CHAPTER 2: CASE MANAGEMENT AND SUPPORTS COORDINATION

Contents

CHAPTER 2: CASE MANAGEMENT & SUPPORTS COORDINATION 1

Medicaid Provider Manual Core Requirements for Targeted Case Management 2

Core Components of Case Management/Supports Coordination 4

Key Domains Addressed 6

Yearly Flow of Activity 8

Skills & Abilities for Effective Case Management & Supports Coordination 10

Case Management/Supports Coordination Self-Assessment Tool 22

SCCMHA Case Managment Checklist 34

Chapter
2

CHAPTER 2: CASE MANAGEMENT & SUPPORTS COORDINATION

Understanding the many roles and functions of case management and supports coordination is critical to providing effective services and supports to consumers. This chapter includes information on the core responsibilities and specific activities required of case managers and supports coordinators.

Case management and supports coordination encompass a range of consumer-centered services that link consumers with health care, psychosocial, and other services. The goal is to ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care through ongoing assessment of the consumer's and other key family members' needs and personal support systems.

Using a person-centered planning process, case managers and supports coordinators work with consumers and others identified by the consumer in the development of an individualized support plan that reflects the consumer's personal vision for a desired life. Case managers assist consumers and others in identifying support strategies that can be implemented to guide consumers in attaining self-identified goals and wishes. Support strategies incorporate the principles of empowerment, community inclusion, health, and safety assurances, and the use of natural supports.

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized service plan
- Coordination of services required to implement the plan
- Monitoring to assess the efficacy of the plan
- Periodic re-evaluation and adaptation of the plan as necessary, which may include consumer-specific advocacy, and/or review of utilization of services.

The Case Manager/Supports Coordinator serves as the primary coordinator of needs and services to the consumer.

Case managers and supports coordinators work closely with consumers to assure their ongoing satisfaction with the process by making sure that the activities selected always reflect the supports and services desired and needed by each consumer/family. In addition, case managers/supports coordinators analyze the outcomes of the supports and services implemented and monitor available resources to support each consumer's plan. Strategies and implementation plans are comprehensive and address: health and safety; housing and employment; social networking; scheduling and documentation of appointments and meetings, including ongoing person-centered planning; utilization of natural and community supports; and the quality of the various supports and services utilized by consumers.

Medicaid Provider Manual Core Requirements for Targeted Case Management

The Michigan Medicaid Provider Manual, covered in various sections of this manual, governs the provision of mental health and substance use disorder treatment to Medicaid beneficiaries. It should be noted that because changes/updates are made to the manual on a quarterly basis, it is important to check for updates from http://www.michigan.gov/mdch/0,1607,7-132--87572--,00.html.

- Assuring that the person-centered planning process takes place and that it results in the individual plan of service.
- Assuring that the plan of service identifies what services and supports will be provided, who will provide them, and how the case manager will monitor (i.e., interval of face-to-face contacts) the services and supports identified under each goal and objective
- Overseeing implementation of the individual plan of service, including supporting the beneficiary's dreams, goals, and desires for optimizing independence; promoting recovery; and assisting in the development and maintenance of natural supports
- Assuring the participation of the beneficiary on an ongoing basis in discussions of his/her plans, goals, and status
- Identifying and addressing gaps in service provision
- Coordinating the beneficiary's services and supports with all providers, making referrals, and advocating for the beneficiary
- Assisting the beneficiary to access programs that provide financial, medical, and other assistance such as Home Help and Transportation services.

- Assuring coordination with the beneficiary's primary and other health care providers to assure continuity of care
- Coordinating and assisting the beneficiary in crisis intervention and discharge planning, including community supports after hospitalization
- Facilitating the transition (e.g., from inpatient to community services, school to work, dependent to independent living) process, including arrangements for follow up services
- Assisting beneficiaries with crisis planning
- Identifying the process for after-hours contact

Other responsibilities include:

- Communicating with other key providers, including residential or other supports and community resources
- Coordinating crisis services when appropriate
- Ensuring the person-centered plan is shared with other mental health providers
- Monitoring the implementation of the person-centered plan
- Coordinating primary health care as appropriate
- Visiting residential and other programs as outlined in the person-centered plan
- Advising support staff about changes in the person-centered plan
- Ensuring annual assessment reviews are completed
- Keeping the consumer's medical record current including demographic information which must be kept up to date at all times
- Ensuring all appropriate documentation is current and in the consumer's record
- Ensuring all documents are signed by the appropriate parties
- Ensuring that the frequency of contacts occurs at intervals identified in the person-centered plan
- Ensuring that guardianship or other legal papers are in the consumer's file and match the stated status of the consumer
- Ensuring health and safety are consistently and continually addressed
- Completing intake paperwork
- Documenting level of care changes
- Ensuring the person-centered plan is developed within seven (7) days of commencement of services
- Completing a substance abuse and/or jail assessment as appropriate
- Completing record notes of contacts with the consumer
- Completing assessments as required
- Providing the consumer with conflict resolution information, privacy consents, and notices
- Helping the consumer develop a crisis plan
- Coordinating services and supports

- Documenting the person-centered plan, helping develop natural supports, and providing the consumer with a copy of his/her person-centered plan within fifteen (15) business days of the planning meeting
- Documenting the Pre-planning meeting
- Serving as the facilitator at the person-centered planning meeting if requested by the consumer/their supporters
- Coordinating and assisting with hospital discharges

Core Components of Case Management/Supports Coordination

- **ASSESSMENT:** A written comprehensive assessment addressing the consumer's needs/wants, barriers to needs/wants, supports to address barriers and health and welfare issues. The assessment should clearly state/conclude why the person requires case management services. In addition, it should make recommendations for treatment based on the assessment of the person's:
  - Needs and wants
  - Supports they need to achieve needs and wants
  - Health issues
  - Safety issues
  - Barriers to achieving needs/wants
- **PLANNING:**
  - Planning and/or facilitating planning using person-centered planning principles
  - Developing an individual plan of service using the person-centered planning process
  - Developing the person-centered/family-centered treatment plan
  - The treatment plan must be comprehensive enough to describe the services and supports being purchased to the provider
  - If the consumer has needs that the case manager/supports coordinator cannot address other disciplines need to be included in the treatment planning process (e.g., nurse, dietician, and behavioral specialist, etc.)
  - There must be one integrated plan of service including goals from other entities services are purchased from (e.g., Bayside Lodge, residential provider, SVRC, outpatient therapist, and behavioral specialist, etc.)
  - The plan of service must identify what services and supports will be provided, who will provide them, and how the case manager/supports coordinator will monitor (interval of face-to-face contacts) the services and supports identified under each goal and objective

- The case manager/supports coordinator is responsible for overseeing the implementation of the entire plan including goals from other entities services are purchased from (e.g., Bayside Lodge, residential provider, SVRC, outpatient therapist, and behavioral specialist, etc.)
- The case manager/supports coordinator is responsible for identifying gaps in needed service provision

▣ **LINKING AND COORDINATING**:

- Searching for community resources
- Coordinating the person's services and supports
- Making referrals (e.g., clubhouse, behavioral specialist, peer support specialist, outpatient therapy, DBT team, and psychiatric, dietary, and physical therapy services, etc.)
- Assisting the person to access programs that provide financial, medical and other assistance
- Coordination with the Medicaid Health Plan, Medicaid fee-for-service provider, or other health care providers
- Coordination with SCCMHA Crisis Intervention Services
- Coordination of the transition from inpatient hospital care to the community including inpatient case management services that are designed prevent unnecessary hospitalization or expedite discharge from an inpatient facility
- Linking, coordinating, follow-up, advocacy, and/or monitoring of Specialty Services and Supports and other community services/supports
- Assistance with access to entitlements and/or legal representation

▣ **MONITORING**:

Policy 03.02.03 – Monitoring and Reassessment

- Ongoing monitoring of the consumer including knowing signs and symptoms of decompensation and intervening when symptoms are present
- Monitoring of the entire plan of service and reviewing it with the consumer and other disciplines and committees (e.g., Behavior Management Review and Clinical Risk) as appropriate
- Monitoring the person's care (e.g., health and psychiatric) during a hospital stay
- Monitoring the consumer's living situation addressing any health and safety concerns or quality of care issues
- Monitoring in a variety of settings
- Monitoring whether the services and supports being provided are adequate to meet the needs/wants of the consumer

▣ **ADVOCACY**:

