Quality Service Review

For Use in Integrated Care Settings

Protocol for Review of Integrated Care Practice From a Behavioral Health Perspective

First Use Version - 1c

Designed for Providers of

Behavioral Health Care Services

by
The Quality Service Review Institute, a division of the
Child Welfare Policy and Practice Group

The Quality Service Review

This protocol is designed for use in a consumer-focused, wellness and recovery-oriented, case-based, peer review process and used by behavioral health care providers in integrated care settings. It is used for: (1) appraising the current status of persons receiving services (e.g., persons with serious mental illness and/or substance use disorders) and (2) determining the adequacy of performance of key practices for these same persons. The protocol examines near-term results for persons with serious and persistent mental illnesses and/or substance use disorders and the contribution made by local providers of integrated care and the service system in producing those results. Consumer-based review findings will be used to assess current practice and to stimulate and support efforts to improve services and results.

These working papers, collectively referred to as the *Quality Service Review Protocol*, are used to support a professional appraisal of a person's present status and practice performance for a person reviewed at a given point in time. This is a case-based review protocol for examining frontline practice, not a traditional measurement instrument designed with psychometric properties and should not be taken to be so. Localized versions of such protocols are prepared for and licensed to state agencies for their use. These tools and processes, often referred to as the Quality Service Review or QSR are based on a body of work by Ray Foster, PhD, Ivor Groves, PhD, Paul Vincent, MSW, George Taylor, MA, and Kate Gibbons, MSW, LICSW, working in partnership with the Child Welfare Policy and Practice Group.

Proper use of the *Quality Service Review Protocol* and other QSR tools and processes requires reviewer training, certification, and supervision. Supplementary materials provided during training are necessary for reviewer use during case review and reporting activities.

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Listed below is the table of contents for this QSR protocol. In addition to the materials contained in this protocol, reviewers are provided a set of additional working papers that are used for data collection, reference, and job aids used for particular tasks conducted during the review process.

Introduction to the Quality Service Review Protocol

The Quality Service Review

The Quality Service Review (QSR) provides a case-based appraisal of front-line practice used for organizational learning and development to improve results in agencies providing integrated primary care and behavioral health care services. A multi-method approach is used that includes in-depth case practice reviews applying qualitative measures, focus group interviews, and integration of other sources of information into a discovery-oriented inquiry process. QSR provides ground-level, real-time, rapid assessment, and feedback used by local and state agencies to strengthen frontline case practice, improve training and supervision capacities, and adapt practice to complex, ever-changing conditions.

QSR provides an in-depth case review and practice appraisal process to find out how well persons are benefiting from services received and how well coordinated care services are working for them. Each person served is viewed as a unique test of the local service system or provider agency. Small, spot-checking samples drawn from local service sites are reviewed to determine the person's status, recent progress, and related system practice and performance results. The QSR inquiry process is supported by a qualitative case-based review protocol that measures the performance of core practice functions (in the agency's practice model) in actual cases selected for an in-depth review. QSR places its focus on practice and results, rather than on compliance with funding requirements or agency policies.

This QSR Protocol was specifically designed for use with persons who are receiving individually planned and coordinated primary care for physical issues and behavioral health care services for their diagnosed mental illnesses and, when present, for their substance use disorders.

Basic QSR Concepts

QSR is based on a set of concepts, principles, and strategies related to organizational learning and positive action taken to improve practice in human service agencies. These ideas are explained below.

Case Practice Is Performed to Produce Positive Life Changes for Persons Served

Human service systems exist to help citizens experiencing life-disrupting needs or threats of harm to get better, do better, and stay better in daily life. The collective set of actions used for interventions to alleviate the needs or threats is referred to as *practice*. The purpose of practice is helping a person or family in need or at risk of harm to achieve and maintain, where necessary, adequate and ongoing levels of:

- **Well-being** (e.g., safety, stability, physical and emotional health, living arrangements, and substance free living),
- **Basic supports for daily living** (e.g., housing, food, income, health care, childcare),
- **Adequate daily functioning** (e.g., basic tasks involved in daily living, as appropriate to a person's life stage and ability), and
- **Fulfillment of key life roles** (e.g., competencies necessary for an adult to be a successful parent, employee, tenant, and citizen).

An integrated primary care and behavioral health care agency's organizational performance is defined as practice that produces positive results related to wellness and recovery for a person who is challenged with a mental illness, health problems, and/or a substance use disorder. Results of practice are defined as positive life changes for a person receiving the agency's services. In practice, a positive association should exist between the actions of practice taken and changes observed in a service participant's states of well-being, daily functioning, adequacy of fundamental supports, and/or success in fulfilling life roles. Use of effective practice interventions should lead to necessary life improvements for the service participant. QSR observes the relationships between the actions of practice taken in a case and a service participant's present status and recent progress to understand whether expected life changes are occurring. This protocol provides 15 measurement indicators related to outcomes in the four areas noted above. QSR provides a way of knowing how well practice is working in sampled cases within and across service sites being reviewed.

A Focus on Wellness and Recovery/Resiliency

This QSR Protocol focuses on wellness and recovery outcomes and practices. As used here, wellness is a multidimensional state of being describing the existence of positive health in an individual as exemplified by quality of life and sense of well-being. Behavioral health care services provided to persons should promote recovery from mental and substance use disorders. SAMHSA (the Substance Abuse and Mental Health Services Administration) defines recovery as follows:

> *RECOVERY is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.*

According to SAMHSA, four dimensions that support a life in recovery are:

- **Health** - overcoming or managing one's disease(s) or symptoms by avoiding alcohol, illegal drugs, and non-prescribed medications if one has an addiction problem -- and for everyone in recovery, making informed healthy choices that support physical and emotional well-being.
- **Home** - a stable and safe place to live.
- **Purpose** - meaningful daily activities, such as a job, school, volunteerism, family caretaking, creative endeavors and the independence, income, and resources to participate in society.
- **Community** - relationships and social networks that provide support, friendship, love, and hope.

These broad dimensions provide a useful framework for measuring outcomes achieved by persons in a life of recovery.

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Guiding Principles of Practice

The approach to integrated care practice addressed in this protocol is based on certain guiding principles of practice. High quality practice is: person-centered, strengths-based, solution-focused, wellness- and recovery-oriented, trauma-informed, outcome-focused and results-driven, as well as integrated and coordinated across disciplines, providers, and funding sources. These principles of practice are described as follows:

Person-Centered. Person-Centered Care is an approach designed to assist someone in planning and achieving life goals and supports. It was originally used as a life planning model to enable individuals with disabilities and requiring support to increase their personal self-determination and improve their own independence. It is accepted as evidence based practice. Person-centered care is currently becoming the standard in many areas of practice and is the guiding philosophy behind the integration of medical and behavioral health care. It is evident that individuals and families are more invested in any process where they feel they are an integral part. Self-Directed Care is built upon person-centered care principles and practices.

Strengths-Based. Strengths-based practice is person-centered, with a focus on future outcomes and strengths that the people bring to a problem or crisis. This approach enhances the capacities of individuals and families to deal with their own challenges. Key features of this approach include:

- Strengths-based practice assesses the inherent strengths of a person or family and then builds on those strengths when addressing life changes, recovery and empowerment.
- It avoids the use of stigmatizing language or terms that families use on themselves and eventually identify with, accept, and feel helpless to change.
- It fosters hope by focusing on what has been historically successful for the person and builds on these past successes to support positive future changes.
- It inventories the positive building blocks that already exist in his/her environment that can serve as the foundation for growth and change.

Solution-Focused. This approach is future-focused, goal-directed, and focuses on solutions, rather than on the problems that brought the person to seek help. It targets the desired outcomes of intervention as a solution rather than focusing on the symptoms or issues identified at intake. This technique gives attention to the present and the future desires of the person, rather than focusing on the past experiences. The practitioner encourages the person to imagine their future as they want it to be and then the practitioner and person collaborate on a series of steps to achieve that goal. Solution-focused practice aims to bring about the person's or family's desired change in the least amount of time.

Wellness/Recovery-Oriented. Wellness is an active process in which a person becomes aware of and makes choices toward a more healthy and successful existence. Wellness is a conscious, self-directed, and evolving process of achieving full potential which is multidimensional and holistic, encompassing lifestyle, physical, mental and spiritual well-being, and the environment. Recovery is a process through which persons improve their health and wellness, live a self-directed life, and strive to reach their full potential. Intervention and goals are developed in accordance with the guiding principles of recovery, which are: hope, person-driven, holistic, peer supported, relational, responsive to culture and to trauma, focused on strengths and responsibility, and respectful.

Trauma-Informed. To provide trauma-informed care to youth or adults receiving services, practitioners should understand the impact of trauma on child development and on adult behavior and learn how to effectively minimize its effects without causing additional trauma. A growing body of evidence indicates maltreatment can alter brain functioning and consequently affect mental, physical, emotional, and behavioral development (often called socio- emotional development). Early intervention by human service practitioners provides the opportunity to identify a youth's developmental concerns and help families receive the support they need to reduce any long-term effects. Practices for providing trauma- informed care should be used for adults who have experienced complex trauma and who have lingering adverse affects of trauma today.

Outcome-Focused and Results-Driven. Desired outcomes guide the intervention process and can best be stated as life-change outcomes (related to well-being, essential supports, daily functioning, and/or role fulfillment). Goals are used by the person and his/her team to select strategies, supports, and services for working toward goal attainment. Delivery of intervention strategies and supports is carefully tracked to determine: 1) whether the strategies and supports are being provided in an adequate manner; 2) whether the strategies are working or not working based on progress being made; and, 3) whether the outcome has been met. Case practice decisions are informed by the progress (or lack of progress) being made toward the attainment of planned goals, and when a strategy or provider of the strategy is not working effectively, the practitioner quickly recognizes the failure and promptly replaces the provider or strategy.

Integrated Care. Finding effective ways to integrate primary care and behavioral health care at the level of the person (patient) is the central focus of practice in this case-based review protocol. Four general models are described in the literature. A popular model, especially in the Federally Qualified Health Clinics (FQHCs) is the Primary Care Behavioral Health Consultation model (PCBH). This model is a psychological approach to population-based clinical health care that is simultaneously co-located, collaborative, and integrated within the primary care clinic. The goal of PCBH is to improve and promote overall health within the general population. This approach is important because approximately half of all patients in primary care present with psychiatric comorbidities, and 60% of psychiatric illness is treated in primary care. Primary Care practice has traditionally adopted a generalist approach whereby physicians are trained in the medical model and solutions to problems typically involve medications, procedures, and advice. Appointment times are short, with the goal of seeing a large number of patients in a day. Many patients present with mental health care needs whose symptomology may overlap with medical disorders and which may exacerbate, complicate, or masquerade as physical symptoms. In addition, many medical problems present with associated psychological sequelae (e.g. stress, emotional reactions, dysfunctional lifestyle behaviors), that are amenable to change, through behavioral intervention, that can improve outcomes for these health problems.

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A Case Practice Model Defines the Core Functions Used by Practitioners to Get Results

A behavioral health care agency's integrated practice model should define and support the basic functions or interaction patterns used by frontline practitioners to join with a person receiving services to bring about a positive life change process that helps the person in achieving well-being and recovery outcomes. The diagram shown on below defines a set of basic practice functions expected to be used by agencies providing integrated primary and behavioral health care services. This QSR Protocol is designed to measure an agency's practice performance of basic practice functions for individuals receiving wellness and recovery-oriented services at a point in time. As shown in the diagram, this protocol provides a set of qualitative indicators in the following areas:

1. **Recognition, Connection, Rapport**. This indicator focuses on the degree to which: • The person's sense of identity, culture, values and preferences, social network, and life experiences are recognized by practitioners involved with the person. • Any barriers to personal connection and acceptance are recognized and resolved. • Necessary conditions for building mutual respect and rapport are established as a basis for successful engagement.

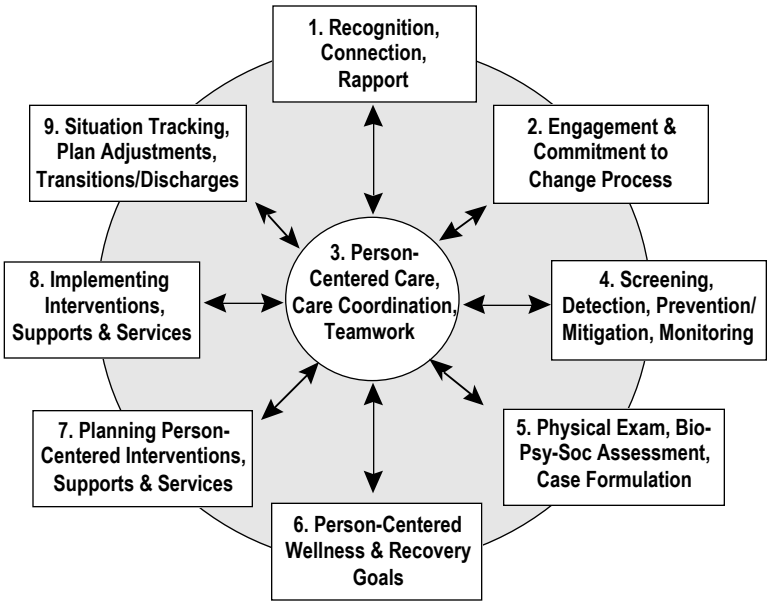
2. **Engagement and Commitment**. This indicator examines the degree to which: • Service providers are building and maintaining a trust-based working relationships with the person and the person's informal supporters to involve them in ongoing assessment, service planning, and wellness and recovery efforts. • Service providers are using effective outreach and ongoing engagement strategies to increase and sustain the person's participation in the service process and commitment to life changes that support wellness and recovery, consistent with the person's needs and preferences.

3. **Person-Centered Care Coordination and Teamwork**. This indicator focuses on the degree to which: Using a person-centered decision making process, the person's service providers and supporters are building and sustaining: • Common purpose by planning wellness/recovery goals and strategies with and for the person. • Unity of effort in service delivery by coordinating actions of the service providers and integrating services across providers, settings, time, and funding sources.

4. **Screening, Detection, Prevention/Mitigation, Monitoring**. This indicator focuses on the degree to which: • Screening detects imminent threats to the person's health, safety, supports, or behavioral well-being upon entry and ongoing thereafter. • Responsive actions are provided in a timely and appropriate manner to prevent or mitigate any foreseeable harm to the person or others around the person arising from the detected threats of harm, risks of near-term life disruptions, or risks of poor well-being outcomes. • Follow-along monitoring tracks the person's situation to detect and respond to any future threats to well-being.

5. **Assessment and Case Formulation**. This indicator focuses on the degree to which: • Ongoing formal and informal fact finding methods

Practice Wheel: Functions in Integrated Care Practice



Practice Functions May Occur Interactively, Concurrently, and Progressively

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are used to develop and update a broad-based understanding of the person's bio-psycho-social situation, clinical history, strengths and assets, unmet needs, life challenges, stressors, and aspirations for wellness and recovery. • An evolving clinical case formulation (describing the person's physical status and clinically significant distress and impairment in functioning) is used to guide development of treatment plans informed by the person's life stage, culture, social context, and preferences.

6. **Wellness and Recovery Goals.** This indicator focuses on the degree to which planned life-change goals for the person: • Are based on understandings developed from current assessments and a clinical case formulation. • Define agreed upon life changes necessary for achieving and maintaining wellness, meeting essential needs, improving daily functioning, gaining greater independence, and supporting ongoing recovery. • Are stated as the person's vision for wellness and recovery in the person's treatment plan. • Are measurable for tracking progress and determining attainment of outcomes.

7. **Planning Interventions.** This indicator focuses on the degree to which: • Meaningful, measurable, and achieveable wellness and recovery goals for the person are supported with well-reasoned, agreed-upon intervention strategies, supports, and services planned for their attainment. Intervention areas that may be examined include: physical wellness, mental health recovery, addiction recovery, trauma recovery, safety from harm, income and basic necessities, functional life skill development, education or work, and community integration.

8. **Delivering Interventions.** This indicator focuses on the degree to which: • Planned strategies, supports, and services are delivered in a manner sufficient to help the person make adequate progress toward meeting planned goals. • The combination of supports and services fits the person's situation so as to maximize benefits and minimize any conflicting strategies or inconveniences.

9. **Medication Management**. This indicator focuses on the degree to which: • Use of any psychiatric/addiction control medications for this person are necessary, safe, and effective. • The person has a voice in medication decisions and management. • The person is routinely screened for medication side effects and treated when side effects are detected. • New atypical/current generation drugs have been tried, used, and/or appropriately ruled out. • Use of medication is being coordinated with other treatment modalities and with any treatment for any co-occurring conditions (e.g., seizures, diabetes, asthma/COPD, GERD, HIV).

10. **Situation Tracking, Plan Adjustment, and Transitions.** This indicator focuses on the degree to which: • Situational awareness is sustained by tracking the person's life situation, changing circumstances, service process, progress, and goal attainment. • Plans are kept relevant and effective by identifying and resolving service problems, overcoming barriers, and replacing failed strategies. • Seamless and successful transitions are achieved by ensuring continuity of care across settings and providers as well as supporting the person's successful post-change life adjustments in a new setting or situation.

These indicators provide a comprehensive picture of how well the broad functions of practice are working for a person at a point in time. An agency's practice model should encompass the core values of the agency (e.g., use of recovery-oriented, culturally competent, person-centered, strengths-based, solution-focused practice principles) and define the fundamental expectations concerning working relationships, integration of efforts among the practitioners serving an adult in recovery, care coordination, and essential action patterns or functions associated with effective case practice. The practice model becomes a central organizer for training of frontline staff, supervision, performance measurement, and accountability.

Taking Action on New Learning To Improve Performance

QSR is intended to stimulate positive next-step actions to improve local case practice and results. QSR enables local practitioners to learn from their own case practice and local service system experiences to improve performance. Local service systems benefit from using QSR results to strengthen practice in a thoughtfully organized next-step action planning process. Local leadership plays an essential role in supporting practice learning and development as well as working to improve local conditions of practice that may limit or hinder best practice efforts.

QSR Informs Leadership Action for Change

Effective use of QSR results for practice development, capacity building, and positive system change requires the understanding and commitment of leaders in various positions, levels, and locations within an agency. This includes supervisors, program managers, policy developers, practice consultants and trainers, resource developers, and executive leadership. QSR works to stimulate and support positive change when leaders own the process and actively use ongoing results to drive practice development and capacity-building efforts. Key aspects of such leadership involve:

- Setting and clarifying expectations about practice and results.
- Committing to modeling, mentoring, coaching of practice.
- Building adequate, stable frontline capacities to support practice.
- Providing flexible funding and use of uniquely designed supports.
- Ensuring that every frontline worker has what is needed every day to succeed with the most challenging service participants.
- Using meaningful measures (e.g., QSR) applied with safe, positive, frequent feedback for affirmation, instruction, and next-step planning.
- Focusing intensively, continuously on practice performance and using results to move changes forward using positive strategies.

Success in any change effort depends on active, committed leadership that learns from QSR results and leads to positive change processes of practice development and capacity building within their agency.

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What's Learned through the QSR

The QSR involves case reviews, observations, and interviews with the person and people important to the person. Results provide a rich array of learnings for next-step action and improvement. These include:

- Detailed stories of practice and results in real situations and recurrent patterns observed across persons reviewed.
- Deep understandings of contextual factors that are affecting daily frontline practice in a site or agency being reviewed.
- Quantitative patterns of service participant status, recent progress, and practice performance results, based on qualitative measures.
- Noteworthy accomplishments and success stories.
- Emerging problems, issues, and challenges in current practice situations explained in local context.
- Critical learning and input for next-step actions and for improving program design, practice, and working conditions.
- Repeated measures revealing the degree to which important service system transformation aspirations are being being fulfilled in daily frontline recovery-oriented practice for adult consumers of mental health and addiction services.

Successful practice change is enhanced by use of positive strategies rather than management actions that are perceived as punitive by frontline staff.

QSR Indicators

The QSR Protocol provides reviewers with a specific set of indicators to use when examining the status of the service participant and analyzing the responsiveness and effectiveness of the core practice functions prompted in the core practice model. Indicators are divided into two distinct domains: *status* and *practice performance*.

- **Status indicators** measure the extent to which certain desired conditions are present in the life of the focus person—as seen over a recent time. Status indicators measure constructs related to *well-being* (e.g., safety and health) and *functioning* (e.g., the person's work status). Changes in status over time may be considered the near-term outcomes at a given point in the life of a case.
- **Practice indicators** measure the extent to which *core practice functions* are applied successfully by practitioners and others who serve as members of the person's support team. The core practice functions measured are taken from the team and provide useful case-based tests of performance achievement. The number of core practice functions and level of detail used in their measurement may evolve over time as advances are made in the state-of-the-art practice.

Collectively, these measures of status, progress, and practice performance provide a basis for a qualitative examination of how services are helping adults seeking recovery to get better, do, better, and stay better.

Rating Scales Used in the QSR

The QSR protocol uses a 6-point rating scale as a "yardstick" for measuring the situation observed for each indicator. [See the two rating scale displays presented on the next page.] Each rating level describes conditions at one of six points along a continuum that ranges from high to low as follows: 6 - Optimal, 5 - Good, 4 - Fair, 3 - Marginal, 2 - Poor, and 1 - Adverse or Absent. A service participant's current status is measured over the most recent 30-day period. Progress is measured over the most recent 180-day period or since admission to services if less that 180 days. Practice is measured over the most recent 90-day period. These time parameters help reviewers clearly and consistently define conditions necessary for a particular rating value. Greater clarity in rating values increases inter-rater reliability. The rating levels are explained in general terms for the Status and Practice indicators as follows.

Status Indicator Ratings

Presented below are general definitions of the rating levels and timeframes applied for the adult status indicators. It should be noted that the 30-day time period is usually associated with a status rating level of 4 (fair). A status rating of level 5 (good) is associated with a more substantial and enduring pattern. A status rating level of 6 (optimal) is associated with a high quality pattern of well-established duration. The general interpretations for these ratings are defined as follows:

- **Level 6 - Optimal and Enduring Status.** The person's status situation has been generally optimal [best attainable taking age, health, and ability into account] with a consistent and enduring high quality pattern evident, without being less than good (level 5) at any point or in any essential aspects over the past 6 months or since admission, if less. This optimal pattern is consistent with meeting major short-term needs and sustaining the attainment of important longer-term case outcomes. The situation may have had brief moments of minor fluctuation over the past six months, but functioning in this area has remained generally optimal and enduring, never dipping below level 5 at any moment. Confidence is high that long-term outcomes are being met in this area.
- **Level 5 - Good and Stable Status.** The person's status situation has been substantially and consistently good and beneficial with indications of stability evident, without being less than fair (level 4) at any moment or in any essential aspect over the past three months. This good and stable pattern is consistent with meeting many short-term needs as well as leading toward the attainment of important longer-term case outcomes. The situation may have had brief moments of minor fluctuation, but functioning in this area has remained generally good and stable, never dipping below level 4 at any moment. This level is consistent with eventual satisfaction of needs or attainment of long-term outcomes in the area.

Interpretative Guide for Status Indicator Ratings

Maintenance/ Green Zone: 5-6

Status is favorable. Efforts should be made to maintain and build upon a positive situation.

6 = **OPTIMAL STATUS**. The **best or most favorable status presently attainable** for this person in this area [taking age and ability into account]. The person is "doing great!" Confidence is high that long-term needs or important life outcomes will be/are being met in this area.

5 = **GOOD STATUS**. **Substantially, dependably positive status** for the person in this area with a strong ongoing positive pattern. This status level is consistent with attainment of long-term needs or outcomes in area. Status is "looking good" and likely to continue.

Adequate & Acceptable Range: 4-6

Refinement/ Yellow Zone: 3-4

Status is minimum or marginal, may be unstable. Further efforts are necessary to refine the situation.

4 = **FAIR STATUS**. Status is **minimally, temporarily adequate** for the person to meet short-term needs or objectives in this area. Present status may be short-term due to changing circumstances, requiring change soon. Status is/has been adequate in all aspects/at all times on this indicator for a month. *[Past 30 days]*

3 = **MARGINALLY INADEQUATE STATUS**. Status is **mixed, limited, inconsistent, somewhat inadequate** to meet the person's short-term needs or objectives in this area. Status now is "not quite enough" for the person to be satisfactory today or successful in the near-term. Risks do not exceed a minimal level.

Improvement/ Red Zone: 1-2

Status is poor and risky. Quick action should be taken to improve the situation.

2 = **POOR STATUS**. Status is and may continue to be **poor and unacceptable**. The person may seem to be "stuck" or "lost" with status not improving. Any risks may range from mild to serious levels.

1 = **ADVERSE STATUS**. The person's status in this area is **poor and worsening**. Any risks of harm, restriction, separation, detention, regression, and/or other poor outcomes may be substantial and increasing.

Active Efforts Indicated Range: 1-3

Interpretative Guide for Practice Indicator Ratings

Maintenance/ Green Zone: 5-6

Performance is effective. Efforts should be made to maintain and build upon a positive practice situation.

6 = **OPTIMAL PERFORMANCE**. **Excellent, consistent, effective practice** for this person in this area for 90 days or longer. This level is indicative of exemplary practice resulting in reaching and sustaining major long-term outcomes.

5 = **GOOD PERFORMANCE**. At this level, the practice function and its implementation is **working dependably well** for this person, under changing conditions and over time. Effectiveness level is generally consistent with meeting long-term needs and goals for the person.

Adequate & Acceptable Range: 4-6

Refinement/ Yellow Zone: 3-4

Performance is minimal or marginal and maybe changing. Further efforts are necessary to refine the practice situation.

4 = **FAIR PERFORMANCE**. The practice function is **minimally or temporarily adequate** in meeting short-term need or objectives. Performance may be time-limited, somewhat variable, or require adjustment soon due to changing circumstances. *[90 days, minimally adequate pattern. Some refinements indicated]*

3 = **MARGINAL PERFORMANCE**. Practice may be under-powered, inconsistent or not matched to change. Performance is **sometimes/somewhat inadequate** for the person to meet short-term needs or objectives. *[Mildly inadequate pattern]*

Improvement Red Zone: 1-2

Performance is inadequate. Quick action should be taken to improve practice now.

2 = **POOR PERFORMANCE**. Practice at this level is **fragmented, inconsistent, lacking focus and/or power** to yield change and achieve goals. Elements of practice may be noted, but it is inadequate/not operative on a consistent basis.

1 = **ADVERSE PERFORMANCE**. Practice may be **absent/not operative**. Performance may be missing (not done). - OR - Practice strategies, if occurring in this area, may be **contra-indicated or performed inappropriately or harmfully**.

Active Efforts Indicated Range: 1-3

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- **Level 4 - Minimally Adequate to Fair Near-Term Status.** The person's status situation has been at least minimally adequate at all times over the past 30 days, without being inadequate at any point or any essential aspect over that time. This pattern is consistent with meeting essential short-term needs in this area in the near term. The situation may be dynamic with the possibility of fluctuation or need for adjustment within the near term. The observed pattern may not endure or may have been less than minimally acceptable in the recent past, but not within the past 30 days.

- **Level 3 - Marginally Inadequate Recent Status.** The person's status situation has been somewhat limited or inconsistent over the past 30 days or longer, being inadequate at some moments in time or in some essential aspect(s) over this recent period. The situation may be dynamic with indications of fluctuation or need for adjustment at the present time. The pattern may have endured more than 30 days being less than minimally acceptable in the recent past but at a level where refinement is indicated rather than improvement.

- **Level 2 - Substantially Poor Status.** The person's status situation has been substantially limited or inconsistent, being inadequate at some or many moments in time or in some essential aspect(s). The situation may be dynamic with a probability of fluctuation or need for improvement at the present time. The observed pattern may have endured or may have been inadequate and unacceptable in the recent past and is substantially inadequate.

- **Level 1 - Adverse or Poor and Worsening Status.** The person's status situation has been substantially inadequate and potentially harmful, with indications that the situation may be worsening at the time of review. The situation may be dynamic with a high probability of fluctuation presenting a great need for immediate improvement at the present time. The observed pattern may be poor and gradually worsening or may have recently become unacceptable and dramatically worsening.

These rating descriptions provide the basic logic and guidance used by reviewers in determining rating values that best describe the situation observed for the indicator at the time of review.

Practice Indicator Ratings

The same general logic with related time periods of pattern duration is applied to the practice performance indicator rating levels as is used with the status indicators. The general interpretations for practice performance indicator ratings are defined as follows:

- **Level 6 - Optimal and Enduring Performance.** The practice performance situation observed for the person has been generally optimal [best attainable given adequate resources] over the past six months with a consistent and enduring pattern evident, without ever being less than good (level 5) at any point or in any essential aspect. The practice situation may have had brief moments of minor fluctuation, but performance in this area has remained optimal and stable. This excellent level of performance may be considered "best practice" for the system function, practice, or attribute being measured in the indicator and worthy of sharing with others.

- **Level 5 - Good and Stable Performance.** The practice performance situation observed for the person has been substantially and consistently good with indications of stability evident for the past three months, without being less than fair (level 4) at any moment or in any essential aspect. The situation may have had some moments of minor fluctuation, but performance in this area has remained generally good and stable. This level of performance may be considered "good practice or performance" that is noteworthy for affirmation and positive reinforcement.

- **Level 4 - Minimally Adequate to Fair Performance.** The practice performance situation observed for the person has been at least minimally adequate at all times over the past 30 days or longer, without being inadequate (level 3 or lower) at any moment or in any essential aspect over that time period. The performance situation may be somewhat dynamic with the possibility of fluctuation or need for adjustment within the near term. The observed performance pattern may not endure long term or may have been less than minimally acceptable in the recent past, but not within the past 30 days. This level of performance may be regarded as the lowest range of the acceptable performance spectrum that would have a reasonable prospect of helping achieve desired outcomes given that this performance level continues or improves. Minor refinement efforts are indicated at this time.

- **Level 3 - Marginally Inadequate Performance.** The practice performance observed for the person has been somewhat limited or inconsistent, being inadequate at some moments in time or in some essential aspect(s) over the past 30 days or longer. The situation may be somewhat dynamic with a probability of fluctuation or need for adjustment at the present time. The observed pattern may have been less than minimally acceptable (level 3 or lower) in the recent past and somewhat inadequate. This level of performance may be regarded as falling below the range of acceptable performance and would not have a reasonable prospect of helping achieve desired outcomes. Substantial refinement efforts are indicated.

