

General

Question

- 1 Each member has a separate record.
- 2 Treatment record that includes the member's address, telephone numbers including emergency contacts, birth and/or identified gender, relationship and legal status, and guardianship information (if relevant).
- 3 All entries in the record include the responsible clinician's name, professional degree/licensure/certification, and relevant identification number, if applicable, and dated and signed (including electronic signature for EMR systems) where appropriate.

Active Engagement

Question

- 4 There is evidence in the record that the member engaged in a person-centered manner in the program space and natural environments where they live, work, learn, and socialize as applicable.
- 5 There is evidence that engagement remains active throughout the course of treatment. This includes evidence that the member is involved in all aspects of their treatment and the inclusion of collaterals, family of choice, and peers is encouraged.
- 6 There is evidence that if a member becomes disengaged from PROS, the program makes proactive efforts to re-engage the member relative to the degree of assessed risk.

Pre Admission and Admission

Question

- 7 There is evidence that the member is offered the opportunity to tour the program, groups/classes and activities as soon as possible, and within one week of request of services (referral).
- 8 There is evidence that the member is seen in-person, onsite or offsite, at least once during pre-admission.
- 9 There is evidence that the member is provided with a written notice of their rights prior to or upon admission. PROS staff provide member with information about their rights in a manner that is person-centered and mindful of their learning styles.
- 10 There is evidence that a screening and admission note for the member is completed by a professional member of the staff at the time of admission and includes the reason for admission, primary service related needs and services to meet those needs, and admission diagnosis.
- 11 There is evidence that if a member is not admitted to PROS, a screening and admission note must be completed and include the reason for not admitting the individual, any referrals made and the dated signature of a professional member of the PROS staff.
- 12 There is evidence in the record that the recommendation by an LPHA for the member is completed at or prior to admission and includes an explanation of the medical need for PROS.
- 13 There is evidence that the Initial Service Recommendation (ISR) is completed and implemented prior to the completion of the Individualized Recovery Plan (IRP).

Risk of Harm to Self or Others

Question

- 14 There is evidence that the member is screened for risk of harm to self and others using standardized risk screening tools.
- 15 There is evidence that if the member has positive risk of harm to self or others screen, an assessment is conducted that considers both static and dynamic factors in conjunction with current mental status, supports and protective factors.
- 16 There is evidence that if the member has positive risk of harm to self or others screen, the assessment includes access or absence of access to means/ weapons.

- 17 There is evidence that if the it is determined that the member is a moderate to high risk this prompts the development of a safety plan, clinical consultation and/or other immediate intervention.
- 18 There is evidence that the member safety plan is reviewed, and updated if needed, after any critical event.

Assessment

Question

- 19 There is evidence that the Alcohol, Tobacco, and Other Drug Assessment is completed with the member within 60 days of admission.
- 20 There is evidence that if the member is enrolled in the Community Rehabilitation and Support (CRS) and Intensive Rehabilitation (IR) components the Alcohol, Tobacco, and other Drug Assessment is completed prior to the development of the initial Individualized Recovery Plan (IRP).
- 21 There is evidence that the assessment includes required screenings for co-occurring substance use disorders and tobacco use.
- 22 There is evidence that if there are positive screens for co-occurring substance use disorders and tobacco use the assessment includes history of use and current use and formulates treatment recommendations and referrals if appropriate.
- 23 There is evidence that the member's Comprehensive Psychiatric Rehabilitation Assessment (CPRA) is completed within 60 days of admission and prior to the development of the initial IRP for all participants enrolled in the CRS, IR, and PRS components. For individuals who are enrolled in ORS only, the assessment may be completed with only an employment focus. (For ORS-only, the program may choose to only complete the relevant/necessary sections for an employment focus)
- 24 There is evidence that the member's CPRA (assessment) is culturally sensitive, trauma informed, and includes all required elements (areas of living, learning, working, socializing, relationships and leisure).
- 25 If the member expresses an interest in employment during the CPRA, a PROS Employment Specialist completed an Employee Interest Interview.
- 26 There is evidence that the Health Assessment included all the required elements per the standards of care.
- 27 There is evidence that if serious health risks are identified in the member Health Assessment, the program provides appropriate follow-up (i.e., collaboration with medical professionals, referrals, etc.).
- 28 For member enrolled in the Clinical Treatment component only: There is evidence in the record that the Psychiatric Assessment is completed for the member within 60 days of admission and prior to the development of the initial IRP.
- 29 For member enrolled in the Clinical Treatment component only: There is evidence in the record that the Psychiatric Assessment includes all required elements.
- 30 There is evidence in the record that each initial required member assessment includes a narrative formulation summarizing the findings and recommendations which are to be prioritized for incorporation into the IRP, as appropriate.
- 31 There is evidence in the record that when the member indicates an interest in employment, an employment interest interview is completed by the employment specialist within 30 days of completion of the Comprehensive Psychiatric Rehabilitation Assessment, with a focus on exploring the member's interest in pursuing an employment goal.

