Introduction to Case Management

Concepts, Theory, Practice and Skills
Class Agenda

• Introduction to Case Management (based on text) – 1 ½ days
• Effective and Integrated Case Management – ½ days
• Developing Effective Case Planning – ½ days
• Ethics in Case Management – ½ days
• Cultural Competency (Bonus)
Day One

Introduction to Case Management
Client Centered- Solution Focused- Mission Oriented- Integrated Casework

Define problem/issue

Collect relevant data

Develop alternative solutions

Assess consequences

Select optimum solution

Implement solution

Measure results

Eclectic and Integrated
Client Centered

- Focuses on client needs, aspirations and goals
- Agency rules focused on the mission for the client
- Values are based on “golden rule” philosophy
Solution Focused

• Long term or short term solutions
• Meeting the needs of the client
• Teaching clients to resolve their own issues
• Give clients a sense of hope
Mission Oriented

• Moving to long term outcomes for:
  – The client
  – The agency
  – The Community
Integrated

- Integrates disciplines and knowledge to benefit the client
- Make it work together better
Case Management Theory, Philosophy and Goals

Beliefs, Thinking and Outcomes
So What does Case Management Do?

Case Management provides an organized, structured process for moving participants through the process of change and toward the goal of self-sufficiency.

Page 5 of Text- not cost containment but coordinated services and resources toward a specific goal.
Assumptions

• Case Management is a **participant centered rather than a program centered** approach. It starts with the participant and uses the program’s resources to try to help each person achieve his or her goals.

• Participants are capable of taking more **control of their lives**. They are capable of solving problems, making decisions, and setting goals. Case management should not do for people what they can do for themselves.
Assumptions of Case Management

- Participants have strengths and resources as well as problems and challenges.
- Case Management attempts to enable participants to use their strengths and resources to overcome their problems and challenges.
Service Delivery Beliefs

• The Case Management process should be a shared partnership between the participant and Case Manager. Although each partner brings different skills, experiences and expertise, they share in the responsibility for producing change.

• Participants should be actively involved in all phases of the process assessment, planning, problem solving, and finding resources. Case Management seeks to have an active participant and not a passive one.
Responsibility

- **Participants** are responsible for the outcome.
- The **Case Manager** is responsible for the process.
- **Participants** are ultimately responsible for making change happen.
- As a general rule- **CM attempts to influence change rather than forcing it**.
Paradigm Shift

A tale of two paradigms- Compliance Model to Client Centered Model

• Old paradigm or model is a “Compliance Model”

• New paradigm or model is the Client Centered or Strength Based Model-
  – A theory of service delivery that focuses on the clients and their strengths instead of weaknesses or agency needs
So What’s the Difference?

- Client Based, Strength Based Case Management (New Muscle)
- Compliance Based Case Management (Old Muscle)
## Compliance Model

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<tr>
<th>MECHANIC</th>
<th>PHYSICIAN</th>
<th>PROBATION OFFICER</th>
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<tbody>
<tr>
<td>Diagnose</td>
<td>Diagnose</td>
<td>Prescribe Behavior Monitoring</td>
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<td>Fix</td>
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<td>Compliance Dosing with Reality</td>
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<td>PARENT</td>
<td>COMMANDER</td>
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<tr>
<td>Prescribe Behavior</td>
<td>Give Orders</td>
<td>Confinement</td>
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<td>Confront Resistance</td>
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<td>Monitor Compliance</td>
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<td>Entice/Warn/Emotional</td>
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<td>Dominate</td>
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<td>blackmail</td>
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<td>Consequences to motivate</td>
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<td>COACH</td>
<td>THERAPIST</td>
<td>POLICE OFFICER</td>
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<tr>
<td>Directs</td>
<td>Identify Dysfunction</td>
<td>Violation</td>
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<td>Rates performance</td>
<td>Advise</td>
<td>Citation</td>
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<tr>
<td>Bench</td>
<td>Confront Resistance</td>
<td>Detain/Arrest</td>
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*Falmouth Institute*
Compliance Model

• Focuses on agency policies and regulations
• Looks at case management primarily as a compliance practice
• Does not focus primarily on client needs
• Prescribes behavior
# Strengths Based, Client Centered

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<tr>
<th>MECHANIC</th>
<th>PHYSICIAN</th>
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<tbody>
<tr>
<td>Quality Warrantee Support Customer Service</td>
<td>Respects Autonomy Empathic Explains Reassure</td>
<td>Emphasize Choice and control Monitor Orders of Probation Focus on Offender’s reason for change Assists in finding ways to be successful</td>
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<tr>
<td>PARENT</td>
<td>COMMANDER</td>
<td>JAILER</td>
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<tr>
<td>Clarify Expectations Teach Skills</td>
<td>Train Motivate Focus on Skills Promote</td>
<td>Observe Respond</td>
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<tr>
<td>Coach Performance Emphasize Choice and Control Support Change Motivation</td>
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<td>COACH</td>
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<tr>
<td>Train Motivate Focus on Strengths</td>
<td>Respect Autonomy Emphasize choice and control</td>
<td>Protect Deter</td>
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Client Centered Model

• Focuses on assessing client needs, strengths, weaknesses and aspirations
• Focuses of client needs within the context of agency policy
• Skill building rather than compliance
• Engages clients rather than prescribe behavior and punish for noncompliance
• Looks at the purpose and function of the behavior
Characteristics of Client Centered Case Manager

- Develop a meaningful relationship with them based on empathy
- Can be trusted and treat them with respect and honesty
- Put client at the center
- Focus on their abilities and strengths
- Support them to make informed choices and decisions;
- Help them get the services and benefits they need
- Are dependable and don’t give up on them where others have.
Theories and Models

What Underlying Theories Influence Case Management Practice
Family Systems Theory

Examining the Context of Behavior
The Components of Family Systems Theory

Family Systems…

- **Have interrelated elements and structure.** The elements of a system are the members of the family. Each element has characteristics; there are relationships between the elements; the relationships function in an interdependent manner. All of these create a structure, or the sum total of the interrelationships among the elements, including membership in a system and the boundary between the system and its environment.

- **Interact in patterns.** There are predictable patterns of interaction that emerge in a family system. These repetitive cycles help maintain the family’s equilibrium and provide clues to the elements about how they should function.
The Components of Family Systems Theory

• **Have boundaries and can be viewed on a continuum from open to close**. Every system has ways of including and excluding elements so that the line between those within the system and those outside of the system is clear to all. If a family is permeable and vague boundaries it is considered “open.”

• **Open boundary systems allow elements and situations outside the family to influence it.** It may even welcome external influences.

• **Closed boundary systems isolate its members from the environment and seem isolated and self-contained.** No family system is completely closed or completely open.
The Components of Family Systems Theory

- Function by the Composition Law: the Whole is more than the Sum of Its Parts. Every family system, even though it is made up of individual elements, results in an organic whole. Overall family images and themes are reflected in this holistic quality. Unique behaviors may be ascribed to the entire system that does not appropriately describe individual elements.
The Components of Family Systems Theory

- **Use messages and rules to shape members.** Messages and rules are relationships agreements which prescribe and limit a family members’ behavior over time. They are repetitive and redundant. They are rarely, if ever, explicit or written down. They give power; they induce guilt; they control or limit behaviors; and they perpetuate themselves and reproduce. Most messages and rules can be stated in one or a few words. For example, More is good, be responsible, and be Perfect are all examples of messages/rules.
The Components of Family Systems Theory

- **Have subsystems.** Every family system contains a number of small groups usually made up of 2-3 people. The relationships between these people are known as subsystems, coalitions, or alliances. Each subsystem has its own rules, boundaries, and unique characteristics. Membership in subsystems can change over time.
Family Systems Theory

- Views change in terms of the systems of interaction between family members
- Emphasizes family relationships as an important factor in psychological health
- Based on the belief that, regardless of the origin of the problem, and regardless of whether the clients consider it an "individual" or "family" issue, involving families in solutions is often beneficial
Family Systems Theory

• The concept of the family is more commonly defined in terms of strongly supportive, long-term roles and relationships between people who may or may not be related by blood or marriage.

• This approach shunned the traditional focus on individual psychology and historical factors – that involve so-called linear causation and content.
Family Systems Theory
Circular Causality

• Emphasized instead feedback and homeostatic mechanisms and “rules” in here-and-now interactions – so-called circular causation and process – that were thought to maintain or exacerbate problems, whatever the original causes.