- Advocating for the person's dreams and desires

- Advocating to the organization when the needed services are not available
- Advocating with a family or guardian when the person's dreams/desires are not being addressed
- Advocating with the primary health care provider
- Advocating for needed financial assistance
- Advocating with other providers (e.g., psychiatrists, hospitals, discharge planners, care management, and residential providers)
- Advocating with the school a consumer attends

Key Domains Addressed

HEALTH AND WELLNESS involves activities designed to promote, support, and maintain the consumer's overall health. When necessary and indicated[1], activities may include:

- Coordination and arrangement of medical and dental appointments and treatments
- Coordination and arrangement of mental health treatment and services
- Coordination and arrangement for nutritional/fitness support
- Coordination and arrangement for any therapies needed (i.e., PT, OT, speech, etc.)
- Assistance in acquiring and usage of any needed medical equipment
- Assistance with the management of chronic illnesses and conditions
- Assistance with grief counseling as needed

QUALITY OF LIFE is a category of service that balances freedom of choice and individual lifestyle, with personal responsibility and system accountability. The focus should always be on promoting the consumer's personal competencies that would result in safety and freedom from abuse, neglect and exploitation. Such activities could include:

- Assist, coordinate, and secure information on services and options that are available so that decisions are informed choices
- Offer assistance and coordination obtaining legal resources such as partial or full guardianship. Assist in the coordination and/or mediation of problem resolutions that may arise with housing, employment, community membership and day support services
- Coordinate services, or engage directly with the consumer, to avoid or resolve a crisis, or any other challenging personal situation

[1] Necessary and indicated refers to activities identified and documented as such in the person-centered planning process and with which the consumer will require assistance in order to achieve (e.g., a consumer who has diabetes and is not able to independently coordinate and arrange for needed medical care, and requires additional supports to maintain health).

- Assist, coordinate, or complete any required reporting obligation

COMMUNITY MEMBERSHIP is a group of services designed to assist consumers in understanding and accessing the neighborhood and community in which one lives. In essence, the purpose of Community Membership services is to locate, and connect the consumer to sources of personal support in their community that enhance the consumer's vision for a desired life. Services may include:

- Assist, coordinate, or introduce the consumer to community groups, agencies and organizations that reflect the consumer's personal interest and vision for a desired life (e.g., faith-based organizations, Weight Watchers, and hiking clubs, etc.)
- Assist, coordinate, or arrange opportunities for the consumer to volunteer in activities that reflect the consumer's personal interest
- Assist, coordinate, or provide information and training on local resources and how to use those resources
- Assist, coordinate, or locate support groups that may reflect the consumer's interest
- Assist, coordinate, or arrange for cooperatives or similar self-help activities

INFORMATION AND REFERRAL is a group of services designed to ensure that the consumer has access to information. When necessary and indicated, services may include:

- Obtaining information and assisting, coordinating, or making referrals to federal programs such as SSI, food, and housing programs
- Obtaining information, and assisting the consumer in obtaining benefits to which they are entitled (e.g., Medicaid, Medicare, prescription drug programs, welfare, vocational supports, educational supports)
- Obtaining information, and assisting or coordinating in the making of referrals for medical and or mental health services
- Obtaining information, and assisting or coordinating in the making of referrals for membership in local support or self-help groups
- Obtaining information, and assisting in the consumer's ability to understand the support system including their rights, responsibilities, grievance options and the decision-making process

PERSONAL SUPPORT AND COORDINATION is a group of services designed to offer assistance and supports to promote the consumer's articulation of a personal vision for a desired life in the community. When necessary and indicated, services in this category may include:

- Assist, coordinate, or facilitate the consumer's future planning process
- Assist in coordination of opportunities for the consumer to attend preferred community activities
- Assist in the coordination of opportunities for the consumer to attend those activities with people who are friends and allies rather than agency staff

- Assist in the coordination of options that offer a greater variety of activities in which the consumer can become engaged
- Assist in the coordination of opportunities for the consumer to engage in more activities with friends and allies and without paid staff
- Assist in the coordination of the expanding the network of the consumer's social relations to include more individuals who are not agency staff

PERSONAL AND SOCIAL RELATIONSHIPS is a group of services designed to connect the consumer to sources of personal support in the community. When necessary and indicated services and supports may include:

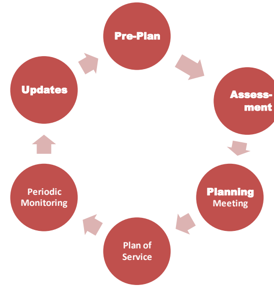
- Assist in, coordinate, or arrange the provision of instruction, guidance, modeling, and mentoring
- Assist in the coordination, or facilitate referrals for adult education, memberships in community groups, agencies, or organizations and or volunteering with community projects
- Assist in the coordination or provision of physical and or other support that may be necessary to consumer in community events
- Assist in the coordination and arranging of one-to-one relationship building, with a decided preference for natural supports from family, friends, neighbors and allies,
- Assist in the coordination and arranging of modeling, mentoring and support from people associated with other generic community and civic organizations
- Assist, coordinate, facilitate, desired outcomes such as connections to sources of support through families, friends, allies or people associated with community or civic organization

Yearly Flow of Activity

Policy 03.01.01 – Eligibility Criteria

Case managers and supports coordinators work with consumers and their supporters on an ongoing basis for as long as services and supports are needed, and consumers continue to meet eligibility criteria. The following shows the steps involved in the annual cycle of work.

Pre-plan ➡ Assessment ➡ Planning meeting ➡ Plan of service ➡Periodic monitoring of the plan and the consumer including ongoing discussion of the plans, goals and status with linking/coordinating and advocating occurring throughout to assure that the plan is implemented as written ➡ Pre-planning when needs change, the consumer desires, or annually, at a minimum.



Periodic reviews are conducted and completed every ninety (90) days.

Skills & Abilities for Effective Case Management & Supports Coordination

MAY 2011

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NOTE: The following document is work product of The Standards Group. Any comments or questions related to this document should be sent to: Laura Vredeveld, TSG Director, laurav@tbdsolutions.com. (616) 427-5957

Introduction: The public mental health system must ensure that supports coordinators/case managers and those who perform aspects of these functions have the knowledge, skills and abilities needed to promote consumer health and welfare, achievement of personal goals, support individuals in their recovery journey, and understand and actively support people to have a meaningful life in the community.

No individual SC/CM would be expected to have all the identified competencies identified below. Rather, systems would be organized to provide and effectively deliver all the various functions of case management/supports coordination. All persons identified in policy and contract to perform any part of these functions, including case managers, supports coordinators, independent facilitators, support brokers, and supports coordinator assistants would be expected to develop the necessary skills, abilities, and knowledge to effectively perform their assigned functions. This set of competencies should be viewed in conjunction with current requirements identified in the Michigan Medicaid Provider manual related to staff qualifications and credentials.

The identification of this comprehensive list of skills, knowledge and abilities for effective case management/supports coordination is intended to be used in system quality improvement efforts. Intended uses include staff self-assessment, supervision, developing staff development plans and training curriculum, and other workforce development efforts. It could also be considered as a tool when establishing expectations for staff when organizing a flexible system of supports and services. It is not intended as a tool for external evaluation of a program or for measuring/monitoring compliance with a particular standard.

