



NYC Department of Youth and Community Development

# Case Management Standards Toolkit

## **ACKNOWLEDGMENTS**

### **Developed with support from The Mental Health Association of New York City, Inc. (MHA-NYC)**

The Mental Health Association of New York City (MHA-NYC) is a national leader in developing innovative approaches to address mental health needs and promote wellness. MHA-NYC served as the lead agency for the development and implementation of the Model for Case Management Services for children, youth and family for New York City's System of Care.

MHA-NYC operates an array of culturally sensitive, state-of-the-art programs to help individuals and families affected by mental illness and provides public education, training and technical assistance services to improve mental health and social service delivery in New York City and nationally.

MHA-NYC's Case Management Training and Technical Assistance Team includes:

Kathryn M. Salisbury, Ph.D.

Susan Grundberg, M.S.W., M.P.A

Michelle Angulo, L.M.S.W.

Yusyin Hsin

Jackie Harootian

Unlimited Mindfulness Consulting, LLC.





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## **About the Department of Youth and Community Development Case Management Toolkit**

The DYCD Case Management Toolkit is designed as a resource to help programs that offer case management services implement the new DYCD Case Management Standards. Implementation of DYCD's Case Management Standards represents the department's commitment to continuous quality improvement efforts aimed at improving outcomes for individuals and families who receive case management services.

### **Contents of the Toolkit**

The toolkit contains the standards and skill building resources as well as checklists to help case managers and their supervisors chart progress toward meeting the standards.

- DYCD Case Management Standards
- Skill Building Tools
- Self Assessment and Monitoring Tools

### **How to Use the Toolkit**

This toolkit creates a common frame of reference and puts case managers and DYCD Program Managers on the same page. It is intended to be used creatively to involve everyone in a process of continuously improving the quality and outcomes of case management services.

We hope that you will apply the tools to support implementation of the case management standards where, when, and with whom you can. Whether the toolkit is used to orient new staff or as a tool for professional development, supervision, and monitoring of a program's progress, the goal is to help organizations guide, support and sustain the changes that will be necessary for case manager to implement best practices in case management.

Keep the toolkit handy, use it often, and remember that small changes can result in big improvements.



## **SECTION I:**

# **Case Management Standards**



## Introduction

This document establishes a set of core case management standards for programs funded by the New York City Department of Youth and Community Development (DYCD). The term “case management” can be defined in a number of ways. Here it describes the basic approach that DYCD expects all its contractors to adopt when delivering individualized support services to program participants.

Case management is a strength based approach that helps participants achieve specific desired outcomes leading to a healthy self reliance and interdependence with their community. Identifiable strengths and resources include family, cultural, spiritual, and other types of social and community based assets and networks. Families come in many forms, are unique, can be composed of extended members, and their influence and impact must be considered in the decision making process.

The core standards represent the agency’s minimum expectations, regardless of a program’s staffing, setting, size, or target population. They were developed to:

- Define and describe a consistent process that all DYCD contractors are expected to adopt in assessing and responding to the needs of individual participants.
- Clarify service expectations and required documentation across all DYCD programs that provide services on an individualized basis.
- Promote quality improvement in the way programs respond to individual needs.
- Set the foundation upon which additional and complementary standards tailored to particular settings, objectives, target populations, and/or DYCD initiatives can be established.



## **Outline of Case Management Services**

In DYCD-funded programs that provide individualized services, case management represents a collaborative, multi-step process designed to identify needs and ensure timely access to, and coordination of, supportive services.

The DYCD case management process is an approach characterized by attention to individual needs, advocacy to facilitate participant access to services and benefits, and effective resource management to promote service quality and positive participant outcomes. The key components are:

- I. *Participant Engagement and Assessment.*
- II. *Service Planning.*
- III. *Monitoring and Documentation of Progress.*
- IV. *Case Coordination.*
- V. *Exit Planning.*
- VI. *Case Closure.*



## Core Principles

- **Individualized:** The focus is on meeting the specific needs of each individual or family through joint development and implementation of the ISP.
- **Outcome-based:** The goals and strategies of the ISP are linked to observable or measurable indicators of success. Progress is monitored based on these indicators, and plans are revised, as necessary, to reflect achievements or address unanticipated or new challenges.
- **Professionally Responsible:** The participant's privacy, confidentiality, health and safety is maintained through adherence to ethical, legal, and program standards and guidelines.
- **Strength-Based:** An affirmative approach is adopted to identify and build on the knowledge, skills, and assets of the individual and his/her family and their community.
- **Culturally and Linguistically Competent:** Program staff understands the culture of the participants and communicates with them in their own language or through interpreters.
- **Community Resource Based:** The DYCD contractor facilitates access to other community resources, as needed.
- **Compassionate:** Activities are implemented with empathy and an understanding of the life experiences and challenges faced by others.

