

Single Point of Accountability Indicators of Recovery Oriented Service Coordination

This is a self-assessment for Service Coordinators to self-evaluate their recovery orientation.

1. **Assessment of Needs and Strengths** – Consumers, family members (depending on age and preferences of consumer) and other professionals are *actively involved* in a collaborative manner in determining the strengths and needs.

- 60% Assessment of needs and strengths done by review of records & referral form
- 70% Assessment of needs and strengths are done by review of records and referral form and with input from professionals from other programs
- 80% Assessment of needs and strengths is conducted interactively with the consumer in addition to review of documents from other programs and the referral form.
- 90% Assessment of needs and strengths are done interactively with the consumer and family members or other individuals at the consumers request in addition to review of documents from other programs, the referral form and with input from other professionals
- 100% Assessment of needs and strengths are done interactively with the consumer, family members and other individuals at the consumers request and with treating professionals and with review of documents from other programs and the referral form.

2. **Assessment/Evaluation Process** – Consumers, family members (depending on age and preference of the consumer) and other professionals are utilized as primary sources of background information and treatment history in an engaging respectful manner which encourages a collaborative assessment process with verification that the information is correct.

- 60% Assessment document is developed in isolation from the consumer and family members and is not shared with the consumer or family.
- 70% Assessment document is developed in isolation from the family, but information from the consumer is actively utilized and verified for accuracy with the consumer but the assessment document is not shared with the consumer or family members.
- 80% Assessment document is developed with active input from the consumer and family members, accuracy of the information is verified verbally but the assessment document is not shared with the consumer or family members.
- 90% Assessment document is developed with active input from the consumer and family members, the assessment document is shown to consumer and the accuracy of the information is verified with the consumer signing the document.
- 100% Assessment document is developed with active input from the consumer and family members, the assessment document is shown to consumer and family members (with permission of the consumer) and the accuracy of the information is verified with the consumer signing the document.

3. Service Planning is Person Centered

- a. **Convening/Facilitating Service Planning Meetings.** Service Coordinator convenes and facilitates service planning meetings in a warm and welcoming manner with coordination across services with consumers, family members (depending on age and preference of the consumer) and other individuals chosen by the consumer are equal members in the service planning process. *ACCR Service Planning Principle 8*

- 60% Consumers are not typically involved in service planning meetings with staff from other programs. Service Plans are generated often without the consumer being present but the consumer is asked to sign the service plan after the fact.
- 70% Consumers are involved in service planning but there are no other programs or family members in the room
- 80% Consumer is present for the multi-disciplinary/multi-program service planning meetings but there is little preparation and the meetings are often tense.
- 90% Consumers are met with before the Service Planning meeting and prepared for the multi-disciplinary/multi-program staff, the consumer is present for the service planning meetings and the meetings are warm and welcoming with all participants acting in a mutually respectful manner
- 100% Consumers are met with before the Service Planning meeting and prepared for the multi-disciplinary/multi-program staff, consumers are present at the service planning meetings with individuals of their choice for support and the service planning meetings are warm and welcoming with all participants acting in a mutually respectful manner.

- b. **Strength Based Planning.** Strengths and needs collected in the assessment process drive the service planning process. Consumers, with input from the family members (depending on age and preference of the consumer), choose and prioritize the service goals and objectives included in the service plan. The plan includes a focus on empowerment rather than doing for consumers. *ACCR Service Planning Principles 1, 2, 6*

- 60% Service plans do not include strengths or only a minimal or token effort to include strengths. Service plan goals are pulled from the referral form, other documents or from the service coordinators impressions. There are no goals that focus on empowerment.
- 70% Service plans include strengths and needs pulled from an interview with the consumer with little or no focus on empowerment
- 80% Service plans are interactively developed with the consumer driving both the strengths and needs identification with the consumers but goals are drafted more by the service coordinator. There is some evidence of an empowerment focus but it is driven by staff.
- 90% Service plans are interactively developed with the consumer, family member (depending on age and preference of the consumer) or other support persons, with the consumer driving the strengths and needs identification, but the drafted of the goals are driven more by a service coordinator. Empowerment goals are evident and come from the consumer