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Advocacy					
Knows the individuals they support well (likes, dislikes, preferences, choices, interests, strengths, needs) and actively supports and coaches the individual and empowers the individual to seek solutions, make decisions and explore new opportunities.	√				
Understands and promotes the person's wishes with other professionals, direct care staff, provider agencies, community and family and to advocate for system change where necessary, including public-policy, resource allocation, and advocacy with other systems as needed.	√				
Communicates and advocates so that activities and processes recognize the individual and the importance of positive and meaningful sense of identity apart from one's condition and support meaningful life opportunities.	√				
Knows and shares information about self-determination, choice voucher, peer supports, family navigator, recipient rights and other programs that provide for self-determination and individual choice	√				
Demonstrates knowledge of rights, complaint and appeals processes in areas of civil/recipient rights, and effectively assists individuals in using these processes as needed.	√				
Communication-facilitation-coaching					
Uses effective communication strategies and skills necessary to engage and establish a collaborative relationship with the individual and to build rapport	√				
Is able to evaluate behaviors relative to potential attempts to communicate or cope with impacts of life events as well as stress or pain	√				
Builds rapport, develop consensus, and actively engage in relationships of trust with individuals and teams	√				
Effectively communicates and shares information to successfully train or educate.	√				
Conveys hope and respect	√				
Coaches individuals in developing healthy, reciprocal relationships.	√				
Assessment Skills					
Develops an understanding and appreciation of the individual in order to establish a positive relationship/alliance. Listens to the person's life story and identify skills, strengths, assets		√			
Aware of and uses uniform, standard, population specific assessment tools, relevant professional expertise, psychosocial and functional assessment along with sound professional judgment to determine eligibility for services and types and intensity of necessary services		√			

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Determines individual's capabilities, preferences and needs including understanding the benefits of a range of interventions that could contribute to improved outcomes and quality of life		√			
Uses the assessment process to involve a variety of sources (including other professional assessments when indicated) in obtaining complete and accurate information in order to gather the following information: • behavioral health data • information about the individual's needs, strengths, desires, abilities, • cultural background, spiritual beliefs • level of education • medical history and current health status • Employment • finances • mental status • substance use • cognitive, emotional, behavioral functioning • history of abuse, trauma • Family and developmental history • Psychiatric history • need for and availability of social support • risk taking behavior • need for assistive technology • any other pertinent information.		√			
Creates a narrative summary that moves from details collected to understanding individual preferences, formulates recommendations for level of care, intensity of treatment and possible goals which can be shared with the individual and is essential to process of developing meaningful plan.		√			
Shares information from assessment with individual in a clear and understandable manner including implications/pros and cons of available choices		√			
Person Centered Planning Process					
Understands and follows the MDHHS PCP policy and practice guideline	√				

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Conveys hope, sense of possibility	√				
Maintains focus on the individual and their decision-making authority while working collaboratively with the individual, allies (friends and family as chosen by participant), guardians, and others in a team approach			√		
Uses planning tools to address key life domains as identified in the Michigan Mental Health Code including the individual's need for food, shelter, clothing, health care, safety, employment opportunities, educational opportunities, legal services, transportation, recreation, social and family relationships, and finances			√		
Explains and provides written resource information and referrals about the full service array, provider options, and benefits and limitations of those services.			√	√	
Provides unbiased, objective information about choice of services and providers and identifies potential for conflict of interest			√		
Develops a plan in partnership with the person that expresses the desires of the individual, reflects the individual's choices and is based on strengths, needs, abilities and preferences and reflective of the individual's age, culture and ethnicity			√		
Develops a comprehensive plan that uses natural and community supports and provides for desired services to help the individual achieve their goals.			√		
Clearly identifies and documents the roles and responsibilities, scope, duration, and intensity of all services and the planned frequency and method for monitoring those services			√		
Understands, documents, and effectively explains the costs of services and supports identified in the IPOS			√		
Presents information about the benefits of crisis planning and transition planning and develops plans when chosen.			√		
Facilitates the necessary sharing of information to ensure that goals and plan information is shared appropriately (with permission), understood and acted upon by providers and others as relevant			√		
Peer Supports					
Understands the role and evidence-base for use of peer supports, including how peers can support individuals by sharing their life experience, acting as a role model and teacher and communicating concerns to other professionals from the perspective of an individual receiving services.	√				
Understands, describes and provides access so that peer supports have a role in assisting individuals in achieving their goals in a variety of domains including employment, housing, education and recreation.			√	√	

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Works collaboratively with peer advocates, peer mentors, family navigators, mentors, parent support partner, or peer support specialists to assist individuals with their goals				√	
Self Determination					
Understands and supports choice and autonomy by providing information, guidance and assistance in the use of self-directed arrangements, Choice Voucher System and control over one's own budget consistent with MDHHS policy	√				
Supports self-advocacy and assists individual to develop collaborative and supportive relationships and networks of support, and able to teach components of self-advocacy including personal values, decision-making, problem resolution and navigating in the human service system	√				
Recognizes and values individual's self-knowledge and supports their right to risk both success and failure through their choices	√				
Cultural Competency					
Knowledgeable of definitions and fundamental concepts of culture and diversity within the context of the beliefs, behaviors, and needs presented by individuals served and their communities.	√				
Respects family and religious culture, race, gender, sexual orientation, issues of poverty and/or economic factors, disability, and rural vs. urban cultures.	√				
Functions effectively within a variety of cultural and religious situations.	√				
Coordinates or links to services that are tailored or matched to the unique needs of individuals, children, families, organizations and communities served, including incorporation of special customs into treatment modalities.	√				
Aware of the ways that culture may influence the acceptance and or understanding of mental illness, intellectual/developmental disability and or substance abuse and addresses and/or mitigates as necessary	√				
Provides or advocates for the provision of information, referrals, and services in the language appropriate to the client, which may include use of interpreters.	√				
Working with families and allies					
Uses a strength-based approach to working with families, guardians and allies in order to respect individual decisions, mitigate negative interactions, and establish boundaries.	√				
Gathers information about family issues and understand family dynamics and systems in order to support the individual's achievement of his/her desired outcomes.		√	√		
Identifies and addresses issues of control if guardians or family members limit individual's autonomy or choice.		√	√		
Facilitates meetings between individuals, family members and allies to accomplish tasks and maintain group cohesiveness	√				

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Demonstrates conflict resolution and problem-solving skills to ensure that the individual maintains control in of decisions for their life.	√				
Assesses, understands and supports the informal care giver's needs		√		√	
Facilitates development of personal support networks by utilizing natural supports within communities, peer support and self and mutual help groups			√	√	
Linking/Coordination/Facilitating Services					
Provides linkage to services in a variety of public and community settings in a professional and safe manner.				√	
Develops and works with teams and resolves conflicts when necessary.				√	
Understands the service system forms, units, policies and procedures, access points, authorization, in order to arrange and assure delivery of agreed upon, necessary services.				√	
Develops and communicates expectations and negotiates with provides to ensure that the provider of services has all relevant individual information to successfully implement the plan and provide effective services.				√	
Works with a multidisciplinary team, including understanding the role of specialty service system/professional services (Psychiatric, Nursing, OT, PT, Speech), peer support specialists, support brokers, and other ancillary services to meet individual's needs.				√	
Works with other systems including schools, courts, housing authorities, police, DHS, SSA, other provider agencies, medical providers				√	
Demonstrates an understanding of organizational mandates and roles, shares relevant information and uses consensus to gain a level of commitment from all parties to work from the same plan.				√	
Works collaboratively with other service delivery systems to effectively coordinate integrated physical and behavioral healthcare services.				√	
Community Knowledge and Networking					
Establishes trust and rapport with colleagues in the community and forms effective community partnerships	√				
Knowledgeable of availability and eligibility for public systems including school, housing, Social Security Administration, Department of Human Services , employment, justice system		√	√	√	
Gathers and uses information about interests, affinities, competencies and strengths to match, plan and support the use of community resources and natural supports		√	√	√	
Skilled in assisting individual to gain access to relevant community services and public systems				√	
Identifies, promotes and supports opportunities for individuals to connect with their community.		√	√	√	

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Vocational, Educational and Career supports					
Provides or arranges the appropriate and necessary supports to assist all individuals to work, earn personal income, transition from school to employment, and be a contributor to their community	√				
Aware of and provides information or linkages to opportunities for generating income, including microenterprise.	√				
Assesses the individual's potential for increasing autonomy through education, work, earning income, and addresses concerns and fears related to responsibilities, loss of benefits, or change.		√			
Aware of and refers to the Evidence-Based Practices of Supported Employment to assist/facilitate an individual seeking competitive employment			√		
Provides information and referral to resources about maintaining benefits, earning income and employment options.			√		
Aware of and refers to available system & community resources to support competitive employment				√	
Prevention and Safety					
Promotes and models a culture of gentleness and respect in environments where individuals with intellectual/developmental disabilities, mental illness, and co-occurring disorder and children with SED and the people who support them interact	√				
Develops a plan based on risk factors and risk tolerance, identifies strengths, provides information and education about risk-prevention strategies where needed in all potential life domains (home, work, school, transportation) while recognizing and supporting personal responsibility and authority.		√	√		
Develops plans for responding to crisis with effective trauma-informed interventions, and provides access to stabilization resources when needed		√	√		
Identifies and reports abuse and neglect in accordance with legal requirements	√				
Understands and monitors the individual's warning signs and responds effectively to signs of crisis using de-escalation skills.	√				
Knowledgeable of how and where to access information about definitions, rights and requirements included in the DCH Technical Requirement for Behavior Treatment Plan, Adult Foster Care licensing rules and related DCH publications	√				
Collaborates as appropriate in the development of behavior plans, using positive behavior supports and physical/non-physical behavior management techniques			√		
Ensures implementation of and effective monitoring of established behavior treatment including training of direct support staff.					√
Health and well being					

