PTEC 155 – DEVELOPMENTAL DISABILITIES

MODULE 49

CASE MANAGEMENT
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INTRODUCTION

Case management is an all encompassing phrase which includes:

1. Monitoring and recording client treatment plan and progress toward prestated goals
2. All data (previous and ongoing) and record keeping related to client care
3. All records of periodic reviews of client’s status and placement
4. Completed forms necessary to meet facility and legal requirements

Case management is dependent upon concise, precise, and current information entered into the chart of the client by members of the interdisciplinary team. The record keeping is governed by legal and ethical issues. The specific requirements of the facility and local, state, and federal licensing and funding agencies all demand a certain level of care and a system of record keeping. Beyond this, the team shares a goal – administration of care with the goal of recovery and/or normalization for every client.

A vast variety of forms comprise the chart of the client in the state hospital system. The form used initially at pre-admission includes data about the client and the family. After the client’s history is obtained and the physical examination is performed and the client is assigned to a residence, the role of the psychiatric technician – a member of the interdisciplinary team – unfolds. Not only is the psychiatric technician active in the planning and implementation of the care and treatment of the client, but the technician is also responsible for making entries into the chart of the client on a regular basis as prescribed by the area where the health care worker is employed.

This module is intended to give you a glimpse of some of the forms which you will encounter in state hospital service as well as provide you with the rationale and importance of maintaining accurate and current records.
OBJECTIVES

THEORY: The successful student will achieve a passing score on a written comprehensive examination based on materials dealing with techniques used to teach and train clients with developmental disabilities in the areas of feeding, positioning, and using orthotic equipment.

ASSESSMENT: There will be a written comprehensive objective type test; multiple choice, true/false, and matching questions.

MAKE UP TESTS MAY BE AN ESSAY TEST!!

INSTRUCTIONAL MEDIA: Study Guides

1. Purposes of assessment
2. Components of assessment
3. Examples of assessment
4. Factors in intervention
OBJECTIVES

The successful student will be able to:

1. Identify the rationale for studying case managements
   
   a. Identify the importance of records for active programming.
   
   b. Identify the rationale for documentation of the interdisciplinary team process and activity.
   
   c. Identify the correct definition for the term "multidisciplinary."
   
   d. Identify the correct definition for the term "interdisciplinary."
   
   e. Identify which disciplinary approach is more desirable in planning client needs and subsequent evaluation.
   
   f. Identify the factor that determines the composition of the interdisciplinary team.
   
   g. Identify the role of the psychiatric technician.
   
   h. Identify the two reasons given for clearly documenting all activities pertaining to the resident/client.
   
   i. Identify the type of programming ensured by recording requirements.
   
   j. Identify the reason measurable objectives are required in training programs.

2. Identify the individuals who might be in attendance at an annual and/or semi-annual client evaluation.

3. Identify information required in annual and semi-annual client reviews.
   
   a. Identify the five (5) items discussed in a client review.
      
      (1) Date of last annual physical
(2) Change in height and weight since prior review

(3) Problems and descriptions of current functioning compared to prior review.

(4) Summary of clinical visits when appropriate.

(5) Community involvement
   (a) Trips
   (b) School
   (c) Shopping

4. Identify when interdisciplinary reviews take place (effective interdisciplinary team reviews occur at predictable intervals).
   a. Identify when client reviews occur.
      (1) Initial planning conference
      (2) Thirty-days after transfer from another program
      (3) Semi-annual planning conference
      (4) Annual planning conference
      (5) Eighteen-year-old review
      (6) Release conference

5. Identify the dilemma between the protections of the rights of the mentally retarded persons while affording these persons the benefits of data systems.
   a. Identify the legislation that was enacted to cover this problem.
   b. Identify the three (3) conclusions of the task force.
The successful candidate will satisfactorily demonstrate skills in carrying out case management activities for the developmentally disabled and/or mentally disabled client. The successful candidate will be able to:

1. Review and complete forms which are used in annual and semi-annual reviews.
   a. Extract information from client’s chart and make appropriate entries on interdisciplinary review forms.

