COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN/PIHP	*Policy and Procedure* *Person Centered Planning Policy*
Department: Clinical Performance Team **Author:**	**Local Policy Number (if used)**
Regional Operations Committee Approval Date **6/10/2020**	**Implementation Date** **8/10/2020**

I. PURPOSE

Establish the service and treatment philosophy of the Community Mental Health Partnership of Southeast Michigan (CMHPSM) is based on the values and principles of the person-centered planning process, establish standards and applications for person-centered planning, and ensure compliance with the requirements governing service delivery established by regulatory and/or funding bodies.

II. REVISION HISTORY

DATE	REV. NO.	MODIFICATION
2003		Original document
2005	1.0	
2011	2.0	
2014	3.0	Revised to reflect the new regional entity.
2015	4.0	Revised to reflect the Quality Improvement Council's (QIC) quality improvement plan.
2018	4.0	Revised to reflect the Quality Improvement Council's (QIC) quality improvement plan.
2018	5.0	Regional Review of Policy.
2020	6.0	Revisions in receiving the estimated annual cost of services re: HSAG EQR review

III. APPLICATION

This policy applies to all staff, students, volunteers and contractual organizations within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM).

IV. POLICY

It is the policy of the CMHPSM that all eligible persons are informed of their right to engage in Person Centered Planning at any time. All individuals who receive services shall have a plan outlining the individual outcomes to be achieved through various means of

support and or services. The process by which a plan is developed shall be done in a way that is person centered as outlined in the standards of this policy.

V. DEFINITIONS

Assessment: The process for obtaining clinically relevant information about each individual seeking behavioral health care, treatment, or services. The information is used to match an individual's need with the appropriate setting, service/program, and intervention. The systematic collection and review of data specific to an individual served. Data from assessments is used in the development of the Individual Plan of Service (IPOS).

Client Services Manager/Supports Coordinator: A designated individual responsible for assisting the individual in accessing needed supports and services. Activities include needs assessment, pre-planning, planning, coordinating, monitoring and evaluating the effectiveness of needed supports and services.

Community Mental Health Partnership of Southeast Michigan: The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program: A program operated under Chapter 2 of the Michigan Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Emancipated Minor: The termination of the rights of the parents to the custody, control, services and earnings of a minor which occurs by operation of law or pursuant to a petition filed by a minor with the Probate Court.

Emergency situation: A situation where the individual can reasonably be expected within the near future to physically injure himself, herself, or another person; or is unable to attend to the need for food, clothing, shelter or basic physical activities, and this inability may lead in the near future to harm to the person or to another person; or, the individual's judgment is impaired, leading to the inability to understand the need for treatment or support which can be expected to result in physical harm to self or others. The sudden disruption of the person's system of supports may constitute an emergency if s/he is unable meet basic needs and maintain health and safety in the absence of these supports.

Family-Centered Planning Process: An approach that recognizes the importance of the family and the fact that supports, and services impact the entire family. Therefore, in the case of minors, the child/family is the focus of service planning, and family members are integral to the planning process and its success.

Family member: A parent, stepparent, spouse, significant other, sibling, child, or grandparent of a primary recipient, or an individual upon whom a primary recipient is dependent for at least 50 percent of his or her financial support.

Legal Representative: Legal Representative - A legal representative is defined as any of the following:

1. A court-appointed guardian,
2. A parent with legal custody of a minor recipient,
3. In the case of a deceased recipient, the executor of the estate or court appointed personal representative,
4. A patient advocate under a durable power of attorney or other advanced directive.

Individual Plan of Services (IPOS): A written individualized plan of supports and services directed by the individual as required by the Mental Health Code. This plan may include both support and treatment elements.

Interim IPOS: A time-limited plan, not to exceed 90 days (best practice within 30 days), that needs to be completed in because an annual re-assessment and/or annual IPOS has not been completed, order to prevent any gaps of the continuation of services that remain medically necessary until an annual re-assessment and/or annual IPOS can be completed.

Minor: A person under the age of 18 years.

Person-Centered Planning: A process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honor the individual's preference, choices, and abilities. The person-centered planning process involves family, friends and professionals as the individual desires or requires. The process is directed by the person and focuses on his or her desires, dreams, strengths and needs for support.

Reassessment: Ongoing data collection which begins at initial assessment, comparing the most recent data with the data collected at earlier assessments. Consumer may be reassessed for many reasons. These include: evaluation of his or her response to care, treatment or services; response to a significant change in status and/or diagnosis or conditions; request from the consumer and/or the consumer's representative for a change in the supports and services authorized in the most current IPOS; as required to satisfy regulatory requirements (i.e. for eligibility determination for a Children's Waiver, or Habilitation Support Wavier (HSW); as required for the determination of ongoing eligibility for supports and services based on a managed care authorization period. In addition, a reassessment of need shall occur during a routine periodic review or annual review prior to the revision of an existing IPOS.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports for people with mental health, developmental disabilities, and substance use disorder needs.

Specialty Assessments: Assessments and evaluations resulting from referrals following an initial biopsychosocial assessment, a reassessment, or as authorized in an IPOS. Included are psychiatric evaluations, nursing assessments, occupational therapy assessments, physical therapy assessments, speech and language assessments, behavior treatment assessments, nutrition assessments, and psychological testing. Autism related screens and assessments also are considered Specialty Assessments.

Significant Change: A Significant Change occurs when a consumer experiences a change in functioning or circumstances potentially impacting service needs. The assessment update will focus on the consumer's current need and may result in change to the Individual Plan of Service (IPOS) that may add new outcomes, amend existing authorizations for services or supports, or add authorizations for new supports or services. A Significant Change may be the result of a positive change so that the consumer needs less service or less restrictive care, such as mainstreaming to primary care as a medical home. Or, consumer may be at risk of, or experiencing, a decrease in functional ability or a loss of supports necessary to maintain functioning. A Significant Change in functioning may result from an acute illness or injury or as a result of a chronic condition. Additionally, environmental change may lead to the need for substantial modifications in service delivery.

Examples of Significant Change that would initiate a reassessment include:

- A sentinel event
- Change in level of care, treatment, or service need. For example, transition to a less independent service (more restrictive service) or transition to a more independent service (less restrictive service)
- Legal status change (involvement with the law enforcement/court action, being charged with a crime or the victim of a crime, or guardianship awarded or modified)
- Significant health, nutrition, safety change or hospitalization (new diagnosis medical diagnosis, nutritional issues including significant weight loss/gain or new mobility issues).
- Loss of parent, significant other or caretaker that effects treatment
- Introduction of protective devices (including a helmet, gait belts, door/bell alarms, or bed rails)
- Introduction of a behavior plan that includes restrictive or intrusive techniques and/or introduction of medication when prescribed solely for the purpose of behavior control not resultant of a documented diagnosis of a psychotic, mood or anxiety disorder
- Introduction of new medical equipment
- When a consumer has a major change in presenting conditions or disabilities
- When a consumer reaches the age of majority
- If a consumer experiences abuse/neglect or other major trauma
- If a new diagnosis is given.

VII. STANDARDS

A. All persons must have a current Individual Plan of Services (IPOS). An IPOS must be reviewed and completed annually. A completed IPOS means the IPOS goals and objectives are written and agreed upon, the plan is signed by all parties (including the consumer/legal guardian) and the authorization is completed.

B. Consumers who are enrolled in a C waiver program (Habilitation Waiver, Children's Waiver, Children's SED Waiver) cannot have an IPOS that exceeds 365 days. Ideally all consumers served by the CMHSP/CMHPSM would have a new plan at least annually.

C. For those consumers not enrolled in a waiver, if a new IPOS cannot begin by the expiration date of the current IPOS, and the continuation of services needs to be ensured, an extension of the current IPOS and current authorization must be completed and submitted for supervisory/UM approval. The reasons for the need of such an extension need to be clearly documented in the consumer record. Depending on the reasons, such an extension would be conducted as an engagement plan or interim plan. The start date of the Interim Plan of Service will be the day after the current IPOS expires, and such an extension cannot exceed more than 90 days.

D. Each individual has the ability to express preferences and to make choices with appropriate supports. The capacity for growth and choice shall be recognized in all persons. Individual choices and preferences shall always be honored, if not always granted.

E. The individual's perceptions, expressions, thoughts, and experiences are the most valid avenue of relatedness.

F. Only the person him/herself can develop his/her potential. Person centered services and supports create a climate and context for that development.

G. Planning shall be based upon individual strengths and abilities and shall presume competence and assume readiness.

H. A person's cultural background shall be recognized and valued in the decision-making process.

I. Planning shall promote the provision of services to children within the context of their family and to adults in the home of their choice.

J. Supports and services are provided with the goal of promoting meaningful connections through relationship, work, recreation and community involvement.

K. Services shall promote growth, maximum independence, and interdependence within the context of natural support systems, and community membership and recognition.

L. Community inclusion and participation include choice and control over living arrangements, relationship building, opportunities to contribute and be productive, and leisure and recreation.

M. Community accountability for services includes addressing health and safety concerns, assuring fairness, equity and privacy and assuring quality

N. Professional services shall be made available to individuals as part of a full array of supports and services and provided based upon individual interest, preference and need. Professional services are offered in the context of providing resources and opportunities and will facilitate a climate of safety for growth.

O. Persons with legal guardians will be included in person centered planning. Wherever possible, guardians shall be educated regarding the values and principles of person centered planning and encouraged to offer the person served maximum input and control over choices and decisions.

P. Parents and significant family member of minors shall participate in the planning process unless:
    1. The minor is fourteen years of age or older and has requested services without the knowledge or consent of parent, guardian, or person in loco parentis within the restriction of the Mental Health Code.
    2. The minor is emancipated.
    3. The inclusion of the parents(s) or significant family members would constitute a substantial risk of physical or emotional harm to the person or substantial disruption of the planning process as defined in the Mental Health Code. Justification of exclusion shall be documented in the clinical record.

