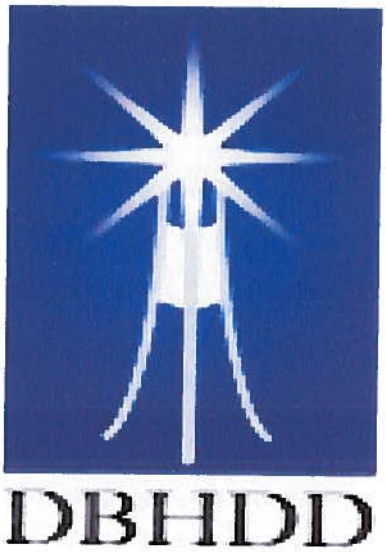

DBHDD
CASE MANAGEMENT TOOLKIT

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INTRODUCTION

DBHDD's Vision

Every person who participates in DBHDD services leads a satisfying, independent life with dignity and respect.

DBHDD Mission

Provide and promote local accessibility and choice of services and programs for individuals, families, and communities through partnerships in order to create a sustainable, self-sufficient, and resilient life in the community.

DBHDD Values

Dedication, Accountability, Integrity, Collaboration, Excellence, Safety, Knowledge, Innovation, and Respect.

DBHDD Strategic Priorities

1. Strengthening communication with individuals, families, advocates, and providers; empowering Georgians with information that will support choosing the best quality care to lead an independent life;
2. Establishing accountability expectations for state and community based providers to ensure all Georgians have access to quality healthcare services and alternatives to institutions;
3. Promoting recovery based approach to coordinated, comprehensive cost effective healthcare;
4. Maximizing university partnerships that promote quality of treatment and care, and research to advance science specifically associated with DBHDD; and
5. Providing support and resources to providers to ensure a viable safety net in Georgia that continues community based care focused on independence and recovery.

Focus on Recovery

The process of moving from a "medical model" to a "recovery model" for mental health services has been an ongoing process over many decades. Expectations regarding the potential of people living with a diagnosis of serious mental illness have shifted dramatically. Under the medical model, individuals with SMI were expected to remain in residential care (state hospitals, group homes and the like), attend day treatment, and have others make their decisions. Under the recovery model, individuals with SMI have the potential to create lives that include meaning, purpose and hope for their future.

Behavioral Health Recovery is:

1. an individual journey of change, which fosters the ability to adapt to one's personal experiences;
2. living a meaningful life in a community of one's choice;
3. a process, a journey rather than a destination, and can look very different for each individual among a group of individuals;
4. person-centered rather than "one size fits all";
5. respectful of and responsive to each person's preferences, needs, values and decision-making.

SAMHSA's Definition of Recovery:
For individuals with mental disorders and/or substance use disorders, recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

SAMHSA's four (4) major dimensions that support a life in recovery-

1. Health: overcoming or managing one's disease as well as living in a physically and emotionally healthy way;
2. Home: a stable and safe place to live;
3. Purpose: meaningful daily activities, such as a job, school, volunteerism, family caretaking, creative endeavors, and the independence, income and resources to participate in society; and
4. Community: relationships and social networks that provide support, friendship, love, and hope.

SAMHSA's Guiding Principles to Recovery-

- *Recovery emerges from hope*: The believe that recovery is real provides the essential and motivating message of a better future-that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them.

- *Recovery is person driven*: Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s).

- *Recovery occurs via many pathways*: Individuals are unique with distinct needs, strengths, preferences, cultures, backgrounds including trauma experiences that that affect and determine their pathways to recovery. Abstinence is the safest approach for those with substance use disorders.

- *Recovery is holistic:* Recovery encompasses an individual's whole life, including mind, body, spirit, and community. The array of services and supports available should be integrated and coordinated.

- *Recovery is supported by peers and allies:* Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery.

- *Recovery is supported through relationship and social networks*: An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recovery; who offer hope, support, and encouragement; and who also suggest strategies and resources for change.

- *Recovery is culturally-based and influenced:* Culture and cultural background in all of its diverse representations including values, traditions, and beliefs, are key in determining a person's journey and unique pathway to recovery.

PURPOSE OF THE CASE MANAGEMENT TOOLKIT

The Case Management Toolkit has been designed to support case managers in providing quality services to individuals who meet service definition criteria for Case Management and Intensive Case Management. As such, the Case Management Toolkit is intended to be a guide and resource for case managers, and it is not intended to replace more specific and detailed information in the Provider Manual. The information outlined herein does not supersede service-specific requirements in the Provider Manual service definitions for Case Management and Intensive Case Management as well as Standards for Community Behavioral Health Providers. Therefore, Case Management and Intensive Case Management providers are encouraged to refer to and review the most current version of the Provider Manual, which can be found on the DBHDD Website at http://dbhdd.georgia.gov/community-provider-manuals.

CONTENTS OF THE CASE MANAGEMENT TOOLKIT

This toolkit outlines the primary components of case management services, recommended approaches, tools to assist the case manager in the provision of service, and self assessment checklists:

- Components of Case Management with Recommended Approaches
- Service Provision Tools
- Quality Improvement Self-Assessment Checklists

OUTLINE OF CASE MANAGEMENT SERVICES

The DBHDD case management service is characterized by engagement, attention to individual needs, advocacy to facilitate participation in service planning, access to services and resources, effective care coordination, monitoring of outcome, and discharge planning that promotes community-based care that focuses on independence and recovery for individuals with serious mental illness.

The key components of case management include:

I. Engagement
II. Reviewing Assessment Information
III. Service and Resource Planning
IV. Care Coordination
V. Linkage and Referral
VI. Monitoring & follow-Up
VII. Discharge Planning

COMPONENTS OF CASEMANAGEMENT SERVICES

I. ENGAGEMENT

Engagement is the coming together of the case manager and the person served. The success of case management is dependent on the development of a good working relationship between the case manager and the individual that is based upon trust, mutual respect, and a willingness to work together to attain agreed-upon goals. The case manager does not attempt to change the individual's beliefs, values, or emotions, but works with the individual to improve his/her living conditions. By doing so, the case manager can help the individual to increase living skills and expand his/her horizons. The case manager-consumer relationship, like any other, thrives on consistency, regularity of contact, openness, honesty, and the careful building of trust.

Three (3) elements important for the case manager to consider when developing a recovery-based relationship with an individual with a mental illness include: demonstrate belief in the individual's ability to recovery; promote personal responsibility, and provide support, hope, and encouragement.

A. Believe in the Individual's Ability to Recovery
A case manager's attitude toward mental illness, the people who are diagnosed as having a serious mental illness, and the possibility of recovery are communicated to the individual seeking help. A successful case manager must truly believe that an individual with mental illness can and will recover and achieve his/her full life potential. The case manager becomes a partner in the individual's recovery process and conveys a positive perspective if the case manager is to have an impact on change.

B. Promote Personal Responsibility
To develop and establish a trusting relationship is an ongoing process and requires a variety of skills. One of the most powerful ways to foster trust is to demonstrate genuine respect for the individual by allowing him/her to make his/her own choices, define his/her own goals, design his/her own path, and set his/her own pace.

C. Provide Support, Hope, and Encouragement
Successful engagement involves regular reinforcing comments. Most people respond positively to praise. Individuals with severe mental illness often experience a lack of confidence. It is important for the case manager to recognize success, but it is equally

important for the case manage to recognize effort. When the case manager uses positive reinforcement, the individual feels competent and confident that they can achieve success.

The role of the case manager during engagement is to establish a relationship with the individual that demonstrates a belief in the individual's ability to recover, promotes personal responsibility, and provides support, hope and encouragement.

Recommended interventions performed by the case manager to facilitate engagement may include:

1. Start slow, not pushing the individual to make decisions about services;
2. Provide intensive support during initial engagement with frequent contacts either by phone or in person;
3. Focus on strengths and not weaknesses or deficits;
4. Offer praise for effort as well as success;
5. Be willing to struggle with the individual as he/she attempts to connect during initial engagement, knowing that establishing a relationship takes time.

Recommended Approach: The case manager establishes a trusting working relationship with the individual that demonstrates: 1) a partnership in the recovery process; and 2) confidence in the individual's ability to reach full potential. Early engagement may begin prior to the provision of service and engagement will continue until time of discharge.

II. REVIEWING ASSESSMENT INFORMATION

Upon enrollment into Core Services, multi-disciplinary assessments are conducted to gather information needed to determine the individual's problems, strengths, needs, resources, preferences, functioning level and abilities. Information from these assessments are used to develop a diagnosis and formulate the individual's service plan.