• Reciprocal or circular causality - as a relation of mutual dependence, action, or influence of cause and effect
Family Systems Theory
Interactive between cause and effect
Causality is Interactive, not Linear
Family Systems Theory

- Family systems theory a view of the family as a dynamic, interactive unit that undergoes continual evolution in structure and function.
- There are subsystems that are discrete units (such as mother-father, sister-brother, and mother-child) and there is a supra-system (the community).
- The main functions of the family are considered to be support, regulation, nurturance, and socialization; specific aspects of the functions change as the subsystems interact with the supra-system.
Key Concepts

• **Homeostasis (balance)** - The concept of homeostasis means that the family system seeks to maintain its customary organization and functioning over time. It tends to resist change. The family therapist can use the concept of homeostasis to explain why a certain family symptom has surfaced at a given time, why a specific member has become the IP, and what is likely to happen when the family begins to change.
More Key Concepts

• **The extended family** - The extended family field refers to the nuclear family, plus the network of grandparents and other members of the extended family. This concept is used to explain the intergenerational transmission of attitudes, problems, behaviors, and other issues.
More Key Concepts

- **Differentiation**- Differentiation refers to the ability of each family member to maintain his or her own sense of self, while remaining emotionally connected to the family. One mark of a healthy family is its capacity to allow members to differentiate, while family members still feel that they are "members in good standing" of the family.
More Key Concepts

- **Triangular relationships**- Family systems theory maintains that emotional relationships in families are usually triangular. Whenever any two persons in the family system have problems with each other, they will "triangle in" a third member as a way of stabilizing their own relationship. The triangles in a family system usually interlock in a way that maintains family homeostasis. Common family triangles include a child and its parents; two children and one parent; a parent, a child, and a grandparent; three siblings; or, husband, wife, and an in-law.
Systems Theory, Ecology and Case Management

Case Management is:

1. An ecological approach - looking at the ecology of where the person/family is now

2. Human behavior is best explained as a system - focuses on human behavior and experience in complex systems

3. Multidisciplinary approach - one approach involving many disciplines

4. Problem solving – both for the client and the case manager
Ecological

• Examines the context of where the client lives to explain behavior

• Urie Bronfenbrenner
  – Micro system
  – Meso system
  – Exosystem
  – Macrosystem
  – Chronosystem
Systems

- **Microsystem**: Refers to the institutions and groups that most immediately and directly impact the child's development including: family, school, religious institutions, neighborhood, and peers.

- **Mesosystem**: Refers to relations between microsystems or connections between contexts, e.g., school experiences, school experiences to church experiences, and family experiences to peer experiences. For example, children whose parents have rejected them may have difficulty developing positive relations with teachers.

- **Exosystem**: Involves links between a social setting in which the individual does not have an active role and the individual's immediate context.
Systems

- **Macrosystem**: Describes the culture in which individuals live. Cultural contexts include developing and industrialized countries, socioeconomic status, poverty, and ethnicity.

- **Chronosystem**: The patterning of environmental events and transitions over the life course, as well as socio-historical circumstances.
Ecological Design - What Influences Client Behavior

- Wider society
- School and local community
- Family
  - Thoughts and behaviors
  - Organic factors
    - Personal values, beliefs, skills, etc.
  - Internal factors
  - External factors
    - Family values, norms, expectations, etc.
    - School policies, availability of mentors, support services, etc.
    - Culture, media, global economic conditions, etc.
Systems Theory

• Case management relies on systems theory and ST is the overriding theoretical theme

• Basic assumption: People’s behavior and attitudes effects everyone and everything around them

• Not a factor only of the person’s unique psychological or biological makeup

• Solution to anyone’s problem in the context of many different levels on intervention
Multi-Disciplinary Approach
How is Systems Theory Used

Potential assessment areas

• Interventions occur at Three Levels
  – Micro Level
  – Mezzo Level
  – Macro Level

• Interventions occur in two ways
  – Direct Intervention
  – Indirect or Outreach Interventions
  – Pages 12-13
## Intervention Focus Areas

<table>
<thead>
<tr>
<th>Direct Interventions</th>
<th>Micro</th>
<th>Mezzo</th>
<th>Macro</th>
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<td>With Clients</td>
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<tr>
<th>Outreach or Indirect Interventions</th>
<th>On Behalf of Clients</th>
<th>On Behalf of Clients</th>
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- **Direct services** – a direct service with the client at any level - e.g., short term crisis intervention
- **Indirect Services** - resource referral and coordination – assessment, case planning, sanctions, etc. (Most CM occurs here)
The Complex Human Ecology
Other Theories Supporting Case Management

An Eclectic Approach
Maslow’s Hierarchy of Needs

A Theory of Human Motivation
Maslow Hierarchy of Needs

- **Physiological**: breathing, food, water, sex, sleep, homeostasis, excretion
- **Safety**: security of: body, employment, resources, morality, the family, health, property
- **Love/belonging**: friendship, family, sexual intimacy
- **Esteem**: self-esteem, confidence, achievement, respect of others, respect by others
- **Self-actualization**: morality, creativity, spontaneity, problem solving, lack of prejudice, acceptance of facts
Maslow Hierarchy of Needs

A Theory of Human Motivation by Abraham Maslow

• Maslow's hierarchy of needs is often portrayed in the shape of a pyramid, with the largest and most fundamental levels of needs at the bottom, and the need for self-actualization at the top.

• Maslow's theory suggests that the most basic level of needs must be met before the individual will strongly desire (or focus motivation upon) the secondary or higher level needs.
Maslow Hierarchy of Needs
Physiological Needs

• For the most part, **physiological needs** are obvious — they are the literal requirements for human survival. If these requirements are not met, the human body simply cannot continue to function.

• **Air, water, and food** are metabolic requirements for survival in all animals, including humans.

• **Clothing and shelter** provide necessary protection from the elements.
Maslow Hierarchy of Needs
Safety Needs

• With their physical needs relatively satisfied, the individual's safety needs take precedence and dominate behavior.

• Safety and Security needs include:
  – Personal security
  – Financial security
  – Health and well-being

• Safety net against accidents/illness and their adverse impacts
Maslow Hierarchy of Needs
Safety Needs

• With their physical needs relatively satisfied, the individual's safety needs take precedence and dominate behavior.

• In the absence of physical safety -- due to terrorist attack, war, natural disaster, or, in cases of family violence, childhood abuse, etc. -- people (re-)experience post-traumatic stress disorder and trans-generational trauma transfer.

• In the absence of economic safety -- due to economic crisis and lack of work opportunities - these safety needs manifest themselves in such things as a preference for job security, grievance procedures for protecting the individual from unilateral authority, savings accounts, insurance policies, reasonable disability accommodations, and the like.
Maslow Hierarchy of Needs
Love and Belonging

- After physiological and safety needs are fulfilled, the third layer of human needs are social and involve feelings of belongingness. The need is especially strong in childhood and can over-ride the need for safety as witnessed in children who cling to abusive parents. Deficiencies with respect to this aspect of Maslow's hierarchy - due to hospitalization, neglect, shunning, ostracism etc. - can impact individual's ability to form and maintain emotionally significant relationships in general, such as:
  - Friendship
  - Intimacy
  - Family
Maslow Hierarchy of Needs
Love and Belonging

- Humans need to feel a sense of belonging and acceptance, whether it comes from a large social group, such as clubs, office culture, religious groups, professional organizations, sports teams, gangs, or small social connections (family members, intimate partners, mentors, close colleagues, confidants).
- They need to love and be loved (sexually and non-sexually) by others.
- In the absence of these elements, many people become susceptible to loneliness, social anxiety, and clinical depression.
- This need for belonging can often overcome the physiological and security needs, depending on the strength of the peer pressure; an anorexic, for example, may ignore the need to eat and the security of health for a feeling of control and belonging.
Maslow Hierarchy of Needs
Esteem

• All humans have a need to be respected and to have self-esteem and self-respect.
• Esteem presents the normal human desire to be accepted and valued by others.
• People need to engage themselves to gain recognition and have an activity or activities that give the person a sense of contribution, to feel self-valued, be it in a profession or hobby. Imbalances at this level can result in low self-esteem or an inferiority complex.
• Maslow noted two versions of esteem needs, a lower one and a higher one.
• The lower one is the need for the respect of others, the need for status, recognition, fame, prestige, and attention.
Maslow Hierarchy of Needs
Esteem

- The higher one is the need for self-respect, the need for strength, competence, mastery, self-confidence, independence and freedom.

- Maslow states that even though these are examples of how the quest for knowledge is separate from basic needs he warns that these “two hierarchies are interrelated rather than sharply separated”
Maslow Hierarchy of Needs
Self-Actualization

“What a man can be, he must be.”

• This level of need pertains to what a person's full potential is and realizing that potential. Maslow describes this desire as the desire to become more and more what one is, to become everything that one is capable of becoming.

