodes, need for mental health treatment and impaired functioning level 4. Individual does not require a more intensive level of care.
Psychosocial, Occupational, and Cultural and Linguistic Factors	<p><i>These factors, as detailed in the Introduction, may change the risk assessment and should be considered when making level of care decisions.</i></p>

Exclusion Criteria	<p><i>The following criterion is sufficient for exclusion from this level of care:</i></p> <ol style="list-style-type: none">1. Individual chooses not to participate in program or requires a higher level of case management such as provided through the Assertive Community Team.
Continued Stay Criteria	<p><i>All of the following criteria must be met for continued treatment at this level of care:</i></p> <ol style="list-style-type: none">1. Individual continues to meet admission criteria at this level of care.2. Individual demonstrates continued inability to obtain or coordinate services without program support.
Discharge Criteria	<p><i>The following criterion is sufficient for discharge from this level of care:</i></p> <ol style="list-style-type: none">1. Individual no longer exhibits need for program as reflected by the demonstrated ability to access needed services/supports and maintain functions of daily living.2. Goals of Case Management have been substantially met.3. Individual is no longer eligible for services4. Individual requests discontinuation of the services in consultation with and concurrence from the primary provider.