

Executive Narrative/Service Summary
S.20 FAMILY CENTERED CASE WORK

1) Family Centered Case Work is a new service provided by Clinical Case Management based upon referral only from organizations in the Partnership for Children. It is not a funded component of Clinical Case Management and operates strictly upon referrals from community agencies on a fee for service basis only. The goal of Children's Aid and Family Services in providing this service is to cooperate with the Partnership for Children by providing therapeutic interventions to a very needy but somewhat resistant population. The State of New Jersey, the Department of Human Services developed the Partnership for Children renamed the Division of Child Behavioral Health Services to provide more comprehensive mental health care for children, youth and young adults.

One of the primary goals of the Division of Child Behavioral Health Services is to avoid or limit the need for separation of the child, youth or young adult from the home or community due to the need for mental health treatment in residential or inpatient mental health settings.

Eligibility for these services is determined by the Department of Human Services or any organization designated by the Department to make such determinations. These entities include Case Management Organizations (CMO), Mobile Response Teams, Community Assessment Resource Teams (CART), designated staff at the Division of Youth and Family Services (DYFS), the Division of Mental Health Services (DMHS) or Medical Assistance and Health Services (DMAHS) designated staff at Value Options, the Contracted Systems Administrator (CSA). Clinical Case Management agreed to partner with these agencies a wraparound to provide community based In-Home therapy.

This family centered case-work program (In-Home Therapy) is a new service that operates on a very small scale based on referrals from Bergen County Care Management Organizations (CMO and the Bergen County Crisis Mobile Response Team). Clinical Case Management's affiliation with the above named agencies was signed in 2001, however, because of a number of challenges, the program had been able to provide the service beginning only in 2002 and on a small scale. The major challenges include, but are not limited to, rapid staff turnover in Clinical Case Management In-Home Program as well as the Care Management Organization. The service is designed to work in conjunction with the referring agency's case managers. Rapid staff turnover from both agencies impedes an effective working relationship. The CMO case managers are responsible for all case management

responsibilities. Children's Aid and Family Services clinicians are contracted to provide therapy only. It can be assumed that the nature of this work produces early burn out among qualified professionals who decide relatively quickly that this intensive community-based case work is more challenging than they care to tolerate for a long period of time. Since implementing the program in 2002, Clinical Case Management has had 6 clinicians who provided these services and all resigned in less than 3 months. They decided to leave the agency for other work settings. With turnover as rapid as this, the agency is seriously considering the plausibility of trying to continue to provide this service.

Rapid staff turnover and the excessive amount of time spent in travel, coordinating and documenting services, exceeds the time spent providing therapy which causes the program to consistently operate at a deficit.

One of the greatest challenges is engaging the family and developing a therapeutic relationship. Family members are often resistant to treatment. The idea behind community-based therapy is great, however, clinicians have found it extremely challenging to provide therapy in the home. All too often accommodations are inadequate and distracting. There is no place for privacy which makes it difficult to engage the identified patient and prohibits an alternative location for therapy, i.e., outside on the steps, taking a walk, etc. Often times, the clinicians show up for an appointment and find no one at home. Families make excuses as to why they cannot have therapy. Often times the areas that the clinicians have to go into are areas considered unsafe, especially for young women. Although all of these conditions are expected of the population we serve, it is important that we evaluate the worker's safety and the cost to the agency for providing this service.

Although we believe that the service provided has produced good results in some families, we know these kinds of services require a vast amount of time. Because of professional ethics, the clinicians will not deny a client a needed service, even when we have not received authorization and may not be reimbursed. Clinicians get involved in advocating and referring clients to needed services identified through their ongoing assessment and therapeutic interventions. Although we believe that this unique program provides needed services to a very special population, we believe that this population is best served by a professional who can spend an unlimited amount of time attending to many needs of the client.

2) The Family Centered Case Work Program/Community based In-Home Therapy is operates from the Clinical Case Management Department of Children’s Aid and Family Services at the site listed below:

Children’s Aid and Family Services, Inc.
240 Frisch Court, 1st Floor
Paramus, NJ 07652
201-226-0300

Rose Zeltser, MSW, LCSW	– Senior Vice President - 24 years experience
Betty Hoskins, MSW, LCSW	– Director Clinical Case Management, Clinical Supervisor - 24 years experience
Ivy Steinmetz, MSW, LCSW	– Senior Clinician - 21 years experience
Anna Przywara, MSW, LSW	– Clinician - 2 years experience

Hours of Operation

Monday and Friday – 9 AM to 6 PM

Tuesday, Wednesday, Thursday – 9 AM to 8 PM

Clinicians providing in-home therapy work flexible hours and are not determined by office hours. Clinician’s are available to clients, depending upon need at any hour and clinicians may be available to provide services any day of the week. Children’s Aid and Family Services issues cellular telephones to each Community Based In-Home clinician ensuring availability to clients around the clock.