IRP Planning

Question

- 32 There is evidence that each member is empowered to participate in the planning of their services and makes informed decisions about the services and supports that they receive in PROS.
- 33 There is evidence that the Individualized Recovery Plan (IRP) is developed in collaboration with the member and any additional individuals (family of choice, collaterals, etc.) desired by the member.
- 34 There is evidence that the value of sharing information with identified collaterals is discussed with the member and their consent is sought and documented as appropriate.
- 35 There is evidence that collaterals, including family of choice, or absence of are identified and documented in the IRP or elsewhere in the case record.

- 36 There is evidence that if the member indicates a willingness to reduce or quit tobacco/nicotine use is provided with services to support that goal.

IRP

Question

- 37 There is evidence that the member initial IRP is completed within 60 days of admission and after the completion of initial assessments.
- 38 There is evidence that the member's IRP includes a person-centered Recovery Vision, PROS goal(s), and objectives which reflect the member's needs and preferences.
- 39 There is evidence the member's IRP Objectives are measurable, have target dates, and clearly represent steps toward the achievement of goals.
- 40 There is evidence that Identified services are directly related to barriers associated with a mental health diagnosis and change as the member's needs change.
- 41 There is evidence that the member's IRP contains all required signatures: Within 7 calendar days of IRP development, the following signatures must be obtained.- PROS Member- Staff Member who developed the IRP- LPHA reviewing and approving the IRP, if the staff member who developed the plan is not an LPHA
- 42 There is evidence that the member's IRP contains all required signatures: For member's receiving CT Medication Management, the following signature must be obtained within 30 days of IRP development - Psychiatrist or nurse practitioner in psychiatry.
- 43 There is evidence that a copy of the most current IRP is made available to the PROS member.

IRP Review/Revision

Question

- 44 There is evidence that the IRP is reviewed in a collaborative process at least every six months or whenever there is a significant life event (e.g., achieving a goal, change in housing, or a hospitalization).
- 45 There is evidence that for each IRP review, an individualized recovery planning meeting is held with the member and any collateral(s) they want to invite.
- 46 There is evidence that the goals, objectives and/or services are changed in response to changes in the member needs and circumstances; OR as progress is made; OR when there is an ongoing lack of progress.

Monthly Summary Note

Question

- 47 There is evidence that the Monthly Summary Notes (MSNs) are completed at least once per calendar month in a manner that meaningfully engages the member around identifying progress and next steps.
- 48 There is evidence that the MSNs include a summary of the progress made (or not made) towards objectives identified in the IRP, subsequent to the previous MSN.
- 49 There is evidence that any member emergent needs or significant life events identified are documented in the MSN or elsewhere in the case record.
- 50 There is evidence that new services are added to the IRP and/or non-routine services (e.g., Crisis Intervention or Complex Care Management) are provided in response to member new or emergent needs.