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Demonstrates knowledge of the principles of good health, preventive health guidelines, use of environmental supports, and communicates using information and techniques that support self care	√				
Knowledgeable and assesses for risk of communicable diseases, high-risk behaviors, medication side effects, acute & chronic health conditions and makes appropriate referrals as needed.		√	√	√	√
Understands basic nutrition and medical terminology, common symptoms, and medical specialties.		√			
Uses structured motivational approaches and principles that strengthen the individual's capacity to set goals for improved self-management of specific health condition			√		
Identifies benefits and uses of advanced directives, explains and links to community resources that assist with development of advanced directives including psychiatric advanced directives and plan for end of life care			√	√	
Problem-solves barriers using the resources of the community and personal support systems in addition to formal services.				√	
Explains, coordinates and connects to the resources of the local health care system including primary care and dental options in the community to ensure access and to promote awareness and collaboration				√	
Participates in discharge planning to community from local inpatient settings to ensure desired and necessary follow up care, including linking to treatment and healthcare resources to address communicable diseases, high-risk acute & chronic health conditions				√	
Monitors and identifies health changes according to the individual's plan and take appropriate action as needed.				√	√
Provides linkages to resources in the community such as health and nutrition classes, smoking cessation, support groups, exercise opportunities, wellness groups.				√	
Role in Ongoing Quality Improvement					
Supports the individuals in their involvement in the quality improvement process so that input from persons receiving services related to satisfaction, responsiveness, process, progress on goals, and outcomes is solicited and addressed.					√
Routinely monitors progress, participates in conflict resolution and problem solving as needed, and makes any desired changes to plan or services, including focusing beyond particular events (behavioral episodes, etc.) to the activities that take place between events that cause them to occur.					√
Knowledgeable of the assurance areas and quality improvement role and requirements in Medicaid Home and Community Based Programs including monitoring of health and safety in all settings.					√
Collects, maintains and evaluates service data					√

The identification of this comprehensive list of skills, knowledge and abilities for effective case management/supports coordination is intended to be used in system quality improvement efforts. Intended uses include staff self-assessment, supervision, developing staff development plans and training curriculum, and other workforce development efforts. It could also be considered as a tool when establishing expectations for staff when organizing a flexible system of supports and services. It is not intended as a tool for external evaluation of a program or for measuring/monitoring compliance with a particular standard.	**Core/Basic**	**Assessment**	**Planning**	**Linking**	**Monitoring**
Ensures the implementation of the person-centered plan and to evaluate the impact of services on goals, satisfaction, and quality of life					√
Fosters communication to ensure that program administrators receive direct input from individuals receiving support, their families and other interested persons.					√

Other Population –Specific Competencies

	Core/Basic	**Assessment**	**Planning**	**Linking**	**Monitoring**
Children/Family Specific					
Uses a holistic planning process that includes a functional assessment and is strength based and identifies the needs of the child and family	√				
Facilitates a planning process that is Family-driven, youth- guided and culturally relevant and focused on building resiliency and family strengths.			√		
Knowledgeable of and provides access as appropriate to the following approaches to children's services o Bio-psychosocial practice o Medication o Trauma focused Cognitive Behavioral Therapy (CBT) o Parent Management Training Oregon Model (PMTO) o Recovery based/Resiliency o Use of Peer to Peer Model o Family to Family Navigator Model		√	√		
Knowledgeable of Child and Adolescent Development, including brain development, Co-occurring disorder risk factors		√			
Knowledgeable of laws allowing children to receive services without parental consent.	√				
Knowledgeable of System of Care Principals and parent-to-parent support models.	√				
Knowledge of special education systems, rules, roles in IEPC and transition to adult services			√	√	
Intellectual/Developmental Disabilities					
Understands, able to express and demonstrates the values behind the vision and mission of the MDHHS for persons with intellectual/developmental disabilities	√				
Demonstrates a personal commitment to the individual and believe in his or her ability to learn, change, and grow.	√				

	Core/Basic	Assessment	Planning	Linking	Monitoring
Knowledge of diagnostic terms, characteristics and implications for functioning, communication and health of individuals with intellectual/developmental disabilities		√			
Knowledge of the characteristics of a range of intellectual and developmental disabilities identified in the DSM–V.		√			
Awareness of the positive behavior supports and interventions necessary to meet the sensory, cognitive, physical and emotional needs of individuals with intellectual/developmental disabilities			√	√	
Effectively relates and interacts with individuals who are non-verbal or have limited verbal communication skills and understands how behaviors are sometimes used to communicate feelings and/or undiagnosed medical conditions or pain.	√				
Mental Illness					
Understands and can articulate the recovery model for individuals with mental illness.	√				
Advocates for persons with mental illness and their families in all areas of their recovery journey.	√				
Actively combats stigma and combats myths related to mental illness.	√				
Demonstrates basic understanding of DSM IV diagnostic classifications, symptoms, characteristics of mental illness and co-occurring disorders		√			
Demonstrates ability to monitor individuals' warning signs which could place them at risk for intentional or unintentional injury to self or others as a result of a range of mental health problems, including affective disorders, mood disorders, anxiety disorders, psychotic disorders, eating disorders and self injury, trauma.		√			
Aware of the supports and interventions necessary to meet the recovery needs of a wide range of individuals various stages of recovery from mental illness. Engages and supports individual in any stage of recovery.			√		
Coordinates and links to a wide range of evidenced based and promising approaches to treatment including trauma – informed services, culture of gentleness, use of psychotropic medications, motivational interventions WRAP facilitation, COD/IDDT, Family Psycho Education, CBT, DBT,				√	
Understands basic pharmacology, including therapeutic effects and side effects of primary psychotropic medications along with the consumer's viewpoint on the medications and their effects		√			
Knowledgeable of the high rate of chronic physical health conditions, increased mortality and modifiable risk factors and vulnerabilities and strategies to address.		√	√		
Substance Use Disorders					
Identifies stages of change and uses a motivational approach with individuals at all stages		√	√		

	Core/Basic	Assessment	Planning	Linking	Monitoring
Understands and provides information about the effects of substances and the relationship between substance use and symptoms of mental illness.		√	√		
Understands the difference between substance use, abuse and dependence		√			
Knowledgeable of the interventions for co-occurring substance use disorders for an individual with a mental illness or an intellectual/developmental disorder.			√	√	
Knowledgeable of professional, peer, social and self-help resources available to help someone with a substance use disorder achieve recovery.				√	
Mental Health System, Public Benefits and Legal Requirements					
Demonstrates knowledge of key elements of the Michigan Mental Health Code, relevant sections of the MDHHS Medicaid Provider Manual, and practice guidelines and related rules and regulations	√				
Demonstrates knowledge of policies, procedures and functions of SC/TC and related positions and case management models	√				
Understands policy requirements for professional ethics and boundaries	√				
Complies with state and federal regulations regarding privacy to ensure use of confidential information is based upon best practices, ethical and legal considerations, the Mental Health Code and HIPAA	√				
Understands and implements agency relevant policy and procedures, including reportable critical incidents, mandatory reporting	√				
Demonstrates understanding of alternatives to guardianship, guardianship law, process and its impact on loss of rights, and able to provide support for the individual in accessing changes to the guardianship order. Refers to legal representatives as appropriate	√				
Knowledgeable of and conveys information and access to resources relate to SSI, role of payee, DHS eligibility, Medicaid application process,	√				
Demonstrates knowledge of operation of mental health and human service systems, civil rights, basic eligibility, service access and delivery, program characteristics and covered benefits, service authorization requirements and processes, waiver services, grievance & appeals processes, and Recipient Rights			√		
Understands the purpose and availability of various funding streams, not-categorical funds and community resources			√		
Professional Role & Self-Development					
Understands and demonstrates professional ethics, boundaries and standards, including scope of practice and professional licensing regulations	√				
Understands and can describe when supervision and consultation is needed and uses feedback from individual receiving services and/or supervisory/mentor feedback effectively	√				

	Core/Basic	Assessment	Planning	Linking	Monitoring
Assesses to determine if there issues related to own safety when making community visits and obtains supervisory or other support to maintain safety	√				
Demonstrates a commitment to ongoing professional development and education such as individual and group supervision, team meetings, seminars, in-service trainings, conferences and individual study.	√				
Identifies areas for self-improvement and opportunities for learning and ability to create a personal self-development plan	√				
Utilizes time management skills, including the ability to organize and prioritize, and implement a schedule of services for persons served and complete documentation in a timely manner,	√				
Documentation					
Demonstrates use of person-first, strength based language	√				
Understands and identifies pertinent data for inclusion in case records, organizes information in clear and concise manner, documents in a timely manner	√				
Utilizes technology to access, collect, summarize and transmit information	√				
Documents in the clinical record in an accurate, clear, and concise manner, including writing goals with behaviorally specific and measurable objectives that relate logically to the overall plan of service			√		
Assures that documentation of all supports and services provided, including the role of the case manager, is accurately reflected in the individuals record and is consistent with the plan of service					√

To provide feedback, learn more about this project, or if you are interested in additional training resources or implementing a demonstration project in support of these competencies, please contact Laura Vredeveld (laurav@tbdsolutions.com) or Nora Barkey (BarkeyN@michigan.gov)

Case Management/Supports Coordination Self-Assessment Tool

MAY 2011

Commented [A2]: Is this the most recent version of this information?