3) **Program Description** – Family Centered Case Work/In-Home Therapy based on referrals is part of a comprehensive health care program for children, youth and young adults who have been determined by the Department of Human Resources or an entity designated by the Department to make such a determination. Bergen County CMOs (Bergen’s Promise, Bergen County Crisis Mobile Response Team) are designated entities with whom Children’s Aid and Family Services have an affiliation to provide therapy as part of a comprehensive treatment plan.

Children’s Aid and Family Services clinicians, the case manager from Bergen’s Promise and the Crisis Mobile Resource Team work in conjunction to provide an array of other rehabilitative services provided as a part of a plan of care authorized by Value Options, the Contracted Systems

Administrator. Clinical Case Management clinicians provide individual and family therapy in the beneficiary's home or other non-institutional community setting. Therapy is aimed at averting admission or readmission to residential mental health or inpatient psychiatric settings.

Clinicians provide professional, personalized, intensive therapeutic interventions to meet the needs of the identified client and his/her family who may be otherwise unwilling to accept mental health intervention under any other condition. These families require special individualized accommodations in regard to location, duration, frequency and flexibility of service.

In-Home therapy services are designed to address symptom reduction through problem solving and strengthening adaptive and coping skills that may restore or maintain a child, youth or young adult's ability to function within the family and in the community. In-Home services endeavor to instill hope in the family that change is possible, that they can master their circumstances, that challenges and crises may be viewed as opportunities for growth and that they can achieve goals to reduce their dependence upon service providers while enriching connections within their home community and utilizing resources more effectively.

Families in need of In-Home therapy typically face a wide range of challenges that affect the child's well being and family stability, creating a risk of out-of-home placement. The risk of disintegration in these families may be due to the psychological, emotional and/or behavioral dysfunction of one or more person. The In-Home clinician addresses a variety of therapeutic issues, including but not limited to: impairments in functioning, maladaptive behaviors, severe emotional disturbance, traumatic experience (i.e., family violence, substance abuse, health issues, etc), marital difficulties impacting family cohesion, custody/visitation issues, housing and financial challenges, interpersonal problems, parent-child relationships, problems of childhood and adolescence, delinquency, academic problems, phobias, anxiety, depression, stage of life adjustments and other serious distress contributing to family dysfunction.

Therapeutic intervention is time limited and intensive to meet a family's service needs. The length and frequency is determined by a number of criteria, most commonly the authorization for services from the referring care management agency. Other criteria for termination may be, but not limited to the following:

- exhaustion of therapeutic benefit to family or individual
- successful progress toward treatment goals
- identified need for alternative treatment
- opportunity for connection with local community based organizations that may intervene to address and service on-going treatment goals.

In some cases, on the clinician's recommendation, In-Home services may be provided for additional limited duration or for as long as the case management team determines that the family requires therapy to remain stable and intact, providing that authorization is approved by the contracted systems administrator.

Termination is discussed with families from the very beginning of treatment and is part of the treatment contract. This enables families to focus on resolution of current issues and encourages them to accept unique, non-traditional, solution-oriented interventions. This process empowers families and prepares them to accept intervention in the event future need is identified or if follow-up services are recommended. Services are always terminated if the family does not wish to continue treatment or when the goals of treatment have been achieved.

The In-Home program is intensive and time consuming. Full-time clinicians could not possibly carry more than six clients based on several variables. These variables include but are not limited to the geographical location which affects the clinician travel time, the number of family members being treated, the special needs of the family (barriers to treatment) and the number of hours needed to address complex and acute family issues. The number of referrals accepted and assigned will be determined based on all of the criteria listed above.

The average caseload is six cases for a full-time clinician, three for a part-time clinician totaling nine cases per month.

A referral is accepted based on the clinician's ability to meet the client's needs. When a referral is accepted and assigned to the clinician, the clinician will make every effort to contact the client within 48 hours. If the client cannot be contacted within 48 hours (this may be due to many reasons, i.e., client not answering outreach attempts, telephone, outreach, letter) the clinician will contact the

referring agency to elicit the case manager's assistance. Efforts to outreach to the family will be communicated to the case manager and documentation is placed in the client's file. The referring agency may provide assistance in making it possible to connect with the family by providing additional directions and/or information.

At the initial meeting with the family, the clinician will do a preliminary assessment to determine if the needs of the client matches the recommendation of the referring agency.

During this assessment, the clinician advises the client of his/her rights. To clarify treatment, a copy of the signed rights are given to the client and a copy is placed in the client's case file. The child and family also signs a treatment agreement at the next session. A copy is given to the family and a copy is placed in the case file.