Q. Persons with emergent or urgent needs, including those which present an imminent danger to self or others, or a health and safety risk, shall receive those immediate services needed to assure the person's well being and stabilization of the situation. To the extent possible, person centered values and principles will be honored in the provision of emergency services, although the complete Person-Centered Process may not be feasible. Limitations of choice and rights will be only those sufficient and necessary to assure the health and safety of the person and others. Following stabilization of the situation,

should the person continue in services, the person shall be invited to participate in Person Centered Planning.

R. An Individual Plan of Service for persons receiving Intensive Crisis stabilization and/or Crisis Residential Services must be developed within 48 hours. The use of interim plans does not apply in these situations.

S. A preliminary plan shall be developed within 7 days of the commencement of services or, if an individual is hospitalized for less than 7 days, before discharge or release.

T. Persons expressing a need or making a request for a single support or service, or short-term services, will be offered services based upon the principles in this policy, assuring maximum choice, control and individualization of services. Persons will be invited to participate in Person Centered Planning, if desired. This may include future planning for children or adults living with family members, particularly when it is anticipated that additional supports will be needed over time.

U. Requests for Interim Plans: In case where an interim plan needs to be completed in order to continue medically necessary services until an annual re-assessment and/or annual IPOS can be completed, the following shall apply:
   a. The reason for the interim plan is clearly stated in the plan. Examples include engagement issues with the consumer, or the need to reschedule a re-assessment/IPOS meeting.
   b. Interim plans need to have a goal, outcomes, and the amount scope and duration of the services provided.
   c. The interim IPOS goals shall state what goal(s) will be accomplished specifically for that interim period of time, and what services will be needed to accomplish that goal. Examples include:
      - Assisting the consumer to re-engage with their CMH clinical team (loss of contact).
      - Interventions staff need to provide or ways they would assist with overcoming barriers to care for the consumer.
      - Goals specific to the consumer they would continue to work on during the interim (such as abilities they are learning through the using of CLS/skill building services that would continue the interim, or their care needing to be maintained in their living setting).

V. All persons expressing complex needs which involve multiple life domains and supports, services or treatment of an extended duration will receive supports and services through the Person-Centered Planning Process.

W. For consumers receiving only substance use disorder treatment services, a recovery plan will be developed using Person Centered Planning principles.

X. Needs Assessment and Pre-Planning
   1. Before a person-centered planning meeting is initiated, an assessment of needs and a pre-planning meeting occurs. The needs assessment can occur on the same day or on a separate day of the pre-planning meeting. The pre-planning meeting cannot occur on the same day of the person-centered planning meeting. Ideally, a pre-planning meeting will occur 30 days prior to the planning meeting so that persons have sufficient time to consider their outcomes and invite those they may wish to attend their planning meeting. Persons are not required to have a 30-day time frame but will be given the choice in the amount of time they need between their pre-planning and planning meetings.

2. The person is offered the opportunity to express needs, desires and preferences. Any needed accommodations for communication are provided. Pre-planning begins with the person's initial contact with the local CMHSP. Information gathering activities include eliciting information about the person's needs for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation and recreation, as defined by the Mental Health Code.
3. The needs assessment and planning process shall acknowledge that the person and those closest to him/her know the individual best. Information may be gathered from family, friends, co-workers, teachers and current service providers with the permission of the person.
4. Potential issues of health and safety are explored and discussed to determine if there is a role for other professionals to provide additional information, opinions or recommendations for supports and services. Such services are arranged for and provided based upon needs assessment and pre-planning activities.
5. Persons will be offered an opportunity to develop a crisis prevention plan.
6. As a result of health or safety concerns, or court ordered treatment, limitations may exist for individual choice. Within the context of any such limitations the individual will be offered the maximum input and control over decisions.
7. If the individual currently has a legal representative, the level of and/or the appropriateness of the legal restriction such as an Alternative Treatment Order (ATO), shall be reviewed considering the expressed desire for independence. As a result, the IPOS may include steps and activities for the consumer to pursue that could lead to a lessening or removal of the legal restriction.
8. Valued outcomes are identified from the perspective of the individual.
9. Potential sources of services and support, including natural, generic, and specialized supports are explored fully with the person. Initial expectations of the service delivery system are identified. Satisfaction with any current services and supports is explored.
10. Persons are assisted in exploring their support network to identify who they would like involved in the person-centered planning process and are offered support and assistance in inviting those persons to participate. Persons are also offered the opportunity to identify which professionals or support providers they would like to participate in their planning meeting. Persons will be educated on and offered peer support services where applicable.
11. Within the context of support for communication needs, and education regarding potential options, the person is given ongoing opportunities to express preferences and make meaningful choices. Choice making shall include adequate information regarding options available. Opportunities for exploration, dialogue and experimentation shall be provided. The service system shall provide education, supports and skill development when needed to support the person's development of the ability to make meaningful choices. The knowledge of those closest to the person regarding the person's preferences shall also be honored and acknowledged.
12. The person is offered the opportunity to identify what information will be shared and discussed during the planning meeting in the presence of all participants and what information should be discussed privately.
13. The person is also offered the opportunity to select a facilitator who will facilitate the meeting on his/her behalf. Ideally, this will be the person him/herself, an advocate, or a person trained specifically for the task. The option of an external independent facilitator will be included in these choices.
14. Persons are offered the opportunity for self-determination arrangements as an alternative in arranging their supports and services.

Y. Planning

1. Planning occurs at a time and place convenient and comfortable to the person and others who have been invited to participate in the process. Ground rules are established to ensure that the person is the focal point, that the process is not "professionalized" and that the meeting is conducted in the manner the person chooses.
2. The person, and those he or she has selected, explore the desired future and valued outcomes, and determine what resources and supports are needed to support those outcomes. The focus is on strengths, abilities and building on the capacities of the person.
3. The person's preferences, choices and abilities are honored in the planning process. The role of professionals is to consult and make recommendations and contributions based upon their expertise and their knowledge of the person. The person retains the right and responsibility to make decisions, and to determine who will be a part of his/her decision-making process.
4. The person's dreams, desires and preferences are captured in short-term and long-term outcomes which are consistent with the person's values.
5. Exploration of resources and the building of a support plan are to be considered in this order:
    a. The person
    b. Family, friends, guardian, and significant others
    c. Resources in the neighborhood and community
    d. Publicly funded supports and services available to all persons
    e. Publicly funded supports and services available through the CMHSP/CMHPSM

    The development of natural supports (family, friends, and community) shall be an equal responsibility of the CMHSP and the person.
6. A written individualized plan of supports and services shall be developed which includes those supports to be provided by natural supports, generic community supports, and the CMHSP service system. Specialized supports augment enriches and do not necessarily supplant those provided by an existing network of natural and community supports. The plan is specific as to the supports to be provided and who/how those supports will be delivered.
7. The plan or accompanying documentation will specify the rationale for deferring, not addressing or not providing any of the supports and services identified as needed or desired.
8. The plan will specify the CSM/Supports Coordination activities to be provided and the planned frequency.

Z. Service Provision and Follow-Up
1. Those implementing a new or changed IPOS, must be in-serviced within 30 days of the effective date. Documentation must occur within 1 business day of the training. The CMHSP and CMHPSM will provide ongoing monitoring to ensure this training occurs.
2. Supports and Services are provided as identified in the person's plan and delivered by the providers of the individual's choice wherever possible. Depending upon the preferences of the person and/or family, the CSM/Supports Coordinator will arrange for and coordinate the provision of supports identified.
3. Supports and Services remain focused on the person and his/her needs, rather than on program elements or slots.
4. The IPOS shall include an authorization for the amount, scope, duration, and frequency of the supports and services to be provided.
5. The IPOS process shall also include providing the consumer/legal representative the estimated annual cost of each covered support and service he or she is re-

ceiving in the IPOS. Providing the annual cost of services will be included in the review and signing of the IPOS process with the consumer/legal representative. This estimated annual cost can be in the form of the consumer budget report in the electronic health record, printed out and included in the IPOS documents.

6. Each individual shall be provided a copy of her/his IPOS no later than 15 business days following the completion of the IPOS. This copy shall include the amount, scope, duration, and frequency of the supports and services that were authorized for the individual.
7. Persons are provided with opportunities to provide ongoing feedback regarding their individual supports and services. These mechanisms include both informal feedback through persons providing or monitoring supports, formal satisfaction and outcome measurement processes, and problem resolution/complaint processes.
8. Planning is an ongoing process. Consumers may experience significant changes in functioning or circumstances potentially impacting service needs. The assessment update will focus on the consumer's current need and may result in change to the Individual Plan of Service (IPOS) Services are tailored or adjusted over time based on changes in needs or preferences. The plan shall be updated and amended as frequently as needed. The person will be provided the opportunity for a person-centered planning meeting no less than annually.
9. The IPOS identifies the frequency that it will formally be reviewed for effectiveness and reviews of the plan are completed at those intervals.
10. The CSM/Supports Coordinator reviews the IPOS and monitors the provision of supports and services at a frequency identified in the planning process to assure implementation and to assess the effectiveness of supports in achieving the outcomes identified.

