Assessment and Service Planning

Definition Assessment: A review of clinical information and a general discussion with the individual and the family, if the individual is a child, to understand the individual's history and present life situation.

Assessment

- Initial assessment must be completed within 30 days of admission date to the program and reviewed and updated as needed.
- Assessment of the individual's strengths needs and interests and should include the life domains within the assessment. These can include the following: mental health; physical health; income/benefits/financial; housing, activities of daily living skills; legal/criminal justice system/juvenile justice; drug and alcohol; social supports; education/vocation; leisure/recreation and risk of out of home placement/currently in an out of home placement.
- Medical history taken within the past 12 months or documentation of case manager's efforts to assist the individual in obtaining a physical examination.
- Completion of Environmental Matrix (EM), Combined Strengths Assessment Scale (CSAS) and Child and Adolescent Needs and Strengths (CANS) within 30 days to ensure that the appropriate level of service is delivered and to be completed every 6 months at a minimum and whenever there is a change in level of service need.
- Documentation of out of home placements including but not limited to hospitalizations, incarcerations, residential treatment facility, etc. and documenting date of admission, reason for admission, duration of stay and discharge plan
- Children/Adolescents: individual education plan, school testing, psychological evaluations, guidance counselor reports or documentation of the case manager's efforts to obtain the information if not in the record.
- Assessment process must be a collaborative process between the case manager, individual and /or family and should reflect cultural competence and acceptance of individual's choices in their recovery process.
- Signed by the individual, the family if the individual is a minor, legal guardian if applicable, case manager and supervisor.

Action Words

Evaluate	Gather	Assess	Observe
Review	Document	Gauge	Obtain

Definition Service Planning: The development of goals and objectives with the individual and the family, if the individual is a child, based on strengths and desires identified through the assessment, to include any activities necessary to enable the individual to live as an integral part of the community.

Service Planning

- Service Plan must be developed within 30 days of admission date to the program and evidence that it is reviewed and updated at a minimum every 6 months. If clinically indicated the service plan should be updated at any time but not less frequently than every 6 months. The service plan is a "life plan" that changes regularly and documentation should reflect this in case progress notes and service plan addendums
- Service Plan will reflect documented assessment of individual's strengths, needs and interests from the assessment.
- Goals should be measurable and individualized.
- Should include outcomes and objectives by identifying the responsible persons completing objectives/tasks, time frames of completion and date of completion. The review may include documentation to show barriers/obstacles for completing objectives/tasks and any accomplishments.
- Recovery oriented: the individual owns the service plan; encourages independence; develops natural community supports; provides for choice; and promotes wellness. Should reflect recovery principles and should identify strategies for case management involvement in the recovery process.
- Include a crisis prevention/relapse plan developed with the individual and/or family and is readily available to guide prevent or guide crisis resolution.
- Signed by the individual, the family if the individual is a minor, legal guardian if applicable, case manager and supervisor.

Action Words

Develop	Create	Contract	Produce	Generate	Collaborate
Implement	Initiate	Construct	Design	Measure	Empower

Linking with Services

***Definition*:** Assisting the individual and the family, if the individual is a child, in locating and obtaining services specified in the services plan including arranging for the individual or the family to be established with the appropriate service provider.

Linking with Services

- Partnering with the individual to identify natural supports for need services.
- Informing individuals on services available or providing contact information such as addresses, phone numbers or directions.
- Explaining how to access services and reviewing what to expect.
- Connecting individuals to community providers.
- Telephone contact or face to face with potential providers when attempting to locate a service for a individual.
- Assisting the individual in completing referrals and applications.

Action Words

Assist	Obtain	Refer	Inform	Explain
Connect	Locate	Apply	Facilitate	Partnering
Empower				
Enable				

Gaining Access to Services

***Definition*:** To help an individual and the family, if the individual is a child, get a needed service or resource. An assertive and creative attempt to help a person gain resources and services identified in the service plan. This may include home and community visits and other efforts as needed. Home and community is defined broadly to include field contacts which may take place on the street, at the person's residence or place of work, psychiatric treatment facilities, rehabilitation programs and other agencies where support or entitlements are available to the individual.

Gaining Access to Service

- Assisting the individual in identifying natural resources to support the individual in goal oriented tasks such as arranging transportation.
- Attending appointments with an individual and document any billable case management services provided as long as that activity is identified as a goal on the service plan
- Meeting an individual at a provider and helping them complete an application.
- Attending a SSI Determination hearing and/or evaluation with an individual
- Making a face-to-face contact with a provider to get services started.
- Helping an individual complete an application to the food bank or other generic community programs.
- Assisting an individual in making phone calls to get a service (PCP, appointment, etc.).
- Introducing an individual to the computer and/or internet to find services/benefits.