• This is a broad definition of the need for self-actualization, but when applied to individuals the need is specific. For example one individual may have the strong desire to become an ideal parent, in another it may be expressed athletically, and in another it may be expressed in painting, pictures, or inventions.
Maslow Hierarchy of Needs  
Self-Actualization

- As mentioned before, in order to reach a clear understanding of this level of need one must first not only achieve the previous needs, physiological, safety, love, and esteem, but master these needs.
Question for Short Discussion

Assuming that the Hierarchy of Needs is an accurate portrayal of human motivation-

• **Where do most of our clients live and how does case management get them up the ladder?**

• **What things influence keeping clients stuck?**
Operant Conditioning

Focus on Thinking
Definition of Operant Conditioning

• Learning through positive and negative reinforcement: a form of learning that takes place when an instance of spontaneous behavior is either reinforced by a reward or discouraged by punishment.
Operant Conditioning

- Reinforcement is a consequence that causes a behavior to occur with greater frequency.
- Punishment is a consequence that causes a behavior to occur with less frequency.
- Extinction is the lack of any consequence following a behavior. When a behavior is inconsequential (i.e., producing neither favorable nor unfavorable consequences) it will occur with less frequency.
- When a previously reinforced behavior is no longer reinforced with either positive or negative reinforcement, it leads to a decline in that behavior.
Operant Conditioning

• A particular act results in an experience that is a consequence of that act, and

• The perceived quality of an act's consequence affects future behavior
  – Reinforce the behavior you seek- positive reinforcement
  – Extinguish the behavior that is undesirable
Operant Conditioning (Learning)

- You are adding something
  - Positive Reinforcement
  - Positive Punishment
- You are removing (withholding) something
  - Negative Reinforcement
  - Negative Punishment
- Extinction

Particular behavior is more likely to occur in the future
Particular behavior is less likely to occur in the future
Particular behavior doesn’t receive any reinforcement therefore it extinguishes
How is this Theory Relevant

• Case Management is a problem solving and skill building method for clients

• Case Managers are attempting to change client behaviors, attitudes and patterns

• Reinforce the behaviors that are desirable and extinguish behaviors that are not desirable
Overview of Case Management
The Circle of Life (for the Case Manager)
Major Case Management Functions

1. Outreach to or identification of clients
2. Assessment of Needs
3. Service or Treatment Case Planning
4. Linking or referring clients to appropriate resources
5. Monitoring cases to ensure that services are delivered or used

• See Page 14 of text more for detail on functions
Case Management Tasks

1. Access to agency
2. Intake
3. Assessment
4. Goal setting
5. Intervention planning
6. Resource identification and indexing
7. Formal linkages to agencies and programs
8. Formal linkages to family and social network
9. Monitoring
10. Reassessment
11. Outcome evaluation

Refer to Pages 16-18 of the text that lists the major tasks of CM.
The Process of Case Management

The goal of case management are two-fold:
1. Help people connect to the personal, interpersonal and community resources that will help them resolve their problems
2. Teach them to be their own case manager- to identify their needs and solve their own problems

The process teaches the client how to solve problems
Eight Steps in the Case Management Process

1. Define the problem
2. Determine the severity of the problem
3. Developing hypotheses concerning *why* the problems are occurring
4. Establishing goals
5. Developing and implementing a service intervention plan
6. Evaluating the success of service intervention
7. Termination
8. Follow Up

*Pages 21-30 explain each step*
Define the problem

• Information gathering
• Systematic find out relevant to problem solving
• Look at Three levels- Micro, mezzo and macro
• Problem (presenting issue) that brought client to the agency
• Systems approach- every problem in life are connected to other problems and issues- tip of the iceberg
• Clients have their own sense of their problems

Every Human Behavior serves a purpose and a function
Determining the Severity of the Problem

• Remember that problems are interconnected (like symptoms)
• Case managers must take into consideration the opinions of their clients
• Use of rating tools such as risk assessment tools are often very helpful
• Sample rating tool
Hypotheses Testing and Case Management

I'm always wrong about everything. What can I do to fix that?

DILBERT: © Scott Adams/Dist. by United Feature Syndicate, Inc.
Definition of Hypotheses

• A tentative explanation for an observation, phenomenon, or scientific problem that can be tested by further investigation.
• Something taken to be true for the purpose of argument or investigation; an assumption.
• A suggested explanation for a group of facts or phenomena, either accepted as a basis for further verification (working hypothesis) or accepted as likely to be true.
Hypotheses Diagram

Induction

Hypotheses

Deduction

Test of Predictions

Observation

Predictions

by Experiment-Resources.com
Developing Hypotheses Why Client Problems Are Occurring

- **Assessment** of controlling conditions
- Various theories and approaches (P. 23)
- Systems theory- understanding the interplay of forces from micro to macro and how they effect your client
- Individual roles, family dynamics, community environment, social environment
Developing Hypotheses Why Client Problems Are Occurring

• What approaches have been already tried and where they successful?
• Community and family resources- social capital
• Family strengths
• Family weaknesses or issues
• Cultural issues
Developing Hypotheses Why Client Problems Are Occurring

• A good assessment leads to good hypotheses- what is causing the problem and how do you resolve it- leads to concrete solutions

• Basic needs to short needs to long term solutions

• Develop a hypotheses of WHY the behavior is occurring, what keeps reinforcing the behavior and how to resolve the situation
Hypotheses Testing and Case Planning

Diagram showing the cycle of hypotheses testing, including:
- Induction
- Deduction
- Observation
- Test of Predictions
- Predictions

Another diagram illustrates the process:
- Define problem/issue
- Collect relevant data
- Develop alternative solutions
- Implement solution
- Select optimum solution
- Assess consequences
- Measure results
Setting Goals for Case Management

- Immediate
- Intermediate
- Long Term

Do's and Don'ts of Goal Setting
Establishing goals

- Goal setting is very important
- “A goal is a statement defining the expected outcomes for each client by the time case management services are terminated.”
- Time framed
  - Immediate
  - Intermediate
  - Long Term
Problem Solving and Goal Setting

1. What behaviors are expected of the client?
2. What community agencies will the client be utilizing?
3. What social, economic, medical, or educational support services is the client expected to use?
4. What community/neighborhood support systems is the client likely to be involved in?
5. What self-initiated problem solving skills are expected of the client?
Goal Setting

- Goals must be realistic and achievable
- Goals must call for client to accept responsibility
- Established with the client, not for the client
- Clients should be involved at all stages of goal setting but this is not always the case especially when services are mandated or where clients do not cooperate – and depends on the severity of the problem
- Vision and hope
Service Planning

• By the completion of the first four steps the types of service intervention should be clear

• Micro and macro levels of planning
  1. Direct intervention
  2. Responsiveness of agency
  3. Community intervention to pave way for clients
Evaluation

• Evaluate the effectiveness of the case plan at various times- in fact it should be an ongoing activity

• Service delivery is NOT an effective way of measuring success- at the very least it just means going through the motions
Evaluation

- Goal attainment- goals must lend themselves to evaluation
- Reduced or alleviated conditions
- Reduced risk
- Problem- high caseloads
- Assessment scales
Termination

- Clients have reached their goals
- Clients have demonstrated they can self-manage their own movement to goals
- Clients are successfully working with other agencies
- Risks have been reduced or eliminated
- Some clients leave because they have reached their time limits with the agency (TANF)
Follow Up

• Often this phase is neglected
• Contact client to see if more follow up is needed
• It is valuable and can be proactive
Another Way of Looking at the Process

- Agency Purpose and Mission
- Risk Assessment
- Assess conditions and review strategies
- Selection of Strategies
- Implement and monitor
- Reassess Risk and Strategies
- Do it all over until situation resolved
The Circle of Life (for the Case Manager)

Clearing
↓
Intake

Evaluation

Assessment

Case Management

Monitoring

Re-Assessment

Planning

Intervention
Use GAP Analysis To See If Change Is Needed: Nothing is Ever Perfect

RESOLUTIONS? ME??
JUST WHAT ARE YOU IMPLYING? THAT I NEED TO CHANGE?? WELL, BUDDY, AS FAR AS I'M CONCERNED, I'M PERFECT THE WAY I AM!
Identifying What Needs to be Done

A. Current Situation

C. Action Required

B. Challenge or Goal
The Role of Case Manager
The Role of the Case Manager

1. Direct Personal Support (P. 32)
2. Crisis Intervention (P. 34)
3. Short-term Treatment Intervention (P. 36)
4. Broker/Facilitator (P. 37)
5. Enabler/Teacher/Mediator (P. 40)
6. Advocate (P. 41)
7. Service Coordinator (P. 43)
   • Tracking/Follow Up Role (P. 44)
   • Oversight and Purchase of Services Coordinator (P. 46)
Example of Case Management