Conducting a clinical assessment is not a direct function of case management service, however it is the role of the case manager to review assessment information in order to become familiar with the individual's diagnosis, abilities, strength's, resources, and service needs as a basis for supporting him/her in the service planning process.

Recommended Approach: The case manager reviews clinical assessment information in order to develop an initial awareness of the individuals strength's, resources, and service needs as a basis for supporting him/her in the service planning process.

III. SERVICE & RESOURCE PLANNING

Service and resource planning is developed collaboratively with the individual to map out a course of treatment that guides the individual and treatment team using a proactive, step-by-step approach. Using information gathered through assessments, the case manager begins to identify service and resource needs to be included in the individual's service plan. The service plan focuses on the individual's hopes, dreams, and vision of a life well lived and addresses the four (4) major dimensions that support a life in recovery including health, home, purpose, and community.

Service plan development is not a direct function of case management service, however the role of the case manager in service and resource planning may include:

- Assisting the individual and consumer-identified natural supports to become full participants in the service planning process, including crisis planning;
- Supporting the individual in identifying his/her treatment goals;
- Assisting the individual to identify and prioritize services and resources needed to support the individual in achieving his/her treatment goals.

A. Service Planning

The service plan should be person driven with the individual defining their own goals. It should reflect an agreement and partnership between the individual, case manager, service providers, and other identified supports. In order for service planning to be person driven, the individual must become familiar with the service planning process, understand how service planning leads to successful outcomes, and understand his/her own service plan.

Recommended interventions performed by the case manager to support a consumer driven **service planning** process may include:

1. Increase the individual's understanding of the service planning process by explaining the components of a service plan;
2. Discuss and negotiate aspects of the service plan to ensure agreement on goals, objectives, and interventions;
3. Advocate on behalf of the individual to ensure the service plan goals meet his/her personal goals;
4. Assist in scheduling service planning at a time and location accessible by the individual and his/her natural supports;
5. Arrange transportation assistance to participate in service planning when needed.

Crisis Planning: Crisis planning should be included as a part of service planning. While there are triggers and signs, it is difficult to predict when a mental health crisis will happen. An individual may experience a mental health crisis, even when following his/her treatment plan.

Every individual enrolled in case management services should have a crisis plan. It is the role of the case manager to ensure the individual has a crisis plan that is developed in partnership with the individual, service providers, and natural supports. The crisis plan should include at a minimum:

- Warning signs;
- Emergency support contacts;
- Emergency professional agency contacts;
- Coping strategies to de-escalate the crisis situation.

Recommended interventions performed by the case manager to support **crisis planning** may include:

1. Ask the individual if they have a wellness recovery action plan (WRAP) that includes a crisis plan, and ensure that crisis planning supports the individual's WRAP crisis plan [there should only be one (1) crisis plan];
2. Periodically review the crisis plan with the individual to ensure it is current and adequate;
3. Maintain a copy of the crisis plan in the medical record accessible to all treatment support staff;
4. Ensure the individual has a copy of the crisis plan to post at home or keep on their person for easy reference; and
5. Reinforce the use of the crisis plan when needed.

Recommended Approach: The case manager ensures the individual understands the service planning process, actively participates in the service planning process, and has a current copy of the service plan and crisis plan at home for daily reference.

Service Planning Tool:
-Crisis & Safety Plan

B. Resource Planning

Individuals with mental illness often lack a sense of belonging, sense of self-worth, sense of choices, and power to choose. Interpersonal interaction may be limited to only others with mental illness and paid staff. When the case manager provides hope and encouragement to the individual, possibilities related to health, home, purpose, and community may be redefined. Successful resource planning may result in the individual developing a new vision of what is possible.

The role of the case manager during resource planning is to partner with the individual to identify service and resources needs to be included in the service plan and suggest strategies and resources for change that might move the individual beyond his/her known limitations.

A recommended intervention performed by the case manager to support resource planning includes the use of the Resource Planning Guide to guide a discussion with the individual to identify and prioritize resources and services needs in the following life areas:

- Mental Health, Substance Abuse
- Medical, Dental, Vision
- Income, Entitlements
- Legal
- Housing
- Employment, Education, Job Training
- Transportation
- Support Networks
- Hobbies and Leisure Activities
- Nutritional and Daily Living Assistance

Recommended Approach: The case manager partners with the individual to identify service and resource needs in areas that support a life in recovery which include health, home, purpose, and community.

Service Planning Tool:
-Resource Planning Guide

C. Reassessment & Update

The service plan must be reassessed periodically in response to the individual's request, changing needs, or circumstances. A re-assessment is conducted periodically to evaluate the impact of the activities, determine progress, and identify barriers to full attainment of the service plan goals. Reassessment allows staff to determine whether current services or service levels are adequately meeting the individual's needs or if he/she is in need of additional or alternative services. The service plan may also be updated between reassessment to reflect changes in goals, case management activities, and individual circumstances. Throughout enrollment, the case manager reviews information gathered through re-assessments in order to maintain awareness of the individual's changing needs.

The role of the case manager in service planning reassessment and update is to monitor the adequacy of the service plan in meeting the individual's needs, seek periodic input from the individual regarding satisfaction with treatment and recovery support services, and follow-up with any recommendations for change.

Recommended interventions performed by the case manager to support service planning reassessment and update include:

1. Periodically ask the individual if the service plan continues to meet their needs;
2. When the service plan does not appear to meet the individual's needs or when the individual identifies changing needs or circumstances, the case manager notifies the treatment team and requests a service plan update.

Recommended Approach: When monitoring the individual in the community, the case manager confirms if the current service plan continues to support the individual's personal goals and if any changes are needed.

IV. SERVICE PLAN IMPLEMENTATION & CARE COORDINATION

Care coordination is a process that links an individual and his/her support network to services and resources in a coordinated effort to minimize service gaps/fragmentation and to maximize service integration and treatment outcomes. Care coordination ensures that the individual receives a full range of services and resources needed to support a live in recovery.

The roles of the case manager during service plan implementation and care coordination may include:

- Assisting the individual as he/she moves between and among services within the core provider as well as community-based agencies outside the core provider;
- Reducing access barriers to services and resources;
- Ensure that all parties involved work collaboratively for the common benefit of the individual.

Recommended interventions performed by the case manager to support service plan implementation and care coordination may include:

1. Regular information sharing among the individual, consumer-identified support persons, physician, and other support services to keep everyone focused on the same goals in a coordinated effort;
2. Encouraging the individual and support persons to complete tasks set out in the service plan;
3. Educating the individual and support persons on navigating the service systems;
4. Providing support and assistance in overcoming barriers that impede access to services;
5. Negotiating and advocating on behalf of the individual a needed.

Recommended Approach: The case manager reduces access barriers, advocates for accommodation, shares information among all parties involved, so that the individual is able to move seamlessly between and among services.

V. LINKAGE & REFERRAL

Linkage and referral is a direct function of case management service. It is imperative that the case manager is knowledgeable of community supports and resources available to individuals, such as, private vs. public treatment providers, self-help groups, housing resources, employment and training programs, financial/health benefits, etc. It is also recommended and beneficial, that the case manager maintain regular contact with these groups to facilitate an individual's access.

It is important for the case manager to consider four (4) factors when seeking community resources:

- Availability: Determine if the desired service/resource is readily available in the individual's local community.
- Accessibility: Identify barriers to access such as transportation or pre-qualifying conditions.
- Accommodation: Identify any special needs the individual may have that must be addressed in order to succeed with the referral.
- Adequacy: Ensure that the service/resource adequately meets the needs of the individual.

The role of the case manager during linkage and referral is to link the individual to services and resources identified through the service planning process.

Recommended interventions performed by the case manager for individuals with service/resource needs identified on the Resource Planning Guide may include:

1. For medical needs, facilitate a referral to primary health care, dental, and/or vision services and assist the individual in attending regularly scheduled exams;
2. For financial needs, assist with applying for and successfully acquiring all income, entitlement benefits (SSI/SSDI, Food Stamps, VA Benefits) for which the individual is eligible to meet their income goals;
3. For employment, education, job training needs, link to supported employment, vocational rehabilitation, local education resources, technical colleges, adult GED program, adult literacy programs, and volunteer opportunities to support the individual with meeting their vocational goals;
4. For housing needs, identify housing resource options (HUD, Housing Authority, GHVP) based on the individual's need and preference;
5. For nutritional and activities of daily living needs, refer to appropriate skill building services;
6. For transportation needs, assist with arranging transportation assistance;

7. For behavioral health needs, locate treatment programs available within the community;
8. For support system and relationship needs, link to self-help groups and peer centers to assist the individual with developing support networks.
9. For leisure, recreational, and/or social activities, assist the individual with identifying areas of interest and related local resources including gyms, libraries, parks, etc..

