

WNY  CCP

Western New York Care Coordination Program

RESULTS

JULY 2008

Periodic Reporting Form 2007

- **2007 analysis of outcomes reported on the Periodic Reporting Form completed quarterly by Care Coordinators for each enrollee**
- **WNYCCP enrollees with a first Periodic Reporting Form dated no earlier than 1/1/03, and with a minimum of 2 Periodic Reporting Forms at least 6 months apart.**
 - **Sample cohort 3,914**
- **Positive change in the lives of enrollees and decreased demand on government resources**

PERIODIC REPORTING FORM INDICATORS % CHANGE BETWEEN FIRST AND MOST RECENT PRF

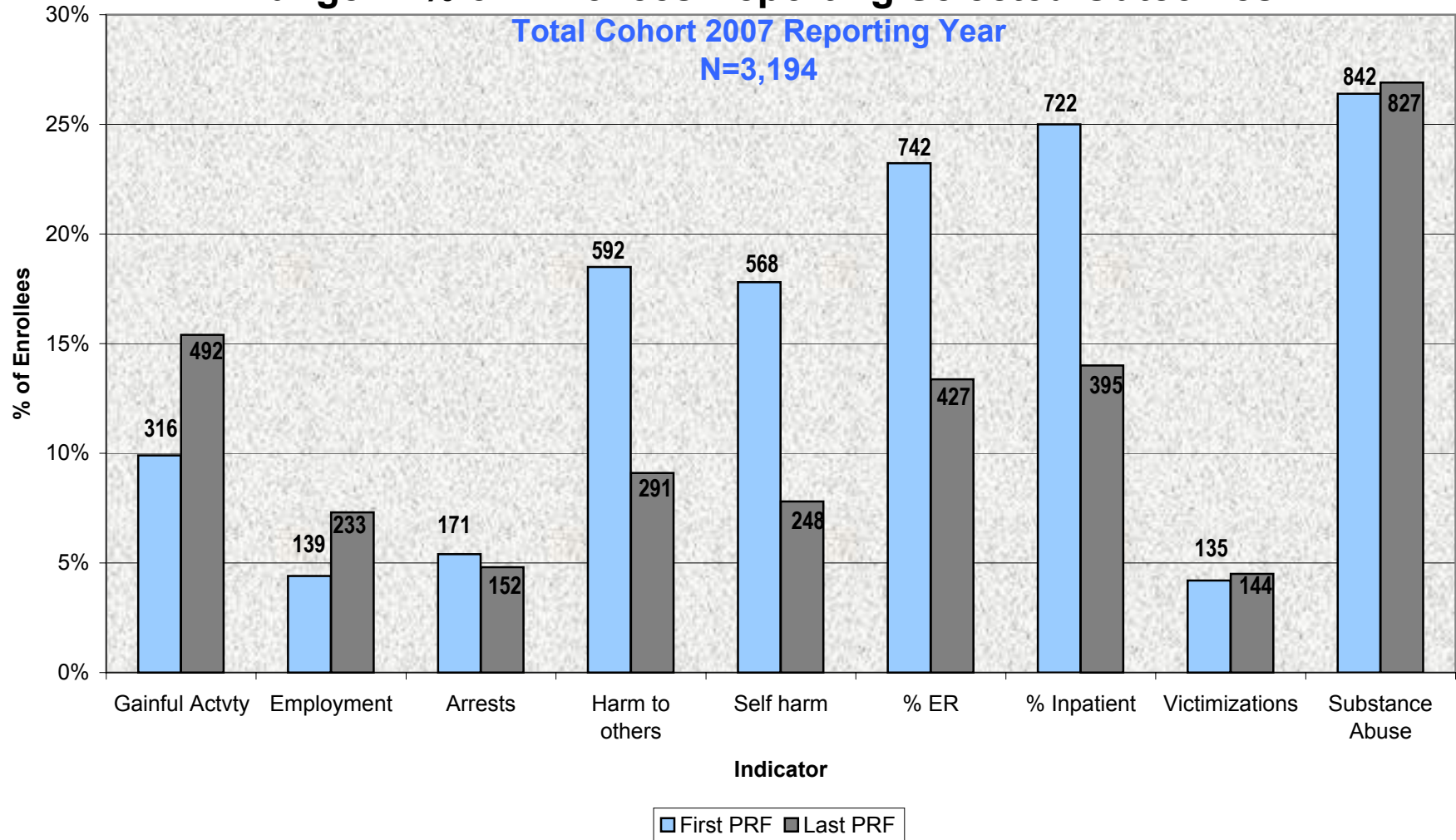
| POSITIVE CHANGES | |
|--------------------------|-------|
| Gainful activity | ↑ 56% |
| Competitive employment | ↑ 68% |
| Arrests | ↓ 11% |
| Physical harm to others | ↓ 51% |
| Self harm | ↓ 56% |
| Emergency room visits | ↓ 43% |
| Days spent in a hospital | ↓ 44% |

| TARGETED AREAS FOR IMPROVEMENT OF OUTCOMES | |
|---|-------|
| Victimizations | ↑ 7% |
| Substance abuse | ↓ 2% |
| Improved living situation | ↑ 10% |
| Worse living situation | ↓ 11% |

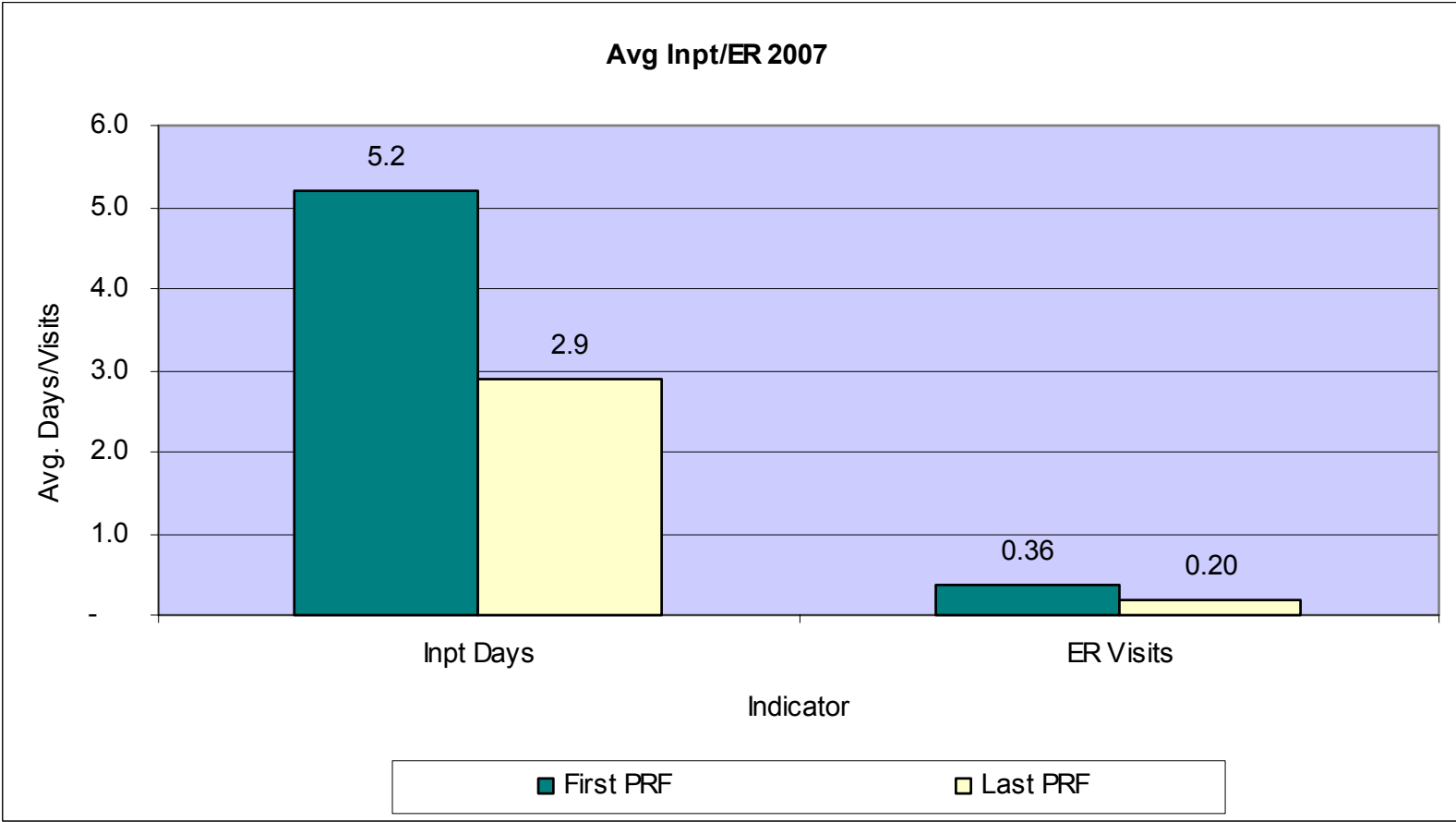
Periodic Reporting Form

Change in % of Enrollees Reporting Selected Outcomes -

Total Cohort 2007 Reporting Year
N=3,194



Periodic Reporting Form – Average Inpatient Days | ER Visits per Cohort Member for the Report Year 2007