It is the policy of Clinical Case Management that treatment goals should be clearly defined. The clinician works with the child and family to insure that the goals are realistic and achievable and offers ongoing support and encouragement toward working towards change. The clinician makes every effort to have ongoing dialogue with the case managers to insure that case management needs as well as therapy needs are met.

Initial treatment goals are delivered by the referring agency and are outlined in the referral. Treatment planning, therefore, is conducted collaboratively between the clinician and the identified client/family beginning at the first session and continues through the course of treatment. The client is made aware and understands fully that the clinician will report on his/her process in regular communication with the referring agency's care manager. Each agency has its own reporting requirements that the In-Home clinician responds to weekly or monthly, verbally (by phone or in conference) or in written form. The In-Home clinician documents all communications in the client's case file. Family Team meetings are scheduled for Bergen's Promise referral. These meetings are scheduled monthly during evening hours. These meetings are care planning sessions that can be scheduled at any time that the clinician feels a decision regarding the client treatment should be discussed collaboratively and a new plan issued. These family team meetings may take place in the Bergen's Promise offices, the family's home or any other agreed upon location in the community.

The client is made aware from the beginning of treatment that the therapy is time limited. The client's understanding of this is indicated by his/her signature on the treatment contract. Cases referred from Crisis Mobile are authorized for 8 weeks of treatment only. If, after 6-7 weeks, the clinician feels that the client/family is in need of continued therapy, a recommendation is made to the referring agency that the client be referred back to Children's Aid and Family Services if, in fact, the client has established a therapeutic relationship with the family.

When the 8 weeks have lapsed, the referring agency will send the recommendations to the CSA. The CSA is then responsible for making the decision to continue treatment based on a Strengths and Needs Assessment. The case may or may not be returned to Children's Aid and Family Services for continued treatment.

There have been occasions when a client's special needs could best be met by a Children's Aid and Family Services clinician. On those occasions, the case has been referred back for continued treatment (i.e., a Polish speaking family was referred because the In-Home clinician could provide therapy in the Polish language).

In the case of Bergen's Promise referrals, the clinician may advocate for continued service for the client based on the client's need and motivation for treatment. Services are terminated in the family does not wish to continue treatment or when the goals of treatment have been achieved.

The In-Home clinician will work with the family toward closure during session leading up to termination. The clinician reviews the progress and readiness for termination. The clinician reviews the client's progress, emphasizes strength, competencies and acquired coping skills and will encourage the family to utilize identified community resources. The clinician will inform the care manager of the termination. The termination will be documented in the case record and the closing date will be confirmed with the referring agency's case manager.

4) Children and families are referred for Community Based In-Home Therapy by Bergen's Promise the CMO, Care Plus the CMRS, and occasionally by Value Options the CSA. Referrals are initiated after assessments by case managers from those agencies indicate that In-Home family and/or individual therapy is warranted. Referrals from Bergen's Promise are typically authorized for an initial three months, while referrals from Care Plus are generally limited to eight weeks maximum. Referrals

from the CMO and CMRS are denied only when an In-Home clinician is not available to accept the case due to caseload maximums.

If during the initial assessment session the client/family is found to require a higher level of care, the In-Home clinician reserves clinical authority to refer the client back to the referring agency with appropriate recommendations for alternative services. Clients with co-occurring mental illness and substance abuse disorders will be excluded if there is evidence of current substance abuse and the client is unwilling to engage in a program that specializes in the treatment of substance abuse disorders. Referrals will also be returned to the referring agency if the family rejects services. Clinicians document all such rejections and the reasons that client referrals are returned to the referring agency.

Clinical records are kept in a separate (non-public) locked area, stored in metal, fire proof cabinets at Children's Aid and Family Services, 240 Frisch Court, Paramus, NJ, 07652. The In-Home file drawer is labeled for easy identification. Each case file is labeled by the client's last name in alphabetical order. Records are never removed from the building. If any portion of the record must be transported elsewhere, such as court, it would have to be photocopied and transported in a secure manner. The clinician will safeguard client confidentiality by limiting recorded information to that which pertains to case goals and progress. Records are reviewed periodically and corrective action plans are carried out when necessary.

During the initial assessment/therapy session the clinician addresses potential approaches and discusses any adaptations in service location that may be identified specific to a family or individual client's needs. Potential benefit of the service is discussed with the child and family members and treatment goals are identified. The clinician discusses client rights, confidentiality, protected information, and grievance processes and provides these written materials. Any exceptions to the above are documented in the client record and the referring agency is notified.