Case managers should consider SAMHSA's four (4) major dimensions that support a life in recovery which includes health, home, purpose, and community when identifying linkage and referral needs of an individual. Develop a resource guide that includes local and statewide resources information, contact information, qualifying criteria, for community services including mental health/addictive disease services, medical, dental, vision, educational, employment, housing, income, leisure activities, transportation, and self-help resources.

Recommended Approach: The case manager assists the individual with referrals to services and resources identified on the service plan, locating available resources, making appointments, completing applications and paperwork, and assisting with transportation when needed.

EXAMPLE OF A RESOURCE GUIDE

A. Mental Health/Addictive Diseases Service Resources

Since all providers of case management services must also be a Core Provider, then many individuals will receive case management and behavioral health services within the same agency. For those individuals receiving psychiatric assessment and treatment services from an outside agency, the Case manager should remain in close collaboration. To assist an individual identify and access behavioral health services, contact the Georgia Crisis & Access Line by phone at 1-800-715-4225 or go online to identify available services at www.mygcal.com . To view service descriptions for all DBHDD behavioral health services, go to the Department's website at www.DBHDD.Georgia.Gov and locate the Behavioral Health Provider Manual.

The Crisis Help Line of Georgia 1-800-338-6745 (www.hodac.org) is another important and informative resource that is staffed by trained specialists and is available 24 hours per day, 7 days per week. Help and information for alcohol/drug problems, victims of violent crimes, gambling problems, legal matters, drug testing information, self-help and support groups, reporting drug trafficking, is provided, and all matters are confidential. It is funded through the Department of Behavioral Health and Developmental Disabilities (DBHDD) and the Criminal Justice Coordinating Council with a goal to assist individuals with locating emergency resource information.

B. Educational Resources

The Case manager should partner with the individual to explore his/her educational goals. If an individual is interested in pursuing a higher level of education the case manager could assist them to identify available colleges, universities, specialty or trade schools in his/her community. Referring the individual to the local school district can be sufficient but it is dependent on the level of education warranted.

- The Georgia Department of Education website at www.doek12.ga.us/ provides information to anyone interested in securing information on available public education and school resources.
- The Technical College System of GA website at www.tcsg.edu/ provides information on business, industry and adult education. Also included at this site is information for individuals that wish to pursue their GED. Testing requirements, sites, fees, etc., are posted.
- Georgia Vocation Rehabilitation Services website at www.vocrehabga.org helps eligible individuals with disabilities prepare, start, and maintain competitive employment. They provide training, technical assistance and support for qualified individuals. Vocational Rehabilitation (VR) has 15 regional offices, and 50 local offices within the state of Georgia. VR may also assist in paying for education, although not guaranteed, as it is determined through their assessment process.

C. Employment/Supported Employment/Volunteering Resources

The Case manager should partner with the individual to explore his/her employment and career goals. Supported Employment services are offered by DBHDD. Inquire if your agency provides Supported Employment Services. Individuals not willing or able to work may choose to help their community by volunteering their services. Case Managers are encouraged to contact schools, government agencies, clubs, libraries, hospitals, etc., in their area regarding volunteer opportunities, and keep a resource book available to refer individuals that would like to volunteer. Various websites that provide employment resources include:

- The Georgia Department of Labor website at www.dol.ga.us provides various services to job seekers to facilitate the employment process. GDOL helps individuals attain their work goals and increase self-sufficiency through training, support services and employment. For more opportunities and information, refer to local supported employment providers such as Labor Ready, Manpower, Spherion and other local temp agencies.
- Georgia Mental Health Consumer Network website at www.gmhcn.org posts job listings in the field of mental health and for peer specialist positions throughout the state of GA.

- Peer Specialist website at www.gacps.org offer information, job listings, training program, qualifications, are available through the Georgia Certified Peer Specialist Project.
- The Work Site website at www.theworksite.com is a resource page that offers numerous sites within it that can be accessed to search for employment in various fields throughout GA and the US.

D. Geriatric Resources

When the Case Manager is working with an older adult, the Case Manager will want to explore resources designed to assist and support the geriatric population. A list of various geriatric resources in Georgia include:

- The Georgia Department of Human Services, Division of Aging Services at www.aging.dhs.georgia.gov includes Adult Protective Services which protects older Georgians that may fall victim to physical or mental abuse, neglect or exploitation.
- The Georgia Association of Area Agencies on Aging website www.georgiaservicesforseniors.org offers a myriad of services to assist senior citizens, such as, counseling, vocational, emergency financial assistance, day care, etc., for the area of Georgia which you wish to receive the service(s).

E. Housing Resources

The Case Manager is to assess the individual's living situation and assist them with attaining or maintaining stable housing. Many resources are available to help the case manager locate housing resources including:

- Department of Community Affairs (DCA) operates the Georgia Housing Search at www.georgiahousingsearch.org which is an affordable housing database covering every county in Georgia. This website helps renters find housing to meet their price, location and accessibility preferences. Case managers are encouraged to register as a provider to assist them in locating housing for traditionally hard to place individuals.
- The Housing Authorities of Georgia at www.hud.gov/local/ga assists with locating a HUD office in a region near you.
- The State of Georgia has a rental assistance voucher program which is part of a comprehensive program administered through the Georgia Department of Community Affairs (www.dca.state.ga.us>RentalAssistance). This program offers affordable housing options to Georgians that meet certain criteria.
- The National Coalition for the Homeless can also provide other options (www.nationalhomeless.org/directories/advocacydirectory) for individuals that are in need of housing.

F. Leisure Activity Resources

The Case Manager should encourage the individual to explore his/her leisure interests. Individuals should be encouraged to explore their surroundings and become involved in positive activities of which many are provided by local Parks and Recreation. YMCAs and local gyms can also provide an outlet for exercise, and many other activities are usually offered. YMCAs also offer low-income memberships. The Case manager can also access local libraries to determine the requirements necessary to obtain a library card for an individual. Certain libraries also provide various training courses to improve computer literacy. Some libraries offer classic movie nights, guest authors, book signings, etc.

G. Medical/Dental Resources

Assessing an individual's medical needs and referral and linkage to medical services is a fundamental function of case management. Many resources are available to assist the case manager with locating medical resources including:

- The Georgia Health Department in your local community can assist with Medicaid applications and various other insurance options. WIC (Women, Infancy, Children) applications, SNAP (Supplemental Nutrition Assistance Program) benefits, and the Department of Child and Family Services can also be found in your local Health Department. (www.health.state.ga.us).
- Dental services for low to no income individuals under the age of 21 can be accessed through their local Georgia Department of Health.
- A listing for Georgia low income dental clinics and medical clinics can be found by accessing www.helppayingbill.com and www.needymed.org . The needy med site also has information on Patient Assistance Programs (PAPs), where pharmaceutical companies may provide free or discounted medications. The site also lists camps/retreats/scholarship information as well that targets children/adults living with a special diagnosis or medical condition.
- The internet contains many other sites that provide information on low to no income medical/dental assistance programs and facilities that offer services.
- Kiwanis (www.kiwanis.org) and Lions Club (www.lionsclubs.org) are charitable organizations which assist with securing hearing aids and eyeglasses. Most communities have these clubs in their area, or can access them through their national register at the addresses listed above.

H. Transportation Resources

The Case manager should assess the individual's transportation needs to ensure ability to make appointments, maintain employment, support leisure activity, remain connected to support networks, etc.. Multiple transportation options are available which may include:

- Public Transportation is available in many larger metropolitan areas that offers a ½ fare card for individuals with disabilities. Refer individuals to your local transportation

system. Each service area should have the telephone numbers or access information for the particular system to be accessed. Also, be cognizant that certain providers may offer bus or train passes to individuals in need.

- Medicaid Non-Emergency Transport (NET) is available to individuals with Medicaid for medical and mental health appointments only. In most cases, the individual must call three days in advance to schedule transportation. All counties in Georgia are grouped into five regions with a transportation broker serving each region. To schedule a Medicaid NET, contact the transportation broker in your region.