- **Level 2 - Substantially Poor Performance.** The practice performance situation observed for the person has been substantially limited or inconsistent, being inadequate at some or many moments in time or in some essential aspect(s) over the past 30 days or longer. The situation may be dynamic with a probability of fluctuation or need for improvement at the present time. The observed pattern may have endured for a while or may have become inadequate and unacceptable in the recent past and is substantially inadequate. This level of inadequate performance warrants prompt attention and improvement.

- **Level 1 - Absent, Adverse, or Poor Worsening Performance.** The practice performance situation observed for the person has been missing, inappropriately performed, and/or substantially inad-

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equate and potentially harmful, with indications that the situation may be worsening at the time of review. The situation may be dynamic with a high probability of fluctuation or a great need for immediate improvement at the present time. This level of absent or adverse performance warrants immediate action or intervention to address the gravity of the situation.

Each status, progress, and practice indicator in a QSR Protocol provides reviewer rating guidance related to the actual construct being measured in the section containing the indicator. Any special time rules or rules related to the applicability of an indicator in certain cases are provided in the section containing the indicator.

QSR Reviewer Expectations

A person who serves as a QSR reviewer is trained, coached, mentored, certified, and supervised to function as an independent peer reviewer of frontline practice in a particular field of human services (e.g., mental health services, addiction treatment, child protection and permanency services). QSR reviewer training and supervision is provided via the agency that employs the QSR process for practice development purposes. Each field in which a QSR Protocol is used requires that a reviewer have mastery of knowledge associated with state-of-the-art practice in that area. A QSR reviewer should be a qualified practitioner in the field of practice in order to be regarded as a peer reviewer by those whose cases are examined in the QSR process.

Preferred qualifications for a QSR reviewer candidate include the person having at least a relevant masters degree and, where appropriate, a license to practice in the field. It is preferred that a reviewer candidate have at least five years of successful frontline practice in the field. Additional preferred qualifications include the candidate having experience as a trainer and/or supervisor in the field of practice. These qualifications would enable a reviewer candidate to recognize good practice when observed in a case as well as to diagnose practice problems and offer constructive solution options for consideration by local agency staff.

QSR Reviewer Training & Certification

Persons using this QSR Protocol should have completed the classroom training program (12-15 hours). Candidate reviewers should be using the protocol in a shadowing/mentoring sequence involving at least two consecutive case review situations conducted in the field with an inter-rater agreement check made with the second case. The trainee's first case analysis and ratings, feedback session with frontline staff, oral case presentation, and first case write-up should be coached by a qualified mentor. With the recommendation of the mentor, trainees who have successfully completed these steps will be granted review privileges on a review team under the supervision of the team leader and the case judge who approves written reports. Trainees may be certified after three successful reviews and successfully meeting the rating standards set by the expert review panel on the certification simulation. Any other users of this protocol should be certified reviewers.

Role Performance Expectations

The role of a qualified and certified QSR reviewer includes fulfillment of the following expectations:

- **Conducting a Useful Appraisal.** A QSR reviewer conducts an independent, competent, accurate, and fair appraisal of the quality and consistency of interventive practices and services by applying the QSR protocol to individuals selected for review.

- **Demonstrating Competence.** A QSR reviewer is a qualified practitioner who is trained on and competent in the use of the QSR protocol and process. Many agencies using QSR Protocols require that a reviewer be certified in order to conduct case reviews.

- **Maintaining Independence.** A QSR reviewer maintains an independent, objective attitude and proper demeanor when conducting review work. A reviewer does not conduct a review for a service participant or agency when the reviewer might have a personal bias (arising from personal relationships or past involvement with the agency or provider) or when there might be the appearance of such. It is essential that QSR findings be viewed as being impartial.

- **Using Due Professional Care.** A QSR reviewer uses due professional care by following the QSR process and using the protocol in the way that the protocol training has directed. It means using the reviewer's best judgment in determining the ratings and suggestions. Due care requires that a reviewer seek assistance, when needed, to deal with a rare or unusually complex situation that may exceed the reviewer's knowledge or experience base.

- **Providing Findings Based on Evidence.** A reviewer's findings and conclusions are based on evidence (records, observations, interviews, deductions) gained from the QSR process and that the reviewer can explain and support with evidence what led to making certain determinations. It means *calling it as one sees it* and yet being tactful in providing information (oral and written) to local staff and end users.

- **Reporting Accurately, Fairly, and Constructively.** A QSR reviewer's oral and written reports are concise, accurate, complete, fair, objective, well supported, constructive in tone, and consistent with QSR objectives and local user needs.

- **Functioning as a Wise and Gentle Teacher.** A QSR reviewer's role includes providing individualized face-to-face feedback to a frontline practitioner and supervisor associated with each case reviewed. A QSR reviewer provides an oral case presentation and deconstruction for each case reviewed during grand-rounds teaching sessions for supervisors and managers. A QSR reviewer provides a written summary of findings for each case reviewed. A QSR reviewer is trained to apply principles of positive psychology and appreciative inquiry when providing feedback to agency staff. Use of these strategies encourage understanding and increase the likelihood that frontline practitioners, supervisors, and managers will take meaningful next steps that will lead to positive practice change. This

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expectation requires that agencies using QSR Protocols and processes apply it for practice development purposes only and never for compliance enforcement purposes.

Organization of the QSR Protocol

This protocol booklet is organized into the following sections:

- **Introduction:** This first section of the protocol provides a basic explanation of the review process and protocol design.
- **Status Indicators:** The second section provides the status indicators used in the review. These indicators span matters related to community living, well-being, and meaningful life activities.
- **Practice Performance Indicators:** The third section provides indicators for measuring and examining key areas of practice that may or may not apply to a case under review. These indicators provide the basis for a review of practice for the person who is the subject of review.
- **Overall Patterns:** The fourth section provides the working papers that the reviewer uses to determine the overall patterns for the person domain, progress domain, and practice performance domain. In addition, this section includes the instructions for making a six-month forecast or estimate of the participant's near-term reconvey trajectory.
- **Reporting Outlines:** The fifth section provides the outlines that reviewers are to use in developing and presenting the ten-minute oral summary of case findings and the written summary report to be submitted following the review.

SECTION 2

PERSON'S STATUS

REMINDERS FOR REVIEWERS

1. **Focus on the central construct measured in each indicator.** While two constructs may be logically related (e.g., behavioral risks and mental health status), the reviewer is to focus on the central matters related to each specific indicator and follow the probe and rating guidance provided for each indicator.

2. **Stay within the time-based observation windows associated with each indicator.** For most indicators, status is measured over the past 30 days unless stated differently for particular indicators. For example, *Status Indicator 2: Behavioral Risk to Self/Others* has observation windows that differ from the 30-day rule.

3. **Rate indicators based on events that have occurred or conditions that were present within the time-based observation window**. Theorizing about events that might have occurred but did not is not a factual basis for rating. The 6-Month Prognosis or Forecast is used to reflect expectations or concerns about future prospects.

Status Indicator 1: Safety from Harm by Others

Focus Measure

SAFETY. Degree to which the person is free from external risks of harm, inclusive of such factors as abuse, neglect, intimidation, and/or exploitation by others.

Core Concepts: This Indicator Applies to All Perons

Safety is defined as freedom from harm, with harm being circumstances or outcomes that are injurious to the focus person and possibly to those around him/her. Harm is broadly conceptualized to include physical injury, emotional/psychological abuse, intimidation causing fear of harm or actual harm, and other material damage. Harm can result from actions of commission, such as crime, abuse, and exploitation; acts of omission, such as neglect; or from features of the environment, such as harm due to infection, accident, or exposure to harmful substances. ***(Note: Harm due to self-neglect is covered under Status Indicator 2: Behavioral Risk to Self/Others.)***

Reviewers should consider each of these various dimensions of potential harm when considering the safety of an individual. In situations where the person is dependent on the protection or oversight of a caregiver or caregivers, attention should be given to the capacity of such caregivers to recognize and protect the individual from imminent risks of harm. This consideration extends to the realistic effectiveness of any protective strategies.

Fact Pattern -- Apply the Probe Questions, Assemble the Facts, and Consider the Pattern Found over the Past 30 Days

While the reviewer looks back over the past 18 months to find possible times and situations in which the person may have been unsafe in order to develop a necessary context for pattern recognitions, the rating made by the reviewer is based on the person's exposures to harm over the 30 days.

1. Is the person currently, or was he/she recently, a victim of maltreatment such as physical, sexual or emotional abuse, neglect, or exploitation (including financial exploitation) in the home or community? • How many instances/reports of maltreatment have occurred in the previous 18 months? • Were such reports substantiated? If any reports were substantiated, were corrective actions taken (e.g., safety plan)? • If so, what is the status of corrective plans (are they up to date, practical, understood by key persons, and effective in actual use)?

2. Is the person fearful, intimidated, or at a high risk of harm in any of his/her current daily settings and activities? • If so, what is the source of harm? • Were mitigating steps implemented to reduce the fear and/or risk of harm?

3. If the person is dependent on others, is he/she receiving an appropriate level of care, supervision, and protection from caregivers and other adults, relative to age and special needs, to keep him/her safe? • Is the person's care or supervision situation currently compromised by the caregivers' behavior or characteristics (e.g., pattern of violent behavior, abuse/addiction to drugs and/or alcohol, mental illness/emotional instability, criminal activity, developmental status, cognitive ability, or being overwhelmed by other responsibilities)? • Is the person protected from known and realistic risks of harm?

4. Does the person have his/her immediate food, clothing, shelter, and medical/mental health needs met? • Are physical living conditions hazardous or threatening to his/her safety?

5. Is the person at realistic risk of harm from elements in his/her environment? • Reviewers should consider toxins, diseases, crime, and other environmental factors that could realistically expose the person to imminent threats of harm.

Status Indicator 1: Safety from Harm by Others

Status Rating Description that Best Fits the Fact Pattern Observed

Description of the Status Situation Observed for the Person — Rating Level

- **Optimal Safety Situation.** The person has a very low risk living situation. Any protective strategies needed are fully operative and dependable in maintaining excellent and safe living conditions. The person is fully free from intimidation and exploitation at home and in other daily settings. **6** ☐

- **Good Safety Situation.** The person has a generally low risk living situation. Any protective strategies needed are generally operative and dependable in maintaining acceptably safe conditions. The person is generally free from intimidation and exploitation at home and in other daily settings. **5** ☐

- **Fair Safety Situation.** The person is at least minimally free from serious risks in his/her living situation and other daily settings. Any protective strategies needed are at least minimally adequate in reducing risks of harm, intimidation, and exploitation. **4** ☐

- **Marginally Inadequate Safety Situation.** The person may be exposed to occasional risks of harm in his/her home and/or in other daily settings. Any necessary protective strategies may not be implemented or effective in reducing risks of harm, intimidation, and exploitation. **3** ☐

- **Substantially Inadequate Safety Situation.** The person may be exposed to substantial and continuing risks of harm in his/her home and/or in other daily settings. Any necessary protective strategies may be limited or inconsistent in reducing risks of harm, intimidation, and exploitation. **2** ☐

- **High Safety Risk Situation.** The person may be exposed to continuing and increasingly serious intimidation, exploitation, abuse, and/or neglect. Any necessary protective strategies may not be implemented or effective, leaving the person at risk of serious, continuing, and possibly worsening harm. **1** ☐

Status Indicator 2: Behavioral Risk to Self or Others

Focus Measure

BEHAVIORAL RISK. Degree to which the person is avoiding self-endangering situations and refraining from using behaviors that may put him/her or others at risk of harm.

Core Concepts: This Indicator May Not Apply to Persons Under 3 Years of Age

Throughout stages of human development, children, youth, and adults learn to follow rules, values, norms, and laws established in the home, school, and community, while learning to avoid behaviors that can put themselves or others at risk of harm. This indicator examines the person's choices, decisions, subsequent behaviors, and activities, and whether or not those choices engage him/her in risky or potentially harmful activities. It addresses behavioral risks, including self-endangerment and risk of harm to others, and considers the individual's engagement in lawful community behavior and socially appropriate activities, and avoidance of risky and illegal activities, such as alcohol/substance abuse.

- Suicidality, self-mutilation, or other forms of self-injurious behaviors
- Homocidality, recent violence toward others
- Placing him/herself in dangerous environments and situations
- Abuse of alcohol/addictive substances
- Self-injurious binging on alcohol or drugs
- Running away (adolescents)
- Dangerous thrill-seeking activities that may result in injury or death
- Bulimia and/or anorexia
- Use of weapons in illegal activities
- Neglecting personal nutrition or other critical self-care requirements
- Rape or sexual perpetration on others
- Neglecting dependent children or adults in the person's care
- Huffing glue, paint thinners, gasoline, or other such toxic chemicals
- Playing with fire or dangerous objects (knives, tools, guns)
- Stealing/theft of property
- Serious property destruction, including fire setting
- Gang affiliation and related illegal activities

This indicator is rated for the person and for others who may be harmed by the person.

Fact Pattern -- Apply the Probe Questions, Assemble the Facts, and Consider the Pattern Found

While the reviewer looks back over the past 36 months to find possible times and situations in which the person may have engaged in sexual offenses or violent behavior directed toward others to develop a necessary context for pattern recognition, the rating made by the reviewer is based on the person's presentation of behaviors that cause harm to self or others and is based on variable time periods as described in ratings of 4, 5, and 6. Note that the look-back period and rating timelines applied for a person having a recent history of sexual offenses or violent behavior directed toward others is longer than the time periods applied to other persons who do not have such a history.

1. Does the person present a recent or current pattern of self-endangering behaviors or danger to others? • If yes, what are these behaviors? *[Self-neglect of basic needs to a degree that harm occurs is regarded as a form of self-endangerment.]*

2. Does the person regularly associate with peers known for engaging in illegal or high risk activities?

3. Does this person have a history of violence over the past 36 months? • Has the person been arrested in the past 36 months for a violent offense or parole violation related to conviction for violent offense? • Has this person ever been ruled non-competent to stand trial for a violent offense?

4. Does this person have a history of sexual offense over the past 36 months? • Has the person been arrested in the past 36 months for a sex offense or parole violation related to conviction for violent offense? • Has this person ever been ruled non-competent to stand trial for a sexual offense?

5. Does the person engage in any high-risk behaviors, such as verbal or physical aggression, running away, robbery, car theft, drug use/sale, having unprotected sex or prostitution? • Is the individual involved with the juvenile/criminal justice system? • Is the youth or adult in a special education or mental health program to address behavior that puts the individual or others at risk?

6. Has the person made suicidal gestures, threatened suicide, or made a suicide attempt? • Does the person need and/or have a Safety Plan? • Is the person presently placed in a specialized treatment setting or detention setting?

STATUS INDICATOR 2: BEHAVIORAL RISK TO SELF OR OTHERS

7. Was seclusion or restraint (emergency physical or chemical restraint) used to control behavior used within the past 90 days to prevent harm to self or others? • If so, how frequently was seclusion or restraint used and for what reasons? • Was the use of any crisis intervention techniques/mobile crisis services used or reduced over the past 90 days? • Has 911 been called because of the person's behavior within the last three months?

8. Does the person have responsibility for dependents? • If so, is he/she providing an appropriate level of care, supervision, and protection (relative to age and special needs) to keep them from risk of harm? • Is the dependent's safety compromised by the person's behavior or characteristics?

Status Rating Description that Best Fits the Fact Pattern Observed

NOTE: The time periods used on the rating scales for levels 6 and 5 differ from the 30-day rating rule applied in most status indicators.

Description of the Behavioral Risk Status Observed for the Person	Rating Level
◆ **Optimal Status.** The person is optimally and consistently avoiding behaviors that cause harm to self, others, or the community. He/she has no history, diagnosis, or presentation of behavioral risk and is continuing this healthy pattern. - OR - The person may have had a related history, diagnoses, or behavioral risk presentation in the past but has not presented risk behaviors at any time during the past six months (or for at least 36 months for a sex offender or violent offender).	**6** ☐ Self ☐ Others
◆ **Good Status.** The person is generally and substantially avoiding behaviors that cause harm to self, others, or the community. This person may have had a limited history, diagnosis, or presentation of behavioral risk that is not significant now. - OR - The person may have had significant history, diagnoses, or presentation of behavioral risk in the past but has not presented the risk behaviors at any time during the past three months (or for at least 24 months for a sex offender or violent offender).	**5** ☐ Self ☐ Others
◆ **Fair Status.** The person is at least minimally avoiding behaviors that cause harm to self, others, or the community but may rarely present a behavior that has low or mild risk of harm (excluding sexual offenses and homocide). The person may have had a related history, diagnoses, or presentation of behavioral risk in the past, but may have presented mild risk behaviors at a much reduced level over the past 30 days, and never at a level where actual harm occurred (or for at least 12 months for a sex offender or violent offender).	**4** ☐ Self ☐ Others
◆ **Marginally Inadequate Status.** The person may be working to avoid behaviors that cause harm to self, others, or the community, but occasionally may present a behavior that has low to moderate risk of harm to self or others (excluding sexual offenses and or violent offenses). The person may have had a related history, diagnoses, or presentation of behavioral risk in the past, but has presented risk behaviors at a somewhat lower risk or reduced level of harm during the past 30 days. The person's behavioral risk status may be of concern to others involved with him/her.	**3** ☐ Self ☐ Others
◆ **Substantially Inadequate Status.** The person's behavioral and diagnostic history over the past 30 days suggests he/she may be at a high level of risk for causing to harm him/herself and others. Behaviors of concern many include sexual offenses and /or violent offenses.	**2** ☐ Self ☐ Others
◆ **Serious and Worsening Status.** The person presents a pattern of extreme and/or worsening behavior that causes serious harm to him/herself, others, or the community. The person may have had a behavioral and diagnostic history over the past 30 days that suggests that his/her behavior is deteriorating and that he/she may be at a dangerous point for causing harming him/herself and/or others. Behaviors of concern many include sexual offenses and /or violent offenses. The potential for further harm may be high and increasing.	**1** ☐ Self ☐ Others

Status Review 3: Physical Health Status

Focus Measure

PHYSICAL HEALTH STATUS. Degree to which the person is: (1) Achieving and maintaining favorable health status, given any disease diagnosis and prognosis that the person may have; and (2) Receiving adequate and consistent levels of health care appropriate for the person's age, personal needs, and preferences.

Core Concepts: This Indicator Applies to Every Person

The goal for a person is to achieve and maintain his or her best attainable health status when taking medical diagnoses, prognoses, and history into account. To achieve and maintain good health, the person's basic needs for proper nutrition, clothing, shelter, and hygiene should be met on a daily basis. Proper medical and dental care (preventive, acute, and chronic) is necessary for maintaining good health. Preventive and primary health care should include periodic examinations, immunizations, dental hygiene, and routine screenings for diseases. This extends to reproductive health care education and services. When indicated, a responsible professional or caregiver should assure that the medications are taken as prescribed, that the effects of the medications (including side effects) are monitored, and that there is a mechanism to provide feedback to the physician on a regular basis. For a person who is cognitively limited, the person to the extent possible should understand his/her condition, how to self-manage issues associated with the condition, the purpose of his/her medication, how to manage or report side effects of the medication, and how to self-administer. If the person requires any type of home health equipment or other special procedures, professionals and caregivers working with the person should provide instruction in the use of the equipment and special procedures. Should the person have a serious health condition, possibly degenerative, the services and supports have been provided to allow the person to remain in the best attainable physical status given his/her diagnoses and prognoses. As a best practice, the person should have a Health Home. A Health Home is provider or team of health care professionals that promotes wellness and provides integrated health care in which the primary physician, dentist, specialists, and behavioral health care professionals share and work from the same set of information. Integration of primary care and behavioral health care may be critical to achieving many important outcomes for a person.

Fact Pattern -- Apply the Probe Questions, Assemble the Facts, and Consider the Pattern Found over the Past 30 Days

1. Has the person achieved favorable health status, given any physical health diagnoses this person may have?

   - What is this person's general physical health situation? • Is the person's present situation indicative of good health status? • If not, why not?
   - Is this person's daily functioning adversely affected by any health issues (e.g., missing work, restriction on activities, frequently ill, hospitalization)?
   - Does the person have any diagnoses of chronic health problems (e.g., COPD, HEP-C, HIV/AIDS, GERD, diabetes, heart disease, seizures, obesity)?
   - If the person has any chronic health problems, is the person receiving an adequate level of care by specialists to treat the health problems and care needs?

2. Is the person maintaining his/her best attainable health status? • Does the person have a Primary Care Physician and a Health Home?

   - Are the person's immunizations complete and up to date?
   - Does the person miss work or other daytime activities due to illness more than would be expected?
   - Does the person have any recurrent health problems, such as infections, sexually transmitted diseases, colds, or injuries?
   - Does the person have recurrent health complaints, and if so, are they addressed (including dental, eyesight, hearing, etc.)?
   - Does the person appear to be underweight or overweight, and if so, has this been investigated?
   - Does the person use illegal substances?
   - If the person has had a need for acute health care services, were they provided appropriately?

3. Are the person's **basic physical needs** met adequately on a daily basis? *NOTE: If basic physical needs are not met, it may be an indication of neglect (failure to provide critical care to a dependent individual) or dangerous self-neglect -- See Status Indicators 1 and 2.*

   - Food, adequate nutrition, sleep, and daily exercise at a level necessary to balance the person's height and weight within a healthy range?
   - Sanitary housing that is free of safety hazards?
   - Daily care, such as hygiene, dental care, grooming, and clean clothing?

4. If the person takes ongoing medication for health maintenance, is the medication properly managed for the person's benefit?

   - Any medications taken appear to be safe and effective for the person.
   - The person, at the level that she/he is capable, has been taught about his/her condition, understands how to self-manage the condition, understands the purpose and impact of the medication, and is able to self-administer his/her medication with supervision.
   - If the person is dependent on another for medication supervision, is the current caregiver responsible for monitoring the use of the medication, ensuring that it is taken properly, watching for signs of effectiveness or side effects, providing feedback to the physician, and making changes as warranted.

Status Review 3: Physical Health Status

Status Rating Descriptions that Best Fit the Fact Pattern Observed

Description of the Status Situation Observed for the Person — Rating Level

- **Optimal Status.** This person appears to be in excellent physical health. The person is demonstrating excellent health status, or if he/she has a chronic condition, is attaining the best possible health status that can be expected given the health condition. The person's growth and weight are well within age-appropriate expectations. Any previous or current health concerns have been met without any adverse or lasting impact, or there is no significant health history. The person's physical care needs for nutrition, exercise, sleep, and hygiene needs are fully met. The person has a long-established relationship with a primary care physician, has a Health Home, and enjoys excellent, high quality health care services as needed. This optimal level of health and physical well-being has been evident over an enduring period of time.

  6
  ☐ Physical status
  ☐ Receipt of care

- **Good Status.** This person appears to be in generally good physical health. The person is demonstrating a good, steady health pattern, considering any chronic conditions. The person's growth and weight are generally consistent with age-appropriate expectations. Any previous or current health concerns have been met in which there may be no lasting impact, or there is no significant health history for this person/youth. The person's physical care needs for nutrition, exercise, sleep, and hygiene are being substantially met. The person has an established relationship with a primary care physician and enjoys usually good quality health care services as needed. This generally good level of health and physical well-being has been evident and sustained over a recent period of time.

  5
  ☐ Physical status
  ☐ Receipt of care

- **Fair Status.** The person appears to be in fair physical health. The person is demonstrating a minimally adequate to fair level of health status, considering any chronic conditions. The person/youth's physical health is somewhat close to normal limits for age, growth, and weight range. If existing, any previous or current health concerns are not adversely affecting functioning. The person's physical care needs for nutrition, exercise, sleep, and hygiene are being met to a minimally adequate to fair degree. The person has a just-established relationship with a primary care physician and has some health care services as needed.

  4
  ☐ Physical status
  ☐ Receipt of care

- **Marginally Inadequate Status.** The person appears to be in marginal health. The person is demonstrating a limited, inconsistent, or somewhat inadequate level of health status. Any chronic condition may be becoming more problematic than necessary. The person/youth's physical health is outside normal limits for age, growth, and weight range. If existing, any previous or current health concerns may be adversely affecting functioning. The person's physical care needs for nutrition, exercise, sleep, and hygiene may be inconsistently met. The person may not have a consistent primary care physician who is seen repeatedly for health care. The person may occasionally depend on emergency room care for acute needs. The person may rarely decline an indicated health care appointment or service.

  3
  ☐ Physical status
  ☐ Receipt of care

- **Poor Status.** The person appears to be in poor physical health and physical health is not improving. The person is demonstrating a consistently poor level of health status. Any chronic condition may be becoming more uncontrolled, possibly with presentation of acute episodes. The person/youth's physical health is significantly outside normal limits for age, growth, and weight range. If existing, any previous or current health concerns may be significantly affecting functioning. The person's physical care needs for nutrition, exercise, sleep, and hygiene may not be being met, with significant impact on functioning. The person may not have a primary care physician. The person may primarily rely on emergency room care for acute needs. The person may sometimes decline an indicated health care appointment or service.

  2
  ☐ Physical status
  ☐ Receipt of care

- **Adverse Status.** The person appears to be in poor physical health and his/her health status is declining. The person is demonstrating a poor and worsening level of health status. Any chronic condition may be increasingly uncontrolled, with presentation of acute episodes that increase health care risks. The person's physical status may be profoundly outside normal limits for age, growth, and weight ranges. If existing, any previous or current health conditions may be profoundly affecting functioning. The person's physical care needs for nutrition, exercise, sleep, and hygiene may not be being met, with the profound impact of adverse health outcomes. The person may not have health insurance. The person may avoid health care services due to his or her undocumented status, religious beliefs, or limited capacities to perceive and respond to urgent or chronic care needs. The person may avoid indicated health care appointments or services.

  1
  ☐ Physical status
  ☐ Receipt of care

Status Indicator 4: Emotional / Mental Health Status

Focus Measure

EMOTIONAL/MENTAL HEALTH STATUS: Consistent with age and ability, degree to which the person is displaying an adequate pattern of: • Presenting an affect regulation appropriate to person and situation; • Managing clinical symptoms of emotional/behavioral/thought disorders that interfere with daily activities; • Socializing and connecting with others; and, • Participating in major activities and decisions affecting the person's life.

Core Concepts: This Indicator May Not Apply to Persons Younger than 3 Years of Age

Mental health functioning and emotional well-being are essential for adequate functioning in a person's daily life settings. To do well in life, a person should:

- Present an affect pattern appropriate to time, place, person, and situation.
- Have a sense of belonging and affiliation with others rather than being isolated or alienated.
- Socialize with others in various group situations as appropriate to age and ability.
- Be capable of participating in major life activities and decisions that affect him/her.
- Be free of or reducing major clinical symptoms of emotional/behavioral/thought disorders that interfere with daily activities.
- Benefit from continuity of care between health care and mental health service providers, especially when the person has chronic health needs that must be managed concurrent with psychiatric needs.

For a person with mental health needs who requires special care, treatment, rehabilitation, or support in order to make progress toward stable and adequate functioning in daily settings, the person should be receiving necessary services and demonstrating progress toward adequate functioning in most aspects of life. Some persons may require well-coordinated health care and mental health services to be successful. Others may require income assistance or support services. Timely and adequate provision and coordination of supports and services should enable the person to benefit from treatment and make progress toward recovery.

Fact Pattern -- Apply the Probe Questions, Assemble the Facts, and Consider the Pattern Found over the Past 30 Days

1. Is the person currently presenting psychiatric symptoms or behavioral problems in daily settings? • If so, which settings and what are the problems? • What **stage of change** is this person at now with respect to recovery and relapse prevention possibilities? The stages of change are:

   - Precontemplation: no intention to change behavior; may be unaware of problems or opportunities.
   - Contemplation: is aware of problems or opportunities; thinks about acting upon it but has not made a commitment to take action.
   - Preparation: combines intention with early behaviors; planning to take action within the next month.
   - Action: activities are being undertaken to modify behavior and take advantage of opportunities with commitment of time and energy.
   - Maintenance: person works to make and consolidate gains while acting to prevent relapse or loss; may enter this stage within six months of behavior change.

2. Does the person receive treatment and rehabilitation services? • If so, are symptoms being reduced or managed? • Is the person's level of functioning improving? • Is the person learning how to cope with troublesome symptoms? • Does the person have a serious behavior problem? • If so, are maladaptive or high risk behaviors being reduced and replaced with functional behaviors?

3. Does the person present an affect pattern appropriate to time, place, person, and situation? • If not, how are mood and/or anxiety problems being addressed?

4. Is the person receiving supportive counseling and, where necessary, special assistance in daily settings consistent with his/her needs for success?

5. Does the person receive medication education? • Is this person managing his/her own medications? If so, how reliably? • Does this person resist medications? • Does he/she present any adverse side effects of medications?

***Note*:** The six statements used in the rating scale for this indicator (see below) couple a general description of emotional/behavioral functioning with the use of the *Scale for Estimating a Person's Level of Functioning* presented on page 21. These are used together when selecting a rating value.

Scale for Estimating a Person's Level of Functioning

Rate actual functioning at the time of review. Examples of behavior provided are only illustrative and are not required for a particular level of functioning. Rely on interview results obtained from the parent/caregiver; community support worker, therapist; psychiatrist; other interveners; and the person, as appropriate.

