DEPARTMENT OF HEALTH
...in pursuit of good health

Bureau of Drug and Alcohol Programs

Outcomes Based Case Management
Monitoring System (OBCMS)

Data Collection Training Handbook

August 2001
Table of Contents

SECTION ONE: INTRODUCTION ................................................................................. 1
   A. BACKGROUND ...................................................................................................... 1
   B. OUTCOME OF THE WORKGROUP EFFORTS ................................................... 1
      1. Development of New Service Descriptions........................................................... 1
      2. Philosophy of Case Management........................................................................... 2
      3. Intensive Case Management Functions ................................................................. 2
      4. Goals of Intensive Case Management.................................................................... 3
   C. AIMS OF THE TRAINING ...................................................................................... 4
   D. CONCEPTUAL MODEL ......................................................................................... 4

SECTION TWO: INVENTORY OF SUPPORT SERVICES........................................... 6
   A. METHOD FOR ADMINISTERING THE ISS ........................................................ 6
   B. COMPLETION AND SCORING OF THE ISS ....................................................... 6

SECTION THREE: SERVICE PLAN............................................................................. 13
   A. METHOD FOR COMPLETION OF THE ICM SERVICE PLAN ....................... 13
   B. SERVICE PLAN COMPLETION .......................................................................... 14

SECTION FOUR: DISCHARGE FORM........................................................................ 17
   A. COMPLETION INSTRUCTIONS ......................................................................... 17
   B. DEFINITIONS OF REASONS FOR DISCHARGE .............................................. 18

SECTION FIVE: CLIENT SATISFACTION SURVEY ................................................ 19
   A. DESCRIPTION OF THE CLIENT SATISFACTION SURVEY .......................... 19
   B. METHOD OF ADMINISTRATION ...................................................................... 19

SECTION SIX: SUPPORT SERVICES FOLLOW-UP CHECKLIST ........................... 22
   A. DESCRIPTION OF THE SUPPORT SERVICES FOLLOW-UP CHECKLIST . 22
   B. METHOD FOR ADMINISTERING THE SUPPORT SERVICES FOLLOW-UP CHECKLIST................................................................................................................. 22
Table of Contents

APPENDICES

APPENDIX A: STANDARD FORMS
   1. Inventory of Support Services
   2. Service Plan
   3. Updated Service Plan
   4. Discharge Form
   5. Client Satisfaction Survey
   6. Support Service Follow-up Checklist

APPENDIX B: SELF-SUFFICIENCY DESCRIPTIONS
   SELF-SUFFICIENCY MATRIX

APPENDIX C: CASE MANAGEMENT WORKGROUP
SECTION ONE: INTRODUCTION

A. BACKGROUND

In December 1997 the Bureau of Drug and Alcohol Programs (BDAP) assembled a workgroup comprised of Single County Authority (SCA) Directors, Case Management Supervisors, Case Managers, BDAP staff and an outside consultant. (See Appendix C for Workgroup Roster.) The workgroup was charged with the following responsibilities:

- Review the current service descriptions and provide suggestions for their improvement
- Develop a philosophy for the provision of case management services
- Develop a strong conceptual model and methodology that can be used for the purposes of outcomes based monitoring
- Develop specific goals and objectives for intensive case management services integral to the conceptual model
- Develop specific outcomes and indicators for each of the goals and objectives
- Develop a structure for managing and monitoring case management services
- Develop data collection instruments to be incorporated in the provision of case management services
- Develop a more standardized format for service plan development
- Provide input in the development of the Outcomes Based Case Management Monitoring System software
- Serve as pilot sites for the implementation of the data collection instruments and the software

B. OUTCOME OF THE WORKGROUP EFFORTS

1. Development of New Service Descriptions

The service descriptions were revised to clearly describe the responsibilities of the intensive case manager (ICM). Areas included in the new service descriptions include the following:

- Philosophy of Case Management – The Strengths-based Approach
2. Philosophy of Case Management

All ICMs have been trained in one consistent philosophy or approach towards intensive case management. This approach believes that “clients are most successful when they identify their own strengths, abilities and assets and will be more successful in attaining goals identified by themselves and not others. Generally, clients are believed to support an approach that basically asks them what their abilities and assets are, and how they can use those abilities and assets to acquire needed services and resources. Most clients can be motivated when they focus on their abilities, interests and past accomplishments, rather than their problems and deficits.” (Bureau of Drug and Alcohol Programs, 1998.)

The underlying assumptions are: 1) all individuals have strengths they can use for quality of life improvement and 2) motivation is encouraged by recognizing strengths from a client perspective. In other words, the ICM should work with the client to identify what areas of need he/she is willing to address at specific points in time.

3. Intensive Case Management Functions

Intensive case management activities are divided into seven functions:

- **Engagement**, the process of establishing rapport between the case manager and the client as a basis for working together. This includes identifying and addressing any immediate needs

- **Evaluation of the Client’s Strengths and Needs**, the process of identifying the client’s personal skills, strengths and abilities in addressing specific domains by administering the Inventory of Support Services (ISS)

- **Service planning and goal setting**, includes the development of a well-written plan to address specific needs identified by the completion of the ISS. By utilizing the
strengths based philosophy of case management, the client determines what areas of need are addressed. Goals are realistic, measurable and mutually acceptable. Action steps are observable and time limited.

- **Linking**, consists of the coordination of activities related to the acquisition of necessary support services including the identification and location of community resources, referral to community resources or support services specified in the service plan, and assistance to access the resources or supports within the community.

- **Monitoring**, involves regular contact with the client both face-to-face in the community and by telephone.

- **Advocacy**, the process of assisting the client in removing any obstacle to accessing necessary services.

- **Coaching**, helps the client access services by rehearsing interviews or role-playing problematic situations to enhance skill building and enhance self-sufficiency.