Region	Broker	Counties Served
North	**Southeastrans** 1-866-388-9844 Or 678-510-4555	Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Cobb, Dade, Dawson, Douglas, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Habersham, Hall, Haralson, Jackson, Lumpkin, Morgan, Murray, Paulding, Pickens, Polk, Rabun, Stephens, Towns, Union, Walker, Walton, White, Whitfield
Atlanta	**Southeastrans** 404-209-4000	Fulton, DeKalb, Gwinnett
Central	**LogistiCare** 1-888-224-7981	Baldwin, Bibb, Bleckley, Butts, Carroll, Clayton, Coweta, dodge, Fayette, Heard, Henry, jasper, Jones, Lamar, Laurens, Meriwether, Monroe, Newton, Pike, Putnam, Rockdale, Spalding, Telfair, Troup, Twiggs, Wilkinson
East	**LogistiCare** 1-888-224-7988	Appling, Bacon, Brantley, Bryan, Bulloch, Burke, Camden, Candler, Charlton, Chatham, Clarke, Columbia, Effingham, Elbert, Emmanuel, Evans, Glasscock, Glynn, Greene, Hancock, Hart, JeffDavis, Jefferson, Jenkins, Johnson, Liberty, Lincoln, Long, Madison, McDuffie, McIntosh, Montgomery, Oconee, Oglethorpe, Pierce, Richmond, Screven, Taliaferro, Tattnall, Toombs, Treutlen, Ware, Warren, Washington, Wayne, Wheeler, Wilkes
Southwest	**LogistiCare** 1-888-224-7985	Atkinson, Baker, BenHill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Clinch, Coffee, Colquitt, cook, Crawford, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Harris, Houston, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Muscogee, Peach, Pulaski, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Talbot, Taylor, Terrell, Thomas, Tift, Turner, Upson, Webster, Wilcox, Worth

- Department of Community Health (DCH) provides the Coordinated Transportation Services for any individual receiving DBHDD state funded Case Management services. Transportation may be to appointments, employment, banking, shopping, church, self-help groups, social activities, etc at no cost to the individual. To arrange transportation, the Case Manager must contact their Regional Coordinated Transportation Office to schedule the trip.

I. Self-Help Group Resources

The Case Manager is to encourage family members, peers, significant others, etc. to become involved with organizations like NAMI (National Alliance on Mental Illness) (www.nami.org) and their local chapters, and other family support groups, such as Al-Anon. Other self-help groups, such as, Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, Overeaters Anonymous are some of the 12-step programs that help an individual with a particular problem. Case managers are encouraged to have a list of meetings in their area for individuals that may have one of these co-occurring disorders.

- The Depression and Bipolar Support Alliance website at www.dbsalliance.org offers information on peer supports, wellness, etc.
- NAMI Georgia offers Classes for family members and Support Groups for peers. Listing of these resources can be located on the NAMI Georgia websit at www.namiga.org
- Georgia Mental Health Consumer Network operates a multitude of peer support resources. Three (3) Peer Support, Wellness and Respite Centers serving DeKalb, Bartow, and White counties offer Daily Wellness Activities, Private Rooms where peers can stay up to a week to receive peer support, and a toll free Warm Line (888-945-1414) for telephone peer support. Double Trouble is self-help for individuals with co-occurring mental health and substance use disorders. For more information about the Peer Centers or Double Trouble groups, go to www.gmhcn.org

Demonstrating/teaching/accompanying an individual until they can access the service on their own is an acceptable and often encouraging approach. The important aspect to remember is to empower the individual as much as possible. Once the skill is mastered by the individual, the Case Manager should back out so that the individual retains as much control over their own life as possible. The Individual should be encouraged to use the natural supports in their community to help integrate into normal living, working, learning, and use of leisure time.

Additional information for agencies that may also be useful:
Georgia Department of Driver Services – www.dds.ga.gov/
Birth/Death/Marriage Licenses – phvitalrecords@gdph.state.ga.us
Social Security Administration – www.ssa.gov/
Veterans Administration – www.va.gov

VI. MONITORING & FOLLOW-UP

Monitoring and follow-up is a direct function of case management services. Individuals receiving frequent case manager-consumer contacts are more likely to remain engaged in treatment. The frequency of face-to-face contact increases when clinically indicated in order to achieve the performance outcomes, and the intensity of service is reflected in the individual's service plan. The use of the telephone is a supplemental engagement strategy, but does not replace the important of or need for face-to-face contact. The majority of case manager-consumer contacts take place out-of-clinic in a community setting considered convenient and preferred by the individual.

The role of the case manager during monitoring and follow-up is to determine whether current services or service levels adequately meet the individual's needs or if he/she is in need of additional or alternative services. The case manager seeks input from the individual regarding his/her level of satisfaction with treatment and any recommendations for change. When the individual identifies changing needs or circumstances, the case manager notifies the treatment team and requests a service plan reassessment and update.

Recommended interventions performed by the case manager for monitoring and follow-up to support service plan reassessment and update may include:

1. Maintain engagement through frequent contacts;
2. Use the telephone to supplement, not replace face-to-face contact;
3. Maintain collateral contact [with consent] with family members, landlords, employers, etc..
4. Periodically ask the individual if the service plan continues to meet their needs;
5. When the service plan does not appear to meet the individual's needs or when the individual identifies changing needs or circumstances, the case manager notifies the treatment team and requests a service plan update.
6. Implement a Consumer Satisfaction Survey to gather input from the individual regarding their satisfaction with treatment and any recommendations for change.

Recommended Approach: The case manager makes frequent contact with the individual to monitor progress toward achievement of service plan goals and follow-up to determine if services are adequate and effectively addressing the individual's needs.

Monitoring & Follow-Up Tool
-Consumer Satisfaction survey

VII. DISCHARGE PLANNING

Discharge planning begins at the onset of service delivery and ensures the individual's timely and smooth transition to the most appropriate setting and service. Discharge planning typically involves participation of the individual, consumer-identified support persons, physician, and other support services with a focus on clear communication regarding:

- strengths, needs, abilities, and preferences of the individual;
- services, supports, and treatment provided;
- outcome of the goals and objectives made during the service provision period;
- necessary plans for referral, appointments;
- the individual's living situation at the time of discharge.

It is the role of the case manager to assist the individual with transitioning from case management services to other services within the agency or outside the agency without disruption that enables the individual to become as independent as possible. The case manager coordinates discharge planning activities to maximize the individual's utilization of community resources.

Recommended interventions performed by the case manager as a part of discharge planning may include:

1. Partnering with the individual to plan his/her discharge from the service. This may include a planned reduction of service as evidence the individual is able to sustain functioning through the reduction plan;
2. Linkage and referral to other services with the consent of the individual;
3. Educating the individual on the referral services to ensure the individual understands the reason for the referral, and the expected benefit of each service;
4. Document discharge planning .

Recommended Approach: The case manager coordinates discharge activities to 1) ensure continuity of care without disruption; and 2)enable the individual to become as independent as possible.

VIII. DOCUMENTATION

Individual records are not only an adjunct to good care coordination; they are a fundamental and integral part of care and are often the focus of both state and federal audits. Therefore maintaining comprehensive records is as critical as the actual services being provided. This section of the Case Management Toolkit focuses on progress note documentation.

Purpose

Case Management progress notes document the implementation of the recovery plan including the identified interventions and care coordination strategies used to assist the individual in the achievement of his/her person-centered goals and objectives. In addition, they document any significant events, untoward incidents, issues and situations occurring in the life of the individual and the individual's response to these events/issues. Progress notes also document contacts (including telephone contacts) with collaterals, landlords, families, hospitals, law enforcement, etc and any missed appointments including strategies to avoid missed contacts in the future and to enhance engagement. Progress notes connect the dots that comprise the entire picture of the case management program's work with the individual. Lastly, the content in progress note documentation must provide all the supporting evidence to justify the need for the services based on the criteria for case management admission and medical necessity.

Components of Case Management Progress Note Documentation:

1. Case management progress note documentation reflects services furnished to assist an individual who resides in the community or is transitioning to the community, to gain access to needed medical, social, educational and other services, such as housing and transportation.

2. Assistance provided under case management includes the following four elements: a) partnership with the individual and other support services, b) development of a specific recovery plan, c) referral, linkages and related activities to help individuals obtain needed services and d) monitoring and follow-up activities necessary to ensure that the recovery plan is effectively implementing and adequately addressing the individual's needs.

3. Progress notes should be clearly linked to the assessments and/or reassessments and the individual's recovery plan and related interventions provided.

4. Progress notes specify the detail of the services/interventions/modalities provided and the individual's clear connection to the recovery plan (unless the notes relate to significant and untoward events). Details include date, time, frequency, duration, location and, when

appropriate, methodology.

5. Progress notes reflect the purpose or goal of the service/intervention and clarify the reasons that the individual is participating in these services and the demonstrated value of these services.

6. Progress notes document the individual's response to interventions and identify how and in what manner the intervention(s) have impacted the individual; what was the effect; and how was this evidenced.