Estimating a Person's Level of Functioning

Level	Levels of Functioning to be Used by the Reviewer in Determining a Person's General Level of Functioning
10	Superior functioning in all areas (at home, at school/work, with peers, in the community); involved in a wide range of activities and has many interests (e.g., has hobbies, participates in extracurricular activities, belongs to an organized group); likable, confident; "everyday" worries never get out of hand; doing well in daily activities; getting along with others; behaving appropriately; no symptoms.
9	Good functioning in all areas: secure in family, in school/work, and with peers; there may be transient difficulties but "everyday" worries never get out of hand (e.g., mild anxiety about an important life event; occasional "blow-ups" with friends, family, or peers).
8	No more than slight impairment in functioning at home, at school/work, with peers, and in the community; some disturbance of behavior or emotional distress may be present in response to life stresses (e.g., parental separation, death, birth of a child, loss of job), but these are brief and interference with functioning is transient; such persons are only minimally disturbing to others and are not considered deviant by those who know them.
7	Some difficulty in a single area, but generally functioning pretty well (e.g., sporadic or isolated antisocial acts, such as occasionally smoking pot or minor difficulties with rule/law breaking; mood changes of brief duration; fears and anxieties that do not lead to gross avoidance behavior; self-doubts); has some meaningful interpersonal relationships; most people who do not know the person well would not consider him/her deviant but those who know him/her well might express concern.
6	Variable functioning with sporadic difficulties or symptoms in several but not all social areas; disturbance would be apparent to those who encounter the person in a dysfunctional setting or time but not to those who see the person in other settings.
5	Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area, such as might result from, for example, suicidal preoccupations and ruminations, school/work refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, poor or inappropriate social skills, isolation, frequent episodes of aggressive or other antisocial behavior with some preservation of meaningful social relationships.
4	Major impairment in functioning in several areas and unable to function in one of these areas; i.e., disturbed at home, at school/work, with peers, or in society at large; e.g., persistent aggression without clear instigation, markedly withdrawn and isolated behavior due to either thought or mood disturbance, suicidal attempts with clear lethal intent; such persons are likely to require intensive supports and/or hospitalization (but this alone is not a sufficient criterion for inclusion in this category).
3	Unable to function in almost all areas, e.g., stays at home, in a ward, or in a bed all day without taking part in social activities or severe impairment in reality testing or serious impairment in communication (e.g., sometimes incoherent or inappropriate).
2	Needs considerable supervision to prevent hurting self or others (e.g., frequently violent, repeated suicide attempts, self-injurious behavior), failure to maintain self-care routines, refusal to eat or maintain one's health, or gross impairment in all forms of communication (e.g., severe abnormalities in verbal and gestural communication, marked social aloofness, stupor, isolation).
1	Needs constant supervision (24-hour care) due to severely aggressive or self-destructive behavior or gross impairment in reality testing, communication, cognition, affect, or self-care.
0	Inadequate information.

STATUS INDICATOR 4: EMOTIONAL / MENTAL HEALTH STATUS

Status Rating Description that Best Fits the Fact Pattern Observed

Description of the Status Situation Observed for the Person — Rating Level

◆ **Optimal Mental Health Status.** The person is fully stable, maintaining, and functioning very well across settings. The person may enjoy many positive and enduring supports from a variety of people. He/she may socialize well with others in various group situations, as appropriate, to ability and preferences. He/she may be participating at a high and consistent level in major life activities and decisions that affect him/her. The person enjoys life and feels connected with others of importance in his/her life. Any co-occurring alcohol, substance use, and/or physical health concerns are fully understood and being well managed with excellent results for the person. **6** ☐

A person functioning at this level would be consistent with the Level 10 range in the *Scale for Estimating a Level of Functioning for a Person* that is presented on page 21.

◆ **Good Mental Health Status.** The person is substantially stable and functioning adequately across settings. The person may have some positive and enduring supports from a variety of people. He/she may socialize in generally acceptable ways with others in various group situations, as appropriate to ability and preferences. He/she may be participating at a substantial level in major life activities and decisions that affect him/her. Any co-occurring substance use or physical health concerns are fully understood and being well managed with excellent results for the person. Any co-occurring alcohol, substance use, and/or physical health concerns are generally understood and being managed with substantially good results for the person. **5** ☐

A person functioning at this level would be consistent with the Level 8-9 range in the *Scale for Estimating a Level of Functioning for a Person* that is presented on page 21.

◆ **Fair Mental Health Status.** The person is functioning with no more than expectable reactions to social stressors and no more than slight impairment. The person may have a few positive and enduring supports, mostly from staff or family. He/she may socialize occasionally in at least minimal ways with others in group situations, as appropriate to ability and preferences. He/she may participate at a minimal level in major life activities and decisions that affect him/her. Any co-occurring alcohol, substance use, and/or physical health concerns are somewhat understood and being managed with minimally adequate to fair results for the person. **4** ☐

A person functioning at this level would be consistent with the Level 6-7 range in the *Scale for Estimating a Level of Functioning for a Person* that is presented on page 21.

◆ **Marginally Inadequate Mental Health Status.** The person is functioning with some symptoms, limited impairments, or difficulties in social situations. The person may have a few positive and enduring relationships. He/she may socialize occasionally or inconsistently with others in group situations, as appropriate to ability and preferences. He/she may be participating at a somewhat inadequate level in major life activities and decisions that affect him/her. At this level, staff may be working diligently, but may be doing things that don't work for this person. The person may have co-occurring alcohol, substance use, and/or physical health concerns that are not well addressed in current treatment efforts. **3** ☐

A person functioning at this level would be consistent with the Level 5 range in the *Scale for Estimating a Level of Functioning for a Person* that is presented on page 21.

STATUS INDICATOR 4: EMOTIONAL / MENTAL HEALTH STATUS

Description of the Status Situation Observed for the Person — Rating Level

- **Poor Mental Health Status.** The person is functioning with moderate-to-serious symptoms or substantial difficulties in social situations. The person may have a few relationships with rare or unpleasant contacts. He/she may not socialize with others in group situations. He/she may not be participating in major life activities and decisions that affect him/her. At this level, staff may be working, but may be doing things that don't work for this person. Efforts may be substantially inconsistent across health and mental health providers. The person may have serious co-occurring alcohol, substance use, and/or physical health concerns that are poorly understood or addressed, thus, limiting current treatment efforts. **2** ☐

  A person functioning at this level would be consistent with the Level 3-4 range in the *Scale for Estimating a Level of Functioning for a Person* that is presented on page 21.

- **Adverse/Worsening Mental Health Status.** The person is functioning with serious-to-severe impairments, possibly with major life disruptions, and with potentially dangerous symptoms. The person may be socially isolated or withdrawn. He/she may not be capable of participating in major life activities and decisions that affect him/her. The person may be experiencing an absence of appropriate treatment or breakdown in coordination of treatment modalities with no continuity in care by health and mental health providers. The person may have unrecognized or ignored co-occurring alcohol, substance use, and/or physical health concerns of a serious nature that undermine current treatment efforts. **1** ☐

  A person functioning at this level would be consistent with the Level 1-2 range in the *Scale for Estimating a Level of Functioning for a Person* that is presented on page 21.

- **Not Applicable.** The person may be younger than 3 years of age. **NA** ☐

Status Indicator 5: Substance Use Status

Focus Measure

SUBSTANCE USE STATUS. Degree to which the person is achieving and maintaining a life free from substance use impairment.

Core Concepts: This Indicator May Not Apply to Persons Under 8 Years of Age

While any alcohol or substance use is problematic and warrants attention, there are varying degrees and types of substance use resulting in subsequent life impairment. **Substance is defined** as an illicit substance, misuse of over-the-counter medications, misuse of prescribed medications, and/or misuse of chemicals, including misuse of alcohol. Individuals with substance use disorders often have impaired parenting abilities and social skills. Early identification and treatment of substance use disorders will contribute to improved functioning and positive outcomes.

Impairment arising from substance use poses potential harm to physical and emotional well-being. If using substances, the person should be making reasonable progress toward recognizing problems with substance use, increasing motivation to "take charge" of reducing their own substance use, lowering the impairment and risks associated with substance use, and decreasing the use of substances. Recovery efforts may involve active treatment (e.g., medication and/or psycho-social intervention), participation in support groups, changing daily activity patterns and social connections, moving to another area away from sources of addictive substances, and creating an environment (physical and social) that is supportive of recovery efforts. This review focuses on the person's pattern of substance use and reliance on supports for recovery. This indicator is **applicable only to persons who have histories of substance use impairment**. This indicator does not apply to a person who has no history of substance use impairment.

Fact Pattern -- Apply the Probe Questions, Assemble the Facts, and Consider the Pattern Found

1. Has the person been screened for substance use disorder? • If yes, what methods are being used? • What are the screening results over the past six months for this person?

2. Is there any alcohol or substance use by the person? • Does the person have a substance use disorder? • If so, what impairments has the disorder caused for the person? • If yes, what type of substance is used, what method is used, how often is the substance used, and what are the consequent life problems? • When was the person's last relapse? • What is the person's pattern of relapse episodes?

3. Is the climate in the home/community supportive of treatment and recovery efforts? • Is the person using substances in isolation, with family, or with a peer group?

4. Is substance use related to other high risk behaviors (needle sharing, sexual activity, DUI, etc.)?

5. Is substance use causing functional impairment (problems with family, peers, or citizens in the community, or difficulty with employment)? • Does the individual recognize the impact of his/her use/abuse of substance? • Has substance use led to criminal activity or involvement with police or courts? • If yes, what is this person's current legal status?

6. What level of motivation does the person have for obtaining/maintaining a substance-free lifestyle? • What **stage of change** is this person operating at now with respect to recovery and relapse prevention possibilities?

   Stages of Change:

   - Precontemplation: no intention to change behavior; may be unaware of problems or opportunities.
   - Contemplation: is aware of problems or opportunities; thinks about acting upon it but has not made a commitment to take action.
   - Preparation: combines intention with early behaviors; planning to take action within the next month.
   - Action: activities are being undertaken to modify behavior and take advantage of opportunities with commitment of time and energy.
   - Maintenance: person works to make and consolidate gains while acting to prevent relapse or loss; may enter this stage within six months of behavior change.

7. Is the person currently receiving treatment for substance use? • Has the person needed and/or received treatment for substance use within the past year?

STATUS INDICATOR 5: SUBSTANCE USE STATUS

8. If treatment for substance use has been received and completed, has relapse presented as a problem? • If so, how often? • Is relapse prevention being pursued?

9. Is this person parenting dependent children? • If so, are these children under protective supervision or out-of-home care (e.g., kinship care or foster care) by the child welfare system? • If so, is the person's recovery and relapse prevention strategies and plans being coordinated with the safe reunification efforts and child/family safety plans being made by the child welfare agency so that this person may get his/her children back home again?

Status Rating Description that Best Fits the Fact Pattern Observed

NOTE: The time periods used on the rating scales for levels 6, 5, and 4 differ from the 30-day rating rule applied in most status indicators.

Description of the Status Situation Observed for the Person	Rating Level
◆ **Optimal Status.** The person is fully free from substance use impairment at this time. If the person has experienced substance use impairment in the past, the person has gone for at least 12 months without relapse. The social climate in the home and support network is fully supportive of recovery efforts. The person enjoys life and feels connected with others of importance in his/her life. Any co-occurring mental health or physical health concerns are fully understood and being well managed with excellent results for the person.	**6** ☐
◆ **Good Status.** The person is generally free from substance use impairment at this time. If the person has experienced substance use impairment in the past, the person has gone for at least six months without relapse. The social climate in the home and support network is generally supportive of recovery efforts. Any co-occurring mental health or physical health concerns are generally understood and being managed with substantially good results for the person.	**5** ☐
◆ **Fair Status.** The person may have had recent substance use, but impairment is substantially reduced or limited and daily functioning is at a minimally adequate level. The person may be actively participating in an appropriate treatment program. The person may be showing progress in treatment. The social climate in the home and support network is somewhat supportive of recovery efforts. Any co-occurring mental health or physical health concerns are somewhat understood and being managed with minimally adequate to fair results for the person.	**4** ☐
◆ **Marginally Inadequate Status.** The person has mild to moderate substance use impairment that may result in some negative consequences or adversely affect functioning in daily settings. The person may be receiving treatment but may be making little progress. The social climate in the home and support network may not be very supportive of recovery efforts. The person has co-occurring mental health or physical health concerns that are not very well addressed.	**3** ☐
◆ **Poor Status.** The person may have an established pattern of substantial and continuing substance use impairment. The person has moderate to serious substance use that results in very negative consequences and/or substantial functioning limitations. The person may be continuing to use substances and may not be making progress in a treatment program. The social climate in the home may substantially undermine recovery efforts. The person's support network is not functioning or there is no network in place for this person. The person has co-occurring mental health or physical health concerns that are poorly understood or addressed in present treatment efforts.	**2** ☐
◆ **Adverse Status.** The person has serious and worsening substance use impairment. The person has serious life-threatening substance use patterns that result in significant negative consequences and/or major functional limitations and may cause restriction in an institutional setting. The person's substance use is worsening. The social climate around the person may actively support continued substance use and possibly other illegal activities. The person has serious co-occurring mental health or physical health concerns that undermine other treatment efforts.	**1** ☐
◆ **Not Applicable.** The person does not have a history of alcohol or substance use impairment or may be younger than 8 years of age. This indicator does not apply at this time.	**NA** ☐

Status Indicator 6: Spiritual Well-Being

Focus Measure

SPIRITUAL WELL-BEING. Degree to which: • The person has a positive guiding force for purpose and direction in life; • The person relies on positive spiritual beliefs and supports to provide comfort and encouragement in times of difficulty, despair, and challenge, while bringing hope and faith to seemingly hopelessness situations; • In times of stress and worry, the person has positive sources for spiritual strength and emotional protection that enable the person to cope with fear, guilt, shame, loss, and gain courage to meet life challenges; • The person belongs to and participates in group activities that support spiritual growth and well-being of members.

Core Concepts: This Indicator May Not Apply to Persons Under 12 Years of Age

Spiritual well-being is about our inner life and its relationship with the wider world. It includes our relationship with the environment, our relationships with others and with ourselves. Spiritual well-being does not just reflect religious belief although for people of a religious faith it is obviously a central feature. Each person's spirituality is greatly influenced by the community they are a part of and their relationships. To be spiritually healthy will mean a positive engagement with self, others, and our environment. Some of the benefits of spiritual well-being include:

- Feeling a purpose and meaning in life
- Maintaining balance and control of life
- Experiencing a connection with a power greater than oneself
- Feeling peaceful and content with life
- Building positive and spiritually supportive relationships
- Accepting and growing from the challenges and changes in life

Because spiritual well-being is personal, different people will find some approaches or factors more helpful than others; however, some of the things that can help spiritual well-being are: Spending time alone or in meditation to find inner peace; Taking time to enjoy nature; Attending a local place of worship for prayer, meditation, devotion, or healing; Joining a group, club, or society which shares your spiritual or religious outlook; Meeting regularly with someone who can help you reflect on your life and your spirituality. Sources of spiritual support offer the person a sense of hope, strength, relief, and protection in times of stress, grief, or loss.

Spiritual support should enable the person to cope with possible life-disruptive events or emotions. Spiritual inspiration and encouragement may be needed to face major life challenges (e.g., overcoming an addiction or escaping a dangerous relationship) while providing guidance, support, empowerment for action in changing the direction of one's life. Finding release from guilt or anger through forgiveness and spiritual healing can be fundamental to finding a sense of peace in one's life. Relying on trust and hope that accompany connection to a spiritual path can console persons during times of loneliness, sadness, and despair. These aspects of spiritual well-being come, in part, through connection to and support from sources of spiritual strength and guidance. A central concern in this indicator is that the spiritual direction, care, and support needs of the person are met leading to a sense of inner peace and contentment arising from the person's relationships with the spiritual aspects of life.

Fact Pattern -- Apply the Probe Questions, Assemble the Facts, and Consider the Pattern Found over the Past 30 Days

1. Does the person report having strong, positive feelings of purpose, direction, and meaning in life? • Does the person report having a feeling of inner peace and contentment with life? • If so, what are the person's sources for spiritual well-being in these areas? • How well does the person find release and relief from guilt or anger through forgiveness and spiritual healing fundamental to finding a sense of peace in one's life?

2. Does the person report being able to achieve and maintain sense of balance and control in life? • Is the person routinely spending time alone or in meditation to find inner peace? • How does the person find inspiration and encouragement that may be needed to face a major life challenge (e.g., overcoming an addiction or escaping a dangerous relationship)?

3. Does the person report having and enjoying positive relationships with others in his or her life? • What resources does the person rely upon in achieving positive regards and interactions with others, especially any with home there is a history of difficult interactions or negative feelings?

4. Does the person report: • Attending a local place of worship for prayer, meditation, devotion, or purification? • Joining a group, club, or society which shares your spiritual or religious outlook? • Meeting regularly with someone who can help reflect on the person's life and spiritual journey?

5. Does this person require assistance or support in participating in spiritual or religious practices? • If so, does the person have the assistance and supports (including transportation) available to participate in and benefit from those practices? • If not, how does the absence of assistance or support impact the person's spiritual well-being?

STATUS INDICATOR 6: SPIRITUAL WELL-BEING

Status Rating Description that Best Fits the Fact Pattern Observed

Description of the Status Situation Observed for the Person — Rating Level

- **Optimal Status**. The person reports experiencing excellent spiritual well-being. The person has a strong, positive sense of purpose and direction in life. The person's very strong faith and positive pattern of beliefs provide excellent protection, comfort, and support in times of trouble or worry. The person participates daily in actions (e.g., prayer, meditation, 12-step meetings) that promote spiritual healing, growth, and well-being. All accommodations necessary to achieve and maintain optimal spiritual well-being are available to the person. — **6** ☐

- **Good Status.** The person reports experiencing substantially good spiritual well-being. The person has a substantially positive sense of purpose and direction in life. The person's generally strong faith and positive pattern of beliefs provide substantial protection, comfort, and support in times of trouble or worry. The person participates regularly in actions (e.g., prayer, meditation, 12-step meetings) that promote spiritual healing, growth, and well-being. Most accommodations necessary to achieve and maintain good spiritual well-being are available to the person. — **5** ☐

- **Fair Status.** The person reports experiencing a fair level of spiritual well-being. The person has a fairly positive sense of purpose and direction in life. The person's faith and usually positive pattern of beliefs provide a fair degree of protection, comfort, and support in times of trouble or worry. The person periodically participates in actions (e.g., prayer, meditation, 12-step meetings) that promote spiritual healing, growth, and well-being. Many accommodations necessary to achieve and maintain good spiritual well-being are available to the person. — **4** ☐

- **Marginally Inadequate Status.** The person reports experiencing a somewhat limited or inconsistent level of spiritual well-being. The person has a marginally inadequate or inconsistent sense of purpose and direction in life. The person's faith and marginally positive pattern of beliefs provide somewhat inadequate or inconsistent protection, comfort, and support in times of trouble or worry. The person may occasionally participate in actions (e.g., prayer, meditation, 12-step meetings) that promote spiritual healing, growth, and well-being. Some accommodations necessary to achieve and maintain minimally adequate spiritual well-being may be available to the person. — **3** ☐

- **Poor Status.** The person reports experiencing a poor level of spiritual well-being. The person often lacks a sense of purpose and direction in life. The person's lack of faith and generally negative pattern of beliefs often fail to provide protection, comfort, and support in times of trouble or worry. The person may seldom participate in actions (e.g., prayer, meditation, 12-step meetings) that promote spiritual healing, growth, and well-being. Few accommodations necessary to achieve and maintain minimally adequate spiritual well-being may be available to the person or the person may not use those available. — **2** ☐

- **Adverse or Avoidant Status.** The person may desire positive spiritual well-being by may avoid opportunities offered to achieve spiritual well-being. The person may wish for a better life but lacks a positive sense of purpose and direction in life. The person may hold to negative pattern of beliefs that exacerbates worries in times of trouble. The person may avoid actions (e.g., prayer, meditation, 12-step meetings) that promote spiritual healing, growth, and well-being. Accommodations necessary to achieve and maintain spiritual well-being may not be available to the person or the person may not use those available. — **1** ☐

- **Not Applicable.** The person may be younger than 12 years of age - OR - rejects the premise of spiritual well-being - OR - does not seek connection with a spiritual source or religious community at the present time. — **NA** ☐

Status Indicator 7: Functional Status

Focus Measure

FUNCTIONAL STATUS. Degree to which the person, based on need and choice, is actively acquiring and/or using acquired functional life skills necessary for successful daily living.

Core Concepts

For some persons seeking recovery from a mental illness or substance use disorder, gaining and using functional life skills in everyday life situations are both needs and aspirations. Among persons having these needs are those who may have intellectual disabilities arising from developmental delay or traumatic brain injury while others may experience functional challenges due to the effects of schizophrenia, long-term drug use, or aging. This indicator focuses on the degree to which the person is seeking and receiving skill-specific training and support to acquire, apply, and sustain functional life skills in daily living situations. Such life skills can be learned via direct instruction provided by a community support worker or formal instruction provided in a classroom setting.

Functional life skills include activities of daily living (ADLs). At the most basic level, such skills apply to dressing, eating, ambulation, toileting, and hygiene. At the next level, these skills apply to housekeeping, taking medications as prescribed, basic money management, shopping for food and clothing, using the phone and other forms of communication, and using transportation in the community. Higher level functional skills apply to care of pets, care of others, child rearing, food preparation and clean-up, financial management, safety procedures, and emergency responses. Skills in these areas are needed for successful everyday living and fulfilling important life roles, such as parenting dependent children or adults in the person's care.

Training and supports for skill acquisition and integration are ways that people gain and use functional skills in daily life. Subject to ability, need, choice, and support, a person seeking functional skill development should be able to access learning activities available within the community via special education, adult basic education, developmental disability services, and/or community support services provided by a Core Service Agency. Advocacy by a community support worker, social worker, or counselor may be necessary to secure opportunities and accommodations for an adult with mental illness or substance use impairment who meets enrollment criteria and who chooses to gain and use functional skills in daily living.

The focus of this indicator is placed upon the person's learning opportunities for gaining functional life skills as available within the community and/or treatment setting. Concerns in this review include whether the person: (1) is aware of learning opportunities; (2) gains skills coached by a community support worker; (3) is assisted in enrollment and securing accommodations, if eligible and interested; and/or (4) is participating with any special supports or services that may be necessary for the person's success. This review is not applicable for persons who, by choice, are not currently seeking and participating in such activities. Consideration of the person's **stage of change** would be useful in understanding a person's refusal of opportunities.

Fact Pattern -- Apply the Probe Questions, Assemble the Facts, and Consider the Pattern Found over the Past 30 Days

1. Does this person demonstrate a need for and interest in gaining functional skills in everyday life situations? • Is the person gaining functional skills via modeling, coaching, and mentoring efforts provided by the person's community support worker?

2. Is the person aware of the learning activities and opportunities currently available in his/her community and/or treatment setting? • Is the person currently accessing and participating in a community learning activity? • If so, what advocacy, support, or special accommodations are being provided to this person? • Does the person meet enrollment requirements to participate in and benefit from learning activities in the community that are of interest to the person? • If given assistance or support, would this person be interested and willing to continue his/her education? • Does this person need educational advocacy to gain access to learning activities, with special accommodations as necessary for participation and success? • If so, has educational advocacy been offered or provided to this person?

3. Does this person's life situation (e.g., parent of a newborn infant, hospitalized, or elderly) or current work schedule prevent the person from pursuing learning opportunities at this time? • Has this person been offered educational opportunities recently but declined participation? • At what **stage of change** is this person now operating?

Stages of Change:

- Precontemplation: no intention to change behavior; may be unaware of problems or opportunities.
- Contemplation: is aware of problems or opportunities; thinks about acting upon it but has not made a commitment to take action.
- Preparation: combines intention with early behaviors; planning to take action within the next month.
- Action: activities are being undertaken to modify behavior and take advantage of opportunities with commitment of time and energy.
- Maintenance: person works to make and consolidate gains while acting to prevent relapse or loss; may enter this stage within six months of behavior change.

STATUS INDICATOR 7: FUNCTIONAL STATUS

Status Rating Description that Best Fits the Fact Pattern Observed

Description of the Status Situation Observed for the Person — Rating Level

- **Optimal Functional Learning Status.** The person has high aspirations and goals to gain and use functional skills in daily living situations. The person is fully and successfully engaged in learning activities (e.g., community support services provided by a Core Service Agency, adult basic education, developmental disability services) for gaining functional skills. The person is making excellent use of the learning opportunities available and participates fully in those opportunities. Any barriers to participation encountered have been fully overcome. **6** ☐

- **Good Functional Learning Status.** The person has many aspirations and goals to gain and use functional skills in daily living situations. The person is actively and substantially engaged in learning activities (e.g., community support services provided by a Core Service Agency, adult basic education, developmental disability services) for gaining functional skills. The person is making consistent and substantial use of the learning opportunities available and participates reliably in those opportunities. Any barriers to participation encountered have been substantially overcome. **5** ☐

- **Fair Functional Learning Status.** The person has some aspirations and goals to gain and use functional skills in daily living situations. The person is somewhat engaged in learning activities (e.g., community support services provided by a Core Service Agency, adult basic education, developmental disability services) for gaining functional skills. The person is making minimally adequate to fair use of the learning opportunities available and participates regularly in those opportunities. Any barriers to participation encountered have been recognized and reduced to support participation. **4** ☐

- **Marginally Inadequate Functional Learning Status.** The person has some aspirations and goals to gain and use functional skills in daily living situations. The person is occasionally engaged in relevant learning activities. The person is making limited or inconsistent use of the learning opportunities available and participates occasionally in those opportunities. Any barriers to participation encountered may have been recognized but some problems of access or participation may remain. A somewhat limited, inconsistent, or inadequate pattern of participation is evident. **3** ☐

- **Poor Functional Learning Status.** The person has some aspirations and goals to gain and use functional skills in daily living situations. The person is poorly or inconsistently engaged in learning opportunities. The person may be experiencing ongoing barriers to gaining and using even a few functional skills in real life situations. **2** ☐

- **Absent Functional Learning Opportunity.** The person has some aspirations and goals to gain and use functional skills in daily living situations. The person is not engaged in learning activities. The person may be experiencing unresolved barriers in accessing learning opportunities or barriers to participation in available learning opportunities. **1** ☐

- **Not Applicable. EITHER:** The person has adequate functional life skills that are used in daily living situations and does not need further skill development. **- OR -** The person made an informed choice not to participate at this time. **- OR -** The person may have a condition or situation that would prevent participation at this time (e.g., serious illness, incarceration, physical disability, or advanced age—frail elderly). **NA** ☐

Status Indicator 8: Voice & Choice / Self-Directed Care

Focus Measure

VOICE & CHOICE / SELF-DIRECTED CARE. Degree to which: • The person is an active ongoing participant (e.g., having a significant role, voice, and influence) in decisions made about wellness and recovery goals, intervention strategies, services, and results; • For a willing and able adult, the person is actively directing some or all aspects of the care being provided.

Core Concepts

Role, Voice, Choice. The appropriateness of Role, Voice, and Choice is determined by consideration of the person's cognitive ability and present capacity for self-agency. The person should be a full and effective partner on the team of service providers, fully participating in all aspects of assessment, service planning, implementation, monitoring, and evaluation of results. Ownership, leadership, full participation, commitment, and follow-through by the person are essential to creating a workable and effective change process for him/her. The person should have an active role in developing goals and objectives, as well as in the development and implementation of plans. His/her role includes, but is not limited to:

- Knowing and explaining his/her strengths, needs, preferences, and challenges so that others may understand and assist.
- Understanding, accepting, and working toward any non-negotiable conditions that are essential for safety and well-being.
- Attending team meetings and shaping key decisions about goals, intervention strategies, special services, and essential supports.
- Advocating for needs, supports, and services.
- Self-directing care, when possible and appropriate, and doing whatever things are necessary to follow through on interventions.

Self-Directed Care. Self-directed Medicaid services means that participants, or their representatives if applicable, have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports. The self-directed service delivery model is an alternative to traditionally delivered and managed services, such as an agency delivery model. Self-direction of services allows participants to have the responsibility for managing all aspects of service delivery in a person-centered planning process. Self-direction promotes personal choice and control over the delivery of waiver and state plan services, including who provides the services and how services are provided. For example, participants are afforded the decision-making authority to recruit, hire, train and supervise the individuals who furnish their services.

Fact Pattern -- Apply the Probe Questions, Assemble the Facts, and Consider the Pattern Found over the Past 30 Days

1. To what degree is the person in control of the intervention/change process? • Does the person want an active role and voice in decisions?

2. How well is the person fulfilling a lead role in advocating for needs, supports, and services? • If a caregiver is representing the needs of the person, how was this person selected? • Can the caregiver speak freely and express his/her wants and needs? • Do others listen?

3. At what level is the person's voice heard and used to influence key decisions? • Does the person understand and accept any non-negotiable requirements or conditions necessary for safety and well-being?

4. How often does the person attend team meetings and other activities in which care and treatment is being planned?

5. Are there factors that substantially and repeatedly prevent or reduce the caregiver's opportunity or ability to function as an advocate? • If so, what are these factors? • What supports are provided to enhance the caregiver's role and voice in decisions?

6. If there are factors that substantially and repeatedly impede the caregiver's opportunity or ability to function effectively in matters related to the person's service needs, has agency staff offered special accommodations or supports to the caregiver to facilitate his/her effective participation? • If so, have they been accepted by the caregiver and has this improved his/her participation? • If accommodations or supports have not been offered, why not?

7. Is the person an able and willing adult who choses to direct his or her own care? • If so, in what ways is the person presently directing his or her own care and treatment? • What aspects of care is the person currently managing? • Is it effective? • Is the person satisfied with the results?