Chapter 4
Assessment and Service Planning
Levels

- Micro Level
- Mezzo Level
- Macro Level
Case Management Skills

The Essential Tools of the Trade

Chapter 5
Interpersonal, Connecting and Information-Gathering Skills

• First Impressions and Diversity Issues (P. 63-65)
• Basic Interviewing Skills (P.65-66)
• Attending to Personal Issues and Commonalties (P. 66-68)
• Active Listening (P. 68-71)
• Focusing and Furthering (P. 71-73)
• Summarizing P. 72
• Empathy, Praise and Support (P. 73-76)
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- Negotiate Boundaries
- Making An Offer
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- Maximize Similarities And Minimize Differences
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Chapter 9: Case Management

Challenges and Vision
Overcoming the Sisyphus Complex

- Setting up to fail is a psychological manipulation performed on a target in which the target is given a task which is designed to fail as it has an unrealistic objective - "the setting of impossible objectives... set up to fail".
- The target will become stressed trying to achieve the impossible, particularly if under pressure.
- Once the task attempt has failed, the outcome can then be used as ammunition to discredit and blame the target.
Overcoming the Sisyphus Complex

• Lend a positive vision
• Create hope for change
• Make the tasks into “baby steps” so the client can achieve success and build positive momentum
• Set realistic goals for the client and keep them involved
Integrated Case Management and Case Planning

The intermixing of disciplines previously segregated
Integrated Case Management

What is it and how is it different
Integrated Case Management (ICM)

• Definitions
  – Integrated: combining or coordinating separate elements so as to provide a harmonious, interrelated whole: an integrated plot; an integrated course of study; organized or structured so that constituent units function cooperatively: an integrated economy.
Integrated Case Management (ICM)

• Definitions (cont’d)
  – Case Management: Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual’s and family’s comprehensive needs through communication and available resources to promote quality cost-effective outcomes.
Integrated Case Management Definition

- **Integrated Case Management (ICM)** is a family-focused, strength-based program that uses an independent facilitator to bring all relevant people, including providers, family and natural supports, to the table. This team then works in partnership with the family to create a safety-based comprehensive plan addressing the needs of all family members. This model is most useful when the families being served are involved with numerous systems.
ICM Principles

- **Client-Centered Service**: putting clients at the center of all service planning and practice. That means supporting clients to identify and achieve their own goals, and direct their own lives to the greatest extent possible. and adapt services to fit client needs, rather than to expect clients to adapt to administrative or service structures.

- **Building on Strengths**: identify the strengths and successes of the clients which may often be the foundations for far more lasting changes in their lives. In addition, a positive approach makes it far easier for clients to stay committed and the team to be collaborative.
ICM Principles (Continued)

- **Advocacy** - Integrated case management provides clients with the opportunity to participate in decisions that affect their lives. They may find it difficult, however, to attend meetings on their own and to speak for themselves.

- **Recognizing Diversity** - the integrated case management team needs to respect and respond to the social, cultural and economic factors that shape clients' perceptions, experiences and need for service.
ICM Principles (Continued)

• **Collaboration**- Integrated case management brings together the varied disciplines, talents, perspectives, knowledge and experience of a broad range of people, including clients, and encourages them to share their individual skills, knowledge and expertise with each other.

• **Mutual Respect**- It is essential that team members show their respect for clients. Likewise, they must show respect for one another’s knowledge, skills, experience and perspective, regardless of age, level of training, position, job classification, particular discipline, or the ministry or agency represented.
ICM Principles (continued)

- **Participation**- Team members need to participate fully in the activities of the team. At the outset, full participation may involve a significant investment of time as team members become familiar with one another and the process. As time goes on, however, they will find that this initial investment is likely both to save time for all team members and to improve outcomes for clients.
ICM Principles (continued)

• **Accountability**- Clients must be informed to the greatest extent possible of all activities that might affect them, and integrated case management activities must be recorded. The review of this documentation will allow us to enhance our practice and to better understand what approaches work best with which clients.

• **A Holistic Approach**- Integrated case management should provide for a complete understanding of the various aspects of clients’ circumstances and needs, including family considerations, and the development of a case plan broad enough to meet those needs.
ICM Principles (continued)

- **Continuity**- Clients need continuity in the services they receive—not only in how the services relate to each other, but also in how the services develop over time. To ensure continuity, during clients’ involvement with the program, every effort should be made to ensure that at least one member of the integrated case management team be constant from the beginning to the end of the process.

- **Planning for Transitions**- Integrated case management teams should take special care to anticipate and plan for transitions in the lives of clients—for example, changing schools or foster homes, moving from childhood to adolescence, and changes in family structure.
ICM Principles (continued)

- **Least Intrusive and Intensive Intervention** - integrated case management complements the promotion, prevention and early supports strategy, which is aimed at providing appropriate interventions and support to children, youth and families before difficulties develop into crises. While it is clear that appropriate supports are necessary when clients encounter difficulties, it is important to minimize the number, intensity, duration and restrictiveness of the interventions in order to acknowledge and build on the strength and independence of the families.
Philosophy

Case Management provides an organized, structured process for moving participants through the process of change and toward the goal of self-sufficiency.
ICM Beliefs

• Case Management is a participant centered rather than a program centered approach. It starts with the participant and uses the program’s resources to try to help each person achieve his or her goals.

• Participants are capable of taking more control of their lives. They are capable of solving problems, making decisions, and setting goals. Case management should not do for people what they can do for themselves.
ICM Beliefs (Continued)

- Participants have strengths and resources as well as problems and challenges. Case Management attempts to enable participants to use their strengths and resources to overcome their problems and challenges.
- The Case Management process should be a shared partnership between the participant and Case Manager. Although each partner brings different skills, experiences and expertise, they share in the responsibility for producing change.
ICM Beliefs (Continued)

• Participants should be actively involved in all phases of the process-assessment, planning, problem solving, and finding resources. Case Management seeks to have an active participant and not a passive one.

• Participants are responsible for the outcome. The Case manager is responsible for the process. Participants are ultimately responsible for making change happen. We cannot force change on them. Instead, the Case Management process attempts to influence change.
Case Management Process

Case Finding → Assessment → Planning → Action → Monitoring → Assessment
The Underlying Tasks of Case Management

- Assessment of need
- Case planning
- Implementation
- Regular review (Monitoring)
- Evaluation and Re-assessment
Case Plan Process Flow

1. Strengths and Risk Assessment is Completed

2. Based on the needs identified during the Strengths and Risk Assessment a Case Plan is created. Birth family, kin, caregiver and other team members participate in the plan development.

3. Services are delivered in accordance with the case plan

4. Case Plan review —assesses if the services are meeting the needs of the child and family. Review SRA.

5. Modification of Service Plan to better meet child and family needs

6. Case Plan Review—assess if the services are meeting the needs of the child and family. Review SRA.

Continual Assessment

Assessment, Case Planning and Case Review Process
Advantages

• This approach helps participants see the connection between the goals they set for themselves and their participation in activities.
• Create higher success rates, particularly among those who have had difficulty taking part under previous “compliance model”.
• It encourages a team approach to solve issues.
• Increases communication.
ICM Teamwork

This section describes the roles and responsibilities of members of an integrated case management team.
ICM Teamwork

• As a team, all members need to work together to:
  – organize meetings,
  – identify team member roles,
  – develop a case plan,
  – review the plan regularly,
  – maintain contact between the team and external referrals
  – determine a process for conflict resolution or mediation when necessary,
  – compile, distribute and maintain meeting records,
  – close or transfer the case and
  – evaluate their work
ICM Teamwork- Staff

• In carrying on team activities, it is important for all members to focus on:
  – the shared goals and outcomes of the integrated case management process.
  – Team member’s individual knowledge, skills and expertise will contribute to realizing those goals and outcomes
  – Focus is on creating relationships and processes in which all team members—particularly clients—can make important contributions over time.
ICM Teamwork- Clients as Experts

- Clients are the most important members of an integrated case management team. While other team members may be the experts about programs and services, the clients are the experts about themselves. They are the people who have the day-to-day experience of how the case plan is working. They are also the people who will know whether the coordination is effective or not. Their feedback and suggestions are essential to the successful functioning of an integrated case management team.
ICM Teamwork- Clients as Team Members