Comparison of WNYCC PRF Outcome Measures for 2004 through 2007
Includes Data for Counties of Chautauqua, Erie, Monroe and Onondaga
By Report Year (Using PRFs Dated 1/1/03 through September of the Reporting Year) ¹

| | By Report Year | | | |
|---|-----------------------|--------------|--------------|--------------|
| Data Measure | 2004 | 2005 | 2006 | 2007 |
| Sample Cohort | 896 | 1,769 | 2,592 | 3,194 |
| <i>Previous Report Version Cohort Totals ^F</i> | 778 | 1,429 | 2,927 | 3,675 |
| # Cohort Members With ER Visits on First PRF | 246 | 427 | 600 | 742 |
| # Cohort Members With ER Visits on Last PRF | 122 | 203 | 337 | 427 |
| Total ER Visits on First PRF | 369 | 639 | 925 | 1,147 |
| Total ER Visits on Last PRF | 189 | 334 | 548 | 651 |
| ER Visits Per Cohort Member on First PRF | 0.41 | 0.36 | 0.36 | 0.36 |
| ER Visits Per Cohort Member on Last PRF | 0.21 | 0.19 | 0.21 | 0.20 |
| ER Visits Used (% Change) ^{2A} | -49% | -48% | -41% | -43% |
| # Cohort Members With Inpatient Days on First PRF | 231 | 394 | 559 | 722 |
| # Cohort Members With Inpatient Days on Last PRF | 108 | 191 | 305 | 395 |
| Total Inpatient Days on First PRF | 4,227 | 8,443 | 12,661 | 16,767 |
| Total Inpatient Days on Last PRF | 2,257 | 4,382 | 6,978 | 9,315 |
| Hospital Days Per Cohort Member on First PRF | 4.7 | 4.8 | 4.9 | 5.2 |
| Hospital Days Per Cohort Member on Last PRF | 2.5 | 2.5 | 2.7 | 2.9 |
| Hospital Days Used (% Change) ^B | -47% | -48% | -45% | -44% |
| Self Harm Indicated on First PRF | 170 | 319 | 463 | 568 |
| Self Harm Indicated on Last PRF | 111 | 205 | 252 | 248 |
| % Cohort Members Indicating Self Harm on First PRF | 19.0% | 18.0% | 17.9% | 17.8% |
| % Cohort Members Indicating Self Harm on Last PRF | 12.4% | 11.6% | 9.7% | 7.8% |
| Self Harm % Variance Between Time 1 and 2 | -6.6% | -6.4% | -8.1% | -10.0% |
| Self Harm Indicated on PRF (% Change) | -35% | -36% | -46% | -56% |
| Cohort Members Involved in Gainful Activity on First PRF | 71 | 177 | 264 | 316 |
| Cohort Members Involved in Gainful Activity on Last PRF | 103 | 272 | 387 | 492 |
| % Cohort Members Involved in Gainful Activity on First PRF | 7.9% | 10.0% | 10.2% | 9.9% |
| % Cohort Members Involved in Gainful Activity on Last PRF | 11.5% | 15.4% | 14.9% | 15.4% |
| Gainful Activity % Variance Between Time 1 and 2 | 3.6% | 5.4% | 4.7% | 5.5% |
| Cohort Members Involved in Gainful Activity Change % | 45% | 54% | 47% | 56% |
| Cohort Members with Competitive Employment on First PRF | 31 | 76 | 115 | 139 |
| Cohort Members with Competitive Employment on Last PRF | 49 | 136 | 196 | 233 |
| % Cohort Members with Competitive Employment on First PRF | 3.5% | 4.3% | 4.4% | 4.4% |
| % Cohort Members with Competitive Employment on Last PRF | 5.5% | 7.7% | 7.6% | 7.3% |
| Competitive Employment % Variance Between Time 1 and 2 | 2.0% | 3.4% | 3.1% | 2.9% |
| Cohort Members with Competitive Employment Change % | 58% | 79% | 70% | 68% |
| Physical Harm to Others Indicated on First PRF | 178 | 351 | 497 | 592 |
| Physical Harm to Others Indicated on Last PRF | 143 | 271 | 317 | 291 |
| % Cohort Members With Physical Harm to Others on First PRF | 19.9% | 19.8% | 19.2% | 18.5% |
| % Cohort Members With Physical Harm to Others on Last PRF | 16.0% | 15.3% | 12.2% | 9.1% |
| Physical Harm to Others % Variance Between Time 1 & 2 | -3.9% | -4.5% | -6.9% | -9.4% |
| Physical Harm to Others Indicated on PRF Change % | -20% | -23% | -36% | -51% |

**Comparison of WNYCC PRF Outcome Measures for 2004 through 2007
Includes Data for Counties of Chautauqua, Erie, Monroe and Onondaga
By Report Year (Using PRFs Dated 1/1/03 through September of the Reporting Year) ¹**

| By Report Year | | | | |
|---|-------------|-------------|-------------|-------------|
| Data Measure | 2004 | 2005 | 2006 | 2007 |
| Cohort Members With Arrests on First PRF | 42 | 88 | 127 | 171 |
| Cohort Members With Arrests on Last PRF | 39 | 89 | 114 | 152 |
| % Cohort Members With Arrests on First PRF | 4.7% | 4.97% | 4.9% | 5.4% |
| % Cohort Members With Arrests on Last PRF | 4.4% | 5.03% | 4.4% | 4.8% |
| Arrests % Variance Between Time 1 & 2 | -0.3% | 0.06% | -0.5% | -0.6% |
| Cohort Members With Arrests Change % | -7% | 1.1% | -10% | -11% |
| Cohort Members With Victimizations on First PRF | 29 | 72 | 108 | 135 |
| Cohort Members With Victimizations on Last PRF | 43 | 78 | 133 | 144 |
| % Cohort Members With Victimizations on First PRF | 3.2% | 4.1% | 4.2% | 4.2% |
| % Cohort Members With Victimizations on Last PRF | 4.8% | 4.4% | 5.1% | 4.5% |
| Victimizations % Variance Between Time 1 & 2 | 1.6% | 0.3% | 1.0% | 0.3% |
| Cohort Members With Victimizations Change % ^c | 48% | 8% | 23% | 7% |
| Substance Abuse Indicated on First PRF | 271 | 489 | 687 | 842 |
| Substance Abuse Indicated on Last PRF | 261 | 478 | 690 | 827 |
| % Cohort Members Indicating Substance Abuse on First PRF | 30.2% | 27.6% | 26.5% | 26.4% |
| % Cohort Members Indicating Substance Abuse on Last PRF | 29.1% | 27.0% | 26.6% | 25.9% |
| Substance Abuse % Variance Between Time 1 & 2 | -1.1% | -0.6% | 0.1% | -0.5% |
| Substance Abuse Indicated on PRF Change % | -4% | -2% | 0.4% | -2% |
| Cohort Members Moving from Homeless to Any Other Level | 30 | 51 | 83 | 110 |
| Cohort Members Moving from Institutional to Integrated/Segregated | 20 | 37 | 49 | 59 |
| Cohort Members Moving from Segregated to Integrated | 37 | 79 | 112 | 162 |
| % Cohort Members With Improved Living Situation ^d | 10% | 9% | 9% | 10% |
| Cohort Members Moving from Any Other Level to Homeless | 10 | 21 | 35 | 51 |
| Cohort Members Moving from Integrated/Segregated to Institutional | 17 | 45 | 64 | 79 |
| Cohort Members Moving from Integrated to Segregated | 68 | 106 | 139 | 211 |
| % Cohort Members With Worse Living Situation ^e | 11% | 10% | 9% | 11% |

Data Sources: CCSI PRF Database for Monroe/Onondaga/Chautauqua
NYS OMH CAIRS Data Export for Erie

4/24/2008

Notes:

1. Sample Cohort includes Clients who have their first PRF later than 1/1/03 and have been enrolled for more than 6 months.
2. For measures of change, a reduction between the first and last PRF is indicative of better outcomes for all measures except Cohort Members Involved in Gainful Activity. For this item, we would be looking for any increase in the rate of gainful activity.

Comparison of WNYCC PRF Outcome Measures for 2004 through 2007
Includes Data for Counties of Chautauqua, Erie, Monroe and Onondaga
By Report Year (Using PRFs Dated 1/1/03 through September of the Reporting Year) ¹

| <i>Data Measure</i> | <i>By Report Year</i> | | | |
|---------------------|-----------------------|-------------|-------------|-------------|
| | <i>2004</i> | <i>2005</i> | <i>2006</i> | <i>2007</i> |

Observations from Data Analyst:

- A. ER Visits Used (% Change): Rerun shows more consistent results across years because of elimination of outliers. Anything greater than 30 visits (for a 3 month period) was considered an outlier. On a previous view of the report, there was an error in the formula computing this line for 2006 and 2007.
- B. Hospital Days Used (% Change): Rerun shows more consistent results across years because of elimination of outliers. Anything greater than 91 days (for a 3 month period) was considered an outlier. This resulted in significant change from previous reports as several Cohort Members had PRF's reporting > 500 days of inpatient for a 3 month period.
- C. Cohort Members With Victimizations Change %: Data from Onondaga County significantly impacts the overall results for this measure.
- D. % Cohort Members With Improved Living Situation: This outcome measure was expanded to show more distinct levels of Living Situation changes in order to provide detail for the Homeless category.
- E. % Cohort Members With Worse Living Situation: This outcome measure was expanded to show more distinct levels of Living Situation changes in order to provide detail for the Homeless category.
- F. Previous Report Totals: Differences in cohort sizes occurred for a variety of reasons and are explained in more detail on each County's report. The most significant reason for change is a change of data source for Erie County data.

WCCP Periodic Reporting Form

Care Coordinator: complete this form at the first ISP development, then Quarterly (every 3 months) and at discharge.

Name of Person Enrolled: _____ DOB: _____ SS (last 4 #s): _____
Last First MI

A. Current Living Situation (circle one, and fill in days of homelessness, if applicable):

| | | |
|---|-------------------------------------|--|
| 1 | Integrated Setting | Private residence alone, with spouse, roommates, domestic partner, parent, child, or other family and rooming house if considered permanent, or other similar independent housing |
| 2 | Segregated/ Transitional Setting | OMH Crisis Residence, OMH Housing Treatment Program (Congregate Treatment, Treatment Apartment, or Transitional Living Center), OMH Supported Housing, Supported SRO, OMH Housing Support Program (Congregate support or Service Enriched SRO), assisted/supported living, DOH Adult Home; drug/alcohol abuse residence or inpatient setting or inpatient general or private psychiatric hospital (without permanent address), rooming house if not considered permanent, etc. |
| 3 | Institutional Setting | Inpatient state psychiatric center, correctional facility, nursing home or other long term medical facility, etc. |
| 4 | Homeless | Streets, parks, drop in center, shelter or emergency housing |
| B1. How many <u>incidents</u> of homelessness occurred in the past three months? | | |
| B2. How many <u>total days</u> of homelessness occurred in the past three months? | | |
| C. How long has the person been in his or her current living situation (circle one)? | | |
| 1 | < 1 month | 2 |
| 2 | 1-3 months | 3 |
| 3 | 4-6 months | 4 |
| 4 | 7-12 months | 5 |
| 5 | > 12 months | 6 |
| 6 | Unknown | |

D. Current employment situation (Circle all that currently apply):

| | | | | | |
|----------|--|----------|--|----------|--|
| 1 | Competitive employment (employer-paid position) with or without formal supports | 2 | Non-paid work experience (includes volunteer position) | 3 | Sporadic/casual employment for pay (includes odd jobs) |
| 4 | Works in a sheltered (non-integrated) workshop or other subsidized job – i.e. agency pays the wage | 5 | No employment of any kind | 6 | Unknown |

Average Scheduled Hours Per Week

| | | | | | | | | | | | |
|--|--|----------|------|----------|------|----------|-------|----------|-------|----------|---------|
| E. Average scheduled hours of employment or non paid work experience per week (circle one): | | 1 | None | 2 | 1-10 | 3 | 11-19 | 4 | 20-30 | 5 | Over 30 |
| F. Number of <u>weeks</u> at current employment or non-paid work experience: | | | | | | | | | | | |

