Tools to Aid in Assuring Quality of Care

Management teams need to meet whenever analysis of monitoring information suggests a need for program changes or at designated review periods. Between meetings, it is the responsibility of the primary manager to ensure care is appropriately monitored and team meetings are called whenever changes are needed. It is the team as a whole, however, that has responsibility for designating necessary changes and working to ensure designated changes are made. The tools within this section include forms:

1) to be completed at team meetings regarding the presenting problems, initial treatment plan and changes to this plan,

2) to write up and circulate changes proposed by the management team and emphasize who has agreed to do which tasks by when, and

3) to evaluate the services provided and client progress.
Management of Care Review Form

Student's Name or ID # ________________________ Birthdate _______

Primary Manager of Care ________________________________________

Management of Care Team (including student/family members):
______________________________________________________________
______________________________________________________________
____________________________________________________________________________

Initial Plan

Date management of care file opened: ___________

Student Lives with: __________________________ Relationship _________________
Address_______________________________  Phone _________________

Home language ____________________________________________________

Type of concern initially presented (briefly describe for each applicable area)

<table>
<thead>
<tr>
<th>How serious are the problems?</th>
<th>not too</th>
<th>very</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>serious</td>
<td></td>
</tr>
<tr>
<td>Learning</td>
<td>1  2  3  4  5  6</td>
<td></td>
</tr>
<tr>
<td>Behavior</td>
<td>1  2  3  4  5  6</td>
<td></td>
</tr>
<tr>
<td>Emotional</td>
<td>1  2  3  4  5  6</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1  2  3  4  5  6</td>
<td></td>
</tr>
</tbody>
</table>

Problem Identified and Referred by: ___________________________  date________

Initial client consultation done with: ___________________________  date _________
Conducted by:_________________________________

Indicate diagnosis (if any): _________________________________

Recommendations/Decisions/consents:

Planned Date for Immediate Follow-up: ___________
(2 weeks after recommended action)
Immediate Follow-up

Date: __________________

Appropriate client follow-through? Yes No

If no, why not?

Is the original plan still appropriate? Yes No

If no, why not?

What changes are needed?

Any problems with coordination of interventions? Yes No

If yes:

What needs to be done? By Who? When? Monitoring Date:

If plan has changed, indicate new recommendations/decisions (including plans for improving coordination):

SYSTEMS OF CARE REVIEW: Any general implications for improving the school's systems for referral, triage, client consultation, management of care, integration of school programs, and work with other agencies? If so, these implications should be directed to those responsible for enhancing the system.

Planned date for first team review: __________________
(in about 2 months or sooner if necessary)

The primary manager must be certain that (1) everyone understands revised plans and needs to improve coordination and (2) appropriate steps are taken to facilitate action. This requires monitoring activity in the days and weeks that follow this follow-up check.
First Team Review  

Date:_________________

Team members present:
______________________  ___________________  ___________________
______________________  ___________________  ___________________

General Update on Client Status (indicate source of information, progress, ongoing concerns, etc.)

With respect to concerns initially presented, at this time --

<table>
<thead>
<tr>
<th>Amount of Improvement Seen</th>
</tr>
</thead>
<tbody>
<tr>
<td>not too much</td>
</tr>
<tr>
<td>very much</td>
</tr>
</tbody>
</table>

| Learning: | 1 | 2 | 3 | 4 | 5 | 6 |
| Behavior: | 1 | 2 | 3 | 4 | 5 | 6 |
| Emotional:| 1 | 2 | 3 | 4 | 5 | 6 |
| Other:    | 1 | 2 | 3 | 4 | 5 | 6 |

Appropriate client follow-through?  
Yes  No

If no, why not?
Is the current plan still appropriate? Yes No

If no, why not?

What changes are needed?

Any problems with coordination of interventions? Yes No

If yes:

What needs to be done? By Who? When? Monitoring Date:

If plan has changed, indicate new recommendations/decisions (including plans for improving coordination):

**SYSTEMS OF CARE REVIEW**: Any general implications for improving the school's systems for referral, triage, client consultation, management of care, integration of school programs, and work with other agencies? If so, these implications should be directed to those responsible for enhancing the system.

Planned date for next team review: ____________________
(in about 2 months or sooner if necessary)

The primary manager must be certain that (1) everyone understands revised plans and needs to improve coordination and (2) appropriate steps are taken to facilitate action. This requires monitoring activity in the days and weeks that follow this follow-up check.
Note: This sheet may be used several times over the course of intervention (e.g., every 2 mths).

**Ongoing Team Review**

Date:_________________

Team members present:
______________________   ___________________   ___________________
______________________   ___________________   ___________________

General Update on Client Status (indicate source of information, progress, ongoing concerns, etc.)

With respect to concerns initially presented, at this time --

<table>
<thead>
<tr>
<th></th>
<th>How Severe?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>not too severe</td>
</tr>
<tr>
<td>Learning:</td>
<td>1  2  3  4  5  6</td>
</tr>
<tr>
<td>Behavior:</td>
<td>1  2  3  4  5  6</td>
</tr>
<tr>
<td>Emotional:</td>
<td>1  2  3  4  5  6</td>
</tr>
<tr>
<td>Other:</td>
<td>1  2  3  4  5  6</td>
</tr>
</tbody>
</table>

Appropriate client follow-through? Yes  No
If no, why not?
Is the current plan still appropriate?  Yes  No

If no, why not?