• Whenever possible, clients should be part of the team, though there are some circumstances when this would not be appropriate. Some reasons why the clients would not be team members are as follows:
  – the client may not wish to be part of the team;
  – the client may be dealing with numerous stresses and this would add to the burden;
  – there may be more than one client, with diverse interests, or with very strained relationships so that it would be difficult to develop a case plan;
  – if one or more of the clients are children or youth, their age and developmental capacity.
ICM Teamwork- Clients as Team Members

• When clients are part of the team, they may be supported to become the integrated case manager. If the team sees the role of the integrated case manager as administrative, it does not require professional expertise or training and may be quite suitable for a parent or older youth. At the beginning, clients may find many of the integrated case manager’s duties overwhelming. If this happens, clients can share the role with one of the other team members, taking on more responsibilities as they feel comfortable in doing so.
ICM Teamwork- Service Partners

- Service Partners or providers may include a variety of agencies:
  - Indian Health Services or medical providers
  - Child Welfare Services
  - Substance Abuse Treatment or Prevention
  - Schools and educational facilities
  - Child care
  - Probation
  - Employment Service providers
ICM Teamwork- Service Partners

- A variety of service providers may be represented on integrated case management teams. All service providers on the team should have a general knowledge of the programs (and of where to acquire information if such knowledge is lacking), as well as specialized knowledge of their own area of expertise.
ICM Teamwork- Service Partners

• Frequently, however, staff from other agencies and staff from contracted agencies (e.g., community agencies, school districts, health authorities) will be involved as well. In addition to their own skills and knowledge, these team members can contribute knowledge of, and access to, the policies and programs of their respective agencies.
ICM Teamwork- Service Partners

- Community agencies provide a range of valuable services to clients, including specialized professional services (for example, a family services agency or a hospital) and more general, non-professional services (for example, Big Brothers).
- Depending on the nature of the services they provide, community representatives may contribute professional knowledge and skills as well as a good understanding of community needs and resources.
The duties of a supportive integrated case manager would include the administrative responsibilities as well as:

- staying in contact with the clients between team meetings,
- reviewing the progress of the case plan from the clients’ perspective,
- serving as primary support to the clients in accessing services and
- maintaining connections with other team members as the case plan is implemented
Duties of Integrated Case Manager

• The integrated case manager may share decision-making equally with all other team members: the role does not confer authority on the individual who holds it.

• At all stages of integrated case management, team members retain the responsibility for managing their own specific involvement with the clients, including the responsibility for decision-making related to their statutory authority.
ICM Case Management

- Remember to focus on strengths
- Consider all aspects of a family’s status
- Build a consistent case plan
- Reduce duplication in the development of plans of care created for other purposes
- Evaluate integrated case management on a regular basis
ICM Case Planning Process

• For each area of consideration, the integrated case management team will use a planning process to develop and document a case plan. The planning process requires the team to:
  – collect information about strengths and weaknesses,
  – establish priorities
  – identify desired outcomes or goals
  – develop actions or strategies
  – assign responsibilities and timelines
  – regularly review and adapt the plan, and evaluate the plan
Gathering Information- Assessment

• Assessment is to gather and pool information about the clients’ strengths and concerns.
  – The purpose of this activity is to build a complete picture of the clients’ situation at the beginning of the integrated case management process and to provide a foundation for the development of a case plan.
  – Collect information about both the strengths (sometimes called protective factors) and the concerns (sometimes called risk factors).
Gathering Information - Assessment (Continued)

• This part of the process is important because often we seem to end up focusing on clients’ problems, when in fact it is more effective to focus on their strengths and to assist them to build resilience.

• Resilience has been defined as the ability to recover from or adjust easily to misfortune, challenge or change.

• In many areas, of course, the clients themselves will be in the best position to provide information.
SOAP Documentation - the Medical Model

Subjective, Objective, Assessment, Planning
Subjective

• Subjective: Record the subjective information --- the "S" in SOAP --- to document symptoms and complaints as reported by the patient in her own words. Include symptom examples, such as pain, vomiting and diarrhea. Document the frequency, onset, location and duration of symptoms.
Objective

- Objective: Take measurements and vitals, such as oxygen saturation, blood pressure and pulse to document objective information. This is the "O" in SOAP. Include measurable signs, such as lab test results, vitals, weight and height, in the objective data section.

- Perform a head-to-toe clinical exam of the patient's body's systems to rule out various diagnoses. Document exam findings in the "O" section.
Assessment

• Assessment: Offer a nursing diagnosis in the "A" or assessment section, which includes both subjective and objective information. Confirm and synthesize subjective and objective notes to create assessment data. Record a nursing diagnosis, such as "at risk for a sexually transmitted infection," in this section.

• Record, for example, "patient complains of shortness of breath" in the subjective section. Document "patient is wheezing in left and right upper lobes upon auscultation" in the objective section after performing a clinical exam. Record "patient is short of breath" in the assessment section as confirmation of data reported in the subjective and objective sections.
Planning

• Plan: Document the "P," which is the "plan" of treatment, last. Record long and short-term treatment actions, such as "antibiotic therapy," "follow-up X-ray in three weeks," "patient education about Foley catheter insertion" or "physical therapy consult."

• Include relief measures or actions that worsen the patient's symptoms. Provide an evaluation of the success or failure of treatment interventions.
Developing an Integrated Service Plan

• Once the ICW has gathered sufficient information regarding the clients’ current situation, members can work together to build an integrated service plan.
• At this level the ICW will identify priorities in case planning.
• In most complex cases, there are many areas that could be addressed, but to try to do all at once would be unrealistic and discouraging.
• It is essential at this stage of the process to plan for success.
Developing an Integrated Service Plan

• Some suggestions that will contribute to the successful selection of priorities are as follows:
  – encourage the clients to identify their priorities,
  – choose areas as priorities that are less complex rather than more complex,
  – choose areas where there is likely to be general agreement about the desired outcomes or goals,
  – choose areas where an immediate impact is likely to be felt, and
  – choose areas that will support the long term self-sufficiency of the family
Integrated Case Plan

The next step is to describe desired outcomes or goals for each of the selected priority areas of focus.
Integrating Effective Outcomes

• Outcomes should reflect the priorities of the clients, and the perspectives of team members:
  – The outcomes should describe a desirable and measurable future condition relating to the clients’ self-sufficiency or well-being.
  – Once the measurable outcomes are developed, they can begin to identify specific strategies or activities for each of the priorities, and identify the people who will be responsible, as well as timelines.
Integrating Effective Outcomes

• It is important that the service plan incorporate any individual case planning that has already happened between the clients and service providers. In the simplest case, team members will already have worked with clients to develop outcomes and services.

• The integrated case management activities will simply ensure that all members are aware of one another’s planning and provide opportunities to improve the coordination of services.
Effective Service Plans

• Service plans will be most effective if they are developed following the principles of integrated case management, and when outcomes and associated activities are:
  – Concrete and measurable
  – Clearly related to the strengths and concerns already identified
  – Focused on the best interests of the clients
Staying Connected: Reviewing the Plan

• Set a date to review the plan and agree on how often meetings may be required.
• At a minimum we recommend monthly case plan reviews
• Intensive case management practice may require more frequent meetings (when the risk factors are high, there is a history of noncompliance, or the issues are pressing
Case Plan Review

• In deciding how often the case plan should be reviewed with the client you should consider:
  – Wishes of the clients – The clients may have the best sense of “how things are going.”
  – Stage of planning – In the early phases of implementing a plan, more frequent meetings can help ensure the plan is working. In later stages, fewer meetings may be required.
  – Life circumstances – Stressful circumstances in the lives of clients may render them more vulnerable: team meetings can help provide the necessary support.
Case Plan Review (Continued)

• **Setbacks** – When people are working to achieve improved outcomes in their lives, progress is often inconsistent, and setbacks can be expected. Team meetings can assist everyone to see the setbacks not as failures but as part of a natural learning and growth process.

• **Milestones** – The beginning of school, summer vacation, Christmas, growth stages, and other milestones can also be vulnerable times and should be considered in the timing of meetings.
Case Plan Review (Continued)

• **Requirements of standards** – For instance, when the client is a child in care, standards require review at least every six months or if policy requires more frequent reviews.

