

## Case Management Action Plan

The purpose of the Case Management Action Plan is that a person receiving services has an individualized, personalized plan for their supports, formal and informal. The plan is created with the assistance of a person's Case Manager. The plan identifies the supports the person has chosen to use, the person's intention or desired outcomes of their supports, who is responsible for the supports, and, how and when those supports will be reviewed for effectiveness. The plan acts as a bridge from the Independent Living Assessment (ILA) to the actual delivery of support services.

- A Case Management Action Plan must be completed for people receiving services that have complex case management needs that extend beyond advocacy or counseling for benefit programs.
- A plan must be completed for all people receiving Choices for Care Highest/High needs at home or in an Enhanced Residential Care (ERC) setting.
- If a person receives services through CFC Moderate Needs or the Older American's Act, and, do not have complex case management needs, the case manager is not required to complete a plan, although their case management services must comply with current DDAS Case Management Standards. Case managers shall use their professional judgment and document, in the person's case notes, their decision to not use a Case Management Action Plan.
- The person, their legal representative, caregiver or family member, develops the plan with the case manager.
- The plan provides a written summary of Issues and Goals, the Plan/Strategy of each support, the Responsible Person(s) for providing that support, and the Target Dates for completion.
- The plan is not simply a to-do list for the case manager.
- Documentation of the plan can be in any format which meets the intent and all the requirements of a Case Management Action Plan, including that it be a format that is easily shared and understood by the person receiving supports.

### **How does a Case Management Action Plan benefit the person being supported?**

- The plan is intended to assist the person, and the people who support them, to better understand the intent and purpose of the supports, and who is responsible to carry out each part of the plan. It should be written so that the person can easily understand and refer to it. It should enable a person to easily review their plan and the agreements that have been made. The plan also allows the person to build upon their own strengths and be an active participant in their supports.

### **How does the Case Management Action Plan benefit the case manager?**

- The plan allows the case manager to quickly review the over-all issues and support plans for a person.
- It serves as a quick reference tool a case manager can use when contacting and visiting a person receiving services. It allows the case manager to accurately record the progress or lack of progress in the person's record.
- The plan guides necessary follow-up with others providing support in the plan.
- The plan is beneficial for a case manager who may suddenly need to take over another case manager's caseload.

### **How does the plan benefit the case management supervisor?**

- The plan can serve as a quick supervisory tool for following the progress or lack of progress of a person's supports.
- The plan can help supervisors to review how a case manager uses the data from assessments to understand a person's needs, and then develop an appropriate plan with the person receiving supports.

## **When do I complete a Case Management Action Plan?**

- A plan is completed at the time of initial assessment, should be regularly discussed by the person receiving supports and their case manager, and updated as a person's support needs change. Progress, lack of progress, and changes to the plan are recorded in the person's file. Any significant change that triggers the need for a new assessment must also trigger the need for a new plan.

## **How lengthy is an Action Plan?**

- Each plan should be clear, concise and easy to understand by both the person receiving services and anyone providing supports. It is not meant to be a narrative of the ILA or other assessments. As many pages as necessary should be used to outline the major issues, goals and strategies.

## **Who receives the Case Management Action Plan?**

- The person receiving services and their case manager. A copy of the plan may also be shared with those providing support as long as the person receiving services allows it.

## **Who signs the Action Plan and where?**

- The Action Plan must be signed and dated by the person receiving services (or their legal representative) and by the case manager who developed the plan with the person.
- If an individual declines or is unable to sign their plan, documentation of that must be noted in the person's file.

## What is included under Issues and Goals?

- All of the issues and goals, identified by the person receiving services, which services are able to support.
- The goals should be what the person receiving services hopes to accomplish with the support of their services.
- Issues and goals should reflect the words and sentiments of the person receiving supports.
- If a person receiving support does not wish to address an area of concern identified by the ILA or other assessments, that should be noted on the plan or in the person's record.
- The status of the issues and goals should be recorded in the person's record kept by their provider.
- Example:
  - Issue – Depression or "I feel down a lot."
  - Goal – Increased energy which would allow me to participate in XXXX (hobby, interest, etc.) as often as I choose. (ie. I would like to have the energy to complete a quilt for my daughter by Hanukkah.)
  - Goals should be measurable so that the person receiving services and the case manager will know when they have been achieved or need to be reevaluated.

## What is included under plan/strategy?

- An outline of the activities that will be used to pursue each goal for each issue.
- There may be more than one activity for each issue/goal.
- An example of a plan/strategy is: Referral to Elder Care Clinician for additional assessment and treatment.
- The Status of the plan(s)/strategies should be documented in the person's record.
- Responsible Persons is the person who will carry out **each** plan/strategy for **each** specific issue/goal is recorded. The Responsible Person may include the case manager, the provider, the person receiving supports, their family, caregiver and other formal as well as informal supports.
- The person receiving support should be given appropriate responsibility implementing and pursuing their plan.

## What is included under Target Date?

- Target Date refers to the time frame in which the Responsible Person hopes to achieve each specific plan/strategy for each issues/goals.
- The Target Date status should be recorded in the person's record.
- The dates should be specific and appropriate to the specific issue, goal, plan and strategy. The dates should not automatically default to "ongoing", year-long, or a reassessment based timeframe (i.e.: 7/05-7/06).
- If a goal is actually an ongoing goal, then it is acceptable to use the annual review date as the completion date or in some cases "ongoing" if the goal is to maintain skills. All aspects of a person's plan should be reviewed during a person's annual reassessment.