AA. Dispute Resolution/Appeal Mechanisms

1. If a person is not satisfied with his or her IPOS, the person, their guardian, or their legal representative may request a review of the IPOS to the designated individual in charge of implementing the plan. The review shall be completed within 30 days and shall be carried out in a manner approved by the appropriate governing body.
2. Persons have the right to access the local CMH grievance, appeals, rights or problem resolutions processes if they believe that:
    a. They have not received the opportunity for person centered planning
    b. They believe they have been inappropriately denied a requested service or provided with less services than they requested
    c. They disagree with limitations that have been placed on choice or preference for health and safety reasons

VIII. EXHIBITS

EXHIBIT A: Process for Person-Centered Planning
EXHIBIT B: Engagement Examples
EXHIBIT C: Person-Centered Process Outcomes Statement Guidelines; Values and Rationale
EXHIBIT D: Outcome Improvement Exercise

IX. REFERENCES

Michigan Mental Health Code, Public Act 258 of 1974, as amended - 330.1409(1-7), 330.1700(g), 330.1707(1-5), 330.1712(1-3)
Department of Community Health Person- Centered Planning Guideline –Attachment P.3.4.1.1 to the MDCH/CMHSP Managed Mental Health Supports and Services Contract

Michigan Renewed Habilitation Supports Waiver, Section 7: Person Centered Process, April 1996
MDHHS Application for Renewal of the 1915(b) Specialty Supports and Services Managed Care Waiver.
MDHHS Policy and Practice Guideline, Attachment P.3.4.4 to the MDHHS/CMHSP Managed Mental Health Supports and Services Contract
CMHPSM Assessment and Reassessment Policy
CMHPSM Diagnosis and Clinical Formulation Policy
CMHPSM Timeliness of Service Provision and Documentation Policy
CMHPSM Self-Determination Policy

EXHIBIT A

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEASTERN MICHIGAN

PROCESS FOR PERSON CENTERED PLANNING

I. VISION AND PURPOSE STATEMENT

The Community Mental Health Partnership of Southeastern Michigan (CMHPSM) is committed to ensuring that consumers have a process to develop a plan that moves the consumer along their recovery path that is inclusive of the people of most significance to them (family, guardian, friends, staff, etc…). This process is called Person Centered Planning (PCP) which is a dynamic process that allows for the flexibility to adjust plans as lives change. It is the role of the case manager and/or supports coordinator (CM/SC) to engage with the consumer to identify what is most important them. This will provide key information for establishing the outcomes of the consumer's Individual Plan of Service (IPOS) which will result in a service authorization. It is with the delivery of these services that directly connect to the consumer's outcomes that will assist the consumer in accomplishing their recovery plan.

II. DEFINITIONS

Community Mental Health Partnership of Southeast Michigan: The Affiliation of Community Mental Health Authorities consisting of Lenawee, Livingston, Monroe and Washtenaw counties.

Individual Plan of Service (IPOS):: The consumer driven individual plan of service that is created from the Person Centered Planning Process.

Peer Support Specialists: A certified employee from one of the CMHPSM Affiliate partners who has or currently is receiving services who can assist consumers in navigating the system and provide personal experience to assist in engaging consumers onto their recovery path.

III. PHASES OF PERSON CENTERED PLANNING

The person centered planning process is a series of phases that shall be followed in order to develop the most comprehensive and meaningful plan for the consumer. The Case Manager/Supports Coordinator (CM/SC) is the staff that will coordinate the process to ensure the inclusion of the consumer. The CMHPSM's value is that in order to engage and build a relationship with the consumer, the following phases should be addressed face to face and with enough time to provide information and education about the process to achieve the best outcomes.

a. **Engagement & Pre-Planning**: The CMHPSM believes that in order to create a meaningful plan with a consumer, relationships shall be developed with the consumer. Based on direct feedback from consumers this should be done by starting the process where the consumer is at in their recovery. This may be

very different for someone brand new to the system than for someone who has been in the system for a while. See EXHIBIT B for examples on engagement.

i. For a new consumer, this phase shall be done face to face and engagement and pre-planning may begin immediately. If a person new to the system is either in crisis, unfamiliar with options or unclear on what to plan for, the CM/SC may consider an interim plan at this time.

ii. For an existing consumer this phase is preferably a Face to Face session that begins a minimum of 3-4 weeks prior to the actual Person Centered Planning (PCP) meeting. Regardless of historical requests from consumers and/or families, they should always be provided the options of how this phase can be completed with the face to face option provided first.

1. For existing consumers where you know the pre-planning takes longer and or there is a possibility the Person Centered Plan will not be completed within the expiration date, the CM/SC shall start this phase earlier. An interim plan is not considered a viable option due to timing.

iii. The Engagement/Pre-Planning phase can be done simultaneously with the Assessment phase that follows.

iv. CM/SC shall give the consumer an opportunity to review the process of person centered planning again and offer a copy of their previous plan if they would like one. This applies to existing consumers.

v. CM/SC shall begin to address the items on the PCP Pre-Mtg page.

vi. CM/SC shall remind and encourage the consumer to invite whomever they would like to their meeting. The more people that know the consumer, the more comprehensive the plan will be.

vii. CM/SC shall ask the consumer if they would like to have an independent facilitator. This can be arranged through a panel of people available.

viii. CM/SC shall provide information about developing a crisis plan and psychiatric advanced directives. The CM/SC shall also inquire about whether or not the consumer already has and advanced directive, and if so, request a copy for the consumer file.

ix. CM/SC shall make available Peer Support Specialists whenever possible at this phase of the process to assist with engaging the consumer. If the consumer is new to the system, this will allow for a more personal interaction from someone who has had to navigate through the system.

b. **Assessment**: This is a critical phase of the PCP process as it determines the consumer needs and supports the CMH will provide for a level of care based on eligibility and medical necessity criteria. These determinations will assist in determining what CMH services to deliver (i.e. specialized residential, community living supports (CLS), supported employment, outpatient treatment, dialectical behavior therapy etc…) . It is during the assessment phase that ***ALL*** applicable

assessments (New or Updated Bio/Psycho/Social, Personal Health Review, CLS, Occupational Therapy, Physical Therapy, Speech etc…) shall be completed. Information from these assessments shall result in recommendations for outcomes to be included in the IPOS. In addition, Health and Safety issues shall be included in the plan if identified.

i. For a new consumer, the assessment shall occur within 14 days of the request for service and be completed in a face to face session.

ii. For existing consumers, assessments shall be completed in a Face to Face session which occurs at a minimum of 3-4 weeks prior to the PCP meeting.

1. Ancillary assessments (OT, PT, Speech etc…) not able to be scheduled prior to the PCP meeting and/or occur right up to the PCP meeting date should not postpone or push back the date of the PCP meeting.

iii. The Assessment Phase may be completed simultaneously with the Engagement/Pre-Planning phase.

iv. CM/SC shall request from the consumer the inclusion of any necessary people (family, direct care staff, friends, nurses etc…) in completing the assessments to ensure all areas of the person's life are addressed.

c. **Getting Ready for the Plan**: It is this phase where the CM/SC and the consumer and/or family meet to discuss the results of the assessments and to begin the discussion about the possible outcomes they would like to have developed for their PCP meeting. This could be done with the Independent Facilitator if one is chosen. It is also at this phase where further engagement and relationship building occurs.

i. CM/SC, Independent Facilitator, Consumer and or family may draft preliminary outcomes to provide during the PCP meeting.

ii. CM/SC shall review any possible service needs with the supervisor to obtain preliminary approval.

d. **Person Centered Planning Meeting**: This is the phase where the past year's accomplishments are celebrated. A facilitated process (MAPs, PATH etc…), if chosen, is used to determine what the consumer would like to address the next year to move them along their recovery path. There may be long term and/or short term outcomes. Whomever the consumer would like to attend this meeting is welcome and the more people that know the person the more likely it is that a comprehensive plan will result.

i. The PCP shall be a face to face meeting that shall happen no less than annually. It shall happen more frequently when requested by the consumer or when a significant change occurs for the consumer.

ii. Items that have been addressed and/or recommended during the assessment phase shall be discussed.

iii. If there are additional things addressed during the meeting that have not been addressed during the assessment, they shall be documented.

iv. The final result of the meeting shall be to have established outcomes/goals that the consumer would like to achieve. These goals may be either short term or long term. Regardless of short or long term outcomes/goals, they shall be measurable. Measurable outcomes/goal shall be able to inform the consumer when they have achieved the outcome/goal. **EXHIBIT C and D** for tools on developing outcomes.

v. Outcomes shall outline the following for each service that will be authorized.

1. **Amount** : how much of a service will be used (i.e. 30 minute CM/SC contact)

2. **Scope**: what is the purpose of the service (i.e. monitor achievement of the PCP outcome, has the consumer learned a new skill and applied it to gain employment or practiced making a lunch and limited verbal prompts were needed). Was there improvement or regression from the last contact.

3. **Duration**: how long will this service be provided (i.e. one month, 30 days, 90 days, etc…)

vi. Outcomes shall differentiate between the role of natural supports (family, friends, community members), CMH supports (CM/SC, therapist, OT, PT etc…) and Provider Support (Community Living supports, Supported Employment etc…) in helping the consumer achieve their recovery plan.

1. Outcomes that outline provider supports shall be explicit in the role of the provider staff in the areas of but not limited to self care, transportation, managing of funds, addressing health and safety and or community involvement.

e. **On-Going Monitoring**: It is important that consumers know if they are achieving their outcomes. The CM/SC shall routinely review with the consumer and or family the progress they are making on their goals. It is at this time that if there have been changes in a consumer's life, the IPOS shall be revised to reflect the change. Since consumers' lives change and are not static so shall the IPOS outcomes. The IPOS shall be adjusted whenever needed. On-going monitoring shall occur routinely to ensure the services and supports being provided are delivering the desired results.

i. CM/SC shall complete a Periodic Review whenever a significant change occurs with a person's life or at least every 6 months.

ii. The Periodic Review shall be the summary of information from the consumer/family, progress notes that demonstrates the consumer's progression towards achieving their outcomes and any other necessary documentation.

iii. The Periodic Review shall reflect what has changed in the person's life and if the person has made progress or not made progress on their outcomes. Any additions/deletions or changes to outcomes shall be reflected in the Periodic Review.

iv. Outcomes in the IPOS shall be updated whenever needed throughout the year.

v. Progress Notes shall be the document used to demonstrate that the services authorized are being delivered. The services documented in a progress note shall directly be related to an outcome. Progress on the outcome shall be documented based on the services delivered and the interventions used.