100% Service plans are interactively developed with the consumer, family member (depending on the age and preference of the consumer) or other support person, with the consumer driving the identification of strengths, needs, the prioritization of needs and development of the focus of change (goals) and empowerment exudes from the plan.

c. **Language and Strengths Evident in Goals.** The language of the consumer and family are clearly evident in the words written in the service plan. Strengths are referenced in the goals/objectives, not just in the strengths section. *ACCR Service Planning Principles 3 and 7*

60% The language of the service plan is not the language or words the consumer typically uses and while the strengths maybe noted at the beginning of the plan, they are not woven into the goals and/or objectives.

70% The language of the service plan includes some words that the consumer uses, it does not include the consumer's language throughout the service plan and while the strengths maybe noted at the beginning of the plan, they are not woven into the goals and/or objectives.

80% The language of the service plan is the language of the consumer but while the strengths maybe noted at the beginning of the plan, they are not woven into the goals and/or objectives.

90% The language of the service plan is the language of the consumer but while the strengths maybe noted at the beginning of the plan, they are not woven into all of the goals and/or objectives.

100% The language of the service plan is the language of the consumer and the strengths are woven into all of the goals and/or objectives.

4. Services

a. **Relationship.** Consumer is actively engaged in a respectful and supportive manner consistent with a strengths-based and recovery oriented services. The relationship with the consumer and/or family is characterized as respectful, enduring and an effective partnership for change. *ACCR Service Planning Principle 5*

60% Relationship with consumers is best characterized as distant and sometimes there is disrespectful communications.

70% The relationship with consumers is best described as somewhat engaged with episodic good working relationships but there is one up/one down dynamic in the relationship.

80% The relationship between consumers and the service coordinator is one of a mutual respect with a variable focus on change.

90% The relationship between consumers and the service coordinator is one of mutual respect, is strength based and focuses most of the time on change.

100% The relationship between consumers and the service coordinator is one of mutual respect, is strength based, enduring and is an effective partnership for change throughout the course of services.

b. **Incremental Change Encouraged.** Consumers are consistently reinforced for steps made toward their goals in a respectful and effective manner. Consumers are encouraged to take on new challenges and not become dependent on the system of care.

60% Consumers are typically served when there are crises or in a perfunctory monitoring role and at times the service coordinator is disrespectful and focuses on the illness, not recovery.

70% Services are more reactive with little focus on change.

80% Services are developed in a planned manner, service coordinators are respectful with the consumer and there is a focus on change.

90% Services are change oriented, staff are respectful and there is much that is made of some changes made by consumers.

100% Service coordination is based on the belief that people can and do recover. Staff exhibit high efforts to be genuinely respectful in beliefs, speech and behavior. Incremental progress and growth are reinforced enthusiastically.

c. **Natural Supports.** Consumers are actively engaged in natural supports with family and/or community resources (churches, support groups, hobbies, fraternal organizations, etc.)

60% Service Coordinator fails to link most consumers to natural supports.

70% Service Coordinator links a 40% of consumers to natural supports.

80% Service Coordinator links 55% of consumers to natural supports.

90% Service Coordinator links 70% of consumers to natural supports.

100% Service Coordinator links 90% of consumers to natural supports.

d. **Concurrent Documentation.** Consumer contributes to the documentation of services which is evident in the language used to describe the services. Consumer signatures are an even better indication of the consumer involvement in the documentation of services.

60% Service Coordinator does not share the assessments, progress notes, closing summary with the consumer and does not give the consumer a copy of the service plan.

70% Service Coordinator talks about what he or she is going to include in service documentation, but does not show the documents to the consumer.

80% Service Coordinator shares the service documents with the consumer.

90% Service Coordinator co-develops all service documents with the consumers.

100% Service Coordinators co-develops all service documents with the consumers and obtains the consumers signatures on service documents.

e. **Frequency of Services.** The intensity of services varies with the needs of the consumer and/or family not based on the minimal requirements of the case management regulations.