## Note on Child Abuse Reporting

Any child abuse or maltreatment of individuals under 18 that is discovered or suspected during the assessment (or at any time during the participant's involvement with your program) must be reported to the NYS Central Registry by calling **1-800-635-1522**. More detailed information about reporting suspected child abuse or maltreatment can be found at <http://www.ocfs.state.ny.us> or by contacting your DYCD Program Manager. All crises and responses must be documented in case notes.



## Case Management Components and Standards

### I. Engagement and Assessment

Engagement and assessment are the beginning of the process and the foundation of the relationship between program staff and participants. The case manager gathers information from the participant about his/her strengths, resources, and needs. This information provides the basis for components of the ISP and delivery of individualized program services.

The case manager assesses the needs and the strengths of participants and their support networks as the ISP is formulated. When appropriate, staff arranges supplementary services to help stabilize support systems, enhance family functioning, or assist in attainment of the ISP goals. This process determines the level of service needed and the participant's willingness and readiness to engage in the program.

Additional staff supervision and support may be required depending on the participant's circumstances and needs. In such cases, the supervisor must review and approve the assessment.

**Standard:** The case manager undertakes an initial assessment of the strengths, resources and service needs of each participant. The initial assessment determines participant eligibility for services, evaluates the willingness and readiness of the participant to engage in services, and provides the basis for the development of the ISP.



## II. Service Planning

The needs identified in the assessment are prioritized and incorporated into the ISP, which is developed collaboratively with the participant, and, when appropriate, with the participant's family, close support persons and other service providers. The ISP is updated following any reassessment or significant change in the participant's circumstances.

### a. Initial Individualized Service Plan Development

Service planning is a critical component of the DYCD case management approach. It guides the participant and case manager using a proactive, step-by-step approach. Where a team approach is adopted, staff other than the case manager may help develop the ISP, but the case manager remains responsible for both the process and completing the related documentation.

**Standard:** Participant strengths and needs identified during the initial assessment are prioritized and incorporated into the ISP, which defines specific goals, objectives, methods, resources and activities. The ISP is completed with the participant and clearly designates who is responsible for undertaking each activity and the timeline for meeting the participant's identified needs.

### b. Service Plan Implementation

Provider contact with the participant may be in person, by phone, or in writing. Generally, the type and frequency of contact will be dictated by participant needs, but, in some initiatives, DYCD may establish and mandate minimum levels of contact and specify the types of contact required.



The bulk of case management work concerns the implementation of the ISP and may include the following types of activity:

- Assisting the participant and support persons with applications for services or entitlements.
- Helping the participant access services and make and keep appointments.
- Encouraging the participant and support persons to complete the tasks set out in the ISP.
- Educating the participant and support persons, as necessary, about systems and services.
- Providing support to help the participant and support persons overcome barriers that impede access to services.
- Negotiating and advocating on behalf of the participant, as needed.
- Monitoring participant progress and service delivery.

**Standard:** Case management services outlined in the ISP proceed as soon as it is completed. The type and frequency of staff-participant contact is generally dictated by need. Case managers monitor participant progress toward achievement of ISP goals and follow up to determine whether services were delivered and were effective in addressing participant needs.

### **c. Reassessment**

Reassessment offers the opportunity to evaluate the impact of ISP activities to date, assess participant progress, and identify barriers to full attainment of the ISP goals. In addition to triggering an update of the ISP, reassessment allows staff to determine whether current services or service levels are appropriate or if the participant should be offered alternative services.