2. Demonstrate knowledge and competency in preparing for client review on assigned client.
   a. Locate appropriate sources of information.
   b. Locate forms specific to assigned facility.
   c. Complete appropriate forms (appropriate number of copies).
   d. Be an active participate (if possible) in an interdisciplinary team's client review.
   e. Complete Candidate’s Performance form - Questions and Answers with appropriate information.
PRINCIPLES

1. Case management is dependent upon accurate and current record keeping by members of the interdisciplinary team.

2. Psychiatric technicians are members of the interdisciplinary team.

3. Each entry into the client’s chart must be legible and signed by the health care worker making the entry. The entry also includes the title designation of the person signing the recorded entry.

4. Clients are evaluated initially, thirty days post admission, semi annually, annually, each 18 year old review, and upon release.

5. All interested parties are invited to attend and participate in revaluation conferences.

6. In state facilities these terms are used:
   a. Resident is used for the person with developmental disabilities. Clients are used for the person with mental disabilities.
   b. In the medical model, the name patient is used.
   c. In this module, the client will be used to designate resident or patient.
Napa Valley College
PTEC 155 – Developmental Disabilities

Module 49 – Case Management

VOCABULARY

Case Management

Interdisciplinary

Multidisciplinary
INTRODUCTION

To be accredited under the Standards for Residential Facilities for the Developmentally Disabled (Accreditation Council, 1971), a facility must provide “active habilitation programming” to each resident. Regulations for Intermediate Care Facilities for the Developmentally Disabled receiving funds under the Social Security Act states that such facilities must provide “active treatment” to each resident. This paper outlines and refers to the same essential requirements as requirements for “active programming”.

DEFINITIONS

As defined by the accreditation council; active programming requires an interdisciplinary team process for:

1. Identifying the specific needs of the client.

2. Establishing priorities for meeting those needs.

3. Determining programs for meeting the priority objectives and assigning responsibility for them.

4. Reviewing regularly the client’s progress toward the objectives.

5. Modifying the objectives and/or the programs in light of that progress.

These activities must result in the development of a continuous self-correcting, and current individual program plan for each resident.
Active treatment requires:

1. An individual plan of care developed from an interdisciplinary evaluation of the resident.

2. The plan must set forth measurable or behaviorally stated objectives.

3. The plan must describe an integrated program of individually designed activities to achieve objectives.

4. The plan must provide for regular review of the client’s progress and the appropriateness of the plan.

5. The overall objective of the plans must be maximization of the client’s development.

Individualization of Programming

The requirements for active programming are logical consequences of the “developmental model” of developmental disabilities (NARC, 1972):

1. The model’s premise that human beings develop in a sequential and predictable way throughout their life spans.

2. The fact that the rate and direction of development can be influenced by systematic training.

3. The conditions that must be met for training to be maximally effective.

Rates of development differ, and therefore, developmental programming must always be individualized. It is not permissible to attempt to fit the person to the program; the program must be designed for the individual.
ENVIRONMENT FOR PROGRAMMING

Since the ultimate goal of active programming is the development, insofar as is possible, of those skills, habits, and attitudes that are essential for adaptation in contemporary society, it must be conducted in an environment that approximates as closely as possible the patterns and conditions of everyday life in the community. Active programming requires an environment that is normalized and normalizing ---physically home like as possible.

The environment must be such that residents can be divided into small groups for which specific direct care staff are responsible so individualized attention can be directed toward the developmental needs of each resident.

MEASURABLE GOALS AND BEHAVIORAL OBJECTIVES

Effective and assessable programming requires the development of specific objectives that are expressed in behavioral terms so that competent observers can understand the objectives and agree on whether or not they have been accomplished.

Objectives must indicate measurable attributes that will be observable in the learner, they must specify the results and outcomes that are desired, and they must be specific and detailed.

Example I

Is not a behavioral objective:
    To develop a positive self-concept. Observers may differ on what a positive self-concept is and how one knows when it has been achieved.

Is a behavioral objective:
    To decrease the frequency of self-denigrating statements, such as “I’m no good, I’m stupid”. Observers can identify and count such statements and agree on the degree objective is or is not accomplished.
Example 2

Is not a behavioral objective:
To reduce disruptive (or aggressive, hostile, hyperactive) behavior. These behaviors need to be defined in observable and measurable terms.