60% The services that are provided are the minimal required by regulation

- 70% Services that are provided vary a little from the minimal amount required by regulation
- 80% Services that are provided vary moderately from the minimal amount required by regulation.
- 90% Services that are provided vary based on the unique needs of consumers and tend to vary considerably from the minimal amount required by regulation.
- 100% Services that are provided vary based on the unique needs of consumers and tend to vary widely from the amount required by regulation.

f. **Re-engaged into Community.** Consumer is incrementally engaged in learning, work and social outlet

- 60% Consumers are generally not encouraged pursue learning, volunteer or work opportunities and the social outlets tend to occur in the mental health service community.
- 70% Consumers are episodically encouraged in learning, or volunteer or work opportunities and some are engaged in social outlets in the community
- 80% Consumers are progressively engaged into learning, or volunteer, or work opportunities and social outlets in the community
- 90% Consumers are progressively engaged into learning and volunteer or work opportunities and are engaged in social outlets in the community
- 100% Consumers are actively engaged in school, training or working and are active members of the community.

g. **Coordinating High Intensity Services/Less Restrictive Services.** The Service Coordinator coordinates services being central in the transitions between levels of care, involved in decisions around diverting from a higher level of care and using less restrictive community based service as preferred services whenever possible.

- 60% Consumers utilize inpatient and other high cost services frequently with the Service Coordinator less involved in decisions around high intensity services and usually getting involved after the admission not before or during the admission process.
- 70% Consumers utilize inpatient and other high cost services often with the Service Coordinator less involved in decisions around high intensity services and often getting involved after the admission not before or during the admission process.
- 80% Consumer utilize inpatient and other high cost services from time to time with Service Coordination involved in the decisions around high intensity services but more as informants and less as advocates for less restrictive and more recovery oriented alternatives.

90% Consumers utilize inpatient and other high cost services infrequently with the Service Coordination actively involved in the decisions around high intensity services as a consistent advocate for less restrictive and more recovery oriented alternatives like Re:solve, Crisis Diversion and Stabilization beds or other supports from the community.

100% Consumers utilize inpatient and other high cost services extremely infrequently with the Service Coordinator persistently involved in decisions around high intensity services with very active advocacy for less restrictive and more recovery oriented alternatives line Re:solve, Crisis Diversion and Stabilization beds or other supports from the community.

5. Evaluation of Services Provided

Service Coordinators evaluate the utilization of services provided in a collaborative process with the consumer and family. Documentation of this evaluation will actively include the consumer and family and will be approved as indicated by the signatures in the service plan review.

- a. **Review of Service Plan.** When services are not being provided as described in the service plan a decision is made whether this goal and service is still needed or desired by the consumer or family.

60% Service plans are rolled over to a new plan with minimal involvement of the consumer or family members.

70% Service plans are reviewed but service needs, goals and services are not critically evaluated with the consumer and underutilized services maybe discontinued with little or no input from the consumer.

80% Service plans are reviewed but service needs, goals and services are not critically evaluated with the consumer. The consumer is asked if they want to discontinue a service but the service coordinator drives the decision.

90% Consumers drive the service plan review process and decisions about the continuation of goals and services are made by the consumers.

100% Consumers and family members (depending the age and preference of the consumer) drive the service plan review process and decisions about the continuation of goals and services are made by the consumers.

- b. **Advocacy.** If the services are still needed and desired, the Service Coordinator will assist the consumer and family in obtaining these services through active advocacy efforts or problem solving activities.

60% The service coordinator typically does not take action to advocate for changes in the service plan or the services being provided.

70% The service coordinator sometimes provides advocacy on significant issues related to the service plan.

80% The service coordinator often provides advocacy on significant issues related to the service plan

90% The service coordinator frequently provides advocacy on deviations on the service plan.

100% The service coordinator frequently provides advocacy on deviations on the service plan and in any issues around discrimination, stigma or system wide problems.

