SUBJECT: INTENSIVE CASE MANAGEMENT

APPLICABILITY: Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) staff and contracted Local Mental Health Authority (LMHA) TCOOMMI program staff.

PURPOSE: To provide guidelines and a process to TCOOMMI contract programs for the delivery of Intensive Case Management services.

AUTHORITY: Texas Health and Safety Code Chapters 614.013, 614.016, 614.017, 614.018

DISCUSSION: TCOOMMI Intensive Case Management (ICM) provides a higher level of mental health services to clients with a severe and persistent mental illness. The higher level of services are intended to stabilize the client's mental health symptoms, reduce the risk of recidivism, increase client awareness of and participation with community and natural supports, develop client skills in self-advocacy, extend client tenure in the community, and assist clients in gaining the ability to participate in independent mental health care.

PROCEDURES:

I. Screening and Referral

A. TCOOMMI referral records are maintained in the TCOOMMI WebApp and should be monitored daily for new referrals. Contracted service providers are required to request and maintain access to the WebApp, as appropriate. Access requests or issues with the WebApp should be emailed to TDCJ TCOOMMI Programs at programstcoommi@tdcj.texas.gov.

B. Contracted service providers may also receive referrals directly from local probation and parole partners as well as client walk-ins (also known as a local referral). Upon receipt of a local referral, the LMHA program staff are to:

1. Check the WebApp to determine if a referral has not already been issued. If not, create a client record and open a referral in the TCOOMMI WebApp within one (1) working day of receipt of the referral.

2. Probation referrals may be made from any existing Probation caseload. Once a client is determined to be an appropriate referral, and if available through the Probation Department, the supervising officer will ensure that the client is placed on the specialized Mental Health Initiative (MHI) caseload prior to admission to the TCOOMMI program.
3. Parole referrals may come from any caseload, however, it is desirable they be on a Mentally Ill (MI) or Special Needs Offender Program (SNOP) caseload.

C. In areas where Probation and/or Parole ICM caseload(s) are funded, the TCOOMMI Program Director and/or designee is to meet with a representative of the Probation and/or Parole departments in their catchment area, at a minimum of once per month, to review possible referrals to TCOOMMI Program services.

II. Intake

A. Clients eligible for ICM services must have a diagnosis of a severe and persistent mental illness.

B. A review of the client's Texas Risk Assessment System (TRAS) risk score or, if unavailable, the Board of Pardons and Paroles Parole Guidelines or Static 99 risk score shall be used in establishing the appropriate level of care. A score of Moderate, Moderate-High, or High is required for admission to ICM services with documentation of this review maintained in the client's clinical record.

C. In regards to clinical need, a score a 2 or higher on a minimum of 15 individual criteria comprising the standard dimensions of the Adult Needs and Strengths Assessment (ANSA) is required and should be documented in the client clinical record.

D. If a client is already receiving Continuity of Care (COC) services through the TCOOMMI program, the client should also be screened for ICM eligibility. If criteria is met, the client should be immediately transferred to the next available caseload opening.

E. If a client does not meet criteria based on risk score but clinical need indicates that a greater level of treatment services is indicated, a written request indicating the reason(s) that ICM is appropriate must be submitted to the program's designated Compliance Monitor for placement consideration and approval. The case will be reviewed and a decision will be provided in writing to the requestor within one (1) business day. Note: It is recommended that discussion with the Interdisciplinary team (IDT) occur prior to submission.

F. A client with Veterans benefits cannot be excluded from TCOOMMI services based solely on that benefit status. While use of doctor services including a private Psychiatrist, through the Veterans Administration is acceptable, case management is the purview of the TCOOMMI ICM program.

G. Clients admitted into ICM Services shall have a referral entered in the WebApp within one (1) working day of admission, and any previous services are to be closed.
III. Benefit Coordination

A. Within seven (7) working days of the client’s admission into ICM, the designated LMHA program staff shall screen all admissions for benefit eligibility and/or reinstatement status. Additionally, during the screening process, both the WebApp is to be reviewed to determine if an application was submitted by TDCJ staff prior to release or if screening was completed in a prior level of service such as COC. If appropriate, staff are to complete benefits applications (i.e., Social Security and/or Medicaid). The TDCJ EMR system may be used to provide supporting documentation regarding diagnosis and medications. Completion of the application for benefits and or reinstatement must be documented in the client’s clinical record.

B. LMHA program staff responsible for benefit coordination are to monitor the application for approval or denial status at least once a month and document efforts and results in the client record. In the event of denial of the application, LMHA staff will coordinate any appeal process as necessary.

C. For each existing or new prescription for psychotropic medications, the LMHA program staff shall ensure that the appropriate Patient Assistance Program (PAP) application is submitted within seven (7) working days, and document application completion and outcome in the client’s clinical record.

IV. Individualized Treatment Plan

A. No later than thirty (30) calendar days after admission, the ICM Case Manager shall be responsible for the coordination, development and implementation of the offender’s Individual Treatment Plan (ITP). Each ITP shall be developed with input from the Interdisciplinary Team (IDT) and must include documentation of all supervision and treatment needs of the offender. Documentation shall be maintained in the client’s clinical file. If the IDT took place over phone, the file shall be documented as such. The IDT is to consist of the following individuals, at a minimum:

1. Case Manager
2. Program Director, or designee
3. Psychiatrist or Nurse (when available)
4. Supervising Officer (Parole or Probation)
5. Client

B. The ITP is developed based upon all areas of the client’s identified needs and include specific goals and objectives as well as the strategies for achieving those goals and objectives. Further, the ITP is to identify the client’s therapeutic and rehabilitative service needs, to include inter- and intra-agency resources, and coordinate the client’s access to those resources. The completed ITP is to be maintained in the client’s clinical record.