NOTE: The following document is work product of The Standards Group. Any comments or questions related to this document should be sent to: Laura Vredeveld, TSG Director, laurav@tbdsolutions.com. (616) 427-5957

Introduction: On the following pages you will find lists of criteria or competencies related to various aspects of case management/supports coordination functions. This self-assessment instrument is offered as a tool to examine an individual or a team's competencies as well as identify areas you may have strengths and/or areas you may wish to develop further through training, supervision or other methods. This tool is intended to be used as an aid in developing a personal or team development plan. Not all criteria or competencies will be relevant to the particular work you do. For each item, assess yourself against the criteria, considering how often or how well you demonstrate that skill or competency. Check one rating for each item.

	N/A	Seldom/ Never	Sometimes	Often/ Always
Advocacy				
I know the individuals I support well (likes, dislikes, preferences, choices, interests, strengths, needs) and actively support, coach, and empower individuals to seek solutions, make decisions and explore new opportunities.				
I understand and promote the person's wishes with other professionals, direct care staff, provider agencies, community and family and advocate for system change where necessary, including public-policy, resource allocation, and advocacy with other systems as needed				
I communicate and advocate in a way that encourages a positive and meaningful sense of identity apart from one's condition and I actively support meaningful life opportunities for the individuals I support				
I know and share information about self-determination, choice voucher, peer supports, family navigator, recipient rights and other programs that provide for self-determination and individual choice				
I demonstrate knowledge of rights, complaint and appeals processes in areas of civil/recipient rights, and effectively assist individuals in using these processes as needed.				
Comments/Identify potential growth areas:				
Communication-facilitation-coaching	**N/A**	**Seldom/ Never**	**Sometimes**	**Often/ Always**

	N/A	Seldom/ Never	Sometimes	Often/ Always
I use effective communication strategies and skills to engage and establish a collaborative relationship and to build rapport with the individuals I support				
I am able to evaluate behaviors as potential attempts to communicate or cope with the impacts of life events as well as stress or pain				
I build rapport, develop consensus, and actively engage in relationships of trust with individuals and teams				
I effectively communicate and share information to successfully train or educate.				
I convey hope and respect				
I coach individuals in developing healthy, reciprocal relationships.				
Comments/Identify potential growth areas:				
<u>Assessment Skills</u>	**N/A**	**Seldom/ Never**	**Sometimes**	**Often/ Always**
I develop an understanding and appreciation of the individuals I support in order to establish a positive relationship/alliance. I listen to the person's life story and identify skills, strengths, assets.				
I understand the principles of co-occurring and complex conditions and offer a welcoming approach to all individuals.				
I am aware of and use uniform, standard, population specific assessment tools, relevant professional expertise, psychosocial and functional assessment along with sound professional judgment to determine consumer eligibility for services and types of intensity of necessary services				
I determine individual's capabilities, preferences and needs including understanding the benefits of a range of interventions that could contribute to improved outcomes and quality of life				
I use the assessment process to involve a variety of sources (including other professional assessments when indicated) in obtaining complete and accurate information in order to gather the following information: • behavioral health data • information about the individual's needs, strengths, desires, abilities, • cultural background, spiritual beliefs • level of education • medical history and current health status • Employment • finances • mental status • substance use • cognitive, emotional, behavioral functioning • history of abuse, trauma • Family and developmental history				

	N/A	Seldom/ Never	Sometimes	Often/ Always
• Psychiatric history • need for and availability of social support • risk taking behavior • need for assistive technology • any other pertinent information.				
I create a narrative summary that moves from details collected to understanding individual preferences, formulates recommendations for level of care, intensity of treatment and possible goals which can be shared with the individual and is essential to the process of developing meaningful plan.				
I share information from the assessment with the individuals I support in a clear and understandable manner including implications/pros and cons of available choices				
Comments/Identify potential growth areas:				

<u>Person Centered Planning Process</u>	N/A	Seldom/ Never	Sometimes	Often/ Always
I understand and follow the MDHHS PCP policy and practice guideline				
I convey hope, sense of possibility				
I maintain focus on the individual and their decision-making authority while working collaboratively with the individual, allies (friends and family as chosen by participant), guardians, and others in a team approach				
I use planning tools to address key life domains as identified in the Michigan Mental Health Code including the individual's need for food, shelter, clothing, health care, safety, employment opportunities, educational opportunities, legal services, transportation, recreation, social and family relationships, and finances				
I explain and provide written resource information and referrals about the full service array, provider options, and benefits and limitations of those services.				
I provide unbiased, objective information about choice of services and providers and identify potential for conflict of interest				
I develop a plan in partnership with the person that expresses the desires of the individual, reflects the individual's choices and is based on strengths, needs, abilities and preferences and reflective of the individual's age, culture and ethnicity				
I develop a comprehensive plan that uses natural and community supports and provides for desired services to help the individual achieve their goals.				
I clearly identify and document the roles and responsibilities, scope, duration, and intensity of all services.				
I understand and effectively explain the costs of services and supports identified in the IPOS				
I present information about the benefits of crisis planning and transition planning and develop plans when chosen.				
I facilitate the necessary sharing of information to ensure that goals and plan information is shared appropriately (with permission), understood and acted upon by providers and others as relevant				

	N/A	Seldom/ Never	Sometimes	Often/ Always
Comments/Identify potential growth areas:				
Peer Supports	**N/A**	**Seldom/ Never**	**Sometimes**	**Often/ Always**
I understand the role and evidence-base for use of peer supports, including how peers can support individuals by sharing their life experience, acting as a role model and teacher and communicating concerns to other professionals from the perspective of an individual receiving services.				
I understand, describe and provide access so that peer supports have a role in assisting the individuals I support in achieving their goals in a variety of domains including employment, housing, education and recreation.				
I work collaboratively with peer advocates, peer mentors, family navigators, mentors, parent support partner, or peer support specialists to assist individuals with their goals				
Comments/Identify potential growth areas:				
Self Determination	**N/A**	**Seldom/ Never**	**Sometimes**	**Often/ Always**
I understand and support choice and autonomy by providing information, guidance and assistance in the use of self-directed arrangements, Choice Voucher System and control over one's own budget consistent with MDHHS policy				
I support self advocacy and assist the individuals I support to develop collaborative and supportive relationships and networks of support, and teach components of self-advocacy including personal values, decision-making, problem resolution and navigating in the human service system				
I recognize individual's self-knowledge and support their right to risk both success and failure through their choices				
Comments/Identify potential growth areas:				
Cultural Competency	**N/A**	**Seldom/ Never**	**Sometimes**	**Often/ Always**
I am knowledgeable of definitions and fundamental concepts of culture and diversity within the context of the beliefs, behaviors, and needs presented by individuals I support and their communities.				
I respect family and religious culture, race, gender, sexual orientation, issues of poverty and/or economic factors, disability, and rural vs. urban cultures.				
I function effectively within a variety of cultural and religious situations.				
I coordinate and/or link to services that are tailored or matched to the unique needs of individuals, children, families, organizations and communities served, including incorporation of special customs into treatment modalities.				