G. Current educational situation (Circle all that currently apply):

| | | | | | |
|----------|---|----------|---|----------|---|
| 1 | Regularly enrolled in formal education (that leads to a diploma or certification) with or without formal supports | 2 | Sporadic enrollment in formal education (leads to a diploma or certification) | 3 | Pursuing informal education (i.e. that does <u>not</u> lead to a diploma or certification). |
| 4 | Considering further education, but not enrolled in an educational program at this time. | 5 | Not contemplating or pursuing further education | 6 | Unknown |

| | | | | | |
|--|--|----------|-----|----------|----|
| H. The person has at least one close non-paid support. (Close friend, family member, etc.) | | 1 | Yes | 2 | No |
| I. Does the person participate in any community groups? (Religious, fraternal, civic, interest, etc.) | | 1 | Yes | 2 | No |
| J. How many incidents as a <u>victim of a crime</u> including property damaged or stolen, physical assault, or sexual assault in the last three months? | | | | | |
| K. Indicate the number of arrests in the last three months. | | | | | |
| L. Number of psychiatric emergency room (ER) visits in the last three months? | | | | | |
| M. Number of psychiatric hospitalizations in the last three months? | | | | | |
| N. Total number of days (overnights) in the hospital in the last three months due to psychiatric illness? | | | | | |

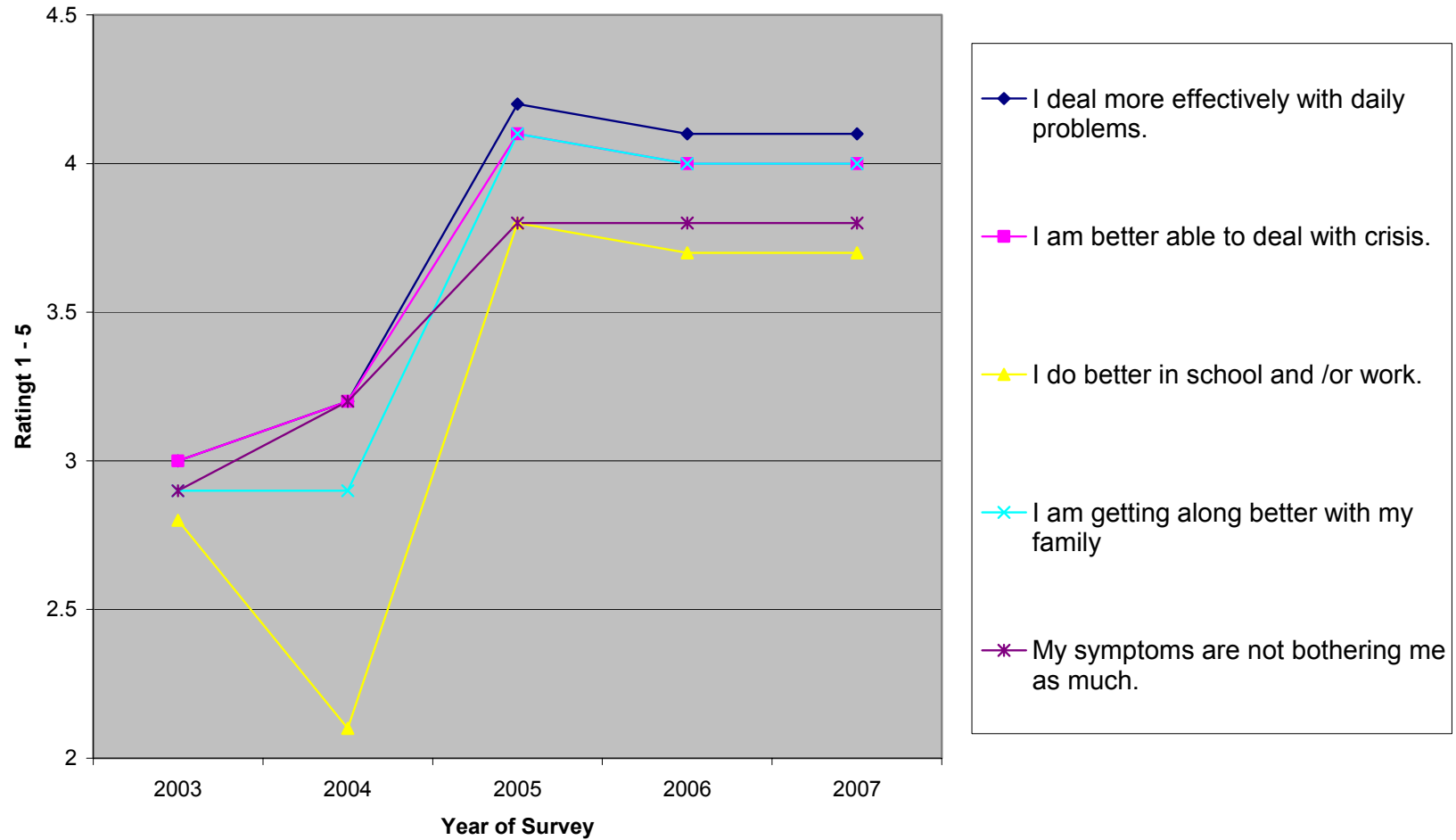
During the last three months, how frequently has this individual engaged in the following risk behaviors?

| (Circle only one response per item) | Never | Once | Occasionally | Frequently |
|--|----------|----------|--------------|------------|
| O. Do physical harm to self, make suicide attempts, or express suicidal threats | 1 | 2 | 3 | 4 |
| P. Do physical harm to others or make threats of physical violence to others | 1 | 2 | 3 | 4 |
| Q. Abuse alcohol or other drugs | 1 | 2 | 3 | 4 |

