

**CASE MANAGEMENT AND RESIDENTIAL SERVICES
OUTCOMES MEASUREMENT PLAN
FY2006**

Case Management and Residential Services at Goochland Powhatan Community Services are divided into 3 program areas: Case Management, In Home Residential Support and Residential Mental Health Support. A brief description of each program area begins each section of this report.

This Long Range Plan will serve two purposes. First, outcome measures and attention to those services currently provided will ensure quality, consumer responsiveness and improvement to current programs. Second, long range plans will address future needs of the consumer population; plan for the use of anticipated resources, and prioritize identified needs in order of importance.

OUTCOME MEASURES AND LONG RANGE PLANS

Outcome Measures will use Consumer and Family Surveys, Stakeholder Surveys, and data accumulated over the next year to measure progress and success on a number of indicators for each program. This plan describes what we intend to measure, how we will measure it, what we expect to learn from measuring these outcomes and how we will use what we have learned to improve programs.

Planning for the long range in Case Management and Residential Support Services requires predictions of consumer numbers and needs and anticipation of the necessary resources to provide services. Accuracy of consumer predictions and availability of resources can both be problematic. This plan anticipates and predicts, as well as one can, who we will be serving in the next three biennia. The larger question of resources to implement plans must be answered as needs arise.

For each service, we list the outcomes measures first followed by the long range plan goals.

CASE MANAGEMENT

Case Management is the process of assessing a consumer's needs, planning to meet those needs, linking consumers and their families to necessary services, and monitoring those services to ensure that they continue to meet the need. This allows for a wide range of very individualized activities with consumers as they work to meet their goals. The newly created multidiscipline case management program headed by one supervisor will consist of case managers for individuals with needs in the areas of mental health, mental retardation and substance abuse. Targeted Case Management, which is reimbursed by

Medicaid, is the most intense level of this service, with a minimum of monthly activity, quarterly face to face contact and an annual plan that is reviewed quarterly.

Goal: All Case Management records reviewed will indicate a monthly contact by phone or face to face and a quarterly face to face visit unless less frequently agreed to on the ISP.

Population Measured: Targeted Case Management Consumers.

Rationale: Continuity of care is basic to any system that serves people with mental health, mental retardation and substance abuse disorders. The criteria chosen for this measure, contacts every 30 days and face-to-face meetings quarterly, are actually minimal; many clients need continuity of care, which is more frequent and more intensive. Lack of continuity is a sign that the treatment plan is not working and it is time to try something else.

Method to measure: Records of consumers receiving targeted case management will be assessed to determine the frequency with which consumers have had contact with the case manager, either face-to-face or by telephone.

Goal: 90% documentation of contact with primary care physician

Population Measured: Targeted Case Management Consumers.

Rationale: Many persons being seen by the case management unit are also in poor health or experience medical problems which may go undetected and untreated. Awareness of this side of the disability may be less pronounced among mental health professionals than those who treat mental retardation or substance abuse. Performance on the measure of Medical Co-morbidity is based on evidence of the clinician's having contact with the client's primary care physician, or the results of a physical exam in the case record.

Method to measure: Records of consumers receiving targeted case management will be assessed to determine the percentage of consumers for whom physical examinations or contact with their primary care physicians can be documented.

Goal: Individuals newly referred for Case Management Services will receive a response from a Case Manager or intake coordinator within 10 days of the referral or assignment.

Population Measured: New referrals to Case Management Services

Rationale: Responsiveness to consumer need is an important facet of Case Management. Making referral and intake easier by responding to referrals in a timely manner fosters confidence in the agency and in the services that it provides.

Method to Measure: Each referral is recorded on a referral form or Access form. Response to the referral to set up intake is also recorded on a Service Ticket. Time lapse for these referrals will be measured on a quarterly basis.

Goal: Reflect the growth in both counties and in consumer population with growth in the availability of Case Management Services.

Rationale: Populations in both Goochland and Powhatan Counties are growing. People are moving to the counties, some with family members who require mental retardation, mental health and substance abuse services. Schools are graduating students who need to transition into adult services. Children with severe disabilities who exit the Parent Infant Education Program continue to need to have their case management needs met. Current Case Management resources (6.5 FTE) are nearing or are at capacity. A Case Manager Supervisor has been hired to directly supervise the case managers.

Method: An additional case manager for mental health will be added during the next fiscal year to support growth in the MH population. MR case managers will be added as needed.