EXHIBIT B

Engagement Examples

The following are examples a CM/SC can use in working on engagement through the Person Centered Planning Process.

a. Based on direct feedback from consumers: Many consumers have been introduced to Community Mental Health (CMH) for the first time when they were in crisis. It was at that time they were asked to develop a plan based on their hopes, dreams and wishes for the future. This may not be the best time to do this given the person may be just trying to get through the day. Developing a plan that addresses the person trying to get through the day may be more appropriate. That outcome may only be applicable for a few weeks, however with the flexible planning process; a new outcome can be established to reflect the new place in the consumer's recovery.

    a. It may be at this time if the person is new to the CMH system that an interim plan be developed that focuses on engagement and/or becoming stable and not in crisis.

    b. Once the person has become stable, the CM/SC can work with the consumer on what would be good short term outcomes. Then build towards long term outcomes.

b. Another example is: A consumer may have been living with their family and not receiving CMH services but are now in need of services. Asking that consumer to go into a meeting to discuss what their plans are when they are not even aware of what is available or what the process is may cause trauma to that consumer and/or family. What may be more appropriate is to begin the process in a phased approach. It may mean that there are several meetings with the consumer and or family. An outcome could be written in the meantime to address where the family and consumer is at in their engagement process. This will work towards engagement and relationship building which allows the CM/SC to have the discussion of what they are looking for in the future.

INDIVIDUAL PLAN OF SERVICE OUTCOME STATEMENT GUIDELINES

"Outcome" Defined:
The final consequence of an action or activity, the end result; that which one wants to have take place; an eventuality; the outgrowth of a series of endeavors; the fruits of one's labors; the impact of a process; the culmination.

1. Consumer Quotes Plus

It is essential to use consumer / family quotes when they can be obtained, but it is often necessary for the clinician to augment them with the clarification, elaboration, and/or paraphrasing necessary to meet the guidelines listed below. This usually requires a conversation in which desired outcomes / goals are expanded upon, clarified or narrowed down. Getting to why a consumer desires a particular outcome can facilitate this narrowing down process if done sensitively and patiently.

Rationale: IPOS outcomes provide guidance, context, focus and meaning to service activities, their steps, interventions and content. A consumer is more likely to be energized, fully participate and experience ownership in these services to the extent that they are seen as moving him or her closer to a desired end point that has been personally chosen. The more motivated consumers are to participate in their services, the more likely they will reach their desired results. When consumers reach their desired results, our primary organizational purpose has been achieved.

To comply with DCH requirements, consumer quotes are to be used.

2. Consistent

The outcome should be consistent with the consumer's expressed desires, with those problematic areas identified in the most recent assessment(s) and with his or her readiness to make changes in those areas.

Rationale: All that consumers may want for their mental health-related improvements / outcomes is not necessarily contained in their responses to our questions about their preferences, desires, dreams and goals. To realize the latter, they may need to advance to a place where, for example, their safety and health are ensured. Thus, it would be a disservice were we not to offer consumers opportunities to obtain support and services in all appropriate areas identified in a comprehensive assessment, outcome areas not already personally identified.

All of our regulatory and accrediting organizations require that our clinical documents make clear that the plan of service flows logically from the assessment(s).

3. Clear

The outcome / goal statement should be clear with little doubt about its meaning. It should be easily understandable to the consumer as well as to the clinician.

4. Concrete

It should be concrete, that is, it should be specific and simple, preferably unique to the individual consumer.

5. Observable / Measurable

It should be observable and/or measurable. Future agreement should be able to be reached between the consumer, staff and other observers as to whether it had or hadn't been achieved.

6. "As Evidenced By" Statements

It is often necessary to make outcome statements less vague, more concrete and, most importantly, more observable. This can be achieved by using and completing the phrase, "as evidenced by…" or "We will know the outcome had been achieved by observing that…" One can get at this by asking the consumer (or yourself) what will be different, what will you be able to do again, what will you be able to do more of, what will you be able to do for the first time, what will you continue to be able to do or what change will others notice once you've achieved this outcome.

The consumer's self-report is an acceptable source of the evidence, but it should be the report of something concrete and observable. When assessing progress, it becomes the clinician's responsibility to ask the consumer for this report if not offered spontaneously.

Rationale for 3 through 6 above:

Our primary focus is on helping consumers achieve their outcomes. It is important for consumers and those providing services and supports to have clarity regarding what their specific outcomes are, how close they are to achieving them and whether and when they have actually realized them. Only when outcomes are clear, understandable, specific, concrete and unambiguous can consumers (and their service and support providers) obtain this clarity. Only then can we maximize consumers' motivation to achieve their outcomes as well as their sense of accomplishment when they have been achieved.

7. Realistic

The outcome / goal should be realistic; if the consumer's desired outcome is unrealistic, the clinician is encouraged to help the consumer add a more modest statement that is of a shorter term, more realistic kind, adding something that must first be accomplished as a prerequisite or stepping stone for accomplishing the more ambitious one.

8. Outcome Achievement Timeframe

A shorter term outcome / goal statement is better than a longer term one; it is fine if the consumer is interested in achieving a long term outcome / goal, but the statement should be supplemented with a shorter term one, one that is a step in the right direction. The statement should be reasonably achievable before or around the time of the next scheduled Periodic or Annual Review, usually in 6 – 12 months.

Rationale for 7 and 8 above:

Although it is important to honor and respect a consumer's wishes, hopes and dreams, no matter how realistic or unrealistic they are, there are other values that come into play when establishing IPOS outcomes. Consumers can experience serious disappointment when an outcome is well out of reach, disappointment that can diminish their interest in pursuing other goals, some of which may be well within reach. There is much research to confirm that more satisfaction, and thus, motivation can result from succeeding at a series of short term, less ambitious tasks than can result from many longer term, more ambitious ones.

9. Positively Stated

It should be stated in positive terms, as an increase in something, as demonstrating a new skill, as a success at something or as reaching a positive state (as evidenced by….), rather than as a reduction or ending of something undesirable. (See 10. below re maintenance outcomes.

Rationale: Striving toward a distinct, rewarding end is often more motivating and sustaining than moving away from something, however undesirable, where the alternative is uncertain, unfocused or ambiguous. Helping someone try to build on strengths is more self-affirming and respectful than helping someone try to overcome a weakness. The former has a positive focus; the latter has a negative one.

DCH requires us to develop service goals that are stated in positive terms.

10. Maintenance Outcomes

Maintenance of a consumer's level of self-sufficiency or independence in a specified area is acceptable if a thorough assessment reveals no capacity for improvement. Maintenance outcome / goal statements should otherwise be consistent with these guidelines.

Rationale: For an assessment to be truly strength-based, it is necessary to explore all potential areas for growth and improvement before concluding that only maintenance outcomes can be developed. Without this exploration, we may miss an opportunity for helping a consumer move toward greater self-sufficiency and experience its resulting satisfaction.

11. Service Participation

A statement about participating in a service, attending a program or having contact with a clinician, although important, is **not** an acceptable outcome / goal statement in itself; one must include a statement about what desirable outcome / goal / end result / impact is sought by way of this service involvement. (See outcome definition above) Statements about participating in, having contact with or attending a CMH program or service are more appropriately written in the "Steps" or "Documentation" section rather than the "Outcome" section.

Rationale: Outcome statements emphasizing service participation may omit a necessary component of an "outcome" as defined in the guidelines: an end result; the impact of the service.

12. Meaningful

The ideal outcome statement will also be individualized, meaningful, real, motivating and even inspiring to the individual consumer or family.

Rationale: To have a goal that is uniquely one's own, that is generated not by impulse or based on what others want for us, but through a thoughtful, inward-looking process, is more likely to be fully embraced and, thus, achieved.

EXHIBIT D

20 OUTCOME IMPROVEMENT EXERCISES

GUIDE TO LIFE AREAS

Life Area		Page(s)
1.	Personal / Self Care	9
2.	Medication Management	1,2
3.	Independent Living Skills	1,2,4
4.	Health Care / Medical	3,13,14
5.	Financial / Money Management	4,10
6.	Housing	10
7.	Education / Learning	5
8.	Employment / Vocational	6,9
9.	Recreation / Hobbies	8
10.	Social / Interpersonal	7
11.	Mood / Affect / Feelings	12
12.	Thinking	5
13.	Behaviors	5
14.	Safety	11,13
16.	Legal / Guardianship	13
17.	Advocacy / Communication	14
18.	Child Care	15
19.	Parenting	7
20.	Transportation	16
21.	Substance Abuse	17
23.	Family	7
24.	Cultural / Spiritual	18
25.	End of Life	20
26.	Developmental Skills (mobility, expr. / rec. commun., range of motion, sens. integ.)	19
27.	Community Inclusion	8,11

OUTCOME IMPROVEMENT EXERCISES
Current Outcome Example #1:

Life Area #2 - Medication Management
Life Area #3 - Independent Living Skills

Rick wants to continue to live independently in his apartment; as evidenced by completing his daily chores, assisting with cooking dinner at least twice per week, taking his medications as prescribed, completing his laundry weekly and grocery shopping with his staff daily.