**Standard:** A reassessment is performed 3 months after finalization of the ISP, or earlier if barriers to implementation are identified or are required by program guidelines (e.g., in programs for runaway and homeless youth, reassessments must take place every 30 days). The reassessment period allows for a re-evaluation of participant strengths and needs, identifies changes since the initial or most recent assessment, and affirms ongoing or new goals, objectives and activities.

#### **d. Service Plan Update**

The ISP will be revised following a reassessment but it may also be updated between reassessments to reflect changes in goals, case management activities and participant circumstances.

**Standard:** A new or updated ISP is required at the completion of each reassessment, or, sooner, if there are significant changes that should be reflected in the ISP.



### **III. Monitoring and Documentation**

Case management activities are documented in case notes. The participant's file must include the following information:

- Name of the assigned case manager.
- Name of the participant.
- Identifying or required demographic information about the participant.
- Details of support persons and collaborating community providers.
- Releases signed by participants to facilitate communication with support persons and collaborating providers.
- Details of referrals.
- Need for coordination with other service providers and actual coordination of services that takes place.
- Dates, locations and time spent on all case management activities.
- Assessment, ISP, updates, progress notes and other required program-specific documentation.



#### IV. Case Coordination and Case Conferencing

**Case coordination** includes regular communication, information-sharing, and collaboration between case management and other staff serving the participant, within a single agency or among several community based agencies. Coordination activities may include direct facilitation of participant access to services and benefits; reducing barriers that prevent access to services; and establishing linkages with other service providers. All coordination activities must be recorded in progress notes.

**Case Conferencing** is not routine service coordination and is not a feature in all DYCD programs. Typically, case conferencing comprises a structured, interdisciplinary meeting between trained social workers and other professional staff in one or more agencies. Case conferences may be face-to-face meetings or take place by phone/videoconference. They may be held at routine intervals or during periods of significant change. If appropriate and feasible, the participant and family members/close supports may attend these conferences.

In general, the aim of case conferencing is to ensure delivery of holistic, integrated services where staff persons from several professions or disciplines are all involved in addressing the needs of a participant, either across units within a single agency or among several service providers. Case conferences are used to address a wide variety of issues: for example, consideration of changed circumstances, needs or goals; reviewing participant progress and barriers to attainment of goals; clarifying and mapping staff roles and responsibilities; resolving conflicts and identifying solutions; and adjusting current service plans. Case conferences and related decisions must be summarized in the participant's case notes.

**Standard:** Case coordination is a routine part of case management involving regular communication and information sharing among several units of a single agency or several independent agencies. The aim is to ensure coordinated delivery of the services and activities identified in the ISP. Case conferencing, in contrast, is a formal mechanism designed to ensure delivery of holistic, integrated services where staff from several professions or disciplines are all involved in addressing participant needs.



## V. Exit Planning

The primary purpose of all service provision is to help participants achieve the goals set out in the ISP. To maximize the chance that progress will be maintained once the participant is no longer in the program, case managers, with input from the participant and support persons, create a follow-up plan. This plan must be in place before the participant exits from the program.

The follow-up plan sets out participant objectives and goals going forward and identifies resources that may be needed in the future. It will also specify steps to be taken, by the participant or the case manager, to ensure access to follow-up services: for example, making appointments and establishing contact with relevant service providers. At a minimum, the follow-up plan will comprise a list of referrals that the participant may need in the future.

**Standard:** Follow-up plans are developed to reinforce and maintain participant successes. They are created with input from the participants and will set out participant goals and objectives going forward. At a minimum, they will include a list of referrals that may be needed in the future. Follow-up plans help participants transition to situations in which they can function well in the absence of case management services. Follow-up plans must be in place before participants exit the program.



## VI. Case Closure

There are a variety of reasons why participants stop receiving case management services. These include:

- Participant has achieved the goals and objectives set out in the ISP.
- Participant chooses to terminate the services or no longer engages in the program activities for other reasons such as relocation outside the service area.
- Relationship between the program and participant terminates by mutual agreement, for example, when there is a transfer to another program that is better placed to address the participant's needs.
- Participant is no longer eligible to receive the services.
- Agency terminates contact with the participant in accordance with its policies and procedures.

There is typically a formal process for bringing the relationship to an end. Cases will be closed in accordance with criteria specified in agency policies and procedures or in government protocols and regulations. A “closure summary” documenting what has been achieved in terms of goals and outcomes will be placed in the participant's file.