4. **Goals of Intensive Case Management**

Three primary goals of intensive case management have been developed:

- Increase retention in case management and access to ancillary support services;
- Increase engagement/participation in support services; and
- Increase level of self-sufficiency\(^1\) in one or more of the following domains:
  - Housing
  - Child Care
  - Educational/Vocational
  - Employment
  - Basic Needs
  - Transportation
  - Alcohol and Other Drug Treatment (AODT)
  - Legal Services
  - Mental Health
  - Physical Health

\(^1\) Five levels of self-sufficiency have been identified: 1. Self-Sufficient; 2. Stable/Safe; 3. Unstable; 4. At Risk; and 5. In Crisis/Not Self-Sufficient.
Family/Social
Life Skills

C. AIMS OF THE TRAINING

One day training sessions will be provided across the state to SCA Directors, Case Management Supervisors and Intensive Case Management Staff. The purpose of the training will be to:

1. Introduce the conceptual model to be used in outcomes based case management
2. Introduce the tools and structure to be used in identifying support service needs, integrating the results of the ISS into a service plan and readministering the ISS at specified intervals to monitor change over time
3. Review the specific instruments, including the structure, method and frequency of administration

D. CONCEPTUAL MODEL

The Outcomes Based Case Management System (OBCMS) provides a structure that will be consistently utilized across the state. The primary aim of OBCMS is to determine the extent to which the case management system has achieved its intended goals, identify areas of success as well as areas in need of improvement and to monitor change over time. Its basic construct consists of the following:

- Provides a standard tool, the Inventory of Support Services (ISS), to identify service needs
- Collects the same information in the same way to allow for more effective measurement of change over time
- Utilizes a standard format to integrate into service plans
- Allows for the consistent comparison of ICM services within and across counties
- Serves as an effective mechanism for determining the extent to which the provision of intensive services leads to improvement in levels of self-sufficiency
- Identifies specific needs that cannot be addressed due to lack of or limited availability of services in the community
The major areas to be examined by OBCMS are:

- What are the needs of the clients
- Are there specific service areas that clients are more willing to address compared to others
- The needs that can be addressed
- How satisfied are the clients with the services being provided
- How long are the clients remaining in case management
- The level of self-sufficiency of the client at the time of discharge from case management
- The level of self-sufficiency of the client following discharge from case management
SECTION TWO: INVENTORY OF SUPPORT SERVICES

The Inventory of Support Services (ISS) is the initial and ongoing tool used to identify the client’s level of self-sufficiency for each of the domains described in the previous section. A range of scores is attached to each level of self-sufficiency ranging from 0: Self-Sufficient to 10+: In Crisis. The rationale for the scoring is the higher the score the greater the need, the lower the score the less the need, i.e. the client is managing that domain on his/her own. The results of the inventory are to be incorporated into the service plan.

A. METHOD FOR ADMINISTERING THE ISS

The ISS should be administered as a structured interview and should be used as a tool for obtaining information from the client using a strengths-based approach. The case manager should explain to the client that this instrument is being used to identify his/her specific support service needs; the results will be incorporated in a service plan that will help address and ultimately meet these needs. It is recommended that the instrument be administered in its entirety. To save time and maintain client interest and involvement in the process, the case manager should try to keep the client focused on the specific questions in the instrument. A suggested approach is for the case manager to say to the client, “I am going to ask you some questions and it will take us about 30 minutes to obtain all of the answers. After we finish, we will review what we have learned from this process and we will then spend some time talking about specific needs. This will help us make sure that we are giving you the kind of help you are interested in receiving.”

B. COMPLETION AND SCORING OF THE ISS

Page 1 of the ISS contains demographic information and a section for scoring the instrument. It is to be completed at the initial administration of the ISS and updated at all required intervals thereafter. The timeframes for the administration of the ISS are:

- Upon entry into Intensive Case Management
- Every 60 days while enrolled in Intensive Case Management
- Upon discharge from Intensive Case Management
Page 2 is also completed during the initial administration of the ISS. This page provides information regarding the client profile and is to be updated as needed. Question 6a has been added to the revised ISS. It provides information regarding the client profile. Information describing the predominant reason the client is receiving Intensive Case Management services is to be completed. This data may be difficult to establish, as there can be numerous reasons for services. When completing this question, choose the primary issue that resulted in the referral to ICM services. For example, if the client has been referred because of criminal justice issues but also is an adolescent, the primary reason would be criminal justice. For ICM providers that serve one specific population such as pregnant or parenting women, criminal justice or adolescents, this would be the primary reason for the referral.

| 6a. Client Profile (Mark Only the one which is the predominant reason the client is on the case load) |
|---------------------------------|---------------------------------|---------------------------------|
| ☐ Dual Diagnosis                | ☐ Domestic Violence Victim      | ☐ Child Welfare                 |
| ☐ Criminal Justice              | ☐ Homeless                      | ☐ Pregnant Woman                |
| ☐ IVDU                          | ☐ Parenting Woman               | ☐ Recurrent User of Tx System   |
| ☐ Medical Complications         | ☐ Adolescent                    | ☐ Other, explain: ____________  |

Page 3 begins the first domain, Housing, which starts with question 7. For each subsequent administration of the ISS at the required intervals, start with question 7 in the housing domain. Complete the basic information at the top of page 3 during each administration of the ISS. Continue to answer all questions in each of the 12 domains ending with either question 81 or 83 on page 26 in the Life Skills domain. Client response will determine the final question for completion of the ISS. At the end of each domain, space is provided for any additional information gathered during the interview. If additional space is required for notes, document this information on the back page of the ISS in the appropriate domain sections.

To complete the ISS, all questions are to be answered but not all questions are scored. Some of the items have been included to provide background information that will be used in assessing client strengths and status on a specific domain. For all questions check the appropriate box by the response, or document the information requested in the correct space. For example, question 23 is not scored. Check the appropriate response, then move to the next
question as directed. Non-scored columns are colored gray in the right column (See the following example):

<table>
<thead>
<tr>
<th>23.</th>
<th>Are you currently in school or a training program?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ Yes</td>
<td>☐ No</td>
</tr>
</tbody>
</table>

For **scored** questions, check the response and write the point value of the response in the far right column which is coded white. All **scored** questions have values in parentheses adjacent to the answer choice. For example, question 10 is scored as follows:

<table>
<thead>
<tr>
<th>10.</th>
<th>Are you interested in improving your current living situation?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ Yes (2)</td>
<td>☐ No (0) [Go to NEXT DOMAIN]</td>
</tr>
</tbody>
</table>

If the response to question 10 would be “NO” the information required for the housing domain is complete and the case manager then proceeds to the next domain as instructed.