Is a behavioral objective:
Objectives expressed in terms such as “to know”, to understand”, “to enjoy” are not acceptable.

Example 3

Is not a behavioral objective:
“To be able to dress himself.” This is too general to be measurable.

Is a behavioral objective:
To be able to pull off his socks, or to be able to put on a button front shirt without assistance except for buttoning.

A fully adequate objective would be:
“When handed his shirt in the morning, Robert will put it on and button it without assistance within three minutes.”

So as to reflect sequential and progressive development, objectives for a program of training must be priorities and sequenced. New objectives must be built upon earlier ones so that the individual program plan consists of a series of short range, time limited objectives that converge on long term goals.

The requirement for observable and measurable objectives is applicable to any program. But for every resident there must always be objectives that go beyond mere physical or health care, because in accordance with the developmental model, every resident must be considered capable of learning and development.
ELEMENTS OF TRAINING

In addition to providing measurable objectives, each training program must include a clear description of the methods:

1. To be used to achieve them.

2. To ensure that all staff implements the program in a consistent manner.

3. To enable reevaluation and modification of the program in the event that the objectives are not attained.

The question “How will we determine whether or not the resident is making progress toward the objectives?” Must be answered in unambiguous terms. The program must also specify who is responsible for conducting the training, as well as the times and places at which training is to occur.

The term “training” is used frequently in both the standards and the regulations. It may refer to the acquisition of desired and adaptive skills or to the elimination of maladaptive and undesired behavior. If training is to be efficient and effective the elements described must be present.

DETERMINING DEVELOPMENTAL LEVEL AND NEEDS

The first step in planning an individualized program is to determine the current status of the resident and the next level toward which his development should be facilitated. Deficiencies in adaptive behavior usually determine the need of the individual for programs or services.

The systematic assessment of developmental status requires the use of one or more scales of adaptive behavior covering the areas that are appropriate for the individual being considered. To be useful for programming, the behavior or skills covered by a scale must be broken down into small steps, and these steps must be arranged in developmental sequence or order of difficulty. To be of practical use, it is also essential that scales be useable by direct care personnel (attendants, cottage parents, etc.) rather than only by trained psychologists or educators.

Each evaluation, psychological, medical, social, etc. must specify the individual’s current developmental status in terms that are pertinent to the areas of concern, identify development problems that should be ameliorated and/or the developmental steps that should next to be attended, and purpose ways of reaching those objectives.
THE INTERDISCIPLINARY APPROACH

Because virtually all developmentally disabled individuals have problems that fall within the purview of more than one professional discipline and all developmentally disabled persons can benefit from developmental programming, the multidisciplinary approach was devised.

Essentially, under this approach, a representative of a particular discipline or program views the individual only from the perspective assigned to his discipline or program. Typically, each member of the multidisciplinary team reports his findings and the recommendations that he purposes to implement, more or less independently of the findings and recommendations reported by other members. Traditionally, this reporting has been done at a “staff conference”. While some diagnostic and treatment decisions may be arrived at jointly during such a conference, a single professional person may then utilize the accumulated reports to formulate a final treatment plan.

The multidisciplinary approach is probably the most common approach to evaluation and program planning within residential facilities for the mentally retarded. But, the multidisciplinary approach is less than fully satisfactory because the boundaries assigned to disciplines limit the contributions that the members of the team are capable of making. Also, membership on the multidisciplinary team has traditionally been limited to a relatively small number of professional disciplines, whereas it is now recognized that the direct care persons who are responsible for the resident’s day to day care and who are most intimately familiar with his behavior and developmental skills can make a crucial contribution to evaluation and programming activities. Since direct care personnel must actually carry out programs on a day-to-day, and hour-to-hour basis, their participation is critical to successful programming.