7. Progress notes reflect monitoring of selected interventions and services to assure that they are occurring and to determine their effectiveness for achieving expected and desired outcomes.

8. Progress notes identify the individual's progress or lack thereof on the recovery plan goals and objectives.

9. Progress notes target next steps and actions to be taken as a result of the contact and services provided.

10. Progress notes also document the ongoing assessment and reassessment of the individual's current needs and progress as they relate to his/her recovery plan in order to determine the need to modify, amend or update the recovery plan and if so, how.

For detailed requirements related to documentation and progress notes, please refer to the latest version of the Provider Manual For Community Behavioral Health Providers which is updated quarterly and can be found on the DBHDD Website. Go to www.DBHDD.Georgia.Gov.

CASE MANAGEMENT TOOLKIT
Service Provision Tools

-Resource Planning Guide
-Crisis & Safety Plan
-ICM Referral Form
-ICM Team Meeting Log

[INSERT AGENCY NAME]

RESOURCE PLANNING GUIDE

Case Manager: Using information already gathered through previous behavioral health assessments, the Case Manager completes the RESOURCE PLANNING GUIDE gathering additional information from the individual and collateral contacts to identify and prioritize resource needs for this individual to be included in the individual Recovery Plan (IRP).

RESOURCE PLANNING GUIDE Overview: The first part of the RESOURCE PLANNING GUIDE gathers information on resource needs covering Life Areas including Medical, Financial, Housing, Nutrition, Transportation, MH/SA Treatment, Support Systems, Knowledge of Illness, Leisure Activities, and Dental. The last part of the RESOURCE PLANNING GUIDE allows for the individual's needs within each area to be scored in order to assist the Case Manager and individual to prioritize resource needs.

Directions: Use the following list of questions to guide your discussion with the individual for each of the Life Areas in order to identify prioritized areas of need. If the individual presents needs that are not covered by the eight life areas, document it as well on the form.

The box at the end of each Life Area allows the Case Manager to documents key information obtained from the discussion as it relates to the provision of Case Management services (e.g., summary of information, if referrals were discussed or made, goals for outcomes, current services already being received, etc.).

Consumer Name:	**Date of Planning Guide:**
Time Begin/End: / **Units:** **Location of Service:**	**Case Manager:** **Person completing Planning Guide:**

Update Consumer Contact Information: Record any relevant updates below.

Street Address:	**Mailing Address:**
Telephone Number(s):	

Has there been any change to your emergency contact? If yes, complete below:

EMERGENCY CONTACT			
Name:			Relationship:
Telephone Number(s):			Current Authorization to Release Information Signed?
Home:	Work:	Cell:	☐ Yes ☐ No

Other Services: Are you receiving case management or other services from another agency?

Agency:	Service(s) Provided:	Case Manager:	CM Phone or E-Mail:

MEDICAL, ADHERENCE AND INSURANCE

When was the last time you had an appointment with your primary care provider?

What percentage of the time do you attend your appointments? Do you need help remembering to attend your appointments? If so, who could help you? Do you need CM help?

How are you feeling today? Do you have any particular health concerns? If yes, is it a new or recent concern? How much is it bothering you? Have you talked to a doctor about these concerns? If no, do you plan to? Do you need assistance with this?

Do you talk with your primary care provider about issues related to medications? Do you need assistance with this?

What other forms of treatment (e.g., acupuncture, herbal therapy, etc.), if any, do you receive? Who provides this treatment? Have you talked to your doctor about this treatment? Do you need assistance with this?

How are you doing with taking your psychiatric and non-psychiatric medications? Do you miss doses? What do you think causes you to miss doses?

If a consumer misses doses, attempt to determine barriers to taking medications as prescribed (e.g., difficulty remembering to take medications, difficulty obtaining medications, insurance problems, side effects as noted above). Encourage the consumer to contact his/her medical provider to discuss these barriers and obtain adherence support.

Is there any chance that you might be pregnant – **or** – are you thinking about getting pregnant? If yes, are you in prenatal care? Does your prenatal care provider know about your psychiatric needs and medicines?

Please consider all your health and wellness needs. Are you receiving care as frequently as you need or as frequently as your provider(s) indicate? Do you have a condition, illness, disease, health concern for which you are not receiving treatment but would like to receive treatment? Would you like to have assistance in gaining access to and receiving healthcare services in order to address your health and wellness needs? Do you wish to include as part of treatment planning gaining access to and successfully using healthcare services?

Insurance

How is your healthcare paid for? Do you ever not attend an appointment, not take medicine as prescribed, or not done things your doctor or other providers have asked you to do because of money?

Is it time for your re-certification for insurance benefits? Would you like help with that?

SECTION NOTES: How does the information obtained from the discussion on the section above with the individual and/or collateral contacts impact the provision of Case Management or Intensive Case Management services?
Would the individual like this to be included within treatment planning? **No** **Yes: What is a specific goal s/he would like to accomplish?**

REFERRALS: _____

FINANCIAL, EMPLOYMENT, LEGAL

Financial

Do you have an income? If yes, what is your source of income? How are you doing with meeting your monthly expenses? Would you like help working out a budget? If no, what type of assistance do you need to acquire income?

Employment

Are you working? How satisfied are you with current employment? Are you planning to get new employment within the next year? Would you be interested in support or assistance that would help, for example, with finding, applying for, interviewing, keeping a job, etc? Are you interested in learning new skills or get additional education for your employment goals? What other types of employment supports or services would be beneficial and useful for your goals? Would you like this to be added to your treatment plan?

Volunteering

Do you volunteer your time or skills? Are you interested in help finding volunteer work or volunteer your time and skills? If so, what type(s) of volunteer work interests you? How much time, effort, etc. are you planning to put forth? Would you like assistance or support for you to volunteer skills, time, etc? Would you like to include volunteering as part of treatment planning (such as finding volunteer services that you enjoy, building skills, being around other people, etc.)?

Job Training

Would learning new skills, taking courses, or getting job training benefit you or be a goal of yours? Would learning literacy (reading and writing skills) skills be useful to you? What areas of your life would additional education or learning interest you: employment/job related, leisure activities, how to live healthier life, learning new hobbies, building projects, religious study, new trade, just for fun, etc? How would learning this benefit you? Do barriers or certain things get in the way of learning new skills, taking course, getting additional training, etc? Would you like to include learning as part of treatment planning?

Legal

Do you have any other legal matters that you would like help with? Do you need any assistance with these issues? Completing or understanding legal forms? *Check all that apply.*

☐ Will	☐ Advance Directives for Health Care	☐ Bankruptcy
☐ Immigration	☐ Power of Attorney	☐ Guardianship

☐ Other: _____

SECTION NOTES: What information obtained from the discussion on the section above with the individual and/or collateral indicated contacts impact the provision of Case Management or Intensive Case Management services?
Would the individual like this to be included within treatment planning? **No** **Yes: What is a specific goal s/he would like to accomplish?**

REFERRALS: _____

HOUSING AND LIVING SITUATION

What type of housing do you currently live in? Do you have a rental agreement or lease?

Do you have any problems with your housing? Do you have any concerns with your housing concerns regarding safety or adequacy?

Are you renting, if so ,how much do you pay each month for rent? Are you behind of current housing, housing subsidy status, behind on rent or utilities, danger of eviction, etc..?

What would your ideal housing look like?

Does anyone else besides you live in the same housing? If so, do you have difficulties with any of the people you live with?

NUTRITION AND PRACTICAL ASSISTANCE/ADL's

Tell me how you are meeting your nutritional/food needs. Do you need any assistance with getting enough nutritious food to eat? Grocery shopping or cooking? Food storage?

Have there been any changes in your use of food assistance? How is your appetite? Do you have any problems eating due to medications? Do you need any of the following:

☐ Food Stamps/EBT ☐ Home Delivered Meals ☐ Food Vouchers/Gift Cards
☐ Food Pantry ☐ Congregate Meals ☐ Other: _____

How often do you eat a nutritious meal at least 3 times a day? If not, what keeps you from eating a nutritious meal at least 3 times a day?

Has your weight increased or decreased over the past 3 months? Did you intend this change to happen? What is your usual weight?

Do you need any assistance with activities of daily living or assistance with housekeeping, laundry, shopping, remembering appointments, using the telephone?

What other basic needs do you have that you need help with?

SECTION NOTES: How does the information obtained from the discussion on the section above with the individual and/or collateral contacts impact the provision of Case Management or Intensive Case Management services?
Would the individual like this to be included within treatment planning? **No** **Yes: What is a specific goal s/he would like to accomplish?**

REFERRALS: _____

TRANSPORTATION

Are you having difficulty arranging transportation? If yes, why?

