

CASE PLANNING & CASE PLAN IMPLEMENTATION

MITEAM Specialist Led Application Exercise GUIDE



MiTEAM Specialist Led Application Exercise: Case Planning & Case Plan Implementation

Purpose: Build on and reinforce information provided in the case planning and case plan implementation tutorials by offering different experiential learning opportunities.

Planning	
Materials	<ul style="list-style-type: none"> • Participant Packet • Large post-it paper and markers • Attendance Sheets • Surveys
Preparation	<ol style="list-style-type: none"> 1. Print off the Participant Packet for each participant. 2. Create a visual for initial implementation of the MiTEAM Enhancements (see appendix, page 14 for guidance). 3. Post the select fidelity indicators for case planning and case plan implementation. <ul style="list-style-type: none"> • Case Planning <ol style="list-style-type: none"> 1. (Interview) The individual described specific examples where his or her input was utilized in decision making. 2. (Documentation) The plan builds resilience including two or more strategies that: <ol style="list-style-type: none"> a) Promote family members ability to develop and build relationships b) Promote family members’ mastery and/or competency c) Improve family member’ self-esteem d) Gives family members voice e) Enables family members choice • Case Plan Implementation <ol style="list-style-type: none"> 1. There is evidence in the documentation that service providers were provided with clear and specific service needs for the family. (Documentation) 2. When developing or adjusting the plan, asks for team member’s input. (Observation)
Outline	
Introduction Time: 7 minutes	<p>Objective: Introduce case planning and case plan implementation and orient participants to the training.</p> <p>Introduction: Before today, you completed the modules for Engagement, Teaming, and Assessment (reference your visual for the initial implementation, see appendix section, page 14). In the application exercises you learned ways to put these skills into practice with your families by implementing small steps of change. Engagement, Teaming and Assessment build on one another. Does anyone remember what skills</p>

	<p>were covered in these competencies (solicit answers from the group)? The prior competencies are the foundation for Case Planning and Case Plan Implementation.</p> <p>The case plan is our intervention, our attempt as a team to change the trajectory of the family’s life, to ensure safety, permanency and well-being for Michigan’s children. The family’s success relies on our case plan. Every effort must be made to create a tailored plan that has a high probability of leading us to our desired goals. This is not something that can be created haphazardly, nor is it something that can be done quickly. Creating a case plan takes skill, dedication, and teamwork. Today we will further explore the case planning process and how to track and adjust our plans so that we can create better outcomes for the families and children we serve.</p> <p>This MiTEAM Specialist Led Application Exercise (MSLAE) is broken up into the following sections:</p> <ol style="list-style-type: none"> 1. Icebreaker activity around brainstorming ideas 2. Case Planning Process Review <ul style="list-style-type: none"> • Review Key Caseworker Activities (KCAs) & fidelity indicators • Review four step case planning process • Introduce how motivational interviewing can be used to negotiate statement of need 3. Case Planning Process Practice 4. Case Plan Implementation <ul style="list-style-type: none"> • Review KCAs, fidelity indicators and Quality Service Review (QSR) measures • Practice tracking and adjusting plans by looking at an example safety plan, a sample Family Team Meeting report (DHS1105), and a Counseling Services Referral form (DHS880) 5. Conclusion
<p>Brainstorming</p> <p>Time: 25 minutes</p>	<p>Objective: Participants will practice brainstorming ideas to better address the needs and concerns of the family.</p> <p>Introduction: Our Icebreaker today involves a brainstorming activity. Before we begin though, it’s important for us to review the concept of brainstorming and how it fits into our social work practice model. Brainstorming occurs throughout our case practice work. It should occur whenever we are faced with barriers and challenges during ongoing interactions and interventions. It is especially critical that we facilitate this concept during our formal Family Team Meeting process.</p> <p>Overview: During the case planning process, brainstorming is the second step after identifying the family’s needs. This step is often too quickly overlooked or minimized. It must not be! Brainstorming allows us to reach many possible ideas, strategies, or services that could help address the family’s circumstance and needs. Having a bigger pool of ideas will only increase the chances of a stronger, more creative plan to help address the family needs, support long term sustainability, and ensure safety, permanency, and well-being. FTM members are given the opportunity to contribute and participate in the solutions to address their own needs and concerns. It gives</p>

participants' voice and choice and ownership of their plan. It also lessens the power differential so participants feel less vulnerable and more empowered.

In the tutorial you learned about the criteria for brainstorming. You practiced how to message the concept to a family's team. Then you practiced developing some ideas around a case scenario.

At this time, I will be distributing some handouts as a refresher regarding these concepts to prepare you for the icebreaker activity today. You can also use these handouts as reminders in the future for your Family Team Meetings.