Guideline	Guideline Followed? Y or N	Possible Improvement / (Explanation of why Y)
1. Consumer Quotes Included?	N	Could be improved if an actual quote from the consumer, parent or guardian was included, e.g., "I'd like to be on my own and stay in my apartment"
2. Consistent?	Y	(With consumer quote added, the outcome becomes consistent with his expressed desires – The clinician would need to determine if the outcome is also consistent with the most recent assessment)
3. Clear?	Y	(It's very clear what will serve as evidence that the outcome has been achieved: completing chores daily, cooking dinner twice per week, etc.)
4. Concrete?	Y	(The statement meets the criteria of simple, specific and unique to this consumer – Including the specific daily chores would make it a little more concrete but this could also be stated in the "Steps.")
5. Observable / Measurable?	Y	(It's quite likely that observers could agree as to whether the consumer had or had not achieved the outcome)
6. "As Evidenced By" Statement?	Y	(Perfectly consistent with this guideline – The "as evidenced by" statement makes the outcome clear, concrete and observable)
7. Realistic?	Y	(It appears likely that the specific outcomes in the statement are within Rick's reach)
8. Outcome Achievement Timeframe	Y	(It appears that the outcome is not only realistic but that goals can be achieved in the short term)
9. Positively Stated?	Y	("completing," "assisting," "taking," etc. are all positive terms)
10. Maintenance Outcomes?	NA	(The outcome does not appear to be a maintenance one)
11. Service Participation?	Y	(The outcome puts emphasis on the impact and end result of the services and interventions, not on Rick's participation in them. Even though the statement includes his taking medication as prescribed, the point is that he will do so independently)
12. Meaningful / Individualized?	Y	If the clinician observed some enthusiasm on Rick's part in relation to achieving this outcome, it could be concluded that it is personally meaningful

Improved Version

Rick states that he would "like to continue to be on my own and stay in my apartment." Outcome achievement will be evidenced by completing his daily chores (making his bed, taking out the trash, straightening up the apartment), assisting with cooking dinner at least twice per week, taking his medications as prescribed, completing his laundry weekly and grocery shopping with his staff daily.

Current Outcome Example #2:

Life Area #2 - Medication Management
Life Area #3 - Independent Living Skills

Jenny will develop some of the necessary skills in order to successfully live independently as evidenced by Jenny preparing a meal once per week. Jenny will be able to call in prescriptions, arrange transportation to pick them up and set up her med box for the week.

Guideline	Guideline Followed? Y or N	Possible Improvement / (Explanation of why Y)
1. Consumer Quotes Included?	N	Could be improved if an actual quote from the consumer, parent or guardian was included, e.g., "I'd like to prepare some meals and handle my medications on my own."
2. Consistent?	Y	(With consumer quote added, the outcome becomes consistent with her expressed desires – The clinician would need to determine if the outcome is also consistent with the most recent assessment)
3. Clear?	Y	(It's very clear what will serve as evidence that the outcome has been achieved: preparing some meals, calling in prescriptions, etc.)
4. Concrete?	Y	(The statement meets the criteria of being simple, specific and unique to this consumer)
5. Observable / Measurable?	Y	(It's quite likely that observers could agree as to whether the consumer had or had not achieved the outcome)
6. "As Evidenced By" Statement?	Y	(Perfectly consistent with this guideline – The "as evidenced by" statement makes the outcome clear, concrete and observable)
7. Realistic?	Y	(It appears likely that the specific outcomes in the statement are within Jenny's reach)
8. Outcome Achievement Timeframe	Y	(It appears that the outcome is not only realistic but contains goals that can be achieved in the short term)
9. Positively Stated?	Y	("preparing," "calling in," "arrange" and "set up" are all positive terms, vs. terms that denote that something will stop happening)
10. Maintenance Outcomes?	NA	(The outcome does not appear to be a maintenance one)
11. Service Participation?	Y	(The outcome puts emphasis on the impact and end result of the services and interventions, not on Jenny's participation in them.
12. Meaningful / Individualized?	Y	If the clinician observed some enthusiasm on Jenny's part in relation to achieving this outcome, it could be concluded that it is personally meaningful.

Improved Version

Jenny states that she "would love to be able to take care of more things without depending on others, like cooking and dealing with my meds." This will be evidenced by Jenny preparing a meal once per week. Jenny will be able to call in prescriptions, arrange transportation to pick them up and set up her med box for the week.

Current Outcome Example #3:

Life Area #4 - Health Care/Medical Issues

"I will become more active in identifying and taking care of my physical health needs as evidenced by attending annual appointments to see my primary care physician, dentist and eye doctor"

Guideline	Guideline Followed? Y or N	Possible Improvement / (Explanation of why Y)
1. Consumer Quotes Included?	Y	Beginning with a quote, as this clinician did, is the best way to set the stage for any clarification or elaboration
2. Consistent?	Y	(With consumer quote, the outcome clearly becomes consistent with expressed desires – The clinician would need to determine if the outcome is also consistent with the most recent assessment)
3. Clear?	y	It's very clear that if the consumer sees his or her primary care physician, dentist and eye doctor annually, a good part of the outcome will have been achieved. What could be made clearer is what is meant by "identifying" health needs and what the consumer will do proactively to follow through when an unexpected medical issue arises.
4. Concrete?	y	An example of the outcome being more clear and concrete would be to include a statement like, "The consumer will make an appointment with her primary care physician when symptoms of a moderate to serious medical condition arise."
5. Observable / Measurable?	y	It's quite likely that observers could agree as to whether the consumer had or had not seen her doctors annually, but, without some clarification as suggested in 4., it would be hard to determine if the consumer had been successful in identifying and taking care of medical problems that arose between annual checkups
6. "As Evidenced By" Statement?	y	The "as evidenced by" statement nicely addresses the specific result that is sought regarding annual preventive checkups, but should be extended to include something about how the consumer would be more active in her physical needs at other times.
7. Realistic?	Y	(It appears likely that the specific outcomes in the statement are within reach)
8. Outcome Achievement Timeframe	Y	(It appears that the outcome is not only realistic but contains goals that can be achieved in the short term)
9. Positively Stated?	Y	("attending" is a positive term)
10. Maintenance Outcomes?	NA	(The outcome does not appear to be a maintenance one)
11. Service Participation?	Y	(The outcome puts emphasis on the impact and end result of the mental health services and interventions, not on participation in them.)
12. Meaningful / Individualized?	Y	If the clinician observed some strong interest on the consumer's part in relation to achieving this outcome, it could be concluded that it is personally meaningful.

Improved Version

"I will become more active in identifying and taking care of my physical health needs as evidenced by attending annual appointments to see my primary care physician, dentist and eye doctor." Further evidence of the consumer achieving the outcome will be contacting, making and keeping appointments with her primary care physician after identifying an unexpected physical health problem that is moderate to serious or lingering.

Current Outcome Example #4:

Life Area #5 – Finance / Money Management
Life Area #3 - Independent Living Skills

"I want to learn how to budget my money so I can earn my checks and pay my bills on my own." Kelly's impulse buying has caused her mother/guardian to retain Kelly's checkbook. Kelly would like CSL support to help her with her budgeting as evidenced by reminding her daily to refrain from impulse buying, prioritize purchase needs weekly and encourage her to deposit checks in her bank account, taking $20 or so out first, if needed. By doing these tasks it will eventually help Kelly regain her checkbook.

Guideline	Guideline Followed? Y or N	Possible Improvement / (Explanation of why Y)
1. Consumer Quotes Included?	Y	Quote nicely sets the stage for any expansion of the outcome statement
2. Consistent?	Y	(The consumer's quote demonstrates that the outcome is consistent with his expressed desires – The clinician would need to determine if the outcome is also consistent with the most recent assessment)
3. Clear?	y	It's clear what will serve as evidence that the outcome has been achieved, retain her checkbook after demonstrating that she can deposit her check, budget her money, pay her bills, and prioritize her purchases. The outcome itself could be clearer if the CSL interventions were stated in another section
4. Concrete?	Y	(The statement meets the criteria of simple, specific and unique to this consumer –
5. Observable / Measurable?	Y	(It's quite likely that observers could agree as to whether the consumer had or had not achieved the outcome)
6. "As Evidenced By" Statement?	y	It's fairly clear what consumer behavior will serve as indicators that the outcome had or had not been achieved. Removing the CLS interventions (reminding and encouraging) would improve the "as evidenced by" statement.
7. Realistic?	y	The outcome may be within reach, but it's hard to be certain about this. It may be more realistic to scale the outcome down to one or two of the tasks.
8. Outcome Achievement Timeframe	y	As with 7, the sought-after accomplishments may not be realistic for the short-term, e.g. six months
9. Positively Stated?	Y	(Obtaining her checkbook, paying bills, budgeting money and prioritizing purchases are all positive statements. The one negative one, refraining from impulse buying, is overshadowed by the positives)
10. Maintenance Outcomes?	NA	(The outcome is clearly not a maintenance one)
11. Service Participation?	y	(The outcome includes the impact and end result of the services and interventions but blurs the focus by including various interventions
12. Meaningful / Individualized?	Y	(Kelly's strong interest in achieving this outcome is seen in the quotes, and thus appears personally meaningful

Improved Version

"I want to learn how to budget my money so I can earn my checks and pay my bills on my own." Kelly's impulse buying has caused her mother/guardian to retain Kelly's checkbook. Through CSL support, she will budget her money, deposit her checks, prioritize her purchases and eventually get her checkbook back from her mother.

Current Outcome Example 5:

Life Area #7 – Educational / Learning Needs
Life Area #12 – Thinking
Life Area #13 - Behaviors

Alex will increase his focus on academic subjects as evidenced by participating in weekly therapy sessions to focus on improving them and on behavioral control.

Guideline	Guideline Followed? Y or N	Possible Improvement / (Explanation of why Y)
1. Consumer Quotes Included?	N	Needs a quote like, Alex says, "I want to do better in school but I can't seem to keep my mind on the work."
2. Consistent	Y	(With the added quote, the outcome statement would be consistent with his expressed desires. The clinician would need to confirm that the outcome statement is consistent with the assessment results.)
3. Clear?	N	It's not clear what is meant by "increase his focus," "focusing on improving them" and "behavioral control." Hence, the end result is far from clear.
4. Concrete?	N	It would be more clear and concrete if it said something like: "By improving his study and concentration skills, Alex will obtain a 2.5 grade average during the next semester." The term "behavioral control would need to be made more simple/concrete, e.g., "Alex will be able to take fewer and shorter study breaks."
5. Observable / Measurable?	N	See 4 above
6. "As Evidenced By" Statement?	N	The "as evidenced by" statement in the current example should contain as observable end result rather than his participation in and the focus of weekly group therapy sessions. The latter would be more appropriate in the steps.
7. Realistic?	Y	(I'll assume it is realistic to expect improved grades.)
8. Outcome Achievement Timeframe	Y	(I'll assume that the outcome has some likelihood of achievement in 6-12 months)
9. Positively Stated?	Y	(Although the example could be clearer and more concrete, it is stated in positive terms, as an increase in something.
10. Maintenance Outcomes?	NA	--
11. Service Participation?	N	See 6 above
12. Meaningful / Individualized?	y	(If the clinician observed or elicited strong interest coming from Alex, the outcome could be considered personally meaningful. If it were imposed by others and Alex was not strongly aligned with it, its meaningfulness may be weak.)