During this session the clinician completes an Intake Assessment and Treatment Agreement with the child client and family. The purpose of this form is to obtain consent for treatment, to give notification on patient rights under HIPAA, to clarify service location/ duration/authorization parameters, to establish treatment goals, to relate emergency and contact information, and to identify any additional

service needs and/or current safety risks. The clinician should give a copy of this form to the client and/or family at the next scheduled session.

Treatment goals are identified by care management agencies and are outlined in the original referral for treatment. Based upon this foundation, treatment planning is conducted collaboratively between the clinician and client/family at the initial session and discussed in each session thereafter to identify direction and progress in the treatment. It is understood by the client that the clinician will report on progress in regular communication with the referring agency case manager. Each care management agency has its own reporting requirement, either weekly or monthly, either verbally (by phone or in conference) or in written form. The CAFS In-Home clinician documents such communication with case managers in the client's record. Bergen's Promise care managers schedule monthly 'family team meetings' which are collaborative case planning sessions, and invite participation from individuals and service agencies involved in the support and/or management of individual family members. These collaborative sessions also provide opportunity to make necessary adjustments in services and to reduce the potential for duplication in service provision. Family-team meetings may take place in the Bergen's Promise offices, the family home, or in any other case relevant location in the community.

In-Home clinicians do not have authority to place children, however, if it is clinically determined that out of home placement would be the best alternative for a particular child, the clinician shall make such a recommendation to the referring agency case manager. Circumstances where this may apply would be, for example:

- a) when extreme clinically significant symptoms persist despite intensive work with the child/family;
- b) parents are unable to provide a safe living environment for the child;
- c) when the child's symptoms are uncontrollable and present a danger to self or others;
- d) they are suspicion that abuse or neglect may be taking place.

In-Home clinicians do not have authority to place children, however, if it is clinically determined that out-of-home placement would be the best alternative for a particular child, the clinician shall make such a recommendation to the referring agency case manager.

Termination is discussed with families from the very beginning of treatment and is part of the treatment contract. This enables families to focus on resolution of current issues and encourages them to accept unique, non-traditional, solution-oriented interventions. This process empowers families and prepares them to accept intervention in the event future need is identified or if follow-up services are recommended. Services are always terminated if the family does not wish to continue treatment or when the goals of treatment have been achieved. Services are also terminated when the referring agency terminates authorization for services.

The In-Home clinician works toward closure with the individual client and family during the sessions leading up to termination. The clinician reviews progress, emphasizes strengths, competencies, and acquired coping skills, and reinforces the family's opportunity to connect with identified community resources. The In-Home clinician will apprise the referring care management agency of progress and readiness for termination. In the event that a family requires continued services, the clinician may appeal to the care manager on behalf of the family to request authorization for additional sessions, providing that a referral for services to provider in the community is not a possibility for the family or individual. The In-Home clinician documents the termination in the case record confirms the closing date with the referring case management agency.

5) In Home Services provided to families in the community are not through contract but rather by affiliation agreement with Bergen County's Care Management Organization (CMO) Bergen's Promise, Children's Crisis Mobile Response (CMRS) Care Plus, and the Contracted Systems Administrator (CSA) Value Options to provide mental health rehabilitation services to families in the community on a fee-for-service basis. These agencies have primary responsibility for coordinating all care management services received by these families. As a function of their services, case management agencies may refer a family for Community Based In-Home Therapy when needed, particularly when families are not likely to benefit from, nor accept traditional clinical services available in the community. CAFS has an affiliation with the CMO/CMRS/CSA to provide In-Home therapy services only. CAFS In-Home clinicians may communicate directly with case managers, however, to advocate for consumer needs, and/or to request that needed referrals be made on behalf of the client-family.

6) a) See Organizational Chart on attachment.

b) Department of Clinical Case Management employs the following staff that is responsible for the provision of clinical services to children in our Community Based In-Home Program:

- Rose Zeltser, MSW, LCSW – Senior Vice President - 24 years experience
- Betty Hoskins, MSW, LCSW – Director Clinical Case Management, Clinical Supervisor - 24 years experience
- Ivy Steinmetz, MSW, LCSW – Senior Clinician - 21 years experience
- Anna Przywara, MSW, LSW – Clinician - 2 years experience

7) Demographics:

- a) Race/Ethnicity: Caucasian – 36% African American – 28%
 Hispanic – 36%
- b) Gender: Female 64% Male 36%
- c) Age: 0 to 5 – 1%
 5 to 10 – N/A
 10 to 15 – 72%
 16 to 20 – 27%
- d) Religion: Protestant – 50% Catholic – 50%
- e) Major Language: English

8) The In-Home Intensive Family Center casework program is in the process of developing program outcomes. We are working together with Evaluation, Compliance, and IT Systems department to identify an appropriate tool for monitoring case work program outcomes.

9) No N/A Request Forms received.