Please turn to handout #1 (page 2) in your packet. The first set of guidelines are for you, as a facilitator, to use when conducting a brainstorming activity. Remember: These are the critical points to keep in mind during the activity. Let's review each point and the clarifying script and examples below each:

Guidelines for Facilitating a Brainstorming Session

1. You are asking question(s) to facilitate solutions.
 - Ask Who, What, Where, and How questions to encourage ideas.
 - Example: *What are all the possible ways you can think of to _____?*
2. Acknowledging and validating what they are communicating.
 - Give compliments and praise for contributions along the way, not just at the end.
 - Example: *Wow, I hadn't thought of that one. Great idea. Keep the ideas rolling!*
3. Paraphrasing their message/solution.
 - As an idea is expressed, it might be confusing so be sure to paraphrase to capture its meaning.
 - Example: *"I want to make sure I understand your idea. Are you suggesting we seek help through private funding or actually doing our own fundraiser?"*
4. Utilizing verbal and non-verbal cues to elicit participation in the dialogue.
 - Be cognizant of participants whose behavior suggests they have something to offer but hesitate.
 - Example: *"Joe, it appeared like you wanted to add something?"*

The second set of guidelines on handout #1 are for you to share with the participants to use during a brainstorming activity. It is important for the facilitator to share these points with the participant(s) so they are free to brainstorm in the most effective way possible. This will hopefully encourage a high level of energy and creativity to emerge from the group. Remember: There will be opportunities to brainstorm in the context of a Family Team Meeting, interactions with family members during ongoing casework, and other meetings. Let's review each point under these guidelines so you understand it's purpose and meaning:

Brainstorming Guidelines

- Quantity vs. Quality
- Everyone participates, no observers

- Anything goes, be creative
- Include other's solutions
- No critical judgement or evaluation
- Every suggestion gets written down
- Include "out of the box" ideas
- Include person's strengths
- Hitchhike ideas (combinations and improvements)
- One person speaks at a time

Large Group Activity: Today you are going to get a chance to practice brainstorming in a large group. We are going to brainstorm ideas about the topic "50 Ways To Leave Your Lover". Some of you may remember this as the title of a song by Paul Simon in the 1970s.

Remember the Brainstorming Guidelines listed on page 2 of your Participant Packet as we do this activity. I will chart your ideas. If someone was going to "leave their lover" how might they do it? (On large paper or on whiteboard, put "IDEAS" at the top and then chart their answers below it. Facilitate this activity by using the four Guidelines for Facilitating a Brainstorming Session on page 2 of the Participant Packet.)

Debrief: (ask the following questions to facilitate debrief)

- Thoughts about this activity?
- Did it follow/hit the points identified in Handout #2?

Conclusion: Brainstorming is the Idea Creation stage after identifying the family's needs. It is suggested you NOT brainstorm an exhaustive list that covers every need in one sitting, but to take one need at a time, brainstorm around it, then write an action step. Then repeat the process for the next need. Otherwise, it is too overwhelming. Participants will more likely feel a sense of accomplishment by doing it this way. This process may seem tedious and long, but upfront it will give the team more ownership of the plan, and, in the long run, allow better case planning and future success.

During the first step in the case planning process you are identifying needs. It is important to look at the generated list and prioritize the items that are necessary, reasonable, and doable. You, as caseworkers, will need to tactfully and persuasively facilitate the group to choose the top areas to be discussed that are manageable in one sitting, while acknowledging that other items will not be ignored, but will be addressed in future meetings or in other ways.

Last, remember that sometimes ideas from earlier brainstorming sessions will transfer and piggy back onto other needs. Solving a transportation problem to a parenting class, for example, might be the same way to solve a problem for getting a parent to therapy. Consider keeping your charting paper for future reference so you can build on previous ideas. The brainstorming concept will be covered more in the Case Planning Process next.

**Case Planning
Process Review**

Time: 30
minutes

Objective: Review the case planning process. Introduce motivational interviewing as a skill that can be used to negotiate statement of need, the first step in the case planning process.

Introduction: Case Plans are only as effective as our assessments. We cannot create a plan for success without having an accurate and broad understanding of the significant factors that positively and negatively impact a child’s safety, permanency and well-being.

Please turn to page 15 in your Participant Packet. Here we’ve provided you a quick overview for our current competencies. As you can see we’ve identified 5 key caseworker activities (KCAs) for case planning. Remember, KCAs are the “it” activities that demonstrate we are effectively case planning. So, we know we are case planning if we...