As a result, the interdisciplinary approach to evaluation and program planning has evolved and is required by both the standards and the regulations. In this approach each participant in the evaluation and planning process, utilizing whatever skills, competencies, insights, and perspectives his particular training and experience provide, focuses on identifying the developmental need of the resident and on devising ways to meet those needs without constraints imposed by assigning particular areas of behavior or development to particular disciplines only. Participants share and discuss, on a face-to-face basis, all information and recommendations so that a totally unified and integrated plan is devised by the team rather than only a member of it. Members of the team then implement the program for which they have been assigned responsibility by the team.
The interdisciplinary team process must include participation of the direct care persons responsible for the resident's day to day care and program (not merely the supervisors of such persons) and all other persons whose participation is relevant to meeting the needs of the resident being considered. Thus, there is no standard team composition. The composition of the team should always be determined by the resident's needs.

The interdisciplinary approach also acknowledges the fact that direct care personnel can learn to perform evaluation and programming activities as members of a team. The facility must provide in service training that will enable direct care staff to perform these functions. A major benefit of the interdisciplinary process is the continuing education and role expansion of all team members.

**BEHAVIOR MANAGEMENT**

All aspect of the resident's program must reflect decisions of the interdisciplinary team and be incorporated into his program plan.

Whenever maladaptive or problem behaviors are to be modified, the resident's plan must include provision to teach him the circumstances under which the behaviors can be exhibited appropriately, to channel the behavior into similar but appropriate expressions, or to replace the undesirable behaviors with behaviors that are adaptive and appropriate. The plan must incorporate the requirements for training.

Application of each program utilizing time out devices or aversive conditioning must be approved by the human rights committee. Use of punishment as the primary means of behavior control is contrary to the requirements of active programming, which demands the use of positive techniques to encourage adaptive behavior and facilitate the resident's development.

**STAFF RATIOS FOR ACTIVE PROGRAMMING**

It has not been possible to stipulate professional staff ratios that are generally applicable to facilities for three reasons:

1. The need of residents vary from one facility to another.
2. Resident's needs may be met through a variety of program approaches.
3. The roles and functions of professionals vary among facilities.

Each facility must determine for itself the numbers of professional staff that are necessary to provide active programming.

The interdisciplinary team process and activity must be documented. This means that there must be for each resident a chronologically continuous record that begins with the preadmission
evaluation, at which time the resident’s specific needs, including his need for residential services, are identified. Because the preadmission evaluation may occur some time prior to admission, its results must be reviewed and updated, as necessary, within one month following admission. During that time there must also be developed a statement of prognosis, defined as a statement of goals of the resident’s habilitation program, with a statement of the time frame within which it is expected or hoped that they can be achieved, and a statement of the time at which the resident’s progress toward the goals will be reviewed and the goals reevaluated. Goals must be specific and expressed behavioral terms; broad or vague statements sometimes associated with the term “prognosis” (good, poor, guarded, continued care, community placement, etc.) are NOT acceptable.

While the residents central or unit record must contain a statement of the overall objectives identified by the interdisciplinary team, it need not contain all the detailed information concerning each specific program that is subsequently designed to meet those objectives. All activities pertaining to the resident must be documented in such a way to show clearly their relationship to the overall plan developed by the team and so as to ensure consistent implementation of the plan. The program plan must provide for such integration and coordination of effort.

At least annually, reviews of the resident’s progress in all specific programs in which he is engaged must be funneled into an overall review – by the entire interdisciplinary team – of the resident’s response to his program and his progress toward the overall objectives established for him. If the objectives have been achieved, new objectives must be set. If the objectives have not been achieved, either the objectives of the programs designed to achieve them or both may require modification.

The recording requirements are those necessary to ensure effective programming and to protect the rights of the resident and the facility.

CONCLUSION

Both accreditations as a residential facility and certification as an intermediate care facility require that the facility must provide each resident with a program that is designed to enhance his development. Both documents reflect the conviction that the resident has a right to receive such programming.
ESSENTIALS OF ACTIVE PROGRAMMING

“The chronologically continuous record indicating continuous process of stating objectives, designing programs to meet them, reviewing progress toward the objectives, and modifying the objectives and/or the programs accordingly until the objectives of residential placement have been attained.”