Some questions are skipped. For example, question 8b is structured as follows:

<table>
<thead>
<tr>
<th>8b.</th>
<th>Is your current living situation stable?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ Yes (0)</td>
<td>☐ No (1) [Go to 10]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9.</th>
<th>Do you feel you are at risk of losing your housing?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes (2)</td>
<td>☒ No (0)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10.</th>
<th>Are you interested in improving your current living situation?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ Yes (2)</td>
<td>☐ No (0) [Go to NEXT DOMAIN]</td>
</tr>
</tbody>
</table>

If the client answers “Yes” to question 8b, question 9 is skipped. For any skipped question, a line should be placed in the scoring column to identify no answer is required. This will assist the case manager to recognize a question has not been missed during the interview process.
Also, some questions may have multiple responses. The scoring method for such responses is explained in column two in bold print. For example, question 11 asks if certain case managers are helping the client with housing needs. Although the client has provided multiple responses, the scoring value for this question remains “1.”

<table>
<thead>
<tr>
<th>11.</th>
<th>In the past 30 days, did any of the following people try to help you find or keep housing?</th>
<th>MARK ALL THAT APPLY, but only award one point</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Drug and Alcohol counselor (1)</td>
<td>1 = Received help</td>
</tr>
<tr>
<td></td>
<td>☒ CYS/OCY/CAO case manager (1)</td>
<td>2 = Wanted help but no one helped me</td>
</tr>
<tr>
<td></td>
<td>☐ Probation/Parole officer (1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Mental Health case manager (1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☒ SCA case manager (1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Managed Care Service Provider (1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Area Agency on Aging (1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ OTHER, specify (1):</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ No one helped me (2)</td>
<td>[GO TO QUESTION 12]</td>
</tr>
</tbody>
</table>

Certain questions have numerous areas that may elicit a response. Instructions for scoring such responses have been included in column three of the question. For example, question 37a addresses basic needs. The client has identified three areas of need that are scored as follows:

<table>
<thead>
<tr>
<th>37a.</th>
<th>In which of the following areas would you like to receive help? (MARK ALL THAT APPLY)</th>
<th>None = 0</th>
<th>1 - 2 Needs = 1</th>
<th>3 - 4 Needs = 2</th>
<th>5 + Needs = 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Gas</td>
<td>☐ Water</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Electricity</td>
<td>☒ Telephone</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Heat</td>
<td>☐ Clothing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Food</td>
<td>☒ Healthcare Benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☒ Other, explain: Veterinarian bills</td>
<td>☐ None of the above</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Upon completion of each domain, add the scores in column 3 and place the total in the box at the bottom of the last page of the section. For example, the total score for the Family/Social domain is four, which is placed in the box at the end of the domain.

<table>
<thead>
<tr>
<th>Question</th>
<th>Response (Value)</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>75. In the past 30 days, have problems with your relationships made it hard for you to participate in school, jobs, AOD treatment, or training programs?</td>
<td>☑ Yes (1)</td>
<td>1</td>
</tr>
<tr>
<td>75a. If yes, how much?</td>
<td>☑ A great deal (3)</td>
<td>3</td>
</tr>
<tr>
<td>76. In the past 30 days, has anyone expressed concern about your relationships With family members, friends or significant others?</td>
<td>☑ Yes (1)</td>
<td>0</td>
</tr>
<tr>
<td>77. Are you interested in receiving help with your relationships?</td>
<td>☑ Yes (3)</td>
<td>0</td>
</tr>
<tr>
<td>78. In the past 30 days, did any of the following people try to help you find family services?</td>
<td>MARK ALL THAT APPLY, but only award one point</td>
<td>1 = Received Help</td>
</tr>
<tr>
<td>Drug and Alcohol counselor (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CYS/OCY/CAO case manager (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Probation/Parole officer (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health case manager (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCA case manager (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managed Care Service Provider (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Area Agency on Aging (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHER, specify (1):</td>
<td></td>
<td>[GO TO QUESTION 79]</td>
</tr>
<tr>
<td>No one helped me (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>78a. Are you still working with that person?</td>
<td>☑ Yes (0)</td>
<td>--</td>
</tr>
<tr>
<td>79. What was the outcome or what is the current situation? (MARK ALL THAT APPLY)</td>
<td>☑ I still need the services</td>
<td></td>
</tr>
<tr>
<td>☑ Received the family services</td>
<td>☑ Services are not available</td>
<td></td>
</tr>
<tr>
<td>☑ Referred to the family services</td>
<td>☑ I did not want the services</td>
<td></td>
</tr>
<tr>
<td>☑ On a waiting list</td>
<td>☑ I did not follow through with the referral</td>
<td></td>
</tr>
<tr>
<td>☑ Ineligible</td>
<td>☑ I never asked for help</td>
<td></td>
</tr>
<tr>
<td>☑ Other, explain:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NOTES:
Client indicated ongoing conflict regarding parenting issues but does not want to deal with this problem yet. More concerned about having stable housing and child care. May decide to terminate relationship when this occurs.

FAMILY / SOCIAL TOTAL 4
Upon completion of the ISS, the total score for each domain is then transferred to the first page of the document. This page has been revised to eliminate the original scoring template and the domain score sheet. It is to be updated after each administration of the ISS with the domain scores recorded in the appropriate time frame. See the following example:

**ISS Interval Scores**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Initial</th>
<th>60 Day</th>
<th>120 Day</th>
<th>180 Day</th>
<th>240 Day</th>
<th>300 Day</th>
<th>360 Day</th>
<th>Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>7/18/01</td>
<td>9/18/01</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing</td>
<td>7</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Care</td>
<td>4</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educational/Vocational</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment</td>
<td>6</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Needs</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td>2</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol &amp; Other Drug Treatment</td>
<td>4</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>4</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Health</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family / Social</td>
<td>4</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life Skills</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Levels of Self-Sufficiency:
- 0 - 1 Self-Sufficient
- 2 - 4 Stable / Safe
- 5 - 7 At Risk
- 8 - 10 Unstable
- 10+ In crisis/Not Self sufficient

This provides ongoing data regarding the level of self-sufficiency over time. This information is then utilized for service planning with the client.
Upon completion of each ISS, both the Intensive Case Manager and the client must sign the document. Signature documentation occurs at the bottom of page 26 in the Life Skills domain of the ISS.