- Involve parents and other team members in the case planning process with a long-term view toward safety and permanency.
- Link services to individual strengths, potential traumatic stress and specific needs of each relevant family member to the identified permanency goal or goals.
- Develop plans that have behaviorally specific and achievable goals and action steps.
- Use visits with the child and parent to make progress on goals and action steps.
- Track progress on case plan implementation and adjust as needed.

Note: Also shown with more detail in the Appendix: Excerpts from Case Planning Practice Guide, KCAs 10 – 14.

After we defined case planning and the associated “it” activities, we had to develop measures, or indicators to evaluate if case planning occurred. These measures had to be answered as a “yes” or “no.” The MiTEAM fidelity indicators are what supervisors will be looking for when they complete the Fidelity Worksheets or the MiTEAM Fidelity Tool. In the assessment module, we utilized our trauma informed approach to identify families’ underlying needs. A natural progression from Assessment to Case Planning is to look at how to build resiliency for families. This begins to address trauma and improves family’s chances for success. Therefore, during the case planning module we focused on the following fidelity indicators (reference page 15 in the Participant Packet):

1. (Interview) The individual described specific examples where his or her input was utilized in decision making.
2. (Documentation) The plan builds resilience including two or more strategies that:
 - a) Promote family members ability to develop and build relationships
 - b) Promote family members’ mastery and/or competency
 - c) Improve family member’ self-esteem

- d) Gives family members voice
- e) Enables family members choice

By demonstrating these indicators we ultimately will impact our outcomes (specifically in the QSR, we see voice and choice, long-term view and planning interventions correspond to case planning).

Today we are going to apply what was presented in the case planning tutorial with the intention of demonstrating the 2 fidelity indicators we just discussed. These MSLAEs are an opportunity to pause and reflect on our work. The hope is that we each take this opportunity to learn and grow.

Small Group Activity: Please turn to page 3 in your Participant Pack. You'll see a Sample Safety Plan for Claudia Lewis, please take 3 minutes to review the plan with your table members and discuss if and how the plan meets the documentation fidelity indicator for case planning.

Debrief: (debrief by asking the following questions)

- What were your thoughts about the plan?
- Did the plan meet the indicator, why or why not? (see note below)

Note: possible responses may include the following:

- Relationships: By including Allison as part of the safety plan, Ms. Lewis is fostering that relationship.
- Mastery and competence: Because Ms. Lewis is committing to these activities, she is building her competence around safety for herself and her son.
- Self-esteem: By taking ownership of the plan, Ms. Lewis is demonstrating a level of self-worth (relates to self-esteem).
- Voice: The family has participated in the safety plan.
- Choice: It is Ms. Lewis' idea to use the phrase, "the school called"; she has chosen to share the code with Allison, her co-worker.

Overview: Let's review the 4 step case planning process (see page 7 in the Participant Packet).

1. Statement of need
2. Brainstorming ideas
3. Select action steps
4. Identify time frames and person(s) responsible

You move through this process sequentially for each identified need. For example, if you have 2 needs, you would state the first need, brainstorm for the first need, select action step for the first need and then identify the time frame and person responsible. Next you would state the second need, brainstorm the second need and so on and so forth. Never combine steps as this is too overwhelming.

The first step, statement of need, is always related to the assessment. The needs must be prioritized as we do not want to overwhelm the team or try to tackle too many things at once. Needs cannot be developed by the caseworker alone. The team must agree that there is a need, and the family must be on board. This can be the most difficult part of our job. If the family is not ready to make changes, that is, they aren't acknowledging there is a problem, or aren't ready to make the change, then the chance of future success is improbable. To increase our chance of success, we can use skills, such as motivational interviewing to explore issues related to ambivalence toward change. This also facilitates goal ownership in a way that builds readiness for change and generates energy for reaching our desired goals¹.

(Break the group into 4 smaller groups and instruct participants to reference page 4 & 5 in the Participant Packet).

Small Group Activity: There are four principles of motivational interviewing. Each table will be assigned one of the principles (assign principle to each group). As a group, take 5-10 minutes to review the principle you were assigned, come up with an example of what you may say to demonstrate that principle and be prepared to share this with the larger group. (Provide 5 minutes, then have each group summarize their assigned principle and an example).

The second step in the case planning process is brainstorming, which we went over during our icebreaker activity.

The third step, is selecting action steps. We should prepare participants for convergent thinking, or the process of synthesizing ideas. Sometimes during the brainstorming, ideas are identified that don't seem feasible, however, when combined with other ideas they can sometimes offer a great solution. We should always strive to use family member's strength to address their needs. Action steps should be relevant, specific, measurable and attainable. Questions the team can ask to determine if they've identified the right action steps are:

- Can we all support this action step? Are there concerns about this action step?
- Is this the right time?
- Do the action steps address the needs and use any of our strengths?¹

After action steps are selected it's important to reality test the steps to ensure we are setting families up for success. Questions the team can ask are:

- Is this something your team can do?
- Does the team have the resources to support this plan? Are there barriers?
- How will you know if the action step is working?
- How can we measure success?