EVALUATION BY INTERDISCIPLINARY TEAM
Pre Admission
Post Admission and Update (within 1 month)

SPECIFIC DEVELOPMENTAL NEEDS IDENTIFIED
Explained in Behavioral Terms

TREATMENT – TRAINING – HABILITATION OBJECTIVES
Expressed in Behavior Terms

PROGRAMS TO ACHIEVE OBJECTIVES
Specific, Detailed

REVIEW OF RESPONSE TO PROGRAM PROGRESS TOWARD OBJECTIVES
(Within 1 year)

MODIFICATION OF PROGRAMS and/or OBJECTIVES

NEW STATEMENT OF OBJECTIVES

NEW STATEMENT OF PROGRAMS

REVIEW (At least annually)

MODIFICATION

ACHIEVEMENT OF OBJECTIVES OF RESIDENTIAL PLACEMENT
ESSENTIALS OF PROGRAMMING

“Program – training – treatment plans (two programs indicating relationship between such plans and the resident’s overall habilitation plan”.

OVERALL OBJECTIVES

OVERALL PROGRAMS

<table>
<thead>
<tr>
<th>Program I</th>
<th>Program II</th>
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<tbody>
<tr>
<td>Trainer</td>
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<td>(Who)</td>
<td>(Who)</td>
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<td>Objectives</td>
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<td>(Detailed Behavioral)</td>
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<td>Schedule</td>
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<td>(When)</td>
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<td>Techniques Method</td>
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<td>(How)</td>
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<td>Progress Data</td>
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<tr>
<td>Review</td>
<td>Review</td>
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<td>(At least monthly)</td>
<td>(At least annually)</td>
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REVIEW

(At least annually)

MODIFICATION

NEW STATEMENT OF OBJECTIVES

NEW STATEMENT OF PROGRAMS
The **multidisciplinary** team is people playing roles and being themselves when possible; the **interdisciplinary** team is people being themselves and playing roles when necessary. The **multidisciplinary** team is people exchanging words through roles and talking to one another person to person when there is time; the **interdisciplinary** team is dialogue between persons, sharing what they feel and know as well as what they do not feel and do not know.

The **multidisciplinary** team
- Prizes categories before persons
The **interdisciplinary** team
- Prized person before categories
The **multidisciplinary** team
- Prizes techniques before relationships
The **interdisciplinary** team
- Prizes relationships before techniques
The **multidisciplinary** team
- Prizes specialized skills applied in impersonal settings
The **interdisciplinary** team
- Prizes personalized skills applied in personal setting
The **multidisciplinary** team
- Sees parts of the person through parts of themselves
The **interdisciplinary** team
- Sees the total person through all of themselves
The **multidisciplinary** team
- Sees problems and symptoms
The **interdisciplinary** team
- Sees potential and goals
The **multidisciplinary** team
- Sees what they have seen before
The **interdisciplinary** team
- Sees what they will never see again
The **multidisciplinary** team
- Sees ambiguity and looks for the answer
The **interdisciplinary** team
- Sees ambiguity and listens for the questions
The **multidisciplinary** team
- Comes to clear and often shallow understandings
The **interdisciplinary** team
- Comes to deep and often conflicting understandings
The investigation and report was initiated because of the concern over the protection of the rights of mentally retarded persons while affording this same population of patients the benefits of data systems. This concern has resulted in the passage of the Privacy Act of 1974. The AAMD (American Association on Mental Deficiency) remains sensitive to the conflicting trends of automated data systems versus the historical abuse of the rights of retarded people in our society.

The AAMD recognize and endorse the following minimal conditions for assurance of data system confidentiality.

a. Personal identification should be employed only when there is a compelling need and when such identification is of direct personal benefit to the retarded person
b. Personal identification and information should be entered into automated data systems only when informed consent of the individual or his legal guardian has been obtained, or after demonstration
c. Access to individually identifiable teams of information should be strictly limited to those with a genuine right to know
d. Organizational and administrative responsibilities for data base supervision must be clearly delineated and audited
e. Provision should be made for continual review of accuracy and timeliness of stored data

One of the greatest risks associated with automated data systems is the retention of out of date information. Therefore, all records on an individual should contain the most recent data available, as well as the historical facts.