Scoring

Assessment

_____Assessment of Needs and Strengths

_____Assessment Process

Service Planning is Person Centered

_____Convening/Facilitating

_____Strength Based Planning

_____Strengths and Language Evident in Goals

Add up all scores_____

Divide total by 14_____

Services

_____Relationship

_____Incremental Change is Encouraged principles

_____Natural Support

_____Concurrent Documentation principles

_____Frequency of Services

_____Re-Engaged into the Community

_____Coord of High Intensity Services/Less Restrictive

60% No use of recovery principles

70% Minimal use of recovery

80% Considerable use of recovery

90% High use of recovery principles

100% Very high use of recovery principles

Re-Evaluation of Service Plan

_____Review of Service Plan

_____Advocacy

Single Point of Accountability - Transformation of Case Management - Progress over 3 years

In January of 2007, a large group of stakeholders were convened regarding transformation of the mental health case management system in Allegheny County. This group of stakeholders developed nineteen recommendations regarding the structure, operations, financing, and workforce development of mental health case management. In January of 2008, four different work groups started working on these recommendations. This is a progress report which describes what has been accomplished in the first three years (*new items in last 6 mo. in italics*).

Ten Single Point of Accountability Affirmative Responsibilities:

- Be the “go-to” resource for the person served and their family.
- Assure that there are effective “safety net” resources for the persons served
- Clearly communicate to the person what they can expect from the system and what the system will expect of them.
- Assure there is periodic assessment & cross system planning to meet their needs while utilizing their strengths.
- Prepare for, convene/facilitate service planning meetings and provide follow-up after meetings.
- Assure there is cross system coordination of services and that services are being provided.
- Develop relationships that endure with persistent outreach even when there is reluctance to receive services.
- Assist the person served in developing and using natural supports.
- Be a persistent advocate for those served and give feedback on systemic problems.
- Provide a consistent positive outlook which encourages recovery and full inclusion in the community.

Changes in Role

- Assessment of the individual’s needs, desires & strengths
- Assisting individuals in choosing their goals
- Developing a cross system plan to reach these goals
- Convene and facilitate cross program/system planning
- Support the person in their journey of recovery
- Document with consumer their achievements/outcomes

A. Recovery Orientation of Services/Planning

Accomplishments	Next Steps	Long Range Developments	Challenges
<ul style="list-style-type: none"> • Changed name to Service Coord. • Broad stakeholder representation • Defined Service Coord. competencies • Universal Service Plan format • Service Planning billing code • 5 agencies approved for new code • Distributed 60,000 Recovery Service Planning Principles brochures • Revised ANSA Assessment tool • Family involvement planning • Oriented other programs & MDs • Universal Referral Forms-Adult/Child • Child Assessment tool implemented • Contingency funds more available • <i>Pilot of Adult Assessment tool begun</i> • <i>Recovery Promoting Relationship Scale implemented (CART, Research)</i> • <i>Requested OMHSAS waiver-common interval between service plan reviews</i> 	<ul style="list-style-type: none"> • Strengths & goals of individual drives planning process • Implement Adult Assessment Tool • Increase involvement of families in services and planning • Increase use of/linkage to community/natural support • Implement Service Planning across programs/agencies • Increase system advocacy by Service Coordinators • <i>Orient consumers, family members & providers to SPA w/brochures for consumers/family members/providers</i> • <i>Replace Adult Environmental Matrix with OMHSAS approval</i> 	<ul style="list-style-type: none"> • Strengths-based comprehensive assessment tool used (web-based) • Service plans are integrated, recovery-oriented and user friendly (portable, electronic) • Services are flexible based on individual need and accountable to persons being served • Service Coordination agencies hire persons in recovery to provide peer support and other services • Service recipients access natural and community supports 	<ul style="list-style-type: none"> • Transition/interface between child/youth and adult systems/services • Starting service planning meetings across agencies – acceptance of outsiders • Electronic interfaces to a central repository cost money to build to link service plans • Reconciling each agency’s electronic health record with different service plan formats • Reconcile privacy concerns with iron clad security precautions • Access to any cross-agency data base must be driven by permission of consumers