• **Changes in the family** – the needs of the clients as well as with the planning process.
Team Reviews

• Integrated case management requires all team members to stay connected on a regular basis to review the progress of a plan – and, unfortunately, it is this ongoing contact that is the easiest to “let slip.” Regular team meetings:
  – Help keep all team members informed,
  – Provide opportunities to measure progress,
  – Review issues of confidentiality,
  – Allow team members to change the plan when it is not working,
  – Allow team members to change the plan to respond to new circumstances and
  – Help prevent crises in the lives of the clients,
Case Reviews Questions

• At this stage, ask yourself:
  – Does the plan reflect the current situation of the clients?
  – Does the team take time to celebrate and document the successes of the clients (and the plan), as well as address areas of continuing concern?
  – Do the clients understand the process that will be used to monitor and evaluate the plan over time?
  – Are the clients actively involved in developing, monitoring and evaluating the plan?
  – Have updated plans been shared with all team members?
  – Have you reviewed the role of the integrated case manager of your team? For example, are the clients now in a position to take on more responsibility for this role?
  – Are the team processes and team membership stable enough to ensure a sense of continuity for the clients?
Evaluating the Case Plan

• In order for the learning process of integrated case management to be complete, it is important that all team members evaluate the process they have shared, from their own perspectives.

• Clients have particularly important contributions to make in evaluating the effectiveness of the integrated case management plan.
Evaluating the Case Plan

• “Was the case plan implemented?” or, “Did we do what we said we would do?” This question allows the team to document whether or not the case plan was put into effect.

• If the answer is no, the effectiveness of the plan cannot really be evaluated, and the reasons for the lack of implementation success need to be examined and addressed.

• If the answer is yes, the second question is, “Was the case plan effective?” or “Did we get what we wanted?”

• In considering the effectiveness of the plan, team members should refer to the goals and activities that were developed over the course of the plan’s implementation.
Client Involvement- an Essential Component

• The involvement of clients is an essential element of integrated case management.

• Clients’ degree of involvement in the process may range from being informed of integrated case management activities undertaken on their behalf, to participation in case conferences and meetings, to coordinating their own case by serving as their own case manager.
Client Involvement- an Essential Component

• In the best of circumstances, case management is a natural part of day-to-day living.
  – For example, parents, in their capacity as “case managers,” plan a range of coordinated “services” to meet their children’s typical and special needs, such as daily care and communication; regular visits to the doctor and dentist; participation in social and recreational activities; school attendance; adaptation of home or school environments to protect a child with allergies; or providing challenges for a child with unusual strengths.
Client Involvement- an Essential Component

- Most people are fortunate in having relatively few sources of severe stress in their lives and adequate sources of support in their homes and communities.
- These people, in managing their own lives or in parenting their children, informally engage in case management. Some people, however, have many sources of stress and few supportive resources.
Client Involvement- an Essential Component

- When seen in this light, it is clear why the involvement of clients is at the heart of integrated case management—clients are already involved.
- Where they may need assistance is in accessing and coordinating interventions and supports or in strengthening a process that has faltered or broken down.
Client Involvement- an Essential Component

• The integrated case management team should therefore support clients to be as fully involved as possible, including acting as the integrated case manager.

• In some situations, this may not be possible right away: clients may have very complex needs, may be experiencing extreme stress, or may not yet have the skills to assume this role.
Client Involvement - an Essential Component

• In determining the level of involvement of clients, team members should consider a variety of factors in their lives and in the development of the integrated case management team.

• In general, the simpler the circumstances, and the more resilient the clients, the more likely they are to be satisfied and successful case managers.
Factors to Consider

• **Factors relating to children or youth**
  – Number of special needs
  – Complexity of needs
  – Duration of needs
  – Age of child or youth
  – Personal strengths of child or youth
  – Ability to understand the process
  – Willingness to engage in integrated case management
  – Relationship between the child or youth and family
  – Legal status
  – Cultural differences
Factors to Consider

• **Factors relating to single adults, parents or caregivers**
  – Existence of other stressors (e.g., unemployment, illness in caregiver or significant others, learning about and dealing with grief about a child’s disability)
  – Previous experience
  – Personal strengths
  – Ability to understand the process
  – Willingness to engage in integrated case management
  – Support of extended family members and community
  – Cultural differences
Factors to Consider

• **Factors relating to the integrated case management team**
  – Number of people on the team
  – Previous experience of team members
  – Relationships of team members with child and family
  – Level of confidence in clients as integrated case manager
  – Level of trust among team members
  – Willingness to engage in integrated case management
  – Support of extended family members and community
  – Cultural differences
Some strategies that may promote the involvement of clients

- Involve clients from the earliest stages of decision-making.
- Encourage the clients to bring an advocate if they feel it would be helpful.
- Provide adequate time to respond to issues and concerns.
- Have one of the team members do some “briefing” and “debriefing” with clients before and after the meeting.
- Select as integrated case manager a person with whom the clients have an open and reasonably trusting relationship.
Some strategies that may promote the involvement of clients

- Deal with some of the least contentious issues first.
- Keep the meeting focused on the case plan and the discussion practical and concrete.
- Gradually increase the involvement of clients as they are ready to take on more responsibility.
- Encourage clients to formulate agenda items and choose advocates and support persons.
- Provide funding for transportation and childcare to facilitate the participation of clients.
- Consider client work schedules and demands in planning time of meetings.
Something to Remember

• Everyone involved should remember that integrated case management is a learning situation—certainly for clients and often for other team members—and should be carried out in an environment that transforms mistakes into learning experiences.

• The practice of involving clients in team case management and as integrated case managers will enable them to acquire the skills, independence and confidence to manage their own circumstances.
Developing an Effective Case Plan

Assisting the Participant Move from Welfare to Self-Sufficiency
1. Strengths and Risk Assessment is completed.

2. Based on the needs identified during the Strengths and Risk Assessment a Case Plan is created. Birth family, kin, caregiver and other team members participate in the plan development.

3. Services are delivered in accordance with the case plan.

4. Case Plan review-assesses if the services are meeting the needs of the child and family. Review SRA.

5. Modification of Service Plan to better meet child and family needs.

6. Case Plan Review-assess if the services are meeting the needs of the child and family. Review SRA.

Continual Assessment

Assessment, Case Planning and Case Review Process
Definition of a Case Plan

- Case management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s (or families) holistic needs through communication and available resources to promote quality cost effective outcomes. - Definition from Case Management Society of America

- A Case Plan studies the identified needs, identifies strengths and weaknesses, and develops a plan to ameliorate the identified needs of the family based upon specific goals, objectives, activities and outcomes tailored to the family's choices.
So What is a Case Plan?

• **A case plan is a well-informed hypothesis.** We believe by providing a specific array of services that a family’s functioning and ability to care for their children will improve.

• **Hypothesis:** A supposition or proposed explanation made on the basis of limited evidence as a starting point for further investigation.; A proposition made as a basis for reasoning, without any assumption of its truth
So What is a Case Plan?

- Providing services tests that hypothesis
- The reality may be that the service providers are not engaging the family in the process, or the services are not addressing the immediate needs of the family, or are lacking in quality.
- Caseworkers and families need to be good consumers of services and be active partners in evaluating service efficacy.
So What is a Case Plan?

Finally, the family’s needs for services and supports change over time. The more relevant the services are to the family’s actual needs, the more likely they will be to use the services.
Paradigm Shift

• Old model is a “Compliance Model”
• New Model is the Strength Based Model
So What does Case Management Do?

Case Management provides an organized, structured process for moving participants through the process of change and toward the goal of self-sufficiency
Beliefs

• Case Management is a participant centered rather than a program centered approach.

• Participants are capable of taking more control of their lives.

• Participants have strengths and resources as well as problems and challenges.
Beliefs

• The Case Management process should be a **shared partnership** between the participant and **Case Manager**.

• Participants should be **actively involved** in all phases of the process assessment, planning, problem solving, and finding resources.
More Beliefs

• Participants are responsible for the outcome. The Case manager is responsible for the process. Participants are ultimately responsible for making change happen. We cannot force change on them. Instead, the Case Management process attempts to influence change.
So What’s the Difference?

