

Practice Guide for Caseworkers

Case Plan Implementation

MITEAM COMPETENCY

Case plan implementation details the who, what, where, when and how with regards to specific tasks and/or objectives for each participating case planning partner (birth parents, foster parents, relatives, caseworker and service providers). Case plan implementation is the utilization of services designed to address a family's underlying needs as identified through the assessment and case planning process. Case plan implementation begins at initial plan development and continues throughout case closure.

FIDELITY MEASURES

Observation:

- Helps the individual(s) identify people who are supportive.
- Addresses reasons for reluctance to including specific team members.
- Facilitates teaming.
- Asks the individual(s) what the team member(s) (informal or formal) have done to provide support.
- Requests individual(s) input regarding the effectiveness of services.
- Asks the individual(s) how s/he can be of assistance to the family.
- When developing or adjusting the plan, asks for team member's input.

Documentation:

- The team member's suggestions and comments are documented in the case file.
- The family's team met within the required timeframes (FOM 722-6B).
- There is evidence in the documentation that the team implements specific safety activities to address safety concerns of the child(ren)/youth.
- There is evidence in the documentation that the team addresses specific permanency plans.
- There is evidence in the documentation that the team addresses specific issues of well-being for the child(ren)/youth.
- The team regularly reviewed the plan.
- There is evidence in the documentation that service providers were provided with clear and specific service needs for the family.
- There is evidence in the documentation that services were provided in a timely manner.
- There is evidence in the documentation that the child's living arrangement has been fully assessed and determined safe.

Interview:

- The individual(s) was able to identify helpful activities of the worker.
- The individual(s) reports being satisfied with services offered and/or referred.
- The individual(s) described specific examples of the worker acknowledging his/her success (however large or small).
- The individual(s) described specific examples where his/her input was utilized in decision making.

In Supervision:

- The worker was able to identify:
 - How trauma is addressed in the case plan.
 - How the parent participates in the process of change.

	<ul style="list-style-type: none"> ○ How successes are acknowledged (however large or small). ○ How the case has progressed and what to expect in next 90 days. 	
POLICY REQUIREMENTS	<ul style="list-style-type: none"> ● Parental participation in the development of the case plan is required. ● Caseworker must provide service referrals within 30 days of initial out-of-home placement. ● Caseworker must identify follow-up steps to obtain compliance when parents decline to participate in services. ● The Parent Agency Treatment Plan (PATP) must be: <ul style="list-style-type: none"> ○ Specific to the individual needs of the parents and children. ○ Inclusive of the parent’s viewpoint. ○ Written in a manner that is easily understood by all parties. ● “Active efforts” for American Indian children require the caseworker to take a proactive approach with children and families as well as actively support them in complying with the case plan rather than the case plan being implemented by family alone. 	
HOW TO USE YOUR SUPERVISOR	<ul style="list-style-type: none"> ● Schedule, prepare and actively participate in regular case conferences with your supervisor to discuss: <ul style="list-style-type: none"> ○ What has been completed, the outcome of that effort, pending activities and possible next steps to support the case planning process. ○ How to address specific barriers to involving the family in the case implementation process and to verify that the plan is individualized to the family’s specific strengths, needs and trauma needs. ○ Ongoing assessment of safety concerns and dynamics of coercive control that might be interfering with or hindering successful completion of the case plan. ○ Availability of services within the family’s community or ways to access/develop the appropriate services to meet the family’s individualized needs as identified in the case plan. ○ Utilize time with supervisor to discuss and evaluate what has been completed, the outcome of that effort, pending activities, possible next steps to support implementation of service plan. 	
KEY CASEWORKER ACTIVITIES	WHERE IN THE LIFE OF THE CASE	PRACTICE GUIDANCE TECHNIQUES
KCA 15 CASE PLAN IMPLEMENTATION <i>Engage with service providers.</i>	Throughout the life of the case.	<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><i>Clarify specific service needs when making referrals.</i></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><i>Provide services promptly and on an ongoing basis to increase safety, reduce risk, address well-being and promote timely permanency.</i></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>	<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.

<p><i>Use caseworker visits to mobilize services.</i></p>		<ul style="list-style-type: none"> • 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><i>Evaluate the appropriateness and effectiveness of services.</i></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><i>Provide services at the time of discharge and case closure.</i></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.