TIME COMPLETED: __________ □ am □ pm

___________________________________         ___________________________________
Case Manager’s Signature                     Client Signature

Life Skills, Page 26
SECTION THREE: SERVICE PLAN

A. METHOD FOR COMPLETION OF THE ICM SERVICE PLAN

Once the administration of the ISS has been completed, the results should be scored; the scores should be placed on the front sheet of the service plan and will serve as the structure for service plan development. The domains to be initially addressed should consist of those with the highest score, as the higher the score the more serious the need. There are six (6) different codes that can be entered. They are:

1) Not a need
2) Client willing to work on identified need
3) Not interested in working on identified need at this time
4) Services not available
5) Client is already working on identified need with another case manager
6) Client willing to work on identified needs that are not a priority, but will do so at a later time

The needs to be addressed should then be prioritized to consist of those that the client is most willing to work on, i.e. coded as number 2. However, there are instances when the client needs the service but is not interested in working on that domain at that point in time. For instance, based on the results of the inventory a client may have an unstable housing situation. However, from the client’s perspective this is not something he/she is ready to address. Based upon the strengths-based approach to case management, you should defer addressing that issue to another time. This decision should be noted by writing the number “3” on the front of the service plan for that specific domain; number three (3) states client is “Not interested in working on identified need at this time.” Once the client is comfortable and engaged in case management services, you may utilize motivational interviewing skills to address the needs coded as 3.
B. SERVICE PLAN COMPLETION

Based on the areas of strengths and needs identified by completing and scoring the ISS, the client and ICM will develop a service plan. The scores from each domain will be documented on the first page of the service plan in conjunction with client strengths. From this information, a goal statement can be developed. The ICM will assist the client in identifying goals, especially those required to stabilize an immediate need. The role of the ICM is to assist in the process of needs identification to ensure the client does not develop counterproductive goals as well as serving as a resource person. Therefore, the service plan should provide opportunities for the client to be empowered to make arrangements to access community resources with support from the ICM. When the ICM is designated as responsible for something, it should be limited to specific activities such as linking, monitoring, advocacy or coaching. The ICMs should not put themselves in a position to become a resource to meet the client’s needs directly but function as a support to increase the client’s self-sufficiency.

Goal statements should reflect the domains of the ISS. This will link the service plan to the ISS to provide a composite of services provided through Intensive Case Management. Goals should be written to specify the situation to be changed by the action steps. For example, if the client and the ISS identify childcare as an area of need, the goal statement could be:

“Jane will obtain appropriate day care services for her children.”

Goal statements should not exceed one sentence identifying one situation to be resolved. Multiple issues to be addressed in one goal statement create confusion for the client and are difficult to complete. Goal statements should be written in positive terms to increase motivation and outcome. The action step of the service plan describes how to reach the goal. It defines the following:

1. What must be done
2. In what order
3. How is it accomplished
4. By whom
5. What time frame
Each of these steps leads to the next step in the process. Action steps are observable and measurable. They are concrete behaviors that can be seen, heard or observed in some fashion. Each step should be focused on one specific behavior to be accomplished. For example, action steps for childcare could be:

1. Jane and ICM will review the resource list of licensed day care agencies.
   Target Date: 9/24/99
2. Jane will call licensed day care agencies to get information on services.
   Target Date: 10/08/99
3. Jane will schedule appointments to see the agencies.
   Target Date: 10/22/99
4. Jane will call for subsidized childcare forms.
   Target Date: 10/01/99
5. Jane and ICM will complete forms.
   Target Date: 10/08/99
6. Jane will return forms.
   Target Date: 10/13/99
7. Jane will decide on a day care provider.
   Target Date: 10/27/99
8. Jane will enroll her children in day care.
   Target Date: 11/01/99

Action steps should be time limited. They assist the client in developing a specific time frame in which to achieve the desired goal. The ICM as the resource person will provide realistic time lines for each of the action steps developed. This will reflect the resources available within the individual community and incorporate the individual strengths of the client in accomplishing each specific step. Time frames may be the same for more than one step or different for each step. Time frames provide a guideline for both the client and the ICM to determine if the plan is having the desired effect and producing a positive outcome for the client. In addition, it will assist the ICM in reviewing the client’s self-sufficiency skills. The action steps are always the means to the end result, which is the identified goal. Well-
constructed action steps with realistic time frames should result in the client accomplishing their goal leading to self-sufficient behavior.

Upon completion of the service plan, the client and ICM sign and date the document. The client is given a copy and the original is filed in the case record. Supervisors are also required to sign the service plan indicating review of the document. Each time the plan is reviewed, the client and ICM are required to initial and date the initial plan. This should be done at each meeting to ensure the service plan is assisting the client in reaching his/her identified goal and the time frames for each action step are realistic. This allows the ICM to update the service plan if any significant changes or crisis situations impact client needs.

Updated service plans may need to be completed due to significant changes in life circumstances or a crisis situation occurring for the client. A crisis may be defined as a temporary problem situation in which the client does not have the immediate resources to resolve the problem by using customary coping skills. It is a crisis for the client because he/she does not know how to deal with the situation, which is creating distress in his/her life circumstances. After defining the problem, the ICM and client can explore alternatives to resolve the immediate situation. For example, if homelessness was the immediate crisis, the ICM could utilize community shelters to resolve the immediate need while then developing an updated service plan to obtain permanent housing. The ICM and client would complete the updated service plan following the same format as the initial plan.

The ICM will document the rationale for the updated service plan in the case note section of the case record. While the note should be as brief and concise as possible, it should adequately describe the nature and extent of the meeting including immediate resources and referrals for the client to resolve the situation. It is helpful to structure the note in a specific format such as DAP. This assists the ICM in focusing on what the content of the note should include:

D – Data – Who, what, where, when and why
A – Assessment – Assess the interaction and relate it to the service plan
P – Plan – When will contact be made again and actions that will occur until then

This provides accurate documentation of the client’s progress toward attaining each goal and any changes which have impeded self-sufficiency.
SECTION FOUR: DISCHARGE FORM

A. COMPLETION INSTRUCTIONS

A discharge form is to be completed for each client at the point of discharge from case management. The primary areas included in the discharge form are:

- **Date of Last Contact and Date of Discharge:** In some cases the date of last contact may be the discharge meeting. However, in cases where this discharge does not occur as part of a face-to-face meeting, the date of last contact should be the last time the case manager has had any direct contact with the client, either face-to-face or via telephone.