**Standard:** When case management services come to an end, there are procedures for formally closing the case. These include preparation of a “closure summary” for the participant's file documenting goal status and outcomes.



## SECTION II:

# Skill Building Tools



## Tools for Skill Building

This section of the Case Management Standards Toolkit provides tools to help Case Managers build the knowledge and skills necessary to perform strength based assessments, formulate case management goals, write progress notes and generally do an excellent job in implementing the DYCD Case Management Standards. The tools are presented in parallel order to the case management standards.

*“Knowledge is gained by learning, skill by practice”  
Thomas S. Szasz*

## Engagement and Assessment

Quality engagement and strength-based assessment rely on mastery of key concepts about strengths-based practice as well as specific skills in interviewing and collaboration.

### Key Concepts of Strengths-based Practice:

- Every individual, group, family, and community has strengths.
- We do not know the upper limits of a person’s capacity to grow and change.
- Every environment, even the most seemingly impoverished has resources and strengths.
- A person’s behavior and achievement is often a function of the resources available to a person or perceived to be available.
- Strengths of the individual and environment can be used to help the person attain the goals that they set for themselves.
- Generating options and alternative pathways to a goal is fundamental to strength based practice.
- Strengths include personal qualities, traits, talents, virtues, interests and the person’s knowledge of the world around them.
- We best serve people by collaborating with them.



## Tips for Conducting a Strength-based Assessment<sup>1</sup>

- Before you begin- Ask yourself if you are expecting strengths as well as challenges.
- Make sure the meeting can be conducted in the person's preferred language.
- Gather information conversationally.
- Give primacy to the person's perspectives by eliciting their voice, hearing their stories and taking their ideas seriously.
- Discover what a person wants, their aspirations, goals and dreams.
- Elicit, point out, and record a person's talents, skills, and accomplishments in multiple life domains.
- Avoid blaming, diagnosing and labeling.
- Have the person identify what unmet needs are most important to address first.
- Identify successful coping and problem solving strategies that the person has used in the past whenever possible.

**Be sure that cultural information that holds meaning for the person is explored and recorded.**

### Questions to Elicit Strengths:

<b>Survival:</b>	How have you managed to overcome/survive the challenges that you have faced? What have you learned about yourself during those times?
<b>Support:</b>	Who are the people that you can rely on? Who makes you feel understood, supported or encouraged?
<b>Exception:</b>	When things were going better in your life, what was different?
<b>Esteem:</b>	What do you feel proud of? What positive things do other people say about you?
<b>Perspective:</b>	What are your ideas about your current situation?
<b>Change:</b>	What do you think is necessary for things to change? What could you do to make that happen?

<sup>1</sup> Adapted from Saleebey, D. (1977). *The Strengths Perspective in Social Work Practice* (2nd ed.). New York: Longman.



## Assessing Strengths and Needs Across Life Domains

In order to assure that the case manager and client are able to create the best plan to meet the client's needs, it is helpful to survey strengths and needs across major life domains. When assessments are too narrowly focused, opportunities are missed to help the client seek solutions that will prevent future crises. An assessment of strengths and needs across domains provides a snapshot of these interconnections and form the foundation for an initial service plan that enlists the client's resources and honestly addresses barriers and obstacles to achieving the desired outcomes.

	Family	
Basic Needs/ Benefits Access	Educational/ Vocational/ Employment	Social Supports/
Health/ Mental Health	Recreational/ Leisure	Cultural/ Spirituality
	Legal Assistance	Financial Management

### Sample Strength-based Questions by Life Domain:

**Family:** Who are you closest to in your family?

**Educational/Vocational/Employment:** What do you hope to be doing in 5 years? 10 years?

**Social supports:** Who helps you when you need help?

**Health/Mental Health:** What do you do to take care of yourself? Do you see a doctor or healer when you don't feel well?

**Culture/Spirituality:** What gives you strength in difficult times?



## Sample Initial Assessment

**Name:** Mrs. Dolores Diaz

Case #0001

**Date:** MM/DD/YY

**Reason for Referral:**

Mrs. Diaz came to this program on October 5<sup>th</sup>. She was referred to us by her pastor, Rev. Jones, for help sorting out her bills and to get help with her taxes.