What changes are needed?

Any problems with coordination of interventions?  Yes  No

If yes:

What needs to be done?  By Who?  When?  Monitoring Date:

If plan has changed, indicate new recommendations/decisions (including plans for improving coordination):

**SYSTEMS OF CARE REVIEW**: Any general implications for improving the school's systems for referral, triage, client consultation, management of care, integration of school programs, and work with other agencies? If so, these implications should be directed to those responsible for enhancing the system.

Planned date for next team review: ____________________
(in about 2 months or sooner if necessary)

The primary manager must be certain that (1) everyone understands revised plans and needs to improve coordination and (2) appropriate steps are taken to facilitate action. This requires monitoring activity in the days and weeks that follow this follow-up check.
End of Intervention

Date: ______________

Final Update on Client Status (indicate source of information, progress, ongoing concerns, etc.)

With respect to concerns initially presented, at this time --

<table>
<thead>
<tr>
<th>How Severe?</th>
<th>not too severe</th>
<th>very severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning:</td>
<td>1  2  3  4  5  6</td>
<td></td>
</tr>
<tr>
<td>Behavior:</td>
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<td>Other:</td>
<td>1  2  3  4  5  6</td>
<td></td>
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</tbody>
</table>

Why is the intervention ending?

If the client still needs assistance, what are the ongoing needs?

What plans are there for meeting these needs?

If there are no plans, why not?
SYSTEMS OF CARE REVIEW: Any general implications for improving the school's systems for referral, triage, client consultation, management of care, integration of school programs, and work with other agencies? If so, these implications should be directed to those responsible for enhancing the system.

With intervention ending, the primary manager must be certain that (1) everyone who should be informed is provided relevant information and (2) evaluation data are entered into the appropriate systems.
Follow-up Rating Form -- Service Status (Intervener Form)  
(To be filled out periodically by interveners)

To: (Intervener's name)

From: _____________________, Primary Care Manager

Re: Current Status of a client referred to you by _________________ school.

Student's Name or ID # ________________________ Birthdate _______ Date___________

Number of sessions seen: Ind.____ Group ____

What problems were worked on?

Current status of problems worked on: (Severity at this time)

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>very severe</td>
<td>severe</td>
<td>not too severe</td>
<td>not at all severe</td>
</tr>
</tbody>
</table>

If the problems worked on differ from the "presenting" problems (e.g., referral problem), also indicate the current status of the presenting problems.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>very severe</td>
<td>severe</td>
<td>not too severe</td>
<td>not at all severe</td>
</tr>
</tbody>
</table>

Recommendations made for further action:

Are the recommendations being followed? YES NO

If no, why not?

How much did the intervention help the student in better understanding his/her problems?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>not at all</td>
<td>not much</td>
<td>only a little bit</td>
<td>more than a little bit</td>
<td>quite a bit</td>
<td>very much</td>
</tr>
</tbody>
</table>

How much did the intervention help the student to deal with her/his problems in a better way?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>not at all</td>
<td>not much</td>
<td>only a little bit</td>
<td>more than a little bit</td>
<td>quite a bit</td>
<td>very much</td>
</tr>
</tbody>
</table>

Prognosis

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>very positive</td>
<td>positive</td>
<td>negative</td>
<td>very negative</td>
</tr>
</tbody>
</table>
Follow-up Rating Form -- Service Status (Client Form)
(To be filled out periodically by the clients)

Student’s Name or ID # ________________________ Birthdate _______ Date___________

1. How worthwhile do you feel it was for you to have worked with the counselor?

   |   1 | 2 | 3 | 4 | 5 | 6 |
---|----|---|---|---|---|---|
not at all | not much | only a little bit | more than a little bit | quite a bit | very much |

2. How much did the counseling help you better understand your problems?

   |   1 | 2 | 3 | 4 | 5 | 6 |
---|----|---|---|---|---|---|
not at all | not much | only a little bit | more than a little bit | quite a bit | very much |

3. How much did the counseling help you deal with your problems in a better way?

   |   1 | 2 | 3 | 4 | 5 | 6 |
---|----|---|---|---|---|---|
not at all | not much | only a little bit | more than a little bit | quite a bit | very much |

4. At this time, how serious are the problems for you?

   |   1 | 2 | 3 | 4 |
---|----|---|---|---|
very severe | severe | not too severe | not at all severe |

5. How hopeful are you about solving your problems?

   |   1 | 2 | 3 | 4 |
---|----|---|---|---|
very hopeful | somewhat hopeful | not too hopeful | not at all hopeful |

If not hopeful, why not?

6. If you need help in the future, how likely are you to contact the counselor?

   |   1 | 2 | 3 | 4 |
---|----|---|---|---|
not at all | not too likely | likely to | definitely will |