Status Indicator 8: Voice & Choice / Self-Directed Care

Status Rating Description that Best Fits the Fact Pattern Observed

Description of the Person's Role in Decision Making Affecting the Person's Life and Service Situation	Rating Level
◆ **Optimal Status.** The person is a full and effective partner on the team of service providers, fully participating in all aspects of assessment, service planning, implementation, monitoring, and evaluation of results. The person (as appropriate) has a central and directive role, providing a voice that shapes the course and pace of decisions. Where appropriate, the person is highly effective in self-directed care activities and in achieving desired results and benefits.	6 ☐
◆ **Good Status.** The person is a substantial contributing partner on the team of service providers, generally participating in most aspects of assessment, service planning, implementation, monitoring, and evaluation of results. The person (as appropriate) has a present and effective role, providing a voice that influences the course and pace of decisions made by the team. Where appropriate, the person is substantially effective in self-directed care activities and achieving desired results and benefits.	5 ☐
◆ **Fair Status.** The person minimally participates in some aspects of team decision making, assessment, service planning, implementation, monitoring, and evaluation of results. The person (as appropriate) has a minimally effective role, providing a voice that suggests and affirms the course and pace of decisions made by the team. Where appropriate, the person is somewhat effective in self-directed care activities and in achieving desired results and benefits.	4 ☐
◆ **Marginally Inadequate Status.** The person is a limited or inconsistent participant in a few aspects of assessment, service planning, implementation, monitoring, and evaluation of results. The person may have limiting circumstances, may not have been offered accommodations or supports, or may not wish greater participation even when offered accommodations or assistance. The person (as appropriate) has a marginal role, providing a somewhat passive voice that acknowledges or accepts the course and pace of decisions made by the team of service providers. Where appropriate, the person is somewhat less than effective in self-directed care activities and in achieving desired results and benefits.	3 ☐
◆ **Poor Status.** The person seldom participates in any aspects of assessment, service planning, implementation, monitoring, and evaluation of results. The person may have challenging circumstances, may not have been offered acceptable accommodations or supports, or may not wish greater participation even when offered accommodations or assistance. The person (as appropriate) has a missing or silent role and a missing or passive voice that tacitly accepts or possibly rejects the course and pace of decisions made by the team of service providers. Where appropriate, the person is not effective in self-directed care activities and in achieving desired results and benefits.	2 ☐
◆ **Adverse Status.** The person has not participated in any aspects of assessment, service planning, implementation, monitoring, and evaluation of results within the past six months or since the last team meeting (whichever is the more recent time event). The person may be experiencing overwhelming life circumstances, without the benefit of special accommodations for support or participation. Where appropriate, the person is woefully ineffective in self-directed care activities and in achieving desired results and benefits. *Note: If the person requires an advocate but does not have an advocate, then the person would be considered to be without a role or voice in decisions being made about him/her.*	1 ☐
◆ **Not Applicable.** The person may not be able to exercise voice and choice at this time due the person's present physical or mental status or current situation (e.g., hospitalization or incarceration).	NA ☐

Status Indicator 9: Financial Security & Personal Management

Focus Measure

ECONOMIC SECURITY & PERSONAL MANAGEMENT. Degree to which: • The person's earned income and economic supports are sufficient to cover basic living requirements (i.e., shelter, food, clothing, transportation, health care/medicine, leisure, childcare). • The person is accessing, receiving, and managing the economic benefits for which he/she is eligible. • The person has economic security sufficient for maintaining stability and for sustaining the ability to meet ongoing life needs.

Core Concepts: This Indicator May Not Apply to Persons Under Age 18 Years of Age

Adults aspire to have adequate income and personal management of their finances. Income may be earned or come from other sources. A person with a serious and persistent mental illness may earn income and/or be entitled to a variety of economic benefits and sources of income. Among these are Social Security Income (SSI or SSDI, SSDAC) VA benefits, Medicaid, HUD housing subsidy, food stamps, subsidized childcare, Temporary Assistance to Needy Families (TANF), and possibly other economic supports, depending on eligibility and need. Such economic supports are intended to cover basic living requirements and other necessities for daily living, childcare (as appropriate), and competitive, integrated employment (a setting typically found in the community in which individuals with disabilities interact with non-disabled individuals). Together, these sources of income and support should provide a level of economic security that enables a person to achieve and maintain a reasonable degree of stability in his/her living situation. Stability in income, housing, nutrition, and health care provides a foundation for effective future life planning for the person.

A person living with mental illness or getting help for a substance use disorder may require assistance from knowledgeable persons in securing benefits to which he/she is entitled. Such assistance may be provided by a case manager or community support worker via a helping agency serving the person. General expectations in this review concerning the status of the person and practice in his/her case are that: (1) to the greatest extent possible, the person is earning income and controlling his/her assets; (2) the person has been/is being assisted in accessing all sources of income and economic security to which the person is entitled, (3) follow-up activities are conducted to ensure that the person is continuing to access the full array of benefits to which the person is entitled, (4) assessments are made to determine that economic supports are adequate to cover the person's basic living requirements, (5) advocacy is undertaken to address any important unmet needs, and (6) the person has a reasonable degree of economic security sufficient to achieve and maintain stability in conditions of daily living. The focus in this review is placed on the person's current status of income adequacy to meet needs and degree of control over his/her money and other assets.

Fact Pattern -- Apply the Probe Questions, Assemble the Facts, and Consider the Pattern Found over the Past 30 Days

1. What are this person's basic living requirements (e.g., shelter, food, clothing, health care, medications) and other necessities of daily living (e.g., transportation, childcare, education, or employment-related necessities)? • To what degree are these requirements and needs currently met?

2. Does this person have dependent children in his/her care? • What is this person's current earned income? • For what types of economic assistance is this person/family eligible? • What other agencies are involved in providing services and supports to this person/family? • What economic assistance is being provided by other agencies?

3. Are the person's basic living requirements, medications, and other necessities known and understood by the community support worker, therapist, or counselor who is coordinating services for this person? • What assessment, follow-up, and advocacy has the staff done on behalf of this person? • Are the person's resources sufficient for future planning?

4. How effective are current efforts in securing the economic and support resources for meeting this person's basic living requirements and other necessities of daily living? • Does this person have a degree of economic security sufficient to achieve and maintain stability in conditions of daily living for him/herself and for any children in his/her care? • Is economic security adequate for maintaining stability and supporting life planning?

5. Has this person lost housing, child custody, or employment due to the lack of income or the ability to meet basic living requirements or other necessities of daily living? • What steps are being taken, if necessary, to prevent future disruptions (e.g., eviction) and/or to achieve stable living conditions for this person/family? • If continued instability is present, is it caused by unresolved income and economic security issues? • If so, what steps are being taken to resolve these matters (e.g., creative assistance in managing limited funds)?

6. What degree of personal control does this person exercise over his/her resources? • Does the person have or need a representative payee or guardian? • If so, what degree of decision making about use of funds is directed by the person and in what areas of decision making does the person exercise a degree of voice and choice? [Shared decision making is possible if a person has a representative payee or guardian.]

Status Indicator 9: Financial Security & Personal Management

Status Rating Description that Best Fits the Fact Pattern Observed

Description of the Status Situation Observed for the Person — Rating Level

- **Optimal Financial Security and Personal Management**. The person is earning income and/or accessing and receiving all benefits to which he/she is entitled. Income and economic supports are sufficient to cover basic living requirements and other necessities. The level of economic security is excellent when the amount and source of funds are considered. There is no recent history of loss of income or benefits. The person may control funds. The person's resources may be more than adequate as well as sufficiently stable for optimal and effective future planning. With or without a representative payee the person directs the use of his or her fund and has a strong pattern of self-management and successful decision making.

6
☐ Sufficiency
☐ Management

- **Good Financial Security and Personal Management** The person is earning income and/or accessing and receiving most economic benefits to which he/she is entitled. Income and economic supports are generally sufficient to cover basic living requirements for the most part or except in extreme emergencies. The level of economic security is sufficient for maintaining stability. The person may control most of the funds most of the time. The person's resources may be substantially adequate as well as generally stable for reliable future planning. The person may direct use of assets with help from a representative payee.

5
☐ Sufficiency
☐ Management

- **Fair Financial Security and Personal Management.** The person is earning income and/or accessing and receiving some economic benefits to which he/she is entitled. Income and economic supports are minimally sufficient to cover basic living requirements and other necessities of daily living. The level of economic security is minimal for maintaining stability. The person may control some of the funds at least some of the time. The person's resources may be minimally adequate and somewhat stable for future planning. The person may collaborate with a representative payee in planning the use of personal funds.

4
☐ Sufficiency
☐ Management

- **Marginally Inadequate Financial Security and Personal Management.** The person is earning limited income and/or accessing and receiving limited economic benefits to which he/she is entitled. Income and economic supports are somewhat inadequate in meeting basic living requirements and other necessities of daily living. The level of economic security is not sufficient for maintaining stability. Economic inadequacies causing disruptions may have occurred in the recent past and the risk of future disruption may be present. Causes of economic disruption are known, but solutions have not been found. The person may have limited control over funds. The person's resources may be somewhat inadequate and inconsistent for future planning. A representative payee may make some decisions with only limited collaboration with the person.

3
☐ Sufficiency
☐ Management

- **Poor Financial and Personal Management.** The person has substantial problems of economic security and is not receiving the range of economic benefits to which he/she is entitled. Current economic security is insufficient for maintaining stability. Causes of economic disruption are known and present but are not adequately or realistically addressed in current plans or remedial actions are not being implemented on a timely and competent basis. The person may have little, if any, control over even a small portion of the funds. The person's resources may be substantially inadequate now and uncertain for future planning. A representative payee may make most key decisions with little or no consultation with the person.

2
☐ Sufficiency
☐ Management

- **Adverse Financial Security and Personal Management.** The person has serious and worsening problems of economic security. Because he/she is not receiving entitled benefits, the person is experiencing serious but avoidable hardships and life disruptions (e.g., eviction, loss of children, unemployment). Life disruptions may be continuing. Causes of economic disruption may be complex or not adequately understood or not realistically addressed with current casework or supportive services at this time. The person's resources may be grossly inadequate now and uncertain for future planning. The person has no control over any of the funds.

1
☐ Sufficiency
☐ Management

- **Not Applicable.** Due to present circumstances, the person may not have the capacity or opportunity to manage his or her income and resources. Such circumstances may include status as minor, hospitalization, incarceration, or guardianship.

NA
☐ Management

Status Indicator 10: Living Arrangement

Focus Measure

LIVING SITUATION. Degree to which:

- **APPROPRIATENESS. The person is living in the most appropriate and least restrictive living arrangement that is consistent with his/her physical and emotional needs, language and culture, life stage, ability level, and support for recovery.**

- **STABILITY. The living arrangement is consistent with the person's preference, enduring and free from disruption, and provides continuity in daily routines, normal rhythms of life, and relationships supportive of recovery.**

Core Concepts: This Indicator May Not Apply to Persons in Secure Confinement

This indicator applies to the person's present living arrangement and to any other home setting where he/she may be staying periodically. "Home" refers to a place where the person has lived for an extended period of time, and includes not merely the immediate physical dwelling in which a person resides, but also the larger community. The community often provides a basis for identity, culture, sense of belonging, and connections with other people and things that provide meaning and purpose to life. The concept of home represents both practical and emotional elements. The reviewer should consider the appropriateness of various aspects of the person's home, including the:

- Physical environment, including furniture, sanitation, and utilities.
- Emotional environment, including the degree to which the home is perceived as a place of comfort and safety.
- Relationships in the home, including the presence and/or absence of persons that contribute to the well-being of the individual.
- Community, including the immediate vicinity of the home and the larger social and cultural network in which the home is situated.

If the person has a disability or is in temporary out-of-home care, consider whether or not the living situation places any unnecessary restrictions on his/her independence and autonomy, as appropriate to age and ability. For a person in out-of-home care, the living arrangement can be a group home, a residential treatment or medical facility, a long-term care unit, detention facility, or any other type of congregate service setting. Having special needs may require temporary services in a therapeutic setting, which should be the least restrictive, most appropriate, and inclusive living arrangement necessary to meet the person's needs and support recovery. Additionally, to thrive and enjoy a satisfactory living situation, the person should achieve and maintain stability. Stability (i.e., freedom from disruption) applies to the consistency, dependability, and continuity in daily activities, routines, rhythms of life, and relationships that contribute positive and enduring conditions for daily living.

Fact Pattern -- Apply the Probe Questions, Assemble the Facts, and Consider the Pattern Found over the Past 30 Days

1. Is the person living in his/her own home or in the home of his/her family? • If not, does the living arrangement facilitate connections to his/her culture, community, faith, extended family, and social relationships? • Do these social relationships support the person's recovery?

2. Is the individual's home an appropriate environment for daily living, which meets any of the special needs that he/she might have? • If applicable, are caregivers able to meet the individual's needs for care and nurturing? • If the individual has special needs, do caregiver(s) have the capacity/supports necessary to address those special needs?

3. If the person is in a temporary out-of-home living arrangement, the following points should be considered in determining the appropriateness of the setting:

   - Is the person living close to friends and family members? Is this home consistent with the individual's language and culture?
   - Does the placement provide continuity in connections to home, work, extended family, and/or culture?
   - Is the placement conducive to maintaining family connections and does the out-of-home caregiver support these activities?
   - Does the person feel safe and well cared for in this setting?
   - Does the out-of-home caregiver encourage the person to participate in activities that are appropriate to his/her age and abilities (i.e., sports, creative activities), and support his/her need to socialize with others?
   - Is there a service plan in place that includes strategies for assisting the person with obtaining an appropriate permanent home?
   - How well does this setting meet near-term needs while supporting long-term recovery?

STATUS INDICATOR 10: LIVING ARRANGEMENT

4. If the person is living in a group care or residential care center, the reviewer should consider the following:

   - Does the person feel safe and well cared for in this setting?
   - Is this the least restrictive and most inclusive setting available to meet the person's needs?
   - Does the placement provide for the appropriate level of supervision, supports, and therapeutic services that are supportive of recovery?
   - Does the placement provide for family/friendship connections and linkages to the community? If the person is placed away from his/her own home, was this placement necessary to provide a specialized service that might have been appropriately provided in the home or a more community-based environment?

5. How long has the person remained in the same living arrangement? • To what extent has he/she achieved and maintained an adequate and stable home and living arrangement? • If the person has experienced a recent pattern of moves or instabilities in his/her living arrangement, is this disruptive pattern likely to continue in the near-term future? • If instability in the person's living arrangement is evident, what are the primary factors leading to disruptions?

Status Rating Description that Best Fits the Fact Pattern Observed

NOTE: The time periods used on the rating scales for levels 6, 5, and 4 differ from the 30-day rating rule applied in most status indicators.

Description of the Status Situation Observed.	Rating Level
◆ **Optimal Living Situation.** The person is living in the most appropriate setting to address his/her needs and support family connections. The setting is optimal for his/her age, ability, culture, language, and faith-based practices. Additionally, if the person is in a group home or residential care center, he/she is in the least restrictive environment necessary to address his/her needs. The person has had a stable living arrangement free of disruption for at least twelve months. Chances of disruption over the next twelve months appear remote.	**6** ☐ Approp. ☐ Stability
◆ **Good Living Situation.** The person is living in a setting that substantially meets his/her needs and supports family connections. The setting is consistent with his/her age, ability, culture, language, and faith-based practices. Additionally, if the person is in a group home or residential care center, he/she is in the least restrictive environment necessary to address his/her needs. The person has had a stable living arrangement free of disruption for at least six months. Chances of disruption over the next six months appear unlikely.	**5** ☐ Approp. ☐ Stability
◆ **Fair Living Situation.** The person is living in a setting that is minimally consistent with his/her needs, age, ability, culture, language, and faith-based practices, and minimally supports his/her family connections. Additionally, if the person is in a group home or residential care center, he/she is in the least restrictive environment necessary to address his/her needs. The person has had a stable living arrangement free of disruption for at least three months. Chances of disruption over the next three months appear appear somewhat unlikely.	**4** ☐ Approp. ☐ Stability
◆ **Marginally Inadequate Living Situation.** The person may be living in a setting that only partially addresses his/her needs and supports for recovery. The setting may be only partially consistent with his/her age, ability, culture, language, and faith-based practices. If the person is in a group home or residential care center, he/she may not be in the least restrictive setting. The level of care or degree of restrictiveness may be slightly higher or lower than necessary to address the scope and intensity of his/her needs. The person may have experienced a disruption in living arrangements within the past three months. Chances of further disruptions over the next three months may be more likely than not.	**3** ☐ Approp. ☐ Stability
◆ **Poor Living Situation.** The person may be living in an inadequate home or setting to address his/her needs and supports for recovery. The setting may be inconsistent with his/her age, ability, culture, language, and faith-based practices. If the person is in a group home or residential care center, the level of care or degree of restrictiveness may be substantially more or less than necessary to meet his/her needs. The person may have experienced one or more disruptions in living arrangements within the past three months. Chances of further disruptions over the next three months may be substantial.	**2** ☐ Approp. ☐ Stability
◆ **Adverse Living Situation.** The person may be living in an inappropriate home or setting for his/her needs. The necessary level of supports for educational needs, family relationships, supervision, recovery supports, and services to address his/her needs may be absent or adverse in nature. If the person is in a group home, detention facility, or residential care center, the environment may be much more restrictive than is necessary to meet his/her needs or protect others from any behavioral risks the individual may present. The person may be without a stable living arrangement and may have had an ongoing pattern of disruption or movement in recent months. **- OR -** The individual may be homeless, residing in a homeless shelter, a runaway, or in temporary shelter care for more than 30 days.	**1** ☐ Approp. ☐ Stability

Status Indicator 11: Social Supports

Focus Measure

SOCIAL SUPPORTS. Degree to which: • The person is connected to a meaningful and supportive network of family, friends, and peers, consistent with his/her choices and preferences. • The person has access to positive peer support and community activities. • The person has opportunities to meet people outside of the service provider organization and to spend time with them. • The person's social network supports recovery efforts.

Core Concepts: This Indicator May Not Apply to Persons Under 6 Years of Age

As a social species, human beings seek, value, and maintain supportive and affirming relationships with others, often for a lifetime. Affiliation gives one's life identity, purpose, and connections. Community is the place where we meet and join with others in life's meaningful activities. Interactions with others provides a sense of belonging and social participation. The focus here is placed upon the person's meaningful social connections and natural supports and the extent to which he/she is provided access to peer support and community activities.

Because a person with a mental illness or a substance use disorder may rely on service providers for assistance necessary to maintain existing positive social connections and develop new ones, concern is placed on having opportunities to meet and get to know people outside the service provider organization. Where the person may require encouragement, supports, and structured opportunities to form and maintain social connections with friends, family, co-workers, and others in the community, how well is the service provider meeting the support requirements? Two essential components of the social network are the quality of the person's network (quality refers to the meaning and benefit gained from positive, enduring relationships and supportive ties) and the extent to which the person's social network actively supports or discourages recovery efforts. Recovery efforts refer to the active and ongoing steps the person is taking to achieve positive life changes that help the person to get better, do better, and stay better.

Fact Pattern -- Apply the Probe Questions, Assemble the Facts, and Consider the Pattern Found over the Past 30 Days

1. How well is this person connected to a natural support network consisting of family, friends, and peers? • What is the overall enduring quality of the support network? • Is the network supportive of recovery activities? *NOTE: Use of social media (e.g, texting, facebooking, etc.) may provide frequent and positive social network connections for a person.*

    - Which family members are part of this person's support network?
    - Which friends (outside the provider agency and service population) are part of this person's support network?
    - Which peers does this person see on a regular basis?

2. What are the characteristics of the person's social network? • Is the network actively engaged in or supportive of the person's recovery efforts?

3. Does this person have friends and opportunities to interact with other members of the community in positive ways, subject to his/her preferences? • What **stage of change** is this person at now with respect to recovery and social integration possibilities?

4. Is this person connected with a local faith community (e.g., church, synagogue, mosque, tribe) or with other ways of meeting his/her spiritual needs? • Does the person have transportation to and from church-related activities?

5. What kinds of peer support and community activities are provided to this person? • To what degree does this person accept and use the peer support and community activities that are currently provided?

6. Does this person have an informal support person who helps in times of crisis? • Does this person have an advance directive to guide helpers in times of crisis?

7. Does this person experience negative influences or effects from persons in his/her social network? • What steps are being taken to minimize any problems?

8. What specific goals and strategies contained within the person's recovery plan are directed toward improving social connections and supports for this person? • Does the person have access to and use of social media for networking?

9. What effect are any goals and strategies directed toward improving the person's social connections and supports having? • What strategies or activities have worked in the past for this person? • Does the person have access to and use social media for networking purposes?

STATUS INDICATOR 11: SOCIAL SUPPORTS

Status Rating Description that Best Fits the Fact Pattern Observed in this Case

Description of the Status Situation Observed for the Person — Rating Level

- **Optimal Support.** This person has a positive, substantial, and enduring social support network. It may consist of many friends, family, and/or peers. Forming and maintaining this social network may be the result of excellent access to peer support and community activities offered by provider agencies. He/she may have many ongoing opportunities to meet people outside of the service provider organization and to spend time with them. The network actively supports the person's recovery goals and provides positive ties for treatment and participation of both leisure activities and routine care.

6
☐ Network quality
☐ Recov. support

- **Good Support.** This person has a meaningful and dependable social support network. It may consist of friends, family, and/or peers. Forming and maintaining this social network may be the result of good access to peer support and community activities offered by provider agencies. He/she may have regular ongoing opportunities to meet people outside of the service provider organization and to spend time with them. Overall, the person's network provides good solid support for social and recovery goals.

5
☐ Network quality
☐ Recov. support

- **Fair Support.** This person has a minimal or possibly recent social support network. It may consist of some friends, family, and/or peers. Forming and maintaining this social network may be the result of minimally adequate access to peer support and community activities offered by provider agencies. He/she may have occasional opportunities to meet people outside of the service provider organization and to spend time with them. The network offers some support for social and recovery goals.

4
☐ Network quality
☐ Recov. support

- **Marginally Inadequate Support.** This person has a limited or inconsistent social support network. It may consist of a few friends, family, and/or acquaintances of limited quality or durability. Forming and maintaining this social network may reflect marginal access to peer support and community activities offered by provider agencies or to limited interest by the person. He/she may have few opportunities to meet people outside of the service provider organization and to spend time with them. Individuals in the social network neither support nor discourage recovery goals. The network may provide some positive and some negative influences from members. **- OR -** The network as a whole is not involved at a level that will sustain social and recovery goals.

3
☐ Network quality
☐ Recov. support

- **Poor Support.** This person has a social support network that consists of limited or inconsistent contact with friends, family, and/or acquaintances that may be of poor quality or durability - OR - may lack a social network. Forming and maintaining this social network may reflect poor access to peer support and community activities offered by provider agencies or to the person's preferences. He/she may have rare opportunities to meet people outside of the service provider organization and to spend time with them. **- OR -** He/she may occasionally form acquaintances around risky or harmful activities. The person's network rarely supports treatment or recovery goals.

2
☐ Network quality
☐ Recov. support

- **Absent/Adverse Support.** This person has no or very few ties to a positive or meaningful support network. The person may have acquaintances who engage or join the person in risky or harmful activities. Absence of a network support or only the presence of negative ties may reflect lack of access to peer support and community activities offered by provider agencies or to the person's preferences. He/she may have no opportunities to meet positive people outside of the service provider organization and to spend time with them. **- OR -** The person may have ongoing acquaintance patterns that result in risky or illegal activities with individuals that discourage participation in treatment and derail recovery efforts.

1
☐ Network quality
☐ Recov. support

- **Not Applicable.** The person may be under 6 years of age.

NA
☐ Network quality
☐ Recov. support

Status Review 12a: Early Learning & Development (Under Age 5)

Focus Measure

EARLY LEARNING STATUS. Degree to which: • The child's developmental status is commensurate with age and developmental capacities. • The child's developmental status in key domains is consistent with age- and ability-appropriate expectations.

Core Concepts: This Indicator Applies to a Child Under the Age of 5 Years

NOTE: *Because compulsory school attendance begins at age 5, Status Review 12a is applied to a child who is under age 5 and who is not yet attending a formal school program.*

From birth, children progress through a series of stages of learning and development. The growth during this period is greater than any subsequent developmental stage. This offers great potential for accomplishments, but also creates vulnerabilities for the child if the child's physical status, relationships, and environments do not support appropriate learning, development, and growth. These developmental years provide the foundation for later abilities and accomplishments. Significant differences in children's abilities are associated with social and economic circumstances that may be impacting learning and development. The cumulative impact of multiple risk factors on development is well established. Examples of risk factors are: having a parent who abuses substances, exposure to violence and trauma, inappropriate child care, and living in a dangerous environment or community. Children served by child welfare systems are at very high risk for developmental delays and they often represent over 50% of the children under age five served through child welfare. Children with a Fetal Alcohol Spectrum Disorder (FASD) and/or with inflicted brain injury may present significant developmental delays and learning problems. Because this developmental period is critical to the child's future social, emotional, and cognitive development, every attempt should be made to provide these children with early intervention services both within the home and in child care settings.

Fact Pattern -- Apply the Probe Questions, Assemble the Facts, and Consider the Pattern Found over the Past 30 Days

1. If this child is in the first 36 months of life, has this child been referred for screening of developmental delay or disability so that any indicated early intervention services can be provided to maximize the child's potential for growth and development?

2. If the child has had a developmental screening or assessment, does he/she show any developmental delays? • If so, to what degree and in what area? • Does this child present signs and symptoms of a Fetal Alcohol Spectrum Disorder (FASD), effects of traumatic brain injury, or reactive behavior patterns associated with repeated exposures to physical abuse or significant early neglect by the parent or caregiver?

3. Does the child appear to be achieving the key development milestones at or above age-appropriate levels?

    - Social/emotional development
    - Cognitive development
    - Physical/motor development
    - Language development
    - Self-care skills
    - School readiness skills

4. Does the child actively participate in self-care, play, socialization, and cognitive activities that appear within the appropriate range of development? • If not, has the child been screened and evaluated for developmental delays or disabilities? • If so, what are the significant findings regarding the child's development path, pace, and potential?

5. If the child presents developmental delays or disabilities, is the child receiving early intervention services provided via an Individualized Family Support Plan (IFSP) if under 36 months of age or an Individual Educational Plan (IEP) if between the ages of 36 and 60 months? • If not, why not?

6. If early intervention services are provided, do the child and parents seem to be responding to the interventions as shown in such areas as improved interaction, acceptance of attempts to nurture, more spontaneous play, emergence of language, etc.?

STATUS REVIEW 12A: EARLY LEARNING & DEVELOPMENT (UNDER AGE 5)

Status Rating Description that Best Fits the Fact Pattern Observed

Description of the Status Situation Observed for the Child, under age 5 years	Rating Level
◆ **Optimal Status.** The child's current developmental status is at or above age expectations in all domains, based upon normal developmental milestones. An optimal pattern is evident over an enduring period of time in the child's life.	**6** ☐
◆ **Good Status.** The child's current developmental status is at age expectations in all domains, however, there may be one or two areas in which the child is not as strong and merits ongoing careful monitoring. A good and sustaining pattern is evident over a recent period of time.	**5** ☐
◆ **Substantial Status.** The child's current developmental status is near age expectations in most of the major domains and may be slightly below expectations in a few areas. If the child and caregiver are participating in early intervention programs either at home or in a child care environment, the child is making substantial gains and appears to be approaching age-appropriate expectations. A minimally adequate to fair pattern is evident.	**4** ☐
◆ **Marginal Status.** The child's developmental status is mixed, somewhat near expectations in some domains, but showing significant delays in others. If the child and caregiver are participating in an early intervention program either at home or in a child care program, the child is making moderate to slow developmental gains and may not be improving in some domains.	**3** ☐
◆ **Poor Status.** The child's developmental status is showing significant delays in several areas as compared to age-appropriate expectations. If the child and caregiver are involved in an early intervention program, either at home or in a child care program, the child may be making gains but has such significant delays that it is not likely that the child will reach age-appropriate levels of functioning for some time.	**2** ☐
◆ **Adverse Status.** The child's current developmental status is far below developmental milestones and there may be a decline in certain domains. The child and caregiver may be involved in early intervention programs, but the rate of improvement is no more than minimal and may be subject to periods of regression.	**1** ☐
◆ **Not Applicable.** The child is age 5 or older and is attending a formal school program; therefore, this indicator does not apply.	**NA** ☐

Status Review 12b: Academic Status (School Age)

Focus Measure

ACADEMIC STATUS. Degree to which: • The child or youth [according to age and ability] is: (1) regularly attending school, (2) placed in a grade level consistent with age or developmental level, (3) actively engaged in instructional activities, (4) reading at grade level or IEP expectation level, and (5) meeting requirements for annual promotion and course completion leading to a high school diploma, a GED, or preparation for employment.

Core Concepts: This Indicator Applies to a Child or Youth who is 5 Years of Age or Older

The child/youth is expected to be actively engaged in developmental, educational, and/or vocational processes that are enabling the child to build skills and functional capabilities at a rate and level consistent with his/her age and abilities. This means that the child should be:

- Enrolled in an appropriate educational program, consistent with age, ability, and any presenting needs for special educational services.
- Attending school regularly and at a frequency necessary to benefit from instruction and meet requirements for grade promotion, course completion, and entry into the next school or vocational program.
- Receiving instruction at a grade level consistent with the child's age [or ability, if the child is cognitively impaired].
- Reading at grade level, except when the child's instructional expectations and placement are altered via an Individual Educational Plan (IEP) to an alternative curriculum. When an IEP is directing the child's education via placement in an alternative curriculum, specialized instruction, and related services, the child should be performing at the level anticipated in the IEP.
- Actively and consistently participating in the instructional processes and activities necessary to acquire expected skills and competencies.
- Meeting requirements for grade-level promotion, completing courses and assessment requirements, and, where indicated in an IEP, fulfilling transition processes and requirements for making a smooth transition to the next school or vocational program.

This status review focuses on the child's current learning and academic status relative to access to, participation in, and fulfillment of basic educational requirements for entry into the next school or vocational program.

NOTE: *If a child has an IEP and receives special education services, his/her IEP should specify whether this student is placed in the regular curriculum leading to high school graduation with a diploma or is placed in an alternative curriculum leading to a different educational outcome.*

Fact Pattern -- Apply the Probe Questions, Assemble the Facts, and Consider the Pattern Found over the Past 30 Days

1. Is this child/youth enrolled in an educational program consistent with age and ability? • If not, why not?

2. Does the child/youth's grade level match his or her age? • If not, why not?

3. Is the child/youth assigned to the general education curriculum leading to a high school diploma? • If not, is the child/youth receiving special education and related services in an alternative curriculum directed via an IEP? • If the child/youth is placed in an alternative curriculum, what is the expected educational outcome?

4. Is the child/youth actively and consistently engaged in the instructional processes and related activities necessary for acquisition of expected skills, competencies, and performances associated with curricular goals and objectives?

5. Is the child/youth reading on grade level or at a level anticipated in an IEP?

6. Is the child/youth meeting curriculum requirements necessary for promotion, course completion, and IEP-directed transitions? • If not, why not?