Action Words

Help	Demonstrate
Attend	Engage
Meet	Reinforce
Provide	Talk
Introduce	

Monitoring of Service Delivery

Definition: Ongoing review of the individual's receipt of and participation in services. Contact with the individual and the family, if the individual is a child, must be made on a regular basis to determine his or her opinion on progress, satisfaction with the service or provider, and any needed revisions to the service plan. Contact with provider/program staff must be made on a regular basis to determine if the individual and the family, if the individual is a child, is progressing on issues identified in the service plan and if specific services continue to be needed and appropriate. Regular contacts must be made with other public agencies serving the individual and with the family, if the individual is a child.

Monitoring of Service Delivery

- Engage the individual and the family, if the individual is a child, to monitor his/her involvement and satisfaction with service providers.
- Communicate with service providers to determine the individual's participation and progress within that service. The discussion will focus on the goals outlined in the individual's service plan, which will be reviewed as needed.
- Evaluate and review the effectiveness of the service delivery, the frequency of participation, the progress made, and needed revisions to the service plan.
- Upon review the case manager and individual will propose recommendations to providers regarding changes that are indicated in goal areas and services provided.
- Coordinate a team meeting to discuss any concerns related to progress or need for services. This meeting may include the individual, service providers, family members and natural supports involved in the individual's service plan.

Action Words

Address	Coordinate	Explore
Advocate	Discuss	Facilitate
Clarify	Inquire	Validate
Encourage	Involve	Review
Collaborate	Engage	Oversee
Communicate	Evaluate	
Examine	Monitor	
Consult	Contact	

Problem Resolution

Definition: Active efforts in advocacy to assist the individual and family, if the individual is a child, in gaining access to needed services and entitlements. Staff shall have easy access to communicate with the county administrator for the purpose of obtaining assistance in resolving issues which prevent an individual from receiving needed treatment, rehabilitation and support services. On a systems level, this may include providing information to help plan modifications to existing services or implement new services to meet identified needs and providing information to help plan modifications for accessing resources.

Problem Resolution

- **Active efforts -** daily activities that are acute in nature and can be resolved in a short time span. Resolution can be reached with the involvement of the case manager and individual and family, if the individual is a child. Examples: utility shut-off notices, discontinuation of benefits, basic needs (identified as goals on the service plan)

- **Systems level** - longer term to reach a resolution, may involve county/base funding, an exception to medical necessity, an actual change in the way things are done needs to be initiated/implemented. Examples: implementation of mobile meds program, co-occurring competence system wide, MATP support

Action Words

Collaborate	Investigate	Gather information
Clarify	Strategize	Adapt
Perform	Formulate	Implement
Utilize	Develop	Advocate

Informal Support Network Building

Definition: Contact with the individual and family, if the individual is a child, (not family counseling or therapy) and friends (with the permission and cooperation of the adult consumer) to enhance the individual's informal support network and empower the individual to become more independent.

Informal Support Network Building

- Assess current and past support network - identify current supports and effectiveness of those supports.
- Develop a list of both informal and natural supports that are available to assist the individual and family in realizing their service plan. This will assist in ensuring that the case manager is not providing a direct service and treatment and not taking responsibility for the completion of goals on the service plan.
- Establish strengths and weaknesses of the support system and provide information on what constitutes a support system.

Action Words

Assess	Expand
Assist in identifying	Develop
Evaluate	Encourage
Enhance	Specify

Use of Community Supports

Definition: Assistance to the individual and family, if the individual is a child, in identifying, accessing and learning to use community resources appropriately to meet daily living needs.

Use of Community Supports

- With participation of the individual, case managers make sure needed services are provided by coordinating services, communicating with service providers and referring to community agencies.
- Assist with WIC enrollment and access to food banks.
- Assist the individual and family to contact educational advocate; neighborhood legal services.
- Assist in learning to use public transportation.
- Encourage enrollment in GED or Adult basic Education Classes, OVR and Career Link.
- Assist in identifying courses offered at local community college
- Introduce to services offered at local library and other recreational facilities like the YMCA.

Action Words

Learn	Identify
Access	Accompany
Assist	Utilize
Apply	Refer