- **Actual Number of Interactive Contacts when Enrolled in Case Management:** Interactive contacts may be face-to-face or via telephone.

- **Reasons for Discharge:**
  - Completed Case Management
  - Institutionalized/Incarcerated
  - Dropped Out
  - Refused Services Offered
  - Unlocatable
  - Deceased
  - Administrative Discharge
  - Referred To Another SCA
  - Other

- **Attainment of Service Plan Goals by Domain:** The case manager should record the level of self-sufficiency based on the ISS administered at the point of discharge. If the ISS is not administered at the point of discharge, the level of self-sufficiency should be based on client progress as documented in the service plan and noted in the appropriate column of the discharge form.

The discharge form should be completed and signed by both the case manager and the case management supervisor.
B. DEFINITIONS OF REASONS FOR DISCHARGE

**Completed Case Management:** Client has completed case management, i.e. support service needs have been adequately addressed and client is no longer in need of additional case management services.

**Institutionalized/Incarcerated:** Client has been currently committed to a long-term psychiatric facility or has been sentenced to a correctional institution, i.e. 30 days.

**Dropped Out:** Client has not followed through with scheduled appointments and indicated that he/she is not interested in being enrolled in case management.

**Moved:** Client has moved out of the area and is no longer eligible for case management services.

**Refused Services Offered:** Client indicated that he/she did not want the case management services or support services that were being offered.

**Unlocatable:** Client is no longer living at the address listed in case management files and after numerous attempts to contact the client it was determined that he/she could not be found.

**Deceased:** Client is no longer living and therefore does not need case management services.

**Administrative Discharge:** Client is not following through with scheduled appointments, is not following through with referrals and is not compliant with recommendations made by the case management office. This discharge was reviewed and approved by the case management supervisor.

**Referred to Another SCA:** Client has moved to another county within Pennsylvania and continues to be interested in receiving case management services; a referral has been made to the case management office in ________________ county.

**Other:** Any other reasons for discharge that do not fit the above categories.
SECTION FIVE: CLIENT SATISFACTION SURVEY

A. DESCRIPTION OF THE CLIENT SATISFACTION SURVEY

The client satisfaction survey is a 15-item self-administered instrument that asks the client to rate each of the items on the survey on a three-point scale ranging from Always to Never. The components of the survey focus on the following:

- The availability of the case manager
- Responsiveness of the case management unit to client calls
- Helpfulness of the service plan
- Whether the client was treated with appropriate sensitivity
- Perception of changes in the client as a result of case management and
- Whether the client is interested in returning to the SCA if case management services were needed in the future.

B. METHOD OF ADMINISTRATION

The client satisfaction survey allows the client to provide feedback to the program regarding the aspects mentioned above. The results of the survey are to be utilized by the case management unit to identify aspects of the program that are being well received by clients as well as those that need improvement. The client is to complete the survey independently. The provider will then be responsible for reviewing the data and forwarding this information to the SCA for review. Should any client identifying information be included in this data due to small sample size, the provider will be responsible to obtain a signed consent to release information to the SCA. Upon review of this information by the SCA Administration, any identifying client information must be removed prior to disseminating data to direct line staff to ensure client anonymity.

To ensure confidentiality and a high response rate, the recommended protocol for administering the Client Satisfaction Survey 30 days post admission and at the time of discharge is as follows:
1. The initial survey will be distributed to the client during a face-to-face contact by the ICM. The ICM will explain the rationale for the survey, inform the client that the ICM will not have access to the actual client survey, that the survey information is anonymous and request the client complete the form during the contact. The ICM will also provide the client with written documentation of this information and request the client sign and date the form to verify the survey has been distributed. This document will be filed in the client record. The ICM will ensure the privacy of the client in order to complete the form accurately. The case manager should give the client a copy of the survey along with an envelope addressed to the case management office and ask him/her to complete it before the client leaves the office.

2. The case management office should have a designated drop box for Client Satisfaction Surveys. For those clients who are completing the survey at the office, the client should be directed to the drop box where he/she can leave the survey. At the completion of the business day, the designated employee will empty the drop box and store the surveys in a locked file cabinet. Information from the survey will be entered into the database by the designated employee who is not directly providing ICM services. This may be a supervisor or support staff. All client information will be stored per the requirements of the current DOH/County contract.

3. For those clients who are completing the survey during a home or community-based visit, the case manager should provide the client with a stamped envelope that can be used to send the completed survey to the ICM office. The client and case manager will mail the completed survey together. To ensure confidentiality, it is NOT to be returned by the ICM. It is important to emphasize that completion of the survey is voluntary and that all responses are confidential. There is no information on the survey that identifies a specific client.

4. At the discharge meeting, the ICM will provide the client with a client satisfaction survey. The ICM will again explain the rationale for the survey, inform the client the ICM does not have access to the information, that the survey process is anonymous and request the client complete the form. The ICM and client will mail
it to the SCA or provider in the stamped, addressed envelope that will be provided. The ICM will not return the survey to the office. If the discharge meeting occurs in the office, the client can complete the survey in privacy and place it in the drop box prior to leaving the office. The ICM will again provide the client with written documentation of this information and request the client sign and date this form. The document will be filed in the client record. At the completion of the business day, the designated employee will collect the surveys and store them in a locked file cabinet. Information will be entered into the database by the designated employee who is not directly providing ICM services such as a supervisor or support staff. All client information will be stored per the requirements of the current DOH/County contract.