Privacy and confidentiality. Privacy is the right of an individual to determine which data about him are recorded, to know how and where they are stored, and by who the data are to be used. The right to privacy includes the right to grant consent for access to one’s individual data and to restrict and control such access. Confidentiality describes the effect of rules, regulations, and procedures concerning the handling of data and their dissemination. Security describes the effect of measures taken to prevent unauthorized access to the data and thus to avoid breaches of confidentiality.

To discuss the need for confidentiality, one must first establish the right to privacy. To specify the level of security, one must first establish the need for confidentiality.

One of the major benefits of automating these data is it facilitates the manipulation, transfer, exchange, and transmittal of information about one or more clients within and across service delivery system.
The task force delineated three conclusions:

1. That administration and individual progress records must be maintained on the care and services provided to persons who are mentally retarded and that automated systems offer great potential in simplifying the provision of these services.

2. That persons who are developmentally disabled may require a variety of services and care over a long period of time necessitating the retention of information that would not ordinarily be kept on other patients/clients. Therefore, it might be necessary to “compromise certain individual rights to the privacy of individual information. Injudicious protection of privacy might seriously impair provision of care to people who need it”

3. That special procedures be developed to handle the information about persons with developmental disabilities, which will result in a proper balance between privacy and provisions of services.
This sample client situation is the source of information for all of the Criteria Reference Guide forms. Therefore, as you study the filled-in forms, use this client situation.

July 1, 1995

Michael Jones is a 14-year-old Caucasian male who was admitted from his home to National State Hospital on January 1, 1995. He is diagnosed as being severely mentally retarded to Down’s syndrome. His father is deceased; his mother is 50 years old and lives in this city. Michael became unmanageable as Mrs. Jones’ arthritis became progressively worse. There are no relatives other than his mother.

Michael experienced an episode of nausea, vomiting and diarrhea on March 25; which lasted until April 2. On March 29, he began to engage in hair pulling behavior, which occurred while walking to the dining room. This behavior lasted for two weeks until April 15. He was placed at the front of the line and praised for appropriate behavior when it occurred. The undesirable behavior was extinguished.

Since January of this year, Michael has lost 8 pounds, going from 82 pounds to 74 pounds. This 8-pound loss occurred within a period of 6 months (from the day of admission to the present time).

Although Michael’s mother is disabled, she wants to be informed of her son’s progress and has requested to participate in his reviews. She participates in a weekly group session sponsored by the Regional Center for Parents of Developmentally Disabled.

She visits her son about once a month. She feels Michael ignores her when she is with him.
The forms used and included in this module for an interdisciplinary team review are provided by the state of California Health and Welfare Agency. As a health care worker, you may have the responsibility for completing these forms. Therefore, studying these forms will be an asset to you. A requirement for the successful completion of this module is that you complete a review based on a client you be assigned in a specified facility. You will also be responsible for obtaining the forms specific to that facility.
CANDIDATE’S PERFORMANCE FORM
QUESTIONS AND ANSWER

Candidate’s Name: ___________________________ Date: ____________________

Clinical Facility: ________________________________________________________

Client’s Initials: ________________________________

Instructor’s /Evaluator’s Signature: _________________________________________

PERSONNEL:

1. What type of team is specific to this facility?
   ________________________________________________________________

2. Who are the members of the team (job titles, classifications)?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

3. How many team members are required to be present at a client’s review?
   ________________________________________________________________

   Do certain disciplines need to be represented at all or most of the reviews?
   If yes, please indicate job titles.
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

4. Which team member serves as the leader of these reviews?
   ________________________________________________________________

5. Which team member is responsible for the recording of information discussed during the reviews?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

   ________________________________________________________________
FORMS:

1. What types of ongoing record forms are used at this facility?

2. What types of case management review forms are specific to this facility? How many copies of each are required? What is the disposition procedure?

3. What are the best procedures to obtain forms and data?

CONFERENCES:

1. What is the appropriate procedure for conference arrangements?

2. What kind of conference/review did you participate in?

Candidate’s Name:__________________________________________________________

Facility Name:____________________________________________________________