How do you get to your medical or support service visits?

☐ Public Transportation (if available) ☐ Medicaid taxi/van ☐ Taxi (non-Medicaid)
☐ Volunteer Ride (if available) ☐ Other: _____

Are you eligible for a discounted pass for public transportation?

How often do you miss appointments (either do not attend the appointment or do not schedule an appointment) because you do not have a reliable way of getting to your health provider? If you are having trouble with not having reliable transportation to your health services provider(s), would you like possibly to receive transportation support?

SECTION NOTES: How does the information obtained from the discussion on the section above with the individual and/or collateral contacts impact the provision of Case Management or Intensive Case Management services?
Would the individual like this to be included within treatment planning? **No** **Yes: What is a specific goal s/he would like to accomplish?**

REFERRALS: _____

MENTAL HEALTH & SUBSTANCE ABUSE

Do you understand your service plan for behavioral health services? Is your current service plan meeting your goals? Do you have other goals or desired outcomes that are not included on your service plan? How can I assist you with getting your service plan goals met?

Would you like to speak with a mental health counselor, therapist, or behavioral health provider for any reason that you're note already speaking to one about?

Have you ever experienced trauma, abuse, or assault? Are you able to talk with your mental health counselor, therapist about this? Do you need to receive support or services for any issues related to this?

Do you have any alcohol or other drug behaviors for which you are not receiving care right now? If so, do you have any addictive disease service needs that are not being met? Would you like to speak to someone to learn more about how your behavior could be different? Would you like to speak to someone about getting help?

Do you currently have thoughts about harming yourself or another person? (If yes, gather information as it relates to current safety. Follow agency protocol for referral to behavioral health clinical staff and document steps taken to ensure safety.)

SECTION NOTES: How does the information obtained from the discussion on the section above with the individual and/or collateral contacts impact the provision of Case Management or Intensive Case Management services?
Would the individual like this to be included within treatment planning? **No** **Yes: What is a specific goal s/he would like to accomplish?**

REFERRALS: _____

SUPPORT SYSTEMS AND RELATIONSHIPS

Do you have trouble getting along with your family, friends, spouse, children, or other significant people to you? Who do you care about the most? How often do you see them? Are you lonely? Do you want to work on getting closer to your family, friends, spouse, children, or other significant people? Do you want to explore ways of getting along with them better? How can I help you with this?

Support Groups / Family Support

Are you attending any support groups? *If yes, check all that apply:*

☐ Hospital-based ☐ Faith-based (e.g., church-related, Celebrate Recovery, etc.)
☐ Narcotics Anonymous (NA) / Alcoholics Anonymous (AA)
☐ National Alliance on Mental Illness/NAMI ☐ Core-Services Based ☐ Double Trouble In Recovery
☐ Other: _____ ☐ Other: _____

Are you interested in receiving information about any support groups? If yes, what type?

Safety of Self and Others

Do you feel safe at home? Are you able to lock your doors and windows? Is anyone hurting you, threatening you, or making you feel afraid? How can I help you with this?

SECTION NOTES: How does the information obtained from the discussion on the section above with the individual and/or collateral contacts impact the provision of Case Management or Intensive Case Management services?
Would the individual like this to be included within treatment planning? **No** **Yes: What is a specific goal s/he would like to accomplish?**

REFERRALS: _____

KNOWLEDGE OF ILLNESS and COMMUNICATION SKILLS

Have you ever told or wanted to tell people in your life about your mental health or psychiatric issues? How did that go? Friends? Family? Co-Workers? Spouse? Children? Health care providers? Employers?

How would it be helpful to know more about your illness(es) so that you can take care of yourself better or get assistance that you need?

Are there reasons that you have difficulty communicating about your wellness issues that are important to you? Knowledge about mental or other health issues? Difficulty speaking? Hearing? Reading? Other sensory impairments? Cultural barriers? Interpreter needs?

SECTION NOTES: How does the information obtained from the discussion on the section above with the individual and/or collateral contacts impact the provision of Case Management or Intensive Case Management services?
Would the individual like this to be included within treatment planning? **No** **Yes: What is a specific goal s/he would like to accomplish?**

REFERRALS: _____

SELF-SUSTAINING ACTIVITIES

Leisure Activities

Do leisure activities do you enjoy? Are there any new leisure activities that you want to try? Sports? Reading? Movies? Cooking? Hobbies? Exercise? Do you want to work on identify leisure activities?

Do you have any outlets to enjoy your leisure activities? Do you have any memberships,
How often do you do these? Where have you done these before? Do you need help getting access to them again? How important would these be to you? How would doing these affect your overall physical and mental health? Do you want to work on increased participating in leisure activities?

Interpersonal Activities

Do you have friends that you spend time with? What do you like to do for fun? Do you have any social activities? Parties? Dating? Do you have a social network? Is increasing your social life important to you? Is this something that I can help you with?

Spiritual Activities

Do you have spiritual beliefs? Do you participate in spiritual activities? Church? Do you want to increase your spiritual activities? How can I help with this?

SECTION NOTES: How does the information obtained from the discussion on the section above with the individual and/or collateral contacts impact the provision of Case Management or Intensive Case Management services?
Would the individual like this to be included within treatment planning? **No** **Yes: What is a specific goal s/he would like to accomplish?**

REFERRALS: _____

DENTAL

Have you ever been to a dentist? When was your last visit? Do you have dental insurance?

Do you have gum disease? Broken teeth? Need repair? Need extraction? Tooth or mouth pain? Need dentures? Would you like assistance with getting these?

SECTION NOTES: How does the information obtained from the discussion on the section above with the individual and/or collateral contacts impact the provision of Case Management or Intensive Case Management services?
Would the individual like this to be included within treatment planning? **No** **Yes: What is a specific goal s/he would like to accomplish?**

REFERRALS: _____

Level of Care Resource Planning

Directions: Upon review and summarization of the information from the first part of the Resource Planning Guide, this section provides a score for each life area that is then used to prioritize needs. **Scoring:** Scores for each area range from 1=Lowest to 4=Highest. Using the Care matrix on the next page as a guide, determine an appropriate score for each corresponding life area by rating the individual's resource needs along the continuum provided. If a question or confusion exists between which of two scores should be chosen, choose the higher score. (For example, if the individual has some ability to purchase nutritional foods but awaiting food stamps in order to purchase healthy foods and this is beginning to affect her/his health, then if may not be clear if the Nutrition life area score should be 2 or 3. In this situation, choose 3, the higher score.) Enter the score for each life area in the "Score" column. **Prioritizing:** Using life area scores as a guide, discuss with the individual the highest priority area for focus of Case Management or Intensive Case Management services. Indicate the highest need area by entering "1" In the corresponding "Priority" field; for the next highest priority, enter "2" in the corresponding "Priority" field. Continue until all areas have been scored. Higher scores indicate higher need and priority. Highest scores should be considered for inclusion into treatment planning. (If the individual indicates no support is needed in an area, the "Priority" field may be left blank.) "Review Score" and "Review Priority" fields may be utilized for reassessment purposes.

Needs Level *Lowest* → *Highest* *(see Care Matrix on the next page for full explanations.)*

LIFE AREAS	1	2	3	4	Score	Priority	Review Score	Review Priority
Medical Care	In Care	Occasional	Frequent	Not in Care				
Adherence	100%	Usually	Rarely	Never				
3rd Party Assistance	Enrolled	Pending	Will Apply	Denied				
Financial Resources	Stable	Adequate	Inadequate	None				
Employment	Employed	Temporary	Unemployed	Unable				
Housing & Living Situation	Self-Managed	Ltd. Probs.	Unsafe	Homeless				
Legal Affairs	None	Some Asst.	Needs Help	Full Asst.				
Nutrition	None	Some Asst.	Needs Help	Full Asst.				
Practical Assistance/ADL	Independent	Some Asst.	Limited	Unable				
Transportation	Consistent	Has Access	Irregular	None				
Mental Health/Substance Abuse	No History	Treatment	Failed Trtmt.	Serious				
Support System	Reliable	Questionable	Crisis Only	None				
Knowledge of Illness	Good	Somewhat	Little	None				
Communication Skills	Good	Fair	Limited	None				
Self-Sustaining Activities	Regular	Needs	Resists	Isolated				
Dental	None	Minor	Moderate	Major				
Other:								