5. Although the discharge meeting should be face-to-face to have the opportunity to review the client’s progress in meeting their goals and providing closure to ICM services, this may not always be possible due to extenuating circumstances. The SCA or provider will develop a letter to be sent to the last known address of the client reviewing the rationale for the client satisfaction survey, ensuring the survey process is anonymous and request the client complete the form within a seven-day time frame and mail it to the SCA or provider in the stamped, addressed envelop provided. The client satisfaction survey should be enclosed with the cover letter and sent to the client upon discharge from ICM services. The ICM will document this procedure in the progress notes of the client record. When the ICM contacts the client for the 30-day follow-up, they will ask the client if the survey was received, completed and returned to the SCA or provider. This response will be documented in the client record as part of the follow-up procedure. If this has not occurred, the ICM will verify that the client has a copy of the survey and request the client complete and return it to the SCA or provider within a seven-day time frame. The ICM will verify the address and mail another survey if the client does not have the document. The ICM will continue to ask the client if the survey was completed and returned at the 90-day follow-up. The response is to be documented as part of the follow-up procedure.
SECTION SIX: SUPPORT SERVICES FOLLOW-UP CHECKLIST

A. DESCRIPTION OF THE SUPPORT SERVICES FOLLOW-UP CHECKLIST

One of the primary goals of ICM is to increase a client’s level of self-sufficiency over time. The ISS was developed to identify service needs and to measure changes in needs while the client is enrolled in case management; the primary assumption being that if the client is linked to and accesses the services, the level of self-sufficiency should improve. However, it is also important to determine whether the levels of self-sufficiency have been sustained after discharge from case management or if the client needs to be reengaged into case management.

The Support Services Follow-up Checklist is a 24-item instrument, i.e. two questions per domain. The case manager should fill out the first question within each domain prior to the implementation of the survey, as it indicates the client’s level of self-sufficiency for each domain at the time of discharge or at the time of the previous follow-up. When asking the questions regarding the current level of self-sufficiency, the case manager should state: *At the time of discharge your level of self-sufficiency for Housing was Stable and Safe. What is your current level of self-sufficiency for Housing, is it Self-Sufficient, Stable and Safe, At Risk, Unstable, or In Crisis.* (To familiarize the client with what comprises each level of self-sufficiency, the case manager should refer to the definitions for each level of self-sufficiency within each domain, which can be found in appendix B)

B. METHOD FOR ADMINISTERING THE SUPPORT SERVICES FOLLOW-UP CHECKLIST

1. The Support Services Follow-up Checklist is to be administered at the following intervals: 30, 90, 180 and 365 days post discharge. The Support Services Follow-up Checklist should be conducted via a telephone or face-to-face interview. It is recommended that an intensive case management approach be employed in administering the face-to-face interview, i.e. in the community, in the client’s home or in the ICM office. **Follow-up is required for all**
clients who have been admitted to Intensive Case Management. During the client’s involvement in ICM, it is good practice to identify as many people as possible who might be potential contacts during the follow-up process. It is recommended the list be reviewed and updated during discharge. This will assist the ICM in having an accurate list of potential contacts still involved with the client.

The ICM will obtain a valid, informed consent to release information for each identified contact person to protect the client’s right to confidentiality. The consent to release information should clearly indicate the purpose of the contact as well as the specific information to be obtained from each contact person, i.e. current telephone number of the client or the current address for follow-up purposes. Since the purpose of the disclosure is to assist the ICM in contacting the client for follow-up, the specific information to be released can be clearly identified on the consent to release information form. This is required by 42 CFR Part 2, Subpart C, 2.31 and 28 PA.Code 709.28c. Any disclosure made under these regulations must be limited to the information necessary to carry out the purpose of the disclosure.

Tracking and successfully locating clients post discharge can be a challenging and time-consuming process. The following strategies may help to increase the case manager’s ability to improve the follow-up process.

- If the client has moved and a forwarding address is not available, the contact person can be called to help update the client’s file. It is important to ask the client to identify as many contact persons as possible. During the time the client is enrolled in case management it is important to ask the client to update the information on potential contact sources and to obtain the appropriate releases as described above.
- At the time of discharge, set up an appointment for the follow-up and then contact the client prior to the actual appointment to remind him/her that the appointment has been scheduled.
- If the client has been involved with other case managers and you have obtained appropriate releases that allow you to contact these case managers, call them to ask if they know how you might locate the client.
- At the time of discharge ask the client to indicate the best time the ICM should try to contact the client.
- Go into the community and meet the client at a location that is convenient for the client.
APPENDIX A:

STANDARD FORMS

1. Inventory of Support Services
2. Service Plan
3. Updated Service Plan
4. Discharge Form
5. Client Satisfaction Survey
6. Support Service Follow-up Checklist
APPENDIX B:

SELF-SUFFICIENCY DESCRIPTIONS

SELF-SUFFICIENCY MATRIX
HOUSING:

- **In Crisis/Not Self Sufficient (10+)**: Housing is insufficient and is not meeting client’s needs, i.e. he/she is at risk of losing housing, and housing needs have caused a great deal of difficulty for participation in AOD treatment, school, jobs, training, etc.

- **Unstable (8-10)**: Housing is insufficient and is not meeting client’s needs, i.e. he/she is at risk of losing housing, and housing needs have made it somewhat difficult for participation in AOD treatment, school, jobs, training, etc.

- **At Risk (5-7)**: Housing is insufficient and is not meeting client’s needs, i.e. he/she is at risk of losing housing, and housing needs have made it a little difficult for participation in AOD treatment, school, jobs, training, etc.

- **Stable/Safe (2-4)**: Housing is sufficient but may not be meeting client’s needs and he/she may be interested in improving current living situation.

- **Self Sufficient (0-1)**: Housing is sufficient and meets client’s needs, i.e. he/she is not at risk of losing housing, and housing needs have not made it difficult for participation in AOD treatment, school, jobs, training, etc.

CHILD CARE:

- **In Crisis/Not Self Sufficient (10+)**: Child care is insufficient, is not meeting the client’s needs, i.e. he/she does not have any arrangements and it has created a great deal of difficulty for participation in AOD treatment, school, jobs, training, etc.

- **Unstable (8-10)**: Child care is insufficient and is not meeting client’s needs, i.e. he/she does not have appropriate arrangements and it has made it somewhat difficult for participation in AOD treatment, school, jobs, training, etc.

- **At Risk (5-7)**: Child care is insufficient and is not meeting client’s needs, i.e. he/she does not have consistent arrangements and it has made it a little difficult for participation in AOD treatment, school, jobs, training, etc.

- **Stable/Safe (2-4)**: Child care is sufficient but may not be meeting client’s needs, i.e. he/she has arrangements most of the time, client is somewhat satisfied with the current arrangement

- **Self Sufficient (0-1)**: Child care is sufficient and meets client’s needs, i.e. he/she has a consistent arrangement for child care, the client is very satisfied with the arrangement and it has not made it difficult for participation in AOD treatment, school, jobs, training, etc.
**EDUCATIONAL/VOCATIONAL SERVICES**

- **In Crisis/Not Self Sufficient (10+):** Educational level is insufficient and is not meeting client’s needs, i.e. it interferes a great deal with his/her ability to achieve goals, and it has created a great deal of difficulty for participation in AOD treatment, jobs, etc.