C. The Case Manager is to ensure that the ITP is reviewed by the IDT and updated based on clinical improvement/decline every ninety (90) calendar days, at a minimum, while in ICM services.
D. If an IDT member is unable to attend the scheduled ITP in person, participation by phone is acceptable. The sign-in sheet or plan must be sent to that individual with the notation “by phone” with a request for both their signature of acknowledgment and the return of the document for inclusion in the file.

V. Intensive Case Management Services

A. In order to provide services at the intensive level required, the caseload ratio for ICM is not to be fewer than 20:1 and no greater than 25:1 without specific written approval from the TCOOMMI Manager.

B. One successful element of ICM is on-going, frequent contact with the client which maintains the focus on continued improvement and stability. Contacts with clients are to be provided as outlined below:

1. Face to face contact with the client is to be made within five (5) calendar days of placement into ICM services.

2. A minimum of 3.5 face-to-face contact hours is to be provided per month. Contact hours can be provided by the Case Manager in combination with the Nurse, Psychiatrist, Benefits Coordinator, and/or Skills Trainer in either an individual or group setting.

3. At least one (1) contact per month must be made by the Case Manager in a community setting and must be for rehabilitative or skills training purposes and must meet the requirements of Medicaid billable contacts/services. Contacts may be made at the client’s home, at the office of the supervising officer, or in any other community setting.

4. A minimum of one (1) contact per month is to be made with the client’s supervising officer in person, by phone or by email. Collateral contacts may be made in conjunction with the client’s appointments with the supervising officer.

5. In the event of a missed appointment, the ICM Case Manager is to attempt to make contact with the client by phone no later than the next working day to bring the client back into services. Regardless of the outcome, the LMHA program staff shall notify the Supervising Officer of the missed appointment and, if unable to locate, collaborate with the Supervising Officer to re-engage the client to reschedule the appointment.

The supervising officer must be notified immediately by telephone or email of any new appointment information.

6. Any recommendations to deviate from the required number of contacts specified in these procedures must be staffed with the IDT. If concurrence from the IDT is obtained, the request to deviate from the outlined services or contacts are to be sent via e-mail to the Compliance Monitor for review and, if appropriate, approval.
C. All service coordination and rehabilitative/skills training are to include social, educational, behavioral, and cognitive interventions that target the client’s ability to develop and maintain supportive relationships, occupational or educational achievement, housing, independent living, transition to both independent mental health care and independence within the community.

D. Services are to be provided over the course of each month in a manner sufficient to monitor the client’s progress, continued stability, crisis resolution, and baseline level of functioning within their natural environment.

E. All services and contacts are to be documented in the client’s clinical record and must meet standards for Medicaid reimbursement.

F. Documentation is to be maintained of the client’s progress in developing natural and/or alternative supports which enable the ability to transition out of TCOOMMI services as well as any barriers to the client’s progress toward transitioning out of TCOOMMI services. This should include the development of interventions and resources to address these identified barriers.

G. Crisis intervention services must be available for the client twenty-four (24) hours per day, seven (7) days per week.

H. Services for ICM are authorized for a period not to exceed two (2) years. Any request for an extension beyond the standard service period must have the recommendation of the IDT and include a plan for the transition from ICM within ninety (90) days. The written recommendation by the IDT, is to be submitted to the TCOOMMI Programs programstcoommi@tdcj.texas.gov mailbox for approval.

VI. Transition Planning

A. Planning for transition out of TCOOMMI ICM services should begin upon admission, by identifying the client’s chronic needs and developing treatment or case management strategies to address those needs as well as any barriers to meeting those needs. This is accomplished by determining whether a client should have gradually reduced case management services as a transition to non-TCOOMMI services. A reduction in case management services through TCOOMMI programming would result in a transfer of the client to COC services or Transitional Case Management (TCM) services, if available, and shall be documented in the client’s clinical record and the client’s Treatment/Service Plan.

B. If it is determined by the IDT that a higher level of service than that offered in the TCOOMMI program (other than hospitalization) is necessary, the client may be transitioned to another service up to the level requiring hospitalization. In this instance, coordination with the receiving program is to be made by the ICM Case Manager and all documents to allow for continuity of care provided.
VII. Services While In Custody

A. In the event a client has been arrested or detained and remains in custody in a county jail for more than fifteen (15) days, the client shall be admitted to Continuity of Care services. COC policy regarding services while in custody shall be followed at that point and monitored until release or disposition. LMHA Program Staff shall be responsible to monitor the client’s status for ninety (90) days in custody and if disposition of case is not resolved, COC services will be closed out.

VIII. Reinstatement

A. Should the client be released from custody, immediate placement back into ICM services should be made with the client receiving priority placement.

IX. Discharge

A. The client shall be discharged from ICM services when the IDT determines that the offender no longer warrants ICM services, or when:

1. The client completes his or her required community supervision;
2. The client’s probation or parole has been revoked;
3. The client moves outside of the Local Mental Health Authority (LMHA) service area. In such cases, the Case Manager shall enter a county-to-county transfer to the TCOOMMI Program serving the area where the client is moving to and coordinate with the receiving LMHA, as outlined in PGP-01.01, Continuity of Care.

B. When the client is discharged from ICM services, the client’s referral in the Web Application is to be closed, with comments indicating the reason for the case closure. This is also applicable when transitioning to another level of service such as COC or Transitional Case Management.

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