Improved Version

Alex says, "I want to do better in school but I can't seem to keep my mind on the work." Alex will improve his grades in the next semester as evidenced by a 2.5 grade point average. He will also show improvement in his ability to concentrate on his school work as evidenced by his reporting that he is completing his homework before dinner and taking fewer and shorter breaks.

Current Outcome Example 6:

Life Area #8 - Vocational/Employment/Volunteer Work

"I would like a part time volunteer position at the Humane Society as soon as possible to keep me busy during the week. I like working with animals and taking care of them."

Guideline	Guideline Followed? Y or N	Possible Improvement / (Explanation of why Y)
1. Consumer Quotes Included?	Y	(Good quote directly from the consumer)
2. Consistent	Y	(Obviously consistent with the consumer's desires – We can probably assume consistency with the assessment's employment section and with the consumer's readiness to go after the volunteer position)
3. Clear?	Y	(The quote is clear and understandable enough that further clarification is not necessary)
4. Concrete?	Y	(The consumer's quoted outcome is simple, specific and individualized)
5. Observable / Measurable?	Y	(Perfectly observable – There should be no doubt among observers as to whether or not the outcome has been achieved)
6. "As Evidenced By" Statement?	Y	(In this case the quote is clear, concrete and observable, making it unnecessary to expand it with an "as evidenced by…" statement
7. Realistic?	y	(The clinician and consumer would need to determine if the outcome could realistically be achieved in the next 6 to 12 months)
8. Outcome Achievement Timeframe	y	(See 7)
9. Positively Stated?	Y	(It is clear that the outcome is something the consumer would be moving toward, rather than something undesirable he or she would be avoiding or reducing)
10. Maintenance Outcomes?	NA	(The outcome is not related to maintaining a current level of functioning, but moving forward and improving the consumer's situation)
11. Service Participation?	Y	(The quote focuses exclusively on an end result, not on service involvement as a means to achieve the end result)
12. Meaningful / Individualized?	Y	(The inclusion of the consumer's quoted interest affirms the outcome as something personally meaningful)

Improved Version – No change

"I would like a part time volunteer position at the Humane Society as soon as possible to keep me busy during the week. I like working with animals and taking care of them."

Current Outcome Example 7:

Life Area #19 – Parenting
Life Area # 23 – Family
Life Area #10 – Social / Interpersonal

Julie will be able to learn, practice and implement PMTO strategies to get her children to cooperate and follow house rules and expectations as evidenced by the children responding positively to Julie's requests and the family enjoying family relationships that are considerate and caring toward each other.

Guideline	Guideline Followed? Y or N	Possible Improvement / (Explanation of why Y)
1. Consumer Quotes Included?	N	Without quotes or evidence of paraphrasing, it raises the question of whether the outcome reflects alignment between Julie and the clinician
2. Consistent	y	(It's a bit unclear if the outcome is consistent with the consumer's expressed desires – Likely but not obvious)
3. Clear?	y	(The outcome is fairly understandable and unambiguous – It would be a bit clearer if Julie's self report or clinician observation or both were going to be used as evidence of outcome achievement and if an example or two of acting considerate and caring were included.)
4. Concrete?	y	(See 3)
5. Observable / Measurable?	y	(See 3)
6. "As Evidenced By" Statement?	Y	(Except for the improvements suggested in 3, the clinician made a pretty good effort to include something that would serve as evidence that the outcome had been achieved)
7. Realistic?	Y	(It's likely that outcome achievement could realistically occur within 6 to 12 months)
8. Outcome Achievement Timeframe	Y	(See 7)
9. Positively Stated?	Y	(Everything is stated in positive terms, "will be able." "cooperate and follow," "responding positively," etc.)
10. Maintenance Outcomes?	NA	(It's cleat that achieving the outcome will move the family to a new and improved state)
11. Service Participation?	Y	(The statement emphasizes the end result of the acquisition of PMTO skills)
12. Meaningful / Individualized?	y	(See 2)

Improved Version

Julie says she is interested in learning how to improve her children's cooperativeness. "I wish they would respond to my requests more positively and we could get along." PMTO strategies will lead to more cooperation as well as enjoyable, considerate and caring family relationships as evidenced by an increase in enjoyable activities, an increase is compliments/words of praise/words of affection as reported by Julie.

Current Outcome Example 8:

Life Area #9 – Recreation / Hobbies
Life Area #27 – Community Inclusion

"I would like Dean to participate in activities he enjoys and be part of the community" as evidenced by leaving his apartment a least three times weekly and participating in activities with others.

Guideline	Guideline Followed? Y or N	Possible Improvement / (Explanation of why Y)
1. Consumer Quotes Included?	Y	(Parent/guardian quote nicely provides the context for the specifics that follow)
2. Consistent	Y	(The outcome follows directly from the quoted desires and likely follows from one of the issues identified in the assessment – What remains somewhat unclear is Dean's personal interest, motivation and readiness to pursue the outcome)
3. Clear?	Y	(There is much clarity as to the meaning of this outcome)
4. Concrete?	Y	(There are good specifics that spell out how it will be concluded that the outcome was or was not achieved –A few examples of activities might have made the statement even more concrete.
5. Observable / Measurable?	Y	(Quite observable and measurable – As stated in 3, a few examples of activities with others would have made it a bit easier to map out what is sought and thus achieve the outcome)
6. "As Evidenced By" Statement?	Y	(See 3-5)
7. Realistic?	y	(The clinician would need to assess whether it is realistic to expect that it could be accomplished in 6-12 months)
8. Outcome Achievement Timeframe	y	(See 7)
9. Positively Stated?	Y	(All terms are positively stated)
10. Maintenance Outcomes?	NA	(It seems that improvement is being pursued)
11. Service Participation?	Y	(Participation/involvement in CMH services is not included in the outcome statement)
12. Meaningful / Individualized?	n	The statement does not appear to capture whether leaving his apartment to engage in activities with others is personally meaningful

Improved Version

"I would like Dean to participate in activities he enjoys and be part of the community" as evidenced by leaving his apartment a least three times weekly and participating in activities with others. Dean has indicated that he enjoys bowling, restaurants, movies and an occasional party.

Current Outcome Example 9

Life Area #1 – Personal / Self Care
Life Area #8 – Vocational/Employment/Voluteer

Jaime would like to improve her hygiene so she can maintain her part-time job as a greeter at Walmart; as evidenced by showering daily, putting on clean and neat clothes daily, brushing her teeth x2 per day and combing her hair as needed

Guideline	Guideline Followed? Y or N	Possible Improvement / (Explanation of why Y)
1. Consumer Quotes Included?	N	Add a consumer quote like, "I'd like to make sure that I keep my job at Walmart"
2. Consistent	Y	(With the added quote, the outcome is consistent with the consumer's desires and likely with the assessment)
3. Clear?	Y	(What will serve as evidence that the outcome has bee achieved is made clear, keeping her job and routinely performing the listed personal care tasks)
4. Concrete?	Y	(Specific examples are given)
5. Observable / Measurable?	Y	(Observers would likely agree as to whether the outcome had or had not been achieved)
6. "As Evidenced By" Statement?	Y	(The statements contain both the end result, maintaining the job, and other results like wearing clean clothes, having brushed hair, etc.)
7. Realistic?	Y	(Let's assume its realistic that the consumer will be able to keep her job and perform the personal care tasks mentioned)
8. Outcome Achievement Timeframe	Y	(It is probably likely that the outcome could be achieved in a relatively short period of time, e.g., 6-12 months)
9. Positively Stated?	Y	(All statements are positive ones)
10. Maintenance Outcomes?	NA	--
11. Service Participation?	Y	(Statements about participating in specified services are not included in the outcome statement)
12. Meaningful / Individualized?	y	(If the clinician had observed a good amount of positive feeling when the consumer was expressing herself about this outcome, it would likely meet the test of being personally meaning ful)

Improved Version

"I'd really like to keep my job at Walmart so I need to take care of my appearance." Jaime will maintain her job as a greeter by showering daily, putting on clean and neat clothes daily, brushing her teeth x2 per day and combing her hair as needed

Current Outcome Example #10

Life Area #6 – Housing
Life Area #5 -- Financial

"I want to move out of my house and buy a house with my brother so it will be more financially affordable;" as evidenced by contacting a realtor and a creditor and following through with the necessary paperwork.

Guideline	Guideline Followed? Y or N	Possible Improvement / (Explanation of why Y)
1. Consumer Quotes Included?	Y	(Beginning with a quote sets the stage for a discussion of some of the actions that will need to occur before the outcome can be fully achieved)
2. Consistent	Y	(Seems consistent with the consumer's interests, but the clinician will need to ensure that the outcome is consistent with the problem areas identified in the assessment)
3. Clear?	Y	(The words and statement appear clear as to their meaning)
4. Concrete?	Y	(The statements are simple and specific)
5. Observable / Measurable?	Y	(Whether or not the consumer moves, buys a house with his brother, contacts a realtor, contacts a creditor and/or completes the necessary paperwork, can be confirmed by an observer
6. "As Evidenced By" Statement?	Y	--
7. Realistic?	y	(The clinician would need to assess the achievability of both the long and short term aspects of the outcome statements)
8. Outcome Achievement Timeframe	y	(see 7 above)
9. Positively Stated?	Y	(All terms point to doing something positive rather that avoiding something negative)
10. Maintenance Outcomes?	NA	--
11. Service Participation?	Y	(The statements emphasize results rather than the CMH services that will facilitate them)
12. Meaningful / Individualized?	Y	"The quote seems to demonstrate that the consumer is well motivated to achieve the outcome"

Improved Version – No change

"I want to move out of my house and buy a house with my brother so it will be more financially affordable;" ;" as evidenced by contacting a realtor and a creditor and following through with the necessary paperwork.