7. If the child/youth presents challanging behavior problems at school, does the child have recent findings from a Functional Behavior Analysis? • Does the child/youth need and have a Behavior Intervention Plan at school that is competently and consistently implemented and that contains strategies that are effective in managing the behaviors of concern at school?

STATUS REVIEW 12B: ACADEMIC STATUS (SCHOOL AGE)

Status Rating Description that Best Fits the Fact Pattern Observede

Description of the Status Situation Observed for the Child or Youth, age 5 years and older — Rating Level

- **Optimal Academic Status.** The child/youth is enrolled in a highly appropriate educational program, consistent with age and ability. The child has an excellent rate of school attendance (≥ 95% attendance with no unexcused absences). The child/youth's optimal level of participation and engagement in educational processes and activities is enabling the child to reach and exceed all educational expectations and requirements set within the child's assigned curriculum and, where appropriate, the child's IEP. The child/youth may be reading at or well above grade level or the level anticipated in an IEP. The child/youth may be meeting or exceeding all requirements for grade-level promotion, course completion, and successful transition to the next school or vocational program. An optimal and enduring pattern is evident. — **6** ☐

- **Good Academic Status.** The child/youth is enrolled in a generally appropriate educational program, consistent with age and ability. The cchild/youth has a substantial rate of school attendance (e.g., ≥90 <95% attendance with no unexcused absences). The child/youth's good level of participation and engagement in educational processes and activities is enabling the child to reach most educational expectations and requirements set within the child's assigned curriculum and, where appropriate, the child's IEP. The child/youth may be reading at grade level or the level anticipated in an IEP. The child/youth may be meeting most requirements for grade-level promotion, course completion, and successful transition to the next school or vocational program. A good and sustaining pattern is evident over a recent time. — **5** ☐

- **Fair Academic Status.** The child/youth is enrolled in a minimally appropriate educational program, consistent with age and ability. The child/youth has a fair rate of school attendance (e.g., ≥85 <90% attendance with no unexcused absences). The child/youth's fair level of participation and engagement in educational processes and activities is enabling the child to reach at least minimally acceptable educational expectations and requirements set within the child's assigned curriculum and, where appropriate, the child's IEP. The child/youth may be reading near grade level or the level anticipated in an IEP. The child/youth may be minimally meeting core requirements for grade-level promotion, course completion, and successful transition to the next school or vocational program. A minimally adequate to fair pattern is evident. — **4** ☐

- **Marginally Inadequate Academic Status.** The child/youth may be enrolled in a marginally appropriate educational or vocational program, or somewhat inconsistent with age and ability. The child/youth may have an inconsistent rate of school attendance (e.g., ≥75 <85% attendance and may have tardy notes or unexcused absences). The child/youth's limited level of participation and engagement in educational processes and activities may be hindering the child/youth from reaching at least minimally acceptable educational expectations and requirements set within the child's assigned curriculum and, where appropriate, the child's IEP. The child/youth may be reading a year below grade level or somewhat below the level anticipated in an IEP. The child/youth may not be meeting some core requirements for grade-level promotion, course completion, and successful transition to the next school or vocational program. — **3** ☐

- **Poor Academic Status.** The child/youth may be enrolled in a poor or inappropriate educational program, or inconsistent with age and ability. The child/youth may have a poor rate of school attendance (e.g., <75% attendance and may have been truant). The child/youth's poor level of participation and engagement in educational processes and activities may be preventing the child from reaching acceptable educational expectations and requirements set within the child's assigned curriculum and, where appropriate, the child's IEP. The child/youth may be reading two years below grade level or well below the level anticipated in an IEP. The child/youth may not be meeting many core requirements for grade-level promotion, course completion, or successful transition to the next school or vocational program. — **2** ☐

- **Adverse Academic Status.** The child/youth may be chronically truant, suspended, expelled from school, or may have dropped out of school. The child/youth may be three or more years behind in key academic areas, may be losing existing skills and/or regressing in functional life areas, and/or may be confined in detention without appropriate instruction or hospitalized. — **1** ☐

- **Not Applicable.** The child is under age 5; therefore, this indicator does not apply. - OR - The youth may have graduated from high school and is not pursuing post-secondary education, job preparation, or employment at the time of review. — **NA** ☐

Status Review 12c: Preparation for Adulthood (Age 15-18 Years)

Focus Measure

PREPARATION FOR ADULTHOOD. Degree to which the youth [according to age and ability] is: (1) gaining life skills, developing relationships and connections, and building capacities for living safely, becoming gainfully employed, and functioning successfully upon becoming independent of child services - OR - (2) becoming eligible for adult services and with the adult system being ready to provide (via a seamless transition) continuing care, treatment, and residential services that the youth will require upon discharge from services.

Core Concepts: This indicator is applied to a focus youth 15 years to 18 years of age.

Preparation for Independent Living. Indications that the youth is building necessary capacities for living independently include:

- Knowing and using key life skills in solving basic problems related to daily living in early adulthood necessary for fulfillment of adult roles -- including, where appropriate, teen parents gaining skills, knowledge, and supports necessary to care for their own dependent children.
- Taking control of one's needs, issues, and assets and having clear life plans for early adulthood.
- Linking with informal supports and resources in the extended family, neighborhood, and community.
- Reducing social isolation and building social networks that create supports, linkages, and opportunities.
- Setting and achieving important life goals (e.g., vocational training, high school graduation, GED, post-secondary education).
- Finding ways to meet fundamental needs (e.g., income, housing, transportation, health care, food, childcare, TANF benefits).
- Establishing and maintaining trusting and supportive relationships among family members and supporters.
- Forming and relying on a sustainable support network independent of agency funding or supervision.
- Knowledge of youth services available through age 21 and adult services that may begin at age 18.

Transition to Long-Term Adult Services. Indicators that the youth needing long-term care is moving toward securing necessary adult services include:

- For a youth with severe disabilities, securing eligibility for and placement in an appropriate level of long-term care, consistent with needs.
- For a youth with serious and persistent disabilities, securing SSI and Medicaid funding, acquiring a supported living arrangement, engaging in supported employment, and gaining admission to other ongoing community care and treatment services as an adult.
- Establishing trusting and supportive relationships among family members and supporters -- including a representative payee or guardian.

Meeting these expectations requires a high standard of practice to ensure that youth have what they require to achieve and maintain adequate levels of well-being, functioning, fulfillment of adult roles, and social integration as a citizen in the community.

Fact Pattern -- Apply the Probe Questions, Assemble the Facts, and Consider the Pattern Found over the Past 30 Days

1. Is the youth progressing in setting career goals, seeking and using employment opportunities, and progressing toward self-sufficiency? • Is the youth finding acceptable ways to meet fundamental living needs (e.g., income, housing, transportation, health care, food, child care, TANF)? • Is the youth forming and relying on sustainable support networks that are independent of public agencies providing supervision and support? • Is the youth setting and achieving functional goals and achievable life plans for living independently upon attainment of adulthood?

2. Is the youth gaining competence in learning, navigating, and relying upon community resources, his/her own social networks of people, his/her own problem-solving abilities, and knowledge of his/her living environment? • Is the youth seeking job training, employment, and legal sources of income? • Does the youth have plans for supported housing/living services, if needed? • Is the youth seeking and sustaining affordable housing?

3. Is the youth developing and maintaining sustainable, positive, long-term relationships with others -- including extended family members?

4. Is the youth making adequate age-appropriate progress toward independence, given the amount of time the youth has remaining under supervision or receiving support services? • How are transitional supports integrated into the combination and sequence of strategies being used?

5. If the youth is disabled, are provisions for meeting long-term care needs in place or will be in place before case closure? • Are SSI, Medicaid, housing, and community treatment services via the adult service system in place or will be in place before case closure?

STATUS REVIEW 12C: PREPARATION FOR ADULTHOOD (AGE 15-18 YEARS)

Status Rating Description that Best Fits the Fact Pattern Observed

Description of the Status Situation Observed for the Youth — Rating Level

- **Optimal Preparation.** The youth has been making excellent progress in: (1) developing long-term supportive relationships; (2) gaining core independent living/life skills; (3) developing community supports and networks; (4) advancing education and employment opportunities; and (5) as needed, securing adult services with continuing long-term care. For a youth within 12 weeks of system exit, youth has acquired and mastered necessary skills in two of the following areas and is making excellent progress in the remaining areas: (1) securing income; (2) acquiring housing or residential placement; (3) finding ways to meet fundamental needs including those related to the care of any dependent children the youth may be parenting; and (4) if needed, accessing essential adult services. — **6** ☐

- **Good Preparation.** The youth has been making good and substantial progress in: (1) developing long-term supportive relationships; (2) gaining core independent living/life skills; (3) developing community supports and networks; (4) advancing education and employment opportunities; and (5) as needed, securing adult services with continuing long-term care. For a youth within 12 weeks of system exit, the youth is making substantial progress in: (1) securing income; (2) acquiring housing or residential placement; (3) finding ways to meet fundamental needs; and (4) if needed, accessing essential adult services. — **5** ☐

- **Fair Preparation.** The youth has been making minimally adequate to fair progress in: (1) developing long-term supportive relationships; (2) gaining core independent living/life skills; (3) developing community supports and networks; (4) advancing education and employment opportunities; and (5) as needed, securing adult services with continuing long-term care. For a youth within 12 weeks of system exit, the youth is making fair progress in: (1) securing income; (2) acquiring housing or residential placement; (3) finding ways to meet fundamental needs; and (4) if needed, accessing essential adult services. — **4** ☐

- **Marginally Inadequate Preparation.** The youth has been making limited or inconsistent progress in: (1) developing long-term supportive relationships; (2) gaining core independent living/life skills; (3) developing community supports and networks; (4) advancing education and employment opportunities; and (5) as needed, securing adult services with continuing long-term care. For a youth within 12 weeks of system exit, the youth is making limited or inadequate progress in: (1) securing income; (2) acquiring housing or residential placement; (3) finding ways to meet fundamental needs; and (4) if needed, accessing essential adult services. — **3** ☐

- **Poor Preparation.** The youth has been making slow, inadequate progress in: (1) developing long-term supportive relationships, (2) gaining core independent living/life skills, (3) developing community supports and networks, (4) advancing education and employment opportunities, and (5) developing meaningful and achievable future plans. For a youth within 12 weeks of system exit, the youth is making poor or little progress in: (1) securing income; (2) acquiring housing or residential placement; (3) finding ways to meet fundamental needs; and (4) if needed, accessing essential adult services. — **2** ☐

- **No Preparation.** The youth has been making no progress in: (1) developing long-term supportive relationships, (2) gaining core independent living/life skills, (3) developing community supports and networks, (4) advancing education and employment opportunities, and (5) developing meaningful and achievable future plans. For a youth within 12 weeks of system exit, the youth is making no progress in: (1) securing income; (2) acquiring housing or residential placement; (3) finding ways to meet fundamental needs; and (4) if needed, accessing essential adult services. — **1** ☐

- **Not Applicable.** The youth is under age 15 years. — **NA** ☐

STATUS INDICATOR 12D: EDUCATION/CAREER DEVELOPMENT (ADULTS)

Focus Measure

EDUCATION/CAREER DEVELOPMENT. Degree to which the person: • Is actively engaged in educational activities (e.g., adult basic education, GED course work, or post-secondary education), vocational training programs, or transitional employment. • Is receiving information about work benefits, access to work supports, rights, responsibilities, and advocacy.

Core Concepts

Opportunities to improve one's skills, knowledge, and life potential are important for all adults. Education and training are ways that people use to promote lifelong learning, enhance life opportunities, and advance career possibilities. Subject to ability, choice, and support, a person with mental illness should be able to access learning activities available within the community. Learning activities include adult basic education, GED classes, post-secondary education (via community college, university, online courses), and vocational training programs for career preparation or advancement. Under provisions of Section 504, Rehabilitation Act, 1973, persons with disabilities may request and receive special accommodations from educational institutions that enable them to participate in and benefit from educational opportunities. Educational advocacy by a case manager, social worker, or counselor may be necessary to secure opportunities and accommodations for an adult with mental illness who meets enrollment criteria and who chooses to advance his/her education or career skill status.

The focus of this indicator is placed upon the person's participation in adult learning opportunities available within the community and/or treatment setting. Concerns in this review include whether the person: (1) is aware of learning opportunities; (2) is assisted in enrollment and securing accommodations (including GED clubhouses; tutoring services; access to computers; consumer education about benefits, losses, access, rights, responsibilities, advocacy, and mental health programs), if eligible and interested; and (3) is participating with any special supports or services that may be necessary for the person's success. This review is not applicable for persons who, by choice, are not currently participating in such activities. Consideration of the person's **stage of change** would be useful in understanding a person's refusal of opportunities.

Fact Pattern -- Apply the Probe Questions, Assemble the Facts, and Consider the Pattern Found over the Past 30 Days

1. Is the person aware of the learning activities and opportunities currently available in his/her community and/or treatment setting?

2. Does the person meet enrollment requirements to participate in and benefit from learning activities in the community that are of interest to the person? • Is the person currently accessing and participating in a community learning activity? • If so, what advocacy, support, or special accommodations are being provided to this person? • Does this person need educational advocacy to gain access to learning activities, with special accommodations as necessary for participation and success? • If so, has educational advocacy been offered or provided to this person? • If given assistance or support, would this person be interested and willing to continue his/her education?

3. Is the person receiving consumer education information and advice on the financial and social benefits gained from employment; possible losses of SSI, SSDI, or Medicaid benefits; rights and responsibilities related to employment; and information about sources of advocacy and assistance?

4. Does this person's life situation (e.g., parent of a newborn infant, hospitalized, or elderly) or current work schedule prevent the person from pursuing learning opportunities at this time?

5. Has this person been offered educational opportunities recently but declined participation? • At what **stage of change** is this person now operating?

Stages of Change:

- Precontemplation: no intention to change behavior; may be unaware of problems or opportunities.
- Contemplation: is aware of problems or opportunities; thinks about acting upon it but has not made a commitment to take action.
- Preparation: combines intention with early behaviors; planning to take action within the next month.
- Action: activities are being undertaken to modify behavior and take advantage of opportunities with commitment of time and energy.
- Maintenance: person works to make and consolidate gains while acting to prevent relapse or loss; may enter this stage within six months of behavior change.

STATUS INDICATOR 12D: EDUCATION/CAREER DEVELOPMENT (ADULTS)

Status Rating Description that Best Fits the Fact Pattern Observed

Description of the Status Situation Observed for the Person — Rating Level

- **Optimal Education/Career Development.** The person has high aspirations and goals to pursue career development activities in the community. And, the person is actively and successfully engaged in formal educational activities (e.g., adult basic education, tutorial assistance, GED course work, or post-secondary education/bachelor's degree) or vocational training. The person is making excellent use of the career development opportunities available and participates fully in those opportunities for which he or she qualifies. Any barriers to access and/or participation encountered have been fully overcome. **6** ☐

- **Good Education/Career Development.** The person has many aspirations and goals to pursue career development activities in the community. And, the person is actively and substantially engaged in formal educational activities (e.g., adult basic education, GED course work, tutorial assistance, or post-secondary education) or vocational training. The person is making consistent and substantial use of the career development opportunities available and participates reliably in those opportunities for which he or she qualifies. Any barriers to access and/or participation encountered have been substantially overcome. **5** ☐

- **Fair Education/Career Development.** The person has some aspirations and goals to pursue career development activities in the community. The person is somewhat engaged in formal educational activities (e.g., adult basic education, GED course work, or post-secondary education) or vocational training. The person is making minimally adequate to fair use of the career development opportunities available and participates regularly in those opportunities for which he or she qualifies. Any barriers to access and/or participation encountered have been recognized and reduced to support participation. **4** ☐

- **Marginally Inadequate Education/Career Development.** The person has some aspirations and goals to pursue career development activities in the community. The person is marginally engaged in formal educational activities (e.g., adult basic education, GED course work, or post-secondary education) or vocational training for which he or she qualifies. The person is making limited or inconsistent use of the career development opportunities available and may participate occasionally in those opportunities. Any barriers to participation encountered may have been recognized but some problems of access or participation may remain. A somewhat limited, inconsistent, or inadequate pattern of participation is evident. **3** ☐

- **Poor Education/Career Development.** The person has some aspirations and goals to pursue learning activities in the community. The person is poorly or inconsistently engaged in career development opportunities for which he or she qualifies. The person may be experiencing ongoing or possibly increasing barriers to accessing and/or participating in career development opportunities. **2** ☐

- **Absent Education/Career Development.** The person has some aspirations and goals to pursue learning activities in the community. The person is not engaged in formal educational activities or vocational training at this time. The person may be experiencing unresolved barriers in accessing career development opportunities and/or barriers to participation in available training opportunities. **1** ☐

- **Not Applicable. EITHER:** The person is presently employed without need for further education or career preparation. **- OR -** The person made an informed choice not to participate at this time. **- OR -** The person may have a condition or situation that would prevent participation at this time (e.g., serious illness, incarceration, physical disability, traumatic brain injury, or advanced age—frail elderly). **NA** ☐

STATUS INDICATOR 13: WORK STATUS (ADULTS)

Focus Measure

WORK STATUS. As appropriate to life stage, functional status, and personal preference, the degree to which the person is: • Actively engaging in employment, competitive or supported (earning federal minimum wage or above, in an integrated community setting), or in an individual placement with supports in a productive situation. • [If presently limited by labor market opportunities or a disabling condition] The person is exploring or engaged in productive volunteer opportunities in consumer-operated services, a community center, or a library.

Core Concepts

Work gives meaning and value to one's life. Work provides a respected social role and a way to participate in and interact with others in the community. Work provides natural forms of affiliation and a way to develop friends via meaningful social contribution. Opportunities to offer one's skills, knowledge, and time for good purpose and personal benefit are important for adults. Subject to choice, a person with mental illness or in addiction recovery should be able to access and participate in productive activities available within the community. Activities may include various forms of work (competitive, supported, full or part-time) or job training-related activities that lead to employment. Under provision of Section 504, Rehabilitation Act, 1973, and the Americans with Disabilities Act (ADA), persons with disabilities may request and receive special accommodations from employers that enable them to participate in and benefit from employment opportunities. Advocacy and assistance by a case manager, social worker, employment support specialist/job coach or counselor may be necessary to secure work or volunteer opportunities and accommodations for the person who seeks employment opportunities. Some individuals may require special supports to which they may be entitled through various government programs, such as Vocational Rehabilitation, Social Security Administration (Ticket to Work), or Temporary Assistance to Needy families (TANF).

The focus of this indicator is placed upon the person's participation in opportunities for work. Concerns here include whether the person: (1) is aware of productive opportunities and supports; (2) is assisted in all phases or choosing, getting, and keeping employment as well as securing accommodations, if eligible and interested; and (3) is participating with any special supports or services that may be necessary for the person's success. This review is not applicable for a person who by choice is not currently participating in work. Yet, for these individuals, a referral to a counselor/primary therapist should be initiated within a few days to discuss the individual's fears, concerns, or anxiety of not wanting to become engaged in employment. Consider the **stage of change** at which the person is operating.

Fact Pattern -- Apply the Probe Questions, Assemble the Facts, and Consider the Pattern Found over the Past 30 Days

1. How is this person made aware of employment or work opportunities currently available in his/her community? • Vocational Rehabilitation, Work One Centers, Social Security Administration (Ticket to Work)?

2. How is the person currently accessing and participating in integrated, community-based services and supports? • How is advocacy, support(s), or special accommodations being provided to this person?

3. How was encouragement, engagement, assistance, or support given to the individual in moving towards an attempt at trying/returning to work?

4. How was it determined that the individual needed assistance or advocacy to gain access to productive activities (with special accommodations as necessary) for participation and success? • If needed, how has advocacy been offered to this person?

5. In what ways does the person's life situation or current educational schedule prevent the person from pursuing productive opportunities at this time? • What is being done to assist the individual? • What choice of job, schedule, work site, and supports has the person been offered?

6. How did the person receive options of his/her choice(s), or were options limited to jobs available in a particular program or service? • Is there an absence of job opportunities locally available for someone with this person's ability, skills, and/or legal record?

7. In what ways has educational information about the impact of earned income and gain of benefits been discussed with this person? • Has assistance been offered to offset any losses of benefits? • Does the person have a low income job of a part-time nature (e.g., waitress or farm worker)?

8. Does the person have goals and plans for employment that are specific, measurable, attainable, results oriented, and timeframed that will assist in achieving their vocational ambitions and interest?

9. In what ways does the individual qualify for Vocational Rehabilitation; e.g., receives Social Security benefits, limited functioning in cognitive and learning skills, communication, interpersonal skills, mobility, motor skills, self-care, self-direction, work skills, work tolerance, or underemployed?

STATUS INDICATOR 13: WORK STATUS (ADULTS)

Status Rating Description that Best Fits the Fact Pattern Observed

Description of the Status Situation Observed for the Person — Rating Level

- **Optimal Work/Opportunities.** The person has aspirations and goals to pursue work in the community. And, the person is successfully engaged in productive activities (e.g., work, on-the-job training, volunteering). The person is making excellent use of the work opportunities available and participates fully in those opportunities for which he or she qualifies. Any barriers to access and/or participation encountered have been fully overcome. The person may be experiencing excellent success in and significant benefits from current work or on-the-job training. **6** ☐

- **Good Work/Opportunities.** The person has aspirations and goals to pursue work in the community. And, the person is actively and substantially engaged in productive activities (e.g., work, on-the-job training, volunteering). The person is making consistent and substantial use of the job opportunities available and participates reliably in those opportunities for which he or she qualifies. Any barriers to access and/or participation encountered have been substantially overcome.. The person may be experiencing good success and substantial benefits in his/her work or job training. **5** ☐

- **Fair Work/Opportunities.** The person has aspirations and goals to pursue work in the community. And, the person is frequently engaged in activities related to work, job training, or volunteering. The person is making minimally adequate to fair use of job opportunities available and participates regularly in those opportunities for which he or she qualifies. Any barriers to access and/or participation encountered have been recognized and reduced to support participation. The person may be experiencing a fair degree of success and some benefits in his/her work or job training. **4** ☐

- **Marginally Inadequate Work/Opportunities.** The person has aspirations and goals to pursue work in the community. But, the person is seldom engaged in work, job training, or volunteering. The person is making limited or inconsistent use of job opportunities available and may participate occasionally in those opportunities. Any barriers to participation encountered may have been recognized but some problems of access or participation may remain. Local work opportunities may be limited. **3** ☐

- **Poor Work/Opportunities.** The person has aspirations and goals to pursue work in the community. But, the person is poorly or inconsistently engaged in productive activities. The person is poorly or inconsistently engaged in work opportunities for which he or she qualifies. The person may be experiencing ongoing or possibly increasing barriers to accessing and/or participating in work opportunities. Local work opportunities may be poor. **2** ☐

- **Absent Work/Opportunities.** The person has aspirations and goals to pursue work in the community. But, the person is not engaged in productive activities. The person is not engaged in formal educational activities or vocational training at this time. The person may be experiencing unresolved barriers in accessing work opportunities and/or barriers to participation in available work or volunteer opportunities. There may be no employment opportunities locally available for someone with this person's skills or legal record. **1** ☐

- **Not Applicable. EITHER:** The person made an informed choice not to participate at this time. **- OR -** The person may be a full-time homemaker caring for young children in the home and chooses not to work at this time. **- OR -** The person may have a condition or situation that would prevent participation at this time (e.g., serious illness, incarceration, physical disability, traumatic brain injury, or advanced age—frail elderly). **NA** ☐

Status Indicator 14: Parent & Caregiver Functioning

Focus Measure

PARENT & CAREGIVER FUNCTIONING. Degree to which: • The person functions as an adequate parent for dependent children and/or a caregiver for a dependent adult for whom the person has caregiving responsibilities. • The person is willing and able to provide the child or dependent adult with the care, assistance, protection, guidance, supervision, and support necessary for daily living, child development, or necessary adult care.

Core Concepts: Applies to Persons Who Care for Dependent Children or Adults in the Person's Home

Parents/caregivers should have and use levels of knowledge, skills, and situational awareness necessary to provide a dependent child or adult (e.g., a frail elderly parent) with the care, nurturance, guidance, age-appropriate discipline, and supervision necessary for protection, physical care, and normal development or age-appropriate support. Understanding the basic developmental stages that youth experience, relevant milestones, expectations, and appropriate methods for shaping behavior is key to parental capacity to support their child/youth's healthy growth and learning. Caring for a dependent person having unique medical, developmental, emotional, and/or behavioral challenges can require additional specialized knowledge and resources. Caregivers who are faced with extraordinary caregiving demands may require additional support, including relief and respite care. The goal of assisting a caregiver who needs assistance with caregiving capacities is to ensure that the family receives the information, assistance, and/or training needed to demonstrate that they have the basic skills and supports necessary to meet the particular needs of the dependent persons requiring care. Interventions should be an appropriate match to the caregiving circumstances, caregiver's learning style, and culture.

Caregivers may require meaningful connections with family members, friends, neighbors, and others in their community to support and sustain their efforts. Family members, neighbors, and others in the person's social network may provide a caregiver with important supports, knowledge, linkages, and opportunities for success. Informal supporters can provide important resources for struggling caregivers in many different ways:

- Gaining and using key life skills in solving basic problems related to daily living and parenting of the child/youth.
- Finding ways to meet fundamental needs (e.g., income, housing, transportation, health care, food, day care).

Fact Pattern -- Apply the Probe Questions, Assemble the Facts, and Consider the Pattern Found over the Past 30 Days

NOTE: This indicator applies only to a person who has parental rights and responsibilities for a dependent child or daily care responsibilities for a dependent adult. This indicator applies to a parent whose child/children may be in state custody when that person is identified in the child's permanency plan as a permanency resource defined in a goal for reunification.

1. Does the person who should be functioning as a caregiver have sufficient income and resources to provide basic necessities adequately, reliably, and consistently on a daily basis, such as food, safe shelter, clothing, transportation, health care, and day care?

2. Does the person who should be functioning as a caregiver demonstrate that he/she has and actively uses knowledge, skills, and emotional capacity to take care of the child and protect the dependent person from harm? • Does he/she make decisions and act in ways that are protective? • Is the caregiver emotionally connected to the dependent person, sensitive to the person's needs, and able to respond in ways that appropriately meet the person's needs?

3. Does the person who should be functioning as a caregiver have the ability, understanding, and willingness to engage with an informal support system that assists his/her with essential caregiving responsibilities, such as family members, close friends, helpful neighbors, informal social service organizations, faith-based organizations, social clubs, and charitable organizations?

4. Does the person who should be functioning as a caregiver have the ability, understanding, and willingness to engage with a formal support system that assists him/her with essential caregiving responsibilities, such as social service agencies, schools, medical providers, transportation, housing, law enforcement, and/or vocational training?

5. Does the person who should be functioning as a caregiver meet a dependent child's special and/or regular educational needs by assuring school attendance, homework completion, conference attendance, attendance at school events, and participation in extracurricular activities?

6. Are there extraordinary demands placed on the person functioning as a caregiver, such as small child/youth, high child/youth/caregiver ratio, frail elderly, ill persons in the home, single parent family, social isolation, child/youth with special health or medical conditions, or a child/youth with a disability, that impact his/her ability to perform adequate caregiving in the present situation?

7. Does the person functioning as a caregiver provide adequate supervision, nurturance, guidance, and emotional support to the person receiving care?

STATUS INDICATOR 14: PARENT & CAREGIVER FUNCTIONING

8. Does the person who should be functioning as a caregiver adequately access the necessary services to meet the age-appropriate physical, dental, and mental health needs of the dependent person in his/her care? • Are there any risk factors that impair the person's caregiving capacities, such as substance abuse, mental disability, domestic violence? • If so, how are these factors being addressed via protective interventions?

9. Is the person who should be functioning as a caregiver able to assist a dependent youth with critical life decisions, such as education, vocation, employment, sexuality, reproductive health care, religion, morality, or the use of addictive substances?

10. If the person's child is in foster care, does the person who should be functioning as a caregiver have the willingness and ability to maintain contact and a relationship while the youth is out of the home? • Does the person attend planned visitations with his/her child/youth?

Status Rating Description that Best Fits the Fact Pattern Observed

Description of the Status Situation Observed for the Person Who should Function as a Parent/Caregiver	Rating Level
◆ **Optimal Functioning.** The person demonstrates excellent and enduring caregiving capacities on a reliable daily basis at or above that required to provide the dependent person with appropriate nurturance, guidance, support, protection, discipline, education, medical care, and supervision. If the child has special needs, the person demonstrates optimal knowledge and excellent use of specialized skills and supports that may be required to meet the needs of the child/youth.	**6** ☐
◆ **Good Functioning.** The person demonstrates good and consistent caregiving capacities on a reliable daily basis at or above that required to substantially provide the dependent person with appropriate nurturance, guidance, support, protection, discipline, education, medical care, and supervision. If the child has special needs, the person demonstrates good working knowledge and proficient use of specialized skills and supports that may be required to meet the needs.	**5** ☐
◆ **Fair Functioning.** The person demonstrates adequate to fair parenting caregiving capacities on a reliable daily basis at a level required to minimally provide the dependent person with appropriate nurturance, guidance, support, protection, discipline, education, medical care, and supervision. If the child has special needs, the person demonstrates at least adequate working knowledge and use of specialized skills and supports that may be required to meet the needs.	**4** ☐
◆ **Marginally Inadequate Functioning.** The person demonstrates a limited or inconsistent pattern of caregiving capacities on a daily basis, sometimes or somewhat less than the level required to provide the dependent person with appropriate nurturance, guidance, support, protection, discipline, education, medical care, and supervision. If the child has special needs, the person demonstrates somewhat inadequate working knowledge and ineffective use of specialized skills and supports that may be required to meet the needs of the child/youth.	**3** ☐
◆ **Poor Functioning.** The person demonstrates an inadequate pattern of caregiving capacities some or most of the time, often less than the level required to provide the dependent person with appropriate nurturance, guidance, support, protection, discipline, education, medical care, and supervision. If the child has special needs, the person demonstrates somewhat inadequate knowledge and ineffective use of specialized skills and supports that may be required to meet the needs of the child/youth. Any dependent children could be in out-of-home care.	**2** ☐
◆ **Adverse Functioning.** The person demonstrates a seriously inadequate pattern of caregiving capacities most of the time, offering much less than the level required to provide the dependent person with appropriate nurturance, guidance, support, protection, discipline, education, medical care, and supervision. If the child has special needs, the person lacks working knowledge and ineffectively uses specialized skills and supports that may be required to meet the needs of the child/youth. Any dependent children could be in out-of-home care.	**1** ☐
◆ **Not Applicable.** The person does not have dependent children or adults in his/her care at this time. The person is not identified as a permanency resource for dependent children in the care and custody of the state.	**NA** ☐

STATUS INDICATOR 15: WELLNESS & RECOVERY ACTION STATUS

Focus Measure

RECOVERY ACTION STATUS. Degree to which the person: • Is actively engaged in activities necessary to achieve and maintain freedom from substance use impairment, reduce psychiatric symptoms, improve health, and increase competencies, coping, self-management, social integration, and ongoing recovery. • [If not engaged in wellness and recovery efforts, the degree to which the person] Has access to wellness, recovery, and relapse prevention opportunities, subject to his/her needs, life ambitions, and personal preferences.