## **Please Note**

The following Case Study and Case Management Action Plan are intended as an example.

Each plan that is developed with a person receiving supports must be individualized to that person's needs.

Two people with similar issues may have different goals, plans, strategies, responsible persons and target dates.

Currently, The Case Management Certification Exam will contain a number of questions about planning services and supports, but will NOT ask you to review a Case Study and Develop a Case Management Action Plan.

## Case Management Action Planning Case Study

Central VT Council on Aging (CVCOA) case manager, Marie, is meeting with Michael Cornell, an individual in need of services, and his granddaughter Jennifer. Marie received the Choices for Care Clinical Certification of Highest Needs from the Long Term Care Clinical Coordinator. Michael age 86, took a bad fall six weeks ago and has been receiving rehabilitation services at a local nursing facility. Discharge planning was not thorough as Michael insisted he was ready to go home with services in place or not. It appeared at the time that Jennifer would be able to be a significant source of help as she was willing to move in with Michael. It was questionable if Jennifer was going to be able to provide Michael with all the assistance he needs, but they agreed to give it a try. Since Jennifer moved in, she has been offered a very good job at IBM and does not wish to turn it down. Jennifer is willing to help as much as she can, but it has become apparent to both Michael and Jennifer that he will not be able to remain at home without the CFC program.

Before rehab, Michael was in the Central VT Medical Center for a hip replacement, and a broken arm which was put in a cast. Michael has diabetes, (two toes amputated in the last two years), macular degeneration and poor hearing. During the ILA assessment it became clear that while Michael is already connected with the Association for the Blind & Visually Impaired and has hearing aides; it can be a challenge to get him to wear his hearing aides. Michael has become quite confused since his stay at the nursing facility and currently his decision making skills are severely impaired. He needs extensive assistance with dressing, bathing, toileting and transfers. Michael is not eating well and continues to lose weight. Michael tells Jennifer and Marie that he has no energy, feels down a lot and doesn't even care about tending to his garden this year. He use to enjoy socializing with people and hobbies like woodworking, gardening and painting, but they don't interest him much any more. Michael attended the local Congregational Church, but has not been to church services since his fall. He agrees that it might be helpful to talk with the pastor, have people around during the day and is willing to accept services that will help him to be able stay at home. Michael and Jennifer are interested in agency directed services at this time and clearly want to receive case management services from CVCOA.

Marie has already assisted Michael and Jennifer with the application for Long Term Care Medicaid. It appears to Marie that he will be eligible because he's been on Community Medicaid and has limited income.

Michael, Jennifer and Marie are now developing Michael's Action Plan together.

## Case Management Action Plan

Client Name: Michael Cornell Date: April 12, 2007

Issues and Goals	Plan/Strategy	Responsible Person	Target Date
1. Issue: I feel down a lot. Goal: Increased energy and interest in my hobbies.	-Refer to Elder Care Clinician for further assessment and treatment.	AAA CM/ECC	July 12, 2007
2. Issue: Not eating well and losing weight. Goal: Eat well to manage my diabetes and gain 10lbs.	-Refer to Nutrition Director at CVCOA for nutrition consult for Michael & Jennifer.	AAA CM	April 19, 2007
	-Refer to Meals on Wheels (MOW) 2x a week.	AAA CM	April 19, 2007
	-Jennifer wants to cook evening & weekend meals.	Jennifer	July 12, 2007
	-Michael will have nutritious meals at Barre Project Independence (BPI) 3x a week.	AAA CM/BPI	
	-Michael, Jennifer & Marie will review in 3 months progress toward goal.	AAA CM/ Michael/Jennifer	July 12, 2007

**We agree to carry out the responsibilities outlined in this Action Plan to the best of our ability.**

**Please sign and date:**

\_\_\_\_\_  
Client/Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Case Manager

\_\_\_\_\_  
Date

Please sign/date the last page of the Action plan.

**Original for client**

**Yellow for office file**

**Pink for case file**

### Case Management Action Plan

Client Name: Michael Cornell Date: April 12, 2007

Issues and Goals	Plan/Strategy	Responsible Person	Target Date
3. Issue: Alone during the day. Goal: I would like to	-Refer to BPI. Michael agrees to attend 3x a wk.	AAA CM/Michael	April 19, 2007
socialize with people and try some activities like	-BPI will help Michael focus on his hobbies.	BPI/Michael	May 12, 2007
woodworking, painting and gardening.	-Michael agrees to give BPI a one month try and	Michael/AAA CM	May 12, 2007
	then discuss if it's right for him.		
4. Issue: Michael's spiritual needs are not being met.	-Michael would like Jennifer to call the minister,	Jennifer	April 19, 2007
Goal: Michael's spiritual needs will be met through	Barbara Watkins to arrange for a visit.		
visits from his minister and attending church.	-Michael will let Barbara know that he would	Michael	April 30, 2007
	like spiritual visits 1-2 x a month if possible.		
	-Jennifer agrees to bring Michael to church 2x a	Jennifer	July 12, 2007
	month. Michael's friend John will bring him 2x	John	July 12, 2007
	if Michael wants.		

**We agree to carry out the responsibilities outlined in this Action Plan to the best of our ability.**

**Please sign and date:**

\_\_\_\_\_  
Client/Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Case Manager

\_\_\_\_\_  
Date

**Please sign/date the last page of the Action plan.**

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