¹ The Coaching Toolkit for Child Welfare Practice,

	<p>The fourth step is to identify the time frame and person responsible. A few things to keep in mind are:</p> <ul style="list-style-type: none"> • If everyone is responsible for a specific action step, it usually ends up that no one takes responsibility. Avoid saying CPS or Foster Care, instead list a specific person's name. • It's important that responsibilities are spread among team members so that one or two people aren't solely carrying the entire weight of the plan. • Along the same lines, ASAP or ongoing are not reasonable timeframes either, because they're vague. To identify timeframes, use begin and end dates. <p>What questions or comments do you have for me?</p>
<p>Case Planning Process Practice</p> <p>Time: 1 hour and 15 minutes</p>	<p>Objective: Participants will practice using the case planning process to create behaviorally specific and achievable plans that incorporate the family's voice and choice.</p> <p>Small Group Activity: Next, we are going to put into practice everything we've covered today. We will use a scenario about Jami Love that can be found on page 6 of your Participant Packet. Please do not look ahead to pages 7-9 as this will spoil the activity (read the scenario or have participant volunteer to read out loud).</p> <p>We are going to work in groups of 3 (help the large group divide into smaller groups if needed). Each member will have a specific role. 1 person will be assigned role A, 1 person role B, and a third person for role C. Please take 1 minute to decide at your tables who will play each role.</p> <ul style="list-style-type: none"> • Role As, raise your hand, you are the caseworker, when it's time, read page 7 in the Participate Packet for guidance about your role. Do not look at the other role's guidance. • Role Bs, you are Jami, you will read page 9 when it's time. • Role Cs, you are a family member you will use page 10 for guidance. <p>It's important once we start the activity that you read only your assigned pages.</p> <p>There are many ways to capture a plan, depending on your program. Every program should be familiar with the FTM process. Today we will use the FTM Activity Report to capture our plans.</p> <p>Role A will lead your group through this practice of applying the case planning process and document your case plan on the blank Family Team Meeting Report, found on page 8 of your Participant Packet. You will have 45 minutes. After the practice we will our share plans with the larger group.</p> <p>What questions do you have for me?</p> <p>Debrief: (debrief by having each table share their plan, see the note below to highlight learning points)</p>

	<p>Note: After each small group shares their plan, ask some of the following questions:</p> <ul style="list-style-type: none"> • (Role B, Jami) How was your voice and choice captured in the plan? • (Role B, Jami) Did anyone applaud you on your years of sobriety and ask what helped you to be successful? • (Role A, caseworker/supervisor) Did you use any principles of Motivational Interviewing, if so, how? • (All Roles in small group) Were any ideas from brainstorming combined (hitch hiked) or eliminated? • (All Roles in small group) Did you have to prioritize any steps or needs? If so, what? • (All Roles in small group) Were action steps relevant, specific, measurable and attainable? Can you provide an example? • (Larger group) Was the documentation fidelity indicator met? Thumbs up for yes, thumbs down for no. How? <p>Larger Debrief:</p> <ul style="list-style-type: none"> • How did it feel? • What did you notice? • What did you learn? <p>Conclusion: Case planning can be a complex and timely process. By following the steps we discussed today and utilizing skills such as motivational interviewing we can create plans that are far more likely to yield success for the children and families we serve.</p>
<p>Case Plan Implementation</p> <p>Time: 1 hour</p>	<p>Objective: Participants will practice how to include the team member’s input when adjusting plans.</p> <p>Introduction: By developing an appropriate case plan, we’re trying to improve the outcomes for the family, but we’ve all seen situations where the best intentions fail and the case plan does not get implemented as intended. We want to ensure our efforts result in the best possible outcome for the family, therefore it is important to continuously track and adjust the plan.</p> <p>Overview: As seen in the MiTEAM Virtual Learning tutorial, and in examples provided in exercises today, we saw how to brainstorm for suggestions and create a plan customized to the family’s needs. Ongoing monitoring of the plan ensures services are delivered as scheduled to increase safety. Tracking and adjusting the plan, according to the changing needs of the family, makes it more likely that the family will be successful in meeting case plan goals.</p> <p>The Key Caseworker Activities for Case Plan Implementation are (page 15 in the Participant Packet):</p> <ul style="list-style-type: none"> • Engage with service provides. • Clarify specific service needs when making referrals. • Provide services promptly and on an ongoing basis to increase safety, reduce risk, address well-being and promote timely permanency.