Care Coordinator Name: _____ Signature: _____ Date: _____

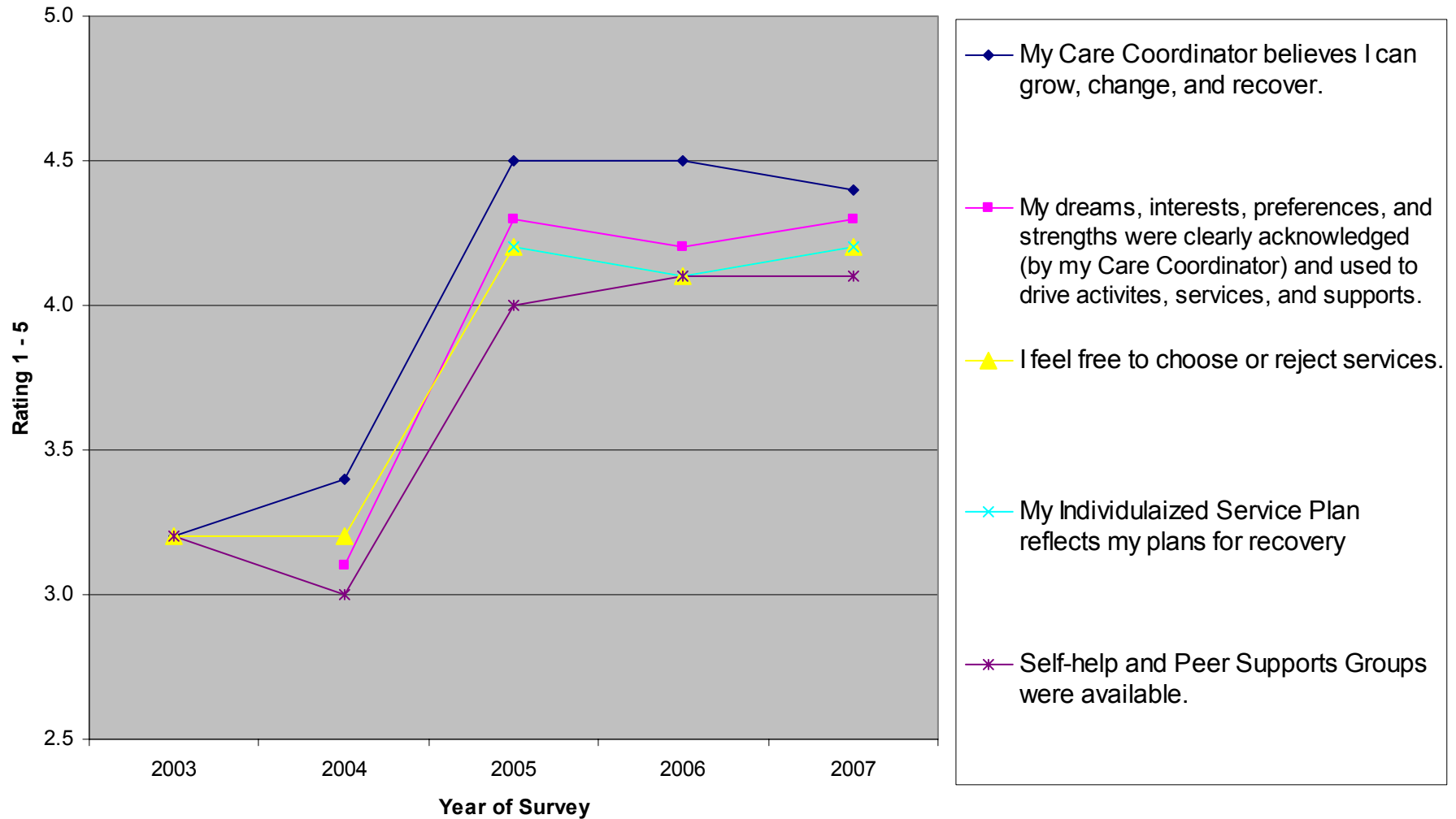
Agency: _____ County: _____

Enrollee Satisfaction Survey 2003 - 2007 Quality of Life



Enrollee Satisfaction Survey 2003 - 2007

Person-Centered Planning and Practices

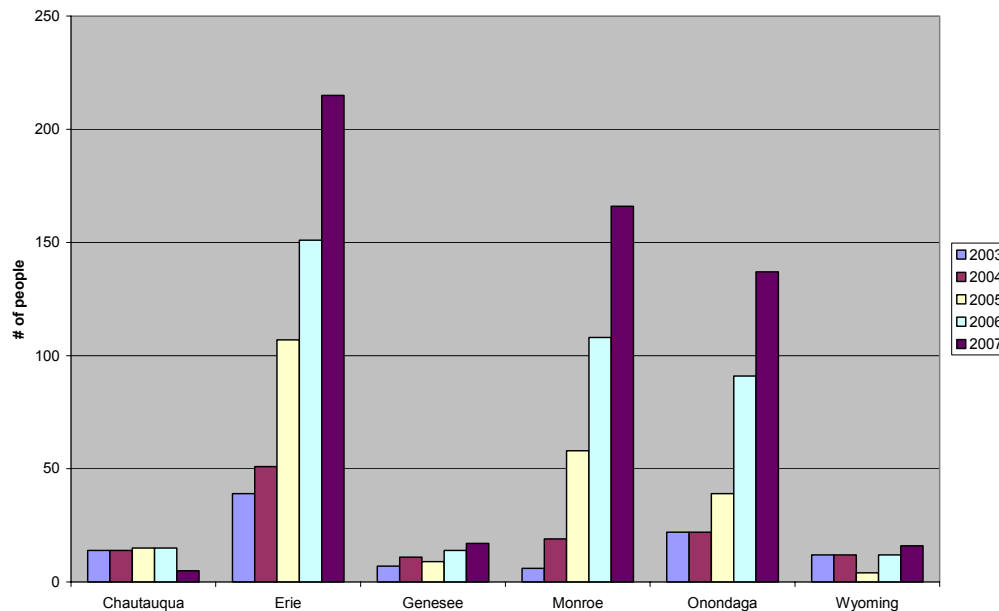


WESTERN NEW YORK CARE COORDINATION PROGRAM 2007 ENROLLEE SATISFACTION SURVEY EXECUTIVE SUMMARY

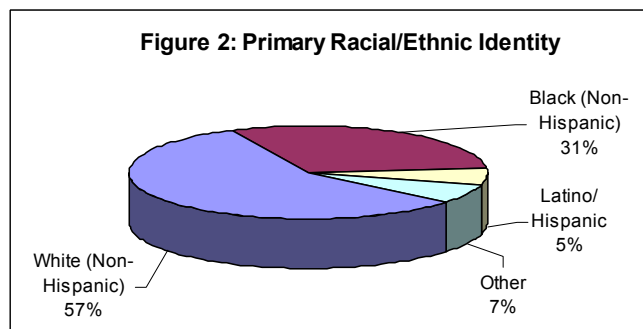
The Western New York Care Coordination Program (WNYCCP) is a unique six county consortium dedicated to transforming mental health services for adults with severe mental illness to become more responsive to the interests of consumers, ensure access to high quality services, and promote recovery. The participating upstate New York counties (Chautauqua, Erie, Genesee, Monroe, Onondaga, and Wyoming) are currently serving approximately 3,000 persons through 12 local, not-for-profit care coordination agencies. The annual Enrollee Satisfaction Survey is an opportunity for enrollees to rate the services they are receiving through the Care Coordination Program.

The 2007 Enrollee Satisfaction Survey was administered during November - December 2007. A total of 556 enrollees from across all six counties participated in the survey, representing a 42% increase compared to 2006. As shown in Figure 1, participation in five out of six counties increased from the previous year.

Figure 1: Number of respondents by County



2007 participants were almost equally split in terms of gender (51% male). The self-reported ethnicity of 2007 survey respondents is indicated in Figure 2 (below).



The survey was divided up into three sections to give enrollees the opportunity to provide separate ratings of his/her care coordinator, the Individual Service planning process, and the primary service provider. All items

were rated on a 5-point scale of “Strongly Agree” (5) to “Strongly Disagree” (1). Average scores for each of the three surveys sections were tallied in addition to individual item scores.

Overall Results

Survey results showed that enrollees reported satisfaction with most areas of the survey (that is, average scores of 4 or above), including the convenience and responsiveness of the care coordinator/case manager (average scores of 4.4 for both), overall experience with the service planning (4.1), and the responsiveness/usefulness of the primary mental health service provider (4.3 and 4.0, respectively). The only area rated below satisfactory was the helpfulness of care coordination services over the past year, which received an overall rating of 3.9.

Individual Items

The highest rated individual items on the survey (i.e. the items with the greatest amount of “Strongly Agree” or “Agree” responses) were from the care coordinator section: “I was treated with respect by my Care Coordinator,” and “My Care Coordinator and I were able to communicate.” The five highest-rated items are listed in Table 1 (below) and suggest that enrollees are particularly satisfied with the relationships that exist with care coordinators and primary service providers. These results are very similar to 2006.

Table 1: Items with the most “Strongly Agree” or “Agree” responses

| <i>Item</i> | % “Strongly Agree” or “Agree” |
|---|-------------------------------|
| I was treated with respect by my Care Coordinator. | 93% |
| My Care Coordinator and I were able to communicate. | 91% |
| I am carefully listened to by my Care Coordinator. | 90% |
| I was treated with respect by my primary service provider. | 89% |
| My Care Coordinator believes I can grow, change, and recover. | 89% |

The five items with the greatest amount of “Strongly Disagree” or “Disagree” responses are shown in Table 2 (below). These items suggest that despite indicating satisfaction with many aspects of care coordination and their primary service providers, many enrollees acknowledge significant clinical, social, and residential needs. Again, these closely parallel the results of the 2006 enrollee survey.

Table 2: Items with the most “Strongly Disagree” or “Disagree” responses

| <i>Item</i> | % “Strongly Disagree” or “Disagree” |
|--|-------------------------------------|
| My symptoms are not bothering me as much. <i>(Care Coordinator section)</i> | 13% |
| My symptoms are not bothering me as much. <i>(Primary Provider section)</i> | 12% |
| I am getting along better with my family. <i>(Primary Provider section)</i> | 11% |
| I am getting along better with my family. <i>(Care Coordinator section)</i> | 10% |
| My housing situation has improved. | 10% |

The results of the 2007 Enrollee Satisfaction Survey indicate that enrollees express satisfaction with many aspects of care coordination and service providers, although a variety of needs and potential areas for improvement are apparent. Efforts will continue to be made across all six counties to further enhance services and promote a recovery-oriented, person-centered approach to service planning and delivery.

Care Coordination Program Services Survey

Background Information

Please tell us about yourself without sharing your name. This anonymous and confidential information is very important to help ensure that services meet your needs. Please put an X in the box of your choice or fill in the blanks that best answer the following questions.

| Demographic Information | | |
|--|---|--|
| 1. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female | 2. Age: _____ | 3. County of Residence: _____ |
| 4. Primary Racial/ Ethnic Background: | <input type="checkbox"/> White (Non-Hispanic) <input type="checkbox"/> Black (Non-Hispanic) <input type="checkbox"/> Other or dual (specify) _____ | <input type="checkbox"/> Asian American <input type="checkbox"/> Native American <input type="checkbox"/> Latino/Hispanic (Any) <input type="checkbox"/> Pacific Islander |
| 5. Primary Language: | <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> American Sign Language <input type="checkbox"/> Chinese <input type="checkbox"/> Other (please specify) _____ | |

SECTION I

Care Coordinator

This set of statements (questions 6-24) should be thought about as they relate to your experiences with your Care Coordinator. For each statement that applies to your experience, indicate how much you agree or disagree by placing an X in one of the boxes. For statements that do not apply to your experience, place an X in the “Does Not Apply” box.

| <i>Please rate the ease and convenience of getting mental health services through your <u>Care Coordinator</u> during the PAST YEAR.</i> | | | | | | | |
|--|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | | Strongly Agree | Agree | I Am Neutral | Disagree | Strongly Disagree | Does Not Apply |
| 6. | I was given helpful information about my service options. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | It was easy to get in touch with my Care Coordinator when I needed them. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | It was easy to get to the places where I met with my Care Coordinator. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | I was satisfied with the range of services suggested by my Care Coordinator | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | My Care Coordinator helped me to get medical services when I needed them. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please rate how care coordination services were provided and how responsive your Care Coordinator was to you during the PAST YEAR.

| | | Strongly Agree | Agree | I Am Neutral | Disagree | Strongly Disagree | Does Not Apply |
|-----|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 11. | I am carefully listened to by my Care Coordinator. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. | My Care Coordinator was sensitive to issues related to my culture, race, gender, sexual orientation and/or religion. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. | My Care Coordinator believes that I can grow, change and recover. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. | I was treated with respect by my Care Coordinator. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. | My Care Coordinator and I were able to communicate. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. | My dreams, interests, preferences and strengths were clearly acknowledged and used to drive activities, services and supports. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please rate how helpful care coordination services from your Care Coordinator have been for you during the PAST YEAR.

| | | Strongly Agree | Agree | I Am Neutral | Disagree | Strongly Disagree | Does Not Apply |
|-----|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 17. | I deal more effectively with daily problems. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. | I am better able to control my life. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. | I am better able to deal with crisis. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. | I am getting along better with my family. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. | I do better in social situations. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. | I do better in school and/or work. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. | My housing situation has improved. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. | My symptoms are not bothering me as much. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Individual Service Planning

This set of statements should be thought about as they relate to your experience with your Individual Service Plan (ISP). For each statement that applies to your experience, indicate how much you agree or disagree by placing an X in one of the boxes.

| | | Strongly Agree | Agree | I Am Neutral | Disagree | Strongly Disagree | Does Not Apply |
|-----|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 25. | I like using the Quality of Life Assessment form (QOL). | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. | The QOL was helpful in developing my Individualized Service Plan. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. | I like using the Individualized Service Plan. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. | My Individualized Service Plan reflects my plans for recovery. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. | My Individualized Service Plan reflects my strengths as well as needs. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. | I feel free to choose or reject services. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. | I have a Crisis Prevention Plan that is helpful. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. | Self-help and Peer Support Groups were available and included in my Individualized Service Plan when I needed them. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. | I was satisfied with the range of services available to me. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

34. Please comment about what aspects of services were particularly good or helpful from your Care Coordinator?

35. What suggestions would you make to improve services by your Care Coordinator?

SECTION II

Other Services

36. Please rate the overall helpfulness of the services listed below that you used in the past year. Put an X in a box in the column that matches the level of helpfulness for each service type. If you did not use a particular service, put an X in the “Does Not Apply” box.

| Service | Very Helpful | Somewhat Helpful | Not Helpful | Does Not Apply |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| Clinic | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Intensive Psychiatric Rehabilitation Treatment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Vocational/educational services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Assertive Community Treatment (ACT) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Inpatient Treatment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Continuing Day Treatment (CDT) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Partial Hospitalization | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Substance Abuse Treatment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Social Club | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Self-help/Peer Services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other Service (Please describe below) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

37. Of the services that you identified above that you used in the past year, CHOOSE ONE that you consider your primary service provider and write it below (this should not be your Care Coordination/Case Management service).