- **Unstable (8-10):** Educational level is insufficient and is not meeting client’s needs, i.e. it interferes somewhat with his/her ability to achieve goals, and it has made it somewhat difficult for participation in AOD treatment, jobs, etc.

- **At Risk (5-7):** Educational level is insufficient and is not meeting client’s needs, i.e. it may interfere a little with his/her ability to achieve goals, and it has made it a little difficult for participation in AOD treatment, jobs, etc.

- **Stable/Safe (2-4):** Educational level is sufficient but may not be meeting client’s needs, i.e. he/she may want to improve current educational/vocational level and it has not made it difficult for participation in AOD treatment, jobs, etc.

- **Self Sufficient (0-1):** Educational level is sufficient and meets client’s needs, i.e. it does not interfere with his/her ability to achieve goals and it has not made it difficult for participation in AOD treatment, jobs, etc.

**EMPLOYMENT SERVICES**

- **In Crisis/Not Self Sufficient (10+):** Employment status is not sufficient, i.e. client does not have a job, and it interferes a great deal with his/her ability to participate in AOD treatment.

- **Unstable (8-10):** Employment status is not sufficient, i.e. client is at risk of losing his/her job or does not have a job, and it interferes somewhat with his/her ability to participate in AOD treatment.

- **At Risk (5-7):** Employment status is not sufficient, i.e. client is at risk of losing his/her job, and it interferes a little with his/her ability to participate in AOD treatment.

- **Stable/Safe (2-4):** Employment status is sufficient, i.e. but client may be interested in improving current employment status, and it does not interfere with his/her ability to participate in AOD treatment.

- **Self Sufficient (0-1):** Employment status is sufficient, i.e. client is not at risk of losing his/her job, and it does not interfere with his/her ability to participate in AOD treatment, school, etc.
BASIC NEEDS

- **In Crisis/Not Self Sufficient (10+):** Basic needs are not sufficient and would like to receive help in 5+ areas, and it interferes a great deal with his/her ability to participate in AOD treatment, school, jobs, training, etc.

- **Unstable (8-10):** Basic needs are not sufficient and would like to receive help in 3-4 areas, and it interferes somewhat with his/her ability to participate in AOD treatment, school, jobs, training, etc.

- **At Risk (5-7):** Basic needs are sufficient but would like to receive help in 1-2 areas, and it interferes a little with his/her ability to participate in AOD treatment, school, jobs, training, etc.

- **Stable/Safe (2-4):** Basic needs are sufficient but would like to receive help in 1-2 areas, and it does not interfere with his/her ability to participate in AOD treatment, school, jobs, training, etc.

- **Self Sufficient (0-1):** Basic needs are sufficient, and it does not interfere with his/her ability to participate in AOD treatment, school, jobs, training, etc.

TRANSPORTATION

- **In Crisis/Not Self Sufficient (10+):** Transportation is not sufficient, and it interferes a great deal with his/her ability to participate in AOD treatment, school, jobs, training, etc.

- **Unstable (8-10):** Transportation is not sufficient, it interferes somewhat with his/her ability to participate in AOD treatment, school, jobs, training, etc.

- **At Risk (5-7):** Transportation is not sufficient, and it interferes a little with his/her ability to participate in AOD treatment, school, jobs, training, etc.

- **Stable/Safe (2-4):** Transportation may not be sufficient and client is interested in receiving help with transportation, but it does not interfere with his/her ability to participate in AOD treatment, school, jobs, training, etc.

- **Self Sufficient (0-1):** Transportation is sufficient, and it does not interfere with his/her ability to participate in AOD treatment, school, jobs, training, etc.
**ALCOHOL AND OTHER DRUG TREATMENT**

- **In Crisis/Not Self Sufficient (10+):** Client is not involved in AOD treatment, is not involved with support groups, others have expressed concern about his/her use of AOD and this interferes a great deal with his/her ability to participate in other services.

- **Unstable (8-10):** Client is not involved in AOD treatment, is not involved with support groups, is interested in receiving treatment, others have not expressed concern about his/her use of AOD and this interferes somewhat with his/her ability to participate in other services.

- **At Risk (5-7):** Client is currently involved in AOD treatment, is not attending on a regular basis, is not involved with support groups and this interferes a little with his/her ability to participate in other services.

- **Stable/Safe (2-4):** Client is currently involved in AOD treatment, is not attending on a regular basis, is involved with support groups and this does not interfere with his/her ability to participate in other services.

- **Self Sufficient (0-1):** Client is currently involved in AOD treatment on a regular basis or completed treatment, is involved with support groups and this does not interfere with his/her ability to participate in other services.

**LEGAL SERVICES**

- **In Crisis/Not Self Sufficient (10+):** Client is currently involved in the criminal justice system, and the legal problems interfere a great deal with his/her ability to participate in school, jobs, training, etc.

- **Unstable (8-10):** Client is currently involved in the criminal justice system, and the legal problems interferes somewhat with his/her ability to participate in AOD treatment, school, jobs, training, etc.

- **At Risk (5-7):** Client is currently involved in the criminal justice system, and the legal problems interfere a little with his/her ability to participate in AOD treatment, school, jobs, training, etc.

- **Stable/Safe (2-4):** Client is not currently involved in the criminal justice system but may need some help with legal problems. This does not interfere with his/her ability to participate in AOD treatment, school, jobs, training, etc.

- **Self Sufficient (0-1):** Client is not currently involved in the criminal justice system, and does not have any legal problems.
PHYSICAL HEALTH

• **In Crisis/Not Self Sufficient (10+):** Client is experiencing health related problems, others have expressed concern about his/her health, and health problems have interfered a great deal with his/her ability to participate in AOD treatment, school, jobs, training, etc.

• **Unstable (8-10):** Client is experiencing health related problems, and the health problems have interfered somewhat with his/her ability to participate in AOD treatment, jobs, training, etc.

• **At Risk (5-7):** Client is experiencing health related problems, and the health problems have interfered a little with his/her ability to participate in AOD treatment, jobs, training, etc.