• Client Based, Strength Based Case Management (New Muscle)
• Compliance Based Case Management (Old Muscle)
Old Muscle

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# New Muscle

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Deficit-Based Approaches

- Prescriptive
- Treatment is “taking over” or “rescuing”
- Interprets Client behaviors as pejorative
- Approach shifts from client to practitioner
- Labels and sub-labels are used to describe clients
- Client’s ways are backward, unsophisticated, incorrect
- Interventions are seen as necessary for client’s own Good
- Effort to address practitioner emotional states over client needs
- Confronting is seen as an intervention based on authority of the practitioner over the client
Deficit-Based (Institutional Memory)

- Prescribed Goals and Objectives
- Encounters are cumulative and general
- Time frames are subjective
- Consumer must accept expert advise
- Consumer must match expectations of system
- Confront Resistance
  - Guardianship
  - Consequences
  - More Restrictive
  - Seclusion and Restraint
  - Behavior Management Committee
Absent From Deficit-Based

- Autonomy and Self Governance
- Right of Choice and Control
- Lifestyle Choices
- Medication Choices
- Relationships
- Hygiene
- Income
- Activities
Family Centered Approach

• Family engagement and the perception the family has of the caseworker’s desire to hear their thoughts and ideas has a direct relationship to the family’s success in carrying out the action steps within the plan.
• Plans that are crafted in the office and brought to the family are less successful in achieving outcomes, than plans crafted with the family—from start to finish.
• Sometimes caseworkers try to save time by drafting the plan first, and then taking it to the family for their review and modification. It is critical for caseworkers to understand that the power imbalance that is inherent in the system minimizes the family’s ability to provide feedback to a previously drafted plan—even in “draft form.”
• The family must be actively involved from the very beginning in identifying how their needs will be met through the case plan.
Some Considerations

- Sometimes it is important that the Caseworker encourage the family to invite individuals to the case planning meeting who the parents and child trusts.
- Families involved in the system frequently feel intimidated and uncertain about how much they have the right to “speak up and disagree with the plan.
- By having extended family or individuals who have a strong relationship with the parents in attendance, the parents have an advocate and another person to help voice their concerns and needs.
Developing the Case Plan Which way should we go?
The Circle of Case Planning

ASSESS \rightarrow PLAN

REVIEW \rightarrow IMPLEMENT
Case Plan Development

• Case plans are individualized and developed with the client. The plan is intended to build on client strengths, resources and goals.
• Plans should be realistic and achievable.
• Case plans include activities that will support the client in meeting their goals, that will reduce or eliminate barriers to self-sufficiency (including modifications or accommodations) and that promote family stability.
• The case plan includes support services which will be provided to support successful completion of the plan.
Case Plan Expectations

- Case plans are individualized and mutually developed with the client.
- Clients are informed about their rights to mutually develop plans, choose whether or not to release information and decide if individuals outside of the benefit group are included in the planning process.
- Case plans are developed and monitored jointly with partners involved with the family; client information can be shared if they have agreed and signed a release.
Case Plan Expectations

- Review safety issues and stabilizing the family
- Long-term goals in case planning can include family stability, increased self-sufficiency and/or employment. For people with disabilities, case plans should promote greater independence and may include various types of treatment.
- Short-term goals include the steps to address safety, immediate family stability, and to help reduce or eliminate barriers to self-sufficiency, employment or job retention.
- Case plans can include other members of the benefit group to enhance family stability and child safety.
Case Plan Expectations

• Case plans continue after a client has obtained employment, to support retention, wage enhancement and eventual independence programs.

• All case plan activities, time lines and support services are documented
Using Screening and Assessment Information

• Information gained from screening and assessment is used to develop the case plan.

• Review initial or new ongoing information, including input from client or other branch staff, other resources and partners, and screening for specific issues such as alcohol and drug (A&D), mental health, domestic violence, learning needs and physical health.
Levels of Goals and Objectives

- Micro - immediate
- Mezzo - intermediate
- Macro - long term change
Developing Goals

Consider the following when developing, updating and reviewing short- and long-term goals with the client:

- Is employment a reasonable short-term (less than six months) goal given the client's goals, strengths, barriers and resources? Consider disability-related issues, other employment barriers.

- Is employment a reasonable intermediate goal (six-12 months)? What intermediate goals and objectives would have to be accomplished first? If a client has a disability, what modifications or accommodations may be needed?

- Is employment a long-term goal (greater than 12 months)? What intermediate goals and objectives would have to be accomplished first? Is there a need for an interdisciplinary team to support the client in accomplishing the intermediate goal? What programs should be involved in the team?
Developing Goals

• If employment is a long-term goal or not likely, how else might the person meet his or her goal of economic security? Should a referral to Social Security or the SFPSS program be made? Is a referral to other case management services, such as FS&C, appropriate?

• What post-employment services will the client need to maintain and/or advance in his or her job? Who might be able to provide those services? Are there modifications or accommodations needed to help the client maintain employment?
Clarifying Needs and Strengths

• Clarify what the client/family needs and strengths are in relation to achieving family stability and employment/self-sufficiency goals
  – What steps do they need to take to achieve goals?
  – What strengths and resources do they already have to help them do this?
  – What skills will they need to develop to reach these goals?
Case Plan Goals/Objectives

- Goals is the ultimate statement of the outcome of the case plan
- Objectives are the measurable benchmarks that measure the success on meeting the case goal
- Activities are the services that the agency, partner or client will perform to achieve objectives
Goals and Desired Outcome

• Goal: A strong goal is one that attempts to solve the condition identified in the problem statement
• Objectives refer to specific activities in a case plan. It is necessary to identify all objectives related to the goals to be reached, and the methods to be employed to achieve the stated objectives.
• Consider things measurable and refer to a problem statement and the outcome of proposed activities when developing a well-stated objective.
• SMART Objectives (Specific, Measurable, Achievable, Realistic, Time Oriented)
Goals and Objectives

• Goals are high level statements that provide overall context for what the project is trying to achieve, and should align to business goals.

• *Objectives* are lower level statements that describe the specific, tangible products and deliverables that the project will deliver.

• Goal statements are designed to be vague.
Goals and Objectives

• Objectives should not be vague. A well-worded objective will be **Specific, Measurable, Attainable/Achievable, Realistic and Time-bound (SMART)**.

• The objective should be written at a lower level, so that it can be evaluated at the conclusion of a project to see whether it was achieved or not.

• Objectives should refer to the deliverables of the case plan.
Establish Objectives

• Clear statements of who will do what, when, where, and how—in collaboration with whom

• Clear picture of what you hope to accomplish, how you will accomplish it, and how you will know when you have accomplished it

• Statements of results to be achieved within specified timeframes
Different Types of Objectives

Objectives are precise, measurable, and time-phased results that support achievement of the goals.

- process objectives – to develop, to implement, to establish, to conduct
- outcome objectives – to increase, to decrease, to improve
Standard Form for an Objective

(verb noting direction of change) + (area of change) + (target population) + (degree of change) + time frame
## Example Development of Objective

<table>
<thead>
<tr>
<th>Standard form:</th>
<th>Example using standard form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direction of change</td>
<td>To reduce</td>
</tr>
<tr>
<td>Area of change</td>
<td>unemployment status</td>
</tr>
<tr>
<td>Target population</td>
<td>for our graduating students</td>
</tr>
<tr>
<td>Degree of change</td>
<td>so that 75% gain full-time employment</td>
</tr>
<tr>
<td>Time frame</td>
<td>within six months of graduation.</td>
</tr>
</tbody>
</table>
Again- Be SMART

- **Specific**
- **Measurable**
- **Achievable**
- **Realistic**
- **Time-bound**
Identifying Activities and Support Services

- For each need identified, use the client's input on their strengths to find matching activities that suit their current abilities
- Assist the client to explore the range of possible activities and services to meet their needs. Verify with the client that these activities will help the client/family achieve the short- and long-term goals
- Discuss what support services, including accommodations, the client will need to complete these activities
- Arrive at an agreement about what the program will pay for and what the client or other resources will provide
Case Plan Format

• Short and long-term goals
• What the activities are to achieve those goals, where and when they occur, their duration and expected hours of participation per week for each
• Need for accommodations
• What support services will be offered
• When the case manager and client will meet again to evaluate the plan progress
• May include a plan component for personal and employment development
Reviewing the Plan with the Client

- When updating or reviewing case plans with clients, confirm the client's understanding of the agreements made, and double check that the plan seems doable. Make changes to the case plan if necessary.
- Have them sign the form and give them a copy.
- You may provide an appointment calendar to keep track of activities and appointments.
- Make sure that immediate needs (such as safety from domestic violence) have been addressed, resources identified, referrals made, and that the client is able to follow up on the referrals.
Case Plan Documentation

• Narrate the contact and the new/updated case plan
• If the client does not sign the case plan, narrate the reason why and that an explanation of the plan was provided to the client
Brokering

• Develop the plan jointly with partners whenever possible
• Discuss release of information with the client and obtain their permission before sharing information, if this applies
• At minimum, contact community partners involved in the case plan to follow up on referrals and give information on changes to the plan that affect them
• Give partners a copy of the plan if and when appropriate
Evaluating Client Progress

• The intent of evaluating progress is to maintain client communication and accountability, and to continue providing the most appropriate services to the client and family.

• These services include not only case plan activities but program benefits.