	N/A	Seldom/ Never	Sometimes	Often/ Always
I am aware of the ways that culture may influence the acceptance and or understanding of mental illness, intellectual/developmental disability and or substance abuse and addresses and/or mitigates as necessary				
I provide and/or advocate for the provision of information, referrals, and services in the language appropriate to the individuals I support, which may include use of interpreters.				
Comments/Identify potential growth areas:				
Working with families and allies	**N/A**	**Seldom/ Never**	**Sometimes**	**Often/ Always**
I use a strength-based approach to working with families, guardians and allies in order to respect individual decisions, mitigate negative interactions, and establish boundaries.				
I gather information about family issues and understand family dynamics and systems in order to support the individual's achievement of his/her desired outcomes.				
I identify and address issues of control if guardians or family members limit individual's autonomy or choice.				
I facilitate meetings between individuals, family members and allies to accomplish tasks and maintain group cohesiveness				
I demonstrate conflict resolution and problem-solving skills to ensure that the individuals I support maintain control of decisions for their life.				
I assess, understand and support the informal care giver's needs				
I facilitate the development of personal support networks by utilizing natural supports within communities, peer support and self and mutual help groups				
Comments/Identify potential growth areas:				
Linking/Coordination/Facilitating Services				
I provide linkage to services in a variety of public and community settings in a professional and safe manner.				
I develop and work with teams and resolve conflicts when necessary.				
I understand the service system forms, units, policies and procedures, access points, authorization, in order to arrange and assure delivery of agreed upon, necessary services.				
I develop and communicate expectations and negotiate with provides to ensure that the provider of services has all relevant individual information to successfully implement the plan and provide effective services.				
I work with a multidisciplinary team, including understanding the role of specialty service system/professional services (Psychiatric, Nursing, OT, PT, Speech), peer support specialists, support brokers, and other ancillary services to meet individual's needs.				
I work with other systems including schools, courts, housing authorities, police, DHS, SSA, other provider agencies, medical providers				
I demonstrate an understanding of organizational mandates and roles, share relevant information, and use consensus to gain a level of commitment from all parties to work from the same plan.				

	N/A	Seldom/ Never	Sometimes	Often/ Always
I work collaboratively with other service delivery systems to effectively coordinate integrated physical and behavioral healthcare				
Comments/Identify potential growth areas:				
Community Knowledge and Networking	**N/A**	**Seldom/Never**	**Sometimes**	**Often/ Always**
I establish trust and rapport with colleagues in the community and form effective community partnerships				
I have knowledge of availability and eligibility for public systems including school, housing, Social Security Administration, Department of Human Services , employment, justice system				
I gather and use information about interests, affinities, competencies and strengths to match, plan and support the use of community resources and natural supports				
I am skilled in assisting individuals in gaining access to relevant community services and public systems				
I identify, promote and support opportunities for individuals to connect with their community.				
Comments/Identify potential growth areas:				
Vocational, Educational and Career supports	**N/A**	**Seldom/ Never**	**Sometimes**	**Often/ Always**
I provide or arrange the appropriate and necessary supports to assist all individuals to work, earn personal income, transition from school to employment, and be a contributor to their community				
I am aware of and provide information or linkages to opportunities for generating income, including microenterprise.				
I assess individual's potential for increasing autonomy through education, work, earning income and am able to address concerns and fears related to responsibilities, loss of benefits, or change.				
I am aware of and refer to the Evidence-Based Practices of Supported Employment to assist/facilitate an individual seeking competitive employment				
I provide information and referral to resources about maintaining benefits, earning income and employment options.				
I am aware of and refer to available system & community resources to support competitive employment				
Comments/Identify potential growth areas:				
Prevention and Safety	**N/A**	**Seldom/ Never**	**Sometimes**	**Often/ Always**

	N/A	Seldom/ Never	Sometimes	Often/ Always
I promote and model a culture of gentleness and respect in environments where individuals with intellectual/developmental disabilities, mental illness, and co-occurring disorder and children with SED and the people who support them interact				
I develop plans based on risk factors and risk tolerance, identify strengths, provide information and education about risk-prevention strategies where needed in all potential life domains (home, work, school, transportation) while recognizing and supporting personal responsibility and authority.				
I develop plans for responding to crisis with effective trauma-informed interventions, and provide access to stabilization resources when needed				
I identify and report abuse and neglect in accordance with legal requirements				
I understand and monitor individual's warning signs and respond effectively to signs of crisis using de-escalation skills.				
I am knowledgeable of how and where to access information about definitions, rights and requirements included in the DCH Technical Requirement for Behavior Treatment Plan, Adult Foster Care licensing rules and related DCH publications				
I collaborate as appropriate in the development of behavior plans, using positive behavior supports and physical/non-physical behavior management techniques				
I ensure implementation of and effective monitoring of established behavior treatment including training of direct support staff.				
Comments/Identify potential growth areas:				

Health and well being	**N/A**	**Seldom/ Never**	**Sometimes**	**Often/ Always**
I demonstrate knowledge of the principles of good health, preventive health guidelines, use of environmental supports, and communicate using information and techniques that support self care				
I am knowledgeable of and assess for risk of communicable diseases, high-risk behaviors, medication side effects, acute & chronic health conditions and make appropriate referrals as needed.				
I monitor symptoms of specific health conditions identified by health professionals, provide related educational materials and supports, support treatment adherence, and take action when indicated				
I use structured motivational approaches and principles that strengthen the individual's capacity to set goals for improved self-management of specific health condition				
I identify benefits and uses of advanced directives, explain and link to community resources that assist with development of advanced directives including psychiatric advanced directives and plan for end of life care				
I problem-solve barriers using the resources of the community and personal support systems in addition to formal services.				
I explain, coordinate and connect to the resources of the local health care system including primary care and dental options in the community to ensure access and to promote awareness and collaboration				

	N/A	Seldom/ Never	Sometimes	Often/ Always
I participate in discharge planning to the community from local inpatient settings to ensure desired and necessary follow up care, including linking to treatment and healthcare resources to address communicable diseases, high-risk acute & chronic health conditions				
I monitor and identify health changes according to the individual's plan and take appropriate action as needed.				
I provide linkages to resources in the community such as health and nutrition classes, smoking cessation, support groups, exercise opportunities, wellness groups.				
Comments/Identify potential growth areas:				
<u>Role in Ongoing Quality Improvement</u>	**N/A**	**Seldom/ Never**	**Sometimes**	**Often/ Always**
I support individuals in their involvement in the quality improvement process so that input from persons receiving services related to satisfaction, responsiveness, process, progress on goals, and outcomes is solicited and addressed.				
I monitor progress, participate in conflict resolution and problem solving as needed, and make any desired changes to plan or services, including focusing beyond particular events (behavioral episodes, etc.) to the activities that take place between events that cause them to occur.				
I am knowledgeable of the assurance areas and quality improvement role and requirements in Medicaid Home and Community Based Programs including monitoring of health and safety in all settings.				
I collect, maintain and evaluate service data				
I ensure the implementation of the person-centered plan and evaluate the impact of services on goals, satisfaction, and quality of life				
I foster communication to ensure that program administrators receive direct input from individuals receiving support, their families and other interested persons.				
Comments/Identify potential growth areas:				

Other Population –Specific Competencies				
<u>Children/Family Specific</u>	**N/A**	**Seldom/Never**	**Sometimes**	**Often/Always**
I use a holistic planning process that includes a functional assessment and is strength based and identifies the needs of the child and family				
I facilitate a planning process that is Family-driven, youth- guided and culturally relevant and focused on building resiliency and family strengths.				
I am knowledgeable of and provide access as appropriate to the following approaches to children's services				

Other Population –Specific Competencies				
○ Bio-psychosocial practice ○ Medication ○ Trauma focused Cognitive Behavioral Therapy (CBT) ○ Parent Management Training Oregon Model (PMTO) ○ Recovery based/Resiliency ○ Use of Peer to Peer Model ○ Family to Family Navigator Model				
I am knowledgeable of Child and Adolescent Development, including brain development, Co-occurring disorder risk factors				
I am knowledgeable of laws allowing children to receive services without parental consent.				
I am knowledgeable of System of Care Principals and parent-to-parent support models.				
I am knowledge of special education systems, rules, roles in IEPC and transition to adult services				
Comments/Identify potential growth areas:				