My Primary Service Provider is: _____

SECTION III

Primary Service Provider

This section (questions 38-60) will repeat many of the same questions answered about your Care Coordinator but will be about your experiences with your Primary Service Provider (the one you wrote in above). For each statement, indicate how much you agree or disagree by placing an X in one of the boxes. For statements that do not apply to your experience, place an X in the “Does Not Apply” box.

| <i>Please rate the ease and convenience of getting mental health services at your Primary Service Provider during the PAST YEAR.</i> | | | | | | | |
|---|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | | Strongly Agree | Agree | I Am Neutral | Disagree | Strongly Disagree | Does Not Apply |
| 38. | I was given helpful information about my service options. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. | I was given helpful information about self-help and peer support groups | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. | It was easy to get services when I needed them. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. | It was easy to get to the places where my primary services were provided. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. | I was satisfied with the range of services available to me from my primary service provider. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. | My primary service provider helped me to get medical services when I needed them. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| <i>Please rate how mental health services at your Primary Service Provider were provided and how responsive they were to you during the PAST YEAR.</i> | | | | | | | |
|---|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | | Strongly Agree | Agree | I Am Neutral | Disagree | Strongly Disagree | Does Not Apply |
| 44. | I am carefully listened to by my service provider. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. | Staff was sensitive to issues related to my culture, race, gender, sexual orientation and/or religion. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 46. | The staff believe that I can grow, change and recover. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 47. | I received helpful information from staff about my medication and any side effects. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 48. | I received helpful information about my diagnosis and treatment. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 49. | I was treated with respect by my primary service provider. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | | Strongly Agree | Agree | I Am Neutral | Disagree | Strongly Disagree | Does Not Apply |
|-----|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 50. | My primary service provider offered me choices in my care. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 51. | My primary service provider and I were able to communicate. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 52. | My dreams, interests, preferences and strengths were clearly acknowledged and used to drive activities, services and supports. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

*Please rate how helpful mental health services at your **Primary Service Provider** have been for you during the PAST YEAR*

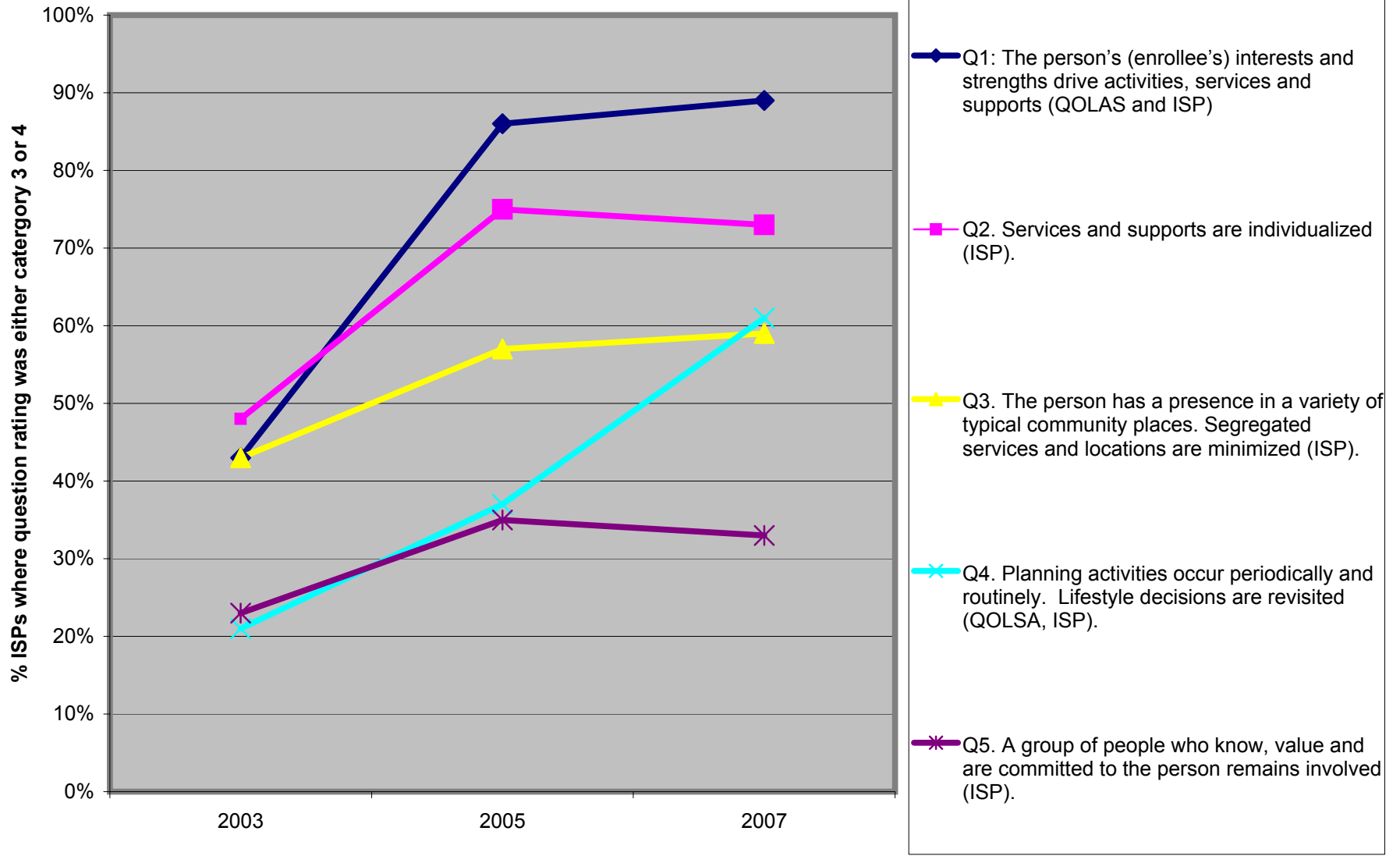
| | | Strongly Agree | Agree | I Am Neutral | Disagree | Strongly Disagree | Does Not Apply |
|-----|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 53. | I deal more effectively with daily problems. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 54. | I am better able to control my life. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 55. | I am better able to deal with crisis. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 56. | I am getting along better with my family. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 57. | I do better in social situations. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 58. | I do better in school and/or work. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 59. | My housing situation has improved. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 60. | My symptoms are not bothering me as much. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

61. Please comment about what aspects of services were particularly good or helpful from your Primary Service Provider:

62. What suggestions would you make to improve services by your Primary Service Provider?

Thank you for completing this survey!

Review of Individual Services Plans for Hallmarks of Person-Centered Planning



2007 INDIVIDUALIZED SERVICE PLAN REVIEW EXECUTIVE SUMMARY

Background

This analysis is one component of a multi-pronged effort to evaluate the impact of the Western New York Care Coordination Program (WNYCCP). The specific objective of this analysis is to assess the degree to which the program is being implemented in a manner that reflects the key tenets of Person-Centered Planning.

Methods

In order to assess the level of fidelity to the Person-Centered Planning model, representatives in each of the six participating counties reviewed Individual Service Plans (ISP) and Quality of Life Self-Assessment surveys (QOLSA) for 10% of program enrollees or a minimum of 10 charts, whichever number was larger. Efforts were made to ensure that sample selection was done in a random manner. Sample sizes have increased substantially over the five years since this process was implemented, as noted in the chart below:

| County | 2003 | 2004 | 2005 | 2006 | 2007 |
|--------------|------------|------------|------------|------------|------------|
| Chautauqua | 9 | 10 | 19 | 15 | 14 |
| Erie | 50 | 65 | 54 | 49 | 74 |
| Genesee | 1 | 4 | 10 | 12 | 11 |
| Monroe | 15 | 48 | 82 | 90 | 98 |
| Onondaga | 22 | 28 | 50 | 61 | 69 |
| Wyoming | 5 | 6 | 10 | 7 | 11 |
| TOTAL | 102 | 161 | 225 | 234 | 277 |

Reviewers were asked to rate each case using a standard assessment tool developed by WNYCCP which was identical to the version used in 2006. Areas of interest included the following specific indicators, all of which were rated on scales of 1 to 4 (see scale details in analysis below):

1. The person's (enrollee's) dreams, interests and strengths drive activities, services and supports.
2. Services and supports are individualized and don't rely solely on preexisting models
3. The person has a presence in a variety of typical community places. Segregated services and locations are minimized
4. Planning activities occur periodically and routinely. Lifestyle decisions are revisited.
5. A group of people who know, value and are committed to the person remains involved.
6. The person's opportunities and experiences are maximized and flexibility is enhanced within existing regulatory and funding constraints.

It should also be noted that the current summary includes information regarding ACT enrollees. This has not been the case in all previous years due to difficulties applying the review instrument to ACT programs. However, a task group comprised of ISP reviewers and ACT providers was formed in 2007 to address these challenges and developed a set of recommendations for applying the review instrument to service plans developed within ACT programs.

Findings

In this analysis, we focused primarily on assessing the extent to which there have been any shifts in the distribution across the rating categories for all content areas. We were interested in learning if an increase would be evident in the percentage of cases being rated at the higher end of the spectrum, which would indicate solid, ongoing application of key principles of Person-Centered Planning. As such, the summary that follows focuses on examining the degree of movement across these rating categories between 2003 (the first full year of program operations) and 2007 for items 1-5, as well as results from the past two years for item 6, which was added in 2006 to address limitations of the original instrument.

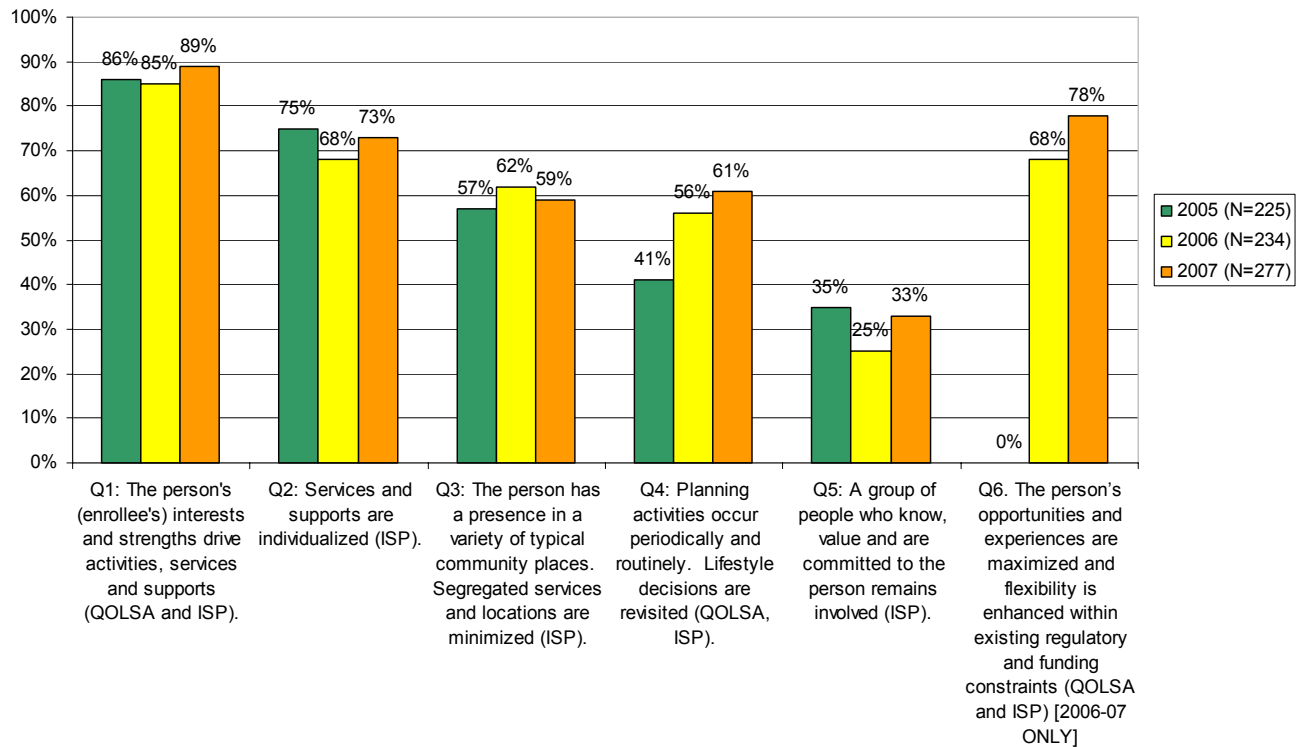
In reviewing the trended data, it is important to note that there was a change in review methodology in 2005. Some ratings completed in 2004 took into consideration other supplemental information, including chart notes. Ratings completed since 2005 relied only on information available in the ISP or QOLSA. While this change was

important in achieving consistency in the approach across sites, it does impact the ability to make comparisons between 2004 and information for other years. However, when looked at from a longitudinal perspective, the results from 2004 largely seem consistent with overall trends.