**Background Information:**

Mrs. Diaz is a 67 year old woman of Puerto Rican descent who was recently widowed. She lives alone in a one-bedroom apartment in the South Bronx. She moved to NYC with her parents when she was four years old. Her preferred spoken and written language is English.

She graduated from high school and took a job as a clerk in a local business. Shortly thereafter, she married her high school boyfriend Sammy. They had four children within five years and Mrs. Diaz stayed at home to care for them until the youngest was ten years old. She worked part-time as a teacher's assistant until she was 62 and began receiving social security. Mr. Diaz was employed as a mechanic until he suffered an injury at work 20 years ago.

Mr. Diaz died suddenly last winter. Her children are now 48, 46, 45 and 43 years old. One daughter lives in Florida, one has returned to Puerto Rico, and her son and youngest daughter live near her in the South Bronx.

**Strengths:**

Mrs. Diaz successfully raised four children and worked part-time most of her adult life. She is active in her church and has good relationships with her children. She noted that she enjoys cooking and likes helping others. Above all, she values her independence.

**Needs:**

Mrs. Diaz has been having difficulty making ends meet since her husband died nearly a year ago. She says that she is feeling very overwhelmed with her mounting bills and is afraid she won't be able to stay in her apartment. Her son had been helping her buy groceries and was paying her utilities until he lost his job three months ago. She does not currently receive any food or rental assistance. Her only income at the present time is her monthly social security check. She used all of her savings for burial expenses and her husband's outstanding medical bills. We explored options for immediate food assistance and longer term financial assistance and Mrs. Diaz agreed to pursue these options.

She also said she loves to cook and that her church is very important to her, but lately she seems to have lost interest in doing the things she loves to do. She says she is also disappointed that her children don't come to visit her as often. She understands that they are busy and that her son is also experiencing his own financial difficulties, but with the anniversary of her husband's death approaching she is feeling lonely. She also says she has not been feeling well and is worried that she may have diabetes like her mother and sister did so I asked if she has been to see her doctor about her health concerns. She reported that she does not currently have a primary care provider but she agreed that she would like to find one and would allow us to help her arrange a medical appointment.

When we explored her sense of isolation and how she has been feeling, Mrs. Diaz agreed that it would be helpful to have a reason to get out of the house more often. I spoke with her about attending yoga and movement classes at the Senior Center and she agreed that it might help her spirits to try it. We also spoke about whether she thought it would be helpful to see a counselor. She said she would rather try going to the classes at the Center first.



## Initial Service Plan Development

### Translating Strengths and Needs into Actions

The initial service plan charts the course of action for the case manager, client and others who will assist in helping the client to achieve the desired outcomes. The key to developing a successful initial service plan is to be able to link the needs that were identified during the initial assessment to specific, measurable, realistic, strength based, actionable goals. SMARTS can be used as a guide for writing goals.

#### SMARTS Goals, Objectives and Tasks

- **Specific-** Goals, Objectives and tasks should specify what the person wants to achieve
- **Measurable-** You and the person should be able to measure whether the goals, objectives and tasks are being achieved.
- **Achievable-** Are the goals, objectives and tasks achievable and attainable?
- **Realistic-** Can the person realistically achieve the goals, objectives and tasks with the resources /he she has?
- **Time Framed-** Is there a specific timeframe set for each goal, objective and task?
- **Strength-based** –Were the person's strengths and resources used in developing the goals objectives and tasks?

It may also be helpful to think of SMARTS Goals as having:

- Subject/Verb
- Action/Object
- Frequency
- Duration

Mrs. Diaz. will improve her English by attending ESL classes  
3x/week from 6:00 pm to 8:00 pm  
between March 1 and June 1.



## Sample SMARTS Goals

### Long-term Goals:

- Within six months Mrs. Diaz will obtain needed benefits and services to be able to resolve her current financial problems and maintain her current living situation long-term.
- Mrs. Diaz will demonstrate improved, physical, psychological and social well being over the next 6-9 months.