Core Concepts

Wellness and recovery activities may involve use of various forms of medical care along with psychosocial adjustment and vocational training/retraining in an effort to maximize physical well-being functioning, adjustment, and recovery for a person having serious and persistent mental illness and/or addiction. Wellness and recovery aims to prepare the person physically, mentally, socially, and vocationally for the fullest possible life, consistent with his/her abilities, ambitions, and choices. It is an individualized, dynamic, and purposeful process built around skills training and support modalities, as well as directed socialization complimenting therapy and retraining.

Wellness and recovery activities and services aim to help a person make the best use of his/her capacities within as normal as possible social context. For a person with a serious and persistent mental illness and/or addiction, rehabilitation usually aims to: (1) prevent relapse and rehospitalization by achieving successful community supports and services, (2) improve the person's quality of life by assisting the person manage his/her life, and (3) achieve valued social roles in the community. Recovery efforts focus on strengthening the person's skills and developing the environmental supports necessary to sustain the person in the community. Successful recovery depends on a network of community services. The focus in this review is placed on access to and use of recovery and relapse prevention support opportunities. Recovery support activities are oriented toward successful community living and self-directed life management. This review may be deemed not applicable for a person who is functioning independently and successfully in the community or who declines recovery opportunities after reasonable, ongoing efforts have been made to engage the person via outreach with attractive offers of supports and services. Consider the **stage of change** at which the person is operating.

Stages of Change:

- Precontemplation: no intention to change behavior; may be unaware of problems or opportunities.
- Contemplation: is aware of problems or opportunities; thinks about acting upon it but has not made a commitment to take action.
- Preparation: combines intention with early behaviors; planning to take action within the next month.
- Action: activities are being undertaken to modify behavior and take advantage of opportunities with commitment of time and energy.
- Maintenance: person works to make and consolidate gains while acting to prevent relapse or loss; may enter this stage within six months of behavior change.

Fact Pattern -- Apply the Probe Questions, Assemble the Facts, and Consider the Pattern Found over the Past 30 Days

1. What outreach and engagement efforts are being used to develop this person's interests in wellness, recovery, and relapse prevention opportunities?

2. What wellness/recovery/relapse prevention opportunities have been offered to this person? • If the person declined participation, what efforts were made to engage the person? • Were reasonable and attractive choices (to the person) offered? • What supports or incentives were offered?

3. Is this person currently participating in wellness and recovery activities? • What is the nature of wellness and recovery activities in which the person is now participating: a general program for a group of participants or individually tailored services and activities designed to meet specific needs and personally selected goals? • Has this person progressed to the self-management and sustainability stage of recovery?

4. Do wellness and recovery activities offered or used include skills development, social networking, hope, coping, self-agency, self-management, relapse prevention/support, restarting recovery, and choices about where and how to work the process?

5. Given current wellness and recovery services, is the person making progress toward achievement of personally selected recovery goals? • Does the person see them as meaningful?

6. Are any of the available wellness and recovery activities peer supported?

STATUS INDICATOR 15: WELLNESS & RECOVERY ACTION STATUS

Status Rating Description that Best Fits the Fact Pattern Observed

Description of the Status Situation Observed for the Person — Rating Level

- **Optimal Status.** The person has the need, ambition, and interest to pursue recovery opportunities. And, the person is highly motivated to participate in recovery-oriented activities. The person is fully engaged in recovery efforts. The person may be experiencing excellent progress toward accomplishing personally chosen life goals and recovery. Any barriers to access to and/or participation in recovery-oriented services encountered have been fully overcome. — **6** ☐

- **Good Status.** The person has the need, ambition, and interest to pursue recovery opportunities. And, the person is substantially motivated to participate in recovery-oriented activities. The person is making consistent and substantial use of the recovery opportunities available and participates reliably in those opportunities. Any barriers to participation encountered have been substantially overcome. The person may be experiencing good and substantial progress toward accomplishing personally chosen life goals and recovery. — **5** ☐

- **Fair Status.** The person has the need, ambition, and interest to pursue recovery opportunities. And, the person is somewhat motivated to participate in recovery-oriented activities. The person is making minimally adequate to fair use of the recovery opportunities available and participates regularly in those opportunities. Any barriers to participation encountered have been recognized and reduced to support participation. The person may be experiencing fair progress toward accomplishing personally chosen life goals and recovery. — **4** ☐

- **Marginally Inadequate Status.** The person has the need, ambition, and interest to pursue recovery opportunities. But, the person may have difficulty in sustaining motivation to participate in recovery-oriented activities. The person is making limited or inconsistent use of the recovery opportunities available and participates occasionally in those opportunities. Any barriers to participation encountered may have been recognized but some problems of access or participation may remain. The person may be experiencing limited progress toward accomplishing goals possibly set by others. — **3** ☐

- **Poor Status.** The person has the need, ambition, and interest to pursue recovery opportunities. But, the person may not have been able to sustain motivation to participate in recovery-oriented activities. The person is poorly or inconsistently engaged in recovery opportunities. The person may be experiencing ongoing barriers to accessing and/or participating in recovery activities. The person may be experiencing little, if any, progress toward accomplishing goals. — **2** ☐

- **Adverse Status.** The person has the need, ambition, and interest to pursue recovery opportunities. But, the person may not agree to participate in recovery-oriented activities. The person is not engaged in recovery activities. The person may be experiencing unresolved barriers in accessing recovery opportunities or barriers to participation in available recovery activities. The person may be experiencing no progress toward life goals or could be becoming increasingly isolated or disabled. — **1** ☐

- **Unable to Participate at this Time.** The person may have a condition or situation that would prevent participation at this time (e.g., terminal illness, incarceration, major physical disabilities, traumatic brain injury, or advanced age—frail elderly). — **NA** ☐

SECTION 3

PRACTICE PERFORMANCE INDICATORS

[PERFORMANCE OBSERVED OVER THE PAST 90 DAYS]

REMINDERS FOR REVIEWERS

The reviewer should follow these directions when applying a practice performance indicator to a case situation being reviewed:

1. **Focus on the central construct measured in each indicator.** While two constructs may be logically inter-related (e.g., engagement and teamwork or assessment and planning), the reviewer is to focus on the central matters related to each specific indicator and follow the probe and rating guidance provided for each indicator. For example, if a reviewer discovered that strong recent assessments were present but that planning did not reflect the most recent assessments, then the reviewer would rate the assessments as being strong and rate the planning as less than acceptable for not reflecting the most recent and important information. Assessment would not be rated lower because assessment findings were not reflected in the planning of appropriate strategies, supports, and services. Planning would not be rated higher because of the strong assessments until planning reflects the most recent assessment and clinical case formulation.

2. **Stay within the time-based observation windows associated with each indicator.** Practice performance is measured over the past 90 days.

3. **Rate indicators based on events that have occurred or conditions that were present within the time-based observation window.** Theorizing about events that might have occurred but did not actually happen is not a factual basis for rating. The 6-Month Prognosis or Forecast is used to reflect expectations or concerns about future prospects or the suspected future effects of any present insufficiencies in core practice functions.

4. **Follow the guidance provided in rating statements when selecting a rating value for measuring an indicator having multiple components or conditions to be met.** For example, in *Practice Indicator 7: Planning Interventions*, multiple intervention strategies may be necessary in a case (e.g., for mental health recovery, substance use recovery, trauma recovery, community integration, safety, income and basic necessities, managing chronic health concerns) to attain key outcomes for a person. *For a rating of 4*, there has to be at least a minimally adequate fit between the outcomes to be achieved and the assessed strengths, needs, underlying issues, and life goals of the person being served. The preponderance of elements are found to be in the fair range or higher of practice performance with no essential elements found below minimal adequacy over the past 90 days.

Practice Review 1: Recognition, Connection, Rapport

Focus Measure

RECOGNITION, CONNECTION, RAPPORT: Degree to which: • The person's/family's sense of identity, culture, values and preferences, social network, and life experiences are recognized by practitioners involved with the person. • Any barriers to personal connection and acceptance are recognized and resolved. • Necessary conditions for building mutual respect and rapport are established as a basis for successful engagement.

Core Concepts: This Indicator Applies to All Persons Served

Building a relationship with a person entering services requires practitioners to recognize the nature of the person's situation and life story and to discover the circumstances that have brought the person into agency services. One of the most important first steps is recognition of any barriers that could thwart formation of positive connections with the person that could undermine acceptance and rapport building necessary for successful engagement. Practitioners must take steps for creating conditions necessary for building mutual respect and rapport required in developing trust-based working relationships. Also key to successful engagement and connection is the recognition of the person's sense of identity, culture, values and preferences (especially any arising from race, sexual identity, and/or religious conviction), social and economic supports, and life-shaping experiences (e.g., adverse childhood experiences, combat trauma, addiction, emigration, poverty) that explain the person's life story and reasons for entry into services.

Persons coming into service require use of culturally relevant and responsive interactions and interventions in order to successfully connect, educate, assist, and support them moving through the system. Responsiveness includes valuing cultural diversity, understanding how it impacts family functioning in a different culture, and adapting service processes to meet the needs of culturally diverse groups of persons receiving services. Properly applied in practice, cultural responsiveness reduces the likelihood that matters of language, culture, custom, identity, value, or belief will prevent or reduce the effectiveness of life change efforts undertaken via interventions, supports, and services. A person's identity [e.g., race, tribe, ethnicity; social group; sexual orientation; religion; or disability, such as deafness] may shape his or her world view and life goals in ways that must be understood and accounted for in practice. Recognition, connection, and rapport provide a foundation for building and sustaining trust-based working relationships.

Fact Pattern -- Apply the Probe Questions, Assemble the Facts, and Consider the Pattern Found over the Past 90 Days

1. What steps have been taken/are being taken to learn the reason the person/family is seeking help? • If the person reports being in physical pain or emotional distress, what is its nature, source, history, and impact on the person's life situation? • How well has the practitioner determined whether the reported problem is a present threat to health or safety so that any need for crisis intervention or urgent response can be identified and provided? • How well has the practitioner determined whether the person's problem is emergent/transient or serious/persistent?

2. In early interactions, what steps have been taken/are being taken to discover the person's/family's sense of identity, language, culture, values and preferences (especially any arising from race, sexual identity, and/or religious conviction), world view, social and economic supports, strengths and needs, present life challenges, and life-shaping experiences (e.g., adverse childhood experiences, deteriorating physical health, combat trauma, recent loss, addiction, emigration, poverty) that explain the person's situation and reasons for requesting help?

3. How well to practitioners recognize any barriers (arising from culture, language, gender, class, religious or political beliefs, life experiences, sexual orientation, work or family demands, or disability) that could thwart or limit the formation of positive connections with the person/family that would undermine acceptance and rapport building necessary for developing successful trust-based working relationships?

4. What active steps have been taken in establishing positive conditions for connecting with the person/family and building mutual respect and rapport with the person/family? • Remember: recognition, connection, respect, and rapport are the building blocks of a trust-based working relationship and are performed concurrently by the practitioner when a person is entering services?

5. Have the practitioners used the person's/family's responses to form a theory that explains how the pain or distress came about, what causes it to continue, what has been done to alleviate it in the past, what has worked/not worked before, and who else may be helping the person relieve or solve this problem now? • Have they determined who else needs to be involved?

PRACTICE REVIEW 1: RECOGNITION, CONNECTION, RAPPORT

Practice Rating Description that Best Fits the Fact Pattern Observed

Description of the Practice Performance Situation Observed — Rating Level

- **Optimal Practice.** Practice efforts evidence excellent recognition of the person/family's sense of identity, culture, values and preferences, social network, life experiences and reasons for coming into service. Practioners have developed conditions conducive to quickly building rapport, genuine connection with the person/family, and responsiveness to presenting concerns including the level of urgency. All accommodations and considerations necessary for establishing quick, sincere, and effective connection have been met including the determination of who else might need to be involved. **6** ☐

- **Good Practice.** Practice efforts evidence significant and substantially good recognition of the person/family's sense of identity, culture, values and preferences, social network, life experiences and reasons for coming into service. Practioners have developed conditions conducive to building rapport, genuine connection with the person/family, and responsiveness to presenting concerns including the level of urgency. Most accommodations and considerations necessary for establishing quick, sincere, and effective connection have been met including the determination of who else might need to be involved. **5** ☐

- **Fair Practice.** Efforts of practitioners evidence a fair level of recognition of the person/family's sense of identity, culture, values and preferences, social network, life experiences and reasons for coming into service. Attempts to connect and build initial rapport with the person/family have not been entirely successful or have been cumbersome. Level of urgency has generally been attended to. Some accommodations and considerations necessary for establishing quick, sincere, and effective connection have been met, and some attention has been given to who else needs to be involved. **4** ☐

- **Marginally Inadequate Practice.** Efforts of practitioners evidence a limited or inconsistent level of recognition of the person/family's sense of identity, culture, values and preferences, social network, life experiences and reasons for coming into service. Attempts to connect and build initial rapport with the person/family have been challenging, resulting in misunderstandings, missed appointments, missed opportunities and/or confusion about the level of urgency requiring attention. Some, but not enough accommodations and considerations necessary for establishing quick, sincere, and effective connection have been met, and little attention has been given to who else might need to be involved. **3** ☐

- **Poor Practice.** Efforts of practitioners evidence a poor level of recognition of the person/family's sense of identity, culture, values and preferences, social network, life experiences and reasons for coming into service. Attempts to connect and build initial rapport with the person/family have been troublesome, resulting in misunderstandings, missed appointments, changes in providers and/or lack of attention to the urgency of need in the case. Few accommodations and considerations necessary for establishing quick, sincere, and effective connection have been met, and little effort has been made to identify others who might need to be involved. **2** ☐

- **Absent or Adverse Practice.** Efforts of practitioners evidence an adverse or absent level of recognition of the person/family's sense of identity, culture, values and preferences, social network, life experiences and reasons for coming into service. Attempts to connect and build initial rapport with the person/family have been troublesome, resulting in misunderstandings, missed appointments, changes in providers and/or lack of attention to the urgency of need in the case. Accommodations and considerations necessary for establishing quick, sincere, and effective connection have not been made and no effort has been made to identify others who might need to be involved. The person/family may experience alienation or disrespect. **1** ☐

PRACTICE INDICATOR 2: ENGAGEMENT & COMMITMENT

Focus Measure

ENGAGEMENT & COMMITMENT. Degree to which: • Service providers are building and maintaining a trust-based working relationships with the person and the person's family and informal supporters to involve them in ongoing assessment, service planning, and wellness and recovery efforts. • Service providers are using effective outreach and ongoing engagement strategies to increase and sustain the person's participation in the service process and commitment to life changes that support wellness and recovery, consistent with the person's/family's needs and preferences.

Core Concepts: This Indicator Applies to All Persons Served

Engagement Builds Trust-Based Working Relationships. Effective wellness and recovery services depend on ongoing working relationships between a person/family in need and the service providers who help meet those needs. Service providers make concerted efforts to reach out to the person, engage him/her meaningfully in all aspects of the service process, establish and maintain a trust-based working relationship that is consistent with the person's/family's language and culture, coordinate efforts with other providers and secure and sustain the person's commitment to a change process. Engagement strategies build a mutually beneficial partnership in decision-making and life change efforts. The person's/family's direct, ongoing, active involvement is used in assessment, planning interventions, selecting providers, monitoring and modifying service plans, and evaluating results.

Practice approaches that support effective relationship building are:

- Person-centered (organizes around the person's goals)
- Strengths-based (builds on the person's positive assets)
- Solution-focused (moves from problems to solutions)
- Need-responsive (recognizes and responds to needs)
- Wellness-oriented and outcome-driven (starts with the end in mind)
- Builds readiness for change (uses motivational interviewing strategies)
- Fits the person's stages of change (starts where the person is ready)
- Respects the person's identity, culture, aspirations, and preferences

In the absence of a trust-based working relationship with the service provider, the person is unlikely to reveal the underlying issues that explain the dynamic circumstances causing the problem that must be solved in order to achieve desired wellness and recovery outcomes.

Commitment. Building a commitment to positive life change is essential. A major contribution of effective engagement is the person's ongoing commitment to personally chosen wellness and recovery outcomes and to the change process used to achieve these outcomes. In the absence of the person's commitment to life change, wellness and recovery outcomes are not likely to be achieved.

Fact Pattern -- Apply the Probe Questions, Assemble the Facts, and Consider the Pattern Found over the Past 90 Days

1. Is the practitioner using listening as the key to learning, conveying empathy & respect, and trust building? • Is effort being made to build a relationship with a person by recognizing the nature of the person's life situation and reasons for requesting help? • Is the practitioner effectively finding and overcoming any barriers to personal connections? • What steps are being taken using recognition and rapport to develop a foundation for building and sustaining a trust-based working relationship?

2. To what extent is the practitioner using a person-centered approach that puts the person's voice and choice at the center of the service process? • How well are the person's unmet needs related to wellness, well-being, and daily functioning being recognized and responded to?

3. Is the practitioner using a strengths-based practice approach that emphasizes a person's self-determination and identifies and builds upon the person's strengths and assets to create sustainable resources for solutions to bring about the person's desired change in the least amount of time? • To what extent is the practitioner using a solution-focused approach that is future-oriented, goal- directed, and focuses on solutions, rather than on the problems that brought the person to seek help?

3. Is the practitioner using a change-oriented approach to address lifestyle modification for risk reduction, disease prevention, long-term disease or disorder management, and addiction? • Does the practitioner understand the person's/family's readiness to make change, appreciate barriers to change, and help anticipate relapse to improve the person's satisfaction and lower practitioner frustration during the change process? • Is the change approach being effectively used to both stimulate change and to overcome resistance?

4. Is the practitioner effectively using engagement as an ongoing process to build and sustain: 1) a mutually beneficial trust-based working relationship with the person/family and 2) the person's commitment to personally selected wellness and recovery outcomes and to the life change process?

PRACTICE INDICATOR 2: ENGAGEMENT & COMMITMENT

Practice Rating Description that Best Fits the Fact Pattern Observed

Description of the Practice Performance Situation Observed — Rating Level

- **Optimal Practice**. Service providers are using optimal outreach and ongoing engagement strategies to build and maintain a trust-based working relationship with the person, the person's family and informal supporters in order to involve them in ongoing assessment, service planning, and wellness and recovery efforts. Any barriers to personal connections have been effectively overcome. A person-centered approach is consistently being used to put the person's voice and choice at the center of the service process. **6** ☐

- **Good Practice.** Service providers are using good outreach and ongoing engagement strategies to build and maintain a trust-based working relationship with the person, the person's family and informal supporters in order to involve them in ongoing assessment, service planning, and wellness and recovery efforts. Most barriers to personal connections have been effectively overcome. A person-centered approach is being used most of the time to put the person's voice and choice at the center of the service process. **5** ☐

- **Fair Practice.** Service providers are primarily using good outreach and ongoing engagement strategies to build and maintain a trust-based working relationship with the person, the person's family and informal supporters in order to involve them in ongoing assessment, service planning, and wellness and recovery efforts. Some barriers to personal connections remain. A person-centered approach is being used some of the time to put the person's voice and choice at the center of the service process.. **4** ☐

- **Marginally Inadequate Practice.** Service providers are occasionally using somewhat inadequate outreach and ongoing engagement strategies to build and maintain a trust-based working relationship with the person, the person's family and informal supporters in order to involve them in ongoing assessment, service planning, and wellness and recovery efforts. A few barriers to personal connections have been overcome, but others significant to the process remain. A person-centered approach is being used inconsistently resulting in the person's voice and choice at times not being at the center of the service process. **3** ☐

- **Poor Practice.** Service providers are rarely using adequate outreach and ongoing engagement strategies to build and maintain a trust-based working relationship with the person, the person's family and informal supporters or involving them in ongoing assessment, service planning, and wellness and recovery efforts. Many barriers to personal connections remain and need to be resolved. A person-centered approach is not being used effectively or consistently to reflect the person's voice and choice **2** ☐

- **Absent or Adverse Practice.** Service providers are failing to use outreach or ongoing engagement strategies to build and maintain a trust-based working relationship and/or they are in conflict with the person. The person, the person's family and informal supporters are excluded from ongoing assessment or service planning. Multiple barriers to personal connections remain unresolved. The person's desires and unmet needs are being ignored or unrecognized by providers. **1** ☐

  NOTE: When reviewing persons under age 5 years who are receiving services, the primary focus in engagement and commitment is placed on the parents, guardians, or primary caregivers.

Practice Indicator 3: Care Coordination & Teamwork

Focus Measure

CARE COORDINATION & TEAMWORK. Degree to which providers are: • Using a person-centered, shared decision making process. • Building common purpose by planning wellness/recovery goals and strategies with and for the person. • Achieving and maintaining unity of effort in service delivery by coordinating actions of the service providers and integrating services across providers, settings, time, and funding sources.

Core Concepts: This Indicator Applies to All Persons Served

Person-Centered, Shared Decision-Making Process. Person-centered, recovery-oriented practices and self-directed care principles put the person's needs, aspirations, and choices at the center of the service provision efforts. A team-based, shared decision-making process helps the person create a vision for a better life based on aspirations for well-being, supports for living, and improved daily functioning and role fulfillment. Informal supporters and service providers join with the person/family to define wellness and recovery goals to be achieved along with related strategies for provision of supports and services. Because the efforts of many may be involved in helping the person, achieving common purpose and unity of effort are essential for success, and will create the "glue" that holds things together in practice for the benefit of the person/family receiving services.

Common Purpose. Common purpose is created when the person/family and service providers involved agree upon and commit to clear goals and a related course of action. An ongoing, person-centered/recovery-oriented, team-based, shared decision-making process may be used to achieve and maintain a CONSENSUS and COMMITMENT to a set of well-planned goals and related strategies which are essential for building common purpose.

Unity of Effort. Unity of effort is based on achieving and maintaining:

- A common understanding of the person's/family's situation;
- A common vision for a better life;
- Coordination of efforts to ensure coherency and continuity;
- Common measures of progress and ability to change course, if necessary.

Unity of effort is achieved and maintained via ongoing teamwork, coordination of actions among the person, providers and supporters, and integration of services across providers, settings, funding sources, and points in time.

Fact Pattern -- Apply the Probe Questions, Assemble the Facts, and Consider the Pattern Found over the Past 90 Days

1. Are the right people working together with and for the person being served? • If not, who else needs to be involved and have they been asked to join?

2. Does the team have the essential qualities to produce good results: the technical and cultural competence; the knowledge of the person; the authority to act on behalf of funding agencies and to commit resources; and the ability to flexibly assemble supports and resources in response to specific needs? • Do members of the team have the time available to fulfill commitments made to the person/family?

3. Does the team effectively conduct person-centered planning activities and provide assistance, support, and interventions after plans are made in order to meet important goals? • Are team members working together to support the person in identifying needs, setting goals, and planning strategies with related services that will enable the person and family to meet those goals? • Is the team functioning in an effective, ongoing, collaborative problem-solving manner?

4. Is there a designated leader (e.g., a care coordinator) who prepares team members, convenes and organizes meetings, effectively facilitates a shared decision-making processes, has the authority to act on behalf of the team, monitors and evaluates results in order to determine progress, and follows up on commitments made? • In a case where several agencies and providers are involved, does the care coordinator have the necessary negotiation skills to achieve and sustain a coordinated and effective service process? • If the person receiving services is empowered and capable, are leadership and coordination responsibilities effectively being shared with him/her to increase self-direction of care?

5. Is there evidence of effective team functioning over time demonstrated by the quality of relationships built, the commitments fulfilled, the results achieved, the unity of effort shown by all members of the team, the focus and proper fit of services assembled for the person, the dependability of service system performance, and the connectedness of the person to critical resources necessary for achieving important life goals?

PRACTICE INDICATOR 3: CARE COORDINATION & TEAMWORK

Practice Rating Description that Best Fits the Fact Pattern Observed

Description of the Practice Performance Situation Observed — Rating Level

- **Optimal Practice**. Excellent unity of effort is achieved by evidenced of optimal teamwork, coordination of team members for the effective identification of needs, setting of goals and planning strategies with the person. There is excellent integration of services across providers, settings, funding sources, and points in time. All of the right people are present on the team, including a clearly designated point person for coordination of planning, goal development, implementation of treatment and supports, and accountability. Team members adhere to a strong person-centered approach when working with the person, as evidenced by capturing and cultivating the person/family's vision, voice, and choice in all aspects of care. Services are optimally designed for excellent fit and focus, and critical resources are available to the person. **6** ☐

- **Good Practice.** Good unity of effort is achieved by good quality teamwork, coordination of actions with team members for the good identification of needs, setting of goals and planning strategies with the person. There is good integration of services across providers, settings, funding sources, and points in time. Most of the right people are present on the team. Most team members are aware of a designated point person for coordination of planning, goal development, implementation of treatment and supports, and accountability. Team members mostly adhere to a person-centered approach when working with the person. Services are designed for good fit and focus, and many critical resources are available to the person. **5** ☐

- **Fair Practice.** Fair unity of effort is achieved with fair teamwork, coordination of team members for the minimally adequate identification of needs, setting of goals and planning strategies with the person. There is adequate integration of services across providers, settings, funding sources, and points in time. Some of the right people are present on the team, with at least one key member absent, inconsistent in participation, or obstructive to the teaming and decision-making process. There is a point person for coordination of planning, goal development, implementation of treatment and supports, and accountability; however, not all team members are clear as to who this person is or their role. Team members are inconsistent in use of person-centered approaches. Services are inconsistently designed for fit and focus, and some critical resources may not be available to the person. **4** ☐

- **Marginally Inadequate Practice.** Marginally inadequate unity of effort is demonstrated with limited or inconsistent teamwork, lack of coordination of team members for adequate identification of needs, setting of goals and planning strategies with the person. There is inadequate integration of some services across providers, settings, funding sources, and points in time. Some of the necessary people are missing, inconsistent in participation, or obstructive to the teaming and decision-making process. There is a point person for coordination of planning, goal development, implementation of treatment and supports, and accountability; however, their role is vague or undefined or team members are lack clarity as to who fulfills this role. Team members are inconsistent in use of person-centered approaches, and/or do not fully understand the how to implement the approach. Services have poor fit and focus, and critical resources may not be consistently available to the person. **3** ☐

- **Poor Practice.** Poor unity of effort is demonstrated in a team that lacks collaboration, coordination, and integration of services. Unrecognized needs, lack of goal setting and poor planning are present. Key people are missing from the team, are inconsistent in participation, or obstructive or undermining to the teaming and decision-making process. There is not a clear point of contact for coordination, or there are possibly multiple team members responsible for various functions, causing duplication, gaps, and confusion. Team members are not using or do not understand person-centered approaches. Services are inadequate in fit and focus, and many critical resources are not consistently not available to the person. **2** ☐

- **Absent or Adverse Practice.** Absent or adverse unity of effort is occurring either because no team has been formed or because the existing team lacks collaboration, coordinative decision-making, and integration of services. Most of the person's needs go unrecognized and there is a lack of goal setting or planning. Several key people are missing from the team, are inconsistent in participation, or obstructive or undermining to teaming processes. There no clear point of contact for coordination, or there are possibly multiple team members responsible for various functions, causing duplication, gaps, in-fighting and confusion. Team members are not using or do not believe in person-centered approaches. Services lack fit and focus and critical resources have not been identified. **1** ☐

Practice Indicator 4: Screening, Detection, Response, Monitoring

Focus Measure

SCREENING, DETECTION, PREVENTION/MITIGATION, MONITORING. Degree to which: • Screening detects imminent threats to the person's health, safety, supports, or behavioral well-being upon entry and ongoing thereafter. • Responsive actions are provided in a timely and appropriate manner to prevent or mitigate any foreseeable harm to the person or others around the person arising from the detected threats of harm, risks of near-term life disruptions, or risks of poor well-being outcomes. • Follow-along monitoring tracks the person's situation to detect and respond to any future threats to well-being.

Core Concepts: This Indicator Applies to All Persons Served

A timely and appropriate response is provided for a person who is detected via screening processes or self-report as has having a threatening life situation, behavioral condition, disorder, or disease for which intervention or treatment is indicated, possibly with urgency.