- Use caseworker visits to mobilize services.
- Evaluate the appropriateness and effectiveness of services.
- Provide services at the time of discharge and case closure.

Note: Also shown with more detail in the Appendix: Excerpts from Case Plan Implementation Practice Guide, KCAs 15 – 20

We're not only trying to improve our skills, we're trying to show our improved skill development in data collected from use of the QSR process and MiTEAM Fidelity Tool. The Quality Service Review Protocol defines 'best practices' for caseworkers.

For Tracking and Adjustment, the QSR measures the following:

Tracking

- the service delivery processes,
- progress made,
- changing family circumstances, and
- goal attainment and
- well-being outcomes for the child and family.

Communicating with team members to

- identify and resolve intervention delivery problems,
- overcome barriers, and
- replace strategies that are not working.

Adjusting the combination and sequence of strategies used in response to

- progress made,
- changing needs, and
- knowledge gained from trial-and-error experience.

Note: Also shown with more detail in the Appendix: Resource from QSR: Pages 74 and 75 Condensed.

The Fidelity Indicators measured by the MiTEAM Fidelity Tool that we focus on in Case Plan Implementation are:

- There is evidence in the documentation that service providers were provided with clear and specific service needs for the family. (Documentation)
- When developing or adjusting the plan, asks for team member's input. (Observation)

Documentation in the case file is important evidence of how the requirements were met. Observation is another way we see that caseworkers are meeting requirements around getting team members' input for the case plan.

Specific techniques that can be used are:

	<ul style="list-style-type: none"> • Caseworker can initiate conversation with the parent in a weekly contact to ensure participation in services. • Caseworker can ask specific questions of team members to elicit additional input. • Caseworkers can make frequent contact with service providers to get updated on progress. • Caseworker or supervisor can contact service provider when services not provided according to expectations. • Caseworker can schedule a meeting or conference call (such as, between parent and provider) to correct misunderstandings. • Caseworker should document contacts with parents, providers and supervision in case record and adjust the case plan as needed. <p>Small Group Activity: We'll take another look at the 'Claudia Lewis' scenario to discuss ways to practice our Case Plan Implementation skills. (Divide the large group into 3 smaller groups. Assign one group Handout 9 (pages 11 – 12), the second group, Handout 10 (page 13) and the third, Handout 11 (page 14)). Please read the handout you've been assigned and answer the questions at the end of your handout. Choose a spokesperson from your group to summarize your discussion for the larger group. We'll allow 15 – 20 minutes for your small group discussion.</p> <p>Debrief: (debrief by having each group to summarize their discussion and answers to their questions, see note below to facilitate discussion).</p> <p>Note: See pages 21-23 in the Appendix for suggested answers and add to the discussion as needed.</p> <p>Conclusion: When communication is strong among the family's team, there is more successful team functioning and team coordination. Tracking ensures that the steps, services and goal of the plan are regularly reviewed and assessed for progress. Documentation communicates that the planning and activities required have been completed.</p>
<p>Closure</p> <p>Time: 5 minutes</p>	<p>Objective: To bring closure to the MSLAE by summarizing the importance of using the case planning process to create behaviorally specific case plans that can be tracked and adjusted, as needed.</p> <p>Final Thoughts: We must use the power of the case planning process to shape our case plans. This means guiding families to broaden their teams and having members at the table to participate in the process. Solid efforts at Teaming and Engagement will lay the foundations for success during the case planning process. Families are experts on themselves. Allowing the Family's team to brainstorm ideas will often result in better and more creative plans that are supported and embraced by the team. By giving the family team members voice and choice they will take more ownership in working the plan. "Voice and choice" means team members have an active and significant role in shaping decisions around their strengths and needs, supports and services, and goals for life change.</p>

	<p>There is a saying: “Those who plan the battle, rarely battle the plan.” (author unknown).</p>
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“Individual commitment to a group effort—that is what makes a team work, a company work, a society work, a civilization work.” (Vince Lombardi)



CASE PLANNING & CASE PLAN IMPLEMENTATION

**Appendix
MITEAM Specialist Led Application Exercise**

Initial Implementation Visual



Excerpts from Case Planning Practice Guide, KCAs 10 - 14:

KEY CASEWORKER ACTIVITIES	WHERE IN THE LIFE OF THE CASE	PRACTICE GUIDANCE TECHNIQUES
<p>KCA 10 CASE PLANNING</p> <p>Involve parents and other team members in the case planning process with a long- term view toward safety and permanency.</p>	<ul style="list-style-type: none"> • Within first 30 days of placement. • Every 90 days after initial case opening. 	<ul style="list-style-type: none"> • Conduct diligent searches for extended family and parents who should participate in case plan and goal development. • Coordinate support needed to ensure family participation in case planning (e.g. transportation, flexible schedule, child care). • Include age/developmentally appropriate children in the planning process. • Utilize pre-meeting discussions to prepare family members to participate in case planning. • Encourage family members to identify their strengths, needs, types of services and service provider preferences that will promote safety, permanency and well-being. • Assess the effectiveness of services/case plan to create conditions that will support safety and permanency jointly with family team members and make necessary case plan revisions to support progress toward goals. • Involve family team members in determining the need to change case plan goal. • Develop, write and monitor a safety plan. See DPG develop write safety plan. • Develop, write and monitor a case plan. See DPG develop write monitor case plan.
<p>KCA 11 CASE PLANNING</p> <p>Link services to individual strengths, potential traumatic stress and specific needs of each relevant family member to the identified permanency goal or goals.</p>	<ul style="list-style-type: none"> • Assessment. • Prior to developing case plan. • Caseworker visits and FTMs. • When family's situation changes. 	<ul style="list-style-type: none"> • Describe the conditions that must be created in the identified permanency resource in order to support achievement of the permanency goal and the skills/capacities needed by caregivers to create these conditions. Identify the services needed to support development of the capacities and conditions needed to safely parent. • Identify relevant cultural, tribal, background issues to be considered in mobilizing and structuring services. • Assess the strengths, needs and capacity of the caregivers to safely parent and align services to support needed skill development. • Continuously re-evaluate permanency goal, conditions needed to achieve permanency goal, caregiver capacity to create these conditions, and services to support needed skill development and ensure their alignment. • Use caseworker visits, family team meetings and other case planning meetings and activities to identify individual strengths and needs of children and families. • Match services to strengths and needs. • Review and use information from the parents, extended family members, assessment tools, historical case records, and reports from providers to inform the case planning process. • Review independent living needs to identify and match individual services. • Identify and address needs of all relevant family members, including non- custodial parents and children who are not the subject of maltreatment reports, in addition to target children and custodial parents. • Help the family identify needed services. See DPG help family ID services. • Identify services in collaboration with child and parent that will best meet identified needs. • Use re-assessments to re-evaluate strengths and needs of family members, based on changing circumstances, progress in achieving goals, emerging issues.

<p>KCA 12 CASE PLANNING</p> <p>Develop plans that have behaviorally specific and achievable goals and action steps.</p>	<ul style="list-style-type: none"> • Within first 30 days of placement. • Every 90 days after initial case opening. 	<ul style="list-style-type: none"> • Use information from the FANS and CANS assessments and other information gathered about the family to develop the case plan. • Ensure the desired outcome is a description of the change in behavior, which must be accomplished to assure the safety, permanency and well-being of the child. • Include clear descriptions of the goals, objectives and action steps/activities in the case plan. • Ensure objectives consist of a series of small steps needed to resolve the problems, which led to child maltreatment and departmental involvement. • Develop action steps to specify tasks that parents, service providers and caseworkers must do. • Include specific activities and behaviors to be assessed as part of the parenting time plan for all parents/caregivers including the non-custodial parents. • Identify how past trauma is being addressed for the parents and child. • Identify each goal and objective for the parent/child/youth, specific action steps/activities, time frame for achieving and expected outcome, including the discipline and child handling techniques, supervision of child, and activities to promote educational stability and success.
<p>KCA 13 CASE PLANNING</p> <p>Use visits with the child and parent to make progress on goals and action steps.</p>	<ul style="list-style-type: none"> • Caseworker visits. 	<ul style="list-style-type: none"> • Conduct visits with family members at required (or more) intervals to support goals. 37 • Visit privately with children to create a safe environment for them to share sensitive information regarding their needs and circumstances. • Discuss how the child's trauma may be exhibited through behaviors and emotions with foster parents and strategies for meeting needs.
<p>KCA 14 CASE PLANNING</p> <p>Track progress on case plan implementation and adjust as needed.</p>	<ul style="list-style-type: none"> • Reassessment. • Case plan reviews. • Caseworker visits. • Case plan monitoring. • FTMs. 	<ul style="list-style-type: none"> • Meet with the parent and child at required intervals or more frequently if necessary to support goals and determine if they are participating in the service(s) identified in the plan and if they feel the services are assisting them in making behavioral changes. • Review case plans at least quarterly for ongoing appropriateness of permanency goals outcomes, activities/steps and timeframes. • Develop case plans during FTMs, not in advance. • Review re-assessments, service reports and information from family team members to determine whether permanency goal and case plan modifications are warranted. • Have frequent contact with service providers to ensure individualized service delivery/ expected progress and identify needs for changes in services or method of delivery. • Convene FTMs to make needed changes to case plans in order to reflect individual strengths and needs and progress to goals. • Evaluate with family, caregivers, and service providers continuing responsiveness and relevance of current services, their effectiveness to achieve permanency goals.