Current Outcome Example #11

Life Area #14 – Safety
Life Area #27 – Community Inclusion

Jim would like to maintain his safety regarding ambulation in the community through the use of sighted guide techniques

Guideline	Guideline Followed? Y or N	Possible Improvement / (Explanation of why Y)
1. Consumer Quotes Included?	N	Without a quote from the consumer or his guardian, it leaves it open as to whether this is something that is desirable – Even adding something like his guardian says "he loves to get out of his house and do something," would improve the outcome statement
2. Consistent	Y	(With the inclusion of the quote, the outcome would be made clearly consistent with expressed desires -- We can probably assume that safety in the community was identified in the assessment)
3. Clear?	N	It should be made clearer what "safety regarding ambulation" means – Without this clarification, the end result is vague – Does it mean safe from injury from falls, safe from being hit by a car, etc.?
4. Concrete?	N	See 3 above
5. Observable / Measurable?	N	See 3 above
6. "As Evidenced By" Statement?	N	See 3 above
7. Realistic?	Y	(It's probably safe to say that the consumer will be reasonably able to make progress toward this outcome)
8. Outcome Achievement Timeframe	Y	(I'll assume the outcome can be achieved in 6-12 months)
9. Positively Stated?	Y	--
10. Maintenance Outcomes?	Y	(Although the word "maintain" is used, it sounds like the outcome may involve some improvement)
11. Service Participation?	Y	(It's okay to include the step of "sighted guide techniques," but specifics should be spelled out in the steps section of the outcome page of the PCP)
12. Meaningful / Individualized?	y	(It depends on the importance the consumer gives this outcome)

Improved Version

His guardian says "he loves to get out of his house and do something." Jim will be safe when he walks during a community activity as evidenced by always remaining upright rather than falling and, thus, being free from injuries due to falls.

Current Outcome Example #12

Life Area #11 – Mood/Affect/Feelings

"I want to keep my moods stable so John won't worry. "I want to stay out of the hospital." I want to feel better about myself, have a little more self-image."

Guideline	Guideline Followed? Y or N	Possible Improvement / (Explanation of why Y)
1. Consumer Quotes Included?	N	Without a quote from the consumer or his guardian, it leaves it open as to whether this is something that is desirable – Even adding something like his guardian says "he loves to get out of his house and do something," would improve the outcome statement
2. Consistent	Y	(With the inclusion of the quote, the outcome would be made clearly consistent with expressed desires -- We can probably assume that safety in the community was identified in the assessment)
3. Clear?	N	It should be made clearer what "safety regarding ambulation" means – Without this clarification, the end result is vague – Does it mean safe from injury from falls, safe from being hit by a car, etc.?
4. Concrete?	N	See 3 above
5. Observable / Measurable?	N	See 3 above
6. "As Evidenced By" Statement?	N	See 3 above
7. Realistic?	Y	(It's probably safe to say that the consumer will be reasonably able to make progress toward this outcome)
8. Outcome Achievement Timeframe	Y	(I'll assume the outcome can be achieved in 6-12 months)
9. Positively Stated?	Y	--
10. Maintenance Outcomes?	Y	(Although the word "maintain" is used, it sounds like the outcome may involve some improvement)
11. Service Participation?	Y	(It's okay to include the step of "sighted guide techniques," but specifics should be spelled out in the steps section of the outcome page of the PCP)
12. Meaningful / Individualized?	y	(It depends on the importance the consumer gives this outcome)

Improved Version

His guardian says "he loves to get out of his house and do something." Jim will be safe when he walks during a community activity as evidenced by always remaining upright rather than falling and, thus, being free from injuries due to falls.

Current Outcome Example #13

Life Area #16 – Legal/Guardianship Issues
Life Area #14 – Safety
Life Area #4 – Health / Medical Issues

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Margaret needs help in making appropriate and safe decisions for herself so she can live a stable and healthy lifestyle; as evidence by Supports Coordinator arranging a guardian (contacting OLHSA) as soon as possible and assisting with submitting the necessary paperwork for guardianship

Guideline	Guideline Followed? Y or N	Possible Improvement / (Explanation of why Y)
1. Consumer Quotes Included?	N	No consumer quotes or other indications that the consumer feels a need for this outcome are included. Something like, "The consumer says she 'would like a lot of help in making decisions about my daily life' would be an improvement."
2. Consistent	Y	(It might be consistent with the assessment, but, without a corresponding quote, it might not be consistent with the consumer's preferences)
3. Clear?	N	It's not clear what is meant by a "stable and healthy lifestyle" or "making appropriate and safe decisions." For example, either specific examples of safety issues or, at least, general areas where safety risks are present should be added. The statement could also be made clearer by eliminating the clinician's activities and responsibilities
4. Concrete?	N	The statement isn't simple or specific enough. "The consumer will obtain an OLHSA guardian," would partially remedy this.
5. Observable / Measurable?	N	Obtaining a guardian is observable, but the statement also needs some observable, concrete changes or improvements that would result from a more stable, safe, healthy lifestyle.
6. "As Evidenced By" Statement?	N	See 3, 4 and 5 above
7. Realistic?	Y	(This is probably achievable)
8. Outcome Achievement Timeframe	Y	(This is probably achievable in the short term)
9. Positively Stated?	Y	--
10. Maintenance Outcomes?	NA	--
11. Service Participation?	Y	(The statement excludes the consumer's role in service involvement)
12. Meaningful / Individualized?	N	No evidence is given that the consumer wants this for herself

Improved Version

The consumer says she needs "a lot of help in making decisions about my daily life." Because she puts herself at risk of being taken advantage of by others and risks her health by not obtaining needed medical attention, she will obtain an OLHSA guardian. An increase in medical appointment will be observed as well as an increase in relationships with friends that are not exploitative.

Current Outcome Example #14

Life Area #17 – Advocacy / Communication
Life Area #4 – Health / Medical Issues

"I need help with understanding what my doctor is saying when I go in for my yearly exams. I get confused easily and I have a hard time communicating with my doctor." Lisa needs assistance from CSL contract staff to attend the medical appointments with her to help communicate Lisa's concerns to the doctor as well as explaining the doctor's instructions to Lisa.

Guideline	Guideline Followed? Y or N	Possible Improvement / (Explanation of why Y)
1.Consumer Quotes Included?	Y	
2. Consistent	N	The issue of consistency is difficult to address since the statement does not include an impact or end result. It only addresses to role of CSL staff in assisting the consumer.
3. Clear?	N	A clear statement about the concrete, observable impact of the staff's help needs to be included. An example would be, "The consumer will show an improvement in her health as evidenced by an increase in days at work" (or an increase in days when she feels well enough to participate in community activities or an increase in sufficiently pain-free days to report to her supports coordinator that she had a good week, etc.)
4. Concrete?	N	See 3 above
5.Observable / Measurable?	N	See 3 above
6. "As Evidenced By" Statement?	N	The only clarification or expansion of the quote is the support person's interventions
7. Realistic?	N	Unable to determine
8. Outcome Achievement Timeframe	N	Unable to determine without an outcome statement
9. Positively Stated?	N	Positive result statements are not included
10.Maintenance Outcomes?	NA	The issue appears to be one of improvement, not maintenance
11. Service Participation?	N	The focus is on the responsibilities of the provider and, thus, the consumer's involvement with the provider's services
12.Meaningful/ Individualized?	N	The quote clearly expresses the consumer's individual concerns but the additions do not reflect the personal importance of achieving a result

Improved Version

"I need help with understanding what my doctor is saying when I go in for my yearly exams. I get confused easily and I have a hard time communicating with my doctor." With communication help from her CSL support person during doctor appointments, the consumer with experience an improvement in her health status as evidenced by an increase in days when she feels well enough to participate in community activities and an increase in sufficiently pain-free days to be able to report to her supports coordinator that she had a good week.

Current Outcome Example #15

Life Area #18 – Child Care

"I would like to have more stable childcare in my home so I don't feel so uneasy when I leave my children to go to work;" as evidenced by my kids expressing their happiness and comfort with their sitter each time I return home from work.

Guideline	Guideline Followed? Y or N	Possible Improvement / (Explanation of why Y)
1.ConsumerQuotes included?	Y	
2. Consistent	Y	(The outcome statement is quite consistent with the consumer's quoted desire – The clinician would be responsible for ensuring consistency with the most recent assessment)
3. Clear?	Y	The meaning of the end result is clear
4. Concrete?	Y	(The stated outcome is specific and simple)
5.Observable/ Measurable?	Y	(The kids' statements of satisfaction are observable)
6."AsEvidenced By" Statement?	Y	(The 'as evidenced by' statement receives appropriate emphasis)
7. Realistic?	Y	(Kids' happiness with their sitter can be a realistic result, although not always easy to attain)
8.OutcomeAchievement Timeframe	Y	(This outcome seems achievable in 6 to 12 months)
9. Positively Stated?	Y	(There's nothing much more positive than expressions of happiness)
10. Maintenance Outcomes?	NA	("More stable" implies improvement, not the status-quo)
11. Service Participation?	Y	(The way in which the family will be involved in the services was not included in the outcome statement)
12. Meaningful / Individualized?	Y	(The content of the quote confirms the importance of the outcome to the consumer)

Improved Version – No change

"I would like to have more stable childcare in my home so I don't feel so uneasy when I leave my children to go to work;" as evidenced by my kids expressing their happiness and comfort with their sitter each time I return home from work.