Screening & Detection. Screenings are performed to identify a person who may have an undiagnosed health or behavioral condition or who may be at high risk of developing a condition requiring treatment, and to identify any imminent threat of harm from life partners/caregivers creating a major breakdown in essential supports. Screenings include labs to detect health problems as well as screening activities used to identify safety threats, behavioral concerns, and breakdowns in essential supports. Screenings may include medical issues such as metabolic syndrome factors, HIV, Hep-C, thyroid issues, TBI; and behavioral/social issues such as depression, drug and alcohol use, suicide/homicide risks, trauma including domestic violence, and fall risk for the elderly. Detection involves identification of a specific health problem, safety threat, behavioral concern, or support breakdown that could cause harm. Areas in which screening can provide direction for a person/family are:

- Safety / threats of harm at home, work, or school
- Self-endangerment / threats of harm to others
- Unstable living situation or major break-down in key supports
- Adverse childhood experiences / complex trauma
- Emotional status / behavioral disorders
- Diseases: diabetes, COPD, obesity, hypertension, seizures, thyroid issues, etc.
- Drug or alcohol use
- A pattern of instability / trajectory of physical or emotional decline
- Intellectual or developmental disability / TBI / learning problems
- Health status / physical well-being / illness

Prevention or Mitigation and Follow-Along Monitoring. Following detection of a threat of harm or an emergent condition, a response is an action taken to avert a safety threat, stop the progression of a disease, control a behavioral disorder, or to mitigate preventable injury or illness. The response must match the urgency, severity, and intensity of a detected problem, especially when the person is at imminent risk of harm (e.g., sudden death via suicide) or at high risk of a poor health outcome (e.g., a brittle diabetic adolescent who violates dietary restrictions). Prevention strategies keep harmful things from happening. Mitigation strategies reduce risks or minimize adverse effects of something that is already happening. Follow-along monitoring is used to track risk factors and mitigation strategies used to manage health, safety, behavioral, or support problems in order to provide knowledge for planning next step actions.

Fact Pattern -- Apply the Probe Questions, Assemble the Facts, and Consider the Pattern Found over the Past 90 Days

1. Was any problem requiring a crisis intervention or urgent response identified? • If so, was it addressed in a timely, appropriate, and sufficient manner so as to prevent unnecessary harm, pain, loss, or hardship for the person commensurate with the urgency and severity of the presenting problem? • Was the response effective in providing protection for the person from preventable harm or mitigating the impact the problem would have likely had if not treated promptly and effectively?

2. Do practitioners continue to conduct screenings upon admission and periodically thereafter to detect safety, health, and behavioral risks as well as any emergent conditions or disorders as an ongoing assessment process to assure that any problems of significance (involving safety, health, or behavioral risks or other situations that could lead to instability or decline) are promptly detected?

3. Was the nature, significance, and history of any problem detected by the practitioner doing the screening defined and reported to any other practitioners or agencies that should be involved in providing an appropriate response to the person's need for prevention, protection, treatment, or care?

4. Were the results of initial and ongoing screenings incorporated into the person's ongoing Bio-Psycho-Social Assessment and Case Formulation? • Were any significant screening and detection results are used to develop necessary protective interventions and/or treatments to keep the person safe, physically and behaviorally healthy, and functioning effectively in daily life?

PRACTICE INDICATOR 4: SCREENING, DETECTION, RESPONSE, MONITORING

Practice Rating Description that Best Fits the Fact Pattern Observed

Description of the Practice Performance Situation Observed — Rating Level

- **Optimal Practice**. Optimal practice efforts are evident in initial and comprehensive screening and detection of current and imminent threats to the person's (and family's) health, safety, supports, or behavioral well-being. Screening, detection, and response actions of optimal power are delivered are in a timely, appropriate, and continuous manner to prevent or mitigate any foreseeable harm or poor outcome. Practitioners respond with optimal appropriate urgency to current or future threats to well-being, others who need to know about the issue are informed, and the person's chart is updated resulting in accurate situational awareness. **6** ☐

- **Good Practice.** Good practice efforts are evident in initial and comprehensive screening and detection of current and imminent threats to the person's (and family's) health, safety, supports, or behavioral well-being. Screening, detection, and response actions of adequate power are delivered are in a timely and appropriate manner that is mostly may consistent to prevent or mitigate foreseeable harm or poor outcome. Practitioners respond with good urgency to current or future threats to well-being, most of the others who need to know about the issue are informed, and the person's chart may be updated resulting in good situational awareness. **5** ☐

- **Fair Practice.** Fair practice efforts are evident in screening and detection of current and imminent threats to the person's (and family's) health, safety, supports, or behavioral well-being. Screening, detection, and response actions of minimally adequate power are usually delivered are in a timely and appropriate manner, although may not be consistent to prevent or mitigate foreseeable harm or poor outcome. Practitioners respond with fair urgency to current or future threats to well-being, some others who need to know about the issue may be informed and the person's chart may not be adequately updated resulting in fair or dated situational awareness. **4** ☐

- **Marginally Inadequate Practice.** Marginally inadequate practice efforts in screening and detection of current and imminent threats to the person's (and family's) health, safety, supports, or behavioral well-being are present. Screening, detection, and response actions are marginally inadequate in power or inconsistently delivered in a manner that is timely and appropriate to prevent or mitigate foreseeable harm or poor outcome. Practitioners lack urgency to current or future threats to well-being, many others who need to know about the issue may not be informed and/or the person's chart may not be updated in a timely manner resulting in inaccurate situational awareness. **3** ☐

- **Poor Practice.** Poor practice efforts in screening and detection of current and imminent threats to the person's (and family's) health, safety, supports, or behavioral well-being are evident. Screening, detection, and response actions are inadequate in power or lack timeliness or appropriate urgent responses to prevent or mitigate foreseeable harm or poor outcome. Practitioners lack urgency to current or future threats to well-being, others who need to know about the issue may not be informed and/or the person's chart may not be updated resulting in poor or incorrect situational awareness or assumptions about the person/family. **2** ☐

- **Absent or Adverse Practice.** Practice efforts are absent or adverse in screening and detection of current and imminent threats to the person's (and family's) health, safety, supports, or behavioral well-being. Screening and detection actions may be absent, extremely lacking in timeliness, or have not been identified as being urgent. Practitioners have no sense of urgency to current or future threats to well-being, resulting in no sense of situational awareness. Practioners may be biased or making inappropriate and incorrect assumptions about the person/family. **1** ☐

Practice Indicator 5: Physical Exam, Assessment, Case Formulation

Focus Measure

PHYSICAL EXAM, BIO-PSYCHO-SOCIAL ASSESSMENT, CASE FORMULATION. Degree to which ongoing formal and informal fact finding methods are used to develop and update: • A broad-based understanding of the person's physical status and medical history, bio-psycho-social situation, strengths and assets, unmet needs, life challenges, stressors, and aspirations for wellness and recovery. • An evolving clinical case formulation (describing the person's clinically significant distress and impairment in functioning) is used to guide development of treatment plans informed by the person's life stage, culture, social context, and preferences.

Core Concepts

Ongoing physical examination, bio-psycho-social assessment, and clinical case formulation guide the course of action designed and used over time by service providers in collaboration with the person being served to help her/him meet wellness and recovery goals that have been selected. Assessment provides answers to practical and clinical questions that are used to develop a functional, working understanding for the person from which treatment decisions are made. Based on the working understanding, a clinical case formulation is developed and updated as new understandings emerge.

Assessment and Understanding. As appropriate to the person's situation, a combination of clinical, functional, and informal assessment techniques are used to determine the strengths, needs, risks, underlying issues, and future goals of the person. Once gathered, the information is analyzed and synthesized to form a functional understanding and a bio-psycho-social based clinical case formulation used in developing a course of action with and for the person. Areas in which essential understandings are developed include:

- Earlier life traumas, losses, and disruptions
- Learning problems affecting school or work performance
- Subsistence challenges of the family
- Risks of harm, abuse, or neglect
- Traumatic brain injury and/or intellectual disabilities
- Court-ordered requirements/constraints
- Recent life disruption (e.g., eviction, bankruptcy)
- Co-occurring life challenges (mental illness, addiction, domestic violence)
- Physical, cognitive, and/or behavioral health concerns
- Recent tragedy, trauma, loss, victimization
- Problems of attachment and bonding
- Recent life changes (e.g., new baby) requiring major adjustments
- Extraordinary caregiver burdens
- Dislocation due to disasters or changes in the job market

Case Formulation and Clinical Reasoning. Understandings developed from ongoing assessments are used to create a clinical case formulation that guides service decisions and actions. Clinical reasoning is applied in moving from understanding to action. Any compelling urgency is addressed first. Practical solutions may precede clinical solutions in the course of action. Opportunities for early and repeated successes are identified and pursued. A pace of action that could confuse or overwhelm the person/family is avoided.

Fact Pattern -- Apply the Probe Questions, Assemble the Facts, and Consider the Pattern Found over the Past 90 Days

1. To what extent is the assessment being used to gain a functional understanding of the person's/family's situation and to build a clinical case formulation that guides decision-making, goal setting and intervention planning? • Are screening data, detection of threats to the person's well-being, results of prevention or mitigation strategies, follow along monitoring findings, and evaluation of results being effectively used in the ongoing assessment process?

2. Is a clinical case formulation present that includes a clinical history and concise summary of the bio-psycho-social factors contributing to the present concern? • Does it focus on clinically significant distress and impairment in functioning experienced by the person? • Does the case formulation include the combination of predisposing, precipitating, perpetuating, protective, and predictive factors contributing to the condition of concern? • Is it being used in making a reliable assessment of factors related to a person's disruption in daily functioning or role fulfillment?

3. Are practitioners using the functional understandings and clinical case formulation to guide development of a comprehensive treatment plan, including support plans where indicated, informed by the person's life stage, culture, social context, and preferences?

PRACTICE INDICATOR 5: PHYSICAL EXAM, ASSESSMENT, CASE FORMULATION

Practice Rating Description that Best Fits the Fact Pattern Observed

Description of the Practice Performance Situation Observed — Rating Level

- **Optimal Practice.** Optimal ongoing formal and informal fact finding methods (assessments, diagnostic tools, inquiry) are used to develop a strong initial and ongoing understanding of the person's bio-psycho-social situation, clinical history, strengths and assets, clinically significant distress and/or impairment in functioning, unmet needs, life challenges, stressors, and aspirations for wellness and recovery. Understandings developed from an ongoing assessment process are used to create a reliable clinical case formulation that guides optimal service decisions and actions. The evolving clinical case formulation is strong, precise, and used to guide development of comprehensive treatment plans informed by the person's vision for well-being and preferences for care. **6** ☐

- **Good Practice.** Good ongoing formal and informal fact finding methods (assessments, diagnostic tools, inquiry) are used to develop a good initial and ongoing understanding of the person's bio-psycho-social situation, clinical history, strengths and assets, clinically significant distress and/or impairment in functioning, unmet needs, life challenges, stressors, and aspirations for wellness and recovery. There is good understanding of the person/family developed from an ongoing assessment process that is used to create a clinical case formulation that guides service decisions and actions. A good clinical case formulation is used to guide development of treatment plans mostly informed by the person's vision for well-being and preferences for care. **5** ☐

- **Fair Practice.** Fair formal and informal fact finding methods (assessments, diagnostic tools, inquiry) are used to develop some initial and ongoing understanding of the person's bio-psycho-social situation, clinical history, strengths and assets, clinically significant distress and/or impairment in functioning, unmet needs, life challenges, stressors, and aspirations for wellness and recovery. Practitioners and team members have fair understanding of the person/family developed from a somewhat continuous assessment process that is used to create a clinical case formulation that mostly guides service decisions and actions. The clinical case formulation usually guides development of treatment plans somewhat informed by the person's vision for well-being and preferences for care **4** ☐

- **Marginally Inadequate Practice.** Marginally inadequate formal and informal fact finding methods (assessments, diagnostic tools, inquiry) are used to develop understanding of the person's bio-psycho-social situation, clinical history, strengths and assets, clinically significant distress and/or impairment in functioning, unmet needs, life challenges, stressors, and aspirations for wellness and recovery. Practitioners and team members have limited understanding of the person/family developed through an inconsistent assessment process used to create a clinical case formulation that sometimes guides service decisions, actions, and development of treatment plans somewhat informed by the person's vision for well-being and preferences for care. **3** ☐

- **Poor Practice.** Poor fact-finding methods (assessments, diagnostic tools, inquiry) are used to develop a limited understanding of the person's bio-psycho-social situation, clinical history, strengths and assets, clinically significant distress and/or impairment in functioning, unmet needs, life challenges, stressors, and aspirations for wellness and recovery. Understanding is fragmented and inconsistent, resulting in misunderstandings, inaccuracies, and missing information. Clinical formulation and assessment processes may not be used or are poorly used to create a clinical case formulation that guides service decisions, actions, and development of treatment plans. Some treatment processes lack the person/family's vision for well-being and preferences for care. **2** ☐

- **Adverse or Absent Practice.** Fact-finding methods (assessments, diagnostic tools, inquiry) used to develop understanding of the person's bio-psycho-social situation, clinical history, strengths and assets, unmet needs, life challenges, stressors, and aspirations for wellness and recovery are erroneous or absent. Understanding is fragmented and incorrect at best, resulting in missing, incorrect, or outdated information. Clinical formulation and assessment processes are not be used to create a clinical case formulation to guide service decisions, actions, and development of treatment plans. Most, if not all, treatment processes lack the person/family's vision for well-being and preferences for care. **1** ☐

PRACTICE INDICATOR 6: PERSONAL WELLNESS & RECOVERY GOALS

Focus Measure

PERSON-CENTERED WELLNESS & RECOVERY GOALS. Degree to which life-change goals are planned for the person based upon: • Understandings developed from current assessments and a clinical case formulation. • Agreed upon life changes necessary for achieving and maintaining wellness, meeting essential needs, improving daily functioning, gaining greater independence, and supporting ongoing recovery. • Being stated as the person's vision for wellness and recovery in the person's treatment plan. • Being measurable for tracking progress and determining attainment of outcomes.

Core Concepts

WELLNESS AND RECOVERY GOALS define how all involved in the service process will know that the person is getting better, doing better and staying better in life. Planned goals and life change outcomes specify states of well-being (e.g., safety, health, or substance free lifestyle), functioning (e.g., competency or capacity), or support (e.g., shelter or income) that was absent or insufficient at the time the person entered the service system and that will be necessary for the person to gain and maintain success in life without ongoing assistance from the service system, or when the person is ready to transition from one level of care or living arrangement to another.

The creation of a person's wellness and recovery goals should be:

- Derived from current assessments and the clinical case formulation
- Based on collaborative understandings of necessary life changes, and, where appropriate
- Reflective of any court orders that require specific life changes

Defining wellness and recovery goals creates a guiding view for services (working from outcomes to actions) that should precede the planning of intervention strategies and actions used to achieve outcomes. Having clear life outcomes enables the person and those helping the person to see both the next steps forward and the end-point on the horizon -- thus, providing a clear vision of the pathway to wellness and recovery.

Fact Pattern -- Apply the Probe Questions, Assemble the Facts, and Consider the Pattern Found over the Past 90 Days

1. Is the practitioner/team using person-centered, wellness/recovery-oriented planning techniques to help the person identify and state what he/she expects to gain or achieve from the service process? • Are expectations being framed as life-change goals using the person's own words? • Are the goals created to guide service planning based on the person's assessed needs, expressed aspirations for a better life, and socially-beneficial choices (important for/important to)?

2. To what extent is the practitioner addressing life-change goals in a logical order: 1) first any compelling urgencies requiring immediate action to prevent harm; 2) goals for achieving well-being such as ongoing safety and health; 3) goals related to supports for living such as income, food, housing, health care; 4) goals related to improving daily functioning and to fulfilling key life roles? • Is the progression of meeting essential needs and strategic life changes designed to enable the person to achieve and maintain an adequate daily life situation and gain greater independence from the service system?

3. Has the practitioner/team been able to discover and implement any opportunities available for making early progress and repeated success or achieving any important life outcome that could change the trajectory of the case and give hope to the person/family?

4. Is the practitioner constructing goals that are "SMART:" Specific, Measurable, Achievable, Relevant, and Time-bound? • Are the goals chosen by the team clear, relevant and achievable to effectively help in planning intervention strategies, in measuring of results and in promoting the person's motivation and commitment to the change process? • Are goals focused on long-term outcomes, containing positive replacement behavior, adequate to solve the main problem without being overwhelming, containing a time for achievement, and clearly able to be measured and completed?

5. To what extent are the person's life-change goals being used to guide the selection of intervention strategies used for their attainment? • Are teamwork and unity of effort being used to develop consensus on goals which require the involvement of other practitioners or agencies in order to help the person achieve the desired outcomes and to coordinate and integrate services?

Practice Indicator 6: Personal Wellness & Recovery Goals

Practice Rating Description that Best Fits the Fact Pattern Observed

Description of the Practice Performance Situation Observed — Rating Level

- **Optimal Practice.** Optimal practice and processes are used by practitioners in development of life-change goals for the person/family that are based on understandings developed from current assessments, clinical case formulation and person-centered practices. There is full consensus regarding life changes necessary for achieving and maintaining wellness, meeting essential needs, improving daily functioning, gaining greater independence, and supporting ongoing recovery based on or aligned with the person/family's vision for wellness. Goals are Specific, Measurable, Achievable, Relevant, and Trackable. The life-change goals developed are optimally being used to guide the selection of intervention strategies. **6** ☐

- **Good Practice.** Good practice and processes are used by practitioners in development of life-change goals for the person/family based on understandings developed from current assessments, clinical case formulation and person-centered practices. There is partial consensus regarding life changes necessary for achieving and maintaining wellness, meeting essential needs, improving daily functioning, gaining greater independence, and supporting ongoing recovery somewhat based on or aligned with the person/family's vision for wellness. Goals are mostly Specific, Measurable, Achievable, Relevant, and Trackable. The life-change goals developed are mostly being used to guide the selection of intervention strategies. **5** ☐

- **Fair Practice.** A somewhat informed and accepted set of goals/objectives for the person may be found constructed in a preformed template or found in scattered details of plans and in conversations among the team of service providers. Fairly understandable statements of recovery goals or treatment objectives define levels of well-being, functioning, personal aspirations, and sustainable supports to be achieved via intervention. The level of detail in the goals and objectives is minimally adequate to measure progress made. **4** ☐

- **Marginally Inadequate Practice.** Marginally inadequate processes are used by practitioners for determining life-change goals for the person/family based upon understandings developed from current assessments, clinical case formulation and person-centered practices. There is inconsistent or a lack of consensus with some team members regarding life changes necessary for achieving and maintaining wellness, meeting essential needs, improving daily functioning, gaining greater independence, and supporting ongoing recovery that is partially aligned with the person/family's vision for wellness. Goals lack one or more of the following: specificity, measurability, achievability, and relevance or may be vague or contain no end-point for attainment. The life-change goals developed may not be used to guide the selection of intervention strategies. **3** ☐

- **Poor Practice.** A poorly reasoned, inadequate, and/or incomplete set of goals and objectives for the person may be unresponsive to needs, inconsistent with the person's choices, or confusing or objectionable to those involved. The available goals/objectives for the person may be drawn from a pick list on a computer screen or narrow checklist on a planning worksheet, but may not be individualized or relevant to the person's actual needs or aspirations for a better life. Present details are insufficient for guiding intervention and may be in dispute among the team of service providers. Major gaps may exist in defining a path for intervention or for setting useful outcomes. **2** ☐

- **Absent or Adverse Practice.** Either absent or adverse processes are used by practioners for determining life-change goals for the person/family based upon understandings developed from current assessments, clinical case formulation and person-centered practices. There is a lack of consensus or full understanding of life changes necessary for achieving and maintaining wellness, meeting essential needs, improving daily functioning, gaining greater independence, and supporting ongoing recovery. Goals do not aligned with the person/family's vision for wellness and lack several of the following: specificity, measurability, achievability, and relevance or may be vague or contain no end-point for attainment. The life-change goals are logically flawed and may not be useful in guiding the selection of intervention strategies. **1** ☐

Practice Indicator 7: Person-Centered Planning

Focus Measure

PERSON-CENTERED PLANNING. Degree to which meaningful, measurable, and achievable wellness and recovery goals for the person are supported with well-reasoned, agreed-upon intervention strategies, supports, and services planned for their attainment that puts the person/family at the center of the planning process that is determining what is "important to" and "important for" the person.

Core Concepts

PERSON-CENTERED INTERVENTIONS consist of a combination and sequence of planned strategies, supports, and services which are developed with the person/family at the center of the process and which guide implementation toward life changes for a person/family. Strategies are designed to lead to the attainment of wellness and recovery goals identified by the person and team. Intervention planning is an ongoing process throughout the life of the case, and planned interventions should be consistent with the person's aspirations for a better life. Planned intervention strategies, supports, and services related to a person's wellness and recovery goals may be developed in one or more the following areas where co-occurring needs are identified.

Fact Pattern -- Apply the Probe Questions, Assemble the Facts, and Consider the Pattern Found over the Past 90 Days

Each outcome may be addressed through one or more interventions. For the purpose of this review, **intervention strategies** are classified and rated in the following categories of interest:

A. **Physical Wellness** - To what extent is the team planning for achieving and maintaining the person's best attainable health status by managing any health concerns? Is the person receiving needed assistance to access services necessary to manage chronic health conditions (e.g., seizures, COPD, diabetes, obesity, hypertension, thyroid issues, Hep-C, HIV/ AIDS, etc.) that require involvement of practitioners from primary health care and other health care specialties?

B. **Mental Health Recovery** - Are practitioners focused on reducing and managing psychiatric symptoms that impair daily functioning through the use of psychiatric medication in combination with counseling and supportive services necessary to reduce symptoms and build coping skills?

C. **Addiction Recovery** - Is the team addressing various aspects of substance use, relapse prevention and addiction recovery with careful identification of co-occurring issues that are essential for effective planning?

D. **Trauma Recovery** - How effectively are the practitioners addressing the lingering adverse effects of complex trauma (e.g., processing trauma-related memories and feelings, discharging pent-up "fight-or-flight" energy, learning how to regulate strong emotions via new coping skills, and rebuilding the ability to trust other people) by designing a process that may involve safety planning, cognitive behavioral strategies, social supports, and medication?

E. **Safety from Harm** - To what extent is the team planning strategies for keeping persons safe from risk of harm by self or others, and from life-threatening health crises? Is there an effective safety plan in place known and understood by the entire team and supporters of the person?

F. **Income & Basic Necessities** - Is the team effectively developing strategies and securing supports for work, earned income, securing and managing benefits, obtaining housing, food stamps, housing, income maintenance, health care, medicine, or child care necessary for maintaining the functioning of the person/family?

G. **Functional Life Skills** - To what extent are strategies being developed for the person involving skill-specific training and direct support (e.g., activities of daily living (ADLs), managing health issues and medication, and managing behavioral issues via effective coping skills) to acquire, apply, and sustain functional life skills in daily living situations necessary for successful everyday living and fulfilling important life roles?

H. **Education or Work** - How effectively is the team addressing issues of education, career development, volunteering as a productive activity, and work, either competitive or supported as needed and desired by the person.

I. **Community Integration** - To what extent do recovery plans include regaining degrees of community integration involving making decisions about choice of social supports and life activities in mainstream settings outside of an institution or provider agency (e.g., attending a ball game, eating in a cafe, riding a public bus, voting in an election)?

J. **Another Intervention Area Not Stated Above**.

PRACTICE INDICATOR 7: PERSON-CENTERED PLANNING

Practice Rating Description that Best Fits the Fact Pattern Observed

Description of the Practice Performance Situation Observed for Applicable Intervention Categories	Rating Level
◆ **Optimal Practice.** Practice efforts indicate optimal planning in the identified domains, resulting in well-reasoned, agreed-upon interventions consisting of a combination and sequence of planned strategies, supports, and services developed with the person/family at the center of the process, which guide implementation toward life changes for the person/family. Strategies are evidence-based and/or known to work for the person/family. Accommodations, abilities, and preference are fully and accurately recognized and incorporated into planning processes and identification of strategies and supports.	**6**
◆ **Good Practice.** Practice efforts indicate good planning in the identified domains, resulting in generally well-reasoned, agreed-upon interventions consisting of a combination and sequence of planned strategies, supports, and services that are mostly developed with the person/family at the center of the process and which usually guides implementation toward life changes for a person/family. Many strategies are evidence-based and/or known to work for the person/family. Many accommodations, abilities, and preference are recognized and incorporated into planning processes and identification of strategies and supports.	**5**
◆ **Fair Practice.** Practice efforts indicate fair planning in the identified domains, resulting in somewhat reasoned, agreed-upon interventions consisting of a combination and sequence of planned strategies, supports, and services that are sometimes developed with the person/family at the center of the process and/or sometimes guide implementation toward life changes for a person/family. Most strategies are evidence-based and/or are known to work for the person/family. Some accommodations, abilities, and preference are recognized and incorporated into planning processes and identification of strategies and supports..	**4**
◆ **Marginally Inadequate Practice.** Practice efforts indicate marginally inadequate planning in the identified domains, resulting in limited or partially reasoned and agreed-upon interventions consisting of a combination and sequence of planned strategies, supports, and services that are inconsistently developed with the person/family at the center of the process and/or inconsistently guide implementation toward life changes for a person/family. Many strategies are not evidence-based or known to work for the person/family. Accommodations, abilities, and preference are not fully recognized, understood, or incorporated into planning processes and identification of strategies and supports.	**3**
◆ **Poor Practice.** Practice efforts indicate poor planning in, or failure to identify relevant domains, resulting in a lack of reasoned and agreed-upon interventions that do not consist of a combination and sequence of planned strategies, supports, and services developed with the person/family at the center of the process. Strategies are not evidence-based or are not known by practioners to be effective with the person/family. Accommodations, abilities, and preference are not recognized, understood, or incorporated into planning processes and identification of strategies and supports.	**2**
◆ **Absent or Adverse Practice.** Practice efforts indicate absent or adverse planning in, and/or failure to identify relevant domains, resulting in misidentification of interventions, strategies, and supports. Strategies are not evidence-based or may be negatively affect progress toward the person/family's goals. Accommodations, abilities, and preference are unrecognized, misunderstood, or possibly disregarded or disrespected by some or all practitioners. Planning processes are not person-centered and maybe causing distress to the person/family.	**1**
◆ **Not Applicable.** There is no identified need nor personal recovery goal in this area at this time; therefore, no planned intervention is expected for this area at this time.	**NA**

NOTE: **Using the QSR Roll-Up Sheet, rate each applicable area by applying the 6-point rating scale to each. Mark any intervention area that does not apply as Not Applicable.**

☐ a. Physical wellness	☐ d. Trauma recovery	☐ g. Functional life skills	☐ j. Other
☐ b. MH recovery	☐ e. Safety from harm	☐ h. Education or work	
☐ c. Addiction recovery	☐ f. Income & necessities	☐ i. Community integration	

Practice Indicator 8: Implementing Interventions

Focus Measure

IMPLEMENTING INTERVENTIONS. Degree to which interventions: • Are delivered in a manner sufficient to help the person make adequate progress toward meeting planned goals. • The combination of supports and services fits the person's situation so as to maximize benefits and minimize any conflicting strategies or inconveniences.

Core Concepts

Implementation of PERSON-CENTERED INTERVENTIONS provides for the timely, competent, and consistent delivery of planned interventions (strategies, supports, services) in ways that are consistent with the goals set by and for the person, convenient for the person and family, and sufficient in power and effectiveness to bring about the life changes that lead to goal attainment. Implementation follows and flows from the strategies, supports, and services specified in person's treatment and support plans. Implementation of intervention strategies, supports, and services may occur in one or more the following areas.

Fact Pattern -- Apply the Probe Questions, Assemble the Facts, and Consider the Pattern Found over the Past 90 Days

A. **Physical Wellness** - To what extent is the team achieving and maintaining the person's best attainable health status by managing any health concerns and/or helping the person access services necessary to manage chronic health conditions (e.g., seizures, COPD, diabetes, obesity, thyroid issues, hypertension, Hep-C, HIV/AIDS, etc.) that require involvement of practitioners from primary health care and other health care specialties in the ongoing monitoring and coordination of multiple treatment modalities for the person? • Strategies in this area involve not only the health care practitioners but also those supportive persons (e.g., the person, caregiver, health educator, care coordinator, and/or community support worker) having important roles in health education, transportation, medication administration, and meeting other daily health maintenance requirements.

B. **Mental Health Recovery** - Are practitioners focused on reducing and managing psychiatric symptoms that impair daily functioning through the appropriate use of psychiatric medication in combination with counseling and supportive services necessary and sufficient to reduce symptoms and build coping skills?

C. **Addiction Recovery** - Is the team addressing various aspects of substance use dependence treatment, relapse prevention, and addiction recovery with careful identification and attention being given to co-occurring disorders (e.g., depression and opiate addiction)? • When appropriate, is the use of psychiatric medications to treat mental health issues and medication to treat addictions issues used for dual intervention strategies to achieve key outcomes for sobriety and mood stability?

D. **Trauma Recovery** - How effectively are the practitioners addressing the lingering adverse effects of complex trauma (e.g., processing trauma-related memories and feelings, discharging pent-up "fight-or-flight" energy, learning how to regulate strong emotions via new coping skills, and rebuilding the ability to trust other people) by designing a process that may involve safety planning, cognitive behavioral strategies, social supports, and medication?

E. **Safety from Harm** - To what extent is the team planning strategies for keeping persons safe from risk of harm by self or others, and from life-threatening health crises (e.g., no contact orders, crisis responses, safety supports, plan for immediate medical care)? Is there an effective safety plan in place known and understood by the entire team and supporters of the person?

F. **Income & Basic Necessities** - Is the team effectively developing strategies and securing supports for work, earned income, securing and managing benefits, obtaining housing, food stamps income maintenance, health care, medicine, or child care necessary for maintaining the functioning of the person/family?

G. **Functional Life Skills** - To what extent are strategies being developed for the person involving skill-specific training and direct support (e.g., activities of daily living [ADLs], managing health issues and medication, and managing behavioral issues via effective coping skills) to acquire, apply, and sustain functional life skills in situations necessary for successful everyday living and fulfilling important life roles?

H. **Education or Work** - How effectively is the team addressing issues of education, career development, volunteering as a productive activity, and work, either competitive or supported, as needed and desired by the person?

I. **Community Integration** - To what extent do recovery plans include regaining degrees of community integration involving making decisions about choice of social supports and life activities in mainstream settings outside of an institution or provider agency (e.g., attending a ball game, eating in a cafe, riding a public bus, voting in an election)?