### Short-term Goals and Activities:

- Mrs. Diaz will seek immediate food assistance from X Food Bank on Wednesday and will complete an application for food stamps when she returns for her next visit with this case manager on Friday.
- Mrs. Diaz agreed to attend the yoga and movement classes held at X Senior Center 2x/week for the next 3 months and this writer will check in with her via phone weekly.
- Mrs. Diaz will call X Community Health Center later today and make an appointment for a physical examination.
- At her next visit Mrs. Diaz will be provided with information about where she can receive tax preparation assistance and financial counseling.



## Documenting Progress

Progress notes tell the story of your interactions with and on behalf of the clients. They document what has been accomplished and point the way to what still needs to be done. The SOAP-D format will help you remember key elements of the progress note.

### Progress Note Format

- **S** = Strengths observed
- **O** = Objective account of the interaction
- **A** = Assessment of the situation/individual
- **P** = Plan (progress toward specific goal)
- **D** = Data/ New information gathered

### Litmus Test for a Good Progress Note

- When I am unable to be present, a colleague can open the record and easily figure out the next step to help the client achieve their goals.
- If my client read the note, they would feel respected and would agree with my objective account of our interaction.



## Tips for Writing Good Progress Notes

- Think about what you are going to write and formulate it before you begin.
- Be sure you have the right chart!
- Be thorough yet concise.
- Make sure the client's name is on every page.
- Write notes immediately after you meet with the person or complete an activity on behalf of the client.
- Date and sign every entry.
- Record as "late entry" anytime it doesn't fall in chronological order; be timely.
- Think about how the person comes through on paper.
- Write neatly and legibly if the note is handwritten and print if handwriting is difficult to read.
- Use proper spelling, grammar and sentence structure.
- Don't leave blank spaces between entries; can imply vital information left out.
- Use respectful language and avoid slang.
- Describe what you directly observed and if you offer an opinion rather than a direct observation, clearly identify it as your opinion.
- Provide an assessment of progress toward goals/concerns identified in service plan.
- Proofread.



## Sample Progress Note

### **S = Strengths**

I met with Mrs. Diaz on xx/xx/xx. Despite her financial and health concerns and her reported sadness, she has followed through with most previously agreed upon tasks. She also reached out to her children this past week, which resulted in her receiving a nice visit from her son and his family. She said that she felt in slightly better spirits because of it.

### **O = Objective Account**

Mrs. Diaz reported that she went to the food bank and has enough food to last until her next social security check arrives next week. With my assistance, Mrs. Diaz completed an application for food stamps. We also made an appointment for her at the food stamps office on Friday and I provided her with a Metro Card to get to and from her appointment. She stated that she did not call the Community Health Center to make a medical appointment as planned. When I asked her why she didn't follow through with this, she said she is uncomfortable attending a community health center and that she is fearful of what the doctor might tell her. This writer also provided Mrs. Diaz with a referral to Agency T for financial counseling and tax preparation. This writer scheduled an appointment at Agency T on xx/xx/xx.

### **A = Assessment**

Ms. Diaz has followed up on all tasks agreed upon with the exception of making a medical appointment and says she is feeling more hopeful.

### **P = Plan**

- Ms. Diaz is looking forward to attending her first yoga/movement class at the senior center tomorrow.
- She will attend her intake appointment to complete the food stamps application process on Friday.
- She will attend her appointment with the financial counselor on xx/xx/xx.
- The plan to go to the community health center was revised and Mrs. Diaz was given a list of private M.D.'s that accept Medicare. Mrs. Diaz will make an appointment with one of the doctors this week.
- This writer will check in with Mrs. Diaz via phone every Friday for the next month and we will meet again in person one month from today.

### **D = Data/New Information**

Ms. Diaz provided me with phone number and email addresses for her son and daughter and they have been entered in the chart under emergency contacts.



## SECTION III:

# Self Assessment Tools



## Introduction to Self Assessment Tools

The following checklists reflect best practices in case management and have been developed to help case managers and their supervisors chart progress toward meeting DYCD's Case Management Standards. Providers should follow-up with their DYCD Program Managers to review specific monitoring requirements for their programs.

- Documentation Checklist
- Initial Assessment Checklist
- Initial Service Plan Checklist
- Progress Notes Checklist

In addition to Self Assessment, checklists can be used for:

- Teaching about key elements of DYCD's Case Management Standards
- Internal auditing
- To help supervisors to identify areas where staff need additional training or coaching
- By DYCD Program Managers for Case Record Review



## Documentation Checklist

**Standard:** Case management documentation must be organized in a manner that clearly identifies the case management activities and follow-up conducted to meet the participant and family needs and to measure progress toward goals identified in the Individualized Service Plan. The documentation should also include notes regarding whether the participant or the participant's support persons have declined any case management services.

