

Tools to Aid in Assuring Quality of Care



This **Quick Training Aid** was excerpted from a Technical Aid packet entitled: *School-Based Consultation, Referral, and Management of Care*, Appendix D. Center for Mental Health in Schools (1997).

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.

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 --

Amount of Improvement Seen

not too much						very much
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Learning:	1	2	3	4	5	6
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Behavior:	1	2	3	4	5	6
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Emotional:	1	2	3	4	5	6
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Other:	1	2	3	4	5	6
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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 --

	How Severe?					
	not too severe					very severe
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?
If no, why not?

Yes No

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 --

	How Severe?					
	not too severe					very severe
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

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)

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

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

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

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?

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

How much did the intervention help the student to deal with her/his 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

Prognosis

1	2	3	4
very positive	positive	negative	very negative

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