IN HOME SUPPORT SERVICES

In Home Support Services is a highly individualized one on one training and support services that is usually provided in the consumer’s home and in the community. Consumers have an In Home Support Specialist who works with them regularly. Each consumer has a set of goals and objectives that they are working on with their In Home Support Specialist. In the process, families are relieved of some of the care taking responsibilities of their family member and often find that they are better able to function. This program currently serves 50 people in Goochland, Powhatan and Hanover Counties.

Goal: 75 % of the individuals served will have monthly contact with a coordinator or supervisor of the In Home Support Services Staff either by phone, in writing or in person.

Population measured: All individuals receiving services and new referrals.

Rationale: The In Home Support Services Program is a program run out of a central location, but carried out in the individual’s home and in the community. It is important to know the quality of services being provided and that the program continues to function in a way that is meaningful to the participants in the program. Ways to assure the quality of services is to have regular contact with the consumers and families receiving services.

Method to Achieve Goal: Staff will contact each consumer or family monthly. The staff will fill out the Quarterly Report, Phone Contact or the Staff Observation form.

Method to Measure: Each contact will be recorded on the Home Visit/Contact Log and will be reviewed monthly to assure that at least 75% of the population was contacted.

Goal: In Home Support Services Program will serve all referred consumers with appropriate staffing levels and support services.

Population Measured: All consumers receiving In Home Support Services

Rationale: The In Home Support Services Program relies on staff being in the home to provide services to the individuals who are being served. If the participant has no staff, the goals cannot be worked on, the family is left with the burden of providing the services and the program loses revenue. Therefore, it is imperative that staff is retained to provide services for the benefit of the consumer, family and program.

Method to Achieve Goal: In home Support Services Staff will continue to recruit personnel for new referrals and to react swiftly to turnover in personnel

Method of Measurement: The percentage of services received will be recorded monthly. At the end of the year, an analysis of the percentage of people served at an appropriate level will be reported.

Goal: 100% of staff certifications will be maintained for First Aide, CPR and CPI training.

Population Measured: All staff employed by the In Home Support Services Program

Rationale: Staff works one on one with consumers some of whom have medical concerns and any of whom may become a victim of an accident. First Aide and CPR certification should be maintained. It is also a licensure requirement that all staff maintain their certification. A number of the consumers have aggressive behaviors, for those consumers, CPI/Tova training is necessary to avoid those consumers hurting themselves or others.

Method to Achieve Goal: All staff will receive First Aide and CPR Training within the first 90 days of being hired. All Staff will receive MR Waiver Training within the first 30 days of being hired. Staff working with consumers with reported aggressive tendencies will receive CPI/Tova Training at the first available scheduled training. The In Home Support Services team will continue to provide quarterly trainings in First Aide and CPR and monitor to assure all staff are attending the trainings. The IHSS team will also continue to schedule staff to receive CPI/Tova Training and resertification.

Method of Measurement: Certification will be tracked on the “Staff Certification Log” which will be monitored quarterly to assure all staff are in compliance.

MH/SA RESIDENTIAL SERVICES

GOAL: Consumers will have 50% achievement of ISP goals from prior year baseline.

Population Measured: Consumers in the supervised apartments and community-based Residential Services

Rationale: The mission of Residential Services is to provide training in or reinforcement of functional skills and behavior related to the individual's health and safety, activities of daily living, nutrition and physical condition. A measure of ISP goal achievement by the program and staff is instrumental in an on-going assessment of consumer's progress and in program planning.

Method to Measure: The information will be gathered from monthly documentation done on all consumers. Baseline data will be gained from documentation from previous year, and/or entry level of functioning.

GOAL: Reduction in the occurrence of the negative Psychiatric symptoms that led to referral.

Population Measured: Community based consumers

Rationale: One element of GPCS' Residential Services is to provide training and assistance in medication management.

Method to Measure: The information will be gathered from quarterly progress reports and monitoring of consumers' medication compliance by Residential Specialists. Quarterly progress reports are written with input from Case Managers. Feedback will reflect the case manager's assessment of level of reduction in negative psychiatric symptoms as a result of medication monitoring by Residential Services.

GOAL: To accurately assess the need for future directions for the MH/SA Residential Services

Population Measured: GPCS Clinical Staff

Rationale: Staff surveys have revealed MH/SA residential services to be an area of need. A residential services-specific survey was distributed to the clinical staff and has been returned. The results will be tabulated and analyzed regarding the needs and directions of the program.