Intellectual/Developmental Disabilities	**N/A**	**Seldom/ Never**	**Sometimes**	**Often/ Always**
I understand and am able to express and demonstrate the values behind the vision and mission of the MD HHS for persons with intellectual/developmental disabilities				
I demonstrate a personal commitment to the individual and belief in his or her ability to learn, change, and grow.				
I am knowledgeable of diagnostic terms, characteristics and implications for functioning, communication and health of individuals with intellectual/developmental disabilities				
I am knowledgeable of the characteristics of a range of intellectual and developmental disabilities including in the DSM - IV.				
I am aware of the positive behavior supports and interventions necessary to meet the sensory, cognitive, physical and emotional needs of individuals with intellectual/developmental disabilities				
I effectively relate and interact with individuals who are non-verbal or have limited verbal communication skills and understand how behaviors are sometimes used to communicate feelings and/or undiagnosed medical conditions or pain.				
Comments/Identify potential growth areas:				

Mental Illness	**N/A**	**Seldom/ Never**	**Sometimes**	**Often/ Always**
I understand and can articulate the recovery model for individuals with mental illness.				
I advocate for persons with mental illness and their families in all areas of their recovery journey.				
I actively combat stigma and combats myths related to mental illness.				
I demonstrate basic understanding of DSM IV diagnostic classifications, symptoms, characteristics of mental illness and co-occurring disorders				

Other Population –Specific Competencies				
I demonstrate the ability to monitor individuals' warning signs which could place them at risk for intentional or unintentional injury to self or others as a result of a range of mental health problems, including affective disorders, mood disorders, anxiety disorders, psychotic disorders, eating disorders and self injury, trauma.				
I am aware of the supports and interventions necessary to meet the recovery needs of a wide range of individuals various stages of recovery from mental illness. I can engage and support individuals in any stage of recovery.				
I coordinate and link to a wide range of evidenced based and promising approaches to treatment including trauma – informed services, culture of gentleness, use of psychotropic medications, motivational interventions WRAP facilitation, COD/IDDT, Family Psycho Education, CBT, DBT,				
I understand basic pharmacology, including therapeutic effects and side effects along with the consumer's viewpoint on the medications and their effects				
I am knowledgeable of the high rate of chronic physical health conditions, increased mortality and modifiable risk factors and vulnerabilities and strategies to address.				
Comments/Identify potential growth areas:				

Substance Use Disorders	**N/A**	**Seldom/ Never**	**Sometimes**	**Often/ Always**
I can identify the different stages of change and use a motivational approach with individuals at all stages				
I understand and provide information about the effects of substances and the relationship between substance use and symptoms of mental illness.				
I understand the difference between substance use, abuse and dependence				
I am knowledgeable of the interventions for co-occurring substance use disorders for an individual with a mental illness or an intellectual/developmental disorder.				
I am knowledgeable of professional, peer, social and self-help resources available to help someone with a substance use disorder achieve recovery.				
Comments/Identify potential growth areas:				

Mental Health System, Public Benefits and Legal Requirements	**N/A**	**Seldom/ Never**	**Sometimes**	**Often/ Always**
I demonstrate knowledge of key elements of the Michigan Mental Health Code, relevant sections of the MDHHS Medicaid Provider Manual, and practice guidelines and related rules and regulations				
I demonstrate knowledge of policies, procedures and functions of SC/TC and related positions and case management models				
I understand policy requirements for professional ethics and boundaries				
I comply with state and federal regulations regarding privacy to ensure use of confidential information is based upon best practices, ethical and legal considerations, the Mental Health Code and HIPAA				

Other Population –Specific Competencies				
I understand and implement agency relevant policy and procedures, including reportable critical incidents, mandatory reporting				
I demonstrate understanding of alternatives to guardianship, guardianship law, process and its impact on loss of rights, and able to provide support for the individual in accessing changes to the guardianship order. I refer to legal representatives as appropriate				
I am knowledgeable of and convey information and access to resources relate to SSI, role of payee, DHS eligibility, Medicaid application process,				
I demonstrates knowledge of operation of mental health and human service systems, civil rights, basic eligibility, service access and delivery, program characteristics and covered benefits, service authorization requirements and processes, waiver services, grievance & appeals processes, and Recipient Rights				
I understand the purpose and availability of various funding streams, not-categorical funds and community resources				
Comments/Identify potential growth areas:				

Professional Role & Self-Development	**N/A**	**Seldom/Never**	**Sometimes**	**Often/ Always**
I understand and demonstrate professional ethics, boundaries and standards, including scope of practice and professional licensing regulations				
I understand and can describe when supervision and consultation is needed and I use feedback from individual receiving services and/or supervisory/mentor feedback effectively				
I assess to determine if there issues related to my own safety when making community visits and obtain supervisory or other support to maintain safety				
I demonstrate a commitment to ongoing professional development and education such as individual and group supervision, team meetings, seminars, in-service trainings, conferences and individual study.				
I identify areas for self-improvement and opportunities for learning and ability to create a personal self-development plan				
I utilize time management skills, including the ability to organize and prioritize, and implement a schedule of services for persons served and complete documentation in a timely manner,				
Comments/Identify potential growth areas:				

Documentation	N/A	Seldom/Never	Sometimes	Often/Always
I use person-first, strength based language				
I understand and identify pertinent data for inclusion in case records, organize information in clear and concise manner, and document in a timely manner				
I utilize technology to access, collect, summarize and transmit information				
I document in the clinical record in an accurate, clear, and concise manner, including writing goals with behaviorally specific and measurable objectives that relate logically to the overall plan of service				
I assure that documentation of all supports and services provided, including the role of the case manager, is accurately reflected in the individuals record and is consistent with the plan of service				
Comments/Identify potential growth areas:				

Based on this self-assessment, the following are areas of particular strength:

Based on this self-assessment, the following are areas I wish to pursue for additional training, development, supervision or mentoring:

SCCMHA Case Managment Checklist

Chapter 1	Organizational Overview	
	Service Array	I am familiar with the current SCCMHA service array available to meet the needs of the individuals of the population(s) I serve as well as eligibility for each service area, including for co-occurring disorders.
	Community Resources	I am familiar with and seek out community resources that are available to meet the needs of the persons I serve.
	Service Access	I offer (and re-offer) appropriate services to the persons I serve to meet their needs as appropriate.
	Consumer Feedback	I assist the persons I serve to determine their satisfaction with services and/or to give feedback including regarding my own supports for them.
Chapter 2	**Case Management & Supports Coordination**	
	Authorizations	I ensure proper and timely authorizations for services are obtained for each consumer I serve.
	Responsibilities	I utilize all five of the core CM functions to support each consumer I work with (assessment, planning, linking & coordinating, monitoring, and advocacy).
	Domains of Focus	I address all six key domains to support each consumer/family/natural support system with whom I work (health & well-being; quality of life; community membership; information & referral; personal support & coordination; personal & social relationships).
	Skills & Abilities	I continuously seek to improve and expand my skills, abilities, and knowledge to do my job effectively.
	Professional Development	I actively seek supervision, consultation, and ongoing education to improve my skills.
	Required Training	I comply with all SCCMHA training requirements as well as those needed to maintain my professional license and other certifications.
Chapter 3	**Understanding Behavioral Health Conditions**	
	Who SCCMHA Serves	I have a general understanding of all the populations served by SCCMHA.
	Specific Population(s) Knowledge	I am very familiar with the specific population(s) including diagnose(s) of persons I serve including

		co-occurring behavioral health and general health conditions.
	Symptoms & Behaviors	I appreciate the symptoms/behaviors inherent in the diagnoses of persons I serve.
	Individualization	I work with each person as a unique individual, regardless of their diagnosis.
	Stigma	I am sensitive to the stigma that the persons I support may experience and assist them to manage and overcome common misconceptions, myths and stereotypes while seeking to avoid re-stigmatization.
	Medications	I strive to be familiar with the common medications prescribed to treat symptoms including the consumer's adherence, efficacy, side effects and tolerance.
	Medication Observation & Feedback	I contribute to the clinical team observation and feedback from consumers on medication issues.
	EBPs	I am trained and/or privileged by SCCMHA in appropriate evidence-based practices to meet consumer needs and understand the importance of matching appropriate practices to meet needs, including referrals, as well as adhering to the practice model(s) towards positive outcomes.
Chapter 4	**Benefits and Funding**	
	Medicaid Eligibility	I understand and impart to consumers the importance to obtain and maintain Medicaid and other benefits to meet their overall health needs and maintain services.
	Medicaid Deductibles	I follow procedures to support consumers who have Medicaid deductibles for them to quickly meet such deductibles to maintain funded services.
	Other Benefits	I assist consumers to obtain and maintain other benefits for which they may be entitled or eligible.
	Benefit Advocacy	I advocate for consumers when needed to support their proper entitlements.
	Ability To Pay	I assist consumers to complete initial ATP paperwork and on an annual basis or as often as needed.