Also shown with more detail in the MiTEAM Practice Model Manual located on the MiTEAM Virtual Learning Site under Resources.

Excerpts from Case Plan Implementation Practice Guide, KCAs 15 – 20:

KEY CASEWORKER ACTIVITIES	WHERE IN THE LIFE OF THE CASE	PRACTICE GUIDANCE TECHNIQUES
<p>KCA 15 CASE PLAN IMPLEMENTATION</p> <p>Engage with service providers.</p>	<p>Throughout the life of the case.</p>	<ul style="list-style-type: none"> • Identify service providers to meet family’s needs, preferences, locations, cultural needs. • Ensure providers tailor services to meet family’s needs, including the frequency, and intensity of service, where and when services are provided, by negotiating clear expectations at referral for behavior changes, monitoring service attendance and improved behavioral changes, and linking payment to service delivery. Contact service providers frequently for written reports on child/family’s participation in services and progress toward goals/, specific to referral needs. • Advise service providers of significant changes affecting service delivery or client needs. • Plan with service providers how to address potential barriers to successful completion of treatment. • If services are not available to address the family’s unique needs, work with the service provider to develop needed services or identify another provider.
<p>KCA 16 CASE PLAN IMPLEMENTATION</p> <p>Clarify specific service needs when making referrals.</p>	<ul style="list-style-type: none"> • At case plan development and reviews. • At service referrals. • Caseworker visits and FTMs. • When situation changes. 	<ul style="list-style-type: none"> • Develop treatment goals with families and service providers. • Ensure providers tailor services to include frequency, intensity, level and location of services. • Select providers whose approach is evidence-based and whose services match the needs of families. • Provide written referrals for services that identify the needs of family members, behavioral and specific goals, time frames to complete services/achieve goals, and potential barriers to receiving/benefitting from services. • Clarify jointly with family members (including parents and children) and service providers the expectations for participation in services, including frequency, level, location, goals, and duration of services. • Document service referrals, reviews provided in individual case plans. • As circumstances and behavior changes, review progress jointly with family members and providers, adjust services as needed, confirm in writing, document in case plan. • Familiarize yourself with mission and confidentiality policies of providers.

<p>KCA 17 CASE PLAN IMPLEMENTATION</p> <p>Provide services promptly and on an ongoing basis to increase safety, reduce risk, address well-being and promote timely permanency.</p>	<p>From initial contact to case closure or permanency.</p>	<ul style="list-style-type: none"> • Use assessment information to identify immediate needs to protect children and caregivers. • Make verbal and written referrals to appropriate service providers as soon as needs for services are identified. • Follow up with providers to ensure timely response to referrals and to mobilize service provision. • Document service referrals and provision in case file; review and revise as needed in case plan. • Review and update case plan at required intervals and evaluate progress toward achieving permanency goals. • Monitor service provision to ensure conformity with case plan and progress toward achievement of goals. • Evaluate with child/family/service provider the effectiveness of current services and adjust service levels, intensity, type, location, duration as needed. Change providers if indicated. • In family team meetings and caseworker visits, ensure that services are directly linked to overcoming barriers to achieving safety, permanency and child well-being goals within prescribed timeframes. • Make prompt written service referral when need is indicated. Referrals should specify level, intensity, duration, type of service requested. • Revise case plan with child and family when new services are implemented. • Link new services to goals. • Notify service providers of significant events or changes for the child or family, including change of permanency goal. • Implement a concurrent plan. See DPG implement permanency plan.
<p>KCA 18 CASE PLAN IMPLEMENTATION</p> <p>Use caseworker visits to mobilize services.</p>	<ul style="list-style-type: none"> • Caseworker visits. 	<ul style="list-style-type: none"> • Visit with individual family members at required intervals or more frequently if necessary to support goals. • Discuss effectiveness/satisfaction with services with family members as well as their views on progress toward goals, emerging issues and changes. • Identify need for changes in service delivery with family members. • Discuss with family members if they feel there are any unresolved issues that the department and/or service providers are not meeting or addressing. • Conduct pre-meeting discussions with family to determine involvement of service providers at family team meetings.
<p>KCA 19 CASE PLAN IMPLEMENTATION</p> <p>Evaluate the appropriateness and effectiveness of services.</p>	<ul style="list-style-type: none"> • Case plan reviews. • Caseworker visits and FTMs. • When situation changes. 	<ul style="list-style-type: none"> • Evaluate the appropriateness and effectiveness of services. See DPG evaluate services. • Review PATP/SA at least monthly with the family for continuing appropriateness of services provided. • Update PATP/SA when significant changes occur or as needed through discussion with family and service providers. • Contact service providers frequently to discuss client progress, effectiveness of services, necessary changes to ensure client success.
<p>KCA 20 CASE PLAN IMPLEMENTATION</p> <p>Provide services at the time of discharge and case closure.</p>	<ul style="list-style-type: none"> • At final FTM. • Reassessment. • Case closure. 	<ul style="list-style-type: none"> • Identify and provide services to maintain behavior change at discharge and case closure. Begin to develop an after-care plan with youth, family and significant others at least six months prior to planned case closing/discharge. Plan should outline, but not be limited to, how services will address ongoing needs to provide for child safety, permanency and well-being. • Make written service referrals for discharge services and follow-up with providers. • Provide and connect youth/family with documentation, information and support needed to secure and participate in aftercare services. • Provide contact information for youth/family to contact agency, as needed. • Prepare families for identifying community services to support future needs.