J. **Another Intervention Area Not Stated Above**.

PRACTICE INDICATOR 8: IMPLEMENTING INTERVENTIONS

Practice Rating Description that Best Fits the Fact Pattern Observed

Description of the Practice Performance Situation Observed for Applicable Intervention Areas	Rating Level
◆ **Optimal Practice.** Evidence shows excellent implementation of identified strategies, services, and supports. Planned interventions are applied with discipline and fidelity, in a timely, competent, and consistent manner. The combination of supports and services fits the person's situation so as to maximize benefits and minimize any conflicting strategies or inconveniences. Supports are implemented in ways that are consistent with the goals set by and for the person, convenient for the person and family, and sufficient in power and effectiveness to facilitate progress.	**6**
◆ **Good Practice.** Evidence shows good implementation of identified strategies, services, and supports. Planned interventions are mostly applied with discipline and fidelity, in a timely, competent, and consistent manner. The combination of supports and services usually fits the person's situation so as to maximize benefits and minimize any conflicting strategies or inconveniences. Supports are implemented in ways that are mostly consistent with the goals set by and for the person, convenient for the person and family, and sufficient in power and effectiveness to facilitate progress.	**5**
◆ **Fair Practice.** Evidence shows fair implementation of identified strategies, services, and supports. Planned interventions are applied with some discipline and fidelity, in a mostly timely, competent, and consistent manner. The some combinations of supports and services fit the person's situation, however, don't necessarily maximize benefits and minimize conflicting strategies or inconveniences. Some supports are implemented in ways that are somewhat consistent with the goals set by and for the person, convenient for the person and family, and sufficient in power and effectiveness to facilitate progress.	**4**
◆ **Marginally Inadequate Practice.** Evidence shows marginally inadequate implementation of identified strategies, services, and supports. Planned interventions are inconsistently applied with discipline and fidelity, in a limited timely, marginally competent, and/or inconsistent manner. Combinations of supports and services may not fit the person's situation or may only occasionally maximize benefits and minimize conflicting strategies or inconveniences. Some supports are implemented in ways that are somewhat inconsistent with the goals set by and for the person, convenient for the person and family, and may be sufficient in power and effectiveness to facilitate some progress.	**3**
◆ **Poor Practice.** Evidence shows poor implementation of identified strategies, services, and supports. Planned interventions are seldom applied with discipline and fidelity or in a timely, competent, and consistent manner. Combinations of supports and services do not fit the person's situation and/or rarely maximize benefits or minimize conflicting strategies or inconveniences. Supports are implemented in ways that do not match with the goals set by and for the person, are inconvenient for the person and family, or are insufficient in power and effectiveness to facilitate progress.	**2**
◆ **Absent or Adverse Practice.** Evidence shows absent or adverse implementation of identified strategies, services, and supports. Planned interventions are not applied with discipline and fidelity or in a timely, competent, and consistent manner. Combinations of supports and services do not fit the person's situation and/or may be delivered in a manner that is contraindicated for the progress and/or well-being of the person/family. Some services and supports are not being delivered, or are being implemented in ways that disregard the goals set by and for the person, are inconvenient for the person and family, or are insufficient in power, consistency, and effectiveness to facilitate progress.	**1**
◆ **Not Applicable.** One or more of the intervention areas do(es) not apply at this time.	**NA**

NOTE: **Using the QSR Roll-Up Sheet, rate each applicable area by apply the 6-point rating scale to each. Mark any intervention area that does not apply as Not Applicable.**

☐ a. Physical wellness	☐ d. Trauma recovery	☐ g. Functional life skills	☐ j. Other
☐ b. MH recovery	☐ e. Safety from harm	☐ h. Education or work	
☐ c. Addiction recovery	☐ f. Income & necessities	☐ i. Community integration	

PRACTICE INDICATOR 9: MEDICATION MANAGEMENT

Focus Measure

MEDICATION MANAGEMENT. Degree to which: • Use of any psychiatric/addiction control medications and medications for physical health issues (e.g., seizures, diabetes, asthma/COPD, GERD, HIV) for this person are necessary, safe, and effective. • The person has a voice in medication decisions and management. • The person is routinely screened for medication side effects and treated when side effects are detected. • New atypical/current generation drugs have been tried, used, and/or appropriately ruled out. • Use of medication is being coordinated with other treatment providers as necessary for any co-occurring conditions.

Core Concepts: This Indicator Applies to Persons Taking Psychiatric/Addiction Control Medications

Use of psychiatric/addiction control medications is one of many treatment modalities that may be used in treating a person having a serious emotional disorder or addiction. The person also must have access to necessary specialized health care services, including treatment and care for any co-occurring conditions (e.g., seizures, asthma, diabetes, addiction, HIV). When use of any such medications is deemed necessary and appropriate, it should conform to standards of good and accepted practice, including informed consent, consultation, most efficacious drug selection, consistency with medication protocols, demonstrated treatment response, and minimal effective dose. Effects and side effects of medication use should be assessed, tracked, and used to inform decision making. Any adverse side effects should be addressed and treated.

Use of medications should be coordinated with other modalities of treatment, including positive behavioral supports, behavioral interventions, counseling, skill development, and social supports. Continuity in medication regimes should be present across treatment settings. The purpose is to determine whether the person receives and benefits from safe medication practices. **This review does not apply to a person who has not taken psychotropic medications within the past 90 days.**

Fact Pattern -- Apply the Probe Questions, Assemble the Facts, and Consider the Pattern Found over the Past 90 Days

1. Does the person take a psychotropic/addiction control medication?

2. Is there a DSM-5 diagnosis to support each psychotropic medication? • Is use consistent with current treatment protocols?

3. Does the person take medication for co-occurring physical health care conditions? • Have coordinating staff consulted with other treating professionals (e.g., PCP, neurologists, psychiatrists) for a person having chronic and/or complex health care needs?

4. Does the person know what each psychotropic/addiction and physical health medication is, as well as its intended benefits and possible risks?

5. If multiple psychotropic medications are used with the person, is there written justification by the physician? • Is the primary care physician informed of these medications?

6. Is the purpose for each medication documented and tracked to target symptoms or maladaptive behaviors? • Is each medication consistent with intended use?

7. Has a minimum effective dosage of each medication been determined or are steps being taken to do so? • Who is responsible for medication monitoring and screening for side effects?

8. Is there periodic evaluation of the person's response to treatment using data to track target symptoms or behaviors?

9. Is there quarterly screening of the person for adverse effects of medications? • If adverse effects have been found, have appropriate countermeasures been implemented?

10. Is medication use coordinated with other treatment modalities?

11. Does the person have access to specialized health care services? • Have coordinating staff consulted with other treating professionals (e.g., neurologists, psychiatrists) for a person having chronic and/or complex health care needs?

12. Is relapse prevention information available to the person? • Is educational information about medications, effects/side effects, and self-medication available?

PRACTICE INDICATOR 9: MEDICATION MANAGEMENT

Practice Rating Description that Best Fits the Fact Pattern Observed

Description of the Practice Performance Situation Observed for the Person — Rating Level

- **Optimal Medication Management.** The person presents symptoms, behaviors and/or illnesses that are responding well to current generation medications with no report of bothersome side effects. The person reports good compliance with the prescribed medications and is not requesting any changes at this time. Use of medications is well coordinated between mental and physical health practitioners and with other treatment modalities. The person and physicians have an understanding about how he/she is to manage increases/decreases in medications. The person has full and timely access to both high quality mental and physical health care for any serious co-occurring conditions. **6** ☐

- **Good Medication Management.** The person presents symptoms, behaviors or illnesses that are responding fairly well to current generation medications but reports some mild side effects. The person reports that sometimes medications are not taken as prescribed. Use of medications is sometimes coordinated between mental and physical health practitioners and with other treatment modalities. The person and physicians have an understanding about how he/she is to manage increases/decreases in medications. The person has full and timely access to both high quality mental and physical health care for any serious co-occurring conditions. **5** ☐

- **Fair Medication Management.** The person is becoming stable on appropriate medication and presents some symptoms or behaviors of concern and complains of side effects. Use of medication is checked conversationally and staff hint at non-compliance. The person may refuse participation in medication education activities. Medication is minimally coordinated between mental and physical health practitioners and with other treatment modalities. The person has minimally adequate access to both fair quality mental and physical health care for any serious health co-occurring conditions, including specialists with a short waiting period. **4** ☐

- **Marginally Inadequate Medication Management.** The person presents symptoms or behaviors that may be responding somewhat to medications. Medication use may be inconsistent. Consents may not have been obtained. Screening for side effects may not be current or mild side effects may be noted but minimally treated. Use of medication is seldom coordinated between mental and physical health practitioners and with other treatment modalities. The person has somewhat limited access to fair to poor quality mental and physical health care for any serious health co-occurring conditions and may receive most care from emergency rooms. **3** ☐

- **Poor Medication Management.** The person presents symptoms or behaviors that may not be responding to medications. Medication use may not be well documented or justified. Consents may be missing. Screening for side effects may not be current or moderate side effects may be noted. Use of medication is not coordinated between mental and physical health practitioners or with other treatment modalities. The person has inconsistent or very slow access to mental or physical health care for any serious co-occurring conditions. The person's physical or psychiatric status may be at risk due to inadequate health care for treating nay co-occurring conditions. **2** ☐

- **Absent or Adverse Medication Management.** The person presents increasing symptoms or behaviors that may not be responding to medications. Medication use may be undocumented, not justified, or experimental. Consents may be missing. Screening for side effects may not occur or serious side effects may be present and untreated. Use of medication is conflicting with other treatment modalities. The person has poor or no access to needed mental or physical health care for any serious co-occurring conditions. The person's physical or psychiatric status may be declining due to inadequate health care. **1** ☐

- **Not Applicable.** The person does not now take psychotropic medications, nor has the person used such medications within the past 90 days. Therefore, this review does not apply. **NA** ☐

Practice Indicator 10: Tracking, Adjustments, Transitions, Discharges

Focus Measure

SITUATION TRACKING, PLAN ADJUSTMENT, TRANSITIONS/DISCHARGES. Degree to which: • Situational awareness is sustained by tracking the person's life situation, changing circumstances, service process, progress, and goal attainment. • Plans are kept relevant and effective by identifying and resolving service problems, overcoming barriers, and replacing failed strategies. • Seamless and successful transitions are achieved by ensuring continuity of care across settings and providers as well as supporting the person's successful post-change life adjustments in a new setting or situation.

Core Concepts

Situational Awareness is accomplished through ongoing situational tracking used to: 1) monitor the person's status, service process, and progress; 2) identify emergent needs and problems; and 3) plan adjustments in services to keep strategies relevant and effective. Measuring progress toward wellness/recovery goals is an essential part of tracking and is accomplished by tracking the direction and pace of life changes made and proximity to the attainment of goals.

Plan Adjustment involves effective tracking and adjustment that build results-based accountability into case practice. Intervention strategies, supports, and/or services are tracked and are modified when goals are met, strategies are determined to be ineffective, new preferences or dissatisfactions with existing strategies or services are expressed, and/or new needs or circumstances arise. Working together, the care coordinator, team members, and the person/family play a central role in tracking and adjusting intervention strategies, services, and supports by applying knowledge gained through ongoing assessments, monitoring, and periodic evaluations.

Transitions & Discharges. Care transition refers to movement of a person between care locations, providers, or different levels of care within the same location as the person's condition and care needs change. It is a subpart of the broader concept of care coordination which involves organizing numerous providers who are dependent upon each other to carry out disparate activities in a person's care. This shared decision-making requires that each provider have adequate knowledge about their own and others' roles and available resources, and relies on the exchange of information in order to gain this knowledge. An effective discharge and care transition ensures the person/family are able to understand and use essential health information they have been given in order to move seamlessly from one service setting or provider to another. Carefully planned transfer of clinical responsibility is essential with the information needed to fulfill that responsibility safely and effectively. The process requires: 1) essential clinical information be provided at transition or discharge, 2) the opportunity to ask questions, 3) a "seamless clinical envelope" with a responsible clinician (i.e., the person is always enclosed in and surrounded by the care system, there are no lapses in care, and at all times in the transition there is an identifiable knowledgeable available clinician who is responsible for managing the person's/family's clinical issues), 4) and that logistical/management support is present for the person/family with the person's status and well-being being monitored across life adjustments throughout the transition process. Care and support are provided during the change process to ensure the person is managing the stress of the change, is stable and functioning successfully in the new setting and has adequate supports provided for ongoing success.

Fact Pattern -- Apply the Probe Questions, Assemble the Facts, and Consider the Pattern Found over the Past 90 Days

1. **Sustaining Situational Awareness.** To what extent is the team maintaining adequate awareness and understanding of the person's status, service process, and progress that are essential for effective care coordination? • Is there an identified care coordinator has a lead responsibility for sustaining situational awareness while working collaboratively with the person and others involved in the person's care? • Is there a tracking process in place to: • Monitor the person's status, service process, and progress and • Identify emergent needs and problems?

2. **Keeping Plans Relevant**. Are the care coordinator or case manager and clinician who have lead responsibilities for working collaboratively with the person and his/her team updating assessments, advancing the clinical case formulation, modifying goals, and refining risk management and intervention plans for the provision of supports and services? • Is there adequate focus on: 1) facilitating team decision-making about next step actions 2) by planning adjustments in strategies, supports, and services to keep plans relevant and effective?

3. **Achieving Successful Transitions/Discharges and Continuity of Care**. Are the person's care coordinator, clinician, and care team effectively taking a central role in planning and facilitating transition activities (including those involving discharge from one place of care and movement to another) in order to ensure continuity of care during a seamless transition to and successful life adjustment in a different care location? • Are the lead clinician and care coordinator: - Providing essential clinical information at discharge and during the transition process; - Answering questions posed by the person/family; - Providing wraparound care and support to prevent any lapses or breakdowns in care during and after the transition; - Providing logistical and management support for the person/family during the transition; - Providing follow-along support after the transition to ensure that the person has continuity of care and achieves a successful life adjustment with sufficient ongoing supports in place?

PRACTICE INDICATOR 10: TRACKING, ADJUSTMENTS, TRANSITIONS, DISCHARGES

Practice Rating Description that Best Fits the Fact Pattern Observed

Description of the System Performance Situation Observed for the Person — Rating Level

- **Optimal Practice.** Optimal practice efforts indicate strong and accurate situational awareness and tracking of the person's life situation, changing circumstances, effectiveness of services, and progress toward goal attainment. Practioners and team members are engaged in a process of clearly identifying and resolving service problems, overcoming barriers, and replacing failed strategies. Transitions are seamless and successful with excellent continuity of care across settings and providers resulting is successful life adjustments. **6** ☐

- **Good Practice.** Good practice efforts indicate accurate situational awareness and tracking of the person's life situation, changing circumstances, effectiveness of services, and progress toward goal attainment. Practioners and team members are generally engaged in a process of identifying and resolving service problems, overcoming barriers, and replacing failed strategies. Transitions are generally seamless and substantially successful with good continuity of care across settings and providers resulting in positive life adjustments. **5** ☐

- **Fair Practice.** Fair practice efforts indicate mostly accurate situational awareness and tracking of the person's life situation, changing circumstances, effectiveness of services, and progress toward goal attainment. Practioners and team members are sometimes engaged in a process of identifying and resolving service problems, overcoming barriers, and replacing failed strategies. Some transitions are seamless and successful with some continuity of care across settings and providers, resulting in some fair life adjustments. **4** ☐

- **Marginally Inadequate Practice.** Marginally inadequate practice efforts indicate inconsistently accurate situational awareness and tracking of the person's life situation, changing circumstances, effectiveness of services, and progress toward goal attainment. Practioners and team members engage in a limited or inconsistent process of identifying and resolving service problems, overcoming barriers, and replacing failed strategies. Transitions are erratic, with some gaps occurring in continuity of care across settings and providers resulting in some insufficient supports for life adjustments. **3** ☐

- **Poor Practice.** Poor practice efforts indicate very limited situational awareness and tracking of the person's life situation, changing circumstances, effectiveness of services, and progress toward goal attainment. Practioners and team members don't regularly engage in a process of identifying and resolving service problems, overcoming barriers, and replacing failed strategies. This process may not be occurring or does not include all team members or the person/family. Transitions are cumbersome and include breaks in service or no continuity of care across settings and providers resulting in poor life adjustments. **2** ☐

- **Absent or Adverse Practice.** Absent or Adverse practice efforts indicate no situational awareness and tracking of the person's life situation, changing circumstances, effectiveness of services, and progress toward goal attainment. There is no process of identifying and resolving service problems, overcoming barriers, and replacing failed strategies. Transitions are troublesome and include long breaks in service and no continuity of care across settings and providers. The person/family may be experiencing set backs in treatment, relapse, or are possibly unsafe. **1** ☐

- **Not Applicable.** Identification efforts reveal no evidence of needs to be addressed for transition services for this person at this time. This review indicator is deemed **not applicable** to this person. **NA** ☐

Section 4

Overall Patterns

GUIDANCE FOR DETERMINING AN OVERALL STATUS RATING

GENERAL DIRECTIONS

The QSR Protocol provides directions to reviewers for determining an Overall Status Rating and Overall Practice Rating in a case for which a review has been completed for all of the indicators in each section. Each section (status and practice) has guidance for determining conditions under which Overall Status and Overall Practice Performance are deemed acceptable. For example, the status of the focus person cannot be regarded as acceptable if the person is found to be unsafe in her/his daily settings. Provided in the sections that follow are general rules of thumb used by reviewers. This guidance is used when selecting an overall rating pattern that best fits the aggregate ratings for a person and family being reviewed.

OVERALL STATUS RATING

General guidance is provided to assist QSR reviewers when selecting one of six possible rating categories for reporting the Overall Rating for the Status Section for the person being reviewed. This rating provides an answer to the question: *Overall, how well is the person doing at the time of the review?* Presented below are descriptions of six possible aggregate rating patterns for status indicators that may be found in a case under review. These general descriptions are offered to guide QSR reviewers in making their selections of overall status ratings so reviewers will be consistent in their work and so users of QSR findings will be aware of the manner in which overall ratings are determined. *Please refer to page 2 of the QSR Roll-Up Sheet after recording the indicator ratings when applying the following instructions.*

Selecting the Overall Status Rating category is based on the aggregate pattern found for the applicable status indicators in a case. The aggregate pattern is taken into account by the reviewer after assuring that the person is **SAFE** -- *that is, having ratings of 4 or higher for all applicable settings on Status Indicator 1: Safety from Harm by Others.*

The general interpretations for these overall ratings are defined as follows:

- **Level 6 - Optimal Overall Status**. At level 6, the person is SAFE. The preponderance of applicable indicator ratings in the status domain are rated 6. All status ratings for the person are in the 4-6 range.

- **Level 5 - Good Overall Status**. At level 5, the person is SAFE. The preponderance of applicable indicator ratings in the status domain are rated in the 5 range. No status indicator is rated lower than 3.

- **Level 4 - Fair Overall Status**. At level 4, the person is SAFE. The preponderance of applicable indicator ratings in the status domain are rated in the 4 range. No status indicator is rated lower than 2.

  Note: *In a situation in which status indicator ratings are equal, the reviewer should give weight to the following key status indicators when selecting an overall rating of 3 or 4: Financial Security & Personal Management, Social Network, Mental Health Status, and Substance Use Status. That is, if the majority of these indicators is rated 4 or higher, then the overall rating should be 4. Conversely, if the majority of these indicators is rated 3 or lower, then the overall rating should be 3.*

- **Level 3 - Marginally Inadequate Overall Status**. At level 3, the person may have some occasional safety concerns of a mild nature and/or the preponderance of applicable indicator ratings in the status domain may be rated in the 3 range.

- **Level 2 - Poor Overall Status**. At level 2, the person may have some significant safety concerns and/or the preponderance of applicable indicator ratings in the status domain may be rated in the 2 range.

- **Level 1 - Adverse and Worsening Overall Status**. At level 1, the person and/or family situation may pose serious and worsening safety threats and/or the preponderance of applicable indicator ratings in the status domain may be rated in the 1-2 range.

The reviewer uses the rating patterns and ranges noted on the completed QSR Roll-Up Sheet for the person to determine the rating category above that best describes the overall status situation observed at the time of review.

NOTEWORTHY EXCEPTIONS - REASONS FOR GIVING AN ALTERNATIVE STATUS SECTION RATING

The patterns of aggregate ratings suggested to guide a QSR reviewer to an overall status and practice rating are meant to be used under general conditions. If, in the course of a review, the reviewer finds a rare and complex situation that, by its unusual nature, strongly points to a different rating interpretation, the reviewer should present the evidence and compelling reasons that a higher or lower domain rating should be given.

The presentation of evidence and compelling reasons should be made to the QSR team and team leader. If the team concurs with the reviewer's recommendation and if the leader so directs, the reviewer may report a rating that fairly fits the situation found although it departs from the rating guidance offered above.

GUIDANCE FOR DETERMINING AN OVERALL PRACTICE RATING

OVERALL PRACTICE RATING

The following guidance is provided to assist QSR reviewers when selecting one of six possible rating categories for reporting the Overall Rating for the Practice Section for the person being reviewed.

This rating provides an answer to the question: *Overall, how well is case practice working for the person at the time of the review?* Presented below are descriptions of six possible aggregate rating patterns for practice indicators that may be found in the case under review. These general descriptions are offered to guide QSR reviewers in making their selections of overall practice ratings so reviewers will be consistent in their work.

Selecting the Overall Practice Rating category is based on the aggregate pattern found for the applicable practice indicators in a case. Reviewers are directed to determine where the preponderance of ratings falls when examining the rating patterns.

Once the preponderance of ratings and lowest rated indicators are determined, the reviewer selects the overall rating description that best fits the pattern of findings.

The interpretations for these overall ratings are defined as follows:

- **Level 6 - Optimal Overall Practice**. At level 6, the preponderance of applicable indicator ratings in the practice domain are rated 6. All practice ratings for the person are in the 4-6 range.

- **Level 5 - Good Overall Practice**. At level 5, the preponderance of applicable indicator ratings in the practice domain are rated in the 5 range. No practice indicator is rated lower than 3.

- **Level 4 - Fair Overall Practice**. At level 4, the preponderance of applicable indicator ratings in the practice domain are rated in the 4 range. No practice indicator for the person is rated lower than 2.

  Note: *In a situation in which practice indicator ratings are equally divided between 3 and 4 ratings across the applicable set, the reviewer should give weight to the following core practice functions when selecting an overall rating of 3 or 4: Engagement, Teaming & Care Coordination, Assessment & Case Formulation, Planning Interventions, and Implementing Interventions. That is, if the majority of these core indicators is rated 4 or higher, then the overall rating should be 4. Conversely, if the majority of these indicators is rated 3 or lower, then the overall rating should be 3.*

- **Level 3 - Marginally Inadequate Overall Practice**. At level 3, the preponderance of applicable indicator ratings in the practice domain may be rated in the 3 range for the person. Some indicators may be rated in the 1-2 range.

- **Level 2 - Poor Overall Practice**. At level 2, the preponderance of applicable indicator ratings in the practice domain may be rated in the 2 range for the person. Many indicators may be rated in the 1-2 range.

- **Level 1 - Adverse Overall Practice**. At level 1, the preponderance of applicable indicator ratings in the practice domain may be rated in the 1-2 range for the person with many falling into the 1 rating.

The reviewer uses the rating patterns and ranges noted on the completed QSR Roll-Up Sheet for the person to determine the rating category above that best describes the overall case practice situation observed. The Overall Practice Rating is used to reflect the level of service system performance for the person at the time of review.

NOTEWORTHY EXCEPTIONS - REASONS FOR GIVING AN ALTERNATIVE PRACTICE SECTION RATING

The patterns of aggregate ratings suggested to guide a QSR reviewer to an overall status and practice rating are meant to be used under general conditions. If, in the course of a review, the reviewer finds a rare and complex situation that, by its unusual nature, strongly points to a different rating interpretation, the reviewer should present the evidence and compelling reasons that a higher or lower domain rating should be given.

The presentation of evidence and compelling reasons should be made to the QSR team and team leader. If the team concurs with the reviewer's recommendation and if the leader so directs, the reviewer may report a rating that fairly fits the situation found although it departs from the rating guidance offered above.

Six-Month Forecast

Forecasting the Trajectory of the Person's Expected Future Course

Determination of the Overall Status, Progress, and Practice Ratings for the person is based on the observed current patterns as they emerge from the recent past. When making a six-month forecast, the reviewer projects the person's overall status pattern six months forward from the date of the review estimating whether the person will likely remain at a high level (if currently at a high level), improve to higher level, decline to a lower level, or remain at a low level (if currently at a low level).

The **projection method builds on known facts, historic patterns, and recent tendencies** known about the person's current status, known case circumstances, present practice performance, and local conditions at the service site. Forming a six-month forecast is based on **predicable future events** (e.g., the person being discharged from residential treatment and returned to home and work within the next 60 days) and **informed predictions** (e.g., probability of termination of parental rights for a parent that has a poor prognosis for reunification for his or her child who has been in care for 22 months or longer) about the expected course of change over the next six months, grounded on known current status and practice performance as well as knowledge of tendency patterns found in case history.

Based on what is known about this case and what is likely to occur in the near-term future, the reviewer makes an informed prediction of the near-term trajectory in this case. *Assume that the service system's practice performance continues doing business as usual when making the six-month prediction.* Mark the appropriate alternative future statement in the space provided for the Six-Month Prognosis on the roll-up sheet. The facts that lead the reviewer to this view of case trajectory should be reflected in the reviewer's findings and recommendations.

Six-Month Forecast

Based on the person's **current overall status**, recent progress, the current level of **overall practice performance**, and **events expected to occur over the next six months**, is this person's overall status expected to maintain at a high level, improve to a higher level, remain about the same, decline over the next six months, or remain at low level six months from now -- if current practice continues business as usual? (check only one)

- ☐ **MAINTAIN at a CURRENTLY HIGH STATUS LEVEL (5-6 range)**
- ☐ **IMPROVE to a level HIGHER than the current overall status**
- ☐ **CONTINUE at the SAME STATUS LEVEL — status quo**
- ☐ **DECLINE to a level LOWER than the current overall status**
- ☐ **REMAIN at a CURRENTLY LOW STATUS LEVEL (1-2 range)**

Section 5

Reporting Outlines

Written Case Review Summary

Person's Story & Status Findings

Facts about the Review

- Provider Agency
- Person's Code
- Reviewer's Name
- Review Date
- Date of Report
- Person's Placement

People Interviewed during this Review

Indicate the number and role (person, home provider, live-in associated, service coordinator, therapist, job coach, etc.) of the persons interviewed during the course of review. Indicate any key persons who were unavailable or unwilling to participate in interviews.

Facts About the Person and Living Arrangement

- Person's situation and living arrangement
- Reasons for mental health and/or addiction treatment services
- Service presently received
- Other agencies involved

Person's Current Status

Describe the current status of the person and living arrangement based on status review findings relative to well-being, daily functioning, necessary supports, and fulfillment of applicable adult roles. Mention relevant historical facts that are necessary for an understanding of the person's current status. Use a concise flowing narrative to tell the "case story" and make sure that it supports and adequately illuminates the Overall Status rating. If any unfavorable status result puts the person at risk of harm, explain the situation.

Person's Recent Progress

Describe the person's recent progress as revealed in the progress indicators. As appropriate to the person's situation, address matters related to recovery and relapse prevention.

Factors Contributing to Favorable Status & Progress

Where status is positive, indicate the contributions that the person's own strengths, good clinical reasoning and practical problem solving by practitioners, and uses of natural supports and generic community services made to the results.

Factors Contributing to Unfavorable Status

Describe any personal challenges or local practice conditions that seem to be contributing to the current unfavorable status and how the person may be adversely affected now or in the near-term future, if status is not improved.

Practice Performance Findings

Describe the current practice performance of the service system for this person using a concise narrative form. Mention any historical facts or local circumstances that are necessary for understanding the situation.

What's Working Now

Identify and describe which service system functions are now working adequately for this person. Focus on practice strengths in engaging/teaming, understanding, planning, implementing, and getting/using results. Briefly explain the factors that are contributing to the current success of these system functions.

What's Not Working Now and Why

Identify and describe any service system functions that are <u>not</u> working adequately for this person. Focus on practice challenges in engaging/teaming, understanding, planning, implementing, and getting/using results. Briefly explain the problems that appear to be related to any current breakdowns in any of these functions.

Six-Month Forecast/Stability of Findings

Based on current service system performance found in this case, is the person's overall status likely to improve, stay about the same, or decline over the next six months -- assuming that practice continues business as usual? Take into account current service quality and important life change adjustments that may occur over this time period. Explain your rationale for the prognosis made.

Practical Steps to Sustain Success and Overcome Current Problems

Suggest several practical *next steps* that could be taken to sustain and improve successful practice activities over the next six months. Suggest practical steps that could be taken to overcome current problems and to improve poor practices and local working conditions for this person in the next 90 days.

Reporting Considerations

When using an unbounded reporting format, the summary should not exceed six typed pages, depending on the complexity of the case and the extent of supports and services being provided by various agencies. When using a writing template, complete all sections and elements as appropriate to the case. Follow the guidance provided for length of statements entered into text blocks in the template.

Ensure that consistency exists between all forms of reporting made to agency staff, including the feedback session, grand rounds session, roll-up sheet and case review summary. Submit the completed report in the manner directed and by the deadline set by the QSR Team Leader.

10-Minute Oral Presentation Outline for Grand-Rounds

Oral Presentation Outline*

1. Facts about the Person — 3 minutes

- Key facts: age, gender, diagnoses, medications, residence, work, family/informal supports
- Strengths and needs of the person
- Reasons for current services
- Person's wellness / recovery goals and treatment services
- Other agencies involved

2. Person's Current Status & Recent Progress — 3 minutes

- Status in well-being areas (safety, health, income, living arrangement, etc.)
- Status in community living and daily functioning
- Status in fulfilling key life roles (employee, parent/caregiver)
- Overall status rating (on 1-6 scale)
- Overall progress rating (on 1-6 scale)
- Any present problems or unmet needs

3. Practice Performance — 3 minutes

- Engagement and quality of trust-based working relationships
- Care coordination and teamwork
- Understanding the situation (assessment and case formulation)
- Planning goal and interventions
- Implementing interventions
- Getting and using results (including tracking)
- Overall practice rating (1-6 scale)
- Six-month forecast

4. Closing Items — 1 minutes

- Suggested Next Steps
- What this case teaches about practice

Total Presentation Time	10 minutes

5. Questions to Presenter — 5 minutes

** NOTE: This is a facilitated presentation and discussion session that uses a timekeeper.*