

**TCM TIP SHEET 2**  
**CORE TARGETED CASE MANAGEMENT ACTIVITIES**

**ASSESSMENT**

- A written comprehensive assessment at intake and periodic reassessments inventories needs and wants, barriers to those, and identifies supports that will address the individual's barriers, health, educational and social issues
- Assessment activities may include collecting the individual's history, gathering information from other sources such as family members, medical providers, social workers and educators to form a complete assessment of the individual.
- The comprehensive assessment should be wide ranging and not solely focused on a single assessment area.
- The completed comprehensive assessment should be reviewed with the individual.
- A periodic reassessment must be conducted at least annually, or more frequently as needed. especially when there is a significant change in the status of the individual regardless of when the next update is due.

If an assessment was completed in order to inform and guide recovery planning, it should be coded as a TCM service.

**DEVELOPMENT OF A RECOVERY PLAN**

- Development and periodic revision of the Recovery Plan is based on the information collected through the assessment process and specifies goals and interventions The core requirements of the Recovery Plan are that it should be person centered and individualized and include supporting the individual's hopes, dreams, desires and wishes for optimizing independence, promoting recovery and developing natural supports.
- The Plan identifies what services and supports will be provided, who will provide them and how the case manager will monitor those services and supports.
- The case manager must review the plan with the individual at intervals specifically defined in the plan.
- The plan should always be kept current and must not be allowed to expire.
- The Plan should be modified whenever there is a change in the scope or intensity of the individual's health and welfare needs.

Any service which involves a meeting with the targeted individual, collateral providers or a natural resource to develop, revise or update a recovery plan, should be coded as a TCM service.

**REFERRAL**

- Referrals to external resources where the provider takes an active role in linking the person to the referral resource in order to help individuals obtain needed services that address needs and support the achievement of goals specified on the Recovery Plan.

- Referrals must be linked to the needs and problems identified in the Recovery Plan
- If the individual faces barriers in utilizing referrals; document the barrier and describe the advocacy efforts on the part of the case manager in eliminating the barrier to help the client attain their desired goals.

Any service which involves linkage to or coordinated care with a resource external to the case manager's agency, should be coded as a TCM service.

### **MONITORING & PLANNING**

- The purpose of monitoring is to effectively assess whether the needs and problems identified for or by the individual are being adequately met by the referrals and resources provided to the individual by the case manager.
- Monitoring activities and contacts are necessary to ensure the Recovery Plan is effectively implemented and adequately addresses the needs of the individual.
- These monitoring activities may be with the individual, service providers, family members or other supports and conducted as frequently as necessary to determine the following are being met:
  - The services are being provided as specified in the Recovery Plan
  - Services in the Recovery Plan are adequate- if there are changes in the needs or status of the individual, monitoring includes making necessary adjustments to the Recovery Plan and services through planning with the individual and relevant external providers or supports.

Any intervention that involved monitoring the progress of a recovery plan objective should be coded as a TCM service.