Discharge Planning

Question

- 51 There is evidence that the discharge plan are developed collaboratively by the member, staff, and relevant collaterals, and reflect an understanding by all parties about when discharge will occur, based on the achievement of specific and measurable goals.
- 52 There is evidence that arrangements for appropriate post-discharge services are made and discussed with member and collaterals prior to the planned discharge.
- 53 There is evidence that a discharge summary is completed at the time of discharge, includes all required elements, and is shared with the receiving program within 2 weeks, as applicable.
- 54 There is evidence that the member is informed that the program may be accessed again, subsequent to discharge.

Person Centered Services

Question

- 55 There is evidence that services are collaborative in nature and based on the individual's interests, preferences, strengths, and needs
- 56 There is evidence that services are designed to empower the member by fostering skills to achieve desired personal relationships, community participation, dignity, and respect.

PROS Components

Question

- 57 There is evidence that services are offered of site or through telehealth when appropriate.

PROS with Clinical Treatment

Question

- 58 There is evidence that the program rapidly admits and assesses member referred from inpatient, forensic, or emergency settings to ensure that there is no lapse in psychiatric medications
- 59 There is evidence that medication management services for the member include the prescribing and availability of the full range of atypical antipsychotic medications and injectable psychotropic medication administration.
- 60 There is evidence that clinical treatment services for the member are fully integrated with other PROS services, as evidenced by team meetings, clinical reviews, case conferences, and team communication.
- 61 There is evidence that the member's health issues are monitored, as needed, beyond the initial assessment, by medically qualified staff.
- 62 There is evidence that Abnormal Involuntary Movement Scale (AIMS) testing or equivalent by a medically qualified staff is conducted on a regular basis for member's when clinically indicated.
- 63 There is evidence that metabolic monitoring is conducted regularly for member's taking medications that increase the risk of metabolic syndrome.

Cognitive Remediation

Question

- 64 If there is evidence of cognitive remediation, the program provides access to specialized computer software or online programs to support the provision of evidence-based cognitive remediation. (Non Scored)

Program Schedule

Question

- 65 There is evidence that the member has a program schedule and is reflective of changing goals and needs of member.

Recovery Oriented Activities

Question

- 66 There is evidence that recovery resources and activities are available for member throughout the program day, offering opportunities for self-directed, meaningful recovery oriented activities and skill development.

Employment Services

Question

- 67 There is evidence through documentation that the following principles are reflected in employment services: The benefits of competitive, integrated employment are discussed with member, and individualized options for employment consistent with member preferences are discussed with member who expresses an interest in working, regardless of previous employment history or current barriers.
- 68 There is evidence through documentation that the following principles are reflected in employment services: The program provides support to member on an individualized basis for as long as a need exists. Employment specialists are involved on an ongoing basis in developing relationships with local employers who can provide job opportunities consistent with the work preferences of member.

Whole Health & Integrated Care

Question

- 69 There is evidence that the program provides information about the negative impact of tobacco/nicotine use and the benefits of reduction/ cessation to identified tobacco users at intake and at each IRP review.
- 70 There is evidence that the member is asked if they have a primary care provider (PCP), and the program takes appropriate follow-up steps to collaborate with the PCP or make a referral if the member does not have one.
- 71 There is evidence that the program maintains communication and collaboration with primary care providers and other medical specialists. When serious health risks are identified, programs share this information with the member's Primary Care Provider, Medical Specialists, and Health Home Care Manager, if applicable.
- 72 There is evidence that the program supports integration with outside Clinical Treatment providers (i.e., Article 31 or 32 Programs) as evidenced by identifying outside clinical treatment providers, obtaining informed consent to release/receive information, and engaging in an ongoing exchange of information with outside providers on at least a quarterly basis (if applicable).
- 73 There is evidence that the program has established linkages with various community resources and promotes appropriate information sharing within the program and with outside agencies, natural supports, and other collaterals in providing coordinated services for member.

Telehealth

Question

- 74 There is evidence that if the member is receiving Telehealth Services, each IRP review must include a discussion of the individual's telehealth access, skills, preferences, or needs moving forward.