B. Workforce Development

Accomplishments	Next Steps	Long Range Developments	Challenges
<ul style="list-style-type: none"> • Adult Mentors Curriculum/19 grads • Distributed Documentation Manual • Convening/facilitation training • Regular mtgs/training w/supervisors • Mentor standards/added to contract • New Hire training implemented • Model job descriptions distributed • BSW/<i>Psych</i> Service Coord. degrees • <i>Mentor/Mentee Evaluation</i> • <i>Child Mentors—16 trained Fall 2010</i> • <i>Certificate course — 33 staff trained</i> • <i>Facebook, Twitter, Web Page created</i> • <i>Recruiting in university classrooms</i> 	<ul style="list-style-type: none"> • Competency based performance evaluation pilot • <i>300 staff to be trained over the next two and half years</i> • <i>Advanced Workshops being developed for Fall 2013</i> • <i>Field Placements for Psych/BSW’s</i> • <i>Stipends for Field Placements</i> 	<ul style="list-style-type: none"> • Provide mentors for all new staff • Provide High Fidelity Wraparound, Trauma, and other pertinent training for Children’s Service Coordination • BSW Service Coordination graduates hired by agencies • Training for Service Coordinators is enhanced and expanded 	<ul style="list-style-type: none"> • Training takes time away from billable services • Service Coordinators may lack confidence to convene/facilitate service planning meetings • Certificate programs are limited to two local universities • Dynamic changes in both child and adult systems may make it hard to keep up.

C. Workforce Stabilization

Accomplishments	Next Steps	Long Range Developments	Challenges
<ul style="list-style-type: none"> • Gathered data on salary (FY 08 & 10), training and Administration Management Service Coordination • 10% increase Service Coordination designed to raise base salary by as much as 35% • Providers reimb. 50% cost of training • <i>2nd base salary increase in lower paying agencies</i> • <i>New level of Service Coordination approved by OMHSAS</i> • <i>Nominated for Best Practice award</i> 	<ul style="list-style-type: none"> • Continue to phase in base salary increases over next three years • <i>Implement new level of Service Coordination available at most agencies with caseloads of 75</i> 	<ul style="list-style-type: none"> • Assure that all agencies meet a minimum floor for the base starting salary by FY 13 which will be 33% of the lowest paying agency in FY 07 • Establish a “career ladder” within Service Coordination • Improve staff retention by 50% 	<ul style="list-style-type: none"> • Rate increases require significant cost outlays and depend on deep-end cost offsets • Each Service Coordination Unit provides Admin. Mgmt. very differently • Many Service Coordination programs are operating in a deficit • Fee for service billing encourages a focus on productivity, not necessarily quality of care • Service Coordination is viewed as an “entry level” position in Behavioral Health and lacks a “career ladder”

D. Performance-Based Contracts

Accomplishments	Next Steps	Long Range Developments	Challenges
<ul style="list-style-type: none"> • Contingency fund expectations added to contracts and increased in 2nd year • Added SPA expectations to county contracts <i>with revisions for 2nd year</i> • Contract monitoring tool developed and utilized with scoring devise • Using Consumer Recovery Promoting Environment scale in CART surveys and consumer baseline study • 100 consumer surveyed for baseline • Research funded for 2 year • Conducted cost analysis FY09 FY10 • Oriented other MH programs & MD’s • <i>Ethnographic research completed in four agencies</i> • <i>CART Survey of Service Coordination</i> 	<ul style="list-style-type: none"> • Make provider profiles available and feedback measures available <ul style="list-style-type: none"> • <i>Unit Cost Analysis</i> • <i>Salary Survey</i> • <i>Customer Satisfaction</i> • <i>Recovery Orientation</i> • Conduct evaluation of SPA <ul style="list-style-type: none"> ⇒ Mixed methods—Is it occurring ⇒ Frequency of visits trends ⇒ Year 3 Consumer survey ⇒ Year 5 consumer survey • <i>Orient consumers, family members & providers to SPA changes by developing brochures for consumers/family members and providers</i> • <i>Child & Adult Assessment tools used as outcomes measures</i> 	<ul style="list-style-type: none"> • Measurable progress toward SPA goals made by Service Coordination Agencies • Implement performance-based contracts • Publish provider performance for stakeholder review 	<ul style="list-style-type: none"> • Central repository for assessment tool does not exist and will cost money to build • Build interface between providers and central repository • Build interface between any county data repository with OMHSAS – POMS and CCRS-POMS • Youth and adult systems require developing different goals/initiatives