Significant Findings/Prioritization of Needs

Spoken or Sign Interpreter Needed: ☐Yes ☐No If so, language: _____

CM Signature: _____ **Date:** _____

Client Signature: _____ **Date:** _____

Level of Care Resource Planning Matrix

Dimension	1-Excellent	2-Good	3-Fair	4-Poor or In Crisis
Medical Care: medical status; need for CM intervention; other medical needs	Has primary care, medically stable, and adheres to appointments without CM oversight; no chronic condition or chronic condition is under control with medication and/or treatment; doesn't rely on CM assistance to attend appointments >30%	Receives primary care when needed, generally medically stable, and adheres to appointments without CM assistance >30% of time; may have minor conditions requiring treatment	Physical health conditions are stable/ improving; no new side effects/current side effects being controlled; inconsistent with appointments, medically unstable, and CM intervention needed 30-74% of time	Physical health deteriorating; physical side effects increasing; new health issues emerging; medically unstable or unknown (newly diagnosed); not in care or CM intervention need >75% of appointments;
Adherence: understanding and compliance to treatment regimen	Always adheres to treatment; clearly communicates importance; no side effects or side effects are not interrupting activities of daily living; obtains meds without assistance; willingly participates in care plan	Usually adheres to treatment; fair communication of importance; side effects are minimally impacting daily activities; may be dependent on prescription assistance or other source for obtaining meds; participates in care plan	Sometimes adheres to treatment; reflects little understanding or willingness to comply; side effects moderately impacting daily activities; dependent on Medicaid, Non-Medicaid, etc. for meds; does not readily participate in plan but follows most directives	Rarely adheres to treatment; cannot communicate understanding of compliance; numerous side effects severely impacting daily activities; dependent on Medicaid, Non-Medicaid, etc. for meds; cannot or will not participate in plan; compliance issues
3rd Party Assistance: need for assistance, ability and willingness to apply	Has independently completed all necessary paperwork and received approval; no longer has need beyond possible annual reapplication	Completed necessary forms with limited assistance from CM; forms submitted; approval pending	Needs assistance from CM to complete forms; requires regular reminders; forms yet to be submitted or denied for reasons other than need	Needs assistance from CM to complete forms; will not meet with CM to complete; forms late for submission; application denied
Financial Resources: income/savings, benefits, entitlements	Stable income/benefits adequate to meet needs; completes all necessary/applicable benefit documents	Adequate income; needs some help completing benefit documents; medical state may jeopardize income	Inadequate current resources; has not applied for benefits or awaiting benefit determination	No current resources; requires help to understand/complete benefit documents or benefits denied
Employment: status, ability/desire to work; job-seeking skills	Stably employed, regularly meets expenses	Under- or temporarily employed; able and wants to work; has some job-seeking skills	Unemployed or job threatened by psychiatric illness or other disease; able and wants to work at suitable job	Unemployed or unable to work on regular basis; no job-seeking skills
Living Situation: environment, payments, options	Has safe, stable, and clean living situation and has self-managed options	Has safe, stable, and clean living arrangement; externally controlled; payment up-to-date; limited self-managed options; known stressors may necessitate relocation	Housing unsafe, unstable, or ill-kept; week-to-week occupancy; no personal control; payments behind, or in temporary shelter; no self-managed options	Facing imminent eviction or no place to live currently; NO self-managed options
Legal Affairs: will, directives	All necessary legal documents completed	Needs some help completing standard documents	Requires assistance with many documents	Requires help understanding and completing most documents
Nutrition:	Eating nutritious meals regularly; has adequate resources/assistance to purchase foods; treatments/symptoms not affecting appetite or weight.	Ability to purchase foods but does not always purchase nutritious foods; treatments/symptoms affecting appetite but no significant change in weight; has applied for and receives assistance with	Eating substantially more or less foods due to treatment/symptoms that has led to noticeable change in body weight in past 3 mo; limited ability to purchase foods as needed; needs some assistance with obtaining	Does not eat nutritious meals; fails to eat at least one meal a day due to lack of ability to purchase foods or obtain foods; not eligible for government food assistance program; significant change in weight w/n 3 mo; needs

		getting foods	foods regularly	assistance to acquire foods regularly
Practical Assistance/ADL: nutrition, clothing, hygiene, mobility, dependent children	Able to independently provide for own needs and perform all activities of daily living (ADLs)	Can provide for some ADLs and arrange for the rest; may have dependent children not living in household	Limited capacity for arranging ADLs on a regular basis; dependent children in household with another adult in parental role	Unable to arrange for food, clothing, and other ADLs; client is a dependent child or has sole responsibility for dependent(s) in household
Transportation: availability, dependability	Has own/other means of transportation consistently available	Has general access to public/private transportation; must occasionally rely on others	Has irregular access to public/private transportation	Public/private transportation unavailable
Mental Health and Substance Abuse: history, risk, and/or treatment	No history of functional impairment or sustained decompensation in past 6 mo (e.g., no CSU/IP admits, no jail/legal due to diagnosis, no abuse of drugs, etc.).	More than one but less than 5 days each month with some symptoms of illness or substance abuse but connected and compliant with treatment; may need some support or counseling but otherwise functional	5 to 10 days each month with symptoms of illness or substance abuse; needs high level of emotional support; connected with treatment but may have compliance issues; experiencing stress	More than 10 days each month with symptoms of illness or substance abuse; active problems and crisis; requires significant emotional support and therapy but not accessing it; high stress; not functional
Support System: informal, helping network, reliability	Has reliable friends/family to provide ongoing support	Often has help, but not always reliable; sometimes feels lonely; conflict in significant relationships from time to time;	Some support in a crisis only; resists group involvement	No reliable support when needed; support group unavailable
Knowledge of Illness: knowledge of physical health, MH/AD diagnosis; ability to communicate;	Effectively demonstrates knowledge of physical or mental health disease and treatment/recovery	Can discuss knowledge and understanding of physical or MH/AD diseases and treatment/recovery; may have some misconceptions but listens when addressed	Cannot fully communicate concerning physical/MH/AD diagnosis and may have cultural or other barriers	Cannot or will not communicate concerning physical/MH/AD diagnosis; barriers cannot be fully addressed
Communication Skills: ability to communicate effectively with CM	Can effectively communicate concerns with CM; no language, sensory, cultural, or other barriers to care	Can generally communicate with CM; can read written materials and communicate understanding; no other barriers	Difficulty communicating with CM; cannot read written materials as provided; English not first language; interpreter needed at all appointments	Extreme difficulty communicating with CM; interpreter necessary but unavailable; barrier to care but cannot be easily resolved
Self-Sustaining Activities (SSAs): Alternate activities	Regular involvement in spiritual, leisure, or other SSAs	Needs education/exposure to SSAs	Actively resists SSAs involvement	Isolated from suitable SSAs
Dental: significance of dental needs	No dental needs beyond regular check-ups; has pay source	Minor dental needs; may need assistance from 3rd party payer	Significant dental needs affecting other health; needs pay source	Major dental needs; needs pay source or denied; noncompliant in correcting issues

CRISIS & SAFETY PLAN

Client Name:	Date:

Step 1: Warning signs:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place _____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5:Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Local Urgent Care Services _____
   Urgent Care Services Address_____
   Urgent Care Services Phone _____
5. Suicide Prevention Hotline Phone: 1-800-273-TALK (8255)
6. Georgia Crisis and Access Line (GCAL): 1-800-715-4225 www.mygcal.com

Step 6: Making the environment safe:

1. _____
2. _____

Barbara Stanley, Gregory K. Brown, Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk, Cognitive and Behavioral Practice (2011), doi:10.1016/j.cbpra.2011.01.001

The one thing that is most important to me and worth living for is:

INTENSIVE CASE MANAGEMENT
REFERRAL FORM

(Insert directions on referral, e.g., where to send, etc.)

Referring Agency		**Date of Referral**	
Individual Referring		**Phone**	

Client Current Demographic Information

Last Name		**First Name**	
Date of Birth		**Gender**	
Marital Status		**Phone Number**	
Address			
City/State		**Zip Code**	
County			
Guardian		**Guardian Phone**	
Collaterals' Names		**Phone**	
Collaterals' Names		**Phone**	
LOCUS Score (if available)			
Please attach Authorization for Release of Information for collateral/s listed above if available			
Has client been informed about this referral for case management services?			

Please provide referral information as completely as possible. If information is not known, please skip that item. Alternatively, please provide other relevant referral information that may be useful but not asked for by this form.