• **Stable/Safe (2-4):** Client is experiencing some health related problems, but the health problems have not interfered with his/her ability to participate in AOD treatment, jobs, training, etc.

• **Self Sufficient (0-1):** Client is not experiencing any health-related problems.

FAMILY/SOCIAL

• **In Crisis/Not Self Sufficient (10+):** Client is experiencing difficulty with his/her relationships with family members, et al., and the problems interfere a great deal with his/her participation in AOD treatment, school, jobs, training, etc.

• **Unstable (8-10):** Client is experiencing difficulty with his/her relationships with family members, et al., and the problems interfere somewhat with his/her participation in AOD treatment, school, jobs, training, etc.

• **At Risk (5-7):** Client is experiencing difficulty with his/her relationships with family members, et al., and the problems interfere a little with his/her participation in AOD treatment, school, jobs, training, etc.

• **Stable/Safe (2-4):** Client is experiencing difficulty with his/her relationships with family members, et al., but the problems do not interfere with his/her participation in AOD treatment, school, jobs, training, etc.

• **Self Sufficient (0-1):** Client is not experiencing any difficulty with his/her relationships with family members.
LIFE SKILLS

- **In Crisis/Not Self Sufficient (10+):** Life skills are not sufficient and client would like to receive help in 4+ areas, and this interferes a great deal with his/her ability to participate in AOD treatment, school, jobs, training, etc.

- **Unstable (8-10):** Life skills are not sufficient and client would like to receive help in 3+ areas, and this interferes somewhat with his/her ability to participate in AOD treatment, school, jobs, training, etc.

- **At Risk (5-7):** Life skills are sufficient but would like to receive help in 1-2 areas, and it interferes a little with his/her ability to participate in AOD treatment, school, jobs, training, etc.

- **Stable/Safe (2-4):** Life skills are sufficient but client would like to receive help in 1+ areas, and it does not interfere with his/her ability to participate in AOD treatment, school, jobs, training, etc.

- **Self Sufficient (0-1):** Client does not need help in any life skills areas.
Bureau of Drug and Alcohol Programs  
Division of Treatment  
Self-Sufficiency Matrix

<table>
<thead>
<tr>
<th>Domains</th>
<th>Self-Sufficient</th>
<th>Stable/Safe</th>
<th>At Risk</th>
<th>Unstable</th>
<th>InCrisis/Not Self-Sufficient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Score: 0-1</td>
<td>Score: 2-4</td>
<td>Score: 5-7</td>
<td>Score: 8-10</td>
<td>Score: 10+</td>
</tr>
<tr>
<td>Housing</td>
<td>Housing is sufficient and meets client needs</td>
<td>Housing is sufficient but may not be meeting client needs</td>
<td>Insufficient or housing is at risk but help is available</td>
<td>At risk of losing housing and has no one to help</td>
<td>Housing help is needed</td>
</tr>
<tr>
<td>Basic Needs</td>
<td>Basic needs are being met</td>
<td>Client has resources to meet his needs but may not be adequate</td>
<td>Client lacks resources to meet basic needs but help is available</td>
<td>Basic needs are not being met and has no one to help</td>
<td>Basic needs are not being met</td>
</tr>
<tr>
<td>Transportation</td>
<td>Client has adequate transportation which meets their needs</td>
<td>Client has adequate transportation that is sometimes reliable</td>
<td>Client lacks adequate transportation but help is available</td>
<td>No transportation and has no one to help</td>
<td>No reliable transportation</td>
</tr>
<tr>
<td>Physical Health</td>
<td>No problems or health needs are being met</td>
<td>Immediate health problems are being addressed</td>
<td>Client has health problems but help is available</td>
<td>Client has severe health problems and has no one to help</td>
<td>Client has health problems which are not being addressed</td>
</tr>
<tr>
<td>Family/Social</td>
<td>Family system is stable; no help is needed</td>
<td>System is somewhat stable; but has someone to help</td>
<td>System is unstable but help is available</td>
<td>System is very unstable; and has no one to help</td>
<td>System is in crisis</td>
</tr>
<tr>
<td>AODT</td>
<td>In recovery and no other help is needed</td>
<td>In treatment or involved in self help group with regular attendance and help is available</td>
<td>In treatment or involved in self help group with no regular attendance but help is available</td>
<td>Client not in treatment or recovery; and has no one to help</td>
<td>Not in treatment or self help group and not seeking help</td>
</tr>
<tr>
<td>Mental Health</td>
<td>No problems or mental health needs are being met</td>
<td>Immediate mental health problems are being addressed</td>
<td>Client has mental health problems but help is available</td>
<td>Client has severe mental health problems and has no one to help</td>
<td>Severe mental health problems not being addressed and not seeking help</td>
</tr>
<tr>
<td>Legal</td>
<td>No legal problems; no help needed</td>
<td>Few legal problems and receiving help</td>
<td>Some legal problems and receiving help or help is available</td>
<td>Legal problems not being addressed; and has no one to help</td>
<td>Legal problems are not being addressed</td>
</tr>
<tr>
<td>Education</td>
<td>Sufficient education level; no help needed</td>
<td>Insufficient education level but currently in school or attending training</td>
<td>Insufficient education level but help is available</td>
<td>Insufficient education level and wants help but has no one to help</td>
<td>Insufficient education level and is not seeking help</td>
</tr>
<tr>
<td>Employment</td>
<td>Working full time; no help needed</td>
<td>Working but is in need of help</td>
<td>Working but job is in jeopardy but help is available</td>
<td>Working but job is in jeopardy; wants help but has no one to help</td>
<td>Unemployed and not seeking help</td>
</tr>
<tr>
<td>Life Skills</td>
<td>No basic life skills needed</td>
<td>Life skills are sufficient but may not be meeting needs</td>
<td>Life skills are inadequate and help is available</td>
<td>Life skills are inadequate and has no one to help</td>
<td>Life skills are inadequate and not seeking help</td>
</tr>
<tr>
<td>Child Care</td>
<td>Child care needs are being met</td>
<td>Child care is sufficient but may not be meeting needs</td>
<td>Child care is unstable or insufficient but help is available</td>
<td>No child care or at risk of losing child care</td>
<td>Needs child care</td>
</tr>
</tbody>
</table>
APPENDIX C:

CASE MANAGEMENT WORKGROUP