Comparison of top two rating categories

As in previous years, we were interested in the percentage of cases that fell into the top two rating categories during 2007 compared to previous reviews. An analysis of data from 2005-2007 shows that previous levels have generally been maintained or improved upon for all items. The most notable increases were seen in items 4 (“Planning occurs periodically and routinely”) and 6 (“The person’s opportunities and experiences are maximized...”). This could be due to increased provider sensitivity to the timeliness of ISP reviews as well increased reviewer comfort with item 6, which was added in 2006.

% of ISPs where question rating was either category 3 or 4: 2005-2007



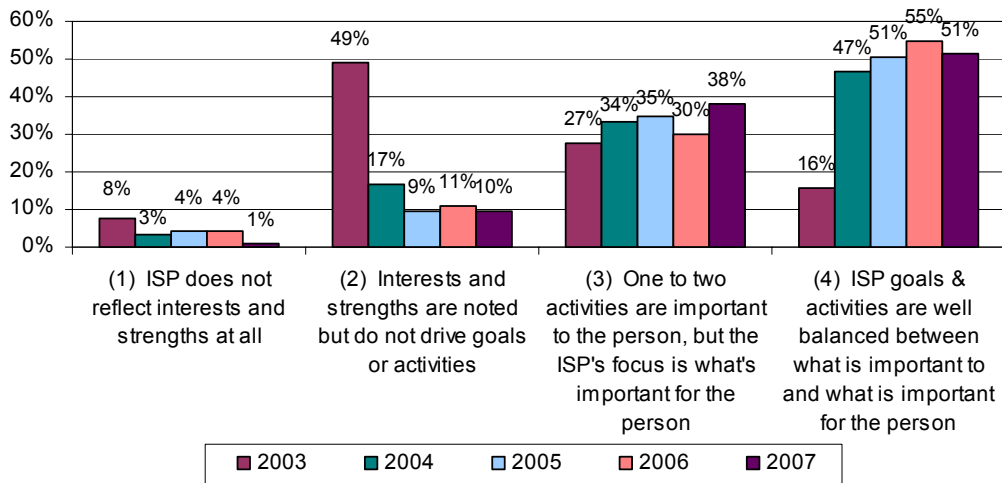
Results by individual items

In addition to aggregating the results of the two top rating categories, we also were interested in specific results for each scale item. The distribution of scores for each scale items is shown below, along with comparisons to previous years.

1. The person’s dreams, interests and strengths continue to drive activities, services and supports.

- 51% of the cases reviewed in 2007 indicated that “goals & activities are well balanced between what is important TO and what is important FOR the person.” This is fairly consistent with results from the previous three years (50%) and maintains the substantial gain compared to 2003.

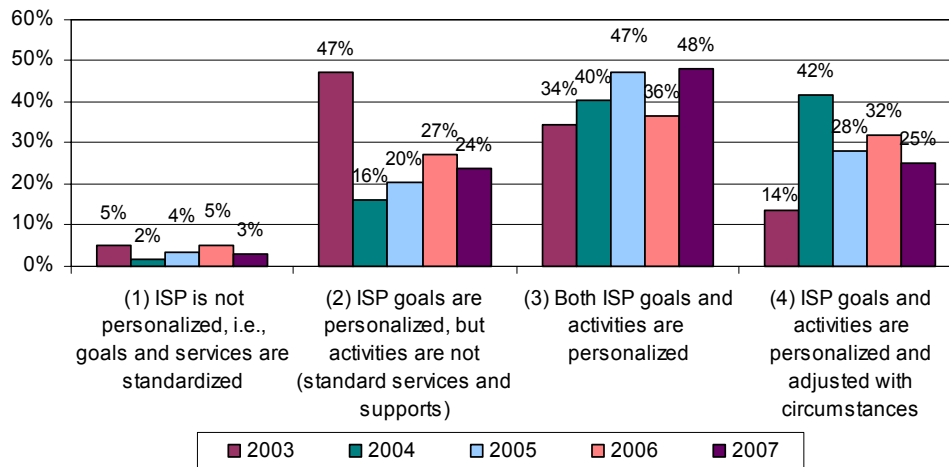
Q1: The person's (enrollee's) interests and strengths drive activities, services and supports (QOLSA and ISP).



2. Case reviews continue to show a consistently high number of service plans that incorporate individualized services and supports compared to the previous year.

- Reviewers noted that 73% of cases indicated that ISP goals and activities are personalized and/or are adjusted with circumstances, compared to 68% in 2006 and 75% in 2005.

Q2: Services and supports are individualized (ISP).

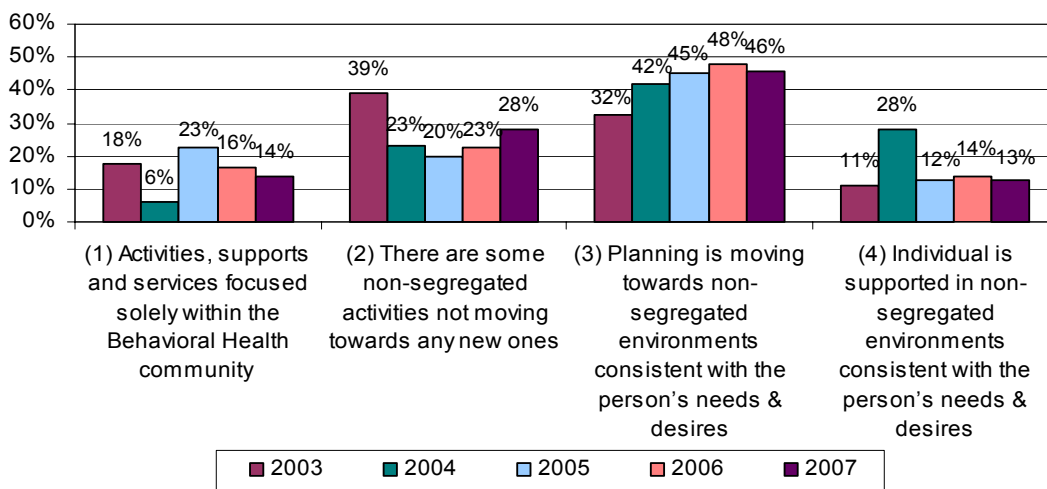


3. Planning appears to be moving towards non-segregated environments consistent with the person's desires, but enrollees continue to have a limited presence in such settings.

- In 13% of the cases, the reviewer indicated that the “Individual is supported in non-segregated environments consistent with the person's needs & desires”, and in 46% of the cases, “Planning is moving toward non-segregated environments consistent with the person's needs and desires.” This maintains the marginal

improvements apparent increase since 2003, but these results appear to have reached a plateau.

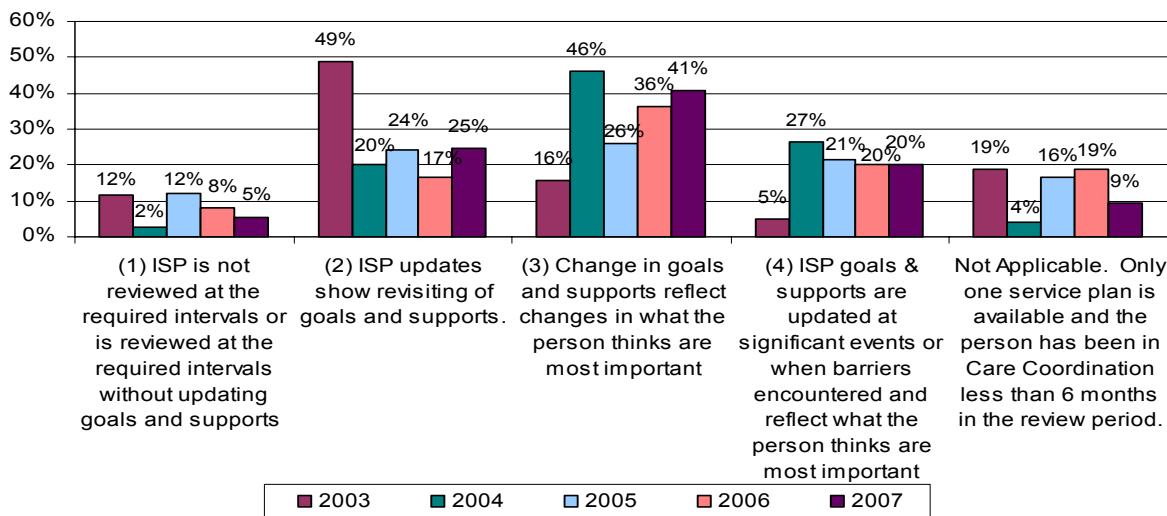
Q3: The person has a presence in a variety of typical community places. Segregated services and locations are minimized (ISP).



4. Progress has been maintained in ensuring planning occurs on a routine basis and lifestyle decisions are revisited.

- In 41% of the cases reviewed in 2007, reviewers indicated that *Changes in goals and supports reflect changes in what the person thinks are most important* (compared to 36% in 2006). In addition, for 20% of the cases there was evidence that *ISP goals are updated at significant events or when barriers are encountered*.