Reason/s for referral:

Psychiatric, Substance Abuse & Medical Information			
Diagnosis Axis I-Primary		Secondary	
Diagnosis Axis II-Primary		Secondary	
Axis III—/Health Issues Medical			

Axis IV—Please indicate any psychosocial and environmental factors contributing to the disorder or resource needs

Problems with primary support group
Problems related to the social environment
Educational problems
Occupational problems
Housing problems
Economic problems
Problems with access to health care services
Problems related to interaction with the legal system/crime

Other psychosocial and environmental problems

Axis V (GAF): _____

Psychotropic and Physical Health Medications

Substance Abuse Current and History—Include treatment history if known

Other relevant information including but not limited to:
Dates of Hospitalization, Current Placement, SI/HI, Criminal/Legal, & Other Critical Issues including trauma.

*Are there any extraordinary safety concerns for staff serving the client in the home and community? If so, please describe.

Referral Must Meet ICM Eligibility Criteria

In order for an individual to receive ICM services, he/she must meet the Core Customer Eligibility Definition and the following eligibility criteria below. Current criteria for ICM service is listed in the Provider Manual for Community Behavioral Health Providers for DBHDD http://dbhdd.georgia.gov/community-provider-manuals
Please check all boxes below that apply for the individual whom you are referring to ICM service to ensure he/she meets this service eligibility criteria.

ICM Eligibility Criteria

☐ 1. Individual has a severe and persistent mental illness that seriously interferes with their ability to live in the community and at least one (1) of the following:
- ☐ a. transitioning or recently discharged (i.e., within past 6 months) from a psychiatric inpatient setting;
- ☐ b. frequently admitted to a psychiatric inpatient facility (i.e. 3 or more times within past 12 months) or crisis stabilization unit for psychiatric stabilization and/or treatment;
- ☐ c. chronically homeless (i.e. continuously homeless for a year or more, or 4 episodes of homelessness within past 3 years);
- ☐ d. recently released from jail or prison (i.e. within past 6 months);
- ☐ e. frequently seen in the emergency room (i.e. 3 or more times within past 12 months) for behavioral health needs;
- ☐ f. transitioning or have been recently discharged from Assertive Community Treatment services. **AND**

☐ 2. Individual has significant functional impairments that interfere with integration in the community and **needs assistance in two (2) or more of the following areas** which, despite support from a care giver or behavioral health staff (i.e. Community Support) continues to be an area that the individual cannot complete. Needs significant assistance to:
- ☐ a. navigate and self manage necessary services;
- ☐ b. maintain personal hygiene;
- ☐ c. meet nutritional needs;
- ☐ d. care for personal business affairs;
- ☐ e. obtain or maintain medical, legal, and housing services;
- ☐ f. recognize and avoid common dangers or hazards to self and possessions;
- ☐ g. perform daily living tasks ;
- ☐ h. obtain or maintain employment at a self-sustaining level or consistently perform homemaker roles (e.g., household meal preparation, washing clothes, budgeting, or childcare tasks and responsibilities);
- ☐ i. maintain a safe living situation (e.g. evicted from housing, or recent loss of housing, or imminent risk of loss of housing); **AND**

☐ 3. Individual is engaged in their Recovery Plan but **needs assistance with one (1) or more of the following areas** as an indicator of demonstrated ownership and engagement with his/her own illness self management:
- ☐ a. taking prescribed medications;
- ☐ b. following a crisis plan;
- ☐ c. maintaining community integration, or
- ☐ d. keeping appointments with needed services which have resulted in the exhibition of specific behaviors that have led to two or more of the following within the past 18 months:
  - ☐ i. hospitalization,
  - ☐ ii. incarceration,
  - ☐ iii. homelessness, or use of other crisis services (i.e. CSU, ER, etc.)

INTENSIVE CASE MANAGEMENT
Team Meeting Log/Minutes

Attendance - Team Members					
X	Team Member Name				

X=staff member was present.

Topic	Discussion	Action/Target Date
Administrative Management		
Team Development		

Consultation/Staffing		
First Two Initials of Client's First & Last Name Client ID #	Presenting Issue	Plan

Additional rows may be added as needed. Maintain meeting logs in a binder along with sign in sheet.

CASE MANAGEMENT TOOLKIT
Self-Assessment Tools

Contents Include:
-Service Components Self-Assessment Checklist
-Documentation Self-Assessment Checklist
-Consumer Satisfaction Survey

Case Management / Intensive Case Management Toolkit: Quality Improvement Self-Assessment Checklist

CM/ICM Service Components	Yes	No	Comments
Has the service been ordered by an authorized licensed professional	☐	☐	
Does the assessment include the individual's strengths, needs, abilities, and preferences	☐	☐	
Are the individual's natural supports and other collaterals identified with contact information	☐	☐	
Has a release of information been completed and signed by the individual for each collateral contact	☐	☐	
Has a crisis/safety plan been completed	☐	☐	
Are the documented referrals related to the Individual Recovery Plan	☐	☐	
Is the Individual Recovery Plan signed by the individual	☐	☐	
Is the Individual Recovery Plan signed by an authorized license professional on or before the first date of service?	☐	☐	
Have revised Individual Recovery Pans been documented following a reassessment at a minimum of every 6 months	☐	☐	
Goals in the Individual Recovery Plan reflect needs identified in the assessment	☐	☐	
Is there evidence of attempts to contact after missed appointments	☐	☐	

Has a Behavioral Health Assessment been completed at a minimum of every 3 years	☐	☐	
Was there evidence of collaboration with collateral contacts in the development of the Individual Recovery Plan	☐	☐	
Has there been a minimum of two contacts, with at least 1 being face to face	☐	☐	
Are at least 50% of contacts provided out of clinic	☐	☐	
Do progress notes document progress (or lack of) towards goals on the Individual Recovery Plan	☐	☐	
Is there documented evidence that the individual meets the admission criteria	☐	☐	
If the individual has a recent hospitalization, has the discharge paperwork obtained	☐	☐	
Is there evidence of referral and linkage to needed services/resources	☐	☐	

Case Management / Intensive Case Management Toolkit: Quality Improvement Self-Assessment Checklist

CM/ICM Progress Notes	Yes	No	Comments
Are the signature, printed name, and credentials of the provider present	☐	☐	
Time in, Time out, and # of units present	☐	☐	
Date of service present	☐	☐	
Signature date present	☐	☐	
Is the procedure code present with all required modifiers	☐	☐	
Are practitioner and location codes present	☐	☐	
Are locations identified for all out of clinic contacts	☐	☐	
Was whiteout used	☐	☐	
Have errors been corrected with a single line drawn through, initial, and date	☐	☐	
Are multiple pages indicated as Page 1 of # (total number of pages)	☐	☐	
Are all handwritten progress notes written in blue or black ink	☐	☐	
Are all handwritten progress notes readable, decipherable and easily discernible to the readers	☐	☐	
Printed Name and Credentials (Education, License/Certifications, & DBHDD Approved Abbreviation)	☐	☐	
Content of the note reflects a goal on the Individual Recovery Plan	☐	☐	
Progress (or lack of) towards the identified goal is documented	☐	☐	
If lack of progress, is a plan to address barriers indicated	☐	☐	

CASE MANAGEMENT / INTENSIVE CASE MANAGEMENT TOOLKIT: CONSUMER SURVEY

Survey Items	Strongly Disagree	Disagree	Agree	Strongly Agree
1. I believe the Case Manager puts my best interests first.				
2. Case Manager demonstrates a willingness to help me.				
3. Case Manager communicates clearly with me.				
4. I have a say in the goals and objectives in my recovery plan.				
5. I am satisfied with the services I receive.				
6. Case Manager makes information and resources available to me.				
7. Case Manager is flexible in helping me find solutions to my problems.				
8. The services received by Case Management meet my expectations.				
9. Case Manager gives me the individual attention I need.				
10. Case Manager maintains my confidentiality.				
11. Case manager treats me with respect.				
12. Case Manager has helped me increase my self confidence.				
13. Case Manager conducts himself/herself in a professional manner.				
14. My opinion was important in setting the goals I am working on.				
15. I have increased the skills needed to take care of myself since having a Case Manager.				

CM TOOLKIT RECOMMENDATIONS FOR CHANGE OR REVISION

Instructions:
As the CM Toolkit is periodically updated and revised, DBHDD requests ongoing input regarding recommendations for change or revision to offer maximum benefit and assistance to DBHDD Providers of ICM and CM Services.

Please email this form with recommendations for change or revision to www.DBHDD-CM@dhr.state.ga.us.

Originator Name	
Originator Email	

Type of Change ☐ New ☐ Revision

Toolkit Location for Content Changes: *Section, Page, Paragraph, etc.*	**Proposed Changes:** *Enter brief summary of recommended change.*	**Rational for Proposed Changes:** *Identify the benefit/justification for the change.*