Chapter 5	Working with Consumers	
	Person-First Language	I use person-first language when referring to and communicating with consumers.
	Relationship	I understand the importance of striving for a positive, respectful, and supportive relationship in order to best serve consumers.
	Active Listening	I use active listening and my observation skills when I interact with consumers.
	Recovery & Resiliency	I support the concepts of recovery and resiliency when I work with consumers.
	Trauma	I am sensitive to the fact that many persons I serve will have some history of trauma and make efforts to reduce the risk of re-traumatization.
	Welcoming	I make every effort to be welcoming to each and every consumer and their natural supports in my work.
	Consumer Directed Plan	I appreciate the principles of the person-centered planning process and understand that the consumer directs their plan of care and supports.
	Choice, Risk & Harm	I recognize that all persons have the right to take risks, and I honor each person's choices and preferences, and offer considerations where indicated on risk and harm factors.
	Cultural Considerations	I assist in promoting each consumer's cultural beliefs and priorities during every contact as well as during planning and goal setting processes, including sexual orientation and gender identity.
	Community Inclusion	I support the ability of every consumer to explore how to be actively involved in their community based on their interests.
	Health & Well-Being	I promote and actively monitor the well-being of each person including their whole health and overall wellness.
	Monitoring Plan	I actively monitor and reassess the plan of service with the consumer for effectiveness and changes in the consumer's circumstance or challenges.
	Positive Behavior Supports	I facilitate the development of a positive behavior support plan when indicated to meet consumer needs and monitor for effectiveness and needed duration.
	Motivational Interviewing	I understand the stages of change and use motivational interviewing skills to help consumer make positive changes in their lives.

	Teach-Back	I use teach-back skills to ensure persons with whom I work understand important points, key issues and next steps and procedures.
	Guardianships	I understand that guardianship is a legal mechanism to limit rights of an individual and should only be used when necessary and recognize available alternatives.
	Crisis Planning	I actively offer advance crisis planning with consumers, including psychiatric and medical.
	Self-Determination	I understand the self-determination option available to consumers, offer this routinely during planning and support them when they elect this option.
	Independent Facilitation	I understand the role of an independent facilitator and offer this during the pre-PCP process as an option.
	Appeals & Grievances	I assist or refer consumers who need information about grievances and appeals to the SCCMHA Customer Service unit.
	Language Assistance	I work with the SCCMHA Customer Service unit to obtain services for consumers who need translation or other communication assistance and support the consumer (and family or natural support system} in the use of this service.
	Dignity & Respect	I honor consumer boundaries around their living spaces, possessions, and physical contact as well as any of their preferences.
Chapter 6	**The Legal & Regulatory Environment**	
	Recipient Rights & HIPAA	I understand the recipient rights of all consumers, including protection of PHI and privacy and confidentiality, and when to file on behalf of a consumer or assist a consumer in doing so.
	Suspected Abuse & Neglect Reporting	I understand my role in reporting suspected abuse and neglect where found.
	Duty to Warn & Protect	I understand when I might have a Duty to Warn and Protect.
	Suspected Fraud & Abuse of Public Funding	I understand my role in reporting suspected fraud and abuse of public funding.
	Responding to FOIAs & Subpoenas	I understand who to contact when I receive a FOIA, a subpoena or I am contacted by an attorney.

	Consent	I ensure that proper written consents are completed in the EHR prior to providing services.
	Release of Records	I coordinate the release of any consumer records with SCCMHA's Medical Records unit.
	Disposal of PHI	I ensure proper disposal of any document that contains PHI.
	Use of EHR	I protect my passwords and ensure privacy and confidentiality in my use of the electronic health record.
	Consumer Advance Directives or Guardianships	I am aware of consumers who I serve with guardians and/or advance directives and ensure that consumer legal status documents are verified, scanned into the record and properly acknowledged during service.
	Transmission of Consumer PHI	I understand cautions about the use of technology and social media relative to consumer communications and use acceptable secure communication venues (sealed hard copy mail, voice mail, fax, encrypted e-mail or Sentri messaging).
Chapter 7	**Documentation**	
	Death Reporting	I know how to file a death report when a consumer expires.
	Incident Reporting	I know to ensure that incident reports are completed when needed, understand that they are not part of the record, and review trends to help promote consumer safety and well-being.
	Consumer Demographics (BH TEDS)	I keep consumer demographics current in the electronic health record.
	Assessments	I complete required assessments and request additional assessments from other professionals based on consumer needs in a timely manner.
	Required Documentation	I keep progress notes and other required documentation current including proper scanning of documents into the record.
	Outcome Tools	I complete and use outcome or other required tools to review progress towards consumers' goals, identify barriers and strategies to overcome those barriers. (ANSA-initial, every six months, exit, CAFAS/PECFAS-quarterly, SIS-every 2 years)
	Consumer Feedback	I document in progress notes ongoing feedback from consumers on their satisfaction with services.

	Documentation Quality	I am familiar with and adhere to SCCMHA policy on provider documentation content including what not to include in the record.
Chapter 8	**Linking & Coordinating**	
	Coordination of Care	I understand my role in the coordination of care, especially during consumer transitions or episodes of higher risk.
	Provider Inclusion in the PCP	I include all other providers serving or potentially serving the consumer in the PCP process including revisiting the PCP when services are added.
	Residential Services	I provide support for consumers' housing selections based on key guiding principles, including least restrictive setting.
	Housing Options	I ensure that consumers are offered housing choices at the level of support they need, and I provide support so that consumers can change locations based on their choice and/or level of care when their needs change and in keeping with their goals. I ensure consumers are offered choices in housing and housing assistance.
	Independent Living	No matter where consumers live, I make sure they are offered opportunities to develop greater independent living skills in keeping with their goals and abilities.
	Monitoring	I monitor consumers in residential/living settings monthly for safety, health and well-being, or more often if needed. Any noted concerns for the consumer and/or regarding provider support of the consumer are addressed and reported as appropriate.
	Role of CM/SC in Specialized Residential Settings	I work with consumers to help them obtain the specialized residential care of their choice and periodically reassess that care to ensure consumers are being provided the appropriate level of care and that their needs are met.
	Working with Residential Providers	I work with residential care providers to: in-service on the person-centered plans and consumer needs, including updates; coordinate care; actively discuss and solve issues; and report any concerns about provider compliance or performance to the Residential Watch Committee.

	ASAP (Adult Services Authorized Payments)	I complete necessary documentation for eligible consumers to receive ASAP including annual renewals and monthly reviews.
	Health Care Coordination	I actively coordinate care with medical providers in all aspects of consumer health needs.
	Involuntary Hospitalization	I work with SCCMHA Crisis Intervention Services to ensure that all documentation required for court-ordered treatment is completed as needed.
	Health Promotion	I encourage consumer self-care and the identification of wellness goals in my interactions with consumers.
	Transportation	I help consumers identify their transportation needs and assist them in making appropriate arrangements.
	Recreation & Leisure	I encourage consumers to use tools such as *A World of Choices* to help them identify their interests and promote meaningful personal and/or community involvements.
	Level of Care	I monitor and identify consumer functional changes that might indicate a need for a different level of care in service and facilitate new arrangements as needed.
Chapter 9	**Taking Care of Yourself**	
	Wellness	I am familiar with methods I can use to reduce my level of stress and improve my well-being.
	Time Management	I know how to use various tools, including automated reports available to me, to help me manage my time effectively and improve my productivity.
	Personal Safety	I am aware of potential safety issues and take appropriate measures to ensure I am safe while also making sure that I serve consumers effectively.
	Dealing with Aggression	I use de-escalation techniques to defuse potentially volatile situations.
Chapter 10	**Acronyms, Symbols & Glossary**	
	Knowledge of Acronyms, Symbols & Abbreviations	I am familiar with commonly used acronyms and symbols.
	Use of Acronyms, Symbols & Abbreviations	I do not use acronyms or abbreviations or symbols in official documents, including consumer health records.

Commented [A3]: Is this something that is still offered to consumers?

Chapter 11	**Resources**	
	Available Resources	I am familiar with resources available to meet the individual needs of the population(s) I serve.
	Updating Resource Knowledge	I continuously update my knowledge of available resources.
	Sharing Resource Information	I share information about available resources with consumers and with colleagues.
	Resource Finding	I know how to search for additional resources and actively pursue resources that may help the consumers I serve.