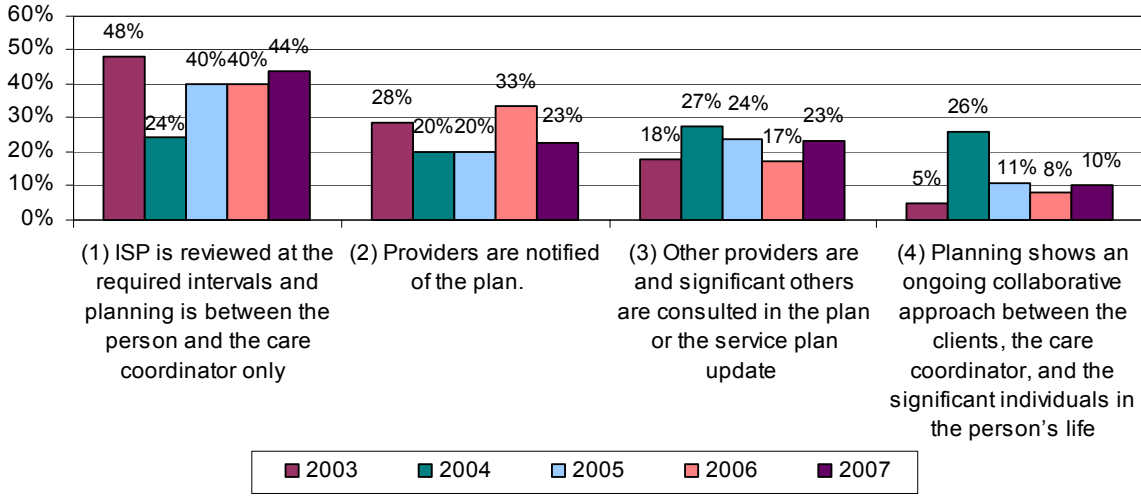
Q4: Planning activities occur periodically and routinely. Lifestyle decisions are revisited (QOLSA, ISP).



5. Progress continues to be limited regarding documented efforts to engage others in the enrollee's ISP process.

- As noted last year, this is an area showing a need for improvement. 33% of cases reviewed in 2007 showed that either *other providers are and significant others are consulted in the plan or the service plan update* or *planning shows an ongoing collaborative approach between the clients, the care coordinator, and the significant individuals in the person's life*, representing an 8% increase over last year.

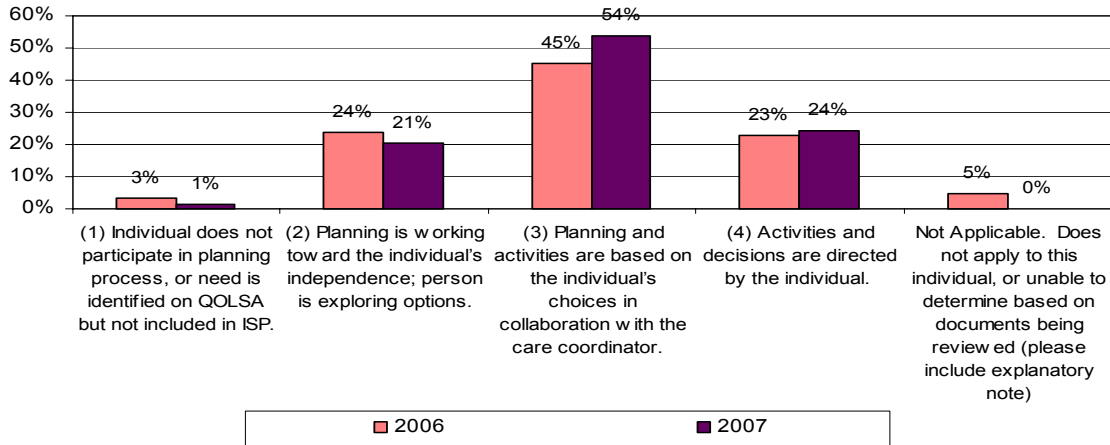
Q5: A group of people who know, value and are committed to the person remains involved (ISP).



6. The person's independence is being encouraged via participation in decision making regarding opportunities and experiences within existing regulatory and funding constraints.

- Reviewers noted that 54% of cases showed evidence that *planning and activities were based on the individual's choices in collaboration with the care coordinator* (an increase of 9% compared to 2006), and an additional 24% indicated that *activities and decisions were directed by the individual* (compared to 23% in 2006).

Q6: The person's opportunities and experiences are maximized and flexibility is enhanced within existing regulatory and funding constraints.



Conclusions

The aggregate results of the 2007 ISP reviews indicate that the gains made in previous years have been maintained and some areas have actually continued to increase. However, there continue to be specific aspects of person-centered practices and service plan documentation that are in need of improvement, including the involvement of others in the planning process, as well as a focus on community-based goals.

WNYCCP Indicators of Person Centered Planning

1. The person's (enrollee's) interests and strengths drive activities, services and supports (QOLSA and ISP).

Examples include:

- Quality of life areas that the person wants on the service plan are included in the ISP.
- ISP goals, activities (services and supports) reflect the person's interests and strengths.
- ISP goals and activities are a balance of important to and important for the person.

| 1 | 2 | 3 | 4 |
|--|---|--|---|
| ISP does not reflect interests and strengths at all. | Interests and strengths are noted but do not drive goals or activities. | One to two activities are important <u>to</u> the person, but the ISP's focus is what's important <u>for</u> the person. | ISP goals and activities are well balanced between what is important <u>to</u> and what is important <u>for</u> the person. |

Comments: _____

2. Services and supports are individualized (ISP).

Examples include:

- See supportive language such as “explore”, “work out”, “negotiate”
- Not using “police language” such as “will comply”
- When reviewing several ISPs, they are not the same

| 1 | 2 | 3 | 4 |
|--|--|--|---|
| ISP is not individualized, i.e. goals and services are standardized. | ISP goals are personalized, but activities are not (standard services and supports). | Both ISP goals and activities are personalized | ISP goals and activities are personalized and adjusted with circumstances |

Comments: _____

3. The person has a presence in a variety of typical community places. Segregated services and locations are minimized (ISP).

Examples include:

- Items such as “community education”, various generic (non-mental health) clubs, volunteer work etc. and
- ISP demonstrates empowerment

| 1 | 2 | 3 | 4 |
|--|--|---|---|
| Activities, supports and services focused solely within the behavioral health community. | There are some non-segregated activities, but not moving towards any new ones. | Planning is moving towards non-segregated environments consistent with the person's needs & desires | Individual is supported in non-segregated environments consistent with the person's needs & desires |

Comments: _____

4. Planning activities occur periodically and routinely. Lifestyle decisions are revisited (QOLSA, ISP).

Examples include

- There are modifications to the ISP at significant events that impact on the person and;
- See evidence on the ISP review that there has been progress, not all goals are continuations, and there have been changes in the plan.

| 1 | 2 | 3 | 4 | Not applicable |
|--|--|---|--|--|
| ISP is not reviewed at the required intervals or is reviewed at the required intervals without updating goals and supports | ISP updates show revisiting of goals and supports. | Change in goals and supports reflect changes in what the person thinks are most important | ISP goals and supports are updated at significant events or when barriers are encountered. Change in goals and supports reflect what the person thinks are most important. | Only one service plan is available and the person has been in Care Coordination less than 6 months in the review period. |

Comments: _____

5. A group of people who know, value and are committed to the person remains involved (ISP).

Examples include

- ISP review indicates feedback from other providers;
- Signoff on the ISP by an individual external to the Care Coordination program and;
- ISP review indicates feedback from non-providers i.e. family, landlords etc.

Note: all collaboration needs to be with the person's consent

| 1 | 2 | 3 | 4 |
|--|-------------------------------------|---|---|
| ISP is reviewed at the required intervals and planning is between the person and the care coordinator only | Providers are notified of the plan. | Other providers and significant others are consulted in the plan or the service plan update | Planning shows an ongoing collaborative approach between the client, the care coordinator, and the significant individuals in the person's life |

Comments: _____

6. The person's opportunities and experiences are maximized and flexibility is enhanced within existing regulatory and funding constraints.

Examples include:

- Individual is making or participating in decisions regarding self-sufficiency
- Desire for employment is associated with a work goal and activities towards that goal

| 1 | 2 | 3 | 4 | Not applicable |
|--|--|---|--|--|
| Individual does not participate in planning process, or need is identified on QOLSA but not included in ISP. | Planning is working toward the individual's independence; person is exploring options. | Planning and activities are based on the individual's choices in collaboration with the care coordinator. | Activities and decisions are directed by the individual. | Does not apply to this individual, or unable to determine based on documents being reviewed (<u>please include explanatory note</u>) |

Comments: _____

QUALITY OF LIFE SELF-ASSESSMENT

This self-assessment asks you to tell us how things are going for you these days. It should take you about five minutes to complete. What finished, please give the self-assessment to the staff member you are seeing today so that you can review the results together. This should be completed for the initial plan and at every plan review.

Please *print* your name, the staff member's name, and today's date below:

1. Your Name (Please Print): _____
2. Staff Member's Name: _____
3. Today's Date: _____

In this section, we ask you to rate how things are going in different areas of your life. For each statement below, circle the answer that best matches your experience.

Circle **ONE** choice for each statement below

| Overall, how would you rate...? | 1 | 2 | 3 | 4 | Should this be on your service/ recovery plan? | |
|---|--------|----------|---------|-----------|---|-----------------------------|
| 1. The place where you live (your housing). | Poor | Fair | Good | Excellent | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. The amount of money you have to buy what you need. | Poor | Fair | Good | Excellent | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Your involvement in work, employment. | Poor | Fair | Good | Excellent | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Your level of education | Poor | Fair | Good | Excellent | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Your access to transportation to get around | Poor | Fair | Good | Excellent | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Your social life | Poor | Fair | Good | Excellent | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Your participation in community activities (Leisure, sports, spiritual, volunteer work) | Poor | Fair | Good | Excellent | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Your ability to have fun and relax | Poor | Fair | Good | Excellent | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Your physical health | Poor | Fair | Good | Excellent | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Your level of independence | Poor | Fair | Good | Excellent | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Your ability to take care of yourself (staying healthy, eating right, avoiding danger) | Poor | Fair | Good | Excellent | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Your self-esteem (how you feel about yourself) | Poor | Fair | Good | Excellent | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. Your personal relationships | Poor | Fair | Good | Excellent | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. Overall, how things are going in your life? | Poor | Fair | Good | Excellent | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. The effect of alcohol and other drugs on your life | Severe | Moderate | Minimal | None | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 16. Your mental health symptoms | Severe | Moderate | Minimal | None | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is there anything else that you want on your service plan? | | | | | | |
| | | | | | | |
| Comments (for example, what are your personal goals in this program?) | | | | | | |
| | | | | | | |

Participant Name: _____
ID: _____

Care Coordination Program: _____
Date of Plan: _____

INDIVIDUAL SERVICE PLAN

You and your Care Coordinator have the opportunity to work together on an Individual Service Plan (ISP) and a Crisis Prevention Plan. You may also want a friend, a family member and/or a valued provider included in the development of this plan.

Services in the plan may include mental health and/or chemical dependency treatment, housing and financial assistance, and any other things that you identify as a support. You can also address life areas that you are not satisfied with or need more help with. You may want to set goals and develop a service plan that addresses some or all of the following life areas:

Recovery & Rehabilitation

Physical Health & Wellness

Financial

Housing

Community Presence & Participation

Self-Help & Empowerment

Educational & Employment

Legal

Spirituality

Other _____

You may write a plan with as many goals and services as you want. You may review the plan and add goals and services at any time by talking about this with your Care Coordinator.