## General Requirements

- | YES                      | NO                       |                                                                                                                                                                        |
|--------------------------|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | The name of the case manager is present.                                                                                                                               |
| <input type="checkbox"/> | <input type="checkbox"/> | The name of the participant is provided.                                                                                                                               |
| <input type="checkbox"/> | <input type="checkbox"/> | The note is an objective account of the interaction.                                                                                                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Identifying and demographic information is complete.                                                                                                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Collaborating community providers and support persons are identified.                                                                                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Release of information forms are signed by participant for collaborating organization.                                                                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Referral materials are included.                                                                                                                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | The Assessment, Individualized Service Plan, Updates to Service Plans and Progress Notes are included in the record.                                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | A reassessment is performed and documented every three (3) months at a minimum.                                                                                        |
| <input type="checkbox"/> | <input type="checkbox"/> | A revision of the service plan was made following each reassessment. Check with your DYCD Program Manager to determine how notes should be entered into your database. |
| <input type="checkbox"/> | <input type="checkbox"/> | Prior to case closure, an aftercare plan has been made in conjunction with the participant and has objectives and articulated goals.                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | When a case has been closed a closure summary documenting goals status, case disposition and reason for case closure is included in the chart.                         |



## Initial Assessment Checklist

**Standard:** Each service participant will have an initial assessment of their strengths, resources and service needs conducted in the language that they speak. The initial assessment should determine eligibility for services, evaluate the participant's willingness and readiness to engage in services, and provide the basis for the development of the initial individualized service plan.

**YES**   **NO**

- |                          |                          |                                                                                       |
|--------------------------|--------------------------|---------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | The assessment is conducted in the language they speak.                               |
| <input type="checkbox"/> | <input type="checkbox"/> | The strengths of the individual/family are noted in the assessment.                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Family members or other close supports are identified.                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Assessment includes the individual's willingness and readiness to engage in services. |



## Initial Service Plan Checklist

**Standard:** Participant needs identified during the initial assessment are prioritized and translated into an Initial Individualized Service Plan, which defines specific goals, objectives, methods, resources and activities. The plan should clearly designate the responsible party and the timeline required to meet identified needs.

YES NO

- |                          |                          |                                                                                                           |
|--------------------------|--------------------------|-----------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | The ISP goals reflect the top priority needs identified in the assessment.                                |
| <input type="checkbox"/> | <input type="checkbox"/> | The ISP contains specific short and long term goals.                                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | The methods for achieving the goals are identified and broken down into manageable tasks.                 |
| <input type="checkbox"/> | <input type="checkbox"/> | The people responsible for task completion and completion dates are identified.                           |
| <input type="checkbox"/> | <input type="checkbox"/> | The person's strengths and resources are taken into consideration when setting goals and assigning tasks. |
| <input type="checkbox"/> | <input type="checkbox"/> | Goal attainment is measurable and indicators are identified.                                              |



## Progress Notes Checklist

**YES**   **NO**

- |                          |                          |                                                                                                                 |
|--------------------------|--------------------------|-----------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | All entries are signed and dated and indicate the amount of time spend on case management activities.           |
| <input type="checkbox"/> | <input type="checkbox"/> | The note indicates strengths observed.                                                                          |
| <input type="checkbox"/> | <input type="checkbox"/> | The note is an objective account of the interaction.                                                            |
| <input type="checkbox"/> | <input type="checkbox"/> | The note contains an assessment of progress made toward goals and tasks are identified in the ISP.              |
| <input type="checkbox"/> | <input type="checkbox"/> | Barrier to task completion are noted and a plan to reduce barriers is noted.                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | New information that has been gathered is noted or placed on the chart.                                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Errors should have a line through incorrect information. Write error, initial and date.                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Another case manager should be able to read the progress note and provide needed follow-up.                     |
| <input type="checkbox"/> | <input type="checkbox"/> | When a participant or the participant's support persons have declined any case management services it is noted. |