Current Outcome Example #16

Life Area #20 -- Transportation

"I'm a good driver. I want to have reliable transportation. I want a gas powered golf-cart. I want a green Corvette." Leif would like to pursue obtaining his driver's license; as evidenced by participating in an assessment for driver's training and going to driver's education as scheduled.

Guideline	Guideline Followed? Y or N	Possible Improvement / (Explanation of why Y)
1. Consumer Quotes Included?	Y	(The consumer's quote gives the clinician a good idea of what is desired and provides an opportunity for clarification and developing other, more modest, goals)
2. Consistent	Y	(The clarification and final outcome statement is consistent with the consumer's initial goal – The obtaining of a driver's license could have been added to the statement or reserved for the next Periodic Review – I'm assuming there are no inconsistencies with the most recent assessment)
3. Clear?	Y	(There is little doubt about the meaning of the clarified outcome statement)
4. Concrete?	Y	(The statement become specific and simple, not abstract)
5. Observable/ Measurable?	Y	(Agreement could easily be reached as to whether the consumer participated in driver's education)
6. "As Evidenced By" Statement?	Y	(The importance of its inclusion is nicely demonstrated in this outcome statement)
7. Realistic?	Y	(The consumer's participation in driver's education is probably realistic)
8. Outcome Achievement Timeframe	Y	(It's likely that the clinician and consumer judged the outcome to be achievable in the next 6 to 12 months)
9. Positively Stated?	Y	(All of the statements reflect movement toward something positive)
10.Maintenance Outcomes?	NA	See 9 above
11. Service Participation?	Y	(The CMH services that will facilitate the achievement of the outcome are absent from the statement)
12.Meaningful/ Individualized?	Y	(The quote seems to express the consumers strong interest in achieving the outcome)

Improved Version – No change

"I'm a good driver. I want to have reliable transportation. I want a gas powered golf-cart. I want a green Corvette." Leif would like to pursue obtaining his driver's license; as evidenced by participating in an assessment for driver's training and going to driver's education as scheduled.

Current Outcome Example #17

Life Area #21 – Substance Abuse

"I need to obtain a sponsor to help me keep sober; especially during the holidays;" as evidenced by client attending AA regularly (x3-x5 per week), getting to know the sponsors, and then selecting one of interest.

Guideline	Guideline Followed? Y or N	Possible Improvement / (Explanation of why Y)
1. Consumer Quotes Included?	Y	(In this quote the consumer provides a clear statement of an outcome, keeping sober during the holidays, and the shorter term goals that need to be accomplished in order to attain it, attending AA and obtaining an AA sponsor.)
2. Consistent	Y	(Clearly consistent with the consumer's desires and, most likely, with the assessment)
3. Clear?	Y	(The meaning is clear and a positive or negative result would be observable – A designated period of time during which sobriety is maintained would add some concreteness to the statement)
4. Concrete?	Y	(See 3 above)
5. Observable / Measurable?	Y	(See 3 above)
6. "As Evidenced By" Statement?	Y	(See 3 above)
7. Realistic?	Y	(It appears realistic on the face of it)
8. Outcome Achievement Timeframe	Y	(It appears the outcome could be achieved in a relatively short period of time)
9. Positively Stated?	Y	(All terms are positively stated
10.Maintenance Outcomes?	NA	(Staying sober sounds like as maintenance goal, but staying sober for a longer-than-usual length of time for this consumer would bring it into the category of improvement)
11. Service Participation?	Y	(The consumer's sought after outcome is emphasized over participation in CMH services)
12.Meaningful/ Individualized?	Y	(The quote appear to reflect the consumer's strong individual desire to pursue this outcome)

Slightly Improved Version

"I need to obtain a sponsor to help me keep sober; especially during the holidays;" as evidenced by client attending AA regularly (x3-x5 per week), getting to know the sponsors, selecting one of interest and staying sober for a minimum of six month period which includes the winter holidays

Current Outcome Example #18

Life Area #24 – Cultural / Spiritual

"I would really like to be able to go back to church again, but I have to be reinstated by the council." [Successful completion of the Outcome will be evidenced by Ms. J. completing the following in the term of her treatment plan: 1.Contacting her former church. 2. Meeting with the Council. 3. Developing a plan for Reinstatement. 4. Getting approval. 5. Official Reinstatement. 6. Registering at her Church office. 7. Active and regular participation in services. This evidence will be collected and monitored via self-report during interviews at monthly case management contacts. Ms. J. will report on her progress at each contact.

Guideline	Guideline Followed? Y or N	Possible Improvement / (Explanation of why Y)
1. Consumer Quotes Included?	Y	(The consumer quote serves as an excellent jumping off point for specifics and observables)
2. Consistent	Y	(The specifics that were added are clearly consistent with the consumer's desired outcome – It is also quite likely that there is nothing in the assessment that would make the outcome statements inconsistent with it)
3. Clear?	Y	(Spelled out very clearly – There is negligible ambiguity)
4. Concrete?	Y	(Statement is simple, straightforward and individualized)
5.Observable/ Measurable?	Y	(There should be no difficulty in obtaining agreement about whether the outcome(s) has been achieved)
6. "As Evidenced By" Statement?	Y	(In this case, adding the steps provides ample evidence about which smaller goals are needed to be achieved before the broader outcome of going back to church, the end result, is achieved – Including some of these shorter term goals in the steps would have also been acceptable)
7. Realistic?	Y	(Probably)
8. Outcome Achievement Timeframe	Y	(It appears that the outcome(s) can be achieved during the term of the plan – In fact this is nicely added to the statement)
9. Positively Stated?	Y	(Everything is stated positively in terms of actions the consumer will take to move toward outcome achievement)
10.Maintenance Outcomes?	NA	
11. Service Participation?	Y	(Only the method of determining whether outcomes have been achieved is related to the service contacts, rather than service participation being stated as an outcome in itself)
12.Meaningful / Individualized?	Y	(The quote provides evidence that outcome achievement will be important and meaningful to the consumer)

Improved Version – No change

"I would really like to be able to go back to church again, but I have to be reinstated by the council." [Successful completion of the Outcome will be evidenced by Ms. J. completing the following in the term of her treatment plan: 1.Contacting her former church. 2. Meeting with the Council. 3. Developing a plan for Reinstatement. 4. Getting approval. 5. Official Reinstatement. 6. Registering at her Church office. 7. Active and regular participation in services. This evidence will be collected and monitored via self-report during interviews at monthly case management contacts. Ms. J. will report on her progress at each contact

Current Outcome Example #19

Life Area #26: Developmental Skills

Frank would like to improve his sensory processing skills (per mom – guardian) in order to be more comfortable in his environment.

Guideline	Guideline Followed? Y or N	Possible Improvement / (Explanation of why Y)
1. Consumer Quotes Included?	N	Actual quotes would improve the statement
2. Consistent	Y	Probably consistent with the assessment and the desires of the mom
3. Clear?	N	There needs to be more clarity about which specific sensory processing skills are needing improvement and about the meaning of being more comfortable in his environment – An example of the latter would be something like, "Frank will show an increase in the frequency of activities in which he appears alert and relaxed"
4. Concrete?	N	Same as 3 above
5.Observable/ Measurable?	N	Same as 3 above – The end result needs to be something that is observable – In this example a way of determining whether the consumer is comfortable or not needs to be spelled out
6. "As Evidenced By" Statement?	N	See 3 above
7. Realistic?	Y	(Probably)
8. Outcome Achievement Timeframe	Y	(Probably)
9. Positively Stated?	Y	(An increase, rather than a decrease, is stated)
10.Maintenance Outcomes?	NA	An increase in something indicates an improvement as opposed to maintaining a current level of functioning
11. Service Participation?	Y	(The focus is on the impact of services, rather than on participating in a service)
12.Meaningful/ Individualized?	N	A fuller quote and additional clarification might produce a statement that is more individualized and personally meaningful

Improved Version

Frank's mom says that "Frank often appears very frustrated, unhappy and confused when he is in the presence of a moderate or high amount of visual/sound/tactile stimulation" – "I'd like to him to be able to take in these sights and sounds and touches more satisfactorily" – Frank will benefit from sensory integration assistance as evidenced by showing an increase in the frequency of activities in which he appears alert and relatively relaxed – These activities will include …

Current Outcome Example #20

Life Area #25: End of Life Needs

"I don't want to end up dying alone"

Guideline	Guideline Followed? Y or N	Possible Improvement / (Explanation of why Y)
1. Consumer Quotes Included?	Y	(Clearly states consumer's concerns and wishes)
2. Consistent	Y	(The quote is very likely consistent with issues raised in the assessment)
3. Clear?	N	A more specific picture of the consumer's desired social, interpersonal environment as she approaches death is lacking -- Something like the following would improve the statement: " Leslie will increase her feelings of belonging as evidenced by developing and maintaining closer relationships with her acquaintances, her church and other community supports such as hospice and reporting feeling accepted and cared for"
4. Concrete?	N	See 3 above
5.Observable/ Measurable?	N	See 3 above
6. "As Evidenced By" Statement?	N	See 3 above
7. Realistic?	Y	Let's assume the consumer has the capacity to develop meaningful relationships
8. Outcome Achievement Timeframe	Y	Let's assume the consumer can do the above within the duration of the PCP
9. Positively Stated?	N	See 3 above
10.Maintenance Outcomes?	NA	
11. Service Participation?	Y	(Service participation / contacts with CMH providers are left for inclusion somewhere else in the plan)
12.Meaningful/ Individualized?	Y	(The quote itself meets the criteria for personal meaningfulness)

Improved Version

"I don't want to end up dying alone" Leslie will increase her feelings of belonging as evidenced by developing and maintaining closer relationships with her acquaintances, her church and other community supports such as hospice and reporting feeling accepted and cared for.