As you work with your Care Coordinator on the Individual Service Plan, you will want to consider what personal supports and community resources can help you achieve your goals, what services and which service providers have been most helpful in the past, what prevents you from getting and keeping what you need and what strengths, supports and experiences you can use to achieve your goals. Your Care Coordinator will assist you in accessing the services, supports and organizations that you need in order to carry out your plan.

Your Care Coordinator will also work with you to develop a Crisis Prevention Plan. This plan will help you recognize situations and people that may cause you stress, and identify people and things that may help you to relieve stress.

Participant Name: _____ Care Coordination Program: _____
ID: _____ DOB: _____ Date of Plan: _____

Part A – Participant’s Personal Profile
(As established in the Assessment)

Values and areas of interest (Things that are important to me: hopes, dreams, interests)

Strengths (Skills, qualities, and experiences that can help me achieve my goals)

Personal and community supports (People and/or things I have in my life that can help me achieve my goals)

Possible barriers (Things that could prevent me from achieving these goals)

Participant Name: _____ Care Coordination Program: _____
 ID: _____ DOB: _____ Date of Plan: _____

**Part A – Participant’s Personal Profile
 (As established in the Assessment)**

Discharge criteria (How I will know that I don’t need Care Coordination anymore)

| Date | Update Information | Participant Initials | Provider Initials |
|------|--------------------|----------------------|-------------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Participant Name: _____ Care Coordination Program: _____
 ID: _____ DOB: _____ Date of Plan: _____

Part B – Participant’s Goal, Objective and Services

Goal # _____ Participant’s Desired Outcome: _____

Development Date: _____

| | | | | | |
|--|--|--|-------------------------------|---------------------------------|--|
| Barriers (What is getting in the way of achieving the goal as per assessment) | | Objective _____ (Step toward the goal and how I will know I have accomplished this) | | | |
| Strengths (Existing supports for achieving the goal) | | | | | |
| Specific Services/Activities/Supports/Tasks (What I and/or others will do to achieve this objective) | Who is Responsible (Person/s who will provide the service or carry out the task) | Start Date | Target Completion Date | Frequency (How often) | Service \$ Expense (CK if yes) |
| | | | | | |
| | | | | | |
| | | | | | |

| Ongoing Updates | | | | |
|------------------------|-----------------|-------------------------|-----------------------------|--------------------------|
| Date | Progress | Achievement Code | Participant Initials | Provider Initials |
| | | | | |
| | | | | |
| | | | | |

Copy this page as often as needed to create new goals and/or objectives. Attach additional pages as needed to provide updates to this objective.

Participant Name: _____ Care Coordination Program: _____
 ID: _____ DOB: _____ Date of Plan: _____

Part B – Participant’s Goal, Objective and Services

Goal # _____ Participant’s Desired Outcome: _____

Development Date: _____

| | | | | | |
|--|--|--|-------------------------------|---------------------------------|--|
| Barriers (What is getting in the way of achieving the goal as per assessment) | | Objective _____ (Step toward the goal and how I will know I have accomplished this) | | | |
| Strengths (Existing supports for achieving the goal) | | | | | |
| Specific Services/Activities/Supports/Tasks (What I and/or others will do to achieve this objective) | Who is Responsible (Person/s who will provide the service or carry out the task) | Start Date | Target Completion Date | Frequency (How often) | Service \$ Expense (CK if yes) |
| | | | | | |
| | | | | | |
| | | | | | |

| Ongoing Updates | | | | |
|------------------------|-----------------|-------------------------|-----------------------------|--------------------------|
| Date | Progress | Achievement Code | Participant Initials | Provider Initials |
| | | | | |
| | | | | |
| | | | | |

Copy this page as often as needed to create new goals and/or objectives. Attach additional pages as needed to provide updates to this objective.

Participant Name: _____ Care Coordination Program: _____
 ID: _____ DOB: _____ Date of Plan: _____

Part B – Participant’s Goal, Objective and Services

Goal # _____ Participant’s Desired Outcome: _____

Development Date: _____

| | | | | | |
|--|--|--|-------------------------------|---------------------------------|--|
| Barriers (What is getting in the way of achieving the goal as per assessment) | | Objective _____ (Step toward the goal and how I will know I have accomplished this) | | | |
| Strengths (Existing supports for achieving the goal) | | | | | |
| Specific Services/Activities/Supports/Tasks (What I and/or others will do to achieve this objective) | Who is Responsible (Person/s who will provide the service or carry out the task) | Start Date | Target Completion Date | Frequency (How often) | Service \$ Expense (CK if yes) |
| | | | | | |
| | | | | | |
| | | | | | |

| Ongoing Updates | | | | |
|------------------------|-----------------|-------------------------|-----------------------------|--------------------------|
| Date | Progress | Achievement Code | Participant Initials | Provider Initials |
| | | | | |
| | | | | |
| | | | | |

Copy this page as often as needed to create new goals and/or objectives. Attach additional pages as needed to provide updates to this objective.

Participant Name: _____
 ID: _____ DOB: _____

Care Coordination Program: _____
 Date of Plan: _____

Part C – Participant’s Crisis Prevention Plan

If the participant has a Wellness Action Recovery Plan (WRAP), it may be attached and the form used only for additional or updated information.

| HEALTH CARE PROXY HAS BEEN EXECUTED? () Yes () No <input type="checkbox"/> Copy Attached | | OTHER ADVANCED DIRECTIVE HAS BEEN EXECUTED? () Yes () No <input type="checkbox"/> Copy Attached | | WELLNESS ACTION RECOVERY PLAN (WRAP) HAS BEEN EXECUTED? () Yes () No <input type="checkbox"/> Copy Attached | |
|--|--|---|--|--|--|
| Document Location: Does the Participant have a copy? () Yes () No | If No: _____ Need More Information _____ Refused (state reason below) | Document Location: Does the Participant have a copy? () Yes () No | If No: _____ Need More Information _____ Refused (state reason below) | Document Location: Does the Participant have a copy? () Yes () No | If No: _____ Need More Information _____ Refused (state reason below) |
| MY CRISIS PREVENTION PLAN: (How can I avoid a crisis?): | | | | | |
| Are there people, places or things I should avoid? What are they? | | | | | |
| What are my early warning signs? | | | | | |
| My CRISIS PLAN (What can be done if I am in crisis?) | | | | | |
| Ways I can relieve stress, regain balance, calm myself or make myself safer: | | | | | |
| Persons I can call: | | | Resources I can use: | | |
| Things I or others can do that I find helpful or keep me safe: | | | | | |
| Medications that have helped in the past: | | Medications that have Not helped: | | Types of medication(s) I take: | |

Participant Name: _____ Care Coordination Program: _____
 ID: _____ DOB: _____ Date of Plan: _____

IF I BECOME UNABLE TO HANDLE MY PERSONAL AFFAIRS, the following people have agreed to look after my personal affairs
 (For example: pets, housing, family/job notification):

| Name | Phone | Area(s) of Assistance |
|------|-------|-----------------------|
| | | |
| | | |
| | | |
| | | |

I have developed this Crisis Plan to describe the actions that I would like to take place should I be in a crisis situation.
Participant's Signature: _____ **Date:** _____

| Ongoing Updates | | | |
|------------------------|------------------|----------------------|-------------------|
| Review Date | Update / Comment | Participant Initials | Provider Initials |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Participant Name: _____ Care Coordination Program: _____
 ID: _____ DOB: _____ Date of Plan: _____

Assessment / Plan Summary / Review – Signature Page

TYPE: Initial Plan: _____ Periodic Review 3 mo _____ Periodic Review 6 mo _____ Other Review _____ Date: _____

Participant Comments (Progress toward goal, accomplishments, other)

Provider Comments (Narrative summary)

Topics Requiring Further Discussion and/or Services That I or My Care Coordinator Need to Explore Further
 (Address any areas identified in the QOL/CCAF which are not in the ISP, reasons for not including them at this time, and what, if any future actions will be taken to include them)

Signatures of Individuals Contributing to the Individual Service Plan:

Copies of Plan Provided To:

| | |
|--------------------------------------|---------------------------------|
| Participant Signature: Date: | Participant Name: Date: |
| Care Coordinator Signature: Date: | Care Coordinator Name: Date: |
| Service Provider Signature: Date: | Service Provider Name: Date: |
| Other Signature (specify): Date: | Other Name (specify): Date: |

CARE COORDINATOR'S ASSESSMENT OF FUNCTIONING (CCAF)

The Care Coordinator's Assessment of Functioning (**CCAF**) is completed at the time of the admission ISP and then annually thereafter. While the dimensions represented below are similar to the items on the Quality of Life--Self Assessment completed by individuals in the Western New York Care Coordination Project, the **CCAF** represents your assessment of the recipient's strengths and needs.

1. Name (please print):

2. Care Coordinator's name:

3. Today's date:

Please rate the recipients ability to function in different areas of the individual's life **during the past 3 months**. A response of '**poor or severe**' indicates an area of immediate need. '**Fair or moderate**' indicates an area with some identified needs where some action maybe appropriate. '**Good or minimal**' indicates an area of strengths but some minor/episodic need. '**Excellent or none**' indicates an area of clear strengths for the individual.

| Overall, how would you rate ... | (Circle <u>one</u> choice for each statement) | | | |
|--|---|----------|---------|-----------|
| | 0 | 1 | 2 | 3 |
| 1. Housing | POOR | FAIR | GOOD | EXCELLENT |
| 2. Finances | POOR | FAIR | GOOD | EXCELLENT |
| 3. Work or work readiness | POOR | FAIR | GOOD | EXCELLENT |
| 4. Level of education | POOR | FAIR | GOOD | EXCELLENT |
| 5. Community mobility (transportation) | POOR | FAIR | GOOD | EXCELLENT |
| 6. Social life (family, friends) | POOR | FAIR | GOOD | EXCELLENT |
| 7. Community involvement/activities (church and other community organizations) | POOR | FAIR | GOOD | EXCELLENT |
| 8. Leisure pursuits and ability to have fun (clubs, hobbies, other activities) | POOR | FAIR | GOOD | EXCELLENT |
| 9. Physical health | POOR | FAIR | GOOD | EXCELLENT |
| 10. Level of independence | POOR | FAIR | GOOD | EXCELLENT |
| 11. Activities of daily living (ADLs) | POOR | FAIR | GOOD | EXCELLENT |
| 12. Self-esteem or self-confidence | POOR | FAIR | GOOD | EXCELLENT |
| 13. Effect of alcohol & other drugs | SEVERE | MODERATE | MINIMAL | NONE |
| 14. Mental health symptoms | SEVERE | MODERATE | MINIMAL | NONE |
| 15. Overall, how things are going for this individual | POOR | FAIR | GOOD | EXCELLENT |