Also shown with more detail in the MiTEAM Practice Model Manual located on the MiTEAM Virtual Learning Site under Resources.

Resource from QSR: Tracking and Adjustment

Tracking

- the service delivery processes,
- progress made,
- changing family circumstances, and
- goal attainment and
- well-being outcomes for the child and family.

Communicating with team members to

- identify and resolve intervention delivery problems,
- overcome barriers, and
- replace strategies that are not working.

Adjusting the combination and sequence of strategies used in response to

- progress made,
- changing needs, and
- knowledge gained from trial-and-error experience.

***Based on MI QSR Protocol - Field Use Version**

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Handout 9: Tracking and Adjusting a Safety Plan Suggested Answers

Questions: *(Answers will vary; some examples provided below.)*

1. How would you update the Safety Plan given the new information provided? *(Documentation)*
 - *Continue to practice most of the Action Steps in the plan, but with new address.*
 - *Replace the Action Step: “Pack an emergency bag for Cade and I take it to work, give it to Allison” with new Action Steps, such as planning for a more permanent place to live.*
 - *The new Action Steps should be documented in the adjusted plan.*

2. How would you be sure the team member’s input is included in the plan? *(Observation)*

Ask specific questions to encourage more contributions, such as:

 - *What specific steps would be necessary at this time?*
 - *What type of services would be useful to the family at this point?*

3. How often should the status of the child be reviewed? *(Documentation)*

The answer should state the intervals when the child’s status should be reviewed (such as: weekly, monthly, quarterly) and be documented, including the next date for review.

4. What should be done to track and adjust for this type of plan? *(Documentation)*

Answers may include more than one of the following:

 - *Contact the parent to discuss needs.*
 - *Contact a provider to discuss changes.*
 - *Schedule a meeting for team members to discuss changes.*
 - *Document changes in plans.*

Handout 10: Tracking and Adjusting a Case Plan Suggested Answers

Questions: *(Answers will vary; some examples provided below.)*

1. How would you plan to track and adjust for this parent's success? *(Documentation)*
 - *Schedule Family Team Meeting to discuss options available at this time.*
 - *Ask Claudia what she suggests for her substance abuse treatment.*
 - *The new Action Steps should be documented in the adjusted plan.*

2. What would you say or do to get the team member's input? *(Observation)*

Ask specific questions to encourage more contributions, such as:

 - *Given this new information, what are Claudia's options?*
 - *What specific steps would be necessary at this time?*

Handout 11: Tracking and Adjusting a Counseling Services

Questions: *(Answers will vary; but must include specific information. SMART acronym is helpful to prompt coverage of essential information: Specific, Measurable, Activity-Oriented, Reasonable and Time-Limited. Some examples provided below.)*

1. Is there is evidence in the documentation that service providers were provided with clear and specific service needs for the family?

No (or somewhat). The counselor responded appropriately by contacting the caseworker to let her know of the conflicting information.

Reason for Referral: A little more specific information regarding the reason for referral would be helpful to the provider.

Expected Outcomes: Claudia will attend counseling sessions, one hour per week, to discuss and practice acceptable methods to discipline her child, without using physical force.

2. How would you handle the communication with the provider?
The caseworker (or supervisor) may inquire as to progress in the case, and clarify information regarding Expected Outcomes, including necessary specifics. (See example in #1. above.) May discuss whether monthly reports are sufficient for updates.