• Evaluation allows for an ongoing review of eligibility for services and benefits.
Evaluation Expectations

• Contact clients and partners regularly for effective case management and for accurate delivery of benefits
  – Review attendance reports regularly
  – Continue to help clients take an active role in identifying their strengths and needs

• Review case plans and client reports, such as income reporting, periodic reviews and reported changes for eligibility and case management information
Evaluation Expectations

• Information gathered in evaluation includes:
  – Client progress, attendance and observed behavior in case plan activities
  – Client's best thinking on the case goals, services and time lines
  – Ongoing assessment by partners and the client themselves of abilities, needs and strengths
  – Partner input on case plan goal, activities and time lines

• Input from other family members
  – Other progress and eligibility information
Ongoing Case Planning

Case Planning never ends
Integrating Case Plan Evaluation and Eligibility Review

• Many of the steps of evaluating client progress have already been explained in describing ongoing assessment, case plan development and brokering.

• Just as in eligibility determination, where client assessment is integrated with reviewing eligibility factors, evaluation involves both case plan and eligibility review.
  – Review each piece of eligibility information for case plan implications
  – review each piece of case plan information for eligibility implications.
Client and Provider Contacts

- Use regular and frequent client and provider contacts to evaluate progress as follows:
  - Have a regular contact schedule for all case managed clients and a tickler system to remind you of scheduled contacts;
  - Include provider contacts in your client contact schedule; negotiate with case plan activity providers to develop a regular schedule and format for sharing client information;
  - Contacts may be in person, in the office or the client's home, in the form of reports or evaluations, joint staffing or phone conversations, depending on the purpose of the contact and the urgency of the issue;
  - Narrate the content of case management and eligibility contacts
Client and Provider Contacts

- Use tools such as Outlook to simplify, organize and record your monitoring contacts;
- Continue to use open-ended questions, summarizing and other communication techniques to assess how the client is progressing and what their abilities are;
- Expect that the client will share more about themselves as trust increases;
- Remind the client immediately of their accountability for participation, progress and reporting eligibility information;
- Use the re-engagement process to assess client's motivation and goals for outcomes and to determine whether an aspect of a known disability causes the lack of participation. Also, ensure that all required screenings have been offered.
Tracking Outcomes

- Our case management activities are directed toward client outcomes, and we monitor progress toward outcomes by:
  - Keeping track of the outcomes of all case plan referrals, activities, goals and eligibility issues, and narrate these outcomes
  - Using client and partner contacts and staffing with partners and team members to get information on progress toward outcomes
  - Updating outcome expectations based on more complete information on client needs and abilities
  - Following up immediately on all no-shows and other potential instances of noncooperation
  - Using the re-engagement process to assess client's motivation and goals for outcomes and to determine whether an aspect of a known disability causes the lack of participation. Also, ensuring that all required screenings have been offered
Other Reading

• **For Workers**: Fundamentals of Case Management Practice: Skills for the Human Services – Nancy Summers

• **For Managers**: Managing Social Service Staff for Excellence: Five Keys to Exceptional Supervision – Nancy Summers
Resource Links

• Resource Link:  
http://www.uiowa.edu/~nrcfcp/resources/related_links.shtml
The End
Supplemental Presentation: Systems of Care (SOC)

Coordination and wrap around
System of Care Concept

I. Mental Health Services
II. Social Services
III. Educational Services
IV. Health Services
V. Substance Abuse Services
VI. Vocational Services
VII. Recreational Services
VIII. Juvenile Justice Services

CHILD & FAMILY
System of Care

- In systems of care, agencies partner with families and communities to address the multiple needs of children and families involved in service systems.
- A system of care (SOC) is where multiple systems such as mental health, education, child welfare, juvenile justice, and other agencies work together to ensure that children with mental, emotional, and behavioral problems and their families have access to the services and supports they need to succeed.
Systems of Care Principles and Values

- Staff members of systems of care agencies and organizations regard children, youth, and families as priorities within the community.
- For certain positions within systems of care, life experience is considered equal to, or in some cases more important than, a degree or other credentials.
Systems of Care Principles and Values

• Outcomes are developed that measure and identify changes generated from systems of care principles into training, development, and human resources functions.

• A culturally, linguistically, and ethnically diverse and competent staff is evident in training, development and human resources activities.
Systems of Care Principles and Values

• Family and youth involvement is evident in positions (employees or contractors) within the system of care.
• An interagency training and development committee with family membership creates a cross-agency training and development agenda to address system of care personnel needs.
• Ongoing training and development occurs across all systems of care partners to enhance performance of interagency teams.
Interagency Collaboration

- In a system of care, collaborative partners work together to address the complex needs of children and families in a spirit of community partnership.
- Interagency collaboration is reflected at both the governance and direct practice level.
Individualized, Strengths-Based Care

• Individualized, strengths-based care acknowledges each child and family's unique set of strengths and challenges.

• Formal and informal supports are used to create services and supports for each child and family (rather than families "fitting in" to preexisting service structures)

• Issues of culture, language, ethnicity, gender, age, religious background, and class are addressed in the individualized plan of care.
Individualized, Strengths-Based Care

• The plan changes frequently based on ongoing individualized assessments of family strengths and needs.

• Plans are created by teams comprising people who know the child and family, including neighbors; friends; family; and child welfare, mental health, education, substance abuse, and juvenile justice professionals.

• The team's major task is to create an individualized plan of care that is community- and strength-based, made up of formal and informal services and supports
Why is individualized, strengths-based care important?

• Each child and family has unique attributes that must be addressed if services are going to be successful.
• Individualized care fully engages the family in designing and implementing a plan of care.
• Children and families receive services that match their unique strengths and needs
Cultural Competence

• To best serve those in need of services and supports, providers must develop the capacity to understand the cultural filters that mediate the family's perspective of the agency and its plan of care.
Cultural Competence

• Cultural competence refers to:
  – A defined set of values and principles, as well as behaviors, attitudes, policies, and structures, that enable systems to work effectively cross-culturally
  – The capacity to value diversity, conduct self-assessment, manage the dynamics of difference, acquire and institutionalize cultural knowledge, and adapt to diversity and the cultural contexts of the communities served
  – The incorporation of the above in all policymaking, administration, practice, and service delivery, and the systematic involvement of consumers, key stakeholders, and communities
Family and Youth Involvement

• Family and youth involvement within a system of care requires mutual respect and meaningful partnerships between families and professionals.

• Families and youth are involved as key stakeholders, whether they are helping tailor one child's individualized plan of care or helping design, build, or maintain the system of care.
Family and Youth Involvement (Continued)

• Families and youth are involved in policy development, care coordination, evaluation, strategic planning, service provision, social marketing, and individual and system advocacy.

• Families and youth involved in systems of care activities may include caregivers, kin, extended family members, former service recipients, and others that families identify as important.
Why is family and youth involvement important?

- The goal of permanency for children—either by reunification with their biological parents or other permanency options—is best facilitated when the family and youth are involved in planning services and participate actively in them.

- Engaging family members and youth in the planning and provision of services emphasizes a respect for their capabilities and their role as part of the solution to their problems.

- Involving families and youth helps ensure sensitivity to cultural, service, and support needs.
Community-Based Services

• A system of care builds not only on the strengths of the child and family, but also on the strengths of their community
• Providing community-based services means having high quality services accessible to families in the least restrictive setting possible
• A community-based system of care requires systems to see the home, school, and neighborhood of the family from an asset-based perspective, and to identify the natural supports in these familiar surroundings as part of a strengths-based approach
Why are community-based services important?

• Keeping children in their homes, neighborhood schools, and local communities has a positive effect on child and family well-being. Moving, in many cases, generates unnecessary stress for an already traumatized child.
• By remaining in the community, the child is able to retain critical bonds with friends, family, and school personnel.
• When services are community-based, the work done with the child and family is in the context of where the child lives.
• The community (faith-based organizations, nonprofit agencies, neighbors, and other institutions) can offer additional positive, informal supports to the child and family.
Accountability

• Accountability refers to the continual assessment of practice, organizational, and financial outcomes to determine the effectiveness of systems of care in meeting the needs of children and families.

• Two essential components of an effective accountability strategy in a system of care are:
  – The development of an interagency management information system that tracks important indicators of service and system performance
  – A strong evaluation strategy
Why is accountability important?

• By focusing on the effects and outcomes of the services provided, such as child safety while in care, communities are provided a benchmark against which they can set realistic goals and measure continuous improvement.

• To ensure continuous improvement of systems of care, it is critical to incorporate process and outcome data into ongoing decision-making at all levels.
Why is accountability important? (Continued)

• In times of limited resources, decision-makers are most likely to allocate resources to initiatives that demonstrate effectiveness and an efficient use of funds.

• The safety and well-being of children, youth, and families is a responsibility shared by the entire community. As such, systems of care communities join together in holding one another accountable for ensuring positive outcomes, regardless of where the child and family seek help.